Two-month-old female patient brought to Endoscopy Service for consultation due to inspiratory stridor present since birth, swallowing disorder and increasingly difficult respiration. Cervical X-ray in profile revealed a mass at the base of the tongue (Fig. 1A); fibreoptic laryngoscopy showed a round mass that caused posterior prolapse of the epiglottis. A cervical sonogram was performed and thyroid function was assessed, ruling out the possibility of lingual thyroid.

Direct laryngoscopy was performed under general anaesthesia (Fig. 1B), as well as diagnostic transoral puncture, after orotracheal intubation to ensure the airway; a gelatinous fluid was seen from the puncture. The cyst was completely resected using a CO$_2$ laser under microscopic control (Fig. 2A).

The patient was extubated in the operating theatre, fed orally within 24 h and given postoperative treatment with antibiotics and corticoids. Pathology reported that the wall of the cyst was lined with stratified pavement epithelium, without cellular atypia, confirming the diagnosis of epithelial-type laryngeal cyst (Fig. 2B). There were no complications. The patient remained asymptomatic at the 6-month follow-up.

Figure 1  (A) Profile cervical X-ray showing cystic image (arrow). (B) Endoscopic image of the vallecular cyst.
Duct cysts represent 75% of congenital laryngeal cysts. They arise from the obstruction of the submucosal gland ducts and are mainly found in the vallecula. Although congenital vallecular cysts are rare, they should be included in differential diagnosis of stridor and progressive obstruction of the airway in newborns and infants. Marsupialization is rarely sufficient; complete removal of the cyst wall is necessary to prevent relapse.