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## Correspondence

## Reply to: Selective history of radioactive iodine in medicine: Inexactitudes no longer



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Dear Editor:

We enjoyed reading Tulchinsky's letter. Admittedly, we are mainly pleased that someone read our article [1]. His remarks provide some interesting insights into the challenges physicians face as we seek to build consensus on how to best reduce overtreatment in oncology.

Our article was a review of the evidence supporting a more limited use of radioactive iodine (RAI) therapy for thyroid cancer. Adjuvant RAI therapy continues to be widely used, despite offering no clear benefit in reducing survival or recurrence rates in low or intermediate-risk differentiated thyroid cancer. Tulchinsky's criticism was mainly focused on two historical paragraphs in the Background section of our nine-page article. He felt that we were "defaming" the pioneer Dr. Saul Hertz by supposedly "distribut[ing] the credit" for the development of RAI among the researchers at the hospital where he worked, rather than giving him sole credit. At first glance, this accusation seemed off base, given that *the very next sentence* of our article singled out Dr. Hertz: "Saul Hertz, a nuclear medicine physician, and the director of the Thyroid Clinic at MGH, was the first to use radioactive iodine for therapeutic use in humans". Dr. Saul Hertz was a pioneer who has been credited with first conceiving the idea and performing early experiments with radioactive iodine.

At first, his focus on historical background and terminology seemed like a substitute for an argument about the data. However, we now appreciate that Tulchinsky is a passionate activist and vigorous defender of the work of nuclear medicine physicians in treating thyroid cancer. Over the past few years, he has harshly criticized a number of publications that have reported data in support of more limited use of nuclear medicine – such as RAI therapy or PET/CT imaging – in patients with thyroid cancer. In his correspondence, he has generally raised interesting, albeit minor, technical comments. At the same time, however, he has on occasion accused authors of acting in bad faith (e.g., accusing us of "defamation") or insinuated that authors engaged in academic dishonesty (accusing others of "ethical concerns" or "malfeasance"). In one case, he unsuccessfully demanded retraction of a paper describing the elevated risks of leukemia in patients treated with RAI [2–4].

With these letters, he has sought to discredit work that he perceives as flawed and harmful to the specialty of nuclear medicine.

We agree that it is important to perform high quality research, publish data in peer-reviewed journals, and openly discuss data and interpretations with our colleagues in good faith. Employing accusations and innuendo to discredit authors with whom one disagrees seems less persuasive.

It has been demonstrated that the likelihood of a patient with stage I differentiated thyroid cancer being unnecessarily treated with RAI is much higher if the primary decision maker was a nuclear medicine physician, rather than an endocrinologist or surgeon [5]. Which brings us to the challenges of how we can best work to reduce overtreatment in thyroid cancer. This was the theme of this issue of the *EJSO*, which focused on de-escalation of therapy in thyroid cancer. Most of the articles were written by surgeons and argued for less surgery. Thyroid oncology is a multi-disciplinary specialty, and our colleagues in nuclear medicine should have a seat at the table, ideally by contributing expertise, experience, and high-level evidence to the literature.

Earlier this year, at a meeting of the Society for Nuclear Medicine and Molecular Imaging (SNMMI), Tulchinsky discussed his protests of these publications, and exhorted the audience: "Stand up to defend your field of practice – no one else will!" [6] We would counter with an alternative: "Stand up for your patients – and your multi-disciplinary colleagues will stand with you!"

Sincerely,

#### Conflict of interest statement

The authors disclose no financial or other relationships that may lead to a conflict of interest.

#### References

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