How Should We Approach This Outbreak of Papillary Thyroid Microcarcinoma?

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Editorial

Any Papillary Thyroid Cancer (PTC) with a maximum diameter of 10 mm or less is referred to as a Papillary Thyroid Microcarcinoma (PTmC). Numerous epidemiological studies conducted worldwide over the past 40 years show an increase in the trend incidence of PTC, particularly the microtumors. Increasingly, microcarcinomas are discovered incidentally during imaging or histology of thyroidectomy materials. A tumour that is not the target lesion and is discovered after a histological study of a thyroid removed for another reason, such as nodular goitre, is referred to as an accidental tumour. These lesions almost always take the shape of papillaries.

Although it is common and has a high incidence, PTmC rarely results in fatalities. Since these tumours have been classified as low risk thyroid cancer because of their generally indolent course, the majority of patients with these lesions have excellent prognoses. However, because the definition, epidemiology, and management of these types of cancers are unclear, many patients receive treatment that is similar to that given to those with more aggressive thyroid cancers [1]. Victims of Modern Imaging Technologies, or VOMIT, is an acronym that describes this circumstance. The management of this ailment may undergo a revolution as a result of new evidence that has improved our understanding of it. The clinical and histopathological characteristics of the PTmC were reviewed in a number of studies. Of the patients, 28% had multifocal tumours, 18% had bilateral tumours, 12.5% had extratiroidal invasion, 10.7% had lymph node extension, 3.3% had distant metastasis, 4.2% had tumour recurrence, and only 0.2% died from the PTmC.

The renowned investigations by Ito et al., which comprise patients without incidental PTmC, attended in the years 1993–2011, provide information on the spontaneous progression of PTmC. Fine Needle Aspiration Biopsy (FNAB) diagnoses are all guided by echography. Patients with lymph node invasion, tumours next to the trachea, and nodules with high-grade malignancy-related histopathological characteristics were eliminated. From the 1235 patients who were a part of the study, 8% had tumours that had grown by at least three millimetres, 6.8% had tumours that had grown to at least ten millimetres, and only 3.8% had lymph node invasion that had not previously been observed [2]. The Mayo Clinic's experience is particularly evident in regards to the post-surgical result of PTmC. From 1945 through 2004, Hay et al. examined 900 cases of PTmC treated at the institution in question.

They found that the overall survival of these individuals is comparable to the expected survival of people their age and sex. More than 99% of patients did not experience mortality or distant spread. Only 0.3% of cases had PTmC-related death. At 20 years of follow-up, the cumulative risks of tumour recurrence development at any site were 5.5%. Therefore, the issue with PTmC care is the return of the tumour. The outcomes of these patients are determined by the clinical or histopatological aspects of the PTmC, which have been the focus of several research groups. Age, gender, tumour size, incidental tumour, multifocal tumour, lymph node extension, and molecular traits like the BRAF mutation were all assessed for their prognostic relevance. In summary, the outcome of PTmC demonstrated a more consistent correlation with lymph-node invasion and incidental tumours, the first of which is a prediction of recurrence and the latter a predictor of a very favourable prognosis. The majority of PTmC have excellent prognoses, which has led multiple authors and the recommendations from various institutions to suggest conservative therapy for these tumours [3]. Based on the forementioned data, lobectomy is the recommended course of treatment for unifocal PTmC in the absence of additional risk factors, primarily lymph node involvement, with the option of observation without surgery. In circumstances when this treatment is necessary, neither adjuvant radioiodine therapy nor the use of suppressive dosages of L-Tiroxine are advised. Regarding the follow-up, it would be based on imaging modalities, primarily ultrasonography, over a period of five years. These patients would then have the choice of ceasing all cancer-related follow-up and being released into the care of their general practitioner.

References

1. Pazaitou-Panayiotou, K., et al. "Clinical features and therapeutic implication of papillary thyroid microcarcinoma." Thyroid 17.11 (2007): 1085-1092.
2. Rusinek, D., et al. "Current advances in thyroid cancer management. Are we ready for the epidemic rise of diagnoses?." Int j mol sci. 18.8 (2017): 1817.
3. Ito, Y., et al. "Low-risk papillary microcarcinoma of the thyroid: a review of active surveillance trials." Eur J Surg Oncol. 44.3 (2018): 307-315.

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