BJCR
Brazilian Journal of Case Reports

PCAA
Publicações Científicas de Acesso Aberto

Clinical Image

Eagle's Syndrome: from diagnosis to treatment

Pedro Abecasis [1,2*], **Carlos Zagalo** [1]

[1] Egas Moniz School of Health and Science, Lisbon, Portugal.
[2] International University of Catalonia, Barcelona, Spain.

* Correspondence: pedroabecasis@hotmail.com.

Abstract: Not applied.

Keywords: Eagle Syndrome; Cone Beam Computed Tomography; Pain.

Citation: Abecasis P, Zagalo C. Eagle's Syndrome: from diagnosis to treatment. Brazilian Journal of Case Reports. 2025 Jan-Dec;05(1):bjcr27.

https://doi.org/10.52600/2763-583X.bjcr.2025.5.1.bjcr27

Received: 19 September 2024
Accepted: 11 October 2024
Published: 14 October 2024

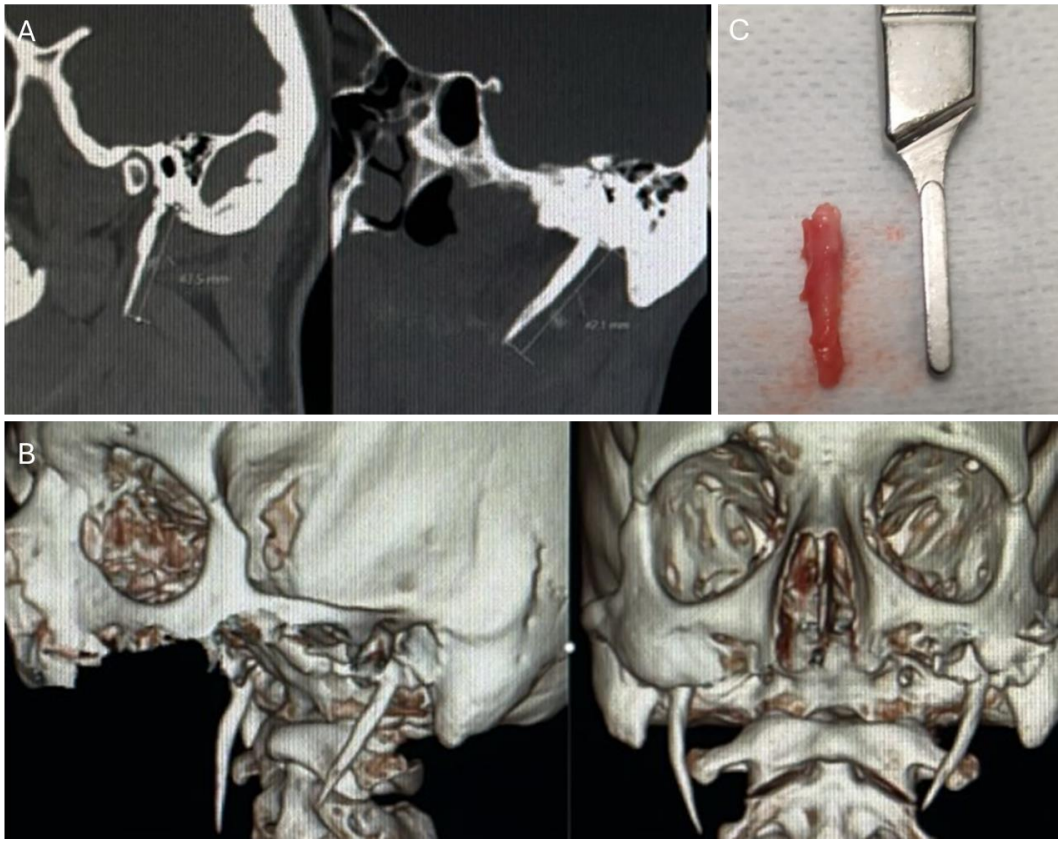

Figure 1: A. CBCT showing an increase in the size of the styloid apophyses. B. CBCT 3D reconstuction mega styloid apophyses. C. Surgically removed styloid apophysis.

The clinical image depicts a 2024 case of Eagle's Syndrome diagnosed via cone beam computed tomography (CBCT). The elongated styloid processes, measuring approximately 4.3 cm bilaterally, are clearly visible on the CBCT scan (Figure 1A and 1B). The patient was presented with recurrent sore throat, neck pain, and dysphagia, and was initially misdiagnosed despite undergoing a biopsy and multiple examinations. The CBCT

scan provided the crucial evidence needed to confirm the diagnosis, showing the significant elongation of both styloid processes, a hallmark feature of Eagle's Syndrome. This finding prompted a left-sided styloidectomy and tonsillectomy (Figure 1B), which successfully alleviated the patient's symptoms.

After this diagnosis, tonsillectomy and styloidectomy were performed on the left side (the one that had symptoms and was palpable) to eliminate the patient's symptoms (Figure 1C). This clinical image vividly demonstrates the importance of CBCT in diagnosing Eagle's Syndrome, particularly in cases where standard imaging modalities fail. The distinctive elongation of the styloid process, as visualized in this case, serves as a key diagnostic feature that clinicians and radiologists should recognize when encountering similar symptomatology [1-5].

Funding: None.

Research Ethics Committee Approval: We declare that the patient approved the study by signing an informed consent form and the study followed the ethical guidelines established by the Declaration of Helsinki.

Acknowledgments: None.

Conflicts of Interest: None.

Supplementary Materials: None.

References

1. Bafaqeeh SA. Eagle syndrome: classic and carotid artery types. J Otolaryngol. 2000;29(2):88–94.
2. Chrcanovic BR, Custódio ALN, de Oliveira DRF. An intraoral surgical approach to the styloid process in Eagle's syndrome. Oral Maxillofac Surg. 2009;13(3):145–151. https://doi.org/10.1007/s10006-009-0164-6.
3. Fini G, Gasparini G, Filippini F, Becelli R, Marcotullio D. The long styloid process syndrome or Eagle's syndrome. J Cranio-Maxillofac Surg. 2000;28(2):123–127. https://doi.org/10.1054/jcms.2000.0128.
4. Fonseca HB, Costa SM da, Jamil LC. Eagle syndrome: a case report. Rev Bras Cir Plást (RBCP) – Braz J Plast Surg. 2019;34(2):287–290. https://doi.org/10.5935/2177-1235.2019RBCP0147.
5. Keur JJ, Campbell JPS, McCarthy JF, Ralph WJ. The clinical significance of the elongated styloid process. Oral Surg Oral Med Oral Pathol. 1986;61(4):399–404. https://doi.org/10.1016/0030-4220(86)90426-3.