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# Anterior advancement flap stomaplasty for stomal stenosis

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**SUMMARY**

Presence of stomal stenosis post total laryngectomy can impair an effective usage of voice prosthesis for vocal rehabilitation. Thus, it is crucial to address the stomal stenosis with a better surgical technique. A 56-year-old Malay male, presented with a history of hoarseness for 3 months, associated with loss of appetite and loss of weight. Clinical examination revealed a left glottic exophytic mass, extending to anterior commissure and subglottic region. Imaging and tissue diagnosis assessment confirmed it was transglottic squamous cell carcinoma, T3N0M0. Patient underwent total laryngectomy with bilateral selective neck dissection and provox voice prosthesis insertion. At 4 months post-operatively, the patient developed stomal stenosis due to persistent infection at the stoma region. The stomaplasty via anterior advancement flap was performed. The voice prosthesis remains in-situ and the wound heals with a better functioning stomal and the prosthesis remains viable at 1 year post-operatively. Stomal stenosis is a common and dreadful complication of post laryngectomy cases. Once sets in, it is generally progressive and requires active intervention. Optimal function of the prosthesis requires an adequate stoma. The cleaning of the prosthesis also better if patient has sufficient diameter of the stoma. Critical stomal stenosis need surgical widening to facilitate efficient use of voice prosthesis. There are many surgical techniques described but frequently results in re-stenosis. The anterior advancement flap is a simple and effective techniques for stomaplasty. The triangular skin flap is sutured to the laterally splayed trachea to its apex of incision. The resultant stoma is satisfactory which facilitate efficient voice prosthesis usage. Anterior advancement flap is a viable and efficient approach for treating stomal stenosis and facilitate adequate voice prosthesis functioning and vocal rehabilitation.

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# Overcoming severe upper airway obstruction with lingual tonsillectomy: A case report

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**SUMMARY**

Tonsillar enlargement can be associated with airway obstruction and is a potential medical emergency. Failure to treat it immediately can be life-threatening. Any form of obstruction then needed to be surgically removed. However, after a routine palatine tonsillectomy, there is a risk of compensatory enlargement of the lingual tonsils causing a more severe upper airway obstruction. A 34-year-old gentleman had a prior history of palatine tonsillectomy following a diagnosis of moderate obstructive sleep apnoea (OSA). There is no history of gastro oesophageal reflux disease (GERD). Over the years, he became more breathless but is tolerable. He presented to us with a month history of worsening of his dyspnoea, with occasional odynophagia, unable to sleep supine and now interfered and affected his daily routines. Flexible fibreoptic laryngoscopy showed a grade 4 lingual tonsils with a Muller's manoeuvre showing more than 50% collapse at the retro lingual level. A computed tomography (CT) scan of neck revealed bilateral and symmetrical enlargement of the lingual tonsils. A repeated polysomnography (PSG) concluded a moderate OSA. A treatment trial with a positive airway pressure (PAP) therapy could not overcome the problem as patient is unable to tolerate the machine. Following a successful lingual tonsillectomy, the patient showed significant improvement in breathing and oral intake while also developing significant dygeusia after the surgery.