HYPOPHARYNX Tumours of the hypopharynx

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Benign Benign tumours of the hypopharynx are very rare, the most common being the fibroma and the leiomyoma. They show a smooth, submucosal mass lying in the lumen of the hypophar ynx or oesophagus. Malignant Malignant tumours of the hypopharynx are almost exclusively squamous cell carcinomas and typically behave aggressively . The tumours are usually classified according to their probable anatomical site of origin from the piriform fossa, postcricoid region or posterior pharyngeal wall. Marked di ff erences in the incidence of these tumours occur globally because of factors such as iron deficiency anaemia (see Sideropenic dysphagia). They may be associated with marked submucosal spread, which further complicates evaluation. Tumours arising from the piriform fossa and posterior pharyngeal wall may spread to upper or lower cervical nodes. Tumours arising in the postcricoid area typically metastasise to paratracheal and paraoesophageal nodes, which may not be palpable. As with other non-HPV head and neck cancers, alcohol and tobacco are two principal carcinogens. Postcricoid carcinoma, though rare, is more common in women than in men. Thomas Hodgkin , 1798–1866, Curator of the Museum and Demonstrator of Morbid Anatomy , Guy’s Hospital, London, UK, described lymphadenoma in 1832. - considered in all patients presenting with dysphagia, hoarse - ness or referred otalgia, particularly if they have a history of smoking or significant alcohol consumption. Fibreoptic endoscopic examina tion in the clinic may show only subtle signs such as oedema or pooling of saliva unilater - ally in the piriform fossa. Note should also be made that this region is not well seen on flexible gastroscopy . The pr eferred investigation is with direct rigid phar yngoscopy and oesopha - goscopy with biopsy under a general anaesthetic. All regions of the neck must be assessed in a systematic manner. Fine-needle aspiration is advocated for suspicious nodes. Radiological examination As for other head and neck cancers, a suspected primary tumour requires an MRI or CT scan of the neck together with a CT scan of the thorax and upper abdomen. Treatment Squamous cell carcinoma of the hypopharynx commonly presents late and carries a poor prognosis. Early lesions may be treated with radiotherapy or transoral robotic or transoral laser microsurgical resection and a neck dissection plus postopera - tive radiotherapy . Non-surgical strategies, designed to preserve function, rely on chemoradiotherapy . Major open excisional surgery is generally used for recurrence after radiotherapy or as primary excision in advanced disease . Total laryngectomy and either partial or total pharyngectomy followed by pharyngeal reconstruction involving myocutaneous or free flap reconstruc - tion (e.g. jejunum or anterolateral thigh) or gastric transposition is commonly required (Figure 52.38). Swallowing and voice -

Figure 52.38 Total pharyngolaryngectomy specimen showing hypopharyngeal carcinoma (hypopharynx opened from the posterior aspect of the resection).

surgery if they are to adjust and maintain some quality of life. Summary box 52.7 Tumours of the hypopharynx /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Variable symptoms – discomfort, pain, dysphagia, hoarseness Incidence increased by history of smoking and alcohol Expert examination with nasendoscopy Late presentation Referral to multidisciplinary team for detailed assessment and treatment – radiotherapy with/without chemotherapy, transoral or open surgery

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