Thyroid Nodule/Cancer Clinic – Guide for Registrars

General thoughts

- Please take time to read the 2014 BTA guidelines on thyroid cancer and the ECED local protocol on thyroid cancer.
- The clinic starts at 1pm sharp in OPD 4, RIE – please be on time!!
- Log in to Trak as though you are in OPD-2, RIE, NOT Metabolic Unit
- Janey makes all clinic appts after the clinics; the patient does NOT book them on the way out of OPD-4
- You dictate a letter relevant to the encounter. FWG and MWJS will dictate a letter at a later date with the Tg and TFT results.

Follow-Up of Thyroid Cancer

- Patients with low risk tumours who have been treated with surgery only do not require TSH suppression.
- Patients with an 'excellent response' (i.e. undetectable Tg and normal neck USS) and no high risk features, do not need TSH suppression beyond 12 months – target TSH 0.2-2.0
- Standard clinic follow-up for patients with differentiated thyroid cancer is:
    - 3 months post RAI
    - 6 months post RAI
    - 12 months post RAI
    - Annually thereafter if 'excellent response'
- Tg and TFT's should be measured at each visit.
- A neck USS should be booked for just before the 12 month visit in patients with undetectable Tg (the purpose of this scan is to detect Tg negative residual disease).
- A neck USS should be booked after the 3 month visit if Tg antibody interference is detected.

- Patients with stage 1 disease at presentation and 'excellent response' (i.e. consistently negative Tg and a normal year 1 scan) may be discharged to the **Virtual Clinic** at 5 years. In the virtual clinic, we send out a letter and blood form to the patient. Sample for TFT's and Tg is taken at GPs and results come back to us for interpretation.

Thyroid Nodules

- USS is now the primary investigation in people with thyroid nodules.

- U2 nodules do not routinely require a biopsy. Options of surgery vs surveillance should be discussed with the patient. If the latter, then a 12 month scan should be booked.

- U3-U5 nodules should be biopsied. For U4 and U5 nodules, a biopsy helps guide surgical management.

- For U3 nodules, if cytology is Thy 1 or Thy 3a, consideration should be given to repeat biopsy. U3 with Thy 2 cytology merits a discussion about surgery vs surveillance. If the latter, timing of USS should be between 6-12 months depending on the level of clinical concern. U3 with Thy 4-Thy 5 cytology should be referred for surgery.

- For nodules under surveillance, it is hard to give definitive guidance on the duration of follow-up. This depends on many factors including U and Thy gradings, co-morbidities etc. A growing nodule does not automatically mean malignancy, but consider repeat biopsy, surgery and/or further discussion about the pros and cons of surgery vs surveillance.

Thyroid FNAC

- In most instances, a FNA should only be performed with the knowledge of the USS grading of the nodule.

- If you are doing an FNA – remember 2x fixed slides; two air-dryed slides and one Cytolyt container for the needle rinse. After 10-15 minutes, empty the fixed slide container of alcohol before sending to pathology (its been sent full before!!).

- Write the patient name and CHI on **each slide**; put a patient label on each slide container and the cytolyt container and write on the slide containers if air-dried or fixed. Slides will not be processed if all this information is not provided.

- Do not do an FNA if the patient is on Warfarin, clopidogrel or a DOAC (e.g. apixaban). It is fine to do the biopsy if the patient is on aspirin

- The turn-around time for FNA's is about 2 weeks, so ask Janey to book a 2 week appt.

- Advise the patient to seek urgent medical attention if any undue swelling or breathing problems after the FNA

Ultrasound and other imaging

- There are 4 USS slots available before each Monday clinic, these are generally reserved for 'new patients', rather than say annual surveillance scans, unless the patient has to travel a long way

- CT/MR scans and USS-guided biopsies need to be booked on Trak by you.

- Janey will book the USS, but you need to dictate for her the clinical details. All USS scans should be performed at the RIE and marked for the attention of Dilip Patel. **If you are booking an interval scan yourself, remember to make clear the scan interval and double check it is being sent to RIE USS.**

Radio-iodine Consent

- When consenting patients for radio-iodine, remember to make it very clear that they will be in isolation and that they should expect no practical help from nursing staff.

- Remind them not to wear nice clothes, that there is no WIFI or mobile reception and that their food will be served on paper plates with plastic crockery. There may be polythene sheeting on the floors. Wrap any electronics in cling-film to avoid contamination. Advise that there may be plastic sheeting on the floor and to expect to be very bored!!

- **Assess very carefully medical fitness for isolation**, e.g. if the patient has diabetes, are hypos an issue? Is their mobility OK…are they a falls risk?

- **Women of reproductive age must be counseled very carefully and clearly about the serious risks to a pregnancy following RAI.**

- Check on Trak what dose of RAI is being recommended by the MDT. If 1,100 MBq, then the patient will likely spend 1 night in hospital; 2 nights if 3,700; and 2-3 nights if 6000.

- Please check U&Es in all patients over 65; impaired renal function slows the clearance of RAI and may affect the length of stay in the isolation room.

- **Please check a baseline Thyroglobulin at the consent visit.** If the Tg is significantly high (>1), discuss with MWJS or FWG, as we might want to get imaging done prior to RAI.

- Write a contact number for the patient on the consent form and give to MWJS **with a sheet of sticky labels**. If sending in the internal mail, make sure you let MWJS know to look out for this.

Thyroglobulin

- Thyroglobulin samples require **two brown tubes**; use the RIE 'Diff Thyroid Cancer' order set….do not order TFT's and Tg separately. Do not order against any other episode than the clinic visit and again, remember to ensure you are logged into Trak under RIE OPD-2.

- When interpreting Tg levels, remember that the Birmingham assay is low-sensitivity and is there to detect antibody interference. Birmingham reads high when there is antibody interference and Edinburgh low – both results are unreliable.

- If Edinburgh is detectable and Birmingham is undetectable, this is a sign of residual disease.

Hypoparathyroidism

- Post-operative hypoparathyroidism is not always permanent, so when seeing patients in the aftermath of surgery consider whether or not it would be appropriate to reduce the calcium and vitamin D supplementation.

- In patients with permanent hypoparathyroidism, do remember to check calcium levels on the annual clinic blood sample.

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