Thrombocytosis and follicular thyroid carcinoma

We report a rare case of thrombocytosis associated with thyroid follicular carcinoma. Thrombocytosis associated with malignant disease has been described in lung carcinoma, pleural mesothelioma, gastrointestinal tract carcinoma, lymphoma and acute leukaemia, hepatocarcinoma, neuroblastomas, hystiocytosis and other epithelial cell origin tumours; it has not been described in association with thyroid carcinoma. 1-4

A 72 year old woman was diagnosed as having a follicular thyroid carcinoma because of progressive enlarging goitre. A fine needle aspiration biopsy specimen was consistent with follicular lymphoma, the diagnosis of which was confirmed when the excised thyroid was examined microscopically. Pre-operative tests had shown increased numbers of platelets (746 x 10^9/l and 731 x 10^9/l, respectively). The haemoglobin concentration was 14.4 g/l, the haematocrit 41.8%, while red blood cell count, white cell count, mean corpuscular volume, mean corpuscular haemoglobin concentration, and serum ferritin and serum iron concentrations were normal. Haemostatic evaluation showed normal prothrombin and partial thromboplastin times. FDP concentrations were within the normal range. Two months after surgical resection the platelet count returned to normal.

Most cases of thrombocytosis secondary to malignant disease have a platelet count from 4 to 6 x 10^9/l. Iron deficiency may also contribute to an increased platelet count. 5 In other cases slow activation of clotting and disseminated intravascular coagulation have occurred and FDP was detectable. 6 It was not specified, however, whether these cases also had thrombocytosis. Although haemorrhagic and thrombotic episodes are characteristic of primary thrombocythaemia, 7 in these patients platelet production probably occurs in the tumour and in bone marrow by a protein produced by the neoplasm (thrombocyte stimulating factor) (TSF). 8 The occurrence of unexplained thrombocytosis precludes malignancy.

We suggest that clinicians should be aware of this rare sign in malignant diseases.

M OLM, G OBIOLS, L GARCIA-PASCUAL, R SIMO, JA MESA
Departments of Internal Medicine and Endocrinology, Hospital General Vall d’Hebron, Barcelona, Spain


This book comes at a time when British pathologists are beginning to come across the types of lesions, such as in situ carcinoma and atypical hyperplasia, that are more common in screening for breast cancer than in the general symptomatic workload. The illustrations are, for the most part, good, and many of the rarer lesions which can cause diagnostic difficulties, if unrecongnised, are included. In contrast to a number of other texts, the lesions are in general recognisable as the entity they are stated to portray, no mean feat in an area as controversial as atypical hyperplasia.

A refreshing finding is the adoption of nomenclature similar to that of the National Screening Programme and hence the avoidance of confusing terminology such as the British “epitheliosis” and the American “papillomatosis”. These lesions are now correctly termed “hyperplasia” and qualified by the terms “typical” or “atypical”.

If criticism has to be found in this work one can only say that some of the more modern oncogene work has not been mentioned, the typing of in situ ductal carcinomas of comedo-type is slightly suspect, being primarily dependent on necrosis; some of the references at the chapter end are not referenced in the text; a little expensive, but these are minor criticisms in a useful diagnostic text.

The accompanying optional set of slides