

# Evaluation of the Dysphonic Patient (in: Function Preservation in Laryngeal Cancer)



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## KEYWORDS

- Diagnosis • Dysphonia • Hoarseness • Voice • Cancer • Laryngoscopy • Stroboscopy

## KEY POINTS

- Evaluation of the dysphonic patient begins as soon as the clinician can hear the patient's voice. This evaluation involves a thorough history, head and neck examination, a perceptual evaluation of the voice, and a detailed assessment of the patient's laryngeal anatomy and function.
- Dysphonia results from a disruption in the anatomy and function of the vocal folds. Stroboscopy is critical in evaluating the function of the vocal fold vibratory characteristics.
- High-speed digital imaging also can play an important role in patients with aperiodic vocal fold vibration.
- Concerning lesions warrant a biopsy for pathologic diagnosis.
- In the operating room, a telescope or microscope provides optimal visualization, mapping ability, and tactile evaluation of the tissue. Additionally, in-office biopsy is a cost-reducing and effective alternative in select patients for pathologic sampling.

## INTRODUCTION

Dysphonia is defined as an impairment of the speaking or singing voice, and it affects up to one-third of people during their lifetime.<sup>1,2</sup> The evaluation of dysphonia by general otolaryngologists varies with different practice patterns depending on

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Neither C.W. Whited nor S.H. Dailey have any conflicts of interest, financial or otherwise, to disclose.

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Otolaryngol Clin N Am 48 (2015) 547–564

<http://dx.doi.org/10.1016/j.otc.2015.04.003>

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### Abbreviations

CAPE-V	Consensus Auditory Perceptual Evaluation of Voice
DL	Direct laryngoscopy
F <sub>0</sub>	Fundamental frequency
GRBAS	Grade, roughness, breathiness, asthenia, strain
HSDI	High-speed digital imaging
NBI	Narrow Band Imaging
SLP	Speech-Language Pathologist(s)
VHI	Voice Handicap Index
V-RQOL	Voice-related quality of life

training background, practice type, and available resources.<sup>3</sup> There are multiple techniques to visualize the larynx from mirror laryngoscopy to high-speed digital imaging (HSDI). Some practices frequently employ speech-language pathologists (SLPs) to assess the perceptual, aerodynamic, and acoustic measurements, as well as treatment counseling and therapy. This lack of consensus in approach to dysphonia contributed to the Academy of Otolaryngology–Head and Neck Surgery to develop clinical practice guidelines on dysphonia.<sup>4</sup> There are both benign and malignant factors that can cause dysphonia, but what is concerning is that up to 52% of patients with laryngeal cancer thought their hoarseness was harmless, leading to a delay in evaluation and treatment.<sup>5</sup> The guidelines list comorbidities that should trigger a patient and clinician to suspect a serious underlying cause of the dysphonia (**Box 1**). This article builds on the invaluable article by Blitzer, elsewhere in this issue, regarding laryngeal anatomy and function, and presents a laryngologist's focus on the different tools, highlights, and pitfalls in the evaluation of the dysphonic patient.

### Box 1

#### Concerning signs with dysphonia

*Conditions leading to suspicion of a "serious underlying cause"*

Hoarseness with a history of tobacco or alcohol use

Hoarseness with concomitant discovery of a neck mass

Hoarseness after trauma

Hoarseness associated with hemoptysis, dysphagia, odynophagia, otalgia, or airway compromise

Hoarseness with accompanying neurologic symptoms

Hoarseness with unexplained weight loss

Hoarseness that is worsening

Hoarseness in an immunocompromised host

Hoarseness and possible aspiration of a foreign body

Hoarseness in a neonate

Unresolving hoarseness after surgery (intubation or neck surgery)

*From Schwartz S, Cohen S, Dailey S, et al. Clinical practice guideline: hoarseness (dysphonia). Otolaryngol Head Neck Surg 2009;141(3 Suppl 2):S1–31; with permission.*

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