Al Ameen J Med Sci 2025;18(4):326-334 ● US National Library of Medicine enlisted journal ● ISSN 0974-1143

ORIGINAL ARTICLE CODEN: AAJMBG

Epiglottic Cysts – A retrospective case series study from a tertiary care hospital

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Received: 08th July 2025; ***Accepted:*** 22nd September 2025; ***Published:*** 01st October 2025

Abstract: *Background:* Epiglottic cysts, were diagnosed de novo, few previously undiagnosed or asymptomatic, and may be incidentally found during intubation. Surgical management basically consists of marsupialization and excision. *Aim of the study:* To highlight the situations of diagnosis of epiglottis cysts including being detected during intubation. To report the surgical method used for the treatment. *Materials:* Fourteen patients who underwent endoscopic Microlaryngeal surgery after being diagnosed under general anesthesia at our hospital over an eight year period retrospectively. *Results:* 14 patients with epiglottis cysts were reported out of 3584 patients in different encounters in a tertiary care Hospital. 04 were diagnosed in children aged less than 12 years. 05 patients were aged between 25 and 38 years. 04 were aged between 55 and 68 years and 01 in the age group of 69 to 75 years. The incidence was 0.39% among the entire OPD of the Hospital. *Conclusions:* In the present study and our experience with patients undergoing oral surgery under general anesthesia, epiglottis cysts were encountered more often than previously documented. Video laryngoscopes (VLs) proved to be generally effective in aiding intubation in these cases. It is advisable to have VLs readily accessible to manage unforeseen challenges with ventilation and intubation. When available, preoperative imaging such as craniocervical CT or MRI should be thoroughly reviewed.

Keywords: Epiglottis, Cyst, Congenital, Microlaryngeal, excision and video-endoscopy.

Introduction

Epiglottic cysts are relatively rare, accounting for about 0.025–0.1% of benign laryngeal masses, and are often detected incidentally during laryngoscopy or intubation [1]. Their reported incidence during laryngoscopy is around 0.08%, with large cysts being even rarer (0.02%). While more common in males and typically seen in infants or adults in their 50s, many cysts remain undetected due to a lack of symptoms [2]. When present, symptoms can include hoarseness, discomfort, dysphonia, dysphagia, or dyspnea.

Although often asymptomatic and managed conservatively, surgical removal is recommended if airway obstruction, symptoms, or sleep apnea is suspected. Recurrence after proper excision is uncommon. Laryngeal cysts, particularly those originating from the epiglottis, represent uncommon benign entities of the upper aerodigestive tract, with a predilection for the lingual surface of the epiglottis. These lesions constitute approximately 5–10% of all benign laryngeal pathologies reported in the Indian pediatric demographic [1-2].

Although frequently asymptomatic, they can manifest with signs of upper airway obstruction, feeding difficulties, or stridor in pediatric patients, warranting timely identification and surgical intervention to avert potential complications [3-4]. Dutta et al. report the incidence of congenital laryngeal cysts in India at 1.87 per 100,000 live births, with epiglottis cysts comprising approximately 30% of these cases [5].

Reports of epiglottis cysts in neonates and infants remain sparse in Indian literature, with fewer than 50 cases documented from rural regions over the past decade [6]. Laryngeal cysts are uncommon benign lesions of the upper aerodigestive tract, characterized by epithelium-lined cavities containing fluid or mucus within the laryngeal structures.

Epiglottic cysts represent about 5–10% of all benign laryngeal lesions in the Indian population, with a slightly higher incidence in males (ratio 1.5:1), based on data from Indian tertiary care centers [7].

These cysts are broadly classified into ductal (retention) cysts arising from obstructed mucous gland ducts and saccular cysts, which result from congenital anomalies, inflammation, or trauma. Dharambir et al [8] proposed a widely adopted classification system based on anatomical location and histopathological features. Anatomically, laryngeal cysts are most commonly found in the epiglottis (30%), followed by the aryepiglottic folds (20%), vallecula (10–15%), and vocal cords (10%), with fewer cases in other laryngeal regions [9]. Cysts on the lingual surface of the epiglottis are particularly rare, with a reported prevalence of less than 0.3 per 10,000 children, according to Reddy et al [10].

