Evaluation of Head and Neck Masses in Adults

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Annual Refresher Course for the Family Physician
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Objectives

- Recognize when practitioners should worry about head and neck adenopathy

- Identify what are common serious causes of cervical lymphadenopathy and neck masses

- Understand how location of a neck mass guides differential diagnosis

- Identify indications warranting a biopsy of a neck mass and referral to an otolaryngologist
Neck mass – Background

- Definition: abnormal lesion that is visible, palpable, or seen on imaging study
  - can be acquired or congenital

- Location:
  - below mandible, above clavicle, deep to skin

- Etiologies can be varied
  - Adult neck masses are more likely to be malignant neoplasms
  - Persistent neck masses should be considered malignant until proven otherwise
Neck Mass - History

What is the **Age** of patient?
- Adults > 40 yrs old ~ 80% of neck masses are neoplastic (except thyroid)
- Peds neck masses ~ 80% infectious/inflammatory
- 16-40 yrs ~ 30% neoplastic, 50% infectious/inflammatory

What is the **DURATION** of the mass?

What is the **LOCATION** of mass?
Duration and location are key factors in developing differential diagnosis

Any new, persistent lateral neck mass in an adult > 40 yrs old is likely to be malignant

Many upper aerodigestive tract cancers present with the chief concern of a painless neck mass
Neck Mass - Duration impacts Etiology

- **ACUTE**: onset over days
  - more likely to be symptomatic

- **SUBACUTE**: weeks to few months
  - often asymptomatic
  - more concerning for possible malignancy

- **CHRONIC**: more likely to be benign

- Traumatic: hematoma, vascular injury
- Infectious/Inflammatory:
  - adenopathy from viral or bacterial infection
  - odontogenic
  - salivary gland

- Neoplastic process more likely:
  - metastatic from upper aerodigestive tract mucosa
  - salivary gland tumor
  - metastatic from skin, thyroid primary
  - lymphoma
- Inflammatory: sarcoidosis, Castleman, Kikuchi, Kimura diseases

- Neoplasm: lipoma, paraganglioma
- Congenital: branchial cleft cyst, thyroglossal duct cyst, laryngocele
Figure 8-2. Triangles of the neck. The anterior triangle is divided from the posterior triangle by the sternocleidomastoid muscle.

Cummings et al. Otolaryngology-HNS, 5th ed
# Neck masses – Differential diagnosis

## Evaluation of Neck Masses in Adults

**JAMES HAYNES, MD; KELLY R. ARNOLD, MD; CHRISTINA AGUIRRE-OSKINS, MD; and SATHISH CHANDRA, MD, University of Tennessee Health Science Center College of Medicine, Chattanooga, Tennessee**

