



# Dysphagi, brystsmarter, motilitetsforstyrrelser

MANDAG 9. MAI.

Akutt dysfagi – fastsittende bolus – gastroskopi

Ikke-akutt dysfagi:

Dysfagi - subjektiv følelse av vanskeligheter ved eller unormal svelging.

Odynofagi - smerte ved svelging

Globus følelse - funksjonell esofagustilstand med følelse av klump, tetthet eller fastsittende mat i farynx/cervical området uten endret anatomi/sykdom.

Kan være alarm-symptom

Ikke ledd i normal aldring

Orofaryngeal vs Esofageal dysfagi

## Orofaryngeal dysfagi:

Initiering av svelget er problematisk

Symptomer i cervikal-området

Regurgitasjon til nasofarynks

Aspirasjon - hoste - heshet

Mat blir igjen i farynks

Sleving - Sialore

Hoste

Anamnesticke opplysninger

## Esofageal dysfagi

Vanskeligheter flere sekunder etter initiering av svelget  
Følelse av obstruksjon ved passasje av bolus  
Retrosternale symptomer oftest

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### Causes of esophageal dysphagia

#### Mechanical lesions

##### Intrinsic

Benign tumors
Caustic esophagitis/stricture
Diverticula
Malignancy
Peptic stricture
Eosinophilic esophagitis
Infectious esophagitis
Pill esophagitis
Postsurgery (laryngeal, esophageal, gastric)
Radiation esophagitis/stricture
Rings and webs
Lymphocytic esophagitis

##### Extrinsic

Aberrant subclavian artery
Cervical osteophytes
Enlarged aorta
Enlarged left atrium
Mediastinal mass (lymphadenopathy, lung cancer, etc)
Postsurgery (laryngeal, spinal)

#### Motility disorders

Achalasia
Chagas disease
Primary motility disorders
Secondary motility disorders

#### Functional

Functional dysphagia
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Graphic 80528 Version 5.0

## Symptomer ved dysfagi

Karakteriser type mat som gir symptomer; fast føde, væske eller begge?  
Eks.: dysfagi for både fast føde og væske fra symptomstart kan være motilitetspatologi.

Progressive eller intermitterende symptomer?

Eks.: progressiv dysfagi, starter med fast føde og senere væske, kan være peptisk striktur. Ved malign prosess ofte raskere progresjon. Motilitetspatologi kan være progredierende (akalasi) eller intermitterende eller ikke-progressiv (f.eks. distal esofagus spasme).

Øvrige symptomer: halsbrann/brystsmerter, vekttap, hematemese, anemi/jernmangel, regurgitasjon, luftveissymptomer?



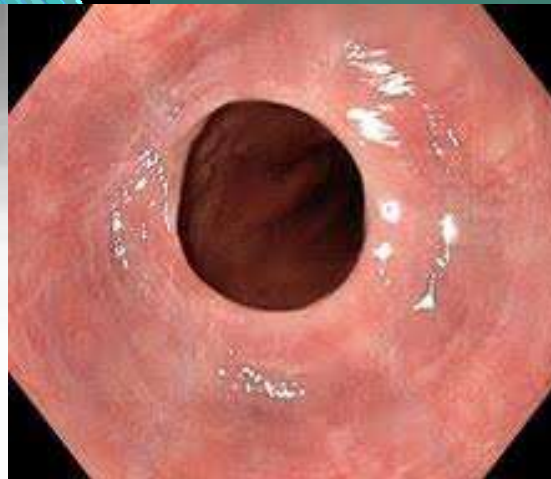
Mekanisk, intrinsic

- ▶ Eosinofil esofagitt ~ 15 % av pasienter som kommer til gastroskopi for dysfagi



## Mekanisk, intrinsic

- ▶ Eosinofil esofagitt ~ 15 % av pasienter som kommer til gastroskopi for dysfagi
- ▶ Esofageale “webs and rings” - Intermitterende dysfagi for fast føde.
  - Diagnose ved rtg esophagus/gastroskopi.



