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Case Report

Type II Achalasia in a Young Adult with Symptoms Since Childhood: Laparoscopic Surgical Resolution: A Case Report

Gasman Humberto Ochoa Álvarez[1*], Benjamin Fernando Pèrez Erazo[2], Walter Geovanny Barba Bermeo[3]

[1]General and Laparoscopic Surgeon, Surgeon, IESS Riobamba Hospital, Specialist in Bariatric Surgery; Professor of the Postgraduate Program in General Surgery, Technical University of Ambato, Ecuador

[2]General and Laparoscopic Surgeon, Surgeon at the IESS Riobamba Hospital; Professor of Undergraduate Surgery, National University of Chimborazo, Ecuador

[3]Postgraduate Resident in General Surgery, Technical University of Ambato, Ecuador

***Correspondence author:** Gasman Humberto Ochoa Álvarez, General and Laparoscopic Surgeon, Surgeon, IESS Riobamba Hospital, Specialist in Bariatric Surgery; Professor of the Postgraduate Program in General Surgery, Technical University of Ambato, Ecuador; Email: gasmanoa@hotmail.com

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Abstract

Background: Achalasia is a primary esophageal motility disorder characterized by impaired relaxation of the lower esophageal sphincter and absent peristalsis. High-resolution esophageal manometry is the diagnostic gold standard and allows clinically relevant subtype classification.

Case Report: A 21-year-old man presented with dysphagia since childhood, initially to solids and later to liquids, chronic postprandial regurgitation and weight loss greater than 10 kg. He was underweight, with a body mass index of 18 kg/m². Barium esophagram showed distal narrowing with a bird's-beak appearance and contrast retention. Upper endoscopy excluded mechanical obstruction. High-resolution manometry demonstrated lower esophageal sphincter hypertension, incomplete relaxation, aperistalsis and panesophageal pressurization, consistent with type II achalasia according to Chicago Classification version 4.0.

Intervention and Outcome: Computed tomography excluded secondary causes of pseudoachalasia. Laparoscopic Heller cardiomyotomy with anterior Dor fundoplication was performed. Intraoperative endoscopy revealed whitish plaques consistent with esophageal candidiasis and no perforation was identified. During 5 weeks of follow-up after surgery, dysphagia and regurgitation resolved, oral intake progressively improved and weight stabilized with early recovery.

Conclusion: Type II achalasia usually shows an excellent response to definitive therapy. In young patients with long-standing symptoms, high-resolution manometry is essential for diagnostic confirmation and treatment planning, whereas adding Dor fundoplication may help reduce postoperative reflux without compromising symptomatic relief.

Keywords: Achalasia; High-Resolution Esophageal Manometry; Heller Cardiomyotomy; Dor Fundoplication; Laparoscopic surgery; Dysphagia

Introduction

Achalasia is an uncommon esophageal motility disorder caused by degeneration of inhibitory neurons in the myenteric plexus, resulting in impaired lower esophageal sphincter relaxation and failure of organized esophageal peristalsis [1]. Patients typically present with progressive dysphagia to solids and liquids, regurgitation, chest pain and weight loss [1]. Although upper endoscopy and barium esophagram provide important diagnostic clues, high-resolution manometry is considered the diagnostic gold standard because it confirms the diagnosis and classifies achalasia into clinically meaningful subtypes [1,2].

This report describes a young adult with symptoms since childhood who was diagnosed with type II achalasia and successfully treated with laparoscopic Heller myotomy and anterior Dor fundoplication [1-5].

Case Presentation

A 21-year-old single male from Riobamba, Ecuador, presented on October 2, 2025, with dysphagia that had been present since childhood. He reported needing liquids to facilitate the passage of food and tablets, as well as persistent regurgitation of food without vomiting. After meals, he experienced a retrosternal sensation of obstruction that improved approximately 10 minutes after drinking fluids. He denied significant heartburn and nocturnal symptoms.

Initial Physical Examination

The patient was calm and hemodynamically stable: blood pressure 110/60 mmHg, heart rate 55 bpm, respiratory rate 12 breaths/min, weight 50 kg, height 167 cm and body mass index 17.98 kg/m². The abdomen was soft and non-tender, with minimal subcutaneous tissue. A small umbilical hernia was noted, with no pathological inguinal findings.

