

Intralesional use of Bevacizumab in Adult Recurrent Laryngeal Papillomatosis

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1. Introduction

Recurrent laryngeal papillomatosis (RLP) is a disease characterized by the development of exophytic proliferative lesions of the connective tissue, covered by epithelium, which affects the mucosa of the airways. The responsible agent is human papillomavirus (HPV) infection, and it has a great predilection for the larynx [1]. The most frequently found viral subtypes are HPV 6 and 11, in 90% of cases. Subtypes 16 and 18 are rarer in children with PLR, but if they are present there is a greater potential for malignancy [2].

Recurrent laryngeal papillomatosis has an incidence in the US of 4.3 per 100,000 in the pediatric population and 1.8 per 100,000 in adults [1]. In Peru, few studies have determined the epidemiology of papillomavirus, and there are no reports on the incidence of PLR. A study with 5,435 patients in the department of San Martín determined an incidence of HPV of 12.6% [3]. The presence of high-risk HPV was 33.6% in a study of 2,208 women in different cities of the country, and 34.49% in a study of 2,247 [4]. In an investigation with 1,099 individuals from a poor district of Lima, the presence of oral HPV and high-risk oral HPV was identified, 6.8% and 2.0%, respectively [5].

The virus initially infects the basal layer of the epithelium through minor abrasions. The E6 and E7 proteins, expressed by the virus, inactivate the regulatory factor interferon, allowing the HPV infection to remain persistent and asymptomatic [6]. Additionally, an important factor in determining the reappearance of lesions is vascularity in tumor growth, initiated by vascular endothelial growth factor (VEGF) [7].

There is currently no consensus on the best and most effective single or combined treatment for the management of PLR. The

most used method is surgery (CO2 laser, KTP, cold technique, microdebrider or tracheostomy), which maintains the objective of providing a safe airway avoiding complications of stenosis and voice disorders. However, the aggressiveness and recurrence of the disease makes the use of adjuvant therapy necessary in some patients [1, 2, 7].

The present case shows us a female patient diagnosed with recurrent laryngeal papillomatosis treated with the cold technique and bevacizumab as adjuvant therapy.

2. Clinical Case

A 53-year-old female patient, hypertensive controlled with valsartan and atenolol, without harmful habits. She presented a diagnosis of recurrent laryngeal papillomatosis since 1973, with 45 laryngeal microsurgeries (cold technique), the last of which was in September 2013. She presented with 42 years of disease characterized by persistent dysphonia and recent respiratory distress. The voice disability index-10 (VHI-10) was 28 at her admission. Flexible laryngoscopy revealed papilloma-cough lesions in the epiglottis, arytenoids, bands, aryepiglottic fold, and incomplete glottic closure (Figure 1).

The first surgery required a prior tracheostomy due to extensive airway compromise, and the tracheostomy was removed 5 days postoperatively. The resection of the papillomatous lesions was by means of video-assisted laryngeal microsurgery with a rigid endoscope and cold technique, and sublesional injection of 2 mL of bevacizumab at a concentration of 16.5 mg/mL (33 mg in total per dose, distributed in all the lesions), present). Two more infiltrations were performed, with an interval of 6 weeks, after nasofibrosopic evaluation. The control 12 months after the first application of bevacizumab showed an VHI-10 of 5, and absence of lesions (figure 2).

The 2002 Official Patients Sourcebook On Laryngeal Papillomatosis

**Icon Health Publications, James N.
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