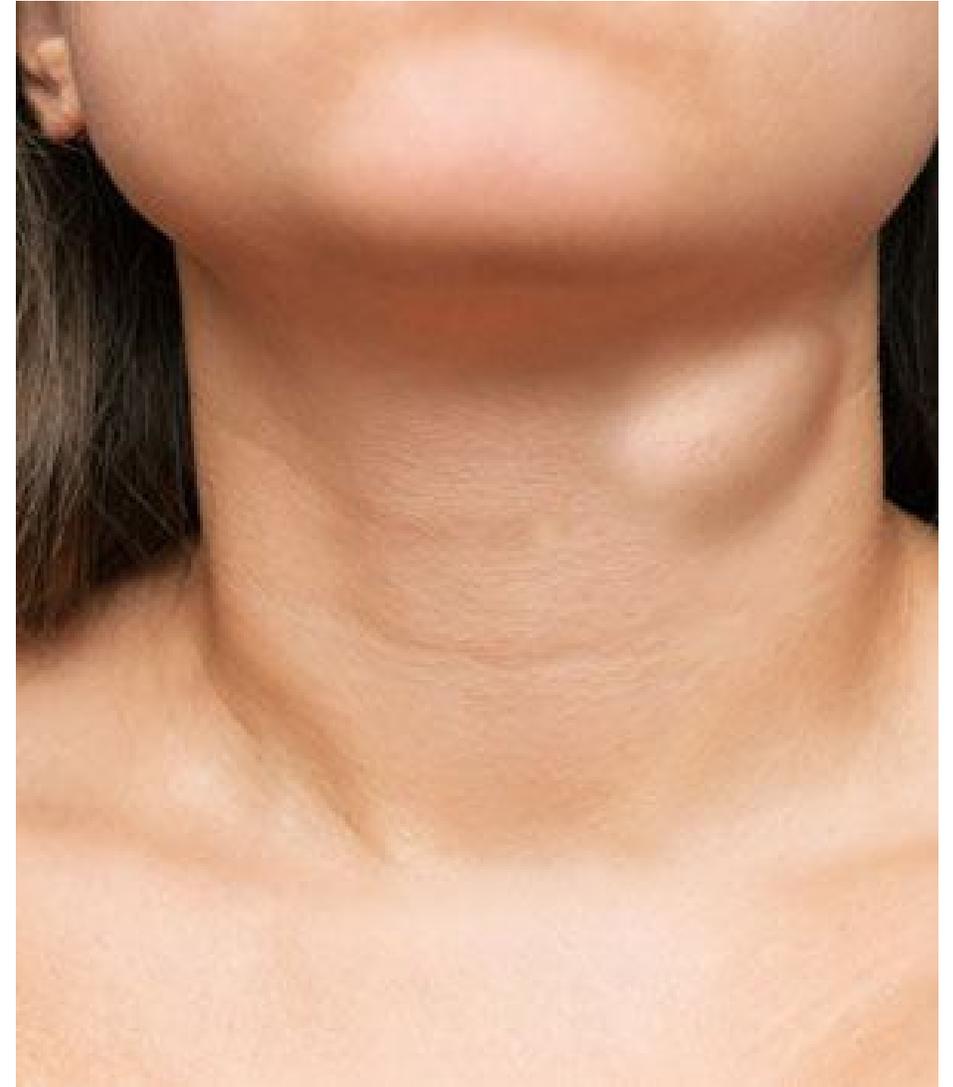


HOW TO APPROACH CERVICAL LUMP

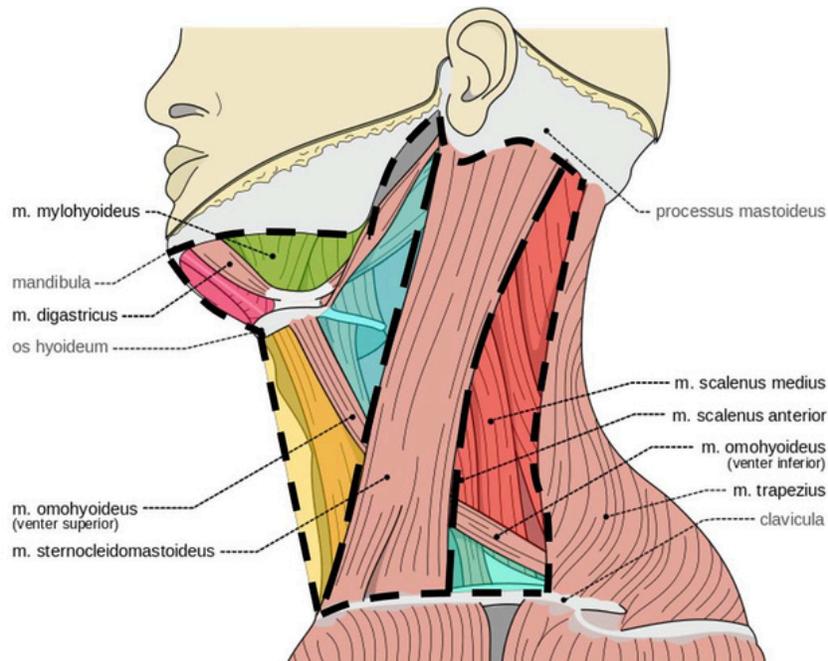
SUPERVISED BY : DR.MAHMOUD AL-AWAISHEH

presented by :

**Jameelh Al Maaitah
Teeb alsaraireh
Sumaya Abu radaha
Hadeel albawareid
Tala migdadi**



SURFACE ANATOMY OF THE NECK



The limit of the neck are:

Medial: midline of the neck.

Lateral: anterior margin of trapezius.

Superior: inferior border of the mandible.

Inferior: superior border of the clavicle.

- The neck can further be divided into the **anterior triangle** and the **posterior triangle**. The muscle which delineates these two regions is the **sternocleidomastoid (SCM)**.

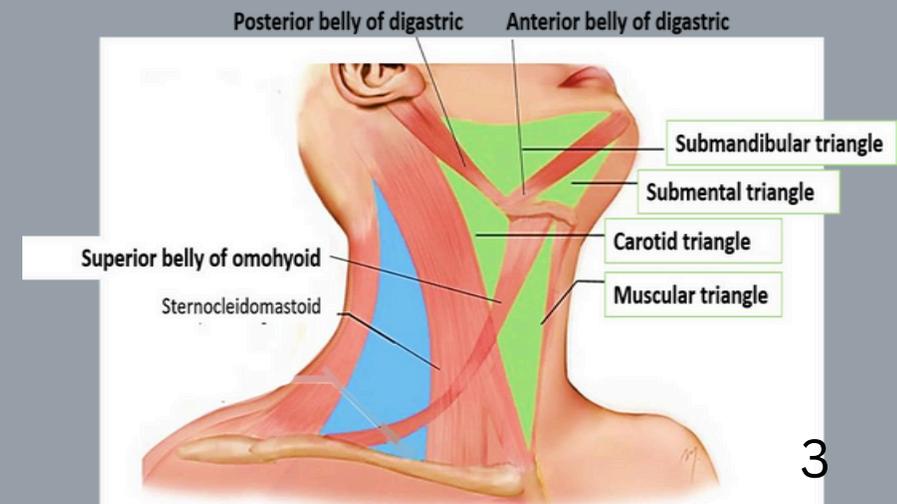
THE TRIANGLES OF THE NECK

Anterior Triangle Boundaries :

- 1) **Laterally**: Anterior border of Sternocleidomastoid.
- 2) **Superiorly**: The body of the mandible.
- 3) **Anteriorly**: The midline of the neck

Posterior Triangle Boundaries:

- 1) **Anteriorly**: Posterior border of Sternocleidomastoid
- 2) **Posteriorly**: Anterior border of Trapezius.
- 3) **Inferiorly**: Middle 1/3 of the Clavicle.

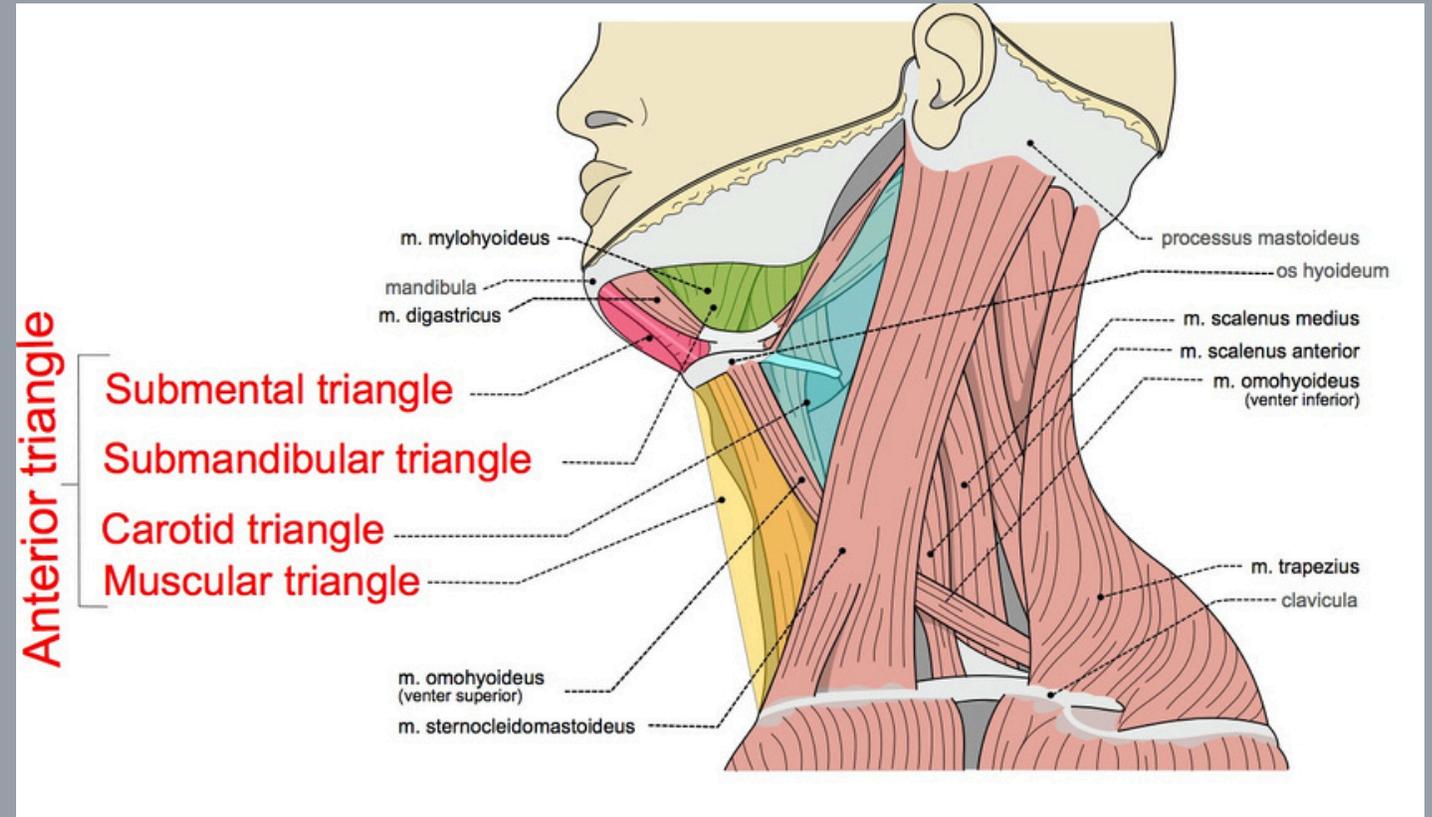


ANTERIOR TRIANGLE

The anterior triangle is subdivided by the **hyoid bone, Digastric and Omohyoid muscles** into four

Triangles:

- Submental Triangle.
- Submandibular Triangle.
- Carotid Triangle.
- Muscular Triangle.



