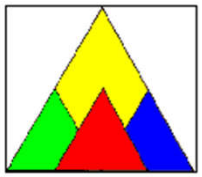
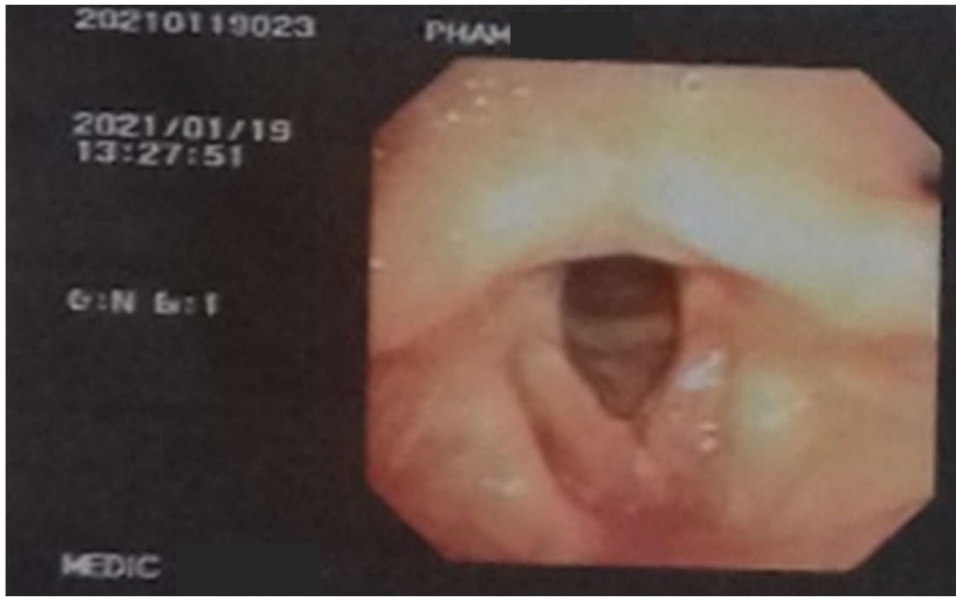


