Papillary thyroid carcinoma manifesting as an autonomously functioning thyroid nodule

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Thyroid hot nodule usually suggests benign tumor, and less than 1% of all cases have been reported as malignant. The case we’d like to present here is a 58-year-old woman who visited hospital for 5kg of weight loss during the last 6 months. TFT revealed as, TSH 0.006 μIU/mL, fT4 2.91 ng/mL, T3 2.77 ng/mL and thyroid autoantibody were normal range. 99mTc thyroid scintigraphy showed 2x2cm sized hyperactive hot nodule at left thyroid lobe, and it was treated with radioactive Iodine with dose of 10mCi 131I. Despite of the therapy, TFT didn’t show any improvement for 6 months. And thyroid ultrasonography showed 1.7x1.8 cm sized hypoechoic nodule. On fine needle aspiration biopsy, the thyroid nodule revealed papillary thyroid cancer. The patient underwent total thyroidectomy and pathologically confirmed papillary carcinoma. We suggest that although clinical feature and thyroid scan present benign thyroid nodule, the possibility of malignant hyperfunctioning thyroid carcinoma should not be totally ruled out. Malignant thyroid hot nodule is rare however the possibility of it should be taken into account when diagnosing the case because treatment and prognosis is different from benign one. Therefore, we suggest that ruling out malignancy simply by existing diagnostic guideline can be inappropriate even in the case of typical representing case of benign feature. In recent years thyroid nodule detection is getting sensitive and accurate, we present this case to discuss whether the additional diagnostic approach will be necessary for thyroid nodule.

A Case of Graves’ Disease Followed by Painless Thyroiditis

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Painless thyroiditis has a clinical course of thyroid dysfunction. Initially, patient show signs of thyrotoxic phase, passing through euthyroidism to hypothyroidism and finally returning to euthyroidism. The thyrotoxicosis in this disorder is different from that of Graves’ disease. It is induced by the aggravation of Hashimoto’s thyroiditis or autoimmune thyroiditis and parturition is well known as the triggering factor. On the other hand, Graves’ thyrotoxicosis is induced by thyroid stimulating antibodies. Here we report a case of Graves’ disease followed by painless thyroiditis. A thirty-year-old men was admitted because of fatigue, palpitation. Initially, the TFT was revealed as, TSH 0.005 μIU/mL, free T4 2.89 ng/mL, T3 2.33 ng/mL and thyroid autoantibody was revealed Anti-TPO 5.42 IU/mL, Anti-TG 15.66 IU/mL, TSI 12.6%. 131I thyroid iodine scan showed low radioactive iodine uptake. He was treated for painless thyroiditis about 4 months, but his thyroid function was still thyrotoxic state. Follow up TFT was showed as, TSH 0.007 μIU/mL, free T4 4.97 ng/mL, T3 3.62 ng/mL and thyroid autoantibody was showed Anti-TPO 16.67 IU/mL, Anti-TG 14.59 IU/mL, TSI 22.1%. We performed follow up 131I thyroid iodine scan showed high radioactive iodine uptake. So, we treated as Graves’ disease with methimazole and propranolol. Painless thyroiditis often relapses but rarely develops into Graves’ disease. This is a rare case in which painless thyroiditis was followed by Graves’ disease.