



Atlas of Pharyngeal and Laryngeal Disorders

- ▶▶ Acute tonsillitis
- ▶▶ Chronic tonsillitis
- ▶▶ Peritonsillar abscess
- ▶▶ Mycotic infections of the pharynx
- ▶▶ Malignant tumors of the oropharynx
- ▶▶ Foreign bodies in oropharynx
- ▶▶ Laryngeal papillomas
- ▶▶ Laryngitis sicca

Supplementary video and online contents available at
<http://collections.medengine.com/ent/atlas-of-nose-and-paranasal-surgeries/>



For vertigo of all origins

Start with

Stugeron[®] Plus

Cinnarizine 20 mg + Dimenhydrinate 40 mg tablets

RAPID AND SUSTAINED RELIEF



VERTIGO
IS CHALLENGING,
MAKE THE
FIRST MOVE
WITH PLUS.

For the use only of a Registered Medical Practitioner or a Hospital or Laboratory

Stugeron[®] Plus

Description: Stugeron[®] Plus consists of 20 mg cinnarizine and 40 mg dimenhydrinate as a fixed dose combination. Therapeutic Indication: For the treatment of vertigo. Contraindications: Severe renal impairment, severe hepatic impairment, patients with known hypersensitivity to the active substances, diphenhydramine or other antihistamines of similar structure or to any of the excipients. Warnings and Precautions: Should be taken after meals to minimize any gastric irritation; Should be used with caution in patients with conditions that might be aggravated by anticholinergic therapy; Should be used with caution in hypotensive patients; When administering patients with Parkinson's disease, caution should be exercised. Interaction: Concurrent use of Alcohol/CNS depressants/Tricyclic Antidepressants may potentiate the sedative effects of either of these medications or of Stugeron[®] Plus. Stugeron[®] Plus may mask ototoxic symptoms associated with amino glycosidic antibiotics and mask the response of the skin to allergic skin tests. The concomitant administration of medicines that prolong the QT interval of the ECG (such as Class Ia and Class III antiarrhythmics) should be avoided. Pregnancy and lactation: Stugeron[®] Plus should not be used during pregnancy and usage should be discouraged in nursing women. Effects on Ability to Drive and Use Machines: Stugeron[®] Plus may cause drowsiness, especially at the start of treatment, therefore, should not drive or operate machinery. Posology and Method of Administration: Adults and Elderly: 1 tablet three times daily, to be taken unchewed with some liquid after meals. Children and adolescents under the age of 18 years: Stugeron[®] Plus is not recommended. Undesirable Effects: Commonly observed adverse reactions include somnolence and dry mouth. Other adverse reactions include constipation, weight gain, tightness of the chest, worsening of an existing angle-closure glaucoma, reversible agranulocytosis and extrapyramidal symptoms. Overdose: Drowsiness and ataxia with anticholinergic effects are usually seen. Convulsions, respiratory depression and coma may occur in cases of massive overdosage. General supportive measures and gastric lavage with isotonic sodium chloride solution are recommended. Short-acting barbiturate and physostigmine (after physostigmine test) can also be used in case of marked symptoms.

® - Registered trademark of Johnson & Johnson, USA.

Version of API: CCDS dated 05 Jan 2016.

Date of printing: Sep 2019

Disclaimer: The Information provided herein shall in no manner be construed to replace the clinical judgment or guide to individual patient care. Furthermore, although the information provided herein is believed to be true and accurate, Janssen, a division of Johnson & Johnson Private Limited assumes no responsibility in any manner whatsoever for any errors or omissions that may occur either directly or indirectly due to any action or inaction you take based on the information provided herein.

Additional information available on request.

For complete prescribing information, please contact: Johnson & Johnson Private Limited, Arena Space, Behind Majas Depot, Opp. J.V. Link Road, Jogeshwari (E), Mumbai 400060.

Website: www.jnjindia.com

Atlas of Pharyngeal and Laryngeal Disorders

All All rights reserved. No part of this publication may be reproduced, transmitted or stored in any form or by any means either mechanical or electronic, including photocopying, recording or through an information storage and retrieval system, without the written permission of the copyright holder

Although great care has been taken in compiling the content of this publication, the publisher, its employees and editors/officers are not responsible or in any way liable for the accuracy of the information, for any errors, omissions or inaccuracies, or for any consequences arising therefrom. Inclusion or exclusion of any product does not imply its use is either advocated or rejected. Use of trade names is for product identification only and does not imply endorsement. Opinions expressed do not necessarily reflect the views of the Publisher, Editor/s, Editorial Board or Authors. The image/s used on the cover page, have been obtained from Shutterstock/Fotolia under a valid license to use as per their policy. The images used are representational and not of actual health care professional (HCP) or patient.

Please consult the latest prescribing information from the manufacturer before issuing prescriptions for any products mentioned in this publication. The product advertisements published in this reprint have been provided by the respective pharmaceutical company and the publisher, its employees and editors/officers are not responsible for the accuracy of the information.

© Springer Healthcare 2019.

September 2019

 Springer Healthcare

This edition is published by Springer Nature India Private Limited.
Registered Office: 7th Floor, Vijaya Building, 17, Barakhamba Road, New Delhi - 110 001, India.
Phone: 91 (0) 11 4575 5888
www.springerhealthcare.com

Part of the Springer Nature group

Contents

Acute tonsillitis.....	1
Chronic tonsillitis.....	2
Peritonsillar abscess.....	3
Mycotic infections of the pharynx.....	4
Malignant tumors of the oropharynx	5
Foreign bodies in the oropharynx	6
Zenker’s diverticulum	7
Acute laryngitis	8
Laryngeal papillomas.....	9
Laryngeal carcinoma	10
Leukoplakia of the left vocal fold	11
Unilateral vocal fold paralysis.....	12
Recurrent respiratory papillomatosis of the larynx	13
Carcinoma of the right vocal cord with vocal fold hypomobility	14
Anterior glottic carcinoma	15
Carcinoma of the left vocal cord reaching the anterior commissure	16
Supraglottic carcinoma.....	17
Acute laryngitis with laryngopharyngeal reflux.....	18
Laryngitis sicca.....	19

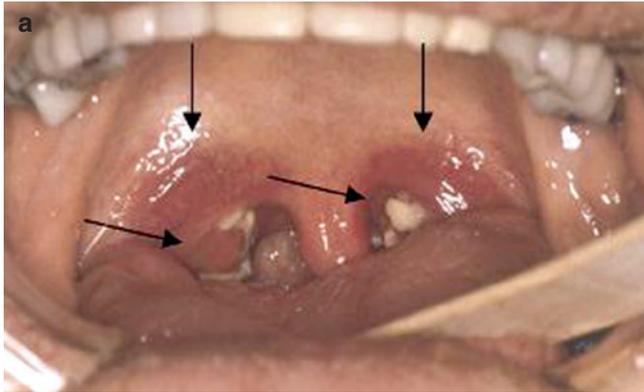
Granuloma of the larynx.....	20
Laryngeal amyloidosis.....	21
Behcet's disease presenting laryngopharyngeal ulcer and scar.....	22
Recurrent laryngopharyngeal ulceration	23
Relapsing polychondritis presented with bilateral vocal fold paralysis and laryngotracheal stenosis.....	24
Relapsing polychondritis presenting subglottic stenosis	25
Reflux laryngitis	26
Tuberculous laryngitis	27
Syphilis of the pharynx	28
Laryngopharyngeal hemangioma	29
Chondroma of the larynx	30
Laryngomalacia	31
Congenital laryngeal web	32

Step by step procedure to view the online contents and video(s):

1. Go to <http://collections.medengine.com/ent/atlas-of-nose-and-paranasal-surgeries/> or scan QR code.
2. Web page of the issue will be opened.
3. You can read the PDF and view the video(s) online.
Both can be downloaded also.



Acute tonsillitis



View into the oropharynx of a patient with acute tonsillitis (**a**). Typical findings are enlarged *red* tonsils, pus on the tonsils, and reddened palatine arches (*arrows*). When tonsils become so large that they touch each other, they are called "kissing tonsils," as seen in this picture from flexible nasal endoscopy (**b**). *Acute tonsillitis* (angina) is commonly caused by group A streptococci. Clinical features are an initial high-temperature (angina catarrhalis) with severe dysphagia, hypersalivation, cephalgia, and enlarged *red* tonsils with *white dotted* coats (angina lacunar).