### Table 2. Differential Diagnosis of Neck Masses in Adults

<table>
<thead>
<tr>
<th>Condition</th>
<th>History/risk factors</th>
<th>Physical findings</th>
<th>Diagnosis</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute</strong></td>
<td></td>
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<tr>
<td>Acute salivary gland abscess</td>
<td>Older, debilitated persons with dehydration or recent dental procedures</td>
<td>Rapid or gradual onset of pain and swelling; local edema, erythema, tenderness, or fluctuance consistent with an abscess</td>
<td>Contrast-enhanced CT</td>
<td>Stilagrapy; gentle massage; abscess, express by compressing abscess</td>
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<tr>
<td>Hematoma</td>
<td>Trauma</td>
<td>Soft, possible overlying ecchymosis</td>
<td>Ultrasound or contrast-enhanced CT</td>
<td>Monitor if small; surgical drainage if large or expanding</td>
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<tr>
<td>Pseudoneurysm or arteriovenous fistula</td>
<td>Trauma with shearing forces</td>
<td>Lateral, soft, pulsatile mass with a thrill or bruit</td>
<td>CT with or without CT angiography</td>
<td>Surgical evaluation for ligation</td>
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<tr>
<td>Reactive lymphadenopathy</td>
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<tr>
<td>Bartonella henselae infection</td>
<td>Kittin or flea exposure</td>
<td>Isolated, mobile, fluctuant, tender, warm, erythematous, &gt; 2 cm near site of inoculation</td>
<td>Bartonella antibody titer</td>
<td>Antibiotic (Azithromycin)</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td>URI symptoms</td>
<td>Rubbery, mobile, cervical, and generalized; &gt; 2 cm in diameter</td>
<td>Cytomegalovirus titer</td>
<td>Biopsy if no resolution after 8 weeks</td>
</tr>
<tr>
<td>Epstein-Barr virus infection</td>
<td>URI symptoms</td>
<td>Rubbery, mobile, cervical, and generalized; &gt; 2 cm in diameter</td>
<td>Cytomegalovirus titer</td>
<td>Biopsy if no resolution after 8 weeks</td>
</tr>
<tr>
<td>HIV infection</td>
<td>Bloodstream contact</td>
<td>Rubbery, mobile, and generalized</td>
<td>HIV enzyme-linked immunosorbent assay</td>
<td>Highly active antiretroviral therapy</td>
</tr>
<tr>
<td>Mycobacterium tuberculosis (extrapulmonary)</td>
<td>Travel or immigration from an endemic area, homelessness, immuno compromised</td>
<td>Diffuse, bilateral lymph nodes (multiple, fixed, firm, nontender)</td>
<td>Purified protein derivative test to rule out other mycobacteria infections; acid-fast bacilli culture</td>
<td>Anti-tuberculosis antibiotics: rifampin andisoniazid and pyrazinamide or ethambutol or streptomycin in endemic areas; refer to a head and neck surgeon if persistent after initial diagnosis and treatment</td>
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<tr>
<td><strong>Subacute (weeks to months)</strong></td>
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<tr>
<td>Hodgkin lymphoma</td>
<td>History of smoking, heavy alcohol use, and multiple sex partners (especially involving gonadal contact)</td>
<td>Painful, rapidly growing lymph node; rubbery, soft, mobile</td>
<td>Contrast-enhanced CT of the neck, chest, abdomen, pelvis: biopsy</td>
<td>Refer to oncology</td>
</tr>
<tr>
<td>Human papillomavirus–related squamous cell carcinoma</td>
<td>History of smoking, heavy alcohol use, and multiple sex partners (especially involving gonadal contact)</td>
<td>Rapidly enlarging, lateral, cystic lymph nodes; persistent cervical nodal hypertrophy, palpable or lingual toriolar asymmetry, dysphagia, voice changes; pharyngeal bleeding</td>
<td>Contrast-enhanced CT of the neck, chest, abdomen, pelvis: biopsy</td>
<td>Refer to oncology</td>
</tr>
<tr>
<td>Metastatic cancer</td>
<td>History of melanoma or lung, breast, colon, gastrointestinal cancer</td>
<td>Mattened, fixed lymph nodes</td>
<td>Biopsy</td>
<td>Refer to oncology</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>Older persons</td>
<td>Painless, rapidly growing lymph node; rubbery, soft, mobile</td>
<td>Biopsy</td>
<td>Refer to oncology</td>
</tr>
<tr>
<td>Parotid tumors</td>
<td>Asymptomatic</td>
<td>Nonenlarging, bilateral, submandibular, tonsillar, pharyngeal</td>
<td>Biopsy</td>
<td>Refer to ENT for excisional biopsy</td>
</tr>
<tr>
<td>Upper aerodigestive tract squamous cell carcinoma</td>
<td>Male sex; use of tobacco, alcohol, betel nut</td>
<td>Nonenlarging, bilateral, submandibular, tonsillar, pharyngeal</td>
<td>Biopsy</td>
<td>Refer to ENT for excisional biopsy</td>
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<tr>
<td>Chronic salivary diseases</td>
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<td>Idiopathic diseases</td>
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<tr>
<td>Cystic disease (angiolympillary proliferative disease)</td>
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<td>Solitary lymph node</td>
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<tr>
<td>Kikuchi disease (histiocytic necrotizing lymphadenitis)</td>
<td>Lymphadenopathy, fever, leukopenia</td>
<td>Posterior lymphadenopathy resolves in 3 months</td>
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<td>Kimura disease</td>
<td>Endemic in Asia; painless subcutaneous mass, eosinophilia</td>
<td>Submandibular triangle, orbital, epidermal, periarteric, nontender, ill-defined</td>
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<tr>
<td>Rosai-Dorfman disease</td>
<td>Occasional fever in healthy adults</td>
<td>Mattened lymphadenopathy</td>
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</table>

