CASE REPORT

LARYNGEAL MYXOMA: EMERGENCY MANAGEMENT

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ABSTRACT

A sixty five years male presented with stridor and dysphonia in emergency clinic of Govt. CIMS medical college, Bilaspur. Indirect laryngoscopic examination revealed a polypoidal lesion in glottic chink. CT scan evaluation confirmed the findings of clinical examination. Patient was relived of symptoms after emergency tracheostomy followed by surgical removal of polypoidal lesion from right vocal cord by microlaryngeal surgery. Histopathological examination revealed myxoma. Clinical examination after eight months showed significant improvement in hoarseness of voice with no evidence of recurrence of lesion.

Keywords: Laryngeal Myxoma, Emergency, dysphonia

INTRODUCTION

Myxoma is benign mesenchamal tissue tumour. Term myxoma was first introduced by Virchow in 1871 for tumour with a histologically similar to the mucinous tissue of the umbilical cord [1] . In 1948 Stout redefined myxoma as a true mesenchymal neoplam consist of undifferentiated stellate cells in loose myxoid stroma that do not metastasize [2] . The histological criteria for myxoma as true neoplasm that do not metastasize and exclude the presence of recognisable cellular component of other mesenchymal tissue specially chondroblast, lipoblast, & robdomyoplast . Occurrence of myxoma is most common in heart. In the head neck regions most common locations are facial bones specially mandible and maxilla (3% to 6%) [3] . Laryngeal myxoma are extremely rare. Review of literature revealed out of seventeen cases of laryngeal myxoma reported, three were female.

CASE REPORT

A sixty-five year old male presented to casualty with four month history of change in voice and dysponea since last one week. It was sudden in onset, gradually progressive. He had severe stridor. Previously he visited two of the private hospitals and all the basic investigations within normal limit. He didn't have any history of diabetes, hypertension asthama, alcholism and smocking. On indirect laryngeal examinations large polypoidal mass seen in glottic regions, which was completely obstructing the glottic chink .On CT scan neck (Fig. 1) showed low density lesions about 17x12mm completely occupying the chink.

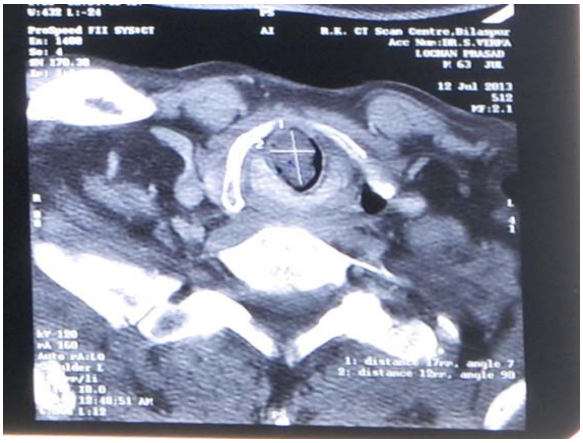

Fig 1: CT Scan of Neck

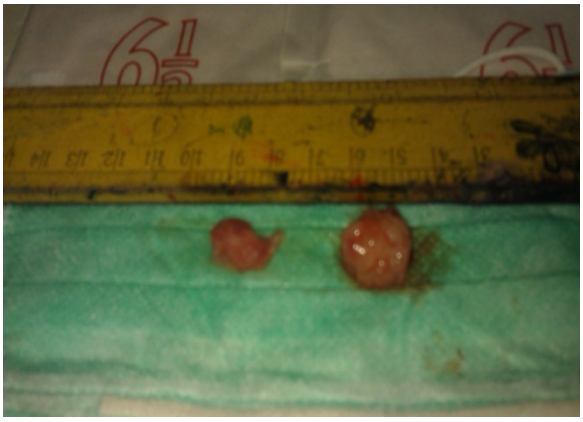

Fig 2: Post Operative Specimen.

