Attention Should Be Paid to the Psychological Status of Patients With Achalasia

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We read with interest the study by Xu et al (1) assessing psychological distress status in patients with achalasia. They concluded that psychological distress was more common in achalasia than healthy controls, and peroral endoscopic myotomy seemed to improve psychological distress. The authors deserve congratulations and praise for completing the first large sample study to evaluate differences in psychological status between patients with achalasia and the healthy controls. Meanwhile, we would like to raise some considerations.

First, patients with achalasia are deeply troubled by psychological disorders, so it is essential to conduct a timely psychological evaluation when diagnosing achalasia. The Eckardt score is the current gold standard for measuring the severity of achalasia symptoms (2). It is widely used in clinical practice and research, focusing on 4 symptoms: regurgitation, dysphagia, chest pain, and weight loss (2). However, compared with these common symptoms, the psychological symptoms and burden of achalasia are often underestimated and overlooked. Chronic course and reduced quality of life in achalasia are associated with increased symptoms of psychological distress. Xu et al (1) found that the degree of psychological distress in somatization, anxiety, and anger hostility increased significantly in achalasia. In addition, a recently published study has shown that depression and sleep disorders are also prevalent in achalasia (3). Therefore, establishing symptom assessment, including psychological status, will be more beneficial in managing achalasia.

Second, not all patients with achalasia develop psychological disorders, so it is crucial to identify risk factors for progressing. Hanschmidt et al (4) found that the prevalence of depression and anxiety in female patients with achalasia was 3.04–7.87 times and 3.10 times higher than in the general population, respectively. This difference was not seen in the male. It suggests that the female sex may be a risk factor for psychological distress in achalasia. Therefore, we need to pay more attention to the psychological status of female patients with achalasia in clinical practice and identify other risk factors in future research.

Third, although peroral endoscopic myotomy treatment can improve the psychological status of achalasia, postoperative gastroesophageal reflux may still lead to a psychological burden that needs attention. On the one hand, the decline in quality of life caused by gastroesophageal reflux can cause psychological distress; on the other hand, the appearance of psychological distress can aggravate the original esophageal symptoms. Current research has proved that psychological processes, rather than physiological parameters, are the most critical factor in the severity of symptoms in patients with refractory heartburn and reflux symptoms (5). These psychological processes include general psychological distress, such as depression and state anxiety; health-related psychological distress, such as visceral and pain anxiety; and esophageal-specific psychological distress, such as esophageal hypervigilance. Therefore, attention should be paid to the psychological status of achalasia not only before treatment but also throughout the course of the disease.

Last, psychological distress can affect the adherence of the treatment and monitoring of achalasia and may ultimately affect patients' clinical outcomes. If the goal of treating achalasia is the quality of life, psychological support treatment should not be neglected, and more attention should be paid to the psychological symptoms of achalasia.

CONFLICTS OF INTEREST

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