FUNCTIONAL DISEASE OF THE OESOPHAGUS

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This term is used to embrace all those causes of dysphagia dependant upon a disorganization of the normal, co-ordinated, neuro-muscular function of the oesophagus. All forms of dysphagia due to organic stenosis of the gullet, obstruction of its lumen by foreign bodies, or compression by extrinsic pressure are excluded.

Consideration of the causes of functional dysphagia is complicated by a lack of certainty in our knowledge of the normal activity of the gullet. This organ is not a mere inert drainpipe or passive conduit. Not only does it function with efficiency and consistency as a pump to propel the bolus or fluid from mouth to stomach under normal conditions in man, but can also overcome the forces of gravity, as demonstrated by the sportsman who, for a wager, imbibles a pint of beer whilst standing on his hands in the inverted position. Anyone who has witnessed a giraffe in the act of drinking will appreciate the dynamic propensities of this organ.

Peristalsis, as normally accepted, probably does not occur in the oesophagus.

The oesophagus is essentially a muscular tube with a sphincteric mechanism at both ends. The lumen normally contains a small quantity of saliva, and a larger quantity of air under a mild negative pressure reflecting and varying with the negative pressure in the pleural cavities. The sphincter at the upper end is controlled by the cricopharyngeal muscle in a state of tonic contraction. The vigilance of this sphincter is testified by the infrequency with which sudden inversion is accompanied by regurgitation of oesophageal contents. Were it not so, then every patient with achalasia of cardia and a resting oesophageal residue of up to two pints, or more, of fermenting food would run the risk of drowning every night. During normal deglutition the upper sphincter relaxes as the pharyngeal muscles voluntarily propel the bolus from the mouth. The lower sphincter is more complex. There is considerable doubt as to whether any intrinsic sphincter mechanism exists. Probably the control of gastro-oesophageal reflux is maintained by a combination of factors: the pinch-cock action of the diaphragmatic hiatus on the lower oesophagus; the angulation of the oesophago-gastric junction by the muscular sling of the right crus analogous to the action of the pubo-rectalis muscle on the ano-rectal junction; the compression of the intra-abdominal segment of oesophagus by positive pressure; the plugging of the lumen by valvular folds of gastric mucosa. Whatever its true nature, the lower sphincter shows a diminished sense of responsibility as compared with the upper.

During deglutition the bolus is first propelled across the relaxed upper sphincter by the pharyngeal muscles. The sphincter then closes and a generalized contraction of the whole gullet rapidly moves the bolus onward into the stomach across the lower sphincter, after a temporary pause in the lower third of the organ. On screening no true peristalsis is observed but repeated rhythmical contractions of the gullet propel all but a small residue of the remaining bolus onwards. Serial pressure recordings from small balloons located at various points in the lumen have contributed to our knowledge of normal and abnormal function. As revealed by this method the contraction of the organ is progressive from above downwards, although the rise in luminal pressure during normal swallowing is probably generalized throughout the organ.

Disorganization of normal activity can occur in several ways. The upper sphincter may fail to relax, with a consequent and very considerable rise in pharyngeal pressure. Contraction rings, or segmentation, may occur at certain constant points in the oesophagus, replacing the normal progressive contraction, and giving rise to the radiological appearances known as corkscREW oesophagus. The degree of contraction at the site of the rings may lead to complete occlusion at these points, with localized areas of raised intra-luminal pressure. A bizarre sequel to this rise of intra-luminal pressure is the development of 'blow-outs', or pulsion diverticula of mucosa through the muscular wall of the organ. Intermittent, but often severe, spasm of the lower end of the gullet may occur as a result of gastro-oesophageal reflux and oesophagitis, less commonly from the swallowing of corrosive fluids. Impacted foreign bodies can probably produce localized...
spasm at any point. Failure of the lower end of
the gullet to relax during swallowing leads to
the well-known condition of achalasia, with diffuse
hypertrophy and dilatation of the whole organ.

Failure of the lower sphincter and the reflux of
gastric secretion into the oesophagus is the essential
functional disturbance responsible for most of
the symptoms in hiatus hernia, and will not be
considered further in this communication.

Finally, a rare form of dysfunction in which
acute spasm of the mid-third of the organ accom-
panies the attempt to vomit large quantities of
food and fluid after an alcoholic debauch, may
lead to a rise in intra-luminal pressure sufficient
to result in spontaneous rupture of the lower
third with catastrophic results.

