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Close Enough to Reach with your Hands: A Case with Anaplastic Thyroid Carcinoma

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Abstract: Anaplastic thyroid carcinoma is a rare cancer. Unlike other thyroid cancers, it is rapidly progressive and almost fatal. As it is usually locally advanced at the time of diagnosis with concomitant pulmonary metastasis in half of the cases. Detailed physical examination can be useful for detecting this disease at early stage.
Keywords: Anaplastic thyroid carcinoma, physical examination, radiotherapy and chemotherapy, thyroid cancers

INTRODUCTION

Anaplastic thyroid carcinoma, originating from the thyroid epithelium, is a rare cancer that is often seen in the 6th and 7th decades with a female-male ratio 3/1[1,2]. Unlike other thyroid cancers, it is rapidly progressive and almost fatal. It has a median survival 3–9 months and overall survival over 3 years is below 10%[3,4]. As it is usually locally advanced at the time of diagnosis with concomitant pulmonary metastasis in half of the cases[5,6].

CASE PRESENTATION

A 74-year-old female patient admitted to another health institution where metastatic lesions were detected in HRCT, with complaints of productive cough, malaise and loss of appetite. Then the patient was admitted to our clinic with the aim of investigating primary malignancy. Her overall general condition was bad and physical examination revealed a 5–6 cm sized firm and nodular mass in the right lobe of thyroid gland and wheezing.

Multiple bilateral breast masses, the largest one about three centimeters, were palpable in the medial side and lower outer quadrant of the right breast. Elevated erythrocyte sedimentation rate, CRP and LDH were detected in the laboratory study. Erosive gastritis was detected on endoscopy by evaluating that lesions on chest X-ray and thorax tomography may be metastasis of primary GIS malignancies. The patient could not take a colonoscopy. The masses in the breast were reported as BRAIDS-2. Anaplastic thyroid carcinoma was defined by thyroid fine needle aspiration biopsy made with the strong suspicion of malignancy. The patient was referred to the oncology clinic in terms of chemotherapy and radiotherapy.

CONCLUSİON

There are two features that make our case worth sharing. First is to review literature and help determine our priorities in anaplastic thyroid cancer which is quite rare with increased healthcare access. Like in our cases with metastatic disease, securing the airway and ensuring access for nutritional support should be a priority treatment approach through combined radiotherapy and chemotherapy. Secondly; to emphasize the fact that detailed physical examination-gradually lost its importance, unfortunately-can be life-saving for diseases in which early diagnosis and treatment are indispensable.

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