



# Common Throat Problems and its Management For MO





# LEARNING OBJECTIVES

- Describe common throat disorders
- Identify age-related clinical scenarios
- Emphasize appropriate emergency interventions
- Describe common therapeutic measures
- Focus on preventive strategies





# CLINICAL PRESENTATION



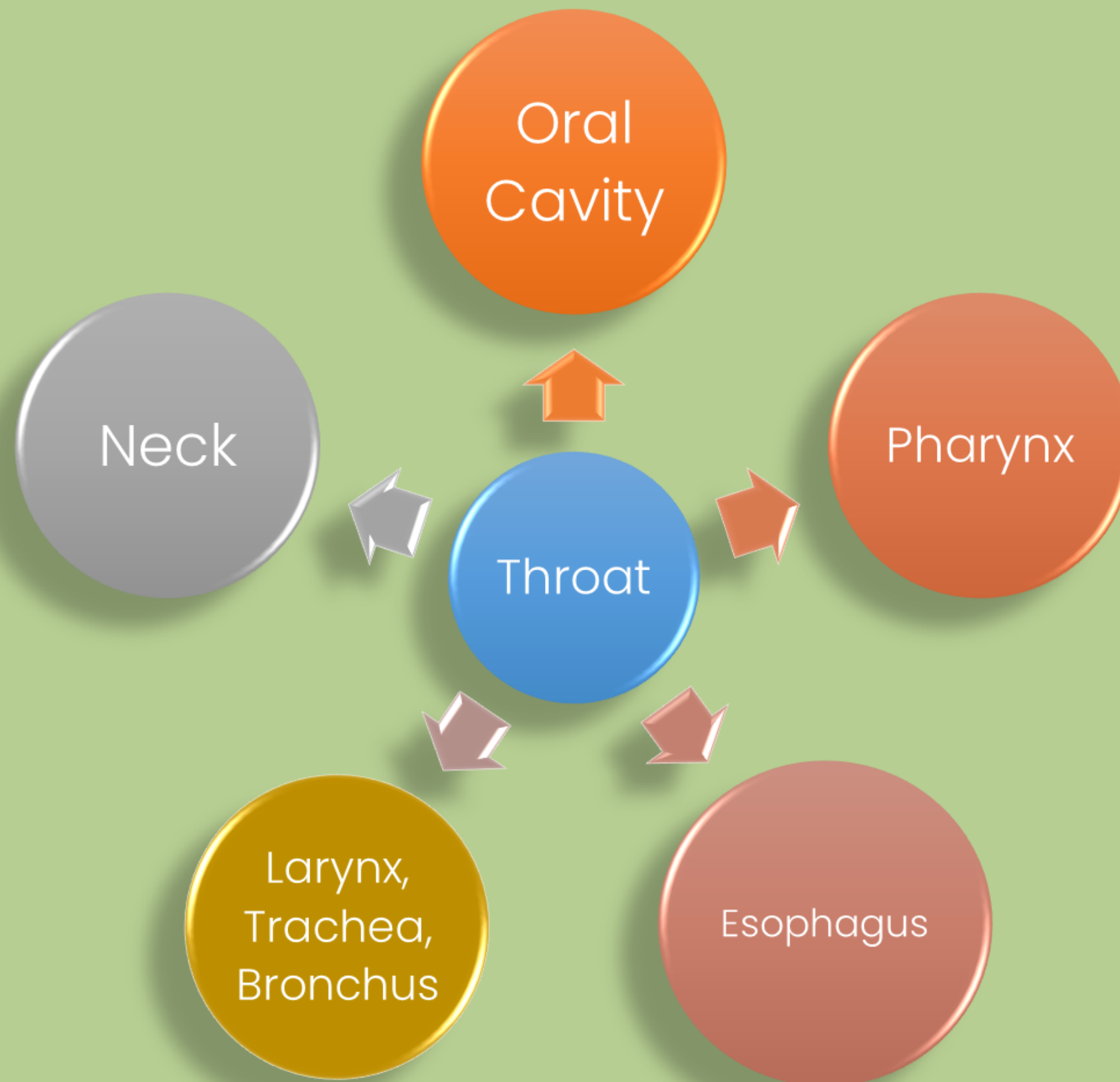
**Common symptoms of throat disorders are:**

1. Sore throat
2. Foreign body sensation
3. Hoarseness
4. Dysphagia
5. Odynophagia





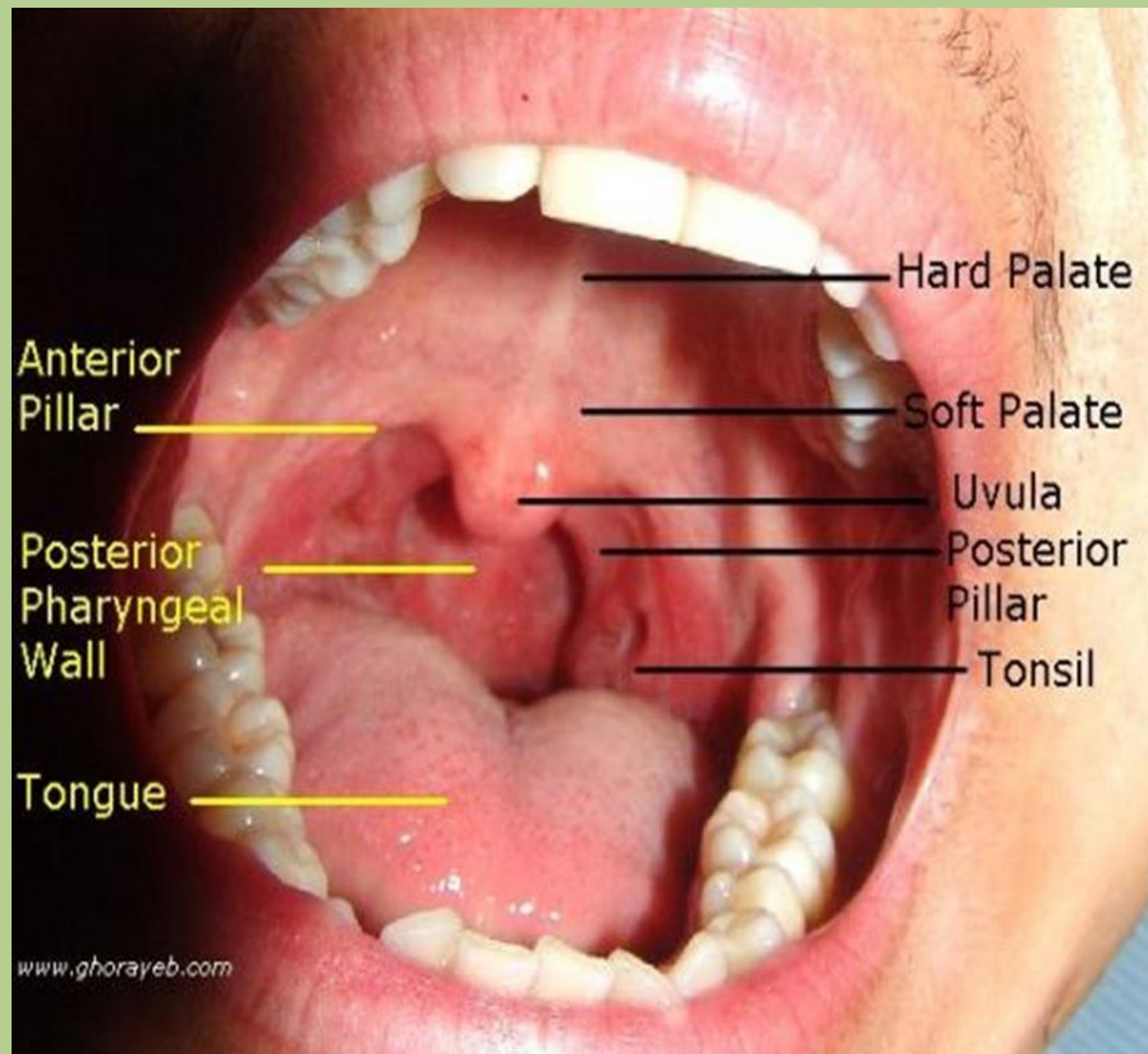
# INTRODUCTION







# ORAL CAVITY AND SALIVARY GLANDS





# ORAL CAVITY AND SALIVARY GLANDS



## Symptoms:

- Pain
- Xerostomia
- Excess Salivation
- Dysguesia
- Trismus
- Ulcers





# ORAL CAVITY AND SALIVARY GLANDS



## Disorders seen

1. Buccal mucosa
  - Aphthous ulcers
  - OSMF
  - Lichen Planus
  - Pemphigus
  - Leukoplakia
  - Erythroplakia





# ORAL SUBMUCOUS FIBROSIS(OSMF)



- Prevalence: 2-5 per 1000 in the Indian subcontinent
- Prolonged local irritation of betel, areca nut, tobacco
- Dietary deficiency
- Cell mediated immune reaction to Arecoline
- Leukoplakia and Squamous cell carcinoma is associated with OSMF





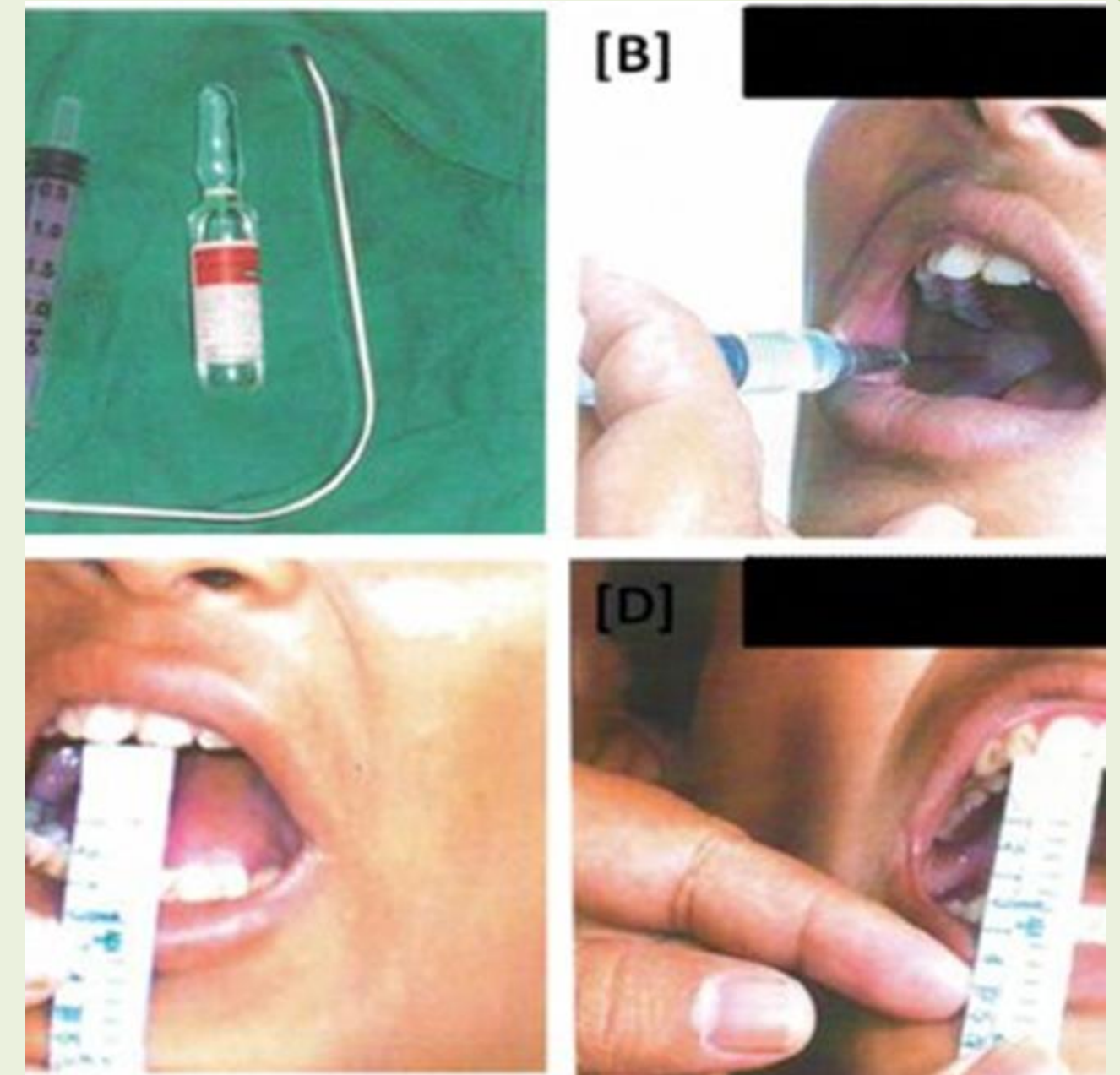


# ORAL SUB MUCOUS FIBROSIS(OSMF)



## Management:

- Topical Injection of Kenacort and Hyaluronidase- intraoral submucosal at different sites for 6 weeks
- Avoidance of irritant factors
- Jaw opening exercises
- Surgical: fibrous band release, lasers, coronoidectomy, and temporal muscle myotomy







# LEUKOPLAKIA



- Clinically, presents as a white patch
- Risk factors: Tobacco chewing, tobacco smoking, alcohol abuse
- Areca nut and betel
- Chronic trauma( friction-induced hyperkeratosis)
- Most common site: Buccal mucosa, Oral Commisure
- Homogenous, heterogenous or multifocal, Speckled, Ulcerative, nodular, Verrucous
- Erythroleukoplakia







# LEUKOPLAKIA



- Most common premalignant oral mucosal lesion
- 25% of Leukoplakias show epithelial dysplasia and about 5 % show malignant change
- Induration indicates malignancy

## Management:

- Counselling
- Observation and follow up (homogenous/benign/ minimal dysplasia)
- Incisional biopsy from suspicious areas (Erythematous, granular, ulcerated, indurated)





# ORAL CAVITY AND SALIVARY GLANDS



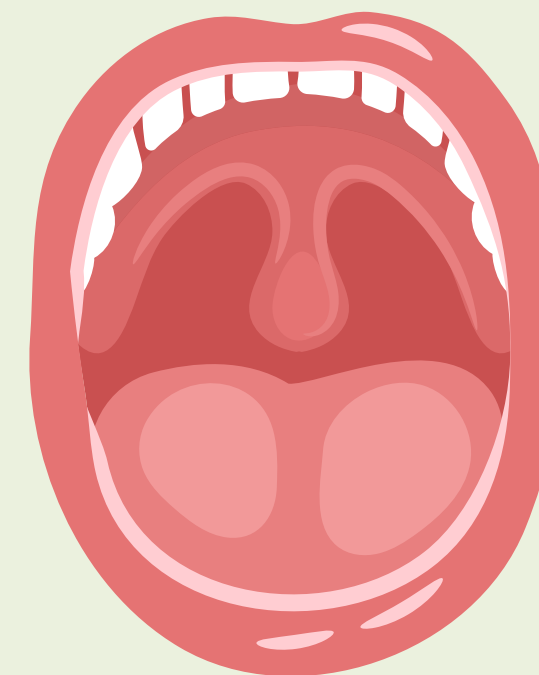
## Tongue

- Macroglossia
- Ankyloglossia
- Ulcers- Traumatic, aphthous, malignant, syphilitic, tubercular
- Proliferative growth- malignancy



## Floor of mouth

- Tongue tie
- Ulcers
- Ranula
- Sublingual dermoid
- Herpes Simplex infections





# ULCERS OF ORAL CAVITY



Traumatic  
Ulcer



Aphthous  
Ulcer



Malignant  
Ulcer





# ORAL CAVITY AND SALIVARY GLANDS



## Salivary Glands

- Viral Parotitis- Mumps
- Acute Suppurative Sialoadenitis
- Parotid gland abscess
- Sialolithiasis







# ORAL CAVITY AND SALIVARY GLANDS



## Salivary Glands

- Viral Parotitis- Mumps
- Acute Suppurative Sialoadenitis
- Parotid gland abscess
- Sialolithiasis







# ORAL CAVITY AND SALIVARY GLANDS



- Neoplasms- 70 % arise from the Parotid gland
- Benign: Pleomorphic Adenoma, Warthin's tumor
- Malignant: Mucoepidermoid Carcinoma, Adenoid cystic carcinoma
- Investigations: FNAC, USG, CT/MRI

