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شبكة المعلومات الجامعية

التوثيق الالكتروني والميكروفيلم

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MANAGEMENT OF PHARYNGOCUTANEOUS FISTULA AFTER TOTAL LARYNGECTOMY FOR LARYNGEAL CANCER

Thesis

Submitted For Partial Fulfillment For The Master Degree In

" EAR NOSE AND THROAT "

By

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(M.B., B. Ch.)

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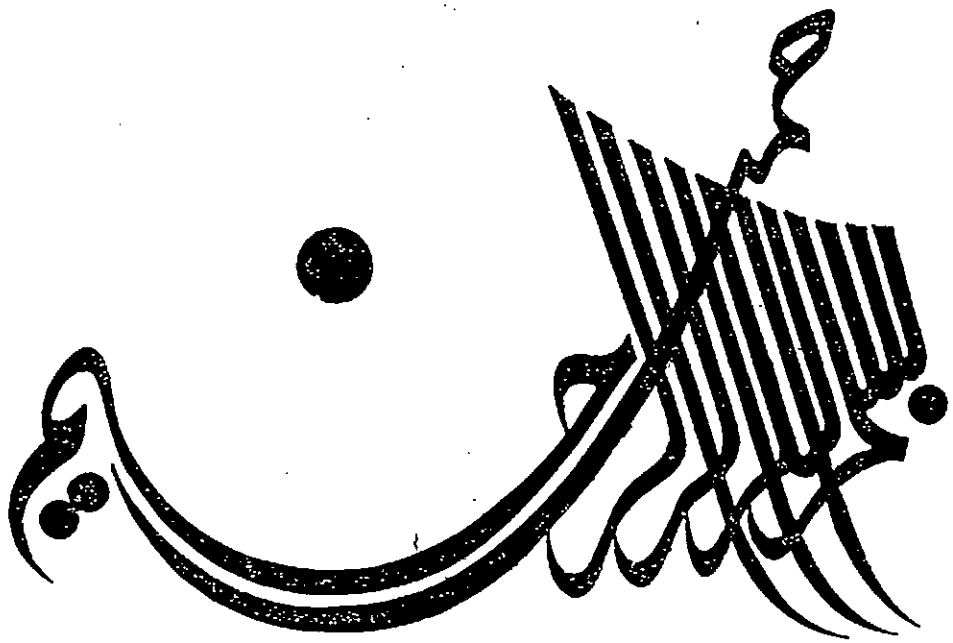


قالوا سبحانك لا علم لنا إلا ما علمتنا
إنك أنت العليم الحكيم

صدق الله العظيم
(٣٢ / البقرة)

ACKNOWLEDGEMENT

First and formost, thanks are due to **ALLAH**.

I wish to express my sincere appreciation and everlasting gratitude to Prof. Dr. **ABDEL-HAY RASHAD EL-ASSY**, *Professor of Ear; Nose and Throat - El-Menoufyia University, for his helpful suggestion, instructive supervision nad experienced guidance together with the revision of the text.*

I wish to express ny deepest gratitude and sincere indebtedness to Prof. Dr. **MAHMOUD MOUSTAFA BASSIOUNY**, *Professor of Surgical Oncology, National Cancer Institute - Cairo University. Without his prospective guidance and full provision of all facilities, with the revision of the text, the undertaking of such a task would have been a practical impossibility.*

Gracious thankfulness are due to Dr. **AMR ALI SOBEIH**, *Lecturer of Ear, Nose and Throat El Menoufyia University, for his cordial supervision, continuous encouragement, together with the revision of the text.*

I am deeply grateful for Dr. **MOHAMED AKRAM METWALY**, *Lecturer of Ear, Nose and Throat El Menoufyia University, for his valuable advices and continuous support.*

Extended thanks are due to Dr. **M. HANI EL-NAGGAR**, *Lecturer of Surgical Oncology, National Cancer Institute- Cairo University, for his continuous encouragement and help.*