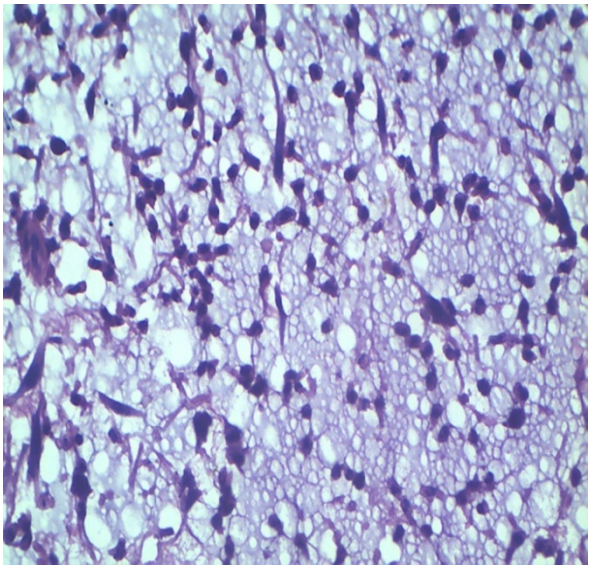

Fig 3: Histopathological Slide

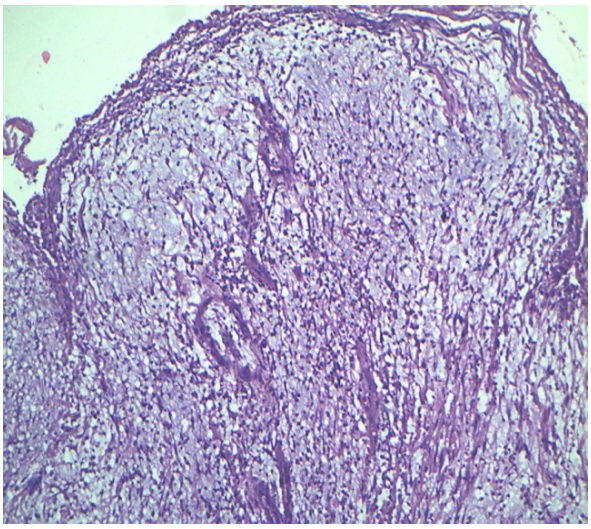

Fig 4: Histopathological Slide

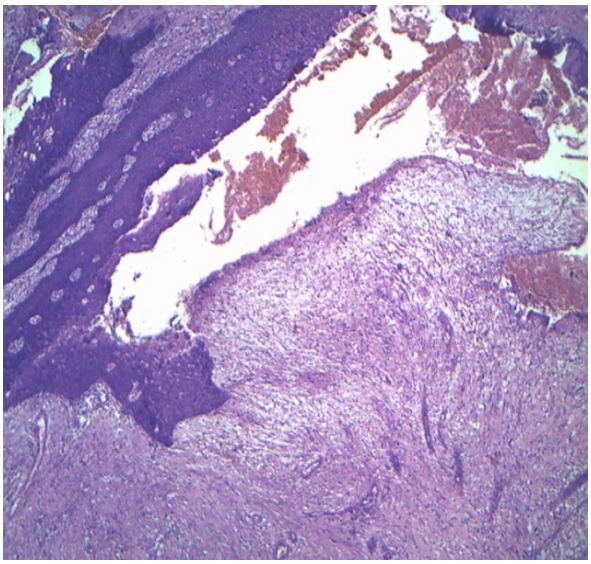

Fig 5: Histopathological Slide

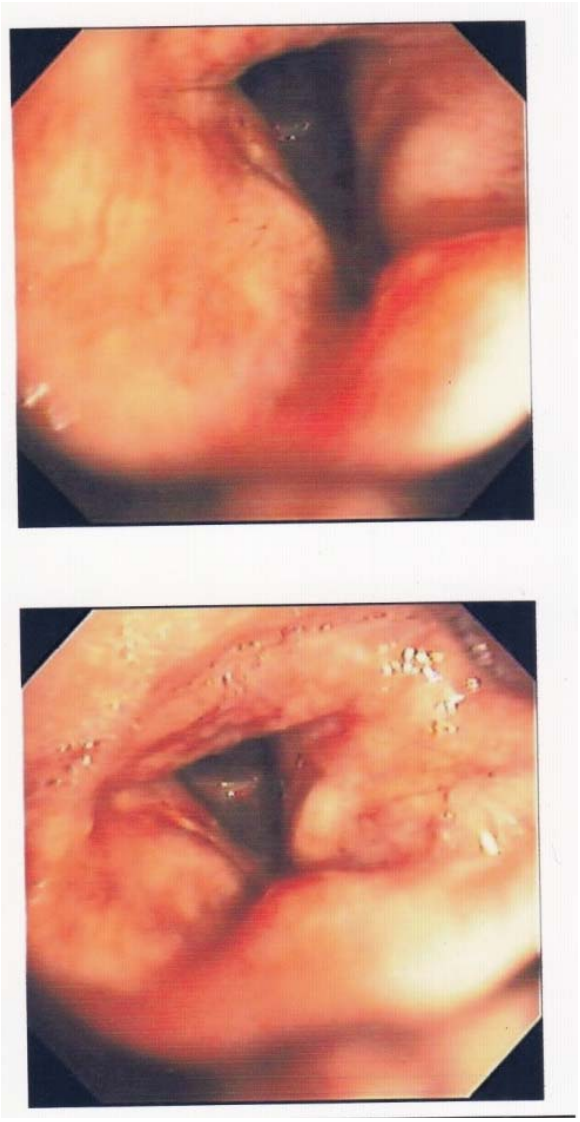

Fig 6: Follow up after eight month

After emergency tracheostomy, during direct laryngoscopy micro laryngeal surgery of polypoid mass was done under general anesthesia. Two polypoid masses of pink colour arising from the right vocal cord were pedunculated (Fig. 2). It was attached to broad base extending up to posterior commissure. After surgical removal it was sent for hisopathological examination. The excised mass was 1.5 X1.4X 1.0 cm, microscopic examination revealed portions of squmaous mucosa with an ulcerated mesenchymal neoplasm composed of bland looking elongated stellate shaped cells set against abundant myxoid background with scattered congested blood vessels. Focal scattered microabscesses were also seen. No increased mitosis, necrosis or nuclear pleomorphism was seen (Fig No. 3, 4 & 5). There was no evidence of recurrence of lesion after eight months of follow up (Fig No. 6).

DISCUSSION

A myxoma is a benign mesenchymal origin, mostly occurs in subcutenous soft tissue, intramuscular or cardiac chamber [4] . Most common benign tumor of the larynx are vocal polyp, vocal nodules, reinke's edema , vocal cyst and papiloma. It can occurs in all age group from birth to old age, although it is most commonly present in