Paediatric Neck Lump Clinic: What we see at a busy district general hospital

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Introduction

Neck lumps are a common paediatric ENT presentation with a myriad of differential diagnoses. Rapid access to an ENT clinician experienced in the management of these and timely investigation is vital. Since 2004 NICE guidance advocated a diagnostic one-stop clinics for adult neck lumps operated by a clinician, consultant cytologist and ultrasonographer. The aim of this project was to describe the paediatric cases seen in a general one-stop neck lump clinic.

Methods

A Retrospective review of all children aged ≤16 years referred to the Peterborough City Hospital neck lump clinic over 6 months from 1st January to 30th June 2017. The clinic takes place weekly or every two weeks. Referrals can be made by general practitioners (GP) and other hospital clinicians. Paediatric and adult patients are seen in the same clinic. It is operated by one of three head & neck consultants, ENT trainees, an ultrasonographer and a consultant cytologist. Patients seen in the clinic may be discharged on the same day, scheduled for further investigation or under a period of monitoring with clinic follow up. Where indicated cases are discussed at the weekly multidisciplinary meeting (MDT). Children are referred to one of two tertiary centres if they require specialist input.

Results

Patient demographics

There were 35 children referred to the clinic; 18 males and 17 females. The mean age was 6.2 years (range 1-16 years). Referral was from the GP in 14 cases, a paediatrician in 9, ENT surgeon in 11 and A&E in 1 case.

Patient investigation

A unilateral neck lump was the most common finding in 21 children. Nine children had bilateral lumps and 5 had a mid-line lump. Most of the children had radiological imaging (89%). The modality was US in 26 children, MR in 2, and US with subsequent MR in 3. Of the children who had US only, 3 had more than 1 US to monitor for changes. Six children had a histological diagnosis; 3 had an excision biopsy, 2 had excision of a thyroglossal cyst and 1 had an excision biopsy of a neck node and a tarsillectomy for histology.

Patient Diagnosis

Reactive lymphadenopathy was the most common diagnosis, then arterio-vascular malformation (3), thyroglossal duct cyst (3), sebaceous cyst (1), cystic hygroma (1) and juvenile parotitis (1). There was no cases of malignancy.

Discussion

The paediatric patients in our study were successfully managed in general one-stop neck lump clinic. There was a wide range of diagnosis but reactive lymphadenopathy was the most common as expected. It is important to recognise that the diagnosis seen in the neck lump clinic may vary depending upon hospital location and patient population. At this centre the number of referrals does not warrant a specific paediatric clinic. However, future work may focus upon the child’s and parent’s reported experience of the clinic to identify if there are aspects that could be developed to better serve the paediatric patients.

Conclusion

Paediatric neck lumps can be managed appropriately in a one-stop neck lump clinic and numbers at our centre do not warrant specific paediatric clinic. It is vital to have access to a tertiary centre for specialist input when required.

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References