Acta Scientific Otolaryngology (ISSN: 2582-5550)

Volume 8 Issue 1 January 2026

Case Report

Rare Cause of Stomal Bleed in a Post Laryngectomy Patient: A Case Report

Annju Thomas*

ENT Surgeon, Little Flower Hospital, Angamaly, Kerala, India

***Corresponding Author:** Annju Thomas, ENT Surgeon, Little Flower Hospital, Angamaly, Kerala, India.

Received: April 18, 2022

Published: June 15, 2025

Abstract

Introduction: Post laryngectomy the trachea is separated from the esophagus and a permanent opening is created at the anterior part of the neck. Stomal site complications include bleeding, pharyngocutaneous fistula, stomal crusting, stomal stenosis, voice prosthesis dislodgement, acute airway obstruction of which bleeding is one of the most common complications.

Case Report: We report a case of 56 year old male who presented with a late stomal site bleed.

Discussion: Many early and late complications if left undiagnosed can pose a danger in a post-operative laryngectomy patient. Through this case report we emphasize that the rarely seen cause must be kept in mind as a differential diagnosis in case of a post laryngectomy stomal site bleed.

Keywords: Post laryngectomy; Stomal; Trachea

Introduction

A post-laryngectomy stoma is a circular opening in the midline of the neck just above the clavicles and only tracks inferiorly into the chest with no connection superiorly to the throat and mouth [1]. Bleeding from laryngeal stoma may occur because of dry air irritating the lining of the trachea, fistula formation, carotid blow out, dislodgement of laryngeal device [2]. It may result in airway compromise hence is an emergency and needs to be attended promptly [2].

Case Report

A 56-year-old male, came to our hospital with complains of bleed from post laryngectomy stoma since 2 days and whistling sound on inspiration and expiration with cough since 1 week, no complains of breathlessness. On examination blood clots were seen around the stoma, and bleeding with every episode of cough, oxygen saturation was 98% in room air and vitals were normal. On palpation no evidence of tenderness or local rise in temperature. A 70 degree endoscope was passed through the stoma, a foreign body surrounded by granulation tissue was visualized 2cm below the stomal site. On further probing the patient gave history of self-insertion of a plastic tube to facilitate voice production, which couldn't be retrieved post insertion 1 week back. Under local anaesthesia flexible bronchoscope was passed through the stoma, foreign body plastic tube measuring 5cm (Image 1) was removed and followed by which a check bronchoscopy was done which was within normal limits. Post procedure recovery was uneventful.

Image 1: Plastic tube foreign body removed measuring 5 cm (above) and endoscopic view of foreign body (below).

Discussion

Foreign-body aspiration into the trachea is mostly seen in children as compared to adults [3,4]. Except for adults who have impairment of their protective airway mechanisms [3,4]. Very few cases of aspiration in patients with a postlaryngectomy stoma have been previously reported in the literature [5-7]. Rigid bronchoscopy has been the gold standard for the removal of foreign bodies, as it is easy to ventilate and to pass a wider variety of extraction instruments [8]. Some authors advice usage of flexible bronchoscopy depending on the nature and location of the foreign body [9,10]. In our case report we used a flexible bronchoscope for visualising and retrieving the foreign body. In laryngectomized patients, the passage of the rigid scope through the stoma can be difficult because of interference from the chin, even when the neck is hyperextended [8]. Hyperextension can be difficult in elderly patients with cervical arthritis [8]. In several of the previous case reports, chest X-rays were the initial method for locating the foreign body; in our case due to the transparent nature of the foreign body it was challenging to identify [11].

Conclusion

Early identification of a foreign body along with timely and appropriate anaesthetic and surgical management can prevent an airway emergency due to bleeding and airway obstruction.

Bibliography

1. Shweta G PA-C., *et al.* "Care of the post-laryngectomy stoma". *Fast Facts and Concepts* (2014): 281.

2. St. John RE and Malen JF. "Contemporary issues in adult tracheostomy management". *Critical Care Nursing Clinics of North America* 16 (2004): 413-430.

3. Abdulmajid OA., *et al.* "Aspirated foreign bodies in the tracheobronchial tree: Report of 250 cases". *Thorax* 31 (1976): 635-640.

4. Limper AH and Prakash UB. "Tracheobronchial foreign bodies in adults". *Annals of Internal Medicine* 112 (1990): 604-609.

5. Rehurek L. "Unusual complications caused by a foreign body in the tracheobronchial tree". *Laryngoscope* 85 (1975): 1767-1769.

6. Cannon CR. "Small tracheal stoma: An unusual cause of aspiration". *Southern Medical Journal* 75 (1982): 512-513.

7. Finkelstein OM., *et al.* "Inhalation of a safety pin by a laryngectomized patient: A case report". *Journal of Otolaryngology* 18 (1989): 189-192.

8. Jonathan N and James F. "Aspirated foreign body in a laryngectomized patient: Case report and literature review". *ENT- Ear, Nose and Throat Journal* (2001): 744-748.

9. Lan RS., *et al.* "Use of fiberoptic bronchoscopy to retrieve bronchial foreign bodies in adults". *American Review of Respiratory Disease* 140 (1989): 1734-1737.

10. Cunanan OS. "The flexible fiberoptic bronchoscope in foreign body removal. Experience in 300 cases". *Chest* 73 (1978): 725-726.

11. Kadam VR., *et al.* "Speaking valve' aspiration in a laryngectomy patient". *Anaesthesia and Intensive Care* 38.1 (2010): 197-200.