third or fourth decade of life and etiology is not known [1,6] . In the head neck region myxoma involved in maxilla and mandible (3 – 6%) as odontogenic origin known as fibromyxoma or myxofibroma. It most common site of involvement is vocal cord, aryepiglottic fold and epiglottis within the larynx. Clinically laryngeal maxoma presented as a hoarseness followed by dyspnea, dysphonea and dysphagia depending on the size and site of the tumor. Myxoma may infiltrate the surrounding tissues, so it has a high chance and predispositions to local recurrence because of this behavior during surgery myxoma is excised with normal tissue to prevent recurrence [5] . It can be always confused with vocal polyp, so a high index of suspicion needed to detect myxoma.

The deferential diagnosis of laryngeal maxoma is the myxoid degeneration of laryngeal polyp that is histologicaly scanty vascularity, no fibrin, no hemorrhage as opposed to a plenty full vascularity and hemorrhage with hemosiderin ladan macrophage in the maxyoid changes of polyp [7] . Differential diagnosis of myxoma also includes liposarcoma, chondrosarcoma, leiomyosracoma, rhabdomyosarcoma, neurofibroma and angiomyxoma [5] . Treatment of choice for laryngeal maxoma is complete excision with healthy margins.

In conclusion laryngeal myxoma is a rare benign mesenchymal tumor and can be easily confused with laryngeal polyp and should be included in differential diagnosis of laryngeal masses.

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