Cytologic and Histological Features of Rare Nonepithelial and Nonlymphoid Tumors of the Thyroid

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Thyroid tumors can be classified into epithelial, nonepithelial, and nonprimary lesions. Nonepithelial thyroid tumors are rare. They can be of primary origin within the thyroid gland, arise secondary to contiguous growth from adjacent tissues, or represent metastatic disease. The incidence of nonepithelial tumors of the thyroid is only 1% to 2%, most of which are lymphomas; the remainder includes mesenchymal and histiocytic tumors. This review examines the cytohistological features of various nonepithelial and nonlymphoid tumors of the thyroid, including vascular lesions, neural tumors (including granular cell tumor and paraganglioma), smooth muscle tumors, solitary fibrous tumor, histiocytic neoplasms (eg, Langerhans cell histiocytosis and Rosai-Dorfman disease), and follicular dendritic cell sarcoma. Their differential diagnosis is discussed, including recommendations to prevent the pitfall of mistaking these rare tumors for more common epithelial thyroid neoplasms. ***Cancer Cytopathol* 2021;129:583-602**. © *2020 American Cancer Society*.

KEY WORDS: fine needle aspiration cytology; malignancy; nonepithelial tumors; rare thyroid entities; sarcoma; thyroid nodules.

INTRODUCTION

The majority of thyroid lesions, including benign and malignant entities, are of epithelial origin.[1-3] Of the follicular-derived epithelial malignancies, papillary thyroid carcinoma is the most common type of cancer, followed by follicular thyroid carcinoma. Medullary thyroid carcinoma arises from parafollicular cells. Nonepithelial malignancies (including lymphoma and mesenchymal lesions, among others) account for only 1% to 2% of thyroid tumors, the vast majority of which are attributed to different types of lymphoma.[3] Nonetheless, the thyroid gland may rarely be involved by other nonepithelial tumors, including vascular, neural, smooth muscle, fibroblastic, histiocytic, and follicular dendritic cell tumors, as well as teratomas.[1,3,4]

Mesenchymal tumors of the thyroid can present as a solitary nodule or larger mass or may be identified in a thyroid gland that has been removed for another epithelial lesion. Both benign and malignant mesenchymal tumors of diverse lineages may occur in the thyroid.[3,4] Sarcomas represent only a small proportion of primary thyroid malignancies. Virtually all types of sarcoma have been documented manifesting as a primary thyroid malignancy, including osteosarcoma. Among them, angiosarcoma is the most common entity reported in endemic goiter regions of Europe.[4-7] Akin to undifferentiated carcinomas of the thyroid gland, these rapidly growing sarcomas tend to occur in older people and are usually fatal due to their local invasiveness.

The cytomorphology of nonepithelial thyroid lesions is identical to that of their counterparts in other body sites; however, their unusual location in the thyroid frequently leads to misinterpretation and misdiagnoses on fine needle aspiration (FNA).[1,4] The cytological diagnosis of a nonepithelial thyroid tumor can

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TABLE 1. Cytomorphologic Overlap Between Nonepithelial and Epithelial Lesions of the Thyroid Gland

Cytomorphology	Nonepithelial Thyroid Disease	Epithelial Thyroid Disease
Nuclear grooves	LCH	PTC, HTT, some MTC
Nuclear pseudoinclusions	LCH	HTT, PTC, some MTC
Spindle nuclear features	FDCT, GCT, leiomyoma, leiomyosarcoma, PNST, MPNST, paraganglioma, SFT	HTT, some PTC, MTC, metastases including melanoma
Voluminous cytoplasm	FDCT, GCT, LCH, paraganglioma, RDD	Oxyphilic neoplasms including oxyphilic variant of PTC and/or MTC, metastases
Granular cytoplasm	Angiosarcoma, GCT, LCH, paraganglioma, RDD	Oxyphilic neoplasms including oxyphilic variant of PTC and/or MTC, metastases
Naked nuclei	GCT, paraganglioma	HTT, MTC, PTC, metastases

Abbreviations: FDCT, follicular dendritic cell tumor; GCT, granular cell tumor; HTT, hyalinizing trabecular tumor; LCH, Langerhans cell histiocytosis; MTC, medullary thyroid carcinoma; MPNST, malignant peripheral nerve sheath tumor; PNST, peripheral nerve sheath tumor; PTC, papillary thyroid carcinoma; RDD, Rosai-Dorfman disease; SFT, solitary fibrous tumor.

be extremely challenging for cytopathologists. Despite the rarity of these lesions in this anatomic location, several of their morphological features (eg, papillary structures with fibrovascular cores, granular cytoplasm) may overlap with more typical thyroid epithelial lesions (Table 1). The purpose of this review is to explore the cytohistological features of various nonepithelial and nonlymphoid tumors that may involve the thyroid gland, highlight the diagnostic role of helpful ancillary studies, and offer recommendations to prevent mistaking these rare tumors for more common epithelial thyroid neoplasms.

VASCULAR LESIONS

Vascular lesions that may involve the thyroid gland include benign entities such as hemangiomas and malignant lesions such as angiosarcoma.[4-19]

Hemangioma

Clinical findings

Hemangiomas are more likely to be found in the skin and subcutaneous tissue but have been recorded rarely within the thyroid gland.[1,2,15] The majority are clinically obvious and hence not aspirated, unless FNA is performed to exclude malignancy.[15]

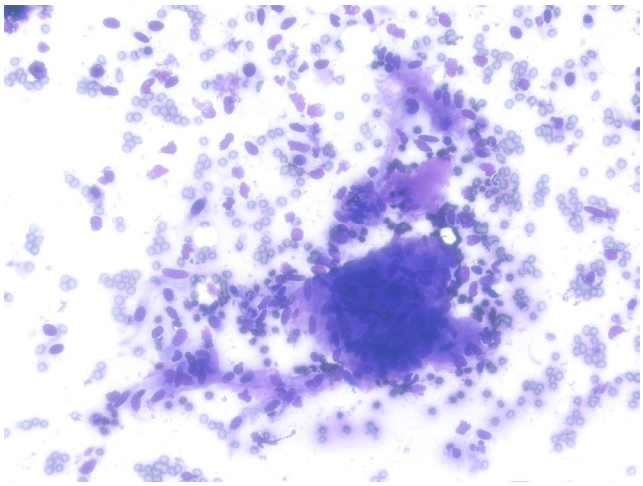

Figure 1. Cytological details of a hemangioma. The image is characterized by single spindle-shaped cells with swirls of endothelial cells (Diff-Quick, original magnification ×8).

Cytopathology

The cytological features are those of an acellular or scant bloody sample, with rare, isolated spindle or polygonal cells with moderate cytoplasm and/or tangles or swirls of bland endothelial cells[1,2,4,15] (Fig. 1).

Histopathology

Hemangiomas are composed of multiple irregular, dilated vessels. These vessels are lined by a monolayer of bland endothelial cells and are usually filled with red blood cells. There may be a zone of hemorrhage and atrophy of the adjacent thyroid tissue.[15]

Ancillary studies

The cells lining blood vessels are positive for endothelial markers such as CD31, CD34, and ERG. Thyroglobulin and thyroid transcription factor 1 (TTF-1) are negative.

Differential diagnosis

The differential diagnosis includes an organizing thrombus, hematoma, or other vascular neoplasm (eg, epithelioid hemangioendothelioma, Kaposi sarcoma,

