

بنام خداوند جان و

بناام خدا

نحوه برخورد با توده گردنی
در آقای ۵۴ ساله از دیدگاه پزشکی خانواده

استاد راهنما سرکار خانم دکتر محبی متخصص ENT و عضو هیات علمی

ارایه دهنده کورش فرزین دستیار پزشکی خانواده

۱۹ فروردین ۱۴۰۲

- CC – بیمار آقای ۵۴ ساله با شکایت توده گردنی در سمت چپ از یکماه پیش متوجه آن شده است توده دردناک نیست علایم سیستمیک مثل تب و لرز، کاهش وزن، بی اشتهایی، ضعف، خستگی، سرگیجه، تهوع استفراغ، سختی در بلع و گرفتگی صدا را ذکر نمیکند از گرفتگی بینی از سه ماه قبل هم شکایت دارد که البته قبلا هم در فصول بهار و تابستان این گرفتگی را داشته است مقداری درد و گرفتگی خفیف گوش را نیز ذکر میکند که زمان دقیق شروع آن را به خاطر ندارد
- PMH – بغیر از سابقه هایپرتانسیون مختصر از ده سال پیش که تحت درمان و کنترل است و حساسیت فصلی که گاهی اوقات دارو استفاده میکرده سابقه بیماری عمل جراحی و اقدام تشخیصی و درمانی خاصی را ذکر نمیکند
- Drug H – لوزارتان ۲۵ روزی دوبار از حدود ده سال پیش تا کنون استفاده میکند همچنین لوراتادین گهگاه جهت آلرژی فصلی
- Habitual H – سابقه مصرف سیگار الکل و مواد مخدر را نمیدهد
- Family H – متاهل دارای دو فرزند، کارمند شهرداری سابقه توده گردنی در خانواده را نمیدهد والدین در قید حیات پدر سابقه بیماری قلبی تحت CABG و مادر سابقه هایپرتانسیون تحت درمان همسر و فرزندان فاقد بیماری و مشکل خاصی

BP= ۱۳۵/۹۰ PR= ۸۵ RR= ۲۰ T= ۳۷/۵ Weight= ۸۵ Haight= ۱۷۵ –Physical Exam •
BMI=۲۷/۵

• در معاینه سرو گردن توده ۲ در ۳ با قوام سفت غیر متحرک بدون تندرنس در ناحیه (level) ۲ گردنی و در سمت چپ بدون اریتم و تغییرات پوستی روی توده در بقیه نواحی گردن توده و لنفادنوپاتی خاصی لمس نگردید ملتحمه رنگ پریده و ایکتریک نبود مردمکها قرینه و ریاکتیو در معاینه گلو اریتم تورم و عدم قرینگی نداشت مخاط دهان نرمال بود باز شدن دهان نرمال و بدون محدودیت وضعیت دندانها در ظاهر نرمال بود و دندانی که در ظاهر نیاز به اقدام خاصی داشته باشد رویت نگردید در معاینه بینی با اسپکولوم مخاط محتقن و آلرژیک به نظر میرسید مقداری ترشح داشت و زخم و ضایعه قابل توجه ای رویت نشد در معاینه گوش با اتوسکوپ کانال هر دو نرمال پرده ها اینتکت در گوش چپ مقداری مایع کهربایی در پشت پرده قابل رویت بود در تست دیاپازونی کاهش شنوایی هدایتی سمت چپ دیتکت شد

• در معاینه قلب و ریه مشکلی نداشت

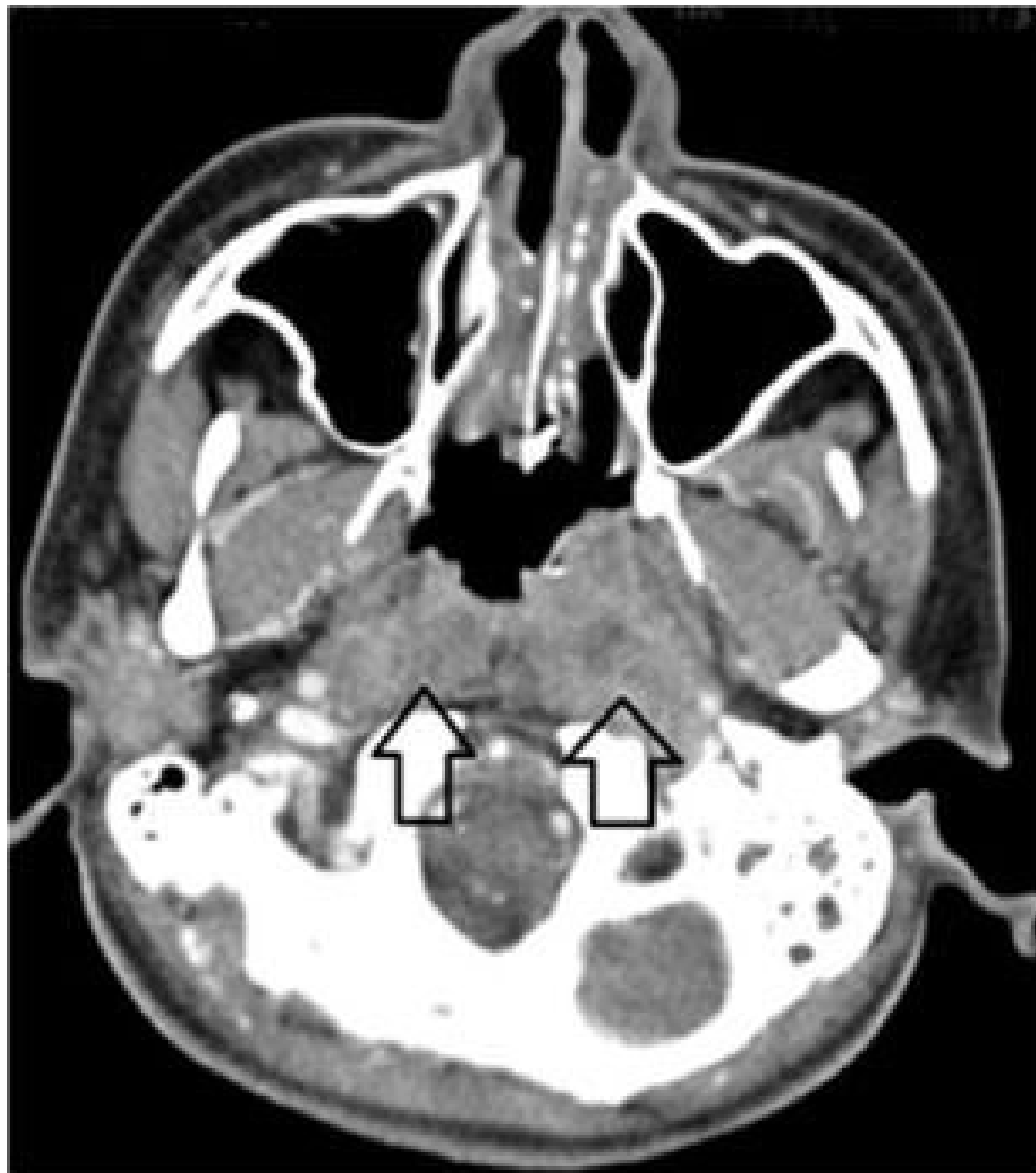
• در شکم ارگانومگالی آسیت و تندرنس نداشت در نواحی زیربغل و اینگوینال لنفادنوپاتی خاصی قابل لمس نبود

