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Hyperthyroidism during pregnancy due to coexistence of struma ovarii and Graves’ disease

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Summary: A patient with hyperthyroid Graves’ disease and struma ovarii is described. She had pre-existing Graves’ disease and positive thyrotropin receptor antibody. She was treated with radioactive iodine 5 months before she became pregnant. Paripartum she had torsion of an ovarian cyst with histological evidence of a functional struma ovarii. Immediate exacerbation of her thyrotoxic state was observed after operation as a result of release of thyroid hormone from the tumour. It is postulated that the tumour was stimulated by circulating thyrotropin receptor antibody.

Introduction

Struma ovarii causing hyperthyroidism is a rare clinical condition. The diagnosis is usually suspected in a clinically hyperthyroid patient with negative scintiscan of the neck, who has no history suggestive of thyroiditis, iodine contamination or iatrogenic thyroid hormone consumption. We report here a unique patient with relapse of hyperthyroidism during pregnancy due to coexistence of struma ovarii and Graves’ disease.

Case report

A 40 year old woman was referred to our hospital for management of recurrence of her hyperthyroidism. She had a history of diffuse thyroid enlargement and hyperthyroidism 4 years before and was treated with anti-thyroid drugs for one year with clinical remission. On this presentation she had recurrence of palpitation, marked sweating and weight loss for 2 months together with increase in goitre size. There was no family history of thyroid or autoimmune disease. Examination revealed tachycardia, diffuse moderately enlarged thyroid gland and no eye signs. Total T4 (TT4) was 258 nmol/l (normal 62 to 154), with free thyroxine index (FTI) of 297 (normal 56 to 152) and free T4 (FT4) of 54.7 pmol/l (normal range 9.9–25.9). TSH was undetected by sensitive immunoradiometric assay (Boots-Celtech). There was diffuse increased uptake at the neck on 131I scan with a 4-hour thyroidal uptake of 70% (normal 12 to 45). She was treated with 320 MBq of radioactive iodine and also advised to practise contraception. She became euthyroid 3 months afterwards but returned 2 months later with a relapse of symptoms and was also found to be pregnant. TT4 then was 307 nmol/l with a FTI of 203. The thyrotropin receptor antibody was positive at 23.8% (normal <10%). Carbimazole was given and the patient subsequently remained euthyroid and the drug was withdrawn at 38 weeks of gestation. Ultrasoundography (at 18 weeks of gestation) showed a normal fetus with no abnormal pelvic mass.

At 41 weeks of gestation, the patient developed sudden onset of severe right lower quadrant abdominal pain. This was associated with signs of fetal distress. Laparotomy showed torsion of a haemorrhagic right ovarian cyst of 5 x 4 cm diameter. There was no ascites and ovarian cystectomy was performed. The fetus was delivered by Cesarean section and was normal without any thyroid enlargement. Thyroid function test of the patient one day after delivery showed marked elevation of TT4 to 1580 nmol/l and FTI of 1254. Carbimazole and propranolol were reintroduced with rapid improvement of symptoms and 2 weeks later, the patient was rendered biochemically euthyroid.

Histology of the ovarian cyst showed multiple colloid-containing follicles with positive immunoperoxidase staining for thyroglobulin and thyroxyne. Some follicles were markedly distended by colloid with attenuation of epithelium. There were no other teratomatous or germ cell elements. The finding was that of struma ovarii.

In view of the diagnosis of struma ovarii, carbimazole was stopped to assess the possibility of remission after tumour removal. Total body 131I scintiscan performed 4 weeks after stopping car-

Discussion

Struma ovarii is a thyroid tissue is grossly recognizable teratoma. The incidence of thyroid function tests is 15% of the total. Many of the reported studies have been published by high risk patients with struma ovarii.

The diagnosis is prior to surgery. Uptake in the pelvis is the highest in the n

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References


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The thyrotoxicosis of Graves' disease,