

Thyroid Cancer Brain Metastases and Thyroglobulin

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Abstract

Background: Thyroid cancer (TC) is the most common endocrine cancer. The majority of patients reach long survival rates, but 10-15% of patients show recurrent disease, and 5% have distant metastases. Brain metastases (BMs) from TC are rare and carry high morbidity and mortality.

Methods: From January 2010 to December 2015, nearly 400 patients with TC were treated at a tertiary referral center. This study reports the findings of all seven patients with BM, which were compared to historical controls.

Results: Male patients and older age are associated with a higher frequency of distant metastases from TC. Among patients with BM, surgical excision when indicated, followed by whole brain radiotherapy, was the treatment associated with longest survival rates.

Conclusion: Thyroglobulin was the most useful serum marker to diagnose recurrence or distant disease. High levels of thyroglobulin (mean: 15,029; IQR: 300 - 13,687) were mainly associated with BMs.

Keywords: Thyroid; Cancer; Thyroglobulin; Metastases; Brain

Introduction

Thyroid cancer (TC) accounts for more than 90% of all endocrine malignancies but represents only about 1% of all human cancers [1]. Differentiated thyroid cancer (DTC) that arises from

the thyroid follicular cells accounts for more than 90% of TC cases diagnosed; within this group, papillary TC (90%) and follicular (10%) account for more than 90% of new cases, whereas around 10% of patients develop medullary TC [2]. DTC is initially treated with surgery (e.g., total thyroidectomy and central lymph node dissection), followed by radioiodine treatment in patients with a substantial risk of persistent or recurrent disease [3]. Follow-up with neck ultrasonography and measurement of serum thyroglobulin (Tg) concentration after stimulation with recombinant human thyroid stimulating hormone (TSH) or after thyroid hormone withdrawal contributes to the detection of persistent or recurrent diseases. More than 85% of patients with DTC express a limited disease and become disease-free after initial treatment [4]. Nearly 10-15% of patients with TC have recurrent disease, and about 5% show distant metastases at presentation. In 75% of the patients with recurrent disease, tumor cells are located more often inside the neck lymph nodes [5]. No randomized controlled trials assessing primary treatment or treatment of recurrent disease have been reported [3]. Patients with recurrent disease outside the neck structures usually show lung micrometastases or bone infiltrations [5]. Brain metastases (BMs) from TC, however, are quite rare, involving only 0.5-2.3% of all DTC cases [6-12]. Prognosis is usually poor due to its high morbidity and mortality rates.

Materials and Methods

From January 2010 through December 2015, TC patients seen at a tertiary referral center that required neurological consultation were included. Demographic and radiologic characteristics were described as well as their clinical prognosis. Serum Tg, TSH and anti-Tg antibodies were measured as previously reported [13]. Serum Tg from patients with TC and BM (group 1) was compared to patients with TC during follow-up at the thyroid cancer clinic. Group 2 included patients with TC and systemic (outside brain)/local disease, and group 3 included TC cases with no systemic/local disease. Our local IRB and ethics committee approved all interventions.

Results

During the study period, 384 new patients were diagnosed

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Table 1. Characteristics of Seven Patients With Thyroid Cancer and Brain Metastases

Case	Gender	Age (years)	Histology	Time for BM from diagnosis (months)	Tg (ng/mL)	Other sites affected	Number and size (mm) of BM	Treatment	Survival (months)
1	F	65	PD follicular	5	8,555	Local, lung	S 41	WBRT	7
2	M	62	WD papillary	1	116	Local, lung	M 38	WBRT	1
3	M	50	WD papillary	20	13,687	Local, bone, lung	M 57	WBRT	6
4	M	54	WD papillary	29	24,551	Local, bone, lung	M 38	WBRT	1
5	M	55	WD papillary	15	300	Local, lung	S 55	Qx + WBRT	58
6	F	56	WD papillary	31	8,555	Local, lung	S 41	Qx + WBRT	34
7	M	72	PD papillary	9	849	Local, bone, lung	M 10	WBRT	13

WD: well differentiated; PD: poorly differentiated; S: single; M: multiple; WBRT: whole brain radiotherapy; Qx: surgical resection; Tg: thyroglobulin.

with TC [14] and 61 (16%) were referred for a neurological evaluation. Seven patients were then detected with BM. Base-line characteristics are described in Table 1. Mean age at diagnosis was 59 years (range: 50 - 72 years) with a mean interval between the diagnosis of TC and BM of 16 months (range: 1 - 31 months). All patients had other sites of metastases at the time BMs were detected. Three patients showed single brain metastasis, two of whom were declared candidates for surgical resection followed by whole brain radiotherapy (WBRT). Mean maximum diameter of metastases was 40 mm (range: 10 - 57 mm). Mean survival time was 17 months (range: 1 - 58 months). Most patients died due to complications related either to BM or systemic disease.

Serum Tg of patients with BM (group 1, n = 7) had a mean value of 8,087 ng/mL (range: 116 - 24,551; IQR: 300 - 13,687). Mean Tg for patients with local or systemic disease (group 2, n = 20) was 210 (range: 8.4 - 1,832; IQR: 30 - 125) and mean Tg for those patients with no evidence of neoplastic activity (group 3, n = 99) was 2.4 (range: 0.2 - 47; IQR: 0.2 - 1) with a statistical significance ($P < 0.0001$) as shown

in Figure 1.

