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Summary

Endoscopy was normal, but dysphagia persists. How to proceed?

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Education & Training | Endoscopy | Neurogastroenterology & Motility | Oesophagus | Primary Care | Surgery

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The speaker reviewed the diagnostic approach to persistent dysphagia after apparently normal endoscopy, emphasising careful history taking, consideration of subtle endoscopic findings, and systematic use of manometry and timed barium studies to identify structural and motility causes.

KEY POINTS

- Endoscopy reported as normal may miss subtle findings such as achalasia (white oesophagus, mucus) or eosinophilic esophagitis (oedema, rings, narrowing), so clinicians should consider rare diseases and take adequate biopsies.
- History should distinguish oropharyngeal dysphagia (difficulty initiating swallowing, aspiration, neuromuscular causes) from oesophageal dysphagia (food stuck after swallow, motility disorders, strictures) and exclude mimics like Globus sensation and odynophagia.
- High resolution manometry using the Chicago classification protocol assesses oesophageal motility, but manometric findings must be interpreted in clinical context as they may not always be clinically relevant.
- Timed barium esophagram identifies structural changes and stasis, with normal bolus clearance within five minutes; lateral views are essential to detect lesions like Zenker's diverticulum.
- A study presented by the speaker showed that stasis of solids such as barium-dipped marshmallows occurs normally in healthy controls without dysphagia sensation, indicating that stasis does not explain the symptom.

– EndoFLIP may be used when manometry and barium studies are inconclusive to measure distensibility of the lower oesophageal sphincter and complement achalasia diagnosis.

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