***Pleomorphic adenoma***



***Mucoepidermoid Carcinoma***





# LUDWIG'S ANGINA

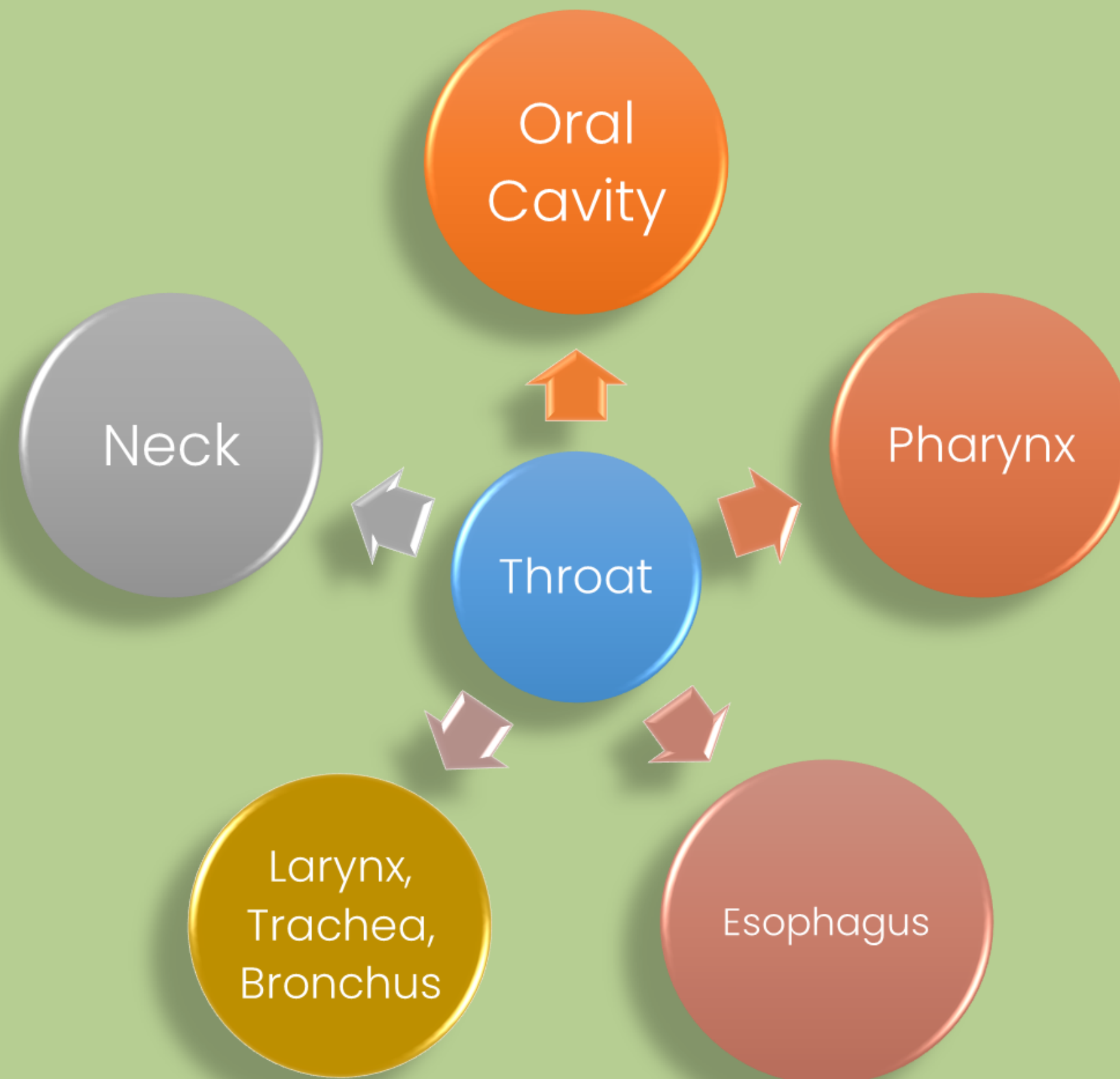


- Infection of Submandibular space
- Dental infections in 80% cases
- Dysphagia, odynophagia, trismus
- Sublingual space → submaxillary space, submental space swollen & tender (feels woody hard) marked cellulitis
- Management: Systemic antibiotics, Incision & drainage, Tracheostomy if necessary





# INTRODUCTION



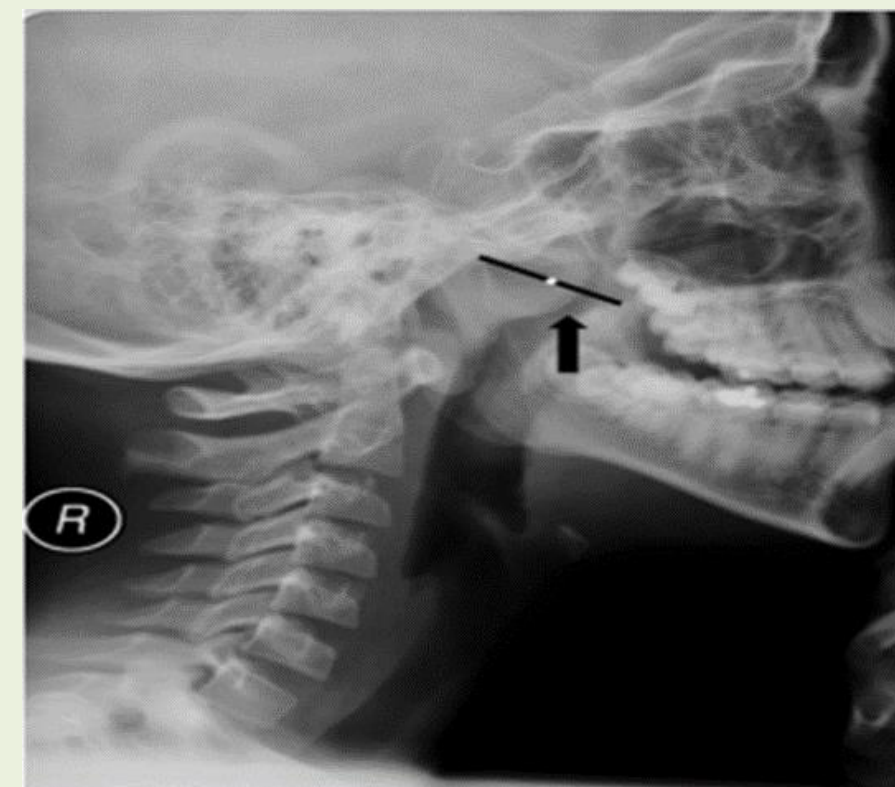
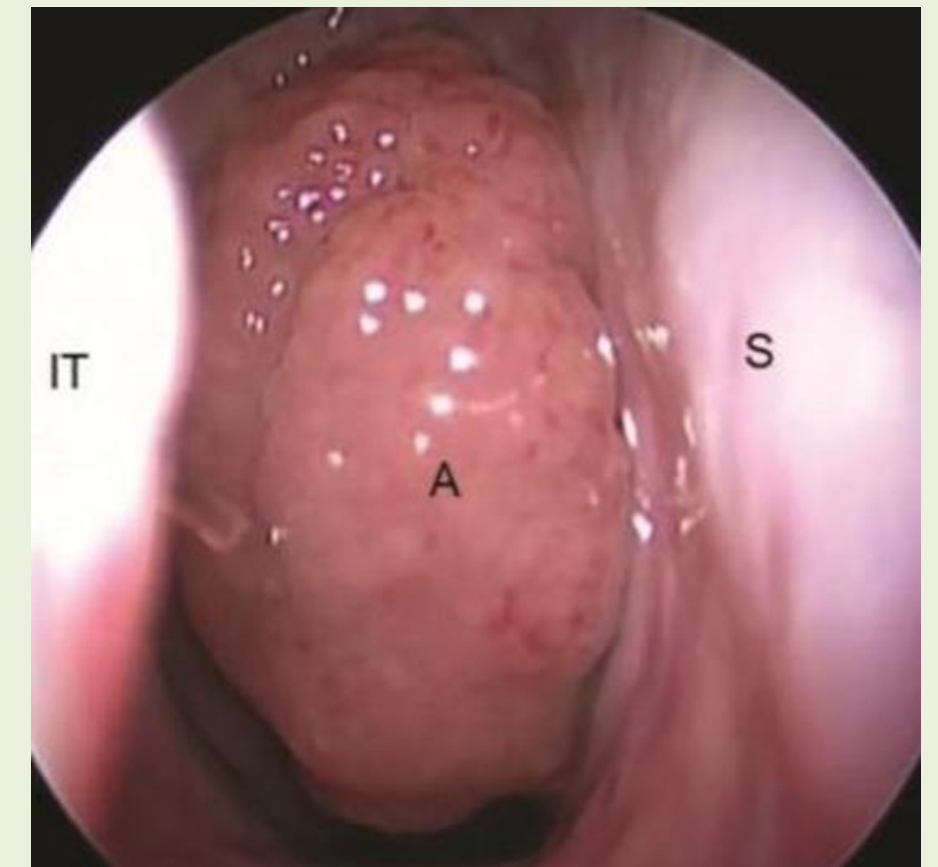




# ADENOIDITIS



- Presents as Acute Adenoiditis or Chronic adenotonsillar hypertrophy
- Nasal obstruction
- Nasal discharge
- Rhinolalia Clausa
- Conductive hearing loss
- Recurrent acute/serous otitis media
- Aproxexia( lack of concentration)
- Obstructive Sleep Apnea

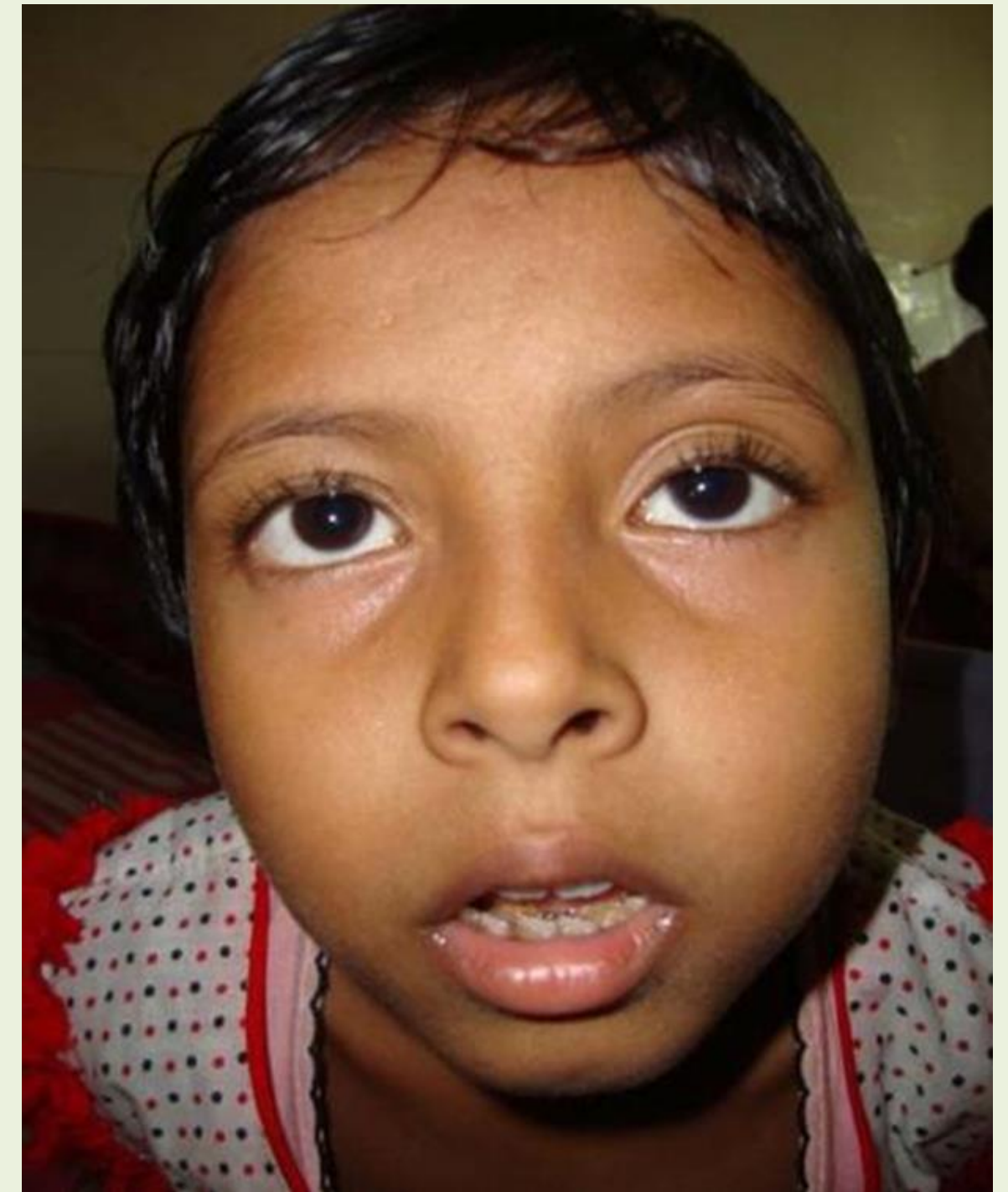




# ADENOIDITIS



- “Adenoid Facies”
- Dull face
- Open mouth
- Pinched nose
- Hitched up upper lip
- Retrognathic mandible
- High arched palate
- Management: Medical- Breathing exercises, Decongestants, Antihistaminics, Antibiotics,
- Surgical- Adenotinsillectomy







# TONSILLITIS

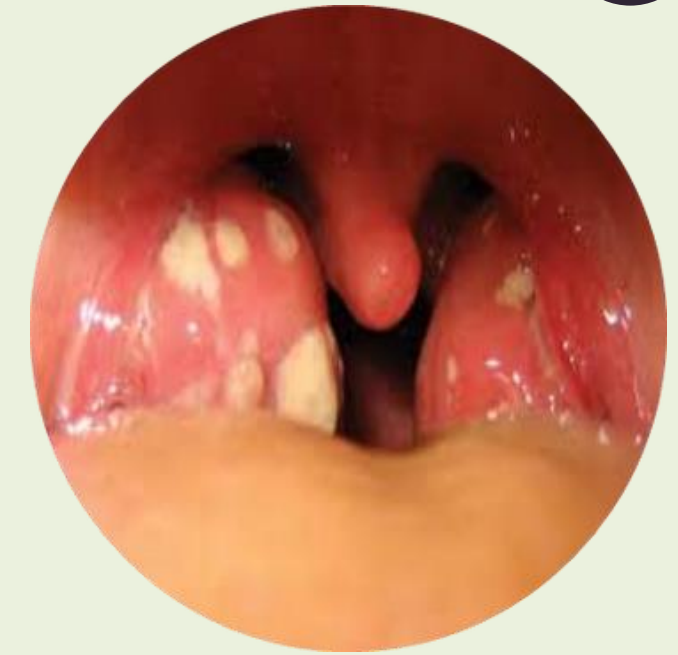


## Symptoms:

- Throat pain
- Dysphagia
- Fever
- Earache
- Change in voice
- Constitutional symptoms-  
headache, malaise

## Sign

- Dry and coated tongue
- Halitosis
- Hyperemia of pillars, soft palate, uvula
- Tonsils are red and swollen
- Pus at openings of crypts
- Membranous tonsillitis
- Tender Jugulodigastric  
lymphadenopathy





*Catarrhal  
Tonsillitis*



*Membranous  
Tonsillitis*



*Parenchymato  
us Tonsillitis*





# TONSILLITIS



## Treatment:

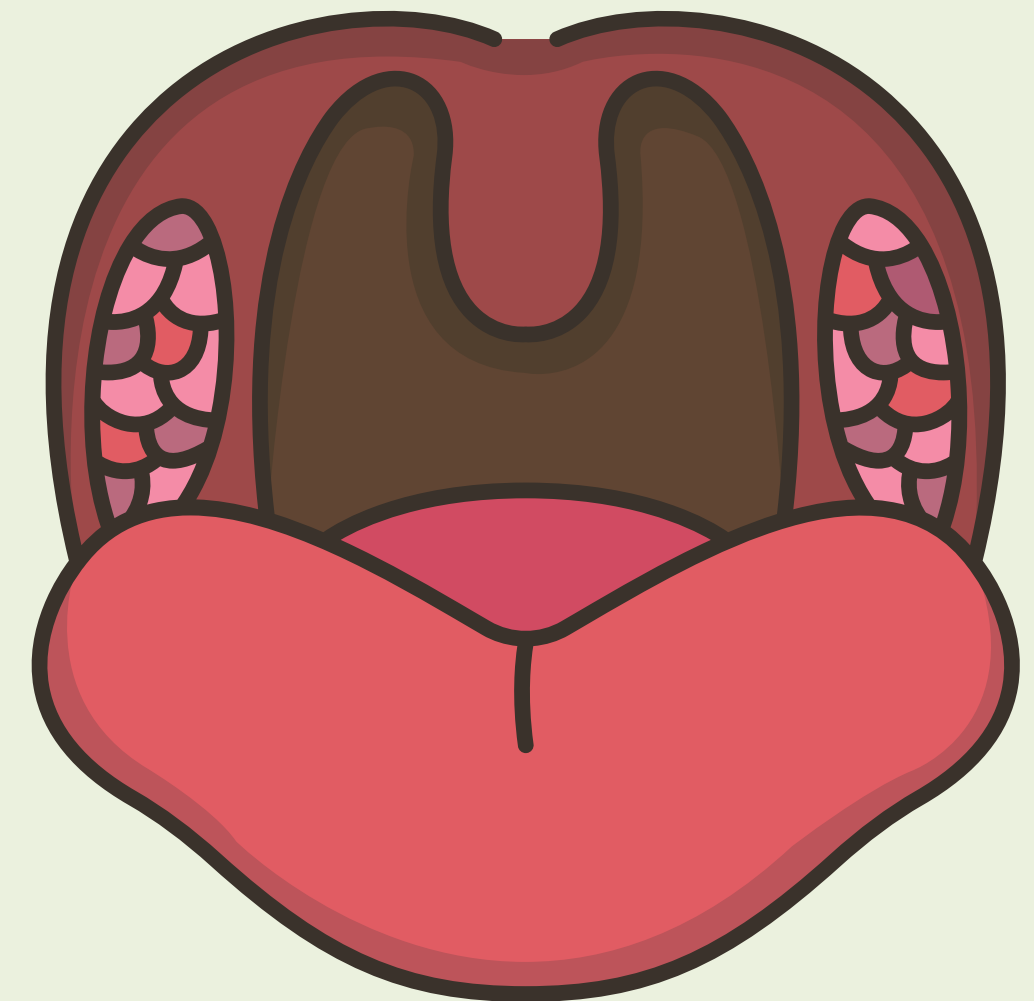
### Medical

- Bed rest, fluids, Analgesics, Antipyretics,
- Antibiotics- Penicillin or Amoxicillin/  
Clindamycin/Erythromycin + Metronidazole

