Survivorship – Thyroid Cancer (Includes Papillary, Follicular, and Medullary Carcinoma)

Disclaimer: *This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.*

ELIGIBILITY

Thyroid Cancer after completion of treatment[1]

CONCURRENT COMPONENTS OF VISIT

- **SURVEILLANCE**
- **MONITORING FOR LATE EFFECTS**
- **RISK REDUCTION/ EARLY DETECTION**
- **PSYCHOSOCIAL FUNCTIONING**

→ See Page 2

SURVEILLANCE

Low Risk[2] →

Years 2-5: (may be transitioned to Survivorship if Low Risk criteria met[2]):
- History and physical exam annually
- Annual labs: TSH, free T4, and either
  - Thyroglobulin **or** calcitonin and CEA
- Neck ultrasound annually

Years 6 and up:
- History and physical exam annually to year 10, then every 2 years
- Annual labs: TSH, free T4, and either
  - Thyroglobulin **or** calcitonin and CEA
- Neck ultrasound every 3-5 years

Moderate Risk[2] →

Years 4-10 (may be transitioned to Survivorship if Moderate Risk criteria met[2]):
- History and physical exam annually
- Annual labs: TSH, free T4, and either
  - Thyroglobulin **or** calcitonin and CEA
- Neck ultrasound every year until year 5, then every 2 years until year 10

Years 11 and up:
- History and physical exam annually to year 20, then every 2 years
- Annual labs: TSH, free T4, and either
  - Thyroglobulin **or** calcitonin and CEA
- Neck ultrasound every 3 years

High Risk[2] →

Years 6 and up: (may be transitioned to Survivorship if High Risk criteria met[2]):
- History and physical exam annually
- Annual labs: TSH, free T4, and either
  - Thyroglobulin **or** calcitonin and CEA
- Ultrasound annually
- Chest x-ray as clinically indicated

DISPOSITION

Positive findings[3]?

- Yes → Return to primary treating physician
- No → Continue survivorship monitoring

[1] Patients followed and managed in Acute Care Clinic prior to transition to Survivorship

[2] **Low Risk:** Well differentiated neoplasm of uncertain potential, Noninvasive Follicular Thyroid Neoplasm with Papillary (NIFTP), T1 N0 M0, no evidence of disease (thyroglobulin ≤ 1 or calcitonin ≤ 5; no suspicious lymph nodes or thyroid bed lesions by ultrasound) at 1 year

Moderate Risk: T1N1 M0, T2-4 N0-1 M0, no evidence of disease (thyroglobulin ≤ 1 or calcitonin ≤ 5; no suspicious lymph nodes or thyroid bed lesions by ultrasound) at 3 years

High Risk: T2-4 N0-1 M0, stable minimal evidence of disease (thyroglobulin ≤ 5 or calcitonin ≤ 50; no suspicious lymph nodes or thyroid bed lesions or stable subcentimeter lesions by ultrasound) at 5 years

[3] Positive findings: • Enlarging nodules by ultrasound > 1 cm • Rising tumor markers • Biopsy or confirmed recurrence • New evidence of metastases

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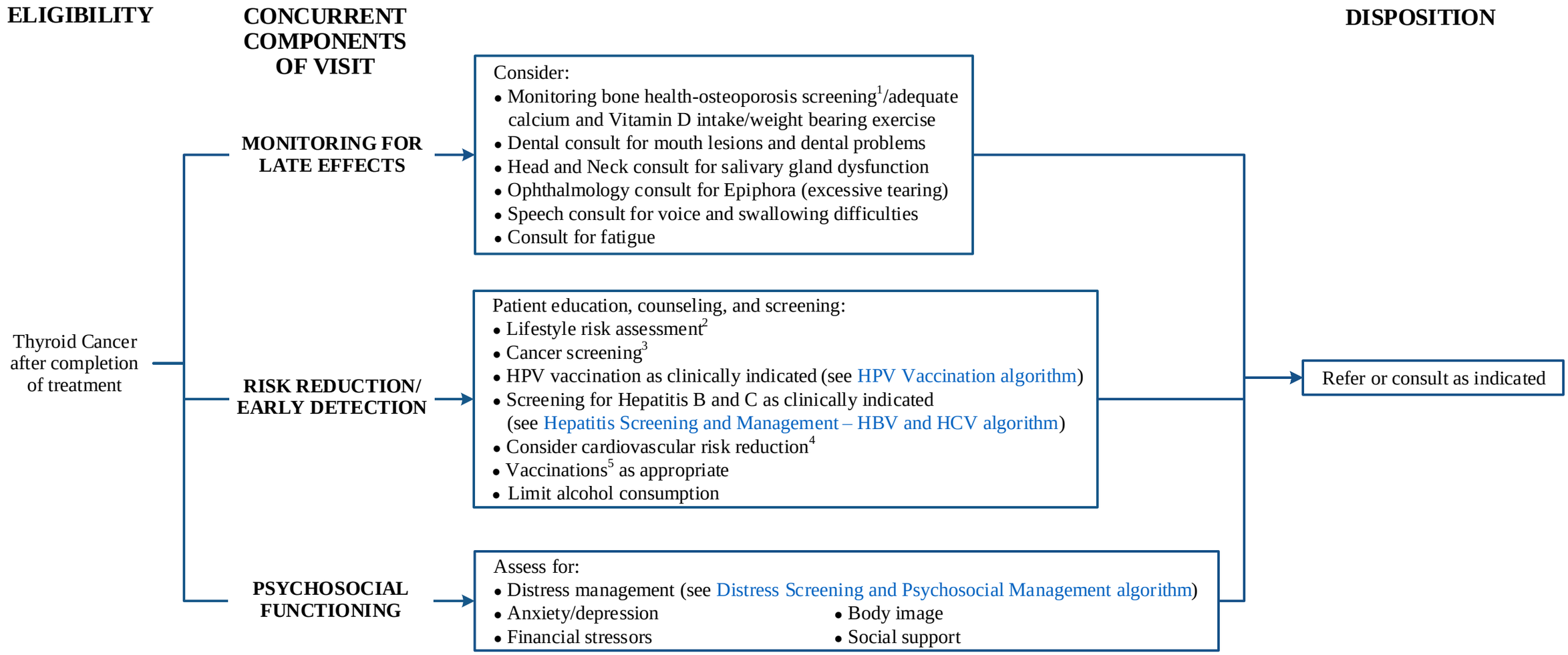

[1] Recommend osteoporosis screening based on the National Osteoporosis Foundation Clinician's Guide 2014 and consider earlier screening as clinically indicated
[2] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[3] Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate and skin cancer screening
[4] Consider use of Vanderbilt's ABCDE's approach to cardiovascular health
[5] Based on Centers for Disease Control and Prevention (CDC) guidelines

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SUGGESTED READINGS

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DEVELOPMENT CREDITS

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