Dysphagia & Esophageal Disorders

Two questions sort almost every case: where does it stick, and is it solids only or solids and liquids

Always an alarm symptom
scope it, do not trial a PPI

THE TWO QUESTIONS *they pick the test and name the mechanism*

1. WHERE DOES IT STICK?

Oropharyngeal (transfer): difficulty *initiating* the swallow -coughing or choking on the first swallow, nasal regurgitation, drooling, **wet or gurgly voice after eating**, recurrent aspiration pneumonia. Patients point to the **neck**. Usually neuromuscular (stroke, Parkinson, myasthenia, ALS, dementia). → **video swallow study with speech pathology.**

Esophageal (transport): food sticks *seconds after* the swallow starts; patients point to the **sternum**, though a distal lesion is often felt higher (never the reverse). → **endoscopy.**

2. SOLIDS ONLY, OR SOLIDS AND LIQUIDS?

Progressive solids only = narrowing lumen: peptic stricture (long reflux history) or **malignancy** (rapid, with weight loss).

Intermittent, non-progressive solids only = fixed but non-narrowing lesion: Schatzki ring or **eosinophilic esophagitis** -the classic causes of sudden food impaction in an otherwise well person.

Solids AND liquids from the outset = motility disorder: the lumen is open but the pump is broken -achalasia, scleroderma esophagus, diffuse spasm.

⚠ DYSPHAGIA IS AN ALARM SYMPTOM

New dysphagia warrants endoscopy, never an empiric PPI trial, because esophageal cancer presents exactly this way. **Treating it as reflux and re-booking in three months is the classic delayed cancer diagnosis.** Weight loss, anemia, odynophagia, age over 60 or rapid progression raise urgency further. **Odynophagia points elsewhere:** infectious esophagitis (Candida, HSV, CMV) or **pill esophagitis** (doxycycline, bisphosphonates, KCl, NSAIDs).

THE DIAGNOSES TO RECOGNIZE *and the one that hides behind normal-looking mucosa*

Diagnosis	Recognize it by	Treatment
⚠ **Eosinophilic esophagitis**	**Younger, often male, atopic** (asthma, eczema, allergic rhinitis); intermittent solid dysphagia and **food impaction**. Endoscopy may show rings, furrows or exudate **-or look entirely normal**. Diagnosis is histologic: **≥ 15 eos/hpf, proximal AND distal biopsies**	PPI, swallowed topical steroids (budesonide, fluticasone), elimination diet, dupilumab if refractory; dilation for stricture. **Dilation treats the narrowing, not the inflammation**
Achalasia	**Solids AND liquids from the start**, regurgitation of undigested food, chest pain, weight loss. Manometry: **failure of LES relaxation with absent peristalsis**; barium: dilated esophagus with a **"bird's beak"**	Pneumatic dilation, Heller myotomy, or POEM; botulinum toxin for poor surgical candidates. **All treatments create reflux**, and achalasia carries a small long-term cancer risk
Peptic stricture	**Progressive solid dysphagia with a long reflux history**, often in an older patient whose heartburn paradoxically *improved* as the stricture formed	Endoscopic dilation **plus long-term PPI** -the acid suppression is what prevents recurrence
Esophageal cancer	**Rapidly progressive solid dysphagia with weight loss.** Adenocarcinoma distal (Barrett, reflux); squamous cell proximal (smoking, alcohol)	Staging and multidisciplinary oncology; stenting for palliation
Zenker diverticulum	Oropharyngeal symptoms with **regurgitation of UNDIGESTED food hours later, halitosis, gurgling neck mass** -food is stored, not refluxed	Diverticulotomy. ⚠ **Barium swallow BEFORE endoscopy**: a blindly advanced scope can enter and perforate the pouch
Scleroderma esophagus	Severe reflux plus dysphagia in systemic sclerosis or Raynaud; manometry shows **absent distal peristalsis with a HYPOtensive LES** -the opposite of achalasia	Aggressive PPI; dilate strictures

MANAGEMENT *the rules that prevent perforation and repeat visits*

Situation	Detail
⚠ **Acute food impaction**	**Inability to handle secretions (drooling, distressed) is an emergency**: endoscopy within hours, because prolonged impaction risks pressure necrosis and perforation. **NEVER use meat tenderizer (papain)** -associated with esophageal injury and perforation. Glucagon is largely ineffective and must not delay the scope. **Always biopsy for EoE** at or shortly after disimpaction: a large share of adult impactions are EoE, and finding it prevents the next one
Choosing the first test	**Endoscopy first for esophageal dysphagia** -it visualizes, biopsies and dilates in one session, which barium cannot. **Barium first** when a proximal lesion or Zenker is suspected, or to support suspected achalasia. **Manometry** when endoscopy is normal and motility is suspected (the standard for achalasia)
⚠ **Before treating achalasia**	**Exclude pseudoachalasia** -malignancy at the GE junction reproduces the manometry and barium findings exactly. Endoscopy with careful GE-junction inspection is mandatory; **older age, short symptom duration and pronounced weight loss** are the red flags
Oropharyngeal dysphagia	**Speech-language pathology is the primary intervention**: texture modification, thickened liquids where appropriate, chin-tuck and compensatory maneuvers, swallowing rehabilitation. **Treat the underlying disease** -optimizing Parkinson dose timing or treating myasthenia is where swallowing actually improves. Upright positioning, supervision and **oral care** (which measurably reduces aspiration pneumonia)
⚠ **Feeding tubes**	**Do NOT prevent aspiration pneumonia**: patients keep aspirating secretions and refluxed contents. In advanced dementia they do not improve survival, healing or comfort, while adding restraints and complications. **Careful hand feeding is the alternative**, and the decision belongs in a goals-of-care conversation rather than being a reflex to a failed swallow study

ODYNOPHAGIA: A DIFFERENT LIST

Pain *on* swallowing points away from obstruction. **Infectious esophagitis**: **Candida** (white plaques, think HIV, steroids, inhaled steroids without rinsing, diabetes), **HSV** (small punched-out ulcers), **CMV** (large solitary ulcers, advanced immunosuppression) **-odynophagia in an immunosuppressed patient warrants endoscopy with biopsy**, since empiric fluconazole treats only one of the three. **Pill esophagitis**: doxycycline, bisphosphonates, potassium chloride and NSAIDs taken with too little water or lying down.

OROPHARYNGEAL CAUSES WORTH NAMING

Stroke (the commonest, and the reason every stroke gets a swallow screen before oral intake), **Parkinson disease**, **myasthenia gravis** (fatigable, worse through the meal), **ALS**, advanced **dementia**, post-radiation and post-surgical change, and **Zenker diverticulum** as the structural exception. **The neurologic exam is part of this GI workup**, because several of these declare themselves through swallowing first.

PEARLS & PITFALLS

- **A patient localizing dysphagia to the neck may still have a distal lesion** -referral goes upward, never downward, so neck localization does not exclude an esophageal cause.
- **Heartburn that improved while swallowing got harder** is not recovery: a peptic stricture can silence reflux symptoms as it narrows.
- **Take pills upright with a full glass of water and stay up 30 minutes** -pill esophagitis is entirely preventable, and doxycycline, bisphosphonates and potassium chloride are the usual culprits.
- **Recurrent aspiration pneumonia is a swallowing diagnosis until proven otherwise**, and belongs to the neurologic exam as much as the chest film.

References: ACG clinical guideline on the evaluation and management of dysphagia · ACG clinical guideline for the diagnosis and management of eosinophilic esophagitis · ACG clinical guideline on achalasia · ASGE guidance on the management of ingested foreign bodies and food impactions.