

Position Paper on Management and Shared Decision-making in Patients with Low-risk Micro Papillary Thyroid Carcinoma from the Endocrine Task Force of the European Organization for Research and Treatment of Cancer

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Abstract

Globally, there has been an increase in the incidence of differentiated thyroid cancer (DTC), primarily due to an increase in the incidental discovery of micro papillary thyroid carcinomas (microPTCs), many of which may have received unnecessary treatment based on the unchanging mortality rate. A less combative strategy has been recommended by several international guidelines. Active surveillance or minimally invasive therapies (MIT) have lately been proven to be effective alternatives for the management of these individuals. Participation of the patient in the decision-making process is crucial in this situation. The European Organization for Research and Treatment of Cancer's Endocrine Task Force (EORTC) has taken on the task of reaching agreement and defining its position based on the scientific evidence regarding 1) the current state of diagnostic and management options in microPTCs, including the current opinion of physicians regarding shared decision making (SDM), 2) the available evidence concerning patients' needs and the available decision instruments, and 3) to provide useful suggestions for implementing SDM in this context. Knowledge gaps and future research directions were emphasized in order to increase SDM and patients' participation [1-4].

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Introduction

The most prevalent endocrine cancer is differentiated non-medullary thyroid carcinoma (DTC). Over the past few decades, DTC has become more common throughout the world, partly as a result of increasing diagnostic scrutiny and easier access to imaging and monitoring. Papillary thyroid carcinoma (PTC), a histologic type characterised as a slow-growing indolent tumour with an excellent prognosis and a low mortality rate, makes up the majority of these, frequently incidental findings, and malignant lesions. One-centimeter intrathyroidal tumors, also known as low-risk micro papillary thyroid carcinomas (microPTCs), make up about half of these. Papillary micro carcinomas that are larger than 1 cm should be subtyped in detail, according to the 2022 WHO classification, which also advises against classifying them as a subtype of PTC. Therefore, PTCs with a size of

less than 1 cm, a known BRAF, TERT, or RET mutation, and no other concerning characteristics such extrathyroidal extension, aggressive histology, vascular invasion, lymph node, or distant metastases are considered low-risk microPTCs in this study (6). Other histological types of micro carcinoma, such as follicular and oncocytic thyroid micro carcinomas will not be covered in this paper because they are extremely uncommon and there are not enough studies comparing the effectiveness of various management approaches for these tumors [5-8].

This paper aims to present the current state of diagnostic and treatment approaches towards microPTCs, including the current opinion of doctors regarding SDM, the available evidence concerning patients' needs and the available decision instruments, and to provide practical suggestions based on the available evidence, which can aid clinicians managing patients

with microPTC. Additionally, for DTC patients in general and for microPTC patients in particular, knowledge gaps and research initiatives will be emphasized in order to promote SDM and improve patient participation and empowerment. The members of the European Organization for Research and Treatment of Cancer's (EORTC) Endocrine Task Force (ETF) understand how critical it is to address these problems.

Additionally, they offer a perfect setting for designing and carrying out prospective studies that compare various treatment techniques for low-risk patients, as well as for conducting research to raise awareness of the significance of the SDM process in the care of patients with microPTC. In order to improve the care for patients with microPTC in terms of doctor-patient communication, information provision, patients' participation in the decision-making process about their treatment, and patient empowerment, the EORTC ETF is also helpful in customising the decision-making process in a country/culture-specific manner [9-10].

In November 2021, the committee issued an invitation to all EORTC ETF specialists in thyroid cancer to contribute to the position paper. Four endocrinologists (AK, ER, RN-M, CD), one researcher (PS), one molecular pathologist (MB), two surgeons (MD, EN-D), one nuclear medicine specialist (ML), three oncologists (PO, CF, LDL), one expert in developing DA instruments and SDM (PSt), and one expert in using and evaluating innovative tools in healthcare (RH) were among the participants.

The participants came from seven different European nations several clinical criteria have been described for choosing patients who are suitable for various treatments. According to the Japan Association of Endocrine Surgery and the ETA, active surveillance and MIT therapy can both be taken into account in low-risk microPTC (11, 17). The Japan Association of Endocrine Surgeons opposes active surveillance in patients with microPTC who have a potentially more aggressive clinical phenotype based on cytology (such as tall cell variant PTC), for tumours along or invading the RLN, for tumours adherent to or invading the trachea, and in patients under the age of 20. The latter due to a lack of information on outcomes for this age group.