### Rings or Webs

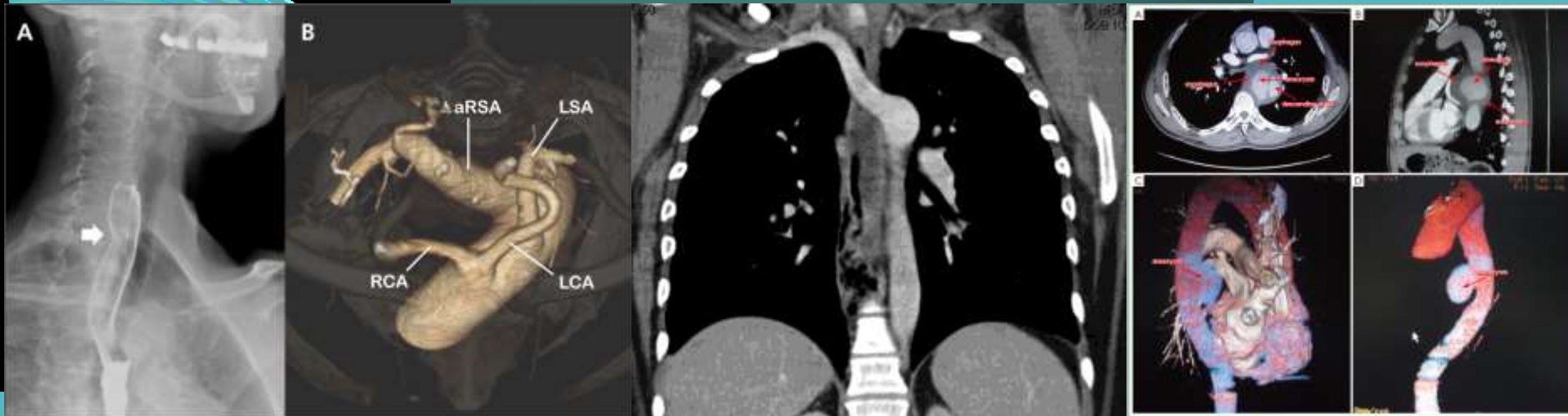
- Ring
  - Circumferential, muscle or mucosa, at distal esophagus
  - Schatzki's ring
  - Eosinophilic Esophagitis (>15 eosinophils/hpf in mucosa)
- Web
  - Part of lumen, mucosal, proximal esophagus
  - Plummer Vinson



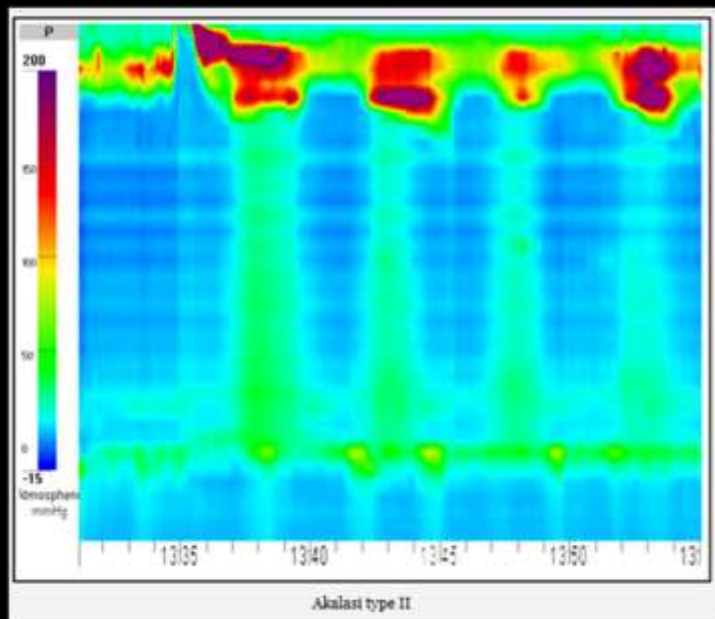


Mekanisk, extrinsic

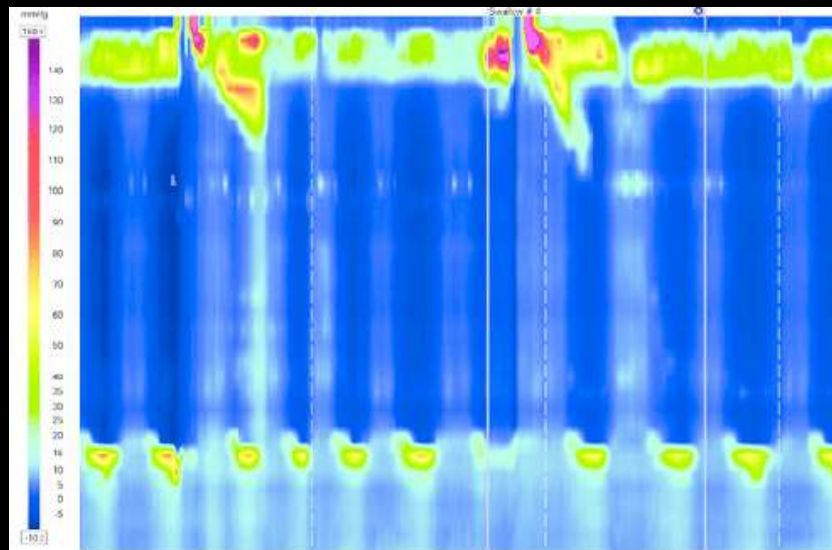
- ▶ Cardiovaskulære abnormaliteter - Dysfagi ved kompresjon av esofagus.
  - Diagnose ved rtg esofagus + CT.



