A 57-year-old female church singer presented to our voice center with worsening dysphonia. During the Christmas holiday, she had had increased vocal demands and had pushed to reach her higher range during holiday mass. The day after she had performed at several masses, she woke up with “no voice.” A course of tapered methylprednisolone was prescribed by her physician. Initially, her voice improved. However, her voice quality deteriorated with continued performing.

Initial assessment revealed a raspy, loud, and strained voice with frequent breaks. Stroboscopic examination of the larynx demonstrated a large, posthemorrhagic polyp on the midportion of the right true vocal fold causing glottic insufficiency anterior and posterior to the polyp. Further examination revealed subjacent cupping of the vocal fold deep, anterior, and posterior to the polyp with fibrosis (Figure 1). Additionally, there was a contralateral reactive true vocal fold mass with fibrosis (Figure 2). Both true vocal folds were scarred, and sulci were noted. She also had mild reflux laryngitis, fluctuating paresis, and bilateral varicosities. The patient was referred to voice therapy, placed on intensive medical therapy for reflux, and asked to return in approximately 6 weeks for a follow-up evaluation. Surgical options were discussed.

Hemorrhagic vocal fold polyp is one of the most common benign lesions of the vocal fold. Etiologies include trauma, vocal overuse and abuse, tobacco, allergies, reflux, alcohol, and chronic infections of the upper airway. Repeated shearing forces placed on the vocal folds cause microvascular trauma within the superficial lamina propria. This vocal trauma leads to injury followed by wound healing and remodeling, resulting in the formation of a vocal polyp. Consequently, vocal fold movement is disrupted, and compensatory behaviors ensue, which continues the cycle of trauma and damage. Hemorrhagic vocal fold polyps have been described as translucent, red, sessile, and pedunculated. Associated findings include scalloping of the vocal fold edge, stiffness deep to the polyp along the vibratory margin, and prominent varicosities.

Vocal fold polyps, unlike nodules, are unlikely to resolve with voice therapy alone. Voice therapy may decrease the size of a polyp and particularly of a reactive mass, but surgical excision is often required. Typically, the presence of a mass associated with vocal fold hemorrhage at the time of presentation carries a poor prognosis and is likely to require surgery. Contralateral reactive lesions (CRLs) with hemorrhagic polyps

Figure 1. Large, posthemorrhagic polyp on the midportion of the right true vocal fold causing glottic insufficiency anterior and posterior to the polyp. There is subjacent cupping of the vocal fold deep, anterior, and posterior to the polyp with fibrosis.

Figure 2. Contralateral reactive true vocal fold mass with fibrosis.
are common.\textsuperscript{5,6} Pressure from a vocal polyp induces epithelial injury of the contralateral vocal fold creating a CRL. Grossly, a CRL initially appears as an indentation at the point of maximum contact with a primary polyp. Over time, the indentation often develops into a raised mass. Treatment of a CRL depends on numerous factors. Simultaneous surgical excision of a vocal polyp and CRL results in improved voice quality in some patients postoperatively.\textsuperscript{5} However, some CRLs regress or resolve without surgery after the primary polyp has been resected, decreasing the risk of bilateral, opposing vocal fold scar.

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