Abstract

An increased pressure on ENT departments has evolved as head and neck pathology is showing a higher incidence and prevalence. Therefore, the ENT specialist should develop good skills in ultrasonographic examination of patients with head and neck masses. The aim of this paper is to enable the ENT specialist to identify anatomical landmarks on ultrasonographic images in order to expedite the diagnosis with a higher degree of certainty. We describe the steps for a proper ultrasound examination of the patient. We illustrate the following anatomical areas: submandibular gland, thyroid gland, parathyroid glands, oropharinx, larynx, parotid glands, etc. Moreover we emphasize the differential diagnosis that should be taken into account when examining pathology in these regions. Ultrasonographic examination of head and neck pathology is cost efficient, non irradiating and permits fast follow up with serial examination of the lesions. Furthermore one can perform an initial TNM staging of the case prior to other expensive imaging studies such as CT and MRI. We hope to raise the awareness of fellow ENT specialists in performing ultrasonography as future developments such as elastography and CEUS will increase the specificity and sensitivity of this diagnostic method.

Keywords: ultrasonography, head, neck, ENT, anatomy

Introduction

There is a growing interest for ENT specialists worldwide in using first hand ultrasonography (US) examination of patients with head and neck masses [1,2]. Questioning our fellow ENT colleagues we discovered a fear of approaching this imaging method and a tendency to rely on examinations performed only in radiology departments. Given the fact that only in our Hospital there are thousands of cases with head and neck tumors, the costs associated with imaging studies could be reduced by using US performed by the ENT specialist as a central diagnostic imaging tool, thus reducing the pressure on the radiology department and expediting the diagnosis [3]. Of course for a good diagnosis first of all a good knowledge of the US anatomical landmarks is necessary [4].

The aim of this paper is to present the investigation techniques and enable the ENT specialists and allied specialties to master the first key steps in US examination of head and neck The main anatomical regions depicted in this pictorial review are: submandibular gland, thyroid gland, parathyroid glands, oropharinx, larynx, parotid glands, etc. For every above mentioned anatomical region, we will emphasize the differential diagnosis and common pitfalls.

Investigation technique

Patient position

The patient is placed in a supine position with the head in mild extension. As in any other US examination the patient should feel comfortable and, if not naked, wearing a blouse that should not cover the base of the neck. A small pillow should be available in cases the examination requires a hyperextension of the neck.

Equipment

Although current equipments enable the use of linear probes with higher frequency one should use at least a
linear transducer with a frequency of 10 MHz, this aspect being correlated with the diagnostic capability; with a higher frequency there is a better resolution but with a lower depth of the examined structures. Therefore a transducer with a variable frequency would be of great help enabling the examination of both deep and superficial structures in the same session. For thin patients a depth of examination of only 45mm is sufficient and this will enable the identification of the vertebral body in the lower part of the image. When examining the tongue and the oropharynx the depth of the examination should be increased to 60-70mm. As a general rule any anatomical region should be examined in 2 perpendicular ultrasonicographic windows [5]. A very important step of any US exam is the Doppler examination as every structure visualized should be depicted in Doppler signal also, especially for differentiation between benign/malignant tumors or inflammatory/non-inflammatory lesions.

**Structures that need to be examined**

**Thyroid gland**

The thyroid gland is situated below the sternothyroid and sternohyoid muscles and anterior to the trachea, at the level of projection of the C5-T1 vertebrae. Normal value for the thickness of the istmus gland is 5 mm and for the thyroid lobes the antero-posterior diameter is 10-20 mm and the medio-lateral diameter 10-30 mm [6]. Figure 1 and 2 depict the longitudinal and transversal view of the thyroid with the positioning of the transducer and the anatomical landmarks. The structure of the gland is slightly granulated but homogenous and the echogenicity is higher when compared with the sternocleidomastoid muscle. Differential diagnosis for diffuse changes of the thyroid gland are the acute and subacute thyroiditis, Hashimoto thyroiditis, Graves disease, Riedel thyroiditis, malignant lymphoma, diffuse parenchymatous goiter, diffuse colloid goiter, or regressive fibrotic changes. Circumscribed changes in the thyroid gland are realized by true cysts, pseudocysts, nodular goiter, adenoma, colloid nodule, hyaline connective tissue, abscess, oncocytoma, malignant tumors and calcifications.

