A 42 year old female presented with a several month history of a right level II neck mass. Associated symptoms included hoarseness, right-sided headaches, episodes of flushing, diaphoresis, and palpitations. On several occasions, she had episodes of near syncope. She was noted to have an immobile right true vocal cord on fiberoptic nasopharyngoscopy. VMA, CBC, ESR, ANA, anti-double-stranded DNA, ANCA, and RF were all negative. Imaging was consistent with inflammatory pseudotumor of the carotid sheath. The patient completed a course of oral prednisone with no improvement in symptoms. Open biopsy was then performed for definitive tissue diagnosis which was consistent with inflammatory pseudotumor. Given the patient’s refractory course to medical management and progression of symptoms, surgical resection was recommended.

Inflammatory Pseudotumor of the Carotid Sheath: A Case Report
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INTRODUCTION
A 42 year old female presented with a several month history of a right level II neck mass. Associated symptoms included hoarseness, right-sided headaches, episodes of flushing, diaphoresis, and palpitations. On several occasions, she had episodes of near syncope. She was noted to have an immobile right true vocal cord on fiberoptic nasopharyngoscopy. VMA, CBC, ESR, ANA, anti-double-stranded DNA, ANCA, and RF were all negative. Imaging was consistent with inflammatory pseudotumor of the carotid sheath. The patient completed a course of oral prednisone with no improvement in symptoms. Open biopsy was then performed for definitive tissue diagnosis which was consistent with inflammatory pseudotumor. Given the patient’s refractory course to medical management and progression of symptoms, surgical resection was recommended.

MATERIALS AND METHODS
Pre-operatively, the patient passed a balloon test occlusion (BTO). The involved portion of the common carotid artery was resected via an extended vertical carotid endarterectomy approach. Reconstruction consisted of a polytetrafluoroethylene (PTFE) interposition graft. Electroencephalograms (EEG) and somatosensory evoked potentials (SEP) were monitored intra-operatively.

RESULTS
The patient underwent successful resection of the involved portion of the carotid artery. The ipsilateral vagus nerve was sacrificed due to involvement. A thyroplasty was performed three months later to improve voicing. Post-operatively the patient had resolution of her presenting symptoms of syncope and neck tenderness. Her only complaint was of first bite syndrome, or pain in the parotid region during the first few bites of a meal. This is likely secondary to injury to her sympathetic chain causing a hypersensitive denervation of the parotid.

CONCLUSIONS
Inflammatory pseudotumor (IP) is a fibroinflammatory process most commonly seen in the lungs but, in the head and neck, most commonly involves the orbit. IP of the carotid sheath is a rare etiology that should be on the differential for neck masses. Characteristic histological findings include myofibroblastic mesenchymal spindle cells, inflammatory infiltrate of plasma cells, lymphocytes, and eosinophils.

The etiology of inflammatory pseudotumor remains controversial though it is generally considered to be a benign process. IP lesions, however, may demonstrate locally aggressive behavior and an estimated 5% will even metastasize. The mainstay of treatment for inflammatory pseudotumor has been systemic steroids. However, surgical resection may be used in refractory cases.