In adults, epiglottic cysts are often asymptomatic and discovered incidentally during endoscopic evaluations. In contrast, pediatric patients especially infants under one year may exhibit significant symptoms even with small cysts (1–2 cm), due to their narrow and compliant upper airway [11]. A multicenter study across five Indian states found that symptomatic cysts in infants had a median diameter of just 1.8 cm, compared to 2.7 cm in adults [12]. The etiology of epiglottic cysts is multifactorial, commonly involving mucous gland obstruction, chronic inflammation from laryngopharyngeal reflux, or embryological ductal remnants.

Singh et al [13] have also linked upper respiratory infections particularly in rural Indian children to cyst development, likely due to limited healthcare access. Diagnosis typically involves flexible nasopharyngolaryngoscopy for initial visualization, supported by contrast-enhanced CT or MRI for surgical planning. Direct laryngoscopy under general anesthesia remains the gold standard for both diagnosis and treatment. Surgical removal is the definitive treatment, with approaches including endoscopic marsupialization, complete excision, and CO_2 laser ablation [14]. The Association of Otolaryngologists of India recommends complete excision to reduce recurrence, which occurs in up to 10% of marsupialization cases. Postoperative outcomes are usually excellent with minimal complications in experienced hands. Despite their clinical significance, epiglottis cysts remain underreported in Indian pediatric literature, particularly in rural areas. A systematic review by Gupta et al [15] found only 37 documented pediatric cases in the past two decades 89.2% of which were from urban tertiary centers [15].

As emphasized by the Indian Council of Medical Research, early recognition and timely referral from primary healthcare providers are critical to improving outcomes. The present case aims to contribute to the limited body of rural pediatric data and raise awareness among healthcare providers in resource-constrained environments [16].

Material and Methods

Retrospective review of case sheets of 14 patients with epiglottis cyst belonging to a period of 08 years from June 2014 to June 2022 was done. These patients reported from a tertiary care Hospital in Andhra Pradesh. An Institute ethics committee approval was obtained before starting the study. The IEC approved proforma was used for the study.

Inclusion Criteria: Patients aged between 01 and 68 years were included. Patients of both the genders were included. Patients with epiglottis cyst diagnosed under different situations were included. Child patients with complaints of poor feeding, nocturnal snoring, and intermittent cyanotic episodes over a period of 01 to 03 months were included.

Exclusion Criteria: Patients already undergone laryngeal surgery was excluded. Patients with malignant lesions of the Larynx were excluded. Patients with incomplete case sheets were excluded. Upon referral from other departments, the patients were subjected to video laryngoscopy and video clip recorded. Comprehensive evaluation was undertaken in all the patients. The clinical assessment revealed mobile, cystic masses with measurements varying from 2.8×2.5 cm to 4.2x4.9 cms. The cysts were originating from the lingual surface of the epiglottis and partially compromising the upper airway.

All the patients were subjected to hematological and biochemical investigations, including complete blood count, thyroid function tests, and serum electrolytes, were within normal reference ranges. The differential diagnosis of epiglottic cyst, vallecular cyst, ectopic lingual thyroid, and laryngeal hemangioma were kept in mind, as proposed by Sharma et al. in their analysis of pediatric laryngeal masses [7]. Contrast-enhanced computed tomography (CT) of the head and neck delineated a well-defined, non-enhancing cystic lesion arising from the epiglottis, corroborating imaging patterns observed in similar cases reported by the All India Institute of Medical Sciences [8].

The *Cormack–Lehane classification system* was used in assessing the view of the Larynx while intubation was carried out. This method, used in anaesthesiology, is designed to classify the view seen during direct laryngoscopy, focusing mainly on the visibility of the glottis and adjacent laryngeal structures. Developed in 1984 by British anaesthesiologists R.S. Cormack and J. Lehane, it serves as a tool for predicting the difficulty of tracheal intubation. In 1998, a revision of the system was introduced, which further divided Grade 2 to improve its accuracy in predicting intubation challenges. All patients underwent general anesthesia, which was induced using continuous remifentanil infusion (0.1–0.3 μg/kg/min), along with intravenous doses of propofol (1.0–1.5 mg/kg) and rocuronium (0.6 mg/kg). Anesthesia was maintained with either sevoflurane (~1.5%) or desflurane (~4%) in combination with remifentanil infusion. Mask ventilation was uncomplicated, and all patients experienced smooth anesthesia emergence and extubation. The details were collected from each patient's anesthetic record.

