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· 防治实践 ·

## 腮腺区异位甲状腺1例报道及文献回顾

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**【摘要】** 目的 探讨腮腺区异位甲状腺的临床特点与诊治,为异位甲状腺的诊治提供临床思路。方法 报道1例颈部存在正常甲状腺伴腮腺区异位甲状腺组织的病例。患者,男性,20岁,主诉:左侧耳垂下无痛性肿物渐大1月;临床检查见左耳垂下组织膨隆明显,可触及一长约3.0 cm条形肿物,质软,边界清,位于皮下,肤色淡红,皮温不高,体位移动实验阴性;颈部彩超显示甲状腺形态、大小正常;头颈部CT报告左侧耳垂后下方腮腺区见条带状软组织密度影,边界清,CT值约30 HU,强化后未见强化影像;入院诊断为左腮腺区肿物;通过常规腮腺区手术方法切开,术中见肿物位于皮下,内容为鲜红色肉芽肿样组织,无包膜,与表面皮肤组织粘连,未波及腮腺包膜,彻底刮除肿物后给予间断缝合,切除肿物送病理检查,结合文献对该类型病例的诊疗进行回顾性分析。结果 该患者术后伤口未能一期愈合,通过每周给予碘仿纱条加压换药,约2个月后创口逐渐愈合,术后病理报告为左腮腺区异位甲状腺。文献回顾结果表明异位甲状腺包括部分和完全甲状腺异位,前者颈部存在正常甲状腺组织,部分甲状腺组织出现在其他位置,多发生于舌根、纵隔;后者颈部甲状腺缺失。两者均可出现甲状腺功能异常及局部压迫症状,完全异位者症状更为明显;异位甲状腺主要通过体格检查及影像学检查进行诊断和鉴别,发生于腮腺区皮下的异位甲状腺则罕见。医师应依据临床检查及手术适应证,设计个性化治疗方案。结论 腮腺区皮下异位甲状腺罕见,异位甲状腺手术应充分考虑患者美观需求及转归等问题设计合理的手术方案,必要时行穿刺活检。

**【关键词】** 异位甲状腺; 腮腺肿物; 皮下肿物; 彩色B超; CT检查; 穿刺活检; 手术切除; 病例报告

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**Ectopic thyroid gland in parotid region: a case report and literature review** ZHANG Lei, CHEN Xibo, HENG Wei, WANG Xuefeng, WANG Yangyang, LIU Rui. Department of Stomatology, The Affiliated Hospital of Chengde Medical College, Chengde 067000, China

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**【Abstract】 Objective** To explore the clinical characteristics, diagnosis, and treatment of ectopic thyroid gland in the parotid gland area, and to provide clinical ideas for the diagnosis and treatment of ectopic thyroid gland. **Methods** A case of a normal thyroid gland with ectopic thyroid gland tissue in the parotid gland area in the neck was reported. The male patient was 20 years old. The chief complaint was the discovery of a painless mass gradually increasing under the left earlobe for one month. Clinical examination showed obvious bulging of the tissue under the left earlobe. A strip-shaped mass approximately 3.0 cm long could be palpated. It was soft in texture, with a clear boundary, and located under the skin. The skin was pale red and of normal temperature. The body position movement test was negative. Color Doppler ultrasound of the thyroid gland in the neck showed that the shape and size of the thyroid gland were normal. CT images of the head and neck showed a band-like soft tissue density shadow at the area of the parotid gland behind



