中文題目：分化不良甲狀腺癌同時合併甲狀腺高能症之病例報告

英文題目：A case report of poorly differentiated thyroid carcinoma with concomitant hyperthyroidism

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Introduction: Clinically overt hyperthyroidism induced by primary thyroid carcinoma is rare, and only one such reported case have been found with poorly differentiated carcinoma, which remained a great challenge for preoperative cytologic diagnosis.

Case report: The patient was a 58 year-old male who discovered a non-tender mass in his left anterior neck during physical checkup. He visited our hospital where physical examination revealed a soft, 3-cm mass in the left lobe of the thyroid gland. Subjective symptoms including bilateral hand tremor, easy nervousness, and intermittent dysphagea were complained. The serum thyrotropin (TSH) was suppressed to less than 0.02 μU/ml while the total serum thyroxine (T_4) elevated to 16.2 μg/dl. With the triiodothyronine (T_3) resin uptake ratio being 27.9%, the free T_4 index (FT_4I) was calculated to be 4.52 (normal range: 1.55-4.0). The first fine-needle aspiration cytology (FNAC) of the thyroid showed hemorrhagic colloid cyst with 4cc dark-reddish fluid obtained. Patient was treated with methimazole 5mg tid for his hyperthyroidism. Then thyroid scintigraphy was done to rule out toxic adenoma. The report came out to be left goiter with a significant cold lesion in the lower outer portion. Malignancy was highly suspected. His thyroid function had returned to euthyroidism under medications, but the serum thyroglobulin level was markedly elevated to 13498 ng/ml (normal range: < 50 ng/ml). The second FNAC was performed. Follicular neoplasm was suspected. Patient underwent left hemithyroidectomy and the pathologic diagnosis proved poorly differentiated carcinoma with cells arranged in insular pattern, invasion of blood vessels, areas of tumor necrosis, and peritheliomatous changes. No metastatic evidence found.

Conclusion: In treating patients with hyperthyroidism with a solitary nodule, thyroid carcinoma should be carefully ruled out. Due to limited sampling of a large tumor when performing FNAC, larger lesions should be sampled more extensively. However, a definite preoperative diagnosis of insular carcinoma would remain a challenge until more cytologic features could be identified or specific immunohistochemical profile recognized.