While the confidence intervals for sensitivity and specificity are wide, due to the small number of liver patients identified in our study, we believe that the major difference between the two studies is in the choice of diagnostic criteria, Screening for hepatopathy by ultrasound alone, as our peers have done, will result in fatal delay or underdiagnosis. For this reason we agree with the conclusion that the diagnosis of FC liver disease must be based on the sum of, clinical, biochemical and ultrasound findings.

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## Esophageal achalasia and eosinophilic esophagitis

Dear Editor,

I would like to add some data on the subject of esophageal achalasia. The article presented the diagnostic and therapeutic propaedeutic for the condition brilliantly,[1] but omitted to include data related to the results of biopsies. This is an important data in that it may show suggestive abnormalities of the associated pathologies related to the origin of the esophageal achalasia. As examples it is worth citing systemic lupus erythematosus, sarcoidosis and eosinophilic esophagitis (EE).[2]

Eosinophilic esophagitis is a cause of esophageal dysmotility that is being described with ever increasing frequency, as it becomes better known and investigated by physicians.[3] Its clinical presentation is very similar to gastroesophageal reflux, presenting with symptoms such as abdominal pains, vomiting and dysphagia, among others, which do not respond to conventional anti-reflux treatment. Additionally pH measurements reveal a tendency to high pH values.[4] Diagnosis is made by biopsy which will reveal the presence of eosinophils in the lower third of the esophagus with numbers greater than 20 or 24 per 40-times magnification field. In general it will progress to more serious motility disorders and the presentation of odynophagia, food impaction, weight loss, failure to thrive and cachexia.[2-4]

Despite being more often associated with esophageal wall thickening and stenosis, the association between esophageal achalasia and an eosinophilic esophagitis has been described.[2,5] In a series of 42 patients with diagnoses of esophageal achalasia, subjected to thoracic esophagectomy, with esophageal fragments studied microscopically, 22 patients (52%) presented eosinophila in the muscular layer.[6] The role of these eosinophils in the formation of achalasia injuries is not yet well understood.[7] In EE, in addition to procedures to permit the passage of food, such as dilatation or esophageal surgery, it is also necessary to investigate possible food allergens, which are found in 50 to 80% of affected individuals.[8] In general exclusion of the food allergen leads to considerable symptomology improvements. However, in some cases symptoms will persist or recur, making it necessary to prescribe drugs such as oral or inhaled corticoids or even antileucotrienes.[9] The absence of food allergens is also corroborated with the use of these drugs.[8,9]

The growing knowledge and increasing number of case histories of patients with EE, primarily children, but also adults,[10] was the motive for this letter, on the aspect of both achalasia and esophageal stenosis – both associated with this disease which is acquiring significant importance all over the world.

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