NHS

Kent and Medway Cancer Collaborative

Thyroid Tumour Site Specific Group meeting Tuesday 4th March 2025 Park View Meeting Room, Mercure Great Danes Hotel, Ashford Road, Maidstone. ME17 1RE 09:30 - 12:30
Final Meeting Minutes

Present	Initials	Title	Organisation
Chris Theokli **(Chair)**	**CT**	Consultant ENT Thyroid Surgeon	EKHUFT
Nicola Chaston	**NCh**	Consultant Cellular Pathologist & Associate Medical Director for Diagnostics	EKHUFT
Eranga Nissanka-Jayasuriya	**ENJ**	Consultant Head & Neck Histopathologist	EKHUFT
Vikram Dhar	**VD**	ENT / Head and Neck Consultant Surgeon	EKHUFT
Susan Honour	**SH**	Macmillan Lead Head & Neck and Thyroid CNS	EKHUFT
Elizabeth Hall	**EH**	Principal Clinical Scientist, Clinical Biochemistry	EKHUFT
Amy Organ	**AO**	MDT Co-ordinator	EKHUFT
Ali Al-Lami	**AAL**	Consultant ENT / Head & Neck Surgeon	EKHUFT
Muhammad Eraibey	**ME**	Consultant Radiologist	EKHUFT
Bharath Jayaram	**BJ**	Consultant Radiologist	EKHUFT
Gemma McCormick	**GMc**	Consultant Oncologist	MTW
Julian Hammond	**JH**	Consultant Surgeon	MTW
Mary Boyle	**MP**	Consultant Pathologist	MTW
Luisa Roldao Pereira	**LRP**	Advanced Clinical Practitioner	MTW
Miles Pope	**MP**	MDT Co-ordinator	MTW
Dennis Baker	**DB**	Consultant Radiologist	MTW
Jonathan Bryant	**JB**	Clinical Lead / GP	KMCA / NHS Kent & Medway ICB
Karen Glass	**KG**	PA & Business Support Manager	KMCA & KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams **(Minutes)**	**SW**	Administration & Support Officer	KMCC
Navdeep Upile	**NU**	Consultant Otolaryngologist Head and Neck Surgeon	MFT & QVH
Adam Gaunt	**AG**	Consultant ENT Surgeon	MFT
Maria Acosta	**MA**	Consultant Physician in Nuclear Medicine	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT

Amy Cass	**AC**	Cancer Pathway Co-ordinator	MFT
Debbie Hannant	**DH**	Macmillan Head & Neck CNS	MFT
Ahmed Elaktaie	**AE**	Consultant Radiologist	MFT
Iain Nixon	**IN**	Consultant ENT Surgeon	NHS Lothian/Edinburgh
Apologies			
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Abbie Smith	**AS**	Macmillan Head & Neck & Thyroid CNS	EKHUFT
Edmund Lamb	**EL**	Consultant Clinical Scientist/Clinical Director of Pathology	EKHUFT
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Pippa Enticknap	**PE**	Deputy General Manager - Cancer, Clinical Haematology & Haemophilia	EKHUFT
Alistair Balfour	**AB**	Consultant ENT, Head & Neck and Thyroid Surgeon	EKHUFT
Joanne Bailey	**JBa**	Early Diagnosis Programme Manager	KMCA
Joanne Jackson	**JJ**	Early Diagnosis Project Manager	KMCA
Emma Lloyd	**ELl**	Cancer Pathways Improvement Manager	KMCA
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
Ann Courtness	**ACo**	Primary Care Nurse Facilitator	KMCA
Anju Kulkarni	**AK**	Consultant Clinical Geneticist	GSTT
John Schofield	**JS**	Consultant Pathologist	MTW
Nadine Caton	**NCa**	Consultant ENT	MTW
Supriya Joshi	**SJ**	Consultant Pathologist	MTW
Bindu George	**BG**	Head & Neck CNS	MTW
Joanne Patterson	**JP**	Lead Clinical Trials Pharmacist	MTW
Gowri Ratnayake	**GR**	Consultant Endocrinologist	MFT
Annaselvi Nadar	**AN**	Matron – Faster Diagnosis	MFT
Hayley Martin	**HM**	PCS Facilitator	MFT
Helen Graham	**HG**	Research Delivery Manager	NIHR
Charmaine Walker	**CW**	Cancer Performance Manager	DVH