• اندام ها نرمال بدون دفورمیتی نبض ها قرینه و ادم مشهود نبود

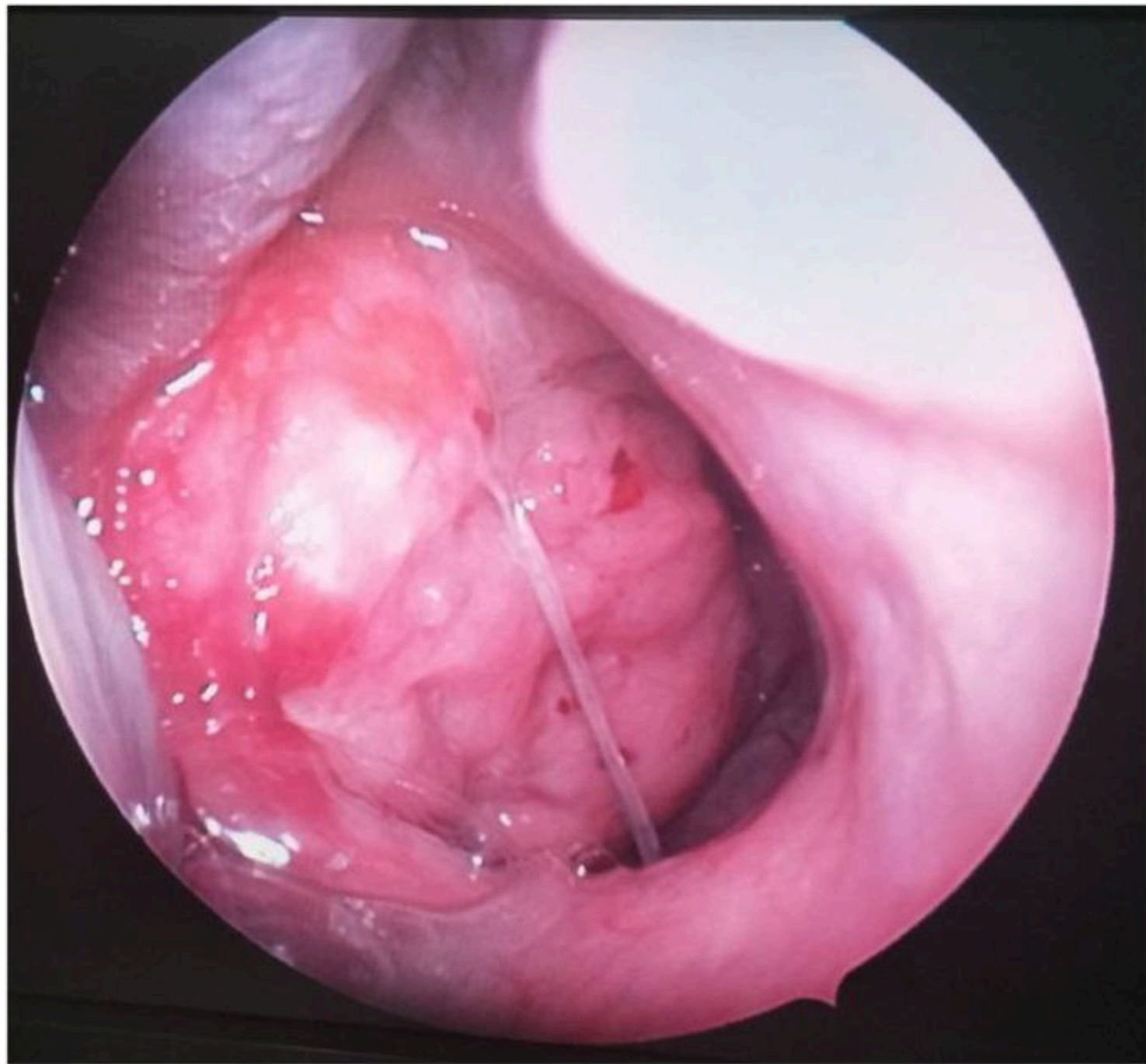
- در سونوگرافی چند لنف نود کروی هایپواکو با بزرگترین سایز ۲ در ۳ سانتی متر در نواحی ۲ و ۵ گردنی با افزایش واسکولاریته در محیط لنف نود که در ظاهر به نفع لنف نود مشکوک به متاستاز است.