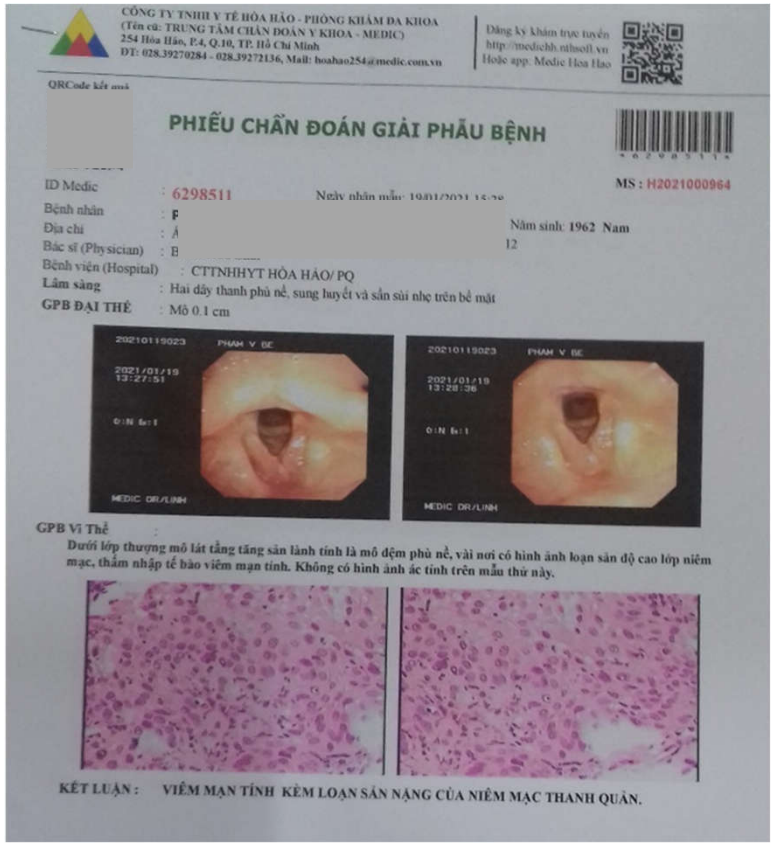
CÁC TỔN THƯƠNG BỆNH LÝ Ở THANH QUẢN

BS TRƯƠNG NGỌC LỄ

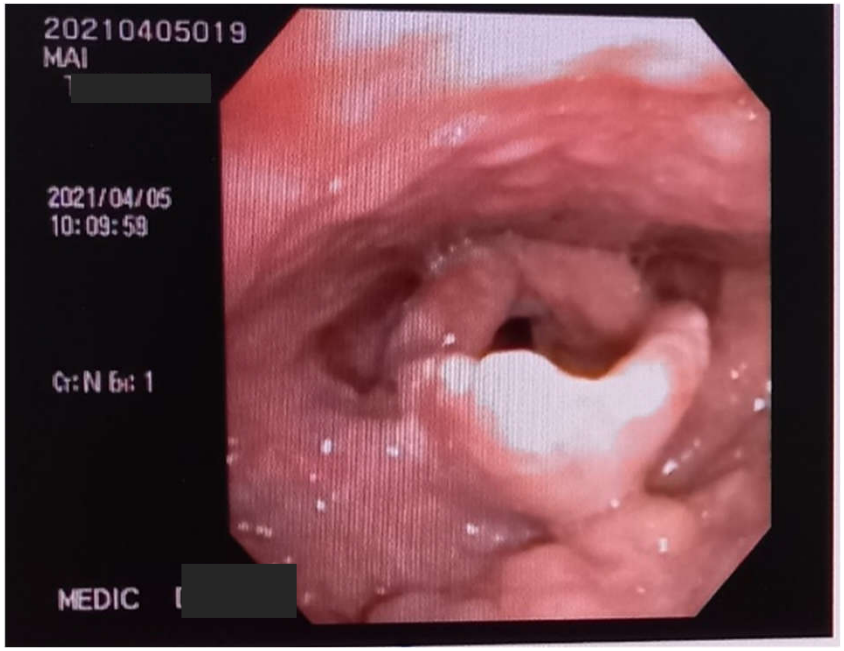
Case report :viêm mạn

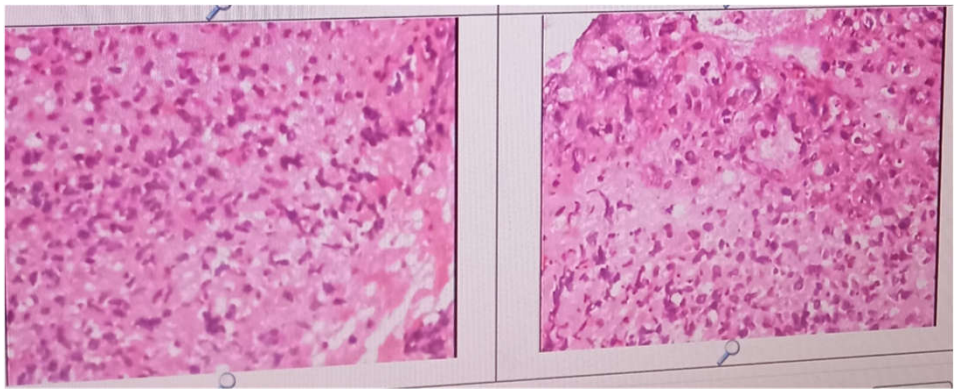


-LS:khàn tiếng
-NS:2 dây thanh phù nề,sung huyết và sần sùi nhẹ trên bề mặt



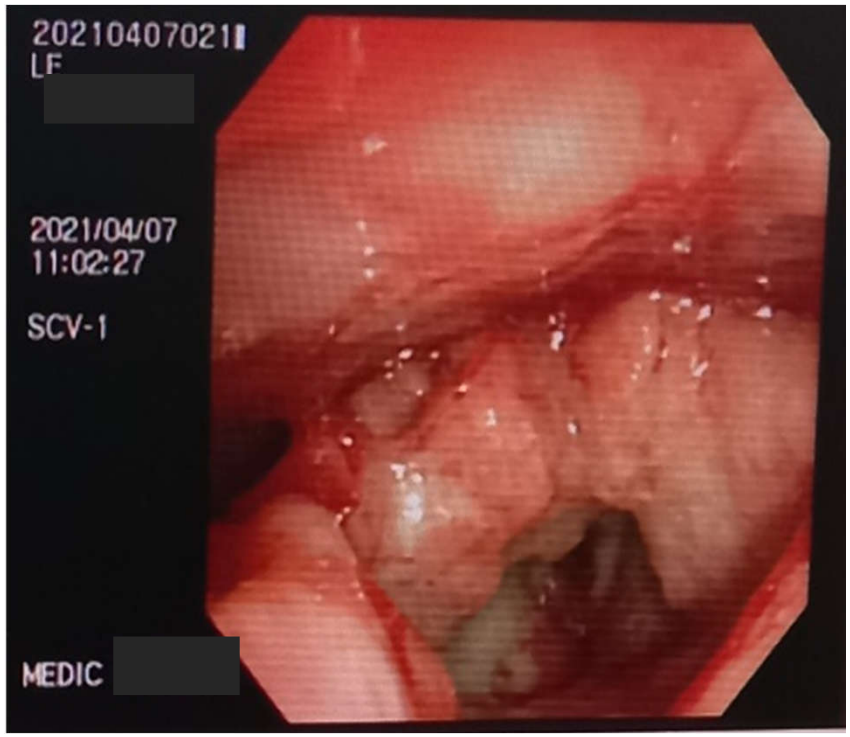
Case report :viêm cấp

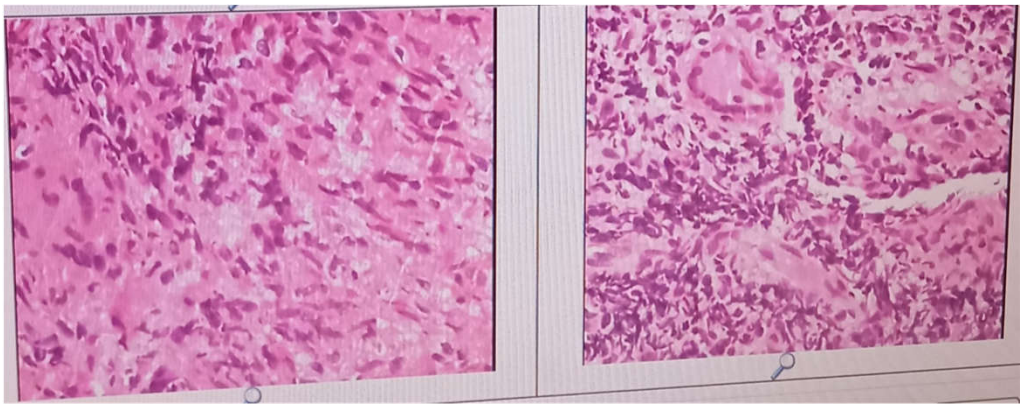




- LS:đau họng
- Nội soi:phù nề thanh thiệt ,sụn phễu 2 bên,bề mặt có ổ loét và giả mạc
- GPB:viêm loét thanh thiệt,sụn phễu cấp tính

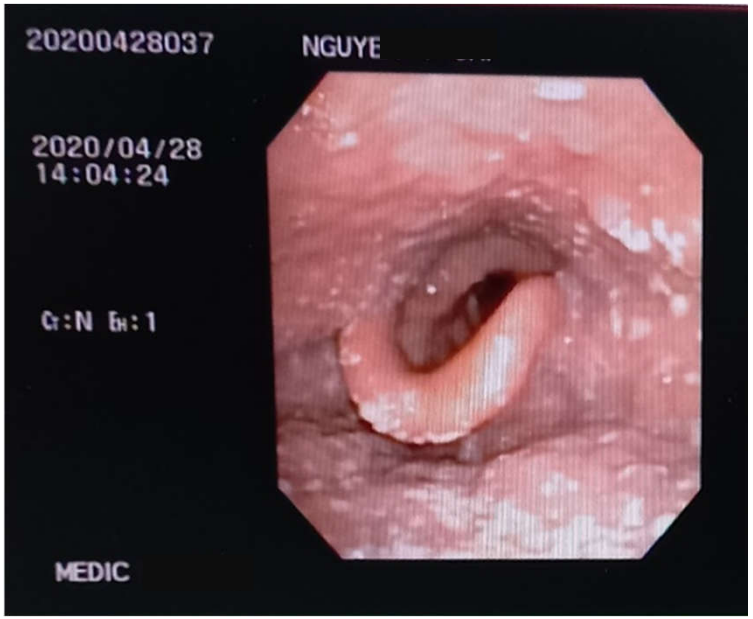
Case report: lao

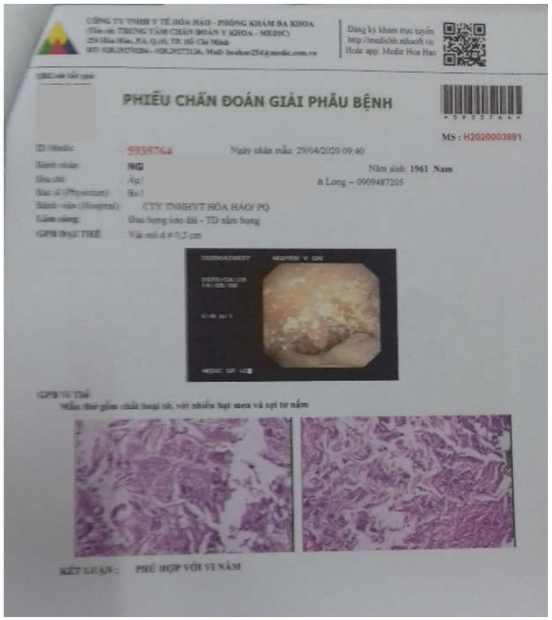




- LS:nuốt đau
- Nội soi:phù nề và sần sùi niêm mạc thanh quản.
- GPB:viêm lao ở thanh quản.

