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Recent Advances in Head and Neck
Cancer Surgery

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Current Status of Surgical Treatment of
Hypopharyngeal Carcinoma

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Hypopharyngeal carcinoma is associated with a poor prognosis. In advanced cases, adequate surgical ablation followed by radiotherapy is curcial for survival.

Reconstruction of the hypopharyngeal defect is also important for quality of life.

In the Department of Surgery, The University of Hong Kong at Queen Mary Hospital, before 1980, pharyngolaryngo-oesophagectomy and pharyngogastric anastomosis were carried out in all patient who had carcinoma involving the hypopharynx. In recent years, with the development of myocutaneous flaps and free flaps, more options of reconstruction are available. Currently, the extent of pathology in the hypopharynx determines the size and type of defect and hence the appropriate reconstructive procedure.

When the tumour involves upper lateral aspect of the hypopharynx, total laryngectomy and partial is still a bridge of full thickness pharyngeal wall lying between the oropharynx and cervical oesophagus.

This partial pharyngeal defect could be closed with a patch pectoralis major myocutaneous flap.

Alternatively, when the tumour involves apex of the pyriform fossa, or the postcricoid region, resection should include the whole circumference of hypopharynx. The circumferential defect between the oropharynx above and cervical oesophagus below could be reconstructed either with a tubed pectoralis major myocutaneous flap or with a free jejunal graft.

When the tumour affects the lower hypopharynx or cervical oesophagus, the oesophagus needs to be removed for tumour clearance. This long defect gastric pull-up procedure.

From 1984 to 1992 we have managed a total of 129 patients with hypopharyngeal tumours.

1) Forty-eight patients had partial pharyngeal defects and reconstruction was performed using the pectoralis major myocutaneous flaps. Two patients in this group died in hospital and eight patients had minor leakages at the pharyngeal closure.

2) Thirty-three patients had circumferential defects ; tubed pectoralis major myocutaneous flap was used to repair the defect in 23, whereas free jejunal graft was used in the remaining 10 patients. Four patients in this group died in hospital and the leakage rate of the pectoralis major myocutaneous flap was 30%. Two patients in the free jejunal graft group lost their grafts but of them were successfully salvaged.

3) Forty-eight patients underwent pharyngolaryngo-oesophagectomy and pharyngogastric anastomosis. Six patients in this group died in hospital. The hospital mortality of 12% was lower than that previously reported. From 1966 to 1979, we carried out gastric pull-up operation for 157 patients and the hospital mortality was 31%. From 1980 to 1983, we performed 91 gastric pull-up procedures and the hospital mortality was 18%. There was no anastomo-