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Response to: Letter to the Editor Regarding "Validation of Ultrasound and Computed Tomography-Based Risk Stratification System and Biopsy Criteria for Cervical Lymph Nodes in Preoperative Patients With Thyroid Cancer"

Young Hun Jeon[1], Ji Ye Lee[1,2]

[1]Department of Radiology, Seoul National University Hospital, Seoul, Republic of Korea
[2]Department of Radiology, Seoul National University College of Medicine, Seoul, Republic of Korea

We appreciate the insightful comments of Drs. Lim and Sim [1] on our recent article [2]. They have elucidated several crucial issues encountered while assessing cervical lymph nodes (LNs) in patients with thyroid cancer.

In our practice, we conduct fine-needle aspiration (FNA) with washout thyroglobulin assays on suspicious LNs, irrespective of their size. This approach aligns with the methodology presented by Roh et al. [3]; however, it differs from the biopsy criteria proposed by the Korean Society of Thyroid Radiology (KSThR) [4].

The KSThR criteria likely reflect the fact that the risk of recurrence is higher in cases of macroscopic metastasis than in cases of microscopic metastasis (metastatic deposits ≤ 2 mm) [5,6]. Nevertheless, it is essential to note that the biopsy cutoff size recommended by the KSThR is based on the short diameter LNs visualized on imaging, which may not always correspond to the maximal diameter of metastatic tumor deposits, potentially leading to measurement discrepancies. With recent advancements in ultrasound (US) technology providing high resolution and enabling differentiation of internal features in small LNs, we believe that if an LN exhibits evident suspicious features on US, FNA is necessary for the accurate preoperative diagnosis of cN1 disease, regardless of the background nodal size. This is particularly critical for patients with suspected cN1b disease, in whom the risk of recurrence can increase by as much as 30% [7].

Proper management of indeterminate LNs remains elusive. Current guidelines have employed traditional size criteria for further differentiation of indeterminate LNs, which are known to reflect the tumor burden [8,9]. However, recent studies have suggested that the nodal size in both suspicious and indeterminate LNs does not necessarily correlate with an increased risk of metastasis in thyroid cancer patients [10-12]. This trend was also confirmed in our study, wherein we found a lower risk of malignancy for large indeterminate LNs detected on computed tomography (CT). Although a paradoxically high malignancy risk was observed in small US-detected indeterminate LNs, we did not consistently observe this tendency in the CT-indeterminate LNs. Overall, considering the low malignancy risk of indeterminate LNs localized on CT, these LNs should not be considered indications for FNA. We believe that this change will eventually lead to a reduction in indications for FNA of indeterminate LNs in the CT category.

As mentioned in our limitations section, we acknowledge that the generalizability of our results may be challenging because of the small number of biopsies performed on benign and indeterminate LNs. A multi-reader study with a large sample size needs to be conducted in the future to support these findings.

We express our gratitude to Drs. Lim and Sim for their

valuable comments. We believe that their insights have enriched our study and sincerely appreciate their attention.

Author Contributions

Writing—original draft: all authors. Writing—review & editing: all authors.

ORCID IDs

Young Hun Jeon
  https://orcid.org/0000-0001-7672-3932
Ji Ye Lee
  https://orcid.org/0000-0002-3929-6254

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