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## A unique presentation of ectopic thyroid, a case report

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## ABSTRACT

**INTRODUCTION:** This case presents a painful ectopic thyroid, an unusual presentation, in an atypical location. The patient's history of an ingested fish bone, her acute presentation, and inconclusive imaging, made this case a diagnostic dilemma.

**PRESENTATION OF CASE:** 61-year-old female presented with acutely worsening history of left throat pain and dysphagia after swallowing a fish bone. CT scan showed a foreign body in the anterior wall of the cervical esophagus. EGD studies were inconclusive. Surgical exploration identified and excised a multinodular cystic lesion without connection to esophageal lumen. Pathology described multinodular thyroid parenchyma with chronic inflammation and no evidence of malignancy. No foreign body was located.

**DISCUSSION:** Based on the patient's history, imaging, and acute presentation, an esophageal perforation with abscess formation was the most likely diagnosis. Surgical exploration was the necessary intervention for this patient's acute symptoms as both a diagnostic and therapeutic tool. The diagnosis of ectopic thyroid tissue from pathology of the excised cystic lesion was unexpected, as the location of tissue and the painful presentation are not typical characteristics of ectopic thyroid tissue. Management of the this case illustrates the dilemma faced in determining the appropriate work up for a patient, without compromising the patient's safety.

**CONCLUSION:** Though painful presentation and this case's location are rare, ectopic thyroid tissue should be included in the differential diagnosis of point tenderness with an associated lesion on imaging.

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## 1. Introduction

Ectopic thyroid is the most common form of thyroid dysgenesis, but its presentation varies. Common presentations of ectopic thyroid include incidental, asymptomatic, functional hypothyroidism, and mass effect. This case presents a painful ectopic thyroid, an unusual presentation, in an atypical location. With the clinical background of the patient's subjective feeling of a fish bone stuck in her throat, her acute presentation, and inconclusive imaging, this case proved to be a diagnostic dilemma.

## 2. Presentation of case

A 61-year-old female from Myanmar presented with a two day history of left throat pain, tenderness, dysphagia and odynophagia that had acutely worsened. She swallowed a fish bone that she believed became lodged in her throat. Her acute left sided throat pain radiated to the left jaw. She had no prior history of dysphagia or odynophagia. She had no clinical signs or symptoms of hyperthyroid or hypothyroid disease and her review of systems was

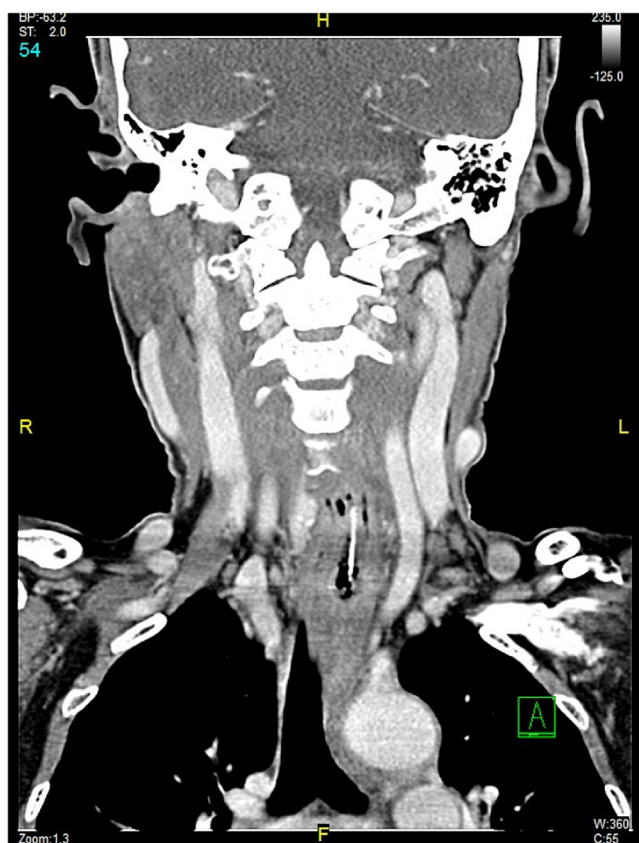
otherwise negative. There was no significant past medical history or surgeries, and no home medications. She did not drink, smoke, or use drugs. The patient's vitals were all within the normal limits, though she was visibly uncomfortable and in pain. Her neck was supple with a full range of motion. Left supraclavicular lymph nodes were tender to palpation, but not enlarged. There was pinpoint tenderness of the left neck medial to the sternocleidomastoid (SCM). No crepitus of the neck was appreciated. The remainder of the exam was normal. Her laboratory results were within normal limits except for leukocytosis of 13,100  $\mu$ L.

