Supposed otolaryngology emergency which presents late: Bilateral congenital choanal atresia

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SUMMARY

Choanal atresia is the congenital obstruction of the posterior nasal cavity, and encountered at a rate of 1 in 5000 to 1 in 8000 live births, with slight female preponderance. Bilateral congenital choanal atresia always presents as upper airway emergency where the newborn shows respiratory distress, cyanosis, apnoea which are relieved by crying. We report a rare care of bilateral congenital choanal atresia which has escaped detection of during her neonatal period. A 5-year-old girl presented to our otolaryngology clinic with bilateral persistent nasal blockage and rhinorrhea since birth. Besides, parents noticed that the child had persistent mouth breathing and did not seem to be interested in food stuff that most children were. She had never experienced any respiratory distress or cyanosis thus far. The diagnosis of bilateral mixed bony/membranous choanal atresia was made via endoscopic examination and computed tomography (CT). Transnasal endoscopic surgery was performed under general anaesthesia where a cruciate incision was made onto the atretic membrane with gradual dilatation using modified endotracheal tube and the edges was injected with mitomycin C (0.4mg/ml). Single stent (Size 8 French Ryle's tube) was inserted and removed under general anaesthesia 6 weeks later. Post-operative at 6 months, there was partial restenosis at the right side, but the left side remained wide open. She is currently well and asymptomatic 3 years post-operatively. Choanal atresia is a rare entity especially if it escapes through the neonatal period without being detected. It may be misdiagnosed as allergic rhinitis or chronic rhinosinusitis if not properly examined particularly in children who are not cooperative with office procedures such as feeding tube passage or endoscopic examination. Sensation of smell may not revert to normal after successful surgery, but the relief of nasal blockage and rhinorrhea definitely helps in quality of life of patients.

A curious case of Syphilis causing retropharyngeal abscess with airway compromise: Are we missing a common etiology?

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SUMMARY

Retropharyngeal abscess is a deep neck space collection arising from the space bounded by the buccopharyngeal and prevertebral fascia. While a retropharyngeal abscess is a widely known complication of upper airway infection caused by polymicrobial infection, treponema pallidum can often be missed as it is rarely associated with retropharyngeal abscess. A 30-year-old gentleman had presented with sore throat, dysphagia, odynophagia, limited neck movement and fever for 3 days. Clinical examination revealed a bulging posterior oropharyngeal wall compromising the upper airway. An intra-oral drainage of the oropharynx was then done and he was kept in intensive care for 1 week. He had responded well to conventional syphilis treatment using penicillin group antibiotics and was discharged after being warded for 2 weeks. RPR yielded a titre of 1:128 and TPPA was positive. Light microscopy revealed characteristic spirochetes based on swab cultures from the retropharyngeal abscess. CECT neck and plain lateral neck radiograph revealed a collection at retropharyngeal region extending from C2 to C4 level with multiple cervical lymphadenopathy. Our case demonstrates the rare case of treponema pallidum causing a retropharyngeal abscess. As syphilis is sexually transmitted disease, it is often not the primary choice of investigation in a retropharyngeal abscess. Hence, the authors recommend performing regular viral and treponema screening for retropharyngeal abscesses with no known source of extension based.