

SM Otolaryngology Subglottic Lobular Capillary Hemangioma: A Case Report

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Abstract

Lobular Capillary Hemangioma (LCH) is a benign proliferation of capillary blood vessels adopting a lobular configuration. A laryngeal origin of LCH is exceedingly rare. Here, we describe a case of an 11-year-old boy presenting with a subglottic lesion, leading to a subglottic stenosis. Histopathologic findings of the lesion implicated an LCH, which was removed successfully by a coblator. This is the first report of a subglottic LCH. Physicians should be aware of this unique lesion and laryngeal LCH should be considered in diagnosing the cause of a subglottic stenosis. Additionally, coblation should be an effective treatment for laryngeal LCH.

Introduction

Lobular Capillary Hemangioma (LCH), also known as pyogenic granuloma, is a benign proliferation of capillary blood vessels adopting a lobular configuration [1]. The term 'pyogenic granuloma' is a misnomer as the lesion does not contain purulent material and is not a granuloma. LCH is a smooth or lobulated red lesion on a sessile or pedunculated base that varies in size from a few millimeters and rarely exceeds 2.5 cm [2,3]. The usual sites for this tumor are the skin and the nasopharyngeal and oral mucosal surfaces [4]. LCH in the gastrointestinal tract has also been reported [5]. LCH lesions are very rare in the airway, with only a few cases reported to date [6-23] and subglottic LCH is unique. Here, we present the case of an 11-year-old boy who presented with a subglottic LCH, posing both a diagnostic and therapeutic challenge.

Case Report

An 11-year-old Vietnamese boy presented to the Department of Otolaryngology, Children Hospital I, Ho Chi Minh City, Vietnam, with a complaint of dyspnea and dry coughing. He had been suffering from increasing dyspnea, coughing, and occasional wheezing for two weeks but had not been suffering from hoarseness or fever. He had no history of previous intubation, airway surgery, trauma, or tuberculosis.

Clinical examination of lung and heart revealed no abnormalities. Consequently, a neck and chest Computed Tomography (CT) with intravenous contrast was performed, which did not reveal any parenchymal lung disease. However, we observed a lesion on the left and posterior wall of the larynx, which probably caused a subglottic stenosis leading to dyspnea, wheezing, and coughing in this patient (Figure 1).

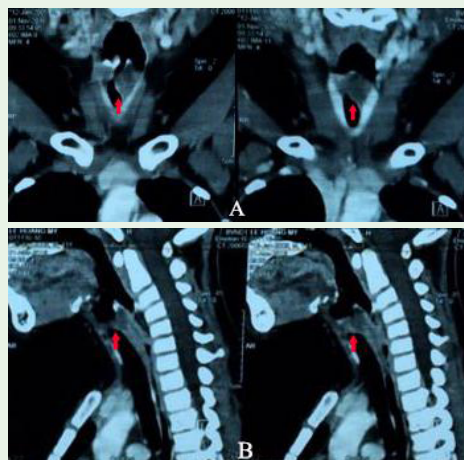


Figure 1: Neck CT scan revealed 2-cm diameter lesion on the left and posterior wall of the larynx (arrow). (A) Coronal image. (B) Sagittal image.

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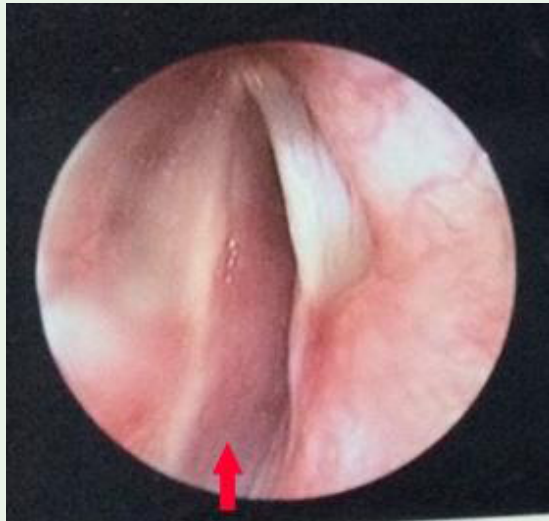


Figure 2: Laryngeal endoscopy revealed a pink soft lesion (arrow) located under the left vocal cord, leading to a grade III subglottic stenosis with a 75% obstruction.

