Quality Indicators for Primary Hyperparathyroidism-Reply

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Published in:
JAMA Otolaryngology. Head & Neck Surgery

DOI:
10.1001/jamaoto.2022.0926

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Document Version
Publisher's PDF, also known as Version of record

Publication date:
2022

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

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Letters

COMMENT & RESPONSE

In Reply We thank Tam-Lin Chow for the letter to the editor highlighting the importance of the development of quality indicators (QIs) to reflect optimal evidence-based care for those patients with primary hyperparathyroidism laid out in our article.1

We would like to respond regarding the use of parathyroid hormone (PTH) and help clarify the recommendation regarding surgery QI 1: “Appropriate surgical strategies for parathyroidectomy include limited parathyroid exploration with use of intraoperative PTH or four gland parathyroid exploration.”2,3

The success of a surgery for patients with primary hyperparathyroidism depends on choosing the effective operative approach for the disease process, whether single adenoma or multigland disease. For surgeons who perform single-parathyroid excision, the rate of disease persistence if the surgeon is experienced and adenoma is well localized is dependent on the prevalence of multigland disease in the population taken for surgery. Although patients with primary hyperparathyroidism have up to 15% chance of multigland disease, it is admittedly lower for cohorts of patients who have positive localization study results. The ultimate risk of disease after performing single-gland excision would be related to the reliability of localization studies, which can have variable performance.2,3 Depending on surgeon and radiological expertise, this approach may expose patients to operative risk without durable cure.4,5

As multiple parathyroid guidelines have suggested, there is a large proportion of patients with primary hyperparathyroidism who would benefit from surgical intervention. Most of the published literature on commonly used localization tools suggests the likelihood of finding a well localized gland is variable, especially because, in some health systems more advanced preoperative scans such as 18F-choline positron emission tomography-computed tomography are not standard of care yet. In most health systems, if the surgical approach does not include either use of intraoperative PTH or bilateral neck exploration, surgeons may deny curative therapy to a large proportion of patients who may not be treated given a lack of positive localizing scan results.

The authors acknowledge that intraoperative PTH is expensive and time-consuming, which may make its feasibility questionable in many health systems around the world. For these reasons, there are high-volume centers using preoperative imaging but still performing bilateral neck exploration with excellent results. This allows both high cure rates as well as ability to treat all patients who benefit from surgery even without positive preoperative localization study results.6

Health systems may use our QIs to support clinicians in offering the best possible care for their patients with primary hyperparathyroidism. Given the available data and regional imaging performance, our panel concluded that either intraoperative PTH or bilateral neck exploration (with or without preoperative localization) produces the most ideal outcomes for patients who would benefit from surgical cure.

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Published Online: June 9, 2022. doi:10.1016/j.jamato.2022.09.26

Conflict of Interest Disclosures: None reported.