**Parathyroid glands**

The possible location of the parathyroid glands at the level of the upper and lower poles of the thyroid lobes is depicted in figure 3. Normally parathyroid glands are small structures (around 3/4/5 mm) and can be identified only using the high frequency transducers. So, any hypoechoic lesion at these levels is suspected to be a parathyroid adenoma [7].

**Submandibular gland**

The submandibular gland is a seromucous salivary gland with a complex shape given in its division into a superficial and profound portion by the posterior belly of the milohioid muscle [8]. Figure 4 shows the positioning of the transducer and the anatomical structures of the region. Possible pathologies encountered at the level of the submandibular glands are sialadenitis, sialolithiasis, mixed benign tumors, carcinoma, enlarged lymph nodes, brachial arch cysts and sarcoidosis.

**Oropharynx**

The external transcutaneous approach of the oropharynx is hindered by the mandible and hyoid bone which appear as hyperechoic structures with posterior acoustic shadow. The muscles appear as hypoechoic structures and the surface of the tongue presents a curved shape against the air from the oral cavity. The posterior wall of the pharynx can be visualized only with special endocavitary transducers [9]. The transverse and longitudinal
scan of the oropharynx, together with transducer position and anatomical structures are depicted in figure 5 and 6.

**Parotid gland**

A normal parotid gland has a uniformly hyperechoic texture (comparing to adjacent muscles) with a clear delineation from the superficial tissue. The Stensen duct is normally undetected unless it is obstructed. The facial nerve is difficult to be examined due to the anatomical situation (between the deep and superficial lobes) and the intra-parotid division. The intraglandular lymph nodes, normally under 5 mm, are clearly visible when there is an associated pathology [10]. Figure 7 illustrates the positioning of the transducer and the transverse view of the parotid gland. Possible pathological findings at the level of the parotid gland are cysts, abscess, sialadenitis, sarcoidosis, parotid tumors, sialolithiasis, etc.

**Larynx**

Although ENT specialists can rely on specific fibroscopic procedures in order to evaluate the laryngeal function these procedures could be complimentary to an US exam. This exotic use of US could be useful in emergency departments that do not have immediate access to an ENT service and thus the emergency specialist could extend the FAST-like protocol by discovering edema of the epiglottis or laryngeal fractures. Unfortunately there have been only pilot studies regarding laryngeal US and there is no evidence based standard for performing this procedure. Figure 8 focuses on the longitudinal plane of the larynx at the level of epiglottis. In Figure 9 a transverse view of the larynx at the level of the superior border of the thyroid cartilage is shown. In order to correctly visualize the vocal cords the transducer must be placed in the transverse position at the middle of the thyroid cartilage and in a slightly upward oblique movement as shown in Figure 10. The entire length of the vocal cord and the piriform sinus can be ascertained in an oblique left transverse laryngeal view (fig 11). Another important landmark is the cricoids cartilage with its ring like shape illustrated in transverse view in Figure 12. The entire anterior compartment can be examined through a longitudinal median view at the level of the larynx (fig 13).
Conclusions

US of head and neck is credited with high sensitivity and specificity similar if not in some cases superior to other imaging studies [11]. Moreover, US guided procedures like FNAB expedite the diagnosis with minimal costs and risks for the patient. Numerous evidence based articles bring new arguments for the use of novel techniques such as elastography [12] and contrast enhanced US [13]. Nevertheless for the oncologic patient, US permits serial examinations during radiation and chemotherapy in order to ascertain the response to treatment and to lower the overall radiation dose by minimizing CT exposure. Given these prospects a first step is to master basic identification of anatomic structures and to combine these data with the experience of ENT specialists in a better preoperative planning of every surgery.

Acknowledgements: This paper is supported by the Sectoral Operational Programme Human Resources Development (SOP HRD), financed from the European So-
Ultrasonographic anatomy of head and neck – a pictorial for the ENT specialist

Conflict of interest: none

References