Calcitonin-negative primary neuroendocrine tumor of the thyroid (nonmedullary) in a dog

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Abstract
The Calcitonin-negative neuroendocrine tumor of the thyroid (CNNET) or “nonmedullary” in humans is a rare tumor that arises primarily in the thyroid gland and may be mistaken for medullary thyroid carcinoma; it is characterized by the immunohistochemical (IHC) expression of neuroendocrine markers and the absence of expression for calcitonin. An Argentine dogo bitch showed a solid, compact thyroid tumor, which was IHC negative for the expression of calcitonin, carcinoembryonic antigen, thyroglobulin and S100 protein, and positive for synaptophysin and cytokeratin AE1-AE3. The Ki-67 proliferation index was low. We cite this case not only because it is the first case report of calcitonin-negative primary neuroendocrine tumor of the thyroid in dogs but also because we want to highlight the diagnostic importance of IHC in this regard.

Keywords: Calcitonin-negative, Immunohistochemistry, Ki-67, Medullary thyroid carcinoma, Neuroendocrine.

Introduction
With the exception of the medullary thyroid carcinoma (MTC), other neuroendocrine tumors (NETs) can rarely be seen in the human thyroid gland (Nakazawa et al., 2014); among these tumors we can cite the paranglioma (Pg), the hyalining trabecular tumor, the metastatic neuroendocrine tumor to the thyroid gland and the intrathyroid parathyroid adenoma or tumor. Several reports have recently postulated a rare calcitonin-negative NET of the thyroid or nonmedullary (CNNET) as a new entity based on its IHC features: negative staining for calcitonin (CT) and carcinoembryonic antigen (CEA) and positive staining for neuroendocrine markers Chromagranin A (CGA) and Synaptophysin (Syn) (Ismi et al., 2014; Kim et al., 2015; Chernyavsky et al., 2011; Zengguang et al., 2016). These tumors pose a challenge in terms of diagnosis due to their histopathological similarities to MTC and the corresponding IHC expression of neuroendocrine markers. Several reports on MTC in dogs have been published (Campos et al., 2014; Patnaik et al., 2002). However, as per the best knowledge of authors, this would be the first CNNET case to have ever been published.

Case details
A 8-year old spayed, Argentine dog was presented to the Endocrinology Service Unit at our hospital. The patient presented a cervical region tumor, located in the left thyroid lobe’s projection area. The ultrasound revealed a 7 x 4.5 cm hyperechoic, well-defined, multilobed mass with moderate peripheral and intratumoral vascularization; the right thyroid lobe had preserved shape and size with a slightly increased heterogeneous echogenicity. The regular blood test and the endocrine/biochemical testing (TSH: 0.22 ng/ml, reference value 0.30 - 3.50 ng/ml; T4f: 0.98 ng/dl, reference value 0.6 - 1.6 ng/dl; PTH: 1.7 pmol/l, reference value 0.6 –3.55 pmol/l) showed all results within the reference values, with the exception of the alkaline phosphatase: 635UI/l (Reference value up to 250UI/l).

The exact nature of mass could not be determined by cytology, however, it was indicative of malignant. A left hemithyroidectomy was performed under suspicion of thyroid carcinoma, after ruling out other thoracic and abdominal neoplasias by means of X-rays and ultrasonography. The clinical stage of the thyroid gland tumor (TNM) was: T3b (>5cm, fixed), N0 (no evidence of regional lymph node involvement), M0 (no evidence of distant metastasis) (Owen, 1980). During the surgery, local extension of the tumor to sternothyroid muscle and the esophagus wall was observed. No evidence of invasion to the regional lymph node was detected (Fig. 1A). The neoplastic cells were arranged in nests surrounded by a moderate fibrovascular stroma with large nuclei and abundant, slightly acidophilic cytoplasm. At that moment, the histological diagnosis of neoplasia was thyroid carcinoma subclassified as the solid, compact type.

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everal whitish foci, which...

Immediately after the surgery, the surgical specimen was fixed in 10% buffered formalin and embedded in paraffin blocks. 3µm-thin sections were cut and stained with hematoxylin and eosin.

