



Thry'vors News

CANADIAN THYROID CANCER SUPPORT GROUP (THRY'VORS) INC.

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An Overview of Neck Dissection Surgery

by Sarah Lyons

Many patients are overwhelmed when they receive news of a thyroid cancer diagnosis and the need for surgery. In the majority of cases patients undergo a simple surgery involving a partial or total thyroidectomy. However, it is not uncommon for some thyroid cancer patients to be faced with a more extensive surgery in order to remove lymph node metastases, either at the time of diagnosis, in response to a recurrence, or to address malignancy ‘missed’ the first time. Facing a neck dissection surgery can be terrifying when the patient learns of the potential complications, recovery time, and the large scar associated with the procedure. In this article, patients share their stories of their own surgery and Toronto-based Otolaryngologist, Dr. Jeremy Freeman, shares statistics from his practice along with some of the more unusual cases he has encountered.

A neck dissection is a surgical procedure that involves the removal of fibrofatty contents of the neck to treat cervical (neck) lymph node metastases.^{1,2} A **lateral** neck dissection refers to surgery performed on one side of the neck, whereas a **bilateral** neck dissection refers to surgery performed on both the right and left sides of the neck.

Over the years, a number of different ‘types’ of neck dissections have been performed using varying technique and terminology.^{1,3} There are now four standardized types of neck dissections¹⁻⁴:

Radical Neck Dissection. This type is generally reserved for patients with advanced neck disease. It includes the removal of fibrofatty tissue, including

This is the 23rd in a series of seasonal newsletters, from the Canadian Thyroid Cancer Support Group (*Thry'vors*) Inc. Your comments and suggestions are most welcome.

Please direct your comments to the Newsletter Committee at thryvors@sympatico.ca

Editor's Note:

It's been a busy year for *Thry'vors* with no sign of slowing down. At a time when thyroid cancer has been named the most prevalent cancer in young Canadian women, *Thry'vors* is increasing its presence in the community and we are casting our net wide. Look for more exciting developments to come. Well done *Thry'vors*!

Sarah Lyons, *Editor*

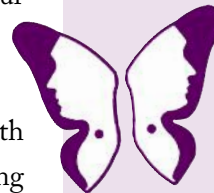
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Offering information and support



lymph nodes from levels I to V, lymph nodes surrounding the tail of the parotid gland, the internal jugular vein, the spinal accessory nerve, and the sternocleidomastoid (SCM) muscle.

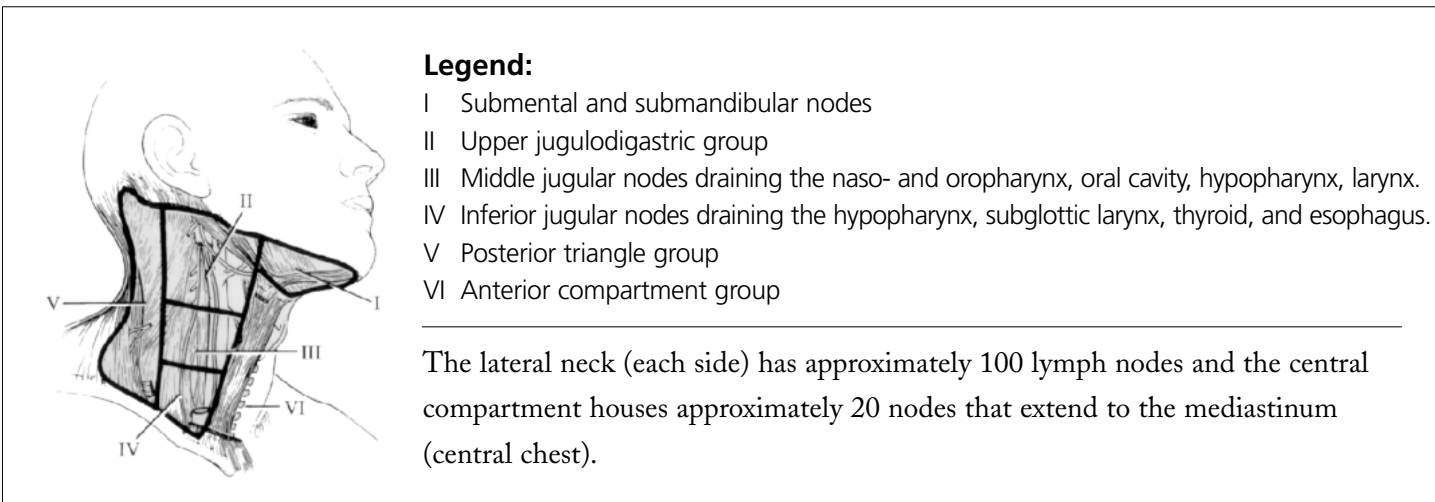
Modified Radical Neck Dissection. This type includes the removal of lymph nodes levels I to V, however one or more of the following nonlymphatic structures are preserved: the SCM muscle, the accessory nerve, and the internal jugular vein.

