

**Answer**

The focus of this review was the diagnosis, treatment and follow-up of differentiated thyroid cancer (DTC), rather than evaluation of thyroid nodules. We do agree with Dr Giovanella that in the work-up of thyroid nodules TSH has to be the first test followed by scintigraphy in case of subnormal or suppressed TSH. FNAB should not be performed in autonomous nodules taking up I-131.

The value of post-surgical I-131 ablation in low or intermediate risk DTC (T1 and T2, up to 4 cm without evidence for metastases) is indeed controversial. A recent large study from France analyzed almost 1300 of such patients with DTC during a mean follow-up of 10 years and found no clear benefit of I-131 treatment regarding overall or disease-free survival [1]. In this study, 378 patients did not receive radioiodine treatment, and 45% of the entire population (n = 587) had unknown lymph node involvement. 19 recurrences were recorded (1,6% in those with I-131, and 1% in those who had surgery only) during the observation period. Although retrospective in nature, this study indicates that even patients with well-differentiated T2 DTCs may not benefit from I-131 treatment. Indeed, increasing evidence suggests, that the harms of treatment (secondary cancers) in this low-risk population may not be negligible [2].

Routine follow-up of DTC should include a clinical examination, measurement of TSH, fT4, thyroglobulin (using a sensitive assay and including Tg recovery), Tg-

antibodies as well as neck ultrasound. Diagnostic I-123 scintigraphy has been evaluated in various studies with and without previous TSH stimulation and showed a sensitivity and specificity that precludes its use in routine clinical practice [3, 4]. This does, however, not exclude the application of this imaging modality in specific patients, such as those, where Tg measurement is not possible because of positive antibodies.

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**References**

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