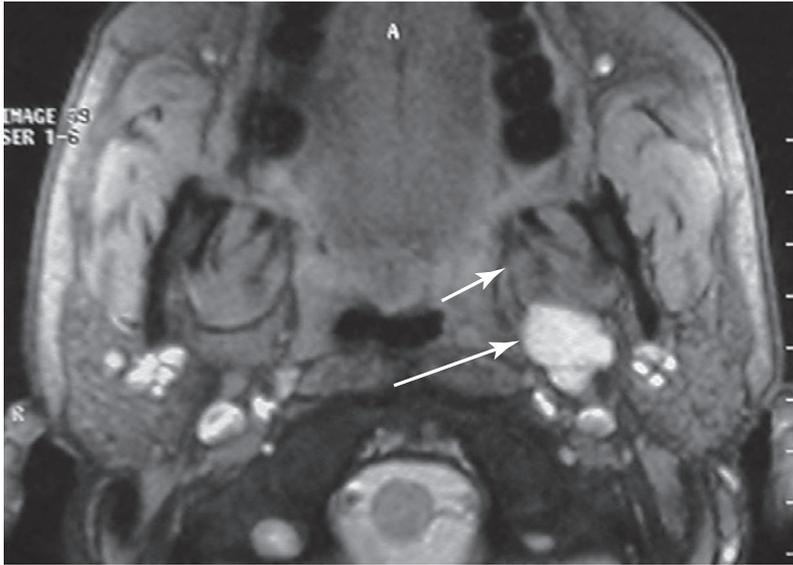
Authors: Jens Peter Klussmann, Markus Stenner, Orlando Guntinas-Lichius, Elke R. Gizewski
Title: Pathology of the ear, nose, and throat
Book: Atlas of Anatomic Pathology with Imaging
DOI: 10.1007/978-1-4471-2846-5_12
© Springer-Verlag London 2013

Chronic tonsillitis



In chronic tonsillitis, the tonsils show cicatricial conversion of the tissue. The results are often small tonsils serving as a bacterial focus for a variety of different diseases in the body. Recurrent infections lead to with scarring; persistent bacterial foci may account for a variety of subsequent diseases, such as rheumatic fever, glomerulonephritis, and psoriasis.

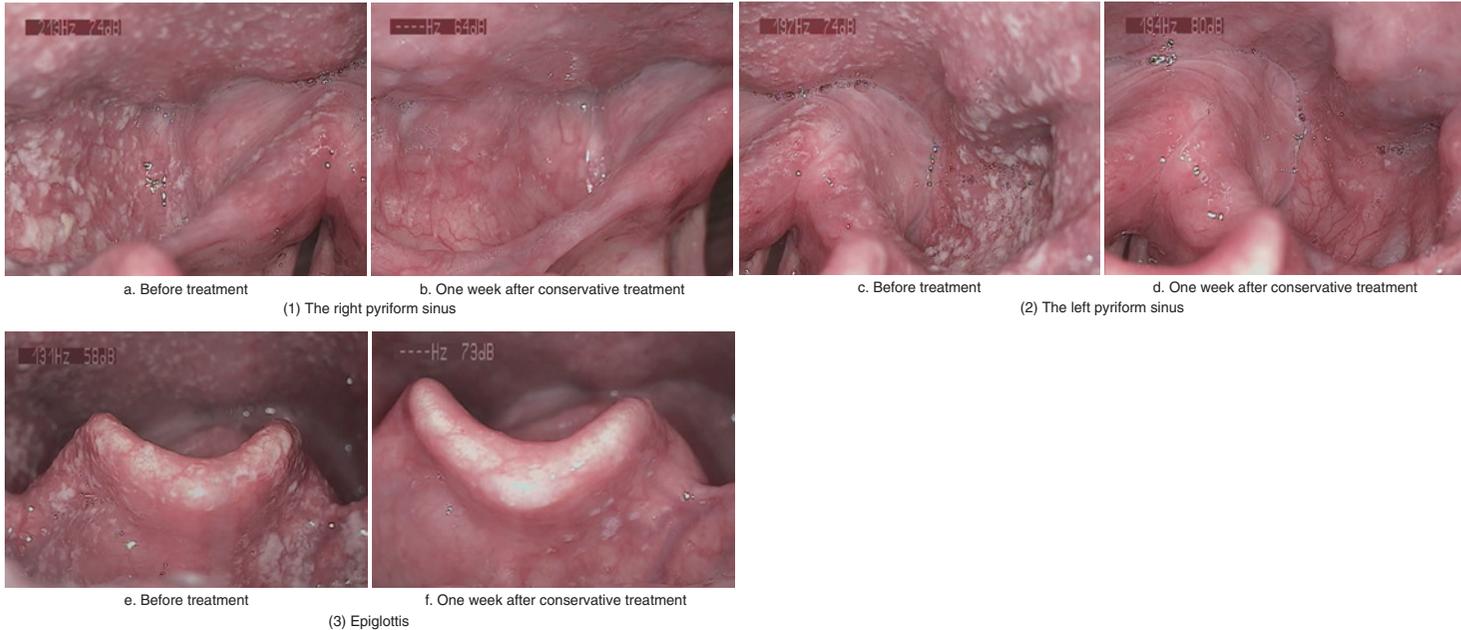
Peritonsillar abscess



Peritonsillar abscess extends deep into the tissue between the tonsillar parenchyma and the pharyngeal constrictor muscle. Clinical findings are a severe, unilateral, red swelling of the soft palatine arch, muffled voice, and even fixed jaws in some cases. The image is NMR scan showing a peritonsillar abscess in the left palatine tissue (*long arrow*), deriving from the left tonsil (*short arrow*) in acute tonsillitis.

Authors: Jens Peter Klussmann, Markus Stenner, Orlando Guntinas-Lichius, Elke R. Gizewski
Title: Pathology of the ear, nose, and throat
Book: Atlas of Anatomic Pathology with Imaging
DOI: 10.1007/978-1-4471-2846-5_12
© Springer-Verlag London 2013

Mycotic infections of the pharynx



Mycotic infections of the pharynx. (1) The right pyriform sinus: **(a)** before treatment, **(b)** one week after conservative treatment. (2) The left pyriform sinus: **(c)** before treatment, **(d)** one week after conservative treatment. (3) Epiglottis: **(e)** before treatment, **(f)** one week after conservative treatment. Strobolaryngoscopy showed patchy materials diffused and slightly protruded from the root of tongue, the lateral and posterior wall of pharynx, the lingual surface of the epiglottis and bilateral pyriform sinuses. These lesions disappeared after conservative treatment.

Author: Wen Xu

Title: Specific infectious diseases

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_5

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

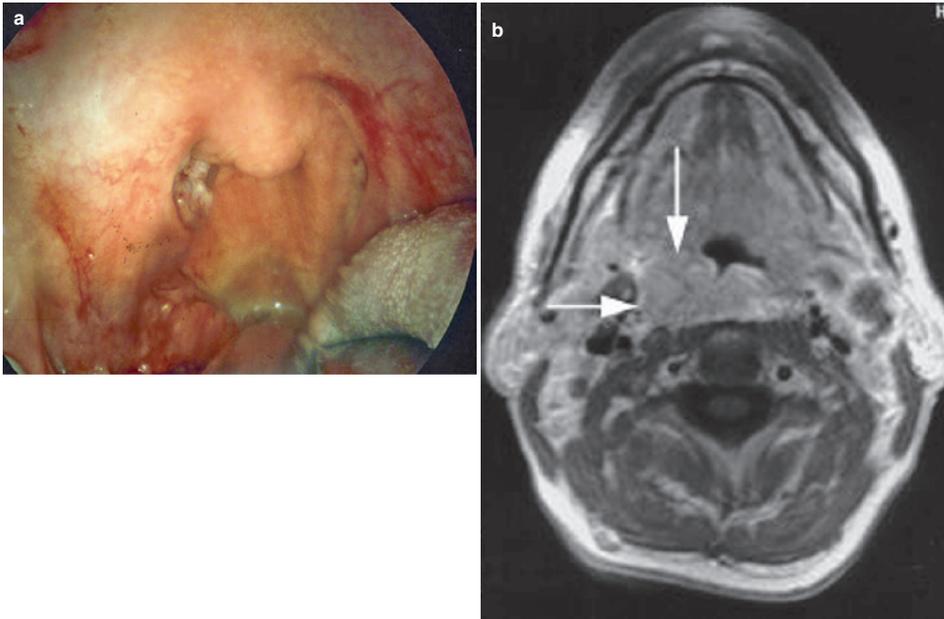


Malignant tumors of the oropharynx



Malignant tumors of the oropharynx are mainly squamous cell carcinomas; 80 % are located in the palatine tonsils and at the lingual base. Long-term alcohol and nicotine abuse plays a crucial role in the development of these cancers. The main symptoms are burning pain, dysphagia, bloody saliva, and fetor ex ore. Tonsillar carcinomas may grow exophytic or sometimes become ulcerating and infiltrative. Some microcarcinomas of the tonsils cannot be seen grossly and may first be diagnosed through lymph node metastases. The image shows squamous cell carcinoma of the left tonsil with fibrinoid, necrotic surface tissue (*arrow*).

