Letter to the Editor

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Congenital Midline Cervical Cleft

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Congenital midline cervical cleft (CMCC) is a very uncommon condition often present at birth; however, a definitive diagnosis may not be established until several years later. It may be associated with other congenital anomalies, such as thyroglossal duct fibrosis. The embryological origin remains to be fully clarified, but impaired midline fusion of the branchial arches, particularly the second, along with improper interaction between ectoderm and mesoderm, has been cited as contributing factors. Alshihaby WJ recently published a case study in this Journal detailing a 5-year-old girl with a midline anterior cervical lesion characterized by a skin tag and clear discharge, diagnosed as CMCC.[1] After careful preoperative evaluation, the surgical option chosen was excision of the lesion followed by multilayered closure and multiple Z-plasty incisions to promote optimal healing and minimize scarring. The patient had an uneventful follow-up, and scar treatment included the application of silicone gel.[1] The author emphasized the importance of early diagnosis and prompt accurate surgical intervention to get a better aesthetic outcome without complications, particularly in pediatric cases, where Z-plasty enhances both functional and cosmetic appearance of scars.[1] With enhanced interest, we decided to review additional literature from the past three years addressing this rare entity, providing brief comments on the relevant issues.[2-5] An 8-year-old girl diagnosed with CMCC at birth presented with a 5 cm by 0.5 cm sinus and a 1 cm skin tag, which caused some difficulty in neck extension.[2] Surgical excision of the fibrosis and sinus was performed using a vertical elliptical incision, followed by simple vertical closure of the wound in two layers. After an uneventful postoperative course, she underwent physiotherapy for six months (extension, flexion, and lateral neck movements twice daily) and nighttime soft cervical collar at night for one year.2 Following this treatment, with the scar well healed, the child experienced no difficulty in neck extension. The authors noted that Z-plasty is preferable for infants, as their necks will continue to grow in extension, while vertical approximation is a better choice for older children. A 10-month-old male infant diagnosed with CMCC immediately after birth underwent surgical excision, which was closed in layers, resulting in unremarkable postoperative evolution and successful functional and cosmetic outcomes. The authors emphasized that lesions should be treated within the first year after diagnosis to prevent micrognathia or neck contracture.[3] An 8-year-old boy diagnosed with CMCC concomitant with thyroglossal duct fibrosis underwent

successful surgical management, including repair via Z-plasty. The authors commented on the rarity of CMCC and the necessity for timely surgical correction.[4] CMCC is an exceedingly rare condition, and accurate early diagnosis is crucial for facilitating prompt and appropriate management because of the functional and aesthetic complications. Surgical treatment may involve Z-plasty, although the best option for repair method has yet to be established.[5] Case reports can enhance general awareness and increase the suspicion index regarding rare entities

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