

T-Tube in a complete subglottic stenosis: Is it worthwhile?

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SUMMARY

Laryngotracheal stenosis causes significant morbidity to the airway, and speech. In a complete airway stenosis, open resection and anastomosis surgery remains the mainstay. Airway stenting using T-tube is not a traditional indication for a complete airway stenosis due to lack of epithelized lumen to be augmented. Open surgical intervention such as laryngotracheal resection along with end-to-end anastomosis is the choice of treatment in complete subglottic stenosis. However, this surgical intervention is contraindicated in patients with multiple comorbidities and unacceptable anesthetic risks. We highlight a patient with multiple comorbidities and complete subglottic stenosis following prolonged intubation in a setting where open surgery was contraindicated. He was alternatively managed with T-tube stenting and developed a complicated early postoperative period, which later stabilized after 2 months. Open surgical intervention such as laryngotracheal resection along with end-to-end anastomosis is the choice of treatment in complete subglottic stenosis. However, this surgical intervention is contraindicated in patients with multiple comorbidities and unacceptable anesthetic risks. Hence, we try to provide the alternative way for the patient for airway stenting as well as voice demand.

Primary laryngeal tuberculosis manifested as unilateral irregular vocal fold lesion

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SUMMARY

Introduction: Laryngeal tuberculosis (LTB) accounts for <1% of the cases of extrapulmonary tuberculosis. The absence of pathognomonic symptoms of LTB and its evolving clinical manifestations in recent years causes a diagnostic dilemma and delay in treatment. Combined diagnostic techniques with particular attention to the utility of Xpert MTB/RIF assay may provide a definitive diagnosis of LTB. **Methods:** Retrospective review of the last two years' medical records in a Malaysian tertiary hospital. **Results:** We report three patients aged 31, 70 and 73 years respectively, presented with hoarseness for 1 to 24 months. Flexible laryngoscopy in all three cases showed a similar finding of irregular mucosa involving the entire length of unilateral vocal fold. Mucosal waves were absent on stroboscopic examination. They were diagnosed to have primary LTB by tissue specimen sent for Xpert MTB/RIF assay and subsequently commenced on anti-tuberculous therapy. The clinical course and response to the treatment were diverse, in which the first and third case showed good response whilst the second case developed disseminated tuberculosis during treatment. **Conclusion:** With the emergence of LTB with atypical morphological appearance, otolaryngologists need to be more vigilant on laryngoscopic findings. LTB must be considered as one of the differential diagnoses in vocal fold mucosal lesions. The laryngeal tissue specimen sent for Xpert MTB/RIF assay is exceedingly beneficial for early detection of *Mycobacterium tuberculosis* infection to achieve a favourable outcome.