1) Submental Triangle:

boundaries:

apex: symphysis menti.

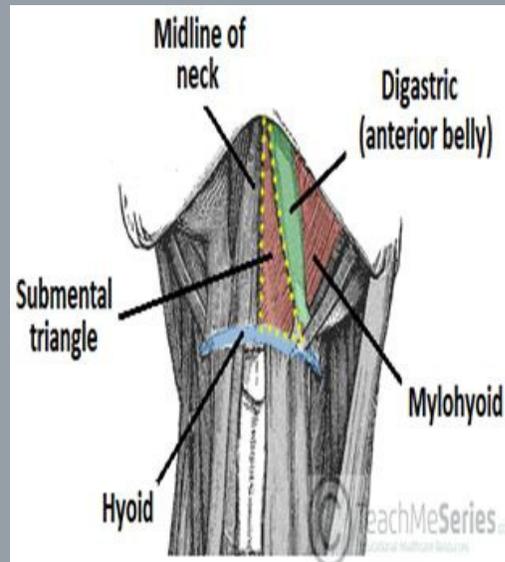
Base: body of hyoid bone.

On each side: anterior belly of the digastric muscle.

Floor: the two mylohyoid muscles with their median raphe.

Contents:

- Submental lymph nodes
- Submental vessel.



2) Submandibular (digastric) Triangle:

Boundaries:

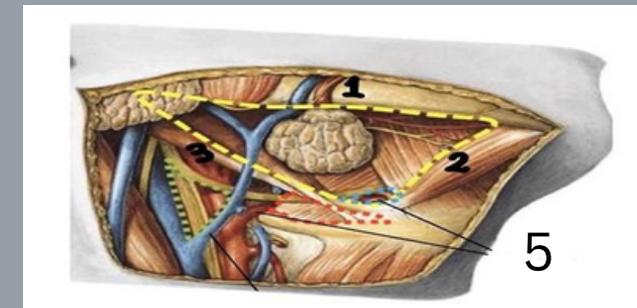
Above: lower border of the mandible.

Below and in front: anterior belly of digastric.

Below and behind : posterior belly of digastric.

Contents:

- submandibular gland.
- part of parotid gland.
- submandibular lymph nodes.



3) Carotid Triangle:

Boundaries:

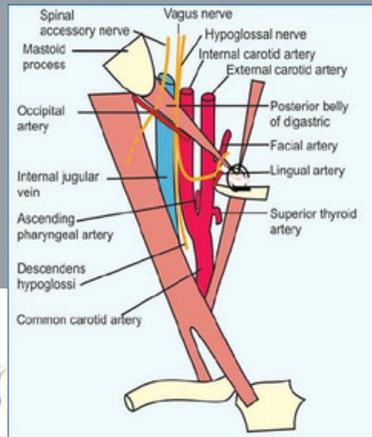
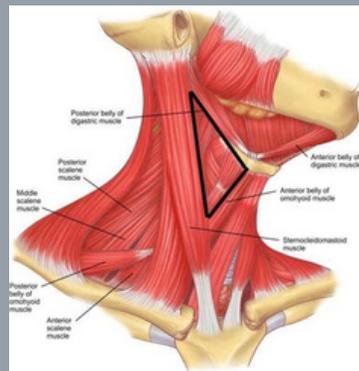
Behind: sternocleidomastoid muscle.

In front and above: posterior belly of digastric and stylohyoid muscles.

In front and below: superior belly of omohyoid

Contents:

- 1) Common Carotid artery.
- 2) Internal Jugular vein
- 3) Vagus nerve.
- 4) Hypoglossal nerve.



4) Muscular Triangle:

Boundaries:

Medially: midline of the neck.

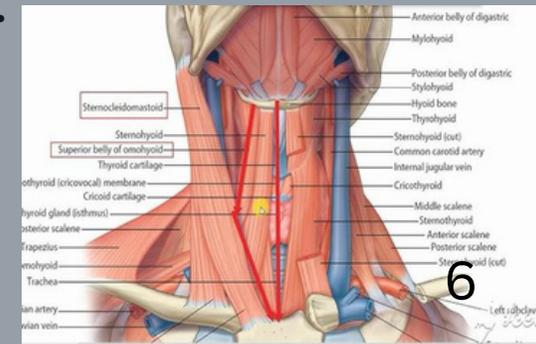
Superiorly: Hyoid bone.

Behind and above: superior belly of omohyoid.

Behind and below: sternocleidomastoid

Contents:

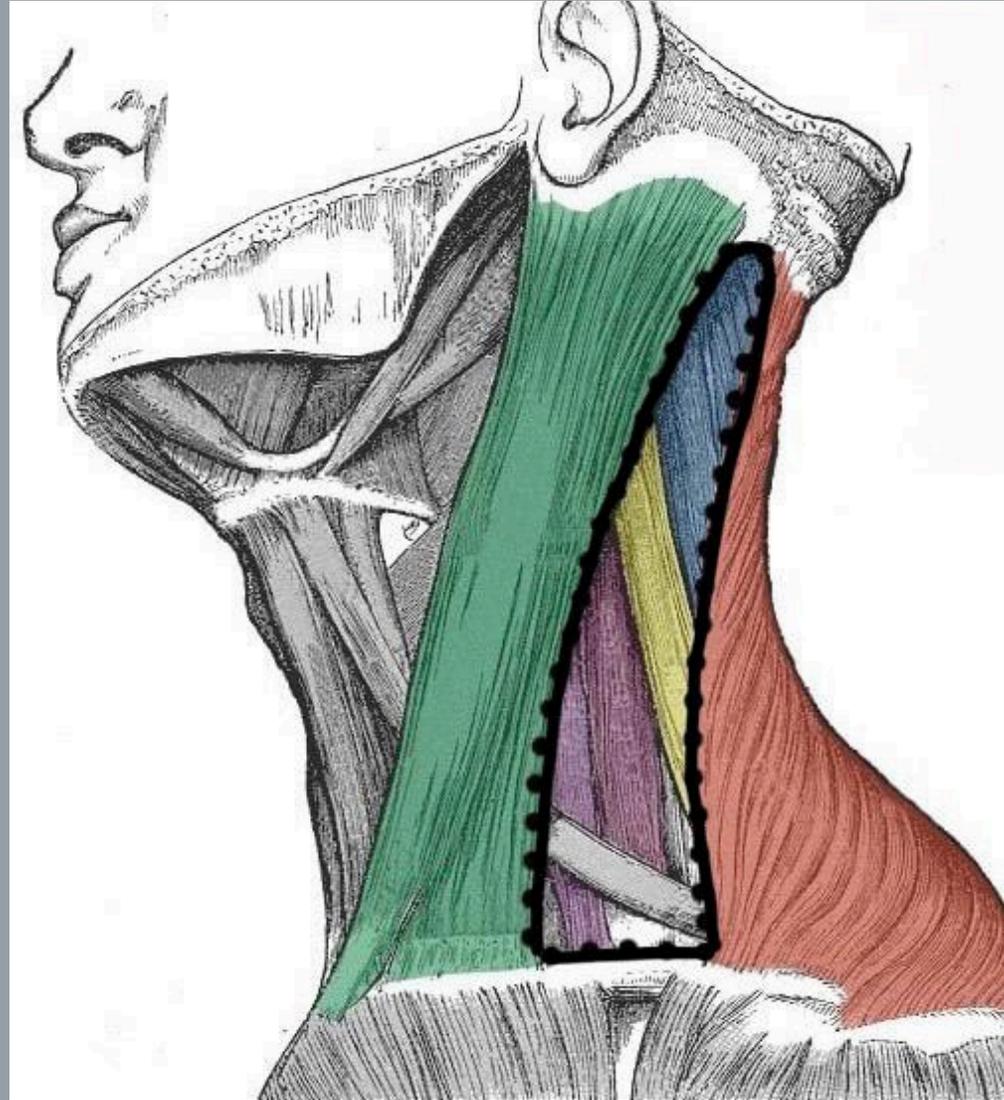
- 1) Thyroid gland.
- 2) Parathyroid gland.



POSTERIOR TRIANGLE

The posterior triangle is subdivided by the inferior belly of Omohyoid muscle into two triangle:

- Occipital triangle.
- Subclavian triangle.



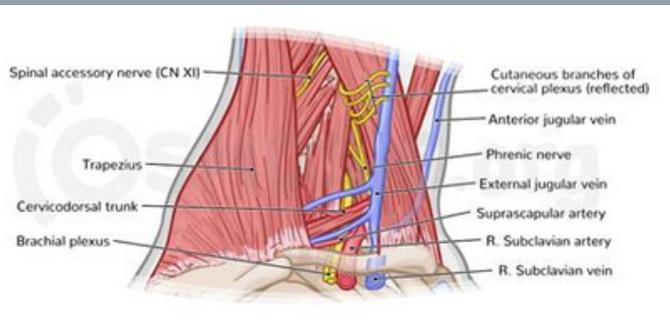
1) Occipital triangle:

Boundaries:

- 1) **Anteriorly**: Posterior margin of Sternocleidomastoid.
- 2) **Posteriorly**: Anterior margin of Trapezius.
- 3) **Inferiorly**: Inferior belly of Omohyoid muscle .

Contents:

Brachial Plexus.
accessory Nerve.



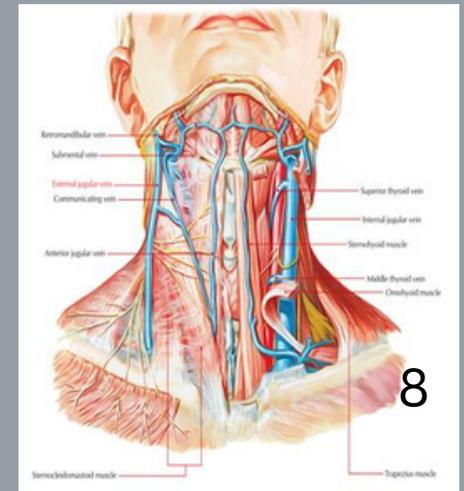
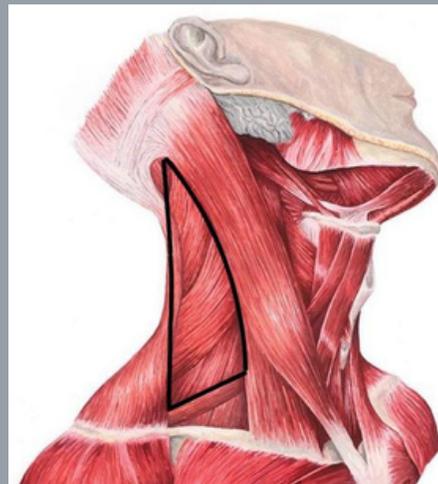
2) Subclavian Triangle:

Boundaries:

- 1) **Superiorly**: Inferior belly of omohyoid.
- 2) **Anteriorly**: Posterior edge of Sternocleidomastoid.
- 3) **Posteriorly**: Anterior edge of trapezius.

Contents:

- 1) Brachial plexus.
- 2) External Jugular vein.



LYMPH NODES

About one-third of the lymph nodes of the body are located in the head and neck area .

Can be divided into two groups :

Superficial lymph nodes.

Occipital Mastoid (Post-auricular).

. Submental. Submandibular.