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and below the left earlobe, with a clear boundary. The CT value was approximately 30 HU, and further enhancement yielded no additional findings. The admitting diagnosis was a mass in the left parotid gland area. The tumor was incised using a conventional surgical method for the parotid gland area. During the operation, it was found that the tumor was located under the skin, and the contents were bright-red granulomatous tissue without a capsule and adhesive to the skin tissue. The parotid gland capsule was not involved. After the tumor was completely scraped off, intermittent suturing was performed. The resected tumor was sent for pathological examination. A retrospective analysis of the diagnosis and treatment of this type of case was conducted in combination with a literature review. **Results** The wound of the patient failed to heal in the first stage after the operation. By applying iodoform gauze for pressurized dressing changed weekly, the wound gradually healed about 2 months later. The postoperative pathological report showed an ectopic thyroid gland in the left parotid gland area. The results of the literature review indicate that ectopic thyroid glands can be partial or complete. In the former, normal thyroid gland tissue exists in the neck, and some thyroid gland tissue appears in other locations, mostly at the base of the tongue and mediastinum. In the latter, the thyroid gland in the neck is absent. Both can present with abnormal thyroid gland function and local compression symptoms, and the symptoms are more obvious in patients with a complete ectopic thyroid gland. Ectopic thyroid glands are mainly diagnosed and differentiated through physical examination and imaging examination. Ectopic thyroid glands occurring subcutaneously in the parotid gland area are extremely rare. Physicians should design personalized treatment plans based on clinical examinations and surgical indications. **Conclusion** A subcutaneous ectopic thyroid gland in the parotid gland area is rare. For ectopic thyroid gland surgery, a reasonable surgical plan should be designed considering the patient's aesthetic needs and prognosis. Puncture biopsy should be performed when necessary to formulate the surgical plan.

**【Key words】** ectopic thyroid gland; parotid gland mass; subcutaneous mass; color B-ultrasound; CT examination; puncture biopsy; surgical resection; case report

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异位甲状腺是指在正常甲状腺位置以外出现的甲状腺组织,在胚胎发育过程中由于某种原因,甲状腺原基迁移出现错位,出现在异常位置如舌根部、纵隔以及胸骨前后等<sup>[1-2]</sup>,可表现为单个或多个结节,不易被发现,其甲状腺功能可能正常、亢进或减退<sup>[3-4]</sup>。目前异位甲状腺病例比较少见,缺少高质量的临床数据,同时临床表现差异较大,容易出现漏诊及误诊<sup>[5-7]</sup>,术前影像学检查是减少误诊的首要措施,亦是制定正确的手术方案的关键所在。本文回顾分析1例颈部存在正常甲状腺的腮腺区异位甲状腺组织的患者病例资料,并进行相关文献复习,旨在通过对其诊疗经过进行总结分析,以提高临床医师对该疾病的认识。

## 1 病例资料

本病例报道患者知情同意,获得承德医学院附属医院伦理委员会的批准(伦理审批号:CYFYLL2023417)。

### 1.1 一般资料

患者,男性,20岁,学生。以“左侧耳垂下无痛性肿物渐大1月余”为主诉就诊。现病史:患者约1个月前发现左侧耳垂下腮腺区有一约“大拇指腹”大小肿物,无疼痛、无发热,无破溃流脓等不适,自行口服抗菌药后肿物有所减小,其后反复发作逐渐变大,遂来我科就诊。既往无外伤史,否认药物过敏史、手术史及其他系统性疾病。

### 1.2 专科检查、实验室检查及影像学检查

专科检查:左侧腮腺区无痛性肿物1个月余。专科检查:左侧腮腺区膨隆明显,可触及一长约3 cm条形肿物,质软,边界清,位于皮下,肤色淡红,皮温不高,体位移动实验阴性(图1)。张口度及开口型正常,口内未见异常。

实验室检查:促甲状腺激素(TSH)为2.27  $\mu\text{IU/mL}$ (正常值:0.35 ~ 4.94  $\mu\text{IU/L}$ ),游离甲状腺素(FT4)为13.05 pmol/L(正常值:9.1 ~ 19.24 pmol/L)。

影像学检查:①头颈部CT:左侧耳后下方腮腺外缘见条片状软组织密度影,边界清,CT值约



A strip-shaped mass about 3.0 cm long was palpated in the left parotid gland area. It was soft in texture, with a clear boundary, and located under the skin. The skin was pale red and of normal temperature

