

A Case Presentation and Discussion on Anterior Neck Mass

Dr. Nolan Ortega Aludino

General Data:

O.B. 60/F

Quezon City

Chief Complaint:

Anterior Neck Mass
supraclavicular area, Left

History of Present Illness

1 month PTC → slowly enlarging palpable
anterior neck mass,
supraclavicular area, left
consult at OMMC
advised surgery



admission

Past Medical History

December 12, 2000

- OMMC
- MRM, Left
- Breast CA, Left, Stage IIB (T2N1M0)

Physical Examination

General Survey:

conscious, coherent, not in
cardiorespiratory distress, ambulatory

Vital Signs:

BP = 120/70

CR = 88

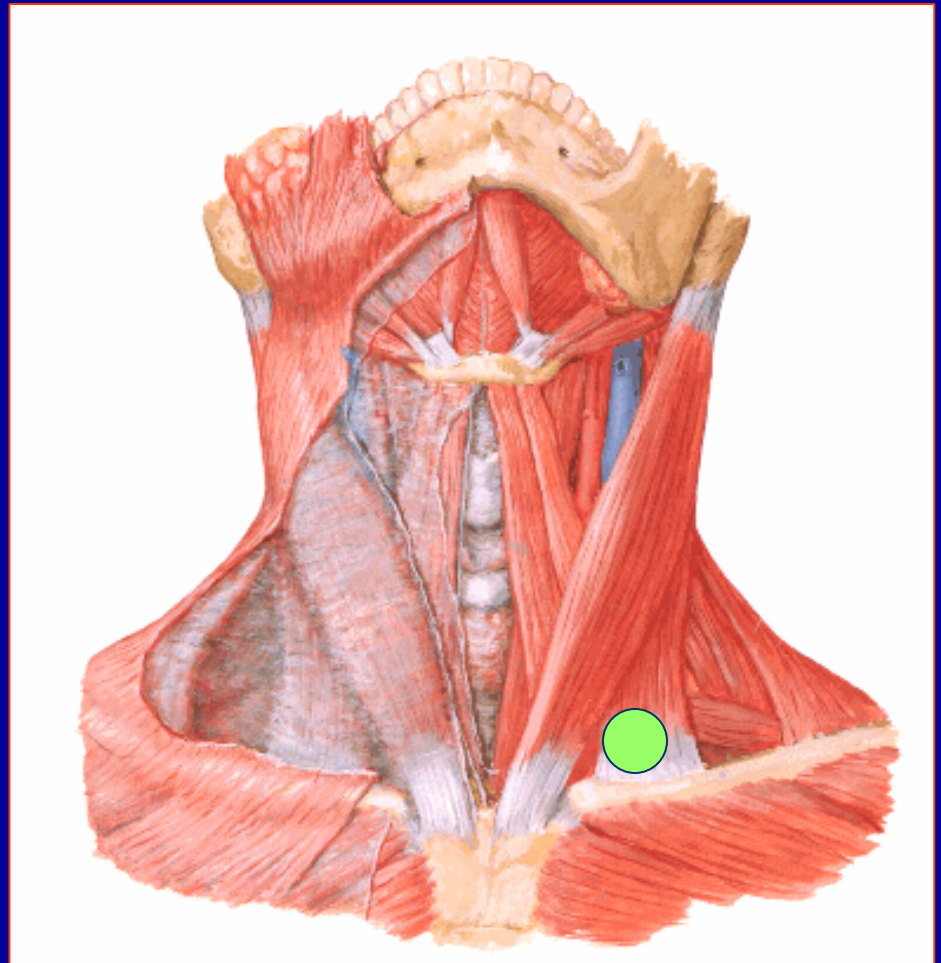
RR = 18

Temp = 37.3°C

Physical Examination

HEENT:

2 x 2 cm mass,
supraclavicular L,
lateral to the
sternal head of
the SCM,
solid, nonhard,
slightly movable,
nontender

