INTRODUCTION

The thyroid gland is unique among endocrine gland in that it is the first endocrine gland to appear in the foetus. It is the largest endocrine gland (weighing about 25g) and is the only one which is amenable to direct physical examination of its superficial location. Diseases of thyroid gland are extremely common. Palpable thyroid nodule of which majority are asymptomatic occurs in 5% of the population. Estimate are that about 1% of the women will have hypothyroidism a similar number hyperthyroidism and 3 to 4% clinically detectable thyroid nodule at some times in their lives. Prevalence rate in male are considerable lower, but still significant while most dreaded thyroid condition -thyroid storm and myxoedema coma, sever graves ophthalmopathy and anaplastic thyroid carcinoma are uncommon thyroid disorders as group can cause considerable morbidity. Because of the possibility of the malignancy, sometime clinicians those in the surgical field recommended that all the nodules be removed. On the other hand, endocrinologist recommend that FNAC be performed as the initial steps of evaluation in order to avoid unnecessary surgery this thoughts were in the past.
Because the thyroid nodularity is common, it would be impossible to operate on every patient with a thyroid mass, as the incidence of malignancy is quite low compared with over all incidence of thyroid nodularity. So the goal of diagnostic workup is to select that patient for surgery who has a high likelihood of harbouring malignancy in the nodule. At one extreme, the diagnosis of malignancy may strongly suspected on clinical ground (male, sex growing nodule, firm/hard nodule, ill-defined nodule margin, cervical adenopathy, dysphonia, dysphagia and cough) and such patient generally require open exploration. On the other hand one finds many patients in whom the history and clinical findings are not so conclusive. Many investigations are used to differentiate between benign and malignant nodule so as to avoid surgery in those who don’t need it. Among these FNAC, USG AND TFT are commonly used in association with the clinical feature but there are drawbacks of each technique and the final answer to the problem is still elusive.

The present study is undertaken to evaluate the utility of FNAC in preoperative diagnosis of thyroid swelling and evaluate the efficiency of FNAC, USG, TFT in differentiating between benign and malignant thyroid swelling. On USG the findings of micro/ macro calcification, lymphadenopathy. Hyper vascularity, hypoechocity, degenerative changes with multiple fluids areas are mostly suggestive of malignancy. While in multinodular toxic goiter, with deranged TFT is the incidence of malignancy is higher the present study is carried out in the department of ENT from May 2015 to May 2018, in this study a modest attempt is made to do comprehensive study of clinical profile and pathological correlation of thyroid swelling.

METHODS

This prospective study is carried out on 120 cases of thyroid swelling attending to the dept. of ENT OPD at JIUS IMSR Warudi Taluk, Badnapur Dist, Jalna during the period of May 2015 to May 2018. For the purpose of inclusion in this study, a thyroid swelling was defined as clinically palpable lesion involving either lobe or the isthmus of the thyroid gland.

Inclusion criteria

- All the patient present with thyroid swelling to ENT department.
- Patient referred from other department to ENT department for thyroid swelling evaluation

Exclusion criteria

- Those patients who are not giving consent and not willing for surgery.
- Those patients having pubertal goiter.

The entire patient subjected to detailed history of with thorough clinical examination of, pathological and radiological investigation. FNAC, USG and TFT were done in each case. The result of FNAC was interpreted as benign, malignant and inadequate aspirate. sonographically, the nodule were evaluated for size, location, echo texture, margins, presence of halo, calcification, accessory nodule, associated cervical lymphadenopathy and consistency (colloid, cystic, or mixed) in order to differentiate between benign and malignant nodules. Patient with deranged TFTs were treated medically. Then the patient underwent surgery and histopathological examination of the specimen was obtained. Finally, the histopathology reports were correlated with the findings of FNAC in order to evaluate their sensitivity and specificity by statistical methods.

RESULTS

The present study includes 120 cases which are studied thoroughly clinically, pathologically and radiological and after analyzing following observation were made.

Table 1 showing age distribution of patients.

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-20</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>21-30</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td>31-40</td>
<td>40</td>
<td>4</td>
</tr>
<tr>
<td>41-50</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>51-60</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>61-70</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 2: Showing the clinical symptoms in 120 cases.

