CASE STUDY

Treatment of Two Cases of Forestier-Rotes-Querol’s Disease

Tratamiento de dos casos de enfermedad de Forestier-Rotes Querol

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Clinical Cases

Case 1

A 63-year-old male was referred to our department from Primary Care with odinophagia of several years’ evolution, with episodes of fluctuating dysphonia and dyspnoea. He has a history as a smoker and moderate drinker, COPD, hiatus hernia with gastroesophageal reflux and ankylosing spondylitis. Physical exploration showed no changes to the larynx, with protrusion of the posterior wall of the hypopharynx. Nasofibroscopy revealed no suspicious lesions or signs which could attribute the odinophobia to other diseases or concomitant conditions. A cervical CT found degenerative lesions with prominent osteophytes on the anterior face of vertebral bodies C3 and C4, and of less intensity on C2 and C5, which were distorting and compressing the hypopharynx (Figs. 1–3). The lack of involvement of the intervertebral discs and the absence of ankylosis were key to a diagnosis of Forestier’s disease. As the airway was not compromised, the condition was managed using hygiene and dietetic measures and anti-inflammatories. The hygiene and dietetic measures consisted of preferably following an easy-to-chew diet, avoiding foods with a heterogeneous consistency which could cause choking and making eating easier by using postural measures. The drugs used were oral ibuprofen 600 mg/8 h, preferably administered 30 min to 1 h before meals, only on the days when the patient felt the most severe discomfort. On the days that the odinophobia was most marked, he was also recommended to take 1 g of paracetamol or 575 mg metamizol, between doses of ibuprofen. He was also advised to stop smoking and drinking.

Case 2

A 74-year-old male diagnosed with Forestier-Rotes-Querol’s disease or diffuse idiopathic skeletal hyperostosis (DISH), undergoing outpatient monitoring of dysphonia and dyspnoea due to hypertrophy of the arytenoid mucosa caused by chronic irritation of the cervical osteophytes. He has a history of COPD and is an ex-smoker. The patient underwent endolaryngeal microsurgery, with partial resection of the arytenoid mucosa by CO₂ laser. Anatomopathological analysis showed epithelial hyperplasia with no dysplasia, with superficial keratosis and submucosal oedema with marked vasodilation. After surgery, the symptoms improved, and were controlled thereafter with the same hygiene and dietetic measures and anti-inflammatory agents as mentioned in case 1.

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by an increase in bone in certain anatomical locations. The spinal column is frequently affected, most commonly the cervical and dorsal regions. The main difference from other rheumatic diseases is the absence of cervical ankylosis or involvement of the intervertebral discs. In order to diagnose the condition, it is very important to observe the hard protrusion in the posterior wall of the oro- and hyperpharynx. Lateral radiography of the neck is helpful, easy and fast. However, CT scanning enables differential diagnosis from other conditions. Oesophagogram and high digestive endoscopy are reserved for cases where there is doubt.

The radiographic criteria laid down by Resnick help to establish a diagnosis: (1) ossification of the antero-lateral side of four contiguous vertebrae; (2) absence of ankylosis of the apophyseal joints or of the sacroiliac joint; and (3) preservation of intervertebral discs.6,7

Although a very varied clinical history has been described in these patients, it is more usual for them to present with symptoms such as a sensation of a foreign body, choking, dysphagia, cough and dysphonia. This is due to the involvement of the anterior ligament at dorsocervical level, osteophytes cause a mechanical problem which provokes pharyngeal symptoms; a perilesional inflammatory component adds to this problem, which justifies the partial improvement achieved with anti-inflammatories. Cricopharingeal muscle spasm and changes to the mobility of the epiglottis can also be a cause of dysphagia.

In terms of treatment, the great majority of authors propose conservative measures, using hygiene and dietetic measures in association with anti-inflammatories. A surgical approach is reserved for patients with incapacitating symptoms or when the airway and digestive tract are compromised. However, there are authors who defend surgery as the treatment of choice, using a transoral approach route for high cervical exostosis and anterolateral cervicotomy for low.6,7 Published work suggests that existing osteophytes should be removed together with an anterior cervical fusion, as ossification of the ligament progresses to rigidity, so that recurrence is likely if a cervical fusion is not performed.

In our work, the first patient presented with problems with swallowing and was managed conservatively (easy-to-chew diet and anti-inflammatories); the second patient presented with problems not only with swallowing, but also had an arytenoid oedema which could not be explained by other comorbidities; the problem was managed by resection of the excess mucous membrane by laser. The symptoms of both patients were relieved using this strategy and they are currently well-controlled.

**Conflict of Interest**

The authors declare no conflict of interest.

**References**