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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 evolution[4] 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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As our colleagues Dr. González and Dr. Franch Arcas have indicated, it is not possible to carry out randomized prospective studies that would resolve all these uncertainties. Above all, because central lymph node dissection is not harmless and entails morbidity.[6] Also, there is currently no solid evidence to recommend prophylactic central lymph node dissection in papillary microcarcinomas with a good prognosis (quite the opposite).[7] What is important is to be able to select that small percentage of cases that could benefit from therapeutic central lymph node dissection. Despite its limitations, our study tried to address this objective.[1]

For all these reasons, we consider that the comparison of the groups performed in the study is useful.[1]

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Response to «Management of Splenic Injuries Utilizing a Multidisciplinary Protocol in 110 Consecutive Patients at a Level II Hospital»☆

Respuesta a «Resultados en el tratamiento de traumatismos esplénicos utilizando un protocolo multidisciplinar en 110 pacientes consecutivos en un hospital de nivel II»

Dear Editor,

We have read with interest the article by Zurita Saavedra et al.[1] about their experience in splenic trauma management at a level II, hospital. We congratulate the authors for their experience, commitment to the care of splenic trauma patients. However, we would like to add some considerations based on our experience.

Like the authors, we believe that non-operative management (NOM) of blunt splenic trauma is the treatment of

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