Basilingual Thyroglossal Cyst: An Infrequent Cause of Dysphagia and Dyspnoea

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CLINICAL IMAGE

Thirty-four-year-old female with central neck pain and odynodysphagia and dyspnoea in supine decubitus position, gradually increasing over 48 hours and improving in lateral decubitus position.

She reported having suffered similar previous bouts, but without dyspnoea, catalogued as acute thyroiditis. A smooth sub-mucosal expansive tumour was detected to be under tension, in valleculas, with posteroinferior displacement of the epiglottis reducing the airway lumen particularly in decubitus position (Figure 1). The ultrasound scan showed multinodular goitre and associated acute thyroiditis. The computerized tomography and the magnetic resonance imaging revealed voluminous medial basilingual cyst compatible with a cyst of the thyroglossal duct. Although it varied in T1 depending on its protein content, the uptake remained excessive in T2, unlike a vallecular retention cyst located on the edge of the mucosa, not along the run of the thyroglossal duct and deeper into the tissue, as in our patient (Figure 2). It was decided to monitor the course of the condition with anti-inflammatory and antibiotic therapy, with deferral of surgery using the Sistrunk technique to the foramen caecum, together with peri-cystic tissue in a single block to minimize the risk of leaving behind other minor embryonic remains. An indented circular suture was made, with invagination of the edges of the lingual defect on the surface to avoid complications, suppuration and fístulae. In intralingual cysts, particularly in bulky ones, it is imperative to ensure extremely careful dissection, as any tear would hinder complete exeresis and, very probably, entail a relapse or the formation of an embryonic sinus. This tear is inevitable in the foramen caecum if it is attached to the mucosa. In severe cases causing dyspnoea or abscesses, drainage can be achieved through endo-oral puncture or externally over the hyoid or by marsupialization prior to its definitive surgical resolution, which would have to be deferred in the presence of infection. This option was included in our therapeutic approach should the circumstances have required it. In our opinion, puncture would be the treatment of choice so as not to hinder a subsequent complete dissection of the cyst.

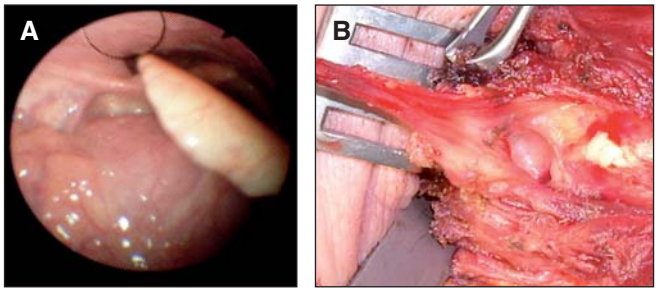

Figure 1. A: flexible pharyngolaryngoscopy. B: intra-operative image.

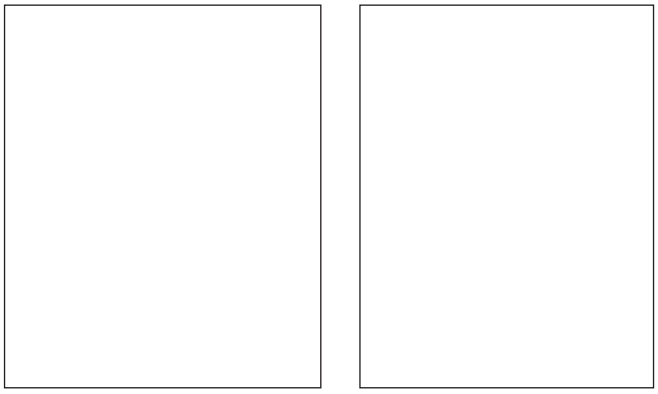

Figure 2. Computerized tomography (left) and magnetic resonance (MR) image of the neck (right): round hypodense tumour not absorbing contrast located above the mylohyoid muscle, in contact with the hyoid bone and constraining the displacement of the floor of the mouth and protrusion of the anterior wall of the oropharynx at the level of the vallecula and base of the tongue. MR image compatible with cystic formation in T2. Study indicative of thyroglossal cyst.

The authors have indicated there is no conflict of interest.

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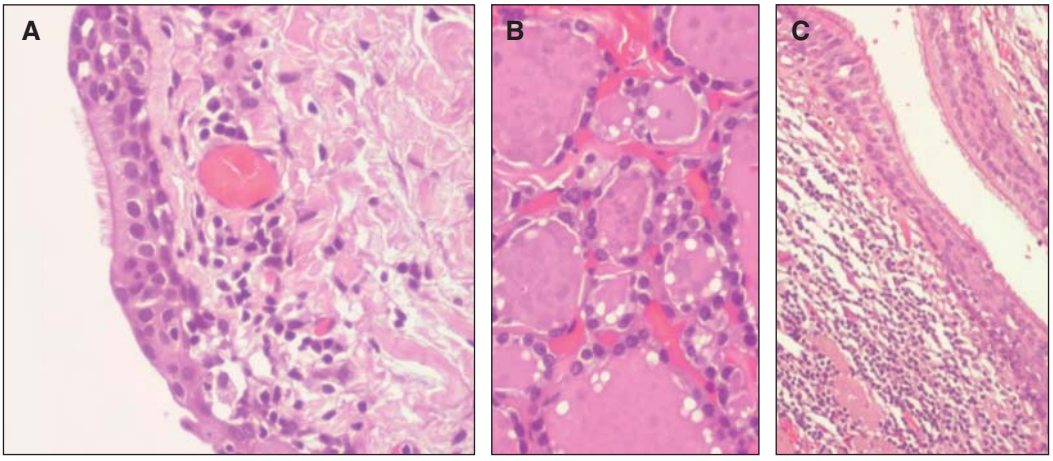

Figure 3. Histological study. A: evidence of epithelium coating the cyst; visible areas of ciliate respiratory epithelium in transition towards squamous epithelium, both findings highly characteristic of this entity (HE, ×10). B: thyroid follicles (HE, ×40). C: cyst wall and thyroglossal duct with squamous surface and respiratory epithelium, together with chronic underlying infiltrate (HE, ×10).

The diagnosis was confirmed histologically, as was complete exeresis and the absence of accessory routes (Figure 3). Isolated thyroid follicles were observed in some areas (40%, 1/3 active) (Figure 3B). There has been no relapse. As far as we know, there are very few cases causing dyspnoea in adults.