A 19-year-old male presented with a swelling on the posterior part of tongue of 2 months duration. The swelling was of insidious onset and not associated with pain or trauma. On intraoral examination, the swelling was cystic in consistency and measured 1.5 × 1.5 cm. [Figure 1a]. Fine needle aspiration cytology (FNAC) was done from the swelling. The aspirate was mucinous and smears showed scattered mucinophages and lymphocytes in a mucinous background [Figure 1b and c]. A diagnosis of mucocele was suggested based on the clinical and cytological findings. The swelling was surgically excised. Grossly, it measured 1.5 × 1.5 cm. On the cut section, it was cystic and milled with mucinous material. Histopathological examination revealed both hypocellular and hypercellular areas with cystic areas [Figure 1d]. On immunohistochemistry (IHC), the cells were strongly positive for S100. A final diagnosis of cystic schwannoma was made. The patient was discharged on the third postoperative day and is on regular follow-up. There was no recurrence at 1 year of follow-up.

**Discussion**

Schwannomas are benign, encapsulated nerve sheath neoplasm developed from Schwann cells. Schwannomas usually occur between 20 and 50 years of age; however, it may occur at any age and show equal sex predilection. Schwannomas usually present as solitary, painless, and slow-growing mass of variable size usually 2–4 cm. However, multiple lesions may be seen in association with von-Recklinghausen’s neurofibromatosis. Of all extracranial schwannomas, head and neck region accounts for 25–45% of the cases whereas intraoral schwannomas are extremely rare and account for only 1% of cases. Intraoral schwannomas most commonly affect the tongue, followed by palate, buccal mucosa, lip, and gingiva. Schwannomas affecting the tongue arise from the hypoglossal nerve and vagus nerve.

Schwannomas are usually solid; however, cystic changes are seen in approximately 4% of the cases. Cystic schwannomas are often comparatively large and appear to have a more rapid growth because of their cystic expansion. Mucinous degeneration, necrosis, hemorrhage, and microcysts formation are thought to be the reasons for these cystic changes. FNAC in such cases may yield hypocellular fluid altogether missing the solid cellular areas. The aspirated fluid may contain individual spindle cells, fibroblasts, histiocytes, or lymphocytes but in the absence of characteristic cellular architecture, such schwannomas may escape diagnosis. FNAC has been found to be of limited value in achieving a preoperative diagnosis in such cystic lesions.

Differential diagnosis that should be considered while dealing with a small, slow-growing cystic mass in tongue are mucocele, epidermoid cyst, dermoid cyst, lymphoepithelial cyst, lingual cyst, schwannoma, neurofibroma, and minor salivary gland tumor. Histologically, schwannomas show alternating pattern of hypercellular Antoni A and hypocellular Antoni B areas, nuclear palisading, whorling of cells, and Verocay bodies. Sometimes, cystic schwannomas are difficult to diagnose even on histopathology due to secondary changes. In such situations, IHC plays a pivotal role in the definitive diagnosis. Schwannomas are strongly positive for S100.

It is of paramount importance to differentiate between these two entities both preoperatively and postoperatively. Mucocele is managed by marsupialization whereas surgical excision is recommended in case of schwannoma. Schwannoma rarely recurs if completely excised.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**

There are no conflicts of interest.
Papillary Carcinoma Thyroid Presenting as Huge Scalp Metastases

nuclear grooves, and abundant cytoplasm consistent with features of PTC [Figure 1c]. Immunocytochemistry showed diffuse positivity thyroid transcription factor -1 [Figure 1d]. A diagnosis of PTC with metastases to skull, and bilateral level II, III neck lymph nodes was made. The patient succumbed to death before receiving any treatment.

Metastatic tumors to skull are infrequent and arise mostly from the lung, breast, prostate, and renal cell carcinoma. The incidence of skull metastasis from thyroid carcinoma is 1.8–5.8%, predominantly from follicular carcinoma of thyroid.

After extensive search on PubMed database, we found 16 cases of PTC in English literature that metastasized to the skull, except two cases in females. In only two of these cases, simultaneous brain infiltration was noted. In one case, neurosurgery was performed to excise metastatic tumor, but the patient died after 17 months. [3] The follow-up of the other patient is not known. [4]

Outcome of patients with skull metastasis due to PTC are poor with a mean survival time of 4.5 years, ranging from 5 months to 17 years in a series of 12 patients with thyroid carcinoma including both papillary and follicular subtypes. [5] Our patient developed a rapidly progressive swelling in the scalp within 5 months and died after 4 months.

Though PTC has an indolent course, our case is an exception, where the patient developed skull metastases with brain infiltration within a short span of time and died. Hence, skull metastasis due to PTC is a rare occurrence and the patient is the first reported case of PTC masquerading as mucocele.

Sir,

Papillary thyroid carcinoma (PTC) is the most common subtype of thyroid carcinoma that predominantly occurs in females of any age group. It is an indolent tumor with excellent overall outcome, except in cases with distant metastasis, and shows a propensity for local infiltration and metastasis to locoregional lymph nodes (40%). Distant metastasis occurs in ~9–14% of the cases. Common sites for metastases are lung (49%), bone (25%), and brain (12%). Vertebrae are the favored site for bone metastases. It seldom metastasizes to skull. We present a case of PTC in a male patient in whom metastasis developed in the frontal bone with frontal lobe infiltration within a period of 5 years.

A 51-year-old male presented with a rapidly growing anterior neck and scalp swellings. Neck swelling measuring 15 × 13 × 12 cm started 5 years back with recent rapid growth along with a scalp swelling measuring 13 × 12 × 8 cm [Figure 1a] since 5 months. He was having bilateral cervical lymphadenopathy. Computed tomography (CT) of the head showed an expansile lytic destructive lesion arising from the frontal bone with both intracranial and extracranial extension [Figure 1b]. CT chest and abdomen did not reveal metastasis to lung and other abdominal organs. Fine needle aspiration cytology of the neck and scalp swelling and LN showed papillary clusters of cells with nuclear overlapping, moderate anisonucleosis, prominent intranuclear pseudoinclusions, and abundant cytoplasm consistent with features of PTC.