CLINICAL RECORDS

A COMPLICATION OF THYROID ADENOMA

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HÆMORRHAGE into a thyroid adenoma is a rare complication but one well enough known. Such an occurrence is usually precipitated by coughing but in this case by shouting.

Otherwise this is a typical case presenting as acute dyspnœa with recurrent laryngeal nerve paralysis.

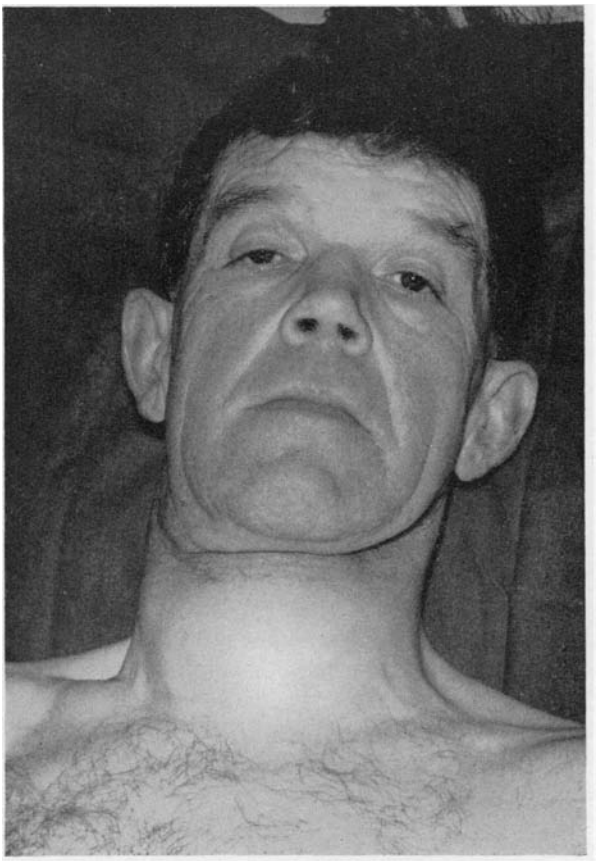


FIG. 1.
Anterior view of neck showing extent of swelling.

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Patient W. K. Male, aged 60 years. Occupation: Farm Manager.

This patient had a non-toxic goitre for 35 years. Several years before the present episode the adenoma had increased in size but returned to its former

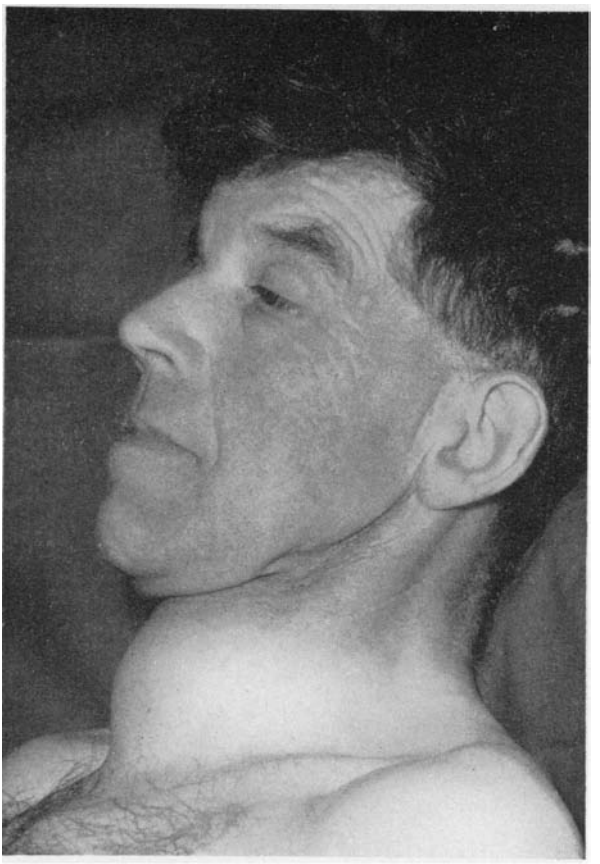


FIG. 2.
Lateral view of neck, taken at the same time as Fig. 1.

state after a course of Lugol's iodine. Three weeks before the patient was seen the adenoma started to enlarge, and he had taken a few spasmodic doses of iodine.

On the day of admission the patient was shouting at his cattle when he suddenly felt his neck become tight. After a quarter-of an hour there was a large tense swelling over the lower part of the neck. One hour later his voice was hoarse. The patient had a cup of tea and a slice of bread and butter, but it was difficult to swallow, so he did not attempt to take anything else by mouth. Two hours later he was unable to cough properly and on attempting to do so thought he would choke.

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Past History

Twelve years ago, after having an impacted fish bone removed from the throat, he was told that his trachea deviated to the right.

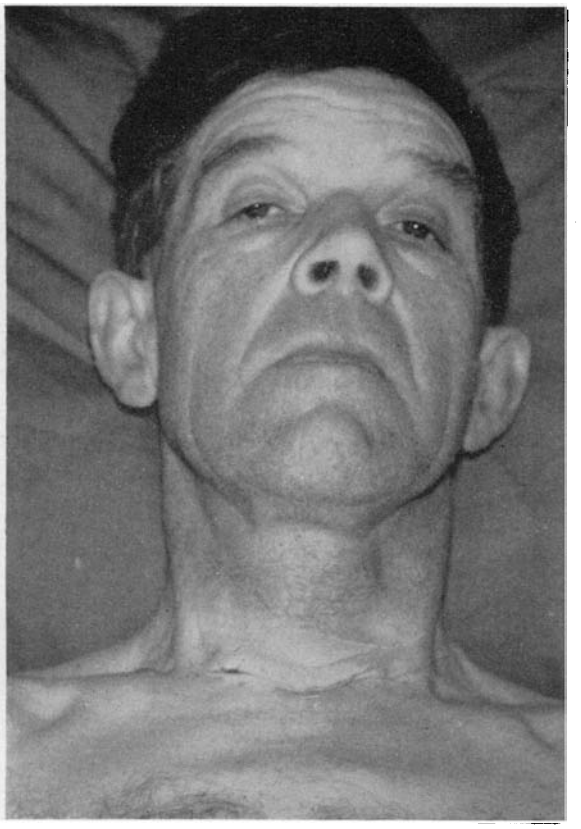


FIG. 3.
Anterior view of neck after operation.

