

Barium esophagography

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TO THE EDITOR: I would like to comment on the excellent review article on barium esophagography by Drs. Allen, Baker, and Falk in your February 2009 issue. In their opening clinical vignette, they describe a 55-year-old female patient with gastroesophageal reflux disease (GERD) and slowly worsening dysphagia for solids. The patient was sent for barium esophagography, which disclosed an obstructing mucosal ring in the distal esophagus. The patient was then sent for endoscopy so that the ring could be treated with dilation. The authors present this case as an example of the type of patient who could obtain benefit from barium esophagography as the initial study. I disagree. In this patient's case, the barium procedure accomplished nothing, but it did unnecessarily cost the patient money, time, and radiation exposure. The patient would have been better served by being sent directly for endoscopy at the start of her workup, so that her condition could be diagnosed and treated with a single procedure. In her case, this would have spared her any need for the barium procedure. I believe that patients with dysphagia and GERD are best served by initial endoscopy, since GERD is associated with esophageal strictures, dysplasia, and cancer. Barium esophagography can be reserved for those who have had a normal or nondiagnostic endoscopy. For example, a patient with dysphagia and a normal endoscopy might then be sent for esophagography to diagnose a motility disorder.

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IN REPLY: We thank Dr. Keller for his kind remarks and feedback. However, we do not necessarily agree that the case presented was a bad example of a patient to be evaluated

with a barium study. While a significant distal mucosal ring was identified on the study as the cause of the patient's symptoms, this was not known before the examination. This patient could easily have had a subtle peptic stricture as the cause of the dysphagia. It is well known that subtle strictures can be missed with endoscopy. Further, if we knew that the patient had a significant distal mucosal ring before any testing, one could argue that all that was necessary was a dilation. When one knows, after the fact, what the cause of a patient's symptoms are, one can always retrospectively determine which tests were necessary and which tests were not.

In our experience, we find that a well-performed barium study can identify many abnormalities that further direct a patient's care. This examination, when performed correctly, provides both functional and anatomic information about the esophagus. We believe that too many patients undergo unnecessary endoscopic procedures and that endoscopy is not necessarily the initial examination in patients with dysphagia. As a result, the barium examination of the esophagus is underused. Furthermore, we view the barium examination and endoscopy as complementary examinations. We realize this is in many respects a philosophy. But Dr. Keller is also expressing a philosophy when he states, "I believe that patients with dysphagia and GERD are best served by initial endoscopy." We, including most of our gastroenterologists and esophageal surgeons, believe that the barium examination is an important and often the best initial examination in patients with dysphagia.

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