

Clinical Image

Right Vocal Cord Paralysis Due to Lymphatic Spread of Lung Cancer

Parálisis de cuerda vocal derecha por diseminación linfática de cáncer de pulmón



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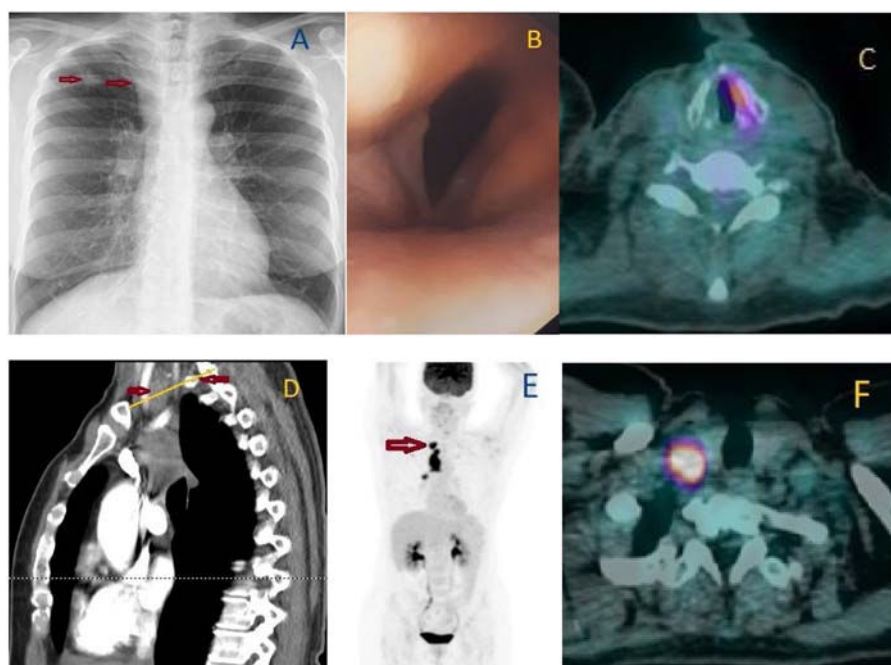


Fig. 1. (A) Chest X-ray. Right apical solitary nodule and thickening of the right paratracheal stripe (arrows). (B) Endoscopic view of the larynx reveals RVCP. (C) CT-PET at the larynx. No uptake in the right vocal cord is compensated by hypermetabolism in the left one. (D) Chest CT, sagittal view. A lower neck adenopathy (left arrow) lies just above the level of the first rib's (right arrow) trajectory (line). Therefore, it belongs to the 1R nodal station.¹ (E) PET scan. Increased uptake of the radiotracer noted at 1R (arrow), 2R, 4R and 10R nodal stations. The lung nodule was also hypermetabolic (not shown). (F) CT-PET reveals hyperactivity in the right juxta thyroid adenopathy (1R).

A 50 year-old female smoker complained of recent onset hoarseness. The ENT physician diagnosed right vocal cord paralysis (RVCP) and ordered a chest X-ray (Fig. 1A), which was followed by CT, bronchoscopy, and CT-PET scan (Fig. 1B–F).

Fine needle aspiration of the lower neck adenopathy yielded cells of adenocarcinoma, later confirmed by surgical biopsy. The invasion of the right recurrent laryngeal nerve by proliferation of neoplastic cells in lymph nodes at 1R and possibly 2R stations

caused the RVCP and dysphonia. The lymphatic spread of lung cancer causing RVCP has been described, but it is seldom reported.²

References

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