Infected Congenital Cystic Hygroma

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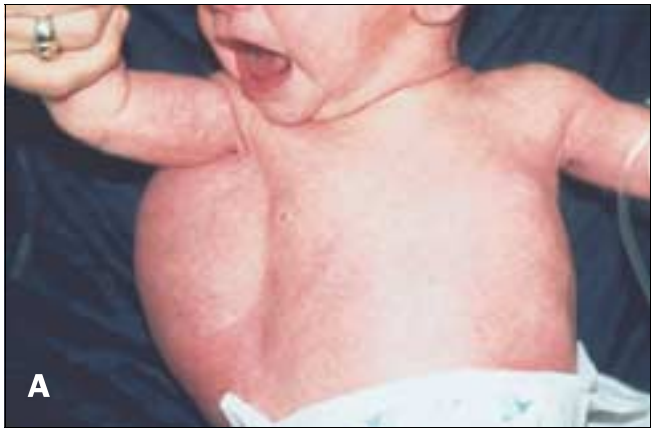

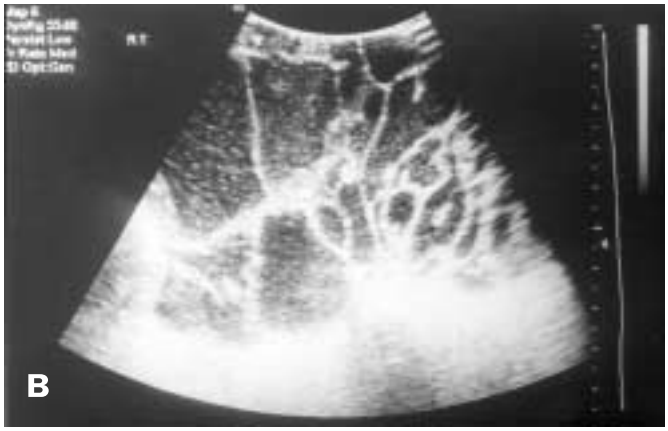

A 20 day old infant was referred to the emergency room for evaluation of a large infected mass located on his back. The mass was apparent at birth and rapidly enlarged during the early weeks of life [Figure A].

On admission, his temperature was 38.5°C, white blood cell count 17,000/mm^3 (80% neutrophils), and erythrocyte sedimentation rate 60 mm/hr. Ultrasound demonstrated a cystic multi-septuated nature of the mass [Figure B]. The infant was initially treated with intravenous ampicillin, cloxicillin and gentamicin without any significant improvement. After a week, treatment was switched to vancomycin and ceftazidime for 3 weeks, and his condition steadily improved. Surgical excision was the treatment of choice. The postoperative course was uneventful. The diagnosis was infected congenital cystic hygroma.

Cystic hygroma occurs as a result of sequestration or obstruction of developing lymph vessels. Although the lesion can occur anywhere, the common sites are in the neck posterior to the sternocleidomastoid muscle, axilla, groin and mediastinum [1–5]. The cysts are lined by endothelium and filled with lymph. The mass may be apparent at birth or may appear and enlarge rapidly in the early weeks of life as lymph accumulates. Occasionally cystic hygromas contain nests of vascular tissue. Infection within the cyst is usually caused by *Streptococcus* or *Staphylo-coccus* [1,4] Sonographically, cystic hygromas usually appear sonolucent and multi-cystic or multiseated. Sonography is useful in first identifying and categorizing the cystic hygroma, but magnetic resonance imaging is best for defining its geographic limits [1–3].

Excision is the treatment of choice for these lesions and the only effective treatment available [1]. Delay is unwarranted due to infection and progressive growth, with extension into previously uninvolved areas [1,2].

References

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