Figure 1 Preoperative images of left parotid gland mass  
图1 左侧腮腺区肿物病例术前图像

30 HU, 强化后未见强化影像(图2a), 颈部双侧可见清晰的蝶形甲状腺组织, 边缘光滑, 规整, 强化

后呈均匀强化的稍高密度影像(图2b)。②甲状腺彩超: 颈部甲状腺形态, 大小未见异常, 实质回声均匀。颈部双侧甲状腺内可见散在的彩色血流分布。左颈侧甲状腺内可见数个无回声结节, 最大直径2.6 mm(图3)。

1.3 诊断

入院诊断: 左侧腮腺区肿物。

1.4 治疗经过及预后

结合头颈部CT、B超及临床检查, 考虑为左侧腮腺区肿物, 科室讨论后决定采取腮腺区常规手术治疗, 自耳后经肿物表面做弧形切口(图4), 术中见肿物位于皮下, 内容为鲜红色肉芽肿样组织, 无包膜, 未突破腮腺包膜, 与表面皮肤组织界限不清, 考虑患者年龄较小及美观问题, 结合患者家属意愿, 采用刮匙彻底刮出病变组织保留皮肤组织, 电刀止血后间断缝合皮肤组织。术后半个月出现术区创口不愈合, 可见部分缝线脱落, 暴露出创面, 呈鲜红色肉芽组织改变(图5a), 每周给予

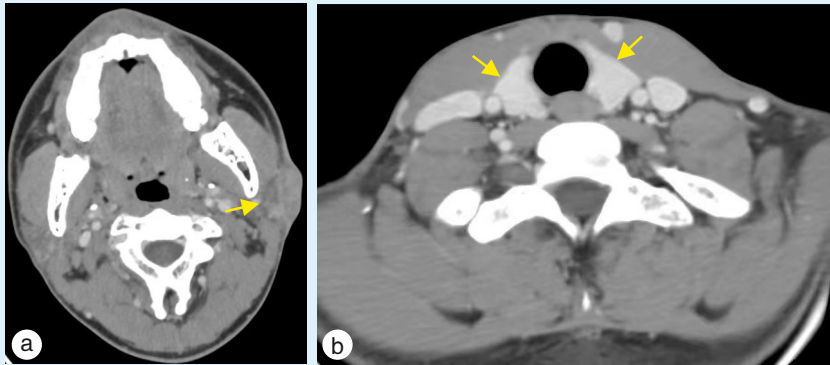
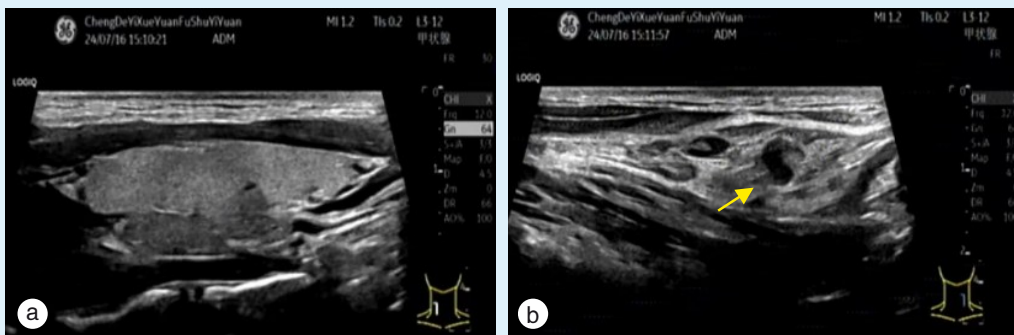


Figure 2 CT images of left parotid gland mass and bilateral neck thyroid gland tissue  
图2 左侧腮腺区肿物及双侧颈部甲状腺组织CT影像

a: the left parotid gland mass was subcutaneous with unclear boundaries, and further enhancement yielded no additional findings (as indicated by the arrow); b: both sides of the neck showed a clear butterfly thyroid gland group with smooth and regular edges and a slightly higher density image with uniform enhancement (as indicated by the arrows)



clear boundary (as indicated by the arrow)

