

OESOPHAGEAL DISEASES

Clinical Surgery Ebook

High-yield dysphagia, reflux, achalasia, perforation, cancer, emergencies, and postoperative care

Surgical Anatomy & Dysphagia Assessment • GORD & Hiatus Hernia
Barrett Oesophagus & Achalasia • Diverticula & Benign Lesions
Perforation & Caustic Injury • Oesophageal Cancer
Oesophageal Surgery & Complications • Clinical MCQ Bank

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A concise, examination-oriented text for medical students and surgical trainees, with high-yield clinical MCQs for viva and ward-based teaching

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Scope

A practical surgical overview of oesophageal disease for medical students: clinical assessment, differential diagnosis, investigations, emergency decisions, operative principles, and one-best-answer MCQs.

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Teaching Note

The emphasis is exam-facing clinical reasoning: dysphagia pattern, red flags, investigation choice, staging, emergency management, and postoperative complication recognition.

1. Surgical Anatomy and Physiology

- The oesophagus extends from the cricopharyngeus to the gastro-oesophageal junction and passes through cervical, thoracic, and abdominal segments.
- Important constrictions occur at the upper oesophageal sphincter, aortic arch or left main bronchus crossing, and diaphragmatic hiatus; foreign bodies and strictures often lodge at narrow points.
- Blood supply, lymphatic drainage, and lack of serosa influence spread of infection and malignancy. Lymphatic spread can be longitudinal and may involve cervical, mediastinal, or abdominal nodes.
- Lower oesophageal sphincter function and diaphragmatic crura protect against reflux. Failure of this barrier contributes to gastro-oesophageal reflux disease and Barrett change.
- Motility depends on coordinated peristalsis and sphincter relaxation; manometry is central when achalasia or functional motility disease is suspected.

2. Approach to Dysphagia and Oesophageal Symptoms

- Dysphagia must be separated into oropharyngeal transfer difficulty and oesophageal transit difficulty. Coughing, choking, nasal regurgitation, or aspiration suggests oropharyngeal disease.
- Progressive dysphagia first to solids and later to liquids suggests mechanical obstruction such as carcinoma or stricture. Dysphagia to both solids and liquids from onset suggests motility disorder.
- Alarm features include weight loss, anorexia, anaemia, haematemesis, progressive symptoms, odynophagia, persistent vomiting, and age-related cancer risk.
- Initial investigation of suspicious dysphagia is usually upper gastrointestinal endoscopy with biopsy. Contrast swallow helps define strictures, diverticula, motility patterns, and leaks.
- CT, endoscopic ultrasound, PET-CT, bronchoscopy, laparoscopy, and nutritional assessment are used in staging or operative planning for cancer according to tumour site and local pathways.

3. Gastro-oesophageal Reflux Disease and Hiatus Hernia

- Gastro-oesophageal reflux disease presents with heartburn, regurgitation, chest discomfort, cough, laryngitis, dysphagia, or complications such as oesophagitis and stricture.
- Hiatus hernia may be sliding or para-oesophageal. Para-oesophageal hernia can cause obstruction, volvulus, bleeding, aspiration, or acute chest and epigastric symptoms.
- Endoscopy assesses oesophagitis, Barrett oesophagus, stricture, ulceration, and malignancy. pH monitoring and manometry are useful before anti-reflux surgery in selected patients.
- Medical treatment includes lifestyle measures and acid suppression. Surgery is considered for refractory symptoms, volume regurgitation, large hernia, complications, or patient preference after assessment.
- Fundoplication aims to restore the anti-reflux barrier while avoiding dysphagia; preoperative manometry helps identify major motility disorders.

