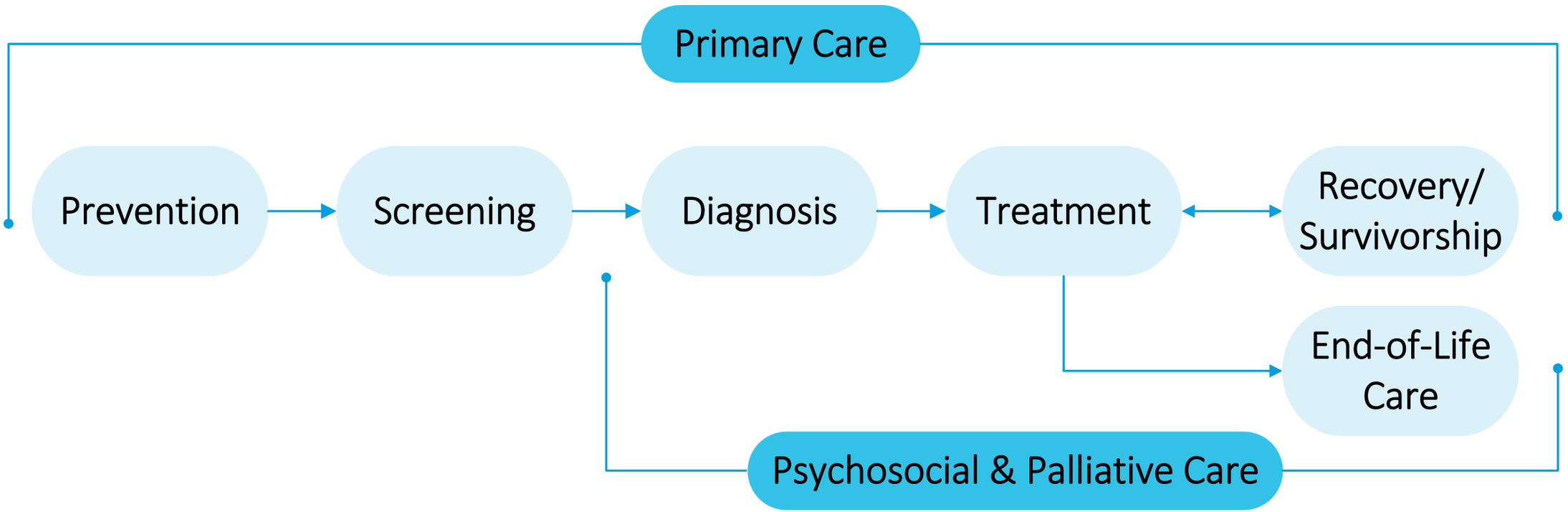
Thyroid Cancer Treatment Pathway Map

Version 2024.10



Ontario Health
Cancer Care Ontario

Target Population

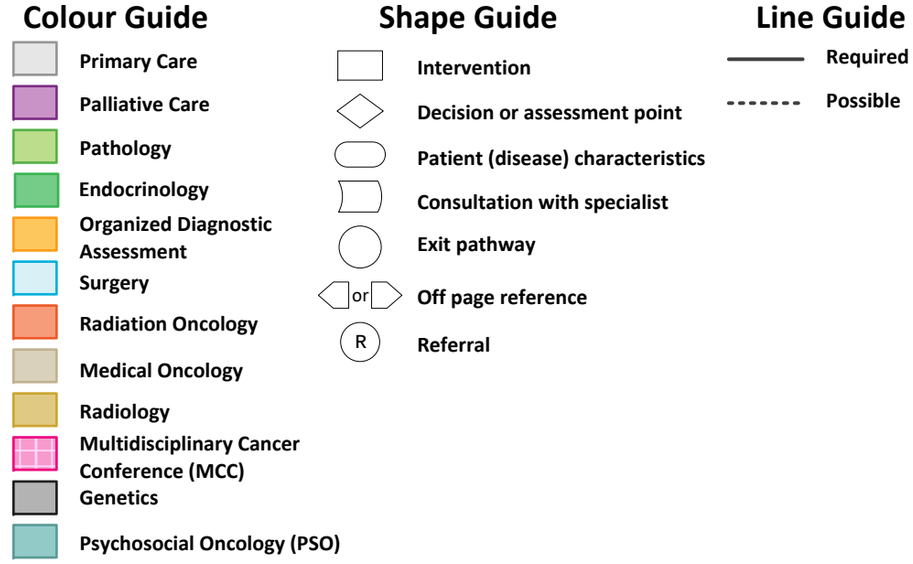
- Patients with a confirmed thyroid cancer diagnosis who have undergone the recommended diagnostic and staging procedures outlined in the **Thyroid Cancer Diagnosis Pathway**.