*Continues...*
## Neck masses – differential diagnosis

<table>
<thead>
<tr>
<th>Table 2. Differential Diagnosis of Neck Masses in Adults (continued)</th>
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<tbody>
<tr>
<td><strong>Condition</strong></td>
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<tr>
<td>----------------</td>
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<tr>
<td><strong>Subacute (weeks to months) continued</strong></td>
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<tr>
<td><strong>Systemic diseases</strong></td>
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<tr>
<td>Amyloidosis</td>
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<tr>
<td>Sarcoidosis</td>
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<tr>
<td>Sjögren syndrome</td>
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<tr>
<td><strong>Chronic (usually evident as long-standing)</strong></td>
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<tr>
<td>Carotid body tumors</td>
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<td>Congenital cysts</td>
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CHF = congestive heart failure; CT = computed tomography; ENT = ear, nose, throat; FNAB = fine-needle aspiration biopsy; FT4 = free thyroxine.

HIV = human immunodeficiency virus; TSH = thyroid stimulating hormone; URI = upper respiratory infection.
Neck Mass - History

Age of patient?
Location of mass?
Duration?: > 2-4 wks

Growth pattern?: worrisome if growing
Pain?: most metastatic nodes are painless
Recent infection?: cervical lymphadenitis more likely
Other similar masses?
Exposures?: sick contacts, travel, pets/animals , h/o TB
Prior trauma or surgery in that area
Previous head and cancer or other CA
Neck mass - History

Associated symptoms?
- Dysphagia
- Odynophagia/sore throat
- Hoarseness
- Otalgia
- Dyspnea/stridor
- Constitutional symptoms

Risk factors for malignancy:
- smoking
- alcohol
- prior XRT to head and neck
- other malignancy, including skin cancer *
- immunosupression
- family hx
  - thyroid, lymphoma

* Must r/o malignancy in any patient with facial or parotid mass with an associated facial nerve weakness or paralysis

- fever/chills
- fatigue
- weight loss
- night sweats
- flushing
- palpitations
- elevated BP
Neck mass - Exam

Location helps guide differential dx
- Lateral neck most common site for metastatic disease from UADT
  - upper neck anterior/deep to SCM
- Midline neck masses likely related to thyroid, elevates with swallowing

Concerning features:
- any abnormality in other area of head and neck:
  - skin/scalp/ear lesions, mucosal lesion of nasal cavity,
    oral cavity, pharynx, larynx
  - salivary gland mass
- hard mass
- fixation to surrounding structures (skin, SCM, mandible), ulceration
- single, asymmetric node/mass > 1.5 cm
- mass in posterior neck or supraclavicular fossa
- neurologic abnormalities (cranial nerves)
- multiple rapidly growing nodes may suggest lymphoma

Concern for abscess or suppurative infection warrants antibiotic therapy, referral to ENT for possible I & D
Neck mass - exam

Head and neck examination not complete without visualization of all mucosal surfaces of upper aerodigestive tract in patient with concern for primary head and neck malignancy --> ENT referral

• Waldeyer’s ring: tonsils, base of tongue (oropharynx), nasopharynx
• hypopharynx
• larynx
Neck Masses – Differential Dx

Inflammatory/infectious
- lymphadenopathy/lymphadenitis → LN > 1.5 cm
  - bacterial, viral, fungal, parasitic
  - can become neck abscess
- infectious granulomatous disease
  - TB, atypical mycobacteria, cat scratch
- non-infectious granulomatous disease
  - sarcoidosis, Kawasaki, Castleman, Kikuchi, Kimura
- sialadenitis/sialolithiasis

Neoplastic
- metastatic disease
  - usually from lesion of mucosa of upper aerodigestive tract (UADT) or skin
- Primary neoplasms:
  - lymphoma
  - thyroid
  - salivary gland
  - neurogenic
  - paraganglioma
  - lipoma
  - sarcoma
  - others

Congenital
- branchial cleft cysts
  - very rare in adults >40
- laryngocele

Traumatic
Vascular

• Most inflammatory adenopathy is self-limited and will resolve without treatment
• If concerned about bacterial infection, treat with a course of antibiotics
  • 1st gen cephalosporins, Augmentin, Clindamycin
Common neck lumps and locations