This communication is mainly concerned with
the management of the three commoner forms of
functional dysphagia amenable to surgical treat-
ment—spasm of the upper sphincter, 'corkscrew
oesophagus', and achalasia of the cardia. The 132
cases reviewed were all admitted to a Regional
Surgical Thoracic Unit under the care of one
surgeon over a period of 20 years. The reason
for investigation was either dysphagia or the
pulmonary complications of oesophageal dysfunc-
tion. Non-surgical functional disorders, such as
those due to basilar artery thrombosis or myasthenia gravis, will not be considered further
although they complicate the problem of
differential diagnosis.

TABLE I
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<th>Relative Frequency of Three Principal Forms of Functional Disorder</th>
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<tr>
<td>(i) Upper oesophageal spasm, with pouch formation</td>
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<td>(ii) Corkscrew oesophagus</td>
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<td>(iii) Achalasia of cardia</td>
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Achalasia of Pharyngo-oesophageal Junction
with Pouch Formation

Globus hystericus has been a popular diagnosis
in any case where intermittent symptoms of
dysphagia have been referred to the cervical
oesophagus. In fact, the majority of these patients
are suffering not from hysteria but from organic
obstruction of the cervical oesophagus by muscular
spasm, or achalasia, in the region of the pharyngo-
oesophageal junction (Fig. 1). The spasm may be
sufficiently severe to lead to the formation of a
pulsion diverticulum through the posterior wall
of the pharynx. When the patient presents with
the well-established picture of a pharyngeal
diverticulum, the underlying obstructive element
is usually overlooked, and completely ignored in
planning treatment. This omission undoubtedly
accounts for the unsatisfactory results of treatment
and the high incidence of recurrent diverticulum
formation. Attention is diverted from the under-
lining cause of the dysphagia by the bizarre
radiological manifestations of the sequelae. The
diagnosis is made largely on the symptoms, the
localization of the obstruction, the radiological
demonstration of a zone of persisting spasm in this
area, and the exclusion of other possible causes
of obstruction. A barium swallow examination
may reveal a small pulsion diverticulum of the
lower pharynx, too small to be able to contribute
to the dysphagia. Oesophagoscopy will contribute
little to the diagnosis except to exclude other
possible causes for the symptoms, e.g. a malignant
stricture. Apart from the distress caused by the
dysphagia, the importance of this lesion lies in the
fact that it is the precursor and cause of a
pharyngeal diverticulum. Before the onset of this
complication the dysphagia is variable, and
influenced by emotional stress—hence the term
'globus hystericus'. Once a pouch has developed
and assumed a dependant position the symptoms
increase in severity and are more constant. These
symptoms are well recognized and will not be
elaborated here, except to stress the frequency
with which these patients present with chronic or
recurring aspiration pneumonitis due to the
nocturnal inhalation of the debris that may
accumulate in the pouch.

The development of a pulsion diverticulum is a
reversible process in its early stages, and relief of
FIG. 2.—(a) Spasm of the cervical oesophagus with early pulsion diverticulum. (b) Following myotomy; the spasm and dysphagia have been relieved and the diverticulum has disappeared.

FIG. 3.—Pulsion diverticulum of the pharyngo-oesophageal junction. The diverticulum disappeared completely following an upper oesophageal myotomy.

FIG. 4.—Lipiodol accumulating in the mediastinum following instrumental perforation of a pharyngeal diverticulum. Spontaneous healing occurred, and at a later date successful myotomy and diverticulopexy were carried out.
the obstruction may lead to rapid disappearance of the pouch (Fig. 2). Hence the importance of early recognition of this condition and its prompt relief.

Negus (1950) has advocated dilatation of the spastic pharyngo-oesophageal junction, repeated as necessary. Even in the hands of an expert, endoscopic dilatation of the oesophagus is not devoid of risk of perforation or abrasion of the gullet, the risk being directly proportional to the frequency with which it has to be performed. If the dysphagia recurs after the initial dilatation, then other methods are indicated. That preferred by the author consists of an extramucous myotomy similar to the classical Heller operation performed on the lower oesophagus for the relief of achalasia. A vertical myotomy incision is made over the antero-lateral aspect of the lower half-inch of the pharynx and the upper two inches of the cervical oesophagus, usually on the right side. This procedure has proved satisfactory and has led to the disappearance of early diverticula (Fig. 3).

It is logical to assume that destruction of the superior oesophageal sphincter might expose the patient to the hazards of recurring aspiration pneumonitis. Provided that one of the oesophageal sphincters remains competent, in practice the risk appears to be small, and no instance has been encountered so far in this small series. In fact there has been in this series no instance of 'oesophageal breathing' as anticipated by Negus (1950) in discussing the principles of this procedure.

