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Huge Cervical Swelling Hiding a Tonsillated Cyst: About 01Case

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Abstract:- Tonsilloid cysts are the most common gill abnormalities, they account for 6.1 to 85.2% of the anomalies in the second slot. They are due to the persistence of the cervical sinus during the differentiation of the branching apparatus. The usual seat is the middle third of the anterior edge of the sterno-cleido-mastoid muscle but they can be located at any point from the average constrictor muscle of the pharynx to the above-clavicular region. We report in this work the clinical observation of a 6-year-old child who consulted for a left laterercervical swelling evolving for 2 months without associated signs, good general condition.the patient was stable on the hemodynamic and respiratory level in which the presence of a latero cervical left, non-inflammatory, painless firm fixed in relation to the superficial and deep plane, non-pulsatile. The etiological check-up was supplemented by imaging, the patient benefited from an exploratory cervicotomia with a resection of the entire cyst and sending the piece to the anatomopathological study. the histological diagnosis retained was a tonsilloid cyst with no signs of malignancy. Through our work we emphasize the value of therapeutic management as early as possible to limit the risk of inflammatory changes.

I. INTRODUCTION

The amygdaloid cyst is a rare high-breast-lather-cervical cystic tumor, resulting from the 2nd branching cleft. It accounts for 2% of lateral-cervical neck tumors, and 6.1 to 85.2% of abnormalities of the second cleft. They are due to the persistence of the cervical sinus during the differentiation of the branching apparatus. The usual seat is the third middle of the anterior edge of the sterno-cleido-mastoid muscle but they can be located at any point from the average constrictor muscle of the pharynx to the above clavicular region. We report a rare observation of cervical seat tonsilloid cyst.

II. CASE REPORT

This is a 06-year-old child from a follow-up pregnancy, well vaccinated, with no particular pathological history. The child two months before her consultation noticed isolated left cervical swelling without signs of compression, the mother found that it was increasing in volume. Clinical examination found a child with stable general condition stable on the hemodynamic and respiratory level. We note a left cervical latero swelling, non-inflammatory, hard pain fixed in relation to the superficial and deep plane, not pulsatile.

Cervical ultrasound objectived an oval mass of 7.2x3.7x3.3 cm left latero-cervical located at the deep part of the sterno-cleido-mastoid muscle and outside the deep vascular axis, hypoechogen at hyperechogen center. On cervical MRI, the mass appears in iso T1 signal, discrete hypersignal on the T2 sequence and presenting an essentially peripheral enhancement with a central area is avascular. The lesion appears in hypersignal diffusion with decrease of CED, an infiltration of adjacent soft parts including the sterno-cleidomastoid muscle, on the data of this MRI, we note a refoulement of the laminated jugular vein but which remains permeable without signs of carotid dissection. (Figure2.1)

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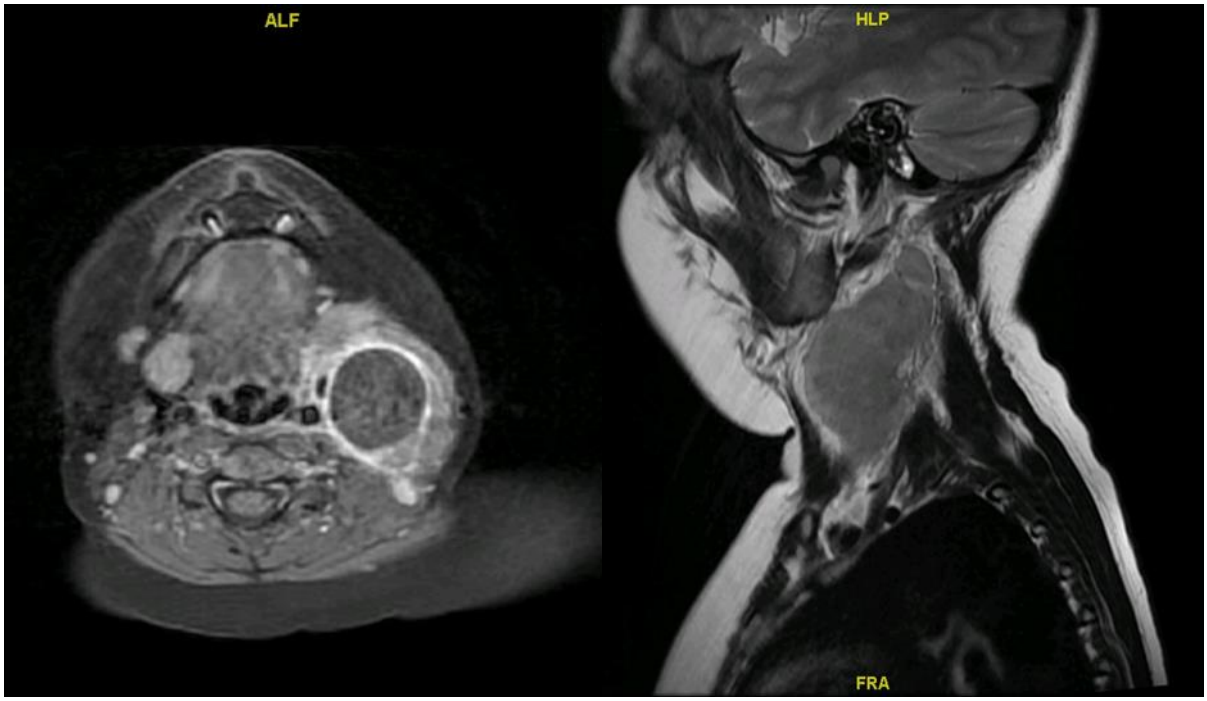

