CASE REPORT

Laryngeal myxoma masquerading as laryngeal polyp – A rare entity

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ABSTRACT

Laryngeal myxomas, although benign in nature, represent a diagnostic challenge due to their infrequent occurrence and the commonality of their symptoms with more routine laryngeal pathologies, such as polyps or nodules. Predominantly affecting the mandible and maxilla within the head and neck region, the occurrence of myxomas in the larynx is notably rare thus making each case a valuable addition to the medical literature.¹ Myxomas are characterized by their mesenchymal origin, with a histological hallmark being the production of an abundant extracellular myxoid matrix. This matrix is composed of undifferentiated stellate cells, embedded within a loose mucoid stroma, distinguishing them from other laryngeal lesions on microscopic level. Clinically, patients with laryngeal myxomas may present with symptoms ranging from hoarseness to less commonly airway obstruction, mimicking the presentation of more frequently encountered laryngeal conditions.² Keywords- Myxoid matrix, Alcian blue, Keratinized stratified squamous epithelium

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INTRODUCTION

Laryngeal myxomas, although benign in nature, represent a diagnostic challenge due to their infrequent occurrence and the commonality of their symptoms with more routine laryngeal pathologies, such as polyps or nodules. Predominantly affecting the mandible and maxilla within the head and neck region, the occurrence of myxomas in the larynx is notably rare, making each case a valuable addition to the medical literature.¹ Myxomas are characterized by their mesenchymal origin, with a histological hallmark being the production of an abundant extracellular myxoid matrix. This matrix is composed of undifferentiated stellate cells, embedded within a loose mucoid stroma, distinguishing them from other laryngeal lesions on a microscopic level.

CASE REPORT

A 42 years old male patient presented in ENT OPD with persistent hoarseness of voice spanning over a period of 18 months. There was no history of dysphagia or odynophagia. Patient was farmer, used to smoke 5-6 cigarettes per day nearly for the last two years and occasional alcoholic. On Indirect laryngoscopy, a polyp was visualised arising from left vocal cord from the anterior commissure. Based on a history of long-standing hoarseness, smoking, and presence of a solitary polypoidal lesion over the left vocal fold, a preoperative diagnosis of benign laryngeal polyp was made. Surgical excision of the polyp was done and sent for histopathological examination. Post-operatuve period was uneventful. Grossly, three greyish white soft tissue pieces together measuring 1x0.5x0.2 cm were received. Microscopic examination revealed a polypoidal lesion lined by keratinised stratified squamous epithelium (KSSE). The tumour shows hypocellular areas revealing spindled to stellate cells with hyperchromatic nuclei having tapering eosinophilic cytoplasm in a background of abundant basophilic myxoid material. No areas of cellular atypia/pleomorphism/mitotic figures were seen in sections studied. In addition, lymphocytes and mast cells were also seen. Alcian blue staining highlighted the myxoid areas within the lesion. Immunoperoxidase staining performed on the paraffin section of the tumour using the standard technique was negatve for CD-34 and S-100.

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A.Photomicrograph (200x- showing apolypoidal lesion lined by keratinized stratified squamous epithelium). B.Photomicrograph (200x- Showing a tumor with abundant basophilic myxoid areas). C Photomicrograph(400x-showing myxoid areas with spindle to stellate areas. D. Photomicrograph(200x-Alcian blue positivity for myxoid areas).

E. Photomicrograph showing tumor cells Immunoegative for CD34

DISCUSSION

Laryngeal mxyomas are extremely rare tumours with only a few cases reported in the literature. Most of the patients present with hoarseness of voice, dysphonia, dyspnea and difficulty in swallowing. Mxyomas are true mesenchymal neoplasm consisting of undifferentiated stellate cells admixed in a loose mxyoid stroma.³ Laryngeal mxyomas are most commonly seen in the vocal cord, vocal fold, aryepiglottic fold. Size averagely varies between 0.5-0.7cm. They can persist for several years and size remains the same. These lesions have a strong male preponderance and are associated with smoking and are seen over a varied age group. Most of these lesions are unilateral. Clinically, differential diagnosis for vocal cord polyps include benign polyps, nodules, cysts and squamous cell carcinoma, underscoring the paramount importance of histopathological confirmation. ⁴ Laryngoscopy is helpful in diagnosis but final diagnosis is made through biopsy confirmation. Histological differential diagnosis include mxyoid liposarcoma, mxyoid chondrosarcoma

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and chondrosarcoma. Immunohistochemistry can be used to distinguish these entities, S100 will be positive in lipoblasts and chondrocytes whereas it will be negative in mxyomas.^{5,6} Given the benign yet infiltrative propensity of laryngeal myxomas, complete excision with clear margins remains the gold standard of treatment. However, the absence of a capsule and the potential for tissue infiltration necessitates a vigilant follow-up strategy to detect any signs of recurrence early. Treatment of choice for laryngeal mxyomas is complete excision, although treatment modality vary according to size of lesion.^{6,7}

CONCLUSION

Laryngeal myxoma should be kept in the differential diagnosis of benign vocal cord lesions. Although myxoma is a benign tumour but it lacks a capsule and tends to infiltrate the surrounding tissue so the patients need to be kept on close follow up if excision has been suboptimal. This case underlines the necessity for otolaryngologists to maintain a broad differential diagnosis and appreciate the role of histopathology in guiding treatment.^{6,7}

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