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A 78-Year-Old Man With Historical Goiter

Amel Ait Boudaoud,[1,3] Claire Rives-Lange,[1,3] Alina Radu,[1] François Rubin,[2,3] Claire Carette,[1,3] Charles Barsamian,[1] and Sebastien Czernichow[1,3]

[1]Diabetology, Endocrinology and Nutrition Department, Hospital European Georges Pompidou (AP-HP), 75015 Paris, France; [2]Otorinolaryngology and Surgery Department, Hospital European Georges Pompidou (AP-HP), 75015 Paris, France; and [3]University Paris V Descartes, 75006 Paris, France

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We report the case of a 78-year-old man with historical goiter. The patient's medical history included recurrent phlebitis treated with fluindione and untreated hypertension. He had been retired from public service since 2001. He was single, without children, and suffered from severe social isolation.

His goiter was first diagnosed in 2003, with the initial thyroid ultrasound describing a multinodular goiter; the right lobe was measured 69 × 18 × 15 mm (10 mL) and the left measured 55 × 45 × 38 mm (50 mL). The total goiter volume assessed was underestimated because the intrathoracic part could not be measured using ultrasound. There was a voluminous nodule 45 × 35 × 50 mm thyroid nodule imaging reporting and data system 4B on the left lobe. Surgery was proposed in 2005 but refused by the patient because he did not want to be dependent on thyroid medication for life, despite the insistence of his doctor. He was hospitalized several times, notably in July 2016 because of local bleeding following an excess of fluindione use.

The physical examination revealed a giant goiter, especially in the left cervicothoracic region. The mass was mobile in deep zones, where hard lumps could be felt. There were also numerous swollen cervical lymph nodes. The goiter extended from the thoracic cervical region to the border of the upper mandible. The skin was fistulized and there was minimal bleeding. There were signs of local compression with dysphonia, respiratory distress, and superior vena cava syndrome with collateral venous circulation (Figs. 1, 2). The rest of the clinical examination revealed asthenia, slow movement, and weight loss, but no sign of heart failure. The cervicothoracic region was distorted by the goiter. Serum thyrotropin was 20 mU/L, free thyroxine level was normal, and markers of autoimmunity (anti-thyroperoxidase and anti-thyroglobulin antibody) were negative. Computed tomography scans revealed a giant cervicothoracic goiter unmeasurable with voluminous bilateral confluent cervical adenopathy. Most lymph nodes were necrotic and were more swollen on the left, generating a mass effect on the laryngeal cavity and causing severe narrowing of the laryngeal and tracheal lumen (Fig. 3).

Pathology studies of biopsies were noncontributory because they were difficult to interpret as a result of abundant necrosis; the rare nonnecrotic territories included connective tissue with nonspecific inflammatory changes. The anti-AE1/AE3 histochemical antibody study revealed no carcinomatous cells in the biopsy tissues.

Treatment with levothyroxine 50 μg was started after a long negotiation with the patient. A psychiatric evaluation concluded that the patient probably had chronic delusional disorder with Ekbom syndrome. The patient was also reluctant to take antipsychotropic medication.

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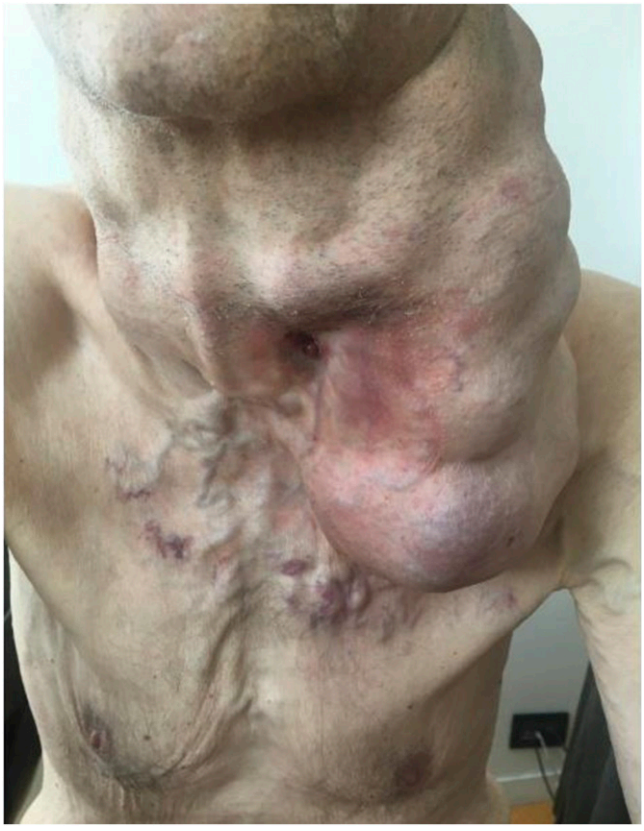

