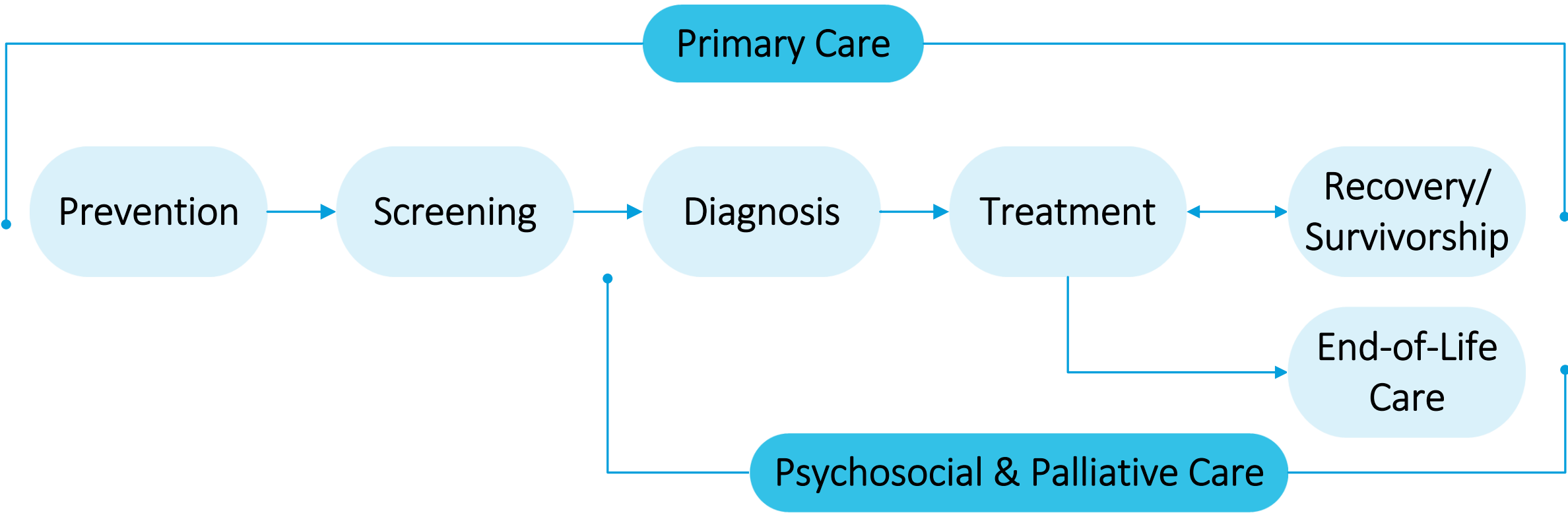


Thyroid Cancer Treatment Pathway Map

Version 2024.10



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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

Primary Care

Palliative Care

Pathology

Endocrinology

Organized Diagnostic Assessment

Surgery

Radiation Oncology

Medical Oncology

Radiology

Multidisciplinary Cancer Conference (MCC)

Genetics

Psychosocial Oncology (PSO)

Intervention

Decision or assessment point

Patient (disease) characteristics

Consultation with specialist

Exit pathway

Off page reference

Referral

Required

Possible

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.

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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

