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## Proceedings of Semon Club, 24 November 2000

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## Proceedings of Semon Club, 24 November 2000

OTOLARYNGOLOGY DEPARTMENT, GUY'S HOSPITAL, LONDON

**Chairman:** Ms E. B. Chevretton, Consultant Otolaryngologist, Guy's & St Thomas' Hospitals

**Pathologist:** Professor L. Michaels, University College London

**Radiologist:** Dr J. Bingham, Consultant Radiologist Guy's Hospital

**Minutes:** Mr A. Bibas, Specialist Registrar in Otolaryngology, Royal Sussex County Hospital, Brighton.

### **Case 1: Extensive tracheomalacia following thyroidectomy: management by insertion of T-Y stent**

T. Price, M. Gleeson.

A 64-year-old lady presented with acute respiratory obstruction caused by a massive retrosternal goitre. Resection of the left lobe of the thyroid gland removed the most significant element of her goitre. Extubation after surgery was impossible as she had developed a long segment of tracheomalacia which involved the lower part of her trachea and carina. The pericarinal element of her disease precluded the use of simple tracheal stents or long tracheostomy tubes. A T-Y stent was inserted after modification to avoid occlusion of her right upper lobe bronchus. The patient was discharged home and has returned to near normal activity.

**Discussion:** Tracheomalacia, loss of tracheal cartilage, is a very uncommon complication of thyroidectomy (0.001–5 per cent). It is best assessed by flexible endoscopy during spontaneous ventilation. Short segments may recover spontaneously by fibrosis. Some need to be resected or can be managed by tracheostomy and/or the insertion of a T tube. Use of marlex mesh, ceramic ring prostheses and suspension sutures has been described. The T-Y stent would seem to provide a solution for those cases with carinal or bronchial collapse.

### **Case 2: Recurrent neck abscesses in an eleven-year-old girl with diagnostic delay**

N. J. Holland, B. E. J. Hartley, J. Lim, C. M. Bailey. (Great Ormond Street Hospital for Children, London)

An 11-year-old girl presented with a five-day history of sore throat, left-sided neck pain and torticollis. From the age of 18 months she had ten surgical neck explorations for a presumed thyroglossal duct abnormality; including Sistrunk's procedure, excision of 'tract remnants', and strap muscle excision. A barium swallow in 1996 showed a minor filling defect in the (L) pyriform fossa, but did not confirm a congenital pouch.

After treatment with IV antibiotics, a subcutaneous swelling developed in the (L) lower anterior neck. Pre-operative U/S and MRI scans confirmed an abscess lying superior to a compressed (L) lobe of thyroid. Careful operative endoscopy of the apex of the (L) pyriform sinus showed an aperture with a small mucosal fold, suggestive of a congenital 3rd branchial pouch abnormality. The abscess was drained externally and a drain placed.

**Discussion:** The Ba swallow, U/S. MRI and operative photographs were presented. Miss E. B. Chevretton and Professor M. J. Gleeson both reported treating a similar case, commenting that the neck dissection was likely to be difficult but should include a left hemithyroidectomy with tract excision, because of the close association of the tract with the thyroid gland.

Careful endoscopy of the pyriform fossa is mandatory in all children presenting with this history to avoid delays in diagnosis and unnecessary surgical morbidity.

### **Case 3: Retropharyngeal haematoma following an argument**

V. Yeung, V. Ward, R. Simo. (University Hospital Lewisham, London)

A 53-year-old Asian lady presented to the casualty department with central cyanosis and shortness of breath after a severe family argument where she had been shouting excessively. There was no apparent physical violence. Examination revealed widespread respiratory wheezes only, so she was diagnosed with bronchospasm and sent home after nebulisers, antihistamines and steroids were given.

Five days later she was referred to our ENT department with shortness of breath and dysphagia. She was pyrexial, had a hoarse voice, but no stridor or stertor and extensive bruising and swelling over the anterior neck. Nasendoscopy revealed oedema and submucosal haemorrhages in the epiglottis and posterior pharyngeal wall. Full blood count and clotting were normal. Lateral soft tissue neck radiograph showed gross swelling in the retropharyngeal space, which was confirmed on computerized tomography. No fracture of the laryngeal framework was evident. She was successfully managed with humidified oxygen, intravenous fluids, steroids and antibiotics.

