

Impact of Noninvasive Follicular Thyroid Neoplasm with Papillary-Like Nuclear Features (NIFTP) on the Outcomes of Lobectomy

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TO THE EDITORS:

I have read with great interest the recent systematic review by Gartland and Lubitz. Their results and conclusion suggest that lobectomy and total thyroidectomy yield comparable oncologic outcomes for papillary thyroid carcinoma (PTC) measuring 1–4 cm.¹ Although the authors themselves recognize this limitation, I highlight the confounding role that noninvasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) can play in the results.

As already known, the noninvasive encapsulated follicular variant of papillary thyroid carcinoma (EFVPTC) is no longer considered “cancer”, and these tumors currently are termed NIFTP. Tumors that currently correspond to NIFTP were previously classified in the low-risk PTC group. If the virtual absence of recurrences after complete resection of NIFTP are considered, the rate of tumor persistence/recurrence in low-risk PTC recalculated after the exclusion of NIFTP somehow increases. Obviously, the magnitude of this increase depends on the frequency of NIFTP in the population studied.

In general, 15% of our patients with PTC larger than 1 cm received the diagnosis of NIFTP after revision.² However, if only the cases of low-risk PTC larger than 1 cm seen in recent years ($n = 356$) are considered, NIFTP would be diagnosed in 27.4% of the cases. In another study, NIFTP corresponded to 37.5% of low-risk PTC.³

Even before noninvasive EFVPTC was no longer considered cancer, patients with exclusive indeterminate cytology were already more frequently submitted to

lobectomy, and this cytologic result is known to be more frequent in EFVPTC than in classical/aggressive PTC. Therefore, the frequency of NIFTP likely is even higher among patients with low-risk PTC larger than 1 cm submitted to lobectomy. The data of Rajjoub et al.⁴ corroborate this impression. Among patients with PTC 1- to 4-cm/N0–Nx/M0, 55% of those undergoing lobectomy had FVPTC compared with 35% of those submitted to total thyroidectomy).⁴

If NIFTP indeed accounts for one-third to one half of low-risk PTC measuring 1–4 cm and submitted to lobectomy, recalculation of the recurrence and mortality rates after exclusion of these tumors can significantly increase the aforementioned rates (even double them). Consequently, the conclusion that lobectomy is sufficient for low-risk PTC measuring 1–4 cm might be questioned. Even in the case of FVPTC, after the exclusion of NIFTP and recalculation of the rates considering only the invasive and infiltrative encapsulated variants, the conclusion possibly is different.

COMPLIANCE WITH ETHICAL STANDARDS

ETHICAL APPROVAL The study was approved by the Research Ethics Committee of our institution.

DISCLOSURE There is no conflict of interest.

REFERENCES

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