This tool addresses common symptoms and symptom complexes. Imaging requests for patients with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or patient’s Primary Care Physician (PCP) may provide additional insight.

This version incorporates MSI accepted revisions prior to 7/22/11
# 2011 Neck Imaging Guidelines

## 2011 Neck Imaging Guideline Number and Title

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- NECK-6 Neck Masses

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## Abbreviations for Neck Guidelines

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<td>ALS</td>
<td>Amyotrophic lateral sclerosis</td>
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<tr>
<td>CT</td>
<td>Computed tomography</td>
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<tr>
<td>ENT</td>
<td>Ear, Nose, Throat</td>
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<td>FNA</td>
<td>Fine needle aspiration</td>
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<td>GERD</td>
<td>Gastroesophageal reflux disease</td>
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<td>GI</td>
<td>Gastrointestinal</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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2011 NECK IMAGING GUIDELINES

NECK-1~GENERAL GUIDELINES

- Advanced imaging of the neck covers the area from the skull base, nasopharynx, and upper oral cavity to the head of the clavicle.
  - Neck imaging includes the parotid glands and the supraclavicular region.
  - Neck imaging includes the skull base; thus a separate CPT® code for head imaging in order to visualize the skull base is not necessary.
- Ultrasound of the soft tissues of the neck including thyroid, parathyroid, parotid and other salivary glands, lymph nodes, cysts, etc. is coded as CPT® 76536.
- Neck CT is usually obtained with contrast only (CPT® 70491). Little significant information is added by performing a neck CT without and with contrast (CPT® 70492), and there is the risk of added radiation exposure, especially to the thyroid. Neck CT without contrast (CPT® 70490) can be difficult to interpret due to difficulty identifying the blood vessels.
  - Exception: Contrast is not generally used when evaluating the thyroid gland with CT scan, since contrast may cause intense and prolonged enhancement of the gland which interferes with radioactive iodine nuclear medicine studies.
- Neck CT is indicated in the majority of cases to evaluate pathology in the neck when advanced imaging is appropriate. Indications for neck MRI are much less common.
  - MRI neck without and/or with contrast is also appropriate when there are concerns about CT contrast as in renal insufficiency or contrast allergy.

NECK-2~CEREBROVASCULAR AND CAROTID DISEASE

- See in Head Imaging Guidelines:
  - HD-3 CT and MR Angiography
  - HD-17 Hyperacute Headache, Intracranial Aneurysm, AVM, Subarachnoid Hemorrhage
  - HD-29 General Stroke/TIA
  - HD-30 Special Stroke/TIA
  - HD-31 Syncope
  - HD-32 Cerebral Vasculitis
  - HD-33 Vertigo
  - HD-37 Horner’s Syndrome
  - HD-46 Tinnitus
- See PVD-3 Cerebrovascular and Carotid Disease in Peripheral Vascular Disease Imaging Guidelines
Dysphagia (difficulty swallowing) can be caused by anything that affects the body’s ability to move food, liquid, or saliva from the mouth to the pharynx and into the esophagus.

A wide range of etiologies, including weak tongue or cheek muscles, neurological disability from stroke, ALS, neuromuscular disease, or Alzheimer's disease, medication side-effects, decreased function of the esophageal sphincter due to advanced age, esophageal spasm, benign strictures, chronic reflux or cancer, can cause dysphagia.

A detailed history of the dysphagia symptoms is important to distinguish neurogenic, pharyngeal and esophageal disorders. The most common cause of dysphagia is stroke. Neurogenic causes of dysphagia frequently cause oropharyngeal dysphagia.

A short duration (weeks to months) of rapidly progressive esophageal dysphagia with associated weight loss is highly suggestive of esophageal cancer. (See ONC-10 Esophageal Cancer in the Oncology Imaging Guidelines).

Barium swallow, endoscopy, and/or esophageal manometry should be the initial imaging studies obtained to evaluate dysphagia.

Abnormalities seen on the above studies can be further evaluated with CT or less commonly, MRI.

Chest MRI, contrast as requested, can be performed if vascular ring is suspected as a cause of dysphagia based on other studies such as CT or endoscopy. However, vascular ring is very uncommon.

Chest MRA and cardiac MRI should not be necessary to establish the diagnosis of vascular ring.

GI, ENT, Neurology or Thoracic surgery specialist consultation is helpful in determining the appropriate imaging pathway.

References:
- British Journal of Nursing 2006;13(10):558-561

Symptoms of dysphagia, odynophagia (painful swallowing), or regurgitation should be evaluated initially with barium swallow, endoscopy, and/or esophageal manometry.

