



Letter to the Editor

Does the delay in the start of replacement therapy influence recovery from postoperative hypocalcemia?[☆]



¿Influye la demora en el inicio del tratamiento sustitutivo en la recuperación de la hipocalcemia postoperatoria?

To the Editor: We have read with interest the article published in your journal by Gutiérrez Fernández et al.¹ regarding biochemical parameters and the appearance of post-thyroidectomy hypocalcemia. In their study, hypocalcemia was defined as the appearance of symptoms of hypocalcemia or persistence of total serum calcium <8 mg/dL 48 h after the intervention. This paper has certain similarities with a communication our group presented at the 33rd National Surgery Congress, in which we analyzed the static and dynamic definitions of hypocalcemia considering the presence of symptoms². However, one important difference is the time when symptoms were evaluated. In our case, symptoms were evaluated 24 h after surgery, at which time we initiated treatment for biochemical hypocalcemia, even when asymptomatic. In the study by Gutiérrez Fernández et al., however, most patients were not treated until after 48 h, as long as they remained asymptomatic.

This management protocol differs from the current recommendations of leading clinical guidelines^{3,4} and the most recent reviews regarding hypocalcemia⁵. These documents recommend early treatment of biochemical hypocalcemia without waiting for symptoms to appear, even in the first few hours right after surgery. It should be noted that the period of the Gutiérrez Fernández et al. study predates these recommendations.

However, precisely because of this difference, we believe it would be very interesting to know some additional data from the study, which would allow us to better define the advantages of early initiation of treatment for asymptomatic biochemical hypocalcemia. Specifically, we believe that it would be interesting to know the rate of the appearance of

symptoms after the 24-h lab workup, which hypothetically could have been avoided or at least attenuated with early treatment.

Another factor that is not clearly defined is the long-term evolution of biochemical hypoparathyroidism depending on whether replacement treatment is started early or not. In this context, the data obtained by studies like the Gutiérrez Fernández et al. article have even greater value, since a prospective design analyzing this evolution would be very controversial from an ethical standpoint today. This analysis could be especially interesting if it could demonstrate the possible advantage (or lack thereof) of early treatment of asymptomatic hypocalcemia in terms of long-term recovery.

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Conflict of interests

The authors have no conflict of interests to declare.

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Reply to the article: Does the delay in the start of replacement therapy influence recovery from postoperative hypocalcemia?☆



Respuesta al artículo: ¿Influye la demora en el inicio del tratamiento sustitutivo en la recuperación de la hipocalcemia postoperatoria?

To the Editor:

Recently, the authors of the article “Does the Delay in the Start of Substitution Treatment Influence the Recovery of Postoperative Hypocalcemia?”¹ referred to our paper that was published months ago in your journal², asking for clarification.

First of all, I want to thank this group of surgeon-researchers who have taken notice of our study and have doubts or would like to clarify certain aspects of the article.

Secondly, I will begin by clarifying that, indeed, the study was conducted at a time when patients with total thyroidectomy remained hospitalized until they reached clinical and analytical stability. After this study, a protocol was developed so that patients could be discharged 24 h after surgery with calcium and calcitriol therapy, in accordance with the algorithm created¹. What surprised me about the study was the number of patients with biochemical hypo-

calcemia that did not translate into symptoms. We even repeated urgent tests in case there had been a laboratory error. Some patients (around 8%) were given oral calcium to be able to be discharged when they still had not developed symptoms.

To answer your question, around 53% of the patients presented symptoms beyond the first 24 h while hospitalized. It is possible that patients with biochemical but not symptomatic hypocalcemia who were administered oral calcium could have developed symptoms, but perhaps they would have had to be hospitalized for a longer time and without such treatment. The circumstance of being hospitalized for at least 48 h and up to 4 days in symptomatic cases allowed us to see the evolution of postsurgical hypocalcemia. I agree with the authors that this is currently impossible to carry out given that there is sufficient evidence to affirm that patients can be safely discharged after 24 h. But where complete evidence is lacking is regarding *who* to treat and *when*. This is partly due to what the authors indicate in the communication presented at the 33rd National Congress: the variability of the definitions used, even including the most basic definition of hypocalcemia. In my opinion, the advantage of early treatment is being able to discharge patients early and safely, and I have not seen that this influences the recovery of posterior parathyroid function. However, I do believe that de-escalation/suspension of supplemental treat-

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