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Caso clínico

Pharyngolaryngeal haematoma: two cases report and a review of the literature

Hematoma faringolaríngeo: dois casos clínicos e revisão da literatura

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Abstract

Background: Pharyngeal and/or laryngeal haematoma is a rare entity with multiple aetiological factors. If no cause can be found, it is labeled spontaneous haematoma. It is an alarming condition and although associated with life-threatening complications, often the condition resolves eventful.

Methods: We report two cases of old women who presented with spontaneous pharyngolaryngeal haematoma. A bibliographic review is also presented.

Cases reports: A 87 year-old woman, under platelet antiaggregation, presented at emergency ENT department complaining of dysphonia and the presence of cervical equimosis extending from submentonian region to sternal furcula with <24h of evolution. Another woman, 85 years-old, hypocoagulated, presented a submentonian equimosis after a coughing fit. They both denied cervical trauma. Fiberoptic laryngoscopy revealed pharyngolaryngeal haematoma without airway obstruction in the first case, and with partial airway compromise in the second one. Conservative management, including stopping antiaggegration/anticoagulation medication, was adopted, being both

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patients hospitalized and having a favorable clinical evolution.

Conclusion: It is important to be aware of this unusual condition with its distinct presentation. Surgical intervention should be resisted unless a treatable aetiological factor is found or airway compromise occurs, the main reason why close airway monitoring is needed. Most cases will resolve with conservative management.

Keywords: laryngeal haematoma, airway, cervical equimosis, dysphonia

Resumo

Introdução: O hematoma faríngeo e/ou laríngeo é uma entidade clínica rara com múltiplos factores etiológicos. Se não se encontrar uma causa, é denominado hematoma espontâneo. É uma condição alarmante e embora possa estar associada com complicações graves, geralmente resolvem sem problemas.

Métodos: Os autores reportam os casos clínicos de duas idosas que se apresentaram com hematomas faringolaríngeos. É igualmente efectuada uma revisão bibliográfica.

Casos clínicos: Uma doente do sexo feminino de 87 anos, sob antiagregação plaquetária, recorreu ao serviço de urgência de ORL por disfonia e pelo aparecimento de equimose cervical desde região submentoniana até à fúrcula esternal com <24h de evolução. Outra doente do sexo feminino, 85 anos, hipocoagulada, apresentou uma equimose submentoniana após um acesso de tosse. Ambas negaram trauma cervical. Fibroscopia laríngea revelou hematoma faringolaríngeo sem compromisso da via aérea no primeiro caso, e com compromisso parcial no segundo. Tratamento conservador, incluindo parar antiagregação/hipocoagulação, foi adoptado, sendo ambas as pacientes hospitalizadas e tendo uma evolução clínica favorável.

Conclusão: É importante estar alerta para condição rara. Intervenção cirúrgica deve ser reservada para casos em que haja um factor etiológico identificável ou quando ocorre um compromisso da via aérea, motivo pelo qual é necessário a monitorização do doente. A maioria dos casos resolve com tratamento conservador.

Palavras-chaves: hematoma laríngeo, via aérea, equimose cervical, disfonia.

Introduction

Pharyngeal and/or laryngeal haematoma is a rare entity with multiple aetiological factors[1]. It has been described too infrequently to determine the prevalence[1]. It is associated with a wide variety of aetiologies, that include trauma, haematological issues, neoplasia, Epstein-Barr virus, vascular aneurysms and parathyroid lesions[1,2]. If no cause can be found, it is labeled spontaneous haematoma[1]. It is an alarming condition and although associated with life-threatening complications, often the condition resolves uneventfull[3].

Cases report

Case 1

A female 87 year-old Caucasian, under platelet antiaggregation, presented at emergency otolaryngology department complaining of dysphonia and appearance of a cervical equimosis extending from submentonian region to sternal furcula with <24h of evolution. No dyspnea or cervical trauma was reported. On physical examination, it was observed an anterior cervical equimosis of about 7x7 cm from submentonian region to sternal furcula, without fluctuation (figure 1a). On laryngeal fiberoscopy it was observed a right laryngeal haematoma (piryform sinus, aryepiglotic fold, arytenoid and false and true vocal folds) with patent glottic lumen (figure 1b). Blood analysis revealed Hb 12,6 g/dL, platelets count of 260000/µL and normal coagulation test. Cervical ultrasonography revealed subcutaneous oedema and densification of anterior cervical region, but without collections defined. The patient was hospitalized with conservative measures of airway surveillance, and with platelet antiaggregation medication stopped. She evolved favorably with total regression of laryngeal haematoma and cervical equimosis within one week.