Patients who present with hematemesis (including hematemesis from suspected Mallory-Weiss tear in the distal esophagus caused by severe vomiting) should be evaluated initially with endoscopy.

Advanced imaging is not routinely indicated to evaluate patients with hiatal hernia.
- **Exception**: chest CT with contrast (CPT®71260) and abdominal CT with contrast (CPT®74160) can be obtained for preoperative planning in patients with large hiatal hernias or paraesophageal hernias.
- Postoperative advanced imaging is not routinely indicated unless the patient has signs/symptoms of a potential complication from surgery.

**Advanced imaging is not routinely indicated to evaluate patients with gastroesophageal reflux disease (GERD) unless requested as a preoperative study in patients undergoing Nissen fundoplication or other surgical treatment for the reflux.**
- Postoperative advanced imaging is not routinely indicated unless the patient has signs/symptoms of a potential complication from surgery.
- Advanced imaging in patients with Barrett’s esophagus is not indicated unless biopsy shows frank malignancy.

- Suspected foreign body obstructing the esophagus should be evaluated with x-ray, contrast study such as barium or Gastrografin study, and endoscopy.
- Suspected esophageal stricture due to any cause (e.g. radiation, peptic stricture from reflux, lye stricture, neoplastic, postoperative, drug-induced, Crohn’s disease, Schatzki’s ring at the squamocolumnar junction, esophageal web) should be evaluated initially with barium swallow and endoscopy.

**Esophageal Perforation:**
- Associated with high morbidity and mortality
- Esophageal endoscopy accounts for the vast majority of esophageal perforations.
- Esophageal perforations occur most commonly at the distal esophagus and in the posterior wall of the cervical esophagus.
- Chest x-ray should be obtained initially and can show subcutaneous emphysema, pneumomediastinum, or prevertebral air.
- Contrast study using water-soluble contrast such as Gastrografin should be performed. If no perforation is seen, repeat contrast study using barium should be done.
- Neck CT and/or chest CT with contrast (CPT®70491 and CPT®71260) can be performed to evaluate for abscess.

**Motility Disorders:**
- Suspected motility disorders such as aperistalsis, achalasia, diffuse spasm, nutcracker esophagus, myasthenia gravis, and scleroderma should be evaluated by barium swallow and manometry. Advanced imaging is not routinely indicated.

**Esophageal Diverticulum:**
- Pulsion and traction diverticula can occur.
- Midesophageal diverticula are usually traction in origin (contain both mucosal and muscular layer).
- Zenker’s (pharyngoesophageal) and epiphrenic diverticula are usually pulsion (mucosa only).
- Initial evaluation includes barium swallow, endoscopy, and manometry studies.
CT scan of the neck and/or chest (contrast as requested) can be performed for further evaluation if needed.

- **Leiomyoma:**
  - Most common benign esophageal neoplasm.
  - 60% of leiomyomas occur in the distal third of the esophagus, 30% in the middle third, 10% in the upper third.
  - Usually solitary, but multiple leiomyomas can occur.
  - Appears as a filling defect on barium swallow, but mucosa is normal on endoscopy since the leiomyoma is a submucosal lesion.
  - Neck CT and/or chest CT with contrast (CPT®70491 and/or CPT®71260) or MRI (CPT®70543 and/or CPT®71552), and endoscopic ultrasound (CPT®76975) are helpful in evaluating this lesion and for preoperative planning.

- Other esophageal masses should undergo evaluation with barium swallow, endoscopy, and biopsy prior to considering advanced imaging.
- Esophageal Carcinoma—See **ONC-10 Esophageal Cancer** in the Oncology Imaging Guidelines.

- **Reference:**

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**NECK-5~CERVICAL LYMPHADENOPATHY**

- Causes of cervical lymphadenopathy can be divided into **two** categories:
  - a) Inflammatory
  - b) Neoplastic
  - **Inflammatory**
    - Inflammatory lymph nodes from acute lymphadenitis are usually painful, tender and mobile, frequently associated with upper respiratory infection, pharyngitis or dental infection.
    - Occasionally, sarcoidosis or toxoplasmosis and HIV can cause inflammatory lymphadenopathy.
    - Painful acute lymphadenopathy and other painful neck masses (including neck “swelling”) should be treated with a trial of conservative therapy, including antibiotics if appropriate.
      - If there is improvement with conservative treatment, advanced imaging is not indicated.
    - Ultrasound (CPT®76536) can be helpful in determining whether a distinct mass/abnormality is present
  - **Neoplastic lymphadenopathy**
    - Most common causes are metastasis from head and neck tumors and lymphoma.
    - Neoplasm should be suspected in patients over age 40 with painless, enlarged, firm and fixed lymph nodes.
    - ENT evaluation and/or a thorough head and neck examination including laryngoscopy, if indicated, should be performed initially.
CT neck with contrast (CPT®70491) is helpful in determining an association with underlying structures, determining the full extent of the lesions, and to identify other pathologic lymph nodes.