### Surgical- Tonsillectomy

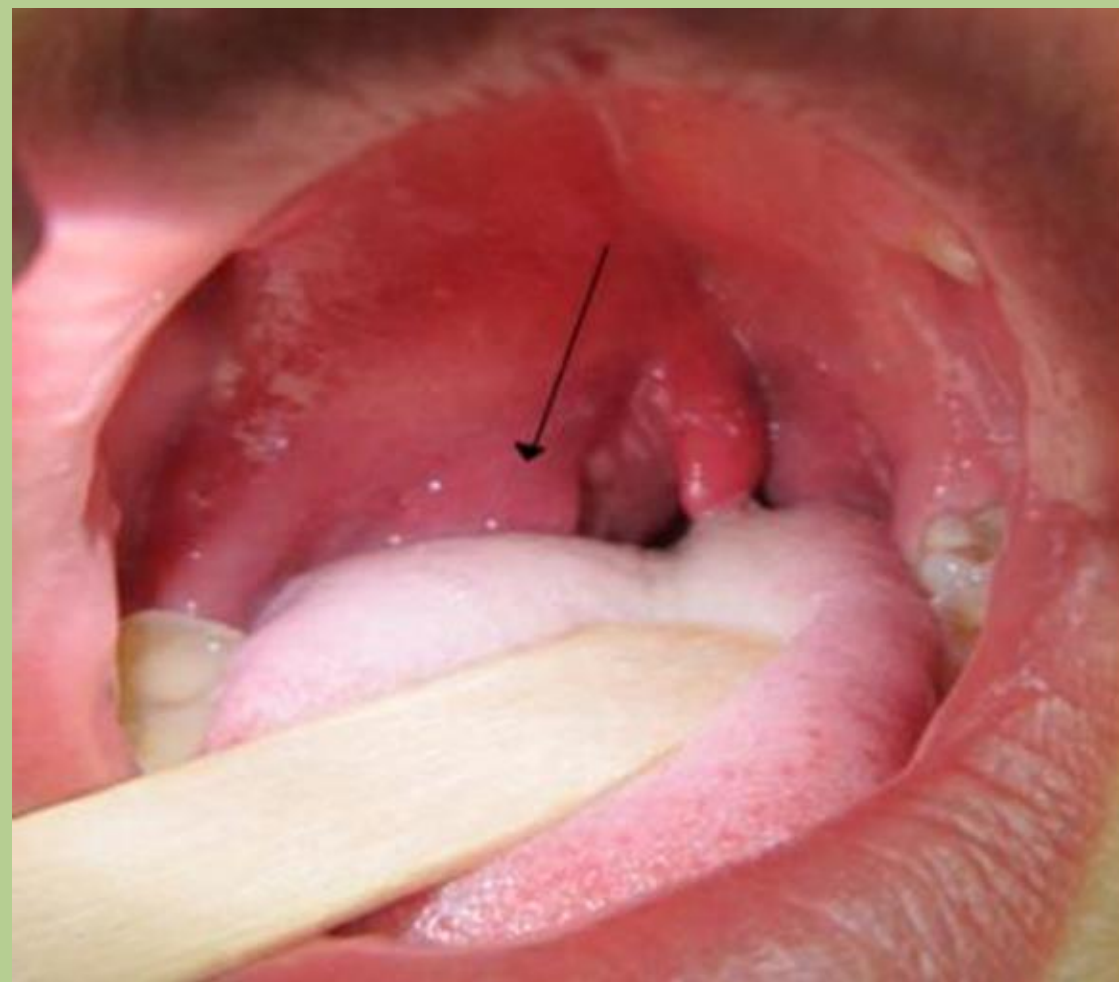
### Complications: Peritonsillar Abscess

- Retropharyngeal abscess
- Parapharyngeal abscess





# COMPLICATIONS



Peritonsillar Abscess

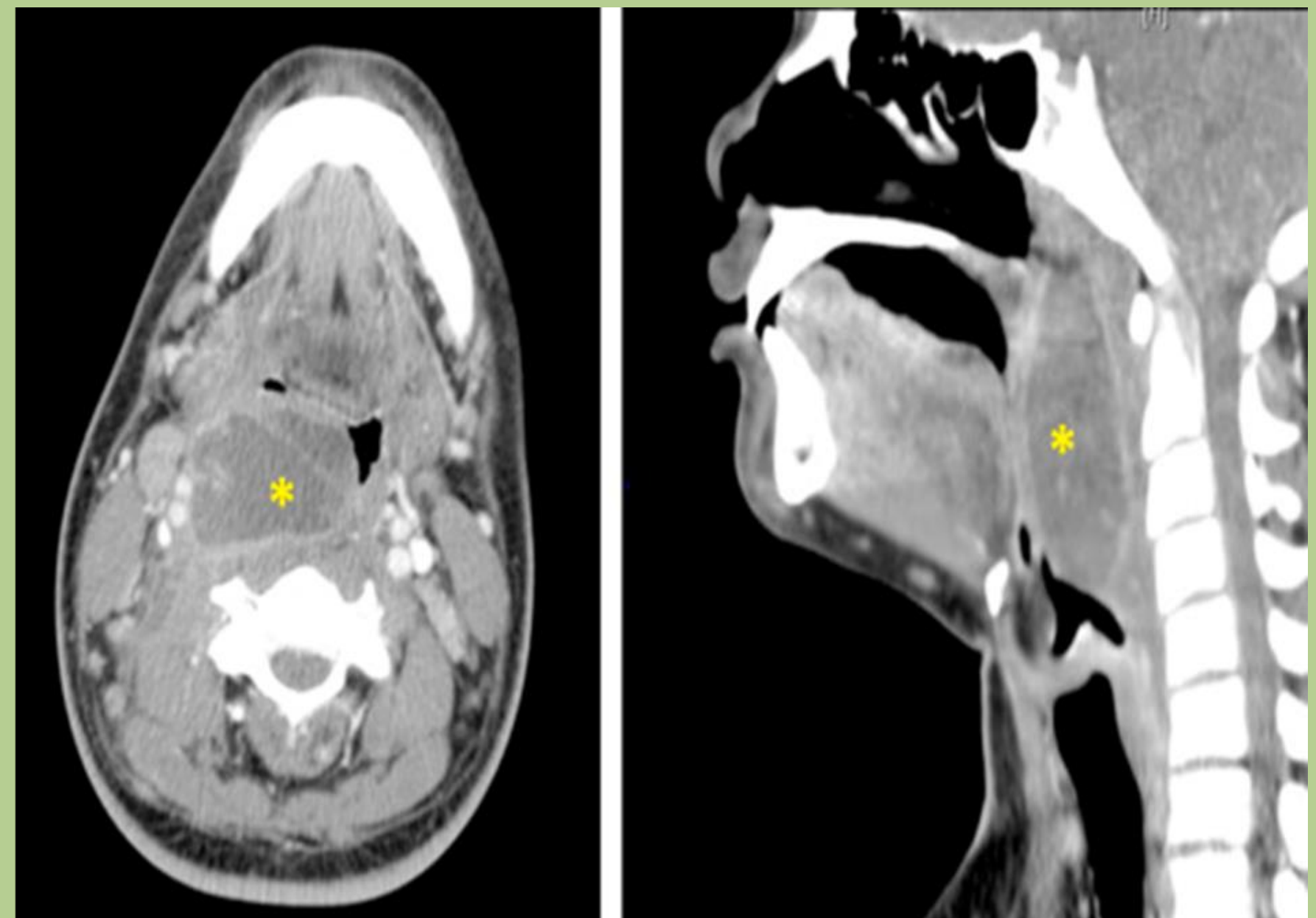


Retropharyngeal Abscess





# COMPLICATIONS



Parapharyngeal Abscess



# TUMOURS OF PHARYNX



Nasopharynx- JNA, Squamous cell carcinoma of nasopharynx

Oropharynx- Parapharyngeal tumours, lymphoma, Sq. cell carcinoma

Hypopharynx- Marginal zone cancers, Sq cell carcinoma of pyriform Sinus





# NASOPHARYNX

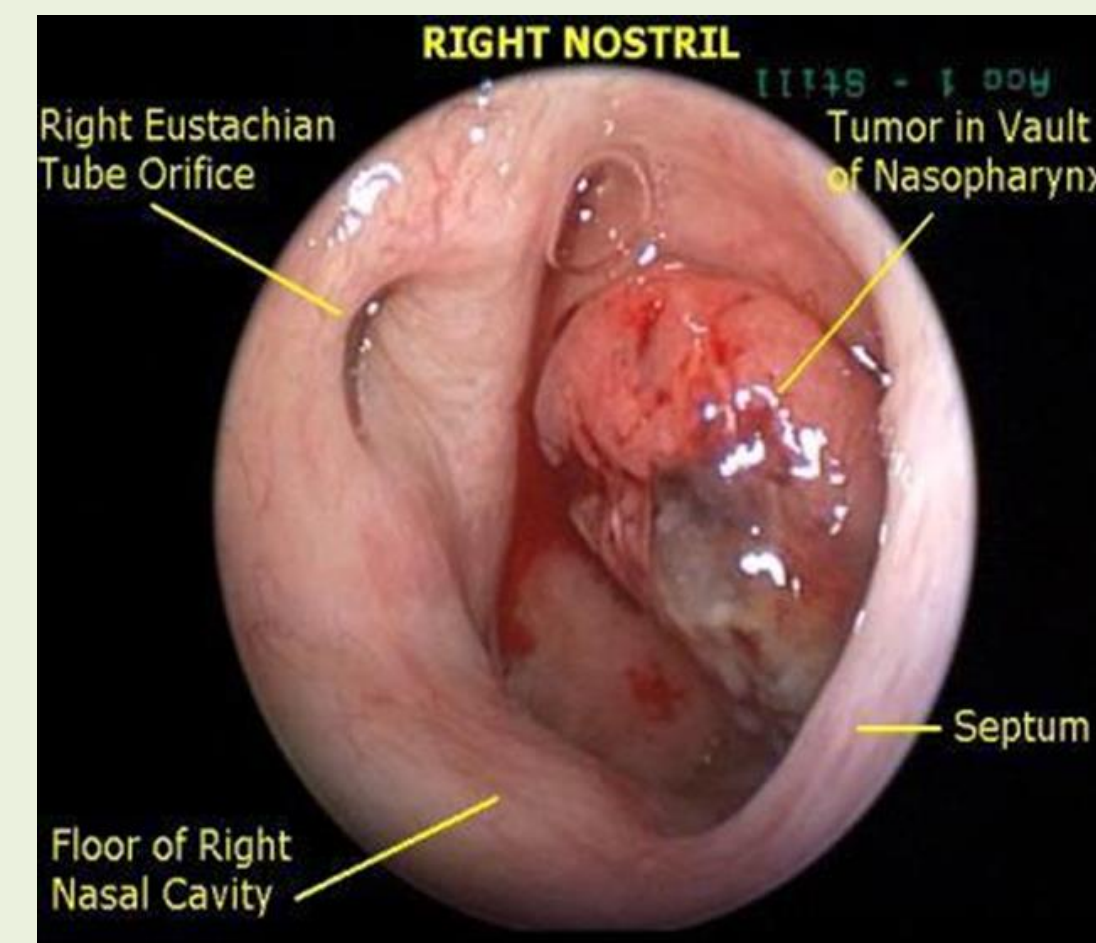


## Clinical presentation.....

- Nasal obstruction
- Conductive hearing loss
- Epistaxis
- Cranial nerve palsies (CN III, IV, VI- Ophthalmoplegia)
- V th CN , IX,X,XI CNs
- Cervical Nodal metastasis- 75% patients present with enlarged nodes between angle of jaw and mastoid

## What to do.....

- Nasal endoscopy
- FNAC of cervical lymph node
- Biopsy from nasopharynx (Fossa of Rosenmuller)
- EBV DNA titres
- MRI
- CT Scan
- PET Scan





# OROPHARYNX



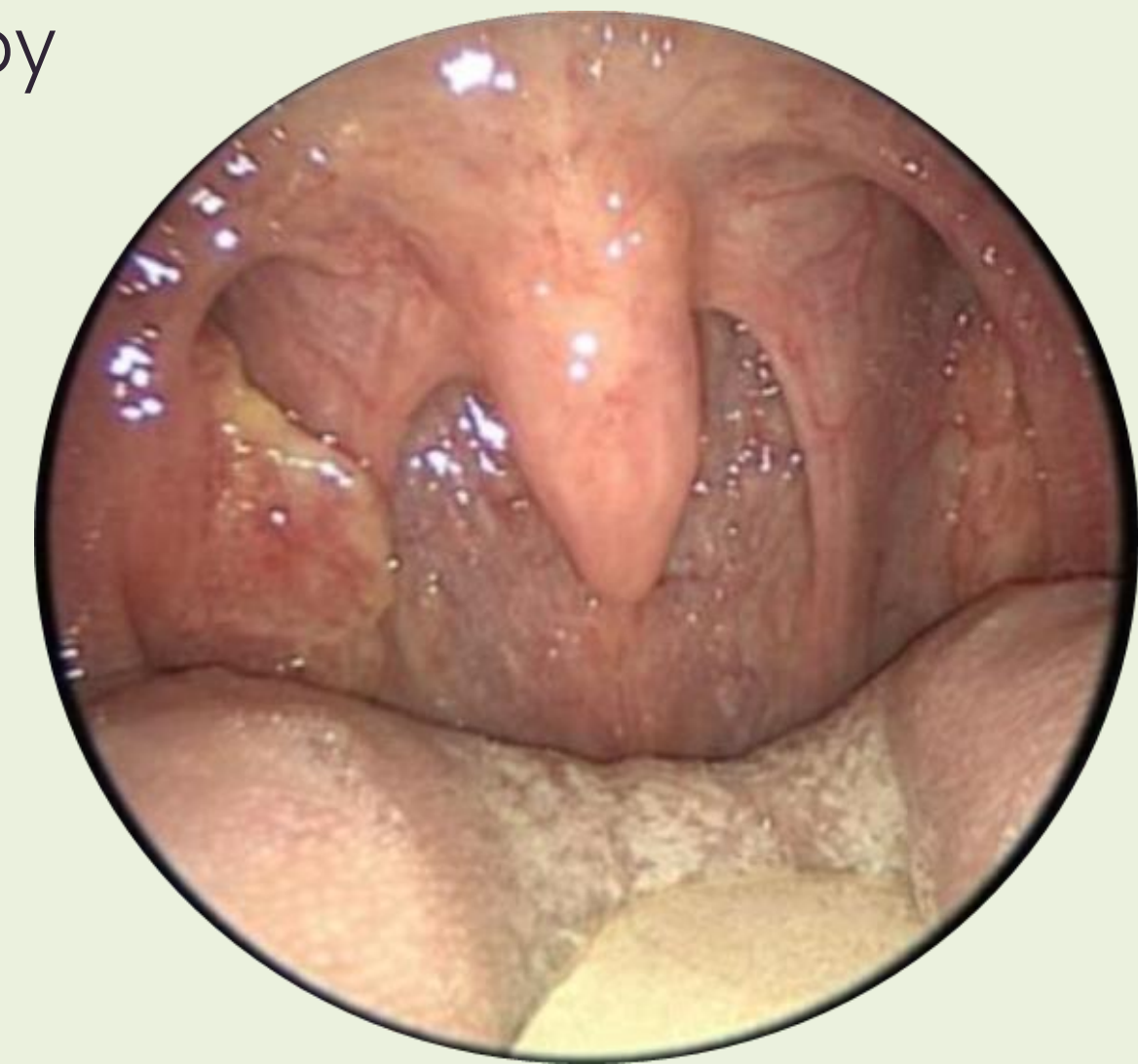
## Clinical presentation.....

- Carcinoma of Base of the tongue, Tonsil, Soft Palate-  
Ulcer with induration, local pain referred otalgia,  
Dysphagia
- Parapaharyngeal tumors-  
Bulge in Lateral pharyngeal wall, Cervical swelling
- Cervical Nodal metastasis-  
Base of tongue malignancy

## What to do.....

- CT/MRI Scan
- FNAC from lymph node
- Biopsy from primary site
- Panendoscopy
- PET Scan

Tonsillar growth





# OROPHARYNX



Base of tongue growth



Parapharyngeal tumours



# HYPOPHARYNX



## Clinical presentation.....

- 3 Subsites: Pyriform Sinus (most common site), Postcricoid region, Posterior pharyngeal wall
- Neck mass, Dysphagia, referred otalgia, shortness of breath, hoarseness of voice
- Marginal zone cancers