Roland N, and Bradley P J BMJ 2014;348
Lymphatic drainage of head and neck

Majority of mets in neck are to upper deep neck nodes

Posterior neck NP mets, posterior scalp, thyroid

GI, lung, GU
Neck masses - Examples

- Lymphoma
- Lipoma
- Branchial cleft cyst
- Carotid body tumor

Roland N, and Bradley P J BMJ 2014;348:bmj.g1078
<table>
<thead>
<tr>
<th>Statement</th>
<th>Action</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Avoidance of antibiotic therapy</td>
<td>Clinicians should not routinely prescribe antibiotic therapy for patients with a neck mass unless there are signs and symptoms of bacterial infection.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>2a. Stand-alone suspicious history</td>
<td>Clinicians should identify patients with a neck mass who are at increased risk for malignancy because the patient lacks a history of infectious etiology and the mass has been present for (\geq 2) weeks without significant fluctuation, or the mass is of uncertain duration.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>2b. Stand-alone suspicious physical examination</td>
<td>Clinicians should identify patients with a neck mass who are at increased risk for malignancy based on (\geq 1) of these physical examination characteristics: fixation to adjacent tissues, firm consistency, size (\geq 1.5) cm, and/or ulceration of overlying skin.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>2c. Additional suspicious signs and symptoms</td>
<td>Clinicians should conduct an initial history and physical examination for adults with a neck mass to identify those patients with other suspicious findings that represent an increased risk for malignancy.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>3. Follow-up of the patient not at increased risk</td>
<td>For patients with a neck mass who are not at increased risk for malignancy, clinicians or their designees should advise patients of criteria that would trigger the need for additional evaluation. Clinicians or their designees should also document a plan for follow-up to assess resolution or final diagnosis.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>4. Patient education</td>
<td>For patients with a neck mass who are deemed at increased risk for malignancy, clinicians or their designees should explain to the patient the significance of being at increased risk and explain any recommended diagnostic tests.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>5. Targeted physical examination</td>
<td>Clinicians should perform, or refer the patient to a clinician who can perform, a targeted physical examination (including visualizing the mucosa of the larynx, base of tongue, and pharynx) for patients with a neck mass deemed at increased risk for malignancy.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>6. Imaging</td>
<td>Clinicians should order neck computed tomography (or magnetic resonance imaging) with contrast for patients with a neck mass deemed at increased risk for malignancy.</td>
<td>Strong recommendation</td>
</tr>
<tr>
<td>7. Fine-needle aspiration (FNA)</td>
<td>Clinicians should perform FNA instead of open biopsy, or refer the patient to someone who can perform FNA, for patients with a neck mass deemed at increased risk for malignancy when the diagnosis of the neck mass remains uncertain.</td>
<td>Strong recommendation</td>
</tr>
<tr>
<td>8. Cystic masses</td>
<td>For patients with a neck mass deemed at increased risk for malignancy, clinicians should continue evaluation of patients with a cystic neck mass, as determined by FNA or imaging studies, until a diagnosis is obtained and should not assume the mass is benign.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>9. Ancillary tests</td>
<td>Clinician should obtain additional ancillary tests based on the patient’s history and physical examination when a patient with a neck mass is at increased risk for malignancy and/or does not have a diagnosis after FNA and imaging.</td>
<td>Recommendation</td>
</tr>
<tr>
<td>10. Examination under anesthesia of the upper aerodigestive tract before open biopsy</td>
<td>Clinicians should recommend examination of the upper aerodigestive tract under anesthesia, before open biopsy, for patients with a neck mass who are at increased risk for malignancy and without a diagnosis or primary site identified, with FNA, imaging, and/or ancillary tests.</td>
<td>Recommendation</td>
</tr>
</tbody>
</table>
Clinical Practice Guideline: Evaluation of the Neck Mass in Adults Executive Summary

Figure 1. Algorithm depicting the relationship among the key action statements (KASs). CT, computed tomography; MRI, magnetic resonance imaging.
Imaging of neck masses

CT neck with contrast *
- study of choice – >skull base to clavicles
- evaluation of mucosal surfaces, neighboring structures, detailed 3-d anatomy, LN size and morphology, enhancement, necrosis
- excellent bony resolution

Ultrasound: best for thyroid lesions, pediatric pts
Can distinguish cystic vs solid, guide biopsy

MRI with contrast:
- best soft tissue resolution, useful for salivary glands, concerns for nerve enhancement
- pts with iodinated contrast allergy

