Direct Pharyngoesophagoscopy Audit

Effectiveness of Endoscopy in the management of patients with a new throat complaint at GCH

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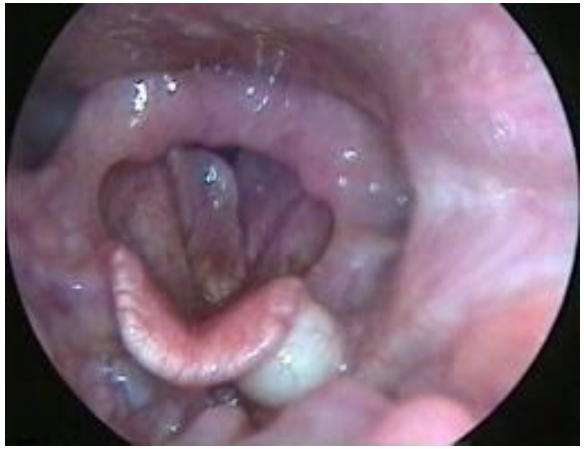
PLAN

A. Aims
B. Methodology
C. Results
D. Discussion and recommendation



AIM and OBJECTIVES:

Aim:

To assess Effectiveness of Endoscopy in the management of patients with a new throat complaint at GCH

Objectives:

- Review the main indications for endoscopy
- Review the management of these conditions
- Discussion and Recommendation where applicable

OUR DATA:

- Statistical data
- Referral patterns/sources
- Main clinical presentations/indications for referrals
- Endoscopy : major findings
- Preoperative management
- Postoperative management

Common indications of DL/Dph ?

- To rule out sinister changes
- To obtain specimen for histology
- Inability to assess Pt in OPD
- To consider treatment as addition to diagnostic endoscopy
- To “double check – reassure and discharge” ?

Material and Method

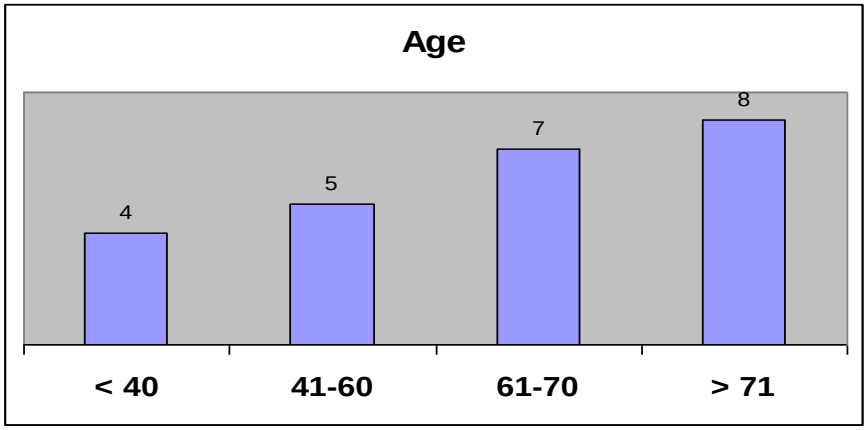
- Retrospective notes review of DL/DPh+/-O+/-Bx
- Information collected via Theatre ORSOS
- Procedures done from 1.01.12 to 31.07.12 (6 months)
- Exclusion criteria:
    * hoarse Pts with pure laryngeal lesions and DL/ML
    * known oesophageal lesions/strictures
    * known oral Ca requiring Bx
    * FB's pharynx/oesophagus
- Individual Management vs Current Evidence