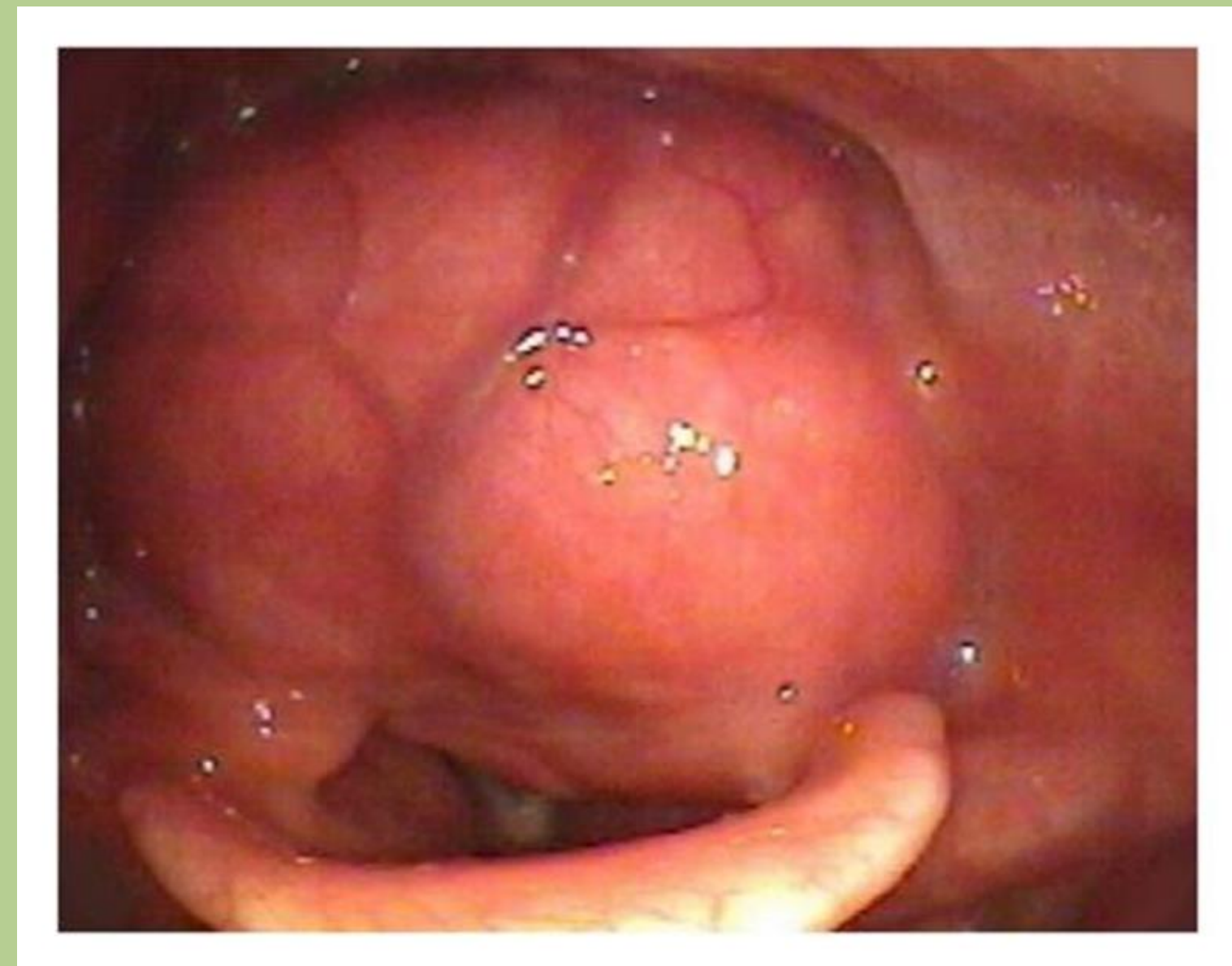
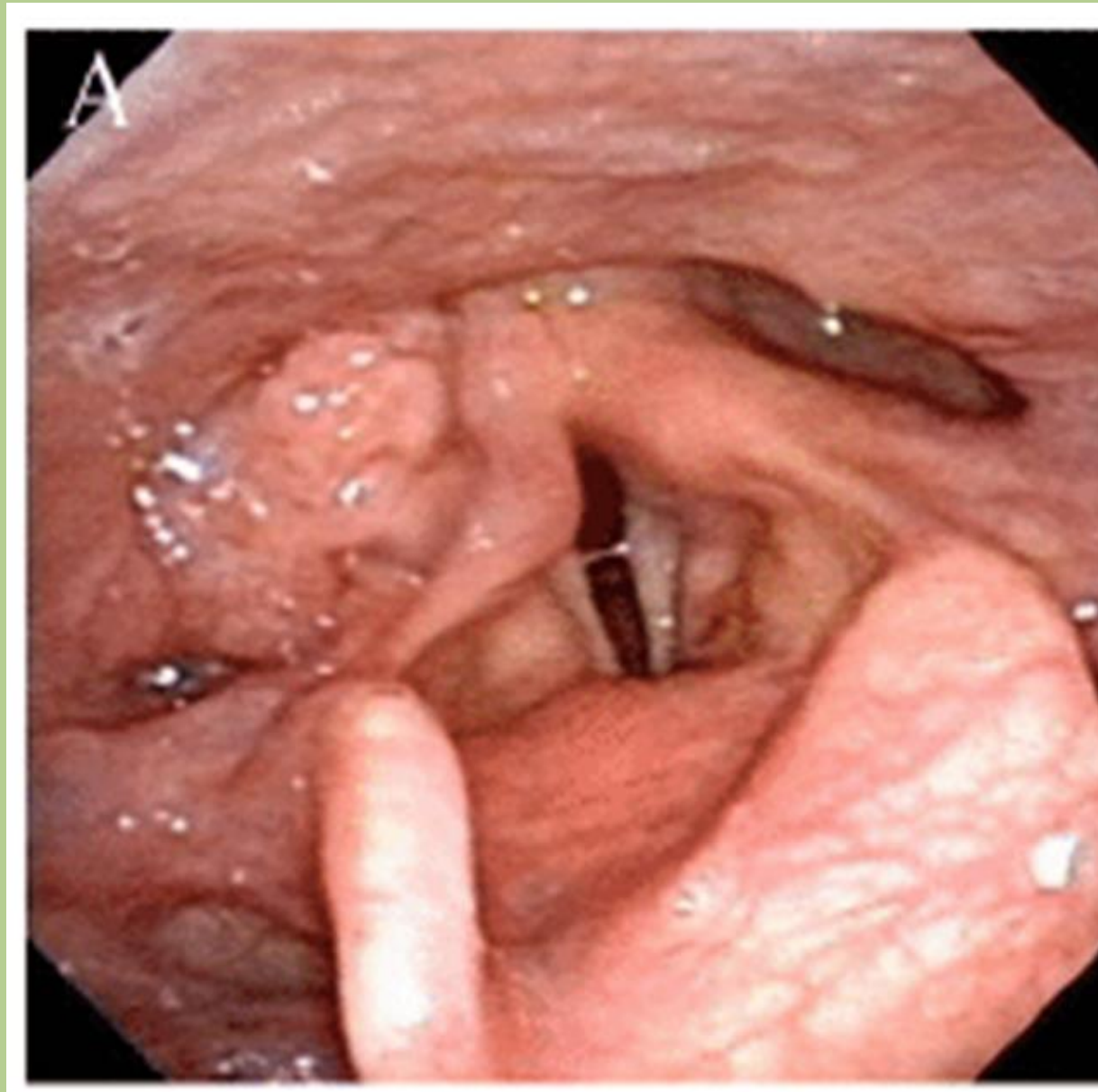
## What to do.....

- Endoscopic evaluation
- Barium Swallow
- CT/MRI Scan
- FNAC from lymph node
- Biopsy from the primary site
- Panendoscopy
- PET Scan





# HYPOPHARYNX







# ESOPHAGUS

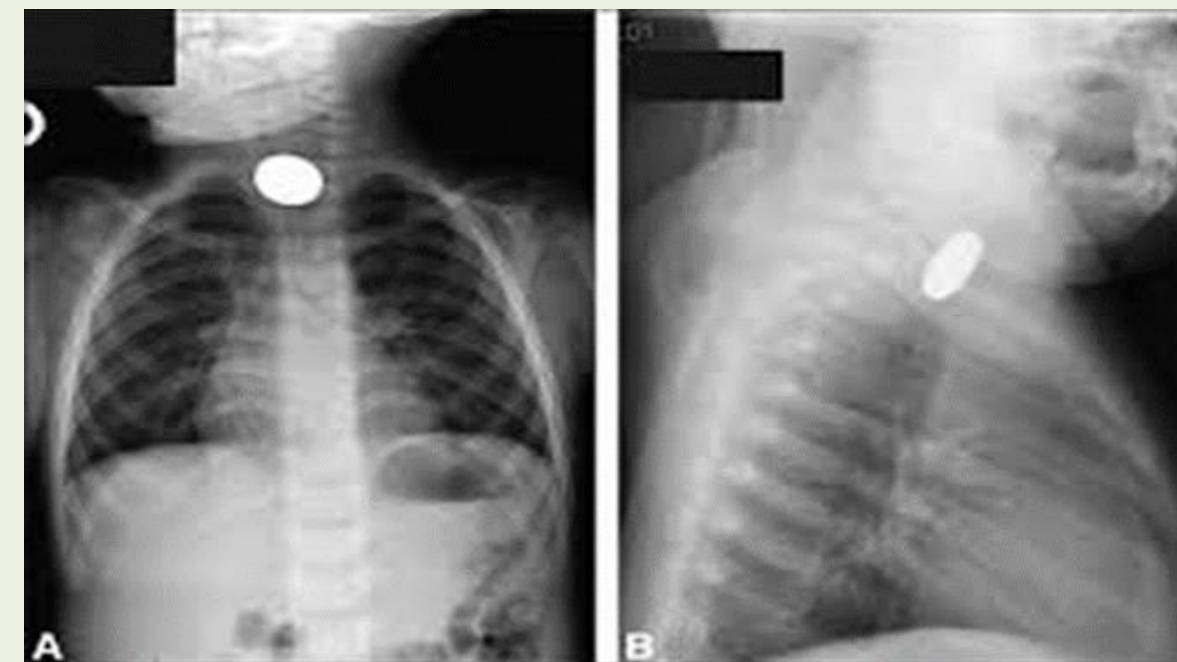


## Foreign bodies

- Coin, meat, chicken bone, denture, safety pin, batteries
- Common sites of impaction:
  - Cricopharyngeal spincter/  
Bronchoaortic constriction/  
Cardiac end
- Dysphagia, gagging, odynophagia, drooling of saliva

## What to do.....

- Xray- Soft tissue neck and chest, Barium swallow
- Esophagoscopy and fb removal under GA







# ESOPHAGUS



- Gastroesophageal Reflux disease( GERD)
- Inappropriate function of LES , reflux of gastric content

Fatty foods, chocolates, alcohol,

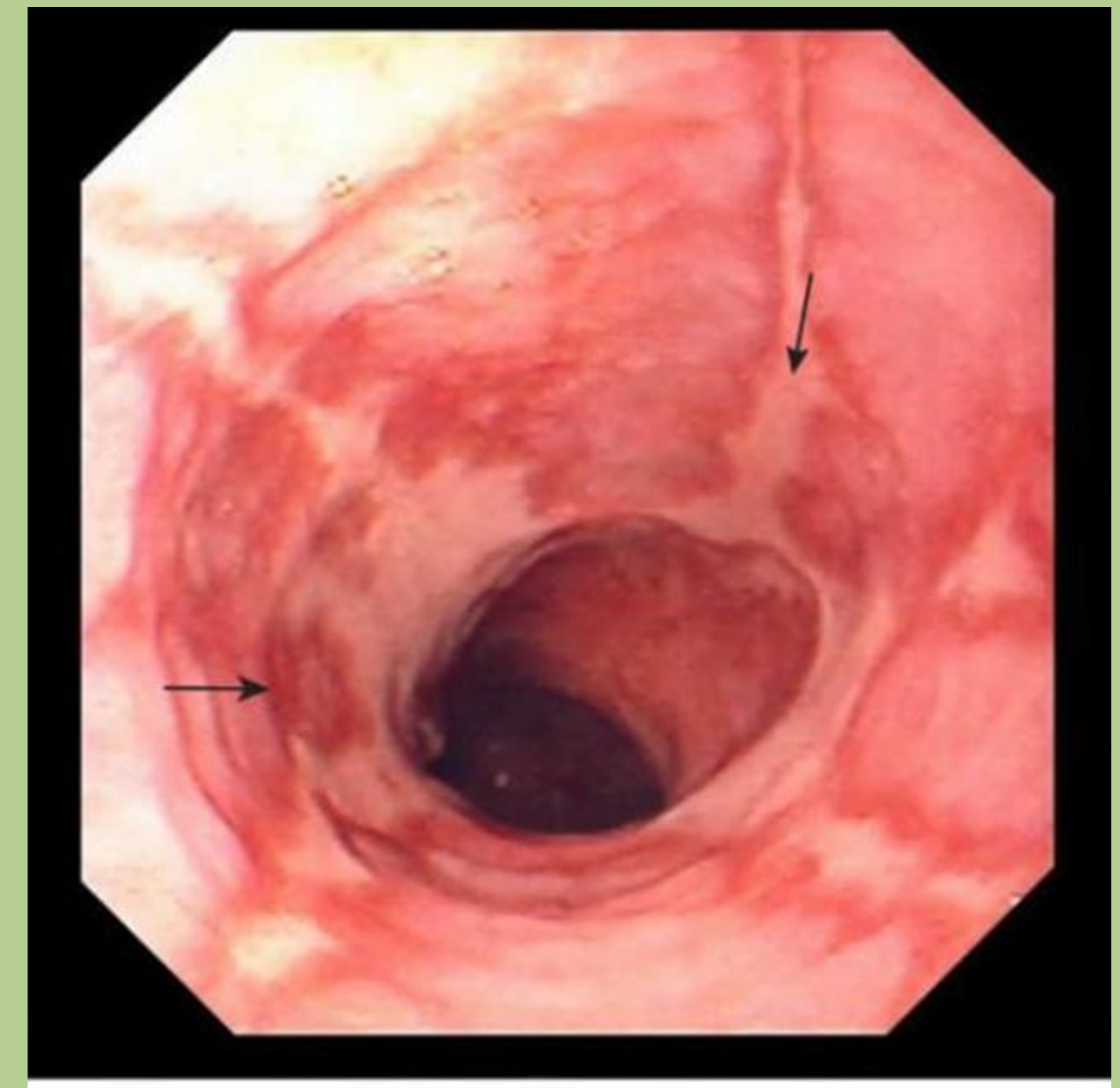
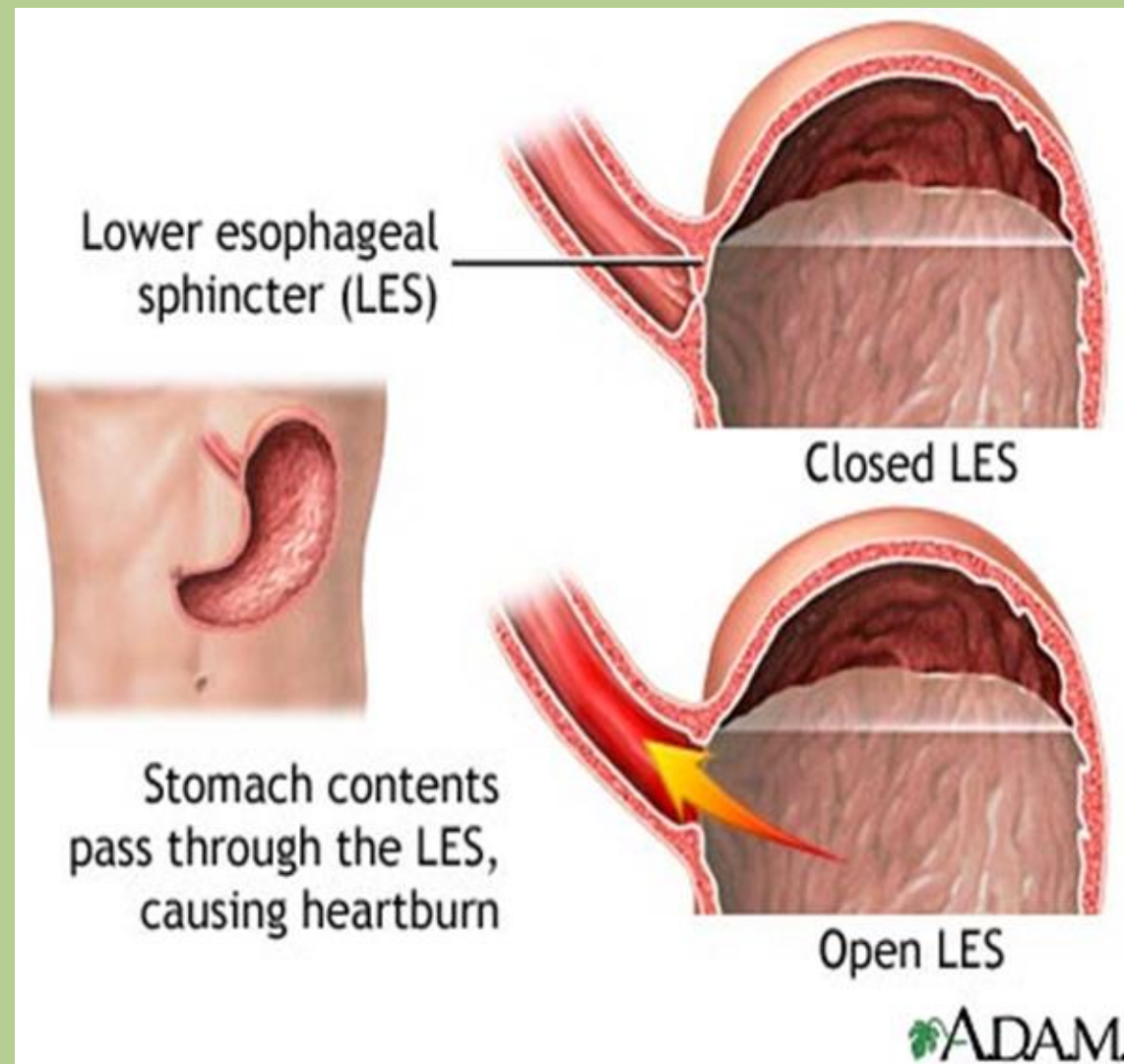
LES tone  
reduced  
by

- Pregnancy
- Sliding hiatus hernia
- Obesity

- Heartburn, Dysphagia, belching,
- “Lump in throat” sensation, Globus



# ESOPHAGUS





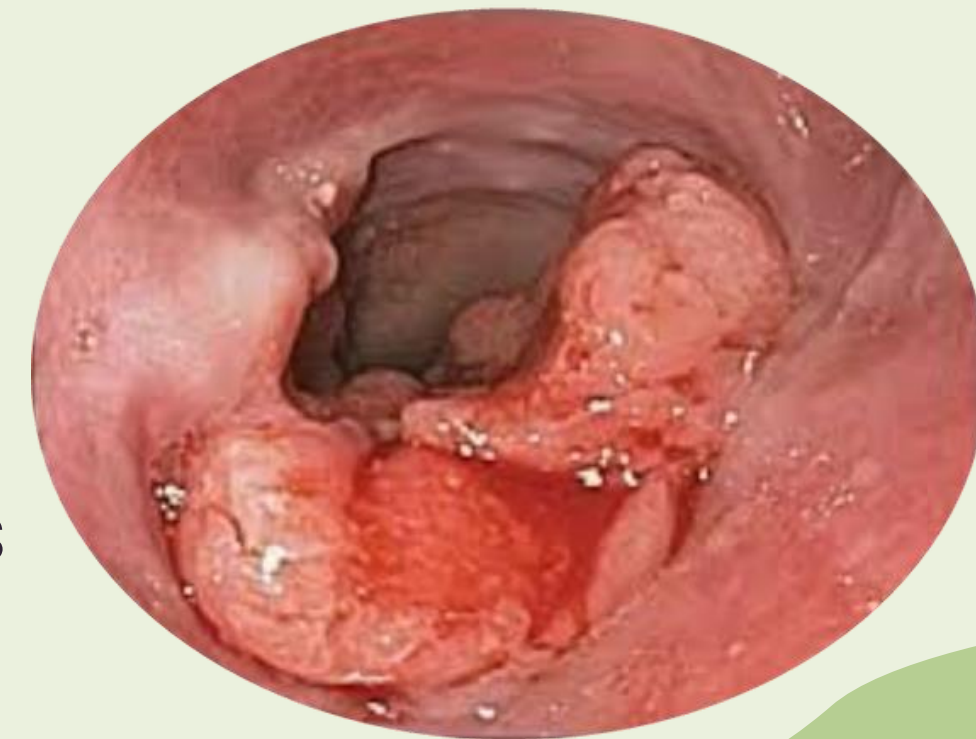
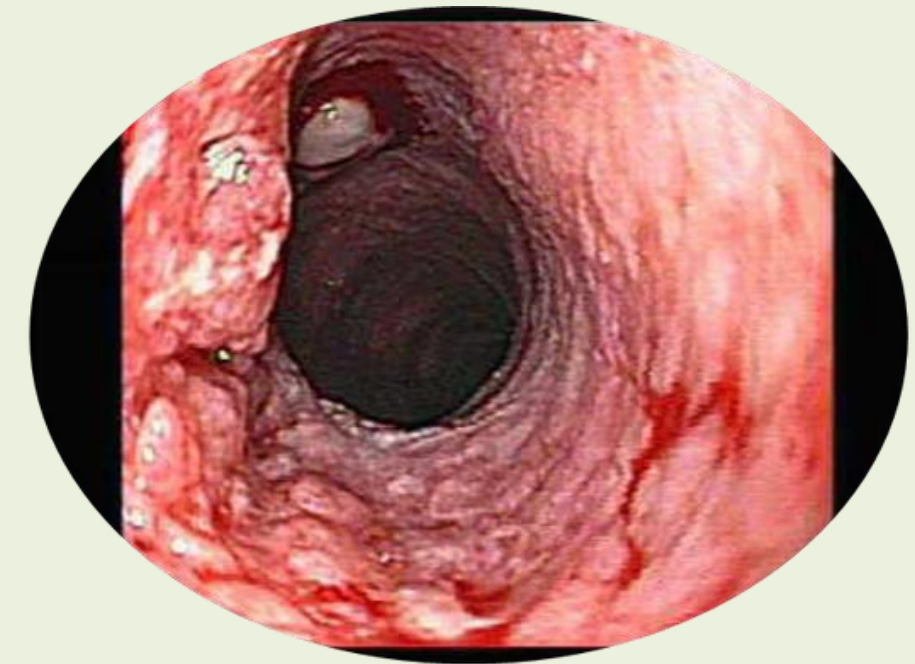


