Laryngopharyngeal Disease

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Contents

The laryngopharyngeal area is usually dealt in the otolaryngology and can be easily ignored by endoscopists because it is hard to observe due to laryngeal refluxes. However, a closer observation has to be made, especially when the patient has hoarseness, mogiphonia, bulbar symptom, dysphagia, odynophagia, and dyspnea at inspiration. Laryngopharyngeal lesions that can be observed with the endoscopy include reflux laryngopharyngitis; corrosive lesion; benign laryngopharyngeal tumor such as papilloma, lipoma, cyst, and vocal cord nodule; malignant laryngopharyngeal tumor; and laryngeal cancer.

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2.1 Reflux Laryngopharyngitis

Laryngopharyngeal reflux disease (LPRD) is a common condition that most primary care physicians encounter frequently. Common symptoms include hoarseness, dysphagia, globus sense, and chronic cough, as well as odynophagia and excessive throat mucus. Heartburn is a primary complaint of patients with GERD, but it is reported by little more than a third of those with LPRD.

Laryngeal endoscopy may reveal many changes from diffuse irritation. Diffuse erythema, edema and interarytenoid hypertrophy, and cobblestoning are the most useful finding for an LPRD diagnosis (Fig. 2.1) [1]. The Reflux Finding Score (RFS) is a clinical tool developed to quantify laryngeal inflammation and standardize objective endoscopic finding. The RFS includes subglottic edema, ventricular obliteration, erythema/hyperemia, diffuse laryngeal edema, posterior commissure hypertrophy, granuloma/granulation tissue, and thick endolaryngeal mucus.

