

## ***Maximizing results of esophagectomy for advanced achalasia***

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***Background:-*** The tortuous megaesophagus acts mechanically as a sink trap. At this stage of the disease, we do not relieve the dysphagia performing a myotomy of the lower esophageal sphincter. Therefore, esophagectomy is required, but feared due its postoperative morbid-lethality.

***Aim:*** To check good outcome providing the adequate prepare and technical care to the procedure.

***Materials and methods:*** Eleven patients with sink trap megaesophagus (8 men and 3 women, 44 +/- 8.7 years old), after endoscopic exclusion of associated esophageal diseases were submitted to conventional esophageal manometry revealing aperistalsis and contractions with amplitude of less than 12 +/- 1.6 mmHg. Initially gastric tube was passed with aid of endoscopy to make patient regain weight until reaching body mass index (BMI) 20. Hence admitted on the eve of the operation, they were submitted to fasting, parenteral hydration and washing of the esophagus until clean water returns. Antibiotic prophylaxis was performed with cefuroxime or ceftriaxone. The procedure consisted initially of laparotomy, cervicotomy and trans-hiatal esophagectomy. We passed a 3cm large gastric tube to the neck through esophageal bed, resecting cranial redundant part of the tube, and then performing esophago-gastric end-to-end anastomosis, 3 cm below

*cricopharyngeus muscle, in two layers, applying continuous suture in muscular layer and on rear face of mucosal layer, and separate stitches on the anterior mucosal face. Pediatric chest drains were placed in both pleural cavities, removed from the fourth to the sixth postoperative day; a soft abdominal drain was always used and a tube was passed through a nostril until the proximal jejunum providing route to enteral nutrition used until 10<sup>th</sup> postoperative day, when oral nutrition was reintroduced. Extubation occurred always at the end of the surgery and patients walked since the first postoperative day.*

**Results:***Two patients had superficial surgical wound infection delimited in less than 3cm of extension and other two, abdominal lymphatic drainage above 200mL respectively for five and six postoperative days. There were not severe complications or deaths. Fistulas did not occur in the series. Followed at least for one year the patients did not present changes in esophageal stump, referring good quality of life and normal swallowing of any kind of food. All gained weight ( $P<0.01$ ).*

**Conclusions:***The small series asks for better judgment but results strongly suggest that esophagectomy and esophagogastroplasty tend to achieve splendid results in young patients with advanced achalasia if preoperatively well prepared and then submitted to adequate operative technique.*

### **Bibliography**

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