4. Barrett Oesophagus and Peptic Stricture

- Barrett oesophagus is columnar metaplasia of the distal oesophagus associated with chronic reflux and increased risk of adenocarcinoma.
- Biopsy during endoscopy confirms intestinal metaplasia and detects dysplasia. Management depends on dysplasia grade, segment length, symptoms, and patient risk.
- Peptic stricture presents with progressive solid dysphagia in a reflux background. Endoscopy with biopsy is essential to exclude malignancy before dilatation strategy.
- Treatment combines dilatation when required, acid suppression, and surveillance or endoscopic therapy when Barrett dysplasia is present.
- New dysphagia, weight loss, bleeding, or rapid symptom progression in a reflux patient must not be attributed to benign reflux without investigation.

5. Achalasia and Motility Disorders

- Achalasia causes dysphagia to solids and liquids, regurgitation of undigested food, nocturnal cough or aspiration, chest pain, weight loss, and a dilated oesophagus in established disease.
- Barium swallow may show a dilated oesophagus with smooth tapering at the gastro-oesophageal junction. Endoscopy excludes pseudoachalasia and carcinoma.
- Manometry demonstrates impaired lower oesophageal sphincter relaxation and absent or abnormal peristalsis, confirming the diagnosis.
- Treatment options include pneumatic dilatation, laparoscopic Heller myotomy with partial fundoplication, peroral endoscopic myotomy, and botulinum toxin in selected frail patients.
- Pseudoachalasia is suspected in older patients with short symptom history, marked weight loss, or difficult endoscope passage at the cardia.

6. Diverticula, Rings, Webs, and Benign Lesions

- Pharyngeal pouch presents with dysphagia, regurgitation of undigested food, halitosis, cough, aspiration, and a gurgling neck swelling in some patients.
- Epiphrenic diverticulum is often associated with motility disorder and may cause dysphagia, regurgitation, aspiration, and chest symptoms.
- Oesophageal webs can cause intermittent dysphagia and may be associated with iron deficiency in Plummer-Vinson syndrome.
- Schatzki ring causes intermittent solid food dysphagia, especially with meat or bread, and is commonly near the gastro-oesophageal junction.
- Benign tumours such as leiomyoma may present with dysphagia or be found incidentally; endoscopic biopsy can be avoided when submucosal vascular or benign smooth muscle lesion is suspected.

7. Perforation, Foreign Body, and Caustic Injury

- Oesophageal perforation causes severe chest or neck pain, fever, tachycardia, surgical emphysema, sepsis, pleural effusion, or mediastinitis depending on site and delay.
- Boerhaave syndrome follows forceful vomiting and causes transmural rupture, classically distal oesophagus, with rapid mediastinal contamination.
- Management depends on site, timing, contamination, patient stability, and underlying pathology, and may include resuscitation, nil by mouth, broad antimicrobials, drainage, endoscopic stenting, or surgery.
- Foreign body or food bolus impaction causes acute dysphagia, drooling, chest discomfort, or inability to handle secretions; batteries and sharp objects require urgent action.
- Caustic ingestion can cause airway compromise, oesophageal necrosis, perforation, and later strictures. Early airway assessment and specialist endoscopic planning are important.

8. Oesophageal Cancer

- Oesophageal cancer commonly presents with progressive dysphagia, weight loss, anorexia, odynophagia, regurgitation, aspiration, hoarseness, or metastatic symptoms.
- Squamous cell carcinoma is associated with smoking, alcohol, nutritional factors, and upper or middle oesophageal disease. Adenocarcinoma commonly arises in Barrett oesophagus near the distal oesophagus and junction.
- Endoscopy with biopsy confirms diagnosis. CT evaluates local and distant spread; endoscopic ultrasound helps local nodal and T staging when potentially curable disease is considered.
- Treatment may include endoscopic therapy for very early disease, neoadjuvant therapy, oesophagectomy, definitive chemoradiotherapy, stenting, radiotherapy, feeding access, or best supportive care.
- Operability depends on tumour stage, physiological fitness, nutrition, pulmonary reserve, comorbidity, and patient preference.