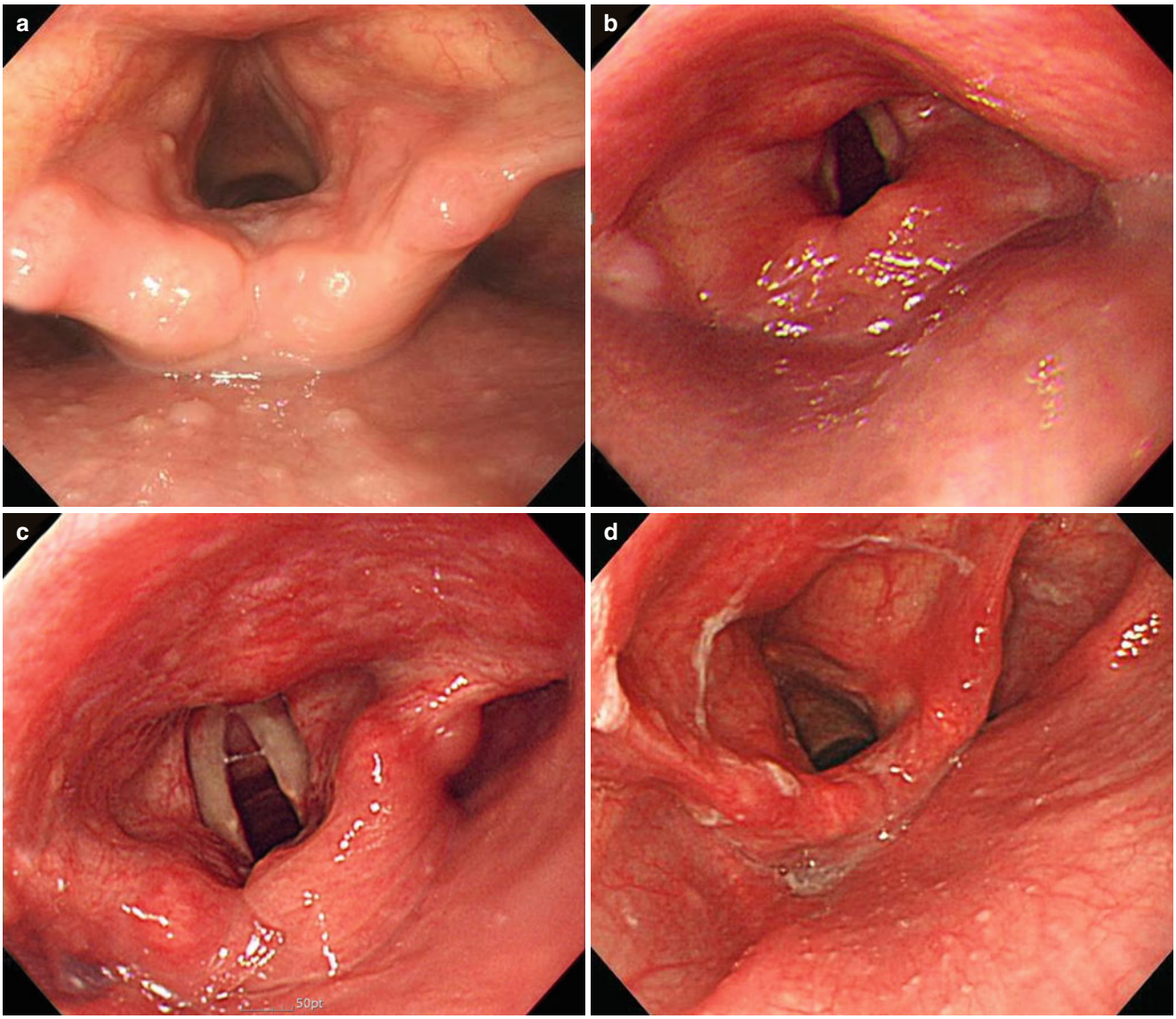

Fig. 2.1 Endoscopic finding of LPRD. (**a**) Subglottic edema, most common findings of LPR, (**b**) ventricular obliteration, (**c**) laryngeal edema, (**d**) laryngeal hyperemia

2.2 Corrosive Lesion

The ingestion of corrosive substances has devastating effects on the upper gastrointestinal tract, and the severity of the resulting damage depends largely on the corrosive properties, duration of contact with the mucosa, and the concentration of the ingested agent. Acids and alkalies in various forms cause different patterns of injuries depending on the quantity which has been ingested and the concentration. Endoscopic findings are diverse according to severity of injury from epiglottic hyperemia to severe mucosal edema or ulceration (Fig. 2.2).

Swelling of the epiglottis and larynx may impair breathing.

