

of any dominant nodule or suspicious nodule that might be cancer by aspiration biopsy cytology, and a partial or subtotal resection of the contralateral lobe. Although all large (greater than 1.5–2.0 cm) or palpable nodules in patients with multinodular goiter should be removed, it is not necessary to remove the entire gland. I have one other question. What is the authors' rate of recurrent goiter in patients who have been treated by less than total thyroidectomy?

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but the preferred option for the patient, provided that the surgeon is comfortable with the operation required to meet that option.

T. S. REEVE
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Reference

1. Reeve TS, Delbridge L, Brady P, et al. Secondary thyroidectomy; a twenty year experience. *World J Surg* (in press).

January 10, 1988

Dear Editor:

Thank you for the opportunity to reply to Dr. Clark's comments. We believe that there is a certain ambivalence in his comments in that, while he acknowledges our basic observation that multinodular goiter almost always involves both lobes of the thyroid gland, he then proposes that multinodular goiter should be treated in a manner not in general accord with well-accepted surgical principles—namely, to excise all diseased tissue when it is surgically safe to do so. This surgical tenet promotes the preservation of important anatomic structures unless they are involved in the disease process. Hence, while it is seen as desirable to perform total thyroidectomy in multinodular goiter, if anatomically necessary, a lesser procedure should be performed on the less affected side.

As we have pointed out, it is necessary to fully mobilize both lobes of the gland to ensure that no residual nodular thyroid tissue with growth potential is left *in situ* after thyroidectomy. This is important since "suppressive" therapy with thyroxine is not guaranteed to retard remnant growth.

It is the fundamental pathology of the disease and the anatomical features of the posterior lobule that have led us to expand our indications for total thyroidectomy in benign disease, and with increasing experience we are continuing to do so. In our unit, the percentage of cases where multinodular goiter has been treated by total thyroidectomy has increased from 50% in 1985 to 72% in 1987. We have also been able to achieve and maintain a morbidity pattern that is at least equal to that for subtotal thyroidectomy.

Dr. Clark rightly questions the rate of recurrence in our series of patients who have had less than total thyroidectomy. An idea of the rate of recurrence of multinodular goiter and the problems it poses can be gained from the following figures from our Unit. In the period 1976 to 1985, there were 311 secondary thyroidectomies performed, 173 of which (56%) were for recurrent multinodular goiter. During that same period, the total number of operations for multinodular goiter was 853; thus, over 20% of the surgeries performed for multinodular goiter was for recurrent disease. Of the patients who experienced recurrences, 64 (37%) had their initial surgery performed in this unit, and the remainder elsewhere. When one considers that the complication rate for secondary thyroidectomy is considerably greater than that for the initial procedure,¹ we believe that, in the patient with disease involving the entire gland, a total thyroidectomy is not only justified,

Dear Editor:

Since I read some of the issues of the *Annals of Surgery* with some delay, I can only now comment on one of the more interesting articles, "A Successful Cardiac Transplantation Program Using Combined University and Community Resources" by L. A. Gray, Jr. et al. Their contribution deserves the highest acknowledgement of the reader. The authors' final conclusion—that the orthotopic cardiac transplantation has become an effective treatment for end-stage heart-disease—seems perfectly right and justifies the enormous efforts of the pioneers of this field of medicine and surgery.

This is why I cannot agree with the first sentence of the article, "After the *first* human cardiac transplantation in 1967",¹ citing C. N. Barnard's report, in which even the author did not use the word "first." But he did use the word "successful"¹ and I could accept the introductory sentence of C. Gray's article had he used this word, instead.

The first—and unfortunately, unsuccessful—human cardiac transplantation—considering of course the acceptor and not the donor, which was a baboon, due to compulsion—was performed by Mr. James Hardy and his team 3 years earlier, in 1964, and it was published in *JAMA*.² Unfortunately, since 1964, this milestone of surgical intervention has been overlooked several times, even in American medical literature, (for example, in an editorial of *American Journal of Diseases of Children*³).

It is typical human behaviour to consider as "first" only the first *success*. Whether good or bad, there are many examples of this misconception in the history of medicine. The partial gastrectomy is attributed to Billroth (1881), although it was performed earlier—albeit unsuccessfully—by Rydygier (1880) and Pean (1879).⁴ Nor was it Whipple who made the first duodenopancreatectomy in 1935, but Sauv  (1908) and Kausch (1912),⁵ and the original technique did not include gastric resection, as we believe and still perform today. Many distinguished surgeons contributed to the so-called Whipple procedure.⁶ The pylorus-preserving pancreatoduodenectomy is considered Traverso and Longmire's modification (1978), but it was first suggested and performed by Watson in 1942,⁷ as well as *successfully* performed. And, on your side of the Atlantic, who, beside your Oliver Wendell Holmes,⁸ knows our Ign c Semmelweis's name, who discovered asepsis, long before the discovery of germs?⁴

Of course, the main point is whether the patient benefits. Nevertheless, even here in Hungary, I have had my own strug-