Examination

The patient was dyspnœic and frightened. There was a tense diffuse swelling over the lower part of the neck limited above by the oblique line of the thyroid cartilage, and below extending into the superior mediastinum (Figs. 1, 2). Laterally the swelling extended beneath the sternomastoid muscle on the left side.

Indirect Laryngoscopy

The larynx and trachea were deviated to the right. There was a left recurrent nerve paralysis.

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Diagnosis

A diagnosis of hæmorrhage into an adenomatous cyst of the thyroid was made.

Management

The patient was put to bed in Fowler's position with oxygen available. His respirations improved and it was decided to keep him under observation, on penicillin: for exploration the following morning.

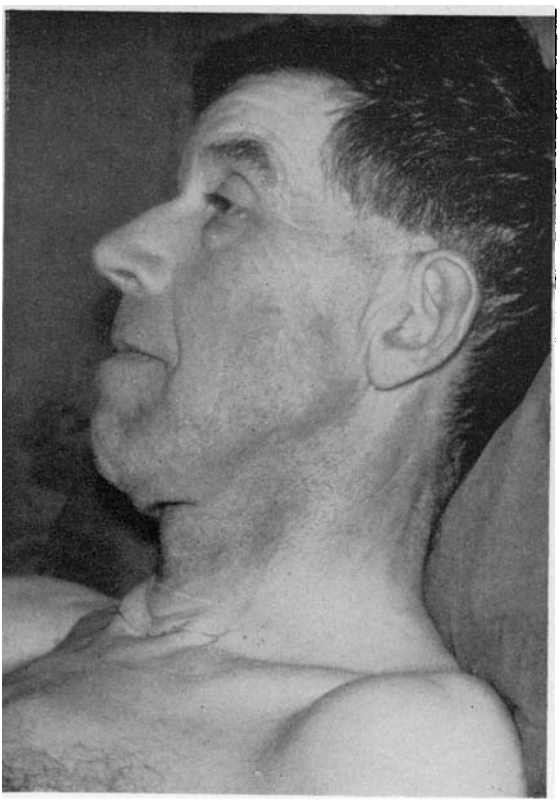


FIG. 4.
Lateral view of neck after operation.

Operation. Exploration of the Neck. (J. D. K. Dawes.)

A collar incision was made over the middle of the mass. The left sterno-hyoid and sterno-thyroid were divided. The mass was a thyroid adenoma into which there had been a large hæmorrhage. The mass extended to the left along the thyroid cartilage laterally to the carotid sheath, and inferiorly into the superior mediastinum to the level of the aortic arch. It was possible to separate

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it from the overlying structures and remove the adenoma. Another calcified adenoma occupying the isthmus of the thyroid gland was also removed. A corrugated drain was placed in the left superior mediastinum and the wound closed.

The patient made an uneventful recovery and was discharged seven days later (Figs. 3 & 4). The recurrent laryngeal nerve paralysis was permanent in

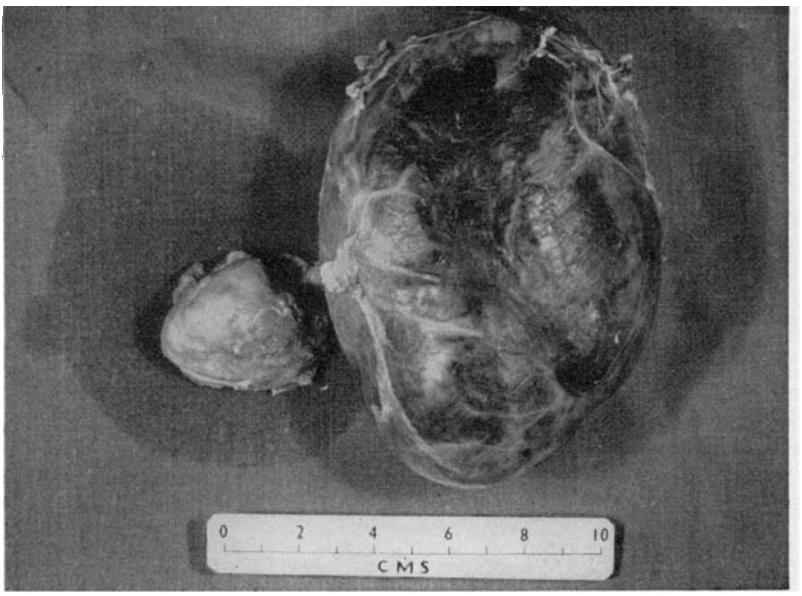


FIG. 5.

Large cyst into which hæmorrhage had occurred, with smaller calcified cyst which was removed at the same time.

this instance. If surgery had been earlier it is possible that the recurrent laryngeal nerve paralysis might have recovered.

Pathology (Fig. 5)

The specimen consisted of (1) a smooth walled ovoid tumour 12 cms. in length weighing 400 gms. On section it consisted of 2 thyroid cysts containing a mass of recent blood clot; (2) a small fragment of thyroid tissue containing calcium.

Histology

Both portions showed an adenomatous goitre with retrogressive changes and recent hæmorrhage into a cyst.

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