LETTER TO THE EDITOR
https://doi.org/10.1590/1806-9282.20201013

Emphasis on the novel age cutoff, 55 years, for postsurgical adjuvant radioiodine as consideration for American Thyroid Association ¾ low-intermediate risk differentiated thyroid carcinoma

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Dear Editor,

We have read with a great deal of respect the research article entitled 'Older patients with differentiated thyroid cancer exhibit more aggressive pathological characteristics than younger patients'[1]. This beneficial research seems to be demanded out of determining any alteration in the clinical and/or pathological characteristics of differentiated thyroid cancer (DTC) without microcarcinomas, extrathyroidal extension (ETE); tumor size ≥2 cm, an emphasized size cutoff for the thyroid nodules, particularly with indeterminate cytology[2-5]; completeness of resection; multifocality; angioinvasion; and regional/distant metastasis, with regard to revised age cut-point, 55 years.

They stated that the younger cases differed significantly from the older ones, in terms of ETE, tumor size ≥2 cm, completeness of resection, except multifocality, angioinvasion, and regional/distant metastasis. Interestingly, only ETE was recognized as significant regarding an alternate cut-point, 45 years[1]. In 2015, management guidelines from the American Thyroid Association (ATA) for adult patients with thyroid nodules and differentiated thyroid cancer[2] reported characteristics in accordance with the ATA Risk Stratification System and the American Joint Committee on Cancer (AJCC)/TNM Staging System that may impact Postoperative Radioiodine Decision-Making (Recommendation 51, Table 14). They recommended postsurgical radioactive iodine, radioiodine (RAI) to be considered in four different categories of ATA low-intermediate risk. Engrossingly, they proposed the use of 55 years as a more appropriate prognostic age cutoff for the relevant classification systems, rather than 45 years, particularly for women, considering the suggestion of recent data from the National Thyroid Cancer Treatment Cooperative Study Group (NTCTCSG) for three of four categories of ATA low-intermediate risk [(i) T3, N0, Nx, M0, Mx; (iii) T1-3, N1a, M0, Mx; and (iv) T1-3, N1b, M0, Mx]. Interestingly, only one category of ATA low-intermediate risk [(ii) T3, N0, Nx, M0, Mx] includes "microscopic ETE, at any tumor size" for which the NTCTCSG and also the 2015 ATA management guidelines did not recommend to reckon 55 years as a more convenient prognostic age cutoff for the associated classification systems. Johar and colleagues[1] also reported solely ETE as being a revealed difference while the age cutoff described was 45 years. As we evaluate and comment from the other side, the NTCTCSG and also the 2015 ATA management guidelines recommended the use of postsurgical RAI treatment for advanced age patients for whom (with a latter age cutoff; i.e, >55 years) that may favor the use in the following three conditions: tumor size >4 cm, central compartment neck lymph node metastases, and lateral neck or mediastinal lymph node metastases [(i), (iii), and (iv),

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Conflicts of interest: the authors declare there are no conflicts of interest. Funding: none.
Received on November 18, 2020. Accepted on December 15, 2020.

respectively], which were aggressive pathologic characteristics, Johar et al.[1] expressed.

Consequently, postsurgical adjuvant RAI treatment is recommended in compliance with the ATA low-intermediate risk. The NTCTCSG and also the latest ATA management guidelines indicate its use considering the age cutoff of 55 years, instead of 45 years, for three of four categories of ATA low-intermediate risk, those consisting of more aggressive pathological characteristics. Due to that fact, this issue merits further investigation. We thank Johar et al.[1] for their valuable research.

AUTHORS' CONTRIBUTIONS

IS: Conceptualization, Data Curation, Formal Analysis, Writing – Original Draft, Writing – Review & Editing. **DS:** Conceptualization, Data Curation, Formal Analysis, Supervision, Writing – Original Draft, Writing – Review & Editing.

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