

## Letters

### AN UNUSUAL PRESENTATION OF RECURRENT FOLLICULAR THYROID CARCINOMA

Editor,

Around 1500 new cases of thyroid cancer are diagnosed each year in the United Kingdom, being responsible for around 320 deaths annually<sup>1</sup>. Detecting recurrent thyroid carcinoma is important for the speedy imposition of treatment regimens, but occasionally detecting subsequent disease can be problematic. Bone is the commonest site for distant thyroid carcinoma metastases<sup>2</sup>, but other sites such as the parapharyngeal space<sup>3</sup> are not unknown. We describe the case of a patient presenting with recurrent follicular thyroid carcinoma following total thyroidectomy in which bilateral internal jugular vein thrombosis, in association with a right jugulodigastric mass were the main features. We believe that this is the first such report of a recurrent follicular carcinoma of the thyroid presenting in this manner.

**Case Report:** A 39 year old Caucasian lady presented with a large anterior midline mass and hoarseness due to left vocal cord palsy. Due to airway difficulties a surgical tracheostomy was performed, at which time biopsy was taken. Histology reported a poorly differentiated follicular cell carcinoma of the thyroid, CT scan demonstrating masses in both lobes of the thyroid, but no metastatic spread.

Total thyroidectomy was performed followed by thyroid ablation therapy with radioactive iodine. Fourteen months following thyroidectomy the patient was readmitted to hospital with a diffuse red tender right sided neck swelling centred over the jugulodigastric area. Fibreoptic nasendoscopy was unremarkable. Both her inflammatory markers and white cell count were found to be raised, and intravenous antibiotics were commenced. A CT of the neck was performed, which demonstrated extensive bilateral thrombosis of the internal jugular veins, the left displaying intracranial extension involving the sigmoid sinus. An ultrasound scan revealed changes suggestive of right sided parotiditis, but an MRI added nothing new. With no recurrence of tumour found investigations for other causes of thrombosis were undertaken, but were all negative. Fine needle aspiration cytology of the mass was unhelpful.

Subsequently the patient developed dysphagia, dysarthria, and bilateral impairment of cranial nerves IX, X and XII. Ultrasound scan of the liver, and bone marrow biopsy were undertaken and found to be unremarkable. A PET scan was performed, but highlighted nothing other than the right sided neck lump. An incision biopsy of the right sided neck lump was undertaken, the histology revealing a poorly differentiated necrotic carcinoma similar in appearance to the follicular thyroid carcinoma previously excised. Her condition deteriorated and she died shortly after.

**Discussion:** Diagnosing recurrent thyroid carcinoma following attempted curative surgery is of paramount importance in order to institute the correct treatment as soon as possible. Recurrence of thyroid carcinomas can be difficult to detect, and while thrombosis of jugular veins has

been described as a feature of papillary thyroid carcinomas<sup>4</sup>, we believe this is the first description of this occurring with a follicular thyroid carcinoma. Some authors have postulated that thyroid carcinomas may result in a hypercoagulable state<sup>5</sup> and we hope that this report highlights the importance of ruling out recurrence of follicular thyroid carcinoma as a cause of unexplained thrombosis in a patient which has previously undergone curative surgery.

No conflict of interest declared.

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### SUCCESSFUL ENDOSCOPIC MANAGEMENT OF FRACTURED DORMIA BASKET DURING ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY FOR CHOLEDOCHOLITHIASIS

Editor,

Endoscopic retrograde cholangiopancreatography (ERCP) is a valuable tool in pancreaticobiliary evaluation and treatment. ERCP has become the mainstay in the treatment of choledocholithiasis through sphincterotomy and trawl of the common bile duct with either a balloon or a metal basket being used to retrieve stones. Complications of ERCP and sphincterotomy have been reported to occur in five to ten per cent of cases<sup>1-3</sup>, and range from minor bleeding to severe pancreatitis. We report an unusual complication of ERCP with basket fracture and retention followed by recovery of the retained basket at second ERCP.

**Case report:** A 61-year-old gentleman presented with a 10-day history of nausea, right upper quadrant discomfort, dark urine and pale stools. He had a past medical history of ischaemic heart disease and peptic ulcer disease. There was no history of liver disease or gallstones and no risk factors for jaundice. On examination he was afebrile, icteric and was mildly tender in the right upper quadrant without rebound or



Fig 1. ERCP image of stone engaged in Dormia basket.

guarding. There were no stigmata of chronic liver disease. Initial blood investigations showed Hb 13.4G/dl, WCC 6.34 THOUS/uL, Bilirubin 175umol/l, AST 164 U/L, GGT 603 U/L, ALP 215 U/L. Urea, electrolytes and albumin were within normal limits. Ultrasound scan (USS) of abdomen was performed the day following admission and showed a calculus within the lower common bile duct (CBD). The CBD and intrahepatic ducts were dilated.

As a result of these findings, an ERCP was arranged. ERCP was carried out 4 days following admission. Technique of conscious sedation was employed using midazolam and



Fig 2. Videofluoroscopy image showing contrast in duodenum and fractured basket fragment in CBD.



Fig 3. ERCP image of basket fragment engaged in second Dormia basket.