# ESOPHAGUS



## Carcinoma Esophagus

- Squamous cell carcinoma in the upper two-thirds of the esophagus
- Adenocarcinoma in lower one-third
- Premalignant conditions are Plummer-Vinson Syndrome, Human Papilloma Virus, Barrett's esophagus, Hiatus Hernia  
Clinical features-Substernal discomfort, dysphagia to solids more than liquids, weight loss, emasciation, coughing, hoarseness of voice, Iron-deficiency Anemia

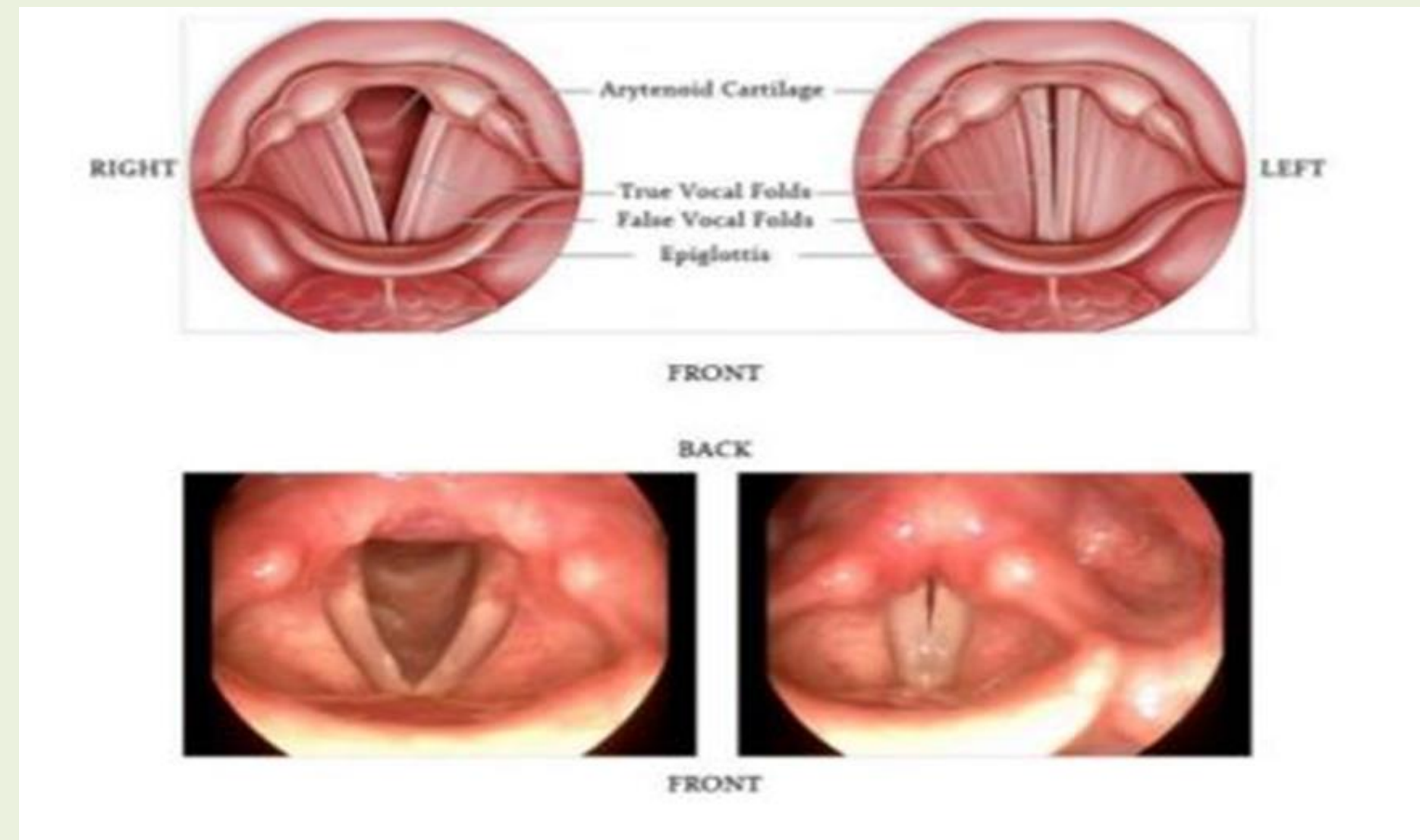


# LARYNX, TRACHEA AND BRONCHUS



- ***Hoarseness of voice***

The roughness of voice resulting from variations in periodicity and intensity of consecutive sound waves.







# CAUSES OF HOARSENESS OF VOICE



Infections

Neoplasms

Congenital

Traumatic

Neurological



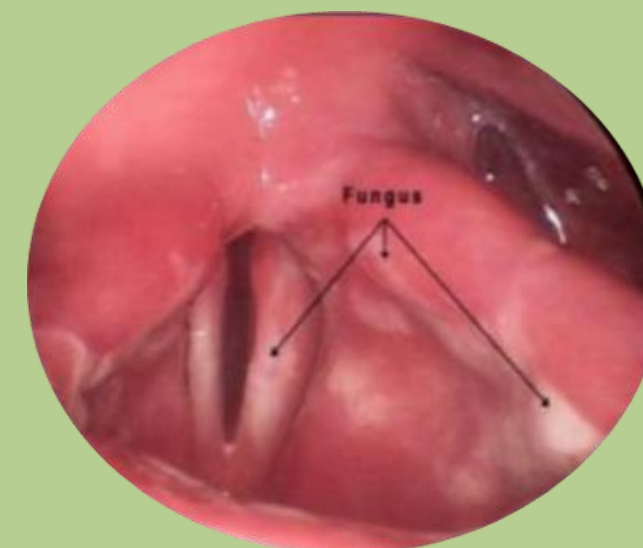
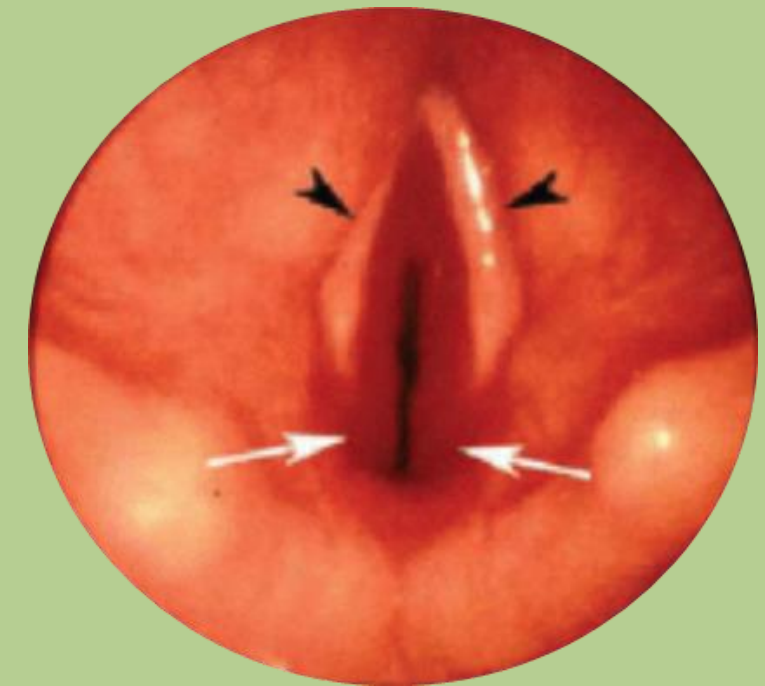
# CAUSES OF HOARSENESS OF VOICE



## Infections



- Laryngitis
- Larngotracheobronchitis
- Diptheria
- Influenza
- Tuberculosis
- Candidiasis







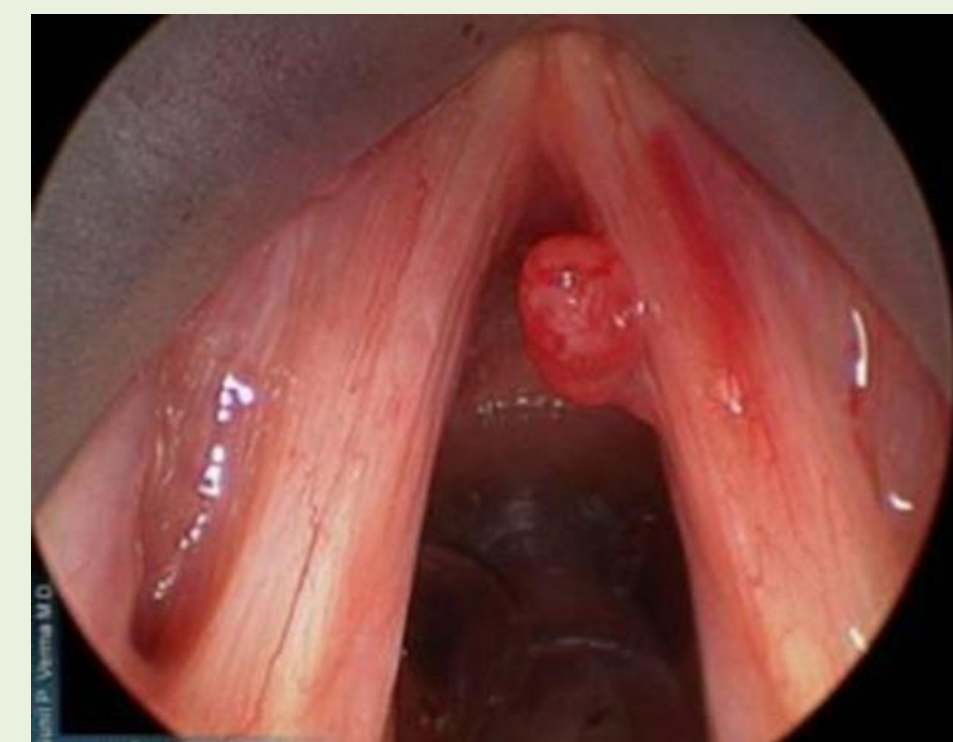
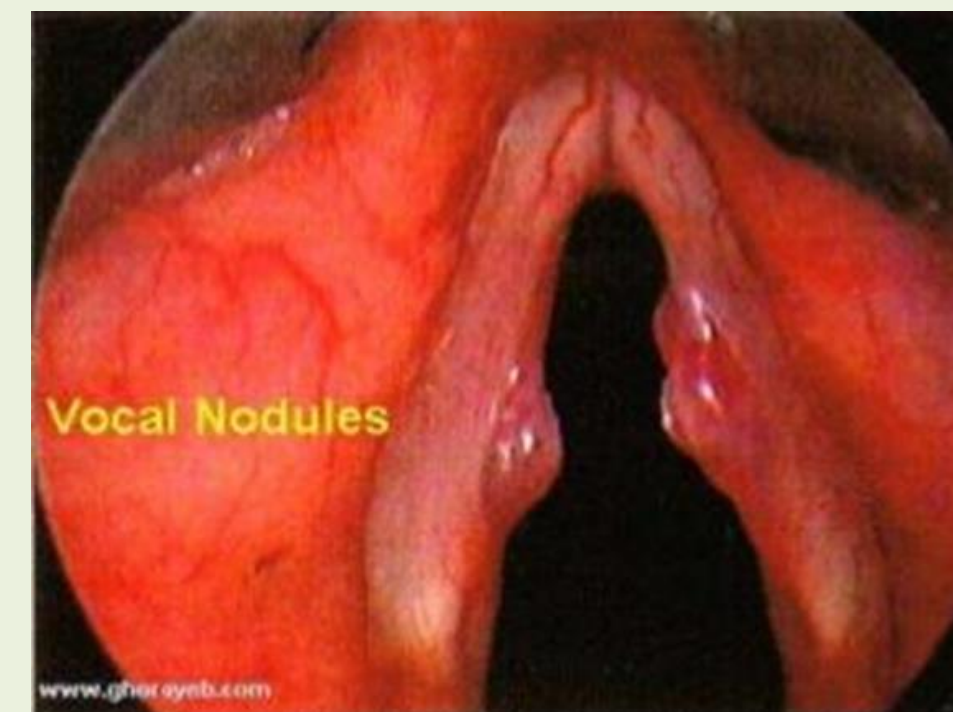
# CAUSES OF HOARSENESS OF VOICE



Neoplasms



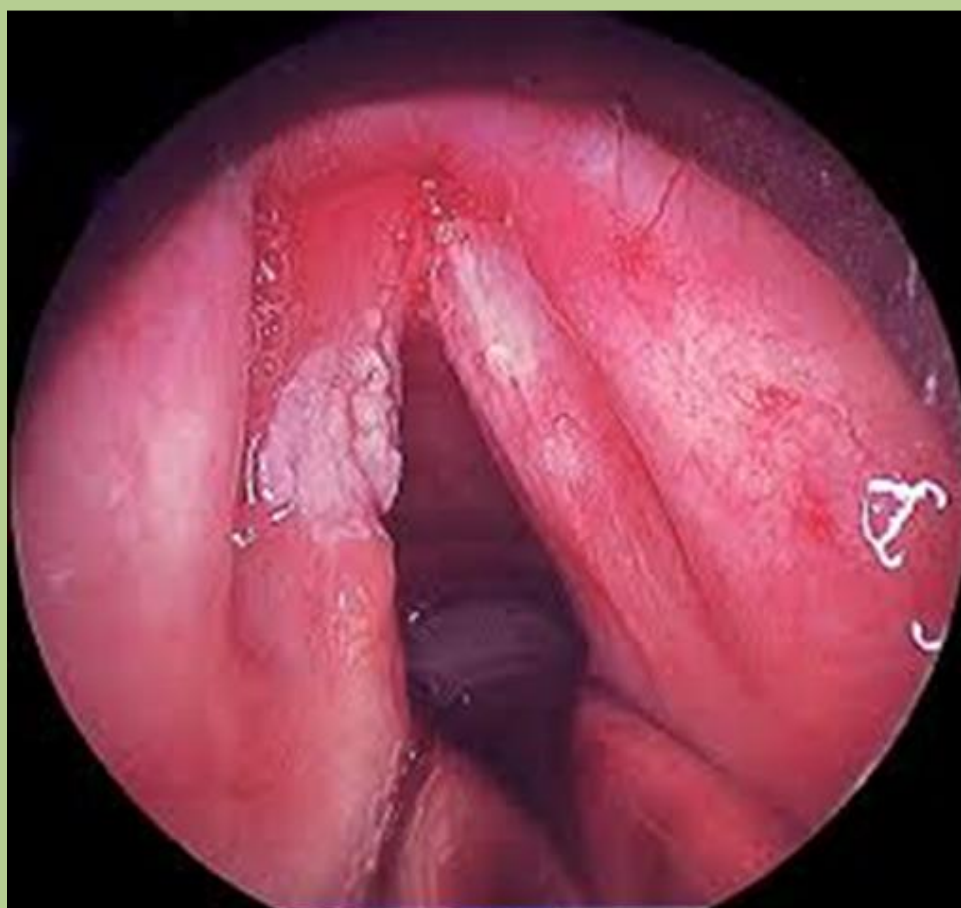
- Papilloma
- Hemangioma
- Vocal nodule
- Vocal Polyp
- Leukoplakia
- Carcinoma



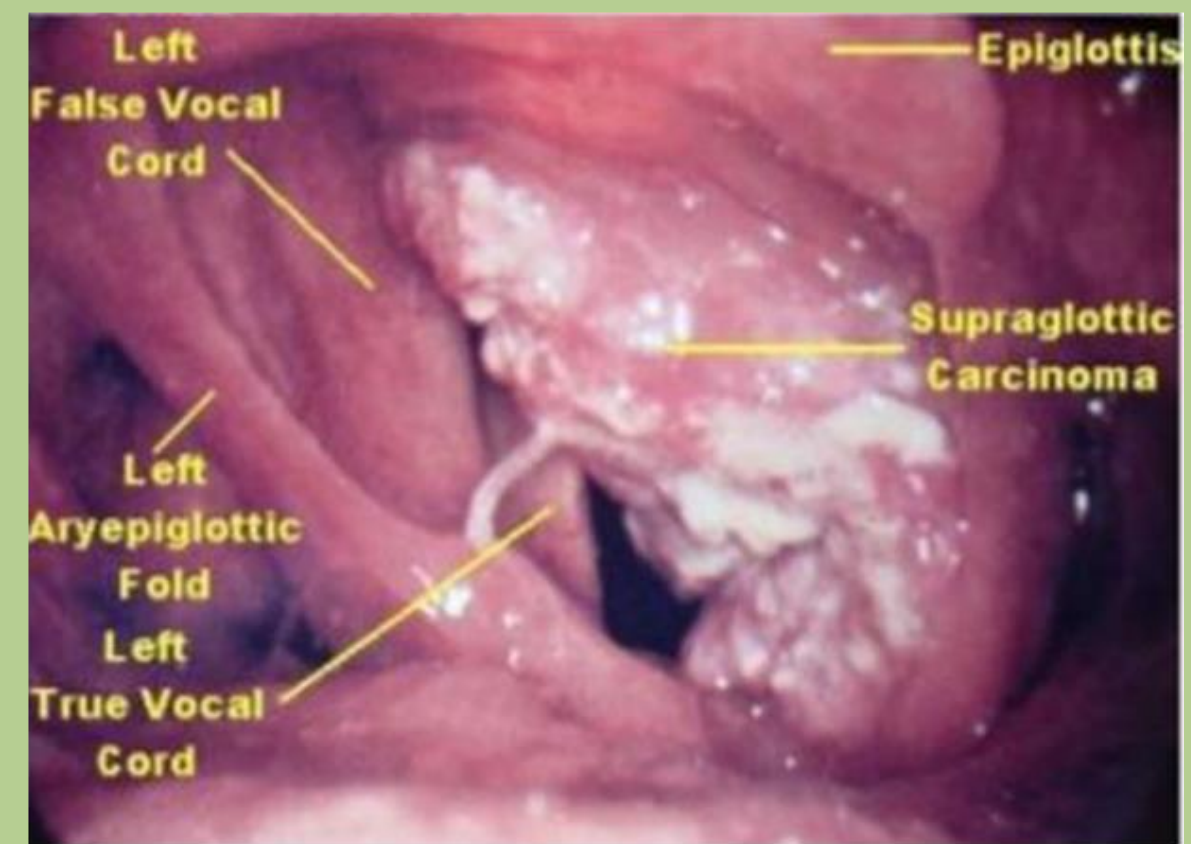




*Papilloma of larynx*



*Leukoplakia of vocal cords*



*Carcinoma of larynx*





# LARYNGOMALACIA



- Congenital anomaly
- Hyperflaccidity of infantile supraglottic laryngeal tissue, inward collapse, upper airway obstruction,
- The commonest cause of stridor in infants
- More common in term and male baby
- Association with neurological impairment- cerebral palsy

## LARYNGOMALACIA

Normal larynx



Omega shaped larynx  
(Laryngomalacia)



Laryngomalacia presents with inspiratory stridor which worsens with supine position, crying & feeding & improves in prone position.



