Retrospective study of pharyngeal pouch surgical management

R Gan, S Sood, M Aziz, I Smith,
Ear, Nose & Throat Department, Bradford Teaching Hospitals, UK.

Introduction

- * Pharyngeal pouches are uncommon (2/100000 per year) associated with older age.
- * The most common primary treatment for pharyngeal pouches is endoscopic stapling.
- * However, there are other potential treatment options such as open excision with cricopharyngeal myotomy that although can have greater potential risk, may confer better long term outcomes. Other options include laser division of cricopharyngeal bar.

Objectives

- * Retrospective analysis of pharyngeal pouch management at Bradford Royal Infirmary.
- * To investigate the outcomes of patients with pharyngeal pouches managed surgically.

Method

- * Patients with pharyngeal pouch treated surgically at Bradford Royal Infirmary from Aug 2012 to Sept 2017.
- * Review of notes, letters, barium swallow on PACS

Patients and surgical treatment

- * 44 surgical procedures to treat pharyngeal pouch.
- * 8 notes\letters unavailable.
- * N=36 included.

Fig 1: Age of patients

Age range	Patients
<50	1 (2.7%)
50-59	6 (16.7%)
60-69	8 (22.2%)
70-79	9 (25%)
80-89	10 (27.8%)
90-99	2 (5.6%)

Fig 2: Stage of pouch (Van Overbeek)

Fig 3: Surgical treatment

Endoscopic stapling of pharyngeal pouch (N=25) (4 revisions)

- * Factors deciding surgery: patient choice, good access, large enough, elderly, learning difficulties- will not tolerate NG feed
- * 15 (60%) successful- 14 discharged after first follow up, 1 multiple follow ups due to multiple revisions
- * 4 (16%) had partial success (occasional regurgitation, gurgling, pooling)
- * 3 (12%) temporary success- X2 went on to have revisions
- * 1 unknown result
- * 2 (8%) failed
- stapling abandoned due to difficult access
- perforated pouch

Open excision of pouch + cricopharyngeal myotomy (N=10)

- * Factors deciding surgery: - failed stapling, pouch too small, relatively young age- better long term outcome
- * 10 (100%) success
- * 7 discharged after 1st follow up
- * 1 after second follow up (had post op infection)
- * 1 ongoing follow up due to persistent globus
- * Complications:
 - 1 leak- treated with NG feed, same patient developed granulations on surgical wound
 - 1 post op wound infection –IV abx

Laser (N=1)

- * Factors deciding surgery: recurrent pouch following open excision but difficult access
- * Temporary improvement- required revision stapling

Endoscopic stapling vs Open excision

Endoscopic stapling	
Advantages	Disadvantages
<ul style="list-style-type: none">-short anaesthetic-early oral intake-short in patient stay-minimal pain-straightforward revision surgery-low complication rates	<ul style="list-style-type: none">-access- if small pouch- stapling gun can't fit-no specimen (although biopsies should be taken if suspicious)
Open excision	
Advantages	Disadvantages
<ul style="list-style-type: none">- completely removes pouch- can treat all sizes of pouch- eliminates risk of carcinoma	<ul style="list-style-type: none">- revision difficult -scar tissue makes identification of diverticulum difficult- ?more potential risk – infection, haematoma, fistula, mediastinitis, leak, VC palsy- Longer anaesthetic and hospital stay

Conclusion

- **High success rate of open surgery with better long term outcomes**
- **Complication rates comparable to other studies**

References

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