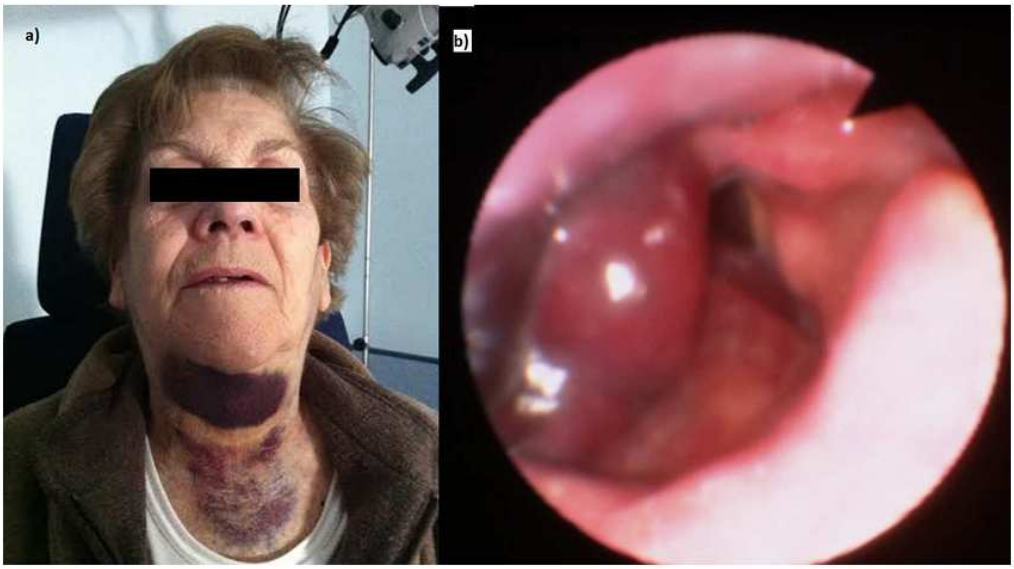

Figure 1a: Anterior cervical equimosis of about 7x7 cm from submentonian region to sternal furcula, without fluctuation. **Figure 1b:** Laryngeal fiberoscopy: right laryngeal haematoma (piryform sinus, aryepiglotic fold, arytenoid and false and true vocal folds), patent glottic lumen.

Case 2

A female, 85 year-old, caucasian, with personal history of atrial fibrillation hypocoagulated with warfarin, presented at emergency otolaryngology department because of an appearance of a cervical equimosis after a coughing attack. No dysphonia, dyspnea or cervical trauma was reported. On physical examination, it was observed a cervical equimosis (submentonian and submandibullary regions), without fluctuation (figure 2a). On laryngeal fiberoscopy it was observed an extensive pharyngolaryngeal haematoma, including haematoma of soft palate and oropharynx (figure 2b and figure 2c**).** Blood analysis revealed Hb 7,8 g/dL, platelets count of 33000/µL, over-therapeutic INR. Cervical computerized tomography showed diffuse thickning of the walls of oro- and hypopharynx with partial occlusion of airway, as well as thickning of the

soft palate and uvula (figure 3). The patient was hospitalized in an intensive care unit for two days for close monitoring, with conservative measures of airway surveillance; it was stopped warfarin and started enoxaparine in prophylatic doses, and she was transfunded with red blood cells and platelets and administration of prothrombin complex concentrate, vitamin K and aminocaproic acid to treat acute anaemya, thrombocytopenia and coagulation function. She evolved favorably with regression of pharyngo-laryngeal haematoma and cervical equimosis, correction of red blood cells and platelets values. She was then transfered to the ENT unit and restarted warfaryn without problems. The patient was discharged from the hospital eight days after admission, with almost total regression of the cervical equimosis.

