



Gastroesophageal Reflux Disease Could Progress to Achalasia

TO THE EDITOR: We read with interest the article entitled “Is Gastroesophageal Reflux Disease and Achalasia Coincident or Not” published in January 2017, by Jung and Park.¹ The title raises a very interesting question, however, in the end, the question remains unanswered and the paper mostly focuses on the overlapping symptoms between gastroesophageal reflux disease (GERD) and achalasia, thus leading to diagnostic delay in many achalasia patients. The arguments for and against whether the coexistence of the 2 diseases is accidental or not, are poorly supported. We have previously put the question to ourselves as well, and based on our own experience and thorough review of the literature, we believe that the development of achalasia in certain GERD patients is not a coincidence, but that there may be a cause-and-effect relationship between the 2 diseases.² Our surgical work team have operated on over 40 patients with achalasia in the past 15 years and in 10% of them, the etiological role of reflux arose.³ Similar to the fact that the human body has developed several aero-digestive reflexes to protect the airways from aspiration,⁴ we suggest that chronic acid exposure may lead to structural and functional changes in the esophagus, as, for example, to the development of achalasia. By this means, the narrowing of the distal lumen of the esophagus could be interpreted as another kind of protective mechanism of the body aiming at preventing the refluxate entering the esophagus or beyond. A convincing argument for the chronological order, and presumably, the casual relationship between reflux and achalasia is that several reports have been published describing the presence of Barrett’s esophagus among untreated achalasia patients.^{5,6} The most plausible explanation for this is that these patients had long-standing reflux disease before the development of achalasia. Also, several cases have been described where achalasia occurred with concomitant hiatal hernia⁷ and it is well-known that hiatal hernia induces the development of GERD. Among our own untreated achalasia cases we also had one patient with concomitant Barrett’s esophagus and one with hiatal hernia. Altorjay et al^{8,9} reported an interesting observation after comparing muscle samples taken from the lower esophageal sphincter of reflux patients and those of a control group. They found that reflux

patients had smooth muscle hypertrophy and enteric ganglionitis at the gastroesophageal junction, and they suggested that these morphological changes might result in various functional esophageal diseases. Based on these findings we assume that in certain cases GERD may progress to achalasia.

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Conflicts of interest: None.