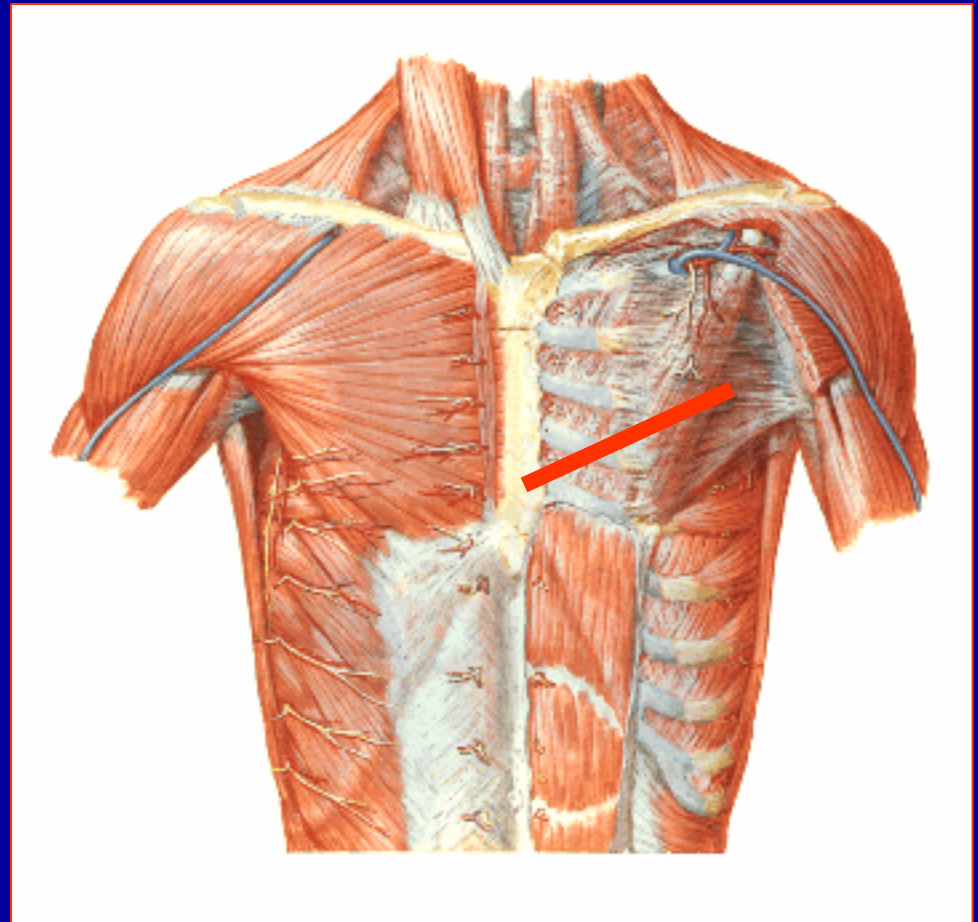


Physical Examination

Chest and Lungs:

Symmetric chest
expansion,
(+) oblique incision
scar at Left
anterior chest
wall

Clear breath
sounds



Physical Examination

Cardiac: adynamic precordium, normal rate, regular rhythm, no murmurs

Abdomen: flat, normoactive bowel sounds, soft, non-tender

Extremities: grossly normal

Salient Features

- 60 year old
- Female
- Mass, supraclavicular area
- S/P MRM, left for Breast CA, Stage IIB (T2N1M0) S/P chemotherapy

INITIAL IMPRESSION:

Mass supraclavicular area

T/C malignancy

S/P MRM left

Anterior Neck Mass

```
graph TD; A[Anterior Neck Mass] --> B[Skin]; A --> C[Soft Tissue]; A --> D[Bone and Cartilage]; C --> E[Thyroid]; C --> F[Non Thyroid]; E --> G[Not adherent to overlying skin]; F --> H[Does not move with deglutition]; D --> I[Consistency is not hard.];
```

