The total hypocalcemia ratios were lower in the IONM group. Surgical factors, such as the extent of surgery, central node dissection, reoperation for bleeding, presence of Graves disease or thyroid cancer, operation for recurrent goiter, inadvertent parathyroid excision, and parathyroid autotransplantation may also affect the postoperative ratios of hypocalcemia [4]. Can a reduction in the rate of hypocalcemia be attributed to IONM without assessing these considerations?

The conclusion of the article mentions that the authors' research and similar studies in the literature did not reveal a benefit to IONM usage in terms of decreasing the rate of RLN injury. In the literature, the impact of IONM on RLN paralysis is still controversial. Nonetheless, in a recent meta-analysis of 34 comparative studies on this subject, it was determined that IONM significantly reduced total, temporary, and permanent RLN paralysis [5].

This study [1] is a retrospective study. Features such as the preoperative diagnosis, which can affect the results, were not evaluated and compared. The number of cases was insufficient for a reliable assessment and the standard IONM technique was not implemented. Considering all of these limitations, the conclusions about IONM are questionable.

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Author's Reply

To the Editor,

We are grateful for the interest of our colleagues in our article, "Effect of nerve monitoring on complications of thyroid surgery," published in the Northern Clinics of Istanbul journal. However, we strongly believe that the stated aim and context of our article was not fully appreciated and that our clearly written purpose was not given enough attention. As we explained, it was a retrospective study of thyroid surgeries performed between 2014 and 2016 at a single center by a single surgeon. Our research was accepted for publication in 2017; therefore, data from the mentioned review article from 2018 was not available for consideration for this paper.

Our study included a group of patients who had thyroidectomy indications and the operations were approved by an anesthesiology specialist at our state hospital. All of these patients were in a euthyroid state, and their postoperative primary pathological diagnoses were also reported in our published paper. Preoperative diagnoses were disregarded in order to preserve the reliability and focus of our article, since there was no significant statistical correlation between the pathological primary diagnoses and the complications encountered. Interventions such as parathyroid surgery, retrosternal goiter surgery, preoperative planned oncological surgery, or neck dissection did not need to be mentioned because additional procedures were not performed at that time. The postoperative primary pathological diagnoses were reported; however, we did not mention each patient's pathological diagnosis in greater detail in order to avoid adding unnecessary data. Furthermore, if the inclusion of the details mentioned above would have made an additional contribution to our paper, the editorial experts would certainly have urged us to do so during the meticulous evaluation period. As our colleagues will surely agree, when the text of an article is lengthened with nonessential information the reader may be distracted from the focus of article and the intended message may be lost.

In addition, we believe that mentioning the technical details of neuromonitorization, which is almost a ritual technique in endocrine surgery, would also have been extraneous and would not have served the concept of our article [1–3]. Developing new standards for the intraoperative neuromonitoring (IONM) technique was not the objective of this study and for this reason, superfluous, unnecessary technical details were not included. The data from patient files that really contribute to the aim of the study are what is appropriate in a retrospective paper. We object to the criticism that standard IONM was not implemented simply because the details of technical usage of the device were not mentioned. Finally, we wish to mention that the superiority of a study that included 191 surgeries performed by a single surgeon was completely ignored. We believe this experience with IONM contributed to the shorter operation time in the IONM group.

It is accepted in endocrine surgery that the risks of recurrent laryngeal nerve (RLN) injury and hypocalcemia should be taken into account in near total thyroidectomies [4, 5]. The RLN is prone to damage and can easily be harmed during various intraoperative actions (e.g., cutting, clamping, stretching, compression, and heating) [6]. Cirocchi et al. [7] accepted near-total thyroidectomy as a total thyroidectomy in their study. We did not find any significant relationship between the surgical technique employed in our study and complication rates. As was clearly expressed in our paper, we found no meaningful data supporting a correlation between a decrease in RLN injuries and the use of IONM. We would like to emphasize once again here, as in our article, that we received no financial support during and/or after the study period. Furthermore, the research and results of this study presented no conflicts of interest.

In terms of scientific paper writing technique, it is our opinion that the letter written by our colleagues seems to position itself as a post-review review, rather than a letter to the editor. It is important to remember that papers on retrospective research, despite all the limitations, are considered written products of general surgery. There are many retrospective studies in the literature from the field of endocrine surgery [5, 8, 9]. In addition, ethics policies in many hospitals of our country take the Helsinki Declaration into account, and due to widespread belief that prospective studies violate these terms, prospective studies are often not feasible.

We would like to kindly remind you that the late Professor Doctor Sami Zan advised us: "*Do not laugh at them. A doctor will not laugh, but smile*!"

Suleyman Demiryas,[1] Turgut Donmez,[2] Erdinc Cekic[3]

[1]Department of General Surgery, Istanbul University Cerrahpasa Faculty of Medicine, Istanbul, Turkey

[2]Department of General Surgery, Lutfiye Nuri Burat State Hospital, Istanbul, Turkey

[3]Department of Otolaryngology Surgery, Lutfiye Nuri Burat State Hospital, Istanbul, Turkey

E-mail: suleyman.demiryas@istanbul.edu.tr

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