CYSTIC HYGROMA IN THE AXILLA OF AN INFANT: CASE REPORT

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ABSTRACT

Cystic hygroma is a congenital lymphatic disorder, usually seen in infants and children. Cervico-fascial and axilla are the usual locations of a cystic hygroma but can also be present in mediastinum, abdominal wall and retroperitoneum. Here we present a case of cystic hygroma in the axilla of an infant and discuss about the clinical features, complications and its management.

KEYWORDS

Cystic Hygroma, Cervico-Fascial and Axilla.

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CASE REPORT

A 10 month old male baby presented with complaints of swelling in the right axillary region since birth, gradual in onset and progressive in nature. A smooth well, defined, mobile, soft swelling was noted in the right axilla measuring around 4 X 5cm. FNAC of the cyst showed yellow coloured fluid with lymphocytes and histiocytes. CT scan - Surgical excision of the cyst was done and sent for histopathology examination.

DISCUSSION

Cystic hygroma is water filled cyst formed due to lymphatic malformation, lined by single layer cell. They are formed due to miscommunication between the lymphatic and venous system causing lymphatic obstruction. They are usually seen in infants and children. Cystic hygroma is fluid filled cyst with multiple locules with collagen and smooth muscle. Usual location for cystic hygroma is cervico fascial whereas axilla, mediastinum, abdominal wall and retroperitoneum are rare locations.[1] Cystic hygroma in an adult is unusual. Cystic hygroma are soft, well circumscribed mass, mobile, painless and trans-illuminant.[2] CH identified at early pregnancy are associated with higher malformations. Septate hygromas are associated with worst outcome than the non septate.[3]

CH are usually associated with Noonan's syndrome, Turners syndrome and foetal hydrops. As the cyst grows in size it compresses the surrounding structures like the trachea, vessels and nerves leading to complications. MRI is the gold standard test for cystic hygroma followed by Doppler USG and CT scan.

Cystic hygroma are benign lesions, patient presents to the emergency department in case of complications like haemorrhage, infection and other complications like compression on the trachea, facial nerve, facial artery.

Surgical excision is the treatment of choice for small cysts. Other treatment modalities are injection of sclerosant, radiotherapy and CO2 laser. Recurrence is common if the cyst is not excised completely. The sclerosant used in practice are bleomycin which is a chemotherapeutic drug and OK 432.[4] OK 432 is injected into the cyst, it reacts with the leukocytes leading to release of cytokines leading to damage of endothelial cells and shrinkage of the cyst.

In conclusion, CH are benign tumours and surgical excision is the treatment of choice in majority of the cases.

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