The IHC staining and control (Table 1) were performed by means of the Avidin-Biotin Complex (ABC) and the 3,3'-diaminobenzidine chromogen (DAB). The images were taken with a Leica DC160 digital camera connected to a trinocular microscope (Leica DM4000B led).

Quantification of the staining IHC was performed semi-quantitatively through the percentage of tumor cells stained positively/cells per field. Staining intensity was subjectively classified as mild, moderate and intense.

Macroscopically, the entire left lobe of the thyroid was affected by neoplasia, which was well-defined by a moderately vascularized, thin capsule. The cutting surface showed solid-cystic features with hard, yellowish consistency and dark-colored, doughy areas. Histologically, the tumor was surrounded a thin capsule fibrous peripheral.

In some sections, the invasion of neoplastic cells into the striated muscle was visible. Additionally, atrophic thyroid follicles were observed, as well as a few healthy follicles trapped in neoplasia. The tumor was composed of polyhedral cells with moderate pleomorphism and anaplasia, large and round nuclei, prominent nucleoli and acidophilic cytoplasm. No mitotic figures were discerned. The cells were arranged in the form of solid nests supported in by a moderate fibrovascular stroma (Fig. 1C). IHC data is summarized in Table 2.

The cytoplasm of tumor cells (20 % of the field) was moderately positive for CK AE1-AE3 (Fig. 1D), whereas 100 % of the cells were intensely positive for Syn (Fig. 1E). "With the exception of a few healthy follicles trapped in neoplasia," it stained negative for Tg (Fig. 2A), CT (Fig. 2B), CEA and S100. The determination of the nuclear antigen Ki-67 was 3%, which is deemed as low (Fig. 2C).

**Discussion**

This report depicts the contribution of IHC to the definitive diagnosis of a rare NET, which primarily arises in the thyroid gland, and of which, to the authors' knowledge, there are no prior references in veterinary bibliography. Upon review of human literature, some case reports were found displaying similar IHC features. Those cases were initially referred to as "atypical medullary thyroid carcinoma" (Schmid and Ensinger, 1998), then, "calcitonin-negative medullary thyroid carcinoma" (Wang et al., 2008) and finally, "Calcitonin-negative neuroendocrine tumor of the thyroid" or nonmedullary (CNNET) (Chernyavsky et al., 2011). The use of Syn helped determining the neuroendocrine origin of our case. The procedure can also be performed by means of CGA or Neuron-specific enolase (ENS), even though the latter is less specific.
Consequently, MTC was ruled out. However, its highly variable histological features call for the use of IHC with its most specific marker, the CT, coupled with CEA. The latter is not specific, it has a major role in the diagnosis of poorly differentiated MTC, though. (Ismi et al., 2014; Schmid, 2015). In our case, the tumor cells were negative for CT and CEA. Consequently, MTC was ruled out.

Regarding the NETs that may affect the thyroid gland, the MTC certainly is the most prevalent tumor both in dogs and in humans (Campos et al., 2014; Kim et al., 2015). However, the other NETs rarely affect the thyroid. Even though it has not been deemed as a primary thyroid tumor, among the rare NETs we find the Pg (Nakazawa et al., 2014), which is typically composed of two cell types: the principal cells, which stain positive for neuroendocrine markers but negative for CKAE1/AE3, Tg, CT, CEA and PTH; and the sustentacular cells, which stain positive for S100 protein and are located at the periphery of tumor nests (Yu et al., 2013). Therefore, the lack of S100 expression and the presence of CK expression in our patient ruled out the Pg.

Table 1. Antibodies used in immunohistochemistry.

| Primary antibody | Type of antibody          | Dilution | Positive control                      | Negative control          |
|------------------|---------------------------|----------|--------------------------------------|---------------------------|
| Tg               | Mouse monoclonal Santa Cruz Biotecnology | 1:50     | Normal thyroid follicular cells in dogs | MTC parafollicular cells in dogs |
| CT               | Rabbit polyclonal Biolaboratorio Dako | 1:400    | MTC (previously reported)            | Normal thyroid follicular cells in dogs |
| CEA              | Mouse monoclonal Biolaboratorio Dako | 1:50     | Colon (epithelial cells)              | Colon (epithelial cells).   |
| Syn              | Mouse monoclonal Santa Cruz Biotecnology | 1:50     | MTC parafollicular cells in dogs      | Normal thyroid follicular cells in dogs |
| CK AE1–AE3       | Mouse monoclonal Biolaboratorio Dako | 1:100    | Liver tissue                          | Liver tissue.               |
| S100             | Rabbit polyclonal Biolaboratorio Dako | 1:200    | Peripheral Nervous Tissue             | Peripheral nervous tissue.  |
| MIB-1            | Mouse monoclonal Biolaboratorio Dako | 1:75     | Nodal lymphoma                        | Non tumoral thyroid tissue. |

