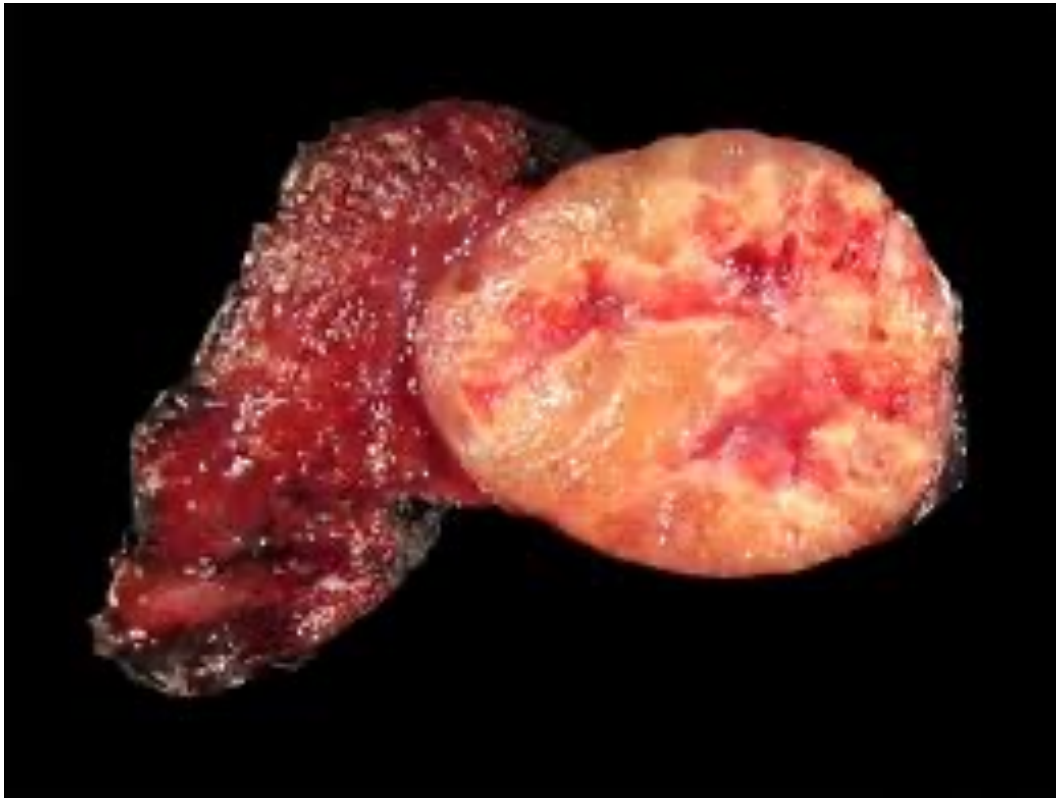
Endocrine system 2023
Thyroid gland part 2

Dr Heyam Awad

MD, FRCPath

Thyroid tumors

- Thyroid neoplasms present as single nodules



Thyroid tumors

- Tumors of the thyroid gland can be benign or malignant.
- They are usually solitary (single not multiple)
- Benign lesions in the thyroid are commoner than malignant ones.

Solitary thyroid nodules

- In clinical practice, if you see a patient with solitary nodule, your differential diagnosis will include neoplastic and non- neoplastic lesions such as:

a. Follicular adenomas
b. A dominant nodule in multinodular goiter
c. Simple cysts
d. foci of thyroiditis

So: neoplasms usually present as single (solitary) nodules, but not every single nodule is neoplastic.

Neoplastic thyroid lesions

Benign: follicular adenoma and its variants (example: Hurthle cell adenoma, atypical adenoma)

Malignant:

1.papillary carcinoma

2. Follicular carcinoma

3. medullary carcinoma

4. Anaplatic carcinoma.

Follicular adenomas

- Are benign neoplasms derived from follicular epithelium.
- Usually solitary.
- The tumor is demarcated and compresses the adjacent thyroid parenchyma by a well-defined, intact capsule

Microscopic examination of follicular adenoma,

- The cells are arranged in follicles and its variants

a. Hurthle cell adenoma:

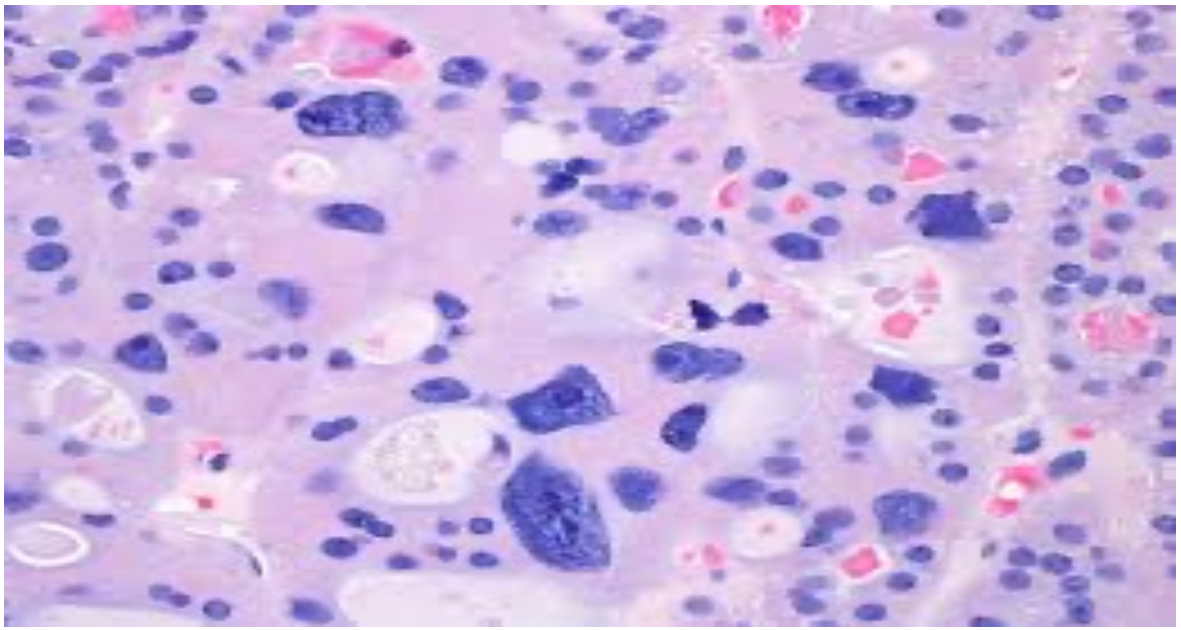
- The neoplastic cells show oxyphil or Hürthle cell change) and its behavior is not different from those of a conventional adenoma.

b. Atypical adenoma:

- The neoplastic cells exhibit focal nuclear atypia, (endocrine atypia);and these features do not constitute evidence of malignancy

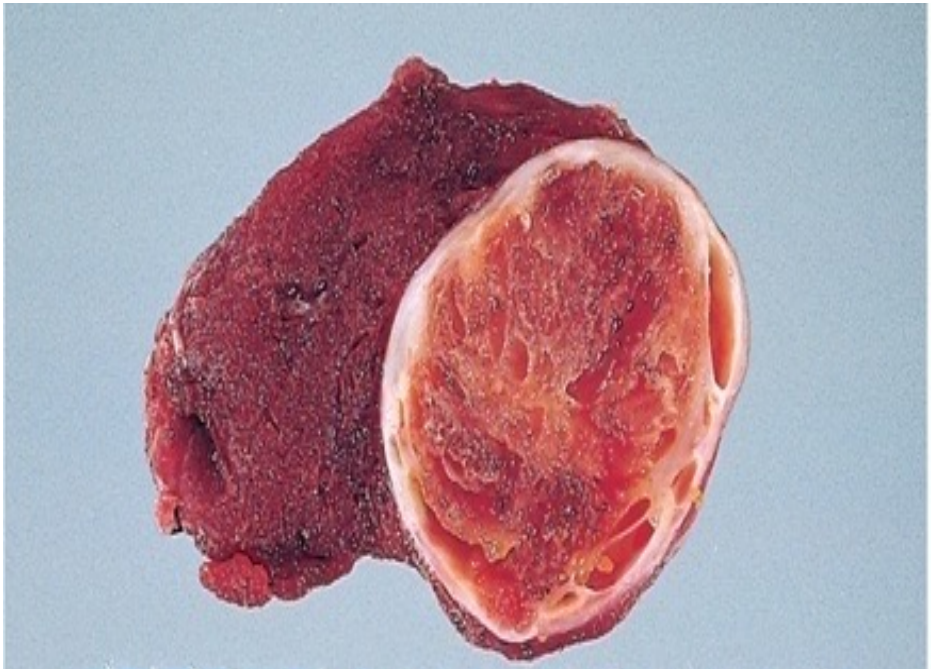
Endocrine atypia

- Note the large, hyperchromatic, pleomorphic cells. These are atypical and this atypia in endocrine glands doesn't necessarily mean malignancy.