Pathway Map Considerations

- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, Health811 is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see Person-Centered Care Guideline and EBS #19-2 Provider-Patient Communication.*
- Hyperlinks are used throughout the pathway map to provide information about relevant Ontario Health (Cancer Care Ontario) tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, and emergency physicians.
- In Ontario, various specialties have taken on an expanded role in the management of differentiated thyroid cancers. Throughout the pathway, specialist referrals imply a physician with specific expertise in that particular aspect of the management of thyroid cancer.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on Multidisciplinary Cancer Conferences, visit MCC Tools.
- For more information on wait times in Ontario, visit Wait Times.
- Clinical trials should be considered for all phases of the pathway map.
- Sexual health should be considered throughout the care continuum. Health care providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See Psychosocial Oncology Guidelines Resources.
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), health care providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See Ontario Fertility Program.
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit EBS #19-3.*
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness: Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care – including restorative or rehabilitative care – or may become the total focus of care. Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient's overall approach to care.

* **Note. EBS #19-2 and EBS #19-3** are older than 3 years and are currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

Pathway Map Legend



Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a health care provider, the reader should always consult a health care provider if they have any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Ontario Health (Cancer Care Ontario) and the reader.

While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an "as-is" basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information's quality, accuracy, currency, completeness, or reliability.

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Staging of Papillary and Follicular Thyroid Carcinoma

Age <55 years old			
Stage I	Any T	Any N	M0
Stage II	Any T	Any N	M1

Age ≥55 years old			
Stage I	T1a,T1b,T2	N0	M0
Stage II	T3	N0	M0
	T1-3	N1	M0
Stage III	T4a	Any N	M0
Stage IVA	T4b	Any N	M0
Stage IVB	Any T	Any N	M1