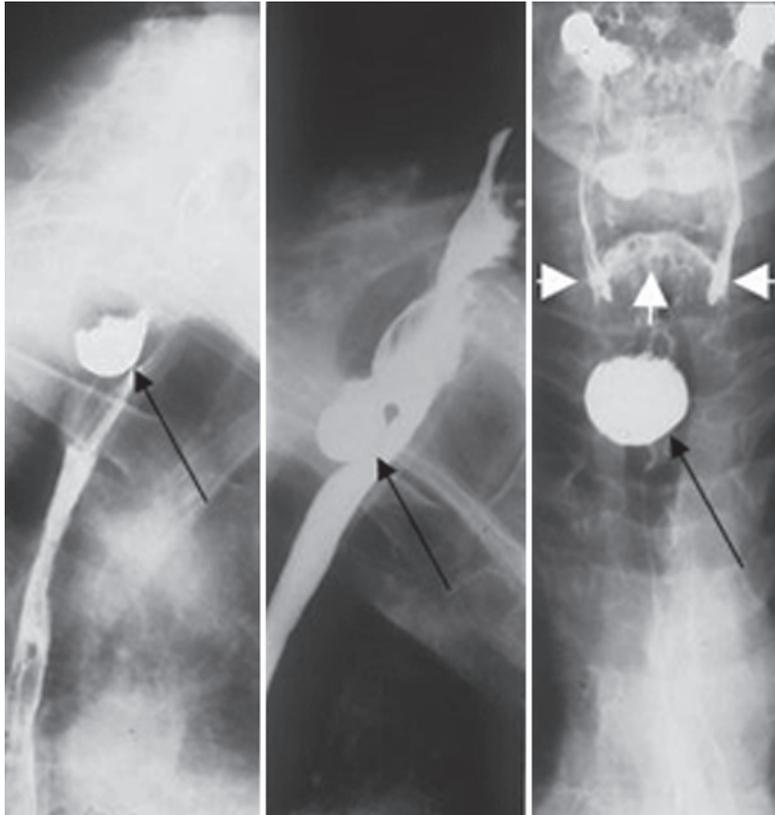
Foreign bodies in the oropharynx



Foreign bodies in the oropharynx are found mainly in the palatine tonsils or at the base of the tongue. Often these are small fish bones or bone splinters, with a typical history of food intake. Patients present with clearly localized pain when swallowing, with a risk of superinfection. This small fish bone, a common foreign body, is found in the vallecula glossoepiglottica, a typical location. If endoscopic extraction fails, it will need to be removed during total anesthesia.

Authors: Jens Peter Klussmann, Markus Stenner, Orlando Guntinas-Lichius, Elke R. Gizewski
Title: Pathology of the ear, nose, and throat
Book: Atlas of Anatomic Pathology with Imaging
DOI: 10.1007/978-1-4471-2846-5_12
© Springer-Verlag London 2013

Zenker's diverticulum



Zenker's diverticulum of the hypopharynx is a common diverticulum above the upper esophageal sphincter in middle-aged or elderly patients. It is called a "pulsion diverticulum" and causes dysphagia and regurgitation in connection with fetor ex ore. Zenker's diverticulum (*black arrows*) as seen radiographically with the swallowing of contrast solution (oblique and anteroposterior projections). Note that the vallecula glossoepiglottic and recessus pyriformis are also filled with contrast solution (*white arrowheads*).

Authors: Jens Peter Klussmann, Markus Stenner, Orlando Guntinas-Lichius, Elke R. Gizewski
Title: Pathology of the ear, nose, and throat
Book: Atlas of Anatomic Pathology with Imaging
DOI: 10.1007/978-1-4471-2846-5_12
© Springer-Verlag London 2013

Acute laryngitis



a. Before treatment

b. After conservative treatment

Acute laryngitis is usually caused by viruses, occasionally by vocal stress in dry and smoky rooms. Symptoms include hoarseness with dry, unproductive coughing, dyspnea, and a burning throat. The vocal cords are reddened, edematous, and thickened, with coatings of viscous mucus. For acute laryngitis, besides the appearance of mucosal hyperemia and edema, laryngoscopy usually reveals obvious white plaque-like inflammatory exudation which is prone to confusing with vocal fold leukoplakia.

(a) Before treatment, (b) after conservative treatment. A 28-year-old male patient had a 1-month history of paroxysmal cough and progressive hoarseness with whispering voice. Stroboscopy revealed mucosal hyperemia and irregular thickened white plaque-like lesions on the surface and edge of the bilateral vocal folds, with severely reduced mucosal waves during phonation. The movements of bilateral vocal folds were normal (a). After conservative treatment, the white lesion disappeared, and the morphology and mucosal waves recovered to normal (b).

Author: Wen Xu

Title: Inflammatory diseases

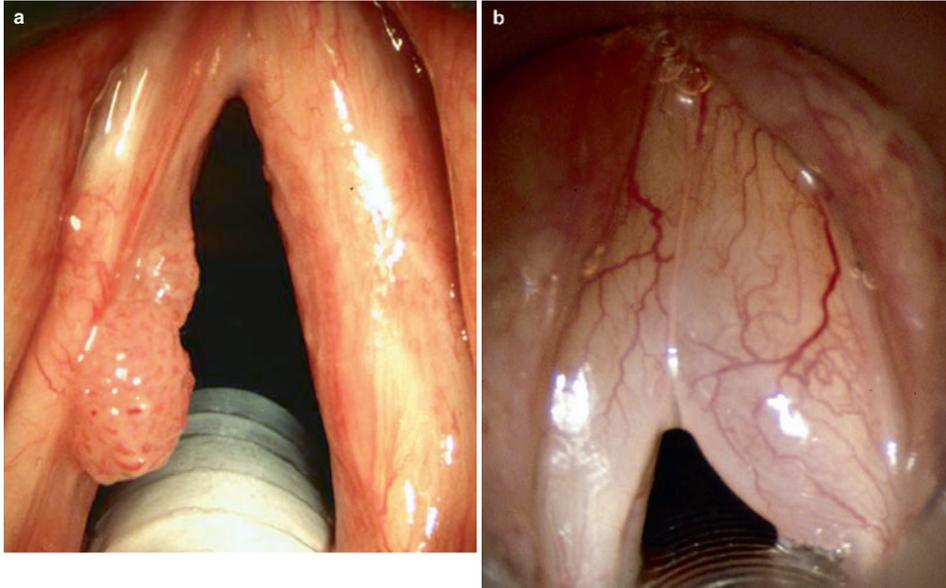
Book: Atlas of Stroboscopy

DOI: 10.1007/978-981-13-6408-2_4

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

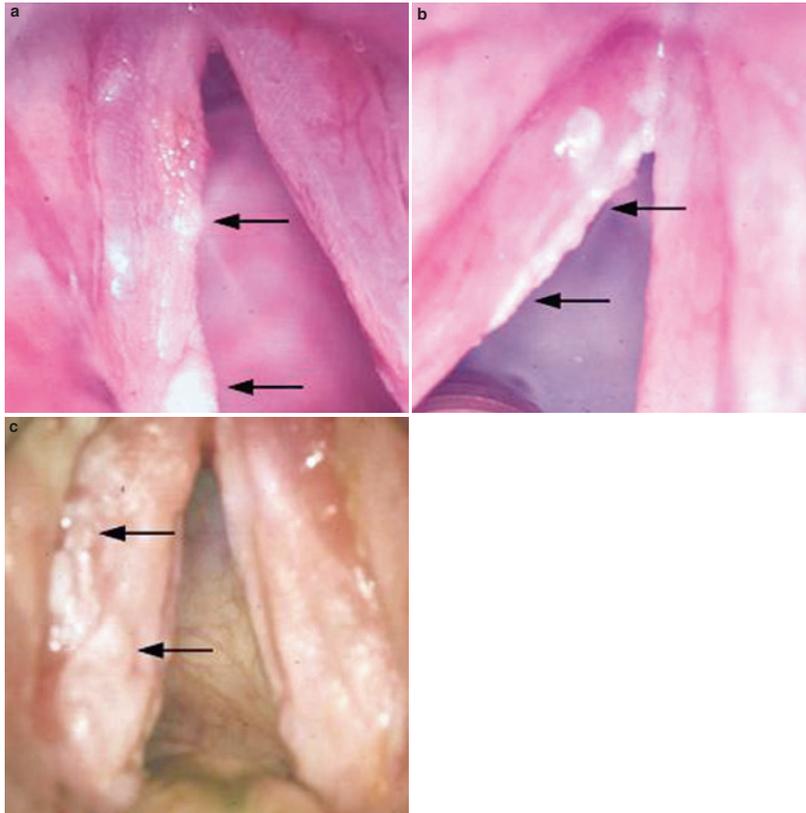


Laryngeal papillomas



Laryngeal papillomas are the most common benign tumors of the larynx caused by human papillomaviruses (mainly HPV-6 and HPV-11) in adults. There is a risk of malignant transformation. Histologically, they are fibroepitheliomas. The sometimes excessive growth of the papillomas may lead to life-threatening airway obstruction. Endoscopically, the spreading, glassy-red, raspberry-like soft tumors are seen most often at the vocal cords. Repeated surgical treatment is needed. **(a)** In laryngeal papillomatosis, spreading, *glassy-red*, raspberry-like soft tumors are seen most often at the vocal cords. **(b)** Reinke's edema is characterized by fluid accumulation between the glottic epithelium and the vocal cord ligament, in the so-called Reinke's room. Laryngoscopy shows edematous, glassy swelling of the vocal cords.

