How Best to Approach Surgery for Primary Hyperparathyroidism—Can We All Agree?

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In the current era of value-based care and a rapid research kinetic, evidence-based guidelines have become increasingly important. For clinicians, patients, and payers, they are an important means of synthesizing a large body of sometimes contradictory evidence to support best practice recommendations. Variation in practice generally implies variation in the quality of care, so efforts to standardize approaches to diagnosis, treatment, and surveillance are timely and valuable.

Primary hyperparathyroidism is a common disease that typically affects women in the sixth to eighth decades of life. Most patients currently diagnosed as having primary hyperparathyroidism are asymptomatic; therefore, there has been disagreement regarding the best management approach and whether that should include surveillance, medical therapy, or surgery. There has long been consensus that symptomatic primary hyperparathyroidism merits surgery.

To date, the management of asymptomatic primary hyperparathyroidism has been the subject of 4 international workshops; the most recent guidelines iteration was published in 2014. Although the expert panel of authors who reached consensus regarding those guidelines included surgeons, the focus was not on surgical algorithms and approaches. Therefore, the new guidelines for the definitive management of primary hyperparathyroidism from the American Association of Endocrine Surgeons (AAES) published in JAMA Surgery are a welcome addition to the literature, especially because they are written for the practicing surgeon. This is a large opus and represents a transdisciplinary effort using a rigorous grading approach to evaluate the quality of evidence. The AAES almost certainly has increased the guidelines’ audience by including an executive summary that reduces 174 pages of recommendations and supporting evidence to the essentials; this is most helpful. It is interesting and perhaps discouraging, however, that overall the quality of evidence in this field is not high. Some controversies are not resolved, and they should not be. Debate will continue about the best preoperative imaging modality protocol and likely needs to be resolved at a local level based on the quality of imaging studies at each institution. Discussion also will persist about the relative merits of minimally invasive parathyroidectomy vs bilateral neck exploration.

Going forward, it will be important for these guidelines to be kept contemporary. All of us share responsibility to communicate the panel’s findings to our colleagues and incorporate them into our practice, even if that implies our needing to change what we do; for example, we must ensure that the extensive biochemical evaluation and imaging suggested preoperatively to accurately risk stratify patients are completed. In the end, the surgical community should ensure this is a living document that is relevant and real by using it.

REFERENCES