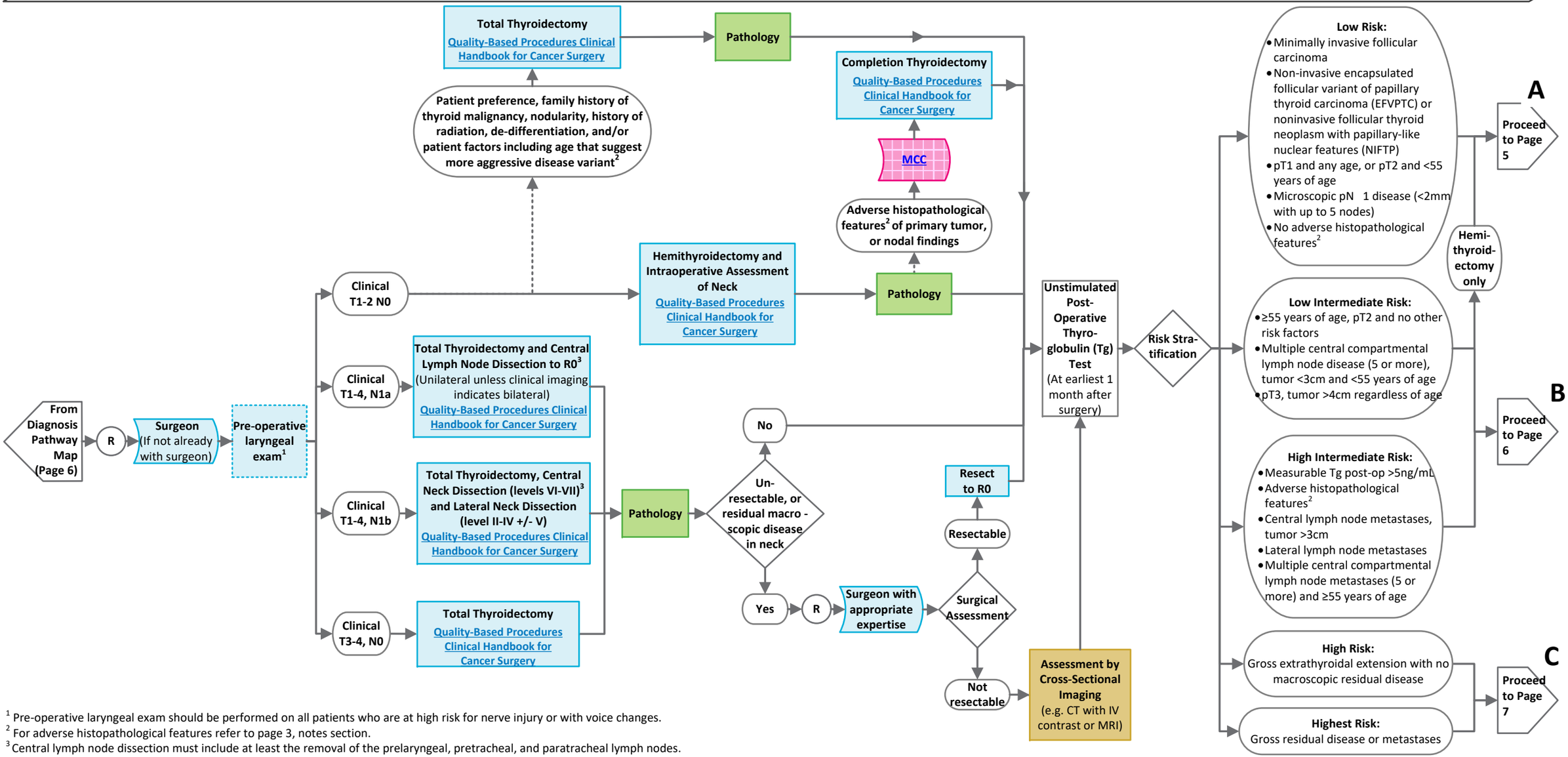
AJCC Cancer Staging Manual 8th edition
UICC The TNM Classification of Malignant Tumours, 8th Edition

Pathway Map Notes

- Conversion factor for Tg ng/mL to pmol/L: 1 ng/mL Tg = ~1.515 pmol/L
- When measuring Thyroglobulin (Tg), include measurement of Thyroglobulin antibodies as well
- Adverse histopathological features: angioinvasion (excluding lymphatic invasion), tall cell (>30%), hobnail cell (>30%), columnar cell change in >30% of tumor, solid growth (>30%), widely invasive growth, any level of dedifferentiation, intrathyroidal psammmatous

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider palliative care needs, early and across the care journey. Click here for more information about palliative care



[1] Pre-operative laryngeal exam should be performed on all patients who are at high risk for nerve injury or with voice changes.
[2] For adverse histopathological features refer to page 3, notes section.
[3] Central lymph node dissection must include at least the removal of the prelaryngeal, pretracheal, and paratracheal lymph nodes.