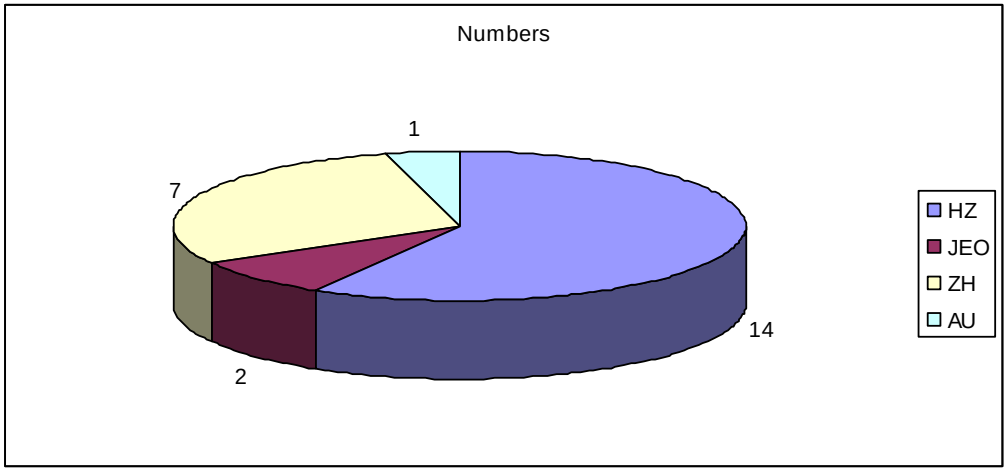
METHOD: what did we look at ?

- Main symptoms
- Referral source
- Triaging
- OPD management : * findings
  * treatment
  * investigations
  * reviews
- Endoscopy : indications and findings
- Postop. management : discharge / FU / referral

RESULTS

- 24 patients
- M:F=12:12
- Age : 20 – 88 (mean=62)



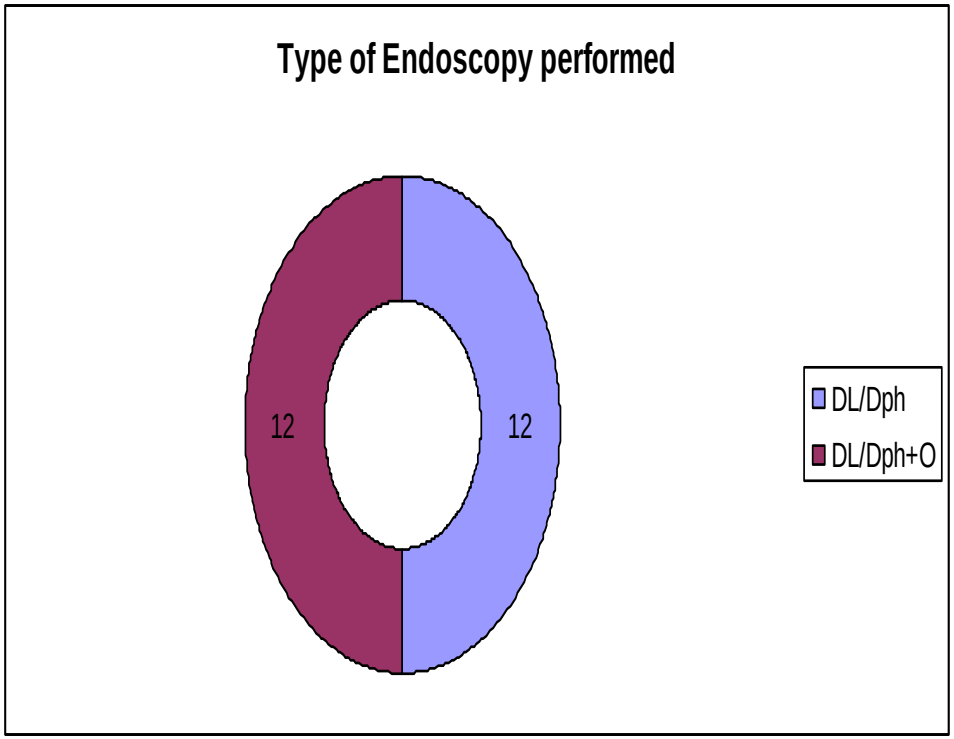


RESULTS

- Biopsy – 12
- **Positive for SCC** - 3

(1 Surveillance case and 2 New)

- Complications – Nil
- Day case – 23 (95.8%)



RESULTS: Types of patients

- Pts with known Ca under review - 3
- New referrals and FU's with :
  - * Sore throats - 5
  - * Globus sensation - 10
  - * Dysphagia - 4
  - * Hoarseness - 2

Pharyngeal Cancer surveillance

- About 25% of recurrences are asymptomatic
- Patients should be followed up by MDT at least 2 monthly in the first 2 years and 3 to 6 monthly in the subsequent years [1]
- Clinical assessment should include adequate clinical examination including nasopharyngolaryngoscopy [1]

