

residents who call radioiodine treatment of Graves' hyperthyroidism "thyroid ablation" rather than "treatment"; ablation implies that hypothyroidism is inevitable, whereas "treatment" leaves the possibility that there may be an outcome of euthyroidism.

The clinical features used for optimizing the dose in the current study may be somewhat arbitrary, such as determining the texture of the gland or the duration of the disease. Nevertheless, within the 12 years of follow-up, the results are impressive. Unfortunately, the history of radioiodine therapy in the United States and Europe makes me suspect that the good outcome will not persist as the patients are followed longer. Sridama et al. at the University of Chicago tried a low-dose program to cure hyperthyroidism many years ago and still found that the incidence of hypothyroidism at 12 years of follow-up was 73%

(2). Many other reports showed that the incidence of hypothyroidism tended to increase at a rate of 2% to 4% per year after 10 years, leading to the conclusion that hypothyroidism eventually develops in nearly all patients after ¹³¹I therapy for Graves' disease. However, my personal experience shows otherwise. Some patients are euthyroid in long-term follow-up.

However, a study of 1086 patients with Graves' disease treated with ¹³¹I in Finland using a dose similar to that used in group 3 of the study under discussion, 7 mCi, found an incidence of 59% hypothyroidism at 10 years and 82% at 25 years (3). Perhaps paying attention to the clinical factors cited in the study under discussion will improve this result. I am optimistic.

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References

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