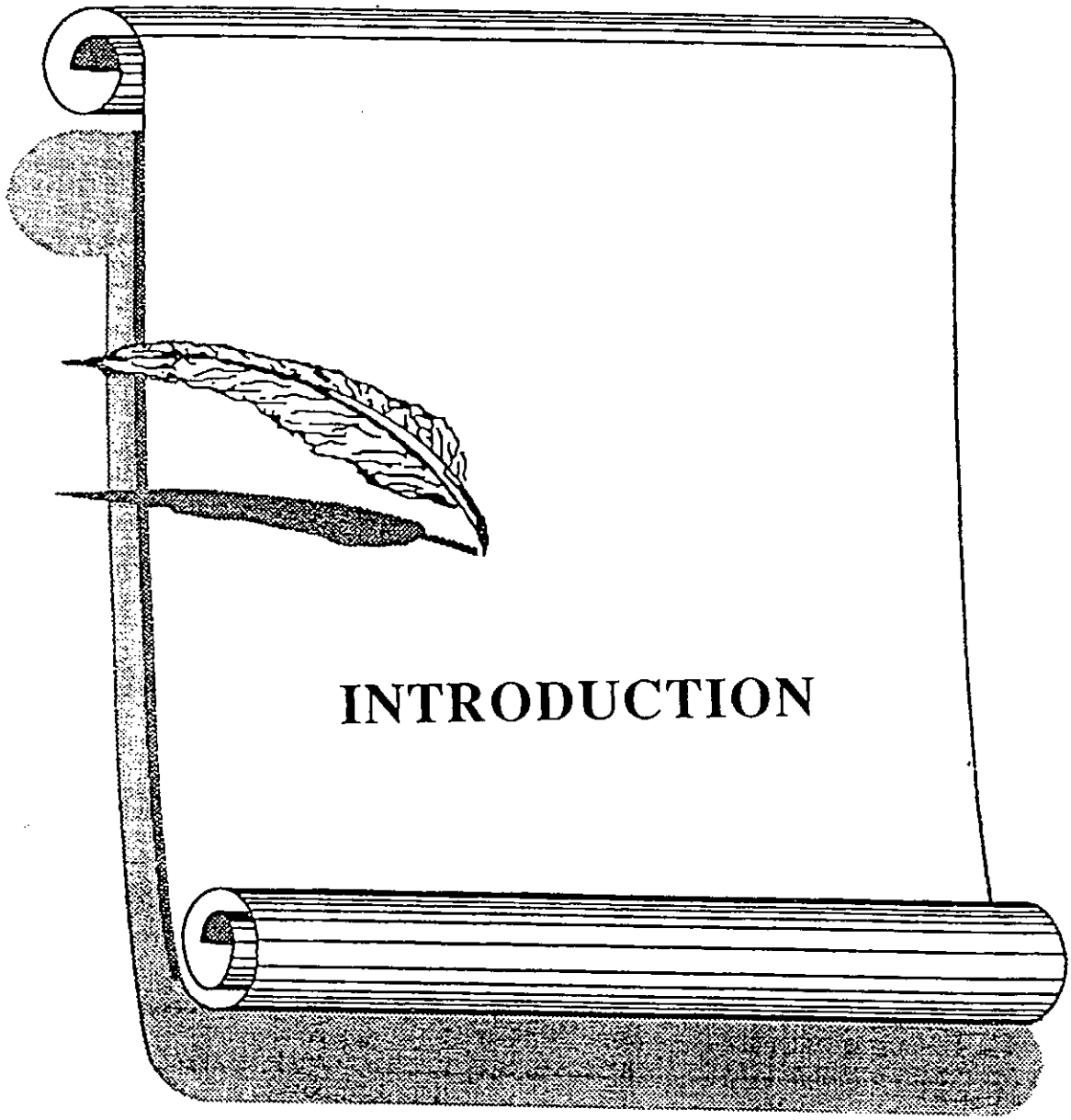
I am especially thankful to Dr. **M. SAAD ZAGHLOUL**, *Assistant Professor of Radiotherapy, National Cancer Institute - Cairo University, for his support and valuable advice.*

Last, I wish to express my deepest gratitude to all the members of Ear, Nose and Throat Department, Faculty of Medicine - El Menoufyia University for their efforts to help to see this work come to light.

