

Thyroid Watch

1. **Radioiodine Therapy for Hurthle Cell Carcinoma:** Radioactive iodine (RAI) uptake by Hurthle cell carcinomas of thyroid has long been a controversial entity, with the general belief being that these cancers do not take up radioiodine. In a recent study 11 out of 16 subjects with recurrent or metastatic Hurthle cell cancer had iodine uptake by the neoplasm and were given RAI therapy (*Thyroid. 2003 Jun; 13(6): 577-84.*)
2. **Further Insight Into the Etiology of Grave's Disease:** It is well known that Grave's disease is an unusual organ-specific autoimmune disorder as it leads to hyperfunction. Recent work has shown that this could be related to the TSH receptor cleavability, and that the TSH receptor breaks into "A" subunits that could indeed be the antigen that incites the autoantibody production. An adenovirus mediated animal model showed that TSH receptors capable of cleavability into "A" subunits led to more hyperthyroidism as compared to a minimally cleavable TSH receptor. (*J Clin Invest. 2003 Jun; 111(12):1897-904*)
3. **Extensive Experience with Video-assisted Endoscopic Thyroid Surgery:** In a recent publications, the authors report their experience with over 180 cases where video-assisted neck surgery (VANS) was performed. This is a totally gasless endoscopic surgical technique that employed an anterior neck-skin lifting method. The authors recount their experience with this technique, citing that they have used it for performing total as well as near-total lobectomy for benign thyroid tumors. In addition total lobectomy as well as prophylactic neck dissection were carried out in some cases of papillary microcarcinoma. In a selected, minority, subtotal thyroidectomy was performed for Grave's disease. According to this report, operating time and the amount of bleeding were statistically significantly reduced. The authors claim that VANS is safe, effective and cosmetically advantageous. (*Asian J Surg. 2003 Apr; 26(2):92-100*)
4. **Deciding on Choice of Therapy for Amiodarone Induced Thyrotoxicosis (AIT)-:** AIT can either be type 1 (due to preexisting thyroid disease) or type 2 (a destructive thyroiditis). In a recent prospective randomized trial comparing iopanoic acid with glucocorticoid therapy for type 2 AIT, the authors report that while both drugs were effective in controlling disease, glucocorticoids would seem to be the first-choice therapy in view of the quicker response that was achieved. (*J Clin Endocrinol Metab. 2003 May; 88(5): 1999-2002*)
5. **Are WHO-based Norms Good Enough For Detecting Endemic Goiter?** In a study of school children in Delhi, it was found that while 24% had a clinical goiter, most fell short of the age-specific ultrasound norms for diagnosing goiter. In contrast, the prevalence of iodine deficiency was 61%. Thus the authors question the ultrasound-based thyroid volume criteria for diagnosing endemic goiter (*J Pediatr Endocrinol Metab. 2003 Jul-Aug; 16(6): 843-9.*)

6. **Antithyroid Drugs in Amiodarone-induced Thyrotoxicosis (AIT):** Most thyroidologists agree that treatment of AIT is difficult, and not least because of the 2 diverse variants of the disease: AIT can be either due to an iodine induced worsening of hyperthyroidism, or due to a destructive thyroiditis with thyrotoxicosis. In a recent study, it has been reported that antithyroid drug therapy improved outcomes in both subjects with the iodine-associated as well as the destructive variant of AIT. If the results of this study are confirmed by future studies, then the problematic role of steroid therapy vs. antithyroid drug could well be resolved in favour of the latter (*Circulation 2002; 105:1275-7*).
7. **Resection of Bone Metastases in Differentiated Thyroid Cancer:** In a recent study, 41 (6%) out of 710 subjects with differentiated thyroid cancer had metastatic bone disease. After total thyroidectomy and I-131 ablation, the survival rate at 5 and 10 years after resection of bone metastasis was 69% and 39% respectively. Amongst these subjects with metastatic disease, the authors aver that those with metastasis only to bone had an improved survival. The authors conclude that surgical resection of a solitary bone metastasis could be particularly promising strategy. (*Clin Endocrinol 2002; 56:377-82*)
8. **Completion Thyroidectomy after Lobectomy in Differentiated Cancer:** When a surgeon encounters a follicular or a non-diagnostic tumor at frozen section, a lobectomy is often done to prevent the need for lifelong thyroxine replacement. Subsequently, if a differentiated cancer is proven on biopsy, completion thyroidectomy is advised, not only because of satellite foci of tumor in the remnant lobe, but also to remove extra thyroid tissue and facilitate thyroglobulin as well as isotope analysis and treatment. A recent study argues that completion thyroidectomy was safe in 36 subjects, as it did not result in even a single case of recurrent laryngeal nerve injury. Hypocalcaemia was documented in only 2 cases, and it was transient in both. The authors aver that completion thyroidectomy can be done safely a few days or several weeks (range 2 to 103 days) after thyroid surgery and reveals a differentiated cancer in the remaining lobe in about half the cases (*Laryngoscope 2002; 112:1209-12*).

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