

Letters to the Editor

Basal-Cell Adenoma of the Subglottis: Laryngotracheal Resection With Laryngotracheoplasty[☆]**Adenoma de células basales subglótico: resección laringotraqueal-laringotraqueoplastia**

To the Editor,

Benign laryngotracheal tumours of the minor salivary glands are rare,¹ so experience in their treatment and evolution is limited. Indeed, we did not find any evidence of previous publication of a case of monomorphic adenoma in a subglottic location (PubMed, keys words: subglottic/laryngotracheal adenoma; larynx salivary adenoma; monomorphic/basal cell adenoma. Period covered: 1979–2012. Updated 17/11/2012).

We describe the case of a 50-year-old man who attended due to a three-month history of progressive dyspnoea on moderate and heavy exertion, with mild inspiratory stridor. A history of previous intubation due to two collarbone surgeries two years previously was noted. Nasofibrolaryngoscopy showed a right anterior subglottic lesion; its extension was determined by computed axial tomography (CT) (Fig. 1A). Rigid bronchoscopy and laser resection (Neodymium-YAG) was scheduled; during surgery, biopsies were taken and partial vaporisation of the lesion was performed. The histopathological result was consistent with a pleomorphic adenoma, so subglottic resection was carried out using an open approach in a second surgical procedure: the trachea was exposed with an incision over the second ring, similar to a tracheotomy; cricothyroid membrane incision; vertical connection of the left side of both incisions (cricoid arch and tracheal ring section), lifting a flap to visualise the lesion directly (15 cm in diameter, situated along the inside of the cricoid arch up to the height of the upper border of the first tracheal ring). Tumour excision was completed with partial cricotracheal resection (cricoid arch and anterior portion of the first tracheal ring). The defect was closed by primary reconstruction with sternothyroid muscle plasty over a Montgomery silicone T-tube (8 mm) and layered wound closure. After five days, the patient was discharged with mild-moderate cervical subcutaneous emphysema, which persisted for five weeks, odynophagia, requiring a soft diet for one month, and dysphonia due to the placement of the upper rim of the stent on the vocal cords. The definitive histopathological study was a benign salivary gland tumour, consistent with basal cell adenoma (monomorphic adenoma), with clear margins. The T-stent was removed after four months. Vocal granulomas were detected, which disappeared in two weeks after treatment with oral prednisone (30 mg in tapered dosage), and the voice returned to normal. The case has been monitored by nasofibrolaryngoscopy and radiological follow-up (Fig. 1B) for the last 1.5 years, with no evidence of recurrence to date.

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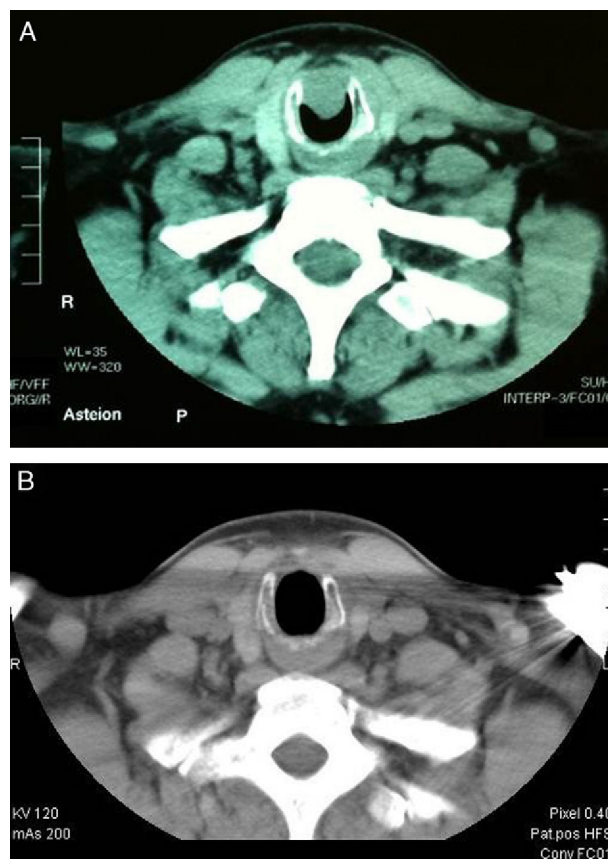


Fig. 1. (A) CT scan: subglottic lesion occupying the airways. (B) Image of the same case one year after the laryngotracheoplasty.