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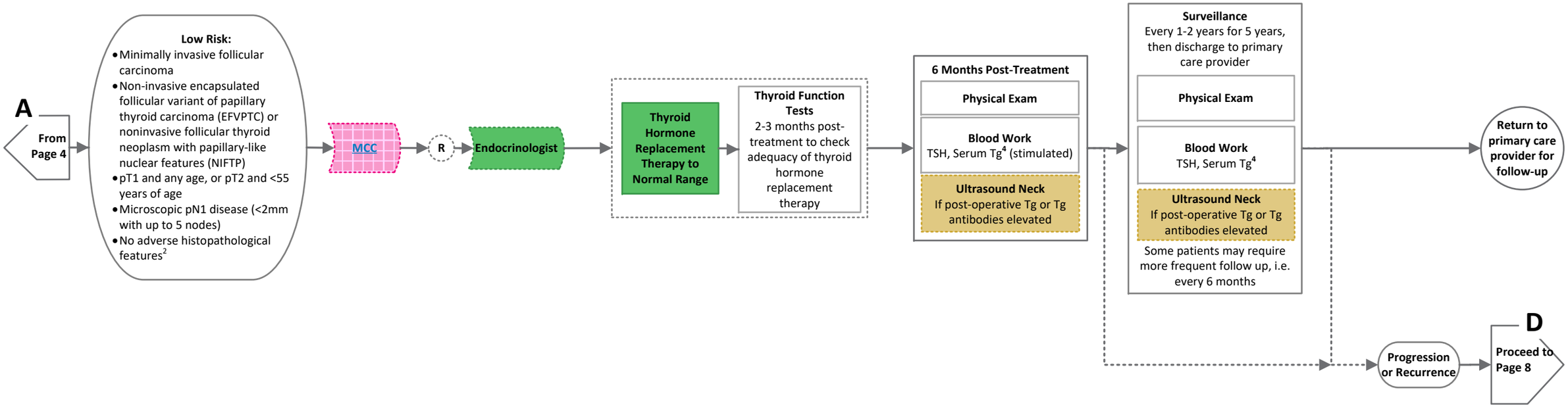

[2] For adverse histopathological features refer to page 3, notes section.
[4] Serum Tg has little value in patients treated with less than total thyroidectomy.

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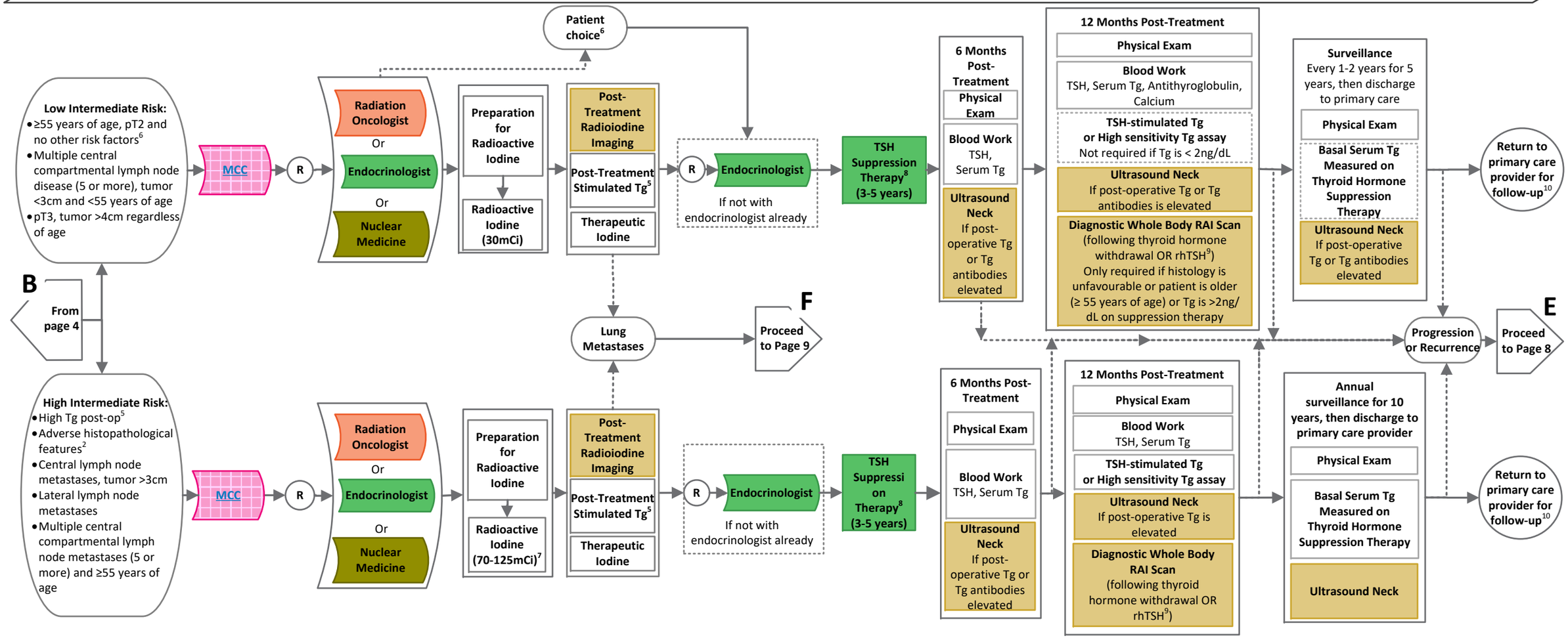