Figure 3 Ultrasound images of bilateral neck thyroid gland  
图3 双侧颈部甲状腺超声影像

a: the echos of the right thyroid gland parenchyma were uniform, and no abnormalities were observed; b: several anechoic nodules were observed in the left thyroid gland, with a maximum diameter of 2.6 mm and a



Arc-shaped incisions were made along the surface of the tumor from top to bottom (as indicated by the yellow line)

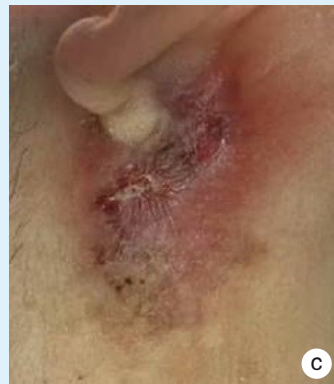
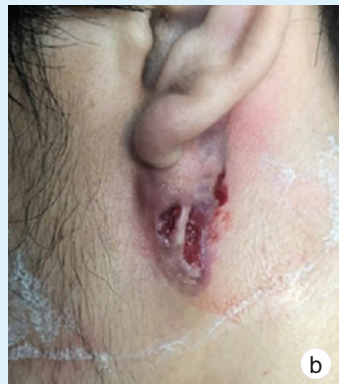
Figure 4 Schematic diagram of surgical incision for left parotid gland mass

图4 左侧腮腺区肿物手术切口示意图

1次术区换药,换药后创面应用碘仿纱条加压包扎,4周后可见愈合欠佳的创面范围明显减少,周围开始形成正常皮肤组织(图5b),8周后可见创面基本完全愈合,形成正常皮肤组织(图5c)。术后10周随访术区愈合良好,无异常改变。

### 1.5 术后病理检查

术后病理学检验回报:左腮腺区病变考虑甲状腺异位伴慢性炎症(图6)。术后1个月复查甲状腺功能:促甲状腺激素(TSH)为2.56  $\mu\text{IU/mL}$ (正常值:0.35 ~ 4.94  $\mu\text{IU/L}$ ),游离甲状腺素(FT4)为14.29  $\text{pmol/L}$ (正常值:9.1 ~ 19.24  $\text{pmol/L}$ )。

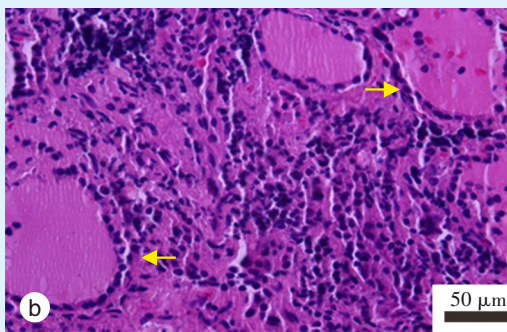
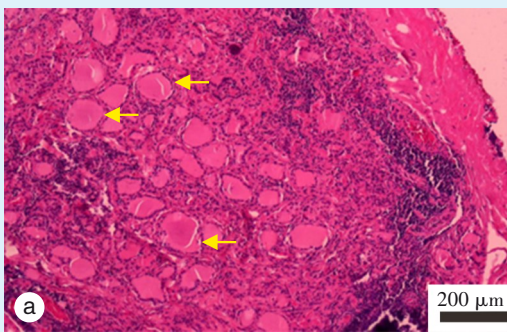


a: two weeks after surgery, the wound healed poorly; some sutures fell off, exposing the wound and revealing bright-red granulated tissue; b: the dressing was changed on a weekly basis for 4 weeks after surgery, and the wound area significantly reduced,

with healthy tissue beginning to form around the wound; c: after 8 weeks, the wound healed completely and formed healthy skin tissue

