
CASE REPORT

**INCIDENTAL METASTASIS OF PAPILLARY THYROID CARCINOMA
IN LYMPH NODES OF PATIENT WITH SQUAMOUS CELL
CARCINOMA OF THE ORAL CAVITY: A CASE REPORT**

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Bosnia and Herzegovina**email: hasan.altumbabic@hotmail.com***ABSTRACT**

Introduction: The incidental discovery of thyroid lesions in lymph nodes during a lymph node dissection performed for a separate primary head and neck tumor is an unusual clinical entity. Its discovery has led to controversy regarding its significance and management.

Case report: We report the case of 58 year-old male with tumour of the right palatine tonsil, soft palate and right side of hypopharynx. The patient was underwent a right side mandibulotomy, hemiglossectomy, extended tonsillectomy and functional neck dissection. Histological examination and imunohistochemical study showed squamous cell carcinoma of oral cavity and tonsil with metastasis in the two lymph nodes of the neck, metastatic squamous cell carcinoma and papillary carcinoma of thyroid gland.

Conclusion: The task of the clinician is that of trying to control strictly the squamous cell carcinoma, taking into consideration its great facility to a rapidly pregressive loco-regional recurrence compared to a papillary thyroid carcinoma.

Keywords: *squamous cell carcinoma; palatine tonsil; papillary carcinoma; thyroid gland*

INTRODUCTION

Malignancies of oral cavity are one of the most common sites of head and neck malignancies, and squamous cell carcinoma (SCC) is the most common malignancy.¹

The cervical region often represents the site of numerous malformative, inflammatory and metastatic diseases. More than 50% of patients with squamous cell carcinoma of the oral cavity have lymph node metastases and histological confirmation of metastatic disease is the most important prognostic factor.² Cervical lymph node metastases are quite common (12-64%) in papillary thyroid cancer (PTC) and the central neck compartment (level VI) is the most common site for

lymph node metastases.³

Among patients with a clinically negative neck, the incidence of occult metastases varies with the site, size and thickness of the primary tumour.

The incidental discovery of metastatic thyroid cancer in lymph nodes during a lymph node dissection performed for a separate primary head and neck tumour is an unusual clinical entity.^{1,2} The incidence of unsuspected metastases of thyroid tissue in lymph nodes of patients with head and neck carcinoma treated with neck dissection is 1.5%.⁴ Some authors propose the possibility that thyroid carcinoma in the cervical lymph nodes are not necessarily metastatic, but may occasionally arise from heterotopic thyroid tissue.⁵

We report a case of metastasis of PTC in lymph nodes

in patient with SCC of oral cavity.

CASE REPORT

We report the case of 58 year-old male with tumour of the right palatine tonsil, soft palate and right side of hypopharynx, admitted to the ENT (Ear, Nose and Throat) Clinic Tuzla, with a history of eating difficulties and enlarged right tonsil with clinically negative neck. The above symptoms are present in the past three months. Preoperative laboratory values were referrals, and biopsy of enlarged right palatine tonsil, after pathological examination showed squamous cell carcinoma.

After preoperative assessment, the patient was underwent a right side mandibulotomy, hemiglossectomy, extended tonsillectomy and right side elective functional neck dissection (T3, N1, M0, stage III). Histological examination showed SCC of the oral cavity and tonsil with metastasis in the two lymph nodes of the neck, metastatic SCC and metastatic PTC. Post operationally, patient were underwent neck ultrasound and FNAB of the thyroid gland. Also patient was presented at the Council for thyroid diseases UCC Tuzla who gave recommendations for further treatment.

Subsequently, total thyroidectomy with left side functional neck dissection was performed (T1,N0,M0, stage I). Histological examination and immunohistochemical study showed PTC (follicular variant) of the right thyroid lobe. Post operationally, the patient underwent chemotherapy and radiotherapy, and he followed up every 3 month, without signs of recurrence.

DISCUSSION

The presence of metastatic occult PTC in lymph node of patients with SCC has been reported in numerous studies.^{1, 2, 6, 9, 10}

A total of 42 cases of incidental metastatic PTC in lymph nodes dissected surgically for treatment of head and neck SCC have been reported. Of 2855 patients with SCC of the tongue studied by Vassilopolou-Sellin and Weber,³ the incidental finding of thyroid metastases to cervical lymph nodes was 0,3% (eight cases). Furthermore, Resta and al.¹⁰ found metastatic thyroid tissue in 0,53% of 1500 patients with head and neck carcinomas treated with a neck dissection. Xavier Leon et al.⁴ are reported five cases metastatic PTC in 752 patients with head and neck carcinoma, and incidence was 0,6%. However, Ansari-Lari and Westra⁸ found metastatic thyroid tissue in 1,6% head and neck carcinomas treated with a neck dissection. The true incidence

of unsuspected metastatic thyroid deposits in the cervical lymph nodes could be much higher, because all reviewed have mainly included patients treated with radical, functional and selective neck dissections. Such surgery does not usually include the central neck compartment (level VI), the most common site for lymph node metastases of the papillary thyroid carcinoma. Optimum management of these patients remains controversial as the treatment of occult thyroid carcinoma in itself is problematic.

Undoubtedly, the incidental presence of PTC in the lymph nodes removed for a SCC of the head and neck, necessitating the search for a different therapeutic strategy with respect to that at first planned. Many authors believe that in case of a PTC, local treatment of the thyroid and lymph nodes could guarantee recovery, especially for small or clinically occult tumours, and for cases of incidental detection.^{4,7,10}

CONCLUSION

Metastasis of PTC in lymph nodes in patient with SCC of oral cavity is rare clinical phenomenon. The behaviour of the disease is determined not by the thyroid neoplasm, but by the SCC. The task of the clinician is that of trying to control strictly the SCC, taking into consideration its great facility to a rapidly progressive loco-regional recurrence compared to a PTC.

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