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REPLY, LETTER TO THE EDITOR

Multifocal Versus Solitary Papillary Thyroid Carcinoma: Reply

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Thank you very much for your interest in our recent publication 'Multifocal versus Solitary Papillary Carcinoma.' In regard to your queries:

1. Ten MFC cases (4.15% of all MFC cases) were truly incidental as the tumors were discovered postoperatively after the pathologic examination. In these cases, we had absolutely no clue about their existence in the preoperative setting, whereas these tumors were discovered by the meticulous study done by our dedicated pathologist. Interestingly enough, from the rest of the MFC cases, identification of at least two foci was accomplished successfully in the vast majority of patients. Whether our dedicated, specialized ultrasonographers were equally able to identify more than two foci on the preoperative setting is something that is open to a new study, but at this time we have no data on that. Nevertheless, specialized ultrasound examiners constitute an absolute requirement in the preoperative investigation of the Papillary Thyroid Carcinoma since according to our policy, identification of mutlifocality calls for a total thyroidectomy.
2. In our study, the correlation of the number of the foci was found to be significant:
   - with *older age* (it proved to be significant only at the level of 10% (p value $= 0.097 < 0.10$)
   - *male gender* ($p = 0.014$) and
   - *presence of N1a/N1b disease* ($p = 0.019$)

   Foci number was not correlated with the gland weight and advanced local disease T3/4 status ($p = 0.111$). Interestingly enough, the number of foci was found to be higher in the tall cell variant, a feature that to the best of our knowledge has never been presented [1]. We can hypothesize, though, that the fact may be attributed to the much worse *N* status of these tumors in our series, which may indirectly be associated with the number of foci.
3. We have no data on the accurate rate of mutlifocality before this study in our series. Admittedly, though, the percentage of the patients that harbored multifocal disease was high enough to warrant a study on the subject.
4. Even though we do follow up our patients, postoperative management is left on a team of dedicated endocrinologists/nuclear radiologists. To that end, we have limited data on the postoperative TG levels since our role kicks in again, whenever we are called for. Our study did not include relative postoperative data, but we reassure that the radioiodine doses do not differ between these patient groups.
5. Furthermore, we did not perform/include any genetic/mutational studies that may offer invaluable information on the subject of mutlifocality versus multicentricity. Nevertheless, these suggestions do serve as distinct guides for future refinement of our study, and from this point of view, we do feel honored for evoking such comments for our study on the subject of Multifocal Thyroid Papillary Carcinoma.

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