Figure1.2: axial and sagittal cut of cervical MRI showing left laterocervical mass

We opted for an exploratory cervicotomia with mass resection that was adregated for the histological study, which objectified the diagnosis of tonsilloid cyst with a pavimental epithelial coating laminated with lymphoid infiltration.

III. DISCUSSION

Dysembryological benign cystic tumours develop in the antero-lateral part of the neck. They are part of the congenital abnormalities of the second branchial cleft, the frequency of tonslonoid cysts compared to abnormalities of the second cleft varies from 6.1 to 85.2%.(1.2.3)

The age of discovery is more advanced than for other congenital fistulas, with a peak of frequency in the 2nd and 3rd decade, without any predominance of sex.Clinically, a cervical sinus cyst appears in the form of an oval, renitent, mobile swelling under superficial planes, most often located near the carotid bifurcation in a sub-hyoid position [4.5.6]. Although these lesions are congenital, they are usually only identified between the second and fourth decade of life, when they increase in size or become symptomatic, it depends on the location and size of the cyst.

The topography of tonslonoid cysts can be explained by the seat of His cervical sinus which normally disappears completely, but it may persist occasionally in the form of a cervical cyst [2]. The cyst sometimes communicates with the skin or pharynx, either spontaneously or as a result of overinfection. Communication with the outside is through a narrow channel called external cervical fistula, whose external opening is often at the meeting of the middle third and lower third of the anterior edge of the sterno-cleido-mastoidian muscle.

While communication with the pharynx, rarer than the previous one, is done by an internal fistula that opens in an embryonic derivative of the second gill pocket, the amygdala [3]. CT or MRI are particularly indicated to differentiate the lesion from other parapharyngeal tumors: a hemangioma, lymphangioma or dermoid cyst, metastatic adenopathy whose distinction with a degenerate tonslonoid cyst or intra-cystic metastasis is very difficult and confirmation remains anatomopathological after surgical exerts (7.8)

Current imaging and especially magnetic resonance imaging (MRI) confirm the cystic nature and proximity of large vessels in the neck, without prejudging the primitive or secondary nature of the malignant amygdaloid cyst. The finding of a fistula of the second cleft, especially if it is bilateral should have a branchiootidinal syndrome sought by a renal ultrasound. These cysts were classified into four stages by Bailey [9]; Type I: superficial cyst, under superficial cervical acrosis, Type II: cyst under the middle cervical apotheosis, in the prevascular region (most common), Type III: intervascular cyst, in the fork between ACI and ACE, Type IV: intravascular cyst, between pharyngeal wall and carotid axis.

The tonsilloid cyst is lined with an epithelium of different types, the most malpighian. It may also be a cylindrical Malpighian epithelium of ectodermic origin. Some authors believe that the presence of keratin, the presence of lymphoid tissue are mandatory criteria for the diagnosis of tonslonoid cyst.

Differential diagnosis occurs especially when there is an isolated fistula-free lateral-cervical mass that should cause children to have unlococular cystic lymphangioma, lipoma or adenopathy [11]. Infection is the most commonly

revealing complication of this malformation complicating her surgical exeresis of the cyst. The tonsilloid cyst, sometimes rapidly evolving and compressive, can cause feelings of discomfort and bradycardia by rapid and significant compression of the carotid bulb, in this case the cyst must be punctured to relieve the patient. Malignant transformation within the gill cyst is described in the literature but it remains exceptional, only 15 cases have been published in the world literature including 4 in situ carcinomas and 11 invasive squamous cell carcinomas [9]. The diagnosis of malignant gill cyst should be given greater reserves and should only be retained after it has eliminated a metastasis within the branchial cyst of a distant primary carcinoma and a simple cystic evolution of a metastatic ganglion.

IV. CONCLUSION

The cyst of the second branching is a benign dysembryoplastic latero-cervical tumor. Diagnosis is imaging-oriented, but confirmation is still surgical and anatomopathological. Therapeutic management is always surgical, it must be carried out as soon as possible to limit the risk of inflammatory changes related to infectious episodes, it will then be necessary to operate only after complete cooling of infections with appropriate antibiotic therapy.

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