Hoarseness of unclear origin in adults

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1 Hoarseness is a common cause of primary care visits

In primary care, 1% of visits are for hoarseness, most commonly self-limited laryngitis. However, laryngeal cancers account for 1% to 2% of principal diagnoses associated with hoarseness.[1]

2 Primary care providers often treat chronic hoarseness of unclear origin empirically

Sixty-four percent of primary care providers who responded to a US survey reported that they treated chronic hoarseness of unknown cause medically, despite a lack of evidence for this practice.[2] The most common medications they prescribed in this context were antireflux agents, antihistamines and antibiotics.[2] This practice should be avoided as it can delay the diagnosis of serious disease.[3]

3 The larynx should be visualized in a patient with a three-month duration of hoarseness of unclear origin[4]

Over half of laryngeal squamous cell carcinomas originate on the vocal folds and present with hoarseness as an early sign of disease. These cancers are identifiable by laryngoscopy, requiring referral to an otolaryngologist.

4 Referral should be considered earlier for patients with red flags

If red flags (Box 1) are present, the threshold to refer should be lower. The most important risk factor for laryngeal squamous cell carcinoma is a history of smoking.

5 Outcomes for laryngeal squamous cell carcinomas are correlated with stage and time to diagnosis

Early-stage disease can be treated by either radiation or larynx-preserving surgery with good outcomes for oncology, voice and swallowing.[5] Advanced local disease is generally treated with chemoradiation or total laryngectomy; however, these patients often have substantial impairment of function after treatment and decreased survival compared with patients with early-stage disease (five-year disease-specific survival 54%–66% v. 85%–95%), respectively.[3] Even in early-stage disease, delays of 12 months or longer in referral for diagnosis of laryngeal squamous cell carcinoma have been associated with an increased risk of local and/or regional recurrence (adjusted hazard ratios 4.6 and 9.5, respectively, $p < 0.02$).[6]

Box 1: Red flags that should lower the threshold to refer a patient with hoarseness to otolaryngology[3]

- History of smoking (10 pack-years or more)
- Enlarged cervical lymph nodes
- Progression of hoarseness without fluctuation
- Referred otalgia
- Dysphagia or aspiration
- Odynophagia or throat pain
- Hemoptysis
- Stridor or dyspnea
- Unexplained weight loss
- Alcohol consumption exceeding low-risk levels

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