

THE CLINICAL PICTURE

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Epiglottic cysts in clinical practice

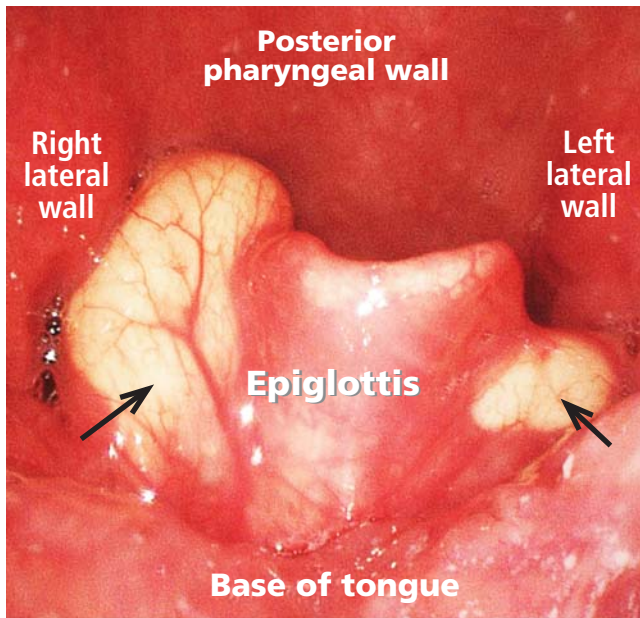


FIGURE 1. Anterior-superior view of the epiglottis, with arrows pointing to the cysts.

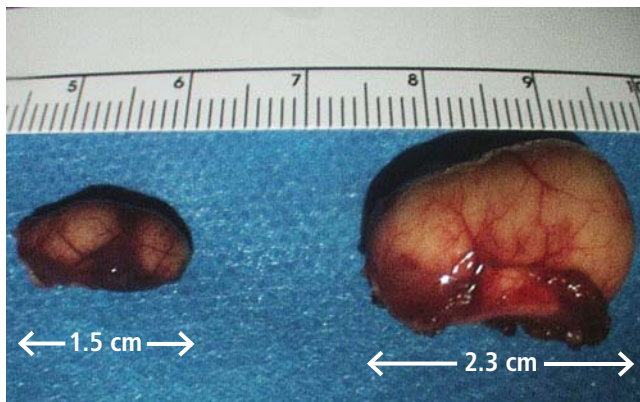


FIGURE 2. The cysts after successful endoscopic resection.

A 50-YEAR-OLD MAN PRESENTED to the otolaryngology clinic, complaining of throat discomfort for the past 3 months that worsened in the supine position. The clinical examination revealed one cystic lesion on either side of the epiglottis (Figure 1). The larger cyst measured 23 × 13 × 12 mm. The man's symptoms resolved completely after endoscopic removal of the cysts under general anesthesia (Figure 2).

CLINICAL IMPLICATIONS

Epiglottic cysts are benign lesions on the lingual or laryngeal aspect of the epiglottis and are often a result of mucus retention. Otolaryngologists, anesthesiologists, and endoscopists are usually the first to discover them. Because the cysts are usually asymptomatic, it is difficult to calculate their prevalence in the general population.

If the cysts are symptomatic, patients usually describe nonspecific complaints such as pharyngeal discomfort and foreign-body sensation. Voluminous cysts discovered incidentally in patients requiring general anesthesia pose a challenge to intubation and increase the risk of airway obstruction.

In addition, epiglottic cysts have been reported in a proportion of adult patients with acute epiglottitis (25% in one series)¹; They may be discovered either during the acute infection or when inflammation subsides.² These patients have been reported to have a higher risk of acute airway obstruction, with a sixfold increase in the need for acute airway management in one series.¹ Moreover, epiglottitis was reported to recur in 12.5% and 17% of patients with cysts in two different series,^{1,2} corresponding to a recurrence rate 15 times higher than in patients with no cysts.¹ Hence, it would be useful to rule out

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their presence after any episode of acute epiglottitis.

Once an epiglottic cyst is discovered in a symptomatic patient, it can be managed either by elective endoscopic resection or by marsupialization. Either procedure is safe, with good long-term results. Simple evacuation of the cyst should be considered in cases of acute airway management. ■

■ REFERENCES

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