Diagnostic Evaluation and Methods

A barium esophagram demonstrated esophageal dilation with progressive distal narrowing at the esophagogastric junction, showing a bird's-beak appearance and contrast retention, suggestive of achalasia. Upper gastrointestinal endoscopy excluded mechanical obstruction; it reported gastropathy, a non-active duodenal ulcer and a subepithelial lesion in the gastric antrum. Because endoscopy did not identify an obstructing intraluminal lesion and the patient had marked chronic dysphagia with weight loss, thoracoabdominal computed tomography with and without contrast was requested to exclude extrinsic compression, malignancy and other causes of pseudoachalasia, as recommended when secondary etiologies must be ruled out in the diagnostic work-up of suspected achalasia [1,2].

Given the history of dysphagia since childhood, high-resolution manometry was performed to confirm the diagnosis and define the manometric subtype. The study showed lower esophageal sphincter hypertension, incomplete relaxation, absence of peristalsis and panesophageal pressurization, findings compatible with type II achalasia according to Chicago Classification version 4.0 [2]. The Eckardt symptom score was also applied, documenting severe symptomatic disease with more than 10 kg of weight loss and frequent dysphagia, which supported the indication for definitive therapy [3]. Computed tomography of the neck, chest and abdomen excluded mediastinal masses and other secondary causes of pseudoachalasia.

Suggested flow chart for the diagnostic sequence: symptoms of chronic dysphagia and regurgitation → barium esophagram suggestive of achalasia → upper endoscopy to rule out mechanical obstruction → computed tomography to exclude pseudoachalasia/secondary causes when clinically indicated → high-resolution manometry for definitive diagnosis and subtype classification (Fig. 1) [1,2].

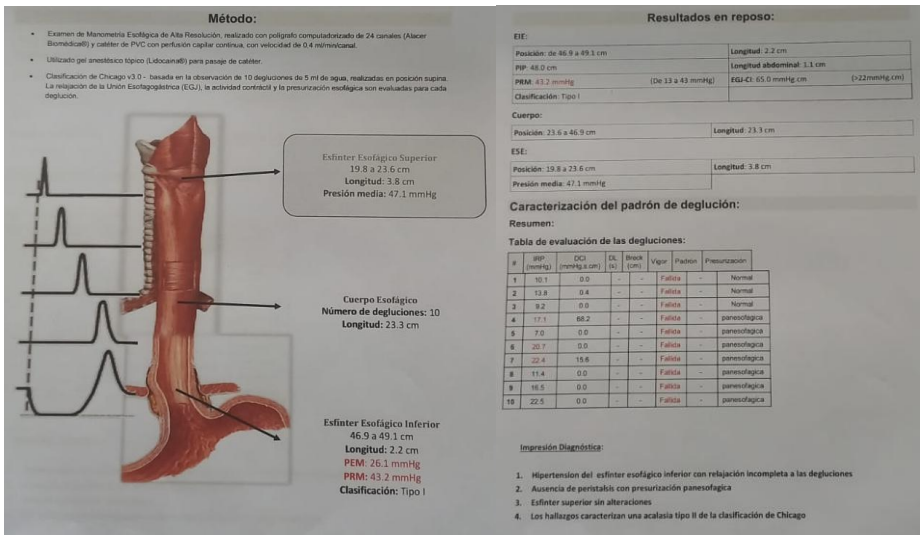

Figure 1: High-resolution esophageal manometry.

Therapeutic Intervention

With a diagnosis of type II achalasia, laparoscopic Heller cardiomyotomy with anterior Dor fundoplication was planned. On November 1, 2025, under general anesthesia, a laparoscopic approach was performed with pneumoperitoneum at 12 mmHg and placement of five trocars (10 mm transumbilical, 5 mm right flank, 10 mm left flank, 5 mm left mid-axillary and 5 mm subxiphoid).

The esophagogastric junction was identified approximately 3-4 cm below the hiatus. The hiatus was wide and the proximal esophagus was moderately dilated; the mucosa appeared very thin.

After mobilization and exposure of the diaphragmatic crura, crural closure was performed using non-absorbable 2-0 polypropylene sutures. A longitudinal myotomy was completed along the anterior esophageal wall, extending 8 cm on the proximal esophagus, across the esophagogastric junction and 3 cm onto the gastric cardia, while preserving the mucosa. An anterior Dor fundoplication was then constructed to cover the myotomy. This approach is supported by comparative evidence showing durable symptom control after laparoscopic Heller myotomy, while partial fundoplication is commonly added to reduce postoperative reflux [4,5].