Selective Neck Dissection. This type refers to the removal of some, but not all, of the lymph node groups that are normally removed in a radical neck dissection. Thyroid cancer patients with neck metastases will frequently have lymph node levels II, III, IV, and V removed in a selective neck dissection. Level VI lymph nodes, located in the central compartment at the front of the neck, are also frequently removed at the time of a total thyroidectomy.

Extended Neck Dissection. When advanced neck metastases exist, additional lymphatic and non-lymphatic structures may need to be removed.

Dr. Jeremy Freeman, MD, FRCS(C), Otolaryngologist-in-Chief at Mount Sinai Hospital (Toronto, Ontario), has been performing thyroid cancer-related surgeries for more than 30 years and has an active practice focusing on head and neck oncology. In a recent interview, Dr. Freeman described his practice and offered some insight into the treatment of thyroid cancer and neck dissection surgery. He performs approximately 350 thyroidectomies and 100 neck dissections each year, the majority of these being selective neck dissections. For those patients undergoing neck dissection surgery, approximately 80% have previously had thyroidectomy surgery, and 15% required a bilateral (both right and left sides) neck dissection. Three indicators are evaluated in determining the need for neck dissection surgery; (1) rising thyroglobulin (Tg), (2) palpable lymph node(s) (ie. ones that can be felt by the doctor), and (3) positive imaging (ultrasound or cross-sectional imaging, such as CT or MR). When asked how he determines whether a lateral vs. bilateral surgery is required, Dr. Freeman explained that the type of malignancy guides this decision. In well-differentiated thyroid cancers (Papillary and Follicular), only the side(s) of the neck with proof of malignancy (positive imaging or palpable lymph nodes)

Figure 1. Levels of Cervical Lymph Node Groupings (I-VI)⁵



are operated on. However, Medullary thyroid cancer has a high incidence of microscopic disease, often not visible on imaging (such as CT and MR scans). In this case, a bilateral neck dissection is often required. While roughly 15% of Dr. Freeman's patients may require a second surgery due a recurrence, it is uncommon for the recurrence to appear on the same side of the neck that has been previously operated on.

Dr. Freeman explained that prior to surgery, he has a clear indication of which levels of lymph nodes will be removed and how the surgery will proceed. He noted that 95% of surgeries proceed as planned. During a neck dissection surgery, Dr. Freeman is very selective in removing lymph nodes that thyroid cancer has a propensity to metastasize to (levels II, III, IV, and V). If lymph node metastases exist, the entire level or grouping will be removed. In a lateral neck dissection, up to 50 or 60 lymph nodes will be removed, leaving areas that do not usually have metastasis potential. In very rare cases, usually with more invasive cancer, additional fatty tissue and muscle may need to be removed, sometimes leaving a person with an asymmetrical and 'hollowed-out' appearance. When asked to share some of the more unusual cases he has seen in his career, Dr. Freeman described a number of "unexpected findings." These included malignant nodes found behind the food passage, disease that had invaded the carotid artery, internal jugular vein and larynx, and malignancy that had spread so far into the chest that he was required to split the breast bone to operate. However, these occurrences are far from the norm.

