A Case of Swelling in the Neck

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Gen Surgery PG 1st year

Moderator: Dr.(Brig)P. KRISHNA MURTHY
A 30 year old female presented with chief complaint of swelling in front of the neck since 5 years.
History of present illness:
Patient was apparently alright 5 years back when she noticed a small swelling in front of the neck which was peanut in size and gradually increased to present size (3X2 cm) No history of pain over the swelling No history of rapid increase in size H/o of decreased appetite and significant weight loss ~ 15 kgs in last 2 years
No h/o fever, nervousness, irritability, intolerance to heat/cold, excessive sweating.

No h/o dysphagia, hoarseness of voice.

No h/o menstrual disorders, bone pains, abdominal discomfort.
Past history:

N/K/C/O: DM, HTN, Epilepsy, TB

No surgical history

No known drug allergies
Personal history:
Mixed diet
Sleep normal
Appetite is decreased
Bowel and bladder habits regular
No addictions
General examination:
Pt is well oriented, thin built, moderately nourished
Afebrile
Pulse : 76bpm, regular, normal in volume
B.P. : 110/60 mmhg
No pallor, icterus, cyanosis, clubbing, pedal edema, lymphadenopathy
No tremors
Local Examination

Inspection:

Single swelling 3x2cms in front of the neck to the left side of the midline, vertically oval in shape, surface is smooth.
Moving with deglutination
Not moving with tongue protrusion
Skin over the swelling is normal.
Well defined borders. Inferior border is close to suprasternal notch
No other neck swellings observed.
Palpation:
Non tender
No local rise in temperature
Inspectory findings of site, size, shape, surface are confirmed
Swelling is firm in consistency
Borders well defined, plane of swelling is deep to left sternomastoid muscle
Trachea is central in position
No palpable cervical lymph nodes
CVS: S1S2 heard, no murmurs
Resp : BAE +, NVBS
P/A : soft, no hepatosplenomegaly, BS+
Musculoskeletal : no bone tenderness

**PROVISIONAL DIAGNOSIS:**
Solitary thyroid nodule arising from left lobe
Investigations

T3 : 1.14mg/dl
T4 : 8.17mg/dl
TSH : 4.74 micro IU/l (0.5-4.5 micro IU/l)

USG neck: swelling arising from lower part of left lobe of thyroid

FNAC : ? Papillary Ca of Thyroid with cystic degeneration
MRI: A well defined thin walled cystic mass noted in left side of neck tracheoesophageal groove inferior to left lobe of thyroid
Serum PTH : 808.4 pg/ml ( 18-80 pg/ml)
Serum Ca: 10.5 mg/dl (8.5 – 10.1 mg/dl)
24 hr Urinary Ca: 118mg/dl ( <250mg/dl)
Alkaline phosphatase: 290IU/l
USG abdomen: B/L medullary nephrocalcinosis
Sestamibi scan: Focal area of retention inferior to left lobe of thyroid gland in early images with delayed wash out in later....

F/S/O parathyroid adenoma
Xray skull : multiple small punched out lesions
X ray both hands: Resorption of terminal phalanges
Final diagnosis:
Left inferior parathyroid adenoma

Planned for left inferior parathyroidectomy +/- left hemithyroidectomy.
Operative finding

Enlarged left inferior parathyroid gland
Left thyroid lobe appeared normal

Left RLN identified and carefully dissected free from swelling
Post operatively serum PTH estimation done - 13.4pg/ml (normal)

Pt serum calcium levels were monitored for 1 week
Post operative:
Serum calcium levels

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On 3rd POD pt complained of perioral tingling, numbness. oral vit D and calcium supplementation were started. Symptoms resolved.

HISTOPATHOLOGY : Parathyroid Adenoma
Patient was discharged on POD9 in stable condition with advice to continue Tablet CALCIJOINT (calcium 500mg + vit D3 250 IU) and review after 2 weeks.
THANK YOU