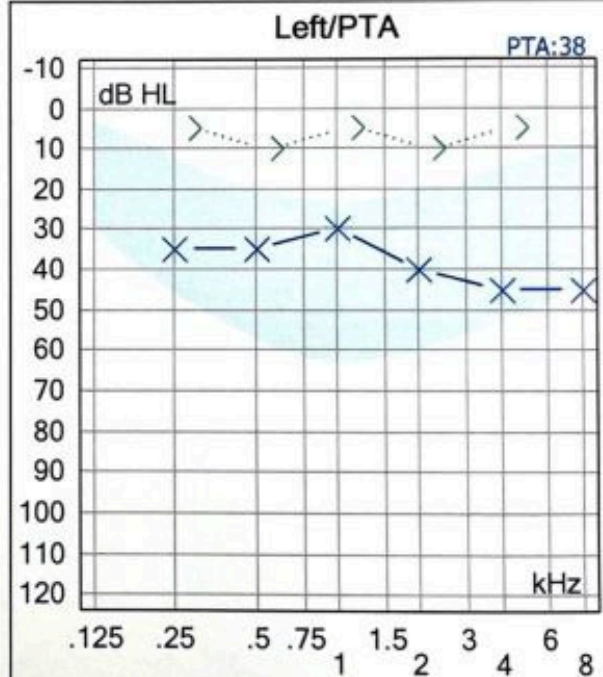
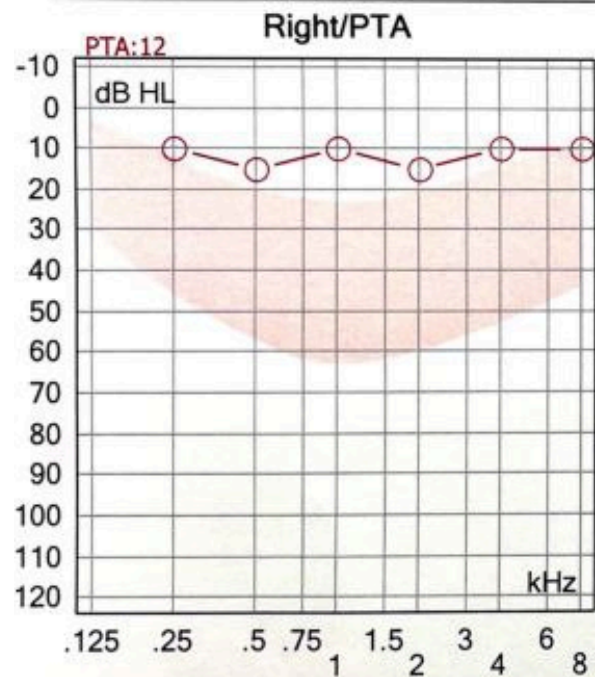


در سی تی یک لنف نود نکروزه در سمت
چپ قابل رویت است که جهت بیوپسی
سوزنی اقدام شد و گزلهش لنف نود
متاستاتیک با منشأ کارسینوم نازو
فارنژیال



همانطور که مشهود است در
کات های بالاتر یک توده در
ناحیه نازو فارنکس قابل رویت
است





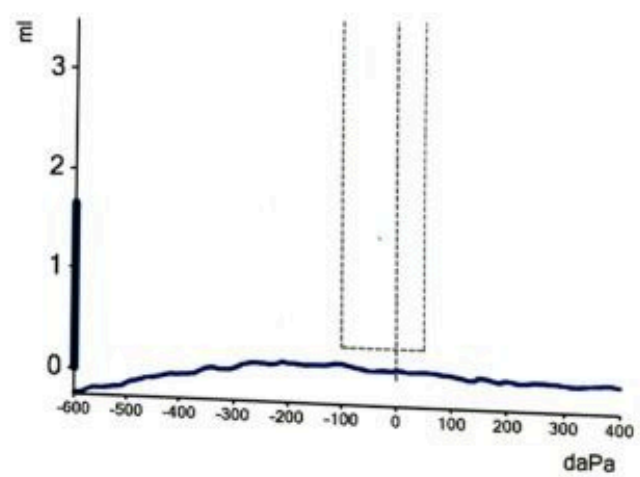
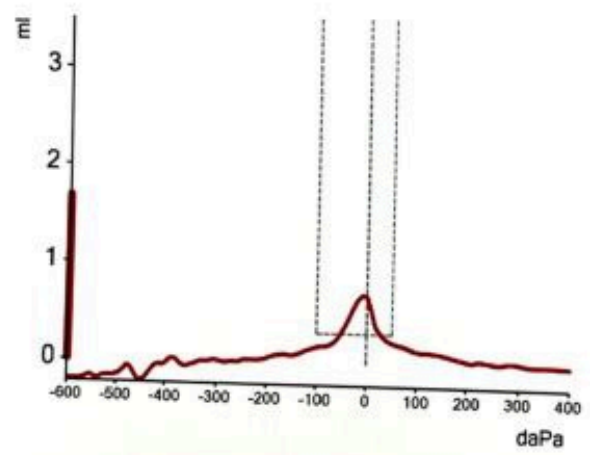
A

Right

Left

ECV: 1.7 ml
Peak: 0.7 ml at -10 daPa

ECV: 1.6 ml
Peak:



B

Clinical Practice Guideline: Evaluation of the Neck Mass in Adults

- Neck masses are common in adults, but often the underlying etiology is not easily identifiable
- Infections cause most of the neck masses in children
- Most persistent neck masses in adults are neoplasms
- Neck mass is defined as an abnormal lesion (congenital or acquired) that is visible, palpable, or seen on an imaging study
- Neck masses may develop from infectious, inflammatory, congenital, traumatic, benign, or malignant neoplastic processes
- An asymptomatic neck mass may be the initial or only clinically apparent manifestation of head and neck cancer, such as squamous cell carcinoma (HNSCC), lymphoma, thyroid, or salivary gland cancer

- Metastatic mucosal HNSCC is the focus of this guideline
- Malignant neck mass can result from other disease entities, including lymphoma, skin, thyroid, and salivary gland cancer
- Mucosal HNSCC may originate in the oral cavity, oropharynx, hypopharynx, nasopharynx, or larynx
- Occult metastatic spread from the primary cancer to the regional lymph nodes
- The incidence of HNSCC of the oropharynx is on the rise as a consequence of HPV infection
- Patients affected with HPV-positive oropharyngeal HNSCC often present with neck metastasis without an obvious primary malignancy
- The target patient for this guideline is anyone ≥ 18 years old with a neck mass.

- This guideline is restricted to addressing the appropriate workup of an adult patient with a neck mass that may be malignant, to expedite diagnosis and referral to a head and neck cancer specialist.
- In recent decades, people in developed countries have reduced their tobacco consumption, resulting in a lower incidence of HNSCC of the oral cavity, larynx, and hypopharynx.
- Unfortunately, these gains have been offset by a precipitous increase in HNSCC of the oropharynx (tonsil and base of tongue) because increasing prevalence of high-risk HPV infection, specifically HPV subtype 16.
- HPV-positive HNSCC is associated with younger age, male sex, more oral and vaginal sexual partners, better dentition, less or no tobacco exposure, less alcohol consumption, greater marijuana use, higher education level, and higher socioeconomic status

- Patients with HPV-positive HNSCC commonly present with a neck mass as the only symptom of concern
- Two features of HPV-positive HNSCC may contribute to delayed diagnosis:
 - 1- Younger and often lack tobacco and alcohol exposure
 - 2- Cervical metastases from HPV-positive HNSCC may be cystic, they are often mistaken for branchial cleft cysts
- Among patients with HNSCC who present with neck mass, diagnostic delay(patient or professional delay) is common(3 to 6 months)
- FNA rather than open biopsy(risks tumor seeding and local and regional tumor recurrence) is the preferred method for cancer diagnosis in a neck mass

KAS = Key Action Statement

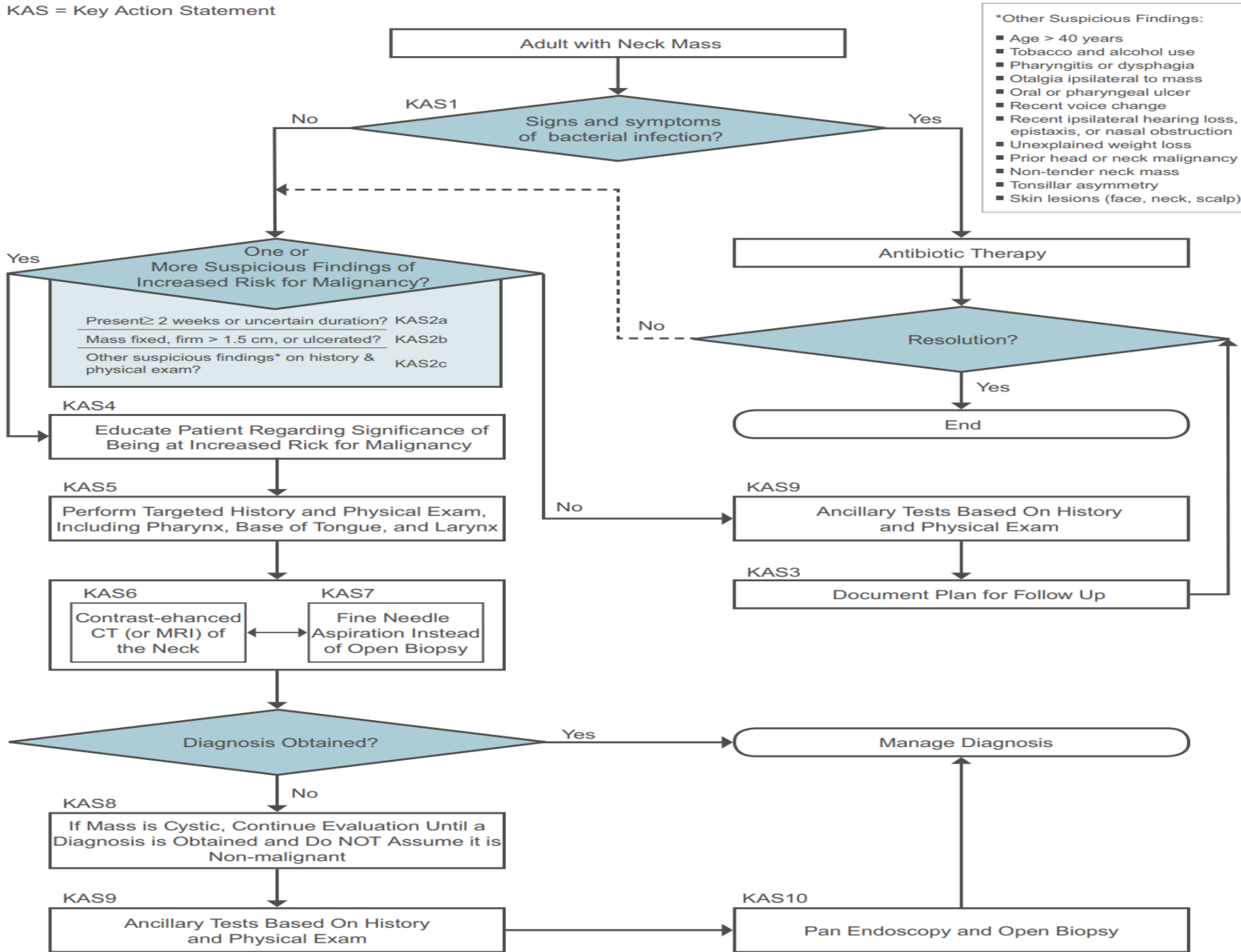


Table 3. Guideline Key Action Statements.

