A male patient, 58 years of age with a history of COPD, a smoker of one pack per day and occasional drinker reporting with a long history of mild dysphagia and difficulty in breathing of recent onset. On arrival at the Accident and Emergency Department the patient presented with marked dyspnoea, inspiratory stridor and supraclavicular retraction. ENT examination revealed laryngeal oedema and right-sided bulging of the area of the 3 vocal folds, with mucous membrane integrity. It was not possible to view the glottis.

Due to the patient’s worsening dyspnoea, it was decided to perform an emergency tracheotomy under local anaesthesia and clinical improvement was achieved. A computed tomography scan was performed during the patient’s stay in hospital which revealed a cystic lesion with a hydroaeric level in the axial images (Fig. 1) and an intra-extralaryngeal component on the right side with extension through the thyrohyoid membrane of 4.7 cm × 2.2 cm × 3.1 cm which could be determined in the coronal sections, with airway collapse, compatible with a superinfectected mixed laryngocele, along with the presence of the tracheotomy cannula and emphysema in the deep planes of the neck associated with said surgical history (Figs. 2 and 3).

Antibiotic treatment was started, and later a cervicotomy with block exeresis of the laryngocele was performed. The patient was decannulated subsequently as an outpatient, and is currently asymptomatic.

This form of laryngocele is rarely seen in clinical practice. The association with laryngoceles and cancer of the larynx should be taken into consideration, particularly in patients with risk factors.

Figure 1