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Reviewing the Use of Per-Oral Endoscopic Myotomy in Esophageal Dysmotility

Dr. Buch:

Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. And joining us today to talk about per-oral endoscopic myotomy, or POEM for short, and its use in achalasia and other esophageal dysmotilities is Dr. Michel Kahaleh. Dr. Kahaleh is a Professor of Medicine and Director of the Pancreas Program in the Department of Medicine at Robert Wood Johnson Medical School. He's also the founder and director of the Therapeutic Endoscopic Ultrasound Society and is one of the co-authors of an article titled "Per-Oral Endoscopic Myotomy: State of the Art," which was published in the *Journal of Clinical Gastroenterology* in January 2022.

Dr. Kahaleh, welcome to the program.

Dr. Kahaleh:

Thank you for having me. I'm very excited to be part of this.

Dr. Buch:

To start us off, Dr. Kahaleh, what's the importance of the Eckardt score in evaluating achalasia?

Dr. Kahaleh:

It's a great question. It's a scoring system that actually allows to assess the severity of the disease achalasia, so it's based on how much the patient can swallow, if they feel any sensation of food being stuck in the esophagus, if they lose any weight and if they have chest pain; and this permits, once you offer therapy, to compare the response by assessing the first Eckardt score pretreatment and compare it to the post-treatment Eckardt score.

Dr. Buch:

And are there subtleties involved with making that determination in the Eckardt score?

Dr. Kahaleh:

It's a very, very easy scoring system literally based on assessing one-by-one is there weight loss, is there chest pain, is there food coming back up, is there food being stuck, etc., and so it allows your score, and it's very easy, very friendly to the patient]. The nurse can do it. Your fellow can do it. It's very reproducible, and it's the easiest tool that we use to assess response to any therapy offered for achalasia.

Dr. Buch:

Thank you. Would you ever consider POEM for a patient with achalasia who has had a botulinum injection or a pneumatic dilation?

Dr. Kahaleh:

Great question. Actually, the majority of the patients that I see have already had some form of treatment. Those interventions give a little bit of scarring, but with time and experience, you're able to deal with those issues and still offer the endoscopic myotomy.

Dr. Buch:

And how does your team develop an algorithm as to using botulinum or pneumatic dilation over POEM? Is there a way that your team approaches this?

Dr. Kahaleh:

That's also a very nice question. We try to avoid Botox because Botox may lead to a lot of scarring, so if we have to do a temporizing measure before offering endoscopic myotomy, we would rather dilate. And actually, this is our best technique to temporize the patient who wants something quick and easy, doesn't want to be admitted, and then think about the POEM procedure or is debating. We dilate the patient, and then we follow up with him after a few weeks, and hopefully, at that time the patient is more amenable to have the POEM procedure.

Dr. Buch:

That's great. What's the current rate of esophageal perforations when we're talking about pneumatic dilation?

Dr. Kahaleh:

It's below 1%. It's extremely rare. And whenever it happens, if it does happen, we tend to stent. This is an option though that was not available in the past, but now it's readily available. Any time we feel the patient might have a perforation or might develop a perforation or has a perforation, we will definitely pop a stent there and protect him and then move on with further intervention.

Dr. Buch:

And following up on these themes, how does POEM compare with pneumatic dilation or Heller myotomy and a fundoplication for the treatment of achalasia?

Dr. Kahaleh:

That's also a very, very interesting question. So as I was saying, pneumatic dilation offers a response, but unfortunately, that response is temporary. So the response of POEM is more sustained. Now if you look at studies that have compared head-to-head POEM to Heller myotomy, the results are similar. The advantage of POEM, obviously, is more minimally invasive, which means patients are very interested in a procedure that is as efficient as surgery but is less invasive.

Dr. Buch:

Thanks for that information. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Michel Kahaleh about per-oral endoscopic myotomy.

Dr. Buch:

How would you approach a patient status post-POEM who has esophagitis not responsive to PPIs?

Dr. Kahaleh:

That's a very important point. You have to be able to deal with those patients. Those are patients that you want to maximize their treatment. You want to try to up their proton pump inhibitor treatment, make sure they have a lot of anti-acid, and if it still doesn't work, you need then to divide the patients in 2 categories: the patient that has hiatal hernia and the patient that don't have hiatal hernia. The patients that have hiatal hernia, we actually refer them for surgical fundoplication. The patients that don't have hiatal hernia, we actually

offer them endoscopic fundoplication.

Dr. Buch:

Can you tell us a little bit about how you work the endoscopic fundoplication these days?

Dr. Kahaleh:

Great question. It's called transoral incisionless fundoplication, or TIF. So it's a device that allows you within the stomach to create a wrap around the esophagus. It's also minimally invasive. It takes approximately 1 hour, and the response is very similar to surgical fundoplication. However, it does not function if you have hiatal hernia. The hiatal hernia patients need to be referred for surgical fundoplication.

Dr. Buch:

So, Dr. Kahaleh, which patients with diffuse esophageal spasm, or jackhammer esophagus, should be considered for POEM?

Dr. Kahaleh:

That's a fantastic question because POEM is an intervention that has totally opened a new window for those patients. Previously, those patients were treated only with medication, and POEM has allowed now to treat the disease itself by offering a very low myotomy. We are talking about a myotomy between 25 to 30 centimeters because the whole esophagus is diseased; hence, you need to offer a very low myotomy, which was not possible before because surgery can only do a 5-centimeter myotomy if they do it laparoscopically. Hence, those diseases, such as jackhammer, can now be dealt more minimally invasive while before this was not possible.

Dr. Buch:

And continuing with these thoughts, what are the limitations of POEM use?

Dr. Kahaleh:

The limitation really is the inability to undergo endoscopy. If you cannot have an endoscopy, if you have very bad heart disease or if you have very poor condition, those are patients that you won't be able to offer this procedure. You need to give yourself 1 hour of procedure under general anesthesia and intubation. If you cannot sustain this, the procedure is not feasible.

Dr. Buch:

Now before we conclude, Dr. Kahaleh, are there any other thoughts you would like to share with our audience today?

Dr. Kahaleh:

I think the biggest thought that I'd like to share is POEM was the very first third-space technique, so you create a space between the epithelium of the esophagus and the muscle to create the myotomy, but this technique has now opened the window to many other techniques that use the third-space approach, and I think this is something very important for the patient to know if they want to have minimally invasive intervention.

Dr. Buch:

That's absolutely fantastic. Thank you. Well that brings us to the end of today's program. I want to thank my guest, Dr. Michel Kahaleh, for helping us better understand per-oral endoscopic myotomy. Dr. Kahaleh, it was a pleasure having you on the program today.

Dr. Kahaleh:

Thank you for having me. It was an honor to be part of this program.

Dr. Buch:

Thank you. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening and see you next time.