Controlled prospective evaluation of the diagnostic yield of a laryngopharyngeal screening examination during upper gastrointestinal endoscopy

B Mullhaupt, D Jenny, S Albert, S Schmid, M Fried

Background and aims: Examination of the laryngopharyngeal area is not always performed during routine upper gastrointestinal (UGI) endoscopies although older studies reported pathological findings in 0.9–3.5% of cases. The aim of our study was to prospectively evaluate the positive and negative predictive value of screening the laryngopharyngeal area during routine UGI endoscopy.

Methods: All patients undergoing elective UGI endoscopy between July 2000 and July 2001 were prospectively enrolled into the study. These patients underwent a careful structured examination of the laryngopharyngeal area, which was videotaped for later blinded review. If a pathological finding was suspected, patients were referred to the study otorhinolaryngologist for further evaluation. In all other cases the videotapes were reviewed by the otorhinolaryngologist, who was blinded to the endoscopic findings.

Results: During the study period, 1311 endoscopies were performed in 1209 patients; 1191 were fully evaluated. In 62 endoscopies a pathology in the laryngopharyngeal area was suspected. Forty-two were examined by the study otorhinolaryngologist whereas in the remaining 19 only a review of the videotape was possible. In 26 patients pathology was confirmed, corresponding to a positive predictive value of 43% and a negative predictive value of 100%. In one patient (0.08%), an early cancer of the pharyngeal region was detected whereas all other findings were benign lesions.

Conclusions: A screening examination of the laryngopharyngeal area should be part of every UGI endoscopy. A serious pathology such as an early cancer may be detected in approximately 1 in 1000 endoscopies.

Abbreviations: UGI, upper gastrointestinal
The whole examination of the laryngopharyngeal area was recorded on videotape for later blinded review by an experienced study otolaryngologist. Patients with a suspected pathology in the laryngopharyngeal area were, in addition, directly referred to the otolaryngologist for indirect laryngoscopy, the standard method of examination of this area. If the study otolaryngologist suspected a pathological lesion during review, he arranged further examinations. The results of the first part (July 2000–December 2000) were compared with those of the second part (January 2001–July 2001) of the study in order to detect a learning curve effect during the progress of the study.

**Statistical analysis**
Statistical analysis of the results was made using the \( \chi^2 \) test. Results are presented as median (range). A \( p \) value of <0.05 was considered statistically significant.

**RESULTS**
During the study period, 1311 endoscopies were performed in 1209 patients; 627 were male and 582 female. Median age was 53 years (range 16–93). In 94 cases an adequate examination of the laryngopharyngeal area could not be performed, generally because of excessive gagging. Therefore, a thorough examination of the laryngopharyngeal area was possible in 93% of cases. In addition, six cases were excluded because of a known pathology in the laryngopharyngeal area, in four the videotape recording did not work, and in 16 the quality of the video tape was not sufficient for a thorough evaluation by the study otolaryngologist. Therefore, 1191 endoscopies were fully evaluated (fig 1).

A total of 1129 (95%) examinations were judged to be normal by the gastroenterologists, and the study otolaryngologist reviewed the videotapes and found no additional pathologies. In 62 (5%) endoscopies a pathology was suspected in the laryngopharyngeal area by the endoscopist and patients were referred for further examination to the study otolaryngologist. Forty two patients were directly examined whereas the remaining 19 patients refused such an examination. In 26 (42%) patients, all directly examined by the study otolaryngologist, the pathology was confirmed whereas in 36 (58%) patients either directly examined by the study otolaryngologist (\( n = 16 \)) or after review of the videotapes (\( n = 20 \)) no pathologies were noted. This corresponds to sensitivity, specificity, and negative and positive predictive values of 100%, 97%, 100%, and 42% respectively.

The confirmed pathologies are listed in table 1. The most common findings were chronic laryngitis (seven cases), retention cysts (five cases), Reinke oedema (four cases), dysphonia (three cases), and different minor lesions (six cases). The most important finding was an early supraglottic cancer T1 N0 (fig 2) which was treated by local CO\(_2\) laser ablation. Two years later, there is still no evidence of a recurrence.

