Neck Lumps in Adults

Disclaimer

Contents

Background ......................................................................................................................................................... 1
  About neck lumps in adults .......................................................................................................................... 2
  Red flags ..................................................................................................................................................... 2
Assessment ...................................................................................................................................................... 2
  General examination ................................................................................................................................. 2
  Neck lump features ............................................................................................................................... 2
  Lateral lumps ............................................................................................................................................ 2
  Lymph node features ............................................................................................................................. 3
  Branchial cyst ........................................................................................................................................... 4
  Normal variant ......................................................................................................................................... 4
  Salivary gland .......................................................................................................................................... 4
  Others ...................................................................................................................................................... 4
  Upper midline lumps ............................................................................................................................... 5
  Thyroglossal duct cyst ............................................................................................................................. 5
  Dermoid .................................................................................................................................................. 5
  Plunging ranula ....................................................................................................................................... 5
  Lower midline lumps ............................................................................................................................... 6
  Thyroid .................................................................................................................................................... 6
  Fine needle aspiration (FNA) .................................................................................................................. 6
Management ................................................................................................................................................... 7
  Broad Spectrum Antibiotics ..................................................................................................................... 7
  Criteria for high suspicion of neck or salivary cancer ............................................................................. 7
Referral .......................................................................................................................................................... 7
Information .................................................................................................................................................... 8
  For health professionals .......................................................................................................................... 8
  For patients ............................................................................................................................................. 8
  Disclaimer .............................................................................................................................................. 8

Background
About neck lumps in adults

- Neck lumps can be categorised as congenital or developmental, inflammatory, or neoplastic.
- Neck lumps in adults are relatively common, but may be the first sign of metastatic cancer.
- The most common primary will be in the head and neck region e.g., upper aerodigestive tract or cutaneous squamous cell carcinoma.
- If metastatic, symptoms may relate to primary site (throat pain, dysphagia, hoarseness), but primary site may also be asymptomatic.

Red flags

- Difficulty swallowing or breathing
- Acute inflammation, pain, or swelling
- Persisting cough
- Persistent lateral neck lump
- Mouth ulcers, hoarseness, nasal obstruction

Assessment

1. History:
   - Duration – A neck lump that has been present for > 4 weeks needs investigation, unless it is shrinking. Lumps < 3 weeks duration are usually due to infection.
   - Smoking, alcohol intake.
   - Associated symptoms e.g., mouth ulcer, dysphagia, nasal obstruction or bleeding, hoarseness, otalgia, persisting cough.
   - Systemic symptoms e.g., weight loss, night sweats.

2. Perform a general examination.

   General examination

   - Lymph nodes, chest and abdominal examination
   - Mouth, oropharynx, dentition, salivary glands
   - Skin for evidence of face and neck skin cancers

3. Examine the patient from in front and behind while they are sitting in a chair and determine lump type based on features and location:

   Neck lump features

   - Size
   - Whether it involves skin (e.g. epidermoid cyst) or is attached to deeper structures
   - Smooth or lobulated
   - Hard or fluctuant
   - Tender or non-tender, or pulsatile

Lateral lumps

Lymph node – normal, reactive or inflammatory (bacterial or viral), or malignant
Lymph node features

- **Normal** – small symmetrical, ellipsoid in shape, and long-standing.
- **Benign reactive or inflammatory:**
  - Recent or current infection e.g., glandular fever, tonsillitis, dental abscess, tuberculosis
  - May be tender
- **Malignant:**
  - More likely to be firm matted and enlarging
  - Metastatic or lymphoma
  - Salivary gland tumour

- FNA can be helpful but often leads to an unnecessary lymph node biopsy due to difficulty differentiating between a normal (or reactive) lymph node and a low grade lymphoma.

*Figure 1. Metastatic neck lump*

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**Branchial cyst**
- Often presents in children and young adults, although occasionally seen in older ages.
- Can present as a cystic upper neck mass.
- Often presents acutely with inflammation.
- Can be difficult to differentiate from an inflamed lymph node.
- It is important to refer and remove before infection occurs.

