AMYLOID GOITER AS THE FIRST MANIFESTATION OF SYSTEMIC AMYLOIDOSIS.

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INTRODUCTION:

Thyroid gland may be asymptomatically involved in most patients with secondary systemic amyloidosis. However, clinically detectable amyloid goiter is quite rare, often it is seen in patient with kidney involvement.

Herein we report a case of amyloid goiter without kidney manifestation.

OBSERVATION

A 30-year- old male diagnosed with bilateral bronchiectasis since 1992 was admitted with rapidly growing goiter.

Symptoms:

- dysphagia for solids,
- change in voice,
- weight loss
- dyspnea.

Physical examination:

- supine blood pressure= 130/70 mm Hg
- standing blood pressure= 120/70 mm Hg
- The goiter was nodular large and hard,
- The rest of the examination was normal.

Laboratory tests:

	value in our patient	Normal values
FT4 (ng/dl)	1.09	0.70–1.48
TSH (µui/ml)	2.19	0.35 – 4.94
Synacthen test CORTISOL 8H (nmol/l) CORTISOL 9H:	 243 400	 > 550

- antithyroglobulin and antimicrosomial antibodies were negatives.

Thyroid ultrasonography:

- Right lobe 5.7 x 5.7 x 13 cm,
- Left lobe 4.4 x 4.4 cm x 13 cm
- With heterogeneous texture and multinodular.

Chest radiography:

- Multiple bilateral lesion of bronchiectasis
- Left deviation of the trachea.

Treatment:

- As he had signs of compression, total thyroidectomy was performed with no complications.
- The patient was treated with colchicine, hydrocortisone and L thyroxin.
- The evolution was favorable and two years after proteinuria was still negative.

Histological examination:

- showed type AA amyloid throughout the gland, with both congo red staining and immune-histochemistry.
- Labial biopsy was positive for type AA amyloid.

DISCUSSION

Rarely the amyloid goiter constitutes the circumstance of discovery of amyloidosis as in our patient. Also it has been known that endocrine defects occur at a later stage of renal amyloidosis.

The enlargement of the gland is rapid. In recorded series the history ranges from four months to three years with an average of about one year. The gland is firm to hard in consistency although a few are soft.

In the setting of a rapidly enlarging thyroid mass a malignant neoplasm of the gland must be excluded. Particularly in the case of anaplastic carcinoma or non Hodgkin's malignant lymphoma. However, in contrast to malignant thyroid tumors that are often a unilateral disease, amyloid goiter affects the thyroid most commonly in a bilateral and diffuse manner.
Fine needle aspiration (FNA) biopsy should be considered as it has been shown to be useful in the diagnosis especially to rule out malignancies of the thyroid and to confirm amyloidosis involving the thyroid.

Although subclinical thyroid dysfunction due to infiltration of the gland is not frequent, hypothyroidism and hyperthyroidism have been described in the literature.

Surgical intervention is inevitable when amyloid goiter presents with obstructive symptoms or the patient prefers surgery because of anesthetic reasons.

Adrenal dysfunction in amyloidosis is an insidious process witch may remain subclinical for a long time so many authors recommend screening of adrenal hypofunction with the short synacthen test in all patients with amyloidosis. Adrenal failure was confirmed in our patient who hadn't clinical signs of adrenal insufficiency.

CONCLUSION

we report perhaps, a new case of amyloid goiter without renal manifestation in the course of secondary amyloidosis. A preoperative diagnosis of amyloid goiter must be considered in patients with thyromegaly who have a predisposing risk factor for developing amyloidosis.

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