Results

Among the 14 patients there were 08/14 (57.14%) males and 06/14 (42.85%) females with a male to female ratio of 1.3:1. Children aged between 01 and 12 years were 4/14 (28.57%), aged between 13 and 25 were 02/14 (14.28%), aged between 26 and 37 were 03/14 (21.42%), aged between 38 and 50 were 03 (21.42%), aged between 51 and 63 years were 01/14 (14.28%), and aged above 64 years were 01/14 (14.28%), (Table 1).

Table-1: Showing the age, gender, clinical features and Intra-operative findings and final outcome of 14 patients (n-14)

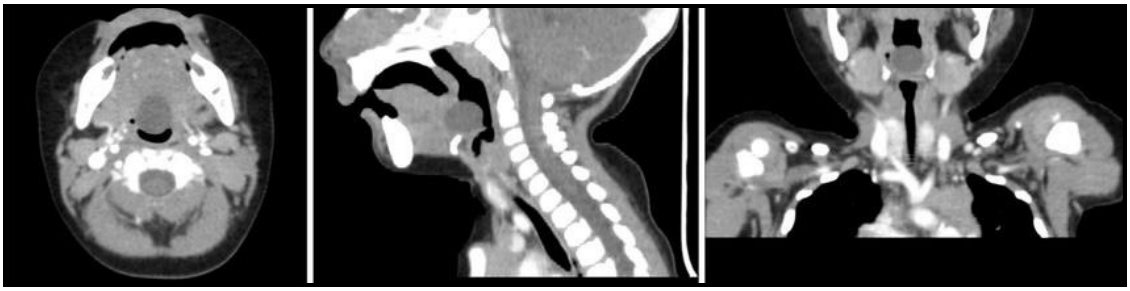
Observations	01 to 12 Yrs (04)	13 to 25 Yrs (02)	25 to 37 Yrs (03)	38 to 50 Yrs (03)	51 to 63 Yrs (01)	>64 Yrs (01)
Gender						
Male	02	01	02	02	00	01
Female	02	01	01	01	01	00
BMI						
<25Kg/M^2	04	01	01	02	00	01
>25 Kg/M^2	00	01	02	01	01	00
Symptoms						
Dyspnea	03	02	01	00	00	00
Snoring	03	01	02	01	00	00
Difficulty to feed	03	00	01	00	01	01
Stertor	00	01	01	02	00	01
None	00	00	01	01	01	00
Timing of the diagnosis						
With symptoms	0	01	01	00	00	00
During intubation	2	01	00	02	00	00
Routine ENT	01	01	01	00	00	01
Examination	01	00	01	01	01	00

Observations	01 to 12 Yrs (04)	13 to 25 Yrs (02)	25 to 37 Yrs (03)	38 to 50 Yrs (03)	51 to 63 Yrs (01)	>64 Yrs (01)
Cormack-Lehane Grade						
III	00	00	01	00	00	00
II	01	01	01	01	00	00
I	03	01	01	02	01	01
Intubation difficulty						
None	03	01	01	00	00	00
Moderate	01	01	01	01	00	01
Difficult	00	00	01	02	01	00
Location- Side of Epiglottis						
Right	01	01	01	00	00	00
Left	02	01	01	01	00	01
Central	01	00	01	02	01	00
Size in cms						
1.5x1.5	01	01	01	01	00	00
2x2	02	01	01	02	00	00
2.5x2.5	00	00	00	01	00	00
3x3	01	01	00	00	01	00
3.5x3.5	00	00	01	00	00	01
4x4	00	00	00	00	00	00
Colour						
Yellow	01	01	01	01	00	01
Pink	01	01	01	01	00	00
Pale yellow	01	02	00	00	00	00
Red	01	01	01	01	01	00
Surgical methods adopted						
Marsupialization	01	01	01	01	00	01
Aspiration and Marsupialization	01	01	01	01	00	00
Excision	02	00	01	00	02	00
Marsupialization and debrider excision	00	00	00	02	01	00
Cyst rupture						
Yes	01	01	01	02	00	00
No	03	01	02	01	01	01
Post op follow-up						
Recurrence	00	00	00	00	00	00
Infection	00	00	00	00	00	00
Voice change	01	01	01	01	01	01
Difficulty breathing	00	00	00	00	00	00