Statement	Action	Strength
1. Avoidance of antibiotic therapy	Clinicians should not routinely prescribe antibiotic therapy for patients with a neck mass unless there are signs and symptoms of bacterial infection.	Recommendation
2a. Stand-alone suspicious history	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 ≥ 2 weeks without significant fluctuation or the mass is of uncertain duration.	Recommendation
2b. Stand-alone suspicious physical examination	Clinicians should identify patients with a neck mass who are at increased risk for malignancy based on ≥ 1 of these physical examination characteristics: fixation to adjacent tissues, firm consistency, size > 1.5 cm, and/or ulceration of overlying skin.	Recommendation
2c. Additional suspicious signs and symptoms	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.	Recommendation
3. Follow-up of the patient not at increased risk	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.	Recommendation
4. Patient education	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.	Recommendation
5. Targeted physical examination	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.	Recommendation
6. Imaging	Clinicians should order a neck computed tomography (or magnetic resonance imaging) with contrast for patients with a neck mass deemed at increased risk for malignancy.	Strong recommendation
7. Fine-needle aspiration (FNA)	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.	Strong recommendation
8. Cystic masses	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 that the mass is benign.	Recommendation
9. Ancillary tests	Clinicians 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.	Recommendation
10. Examination under anesthesia of the upper aerodigestive tract before open biopsy	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.	Recommendation

• STATEMENT \

- Avoidance of antibiotic therapy
- Most neck masses in adults are not infectious most of these masses are neoplastic
- Local signs and symptoms of infection include warmth, erythema of the overlying skin, localized swelling, and tenderness to palpation.
- Systemic signs of infection include fever tachycardia, and other symptoms specific to head and neck infections (eg, rhinorrhea, odynophagia, otalgia, odontalgia).
- Mass developed within a few days or weeks of an upper respiratory infection, dental problem, trauma (including insect bites), travel, or exposure to certain animals.
- A patient with neck mass who is treated with antibiotics should be reassessed within 2 weeks.
- If the mass has not completely resolved, further workup for possible malignancy is recommended
- If infectious lymphadenopathy resolves as expected, the patient should be reassessed once more in 2 to 4 weeks to monitor for possible recurrence,

• STATEMENT Υa , Υb and Υc

Table 4. Characteristics Suspicious for Malignancy in the Presence of a Neck Mass.

Characteristic	Rationale
Standalone characteristics suspicious for malignancy	
1. Absence of infectious etiology	Absence of recent infection makes infection an unlikely etiology for the neck mass.
2. Mass present ≥ 2 weeks or of uncertain duration	A persistent mass is more likely to be malignant.
3. Reduced mobility of neck mass	Metastatic cancer may violate the lymph node capsule and directly invade adjacent structures.
4. Firm texture of mass	A malignant lymph node is often firm due to the absence of tissue edema. A neck mass may be soft due to its fluid content, and while this sometimes is due to a benign cystic mass, fluid-filled cystic masses may also be malignant. An infectious lymph node may be soft due to tissue edema.
5. Neck mass size > 1.5 cm	Lymph node metastases results in nodal enlargement.
6. Ulceration of skin overlying the neck mass	Metastatic cancer may break through the capsule of the lymph node and directly invade and necrose the skin. Alternatively, the ulceration overlying a neck mass may indicate a cutaneous malignancy with direct extension into the neck.

Additional characteristics of history and physical examination suspicious for malignancy

1. Age >40 years
Older age is associated with greater risk of HNSCC—particularly in patients with non-HPV related disease.
2. Tobacco and alcohol use
Tobacco and alcohol are synergistic risk factors for HNSCC.
3. Pharyngitis
“Sore throat” or throat pain may indicate mucosal ulceration or mass
4. Dysphagia
Difficult swallowing may indicate ulceration, mass, or dysfunction of the aerodigestive system.
5. Otalgia ipsilateral to the neck mass
Otalgia, with normal ear examination, may represent referred pain from the pharynx. Unilateral serous otitis media may result from eustachian tube obstruction by a nasopharyngeal malignancy.
6. Oral cavity or oropharyngeal ulcer
Visible ulceration of mass, tenderness to palpation, or decreased tongue mobility may indicate a malignancy.
7. Recent voice change
May indicate a malignancy of the laryngeal or pharyngeal structures.
8. Recent hearing loss ipsilateral to the neck mass
May indicate a nasopharyngeal malignancy with unilateral middle ear effusion.
9. Nasal obstruction and epistaxis ipsilateral to the neck mass
May indicate an ulcerated malignancy in the nose or nasopharynx.
10. Unexplained weight loss
Cachexia is common in cancer patients. Head and neck cancer in particular may cause difficulty swallowing and cause wasting simply from inadequate nutrition.
11. History of treatment for head and neck malignancy, including skin, salivary gland, or aerodigestive sites
Prior head and neck malignancy places a patient at risk for local or regional (nodal) recurrence or a second malignancy. Patients with prior radiation treatment are at risk for a secondary neoplasm decades later.
12. Nontender neck mass
An infectious or inflammatory neck mass may be painful or tender. A nontender mass is less likely infection or inflammation and more likely neoplastic.
13. Tonsil asymmetry
May indicate a malignancy within the larger tonsil.
14. Skin lesions (face, neck, scalp included)
Cutaneous malignancy can metastasize to the cervical lymph nodes.

