

## Comment on: "Evaluating treatment options in managing thyroid nodules with indeterminate cytology of TBSRTC in thyroidology: *addendum aut non?*"

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Management of thyroid nodules with indeterminate cytology remains a major challenge for thyroidology. We read with a great deal and respect the article by Kuta and colleagues<sup>1</sup> entitled, "Treatment choices in managing Bethesda III and IV thyroid nodules: a Canadian multi-institutional study." The authors reported their objective as identifying the factors associated with decision-making in that population and concluded that the larger nodules, younger age, and higher category of The Bethesda System for Reporting Thyroid Cytopathology (TBSRTC)<sup>2</sup> were associated with decision for surgery. However, they stated that they considered 3 cm as the cutoff point for the determination of nodule size<sup>1</sup>. Nevertheless, the 8th edition of The American Joint Committee on Cancer/Tumor, Node, and Metastasis (AJCC/TNM) Staging System reported the size cutoff points of 2 and 4 cm for T2 and T3 tumors, respectively. The size cutoff point of 20 mm, *per se*, is widely considered by the authorities and also stated as a stage by AJCC/TNM, 8th ed., again, after its 7th ed.<sup>3</sup> In addition, the 2017 American College of Radiology (ACR) guidelines emphasized the size cutoff point of 25 mm<sup>4</sup>. Of note, the 2015 American Thyroid Association (ATA) Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer<sup>5</sup> recommended prophylactic central compartment neck dissection, ipsilateral or bilateral, for cases with papillary thyroid carcinoma with over T3 tumor, by remarking significantly to the size cutoff point of 40 mm [Recommendation 36(B); Weak recommendation, Low-quality evidence], like in the 2009 ATA Management Guidelines. In this sense, why did the authors opt for a size cutoff point of 3 cm instead of 2 or 4 cm? Would the outcomes of their valued work be affected in the case of utilizing 2 or

4 cm as the size cutoff point of the nodules? In addition, the age cutoff used for staging was increased from 45 to 55 years at diagnosis in AJCC/TNM, 8th ed. compared with AJCC/TNM, 7th ed.<sup>3</sup> Furthermore, the authors declared that they handled indeterminate cytology as Categories III and IV, TBSRTC. Nevertheless, many authorities in thyroidology, even the 2015 ATA Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer<sup>4</sup>, expressed and described indeterminate cytology as thyroid nodules, possessing cytology adjusted to Categories III, IV, and V, TBSRTC, 2nd ed.<sup>6</sup>, which possess the higher risk of malignancies (ROMs) that compared with its 1st ed. Herewith, would the relevant outcomes be affected in the case of incorporating the possible nodules with Category V, TBSRTC, which possess a higher ROM, into the study design of their respectable study? As such, would it differ in case incorporating both the size cutoff points of 2 and 4 cm with Category V, TBSRTC into the study? As a matter of fact that this issue merits further investigation. *Ubi dubium ibi libertas*. We thank Kuta et al.<sup>1</sup> for their valued study.

### AUTHORS' CONTRIBUTIONS

**IS:** Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Project administration, Resources, Software, Validation, Visualization, Writing – original draft, Writing – review & editing. **DS:** Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Project administration, Resources, Software, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing.

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