The mean age was 21.43±3.45 years in males and 20.55±2.75 years in females. The BMI was <25Kg/M^2 in 09/14 (64.28%) patients and >25Kg/M^2 in 05/14 (35.71%) patients. Dyspnea was noted in 06/14 (42.85%) patients, snoring was noted in 07/14 (50%) patients. Difficulty to feed was noted in 06/14 (42.85%) patients, Stertor was noted in 05/14 (35.71%) patients, and no symptoms in 03/14 (21.42%) patients. Only 02/14 (14.28%) patients were diagnosed with symptoms pointing to the lesion, during intubation the cyst was noted in 05/14 (35.71%) patients and on regular ENT examination in 04/14 (28.57%) patients (Table 1).

Cormack-Lehane grading of visualization of the Larynx view was grade III in 01/14 (07.14%) patient, Grade II in 04/14 (28.57%) patients, Grade I in 09/14 (64.28%) patients. Intubation difficulty was experienced in 04/14 (28.57%) patients, Moderate difficulty in 05/14 (35.71%) patients and no difficulty in 05/14 (35.71%) patients. Epiglottis cyst was noted on the right side in 03/14 (21.42%) patients, on the left side in 06/14 (42.85%) patients and in the midline in 05/14 (35.71%) patients (Fig1).

Fig-1: Showing the midline Epiglottic cyst on CT scan



The size of the Epiglottis cyst was varying from 1.5x1.5 cms in 04/14 (28.57%) patients, 2x2 cms in 06/14 (42.85%) patients, 2.5x2.5 cms in 01/14 (07.14%) patient, 3x3 cms in 03/14 (%) patients, 3.5x3.5 cms in 02/14 (14.28%) patients and 4x4 cms in none (Table 1). The colour was yellow in 05/14 (35.71%) patients, the colour was pink in 04/14 (28.57%) patients, it was pale yellow in 03/14 (21.42%) patients and Red in 05/14 (5.71%) patients (Fig 2, 3 and 4).

Fig-2: Showing the Red colored Epiglottis cyst

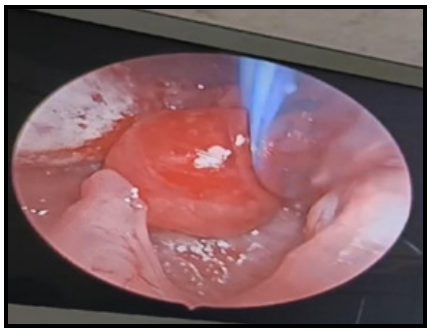
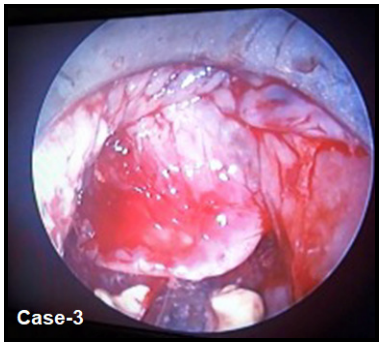


Fig-3: Showing the epiglottis cyst involving the Lingual surface of Epiglottis (Case 3 and 4)



