Airway Evaluation by Indirect Laryngoscopy in Patients With Lingual Tonsillar Hypertrophy

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KEYWORDS
Indirect laryngoscopy; Rigid laryngoscope; Direct laryngoscopy; Difficult airway; Tonsil; Hypertrophy

Abstract
Introduction and objectives: Prevalence of the lingual tonsillar hypertrophy is unknown but it is believed that its presence is associated with the difficult airway. To investigate this, indirect laryngoscopy was performed on patients in the preoperative evaluation and this pathology was diagnosed. The relationship with difficulty of viewing the larynx, intubation and ventilation, under general anaesthesia and using direct laryngoscopy, was then studied.

Methods: We performed the demographic variable checks and tests for predicting difficult intubation (mouth opening, thyromental distance, cervical flexion-extension, neck thickness, and Mallampati test), in the preoperative step on 300 patients who were going to be submitted to general anaesthesia. We then performed indirect laryngoscopy on them using a 70° rigid laryngoscope to ascertain the frequency of appearance of lingual tonsillar hypertrophy. Next, under general anaesthesia, we carried out direct laryngoscopy to verify whether there was difficulty in viewing the larynx and intubation and ventilation. We then investigated the association of demographic predictors of difficult intubation, including indirect laryngoscopy, with the presence of this condition.

Results: Prevalence of lingual tonsillar hypertrophy was 2%. No relationship between the appearance of this entity and the difficulty of viewing the larynx, intubation and ventilation was found. Only indirect laryngoscopy was linked to the appearance of this pathology.

Conclusions: Lingual tonsillar hypertrophy is a relatively frequent disorder, whose presence is not usually associated with difficult airway.

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Introduction

The lingual tonsils are rounded masses of lymphatic tissue which are normally located on both sides of the glossopiglottic fold and are part of the tonsillar tissue ring surrounding the entrance of the upper airway.\textsuperscript{1,2} Due to their small size they usually go unnoticed in normal subjects during the exploration of the tongue base and hypopharynx by indirect laryngoscopy (IL) and fibroscopy. However, chronic infection processes can cause them to become hypertrophied and inflamed, and they can reach a large size, fill the vallecula, displace the epiglottis in an anterior direction and narrow the airway retroglyosally. Moreover, although it is sometimes an asymptomatic disease, it can intermittently cause foreign body sensation and tightness in the throat, dysphagia, difficulty breathing, coughing, snoring, voice alterations and obstructive sleep apnoea syndrome (OSAS).\textsuperscript{1-9} The history of patients suffering lingual tonsillar hypertrophy can sometimes include previous tonsillectomy and adenoidectomy.\textsuperscript{2,4-8}

The prevalence of lingual tonsillar hypertrophy (LTH) is unknown,\textsuperscript{2,9} but it is believed that its presence is a risk factor in the genesis of unexpected difficult airway,\textsuperscript{5,9} a concept which encompasses difficult visibility of the larynx (DVL), intubation, and ventilation. The concurrence of these 3 variables in the same patient due to this condition can have fatal consequences.\textsuperscript{5}

On the other hand, when the patient is intervened due to an otolaryngological disease, the ENT specialist often carries out an IL to explore the upper airway. If LTH is diagnosed at this point and the anaesthesiologist is warned about the finding, he may then implement an adequate anaesthetic induction and intubation strategy.\textsuperscript{6} At other times, patients have even suffered the breakage of incisors during intubation attempts by direct laryngoscopy (DL), and the origin of the difficulty, which was LHT, has remained undetected.\textsuperscript{10} It is usually diagnosed after difficulty or impossibility for intubation using fibroscopy\textsuperscript{2} or magnetic resonance imaging.\textsuperscript{11}

Our primary goal was to employ an IL performed by the anaesthesiologist with a 70° rigid laryngoscope before surgery to verify the frequency of LTH among a group of patients who were scheduled to undergo surgical procedures under general anaesthesia (GA) and DL. Once the disease was diagnosed and GA and DL were carried out, we analysed the association between the presence of LTH and DVL, with difficulty for intubation and ventilation. The secondary objective was to explore the association of demographic and difficult airway predictors (including IL) with the presence of this anomaly.

