pressure effect of the injected drugs, or a partly subdural

drug injection.

Declaration of interest

None declared.

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Uvular trauma from a laryngeal mask

Editor—Sore throat is common after operation with reported
rates of around 40% after intubation and around 7–12% in
laryngeal mask use.1 Pain typically resolves after 24–36 h.
However, persistent or worsening pain, associated with a sen-
sation of something in the throat, odynophagia, or gagging, is
a rare occurrence and likely to indicate some degree of uvula
trauma (oedema or necrosis) or infection.

Uvula necrosis has been reported after tracheal tube
intubation as far back as 1978.2 Necrosis of the uvula may
also occur after long-term intubation,3 blind suctioning,4
gastrointestinal endoscopy,5 and transnasal bronchoscopy.6
Necrosis is thought to result from simple mechanical inter-
ruption of blood supply to the uvula tip.

We report the case of a female, aged 32 who presented to
ENT emergency clinic with severe oropharyngeal pain, dyspha-
gia, and difficulty swallowing. The oropharyngeal pain had
worsened over 3 days since undergoing a minor
gynaecological procedure 4 days previously under general an-
aesthesia with a laryngeal mask airway. The procedure was
short, lasting 15 min, no throat pack was used, and there
was no use of oropharyngeal suctioning perioperatively.

After operation, the patient noted an oedematous uvula
which progressively became indurated, blue and latterly
turned white. These changes were accompanied by worsen-

ing oropharyngeal pain unresponsive to paracetamol and ibu-
profen. Visual inspection revealed a necrotic uvula (Fig. 1).
She was treated conservatively with reassurance, augmented
analgesia, hydrogen peroxide gargles, and prophylactic anti-
bacterial cover with a good outcome.

Uvular trauma has been reported after laryngeal mask
airway (LMA) use.7 LMA cuffs are permeable to nitrous oxide
and carbon dioxide, which can result in increased cuff pressure
during prolonged procedures, resulting in postoperative sore
throat and pharyngeal/uvula oedema. However, this is unlikely
in this case, given the short anaesthetic.

Review of the literature back to 1984 produce 14 reported
cases where routine perioral interventions have led to uvula
necrosis. Details regarding age and gender were available in
nine cases [eight males, mean age 34.5 (range 20–57)], sug-
gesting that males are more at risk of severe uvula oedema
or necrosis. Given the younger age of many of these cases,
trauma/oedema/necrosis may result from a relaxed ap-
proach to oropharyngeal care as this group may be seen as
having fewer co-morbidities and shorter procedure times.
However, it is more likely, as is the case in obstructive sleep
apnoea, that men may be truly at greater risk of uvula/phar-
yngeal trauma, given that there are significant structural dif-
fferences in the upper airway between men and women. Men
have significantly more non-fat soft tissue in the neck, espe-
cially a more bulky tongue and soft palate.8 This non-fatty
tissue is predominantly muscle and thus on reduction in
muscle tone as a result of anaesthesia or sleep may result
in flaccid soft tissue that is prone to mechanical disturbance.

Whatever the mechanism of trauma leading to uvular
necrosis, potentially severe airway compromise can result.
We suggest that it is prudent to consider male patients
undergoing day-case procedures as ‘at more risk’ of

Fig 1 Uvular necrosis.
pharyngeal soft tissue damage and be made aware of potential postoperative complications.

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