

Node Before Nodule

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Conflicts of Interest: Nil

Abstract

Introduction: Lateral aberrant thyroid is an intriguing clinical entity with many debatable hypotheses to its origin. They form a subset of ectopic thyroids which have reported prevalence of 1 in 100,000-300,000 cases. Lateral aberrant thyroid (LAT) is a rare developmental anomaly where thyroid tissue appears in the lateral neck, often presenting as a painless neck mass. While traditionally considered ectopic tissue, most cases in adults are now recognized as metastatic papillary thyroid carcinoma from the orthotopic thyroid gland.

Keywords: Lateral Aberrant Thyroid, Laryngoscopy, Orthotopic Thyroid Gland, Ultrasonography

Case Report

History: A 16 year old female presented in August 2025 with chief complaint of painless swelling in the right upper aspect of neck gradually progressive since 5 years. No history of any other swelling or weight-loss or radiation to neck region.

Clinical Examination

On local examination, a there was a 4cmx3cm well-demarcated, solitary, smooth, firm, non-tender swelling at the junction of right level II neck station. There was a similar swelling of size 2cmx2cm at the level of right level IV lymph node station. No other swelling palpable. ENT examination was normal and bilateral vocal cords were mobile on laryngoscopy.

Systemic examination was normal.



Figure 1:

Investigations

Ultrasonography (USG) neck revealed a heterogeneous hypoechoic lesion measuring 4.3cmx2.7cm in the right submandibular region and level II lymph node station with significant internal vascularity. Another similar lesion in right cervical level IV measuring 2.3cmx2.2cm and 1.1cmx1.3cm respectively suggestive of neoplastic aetiology. The thyroid gland was reported normal.

On Contrast enhanced computed tomography(CECT) of neck and thorax, 2-3 well defined heterogeneously enhancing lesions noted in right cervical level II, III, IV with largest measuring 4.5cmx2.9cmX2.6cm noted in right cervical level II and III suggestive of lymphadenopathy. The thyroid gland was reported normal. No metastasis seen in thorax and abdomen.

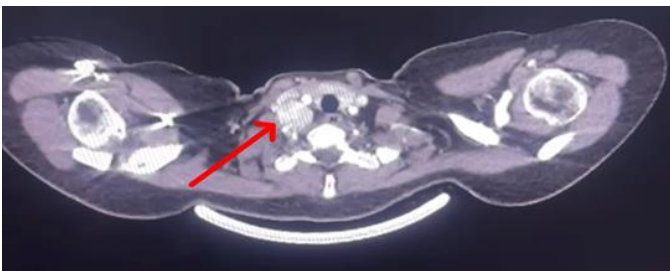


Figure 2:

Thyroid profile, complete blood count was within normal limits.

USG-guided fine needle aspiration cytology (FNAC) of the swellings was suggestive of papillary carcinoma.

Thyroid scintigraphy technetium99 scan showed abnormal hyper-perfusion and increased tracer activity in right submandibular region. Possibility of coexisting

thyroid ectopia should be considered. Normal functioning native thyroid. No abnormal extra-thyroid activity seen elsewhere.



Figure 3:

Differential Diagnosis

1. Metastatic right cervical lymphadenopathy with papillary thyroid carcinoma
2. Papillary carcinoma in thyroid ectopia level IV right cervical lymphadenopathy

Perioperative Sequel

In view of these two differential diagnosis, we performed total thyroidectomy with right central compartment neck dissection and right selective neck dissection (Level II to IV) under general anaesthesia (GA) in August 2025. Intraoperatively we found a smooth, solid swelling measuring $4.5 \times 3 \times 2.5$ cm adherent to internal jugular vein, without any connection with the thyroid gland at junction of level II lymph node. Level III lymph node of size 2x2cm and level IV lymph node of size 3X3cm was noted. Thyroid appeared to be normal.

Post-operative laryngoscopy was normal with bilateral mobile true vocal cords.