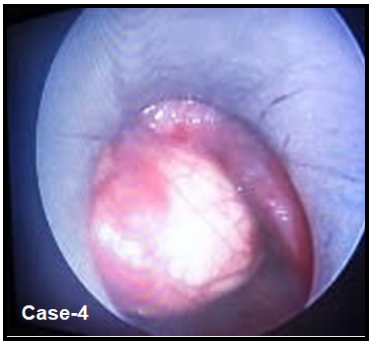
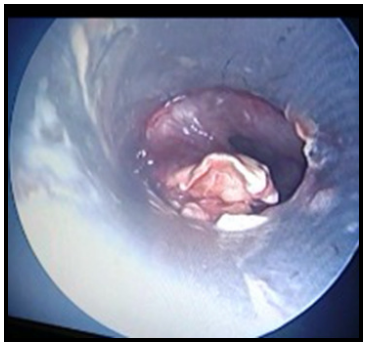


Fig-4: Showing the post-operative endoscopy image (case 4)



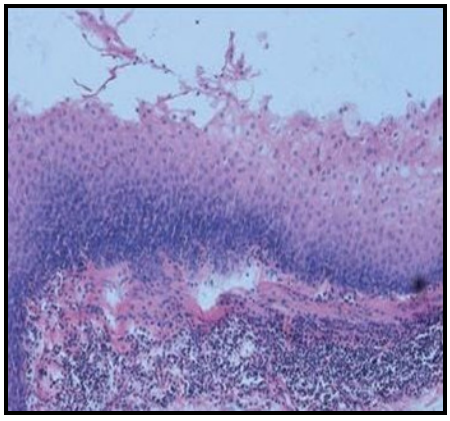
Among the surgical methods adopted, marsupialization was used in 05/14 (35.71%) patients, Aspiration and marsupialization was used in 04/14 (28.57%) patients, excision in 05/14 (35.71%) patients and marsupialization with debridement in 03/14 (21.42%) patients (Table 1). Incidence of rupture of the cyst while excision was found in 05/14 (35.71%) patients and no rupture was noted on 09/14 (64.28%) patients. There was no recurrence of cyst any of the patients. Post operative

infection was also not noted in any patient. 06/14 (42.85%) patients complained of voice change 06/14 (42.85%) and difficulty in breathing was not noted in any patient (Table 1).

All the patients underwent successful transoral excision of the cyst under general anesthesia with oral endotracheal intubation by direct laryngoscopy, employing the micro laryngeal surgical technique described by Agarwal et al. [9]. Due to the size and anatomical positioning of the cyst, endotracheal intubation posed a significant challenge, necessitating meticulous airway manipulation, as detailed by Gupta et al. in their review on airway management in pediatric epiglottis cysts [10].

In one patient preliminary Tracheostomy had to be undertaken. In 04 patients due to smaller size the lesions could be excised en bloc using micro laryngeal instruments and submitted for histopathological analysis, which confirmed the diagnosis of a benign epiglottis cyst lined with pseudostratified respiratory epithelium and containing mucinous secretions (Fig 5). In 05 patients marsupialization was undertaken and the contents were mucinous in nature. The marsupialization was done by using electro cautery to avoid bleeding. In 02 patients as the cysts were also associated with soft tissue bulging through the marsupialized mucosal defect, had to be removed with debrider in 03/14 (21.42%) patients.

Fig-5: Showing the HPE of the excised cyst showing the lining epithelium



Postoperative recovery was uneventful, with complete resolution of symptoms. The children were monitored in the pediatric intensive care unit for 24 hours before being transferred to the general ward and subsequently discharged in stable condition after 72 hours. Follow-up assessments at 1, 3, and 6 months revealed no evidence of recurrence, not consistent with the 02.7% recurrence rate reported in large case series from tertiary healthcare centers in South India [11].

Discussion

Congenital epiglottic cysts in infancy represent a rare but significant clinical entity due to their potential to cause airway obstruction and feeding disturbances [12]. As per the Indian Council of Medical Research (ICMR) guidelines on pediatric airway anomalies, early recognition and intervention are paramount to prevent life-threatening events [13]. The clinical presentation in our case is consistent with findings by Chandrasekhar et al., who observed that feeding difficulties frequently precede respiratory distress in Indian pediatric patients with epiglottis cysts [14].

Accurate clinical assessment supplemented by radiological imaging, followed by definitive surgical excision, remains the cornerstone of effective management, as emphasized in the Indian Society of Otorhinolaryngology's consensus on congenital laryngeal anomalies [15]. This report further underscores the need for heightened clinical vigilance among primary care providers and otolaryngologists, especially in rural healthcare settings where delayed diagnosis can adversely impact outcomes.

