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ENDOSCOPIC FINDINGS IN PATIENTS PRESENTING WITH DYSPHAGIA

Gastroenterology

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ABSTRACT

INTRODUCTION: Dysphagia is a condition in which disruption of swallowing process interferes with patient ability to eat due various causes. Endoscopy is the mainstay of diagnostic workup of these patients and subsequent treatment.
AIM: The objective of the study was to determine the frequency of various types of endoscopic findings in patients with dysphagia.
METHODS: Cross-section descriptive study carried out in DDHD, KMC, Chennai, a tertiary care hospital from November 2018 to May 2019. Duration of symptoms was noted and all patients underwent upper gastrointestinal endoscopy to find out the cause of dysphagia. Tissue biopsies were obtained and further histopathological examination was performed to correlate the findings with symptoms of dysphagia.
RESULTS: A total of 197 patients presenting with dysphagia were studied, 93 (47%) were males and 104 (53%) were females. The mean age was 55 ± 8 years. Oesophageal malignancy was the most common finding noted in 54(27%) patients. It was followed by post cricoid web in 24 (12%), benign stricture oesophagus 21(10%), cricopharngeal malignancy in 14(7%), anastomatic stricture 14(7%), normal UGI in 12(6%), post RT stricture in 11(5%), peptic stricture in 8(4%), hypopharynx malignancy in 8(4%), OGJ growth in 8(4%), corrosive stricture in 7(4%), patients and reflux esophagitis in 5 (2.9%) patients, oesophageal candidiasis in 5(2.9%), achalasia in 4(2%) ,pyriform fossa malignancy in 3(1.5%),oesophageal web in 3(1.5%), one patient each in Schatzki's ring, pill esophagitis, oesophageal varices, oesophageal diverticula(0.5 %).
CONCLUSION: Malignancies and malignancy related conditions are more common cause of dysphagia in our set of population. Patient presenting with dysphagia, endoscopy is initial and better choice of investigation unless contraindicated

KEYWORDS

Dysphagia, Malignancy, endoscopy, early diagnosis

DYSPHAGIA

Dysphagia, a Greek word; dys (difficulty, disordered) and phagia (to eat), refers to the sensation that food is hindered in its passage from the mouth to the stomach[1]. Inability to swallow is caused by a problem with the strengthor coordination of the muscles required to move material from the mouth to the stomach or by a fixed obstruction somewhere between the mouth and stomach [2]. Upper gastrointestinal (GI) endoscopy is the most commonly performed procedure for evaluation and initial diagnosis of dysphagia [2]. Endoscopy aids in direct visualization of the entire esophagus and also helps in taking biopsy of the tissue. Early diagnosis dysphagia cause is associated with significant morbidity and mortality[3]. Upper GI endoscopy is a safe procedure and has a risk of complications of 1 / 1000 procedures approximately[2]. Infection, bleeding, perforation and cardio-pulmonary issues are the common complications seen with this procedure[4].

MATERIALS & METHODS

It is a cross-section descriptive study carried out in DDHD, KMC, Chennai, a tertiary care hospital from November 2018 to May 2019. All patients presenting with dysphagia from age 18-80 years were included in the study. Patients fulfilling the inclusion criteria were recruited in the study after obtaining informed written consent. The patients were assessed with adequate history, thorough examination and investigations and findings were noted down on a pre-designed proforma. Endoscopy was performed and biopsies were taken where required and were sent for histopathological analysis. The results of the analysis were recorded on the proforma and were subjected to statistical analysis.

RESULTS

A total of 197 patients presenting with dysphagia were studied, 93 (47%) were males and 104 (53%) were females. The mean age was 55 ± 8 years.

Table 1 shows various causes of dysphagia in decreasing order of frequency;

Oesophageal malignancy	54(27%)	post RT stricture	11(5%)	achalasia	4(2%)
post cricoid web	24(12%)	peptic stricture	8(4%)	pyriform fossa malignancy	3(1.5%)
benign stricture oesophagus	21(10%)	OGJ growth	8(4%)	oesophageal web	3(1.5%)
cricopharngeal malignancy	21(10%)	Corrosive stricture	7(4%)	schatzki's ring	1(0.5%)
anastomatic stricture	14(7%)	reflux esophagitis	5 (2.9%)	pill esophagitis	1(0.5%)
normal UGI	12(6%)	oesophageal candidiasis	5(2.9%)	oesophageal diverticula	1(0.5%)