Skin

Soft Tissue

Bone and
Cartilage

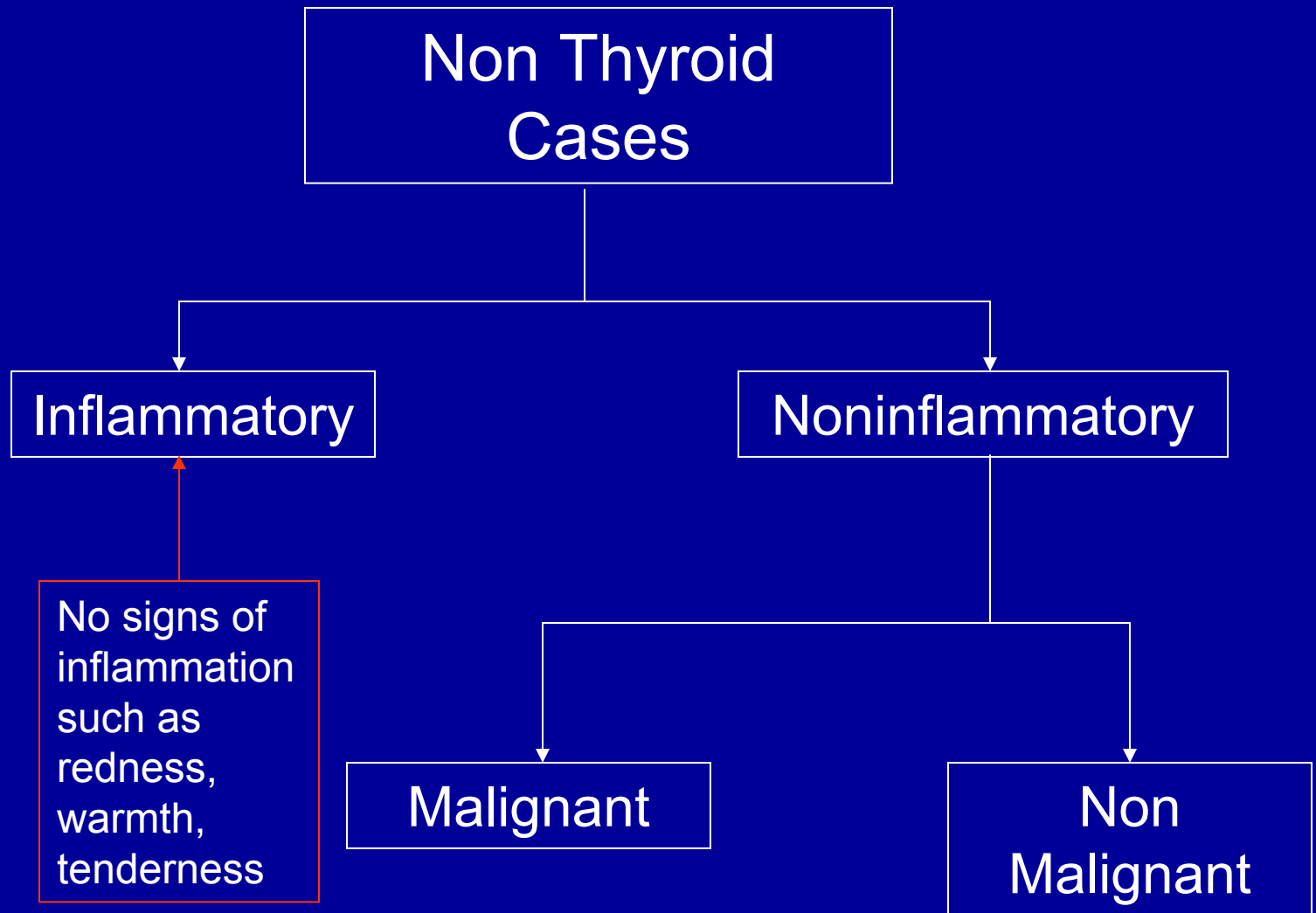
Not adherent
to overlying
skin

Thyroid

Non Thyroid

Consistency
is not hard.

Does not
move with
deglutition



Malignant

```
graph TD; Malignant[Malignant] --> Primary[Primary]; Malignant --> Metastatic[Metastatic]; Primary --> PrimaryList["Lymphoma<br/>Sarcoma<br/>Neurogenic Tumors<br/>Thyroid carcinoma"]; Metastatic --> MetastaticList["Lung<br/>Kidney<br/>Gonads<br/>Stomach<br/>Breast"]
```

This flowchart classifies malignant tumors into two main categories: Primary and Metastatic. The Primary category includes Lymphoma, Sarcoma, Neurogenic Tumors, and Thyroid carcinoma. The Metastatic category includes Lung, Kidney, Gonads, Stomach, and Breast.

Primary

Lymphoma

Sarcoma

Neurogenic Tumors

Thyroid carcinoma

Metastatic

Lung

Kidney

Gonads

Stomach

Breast

Pre treatment Diagnosis

Metastatic Lymph Node Stage IV (T0N3M1) s/p MRM, Left for Breast CA, Left Stage IIB (T2N1M0)	95%
Primary: Lymphoma	5%

Paraclinical Diagnostic Procedure

Do I need to do a paraclinical diagnostic procedure?

No

Treatment Option

- Surgical
 - Excision
- Goal:
 - Removal of the mass

PREOPERATIVE EVALUATION

- Optimize patient
- Secure informed consent
- Screen for medical problems
- Prepare materials for operation

OPERATIVE MANAGEMENT

- Patient supine under GA
- Asepsis and Antisepsis techniques
- Sterile drapes placed
- Incision made over the mass following the crease of the neck
- Lateral border of the supraclavicular head of the SCM deflected
- Intra-op findings noted

OPERATIVE MANAGEMENT

- *Intra-op findings:*

“A 1.5 x 2.0 cm nonhard, poorly delineated mass posterior to the clavicular head of the SCM noted.”

