

## Comments on "Incidental versus non-incident thyroid carcinoma: Clinical presentation, surgical management and prognosis"☆



### Comentarios sobre «Carcinoma de tiroides incidental versus no incidental: presentación clínica, tratamiento quirúrgico y pronóstico»

Dear Editor,

We appreciate the interest in, and the constructive criticism of our paper entitled: "Incidental versus non-incident thyroid carcinoma: Clinical presentation, surgical management and prognosis".<sup>1</sup> In their comments, our colleagues state that our series shows no differences in surgical complications. However, the results did reveal differences (overall hypoparathyroidism rate 9.9% vs 4.2%, and recurrent lesions rate of 3.3% vs 1.8%), though they lacked statistical significance. On the other hand, we observed a significantly greater extent of first surgery, a greater lymphadenectomy rate, more advanced stages, and a greater relapse rate in the clinical carcinoma group versus the incidental carcinoma group. We think that these differences warrant the use of surgery in the early stages.

We do not conclude that early diagnosis based on screening campaigns is required, but advocate early surgery when the tumor is diagnosed in its early stages (microcarcinoma). It is true that the 2015 clinical practice guidelines of the American Thyroid Association<sup>2</sup> recommend conservative management with close follow-up of patients with a high anesthesia risk or very low risk tumors. However, in the event of cytological findings indicative of malignancy, the guidelines strongly recommend surgery. This is based on several articles in the literature in which a small proportion of patients with papillary carcinomas clinically first manifested with nodal or distant metastases.<sup>3-5</sup> Moreover, there are no clinical characteristics which allow for a reliable distinction between these few patients with microcarcinomas who will show an aggressive clinical course and the great majority of cases that will exhibit an indolent clinical course.<sup>6-9</sup>

As regards the anxiety caused by a diagnosis of cancer in patients with microcarcinoma, we would rather emphasize that caused by the possibility (low, but not zero) of patients after being offered follow-up instead of low morbidity surgery at experienced centers then developing nodal and even metastatic disease. In this respect, it should be kept in mind that the treatment options are always discussed and agreed upon with the patients themselves. They are

unlikely to choose to avoid surgery in the case of a diagnosis of cancer, particularly when the surgical treatment option is associated with acceptable morbidity and virtually no mortality.

On the other hand, it should be noted that the term papillary microtumor suggested in the so-called Porto proposal<sup>10</sup> is largely based on histological criteria (the absence of thyroid capsule infiltration, vascular invasion, aggressive histological subtype) which can only be established from evaluation of the surgical specimen. Therefore, with regard to the study conducted by this group, we do not feel it makes sense to conclude that their data warrant a conservative approach to this type of tumor.

Finally, with regard to more limited surgical procedures, such as lobectomy, for tumors even 4 cm in size, mention should be made of the limitation this implies for monitoring with serial thyroglobulin measurements and with radioactive iodine scans. We therefore conclude that early-stage papillary tumors of the thyroid gland should be treated with surgery.

### Conflicts of interest

The authors state that they have no conflicts of interest.

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