

DELAYED PRESENTATION OF A SELF-INFLICTED LARYNGEAL INJURY: 13 DAYS WITHOUT MEDICAL CARE – A CASE REPORT

KESİCİ ALETLE OLUŞAN BOYUN YARALANMASININ 13 GÜN
GECİKMiŞ BAŞVURUSU: NADİR BİR OLGU SUNUMU
Laringoloji

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Özet

Penetran boyun yaralanmaları, önemli morbidite ve mortalite ile ilişkili otorinolarenjolojik acillerdir. Bu raporda, intihar girişiminden 13 gün sonra adli değerlendirme amacıyla polis tarafından acil servise getirilen bir hastayı sunuyoruz. Muayenede, sağ tiroid kıkırdağının üzerinden endolarengeal bölgeye uzanan epitelize olmuş bir laserasyon saptanmış olup aktif kanama veya solunum sıkıntısı yoktu. Bilgisayarlı tomografi incelemesinin ardından trakeostomi ve debridmanı içeren cerrahi onarım uygulanmıştır. Ameliyat sonrası süreç yoğun bakım takibi ile yönetilmiştir. Trakeostomi ameliyat sonrası 5. günde dekannüle edilmiş; 7. günde yumuşak-sıvı diyet başlanmıştır. Takip laringoskopisi, fistül veya majör komplikasyon olmaksızın vokal kord fonksiyonlarının korunduğunu göstermiştir.

Anahtar kelimeler: Larengeal travma; boyun yaralanması; intihar; kesici aletle boyun yaralanması; penetran boyun yaralanması,

Abstract

Penetrating neck injuries represent otorhinolaryngologic emergencies associated with significant morbidity and mortality. In this report, we present the case of a patient who was brought to the emergency department by law enforcement for forensic evaluation 13 days after a suicidal incident. On examination, an epithelialized laceration extending from above the right thyroid cartilage into the endolaryngeal region was identified, without active bleeding or respiratory distress. Computed tomography imaging confirmed the trajectory of the injury, and surgical repair—including tracheostomy and debridement—was subsequently performed. Postoperative management included intensive care follow-up. The tracheostomy was decannulated on postoperative day 5, and a soft-liquid diet was initiated on day 7. Follow-up laryngoscopy revealed preserved vocal cord function with no evidence of fistula formation or other major complications.

Keywords: Laryngeal trauma; neck injury ; suicide; sharp neck injury ; penetran neck injury,

Introduction

Penetrating neck injuries, often resulting from suicide attempts, assaults, or accidents, constitute medical emergencies due to the potential involvement of the airway, esophagus, or major blood vessels. Such injuries require a prompt multidisciplinary approach. Early admission is crucial, especially for deep incisions [1]. In this report, we describe an unusual case of a patient who delayed hospital admission for 13 days after a deep self-inflicted neck injury due to fear of legal repercussions.

Case Report

A 29-year-old male was brought to the emergency department (ED) by law enforcement for forensic evaluation,

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following the discovery of his deceased wife. A foul odor led neighbors to alert authorities. Upon investigation, the patient was found with a concealed neck wound, which he covered with his coat collar.

Initial examination revealed a 5 cm laceration in cervical zone II, extending from above the superior right thyroid cartilage into the endolaryngeal region, with epithelialized margins and no active bleeding (Figure 1a). The patient admitted to a suicidal attempt 13 days prior but abandoned the act. He had survived on minimal food and fluids, covering the wound while drinking. Vitals were stable, with no respiratory distress. Hemoglobin was 15.9 g/dL; toxicology was negative, with no known psychiatric history.

Computed tomography (CT) imaging confirmed the trajectory of the penetrating injury (Figure 1b).



Figure 1

(a) Initial presentation of the penetrating neck injury. The blue arrow indicates the right thyroid cartilage (b) CT scan showing the path of the penetrating neck injury

Following preoperative preparation, the patient underwent surgery. Orotracheal intubation was performed via video laryngoscopy. A tracheostomy was performed, and the endotracheal tube was removed. Surgical findings showed no esophageal injury. Due to chronic inflammation, the thyrohyoid membrane and strap muscles could not be clearly identified (Figure 2a,b).

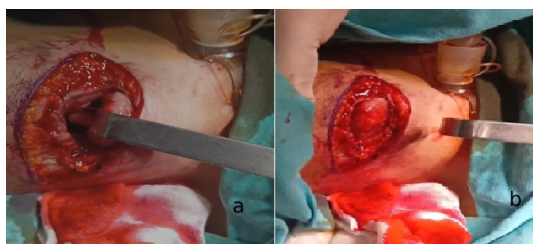


Figure 2

Intraoperative views from the surgeon's perspective. (a) Right thyroid cartilage retracted inferiorly; (b) Overview of the surgical field

Laryngeal structures and strap muscles were repaired using 3-0 prolene and vicryl, respectively. Nasogastric tube (NG) placed for nutrition.

