سامية محمد مصطفى

شبكة المعلومات الجامعية

بسم الله الرحمن الرحيم

سامية محمد مصطفى

شبكة المعلومات الجامعية

شبكة المعلومات الجامعية

التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

سامية محمد مصطفى

جامعة عين شمس

التوثيق الإلكتروني والميكروفيلم

قسم

نقسم بالله العظيم أن المادة التي تم توثيقها وتسجيلها علي هذه الأقراص المدمجة قد أعدت دون أية تغيرات

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بالرسالة صفحات لم ترد بالأصل


بسم الله الرحمن الرحيم

بسم الله الرحمن الرحيم

سبحانك

لا علم لنا إلا ما علمتنا إنك

أنت العليم الحكيم

صدق الله العظيم

THE MANAGEMENT OF LARYNGEAL AND TRACHEAL STENOSIS. ENDOSCOPIC TREATMENT BY LASER VERSUS EXTERNAL TECHNIQUES

Thesis

Submitted to the Faculty of Medicine, University of Alexandria,
In partial fulfillment of the requirements of the degree of

DOCTOR OF
OTORHINOLARYNGOLOGY

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بسم الله الرحمن الرحيم

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TO MY FAMILY

TO MY WIFE

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INTRODUCTION

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Laryngotracheal stenosis has been and remains one of the most vexing problems in the field of head and neck surgery. Today, trauma is the most common cause of laryngeal subglottic and tracheal stenosis. This may be accidental or iatrogenic from prolonged intubation or a high tracheotomy. Other etiologies include congenital stenosis, caustic injury, sarcoidosis, Wegener's granulomatosis and relapsing perichondritis[1]

The numerous articles describing a variety of treatment modalities indicate an absence of uniformity for the successful approach to these problems. Thorough knowledge of the laryngotracheal development, anatomy and physiology is a prerequisite for understanding the pathophysiology and for an adequate treatment of patients with laryngotracheal stenosis.[2]

Development of the larynx and trachea:

During the 4th week of embryonic development the laryngotracheal groove can be seen in the pharynx. The respiratory diverticulum is in open communication initially with the foregut. When the diverticulum extends caudally it becomes separated from foregut by the development of the esophagotracheal ridge which later turns to a septum dividing the foregut into the esophagus and the trachea and the lung buds. The respiratory primordium maintains its open communication with the pharynx through the laryngeal orifice.[2,3]

The laryngeal orifice rapidly changes from sagittal slit to a T-shaped opening. The cartilages and muscles originate from the mesenchyme of the fourth and sixth branchial arches. When the cartilages are formed the typical adult shaped larynx can be seen at about 12 weeks.[3]

The hyoid bone is derived from mesenchymal cells that form cartilaginous masses in the 2nd and 3rd branchial arches. The lesser horn is derived from the 2nd branchial arch while the body and the greater horn are derived from the 3rd branchial arch.[4]