Dear Sirs,

I am writing regarding a recent article entitled ‘Clinicoradiological characteristics of patients with differentiated thyroid carcinoma and renal metastasis: case series with follow up’ by Kand and Basu.1 In this paper, the authors attempted to demonstrate clinicoradiological characteristics in a series of patients with rare occurrence of renal metastasis from primary thyroid carcinoma. It was surprising that a journal of your repute accepted this paper in which pathological proof of renal metastasis was lacking in half of the patients (two of four patients).

Firstly, the authors’ claim that the diagnosis of renal metastasis was primarily confirmed by radiiodine whole-body scintigraphy may not be true. It is well known that radiiodine undergoes physiological excretion through the renal system. Moreover, certain renal abnormalities such as cysts are known to have false positive radiiodine uptake.2–5 Even if an ultrasound or computed tomography correlation has been obtained, fine needle aspiration of the renal lesion is imperative to establish the diagnosis of renal metastasis.

Secondly, variable expression of sodium iodide symporter in different metastatic sites, or selective loss of sodium iodide symporter expression, could explain the rarity of detection of renal metastatic lesion from a primary site in the thyroid.6 This is different from a true ‘flip-flop’ where a lesion that was initially concentrating radiiodine subsequently loses this ability as it undergoes dedifferentiation. No such lesion (i.e. initially radiiodine avid and later (in follow-up scans) fluorine-18 fluorodeoxyglucose avid) was reported by the authors in this paper.

Thirdly, the thyroglobulin secreting nature of these lesions is of immense clinical relevance, as a lower level of thyroglobulin in the follow up of these patients.

G MALHOTRA
Radiation Medicine Centre, Bhabha Atomic Research Centre, Parel, Mumbai, India

References
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