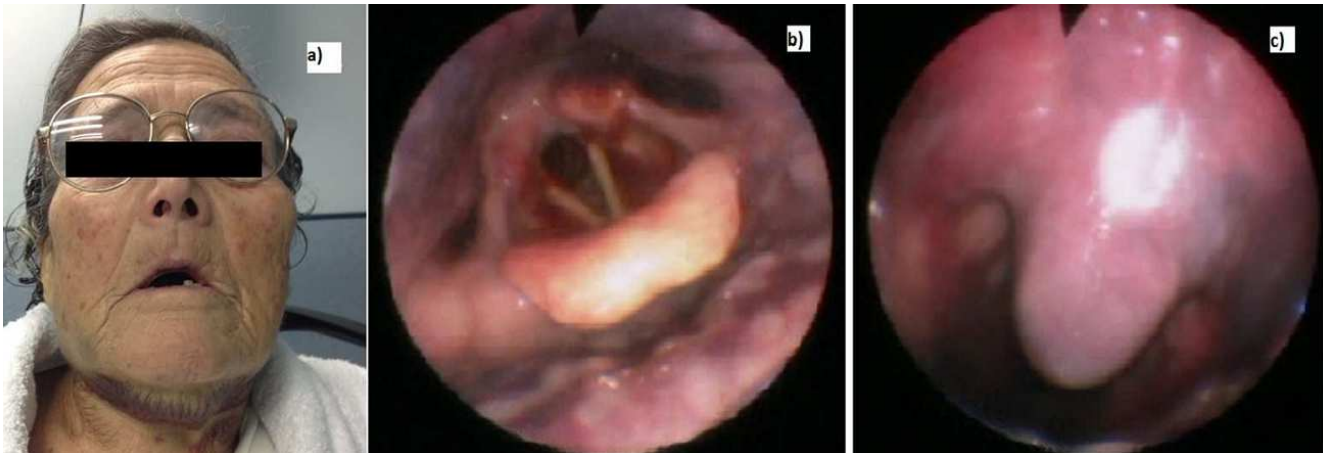

Figure 2a: Cervical equimosis (submentonian and submandibullary regions), without fluctuation. **Figure 2b:** Extensive pharyngolaryngeal haematoma. **Figure 2c:** Haematoma of soft palate and oropharynx.

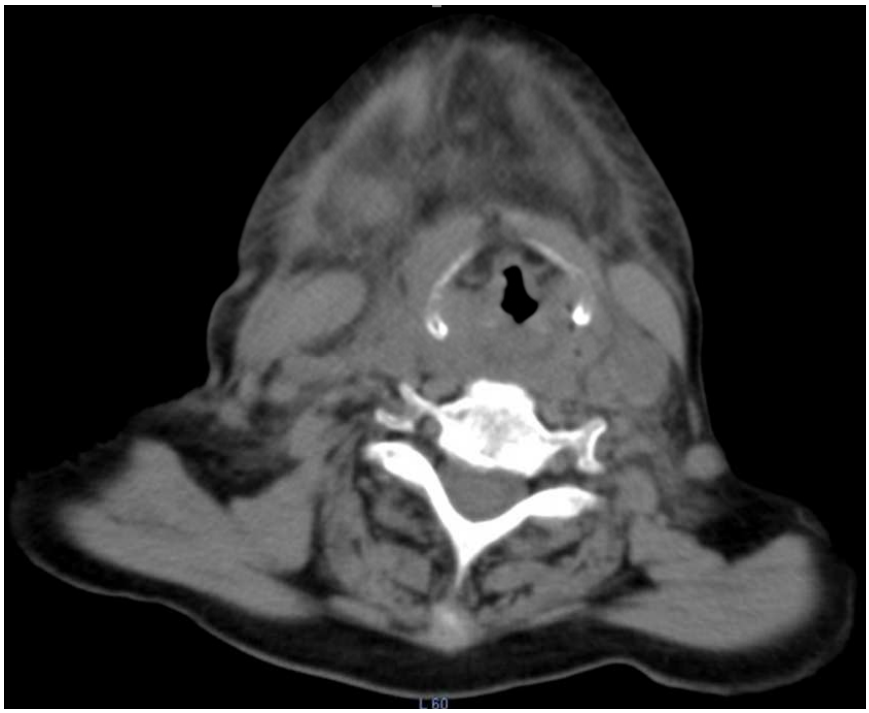

Figure 3: Cervical computerized tomography, axial cut: diffuse thickening of the walls of oro- and hypopharynx with partial occlusion of airway.

Discussion

Spontaneous pharyngeal/laryngeal haematoma is defined by the absence of any clear aetiology[1]. It is important to be aware of this unusual condition with its distinct presentation. Clinically, it may manifest as cervical pain, odynophagia, dysphonia and dyspnoea[2]. A clinical triad has been described, composed of subcutaneous redness in the anterior neck and upper thorax, tracheal and esophageal compression and ventral displacement of the trachea[2,4]. Treatment depends on the size, location and clinical course of the patient[2]. Surgical intervention should be resisted unless a treatable aetiological factor is found or airway compromise occurs, the main reason why close airway monitoring is needed[1]. Most cases will resolve with conservative management[1,2], like the two cases described above. There is an urgent need in referring similar patients to ENT for immediate evaluation of the upper airway[4,5]. Admission for further management of these at risk patients is mandatory, many times with a multidisciplinary approach[5].

Conclusion

It is important to be aware of this unusual condition with its distinct presentation. Surgical intervention should be resisted unless a treatable aetiological factor is found or airway compromise occurs, the main reason why close airway monitoring is needed. Most cases will resolve with conservative management.

Conflict of interests

The authors declare no conflict of interests

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