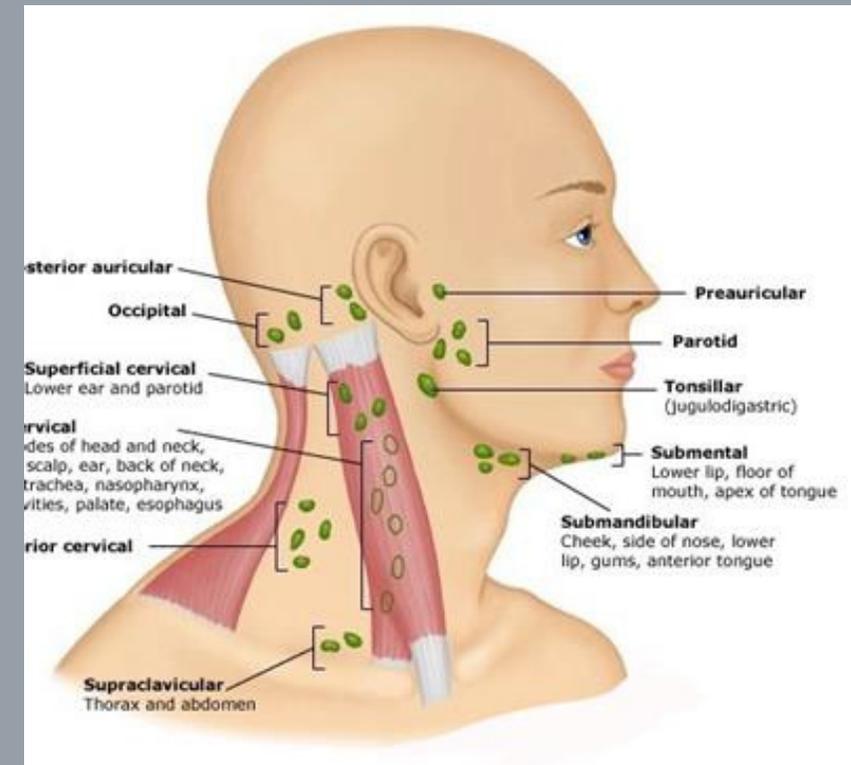
Superficial Cervical.

Deep lymph node :

The nodes can be divided into **superior** and **inferior deep cervical** lymph nodes.

They are numerous in number, but include:-

- Prelaryngeal.
- Infrahyoid.
- Pretracheal.
- Supraclavicular.
- Jugulodigastric.
- Paratracheal.
- Jugulo-omohyoid.



HISTORY

- Patient profile.
- History of presenting illness:
 - How and when did you notice the lump?
- is it Painful? How does it disturb you? (dysphagia)
- Any changes since you first noticed it? If so, over what time frame?
- Has the lump ever disappeared before?
- Have you ever had any lumps before?
- What do you think is the cause?

- Systemic Review:

HEAD & NECK SYMPTOMS:



Pain in mouth/thorax. Mouth ulceration. Nasal congestion or nasal discharge. Difficulty breathing.

- past medical and surgical history.
- Drug and allergy.
- Family History:- Any history of head or neck malignancies
- Social History.



The examination of a lump or ulcer

Local examination

Site

Size

Shape

Surface

Depth

Colour

Temperature

Tenderness

Edge

Composition:

■ consistence

■ fluctuation

■ fluid thrill

■ translucence

■ resonance

■ pulsatility

■ compressibility

■ bruit

Solid, fluid or gas

Vascular

Reducibility

Relations to surrounding structures –
mobility/fixity

Regional lymph glands

State of local tissues:

■ arteries

■ nerves

■ bones and joints

General examination



Mnemonics to remember

Lump examination (3S's, 3C's, 3T's, 1F)

S - Site

S - Size

S - Shape

S - Contour

C - Colour

C - Consistency

T - Tenderness

T - Tethering

T - Transillumination

F - Fluctuance

EXAMINATION

1) site: assess the lump's location in relation to other anatomical structures (e.g. anterior triangle, posterior triangle, midline).

- Midline lumps are likely to be thyroid in origin or thyroglossal/dermoid cysts.

- Posterior triangle lumps are most commonly lymph nodes, although lymph nodes are a common cause of swellings in all areas of the neck.

- Submandibular swellings may be related to the submandibular gland.

- A lump in the left supraclavicular fossa (a Virchow's node) may indicate an infraclavicular metastatic malignancy such as lung or upper gastrointestinal tumors.

2) Size: assess the size of the lump.

3) Shape: assess the lump's borders to determine if they feel regular or irregular.

4) Consistency and mobility: determine if the lump feels

soft (e.g. cyst), hard (e.g. malignancy) or-rubbery (e.g. lymph node).

-Whether it moves on swallowing (thyroid, thyroglossal cysts).

-Whether it moves when the person sticks out their tongue (thyroglossal cysts).

5)Whether it is tender, hot, inflamed.

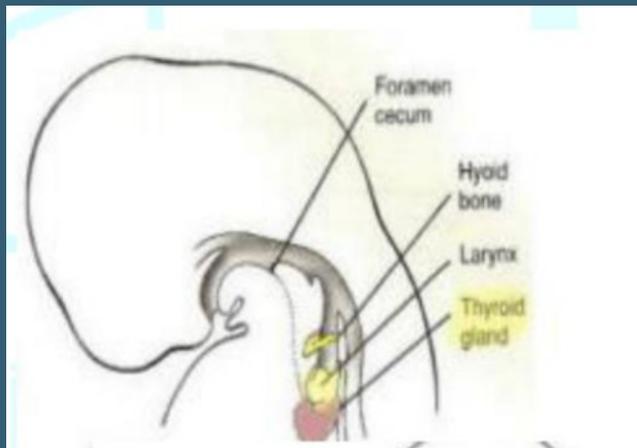
6)How deep the lump is: whether it is intradermal (suggesting sebaceous cyst with a central punctum, or a lipoma), subcutaneous or within deeper tissue.

7)Whether it is pulsatile: suggests vascular origin (e.g. carotid body tumor, aneurysm).



Midline masses

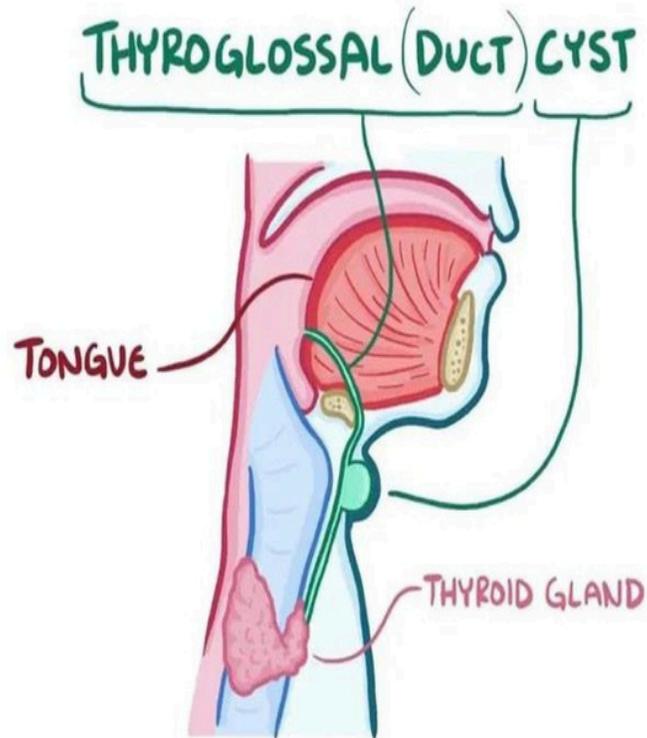
1- Thyroglossal cyst.



EMBRYOLOGY

DURING EARLY IN FETAL LIFE ,THE THYROGLOSSAL DUCT DEVELOPS FROM THE FORAMEN CAECUM AND DESCENDS INTO THE NECK TO GIVE RISE TO THE THYROID ISTHMUS AND ADJOINING PARTS OF LATERAL LOBE . THEN IT IS OBLITERATED AND DISAPPEARS

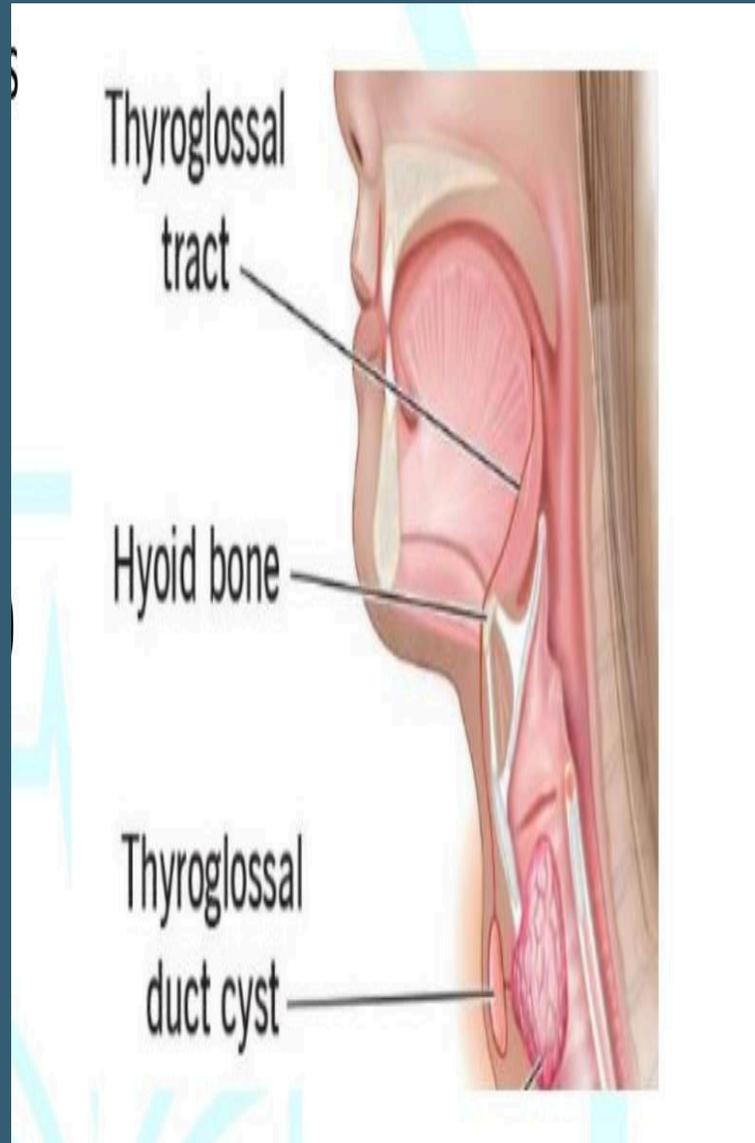
1- THYROGLOSSAL CYST:



Thyroglossal duct cysts is a fibrous cyst that represent a persistence of this track and may therefore be found anywhere in or adjacent to the midline from the tongue base to the thyroid isthmus

the most common midline congenital neck mass

Usually appears in childhood but it may present at any age



PATHOLOGY

- 1- OUTER FIBROUS LAYER & THE WALL IS RICH IN LYMPHOID TISSUES
 2. THE CYST AND FISTULA ARE LINED BY COLUMNAR EPITHELIUM.
 3. THE CONTENT OF THE CYST IS MUCOID FLUID OR PUS IF INFECTED
 4. A FIBROUS CORD CONNECT THE CYST TO THE FORMEN CAECUM AT THE BASE OF THE TONGUE
- . IT MAY PASS IN FRONT, BEHIND OR THROUGH THE BODY OF THE HYOID BONE.

