**Vocal Fold Paralysis**

**Therapy Treatment Approaches for Vocal Fold Paralysis**

The expression vocal fold paralysis encompasses the condition of having reduced or rather total absence of the function accruing to the vagus nerve, the recurrent laryngeal nerve, or even its distal branch. There are several therapeutic treatment approaches for vocal fold paralysis. Nonetheless, this research paper focuses on discussing three of the approaches – medicalization laryngoplasty, tracheotomy, and arytenoid adduction as asserted by an effective literature review.

     According to Simpson & Rosen (2017), arytenoid adduction (AA) entails a paradigm surgery wherein the pull accruing to the LCA muscle encounters recreation with an aim of realizing vocal fold repositioning. This therapeutic approach is more effective for use in cases where the following conditions are prevalent – posterior glottis gap or a lateralized vocal fold amidst phonation and seriously foreshortened vocal fold. AA is further effective when there is the inability of realizing good voice notably when intraoperative with medicalization laryngoplasty solely and that the vertical height variation between the vocal folds prevails (universally the underlying paralyzed vocal fold proves to be superiorly located). Moreover, utilization of the AA approach is linked to four key resultant physiologic effects – lengthening of the vocal fold, lowering the rank of the underlying vocal process, rotating the patient’s arytenoid cartilage, as well as mediatizing and stabilizing the patient’s vocal process.  Invariably, an MPT (maximal phonation time) of not more than five seconds is a key predictor notably for the need of adopting AA in scenarios linked to vocal fold paralysis. Moreover, Pernas & Underbrink (2011) asserts the efficiency of recreating the LCA pull’s muscle to realize a productive and healthy repositioning of the vocal fold. They further stress on the condition that the underlying pyriform mucosa must undergo dissection off the prevailing muscular process accruing to the arytenoid.

    Furthermore, according to Cleveland Clinic (2017), medicalization laryngoplasty outstands as a good set-up therapeutic treatment regarding effective management of the condition of vocal fold paralysis as well as glottis inadequacy. Nonetheless, there has been a constrained attention on the experience linked to the elderly patients’ encounter with the operation. This article centralizes on the elderly patients since they are more susceptible to social isolation and depression and also comorbidities, conditions which can make them feel shy about the procedure. The Clinic appreciates the fact that vocal cord paralysis is capable of yielding substantial vocal handicap and eventually result in reduced quality of life as well as social isolation. Invariably, medicalization laryngoplasty proves to be successful surgery accruing to voice rehabilitation. From the examined sample of mean age 73 years, the postoperative outcomes indicated a 50% improvement on the voice handicap index score as well as the prevalence of 85% complete glottis closure. Only 3% of the patients called for a revision medicalization surgery, and hence this approach is fairly productive in the treatment of vocal fold paralysis. The article, via Dr. Bryson, asserts that the vast majority encountered an improvement regarding the voice-linked quality of life as well as low incidence of the potential complications. The approach was further successful despite the low consumption of aspirin by the elderly patients and there were no scenarios of amplified complications notably for the process. Universally, medicalization laryngoplasty is a successful, viable, and safe option regarding treatment of the elderly patients having a vocal handicap. Besides to that, Pernas & Underbrink (2011) emphasize on the condition that a successful medicalization laryngoplasty must involve exposure of the inferior muscular tubercle with an aim of defining the valid lower border that accrues to the patient’s thyroid cartilage. They further add that achieving an unencumbered medicalization must involve division of the thyroid cartilage’s inner perichondrium.

     In accordance with Mayo Clinic (2018), tracheotomy encompasses a surgical procedure of establishing a hole via the front of the patient’s neck as well as into the patient’s trachea (windpipe). The opening is called tracheostomy and it provides an effective air passage with an aim of assisting the patient in breathing especially once the typical breathing route is nearly impaired or rather obstructed. Invariably, once the tracheostomy is not needed anymore, it is allowed to undergo a healing process to shutting and it can as well be surgically closed. In addition to treatment of vocal fold paralysis, tracheotomy can be deployed in the therapeutic treatment of severe trauma that accrues to the neck or head and obstructs breathing. Additional applicable conditions encompass the medical conditions that narrow or block the patient’s airway, like throat cancer; and the medical analogies that call for utilization of a ventilator (breathing machine) for a lengthy duration, normally exceeding two weeks. Nonetheless, the emergency tracheostomies are hard to perform besides having an amplified danger of complications. During cases of emergencies, cricothyrotomy is a better approach – making a hole into the larynx just below the thyroid cartilage. Moreover, there are two main categories of tracheotomy – surgical tracheotomy and the minimally invasive tracheotomy approach. Mayo Clinic (2018) further highlights several conditions linked to maintenance of the made tracheostomy – speaking, caring for the underlying tracheostomy tube, coping with the dry air, eating, and coping with other scenarios.

**References**

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