

HALF OF THE PATIENTS WITH CLINICALLY UNIFOCAL T1B/SMALL T2 NODE NEGATIVE PAPILLARYTHYROID CARCINOMA SCHEDULED FOR THYROID LOBECTOMY MAY REQUIRE COMPLETIONTHYROIDECTOMY IF THE NODAL STATUS IS EVALUATED

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BACKGROUND

In absence of nodal metastases or aggressive features, thyroid lobectomy (TL) should be preferred over total thyroidectomy (TT) for 1-4 cm unifocal, papillary thyroid carcinoma (PTC). However, occult, despite nonmicroscopic (≥ 2 mm), nodal metastases may be present in clinically node-negative (cN0) PTC.

METHODS

Among **4216** thyroidectomies for malignancy (2014-2023), **110** TL plus ipsilateral central neck dissection (I-CND) were scheduled for unifocal cT1b/small cT2 (≤ 3 cm) cN0 PTCs. Frozen section examination (FSE) of removed nodes was performed: when positive, completion thyroidectomy (CT) was accomplished during the same procedure. In presence of aggressive pathologic features, CT was suggested within 6 months from index operation.

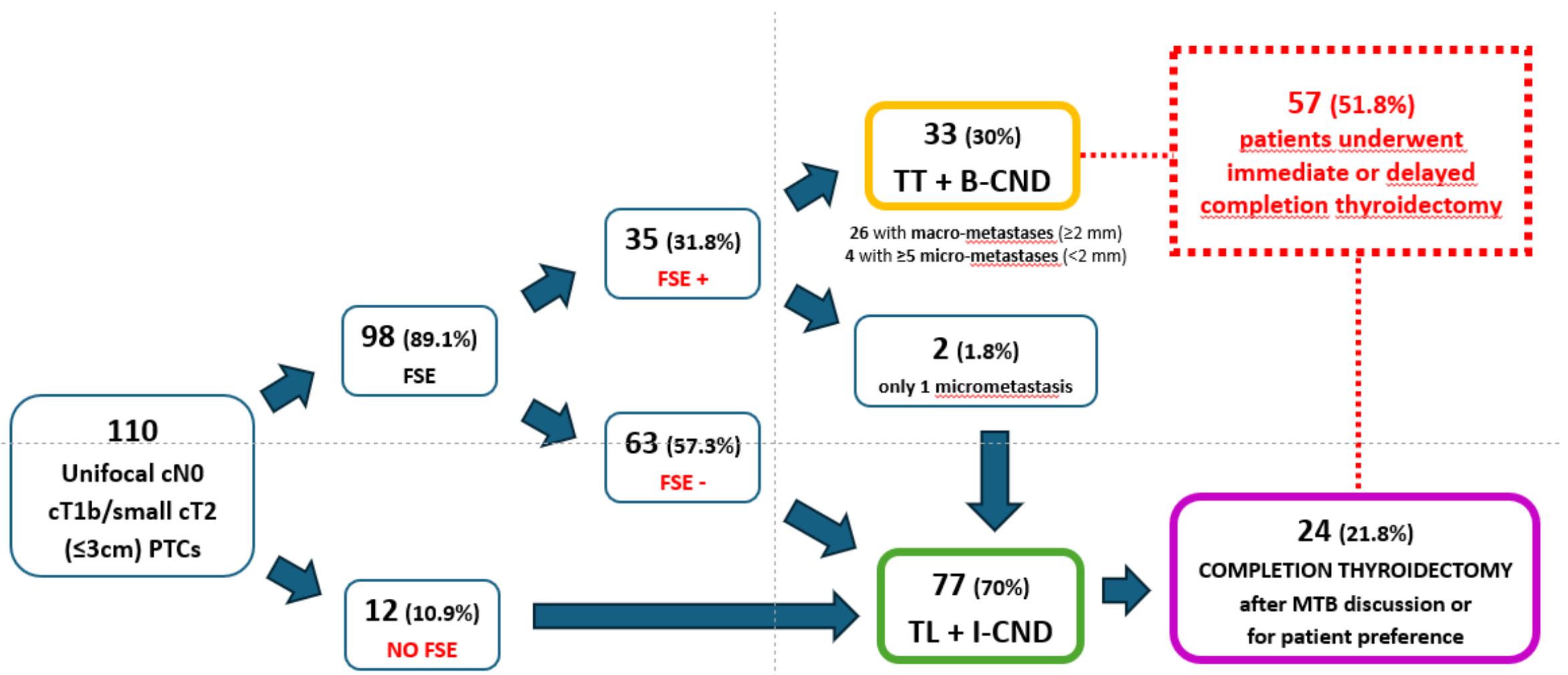


RESULTS

FSE was positive for occult not-microscopic nodal metastases in **33** cases (30%), underwent synchronous CT. Among the remaining 77 patients, **24** (21.8%) were scheduled for CT, due to occult node metastases which were not detected at FSE/aggressive histopathological features.

The median number of removed and metastatic nodes was 8 (5-11) and 2 (1-5), respectively, at definitive histopathology. Furthermore, multifocality was present in 53 (48.2%) cases, lymphovascular invasion in 66 (60%) cases, aggressive subtypes in 20 (18.2%) cases and extracapsular invasion in 5 (4.5%) cases.

Overall, **57** (51.8%) patients underwent immediate or delayed CT.



CONCLUSIONS

More than 50% of patients with unifocal cT1b/small cT2 cN0 PTC scheduled for TL may be eligible for CT because of aggressive tumor features.

An intraoperative decision-making approach based on I-CND and nodes FSE may ensure accurate staging and risk stratification, thus reducing the risk of recurrence and the need for reoperation.