

Cutting Edge Laryngology

for the 21st Century

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Kuala Lumpur, Malaysia

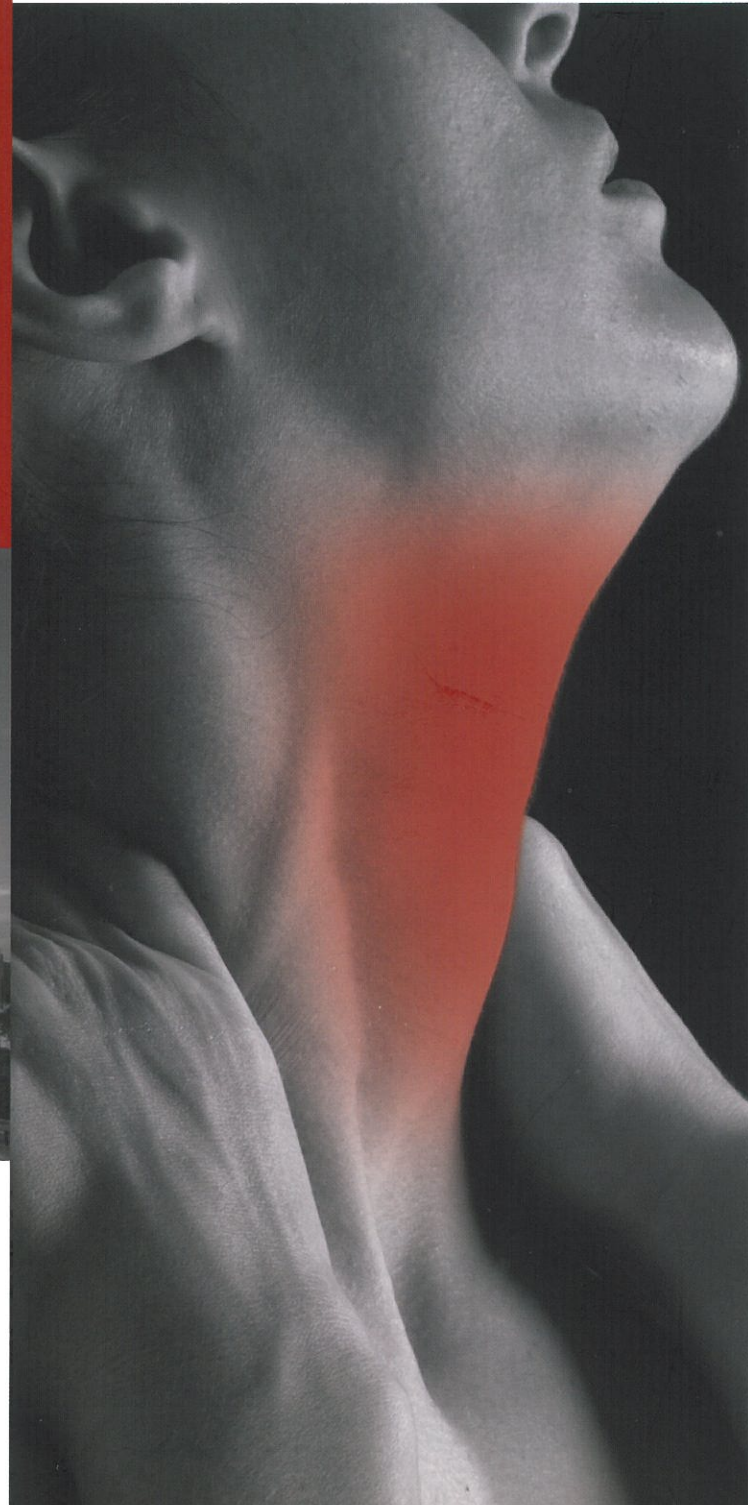
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CUTTING EDGE LARYNGOLOGY FOR THE 21st CENTURY



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Friday, 1-Sunday, 3 June 2012

09.00-17.30

Exhibition Area

P1

Middle frontal horizontal partial laryngectomy: a treatment for Stage T1b glottic laryngeal cancer involving anterior vocal commissure

Wen, W; Chai, L; Lei, W; Su, Z
Otorhinolaryngology, China

Objective:

The clinical efficiency of middle frontal horizontal partial laryngectomy (MFHPL) in treating stage T1b squamous cell carcinoma of the glottic larynx involving anterior vocal commissure (AVC) was compared with that of the anterior frontolateral vertical partial laryngectomy (AFVPL).

Methods:

A total of 65 patients diagnosed with stage T1bN0M0 squamous cell carcinoma of the glottic larynx from January 1996 to January 2010 were randomly assigned to surgical procedure of either MFHPL or AFVPL. The post-operative complications were evaluated and compared between two treatments.