<table>
<thead>
<tr>
<th>Sr. no</th>
<th>Clinical symptoms</th>
<th>No of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thyroid swelling</td>
<td>120</td>
</tr>
<tr>
<td>2</td>
<td>Pain</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Dysphagia</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>Change in voice</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Palpitation</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Sweating</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>Heat tolerance</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Eye signs</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Weakness</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>Cold intolerance</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>Menstrual irregularities</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Weight loss</td>
<td>10</td>
</tr>
</tbody>
</table>
Patient of thyroid swelling mainly present with swelling in the anterior aspect of neck in midline (120 cases). One patient had change in voice. Toxic thyroid symptoms were present in few with eye signs in 5 cases (4.1%), heat tolerance in 4 cases (3.3%), palpitation in 6 (5%) cases, wt. loss in 10 (8.3%) cases, and menstrual irregularity in 2 (1.2%) cases. Dysphagia was next common symptoms (11.6%).

Table 3: Showing duration of swelling.

<table>
<thead>
<tr>
<th>Duration of swelling</th>
<th>Cases (n=120)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 month</td>
<td>20</td>
<td>16.66</td>
</tr>
<tr>
<td>6 month-11 year</td>
<td>35</td>
<td>29.16</td>
</tr>
<tr>
<td>1 year-2 years</td>
<td>25</td>
<td>20.83</td>
</tr>
<tr>
<td>2 years to 3 years</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>10</td>
<td>8.33</td>
</tr>
</tbody>
</table>

Maximum patient present with complaining of swelling in the neck with duration of 6 month to one year 35 cases (29.16%).

Table 4: Showing findings on local examination.

<table>
<thead>
<tr>
<th>Sr no</th>
<th>On examination</th>
<th>No of cases</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Consistency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Soft</td>
<td>52</td>
<td>43.33</td>
</tr>
<tr>
<td></td>
<td>Firm</td>
<td>63</td>
<td>52.5</td>
</tr>
<tr>
<td></td>
<td>Hard</td>
<td>5</td>
<td>4.16</td>
</tr>
<tr>
<td>2</td>
<td>Cervical lymph node</td>
<td>3</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Majority cases 63 (52.2) had firm to hard consistency of the swelling. 5 (4.16%) cases had hard swelling. With cervical lymphadenopathy, which were clinically diagnosed to be malignant thyroid swelling found in 3 cases (2.5%).

Table 5: Showing comparison of pre and postoperative findings of thyroid swellings.

<table>
<thead>
<tr>
<th>Sr no</th>
<th>Thyroid swelling</th>
<th>Preoperative</th>
<th>Post-operative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Solitary nodule</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>Multinodular</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Diffuse</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>4</td>
<td>Thyroid cyst</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>5</td>
<td>Carcinoma</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>Thyroiditis</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>120</td>
<td>111</td>
</tr>
</tbody>
</table>

All 120 cases were evaluated preoperatively and provisional diagnosis was made on the basis of FNAC, TFT and USG. 111 Cases were operated out of total 120 cases. Preoperatively 6 cases of malignancy were diagnosed while 1 case was missed (were reported on HPR). One case multinodular goiter found to be malignant on HPR. Hypothyroid and hyperthyroid cases were medically treated initially and are on follow up.

Table 6: Showing fine needle aspiration cytology reports in 120 cases.

<table>
<thead>
<tr>
<th>Sr no</th>
<th>FNAC reports</th>
<th>No of cases (male+female)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Colloidal goiter</td>
<td>48 (4+44)</td>
<td>21.81</td>
</tr>
<tr>
<td>2</td>
<td>Thyroiditis</td>
<td>8 (0+8)</td>
<td>6.66</td>
</tr>
<tr>
<td>3</td>
<td>Thyroid cyst</td>
<td>30 (4+26)</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>Benign thyroid lesion</td>
<td>18(0+18)</td>
<td>18</td>
</tr>
<tr>
<td>5</td>
<td>Papillary</td>
<td>5 (1+4)</td>
<td>4.16</td>
</tr>
<tr>
<td>6</td>
<td>Follicular</td>
<td>1 (0+1)</td>
<td>1.66</td>
</tr>
<tr>
<td></td>
<td>Inconclusive</td>
<td>9 (1+8)</td>
<td>8.25</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>120 (10+110)</td>
<td></td>
</tr>
</tbody>
</table>

Among 6 cases of carcinoma detected on FNAC cytology 5 were papillary thyroid and 1 follicular carcinoma. 25% cytology had cystic aspirates

Table 7: Showing the histopathological reports in operated cases.

