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Neck swelling: Expect the unexpected!

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SUMMARY

Neck swelling is a relatively common head and neck complaint in patients presenting to ENT clinic. Evaluation of neck masses must be approached in a thorough manner as it helps to narrow our diagnostic possibilities. We report of a rare case of carotid body paraganglioma which mimics the presentation of an infective lymph node. Mr K, 42-year-old gentleman with underlying hypertension and tuberculosis of pleura, diagnosed 1 year ago and completed anti-TB treatment presented with painless left neck swelling for 3 months duration. The swelling did not increase in size and he denied any constitutional symptoms. On examination, there was a solitary mass measuring 3.0 X 3.0 cm at left Level II, firm, mobile, not pulsatile and no bruit felt. Initial diagnosis was made to rule out tuberculosis of lymph nodes in view of a solitary firm non-pulsatile mass with previous history of tuberculosis of pleura. No imaging was done. As the FNAC revealed atypical cells, excisional biopsy was performed under local anesthesia. Intra-operative revealed a firm, vascularized mass located at the bifurcation of the left carotid artery. The mass was excised in total with vagal nerve preservation and minimal blood loss. The histology reported as carotid body paraganglioma. He is free of disease progression after 12 months follow up without any recurrence or new lesion on the neck. In conclusion, paraganglioma of carotid bodies should be considered as a differential diagnosis for painless lateral neck masses. Although infective neck causes are more common, we should have a high index of suspicion in order to prevent unnecessary risky procedures. The mainstay of treatment is surgical excision and follow up is imminent as this tumour poses high risk of malignant transformation and recurrence.

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An intriguing case of unilateral nasal blockage

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SUMMARY

Nasal septal seroma is a collection of serous fluid between the cartilaginous or bony septum and its adjoining mucoperichondrium or mucoperiosteum. This condition is extremely rare, necessitating a thorough history, investigation and prompt management to prevent nasoseptal deformity. We report an intriguing case of spontaneous septal seroma in a young gentleman with no preceding risk factors. Mr F, a 29-year-old healthy male, presented with progressive worsening right nasal blockage for 2 months. He denied nasal pain, rhinitis symptoms, fever, history of trauma or surgery prior to the symptoms. The systemic review on other body systems were unremarkable, making the systemic disorder was unconvincing as its causative factor. Examination revealed fullness of the nasal dorsum. Anterior rhinoscopy showed a soft, fluctuant right septal swelling which was tender on palpation with normal left nostril. Aspiration was performed and drained about 8cc of yellowish serous fluid. He was treated as outpatient with oral antibiotic for 1 week. However, during his subsequent follow up, the swelling recurred with involvement of the contralateral side of the septum, occluding both anterior nares. Incision and drainage were done under local anesthesia, which drained about 10cc of yellowish serous fluid. Samples were sent for biochemistry, culture and AFB stain which came back as negative. There was small septal perforation caudally. Nasal packing was inserted and he was admitted for intravenous antibiotics. He was discharged well with neither any signs of residual nor recurrence of the disease. In conclusion, although neither nasal trauma, nasal surgery nor features of infection were demonstrated, subclinical inflammation, autoimmune and chronic inflammatory disorder of the nasal septum should be thoroughly investigated. Despite the rare occurrence of spontaneous nasal septal seroma, a prompt recognition and treatment is necessary to prevent further deformity of the nose.