- Stridor is the hallmark- low pitched, inspiratory, worsens with crying, feeding and supine position, improves with prone position







# STRIDOR



- Abnormal (stridulate or harsh) noise that is caused by turbulent airflow in impaired airway

## **Etiology:**

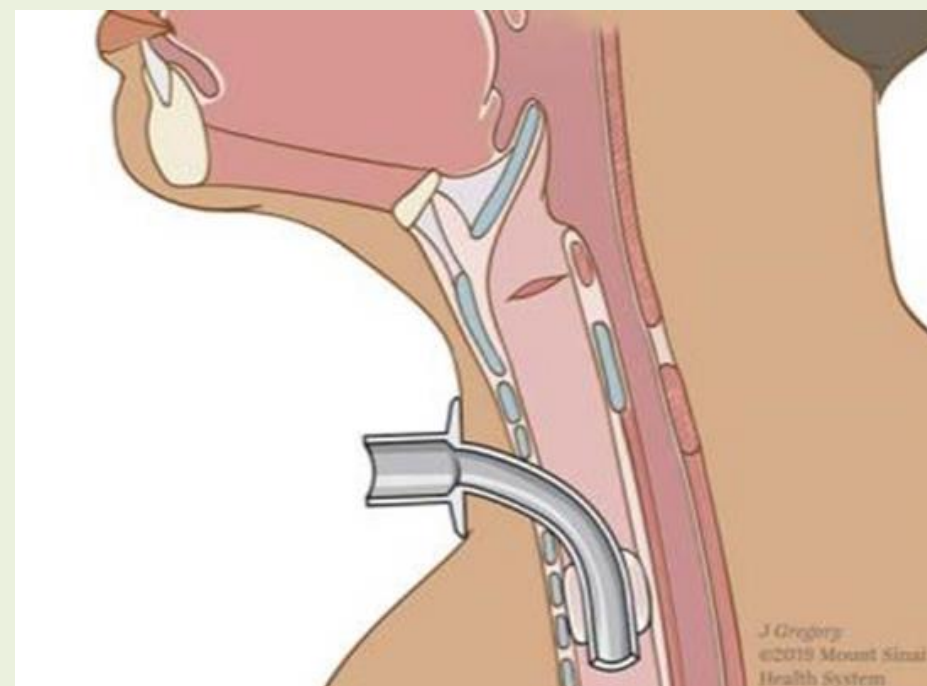
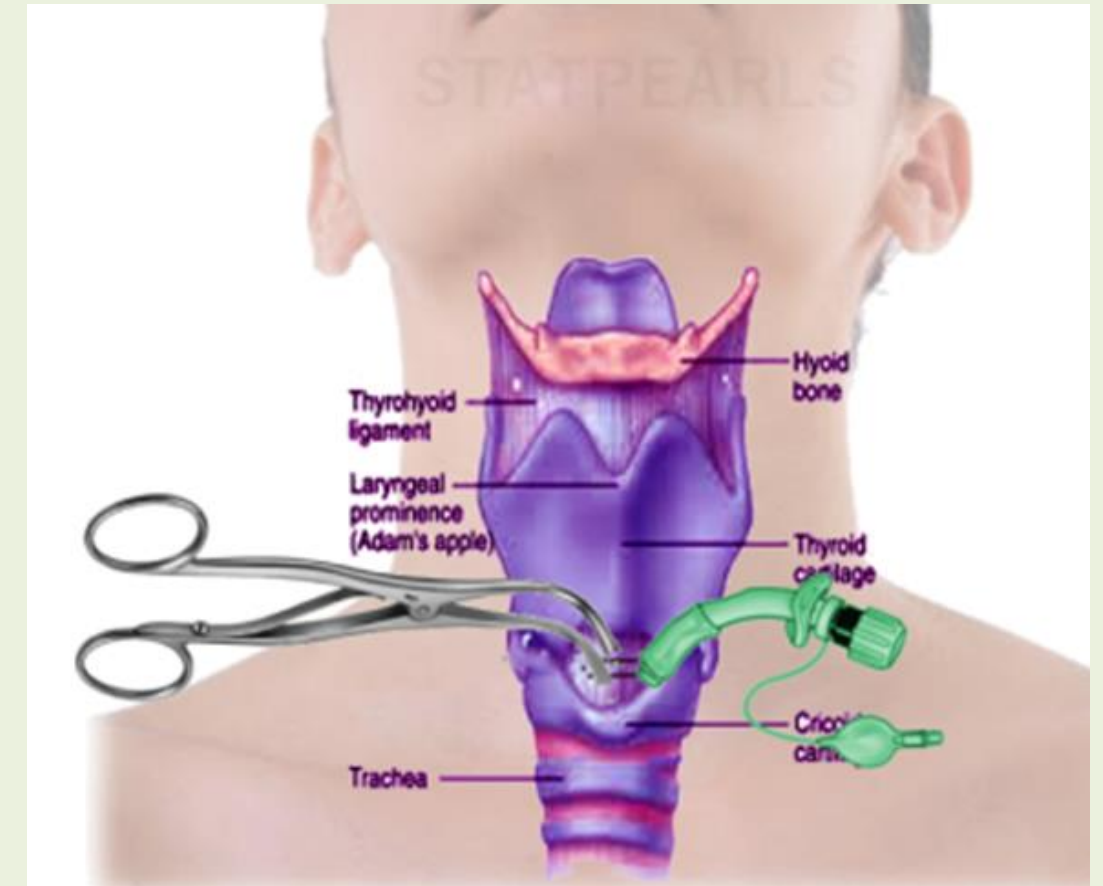
- Laryngomalacia- the most common cause of congenital stridor
- Epiglottitis, Croup, Diphtheria
- Hemangioma, JORRP
- External laryngeal trauma, Nerve paralysis
- Carcinoma of larynx



# STRIDOR



- Timely referral to a higher center
- Steroids
- Nebulisation with L-Epinephrine
- Continuous positive airway pressure
- Cricothyrotomy
- Emergency Tracheostomy







# FOREIGN BODIES IN AIRWAY



- Food items are commonly aspirated
- Peanuts are commonest
- Aspirated foreign body can settle into 3 anatomic sites: larynx, trachea, bronchus

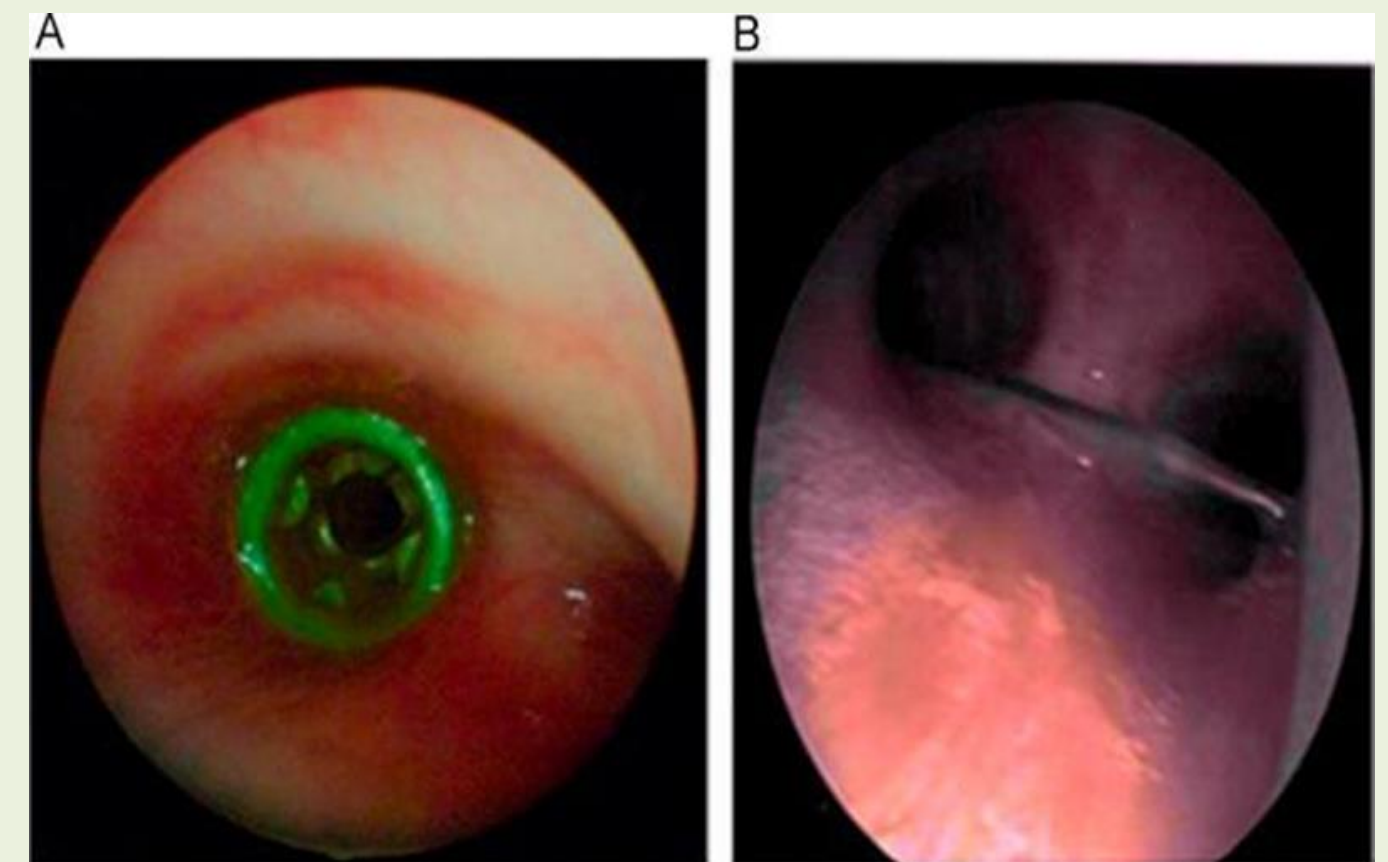




# FOREIGN BODIES IN AIRWAY



- Stages of foreign body aspiration:
- Initial phase: Choking and gasping
- Asymptomatic phase: Subsequent lodging of an object with the relaxation of reflexes
- Complication phase: Erosion or obstruction of the airway leading to pneumonia, atelectasis, or abscess







- **Larynx:** Complete or partial airway obstruction- stridor, cough, hoarseness, dyspnoea, Odynophagia, Aphonia
- Management: Heimlich manoeuvre
- Tracheostomy

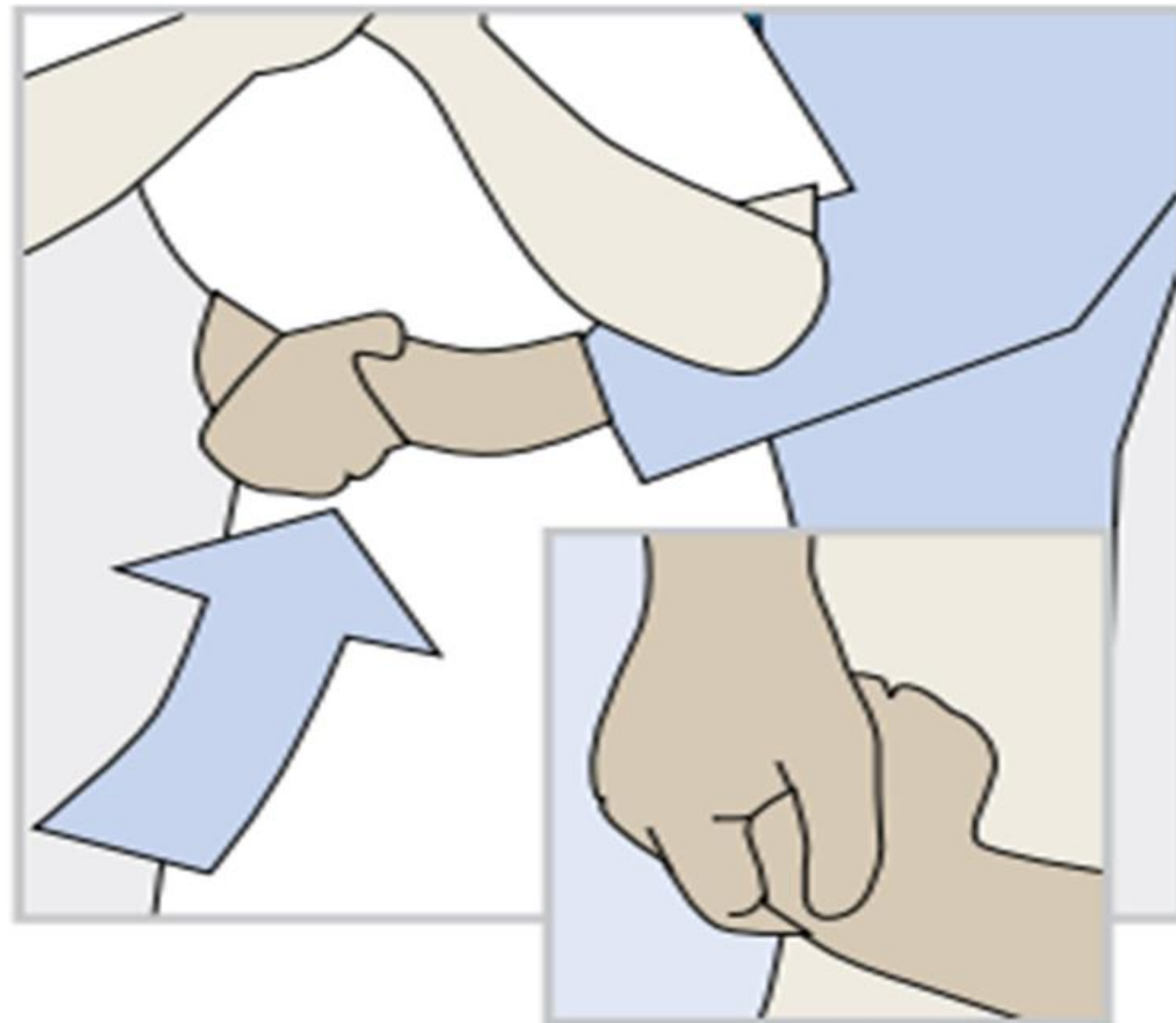




# The Heimlich maneuver

Do not perform the Heimlich maneuver if the victim is coughing, speaking or breathing. If the person cannot cough, speak or breathe, proceed as follows:

- 1.** Stand behind the victim, wrap your arms around his or her waist.
- 2.** Clasp your hands together in a double fist and place the fist — thumb side in — just below the victim's rib cage and above the navel\*.
- 3.** Press into the victim's abdomen (not the rib cage) with a quick, upward thrust.
- 4.** Repeat thrusts until object is dislodged.