**Discussion:** The need for a high index of suspicion and awareness over the given history was emphasized. However, the findings may also have been due to the straining from extreme shouting. The potential risk of a retropharyngeal abscess must be treated.

### **Case 4: An unusual case of unilateral nasal mass**

N. Saravanappa, N. Salama. (University Hospital Lewisham, London)

A 49-year-old lady presented to the otorhinolaryngology emergency clinic with a six-month history of right nasal obstruction and recurrent epistaxis. As the epistaxis was not controlled with nasal packing, examination of the nose under anaesthesia was performed. The procedure revealed a mass in the right middle meatal region, which was biopsied. The biopsy result was inconclusive (fibrin, inflammatory cells and blood clots). The computerized tomography scan of the nose and paranasal sinuses revealed extensive soft tissue opacity within the right nasal cavity, the right maxillary antrum and ethmoidal regions. Subsequently, the patient underwent endoscopic evaluation and biopsy of the right nasal mass was done.

The histopathology again revealed the presence of fibrin, inflammatory cells and blood clots. The patient continued to have a white, rubbery lesion in the right middle meatal region. The clinical history and investigations indicated the possibility of vascular lesion. The differential diagnosis included angioma, papillary endothelial hyperplasia in the nose and organized clot.

**Discussion:** The clinical history, computerized tomography scan findings and the histology was discussed. Professor Michaels held the opinion that the lesion in the nasal cavity was most likely an organized blood clot. Professor Gleeson supported this opinion and stated that he had seen few cases of organized clot in the nose presenting with recurrent epistaxis.

**Case 5: Recurrent laryngeal papillomatosis (RLP): controversies surrounding the potential for malignant transformation**

T. Price, E. B. Chevretton

A 64-year-old non-smoker, non-drinker with a known history of RLP underwent a laryngectomy following a biopsy which revealed invasive squamous cell carcinoma.

**Discussion:** A literature review showed that most authors cannot agree on the malignant potential of RLP. Most claim it is extremely rare and only occurs in those that smoke or have had radiotherapy. However the risk varies from 1.7 per cent to 1.6 per cent in the published literature. There are further conflicting reports of the incidence of HPV-DNA isolated from not only the papilloma themselves (82–95 per cent) but also from specimens of varying degrees of dysplasia (2.3–56 per cent) and SCC de nova (3–95 per cent). This would suggest that HPV are at least a co-factor in the malignant progression of these lesions.

Professor Micheals however, felt that the incidence of carcinoma developing in papilloma was indeed rare. He felt that the majority of carcinomas 'which develop in RLP' revealed two similar cases so the rarity appears to be more common than previously believed. It was agreed that all papillomatous lesions should be analysed for HPV-DNA especially that of HPV 16 which appears to be associated with an increased incidence of malignant transformation.

**Case 6: Osteoradionecrosis of the temporal bone**

A. D. Morley, P. Diamantopolou, J. H. Topham (Royal Sussex County Hospital, Brighton)

A 63-year-old nurse presented with a recent history of crescendo postauricular pain, a discharging ulcer and trismus. At age 19, she was diagnosed with a left parotid carcinoma, underwent a total parotidectomy and three months of radiotherapy. In 1959, recurrence was diagnosed, and she underwent three months of tele-cobalt treatment. A few months before admission, she underwent a deep punch biopsy of the left post-auricular region by the dermatologists. Radiodermatitis was confirmed as the cause of three to five years' ulcerating in this region. Under our care, temporal bone osteoradionecrosis was diagnosed with CT.

