NOT JUST HASHIMOTO'S THYROIDITIS

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Key words: Autoimmune thyroiditis+ Hypothyroidism+ Thyroid enlargement+ Diffuse lymphoma with large B-cell.

A 50-year old woman known for several years with autoimmune thyroiditis and normal function experienced symptoms of hypothyroidism in association with thyroid enlargement within months (Fig. 1). TSH of 30 (Normal: 0.5-4.5) μ UI/ mL and with ATPO > 2000 (Normal <34) UI/ mL required levothyroxine substitution. Despite the therapy, the goiter increased while the level of haemoglobin decreased from 7.8 to 6.9

(normal: 12-15.5) g/ dL [an erythrocyte sedimentation rate of 65 (normal <25) mm/1 hour] requiring 2 units of erythrocyte mass transfusion. Thyroid ultrasound: Right lobe of 3/2.8/5.5

cm, left lobe of 4.1/3/3.7 cm with two nodules, one of 2.4/0.8 cm, and a larger one of 4.5 / 4.4 cm, with hypoechoic pattern and normal blood flow in Color flow Doppler, and left laterocervical conglomerate of 3.6/ 1.5 cm (Figs 2, 3). CT: A 4.4 cm mass in the left lobe and isthmus with longitudinal extension, multiple lymph nodes at laterocervical and mediastinal level, and the smallest tracheal diameter of 1.5/1.6 cm (Figs 4, 5). FNA: chronic thyroiditis background, hyperplasia of germinal centers, blast-like elements (BETHESDA 5)(Fig. 6). Cell block: CD20 + (Fig. 7), CD10 + (Fig. 8), BCL2 negative and high Ki67 suggest lymphoid hyperplasia with phenotype of reactive germinative centers due to autoimmune thyroiditis. The patient refused lymph node biopsy or core biopsy. The bone marrow aspiration result was irrelevant. Based on these, the diagnosis of primary thyroid lymphoma and its type could not be established so total thyroidectomy with lymph nodes resection was done. Pathological and immunohistochemical analysis revealed a diffuse lymphoma with large B-cell requiring further chemotherapy.

Figure 1.

Figure 2.

Figure 3.

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Figure 4.

Figure 5.

Figure 6.

Figure 7.

Figure 8.