Common complications following a neck dissection include numbness in the neck where sensory nerves may have been cut, shoulder weakness due to the impairment of the accessory nerve, chyle (fatty fluids) leaks, and other nerve injuries. Other complications patients have noted

include temporary paralysis of the lower lip/jaw, neuropathic (nerve) pain, numbness in the ear, shoulder and upper chest, and injury to the parathyroid glands.⁶ While many of these symptoms improve over time (e.g., pain, numbness, movement restriction and weakness), some patients report continued mild to moderate numbness in some areas as well as ongoing neck stiffness.

Nola's experience

Nola's first surgery was a total thyroidectomy and central neck dissection at the University of Alberta Hospital in Edmonton, however she was scheduled for a modified radical neck dissection (MRND) only two months later. "Initially, I had a painless enlarged lymph node on the side of my neck that was quite visible. I had a series of FNA [biopsies] and ultrasounds and a CT scan in the next few days...[My surgeon] thought it was probably thyroid cancer with lymph node involvement. I had been prepared for the MRND with the first surgery - was elated to find out it wasn't necessary, then put back onto the thyca roller coaster when I realized I would need the MRND after all.

"The Surgeon spent time discussing the risks of the surgery - and that was quite distressing. Even though the risks were small, they were significant enough to add to my anxiety. I wasn't overly concerned about the huge scar [as] I would have [been]...I was more concerned about getting that cancer removed." When asked to describe her recovery, Nola expressed that it was challenging at times. Due to everyday responsibilities (financial and otherwise), many patients are not able to take extended time away from work, often making the recovery process all the more challenging. "It was painful to lift anything for the first couple of months so that summer I had to change my usual routine both at work and at home. Recovery took longer than I thought it would and didn't follow the time table I had set up prior to surgery."

LID RECIPE BOX**Ginger Snap 'Granny' Cookies**
(makes 3 dozen)

3/4 c. shortening
 1 c. white granulated sugar
 1/4 c. fancy molasses
 1 3/4 c. all-purpose flour
 2 tsp. baking soda
 1 tsp. cinnamon
 3/4 tsp. powdered ginger
 3/4 tsp. cloves



Combine shortening, sugar, and molasses together in a large bowl. In a separate bowl, sift the flour, baking soda, cinnamon, ginger, and cloves together. Combine the two mixtures together until evenly blended. Dough should be slightly sticky. Roll into 1" balls and place on a greased cookie sheet. Bake at 375° F about 10 minutes.

New Recipes are continuously added to the *Thry'vors* LID Recipe Index - now including almost 400. To view LID recipes, go to: <http://health.groups.yahoo.com/group/Thryvors> or view a sampling of recipes at www.thryvors.org

Tom's experience

Tom was diagnosed with Sporadic Medullary thyroid cancer (MTC), in Kingston, Ontario. "For about a year and a half I had a lump on my thyroid and a smaller lump higher up toward my ear." He recalled seeing an ENT specialist in Belleville, Ontario, who ordered two FNA biopsies, revealing 'spindle cells,' and then referred him to a radiation oncologist in Kingston. Once MTC was suspected, Tom underwent a number of scans (CT, MR, bone, and thyroid) and was eventually referred to a general surgeon, Dr. Ross Walker, who confirmed the MTC diagnosis. Tom was then scheduled for a total thyroidectomy and a right modified radical neck dissection. The surgeon removed 32 lymph nodes (7 were positive for MTC) in addition to muscle tissue that appeared 'suspicious.' His surgery was predicted to last 7 hours, however with the additional removal of muscle and fatty tissue, Tom's surgery was completed in 9.5 hours. While Tom did not have surgery on the left side of his neck, his surgeon informed him that he may require a second surgery in the future.

