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Diagnosis of a Case of Achalasia of the Cardiac at the Somine Dolo Hospital in Mopti

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Abstract **Case Report**

We report through this observation the diagnosis of a case of achalasia of the cardia in a 14-year-old adolescent at the Sominé Dolo hospital in Mopti. This was the first case of Achalasia of the cardia out of the 2650 gastroscopies carried out in Mopti from 2018 to 2022. The patient had no particular personal or family medical/surgical history. According to the symptoms, it was classified as Stage 3 of the Eckardt Score. The esogastroduodenal fibroscopy performed revealed a narrowing of the cardia and a jump when passing the endoscope. It was stage II at the time of diagnosis, according to the distension of the body of the esophagus during esophagogastric transit and a Radish tail image at the level of the esophagogastric junction. Frontal chest x-ray showed significant mediastinal widening. However, monomerism (essential examination) inaccessible in our context could not be achieved. The diagnosis of achalasia of the cardia was retained based on clinical, endoscopic and radiological arguments.

Keywords: Achalasia, Adolescent, Diagnosis, HSD-Mopti.

I. INTRODUCTION

Achalasia, also called idiopathic megaesophagus or cardiospasm, is a rare pathology [1]. It is a neurological condition of the esophagus characterized by an alteration of esophageal peristalsis and a failure to relax the lower esophageal sphincter during swallowing [2].

The reported global incidence and prevalence range from 0.03 to 1.63 per 100,000 people per year and 1.8 to 12.6 per 100,000 people per year, respectively [3].

We report through this observation a clinical case of achalasia at the Sominé Dolo hospital in Mopti with a late diagnosis at the stage of complications (vomiting, anemia, weight loss, etc.).

II. OBSERVATION

We present the case of a 14-year-old adolescent, seen in consultation in December 2022 at the Sominé Dolo hospital in Mopti. This is a patient with no particular personal or family pathological history.

Symptomatic for approximately 12 months before the date of consultation, the clinical picture was marked by the onset of progressive dysphagia, more marked with liquids than with solids. Associated signs were heartburn and daily regurgitation.

Faced with these symptoms, he benefited from multiple traditional treatments based on decoctions and several consultations in the various health centers in his native village, without any real improvement in the symptoms.

The evolution was marked by a progressive worsening of his clinical picture, by episodes of intermittent food vomiting, marked weight loss, nocturnal cough, dizziness, headache for which his parents decided to consult the Mopti Regional Hospital.

The clinical examination today revealed:

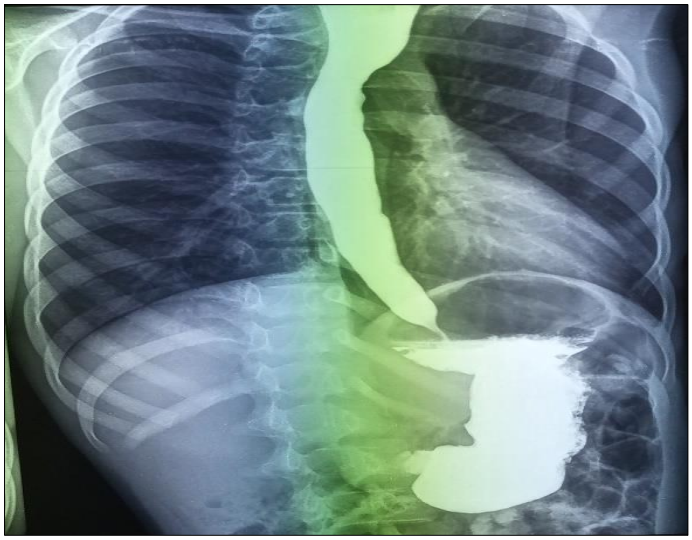
Good consciousness, conjunctival pallor, dry skin, dry mouth. Blood Pressure at 100/60 mmHg, Heart Rate at 100b/min, Respiratory Rate at 20c/min and Temperature at 36.8°c.

Marked weight loss (WHO 2), with a BMI of 14.22. Frontal chest x-ray showed significant mediastinal widening. The esogastroduodenal fibroscopy performed revealed a narrowing of the cardia and a jump when passing the endoscope.

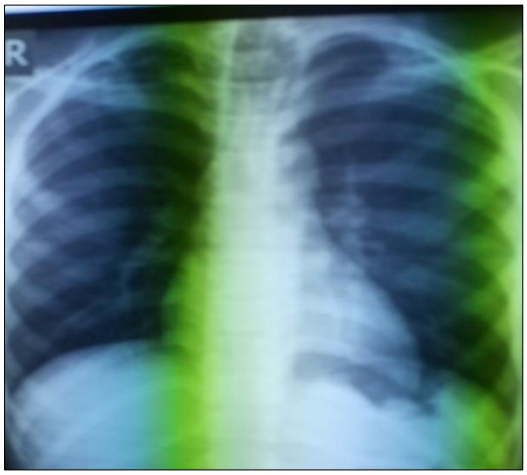
The esophagogastroduodenal transit showed a Radish tail image at the esophagogastric junction and a dilation of the body of the esophagus.

The diagnosis of achalasia of the cardia was retained based on clinical, endoscopic and radiological arguments. However, monomerism was not carried out because it was not available in our context. This was the first case of Achalasia of the cardia out of 2650 gastroscopies carried out in Mopti.

X-ray images



TOGD



Front chest x-ray

III. COMMENTS

Achalasia of the esophagus is generally a benign pathology; little work has been devoted to it. Its incidence has been estimated at around 0.03 to 1.63 per 100,000 people per year, it can be observed at any age, but it appears most often between 25 and 60 years [3, 4].

The onset is insidious and progresses gradually over several months or years. Dysphagia to liquids and solids is the major symptom. Nocturnal regurgitation of undigested food occurs in almost 33% of patients and can lead to coughing and aspiration of the lungs. Chest pain is less common, but can occur during swallowing or spontaneously [5].

According to the symptoms, our patient was classified Stage 3 of the Eckardt Score. The diagnosis of achalasia of the cardia is almost always made late, if applicable in our patient [6].

Radiological images are typical in the late stage showing esophageal dilation. The esogastroduodenal transit (TOGD) allows us to highlight a tapered but regular and well-centered appearance of the

esophagogastric junction in the form of a "radish tail" or a "bird's beak" also called the sock sign.

Our patient was in stage II at the time of diagnosis, according to the distension of the body of the esophagus [7]:

- Stage I: diameter < 4 cm.
- Stage II: diameter between [4 and 6cm].
- Stage III: diameter > 6cm

Endoscopy is an examination which is necessary as a first intention in cases of dysphagia, objectifying a spasm of the cardia by the "rosette" appearance of the mucous folds conversing towards the punctiform orifice of the cardia and the flexible resistance overcome by gentle pressure. that the sphincter opposes the progression of the endoscope [8].

Manometry is essential for any achalasia after having eliminated an obstacle, it is a reference examination making it possible to confirm the diagnosis showing an aperistalsis and an absent or reduced relaxation of the esophagus at the level of the lower esophageal sphincter with a pressure > 8mmHg residual pressure [9].

CONCLUSION

Achalasia is suspected in the presence of functional dysphagia. Endoscopy and esophageal transit can suggest the diagnosis which will be confirmed by manometry.

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