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Primary Papillary Carcinoma Arising from Median Ectopic Thyroid in Multinodular Goitre

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CARCINOMA ARISING from thyroglossal duct remnants is a rare entity [1]. An interesting case of papillary thyroid carcinoma of the thyroglossal duct remnants, observed among 700 patients with thyroid carcinoma, is here reported and its particular features described.

A 66-year-old woman, with a 10-year history of multinodular goitre, noticed a progressively growing mass in the midline of her neck 12 months ago. She had been in suppressive thyroid therapy for the last 7 years (L-thyroxine 2 μg/kg body weight resulting in suppressed thyroid stimulating hormone (TSH) response to thyrotropin releasing hormone (TRH). Free and total T4 and T3 were within normal range and TSH levels were undetectable. No uptake was detected over the midline neck mass in the ^{131}I thyroid scan, in which the thyroid gland appeared enlarged with a dishomogeneous distribution of the tracer. Ultrasonography revealed a diffuse enlargement of the thyroid gland, with mixed lesions and, above the gland, a solid lesion 2.0 cm in diameter with calcification. Cytopathological examination of the neck mass suggested a papillary proliferation. At surgery, a mass of diameter 2.2 cm just below the hyoid bone, was removed and a total thyroidectomy was performed. The mass was 3 cm above the upper margin of the thyroid gland and so was unconnected to it. Histological examination confirmed the presence of papillary carcinoma in the mass, whereas no evidence of neoplasm resulted in the thyroid gland. The interesting aspect of this case is the inability of the continuous, prolonged administration of thyroid hormone in protecting the patient from the occurrence of cancer. The case reported seems to contradict the belief that the growth of papillary carcinoma depends solely on TSH stimulation. This view stems from at least two kinds of observations: (i) that thyroid hyperplasia associated with elevated TSH levels in congenital goitrous patients untreated for many years can lead to malignant degeneration [2] and (ii) that differentiated tumours can show normal TSH receptors. This fact can explain their TSH dependent growth, whereas anaplastic cancer lacks high-affinity receptors and shows TSH-independent growth [3].

In conclusion the case described is consistent with a rare neoplastic localisation in the thyroglossal duct remnants and supports the possible—even though unusual—development of cancer during suppressive therapy.

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Meningiomas and Sex Hormones

Shaun A. Costello and Roy Rampling

WE HAVE read with interest the article by Dr Davis concerning meningiomas and sex hormones [1] and agree with the suggestion that progesterone antagonists might be a logical approach to the treatment of inoperable tumours, particularly in certain classes of patients. However we were surprised to read the unreferenced assertion that there was no evidence that external beam radiotherapy will slow tumour growth rate. Whilst it is true that no prospective randomised trial has been undertaken, a number of retrospective studies indicate that radiation can be of considerable value in extending disease free and overall survival [2–5]. There is also CT scan evidence of tumour response following irradiation [6]. Even when no surgical procedure is possible treatment with radiation alone has been associated with a 46% 10-year survival [3].

In contrast, Dr Davis presents minimal evidence in his article for the clinical efficacy of the antiprogestrogen gestrinone and yet feels able to encourage it as the "best choice in treating men and postmenopausal women with inoperable meningiomas". Whilst formal clinical studies of antiprogestrogenic agents would be most welcome, we believe that radiation therapy currently has an important role in the management of selected patients with incompletely resected or recurrent meningiomas.

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