A very young child in the first few years of life presented with an asymptomatic right neck mass. Neck ultrasound showed heterogeneous enlargement of the right thyroid lobe, and fine-needle aspiration biopsy diagnosed the

**FIGURE.** (A) The right thyroid is distorted by a follicular neoplasm, surrounded by compressed thyroid, with chronic lymphocytic thyroiditis. (B) At the periphery of this neoplasm, tumor cells infiltrate in solid nests. (C) Infiltrating tumor cells have nuclear atypia with elongation, overlap, and irregular contours. (D) Ocular enucleation specimen. The choroid contains a small focus of thyroid carcinoma (black arrow). (E) The metastatic carcinoma has mild cytologic atypia. (F) Completion thyroidectomy: chronic lymphocytic thyroiditis and a single 0.25-cm minimally invasive follicular carcinoma. (G) Magnetic resonance image (MRI) sagittal view: mass lesion at T4 level (white arrow) with cord expansion and intraspinal edema from T1 to T9. (H) MRI transverse view: Mass lesion at T4 level. (I, J, K) Spect-computed tomography, showing areas of thyroid carcinoma metastasis at right acetabular roof (I), spine T4 (J), and spine S1 (K).
mass as benign; the patient was biochemically euthyroid. She underwent right hemithyroidectomy, and the pathology was reported as multinodular goiter with lymphocytic thyroiditis (Figure A-C). Two years later, she was found to have significant left-eye visual loss with photophobia. Ophthalmologic evaluation revealed a choroidal amelanotic mass touching the optic disc, with extensive retinal detachment. Favoring a choroid hemangioma, this was managed with plaque radiation; however, she developed symptomatic neovascular glaucoma, requiring left-eye enucleation. Pathology was interpreted as benign ectopic thyroid tissue (Figure D,E). On re-establishing care 4 years later, she was found to be biochemically euthyroid on a lower-than-expected dose of levothyroxine. A $^{123}$I whole-body scan on thyrogen and low-iodine diet demonstrated uptake in the left thyroid and multiple osseous metastases (Figure G-K). Review of both previous pathology specimens revealed a minimally invasive follicular thyroid carcinoma (FTC) in the right thyroid and metastatic FTC in the left eye.

The patient underwent completion left thyroid lobectomy to facilitate $^{131}$I ablation therapy; there was a 0.25-cm focus of minimally invasive FTC and chronic lymphocytic thyroiditis (Figure F). Next-generation sequencing performed on both thyroidectomy specimens revealed a CHEK2 germline pathogenic mutation c.1100delC(p.T367Mfs*15) but failed to identify any additional mutation. Although CHEK2 mutations are best known in adult breast cancer, they have a much broader significance, as is shown in this example.

POTENTIAL COMPETING INTERESTS
Authors declare no potential competing interests.

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