TRANSIENT ISCHAEMIC ATTACK AT THE ADMISSION UNIT - EXPECT THE UNEXPECTED

ALEKSANDRA LUCIC-PROKIN MD(1,2), ZELJKO ZIVANOVIC MD(1,2), SONJA LUKIC MD(2), JELENA SEKARIC MD(2), PETAR SLANKAMENAC PHD(1,2), VLADIMIR MANOJOVIC MD(1,3)

(1) MEDICAL FACULTY, UNIVERSITY OF NOVI SAD, SERBIA, (2) DEPARTMENT OF NEUROLOGY, CLINICAL CENTRE OF VOJVODINA, NOVI SAD, (3) DEPARTMENT OF VASCULAR SURGERY, CLINICAL CENTRE OF VOJVODINA, NOVI SAD.

INTRODUCTION

Typical clinical symptoms in Transient Ischemic Attack (TIA) last less than one hour and there is no neuroradiology evidence of cerebral infarction. Usually, it is caused by arterial stenosis. However, sometimes other pathological processes can cause the same phenomenon [1].

CASE REPORT

A 51-year-old male with a history of hypertension, tobacco smoking and ten-year professional exposure to radiation was admitted at the Admission Unit of the Emergency Centre with symptoms of recurrent right-sided weakness. The symptoms repeated several times in the previous few days, appearing only during physical activity and reduced at rest, lasting up to 15 minutes. There was no headache, vomiting, dizziness, disturbances of vision or speech.

Family history was negative for cerebrovascular, endocrine and malignant diseases. On admission the patient had no neurological deficit (NIHSS 1, mRS 0, ABCD2 scores 2). Physical examination was normal, save for the neck. Painless, immobile tumour mass at the left side of the neck, near the sternocleidomastoid muscle. Imaging of brain parenchyma and vascular structures were normal. A contrast CT scan of the neck and CT angiography verified well-vascularised cervical tumour mass of the left side, without compression on the surrounding blood vessels. CT angiography excluded carotid artery stenosis, but revealed pathological vascularisation of cervical tumour mass from external carotid artery. Surgical resection of the cervical mass was done and histopathological analysis revealed metastasis of papillary thyroid carcinoma.

Key words: transient ischemic attack, carotid artery, papillary thyroid carcinoma

Summary: We report a 51-year-old Caucasian male admitted at the Admission Unit of the Emergency Centre with recurrent right-sided hemiparesis suggesting transient ischemic attack. Neurological and physical examination was normal, save for the left, painless, immobile tumour mass at the left side of the neck, near the sternocleidomastoid muscle. Imaging of brain parenchyma and vascular structures were normal. A contrast CT scan of the neck and CT angiography verified well-vascularised cervical tumour mass of the left side, without compression on the surrounding blood vessels. CT angiography excluded carotid artery stenosis, but revealed pathological vascularisation of cervical tumour mass from external carotid artery. Surgical resection of the cervical mass was done and histopathological analysis revealed metastasis of papillary thyroid carcinoma.

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Correspondence: Aleksandra Lucic Prokin, Department of Neurology, Emergency Centre, Clinical Centre of Vojvodina, Hajduk Veljkova 1-7, 21000 Novi Sad, Serbia; Phone: +381641278696; Fax: +381214844102; E-mail: japanc09@gmail.com.

cervical mass. CT angiography excluded stenosis of carotid and vertebral arteries which would require vascular surgical treatment. However, a treatment with 100 mg aspirin per day was started. A first non-contrast head computed tomography (CT) scan, as well as the control one, 24 hour later, were normal. Carotid and vertebral duplex ultrasound, as well as transcranial Doppler of intracranial arteries, revealed normal findings. Basic metabolic panel and cell blood count were unremarkable, except hypercholesterolemia. Thyroid function test results were also normal, he was clinically euthyroid. Electrocardiography monitoring and chest X-ray were normal.

After ten days, total neck tumour resection was done. Histopathological analysis revealed metastasis of papillary thyroid carcinoma (PTC) (Figure 1C). After three months, total thyroidectomy was done and the patient received radioiodine therapy treatment (131I). The definitive histopathological diagnosis was PTC. At one-year follow-up, the patient was on substitution thyroid hormone and antiplatelet therapy, without repeated episodes of neurological symptoms.

DISCUSSION
From the beginning, we were skeptical that the typical vascular causes were bases of recurrent TIA in this case. Brain CT and neuroultrasonography did not show cerebral infarction or carotid artery disease. Blood supply of the left cervical mass was found to be from the arteries “feeders” of the External Carotid Artery (probably Artery Thyroid Superior) with drainage in the Internal Jugular vein (IJV), but carotid angiography ruled out the existence of arteriovenous malformation. After that, we suspected ectopic thyroid tissue, but differentiation between a ectopic thyroid carcinoma and a metastatic thyroid carcinoma can be very difficult. According to the literature data, ectopic thyroid carcinoma should be considered when there is separate blood supply of the ectopic gland from extra-cervical vessels, no personal history of malignancy, and normal or absent orthotropic thyroid with no history of surgery [2,3].

In addition, total thyroidectomy and histopathological findings of the thyroid gland still revealed primary papillary thyroid carcinoma (PTC).

The most common of all thyroid carcinoma is PTC with genetic factors and radiation exposure as risk factors. It usually has lymphatic dissemination in regional lymph nodes (90%), while less common is the hematogenous dissemination (2-5%) [4].

On the other hand, distinguishing transient ischemic attack (TIA) from nonischemic causes is difficult in the ER [5]. Up to 60% of patients referred to a TIA clinically do not have a final diagnosis of TIA [6]. In addition to cardiovascular diseases, various...
neoplasms of neck or head can also cause symptoms of the TIA, by mechanism of compression, infiltration, or vascular steal phenomenon [7]. Although it could just be a coincidence, hypervascularized metastasis of PTC neck tumour in this case could cause TIA symptoms by mechanism of carotid compression or steal phenomenon in physical activity. After the surgical resection of the tumour, the neurological symptoms did not repeat.

To our knowledge, we have described a rare and perhaps the first case of such a large and well-vascularized metastatic thyroid carcinoma causing TIA.

In conclusion, with TIA in ER, beside usual causes of TIA, always keep on mind other, nonvascular diseases. So, you can expect unexpected!

REFERENCES