Laryngeal carcinoma

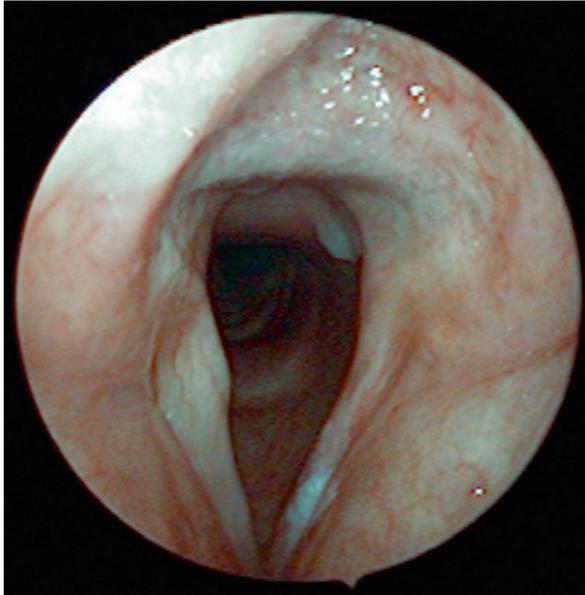


Development of a vocal cord carcinoma: leukoplakia (a), dysplasia (b), and invasive carcinoma (c).

Laryngeal carcinoma is the most common head and neck malignancy, accounting for 40 % of cases. The main risk factor is tobacco use. Squamous cell carcinomas account for 90–95 % of these lesions. About 60 % are located at the vocal cord level (glottis), 40 % are supraglottic, and only about 1 % subglottic. Glottic carcinomas have the best prognosis because of their early detection and different lymphatic drainage. The development of a laryngeal carcinoma is a multistep process. First, the exogenic noxious substance leads to hyperplasia and/or hyperkeratosis of the epithelium. Then dysplasias develop, and a carcinoma in situ finally leads to an invasive carcinoma. Most lesions present with ulcerous, endophytic growth. Precancerous lesions leading to a carcinoma are leukoplakia, erythroplakia, and pachydermia. Symptoms of a laryngeal carcinoma include dysphagia, dyspnea, hoarseness, a feeling of a foreign body, and hemoptysis.

Authors: Jens Peter Klussmann, Markus Stenner, Orlando Guntinas-Lichius, Elke R. Gizewski
Title: Pathology of the ear, nose, and throat
Book: Atlas of Anatomic Pathology with Imaging
DOI: 10.1007/978-1-4471-2846-5_12
© Springer-Verlag London 2013

Leukoplakia of the left vocal fold



Leukoplakia of the vocal folds (left vocal fold). The epithelium has a white coating, and distinction from malignancy can only be made histologically. Stroboscopy helps judge whether the process is infiltrating or not, but cannot replace histology. If the vocal fold does not vibrate in stroboscopy, an infiltrating process is present, and urgent microlaryngoscopy with biopsy for histological examination is indicated.

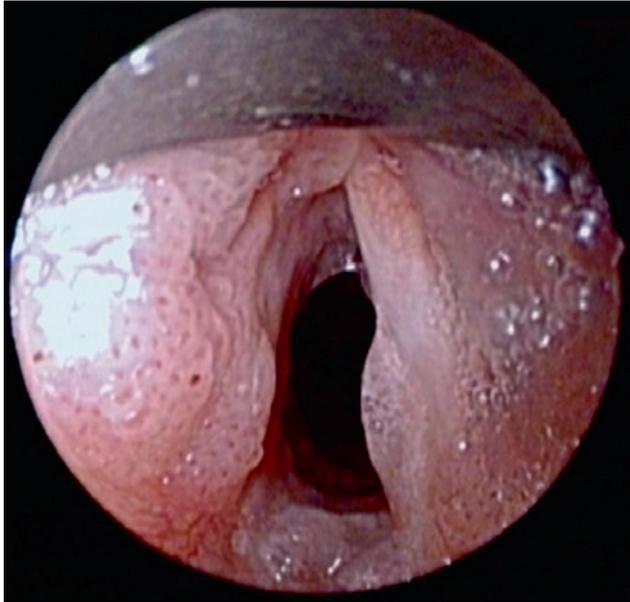
Unilateral vocal fold paralysis



The paralyzed vocal fold is in fixed position (median, paramedian, intermediate or lateral), and the arytenoid may be dislocated anteriorly. During phonation, depending on the position of the vocal fold, glottic closure is incomplete. Stroboscopy may be of some prognostic value: the presence of the mucosal wave is a good prognostic sign. Image shows a left-sided vocal fold paresis in paramedian position.

Autors: Doris-Maria Denk-Linnert, Rainer Schofl
Title: Endoscopy of the pharynx and esophagus
Book: Dysphagia
DOI: 10.1007/174_2012_634
© Springer-Verlag Berlin Heidelberg 2012

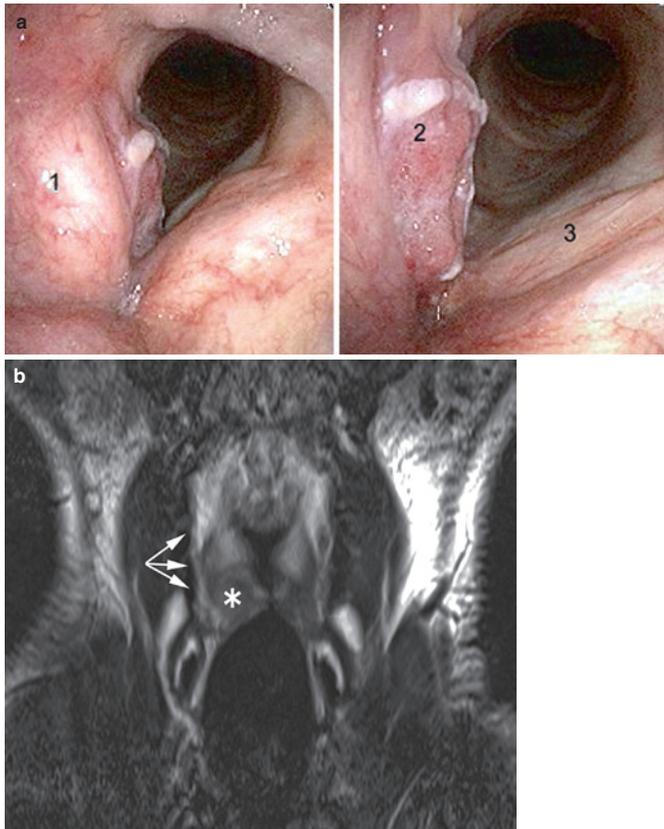
Recurrent respiratory papillomatosis of the larynx



Recurrent respiratory papillomatosis of the larynx (direct microlaryngoscopy). Papillomas are seen at the glottis level bilaterally and the left supraglottic region (ventricular fold).

Authors: Doris-Maria Denk-Linnert, Rainer Schoff
Title: Endoscopy of the pharynx and esophagus
Book: Dysphagia
DOI: 10.1007/174_2012_634
© Springer-Verlag Berlin Heidelberg 2012

Carcinoma of the right vocal cord with vocal fold hypomobility



Carcinoma of the right vocal cord with vocal fold hypomobility (cT2). **(a)** Video laryngoscopy: vegetating-infiltrating lesion of the right vocal cord. 1 Right ventricular band, 2 tumour, 3 left vocal cord. **(b)** Larynx MRI: T2-weighted sequence on coronal plane. The lesion (*) infiltrates the vocal muscle and spreads within the fibres of the lateral thyroarytenoid muscle through the ventricle till the false vocal cord level. The paraglottic fat space (hyperintense stripe pointed by *arrows*) is not infiltrated because the lesion is contained by the thyroarytenoid muscle.

Authors: Marco Lucioni

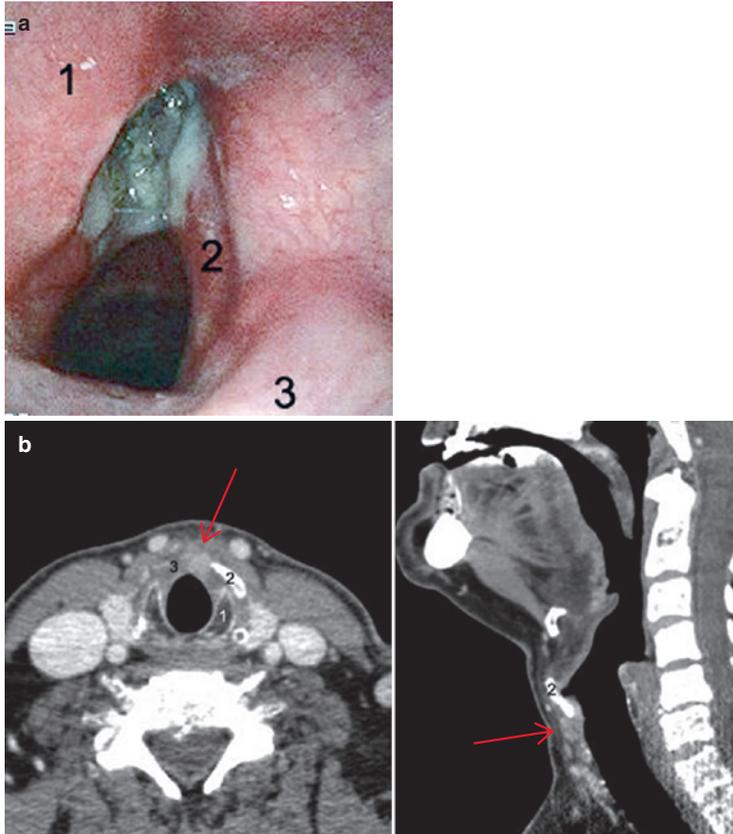
Title: Concerning endoscopy, imaging, and surgical options in larynx cancer

Book: Practical Guide to Neck Dissection

DOI: 10.1007/978-3-642-33977-6_13

© Springer-Verlag Berlin Heidelberg 2013

Anterior glottic carcinoma



(a) Video laryngoscopy: the lesion is to the anterior glottis, with prevalence on the left. 1 Left ventricular fold, 2 right vocal cord, 3 right arytenoid. (b) Larynx TC: on the axial plane passing between cricoid and thyroid cartilages the outspreading of the tumour can be seen (arrows). On the sagittal plane there is a suspected pathologic Delphian node. 1 Cricoid cartilage, 2 thyroid cartilage, 3 cricothyroid space.

