To the Editor:

A 29-year-old female patient attended the clinic for a painless, mobile tumor in the left posterolateral cervical region. There were no associated clinical signs or personal or family history. The patient provided a computed tomography scan (CT) of the neck showing a 4 x 3 x 3 cm lesion lateral to the cervical vessels sparing the fat plane. There was contrast uptake, and the lesion had a homogeneous appearance, with a vascular pedicle in its upper part. Paraganglioma with no thyroid changes or cervical adenopathies was suspected (Fig. 1). Laboratory tests showed normal chemistry, hematology, and thyroid function values; urinary analysis revealed the following levels: epinephrine less than 2 mcg/24 h (NV less than 20 mcg/24 h), norepinephrine 486 mcg/24 h (NV less than 80 mcg/24 h), dopamine 95.4 mcg/24 h (NV less than 400 mcg/24 h), total metanephrine 223.2 mcg/24 h (NV 170-700 mcg/24 h), normetanephrine 144 mcg/24 h (NV 105-354 mcg/24 h), and metanephrine 792 mcg/24 h (NV 74-297 mcg/24 h). Paraganglioma was suspected, and a meta-iodo-benzylguanidine scan was performed after thyroid blockade with potassium iodide, which showed no pathological uptake. A subsequent 111In-pentetreotide scan (Octreoscan®) revealed an abnormal focal uptake in the left side of the neck (periretroclavicular) consistent with paraganglioma expressing somatostatin receptors (Fig. 2). An echo-Doppler of supra-aortic trunks showed a 30 x 28 x 42 mm mass in the left side of the neck, lateral to the vascular bundle and highly vascularized in its base. The tumor was resected by vascular surgery. Pathology reported the specimen as a 3.5 x 3 cm lymph node with metastasis from a papillary thyroid carcinoma. Total thyroidectomy and a nodal resection of the central compartment were performed. A 0.8 x 0.6 cm papillary carcinoma of the follicular variant at its junction to the left lobe was found. In addition, one out of the six lymph nodes removed was invaded by papillary carcinoma (T1N1M0). After surgery, a iodine-131 (131I) scan detected uptake by the thyroid bed. Ablation therapy with 100 mCi of 131I was performed, after which the patient had undetectable thyroglobulin and no pathological uptake at the 131I scan one year after surgery.

This case report shows the atypical presentation of a papillary thyroid microcarcinoma of the follicular variant.

Figure 1 Contrast-enhanced CT of the neck.

Figure 2 111In-pentetreotide scan (Octreoscan®).
detected by the presence of a cervical nodal metastasis showing uptake in the $^{111}$In-pentetreotide scan which initially suggested a probable paraganglioma.

Thyroid microcarcinoma (TMC) has been defined as any thyroid cancer, usually papillary, 10 mm or less in diameter. Guidelines for the management of thyroid nodules and differentiated thyroid cancer (DTC) of the American Thyroid Association state that small nodules rarely have distant metastases (10%-20%), and fine needle aspiration should therefore seldom be required for nodules less than 1 cm in diameter unless they show in an ultrasound examination characteristics suggesting malignancy or there is a history of nodal metastasis showing uptake in the $^{111}$In-pentetreotide scan. This illustrates the potential role of radiolabeled somatostatin analogues for the staging and treatment of these tumors in the future.

References


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