

## Short Term Management of Vocal Fold Paralysis

Matthew S Broadhurst

Sleep Medicine Centre, Australia

Vocal cord paralysis is commonly encountered by ENT surgeons. The standard management usually involves waiting for 6-12 months to assess for recovery or reinnervation. During this time, the patient usually experiences poor quality voice, ineffective cough, and aspiration which may result in pneumonia. Management of these patients includes a search for the aetiology and often requires speech therapy. In addition to this, a reversible, office-based early injection laryngoplasty can minimize the patient morbidity of impaired vocal fold mobility while maximizing glottal function and improving phonatory quality. Methods: A retrospective study was conducted on consecutive patients with unilateral vocal cord paralysis. Voice handicap index, basic and aerodynamic/acoustic data were collected at the initial assessment and following intervention. Intervention consisted of an office-based, unsedated, paraglottic injection of hyaluronic acid to the effected side. All patients underwent videostroboscopy before, during and after office intervention and subjective assessment of these recordings was made. Patients also completed the voice related quality of life. Results: All 185 patients tolerated office-based injection well with no adverse events. All patients experienced an improvement in glottal competency and this was reflected in the aerodynamic and acoustic data. Analysis of videostroboscopy before and after showed a similar outcome, as did patient questionnaire data. Discussion: Office-based, unsedated paraglottic injection of hyaluronic acid is a safe and effective treatment option in the short term management of impaired vocal fold mobility. It improves glottal competency and vocal function while minimizing the risks associated with impaired vocal fold mobility. It allows rapid return to work/social functioning compared to the wait and see approach. The condition is brought about by harm to nerves setting off to the vocal line – the nerve driving forces in the larynx (voice box) are interfered, bringing about loss of motion of the vocal line muscles. It can likewise be brought about by cerebrum harm. Patients with vocal loss of motion normally experience roughness, vocal weakness, mel-low to extreme decrease in discourse volume, an agony in the throat when talking, and gulping things down the incorrect way and stifling. The vocal strings, just as permitting us to create articulations (talk, and so forth.) likewise ensure the aviation route, forestalling food, drink, and spit from entering the trachea (windpipe). In outrageous cases, the resultant stifling can prompt passing. People with vocal line loss of motion may dis-

cover the viability of hacking, gulping or sniffing in evacuating laryngeal zone squander is subverted diminished vocal rope versatility. This may bring about collections in the zone, taking into account bacterial and viral colonization, and resulting con-taminations and throat inconvenience. Vocal line loss of motion treatment relies upon a few elements, including what caused it, how extreme side effects are, and to what extent they have been available. The patient might be encouraged to have voice treatment, medical procedure, or both.

Bilateral paralysis requires medical treatment. You may need to have a tracheotomy so you can eat safely. You might have sur-gery to bring one or both vocal folds closer to the middle.

You may need medical treatment for unilateral paralysis. This might include muscle-nerve transplant or surgery to move the paralyzed fold toward the middle. You might also have some-thing injected into the fold to make it larger. This allows the oth-er fold to move closer to it and may help your voice.

Voice therapy can also help unilateral paralysis. You can work with an SLP on changing your pitch and getting more breath support to speak louder. Changing your head position or push-ing on your larynx may help your voice. Your doctor may want you to try voice therapy before you look into surgery or oth-er medical treatments. It may be the only treatment that you need. requires clinical treatment. You may need to have a tra-cheotomy so you can eat securely. You may have medical pro-cedure to bring one or both vocal overlap nearer to the center.

You may require clinical treatment for one-sided loss of motion. This may incorporate muscle-nerve relocate or medical proce-dure to push the incapacitated overlay toward the center. You may likewise have something infused into the crease to make it bigger. This permits the other overlay to draw nearer to it and may support your voice.

Voice treatment can likewise support one-sided loss of motion. You can work with a SLP on changing your pitch and getting more breath backing to talk stronger. Changing your head po-sition or pushing on your larynx may support your voice. Your primary care physician may need you to attempt voice treat-ment before you investigate medical procedure or other clinical medicines. It might be the main treatment that you need.