BAETS
BRITISH ASSOCIATION OF
ENDOCRINE & THYROID SURGEONS

BAETS statement on COVID-19 and Thyroid Cancer Services

CONFIDENTIAL ADVICE FOR HEALTH PROFESSIONALS TO CONSIDER WHEN PLANNING THYROID CANCER SURGICAL SERVICES March 2020

This document covers thyroid surgery related to cancer – other thyroid surgery is covered in a separate document relating to benign thyroid conditions. This is not a clinical guideline or Standard Operating Procedure, but is a distillation of expert opinion which clinicians may find useful when planning local services.

Introduction

- During the current period of exceptional demand on the UK Health Services as a result of the COVID-19 pandemic, some aspects of Thyroid Cancer services may need to be prioritised where it is not possible to follow normal diagnostic and treatment pathways.
- Any decisions re changes will need to be taken locally and supported by local governance structures. Local planning should take place at the earliest opportunity taking into account varying levels of anticipated disruption at different stages of the pandemic.
- Where investigations and treatments are different from usual pathways it is important to continue to be honest and open with our patients, and to keep good records.
- The following guidance will be subject to change at various stages of the pandemic and recovery. This document deals only with thyroid cancer. Other thyroid surgery is covered in guidance for benign thyroid surgical conditions.

Referrals

- Triage should attempt to identify non-cancer or benign cases and defer/ reject these as appropriate. In England 2ww rules for referral still currently apply currently, but telephone consultations may help triage.
- Patients at high risk from COVID 19 (due to co morbidities or age) that fulfil urgent cancer referral criteria should be identified and streamed to a clinical environment that minimises exposure risk (e.g. One stop clinics)
- Patients with rapidly increasing neck mass associated with stridor should be referred on an emergency basis.

Diagnostic/ staging workup

- Diagnostic strategies should reflect local expertise and available resources
- Limit diagnostic workup in those cases where there is low clinical suspicion of malignancy. These patients will still need support and future investigation so ensure there are robust and tracked plans for ‘catch up’ in the future, and for patients to be upgraded to urgent where

there is a change in their clinical situation.

- For those patients who require face to face consultations, utilise one-top clinics wherever possible to minimise patient hospital visits, with telephone follow up.
- In cases of non-availability of usual USS facilities for assessment
    - Surgeon / other clinician performed USS assessment can be considered if appropriate training has taken place, ideally using recognised reporting system. Carefully record findings in notes.
    - Freehand FNAC can be considered where local expertise exists, this is best done by / with a dedicated Cytologist if available.
- Consider observational strategies in the management of suspicious thyroid nodules (BTA U3 and above) analogous to ACR Tirads system https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/TI-RADS e.g:
    - Only sampling BTA U3 nodules if >2.5 cm in maximal dimension
    - Only sampling BTA U4 if > 1.5cm in maximal dimension
    - Only sampling BTA U5 if > 1cm in maximal dimension
    - Follow up USS in 6 to 12 months if do not meet these thresholds, but would usually have been sampled – plan to sample either when services normalise or if enlarging at interval assessment (50% in volume and 20% in diameter in two directions).

MDT working and decisions

- Any changes to MDT working should be regarded as temporary only. Revert to normal MDT working as soon as circumstances allow.
- Maintain normal MDT frequency wherever possible. If frequency has to be reduced it should not usually be less than 2 weekly (England, because of cancer targets) or monthly in the devolved nations.
- Consider whether the number of core members attending can be reduced temporarily – but all hospitals contributing to the MDT should still be represented and decisions re attendance should be taken by mutual agreement. Any changes should be regarded as temporary only.
- For those MDT's which routinely discuss Thy3a and Thy3f cases, consider whether only those at the higher end of the risk spectrum (taking into account size and patient factors) are discussed until normal working resumes.
- Utilise facilities for dial-in or electronic discussions where possible.
- Record 'pre covid-19' management plan (if this differs) as well as the agreed management plan for the patient in the current covid-19 situation.
- Should situations arise where MDT is not quorate;
    - Take advice on an individual patient basis from experienced colleagues in the relevant disciplines.
    - Follow national/international guidelines.
    - Make careful records including why a full MDT discussion has not been possible
    - Discuss cases retrospectively at MDT when able to do so.
- Cases requiring priority surgical intervention include
    - Evidence of aerodigestive tract compromise/ invasion
    - Recurrent laryngeal nerve palsy due to malignancy