9. Oesophageal Surgery and Postoperative Care

- Oesophagectomy may be transthoracic, transhiatal, minimally invasive, hybrid, or three-stage depending on tumour location, surgeon expertise, and patient factors.
- Key postoperative concerns include airway and respiratory complications, anastomotic leak, conduit perfusion, arrhythmia, chyle leak, sepsis, nutrition, pain control, and early mobilisation.
- Anastomotic leak may present with fever, tachycardia, chest pain, salivary drainage, sepsis, pleural collection, or respiratory deterioration.
- Recurrent laryngeal nerve palsy causes hoarseness, aspiration risk, weak cough, and swallowing difficulty after cervical or upper mediastinal dissection.
- Long-term issues include dysphagia, reflux, dumping symptoms, delayed gastric emptying, weight loss, strictures, and need for nutritional follow-up.

10. Rapid Clinical Reasoning Tables

Pattern Recognition Table

Clinical pattern	Most likely reasoning step
Solids then liquids, weight loss	Mechanical obstruction, especially cancer
Solids and liquids from onset	Motility disorder such as achalasia
Regurgitation of undigested food, halitosis	Pharyngeal pouch
Heartburn with columnar metaplasia	Barrett oesophagus
Forceful vomiting then chest sepsis	Boerhaave syndrome
Food bolus impaction with drooling	Urgent endoscopic assessment
Post-oesophagectomy fever and enteric drain fluid	Anastomotic leak
Milky chest drainage after oesophagectomy	Chyle leak
Dysphagia with distant metastases	Palliation and nutritional support

Red Flags in Oesophageal Symptoms

Red Flags in Oesophageal Symptoms

Progressive dysphagia, especially solids then liquids.
 Weight loss, anorexia, anaemia, haematemesis, or odynophagia.
 Hoarseness, aspiration, recurrent chest infection, or supraclavicular node.
 Severe chest pain, fever, surgical emphysema, sepsis, or pleural effusion after vomiting or instrumentation.
 Short achalasia-like history in an older patient with marked weight loss.
 Postoperative tachycardia, fever, chest pain, or enteric drain output after oesophageal surgery.

11. Clinical MCQ Bank and Answer Key

Instruction

Choose the single best answer. Questions focus on clinical features, examination findings, investigations, emergency decisions, operative planning, and postoperative complications.

Q1. A 66-year-old man has progressive dysphagia first to solids and then to liquids, weight loss, anorexia, and iron-deficiency anaemia. Examination shows cachexia and left supraclavicular fullness. What is the most likely diagnosis?

- A. Achalasia
- B. Diffuse oesophageal spasm
- C. Oesophageal carcinoma
- D. Peptic stricture
- E. Schatzki ring

Answer: C — Oesophageal carcinoma

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q2. A 42-year-old woman has dysphagia to solids and liquids from onset, nocturnal regurgitation of undigested food, cough, and weight loss. Barium swallow shows a dilated oesophagus with smooth distal tapering. What is the most likely diagnosis?

- A. Achalasia
- B. Barrett oesophagus
- C. Oesophageal web
- D. Peptic stricture
- E. Zenker diverticulum

Answer: A — Achalasia

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q3. A 59-year-old man with long-standing reflux develops progressive solid food dysphagia. Endoscopy shows a distal narrowing and inflamed mucosa. Biopsies exclude malignancy. What is the most likely diagnosis?

- A. Achalasia
- B. Diffuse spasm
- C. Peptic stricture
- D. Pharyngeal pouch
- E. Squamous carcinoma

Answer: C — Peptic stricture

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q4. A 48-year-old man has heartburn, regurgitation, cough at night, and endoscopic columnar mucosa above the gastro-oesophageal junction. Biopsy confirms intestinal metaplasia. What is the most likely diagnosis?