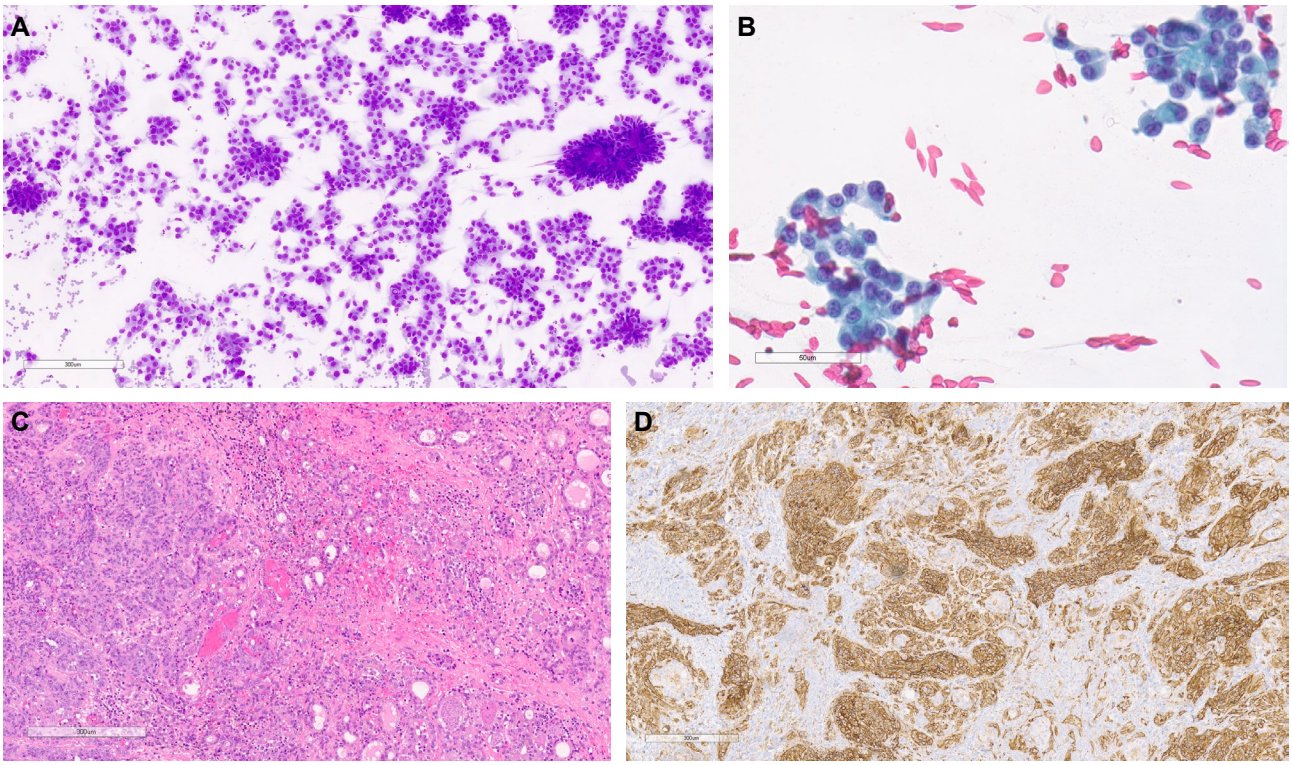

Figure 2. (A, B) Cytological features of a thyroid angiosarcoma (Diff-Quick, original magnification ×40 [A]; Papanicolaou stain, original magnification ×40 [B]). The slides are hypercellular and composed of cells showing spindle/epithelioid and plasmacytoid features. Moderate cytoplasm and large nuclei with moderate to severe atypia can be seen. (C) Morphologic details from a histological case of thyroid epithelioid angiosarcoma defined by nests and sheets of epithelioid cells with eosinophilic cytoplasm (hematoxylin and eosin, original magnification ×40). (D) Expression of CD31 in neoplastic cells (A&B, original magnification ×10).

angiosarcoma). These other vascular lesions are characterized by atypical cellular features.

Angiosarcoma

Clinical findings

Angiosarcomas are malignant vascular tumors that account for <1% of all sarcomas. They arise predominantly in the skin but also occur in deep soft tissue and viscera, including the thyroid gland.[6-10,18] They account for 0.7% of all thyroid cancers.[1-4] According to the literature, they occur more often in women, with a peak incidence in the seventh decade.[1,6] Angiosarcoma of the thyroid appears to be more common in the Alpine countries of central Europe where there is a dietary iodine deficiency.[2-4] Nonetheless, they have also been documented in countries with adequate iodine intake. Some authors confirmed a significant occupational exposure to vinyl chloride, other polymeric materials, and radiation.[6-8,10] In the majority of cases, patients present with a painless mass arising in a long-standing goiter. However, some cases can cause a rapidly growing tumor with compression symptoms. There is a risk of metastases to regional lymph nodes, lung, and bone. The majority of thyroid angiosarcomas are of epithelioid type,[6-11] hence they may exhibit a preponderance of cytological features that resemble carcinoma. For this reason, their cytological diagnosis is challenging.

Cytopathology

FNA smears show variable cellularity ranging from hypocellularity to hypercellular specimens.[5,9,11-14,19] The architectural pattern is characterized by single dispersed cells, loose or tight clusters, and focal papillary structures with fibrovascular cores. Individual cells may have a variable appearance ranging from spindled to plasmacytoid or epithelioid with moderate to abundant cytoplasm (Fig. 2A,B). Nuclei are typically large, round to oval, and of high nuclear grade, and they may have multiple prominent nucleoli.[11-13] A necrotic background and mitotic figures are commonly identified on FNA samples. Hemophagocytosis, cytoplasmic vacuoles, and endothelial wrapping may be identified.

Histopathology

These tumors are usually large and have invasive margins.[1,2,18] They may show different morphological patterns, including solid, spindled, papillary, and pseudopapillary structures composed of irregular gaping vascular channels, although epithelioid cytology is most common (Fig. 2C). The endothelial cells may show multilayering or a hobnail appearance with projection into the vascular lumen. In solid areas, the cells may have hyaline globules and intracytoplasmic vacuoles. Neoplastic cells have abundant eosinophilic cytoplasm, round nuclei with vesicular chromatin, and prominent nucleoli. Necrosis and a high mitotic rate are observed frequently.

Ancillary studies

The neoplastic cells are usually strongly and diffusely positive for vascular endothelial markers, including CD34, CD31 (Fig. 2D), and ERG.[1,2,18] Keratins are variably positive, most often in epithelioid angiosarcomas. Thyroglobulin, TTF-1 and PAX8 are negative.[11]

Differential diagnosis

The differential diagnosis varies depending on angiosarcoma grade. Low-grade angiosarcoma may resemble a hemangioma. High-grade angiosarcoma with solid growth and diverse growth patterns may resemble other poorly differentiated malignancies, including anaplastic thyroid carcinoma and other sarcomas.[5,9,11] Adenomatoid hyperplastic nodules of the thyroid with degenerative and regressive changes might include areas of vascular proliferation. However, these thyroid nodules lack atypia and extensive freely anastomosing vessels. The presence of papillary structures in aspirates from an angiosarcoma, as well an acinar pattern and isolated epithelioid and plasmacytoid cells with cytoplasmic vacuoles that mimic intracellular mucin, may resemble a poorly differentiated adenocarcinoma.[1,6] The diagnosis of angiosarcoma can be confirmed by demonstrating expression of endothelial markers. Also included in the differential diagnosis are metastatic melanoma, epithelioid sarcoma, and plasmablastic lymphoma. A panel of immunostains may be necessary to differentiate these malignancies.

NERVE SHEATH TUMORS

A nerve sheath tumor is determined to be primary by the fact that the tumor arises within thyroid parenchyma.[20-24] Peripheral nerve sheath tumors (PNSTs) of the thyroid account for <0.02% of all thyroid tumors. The morphological criteria used to diagnose a PNST of the thyroid gland are identical to those used for benign (schwannoma, neurofibroma) and malignant peripheral nerve sheath tumors (MPNSTs) in other body sites.[1,2,20-32] PNSTs are difficult to diagnose based on clinical findings and sonographic features alone because they are similar to those of other thyroid entities.

Schwannoma and Neurofibroma

Clinical findings

Benign PNSTs may occur at any age, but preferentially arise in patients between 40 and 60 years, without any significant sex difference. They usually present as a gradually enlarging mass without specific symptoms and signs. While 25% to 45% of schwannomas occur in the head and neck region, they are extremely rare in the thyroid.[1,2,20-25] Isolated neurofibromas of the thyroid are also extremely rare.[23,24] Neurofibromas may be sporadic or can be seen in the context of neurofibromatosis type 1.[23,24]

Cytopathology

Cytological evaluation for the diagnosis of schwannoma shows low sensitivity, ranging between 0% and 40%, with unsatisfactory specimen rates reported between 36% and 50%.[28,29] The low diagnostic yield with FNA is ascribed to their dense interstitial components, hypocellular Antoni B areas, and frequent cystic degeneration,[28] as well as their nonspecific cytomorphology.[26,27,31-33] For this reason, some authors have proposed using core needle biopsy.[30,31] An FNA of a well-sampled schwannoma arising in the thyroid shows spindled tumor cells with elongated slender and wavy nuclei, frequently embedded in metachromatic stroma without associated follicular thyroid cells or background colloid[23] (Fig. 3).

Neurofibroma on FNA is characterized by fragments of cohesive tissue with a myxoid-fibrillary appearance and mesenchymal tissue with intercellular collagen.

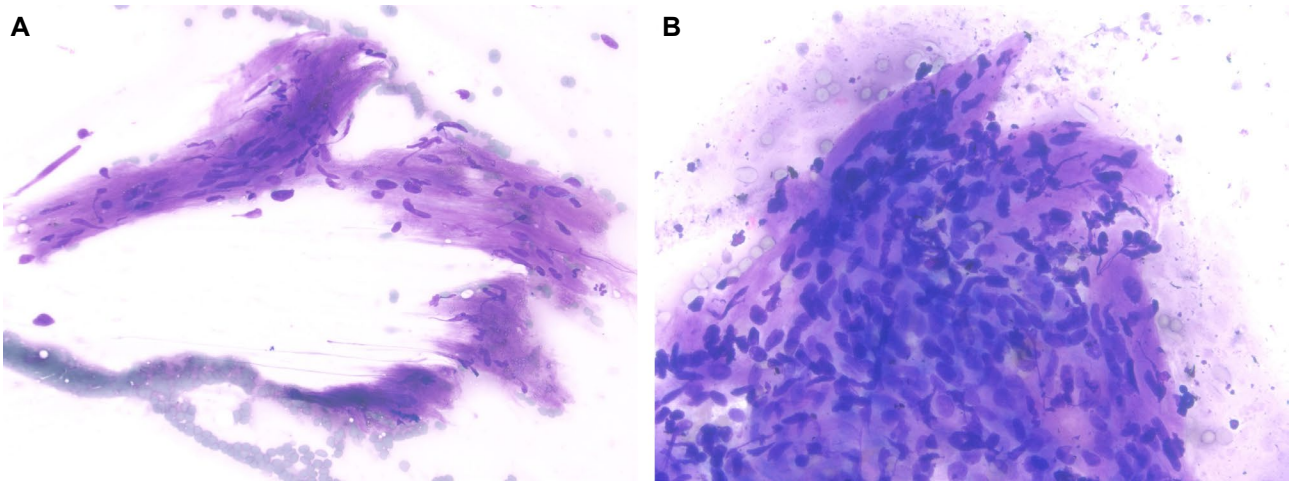

Figure 3. A–B. Cytological details from a case of schwannoma. The images show spindle cells with elongated and wavy nuclei embedded in a metachromatic stroma (Diff-Quick, original magnification ×20 [A] and ×40 [B]).