LIST OF ABBREVIATIONS

BND	=	Block neck dissection
D.M.	=	Diabetes Mellitus
DPF	=	Deltopectoral Flap
ETMCF	=	Extended Island (Lower) Trapezius Myocutaneous Flap
Gy	=	Gray
JF	=	Free Jejunal Flap
LDMCF	=	Latissimus Dorsi Myocutaneous Flap
LTMCF	=	Lateral Island Trapezius Myocutaneous flap
PCF	=	Pharyngocutaneous Fistula
PMMCF	=	Pectoralis Major Myocutaneous Flap
RFF	=	Free Radial Forearm Flap
SCMM	=	Sternocleidomastoid Myoplasty
TMCF	=	Trapezius Myocutaneous Flap(s)
UTMCF	=	Upper (Superior) Trapezius Myocutaneous Flap

CONTENTS



INTRODUCTION

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Treatment of laryngeal carcinoma falls into the following categories; palliative therapy or radical (curative) treatment. Curative treatment may involve radiotherapy, surgery or chemotherapy. (Robin and Olofsson, 1987).

Surgical treatment of laryngeal carcinoma historically precedes radiation therapy. Billroth carried out the first total laryngectomy in 1873. Nowadays, the following types of laryngectomy are used; partial resection and total resection which may be performed as total laryngectomy alone or with partial pharyngectomy and/or partial glossectomy. The operation of radical block dissection of cervical lymphatic chain may be combined with any of these procedures (Robin and Olofsson, 1987).

The most common serious complication following total laryngectomy is spontaneous pharyngocutaneous fistula. It exacerbates post-operative morbidity and expense with long hospitalization and probably further operative procedures. There is a very wide range of the world-wide incidence of post-operative pharyngocutaneous fistulas (Violaris and Bridger, 1990).