Figure 1. Giant goiter extending from the thoracic cervical region to the border of the upper mandible. The skin was fistulized and showed local signs of compression with superior vena cava syndrome with collateral venous circulation.

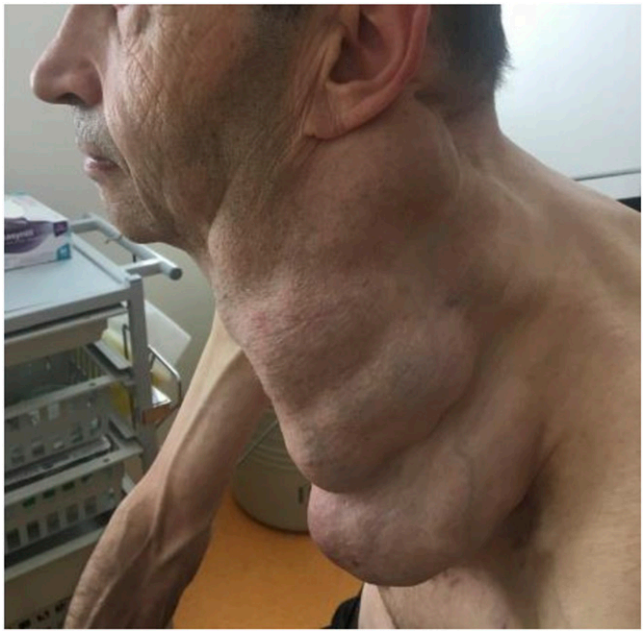

Figure 2. Lateral view of a goiter predominant in the left cervicothoracic region.

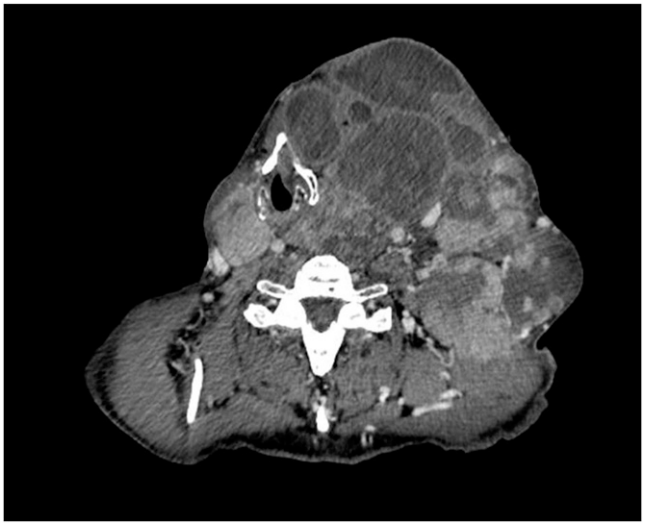

Figure 3. Computed tomography of giant cervicothoracic goiter unmeasurable with voluminous bilateral confluent cervical adenopathy generating a mass effect on the laryngeal cavity and causing severe narrowing of the laryngeal and tracheal lumen.

Acknowledgments

Correspondence: Amel Ait Boudaoud, MD, Diabetology, Endocrinology and Nutrition Department, Hospital European Georges Pompidou (AP-HP), 20 Rue Leblanc, 75015 Paris, France. E-mail: amel.ait-boudaoud@aphp.fr.

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