Methods

Once approved by the Ethics Committee of our hospital, and after obtaining written informed consent, we conducted a prospective, observational study of 300 consecutive patients between September 2009 and November 2010. All of them underwent elective surgery under GA, with endotracheal intubation by DL. We applied the following exclusion criteria: age less than 18 years, inability to sit, coronary disease, ankylosing spondylitis, nasogastric probe carriers, sufferers of infectious diseases such as hepatitis, HIV and TB, recent neck surgery and obstetric and emergency surgery.

On the day scheduled for the intervention, in the surgical area, after consulting the preoperative examination conducted previously in the pre-anaesthesia consultation,
the anaesthesiologist completed a protocol sheet with demographic predictors and airway assessment predictors: Mallampati test, mouth opening, thyromental distance, cervical flexion-extension, and neck thickness. Both types of tests are shown in Tables 1 and 2. The protocol sheet also reflected whether the patient suffered from snoring, retrognathia, and other types of anomalies also considered as predictors of a difficult airway.

It is advisable to perform an IL to study the upper airway in order to diagnose LTH before subjecting the patient to GA with endotracheal intubation. To do this, following the above, patients were moved on a stretcher to the room adjoining the operating theatre where surgery was going to take place. This contained a 70°, 8.5 mm Sopro-Comeg® (Germany), rigid laryngoscope, n.: 162 081 685, mounted on a tower. After preparing the equipment, which also included a DVD recorder to register all the laryngoscopy procedures, patients were seated in a chair with their back to the screen of the monitor and the head in extension and the IL was performed.

Table 1  Demographic Characteristics and Predictors of Evaluation of a Difficult Airway for Each Patient With a Diagnosis of Lingual Tonsillar Hypertrophy.

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (years)</th>
<th>Gender</th>
<th>BMI</th>
<th>Mall</th>
<th>TMD</th>
<th>F-E</th>
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<td>F</td>
<td>29</td>
<td>2</td>
<td>6</td>
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</tr>
<tr>
<td>2</td>
<td>28</td>
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<td>7.5</td>
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<td>3</td>
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<td>F</td>
<td>26.5</td>
<td>2</td>
<td>8.5</td>
<td>N</td>
</tr>
<tr>
<td>4</td>
<td>39</td>
<td>F</td>
<td>26.7</td>
<td>2</td>
<td>8</td>
<td>N</td>
</tr>
<tr>
<td>5</td>
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<td>F</td>
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<td>2</td>
<td>8</td>
<td>N</td>
</tr>
<tr>
<td>6</td>
<td>54</td>
<td>M</td>
<td>26.7</td>
<td>4</td>
<td>8</td>
<td>N</td>
</tr>
</tbody>
</table>

Case | MA | NW | Retr | Snor | DVFM | C-L | DI |
<table>
<thead>
<tr>
<th></th>
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<td>No</td>
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</tr>
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<td>41</td>
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<td>No</td>
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<td></td>
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</tr>
</tbody>
</table>

BMI: body mass index; C-L: Cormack-Lehane; DI: difficulty for intubation; DVFM: difficulty for ventilation with facial mask; F: female; F-E: cervical flexion-extension; L: limited; M: male; MA: mouth aperture in cm; Mall: Mallampati; N: normal; No: no difficulty; NW: neck width in cm; Retr: retrognathia; Snor: snoring; TMD: thyromental distance in cm; Yes: ventilation improves with the aid of a Guedel airway.

Table 2  Bivariate Analysis of Demographic Variables, and Variables Affecting DVL and IL With the Presence of LTH.