# Motilitetspatologi



Akalasi

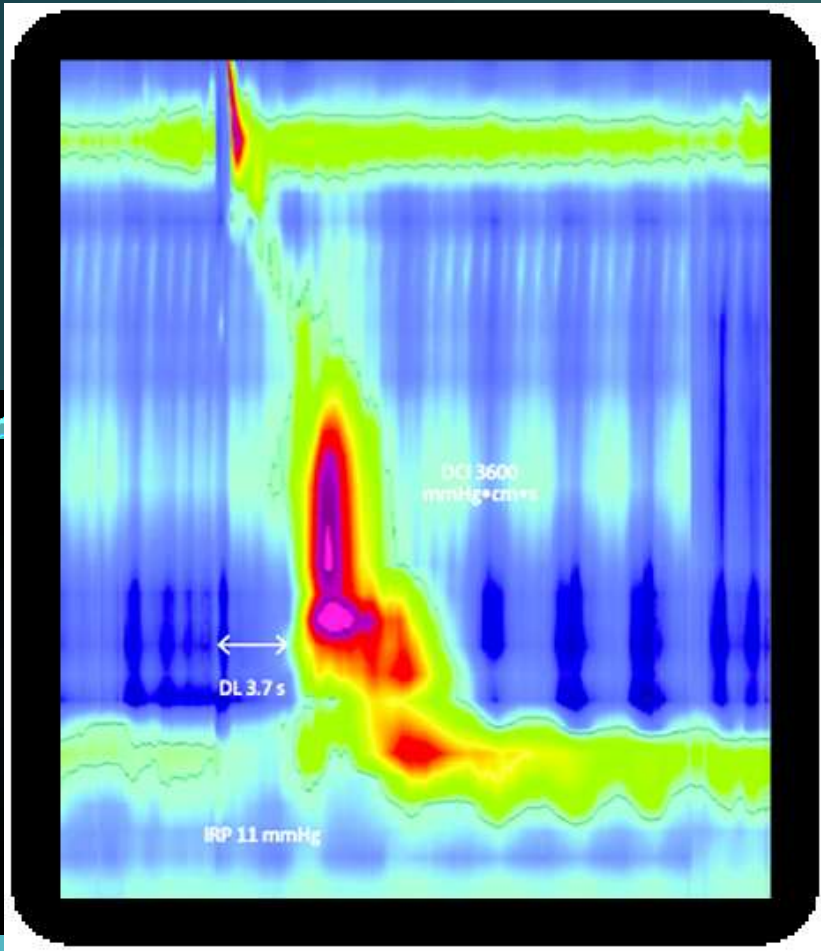


Sklerodermi

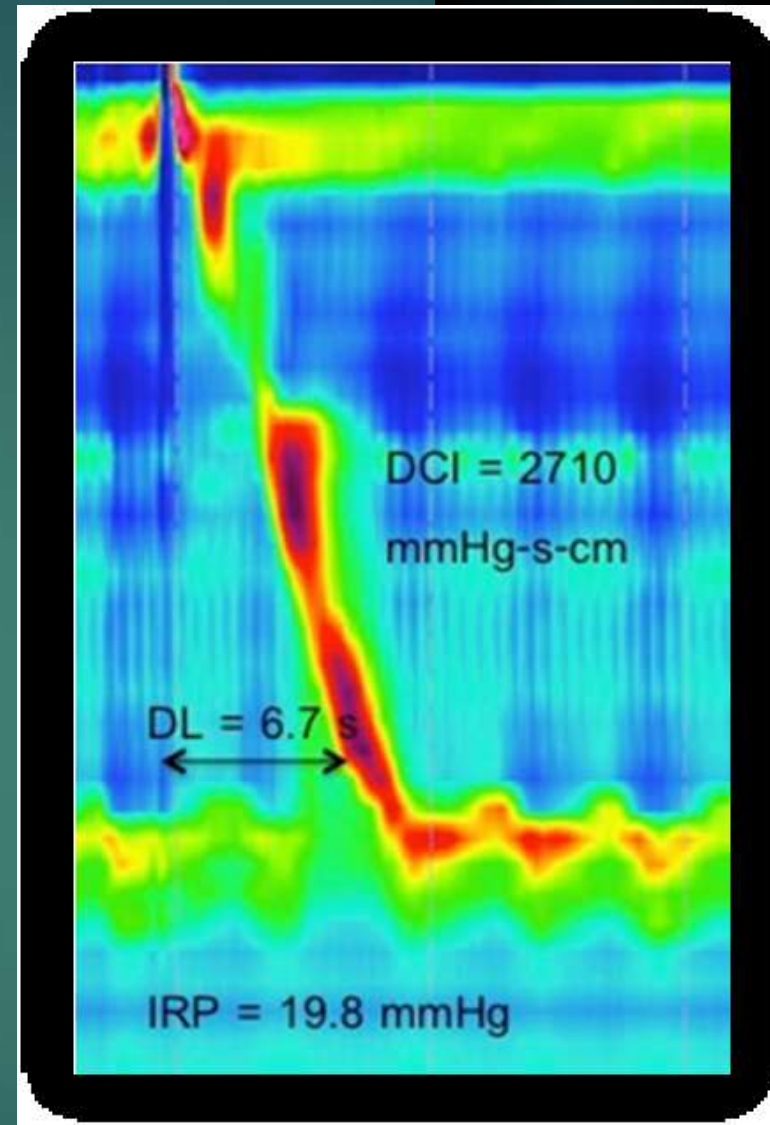


Chagas sykdom

Dysphagi, 9. mai



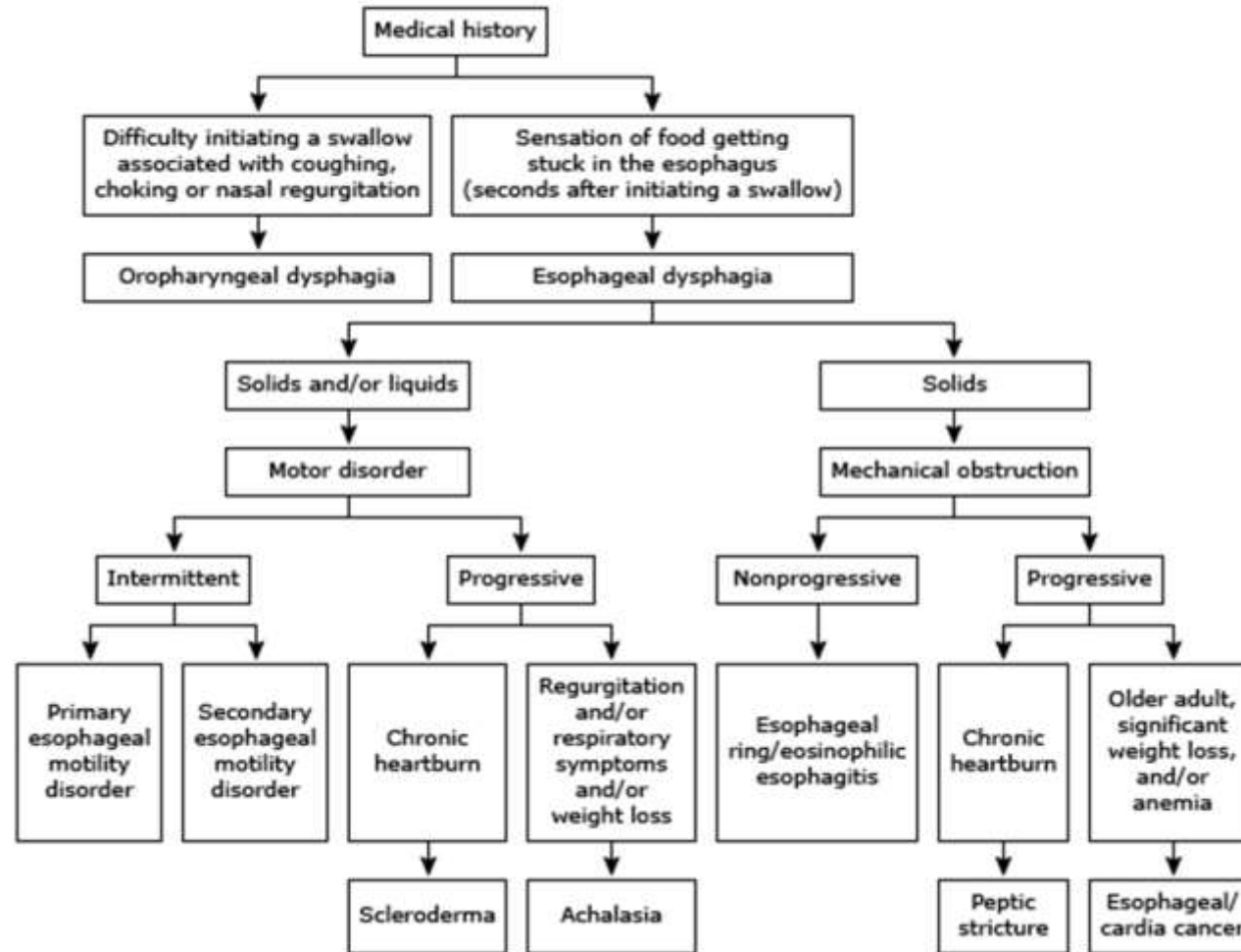
Distal esophageal spasm



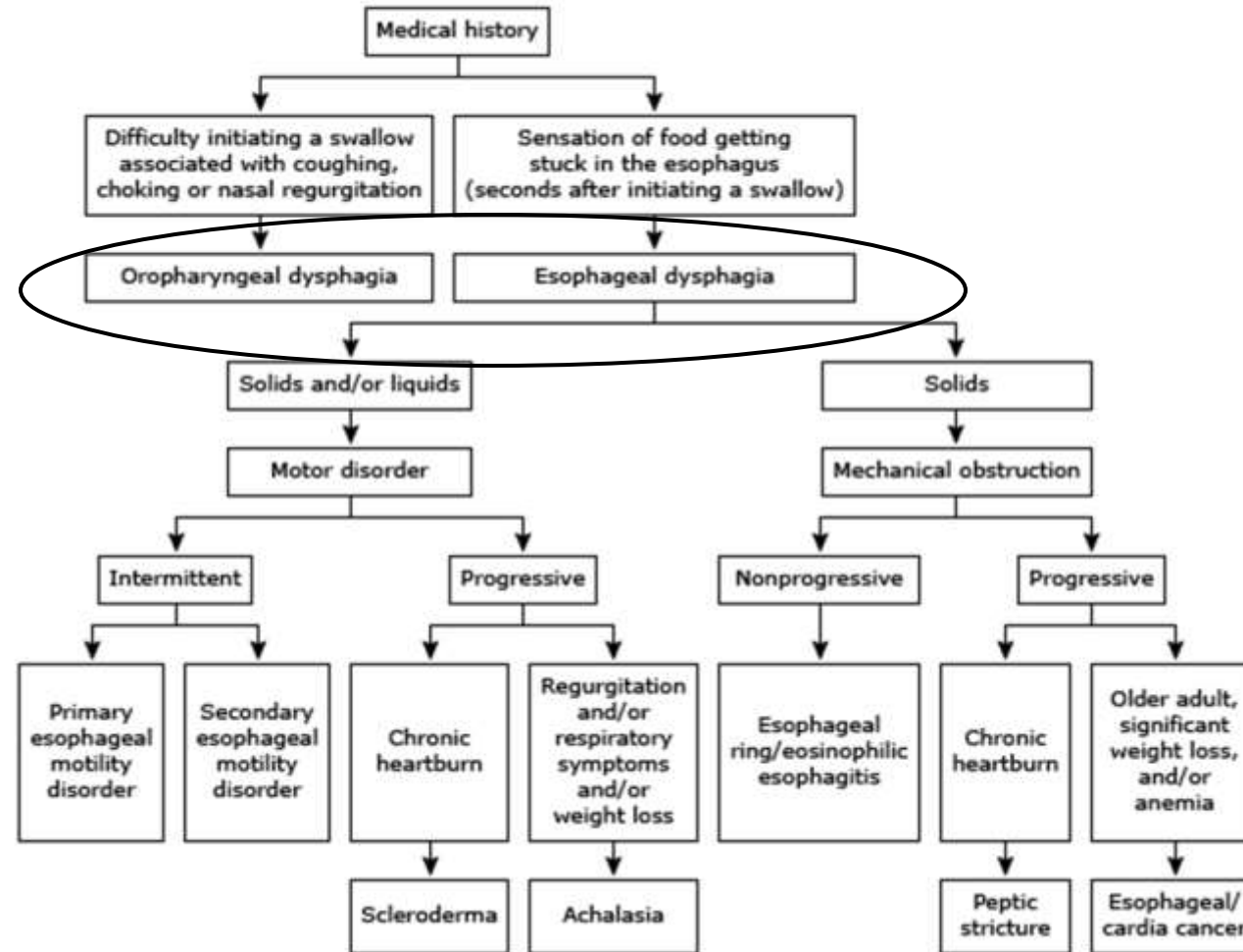
EGJ outflow obstruction



## Diagnosis of dysphagia



## Diagnosis of dysphagia



**Functional dysphagia** — According to the **Rome IV criteria**, functional dysphagia is defined by the following:

- **A sense of solid and/or liquid food lodging**, sticking, or passing abnormally through the esophagus.
- No evidence that an esophageal mucosal or **structural abnormality** is the cause of the symptom.
- No evidence that **GERD or eosinophilic esophagitis** is the cause of the symptom.
- Absence of a major esophageal **motor disorder** (achalasia, esophagogastric junction outflow obstruction, distal esophageal spasm, hypercontractile esophagus, and absent peristalsis) .