We further performed a laryngeal endoscopy and observed a pink soft and hyperemic lesion with smooth surface located just under the surface of the left vocal cord. Consistent with the CT scan findings, the lesion was located on the left wall of the subglottic site, leading to a grade III subglottic stenosis with a 75% obstruction (Figure 2). Based on the clinical symptoms and imaging findings, a diagnosis of hemangioma was established. The patient received a tracheostomy and intravenous propranolol (1 mg/kg/day) for 2 weeks.

To follow up, a second laryngeal endoscopy was done. Surprisingly, the lesion grew into a firm red tumor on the left wall of the subglottic site, resulting in a grade III subglottic stenosis with a 95% obstruction (Figure 3).

Aspiration of the lesion revealed no blood, and a biopsy for pathologic analysis was performed using a micro forceps. Histopathological findings of the lesion biopsy revealed a pyogenic granuloma (Figure 4) with a lobular pattern of vascular proliferation

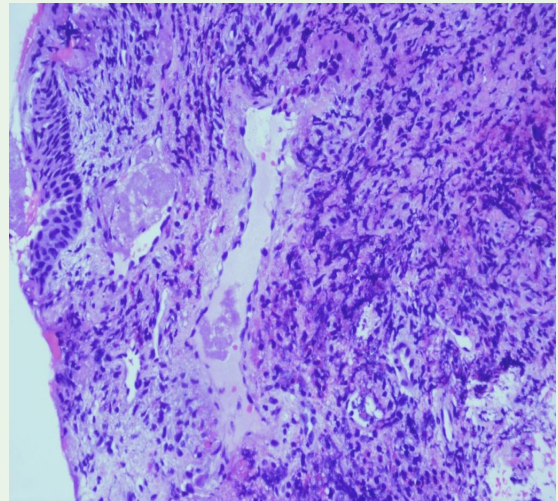


Figure 4: Histopathological findings of the subglottic lesion biopsy specimen revealed a pyogenic granuloma with a lobular pattern of vascular proliferation with inflammation and edema resembling granulation tissue covered by squamous epithelium. (Hematoxylin and Eosin stain; original magnification ×40).

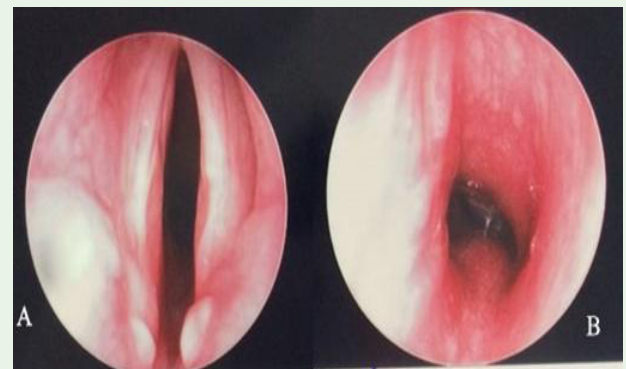


Figure 5: Laryngeal endoscopy was performed through (A) the patient's mouth and (B) the opening of the trachea, after 2 months follow-up. No recurrence was observed.