CT scan of the neck showed the presence of a radiopaque linear foreign body measuring 2.9 cm in length and 0.02 cm in width, located in the anterior wall of the cervical esophagus at the level of C6 to T1 with air surrounding the lesion. A periesophageal abscess post esophageal perforation was a likely explanation. An enlarged lymph node was seen adjacent to the left lobe of the thyroid. Fig. 1.

Multiple esophagogastroduodenoscopies (EGDs) were then performed to attempt to locate the foreign body and esophageal perforation. The first EGD showed slight, left lateral bulging of the esophagus, however, the remainder of the exam was normal and negative for foreign bodies. A repeat EGD with a neonatal scope found an umbilicated lesion 3 cm proximal to the upper esophageal sphincter. Both exams were inconclusive for the presence of a foreign body, but a periesophageal abscess seemed likely.

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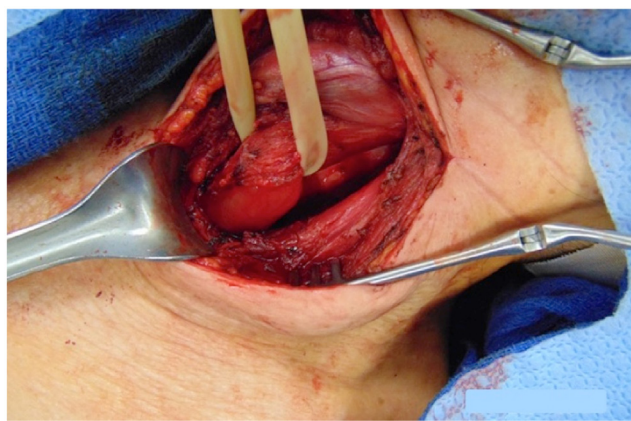


**Fig. 1.** CT Scan of neck with contrast showing the radiopaque foreign body involving the cervical esophagus.

The decision was made not to obtain a gastrografin study due to the acute nature of the patient's increased pain and point tenderness, as well as the likelihood of a periesophageal abscess. A periesophageal abscess creating point tenderness, dysphagia, and odynophagia would need acute intervention. Exploratory laparotomy would serve this patient both diagnostically and therapeutically. At this point, the differential diagnosis included a periesophageal abscess secondary to esophageal perforation, an ingested fish bone embedded within the wall of the esophagus, inflamed ectopic thyroid tissue, or malignancy.

Surgical exploration of the esophagus revealed a multinodular cystic lesion located on the anterior lateral cervical esophagus. The mass was freed from the esophageal adventitia without difficulty. There was no sign of a connection to the esophageal lumen indicating esophageal perforation. **Fig. 2.** A lymph node over the anterior aspect of the cervical esophagus was also removed. The thyroid appeared normal. No foreign body was located. After removing the mass, the esophagus was clamped distally and contrast was introduced intraoperatively. There was no extravasation from the esophagus under fluoroscopy. **Fig. 3.** The day after surgery, she received another barium swallow study before discharge with no extravasation identified. **Fig. 4.**

The lesion was reported to be multinodular thyroid parenchyma with chronic inflammation and no evidence of malignancy. **Fig. 5.** No foreign body was located. The lymph node was a reactive lymph node without evidence of malignancy. Due to the chronic inflammation described in the pathology report, the radiopaque finding on CT scan was most likely calcifications from the chronic inflammation.



**Fig. 2.** Smooth esophagus after removal of cystic lesion. No connection to the esophageal lumen is present.



**Fig. 3.** Multinodular cystic mass after surgical removal.

The patient's pain was immediately relieved after surgery and she went home the following day. She followed up in the outpatient setting and had no complaints (**Fig. 6**).

### 3. Discussion

This case was diagnostically challenging. The acute nature of the patient's presentation and potential for esophageal perforation with abscess formation forced the need for exploratory laparotomy. The diagnosis of ectopic thyroid tissue was surprising, as it was not high on the differential. Time was not devoted to a complete thyroid work up, as delay in the treatment of what was originally thought to be an esophageal perforation with abscess formation could have been harmful to the patient.

Ingested fish bones are one of the most common foreign bodies to become embedded in the esophagus, leading to esophageal perforations and abscesses [1]. The fish bones usually pass through the esophagus without incident [2,3], but if a bone is caught in the esophagus, the cervical esophagus or the thoracic esophagus around the aortic arch are the most common locations [3]. These foreign bodies are not typically visible on EGD and CT scans are considered the most sensitive modality for diagnosis. This case demonstrated these characteristics, as the EGDs were negative for foreign body location and the CT scan demonstrated a lesion in the shape of a thin fish bone. These findings together with the patient's history and acute presentation made esophageal perforation with

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