[2] For adverse histopathological features refer to page 3, notes section.
[5] Tg level is assay dependent. Classifications may vary by center.
[6] Upon careful discussion, patient may opt to not receive radioactive iodine, or patient who had hemithyroidectomy only and will therefore not have RAI.
[7] Appropriate radioactive iodine dosage should be proportional to risk. The high intermediate risk group is heterogenous, which warrants a broad range of appropriate dosages. 30 mCi may be appropriate for limited adverse histological features.
[8] Both the level and duration of TSH suppression is dependent on assessment of potential benefit, patient factors and risks. Initial TSH suppression should be within 0.1-0.5mIU/L for intermediate risk, <0.1mIU/L may be considered for higher risk.
[9] Recombinant TSH is provincially not funded but can be accessed in place of thyroid hormone withdrawal if patient is insured, over the age of 65, or pays out of pocket. Recombinant TSH should be utilized if possible.
[10] Recommend: Annual or biennial neck exam, TSH, thyroglobulin, antithyroglobulin, and calcium as indicated. If there is a new lump(s) or swelling in the neck area, persistent neck pain, change in voice or swallowing or rising thyroglobulin, US of neck and referral back to specialist are to be considered.

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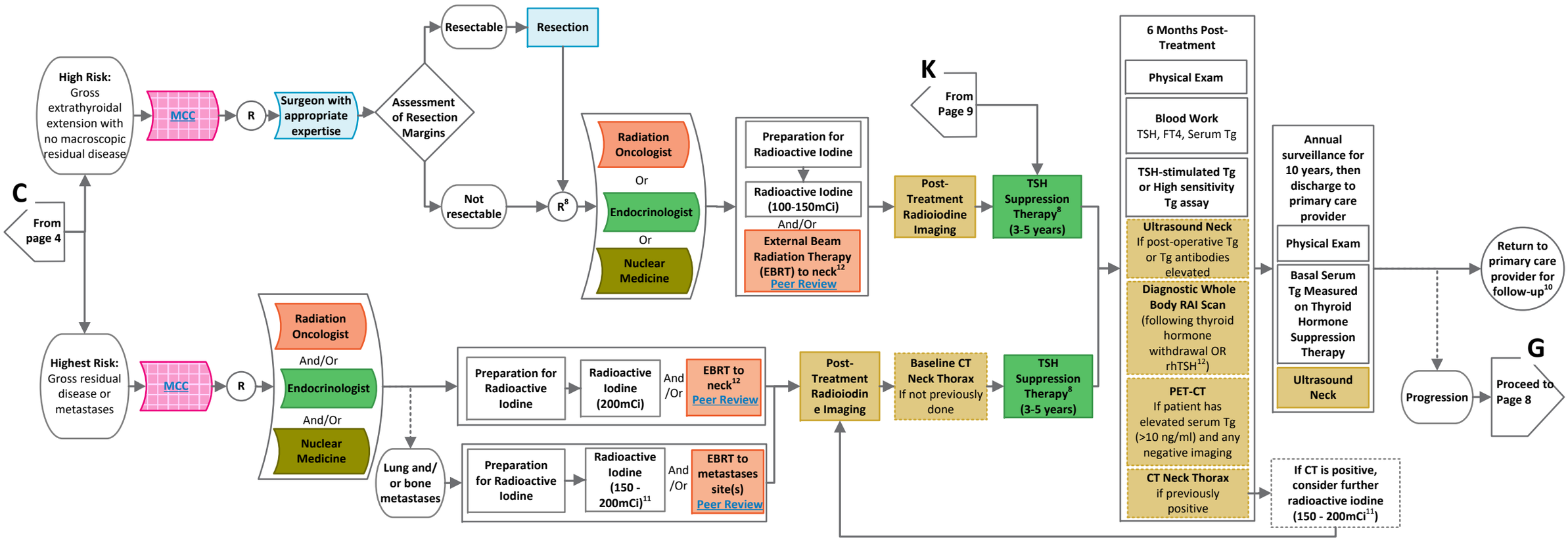