OPERATIVE MANAGEMENT

- Excision of the mass done
- Hemostasis
- Operating sponge and Instrument count done
- Skin closed
- DSD

POST OPERATIVE MANAGEMENT

- DAT
- Adequate analgesia
- Daily wound care

Histopath diagnosis

Invasive Ductal Ca,
supraclavicular lymph node left

- Metastatic work-up
- Ultrasound:
 - “hypoechoic mass seen at the left lobe, measuring 6 x 9 cm extending to the right lobe”
- ER/PR ASSAY: NEGATIVE

Final diagnosis

Supraclavicular lymph node metastasis

Goals of Treatment

- Palliation

TREATMENT OPTIONS

	BENEFIT	RISK	COST	AVAILABILITY
HORMONAL	Response Rate (RR) ER (+) 70-80% ER(-) 10-15% SR	Minimal DVT Hot flushes Bone resorption	++	+

TREATMENT OPTIONS

ADJUVANT CHEMOTHERAPY	BENEFIT	RISK	COST	AVAILABILITY
Doxorubicin + Paclitaxel	Inc disease free 90% Inc overall SR 97% Relative reduction Recurrence 13% Mortality reduction 14% not significant	bone marrow suppression +++ hypersensitivity	++++	+
AC	Inc disease free 86% Inc overall SR 95%	bone marrow suppression +++	+++	+

Introduction

- Adjuvant Systemic Chemotherapy
 - Component of the Tx in breast Ca
 - Improvement of outcomes in breast cancer
 - Control distant micrometastases
- [Anthracyclines, Taxanes etc.]

Introduction

- Present Regimens reduce the odds of death by only 1/3 at best
- Anthracyclines have not produced results
- Taxanes- stimulated a new excitement in this field
[paclitaxel, docetaxel]

Taxanes

- Yew tree – *Taxus brevifoli*
 - *Inhibitor of microtubule disassembly*
 - *Stabilize and promote microtubule polymerization and prevent depolymerization*
 - *Arrest in G2 and M phase cell cycle*

Taxanes

- Interfere with other cellular functions in which microtubules play a role
 - Maintenance of cell shape
 - Cell motility
 - Cell transport

	Paclitaxel	Docetaxel
Potency	+	++
Anti-tumor activity	↑ if ↑ duration	Rapid infusion
Requires premedication	+	+
Neutropenia	++	+
Arthralgia	++	+
Myalgias	++	+
Neurotoxicity	+++	-
Edema	-	++
Cardiac toxicity	++	-

Paclitaxel for metastatic Breast CA

Over all response rates

First line therapy	32%-62%
2 nd line therapy	18%-55%

- Paclitaxel + Doxorubicin > 90%
- * PD vs other Regimen – no improved survival
(RCT's)

Docetaxel for metastatic Breast CA

Over all response rates

First line therapy 50%-67%

Average response rate ↑50%

- Docetaxel + Doxorubicin 50%-80%
- * Combination & sequential strategies underway

Adjuvant Taxanes

- CMF and Anthracycline-based- mainstay
 - 10 yr survival of only 7-11% <50 y/o
2-3% >50-69 y/o
- Taxanes - ability to kill anthracycline-resistant cancer cells
- ??? Ongoing studies if this drug will further to improve outcome in the adjuvant setting

References

- Shah, Jatin P., The Impact of Patterns of Nodal Metastasis on Modifications of Neck Dissection, Ann Surg Oncol, 1994;1(6):521-532.
- Buckingham, E., Pou, A. M., Quinn, F. Jr., Neck Dissection: Classification, Indication, and Technique, Dept. of Otolaryngology, UTMB, Grand Rounds Presentation, Dec 1998.
- Muller, C. et al, Neck Dissection: Classification, Indications and Techniques, Grand Rounds Presentation, UTMB, Dept. of Otolaryngology, Jan 2002
- Robbins, Thomas K., Standardizing Neck Dissection Terminology, Arch otolaryngol Head Neck Surg, June 1991; 117:601-605.
- Medina, Jesus E., Supraomohyoid Neck Dissection: Rationale, Indications, and Surgical Technique, Head and Neck, March/April 1989; 111-122.