COMPLICATIONS



1. Infection: an infected thyroglossal duct cyst can occur
2. Thyroglossal fistula : may occur due to either infection or inadequate surgical removal of the cyst
Thyroglossal duct cyst carcinoma rarely
3. cancer may be present in the duct cyst. These tumors usually arise from the ectopic thyroid tissue within the cyst.

CLINICAL FEATURES

- Asymptomatic, small, soft, painless, round mass in the center front of the neck. If infected Tenderness, redness and swelling of the mass.
- Fistula A small opening in the skin near the mass, with drainage of mucus from the cyst.
- Difficulty swallowing or breathing



REMEMBER HOW TO EXAMINE THE LUMP

Site

The cysts can occur anywhere along the course of the thyroglossal duct from the foramen caecum to the thyroid gland :

1. Suprahyoid: 20- 25% (very rare)
2. At the level of hyoid bone.
3. On the thyroid cartilage , on one side usually left
4. Subhyoid: commonest site.

Size : is small slowly growing

shape : is hemispherical

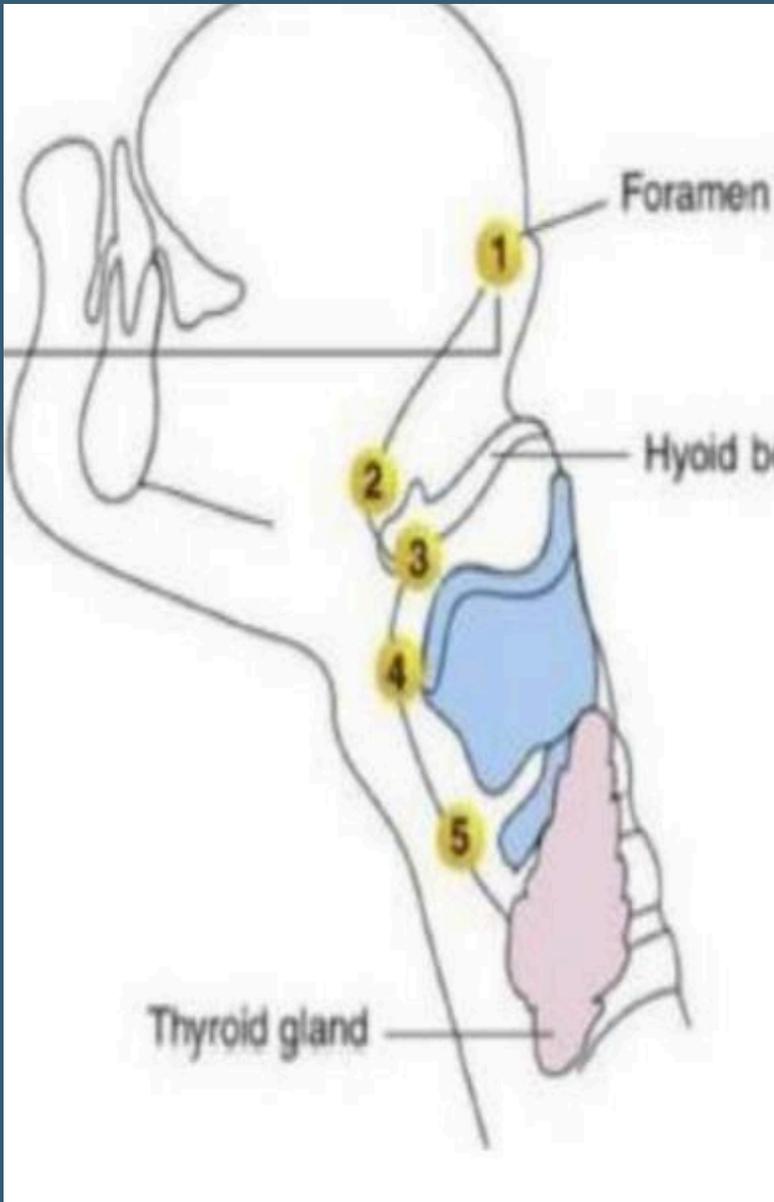
Surface : smooth

Edge : well defined

Consistence : soft to firm cystic

Transillumination : trans opaque

Not attached to skin or surrounding structures unless infected.



THYROGLOSSAL CYST EXAMINATION

Inspection [look 7 Ss] • Site , Shape , Size ,Skin changes ,Surface • Surrounding regional lymph nodes, Shine a light • Tongue protrusion

Thyroglossal cysts will move upwards noticeably during tongue protrusion.

- Observing swallowing thyroglossal cysts typically move upwards

with
swallowing

Palpation

- Cyst is soft to firm in consistency, and fluctuate
- Repeat protrusion and swallowing gently palpating cyst from behind to ensure diagnosis is correct .



INVESTIGATIONS

There is Diagnostic procedures for a thyroglossal cyst after history collection and physical examination

include:

- Blood tests These tests check the thyroid gland function.
- Fine needle aspiration a biopsy to confirm the benign nature of the TGD Cyst

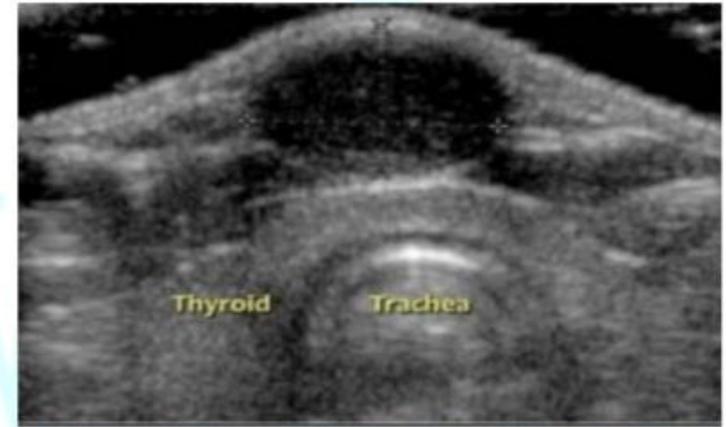
IMAGING :

Ultrasound, a typical thyroglossal duct cysts appears as a smooth

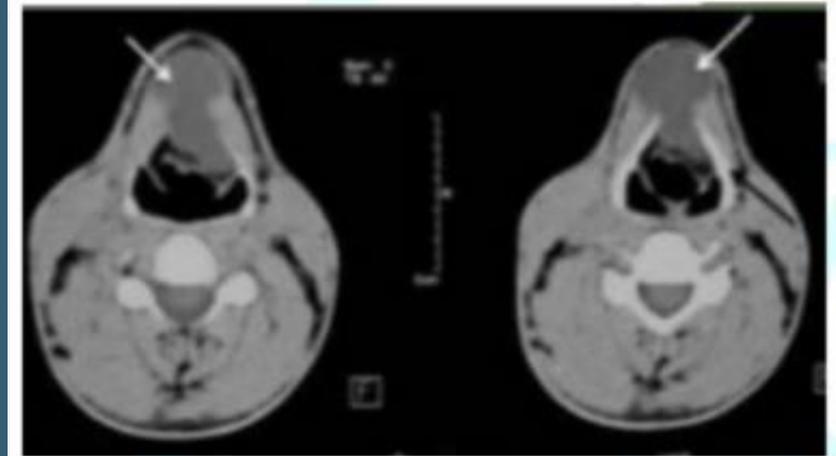
True solid component suggest risk of thyroglossal duct malignancy cyst

CT is often utilized only as a complementary technique for confirmation of diagnosis or for assessing complication .

MRI



Here a transverse image of a hypoechoic thyroglossal duct cyst with some internal .echoes located in the midline



TREATMENT

Complete resection of the cyst and the whole thyroglossal tract is curative.

Complete excision of cyst or fistula by Sistrunk's operation:

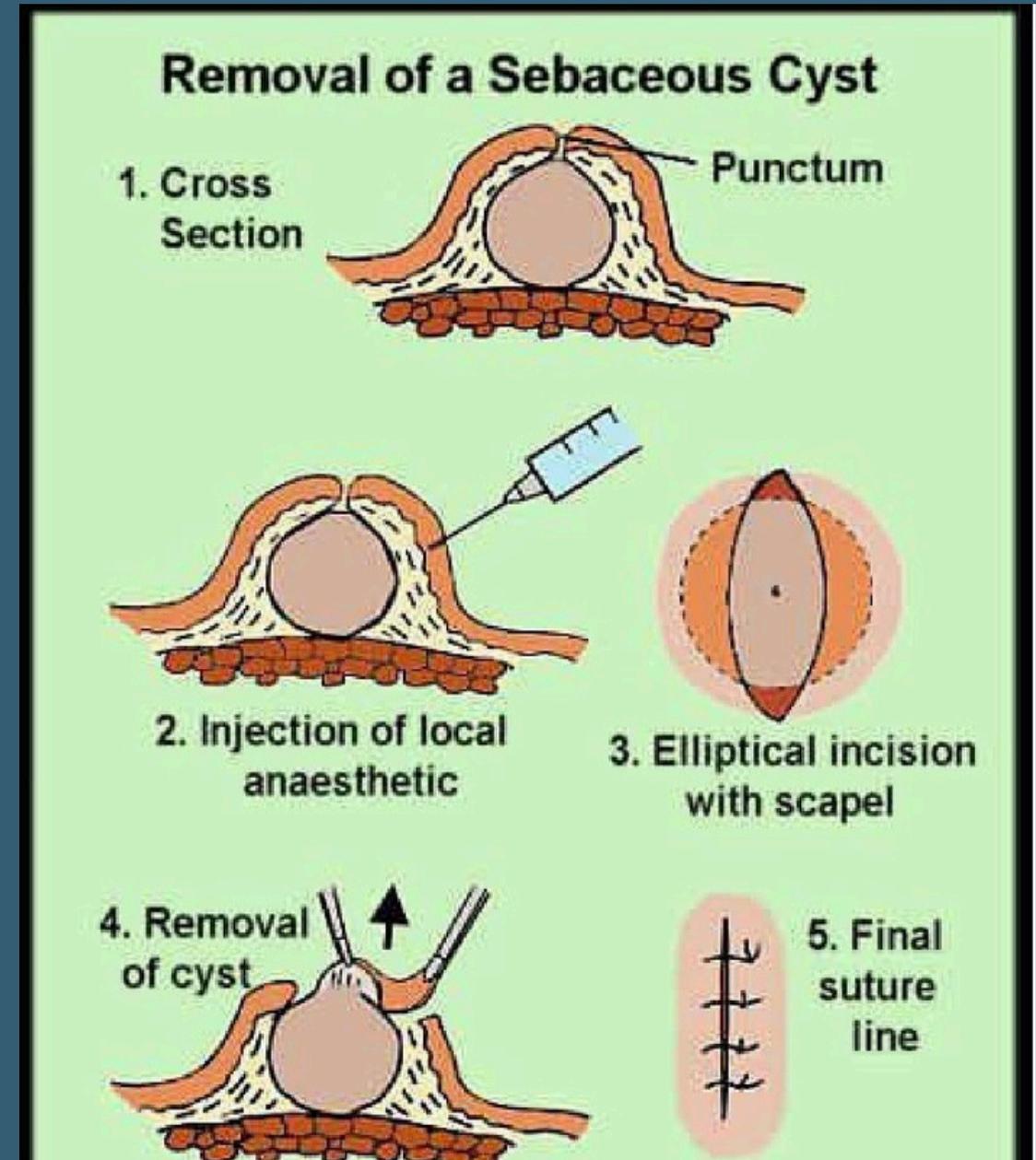
A transverse elliptical incision is made around the cyst, Then Operation involves removal of the body of the hyoid bone and the suprahyoid tract

If incomplete excision → recurrence or fistula may result

Infected cyst should be treated with antibiotics , if the cyst present with abscess ,treatment should consist of drainage and antibiotic.