"Of course I was scared, because the doctor said [MTC] can be lethal. I was scared, but I wasn't really shocked, so I started researching as much as I could. The doctor said, 'Your [cancer] is very indolent [meaning slow moving]. If/when it does come back, we'll get it.' That was kind of encouraging." When asked to describe his experience post-surgery, Tom remarked, "It wasn't pleasant. But I've had a lot of surgeries in my life before, so it wasn't really a big deal to me. I wasn't expecting it to be so bad given I was only going to be two days in the hospital. I had drains in for 1 week following the surgery. I had arranged for a VON nurse to come once a day to clean out the drains and around the incision. My neck swelled up like a balloon because of all the nodes that were removed. I was told the lymph system had to take time to re-route itself. My staples were removed 10 to 11 days later."

What to expect following surgery

Following a neck dissection, most patients remain in hospital for about three days. Patients will have a number of drains (usually two or more), sewn just under the skin around the incision. These are often removed before the patient returns home, but not always. Patients may experience some movement restrictions and numbness around their neck, ear, shoulder, arm, and chest. Pain is often managed with Tylenol 3 or extra strength Tylenol. Recovery time is varied, however most patients report taking two to four weeks before returning to their normal daily activities.

Scar Treatment

With such a large incision, scar treatment is often a concern of many patients. Some patients have found benefits from using products such as, vitamin E oil, Dermatrix, Bio Oil, while others use nothing at all! For more stubborn or keloid scars, cortisone injections have found to be helpful in improving scar appearance. Nola shared her thoughts on her scar, "The scar takes a bit of time to get used to, at first seeming exaggerated, but it gradually became a small part of the big picture. My scar is quite noticeable - perhaps I see it more than other people do, but it's far from the nicest scar I've seen. In the early days when it was more noticeable and more red, I kept it covered, but I haven't felt the need to hide it since that first summer. Over the months and years, it's become a non-issue. It does not define who I am - I prefer to look at it as proof that I am a *Thry'vor* - a survivor."

Special thanks to:

Jeremy Freeman, MD, FRCS(C), Otolaryngologist-in-Chief at Mount Sinai Hospital (Toronto, Ontario). Dr. Freeman is Professor of Otolaryngology and Surgery, at the University of Toronto, and is the Temmy Latner/Dynacare Chair in Head and Neck Oncology. Thank you also to Tom and Nola who shared their stories for this article.

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Get the Right Test!

by Alice Y.Y. Cheng, MD, FRCPC

What is the problem?

It has come to my attention that many patients are not having the correct blood tests performed for thyroid cancer surveillance after having received their Thyrogen® injections. This is very concerning and I am grateful to *Thry'vors* for allowing the newsletter to act as a forum to enlist your assistance in preventing this from happening.

What should be done?

As part of the surveillance for recurrence of thyroid cancer, your doctor may order a stimulated thyroglobulin (Tg) blood test (with or without a radioactive iodine whole body

scan). Thyroglobulin (Tg) is produced by thyroid cells (normal and cancer). After one has had surgery to remove the thyroid and radioiodine ablation to remove any remnant, the Tg level is very useful to detect any recurrence because it should be undetectable or very low. However, if the Tg is detectable, it is a signal that there may be a recurrence. However, the presence of anti-thyroglobulin antibodies can mislead the laboratory testing method and the Tg level obtained may not be real. Therefore, whenever a Tg is ordered, the anti-Tg antibody level must also be ordered at the same time. The purpose of requesting a “stimulated” Tg level is that stimulation of any thyroid cells (cancer or normal) will increase the Tg level. Therefore, if the Tg is undetectable, even when stimulated, then we can be reassured that there is no recurrence. This makes the stimulated Tg level is a very useful surveillance tool. Stimulation can be achieved either through withdrawal of thyroid hormone replacement or with Thyrogen® injections. Thyrogen® injections have the clear advantage of avoiding the symptoms of thyroid hormone withdrawal. However, the timing of the blood-work is critical if using Thyrogen®. Thyrogen® is given on Days 1 and 2 and then the Tg and the Anti-Tg antibody levels must be drawn on Day 5. Testing earlier or later will result in inaccurate results.

