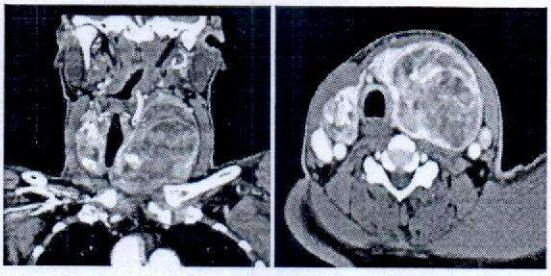
Department of Pathology

A 62 year old man came to OPD with chief complaint of swelling in front of the neck since 20 years.
History of Present Illness- Patient was apparently normal 20 years back, later developed swelling in front of neck, insidious in onset, gradually progressive and attained present size.
H/O weight loss present – approximately 20kgs in last 20years. H/O fever 10days back, low grade (4-5 episodes /day)
No H/o insomnia /tremors /dysphagia /dyspnea /hoarseness of voice /palpitations /diarrhea /constipation / burning micturition.
Past History- K/C/O Hypothyroidism -20years, K/C/O DM – 10years, K/C/O Hypertension – 5years.
Personal History- Mixed diet, normal sleep and appetite, normal bowel and bladder habits. Ex- Smoker, (stopped 20years ago), Ex- Alcoholic (stopped 20years ago)
Family History- mother- K/C/O hypothyroidism, for which thyroidectomy surgery was done. No details of HPE available.
Physical Examination- Patient is conscious, coherent and cooperative – well oriented with time, place and person. General condition: fair. Vitals- Temperature – 98.6F, Pulse: 86bpm, BP 130/80mmHg, Respiratory rate – 18/min, Spo2 – 98% @ room air.
Systemic Examination: No pallor /icterus /clubbing /cyanosis / lymphadenopathy /edema.
CVS – S1, S2 +;RS – B/L air entry +; P/A - soft, non-tender, bowel sounds heard; CNS – no focal neurological deficit
Local Examination - A butterfly shaped swelling of size 10x6cm noted anterior aspect of neck extending laterally up to posterior border of sternocleidomastoid, inferiorly up to suprasternal notch, above up to thyroid cartilage. Surface of swelling appears smooth. Skin over the swelling is normal. No scars / pigmentation / engorged veins/ sinuses / pulsations. No upward movement of swelling on protrusion of tongue. Swelling does not move with deglutition.
Palpation- No local rise of temperature, non-tender. Swelling is firm in consistency. Skin over the swelling is pinchable. Lower margin of swelling is visible. Swelling moves from side to side. No palpable thrill / pulsations.
Kocher's test, Berry's sign, Pemberton sign – Negative.
Percussion: Superior mediastinum is resonant.
Auscultation; No bruit heard.
Provisional Diagnosis: Thyroid swelling under evaluation.
Investigations: Hb-10.7gm/dl, TC-8800cells/mm^3, platelets-2.8lakhs,
T3-0.96ng/ml, T4-6.27ug/ml, TSH-0.29uIU/ml,
PTH- 112.2pg/ml, S.Calcium – 9.5mg/dl.
Ultrasound Neck- well defined hypo echoic nodule with peripheral calcifications and internal vascularity measuring 3.0x1.8cm seen in right lobe of thyroid-TIRADS-4. Suggested FNAC correlation. A hetero echoic lesion which is predominantly hyper echoic with few hypo echoic areas and calcifications seen replacing the left lobe of thyroid measuring 8.8x4.2cm. This is seen inferiorly extending up to the sternum- TIRADS-4. -Suggested FNAC correlation and CT-neck for retrosternal extension.
To consider possibility of multinodular goiter with few of them being colloid nodules and few of them appear hypo echoic and suspicious. Suggested FNAC from hypo echoic nodules.

CT -



Left lobe of thyroid gland is enlarged in size measuring 12.0 (SI) x 8.0 (T) x 6.4 (AP) cms with evidence of multiple nodules and hyper dense foci possibly calcifications. The left lobe of thyroid gland is seen extending from C3-D2 vertebral body level supero-inferiorly with retrosternal extension into superior mediastinum. On post contrast study the left lobe of thyroid gland with multiple nodules is showing heterogenous enhancement. Right lobe of thyroid is enlarged in size measuring 7.4 (SI) x 3.6 (AP) x 2.4 (T) cm with evidence of multiple nodules and hyper dense foci possibly calcifications.
Both lobes of thyroid gland are enlarged in size with evidence of multiple nodules, calcifications and heterogenous enhancement as described above. Left lobe of thyroid gland is showing retrosternal extension into superior mediastinum as described above .

Patient was readmitted in the hospital with the complaint of back pain.