



# Response Letter to Editorials: active surveillance of low-risk papillary microcarcinoma of the thyroid

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Recently, two clinically important editorials related to the management of papillary microcarcinoma (PMC) of the thyroid appeared in *Annals of Thyroid*. The editorial by Donatini G, Rienzo BD, and Kraimps JL described “*The role of active surveillance in low-risk papillary thyroid carcinoma*” (1). They appropriately introduced that the current increase in the incidence of thyroid cancer in many countries was mostly due to the increase in detection of small papillary carcinoma without an associated increase in thyroid cancer mortality. They cited one of our papers by Ito Y *et al.* on active surveillance of low-risk PMCs that reported low incidences of tumor enlargement and/or appearance of lymph node metastasis, which were inversely related to patients’ age and success of rescue surgery for those who showed disease progression (2). This paper strongly influenced the 2015 American Thyroid Association guidelines endorsing active surveillance as an alternative to immediate surgery for low-risk PMCs (3). Although the authors cited our paper mostly favorably, they made a skeptical comment, describing that a surveillance, epidemiology, and end results-based analysis revealed that 7.7% of the patients who died of thyroid cancer in the United States were diagnosed with PMC. PMCs may present with nodal or very rarely distant metastases. Such high-risk cases should be treated appropriately (4). However, most PMC cases that we currently encounter are low-risk without worrisome features; these patients, we think are candidates for active surveillance.

They cited another of our papers by Oda H *et al.* that compared the outcomes of immediate surgery and active surveillance for low-risk PMCs (5). Although the oncological outcomes in both groups were excellent, the incidences of unfavorable events were significantly higher in patients who underwent immediate surgery than in those who

chose active surveillance. These surgeries were performed by well-experienced endocrine surgeons at a center for thyroid diseases (5). Ito Y *et al.*’s paper reported the safety of active surveillance (2). However, some surgeons at Kuma Hospital still tended to believe that performing surgery was easier than explaining and obtaining the consensus of active surveillance until Oda H *et al.*’s paper was published. Oda H *et al.*’s paper convinced all surgeons and physicians at Kuma Hospital that active surveillance should be the first-line management for low-risk PMCs. Donatini G, Rienzo BD, and Kraimps JL described that complication rates were higher in patients who underwent delayed surgery than in those who underwent immediate surgery and attempted to link this with advanced disease in patients who underwent delayed surgery (1). This may be inappropriate. A larger proportion of patients who underwent delayed surgery underwent total thyroidectomy for various reasons. Most endocrine surgeons will agree that 3-mm increases in tumor size do not cause significant increases in complication rates.

Another editorial by Ghaznavi SA and Tuttle RM described “*Disease-related and treatment-related unfavorable events in the management of low-risk PMC of the thyroid by active surveillance versus immediate surgery*” (6). They cited Oda H *et al.*’s paper and provided the most appropriate and favorable comments. They commented on the higher rates of transient hypoparathyroidism in the delayed surgery group. The reason for this may have been the higher proportion of patients who underwent total thyroidectomy in this group. They wrote that “*it is important to note that all surgical complication rates reported by Oda and colleagues are those of experienced, high-volume head and neck surgeons at Kuma Hospital, and can be expected to be higher in both groups when performed by low volume surgeons.*” This is a very important point when we consider the management of low-risk PMCs

in general. It is unfortunate that 2 of the 974 patients who underwent immediate surgery acquired permanent vocal cord paralysis. One case was due to accidental transection of the recurrent laryngeal nerve, although the cut-ends of the nerve were anastomosed immediately. The other case was due to accidental ligation of the nerve, although the ligation was released immediately. However, the paralysis persisted in these two patients. These surgeries were performed by well-experienced endocrine surgeons at Kuma Hospital, a center for thyroid disease. One might assume that surgery for PMCs should be simple. This is correct; however, human errors can arise through the simplest actions. This is the reality.

Both editorials commented on the emotional status of the patients when choosing the management options for low-risk PMCs, the psychological burden of living with a known malignancy, and the quality of life during active surveillance (1,6). These are very important issues to consider. However, it should be emphasized that these are strongly influenced by who and how the nature and management of low-risk PMCs are explained to patients. The physicians who explain the disease to their patients should learn about PMCs and should be confident in their explanations. Education for physicians, surgeons, patients, and the general public is necessary.

Currently, at Kuma Hospital, we recommend active surveillance as the first-line management for patients with low-risk PMCs.

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aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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