Peer Review File

Article information: https://dx.doi.org/10.21037/aoe-22-5

Reviewer A:

Comment 1: Reversal of the interventions was not sufficient: why is this a real pseudo achalasia and not idiopathic achalasia?

Reversal of the interventions was not sufficient because too much time had passed prior to relief of the obstruction at the gastroesophageal junction (i.e. the hiatal repair and the capsule from the laparoscopic band). We had hoped that by reversal of all obstruction at the hiatus, the patient's esophageal function would return but this did not eventuate. In the end, a myotomy was necessary to allow the patient to tolerate more than a fluid diet. This case presentation meets criteria with surgical pseudoachalasia rather than idiopathic achalasia, as there was no history of swallowing difficulty or diet limitations prior to the initial surgery (p.5, lines 79-80).

Comment 2: I miss an Eckardt score. I miss histology, excluding EoE. For the diagnosis of (pseudo) achalasia, you need IRP4.

We did not have an Eckardt score for this patient but have included pre- and post-Dakkak scores (composite score of dysphagia out of 45). Biopsies were taken by the initial surgeon and there was no evidence of EoE. The legend for Figure 1 included the swallow induced LES/GEJ integrated relaxation pressure over 4 seconds (IRP4). For clarity, we have also included this in the main text (p.5, lines 86-89).

Reviewer B:

Kollimarla et al. present a case report of pseudoachalasia after gastric banding and hiatal repair that underwent several failed procedures to end in a Heller's myotomy.

Comment 3: The presented case is not different from other cases of reported pseudoachalasia. As the own authors point out in the discussion, relieving of the obstruction does not lead to recovery in all cases and Heller myotomy is a good solution. The case has another serious limitation. A previous manometry is desirable to call the case a pseudoachalasia. The authors cannot be sure that achalasia was not the initial diagnosis.

The patient did not undergo a manometry prior to laparoscopic band insertion as she had no symptoms of dysphagia nor regurgitation at that point in time, and she was enjoying a normal diet (p.5, lines 79-80). It is impossible (and incorrect) to presume idiopathic achalasia in a patient who has had intervention at the hiatus.

Minor comments:

1) “et al.” not “et al”
2) “failed esophagus” is a terminology not used. It is only tempting to create a new term.

1) This has been corrected.
2) We appreciate the Reviewer’s comment and have changed the title and all reference to “failed esophagus” to “pseudoachalasia”.