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**Apologies**		

		• The formal Apologies are listed above. **Introductions** • CT welcomed the members to today's face to face meeting and the group introduced themselves. • If you attended this meeting and are not captured on the attendance list above please contact Samantha.williams23@nhs.net directly and the distribution list will be amended accordingly. **Review previous minutes** • The final minutes from the previous meeting which took place on the 6th September 2024 were reviewed and agreed as a true and accurate account of the meeting. **Review Action Log** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting.		
2.	**Evolving Surgical Management of Differentiated Thyroid Cancer**	**Presentation provided by Iain Nixon (Guest Speaker)** • The presentation provided an overview of the following :- • Content i) Historical Perspective ii) Recent Progress iii) Future Directions • Disclaimer • The Distant Past – The Era of the Surgeon		**Presentation circulated to the group on Wednesday 5th March**

- Early 20th Century

  i) Recognition of potential fatal consequences
  ii) Unclear how best to avoid
  iii) Surgery was risky
  iv) Disease was unpredictable
  v) Pre-operative Imaging and Biopsy were unavailable
  vi) Variability in practice

- The Past – The Era of Nuclear Medicine
- US Airforce, 1940's Job Opportunities in Nuclear Medicine

- Role of Radioactive Iodine

  i) Remarkable effects demonstrated in patients with advanced incurable cancer
  ii) Role in management of lower risk patients unclear

- The Recent Past – The Era of Endocrinology
- Ernest Mazzaferri (1936 – 2013)

- Papillary Thyroid Carcinoma – the impact of therapy in 576 patients

- Extent of Surgery Affects Survival for Papillary Thyroid Cancer – Recurrence Difference 2.2% at 10 years. Survival Difference 1.3% at 10 years.

- One size fits all – All patients with disease >1cm require – Total thyroidectomy and Radioactive Iodine.

- Rise of the international guideline

- Why this might be a problem – Complications – Nerve Injury TT 4% v TL 2% - Hypocalcaemia (permanent 2.2% TT)

		• First Time Total Thyroidectomy and First Time Thyroid Surgery Graphs • Nerve Injury Rate Unclear and 0% Surgery Breakdown 1930 - 2005 • Not all groups agreed and arguments against • Risk Stratification in WDTC • Differentiated Thyroid Cancer – Prognostic Factors and Survival • MACIS – 1987. Low risk patients had no improvement in survival from total thyroidectomy • Alternate View – Proper risk stratification and low risk patients derive no benefit from aggressive treatment • Aggressive v Conservative Approach for Low Risk Patients • World Map – What makes this even more important? The Status Quo. What went wrong with the message? • Managing Thyroid Cancer and AJCC Staging 8th Ed. • Risk of Structural Disease Recurrence • The Present – the Era of the MDT and Personalised Decision Making • Updated Guidelines – Softening of Approach • Aggressiveness of Treatment • BTA Guidelines – Slow Progress • Real Life Practice in Edinburgh and Decision Making • Variation in UK Practice • Discussed and Undiscussed Risk Factors in Thyroid Cancer • Increasing Evidence Base • Problems associated with Lobectomy • What is changing? • Conclusions NU stated there is variability across the patch with 2 MDT's in East and West Kent. IN believes there is decreasing concrete indications for aggressive surgery and according to NICE guidelines the follow up is for 5 years, 4 (or more) is the magic number for multi-focality.		
3.	**Dashboard**	**<u>Update provided by Chris Theokli</u>** • CT went through the Live Dashboard and encouraged everyone to register in order to gain		**Data Pack circulated to the group on**

		access. • There was a discussion around the figures but there was scepticism. CT suggested that members feed this back to David Osborne, highlighting the lack of data and to query figures with him. **Action – AW to send the Dashboard Link to everyone.**		**Friday 28th February** **AW**
4.	**Clinical Reference Group Discussions**	**<u>Update provided by Chris Theokli</u>** • CT advised that the Thyroid CRG had been set up and now meet monthly. Representatives for the CRG Meeting have been agreed and CT welcomed suggestions to discuss at the next CRG.		
5.	**Thy3 Data Outcomes**	**<u>Presentation provided by Adam Gaunt</u>** • The presentation provided an overview of the following :- • Introduction i) Thyroid cancer is a common endocrine malignancy, increasing in incidence. ii) Indeterminate thyroid nodules (Thy3f/Bethesda IV) present a diagnostic challenge. iii) Standard management with diagnostic surgery may lead to unnecessary surgery. iv) Conservative management is an alternative approach, but its safety is unclear. • Purpose of the Study i) Determine the safety of conservative management for indeterminate thyroid nodules. ii) Assess clinical features associated with benign vs malignant pathology. iii) Provide evidence to guide decision making on surgery vs monitoring. • Methods		**Presentation circulated to the group on Wednesday 5th March**

