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**Letter to Editor** 

# A Novel Endoscopic Approach for Pseudoachalasia Secondary to Anti-Reflux Surgery

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### ABSTRACT

Pseudoachalasia is an uncommon esophageal motility disorder that may clinically resemble idiopathic achalasia but is typically associated with secondary causes, such as malignancy or prior esophagogastric surgery. We report a 65-year-old female with a history of anti-reflux surgery who presented with progressive dysphagia and involuntary weight loss over a six-month period. Despite undergoing multiple sessions of pneumatic dilation, her symptoms remained unresolved. A comprehensive diagnostic workup, including barium esophagography, computed tomography, and endoscopic ultrasound, demonstrated a benign-appearing, long-segment fibrotic stricture in the distal esophagus, without evidence of malignancy. High-resolution manometry could not be performed due to poor patient tolerance. Given the failure of standard therapeutic modalities, we employed a novel endoscopic intervention Endoscopic Circular Stricturectomy (ECS) involving circumferential mucosal incision, excision of fibrotic tissue, and local steroid injection to minimize the risk of restenosis. The procedure was completed without complications, and esophageal patency was restored by postoperative day 5, allowing resumption of oral intake. Follow-up evaluations at one and two months confirmed sustained clinical improvement without recurrence. This case underscores the diagnostic complexity of pseudoachalasia, especially in the context of post-surgical fibrosis, and highlights the limitations of relying solely on manometric findings. ECS appears to be a feasible and minimally invasive therapeutic alternative to surgical revision in select cases of benign fibrotic esophageal strictures. Further investigation is warranted to establish its efficacy and safety in broader clinical settings.

**Keywords:** pseudoachalasia, esophageal stricture, endoscopic circular stricturectomy, anti-reflux surgery

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#### Dear Editor,

Pseudoachalasia is a rare esophageal motility disorder that mimics achalasia but has distinct underlying causes [1]. It may result from malignancy, prior gastroesophageal surgeries, or other secondary factors, making accurate differentiation critical for appropriate management. Endoscopic ultrasound (EUS) plays a key role in distinguishing pseudoachalasia from malignant and fibrotic strictures, guiding therapeutic decisions [2].

A 65-year-old female with a history of gastroesophageal reflux disease (GERD) and prior anti-reflux surgery presented with progressive dysphagia and unintended weight loss (8 kg over six months). Despite multiple endoscopic interventions, including pneumatic dilation, her symptoms persisted. Diagnostic evaluation revealed a circumferential distal esophageal stricture (30 mm) with benign fibrotic changes, confirmed by computed tomography (CT), barium swallow, and endoscopic ultrasound (EUS) (Figure 1,2). Fine-needle biopsy ruled out malignancy. Although high-resolution manometry (HRM) is a valuable tool for distinguishing pseudoachalasia from idiopathic achalasia, it could not be performed in this case due to patient intolerance. Given the failure of conventional treatments, Endoscopic Circular Stricturectomy (ECS) was performed as a minimally invasive

approach (Figure 3). ECS involved a 360-degree circumferential incision and excision of fibrotic tissue, followed by local steroid injection to minimize restenosis risk. The procedure was well tolerated, with no intraoperative complications (Figure 4,5).



**Figure 1.** Endoscopic view showing a distal esophageal stricture beginning at the 34 cm mark, causing significant luminal narrowing and preventing the passage of the gastroscope.



**Figure 2a.** Radiographic imaging reveals a long-segment stricture in the distal esophagus; arrows highlight the narrowed region.

**b.** Endoscopic ultrasound (EUS) demonstrates no additional pathological findings except for increased esophageal wall thickness.



**Figure 3.** Initiation of endoscopic circular stricturectomy, illustrating the circumferential excision of the stenotic esophageal segment.



**Figure 4.** Post-procedural endoscopic view following circular stricturectomy, showing a markedly dilated esophageal lumen with restored patency.



**Figure 5.** EUS-guided local steroid injection into the stricture site using a sclerotherapy needle, performed to prevent restenosis.

By postoperative day 5, contrast imaging confirmed restored esophageal patency, and the patient was gradually advanced to an oral diet. At one- and two-month follow-ups, she remained asymptomatic with no evidence of restenosis.

Pseudoachalasia should be suspected in patients over 50 years old with rapid-onset dysphagia and significant weight loss, as

it is often associated with shorter symptom duration, greater weight loss, and incomplete high-resolution manometry (HRM) patterns compared to idiopathic achalasia.[3] Given the diagnostic overlap in manometric findings, high-resolution manometry (HRM) alone is often insufficient to reliably differentiate pseudoachalasia from idiopathic achalasia, potentially leading to misdiagnosis and inappropriate management. While HRM is a valuable diagnostic tool, its utility may be limited in certain clinical scenarios due to patient intolerance or technical constraints, as observed in our case. Therefore, a multimodal diagnostic approach incorporating barium esophagography, CT, and endoscopic biopsy remains crucial for accurate differentiation and treatment planning. [4] Findings such as a stenotic segment exceeding 3.5 cm or an asymmetric, nodular distal esophagus on barium studies may suggest pseudoachalasia, although these features are not highly specific. [5] Additionally, CT imaging can detect malignant involvement of the esophagogastric junction (EGJ), while endoscopic ultrasound (EUS) remains a valuable tool for identifying external compression at the EGJ. While pseudoachalasia is most commonly associated with malignancy, approximately 12% of reported cases in the literature are attributed to prior esophageal or gastroesophageal junction (GEJ) surgeries. [6]

For refractory esophageal strictures, conventional endoscopic interventions often provide limited long-term efficacy, with

a high rate of restenosis. Among the available techniques, the endoscopic radial incision and cutting (ERIC) method has shown promise in achieving longer restenosis-free periods. [7] Additionally, oral steroid therapy has demonstrated effectiveness in reducing the risk of post-procedural esophageal stricture formation following circumferential endoscopic resection.[8] In some cases, correction of the original fundoplication or torsion may be necessary to restore esophageal function. However, in the present case, revision surgery was not pursued due to the extent of the 3.6 cm stricture. The patient's condition most closely aligned with Type 2 pseudoachalasia, as classified by Poulin et al., which is characterized by fibrotic stricture formation secondary to prior esophageal interventions. [9] The minimally invasive endoscopic approach employed in this case successfully resolved the stricture by excising the dense fibrotic scar tissue while preserving esophageal integrity.

Endoscopic circular stricturectomy (ECS) combined with circumferential endoscopic incision represents a viable and minimally invasive therapeutic option for patients with refractory esophageal strictures. This technique may reduce the need for repeated interventions and mitigate restenosis risk. The present case highlights the importance of accurate differential diagnosis and underscores the advantage of endoscopic techniques over open surgical revision, particularly in cases of long-segment fibrotic strictures following prior esophageal procedures.

Yours sincerely,

**Conflict of interest**: The authors declare that there are no conflicts of interest regarding the publication of this article.

**Informed Consent**: Upon the patient's admission to the hospital for further examination and treatment, informed consent was obtained, permitting the use of his data for academic and research purposes.

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