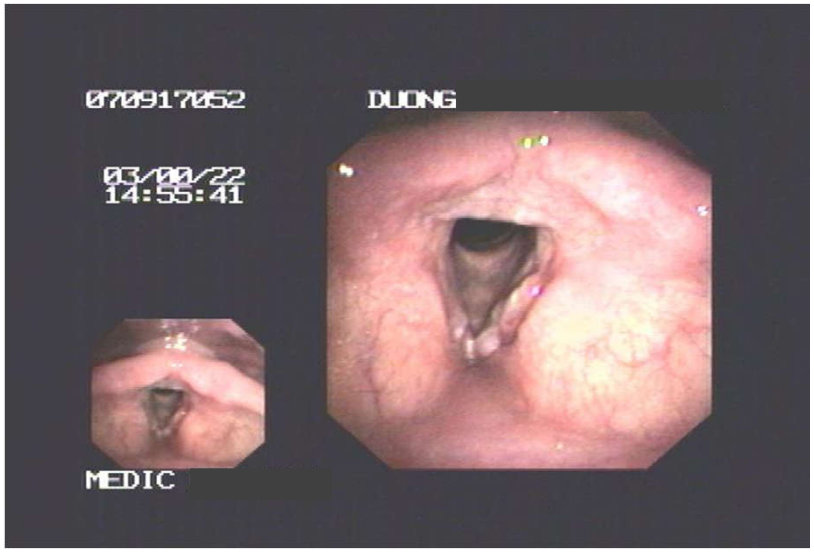
Case report:Nấm



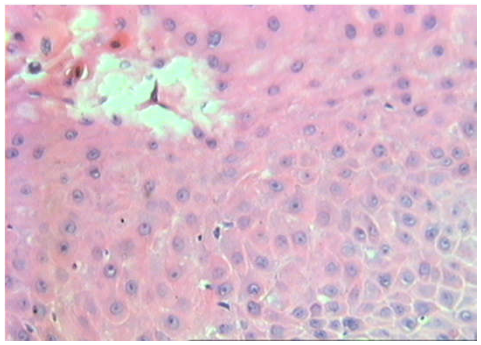


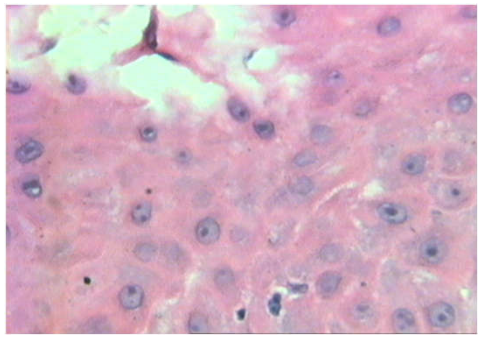
- LS:đau họng kéo dài
- Nội soi:nhiều giả mạc trắng ở trên niêm mạc vòm khẩu cái,đáy lưỡi,hạ hầu thanh quản.

Case report :bạch sản



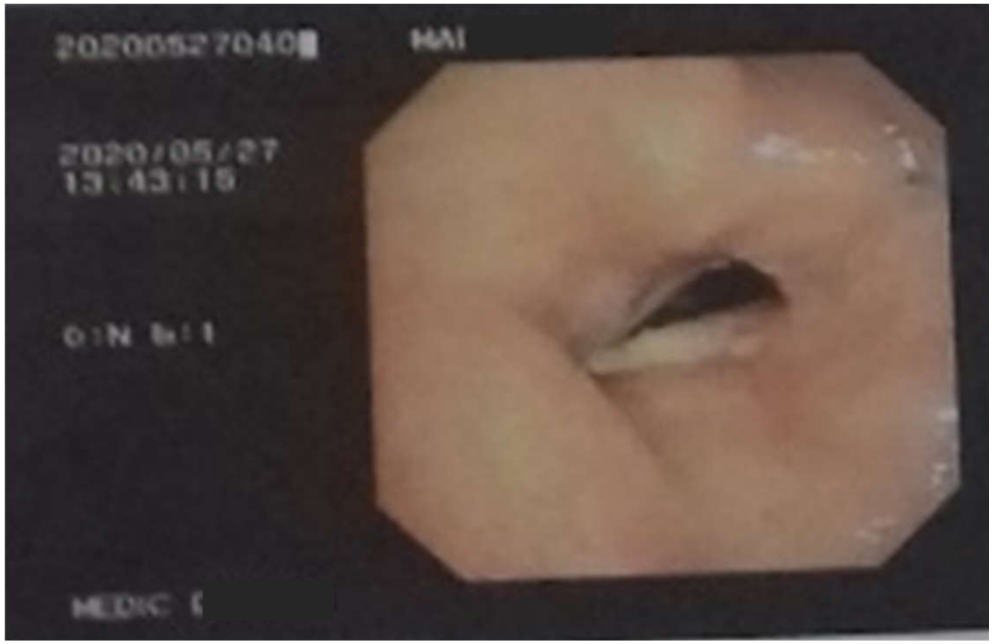
-LS:khan tiếng
-NS:Dây thanh sần sùi,có giả mạc trắng trên bề mặt

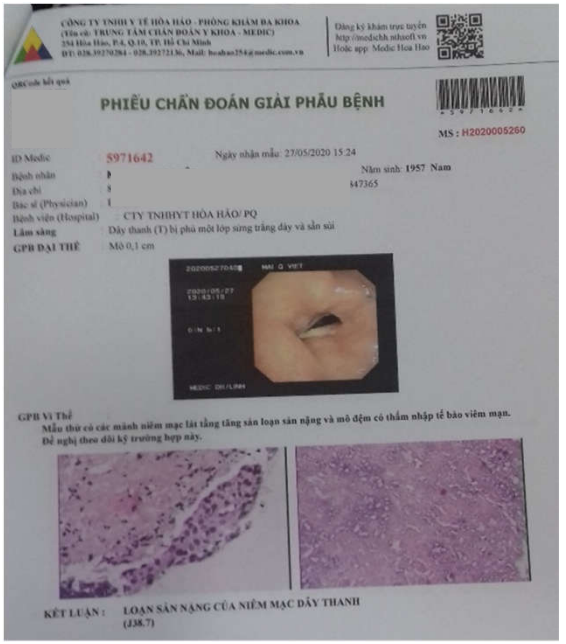




- GPB: Lớp thượng mô có tăng gai,tăng sừng và nghịch sừng.Mô đệm có thấm nhập viêm mạn
- KL: Bạch sản dây thanh âm

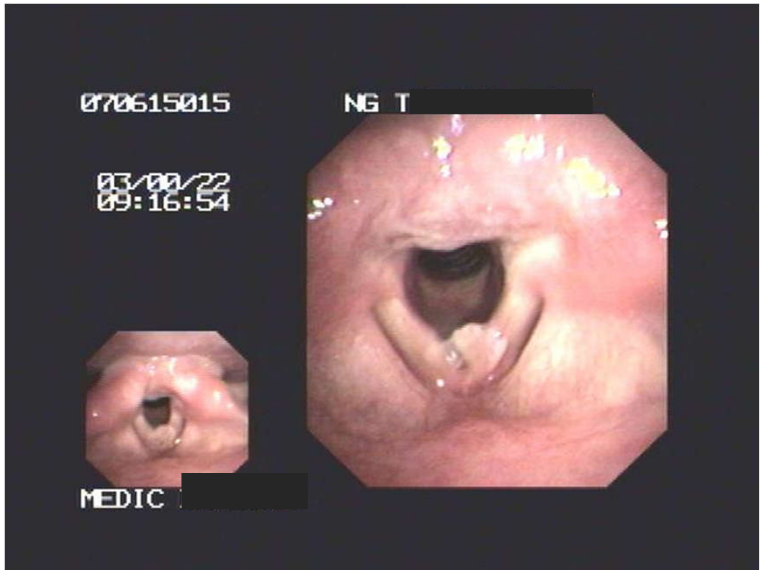
Case report:loạn sản



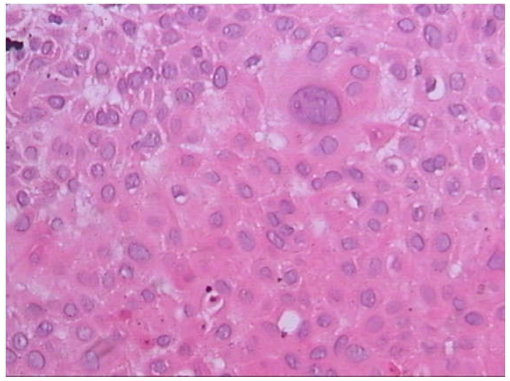


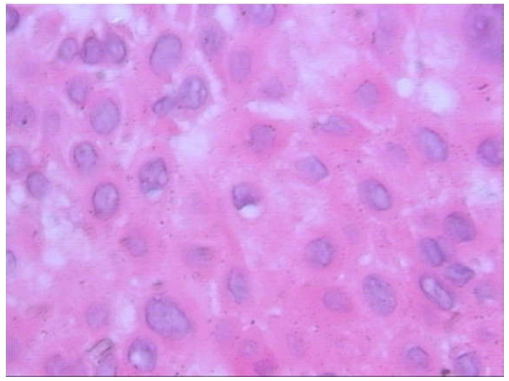
-LS:khàn tiếng
-NS:Dây thanh trái phủ 1 lớp sừng trắng ngà,dày và sần sùi

