Case report of parapharyngeal abscess with vocal cord palsy secondary to trauma

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SUMMARY

The parapharyngeal space is a rare site for infection. Parapharyngeal infections carry a significant risk of extensive suppuration and airway compromise. Majority of patients develop it as a complication of tonsillitis or tonsillectomy, or as a result of either infection or extraction of lower molar teeth. Based on our literature review, no case of parapharyngeal abscess with vocal cord palsy secondary to single assault by hand to neck area, has been reported. Hence, we present a rare case of a parapharyngeal abscess and vocal cord palsy secondary to assault by hand. We describe a case of a 35 year old man with underlying diabetes mellitus, who presented to us with left facial and neck region pain following an assault of a single slap to left side of neck by hand of his friend. Patient also complained of odynophagia with fever and hoarseness. Neck examination noted loss of laryngeal crepitus with tenderness over the left cervical region and fullness of the left supraclavicular area. FNPLS noted inflamed left arytenoid and left vocal cord palsy. A CT neck was done and the report stated that an enhancing collection noted at left parapharyngeal space extends to the retropharyngeal area, which most likely can be due to collection or infected hematoma. DL, EUA and I&D of left parapharyngeal space abscess was done and 5cc pus drained from midline incision and there was minimal bulge at left lateral pharyngeal wall. The intravenous cefuroxime and flagyl were continued for the patient. Subsequently, the patient was fully recovered and the vocal cord palsy resolved. In case of trauma to the neck no matter how trivial, the possibilities of developing parapharyngeal abscess or hematoma is still possible.

Persistent Tracheocutaneous Fistula (PCTF) sequelae of tracheostomy decannulation: A pictorial description of repair with conchal cartilage graft and literature review

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SUMMARY

Persistent tracheocutaneous fistula (PTCF) is a common sequela following decannulation of prolonged use of tracheostomy tube. In most cases, a simple removal of the tube and the application of occlusive dressings over the stoma produce acceptable functional and aesthetic results. However, PTCF can occur in certain patients. This condition develops when the squamous epithelium from the skin migrates into the trachea creating an epithelialized tract that fails to close. A neglect to identify the presence of a fistula can be associated with significant morbidity and even fatality. PCTFs lead to difficulties in secretion clearance, vocalization and recurrent respiratory infections as well as social and cosmetic problems. Many methods of PTCFs repair have been described varying from closure by secondary intention, primary closure, layered primary closure, local tissue, muscle flaps, and free flaps. In larger tracheal defects, reconstruction with rib and conchal cartilage grafts have been reported and described. We describe here steps and pictorial descriptions of the successful closure of PTCFs in two patients with large persistent tracheocutaneous fistula using a simple closure technique with conchal cartilage. A review of the other closure techniques will also be discussed regarding the advantages and the advantages of each type of repair. The closure of a small TCF is often simply, safe, and accomplished by performing limited local procedures, whereas the treatment of a large persistent TCF is potentially complicated. We demonstrate that large PTCF can be closed safely with a conchal cartilage graft with good outcomes.