

# Presentation and Discussion of Medullary Thyroid Carcinoma Clinical Guidelines prepared by American Thyroid Association

*European Thyroid Association Cancer Research Network  
(ETA-CRN) Meeting Lisbon 5 September 2009*

## **Summary prepared by**

Professor Ulla Feldt-Rasmussen,  
President of ETACRN, Chief of Medical Endocrinology, Rigshospitalet, Copenhagen  
University, Denmark

## **Voting results prepared by**

Folke Söderström, Hovtek AB, Copenhagen, Denmark

## **Approved by the Executive Committee of ETACRN**

### Introduction

The one-day ETA-CRN meeting, preceding the ETA meeting in Lisbon, was planned in advance to provide a thorough assessment of the European response to the published American Thyroid Association MTC guidelines (Thyroid 2009,19,565) This was done by different approaches:

1. A scientific programme was organised starting with a presentation of the guidelines by Richard Kloos, followed by European speakers, presenting various aspects of the guidelines (see the Programme of the 9<sup>th</sup> ETA-CRN Meeting, Lisbon).
2. Before the meeting, following an extensive on-line discussion between European experts, a series of questions in relation to the American guidelines were sent to all the presenters, asking for his/her opinion prior to the meeting (Questions and answers by the Speakers)
3. During the Meeting, following each of the European speakers, a series of questions related to the specific aspect were presented to the audience. The responses from the audience were collected by an AudioResponseSystem (ARS voting system). The results of the voting are summarised below and the full details presented in Questions and answers by the Participants.

### Summary of voting results

The initial questions were asked to identify the individual members of the audience, and demonstrated that the audience was 81% Europeans and 83% Doctors in clinical disciplines. The majority was in Medical Endocrinology (62%), oncology (11%) or endocrine/oncological surgery (13%), and most worked in a University hospital (72%). Only 18% were either not a clinical doctor or a doctor not treating patients with MTC. The remaining 82% were equally distributed among those treating >50, between 10 and 50 and below 10 patients, respectively.

Above basic questions were asked after each break in order to correctly identify the individual person's voting results with the person's background. The main reason for that

was to try to correlate responses to the background e.g. differences in response between Europeans and others, between clinicians and basic scientists, between clinicians in medical endocrinology vs oncology or surgery, between clinicians in university hospitals vs local hospitals or private praxis etc. This was eventually not done due to the small numbers in some of the groups and the dominance of others.

The summary of results is thus based on the audience as a whole without any subgroups, with some differences in numbers for each question and at different parts of the meeting.

The number of actively participating voters is provided for each question.

There were 138 participants. A total of 39 questions were asked with between 73 and 127 responders.

The present summary of results will mainly highlight the answers demonstrating a discrepancy i.e. when the European opinion diverged from the American guidelines.

Sixty% of the audience was in favour of measuring plasma calcitonin in all patients referred for nodular thyroid disease, while 19% would like to see a cost-effectiveness study and 21% agreed with the American guidelines (Q1). Less than half agreed with the ATA guidelines on a fixed cut-off for serum calcitonin, while the majority would require local laboratory references (Q2). Sixty-six% were in favour of performing a pentagastrin stimulation test in all patients whose serum calcitonin is either low or in the grey zone. Few agreed with the ATA guidelines (27%)(Q3).

The majority (45%) found that completion thyroidectomy is always indicated after unexpected diagnosis of MTC, and should be completed by at least central LND, even if postoperative calcitonin is normal, while 29% voted for size of the process to decide the procedure, unlike the ATA recommendations (Q5).

The further (Q7) question considered the indications for lateral lymph node surgery and in response, 79% of responders disagreed with the American guidelines, which recommended against prophylactic lateral node dissection irrespective of the central neck lymph node status. Among them, 46% agreed with a minority opinion of the American Task Force favouring prophylactic (elective) lateral neck dissection when lymph node metastases are present in the adjacent paratracheal central compartment. However, this question was quite difficult to be answered and, after questions from the audience, it was decided to repeat the voting with the added alternative response: (Lateral) lymph node dissection should be performed if in a patient with (after) central LND if increased basal or stimulated CT is stated. In the repeated voting 32% voted for the added alternative and in total, 86% of answers disagreed with the American guidelines. In Q8 there was also a disagreement, since approx. half of responders found a stimulation test to be more sensitive than just basal calcitonin without pentagastrin stimulation (Q8). For a patient with postoperatively measurable Ct, a significant part of responders (38%) supported very distinctly the central CND, if previously not done, while other 54% agreed with the ATA guideline, also supporting this intervention but with more caution.

Questions Q9 and Q11-Q18 were related to the staging and treatment of advanced MTC, generally with significant agreement with the ATA Guidelines among responders, ranging between 68% and 84%.

In the third part of the Meeting, the guidelines related to DNA diagnosis and hereditary MTC were discussed (Q19-Q39). Q 21 illustrates some of the levels of disagreement. Only one third of participants agreed with the guidelines on the desirable extent of RET diagnostics.

This was also the case for 55% of responders, who did not agree on the narrowing of indications for early testing for MEN 2B, being such a debilitating disease, for which RET mutation analyses should be offered early according to European opinion (Q26). Thirty-seven % of the European responders were furthermore in favour of using stimulated serum calcitonin levels to decide on the time of prophylactic surgery (Q29).

Overall a median of 53% of the audience (Range 14 – 84%) agreed with the American Guidelines, and in general between 3 and 9% had no opinion on the specific question asked. This leaves roughly 40% in disagreement with the guidelines.

Among the experts asked ahead of the meeting (Annex 2), the disagreement was even stronger than that of the audience during the meeting, in particular if leaving out one expert who actually participated in the Task Force.

## Conclusions

European expert opinion leaders and an audience of specialists in treatment of Medullary Carcinoma welcomes the American Guidelines on management of medullary thyroid carcinoma but simultaneously only partially agrees with some statements expressed by them. The results of the performed survey are biased in that the presenters were selected for presenting the results, but the audience was present upon open invitation through scientific channels. Notwithstanding the EBM based guidelines we should consider that their final acceptance requires unrestricted discussion and consideration of the differences in clinical practice and experience between countries.

These results should then form the basis for considering if European Experts are sufficiently satisfied with the current American Guidelines as they are (and endorsed by ETA) or wish to publish a European view on the matter.