Original Research Paper

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General Surgery

A RARE CASE OF PRIMARY LYMPHOMA OF THYROID

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ABSTRACT Primary thyroid lymphoma is incredibly rare with an annual incidence of approximately 2.1 per million persons, accounting for 2 % of thyroid malignancies.1 Mostly affecting middle to old aged females2.The importance of recognizing primary thyroid lymphoma lies in the fact that this disease is quite curable without the need for extensive surgery if recognized early.

KEYWORDS : Primary thyroid lymphoma, Non-Hodgkin's lymphoma , Chemotherepy .

INTRODUCTION

Primary thyroid lymphoma is an uncommon thyroid malignancy. Frequently it is accompanied by Hashimoto's thyroiditis. Discrimination between primary and secondary lymphoma is important due to variations in diagnostic tools, treatment modalities and prognosis. If Consequent respiratory disturbances and decreased venous reflow from the head and neck (superior vena cava syndrome) is present, requires early diagnosis and immediate treatment.[4]Surgery, chemotherapy, radiotherapy or combinations of these modalities may be applied in treatment.[5]

Case Report

A 55 year, old male presented with history of noticing swelling in neck, hoarseness of voice and weight loss since 1 month. There is no history of any known thyroid disorder, past history of cervical irradiation or family history of thyroid cancer.

On examination: Midline swelling measuring 18×14 cm involving right lobe of thyroid, hard, irregular margins, irregular surface ,did not move with deglutination, was fixed to right sternocleidomastoid. Berry's sign was positive. There was no retrosternal extension. No thrill or bruit.

Laboratory test showed decreased TFTS, cervical ultrasound revealed enlarged right lobe of thyroid. Left lobe, isthmus was normal .No other lymph-node was present.

Xray soft tissue neck showed tracheal deviation to left side.

CT neck with thorax: suggestive of large mass arising from right lobe of thyroid encasing right common carotid artery causing luminal narrowing. Right sternocleidomastoid muscle infiltration was seen. Mass was also seen to invade glottis/Supraglottic region, rest thyroid was normal. His USG guided FNAC was suggestive of Non-Hodgkin's lymphoma.

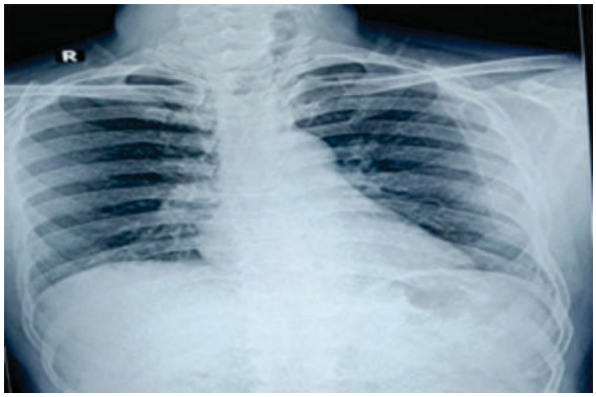

Figure 1. Image Showing Tracheal Shift To Left.

After diagnosis ,thyroxin supplementation, chemotherapy (CHOP regimen) was given to the patient after follow-up.

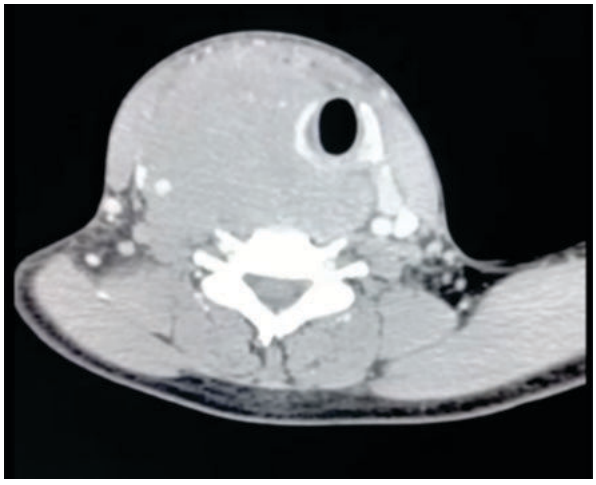

Figure 2: Image Showing Large Thyroid Mass.

After diagnosis, thyroxin supplementation, chemotherapy (R-CHOP regimen) was given to the patient.

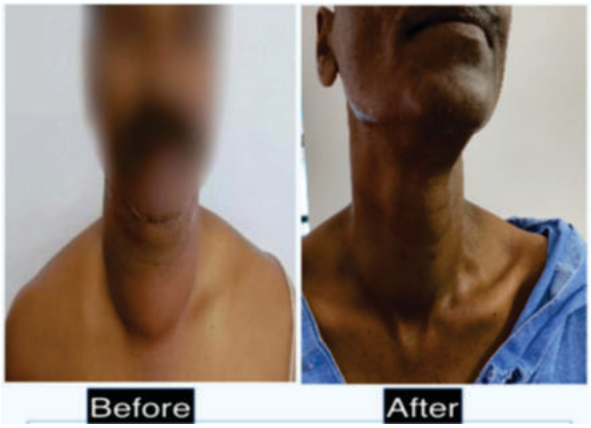

Figure 3: Image Showing Size Of Swelling Before And After Chemotherapy.

DISCUSSION

The Clinical and pathological spectrum of lymphoproliferative disorders affecting thyroid is different and should be differentiated from benign thyroiditis and carcinoma. Thyroid lymphomas are rare entities that possess a real diagnostic challenge. The clinical

presentations include an enlarging neck mass, but patients may also present with symptoms of dysphagia, hoarseness of voice, breathlessness and choking or a thyroid nodule.[6]

Most PTL are non-Hodgkin's lymphomas. It is clinically important to discriminate between primary or secondary lymphomas of the thyroid as the treatment and prognosis differ significantly.

The secondary lymphoma of the thyroid invariably is a widespread disease and the mortality rate is higher, as opposed to primary thyroid lymphoma in early stages.[3]

CONCLUSION

Primary thyroid lymphoma is a rare lymphoproliferative condition of thyroid gland. Another important differential diagnosis of Non-Hodgkin's lymphoma thyroid is anaplastic carcinoma and can easily be diagnosed on fine needle aspiration so that a timely intervention can be undertaken. Chemotherepy is the main stay of treatment.

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