Authors: Marco Lucioni

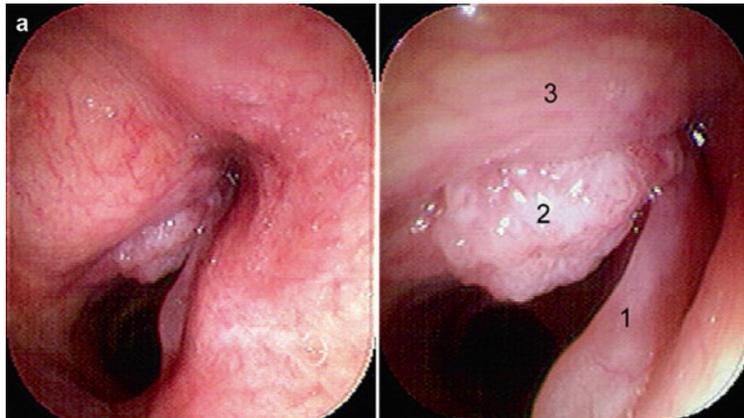
Title: Concerning endoscopy, imaging, and surgical options in larynx cancer

Book: Practical Guide to Neck Dissection

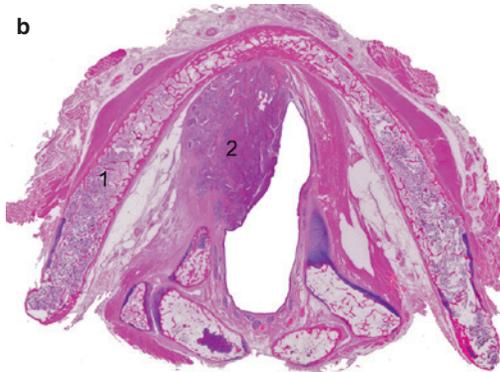
DOI: 10.1007/978-3-642-33977-6_13

© Springer-Verlag Berlin Heidelberg 2013

Carcinoma of the left vocal cord reaching the anterior commissure



The *anterior commissure* is a critical anatomical site for the laryngeal surgeon. The epithelium is only 1–2 mm from the cartilage, there is no perichondrium and, of the whole larynx, it is the site most difficult to expose. The T1a tumour of the vocal cord which arrives at the anterior is a fairly frequent situation and easy to control. CT is rarely required. The images show carcinoma of the left vocal cord reaching the anterior commissure. **(a)** Video laryngoscopy. 1 Right vocal cord, 2 neoplasia, 3 left ventricular fold. **(b)** Axial macrosection. 1 Thyroid cartilage, 2 neoplasia.



Authors: Marco Lucioni

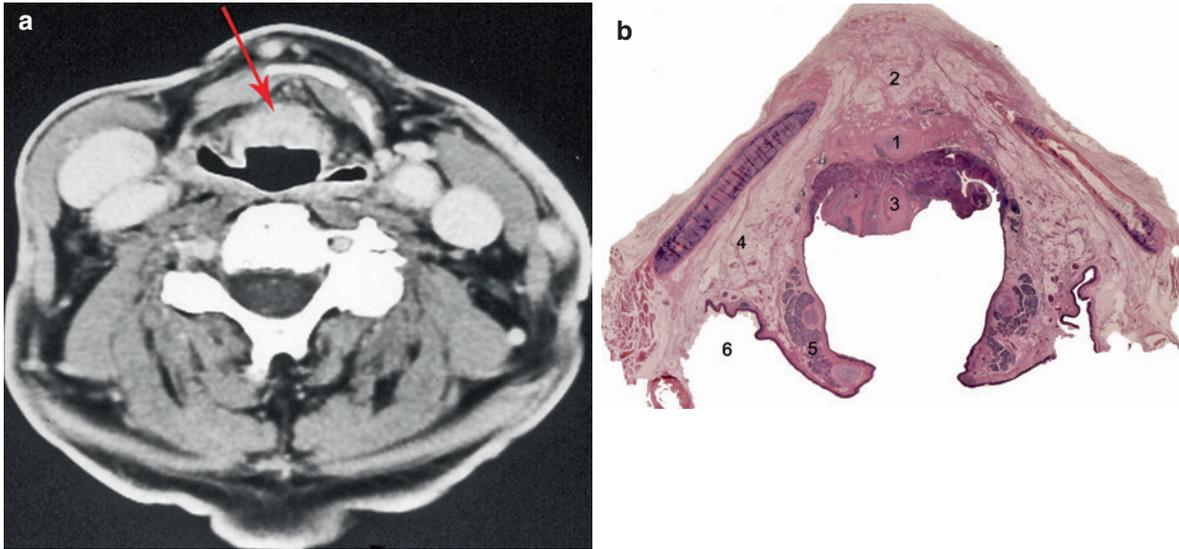
Title: Concerning endoscopy, imaging, and surgical options in larynx cancer

Book: Practical Guide to Neck Dissection

DOI: 10.1007/978-3-642-33977-6_13

© Springer-Verlag Berlin Heidelberg 2013

Supraglottic carcinoma



The preservation of the suprahyoid portion of the epiglottis normally allows better phonation because the preserved arytenoid adapts to it, thus forming an efficacious neoglottis. Whether or not the preepiglottic space is involved must be carefully assessed before deciding to preserve the infrahyoid epiglottis. The imaging of the patient in the Figure (a and b) shows that the preepiglottic space is intact. (a) The CT excludes involvement of the preepiglottic space (red arrow). (b) Axial macrosection of the larynx showing that the neoplasia does not extend beyond the epiglottis. 1 Epiglottis, 2 preepiglottic space, 3 tumour, 4 superior paraglottic space, 5 aryepiglottic fold, 6 pyriform sinus.

Authors: Marco Lucioni

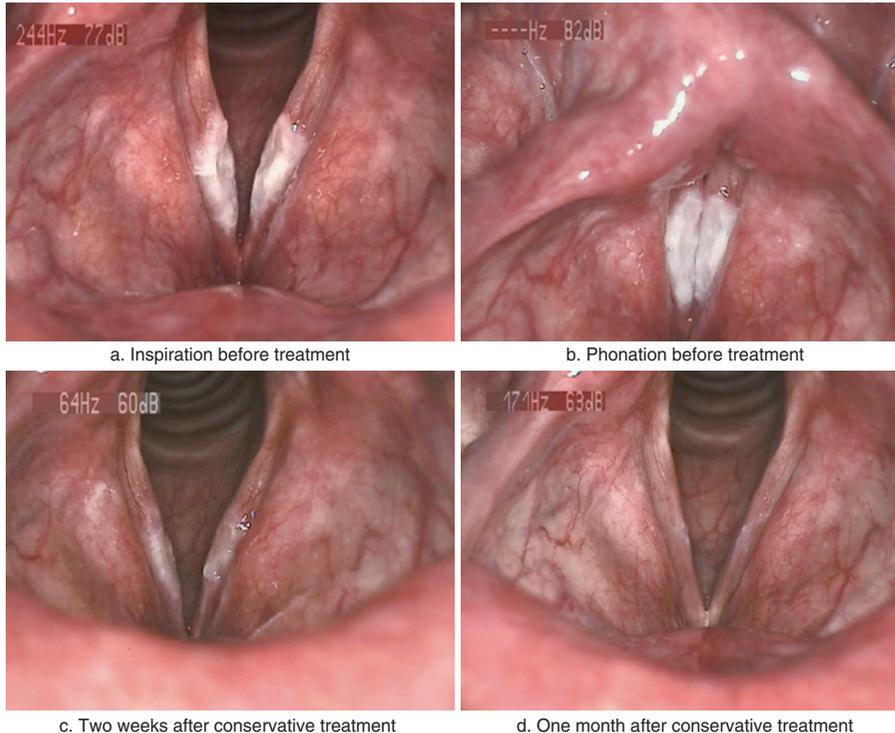
Title: Concerning endoscopy, imaging, and surgical options in larynx cancer

Book: Practical Guide to Neck Dissection

DOI: 10.1007/978-3-642-33977-6_13

© Springer-Verlag Berlin Heidelberg 2013

Acute laryngitis with laryngopharyngeal reflux



(a) Inspiration before treatment, (b) phonation before treatment, (c) two weeks after conservative treatment, (d) one month after conservative treatment. A 47-year-old male patient complained of obvious hoarseness and cough for 1 month after having a cold. The patient had a smoking history for 15 years. The Reflux Symptom Index (RSI) score was 22. Strobolaryngoscopy revealed irregular thick white plaque-like lesions at the anterior-middle portion of bilateral vocal folds, with moderately reduced mucosal waves during phonation. The movements of bilateral vocal folds were normal (a, b). After conservative treatment, symptoms gradually relieved with white lesions disappeared, and the morphology and mucosal waves of the vocal folds recovered to normal (c, d).

