CYST VALLECULA UNUSUAL PRESENTATION

Naresh Nathani,* P.C Verma,** Man Prakash Sharma.***

Abstract: Laryngeal cysts, particularly cyst vallecula are generally benign lesions which cause mild dysphagia or change in voice. We report here a case of cyst vallecula that caused soreness of throat, dysphagia and change in voice. A 22-year male presented with progressive dysphagia and muffled voice secondary to a large cystic mass involving entire vallecula and during coughing presented in oral cavity. Per oral marsupialization done and the problem resolved.

Keywords: Dysphagia, cyst vallecula, laryngeal cysts.

INTRODUCTION

Cysts of larynx are usually benign i.e. non metastasizing masses. The majority of cysts seen in adulthood are asymptomatic, or occur with mild symptoms such as a lump in the throat or voice alterations.⁴ Cysts of the larynx, recently named lateral saccular cysts by Desanto (1970), arise in one of three ways.² They may be derivatives of third visceral pouch, development abnormalities incurred during canalization of laryngeal ventricle and saccule, or form from epithelial buds sequestered during saccular development.

The cysts may become symptomatic at any time from birth to adulthood. The symptoms vary from relatively mild to severe and consist of vocal changes respiratory distress and deglutatory difficulties.⁸ The most common site of laryngeal cysts is on the lingual surface of the epiglottis^{1,3}, but the lesions may occur within the endolarynx and can involve the aryepiglottic folds.

Treatment is dependent on size, anatomical location, and degree of respiratory compromise. Tracheostomy may be necessary to ensure and protect a patent airway prior to definite treatment of the problem. Surgical therapy is most often incision and drainage, but many other methods have been described.^{1,5} We report here a successful management of a huge cyst vallecula by marsupialization.

CASE REPORT

The patient was 22 year male who presented to us in ENT OPD of SMS Medical College, Jaipur in January 2006 with one history of sore throat, and one month history of progressive dysphagia and change in voice. He denied previous fever, odynophagia, trauma or similar past problems. Physical examinations was significant for a "hot potato voice". On examination large cystic mass found filling posterior part of oral cavity and oropharynx. Indirect mirror examination revealed a large pedunculated cyst filling oropharynx, epiglottis and vallecula.

Computed tomography of the neck demonstrated a huge cystic lesion involving vallecula entire epiglottis, left aryepiglottic fold and lateral pharyngeal wall. Marsupialization done and the mass was removed. There was no evidence of recurrence till now postoperatively.

DISCUSSION

Cysts of the larynx, including the epiglottis and vallecula are rare lesions. They are routinely identified on mirror laryngoscopy and may go untreated if asymptomatic. The most common locations of laryngeal cysts are the lingual surface of the epiglottis, the free margins of vocal cord, the arytenoids and aryepiglottic fold, the pyriform sinus, and the ventricle. Laryngeal or epiglottic cysts are found at any age, although they occur less frequently in children than in adults.

Presenting symptoms vary with cyst size, age and extension into the airway. Infants, because of their small larynxes, may present with dyspnea and laboured breathing stridor, or difficulty in feeding. The adults complain of symptoms similar to other space occupying lesions of the airway.⁴ Occasional complaints of hoarseness or other voice alterations are more commonly seen with dysphagia, as noted in our case. The origin of these cysts is thought to be from obstruction of the ducts of mucous glands resulting in subsequent glandular lining dilation. The cyst epithelial lining is most often stratified squamous epithelium.²

De Santo et al² (1970) divided the normal glandular ducts of the laryngeal mucosa into three types: collecting, interlobular and intralobular. Obstruction of the collecting ducts is thought to be the most common cause of laryngeal cysts. De Santo et al² (1970) divided laryngeal cysts into two major divisions, saccular and ductal. A third type thyroid cartilage foraminal cyst, was described as an isolated case. Ductal cysts (76%) are much more common than saccular (24%).

