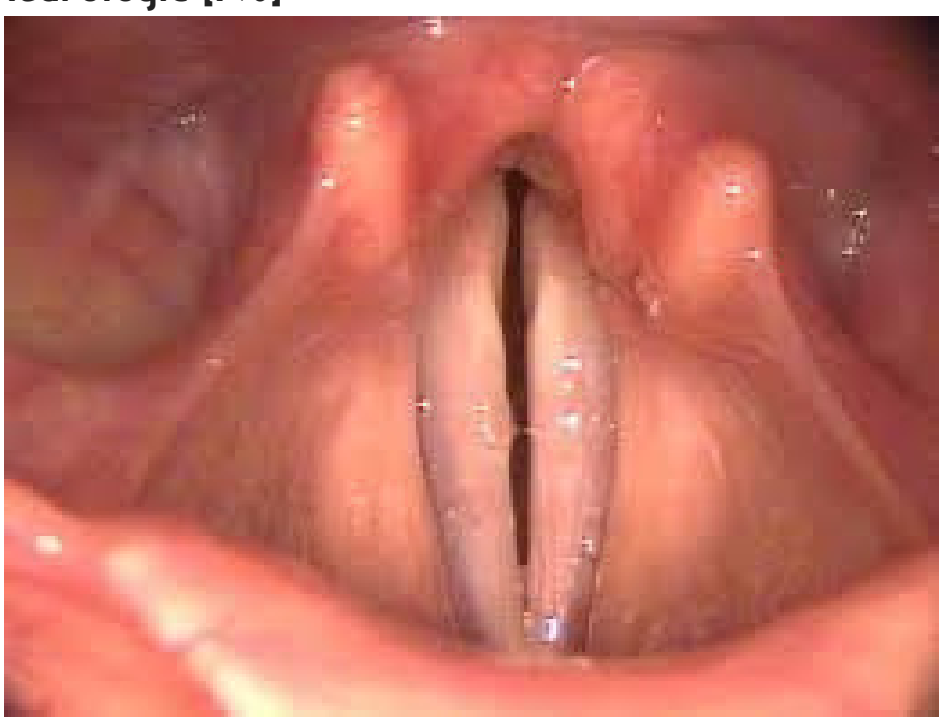
BILATERAL VOCAL FOLD PARALYSIS

NAT'S NOTES IN OTOLARYNGOLOGY HEAD AND NECK SURGERY

Episode 36.1

CAUSES

Iatrogenic (surgical trauma) [55%]
Malignancy [10%]
Idiopathic [8%]
Neurologic [7%]
Intubation [10%]
Nonsurgical trauma [2%]
Other [8%]

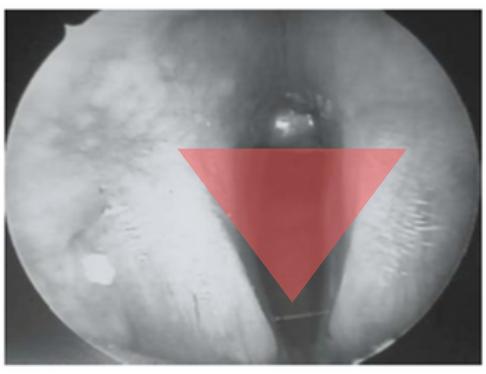


EVALUATION

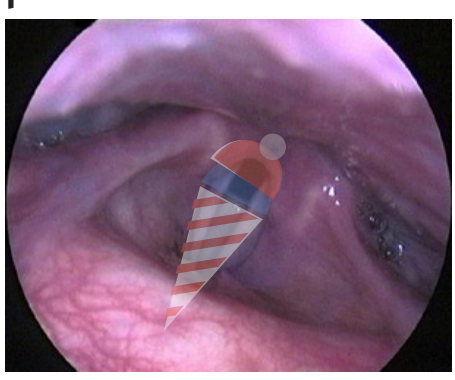
- Non-iatrogenic causes warrant further workup with CT or MRI
- Presentation very different from unilateral vocal fold paralysis--> SOB, stridor, normal voice quality. Urgently assess!
- Vocal folds drift midline after injury causing a slit-like glottis

Transnasal endoscopy:

Posterior glottic stenosis. Remaining cord shape resembles triangle



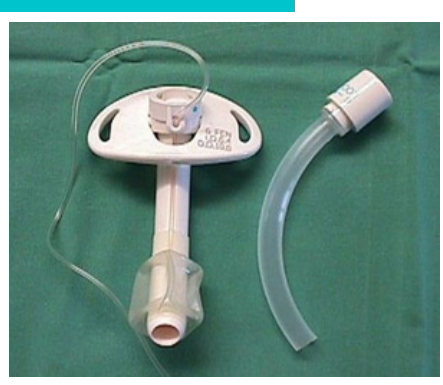
BVFP without stenosis. Glottic shape resembles ice cream cone



TREATMENT

- Management of AIRWAY: ETT preferred, gives time to consider surgery
- Temporizing surgical options

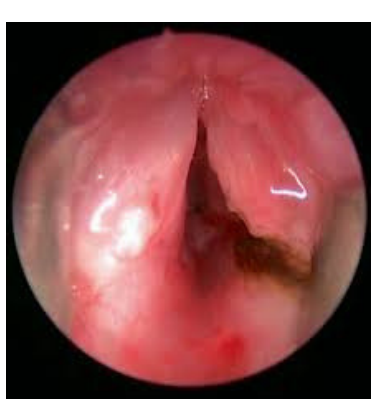
1) tracheostomy
2) laryngeal suture lateralization
3) botox injection (into thyroarytenoid muscle)



Shiley cuffed tracheostomy tube

- Longterm surgical options

4) transverse cordotomy
5) laser arytenoidectomy
6) laryngeal pacing (stimulates cricoarytenoid muscle)
7) arytenoid abduction suture



Post-cordotomy