Despite its rarity, the possibility of a benign salivary gland tumour should not be excluded when there is a subglottic lesion, even in cases in which more common lesions such as granulomas are suspected.^{1,3} The endoscopic surgical approach (laryngoscopy, rigid bronchoscopy or flexible fibrobronchoscopy) for biopsy and histopathological study enables monomorphic adenoma to be diagnosed and differentiated from polymorphic adenoma, a more common tumour, and from basal cell carcinoma.^{1–3} Diagnostic bronchoscopy occasionally permits complete excision of the lesion¹ or reduction of the tumour mass if this is not possible, which in this case achieved clinical improvement until definitive treatment using an open approach.³ Laryngotracheal resection and laryngotracheoplasty have been widely described in the literature by Grillo and Mathisen⁴ and other authors.⁵ In the case reported, reconstruction of the laryngeal (anterior cricoid) and tracheal (first ring) defect was performed using prelaryngeal muscles over a Montgomery T-tube, as anastomosis of the distal trachea to the remaining cricoid was impossible. The use of a T-tube as a stent for the laryngotracheal lumen (with a good

result in this case) may be controversial, and to date, there are no precise indications. Although it ensures the airway in case of eventual laryngotracheomalacia or stenosis, it is not always essential after laryngotracheoplasty,^{4,5} and is not exempt from complications, mainly endoluminal granulomas in 19%–41% of cases, depending on the series.⁶ In conclusion, for benign tumours of the minor salivary glands in an anterior subglottic location, if endoscopic treatment is not possible, an open approach with partial laryngotracheal resection and immediate reconstruction with muscle plasty over a T-stent may be a satisfactory alternative, permitting the voice to be conserved, with relatively low morbidity.

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Bronchioloalveolar Carcinoma in a Young Patient: A Case Report[☆]

Carcinoma broncoalveolar en un paciente joven: caso clínico

Although lung cancer is the second most common cause of mortality due to cancer in young adults, it is an entity that is rarely taken into consideration in young individuals with respiratory diseases.^{1–4}

We present the case of a previously healthy 35-year-old smoker (35 packs/year). In October 2011, he was admitted to the local hospital in the Tulcea district (Romania) due to a two-week history of chest pain, cough and fatigue; he was afebrile and had not lost weight. The patient's general poor health was evident on physical examination. Pulmonary auscultation revealed general hypoventilation with scattered rhonchi. Examination of other organs did not yield any findings of interest. Laboratory tests revealed the following: mild inflammatory syndrome, repeated negative sputum examinations and negative ELISA HIV antibody test. The chest X-ray showed patchy consolidation with air bronchogram.

A diagnosis of bacterial pneumonia was established, and broad spectrum antibiotic treatment was administered (cephalosporin followed by levofloxacin). After two weeks, corticosteroids were added, with a slight but brief improvement in symptoms. Four weeks after admission, since the patient's condition worsened, anti-tuberculosis treatment was initiated, without first obtaining bacteriological tests. The patient's condition continued to deteriorate, the chest pain increased and major dyspnoea appeared, so in December 2011 he was transferred to a regional hospital, where he underwent a chest computed tomography (CT) scan. The chest CT images revealed patchy consolidation with air bronchogram (Fig. 1). For the first time, possible lung carcinoma was suspected. The patient was transferred to the National Respiratory Medicine Institute in January 2012 for confirmation by bronchial biopsy. At the centre we tried to perform a bronchoscopy, but it could not be done due to severe respiratory failure during the anaesthesia; the patient was transferred to the intensive care unit, where he died six days later. Histopathological examination showed the presence of bronchioloalveolar carcinoma.

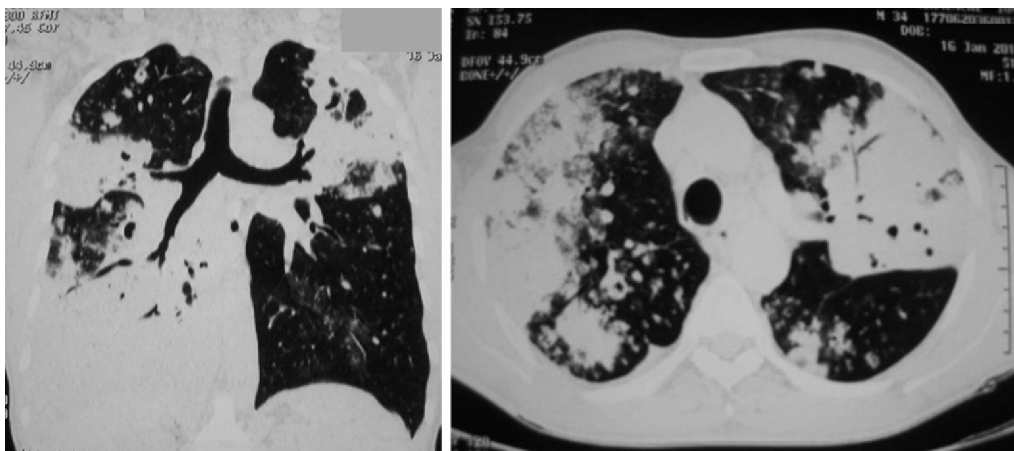


Fig. 1. The chest computed tomography revealed consolidation in both lungs with air bronchogram.

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