# Achalasia Masquerading as *Status Asthmaticus*

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## Case Report

## Past History

79 years old

**Medical History:**
#Moderate persistent Asthma
# Achalasia (dilatation in 2008 e 2015 – pneumatic ballon)
# Saccular bronchiectasis with multiple infectious complications
# Hypertension

**Medication:**
Fluticasone Furoate + Umeclidinium Bromide + Vilanterol (Elebrato®), Montelukast, Salbutamol in SOS, Sucralfate, Omeprazole, Simvastatin, Clebopride, Prevenar13® in 2018, Pneumovax23® in 2019, Seasonal flu vaccine, Covid 19 vaccine

## Pre hospital

**Severe dyspnea** and stridor with 20 min. of evolution as a result of alleged **airway obstruction** with lupins *vs.* ***Status Asthmaticus***

Respiratory Failure

**1st EI and MV**

## ICU

Emergency room – Extubation

D1

IMCU

New episode of severe bronchospasm refractory to medical therapy

D2

ICU

**2nd e 3rd EI and MV**
Failed extubation during ICU stay

*Status Asthmaticus* refractory to therapy?

**4th EI and MV**
New episode of *Status Asmathicus* refratory to medication

Improvement after institution of ambulatory bronchodilators (Elebrato®) - extubation

D9

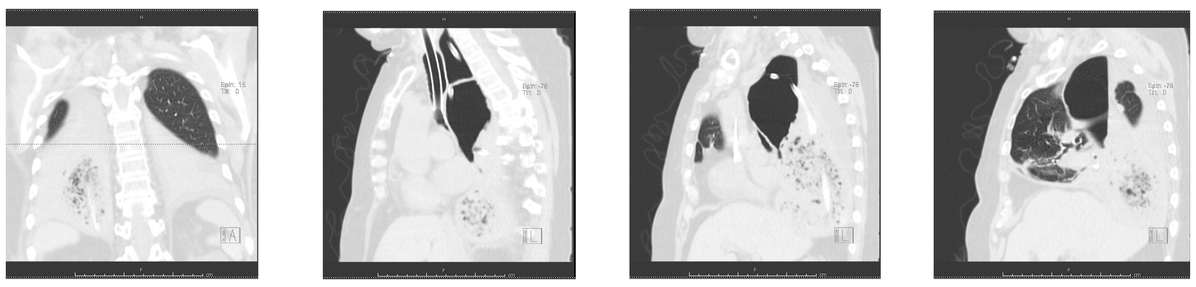
IMCU

D6

ICU



**Chest CT scan**
"Marked dilatation and tortuosity of the esophagus (**esophageal sigmoidization**), with abundant content - **stasis**, which we attribute to a history of achalasia. **The NG tube loops and is misplaced** in the lumen of the esophagus. **Complete atelectasis of the IL's and partial atelectasis of the ML** is highlighted."...



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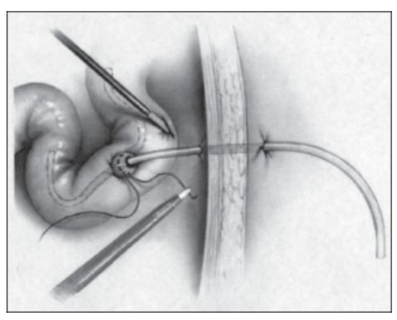
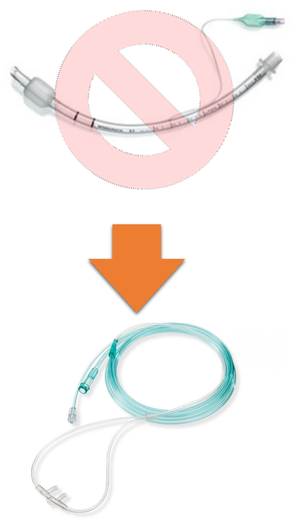


5th post-op day
**Successful extubation**

D25

Internal Medicine ward and rehabilitation

**Surgery**
**Laparoscopic jejunostomy**



## Discussion

Partially controlled or uncontrolled Asthma, despite optimal therapy (30% of cases), should lead the clinician to **reconsider the diagnosis** and **exclude entities** that mimic Asthma.

**Megaesophagus** secondary to **Achalasia** is a rare but potentially fatal cause of airway obstruction. The usual clinical picture consists of dysphagia, regurgitation, progressive weight loss, and in some cases **esophageal distention** which can lead to **stridor and respiratory failure.**

This clinical vignette reports the case of a 79-year-old asthmatic patient with stridor and severe dyspnea. Due to her clinical condition and history, she was admitted to the ICU with the diagnostic hypotheses of **airway obstruction** *vs.* ***Status Asthmaticus***. During hospitalization there were **multiple failed extubation attempts** (3 in total).

In *Status Asthmaticus*, the ICU stay is, as a rule, short and therefore **extubation a priority.** Extubation failures were interpreted as therapeutic failure and multiple aspirations of food content. The CT images were decisive in identifying a megaesophagus, consequent to Achalasia and conditional pulmonary atelectasis.

**After drainage (endoscopic) of the esophageal food impaction** and **surgical bypass by jejunostomy,** the **last extubation was successful** with resolution of the condition and the possibility of reducing the level of care.

This case illustrates the importance of considering **Achalasia** as a **differential diagnosis** of respiratory pathologies and, as reported, of ***Status Asthmaticus***. It also highlights the therapeutic strategy used in an intensive care environment - whose patients are **often unable to be admitted for major surgery** - and this approach may emerge as a **"bridge" to ventilator weaning** and progression in rehabilitation.

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## Abbreviations

D – Day; EI – Endotracheal Intubationl; MV – Mechanical Ventilation; IL's – Inferior Lobes; ML – Medial Lobe; NG – Naso Gastric; ICU – Intensive Care Unit; IMCU – Intermediate Care Unit