Differential diagnosis

- Dermoid cyst
- Ectopic thyroid
- Lipoma •Submental lymph node
- Sebaceous cyst •Lar yngocele •Ranula



2-plunging Ranula.

Ranulas represent cystic lesions of the floor of the mouth , usually occurring secondary to obstruction of the sublingual duct .

Therefore these are also called sublingual gland mucocele or mucous retention cyst.

A ranula is a mucus extravasation cyst involving a sublingual gland and is a type of mucocele found on the floor of the mouth.



Ranulas are divided into 2 types:

1. Oral ranulas are secondary to mucus extravasation of sublingual or submandibular that superior to the mylohyoid muscle pools

2. Cervical(plunging) ranulas are associated with mucus extravasation from sublingual gland into the neck through the mylohyoid muscle, they extend into the fascial tissue planes and cause a diffuse swelling of the lateral or submental region of the neck.

CLINICAL FEATURES

1. ASYMPTOMATIC
2. CONTINUOUSLY ENLARGING MASS THAT MAY FLUCTUATE IN SIZE
3. OVERLYING SKIN IS USUALLY INTACT.
4. FREELY MOVABLE.
5. NON TENDER.



Investigations:

The diagnosis is usually made based on the physical

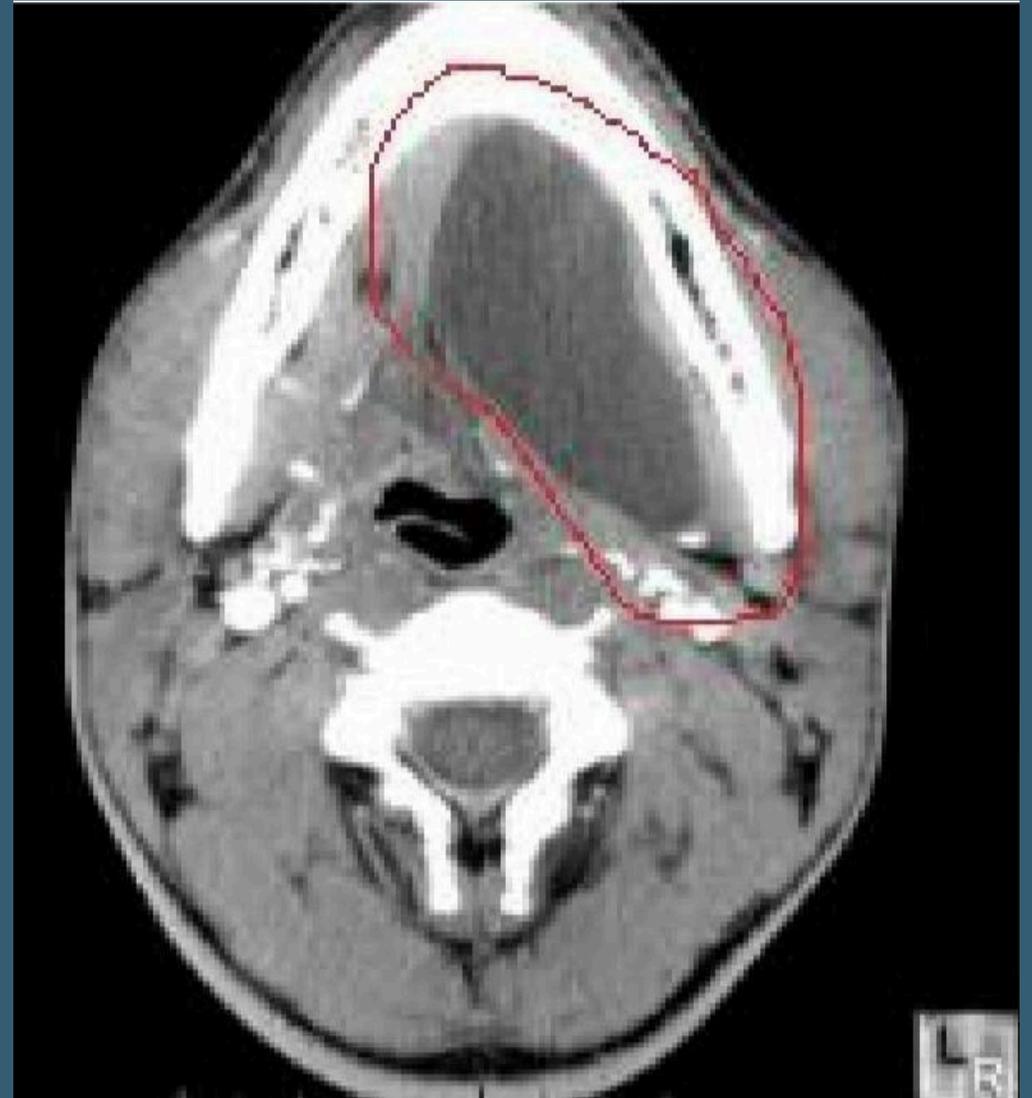
examination, but you can order the following imaging

1- CT scan

2- Ultrasound of the neck

3- MRI

Note : imaging tests can sometime be ordered even after making the diagnosis in order to determine the extent of swelling and also to distinguish whether the symptoms are caused by the ranula or due to other causes.



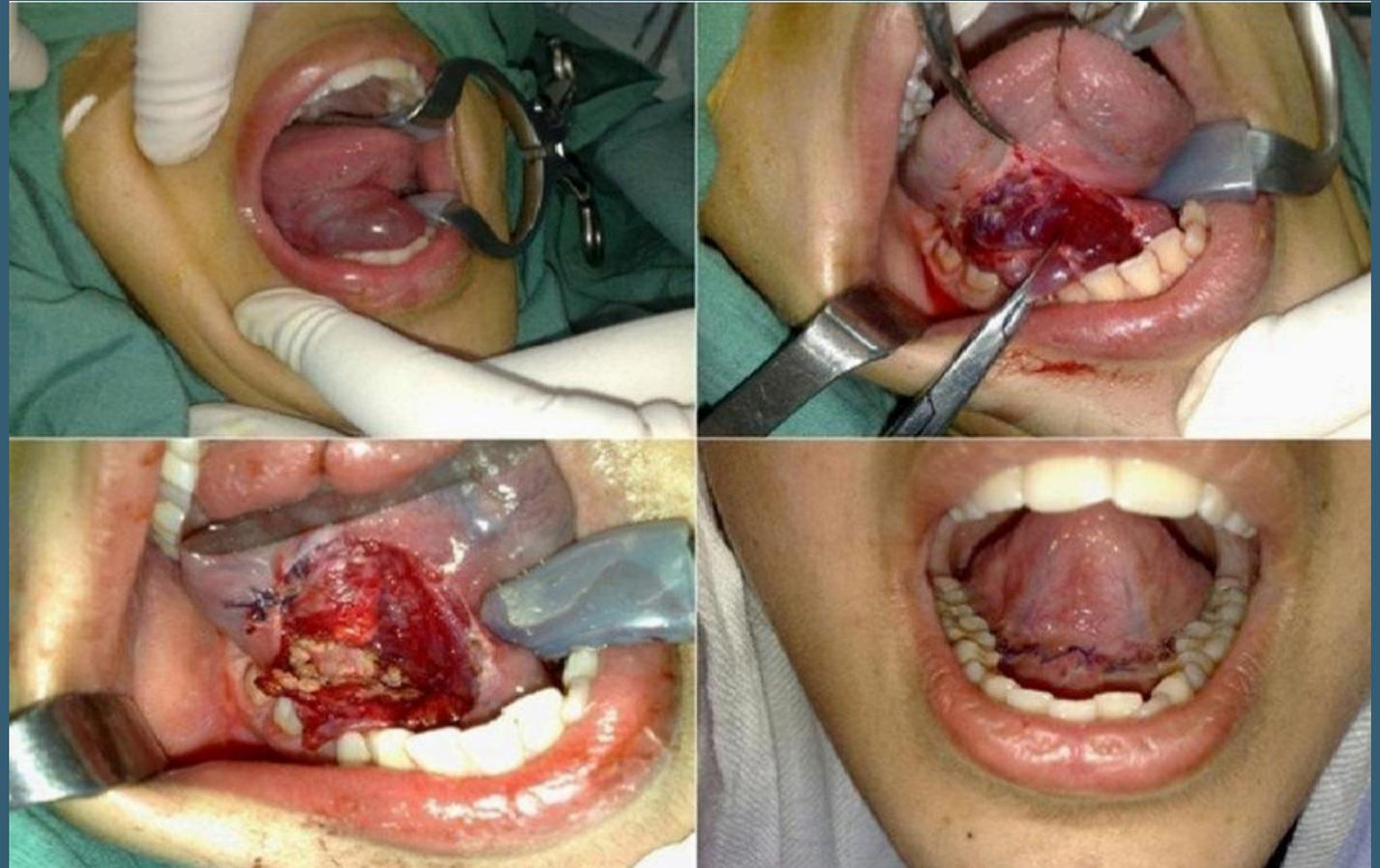
Treatment

A small ranula that causes no symptoms may not require treatment and, in some cases, it may resolve on its own. But if treatment is necessary for enlarged ranulas especially these that can cause difficulty in speaking, swelling, etc. The treatment can be either medical therapy or surgical therapy.

Medical therapy includes sclerotherapy which decreases the size of the swelling.

Surgical therapy and that includes two approaches.