Author: Wen Xu

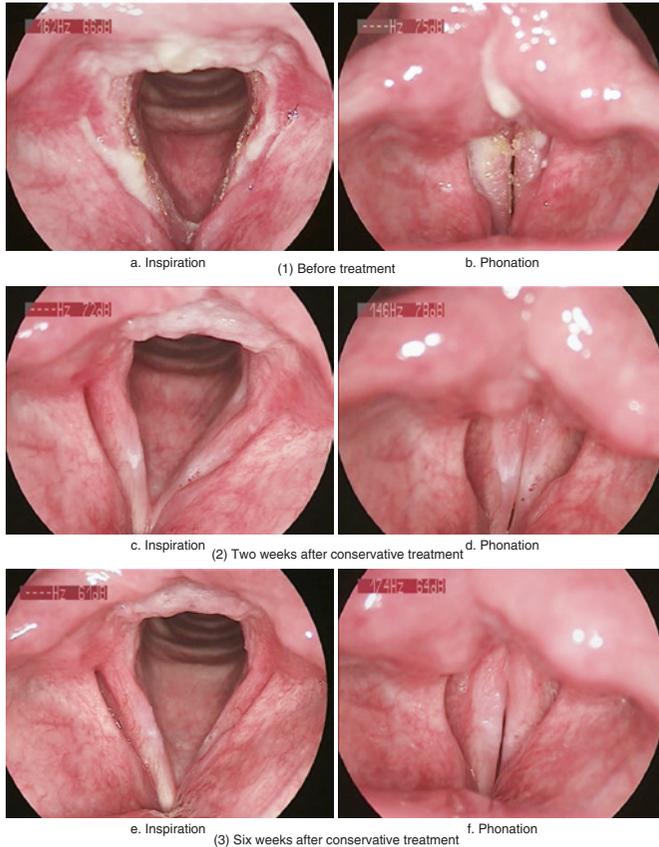
Title: Inflammatory diseases

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_4

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Laryngitis sicca



(1) Before treatment: **(a)** inspiration, **(b)** phonation. (2) Two weeks after conservative treatment: **(c)** inspiration, **(d)** phonation. (3) Six weeks after conservative treatment: **(e)** inspiration, **(f)** phonation. A 54-year-old male patient had a 9-month history of persistent hoarseness, with intermittent dry throat for 2 years. Strobolaryngoscopy revealed white thick mucus and brown dry scabs at the edges of bilateral vestibular folds, vocal folds and interarytenoid region. Mucosal hypertrophy can be seen at the interarytenoid region, with moderately reduced mucosal waves during phonation. The movements of bilateral vocal folds were normal **(a, b)**. After conservative treatment, symptoms and signs gradually relieved, and the dry scabs and thick mucus disappeared **(c-f)**.

Author: Wen Xu

Title: Inflammatory diseases

Book: Atlas of Strobolaryngoscopy

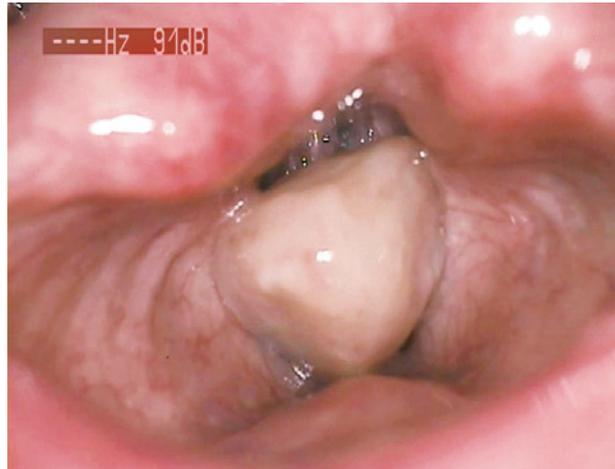
DOI: 10.1007/978-981-13-6408-2_4

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Granuloma of the larynx



a. Inspiration



b. Phonation

Granuloma of the larynx is related to multiple stimulating factors, such as iatrogenic injuries (including endotracheal intubation, surgical trauma), mechanical injuries, and laryngopharyngeal reflux. Contact granuloma of vocal fold is a benign lesion which localizes at the vocal process. Currently, laryngopharyngeal reflux is believed to be one of the major causative factors for contact granuloma.

The images show a granuloma of the right vocal fold caused by previous general anesthesia intubation. **(a)** Inspiration, **(b)** phonation. A patient complained of hoarseness since 2 days after endotracheal intubation under general anesthesia. Stroboscopy showed hyperemia of the right vocal fold and a large yellowish granulomatous mass with smooth surface at the glottis.

Author: Wen Xu

Title: Miscellaneous benign lesions

Book: Atlas of Stroboscopy

DOI: 10.1007/978-981-13-6408-2_7

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

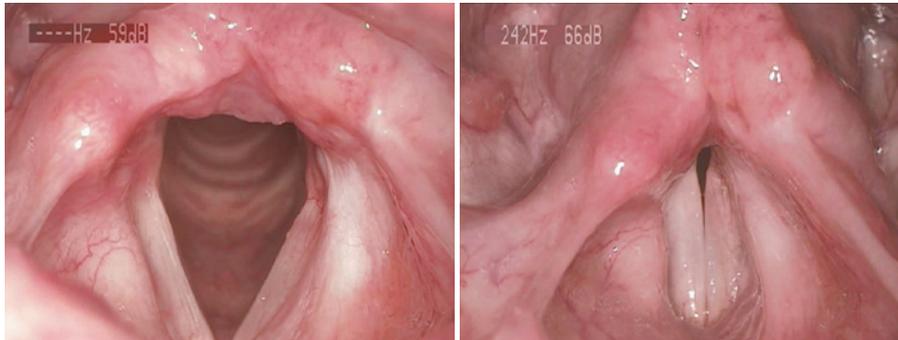
Laryngeal amyloidosis



a. Inspiration

b. Phonation

(1) Preoperative view



c. Inspiration

d. Phonation

(2) One year after CO₂ laser microphonosurgery

Amyloidosis is a metabolic benign disorder in which soluble proteins are deposited in the extracellular matrix in an abnormal insoluble amyloid fibrillar form. This insoluble protein deposits in tissues and interferes with organ function. The larynx is the most common site in the respiratory tract for amyloidosis.

The images show laryngeal amyloidosis on the left side. (1) Preoperative view: (a) inspiration, (b) phonation. (2) One year after CO₂ laser microphonosurgery: (c) inspiration, (d) phonation. Stroboscopy showed irregular reddish amyloid deposits along the left ventricular fold, left ventricle and arytenoid region. The bulging amyloid deposits and supraglottic configuration covered the left vocal fold. The movements of bilateral vocal folds were normal (1). One year after CO₂ laser microphonosurgery, laryngeal configuration appeared normal (2).