Other imaging studies:
- PET/CT in pts with documented malignancy, staging or restaging
- CT or MR angiography in pts with possible vascular lesions
- no role for plain films
Neck mass biopsy

Fine needle aspiration is preferred method of biopsy

- safe, well-tolerated, can distinguish inflammatory vs neoplastic process, helps direct management
- can perform in pediatric patients

Indications for FNA:
- single asymmetric node > 1.5 cm
- persistent enlarged node without prior signs of active infection
- persistence after observation > 2-4 wks, trial of antibiotics if appropriate
- increasing size of mass
- If concerned about vascular lesion, can obtain FNA after imaging studies

FNA success at establishing diagnosis of neck mass ~ 95%
Success at diagnosing malignancy ~ 95%
Success at diagnosing benign process ~ 87%

Amedee et al, Laryngoscope 2001;111:1551-57
Fine needle aspiration is preferred method of biopsy

- try to avoid incisional biopsy if concerned about mass being metastatic SCC
- excisional biopsy may be necessary if FNA is non-dx, concerning for lymphoma or other malignancy
  - flow cytometry can be obtained in evaluation of possible lymphoma
  - negative FNA cannot completely possibility of lymphoma
- can increase yield by U/S guidance or core biopsy
- can send material for gram stain and cultures
- may not be able to diagnose some thyroid malignancies on FNA alone
Predictive Factors for Neoplasia and Malignancy in a Neck Mass


- Final diagnoses for cervical masses
- Distribution of neoplastic and malignant masses by location

Higher risk of neoplasia with increasing age, larger size, longer duration

Posterior or supraclavicular masses, number of masses, fixation predictive in other studies
Case #1: 28 y male, R neck mass x 1 yr

2.5 cm soft mass R level 2
Case #2: 56 y male, L neck mass for 3 months

No other symptoms in head/neck
Former smoker, US showed L neck mass ~ 3 cm and L thyroid mass
HPV associated HN SCC

- Tobacco associated OP SCC is decreasing as tobacco use decreases
- HPV+ OP SCC increase is independent of tobacco-associated decrease → “EPIDEMIC”
  - ~ 63.5% prevalence HPV+ in OP SCC in US

- Most are associated with HPV 16 (~ 85%)
- HPV infection is an independent risk factor for the development of OP SCC
- Males seem to be more susceptible, more than 2-fold

- MANY of these patients with present with an asymptomatic neck mass

Kreimer et al 2005
Hammarstedt et al 2006
Chaturvedi et al 2008
Ang et al 2010
HPV associated HN SCC

- HPV+ pts have different epidemiologic factors compared to HPV-:
  - HPV+ are less likely to smoke tobacco and less likely to use alcohol heavily
  - HPV+ have better dentition
  - HPV+ have higher incidence of oral sex practice, # partners
  - HPV+ present at a younger age and higher socioeconomic status
    - 40-60 yrs

D’Souza et al, 2007

- HPV+ pts have better survival compared to HPV- pts\(^1,2\):
  - 82.4% vs 57.1% in stage III/IV OP SCC at 3 yrs
  - 95% vs 62% at 2 yrs in stage III/IV Lx and OP SCC

- HPV+ pts at lower risk for second primary cancers compared to HPV- pts\(^3,4\):

1. Ang et al, 2010
2. Fakhry et al, 2008
OP SCC – improved prognosis + survival

Chaturvedi et al, 2011  
Ragin et al, 2007
Case#3: 83 y with R neck mass x 1 mo, h/o CLL and skin CA
Case #4 – 31 y male with enlarging R neck mass x 3 months

Some mild compressive symptoms, no dysphagia or odynophagia, no voice changes or dyspnea, non-smoker, no FHx malignancy
Exam: R inferior neck 3.5 cm firm mass, enlarged thyroid, no mucosal lesions
Case #5 – 56 y male w/ chest discomfort, L neck mass
Case #6 – 81 y female, L neck mass x 6 weeks

h/o treatment for breast CA and renal CA, hemi-thyroidectomy for benign nodule
L lower neck soft, ballotable neck mass ~ 4 cm, mobile, non-tender, no inflammatory changes
FNA – cystic, some benign cells
Case #7: 59 y female with R parotid mass x 2 yrs

FNA: benign lymph nodes
Excisional biopsies: reactive follicular hyperplasia
ALPS: auto-immune lymphoproliferative syndrome
Thyroid masses