Trans oral and transcervical



LATERAL NECK LUMP





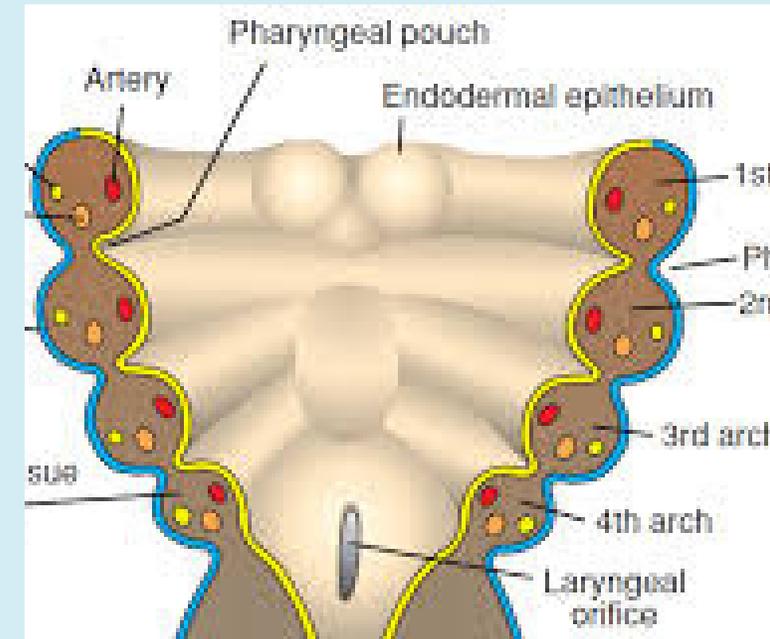
BRANCHIAL CLEFT CYSTS

Etiology

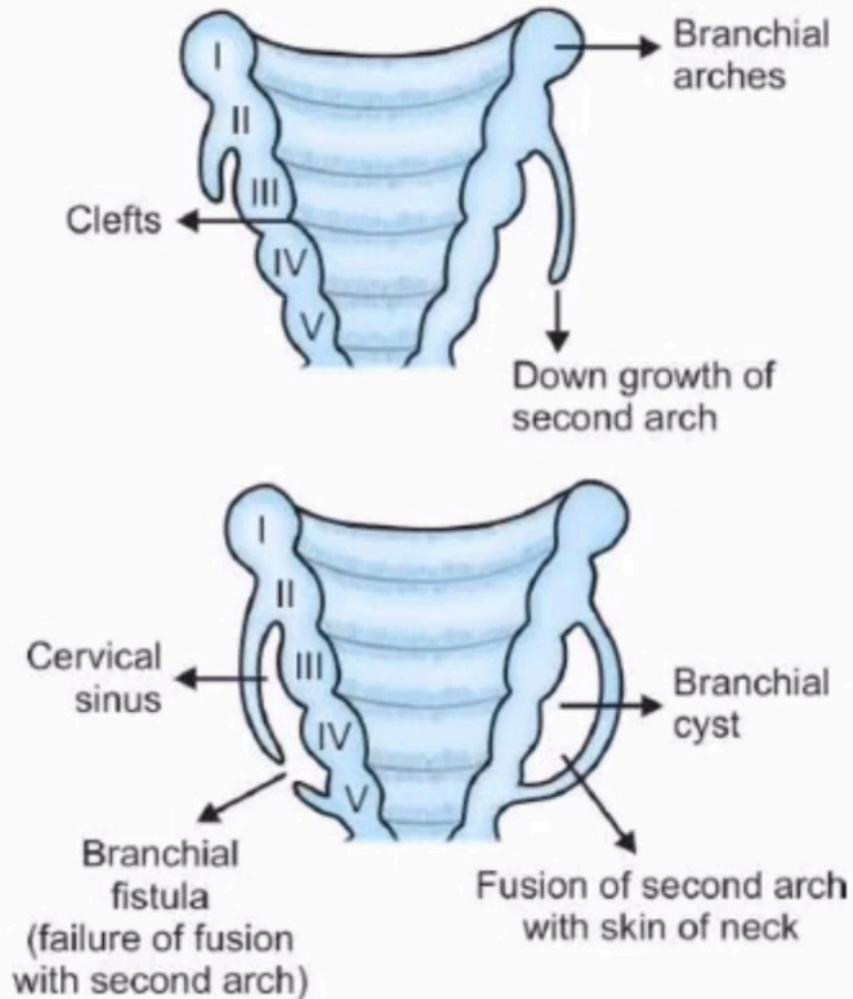
Branchial cleft cysts are congenital epithelial cysts that arise on the lateral part of the neck from a failure of obliteration of the second branchial cleft in embryonic development.

Embryology

At the fourth week of embryonic life, 4 grooves can be seen on the outer side of branchial arches, which normally involute around week 7 of development which contribute to the formation of various structures of the head, neck, and the thorax. If a portion of a cleft fails to involute completely. The entrapped remnant forms an epithelium-lined cyst with or without a sinus tract to the overlying skin.



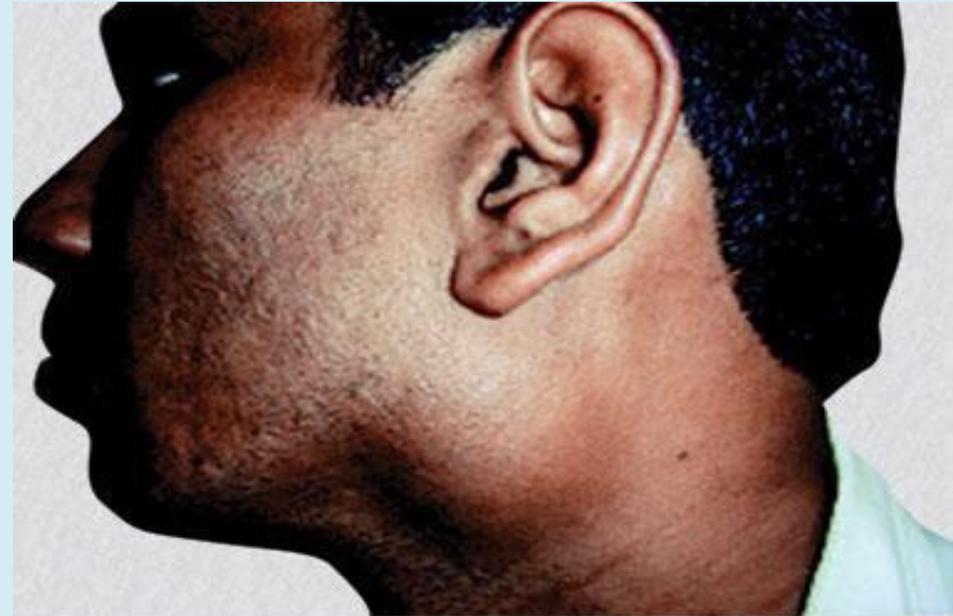
Cause: failure of obliteration of **cervical sinus** in foetal life



The most common type of branchial cleft cyst arises from the second cleft, with anomalies derived from the first, third, and fourth clefts being rarer

Branchial cleft presents as cysts , sinuses or fistulas

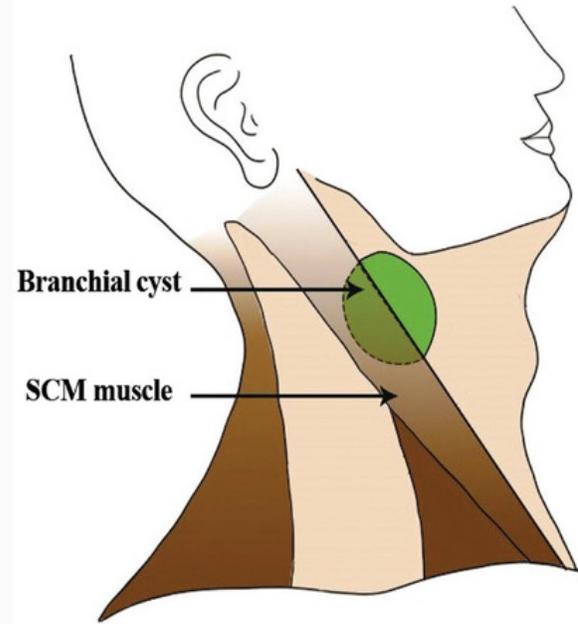
The cyst and fistula are lined by stratified squamous epithelium and contains mucoid fluid rich in cholesterol crystals



Branchial cyst on left side

Clinical picture

- **Child** with neck swelling
- **Lateral** side of the neck
- Behind anterior border of sternomastoid
- The cyst is ovoid, smooth surface, painless
- On muscle contraction **bulge!**
- (Partially deep to the muscle)



Complications

- Infection



- fistula



HISTORY

Site: At the upper third or middle third of SCM at its anterior border

Number: Solitary

Consistency: Soft in its early stages so that it may be difficult to palpate
Fluctuant swelling that may transilluminate

■ A branchial cyst commonly presents as a solitary, painless mass in the neck of a child or a young adult. A history of intermittent swelling and tenderness of the lesion during upper respiratory tract infection may exist.

■ Discharge may be reported if the lesion is associated with a sinus tract.

■ The most concerning symptoms included dysphagia, dyspnea, and stridor due to cyst compression of the upper airway.

■ It becomes enlarged, tender, and erythematous during upper respiratory infections, exacerbating by moving the neck and opening the mouth.

■ +ve family history

PHYSICAL EXAMINATION

- **Primary lesion:** Branchial cysts are smooth, nontender, fluctuant masses, which occur along the lower one third of the anteromedial border of the sternocleidomastoid muscle between the muscle and the overlying skin.
- **Secondary lesion:** The lesion may be tender if secondarily inflamed or infected. When associated with a sinus tract, mucoid or purulent discharge onto the skin or into the pharynx may be present.

INVESTIGATIONS

There is no specific laboratory test needed

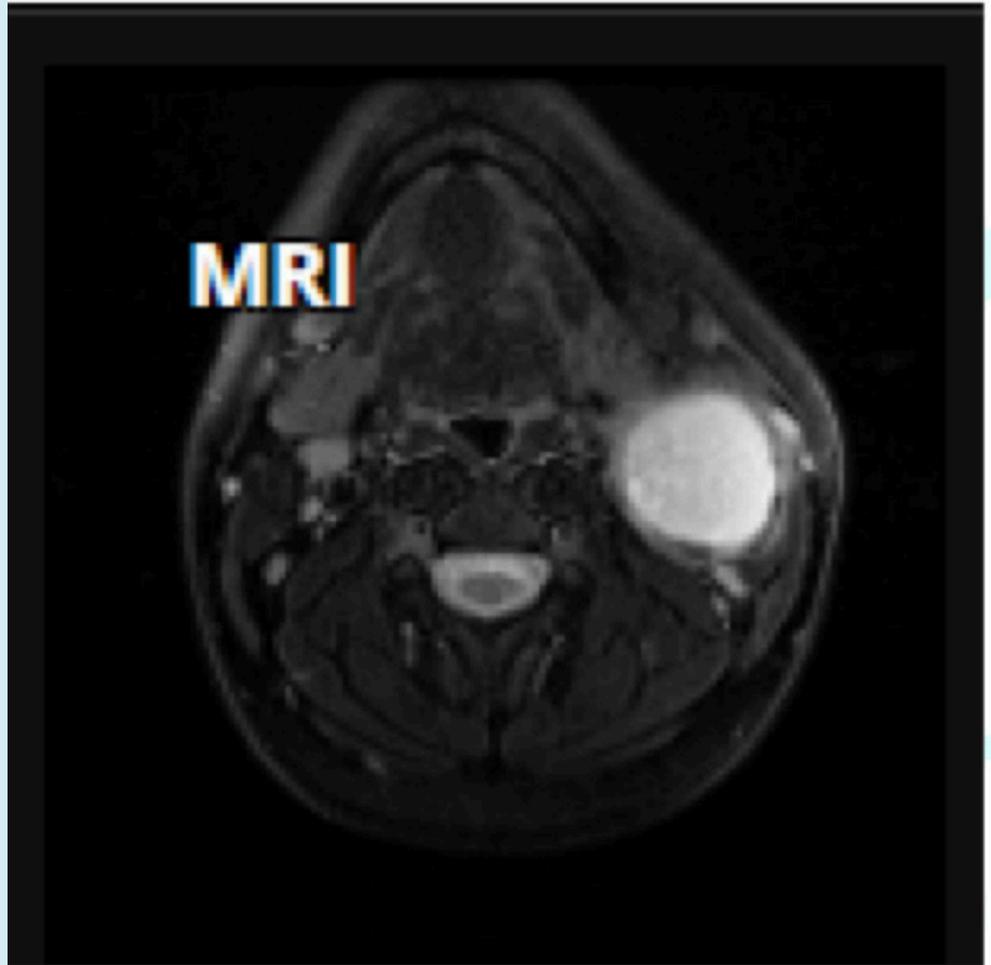
Imaging Studies

Ultrasound can be obtained to determine the cystic characteristics of the cyst (useful in differentiating solid lesions, e.g. malignant lymph nodes from cystic lesions such as a branchial cyst).

Contrast enhanced CT will depict a cystic and enhanced mass in the neck.

MRI can be used for a finer resolution.

Fine needle aspiration is helpful to distinguish a branchial cleft cyst from malignant neoplasm.



Treatment

Antibiotics are required to treat infections or abscesses.