Author: Wen Xu

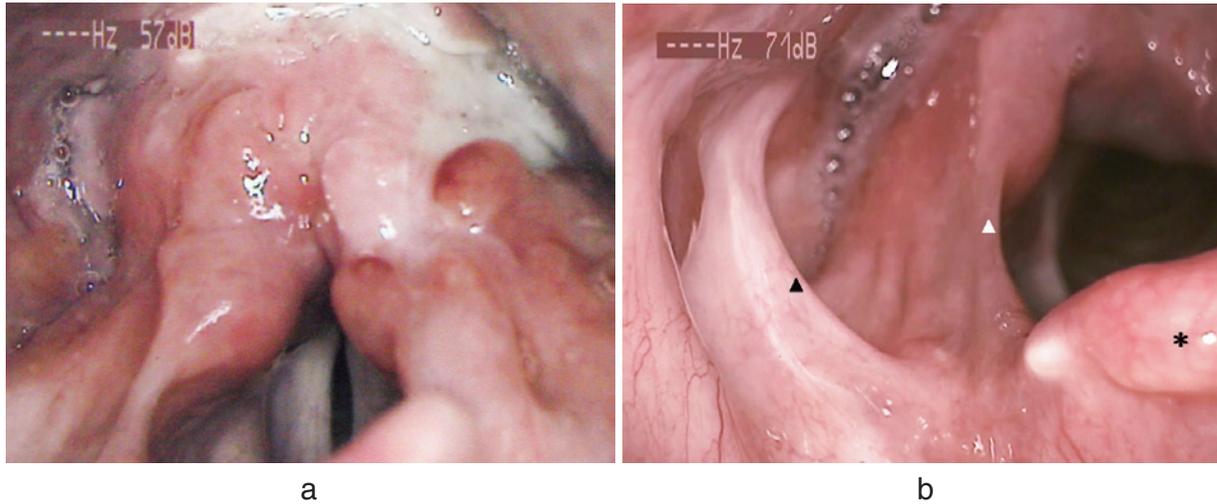
Title: Miscellaneous benign lesions

Book: Atlas of Stroboscopy

DOI: 10.1007/978-981-13-6408-2_7

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Behcet's disease presenting laryngopharyngeal ulcer and scar



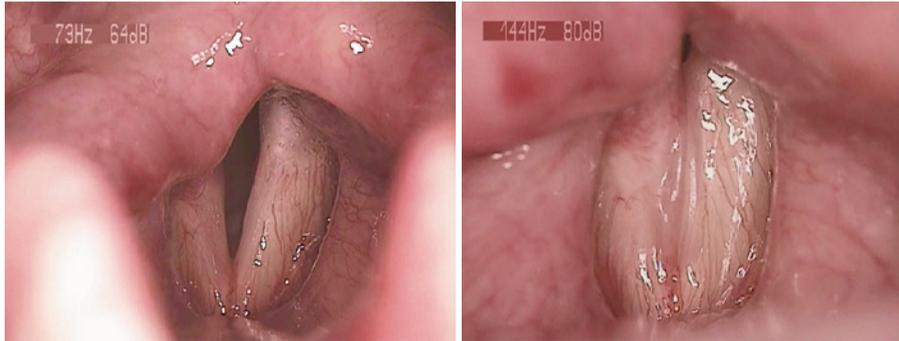
A 33-year-old male patient had recurrent aphthous and genital ulcers accompanied by a sore throat for 3 years. All the symptoms could be relieved by oral corticosteroids. Laryngoscopy revealed scars in pharyngoepiglottic folds (\blacktriangle) and aryepiglottic folds (\triangle). (**a**) Ulcers and necrosis accompanied by proliferation of granulations in postcricoid mucosa. (**b**) The movements of bilateral vocal folds are normal. The region indicated by an asterisk (*) was epiglottis.

Recurrent laryngopharyngeal ulceration



A 40-year-old male patient had recurrent sore throat for 3 years, which had been aggravating in last 1.5 months and could be relieved by oral corticosteroids. Laryngoscopy showed extensive ulcers and necrosis in both the posterior wall of hypopharynx and lateral wall of the pharynx.

Relapsing polychondritis presented with bilateral vocal fold paralysis and laryngotracheal stenosis



a. Inspiration

b. Phonation

(1) The glottic portion of a patient with bilateral vocal fold paralysis after the surgery of right arytenoids cartilage excision



c. Collapsed wall of the upper trachea leading to a narrowed airway. The contour of the trachea is obscured

d. Tracheal mucosa inferior to the lower end of tracheotomy tube thickened and the lumen of trachea became narrow

(2) Collapsed trachea

(1) The glottic portion of a patient with bilateral vocal fold paralysis after the surgery of right arytenoids cartilage excision: (a) inspiration, (b) phonation. (2) Collapsed trachea: (c) Collapsed wall of the upper trachea leading to a narrowed airway. The contour of the trachea is obscured, (d) tracheal mucosa inferior to the lower end of tracheotomy tube thickened and the lumen of trachea became narrow. A 64-year-old female patient with inspiratory dyspnea for 10 years, still couldn't plug the tracheotomy tube 4 months after excision of the right arytenoid cartilage and tracheostomy.

Author: Wen Xu

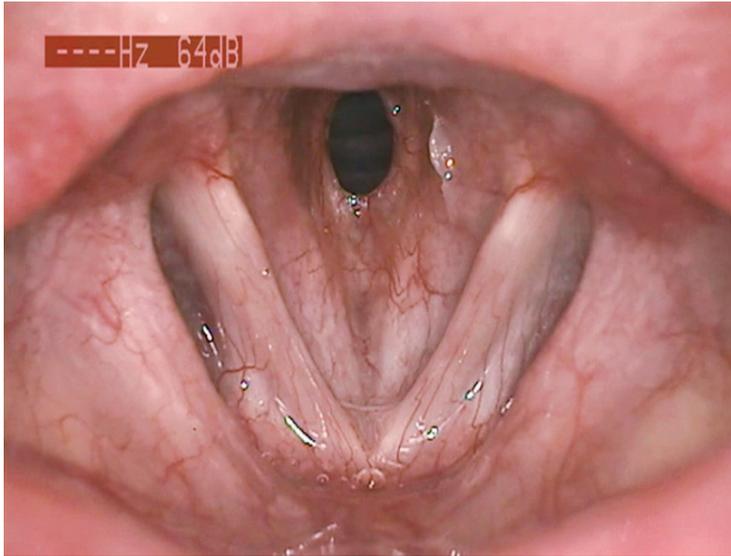
Title: Inflammatory diseases

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_4

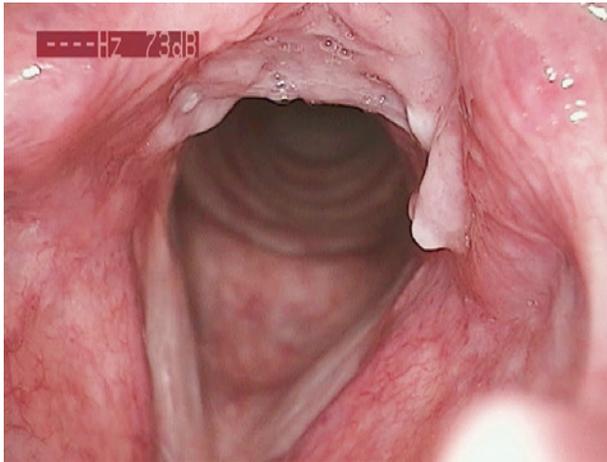
© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Relapsing polychondritis presenting subglottic stenosis



A 40-year-old female patient had dyspnea accompanied with hoarseness for 7 years. Strobolaryngoscopy showed normal supraglottic and glottic portion, but stenosis can be seen at the subglottic portion. Laryngeal CT scan demonstrated a stenosis of airway and hyperplasia of cartilage and soft tissue at the level of cricoid cartilage.

Reflux laryngitis



a. Inspiration



b. Phonation

(a) Inspiration, (b) phonation. A 31-year-old male patient complained of pharyngeal itching with intermittent dry irritating cough for 3 months. The RSI score was 35. The patient had reflux esophagitis for 6–7 years presented with regurgitation and heartburn. Stroboscopy revealed mild edema of bilateral vocal folds, pseudosulcus vocalis presenting at the left side, mucosal hyperemia at the arytenoid region, irregular mucosal hypertrophy at the interarytenoid region with scattered white patches on the surface. The movements of bilateral vocal folds were normal.

Author: Wen Xu

Title: Inflammatory diseases

Book: Atlas of Stroboscopy

DOI: 10.1007/978-981-13-6408-2_4

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Tuberculous laryngitis



Tuberculosis of the left vocal fold. A 50-year-old male patient complained of hoarseness for 2 months after a cold without fever or night sweats. Stroboscopy showed the mucosal wave of the left vocal fold disappeared during phonation. Irregular ulcerative depressions were seen in the anterior-middle portion and bulges in the posterior portion of the left vocal fold. The mobility of vocal folds remained normal.

Author: Wen Xu

Title: Specific infectious diseases

Book: Atlas of Stroboscopy

DOI: 10.1007/978-981-13-6408-2_5

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Syphilis of the pharynx



Syphilis of the oropharynx. The patient had sore throat accompanied by foreign body sensation of the pharynx for 3 months without fever or night sweat. Laryngoscopic examination showed normal larynx, diffusely congested pharyngeal mucosa, bilateral tonsillar hypertrophy with granular surface, and extensive grey white exudation on the surface of palatoglossal arch and tonsils.

Author: Wen Xu

Title: Specific infectious diseases

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_5

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Laryngopharyngeal hemangioma



a. Supraglottic area (inspiration)



b. Supraglottic area (phonation)



c. Pyriform sinus

Laryngeal hemangioma involving the left side of supraglottic area. (a) Supraglottic area (inspiration), (b) supraglottic area (phonation), (c) pyriform sinus. A 40-year-old female patient had no specific discomfort. Stroboscopy showed a diffuse *purple-red* hemangioma at the left supraglottis, no abnormality at the glottis and the subglottis. The movements of bilateral vocal folds were normal.