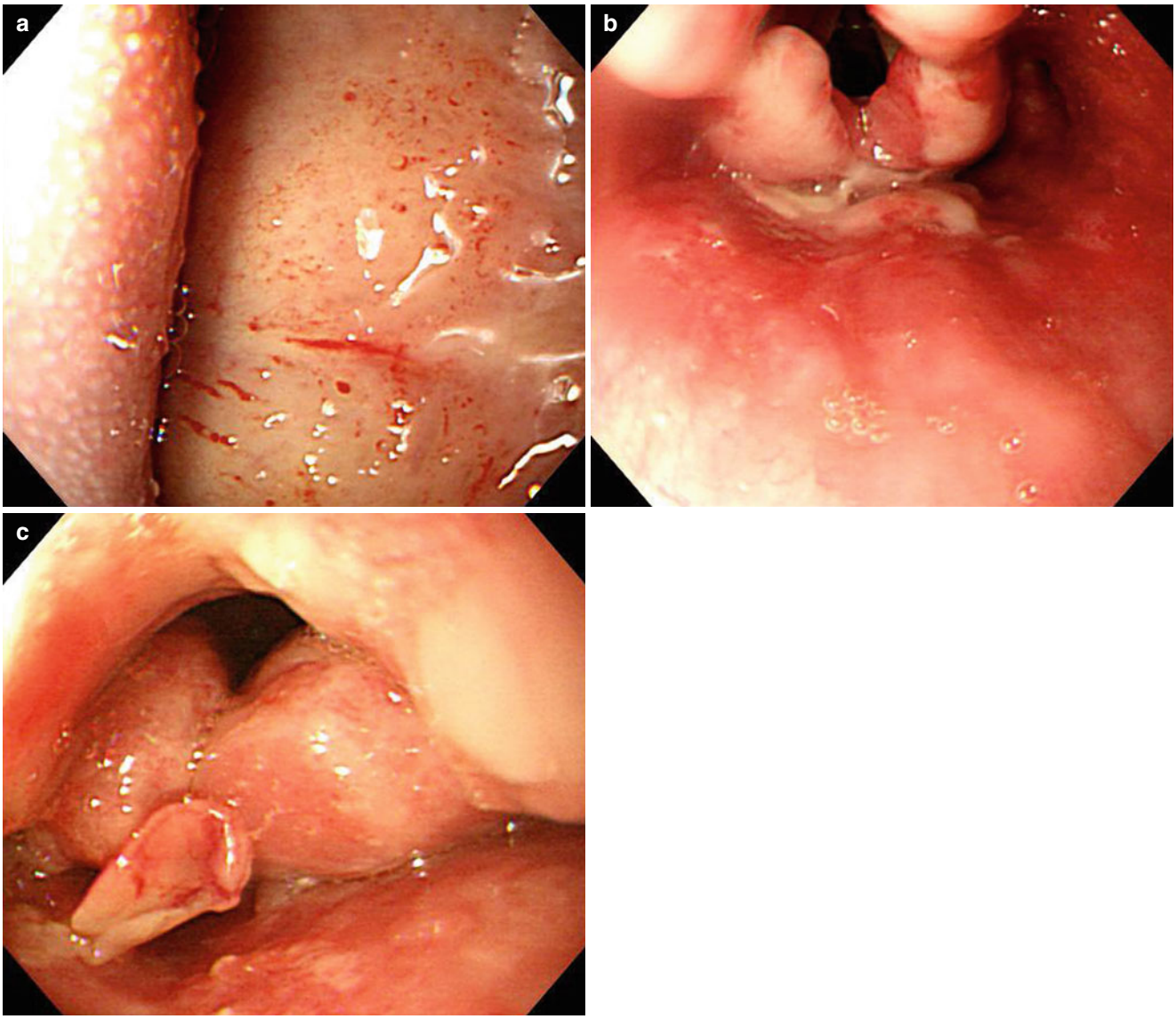

Fig. 2.2 Corrosive lesions. Supraglottic laryngeal edema or mucosal ulcer with narrowed airway. (**a**) Edema and epithelial hemorrhage are observed at the soft palate. (**b**) Laryngeal edema and ulceration. (**c**) Laryngeal desquamation

2.3 Benign Laryngopharyngeal Tumor

2.3.1 Laryngopharyngeal Papilloma

Papillomas are benign epithelial tumors that are caused by infection with the human papillomavirus (HPV). These are the most common benign neoplasms affecting the larynx and upper respiratory tract. They are wartlike appearances of squamous epithelium (Fig. 2.3), and they can be found in the oral cavity, pharynx, vocal cord, or epiglottis.

2.3.2 Laryngopharyngeal Lipoma

Lipoma generally does not require treatment, because they are not cancerous. Lipomas are well-circumscribed lesions with greasy consistency and yellow to orange color (Fig. 2.4) and often exhibit a "pillow sign."

2.3.3 Vocal Cord Nodule

Vocal cord nodules are also known as "calluses of the vocal folds." They appear on both sides of the vocal cords, typically at the midpoint, and directly face each other. They are caused by vocal abuse (Fig. 2.5).

