Journal Homepage: - www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI: 10.21474/IJAR01/12234
DOI URL: http://dx.doi.org/10.21474/IJAR01/12234

ISSN NO. 2320-5407

RESEARCH ARTICLE

AN UNEXPECTED CAUSE OF PERSISTENT DYSPHONIA IN ADULTS!

Azzam I., Sefrioui Ti, Nitassi S., Bencheikh R., Benbouzid A.,Oujilal A. and Essakalli L
Département of Otorhinolaryngology Head And Neck Surgery, Spécialités Hospital, University Hospital Ibn Sina, Rabat, Morocco.

Manuscript Info

Manuscript History
Received: 31 October 2020
Final Accepted: 30 November 2020
Published: December 2020

Abstract

Inhalation of foreign objects is a common reason in paediatric emergency departments, linked to a significant morbidity or even mortality rate, especially in children under 3 years of age. The occurrence in adults without neurological comorbidity remains rare. We report the case of a 50-year-old with a history of alcohol-smoking intoxication who had suddenly presented a symptomatology associating: dysphonia and dyspnea and after 15 days of evolution, an ENT notice was requested. Cervical CT scans and endoscopy of the upper aerodigestive pathways were performed in an emergency and objectified a glottic foreign body: inhaled denture and not noticed by the patient !!. The extraction of the foreign body under general anesthesia led to the disappearance of dyspnea and dysphonia was gradually improved under treatment. In the case of a foreign body of the upper airways, the absence of penetration syndrome at the examination and a non-specific symptomatology can lead to a diagnostic and therapeutic delay that can have dramatic consequences. At the slightest doubt, an endoscopy of the upper airways under general anesthesia should be performed.

Introduction:-

Inhalation of foreign objects is a frequent reason for paediatric emergencies, linked to a morbidity rate, or even not negligible mortality especially in children under 3 years of age. The occurrence in adults without neurological comorbidity remains rare, very often unknown especially before the absence of a complete clinical picture including a penetration syndrome, and thus the diagnosis is often delicate. Early endoscopic extraction is necessary to avoid serious consequences.

Observation:-

This is a 56-year-old patient with a history of chronic alcohol and tobacco intoxication who suddenly showed dysphonia and a respiratory gene upon waking, which motivated his consultation a fortnight after . The clinical examination objectified a slight inspiratory dyspnea with dysphonia in a context of preservation of the state of general and apyrexia the patient benefited from: a nasofibroscopic which was inconclusive given the enormous salivary stasis and a significant nauseous reflex ,a cervico-thoracic CT (fig1) which aimed at a glottic formation partially reducing laryngeal light ,(fig 2) and its extraction led to the disappearance of the dyspnea and the dysphonia was gradually improved under Budésonide aerosols, the patient was also put on antibiotics per os based on protected

Corresponding Author:- Azzam I
Address:- Département of Otorhinolaryngology Head And Neck Surgery, Spécialités Hospital, University Hospital Ibn Sina, Rabat, Morocco.

amoxicillin,oral prednisolone as well as anti-reflux treatment with complete disappearance of any symptoms and a strictly normal control nasofibroscopy

Discussion:-

Foreign body localization in the larynx remains the least frequent (2-12%) of the airways, with the exception of children less than 1 year old [1] Although the frequency is minor, it has dramatic consequences. Edema of the larynx causes a complete obstruction. These patients usually have symptoms of obstruction, dysphonia or aphonia and hoarseness. Symptoms may mimic subglottic laryngitis (unhealthy child). If the blockage is complete, it will cause respiratory distress, cyanosis and respiratory arrest followed by death. If the obstruction is partial, it can occur stridor, hoarseness, cough, croup, sore throat and dyspnea. A main danger can be seen when it comes to thin and punctuated foreign bodies (e.g., fish bones), rounded and soft (asgrapes, olives) and the blade and light (e.g., egg shells) can remain intralaryngeal.

In adults, retrospective studies have suggested that the main causes are decreased alertness due to drunkenness, sedation, general anesthesia, trauma or physical disability, a field of psychopathy, brutal emotions during meals and certain professions (dressmakers, shoemakers, carpenters, etc.). [2]

In the elderly, there is a particular predisposition to false roads during sleep mainly because of the decrease of the reflex tussigene and swallowing in connection either with senescence or with neurological or neuromuscular diseases (Amyotrophic lateral sclerosis, Alzheimer's disease, Parkinson's disease) either with certain drug prescriptions (anticholinergic, antipsychotic or anxiolytic). Also the tachypnea, associated with medical conditions common to this age group, showed a change in the coordination between swallowing and breathing. Dental origin is also often incriminated (fillings, prostheses and dental chicots…) as the case of our patient in whom the incident went to sleep and the missing prosthesis was not noticed [3,4 ,5]

