is the initial surgical treatment of choice. Lobectomy alone—as the definitive initial surgery—is associated with a 5-10% recurrence in the contralateral lobe\(^6\), and a ~25%-30% recurrence rate in the ipsilateral thyroid bed and neck lymph nodes\(^3\). There is also higher incidence of pulmonary metastases following lobectomy alone for PTC vs. performing a more complete surgery\(^6\). There is evidence of increased relapse-free survival with T/NTT, although it is more difficult to demonstrate an effect on overall survival. Mazzaferri et al. showed that T/NTT reduces the risk of mortality by 50% after a median follow-up of 16 years. This effect was independent from subsequent administration of RAI treatment(s)\(^7\). It has to be noted, however, that a remarkable total of 22,000 patient-years of follow-up was necessary to demonstrate the above effect of T/NTT. The guidelines published by the National Comprehensive Cancer Network (NCCN) in the U.S. recommend a total thyroidectomy with bilateral central compartment dissection; if lymph nodes are involved, lateral modified radical neck dissection is additionally advised\(^6\). The British Thyroid Association (BTA) recommends a total thyroidectomy plus removal of all lymph nodes in the central compartment of the neck, along with selective dissection of lateral cervical lymph nodes; there is no recommendation for routine radical neck dissection or more extensive explorations in multiple anatomical levels of cervical lymph nodes\(^6\). In selected cases of PTCs and FTCs with adverse prognostic factors, assuming that these are recognized and appreciated at the preoperative stage after appropriate risk stratification, a more aggressive surgical approach can be used. Moreover, a study suggested that in cases where a completion thyroidectomy is needed, if the latter is performed within 6 months from the initial partial thyroid resection, there is a significant survival advantage and a lower recurrence rate, as opposed to a completion operation performed more than 6 months after initial surgery\(^6\).

\textit{ii) Thyroid remnant RAI ablation}

The universal treatment of all PTC/FTC patients with RAI for the ablation of thyroidal postoperative remnants, as well as RAI activity ("dose") to be administered, remain controversial issues. Most authors, including ourselves, believe that remnant ablation in all patients is justified for the following reasons: (a) it facilitates the subsequent follow-up of patients using among the experts participating in the these panels.

\textit{i) Surgery}

In almost all cases of PTCs and FTCs greater than 1.0 cm, a total or near-total thyroidectomy (T/NTT)