Can errors happen?

Unfortunately, the wrong blood tests have been mistakenly performed by the lab for some patients who had received Thyrogen® stimulation. In these unfortunate cases, the injected Thyrogen® is “wasted” and the entire test needs to be redone. Not only is this very costly (usually the lab will reimburse the cost of the second Thyrogen® injection if it was their error) but it is also very disruptive and disconcerting for the patient who has to make arrangements again for the injections and blood test.

What can you do to help yourself?

How can these errors be avoided? One important way to avoid the errors is through clear and legible indications of the tests required: Thyroglobulin (Tg) and Anti-thyroglobulin (Anti-Tg) antibody. Another effective way is through the patient directly. When you go for your stimulated Tg blood test, please point out to the clerical staff entering your blood work that there are two separate and important tests: 1) Thyroglobulin; 2) Anti-Thyroglobulin Antibody. This simple act can go a long way to ensure that the tests are appropriately entered so that tests can be completed correctly – on the first try.

Ask Thry'vors

by Mia Guilló

The members of *Thry'vors* Medical Advisory Panel are available to answer YOUR general questions about every aspect of thyroid cancer. A list of our Medical Advisory Panel members appears on our website at: www.thryvors.org/AboutThryvors.html

In This Issue:

We ask a special expert researcher in the field of ophthalmology a question about the occasional after-effect that RAI has on tear ducts. Kenneth E. Morgenstern, M.D. FACS of Morgenstern Center for Orbital and Facial Plastic Surgery will assist us with his response.

Question:

Although somewhat controversial, some doctors recommend that patients suck on sour candies or lemons to increase saliva flow and hopefully thereby prevent salivary gland damage following a treatment of radioactive iodine. Following the same logic, would it therefore be helpful to induce the flow of tears such as by cutting onions, and thereby diminish the chances of the after

effect of blocked tear ducts? Are there any other precautions one can take to prevent this occasional after-effect?

Answer:

Normal tears are produced on the lacrimal gland as well as from the Wolfring and Krauss glands of the eye. These tears are secreted onto the surface of the eye itself and help with nourishment, immune protection, and visual function. Blinking of the eyelids pushes the tears across the ocular surface to the inner corner of the eye where a tear drain system lies. Tears enter into the first part of the outflow system known as the canaliculus and then into the secondary outflow system known as the nasal lacrimal sac and duct. They then drain into the nose or back part of the throat.

Traditional thought processes concluded that radioactive iodine sequestered in the tear glands (lacrimal gland) as it does in the parotid gland of the mouth. More recent research discounts this theory. This research suggests that the radioactive iodine sequesters only in the second part of the tear outflow system, the nasal lacrimal sac and duct, and does not affect the overall tear production. If a patient experiences increased amounts of tears in the eye after I131 therapy (usually after doses of greater than 150 mCi) it is most likely due to the blockage of the outflow tear drain system (nasolacrimal sac and duct). Unfortunately, increasing the secretion of the tears will likely only increase the tearing symptoms. It is analogous to a blocked drain in your sink. If you turn on the faucet the water will slowly fill the basin. If you increase the flow of the faucet trying to force more water down the drain you will only fill the basin faster.

Hurry Up and Wait!

by: Cherylyn (Edmonton)

Send us your poems. Email: thryvors@sympatico.ca

Standing in a line up
Hurry up and wait
Off to an appointment
Hurray don't be late.

Will call with a new appointment
Not sure how long that will take
Get the labs completed
Again you have to wait.

Months go by and suddenly
A call out of the blue
A surgery date within three days
You cautiously shout WOO HOO!

Waiting in the office
Slowly time ticks by
Not going to make it back to work
You shrug and heave a sigh!

