EnM
ENDOCRINOLOGY AND METABOLISM

Letter

Endocrinol Metab 2021;36:203-204
https://doi.org/10.3803/EnM.2021.963
pISSN 2093-596X · eISSN 2093-5978

Association of Hyperparathyroidism and Papillary Thyroid Cancer: A Multicenter Retrospective Study (*Endocrinol Metab* 2020;35:925-32, Chaiho Jeong et al.)

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We read with great interest the article by Jeong et al. [1], who investigated the incidence of concomitant papillary thyroid cancer (PTC) in hyperparathyroidism (HPT) patients upon preoperative diagnosis and present a clinical opinion on detecting thyroid malignancy in patients who undergo parathyroidectomy. First of all, we would like to congratulate the authors of this article for raising awareness of the need for PTC screening in patients with HPT in order to eliminate the risk of reoperation and to reduce complications and costs in the preoperative period. We thought some points should be clarified, so we aim to add some helpful comments on this article.

First of all, we understood from the definition given by the authors in the Introduction section [2] and from the high creatinine levels that secondary HPT patients had chronic renal failure. It would have been better if the authors had explained in detail how secondary HPT was diagnosed in the Methods section. We also wondered how many of these patients were on dialysis and whether there was any relationship between disease duration and concurrent PTC.

The authors stated that PTC was diagnosed by fine-needle aspiration (FNA) of the suspected thyroid nodule seen on preoperative ultrasonography or confirmed by pathology after resection. Considering that most of the PTCs in the study were microcarcinomas, how was the decision of thyroidectomy made in the patients without FNA? The authors reported that prophylactic central neck lymph node dissection was the standard surgical procedure for lymph node dissection at both institutions. From this statement, we understand that central neck lymph node dissection was performed in all patients who underwent thyroidectomy. However, FNA was not performed in some patients. Which criteria were used to decide upon central dissection in these patients?

The authors reported that concomitant PTC had a more aggressive pattern than classical PTC. A B-type Raf kinase (BRAF) mutation was confirmed in 56.5% of the concomitant PTC group, but the mutational status was unknown in 34.8% of patients in this group. Might it be possible that mutational positivity in patients with unknown BRAF mutational status was responsible for the aggressive course of the concomitant PTC group?

The authors stated that lymph node metastasis and extrathyroidal invasion were associated with aggressive features in PTC, but it is understood that the histological subtypes were not handled when comparing classical and concomitant PTC patients. Even if not statistically significant, could there have been more lymph node metastasis and extrathyroidal extension related to aggressive histological patterns in concomitant PTC? It would have been more helpful for the readers if the authors had clari-

Received: 10 January 2021, **Accepted:** 18 January 2021

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fied this issue and included it in the tables.

In conclusion, this study allowed us to reconsider the increased concomitant PTC risk in patients with HPT and the need for FNA screening in suspected thyroid nodules <1 cm to avoid reoperations and an increased risk of complications.

CONFLICTS OF INTEREST

No potential conflict of interest relevant to this article was reported.

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