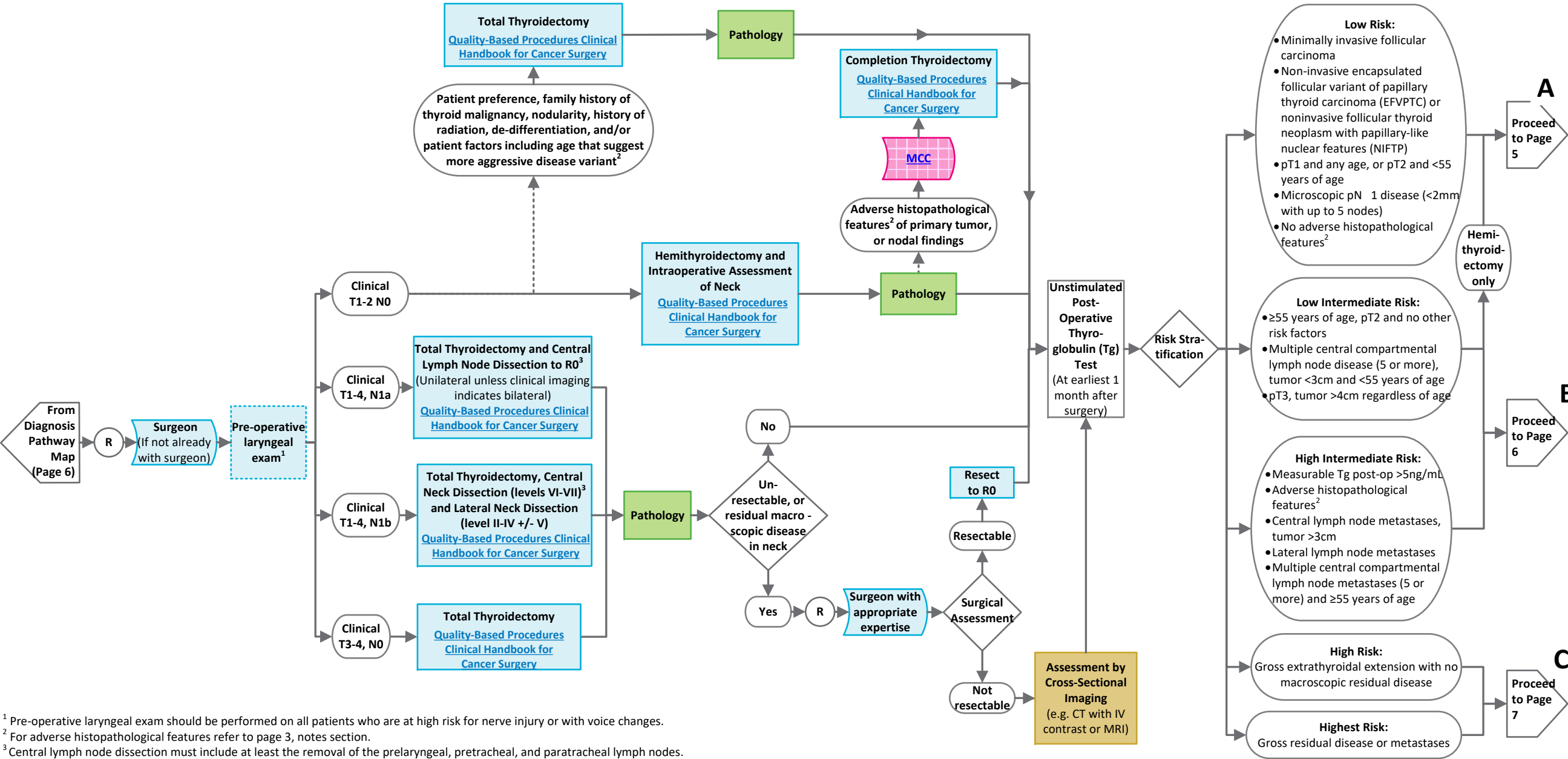
Pathway Map Notes

- 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 psammomatous

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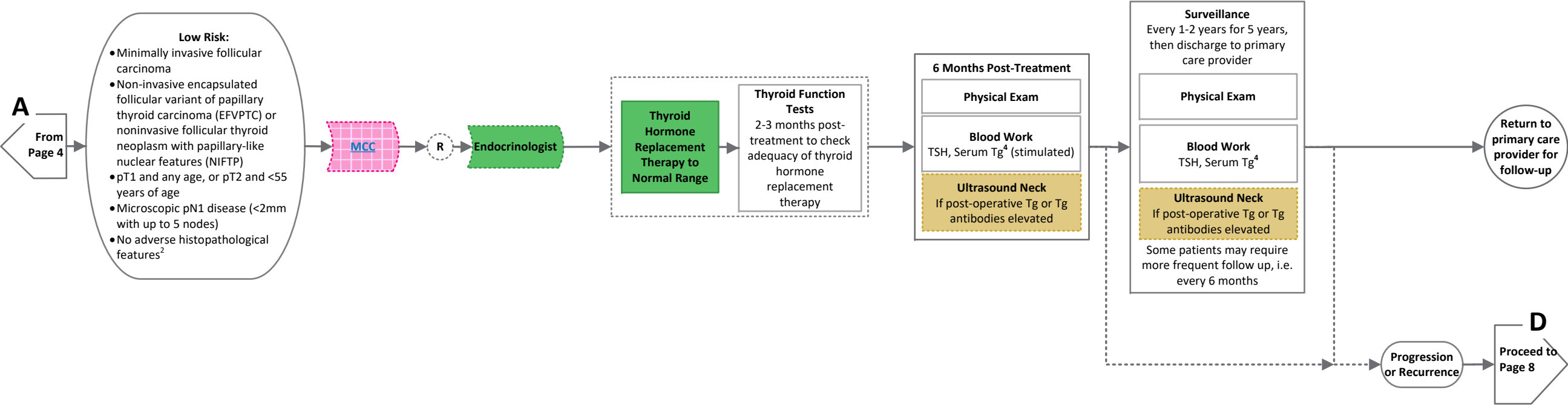


