Airway obstruction caused by retro-laryngeal carcinosarcoma

Yasuyuki Chida,¹ Ryota Inokuchi,² Hiroaki Kikuchi,¹ Kazuaki Shinohara¹

¹Department of Emergency and Critical Care Medicine, Ohta Nishinouchi Hospital, Koriyama, Japan

²Department of Acute Medicine, The University of Tokyo Hospital, Bunkyo-ku, Japan

Correspondence to

Dr Ryota Inokuchi,
inokuchir-icu@h.u-tokyo.ac.jp

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DESCRIPTION

A 78-year-old Japanese man with alcohol dependence syndrome and hypertension presented with a 1-month history of dyspnea and dysphagia. On admission, his blood pressure was elevated but his other vital signs and laboratory tests were normal. A physical examination showed slight stridor and hoarseness; no swollen lymph nodes or tenderness, suggestive of epiglottitis, were detected during lateral laryngeal palpation. Cervical CT revealed a huge retro-laryngeal mass (figure 1), confirmed to be a tumour during laryngoscopy (figure 2). We performed an emergent tracheotomy, with local anaesthesia, for a suspected near-total airway obstruction. Subsequent tumour resection and pathology led to a diagnosis of carcinosarcoma and contrast-enhanced CT did not detect metastasis. We planned postoperative chemotherapy and radiotherapy, but the patient declined additional therapy.

Sarcomas are very rare among head and neck neoplasms, representing only 1% of all primary tumours arising in the head and neck regions. Generally, treatment involves chemotherapy (cyclophosphamide, vincristine, doxorubicin and dacarbazine) and postoperative radiotherapy (total doses of 60–70 Gy in standard fractions over 4–6 weeks).¹ Median survival times are 6.2 years after initial recurrence and 1.5 years after the diagnosis of metastasis.²

Upper airway tumours can obstruct the airway via inflammation, bleeding and/or physical blockage.³ Such oncologic airway emergencies are rare but may require emergent tracheotomies or other forms of immediate airway management. Persistent

Figure 2 Laryngoscopy revealed a tumour above the vocal cord.

Learning points

- ▶ Sarcomas are rare on head–neck lesion, but can cause airway obstruction.
- ▶ Oncologic airway emergency is rare but may require emergency tracheotomy or another form of immediate airway management.
- ▶ Coronal and sagittal CT can help identify the cause and marginal site of the lesion.

dyspnea and/or dysphagia, in the absence of fever or tenderness on laryngeal palpation, may suggest an upper airway tumour; stridor indicates an airway emergency. Coronal and sagittal CT can help assess the size and location of the tumour.

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Figure 1 Sagittal cervical CT scan revealing a retro-laryngeal tumour.

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