A Mobile Retroclavicular Lymph Node of Some Clinical Significance

By R. Barratt Terry

Diagnosis of hematologic disorders often rests upon the biopsy of a lymph node. This is a simple matter if there are palpable lymph nodes, but, if not, more difficult procedures, e.g., scalene node biopsy, must be used. In three patients without demonstrable lymphadenopathy, I have been able to displace a large, though barely detectable, lymph node from behind the clavicle by getting the patient to cough or strain. I felt that these experiences should be reported, since in each case biopsy of this retroclavicular node provided the diagnosis.

CASE REPORTS

Case 1.—A 45 year old white male entered hospital with fever and splenomegaly. A roentgenogram of the chest showed enlargement of the hilar nodes. Examination revealed no superficial lymphadenopathy, but deep behind the left clavicle, about 6.0 cm. from its medial end, a vague swelling was felt. On getting the patient to cough and strain, a large lymph node suddenly moved up into the supraclavicular fossa. Biopsy of this node gave indication of Hodgkin's disease.

Case 2.—A 31 year old colored male was suspected of having extrapulmonary, disseminated tuberculosis. During examination, no enlarged lymph nodes were felt, but a small vague lump was felt behind the right clavicle and about 7.0 cm. from the midline. On instructing the patient to cough, a large lymph node suddenly moved up into the supraclavicular fossa. Biopsy revealed caseous tuberculosis.

Case 3.—A 60 year old white male entered hospital for vague ill health and loss of weight. Physical examination was negative, but there was marked elevation of the serum alkaline phosphatase. Careful palpation behind the right clavicle about 6.0 cm. from its medial end revealed a vague small swelling, which could just be reached with the pad of the forefinger. On getting the patient to cough, a hard lymph node, 3.0 cm. in diameter, slipped up into the supraclavicular fossa (see figures 1 and 2). Biopsy revealed metastatic carcinoma, which at autopsy was found to arise from a small, unsuspected carcinoma of the upper esophagus.

DISCUSSION

These lymph nodes were all suspected clinically because their superior poles could just be palpated, albeit vaguely. After various maneuvers had been unsuccessfully tried in case 1 in an effort to demonstrate the suspected nodes, I recalled the bulging of the supraclavicular fossa which occurs with coughing in patients with herniation of the lung through Sibsen's fascia: the patient was then instructed to cough repeatedly, and the lymph node then slipped up into the supraclavicular fossa.

At first this node resumes its normal position very readily and is difficult to keep in the supraclavicular fossa; but with repeated upward dislocation, it becomes increasingly mobile. Coughing with the shoulders held back is the best method of displacing the node; and straining is the best way of keep-
MOBILE RETROCLAVICULAR LYMPH NODE

The size of these lymph nodes was remarkable. Thus, in case 3, it seemed difficult to believe that such a large node could have been hidden behind the clavicle, and everyone to whom it was demonstrated was surprised that it could disappear so completely. And the surgeon, who was requested to remove the node for biopsy, returned the patient to the ward with the comment that there was in fact no enlarged retroclavicular lymph node to remove. It should be emphasized that initially the node in case 3 was not apparent on inspection, but only became visible to the extent shown in figure 1 after repeated dislocation.

At first the node could not be completely displaced, but with repeated demonstration it could be moved further and further from its bed until it was 7.5 cm. from its original position (see figure 2).

All three nodes were about 7.0 cm. from the midline and just lateral to the clavicular head of the sternocleidomastoid muscle. Nodes of this type apparently lie deep to the deep cervical fascia and are presumably related to the inferior cervical gland. They seem to lie adjacent to Sibsen's fascia on a level with the first rib. They cannot be palpated with the thumb and first finger encircling the clavicle with the shoulders pulled forward. They do not represent the sentinel node of Troisier or Virchow, which lies more medially, and which can be easily palpated with the thumb and forefinger en-

Fig. 1.—Upper pole of retroclavicular node just visible.
circling the head of the sternomastoid; furthermore, the sentinel gland cannot be dislocated upwards by straining or coughing.

The importance of the lymph nodes in the three cases described was that they were the only ones palpable, and but for the dislocation maneuver the diagnosis would have been considerably delayed in each case.

It may well be that this node is involved when there is generalized lymphadenopathy, but inaccessible nodes are not sought in such cases, and it is not possible to state how frequently this node is involved.

**Summary**

The only clinically enlarged peripheral lymph node in three patients was one lying hidden deep behind the medial end of the clavicle. Its presence was established by instructing the patient to cough and strain; this dislocated the node up into the supraclavicular fossa, thus allowing biopsy.

**Summario in Interlingua**

In tres patientes, le sol peripheric nodo lymphatic que eseva clinicamente allargate jaceva celate in retro del termino medial del clavicula. Su presentia eseva establite per instruer le patiente a tussir. Isto dislocava le nodo, movente lo in le fossa supraclavicular, de manera que un biopsia deveniva possibile.
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