Chest x-ray should be performed to identify primary lung disease, involvement of mediastinal lymph nodes or other metastases.

CT chest with contrast (CPT®71260) or without contrast (CPT®71250) may be appropriate if x-ray findings are abnormal or unclear.

Left supraclavicular enlarged lymph nodes are worrisome for metastasis from a chest, abdominal, or pelvic primary. Biopsy is helpful to determine the primary source of a metastatic lymph node in this region.

### References:

### NECK-6~NECK MASSES

- The age of a patient with a neck mass can narrow the diagnostic possibilities:
  - **Patients under age 20**: higher incidence of congenital lesions. (See Pediatric Neck Guidelines for further discussion.)
  - **Patients over age 40**: malignancy is a greater possibility, especially in heavy drinkers and smokers.
- Location of the neck mass is important.
  - Anterior portion of the neck is associated with thyroid and parathyroid disorders.
    - Neck masses that are located on the anterior neck should have ultrasound (CPT®76536) performed as the initial imaging study.
  - Lateral portions of the neck are associated with lymphadenopathy, branchial cleft cysts, and deep neck abscess.
    - If the neck mass is located on the lateral or posterior neck and is described as a definite, nontender, discrete mass on physical examination, neck CT with contrast (CPT®70491) can be performed.
- **Reference**:

- Patients who present with symptoms such as significant dyspnea, stridor, or dysphagia should be referred to the Emergency Department for immediate evaluation and treatment.
- Advanced imaging is not indicated in patients who present with uncomplicated pharyngitis or tonsillitis. These patients should have a trial of conservative therapy including antibiotics, if appropriate.
  - ENT evaluation can be helpful in determining the need for advanced imaging.
- Patients who present with suspected peritonsillar, retropharyngeal or other head and neck abscesses should have neck CT with contrast (CPT®70491).
• For possible neck masses or fullness of the neck that is not well described on physical examination, ultrasound (CPT®76536) or ENT evaluation can be helpful in making decisions regarding the need for advanced imaging.
• Patients with a history of malignancy who present with a neck mass should have neck CT with contrast (CPT®70491) as the initial imaging study.
• CT of the neck without contrast (CPT®70490) is typically indicated in the setting of suspected salivary duct or gland stone. 80% of these stones occur in the submandibular glands.
  - CT of the neck without and with contrast (CPT®70492) may be useful if obstructing calculus and inflammatory disease is suspected.
  - Sialogram (contrast dye injection) under fluoroscopy, CT sialogram (CPT®70486), or MR sialogram (CPT®70540), may be performed to rule out a stone.
• In patients with a suspected parotid gland mass, ENT evaluation can be very helpful in determining the most appropriate diagnostic algorithm, including the use of advanced imaging.
  - CT scan (usually CPT®70488 if stone is also being ruled out; some ENT’s prefer CPT®70492) or MRI (CPT®70543) may be useful in determining a diagnosis.
• MRI of the neck without and with contrast (CPT®70543) is indicated when ultrasound or CT scan suggests neurogenic tumor (schwannoma, neurofibroma, glomus tumor, etc.), or if CT scan suggests the need for further imaging. MRI is also useful in evaluating vascular malformations, deep neck masses and angiofibromas.
• Although CT and MRI scan can have characteristic appearances for certain entities, biopsy and histological diagnosis are the only way to obtain a definitive diagnosis.

NECK-7~MALIGNANCIES INVOLVING THE NECK

• See in Oncology and PET Imaging Guidelines:
  - ONC-5 Squamous Cell Carcinomas of the Head and Neck
  - ONC-6 Salivary Gland Cancers
  - ONC-8 Thyroid Cancer
  - ONC-10 Esophageal Cancer
  - ONC-28 Lymphomas
NECK-8~RECURRENT LARYNGEAL PALSY