Spindle-shaped, widely separated nuclei with pointed ends have been observed.[1,2]

Histopathology

Schwannomas harbor Antoni type A areas characterized by packed, fascicular and focally palisading spindle-shaped cells and Antoni B hypocellular areas with myxoid, cystic, or xanthomatous changes.[1,2,20] The elongated fusiform cells show cytoplasmic extensions, giving them a wavy appearance. Nuclei are mostly elongated with occasional degenerative atypia, fine chromatin, and inconspicuous nucleoli.

Ancillary studies

Schwannomas/neurofibroma are diffusely and strongly positive for S100 protein and SOX10 but are negative for thyroglobulin, chromogranin, smooth muscle actin, muscle-specific actin, desmin, HMB45, and Melan-A.[1,2,20] Nevertheless, 63% of the cases are positive for tyrosinase.[1,2,20] S100 protein shows limited expression (or is completely negative) in MPNSTs.[1,2]

Differential diagnosis

Benign PNSTs are usually accurately diagnosed via hematoxylin and eosin (H&E) staining alone. A possible differential diagnosis includes some epithelial entities (eg, medullary carcinoma) and mesenchymal nonneurogenic lesions with spindle features.

MPNSTs

Clinical findings

MPNSTs are exceptionally rare in children and most often affect older adults.[1,2,18,21,22] Malignant transformation of a PNST in the thyroid has been documented, but this is extremely rare.[1,2,20] MPNSTs are aggressive and invasive tumors that are frequently associated with a fatal outcome.[20,22]

Cytopathology

FNA of MPNSTs is extremely challenging. Cytological smears show highly atypical spindled and/or epithelioid cells without specific features. Wakely et al analyzed 55 cases of MPNST, all with tissue confirmation.[33] The authors found that the majority of smears were highly cellular, though this was somewhat variable, because in a minority of FNAs either fibrosis or abundant blood aspirated with neoplastic cells had a dilutional effect. FNA smears showed single dissociated cells, and syncytial cell clusters of uneven size and cellularity characterized by a 3-dimensional effect led to an inability to observe cells in the center of these aggregates (Fig. 4A,B). In some cases, fascicular arrangements within aggregates have been observed. Smear background is mostly clean, but some aspirates may contain strips of collagen or fibrillary metachromatic-staining stroma and scant or lack of a necrotic component. The majority of dispersed cells are uniform in size and shape with oval and/or elongated nuclei with smooth contours and inconsistently tapered

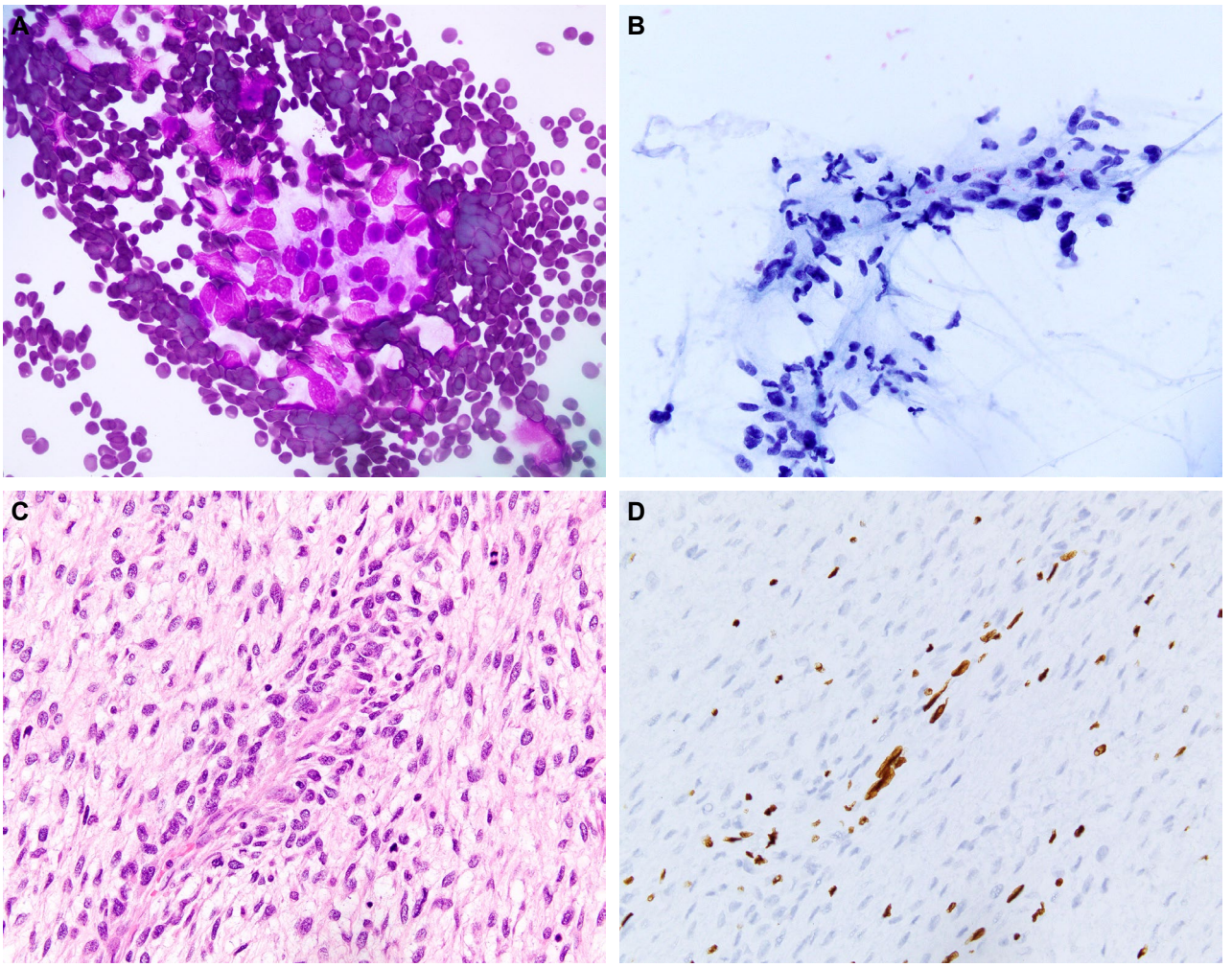

Figure 4. Malignant peripheral nerve sheath tumor. (A, B) Smears with syncytial cell clusters of uneven size and cellularity characterized by a 3-dimensional effect leading to the inability to observe cells in the center of these aggregates. The majority of cells are uniform in size and shape with oval and/or elongated nuclei with smooth contours and inconsistently tapered or blunt ends (Diff-Quick, original magnification ×40 [A]; Papanicolaou stain, original magnification ×20 [B]). (C) Details from a case of malignant peripheral nerve sheath tumor with increased cellularity with spindled cells with marked nuclear atypia arranged in highly cellular fascicles (hematoxylin and eosin, original magnification ×40). (D) Loss of histone H3K27me3 (histone H3 with lysine 27 trimethylation) by immunohistochemistry (A&B, original magnification × 40).

or blunt-ended. In some cases, nuclei have a slight "hook" at one pole, producing a so-called comma shape. Lesional cells have finely granular, evenly dispersed nuclear chromatin with small chromocenters; coarsely granular chromatin and macronucleoli are rare findings. As a result, it is often difficult to reach a conclusive and specific diagnosis before surgical management.

Histopathology

Histologically, the majority of cases show a fascicular appearance; distinctive features that may suggest MPNST include alternating cellular and more myxoid areas, and perivascular accentuation or whirling of tumor cells. MPNSTs have an invasive growth pattern and increased cellularity with fusiform and spindled cells arranged in highly cellular fascicles, sometimes with a herringbone pattern[1,2,20] (Fig. 4C). A diagnosis of MPNST is based on evidence of cellular pleomorphism with highly atypical nuclei, increased mitotic activity, and necrosis. Heterologous differentiation (most often rhabdomyoblastic or chondro-osseous) is observed in 5% to 10% of cases; very rarely, cases show glandular differentiation.

Ancillary studies

MPNSTs express S100 protein and SOX10 in only 30% to 50% of cases. S100 protein immunoreactivity

is less extensive than in benign PNSTs. They are uniformly negative for thyroglobulin, keratin, TTF1, chromogranin, calcitonin, Melan-A, and HMB45. PAX8 can be positive in 70% of cases.[1,2,20] Loss of histone H3K27me3 (histone H3 with lysine 27 trimethylation) via immunohistochemical analysis is highly specific (Fig. 4D) but only moderately sensitive for MPNST.[35,36]

Differential diagnosis

The differential diagnosis between MPNST and anaplastic thyroid carcinoma with spindle cell features may be difficult and requires the support of immunohistochemistry to confirm lack of all epithelial and thyroid markers in MPNSTs.[1,2] The possibility of a medullary thyroid carcinoma can be excluded based on negativity for calcitonin, carcinoembryonic antigen (CEA), and other neuroendocrine markers. Metastatic melanoma can mimic MPNSTs, especially spindle cellular melanoma. Strong and diffuse S100 protein and SOX10 are not seen in MPNSTs; positivity for Melan A, HMB-45, tyrosinase, and/or MITF can also help support the diagnosis of melanoma, although the sensitivity of these markers in the metastatic setting is only moderate. Other entities in the differential diagnosis include malignant teratomas of the thyroid gland and metastases; for both, the combination of morphological features and the evaluation of their immunoprofile are likely to provide useful information for making a cytological diagnosis.[34]

