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The Diagnosis We Almost Miss: Lessons from Acute Laryngeal Dystonia

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SUMMARY

Acute airway symptoms demand immediate treatment, but the working diagnosis should remain open to revision. Antipsychotic-associated Acute Laryngeal Dystonia (ALD) illustrates this challenge: stridor and throat tightness may initially suggest anaphylaxis, while the medication history raises a different possibility. This commentary uses a previously published case to propose two practical steps for reassessment, rather than presenting new case data.

ALD is a potentially life-threatening adverse effect reported with both first- and second-generation antipsychotics. Maguire, Brazel, and Looi (2024) identified 45 cases across 40 reports. These reports describe clinical presentations and treatment responses, but cannot establish incidence, comparative drug-specific risk, or how often clinicians encounter ALD. Their value is to identify a diagnosis that warrants consideration when airway symptoms follow antipsychotic exposure.

In my published case report, recurrent throat tightness, dysphonia, and stridor followed antipsychotic initiation and dose escalation. Initial episodes were treated as anaphylaxis. The exposure timeline and rapid resolution after intramuscular benztropine supported ALD as the most likely diagnosis (Wadhwa, 2026). This response strengthened the clinical interpretation; it was not, by itself, definitive confirmation. The case is cited here as an illustration of reassessment under uncertainty.

The initial emergency response and the subsequent diagnostic review serve different purposes. Treating suspected anaphylaxis promptly is appropriate; continuing to accept that explanation without reviewing the evolving evidence may allow anchoring or diagnostic momentum to develop. These concepts provide a useful interpretive framework, although a retrospective case narrative cannot establish which cognitive processes influenced individual clinicians (Croskerry, 2013).

Keywords: Acute laryngeal dystonia; Antipsychotics; Anaphylaxis; Diagnostic reasoning; Adverse drug reactions; Airway obstruction

RECONSTRUCT THE MEDICATION TIMELINE

Once immediate airway management is underway, document the dates of antipsychotic initiation, dose changes, and symptom onset, including recurrent episodes. Ask specifically about other dopamine-blocking drugs, including antiemetics (van Harten, Hoek, & Kahn, 1999). A reproducible temporal association should raise suspicion for a drug-induced movement disorder, while remaining insufficient to establish causality. This turns a general instruction to review medications into a focused bedside question: what changed before the airway symptoms began?

REASSESS THE MECHANISM WITHOUT DELAYING EMERGENCY CARE

When symptoms recur or the explanation remains uncertain, review the exposure history, examination findings, investigations, and treatment response together. The absence of urticaria or hypotension does not exclude anaphylaxis, and tryptase results require interpretation in relation to sampling time and baseline values. Suspected anaphylaxis still requires prompt intramuscular epinephrine and airway assessment (Cardona et al., 2020).

If ALD is suspected, urgent airway support and parenteral anticholinergic treatment should be considered in accordance

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with local emergency protocols. Reported rapid improvement with anticholinergic medication supports ALD, but must be interpreted alongside the clinical course (Maguire et al., 2024). Documenting the degree of diagnostic certainty and the suspected medication association can help subsequent teams assess recurrent symptoms without automatically inheriting a definitive label.

The contribution of this perspective is a practical approach to uncertainty: make the medication timeline explicit and reassess the mechanism of airway compromise while emergency treatment proceeds. Recognising a possible adverse drug reaction should improve the diagnostic explanation without weakening the urgency of airway care.

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