

## Case Report

# Management of late presenting giant benign tumours of head and neck

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### ABSTRACT

Various benign tumours of the head and neck presents commonly to the Otorhinolaryngologists in their day to day practice, but their very late presentations, due to neglect by the patient, with a history of 10 to 15 years old tumours in the respective cases as discussed below, are rare. Surgery of these large variant of tumours are a challenge to us. Here we discuss 3 such case reports of very unusual benign tumours of the head and neck along with a brief discussion of the operative steps and a brief review of literature respectively.

**Keywords:** Benign, Parotid, Pleomorphic adenoma, FNAC, Facial nerve, Colloid goiter, Lipoma, Parotidectomy

## INTRODUCTION

Benign head and neck tumors are common entities that are regularly dealt by ENT surgeons in their day to day practice. Due to the absence of any gross debilitating symptoms other than the swelling in most of the patients it is usually seen that patients do not consult the surgeon and prefer to live with the disease rather than opt for surgical removal of the tumor. This leads to late presentation in many of the cases like the three cases that we are presenting in this paper. We give a brief account of problems and safe management of such giant benign tumors.

## CASE REPORTS

### Case report I

A 47 years male patient presented with a huge right sided parotid swelling which other than the deformity and weight of mass was causing no other discomfort to the patient hence he had not taken surgical advice and as the patient was reluctant for surgical treatment which he was advised by doctor a decade back for which he was not willing due to financial constraints. Presently the tumor on account of its size and weight was causing difficulty

for manual labour, hence patient agreed for surgery. Giant parotid pleomorphic adenoma of long standing duration tend to undergo malignant transformation, as FNAC done in this patient suggested a benign tumor it was decided to take him for surgery with the aim of facial nerve preservation. The tumor was successfully excised with preservation of facial nerve and postoperative period was uneventful.

### Case report II

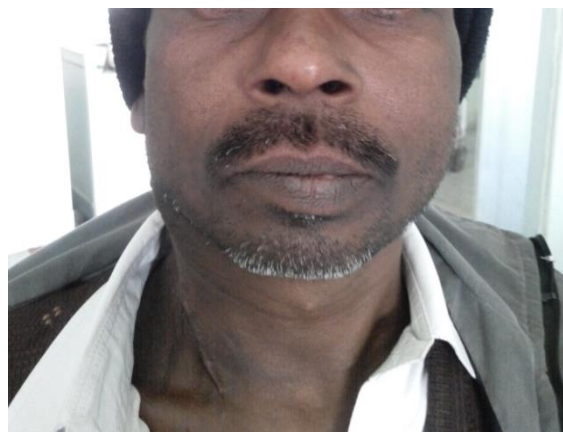
A 53 years old female patient presented with a huge anterior midline swelling which was a long standing thyroid mass which the patient had neglected for over fifteen years as medical therapy was unable to check the progress of swelling and due to non-availability of surgical treatment in the remote area where she lived the tumor had taken massive proportion and was currently causing difficulty in swallowing and mild respiratory distress on lying supine apart from a dragging pain which she now felt due to the weight of the mass. The FNAC report was suggestive of colloid goiter and the patient was taken up for total thyroidectomy. In the post-operative period patient had mild paresis of right vocal cord which became normal after three weeks of surgery.



**Figure 1: Giant multi nodular goiter.**



**Figure 2: Giant lipoma of the neck.**



**Figure 3 and 4: Post-operative healing, following excision of lipoma, with acceptable scar.**



**Figure 5: Giant pleomorphic adenoma of the parotid gland.**



**Figure 6: Excision of the giant pleomorphic adenoma of the parotid gland.**

The post-operative period was uneventful and patient recovered fully.

### Case report III

A 46 years old male patient presented with a giant swelling of the right side of neck which was soft mobile and slowly enlarging for past 12 years and had attained its present size and was now causing restriction of neck mobility and discomfort during lying in right lateral posture. A CT scan showed a huge well encapsulated mass in close proximity to carotid sheath without involving it. FNAC report was suggestive of lipoma. The tumor was safely dissected from the carotid sheath and removed without any injury to deeper structures.

### DISCUSSION

Giant tumors of head and neck look ominous due to the large size that they attain because of long period of neglect by the patient which is usually due to absence of any gross debilitating symptoms other than the large deformity which the patients get used to because of neglected treatment which usually is on account of financial constraints, fear of surgical treatment or ignorance of the patient due to reluctance of hospitalization for long period which will lead to loss of working hours hence the choice to live with the deformity which is seen especially in manual labourers.

Pleomorphic adenoma, the most common salivary gland tumour, accounts for a majority of parotid gland neoplasms. Untreated pleomorphic adenoma can gradually enlarge in size and weigh several kilograms. M.N de Silva et al.<sup>1</sup> reported a giant pleomorphic adenoma of the left parotid gland in a 76 year-old male who complained of a large growth on the left side of the face, which enlarged gradually over a period of over 30 years weighing 3.5 kgs. Yogendra Chauhan et al.<sup>2</sup> reported a case of giant undifferentiated sarcoma of the parotid gland in a 79 years old female, where a right total parotidectomy with modified radical neck dissection was performed sacrificing the sternocleidomastoid muscle. The tumour measures 24.6 cm x 19 cm weighing 3 kgs.

