Carta aos editores

Idiopathic achalasia mistakenly diagnosed as anorexia nervosa

Acalásia idiopática diagnosticada por engano como anorexia nervosa

Dear Editor,

In the past, anorexia nervosa (AN) patients had the correct diagnosis delayed, while they were exhaustively submitted to medical evaluation in the pursuit of an organic disease. Nowadays, physicians seem to have an increased awareness of AN and may find it easier to diagnose. A possible consequence of this is the failure in recognizing organic illnesses causing symptoms related to an eating disorder (ED).

There are several reports of idiopathic achalasia misdiagnosed as AN in the literature.[1,2]

We report a case of a 21-year-old woman, referred to the Eating Disorders Outpatient Program at the University Hospital of the School of Medicine of the Universidade Estadual de Campinas (UNICAMP), with diagnostic hypothesis of AN, weight loss of 22 kg in 11 months (BMI = 15.2 kg/m^2) caused by involuntary vomiting. Organic etiology had been previously excluded by clinical and laboratory investigation and by upper digestive endoscopy (UDE). The patient reported that the early symptoms were regurgitation during sleep, worsening to involuntary vomiting in the morning, in fast and after every meal. The symptoms began soon after she had a weight gain of 8 kg during a period of sedentarism and depressive symptoms. Body-image distortion and intention to lose weight were absent. She denied self-induced vomiting but described that the vomits got worse when she was anxious. She demonstrated ambivalence on the perspective of nutritional recovery and affective dissociation when considering the consequences and risks of malnutrition. Psychotherapy, psychiatric treatment and a new clinical evaluation were recommended. She was submitted to another UDE, an esophagogram and an esophageal manometry that confirmed the diagnosis of idiopathic achalasia. The patient was submitted to surgical intervention – Heller's myotomy plus fundoplication – by video-laparoscopy. The postoperative recovery was very satisfactory, with gradual nutritional recovery and without symptoms of AN.

Idiopathic achalasia is an esophageal motor disorder characterized by incomplete relaxation of the lower esophageal sphincter and by the absence of esophageal peristalsis. These disturbances cause symptoms that can be misinterpreted as AN. It is a disease whose diagnosis is performed by esophagogram and esophageal manometry,[3] and a careful anamnesis with special attention to the gastrointestinal complaints and to the vomiting characteristics can indicate the appropriate investigation.[4] However, differential diagnosis between AN and achalasia is not invariably so evident. Esophageal motility disorders have been reported in patients with diagnosis of AN, and the gastrointestinal symptoms frequently improve with refeeding. Besides, eating avoidance and self-induced vomiting have also been reported in patients with esophageal achalasia.[5]

In the case reported here, the absence of intention to lose weight and body-image distortion was initially neglected. Depressive symptoms, personality traits, familial relationship and ambivalence on the perspective of nutritional recovery were overestimated at the expense of clinical history and vomiting characteristics, leading to the initial misdiagnosis.

We thus conclude that, when assessing patients with a hypothetical ED, psychopathological symptoms must always be carefully evaluated. The exclusion of organic etiology must be a priority, even when the need of psychiatric and psychotherapeutic interventions is evident. In suspected AN cases without self-induced vomiting, idiopathic achalasia must always be excluded before the final diagnosis.

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