Iconography:

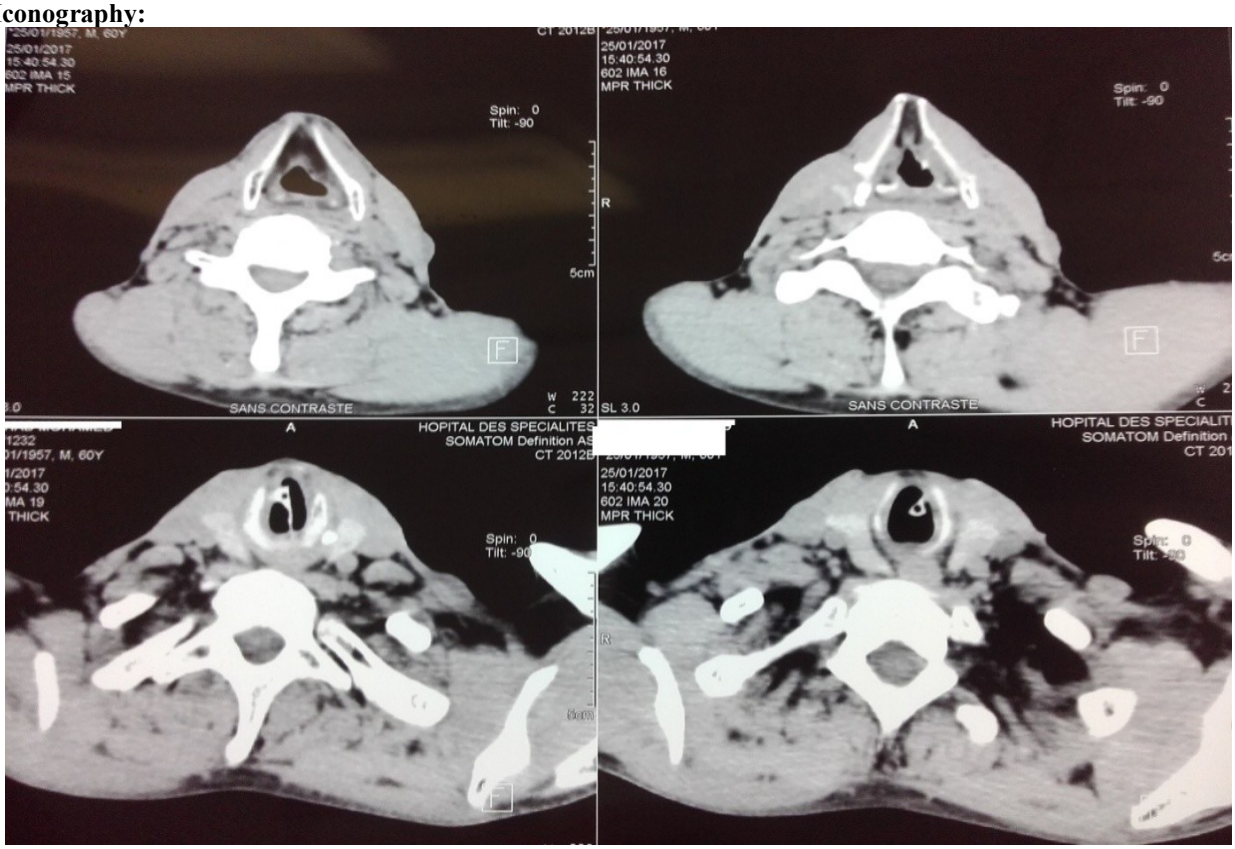

Fig1:- Axial coupe cervical scan with the laryngeal forign body.

