



ACHALASIA CARDIA WITH SCHIZOPHRENIA – HOW I DID – A CASE REPORT

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ABSTRACT

Achalasia cardia is a rare GIT disorder with dysphagia and weight loss, hence frequently associated with psychological depression. Here we are presenting a case report of Achalasia cardia with Schizophrenia who underwent cardio myotomy under General anaesthesia

KEYWORDS : Achalasia cardia/schizophrenia / Laparoscopy/cardiomyotomy

INTRODUCTION

Achalasia cardia is the common cause of motor dysphagia. Though the disease was first described more than 300 years ago, its exact pathogenesis still remains stigmatic (1)

It is caused by the loss of inhibitory ganglion in the myenteric plexus of the esophagus leading to failure of relaxation of the Lower Esophageal Sphincter. Initially, degeneration and unopposed action of excitatory neurotransmitters such as Acetylcholine resulted in high amplitude nonperistaltic contraction (vigorous achalasia), progressive loss of cholinergic neurons resulting in dilatation, and low amplitude contraction. (2)

Case Scenario

48 years old complaining of difficulty in swallowing food for 1 month. No history of Diabetes, Systemic hypertension, Coronary artery disease.

History of previous surgery – fracture of shaft of femur left side, plating done.

Cardiovascular System – S1, S2 heard, No murmur.

Respiratory system – bilateral air entry present, Normal vesicular breath sounds, No added sounds.

Central nervous system – no neurovascular deficit.

Abdomen – soft, no organomegaly.

History of sleeplessness and depression, diagnosed as Schizophrenia on psychiatric medicine.

- T. Sizodem LS - 1 BD
- T. Pacitane - 2mgm 1 at afternoon
- T. Sizopro - 100mgm at night
- T. Zefnetol - ½ BD

Investigations

Routine – within normal limits

- Haemogram
- Diabetic profile
- Liver function tests
- Renal function tests
- Hepatitis B test 1 & 2
- HIV test
- HCV test

Specific Tests –

- UGI scope – Achalasia cardia
- Barium swallow and Barium meal – Achalasia cardia, Pseudoachalasic growth
- Manometry – Achalasia Type 2

Anaesthetic Challenges

1. Pulmonary aspiration due to regurgitation of oesophageal contents
2. Difficult airway
3. Intra peritoneal hemorrhage
4. Problems of laparoscopy and CO2 insufflation

5. Cardiovascular instability
6. Anti-psychiatric medication and its implications

Anaesthetic Management

- The patient was advised to continue antipsychotic medicine as usual
- A wide-bore nasogastric tube was inserted, and gastric and oesophageal contents were aspirated.
- Inj. Ranitidine 50mgm, Inj. Ondansteron 4mgm was given intravenously
- Monitors are ECG, SPO2, EtCO2, NIBP, Temperature
- Premedicated with Inj. Glycopyrrolate 0.2 mg, Inj. Fentanyl 100 micrograms IV slow
- Preoxygenation for 3 minutes
- Induced with Inj. Propofol 150 mg
- Intubated with oral cuffed ETT, 8.0 mm ID after Inj. Suxamethonium 100mgm
- Anaesthesia maintained with Inj. Atracurium, N2O + O2 + Sevoflurane 0.2% + IPPV
- The position of the patient is modified lithotomy
- Inj. Dexmedetomidine infusion started at a rate of 1mic/kg/hour
- Intraoperatively all parameters were stable
- At the end of the procedure, the patient was reversed with Inj. Myopyrrolate and extubated

Surgical Technique

- Patient in the modified lithotomy position, through laparoscopy
- Oesophagus was identified and separated from the crura of the diaphragm
- Oesophageal myotomy is done from 6cms of the mediastinal oesophagus to 2cms gastric esophagus till the gastroesophageal junction
- Air inflation was done to check for any oesophageal perforation
- Absolute hemostasis secured
- Fundoplication is the only surgical modality in Proton Pump Inhibitor resistant patients (3)

DISCUSSION

- The incidence of Achalasia cardia is approximately 1.6 cases per 100,000
- Males and females are affected with equal frequency. Can occur at any age, but onset before adolescence is rare. (4)
- The etiology of primary or idiopathic is unknown, secondary is a protozoal parasite, viral infection, Chaga's disease, Amyloidosis, MEN type 2B, juvenile Sjogren's syndrome

Chicago's classification of oesophageal motility disorders includes – (5)

Type 1 – classic achalasia, failed peristalsis

Type 2 – compressive achalasia

Type 3 – peristaltic fragments or spastic achalasia

Acute tracheal compression in achalasia was described by Bello et al in 1950, stridor was the only presenting symptom, and may be associated

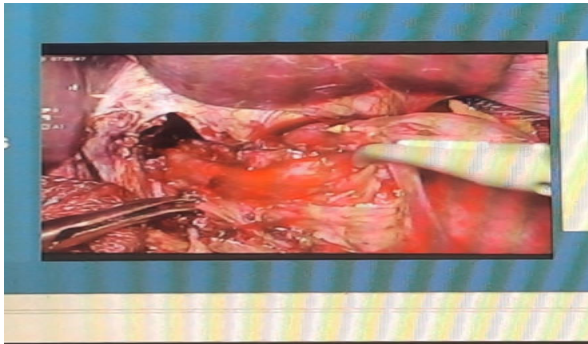
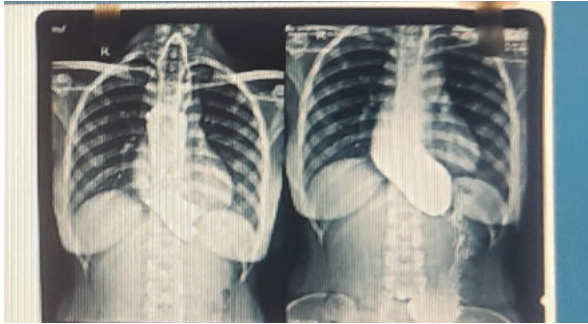
with Superior Vena Cava obstruction or Recurrent laryngeal nerve compression. (6)

Anaesthesia And Psychiatric Medication

The problems are – (7)

1. Antipsychiatric drugs for many years leads to delayed awakening
2. Cardiovascular instability
3. Arrhythmias

Sudden cardia arrest during General anaesthesia - An intriguing relationship between mental illness and Coronary Heart Disease appears to exist. People with severe mental illness including schizophrenia, bipolar disorders, and major depressive disorders have a higher mortality rate, 2-3 times higher. (8)



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