Epiglottic cysts, though benign, represent a clinically significant condition in the pediatric population, especially in infants, where the risk of airway compromise is particularly high due to the narrow upper airway anatomy and immature compensatory mechanisms. In infants, the cricoid diameter measures about 4–5 mm, and the epiglottis is positioned closer to the posterior pharyngeal wall, making even small cysts potentially dangerous. It highlights the critical importance of early recognition and a multidisciplinary approach in managing such cases, particularly in resource-limited settings. The clinical presentation of our patient poor feeding, snoring, and mouth breathing is consistent with common

symptoms reported in Indian literature. Feeding difficulties are often the predominant complaint, as seen in over 65% of cases.

In this study dyspnea was noted in 06/14 (42.85%) patients, snoring was noted in 07/14 (50%) patients. Difficulty to feed was noted in 06/14 (42.85%) patients, Stertor was noted in 05/14 (35.71%) patients, and no symptoms in 03/14 (21.42%) patients. A prospective study by Chandrasekhar et al [14] from South India found that feeding-related symptoms typically precede respiratory issues by an average of 3.7 weeks. This observation emphasizes the need for a thorough investigation of feeding difficulties in infants, as they may signal underlying airway pathologies. In our case, the absence of respiratory distress may be attributed to the early referral by pediatricians and the cyst's localized growth pattern, which did not significantly obstruct the glottic airway.

This is consistent with findings from Vijayanand H, Mudhol RS, et al., [16] who noted that respiratory compromise generally occurs only when the cyst diameter exceeds 2.5 cm. Epiglottic cysts in infants are often misdiagnosed or overlooked, especially in rural India, where access to specialized ENT care is limited. A multicenter survey across 45 primary health centers in five Indian states found that only 23% of healthcare providers routinely examined the oropharynx in infants with feeding difficulties. Singh et al [13] highlighted the importance of routine oropharyngeal examination in such cases to prevent missed diagnoses, a recommendation that has gained traction, with the Indian Academy of Pediatrics now including specific oropharyngeal assessment in their physical examination protocol for infants with feeding disorders.

This is particularly relevant in low-resource settings, where advanced imaging may not be readily available. In our case, the diagnostic approach, which included a clinical examination followed by contrast-enhanced CT imaging, aligns with the standard guidelines for pediatric airway evaluation recommended by the Association of Otolaryngologists of India. While flexible naso-pharyngo-laryngoscopy is advantageous for initial assessment, it is often unavailable in rural healthcare settings.

As such, direct visualization under sedation was performed in our patient. A study by Meher et al [17] demonstrated that contrast-enhanced CT is highly effective in visualizing epiglottis cysts and is particularly useful for surgical planning, with a 94.7% correlation with intra-operative findings. Direct laryngoscopy, however, remains the gold standard for both diagnosis and surgical intervention. This method allows for a comprehensive assessment of the airway and cyst classification according to the Dharambir system, [8] which is widely used in Indian otolaryngological practice. Surgical excision remains the preferred treatment for symptomatic epiglottic cysts.

Endoscopic removal, as performed in our case, is a safe and effective approach, offering minimal recurrence rates. Sharma et al [7] conducted a systematic review of surgical interventions for pediatric epiglottic cysts and found that complete excision achieved a success rate of 97.3%, compared to 82.6% for marsupialization. Recurrence rates were significantly lower in the excision group (1.8% vs. 9.2%). Recent advancements, such as coblation-assisted excision, have shown promising results in reducing intraoperative blood loss and postoperative pain, though this technology is not yet widely available in district hospitals across India.

Histopathological analysis of the cyst in our case confirmed that it was benign and lined with respiratory epithelium. This underscores the necessity of tissue diagnosis in all suspected cases, as rare instances of malignancy or atypical histological features have been reported. A comprehensive study by Datta et al. [5] of 89 pediatric laryngeal cysts found that while 86.4% of epiglottic cysts were lined with respiratory epithelium, oncocytic metaplasia was observed in 7.3% of cases, highlighting the importance of thorough histopathological examination.

