Authors Reply to Letter to Editor: Primary Hyperparathyroidism: An Analysis of Failure of Parathyroidectomy

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We thank the authors for their interest and comments on our manuscript. We have attempted to answer their queries as much as possible, but this is limited by the retrospective nature of the study and logistical considerations in access to the required data.

With regards to combining data from two centers, we think that this is reasonable and appropriate. Data from different centers often demonstrate heterogeneity in terms of management practices and outcomes. The answer to whether such data ought to be pooled together should depend on the objective of the study. This study aimed to analyze failures following parathyroidectomy and to explore the association between success of imaging and surgery in a manner that would be relevant to surgeons managing such patients, regardless of their experience or specialism. We therefore considered it reasonable to present the experience of both centers, hoping that these would be generalizable to a larger community of surgeons and patients.

Imaging policies in both centers have evolved with time and currently, the standard practice in both centers is to offer both ultrasound scan and ^{99m}Tc -sestamibi scintigraphy imaging with a view to performing minimally invasive parathyroidectomy for those with concordant imaging.

Very few (if any) of our patients in this series had normocalcemic hyperparathyroidism. Unfortunately, we do not have the preoperative calcium data to hand, and the results of a significant number of patients in the early part of this cohort are not available on current electronic

systems and we are therefore currently unable to access their medical notes. We are therefore not able to provide an accurate answer to this query.

We have not stated that “40 % of failures were due to large adenomas.” The commonest cause of failure of first surgery in this series was multigland disease (52 %; $n = 13$). Of these, excision of a single large gland was insufficient to cure the condition in ten patients. Here, we defined ‘large’ as those thought by the surgeon to be abnormally enlarged and weighing over 100 mg. With regards to patients 16, 17, 18, 19, and 24, it is possible that the results of imaging were misinterpreted or that imaging did not detect multigland enlargement. Given the retrospective nature of the study and the lack of detailed records in some instances, further insight is not possible.

Regarding patient 6, we understand the authors’ query. It appears that retrieval of a superior mediastinal lesion via the neck was deemed feasible. Intra-operatively, a lesion posterior to the left thymus was identified and excised, but was confirmed to be a lymph node. The patient may not have wanted a sternotomy, but this is only speculative as medical records from that time are not available and the patient has subsequently died from an unrelated condition.

Regarding other patients (7 and 8 with single gland disease; 13 and 15 with multigland disease), we have presented the relevant available information. We have not been able to specifically study the extent of intra-operative exploration and decision making that may have contributed to failure and are therefore unable to comment on whether surgical experience may have played a role.

We agree that patient safety and curative intent to the surgical approach are key considerations and that any attempt to cut down on costs is a secondary objective. We have not claimed otherwise.

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