Objective
Cervical pharyngostomy was initially used for prolonged enteric feeding. In cases of complete pharyngo-esophageal stenosis, cervical pharyngostomy may be proposed to derive the saliva and prevent chronic aspirations. We report our experience with this procedure and discuss the potential indications in pediatric patients.

Materials and methods
Retrospective analysis including 6 patients who underwent cervical pharyngostomy for complete pharyngo-esophageal stenosis requiring delayed reconstruction. The procedure was performed under general anesthesia. After a limited cervicotomy, the pharyngeal wall was dissected by a prevascular approach. The hypopharyngeal wall was sectioned vertically immediately above the cricopharyngeal muscle, and behind the thyroid alar. The border of the pharyngeal wall was then suture to the skin (figure 1, 2). A Blake or Montgomery T-tube was placed in the pharyngostomy for 2 weeks, and the saliva was collected in an urinary bag (figure 3). We reported clinical data and functional outcome.

Results
The population included 2 females and 4 males with a mean age of 29 months (2 to 92 months). Patients presented with long gap esophageal atresia in 4 cases, including 3 type A atresia and 1 type C atresia, and caustic stenosis in 2 cases, involving hypopharynx in one case and upper esophageus sphincter in one case. Associated malformations were observed in 4 cases.

All patients required enteral feeding by gastrostomy, and salivary reduction by atropinic treatment in 3 cases and botulinum toxin injection in 3 cases. One patient required a tracheostomy because of associated laryngeal atresia. Symptoms included salivary aspiration in 6 cases, shocking in 4 cases and chest infection in 6 cases. All patient required oropharyngeal salivary drainage, by continuous suction in 4 cases and discontinuous suction in 2 cases. Cervical pharyngostomy was performed after a mean delay of 3.5 months (2 to 6 months).

No complication was observed during the procedure, but one patient presented a post-operative respiratory distress related with tracheomalacia.

Oropharyngeal suction could be stopped postoperatively in all cases. Oral stimulation using small quantity of food was introduced in all cases. Geans were observed after a mean delay of 3.5 months (2 to 6 months).

Conclusion
Derivation cervical pharyngostomy may be proposed in severe case of complete pharyngo-esophageal stenosis requiring delayed reconstruction. This technique may avoid long term oropharyngeal suction, salivary aspiration, and allows early oral stimulations.