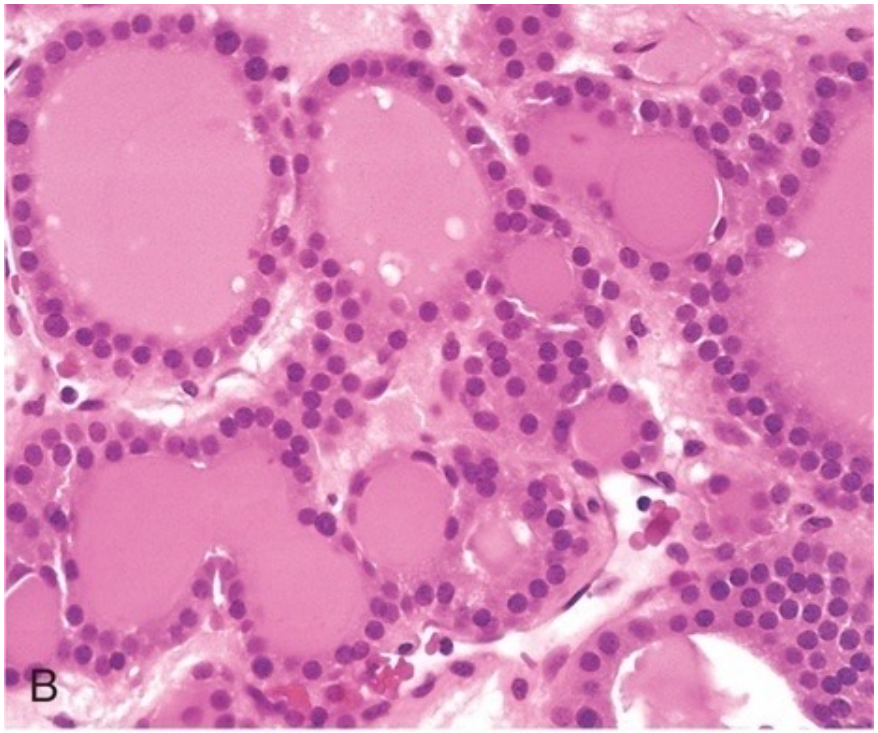


Follicular adenoma

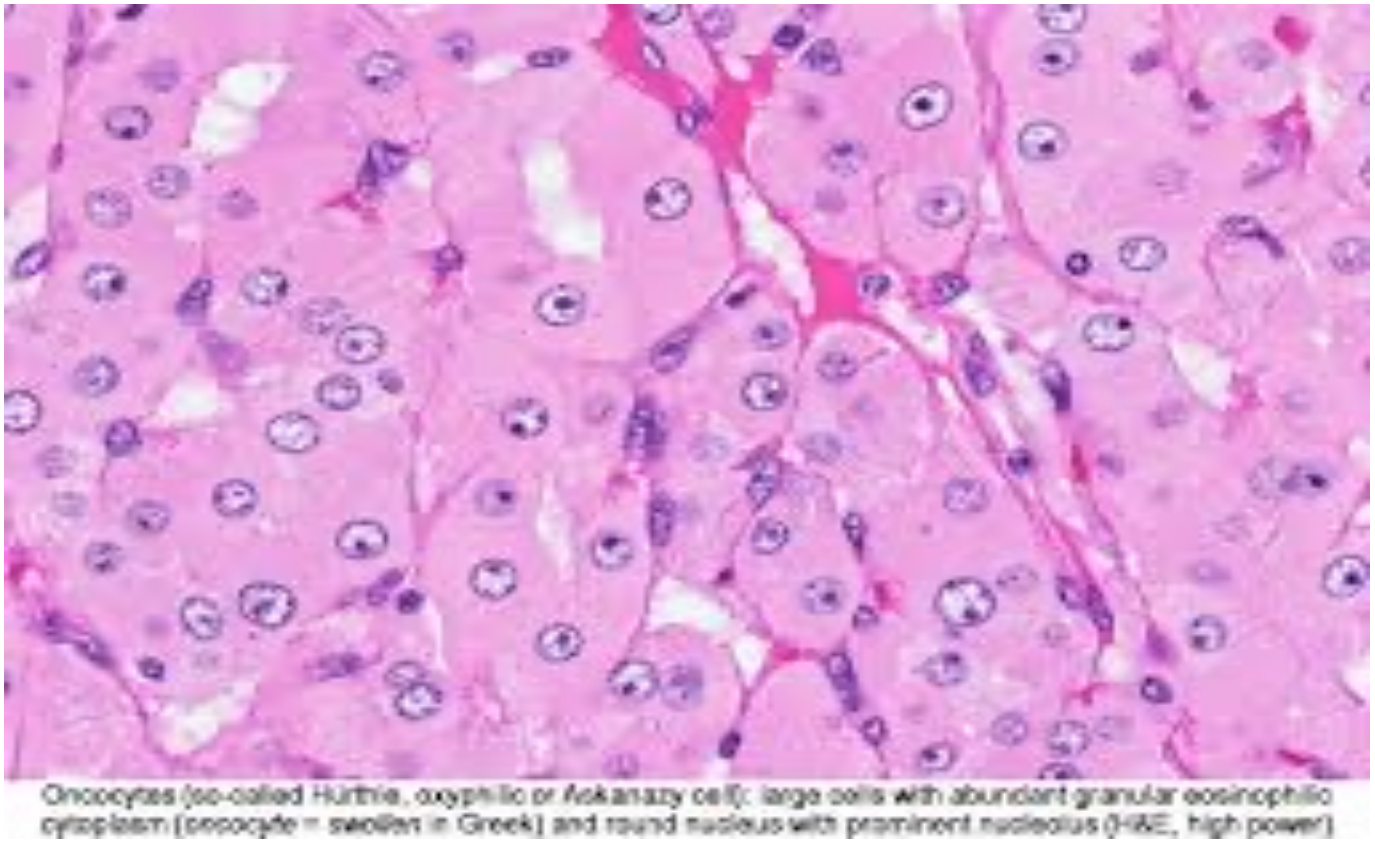
- Well demarcated, encapsulated nodules.



Micro: composed of follicles similar to the normal thyroid follicles.



Hurthle cell adenoma, cells are large with abundant eosinophilic cytoplasm.



- Behavior of thyroid adenomas :

a. Carry an excellent prognosis
b. Do not recur or metastasize
c. *Not* forerunners to carcinomas, i:e they are not premalignant.

Thyroid carcinoma

- Account for about 1.5% of all cancers
- A female predominance has been noted among patients who develop thyroid carcinoma in the early and middle adult years

-cases manifesting in childhood and late adult life are distributed equally between men and women

Main types

1. Papillary carcinoma (for more than 85% of cases)
2. Follicular carcinoma (5% to 15% of cases)
3. Anaplastic carcinoma (less than 5% of cases)
4. Medullary carcinoma (5% of cases

Papillary Carcinoma :

Is the most common form

- accounts for the majority of thyroid carcinomas associated with previous exposure to ionizing radiation.
- May occur at any age.

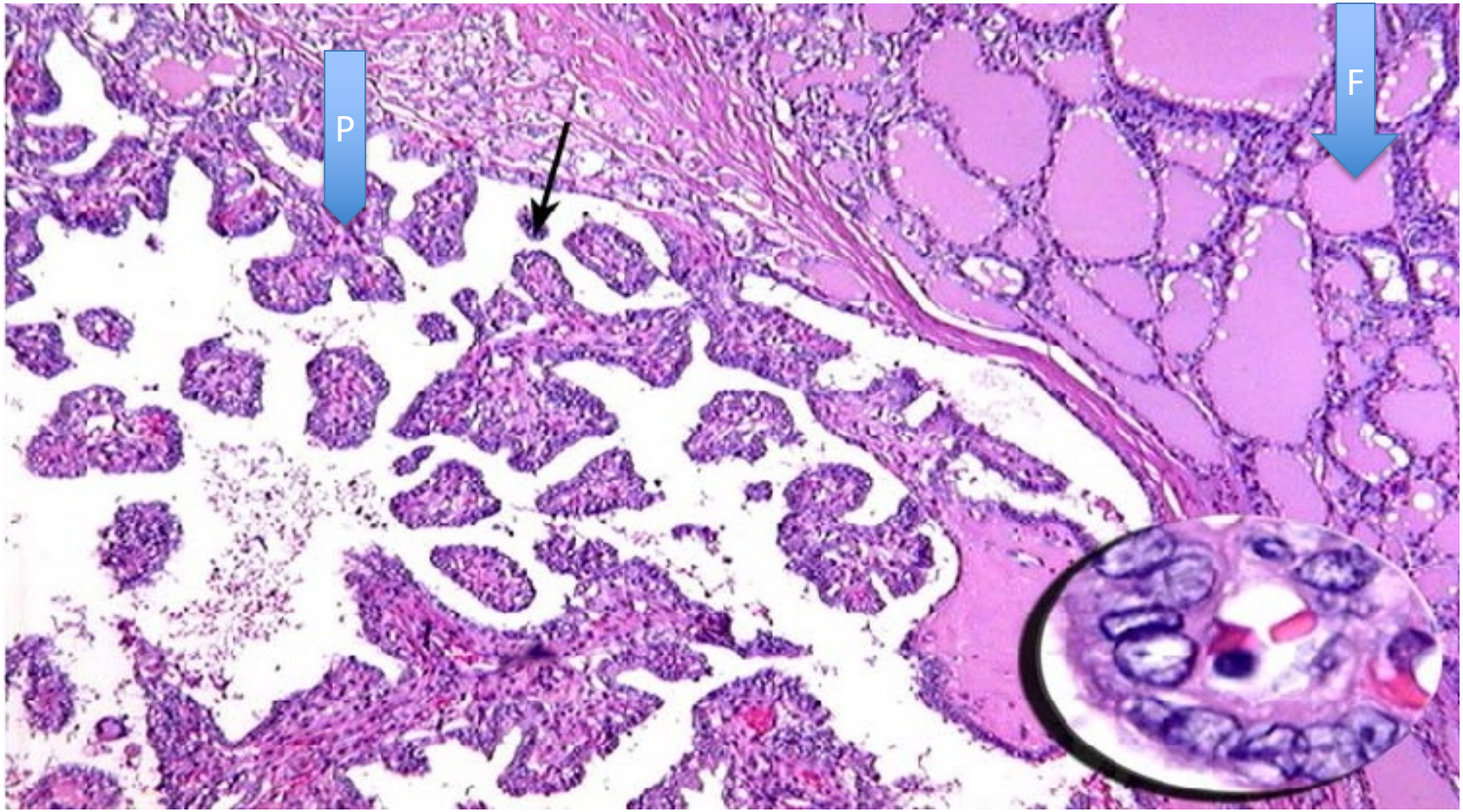
Gross: Either solitary or multifocal lesions

- note: papillary carcinoma can be multifocal.

