

Letters to the Editor

Highly aggressive behaviour of occult papillary thyroid carcinoma

Dear Sir,

I have read with great interest the article by Hefer *et al.*, published in the *JLO* in November of 1995. These authors reported a case of occult papillary carcinoma of the thyroid which presented with disseminated metastases to bone, lung and brain.

There is an indication that the biopsy from the tumour mass from the right bronchus was stained for thyroglobulin. The authors indicate that this 'disclosed focal cytoplasmic staining in a few malignant cells'.

They do not state nor illustrate the degree of staining nor the controls used. Immunostains can be notoriously difficult to interpret as positive if the staining in cells is at the periphery of the tissue, so called edge-effect; it is known that this is often considered false positive staining. In addition, the authors do not give the results of positive and negative controls for their immunoperoxidase staining.

A total thyroidectomy was performed on this patient and multiple serial sections performed on the whole thyroid gland showed no evidence of malignancy. I assume from this statement that the entire thyroid was submitted for histological examination. If so, and there was no tumour found and presumably there was no evidence of scar which could have represented a totally involuted tumour, I cannot imagine how this represents an occult thyroid carcinoma. The definition of occult papillary carcinoma of the thyroid is a thyroid tumour which is undetected clinically (usually because of small size) but is identified in the thyroid specimen (grossly or more commonly microscopically). Occult thyroid carcinoma is not defined as nonexistent thyroid carcinoma.

In addition and most importantly, Figure 3 in this paper shows tumour in lymphatics in the bronchial tissue; the tumour is focally papillary but predominantly solid and does not show the nuclear features even at low power, of papillary carcinoma of the thyroid. I would therefore suggest that this tumour did not arise from the thyroid but most likely was derived from the lung and spread intralymphatically in the lungs and then to distant sites.

Virginia A. LiVolsi, M.D.,
Vice Chair for Anatomic Pathology,
University of Pennsylvania Medical Center,
Philadelphia, PA 19104-4283,
USA.

Dear Sir,

Reading the interesting article from Israel on the subject Occult Thyroid Carcinoma presenting as a parapharyngeal mass reminded me of two cases of middle aged women, whom I have seen in recent years, who have presented with apparently abnormal thyroid swellings, due to occult pharyngeal carcinoma. Lesions lying behind the thyroid gland and pushing forward a multi-nodular goitre, for example, might not be detected on routine examination and thyroid screening, and unfortunately pharyngeal carcinoma may remain occult until it has reached appreciable size. Computerised tomography of the region will of course help to resolve the diagnosis where suspicion is maintained regarding the cause for thyroid prominence.

Mr M. Hardingham, F.R.C.S.,
Consultant ENT Surgeon,
Cheltenham General Hospital,
Cheltenham, GL53 7AN.

Pre-operative information in mastoidectomy: what about the facial nerve and hearing loss (Vol 110: 10–12)

Dear Sir,

Mr Wormald reviewed the pro's and con's of warning patients of facial nerve injury and of hearing loss when undergoing mastoid surgery. He has found that ENT Surgeons in South Africa are substantially less likely than their British counterparts to warn their patients of those potential complications. It is a myth that many patients when informed about their proposed treatment will be frightened from undergoing treatment. Such paternalistic behaviour is no longer tolerated in most modern societies. Research in the field of informed consent has demonstrated that patients want to know about their illness, its effects, the treatment options, their outcomes and side effects and how the treatment will affect their life. Often patients undergoing mastoid surgery have some degree of hearing loss and therefore may be less concerned about this being worse, however facial palsy is a devastating side effect which I think most people would consider 'material' even though the risk may be very small (not necessarily 'material' to a surgeon or a court).

The racial composition and probably the spread of educational standards within South Africa is different to that of the United Kingdom. The black population also probably have different cultural expectations that may influence their response to