![Figure 2. Branchial cyst](image)

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**Normal variant**
- Hyoid bone
- Tortuous carotid artery
- Carotid bulb

**Salivary gland**
See [Salivary Gland Disorders](#).

**Others**
- Lipoma – FNA rarely needed as clinical diagnosis
- Sebaceous cyst – FNA rarely needed as clinical diagnosis
- Carotid body tumour
- Nerve sheath tumour
Upper midline lumps

These are more common in children, but can present later in young adults, and are usually developmental.

**Thyroglossal duct cyst**

- Commonly occurs over the hyoid bone.
- Moves on protruding the tongue and swallowing.
- More common in patients aged younger than 20 years.
- May get enlarged and painful if infected.
- It is important to refer for removal before any infection occurs.

![Inflamed thyroglossal duct cyst](image)

Inflamed thyroglossal duct cyst

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**Dermoid**

Occurs under the chin, usually in young children.

**Plunging ranula**

- Soft, ill-defined swelling in the submental or submandibular region.
- May be associated with swelling in the floor of the mouth.

![Plunging ranula](image)

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Lower midline lumps

**Thyroid**
*Can be thyroid nodule or enlarged thyroid gland.*

4. Examine the rest of the head and neck, chest, abdomen, and look for other lymphadenopathy to find and establish a cause:
   - Check the mouth, including floor of mouth, tongue, tonsils, oropharynx, teeth, gums, and salivary glands.
   - In patients with sun damaged skin or a past history of face and neck skin cancers, examine the skin for a possible primary lesion.

5. Investigations:
   - When history and examination indicate possible malignant or systemic cause, arrange soft tissue CT scan of neck with contrast where appropriate.
   - Consider ultrasound for thyroid and lateral neck masses.
   - **Fine needle aspiration (FNA)** is not essential for referral and must not be performed on possible sarcomas.

**Fine needle aspiration (FNA)**

- The architecture of tumours such as lymphomas cannot be determined from a needle aspirate, and possible sarcoma should not be needled due to risk of tumour spread.
- Ensure any previous diagnostic ultrasound images or reports accompany the patient.
- Out-of-pocket expenses apply, however patients on a pension or healthcare card are bulk-billed.
- Technique is important, so FNA is best performed by specialist radiologists or pathologists.

- If relevant, consider arranging FBE and thyroid function tests.
Management

1. Consider immediate ENT, head, and neck surgery referral or admission if:
   • difficulty with breathing or swallowing.
   • severe inflammation, pain, or swelling.

2. If a lump is likely to have an infective cause, treat with broad spectrum antibiotics and check adequate staphylococcus aureus cover.

**Broad Spectrum Antibiotics**
- Cephalexin
- Amoxicillin and clavulanate

3. Recheck lump in 1 to 2 weeks for resolution, although complete disappearance may take a couple of months.

4. If suspicious neck lump, arrange urgent or routine ENT referral.

5. If criteria for high suspicion of neck or salivary cancer are met, arrange urgent or routine ENT referral within 1 week, irrespective of fine needle aspiration (FNA) result.

**Criteria for high suspicion of neck or salivary cancer**
*Unexplained neck or salivary mass and any of the following:*
- Mass > 1 cm and persisting > 4 weeks.
- Mass is increasing in size.
- Previous head and neck cancer, including skin cancer.
- Facial palsy.
- Any new unexplained upper respiratory tract symptoms e.g., hoarseness, dysphagia, throat or ear pain, blocked nose or ear.
- Persistent cough

6. Observe a reactive node on FNA for 1 to 2 months. If it does not settle, consider a repeat FNA, or urgent or routine ENT, head, and neck surgery referral.

**Referral**
- Arrange for immediate ENT, head, and neck surgery referral or admission if:
  • difficulty with breathing or swallowing.
  • acute inflammation, pain, or swelling.
- Arrange urgent or routine ENT referral within 1 week and mark referral as urgent if:
  • confirmed diagnosis of head or neck malignancy.
  • criteria for high suspicion of neck or salivary cancer met (see above).
- If patient with suspicious neck lumps, arrange urgent or routine ENT referral.
Information

For health professionals

Further information
Medicine Today – Neck Lumps: A Guide to Assessment and Management (registration is required)

For patients

Further information
Patient – Neck Lumps and Bumps

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