BILATERAL ABDUCTOR PALSY CASE PRESENTATION

DR. RAMYA. C
PG FINAL YR (DLO)
DEPT. OF ENT

HISTORY

- **NAME:-** XYZ
- **IP NO.:-** 20130914600
- **AGE:-** 80 years
- **SEX:-** Male
- **OCCUPATION:-** Daily wager
- **D.O.A:-** 11/09/2013

CHIEF COMPLAINTS

- Difficulty in breathing for 3 months.
- Change in voice for 3 months.
- Noisy breathing for 1 day.

HISTORY OF PRESENTING ILLNESS

- K/C/O HTN since 15yrs developed hoarseness of voice & difficulty in breathing since 3 months & noisy breathing since 1 day.

- He was admitted in casualty for above complaints.

ON EXAMINATION

GENERAL EXAMINATION:-

- ✓ Patient was conscious, restless with inspiratory stridor.

VITALS:-

Afebrile

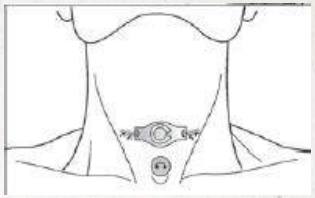
Pulse- 100/min, regular

Blood pressure- 180/120 mmHg in right arm in supine position

Rapid & shallow respiration.

SpO_2- 36%

Emergency tracheostomy



- An emergency tracheostomy was done in OT.

- No. 7.5 portex cuffed tracheotomy tube secured in the stoma.

- Vitals following tracheostomy-

Afebrile

Pulse- 100/min, regular

Blood pressure- 160/100 mmHg in right arm in supine position

RR- 22/min

SpO_2- 98% on room air

Post tracheostomy treatment

- Inj. Cefotaxime - 1gm- IV- BD
- Inj. Tramadol- 2cc- IV- BD
- Inj. Ranitidine- 50mg- IV- BD
- Daily & regular care of the tracheostomy tube
- IV fluids
- Tab. Amlodipine- 5mg- OD + Hydrochlothiazide- 12.5mg- OD

Negative history

- No H/O- any previous surgeries like thyroidectomy/ esophageal/ superior mediastinal surgeries.
- No H/O- neck trauma.
- No H/O- prolonged intubation.
- No H/O- CVA

PAST HISTORY

No history of diabetes, tuberculosis and asthma.

Known hypertensive since 15yrs- on irregular medication.

PERSONAL HISTORY

- ✓**Diet -** Mixed
- ✓**Appetite** – Decreased since 10days
- ✓**Bowel -** Regular
- ✓**Bladder -** Regular
- ✓Known smoker since the age of 20yrs- smokes 20 beedis/day

- **<u>DRUG HISTORY</u>**:- Not significant.

- **<u>FAMILY HISTORY</u>**:- Not significant

ON EXAMINATION

GENERAL EXAMINATION:-

- ✓ Patient is conscious, well oriented to time, place and person.
- ✓ Patient is moderately built and nourished.

VITALS:-

Afebrile

Pulse- 92/min, regular

Blood pressure- 150/90 mmHg in right arm in supine position

RR- 22/min

SpO_2- 98% on room air

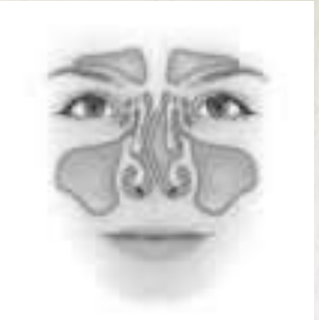
- ✓No pallor.
- ✓No icterus.
- ✓No cyanosis.
- ✓No clubbing.
- ✓No lymphadenopathy.

EAR EXAMINATION

EAR	RIGHT	LEFT
1. Pinna	Normal	Normal
2. Pre-Auricular Area	Normal	Normal
3. Post-Auricular Area	Normal	Normal
4. Tragal Tenderness	Absent	Absent
5. Mastoid Tenderness	Absent	Absent
6. External Auditory Canal	Clear	Clear
7. Tympanic Membrane	Intact with normal movements on siegalization.	Intact with normal movements on siegalization.

TUNING FORK TEST	RIGHT	LEFT
1. Rinne's test	Bone conduction more than air conduction	Bone conduction more than air conduction
2. Weber's test	No lateralization	
3. Absolute bone conduction test	Same as that of examiner	Same as that of examiner

NOSE



✓**ON EXTERNAL EXAMINATION**:-

No deformities or scar present.