Complete excision of cyst or fistula

through

two transverse incisions with dissection of the track upwards to the pharynx

(stairstep or stepladder incision)

Differential diagnosis

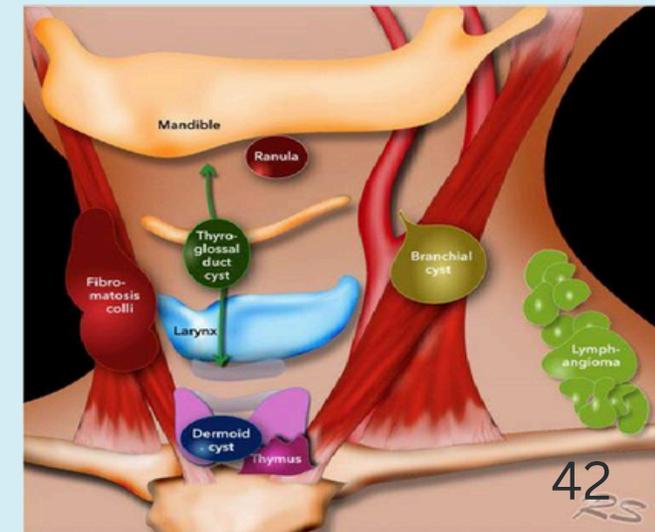
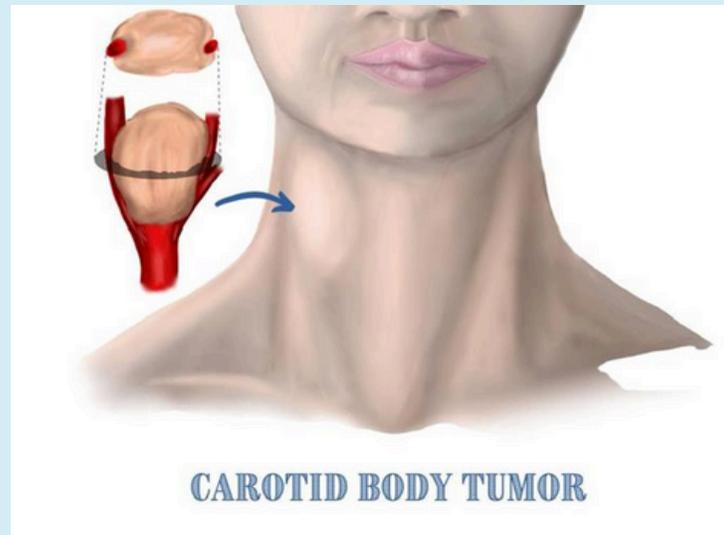
unilateral lymphadenopathy

Cystic hygroma

Carotid body

~~Tumor~~ tumor thyroid

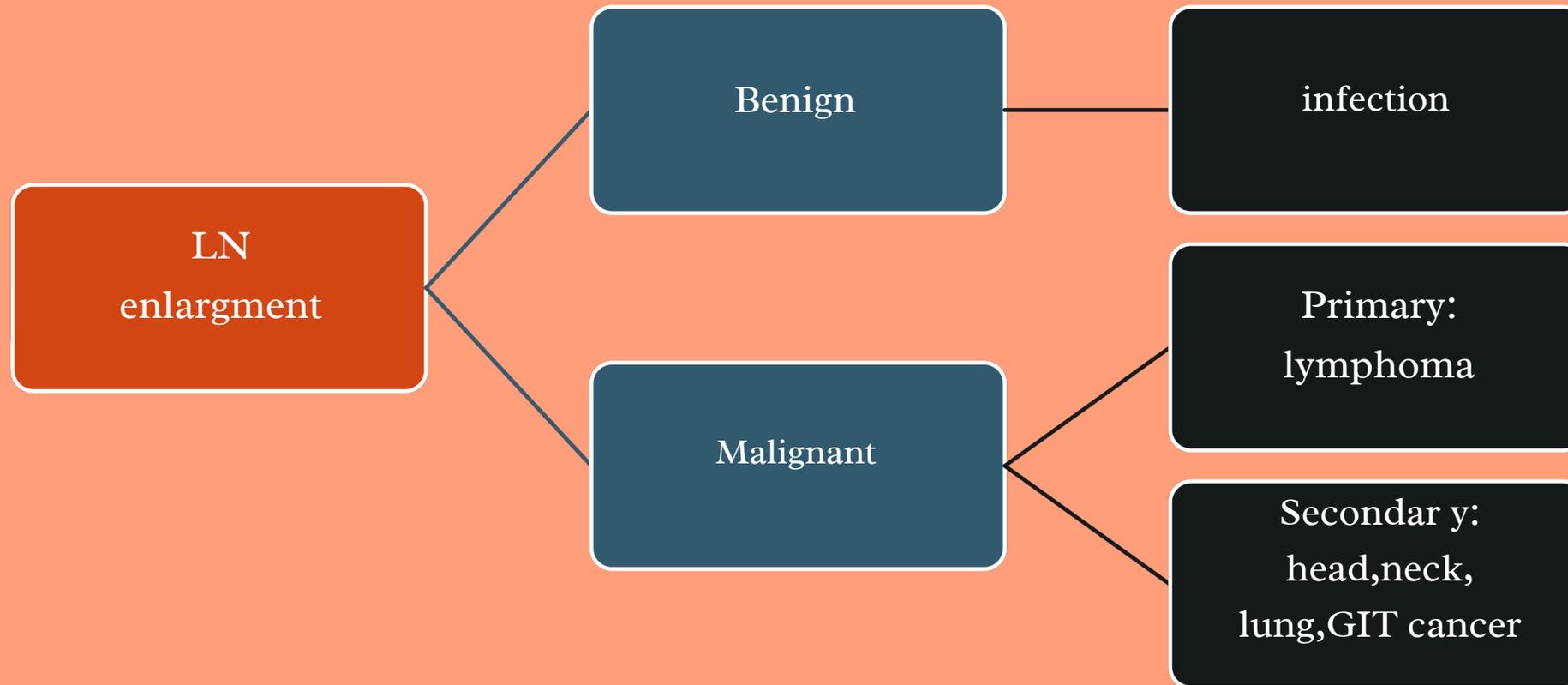
paramedian thyroglossal duct cyst



LYMPHADENOPATHY



MOST COMMON CAUSE OF NECK SWELLING IS LYMPHADENOPATHY



If the mass is tender :



Ask the patient about symptoms of infection: fever – weakness – rigors



-Ask about the source of infection: tooth pain – sore throat – contact with ppl with infection

Painless mass:



The size = > 1.5 cm



-Presence of B symptoms: 1. Significant weight loss
2. Anorexia 3. Night sweat

LYMPHADENOPATHY

Infections :

Nonspecific Lymphadenopathy specific

Lymphadenopathy (e.g., TB, viral, protozoan, other bacteria)

Neoplasms

- Primary – lymphoma
- Secondary – metastasis (EX. GIT & lung cancer metz to supraclavicular LN)

Other causes

connective tissue disorders - SLE/RA

hypersensitivity

INFECTIOUS:

Unilateral cervical lymphadenopathy (UCL) most commonly caused by bacterial infections (> 80%)

Symptoms :

- ✓ Recent or current symptoms of bacterial infections (e.g., upper respiratory tract infection, dental conditions)
- ✓ • Lymph node involvement :Most commonly submandibular or deep cervical nodes (> 80% of cases)
- ✓ (3–6 cm),enlarged tender nodes with warmth and possibly erythematous skin over the node
- ✓ May form an abscess over time or become indurated
- ✓ Chronic cases: insidious enlargement; nontender, immobile, may form to sinus

Bilateral cervical lymphadenopathy (BCL)

most commonly caused by viral infections of the upper respiratory tract Symptoms :

Symptoms of upper respiratory tract infection may be present (e.g. , cough, fever, sore throat)

- Lymph node involvement :Submandibular or deep cervical nodes are most commonly affected Typically small, mobile, tender nodes without erythema or warmth
 - Lymphadenopathy may last for up to several weeks

NONSPECIFIC LYMPHADENOPATHY

History:

Usually, painful lump. difficulty in breathing (snoring).

nasal speech because of tonsillar and adenoid hyperplasia.

systematic symptoms: fever, anorexia , malaise. can occur at any age.

Examination:

Firm

Tender

or warm

SPECIFIC LYMPHADENOPATHY TUBERCULOUS LYMPHADENITIS

Specific Lymphadenopathy caused by *Mycobacterium tuberculosis*.

Chronic, specific granulomatous inflammation of the lymph node with caseation necrosis.

One of the most common presentations of extrapulmonary tuberculosis.

Gradually increasing painless swelling of one or more lymph nodes with weeks to months duration.

Deep upper cervical nodes are most commonly affected

Common in children and young adults.

The infection usually through tonsils, occasionally through blood from lungs.



SYMPTOMS:

Fever

Fatigue

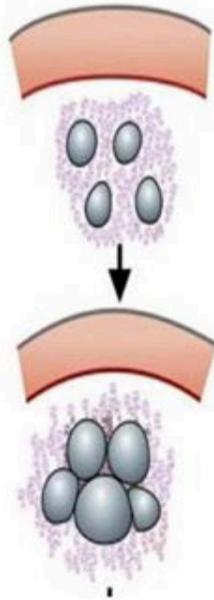
Weight loss

Night sweat

cough (maybe from pulmonary tuberculosis)

failure to thrive (in children)

Stages



Stage 1: Lymphadenitis
(Discrete nodes, nontender, firm/hard mobile)

Stage 2: Matting
(Firm, nontender, move together en mass—due to periadenitis)

- Cold abscess is soft, smooth, nontender, fluctuant, without involvement of the skin. It is not warm. This is a clinical manifestation of underlying caseation
- Left untreated, as a result of increased pressure, cold abscess ruptures out of the deep fascia to form *collar stud abscess* which is adherent to the overlying skin.
- Eventually collar stud abscess bursts open, discharging sinus is formed. It can be multiple, wide open mouth, often undermined, nonmobile with bluish color around the edge. It is usually not indurated.



Stage 3: Cold abscess
(Deep to deep fascia)

Stage 4: Collar stud abscess
(Rupture through deep fascia under the skin, cross-fluctuant, adherent to skin)

Stage 5: Sinus formation

Examination	Tuberculous cervical lymphadenitis	Tuberculous abscess
position	Upper and middle deep cervical glands	Upper half of the neck
temperature	Does not feel hot	Normal (the process of caseation and pus formation is slow and does not stimulate excessive hyperthermia) cold abscess
tenderness	Non or slightly tender	Tender
Color	normal	when the pus reaches the subcutaneous tissues, the overlying skin turns reddish-purple.
Shape and size	discrete and between 1-2cm in diameter.	deep part of the abscess tends to be sausage shaped./ 3-5 cm
consistency	In early stages glands are firm.	firm and rubbery ,and if there is sufficient pus present, it will fluctuate.



INVESTIGATIONS

Labs

Raised ESR and CRP.

Staining (Ziehl-Neelsen-AFB)

Mycobacterial culture

Radiology

X-ray

CT scan

Excisional biopsy

Tuberculin test

TREATMENT

Medical

Anti-tubercular drugs : Isoniazid, Rifampicin, Pyrazinamide and Ethambutol.

Duration is usually 6-9 months.

Aspiration(Zig-zag aspiration of cold abscess by wide bore needle in nondependent area to prevent sinus formation.

Surgical removal

Indicated when: No local response to drugs

When sinus persists

It is done by raising skin flaps and removing all caseating material and lymph node.

Excision of sinus tract (When sinus develops)



CANCERS



Lump in the neck can be caused by various types of cancers.