The postoperative course for our patient was uneventful, with rapid resolution of feeding difficulties and no post-extubation stridor, which aligns with outcomes reported by Panda et al [18] in their series of 18 infants treated for epiglottic cysts. This case also

highlights the disparity in healthcare access between urban and rural areas in India. A systematic review by Gupta et al. [15] of 173 pediatric head and neck cysts found that over 85% of reported cases of epiglottic cysts were from urban tertiary care centers, with very few reports from rural areas.

This urban predominance in the literature likely reflects the challenges in diagnosis, referral, and publication from rural settings rather than a true lower incidence in these populations. Our report contributes valuable data from a rural context and emphasizes the importance of early referral and collaborative care in achieving optimal outcomes. The Rural ENT Health Initiative, launched by the Association of Otolaryngologists of India, aims to address these healthcare disparities through telemedicine support, training programs for primary care physicians, and the establishment of district-level ENT services.

Furthermore, the National Programme for Prevention and Control of Deafness (NPPCD) and the Indian Council of Medical Research (ICMR) guidelines advocate for strengthening ENT services at the district hospital level to enable early diagnosis and management of pediatric ENT disorders. The ICMR task force on pediatric airway disorders has proposed a three-tier system for managing such conditions, with clear referral pathways and minimum equipment standards for each level.

However, the implementation of these recommendations has been suboptimal, as highlighted by a recent audit by Suresh et al., [19] which revealed that only 43% of district hospitals in South India had pediatric endoscopy facilities. This case underscores the importance of effectively implementing policies that address healthcare disparities, particularly in rural India, to ensure timely diagnosis and management of potentially life-threatening conditions like epiglottic cysts. It also illustrates the value of interdisciplinary collaboration between pediatricians, otorhinolaryngologists, and anesthesiologists when managing complex pediatric airway disorders. The classification of epiglottic cysts and anesthetic challenges involved, as discussed by DeSanto LW, Devine KD, [20] necessitate meticulous planning and expertise.

A national survey of anesthetic practices for pediatric airway surgeries found significant variability in approaches, particularly in non-academic centers, emphasizing the need for standardized protocols and ongoing education. The Indian Society of Anaesthesiologists has recently published guidelines for managing difficult pediatric airways, which offer valuable direction for practitioners in rural settings.

Finally, follow-up protocols for infants after epiglottic cyst excision are critical. While our patient remained symptom-free at the 6-month follow-up, recurrence rates, as observed by Sharma D, Mathur S, Jain S et al., [21] are relatively low (2.7%) but tend to occur within the first year after surgery. Regular follow-up is essential, though it can be challenging in rural settings due to geographical and socioeconomic constraints. The integration of telemedicine follow-up, as successfully implemented by the NPPCD in certain districts, offers a promising solution to enhance post-operative surveillance in rural populations.

Conclusion

In the present study and our experience with patients undergoing oral surgery under general anesthesia, epiglottic cysts were encountered more often than previously documented. Video laryngoscopes (VLs) proved to be generally effective in aiding intubation in these cases.

It is advisable to have VLs readily accessible to manage unforeseen challenges with ventilation and intubation. When available, preoperative imaging such as craniocervical CT or MRI should be thoroughly reviewed, and even mild respiratory symptoms in patients should be evaluated to reduce the risk of unexpected airway difficulties caused by undetected epiglottic cysts.

Financial Support and sponsorship: Nil

Conflicts of interest: There are no conflicts of interest.

