OPTIMIZATION OF DIAGNOSTICS OF PATIENTS WITH VOCAL CORD PARALYSIS WITH A DIFFERENTIATED APPROACH TO THEIR MANAGEMENT TACTICS

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Abstract: Vocal cord dysfunction (VCD) is a syndrome characterized by paroxysmal obstruction of the upper respiratory tract as a result of closure of the vocal cords and closure of the glottis during inspiration. The thesis discusses the optimization of diagnostics of patients with vocal cord paralysis with a differentiated approach to their management tactics.

Keywords: Tactics, diagnosis, treatment, vocal cord, syndrome.

INTRODUCTION

To date, no unified terminology has been agreed upon to describe this condition. "Vocal cord dysfunction" is a phrase that is more often used among pulmonologists and allergists; "paradoxical movement of the vocal cords" is usually used by otolaryngologists and phoniatrists. In addition, when describing this condition, terms such as "Munchausen stridor", "hysterical stridor", "functional laryngeal stridor", "episodic laryngeal dyskinesia", "episodic paroxysmal larynx" may also appear "irritable larynx syndrome".

MATERIALS AND METHODS

The opening of the glottis is carried out by the posterior cricoarytenoid muscle, closure by the lateral cricoarytenoid and other muscles. The muscles are innervated by the recurrent laryngeal nerve. The vocal cords provide three main functions: airway protection, breathing, and phonation. These functions are partially reflexively controlled by the medulla oblongata, with the exception of the protection of the respiratory tract, which is controlled only reflexively, without the participation of consciousness. Breathing can be partially controlled by consciousness. Phonation, as a rule, is controlled consciously.

RESULTS AND DISCUSSION

Normally, during inhalation, the space between the vocal cords increases; during exhalation, the area of the space between the vocal cords decreases by approximately 30%. Sniffing, sniffing, puffing, and whistling are also accompanied by the opening of the glottis. The approach of the vocal cords is observed during phonation, coughing, straining and swallowing. In the case of DGS, there is a paradoxical closure of the glottis on inspiration, sometimes complete, sometimes a small open space remains in the posterior part of the glottis.

The prevalence of this condition is difficult to assess due to the lack of generally accepted terminology. According to various authors, in the population of patients suffering from dyspnea, the prevalence of DHS ranges from 2.5 to 22%. But most publications indicate that its prevalence does not exceed 3%. The age of patients varies from infancy to 82 years, the ratio of women to men, according to various estimates, is 2: 1–3: 1.

Attack triggers can be [1]:

1) physical activity, which often leads to difficulties in distinguishing physical effort from AD;

2) complex psychological situations and mental states: anxiety, depression, post-traumatic stress, panic attacks;

3) professional irritants and those associated with environmental factors: dust, smoke, ammonia, cleaning chemicals, organic solvents, chlorination of water in swimming pools;

4) rhinosinusitis with postnasal drip;

5) gastroesophageal reflux;

6) some medications: neuroleptics, inhaled glucocorticosteroids.

M. Morris and K. Christopher proposed diagnostic criteria for DHS (Table 1).

Table 1. Diagnostic criteria for DHS (Morris M., Christopher K.) [5]

Clinical signs	Symptoms are observed over a long period of time, intermittent Dyspnea Signs of upper respiratory tract obstruction Presence of provoking factors and the possibility of reproducing symptoms when exposed to them
Laryngoscopy	Adduction of the vocal cords during inhalation or during inhalation and exhalation with closure of the glottis by more than 50% These changes are intermittent In the absence of symptoms, as a rule, there are no changes In some cases, there is an open space at the back of the glottis
External respiration function	Normal spirometry with no response to bronchodilator Negative bronchoprovocation test Flattening of the inspiratory loop of the flow-volume curve

It should be noted that laryngoscopy is the “gold standard” for diagnosing DHS, i.e. Without this study, the diagnosis is not valid. However, laryngoscopy is often difficult at the height of the attack. At the same time, outside of an attack, laryngoscopy may not reveal any changes. In this situation, triggers are used, often physical activity, to provoke an attack in the patient and perform laryngoscopy at his height.

DHS can be suspected if there is a discrepancy between the severity of shortness of breath and the absence of significant objective changes (dry rales, changes in blood gases). As a rule, after contact with a trigger, an attack of DHS develops within seconds, in contrast to asthma, which requires at least minutes to develop an attack. An attack of DHS does not last very long; in most cases it self-limites within a few minutes. An attack/exacerbation of asthma can last for hours or days. BA is characterized by difficulty breathing on exhalation, while DHS is characterized by difficulty breathing on inhalation. Subjective sensations of obstruction to breathing in asthma are localized in the chest, while in DGS - at the level of the throat and neck.

Objectively, in case of asthma, dry wheezing is heard in the projection of the bronchial tree, in case of DHS, wheezing of inspiratory stridor is heard in the projection of the larynx.

CONCLUSION

Vocal cord dysfunction occurs in the practice of doctors of various specialties (pulmonologists, allergists, otolaryngologists, psychiatrists) and may have clinical manifestations similar to other diseases. Particularly often, difficulties arise in the differential diagnosis of asthma. Clinical and instrumental examination and the use of a special scale make it possible to distinguish between these diseases and choose the optimal treatment method aimed at achieving disease control.

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