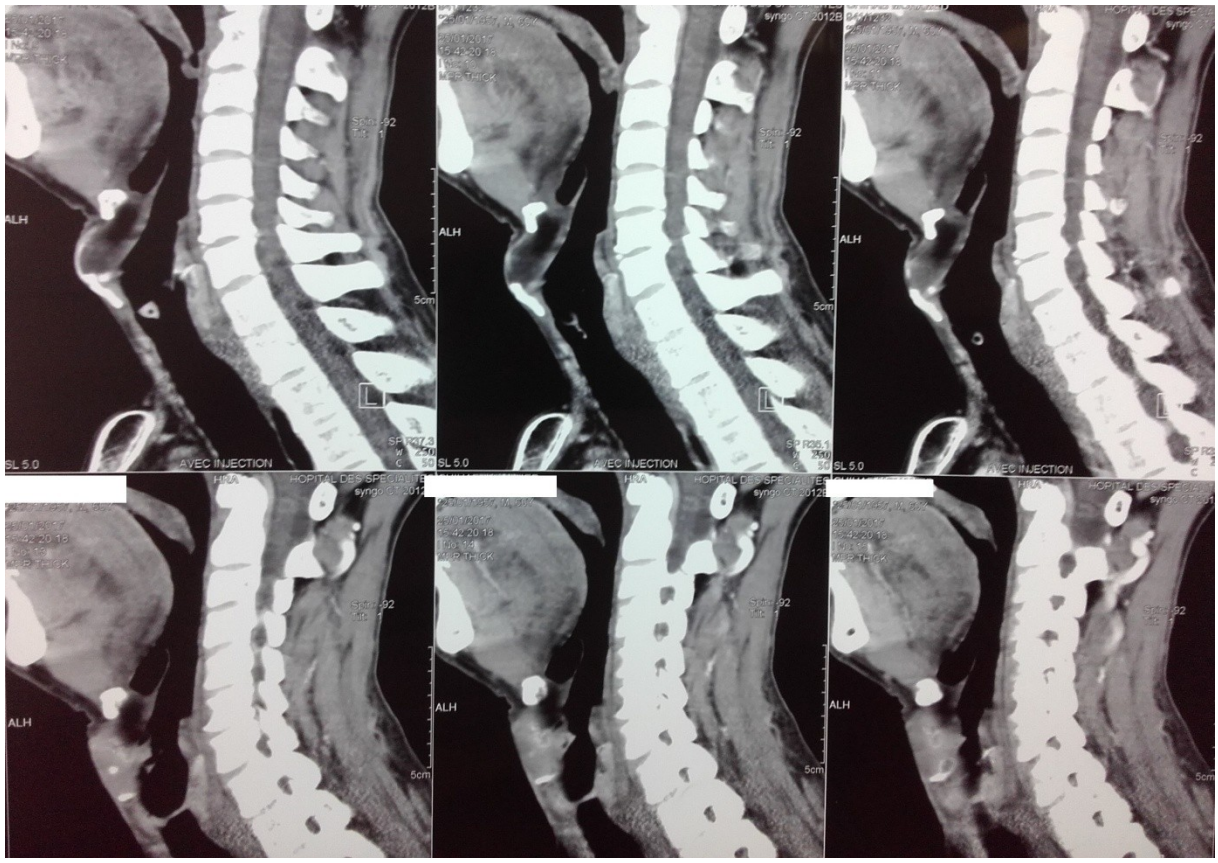

Fig2:- Sagittal coupe of cervical scan showed laryngeal edema and total obstruction.

