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Achalasia in a Young Woman Thought to Have Had an Eating Disorder

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Dear Editor,

We would like to highlight the importance of considering achalasia in the differential diagnosis of an eating disorder, particularly in young, female patients.

Achalasia is a rare oesophageal motility disorder characterised by impaired oesophageal peristalsis and impaired relaxation of the lower oesophageal sphincter (LOS)[1]. Symptoms include progressive dysphagia to solids and liquids, regurgitation, heartburn, chest pain and varying degrees of weight loss[1]. The aetiology of achalasia is thought to be due to loss of inhibitory neurons in the myenteric plexus of the distal oesophagus/LOS leading to unopposed excitatory neuronal activity[1]. This disrupts peristalsis and causes failure of the LOS[1]. The underlying pathophysiology of neuronal loss is not well understood[1].

Mean delay in diagnosing achalasia from symptom onset is four to five years, as symptoms are often attributed to other diseases, such as gastroesophageal reflux disease and, in some cases, eating disorders[2]. Normal endoscopic and radiographic findings early in the disease process can confound the problem[2].

Our case focuses on a young woman in her twenties, admitted with a six-week history of persistent vomiting, retrosternal discomfort, regurgitation of food and weight loss. At times she would induce vomiting to relieve pain. This was on a background of similar symptoms occurring intermittently over the previous six years.

On admission, the patient was 17 days post-emergency caesarean section and was awaiting a community psychiatric assessment for a possible underlying eating disorder. Gastroscopy one year previous was unremarkable. The patient reported a healthy relationship with food and denied low mood/body image issues. Past history consisted of appendectomy. Examination was unremarkable. BMI was 27.4.

Bloods showed hypokalemia. Chest x-ray showed widening of the upper mediastinum with an air-fluid level. Gastroscopy revealed a dilated oesophagus, a tonic, non-relaxing LOS and retained food debris suggestive of achalasia. Psychiatry concluded there was no evidence to support the presence of an eating disorder. Subsequent barium swallow revealed the characteristic 'bird-beak' appearance of achalasia. The patient was referred for laparoscopic Heller's myotomy and is doing well.

Of 37 cases of achalasia mistakenly diagnosed as an eating disorder in the literature, 22 were diagnosed while inpatients in psychiatric units[2, 3]. Mean age was 18 years and all but one was female[2, 3]. It is important to consider achalasia in the differential diagnosis of an eating disorder, particularly in young female patients. Misinterpretation of aspects of the history/behavior and bias towards a patient's age and gender can lead to the erroneous assertion of a pathologic attitude towards eating. This can lead to delays in treatment, worsening of symptoms and poor treatment outcomes. It can also lead to low mood and difficulties in interpersonal relationships[4].

Features that overlap between achalasia and eating disorders include vomiting, regurgitation, weight loss, low mood, and aberrant eating behaviours[4]. Features that point toward achalasia include a patient who is forthcoming with symptoms and has no obvious body image issues. Swallowing difficulties in public, self-induced vomiting to relieve discomfort, regurgitation of undigested, non-acidic food, hunger and the desire to gain weight are also more suggestive of achalasia[2, 4].

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