Postoperatively, the patient was monitored in the intensive care unit (ICU). After dislodgement of the nasogastric tube (NG), intravenous nutrition was required. The patient remained in the ICU due to concerns about compliance and monitoring. Tracheostomy was decannulated on postoperative day 5, and a soft-liquid diet was initiated on day 7 (Figure 3).

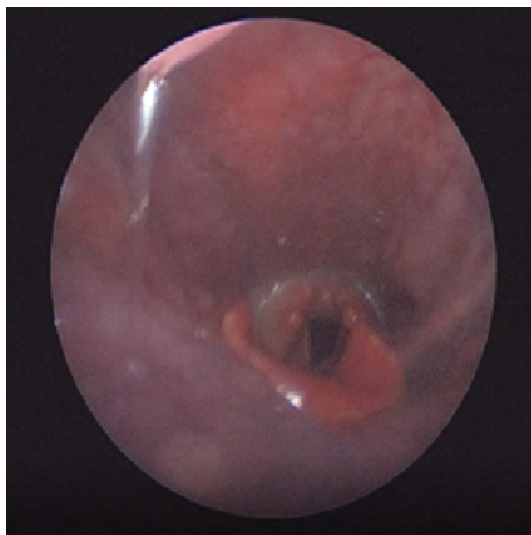


Figure 3

Laryngoscopic view on postoperative day 7

Mild hoarseness was noted, but laryngoscopy revealed mobile vocal cords and no significant pathology. The patient was discharged on day 12, and no complications were observed at one-month follow-up.

Discussion

Penetrating trauma to the cervical region poses a significant risk of morbidity and mortality due to the density of vital anatomical structures within the area. Multiple studies have identified the most frequent clinical manifestations of such injuries, including respiratory distress, subcutaneous emphysema, hoarseness, stridor, dysphagia, and hemoptysis [1].

Despite deep endolaryngeal injury, no distress or bleeding occurred during the 13-day delay. He stated that he covered the wound with his hand while drinking water. According to the anatomical classification proposed by Roon and Christensen, the neck is divided into three zones: Zone I spans from the clavicles to the cricoid cartilage, Zone II from the cricoid cartilage to the angle of the mandible, and Zone III from the angle of the mandible to the base of the skull [2]. The injury in this patient involved Zone II, the region most frequently implicated in laryngeal trauma.

In patients presenting to the ED with penetrating neck injuries, securing the airway is the first and most critical step, especially in the presence of respiratory distress. For hemodynamically stable patients, preoperative CT imaging provides valuable insight into possible injuries involving vascular or visceral structures. When vascular injury is suspected, CT angiography is the preferred diagnostic modality. In cases with suspected esophageal involvement, esophagoscopy may also be beneficial [3]. In the present case, there was no clinical suspicion of vascular or esophageal injury; thus, standard CT imaging was considered sufficient.

Tracheostomy is often required for airway safety in laryngotracheal penetrating neck injuries. Surgical repair depends on injury location and extent. In our case, there was no active bleeding; however, due to the 13-day delay in presentation, the wound edges were epithelialized and inflamed, necessitating thorough debridement in addition to primary repair.

According to the Schaefer-Fuhrman classification, laryngeal injuries are categorized into five grades. Grades I and II represent minor trauma with edema, hematoma, and nondisplaced fractures. Grades III and IV involve more severe findings such as significant mucosal lacerations, exposed cartilage, or vocal cord immobility. Grade V is the

most severe form, characterized by complete laryngotracheal separation [4]. In our case, intraoperative and clinical findings were consistent with a Grade III injury, as there was evidence of exposed cartilage without complete structural disruption. In some Grade I injuries, conservative treatments are possible, whereas in more severe injuries, such as this case, surgical repair is inevitable [4].

Nutritional management following penetrating neck trauma is most commonly achieved through NG placement [3]. Nonetheless, in patients with anticipated prolonged recovery or limited compliance, early consideration of gastrostomy may offer more reliable enteral access [5]. In the present case, premature dislodgement of the NG tube occurred on postoperative day two, underscoring the challenges associated with maintaining enteral feeding in uncooperative patients. Optimal timing of oral feeding is unclear; on day 7, the patient drank water without supervision. Given the absence of aspiration or other adverse effects, a soft-liquid diet was initiated the same day. Oral feeding was well tolerated, with no evidence of coughing, aspiration, or pharyngolaryngocutaneous fistula formation.

Primary repair within 24 hours reduces infection and fistula risk [3]. Remarkably, despite a 13-day delay in presentation in the present case, no such complications were encountered.

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