Case report:u nhú



-LS: khan tiếng
-NS:U dạng đa múi,mép trước thanh môn

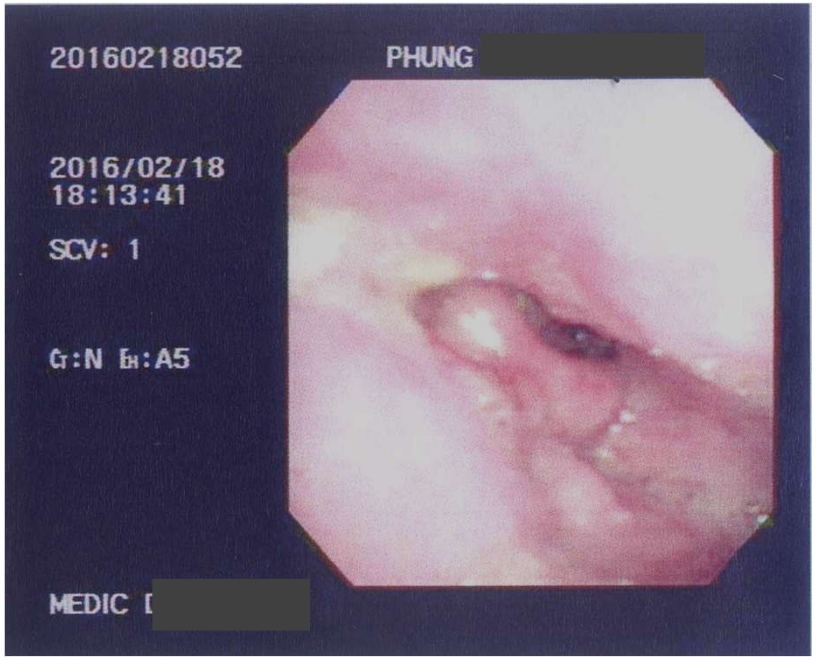


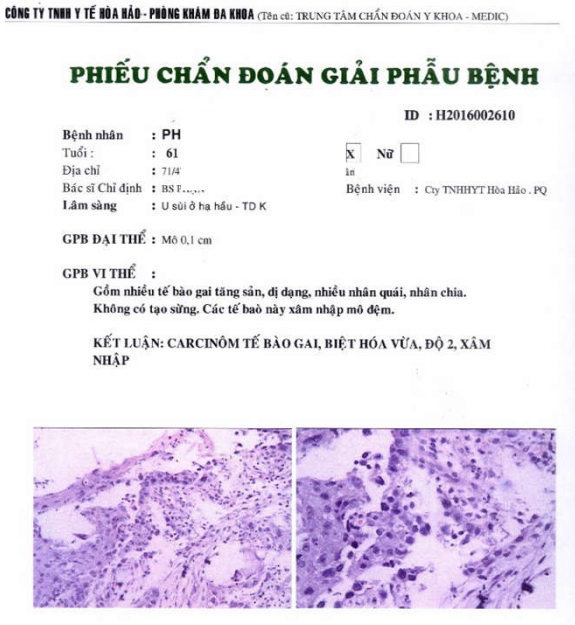


GPB: Sinh thiết có lớp thượng mô lát tầng tăng sản lành tính, tạo nhú, có trục liên kết mạch máu. Mô đệm thấm nhập tế bào viêm.

KL: U nhú gai thanh quản

Case report : K





CÔNG TY TNHH Y TẾ HÒA HẢO - PHÒNG KHÁM ĐA KHOA (Tên cũ: TRUNG TÂM CHẨN ĐOÁN Y KHOA - MEDIC)

PHIẾU CHẨN ĐOÁN GIẢI PHẪU BỆNH

ID : H2016002610

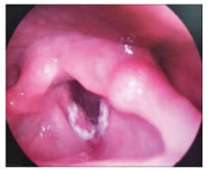
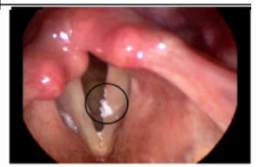
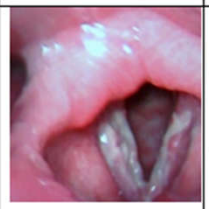
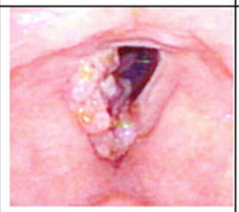
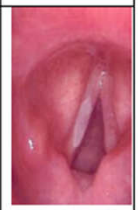
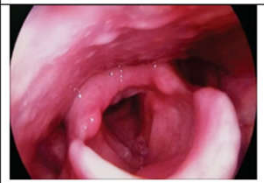
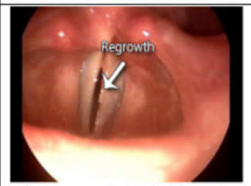
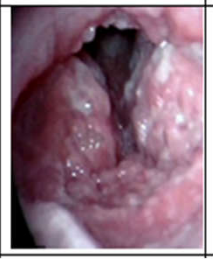
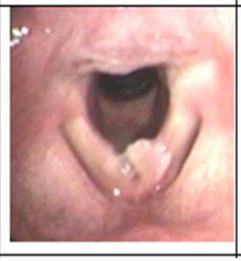
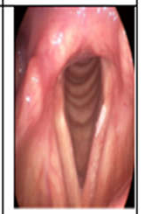
Bệnh nhân : PH
Tuổi : 61 Nữ
Địa chỉ : 71/4
Bác sĩ Chỉ định : BS T...
Lâm sàng : U sùi ở hạ hầu - TD K
Bệnh viện : Cty TNHHYT Hòa Hảo . PQ

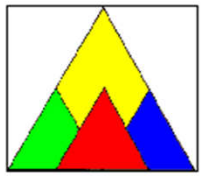
GPB ĐẠI THỂ : Mô 0,1 cm

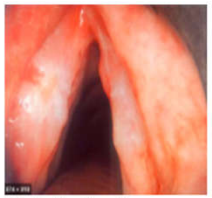
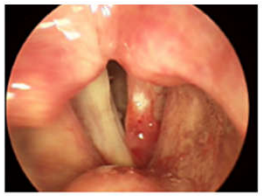
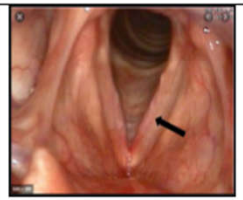
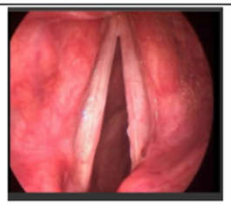
GPB VI THỂ :
Gồm nhiều tế bào gai tăng sản, đị dạng, nhiều nhân quái, nhân chia. Không có tạo sừng. Các tế bào này xâm nhập mô đệm.

KẾT LUẬN: CARCINÔM TẾ BÀO GAI, BIỆT HÓA VỪA, ĐỘ 2, XÂM NHẬP

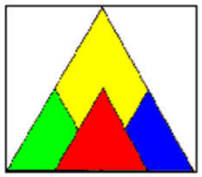
-LS:đau họng
-NS:U sùi ở hạ hầu.