¹ Pre-operative laryngeal exam should be performed on all patients who are at high risk for nerve injury or with voice changes.
² For adverse histopathological features refer to page 3, notes section.
³ Central lymph node dissection must include at least the removal of the prelaryngeal, pretracheal,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

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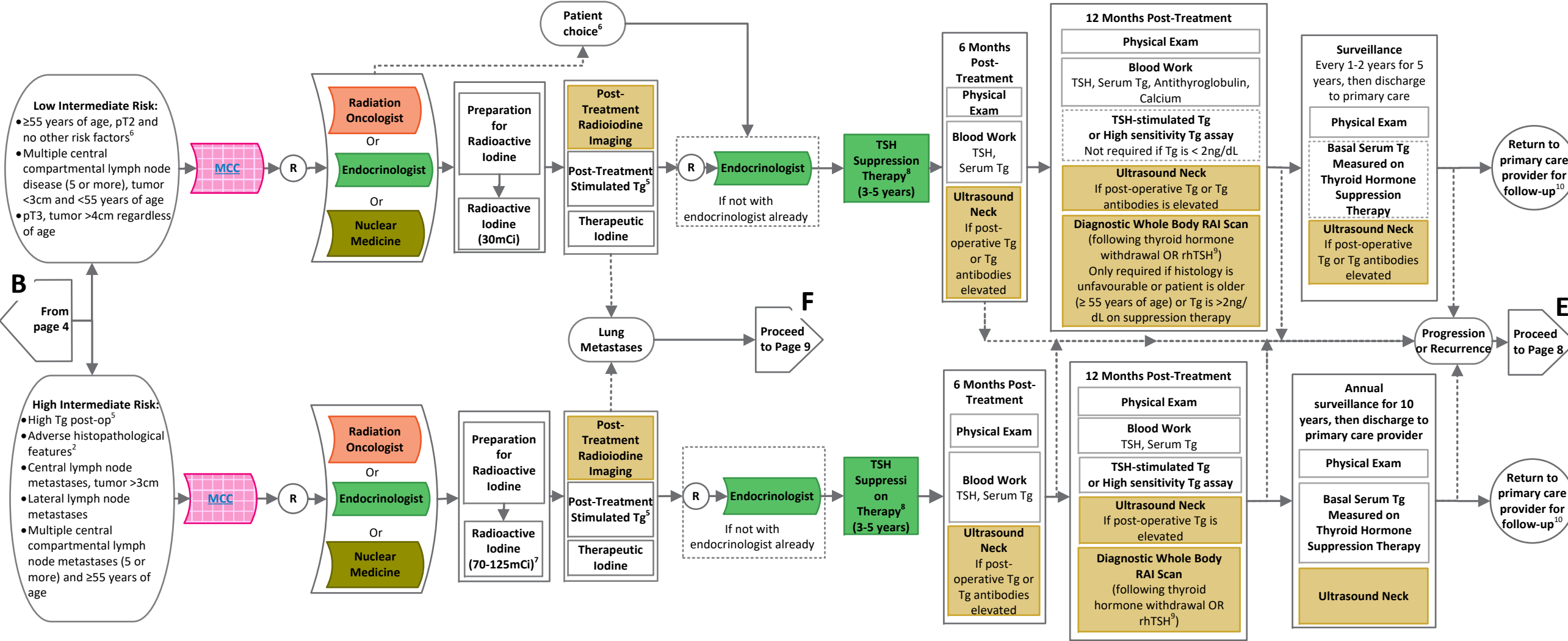


² For adverse histopathological features refer to page 3, notes section.
⁴ Serum Tg has little value in patients treated with less than total thyroidectomy.