<table>
<thead>
<tr>
<th>Sr no</th>
<th>HPR reports</th>
<th>No of cases (male+female)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Colloidal goiter</td>
<td>46 (4+42)</td>
<td>38.33</td>
</tr>
<tr>
<td>2</td>
<td>Thyroid cyst</td>
<td>22 (4+18)</td>
<td>18.33</td>
</tr>
<tr>
<td>3</td>
<td>Adenoma</td>
<td>18 (0+18)</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>MNG</td>
<td>11(0+21)</td>
<td>9.16</td>
</tr>
<tr>
<td>5</td>
<td>Thyroiditis</td>
<td>7 (0+7)</td>
<td>5.83</td>
</tr>
<tr>
<td>6</td>
<td>Papillary</td>
<td>5(2+3)</td>
<td>4.16</td>
</tr>
<tr>
<td></td>
<td>Follicular</td>
<td>2(0+2)</td>
<td>1.66</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>111</td>
<td></td>
</tr>
</tbody>
</table>

Among these 38.33% colloidal goiter and 9.16% multinodular goiter were reported. Thyroid cyst was reposed in 18.33%. Adenoma was the 3rd most common lesion carcinoma was reported in 7 cases of which majority was papillary carcinoma and 2 case of follicular carcinoma reported.

DISCUSSION

In present study most common age of presentation thyroid disease is in second to fourth decades youngest was 15 yrs. female patient and oldest being 68 yrs. female patient.

Ananthakrishnana showed highest incidence in in third and fourth decades of solitary thyroid nodule. Fenn et al showed the highest incidence of solitary thyroid swelling in fourth decade in large series of cases not a single case was below 10 years of age.
Psarra showed that thyroid nodules are more frequent in the age group of 21 to 41 yrs. while they are common in extremes of ages.6

Bhansali noted an incidence of 52% in the same age group. The peak incidence of multinodular goiter was in fourth and fifth decades of which two cases of toxic goiter presented in third decade.1 Kapur noted hyper functioning of gland in multinodular goiter between fourth and sixth decade he also noted solitary thyroid nodule become toxic between fourth and fifth decade among 8 cases of malignancy 6 papillary cases were noted in third and fifth decade.3 According to Kaplan over half of papillary carcinoma of thyroid clinically manifest before the age of 49 yrs. In our series of 120 cases 110 females and 10 males presented with thyroid swelling, showing a female preponderance with ratio 11:1 male. Messaries 75 showed high preponderance of female over male in ratio 8:1.9

Psarras given high preponderance of female similarly with 7:1.6

Alhadeff, Lindsay swelling in the neck is the commonest presentation symptoms.10

One patient complained of change in voice with vocal cord paresis on 70 degree examination. History of change in voice is common symptom of advanced malignancy. It may be sometime caused by benign large nodule compressing the recurrent laryngeal nerve hamburger B.11

Symptoms of toxicity were present in 5(4.16%) cases with eye) sign, in heat tolerance in 4 (3.33%) cases palpitation in 6 (5%) cases, weight loss in 10 (8.3%) cases menstrual irregularity in 2 (1.66%) cases. Toxic nodules are less likely to be malignant Messaries.7

Ananthakrishnana found swelling as the commonest in 94% cases, pain in 10% change in voice in 9.2% and pressure symptoms in 13.9%.4 Duration of swelling in our study varies from about 6 month to 6 years. Maximum patient present with complain of swelling in neck with duration of 6 month to 1 year. According to Sarkar et al the duration varied from 3 month to 20 years. Ananthakrishnana observed duration from 4 days to 17 years one third of which were less than 6 month duration.

In case of multinodular goiter, surface was nodular with firm consistency. Risk of malignancy has been described in literature to the tune of 2-2.7. rapid increases in size of one of the nodule, change in consistency pain, change in voice makes the diagnosis of MNG less likely Till.12

In our study 24 cases of multinodular goiter. In Framingham study, incidence was higher in female incidence of malignagancy in MNG was 7.6% in the series of Anne McCall.13

In present study solitary thyroid nodule present in 20 cases. In Ananthakrishnana study STN is common in female similarly Messaries study female prudence seen

Vittal noted 47% patient with swelling of less than one year duration.14 in our study diffuse goiter was found in 35cases. In present study 7 cases of carcinoma studied of which 5 was papillary carcinoma (2 in male 3 in female) and 2 were follicular carcinoma presented in female Shroff et al reported M:F 1:1.3. Prakash et al had M:F ratio 1.3:1. Fen et al had M: F ratio 1.2.5

These cases presented with hard swelling and cervical lymphadenopathy in our present study 8 cases of thyroid cyst studies which present with firm to cystic consistency

Crile’s cyst of thyroid gland appears to be of two types the commonest and most difficult to recognize clinically is colloid cyst filled with thin brownish fluids. Sometimes they are recognizing by their roundness, hard tense consistency and from rapid growth. Less common but easily recognizable are cyst that result from haemorrhage in to an adenoma or in to surrounding thyroid. Most of them are clinically recognized from history of sudden rapid appearance or growth often associated with pain or discomfort.15

