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Letters to the Editor

Response to the Letter to the Editor on the Article "Fecal Incontinence in Older Patients. A Narrative Review"☆

Respuesta a la Carta al Director relativa al artículo «Incontinencia fecal en el paciente anciano. Revisión de conjunto»

Dear Editor,

I thank you for the opportunity to reply to the Letter to the Editor by Bernal-Sprekelsen et al. in reference to the article on fecal incontinence in elderly patients.[1] Likewise, I would like to thank the authors for their interest and comments. There is absolute agreement in emphasizing the importance of a complete clinical history in the assessment of these patients, with special attention given to current pharmacological treatment. The therapeutic options for fecal incontinence should be implemented progressively, starting with conservative measures that include modifying stool consistency through all the factors that may influence it (defecation habits, diet and drugs, fundamentally).[2] Food intolerance should also be ruled out as a cause of chronic diarrhea. The presence of gastrointestinal symptoms in diabetic patients is related to the duration of the disease and glycemic control.[3] As the authors point out, diarrhea and incontinence are attributed in greater proportion to the consumption of oral hypoglycemic agents than to the disease itself.

Metformin is an oral antidiabetic from the family of biguanides that is widely used for its safety profile, as it presents a low risk of producing hypoglycemia. There are several publications that correlate fecal incontinence with the change in stool consistency secondary to taking this drug. And, as Bernal-Sprekelsen et al. point out, the symptoms improve after its withdrawal.[4–6] Furthermore, certain drugs used in the treatment of cardiovascular diseases have diarrhea as a side effect. Antiplatelet agents like ticlopidine sometimes associate microscopic colitis,[7] and olmesartan can lead to an enteropathy with a histopathological profile of villous atrophy, intraepithelial lymphocytosis and eosinophilic or collagenous colitis, called olmesartan-induced sprue-like enteropathy.[8–10]

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Performance of the Bethesda System in the Cytopathological Diagnosis of the Thyroid Nodule☆

Rendimiento del sistema Bethesda en el diagnóstico citopatológico del nódulo tiroideo

Dear Editor,

We have read with great interest the article by Mora-Guzmán et al.[1] about the performance of the Bethesda system in the cytopathologic diagnosis of thyroid nodules. For the purpose of this study, we would like to complete the information of the authors by reporting our experience.[2] The standardization of the terminology used for the description of thyroid cytology is essential to be able to adapt the therapeutic approach with the utmost precision. In our experience, the results from thyroid fine needle aspiration (FNA) samples analyzed before implementing the Bethesda system were very low quality, so that in 27.7% of the cases there was no concordance between the results of the FNA and the definitive pathology study, with 54.5% of false negatives and 13.9% false positives in 112 patients analyzed. This represents a positive predictive value (PPV) of 57.7% and a negative predictive value (NPV) of 79.1%, which are very poor rates compared with the results obtained by Mora-Guzmán et al., who reported a NPV of 99.5% and a PPV of 93.5%.

One of the difficulties posed by the authors is the importance of the differentiation between category III and category V, although they describe results that are close to what is recommended.[3,4] With regard to category I, the scarce number obtained is noteworthy and is attributed to the fact that all FNA were ultrasound-guided and without aspiration.[5] Our results were only classified as positive or negative according to whether or not there were signs of malignancy. The FNA was negative in 76.8% and positive in 23% of the cases. In our case, ultrasound was rarely used, except in non-palpable nodules, one could think that this might also be related to the poor results obtained. We are currently awaiting a new evaluation of results after the standardization of the technique with the Bethesda system, but *a priori*, after a preliminary analysis and our clinical impression, it seems to indicate a clear improvement. In summary, we can conclude that the implementation of the Bethesda system is essential, since it is an easy and simple to use classification system that allows us to discern the risk of malignancy of a thyroid nodule with relative certainty. Nevertheless, as always, there are other factors, such as the specialist involved (in this case a cytologist), which would be difficult to measure and compare.

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