A few hints for a good Indirect Laryngoscopy (IDL)

You should have a set of three IDL mirrors number 2, 3, 4 and 5. Have three sets at least and keep on changing these when they lose their polish.

- Make the patient sit straight without any bend in the back and ask him to bend his forehead a bit forward making an angle of 10 degrees.

- Begin doing IDL with largest possible mirror and then shift to smaller mirrors if you cannot see the structures. For seeing anterior commissure, you will need mirrors number 2 or 3.

- I usually ask the patient to say “aaaa” this pulls the soft palate back and brings uvula into view. In this space you can place your mirror pushing the uvula back and up.

- Begin with base of tongue and go up to sub glottis step by step spending a few moments on each part, do not jump on to vocal cord movements straightway…this comes much later.

- I always say each part is both independent and part of the whole.

- The areas which will need your special attention are:
    - Arytenoids
    - Inter-arytenoid area
    - False cords
    - Anterior commissure
    - Pyriform sinuses

- When looking for the moments of the larynx do not simply look at true cords, see if the arytenoid moving as well. Because if there is a paralytic lesion you will find that even the arytenoids will not move, even without looking at cords you will come to learn about a paralytic lesion if you see an immobile arytenoid and pooling of secretions in the pyriform sinuses. Another evidence of paralysis is asymmetry of arytenoids and aryepiglottic folds. So by the time you reach true cords you already have made up your mind about an immobile hemilarynx.

- When you see true cords, look at each of these separately and collectively, only then you can make an idea which is immobile and which one is moving, first of all look at the rima glottidis.
    - What its shape
    - Is there any glottis chink left?
    - In which part this chink remains anterior or posterior.
    - Do vocal cords meet in midline or not?
    - Is any vocal cord overshooting midline?
    - What is the tension level of the vocal cord? Is it lax, sagging, boat shaped?

- You may have to repeatedly ask the patient to say “eeeeee” before you can conclude paralysis of one cord.

- In my experience there is no term as vocal cord weakness, it is either paralysed or not, nothing in between.

- you can judge about VC paralysis by looking at one cord alone, you must see both of these… and see the relative force of their movement. So asking the patient to do deep breathing and speaking repeatedly is essential.

- Pooling of secretions is an indirect evidence of VC paralysis. Another thing you must remember to look for area of the PF sinuses. Silver Jackson sign indicates obstruction below… may be in post cricoid area or in oesophagus.

- The causes of an immobile vocal cord include:
    - Direct extension of the growth to the crico-arytenoid joint.
    - Direct extension of the growth to the muscles especially the thyroarytenoid.
    - Invasion and involvement of the branches of recurrent laryngeal nerve in paraglottic space
    - Mechanical obstruction to the movements of the cord by mass effect of the growth
- Similarly, difficult to see areas of larynx include:
    - Laryngeal surface of epiglottis. (Have you ever noticed laryngeal tubercle on IDL)
    - Ventricle (and saccule)
    - Anterior commissure
    - Subglttis

      (To see difficult to see area on IDL is an indication of DL)

- Finally, there are two types of malignant growths of supraglottis:
    - Exophytic (which are usually referred to ulcero-nodular or nodular or cauliflower in appearance)
    - Infiltrative (which might have an ulcerated or crater type look. They have raise margins which are also referred to as pushing margins)
    - When you do IDL and see a mass in the suprglottis you should describe it as you would describe any other mass, size, site, color, surface, mobility, subsites involved, mobility of the hemilarynx i.e. vocal cords., involvement of lateral pharyngeal wall and the pyriform sinuses.