ORIGINAL RESEARCH PAPER

Ent

KEY WORDS: Cavernous Haemangioma Of Larynx, Video Laryngoscopy, Endoscopic Laryngeal Excision.

ADULT CAVERNOUS HEMANGIOMA OF LARYNX-A RARE CASE REPORT

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ABSTRACT

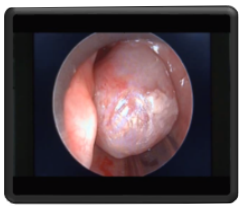
Adult Laryngeal haemangiomas are very rare conditions to occur. A case of adult male laryngeal haemangioma was reported that progressed slowly. A 55-year-old male presented to our ENT OPD with change of voice and breathlessness on exertion. Video laryngoscopy showed a smooth swelling, pink in colour at the anterior commissure and anterior 1/3rd of left vocal cord. Endoscopic micro laryngeal excision was done without tracheostomy. Histopathological examination showed a cavernous haemangioma. In postoperative follow-up after 2 weeks there was no recurrence with near normal voice. There was no recurrence after 1-year follow-up.

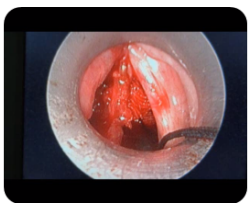
INTRODUCTION:

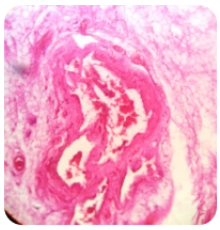
Approximately 60% of the haemangiomas arise in the head and neck region. These are the most common congenital benign vascular tumours. Slow in progression. Children are affected most commonly and very rare in adults. Common sites are vocal cords, arytenoid cartilage or aryepiglottic fold. In adults they occur rarely in the larynx. Common presen tations are hoarseness of voice, dyspnoea, dysphagia or a foreign body sensation based upon the site of the lesion. Present study is cavernous haemangioma of larynx in an adult male, which is a rare presentation. Treatment depends upon the site of the lesion. There is no standardised treatment due to it's rare presentation. Observation is sufficient in small lesions. Surgical treatment indication depends on the size and site of the lesion. Other treatments are steroid injections, ethanol injections, cryosurgery, radium or gold implants, interferon treatment and laser surgery.

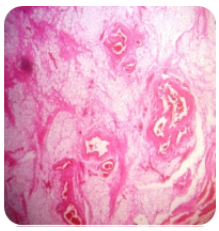
CASE REPORT:

A 55-year-old male presented to the ENT OPD with change of voice and breathlessness on exertion of 4-month duration. Unable to raise the pitch of the voice. Video laryngoscopy showed a smooth swelling, pink in colour at the anterior commissure and anterior 1/3rd of left vocal cord. Mucosa over the bilateral false vocal cords and the remaining part of the vocal cords was normal. Following hospitalization, without any tracheostomy the patient was operated under general anaesthesia with endotracheal tube in the posterior glottis space. Endoscopic micro laryngeal surgery was done. The lesion was identified with it's attachment. The mass was excised at the site of the attachment, without any damage to the normal mucosa. The vocal ligament was preserved. Mitomycin-c was applied over the raw area after excision. The excised mass was sent for histopathological examination, which came out to be a cavernous haemangioma. The patient was administered intravenous antibiotics and analgesics postoperatively for 3 days. The patient was discharged on 7th day and advised the patient to come for follow-up after 10 days. On video laryngoscopy after 10 days of discharge, there was no recurrence, with normal mucosal covering over the raw area. Bilateral vocal cord movement was normal. Voice was near normal. No complaints of breathlessness were noted.









DISCUSSION:

Most common sites for laryngeal haemangiomas are vocal cords, false cords, arytenoids and aryepiglottic folds. They are more common in children when compared to adults, which is very rare in the later. Common presentations are hoarseness, breathlessness, dysphagia or a foreign body sensation depending upon the location of the lesion. In our present study the patient had hoarseness and breathlessness as the presenting complaints.

Computed tomography(CT) and Magnetic resonance imag ing(MRI) are found to help in the site and size of the lesion along with video laryngoscopy.

Cavernous haemangiomas most commonly occur in the supraglottis area.

In our study we came across a rare presentation of glottic cavernous haemangioma, which is confirmed by histopath ological examination. Organised hematoma over the vocal cords can sometimes present as a haemangioma. Haema ngiomas in the posterior glottis area should be differentiated from vocal cord granulomas, which can be most commonly seen in post-intubated patients.

Management can be done either through endoscopic or microscopic assisted micro-laryngeal surgery. Cold instrumentation or laser (co2, KTP) assisted removal can be done depending upon the availability of the equipment. In most of the cases tracheostomy may not be necessary. Other management options include intra-lesion steroid injection; intra-lesion implantation of gold seeds can also be done. In our study we have done endoscopic assisted removal of the cavernous haemangioma.

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