Diffusely enlarged thyroid glands are becoming increasingly infrequent. However, in some geographical areas they are still relatively common and those of with prolonged history of thyroid gland enlargement and are untreated due to patient's negligence, can cause compressive symptoms involving the trachea, esophagus, and recurrent laryngeal nerve. Worldwide, the most common cause of goiter is iodine deficiency. Ahmed Nada et al.<sup>3</sup> reported a case of giant euthyroid endemic multinodular goiter in a 61-year-old female patient measuring 35x27 cm in its largest dimensions and weighed 4.7 kgs.

Lipomas are the most common mesenchymal tumours of adulthood. Malignant degeneration to liposarcomas has

been rarely reported in the literature.<sup>4</sup> A peak incidence of lipoma formation is noted in the fifth and sixth decades of life, and lipomas are more common in obese individuals.<sup>5</sup> Lipomas make up approximately 5% of all benign tumours of the body, and they may occur anywhere on the surface of the body.<sup>6</sup> Most lipomas are less than 5 cm but there are reports of giant lipomas of more than 20 cm.<sup>7</sup> Lipomas are one of the most common mesenchymal tumours and needs to distinguish a benign lipoma from a liposarcomas. They infrequently occur in the head and neck. Carlos R Medina et al;<sup>8</sup> reported a case of giant sub mental lipoma in a 60 years old male having a history of this lump for 15 years. Intramuscular lipoma are rare, though a case of giant intramuscular lipoma of the tongue in a 75 years old male has been reported, with a large tumor at the tip of the tongue that had been present for over 30 years.<sup>9</sup>

A preoperative planning is done on the issues of estimated blood loss and arrangement for intra operative or post-operative blood transfusion. Secondly loco regional vital structures like major blood vessels and nerves must be meticulously preserved to prevent iatrogenic complications. Anesthetic intubation difficulties must be discussed with the anesthesiologist prior to taking up the cases for smooth per and post-operative management.

In our experience we have seen that firm traction of the tumor by the assistant and gently working in the periphery of the tumor with a combination of sharp and blunt dissection, careful use of bipolar cautery and early identification of vital structures like carotid artery, internal jugular vein, vagus and recurrent laryngeal nerves is vital to safe surgery. It is observed that the weight of tumor leads to compression of vascular structures and causes their displacement and working on the periphery of the mass in the long axis of vascular structures leads to early identification of these structures.

The internal jugular vein is found engorged and distended on the margins of tumor and once identified, can be followed under the mass for safe dissection of the vessel from tumor. It is vital not to enter into the substance of tumor which will lead to unnecessary blood loss and prevents visualization of important structures. Inadvertent injury of tumor capsule can be managed by clamping the area with mosquito forceps and sealing the area either by cauterization or local suturing to arrest bleeding.

Finger dissection should be done where vital structures have not been identified and dissection with scissors or artery forceps can damage vital structures and should be avoided. Landmarks for recurrent laryngeal and facial nerves are not always reliable due to anatomical distortion of structures by tumor hence this part needs to be dealt with caution exercising gentle dissection, keeping the surgical field moist by using hot saline mops and firm and gentle traction of tumor away from deeper structures is the key to prevention of inadvertent damage to vital structures.



Large tumors of long standing duration are adherent to normal deeper structures and cause pressure atrophy hence normal structures may appear smaller than usual and this should not be forgotten while identifying structures like jugular vein and facial and recurrent laryngeal nerves. Trachea may undergo pressure necrosis and tracheomalacia must be kept in mind hence dissection around trachea should not be forceful and cautery should be avoided here and dissection with sharp instruments is preferred once the plane of separation of tumor and trachea is identified. Blood loss is to be prevented with gentle, slow surgical dissection and on no account hurried enucleation be attempted without proper identification of vital structures in order to quickly finish the surgery. Gentle traction and meticulous dissection is the key to successful excision of tumor without damage to vital structures, with minimal blood loss and good post-operative healing of wound. Proper respect for tissues is the key to successful removal of such difficult tumors of long standing duration. Post-operative administration of proper antibiotics and other supportive medication and wound dressing plays the most vital role for quick recovery and healing with minimal scar formation.

## CONCLUSION

All giant tumours of the head and neck, with late presentation, should have their history properly taken, along with careful clinical examination, proper investigations including radiological and pathological by which benign lesions should be differentiated from the malignant ones. Proper surgical planning for excision of such tumours to be done with adequate amount of blood arrangement in hand, to cope up with intra operative blood loss. While dissecting such huge tumours, the surrounding vital structure needs to be preserved to the best of the surgeon's effort. Post-operative administration of proper antibiotics and other supportive medication and wound dressing plays the most vital role for quick recovery and healing with minimal scar formation.

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