Comment on the Management of Thyroid Nodules: An Optimum Approach

Sir,

We read the interesting Editorial by Najmul Islam and Asma Ahmed published in JCPSP, Vol. 21 (8): 447-49 about the judicious management of thyroid nodules, where the authors focused the most important aspects involving incidentalomas, clinical challenges, diagnostic tools, and treatment procedures.[1] The cost-effectiveness of more sophisticated imaging modalities and of surgical procedures was highlighted, in special if considering the patients from developing countries. The role of ultrasound studies and fine needle aspirations was emphasised in the evaluation of asymptomatic nodules because they also can give shelter to unsuspected malignancies.[1] Contrary to the old misconceptions, special attention was placed on the multinodular goitre with nodules of 1 cm or greater in diameter and sonographic features suspected of malignancy.[1]

Despite the completeness of that updated analysis, we would like to pose some concerns related to the management of thyroid nodules.

Firstly, the concomitance of a parasitic nodule with chronic Hashimoto's thyroiditis was described in a 53-year-old Brazilian woman.[2] The fine needle aspiration of the nodule showed groups of epithelial cells with irregular nuclei, nuclear grooving and intranuclear cytoplasm inclusions, surrounded by abundant mature lymphocytes, mimicking lymph node metastasis from the follicular variant of a papillary carcinoma.[2] Further histopathology study of the nodule revealed small thyroid follicles surrounded by cells with irregular and voluminous nuclei, nuclear grooving and cytoplasm inclusions. There was accentuated lymphocyte infiltrate constituting germinative centres around the follicles. The cytoplasm appeared either scanty or abundant and granular, with oncocytic features. However, the absence of marginal sinuses in all the silver stained sections ruled out the diagnosis of lymph node metastasis of thyroid cancer. Diagnosis of parasitic thyroid nodule and chronic Hashimoto's thyroiditis was then established, and avoided unnecessary total thyroidectomy with lymph node dissection in consequence of a misdiagnosed malignancy.[3]

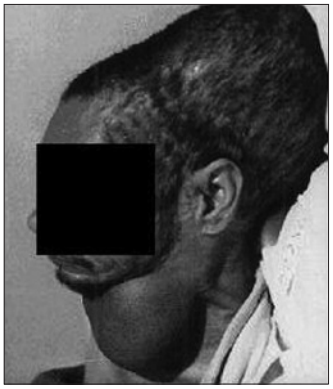

Figure 1: Impressive features of an exceeding late diagnosis of implants in the cranium of a patient with follicular thyroid carcinoma associated with a huge adenomatous goiter.

Another concern is about the participation of patients from low-income regions in the diagnostic and therapeutic decisions.[1] Both the incidence and the death rate from cancer remain persistently high in the non-industrialized countries. In spite of the modern clinical and imaging tools that are available in well-developed centres, the cancer-related morbidity and mortality is high among people from these areas. In fact, poverty and ignorance of individuals usually contribute to far advanced stages at diagnosis and poorer long-term outcome of cancers. Our old registers well illustrate some conspicuous adverse effects (Figure 1) of poor socioeconomic and cultural status in the prevention and early diagnosis.[3]

We strongly believe that the commented Editorial will optimize the pre-operative assessment of thyroid nodules that as earliest as possible should be detected, to be appropriately managed.

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