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A Rare Cause of Foreign Body Sensation: Throat.

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ABSTRACT

Laryngeal cyst is a non-malignant lesion that can affect any age group. It's symptoms can vary according to the size of the lesion and the site of origin in larynx. An asymptomatic cyst requires no surgical intervention. Here we present a case report of an adult female who presented with foreign body sensation in throat due to a cyst in the aryepiglottic fold. The cyst was removed surgically using endoscope.

Keywords: Larynx, Aryepiglottic fold, Endoscope.

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INTRODUCTION

Laryngeal cysts are rare benign lesions of the larynx. They can affect both sexes at any age group. They can be congenital or acquired and acquired can be saccular, ductal or foraminal depending on its aetiology. Most of them are asymptomatic and are seen as an accidental finding. Symptoms depend on the size and site of the lesion inside the larynx. Symptoms can also depend on the age group as newborns and infants may present as an airway emergency.

CASE REPORT

A 35 Year old female came to our OPD with a sensation of foreign body in throat for the past 6 months. It was more while swallowing. She did not have difficulty in swallowing, voice change or breathing difficulty. There were no other associated constitutional symptoms. She was on medical treatment for acidity and pharyngitis outside with no improvement. Her routine clinical ENT examination was within normal limits. All her blood and urine parameters were normal. Videolaryngoscopic examination showed a mucosal intact mass in the (R) ary epiglottic fold near the epiglottis [FIGURE 1]. It was mobile and appeared pedunculated. Since she had no improvement with medical treatment we correlated the symptoms to the presence of cyst and planned surgical removal.under GA.,Patient was put in supine with head extended. The larynx was lifted with long bladed Mcintosh levering on the median glosso epiglottic fold by the Assisting Surgeon . With the endoscope the mass was seen clearly .It was soft to firm with consistency and was attached to the aryepiglottic at the junction with epiglottis(R) side. The mass was held and pulled medially and was cut into two at the base with scissors..The HPE report was consistent with that of laryngeal ductal cyst[FIGURE 2].Section showed squamous epithelium overlying cystic lesion with a squamous lining and enclosing amorphous material. Surrounding stroma shows inflammatory cell collection and congested capillaries.. The patient was symptom free even in the first post op day and is still on regular follow up with no recurrence.

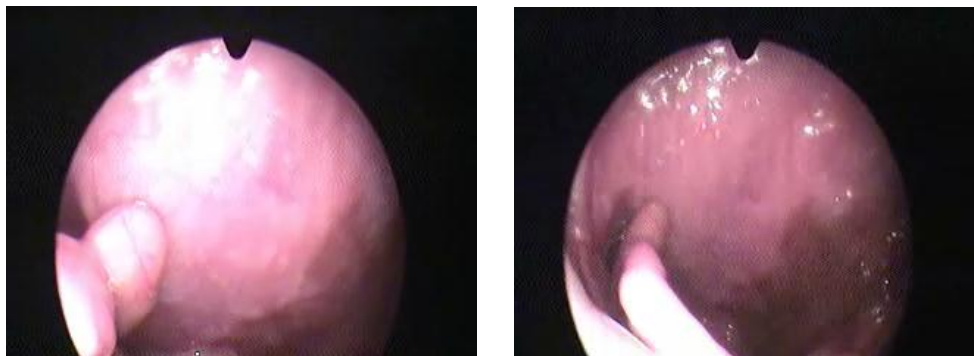


Figure 1: Videolaryngoscopy showing mucosal intact mass in the (R)Aryepiglottic fold.