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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.

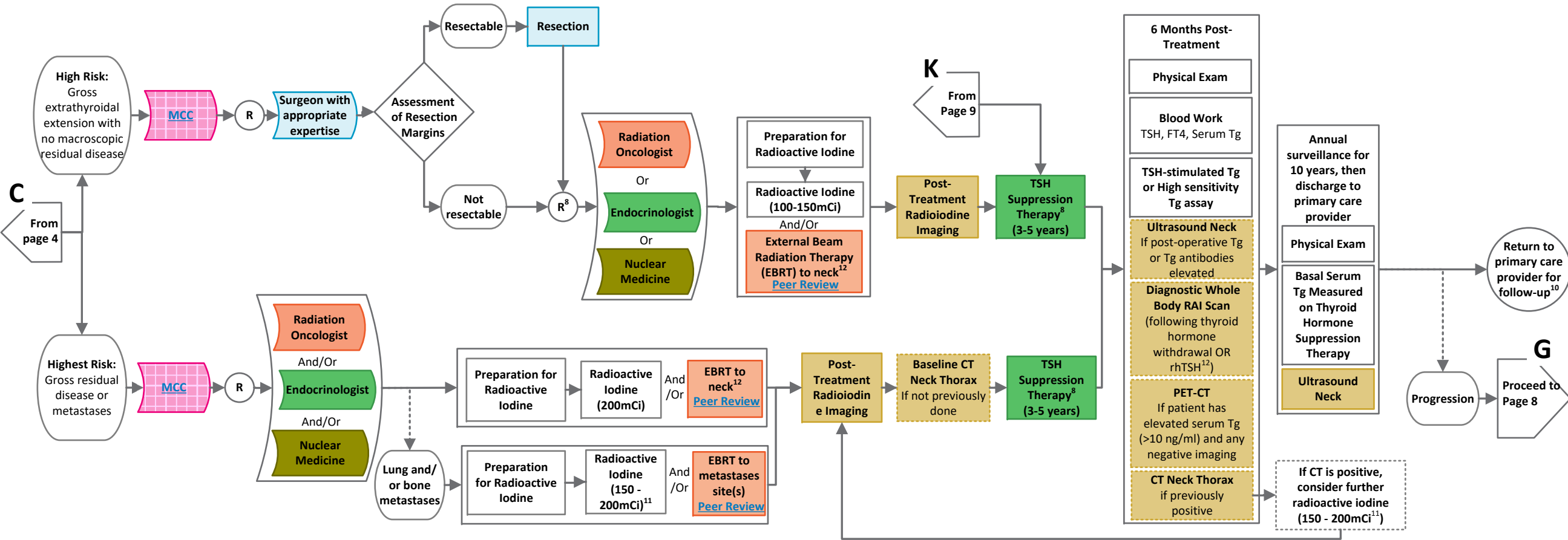
⁹ Recombinant TSH is provincially not funded but can be accessed in place of thyroid hormone withdrawal if patient is insured, over the age of 65, or pays out of pocket. Recombinant TSH should be utilized if possible.

