has been also reported with duodenocutaneous leaks. Most series report removal of the stents after approximately 6 weeks. Migration of fully covered removable stents is a significant problem, and occurs in up to 58% of cases. Dissolvable synthetic sutures have been used to minimise stent migration. This first report expands the potential use of temporary stenting to include the management of complex high-output duodenal fistulas following trauma.

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To the Editor: An 89-year-old woman was referred to Grey’s Hospital after a coughing spell at home during which she coughed out a tissue mass which appeared to be attached to her pharynx. She had previously been well, complaining only of occasional gastro-oesophageal reflux and episodes of dysphagia. Neither had been severe enough for her to seek medical attention. She had no other history of relevance.

She was relatively fit, with a left lower respiratory tract infection and a long protruding soft-tissue structure lined by mucosa and containing a distal soft-tissue mass attached to her left pharynx (Fig. 1). She had no pain, but did have acute dysphagia. A water-soluble contrast swallow showed only moderate narrowing of the proximal oesophagus.

Under anaesthetic, oesophagoscopy revealed the origin of the protruding tissue mass to be at the cricopharyngeus, establishing the diagnosis of a prolapsed Zenker’s diverticulum that was repaired via a left lateral cervical incision. An oesophagostomy allowed the prolapsed Zenker’s diverticulum to be returned to its original position. A standard diverticulectomy and myotomy were then performed.

She recovered well; a contrast swallow after 72 h confirmed restoration of the oesophageal lumen. She was discharged when she could eat a normal diet. The resected diverticulum was found to contain an atypical lipomatous tumour, the lead-point of the prolapse which followed a severe coughing episode.

Recognised complications relating directly to the diverticulum itself are rare and may include fistulation or mediastinitis secondary to iatrogenic perforation, the development of food bolus bezoars, haemorrhage from the pouch secondary to chronic mucosal irritation, and inflammation owing to retained food, NSAIDs or acid reflux. Peptic ulceration within the pouch has also been described.

We believe this to be the first report of a prolapsed Zenker’s diverticulum.

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REFERENCES

Prolapse: rare complication of a Zenker’s diverticulum

Fig. 1. The patient on presentation.