This comprises :

- 1-Lymphoma
- 2-Thyroid cancers
- 3-Salivary gland cancer
- 4-Metastatic cancers
- 5-Carotid body tumour

LYMPHOMA



Neoplastic proliferation of lymphoid cells that forms a mass. Divided into Hodgkin lymphoma (HL,40%) and non-Hodgkin lymphoma (NHL,60%) The most frequent sites were cervical lymph nodes (36.8% of all cases)



Hodgkin

Hodgkin lymphoma is most common among people 15 to 35 years old

and 50 to 70 years old

The male to female ratio is 3:2.



Non-Hodgkin

Non-Hodgkin lymphoma is common in ages 65 to 74, the median age being 67 years

HISTORY

1- Enlarged painless lymph nodes 2-

Fever (which can come and go over several days or weeks)

3-Night sweats

4-Weight loss 5-Fatigue

6-Pruritus may be present

7-A family history is also helpful; in particular, nodular sclerosis

Hodgkin lymphoma(NSHL)

PHYSICAL EXAMINATION

-Palpable lump

-Smooth , rubbery

- Not tender

- Move easily under the skin when pressed

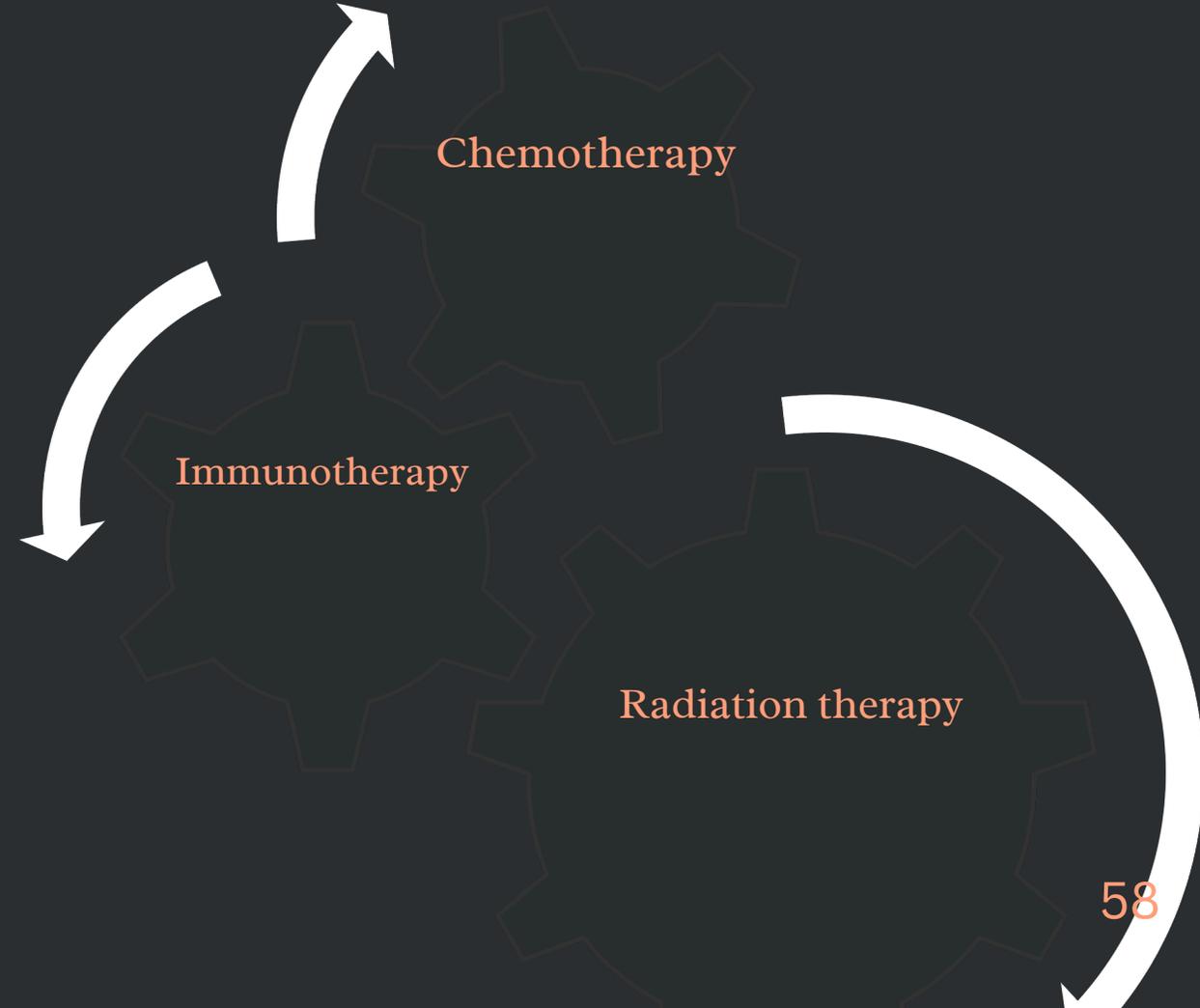
-Splenomegaly and/or hepatomegaly



INVESTIGATION

- *The chief diagnostic test is typically a lymph node biopsy
- Blood tests, which can include CBC, LDH
- Imaging tests, such as X-ray, ultrasound, Positron emission tomography (PET), and computed (tomography CT) scan

TREATMENT



THYROID CANCERS

Thyroid cancer may be the source of a neck lump.

- Thyroid cancer is a rare form of cancer, accounting for less than 1% of all cancer cases in the UK

- There are 4 main types of thyroid cancer. They are:

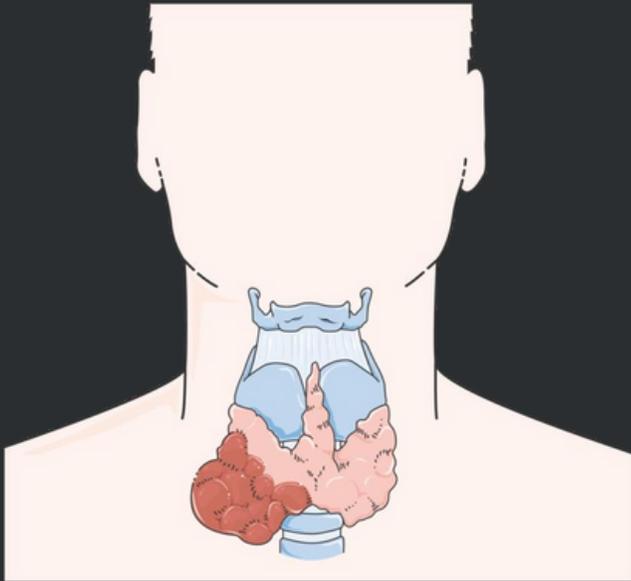
Papillary carcinoma
this is the most common type, accounting for about 6 out of 10 (60%) cases; it usually affects people under the age of 40, particularly women, good prognosis

follicular carcinoma
accounts for around 3 out of 20 (15%) cases of thyroid cancer and tends to affect older adults
Good prognosis

Medullary thyroid carcinoma
accounts for between 5 and 8 out of every 100 diagnosed cases (5% to 8%); unlike the other types of thyroid cancer, medullary thyroid carcinoma can run in families

Anaplastic thyroid carcinoma
this is the rarest and most aggressive type of thyroid cancer; it usually affects older people over the age of 60

HISTORY AND PHYSICAL EXAMINATION



History

Increase in the size of lump

Age >55 years

Asymptomatic

Pressure symptoms such as hoarseness of voice, dysphasia, dyspnea

Weight loss

Fatigue

Family history of thyroid cancer, or childhood irradiation to the head and neck region

Physical examination

- Palpable
- Stony,
- hard
- Immobile

INVESTIGATION

- Laryngoscopy
- Blood hormone studies
- Ultrasound
- CT scan
- Fine-needle aspiration biopsy
- Surgical biopsy

TREATMENT

- Surgery (the most common treatment for thyroid cancer)
- Radiation
- Chemotherapy
- Thyroid hormone therapy



METASTATIC CANCERS



Cervical lymph nodes are a common site of metastases for malignant tumours.

When metastases from other cancers reach the cervical lymph nodes, it often indicates advanced disease and can arise from various primary sites. Common types include lung cancer, breast cancer, and gastrointestinal malignancies, such as colorectal cancer, with lung cancer being one of the most frequent sources. The incidence of cervical lymph node metastasis from these distant cancers is relatively low, estimated to be around 1% to 5%, depending on the primary cancer type. Understanding the potential origins of these metastatic lymph nodes is crucial for proper diagnosis and treatment planning. Early detection and intervention can significantly impact patient outcomes and survival rates.

CAROTID BODY TUMORS

*Carotid body tumors, also known as paragangliomas, are generally slow-growing and are usually benign.

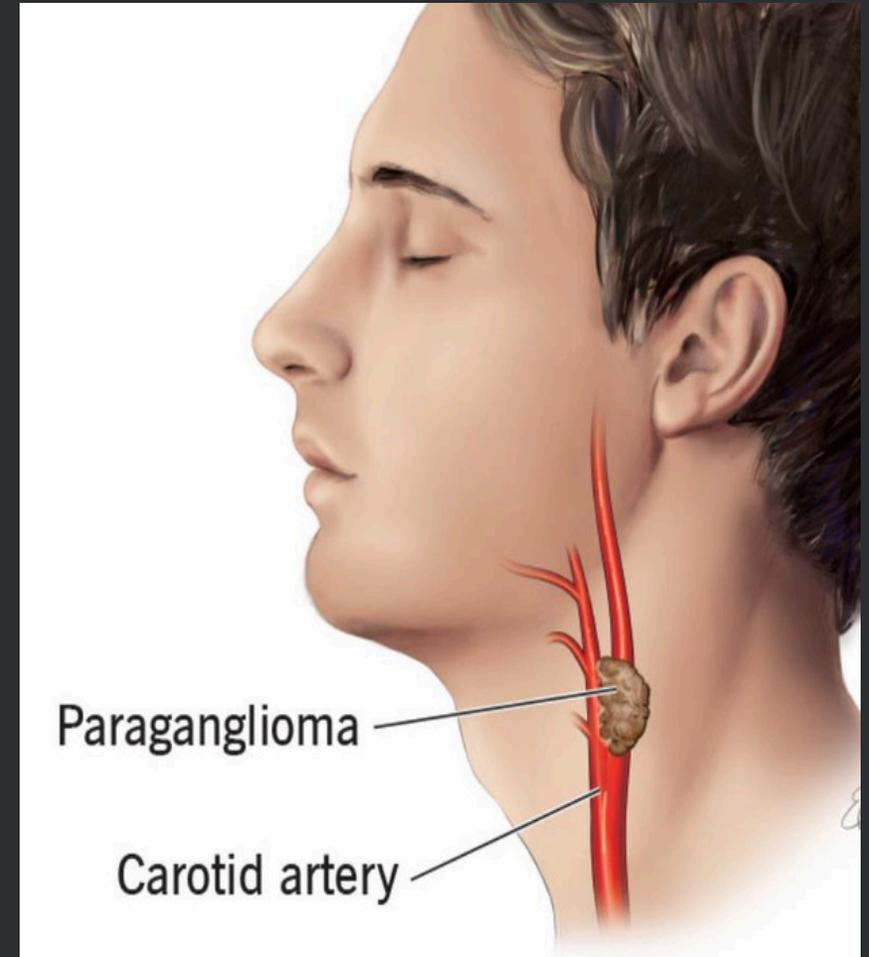
Symptoms:

- Lump in the neck
- Dysphagia
- Hoarseness

Diagnosis and treatment

- CT
- Ultrasound
- MRI

TREATMENT options depend on the size , growth rate and location. Surgical removal may be recommended for large or sympathetic tumors.



THANK YOU