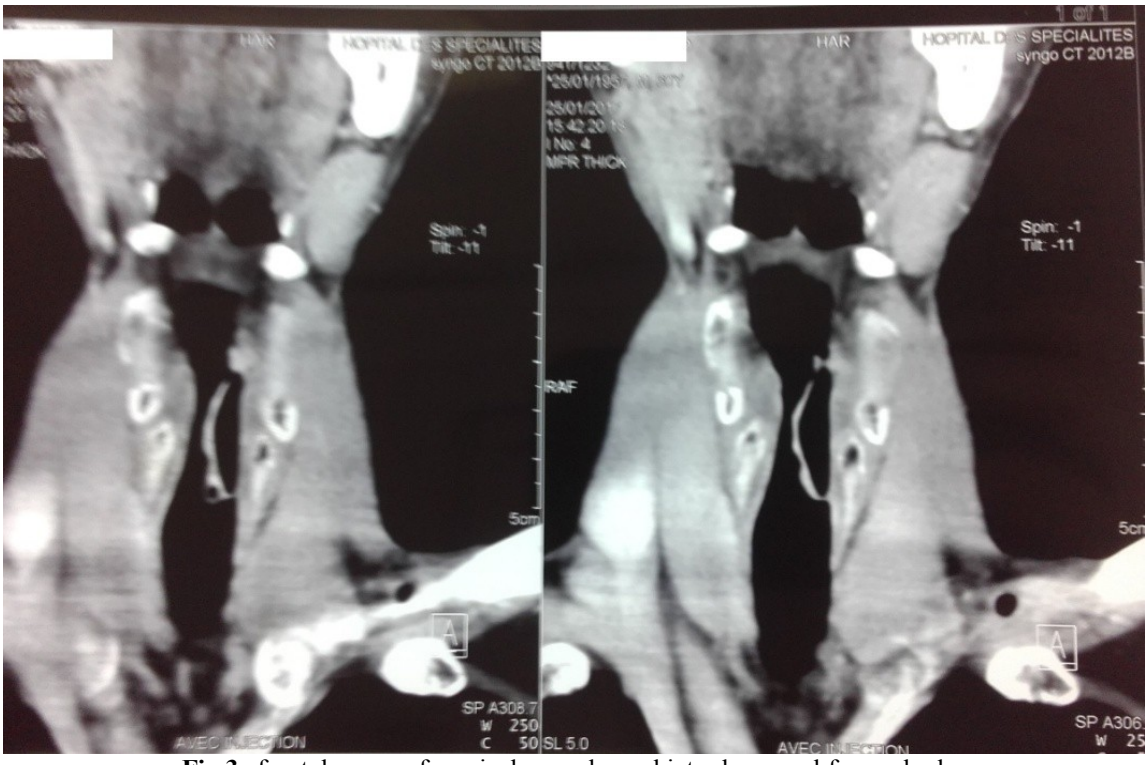

Fig 3:-frontal coupe of cervical scan showed intra laryngeal foregn body

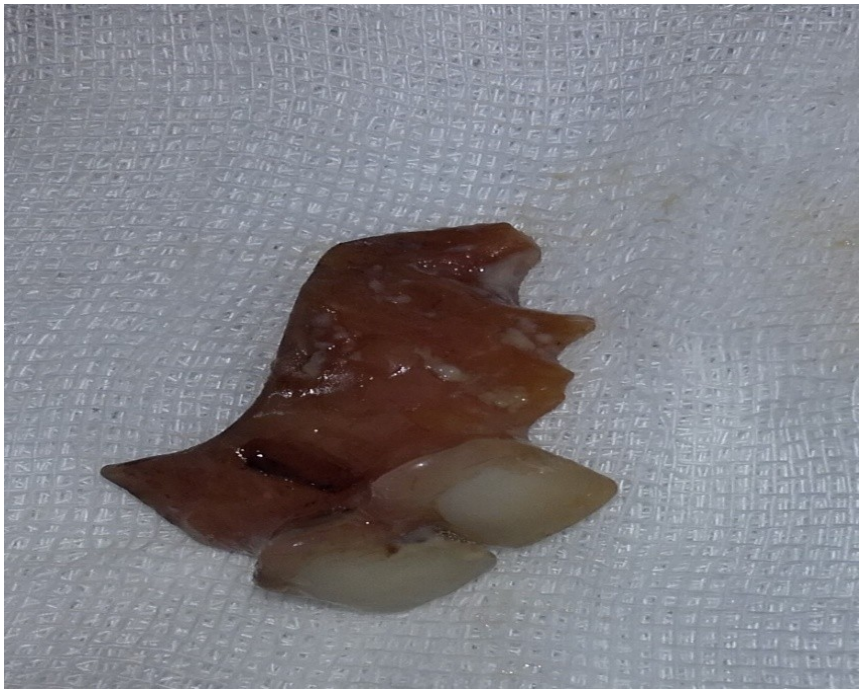

Fig 4:- Dentures extracted by direct laryngoscopy.

Conclusion:-

An atypical clinical presentation can lead to a diagnostic delay with immediate dramatic consequences (death) or secondary (bronchectasia requiring pneumonectomy).

It is important before any respiratory symptomatology of sudden onset to evoke the diagnosis of inhalation of foreign body, perform a thorough examination in search of a penetration syndrome and perform an endoscopy of the Vads under general anesthesia in the slightest doubt.

Reference:-

1. Esclamado RM, Richardson MA. Laryngotracheal foreign bodies in children. A comparison with bronchial foreign bodies. Am J Dis Child. 1987;141:259–62.].
2. 10.11604/pamj.2014.19.220.4952Hanane Benjelloun,1,& Nahid Zaghba,1 Abdelaziz Bakhatar,1 Najiba Yassine,1 et Abdelkrim Bahlaoui[1] Tracheobronchial foreign bodies in adults
3. Herrak L, Ouadnouni Y, Msougar Y, Maidi M, Fennane H, Oouchen H, et al. Une extraction dentaire chèrement payée. Rev Pneumol Clin. 2011;67(5):330–33.
4. Herrak L, Ouadnouni Y, Msougar Y, Maidi M, Fennane H, Oouchen H, et al. Une extraction dentaire chèrement payée. Rev Pneumol Clin. 2011;67(5):330–33.
5. Caidi M, Kabiri H, Lazrek I, El Maslout A, Ben Osman A. Chirurgie des corps étrangers intrabronchiques. Ann Chir. 2002;127(6):456–60.
6. Timbo SK, Keita MA, Doumbia-Singare K, Togola-Konipo F, Traore L, Guindo B, et al. Handicap et corps étrangers ORL: A propos de quatre observations originales. Mali Med. 2010;25(2):50–5.].