presence of hypoechoic mass which was separate from thyroid. Additionally, a 0.5cm TI-Rad 4 left thyroid lobe nodule was found. FNA of the mediastinal mass was suspicious for follicular thyroid neoplasm. Thyramir testing was positive for BRAF V600E and TERT c-124C>T mutations. Thyroid function tests showed frank hyperthyroidism and elevated thyroid stimulating immunoglobulins. Thyroid uptake and scan showed diffuse uptake of 67% at 24 hours.
The patient underwent simultaneous excision of mediastinal mass and total thyroidectomy. The pathology of mediastinal mass showed papillary thyroid cancer with tall and sclerosis features with one involved lymph node. The pathology of thyroid gland did not show any malignancy. She was treated with 100 mCi I-131. Post treatment Whole Body Nuclear Scan after treatment revealed metastatic disease in left lower lung area.
Discussion: Ectopic thyroid gland is usually found anywhere between forman caecum and mediastinum. It is rare to find ectopic thyroid tissue in the presence of eutopic thyroid gland which can create a diagnostic dilemma. Only a very few case reports of thyroid cancer arising from ectopic thyroid tissue have been reported. Our case is unique as the eutopic thyroid gland had Graves' disease with no malignancy but the ectopic thyroid tissue developed aggressive papillary thyroid cancer. There are no specific guidelines for the management of carcinoma in ectopic thyroid glands, possibly due to the rarity of the condition. Our case has a clear metastasis to the lungs. However, it is important to differentiate ectopic thyroid tissue with carcinoma from thyroid cancer metastasis which can be difficult at times. Without specific guidelines for the management of cancer in ectopic thyroids, an individualised approach can be taken using the same therapeutic principals used in the management of eutopic thyroid cancer. Additionally, a finding of a normal thyroid gland or a benign condition in the thyroid gland should not exclude the diagnosis of malignancy in ectopic thyroid tissues.
1) Vázquez, Oscar R., et al. "Ectopic papillary thyroid cancer with distant metastasis." Case reports in endocrinology 2018 (2018).

Thyroid

THYROID CANCER CASE REPORTS

A Rare Case of Classical Hodgkin Lymphoma of the Thyroid Gland

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Background: Hodgkin lymphoma (HL) classically occurs in the lymph nodes and only in about 5% of cases occurs in extra-nodal sites. Primary thyroid lymphomas, most of which are non-Hodgkin lymphomas, comprise less than 5% of all thyroid malignancies. Only a few cases of HL of the thyroid have been reported in the literature, and in most of these cases, fine-needle aspiration biopsy (FNAB) was unreliable for diagnosis. We present a case of classical Hodgkin lymphoma of the thyroid that was falsely negative from both FNAB and core needle biopsy specimens and was diagnosed after surgery.
Clinical Case: A 51-year-old female was seen for a rapidly enlarging neck mass associated with progressive dyspnea and dysphagia. Despite being a telemedicine visit due to the COVID-19 pandemic, significant enlargement and deformity of the neck were startling. The patient was clinically and biochemically euthyroid with a TSH of 2.49 mIU/L (0.5-5.0 mIU/L) and normal FT4. She denied a personal or family history of thyroid disease and neck irradiation. Thyroid ultrasound revealed a 5.3 cm hypoechoic, wider than tall nodule with smooth margins in the left lobe, and a 1.9 cm hypoechoic and taller than wide nodule in the right lobe of the thyroid. A CT scan of the neck also revealed a 1.2 cm lymph node in the left lateral aspect of the thyroid. FNAB of the nodules showed Hurthle cells in a background of crushed lymphocytes with occasional large atypical lymphoid cells. Flow cytometry performed on a repeat FNAB specimen revealed no evidence of lymphoma. A repeat CT scan of the neck performed 2 weeks later due to worsening symptoms demonstrated middle mediastinal lymphadenopathy and a large 8x4.7x4.7 cm mass contiguous with the thyroid with a 3.8 cm cystic collection within. The patient was scheduled for an oncology consultation due to the high likelihood of lymphoma but was admitted to another institution with symptoms. She underwent a thyroid core biopsy and flow cytometry, which again failed to reveal her diagnosis. She then underwent left partial thyroidectomy, and pathology demonstrated infiltrates of small lymphocytes with histiocytes, interspersed with clusters of large, irregular, multilobate cells consistent with Reed-Sternberg cells. She was diagnosed with nodular sclerosing variant of classical HL. Chemotherapy was instituted with rapid improvement in symptoms.
Clinical Lesson: Primary HL of the thyroid is extremely rare and most often presents as a rapidly enlarging neck mass with or without compressive symptoms. Diagnosis with FNAB is challenging and can be misinterpreted as lymphocytic thyroiditis. In our patient, flow cytometry was performed twice and was falsely negative. The treatment of HL differs entirely from that of other primary thyroid cancers and thyroiditis. Hence, in patients presenting with classic symptoms, a high index of suspicion is needed to make an accurate and prompt diagnosis of HL.

Thyroid

THYROID CANCER CASE REPORTS

A Rare Case of T-Cell Histiocyte Rich Large B-Cell Lymphoma of the Thyroid in a Patient With Hashimotos

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Introduction: T-cell/histiocyte-rich large B-cell lymphoma (THRLBCL) is a rare form of large B-cell lymphoma, which usually involves the lymph nodes exclusively. We describe a patient with Hashimoto's thyroiditis who was discovered to have THRLBCL arising from the thyroid. **Clinical Case:** A 78-year-old female with a history of Hashimoto's thyroiditis noted increase in the size of her left thyroid