INTRODUCTION

More advanced neuromas originate from the cranial and spinal nerve roots, and they manifest symptoms as slow and progressive spine compression, and partial or total surgical removal is indicated. Cranial pairs V, VII, IX, X, XI and XII act directly on speech production and swallowing and, when involved, may interfere in the patient’s life quality, especially the social, nutritional and pulmonary aspects. The more these nerves are involved, the higher is the risk of developing aspiration pneumonia, and the multidisciplinary care is fundamental in order to treat these patients and minimize resection sequelae.

Our goal was to check the results of speech, mastication and swallowing rehabilitation in a case of neck and pharyngeal neuroma by means of exams: laryngeal, swallowing video-fluoroscopy, and electromyography of muscular and motor tongue muscles.

CASE PRESENTATION

A 38 year old patient, that after suffering a resection of a neck and pharyngeal neuroma that involved the neck region and the carotid artery, complained of dysphonia, dysphagia and chewing difficulties.

In our evaluation we noticed tongue atrophy and reduction of labial mobility on the right side, associated with reduced tongue elevation. The video-laryngoscopy showed paralysis of the hemilarynx and also of the right vocal fold in total abduction, reduction in soft palate muscle contraction on the right side and a blowy voice pattern. After a type I thyroplasty, she presented with a posterior midline triangular vocal fold slit with partial vocal improvement.

During swallowing videofluoroscopy we noticed for all types of food material: premature food escape; food residues in the oral cavity; difficulty in transporting the food from the oral phase to the pharynx and food stasis in the piriform fossae and piriform recesses. Electromyography showed a reduction in temporal and masseter muscle activity on the right side.

Speech therapy rehabilitation happened in 24 sessions, with isotonic and isometric myofunctional exercises selected, associated or not to therapeutic tests. During swallowing videofluoroscopy exams, muscular movements in the oral cavity and posterior midline triangular vocal fold slit were selected because it was the only one that caused a mild reduction in the glottal slit, and also a mild increase in voice blowing pattern during its performance. Along speech therapy, other vocal exercises were selected, associated or not to neck postural maneuvers, but also without good results as far as vocal quality is concerned.

DISCUSSION

Speech therapy rehabilitation in this patient was those that, besides the exercises selected for the speech therapy rehabilitation, although voice quality remained unaltered.

REFERENCES