• STATEMENT 3

• FOLLOW-UP OF THE PATIENT NOT AT INCREASED RISK

Table 5. Patient Handout: 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 to 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 $>101^{\circ}\text{F}$

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.

• STATEMENT ۶

• PATIENT EDUCATION

Table 6. Patient Handout: Frequently Asked Questions.

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 you have cancer, but it does mean 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 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 don't 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.

What is a computerized tomography (CT) scan?

A CT scan is a series of x-rays that give more detail than regular x-rays. CT scan pictures show soft tissue and bones. The CT machine looks like a large donut that your head, neck, and chest will go through. Patients without an allergy to contrast will need an IV—that is, a needle inserted into a vein—for contrast to enhance the pictures.

Risks include

1. Contrast allergy
2. Discomfort with IV placement
3. Patients with claustrophobia have minimal anxiety during this brief scan (3-5 minutes).
4. A CT scan uses radiation—about as much as 150 chest x-rays.

What is a magnetic resonance imaging (MRI) scan?

An MRI scan creates pictures of the soft tissue but not the bones. An MRI does not use radiation; it uses very strong magnets. The MRI machine looks like a narrow tube that your head, neck, and chest will go inside. You will need an IV for contrast to enhance the pictures. If you have any metal or implants in your body, you may not be able to have an MRI. You must discuss this with your provider.

Risks include

1. IV contrast allergy
2. Discomfort with IV placement
3. Patients with claustrophobia may be very anxious with this lengthy scan (45-60 minutes). Your provider may provide a sedative pill.

What is a fine-needle aspiration (FNA)?

An FNA uses a small needle stuck into the mass to get a tissue sample.

Risks include

1. Discomfort from needle stick
 2. Infection
 3. Bruising
 4. Bleeding
 5. Not enough tissue for a diagnosis—repeat procedure
-

- **STATEMENT** ♡

- **TARGETED PHYSICAL EXAMINATION**

Table 7. Essential Components of a Targeted Physical Examination in a Patient at Increased Risk for Head and Neck Malignancy.

Anatomic Site	Examination Details
Skin and scalp	May reveal a cutaneous malignancy
Otoscopy	Unilateral serous otitis media may suggest a nasopharyngeal malignancy
Cranial nerves	Itemized assessment of ocular motility, facial sensation and movement, hearing, palate elevation, presence of gag reflex, vocal fold movement, tongue mobility, and shoulder elevation
Oral cavity	Visual and digital examination of ventral and lateral surfaces of oral tongue and floor of mouth
Oropharynx	Visual examination of soft palate, tonsillar fossae, and posterior wall. Palpation of the tongue base and tonsillar fossae
Nasal cavity	Visual examination of the septum, floor, and turbinates
Nasopharynx	Visual examination of the eustachian tube orifices and superior and posterior walls
Hypopharynx	Visual examination of pyriform sinuses and posterior pharyngeal wall
Larynx	Visual examination of the epiglottis, vocal folds, and subglottis
Neck	Assessment of the neck mass firmness, size, fixation, location, and presence of additional lymphadenopathy. Bimanual palpation of the floor of mouth and entire neck
Salivary glands	Palpation of parotid and submandibular glands to assess for mass
Thyroid gland	Palpation to assess for mass

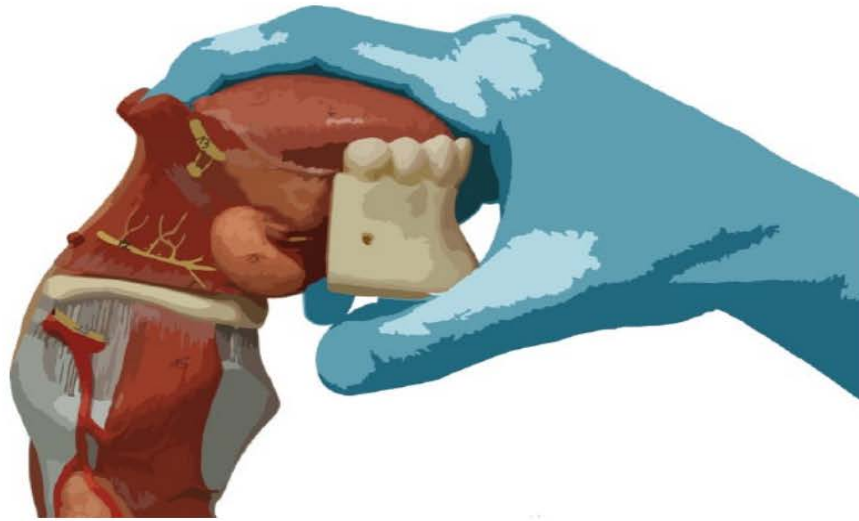


Figure 3. Palpation of the tongue base (lateral view).



Figure 5. Bimanual palpation of floor of mouth.

