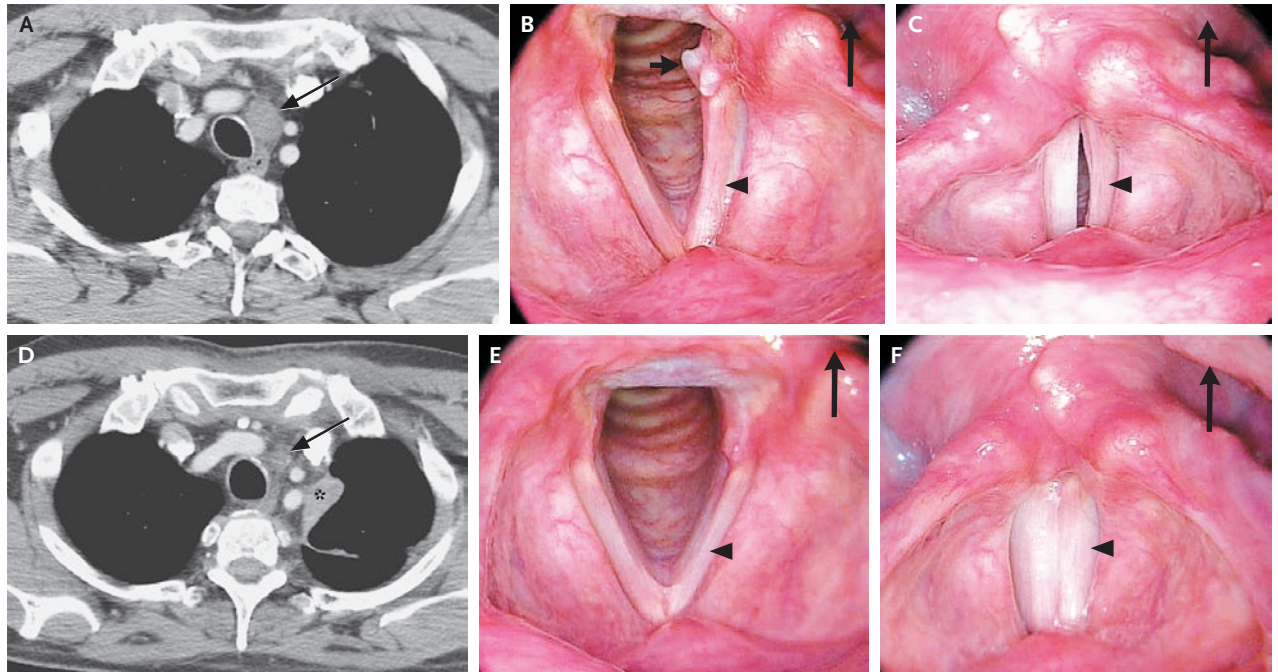


IMAGES IN CLINICAL MEDICINE

Reversal of Laryngeal Paresis



A 51-YEAR-OLD MAN WITH STAGE IV NON-SMALL-CELL LUNG CANCER, who was receiving chemotherapy, had hoarseness and weak vocal intensity, which developed over a period of 3 days, progressing to near-complete aphonia. Computed tomography of the chest showed an enlarged left paratracheal lymph node (Panel A, arrow), and videostroboscopy (Panel B, vocal cords open; Panel C, vocal cords closed; Video 1 [arrows in Panels B, C, E, and F indicate posterior direction, arrowheads left cord]) showed severe left vocal cord paresis, with early atrophy and bowing. A granulomatous lesion on the posterior cord (Panel B, short arrow) was consistent with the patient's history of gastroesophageal reflux. The patient received dexamethasone systemically and 54 Gy to the involved chest lymph node. Within weeks of completing palliative radiation therapy, his voice had nearly normalized. On follow-up imaging 10 months later, the paratracheal lymph node showed a partial response (Panel D, arrow; the asterisk indicates scarring of the lung from radiation therapy), and there was bilateral true vocal cord mobility. A reduction in the granuloma was also noted in response to antireflux medical treatment (Panel E, vocal cords open; Panel F, vocal cords closed; Video 2). Although the left vocal cord continued to show mild decreased mobility, there was good approximation of both cords for phonation, and vocal intensity was much improved. In this case, timely radiation therapy contributed to reversal of the acute left recurrent laryngeal paresis, thereby preserving the patient's voice and reducing the risk of aspiration. Approximately 2 years after the onset of laryngeal paresis, the cancer continues to be managed with systemic therapy, and the patient is otherwise in good physical condition. He speaks normally and effortlessly, eats without aspirating, and continues to participate fully in his professional and social life.

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