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LETTER TO THE EDITOR

Post-fundoplication dysphagia: Laparoscopic intervention or endoscopic dilation?☆

Disfagia posfunduplicatura: ¿intervención laparoscópica o dilatación endoscópica?

We read the original article by Godoy-Salgado et al.[1] with great interest, in which they described their experience in managing post-fundoplication dysphagia associated with esophagogastric junction obstruction. The authors reported that esophageal dilations were carried out on all the patients, but with no improvement. Whether to perform pneumatic dilation or a laparoscopic intervention is always a difficult decision. In addition to the considerable possibility of unsatisfactory dysphagia resolution, perforation is the main risk involved in carrying out pneumatic dilation.

Various studies have failed to find predictive variables for pneumatic dilation success, including endoscopic, radiologic, or manometric factors.[2] However, a greater chance for success largely depends on the correct diagnosis of the etiology of post-fundoplication dysphagia. Therefore, having a high-quality medical history and choosing the correct tests are essential.

First of all, the surgeon must follow the ''do no harm'' principle. Before performing the fundoplication, the past medical history must include the presence or absence of dysphagia, and even nondysphagic patients should undergo preoperative esophageal manometry, to detect esophageal dysmotility disorders. Once fundoplication has been decided upon, only expert foregut surgeons should perform the surgery, to prevent technical errors. A laparoscopic fundoplication video should be recorded for future review, in the case of dysphagia.

When post-fundoplication dysphagia has been established, its time of onset should be determined and the dysphagia classified as transient, early persistent, or late.

Transient dysphagia occurs in 40-70% of patients after fundoplication.[3] The cause is unknown, but the condition is usually tolerable and resolves within 3 months, so no further investigation is needed.[3] However, if disabling symptoms persist, it is considered early persistent dysphagia, and is usually related to technical errors. It can be related to a tight crurorraphy or tight wrap, or due to a misplaced/twisted wrap. The video of the procedure should be analyzed, and if an isolated mistake is observed, it should be laparoscopically corrected. Esophagogram and endoscopy may help identify the error. Only if the exams show fair signs of obstruction, should pneumatic dilation be used.

If the dysphagia begins a long time after surgery, the differential diagnoses are wrap migration, adhesions,[2] late onset achalasia, or even cancer (mainly in Barrett's esophagus). If esophagogram and endoscopy detect wrap migration, the laparoscopic approach will probably be much more effective than pneumatic dilation, which does not resolve the structural problems.[4] If no relevant migration is observed and no dysmotility is detected in the manometric evaluation, local adhesions could be the cause of the dysphagia. In that context, pneumatic dilation could be sufficient.

Pneumatic dilation is a therapeutic option, under certain conditions. However, when laparoscopic intervention is indicated, it should not be delayed, given the risk of esophageal perforation during progressive pneumatic dilations, or the risk of developing pseudoachalasia, due to long-term persistent gastroesophageal obstruction.

The present letter to the editor complies with all ethics standards.

Authorship

All authors approved the final version of the article and have materially participated in the research and/or article preparation.

Conflict of interest

The authors declare that there is no conflict of interest.

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Response to the Letter to the Editor: *Post-fundoplication dysphagia: laparoscopic intervention or endoscopic dilation?*☆

Respuesta a la carta *Disfagia posfunduplicatura: ¿intervención laparoscópica o dilatación endoscópica?*

We appreciate the interest in our article shown by Tustumi et al., and the diagnostic therapeutic approach in adults they proposed was of interest to us, as well. Unfortunately, carrying out esophageal manometry prior to fundoplication is not a common practice in the Mexican pediatric population, thus we did not know if the patients we analyzed presented with a pre-existing motility disorder.[1] As stated by Tustumi et al., post-fundoplication dysphagia resolution should be evaluated in an orderly manner, so that the surgeon can make the decision to perform laparoscopy or pneumatic dilations, depending on patient characteristics.[2] To the best of our knowledge, there are not enough reports in the literature for determining the best approach to that type of complication in children. Thus, we believe that publishing the manometric finding of esophagogastric junction outflow obstruction, in children with post-fundoplication dysphagia, contributes to establishing the correct treatment in those patients and enables new lines of research to be proposed for determining the best approach, according to the surgery performed, the surgical findings, the manometric findings, and especially, the symptomatology and clinical presentation of those patients.

Conflict of interest

The authors declare that they have no conflict of interest.

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