<table>
<thead>
<tr>
<th></th>
<th>LTH No. = 6</th>
<th>No LTH No. = 294</th>
<th>Value of P, χ², Fisher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, M/F</td>
<td>1/5</td>
<td>134/160</td>
<td>NS</td>
</tr>
<tr>
<td>Age, (years)</td>
<td>53.17 (16.38)</td>
<td>56.28 (18.07)</td>
<td>NS</td>
</tr>
<tr>
<td>BMI, (kg/m²)</td>
<td>27.16 (2.58)</td>
<td>28.10 (5.38)</td>
<td>NS</td>
</tr>
<tr>
<td>BMI &gt;30 kg/m²</td>
<td>0/6</td>
<td>91/203</td>
<td>NS</td>
</tr>
<tr>
<td>BMI &lt;30 kg/m²</td>
<td>37.50 (1.87)</td>
<td>39.01 (4.28)</td>
<td>NS</td>
</tr>
<tr>
<td>Neck width, (cm)</td>
<td>0/6</td>
<td>46/248</td>
<td>NS</td>
</tr>
<tr>
<td>Neck width &gt;43 cm</td>
<td>7.66 (0.87)</td>
<td>7.56 (1.18)</td>
<td>NS</td>
</tr>
<tr>
<td>Neck width &lt;43 cm</td>
<td>1/5</td>
<td>35/259</td>
<td>NS</td>
</tr>
<tr>
<td>TMD, (cm)</td>
<td>5.20 (0.78)</td>
<td>4.23 (0.63)</td>
<td>NS</td>
</tr>
<tr>
<td>TMD&lt;6.5 cm</td>
<td>0/6</td>
<td>16/278</td>
<td>NS</td>
</tr>
<tr>
<td>TMD&gt;6.5 cm</td>
<td>1/5</td>
<td>199/95</td>
<td>NS</td>
</tr>
<tr>
<td>Mouth opening, (cm)</td>
<td>5/1</td>
<td>244/50</td>
<td>NS</td>
</tr>
<tr>
<td>Mouth opening &gt;3.5 cm/mouth opening &lt;3.5 cm</td>
<td>0/6</td>
<td>10/1284</td>
<td>NS</td>
</tr>
</tbody>
</table>

Data are expressed as mean (standard deviation) or as frequency. BMI: body mass index; DVL: difficulty to view the larynx; F: female; IL: indirect laryngoscopy; LTH: lingual tonsillar hypertrophy; M: male; NS: not significant; TMD: thyromental distance.
Confimation by an ENT specialist was requested for those patients in whom the anaesthesiologist indicated the presence of LTH after performing IL. The ENT specialist confirmed the diagnosis of the disease through the study of images recorded on the computer during IL. The typical images of LTH usually appeared as an increase in retroglossal tissue shaped as a bilateral and symmetrical mass separated by an isthmus, which occupied the vallecula and invaded the lateral edges of the epiglottis (Fig. 1A–C). The differential diagnosis was primarily carried out with lingual thyroid, thyroglossal cysts, and lymphoma, in addition to hypertrophy of the tongue base. Each of the patients diagnosed with LTH was assigned a number. Cases of misdiagnosis by the anaesthesiologist during this process were also recorded.

Patients were then moved to the operating room, where the difficult intubation trolley was located, as well as a fiberscope ready for use. Anaesthesia was performed by administration of propofol (2 mg/kg) and we verified whether facial mask ventilation was possible without a Guedel airway (1), with it (2) or impossible (3). If ventilation was feasible, we administered succinylcholine 1 mg/kg. Next, the anaesthesiologist (who was unaware of the finding of LTH by IL) proceeded to evaluate DL, using a Macintosh laryngoscope of an appropriate size, without performing the cricothyroid pressure manoeuvre. The DL view obtained was classified according to the Cormack-Lehane grading scale into: grade I, fully exposed and open laryngeal opening; grade II, the posterior portion of the laryngeal opening could be seen; grade III: only the epiglottis was exposed; and grade IV: no glottic structure was visible, only the soft palate could be seen. Grades I and II were considered as a correct view of the larynx, whilst grades III and IV were considered as DVL. We then proceeded to perform the cricothyroid pressure manoeuvre on these patients (the manoeuvre was recorded). If this achieved visualisation of the glottic orifice, then the patient was intubated. If a good visualisation was not obtained and several intubation manoeuvres were required, the case was considered as difficult intubation, appropriate instruments were employed (Eschmann guide or others) and the episode was recorded as such.