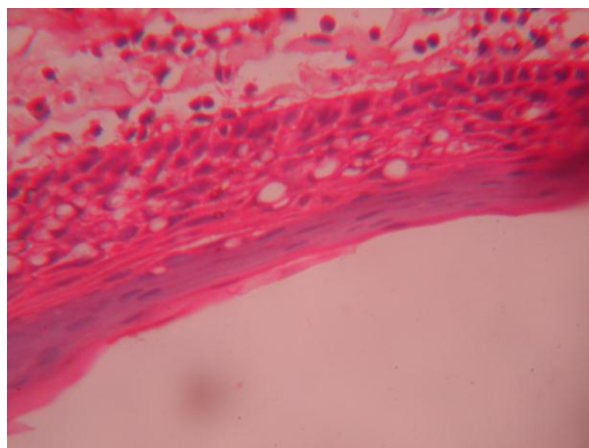


Figure 2: HPE report shows squamous epithelial lining with inflammatory cells and amorphous material.

DISCUSSION

The laryngeal cysts are very rare entity as evidenced by the confusing and contrasting classifications available. This is very clear from a report in which only 9 patient had laryngeal cyst in 24 year study period [1]. Laryngeal cyst classification s are mainly based on the assumption of their origin and localisation. The classification widely accepted are those put forward by Desanto1970[2] and Newman1984 [3] also called as modified Desanto classification and localization. Among malformations in the larynx, being frequently not included as a separate entity, belong branchial cleft cysts [4]. The laryngeal cyst are broadly divided into saccular cyst ,Ductal cyst and Foraminal cyst. The anterior saccular cyst are small submucosal cyst derived from the sacculae and is located at the anterior ventricle overhanging the glottis [5]. Lateral saccular cyst are large and located in the region of false vocal cords and aryepiglottic fold.. Ductal cysts result from obstruction of mucus duct [6] and retention of mucus in dilatated collecting ducts of the submucosal glands. They can arise anywhere in the larynx except true vocal cords and are variable in size. The foraminal cyst are subglottic mucosa that herniate via a persistant foramen in thyroid ala [7]. Male and females seems to be equally affected by laryngeal cysts[8] and these lesions have peak incidence rate in the third decade of life. They appear in the upper one-third of the neck and have a hereditary tendency [8]. There are only a few documented cases of branchial cysts diagnosed later than after the fourth decade [9]. They may arise from sequestration of embryonic cells in the sacculae or ventricle or from seromucinous glands .Due to the damage to the embryonic tissue and obliteration of lumen by recuurent infection some brancial pouch anomalies disappear with time. This is the reason for the limited size of mentioned cysts. The fourth arch remnants are rarest among branchial malformation, and only a few reports are available in the literature [10,11] with the first reported case by Tucker and Skolnick [12]. The location of the malformation is critical in distinguishing 3rd from 4th pouch anomaly. One of the criteria that have been used to differentiate 3rd from 4th pouch sinus or fistula is the position of their internal opening in the pyriform fosse (3rd cephalad; 4th at apex, ie caudal part of the fosse, or even in the proximal esophagus) [13]. Lateralization of both pouch lesions was found to the left side of the body probably because of embryological asymmetry. The rare presence of right side anomaly is difficult to explain. In the literature cases of bilateral remnants [14] and a small number of right-sided changes have been reported [15]. Clinical presentations are highly variable including voice change, Foreignbody sensatioin,difficulty in breathing, difficulty or discomfort while swallowing .Congenital cyst may present as emergency in neonatal period warranting intubation or tracheostomy in some cases. During earlier days repeated aspiration of these cyst were considered atraumatic and successful. But it has high rate of recurrence. A lateral thyrotomy approach was described by New in 1939 while an alternate approach of incising between the thyroid cartilage and thyrohyoid membrane was described by Schall in 1959 [16]. In recent times Endoscopic removal is the treatment of choice . With the advent of laser the CO2 and Diode laser are the excellent tools for removing these lesions with minimal damage to sorrounding tissues [17].

CONCLUSION

Small aryepiglottic fold cyst are a very rare clinical entity. Asymptomatic cyst can be left undisturbed. Symptomatic cyst should be removed completely under proper vision to prevent recurrence. With the advent of endoscopes lesion can be seen , magnified with the help of monitors and removed successfully.

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