Đặc điểm	Nấm thanh quản		K thanh quản		Lao thanh quản		U nhú		Bạch sản	
Yếu tố nguy cơ	suy giảm hệ thống miễn dịch như HIV/AIDS, ung thư, lao,rượu,hút thuốc lá, sử dụng corticoid dạng hít, kháng sinh kéo dài,gerd			**GERD, HPV, weakened immune systemtoxic exposure, voice overuse,smoking,alcohol**	Suy giảm miễn dịch,hiv		Suy giảm miễn dịch,Hpv, hút thuốc lá		Gerd,thuốc lá,rượu	
Triệu chứng	Ho khan, khàn tiếng, khó chịu họng, khó thở dai dẳng,sốt			Khàn tiếng đầu tiên,ho đau họng dai dẳng,khó thở,khạc ra máu	Ho đàm,máu,sốt,đau họng,khàn tiếng,khó thở		Khàn tiếng,khó thở		Khàn tiếng, đau họng	
Nội soi thanh quản (1 số tổn thương giống bệnh ác tính)	các mảng giả mạc trắng hay xám ở dây thanh(,khu trú 1 vùng,hay 1 số vị trí),trên 2 dây thanh	 các mảng trắng 1 vùng ,trên dây thanh hai bên		 Mảng trắng khu trú ,1 dây thanh	Phù nề,Loét sùi,giả mạc trắng		U sùi,khối đa múi,rải rác thanh quản		Lớp trắng trên bề mặt	
	Tổn thương loét sùi	 tổn thương loét sùi với các mảng màu trắng ở phần trước của 2 dây thanh		 Tổn thương loét sùi khu trú 1 dây thanh						



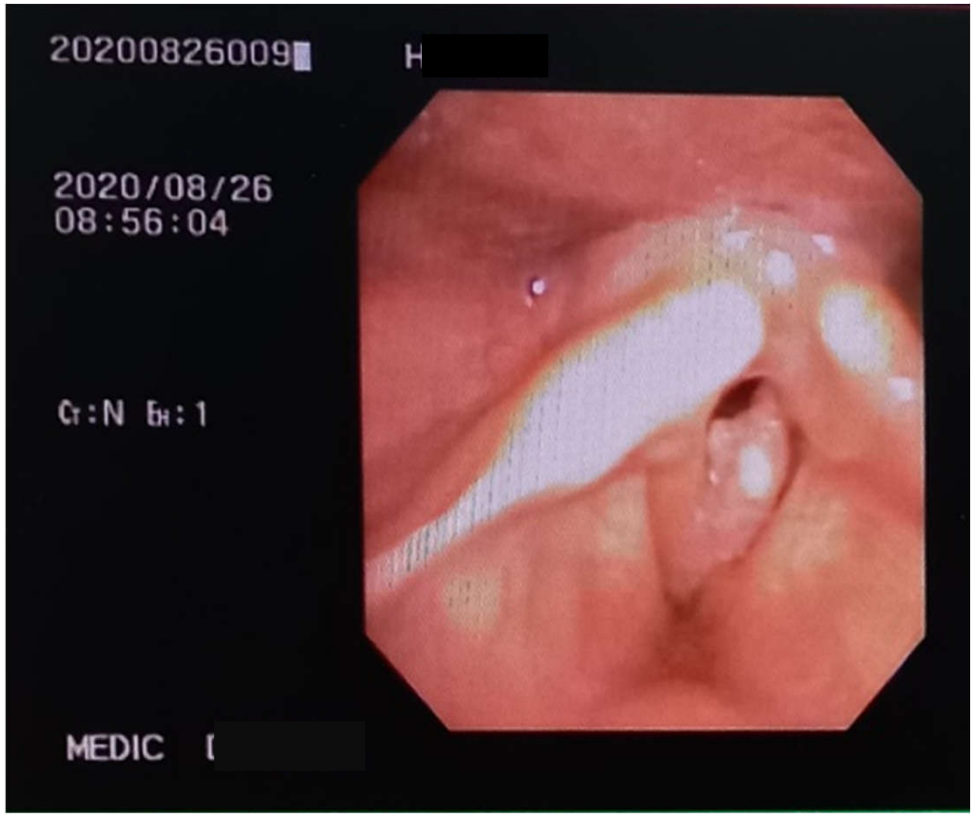
	Tổn thương đa hạt	 Cả 2 dây thanh		 Khu trú 1 dây thanh						
	Không đặc hiệu(case khó phân biệt)	 Dây thanh phù nề,xung huyết ban đỏ		 Dây thanh phù nề ,xung huyết						
Sinh thiết	Sinh thiết lấy bệnh phẩm đúng vị trí tổn thương,nhuộm soi,nuôi cấy	Các loại nấm phổ biến nhất gây viêm thanh quản là Candida . Các bệnh nhiễm nấm khác như Aspergillosis, Cryptococcal , Blastomycosis , Histoplasmosis	Sinh thiết tổn thương	Carcinom tế bào gai	Sinh thiết tổn thương	Phù hợp lao	Sinh thiết tổn thương	U nhú gai	Sinh thiết tổn thương	Bạch sản
	Cần phân biệt lao,k=>gpb không phù hợp ls =>cách xử trí ,theo dõi tiếp theo?		Nếu gpb không phù hợp ls(viêm,dị sản)=>cách xử trí theo dõi tiếp theo?							