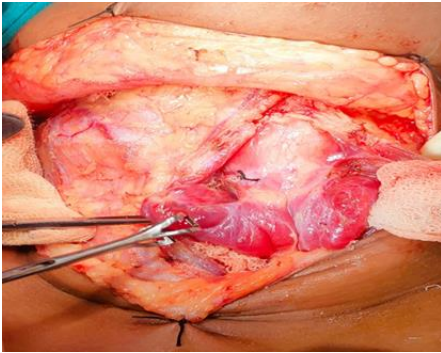


Figure 4:



Figure 5:

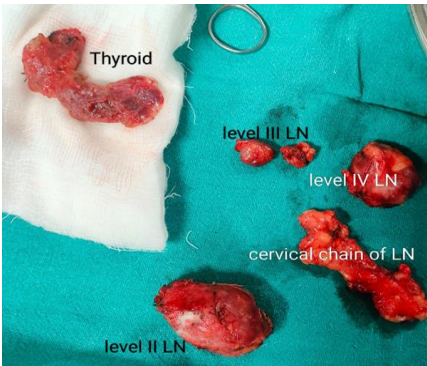


Figure 6:

The final histopathological examination (HPE) showed features of papillary carcinoma of thyroid in a right lobe with area of size 0.5x0.5cm with tumour metastasis in level II, III, IV and cervical chain of lymph nodes (5/12) with immunohistochemistry positive for TTF1 with staging pT1a N1b.

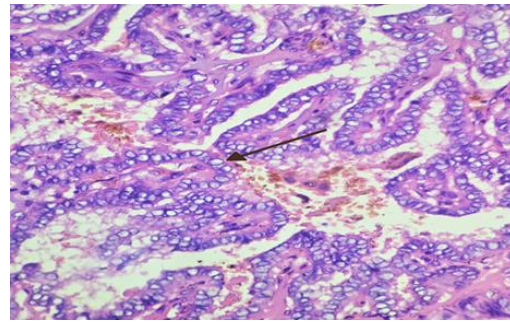


Figure 7:

Orphan Annie nuclei

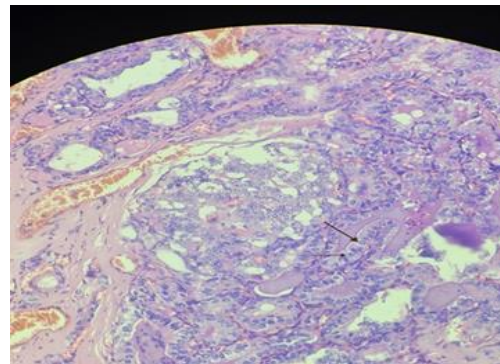


Figure 8:

Coffee bean nuclei

Post-Operative Sequel

Suture site healed with minimum scar.



Figure 9:

3 weeks postoperatively Iodine 131 scintigraphy was done and was suggestive of microscopic thyroid remnant/ residual disease in operative bed. No evidence of any I-131 concentrating metastasis from differentiated thyroid carcinoma.

Thus she was referred for adjuvant radioactive iodine(RAI) therapy.

Discussion

Historically, it was believed that lateral thyroid anlage failed to fuse with the median anlage, causing ectopic thyroid tissue in the lateral neck; hence it was called “lateral aberrant thyroid”. It was a misnomer. However, in modern practice, "lateral aberrant thyroid" is typically synonymous with metastatic papillary thyroid cancer within neck lymph nodes presenting most commonly as swelling in lateral aspect of neck (lymphadenopathy) without any thyroid swelling.

In this case, young patient with a long standing swelling was suspected to be a benign swelling such as branchial cyst or lymphangioma or lipoma or lymphadenopathy or an ectopic thyroid. After fine needle aspiration cytology it was thought of papillary carcinoma in an ectopic thyroid as patient had a history since she was 11 years old. But the other palpable lymph node and its FNAC was a clinching point towards papillary thyroid carcinoma with metastatic lymphadenopathy. Thyroid scintigraphy ruled out any other site of thyroid activity.

The primary treatment has to be total thyroidectomy with ipsilateral selective neck dissection and ipsilateral central compartment neck dissection. Post operative Iodine 131 scan helps to identify any other indolent metastasis. The prognosis is excellent with 95% survival over 20 years.

Hence the title node before nodule justifies this case with lymph node presented before solitary thyroid nodule.

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