1. British Association of Otorhinolaryngology Head and Neck Surgery, Guideline 2011

Cancer surveillance in our sample
n=3

1. SCC supraglottis (RT) : susp. changes on FOL→ DL/DPh in 2/52 → NAD
2. SCC tonsil (Ch-RT) : dysphagia/discomfort → DL/DPh+Bx+dilatation in 3/52 → Negative/Improved
3. SCC oro/hypopharynx (CH-RT) : susp. changes on FOL→ DL/Dph+Bx in 1/52 → **Positive (recurrence)**

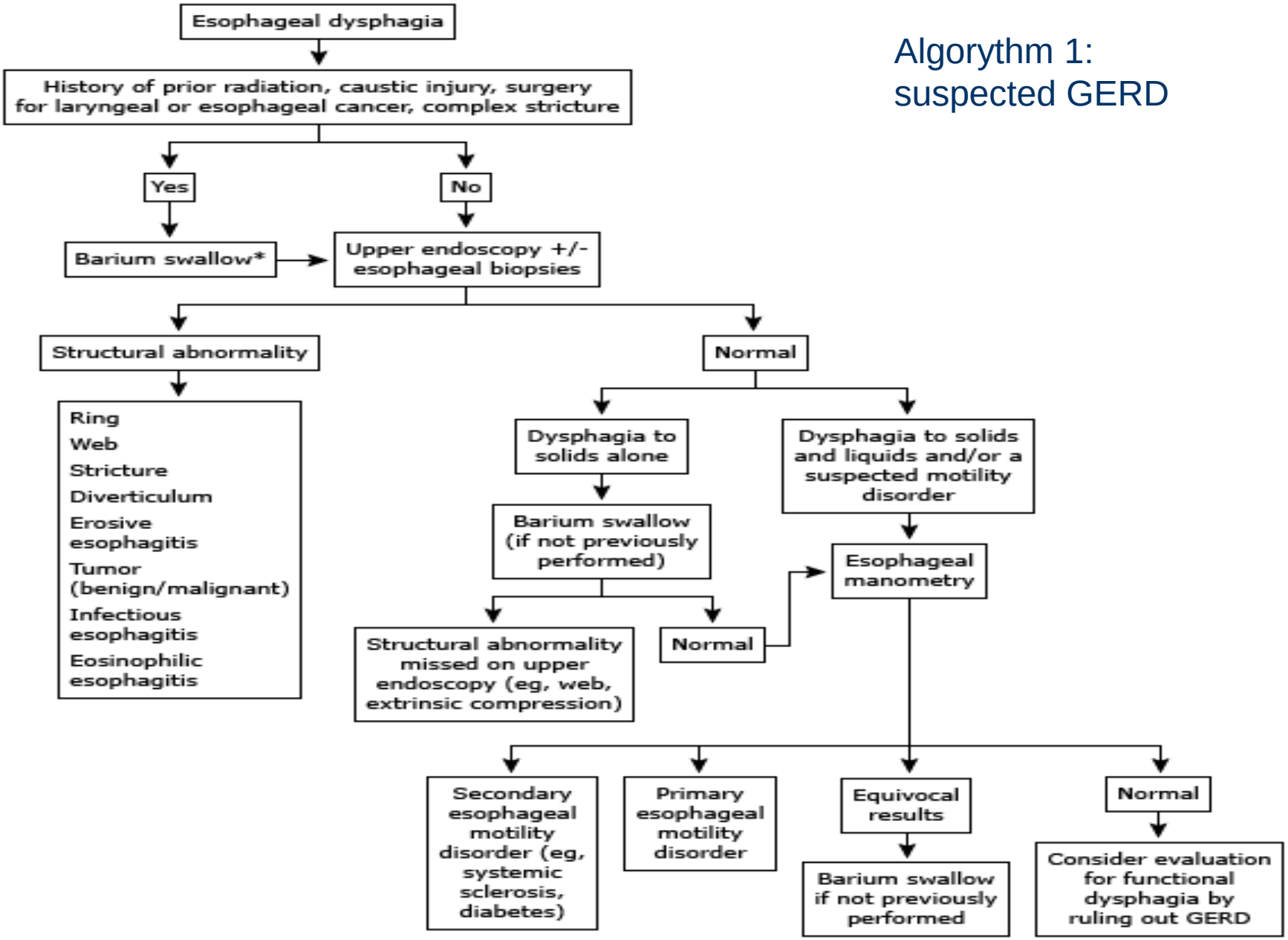
   (CT → lung Mts)