CASE REPORT 1

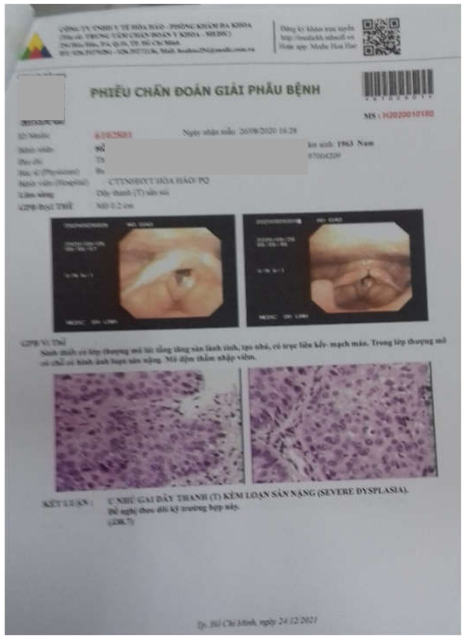


- Bệnh nhân :Hồ…,nam,57 tuổi
- Địa chỉ :Daklak
- LDĐK:Khàn tiếng

Lần 1 :26/08/20

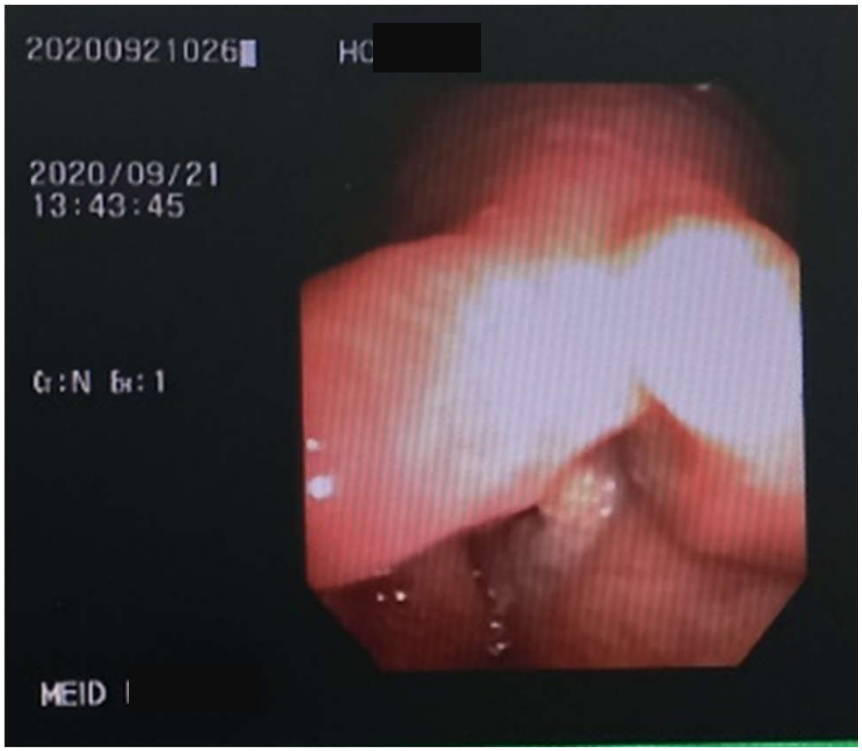


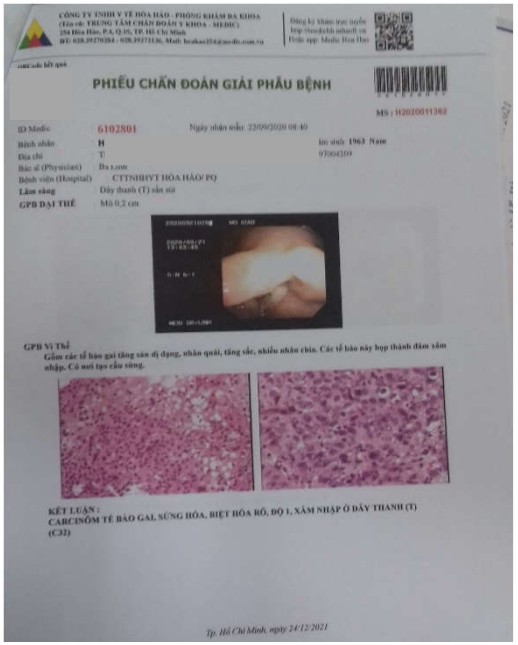
Dây thanh trái sần sùi


PHIẾU CHẨN ĐOÁN GIẢI PHẪU BỆNH

- GPB:U nhú gai kèm loạn sản nặng.

Lần 2:21/09/20

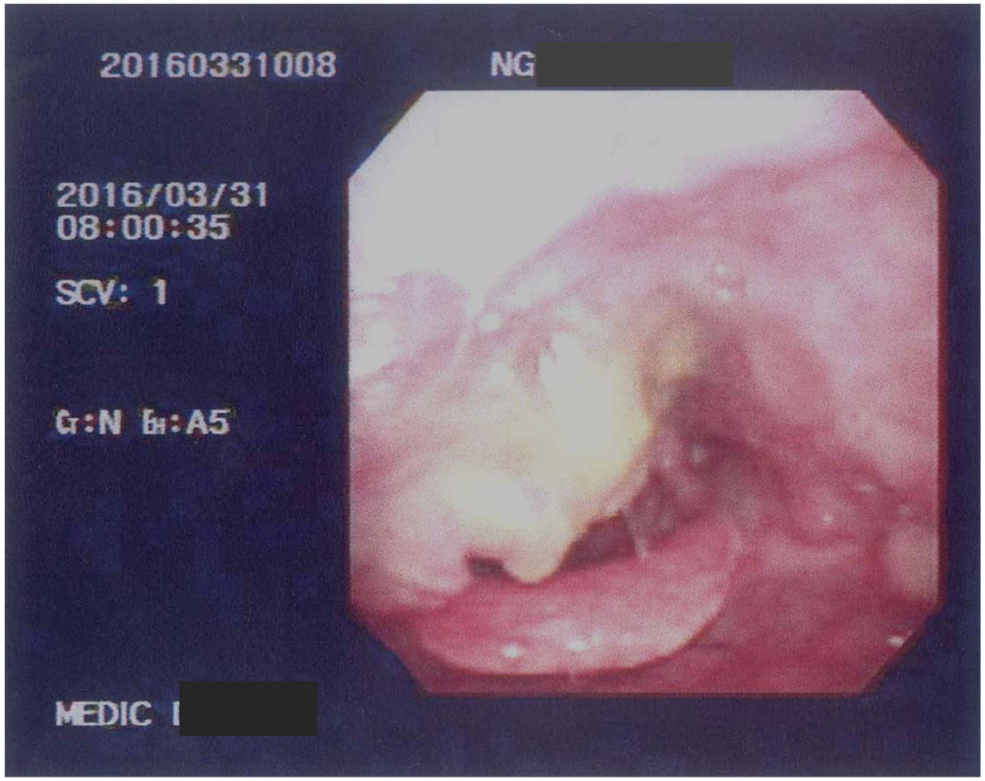




- GPB:Carcinom tế bào gai,sừng hóa,biệt hóa rõ,độ 1 ,xâm nhập ở dây thanh trái.

CASE REPORT 2

- Bệnh nhân:Nguyễn H T,nam,79 tuổi
- Địa chỉ:cm
- LDĐK:đau họng



-NS:U sùi thành phải hạ họng –xoang lê phải,sụn phểu phải

SINH THIẾT,GIẢI PHẪU BỆNH LẦN 1

CÔNG TY TNHH Y TẾ HÒA HẢO - PHÒNG KHÁM ĐA KHOA (Tên cũ: TRUNG TÂM CHẨN ĐOÁN Y KHOA - MEDIC)

PHIẾU CHẨN ĐOÁN GIẢI PHẪU BỆNH

ID : H2016004885

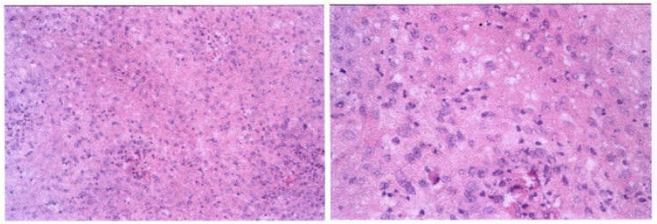
Bệnh nhân : NG
Tuổi : : 79 X Nữ ☐
Địa chỉ : 254 40964
Bác sĩ Chỉ định : BS Bệnh viện : Cty TNHHYT Hòa Hảo. PQ
Lâm sàng : U sùi thành sau hạ họng - xoang lê (P) + Sụn phễu (P) - TD K hạ hầu - thanh quản

GPB ĐẠI THỂ : Mô 0,05 cm

GPB VI THỂ :

Sinh thiết có lớp thượng mô lát tầng tăng sản lành tính, tạo nhú, có trục liên kết- mạch máu. Trong lớp niêm mạc có chỗ có hình ảnh dị sản nặng Mô đệm thấm nhập viêm.

KẾT LUẬN: U NHÚ GAI KÈM DỊ SẢN NẶNG (SEVERE DYSPLASIA) Ở NIÊM MẠC
Đề nghị theo dõi kỹ trường hợp này.



SINH THIẾT GIẢI PHẪU BỆNH LẦN 2

CÔNG TY TNHH Y TẾ HÒA HẢO - PHÒNG KHÁM ĐA KHOA (Tên cũ: TRUNG TÂM CHẨN ĐOÁN Y KHOA - MEDIC)

PHIẾU CHẨN ĐOÁN GIẢI PHẪU BỆNH

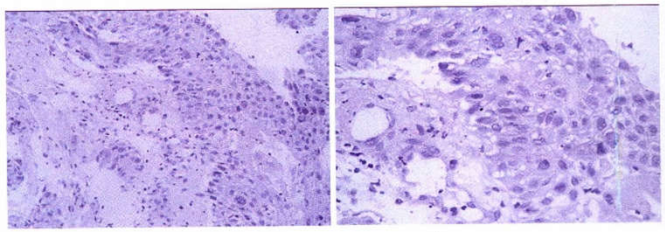
ID : H2016005040

Bệnh nhân : N
Tuổi : : 7 m [X] **Nữ** [ ]
Địa chỉ :
Bác sĩ Chỉ định : B.. ..... Bệnh viện : Cty TNHHYT Hòa Hảo . PQ
Lâm sàng : U sùi ở hạ hầu thanh quản - TD K

GPB ĐẠI THỂ : Mô 0,1 cm

GPB VI THỂ :
Mẫu thử có các mảnh niêm mạc lát tầng tăng sản dị sản nặng và mô đệm có thấm nhập tế bào viêm mạn.
Đề nghị theo dõi kỹ trường hợp này.

KẾT LUẬN: DỊ SẢN NẶNG CỦA NIÊM MẠC THANH QUẢN.



