



Editorial

Dysphagia in Indian Patients—Benign Outnumber Malignant

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Swallowing is a complex motor reflex requires coordination among the neurologic system, the oropharynx and the esophagus. Several disorders, both benign and malignant, interfere with the swallowing process and cause dysphagia.¹ Patients with dysphagia suffer significant social and psychological burdens associated with their symptoms of difficulty with swallowing, including anxiety with meals or avoidance of eating with others.² It affects the quality of life of the individual, one's life expectancy, and may lead to complications and economic burden. The complications may be due to aspiration of ingested materials, resulting in chest infection, malnutrition, and airway obstruction.³

There is paucity of data from India regarding spectrum of dysphagia. In a study, by Panigrahi et al from Coastal Odisha,⁴ published in this issue of *Journal of Digestive Endoscopy*, the authors have studied the spectrum of dysphagia by means of a prospective observational study. The study included a total of 216 patients in which 122 (56.48%) were male and 94 (43.52%) were female. The mean age of patients was 42.3 ± 17.4 years. The common etiologies they found were benign stricture in 68 patients (31.48%) and carcinoma esophagus in 51 patients (23.62%). Among patients, other etiologies they mentioned were included achalasia cardia in 11 (5.09%), esophageal candidiasis in 10 (4.63%), pharyngeal cancer in four (1.85%), upper esophageal web in three (1.39%), reflux esophagitis in two (0.93%), foreign body esophagus in two (0.93%), and esophageal ring in two (0.93%). In 63 cases (29.17%), they could not find any etiology, and they constituted it as functional dysphagia. Most of the benign strictures were due to corrosive injury to the esophagus which was seen in 48 (70.59%) patients, followed by peptic stricture in eight (11.76%), postsurgery in four (5.88%), sclerotherapy-induced stricture in two (2.94%), and pill-induced stricture in two (2.94%). In four (5.88%) patients, the cause was not known. Among the corrosive injuries of

the esophagus, the most common cause was acid injury in 38 (79.17%) patients, followed by alkali injury in four (8.34%) patients. In six (12.5%) cases, the nature of corrosive was not known. Most of the corrosive injuries, they mentioned, were due to suicidal intake (64.58%) rather than accidental exposure (33.34%).

The authors in the present study attributed 63 (29.17) cases, in which no cause was found for functional dysphagia. However, they did not further investigate these patients by means of investigations, like esophageal biopsies or manometry, to rule out other causes, like eosinophilic esophagitis or motility disorders, which may also have normal esophago-gastroscopy findings. The authors had a follow-up period of 6 months which is too short to characterize the natural course of diseases, like corrosive stricture of esophagus. No mention has been made of any therapeutic intervention during this follow-up period which may add greater incentive to the natural course of these disorders. Furthermore, the etiology of dysphagia with respect to age distribution of population needs to be defined. The results of the present study were similar to a study conducted at a tertiary center in Jammu and Kashmir by Iqbal et al⁵ in 2018. They include 58 patients and found a benign cause in 31 (53.4%) patients, carcinoma esophagus in 23 patients, and four had moderate-to-severe dysplasia. Most common benign etiology was gastro-esophageal reflux disease (GERD) and most common malignant etiology was squamous cell carcinoma. The present study encourages other studies from India, especially from different geographic regions, as etiologies may differ from one region to the others. Also, the etiologies differ widely among different age groups. Larger and multicentric studies are needed to address these issues.

Conflict of Interest

None declared.

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