



The 2019 core-needle biopsy practice guidelines

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LETTER

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We read with great interest the article published by Son et al. entitled "Distribution and malignancy risk of six categories of the pathology reporting system for thyroid core-needle biopsy in 1,216 consecutive thyroid nodules" [1]. In this article, the authors evaluated the distribution of thyroid nodules among the six categories of the pathology reporting system for thyroid core-needle biopsy (CNB), along with the range of malignancy risk of each category based on different diagnostic criteria for benignity in a large-population clinical cohort. They suggested that first-line CNB tended to yield a higher rate of conclusive results than second-line CNB with prior inconclusive fine-needle aspiration (FNA) results. The authors achieved excellent CNB results with a low complication rate. Thus, the data presented in this article furnish important support for the recommendations of the CNB guidelines developed by the Korean Society of Thyroid Radiology [2]. Moreover, this study provides useful results that may help patients with thyroid nodules to avoid repetitive FNA or diagnostic surgery involving CNB [3,4]. In particular, the results are valuable in that they provide the range of malignancy risk of each category based on different diagnostic criteria for benignity. It is very interesting that the final diagnosis of a benign nodule was made by three criteria [1]. We agree with the authors' opinion and personally prefer criterion 1.

Although this CNB study presented informative results from a large population, several issues should be considered. First, although the methodology of this study is clear, their pathologic report does not follow the 2019 clinical practice guidelines for CNB [5], in which the nondiagnostic category contains a diverse range of acellular specimens (e.g., acellular fibrotic tissue, acellular hyalinized tissue, cystic fluid only) [5]. Therefore, applying the 2019 clinical practice guidelines for CNB may result in a higher rate of nondiagnostic results. Second, we have a question regarding the high malignancy rate of category 1 in the authors' study, since it was most likely induced by the low incidence of a final diagnosis in category 1. Most of the patients were lost to follow-up or had no further diagnosis. Current guidelines suggest repeated biopsy for thyroid nodules with previous nondiagnostic results [6]. Finally, considering the paradigm shift in thyroid nodule diagnosis from focusing on the cancer detection rate to minimizing the unnecessary biopsy rate [7], we should strive to reduce the unnecessary biopsy rate in our daily practice.

In conclusion, Son et al. [1] reported valuable results regarding the distribution and malignancy risk of the six categories of the CNB pathology reporting system. Although these results are important and interesting, it is essential for operators who perform thyroid CNB to understand the new pathology reporting system [5] and the paradigm shift in thyroid nodule diagnosis.

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Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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