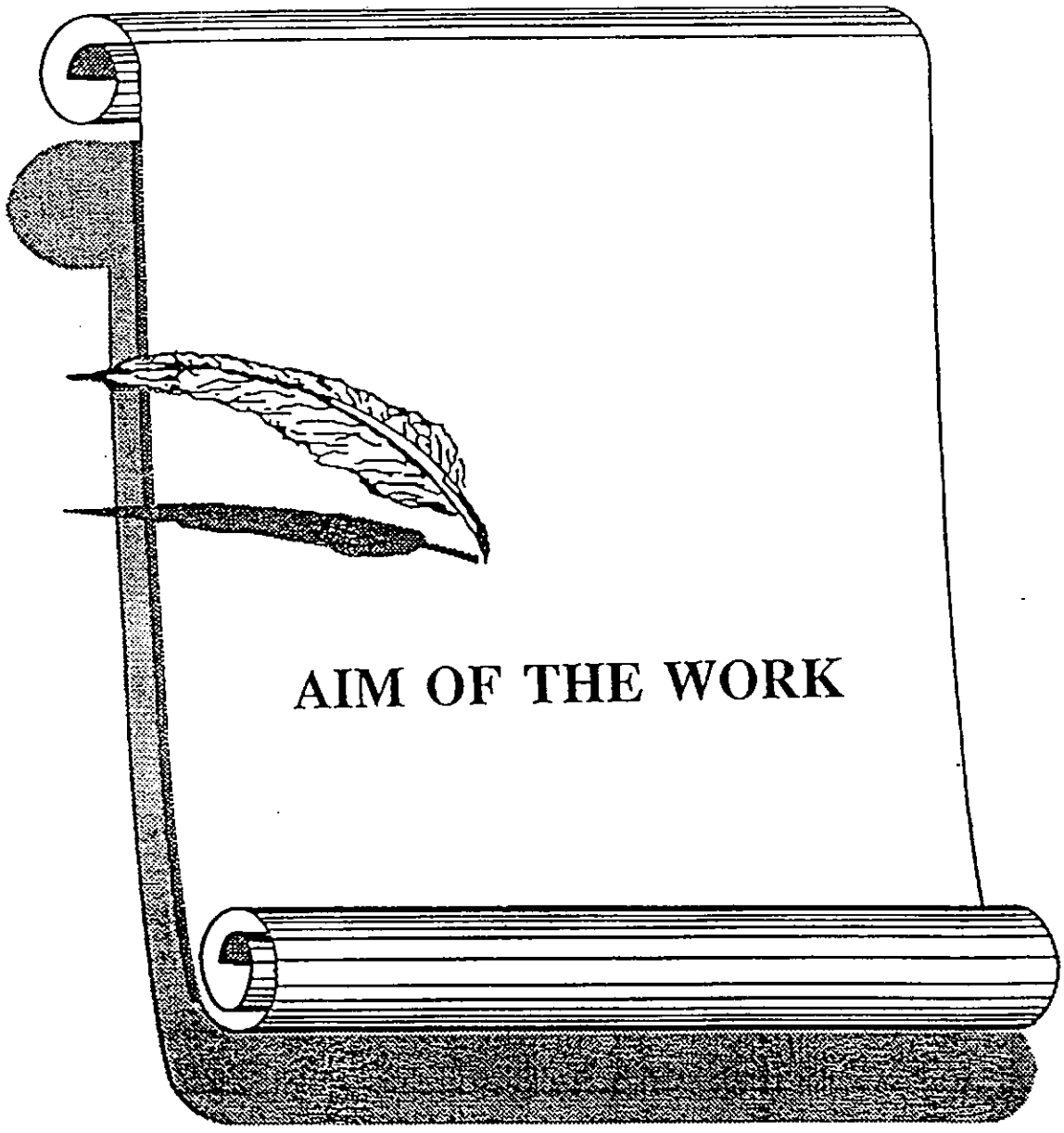
An obvious comment on these figures is that each series comprised the patients of different surgeons and therefore there might be differences in the pre-operative management, operative technique and post-operative management. Many factors have been shown to be significant in the etiology of fistula. Briant

(1975) found that prior radiotherapy and radical neck dissection produced an increased rate of fistula formation. Dedo et al.(1975) reported other factors as being important like persistent carcinoma and tumor extension to the posterior pharyngeal wall. LaVelle and Maw (1972) found that a post-operative hemoglobin level less than 12.5 gm% and pre-operative tracheostomy were significant factors.

Management of pharyngocutaneous fistula includes preventive measures as peri-operative nutritional supplimentation, peri-operative antibiotics and improved surgical techniques (Robb and Swartz, 1986).

The second line of management is conservative measures consisting of adequate wound drainage, antiseptic gauze packing, nasogastric feedings and frequent antibiotic oral swishes to irrigate the fistula. (Maw and LaVelle 1972; Conley 1979).

Surgical procedures for treatment of persistent fistula include local procedures (that show high failure rate) and regional flaps as delto-pectoral flaps which have been long used for cervical reconstruction. Then, the musculocutaneous flap and free micro-vascular tissue transfer replaced the deltopectoral flaps as they increased the potential for reconstruction of significant head and neck defects. they included pectoralis major and latissimus dorsi musculocutaneous flaps which can be modified nowadays to close both mucosal and cutaneous defects with the same flap in one-stage reconstruction (Robb and Swartz, 1986).



AIM OF THE WORK

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This study aims at evaluating the incidence of pharyngo-cutaneous fistula after total laryngectomy and the most significant contributing factors that share in the etiology of such fistula.

Also, it evaluates the various lines of management of fistula that have been formed.