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Letter to the Editor

Thyroid cytomorphological features and risk of malignancy of category III, TBSRTC in thyroidology: Tempora mutantur?

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Dear Editor,

We have perused with a deep sense of scholarly appreciation the recent treatise published within these pages, entitled "*Assessment of cytomorphological features and risk of malignancy of Bethesda category III in thyroid cytopathology"*, published in volume 15, *Journal of Pathology of Nepal* in thyroidology.[1] It is incumbent upon this readership to commend the learned authors for their diligent efforts in assessing the vexatious and heterogeneous category of thyroid nodules known as atypia of undetermined significance. Frankly, the adoption of the Bethesda System Reporting for Thyroid Cytopathology does link diagnostic

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categories with the risk of malignancy (ROM), yet category III continues to present palpable diagnostic and therapeutic dilemmas.[2-6] The study, a retrospective evaluation of 47 cases that underwent thyroidectomy, yields compelling population-specific insights into this indeterminate group. Most notably, the data suggests that the ROM for AUS nuclear (51.7%) was found to be nearly two-fold greater than for AUS-other (27.7%), when one justly considers low-risk neoplasms within the malignant rubric. Furthermore, the investigation has sagaciously identified specific cytomorphological features with heightened malignancy risk. Chief among these predictors were nuclear pseudo-inclusions (100% ROM across three cases), microfollicular pattern, and crowded three-dimensional clusters. Such specific identification of features, it is correctly asserted, does aid the clinician in subsequent patient management. Notwithstanding these substantive findings, we pause upon reflection to consider the constraints duly noted by the authors themselves. The study drew its conclusions from a modest cohort of forty-seven cases. While the 100% ROM observed for the exceedingly rare nuclear pseudo-inclusions is arresting, it is incumbent upon the scientific community to exercise a measure of scholarly caution, lest such robust statistics be generalized too swiftly without corroboration from a larger patient cohort. Moreover, given that the AUS is characterized by low inter-pathologist agreement due to the subjective nature of morphology interpretation, the reliance upon a solitary pathologist for the comprehensive evaluation of both cyto- and histopathology slides necessarily precludes the assessment of inter-observer variability. This crucial element, oft overlooked, is essential for validating diagnostic criteria.[1] Nonetheless, we are in complete accord that establishing the local prevalence of malignancy for this indeterminate category is paramount for tailoring optimal patient management strategies. This work stands as a valuable initial contribution to the localized evidence base, warranting further expansive investigation. This issue merits further investigation. We thank *Kumar et al*.[1] for their study in *J Pathol Nepal* on category III, for thyroidologists.

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