Once a pulsion diverticulum larger than a grape has developed then dilatation becomes even more dangerous owing to the difficulty of gaining access to the lumen of the oesophagus beside the neck of the pouch and the risk of perforating the bottom of the pouch and causing mediastinitis (Fig. 4). In addition to the myotomy already described, either excision of the pouch, or its inversion and suture to the anterior longitudinal ligament of the cervical spine in the up-ended position is necessary. The latter method has been used by the author in 18 cases with complete relief of symptoms and no recurrence of the pouch formation. It is preferred to excision.
owing to the risk of a salivary fistula and the difficulty of performing a satisfactory repair of the thin posterior pharyngeal wall.

A direct attack on the pouch with no attempt to relieve the underlying cause will fail to relieve completely the dysphagia and will be followed by a high rate of recurrent pouch formation (Fig. 5). The longest follow-up period following myotomy and diverticulopexy has been ten years in this series. As yet there has been no recurrence of the pouch formation or dysphagia.

**Diffuse Æsophago-spasm**

This condition is commoner in the lower half of the æsophagus. It is not peculiar to any particular age group or sex. It occurs in two forms—primary and secondary. The primary form appears to be closely allied to achalasia of the cardia in that examination of the Æsophagus reveals diffuse muscular hypertrophy indistinguishable from that which characterizes the latter condition. The secondary form is frequently associated with the presence of a hiatus hernia and gastro-œsophageal reflux (Fig. 6). The assumed association between the two is based upon the observation that surgical control of the gastro-œsophageal reflux leads to relief of the spastic condition of the gullet. The degree of muscular hypertrophy is less in the secondary form.

The radiological appearances presented by this condition are bizarre and have acquired the designation of 'corkscrew Æsophagus'. A series of contraction rings occurs intermittently through-out the lower half of the Æsophagus. They have not been observed above the level of the aortic arch. The rings always occur at the same levels, and are not produced by an exaggerated form of peristalsis. Solitary or multiple pulsion diverticula are commonly associated with this form of Æsophago-spasm and are undoubtedly 'blow-outs' occurring in the zones of increased intra-luminal pressure.

Much of our knowledge of the abnormal physiology of this condition has been elucidated by Good (working at the Mayo Clinic), by means of serial pressure recordings from balloons located at various levels in the gullet. By this method pressure changes at various points within the lumen can be recorded during swallowing and at rest, and the disordered activity of the gullet correlated with the symptoms. The commonest symptom of this condition is dysphagia, but in some cases the presenting symptom is chest pain of an anginal distribution. During swallowing the contraction of the various spastic zones or rings may occur in one of two ways: either synchronously, or progressively from above downwards. In the former instance the presenting symptom is dysphagia; in the latter, substernal chest pain.

The indication for surgical treatment in this condition is the severity of the symptoms. The presence of pulsion diverticula in the lower Æsophagus rarely aggravates the symptoms and in contrast to those at the pharyngo-œsophageal junction, these do not need surgical treatment except in the rare instances when they develop.

FIG. 7.—(a) 'Corkscrew Æsophagus' with a small diverticulum of the lower third. (b) Following Heller's operation. Dysphagia completely relieved, but the diverticulum persists.
to a large size, and cause extrinsic pressure on the gullet below the level of the origin of the diverticulum (Fig. 7). Dilatation is rarely of value in this condition and if diverticula are present can be dangerous. Relief of the dysphagia can be achieved by a Heller type of myotomy performed on the lower oesophagus as in the treatment of achalasia of the cardia. A vertical extra-mucous myotomy incision is made over the lower three inches of oesophagus at least, and extended for a further half inch over the cardia of the stomach to ensure that all the circular muscle fibres of the lower oesophagus have been divided. If a hiatus hernia is present this should be repaired and a functioning valvular mechanism restored to the cardia to prevent any further gastro-oesophageal reflux. Minor degrees of oesophagospasm are frequently encountered complicating reflux and effective control of this reflux leads to prompt and complete relief of the spasm.

Excision of pulsion diverticula of the lower oesophagus, on the mistaken assumption that they are responsible for the patient’s symptoms, without relief of the functional obstruction will lead to catastrophic and often fatal complications in the form of broken-down suture lines and mediastinal and pleural suppuration.

