

BAETS statement on COVID-19 and Benign Thyroid Disease

CONFIDENTIAL ADVICE FOR HEALTH PROFESSIONALS TO CONSIDER WHEN PLANNING SURGICAL SERVICES FOR BENIGN THYROID DISEASE March 2020

This document covers thyroid surgery for benign conditions – other thyroid cancer surgery is covered in a separate document available at BAETS.org.uk. This is not a clinical guideline or Standard Operating Procedure, but is a distillation of expert opinion which clinicians may find useful when planning local services.

Introduction

- During the current period of exceptional demand on the UK Health Services as a result of the COVID-19 pandemic, surgical services for benign thyroid disease will need to be prioritised where it is not possible to follow normal diagnostic and treatment pathways.
- Any decisions regarding changes will need to be taken locally and supported by local governance structures. Local planning should take place at the earliest opportunity taking into account varying levels of anticipated disruption at different stages of the pandemic.
- Where investigations and treatments are different from usual pathways it is important to continue to be honest and open with our patients, and to keep good records.
- The following guidance will be subject to change at various stages of the pandemic and recovery. This document deals only with benign thyroid disease. Other thyroid cancer surgery is covered in separate guidance.

Referrals

- Triage should prioritise cancer cases for assessment; unless there are red flag symptoms, assessment of most benign thyroid disease can be deferred. This includes
 - Patients referred for thyroid surgery for hyperthyroidism whose thyroid function is reasonably controlled on medication
 - Patients with long standing goitre without red flag symptoms and/or benign appearances on ultrasound without progressive symptoms of airway compression.
- Patients that may warrant urgent assessment include:
 - Patients with uncontrolled thyrotoxicosis, and those with severe or sight-threatening thyroid eye disease.
 - Patients with significant thyrotoxicosis who cannot tolerate anti-thyroid medication.
 - Patients presenting with stridor or other features suggestive of significant airway compression.
- Patients with suspicious nodules on ultrasound (U3 and above) should be managed as per BAETS COVID 19 Guidance on Thyroid Cancer.

- Patients with stridor or thyrotoxicosis leading to systemic complications e.g. cardiac failure should be seen on an emergency basis as an inpatient, but treated in a separate stream to COVID19 patients once screened.
- Telephone consultations may help triage in deferred cases.

Diagnostic work-up

- Diagnostic strategies should reflect local expertise and available resources in a multi-disciplinary setting with access to endocrinology and ophthalmology expertise.
- Limit diagnostic workup to investigations that will change management e.g. CT scanning to assess retrosternal extent and tracheal cross-sectional area.
- Serum TSH, Free T4 and T3, and serological tests should ideally be performed in Primary Care.
- Deferred patients will still need support and future investigation so ensure there are robust and tracked plans for 'catch up' in the future, and for patients to be upgraded to urgent when there is a change in their clinical situation.
- For those patients who require face-to-face consultations, utilise one-stop clinics wherever possible to minimise patient hospital visits, with telephone follow up.
- In cases of non-availability of usual USS facilities for assessment
 - Surgeon / other clinician performed USS assessment can be considered if appropriate training has taken place, ideally using recognised reporting system. Carefully record findings in notes.
 - Freehand FNAC can be considered where local expertise exists, this is best done by / with a dedicated Cytologist if available.
- In case of clinically suspicious thyroid disease please refer to guidance on Thyroid Cancer

MDT working and decisions

- Any changes to MDT working should be regarded as temporary only. Revert to normal MDT working as soon as circumstances allow.
- Maintain normal MDT frequency wherever possible. If frequency has to be reduced it should not usually be less than 2 weekly (England, because of cancer targets) or monthly in the devolved nations.
- Consider whether the number of core members attending can be reduced temporarily – but all hospitals contributing to the MDT should still be represented and decisions re attendance should be taken by mutual agreement. Any changes should be regarded as temporary only.
- Utilise facilities for dial-in or electronic discussions where possible.
- Record 'pre covid-19' management plan (if this differs) as well as the agreed management plan for the patient in the current covid-19 situation.
- Should situations arise where MDT is not quorate;
 - Take advice on an individual patient basis from experienced colleagues in the relevant disciplines.
 - Follow national/international guidelines.

