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Chest trauma and aetiology of achalasia

Achalasia is a motility disorder caused by neural dysfunction which may involve both the myenteric plexus of the oesophagus, the vagal nerves, and the dorsal motor nucleus.^{1,2} The aetiology of the disorder is still obscure, viral infection and autoimmunity having been suggested. Recently, Park and Vaezi¹ proposed that different environmental factors in patients with genetic predisposition could lead to the same clinical picture and manometric findings.

As part of an ongoing prospective study in patients with achalasia,¹ we have investigated if chest trauma could be involved in the development of achalasia. Twenty consecutive achalasia patients (eight men), aged 18–79 years (median age 53) at the time of diagnosis, and 20 consecutive patients matched for sex and age (eight men; 17–83 years (median 49)), evaluated at our outpatient clinic, were included. Control patients presented with symptoms other than dysphagia and, at the end of evaluations, diagnosis of irritable bowel syndrome (n = 8), gastro-oesophageal reflux disease (n = 6), peptic ulcer disease (n = 4), chronic constipation (n = 1), and anal incontinence (n = 1) were made. Achalasia patients underwent clinical evaluation, upper endoscopy, x ray barium study, and oesophageal manometry to confirm diagnosis. All patients included in the study underwent a standard questionnaire regarding occurrence of chest trauma. Arbitrarily, only traumas serious enough to require hospitalisation or to determine loss of work of ≥ 7 days were considered. Type of trauma and type of accident causing trauma were also recorded. Traumas were divided according to their occurrence before or after the onset of dysphagia.

Chest trauma was reported by 5/20 (25%) achalasia patients and no control patients ($p < 0.05$ by Fisher's exact test). All traumas occurred before the onset of dysphagia (median 2 years (range 1–13) before), being caused by a road accident in three patients and work accident in two. All traumas were non-penetrating. Hospitalisation was required in three patients. Achalasia patients with and without chest trauma had a similar age at onset of dysphagia (mean 45 (SEM 9) and 43 (5) years, respectively), clinical score (8.8 (0.5) and 7.6 (0.5)) according to Eckardt and colleagues,⁴ oesophageal diameter at x ray barium swallow (4.9 (0.3) and 4.4 (0.5) cm), amplitude of oesophageal pressure waves (41 (18) and 31 (7) mm Hg), and lower oesophageal sphincter pressure (26 (5) and 27 (4) mm Hg) at diagnosis. Independently of previous occurrence of chest trauma, all patients achieved stable clinical remission (that is, clinical score of ≤ 3 for ≥ 1 year after dilatation)³ and a low lower oesophageal sphincter pressure (< 10 mm Hg)⁴ after one (n = 11) or two (n = 9) pneumatic dilatations. Recent retrospective data support our findings⁵: a history of operative or non-operative chest trauma prior to the development of dysphagia was present in 16/64 (25%) achalasia patients compared with 7/73 (9.5%; $p < 0.05$) control patients presenting with dysphagia and normal oesophageal manometry.

In conclusion, chest trauma may be one of the aetiological factors of achalasia. This could occur through ischaemia or compression of neural structures leading to their irreversible damage in susceptible individuals.

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British Society of Gastroenterology guidelines for ulcerative colitis surveillance: creating consensus or confusion?

Absence of grade A evidence combined with discrepancies between retrospective studies in reported survival benefit has led to controversy surrounding the colonoscopic surveillance of ulcerative colitis (UC) patients. Such controversy was demonstrated in 2000 by an audit which revealed widespread variations in surveillance practice.¹ Following the introduction of British Society of Gastroenterology (BSG) guidelines in 2002,² concern was expressed regarding the medicolegal implications posed by national recommendations based on inconclusive evidence and lacking multicentre consensus.³ Three years after the publication of the guidelines, a questionnaire survey has indicated that widespread disparities in opinion and practice still exist.

Questionnaires were distributed to all consultants and specialist registrars in gastroenterology within the Wales deanery. A 45.1% (23/51) response rate was achieved. Although a significant majority (73.9% (95% confidence interval (CI) 56.0–91.8%)) agreed that colonoscopic surveillance of UC patients was a worthwhile exercise, opinions of what constituted "best practice" varied considerably. Only a marginal majority of respondents (52.2% (95% CI 31.8–72.6%)) agreed with BSG recommendations that the initial screening colonoscopy for pancolitis patients should take place 8–10 years after symptom onset, and a substantial proportion (26.1% (95% CI 8.2–44.0%)) felt (contrary to BSG guidelines) that surveillance in left sided colitis was unnecessary, with five respondents

commenting that they knowingly contravened these recommendations in practice. Responses to seven short clinical scenarios elicited opinions regarding the most appropriate intervals between colonoscopic surveillances (table 1).

Despite a consensus with BSG recommendations in cases of lone proctitis, pancolitis, and pancolitis with concomitant primary sclerosing cholangitis (PSC), considerable divergence from the guidelines was eluded to in the response to the remaining cases. As well as repeating concerns over surveillance of left sided disease, respondents repeatedly commented on the difficulties of using age as an inclusion criteria and of the uncertainty surrounding the optimum management of a patient with proctitis and PSC (an admittedly rare scenario). One hundred per cent of respondents reported familiarity with BSG guidelines. Within this context, the disparities of opinion demonstrated indicate that practitioners commonly either misinterpret or knowingly contravene current guidelines.

The controversial nature of the current evidence is further highlighted by differences in the surveillance protocols recommended by major societies. Whereas a consensus exists as to the carrying out of colonoscopy 8–10 years after symptom onset in all UC patients, differences regarding the frequency of surveillance thereafter remain. While the BSG,² American Gastroenterological Association (AGA) (who only recommend that surveillance per se should "be considered"),⁴ and American Society for Gastrointestinal Endoscopy (ASGE)⁵ advise initiation of regular surveillance of left sided colitis 15 years after symptom onset, as opposed to eight (AGA and ASGE) or 8–10 years (BSG) for pancolitis, the American College of Gastroenterology (ACG)⁶ do not consider the evidence "sufficiently strong" to justify discrimination between patient groups, and recommend regular surveillance for all colitis patients after 8–10 years. There is also disagreement surrounding the optimum interval between subsequent surveillances, with the BSG advocating reductions in interval with disease progression (initially three yearly), the ASGE and AGA recommending 1–2 yearly intervals, and the AGA recommending annual or biannual surveillance.^{2,4–6}

If the lack of consensus in opinion and practice demonstrated in the current work is representative of broader opinion, it would indicate that introduction of BSG guidelines have only partially reduced the aforementioned variations in practice.¹ Considering the inconclusivity of the evidence and apparent disparities in professional opinion, and in light of the potential medicolegal implications of deviating from the protocol of a national body, it would seem prudent to review current guidelines with a view to producing more flexible recommendations which would representatively encompass the discrepancies within the evidence and range of professional opinion.

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