Results:

AFVPL and MFHPL were performed in 34 and 31 patients, respectively. The follow-up time was 15 to 160 (median: 63) months with a follow-up rate of 96.9% (63/65). There was no significant difference in the incidence of subcutaneous emphysema, aspiration, pneumonia and laryngeal fistula between two groups. All cases were confirmed as squamous cell carcinoma by postoperative pathological diagnosis. Two cases were found to have mild thyroid cartilage involvement at the AVC area in each group. Electric laryngoscopy revealed that the reconstructed glottis was symmetric with smooth movement of vocal cords and high-degree of glottis closure during phonation in the MFHPL-treated patients. In contrast, AFVPL treatment resulted in irregular glottic area with poor symmetry and tubular glottis with fair to poor closure during phonation. The incidence of postoperative laryngeal stenosis significantly differed between the MFHPL- and AFVPL-treated groups ($P=0.025$). No significant difference was detected in the 3- and 5-year overall- or tumor-free survival rates between two treatments. The Voice Handicap Index (VHI) and maximum phonation time (MPT) after surgery were 51.0 ± 12.99 and 12.42 ± 3.44 sec in the AFVPL-treated group; while in the MFHPL-treated patients they were 31.81 ± 7.48 and 7.65 ± 1.98 sec, respectively. Both differences in VHI ($P=0.012$) and MPT ($P=0.024$) were significant between two treatments.

Conclusions:

MFHPL was comparable to AFVPL with respect to postoperative complications, recurrence rate and survival rate, but had advantages over AFVPL that were reflected by decreased incidence of laryngeal stenosis and improved voice quality. Our study indicated that MFHPL has a potential value in clinical practice of treating stage T1b squamous cell carcinoma of the glottic larynx involving AVC.

P2

Infant with sudden, large, post-extubation subglottic cyst

Asha'ari, Z¹; Suhaimi, Y²; Fadzil, A³

¹Otolaryngology-Head & Neck Surgery, Malaysia;

²Otolaryngology, Malaysia; ³Pediatrics, Malaysia

Background:

Subglottic cyst in infancy is almost always associated with episodes of early life intubation. Most cases typically presented late, usually days to months after endotracheal extubation. We report a case of a subglottic cyst with different presentation than the norm.

Case presentation:

A prematurely born, four-month-old baby girl was on a ventilator via the endotracheal tube for four days after diagnosed with severe pneumoniae. She presented with stridor, two hours after airway extubation. Her conditions deteriorated, needing reintubation. However, laryngoscopy showed a large subglottic cyst totally obstructing the airway. As an attempt to intubate failed, a tracheostomy was performed and the cyst was marsupialized under general anesthesia.

Conclusion:

This case highlights that subglottic cyst can present acutely, and rapidly enlarging soon after the airway extubation. As the management of a large subglottic cyst can be challenging, a close observation for early diagnosis and intervention are recommended post extubation in the high-risk cases, such as in the premature infant.

P3

Tension Dysphonia in English-as-a-Second-Language Speakers

Hu, A; Sumida, Y; Meyer, T

Otolaryngology - Head & Neck Surgery, USA

Background:

Muscle tension dysphonia is a clinical diagnosis describing a spectrum of disturbed vocal fold behavior caused by increased tension of the laryngeal musculature. This tension may be due compensation for underlying disease, like laryngopharyngeal reflux disease. In patients who speak English as a second language (ESL), if they present with muscle tension dysphonia in English, do they also have muscle tension dysphonia in their native language and do they have signs and/or symptoms of laryngopharyngeal reflux disease?

Methods:

A retrospective chart review was conducted of patients who speak English as a second language and who had muscle tension dysphonia. Demographic data, clinical data, and videostroboscopies were reviewed. Muscle tension dysphonia was graded on the Pouburka scale on three phonatory tasks (/I/, E, L1). Patients were asked to count to 10 in English and in their native language. Voice handicap index (VHI-10), reflux symptom index (RSI), reflux finding score (RFS), and consensus auditory perceptual evaluation of voice (CAPE V) were also collected

Results:

Twenty-five ESL patients (60% female, mean age 57) with 14 different native languages completed the study. RFS was 6.7 ± 2.6 , RSI 14.3 ± 12.5 , VHI-10 was 10.6 ± 8.7 , CAPE-V overall severity was 25.6 ± 19.9 . Patients demonstrated MTD in both their primary language and English. MTD did not correlate with the CAPE-V score.

Conclusion:

ESL patients who have MTD in English also show signs of