[8] Both the level and duration of TSH suppression is dependent on assessment of potential benefit, patient factors and risks. Initial TSH suppression should be within 0.1-0.5mIU/L for intermediate risk, <0.1mIU/L may be considered for higher risk.[12] Recombinant TSH is provincially not funded but may have been performed in the place of thyroid hormone withdrawal if patient is insured, is over the age of 65, or patient paid out of pocket. Recombinant TSH should be utilized if possible.

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[11] In presence of lung metastases, consider age, number of lesions, and risk for fibrosis when determining RAI dosage. Avoid >150mCi for over patients over 70; a dosage of 150mCi should be considered for older patients and those with higher risk of fibrosis, and a dosage of 200mCi should be considered for young, healthy patients with a greater number of lesions. Qualify with a glomular filtration rate (GFR) Test.

[12] Patient receiving EBRT should be referred to a Registered Dietitian and Speech Language Pathologist.

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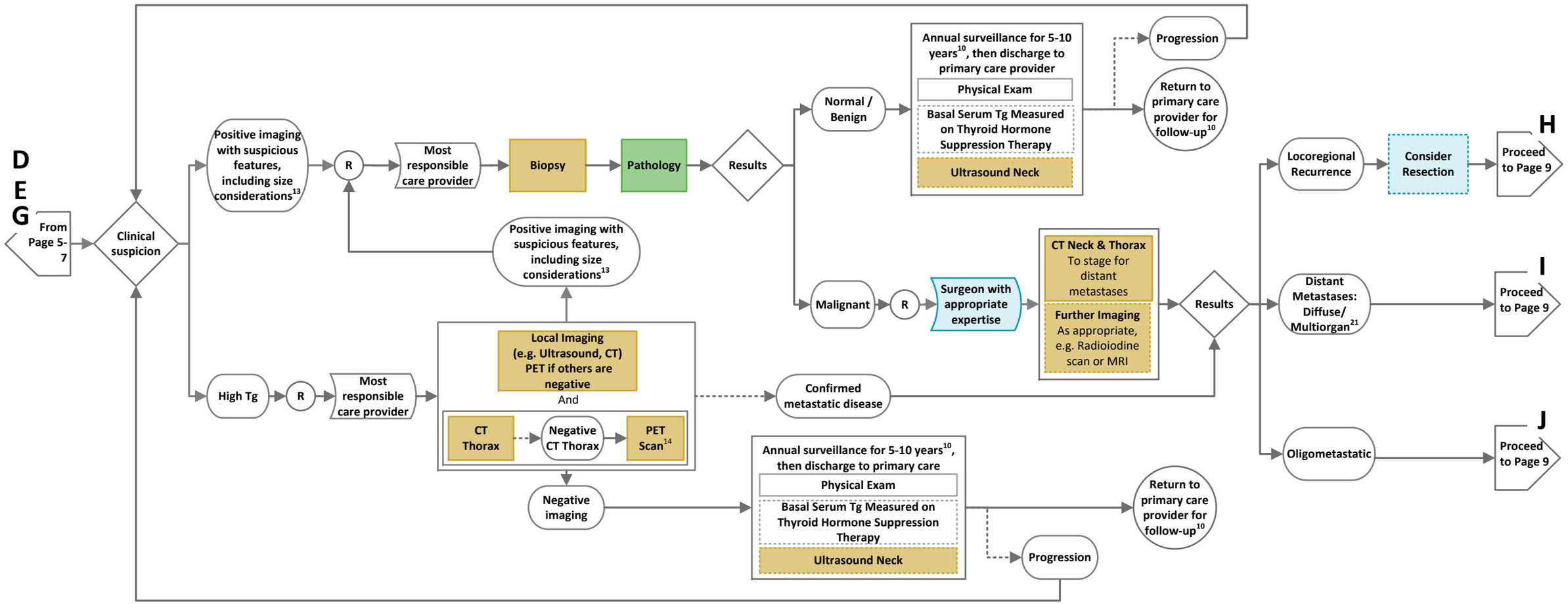