**Discussion:** The patient underwent 30 pre-operative hyperbaric oxygen treatments, a radical mastoidectomy with pectoralis major reconstruction and 10 post-operative hyperbaric oxygen treatments. Thus far, the patient is asymptomatic. Literature review revealed no latency period greater than 23 years in the onset of temporal bone osteoradionecrosis. Professor Michaels commented that he had not seen a case as diffuse as this, but that osteoradionecrosis was not as uncommon as thought. Miss Chevretton said this presents commonly in the tympanic

ring. This case demonstrated the sequelae of trauma to an irradiated area, the index of suspicion for osteoradionecrosis and the value of aggressive treatment with hyperbaric oxygen and ablative and reconstructive surgery.

**Case 7: Vocal fold granuloma: A challenging condition to manage**

M. B. Hesham, H. S. Kaddour, H. Yusut (Havering Hospital Sussex)

The cases of a 57-year-old lady and a 40-year-old man, non-smokers, were presented with six to eight weeks history of recurrent dry cough, occasionally associated with blood stained mucous, husky voice and throat discomfort. Flexible laryngoscopy showed a small polypoidal lesion of the left arytenoid. Microlaryngoscopy and excisional biopsy were performed. Histology showed non-specific chronic inflammatory granuloma. Both patients had the lesions recurring at the same site after three to four months. They were removed by CO<sub>2</sub> laser microlaryngosurgery, and the patients started proton pump inhibitor treatment and speech therapy. In spite of the intensive close management of our patients the lesions had recurred in the same site.

**Discussion:** Vocal fold granulomas are rare non-specific inflammatory lesions usually arising from the vocal process of the arytenoid. Post-intubation granuloma is the commonest type but idiopathic granulomas are rare. Voice abuse, gastroesophageal reflux are the most important aetiological factors in the pathogenesis. They have a marked tendency for recurrence and are very challenging to manage. During the discussion Professor Michaels confirmed the histopathological diagnosis. Miss E. Chevretton emphasized the importance of combined treatment for better outcome.

**Case 8: A rare tumour of the neck presenting with cardiac failure**

H. Yusef, H. Kaddour, H. M. B. Khalil (Havering Hospital, Essex)

A 73-year-old Caucasian man, previously fit, presented with symptoms and signs of acute heart and renal failure. Blood tests and CXR confirmed the above diagnosis. He was also found to have a large fungating and foul smelling mass in the right posterior triangle of the neck, which had been present for many years. It had been increasing in size and bleeding significantly on occasions over the past two years. He was found to be anaemic with Hb of 5.7 gm/dl and in acute heart failure. His medical condition was corrected and he was referred to the ENT department for further management. There was no sign of local or distant metastases. Biopsy under local anaesthetic was reported as adenoid cystic basal cell carcinoma. He underwent complete surgical excision of the mass and reconstruction with deltopectoral flap. Histology revealed nodular eccrine hidradenocarcinoma. He had post-operative radiotherapy. On one-year follow-up there was no sign of recurrence and good cosmesis.

**Discussion:** Tumours of sweat glands are rare with high locoregional and distant metastases. Differentiation between benign and malignant lesions can be difficult even histologically. They mainly affect patients in their fifth decade of life, and female to male distribution is equal. Radical excision is the treatment of choice. Recurrence is common. During discussion, Professor Michaels acknowledged that histological diagnosis could be difficult.

**Case 9: Reversible sensorineural hearing loss in a child**

C. Lee, J. Chelladurai, P. Robinson (Kent & Canterbury Hospital, Kent)

A seven-year-old boy presented with hearing loss. There were no other otological symptoms and no relevant past medical or family history. Examination of the ears was normal. He was seen two years previously for snoring and an enquiry into his hearing then revealed no problem. Pure tone audiometry showed bilateral sensorineural hearing loss with thresholds 15–45 dB. Otoacoustic emissions concurred with the audiogram. The audiograms over the next 21 months showed the hearing loss persisted, after which it improved to near normal.

Five months previously, the gas boiler at home was found to be emitting high carbon monoxide levels. The patient's bedroom was next door. This provided an explanation for the hearing loss, for which no other cause was found. Carbon monoxide exposure is thought to cause deafness by tissue hypoxia and is one of the few recognized causes of temporary sensorineural hearing loss although it can also cause permanent deficit.

