Case	(536) Multinodular intrathoracic goiter with spontaneous haematoma
Authors	A. Oprisan, M. García-juncó Albacete, M. Barreda-solana, D. Veiga-canuto, O. Jácome-torres, C. Fonfría-esparcia.
Centre	Hospital Universtiario Y Politécnico La Fe.

CASE PRESENTATION

A 66-year-old woman presented to the emergency room with spontaneous soft tissue haematoma in neck and chest that has appeared several days before. She noticed dysphagia that was limited to solid foods. No previous trauma. She had prior history of goiter and hypertension.

Chest radiography was normal. A CT was performed revealing a multinodular goiter, with a greater volume increase of the left thyroid lobe. Bilateral heterogeneous solid nodules were seen, some with coarse calcifications and fibrosis. In the lower pole of left lower lobe, a homogeneous hypodense area was observed that didn´t present thyroid nodule morphology with an average density of 30 HU. No signs of acute bleeding were observed.

Biopsy and radiological findings suggested intraparenchymal hemorrhage. The goiter contacted with the trachea and the esophagus without conditioning stenosis. An anterior cervical subcutaneous cellular edema can be seen and can be explained by the blood which has seeped into subcutaneous layer.

DISCUSSION

The diagnosis was a multinodular intrathoracic goiter with spontaneous haematoma in the lower pole of left thyroid lobe. The posterior nodule of left lobe was biopsied without identifying malignant cells. Although the thyroid gland is very well vascularized, the hemorrhage of a thyroid nodule is a very rare complication. It usually tends to be secondary to blunt trauma or mechanisms that increase blood pressure (cough, Valsalva mechanism etc.) especially in anticoagulated patients(1).

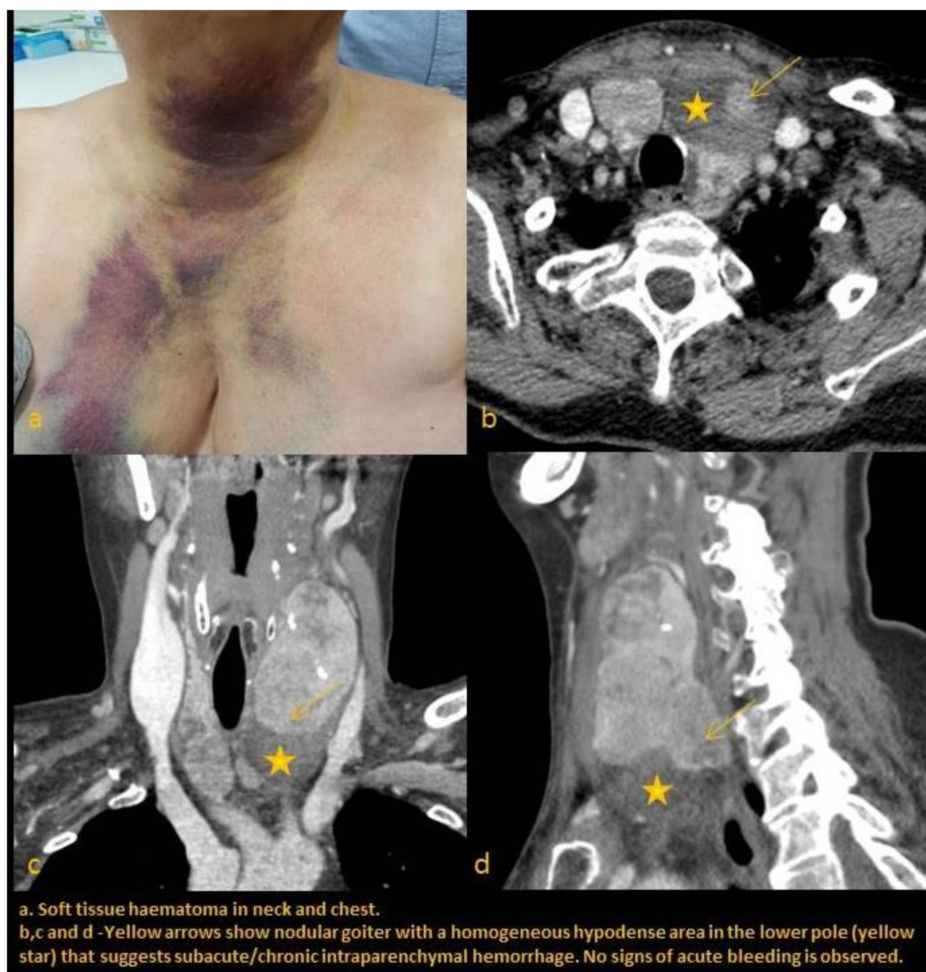
The symptomatology is variable: dysphagia, dyspnea, pain, aphonia. Intracystic hemorrhage in patients with goiter is an uncommon complication, its frequency has been estimated at 3% of simple goiters (2).

Goiter favors the appearance of structural alterations; the tissue is more fragile with predominantly venous vascularization and the enlargement of the gland decreases the covering of the true capsule. In case of a haematoma, all above facilitate its spread through cervical spaces, especially through the retropharyngeal prevertebral space which is a crucial path from neck to mediastinum(1).

It can produce an abrupt increase in the size of the gland, which can lead to important symptoms such as respiratory distress, recurrent paralysis or upper airway obstruction due to the compressive effect of the gland. If the patient is stable and the airway is secured, it can be monitored and conservative treatment can be applied.

CONCLUSION

Even though highly vascularized, the thyroid gland rarely has spontaneous bleeding. Although patients may be stable at initial presentation, bleeding into the thyroid gland can result in potentially lethal acute airway compromise.



a. Soft tissue haematoma in neck and chest.
b,c and d -Yellow arrows show nodular goiter with a homogeneous hypodense area in the lower pole (yellow star) that suggests subacute/chronic intraparenchymal hemorrhage. No signs of acute bleeding is observed.

BIBLIOGRAPHY

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