

Short Communication



Patient Choice and Adherence to Active Surveillance for Low-risk Thyroid Cancer

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Conflict of Interest

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ABSTRACT

Currently, treatment decisions for low-risk micro thyroid cancer (TC) are arguably some of the most challenging in thyroidology. Active surveillance has emerged as an important option for low-risk micro TC. Multiple patient and physician factors affect the final selection, adherence to active surveillance or definitive conservative surgery. While baseline clinical criteria are used to identify candidates for this approach, it is important to identify and understand other forces that may influence the management of low-risk micro TC with active surveillance.

Keywords: Decision making; Patient compliance; Physician-patient relations; Thyroid neoplasms

Active surveillance (AS) is a way of monitoring localised (early) thyroid cancer (TC), rather than treating it straight away (1). If the patient goes on AS, he or she will have regular tests to check on the TC (2). The patient won't have any treatment unless these tests show that TC may be growing, or patient decide for treatment, thus the patient will avoid or delay the side effects of treatment. If there are signs TC may be growing, the patient will be offered treatment that aims to cure cancer (3).

It might seem strange not to have treatment, but localised TC often grows slowly — if at all — and may have a low risk of spreading. So it may never cause patient any problems or affect how long patient live. Many subjects on AS will never need treatment. We read with interest the recent paper by Nickel B et al. (4), “Patients' experiences of diagnosis and management of papillary thyroid microcarcinoma: a qualitative study”, published recently. The manuscript rises significant additions on papillary thyroid microcarcinoma management and factors influencing both choice and adherence on surgery or AS (4). According to study results, predilection of treatment was found on excluding the probability of cancer spreading (i.e., the choice for thyroidectomy) or thyroid replacement drugs (i.e., lobectomy) (4). Additionally, patients experienced associated emotional and physical side-effects (4). Patients along indicated that AS was not something they wouldn't have been

biased in if it was propound them (4). Authors conclude that shared decision making is imperative to completely inform on the meaning of diagnosis, management options, risk and consequences including both immediate surgery or AS (5,6).

There are no universally agreed upon selection criteria for AS for TC and AS uptake continues to vary across countries and practices, and among physicians (3). A demonstrable rise in the use of AS has been noted over a short time frame (1-3). Furthermore, a consistent proportion of patients continue to drop out of AS, despite no evidence of disease progression (1-8).

Few studies have focused on the influence of anxiety and depression on adherence (1-8). Cancer research describes depression as an established response to a diagnosis of cancer, unrelated to stage or severity (6). There is thus a need to identify and understand the barriers and facilitators to AS for TC (7). This would then provide means for future research themes to study interventions aimed at increasing both uptake of and adherence to AS when indicated (8).

Key themes that may emerge as factors influencing both choice and adherence to AS can be: 1) patient and tumor factors (age, co-morbidities, knowledge, education, socioeconomic status, family history, grade, tumor volume, and fear of progression/side effects); 2) family and social support; 3) provider (speciality, communication, and attitudes); 4) healthcare organization (geography and type of practice); and 5) health policy (guidelines, year, and awareness).

The use of AS could be increased by addressing a variety of factors such as information, psychosocial support, clinician education, and standardized guidelines.

Finally, derivative endpoints may influence patients choices for immediate treatment versus AS. For example, the following issues need to be uptaken: early-stage tumors operated, more treatable stage, decrease in metastatic disease, the increased chance of lesser extent surgery (lobectomy), the application of minimally invasive approaches, as well as no need for lifelong thyroid replacement therapy, a consistent follow-up, low-dose or no radioactive iodine administration and complete biological tumor risk factor assessments (8).

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