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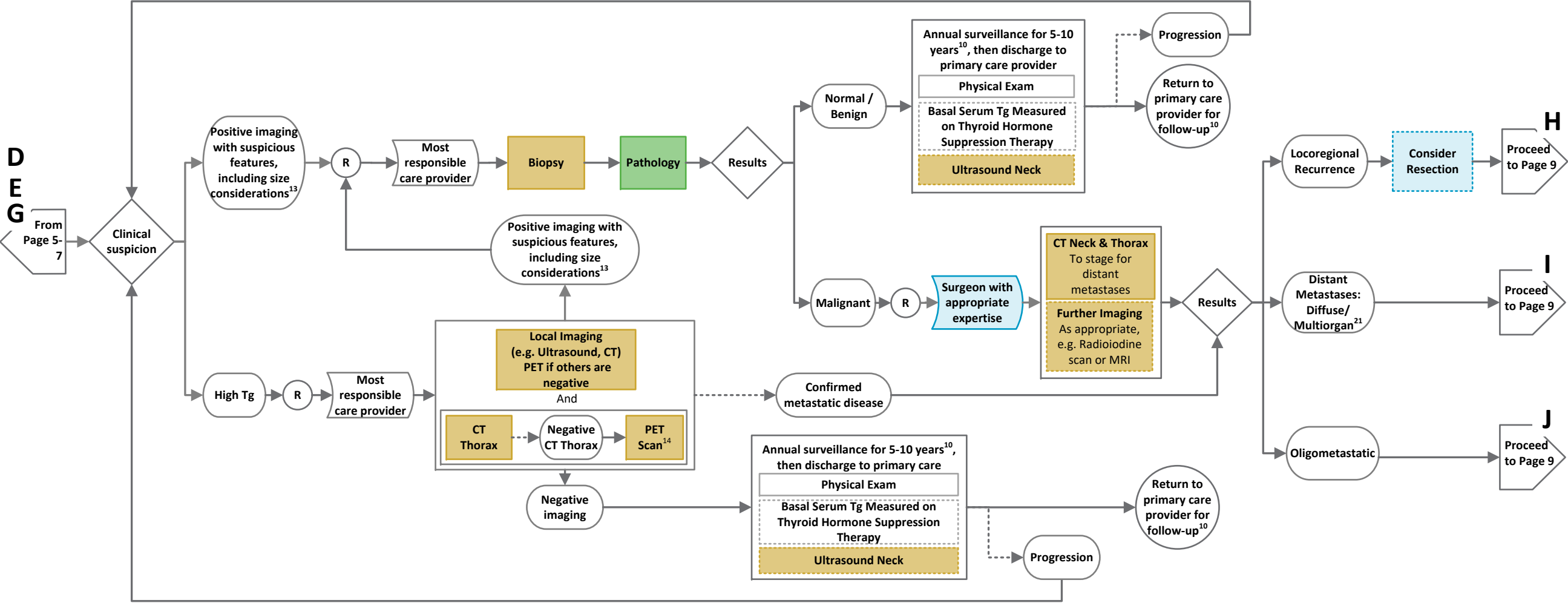
¹¹ In presence of lung metastases, consider age, number of lesions, and risk for fibrosis when determining RAI dosage. Avoid >150mCi for over patients over 70; a dosage of 150mCi should be considered for older patients and those with higher risk of fibrosis, and a dosage of 200mCi should be considered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

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

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¹³ Suspicious features that warrant nodal biopsy:

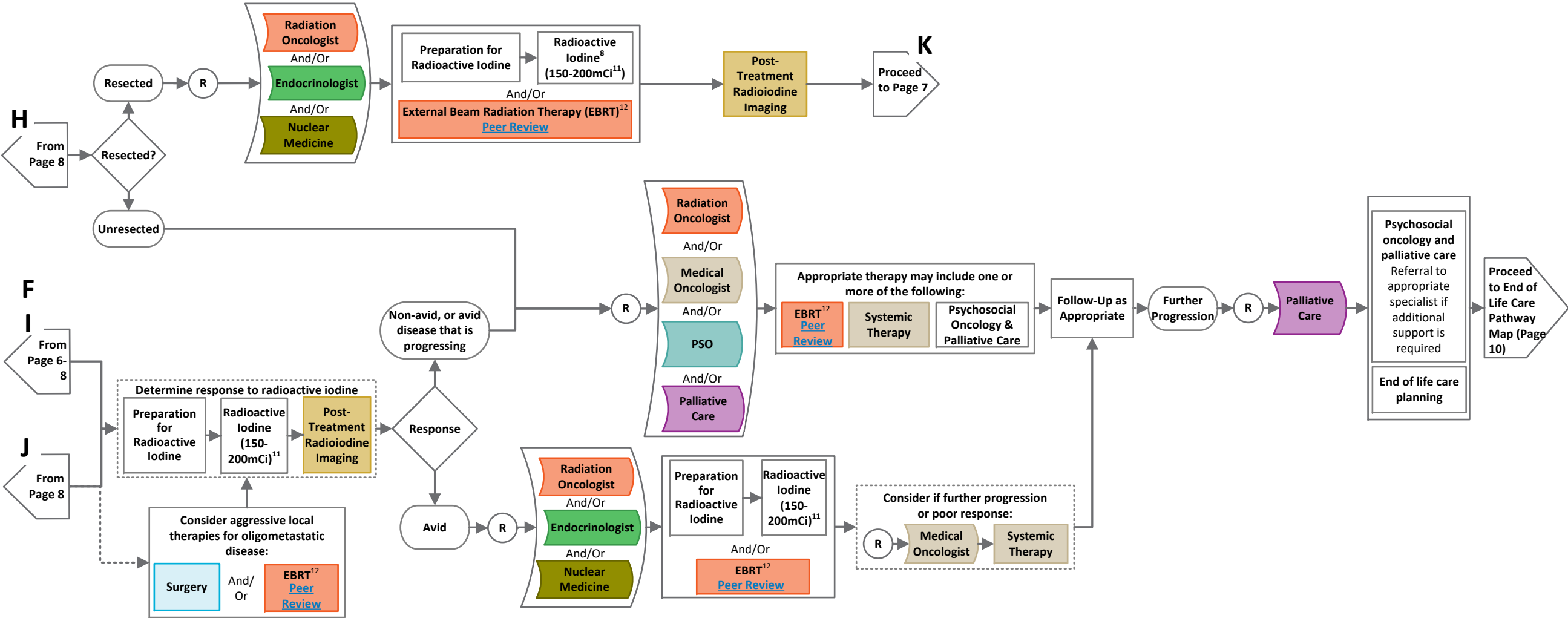
- On ultrasound: rounded shape, hypoechoic, cystic, small foci of calcification, or central necrosis
- On CT: rounded shape, enhancement, cystic, small foci of calcification, or central necrosis
- Size: size is **only** of consideration if there are suspicious features present, there