A week before the phone call
A month before you get in
The labs are inconclusive
Another round you must begin.

The day arrives and finally
The surgery is complete
A new phase will soon begin
A new doctor you must meet.

In the Doctor's office
Again the time creeps past
You should have brought a book to read
Click, he's here at last.

The tests are again repeated
And months have truly past
You are back in the office
Results...finally. ...at last!

A diagnosis is at hand
More appointments, labs, and scans
And somewhere in with all of this
Medications and treatment plans.

Looking through your file
The labs he cannot find
Back for more blood work
I hope you do not mind.

Surgery is required
They'll call you with a date
This could take up to a year
I'm not quite sure of the wait.

And yes...you guessed it still more time
To sit and contemplate
And yes between all of this
Please just hurry up and wait!

Attempts have been made to stent the outflow system open prior to I131 therapy but they have been met with only limited success. On a more promising note, we have developed and are working on an ophthalmic preparation to prevent the scarring from occurring. In theory, the medicine would be given prior to radioactive iodine treatment to minimize injury to the outflow system thus preserving normal tear flow away from the eye.

I hope you find this explanation for a difficult and frustrating problem helpful.

Special thanks to:

Kenneth E. Morgenstern, MD, FACS, of the Morgenstern Center for Orbital & Facial Plastic Surgery in Wayne, Pennsylvania www.morgensterncenter.com. Dr. Morgenstern et al's study "Expression of sodium iodide symporter in the lacrimal drainage system: implication for the mechanism underlying nasolacrimal duct obstruction in I(131)-treated patients" was cited in the Winter 2008 issue of Thry'vors News.

The Generosity of Thry'vors Members

by Rita Banach

Thry'vors members are not only generous with their time and donations, but are a creative bunch as well! In past years, members (or their friends) have created small events and made Thry'vors the recipient group of donations raised at these small gatherings. Recently others have made special efforts on our behalf too. This article describes two recent wonderful efforts.

Alexandra Bilodeau (10 year daughter of our member, Maria Besonart) and her friend Tara Larouche, spearheaded

a fundraiser for our benefit at Sunshine Academy in Dollard des Ormeaux, Quebec. In describing her event Alexandra said:

"We started a fundraiser for thyroid cancer in our school. We put boxes in each class so people could donate money. Then we did a presentation for all the classes with a song we wrote on cancer. We also put up posters around the school to remind everyone about our fundraiser. Tara and I would collect the boxes during recess and lunchtime and then count the money. We missed a lot of free playtime but it was worth it. We raised two hundred dollars for Thry'vors which you will find with this letter. We hope we did enough to help people. We also made a website named www.thyroidat.piczo.com which gives information on thyroid cancer and how to donate."

Thry'vors is very grateful for Alexandra and Tara's efforts. We have also acknowledged their efforts with appreciation certificates and thank you letters.



Maria Besonart, Sylvain Bilodeau and their daughter Alexandra.

Frances Gallop also showed her generosity to Thry'vors in a very thoughtful way. When Frances learned that a member of our group was travelling all the way from the interior of British Columbia to Toronto to see an expert in the field of endocrinology about her somewhat complicated thyroid issues, she (as a partner at Fillion, Wakely, Thorup and Angeletti) was able to secure a donation of a hotel room for

the travelling member. Frances arranged for two nights stay at the lovely Sheraton Centre Hotel, a short walk from the doctor's office in downtown Toronto.



sheraton.com/centretoronto

Thry'vors and Frances are very grateful to the Sheraton Centre Toronto and its staff for their kind support of *Thry'vors* and our members.

If you have a creative idea of your own or would like to make a donation, please contact us at thryvors@sympatico.ca or the mailing address on the back page of this newsletter. Donations can also be made online at www.canadahelps.ca (enter the word *Thry'vors* in the search).

Make a donation online today.