Microscopic features of papillary carcinoma

- 1. the presence of papillae.
- 2. nuclear features
- 3. Concentrically calcified structures (psammoma bodies)

Papillae (P). Note the difference from the normal follicles (F)

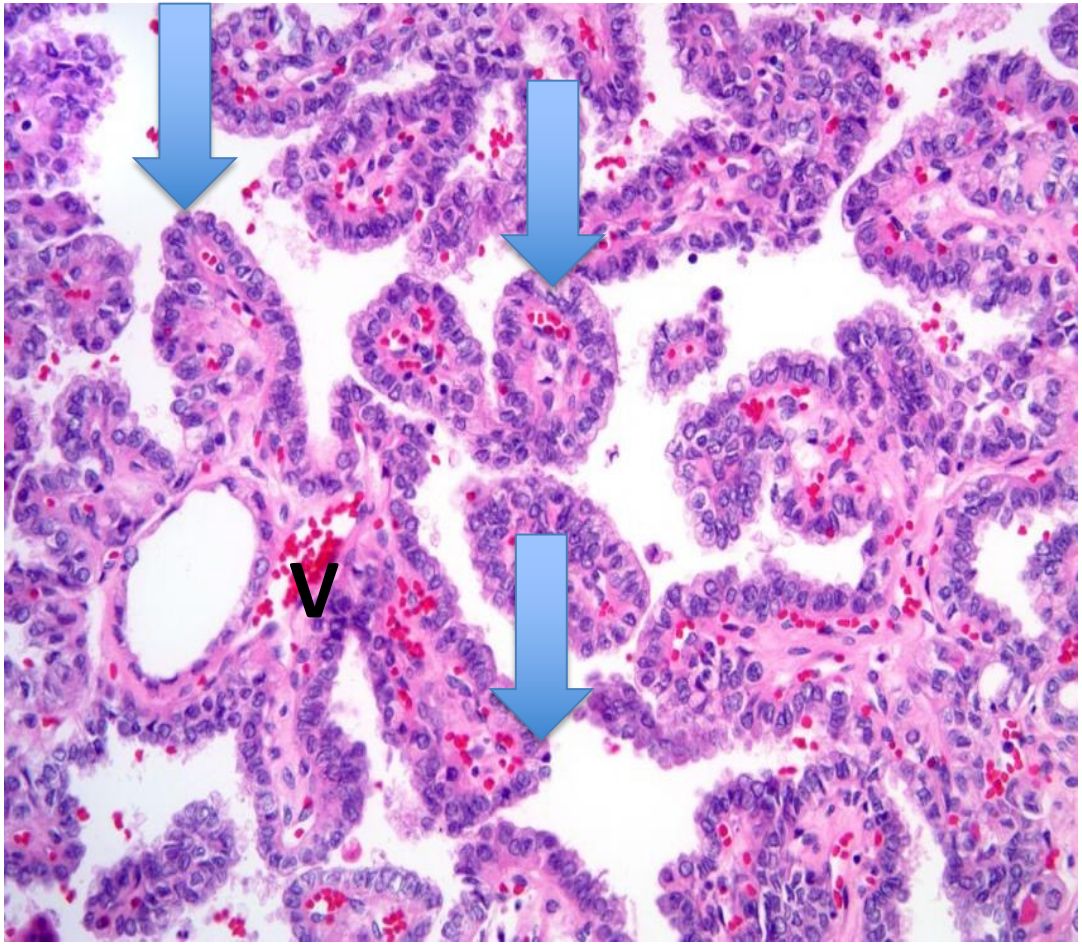


Papillae

-Papillae (arrows) are finger-like projections covered by epithelial cells (the blue dots around the papillae).

-The papillae have fibro-vascular cores (central region which is fibrous and contains blood vessels (V))

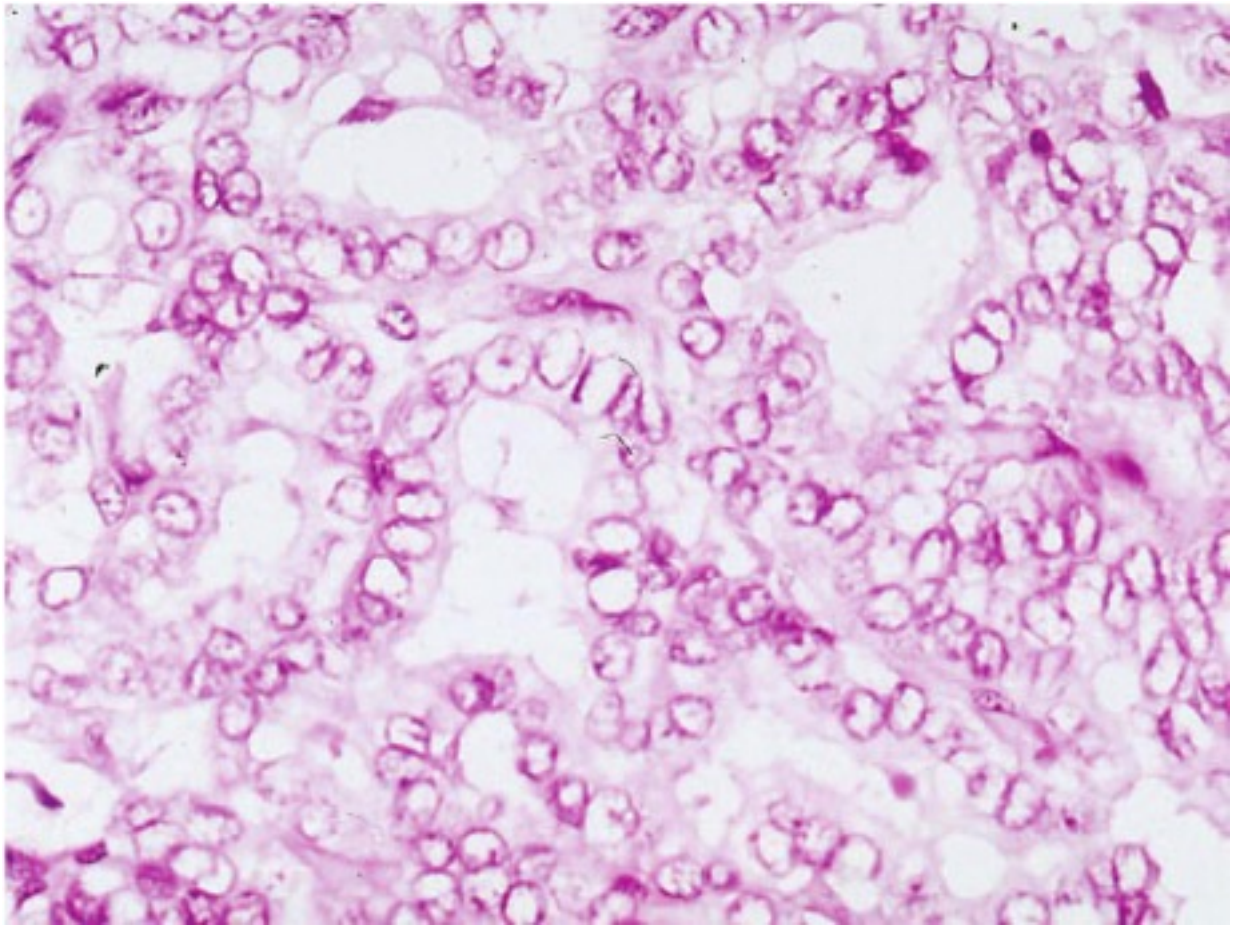
Note: all the red dots in the pic are red blood cells within the vessels.



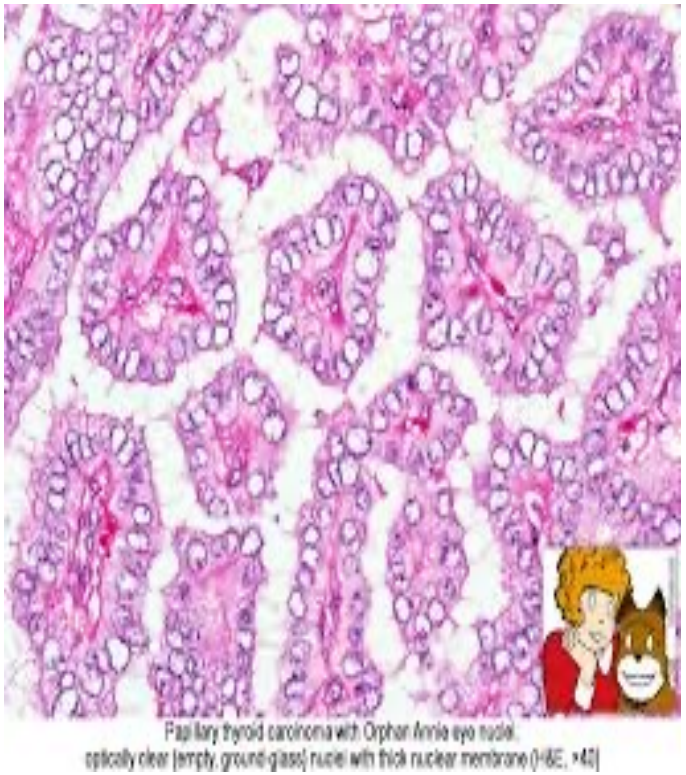
Nuclear features

1. optically clear nuclei, or "Orphan Annie eye" nuclei , seen on histological but not cytological preparations (formalin artefact)
2. Have invaginations of the cytoplasm to the nucleus (pseudoinclusions)
3. Grooves within nuclei: so the nucleus looks like a coffee bean.

Clear nuclei: note the nuclei are white.

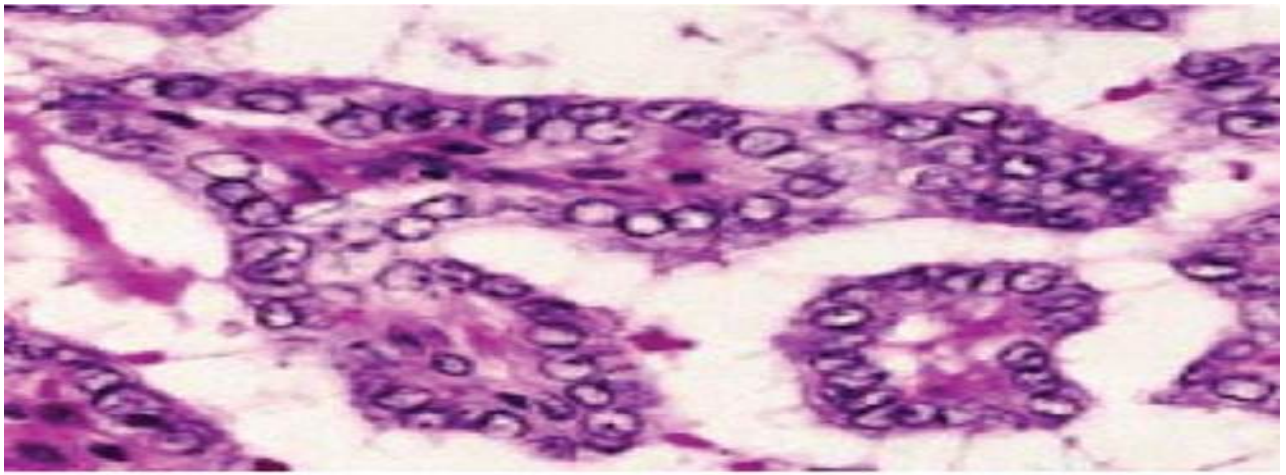


Orphan Annie eye! Because the nuclei are white and empty like Annie's character eyes!!

