

TITLE – TO STUDY THE ROLE OF FINE NEEDLE ASPIRATION CYTOLOGY IN PALPABLE NECK MASSES

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Introduction: Fine needle aspiration cytology is one of the most important tests available in the initial assessment of the patient who presents with a mass in the head and neck region or where a recurrence is suspected after previous treatment¹. It is accurate, inexpensive and quick. The tissues which are most frequently sampled are lymph nodes.²

This study was to assess then FNAC in palpable neck masses and also to study their distribution.

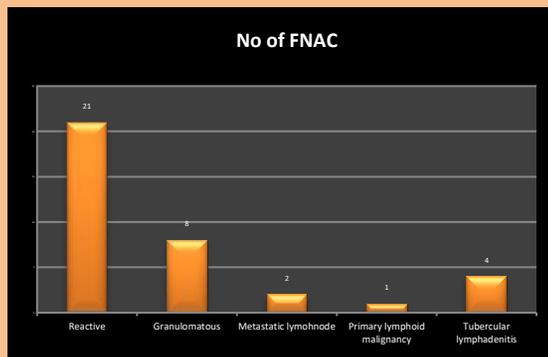
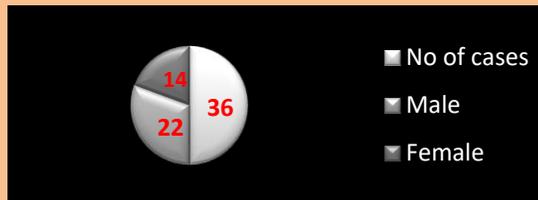
Aim: To Study the Role of Fine Needle Aspiration Cytology In Palpable Neck Masses

Materials and Methods: FNAC was done on 36 patients who presented with palpable neck masses in a tertiary hospital for a period of 6 months. Examination for viable patients for FNAC was done with priority. Relevant investigations were carried out as per requirements. Slides were fixed in methanol and stained by the Papanicolaou stain. The Zeihl-Neelsen's stain for AFB was done in those cases with lymph node swelling, where the clinical suspicion or diagnosis was tuberculosis and /or in those cases where purulent or cheesy material was aspirated. Surgically excised specimens were also available and were routinely processed and stained with Haematoxylin and Eosin stains.

Observations

36 patients were included in the study with satisfactory smears, the distribution is as follows. 22 were males, while 14 were females. Lymphadenopathy was more common in females (12 cases) than males. Reactive (21) and granulomatous lesions (8) constituted the majority of the cases and tuberculous lymphadenitis comprised 4 cases who

were female. Metastatic lymph nodes constituted 2 of the cases (male). Primary lymphoid malignancies comprised only 1 of the cases (1 Non Hodgkin's Lymphoma)



Discussion Study carried out to assess the role of FNAC in palpable neck masses. The observations were compared to previous studies. In this study, non-neoplastic lesions comprised the majority of the cases accounting for 94.5% whereas malignant lesions comprised 5.5%. In most of the national studies inflammatory and non-neoplastic lesions were the predominant cause of neck masses (Kishore et al)³ In the study by Jasmin et al, 54% were male and 46% were female⁴ which was comparable to our study in which 61% were males. Similarity was seen to the study by Rathod GB et al⁵ with our study as female preponderance was evident in both. Results by Lawrence et al 2003 showed 59% of cases with reactive hyperplasia followed by granulomatous

lesion (41%)⁶. In our study also reactive was 58.3% and granulomatous was 22.2%. Hag et al carried out a similar study in Saudi Arabia over a period of 5 years which included 225 patients which showed reactive/nonspecific lymphadenitis to be the commonest cause of neck masses accounting for 33% of cases⁷.

Conclusion and Limitations- The triad of physical examination/ clinical history, appropriate cell preparation and subsequent interpretation is essential for a successful FNAC reporting. The success rate of FNAC diagnosis in material obtained by an experienced cytopathologist is far in excess of that where specimens are taken and sent to a laboratory. Neck mass is the commonly encountered swelling in the OPD of which lymphadenopathy is commonest cause, followed by thyroid lesions, soft tissue swellings and salivary gland swellings. FNAC alone is helpful to avoid unnecessary surgeries and for planning of appropriate management. Thus, FNAC is recommended as a first line of investigation which can be performed as out-patient's procedure in the diagnosis of neck masses for both screening and follow-up.

References

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Keywords- Lymphnodes, FNAC, Non Hodgkin, Palpable, Neck Masses