7 cases of thyroiditis, all female, were diagnosed. They complained of pain and discomfort, dysphagia. There was diffuse enlargement with firm consistency on palpation. Friedman reported that Hashimotos thyroid it is can present as nodule. In present study, thyroid functions test were carried out in each case and among them 20 cases had derange results. 14 were hypothyroid and 6 were hyperthyroid patient were treated accordingly. Vital et al 94 reported 82.4% euthyroid. 7.3% hyperthyroid and 8.5% hypothyroid patient.14 Diagnostic strategy using initial fine needle aspiration biopsy for palpable thyroid nodule easy found to be safe and cost effective.16-18 FNAC was performed in each case of series. Commonest reporting on FNAC was colloidal goiter in 48 cases, other common finding was thyroid cyst in 30 cases and benign lesion of thyroid in 18 cases. Thyroiditis in 8 cases and carcinoma in 6 cases and inconclusive in 8.25% No serious adverse effect and no seeding of tumor cell in the needle tract have been reported. FNAC is now considered as safe, useful, and cost effective. The accuracy of FNAC IS 95%,19-21 According to Kaplan, the incidence of FNAC is as follows 65% colloidal goitre, 2% benign thyroid lesion. 5% malignancy, 10% non-diagnostic. Kin Lyerly stated FNAC as diagnostic procedure of choice in solitary nodule, in his review of total 641 patient undergoing FNAC 68% had benign cytological findings. 7 were false negative, 4% malignant and 20% had intermediate results.20

Routine use of FNAC in evaluation of thyroid nodule can reduce the need for diagnostic thyroidectomy by 20-50% while increasing the yield of cancer diagnosis in thyroid nodule. In present study, 111 of the 120 were operated
and thyroid tissue sent for histopathology reporting. The results confirmed the preponderance of colloidal goiter 38, 33%. Rest being 18.33% thyroid cyst, 15% thyroid Adenoma, 9.16% multinodular goiter 5.83% thyroiditis, papillary carcinoma in 4.16% and follicular carcinoma in 1.6%.

Ananthakrishnan had benign lesion 84.7%, malignancy in 15.3% histopathological; 50.9% benign lesion were follicular adenoma. 36.6% adenomatous goiter. 1.2% was colloidal goiter 3.6% Hashimotos thyroiditis and 2.3% thyroid cyst.

Nagore et al had histopathological incidence of adenoma to be 44%, nodular goiter 33% and malignancy 11%. 21

In similar study, incidence of thyroid cancer was similar between patient with solitary nodule (175 of 1181 patient 14.8%) and patient with multiple nodule (120 of 804, 14.9%). The incidence of malignancy in MNG was 7.6% in series of Ann McCall. 14 About 3.7% of MNG showed malignant changes as reported by William

Thus in present study-total no of malignancy based on HPR 7, clinically diagnosed 3, FNAC diagnosed malignancy 6, missed preoperatively 1

So, the overall accuracy of FNAC in comparisons to HPR IS 99.15% with no false positive reports.

Malignant (positive) results can be identified reliably by the cytopathology. The most frequent malignant lesion encountered is PTC. One of the main roles of USG in the assessment of thyroid swelling is to distinguish non operative between solid and cystic lesion.

In our study, there were 55 cystic lesions, 45 solid nodule and 20 were mixed type of nodules. In our study all 7 cases of malignancy recognized by USG were confirmed by HPE later on.

High resolution ultrasound is the best imaging modality for objectively detecting size, number and cellular nature of nodules. Katz and Kane et al found that USG was unable to differentiate thyroiditis and malignant lesions. 26

CONCLUSION

Thyroid nodules are common with prevalence in general population. The overall incidence of the malignancy in thyroid swelling varies from 10% to 30% according to various studies, in our study the overall incidence of malignancy in thyroid swelling was 5.8%. Female have higher preponderance for thyroid disease male patients are at higher risk of malignancy even though thyroid disease is uncommon. Clinical diagnosis of benign disease has high index of diagnosis accuracy.

This study helps to clinician and general physician to know the preoperative evaluation of cases with respect to utilisation of facility like FNC, USG, and comparing the result with postoperative HPR and helping for early diagnosis and management of thyroid diseases without missing confirmatory diagnosis. So it necessary to keep high index of suspicion during physical examination for detection of malignancy. FNAC should be done in all cases preoperatively. FNAC is safe procedure and cost effective. FNAC has high diagnostic accuracy 99.15% and help to differentiate benign and malignant lesions.

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Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES
