

Laryngeal Rhabdomyoma. Transoral Exeresis With CO₂ Laser

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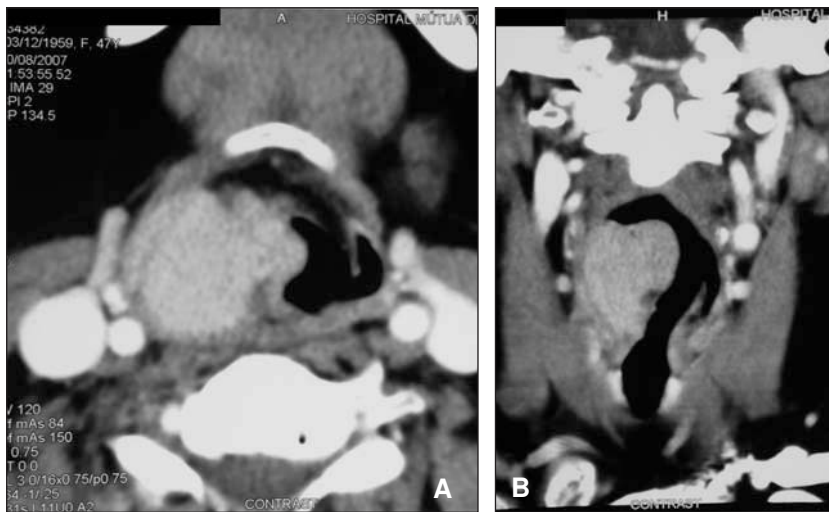


Figure 1. Tomographic image (coronal and axial slices) showing a hyperdense mass 5×3.5×2.5 cm spreading from the glossoepiglottal fold to the right vocal cord, completely obliterating the pyriform sinus.

Fifty-year-old female with dysphagia, presenting on fibrolaryngoscopy a sub-mucosal bulging of the entire right hemilarynx (extending from the pharyngolaryngeal wall to the vocal cord) that spread towards the vallecula and the pharyngoepiglottal fold obliterating the pyriform sinus.

The cervical CT scan revealed a solid, hyperdense mass of approximately 5×3.5×2.5 cm extending from the glossoepiglottal fold to the right vocal cord, completely obliterating the pyriform sinus (Figure 1). It was decided to proceed with a direct microlaryngoscopy with extraction of a biopsy specimen, pre-operative histopathology study and transoral exeresis with CO₂ laser depending on the outcome of the study. Under the microscope, after dissection of the mucosa, it was easy to distinguish the tumourous tissue from healthy tissue, which has clearly distinctive macroscopic characteristics from those of squamous cell carcinomas.

Intra-operatively, the lesion was reported to be benign and compatible with a granular cell tumour. In view of the good accessibility to the lesion, it was decided to perform exeresis using CO₂ laser, even though it was only possible, because of the extension of the tumour and its location, to achieve complete resection by fragmenting the lesion vapourizing the areas where access was more difficult. We were able to respect part of the vocal cord despite the fact that the lesion occupied all of the paraglottal space (Figure 2). The post-operative course proceeded without incident; the patient was fed through a nasogastric tube for 6 days and was discharged on the seventh day after the procedure. No tracheotomy was required. The definitive histopathology study reported an adult rhabdomyoma. After 10 months, the patient is asymptomatic and there are currently no signs of recurrence of the tumour.

Rhabdomyomas are benign neoplasms originating in the striate muscle and most often affecting the cardiac muscle. Extracardiac involvement is usually in the head and neck region. The largest case series of extracardiac rhabdomyomas reviewed is that by Helliwell et al in 1988, with 115 cases, of which 70% were located in the head and neck region and 15 in the larynx. In 1995, Johansen et al published a series of 23 cases of laryngeal rhabdomyoma. The treatment of rhabdomyoma requires exeresis. Despite the size of the lesion

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in our case, we are in favour of a transoral approach using CO₂ laser (providing this is possible in the light of its exposure) and, if necessary, we can resort to fragmenting

and vaporizing the tumourous remnants, as it is a benign tumour that does not metastasize and has scant possibilities of recurrence if the resection is complete.