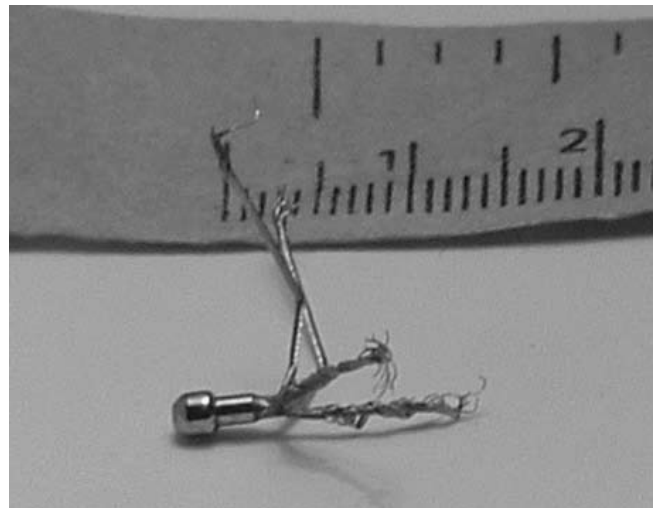


Fig 4. Fragment of fractured basket removed from CBD.

pethidine. Midazolam was titrated to 7mgs and pethidine titrated to 50mgs. Despite this the patient remained agitated throughout the procedure.

Findings were as follows: Ampulla was normal. Pancreatic duct was normal. CBD was dilated to 10-12mm. A single CBD stone approximately 8mm in diameter was present.

An 8mm sphincterotomy was performed. A Dormia basket was placed around the stone. The stone was successfully engaged into the basket (fig.1) but the basket could not be pulled through the ampulla. Subsequently, crushing of the CBD stone with the external lithotripter was attempted. However the patient became extremely agitated and lithotripsy had to be terminated. The end of the impacted basket was cut, the polyethylene sheath was removed and the endoscope withdrawn. It was noted that a portion of the wire had fractured off. The endoscope could not be passed back into the stomach due to the patient's ongoing agitation and the procedure was abandoned.

There was a strong clinical suspicion of retained basket

fragments and the patient was commenced on IV ciprofloxacin. Repeat fluoroscopy with oral contrast confirmed retained basket in the CBD (fig 2).

A second ERCP under general anaesthetic was performed. Cholangiogram demonstrated single calculus which was removed along with the retained fragment of basket (see fig 3). The remaining metal fragment was grasped with a further Dormia basket and removed (fig 4). The patient had no complications post-ERCP and is currently awaiting laparoscopic cholecystectomy.

Discussion: Traction wire or basket fracture, often following stone impaction, is an unusual complication of ERCP and in the past has been managed surgically<sup>4</sup>. Biliary stenting leads to increased risk of cholangitis by disrupting sphincter of Oddi function<sup>5</sup>. Retained metal fragments are likely to similarly disrupt sphincter of Oddi function with subsequent high risk of cholangitis.

Conclusion: We have demonstrated successful medical management of basket fracture with intravenous antibiotics and repeat ERCP facilitating endoscopic removal of the retained fragment. In experienced endoscopic teams this should be considered as an alternative to surgery.

No conflict of interest declared.

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#### APPENDICECTOMY COMPLICATED BY ADDISON'S DISEASE

Editor,

Acute appendicitis is the most common surgical emergency. We describe a case in which

a young man underwent appendicectomy but had a complicated postoperative recovery

requiring admission to ICU.

**Case report:** A 33 year old male presented with a fifteen-hour history of vomiting, diarrhoea, and lower abdominal pain one week after a holiday in Portugal. He had no significant past medical history. On examination he had a tanned appearance, and was tender with guarding and rebound in the right iliac fossa. Rovsing's sign was positive. He proceeded to theatre where the operative findings and subsequent histology confirmed the diagnosis of acute appendicitis.

Over the next 24 hours he had persisting pyrexia and became tachycardic and hypotensive. Examination revealed decreased chest air entry bilaterally and abdominal distension. C reactive protein was increased to 369ug/L, from 5.0ug/L on admission. Electrolyte profile confirmed hyponatraemia. Arterial blood gas sampling showed a metabolic acidosis. He was thought to be septic. The following morning a CT scan of chest and abdomen showed, bilateral pleural effusions with collapse at both lung bases. There was free fluid in the abdomen with dilatation of the small bowel throughout its length. He was thought to have a postoperative ileus, but an atypical pneumonia was also considered.

He was transferred to ICU. Over the next 24 hours the abdominal distention increased and in view of this he returned to theatre. At laparotomy, an inflammatory mass was found in the caecum and terminal ileum, causing small bowel obstruction. A limited right hemicolectomy was done. His general postoperative condition remained poor.

Further discussions with the family revealed that the patient had been of a tanned appearance since he had returned from holiday in a hot climate 10 years previous. The tanned appearance, hyponatraemia, and polyuria raised the possibility of adrenal insufficiency and a Synacthen® test was undertaken. This suggested Addison's disease. Treatment with intravenous hydrocortisone and fludrocortisone lead to an immediate clinical improvement. He was discharged home well five days later.

**Discussion:** The diagnosis of Addison's disease and then Addisonian crisis in a postoperative patient is one which is fraught with difficulty. Virtually all the signs mimic other more common conditions like post-operative ileus or sepsis. A literature review indicates that these would seem to be the most widely considered initial diagnosis<sup>1</sup>. It has been calculated that some degree of unsuspected adrenal insufficiency is present in up to 1 in 1000 surgical admissions<sup>2</sup>, and surgeons should consider this condition when a postoperative patient fails to recover as expected. Abdominal pain as the primary complaint occurs in about 10% although a generalised gastrointestinal upset is much more common. Severe abdominal pain with tenderness mimicking peritonitis is thought to occur in about 7% of cases<sup>2</sup>.

Primary adrenocortical failure is usually due to an autoimmune mediated destruction of the adrenal gland which accounts for around 90% of cases. Females are affected two to three times more frequently than males and there is an association with other endocrine deficiencies such as thyroid disease, premature gonadal failure (usually ovarian failure) and type I diabetes<sup>2</sup>.

The patient should be treated in the Intensive Care Unit with