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Primary and isolated thyroid Hodgkin's lymphoma: A case report

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ABSTRACT

INTRODUCTION: Hodgkin's lymphoma rarely involves the thyroid gland. It is typically presented as a fast growing neck mass that is sometimes accompanied by respiratory compression symptoms.
CASE REPORT: We report one of the few (the seventeenth) case of primary and isolated Hodgkin's thyroid lymphoma presented by a 65 years old man, consulting for a fast growing neck mass with Hodgkin's symptoms. The patient had total thyroidectomy and short courses of chemotherapy, then total resolution of symptomatology.
CONCLUSION: Most thyroid Hodgkin's lymphoma are presented by women, rarely man, isolated and primary. Since 1962, we only found sixteen cases described in the literature. Hodgkin's lymphoma should be considered in the differential diagnosis of patients with a thyroid mass for rapid management.

1. Introduction

Primary lymphoma of the thyroid gland is a rare tumour, with no clinical and paraclinical specificities, accounting for only 5% of thyroid malignancies and 2% of extranodal lymphomas [1]. Hodgkin's lymphoma rarely involves the thyroid gland.

The diagnosis is histological. Treatment is based on chemotherapy, monoclonal antibody and radiotherapy. The surgery must be avoided when the diagnosis can be obtained before or during the intervention, but thyroidectomy must be done and it is the main way to get healing in association with chemotherapy with or without radiotherapy. Only rare cases of Hodgkin's lymphoma presenting in the thyroid have been reported in the literature [2].

We report the case of a 65 years old man consulting in our ENT department, 20 August 1953 Hospital, Casablanca Morocco for primary and isolated thyroid Hodgkin's lymphoma.

This work has been written in accordance with the SCARE criteria [3].

2. Case report

We report the case of a (It is about) 65 years old man, living in Casablanca, Morocco, with no medical or surgical history, admitted in our ENT department for an anterior and medial cervical tumefaction, which started growing 8 months ago, rapidly increasing in volume without pain. The other symptoms were general pruritus, night sweats and fatigue, with no fever, no emaciation, no dyspnea, no dysphonia or thyroid gland disorder. There were no similar cases reported in the patient's family. The palpation found a hard tumefation, and no palpable cervical lymph nodes. The general physical examination didn't find any hepatomegaly, or splenomegalia or other clinically palpable lymphnods in the body. Blood count cells showed a disorder of lymphocytes that were slightly increased. Accelerated sedimentation rate. Cervical and thoracic CT scans were done showing a tissue mass of the right thyroid lobe dipping to the anterior and middle mediastinum. Thyroid fine needle aspiration was performed before thyroidectomy. It contained some atypical cells, raising the possibility of Hodgkin's lymphoma. A total thyroidectomy was decided. The patient was operated without incident, with a good postoperative warning, without dysphonia or dyspnea by trauma of the laryngeal recurrent nerves. The patient is under Levothyroxine sodium 100 μg per day. All the symptoms of the patient have completely disappeared after thyroidectomy. The histological study showed a scleronodular Hodgkin's lymphoma confirmed by the immunohistochemical study which bring out a strong and diffuse positivity of the tumor cells to the anti-CD-15 and anti-CD20 antibodies. It is classified I B (I for the involvement of a single lymph node region, so thyroid gland, and B for the presence of systemic symptoms).

The patient was refered to the haematology department for further treatments. The postoperative course was uneventful and the patient began chemotherapy treatment including four cycles of combined cyclophosphamide, doxorubicin, prednisone and vincristine. Finally, surgery and chemotherapy realized the stable cure

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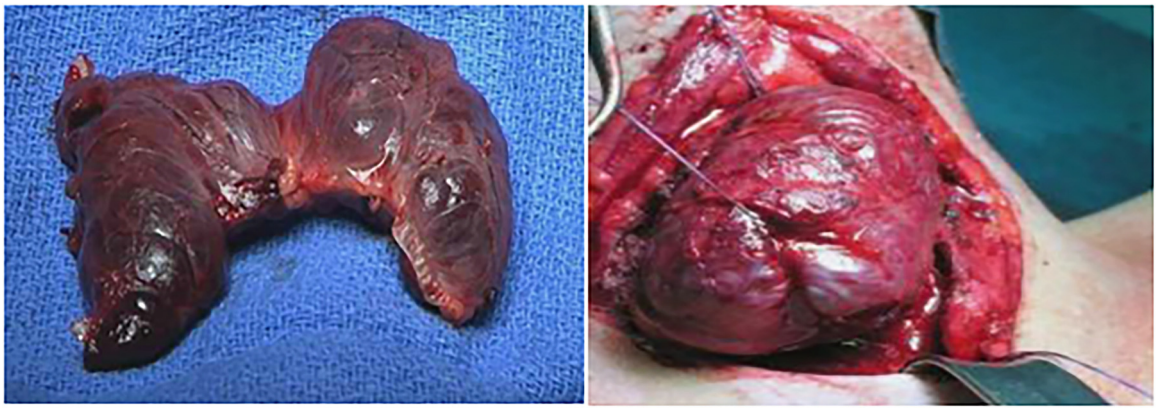

Fig. 1. XXX.