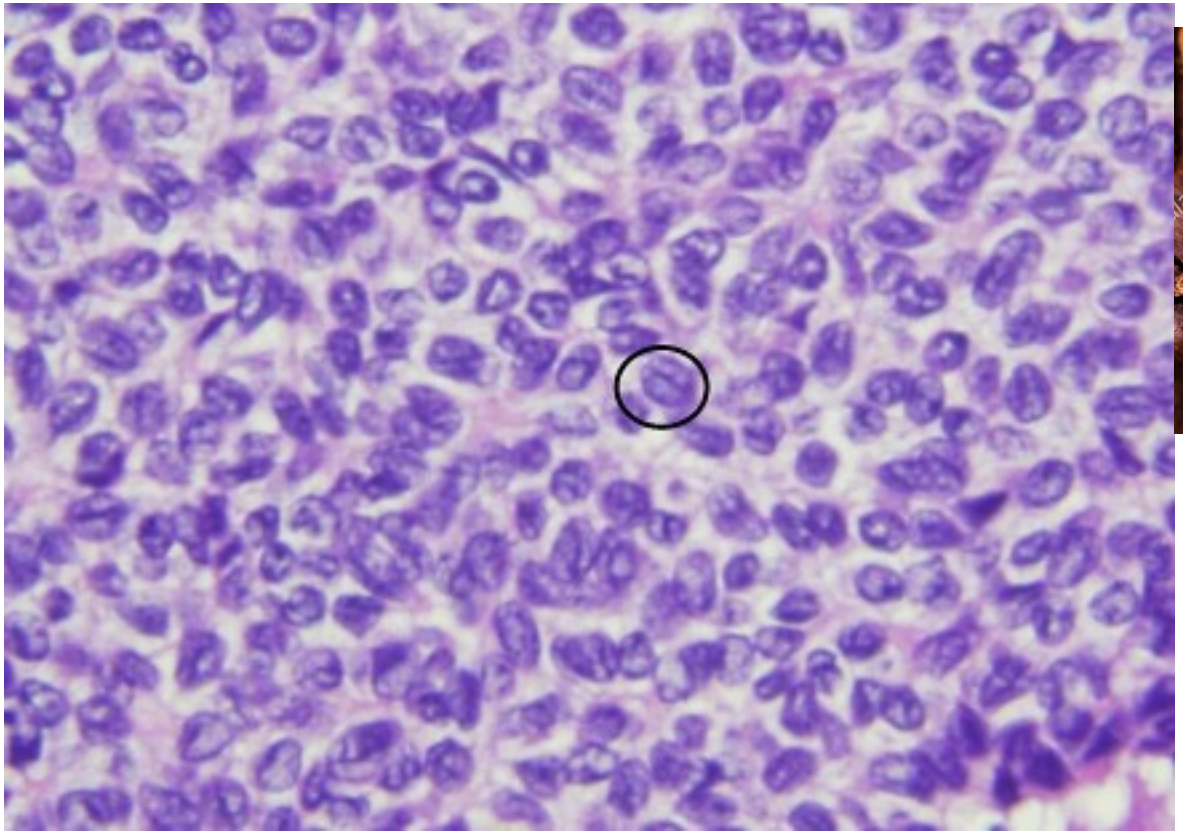


Papillary thyroid carcinoma with Orphan Annie eye nuclei.
optically clear (empty, ground-glass) nuclei with thick nuclear membrane (H&E, ×40)

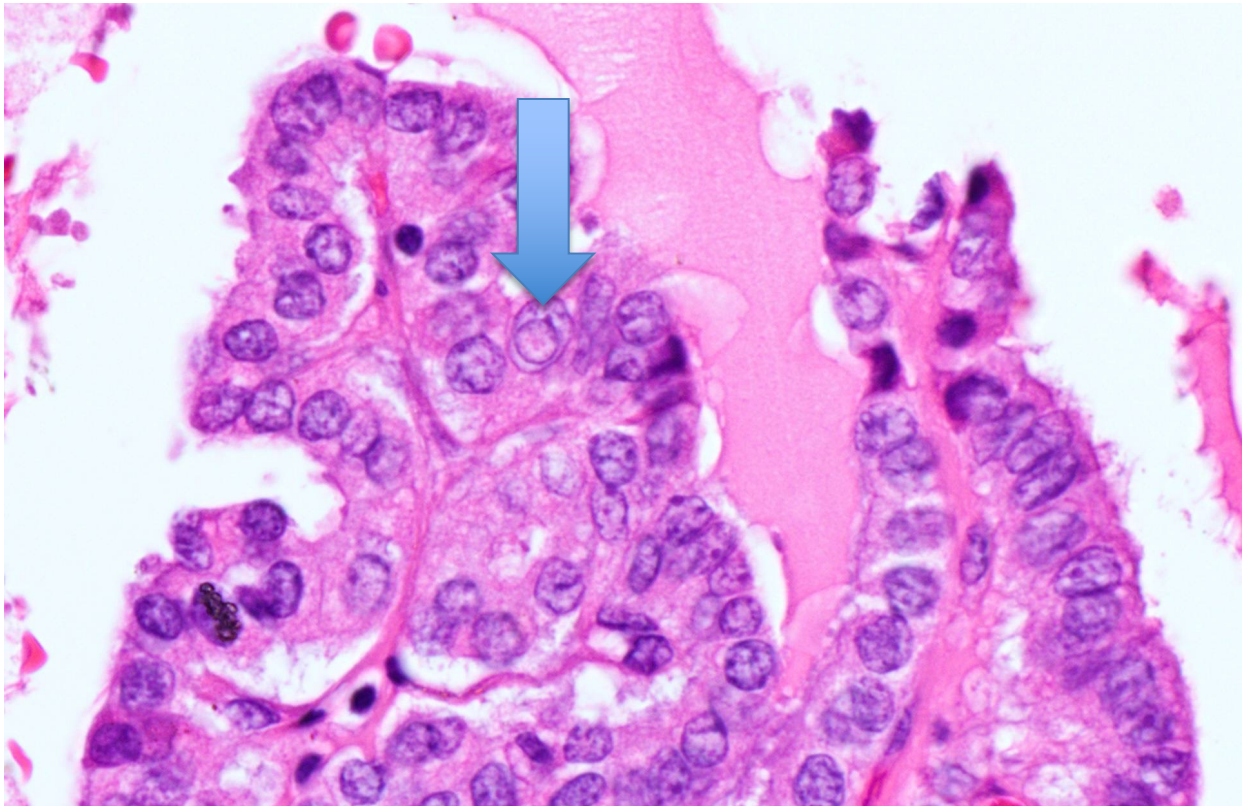
I know what you're thinking: pathological terms are funny.. You’re right