- See HD-10 Recurrent Laryngeal Palsy in the Head Imaging Guidelines

NECK-9~THYROID AND PARATHYROID

- Ultrasound (CPT®76536) and nuclear medicine thyroid scan are the preferred initial imaging studies for suspected thyroid masses. If ultrasound shows a dominant mass, fine needle aspiration (FNA) should be the next diagnostic study. CT Neck is not indicated prior to ultrasound and FNA
  - Benign thyroid nodules should have a follow-up ultrasound (CPT®76536) 6 to 18 months after the initial FNA.
    - If nodule size is stable, follow-up ultrasound exam (CPT®76536) can be performed every 3 to 5 years.
    - If there is evidence for nodule growth, FNA with ultrasound guidance (CPT®76942) should be repeated
  - Reference:
    - Thyroid 2009;19(11):1167-1214
  - Repeat FNA with ultrasound guidance (CPT®76942) should be done for non-diagnostic results on initial biopsy, as there is up to a 10% false negative rate, especially for very small, very large (> 3 cm), and cystic masses.
    - If FNA results are repeatedly non-diagnostic, close observation or surgical excision should be performed.*
      - *Thyroid 2009;19(11):1167-1214
  - There is insufficient evidence-based data to support the use of PET scan to distinguish indeterminate thyroid nodules that are benign from those that are malignant*
  - Thyroid nodules >4 cm should undergo thyroid lobectomy with complete removal due to high incidence of false negative FNA biopsies and the high incidence of malignancy (26%).*
    - *Surgery 2007 Dec;142(6):837-844
- Neck CT (CPT®70490) can be obtained as a preoperative study in patients in whom resection is planned.
  - Contrast is not generally used when evaluating the thyroid gland with CT scan since contrast may cause intense and prolonged enhancement of the gland which interferes with radioactive iodine nuclear medicine studies.
- Incidental thyroid nodules found on imaging (ultrasound, CT, or MRI) can be followed by ultrasound (CPT®76536). FNA is indicated if there is concern for malignancy.
- Nuclear medicine Sestamibi study of the parathyroid gland is the preferred initial imaging study in patients with suspected parathyroid disease (high serum calcium and high serum parathyroid hormone level).
- MRI has good sensitivity and positive predictive value for imaging non-ectopic and ectopic abnormal parathyroid glands and is generally used in patients with recurrent or persistent hyperparathyroidism following neck exploration.*
  

- CT or MRI neck without and with contrast (CPT®70492 or CPT®70543) is useful in patients with very high calcium (greater than or equal to 13) suggesting parathyroid carcinoma.

- Patients with a suspected substernal goiter (i.e., a major portion of the goiter lies within the mediastinum) should have a neck ultrasound (CPT®76536) or radionuclide study first to confirm extension of the thyroid to the sternum.

- If extension of the thyroid to the sternum is confirmed, neck and chest CT without contrast (CPT®70490 and CPT®71250) are sufficient to evaluate the substernal goiter. The vast majority of these goiters can be resected through a cervical incision.

**NECK-10~TRACHEA**

- The initial imaging studies for evaluating patients with suspected tracheal pathology include plain x-ray and bronchoscopy.

- Neck CT with contrast (CPT®70491) or without contrast (CPT®70490) and chest CT with contrast (CPT®71260) or without contrast (CPT®71250) can be performed to further evaluate abnormalities seen on other imaging studies.

- CT is often not helpful in making the diagnosis of tracheomalacia, and cineradiography and bronchoscopy are the imaging studies of choice.*

EVIDENCE BASED CLINICAL SUPPORT

Evidence Based Clinical Support
NECK-6~NECK MASSES

- Most lateral neck masses are enlarged lymph nodes.
- Other entities in the differential diagnosis include branchial cleft cyst, abscess, laryngocele, lipoma, neurinoma, glomus tumor, paraganglioma, and fibroma.
- Adults over age 40 presenting with a cystic neck mass can have cystic metastases from occult squamous cell primaries. Neck CT scan, FNA, and panendoscopy of the head and neck should be performed.
- 25%-45% of extracranial schwannomas occur in the head and neck and usually present as asymptomatic solitary neck lesions. See Peripheral Nerve Sheath Tumors in the Peripheral Nerve Guidelines.
- The most common ENT manifestations of sarcoidosis are neck masses, parotid masses, and facial nerve palsy. Cervical adenopathy is usually bilateral with mobile, nontender lymph nodes. Neck CT scan and biopsy are needed for diagnosis.
2011 NECK IMAGING GUIDELINE REFERENCES

NECK GUIDELINE REFERENCES

NECK-3~Dysphagia

NECK-4~Esophagus

NECK-5~Cervical Lymphadenopathy

NECK-6~Neck Masses

NECK-9~Thyroid and Parathyroid

NECK-10~Trachea