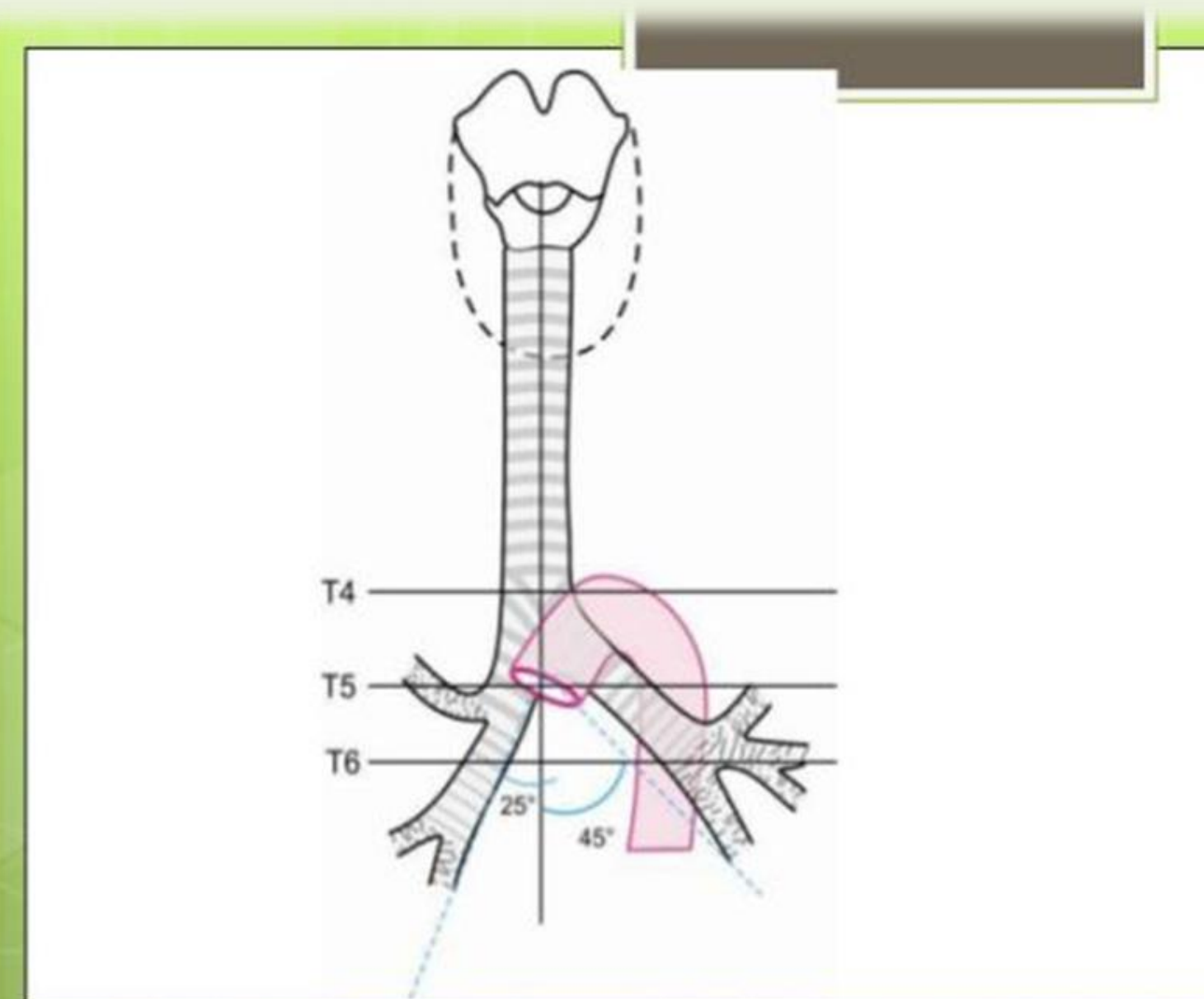




## Tracheobronchial tree:

Coughing, intermittent or continuous  
dyspnoea, cyanosis, pain, intermittent  
hoarseness

The most common site is the Right main  
bronchus





# FIVE-AND-FIVE APPROACH



- If the person is able to cough forcefully, the person should keep coughing.
- If the person is choking and can't talk, cry or laugh forcefully, the American Red Cross recommends a "five-and-five" approach to delivering first aid:







# FIVE-AND-FIVE APPROACH



- a) Give 5 back blows. For a child, kneel down behind. Place one arm across the person's chest for support. Bend the person over at the waist so that the upper body is parallel with the ground. Deliver five separate back blows between the person's shoulder blades with the heel of your hand.
  
- b) Give 5 abdominal thrusts. Perform five abdominal thrusts (also known as the Heimlich manoeuvre).
  
- c) Alternate between 5 blows and 5 thrusts until the blockage is dislodged.





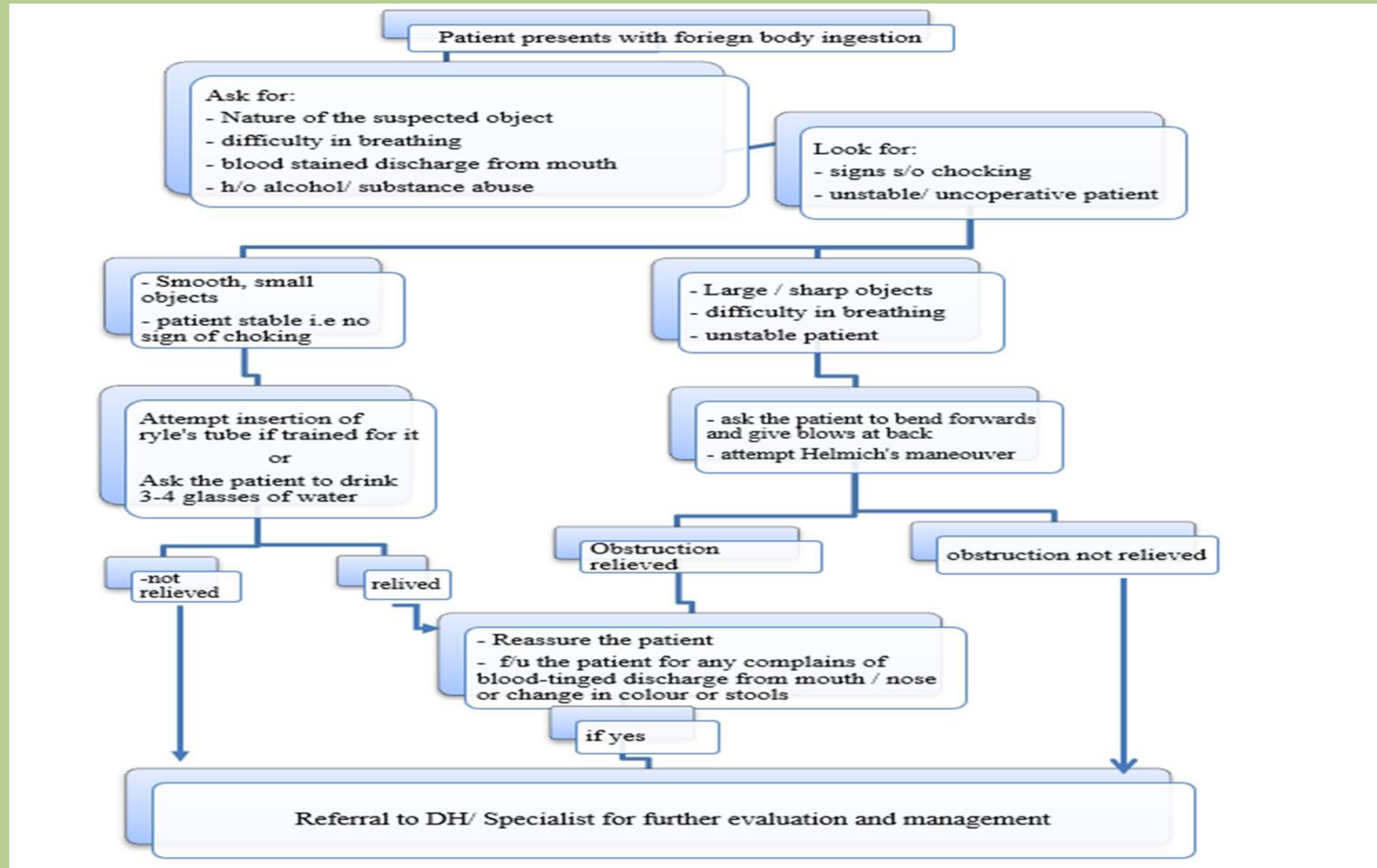
## When to refer to an ENT specialist

- If above all methods fail
- If the patient is turning blue (facial skin color turning blue- cyanosis)
- If the patient becomes unconscious.
- If the suspected foreign body is poisonous
- If the patient requires immediate investigation (like an X-ray) to locate the position of the object





# REFERRAL PATHWAY FOR FOREIGN BODY IN THROAT

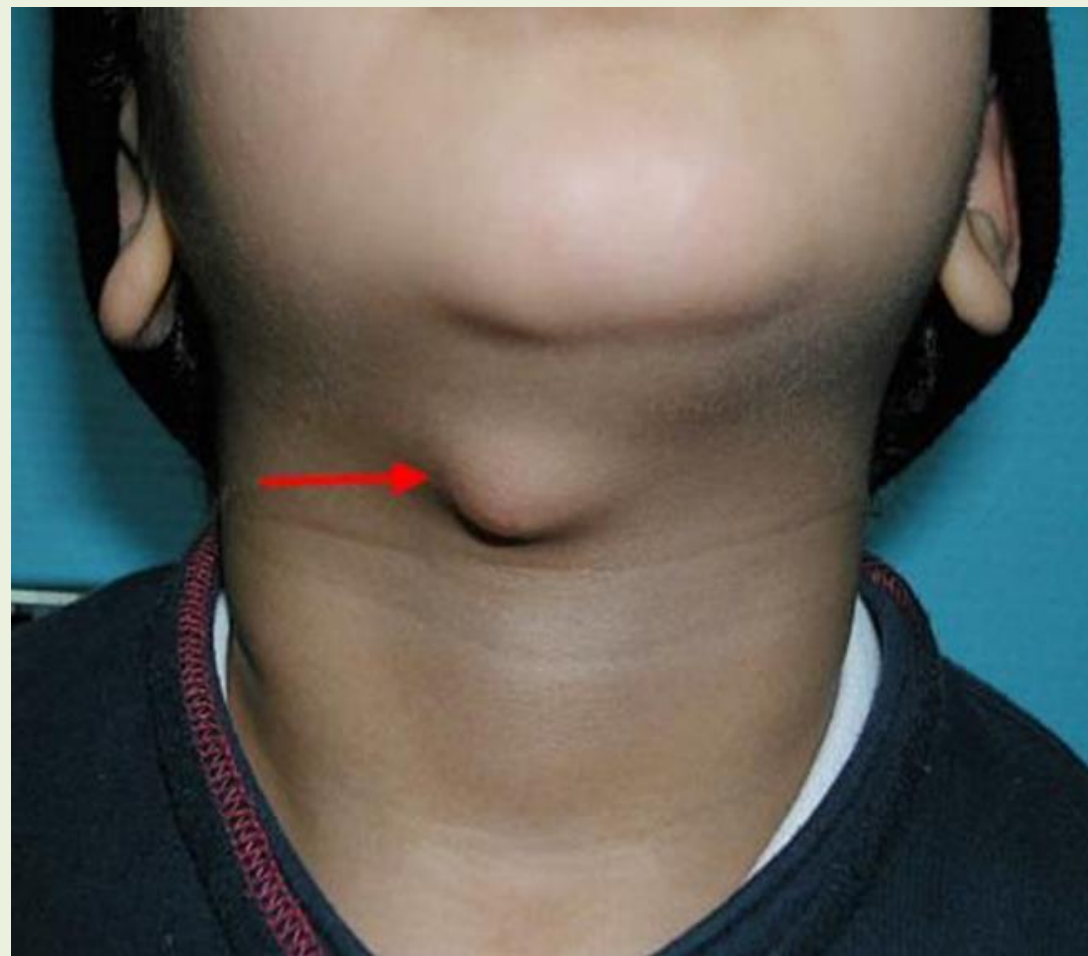




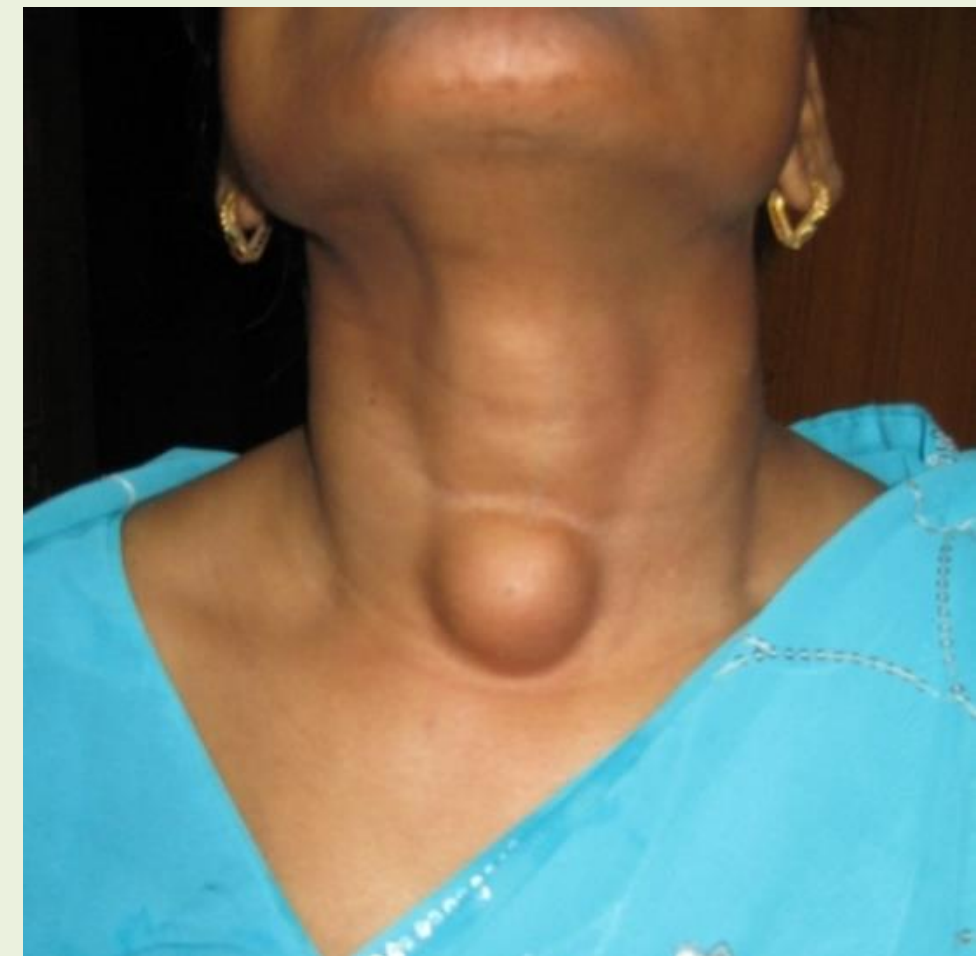
# NECK SWELLINGS- MIDLINE



•Thyroglossal cyst



•Dermoid cyst





# NECK SWELLINGS- LATERAL



Branchial cyst



Cystic hygroma

Ranula







# TUBERCULAR LYMPHADENITIS



**TUBERCULOUS LYMPHADENITIS: Necrotizing granuloma**

Amorphous granular eosinophilic debris material  
**CASEOUS NECROSIS**

Modified macrophages with abundant cytoplasm and pale staining "slipper" shaped nuclei  
**EPITHELOID CELLS**

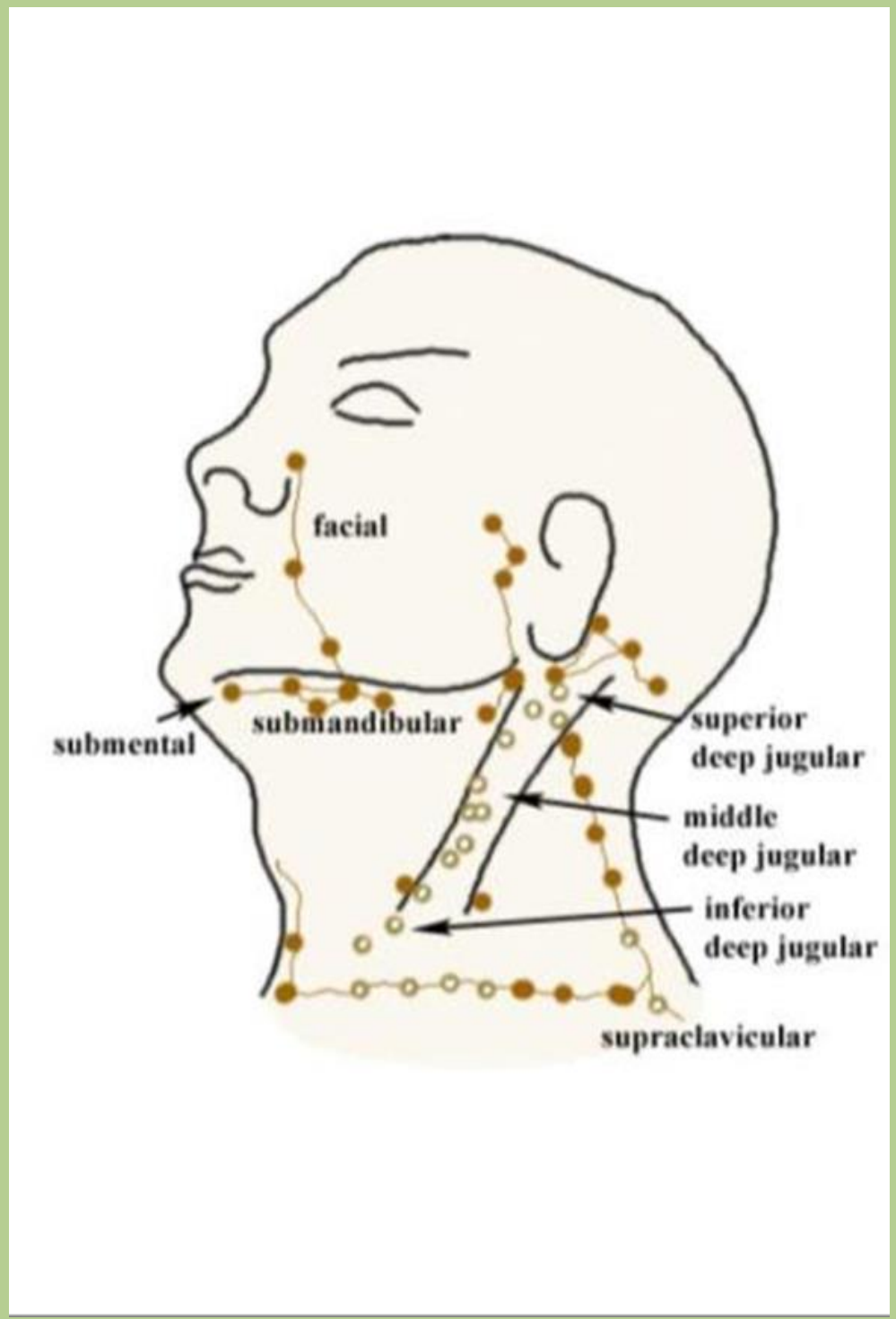
Multinucleated giant cell  
**LANGHAN GIANT CELL**

Collar of lymphocytes surrounding epithelioid cell aggregates





# CERVICAL LYMPH NODES



Lymph nodes are classified into :

Peripheral nodes

Deep cervical nodes

Superficial (outer circle) of cervical nodes.

