

# AMERICAN GASTROENTEROLOGICAL ASSOCIATION

## American Gastroenterological Association Medical Position Statement: Clinical Use of Esophageal Manometry

*This document presents the official recommendations of the American Gastroenterological Association (AGA) on Clinical Use of Esophageal Manometry. It was approved by the Clinical Practice Committee on October 2, 2004, and by the AGA Governing Board on November 7, 2004.*

The following recommendations were developed to assist physicians in the appropriate use of esophageal manometry in patient care. These recommendations are an update from previous recommendations published in 1994 and represent the results of meticulous research into areas of controversy from the previous policy statement. In addition, new techniques have evolved that may improve and complement manometric diagnosis. Thus, these recommendations also take into account how these new technologies may alter clinical practice (Table 1).

### Recommendations

#### Indications for Esophageal Manometry

1. Manometry is indicated to establish the diagnosis of dysphagia in instances in which a mechanical obstruction (eg, stricture) cannot be found. This is particularly important if a diagnosis of achalasia is suspected. However, given the low prevalence of achalasia in patients with esophageal symptoms, more common esophageal disorders should be excluded with barium radiographs or endoscopy before manometric evaluation.
2. Manometric techniques are indicated for placement of intraluminal devices (eg, pH probes) when po-

sitioning is dependent on the relationship to functional landmarks, such as the lower esophageal sphincter.

3. Manometry is indicated for the preoperative assessment of patients being considered for antireflux surgery if there is any question of an alternative diagnosis, especially achalasia.

#### Possible Indications for Esophageal Manometry

1. Manometry is possibly indicated for the preoperative assessment of peristaltic function in patients being considered for antireflux surgery.
2. Manometry is possibly indicated to assess symptoms of dysphagia in patients who have undergone either antireflux surgery or treatment for achalasia.

#### Esophageal Manometry Not Indicated

1. Manometry is not indicated for making or confirming a suspected diagnosis of gastroesophageal reflux disease.
2. Manometry should not be routinely used as the initial test for chest pain or other esophageal symptoms because of the low specificity of the findings

**Table 1.** Summary of the Recommendations for the Clinical Use of Esophageal Manometry

Manometry indicated	Manometry possibly indicated	Manometry not indicated
To establish the diagnosis of dysphagia when obstruction (eg, a stricture) cannot be found. Particularly important if achalasia is suspected.	For the preoperative assessment of peristaltic function in patients being considered for antireflux surgery.	For making or confirming a suspected diagnosis of gastroesophageal reflux disease.
For placement of intraluminal devices (eg, pH probes) when positioning depends on the relationship to functional landmarks, such as the lower esophageal sphincter.	For evaluation of dysphagia in patients who have undergone either antireflux surgery or treatment for achalasia.	As the initial test for chest pain or other esophageal symptoms because of the low specificity of the findings and the low likelihood of detecting a clinically significant motility disorder.
For the preoperative assessment of patients being considered for antireflux surgery if there is any question of an alternative diagnosis, especially achalasia.		

and the low likelihood of detecting a clinically significant motility disorder.

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The Medical Position Statements (MPS), developed under the aegis of the American Gastroenterological Association (AGA) and its Clinical Practice Committee (CPC), were approved by the AGA Governing Board. The data used to formulate these recommendations are derived from the data available at the time of their creation and may be supplemented and updated as new information is assimilated. These recommendations are

intended for adult patients, with the intent of suggesting preferred approaches to specific medical issues or problems. They are based upon the interpretation and assimilation of scientifically valid research, derived from a comprehensive review of published literature. Ideally, the intent is to provide evidence based upon prospective, randomized, placebo-controlled trials; however, when this is not possible the use of experts' consensus may occur. The recommendations are intended to apply to healthcare providers of all specialties. It is important to stress that these recommendations should not be construed as a standard of care. The AGA stresses that the final decision regarding the care of the patient should be made by the physician with a focus on all aspects of the patient's current medical situation.

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