› Laryngorhinootologie. 1996 Oct;75(10):611-5. doi: 10.1055/s-2007-997643.

[Multiple biopsy in diagnosis of laryngeal carcinoma]

[Article in German]

A Welge-Lüssen [1], H Glanz, C Arens, P Oberholzer, R Probst

Affiliations + expand

PMID: 9035665 DOI: 10.1055/s-2007-997643

Abstract

Background: The fate of patients suffering from laryngeal carcinoma is influenced strongly by the stage of the tumor at the time of diagnosis. This factor is also critical for preservation of the organ. It may be impossible to diagnose the tumor with the first biopsy even though the clinical and macroscopic aspect suggests a malignancy.

Methods: In a retrospective study, we examined 468 patients with laryngeal carcinoma who were treated at the departments of otorhinolaryngology at the University of Basel (B) (198 patients from 1983-1992) or in Giessen (G) (270 from 1990-1995). The number of biopsies necessary to confirm the diagnosis was analysed and the follow-up of the patients was evaluated. Thirty of 32 negative histologic samples were reexamined.

Results: Of 468 patients, 32 (7%, 27 [B] 14%; and 5 [C] 2%) required two to six biopsies to confirm the clinically suspected diagnosis: Twenty patients (designated as Group 1) were diagnosed within one to three months, and no patient showed a change of tumor stage within that time. Their first biopsies have to be considered as "nonrepresentative". Eight patients (Group 2) were diagnosed within four to 24 months and four patients (Group 3) more than 24 months after the first biopsy. Final treatment and outcome in patients from Group 1 was unchanged by the time delay in diagnosing the tumor. Seven of eight patients in Group 2 experienced an obvious progression of their tumor during the diagnostic period, which led to laryngectomy in several cases. In four patients, diagnosis was confirmed more than two years after the first biopsy. These were special cases such as development of cancer out of a papillomatosis or chronic laryngitis.

Conclusions: A time delay of three months in diagnosing cancer of the larynx does not have a significant influence on organ preservation and prognosis, even though especially in small tumors suspicion of cancer should lead to a new representative biopsy as fast as possible to preserve the larynx.

Laryngeal dysplasia: Oncological outcomes in a large cohort of patients treated in a tertiary comprehensive cancer centre

Francesco Chu [a], Silvia De Santi [b], Marta Tagliabue [a], Luigi De Benedetto [a], Stefano Zorzi [a], Giacomo Pietrobon [a] ✉, Irene Herman [c], Fausto Maffini [d], Susanna Chiocca [e], Federica Corso [e], Sara Gandini [e], Mohssen Ansarin [a]

Abstract

Purpose

Laryngeal dysplasia represents a series of precancerous lesions, observed as laryngeal leukoplakia. General agreement has been lacking for their management and treatment ranging from simple biopsy to complete excision with cold blade/laser. In this work, we aim at providing the oncological outcomes of patients affected by laryngeal dysplasia, treated with a single modality, and at identifying clinical parameters predictive of malignant transformation.

Materials and methods

We performed a retrospective analysis of patients treated with transoral laser microsurgery between January 2005 and December 2015 in a tertiary comprehensive cancer centre. Data were collected about smoke and alcohol habits, site of the laryngeal lesion, surgical outcomes and progression to invasive squamous cell carcinoma.

Results

The grade of dysplasia, margins' status and smoke habit were not associated with a significantly worse DFS and a higher risk of invasive SCC. We identified three parameters (supraglottic involvement, multifocality and history of more than one recurrence of dysplasia) that have a significant prognostic value.

Conclusions

On the base of these clinical parameters, a more intensive follow-up might be warranted for high-risk patients.

Retrospective study on precancerous laryngeal lesions: long-term follow-up

Studio retrospettivo sulle precancerosi laringee: follow-up a lungo termine

G. RICCI, E. MOLINI, M. FARALLI, C. SIMONCELLI
Otorhinolaryngology and Cervico-Facial Surgery Clinic, University of Perugia, Perugia, Italy

Key words

Larynx • Precancerous lesions • Laryngeal cancer • Treatment

Parole chiave

Laringe • Lesioni precancerose • Tumori della laringe • Terapia

Summary

The classification and the most appropriate treatment of dysplastic lesions of the larynx continue to be controversial issues. Aim of present study was to evaluate the incidence of precancerous lesions of larynx, their potential to evolve in relation to grade of dysplasia, and the most appropriate treatment. The study is based on the review of a series of 207 patients (157 (75.9%) male, 50 (24%) female) with keratosis of the laryngeal epithelium, with or without dysplasia. Patients were divided into four groups, according to Friedmann's classification (1986), based on presence and grade of any dysplasia. The follow-up period ranged from approximately 7 to 16 years. With regard to progression of the disease, 159 of the 185 patients considered were cured following initial treatment (85.9%), whereas 26 (14.1%) had recurrences. Of the latter, 19 had a single recurrence and 7 had multiple recurrences. Progression to carcinoma occurred in a total of 12 cases, above all in patients with the highest grades of dysplasia. Results emerging from this study confirm not only that dysplastic lesions of the larynx have the potential to evolve into frankly malignant lesions, but also that this capacity to evolve is significantly correlated with grade of dysplasia of the covering epithelium. Therefore, the histological classification of precancerous lesions of the larynx, based on the presence or absence of atypical cells and on their severity, is clearly valid from a clinical standpoint, representing, above all, an important prognostic factor. As far as treatment is concerned, mucosal stripping at site of the lesion is considered to be the treatment of choice for precancerous lesions of the larynx. Nevertheless, in patients presenting keratosis with a higher grade of dysplasia, it is mandatory to consider more aggressive treatment.

Riassunto

La classificazione delle lesioni displastiche della laringe ed il loro più adeguato trattamento costituiscono tuttora argomenti assai controversi. Lo scopo di questo lavoro è stato quello di valutare l'incidenza delle lesioni precancerose della laringe, il loro potenziale carattere evolutivo in rapporto al grado di displasia ed il loro trattamento più adeguato. Lo studio si è basato sulla revisione di un gruppo di 207 pazienti affetti da cheratosi dell'epitelio laringeo, con o senza displasia. I pazienti sono stati suddivisi, secondo la classificazione di Friedmann (1986), in quattro gruppi in base alla presenza ed al grado della displasia eventualmente riscontrata. Il periodo di follow-up è risultato compreso tra 7 e 16 anni circa. Per quanto riguarda l'evoluzione della malattia, dei 185 pazienti considerati, 159 (85,9%) sono risultati guariti al primo trattamento, mentre 26 (14,1%) hanno presentato recidive. Di questi ultimi, 19 hanno presentato un'unica recidiva, mentre in 7 si sono manifestate recidive multiple. L'evoluzione in carcinoma si è avuta in 12 casi complessivamente, soprattutto nei pazienti con gradi più elevati di displasia. I risultati forniti da questo studio confermano che le lesioni displastiche della laringe possiedono un potenziale carattere evolutivo verso lesioni francamente maligne, e che tale capacità evolutiva risulta significativamente correlata al grado di displasia dell'epitelio di rivestimento. Pertanto, la classificazione istologica delle lesioni precancerose della laringe basata sulla presenza o meno di atipie cellulari e sulla loro gravità presenta una indubbia validità sul piano clinico e costituisce soprattutto un importante fattore prognostico. Dal punto di vista terapeutico, lo stripping della mucosa sede della lesione è considerato il trattamento di elezione delle precancerosi laringee. Tuttavia, nei soggetti affetti da cheratosi con displasia più elevata sembra senza dubbio opportuno considerare la necessità della attuazione di un trattamento più aggressivo.