Dysphagia

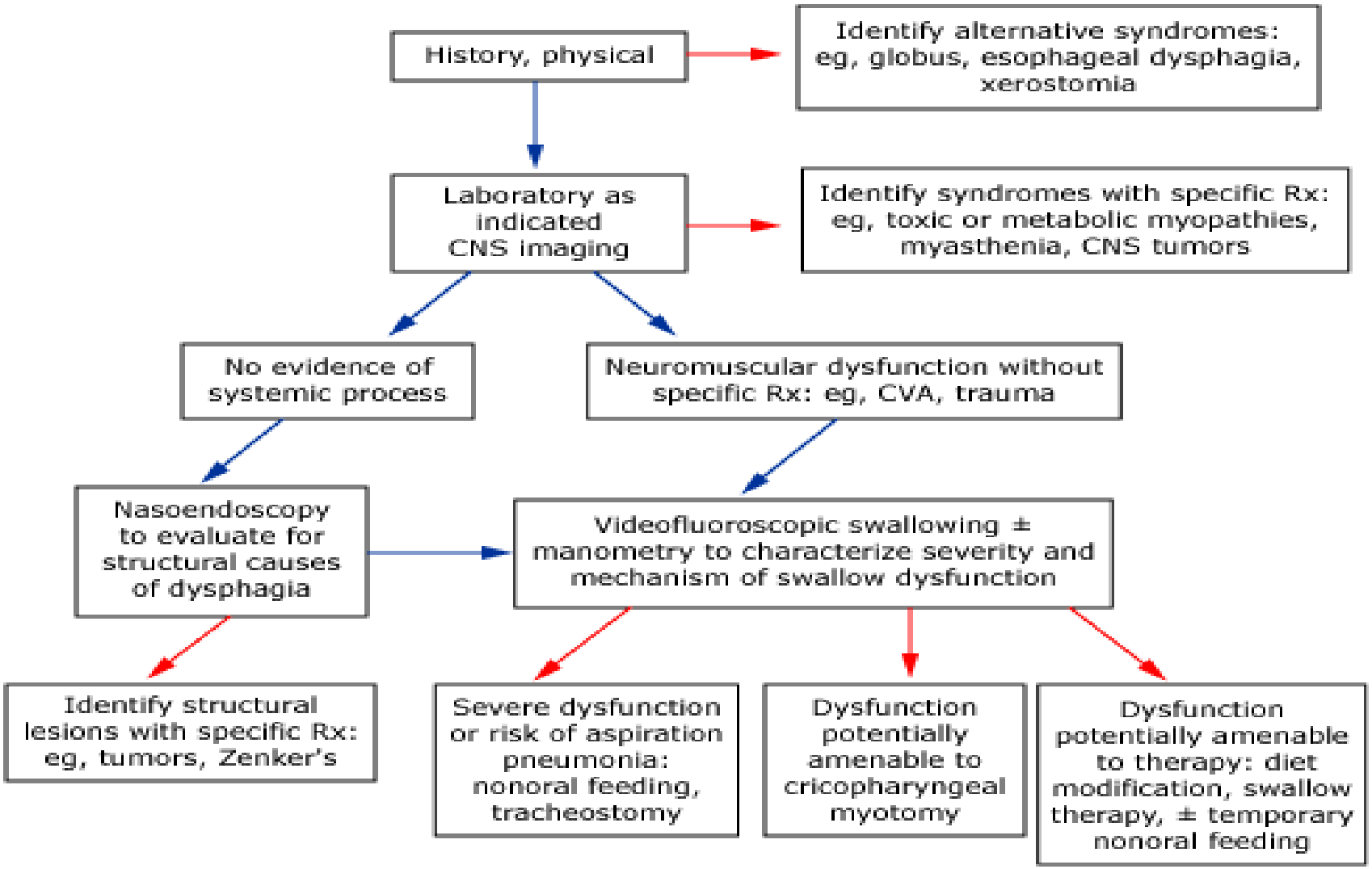
Five major tests can be used

- barium radiography
- videofluoroscopy,
- upper endoscopy,
- fiberoptic nasopharyngeal laryngoscopy,
- esophageal manometry.
- New technique: naso oesophagoscopy