***Thry'vors* relies on the support of individuals, corporations, foundations, and government to fund our efforts.**

Your donations help people who have been diagnosed with thyroid cancer, and their families, access information and support services that allow them to take a more active role in their care and improve their quality of life.



www.canadahelps.org
enter the word ***Thry'vors***

A New Way to Donate



Thry'vors is now a member of Shoppers Drug Mart's Optimum Points program. That means, if you have a Shoppers Drug Mart Optimum Points card, you can donate your accumulated points (or any part of them) to *Thry'vors*. In turn, *Thry'vors* can make use of the points donated towards purchases at Shoppers Drug Mart stores.

To get an Optimum Points card, print an application from the Shoppers website or ask any cashier for a copy of the application. You will receive your card immediately. Present your card each time you make a purchase to accumulate points. At your convenience go online to donate your points to *Thry'vors*.

For information or to donate your points, visit:

www.shoppersdrugmart.ca/english/optimum/donate_points/index2.html



Regional Differences in Radioactive Iodine Treatment

An article review by Charna Gord, BASc, MEd, RD

Charna Gord is a Registered Dietitian working as an Education Coordinator in an Ontario public health unit. She underwent a total thyroidectomy for thyroid cancer in December 2007. This is the fifth in a series of thyroid cancer related journal articles and other resource reviews that Charna has undertaken for Thryvors News.

In this review, Charna summarizes the findings of the following journal article:

Sawka AM, Rotstein L, Brierley JD, Tsang RW, Thabane L, Gafni A, Straus S, Kamalanathan S, Zhao B, Goldstein DP, Rambaldini G, Ezzat S. **Regional Differences in Opinions on Adjuvant Radioactive Iodine Treatment of Thyroid Carcinoma within Canada and the United States.** *Thyroid.* December 2007, 17(12): 1235-1242.

A group of primarily Toronto-based physicians conducted research to “identify regional differences in recommendations for radioactive iodine remnant ablation (RRA) in early stage well-differentiated thyroid carcinoma within Canada and the United States.” In 2006, a cross-sectional self-completed written survey was mailed to a sample of thyroid cancer-related specialty physicians across North America. Canada was divided into 1) western Canada (British Columbia, Alberta, Saskatchewan and Manitoba), 2) eastern Canada (Ontario, New Brunswick, Newfoundland/Labrador and Nova Scotia) and 3) Quebec. Prince Edward Island and the Canadian Northern Territories were not included in the study as they did not have any thyroid cancer specialty physicians listed in the Canadian Medical Directory. The majority of respondents were university-affiliated male endocrinologists.



Respondents were asked to answer questions based on a fictitious case study of a patient diagnosed with early stage papillary cancer. The patient was described as a 38-year-old previously healthy woman who presented with an asymptomatic thyroid nodule. On fine needle aspiration the nodule was found to be suspicious for papillary cancer. She received a total thyroidectomy and a 1.6 cm solitary papillary cancer was resected without noting any further complications or activity elsewhere.

As the questionnaire responses indicated no significant differences between how physicians replied from Canada as compared with physicians from the US, the researchers explored regional differences more closely. They found significant regional differences between respondent answers to the question asking if they would recommend RRA for the test patient. Their research showed strongest support for RRA for the test patient came from Quebec and the southern United States, the least support came from Western Canada, and the western and mid-western United States. Eastern Canada and the north-eastern United States fell in the middle.

There was general agreement on the risk of thyroid cancer-related mortality for the test patient (low) and whether RRA recommendations should change if the test patient



wanted to become pregnant in the next couple of years (they were less likely in this scenario to recommend RRA). One question that showed a wider spread of responses was dose recommendation for RRA for the sample patient.

This study is the first to explore differences in approach to management of well-differentiated thyroid cancer across disciplines. The authors cannot explain why head and neck surgeons, as compared to the other specialists who participated in their study, were the least likely to recommend RRA for the test patient. Further qualitative research to study physicians' interpretations of existing observational evidence, location of clinical training, clinical experiences, acceptance of existing clinical practice guidelines, influence of international and local opinion leaders, and societal or cultural values might provide insight into this question.

