

Letter to the Editor

An interesting case of metastatic thyroid nodules

Sir,

Metastatic carcinoma of the thyroid gland from cervical cancer is very rare.^[1,2] Upon reviewing the literature, only 5 cases of cervical carcinoma are described as having metastasized to the thyroid gland.^[3-5] We report a rare case of metastatic carcinoma of the thyroid gland from villoglandular papillary adenocarcinoma of endocervix (VPA).

A 45-year-old female patient presented to us with a multi-nodular goiter of 3 months duration associated with a foreign body sensation during swallowing. The nodules were hard, non-tender, not fixed to skin, and involved both lobes of the thyroid. One nodule was adherent to trachea. There was no history of nausea, vomiting, diarrhea, and paroxysmal episodes

of flushing. She had undergone Wertheim's hysterectomy one and a half years ago. Biopsy showed it to be a rare case of villoglandular papillary adenocarcinoma of the endocervix with no areas of neuroendocrine de-differentiation [Figure 1], and she received 25 cycles of external beam radiotherapy. Laboratory investigations showed the patient to be euthyroid with all the routine blood parameters within normal limit. Ultrasonography of neck showed a heterogeneous 3×2.2 cm SOL with ill-defined margins and few linear calcifications within right lobe of thyroid mainly middle and lower portion involving isthmus also. Left lobe was normal. A 1.7×0.5 cm lymph node was seen on the right side. FNAC of the thyroid nodule showed it to be papillary carcinoma. Patient was taken up for surgery with diagnosis of papillary carcinoma and planned for total thyroidectomy. Left lobectomy was done with partial removal

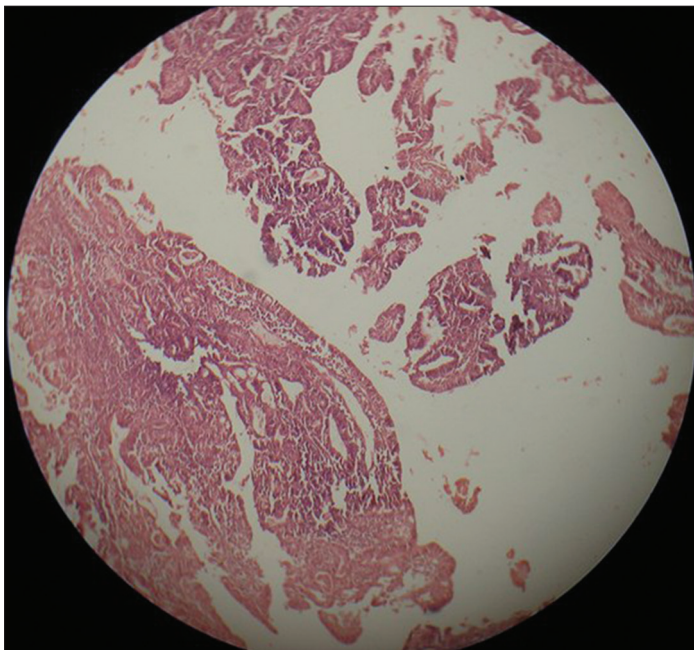


Figure 1: Slide showing villiglandular papillary adenocarcinoma of cervix

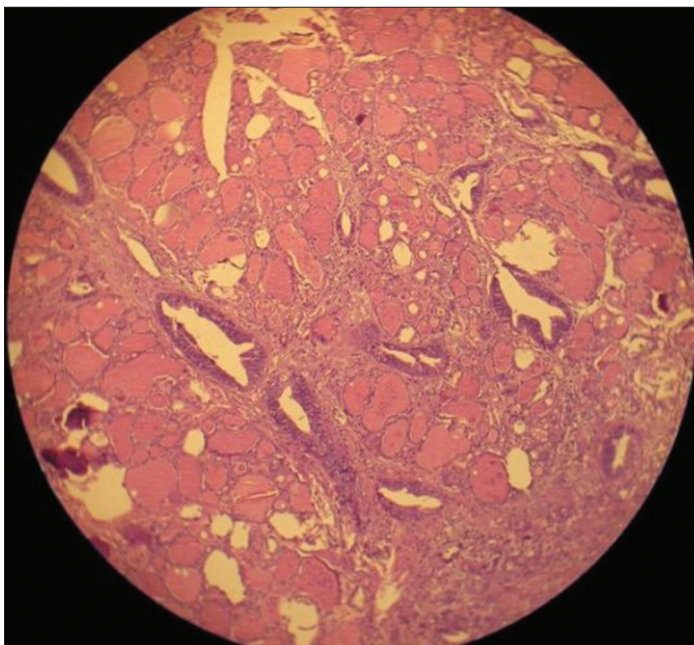


Figure 2: Slide showing histology of thyroid nodule showing metastatic villiglandular papillary adenocarcinoma

of right lobe, as it was densely adherent to trachea. Lymph node dissection also could not be done due to dense adherence to the carotid sheath and vessels. Histopathology of the surgical specimen revealed a secondary deposit to the thyroid gland arising from villiglandular papillary adenocarcinoma of cervix, the histology of which showed the same papillary pattern [Figure 2]. During follow-up, whole body bone scintigraphy was done, which revealed normal bone survey. Patient underwent 6 cycles of chemotherapy with paclitaxel and carboplatin, and follow-up at 6 months showed no recurrence.

Cervical cancer can spread via lymphatic vessels, from the satellite nodes to the para-aortic and supraclavicular nodes and via the hematogenous spread to the caval venous system through the lung parenchyma and systematic circulation. The most frequently observed metastatic sites are the lung (21%), the para-aortic lymph nodes (11%), the abdominal

cavity (8%), the supraclavicular lymph nodes (7%), and bone (16%).^[1] Metastases to the thyroid gland are uncommon, with rates reported between 0.02% and 1.4% of surgically resected thyroid specimens.^[6] VPA of the uterine cervix itself is a rare form of cervical adenocarcinoma, first described by Young and Scully in 1989.^[7] So far, over 115 cases of cervical VPAs have been reported worldwide; of these, only 9 metastases and 2 deaths were reported.^[7] Therefore, thyroid metastasis from VPA is an extremely rare case. The management of such patients is determined by the primary tumor type, the presence of other metastatic sites, the patient's symptoms, and the patient's performance status.^[1] Rarely, cervical adenocarcinoma can actually turn out to be a neuroendocrine tumor of the cervix, such as an atypical carcinoid, which was not in this case.^[8] Thus, patients presenting with unilateral swelling or palpable nodules in the thyroid and having a previous history of malignancy must be considered for metastatic disease. FNAC provides a quick, easy, and reliable way of provisional diagnosis.^[9] Confirmation of diagnosis is done by biopsy of the lesion and histopathological examination. Thyroid metastasis usually indicates a poor prognosis. Aggressive chemotherapy and radiotherapy can provide a much better quality of life in selected cases.

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