

Short Report

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Bilateral giant cervical cystic lymphangioma in an infant**Charu Tiwari¹; Nitin kumar Borkar^{2*}; Rohit Meshram³**¹Assistant Professor, Department of Paediatric Surgery, All India Institute of Medical Sciences, Raipur, CG, India.²Additional Professor and Head, Department of Paediatric Surgery, All India Institute of Medical Sciences, Raipur, CG, India.³Senior Resident, Department of Paediatric Surgery, All India Institute of Medical Sciences, Raipur, CG, India.***Corresponding Author: Nitinkumar Borkar**

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Abstract

Cystic Hygroma is a rare congenital lymphatic malformation; more so rare is the bilateral cystic Hygroma. Bilateral Giant cystic Hygroma is a potential life-threatening congenital malformation as it may cause airway obstruction, difficulties in nursing and feeding and failure to thrive. We present a case of a female infant with bilateral giant cystic hygroma.

Keywords: cystic hygroma; bilateral; giant.

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Introduction

Cystic hygroma, also known as lymphangioma, is a rare congenital malformation of the lymphatic system, most commonly seen in head and neck region [1]. Although lymphangiomas are benign lesions, they can compress the vital structures in the neck or can cause complications like intracystic hemorrhages, cyst rupture or infections. Giant cystic hygroma of neck and oral cavity may present with respiratory distress and dysphagia [2]. We present a case of a female infant with bilateral giant cystic hygroma.

Case summary

A 2 months female child was admitted with bilateral giant cystic cervical swelling, tachypnea, failure to thrive and fever (Figure 1). Tongue was protruded and cystic swelling could be seen at floor of the mouth. Clinical diagnosis of bilateral giant

cervical cystic Hygroma (lymphovascular malformation) was made. Patient was started on nasogastric feeds and intravenous antibiotics. Local Ultrasonography revealed multicystic lymphatic cysts in bilateral neck and floor of mouth. Computed Tomography of neck and upper thorax confirmed the diagnosis and ruled out extension into the thoracic cavity. Patient was taken for surgical excision after stabilization. Intubation was difficult and was possible only after 50 cc of lymphatic fluid was aspirated from the floor of the mouth. Complete excision of the Lymphangioma was done from bilateral cervical region and also from floor of the mouth (Figure 2). The patient was kept on elective mechanical ventilation for 3 days post-surgery and then extubated. Post-operative recovery was uneventful and she was discharged on 15th post-operative day. There is no recurrence at 6 months of follow-up.



Figure 1: Clinical image of the infant showing bilateral giant cervical cystic swelling and protrusion of the tongue.

Discussion

The problems with bilateral giant cervical lymphangiomas in neonates are usually related to airway obstruction, feeding issues, disfigurement and difficult intubation. In recent times, with better antenatal screening, such cases are diagnosed antenatally and are delivered in institutions with appropriate perinatal care facilities. The usual primary management is intralesional Sclerotherapy for large lesions in neonates and infants and/or wait and watch for smaller lesions.

This case was unique that there was no antenatal diagnosis; delayed presentation at two months; significant disfigurement was present with tongue protrusion, inadequate feeding resulting in failure to thrive and presentation with mild tachypnea. Airway was also compressed making the intubation difficult. The difficult intubation was taken care of by aspirating fluid from the floor of the mouth, thereby opening the airway enough for intubation. As there was no intrathoracic extension, complete excision was possible. We proceeded directly to surgical excision as the lesion was large and bilateral causing difficulty in nursing and feeding by the parents and disfigurement of the baby.



Figure 2: Immediate post-operative image of the infant after complete excision of the lymphangioma.

References

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