Intraoperative endoscopy revealed whitish plaques consistent with esophageal candidiasis, without evidence of perforation. A mixed drain was placed. The procedure was completed without complications and the patient was discharged 24 hours later after confirming tolerance of a liquid diet (Fig. 2,3).

Figure 2: Hiatal hernia.

Figure 3: Dor fundoplication.

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Follow-Up and Results

At the first postoperative follow-up, 7 days after surgery (November 8, 2025), the patient reported no dysphagia or odynophagia and tolerated a supervised liquid diet guided by a nutritionist. He remained hemodynamically stable, with blood pressure 110/64 mmHg, heart rate 68 bpm, temperature 36.5°C and weight 48 kg. Surgical wounds showed no signs of infection and the drain had minimal serohematic output. Fluconazole was prescribed for esophageal candidiasis.

At the second follow-up, 5 weeks after surgery (December 8, 2025), he reported good tolerance of liquids and purees, with one isolated choking episode after poorly chewed solid food and no odynophagia. Weight was 48.5 kg (body mass index 17.44 kg/m^2). Adequate mastication and slow eating were reinforced and continued nutritional follow-up and antisecretory therapy with dexlansoprazole were recommended.

Discussion

Achalasia is a chronic primary esophageal motor disorder in which impaired relaxation of the lower esophageal sphincter and absent peristalsis lead to progressive dysphagia, regurgitation, nutritional compromise and reduced quality of life [1]. High-resolution manometry has become the cornerstone of diagnosis because it not only confirms achalasia but also identifies subtypes with prognostic and therapeutic relevance [2]. Under Chicago Classification version 4.0, type II achalasia is defined by abnormal integrated relaxation pressure with failed peristalsis and panesophageal pressurization in at least 20% of swallows and it is generally associated with the best treatment response among the classic subtypes [2].

This case illustrates a markedly delayed diagnosis in a young adult whose symptoms began in childhood, with subsequent nutritional impact and weight loss. The combination of a suggestive barium esophagram and a negative endoscopy for mechanical obstruction appropriately raised suspicion of achalasia, whereas computed tomography helped exclude secondary causes before definitive treatment [1,2]. Applying the Eckardt score also helped document symptom burden and establish a clinical baseline for therapeutic assessment, although its psychometric properties are considered fair rather than perfect [3].

Current evidence supports pneumatic dilation, laparoscopic Heller myotomy with fundoplication and peroral endoscopic myotomy as effective options for achalasia, with treatment selection guided by subtype, expertise and reflux considerations [1,4]. In a randomized trial, POEM was noninferior to laparoscopic Heller myotomy plus Dor fundoplication for symptom control at 2 years, but reflux remains an important concern after endoscopic myotomy [4]. In parallel, evidence reviews indicate that adding fundoplication to Heller cardiomyotomy is intended to mitigate postoperative gastroesophageal reflux and total fundoplication may increase postoperative dysphagia, which supports the use of a partial wrap such as Dor in appropriately selected patients [5].

In the present patient, severe symptoms, prolonged disease course and nutritional consequences justified definitive intervention. Intraoperative endoscopy was useful because it confirmed mucosal integrity after myotomy and identified esophageal candidiasis, which was subsequently treated. Over a follow-up period of 5 weeks, the patient showed resolution of dysphagia, improved dietary tolerance and early weight stabilization without postoperative complications [6-10].

Conclusion

Laparoscopic Heller cardiomyotomy combined with anterior Dor fundoplication was a safe and effective treatment in this patient with type II achalasia. In young patients with long-standing dysphagia, high-resolution manometry is indispensable for diagnostic confirmation, subtype classification and therapeutic planning. Short-term follow-up in this case showed favorable clinical evolution, with symptom resolution and nutritional recovery.

Conflict of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Data Availability Statement
The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Ethical Statement
The project did not meet the definition of human subject research under the purview of the IRB according to federal regulations and therefore was exempt.

Informed Consent Statement
Written informed consent was obtained from the patient for publication of this case report. The authors declare no conflicts of interest.

Authors' Contributions
All authors contributed equally to this paper.

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