- Make careful records including why a full MDT discussion has not been possible
 - Discuss cases retrospectively at MDT when able to do so.
- Cases requiring priority surgical intervention include
 - Patients with uncontrolled thyrotoxicosis (with appropriate pre-operative blockade using Lugol's Iodine/Potassium Iodide and beta blockers)
 - Patients with severe or sight-threatening thyroid eye disease (multi-disciplinary decision in conjunction with endocrinology and ophthalmology)
 - Patients with goitre causing significant airway compression at least >50% confirmed on cross-sectional imaging

Surgical Treatment

- Those surgical cases that cannot be delayed should be undertaken wherever possible by high volume (>20 cases/year) Thyroid Surgeons who have demonstrated good results in the past through meaningful audit (e.g. UKRETS)
 - This should minimise complications and make the most efficient use of available operating theatre time.
 - Hospitals with large numbers of thyroid surgeons may wish to designate two surgeons only to continue provide thyroid surgical services during any period that only priority thyroid surgical cases are being operated on
- Pre-operative fiberoptic naso-endoscopy (FNE) should be used selectively – mainly for patients with previous neck surgery, history of voice change or stridor. Practitioners undertaking FNE should follow the ENT-UK advice related to Covid-19.
- Post-operative FNE should only be done if there is clinical concern of vocal cord palsy or if further contralateral surgery is planned in the near future.
- Clear discharge instructions of whom to contact if advice is needed post operatively will reduce emergency department attendance. Where *possible and safe* patients with or at risk of hypocalcaemia should be discharged and arrangements made to have further blood tests in a safe outpatient environment. These must be reviewed and the patient informed of any change in medication or management plan. If a patient has more severe hypocalcaemia keep in hospital until safe to discharge to avoid emergency readmission.

Communication with patients

- Ensure that, as far as practical, patients remain supported including those whose treatment has been delayed or deferred.
- Be open and honest with patients. Deferring the surgical treatment of the majority of benign thyroid disease will not result in harm.

Follow Up

- Minimise face-to-face follow up, using web based or telephone consultations.
- Reduce frequency of follow up appointments.

- If thyroid function tests are difficult to access, consider treating those thyroid surgery patients who need thyroid hormone replacement with 1.6mcg per Kg Levothyroxine until testing is available

UKRETS and BAETS

- All thyroid surgeons should record their operations and outcomes on the UKRETS national database, subject as usual to individual patient consent.
- We will keep under review the requirement to perform 20 surgical cases per year to remain a full member of BAETS with voting rights etc. We may temporarily suspend that requirement during a period of temporary national reduction in thyroid surgery
- During periods of temporary reduction in the number of thyroid operations being performed, we recommend these will be channelled to a reduced number of high volume surgeons.
 - As those surgeons will be operating on the more complex cases, it is likely their average overall complication and length of stay data will be less favourable than usual, and FNE rates pre and post op will reduce. In planning any future database analysis or publication of individual results we will take account of this probable temporary distortion of figures.
 - When there is a return to normal working teams may need to consider mentoring for colleagues who would normally have undertaken at least 20 relevant procedures per year, but have not done so during the pandemic.

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Thanks to members of the BAETS Executive Committee, and to Mark Lansdown from GIRFT, for their contributions to this document

Disclaimer: This document is intended to help BAETS members when planning services during the Covid-19 pandemic. It will be subject to change and updating over time. It is not comprehensive, and members should take into account other healthcare resources when planning services. The legal responsibility for local decisions is through local governance structures and local healthcare organisations. No liability is accepted by BAETS, including the BAETS executive team, other contributors to this document, and those undertaking work on behalf of BAETS to distribute this document, for any errors or omissions in this document, or for any direct or indirect loss to third parties related to the advice given in the document.