

# Tumours of the larynx

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Benign tumours of the larynx are extremely rare. Squamous cell carcinoma is the most common malignant tumour, being responsible for more than 90% of tumours within the larynx. It is the second most common head and neck cancer (oral cavity is more common) and previously usually occurred in elderly male smokers. However, over the past decades, the incidence among women has risen because of increased smoking. The incidence of laryngeal cancer in the three subsites – supraglottis, glottis and subglottis – varies around the world. Clinical features Patients typically present with voice change. Other symptoms include dysphagia, odynophagia and neck lumps. Advanced tumours can present with airway compromise, usually as inspiratory stridor ( Figure 52.56 ). Investigations Direct laryngoscopy , followed by a general anaesthetic assessment, together with angled (30° and 70°) Hopkins' rod examination, allows precise determination of the extent of the tumour and biopsy confirms the histology . CT and MRI give further details of the extent of larger tumours, demonstrating spread outside the larynx and suspicious nodal involvement within the neck, which may not be obvious clinically . Treatment Early laryngeal cancer (T1 and T2) Early-stage supraglottic and glottic tumours can be treated with a single modality: radiotherapy or endoscopic surgical resection, with the aim of preservation of function. Although both modalities are associated with similar survival rates (approximately 95% local control), transoral laser resection is commonly used as it usually involves day case surgery and more therapeutic options are available for the small number of patients who have local recurrence ( Figure 52.57 ). Advanced laryngeal cancer (T3 and T4) Organ preservation should be a priority when treating locally advanced cancer without extralaryngeal spread and/ or laryngeal dysfunction. The non-surgical standard of care is concurrent chemoradiotherapy; while a variety of open partial laryngectomy procedures are also available, these are best undertaken in specialist centres. Laryngeal cancer with gross extralaryngeal extension is usually best treated with total laryngectomy and adjuvant post operative radiotherapy or chemoradiotherapy ( Figure 52.56 After the larynx has been removed, the remaining trachea is brought out onto the lower neck as a permanent tracheal stoma and the hypopharynx, which is opened at the time of the operation, is closed to restore continuity for swallowing ( Figure 52.58 ). Thus, the upper aero- and digestive tracts are permanently disconnected. Part or all of the thyroid gland and associated parathyroid glands may also be removed, depending on the extent of the disease. - ).

Figure 52.56 A total laryngectomy specimen with a transglottic tumour. Figure 52.57 Flexible nasendoscopy demonstrating a laryngeal tumour seen involving the entire length of the right vocal fold. Figure 52.58 Transverse closure of the pharynx with an endotracheal tube in the end tracheostome.

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