

# CONGENITAL LATERAL FISTULAE ON THE NECK IN 8-YEARS GIRL

\*Monika Jabłońska-Jesionowska, Małgorzata Dębska, Lidia Zawadzka-Głós

Department of Pediatric Otolaryngology, Medical University of Warsaw  
Head of Department: Lidia Zawadzka-Głós MD, PhD

## Summary

**Introduction.** Congenital lateral fistulae, the anomaly of the branchial second cleft derivatives is the most common anomalies of branchial apparatus (1, 3, 4).

**Material and methods.** In Department of Pediatric Otolaryngology Medical University of Warsaw 8-years girl was treated because of the congenital lateral fistulae. The ultrasound image of the neck and radiography with barium (into the external opening) was done.

**Results.** The surgical procedure was performed in general anesthesia. The excision of whole duct of fistulae through the two incisions was made. No recurrence was observed.

**Conclusions.** 1. The complete excision of the entire fistulae duct is preferable treatment of choice. 2. The surgery procedure should be done as soon as possible before inflammation occurs because of high risk of adhesions (5).

Key words: congenital fistulae on the neck, branchial anomalies, children

## INTRODUCTION

Congenital lateral fistulae is the anomaly of the branchial second cleft derivatives. There are the most common anomalies of branchial apparatus (1, 3, 4). The external opening of the fistulae is on the 1/3 lower part of the neck on anterior border of the sternocleidomastoid muscle. The internal opening (not ever observed) is in the fossa of tonsillae palatine. The duct of fistulae goes between the external and internal carotid artery and above the hypoglossal and glosso-pharyngeal nerve (1).

## MATERIAL AND METHODS

In Department of Pediatric Otolaryngology Medical University of Warsaw 8-years girl was treated because of the congenital lateral fistulae.

The external opening of the fistulae was on the neck, above the clavicle, on anterior border of the right sternocleidomastoid muscle. Since early childhood the parents occasionally observed the discharge from the external opening of the fistulae. It was clear and no pus and unpleasant smell was noticed. The girl never had high fever because of this discharge. She never presented inflammatory swelling of the neck, dyspnea and dysphagia.

The ultrasound image of the neck and radiography with barium (into the external opening) was done.

## RESULTS

The ultrasound image showed a duct of the fistulae diameter 2-3 mm going to the top of the neck and pen-

etrating deeply into the soft tissue. The radiography with barium showed the duct of the fistulae going to the palatine tonsil on the right (fig. 1). On the figure 2 is shown barium in the pharynx and next in esophagus. No elevated inflammation parameters was detected in blood tests.



Fig. 1. The duct of fistulae.

The surgical procedure was performed in general anesthesia. The excision of whole duct of fistulae through the two incisions was made: first incision around the external opening on the neck and second on the level of the larynx. The fistulous duct was 8 cm long. Liga-

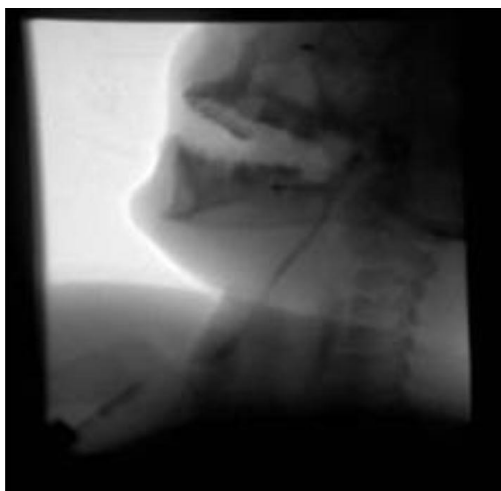


Fig. 2. The barium in the fistulae and next in pharynx and esophagus.

tion and removal of fistulae near the palatine tonsil was done (1, 2). The course of the fistulous duct was typical, between the external and internal carotid artery and near the hypoglossal and gloss-pharyngeal nerves. Tonsillectomy was needless because of lack of history

of tonsillitis (1). The histological check identified a cystis branchiogenes. No recurrence was observed with the mean follow-up of 11 months (3).

#### CONCLUSIONS

1. The complete excision of the entire fistulae duct is preferable treatment of choice.
2. The surgery procedure should be done as soon as possible before inflammation occurs because of high risk of adhesions (5). □

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Correspondence to:

\*Monika Jabłońska-Jesionowska  
Department of Pediatric Otolaryngology  
Medical University of Warsaw  
24 Marszałkowska St., 00-576 Warsaw  
tel./fax: +48 (22) 628-05-84  
e-mail: laryngologia@litewska.edu.pl