- A. Barrett oesophagus
- B. Candida oesophagitis
- C. Mallory-Weiss tear
- D. Schatzki ring
- E. Zenker diverticulum

Answer: A — Barrett oesophagus

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q5. A 75-year-old man has dysphagia, halitosis, gurgling in the neck, cough after meals, and regurgitation of undigested food. Contrast swallow shows a posterior outpouching above the upper oesophageal sphincter. What is the most likely diagnosis?

- A. Epiphrenic diverticulum
- B. Hiatus hernia
- C. Oesophageal carcinoma
- D. Pharyngeal pouch
- E. Schatzki ring

Answer: D — Pharyngeal pouch

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q6. A 54-year-old man develops sudden severe chest pain after forceful vomiting. He is febrile, tachycardic, and has a left pleural effusion. CT with water-soluble contrast suggests distal oesophageal leak. What is the most likely diagnosis?

- A. Boerhaave syndrome
- B. Mallory-Weiss tear
- C. Peptic ulcer perforation
- D. Pulmonary embolism
- E. Spontaneous pneumothorax

Answer: A — Boerhaave syndrome

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q7. A 63-year-old woman has intermittent solid food dysphagia, especially with meat. Endoscopy shows a thin ring at the gastro-oesophageal junction. There is no weight loss or anaemia. What is the most likely diagnosis?

- A. Achalasia
- B. Diffuse spasm
- C. Oesophageal carcinoma
- D. Schatzki ring
- E. Zenker diverticulum

Answer: D — Schatzki ring

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q8. A 38-year-old woman has intermittent dysphagia, glossitis, angular stomatitis, and iron-deficiency anaemia. Endoscopy identifies a thin upper oesophageal web. What syndrome is most likely?

- A. Boerhaave syndrome
- B. Plummer-Vinson syndrome
- C. Superior vena cava syndrome
- D. Tropical sprue
- E. Zollinger-Ellison syndrome

Answer: B — Plummer-Vinson syndrome

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q9. A 70-year-old man with rapid-onset dysphagia, marked weight loss, and endoscope resistance at the cardia is initially thought to have achalasia. Which diagnosis must be excluded?

- A. Barrett metaplasia
- B. Diffuse spasm
- C. Pseudoachalasia from malignancy
- D. Schatzki ring
- E. Sliding hiatus hernia

Answer: C — Pseudoachalasia from malignancy

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q10. A 52-year-old man has biopsy-proven lower oesophageal adenocarcinoma. CT shows no distant metastasis and he is being assessed for curative treatment. Which investigation best refines local tumour and nodal stage?

- A. Barium meal only
- B. Endoscopic ultrasound
- C. Serum amylase
- D. Stool culture
- E. Urine cytology

Answer: B — Endoscopic ultrasound

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q11. A 45-year-old man has severe reflux despite medication and is being assessed for anti-reflux surgery. Endoscopy shows no cancer. Which investigation is most important to identify major motility disorder before fundoplication?

- A. Abdominal radiograph
- B. Bronchoscopy
- C. Oesophageal manometry
- D. Serum calcium
- E. Urine microscopy

Answer: C — Oesophageal manometry

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q12. A 60-year-old man presents with acute inability to swallow after eating meat. He is drooling but stable, with no perforation signs. What is the most appropriate initial therapeutic investigation?

- A. Emergency upper endoscopy
- B. Elective colonoscopy
- C. Plain skull radiograph
- D. Serum troponin
- E. Urinary catheterisation

Answer: A — Emergency upper endoscopy

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q13. A 33-year-old woman swallows a caustic household chemical. She has oral burns, drooling, hoarseness, and stridor. What is the immediate priority?

- A. Airway assessment and protection
- B. Barium swallow immediately
- C. Forced vomiting
- D. Neutralising alkali by mouth
- E. Routine discharge

Answer: A — Airway assessment and protection

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q14. A 68-year-old man has squamous carcinoma in the mid oesophagus. He reports cough after swallowing and recurrent chest infections. Imaging suggests communication with airway. What complication is most likely?