		i) Retrospective cohort study (2013 – 2016) at a single centre. ii) Included 164 patients with Thy3f cytology. iii) Data collected demographics, ultrasound features, follow-up details, histology in surgical cases. iv) Statistical analysis conducted to identify risk factors for malignancy. • Results Overview i) 164 patients had Thy3f cytology. ii) 132 (80.5%) underwent surgery, 32 (19.5%) were initially managed conservatively. iii) Of the conservative group, 4 later chose surgery (all had benign pathology). iv) 26 of 134 surgical cases (19.4%) were malignant. • Findings - Conservative Management i) 28 patients remained on conservative management. ii) Median follow-up – 27 months (IQR – 16-40). iii) No significant disease progression observed. iv) 1 patient had a minor nodule increase (4mm) but no clinical concern. • Findings- Surgical Management i) 26 of 134 (19.4%) had malignant pathology. ii) Larger nodules (>40mm) were more likely malignant (p=0.042). iii) No significant association with age, gender or ultrasound classification. iv) 10 malignant cases had no high-risk features (age>55, male, nodule >40mm). • Risk Factors for Malignancy • Differences between Surgical and Conservative Management Groups. • Discussion i) Conservative Management appears safe in selected cases with no progression over short to medium term.		

		ii) Some unnecessary surgeries may be avoided. iii) Nodule size (>40mm) maybe a key predictor of malignancy. iv) There is a need for further research and possible randomised controlled trials. • Conclusions i) Conservative management of Thyf3 nodules is feasible and safe in selected patients. ii) Surgery remains necessary for larger nodules and cases with clinical concerns. iii) More studies needed refine risk stratification and avoid over-treatment. AG remarked that Thyroid is a common cancer and rarely causes problems. CT stated that we should follow NICE Guidelines and offer surgery at Thy4. At EKHUFT and MFT Thy3a/Thy3f are kept on the cancer pathway. Thy3a are offered an alternate pathway at MTW. AO monitors the 31 day pathway as well as the cancer pathway. It was agreed by all that Thy3a is to be monitored by an alternative pathway.		
6.	**Thy 3a Outcomes**	**Presentation provided by Gemma McCormick** • The West Kent Thy3a Experience (October 2023 – October 2024) presentation provided an overview of the following :- • West Kent Data - 86 patients with Thy3a (1 patient with bilateral Thy3a) • Repeat Biopsies/USS Graph – 54/86 had repeat USS • Repeat FNA Results Graph - Only Thy3f and the non-DTC neoplasm patients proceeded to surgery. Non-DTC – dx medullary thyroid ca. Thy3f - 3 benign on hemi. 2 pending. 1 lost to follow-up. • Core Results Graph - All 5 with papillary thyroid ca on core had confirmed papillary ca on hemi (pT1 to pT3b). Of the non-diagnostic who proceeded to surgery - 2/6 – malignancy, 1/6 benign, 3/6 awaiting results.		**Presentations circulated to the group on Wednesday 5th March**

		• No repeat BX Patients - 1.9mm Incidental papillary carcinoma, 30mm Follicular Carcinoma • All Surgical Patients - 27 had surgery, 10 had cancer, 12 had no cancer, 5 had results pending • Cancer Cases, listing Histology and U Grades • Benign Post Op (12) – U Grade and Repeat Bx Results **<u>Presentation provided by Chris Theokli</u>** • The Thy3a East Kent Experience (October 2023 – October 2024) presentation provided an overview of the following :- i) Number of Patients with a Thy3a cytology = 58 ii) NICE guidance = repeat iii) 28/58 had US FNAC repeated (48%) iv) Number of patients proceeding to Surgery = 33 (57% of all Thy3a) • Of the original Thy 3a which have surgery :- i) Total number of cancerous nodules = 7 (21%) ii) Number of incidental T1a PTC = 3 (excluded from statistical analysis as this is purely coincidental – nodule in question was benign. If included, then malignancy rate = 30%) • 7 Cancers were identified :- i) Follicular carcinoma: thy3f on repeat FNAC ii) PTC: thy3f on repeat iii) Follicular carcinoma: 66 mm iv) Medullary carcinoma: U5 v) Poorly differentiated carcinoma: U4 vi) PTC: U4/5 vii) PTC: U4		

