focus of thyroid papillary microcarcinoma (1.6 mm) limited to thyroid with negative margins. Post-operatively, she continued regular follow up and active surveillance of hormonal levels with the Endocrinology service. **Discussion:** It has been estimated that 2 - 15% of patients with primary hyperparathyroidism have concomitant papillary thyroid cancer, most of which are microcarcinomas. Microcarcinoma is defined as a focus of thyroid cancer < 1 cm in size. Previously, microcarcinomas were treated aggressively with thyroidectomy. However, this topic has recently stirred much discussion and debate amongst experts. Current data suggests that microcarcinomas can be managed equally well with either immediate surgical excision or active surveillance. A retrospective study concluded that roughly 10% of papillary thyroid microcarcinoma exhibited progressive clinical course while less than 1% resulted in mortality. Therefore, there is a pressing need to raise awareness about this topic and educate both the medical as well as general community regarding treatment options and bring to attention that active surveillance under the guidance of an expert, although underutilized, is an effective strategy, with excellent outcomes.

Presentation: No date and time listed

Abstract citation ID: bvac150.1627

Thyroid

ODP528

Unwrapping The Mystery in a Hormonal Sandwich - Intra-thyroid Parathyroid with Thyroid Papillary Microcarcinoma

Gunjan Arora, MD, Toral Patel, MD, and Faisal Qureshi, MD

Case presentation: A 60-year-old female with Bipolar disorder (discontinued Lithium > 15 years prior), primary hyperparathyroidism and thyroid nodules (largest ~2 cm) presented to the Endocrinologist for regular follow-up. She had previously not met the criteria for surgical intervention for hyperparathyroidism. Moreover, thyroid nodules were stable - TSH remained within the normal range and FNA-guided biopsy was negative for malignancy. Recently, however, she was noted to have rising serum calcium levels - peak of 11.5 mg/dL (8.6 - 10.3 mg/dL) in conjunction with elevated PTH 150 pg/mL (12 - 88 pg/mL). Localization studies revealed an unusual picture - with the parathyroid ultrasound showing a possible right inferior location while the sestamibi scan pointing to a possible left inferior area. Preoperative thyroid ultrasound showed findings consistent with multinodular goiter. In light of these results, bilateral neck dissection with parathyroidectomy was recommended. Intra-operatively, two left sided parathyroid glands each approximately 100 mg were excised in addition to a larger ~700 mg right sided gland. However, the right inferior gland could not be located. The right thyroid lobe was noted to have a whitish, firm nodule and was excised. Final pathology report showed three gland parathyroid hyperplasia (two left inferior and one right superior) and tissue extracted from the right thyroid lobe serendipitously contained one normal appearing parathyroid gland, a benign calcified cystic nodule and a