All criteria must be fulfilled for the past **three months** with symptom onset at least **six months** prior to the diagnosis and with a frequency of at least once a week.

Symptoms of dysphagia may be **intermittent** or present **after each meal**.

Patients should be reassured and instructed to avoid **precipitating factors** and **chew well**. In our experience, symptoms may improve with time. In patients with severe symptoms, despite these measures, a trial of a smooth muscle relaxant, such as a **calcium channel blocker or tricyclic antidepressant**, can be offered.

**Empiric dilation** with a mechanical (push-type or Bougie) dilator can be offered, but symptom response is variable



# Noncardiac chest pain

Gastroesofageal reflux/GERD/GØRS

Ikke-refluks esofagitt - medikament, infeksjon (Candidia,CMV), stråledskade

Eosinofil esofagitt

Esofagus dysmotilitet

Refluks hypersensitivitet

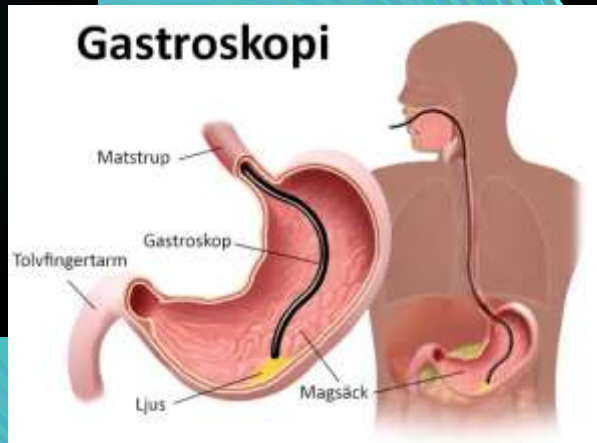
Funksjonelle brystmerter

# Noncardiac chest pain

Gastroesophageal reflux/GERD/GØRS

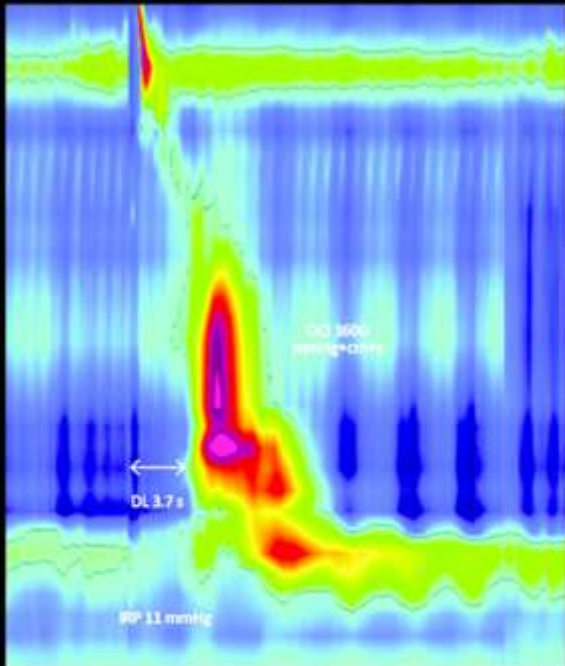
Ikke-refluks esofagitt - medikament, infeksjon (Candidia,CMV), stråledskade