Oesophageal malignancy was the most common finding noted in 54(27%) patients. It was followed by post cricoid web in 24 (12%), benign stricture oesophagus 21(10%), cricopharngeal malignancy in 14(7%), anastomatic stricture 14(7%), normal UGI in 12(6%), post RT stricture in 11(5%), peptic stricture in 8(4%), hypopharynx malignancy in 8(4%), OGJ growth in 8(4%), corrosive stricture in 7(4%), patients and reflux esophagitis in 5 (2.9%) patients, oesophageal candidiasis in 5(2.9%), achalasia in 4(2%) ,pyriform fossa malignancy in 3(1.5%),oesophageal web in 3(1.5%), one patient each in Schatzki's ring, pill esophagitis, oesophageal varices, oesophageal diverticula(0.5 %) as shown in chart 1& 2.

Chart 1:

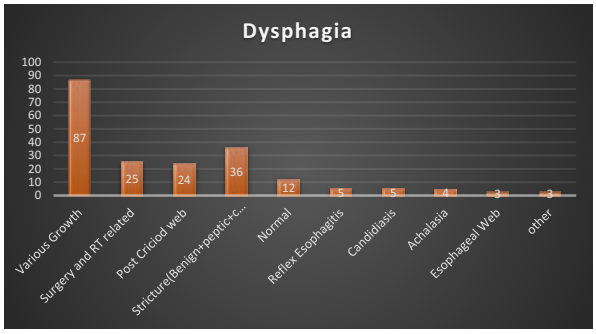
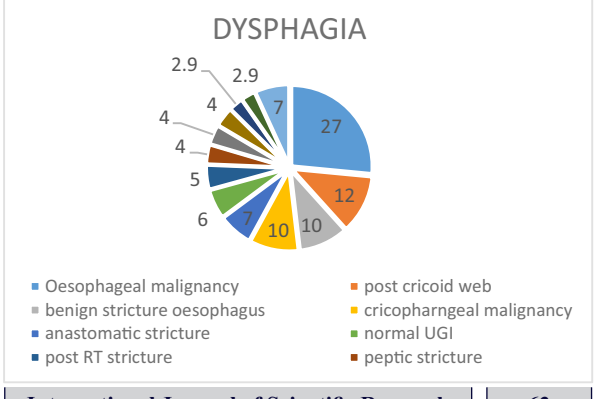


Chart 2:



DISCUSSION

Dysphagia is commonly observed in both hospitalized as well as in outpatient clinics [5]. Causes of dysphagia are numerous; they include reflux oesophagitis, benign or malignant oesophageal strictures, oesophageal motility disorders, achalasia, external compression due to malignancy, scleroderma and Schatzki's ring[6]. Studies have reported a prevalence of dysphagia up to 17% in a population-based study and observed that the peak age for this complain between 40 to 50 years but equally present among both genders[7]. In developed countries, the incidence is recorded in higher frequencies among elderly patients[8]. For patients that complain of dysphagia, upper GI endoscopy is the recommended diagnostic procedure which is the safest procedure evaluating dysphagia initially with an overall complication risk of 1 in 1000[9].

Wilkins et al. reported in their study of 947 participants, that only 214 (22.6%) patients had a complaint of dysphagia with a high percentage of patient being females, i.e. 80.8% females as compared with 19.2% males[10]. In our study, we did not observe this disparity with 53% of our patients being female and 47% male.

In our study of 197 patients, the most common findings according to the areas visualized, Oesophageal malignancy was the most common finding, seen in 54(27%) patients. Khan AN et al. recorded malignant oesophageal stricture to be the most common finding of endoscopy in 27.3% of patients followed by normal endoscopy in 20.9% of patients and reflux oesophagitis to be the third most common cause of dysphagia, reported in 18% of patients with all findings equally reported in both genders[11].

In research done by Satti SA et al., the most common cause of dysphagia reported was reflux oesophagitis (35.8%). They also reported a high percentage of malignant strictures, i.e. 22.5%, while 16% of endoscopies were reported as normal[12] in contrary with our findings where malignant strictures were most common while only 6% of endoscopies were reported normal.

The difference among the findings reported in our study compared with other studies might be because of differences in geographic and genetic variations as well as different sample sizes of the studies.

Limitations of the study

In this study, a whole array of diagnoses was presented in patients presenting with dysphagia using upper GI endoscopy technique. However, our study might not be immune to observer and selection bias. We performed endoscopy as a diagnostic procedure only and did not use it for therapeutic purposes.

CONCLUSION

Malignancies and malignancy related conditions are more common cause of dysphagia in our set of population. Patient presenting with dysphagia, endoscopy is initial and better choice of investigation unless contraindicated.

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