Mr. Editor,

Achalasia is a disorder of the lower esophagus in which its sphincter is unable to relax even during a peristaltic reflex. Its development is related to the loss of both Auerbach’s (myenteric) and Meissner’s (submucous) plexuses of the distal esophagus and lower sphincter, due to a neurodegenerative process that may be autoimmune or secondary to an infection. In Brazil, Chagas disease is one of this disorder’s main etiologies, by promoting the destruction of the myenteric plexus due an inflammatory response to the *Trypanosoma cruzi*. The Chagas megaesophagus is one of its presentations, consisting of the addition of achalasia to ineffective peristalsis that results in esophageal dilatation.

The world’s incidence of achalasia is about 1/100,000 and, because of its chronicity, its prevalence is about 9 to 10/100,000. It is estimated that, currently, about 1 million chronic Chagas patients live in Brazil. Megaesophagus affects about 7% to 10% of these patients, manifesting during about 20 to 40 years old. The main symptom of this condition is the long-lasting dysphagia, that may be followed by regurgitation, retrosternal pain, heartburn and sialorrhea. When facing symptoms like dysphagia, it is necessary, at first, to exclude diagnostic hypothesis of gastroesophageal reflux disease, mechanical obstruction of esophagus, or malignancy, since those are more prevalent; then, it must be proceeded the investigation of esophageal motility disorders, such as achalasia.

Because of this illness’ importance in our setting, and because of the need of accessible radiologic methods that allow diagnosis, classification and follow-up of patients, the barium-based contrast radiography of the esophagus (esophagogram) is still highlighted in the spite of more modern methods. The contrast radiography of the esophagus almost always confirms the diagnosis of megaesophagus, and it can be used to classify the case’s severity according to the classification of Rezende. (FIGURE 1).

In commemoration of the 35 years of this classification, developed by the emeritus professor of our school, we write this letter aiming to reiterate its singularly relevant attributes: it is based on an accessible radiographic technic in the context of Brazil’s radiologic services, it is genuinely Brazilian, it is useful in our hardships, and it uses simple criteria to compose an objective and assertive analysis for the continuity of the patient’s follow-up.

Declared conflict of interest of all authors: none
Disclosure of funding: no funding received
Research performed at: Department of Radiology and Diagnostic Imaging of the Faculty of Medicine of the Federal University of Goiás, Brazil.
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It should be emphasized that, even though there are several technological advances in the field of diagnosis of esophageal impairment due to Chagas, such as the high-resolution esophageal manometry, as well as new reclassifications of megaesophagus, such as those which utilize physiological criteria, the utility of the classification of Rezende remains paramount for the operative orientation of the illness amongst Brazilian surgeons.

This classification evaluates changes of motility (presence of tertiary waves, and hypokinesia and akenesis), slowing of the emptying velocity, changings of caliber, and presences of liquids and barium and presence of the “bird beak” sign. Once the imaging is analyzed, the patient is classified in degrees I-IV. It is believed that a well-done clinical history added to positive serologic testing for Chagas and radiologic changes in the simple and filmed esophagogram are sufficient for diagnosing the disease. Therefore, when applied to clinical-epidemiologic setting that points out to Chagas disease, the classification of Rezende, through the esophagogram, is an extremely useful and accurate tool to consolidate this diagnosis.

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