- A. Aortoenteric fistula
- B. Broncho-oesophageal fistula
- C. Chylothorax
- D. Dumping syndrome
- E. Splenic rupture

Answer: B — Broncho-oesophageal fistula

Source: *Bailey & Love's Short Practice of Surgery*, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q15. A 58-year-old man undergoes oesophagectomy. On day five he develops fever, tachycardia, chest pain, and pleural collection. Drain fluid looks enteric. What is the most likely complication?

- A. Anastomotic leak
- B. Dumping syndrome
- C. Hypocalcaemia
- D. Pulmonary embolism only
- E. Wound keloid

Answer: A — Anastomotic leak

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q16. A 61-year-old woman develops milky drainage from the chest tube after oesophagectomy. Output increases after enteral feeding. She is otherwise stable. What is the most likely complication?

- A. Chyle leak
- B. Gastric outlet obstruction
- C. Hypokalaemia
- D. Recurrent cancer
- E. Vocal cord palsy

Answer: A — Chyle leak

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q17. A 56-year-old man has severe retrosternal pain and odynophagia after difficult endoscopy with dilatation. He is febrile with surgical emphysema in the neck. What diagnosis is most likely?

- A. Acute pancreatitis
- B. Oesophageal perforation
- C. Peptic reflux only
- D. Rib fracture
- E. Zenker diverticulum

Answer: B — Oesophageal perforation

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q18. A 64-year-old man with distal oesophageal cancer has liver metastases and severe dysphagia to liquids. He is losing weight and wants rapid palliation of swallowing. What treatment is most appropriate?

- A. Diagnostic laparoscopy only
- B. Endoscopic self-expanding metal stent
- C. Heller myotomy
- D. Long-term antacids only
- E. Sistrunk operation

Answer: B — Endoscopic self-expanding metal stent

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q19. A 49-year-old man has achalasia confirmed by manometry. He is fit and wants durable treatment. Which operation is a standard surgical option?

- A. Heller myotomy with partial fundoplication
- B. Ivor Lewis oesophagectomy
- C. Nissen fundoplication alone
- D. Pyloroplasty alone
- E. Whipple procedure

Answer: A — Heller myotomy with partial fundoplication

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q20. A 73-year-old frail woman with achalasia is high risk for surgery. Symptoms are moderate and she cannot tolerate major intervention. Which treatment may provide temporary symptomatic relief?

- A. Botulinum toxin injection
- B. Completion thyroidectomy
- C. Emergency oesophagectomy
- D. Left hemicolectomy
- E. Splenectomy

Answer: A — Botulinum toxin injection

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q21. A 57-year-old man has progressive dysphagia and biopsy shows adenocarcinoma at the gastro-oesophageal junction. Which background condition is most closely associated?

- A. Barrett oesophagus
- B. Cervical rib
- C. Meckel diverticulum
- D. Pilonidal sinus
- E. Ulcerative colitis only

Answer: A — Barrett oesophagus

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q22. A 62-year-old man has dysphagia, chest pain, and tertiary contractions on contrast swallow. Manometry shows uncoordinated oesophageal contractions with preserved sphincter relaxation. What is the most likely diagnosis?

- A. Achalasia
- B. Diffuse oesophageal spasm
- C. Peptic stricture
- D. Pharyngeal pouch
- E. Schatzki ring

Answer: B — Diffuse oesophageal spasm

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q23. A 46-year-old woman has sliding hiatus hernia and troublesome regurgitation despite maximal medical therapy. Manometry shows normal motility. Which operation is most appropriate?

- A. Anti-reflux fundoplication
- B. Appendicectomy
- C. Heller myotomy only
- D. Oesophagectomy
- E. Subtotal gastrectomy

Answer: A — Anti-reflux fundoplication

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q24. A 69-year-old man has dysphagia, hoarseness, and weight loss. Endoscopy shows an upper oesophageal squamous carcinoma. Which finding suggests recurrent laryngeal nerve involvement?

