A 39-yr-old woman presented with dyspnea and cough. She had undergone total thyroidectomy for multinodular goiter 15 yr earlier, with subsequent T4 replacement therapy. Inspiratory stridor was noted. Serum TSH was 2.95 mIU/ml (normal, 0.3–4.0 mIU/ml).

A magnetic resonance image (MRI) of the neck showed a subglottic tumor with severe occlusion of the trachea (Figs. 1 and 2). Direct laryngoscopy revealed a subglottic mass covered with normal mucosa. $^{99m}$Tc scintigraphy showed homogenous subglottic uptake compatible with a thyroid tissue. A transtracheal surgical approach was used to remove the tumor. Pathology showed a follicular thyroid tissue with no features of malignancy.

Subglottic ectopic thyroid tissue is rare. A history of total thyroidectomy or goiter should be a clue as to the etiology of an intratracheal mass preoperatively (1–5). The most common clinical feature is stridor (1, 2). Definitive diagnosis is established by biopsy. Ulceration, multiple nodules, and bleeding suggest possible malignancy (2).

Two theories exist regarding the origin of intratracheal thyroid tissue. First, a fetal anomaly could result when the thyroid is divided by the developing trachea and its cartilage rings. Second, thyroid tissue could grow into the tracheal lumen (2, 3).

Computed tomography scan or MRI gives information about the extent of the tumor, the degree of obstruction, and whether the malignant features or lymph node enlargement are present. Thyroid scintigraphy is not helpful if eutopic thyroid is still in place because it obscures visualization of the intratracheal tissue. Differential diagnosis includes other benign conditions like papilloma, and malignant diseases such invasive thyroid carcinoma or chondrosarcoma (2, 5). Treatment has typically been surgical resection.
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