Eosinofil esofagitt

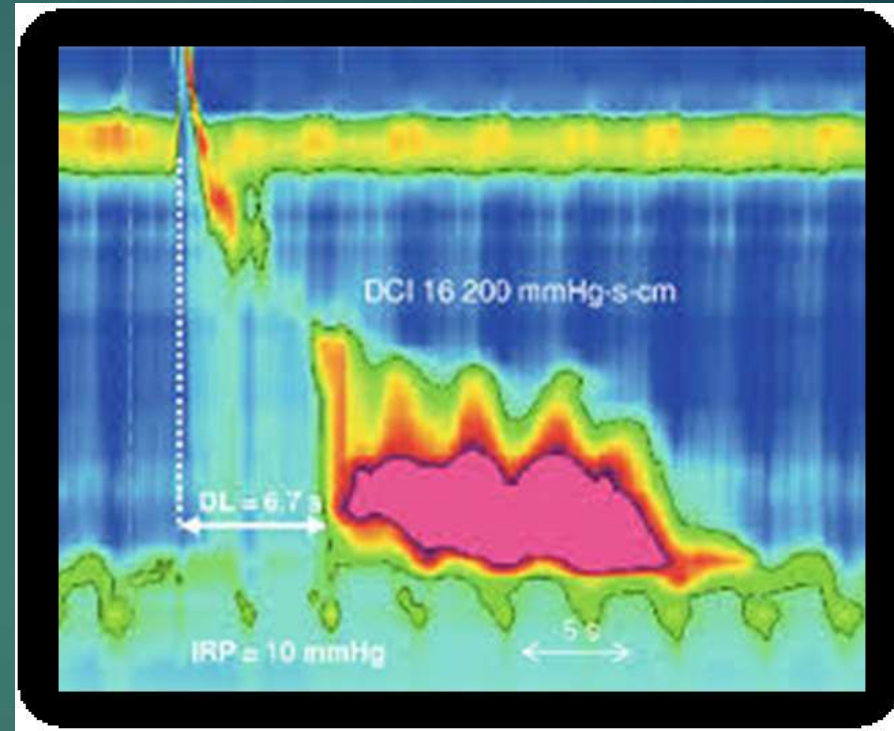


# Noncardiac chest pain.

## Esofagus dysmotilitet



Distal esofageal spasme; premature kontraksjoner  
distal latency time < 4.5 sekunder



Hyperkontraktil (jackhammer) esofagus  
2 / 10 svelg med distal contractile  
integral (DCI) >8000 mmHg·s

# Noncardiac chest pain.

## Refluks hypersensitivitet

Normal fraksjonstid med pH < 4.

Positiv SAP / symptom association probability.

Personnummer: 09058346710

\*\*\* Normal values according to:  
Shay et al. AJG 2004; 99;1037-43

**Symptom results**

Symptom: Symptom

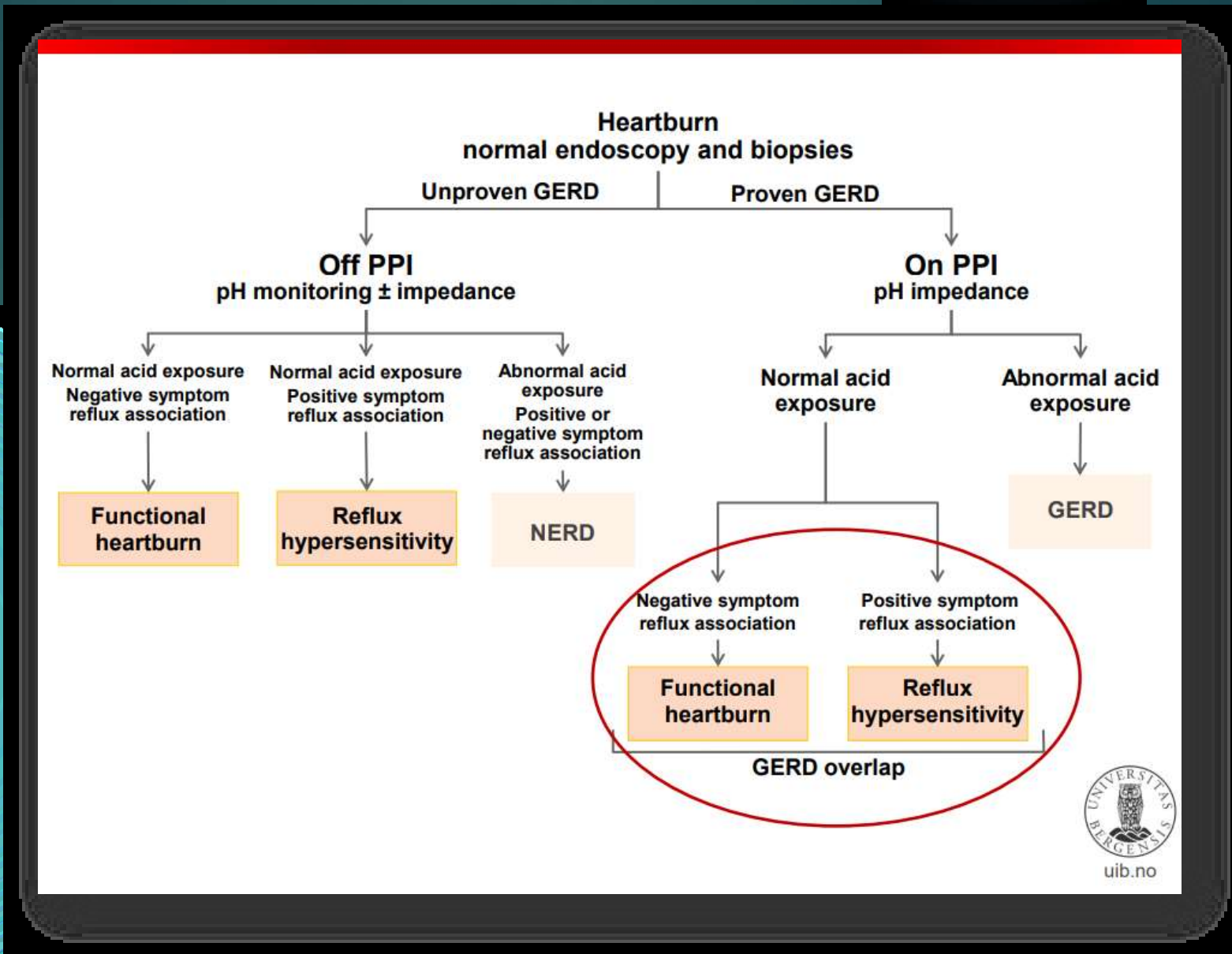
#	Symptom time	pH analysis		Impedance analysis		Total
		Acid Reflux (pH < 4,0)	Acid Reflux (pH < 4,0)	Weakly acid (4,0 - 7,0)	Weakly alkaline (7,0 < pH)	
1	1/16:55:02	.	.	.	.	.
2	1/17:05:11	.	+	.	.	+
3	1/17:05:22	.	+	.	.	+
4	1/18:36:09	.	+	.	.	+
5	1/18:43:18	+	+	.	.	+
6	1/18:50:31	+	+	.	.	+
7	1/18:56:26	.	+	.	.	+
8	1/19:03:00	.	.	.	.	.
9	1/19:06:13	.	.	.	.	.
10	1/19:09:30	.	.	.	.	.
11	1/20:11:27	.	+	.	.	+
12	1/21:00:47	.	+	.	.	+
13	1/21:18:25	.	.	+	.	+
14	2/08:22:24	.	.	+	.	+
15	2/08:24:05	.	.	+	.	+
16	2/08:29:51	+	+	.	.	+
17	2/08:39:18	.	.	+	.	+
18	2/08:49:55	+	+	.	.	+
19	2/09:05:54	.	.	.	.	.
20	2/09:12:05	+	+	.	.	+
21	2/09:21:25	+	+	.	.	+
22	2/09:30:26	+	+	.	.	+
23	2/10:05:02	+	+	.	.	+
24	2/10:20:09	.	.	.	.	.
25	2/10:31:18	.	.	.	.	.
26	2/10:35:59	+	+	.	.	+
<b>Reflux periods</b>		62	53	15	1	69
SI		34,6%	57,7%	15,4%	0,0%	73,1%
SSI		14,5%	28,3%	26,7%	0,0%	27,5%
SAP		100,0%	100,0%	99,8%	0,0%	100,0%

