Ectopic lingual thyroid

Sir,

We read with great interest your article entitled "A rare case of lingual thyroid with hyperthyroidism: A case report and review of the literature" by Jacob, *et al.*[1] the issue of May-June 2012. We would be happy to make our modest contribution in the light of our humble experience. The literature review confirms the rarity of thyroid ectopy and the exceptional character of the association of this abnormal embryogenesis with hyperthyroidism.[2,3]

The ectopic thyroid is the presence of thyroid tissue outside its normal seat secondarily to defective migration of thyroid diverticulum and whose pathogenesis is not fully elucidated. Clinical symptoms are variable from asymptomatic to complicated forms such as dyspnoea, dysphagia. Degeneration is exceptional. The patient may be euthyroid or hypothyroid or exceptionally hyperthyroid. Diagnosis uses 99m-Tc or 123-I thyroid scan which confirms the thyroid tissue, cervical computed tomography or magnetic resonance imaging or doppler. Simple monitoring is recommended in the case of euthyroidism, a hormone replacement therapy in the case of hypothyroidism, and antithyroid drugs, surgery, or radioiodine in the case of hyperthyroidism.

We had to take a child for a double localization, orthotopic, and ectopic lingual position of the thyroid gland with hypothyroidism which responded favorably to Levothyroxine treatment and no surgery was recommended. Moreover, Terris[4] in his work entitled "A new minimally invasive thyroidectomy lingual technique" has reported a case of lingual thyroid ectopy in a patient of 34 years, with dysphagia, who responded favorably to minimally invasive surgical treatment.

In the case reported by Jacob, *et al.*,[1] the patient was in hyperthyroidism, which is, as reported by the author, an exceptional situation. The risks of surgery, namely the risk of bleeding and intubation, led the authors advocate radioiodine preceded by a medical preparation by antithyroid drugs. Regarding the therapeutic component, we adhere to the recommended course of action. In fact, it is very risky to operate this patient because, indeed, there is a hypervascular thyroid mass and hemostasis is difficult to achieve since it is the lingual artery to be ligated on both sides which can cause necrosis of the tongue. However, with regard to intubation, in our humble opinion, there is no indication against because there is the possibility of intubation by using nasal endoscope or tracheostomy under local anesthesia. We believe that the authors have opted for short-term safety and they were right to do so but the risk of degeneration is always present and the possibility of hyperthyroidism recurrence will always be present with multiple risks including increased size of the gland with its mechanical complications. Overall, despite its rarity, the management of ectopic lingual thyroid is a challenge and must be individualized for each patient.

Amani Mohammed El Amine, Chikh Kamel[1]

Departments of Endocrine and Diabetes, and [1]Ear, Nose and Throat, EHU, Oran, Algeria

Corresponding Author: Dr. Amani Mohammed El Amine, Department of Endocrine and Diabetes, EHU, BP 4166 Ibn Rochd Oran, Algeria.
E-mail: medamine11@gmail.com

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