Neck Lumps in Adults

Disclaimer

Contents

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.*

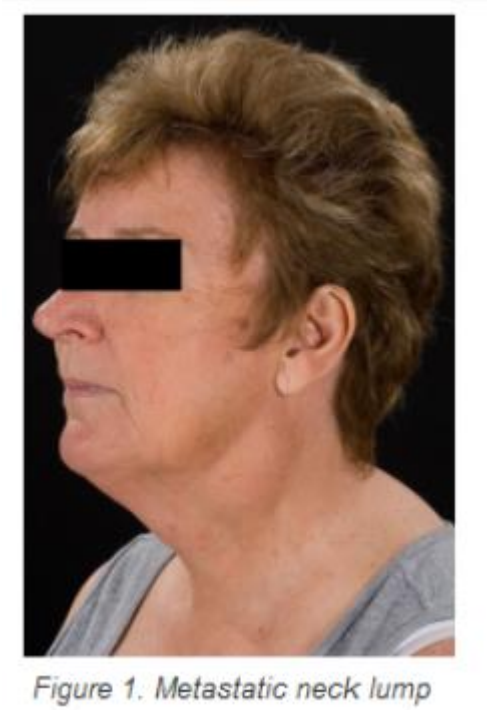

Figure 1. Metastatic neck lump

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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.*

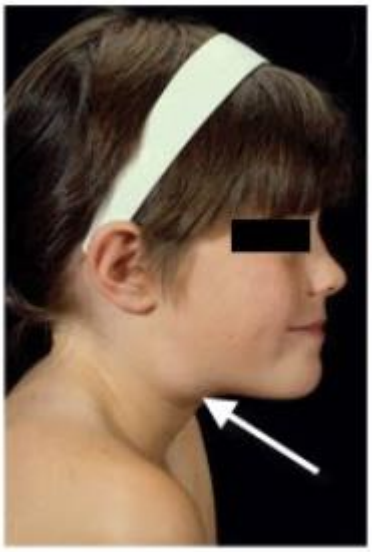

Figure 2. Branchial cyst

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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.*

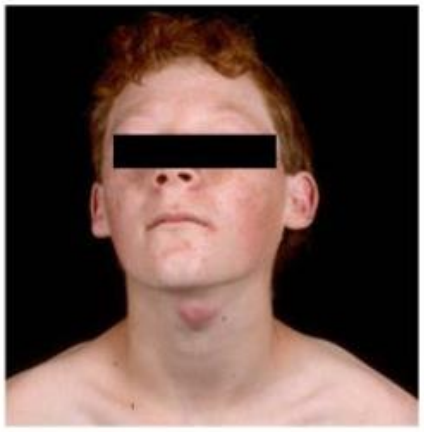

Figure 3. Inflamed thyroglossal duct cyst

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.

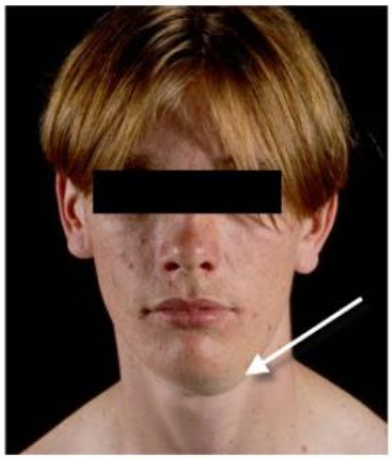

Figure 4. Plunging ranula

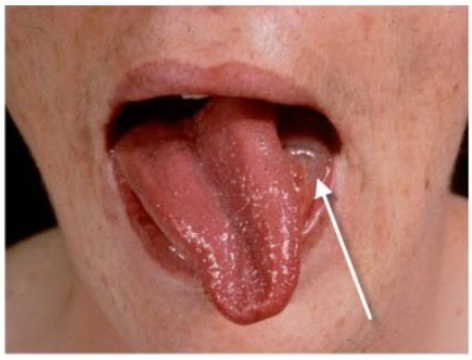

Figure 5. Plunging ranula - inside the mouth

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Lower midline lumps

Thyroid

Can be thyroid nodule or enlarged thyroid gland.

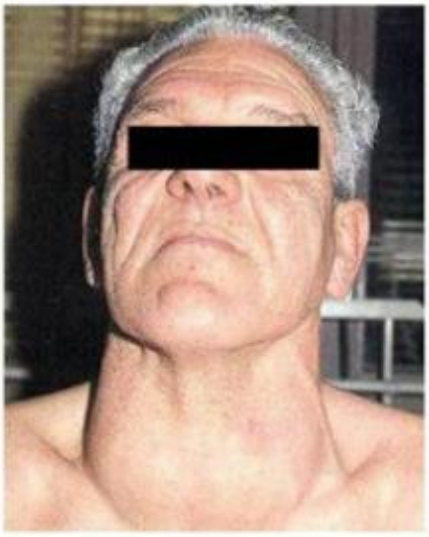

Figure 1. Enlarged thyroid

Figure 2. Thyroid nodule in teenager

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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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