Laparoscopic Heller Cardiomyotomy and Dor Fundoplication for Esophageal Achalasia

Possible Factors Predicting Outcome

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Hypothesis: Laparoscopic Heller myotomy with anterior hemifundoplication is the surgical procedure of choice for the treatment of esophageal achalasia. Specific factors, eg, severity of esophageal body deformity, might affect postoperative outcome.

Design: Prospective case-control study.

Setting: Academic referral center for gastrointestinal tract motility disorders.

Patients: Twenty-nine patients with esophageal achalasia who underwent 1 to 3 sessions of failed pneumatic dilation each.

Intervention: Laparoscopic Heller myotomy with anterior (Dor) hemifundoplication.

Main Outcome Measures: Preoperative and postoperative symptomatic evaluation, esophagoscopy, esophagography, stationary and ambulatory esophageal manometry, and pH monitoring.

Results: Three patients had stage I disease, 10 had stage II, 12 had stage III, and 4 had stage IV at preoperative radiologic examination. At surgery, there were no conversions to open procedures, and 2 mucosal perforations were immediately identified and sutured. Good or excellent results were seen in 26 patients. All patients with stage I or II disease had excellent functional results. Of patients with stage III disease, results were excellent in 7, good in 4, and bad in 1. Of patients with stage IV disease, 2 had good results and 2 had bad results. After surgery, lower esophageal sphincter pressure was reduced significantly (from 46.1±12.1 to 5.4±1.8 mm Hg; P<.001), as was esophageal diameter (from 61±17 to 35±19 mm; P<.001) (data are given as mean±SD). However, an excellent result occurred only in patients with a postoperative esophageal diameter less than 40 mm.

Conclusion: Functional outcome of laparoscopic Heller-Dor procedure for achalasia is related to the preoperative stage of the disease on the esophagogram and to the extent of reduction in esophageal width after surgery.

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When pneumatic dilation of the lower esophageal sphincter (LES) is contra-indicated or poor results are anticipated or the procedure fails to relieve the patient's symptoms, surgery should be considered for the treatment of esophageal achalasia.1-4 Transabdominal cardiomycotomy, first described by Heller in 1914,5 offers satisfactory results in approximately 93% of patients with achalasia.6

More recently, minimally invasive esophagomyotomy by laparoscopy is replacing open surgery for achalasia, but data comparing these 2 different approaches are sparse. Data from small series7 show similar results concerning relief of dysphagia and satisfaction of the patient with the outcome after either approach. The laparoscopic approach is associated with significantly less blood loss, parenteral narcotic use, hospitalization time, and time off work.7,8 However, little has been reported about any predictors of outcome after surgery. It has been suggested that a significant reduction in esophageal body diameter on an esophagogram after surgery is associated with good postoperative functional results, whereas the patient with a dilated and tortuous esophagus is unlikely to respond to cardiomycotomy.9

In the present study, we analyzed data from 29 patients who underwent laparoscopic Heller myotomy and anterior hemifundoplication for achalasia and who completed 1-year follow-up. Emphasis was given to documentation of the results and to definition of any predictors of outcome.
PATIENTS AND METHODS

Between January 1, 1995, and June 30, 1998, 29 patients underwent laparoscopic treatment for esophageal achalasia. Preoperative workup included clinical assessment, esophagogastroscopy, upper alimentary endoscopy, esophageal manometry, 24-hour ambulatory esophageal manometry, and pH monitoring. Severity of dysphagia, regurgitation, and heartburn was assessed separately according to a scoring system similar to that described by Johnson and DeMeester (0 indicates absence; 1, occasional episodes; 2, frequent episodes; and 3, daily episodes). On the esophagogram, the diameter of the esophagus 8 cm proximal to the gastroesophageal junction was measured and the disease was graded as follows: stage I, diameter less than 40 mm; stage II, diameter of 40 to 60 mm; stage III, diameter greater than 60 mm; and stage IV, diameter of any size with sigmoid configuration of the distal esophagus. Ambulatory esophageal manometric and pH monitoring data were assessed according to standard definitions.11

