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LETTER – ENDOCRINE TUMORS

Which Is the Best Endoscopic Procedure for Thyroid Gland?

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To the Editors:

We read with interest the work of Ngo et al.[1] There are very few, if any, surgeons who would still claim that endoscopic thyroidectomy (ET) is not one of the greatest breakthroughs in the field of thyroid surgery in the last two decades.[2] In fact, the "battle" against standard thyroidectomy has been largely won in terms of cosmesis. In recent years, we have seen a virtually unstoppable search for further improvements to make cosmesis even better. Remote thyroidectomy, robotics, transoral thyroidectomy (TOT), and single ports seem to have dominated the scene in recent years.[1–3] Several surgeons have done their best to join the growing enthusiasm for the new approaches. Unfortunately, concerns about the minimally invasive nature have crowded out our initial curiosity for these approaches. The best endoscopic procedure has yet to be described. Currently, all endoscopic procedures have limitations. We read that thyroid glands are removed, at normal volume, in 2–3 h for a procedure that, even if fully indicated for the disease, would normally be performed in less than half an hour.[3] The minimally invasive concept, oncologic concerns, and the issues of time, pain, resources, and cost immediately came to mind.[4] In addition, all surgeries seem difficult to perform, mainly owing to long and non-anatomical dissection, non-median access to the thyroid, limited endoscopic visualization of the nerves and parathyroid glands, and use of inappropriate instruments designed for completely different purposes but modified for the new need. We also saw recurrent laryngeal nerves cut without any semblance of functional control or safety measures to prevent damage to the parathyroid glands or trachea and esophagus.[3] Why would we perforate their "natural orifices" and expose them to unnecessary risks to perform a well-standardized, validated, open procedure? The answers to both questions merit a survey of TOT surgeons. This commentary is not intended to be a criticism of endoscopy. The authors are well aware of the advantages of endoscopy. However, simplification of endoscopic procedures is needed. Robust, large, randomized, clinical trials are needed to convince the surgical community of the utility (and thus acceptance) of TOT for the treatment of thyroid cancer. The surgical community rightly needs evidence before accepting the TOT approach for this common cancer. We understand the importance of research and development of new technologies and new surgical instruments and devices. Only when specific advanced instruments are available can we realistically develop new procedures for the treatment of malignant thyroid disease. AQ3

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