Premalignant Lesions of the Larynx and their Management

[1]Arsheed Hussain Hakeem, [2]Imtiyaz Hussain Hakeem, [3]Sultan A Pradhan

[1]Consultant, Department of Head and Neck Surgery and Surgical Oncology, Prince Aly Khan Hospital, Mumbai, Maharashtra, India
[2]Resident, Department of Internal Medicine, Florida Hospital Medical Center, Orlando, Florida, USA
[3]Professor and Chief Oncologist, Department of Surgical Oncology, Prince Aly Khan Hospital, Mumbai, Maharashtra, India

Correspondence: Arsheed Hussain Hakeem, Consultant, Department of Head and Neck Surgery and Surgical Oncology Prince Aly Khan Hospital, Aga Hall, Nesbit Road, Mazagaon, Mumbai-400 010, Maharashtra, India, Phone: 09892871114 e-mail: drahhakim@gmail.com

Abstract

The classification and the most appropriate treatment of the precancerous lesions of the larynx continue to be controversial. It is an established fact that the dysplastic lesions of the larynx have the potential to evolve into malignant lesion. It is also well-known that the capacity of this transformation significantly correlates to the grade of dysplasia of the epithelium. The diagnosis, treatment, and prognosis of these lesions depend almost entirely on their histological abnormalities.
Keywords: Leukoplakia, Keratosis, Carcinoma *in situ*, Larynx.

INTRODUCTION

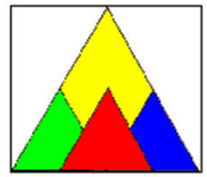
About 90% of malignant tumors of the larynx are carcinomas that often develop from premalignant lesions.[1] Therefore, early detection and prompt treatment should thus prevent the development of invasive cancer requiring more debilitating surgical resection. WHO (World Health Organization) defined premalignant lesions of the larynx as 'morphological alterations of the mucosa caused by chronic local irritative factors or referable to local expression of generalized illnesses, presenting a higher probability of degeneration into carcinoma with respect to surrounding mucosa'.[2]

However, it has been unanimously accepted that the diagnosis of a premalignant lesions of the larynx must be based on the histological characteristics of the lesion.[2] The histological classification of premalignant lesions, most closely followed for clinical purposes, is based on evaluation of the grade of hyperplasia and/or dysplasia of the epithelium. According to Hellquist et al.[3] a distinction can be made between Grade 1 lesions, presenting hyperplasia and/or keratosis with or without mild dysplasia, Grade 2 lesions characterized by moderate dysplasia, and Grade 3 lesions, in which dysplasia is severe or of such type as to configure carcinoma *in situ*. This grading is based on the classification proposed by the Kleinsasser in 1963[1] and later, by Delemarre,[4] distinguishing a first class characterized by simple squamous cell hyperplasia, a second class represented by squamous cell hyperplasia , with atypia and third class represented by carcinoma *in situ*. Freidmann,[5] proposed that dysplastic lesions of the larynx can be considered on the same scale as corresponding lesions of the uterine cervix. Thus, this classification distinguishes keratosis without dysplasia to keratosis with mild dysplasia (Laryngeal intraepithelial neoplasia or LIN 1), moderate dysplasia (LIN 2), and severe dysplasia or carcinoma *in situ* (LIN 3).

A classification proposed in Ljubljana, Slovenia, followed for more than 25 years, does not follow the three grade criteria but was devised to cater to specific clinical and histological laryngeal problems.[6,7] The working group of the European Society of Pathology re-evaluated and further formulated the histological criteria of Ljubljana classification in November 1997 in London, UK .The system is divided into 4 grades as follows:

- Simple hyperplasia (SH) is benign group.
- Abnormal (AbH) hyperplasia is benign group.
- Atypical Hyperplasia (AtH) is potentially malignant.
- Carcinoma *in situ* is malignant.

Malignant transformation of these lesions is a well-known fact. Simple and abnormal hyperplasia is considered benign forms with 0.7% and 1% risk of malignant transformation respectively. Atypical hyperplasia is precancerous lesion in the essential meaning of the word, with 9.5% of malignant alteration within 15 years.[6]



High-risk patients should be followed up in the same manner as T1 laryngeal carcinoma: monthly for the first year, two monthly for the second year, three monthly in the third year and six monthly in years 4 and 5
Low risk lesions-patients who have mild or moderate dysplasia with no visible lesion or hoarseness, or who are not smoking should be followed up for a minimum of 6 months. Following that, if the patient agrees then they may be discharged with instructions to return if there is a change in voice or other suspicious symptoms appear. It should be noted that there were diverse opinions regarding the follow-up duration of low-risk patients. Some clinicians recommended at least a 2 year follow-up, as the mean duration of risk of progression has been documented to be of that duration. Others recommend early discharge from clinic, with open or early return should patients develop anxiety, recurrence of their hoarseness, or 'throat symptoms'.Radiation therapy has not been shown to prevent the progression

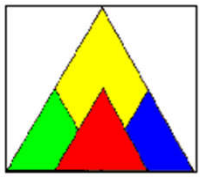
of dysplastic lesions to carcinoma; in fact, it may even precipitate malignant degeneration. Therefore, radiation therapy should be reserved for invasive carcinoma. Due to multicentricity of the cancer in hyperplastic lesions, random biopsies are discouraged. Excision biopsy is performed with special emphasis on preserving the structural integrity of the deeper uninvolved layers of the vocal fold and surrounding normal mucosa (Fig. 4).[11]
In the absence of carcinoma, the most hyper plastic lesions occur on the superior or ventricular surface of the vocal fold.[11] Therefore, dissection to the phonating edge of the vocal fold is not necessary for complete excision. The lesion is carefully dissected of the deeper layers of the lamina propria using precise phonosurgical technique (Fig. 6). This minimizes the chances of adversely affecting vocal function due to extensive vocal fold fibrosis. At the completion of the procedure, the specimen is labeled and sent for serial section to avoid missing a focus of carcinoma.
Difficulty in dissecting the lesions off the deeper layers of the lamina propria or vocalis muscle suggests an invasive carcinoma or significant fibrosis from previous surgery.

Persistent or Recurrent Precancerous Lesions

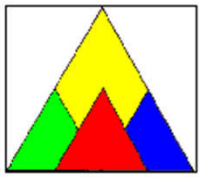
The management of the recurrent or persistent premalignant lesions depends mainly on their histology.

- Recurrent, focal mild or moderate dysplasia should be excised if possible.
- Recurrent, widespread mild or moderate dysplasia can be observed or excised: excision is especially under taken if there is change in appearance (erythroplasia) or texture (heterogenous, proliferative features).
- Recurrent, focal severe dysplasia: should be managed as a T1 laryngeal carcinoma with resection where possible. Radiotherapy may be considered by the multidisciplinary team in certain circumstances, including:
  - Patients who have had two or more recurrences
  - Patients who continue to smoke
  - Patients who have a high-risk of anesthetic complications
  - Patients who have access problems for surgery
  - Patient preference.
- Persistent or recurrent widespread severe dysplasia: Radiotherapy should be considered as an option by the multidisciplinary team and discussed with patients who have persistent or recurrent widespread severe dysplasia, especially in patients who continue to smoke

Bài học



- Các tổn thương ở thanh quản thường có đặc điểm lâm sàng,nội soi,giải phẩu bệnh đặc trưng nên chẩn đoán nhanh chóng ,chính xác.
- Tuy nhiên,có 1 số trương hợp khó chẩn đoán do không phù hợp giữa lâm sàng,nội soi,giải phẩu bệnh,dễ dẫn đến chẩn đoán sai lầm ,làm chậm trễ điều trị.
- Cách theo dõi,xử trí tiếp theo trong những trường hợp nghi ngờ theo những nghiên cứu để phát hiện sớm những trương hợp hóa ác.
- Xin ý kiến đóng góp ,chia sẻ kinh nghiệm của các thầy cô ,anh chị đồng nghiệp để việc chẩn đoán,điều trị,theo dõi những trường hợp sau này tốt hơn.



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CÁM ƠN QUÝ THẦY CÔ VÀ CÁC ANH CHỊ
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