Table 2. Immunohistochemical profile of calcitonin-negative neuroendocrine tumor of the thyroid, previously reported.

| Author               | Immunohistochemistry | Nomenclature                                                                 |
|---------------------|----------------------|-------------------------------------------------------------------------------|
| Chernyavsky et al., 2011 | + - Np + W Np - Np     | Calcitonin-negative neuroendocrine tumor of the thyroid.                      |
| Ismi et al., 2014    | - - - - + + Np       | Calcitonin-negative neuroendocrine tumor of the thyroid.                      |
| Kim et al., 2015     | + - - + + Np - Np    | Calcitonin-negative neuroendocrine tumor of the thyroid with follicular cell origin. Thyroid neuroendocrine cancer accompanied with papillary carcinoma. |
| Zengguang et al., 2016 | - - Np + + Np        | Calcitonin-negative nonmedullary neuroendocrine tumor of the thyroid.          |
| Gonzalez Alcolea et al., 2015 | - - Np + Np Np Np Np | C-cell-derived calcitonin-free neuroendocrine carcinoma of the thyroid ●CGRP. Calcitonin-negative primary nonmedullary neuroendocrine tumor of the thyroid |
| Nakazawa et al., 2014 | - - - - + + Np       | Calcitonin-negative primary nonmedullary neuroendocrine tumor of the thyroid |
| Soler et al., 2016*  | - - - + Np - +       | Calcitonin-negative primary nonmedullary neuroendocrine tumor of the thyroid |

W: Weak.
Np: Not performed.
*: This report.
●CGRP: positive for the calcitonin gene-related peptide (CGRP).
Although, our final diagnosis was: calcitonin-negative primary neuroendocrine tumor of the thyroid (nonmedullary), an entity described by Chernyavsky et al. (2011), which had not been reported in dogs so far. Other cases of similar IHC features have arisen in human medicine in the recent years (Table 2). Only two reports stated that the tumor had also been positive for Tg. Thus, their authors implied that those tumors might have a follicular origin (Kim et al., 2015; Chernyavsky et al., 2011).

Nakazawa et al. (2014) described a CNNET with positive staining for the calcitonin gene-related peptide (CGRP), which proved it originated in parafollicular cells, where both CGRP and CT are coexpressed. This confirms the existence of an unusual type of MTC. In a study performed in dogs, six MTC were positive for CGRP and only four of them showed positivity for CT. These findings indicate that CGRP may be a better marker for the diagnosis of MTC in dogs than CT (Leblanc et al., 1991). In that study, CEA levels were not measured. While in one of the cases the expression of CGRP was only observed in the parafollicular cells trapped in neoplasia, in the second case the expression was mild. Consequently, we suggest CGRP measurements should be made in a larger group of MTC cases in dogs.

Regarding neoplasia malignancy, the presence of local invasion to the capsule, soft tissues and striated muscle were sufficient evidence to confirm its malignant behavior. Nevertheless, both the low Ki-67 and mitotic index matched a low-grade neuroendocrine tumor of the thyroid in histopathology (Klimstra et al., 2010). This fact highlights the importance of linking the findings deriving from surgery, histopathology and IHC so as to properly stage the tumor.

In conclusion, many of the thyroid tumors cannot be correctly diagnosed without the routine use of IHC. The implementation of CGRP and CEA markers to differentiate atypical MTC from CNNET is highly recommended. The direct effect of specific identification and differentiation of each type of thyroid carcinoma, as well as the search for new molecular markers with a therapeutic targets will facilitate the provision of more realistic prognosis, based on recurrence and survival rates applicable to upcoming cases.

**Conflict of interest**
The authors declare that there is no conflict of interest.

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