Images in Endocrinology
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ULCERATIVE GOITER AS EXPRESSION OF PAPILLARY THYROID CARCINOMA

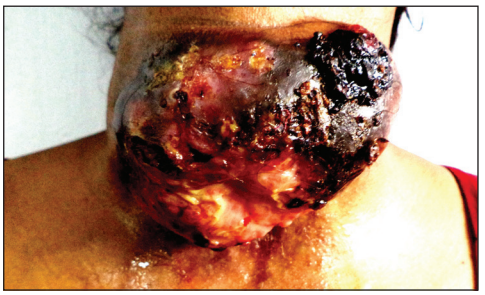

Figure 1. Large ulcerative, hemorrhagic, fungating growth of the thyroid.

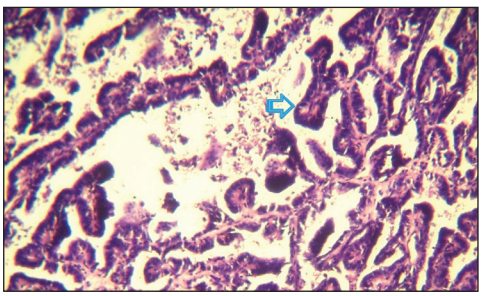

Figure 3. Histopathology showing papillary micro architecture (blue arrow).

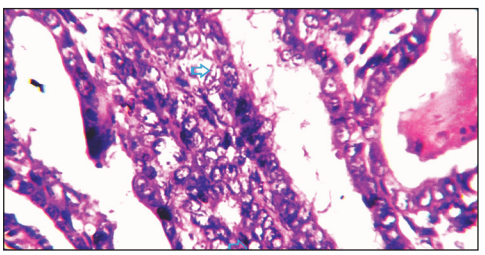

Figure 4. Histopathology showing nuclear features of papillary thyroid carcinoma (blue arrow).

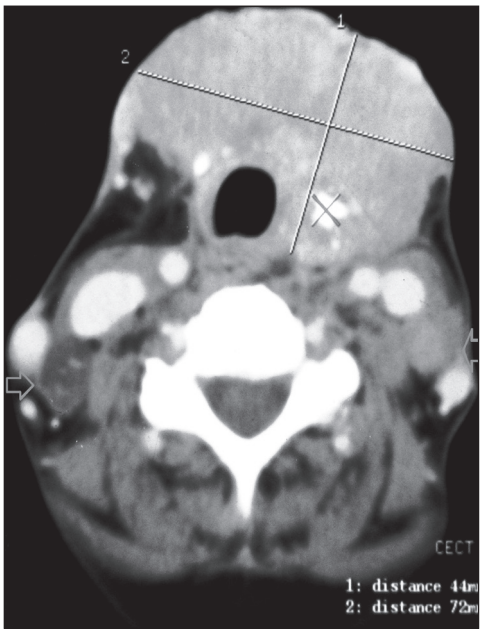

Figure 2. Neck CT scan showing calcifications and enlarged lymph nodes (arrow).

A 45 year-old female presented with pallor and a large ulcerative, hemorrhagic, fungating growth in front of neck measuring 7 cm × 5 cm (Fig. 1). Biochemical investigations revealed severe anemia (hemoglobin - 5.6 g/dL) and primary hypothyroidism (free T4 - 0.5 ng/dL and TSH - 78.61 μIU/mL). Chest x ray and pulmonary CT scan chest showed evidence of pulmonary metastases. Neck CT scan (Fig. 2) showed a large (72 mm × 44 mm) enhanced mass involving both thyroid lobes and isthmus

resulting in destruction of thyroid cartilage with punctate calcifications and enlarged lymph nodes at levels III and IV on the right side and level III on the left side. In 2006, she underwent total thyroidectomy at a separate hospital on the basis of fine needle aspiration cytology (FNAC) with features of papillary thyroid carcinoma. She was advised to take levothyroxine 200 µg/day along with referral to an endocrinologist which she did not comply. Neck swelling reappeared in 2009, palliative excision was performed. Histopathology features confirmed papillary thyroid carcinoma (Figs 3, 4). The patient received external beam radiotherapy and suppressive dose of levothyroxine, but refused other modalities of treatment.

Negation of the appropriate treatment could result in life-threatening cases of recurrent papillary thyroid carcinoma, such as presented here.

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