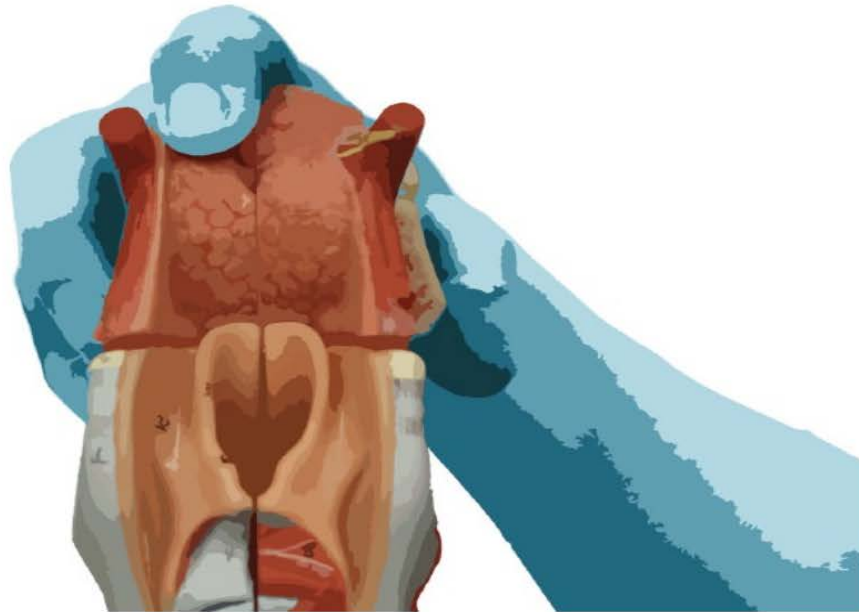


Figure 4. Palpation of the tongue base (posterior view).

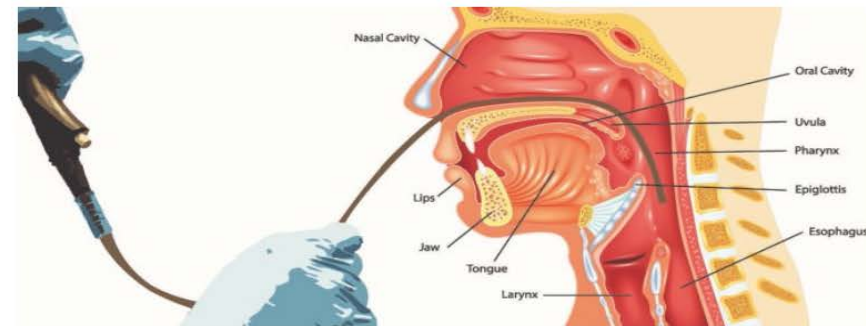
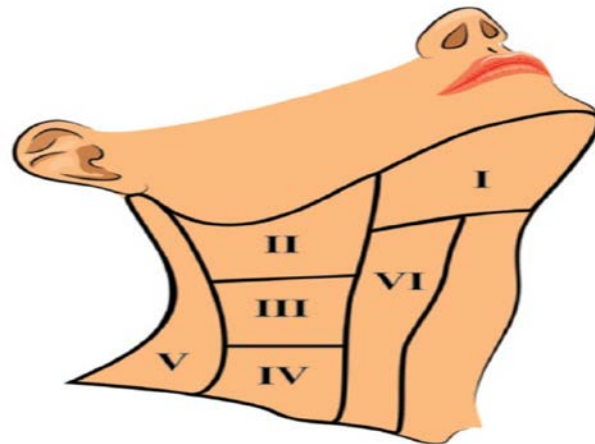


Figure 6. Scope examination.

- Based on expected patterns of lymphatic drainage, the location of the neck mass may suggest the site of a primary malignancy.
- Lip and oral cavity primaries usually metastasize to lymph nodes in levels I to III
- Oropharyngeal, hypopharyngeal, and laryngeal primaries commonly metastasize to levels II to IV
- Nasopharyngeal and thyroid primaries as well as lymphoma can spread to level V
- 50% of masses in level IV and the supraclavicular fossa arise from primary malignancies below the clavicle, including the chest and gastrointestinal tract
- Skin cancers can metastasize to levels I to V as well as the external jugular, postauricular, suboccipital, and parotid regions.
- Nasopharyngeal, tongue base, and midline oral cavity (tongue) cancers may result in bilateral cervical metastases
- Distant lymphadenopathy may have a malignancy outside the head and neck, including lymphoma, lung, breast, or gastrointestinal tract
- Midline neck masses: thyroglossal duct cyst, thyroglossal duct carcinoma, thyroid malignancy, or metastatic spread from laryngeal malignancy (Delphian node)



• **STATEMENT** ♪

• IMAGING

- Contrast-enhanced CT or MRI examinations obtained in patients with a neck mass of uncertain etiology will help localize and characterize the mass, assess for additional nonpalpable masses, and screen visualized organs that are potential sites of primary malignancy
- Provide useful ancillary information, such as evidence of dental disease, granulomas of the lung apices, and salivary calculi
- CT has several benefits that support its utilization as a primary imaging modality:
 - **more readily available, costs considerably less, more easily tolerated by patients because of shorter scanning time (< 5 min) and larger scanner bore**
- MRI is preferred when a primary tumor of the nasopharynx is suspected or when there is cranial nerve abnormality on physical examination
- Regardless of whether CT or MRI is performed, intravenous contrast should always be used, unless there is a contraindication, such as contrast allergy, renal insufficiency, or prior diagnosis that excludes the use of contrast
- Ultrasound can be used to characterize a neck mass, to guide percutaneous tissue sampling, and to search for additional masses
- Ultrasound may be considered a first option in clinical situations excluded by this review (thyroid, salivary masses)

- **STATEMENT V**

- FINE-NEEDLE ASPIRATION

- Initial diagnostic test for a patient at increased risk for a malignant neck mass and to limit the use of open biopsy
- Open biopsy should be avoided whenever possible(nonhealing wounds, regional recurrence, distant metastasis)
- Core biopsy is an option after an initial inadequate or indeterminate FNA