<table>
<thead>
<tr>
<th>Pathology</th>
<th>No of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic laryngitis</td>
<td>7</td>
</tr>
<tr>
<td>Retention cyst</td>
<td>5</td>
</tr>
<tr>
<td>Reinke oedema</td>
<td>4</td>
</tr>
<tr>
<td>Dysphonia</td>
<td>3</td>
</tr>
<tr>
<td>Neoplasia</td>
<td>1</td>
</tr>
<tr>
<td>Different minor lesions</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
</tr>
</tbody>
</table>

In the first part of the study (July–December 2000), in 35 (6.6%) of the 527 examinations a pathology was suspected by the gastroenterologist whereas in the second part of the study (January–July 01) this number decreased to 27 (4.0%) out of 680 examinations; this difference was significant (\( p = 0.04 \)). Also, the number of confirmed pathologies was higher in the second part of the study (second part: 13/27 (48%); first part: 13/35 (37%); NS).

**DISCUSSION**
Our study has shown that careful examination of the laryngopharyngeal area is possible during most routine endoscopies and may provide significant clinical findings. Failure to visualise the vocal cords and the associated structures was usually caused by patient retching and gagging. In the two prospective studies published so far, the success rate for visualisation of the laryngopharyngeal area ranged from 78% to 95%. Therefore, in the majority of upper gastrointestinal endoscopies, performed with appropriate sedation, visualisation of the laryngopharyngeal area is possible without additional patient discomfort, and little additional time is required to complete the whole examination. In 5% of all endoscopies a pathology was suspected by the gastroenterologist, which was finally confirmed by the
Examination are more important statistical parameters than sensitivity and negative predictive value of a screening examination should identify all patients at risk, the negative predictive value of our study was 100%. As screening examination and the remainder were not examined.

We detected one case of a supraglottic cancer which amounts to a cancer prevalence in the laryngopharyngeal area of approximately 1 per 1000 endoscopies. This is very similar to the prevalence of approximately 1.85 per 1000 in a previous study. In another study, no cancer lesions were found but two precursor lesions were detected. The other lesions detected in our series were benign, such as chronic laryngitis and Reinke oedema, which are nevertheless of clinical relevance.

This is the first prospective study which attempted to determine the rate of false negative examinations. In the three published studies, no such controls were included (table 2). In contrast with the positive predictive value, the negative predictive value of our study was 100%. As screening examinations should identify all patients at risk, the sensitivity and negative predictive value of a screening examination are more important statistical parameters than the positive predictive value. Although video review may not be as sensitive for the detection of a pathology as a direct examination, this was in our opinion the only practical way to control for false negative examinations.

The number of false positive findings was reduced by 11% in the second half of the study compared with the first half, indicating that there is a learning curve for the confident detection of laryngopharyngeal pathologies. Therefore, thorough teaching and continuous training is mandatory to achieve sufficient diagnostic accuracy in the screening of the laryngopharyngeal area during UGI endoscopy.

Gastroscopy is one to the most frequent diagnostic procedures performed. In the USA, approximately 1.5 million outpatient endoscopies are performed each year. Assuming a cancer detection rate of approximately 1 per 1000 endoscopies, as shown in our study, examination of the laryngopharyngeal region could lead to the detection of 1500 new potentially curable cancers. Therefore, with the little extra time needed at no extra cost and the negligible risk and discomfort, a screening examination of the laryngopharyngeal area should be an integral part of every upper oesophago-gastro-duodenoscopy.

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**REFERENCES**


**EDITOR’S QUIZ: GI SNAPSHOT**

**Answer**

From question on page 1219

The endoscopic picture was suggestive of ischaemic necrosis of the duodenal folds and the histological changes were consistent with ischaemic mucosal damage. Histological appearance of ischaemia in the duodenum is not pathognomonic and therefore it is essential to provide the pathologist with a good history. Extensive haemoconcentration in Addisonian crisis seemed to have reduced mucosal blood circulation with subsequent necrosis. However, the endoscopic appearance after treatment underlines the pathophysiology of the mucosal damage. The patient was treated by rehydration and hydrocortisone replacement therapy and recovered well. To date, ischaemic duodenitis has been described only in patients with classical abdominal angina or severe atheromatous disease of the splanchnic arteries (Force T, MacDonald D, Eade OE, et al. Ischemic gastritis and duodenitis. Dig Dis Sci 1980; 25:307–10). To our knowledge, this case is the first description of ischaemic duodenitis in a patient with Addisonian crisis.

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