Achalasia of the Cardia

The cause of this condition remains obscure. Commonly the obstruction is confined to the cardia but in the early stages of the condition there may be diffuse spasm of the lower half of the organ; in the later stages this is superseded by diffuse progressive dilatation and lengthening of the organ. The irregular spasm already described as ‘corkscrew oesophagus’ may be associated with achalasia and there appears to be a close pathological affinity between the two conditions. However, pulsion diverticula are rarely seen in achalasia. There is diffuse uniform hypertrophy of the muscle layers of the oesophagus, maximal in the lower half.

At the cardia, the point of obstruction, the architecture of the muscle layers suddenly becomes normal and in this region there is no hypertrophy, supporting the thesis that the obstruction is due to failure of normal relaxation rather than true spasm. Pathological changes have been observed in the nerve plexes in the muscle layers but whether these are primary or secondary, congenital or acquired, is not known; nor is their significance in the aetiology of this condition. In longstanding cases the degree of dilatation or mega-oesophagus that develops is prodigious and this undoubtedly jeopardizes the functional result following surgical relief of the obstruction. Moderate dilatation will disappear following operation; gross dilatation will diminish but some degree will remain permanently (Fig. 8).

Considerable quantities of ingested food and fluid, some taken several days previously, are commonly retained in the dilated gullet. In the erect position a fluid level can be seen in the region of the clavicles on radiological examination. Conditions are ideal for alcoholic fermentation, a fact which may explain the unnatural euphoria enjoyed by many patients suffering from this condition. Of greater importance is the diffuse retention oesophagitis that may occur in advanced
cases. The mucosa is then reddened and oedematous, and has a characteristic granular appearance, bleeding readily if touched. There is no resemblance to the oesophagitis caused by gastro-oesophageal reflux. The significance of the oesophagitis is twofold. First, it appears to be a definite pre-malignant condition; reference to this will be made later. Second, the presence of gross retention oesophagitis is a contra-indication to radical surgical treatment and some preliminary form of drainage is necessary to control it before any form of Heller procedure is attempted, owing to the risk of perforation or spontaneous rupture of the softened oedematous mucosa whose texture can rightly be likened to that of the proverbial wet blotting paper.

**Diagnosis**

Although dysphagia is the presenting symptom in approximately 90% of cases, the patient may come under observation in other ways. The dysphagia is of such long duration, and so insidious in onset and progress that the patient may accept his disability as natural and inevitable. Only by asking leading questions can the clinician elicit a true picture of the patient's disability. These patients are often diagnosed as hysterical in the early stages before obvious dilatation of the gullet has occurred. Four patients with achalasia were referred to the author from mental hospitals with a diagnosis of chronic depression and 'an oesophageal abnormality'. On questioning it was learnt that the patients were depressed merely because they could not swallow. Relief of the dysphagia resulted in a dramatic psychiatric cure.

Pulmonary complications due to recurring aspiration pneumonitis, following regurgitation of oesophageal contents at night when the upper oesophageal sphincter is caught off its guard, are common, and may result in extensive, diffuse, pulmonary fibrosis. The dyspnea and pulmonary symptoms then overshadow the dysphagia. It is surprising that more patients do not drown in their own oesophageal residue. The youngest patient in the author's series, a boy of 8 years, was admitted to hospital with a diagnosis of bronchiectasis for further investigation. It was the noise caused by the aspiration of fluid into the trachea and bronchi at night that led to the correct diagnosis. As long ago as 1943 Hurst described four cases with respiratory complications following regurgitation, and a fifth, fatal, case of asphyxia.

Achalasia may be brought to light as the result of a routine mass miniature radiography examination. The opaque, fluid-filled, dilated oesophagus presents many of the radiological appearances of a mediastinal tumour. When the dilatation is greatest in the air containing upper third of the organ, a diagnosis of lung cyst, lung abscess, or even pneumothorax may be made.

In one instance the patient was admitted to a medical ward with a diagnosis of acute rheumatoid arthritis. Examination suggested acute pulmonary osteoarthropathy and further investigation confirmed the presence of achalasia of the cardia. The association of pulmonary osteoarthropathy and oesophageal disease is now recognized. In this case the retention oesophagitis was so severe that all mouth feeding was stopped and a preliminary gastrostomy performed: within 48 hours all pain and swelling had disappeared from the joints. One month later a Heller operation was performed and the gastrostomy allowed to close.

Investigation is carried out by means of radiological examination and oesophagoscopy. The radiological appearances are well recognized, especially the smooth, conical, constriction confined to the cardia that characteristically relaxes after the inhalation of octyl nitrite. The protean appearances presented by the dilated oesophagus on plain radiological examination mimic all forms of mediastinal pathology. In no other form of oesophageal obstruction is a comparable degree of oesophageal dilatation seen.

