

Alternative Treatment without Surgery Thyroid Papillary Cancer

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ABSTRACT

Papillary thyroid carcinoma (PTC) is the most common malignant thyroid neoplasm¹ with the median age at presentation for papillary carcinoma being around 50 years. This case report describes the author's experience of being diagnosed with PTC at the age of 20, as well as the course of treatment without surgery, and eventual outcome. Since the thyroid gland was palpable during routine controls at the age of 20, the patient was taken for further evaluation, and after thyroid papillary cancer was detected by USG and fine needle aspiration biopsy, total thyroid surgery was recommended to the patient. No additional disease being detected. The patient was evaluated in our institute after refusing the operation proposal. Various blood analyzes were requested from the patient. Treatment was arranged in terms of vitamin and mineral levels, and diet adjustments were made. USG was checked at 3-month intervals and followed up. The treatment was continued after it was determined that the mass did not grow and gradually shrank. After a significant regression in USG performed at the end of 1 year, treatment was continued with follow-up. The patient is still being followed up.

Keywords: Thyroid papillary cancer; Alternative treatment; Without surgery

1. Introduction

Papillary thyroid carcinoma (PTC) is the most common malignant thyroid neoplasm¹ with the median age at presentation for papillary carcinoma being around 50 years. Carcinoma of the thyroid gland accounts for approximately 1% of all newly diagnosed malignant diseases and is predominantly found in females (3:1)^{2,3}.

These carcinomas are commonly classified as papillary, follicular, medullary, or anaplastic carcinomas. Papillary carcinomas are considered "well-differentiated" and are responsible for between 80-85% of all thyroid malignancies²⁻⁴. The median age at presentation for papillary carcinoma is 50 years. The most common presentation of papillary carcinoma of the thyroid is an asymptomatic (painless) mass at the level of the thyroid. In around 20% of cases, patients may present with

dysphagia or hoarseness which likely indicates involvement of the recurrent laryngeal nerve and/or tracheal compression^{2,5}.

These patients will often have normal thyroid function testing. The diagnosis is made with ultrasound and fine needle aspiration (FNA)⁵. Definitive treatment is surgical intervention with total thyroidectomy or lobectomy if the tumor is noted to be unifocal and < 4 cm with evidence of lymph node metastasis. In those with advanced primary tumors, unilateral or bilateral neck dissection is indicated based on severity to evaluate the extent of local lymph nodes and for further staging^{2,3,5}. A 1-year follow-up of the patient, who was diagnosed with fine needle aspiration biopsy, whose standard treatment protocol is known, disappeared with the different treatment applied before the operation is described.

Case Presentation

At 25 years of age, I was less than two weeks from graduating from my undergraduate institution and had already accepted an offer to attend medical school at the University. Other vitamin and mineral deficiency and fatigue complaints are present. Upon securing the top button, I found myself struggling to breathe and released the button to take a closer look at my neck. On inspection, I noted a large visible outline on the right side of my neck near the level of the thyroid that I had not visualized previously (**Figure 1**). Two days later, I was seen by a local ENT who was conservative in her initial workup due to the acute onset of the mass, which made malignancy less likely. Thyroid ultrasound and fine-needle aspiration were also ordered for possible malignancy workup²⁻⁴.



Figure 1: Initial Presentation.

Findings

Results of TSH and free T4 blood tests were both within normal limits, which is common in thyroid malignancies². Ultrasound findings included an 2,5 x 1,5 cm solid mass occupying essentially the entire right thyroid lobe for which FNA was indicated, there are two lymph nodes and the appearance of calcium deposits (psammom body). Fine needle aspiration of the mass was histologically consistent with papillary thyroid carcinoma and surgical intervention was indicated. The patient's treatment was replaced by vitamin and mineral replacement and a diet free of gluten, cow's milk and synthetic sugar and sweeteners. No additional disease being detected. In the first 3 months of follow-up, more than 30% regression was observed (confirmed by usg), and the follow-up was extended with replacement and diet. The appearance of a well-circumscribed mass in six months, the visibility of the mass and lymph nodes in one year completely disappeared.

Discussion

This patient comes to the outpatient clinic with clinical data suggestive of hypothyroidism who also has a history of infertility and glandular growth. However, the thyroid profile was found with normal levels and a slight elevation of Thyroglobulin, which may be associated with thyroid disease⁶ and is a marker of tumor growth. Few cases of thyroid carcinoma present

initially due to suspected hypothyroidism without the presence of palpable nodules. Among the patient's antecedents related to thyroid disease, he refers to a brother with unspecified thyroid disease; underwent hormonal treatment and in vitro insemination for infertility the previous year. Multiple studies have associated infertility, and thyroid carcinoma with contradictory results⁷⁻¹⁰.

Conclusion

Thyroid carcinoma is a disease of current relevance since its incidence has been increasing in recent years, it should be suspected not only in patients who present with an asymptomatic thyroid nodule but also in cases of women with a history of the use of hormonal treatments for fertility, where proper management and follow-up allows reducing the recurrence rates of the disease. Although surgical operation can always be considered in terms of treatment in thyroid carcinoma, vitamin, mineral replacement and diet regulation can still be tried. Since papillary thyroid cancer is a non-aggressive and slow-spreading tumor, patients should not be rushed for surgery and radioactive iodine treatment, and this protocol should be used for treatment, and if surgery is required, it should be done after alternative treatment

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