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Rapidly Growing Neck Metastasis in Immunodeficiency

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Abstract

An 80-year-old fit male with known long-standing stable chronic lymphatic leukaemia (CLL) presented with a rapidly enlarging left neck mass. The mass invaded the neck skin and began to fungate reaching to 10 cm in less than 3 weeks. Whilst head and neck skin SCC can metastasise to the regional lymph nodes (including to the contra-lateral side) rapid growth as occurred in this case is exceptionally rare and to our knowledge has not been previously reported.

Keywords: Metastasis; CLL; Chronic lymphoid leukaemia; Head and neck cancer; SCC; Contra-lateral growth

Case Report

An 80-year-old fit male with known long-standing stable chronic lymphatic leukaemia (CLL) and several stable small volume 1.5 cm neck nodes presented with a rapidly enlarging left neck mass. The mass invaded the neck skin and began to fungate (Figure 1). Initial Ultrasound and fine need aspiration showed a 3 cm mass, which on subsequent CT staging was shown to have grown to 10 cm in less than 3 weeks. There was no evidence of any lung metastasis. Some 2 years earlier he underwent removal of a 1 cm squamous cell carcinoma (SCC) from the right alar region of his nose. Ultrasound-guided fine needle aspiration cytology of the neck mass confirmed metastatic SCC rather than CLL. CT demonstrated a large necrotic mass with necrosis confirming rapid growth, with the tumour outstripping its blood supply (Figures 2 and 3). Following discussion at the head and neck MDT, he was managed surgically with a radical neck dissection including removal of the overlying skin, with a latissimus dorsi flap reconstruction (Figure 4) followed by post-operative radiotherapy. To date there has been no tumour recurrence.

Whilst head and neck skin SCC can metastasise to the regional lymph nodes (including to the contra-lateral side 1) rapid growth as occurred in this case is exceptionally rare and to our knowledge has not been previously reported. In a presentation such as this, immunosupression (such as CLL, drugs, HIV and other causes) should always be considered resulting in rapid primary tumour growth or unusual metastatic presentation [1,2].

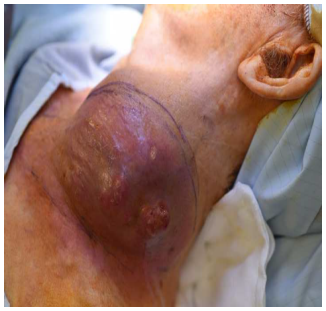

Figure 1: Large 10 cm fungating left neck mass.

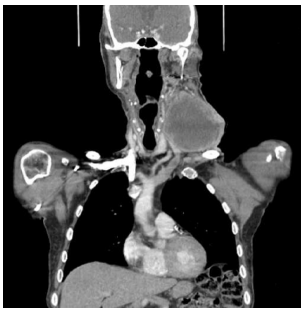

Figure 2: Coronal view of CT scan showing fungating neck mass.

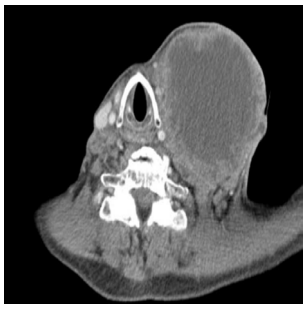

Figure 3: Axial view of CT scan showing fungating neck mass.

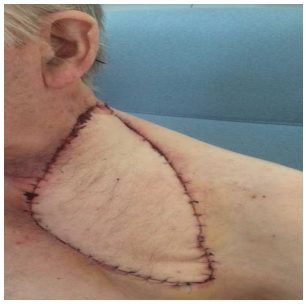

Figure 4: Post operative reconstruction with latissimus dorsi flap.

References

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