		• High Risk Features - >U3, >40mm and Thy 3f+ • High Risk Features in Cohort :- i) 33 cases proceeding to theatre ii) 13 had high risk features iii) Of these 13 patients, 5 had cancer (38%) iv) Of the remaining 20 patients that were: thy3a (originally or repeat), U3, <40mm – none had cancer. • Agreed to take forward as a Thyroid TSSG – U3 / Thy3a < 4 cm – take the patient off the cancer pathway and place onto an alternate (P3 urgent) pathway which is monitored by the MDM coordinators, with the aim of operating on these patients within 3 months.		
7.	**Systemic Options in Metastic Thyroid Cancer**	**<u>Presentation provided by Gemma McCormick</u>** • The presentation provided an overview of the following :- • When to start treatment? i) Iodine Refactory ii) Disease is progressing rapidly iii) Disease is causing or is expected to imminently cause symptoms iv) In Anaplastic Thyroid Cancer • Differentiated Thyroid Cancer i) 1st Line – Lenvatinib or Sorafenib, RET – mutation carrier – Selpercatinib (as of February 2025 ii) 2nd Line – Lenvatinib or Sorafenib (if previous Selpercatinib), RET – mutation carrier Selpercatinib (as of February 2025) if previous Len or Sor.		**Presentation circulated to the group on Wednesday 5th March**

		• Lenvatinib and Sorafenib - Adverse Effects • Selpercatinib can be used in DTC or ATC or Medullary if a RET mutation is present. Selective inhibitor of RET Kinase. • Cabozantinib i) 1st Line for Non RET mutant MTC ii) Multi-kinase inhibitor – targets angiogenesis and metastic potential iii) Exam Trial – PFS 11.2m vs 4 in placebo group iv) Side effects – hand-foot syndrome, diarrhea, HTN and risk of fistualae • NTRK Fusion Mutation i) Entrectinib and Larotrectinib – NTRK Fusion Inhibitors ii) NTRK fusion creates a protein which activates cell grown pathways iii) 2-3% prevalence • BRAF Mutation i) 20-50% Anaplastic Thyroid Cancer ii) Enables Dabrafenib/Trametinib to be given neo-adjuvantly/adjuvantly/palliatively • Anaplastic Thyroid Cancer • References GM added that the treatments she provides are toxic and only carried out when disease is progressing rapidly.		
8.	**CNS Update - All Trusts**	**<u>EKHUFT</u>** • SH stated that EKHUFT are making progress with Stratified Follow Up – 10 patients active on the pathway and discharged over 100 patients.		

		• A Thyroid Support Group is needed as younger patients are struggling with their energy levels after having a total thyroidectomy. GM added that this is also happening in menopausal women. • Working on Treatment Summaries. **<u>MTW</u>** • LRP stated that Stratified Pathways are being carried out. Frustrated at SOP sign off with Oncology Governance. **<u>MFT</u>** • DH is using own clinic codes and working on setting up the Nurse Led Clinics, meeting in two weeks time to discuss how to take this forward. No CNS update was provided by QVH.		
9.	**Clinical Audit Updates**	• No update provided.		
10.	**Research Update**	**<u>Update provided by Maria Acosta</u>** **<u>Trial Updates</u>** HoT trial is doing well, 18 patients recruited so far, recruiting until July 2025. MOHS is going very well. INSPIRE trial, 1 patient recruited. **Action – MA to provide an update on Trials at next TSSG Meeting**		**MA**

11.	**AOB**	• AAL asked for a member to volunteer for the role of Audit Lead. **Action – CT to discuss the Audit Lead role at next CRG Meeting** • CT announced that AW was retiring in June 2025 and thanked her personally for all of her support over the years.		**CT**
12.	**Next Meeting Date**	• Date in September 2025 (preferably a Wednesday) to be agreed in collaboration with the Head & Neck TSSG meeting which is taking place later today.		