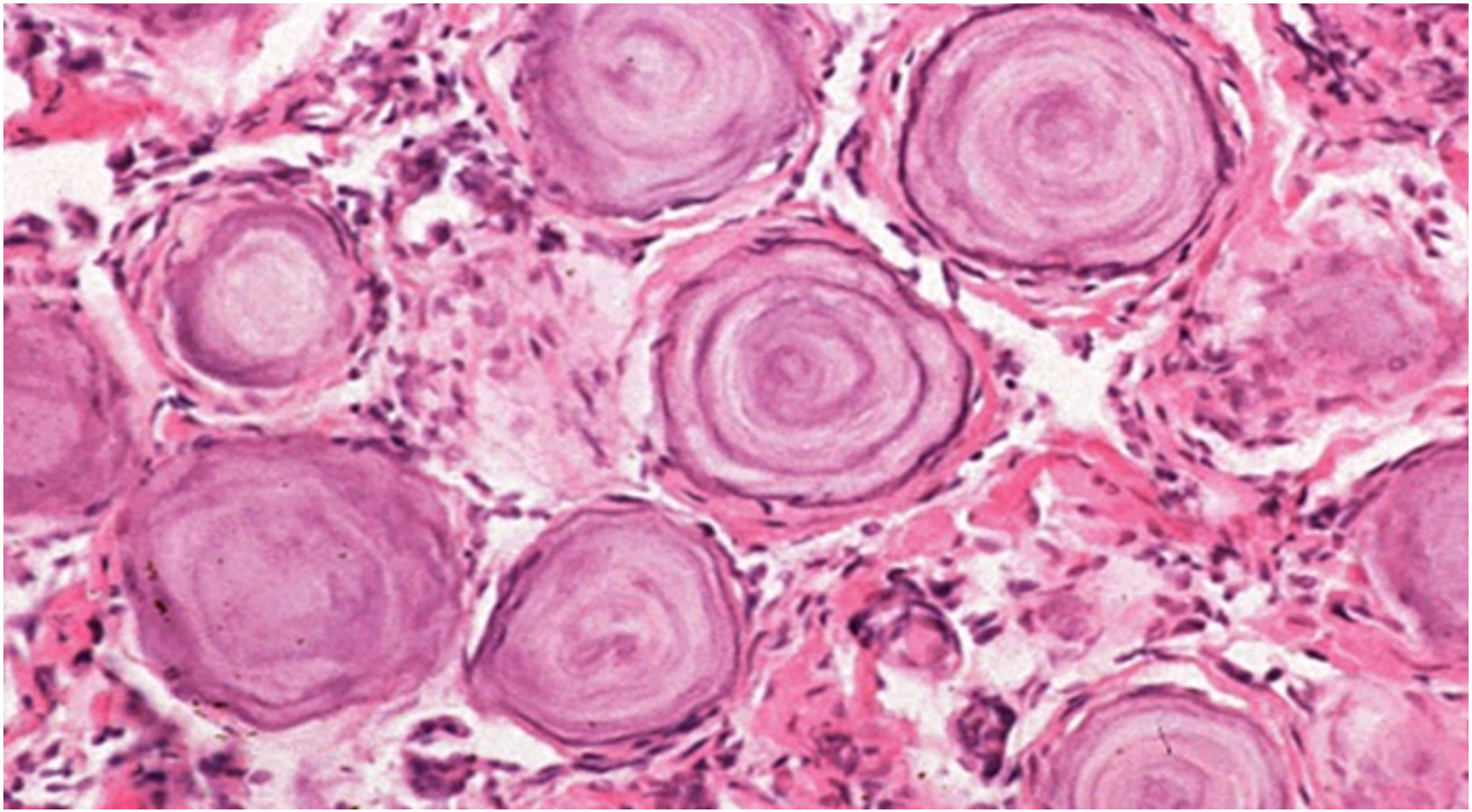
Nuclear grooves= coffee bean nuclei



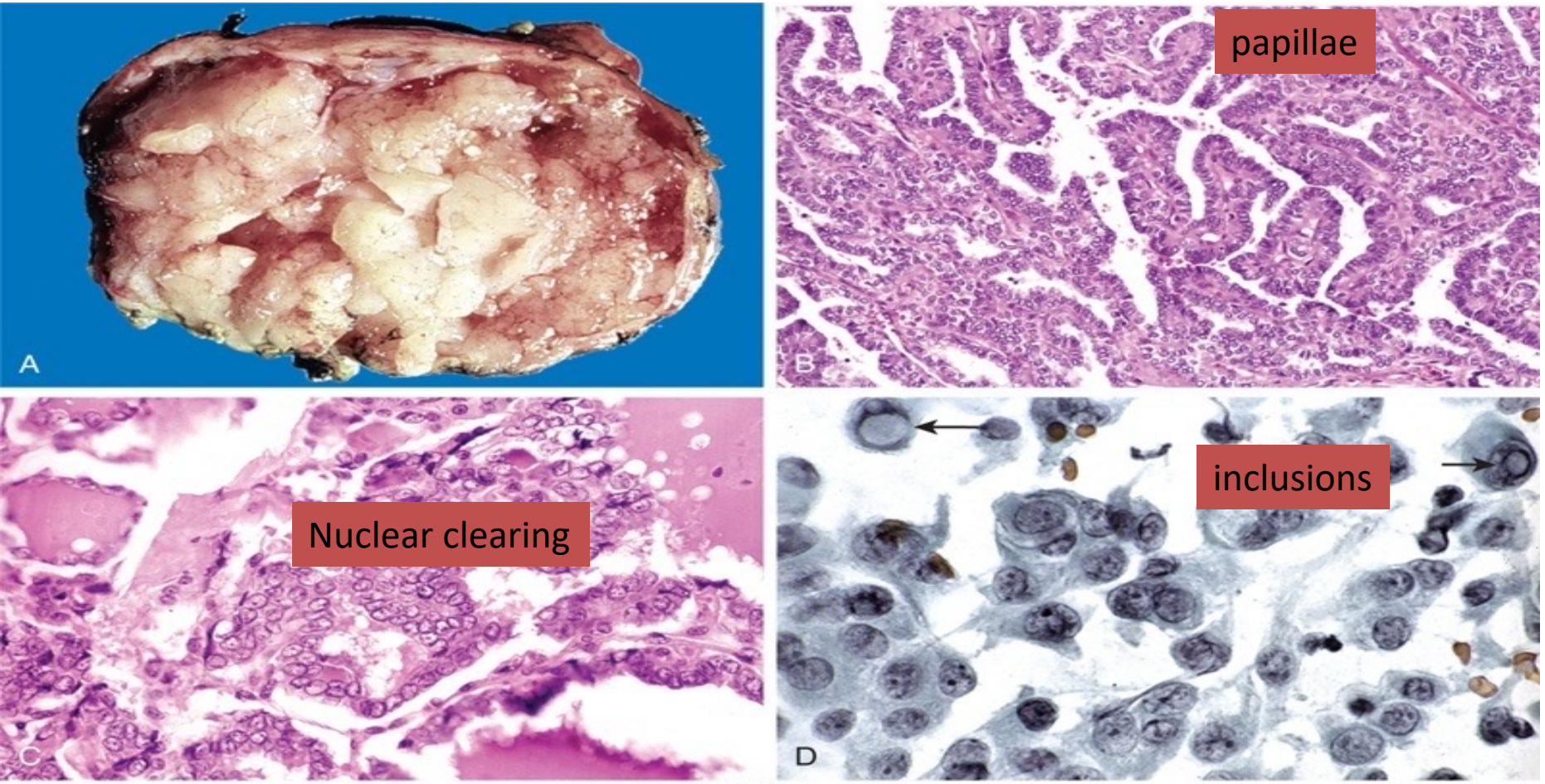
Nuclear inclusions



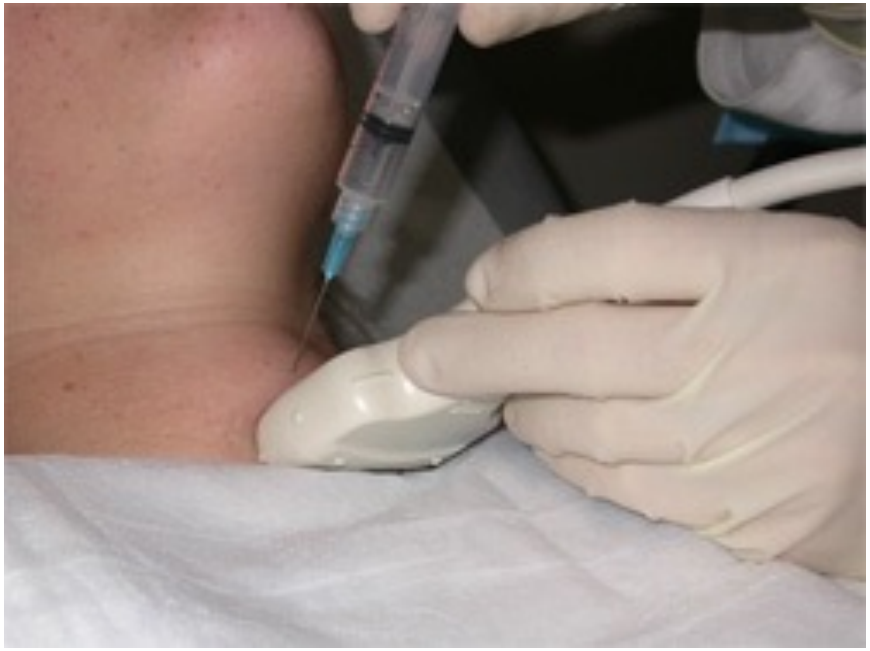
Psammoma bodies



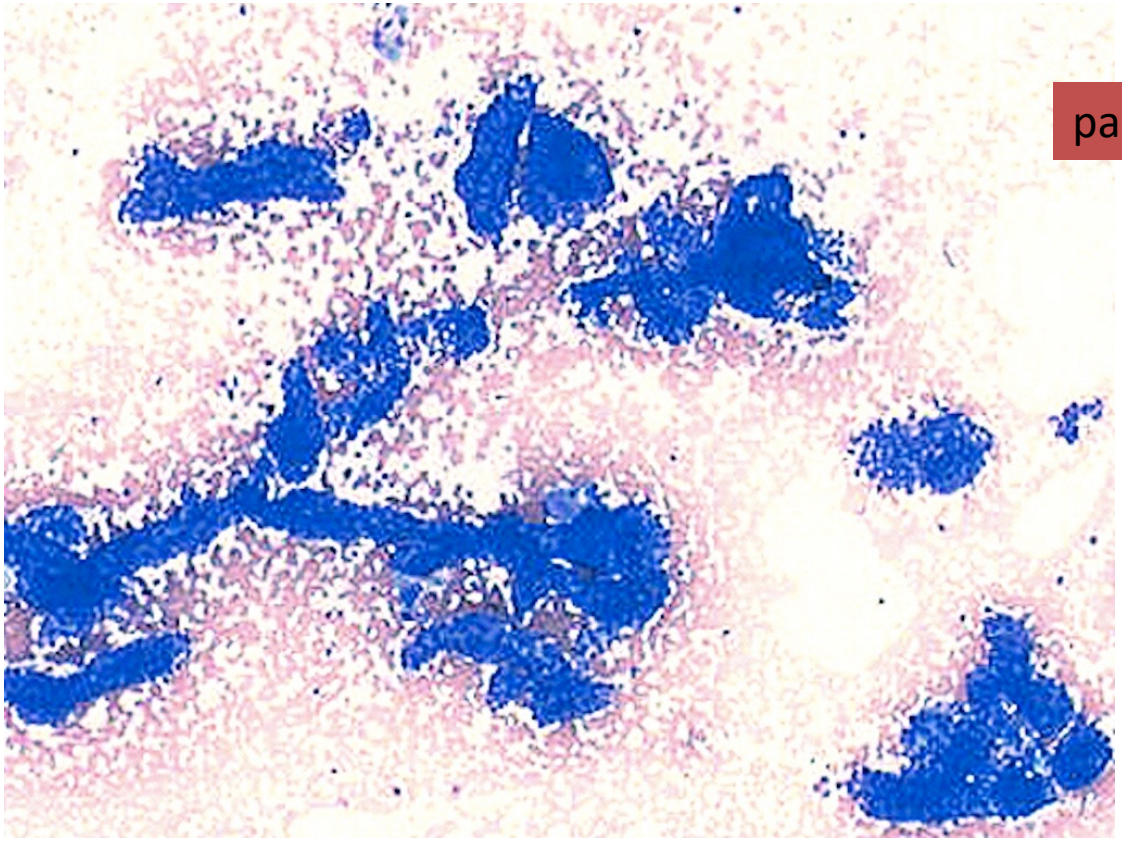
Papillary carcinoma



Papillary carcinoma can be diagnosed on FNA

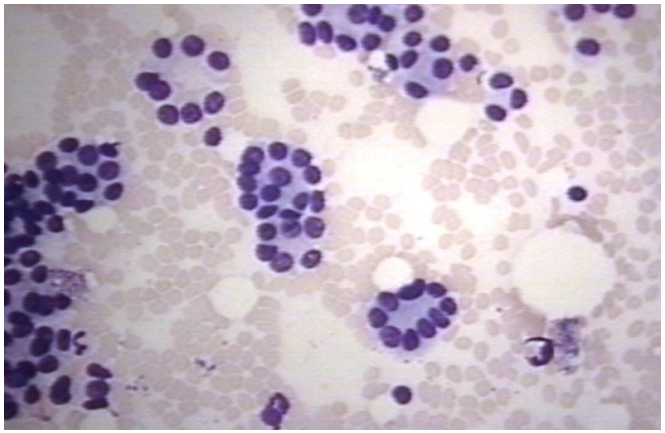


Papillae on FNA: compare to how rounded follicles are seen on the bottom pic

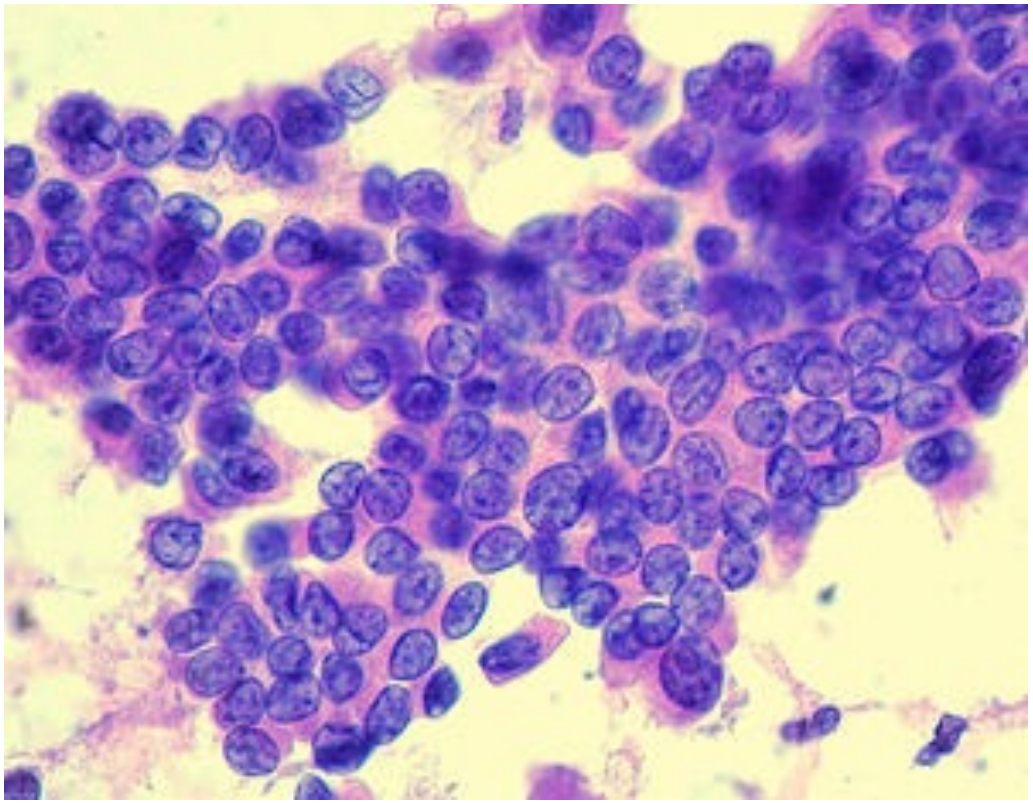


papillae

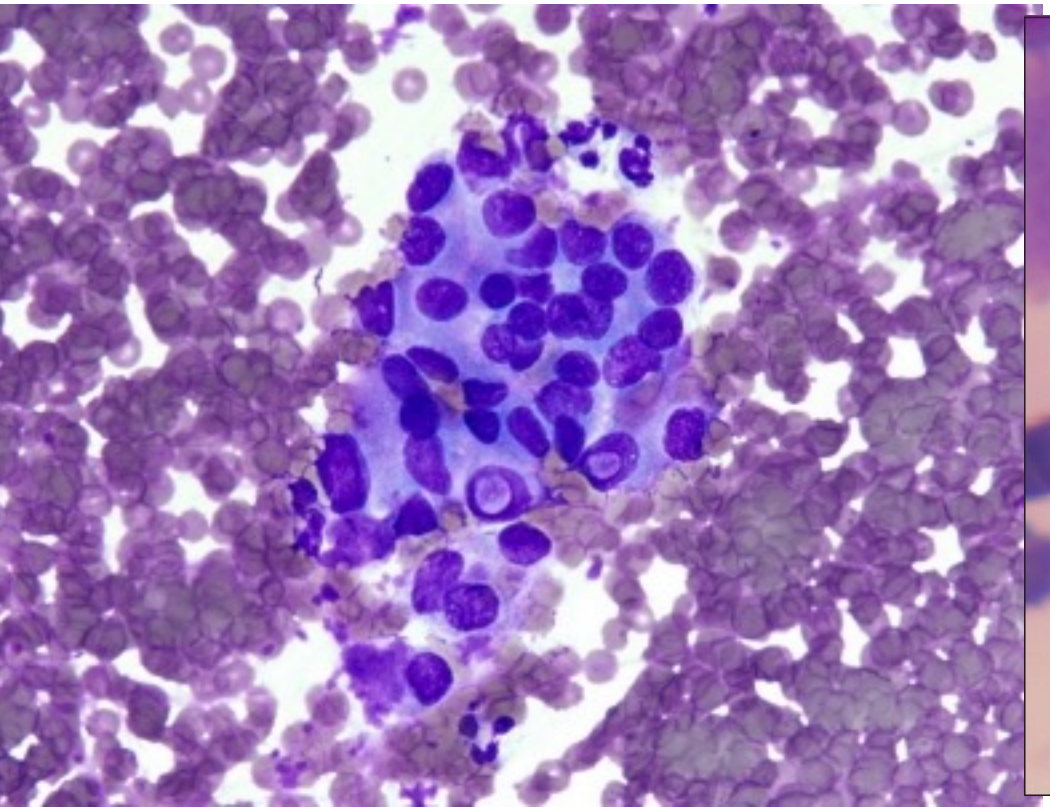
follicles

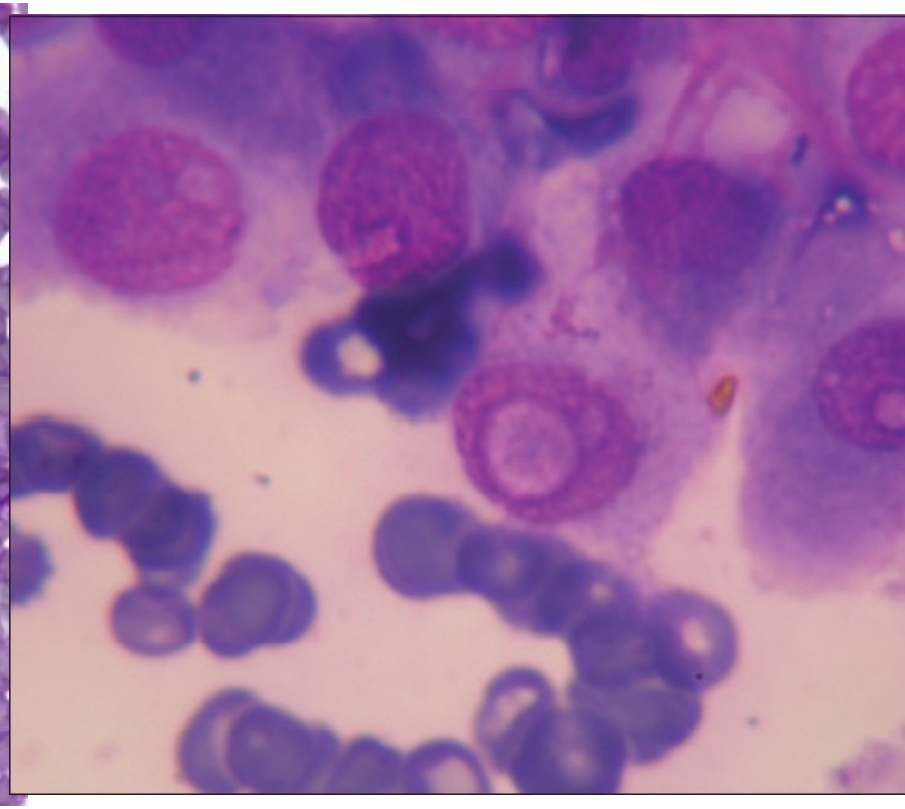


Grooves seen on FNA

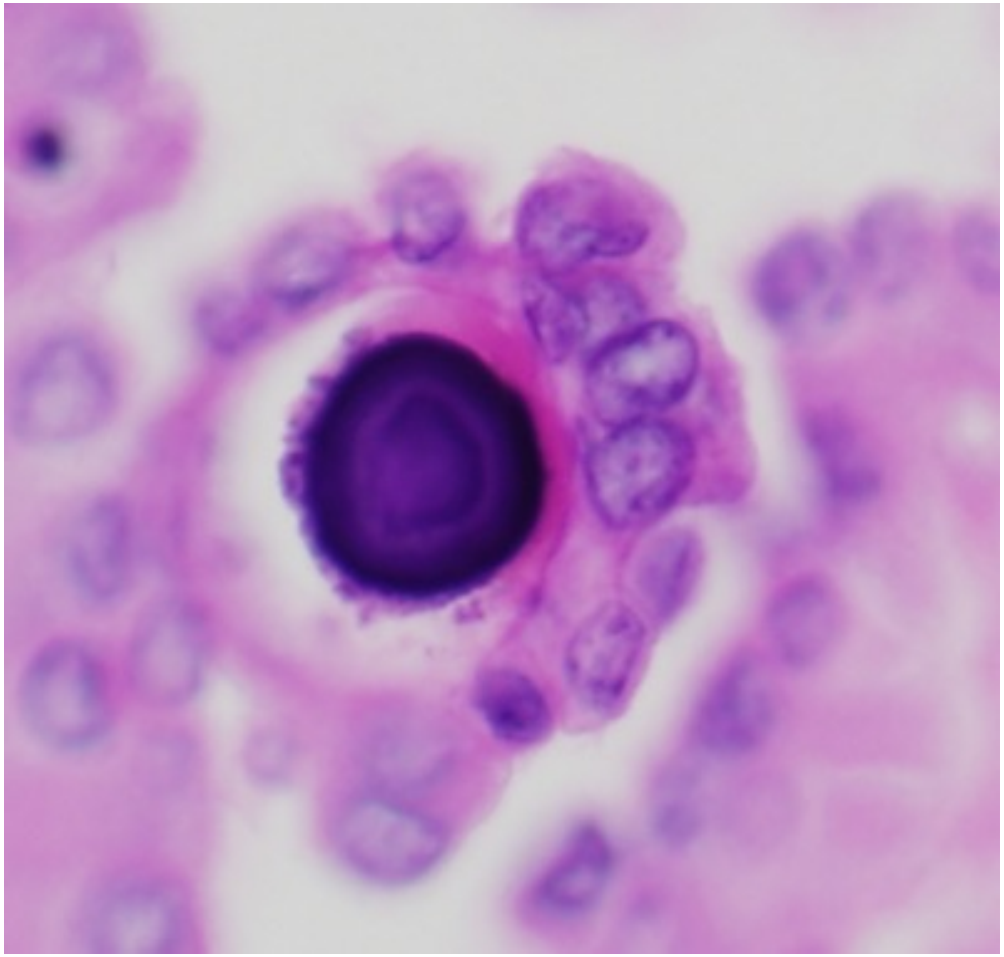


Inclusions seen on FNA





Psammoma bodies can be seen on GNA



Clinical Features of papillary carcinomas

a. Are nonfunctional tumors that manifest as painless masses in the neck, either within the thyroid or as metastasis in a cervical lymph node

b. Are indolent lesions, with 10-year survival rates of 95%.

c. The presence of isolated cervical nodal metastases does not have influence on good prognosis of these lesions.

d. In a minority of patients, hematogenous metastases are present at the time of diagnosis, most commonly to lung.

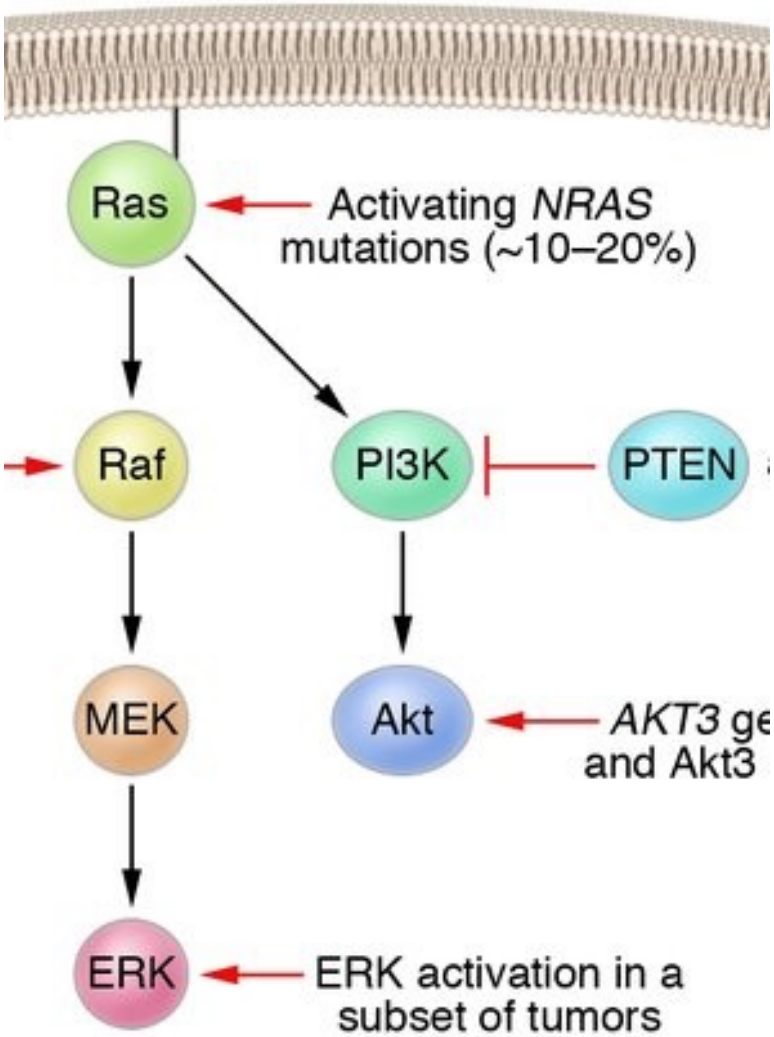
Genetic factors related to papillary carcinoma

- Mainly 2 oncogenes are involved:
- 1. BRAF amplification. (protein in the ras pathway)
- 2. RET gene rearrangement resulting in a novel protein kinase.

Remember that RAS is the most commonly mutated oncogene.

RAS acts via second messeanges .. RAF is one of them

BRAF (of the RAF family genes) is an oncogene in the RAS pathway.



RET rearrangement= translocation

- The *RET* gene is not normally expressed in follicular cells but in papillary cancers, chromosomal rearrangements place the tyrosine kinase domain of *RET* resulting in a novel kinase .
- RET rearrangement is present in 20% to 40% of papillary thyroid cancers.

Note: RET rearrangements and *BRAF* point mutations are not observed in follicular adenomas or carcinomas.

Follicular Carcinoma :

-- More common in women and in areas with dietary iodine deficiency .

- The peak incidence between the ages of 40 and 60 years

On microscopic examination,

- Are composed of fairly uniform cells forming small follicles,
- In other cases, follicular differentiation is less apparent
- It may be

a. widely invasive, infiltrating the thyroid parenchyma and extrathyroidal soft tissues, or

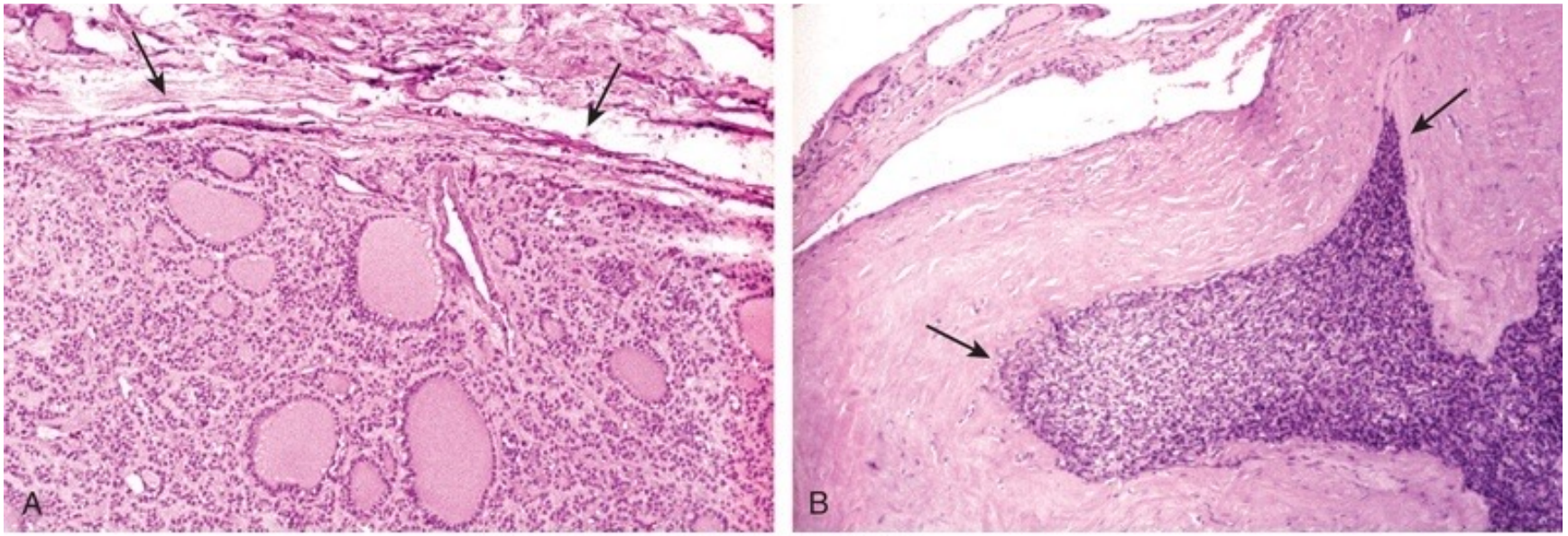
b. Minimally invasive that may be impossible to distinguish from follicular adenomas on gross examination and the .

- requires extensive histologic sampling to exclude capsular and/or vascular invasion

