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CASE STUDY

Pharyngocele☆

Faringocele

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Introduction

Pharyngocele is a rare pathology, which is usually asymptomatic. In 1979 Norris[1] indicated 18 cases published up till then and added another 24 that were diagnosed in 3 years, showing that pharyngocele was more common than what had been believed.

The pathology involves a dilation of the pharyngeal wall through its areas of muscular weakness. In the pathogenesis of pharyngocele, 2 factors are involved: pharyngeal wall weakness and increased intrapharyngeal pressure from chronic cough or repeated valsalvas of professional origin (glass blowers, wind musicians, etc.). The weakness of the pharyngeal wall can be congenital or acquired (advanced age, prior surgeries in the area).[1] Some authors postulate that it might be an anomoly of the branchial sinus.[2]

We present the clinical case of a male who had a symptomatic right pharyngocele lacking personal history of activities that develop with increased intrapharyngeal pressure. The patient was operated on because the hernia sac was very large.

Clinical Case

The patient was a 54-year-old male, who smokes 40 cigarettes/day and drinks moderately. He presents for a right lateral cervical mass of 10 days' progression and a change in the tone of his voice of several months' development. There is no relevant work or pathological history. Nasofibrolaryngoscopy revealed a mass of cystic appearance in the right vallecula that displaces the epiglottis, but does not affect vocal fold mobility. Upon cervical palpation, a soft mass can be felt in the right subdigastric area, increasing in size with valsalva manoeuvres. The CT requested showed an air-filled lesion, reported as suspicion of a very large mixed laryngocele on the right that displaces supraglottic structures contralaterally (Fig. 1). Because of size of the lesion, surgical treatment was chosen. This consisted of right lateral thyrotomy and extirpation, with routine tracheotomy because intubation was impossible. The pedicle of the pharyngocele was in contact with the common carotid behind, while it reached the hypoglossal nerve above. The opening of the pharyngocele made it possible to locate its origin in the vallecula (Fig. 2). The neck of the pharyngocele was severed and the pharynx was sutured, closing by planes, and a nasoesophageal tube was placed.

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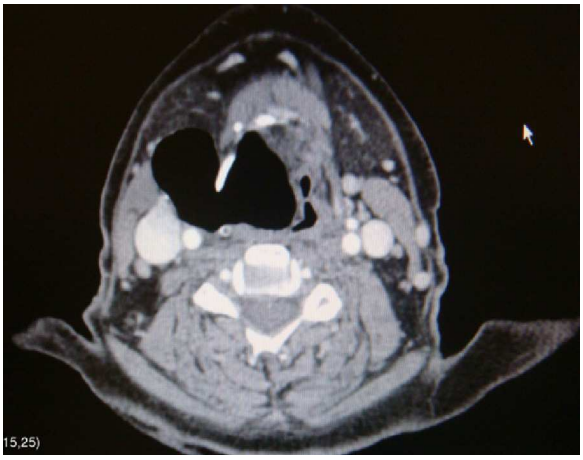

Figure 1 Axial CT section in which the image of the right laterocervical air content can be seen.

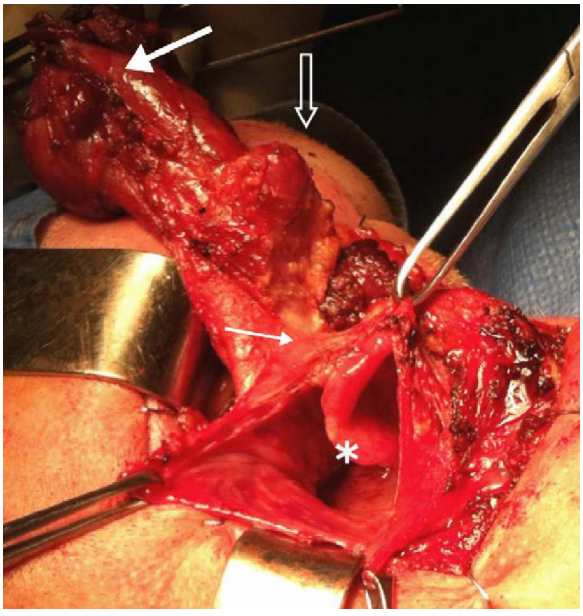

Figure 2 Surgical image of the pharyngocele. The thick arrow indicates the end and the thin arrow indicates the base. The asterisk marks the epiglottis and the open arrow, the chin.

Discussion

Pharyngoceles are classified as upper and lower, based on the area of weakness through which the hernia sac protrudes. In the lateral pharyngeal there are 2 areas that lack a muscular layer, being located between the superior and middle constrictor muscle, and between the middle and inferior constrictor muscle.[1] The upper pharyngocele originates in the lateral zone of the vallecula and is small and asymptomatic. Our clinical case corresponds to this group, but its large size was the reason for the consultation.

Differential diagnosis for pharyngocele should include numerous entities such as Zenker's diverticulum,[3] laryngocele and jugular vein phlebectasia,[4] which are pathologies that involve increase in size with the valsalva manoeuvre. This pathology is frequently mistaken for laryngocele because the symptoms overlap. Anatomically, both protrude through the thyrohyoid membrane; however, the laryngocele develops from the laryngeal ventricle as a result of increased glottic pressure.[3]

Barium swallow can be used to locate the point of pharyngeal herniation.[5,6]

In asymptomatic pharyngocele the treatment of choice is conservative.[1] It consists of maintaining appropriate oral hygiene to prevent bacterial growth and of avoiding activities that involve increases in intrapharyngeal pressure. Surgical treatment through external extirpation of the hernia sac is considered when the size or the associated signs and symptoms are significant.[3]

Conflict of Interest

The authors declare no conflict of interest.

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