INTRODUCTION
The upper esophageal sphincter (UES, also called the pharyngoesophageal segment) is comprised of the upper esophagus, the cricopharyngeal portion of the inferior pharyngeal constrictor known as the cricopharyngeus (CP) muscle. Coordination of CP contraction and esophageal peristalsis is necessary to ensure adequate food transit into the stomach. Dysfunction of the pharyngo-esophageal segment can result in several clinical presentations and can include: dysphagia, aspiration, airway irritation, and intractable hoarseness (1). Our goal in this project was to contribute to the diverse experiences regarding treatment of symptomatic upper esophageal sphincter disorders and assess the operative modality used for success rates, complications, and economic impact. We also were able to compare our academic institution’s experience with a sample of the South Carolina Medicare database. The open approach is widely used as the majority of endoscopic instrumentation is performed via the open cervical neck dissection approach. Endoscopic laser diverticulotomy was performed on 47 patients with laser or GIA (gastrointestinal anastomosis) stapler assistance. The other three patients underwent either a cervical myotomy or cricopharyngeal myotomy; however, two of these cases were originally attempted as endoscopic and required conversion to an open procedure for adequate exposure (conversion rate 4%). This is compared to the MUSC experience comparing endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard. The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard. The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard.

METHODS AND MATERIALS
A chart review of patients treated by a single otolaryngology surgeon at MUSC from 2004-2010 for upper esophageal disorders, including hypopharyngeal diverticulum, cricopharyngeal bar, and upper esophageal stenosis, was conducted. The two primary modalities utilized were endoscopic diverticulotomy and transoral cervical myotomy. Records were searched by ICD-9 (530.3-stricture or stenosis of upper esophagus or 530.6-diverticulum of esophagus) and CPT codes 43425 (endoscopic laser diverticulectomy and myotomy) vs standard open-neck technique. Arch Otolaryngol Head Neck Surg 2002;128:141-44.

RESULTS
A comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard. The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard.

DISCUSSION
The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard. The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard.

CONCLUSIONS
The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard. The comparison of techniques reveals that long-term outcomes are similar, but the immediate postoperative sequelae of endoscopic diverticulotomy and with its widespread use, could be considered the new gold standard.

REFERENCES