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A retrosternal retrotracheal multinodular goitre

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DESCRIPTION

A 58-year-old lady with a history of rheumatoid arthritis on methotrexate therapy was admitted to the intensive care unit for non-invasive ventilation following acute pneumococcal pneumonia. A CT pulmonary angiogram was performed to rule out pulmonary embolus which revealed a retrotracheal mass arising from the thyroid (figure 1). MRI scanning was performed subsequently, and the mass was confirmed to be a retrosternal retrotracheal goitre (figure 2). There was no radiological evidence of collapse of the trachea. The patient was clinically euthyroid with borderline raised free T4 of 23.7 pmol/l (9–19) and thyroid-stimulating hormone level of 0.1 μ/l (0.3–5) on acute presentation.

Retrotracheal goitres represent around 4% of retrosternal goitres – the rest being anterolateral to the trachea. They are thought to arise from the posterior lobes of the thyroid gland and descend through the neck to lie in the posterior mediastinum anterior to the vertebral body.[1] They can remain silent for many years and are most often incidentally found on radiological imaging or if they grow large enough to cause effects by compression promise due to mild lateral displacement of the trachea which was decompensated by acute infection. Flow volume testing was not performed to delineate this on the intensive care unit.

Management is by surgical excision of the gland. This lady recovered from her pneumococcal pneumonia and is currently being followed up in the ENT clinic with a view to excision in due course.

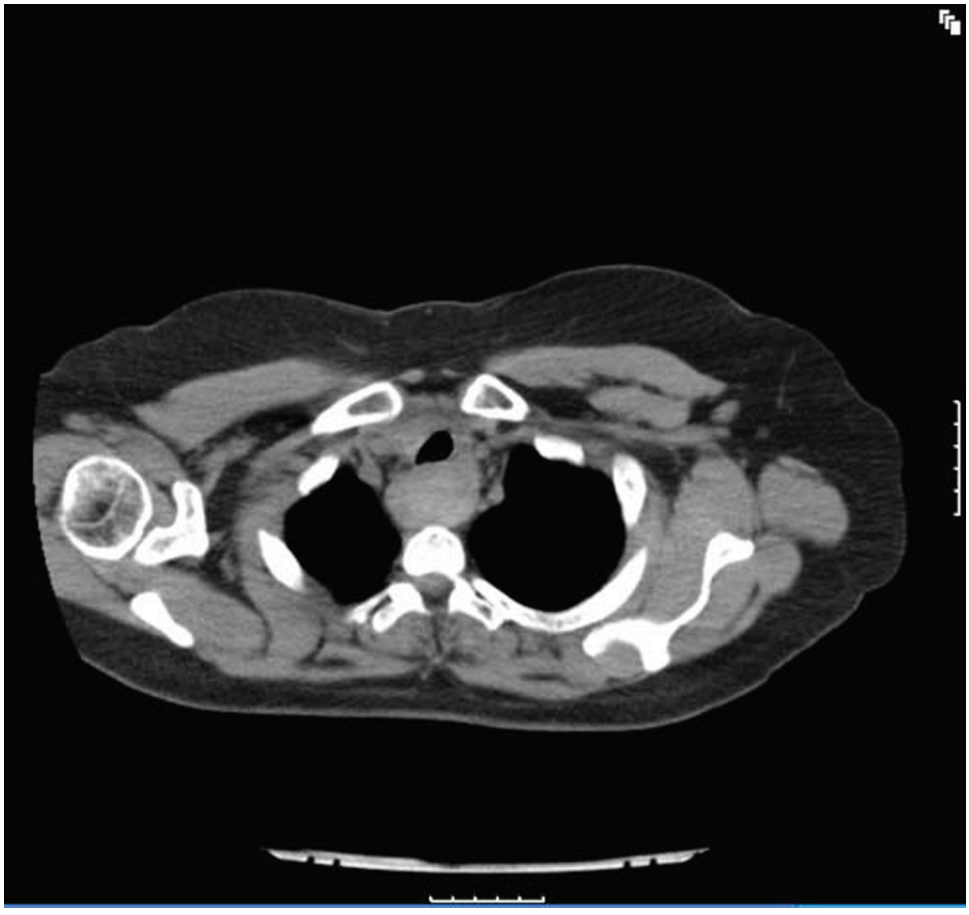

Figure 1 CT chest: a 4.9 cm retrotracheal mass is demonstrated.

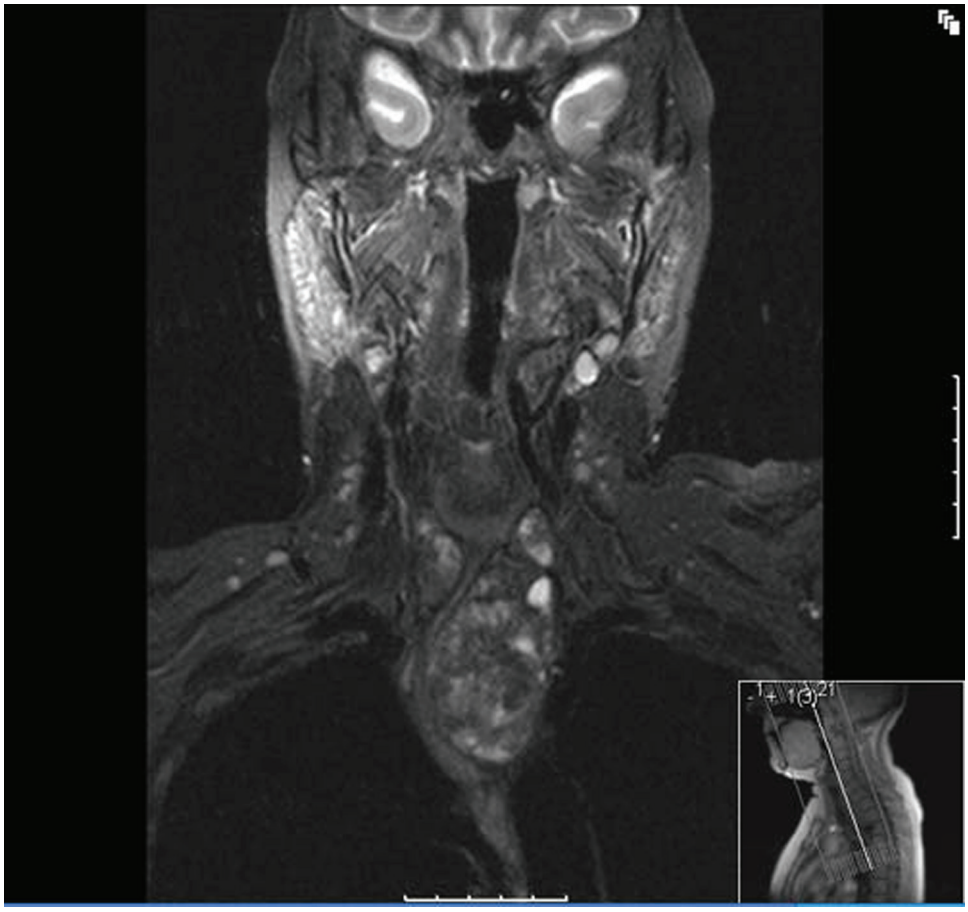

Figure 2 Coronal reformatted T2-weighted MRI neck: the retrosternal retrotracheal goitre is now clearly delineated.

Competing interests None.

Patient consent Obtained.

REFERENCES

1. **De Perrot M,** Fadel E, Mercier O, *et al*. Surgical management of mediastinal goiters: when is sternotomy required? *Thorac Cardiovasc Surg* 2007;**55**:39–43.