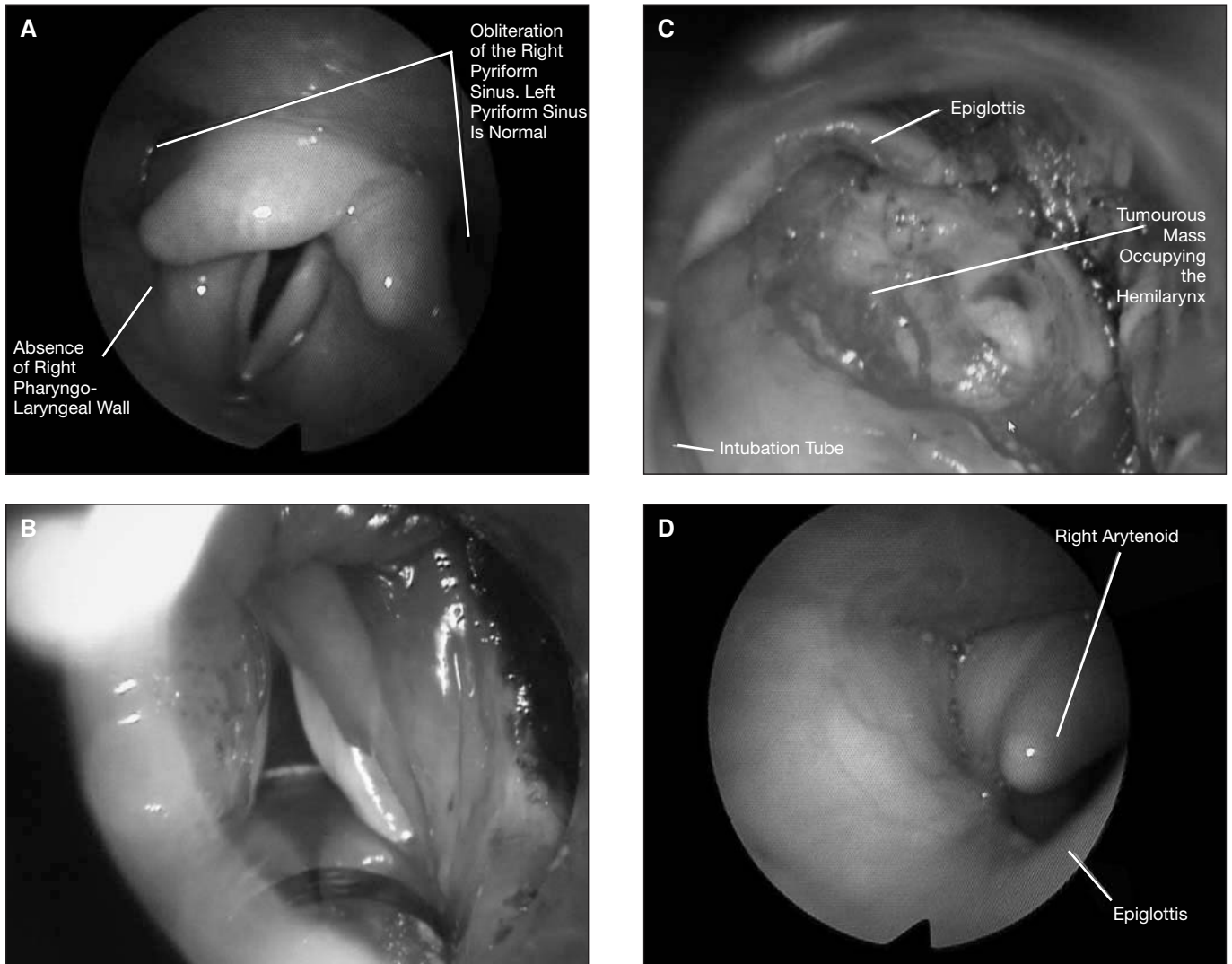


Figure 2. Intra-operative laryngoscopic image. After removal of the healthy mucosa, a large tumour can be seen to occupy all of the right hemilarynx. After extirpation, the endolarynx was respected. Post-operative examination 6 months later. Scarring changes in the right pyriform sinus. Cords mobile.