Cervical ultrasound confirmed the 56×34×40 mm EU-TIRADS IV nodule where fine-needle aspiration (FNA) classified it as Bethesda II. Calcitonin level was normal. Despite normal calcitonin level, the clinical context and suspicious imaging findings prompted total thyroidectomy. Histopathology revealed a conventional subtype papillary carcinoma (pT3aN1M1). Case 2: A 20-year-old female presented with dysphagia and a cervical swelling. Ultrasound identified a 15×8×14 mm right loboisthmic nodule (EU-TIRADS III) and a 5×3 mm left mediolobar nodule (EU-TIRADS III). FNA of the right nodule indicated a benign lesion (Bethesda II). Due to compressive symptoms, a right lobectomy was performed, revealing a 20 mm encapsulated variant of papillary carcinoma (pT1bN0). Subsequent left lobectomy identified a 3 mm follicular variant of papillary carcinoma with capsular invasion (pT1bNxMx). Initial thyroglobulin level was 7 ng/ml.
Discussion
The diagnostic evaluation of thyroid nodules aims to accurately identify malignancy while avoiding unnecessary interventions. However, discordance between imaging and cytological findings should prompt clinicians to pursue further investigations and engage in specialized multidisciplinary discussions to reach an appropriate therapeutic decision, ensuring thyroid neoplasms are not overlooked. Our study highlights the limitations of FNA in certain clinical scenarios and the potential of multifocal disease despite benign cytology.

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JOINT3619

Rare recurrence of de quervain's thyroiditis

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Introduction
Subacute thyroiditis of Quervain is an acute inflammatory condition of the thyroid, most likely triggered by a viral infection. Its prevalence is estimated to be around 0.1% to 0.5% of the general population, making it relatively rare compared to other types of thyroiditis.
Case report
A 55-year-old female patient with no significant medical history who presented with a cervical swelling. Ultrasound examination revealed a thyroid nodule classified as EUTIRADS 4, with a Bethesda II on fine-needle aspiration cytology. In June 2024, the patient developed flu-like symptoms followed by the onset of a painful, vascular goiter in the context of a febrile illness. Laboratory investigations showed an inflammatory syndrome with a CRP of 179, and hyperthyroidism (TSH 0.02 mIU/l, FT4 36 pmol/l). The patient was treated with anti-inflammatory drugs for one month, resulting in significant improvement of the pain. Subsequent tests two months after the first episode revealed a hypothyroidism with a TSH of 87 mIU/l and FT4 of 3.6 pmol/l. Ultrasound imaging confirmed the presence of a goiter with features suggestive of acute thyroiditis. Levothyroxine therapy was initiated. Six months after this episode, the patient re-presented with the same plaints: bilateral neck pain and odynophagia. Examination revealed a tender goiter, with a CRP of 92 and an elevated erythrocyte sedimentation rate (ESR) of 91 mm/h and a TSH level at 13 mUI/l, confirming the recurrence of the Subacute thyroiditis.
Conclusion
The Quervain's thyroiditis typically follows a course of three phases: an initial hyperthyroid phase, followed by a hypothyroid phase, and eventual spontaneous recovery within two to three months, with recurrence being rare, occurring in only 1.4% to 10% of cases. These recurrences are mainly due to the inflammatory origin of this pathology, the underlying inflammation may persist or reactivate, potentially causing a recurrence of the disease. Additionally, factors such as genetics, the immune system, and recurrent viral infections could contribute to this reactivation.

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JOINT98

De Quervain thyroiditis mimicking an aggressive thyroid malignancy

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We report on a patient with likely de Quervain thyroiditis who presented with clinical features of an aggressive thyroid malignancy. A 46-year-old female was referred from the ENT department with a 4-week history of weight loss, feeling hot, and fullness of her neck which was becoming increasingly painful. There was no family history of thyroid disorders. The patient did not mention any clear predating symptoms of any viral catarrh or relevant history. Initial biochemistry through her doctor showed thyrotoxicosis with elevated T4, and T3 and suppressing TSH. Examination revealed a large irregular tender mass over the left lobe of the thyroid and multiple tender palpable lymph nodes in the neck. The patient was clinically thyrotoxic with tachycardia of 110 beats per minute and fine tremors over her outstretched hands but no clinical signs of any thyroid eye disease. An ultrasound of the thyroid revealed a poorly defined hypoechoic mass over the left lobe with a possible extension through the thyroid capsule and several level 3 and level 5 cervical lymph nodes. Thyroid antibodies were negative. She was initially commenced on carbimazole and propranolol for symptomatic control of her thyrotoxicosis while choosing simple analgesia over steroids for her neck soreness. An ultrasound-guided FNAC was carried out 2 weeks later. This revealed only scant follicular epithelial cells and hence labelled as Thy1. The patient made good progress with the carbimazole with good symptom control of her thyrotoxicosis and biochemical improvement. A repeat ultrasound-guided FNAC was carried out 2 weeks later which however showed very scant cells and hence relabelled as Thy1. The ultrasound at this stage however confirmed a sizeable reduction in the left lobe thyroid mass and now insignificant cervical lymphadenopathy. The patient was monitored for her thyroid biochemistry every 3 to 4 weeks with a titrating regime of carbimazole. The initial ENT opinion and a further review after 4 weeks concurred with the clinical diagnosis of likely thyroiditis. Further monitoring was deemed to be under endocrinology, and a further thyroid ultrasound in 3 to 6 months was agreed upon. The patient had come off her carbimazole after 6 weeks and remained euthyroid without any intervening hypothyroid phase. This case serves to highlight the need for clinical assessment and pertinent investigations to avoid overdiagnosis and potentially unhelpful surgical intervention. Hyperthyroidism can very rarely be a manifestation of metastatic follicular thyroid cancer which however was not the case in our patient.

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JOINT3818

The impact of nighttime liothyronine and selenium supplementation on hypothyroid patient well-being and thyroid function

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Many patients with hypothyroidism who are taking levothyroxine (LT4) continue to experience ongoing symptoms and a general sense of unwellness, alongside issues like a slow metabolism and obesity. This observational study investigates the impact of adding low-dose liothyronine (LT3) taken at night, along with selenium supplements and foods rich in selenium, e. g. mushrooms, three times a week, for these patients. The study included seven participants of both genders, aged between 21 and 49 years, with TSH levels reaching as high as 6.4. By monitoring T3 levels and ensuring that both T3 and T4 remained within the upper normal range, adjustments were made to their TSH levels, targeting a range of 0.8-2 based on age. This treatment approach resulted in enhanced well-being, improved weight management through diet and exercise, and even a decrease in the size of thyroid nodules. Regular thyroid function tests every three months, including serum T3 assessments, along with thyroid ultrasounds every six months, proved crucial for these patients. These results emphasize the necessity for further research into the combined therapy of LT4, LT3, and selenium in a larger population.

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JOINT748

A rare presentation of hypothyreosis complicated by rhabdomyolysis and acute renal injury

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