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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 journal[2], 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 created[1]. What surprised me about the study was the number of patients with biochemical hypocalcemia 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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ment should be initiated early on, starting 7–10 days post-thyroidectomy. In this manner, permanent hypoparathyroidism can be detected earlier, while unnecessary treatments can be terminated.

We are currently conducting a prospective study about which parameters better predict patients who will require oral calcium and when.

To finish, I would just like to add that parathyroid hormone (PTH) is surely the best biochemical parameter to assess, but it cannot be generalized because its variable forms and times for analysis are very heterogeneous.

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