Author: Wen Xu

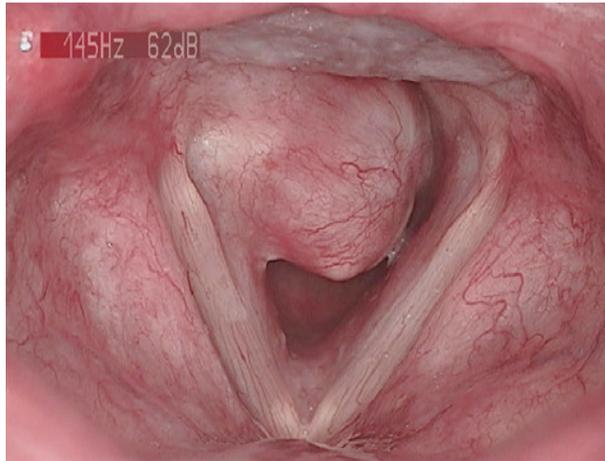
Title: Benign tumors of the larynx

Book: Atlas of Stroboscopy

DOI: 10.1007/978-981-13-6408-2_14

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Chondroma of the larynx



a. Inspiration



b. Phonation

Laryngeal chondrosarcoma with dyspnea. **(a)** Inspiration, **(b)** phonation. Female, 74 years old. Strobolaryngoscopy showed a smooth broad-base mass bulging under the right vocal process with normal vocal fold mobility. The patient had a laryngeal chondroma resection at the same area 12 years ago.

Author: Wen Xu

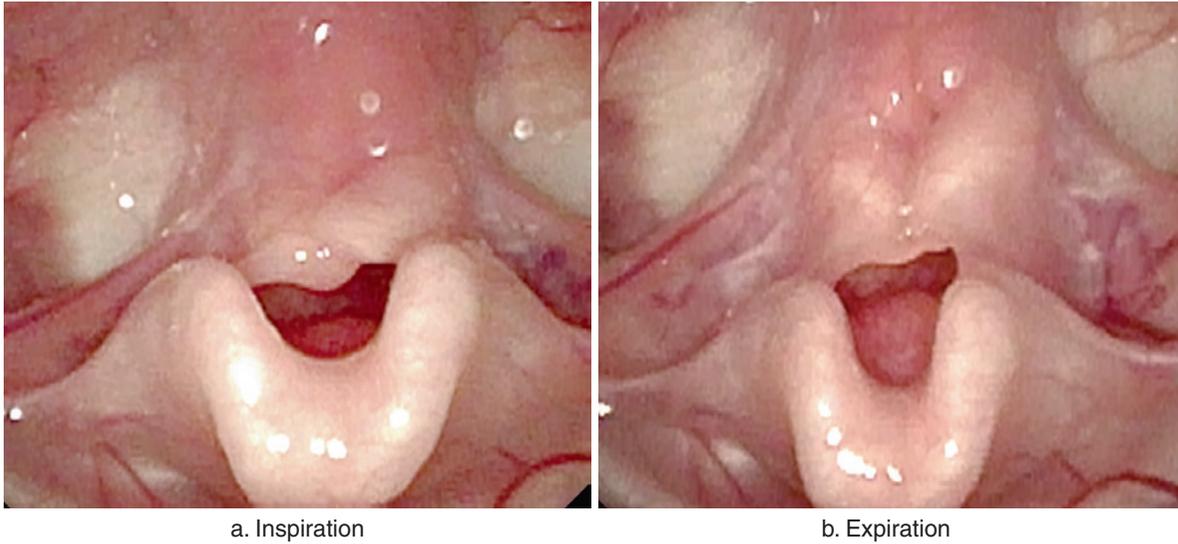
Title: Benign tumors of the larynx

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_14

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Laryngomalacia



Laryngomalacia is the most common cause of laryngeal stridor in newborns and infants. The cause of the disease may be caused by the collapse of supraglottic structures into the respiratory tract (laryngeal cavity) during inspiration, and the symptoms is aggravated by any kind of activity, e.g. emotional agitation, crying, and feeding or sleep.

(a) Inspiration, (b) expiration. A 2-year-old girl had laryngeal stridor after birth. Laryngoscopy showed Omega-shaped epiglottis, anteriomedial displacement of arytenoid cartilages, mucosal edema and hypertrophy of arytenoid area, which covered the glottis and collapsed into the laryngeal cavity during inhalation. No abnormality was seen in the glottis and subglottis. Vocal fold movements were normal.

Author: Wen Xu

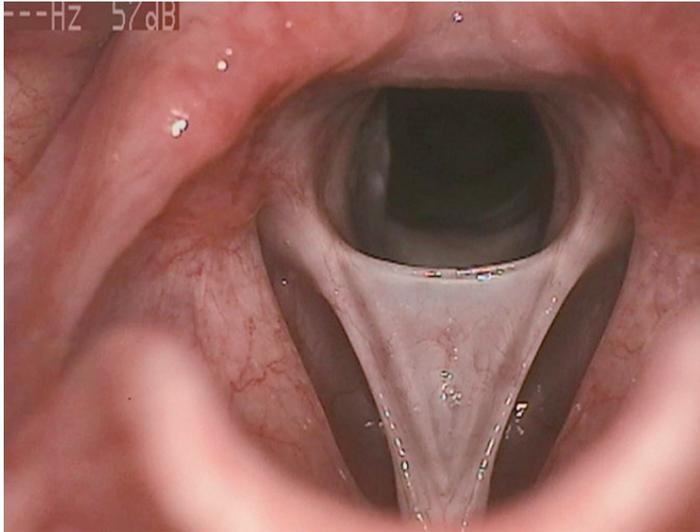
Title: Congenital disorders of the larynx

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_3

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

Congenital laryngeal web



A 13-year-old boy had persistent hoarseness with whispering voice since birth. Laryngoscopy showed membranaceous web in glottis and normal vocal fold movement but with abnormal morphology.

Author: Wen Xu

Title: Congenital disorders of the larynx

Book: Atlas of Strobolaryngoscopy

DOI: 10.1007/978-981-13-6408-2_3

© Springer Nature Singapore Pte Ltd. and Peoples Medical Publishing House 2019

For vertigo of all origins

Start with

Stugeron® Plus

Cinnarizine 20 mg + Dimenhydrinate 40 mg tablets

RAPID AND SUSTAINED RELIEF



VERTIGO
IS CHALLENGING,
MAKE THE
FIRST MOVE
WITH PLUS.

For the use only of a Registered Medical Practitioner or a Hospital or Laboratory

Stugeron® Plus

Description: Stugeron® Plus consists of 20 mg cinnarizine and 40 mg dimenhydrinate as a fixed dose combination. Therapeutic Indication: For the treatment of vertigo. Contraindications: Severe renal impairment, severe hepatic impairment, patients with known hypersensitivity to the active substances, diphenhydramine or other antihistamines of similar structure or to any of the excipients. Warnings and Precautions: Should be taken after meals to minimize any gastric irritation; Should be used with caution in patients with conditions that might be aggravated by anticholinergic therapy; Should be used with caution in hypotensive patients; When administering patients with Parkinson's disease, caution should be exercised. Interaction: Concurrent use of Alcohol/CNS depressants/Tricyclic Antidepressants may potentiate the sedative effects of either of these medications or of Stugeron® Plus. Stugeron® Plus may mask ototoxic symptoms associated with amino glycosidic antibiotics and mask the response of the skin to allergic skin tests. The concomitant administration of medicines that prolong the QT interval of the ECG (such as Class Ia and Class III antiarrhythmics) should be avoided. Pregnancy and lactation: Stugeron® Plus should not be used during pregnancy and usage should be discouraged in nursing women. Effects on Ability to Drive and Use Machines: Stugeron® Plus may cause drowsiness, especially at the start of treatment, therefore, should not drive or operate machinery. Posology and Method of Administration: Adults and Elderly: 1 tablet three times daily, to be taken unchewed with some liquid after meals. Children and adolescents under the age of 18 years: Stugeron® Plus is not recommended. Undesirable Effects: Commonly observed adverse reactions include somnolence and dry mouth. Other adverse reactions include constipation, weight gain, tightness of the chest, worsening of an existing angle-closure glaucoma, reversible agranulocytosis and extrapyramidal symptoms. Overdose: Drowsiness and ataxia with anticholinergic effects are usually seen. Convulsions, respiratory depression and coma may occur in cases of massive overdosage. General supportive measures and gastric lavage with isotonic sodium chloride solution are recommended. Short-acting barbiturate and physostigmine (after physostigmine test) can also be used in case of marked symptoms.

® - Registered trademark of Johnson & Johnson, USA.

Version of API: CCDS dated 05 Jan 2016.

Date of printing: Sep 2019

Disclaimer: The Information provided herein shall in no manner be construed to replace the clinical judgment or guide to individual patient care. Furthermore, although the information provided herein is believed to be true and accurate, Janssen, a division of Johnson & Johnson Private Limited assumes no responsibility in any manner whatsoever for any errors or omissions that may occur either directly or indirectly due to any action or inaction you take based on the information provided herein.

Additional information available on request.

For complete prescribing information, please contact: Johnson & Johnson Private Limited, Arena Space, Behind Majas Depot, Opp. J.V. Link Road, Jogeshwari (E), Mumbai 400060.

Website: www.jnjindia.com

