

Cutaneous Tumour of the Left Cricothyroid Area!?

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Abstract

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BACKGROUND: The cricothyroid area is an atypical localisation for placement of basal cell carcinomas. The main differential diagnosis for cutaneous tumours in this area is between BCC, spinocellular carcinoma and melanoma. The area is problematic about the choice of therapeutic approach, especially in the case of a vague clinical tumour type accompanied by enlarged lymph nodes in the immediate proximity.

CASE REPORT: We present an 84-year-old woman with a tumour formation located next to the left cricothyroid area. The lymph node ultrasonography performed during the hospitalisation revealed the presence of an enlarged lymph node in the upper third of m. Sternocleidomastoideus. The initial ultrasound data of the lymph nodes were in the direction of an inflammatory rather than a metastatic process. Therefore 5 days of therapy with Ceftriaxone x 2 g/day was conducted. The nodular tumour formation was surgically removed by radical elliptical excision. The subsequent histological study found that it was Stage II basal cell carcinoma (T2N0M0). A surgeon's consultation was conducted due to a patient's complaint about abdominal pain, and clinical evidence of a hernia inguinalis incarcerata was established for which the patient was urgently transferred to a surgical ward. Two weeks after the antibiotic treatment, a control echography of the enlarged lymph node in the area of m. Sternocleidomastoideus was performed, which showed complete involution of the lymph node.

CONCLUSION: Due to the specific anatomical features of the neck, such as a large number of lymph nodes and the resulting proximity between them and the primary tumours located in the area, it is often difficult to determine whether the lymph nodes are metastatically affected or inflammatory enlarged. In cases of missing ultrasound data for the metastatic process in the lymph nodes, surgical excision of the skin tumour with regular follow-up echographic control of the relevant lymph nodes represents an optimal therapeutic solution.

Dear Editor,

We present an 84-year-old woman with arterial hypertension and inguinal hernia. For arterial hypertension, the patient is on therapy with Bisoprolol fumarate 5 mg (1/2-0-0) and Simvastatin 20 mg (1-0-0). The patient was hospitalised for surgical removal of a tumorous formation in the left lateral part of the neck. The lesion dates from 5-6 years, during which it progressively increases in size, beginning to secrete and bleeds. During the dermatological examination, next to the left cricothyroid area, a nodular formation with a tight edge and an erosive bleeding surface was found (Figure 1a-c). According to the clinical data, the lesion was suspected for spinocellular carcinoma. In the differential diagnosis, it was also thought of Merkel cell carcinoma. A consultation was conducted with a vascular surgeon who identified the presence of an enlarged lymph node in the upper third of m.

Sternocleidomastoideus, size 7.6 mm. Initial ultrasound of lymph nodes showed visual data rather for inflammatory than metastatic process. Five-day therapy with Ceftriaxone x 2 g/day was performed, and dressings with jodasept ointment were applied topically every day. Prophylactically, nadroparin calcium was applied at a dose of 0.4 ml/per day, subcutaneously. The nodular tumour formation was surgically removed by radical careful elliptical excision (Figure 2a, 2b). The resulting surgical defect was closed by a single interrupted sutures (Figure 2c).

The subsequent histological study found that it was basal cell carcinoma with extensive erosion, at places with the character of an adenoid-cystic variant; size 24/8 mm; free resection lines. The staging was performed according to which the data was for basal cell carcinoma stage II (T2N0M0). On the patient's complaint about abdominal pain, a surgeon was consulted, and clinical data for hernia inguinalis

incarcerated have been identified. For this reason, the patient was urgently transferred to a surgical department for surgical treatment. An ultrasound control of the enlarged lymph node in the area of m. Sternocleidomastoideus was planned after the antibiotic treatment, and the control echography after 2 weeks showed complete lymph node involution.



Figure 1: 1a- 1b, Clinical view of nodular formation with an erosive, bleeding surface, located next to the left cricothyroid area; 1c, Preoperative finding: outlining the surgical margins;

The presented case is interesting due to 1) atypical localization and clinical picture of basal cell carcinoma-adjacent to the cricothyroid region and 2) the choice of treatment approach in the case of a vaguely enlarged lymph node near the area of the primary cutaneous tumour. The most common localisations of basal cell carcinomas are nose and cheek area [1]. Unlike the clinical presentation described in our patient, BCC is usually presented as a nodule or plaque with pearly border and overlying telangiectasia and may be combined with a rodent ulcer [2].



Figure 2: 2a-2b, Intraoperative view: elliptical excision of the nodular lesion; 2c, Postoperative finding: surgical defect closed by single interrupted sutures

The main differential diagnosis of skin tumours in the neck area is between BCC, spinocellular carcinoma (SCC) and melanoma [2].

In our case, based on clinical data, we considered SCC, an amelanotic variant of melanoma or Merkel cell carcinoma. It is believed that around 90% of the cases of skin tumours at the top of the aerodigestive tract are spinocellular carcinoma, which is characterized by being able to metastasize lymphogeneously [3]. Therefore, a surgical excision of the cutaneous lesion and a subsequent histological examination without an initial biopsy was selected for the described patient.

In the neck area, it is extremely difficult to determine the condition of the lymph nodes and whether they are metastatically affected by tumour cells due to 1) the anatomical characteristics of the area and a large number of lymph nodes and 2) due to the immediate spatial proximity between the primary tumour and the lymph nodes [3]. For this reason, our patient did not undergo lymph node dissection within surgical removal of the tumour formation, and a more gentle treatment approach was chosen with antibiotic treatment and observation of the therapeutic response from the lymph nodes.

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