advocated by the introduction of the intermediate/borderline tumor group (eg, NIFTP) in the new World Health Organization classification of thyroid tumors, and the majority of the histologically validated NIFTPs have a cytologic equivalent of AUS and FN. Further efforts should be directed at excluding malignantancies from borderline (AUS and FN) cytologic categories as much as possible, from 0.26% to nearly zero.

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1. Schnadig VJ. Overdiagnosis of thyroid cancer: is this not an ethical issue for pathologists as well as radiologists and clinicians? Arch Pathol Lab Med. 2018;142(9):1018–1020.


In our practice, however, we find that intraoperative gross examinations in colorectal resections requested by surgeons are valuable because they ensure that the lesion or lesions of interest are incorporated into the resection specimen, determine the adequacy of the surgical margins, are helpful in evaluating for residual tumor and margins in the specimen after neoadjuvant therapy, allow for proper orientation of the specimen with respect to endoscopic markings (ie, tattoo), identify additional pertinent findings (ie, fistula, perforation, diverticula), and provide important information to the surgeon and the patient’s family.

Additional benefits to the pathology department include enhanced specimen fixation as well as improvement in accessioning, processing, and reporting of the specimen.

The current Medicare allowable payment in our area for an operating room consultation (Current Procedural Terminology code 88329) is $41.00. We believe that the intraoperative gross examination of colorectal specimens is a good value for the important information and improvement in specimen processing that it affords.

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The author has no relevant financial interest in the products or companies described in this article.


In Response to “Cost Effectiveness of Intraoperative Gross Examination in Colorectal Resections”

To the Editor.—We agree with Khararjian et al1 that “decreasing unnecessary consultations [would] directly save the health care system money.”

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1. Schnadig VJ. Overdiagnosis of thyroid cancer: is this not an ethical issue for pathologists as well as radiologists and clinicians? Arch Pathol Lab Med. 2018;142(9):1018–1020.

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In Reply.—Kakudo and Bychkov rightly remind us that active surveillance (AS) is being used in Asia as an alternative to surgery for indeterminate thyroid nodules. AS for low-risk papillary thyroid carcinoma has been successfully implemented in Japan. AS is, as yet, in its infancy in the United States,1 where nonoperative management may relate more to comorbidities, distant metastases, and lack of health care access than elective AS for low-risk tumors.2 The key to successful use of AS seems to be selection of low-risk patients, trust, and good patient-physician communication. My fear is that use of the term risk of malignancy for occult incidentalomas may cause more harm than good. The word malignancy can dissuade eligible patients from choosing AS. Even the term atypia of undetermined significance may generate uncertainty-related anxiety in some patients, and, as Kakudo and Bychkov state, may confuse clinicians. I suggest that we need to take a closer look at our vocabulary and to study ways of reducing not just surgery but also fine-needle aspiration and endless ultrasound follow-up. I have addressed my concerns in more detail in my reply to “In Response to Overdiagnosis of Thyroid Cancer: Is This Not an Ethical Issue for Pathologists As Well As Radiologists and Clinicians?” by Renshaw and Gould, published in this issue.

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