The authors conclude that there are significant regional differences in opinions and that these differences seem to follow east-west differences and distinct cultural regions. In their discussion on what might be the cause of these regional differences they are able to rule out differences

Resources in the File Section of *Thry'vors* Online Forum

Thry'vors Online Forum is not just a great place to chat with other members of our group on-line. It is also a place where we store lots of reference material for you to access in one place on the internet.

<http://health.groups.yahoo.com/group/Thryvors/files>



We're also on Facebook

Canadian Thyroid Cancer Support Group
(Thry'vors) Inc.

facebook

in interpretation of patient risk. The authors note that the consequences of these regional differences may have implications for health care planning for thyroid cancer treatment. For example, future success for regional cancer care resource utilization and national treatment initiatives may be compromised.

As thyroid cancer patients may receive conflicting recommendations from their physician specialists on whether or not to consent to radioactive iodine treatment, it is important to acknowledge the differences in approach to management of early stage well differentiated thyroid cancer.

Tell us what you think

Your comments and suggestions are welcome.



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Upcoming Events

PATIENT FORUMS

The following events are being held by Genzyme Canada Inc. *Thry'vors* is a partner organization at these events and we hope to see you there.

Edmonton, AB

Speakers from Cross Cancer Institute:

Dr. Donald W. Morrish, Endocrinologist
 Dr. Ernst J. Postema, Nuclear Medicine Physician
 Lori House, Registered Technologist Nuclear Medicine

Topic: An Overview of The Treatment and Management Of A Thyroid Cancer Patient: Addressing Your Questions and Concerns

Place: The Maple Leaf Room, at the Lister Conference Centre, University of Alberta, 116th Street and 87th Avenue, (780) 492-6057, Parking in Lot M

Date: Wednesday June 24th, 2009

Time: 5:30 pm to 9:00 pm

Refreshments available. Advance registration required by Thursday June 18, 2009 to info@thyroidupdate.ca or call (780) 989-4315.

Surrey, BC

Speakers:

Dr. Frances Wong, Radiation Oncologist; BC Cancer Agency, Fraser Valley Centre & Abbotsford Centre
 Dr. Julie Lee, Endocrinologist; Royal Columbian Hospital, Eagle Ridge Hospital
 Dr. Allan Belzberg, Nuclear Medicine Physician; Surrey Memorial Hospital, St. Paul's Hospital

Topic: An Overview of The Treatment and Management Of A Thyroid Cancer Patient: Addressing Your Questions and Concerns

Place: The Studio Theatre at the Surrey Arts Centre, 13750 - 88 Avenue, Surrey, (604) 501-5566, Parking is free

Date: Monday June 22nd, 2009

Time: 5:30 pm to 8:30 pm

Refreshments available. Advance registration required by Thursday June 18, 2009 to info@thyroidupdate.ca or call (604) 930-4032.

PANEL DISCUSSION

The following event is co-sponsored by Wellspring Cancer Support, Women's College Hospital, and *Thry'vors*.

Toronto, ON

Facilitators/Panel Members:

Terri Stuart-McEwan, RN, BScN, MHS
 Dr. Catherine M. Kelly, Endocrinologist; Women's College Hospital
 Patient members of *Thry'vors*

Topic: Navigating Support and Education Resources for Thyroid Cancer Patients

Place: Women's College Hospital, 76 Grenville Street (Room: TBA)

Date: Wednesday June 24th, 2009

Time: 1:00 pm to 2:30 pm

Advance registration suggested to Wellspring Women's College Hospital, (416) 323-6400, Ext. 4240

Like you, we have been touched by thyroid cancer. We are a non-profit organization and we are all volunteers. If you would like to donate or to become a volunteer please visit www.Thryvors.org.

Donation cheques can be made payable to: Canadian Thyroid Cancer Support Group (Thry'vors) Inc.

Mail to: Canadian Thyroid Cancer Support Group (Thry'vors) Inc.

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