Algorythm 1: suspected GERD



Algorythm 2: suspected GERD



Dysphagia n=4

1. Long term FU (6y) : 88 F, non-smoker and postcricoid web.
   Had DPh/O – 07 ; FOG -09 (dysmotility) .
   DPh+dilatation within 1/12. No change of web

2. Long term FU (2y) : 60 F, smoker/drinker; hs of Ca larynx age 35 + postcricoid web ,wt loss. Had Ba sw. (web,osteophytes) DL/UO 11(neg).
   DL/DPh+UO within 2/12. NAD. Improved. Referred to GI→DNA→Discharged

Dysphagia n=4

3. **GP referral (Urg. 1m)** : 64 F ex-smoker with progressive dysphagia to solids. Hs of haemangioma pharynx 98. FOL- NAD. Ba sw.: small ant web +small pouch+mild GOR

   DPh+UO+Bx+Dilatation in 4/12. Negative. Better . Discharged

4. **A&E referral** : 88 M , smoker with 3/12 dysphagia, Wt loss, food bolus (toast) . FOL – mass Rt PF.

   DL/DPh+Bx next day . Positive (SCC) → RT completed 2.5 months after referral

Dysphagia group n=4

Discussion :

- Main indications : Exclude neoplasm
  Therapeutic dilatation
  Suspicious findings on FOL

- Shorter review – Quicker referral to GI ? **(Pts 1 & 2)**
- Long wait for EUA ? **(Pt 3)**
- Very quick management **in Pt 4 !**

Hoarseness n=2

1. **Resp. SpR referral (urg. 1/12) :** 20 F non-smoker with asthma,bronchoectasia,GOR . Hoarse+cough. OPD x2. No FOL (“too sensitive”). Ba sw.: mild reflux

   DL/DPh in 6/52 . Non spesific. Thrush. A/fung. Discharged.

2. **GP referral (USC) :** 55 M ex-smoker with huskiness,cough, some Wt loss. FOL: large vallecular cyst

   DL/DPh+decapping in 3/52 . Benign. Discharged (N/Pr)

Hoarseness n=2

Discussion :

- **Main indications :** Inability to examine in OPD
  Findings on FOL
- No strong suspicion for sinister changes
- Need for examination and discharge (Pt 1)
- Pt 2 informed that cyst removal may not improve hoarseness

Sore Throat n=5

- M:F = 3:2 Age : 40-74 (mean=63)
- Smoking : Yes – 3 Ex – 1 ? -1
- Referral : GP = 4 (USC -2 ; Urg.6/52 – 2)
  A&E=1 (sore throat, ?Fish bone)
- Factors affecting referral/decision to scope:
  * Hs of Ca tonsil+ Cerv.LN - 1
  * MNG + sore throat - 1
  * suspicious findings in OPD - 2

Sore Throat n=5

- **Degree of suspicion for Neo:**

  * Very strong - 1 **(fungating mass BoT from A&E). Confirmed as SCC T3N0M0**

  * Moderate - 1 **(irregular tonsil). Negative Bx. Ds:Chr.Tonsillitis .**

  * Some degree - 2 **(prolonged Hs, cervical LN). NAD . Discharged**

  * Minimal - 1 (**GOR !) NAD . Discharged**

- **Waiting time for DL/DPh :** 2-6 w (1 case – 3m)

- **Preop. management : PPI / NSS - 2 US/FNAC - 2 CT - 1 1 review OPD - 2**

Sore Throat n=5

Discussion :

- All scopes – to exclude malignancy
- Among suspected cases – 1 positive
- GORD Pts - more referral to GI ? (1 Pt re-referred in 9/12 with recurrent sore throat and unsuppressed GPhR)
- Some USC probably not justified :

? How can we Improve quality of referrals

? Questionnaire needed

Globus Pharyngeus

DEFINITION — Globus sensation has been defined using the following criteria :

- The persistent or intermittent non painful sensation of a lump or foreign body in the throat
- Occurrence of the sensation between meals
- Absence of dysphagia and odynophagia
- Absence of evidence that gastroesophageal reflux is the cause of symptoms
- Absence of histopathology-based esophageal motility disorders
- Criteria fulfilled for the last three months with symptom onset at least six months before diagnosis.