Discussion

We report seven patients with TC and BM at a single tertiary referral unit. The female to male ratio for the cohort with BM was of 1:2.5, in contrast to the overall gender ratio of 2-4:1 for patients with TC [6, 15]. Some authors support the theory of a higher relative risk of distant metastases among male patients. After reviewing 131 cases reported [6-8, 11, 16-29] including our seven patients (82 female and 56 male patients with TC and BM), there is a female to male ratio of 1.5:1, further supporting the hypothesis of a higher proportion of BM among the male population. It has been suggested that male patients, older in age, with larger primary tumors, and frequent evidence of extrathyroidal invasion tend to have distant metastases, including BM [15, 16, 18, 30] and have shown to be independent predictors of prognosis [31-34]. There are different staging and scoring systems to distinguish between patients at low or high

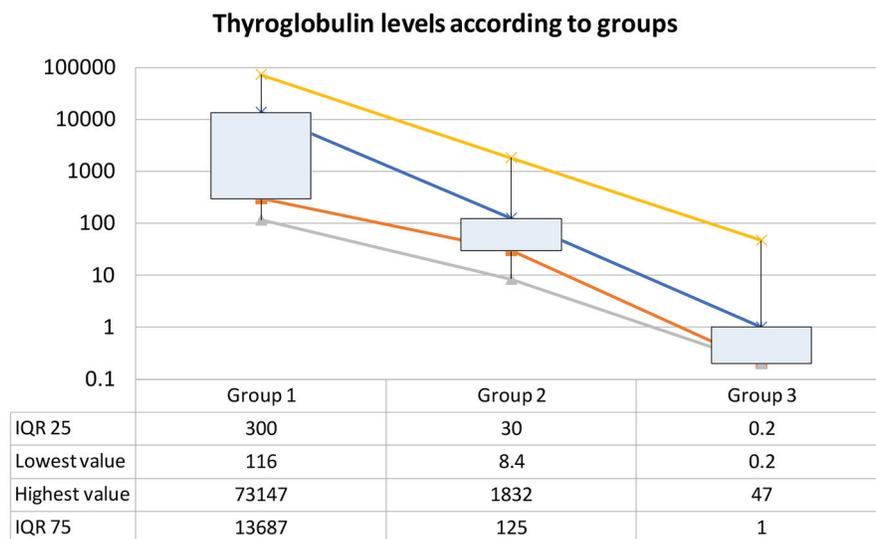


Figure 1. Thyroglobulin levels in patients with brain metastases from thyroid cancer (TC) (group 1), TC with systemic/local disease (group 2), and TC with no evidence of disease.

risk of cancer-related death [5, 34-36], but they are beyond the scope of this study. The average interval between diagnosis of TC and BM was 15.7 months (range: 1 - 31 months), the same as others [17, 18, 25].

The median survival for patients with BM from TC treated at our center was 17 months, higher than some [6] but similar to others [16, 18, 25]. Histologically, well-differentiated (WD) papillary cancer was found in five and two with anaplastic component (one follicular and one papillary). Patients with anaplastic carcinoma had a different survival rate (mean: 10 vs. 20 months for WDTC), but did not reach statistical significance found by others [17]. BMs had a high negative effect on survival (mean: 6.7 vs. 25 months for those without BMs, P: NS) also found by others [17].

Solitary metastases from TC have been established. In our series, three patients had single BM (43%), but only two were considered candidates for surgical resection followed by WBRT. The remaining patient showed a very poor performance status. Solitary metastases were thought to be rare [19], but as more cases have been reported, cases have increased up to 46% of patients with BM from TC [16].

Surgery, followed by WBRT as a treatment modality of BM, has shown to improve survival rates [37]. In our series, patients treated surgically had a longer survival average (mean: 46 vs. 5.6 months for those who were not candidates for metastasectomy, P = 0.003) similar to others [6, 16]. However, selection bias is likely a factor in the improved survival because those patients who have solitary or few lesions and are considered appropriate candidates for surgery are likely to have a longer survival. Gamma knife radiosurgery may play a key role in the management of BM from TC for its effectiveness and minimal invasive nature [16, 23, 27].

Treatment with radioactive iodine should be considered because it has been reported to improve response of distant metastases including BM [9, 11, 24]. However, there is a risk of cerebral edema.

Persistence, recurrence, or locoregional metastases of DTC, most commonly involve lymph nodes in neck and are usually detected by measurement of serum Tg concentrations, combined with physical examination, high resolution ultrasonography, or other imaging strategies and, if required, fine-needle aspiration biopsy (FNAB) with Tg measurement where available [38]. Serial Tg levels are recommended for follow-up [39], specially after the use of recombinant human TSH or cessation of thyroid replacement therapy [40-42]. Tg is a specific and extremely useful tumor marker for follow-up of patients with TC [4, 15, 43].

High Tg levels have been associated with residual or distant disease from TC [5, 9, 44]. We found higher levels of Tg in patients with BM or systemic disease, but significantly higher for those with BM (mean 15,029 ng/mL) than for the ones with systemic disease (mean: 210 ng/mL) and for those with no local or systemic disease (mean: 2.4 ng/mL; P < 0.0001). This result is consistent with previous reports [22, 25, 31]. There are some reports of patients with BM from TC with normal Tg [11, 27], suggesting very dedifferentiated tumors. Serum Tg level also correlates independently with survival rates [45]. The findings achieved in this study need to be further studied because a referral bias may exist.

Conclusion

BM from TC is a rare complication with a poor prognosis. Male patients and older age are associated with a higher frequency of distant metastases from TC. Among patients with BM, surgical excision when indicated, followed by WBRT is the treatment associated with the longest survival rates. Tg is a useful tumor marker for follow-up in patients with TC; high levels are associated with recurrence or distant disease and very high levels with BMs.

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