

UCSF Voice and Swallowing Center
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Patient:

Stephen Gaudet

MR Number:

xxxxxxxx

Date of Birth:

09/12/1954

Date of Visit:

2/14/2019

Dear Dr. Russell:

It was my pleasure to see Stephen Gaudet at the UCSF VOICE AND SWALLOWING CENTER on 2/14/2019 in consultation at your request for laryngeal stenosis.

Mr. Gaudet has a history of asthma since childhood. He has been intubated 44 times in the past, and has sometimes been intubated multiple times within the same hospitalization. He has a history of multiple self-extubations in the past but this did not occur with his latest intubation. The average time of intubation for the patient is about 2-3 days.

The patient's last intubation was in October of 2018. He was intubated twice for a total of a few days. After the patient's last two intubations, his partner has noticed stridorous noises.

After Christmas of 2018 he was experiencing difficulty inhaling. He has never experienced this in the past. This difficulty is worsened by exertion, which the patient's noticed as he is an avid fitness walker. This difficulty worsened over time until he felt as though he was breathing through a straw. He had a pulmonary appointment that week on 1/10/19 and spirometry was performed. He is an RT by profession. He received a CT scan that same day, then he was contact by pulmonology and asked to report to the ED.

He then met with the otolaryngology team and was found to have PGS. A dilation was performed in January of 2019. Immediately after this procedure his dyspnea was significantly improved. He was still in the midst of an asthma flare but he was able to notice the difference in his breathing. He could take a full easy breath in. His voice was normal at this time, though he did experience a sore throat for 1-2 weeks.

His current breathing is not quite to baseline but it is close. He has always had difficulty with exhalation due to asthma, and this persists now. He states that he is a poor perceiver of his dyspnea due to his long history.

His voice is raspy currently and has been growing worse over time. It does not bother him except when he is on the phone. Others cannot understand him. He is generally not particularly bothered by his voice, as he does not generally have a significant amount of contact with others. He is not experiencing any anxiety due to his voice. He does feel as though when he has to communicate his voice is unreliable.

He reports frequent throat clearing today. He denies any globus, cough or heartburn. He has been tested for reflux in the past and his PH monitoring was negative. He denies dysphagia today. His partner reports that the patient has frequent muscle cramps in his throat when he starts to eat. (The patient has a history of muscle cramps al over his body). He eats a regular diet currently. He does not cough or choke with liquids. His weight has increased recently with steroids. He reports pneumonia as a child but none recently.

He has not history of tobacco use. He drinks 1 cup of coffee and 2.5 cups of water per day. He worries about becoming bloated easily which affects his breathing. His goal is to experience a better quality of breathing and of life.

Assessment

Stephen Gaudet's voice and laryngeal evaluation is consistent with dysphonia which is a new problem, dyspnea which is a new problem, hypomobility of the bilateral true vocal folds most likely due to posterior glottic stenosis which is a new problem and posterior glottic stenosis which is a new problem.

Plan

Today I performed a flexible video stroboscopy and a bronchoscopy. Posterior glottic stenosis (PGS) is directly visualized on his exam today. Vocal fold motion is decreased bilaterally likely due to his PGS. Vocal fold closure is complete. There is mild-moderate stiffness of the medial aspect of the right vocal fold without apparent mass or lesion. This may be suggestive of possible scar.

I have had a long discussion with the patient regarding the findings of the laryngeal exam and the associated symptoms.

Regarding the patient's dyspnea, the patient's vocal fold abduction is decreased due to posterior glottis stenosis (PGS). This may be related to his multiple previous intubations or may be the result of this most previous intubation event. At present, we are treating the PGS as if it were a new development. He does still appear to be in the acute healing phase after his recent surgery. The patient's airway is small currently, and this is likely contributing to his dyspnea on top of his underlying asthma and pulmonary issues (likely the primary factor). I do not see evidence of vocal cord dysfunction (or paradoxical vocal fold motion) today.

I had a long discussion with the patient regarding options for next step in treatment. These include:

1) We have discussed the option of continued observation alone. In the absence of dysphagia/aspiration symptoms, observation alone is an option. The patient is aware that intervention remains a possibility in the future, if so chosen. Advantages of observation include an avoidance of further procedures and the potential impact of general anesthesia on his underlying breathing difficulties. Disadvantages include potentially allowing further maturation of scar tissue which can result in worsening of PGS.

2) Performing another surgical procedure to examine his PGS and see if there are any options to further improve his airway. Advantages to this include gaining additional information regarding his dysphonia and dyspnea and potential treatments for this as well as potentially improving his PGS. Disadvantages of this option include the risks of general anesthesia on an individual with significant asthma and underlying pulmonary issues.

I did discuss with the patient in depth regarding microsuspension laryngoscopy with examination under anesthesia, possible balloon dilation of PGS, possible steroid injection of PGS, possible steroid injection of right vocal fold, possible CO2 laser division of PGS. We discussed risks, benefits, and alternatives. Risks include but are not limited to infection, bleeding, scarring, numbness, heart attack, stroke, death, injury to the teeth or gums or lips, numbness of the tongue or change in sense of taste, temporomandibular joint dysfunction, persistent or worsening hoarseness, persistent or worsening shortness of breath, or need for further procedures. The patient's dyspnea may not improve with this procedure, and if it does improve it may worsen over time following the procedure. This procedure is performed in the operating room, under general anesthesia. It is performed as a same-day surgical procedure. The patient will likely spend one night in the hospital for observation following surgery.

My goal is to perform this procedure without requiring a tracheostomy for him. There is a chance that a trach may be necessary, but I will do everything possible to avoid this. If he does require a trach, I believe it is very unlikely that it will be permanent although he is aware that it may yet be.

This procedure will not affect the chance that he must be intubated in the future, however it will improve the size of his airway which will make a future intubation safer.

I gave the patient recommendations for getting a medical alert bracelet. This will indicate that there is a narrowing (stenosis) of the airway and that the patient should be intubated with as small an endotracheal tube as possible. This may be a critical safety measure in the event of a medical emergency during which the patient is unable to directly communicate this important medical issue. I do believe that the patient could be intubated, but this would likely require skilled anesthesiologist as well as preferably a planned awake fiberoptic intubation. In the event of an acute emergency, this understandably may not be possible. I would also advise use of the smallest size endotracheal tube possible - prefer 5.0 or 6.0 ETT or pediatric size tube if possible. Use of a pediatric scope would likely also be helpful.

He is noted to have stiffness of the right vocal fold which may be contributing to his hoarseness. The exact etiology and duration of this finding is unclear. He is also noted to have some evidence of muscle tension dysphonia that may also be contributing to this issue. During surgery, I will be able to further explore the vocal folds and possibly intervene if indicated to try to give him some voice improvement.

I have scheduled the following surgery: microsuspension laryngoscopy with examination under anesthesia, possible balloon dilation of PGS, possible steroid injection of PGS, possible steroid injection of right vocal fold, possible CO2 laser division of PGS. He is agreeable to this. Given his underlying pulmonary disease, he is aware that he may need to be monitored overnight. We will look to perform this procedure likely at Mission Bay Hospital.

I have asked the patient to follow-up for surgery.

All of the patient's and his partner's questions were answered.

Thank you for allowing us to participate in Stephen Gaudet's care. Please do not hesitate to contact us if you have any additional questions.

Sincerely,

Vyvy N. Young, MD

Electronically signed by Vyvy N. Young, MD on 2/14/19, 12:21 PM

CC

Gina T. Moreno-John, MD

Stephen Gaudet

John V. Fahy, MD

This letter was initially viewed by Stephen Gaudet at 2/14/2019 1:58 PM.
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