Figure 5 Postoperative wound healing related images of left parotid gland mass

图5 左侧腮腺区肿物术后伤口愈合相关图像



a: HE staining (bar = 200  $\mu\text{m}$ ) showed shapeless thyroid gland follicular tissue of different sizes and regular arrangement (as indicated by the arrows); b: HE staining (bar = 50  $\mu\text{m}$ ) showed more inflammatory cells, mainly lymphocytes and plasma cells, between thyroid gland follicular tissues (as indicated by the arrows)

phocytes and plasma cells, between thyroid gland follicular tissues (as indicated by the arrows)

Figure 6 Postoperative pathological report of the mass in the left parotid gland area indicated ectopic thyroid gland tissue

图6 左侧腮腺区肿物术后病理报告为异位甲状腺组织

## 2 讨论

### 2.1 异位甲状腺病因

异位甲状腺是一种先天性疾病,在临床上较为罕见,约占所有甲状腺疾病的1/10万,其中女性

较为多见,男女比例大约为1:3<sup>[8]</sup>,这可能是由于女性体内雌激素水平的变化对甲状腺发育会产生一定的影响,可发生在任何年龄<sup>[9]</sup>,主要在儿童和青少年时期经过临床检查而被发现,其病因较为

复杂,目前学者研究主要考虑为胚胎发育异常,即甲状腺原基从舌根部下降至颈部正常位置的过程中发生异常,常见原因主要有遗传因素、个别基因发生突变、母体在孕期发生感染、辐射或口服甲状腺药物,此外,血管结构异常或局部血管阻塞阻碍迁移亦可引起甲状腺在发育过程中发生异位<sup>[10]</sup>。初期患者无明显异常症状,随着年龄增长,可表现为局部肿物或包块等,而甲状舌管囊肿、颈部淋巴结肿大、颈部血管瘤及脂肪瘤等可能存在相似的临床症状,但甲状舌管囊肿主要位于颈部正中,CT可见多与舌骨关系密切,且随吞咽移动,而淋巴结肿大多为结节状,质地中等,血管瘤和脂肪瘤质地较软,超声和CT为均匀的低回声,且血管瘤体位移动实验为阳性,但核素扫描均无甲状腺组织的摄取功能<sup>[11-12]</sup>,异于甲状腺组织来源的病变。

## 2.2 异位甲状腺临床表现

正常的甲状腺组织具有维持内分泌平衡和反映身体健康状态的作用,而异位甲状腺是指位于第2~4气管软骨以外的甲状腺组织,包括部分甲状腺异位和完全甲状腺异位<sup>[13]</sup>,部分甲状腺异位其颈部正常位置存在甲状腺组织,部分出现在其他位置,临床上部分异位较为多见,主要异位于舌根及颈部,表现为颈部中线区肿块,可能无明显症状,也可能出现心慌、手抖、多汗、消瘦、烦躁等甲状腺功能亢进症状。而发生于舌根部异位甲状腺最多<sup>[14-15]</sup>,患者常因出现局部压迫症状而就诊,如吞咽困难、异物感、言语不清等。当肿块较大时,可能会影响呼吸,导致呼吸困难<sup>[16-17]</sup>。因颈部存在正常甲状腺组织,甲状腺功能影响一般较小。而完全性甲状腺异位,颈部正常位置无甲状腺组织,临床极为罕见,甲状腺功能更容易受到影响,更易出现甲状腺功能减退等症状,而完全异位的甲状腺在异常位置更易受到周围组织的影响,出现压迫症状或其他并发症的概率相对更高<sup>[18-19]</sup>。本病例部分甲状腺异位发生于腮腺区,国内外少有报道<sup>[20]</sup>。

