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CONFERENCE ABSTRACT

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A case report of a rare presentation of follicular thyroid carcinoma with pelvic and kidney metastases: Emphasis on multidisciplinary and multimodality management approach

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***Abstract*: Introduction:** Follicular thyroid carcinoma (FTC) is the second most common type of thyroid cancer, after papillary thyroid carcinoma (PTC), accounting for approximately 10% of all malignant thyroid tumours with higher predilection for women. FTC demonstrates capsular and/or vascular invasion and often presents with distant metastasis in 20%–30% of cases via the haematogenous spread. FTC tends to commonly metastasize to the lung and bone although other sites have been identified. Kidney metastasis from a primary FTC however is rare and has not been widely reported. We report a case of FTC with metastatic to the kidney in a patient presenting with a large left pelvic mass. **Case presentation:** A 54-year-old, Malay, lady with underlying hypertension and dyslipidaemia presented with chronic left pelvic pain since 1 year ago, following a fall during a recent vacation trip. She also experienced significant unintentional weight loss for the past few months. Clinical examination noted an ill-defined palpable firm mass over the left inner thigh. Pelvic radiograph showed a solitary ill-defined osteolytic lesion at the left superior and inferior pubic rami with cortical destruction. MRI of the pelvis showed a large lobulated enhancing expansile mass originating from the left pubic bone measuring 10.0(AP) × 6.0(W) × 8.5(CC) cm, hypointense signal on T1W and hyperintense signal on T2W. The mass infiltrated adjacent bony structures and muscles. Patient subsequently undergone core biopsy of the left pelvic mass and histopathological examination (HPE) noted metastatic follicular thyroid carcinoma. An ultrasound examination of the thyroid showed a multinodular goitre with suspicious nodule in the left thyroid gland. Pre-operative contrast-enhanced computed tomography (CECT) showed primary thyroid carcinoma with nodal, lung and bone metastases with possible left kidney involvement. Total thyroidectomy was ensued and follicular thyroid carcinoma was confirmed based on HPE. She received external beam radiotherapy of 30 Gy in 10 fractions to the left pelvic mass followed by high dose radioiodine 131I therapy of 150mCi (5.5GBq). Her post 131I therapy whole-body scan showed iodine avid left pelvic mass with multiple other iodine avid disease in the vertebrae. A hybrid SPECT/CT of the abdomen and pelvis showed intense iodine localization in the soft tissue mass at the superior pole of the left kidney, confirming left kidney metastasis. She is currently on TSH suppression therapy and is clinically asymptomatic. **Conclusion:** FTC is an aggressive disease and commonly present with distant metastasis. Although skeletal and lung metastases are more common, kidney metastasis is rare. A thorough work-up with multimodality investigative and imaging techniques allow complete staging and determination of the extent of disease. Management of metastatic FTC should be a multidisciplinary approach to ensure better survival and quality of life.

***Keywords*:** case report; follicular thyroid carcinoma; kidney metastasis

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