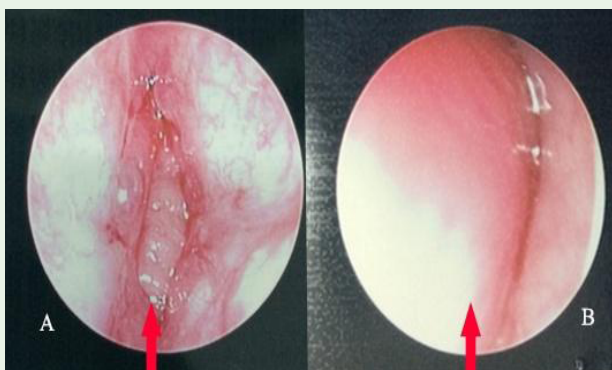


Figure 3: A second laryngeal endoscopy performed 2 weeks after the first tracheostomy revealed a firm red lesion in the left wall of the subglottic site (arrow), leading to grade III subglottic stenosis with a 95% obstruction. Endoscopy image was taken through (A) the patient's mouth and (B) the opening of the trachea.

with inflammation and edema resembling granulation tissue covered by squamous epithelium. There was no pathological evidence of dysplasia or malignancy.

Consequently, the patient underwent an endoscopy for a complete excision of the tumor using a coblator needle-tip wand (in the coagulation mode) (Coblator II, model RE 8000E, from Arthrocare, Costa Rica 680 Vaqueros Ave, Sunnyvale CA 94085). No complications occurred during or after the procedure. The tumor specimen was sent for pathologic analysis. Histopathological findings of the specimen revealed a pyogenic granuloma. At follow-up 2 months later, a third endoscopy was performed and did not reveal any recurrent laryngeal lesion (Figure 5). The patient did not suffer from dyspnea after decannulation.

Discussion

LCH is also called Pyogenic Granuloma (PG) although it is neither induced by bacterial infection nor a true granuloma [24]. The causes

of this disease remain unclear, and may include trauma, drug side effects, hormonal shifts, viral oncogenes, production of angiogenic factors, cytogenetic clonal deletion abnormalities, low-grade local irritation, and traumatic injury [14,15,20,24-26]. In children, 76.9% of LCH lesions appear on the head and neck, and 76.7% of those have no history of trauma or predisposing factors. Most of the manifestations are single lesions [27,28].

LCH lesions are very rare in the airway, with only 18 cases reported in the trachea and the main bronchus, and 4 cases reported in neonatal vocal cords [6-23]. Table 1 summarizes all reported LCH cases, including the current one. However, to the best of our knowledge, LCH has not been described in the subglottic area previously.

Based on the clinical symptoms as well as the chest and neck CT and laryngeal endoscopy findings, a diagnosis of hemangioma was established first. We did not perform a biopsy during the first laryngeal endoscopy due to the high risk of bleeding of the hemangioma. The differential diagnoses of this type of lesion may include granulation tissue, tuberculosis, hemangiopericytoma, angiofibroma, angiosarcoma, and LCH. Notably, LCH located in the airways is very rare. Granulation tissue may result from an endotracheal intubation, or sometimes secondary to an inflammation

or chemical irritation. Hyperplasia lesion of laryngeal tuberculosis was also considered; however, patients who suffer from laryngeal tuberculosis often have a chief complaint of hoarseness with the lesion mainly located on the vocal cord [29,30]. LCH is distinguished from hemangioma clinically and histologically based on its lobular growth pattern, fibromyxoid background, overlying ulceration, and acute inflammation [31]. LCH is also distinguished from other neoplasms based on its histopathological findings. Consequently, biopsy for histopathology could play a key role in diagnosis of a laryngeal lesion, and LCH should be considered when diagnosing the cause of a subglottic stenosis.

Many effective treatment modalities have been reported for LCH of the airway, including endoscopic excision, electrocautery, embolization, brachytherapy, argon plasma coagulation, and cryotherapy [6-23]. To date, there have been no comparisons among the various treatment methods for LCH located in the airway. These methods generally achieve good therapeutic effects, but long-term observation is still needed. In the present case, the laryngeal LCH lesion did not respond to intravenous propranolol, but it was successfully removed by an endoscopic coblator, which could be an effective treatment for this type of LCH. Recurrence of skin and mucosal LCH after local therapy is well-known. A recurrence rate of 16% has been reported for oral LCH; the causes were incomplete excision, failure to eradicate the etiological factors, or reinjury

Table 1: Pyogenic granulomas cases in trachea and main bronchus.