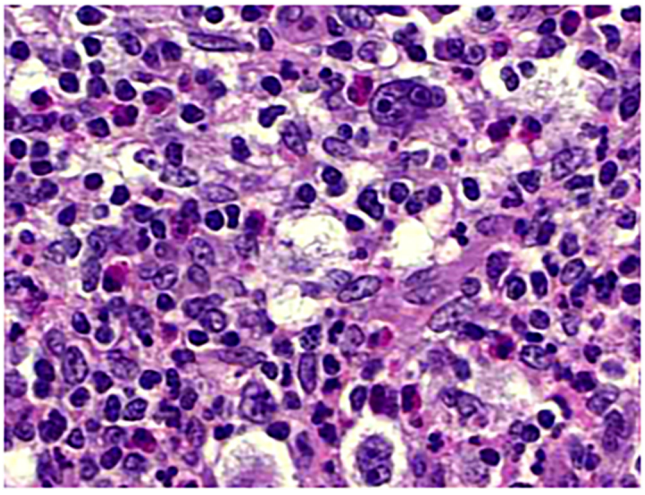

Fig. 2. XXX.

of the disease and the patient is alive after two years without recurrence or metastases (Figs. 1 and 2).

The ABVD (Dacarbazine, Bleomycin, Vinblastine and Doxorubicin) protocol was established, four courses were done. PET scan, cervicothoracoabdominopelvic scan is completely normal in postoperatory, and the blood count is balanced with a normal lymphocyte rate.

3. Discussion

Thyroid carcinoma is the most common endocrine malignancy however primary thyroid lymphoma (PTL) accounts from only 1–5% of all thyroid malignancies. B-cell type non-Hodgkin lymphoma (NHL) is a frequently described type of PTL, while Hodgkin's and T-cell lymphoma are rare [1]. Thyroid lymphoma typically presents with a rapidly enlarging neck mass leading to compressive symptoms [4]. However, primary thyroid lymphoma develops in only 0.5% of all cases of Hashimoto's thyroiditis [5]. Due to this underlying risk factor, primary thyroid lymphoma typically occurs more often in women than men (8:1) and usually later in life (sixth or seventh decade) [6].

In this study, it is about a man, which is making the case more interesting and rare.

And this patient present scleronodular Hodgkin's lymphoma and it is rarely described in the literature.

The lesion having an eventual history of Hashimoto's thyroiditis (HT) appears as a more or less rapidly enlarging anterior cervical mass associated or not with lymphadenopathy which in time add symptoms related to compression such as hoarseness, dyspnea and dysphagia. In our case, no known antecedent of thyroidite. Patients with a background history of chronic thyroiditis has a 67- to 80-fold greater risk factor to develop PTL than those without this inflammatory process [7].

Similar to other lymphomas, subtypes in thyroid lymphoma are classified according to histological and immunological features. The thyroid gland contains no native lymphoid tissue; intrathyroidal lymphoid tissue can develop in various pathological conditions, but most commonly occurs in the setting of autoimmune thyroiditis. This acquired lymphoid tissue bears a close resemblance to mucosa-associated lymphoid tissue and can evolve to an extranodal marginal zone B-cell lymphoma [8]. The development of extranodal marginal zone B-cell lymphoma in the thyroid gland is often characterized by an indolent course, but transformation to an aggressive lymphoma can also occur [8]. In contrast, any association between Hodgkin's lymphoma and underlying thyroiditis has been difficult to document because of the small number of cases.

A review of the English literature between 1962 and 2005 revealed 16 cases of thyroid Hodgkin's lymphoma, with a female preponderance and generally favourable outcome similar to our case [9], patients with Hodgkin's lymphoma commonly presented with a rapidly enlarging thyroid gland as our case, or a thyroid mass, similar to the presentation of non-Hodgkin's lymphoma of the thyroid. The mass may cause symptoms related to compression or infiltration of the surrounding neck organs. Symptoms reflecting airway or esophageal obstruction occurred in 9/16 of the previously reported cases, but this signs were not reported by the patient.

On physical examination, the thyroid mass was commonly described as being hard upon palpation (Table 1).

Ultrasonography is usually the first imaging modality performed in the evaluation of a thyroid mass. Previous studies have categorized ultrasound findings into three categories: diffuse, nodular or mixed. It has significant overlap with anaplastic thyroid cancer [10–12]. The presence of significant internal vascularity and absence of calcifications may be distinguishing features between thyroid lymphoma and anaplastic thyroid cancer on ultrasonography [13].

The diagnosis of Hodgkin thyroid lymphoma is often postponed by its prolonged indolent evolution which does not always appear clear. Although FNA has become the procedure of choice for the diagnosis of any thyroid tumor it has yielded mixed results asserting the presence of MALT so that core or open biopsy and even surgical excision (as in our case) is decisive for diagnosis [14].

Combined pathology and immunohistochemistry may specify microscopy of these lesions orienting therapeutic planning and predicting prognosis of the patients. [15]