Bilateral Vocal Cord Paralysis following Radiation Therapy for Nasopharyngeal Carcinoma

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Key Words
Radiation therapy
Complications
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Abstract
Cranial nerve palsies are uncommon late sequelae of radiation therapy. We present a rare case of bilateral vocal cord paralysis secondary to radiation-induced recurrent laryngeal nerve paralysis. The exact mechanism accounting for radiation-induced nerve damage is unknown. The complication may occur years following radiation therapy thus making a causal relationship difficult. As there is no treatment available, the therapy should aim to improve the functional impairment produced by the nerve involved.

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Introduction
Paralysis of one or more cranial nerves as a result of direct involvement by the tumor is a frequent finding in patients with cancer of the head and neck region. Radiation therapy, a vital tool in the treatment of head and neck cancers, usually leads to an improvement in the paresis [1]. As the cranial nerves are relatively radioresistant, their presence in a radiation treatment field does not affect the treatment strategy [2]. However, radiation-induced cranial nerve palsies are being observed more frequently in the recent years. Bilateral vocal cord paralysis can be one of its life-threatening complications [3]. Fortunately, involvement of recurrent laryngeal nerves is rare with only 4 cases reported in the English literature [4-7]. We present a case of a 53-year-old gentleman who developed bilateral vocal cord paralysis 3 years following radiation therapy for nasopharyngeal cancer.

Case
A 50-year-old man presented to the ENT service in January 1984 with a 1-month history of a neck mass and epistaxis. On head and neck examination, two lymph nodes 3×4 mm and 5×7 mm were palpated in the cervical region. Endoscopic examination of nasopharynx revealed an ulcerated mass lesion in the nasopharynx. Biopsy of the lesion confirmed it to be a squamous cell carcinoma. CT scan of the head showed no local destruction. Except for the neck nodes, a metastatic work-up was negative. The treatment plan consisted of chemo- and radiation therapy. After chemotherapy with cis-platin, the patient underwent 5,000 cGY of radiation therapy divided over a period of 5 weeks. Therapy was given by means of parallel opposing ports to the nasopharynx. To spare the spinal cord of further exposure, the port was reduced in width after delivering 4000 rad. In addition, he received the same dose at the same rate using an anterior port
to the lower neck nodes down to the infraclavicular area. The midline was blocked on this port
to avoid radiation to the spinal cord. Except for some local dermatitis, radiotherapy did not result
in any major immediate side effects.
Following treatment, the patient did well until February 1987, when he developed hoarseness of
voice and mild exertional dyspnea. A detailed clinical and laboratory work-up did not indicate a
local recurrence or metastatic disease. The hoarseness and exertional dyspnea progressively increased
over the next year without an identifiable cause. Subsequently, the patient was admitted to the
hospital with an acute episode of dyspnea. On examination, glottic chink was observed to be 3
mm with weak movement of both vocal cords. A tracheostomy was performed to restore airway
patency. As the vocal cord mobility failed to improve, a left arytenoidectomy was performed a
year later. The procedure resulted in the alleviation of symptoms and an acceptable quality of
voice. Eventually, the patient was decanulated.
The patient has been followed regularly over the past 9 years with no evidence of recurrent
disease. The vocal cords are still paralysed with borderline airway patency.
Discussion
Radiation therapy is the most suitable and effective mode of therapy available for the treatment
of naso-pharyngeal cancer [8]. However, the destructive nature of radiation therapy and the close
proximity of the nasopharynx to sensitive structures like eyes, nervous tissue and major blood
vessels predisposes to a variety of side effects. Minor problems such as erythema of skin and
mucositis usually resolve in few weeks. Radiation-induced cancers and strictures are some of the
more serious and potentially fatal complications [3]. Most of the complications occur early but
some may occur years after the radiation therapy. These late sequelae include spinal cord
myelopathy, necroses with fatal hemorrhage and cranial nerve palsies [3].
Radiation-induced nerve palsies usually become apparent after a latent period of 1-5 years
following therapy
[4]. Many studies have reported an inverse relation between the dose and the latent period [2].
The exact mechanism accounting for radiation-induced peripheral nerve damage is unclear [4].
Some authors suggest a direct nerve damage as the possible mechanism. This conclusion is based
on short follow-up in experimental studies [9]. Additionally long latent periods observed in
clinical situations do not support this theory. A more likely mechanism is the radiation induced
fibroses in the vicinity of nerves. The progressive growth of the fibrous tissue may lead to the
mechanical compression of the nerves, resulting in permanent functional changes [2].
Tumor-induced nerve damage is a common cause of cranial nerve paralysis in the head and neck
region [1]. In our case, a close follow-up did not reveal any local recurrence or distant
metastasis. This rules out the possibility of direct damage to the nerve by the tumor. However, a
latent period of 2 years supports our diagnosis of radiation-induced recurrent laryngeal nerve
paralysis. Bilateral vocal cord paralysis can compromise the airways resulting in a life-
threatening situation. As in our case, the airway management may necessitate a tracheostomy.
Radiation-induced palsies are progressive and not treatable at present [6]. Given the location and
high dose of radiation therapy required in some patients, this complication may not be avoidable.
This demands that the physicians be alert to the possibility, even years following the radiation
therapy. Radiation-induced recurrent laryngeal nerve paralysis is a rare complication. The
common causes of vocal cord paralysis should be ruled out before considering this diagnosis.
References