LYMPHANGIOMA OF THE LARYNX AS A CAUSE OF PROGRESSIVE DYSPNOEAE

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The following is a case report of a lymphangioma of the larynx in a 16-year-old girl with Down's Syndrome. The clinical record of the girl, the diagnosis of the tumour and its surgical treatment as well as the postoperative course and the follow-up results are described.

Key words: lymphangioma, larynx tumour, vascular tumour

INTRODUCTION

A case is presented of a lymphangioma of the larynx. Vascular tumours can be divided into angiomas and lymphangiomas, depending on whether they are formed by vascular or lymphatic elements. Lymphangiomas are congenital cystic malformations arising from an abnormal development of the lymphatic vessels. In the larynx they are usually located within the true and false vocal cords. In the supraglottic area they are found within the epiglottis. Hamartomas derive from an abnormal development of blood vessels. They are found in the skin and also in the larynx.

CASE REPORT

Clinical features

A 16-year-old female patient with Down's syndrome (clinical record No. 219893) presented with a history of progressive dyspnoea. A complete cardiopulmonary examination was negative. A tentative diagnosis of macroglossia was entertained. The patient had a partial excision of the anterior portion of her tongue with a pathological diagnosis of cavernous haemangioma. The intubation for this operation was difficult. The anaesthesiologist noted a fleshy-reddish tumour in the left of the epiglottis. This mass deformed the entire area and displaced the epiglottis to the right side. The patient was referred to the Otorhinolaryngological Department with the diagnosis of a laryngeal malformation.

Diagnosis

An X-ray examination demonstrated a tumour which obscured the whole of the epiglottis (Fig. 1). In December 1982 a direct laryngoscopy was

Fig 1. X-ray study before surgery.
performed under general anaesthesia which exposed a large tumour of the epiglottis.

**Treatment**

The lesion was removed by way of a supraglottic partial laryngectomy with tracheostomy.

**Follow-up**

After the operation the patient was monitored in the Intensive Care Unit, where she spent 5 days without problems. Six hours after the operation feeding was started by a nasogastric tube, which was perfectly well tolerated.

Seven days later the tracheostomy was withdrawn without difficulty, with a prior period of adaptation with a fenestrated cannula. Nineteen days after the operation the nasogastric tube, was also withdrawn, after first checking correct swallowing of fluids and semisolids. (This longish period is due to the greater difficulties of adaptation of patients with Down's syndrome).

On April 13th, 34 days after the operation, the patient was discharged from the hospital, with good voice, breathing and perfect deglutition. One month later a direct laryngoscopy under general anaesthesia was performed, in order to check the condition of the larynx, since indirect studies were not possible. We observed edematous hypertrophy of the arytenoids as one might observe.