Majority are benign, but need to be concerned about potential malignancy
Common benign process: cysts, multinodular gland, adenoma, TGDC

Workup: hx and exam, thyroid /neck US, FNA of any concerning lesions

5-10% of thyroid nodules are malignant
Neck mass - Summary

- Do not observe a neck mass for > 2-4 wks in an adult
  - need to r/o malignancy
  - adult LN/mass size >1.5 cm

- CT scan with contrast and FNA of mass are most useful dx tools, helpful if done before referral
  - U/S better than CT if pediatric patient or thyroid mass
Table 5. Patient Handout: Adult Neck Mass Follow-up.

What do I need to know about my neck mass?
A neck mass is an abnormal lump in the neck. A neck mass may be caused by infection, benign tumor, or a cancerous tumor. A neck mass from infection should go away completely when the infection goes away. If it does not, your health care provider will help you to choose tests to determine the cause of your neck mass.

What should I do?
- If you were given antibiotics, take them as prescribed.
- Once each week, check the size of the neck mass using your fingertips.
- Follow up with your provider to be sure that the neck mass decreases in size over time.
- Be sure to follow through with any tests your provider ordered.

How do I check the size of my neck mass?
Once each week, use your fingertips to check the size of the mass. How wide is the mass? One fingertip wide? Two fingertips wide? How does that compare with the size last time you checked? The mass should get smaller over time. A mass due to infection should go away completely or return to a much smaller size, typically in 2 or 3 weeks.

Contact your provider if
- The mass gets larger.
- The mass does not go away completely.
- The mass goes away but then comes back.

What else should I look for?
Notify your provider if you have
- Difficulty or pain with swallowing
- Neck pain or throat pain
- Mouth sores or tooth pain
- Ear pain or hearing loss on the same side as the lump in your neck
- Change in voice
- Unexplained weight loss
- Fever >101°F

How should I follow up with my provider?
You and your provider may stay in contact by phone, through electronic messages, by mail, or in person at the provider’s office. You may need to go back to your provider’s office for a repeat examination.

No matter how you follow up with your provider, be sure that the mass has gone away. If the mass does not go away, your provider will help you decide what to do next.

What does it mean that I have a neck mass at increased risk for malignancy?
The mass in your neck may indicate a serious medical problem. It does not mean that you have cancer, but it does mean that you need more evaluation to make a diagnosis. Common symptoms in patients with a neck mass at increased risk for malignancy include
- The mass lasts longer than 2-3 weeks
- Voice change
- Trouble or pain with swallowing
- Trouble hearing or ear pain on the same side as the neck mass
- Sore throat
- Unexplained weight loss
- Fever >101°F

What do I do next?
Your provider will ask about medical history and examine your head and neck. Your provider may order tests or refer you to a specialist.

How urgently should I be evaluated?
Your provider will want to make sure you have a thorough evaluation, testing, and follow-up within a short period of time. It is important that you discuss this timeline with your provider and make sure that there is a plan for follow-up after testing. It is important for you to follow this neck mass until it goes away or until you have a diagnosis.

What questions may my doctor ask?
- When did you first notice the lump? Has it grown?
- Have you had a recent illness?
- Do you have any trouble with eating, talking, swallowing, or hearing?
- Any sore spots in your mouth or throat?
- Do you have any sore or growing spots on your scalp, neck, or face?
- Have you lost weight?
- Are citrus fruits or tomatoes painful to eat?
- Do you have ear pain or sore throats that do not go away?
- Has your voice been hoarse?
- Have you coughed up any blood?
- Do you currently smoke, or do you have a smoking history? How much? How long?
- Do you drink alcohol, or do you have a history of drinking alcohol? How much? How long?
- Do you have a history of head and neck cancer?
- Any radiation exposure to your head or neck?
- Do you have any family history of head and neck cancer?

How will the provider examine my mouth and throat?
The provider will look in your mouth and throat with a bright light. If you wear dentures, you will need to remove them. The provider may use gauze to hold your tongue and feel the surfaces of the mouth, tongue, tonsils, or the back of your tongue.
The provider may use a small mirror in your mouth to see the voice box. If a “scope” is needed, the provider may first numb the nose and throat. The provider will then place a small tube in your nose and use a camera to examine your throat. You may have mild discomfort.
Questions?

Thank you!