PARAGANGLIOMA

Clinical Findings

Paraganglioma of the thyroid is defined as an intrathyroidal neuroendocrine tumor that originates from neural-crest derived paraganglia of the autonomic nervous system.[37-40] They likely arise from the inferior laryngeal paraganglia, which can be frequently seen within the thyroid gland instead of adjacent to the larynx.[1,2] Thyroid paraganglioma is an extremely rare thyroid entity, accounting for <0.01% of all head and neck neoplasms.[1,2,4] Only 36 cases have been described, mostly on surgical samples.[40] There is a slight female predominance, and the median age at presentation is ~48 years. The majority of these neoplasms are asymptomatic and occasionally may be discovered during an ultrasound evaluation of the thyroid. Multifocal tumors may be seen in patients with familial paraganglioma-pheochromocytoma syndrome, defined by a mutation in the succinate dehydrogenase subunit genes *SDHD*, *SDHC*, or *SDHB*.[1,2,37-45]

Cytopathology

The cytological diagnosis of paraganglioma is challenging and, not surprisingly, might lead to misdiagnoses. FNA smears are cellular and contain single cells or loose clusters of medium to large cells.[37,41-43] The neoplastic cells have epithelioid, plasmacytoid, and spindle features. They have scant to moderate basophilic cytoplasm, round to oval nuclei, open chromatin, and inconspicuous nucleoli (Fig. 5A,B). Nuclear overlapping, naked nuclei, nuclear crush artifact, and occasional intranuclear pseudoinclusions may be seen in some samples. Occasional pleomorphic cells may be noted, a typical feature of neuroendocrine tumors. The smears are characterized by a bloody background and lack colloid or an amyloid component. Malignancy in paraganglioma cannot be reliably diagnosed on cytological smears (or histology).[41-43]

Histopathology

Paragangliomas are usually well-circumscribed and encapsulated tumors.[1,2] They are highly vascular with cells organized into alveolar, lobular and a Zellballen pattern with delicate fibrous septa (Fig. 5C). The neoplastic cells are polygonal with abundant granular and amphophilic cytoplasm and may have occasional vacuoles (Fig. 5D). These cells have round to oval nuclei with coarse chromatin and small nucleoli. Spindled sustentacular cells can be seen at the periphery of the cell nests. They frequently show intratumoral sclerosis and hyalinization. These lesions do not typically have necrosis or mitotic figures.

Ancillary Studies

There is a different immunohistochemical profile for carotid body versus soft tissue paragangliomas.[43-46] Specifically, soft tissue paragangliomas show diffuse positivity for synaptophysin (98%) and S100 (80%) and focal positivity for keratins (5%), while carotid body paragangliomas have focal positivity for S100 (2%) and negativity for keratin and synaptophysin.[44] A study by Satturwar et

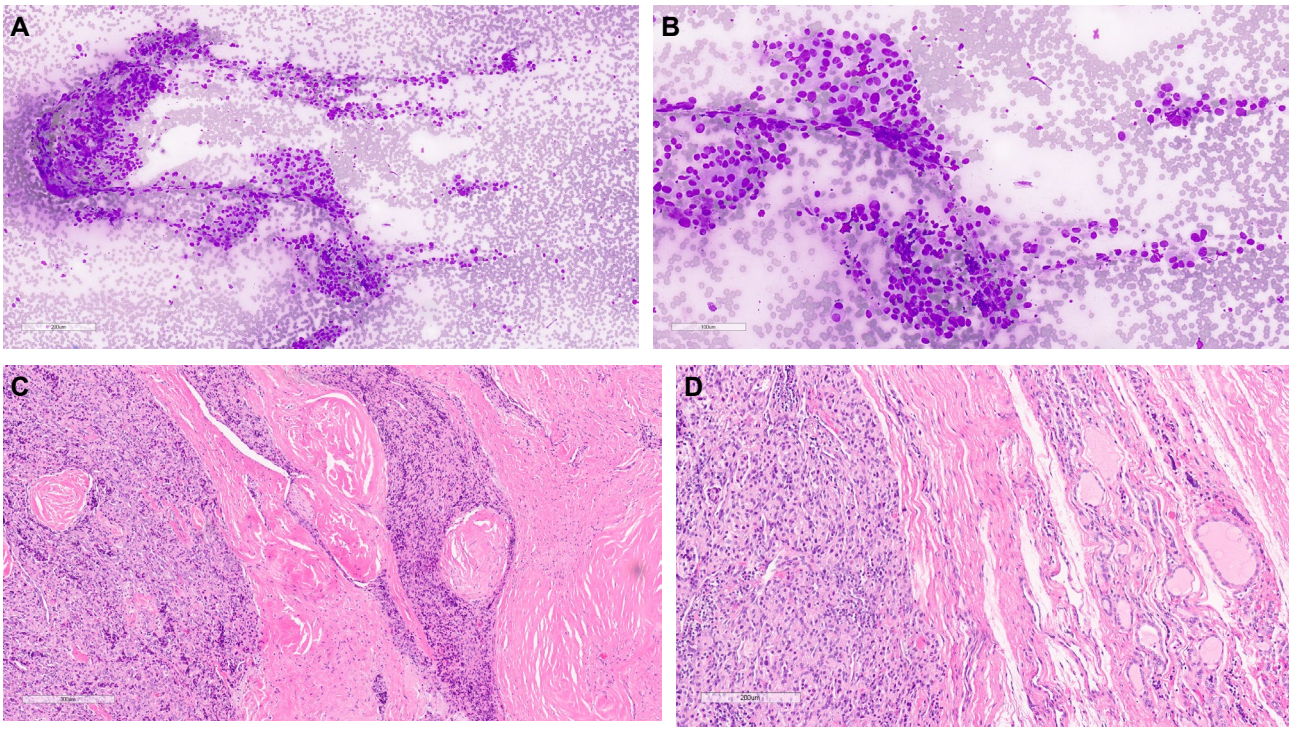

Figure 5. Paraganglioma of the thyroid gland. (A, B) Smears show single cells or loose clusters of cells, with epithelioid, plasmacytoid, and spindle features. Nuclear overlapping and crush artifact may be seen (Diff-Quick, original magnification ×10). (C, D) Details from the histological features of the same fine needle aspiration case. The images show a solid pattern with intratumoral sclerosis. Neoplastic cells have small- to medium-sized nuclei with round to oval shape and small nucleoli (H&E, original magnification ×40).

al[47] that included 5 thyroid paragangliomas yielded positivity for synaptophysin and chromogranin, as well as S100 of sustentacular cells, but negative staining for pankeratin, TTF-1, thyroglobulin, calcitonin, CEA, and HBME. Hence, based on this limited case series, the immunohistochemical profile of thyroid paragangliomas seems to best match that of soft tissue paragangliomas and not carotid body tumors. Furthermore, paragangliomas are also negative for PAX8. Loss of SDHB is observed in tumors from patients with germline *SDHX* mutations.[1,2,43-50]

Differential Diagnosis

The most important differential diagnoses to consider include hyalinizing trabecular tumor (HTT), papillary thyroid carcinoma (PTC), medullary thyroid carcinoma, intrathyroid parathyroid tumor, and metastases (eg, melanoma, neuroendocrine tumor). HTT, previously known as "paraganglioma-like adenoma of the thyroid," may resemble a paraganglioma. HTT is characterized by a trabecular pattern, intralesional fibrosis, intranuclear cytoplasmic inclusions, low nuclear/cytoplasm ratio, perinucleolar halos (vacuoles), and yellow bodies. Additionally, HTT cells show positivity for TTF-1 and thyroglobulin and have characteristic membranous positivity for MIB-1. With molecular testing, *GLIS* fusions are also highly specific for HTT. PTC has intranuclear inclusions and nuclear grooves that are not typically seen in paraganglioma. PTC shows positivity for thyroid markers. Of note, a paraganglioma-like medullary thyroid carcinoma has been described.[50] The presence of intracytoplasmic eosinophilic granules and amyloid are helpful clues for diagnosis of medullary thyroid carcinoma.[37-40] Furthermore, medullary thyroid carcinomas show immunopositivity for TTF-1, calcitonin, and CEA. Unlike paraganglioma, intrathyroid parathyroid tumors are positive for parathyroid hormone. Metastatic neuroendocrine tumors to the thyroid gland share similar morphologic features and an immunoprofile with paraganglioma. However, metastatic neuroendocrine tumors tend to be multifocal and demonstrate immunoreactivity for keratins (eg, AE1/AE3).