OPERATIVE TECHNIQUE AND POSTOPERATIVE MANAGEMENT

Dissection was limited to the anterior aspect of the abdominal esophagus and the diaphragmatic crura. The anterior vagal trunk was dissected and preserved, as was the hepatic branch of the anterior vagus. After dissecting and excising the fatty pad of the gastroesophageal junction, the myotomy was started from the junction and was extended proximally on the esophagus up to 5 cm by dividing the circular muscular layer and distally on the stomach up to 1.0 to 1.5 cm by dividing the oblique muscular fibers. Division of the muscular fibers was achieved using a hook device and minimal electrocautery. The cut muscular edges were dissected laterally to fully expose the anterior aspect of the submucosa. The integrity of the submucosal layer was tested by instilling 50 mL of diluted methylene blue through a nasal tube into the esophageal lumen. The operation was completed with an anterior hemifundoplication of the Dor type, which was accomplished by suturing the anterior gastric fundus first to the left cut edge of the myotomy and the left pillar of the crus and then to the right cut edge of the myotomy and the right pillar of the crus.12

The nasogastric tube was left in place for 24 to 48 hours and was removed after a meglumine diatrizoate (Gastrografin) swallow showed easy passage through the lumen of the gastroesophageal junction and no leaks. A liquid diet was then resumed. On the second postoperative day and continuing for 6 to 8 weeks, a soft diet was recommended. Unless other complications occurred, patients were discharged from the hospital on the second to third postoperative day.

POSTOPERATIVE ASSESSMENT

Patients were clinically assessed 2 weeks, 3 months, and 1 year after surgery. Clinical outcome was classified as excellent (symptomatic score of 0-1), good/satisfactory (symptomatic score of 2-4), or bad (symptomatic score of ≥5). Nine months to 1 year after surgery, all patients underwent esophagography, standard stationary manometry, and 24-hour ambulatory esophageal pH monitoring.

STATISTICAL ANALYSIS

Unless otherwise stated, all values are expressed as mean±SD. Comparisons between preoperative and postoperative values of the various variables were made by applying the Mann-Whitney test for paired values and the χ² test with the Yates correction, as appropriate. Regression analysis was also used to identify any correlation between the preoperative stage of the disease and the clinical and laboratory outcomes after surgery. P<.05 was considered statistically significant.

RESULTS

PREOPERATIVE ASSESSMENT

There were 12 men and 17 women aged 47.5±18.9 years (range, 18-74 years). Duration of symptoms was 5.2±4.5 years (range, 1-19 years). Twelve patients underwent 1 session, 10 underwent 2 sessions, and 4 underwent 3 sessions of LES pneumatic dilation before surgery, with temporary or no relief of dysphagia. In only 3 patients with stage IV disease on esophagography (dilated sigmoid shape of the distal esophagus) was pneumatic dilation not attempted immediately before surgery, although they had 1 to 2 attempts at earlier stages of disease. All patients had constant dysphagia and regurgitation. Twelve patients reported weight loss, 10 experienced recurrent respiratory tract symptoms, and 7 had heartburn. Two young patients reported spontaneous or postdeglutition chest pain.

According to the preoperative esophagogram, patients were classified as follows: stage I, 3 patients; stage II, 10; stage III, 12; and stage IV, 4. Mean esophageal diameter was 61±17 mm. Mean LES pressure was 46.1±12.1 mm Hg (range, 29-69 mm Hg). Lower esophageal sphincter relaxation was absent in 23 patients and incomplete in 6. At standard esophageal manometry, esophageal peristalsis was absent in all patients. Ambulatory manometry showed aperistalsis in 26 patients, failed peristalsis in 2, and dropped peristalsis in 1. An abnormal DeMeester score (51±22) on esophageal pH monitoring was found in 9 patients, 7 of whom reported heartburn. In these 9 patients, the pattern of reflux was characterized by a few long-duration reflux episodes (total reflux time, 18%±7%), with a pH just less than 4.