- **STATEMENT A**

- CYSTIC MASSES

- **STATEMENT 9**

- **ANCILLARY TESTS**

Table 9. Common Ancillary Tests for Evaluation of an Adult Neck Mass.^a

Ancillary Test	Suspected Disease
Complete blood count (CBC) with differential	WBC elevation: bacterial infection, lymphoma WBC depression: immunosuppression
Antineutrophil antibody (ANA); anti-Ro/SSA, anti-La/SSB	Autoimmune diseases such as Sjogren's syndrome or systemic lupus erythematosus (SLE)
Estimated sedimentation rate (ESR)	Autoimmune diseases as mentioned above; nonspecific marker for systemic inflammation
Thyroid-stimulating hormone (TSH)	Elevated: toxic multinodular goiter Decreased: Hashimoto's thyroiditis, Graves' disease
Parathyroid hormone (PTH)	Parathyroid adenoma/hyperplasia or carcinoma
HIV enzyme-linked assay	HIV infection
Epstein-Barr virus (EBV) antibody titers	EBV infection
CMV IgM titer	CMV infection
Mantoux tuberculin test (PPD)	Mycobacterium tuberculosis infection
Bartonella titer	Bartonella infection (cat-scratch disease)
Thyroid ultrasound	Thyroid nodule, thyroid goiter Parathyroid adenoma
CT chest with contrast	Mycobacterium tuberculosis, nontuberculosis atypical mycobacterium, sarcoidosis, lung malignancy
Thyroglobulin FNA–needle wash assay	Thyroid cancer

Abbreviations: CMV, cytomegalovirus; CT, computed tomography; FNA, fine-needle aspiration; PPD, purified protein derivative; WBC, white blood cell.

^aTests from this list should be chosen selectively, based on clinical suspicion. Ancillary testing should not delay workup of a possible malignancy.

• STATEMENT \ .

• XAMINATION UNDER ANESTHESIA OF THE UPPER AERODIGESTIVE TRACT BEFORE OPEN BIOPSY

Table 10. Patient Handout: Examination under Anesthesia—What Should the Patient Expect.

What is examination (endoscopy) under anesthesia?

Examination under anesthesia is performed by a surgeon to evaluate the back of your throat, voice box, the back of your nose, upper trachea (breathing tube), and upper esophagus (swallowing tube).

Why do I need an examination under anesthesia?

This test allows a complete evaluation of the back of your nose and throat, your voice box, the windpipe, and esophagus (swallowing tube). If your doctor sees an area of concern, he or she will take a small piece of tissue for evaluation (biopsy).

How is this examination performed?

Examination under anesthesia is performed in the operating room. You will be asleep with general anesthesia. A scope with attached camera is inserted through your mouth and into your throat, voice box, windpipe, and esophagus.

How will I feel after the procedure?

After general anesthesia, you may feel sleepy for a day. You will be able to eat and drink as you did before the procedure. You will receive medication for pain.

You may have the following symptoms:

- A sore throat lasting 1-2 days
- Hoarse voice
- Coughing or spitting up small amount of blood for 1-3 days

What are the risks of examination under anesthesia?

A risk is a problem that you might have.

Some risks include

- Reaction to anesthesia
- Bleeding that may recur where the tissue samples were taken
- Damage to teeth
- Swelling where tissue samples were taken may cause difficulty breathing
- Damage to the back of the throat or esophagus (swallowing tube)

When will I receive my results?

After the examination under anesthesia, your doctor will be able to tell you what he or she saw and if biopsies were taken. Biopsy results will take at least a few days, sometimes longer. Your doctor will call you or schedule a follow-up visit to review the biopsy results.

Call your doctor if you experience

- Severe bleeding or any bleeding >3 days
 - Fever >101°F
 - Inability to swallow
 - Vomiting
 - Difficulty breathing
-

Primordial Prevention

Primary Prevention

Secondary Prevention

Tertiary Prevention

Quaternary Prevention

Primordial Prevention

- ۱- اقدام در خصوص ترویج سبک زندگی سلام تغذیه مناسب، ورزش و پرهیز از چاقی، اضافه وزن، الکل و تنباکو
- ۲- آموزش در خصوص تشکیل پرونده الکترونیک سلامت جهت تمامی آحاد جمعیت کشور و ارزش و اهمیت انجام مراقبتهای لازم در هر گروه سنی
- ۳- آموزش های لازم در سطح ملی برای آشنایی با علایم بیماری ریسک فاکتورها

Primary Prevention

- ۱- انجام مراقبتهای دوره‌های در هر گروه سنی حسب مورد
- ۲- شناسایی افراد پر خطر و در معرض ریسک جهت توصیه‌های لازم بهداشتی در خصوص دوری از عوامل خطر (الکل، تنباکو، و چاقی)

Secondary Prevention

- ۱- بیماریابی بموقع در جمعیت در معرض ریسک و انجام اقدامات تشخیصی اولیه
- ۲- انجام واکسیناسیون HPV در افراد در معرض خطر
- ۳- غربالگری کوموربیدتی های زمینه ای

Tertiary Prevention

- ۱- انجام اقدامات تشخیصی بموقع و بر اساس آخرین راهنماهای بالینی
- ۲- دادن اطلاعات لازم به بیمار جهت اطلاع از بیماری و شرکت فعال در انجام اقدامات تشخیصی و درمانی
- ۳- پیگیری مستمر بیماران تا تعیین تکلیف نهایی

Quaternary Prevention

- ۱- مونتورینگ دقیق و درمان بموقع جهت جلوگیری از عوارض احتمالی
- ۲- عدم انجام اقدامات پاراکلینیکی و دارویی که تاثیر خاصی بر پیش آگهی و عوارض بیماری ندارد