



ORIGINAL ARTICLE

Cicatricial Posterior Glottic Stenosis. Our Experience[☆]



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KEYWORDS

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Abstract

Introduction and objectives: Presentation of the results obtained in the treatment of cicatricial posterior glottic stenosis.

Methods: A retrospective study of 34 patients diagnosed and treated for cicatricial posterior glottic stenosis in our ENT department.

Results: In our series, 85.36% of our patients were decannulated. Of these, 80% of the patients with glottic stenosis were decannulated, while 92.9% of the patients with other associated laryngotracheal stenosis were paradoxically decannulated.

Of all the patients, 70% required more than 1 surgical procedure, although most of these interventions were to resolve minor issues following our protocol.

The number of subsequent interventions was determined by the location of the stenosis, with there being more interventions when the posterior glottic stenosis was associated with another type of laryngotracheal stenosis ($P=.001$).

Conclusions: The surgical results for treating cicatricial posterior glottic stenosis are quite positive. However, unlike other types of posterior glottic stenosis (such as neurogenic abductor paralysis), it requires a greater number of interventions to achieve definitive decannulation. Endoscopic procedures play an important role and represent our main tool.

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PALABRAS CLAVE

Estenosis laríngeas;
Mitomicina C;
Láser CO₂

Estenosis glóticas posteriores de origen cicatricial. Nuestra experiencia**Resumen**

Introducción y objetivos: Presentar los resultados obtenidos en el tratamiento de estenosis glóticas posteriores cicatriciales.

Métodos: Estudio retrospectivo de 34 pacientes diagnosticados y tratados de estenosis glóticas posteriores cicatriciales por nuestro servicio.

Resultados: El 85,36% de nuestros pacientes fueron decanulados. Los pacientes con estenosis de localización únicamente glótica fueron decanulados en un 80%, mientras que paradójicamente en los que tenían asociada además otro tipo de estenosis laringotraqueal, el porcentaje de decanulación fue del 92,9%.

El 70% de los pacientes requirieron más de un procedimiento quirúrgico, aunque la mayoría de ellos se hicieron por protocolo y con la finalidad de resolver pequeños problemas.

El número de reintervenciones está condicionado por la localización de la estenosis, siendo mayor cuando la estenosis glótica posterior se asocia a otro tipo de estenosis laringotraqueal ($p = 0,001$).

Conclusiones: Los resultados quirúrgicos obtenidos en el tratamiento de las estenosis glóticas posteriores cicatriciales son buenos, pero a diferencia de otro tipo de estenosis glóticas posteriores (como por ejemplo las parálisis de abductores de origen neurogénico) requieren más intervenciones para la decanulación definitiva.

Los procedimientos endoscópicos juegan un papel destacado y suponen nuestra principal herramienta de trabajo.

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Introduction

Glottic stenoses are classified as anterior and posterior. The latter are divided into two differentiated types¹:

- (a) Those caused by bilateral paralysis of the abductor muscles, due for the most part to direct involvement of the lower laryngeal nerves, in accidents during cervical surgery or upper mediastinal surgery (almost always after total thyroidectomy, which is the most common cause).
- (b) Those resulting from scarring processes that, in addition to reducing the calibre of the posterior glottis, can occasionally compromise the mobility of one or both cricoarytenoid joints to a greater or lesser extent. These stenoses, in the majority, are the sequelae of prolonged intubation,² although they can be due to other causes, such as the sequelae of external trauma and exceptionally they can be considered to be of idiopathic origin, as they cannot be attributed to any known cause.

These cicatricial posterior glottic stenoses (CPGS) are more complex and have a poorer prognosis than stenoses of neurogenic origin, they usually require more surgical interventions because they tend to recur and are frequently associated with other stenoses.

The objective of this study is to demonstrate our results in the surgical treatment of CPGS (associated or otherwise with other laryngotracheal stenoses), focussing on the approaches and surgical techniques used.

We interpret as treatment success the definitive decannulation of the patient and respiratory improvement, which we assess as tolerance of normal exercise.

Material and Method**Patient Selection**

We looked at all the patients operated by our ENT department at the *Hospital Universitario de Móstoles* for laryngotracheal stenosis in the last 25 years (from January 1990 to December 2014), and we found 144 patients.

The inclusion criterion for this study was the presence of cicatricial posterior glottic stenosis, associated or otherwise with other laryngotracheal stenosis locations.

Of the 36 patients that met this criterion, we excluded 2, because there was no minimum follow-up (6 months), and because the necessary data had not been sufficiently documented.

A database was created of the 34 patients containing:

- The cause of the stenosis.
- Previous CPGS surgery in a different hospital.
- The existence or otherwise of subglottic extension or the simultaneous presence of laryngotracheal stenosis of another type.
- The presence or otherwise of tracheostomy at the time of surgery in our hospital (dependent tracheostomy).
- Laryngeal function prior to surgery, i.e., if vocal fold mobility had been preserved, if it had been limited by

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