**Discussion:** At the Semon Club we were interested in, but unable to explain the relative sparing of threshold at 4 kHz. Carbon monoxide is an unusual cause of sensorineural deafness but one not to forget.

**Case 10: A rare cause of chronic dysphagia and cough**

T. Price, G. Fayad, P. A. Williamson (St Georges' Hospital, London)

A 62-year-old non-smoker presented with a 10-year history of dysphagia and non-productive cough. A CXR revealed a right-sided paratracheal air cyst in the thoracic inlet. Barium swallow revealed no oesophageal communication. A CT scan revealed it to be an acquired tracheal diverticulum (tracheocele) with an apparent communication with the trachea, which was not evident on bronchoscopy and insufflation. The patient was treated conservatively.

**Discussion:** These lesions are said to be associated with COPD and are thought to be produced by mucosal herniation through a weak point in the trachea as a result of raised intraluminal pressure. The stated incidence at autopsy is one per cent. The symptoms attributed to them are non-specific and related to chronic infection. A few reports of symptoms due to a mass effect have been reported but not of longstanding dysphagia. As surgery has a high morbidity and symptoms may not be fully resolved, conservative management is the initial preferred option.

**Case 11: Esthesioneuroblastoma of the nose**

H. Sharp, E. Chevetton, D. Roberts (Guy's Hospital, London)

The case of a 48-year-old male presenting with a unilateral nasal polypoid mass was described. He had a two-month history of unilateral nasal obstruction, epiphora and facial pain. The tumour was localized to the nasal cavity and free

from the cribriform plate. Following profuse haemorrhage at initial biopsy, bilateral maxillary artery ligation was performed prior to removal via an extended lateral rhinotomy and medial maxillectomy.

**Discussion:** Clinical staging is via the Kadish system and histopathological grading via the Hyam scale. It is often necessary to perform immunohistochemistry to accurately diagnose this primitive and often undifferentiated neuroectodermal tumour. Two papers from the recent literature were presented: Polin *et al.* (*Neurosurgery* 1998;**42**(5):1029–36) described their experience with 34 cases treated with combination surgery (predominantly craniofacial resection) and combination radiotherapy (in stage A and B disease) and chemotherapy (in stage C disease). They had overall five year survival of 54 per cent. Tumours in 2/3 of patients were radiologically reduced by 20 per cent with neoadjuvant therapy, and by 50 per cent in half of patients, with a corresponding higher disease free interval in responders. Advanced age and advanced stage were associated with decreased survival.

Welch *et al.* (*Laryngoscope* 2000;**110**:635–40) describe their experience of endoscopic resection and post-operative stereotactic radiosurgery in three cases of disease localized to the nasal cavity and paranasal sinuses. Their three cases are disease free at 39, 50 and 71 months.

**Case 12: A wolf in lamb's clothing**

R. G. Kanegaonkar, A. Ali, N. Thomas (Farnborough Hospital, Kent)

A 57-year-old lady presented with a one-day history of increasing sore throat and absolute dysphagia. She denied any hoarseness or dyspnoea. She had presented to her general practitioner complaining of joint pain and lethargy, and was under investigation for hepatosplenomegaly. Her medication included atenolol and hydralazine. Examination revealed a left peritonsillar swelling consistent with a quinsy. She also demonstrated marked cervical lymphadenopathy. Aspiration was attempted, but failed to draw frank pus, and she was commenced on intravenous cefuroxime and metronidazole. Intravenous hydrocortisone was also started. Blood tests performed on admission revealed a leukopenia and mild normochromic normocytic anaemia.

Over the next 48 hours she made a slow recovery, the left peritonsillar swelling gradually subsided, her arthralgia settled, and she began eating and drinking normally. However, prior to discharge, an erythematous rash was noted over the anterior aspects of both her lower limbs. Additional blood tests arranged proved positive for anti-nuclear antibodies and DNA binding antibodies. A provisional diagnosis of systemic lupus erythematosus was made, possible drug induced, and she was therefore referred to the rheumatology team for further investigation.

**Discussion:** This case highlights the need for awareness of concomitant symptoms and signs as serious systemic disorders may mimic common ENT emergencies.