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[13] Suspicious features that warrant nodal biopsy:
- On ultrasound: rounded shape, hypoechoic, cystic, small foci of calcification, or central necrosis
- On CT: rounded shape, enhancement, cystic, small foci of calcification, or central necrosis
- Size: size is **only** of consideration if there are suspicious features present**,** there is no need to biopsy on size alone. In presence of suspicious features, biopsy is recommended if the shortest dimension in the axial plane is >8mm.

[14] Indications for PET Scan include: recurrent or persistent disease suspected on the basis of an elevated and/or rising thyroglobulin level(s) but standard imaging studies, including I-131 scan and/or neck ultrasound, are negative or equivocal.

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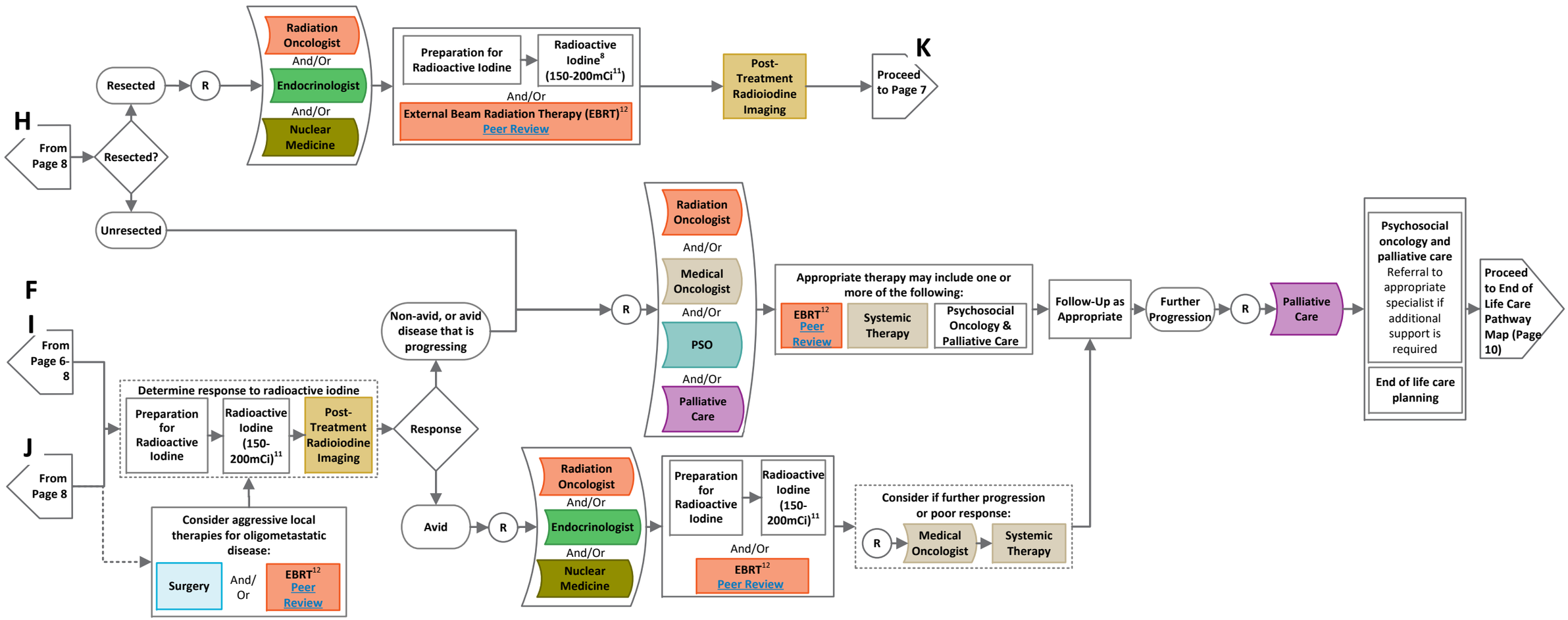

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[12] Patient receiving external beam radiation therapy (EBRT) should be referred to a Registered Dietitian and Speech Language Pathologist.

