Original article

Follicular Adenoma of the Thyroid Gland in Children

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Summary
Follicular adenoma is the most frequent cause of a solitary thyroid nodule in children. We reviewed our own patient material and the literature and discuss etiology, available diagnostic methods, differential diagnosis, natural course and clinical management. In spite of the fact that the great majority of solitary thyroid nodules are benign, the treatment strategy is completely dominated by the risk for malignancy.

Key words
Thyroid – Adenoma – Child

Introduction
Surgery does not play an important role in the treatment of diseases of the thyroid gland in children. Besides remnants of the thyroglossal duct and an exceptional case of goitre, which does not regress adequately on medical treatment, a solitary thyroid nodule is the most frequent indication for surgery. The interest in solitary thyroid nodules is dominated by the risk for malignancy. Nevertheless, only a small proportion of solitary nodules turn out to be malignant and the majority are benign lesions. In the group of benign lesions, which present as a solitary nodule, more than half are follicular adenomas. Reviewing the literature on follicular adenoma, it is striking that hardly anything is known about follicular adenomas, especially in children. Based on our patient material and the available literature we discuss the etiology, diagnostic methods, differential diagnosis, clinical course and management.

Material and methods
In the period from January 1976 till January 1992 in the Pediatric Surgical Center and the Department of Pediatrics 5 patients were seen with a solitary thyroid nodule which, after excision and histologic examination, proved to be a follicular adenoma (Table 1). Age ranged from 11 months till 18 years. There were 4 girls and 1 boy. Three adenomas were in the left and two in the right thyroid lobe. The mother and a niece of one of the girls (Case 2) and the father of the boy (Case 1) were treated in the past also for a thyroid nodule. The mother of another girl (Case 5) was treated for hyperthyroidism.

T4 and basic TSH values were normal in all patients. In the boy (Case 1) a slight hyperresponse to TRH stimulation was found, suggesting subclinical hypothyroidism. In the boy and two girls (Cases 1, 2, 3) normal values for thyreoglobuline and low molecular weight iodinated material were found, making an inborn error of thyroid hormone synthesis unlikely. Thyroid scanning showed a cold nodule in all. A fine needle aspiration in one of the girls (Case 5) revealed follicular cells, without signs of malignancy.

With the exception of Case 4 who, had a subtotal thyroid lobectomy, in all the others a total thyroid lobectomy was performed. There were no postoperative complications. Three patients (Cases 1, 2, 5) on histologic examination were shown to have two nodes in the resected lobe. Two patients, one boy and one girl (Cases 1 and 2) after respectively 10 and 24 months presented with a second node on the other side and underwent a total thyroid lobectomy on that side. After the first operation the boy (Case 1) had an elevated basic TSH, but all the other patients had normal values for thyroid function tests.

No patient received thyroid suppression therapy.

Discussion
Although solitary thyroid nodules in children are much less common than in adults (12), there is a considerably higher risk of malignancy (20). In the literature the reported
Table 1: Parent data of bilateral fluid masses in children

<table>
<thead>
<tr>
<th>N.A.</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Brief Cons.</th>
<th>Group</th>
<th>Treatment</th>
<th>Follow-up</th>
</tr>
</thead>
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<td>120</td>
<td>R</td>
<td>M</td>
<td>2</td>
<td>L20 cm mod.</td>
<td>1</td>
<td>L20 cm</td>
<td>12/18/97</td>
</tr>
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<td></td>
<td></td>
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<td>L20 cm</td>
<td>12/18/97</td>
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<tr>
<td>511</td>
<td></td>
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<td></td>
<td></td>
<td>2</td>
<td>L20 cm</td>
<td>12/18/97</td>
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<tr>
<td>88</td>
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<td></td>
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<td>2</td>
<td>L20 cm</td>
<td>12/18/97</td>
</tr>
<tr>
<td>87</td>
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<td></td>
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<td>2</td>
<td>L20 cm</td>
<td>12/18/97</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>2</td>
<td>L20 cm</td>
<td>12/18/97</td>
</tr>
</tbody>
</table>

Note: The table contains data on patients with bilateral fluid masses in children. The data includes the patient's name, sex, age, brief clinical information, group, and treatment details along with follow-up dates.
The surgical literature unanimously advises operative excision. Because of the risk of malignancy and the limited value of frozen-section diagnosis during operation (19), enucleation as was proposed (1) does not seem a wise option. At least a subtotal thyroid lobectomy should be done, which gives the opportunity of studying the node with its environment. To avoid a later reoperation a total thyroid lobectomy seems preferable. Although thyroid suppression preoperatively is controversial (8), several authors recommend postoperative suppression therapy as recurrence prophylaxis (1, 21). The mean recurrence rate after benign lesions of the thyroid is reported to be 3% (1). Although some authors advised suppression therapy as a routine, others only do so in case of an elevated TSH-level (21). In accordance with the literature in our patients follicular adenomas were found predominantly in girls and diagnosis was made around puberty. However, we saw one girl 11 months of age. Three adenomas were left-sided and two on the right. In three patients on histologic examination two nodes were identified in the resected thyroid lobe. All the nodes were cold on scanning. Four patients had a total thyroid lobectomy and one patient a subtotal thyroid lobectomy. There were no postoperative complications.

Our patients did not receive suppression therapy. Two patients developed a second adenoma in the other thyroid lobe, respectively ten and twenty-four months after the first operation. In one of them there was an elevated TSI level postoperatively; in all the others we found normal values.

Conclusions

Although most solitary thyroid nodules are benign, there is a definite risk for malignancy. With the exception of clear signs of malignancy, like irregular hard consistency, definitive adherence to the trachea, cervical lymphnodes or a lesion of the recurrent laryngeal nerve, it is as a rule impossible to make a clinical distinction between benign and malignant lesions. Thyroid function tests are mostly normal with exception of elevated calcitonin levels in medullary carcinoma. Ultrasonography is of limited value except in case of cysts. If scintigraphy with 90mTC-pertechnetate indicates a cold nodule, the scanning is repeated with iodide 123. Although both warm and hot nodules are described in carcinoma, especially cold nodules have a higher risk for malignancy. FNA is an inexpensive and specific method with Iodide 123. Although both warm and hot nodules are described in carcinoma, especially cold nodules have a higher risk for malignancy. FNA is an inexpensive and specific method. Postoperative thyroid suppression therapy is controversial but seems worthwhile when TSH-levels are elevated. Autonomous hot thyroid nodules in children deserve operation merely because of the risk for thyrotoxicosis (2).

References


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