

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.

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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.

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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

pre-operative information. I am not in a position to comment upon these factors.

In my research in informed consent the population studied has covered a variety of education levels but the majority of patients were only taught up to CSE/ 'O' Level. The educational status did not influence individuals' desire for information. Dawes and Davison (1994) found that most of patients want to be fully informed when deciding to have an ENT procedure.

Mr Wormald, in his editorial, has not discussed the populations attitudes toward informed consent and these need to be investigated as well as research performed upon the effect that pre-operative information has upon an individuals decision to undergo or refuse mastoid surgery, before physicians can confidently state that many of their patients will be adversely affected by being given such information. When deciding what to tell a patient, a practitioner should determine what that individual wants to know rather than decide what they may want to know. For the predominantly European population in the UK we know patients want information.

Twenty-five per cent of South African surgeons have had a patient refuse mastoid surgery when told of these risks 'This high incidence of patients refusing surgery for a potentially life threatening condition is probably owing to the relative lack of education in parts of rural South Africa'. I would not be surprised if most ENT surgeons throughout the world have had a patient refuse mastoid surgery because of the risk of such complications, that remains the patients prerogative. The true incidence of refusal in South Africa is not given and incidence of CSOM is high and families should be well aware of the severity and potential mortality from this disease. Certainly in my practice most adults over 50 years know what 'mastoid' is and are respectful of the severity of this condition. Thus I (would) postulate that in rural South Africa a careful easily understood explanation of the morbidity of CSOM

should balance an individual in favour of surgical intervention.

Additionally, failure to warn a highly strung professional of such morbidity may place oneself at risk of being sued for negligence when obtaining consent. (Let alone negligent surgery). Even though, in South Africa, an ENT surgeon will have no difficulty finding colleagues who support this approach to consent there will no doubt be a prolonged, stressful debate through the Court. The presentation of information about disease, its effects when untreated in addition to surgical details should leave an individual in no doubt about the correct course of action. A greater feeling of autonomy is given to the patient and this will improve compliance with post-operative care as well as allowing the patient to feel involved in their treatment. It is the patient who feels little autonomy who is most likely to be aggrieved by a poor surgical outcome.

Mr Wormald is correct that Junior Surgeons should warn their patients of these risks. However if closely supervised by a Consultant the argument should be that the incidence of complications will be no greater than that of the supervising Consultant responsible for the patients care. Therefore why tell more than that Consultant—the patient may even be frightened from having surgery!

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Reference

Dawes, P. J. D., Davison, P. (1994) Informed consent: what do patients want to know? *Journal of the Royal Society of Medicine* 87.

Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient Practitioner Relationship, Vol 2, Appendices: empirical studies of informed consent.