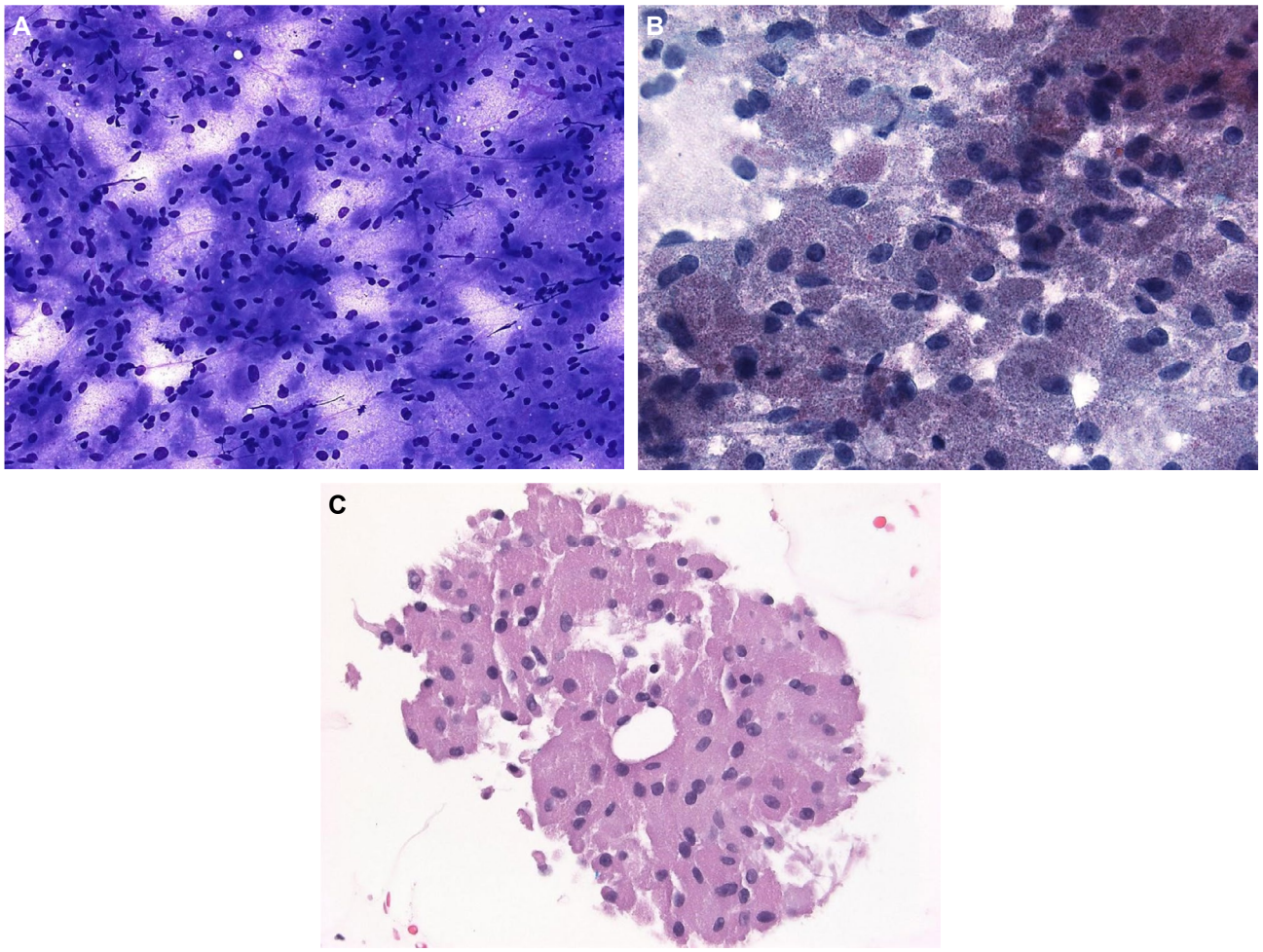

Figure 6. Granular cell tumor. (A, B) Cytological details from a granular cell tumor involving the thyroid gland. The smears show a pattern defined by single cells or syncytial clusters of cells with indistinct cell borders, fragile cytoplasm, and eosinophilic cytoplasmic granules (Diff-Quick, original magnification ×20 [A]; Papanicolaou stain, original magnification ×60 [B]). (C) Histological features of a granular cell tumor obtained from a cell block. Large cells with an epithelioid and polygonal appearance show granular eosinophilic cytoplasm (hematoxylin and eosin, original magnification ×40).

GRANULAR CELL TUMOR

Clinical Features

Granular cell tumor (GCT) is an extremely rare primary tumor of the thyroid. With the aid of ultrastructural and immunohistochemical studies, they are now confirmed to be of neural (Schwann cell) origin.[51] Their most common location is the head and neck, particularly the tongue.[1,2,51-65] To date, around 20 GCTs arising in the thyroid gland have been described in the literature. Their diagnosis is challenging mostly due to the rarity in this exact anatomic location and because their clinical-radiological findings mimic malignancy.[1,2,4,56-63] The majority of reported patients were women between the ages of 20 and 50 years.[51-65]

Cytopathology

A GCT in the thyroid can be easily misdiagnosed as follicular neoplasm.[60-63] FNA smears are composed of single cells, pseudofollicles, or syncytial clusters of large epithelioid cells characterized by indistinct cell borders and fragile cytoplasm with prominent eosinophilic granules (Fig. 6A,B). Tumor cells have bland oval to round or sometimes spindle-shaped nuclei with rare and/or inconspicuous nucleoli. One of the most helpful findings is the granular background in smears.

Histopathology

GCTs are composed of sheets or nests with fibrous septa.[1,2] Tumor cells are large, epithelioid, and polygonal with abundant granular eosinophilic cytoplasm. Their

TABLE 2. Cytopathology of Granular Thyroid Gland Lesions

Diagnosis	Granular Cell Tumor	Hürthle Cell Neoplasm/Lesion	Medullary Thyroid Carcinoma
Cell arrangement	Clusters and single cells	Clusters with or without single cells	Clusters ± single cells
Cell borders	Indistinct	Distinct	Distinct
Cytoplasm	Fine granules	Fine granules	Red granules
Nucleus	Round with nucleoli	Round with nucleoli	Round without nucleoli
Background	Granular	Clean	Amyloid

nuclei are round to oval with regular nuclear membranes, uniform chromatin, and inconspicuous nucleoli (Fig. 6C). Mitotic figures are rare.

Ancillary Studies

The immunoprofile of GCT shows strong positivity for S100 protein (nuclear and cytoplasmic), SOX10, and calretinin. They are negative for keratins, TTF-1, thyroglobulin, PAX8, calcitonin and chromogranin.

Differential Diagnosis

GCT may mimic oncocytic thyroid neoplasms (Hürthle cell adenoma, Hürthle cell carcinoma, oncocytic variant of PTC, and oncocytic variant of MTC) or a paraganglioma (51-60) (Table 2). While Hürthle cell neoplasms are similarly comprised of large epithelioid cells with abundant granular cytoplasmic granules, unlike GCT, their cells have well-defined cell borders and lack a granular background. Hürthle cell nuclei also show typical cherry red nucleoli. Oncocytic metaplasia is often associated with a lymphocytic background. GCT can also mimic macrophages seen with cystic change in thyroid lesions. Macrophages, however, are characterized by foamier cytoplasm and vesicular nuclei and may have hemosiderin-laden granules. One of the most important diagnoses to be excluded is MTC, which can exhibit a wide cytomorphologic spectrum, including spindle-shaped and/or oncocytic cells with granular cytoplasm, large nuclei, stippled chromatin, and prominent nucleoli.[60-63] Immunopositivity for synaptophysin, chromogranin, CEA, and calcitonin will help confirm the diagnosis of MTC.

SMOOTH MUSCLE TUMORS

Clinical Findings

To date, fewer than 50 cases of benign and malignant primary smooth muscle tumors of the thyroid have been reported in the literature.[1,2,66-76] Primary smooth muscle tumors of the thyroid represent <0.02% of all thyroid gland tumors. This extremely rare group of thyroid neoplasms is defined by pathologic criteria similar to those used to diagnose leiomyoma and leiomyosarcoma in other locations.[1,2,66,71-77] There is no known etiology for most smooth muscle tumors of the thyroid, other than the rare Epstein-Barr virus-associated tumors associated with AIDS.[75] Leiomyomas are more common in younger patients than leiomyosarcomas, which usually affect patients during the sixth and seventh decades. There is a prevalence of cases in female patients.[70-73]

Cytopathology

Cytological specimens from a leiomyoma show a population of monomorphic spindle-shaped cells.[67,73] Tumor cells show slightly hyperchromatic, blunt-ended elongated nuclei, which are usually centrally located. Only case reports of leiomyosarcomas have been published, which reported showing a population of atypical spindle cells with pleomorphic nuclei, mitotic figures, and possible necrosis (Fig. 7).

Histopathology

Leiomyomas are characterized by intersecting fascicles of bland spindle-shaped smooth muscle cells.[1,2,66,71] The cells are spindled and blunt-ended (cigar-shaped) with hyperchromatic centrally located nuclei. Leiomyosarcomas show the morphological features of malignant smooth muscle tumors, including high cellularity, disordered fascicular growth pattern, and tumor necrosis. Leiomyosarcoma cells are usually characterized by markedly atypical and pleomorphic nuclei as well as mitotic activity.

Ancillary Studies

Both leiomyoma and leiomyosarcoma are positive for smooth muscle actin, muscle-specific actin, h-caldesmon,

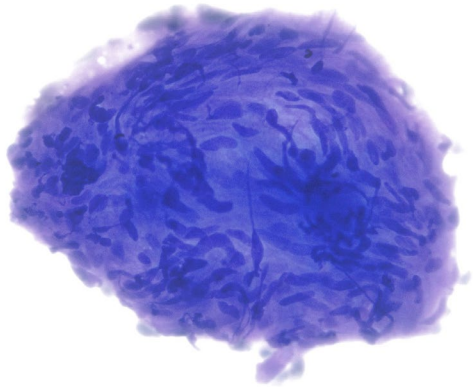

Figure 7. Cytological smear from a leiomyosarcoma. This cytological smear shows a cluster of spindle-shaped cells with a disordered fascicular growth pattern and pleomorphic nuclei (Diff-Quick, original magnification ×40).

and desmin. Thyroglobulin, TTF1, PAX8, calcitonin, chromogranin, and S100 protein are negative.

Differential Diagnosis

The differential diagnosis of a smooth muscle tumor will depend on whether it is benign or malignant. Other spindle cell neoplasms to consider in the thyroid are the spindle cell variant of anaplastic carcinoma (ATC), MTC, spindle epithelial tumor with thymus-like differentiation (SETTLE), and other mesenchymal spindle cell neoplasms (Table 3). A panel of immunohistochemical stains can be used to confirm the diagnosis and exclude other entities.

SOLITARY FIBROUS TUMOR

Clinical Findings

Solitary fibrous tumor (SFT) has been described in several extrapleural sites including the thyroid gland.[1,2,78-80] Regardless of its location, SFT is defined as a fibroblastic tumor composed of spindle cells, showing a characteristic hemangiopericytic vascular pattern associated with *STAT6* rearrangement.[1,2] SFT has an equal sex distribution and presents mostly in middle-aged patients. SFTs tend to be slow-growing masses.