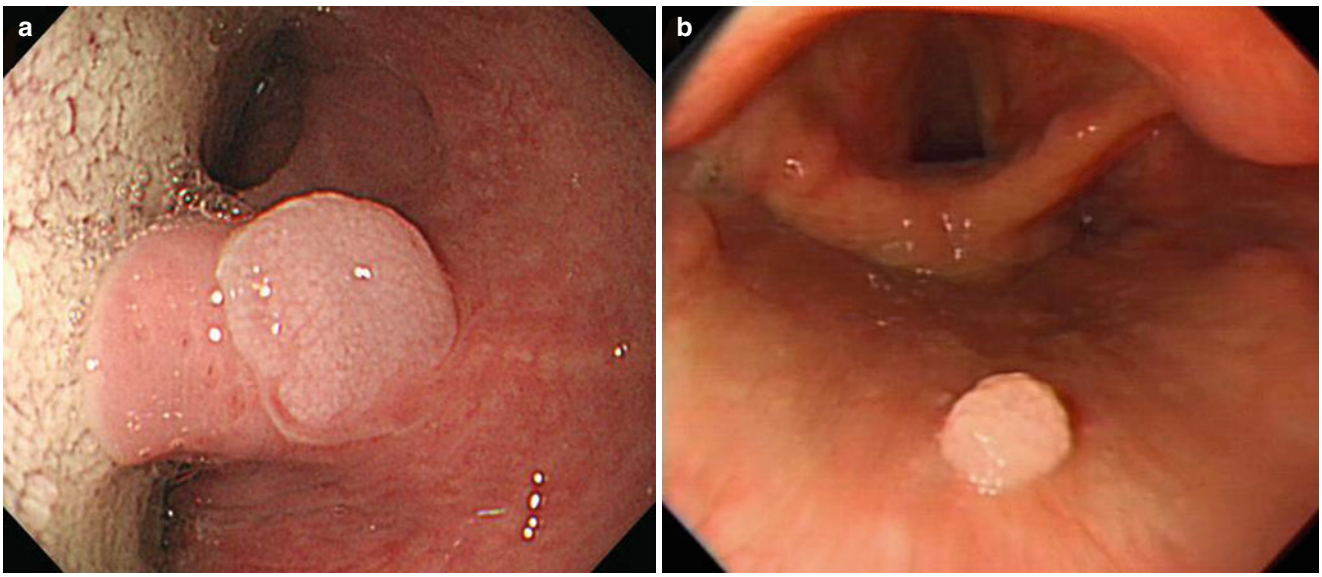

Fig. 2.3 Laryngopharyngeal papilloma. (**a**) Papilloma at uvula. (**b**) Papilloma at larynx

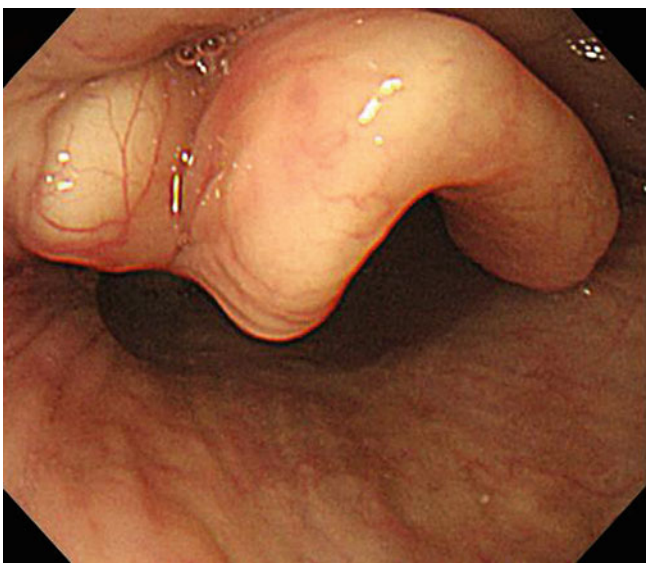

Fig. 2.4 Laryngeal lipoma. Well-circumscribed yellowish soft mass at the epiglottis

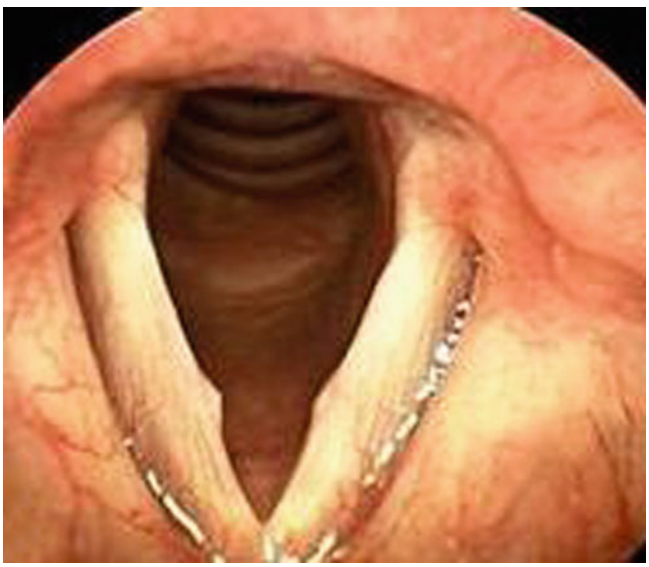

Fig. 2.5 Vocal cord nodule. Bilateral focal thickening of the vocal cords is noted

2.4 Malignant Laryngopharyngeal Tumor

2.4.1 Laryngeal Cancer

Most commonly they arise from the glottic region of the larynx, namely, the true vocal cords, so they almost always cause hoarseness or other changes in the voice. Smoking is the major risk factor associated with developing cancer of the larynx, and heavy drinking also increases the risk (Fig. 2.6).