    - Locoregional metastasis
    - Large, compressive tumours.
    - Clinical concern e.g. rapid growth
    - Poorly differentiated and anaplastic thyroid malignancy (if surgery is likely to benefit patient).
- Medullary thyroid cancer should be managed as clinically appropriate, adhering as closely as possible to usual practice.
- MEN2 - prophylactic surgery in paediatric MEN2 patients with a genetic profile suggesting a statistically high risk of developing malignancy should not have surgery deferred wherever possible. If surgery is deferred, including in both high and medium risk patients, monitor calcitonin levels and ultrasound findings carefully and upgrade to urgent if indicated
- Deferred Surgical treatment might be considered in patients with "lower risk" Thyroid Cancers including:-
    - Suspected Differentiated cancers (PTC and FTC) without compressive symptoms / signs.
        - No evidence of Nodal Metastasis
        - No Airway issues
        - No voice changes
    - Where the MDT would usually recommend completion surgery following hemithyroidectomy *but where there is no evidence of persistent disease on imaging or clinically* - consider TSH suppression until more normal working resumes.
- Where a decision has been made to delay surgery for a nodule which is either malignant, or with significant possibility of malignancy, the nodule should be monitored with USS at 20 weeks and if it either grows substantially (50% in volume and 20% in diameter in two directions) or if metastatic nodes are identified surgical management should be initiated as soon as it can be undertaken. In all cases surgery should be delayed for the shortest time possible in the circumstances

Surgical Treatment

- Those surgical cases that cannot be delayed should be undertaken wherever possible by high volume (>20 cases/year) Thyroid Surgeons who have demonstrated good results in the past through meaningful audit (e.g. UKRETS)
    - This should minimise complications and make the most efficient use of available operating theatre time.
    - Hospitals with large numbers of thyroid surgeons may wish to designate two surgeons only to continue provide thyroid surgical services during any period that only priority thyroid surgical cases are being operated on
- Pre operative fibreoptic naso-endoscopy (FNE) should be used selectively – mainly for patients with previous neck surgery, history of voice change or stridor. Practitioners undertaking FNE should follow the ENT-UK advice related to Covid-19.
- Post-operative FNE should only be done if there is clinical concern of a vocal cord palsy or if further contralateral surgery is planned in the near future.
- Clear discharge instructions of whom to contact if advice is needed post operatively will reduce emergency department attendance. Where *possible and safe* patients with or at risk

of hypocalcaemia should be discharged and arrangements made to have further blood tests in a safe outpatient environment. These must be reviewed and the patient informed of any change in medication or management plan. If a patient has more severe hypocalcaemia keep in hospital until safe to discharge to avoid emergency readmission.

Communication with patients

- Ensure that, as far as practical, patients remain supported, including whose treatment has been delayed or deferred.
- Be open and honest with patients. For low risk tumours, delayed surgery is very unlikely to cause physical harm or lead to a worse long-term outcome for the patient, but it is not possible to be completely certain regarding that.

Follow Up

- Minimise face to face follow up, using web based or telephone consultations.
- Reduce frequency of follow up appointments.
- If thyroid function tests are difficult to access, consider treating those thyroid surgery patients who need thyroid hormone replacement with 1.8mcg per Kg Levothyroxine until testing is available

UKRETS and BAETS

- All thyroid surgeons should record their operations and outcomes on the UKRETS national database, subject as usual to individual patient consent.
- We will keep under review the requirement to perform 20 surgical cases per year to remain a full member of BAETS with voting rights etc. We may temporarily suspend that requirement during a period of temporary national reduction in thyroid surgery
- During periods of temporary reduction in the number of thyroid operations being performed, we recommend these will be channelled to a reduced number of high volume surgeons.

    - As those surgeons will be operating on the more complex cases, it is likely their average overall complication and length of stay data will be less favourable than usual, and FNE rates pre and post op will reduce. In planning any future database analysis or publication of individual results we will take account of this probable temporary distortion of figures.

    - When there is a return to normal working teams may need to consider mentoring for colleagues who would normally have undertaken at least 20 relevant procedures per year, but have not done so during the pandemic.

Jeremy Davis – President, BAETS

Michael Stechman – Secretary, BAETS

Omar Hilmi – Thyroid Cancer Statement Lead, BAETS

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