Cytopathology

The cytological features include paucicellular smears comprising slender, dyscohesive, spindle-shaped cells intermingled with pink, amorphous, and collagenized stromal tissue[1,78-80] (Fig. 8A). Naked nuclei may be observed in the background. SFTs with a high risk for metastasis often show more nuclear atypia and mitotic activity. Cases in which a cell block is available may reveal tumor fragments with a hemangiopericytoma-like architecture.

Histopathology

SFTs are composed of spindle cells with a patternless distribution of either nodular or infiltrative architecture within the surrounding thyroid parenchyma.[1,2,18,78-82] They often have extensive collagen and dilated, thin-walled, branching ("staghorn") vessels (Fig. 8B). Tumor cells have minimal eosinophilic cytoplasm, nuclei with variable shapes ranging from oval to spindle shaped, and finely dispersed chromatin with inconspicuous nucleoli. The degree of tumor cellularity is variable. Risk of malignant behavior can be predicted by age, tumor size, mitotic activity, and necrosis.[81]

Ancillary Studies

SFTs are consistently positive for STAT6 protein, showing nuclear expression that reflects the presence of an *NAB2-STAT6* gene fusion characteristic of these tumors.[1,81] Coexpression of CD34, CD99, and bcl-2 in these tumors has been reported, although these markers lack specificity.[83] Neoplastic cells are negative for keratins, actin, desmin, S100 protein, thyroglobulin, TTF-1, PAX8, calcitonin, chromogranin, and synaptophysin.

Differential Diagnosis

In the thyroid, SFT needs to be distinguished from several entities including MTC, which can often be of spindle cell type, follicular adenoma with spindle cell features, ectopic thymoma, SETTLE, HTT, and other spindle-shaped mesenchymal lesions. Of note, the presence of pleomorphic nuclear features and high-grade nuclear morphology may help rule out some malignant tumors in the differential diagnosis. Immunohistochemistry is needed to confirm the diagnosis, especially STAT6, which is highly specific for SFT.[81] Suster et al[84] reported 7 cases of papillary thyroid carcinoma with desmoid- and fibromatosis-like stroma and 1 nodular fasciitis-like stroma. All cases had features of conventional papillary thyroid carcinoma embedded in abundant myofibroblastic stroma. The myofibroblastic stroma in 6 cases resembled desmoid fibromatosis, and in 1 case more closely resembled nodular fasciitis. The immunohistochemical staining demonstrated that the stromal spindle component had positivity for SMA and low

TABLE 3. Cytologic Features of Nonepithelial Spindle Cell Tumors of the Thyroid

	Leiomyoma	Leiomyosarcoma	PNST	MPNST	SFT	SETTLE
Clinical findings	Thyroid mass; variable size	Thyroid mass; mean size, 6 cm; infiltrative pattern	Gradually enlarging mass	Mass increasing in size; infiltrative pattern	Well-defined mass; mean size, 4.5 cm	Long-standing mass; circumscribed to infiltrative
Ultrasound features	Hypoechoic, cold nodule	Ill-defined hypoechoic mass with halo	Circumscribed hypoechoic mass	Infiltrative hypoechoic mass	Solid or hyperechoic nodule	Solid or cystic hypoechoic mass
Morphological architecture	Cluster of spindle-shaped monomorphic cells	Clusters of atypical spindle cells	Clusters of spindle cells	Clusters of highly atypical spindled/epithelioid cells in a loosely hemorrhagic and/or necrotic background	Dyscohesive clusters of cells intermingled with amorphous pink stromal tissue; naked nuclei	Highly cellular, lobular cohesive clusters, isolated cells, metachromatic extracellular material in granules or clumps
Cytoplasm	Scant	Scant	Scant	Fibrillary cytoplasm	Scant	Scant fibrillar
Nuclei	Monomorphic spindled	Pleomorphic and atypical spindled	Slender, wavy, and spindled	Atypical, pleomorphic fusiform; typical and atypical mitotic figures	Spindle	Bland uniform spindle
Nucleoli	Inconspicuous	Inconspicuous	Inconspicuous	Inconspicuous	Inconspicuous	Inconspicuous
ICC positivity	Desmin, SMA, H-caldesmon, muscle-specific actin	Desmin, SMA, H-caldesmon, muscle-specific actin	S100, SOX10	S100, SOX10, loss of H3K27me3	STAT6, CD34	Keratins

Abbreviations: ATC, anaplastic thyroid carcinoma; HTT, hyalinizing trabecular tumor; LCH, Langerhans cell histiocytosis; MPNST, malignant peripheral nerve sheath tumor; PNST, peripheral nerve sheath tumor; SETTLE, spindle epithelial tumor with thymus-like differentiation; SFT, solitary fibrous tumor; SMA, smooth muscle actin.

MIB1 proliferation index in all cases, with patchy strong nuclear positivity for beta-catenin in 6 of 7 cases. Stains for keratins AE1/AE3 and PAX8 were positive in the epithelial elements but negative in the stromal component.

FOLLICULAR DENDRITIC CELL SARCOMA

Clinical Findings

Follicular dendritic cell (FDC) sarcoma is a rare neoplasm that arises from follicular dendritic cells.[85-92] FDC sarcomas are mostly nodal in origin, with cervical lymph nodes being the most common site of presentation.[1,2,4] Involvement of the thyroid gland has been exceptionally reported.[85-92] It is more frequently seen in women as a slow-growing, painless mass without any significant correlation with Hashimoto thyroiditis. In up to 20% of cases, cervical lymph nodes have alterations of the hyaline vascular type of Castleman disease.

Cytopathology

FDC sarcoma is often difficult to diagnose on cytologic material alone.[85-92] The presence of spindle and epithelioid cells forming a fascicular, syncytial, and/or whorled pattern is often observed. The tumor cells have moderate cytoplasm, round to spindled nuclei, vesicular nuclear chromatin, and prominent nucleoli. Lymphocytes are often present.

Histopathology

FDC sarcomas are unencapsulated.[1,2,4,85-92] Tumor cells form syncytia, sheets, and fascicles and often show a whorled appearance. The cells may be spindled and/or epithelioid. Their nuclei are round/ovoid, elongated with delicate nuclear membranes, and vesicular and have dispersed chromatin and prominent nucleoli (Fig. 9). The presence of open-vesicular nuclear chromatin, resembling intranuclear inclusions, might be problematic in thyroid cytological samples, leading to a false suspicion of PTC. Some authors report the presence of grape-like clusters of nuclei forming giant cells resembling Warthin-Finkeldey cells.[85-92] The mitotic rate is variable.

Ancillary Studies

FDC sarcoma neoplastic cells show immunopositivity for CD21, CD35, CD23, D2-40, and clusterin and variable expression of EMA and S100 protein. These cells are

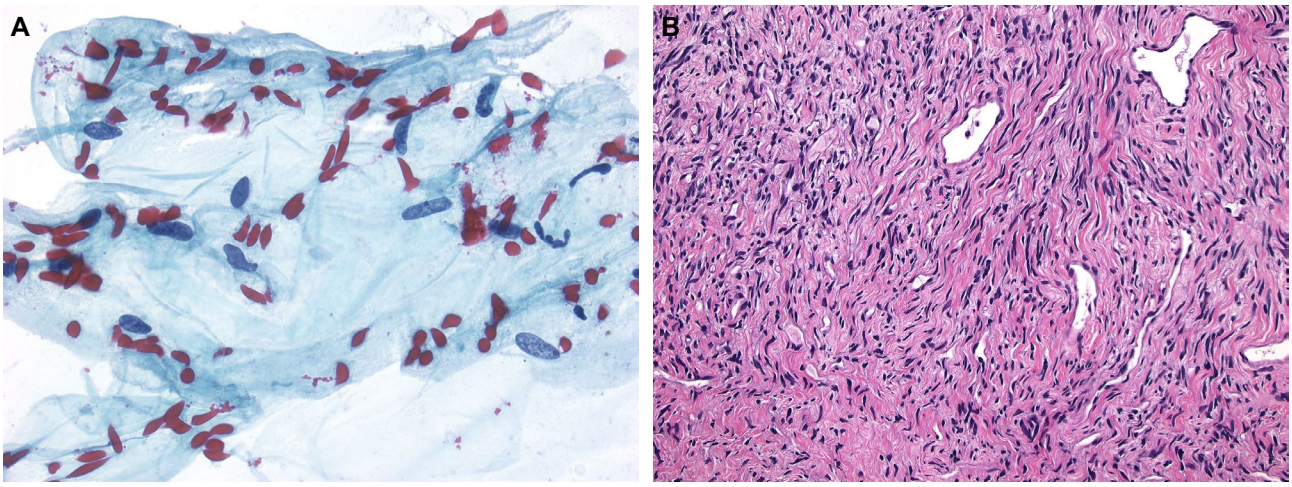

Figure 8. Solitary fibrous tumor. (A) Paucicellular smear with slender discohesive spindle-shaped cells intermingled with amorphous collagenized stromal tissue (Papanicolaou stain, original magnification ×60). (B) Histological features, including patternless appearance of the spindle cells and characteristic branching vessels (hematoxylin and eosin, original magnification ×20).

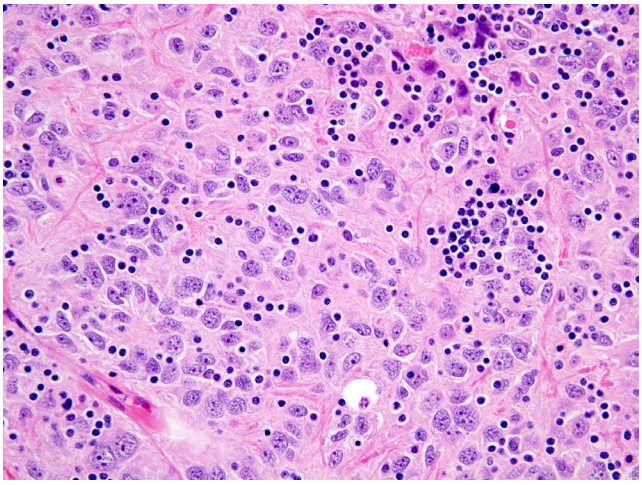

Figure 9. Histology of a follicular dendritic cell sarcoma characterized by syncytial sheets of epithelioid cells with round/ovoid vesicular nuclei, delicate nuclear membranes, and prominent nucleoli (hematoxylin and eosin, original magnification ×40).

negative for keratins (AE1/AE3 and CAM 5.2), actin, desmin, CD34, calcitonin, PAX8, and CD1a. Griffin et al[93] identified recurrent loss-of-function alterations in tumor suppressor genes, mutations in genes involved in the negative regulation of nuclear factor κB activation, and cell cycle progression.

Differential Diagnosis

The most important differential diagnosis due to the often spindled nature of the cells includes MTC, ATC, SETTLE, and other mesenchymal tumors.[91] The cytological features combined with the support of immunocytochemistry are extremely helpful in rendering a conclusive diagnosis.

LANGERHANS CELL HISTIOCYTOSIS

Clinical Findings

Langerhans cell histiocytosis (LCH) is associated with 3 different syndromes that share the same histological features: eosinophilic granuloma, Hand-Schuller-Christian disease, and Letterer-Siwe disease.[1,2,4] In each of these diseases, there are neoplastic cells with the immunophenotype of Langerhans cells, which are derived from the myeloid/monocyte lineage. These cells contain Birbeck granules on electron microscopy. The presence of Langerhans cells in the thyroid can be an isolated phenomenon or part of a systemic disease.[90-101] Primary LCH of the thyroid is extremely rare. Afflicted patients range in age from a few months to the elderly, and there is an equal sex distribution.[93-100] Young age at presentation is more common with systemic disease, while patients of older age more commonly manifest with isolated involvement of the thyroid.[93-98] Prior reported cases were initially diagnosed as thyroid malignancies with lymph node metastasis.[99] The final diagnosis in these cases was made histologically only after total thyroidectomy was performed. Of note, some authors reported that LCH occurs in conjunction with PTC.[102-104]

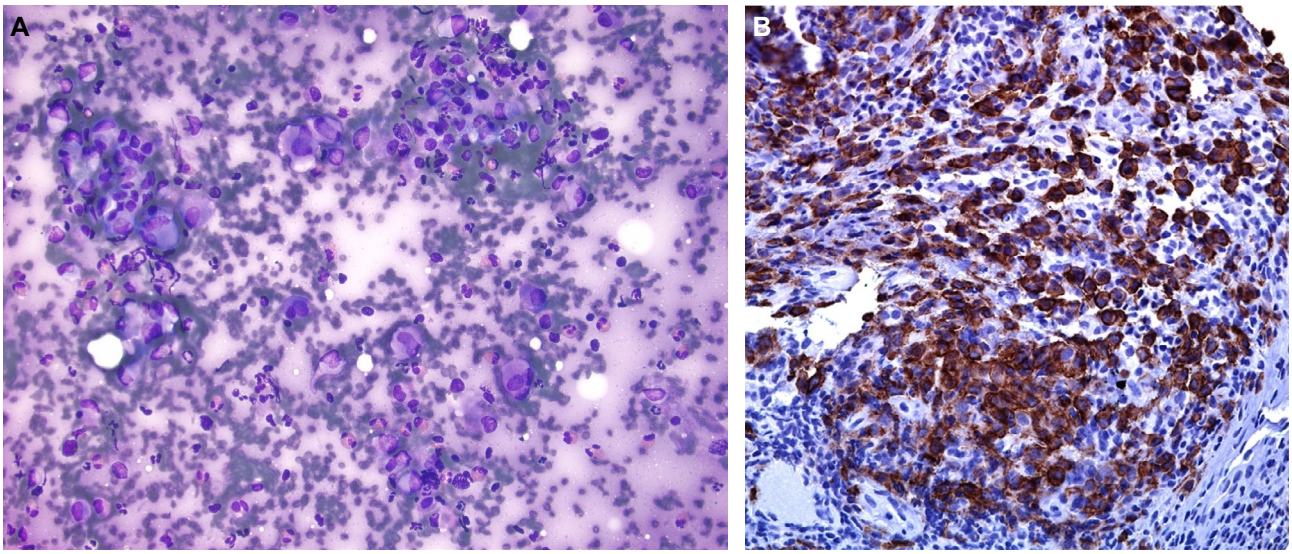

Figure 10. Langerhans cell histiocytosis. (A) Fine needle aspiration with a mixture of mononuclear and multinucleated histiocytoid cells, some with foamy granular cytoplasm (Diff-Quick, original magnification ×20). (B) Langerin-positive cells (A&B, original magnification ×40).

Cytopathology

LCH is characterized by cellular smears.[92,100,101,105,106] There is usually a mixture of large mononuclear or multinucleated histiocytoid cells with nuclear grooves and foamy granular cytoplasm (Fig. 10A), along with eosinophils and possible Charcot-Leyden crystals. FNA samples lack follicular cells and background colloid. Phulware et al[106] described a series of 47 cases of LCH diagnosed on cytological material over a period of 14 years. Their findings showed moderate to high cellularity in 58% of cases and abundant Langerhans cells in 72% of them. The presence of giant cells was recognized in 78% of their cases, combined with mild eosinophilia in 61%, sparse lymphocytosis in 83%, and mild neutrophilic infiltration in 64%. Hang et al[107] described similar cytological features concluding that LCH can be accurately diagnosed in FNA based on the characteristic cytomorphology and selected immunohistochemistry. Diagnosis may be difficult in cases with scant or insufficient cellular material.

Histopathology

LCH can be either diffuse or focal, and composed of histiocytoid cells with delicate pale or eosinophilic cytoplasm and vesicular nuclei.[1,2,4,102-106] Tumor cell nuclei show indented, folded, grooved, and often coffee bean–shaped appearance. An increased number of eosinophils have been documented. The infiltrate of Langerhans cells pushes on the surrounding thyroid parenchyma, destroying neighboring follicular structures. A background of Hashimoto thyroiditis is common.[1]

Ancillary Studies

Tumor cells in LCH show positivity for S100 protein (nuclear), CD1a (cytoplasm), Langerin (CD207, in Birbeck granules [Fig. 10B]), and CD68. A subset of LCH cases may be immunoreactive for *BRAFV600E*–VE1 antibody. Langerhans cells are negative for keratins, thyroglobulin, TTF-1, and PAX8. Approximately 50% of cases have either $BRAF^{V600E}$ or *MAP2K1* (*MEK1*) mutations.[104,105] Kuhn et al[104] emphasized the critical diagnostic pitfalls due to the use of $BRAF^{V600E}$ mutation analysis in thyroid FNA. In fact, $BRAF^{V600E}$ mutation may be found in melanoma, colorectal carcinoma, lung carcinoma, ovarian carcinoma, brain tumors, hairy cell leukemia, plasma cell myeloma, and histiocytosis.[107-109]

Differential Diagnosis

The most important differential diagnoses include PTC, especially those cystic neoplasms with atypical histiocytoid cells, ATC, and other histiocyte-rich inflammatory conditions or histiocytic disorders. PTC contains malignant follicular cells showing nuclear pseudoinclusions, nuclear grooves, and atypical/pleomorphic nuclei. The expression of thyroglobulin and TTF-1 is useful, while $BRAF^{V600E}$ may be seen in both lesions.[108] ATC always comprises cells with severe