**SAP: Symptom**

pH	p = 0,0001			Impedance	p = 0,0000		
	S+	S-	Total		S+	S-	Total
R+	9	44	53	R+	19	41	60
R-	17	551	568	R-	7	554	561
Total	26	595	621	Total	26	595	621



# Refluks hypersensitivitet vs. funksjonelle smerter



## Must include all of the following:

- Burning retrosternal discomfort or pain
- No symptom relief despite optimal antisecretory therapy
- Absence of evidence that gastroesophageal reflux disease (elevated acid exposure time and/or symptom reflux association) or eosinophilic esophagitis is the cause of the symptom
- Absence of major esophageal motor disorder (achalasia, esophagogastric junction outflow obstruction, distal esophageal spasm, jackhammer esophagus, absent contractility)

<sup>a</sup>Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis and a frequency of at least twice a week.



## Noncardiac chest pain.

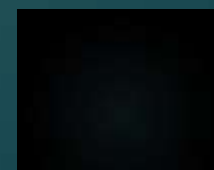
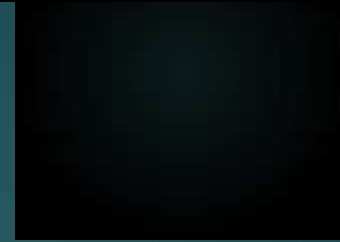
- Behandling:
- God refluksbehandling
  - Jorveza
  - Reduserer tonus glatt musklatur (NG, Ca-antagonist, peppermynteolje, botox, POEM)
  - Sarotex/SSRI
  - Fysioterapi

Take home message:

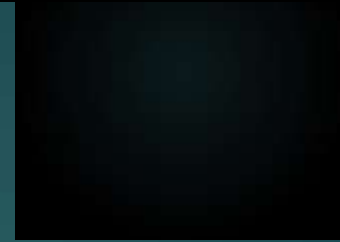
Karakteriser symptomer: Orofaryngeal eller esofageal dysfagi?  
Fast føde, +/- væske?  
Når oppstår smerter? Ledsagende symptomer  
Progresjon av symptomer? Intermitterende symptomer?

Tenk på differentialdiagnoser og utred med:

- Gastroskopi med **biopsier fra esofagus**
- Rtg esofagus
- CT? Ved mistanke om ekstern kompresjon
- 24t pH måling og HRManometri undersøkelse av esofagus



Dysphagi, 9. mai



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