SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

President: R. J. CANN, M.S., F.R.C.S.

December 6th, 1957

Discussion on Pharyngeal Diverticula

THE opening papers by Mr. Boyes Korkis and Mr. Spencer Harrison will be found on pp. 509-534.

Discussion

PROFESSOR E. W. WALLS opened the meeting with a brief account of the anatomy of the lower pharynx with particular reference to the innervation of the inferior constrictor.

SIR VICTOR NEGUS thanked the President for inviting him to speak. He had a long-standing interest in pharyngeal diverticula, but he would not weary the meeting with any remarks about etiology based on the evidence of comparative anatomy, since he had published articles in the *Journal of Laryngology* in 1925, in the report of a lecture in the *Annals of the College of Surgeons* in 1950 and recently the report of a lecture given at the Johns Hopkins Hospital, published in the Bulletin of that institute.

His opinion was that a pharyngeal diverticulum, unless extremely large, was the result and not the cause of dysphagia; it was usual to find evidence of lack of relaxation of the cricopharyngeal sphincter, sometimes associated with chronic inflammatory changes. By means of dilatation with a large hydrostatic bag it had been found possible to make certain small pouches disappear, with relief of all symptoms; and in one case, of a moderate sized pouch, preliminary dilatation was to be followed by external operation after some days, but when this was arranged it was found that there was no evidence of a pouch.

Sir Victor said that he knew of the operation proposed by Dr. Mosher many years ago, with division of the party wall as far down as within a quarter of an inch of its lower margin and without diathermy. This had appeared to be somewhat precarious, but the recent improvements in the operation introduced by Dr. Dohlman seem to have made the procedure a safe one. Dr. Seiffert of Berlin had, it was believed, carried out similar operations.

W. O. LODGE asked if the openers had found themselves, during excision of pharyngeal diverticula, practising *pari passu* repair of the pharynx as shown in a diagram ; see Fig. 1.

E. D. D. DAVIS said he had seen about 26 cases of pharyngeal diverticula during a period of 35 years and he had collected brief notes on 19 of them.

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X-ray photographs were sometimes misleading and showed the fundus of the diverticulum to be below the level of the clavicle and in the mediastinum, whereas in all the 19 operations he had seen the fundus was in the neck well above the clavicle.

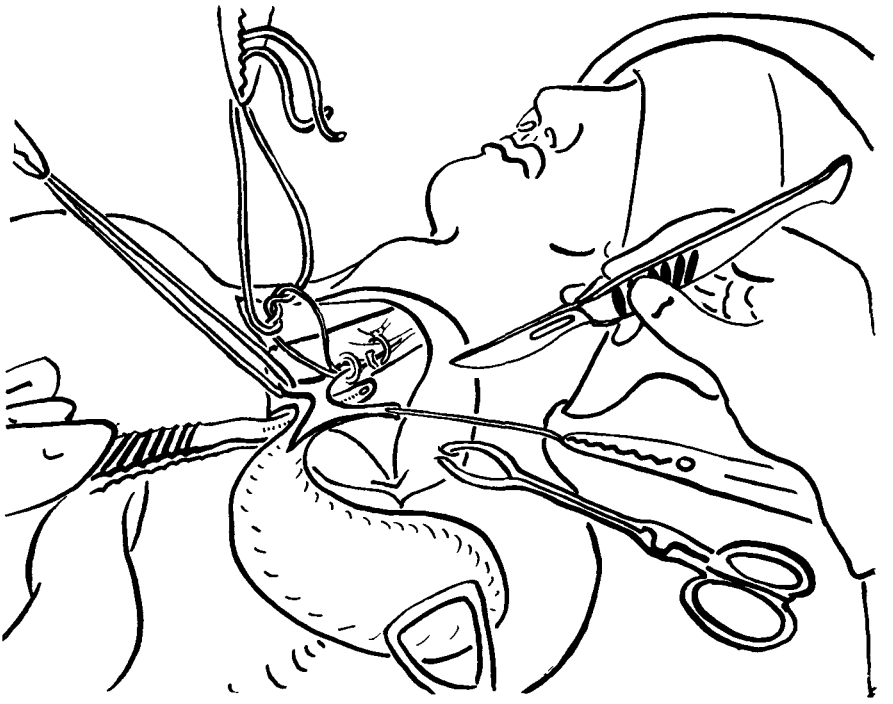


FIG. 1.

Endoscopy was always necessary before operation and it helped to determine whether the diverticulum was suitable for the Dohlman operation or for excision. In his day sepsis and mediastinitis were the bogies of operation and several methods of treatment were tried to avoid these complications. The first case he saw was submitted to Gerard's operation, i.e. the diverticulum was exposed by an oblique incision along the anterior border of the sternomastoid, the omohyoid muscle was divided, the pouch dissected and invaginated into the pharynx. The slit-like opening left in the wall of the pharynx was carefully closed by stitches. During the operation, before the closure of the slit, the patient coughed, with the result that the diverticulum returned to the position in the neck. He was made to cough after stitching, and the diverticulum remained securely in the pharynx. Two months later an attempt was made to remove the polyp-like diverticulum with the œsophagoscope. The patient disappeared for nearly 12 months, when he reported that he had sneezed violently, felt something give in his neck and his symptoms returned. The diverticulum was shown by

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radiography to be in the same position as before operation. It was then excised at a second operation, but a slight recurrence was seen 18 months later.

The next four cases were treated by what is known as diverticulopexy. The fundus of the diverticulum was drawn up in the neck and stitched to the hyoid bone. Three of the diverticula returned to their original position in the neck within two months. A fourth sloughed and a fistula resulted. In his experience the two-stage operation resulted in a return of the diverticulum. He also knew of two such cases who died of mediastinitis.

The one-stage operation done by Wilfred Trotter was the most successful. After the diverticulum was excised the pharyngeal wall was closed by four layers of sutures. The sternal portion of the sternomastoid muscle was divided at the sternum and the muscle stitched over the carotid sheath to fill up the gap and to strengthen the pharyngeal wall. Trotter treated the diverticulum as a hernia which he considered to be caused by the increased pressure within the pharynx arising from the functional contraction of the cricopharyngeus. Dunhill's collar or transverse incision, done for æsthetic reasons, resulted in injury to the recurrent laryngeal nerve in one case. There was a recurrence in a few of the excision cases.

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