OPERATIVE AND POSTOPERATIVE COURSE

Operative time was 73±18 minutes (range, 45-105 minutes). Blood loss was minimal. The location of the gastroesophageal junction with use of the endoscope as the Z-line was usually 0.5 to 1.0 cm more proximal than that found using the laparoscope as the proximal border of the oblique muscle fibers of the stomach. In most patients, there was considerable difficulty in detaching the cut edges of the circular muscle fibers away from the underlying esophageal submucosa. Two intraoperative mucosal perforations occurred, both at the level of the gastroesophageal junction: one using the transesophageal endoscope and the other using the hook device dur-
an esophageal mucosal burn at the upper site of my-
6 days later. The late leak was attributed to desloughing of
cutaneous drainage. He was discharged from the hospital
fluid below the left hepatic lobe that was treated with per-
He developed an esophageal leak and a small collection of
operative hospital stay was 2.2±0.9 days (range, 1-8 days).
and antibiotic treatment. Post-
patients developed atelectasis that was promptly resolved
were repaired using 4-0 absorbable stitches. There were
myotomy of the muscle fibers. These perforations
no increase in the diameter of the lower esophagus after my-
 scored 2.52 ± 0.78 0.41 ± 0.78 <.001
Dysphagia scoring 2.62 ± 0.49 0.48 ± 0.91 <.001
Regurgitation scoring 2.52 ± 0.78 0.41 ± 0.78 <.001
Esophageal diameter, mm 61 ± 17 35 ± 19 <.001
Lower esophageal sphincter 46.1 ± 12.1 5.4 ± 1.8 <.001
resting pressure, mm Hg 46.1 ± 12.1 5.4 ± 1.8 <.001
Esophageal pH monitoring,
DeMeester score 25 ± 21 16 ± 11 .02
*
Data are given as mean ± SD.

LONG-TERM FOLLOW-UP
At 1-year follow-up, excellent or good results were reported
by 26 patients (90%). Twenty-one patients (72%) reported
total relief of dysphagia and absence of regurgitation events
(score of 0 for both symptoms in all patients), and another
5 patients (17%) were satisfied with the final outcome, re-
porting considerable improvement of dysphagia (a score
of 1 in 4 patients and a score of 2 in 1 patient) and occa-
sional episodes of regurgitation (a score of 1 in all patients).
The remaining 3 patients (10%) did not show any improve-
ment in dysphagia (a score of 2 in 1 patient and a score
of 3 in 2 patients) and complained of frequent episodes of
regurgitation (a score of 2 in 2 patients and a score of 3
in 1 patient). In addition, 3 patients had severe heartburn (a
score of 2 in 1 patient and a score of 3 in 2 patients), and
they all had stage IV disease at preoperative classification.
All patients with stage I or II disease at preoperative as-
sement reported excellent results. Of 12 patients with
stage III disease, 7 had excellent results, 4 had good results,
and 1 reported a bad outcome. Of 4 patients with stage IV
disease, the procedure failed to relieve the symptoms in 2
and the remaining 2 showed improvement but not com-
plete dissolution of dysphagia. Conceivably, postoperative
outcome was significantly related to the preoperative ra-
diologic stage of the disease (r=0.66; P<.001). An advanced
radiologic stage at preoperative assessment was usually as-
associated with a nonsatisfactory clinical outcome.

The esophagogram showed a significant overall de-
crease in the diameter of the lower esophagus after my-
omy (Table and Figure). However, an excellent result
(total relief of symptoms) occurred only when the post-
operative esophageal diameter was less than 40 mm. Fur-
thermore, the 5 patients with fair or satisfactory clinical out-
comes had a significantly narrower esophagus after surgery
than did the 3 patients with bad outcomes (P=.03).
The increased preoperative LES pressure was low-
ered significantly after myotomy (Table). The fact that
postoperative LES resting pressure decreased invariably
below 10 mm Hg signified a complete myotomy. There
was no correlation between preoperative LES pressure
or the extent of the postoperative decline in LES pres-
ure and the clinical results. Ambulatory esophageal ma-
nometry did not reveal evidence of even partial restora-
tion of esophageal peristalsis in any patient.

