



AN UNUSUAL PRESENTATION OF SCHWANNOMA NECK DINESH D DHANASEKARAN

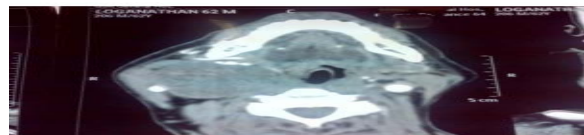
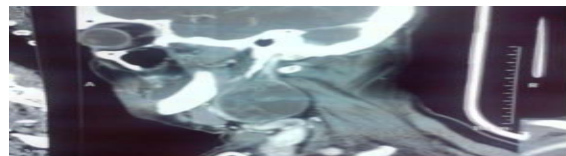
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Abstract : 62 yr old male patient presented with (R) sided painless neck swelling for past 5 months with no pressure symptoms. On examination 6x5 cm swelling present in upper part of (R) side of neck which is well defined, mobile, variable in consistency. Examination of lower cranial nerves and oral cavity examination was normal. Provisional diagnosis of secondaries neck (R). But panendoscopy was normal. CT Neck showed possibility of metastatic node in (R) carotid space. 1st FNAC showed carcinomatous deposits from thyroid but thyroid FNAC was normal. Hence Trucut biopsy taken from node shows spindle cell tumour with possibility of fibromatosis. So planned for excision biopsy. Intraoperatively tumor was wedged between ICA and ECA and found to be arising from nerve sheath of vagus nerve. Post op uneventful. HPE showed Schwannoma

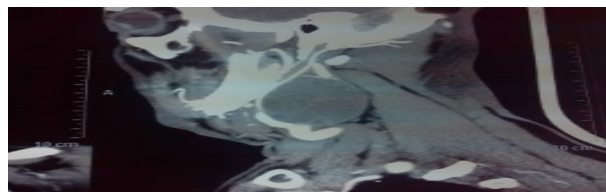
Keyword : Panendoscopy, Metastatic node, Schwannoma Loganathan 62 yrs presented with swelling in (R) side of neck for 5 months

He was apparently normal before 5 months. Then he noticed a painless swelling in upper part of right side of neck which was small to start with gradually progressive and attain the present size. No H/o difficulty in swallowing, change of voice, fever, cough, nasal obstruction, ear pain. No comorbid illness in the past. General examination was found to be normal; BP: 120/80 mmHg; Pulse: 78/min On examination, swelling of size 6*5cm present over the upper 1/3 of (R) side of neck extends from just below (R) mastoid to lower border of thyroid cartilage and from posterior border of (R) sternocleidomastoid to midline, swelling is nontender, well defined, irregular surface, variable in consistency, mobile. Swelling arises deep to sternocleidomastoid. Carotid pulse felt equally on both sides. No cervical lymphadenopathy. Oral cavity examination was found to be normal. Provisional diagnosis of secondaries neck (R) was made.

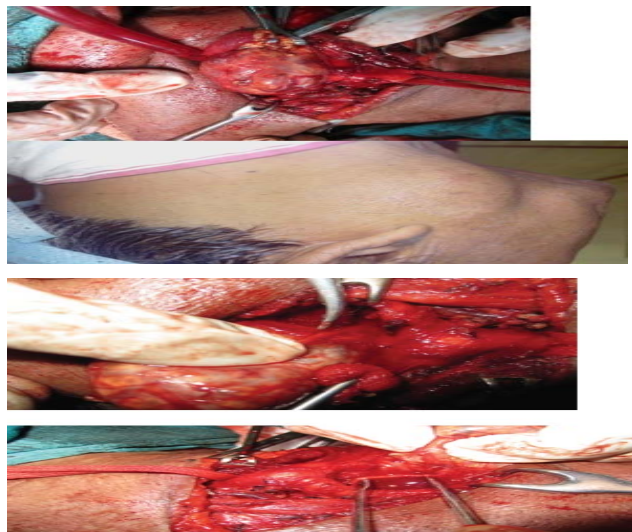
1) Basic investigations normal 2) Pan endoscopy normal 3) CT Neck shows metastatic node in (R) carotid space with minimal extension into parapharyngeal space.



- 4) FNAC from node - metastatic deposit from thyroid
- 5) But Thyroid FNAC was normal
- 6) Trucut biopsy from the node- spindle cell tumour with possibility of fibromatosis
- 7) CT Carotid Angiogram taken which shows well defined encapsulated hypodense lesion with necrotic changes and no significant contrast enhancement in (R) carotid space with minimal extension into parapharyngeal space and pushing the (R) IJV and internal carotid artery. Possibility of lymph node enlargement/minor salivary gland tumor.



Excision biopsy was planned. Intraoperatively, tumor was wedged between internal carotid and external carotid artery and found to be arising from nerve sheath of vagus nerve. Post op uneventful and there is no post op paralysis of vagus nerve. HPE showed Schwannoma



DISCUSSION :

Schwannomas is otherwise called Neurilemmomas which are benign tumors. Most common site being Head & Neck, flexor surface of extremities and paravertebral region. It is manifesting between 3rd and 6th decade of life as a slow growing firm painless mass in lateral neck. Hoarseness, pain, cough may be presenting complaints. 42% of patients had Schwannomas from cervical sympathetic chain and 58% had Schwannomas from cervical vagus nerve. On CT images, vagal Schwannomas appear as well defined masse, usually of higher attenuation than muscle on contrast enhanced images. Schwannomas are usually confined to retrostyloid parapharyngeal space. Vagal schwannomas separate the common or ICA from IJV whereas schwannomas of the cervical sympathetic chain do not. MR evaluation typically shows masses of intermediate signal on T1 weighted images and increased signal intensity on T2 weighted images with smooth well defined margins and a homogenous overall appearances. Occasionally a necrosis and cystic degeneration are seen. Schwannomas of the vagus nerve must be differentiated from the carotid body tumours and glomus vagale tumour because treatment differs. Histologically it exhibits two main patterns. Antoni-A and Antoni-B cells. Antoni-A tissue is represented by a tendency towards palisading of the nuclei about a central mass of cytoplasm (Verocay bodies). In contrast Antoni-B tissue is a loosely arranged stroma in which fibers and cells form no distinctive pattern. Often typical features include necrosis hemorrhage, cystic degeneration. Treatment is surgical removal with preservation of nerve and reanastomosis and/or nerve grafting if that is not possible. Surgical methods used to resect Schwannomas include transcervical approach, a cervical transparotid approach, a cervical transpharyngeal approach. Usually 85% of the patient will undergo complete surgical resection and 12% will have subtotal resection. Post op nerve weakness occurred in 62% of the patients with complete resolution in 44%. Malignant change in nerve sheath tumour is rare

CASE IS PRESENTED HERE BECAUSE,

1. It is masquerading as neck secondaries.
2. On palpation of swelling, cough is absent. Usually vagal schwannoma will have cough on manipulation of swelling.
3. Intra op diagnosis is different from that clinical, imaging and biopsy findings
4. No post op nerve paralysis

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