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Letters to the Editors

Management of globus pharyngeus: review of 699 cases

J Laryngol Otol 2004;**118**:522–7

Dear Sirs,

My colleagues and I read with interest the article by Harar *et al*.[1] in the July 2004 issue of your journal. We agree with the authors that a policy of not investigating a patient with globus symptoms could produce significant savings for the health service. However, one needs to be more vigilant in those patients who are at high risk of developing a cancer, e.g. those of a typical age and sex with a history of heavy smoking.

We were recently referred a 65-year-old man, who was initially seen by his general practitioner (GP) in August 2004 with a history of difficulty in swallowing solid food. The patient was able to swallow fluids reasonably well and there was no history of vomiting. He had no associated weight loss. He had been smoking about 10 cigarettes a day for more than 20 years.

This gastroscopy was done by gastroenterology team for reflux symptoms in April 04. He subsequently developed dysphagia symptoms in August 04 and was seen by the GP, who organised the barium swallow for Sep 04. He underwent rigid oesophagoscopy in Dec 04 by ENT surgeon which led to the diagnosis.

Because of persistent symptoms, the patient was referred to the ENT clinic in December 2004. Clinical examination at this time showed normal findings except for pooling of saliva in the pyriform fossae. The patient subsequently underwent a rigid oesophagoscopy, which revealed a hard, fixed mass in the posterior wall of the oesophagus at 15 cm, which the scope could not be passed beyond. Biopsy of the lesion revealed a poorly differentiated squamous cell carcinoma. The patient was referred for further management.

The barium swallow did not pick up the extensive growth in the upper third of the patient's oesophagus. This false negative finding delayed his referral to our ENT clinic. I therefore wish to emphasize that those patients who are at high risk of developing a cancer warrant further investigation.

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Reference

1 Harar RPS, Kumar S, Saeed MA, Gatland DJ. Management of globus pharyngeus: review of 699 cases. *J Laryngol Otol* 2004;**118**:522–7

Author's reply

We agree entirely with Mr Suryanarayanan that a barium swallow is an insensitive investigation, and in our paper we mentioned that barium swallow may fail to detect 50 per cent of hypopharyngeal malignancies. Clinicians need to beware false reassurance from contrast studies, and it is most unfortunate that this patient's GP delayed his referral, especially now that possible head and neck cancer cases in the UK are seen promptly within two weeks of referral.

However, the focus of our paper was on globus pharyngeus patients rather than patients with marked dysphagia. The current UK practice is to thoroughly investigate the most typical of globus pharyngeus cases, even in young, non-smoking patients. The message of our paper was to recommend against such overly invasive management.

In our study and in the literature, not a single malignancy has been detected on barium studies of typical globus patients. We found that about two-thirds of our series were typical globus patients and suggested that they required no further investigation other than an out-patient transnasal fibre-optic flexible endoscopy. Provided that this assessment of the upper aerodigestive tract was adequate, we recommended that the patient be discharged after their first consultation.

The management of atypical globus pharyngeus patients is more debatable, and we suggested two possible investigative strategies:

(1) Transnasal fibre-optic endoscopy and barium swallow, followed by flexible oesophagoscopy if deemed necessary.
(2) Transnasal fibre-optic endoscopy and flexible oesophagoscopy, avoiding barium studies altogether.

A few patients will remain with clinical suspicion of serious pathology, and in this group rigid endoscopy will be required.

The above protocol would not have applied to Mr Suryanarayanan's case as it is only applicable to globus pharyngeus patients. In his case of dysphagia with salivary pooling in the pyriform fossae, an examination under anaesthesia may have been warranted at an earlier stage.

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