Introduction

Pharyngoesophageal perforations are a major complication that may have serious adverse consequences for patients.1-11 2, 16,19 Inspecting the presence of a perforation is questionable, irrigation of the pharyngoesophagus with dilute methylene blue to help properly identify the fistula. A sternocleidomastoid flap was elevated from the lateral pharyngoesophagus. The wound’s mucosal edges were approximated with an inverting simple interrupted 3-0 chromic suture. A tracheostomy was also performed before the patient left the operating room. On examination on post-operative day 15, and the patient was discharged home on a normal diet. A tracheostomy was also performed before the patient left the operating room. On examination on post-operative day 15, and the patient was discharged home on a normal diet.

Case 1: Chronic Esophageocutaneous Fistula

M.C. is a 41-year-old male who underwent anterior cervical discectomy and placement of anterior cervical plate. On post-operative day 10 he complained of dysphagia. He was a former smoker with no history of heavy alcohol use. On physical examination he did not yet regain the strength and ability to swallow well to do his work. Two years following intervention to remove and repair the cervical plate and the pharyngoesophageal repair, the patient was still dysphagic. He was placed on a soft diet. A tracheostomy was performed before the patient left the operating room. On examination on post-operative day 15, and the patient was discharged home on a normal diet. A tracheostomy was also performed before the patient left the operating room. On examination on post-operative day 15, and the patient was discharged home on a normal diet.

Case 2: Esophageal Tear in the Early Post-Operative Period

J.P. is a 45-year-old male who underwent anterior and posterior approach to the cervical spine for depression and fusion. The patient on post-operative day 10 developed neck pain and dysphagia that required intubation after a swallowing test. A gastroscopy was performed before the patient left the operating room. On examination on post-operative day 15, and the patient was discharged home on a normal diet. A tracheostomy was also performed before the patient left the operating room. On examination on post-operative day 15, and the patient was discharged home on a normal diet.

Conclusion

Early diagnosis and treatment of pharyngoesophageal perforations is the key in improving overall mortality and morbidity from this complication. A high index of suspicion must be present for any patient who develops the signs and symptoms of perforation after neck trauma or cervical spine surgery in the pharyngoesophageal area. The use of local muscle flaps (sternocleidomastoid and thyrohyoid) is a definitive approach to the repair of cervical esophageal defects in the setting of pharyngoesophageal perforation. The sternocleidomastoid muscle flap can be used for many purposes including protection of the great vessels. Removal of cervical plates and bone grafts that are exposed to infection is essential to prevent the progression of infection. In addition, a C-reactive protein level over 40 mg/L indicates infection. Removal of posterior cervical plate and sternocleidomastoid muscle flap facilitates repair of the eosphageal tear. The otalaryngologist/head and neck surgeon with useful information for a rational approach to a complex problem. It is crucial to be able to properly identify and repair pharyngoesophageal perforations. The pharyngoesophageal tear was confirmed in all 3 cases in their ability to restore oral intake without the ongoing presence of a fistula. The patient in Case 2, although developed post-operative problems due to infection of his anterior cervical plate and osteomyelitis of his cervical spine. Kelly, et al reported in 1991 of the need for removal of bone graft and plates once they are exposed to infection. Kelly, et al also noted that the anterior cervical plate and osteomyelitis of the cervical spine was the primary cause of the infection. 12 Case 1 had a chronically draining esophageocutaneous fistula that quickly resolved after removal of his anterior cervical plate and sternocleidomastoid muscle flap. Case 3 was also posed to have problems after repair of his esophageal perforation due to infection of the anterior cervical plate and osteomyelitis of the cervical spine. The sternocleidomastoid flap was used to repair the patient in Case 2 improved after adequate drainage and removal of the anterior cervical plate.

References

7. vector = [0, 0, 1]; angle = 0; rotation = 0; scale = 1; shift = [0, 0];
8. vector = [0, 0, 1]; angle = 0; rotation = 0; scale = 1; shift = [0, 0];
9. vector = [0, 0, 1]; angle = 0; rotation = 0; scale = 1; shift = [0, 0];
10. vector = [0, 0, 1]; angle = 0; rotation = 0; scale = 1; shift = [0, 0];