LETTER TO THE EDITOR
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Incidental identification of cervical nodal metastases from papillary thyroid carcinoma: Experiences related to esophageal cancer surgery

Dear Editor,

We read with great interest the article by Mandapathil et al. They thoroughly reviewed their three-decade experience with incidental discovery of lymph node metastases from papillary thyroid carcinoma (PTC) in neck dissection specimens from operations for head and neck malignancies (n = 26). Their report attracted our attention, not only because of the careful analysis and discussion, but also because of our similar clinical experience with regard to esophageal cancer surgery.

From July 2015 to March 2019, a total of 153 consecutive patients underwent curative esophagectomy with three-field lymph node dissection for esophageal carcinoma (EC) in our institution. Pathology revealed unexpected thyroid cancer metastases to the cervical lymph nodes in four cases: one was a follicular carcinoma and the other three were PTC (3/153, 2.0%).

Characteristics of the three subjects with PTC metastases are shown in Table 1. Routine inspections before esophagectomy, including contrast-enhanced computed tomography and cervical ultrasonography, had depicted a tiny nodule in the thyroid gland in case 3 but none in the other two. On histopathological examinations of the specimens from neck nodal clearance, three PTC-positive nodes at level III were identified in case 1, two at level III in case 2, and one at level II in case 3. In case 1, no thyroid gland nodules manifested even during post-esophagectomy surveillance and we thus refrained from performing subsequent thyroid resection. Also, in case 2 with advanced EC (T3N1M0), thyroidectomy was not carried out though postoperative ultrasonography revealed a nodule, 5 mm in size, in the thyroid gland. Additional thyroidectomy was conducted only in case 3, with EC-related outcomes predicted to be favorable (T1aN0M0). Detailed histopathological examinations of the resected thyroid gland confirmed the presence of papillary microcarcinoma, measuring 3 × 3 mm, in the lower pole of the right lobe. The patients are all alive, with no recurrence of EC or PTC detected in any case to date.

PTC is the main histological subtype of thyroid cancer, accounting for 80% of all thyroid malignancies. Although occult or subclinical PTC is not rare, to the best of our knowledge, incidental detection of nodal metastases of PTC has not been discussed in the context of surgery for EC. This is probably owing to the current situation that three-field nodal dissection is not a mainstream option for EC surgery worldwide, despite it being accepted as a radical treatment in Japan. Therefore, the clinical significance of PTC nodal metastases after esophageal surgery has yet to be elucidated and no treatment consensus has been reached.

EC and head/neck malignancies are similar with respect to their etiologies and clinical behaviors, and the prognosis is generally poorer than that of indolent PTC. Hence, the proposals by Mandapathil et al can be directly applied to EC. Namely, conservative monitoring without...
aggressive thyroidectomy may well be a reasonable option if EC-related factors are deemed to be the more reliable prognostic determinants. Indeed, meticulous surveillance with computed tomography and cervical ultrasonography is generally offered to post-esophagectomy patients. When the overall prognosis is good on the basis of EC-stage, radical thyroidectomy can be selected, as in our case, because there is evidence of relatively unsatisfactory outcomes when occult PTC is the origin of nodal metastases. Moreover, surgical decision making should be carried out with consideration of the morbidity possibly associated with extensive thyroid removal.

CONFLICT OF INTEREST
The authors declared no potential conflicts of interest.

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REFERENCES