Newman⁶ in 1983 argued that the anatomic relationships which comprise Desanto's system are usually destroyed during surgery, making an accurate pathologic diagnosis on these grounds impossible. He states that the epithelial lining can be used to better characterize these cysts. Epithelial cysts, in his systems, correspond to the lesions described by Desanto, both ductal and saccular. In addition, he introduces the tonsillar and oncocytic cysts. Tonsillar cysts are typified by a lining epithelium which had undergone oncocytic metaplasia. Newman felt that these epithelial types had clinical significance in describing the behavior of the cysts. Tonsillar cysts were more likely to found in young patients and to be located in the vallecula, epiglottic and pyriform sinuses.

Fig. 1 : CT Scan showing large cyst arising from vallecula.

Fig. 2 : Large cystic lesion involving left vallecula and lateral pharyngeal wall.

Fig. 3 : Large cystic lesion involving left lateral pharyngeal wall.

Recently a modified working classification of laryngeal cysts has been proposed by Ramesar et al⁷ (1988), based on histology. However because this classification is based on histology it is largely retrospective and it diverts attention from the site, which is the primary factor in management.

Treatment of these cysts depends on their size and location. Tracheostomy is necessary if standard endotracheal intubation cannot be performed. Puncture of the cysts to allow decompression adds the risk of pulmonary aspiration; this procedure is not recommended prior to securing an airway. Many of these cysts may be treated by utilizing direct laryngoscopy⁹, incision with microsurgical instruments or removal with a nasal snare⁹ or tonsillotome.¹ Giant obstructing cysts may be removed by the trans oral route, but may require a lateral pharyngotomy¹ or laryngofissure^{1,2} for complete excision.

This case of vallecula cyst was marsupialized under general anesthesia without tracheostomy with nasotracheal intubation and follow up was uneventful.

REFERENCES:

1. Asherson N. Large cysts of the epiglottis: a classification and case records. *JLO*, 1957;71:730-43.
2. DeSanto LW et al. Cysts of the larynx-classification. *Laryngoscope*, 1970;80:145-76.
3. Heeneman H, Ward KM. Epiglottic abscess: its occurrence and management. *J Otol Laryngol*, 1977;6:31-6.
4. Henderson et al. Airway obstructing epiglottic cyst. *Ann Otol Rhinol Laryngol*, 1985;94:473-6.
5. Keenleyside et al. Management of pre-epiglottic cysts: a report of nine cases. *Can Med Assoc J*. 1968;99:645-9.
6. Newman DH ET al. laryngeal cysts in adults: a clinicopathologic study of 20 cases. *Am J Clin Pathol*, 1984;81:715-20.
7. Ramesar K, Albizzati C. Laryngeal cysts: clinical relevance of a modified working classification. *J Otolaryngol Otol*, 1988;102:923-5.
8. Van De Water FW. Laryngeal cysts- their surgical management. *Laryngoscope*, 1973;83:1185-94.
9. Kasliwal KC et al. Pharyngeal cysts. *J Indian Med Association* 1977;69:158-60.

Address for correspondence

Dr. Naresh Nathani,
Senior Resident, Department of ENT,
SMS Medical College, Jaipur

Short Communications

CANCERUM ORIS: A CASE REPORT

Sudhakar Vaidya,* Anjana Agrawal,** VK Sharma***

Abstract: Cancrum Oris is acute gangrenous stomatitis of oral and para-oral structures in age group between 2 to 16 years particularly in sub-Saharan Africa with high morbidity and mortality. Exact bacteriology is uncertain. Acute necrotising gingivitis and oral herpetic ulcers are considered to be antecedent lesions. The treatment of cancrum oris is penicillin, tetracycline, metronidazol and clindamycin. second step of management includes reconstructive surgery for the treatment of the functional and cosmetic problems. The authors are reporting a case of cancrum oris in a 1.5-year-old child.

Keywords: Cancrum Oris, Noma, Acute Gangrenous Stomatitis, Acute Necrotising Gingivitis.

INTRODUCTION

Cancrum oris (syn:NOMA ,Gangrenous Stomatitis) is a rapidly spreading gangrenous condition affecting the soft and hard

tissue of the oral and para- oral structure. However it is very rare now, even in developing countries. It predominantly affects children between 2- 16 Years of age . (Ref 1) It usually starts from