- A. Hoarseness
- B. Hypercalcaemia
- C. Jaundice
- D. Melena alone
- E. Polyuria

Answer: A — Hoarseness

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q25. A 55-year-old man after oesophagectomy has weak cough, aspiration, and breathy voice. Laryngoscopy shows unilateral vocal cord palsy. Which complication is most likely?

- A. Accessory nerve injury
- B. Hypoglossal palsy
- C. Recurrent laryngeal nerve palsy
- D. Superior mesenteric thrombosis
- E. Tracheomalacia

Answer: C — Recurrent laryngeal nerve palsy

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q26. A 40-year-old man has sudden haematemesis after repeated retching. He is stable and has no mediastinal emphysema. Endoscopy shows a mucosal tear at the gastro-oesophageal junction. What is the most likely diagnosis?

- A. Boerhaave syndrome
- B. Mallory-Weiss tear
- C. Oesophageal cancer
- D. Peptic stricture
- E. Zenker diverticulum

Answer: B — Mallory-Weiss tear

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q27. A 65-year-old man has progressive dysphagia. Endoscopy confirms oesophageal carcinoma. CT shows multiple lung metastases. Which treatment goal is most appropriate?

- A. Curative oesophagectomy for all cases
- B. Palliation and nutrition support
- C. Routine no treatment
- D. Sistrunk operation
- E. Total colectomy

Answer: B — Palliation and nutrition support

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q28. A 50-year-old woman has chronic reflux, anaemia, and dysphagia. Endoscopy shows a distal ulcerated stricture. What is essential before assuming benign peptic disease?

- A. Biopsy of the stricture
- B. Immediate blind dilatation only
- C. No investigation
- D. Serum amylase only
- E. Urine culture

Answer: A — Biopsy of the stricture

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q29. A 72-year-old man has para-oesophageal hernia with acute chest pain, retching, and inability to pass a nasogastric tube. Imaging suggests gastric volvulus. What is the most appropriate management principle?

- A. Emergency assessment and operative planning
- B. Ignore as simple reflux
- C. Long-term antacid only
- D. Routine outpatient review
- E. Tonsillectomy

Answer: A — Emergency assessment and operative planning

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Q30. A 59-year-old man has oesophageal cancer and severe malnutrition before planned neoadjuvant treatment. He can barely swallow fluids. What supportive measure is most relevant before major therapy?

- A. Nutritional optimisation and feeding access
- B. Permanent bed rest
- C. Routine appendicectomy
- D. Stopping all hydration
- E. Urine alkalinisation

Answer: A — Nutritional optimisation and feeding access

Source: Bailey & Love's Short Practice of Surgery, relevant chapter on oesophagus and upper gastrointestinal surgery.

Answer Key

1. C — Oesophageal carcinoma	11. C — Oesophageal manometry	21. A — Barrett oesophagus
2. A — Achalasia	12. A — Emergency upper endoscopy	22. B — Diffuse oesophageal spasm
3. C — Peptic stricture	13. A — Airway assessment and protection	23. A — Anti-reflux fundoplication
4. A — Barrett oesophagus	14. B — Broncho-oesophageal fistula	24. A — Hoarseness
5. D — Pharyngeal pouch	15. A — Anastomotic leak	25. C — Recurrent laryngeal nerve palsy
6. A — Boerhaave syndrome	16. A — Chyle leak	26. B — Mallory-Weiss tear
7. D — Schatzki ring	17. B — Oesophageal perforation	27. B — Palliation and nutrition support
8. B — Plummer-Vinson syndrome	18. B — Endoscopic self-expanding metal stent	28. A — Biopsy of the stricture
9. C — Pseudoachalasia from malignancy	19. A — Heller myotomy with partial fundoplication	29. A — Emergency assessment and operative planning
10. B — Endoscopic ultrasound	20. A — Botulinum toxin injection	30. A — Nutritional optimisation and feeding access

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