

LETTER TO THE EDITOR

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Puzzling Persistent Anterior Cervical Pain: to Be or Not to Be?

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Dear Editor,

It is obvious to take note of the changes that have occurred in the field of Thyroidology and Thyroid Pathology during the past 50-years. The most significant and “newsworthy” innovations have occurred during the past 10-years in diagnostic and management paradigms in Thyroidology.¹⁻⁵ Herein, a 49-year-old female, was admitted to an outside clinic with her complaints of chilling, fever, cervical tenderness, and a significant odynophagia on September 6, 2017. Her laboratory findings were detected as white blood count (WBC), $10,2 \times 10^3/\mu\text{L}$; neutrophil, $7,07 \times 10^3/\mu\text{L}$ ↑; lymphocyte, $4,13 \times 10^3/\mu\text{L}$ ↑; monocyte, $1,06 \times 10^3/\mu\text{L}$ ↑; eosinophil, $0,31 \times 10^3/\mu\text{L}$; C-reactive protein (CRP), 24,95 mg/dl↑; thyroid-stimulating hormone (TSH), 0,023 uU/mL↓; free thyroxine (fT4), 3,26 ng/dL↑; and free triiodothyronine (fT3), 7,23 pg/mL on the same day of admission and medical treatment for upper respiratory infection was administrated for her. Afterward, she underwent a methylprednisolone treatment, additionally. However, her complaints proceeded and some annoying episodes of tachycardia appeared. Then, her laboratory findings were reported as WBC, 11.140↑; TSH, 0,014 uU/mL↓; fT4, 2,03 ng/dL↑; and fT3, 2,54 pg/mL on September 18, 2017. She was admitted to our department with her ongoing signs and symptoms on September 20, 2017. As such, she had a history of rheumatoid arthritis and hypertension. The laboratory findings of our vignette case were detected as WBC, $7,51 \times 10^3/\mu\text{L}$; neutrophil, $4,49 \times 10^3/\mu\text{L}$; lymphocyte, $2,38 \times 10^3/\mu\text{L}$; monocyte, $0,5 \times 10^3/\mu\text{L}$; eosinophil, $0,08 \times 10^3/\mu\text{L}$; CRP, 13,00 mg/dl↑; erythrocyte sedimentation rate, 23,0 mm/s↑; TSH, 0.026 uU/mL↓; fT4, 1,70 ng/dL; fT3, 2,52 pg/mL; thyroglobulin (Tg), 4,34 ng/mL; anti-Tg, 442,3 IU/mL↑; anti-thyroid peroxidase, 18,8 IU/mL; while a left shift in her peripheral blood was recognized. A patchy hypoechoic lesion in her enlarged right thyroid lobe with the bilateral multiple reactive cervical lymph nodes was observed in the bedside neck ultrasonography. Of note, a normal radioactive iodine uptake with radioisotope, ¹³¹I iodide was stated. To this end, her TSH-receptor antibody was reported as 0.3<IU/L and she was hospitalized by the cessation of the methylprednisolone, administrated by the previous outside clinic to start her relevant medical therapy and procedures.

What is the most likely diagnosis at this stage for the mentioned challenging condition at this stage? The answer is acute suppurative thyroiditis. Last but not least, our comments as keynotes for these kinds of situations that seem contradictory are as follows; *i*) Subacute granulomatous thyroiditis (SGT), intranodular/intracystic hemorrhagia, malignities, including lymphoma, radiation thyroiditis, and primary and secondary thyroid amyloidosis constitute the differential diagnoses of acute suppurative thyroiditis (AST); *ii*) Of note, AST is a sudden initiating disease, unlike SGT, possessing a lower pain curve and the others, retaining a clinical pain without exhibiting infectious symptoms; *iii*) SGT has ipsi-/bilateral gland enlargement while AST has one-sided suppuration; *iv*) A transient increase in T3 and T4 may be seen in AST, as such, the presence of thyrotoxicosis can not eliminate AST as a preliminary diagnosis; and *v*) Herewith, SGT has a minimal RAIU, while AST has a normal value.

Keywords: Thyroid; Thyroiditis; Cervical pain; Acute; Suppurative.

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