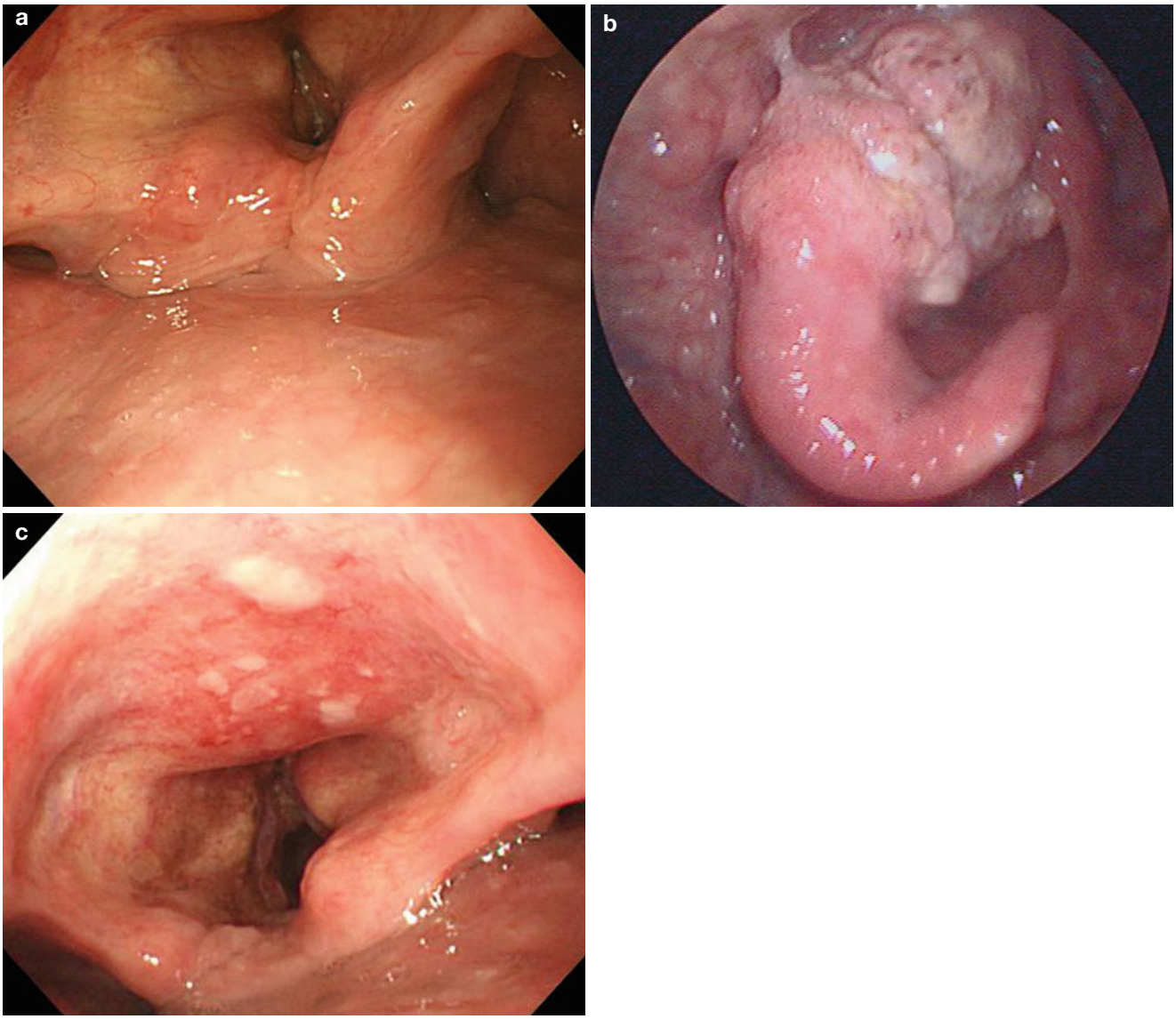

Fig. 2.6 Laryngeal cancer. (**a**) Thickening of the left vocal cord is noted. (**b**) Irregular large mass is found nearly obstructing the trachea. (**c**) Asymmetrical thickening of the larynx

Reference

1. Berthold B, Guido S, Hartmut S. Endoscopy of the upper GI tract. New York: Thieme; 2004.