Sir,

A 52-year-old male presented at our outpatient department for evaluation of thyroid nodule in the right lobe. He incidentally noticed swelling on the lower neck on coughing or forceful expiration for last 2 months. He was a nonsmoker and had no history of long standing cough or any hernia at other sites. On examination, a swelling was confirmed in the right lower neck when the Valsalva manoeuvre was performed [Figure 1; clinical photograph at rest and with Valsalva]. In addition, pulsatility was seen on the left neck supraclavicular region due to displaced subclavian artery pulsations. Computed tomographic (CT) evaluation with Valsalva manoeuvre was performed keeping a differential diagnosis of laryngocele. Cervical lung herniation was excellently depicted with Valsalva CT acquisition [Figure 2; coronal panels D and sagittal, panel E images] in comparison to images without Valsalva [Figure 2; coronal images, panels A and C]. In addition, CT depicted bilateral cervical ribs (arrows) and arthrosis of the left cervical rib with exostosis from the superior surface of the first rib. Laboratory investigations revealed euthyroid state, and other investigations including routine chest X-ray were within normal limits. Fine needle aspiration cytology (FNAC) of thyroid nodule done under ultrasound guidance confirmed its benign nature. Patient is on conservative treatment.

**Discussion**

Spontaneous herniation of the lung, a congenital defect, is extremely uncommon and is defined as protrusion of the lung beyond the confines of the thoracic cavity. Apical lung herniation is a very unusual cause of lower neck swelling.

![Figure 1 (A and B): (A) Photograph of the patient at rest. (B) Photograph of the patient with Valsalva](image1)

![Figure 2 (A-F): Cervical lung herniation was excellently depicted with Valsalva CT acquisition on Ray sum projection neck and upper chest without and with Valsalva (A and B) CT coronal reformat without and with valsalva (C and D), sagittal reformat with valsalva (E). Volume rendered image (F) depicting bilateral cervical ribs (arrows) and arthrosis of left cervical rib with exostosis from superior surface of first rib (arrow head)](image2)
Letters to the Editor

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References


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Our patient was a middle-aged adult without any history of trauma, predisposing factors to account for any acquired defect, or connective tissue disorders. The presence of cervical rib points to congenital defective anatomical organization in region.

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Conflicts of interest
There are no conflicts of interest.

costomembranous with an origin at the neck of the first rib). All three insert on the first rib. Sibson’s fascia extends posteriorly and laterally to vertebral column, first rib, levator scapulae, and scalenus medius muscle; medially, the superior mediastinal structures and anteriorly upto scalenus anterior and sternocleidomastoid muscles.[1,2]

Lung hernias are classified according to the location as cervical, chest wall (intercostal), or diaphragmatic. Etiologically, each type may be congenital, spontaneous, traumatic, or pathological.[2]

Spontaneous herniation, usually reported in infants, is caused by a defect in Sibson’s fascia and increased intrathoracic pressure. Cervical lung herniation in adults is mainly caused by trauma. Apical herniation also may result from lifting heavy weights, playing wind instruments, chronic cough, and emphysema where the deep cervical fascia becomes weak.[1,3,4] These patients have higher chances of complications if procedures such as tracheostomy, subclavian line placement, or thoracic interventions are done, hence adequate caution must be exercised.[5]

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