Letter to the Editor

Surgical management of cervico-mediastinal goiters: Our experience and review of literature

Dear Sir,

We read with interest the article “Surgical management of cervico-mediastinal goiters: Our experience and review of literature” addressing an uncommon entity—substernal goiter [1]. We congratulate the authors on their work on cervico-mediastinal goiters; the literature is sparse due to lack of single acceptable definition and also multiple classifications followed by different societies and institutions. We have a few comments to make. As there is no consensus on what constitutes a substernal goiter universally; the clinical definition which is easiest to apply in clinical practice, defines a substernal goiter as one whose lower border is not visible with the neck in extension even on deglutition [2]. The other definitions which are used include Lindskog definition where substernal goiter is defined as one whose growth up to the level of the fourth thoracic vertebra is evident on x-ray examination. Katlic defined it as a goiter in which at least 50% is retrosternal [2]. The substernal goiter can be classified into either primary mediastinal goiter or secondary mediastinal goiter [1]. Primary mediastinal goiter is one that develops from detached thyroblast cells that descend into the thorax, hence derives blood supply from thoracic vessels while secondary mediastinal goiter develops from a pre-existing cervical goiter as evident by the persistent connection to the cervical gland & maintained cervical blood supply [1]. The pathogenesis of sub sternal goiter is poorly understood but the descent into the thorax appears to be multifactorial [1,3]. Anatomically sub sternal goiter can extend either into anterior mediastinum or posterior mediastinum with extension into anterior mediastinum being more common [1]. The incidence of sub sternal goiter varies from 5 to 20% in the literature partly due to lack of a definitive definition of this entity [4]. The incidence of cervical & substernal goiter appears to be decreasing, especially in developed countries, perhaps due to iodized salt intake; early detection & treatment of cervical goiter [3]. Some patients may be asymptomatic but majority of patients have compressive symptoms (dyspnea, dysphagia, superior vena caval syndrome) [1,3]. In some cases, symptoms of hyperthyroidism may develop [1,3]. Acute airway compromise might occur in a subset of patients necessitating emergency admission & intervention [1,3]. In addition to detailed history & good examination, all patients with substernal goiter should undergo imaging of neck & mediastinum to characterize the mass & its relation with surrounding structures preferably a computed tomogra-

References


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