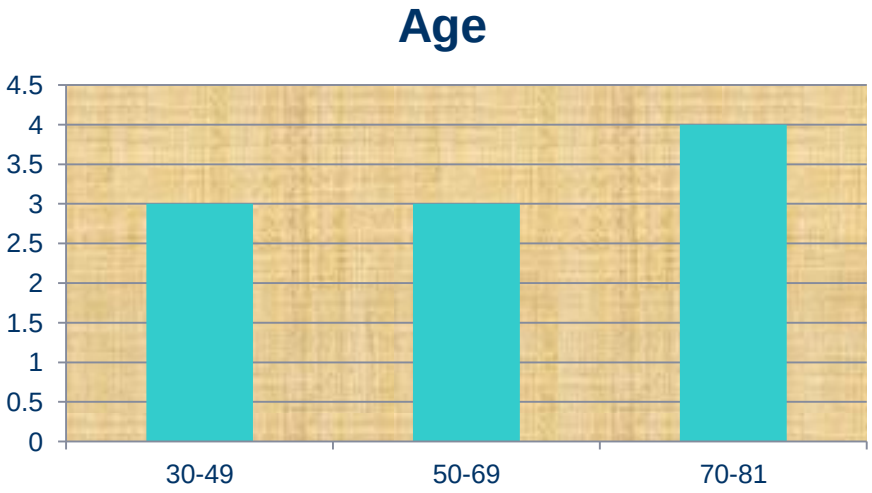
Globus Pharyngeus

Clinical Evaluation

- Careful History (esophageal motility disorder? E.g achalasia).
  + A complete physical and ENT examination +/- barium swallow with a solid bolus to exclude a mechanical problem
- **A**ppropriate endoscopic or barium studies : New Globus, changed Globus, or alarm symptoms (weight loss, anemia, Dysphagia, Odynophagia.)

Globus Pharyngeus n=10

- F:M=5:5
- Age : 36-81 (mean 60)
- GP referrals
- Symptoms:
  * FB sensation
  * Cough
  * Interm. huskiness
  * Discomfort , sore throat
  * Some difficulty in swallow



Globus Pharyngeus n=10

Triage

- Urgent (4-6/52) = 6
- USC = 4

    1. 81 F. non-smoker +hs of vallecular cyst 2003 + some Wt loss
    2. 53 M. smoker + globus / cough
    3. 39 F. + globus / Fe-def.anaemia
    4. 76 M. ex-smoker + globus/slight dysphagia+ longstanding hoarseness

Globus Pharyngeus n=10

PMH :

- Fe-deficiency anaemia - 2
- Anxiety - 2
- Known GORD - 1
- Smoking - 1

Treatment/Investigations :

- PPI/NSS – 5
- Sx for nasal polyps -1
- Vallecular cyst removed 2003 - 1
- Ba-swallow 2010 (N) - 1
- FOG 2009 (N) - 1

Globus Pharyngeus n=10

OPD findings :

- Nasal polyps – 1
- Small nodules VC's – 2
- PND – 1
- Oedema arytenoids – 2
- Prominent lingual tonsil -1
- Cyst lingual epiglottis – 1
- LN level 2 – 2 **(US: 1. - benign 2. – prominent carotid bulb)**
- NAD – 2

Globus Pharyngeus n=10

OPD management :

- PPI+/Antacids **(or change / increase dose)** - 6
- NSS - 2
- Ba swallow : at 1st visit - 4 **(some dysphagia – 1)**

  at 2nd visit - 1

Results : **1. C5 – web ? Dismotility/HH/ GOR/peptic ulcer ?**

2. osteophytes at C6 /small pouch ?/ tertiary contractions/ HH

3. anterior web at C5

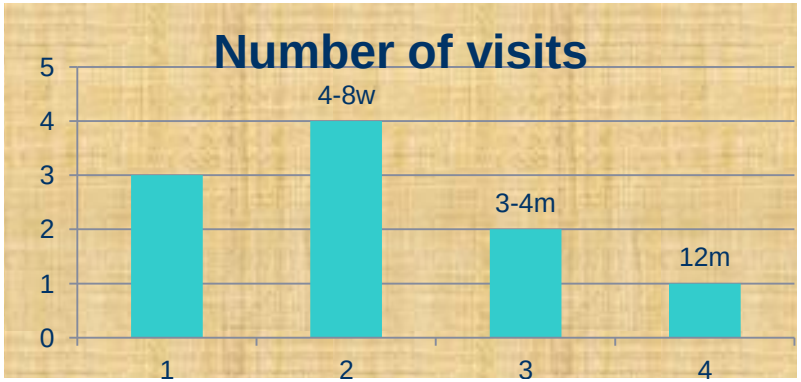
4. NAD

5. NAD /mild GOR

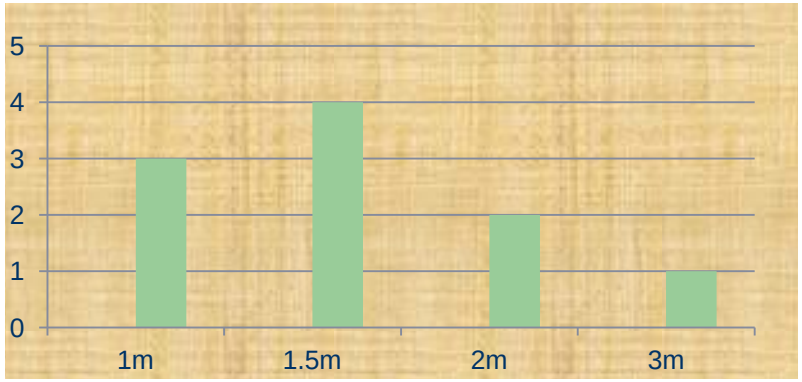
Globus Pharyngeus n=10

Listing at 1st visit:

1. Prominent lingual tonsil/fullness/LN level 3 (SG)
2. Small lesion VC (locum)
3. Epiglottic cyst (AS)



Wait for DL/DPh :



Globus Pharyngeus n=10

Procedure :	DL/DPh	- 4
	DL/DPh+UO/O	- 6
Surgeon :	Cons.+/-SpR	- 7
	AS	- 3
Findings :	Tight CrPh	- 3
	General oedema (hypoph./arytenoids) – 3	

Reflux - 2

Lingual tonsil hyperplasia - 2

Web upper oesophagus - 2

Cyst epiglottis - 1

Globus Pharyngeus n=10

- Biopsy - 4 (cyst epigl.,web; BoT= benign)
- Discharge same day - 10
- Follow up - 7 (3 – post Bx)
- Referral to GI - 2 (all had FOG-advice-discharge)

Globus Pharyngeus n=10

Discussion :

- No strong suspicion of malignancy
- Some suspicion – when uncertain change on Ba swallow – 3
- Do we need to do Ba swallow if no dysphagia ?
- Other Indications: reassure and discharge - 3
  - * additional sy's (sore throat), long Hs - 2
  - * findings on FOL (cyst , ? Lesion VC) - 2
- Some USC referrals are not justified
- Earlier referral to GI ?
- Shorten OPD review ?

Direct Pharyngoesophagoscopy

SUMMARY

- Main indication – to exclude malignancy
  also as the last investigation prior discharge
- Pick up rate is 12.5 % and usually would be expected at preop. examination
- Safe to do as a day case procedure
- Potential to reduce number of OPD review visits
- " Routine" DL/DPh could be avoided by some change in management : earlier referral to GI-physicians , use of new techniques ,

Direct Pharyngoesophagoscopy

RECOMMENDATIONS

- Earlier referral to GI-physicians, use of new techniques (naso-oesophagoscopy done in OPD)
- Thorough History taking and clinical examination for all patients: evaluate cancer suspicion
- Need to audit and develop protocol for Globus Pts
- Need to improve system of triage (criteria for USC for GP’s?)

THANK YOU FOR LISTENING

HARRY PICKED A BAD TIME TO GET LARYNGITIS