CASE REPORT

Mixed laryngocele: a case report and review of the literature

Laringocele misto: case report e revisione della letteratura

A. LANCELLA, G. ABBATE, R. DOSDEGANI
Otorhinolaryngology Unit, “S. Biagio” Hospital, Domodossola (VB), Italy

SUMMARY

Laryngocele is a rare, benign dilatation of the laryngeal saccule that may extend internally into the airway or externally through the thyrohyoid membrane. Many laryngoceles are asymptomatic; sometimes they may cause a cough, hoarseness, stridor, sore throat and may present as a swelling on one or both sides of the neck. Laryngocele may be associated with supraglottic squamous cell carcinoma. Computed tomography scan is the most effective imaging method for diagnosis. Surgery is the treatment of choice. A case of large mixed laryngocele in a 75-year-old male is described together with surgical management and follow-up. A review of the literature is also presented.

KEY WORDS: Larynx • Laryngocele • Professional diseases • Surgical treatment

Case report

The patient B.D.G., a 75-year-old male had been suffering from hoarseness for approximately 5 years. Over the last month, he had been suffering from dyspnoea on exertion and, in the last few days even when at rest.

The patient also suffered from hypertension, chronic atrial fibrillation, emphysema and chronic bronchitis; despite these problems, he managed a mixed farm with crops and livestock. On examination, he was found to have a painless soft mass at the right side of the neck, about 5 cm in size, conducting vibration during speech, manually reducible, covered with normal skin (Fig. 1).

Fibrolaryngoscopy showed a supraglottic mass covered with normal mucosa, extending into airways from the right wall of hypopharynx (Fig. 2).

A computed tomography (CT) scan showed a large mixed internal and external laryngocele without regional lymphadenopathy (Fig. 3).

The patient had a CT scan about five years before. Surgical resection of the laryngocele had previously been deferred at the request of the patient who now agreed to undergo surgery in our Department and resection of the laryngocele was performed by the external lateral cervical approach. Post-operative recovery was uneventful.

The patient was discharged from hospital 7 days after surgery in good health.

Swallowing of semisolid food was normal.

The final histological diagnosis of the specimen was laryngocele.
Post-operative CT 4 months after surgery, showed complete removal of the laryngocele (Fig. 4). The larynx and the other neck structures were normal. The patient remains free from disease.

**Conclusion**

Laryngocele is a rare benign laryngeal disease which is often asymptomatic. The diagnosis may be incidentally discovered when the pa-
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A patient undergoes a CT scan for a nagging cough or persistent hoarseness. In our opinion, the present case is of particular interest since the patient was affected by a large laryngocele unrelated to his profession. It is mandatory, in any patient presenting with a soft cervical mass, even if not a wind instrument player or a glass blower, to exclude the possibility of a laryngocele.

In fact, the patient described had no predisposing factors for laryngocele although he presented increased intra-glottic pressure due to chronic bronchitis and emphysema. In the present case, laryngocele was not associated with laryngeal cancer, but it is most important to remember and to consider the possibility of this association.

An external cervical approach to laryngocele gave adequate exposure of the lesion; post-operative recovery was free from complications. In our opinion, endoscopic laser treatment would not have permitted complete excision of this large and mixed (external and internal) lesion.

Address for correspondence: Dr. A. Lancella, Reparto ORL, Ospedale “San Biagio”, piazza Vittime dei Lager Nazifascisti 1, 28845 Domodossola (VB), Italy. Fax +39 0324/491301. E-mail: antolancy@tiscali.it

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