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Second branchial cyst in the parapharyngealspace: A case report

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Abstract

Objective: We report the clinical findings and management of a large retro- and parapharyngeal branchial cyst in a 54-year-old man whose only complaint was a 12-month history of snoring.
Method: Case report and a review of the world literature concerning parapharyngeal cysts are presented.
Results: On computed tomography (CT) images, a well-marginated cystic mass was observed in the left retro- and parapharyngeal spaces, with displacement of the left internal and common carotid arteries. The cyst contained thick, sterile, yellowish pus, without malignant cells. We performed a transoral resection without any surgical complications. No recurrence was observed 2 years later.
Conclusion: Parapharyngeal branchial cysts are rare and often paucisymptomatic. The transoral approach can provide good exposure allowing complete resection without significant post-operative complications or cervical scarring.
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Keywords: Branchial cyst; Parapharyngeal space; Transoral approach

1. Introduction

Branchial cysts are common neck masses in adults but very rarely develop in the parapharyngeal space. The parapharyngeal space lies adjacent to the naso- and oropharynx between the base of the skull and the hyoid. The most common symptoms are hearing loss due to middle ear effusion, dysphagia, dysarthria and dyspnea. According to Bailey and Proctor, second branchial cysts can be divided into four subtypes: (i) type 1 cysts are located superficially along the anterior edge of the sternocleidomastoid muscle beneath the cervical fascia, (ii) type 2 cysts lie on the great vessels beneath the enveloping fascia of the neck, (iii) type 3 cysts pass between the great neck vessels to reach the pharyngeal wall and (iv) type 4 cysts are situated under the pharyngeal wall medial to the great neck vessels [1,2]. Total excision of the cystic mass is the only way to prevent recurrence. Here, we describe a case of large retro- and parapharyngeal branchial cyst (type 4) revealed only by snoring and that was successfully resected transorally. We discuss the embryological origin of this parapharyngeal cyst and the therapeutic options described in the literature, especially the transoral approach.

2. Case report

A 54-year-old man presented at the otolaryngological consultation with a 12-month history of snoring. The patient did not describe any dysphagia but exhibited weight loss of 6 kg during the previous 3 months. He did not report alcohol abuse and had stopped smoking 18 months earlier.

The clinical examination revealed a large submucosal tumefaction of the left postero-lateral wall of the oropharynx, extending from the nasopharynx to the hypopharynx (Fig. 1a). This lesion was not palpable in the neck or in the parotid region. The remainder of the examination was normal, with normal larynx mobility and no cervical adenopathies. Head and neck computed

