Abstract:
A small percentage of papillary thyroid cancers present with enlarged lymph nodes in the jugular chain with no palpable abnormality of the thyroid. The primary tumour may be no more than a few millimeters in size and is often termed occult. We report a case of 36-year-old female who presented with swelling in the right side of neck for two years duration. Clinically thyroid appeared normal. Ultrasound and CECT showed multiple level 2,3,4 lymph nodes on right side of the neck with normal thyroid. FNAC from the node showed papillary carcinoma of thyroid. Total thyroidectomy with Right modified radical neck dissection was done. The HPE was reported as papillary carcinoma of thyroid with metastasis to cervical lymph nodes. The case is presented for its rarity and the importance of suspicion of occult thyroid malignancy in the setting of cervical lymphadenopathy.

Keyword: OCCULT PAPILLARY CARCINOMA, LATERAL ABERRANT THYROID

INTRODUCTION:
Thyroid tissue situated lateral to the carotid sheath and jugular vein, previously termed "lateral aberrant thyroid," almost always represents metastatic thyroid cancer in lymph nodes, and not remnants of the lateral anlage that had failed to fuse with the main thyroid, as previously suggested by Crile. Even if not readily apparent on physical examination or ultrasound imaging, the ipsilateral thyroid lobe contains a focus of papillary thyroid cancer, which may be microscopic.

CASE REPORT:
36 year old female patient presented with complaints of swelling in the right side of neck for two years duration. She had no history of tuberculosis. On physical examination, a painless, mobile, firm level 2 node was palpable on the right side of the neck. There was no swelling in the thyroid region. Spine and cranium were normal. CBC, RFT were within normal limits. Thyroid function tests showed normal levels of T3, T4 and TSH. An Indirect laryngoscopy done showed normally mobile vocal cords bilaterally. FNAC from the node was suggestive of papillary carcinomatous deposits. Ultrasound of the neck showed multiple hyperechoic nodules with central necrotic areas on the right side levels 2, 3 and 4 with calcifications. CECT of the neck revealed multiple nodes in level 2, 3 and 4 cervical lymph nodes with calcification with no obvious focus in the thyroid gland (Fig.1).

The case was discussed in the tumour board and a decision of Total thyroidectomy with Rt MRND was taken. Per operatively multiple level 2, 3 & 4 cervical lymph nodes on the right side of neck, largest measuring 3x3 cm. Thyroid gland was apparently normal (Fig.2). Total thyroidectomy with right Modified Radical Neck Dissection type III was done (Fig.3). Postoperative period was uneventful.

Fig 1: CECT neck showing enlarged level 2 node with calcifications

Fig 2: Total Thyroidectomy with Right Modified Radical Neck Dissection Type III

Fig 3: Postoperative recovery
After successful thyroidectomy and ablation of residual normal or malignant thyroid tissue by radioiodine, the Tg should be in the athyreotic range. Levels above the athyreotic range are indicative of persistent, functioning thyroid tissue or carcinoma. At the time of thyroid hormone withdrawal or recombinant human TSH (rhTSH) stimulation for both initial postoperative scans and for subsequent follow-up scans, Tg is measured in conjunction with the diagnostic whole-body scan. Tg cutoff level above 2 ng/mL after TSH stimulation (either after thyroid hormone withdrawal or 72 hours after rh TSH administration) is highly sensitive in detecting patients with persistent or recurrent tumor. Serum Tg levels should be measured every 6 to 12 months after definitive therapy. Cervical ultrasonography, however, has become increasingly used in the follow-up management of patients with differentiated thyroid cancer. Cervical metastases may occasionally be detected by ultrasonography even when TSH stimulated Tg levels are negative. Thus, recent recommendations suggest that neck ultrasound should be performed 6 and 12 months after surgery, and then annually for 3 to 5 years depending on the patients risk for recurrence and Tg status. Recent studies and reports have indicated that not all aberrant thyroid tissues in adults are malignant or associated with endocrine disorders. Rarely ectopic thyroid can also occur in the presence of normally located and functioning thyroid gland. This can be explained by a somatic mutation in a transcription factor important in thyroid migration (3). This ectopic thyroid tissue can occasionally form a benign tumour or a primary malignant tumour in the face of a normal thyroid gland (4). Hence the histologic condition of the nodule combined with intraoperative examination of the ipsilateral thyroid lobe can reliably guide therapy (5).

CONCLUSION:
Papillary carcinoma of thyroid presenting as cervical lymphadenopathy is a rare occurrence. High levels of Tg and other markers are associated with occult papillary carcinoma of thyroid are treated with total thyroidectomy with modified radical neck dissection and are followed up in the usual way as done for differentiated thyroid cancer.

REFERENCES: