



Letters to the Editor

Risk Factors of Metastatic Lymph Nodes in Papillary Thyroid Microcarcinoma. Comment on Patients Selection for the Study[☆]

Factores de riesgo de metástasis ganglionares en el microcarcinoma papilar de tiroides. Comentario sobre la selección de pacientes para el estudio

Dear Editor:

We have read with interest the recent article by Dr. José Ruiz Pardo et al.¹ This is a retrospective study in which the authors compared a group of patients with papillary thyroid microcarcinoma and metastatic cervical lymphadenopathies (group 2, n = 15), with another group of patients without metastatic lymphadenopathies (group 1, n = 146) in order to identify predictive factors for the presence of lymph node metastases. The interest lies in the controversy over whether to perform prophylactic dissection of the central lymph node compartment in papillary thyroid cancer. Methodologically, it has not been possible to design or conduct a randomized study that could provide definitive data on this topic.² Current scientific guidelines would reserve their use for cases of higher risk: advanced tumors (T3 or higher; >4 cm), multicentricity, patients older than 50 or younger than 15 years of age, or presence of lateral cervical metastases.^{3,4} Despite this, many surgical groups systematically perform prophylactic dissection of the central compartment, showing that 30–35% of cases with microcarcinoma present cervical metastatic lymphadenopathy in the final histological study.^{5–7}

In the study presented by the authors, it is interesting that, in the group of 146 patients without lymph node metastases, only 11 (7.5%) underwent central compartment dissection. Therefore, in the remaining 135 cases (more than half incidental findings after thyroidectomy or another cause [87 patients]), no type of cervical lymph node dissection (central or

lateral cervical) was performed. The following question arises: how can these patients be considered to have “no lymph node metastases”, knowing that lymph node metastases would have been found in 30–35% of cases if a central lymph node compartment dissection had been performed? In short, the authors compared a group of patients in whom lymph node metastases were diagnosed by lymph node dissection with another group of patients in whom the majority (>90%) did not undergo any type of lymph node dissection, and in whom it is unknown how many of them actually metastasized or not. A proper analysis would have compared patients with lymph node dissection and lymphadenopathies with no metastasis (n = 11, instead of n = 146) with patients with lymph node dissection and lymphadenopathies with metastasis (n = 15).

REFERENCES

1. Ruiz Pardo J, Rios A, Rodriguez JM, Paredes M, Soriano V, Oviedo MI, et al. Risk factors of metastatic lymph nodes in papillary thyroid microcarcinoma. *Cir Esp.* 2020;98:219–25.
2. Carling T, Carty SE, Ciarleglio MM, Cooper DS, Doherty GM, Kim LT, et al. American Thyroid Association design and feasibility of a prospective randomized controlled trial of prophylactic central lymph node dissection for papillary thyroid carcinoma. *Thyroid.* 2012;22:237–44.
3. Sancho JJ, Lennard TW, Paunovic I, Triponez F, Sitges-Serra A. Prophylactic central neck dissection in papillary thyroid

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- cancer: a consensus report of the European Society of Endocrine Surgeons (ESES). *Langenbecks Arch Surg*. 2014;399:155-63.
4. Haugen BR, Alexander EK, Bible KC, Doherty GM, Mandel SJ, Nikiforov YE, et al. 2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer: The American Thyroid Association Guidelines Task Force on thyroid nodules and differentiated thyroid cancer. *Thyroid*. 2016;26:1-133.
 5. Liu LS, Liang J, Li JH, Liu X, Jiang L, Long JX, et al. The incidence and risk factors for central lymph node metastasis in cN0 papillary thyroid microcarcinoma: a meta-analysis. *Eur Arch Otorhinolaryngol*. 2017;274:1327-38.
 6. Luo Y, Zhao Y, Chen K, Shen J, Shi J, Lu S, et al. Clinical analysis of cervical lymph node metastasis risk factors in patients with papillary thyroid microcarcinoma. *J Endocrinol Invest*. 2019;42:227-36.
 7. Zhang C, Li BJ, Liu Z, Wang LL, Cheng W. Predicting the factors associated with central lymph node metastasis in clinical node-negative (cN0) papillary thyroid microcarcinoma. *Eur Arch Otorhinolaryngol*. 2020;277:1191-8.

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Reply - Risk factors of metastatic lymph nodes in papillary thyroid microcarcinoma[☆]



Respuesta - Factores de riesgo de metástasis ganglionares en el microcarcinoma papilar de tiroides

To the Editor:

First of all, we would like to thank Dr. González and Dr. Franch Arcas for their comment on our article "Risk Factors for Lymph Node Metastasis in Papillary Thyroid Microcarcinoma".¹

The authors' comments are interesting. However, several factors must be considered, as they determine the study design carried out instead of strictly comparing those cases in which only central lymph node dissection was performed (11 vs. 11 cases, with and without central metastatic lymphadenopathies, respectively).

What initially determines the design of our study is the fact that prophylactic central node dissection in papillary microcarcinoma is practically not performed today. When Dr. González and Dr. Franch Arcas argue that prophylactic dissection of the central compartment is routinely performed, the references they indicate are from Asian centers, where this technique is more widespread.^{2,3} However, this trend is

currently changing, and the treatment that is being used more extensively in these groups involves 'active surveillance', meaning conservative management with follow-up and no therapeutic actions. The small percentage of microcarcinomas that are treated surgically are those that present tumor evolution⁴ and are therefore more aggressive and consequently present greater lymphatic involvement.

Thus, if we only compare patients with central lymph node dissection, a comparison would be made between microcarcinomas with a worse prognosis,¹⁻⁵ since this the situation in which it is considered. This would provide an unrealistic view of the microcarcinomas treated and exclude the majority of tumors that present an excellent prognosis.

In this context, it is accepted that patients who have been treated with surgery and who, after a long follow-up, meet criteria for cure can be considered cured and do not present lymph node extension. Nevertheless, there will always be a small doubt as to whether or not a subclinical micrometastasis occurred that remained latent over time.

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