LETTER TO THE EDITOR

Reply to Comment on “Surveillance and Intervention after Thyroid Lobectomy”

TO THE EDITORS:

As the letter's authors point out, the purpose of our study was to quantify the postoperative care required by patients who underwent thyroid lobectomy at our institution over the 2.5-year study period.

Our practice is to initiate therapy with thyroid hormone replacement in patients who are biochemically hypothyroid with a thyroid-stimulating hormone above the upper limit of normal (4.20 μ IU/ml). In our study, 45 (63%) of 71 were hypothyroid at the first follow-up visit, and 30 (42%) remained hypothyroid over the study period. Our rate of 42%, as well as the 10% rate at the authors' institution, are both within the published range of thyroid hormone replacement after thyroid lobectomy.

The decision to perform thyroid lobectomy versus total thyroidectomy in patients with multinodular disease depends primarily on malignant potential. As the letter's authors point out, thyroid nodules of <1 cm, disease with negative fine-needle aspiration findings, and disease of stable radiographic size are unlikely to be malignant. It is not our typical practice to perform total thyroidectomy if the contralateral lobe is normal or has other findings that are of low potential for malignancy. However, the results of our study indicate that on the basis of patient preference

and efficient use of health care resources, there might be a role for total thyroidectomy in this patient population when performed with a low complication rate.

The mean length of follow-up in our study was only 240 days. A longer study period and increased frequency of radiographic screening would increase the rate of intervention. It is not our usual practice to follow all lobectomy patients with ultrasound. Instead, we follow patients with ultrasound who have documented contralateral lobe disease or who develop concerning clinical findings, including a nodule found at examination, palpable lymph node, or other signs of malignancy. It is likely that additional patients included in our study will in the future require imaging, fine-needle aspiration, and even completion thyroidectomy. The development of malignancy in the contralateral lobe increases the burden of care after thyroid lobectomy beyond what we have described. Despite our small sample size, we think that the extent of surveillance and intervention after thyroid lobectomy warrants discussion with the patient during operative planning. As we conclude in our article, it is possible that for some patients with benign nodular disease, total thyroidectomy is the more efficient treatment.

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