

Comments to SEOM clinical guidelines for the treatment of thyroid cancer

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Dear Editor:

We have carefully read the SEOM clinical guidelines for the treatment of thyroid cancer published in this journal last year. We hope that the recent interest medical oncologists in Spain have demonstrated in thyroid cancer will contribute to increase our knowledge in the thyroid cancer field. It also highlights the importance of a multidisciplinary approach, particularly with those rare patients with refractory disease receiving small molecule inhibitors. However, the SEOM clinical guidelines have a number of inconsistencies that we honestly believe can be misleading. We would like to highlight the most important:

1. Regarding thyroid nodule management, the authors state that thyroid fine needle aspiration (FNA) cytology should be performed “when nodule bigger than 1 cm and/or low TSH...” On the contrary, in the initial evaluation of a patient with a thyroid nodule, if the serum TSH is low, a radioactive iodide (RAI) thyroid scan should be performed prior to FNA to document whether the nodule is hyperfunctioning or not. Since hyperfunctioning nodules are rarely malignant, if one is found that corresponds to the nodule in question, no cytological evaluation is necessary.
2. The sentence mentioned above ends as follows “...or radiological signs of suspect” We suppose the authors are referring to suspicious ultrasonography (US) findings because other radiological techniques such as CT scan are not routinely used in the initial evaluation of thyroid nodules. Suspicious US features of thyroid cancer are well established in the literature and mainly consist of microcalcifications, hypoechoic, increased nodular vascularity, infiltrative margins and taller than wide on transverse view. When two or more of these features are present no matter the size of the nodule a cytological evaluation is required. Thus, US findings provide valuable information and should be reflected in the guidelines.
3. A very important aspect in thyroid cancer management and one of the most challenging is the cytopathological interpretation of FNA samples. These guidelines do not cover this issue at all.
4. It is inaccurate to say that lobectomy may be considered in “unilateral lesions”. Does this mean that a unilateral tumour larger than 4 cm should be treated initially with a lobectomy? If so, the risk of recurrence will surely increase significantly and completion thyroidectomy will be needed thereafter. On the other hand, there is evidence supporting that microcarcinomas (<1 cm) with low-risk, unifocal,

intrathyroidal papillary carcinomas may be treated with thyroid lobectomy alone (provided the absence of risk factors such as prior head and neck irradiation or radiologically or clinically involved cervical nodal metastases). Finally, both the American and the European guidelines strongly recommend total thyroidectomy for patients with thyroid cancer ≤ 1 cm because it significantly improves recurrence and survival rates.

5. The follow up recommendations are incomplete and need to be updated. Follow-up for thyroid cancer patients should be based mainly on TSH-suppressed thyroglobulin (Tg) and cervical US, followed by TSHstimulated serumTg measurement if the TSH-supressed Tg is undetectable. In fact, the best definition of successful thyroid ablation is an undetectable serum Tg level following TSH stimulation and normal neck US. Diagnostic whole body RAI scans are no longer necessary for low risk patients (the majority) and it may be of value for patients with intermediate- or high-risk, though this recommendation is based on expert opinion and is still under debate. Additionally, Tg antibodies should be assessed with every measurement of serum Tg, as high levels of Tg antibodies may interfere with Tg determination.

Finally, it is our intention to be constructive and all of our suggestions are based on the recent and comprehensive Revised American Thyroid Association Guidelines for the management for Thyroid Nodules and Differentiated Thyroid Cancers published in 2009 as well as on the Consensus Guidelines of the European Thyroid Association published in 2006. Controversy still exists in some areas including the most appropriate approach for the diagnostic evaluation of a thyroid nodule, the extent of surgery for microcarcinomas and the use of RAI to ablate remnant tissue following thyroidectomy among others. As new advances appear in the future, we hope new clinical guidelines using principles of evidence-based medicine will improve the optimal care for patients with thyroid cancer.