There was an overall significant decrease in
DeMeester reflux scores to almost normal levels (Table).
In particular, reflux scores were overall significantly de-
creased in the 9 patients with increased preoperative re-
flux (DeMeester score, 26±21; P=.01, and total reflux time
of pH <4, 10%±10%; P=.03). However, 2 of these 9 pa-
tients continued to present with abnormal scores after sur-
gery. Only 1 patient without reflux before surgery showed
abnormally increased reflux scores after surgery.

Although the number of series reported in the literature
and the overall number of patients included is rather small,
Laparoscopic surgery for esophageal achalasia offers satisfactory functional results with minimal morbidity and almost no mortality. 1,4,7,9,12,13 In a large series by Patti et al., 14 100 of 112 patients who underwent laparoscopic Heller myotomy and partial fundoplication had good or excellent results. At postoperative functional evaluation in 35 of those patients, reflux was present in 17%, and the mean LES pressure decreased from 28 mm Hg before surgery to 10 mm Hg after surgery. In even the most recent series by Yamamura et al., 15 85% to 90% of patients who underwent laparoscopic Heller myotomy and anterior fundoplication for achalasia were relieved of dysphagia, but laboratory documentation is insufficient.

In the present series, in which 4 patients had stage IV disease on the preoperative esophagogram, excellent or good results were obtained in 26 patients with laparoscopic myotomy at 1-year follow-up. These results are similar to those reported by other researchers, 3,4,7,8,11 although patients with stage IV were usually excluded from these series. It is widely accepted that advanced disease does not respond to myotomy, and that esophagectomy should be offered to these patients first. 3 However, 2 of 4 patients in the present series with a very dilated and tortuous distal esophagus reported satisfactory functional results, with occasional dysphagia or regurgitation. Furthermore, 83% of patients with a dilated and straight distal esophagus and all patients with a dilated and sigmoid-shaped esophagus had a satisfactory functional outcome in a series reported by Patti et al. 10

Taking into account the minimal morbidity of the laparoscopic approach, we believe that all patients with stage IV disease should be offered laparoscopic myotomy first, reserving esophagectomy for patients who were not relieved of their symptoms.

In any case, the functional outcome of myotomy is strongly related to the preoperative stage of the disease on the esophagogram. All patients with stage I or II disease in the present series had excellent results, whereas less satisfactory or bad results were seen only in some patients with stage III and all with stage IV disease. Furthermore, the results of the present series showed that good or excellent functional results are obtained only in patients with a postoperative esophageal diameter of less than 40 mm on the esophagogram. Patients with less satisfactory or even bad outcomes demonstrated a more dilated esophagus after surgery.

After pneumatic dilation of the esophagus, a reduction of LES resting pressure to less than 10 mm Hg is considered a prerequisite for satisfactory results. 17 This seems to be the case in patients treated with myotomy, using either the open or closed approach. 1,12,13,16 All patients in the present series invariably had resting LES pressure of less than 9 mm Hg at postoperative esophageal manometry, signifying an adequate myotomy. However, not all these patients had satisfactory functional results. Therefore, a complete myotomy is a necessary but not adequate factor for good outcome.

The addition of Dor fundoplication in the present series prevented gastroesophageal reflux. Heartburn and pathological findings on esophageal pH monitoring occurred in 3 patients after surgery and were attributed to delayed esophageal emptying rather than to true reflux because all patients had stage IV disease. The pattern of esophageal acidity, as detected on pH monitoring, is different in the case of true esophageal reflux than in that caused by delayed esophageal emptying. In the latter case, there is usually a constant decrease in esophageal pH to just less than 4. In the former case, sharp declines to pH less than 2 are observed.

In conclusion, laparoscopic Heller myotomy with Dor fundoplication is effective in relieving dysphagia in most patients with achalasia, preventing simultaneous gastroesophageal reflux. A good postoperative result is expected when the length of myotomy is adequate, LES pressure declines substantially, preoperative esophageal dilation is not excessive, and distortion of the distal esophagus is absent. Patients with stage IV disease can be treated with myotomy provided that the postoperative width of the esophagus decreases to less than 40 mm. Increased esophageal acidity and heartburn in patients after myotomy is attributed to delayed esophageal emptying.

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REFERENCES


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