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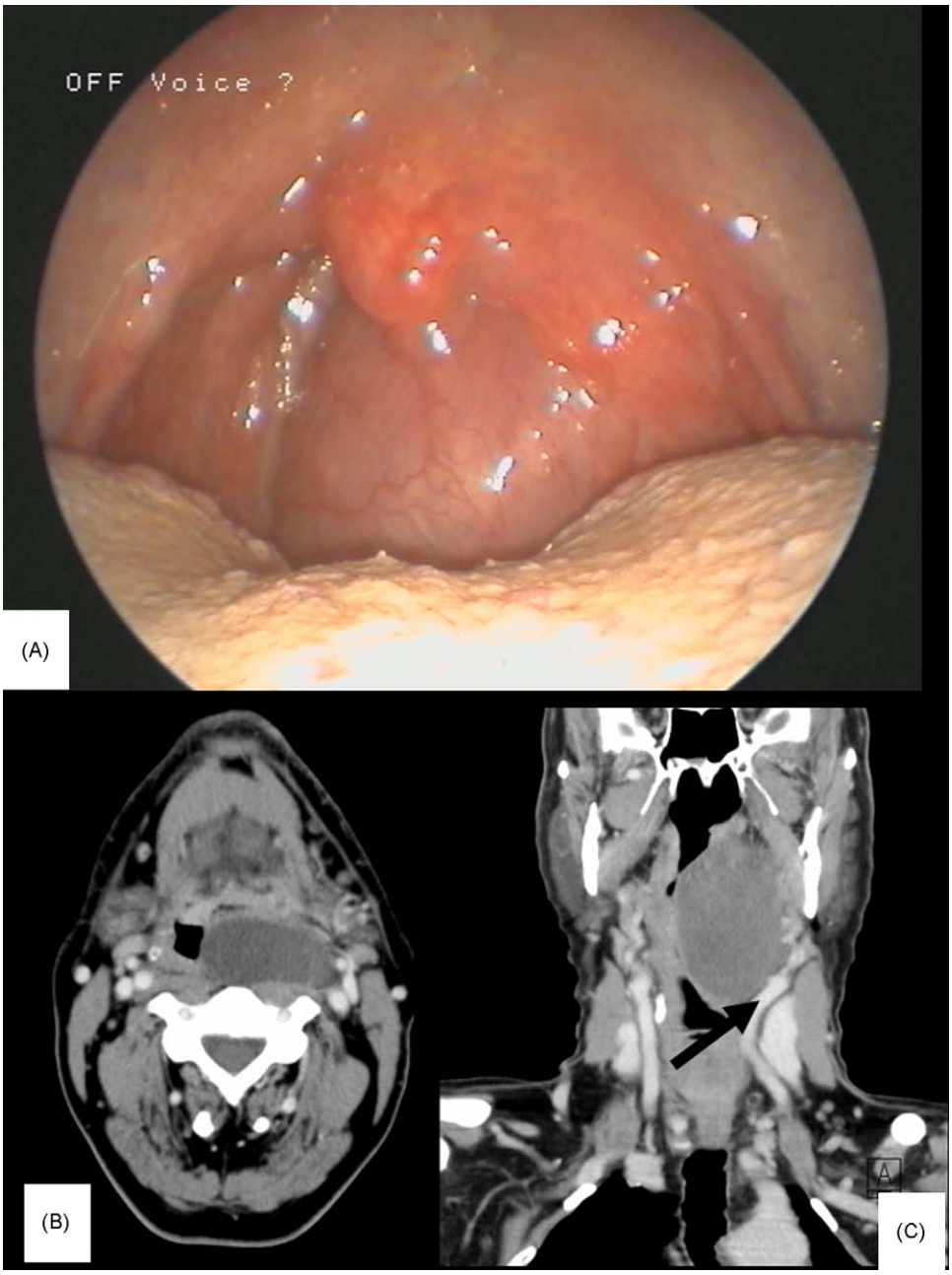

Fig. 1. The para- and retropharyngeal cyst was observed directly when the patient opened his mouth (A). Axial (B) and coronal (C) head and neck CT-scans show the branchial cyst before the resection. The cyst filled the retropharyngeal and parapharyngeal spaces and displaced the left common -black arrow- and internal carotid arteries laterally.

tomography (CT) revealed a 10-cm diameter cyst situated medially to the internal and common carotid arteries, enlarging the left para- and retropharyngeal spaces (Fig. 1b and c). An intraoral fine-needle aspiration of the cyst revealed thick, sterile, yellowish pus, without malignant cells.

After aspiration and drainage of the parapharyngeal cyst, we performed a complete transoral resection under general anesthesia. In fact, we placed the patient in supine decubitus position with forced cervical extension and used an amygdalectomy autostatic retractor to realize this transoral resection. First of all, we performed a very superficial incision – 7–8 cm length – of the lateral oropharyngeal wall. We prolonged this incision in the lateral part of the soft palate which allowed one to dissect the superior – nasopharyngeal – part of the cyst. The wall cyst was very thin and located just below the pharyngeal wall. After that, we visualized the cyst wall and aspired this content – not completely – decreasing significantly the cyst size but avoiding complete collapsus. Then, using the electrothermal bipolar vessel sealer, we dissected very carefully the space between the lateral cyst wall and the middle, inferior

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