

and may also be attached to the sternum below, resulting in neck contracture^{1,3,4}.

The midline cleft is usually an isolated phenomenon however it has been seen in association with midline cleft of the tongue, lower lip, mandible and sternum. The median cervical cleft is of cosmetic importance. It can be effectively treated by elliptical excision of the cleft. This alone results in an unsightly

keloid as it undergoes contraction. The use of multiple Z-Plasties to break up the suture line leave a more cosmetically acceptable scar^{1,3,4,7,8}.

There are reports of recurrence following Z-plasty in the first few months of life which has been ascribed to the regional hypoplasia which may require tissue supplementation. Disturbed mandibular growth may require genioplasty in adolescents⁹.

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Median Cervical Cleft

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There are very few reports about median cervical cleft in the literature. Unless there is an awareness of this condition this may easily be confused with other congenital conditions like infected thyroglossal tract and acquired conditions like tuberculous sinuses. In the last 20 years of paediatric surgical practice this is the first case that we have come across with typical features of median cervical cleft. The interesting findings of this case and review of literature are discussed.

Key words : median cervical cleft, congenital anomaly, congenital midline cleft.

The median cervical cleft is a rare sporadic congenital anomaly of the ventral neck with unknown etiology that has been labeled as the mildest form of anterior midline cleft abnormality in the group that includes supraumbilical raphe, cleft sternum, and congenital heart defects. There appears to be a predilection for white females¹.

The most likely cause of this defect is an imperfect fusion of branchial arches in the midline. Intrauterine insult has been postulated as another possible cause of this condition^{2,3,5,6}.

Case Report

A nine years old boy presented with a painless midline cervical congenital lesion (Fig. 1). This had caused problems of local hygiene and occasional infection and ulceration. On examination a vertically placed midline irregular light colored epithelialized incomplete tract was noted. Its edges were irregular and it extended from just above the hyoid to the suprasternal region. There was surrounding tethered skin with a prominent skin tag at its upper limit, a typical feature which has been noted in cases of median cervical cleft. It was excised with a surrounding elliptical incision employing multiple Z plasties to camouflage the surgical scar.

Histology confirmed the interwoven bundles of neck muscles with surrounding fibrous tissue and a squamous epithelial base all along the tract. Postoperative progress was satisfactory.



Fig. 1 Typical median cervical cleft with surrounding discoloration and irregular edges with a skin tag above and a blind pit below

Discussion

Median cervical cleft appears as a mucosa covered midline trough and a characteristic tag of skin superiorly. The adjacent skin is tethered by scarred tissue and the trough ends in a blind pit inferiorly. There is an associated submucosal fibrous cord and interwoven bundles of neck muscles. The fibrous band grows at a slower rate than the surrounding tissue and this sometimes tethers the mandible above