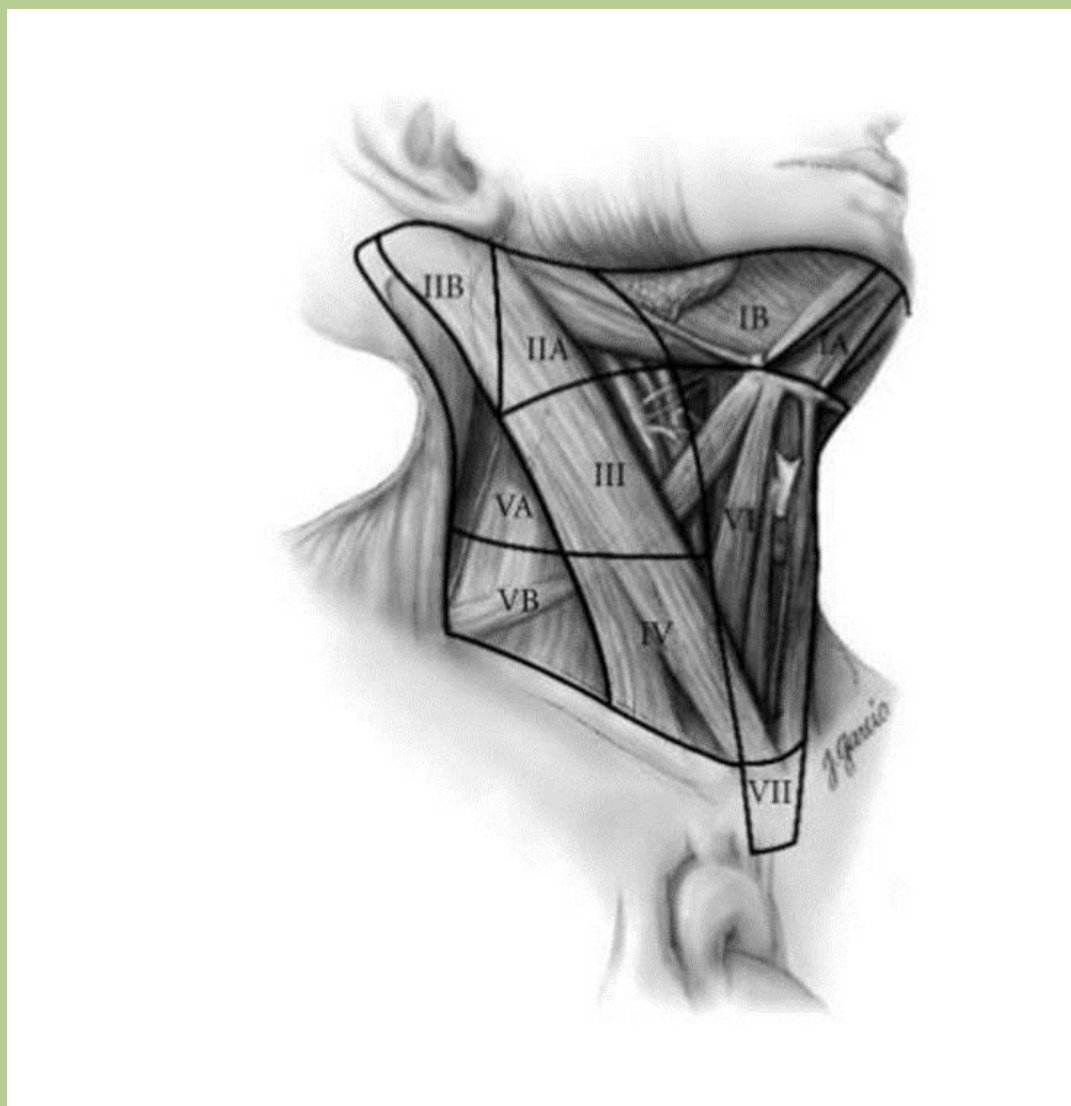
Deep (inner circle) of cervical nodes

- 1. Jugulo-diagastric node
- 2. Jugulo-omohyoid node

- 1. Submental
- 2. Submandibular
- 3. Preauricular
- 4. Postauricular
- 5. Occipital
- 6. Anterior cervical
- 7. Superficial cervical nodes.

- 1. Pretracheal
- 2. Paratracheal
- 3. Retropharyngeal
- 4. Waldeyer's ring.

# CERVICAL LYMPH NODES



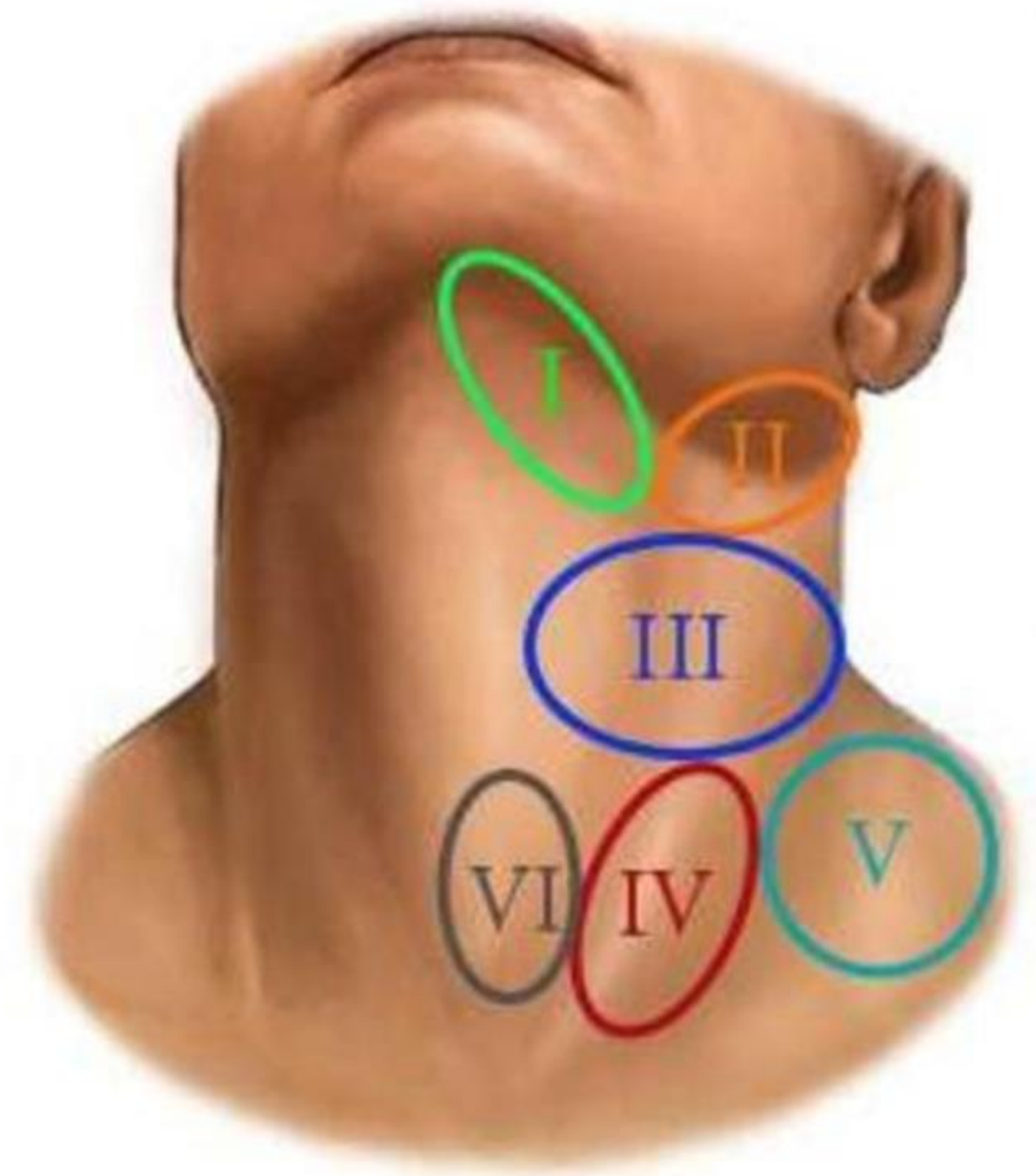
- The cervical group of lymph nodes extend from
  - Mandible & skull base superiorly
  - Clavicle inferiorly
  - Posterior triangle of neck laterally & posteriorly
  - Midline viscera anteriorly
  
- LN groups are categorized acc to original description by Memorial Sloan-Kettering Group



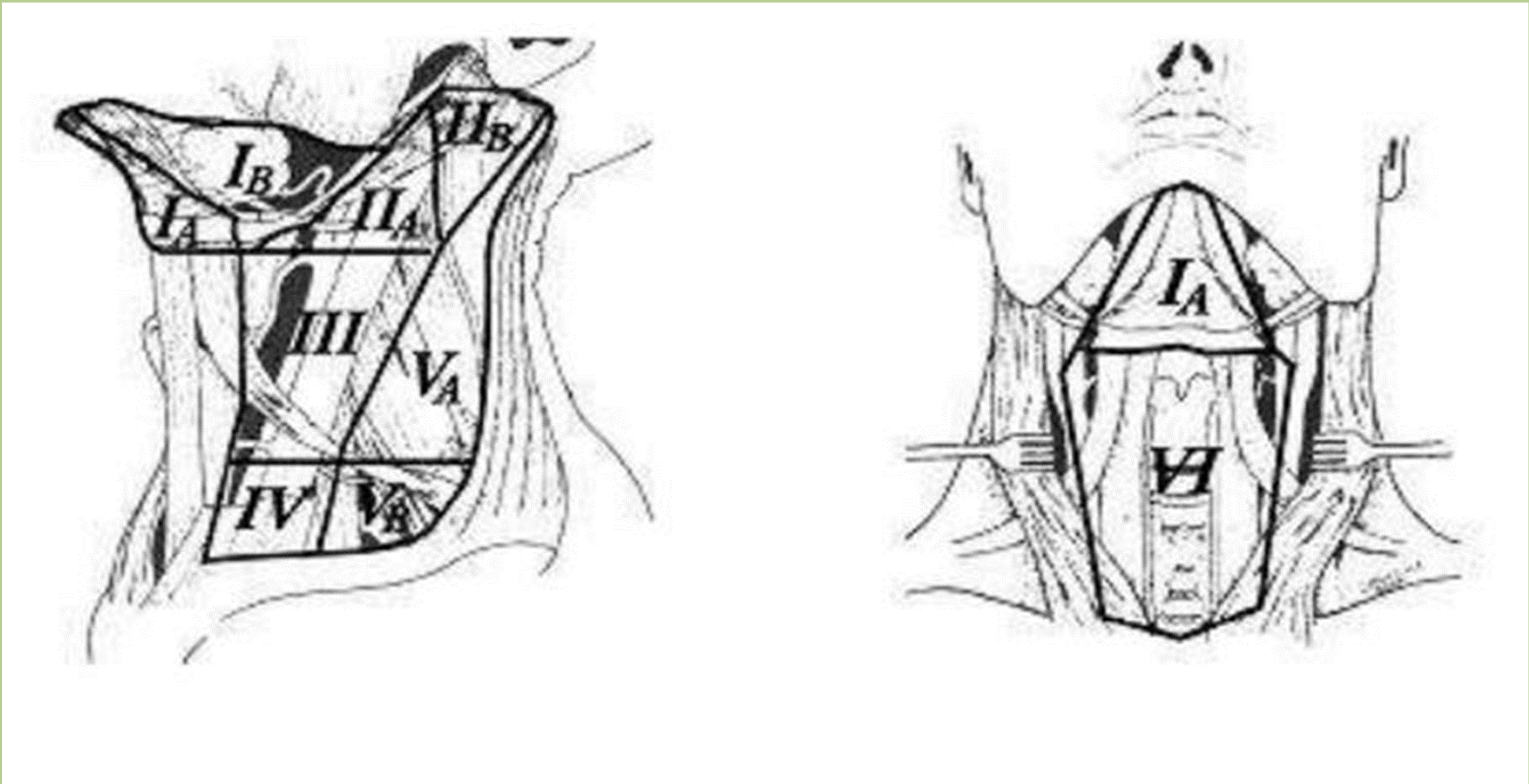
# Levels of Neck Nodes



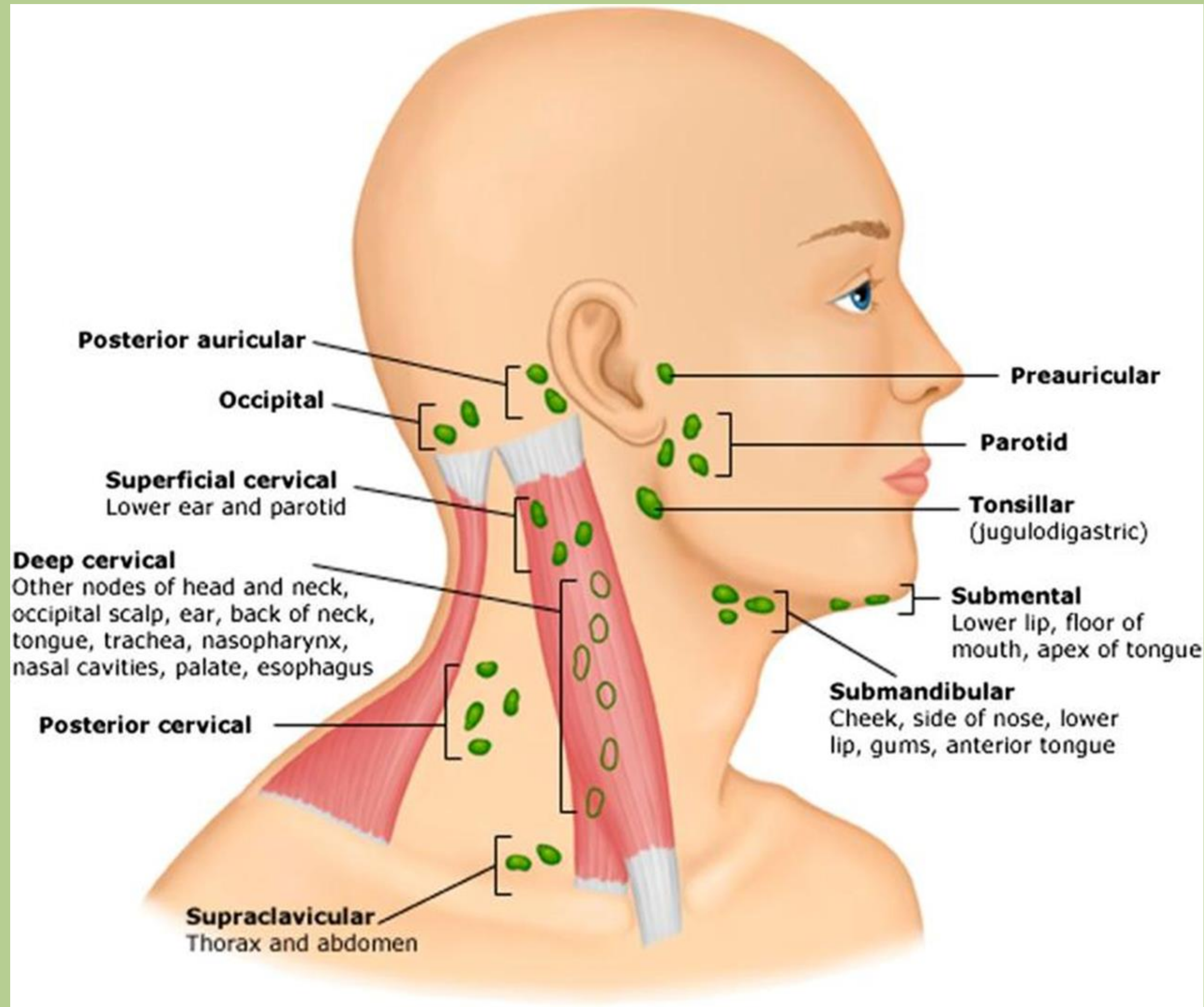
- There are 7 levels of neck and most have sublevels containing specific group of nodes
- Level I – Submental & Submandibular
- Level II – Upper Jugular
- Level III – Middle Jugular
- Level VI – Lower Jugular
- Level V – Posterior Triangle
- Level VI – Anterior/Central Compartment
- Level VII – Superior Mediastinal













# TAKE HOME MESSAGE...



- Squamous cell carcinoma of head and neck arises from the epithelial cells and occurs in oral cavity, pharynx and larynx
- Localised pain in the throat indicates definitive cause and needs thorough evaluation
- 75%-85% of head neck cancer is due to tobacco use and alcohol consumption
- Human Papillomavirus (HPV) as a cause of Oropharyngeal cancer is increasing(35%)

Types of throat cancer:

- Oropharyngeal cancer
- Hypopharyngeal cancer
- Oral cavity cancer
- Laryngeal cancer
- Cancer of the salivary glands





# TAKE HOME MESSAGE...



Red flags for cancer throat are:

- Persistent hoarseness
- Dysphagia
- Radiating pain in ears
- Spitting of blood
- Nonhealing ulcers or red/white patches in the oral cavity
- Neck masses
- Cough
- Weight loss





# ASSESSMENT



Clinical evaluation should include:

- History of symptoms
- Physical examination (palpation of neck masses and flexible head and neck fiberoptic endoscopy)
- Performance status (PS)
- Nutritional status
- Dental examination
- Speech and swallowing function

Investigations

- Complete blood count, LFT, RFT
- Pathological confirmation is mandatory
- CE-CT and/or MRI
- Chest imaging
- USG abdomen
- p16 Immunohistochemistry
- PET-CT (distant metastasis, response to chemo-radiotherapy, suspected recurrence)





# HOW TO MAINTAIN THROAT HYGIENE

1. Drink lots of fluids
2. Breathing- Sit and stand with good posture. Breathe through your nose.
3. Talking- Limit shouting, screaming,
  - Do not whisper as it increases the air pressure in your vocal cords
  - Use your natural voice- not too high or too low
  - Limit throat clearing
4. Avoid using tobacco/ paan/ gutkha/ alcohol consumption





# Thank You

