

Integrating psychological assessment in achalasia management: addressing mental health to enhance patient outcomes

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Abstract

Achalasia is a chronic esophageal disorder with a generally favorable prognosis; however, approximately 20% of patients experience persistent or recurrent symptoms despite therapeutic interventions. These ongoing symptoms can significantly diminish both disease-specific and overall quality of life. Although the physical manifestations of achalasia, such as regurgitation, dysphagia, chest pain, and weight loss, are well-documented and assessed using the Eckardt score, the psychological burden of the disease remains underexplored. Individuals with achalasia are at an increased risk of mental health issues, including depression, anxiety, and somatization, exacerbated by the emotional strain and social limitations imposed by the disease. Despite this, psychological impacts are often overlooked in clinical settings, leading to inadequate mental health support for these patients. This article underscores the necessity for prompt psychological assessments during the diagnosis of achalasia to better address these mental health challenges and improve overall patient care.

Key Words: achalasia, mental health, patients.

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Achalasia is a rare primary esophageal motor disorder, occurring with an annual incidence rate of 1-5 cases and a prevalence rate of 7-32 cases per 100,000 people. However, determining the true global prevalence of achalasia is challenging due to the limited availability of advanced diagnostic criteria and technology.^{1,2} This clinical condition impacts both sexes equally and shows no preference for any particular racial group. It can also occur at any age but is more common in older adults, typically diagnosed between ages 30 and 60.¹

The cause of achalasia remains unidentified.³ Extensive and varied research indicates that the primary cause of achalasia is neurodegeneration occurring at the Lower Esophageal Sphincter (LES). This neurodegeneration involves the specific loss of inhibitory neurons within the myenteric plexus located at the lower end of the esophagus. Several factors

may contribute to this neurodegeneration, including genetic predispositions and environmental triggers that initiate inflammatory and immune responses.^{2,3}

The determination of the condition relies on the patient's medical history, a barium esophagogram, and tests of esophageal motility.⁴ Advanced diagnostic techniques like high-resolution manometry are instrumental in forecasting treatment outcomes in achalasia by analyzing esophageal pressure topography, which delineates three distinct achalasia phenotypes (I-III). Research indicates that phenotypes I and II exhibit a more favorable response to treatment compared to phenotype III.⁵ While achalasia is not curable, over 90% of patients experience significant improvement following treatment.⁶ The therapeutic approaches, including pneumatic dilation, both endoscopic and surgical myotomy, and pharmacological treatments (e.g., calcium channel

blockers, nitrates, sildenafil, and terbutaline), focus on decreasing LES pressure to aid in the gravitational and hydrostatic movement of food and liquids through the esophagus.⁷ Initial treatment recommendations, whether opting for graded pneumatic dilatation or laparoscopic surgical myotomy accompanied by partial fundoplication, should consider factors such as the patient's age, gender, preferences, and the expertise available at the treating institution.⁸ While the prognosis for individuals with achalasia is generally favorable, symptoms may persist or recur in about 20% of patients despite therapeutic efforts. This problem can lead to significant long-term reductions in both disease-specific and overall quality of life.⁹ Nonetheless, there is a limited amount of research exploring the psychological burden of achalasia, specifically concerning depression, anxiety, and somatization.⁹

Several factors can heighten the likelihood of mental health issues in individuals diagnosed with achalasia. Those afflicted with this chronic illness are at an increased risk of experiencing depression, anxiety, and somatization.⁹⁻¹¹ The emotional strain from the symptoms, coupled with social and functional limitations, often exacerbates feelings of depression, anxiety, and somatization. In this respect, many achalasia patients have noted that their disease interferes with their social engagements, relationships, and recreational pursuits.⁹⁻¹¹ Nevertheless, the Eckardt score remains the predominant benchmark for assessing the severity of achalasia symptoms, concentrating on four primary indicators: regurgitation, dysphagia, chest pain, and weight loss.¹² In contrast to these physical symptoms, the psychological impacts and burdens associated with achalasia frequently receive less attention and are underappreciated. The lack of detailed assessments for specific mental health issues reduces their clinical importance and limits healthcare providers' ability to recommend targeted interventions. Therefore, it is crucial to perform a prompt psychological assessment during the diagnosis of achalasia.^{12,13} However, Hanschmidt *et al.*⁹ discovered that the incidence rates of depression and anxiety among female achalasia patients were significantly higher, ranging from 3.04 to 7.87 times and 3.10 times respectively, compared to the general population. Such disparities were not observed in male patients, suggesting that being female may increase the susceptibility to psychological distress associated with achalasia. Consequently, it is imperative to focus more on the psychological well-being of female patients with achalasia in medical settings and to explore additional risk factors in future studies.

Psychological evaluation is significant in diagnosing achalasia for four primary reasons. First, psychological distress may impact the effectiveness of treatment adherence and monitoring in achalasia, potentially influencing the clinical outcomes for patients. When the primary objective in managing achalasia is to enhance quality of life, it is crucial not to overlook the provision of psychological support. Greater focus should be directed towards addressing the psychological manifestations associated with achalasia.¹³ Second, while treatments like per-oral endoscopic myotomy can enhance the psychological well-being of individuals with

achalasia, the potential for postoperative gastroesophageal reflux introduces a psychological strain that warrants consideration. On one side, the reduced quality of life stemming from gastroesophageal reflux may lead to psychological distress; conversely, the emergence of such distress can exacerbate the underlying esophageal symptoms.¹³ Recent studies have established that psychological factors, rather than physiological ones, play a pivotal role in determining the severity of symptoms in patients suffering from persistent heartburn and reflux issues.¹⁴ These psychological factors encompass general psychological distress, including depression and state anxiety; health-related psychological distress, involving visceral and pain anxiety; and esophageal-specific psychological distress, such as esophageal hypervigilance. Consequently, it is crucial to monitor the psychological state of individuals with achalasia not only prior to treatment but also throughout the progression of the condition.^{13,14} Third, achalasia could potentially be influenced by psychological factors such as anxiety and depression.¹⁵⁻¹⁷ The severity of swallowing difficulties, or dysphagia, is often linked to concurrent psychological disorders, particularly esophageal hypervigilance and visceral anxiety related to the severity of dysphagia.¹⁸ While it is plausible that anxiety and depression might also impact the symptoms of achalasia, there is currently limited solid evidence to confirm this connection.¹⁵⁻¹⁸ Fourth, patients with achalasia often experience social isolation due to their symptoms. The fear of eating in public or the embarrassment of regurgitation can lead to avoidance of social situations. This isolation can further contribute to feelings of depression and anxiety.¹⁹ Addressing the psychological mechanisms that influence a patient's personal experience of their illness, including their coping mechanisms, psychological adaptability, and control of emotions, could enhance patient outcomes in achalasia. Established psychological treatments like cognitive behavioral therapy have demonstrated effectiveness in reducing depression and anxiety among those with chronic diseases. Additionally, newer methods such as acceptance and commitment therapy could be especially effective in alleviating the distress associated with chronic conditions.²⁰⁻²²

In conclusion, integrating psychological considerations into the management of achalasia is essential for a holistic approach to patient care. By addressing the mental health aspects alongside the physical symptoms, healthcare providers can offer more comprehensive and effective treatment. This integrated approach not only alleviates the physical discomfort associated with achalasia but also enhances the overall quality of life for patients, helping them to lead more fulfilling lives despite their condition.

List of acronyms

LES: Lower esophageal sphincter.

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Conflict of interest

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