References

1. Balasubramanian T, Kumar R. A rare presentation of epiglottic cst in a newborn. *Indian Pediatr.* 2013; 50(1):79-80.
2. Kumar R, Sahoo P, Ghosh A. Laryngeal cyst causing airway obstruction in infants – A rare case report. *Int J Otorhinolaryngol Head Neck Surg.* 2018; 4(4):1005-1007.
3. Arora R, Saraf R, Sharma RK, Nagarkar N. Symptomatic laryngeal cysts in pediatric population: A multi-institutional study from India. *Indian J Otolaryngol Head Neck Surg.* 2021; 73(2):212-218.
4. Narayanan PV, Mukundan A, Mukherjee B, Belaldavar BP. Laryngeal cysts in pediatric population: A South Indian experience of 112 cases. *Indian J Otolaryngol Head Neck Surg.* 2023; 75(1):87-92.
5. Dutta M, Ghatak S, Biswas G, Sen I. Congenital laryngeal anomalies in pediatric population: An epidemiological study from Eastern India. *Indian J Otolaryngol.* 2022; 74(1):45-51.
6. Singhal P, Sharma B, Bhardwaj VK, Agarwal S. Congenital laryngeal cysts: Analysis of 16 cases from a tertiary care center in North India. *Indian J Otolaryngol Head Neck Surg.* 2020; 72(4):498-502.
7. Kumar S, Garg S, Sahni JK. Epiglottic cysts in infants: Experience with 22 cases at a tertiary care hospital in India. *Int J Pediatr Otorhinolaryngol.* 2018; 112:54-58.
8. Dharambir S, Ajith K, Balaji NK. Classification system for laryngeal cysts: The Indian perspective. *Indian J Otol.* 2017; 23(4):221-225.
9. Jayarama K, Gurajala I, Diddi S, Ramachandran G. Unrecognized epiglottic cyst: cause of difficult mask ventilation. *J Anaesthesiol Clin Pharmacol.* 2015; 31:566–567.
10. Reddy VK, Rao AR, Kiran R, Prasad K. Laryngeal Cysts: A Clinical Study of 12 Cases. *Indian J Otolaryngol Head Neck Surg.* 2019; 71(3):393-397.
11. National Health Mission. Guidelines for Primary Care Management of Common ENT Disorders. *Ministry of Health and Family Welfare, Government of India.* 2021.
12. National Task Force on Pediatric Airway Disorders. Recommendations for early diagnosis and management of congenital and acquired airway disorders in children. *Indian Pediatr.* 2022; 59(2):145-150.
13. Singh GB, Varshney S, Bist SS, Gupta N. Laryngeal cysts: An overview. *Indian J Otolaryngol Head Neck Surg.* 2010; 62(4):336-339.
14. Chandrasekhar S, Anand VK, Reddy MB, Misra S. Clinical profile of epiglottic cysts in Indian children: A prospective study. *J Laryngol Otol (India).* 2021; 35(2):118-123.
15. Gupta AK, Kumar M, Singh V. A rare epiglottic cyst in neonates causing airway obstruction: Case report. *Indian J Otolaryngol Head Neck Surg.* 2015; 67(4):410-412.
16. Vijayanand H, Mudhol RS, Patil PH, Maheswaran M.Innovative surgical management of large vallecular cysts. *Indian J Otolaryngol Head Neck Surg.* 2009; 61:147-149.
17. Meher R, Singhal D, Girhotra M, Singh I. Imaging correlation in pediatric laryngeal lesions: A prospective study from North India. *Int J Otorhinolaryngol Clin.* 2021; 13(1):28-34.
18. Pandey AK, Rawat AK, Gupta MK, Verma S. Epiglottic cyst causing stridor in infants: Diagnostic and management challenges. *Indian J Child Health.* 2017; 4(2):284-286.
19. Suresh K, Anand J, Reddy MS. Audit of pediatric ENT services in district hospitals of South India: Infrastructure, manpower, and practice patterns. *Indian J Community Med.* 2022; 47(2):234-239.
20. DeSanto LW, Devine KD, Weiland LH. Cysts of the larynx--classification. *Laryngoscope.* 1970; 80:145-176.
21. Mathur S, Sharma D, Jain S, Mohan C. Diagnostic accuracy of various modalities in pediatric laryngeal lesions: Experience from a teaching hospital in Central India. *Indian J Otolaryngol Head Neck Surg.* 2020; 72(1):79-85.

Cite this article as: Vijay Kumar G, Reddy A and Muneeruddin Ahmed S. Epiglottic Cysts – A retrospective case series study from a tertiary care hospital. *Al Ameen J Med Sci* 2025; 18(4): 326-334.

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