Author	Age, Male/Female (M/F)	Location of LCH lesion	Size	Treatment	Outcome
Madhumita et al. [10]	40 years, F	Upper third of right anterolateral tracheal wall	10 × 5 mm	Endoscopic excision	Good at 1 year
Irani et al. [8]	72 years, F	3 cm below vocal cords	2–3 mm	Endoscopic excision	Good at 1 year
Amy and Enrique [14]	22 years, M	3 cm above carina on left posterior tracheal wall	10–15 mm	Electrocautery	Good
Porfyridis et al. [13]	17 years, M	Upper third of left anterolateral tracheal wall	4 mm	Endoscopic excision	Good at 1 year
Zambudio et al. [21]	66 years, F	Between first and third tracheal rings	Occluding 30–40% of airway	Embolisation	Good at 1 year
Prakash et al. [7]	23 years, F	Posterior tracheal wall	20 × 40 mm	Endoscopic excision with extracorporeal membrane oxygenation	Good
Xu et al. [6]	64 years, M	Left anterolateral tracheal wall	3–4 mm	Endoscopic excision	Good at 8 months
Chawla et al. [9]	62 years, M	Distal right tracheal wall	Unknown	Endoscopic excision and laser therapy	Unknown
Chen et al. [22]	14 years, F	Lower third of anterior tracheal wall	15–20 mm	Cryotherapy and argon plasma coagulation	Good at 3 months
Udoji and Bechara [15]	55 years, M	Distal left lateral tracheal wall	4 × 5 mm	Cryotherapy	Good at 3 months
Putora et al. [23]	64 years, M	Distal tracheal wall	Unknown	Spontaneous remission on cessation of erlotinib for lung cancer	Good
Acharya et al. [18]	56 years, F	2 cm below vocal cords on right tracheal wall	7 mm	Endoscopic excision and electrocautery	Good at 1 year
Liu et al. [11]	17 years, M	Right wall of middle of the trachea	5–10 mm	Argon plasma coagulation, cryotherapy	Good at 11 months
Liu et al. [11]	15 years, F	Lower segment of trachea	15–20 mm	Argon plasma coagulation, cryotherapy	Good at 6 months
Qui et al. [16]	39 years, M	Right intermedium	10 mm	Endoscopic excision, cryotherapy	Good at 2 years
Walner et al. [20]	Neonatal, M	Midportion of the right true vocal cord and ventricle region	Unknown	Endoscopic excision	Good at 36 months
Walner et al. [20]	Neonatal, F	Right true vocal cord	Obstructing 70% of the laryngeal inlet	Endoscopic excision	Good at 6 months
Walner et al. [20]	Neonatal, M	Anterior and midportion of the right true vocal cord	Obstructing 50% of the laryngeal inlet	Endoscopic excision	Good at 2 months
Walner et al. [20]	Neonatal, F	Right false vocal cord and ventricle region	Obstructing 90% of the laryngeal inlet	Endoscopic excision	Good at 2 months
Present case	11 years	Left wall of the subglottic site, just under the surface of the left vocal cord	20 mm	Coblation	Good at 2 months

of the area [12]. Nevertheless, neither recurrence nor malignant degeneration has been reported with LCH of the airways [6-23]. We recommend close follow up for patients who have a history of laryngeal LCH with endoscopy as necessary.

Conclusion

To the best of our knowledge, this is the first report of unique presentation and management of a subglottic LCH. Physicians should be aware of this unique lesion and consider laryngeal LCH as a differential diagnosis of subglottic stenosis, where biopsy for histopathology could play a key role in diagnosis. Moreover, coblation was effective in treating this laryngeal LCH. Finally, further studies are necessary to understand the etiology of laryngeal LCH and ensure effective treatment for these lesions.

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