## 2.3 异位甲状腺辅助检查及临床诊断

针对异位甲状腺的诊断方法较多,其中颈部CT及甲状腺彩超是最常规的检查项目<sup>[21-23]</sup>,可以确诊颈部正常位置是否存在正常的甲状腺组织,是区别部分甲状腺异位和完全性甲状腺异位的主要方法。既往报道的案例中,多数的异位甲状腺患者为部分甲状腺异位,颈部正常位置通常存在甲状腺组织<sup>[24]</sup>。异位位置的甲状腺组织主要通过

病理学诊断进行确诊,优于上述检查的还有甲状腺核素扫描<sup>[25-26]</sup>,常用的是锝-99m(<sup>99m</sup>Tc)或碘-131(<sup>131</sup>I)扫描<sup>[27]</sup>,可显示甲状腺组织对放射性核素的摄取情况,有助于发现异位的有功能的甲状腺组织,对诊断异位甲状腺具有重要意义,但对无功能或微小的异位甲状腺存在漏诊可能,仍需结合细针穿刺细胞学检查<sup>[28-29]</sup>,该方法对于腮腺区肿物术前确诊已得到广泛应用,其准确性高,误诊率低,是术前诊断的金标准。本病例术前CT及颈部彩超均可见正常甲状腺组织,因此术前未考虑该病,未行细针穿刺细胞学检查及其他必要检查,是未能明确诊断的主要原因,虽然行细针穿刺细胞学检查可以明确肿物性质,但也可能出现感染风险,甚至甲状腺功能减退等症状,尤其是舌根部肿物,穿刺出血风险极大,所以很少进行穿刺检查。此外,对于舌根部异位甲状腺患者,据报道大多数异位甲状腺患者合并甲状腺功能减退<sup>[30]</sup>,且三碘甲状腺原氨酸(T3)、甲状腺素(T4)水平下降,而促甲状腺素(TSH)水平大幅升高,尤其是舌根部异位甲状腺,可见甲状腺功能检查也可为该病的诊断提供一定依据<sup>[31]</sup>。

## 2.4 异位甲状腺治疗方法及与预后

异位甲状腺的治疗方法主要取决于其位置、大小、功能状态以及患者的症状。常见的治疗方法有保守观察和药物治疗<sup>[32-33]</sup>,适应于异位甲状腺组织较小、无症状且甲状腺功能正常,但需要定期复查,监测病情变化。其次为手术治疗<sup>[34-37]</sup>,适应于患者出现明显的局部压迫症状,如呼吸困难、吞咽困难等。手术治疗需要依据具体位置和病情而定,同时要尽量保留正常的甲状腺组织,以维持其功能。如果手术中切除过多的甲状腺组织,可能导致甲状腺功能减退,需要长期服用甲状腺激素替代治疗。但患者若能遵医嘱规律服药、定期复查,调整药物剂量,也能较好地控制病情,不影响日常生活。此外,还有放射碘及局部消融治疗<sup>[38-39]</sup>。放射性碘治疗主要用于治疗有功能的异位甲状腺组织导致的甲状腺功能亢进,甲状腺组织摄取碘的能力良好,如果治疗剂量恰当,有效控制了甲状腺功能亢进,预后较好。但部分患者可能会出现甲状腺功能减退,需要后续的治疗和管理。局部消融治疗在成功消融异位甲状腺组织且未引起严重并发症的情况下,预后也较好<sup>[40]</sup>。

在既往腮腺区手术创口愈合欠佳的原因分析中,主要原因为感染<sup>[41-42]</sup>,其次为涎液刺激创口所

致<sup>[43]</sup>,本病例手术未涉及腮腺包膜,无涎瘘存在,但术后伤口不愈合,可能与患者皮肤较薄、血运较差有关。

综上,异位甲状腺的发病率虽然比较低,但大部分异位甲状腺存在一定的功能异常,应该引起高度重视,术前检查是确诊该病避免误诊、漏诊和制定正确手术方式的依据,治疗上应尽可能采取保留甲状腺组织结合手术的综合治疗方式,同时要注意并发症的防治。

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