Table 1 shows the demographic characteristics, predictors of difficult airway, the results of face mask ventilation and DL exploration.

We analysed the association of the onset of LTH and DVL with difficult intubation and difficult ventilation using the χ² and Fisher’s tests.

We also conducted a bivariate descriptive analysis of demographic and difficult airway variables (including IL), with the presence or absence of LTH to explore their association and estimate their statistical significance.

Data were analysed using the software package SPSS® v.15 for Microsoft Windows®. Quantitative values were expressed as mean (standard deviation) and qualitative variables as frequencies and percentages. We used the Student’s t test for independent samples with continuous variables and the χ² and Fisher’s tests with qualitative variables. We tested the normality of continuous variables using the Kolmogorov–Smirnov test. The value of statistical significance was assumed when P<.05.

Results

Descriptive Analysis

Out of the 300 patients, 6 suffered LTH (2%). The classification of these patients by surgical specialty was: 3 general surgery, 2 ENT, and 1 traumatology.

Table 1 shows the demographic characteristics, predictors of difficult airway, result of face mask ventilation and results of DL exploration of each of the 6 patients with a diagnosis of LTH.

Only in 2 patients, numbers 2 and 5 in Table 1, did the anaesthesiologist performing DL recognise the presence of LTH.

Cricothyroid pressure during DL was necessary to obtain a better view of the glottis in patients 1 and 5 in Table 1. The first presented difficult intubation and the Cormack-Lehane scale remained at III. In the second, it went from III to II.

One patient presented a history of tonsillectomy and another patient of dysphagia (numbers 2 and 5 in Table 1).

Fig. 1A–C shows 3 LTH images obtained through IL, which present characteristics of bilateral and symmetrical masses separated by an isthmus, occupying the vallecula.
Airway Evaluation by Indirect Laryngoscopy in Patients With Lingual Tonsillar Hypertrophy

Figure 2 (A) Image of the patient with a normal upper airway obtained using IL. The base of the epiglottis is free, g (glottis). (B) Patient diagnosed with LTH showing the 2 tonsillar lobes (c) separated by an isthmus (i) occupying the base of the epiglottis. (C) Patient with tongue base hypertrophy. In the 3 images (a) corresponds to the epiglottis and (b) to the base of tongue.

and C shows especially clearly how they invade the lateral edges of the epiglottis.

Fig. 2A–C shows the differences between a normal upper airway with free vallecula, an image of LTH occupying the vallecula and an image of the airway with the vallecula occupied by masses without an isthmus, corresponding to tongue base hypertrophy.

Fig. 3A–C is LTH images obtained by IL. Images in Fig. 3A′–C′ correspond to the same patients in whom DL images were obtained with the fiberscope inserted through the mouth. Both the first and the second set show the disease masses invading the edge of the epiglottis.

Predictive Analysis of the Difficulty for Visualisation of the Larynx, of Difficulty for Intubation and Lingual Tonsillar Hypertrophy

We found no significant association between the presence of LTH and DVL ($P = .223$), and difficulty for intubation ($P = .251$) or difficulty for ventilation ($P = .533$).

Table 2 shows the bivariate analysis of demographic variables, predictors of DVL and IL, with a diagnosis of LTH. Only the IL showed a significant association with the presence of the disease. The results obtained from this exploration presented: 5 cases of LTH diagnosed by anaesthesiologists, 1 case of LTH which went unnoticed and 3 misdiagnoses of LTH with hypertrophy of the tongue base.