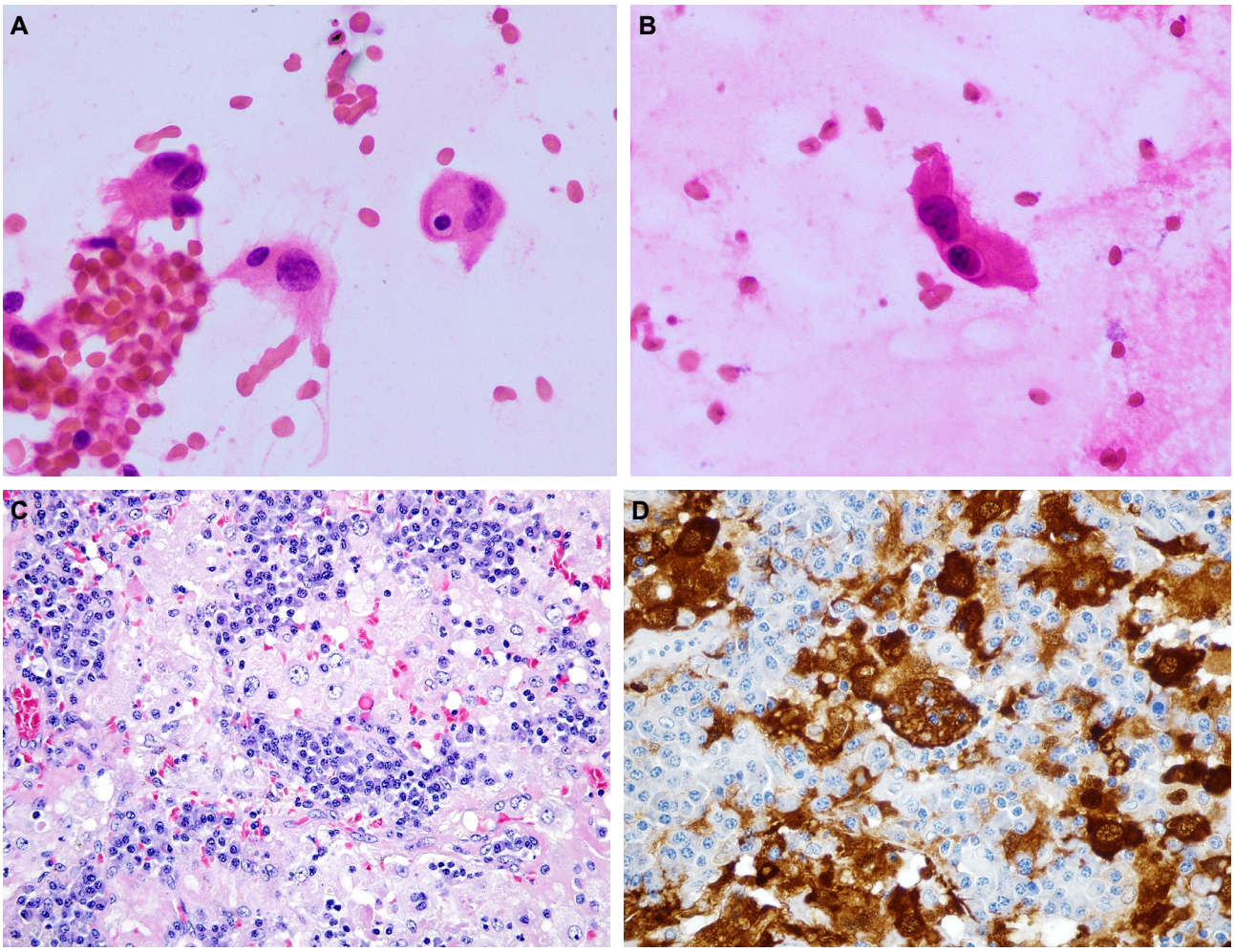

Figure 11. Rosai-Dorfman disease. (A, B) Large histiocytes with abundant cytoplasm, indistinct cell borders, emperipolesis, and round vesicular nuclei. Inflammatory cells such as lymphocytes can be seen in the cytoplasm (Diff-Quick, original magnification ×40). (C) Histologic features consisting of a variable mix of large histiocytes with voluminous cytoplasm as well as lymphocytes, plasma cells, and neutrophils (hematoxylin and eosin, original magnification ×40). (D) S100 positivity (A&B, original magnification ×40).

atypical and pleomorphic features, extensive necrosis, and a different immunoprofile. In Rosai-Dorfman disease, lesional cells are characterized by emperipolesis, which is not seen in LCH.

ROSAI-DORFMAN DISEASE

Clinical Findings

Rosai-Dorfman disease (RDD), also known as sinus histiocytosis with massive lymphadenopathy, is a rare proliferation of distinctive histiocytes that primarily involves lymph nodes.[109-116] Thyroid gland involvement is rare and usually occurs in the context of cervical lymph node or systemic involvement.[114-116] Extranodal involvement of RDD has been reported in 43% of cases, mostly in the skin, central nervous system, and salivary glands. Published data show that RDD occurs mostly in women with a mean age of 56 years.[109-116] Thyroid involvement is usually discovered incidentally. Autoimmune disorders (eg, autoimmune hemolytic anemia, pernicious anemia with gastritis) can be seen in 13% of RDD cases. Gianella et al[111] report that thyroid and tracheal infiltration by RDD can have increased numbers of immunoglobulin G4 (IgG4)-bearing plasma cells. RDD and IgG4-related disease share some similar features; differentiation between the two is based on the presence of the distinctive histiocytes and the degree of IgG4-positive infiltrates and IgG4/IgG ratio.[110]

Cytopathology

FNA smears show large histiocytes with abundant cytoplasm, indistinct cell borders, emperipolesis, and round vesicular nuclei with distinct central nucleolus[103-105] (Fig. 11A,B). Intracytoplasmic inflammatory cells include lymphocytes, plasma cells, and neutrophils.

Histopathology

Lesions contain a variable mix of histiocytes as well as lymphocytes, plasma cells, and neutrophils.[109-116] The neutrophils may be prominent with microabscess formation. The histiocytes are often organized in clusters. These large cells have uniform features, including round to oval nuclei without grooves or nuclear indentations, and vesicular cytoplasm with central nucleoli. The presence of emperipolesis in the cytoplasm of histiocytes is a characteristic finding (Fig. 11C).

Ancillary Studies

The histiocytes are positive for S100 protein (Fig. 11D) and CD68 and are negative for CD1a, T cell antigens, B cell antigens, Langerin, keratins, TTF1, and PAX8.

Differential Diagnosis

The most common differential diagnoses include PTC, ATC, chronic granulomatous inflammation, and LCH. PTC shows nuclear atypia that is not evident in RDD samples. Powell et al[117] reported a case of RDD misdiagnosed as ATC, mostly based on the rapid growth of the lesion. Nevertheless, the lack of pleomorphic cells and bizarre nuclei present in a necrotic background, along with immunohistochemistry, can help exclude ATC. Chronic granulomatous inflammation is associated with acute and chronic inflammation as well as epithelioid histiocytes and multinucleated cells, which are different from the large pale histiocytes of RDD. LCH typically contains eosinophils and folded nuclei with grooves, has less cytoplasm than RDD, and lacks emperipolesis. LCH also has a different immunoprofile compared with RDD. Of note, because RDD can have increased levels of IgG4-bearing plasma cells, the differential diagnosis includes IgG4-related disease. Nevertheless, the presence of abundant emperipolesis is highly suggestive for RDD, and the levels of IgG4-bearing plasma cells insufficient to make a diagnosis of IgG4-related disease. However, the significance of IgG4-bearing plasma cells in RDD remains to be elucidated, and their presence might indicate a better treatment response to corticosteroids and/or rituximab in case of disease progression.[110]

Although emperipolesis is a hallmark feature of RDD, this cellular phenomenon can also occasionally be seen with other hematolymphoid disorders (eg, lymphoma, leukemia) and tumor cell cannibalism associated with nonhematological malignancies (eg, poorly differentiated carcinoma).

TERATOMAS

Clinical Findings

Primary thyroid teratomas are exceptionally rare, representing 0.1% of primary thyroid gland neoplasms.[1,2] The age of afflicted patients ranges from newborns to elderly patients, with an average age of <10 years. Although more than 90% of thyroid teratomas in neonates are benign, more than 50% of such tumors in adults are malignant.[1,2,118-121] Patients usually present with a neck mass, often accompanied by dyspnea. The ultrasound evaluation commonly shows a multicystic mass in the thyroid. Teratomas show a wide size range, up to 13 cm, and a smooth to bosselated or lobulated outer surface. These tumors are firm to soft and may be cystic. Cystic spaces contain creamy or mucoid material or even hemorrhagic fluid with necrosis. Bone, cartilaginous and neural tissue can be seen.[1,2,118-123]

Cytopathology

Cytological smears show different cellular components that can be misdiagnosed as contamination or nondiagnostic. The preoperative diagnosis of primary malignant thyroid teratoma is difficult.[1,2,118-123] The cytological smears from a malignant teratoma reveal the high-grade nature of malignant cells, such as nuclear pleomorphism and variable chromatin structure. Some cells may show powdery chromatin with indistinct nucleoli, suggestive of a neuroendocrine lineage. The presence of immature neuroepithelial small round blue cells is unlikely to be recognized on FNA.[1,2,118-122] The differential diagnosis includes high-grade malignant tumors with neuroendocrine differentiation such as MTC (positive for calcitonin and CEA) and small cell neuroendocrine carcinoma (keratin positive).[123-125] Neuroblastoma and Ewing sarcoma may also rarely involve the thyroid; such tumors are essentially impossible to distinguish from malignant teratomas without histological samples.

Histopathology

To be defined as a thyroid teratoma, thyroid parenchyma should be identified within the mass.[1,2,118-125] Teratomas include a large variety of tissue types and growth patterns in a single lesion. The presence of cystic spaces and solid nests with different types of epithelium can be seen including squamous, glandular, cuboidal, pseudostratified ciliated columnar, and transitional epithelium. The evidence of pilosebaceous and other skin adnexal tissues are documented.[1,2] Neural tissue is commonly found and can be defined as mature and/or immature. Specifically, the maturation of neural-type tissue defines the grade, such as completely mature, predominantly mature, and exclusively immature.[1,2,118-125]

Ancillary Studies

Immunohistochemistry can be used to confirm the various tissue types in a malignant teratoma.[1,2] For example, S100 protein, glial fibrillary acidic protein, synaptophysin, and neurofilament protein are variably positive in neuroectodermal and glial components. MyoD1 and myogenin are useful to identify rhabdomyoblastic differentiation.[1,2,118-125]

Differential Diagnosis

The differential diagnosis in a neonate includes lymphangioma, thyroglossal duct cyst, and branchial cleft cyst. Other considerations in adult patients include MTC, Ewing sarcoma, rhabdomyosarcoma, small cell carcinoma, lymphoma, and melanoma. The diagnosis relies on the identification of the various tissue types with the support of immunohistochemistry.

CONCLUSION

Nonepithelial thyroid tumors, both benign and malignant, represent an extremely rare group of lesions. Apart from their rarity in this location, given the morphologic overlap of these lesions with epithelial thyroid lesions and other similarly appearing nonepithelial tumors that may involve the thyroid, reaching an accurate diagnosis based on cytology material alone is challenging. Given the broad differential diagnosis for many of these conditions, the use of ancillary techniques such as immunohistochemistry and molecular testing is essential. Even though nonepithelial primary thyroid tumors are exceedingly rare, these entities should always be considered when evaluating a thyroid FNA, especially when the cytomorphological features do not match the ultrasonographic, clinical, or expected immunohistochemical findings.

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