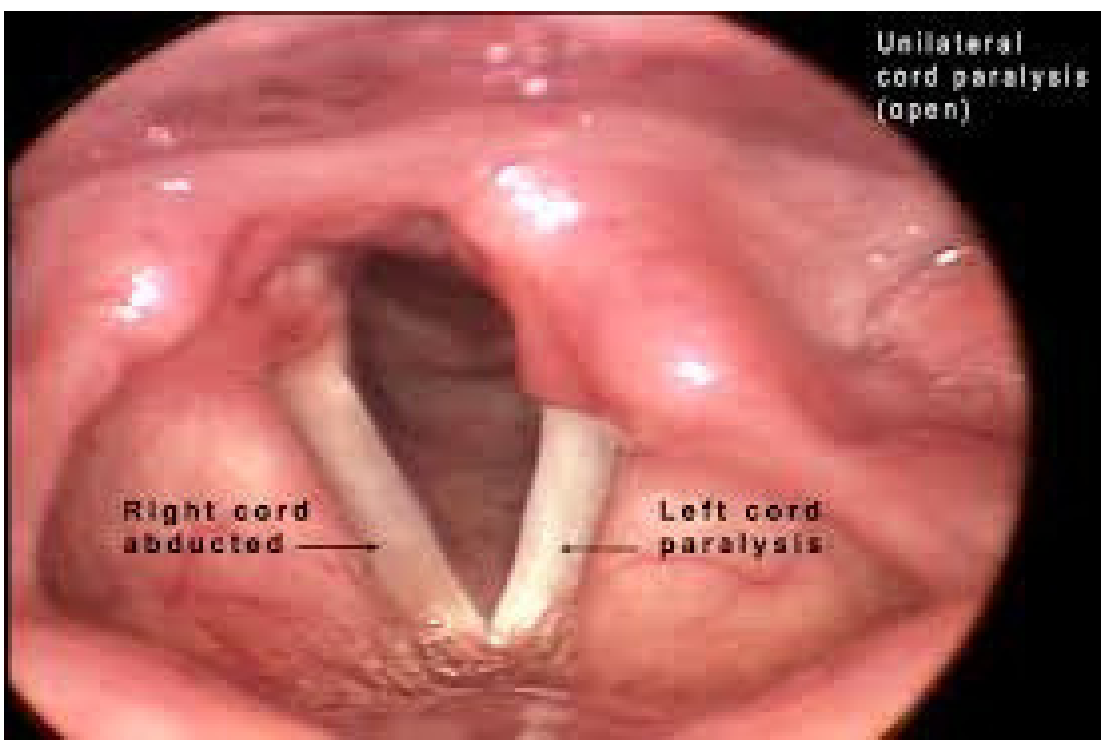
UNILATERAL VOCAL FOLD PARALYSIS

NAT'S NOTES IN OTOLARYNGOLOGY HEAD AND NECK SURGERY

Episode 35.1

CAUSES

Iatrogenic (surgical trauma) [46%]
Malignancy [13%]
Idiopathic [18%]
Neurologic [8%]
Intubation [4%]
Nonsurgical trauma [2%]
Aortic/cardiac [1%]
Other [8%]



EVALUATION

- History. R/O risk factors for cancer, trauma, recent surgery
- AIRWAY: shortness of breath
- VOICE: may present with vocal fatigue (mild) --> aphonia (severe). Weak, breathy, gurgled, rough, pitch locked
- SWALLOWING: aspiration on liquids, weak ineffective cough, solid dysphagia

Transnasal endoscopy:
"eee"-sniff combination. Maximal adduction and abduction
Identify vocal cord position - lateral, median, paramedian

- Imaging: VFSS [extent of aspiration], barium swallow [for suspected cancer], CXR [r/o thoracic lesion], CT/MRI [if diagnosis is unclear]
- Laryngeal EMG --> prognosticate, identify paralysis vs. paresis

TREATMENT

- 3 strategies: 1) observe 2) refer to SLP 3) early intervention

When should you consider early intervention?
Aspiration risk
Denervation on EMG
Due to thoracic injury (poor prognosis)
High voice demand (teacher, singer)
Comorbid

Vocal cord medialization:
-- injection augmentation
-- medialization laryngoplasty
-- arytenoid adduction
-- laryngeal reinnervation