Clinical Features

- Manifest most frequently as solitary *cold thyroid nodules.*
- Tend to metastasize through the bloodstream (*hematogenous dissemination*) to lungs, bone, and liver.
- Regional nodal metastases are uncommon .
- As many as half of patients with widely invasive carcinomas die from their disease within 10 years, while less than 10% of patients with minimally invasive follicular carcinomas die within the same time span.

Follicular carcinoma



GENETIC FACTORS

Follicular thyroid carcinomas:

a. activation of *RAS*

b. Loss-of-function mutations of *PTEN*, a suppressor gene

c. (2;3) translocation,

3. Anaplastic Carcinoma

- Are undifferentiated tumors of the thyroid epithelium,
- The mean age of 65 years.
- They are aggressive, with a mortality rate of 100%.
- Approximately a quarter of patients have a past history a well-differentiated carcinoma, and a 1/4th harbor a well-differentiated tumor in the resected specimen.
- Metastases to distant sites are common, but **death occurs in less than 1 year as a result of aggressive local growth which compromise of vital structures in the neck.**

GENETIC FACTORS

Anaplastic carcinomas:

Inactivation of *TP53*, restricted to anaplastic carcinomas and may also relate to their aggressive behavior

4. Medullary Carcinoma

- Arises from C cells.