ON ANTERIOR RHINOSCOPY:-

Vestibule - Normal

Nasal cavities - Normal

Mucosa - Normal

Nasal septum - Central

Turbinates - Normal

✓**ON POSTERIOR RHINOSCOPY**:-

Choana - Normal

No **post nasal drip**

No **adenoid hypertrophy** seen.

THROAT

ORAL CAVITY:-

Lips - Normal

Teeth - Normal

Gums - Normal

Tongue - Normal

Hard and soft palate - Normal

Floor of mouth - Normal

Cheeks - Normal

✓**OROPHARYNX**:-

Uvula central

Anterior pillar - Normal

No **Tonsillar hypertrophy**

Posterior pillar - Normal

Posterior pharyngeal wall - Normal

ON INDIRECT LARYNGOSCOPY:-

Epiglottis - Normal

Vocal cords - B/L Adducted in position

Immobile

Pyriform fossa - Normal

Arytenoids - Normal

SYSTEMIC EXAMINATION

✓ **RESPIRATORY SYSTEM**:-

Bilateral air entry equal.

No abnormal breath sounds heard.

✓ **CARDIOVASCULAR SYSTEM**:-

S_1S_2 heard.

No murmurs.

✓ **PER ABDOMEN EXAMINATION**:-

Soft, no organomegaly.

✓ **CENTRAL NERVOUS SYSTEM:-**

HIGHER FUNCTIONS - Normal

MOTOR SYSTEM - Normal

SENSORY SYSTEM - Normal

CRANIAL NERVE EXAMINATION - Normal

ROUTINE INVESTIGATIONS

Haemoglobin - 15 gm %

Total WBC count – 16,500/cumm

Differential leucocyte count:

Neutrophils - 80%

Lymphocytes - 14%

Eosinophils - 3%

Monocytes - 3%

Basophils - 0%

Platelets – 3.6 lakhs/cu.mm

Bleeding time - Within normal limits.

Clotting time - Within normal limits.

X-ray chest - Normal

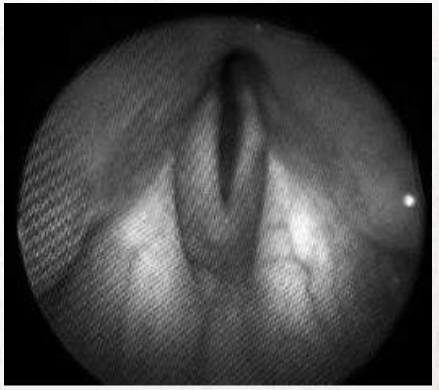
Electrocardiography - Normal

CT scan of skull base & neck - X

- Evaluated for etiology of stridor.

- On IDL - B/L vocal cords were immobile & in adduction- B/L abductor palsy.

- Videolaryngoscopy was done on 18/09/2013 to confirm the findings.



Ruling out central causes

- Physician advice has been taken following the investigations & central causes of vocal cord paralysis were ruled-out.

DIAGNOSIS

IDIOPATHIC B/L ABDUCTOR PALSY

- Patient & his attenders were explained regarding need for arytenoidectomy & cordectomy.
- They refused & left against medical advice on 21/09/2013.
- The patient was again readmitted on 24/09/2013 & gave consent for surgery.

Surgery - 01/10/2013

- Left intralaryngeal arytenoidectomy was done through laryngofissure approach.
- Left vocal cord lateralized by securing it to the thyroid lamina.
- Intra-operatively, Ryle's tube was inserted.

Post-op treatment

- Inj. Amoxycillin + Clavulanic acid- 1.2gm- IV- BD
- Inj. Tramadol- 2cc- IV- BD
- Inj. Ranitidine- 50mg- IV- BD
- Tab. Tab. Amlodipine- 5mg- OD + Hydrochlothiazide- 12.5mg- OD- through Ryle's
- Tab. Metoprolol- 25mg- OD- through Ryle's
- Nebulization with Budesonide 6th hrly
- Nebulization with Salmetrol 8th hrly
- Daily & regular care of tracheostomy tube.
- Chest physiotherapy

- 2nd POD- Oral fluids were given, but patient was not able to tolerate.
- Semi-solid feeds were also attempted- but patient not able to tolerate even those.
- Ryle's tube feeds continued till the 8th POD.
- 9th POD- Patient tolerating oral feeds- both semi-solid & liquid.
- 10th POD- Change to Fuller's tracheostomy tube & discharged the next day.

FOLLOW-UP

- 1st visit : De-cannulation attempted → could tolerate for 1/2hr → re-insertion of tube.

- 2nd visit : De-cannulation re-attempted → tolerated well → stoma closed.

THANK YOU