Left Jugular Phlebectasia in an Elderly Patient

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Jugular phlebectasia, a rare disease in which the jugular vein becomes distended for unknown reasons, is frequently detected with indolent neck swelling. It frequently presents as transient soft bulges in the lateral neck attributable to increased intrathoracic pressure with breath-holding. It is also known that jugular phlebectasia develops more frequently in the right jugular vein because this vessel is more subject to the effects of increased intrathoracic pressure than the left jugular vein. Congenital abnormalities of the venous walls and carotid sheaths are considered to be the causes of this disease; therefore, its development in childhood is described in most case reports. We herein report left jugular phlebectasia without neck swelling in an elderly patient.

A 74-year-old woman had noticed a sensation of neck pressure when lying on her left side for 10 years. About 1 year before coming to our facility, a severe abnormal sensation of the left laryngopharynx had been noted, and she consulted an otolaryngologist. She had a history of hypertension, for which she was taking antihypertensive agents.

At the consultation, no masses were detected on palpation of the neck. No neck swelling was observed even with the Valsalva strain maneuver. A pulsating bulge in the posterior wall of the left oropharynx, which is attributed to an aberrant course of the internal carotid artery, was detected by inspection of the oral cavity (Figure A). There were no swollen cervical lymph nodes. Cervical computed tomography showed left jugular phlebectasia with a maximum diameter of 30 mm (Figure B). Three-dimensional computed tomography revealed significant fusiform distension of the left jugular vein (Figure C and D). Color Doppler ultrasound showed distension of the lumens and blood flow cessation with the Valsalva strain maneuver and resumption of blood flow and reduction of the lumen diameter without this strain (Figure E and F). There was no thrombus formation.

Various causes of abnormal sensations in the laryngopharynx have been considered. In our case, a pulsating bulge in the posterior wall of the left oropharynx was detected by inspection of the oral cavity, and we additionally performed imaging tests leading to a diagnosis of jugular phlebectasia. Because jugular phlebectasia frequently develops in childhood and on the right side, congenital thinning of the carotid sheaths and the presence of an anatomic venous perfusion impairment have been suggested. Although rare, there are reports of this disease in adults. Acquired factors such as inflammation, injury, and the state of Valsalva strain are considered to contribute to its development in adults.

In many cases with jugular phlebectasia, imaging tests such as computed tomography, MRI, and ultrasound show characteristic findings leading to a definitive diagnosis. Laryngeal diverticulum, laryngocele, and superior mediastinal tumors and cysts are important mass lesions that show size changes with the Valsalva strain maneuver. These disorders should be distinguished from jugular phlebectasia.

In the past, jugular phlebectasia was generally resected surgically for fear of possible increases in size and exacerbation of the condition. However, recent long-term observational studies have documented numerous asymptomatic patients with favorable courses, and conservative therapy has now become a mainstream treatment. Surgery is considered only when there is evident thrombus formation, a tendency for an increase in the size of the distension, or a cosmetic problem. Although rare, there are cases with thrombus formation causing intracranial symptoms; therefore, it is important to make an accurate diagnosis in the early stage. Our present patient had no thrombus formation or subjective symptoms, such as neck swelling, and her clinical course was thus observed.

We treated an elderly patient with left jugular phlebectasia but no neck swelling who consulted an otolaryngologist with the chief concern of an abnormal sensation of the laryngopharynx. This case shows the importance of screening for abnormal sensations of the laryngopharynx.

Disclosures

None.

References

Figure. An elderly patient with left jugular phlebectasia. A, A pulsating bulge in the posterior wall of the left oropharynx (arrows). B, Cervical computed tomography showing left jugular phlebectasia with a maximum diameter of 30 mm (arrow). C and D, Three-dimensional computed tomography showing significant fusiform distension of the left jugular vein (C, coronal section; D, sagittal section). E, Color Doppler ultrasound showing distension of the lumens and blood flow cessation with the Valsalva strain maneuver. F, Color Doppler ultrasound showing resumption of blood flow and reduction of the lumen diameter without the Valsalva strain maneuver.
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