- neuroendocrine neoplasms.
- Secrete calcitonin, the measurement of which plays an important role in the diagnosis and postoperative follow-up evaluation of patients.

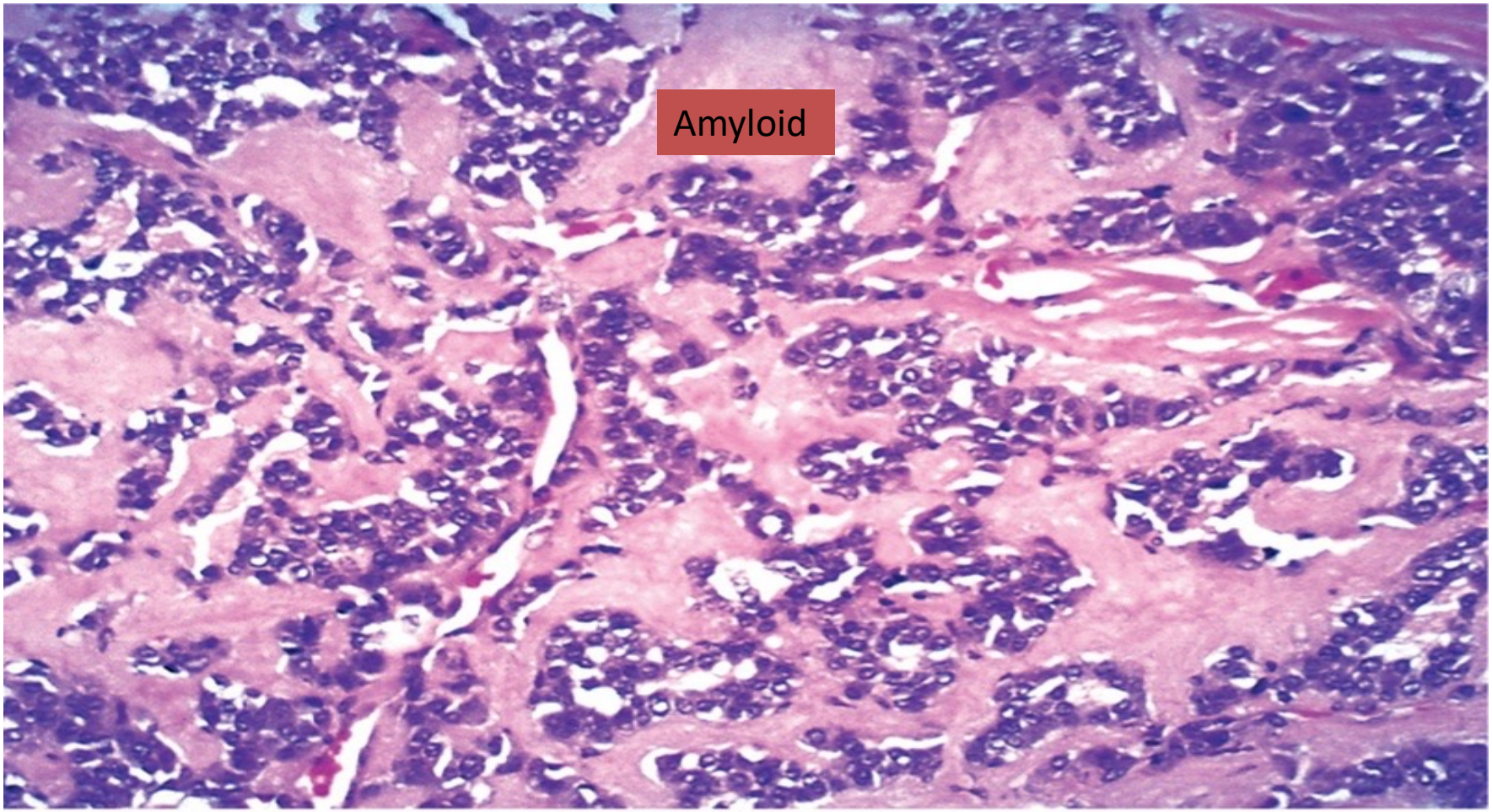
- Are sporadic in about 70% of cases and the remaining 30% are *familial* cases

Note: Both familial and sporadic forms demonstrate activating *RET* mutations.

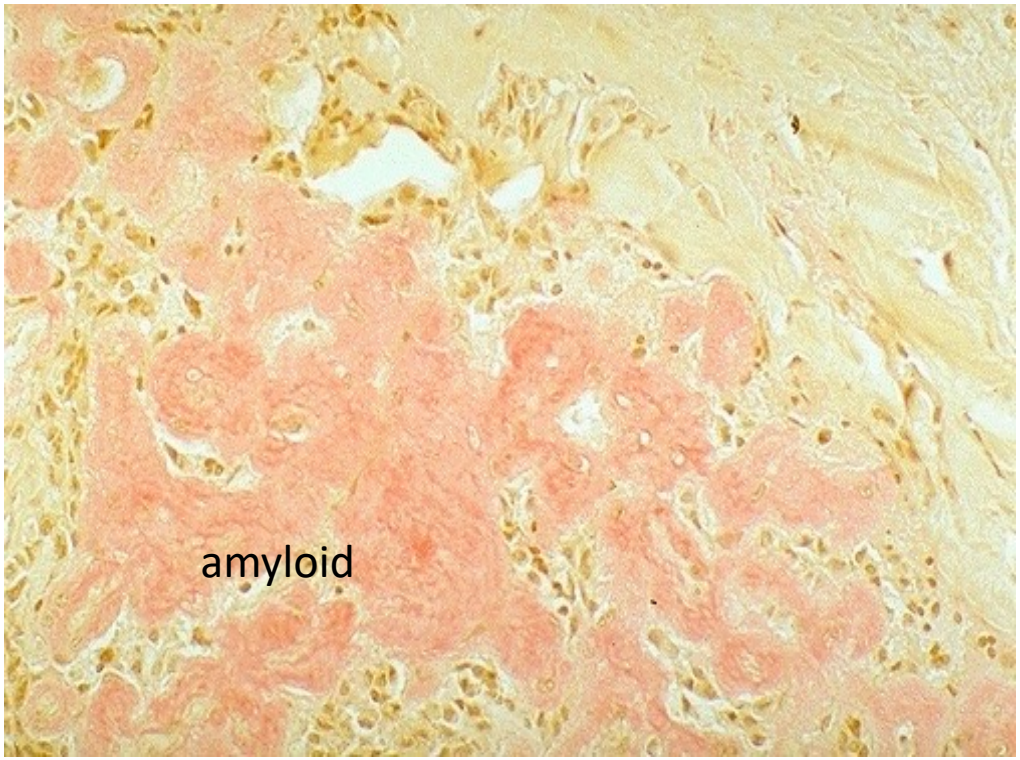
- Because medullary carcinoma secrete calcitonin; this calcitonin can accumulate and form amyloid protein.

- Amyloid: is several, chemically different proteins that share similar physical characteristics.. They can accumulate and form pink material called amyloid.. See next pic.

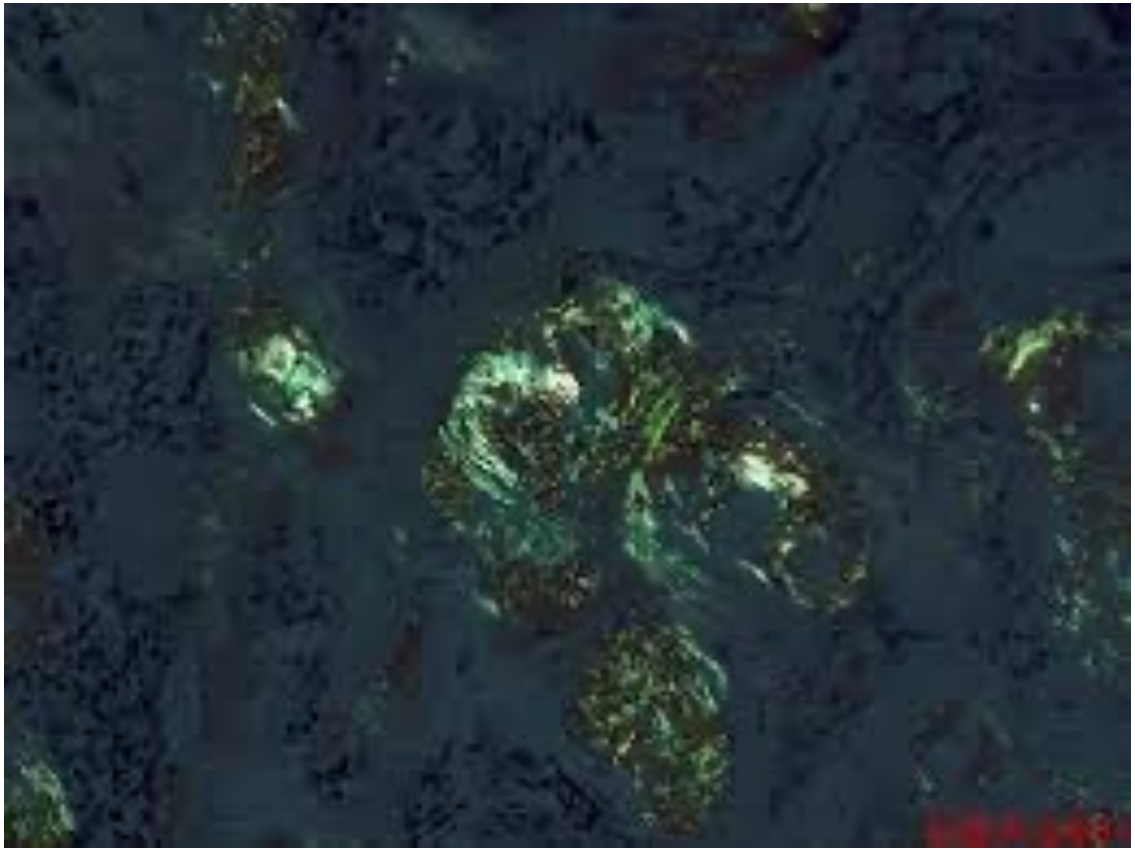
Medullary carcinoma



Amyloid stains with Congo red stain



With polarized light, amyloid gives this apple green color when stained with congo red




Thank you!