Open Respiratory Archives 6 (2024) 100328

Sociedad Española de Neumología y Cirugía Torácica SEPAR

Open Respiratory Archives

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Clinical Image

Supraglottic Stenosis After Caustic Ingestion

Supraglótica tras ingesta de cáusticos

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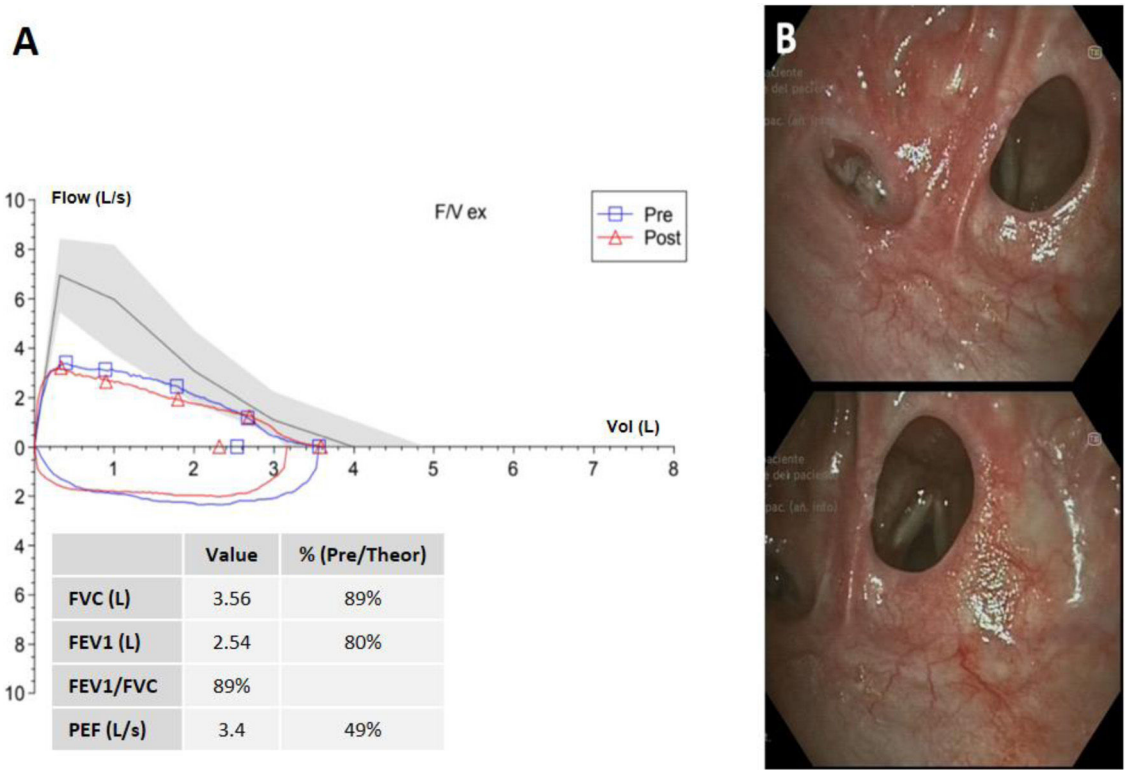
We present the case of a 47-year-old female patient who underwent esophageal replacement via colopharyngoplasty for esophageal stenosis secondary to caustic ingestion thirteen years ago. She was referred to the Pulmonology Department due to moderate dyspnea persisting for a year, accompanied by intermittent productive cough, particularly following ingestion of food or liquids. Physical examination revealed audible inspiratory and expiratory stridor, with baseline saturation of 97%.

Spirometry suggested a fixed airway obstruction with a flattening of the inspiratory and expiratory curves (Fig. 1, Panel A). Quantitative values of spirometry revealed forced expiratory volume in 1 second (FEV_1) 2520 ml (80%) and peak expiratory flow



	Value	% (Pre/Theor)
FVC (L)	3.56	89%
FEV1 (L)	2.54	80%
FEV1/FVC	89%	
PEF (L/s)	3.4	49%

Fig. 1. (Panel A) The spirometry, with the flow-volume curve and spirometric values represented in the table obtained from the patient, suggests a fixed obstruction of the upper airway. (Panel B) Bronchoscopy frames showing supraglottic colopharyngeal anastomosis stenosis with a very narrow entrance to the esophagus.

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https://doi.org/10.1016/j.opresp.2024.100328

(PEF) 3400 ml (49%) meeting Rotman's criteria for upper respiratory tract obstruction with FEV1/PEF 12.45 mL/L/min (Fig. 1, Panel A).[1] A bronchoscopy was performed, revealing stenosis of the supraglottic colopharyngeal anastomosis, characterized by a very narrow entrance to the esophagus. No structure isolating the upper respiratory tract from the gastrointestinal tract was observed (Fig. 1, Panel B), likely leading to microaspirations post-ingestion. Despite expectations, she reported no dysphagia, having adapted her eating habits. She is awaiting gastroscopy to evaluate esophageal dilation, aiming to minimize the risk of microaspiration and alleviate respiratory symptoms.

Informed consent

Written informed consent was obtained from the patient for the publication of the article.

Funding

There was no funding source in this study.

Authors' contributions

Dra. Sonia Salinas has contributed significantly to the design of the study and the writing of the manuscript. Her expertise was crucial in shaping the narrative and structure of the document. Dra. Salinas actively participated in the revision process, providing valuable feedback and insights that enhanced the quality of the manuscript. She has also approved the final version for publication.

Dra. Cristina Lopez has contributed to the work by performing the bronchoscopy and capturing the images presented in the manuscript. Her technical skill and proficiency in conducting the procedure were instrumental in obtaining the visual evidence necessary for supporting the case report. Dra. Lopez's contributions extended to the analysis and interpretation of the bronchoscopic findings, which were key elements in the discussion of the case. She has reviewed the manuscript for accuracy in the description of the procedural details and outcomes, and has approved the final version for publication.

Dr. Carlos Almonacid: has made substantial contributions to the conception and design of the work. He played a significant role in drafting the manuscript and revising it critically for important intellectual content. Dr. Almonacid ensured that all aspects of the work were accurately represented and approved the final version to be published.

Each author has agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflicts of interest

No conflict of interest.

Reference

1. Rotman HH, Liss HP, Wef JG. Diagnosis of upper airway obstruction by pulmonary function testing. Chest. 1975;68:796–9.