is no need to biopsy 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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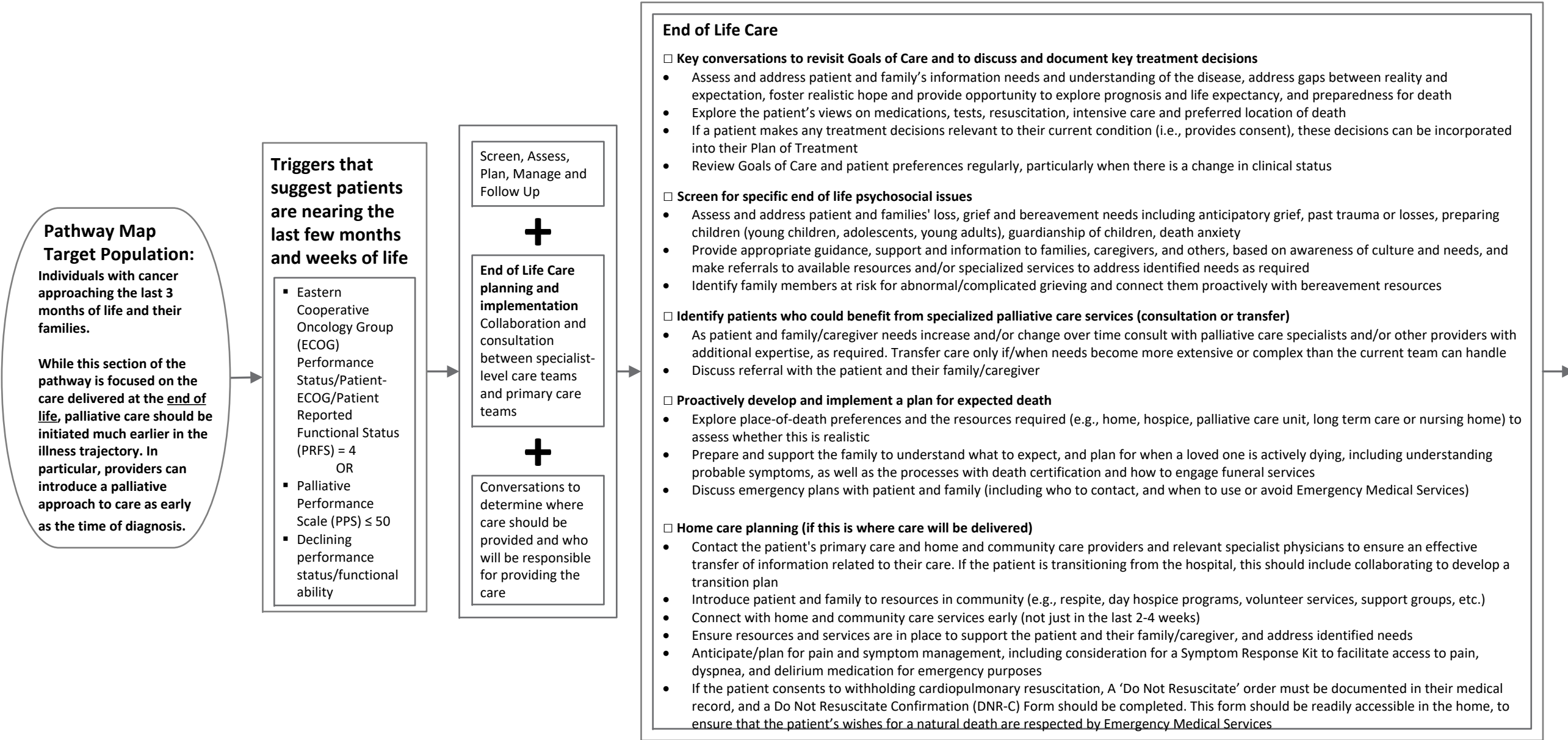
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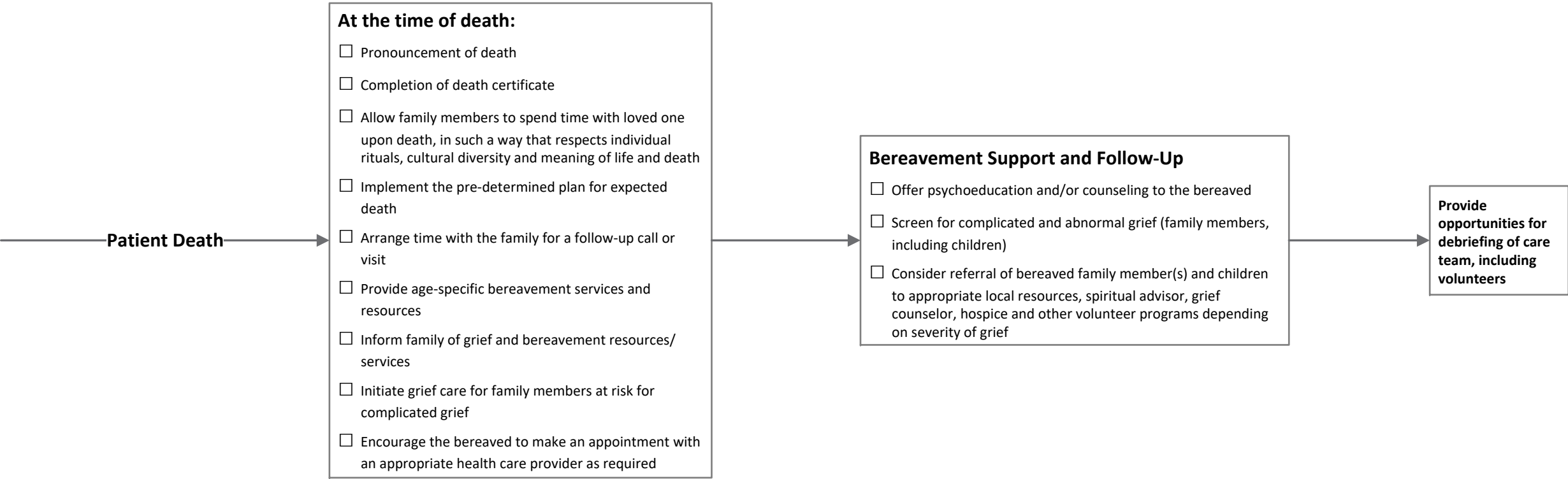
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