Discussion

Cases of LTH associated with DVL, difficulty for intubation and sometimes with difficulty for ventilation are continuously described in the literature. Although their contribution to difficult airway is unknown, these studies seem to indicate that both entities (difficult airway and LTH) are related. In a recent study, anaesthesiologists performed a preoperative exploration of patients undergoing ENT surgery using a fiberscope, in order to facilitate the choice of intubation technique. The conclusions proposed conducting this examination in the preoperative schedule of any type of surgery and cited the presence of LTH as an example of risk of failure in the treatment of the airway which would benefit from this test. Nevertheless, it is known that, both in children and in adults, LTH is one of the findings correlated with gastroesophageal reflux during endoscopic evaluation of the upper airway by ENT specialists. This would mean that it is not an uncommon entity and, therefore, its presence would not necessarily always imply a difficult airway. Our study confirms this assumption, as we found no relationship between the presence of LTH and DVL, difficult intubation and difficult ventilation with a face mask.

The medical histories of the 2 patients undergoing surgery for ENT diseases presented findings of LTH during exploration of the airway carried out by ENT specialists through IL, but this was not included in the pre-anaesthetic report. One of them presented DVL and difficulty for intubation. Similar situations can take place in patients undergoing surgery due to ENT diseases who have been previously diagnosed with LTH, who at the time of treating the upper airway are diagnosed with unexpected difficult airway. Thus, the key study by Ovassapian et al. does not specify whether any of the 33 patients undergoing various surgical procedures, all with failed tracheal intubation by DL and presence of LTH, underwent surgery due to ENT causes and, in that case, whether a previous exploration of the upper airway had been conducted by these surgeons. Therefore, we believe that in
patients undergoing surgery due to ENT diseases, the anaesthesiologist must verify the result of the airway examination by this service. Moreover, if the ENT specialist diagnoses a case of LTH in a patient scheduled for GA, the Anaesthesiology Service should be informed when the preoperative schedule is requested.

The base of the tongue, epiglottis, and glottis (Fig. 2A) are noted during IL with a rigid laryngoscope in patients without disease of the upper airway. However, in patients with LTH, the base of the tongue at its junction with the epiglottis is not free, but instead is occupied by a mass which is almost always bilobed and separated by an isthmus (Fig. 2B). In the case of an increase in the tongue base, its union with the epiglottis is covered by a mass without an isthmus (Fig. 2C). In our study, this was the main cause of confusion with LTH during IL.

When patients have previously undergone IL and are diagnosed with LTH (Fig. 3A–C), if they subsequently undergo DL under GA, this disease also usually appears as bilateral masses (Fig. 3A–C) occupying the vallecula (which supports the tip of the laryngoscope). Moreover, apparently this entity should be visualised and recognised by the anaesthesiologist, but this does not occur (if the anaesthesiologist is not advised about the presence of LTH). In our analysis, only 2 of the 6 LTH cases were recognised by the anaesthesiologist when performing DL. In the cited study, not only were there no patients diagnosed with LTH during the repeated DL manoeuvres that ended in failure, but this was not observed either at the time of intubation with the fibrescope during the anaesthetic procedure. The disease was only discovered during the pharyngoscopic exploration conducted with the fibrescope, once the patient had recovered from the intervention.

Being an ENT disease, the predictors of airway assessment, as well as the indices with the best predictive results for DL, such as those by Arne et al.30 (which include, among others: Mallampati test, TMD, cervical mobility, and mouth opening), decrease their sensitivity and specificity. This could be applied to LTH, as it is an ENT disease, and this requires training by an ENT specialist, which extends the learning period.

Conclusions

We believe that: (a) LTH is a relatively common condition; (b) IL with a 70° rigid laryngoscope was the only predictor which warned of the presence of the entity; and (c) recognition of the presence of this disease during DL under GA is not commonplace.

Conflict of Interests

The authors have no conflict of interests to declare.

Acknowledgement

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References