

MANAGEMENT OF NECK LUMPS

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The purpose of this communication is to call to the attention of the medical profession in general not only to the needlessness but also to the possible harmfulness of excisional lymph node biopsy as the first or even as an early step in the diagnosis of cancer.

Hayes Martin, 1961

The commonest neck lumps seen in a general surgical practice are thyroid lumps and benign lymph node enlargement. The focus of this article is on asymmetric lymph node masses in the neck and the **key concepts I would like to convey are the importance of the ENT examination and Fine Needle Aspiration Cytology or FNAC.** The above quotation applies not only to the management of cancer but also to that of the commoner benign neck lumps. The knee-jerk reaction of indiscriminate biopsy under GA for these clinical conditions should be considered as outdated, and abroad, has been relegated to the pages of surgical history.

By and large, such neck lumps in children are related to chronic sepsis. Certainly, the commonest cause of persistent lymph node enlargement in children is jugulodigastric lymphadenopathy in relation to chronic or recurrent tonsillitis. In the teenage and adult population other infective causes include infective mononucleosis (glandular fever), brucellosis, toxoplasmosis, cat scratch disease and cytomegalovirus infection. Branchial cysts are transilluminable and present just anterior to the sternocleidomastoid muscle at the junction of its upper third with its lower two thirds. Salivary gland lumps, such as submandibular or parotid lumps may be related to calculi, inflammatory or autoimmune disease or neoplasms. Lymphomas frequently present in the head and neck region, in the postnasal space, tonsil or salivary tis-

sue. Firm, rubbery nodes in the posterior triangle of the neck should arouse suspicion, especially in association with a history of weight loss, night sweats or fever.

HISTORY

In the elderly patient with an asymmetric enlargement of a cervical lymph node it is relevant to ask how long the lump has been there, whether it is enlarging and whether there are any associated general symptoms (such as fever, night sweats or weight loss). Head and neck cancer is associated with smoking and alcohol misuse. Malignant neck lumps are generally secondaries from a primary in the ENT region such as the tonsil, piriform fossa, postnasal space (PNS) and sinuses. Specific symptoms such as pain on swallowing or otalgia (tonsil, piriform fossa), dysphagia (hypopharyngeal), hoarseness (laryngeal), conductive hearing loss due to middle ear effusion (postnasal space) is relevant. Thyroid tumours may also present in this fashion. Cough and haemoptysis and recently noted breast lumps may be relevant, as primary sites of malignancy outside the ENT region include the lung, breast, gastrointestinal tract and even prostate.

PHYSICAL EXAMINATION

The ENT examination in a patient with a malignant neck lump immediately reveals the primary site in a third of cases. Nowadays examination of the

PNS is simple and quick using a flexible fiberoptic nasoendoscope without the need for general anaesthesia. A systemic examination e.g. axillae, groin, chest, breasts, abdomen, prostate would also be useful. In patients where the primary is not immediately obvious further investigations are required.

INVESTIGATION

By far the most important investigation is **Fine Needle Aspiration Cytology (FNAC)** using a 22-gauge needle. This gives an accurate diagnosis (sensitivity and specificity in most centres well in excess of 90%) but with an experienced Head and Neck cytopathologist to interpret the slides. It is quick, giving a result within 24 hours and extremely safe—there have been no reports of cell seeding or tumour spillage. FNAC is useful in the management of benign lumps as well. In an elderly patient where FNAC shows a pleomorphic adenoma of the parotid, one may opt to wait and observe, for instance. The same may be said for solitary lymph node swellings where ENT examination is negative and the FNAC shows reactive lymphocytosis. Final decision whether to biopsy depends on clinical suspicion but FNAC and follow-up are a satisfactory alternative to operation.

If the FNAC is positive for carcinoma one should then proceed to panendoscopy of the upper aerodigestive tract, including blind biopsy of PNS, ipsilateral tonsil and piriform fossa.

A second primary tumour is present in 10% of Head and Neck malignancies, which is another reason for endoscopy. Endoscopy reveals the site of the primary in another third of patients presenting with a malignant neck lump. Other investigations of relevance include a CBC, differential and picture, ESR and CXR.

BIOPSY

The main problem with biopsy is related to eventual tumour fungation through skin at the site of incision. This will compromise future definitive surgery because skin adjacent to this area will have to be resected and will limit the way in which skin flaps may be designed. A discrete salivary mass should not be subjected to incisional biopsy (unless inside the oral cav-

ity) because this invites recurrence; salivary masses should be removed completely, preferably with a cuff of surrounding tissue. Salivary gland tumour diversity requires expert evaluation. In cases of clinical doubt one has to proceed to biopsy, e.g. young children with rapidly growing masses and especially, if no primary has been found on panendoscopy. In the remaining third of patients with a malignant neck lump (so-called occult primary) diagnosis requires more time and further investigation, as the primary is not readily identifiable.

CONCLUSION

There is no substitute for proper clinical history taking and physical examination. The progress of cytological methods

has presented us with a tool, which as yet seems to be underused in our islands. ENT examination, FNAC with expert cytological interpretation is a must in our ability to manage neck lumps in a way that offers both cost and morbidity benefits to our patients.

REFERENCES

1. Martin H. Untimely Lymph node biopsy. *Am J Surg* 1961; 102:17-18.
2. Birchall M.A., Stafford N.D., Walsh-Waring G.P., Malignant neck lumps: a measured approach. *Ann R Coll Surg of Eng* 1991; 73: 91-95.
3. Spiro R.H., DeRose G., Strong E.W. Cervical node metastasis of occult origin. *Am J Surg* 1983; 146: 441-446.