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Pathway Map Target Population:

Individuals with cancer approaching the last 3 months of life and their families.

While this section of the pathway is focused on the care delivered at the end of life, palliative care should be initiated much earlier in the illness trajectory. In particular, providers can introduce a palliative approach to care as early as the time of diagnosis.

Triggers that suggest patients are nearing the last few months and weeks of life

- Eastern Cooperative Oncology Group (ECOG) Performance Status/Patient-ECOG/Patient Reported Functional Status (PRFS) = 4
  OR
- Palliative Performance Scale (PPS) ≤ 50
- Declining performance status/functional ability

Screen, Assess, Plan, Manage and Follow Up

+

End of Life Care planning and implementation
Collaboration and consultation between specialist-level care teams and primary care teams

+

Conversations to determine where care should be provided and who will be responsible for providing the care

End of Life Care

☐ **Key conversations to revisit Goals of Care and to discuss and document key treatment decisions**

- Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
- Explore the patient's views on medications, tests, resuscitation, intensive care and preferred location of death
- If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment
- Review Goals of Care and patient preferences regularly, particularly when there is a change in clinical status

☐ **Screen for specific end of life psychosocial issues**

- Assess and address patient and families' loss, grief and bereavement needs including anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Provide appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and make referrals to available resources and/or specialized services to address identified needs as required
- Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

☐ **Identify patients who could benefit from specialized palliative care services (consultation or transfer)**

- As patient and family/caregiver needs increase and/or change over time consult with palliative care specialists and/or other providers with additional expertise, as required. Transfer care only if/when needs become more extensive or complex than the current team can handle
- Discuss referral with the patient and their family/caregiver

☐ **Proactively develop and implement a plan for expected death**

- Explore place-of-death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic
- Prepare and support the family to understand what to expect, and plan for when a loved one is actively dying, including understanding probable symptoms, as well as the processes with death certification and how to engage funeral services
- Discuss emergency plans with patient and family (including who to contact, and when to use or avoid Emergency Medical Services)

☐ **Home care planning (if this is where care will be delivered)**

- Contact the patient's primary care and home and community care providers and relevant specialist physicians to ensure an effective transfer of information related to their care. If the patient is transitioning from the hospital, this should include collaborating to develop a transition plan
- Introduce patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.)
- Connect with home and community care services early (not just in the last 2-4 weeks)
- Ensure resources and services are in place to support the patient and their family/caregiver, and address identified needs
- Anticipate/plan for pain and symptom management, including consideration for a Symptom Response Kit to facilitate access to pain, dyspnea, and delirium medication for emergency purposes
- If the patient consents to withholding cardiopulmonary resuscitation, A 'Do Not Resuscitate' order must be documented in their medical record, and a Do Not Resuscitate Confirmation (DNR-C) Form should be completed. This form should be readily accessible in the home, to ensure that the patient's wishes for a natural death are respected by Emergency Medical Services

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Patient Death

At the time of death:

- ☐ Pronouncement of death
- ☐ Completion of death certificate
- ☐ Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- ☐ Implement the pre-determined plan for expected death
- ☐ Arrange time with the family for a follow-up call or visit
- ☐ Provide age-specific bereavement services and resources
- ☐ Inform family of grief and bereavement resources/ services
- ☐ Initiate grief care for family members at risk for complicated grief
- ☐ Encourage the bereaved to make an appointment with an appropriate health care provider as required

Bereavement Support and Follow-Up

- ☐ Offer psychoeducation and/or counseling to the bereaved
- ☐ Screen for complicated and abnormal grief (family members, including children)
- ☐ Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief

Provide opportunities for debriefing of care team, including volunteers