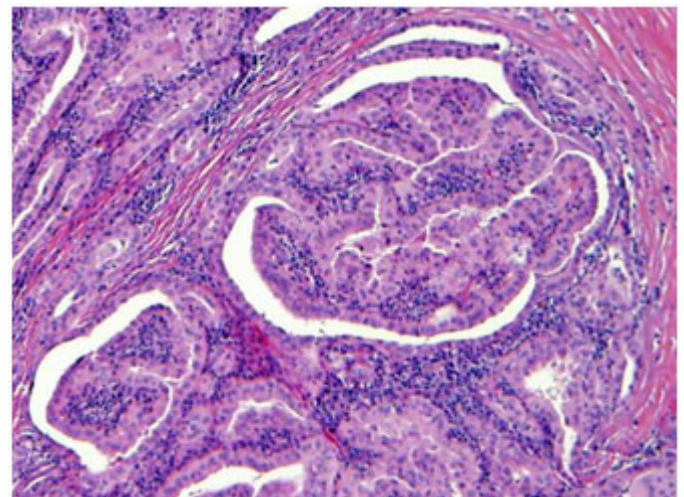
Moreover, patients are not eligible for active surveillance when surgery is necessary for coexisting thyroid or parathyroid disorders. The ETA guidelines state that patients with multifocality or cytologically or molecularly concerning characteristics (such as the existence of a TERT promoter and TP53 mutations) shouldn't be considered for MIT therapy. Additionally, the presence of extrathyroidal extension, subcapsular, posterior, or paratracheal localization, as well as youth, do not favour MIT therapy. Therefore, it is important to critically evaluate the risks of potential overtreatment in terms of an imbalance between benefits, risks, patient distress and anxiety, and medical costs when weighing the various treatment options. A major objective of cancer care has been the early detection of certain cancers.

It is challenging to change the public's preference for early-stage diagnosis and treatment due to the dissemination of this thinking. Reduce the amount of low-risk tumour diagnoses in Europe due to the challenge of preventing overtreatment of low-risk thyroid cancer. This presents a significant obstacle when promoting

a tactic like active surveillance. Active surveillance is a secure and effective treatment for carefully chosen microPTC patients, according to the current clinical trials efficient alternative for therapy. However, even 14–17 years after their diagnosis, 48% of thyroid cancer survivors reported continuing to worry about a recurrence, according to Hedman et al. The researchers also noted that 89% of the survivors claimed that the condition had no impact on how they perceived life both observed that the majority of the patients were anxious. Clinical professionals also express discomfort with the notion of active surveillance, citing a lack of faith in the calibre of the literature, a conviction that patients will respond better to surgical therapy, and worry about the potential emergence of metastatic disease.

Despite these trials, recently demonstrated that about 75% of research participants preferred active surveillance to surgery. In a study of patients who underwent active monitoring, Davies et al. found that 83% of respondents thought it was the best choice, and 60% of respondents reported their fears subsided with time. The results reported above were also verified in a recent. Throughout the investigations, participants who had the choice of active surveillance or surgery overwhelmingly opted for the more conservative course of action, with a range of 70-84% (Figure 1).

The quality of life (QOL) of patients who underwent urgent surgery and those who received active surveillance was compared in a number of studies. For instance, reported that the active surveillance group experienced psychological issues in daily life less frequently than the group that underwent TL patients with microPTC who underwent TL had more health issues and the immediate surgery group had the highest incidence of adverse events conducted a multicenter, longitudinal research reported superior baseline psychological health and follow-up physical and mental health in the active surveillance group. Patients in the surgery group had more complaints and were more anxious and depressed than those in the active surveillance group, according to findings from respectively MIT therapy is an additional therapeutic approach that can significantly enhance patients' quality of life (QOL). It has the same satisfactory therapeutic effects but little post-operative trauma.



Studies contrasting patients who received MIT therapy with those who had urgent surgery revealed that those who received MIT therapy had a higher quality of life (80). For instance, individuals who received MIT therapy had fewer physical and psychological issues; according patients did not express greater concern about the disease's progression. Despite the fact that SDM is generally preferred by patients and doctors, there is paucity of information regarding the diagnosis and care of patients with microPTC.

For individuals with microPTC who have additional therapy options with comparable oncologic outcomes, applying SDM is crucial. Patients with microPTC who were offered this option and chose the non-surgical route reported less anxiety and a higher quality of life examining the requirements and preferences of microPTC patients. Understanding the requirements and preferences of patients, as well as what is most appropriate in the given environment, is crucial when addressing available and potential treatment choices for those with microPTC (55). Recent studies used online questionnaires to conduct a discrete choice experiment to determine the preferences of patients with low-risk papillary thyroid carcinoma.

For instance, demonstrated the value of effective patient-physician communication in helping patients comprehend the

advantages and disadvantages of various surgical procedures already discussed the importance of a solid doctor-patient connection in 2019. As a crucial component of SDM, compared the patient-physician relationship to that of a traveler (the patient) and their guide (the physician a decision should be made with the patient's experience in mind, avoiding unnecessary surgery to avoid uncommon but serious adverse effects.

Furthermore, it is essential to notify the patient about active surveillance before the biopsy sample is obtained so that they can comprehend this information without feeling frightened. The main element encouraging patients to continue with surveillance was retention and consistency of follow-up. According to research, renaming small PTCs as micro carcinomas may help patients feel less anxious and consider less invasive management options. In contrast described the attitudes and beliefs of patients and doctors regarding the management and overtreatment of microPTC emphasized the patients' decision-making process more. Explicit patient preference discussions will be essential for achieving value-based treatment (89). Potentially, a more patient-centered, value-based approach could also aid in reducing pointless therapies that might damage patients or spend resources ineffectively.

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