Oesophagoscopy examination is unsatisfactory owing to the difficulty of clearing the gullet of its retained debris. The examination is safer when performed in the sitting position under local anaesthesia; induction of general anaesthesia may lead to sudden flooding of the air passages with oesophageal contents. The main object of this examination is to inspect the mucosa and determine the severity of the retention oesophagitis. A careful inspection is carried out for any signs of early malignancy. It is rare for any convincing view to be obtained of the cardia and the exclusion of a malignant or benign stricture at the cardia may be impossible.

**Relationship to Carcinoma of the Oesophagus**

In the author's series of 94 cases of achalasia of the cardia there were eight cases of oesophageal carcinoma. In four cases the patients presented with severe obstruction due to advanced carcinomata; radiological examination revealed the underlying achalasia and megaeosophagus. The remaining four patients had previously been treated for achalasia and returned with recurrent obstruction due to malignant strictures 15 months to five years following the Heller operation. In all eight cases the growths were squamous cell in type, were situated in the mid-third of the gullet, and had reached an advanced stage before obstructive symptoms occurred owing to the previous
the gullet, but in no instance was the growth operable by normal standards. It is logical to assume that the sooner steps are taken to relieve the obstruction and oesophagitis in achalasia, the less the risk of subsequent malignant degeneration.

**Treatment**

Pre-operative care is important. If gross oesophagitis is present a course of octyl nitrite inhalations following low residue meals will drain the oesophagus from below. It may be necessary to pursue this regimen for three to four weeks before it is safe to proceed with surgical treatment. In two cases in the author’s series it was necessary to perform temporary gastrostomies and stop all mouth feeding to bring the inflammation under control. Oesophageal washouts are dangerous owing to the risk of drowning the patient.

An intensive course of physiotherapy to improve the pulmonary complications is usually called for. The patient’s nutritional state may be severely depleted from chronic starvation; this again must be corrected and blood transfusion may be necessary.

Numerous operations have been described for the relief of this condition. Repeated dilatations enjoyed a short vogue of popularity which was not justified by the results, and has now been largely abandoned by even its most fervent advocates. Various forms of oesophago-gastrostomy have been performed, to be followed in a high percentage of cases by disastrous gastro-oesophageal reflux and ulceration. An extramucous myotomy (Heller operation) dividing all the circular muscle fibres over the lower two to three inches of oesophagus is the most satisfactory operation available at the present time. The operation is best performed through the chest as only an inadequate myotomy incision is possible through the abdominal approach. Franklin has rightly said that it is an easy operation to perform but a difficult operation to perform well. In its original form the operation was not entirely successful, the occasional poor results being due to the development of fibrous strictures secondary to gastro-oesophageal reflux. It has not been generally recognized that any surgical interference with the region of the cardia may weaken the already precarious valvular mechanism, and precipitate the development of a hiatus hernia or patulous cardia and its sequelae. The author has in recent years employed a modification of the Heller procedure. Recognizing the risk of a hiatus hernia developing, the cardia is boldly freed from its attachments and following the myotomy a formal hernia repair is carried out.
by creating an acute angle of entry at the cardia, restoring an intra-abdominal segment of oesophagus, and approximating the two halves of the right crus behind the hiatus to form a buttress against which the intra-abdominal segment of oesophagus can be compressed by the abdominal pressure. In a personal series of 90 cases treated surgically, in the first 56 a formal Heller operation was carried out with satisfactory initial results, but in six cases, or 11%, fibrous strictures subsequently developed of sufficient severity to need oesophago-gastric resection and reconstruction (Fig. 10). In the last 34 cases the modified operation has been performed and as yet there has been no instance of stricture formation or subsequent necessity for further surgery. There was one post-operative death in this series, from uremia due to co-existing chronic nephritis.

The surgical relief of functional oesophageal obstruction is justified by the gratitude of the patient, by the satisfactory long-term results, and by the relative safety of the surgical procedures indicated.

**Summary**

1. A series of 132 cases of functional disorders of the oesophagus has been described. Of these 120 required surgical treatment for relief of dysphagia, or the pulmonary complications of oesophageal obstruction.

2. No operation for pharyngeal diverticulum is complete unless the underlying spasm of the upper sphincter is relieved.

3. Pulsion diverticula of the lower oesophagus rarely need surgical treatment; the underlying functional obstruction frequently does.

4. Achalasia of the cardia is a pre-malignant condition.

5. The Heller operation must be accompanied by the reconstruction of a functioning valvular mechanism at the cardia to prevent subsequent gastro-oesophageal reflux and fibrous stenosis.

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