**Differentiated Thyroid Cancer – ATA Low Risk for Recurrence Treated with Total Thyroidectomy +/- RAI**

**Letter to Primary Care Physician**

\_\_\_\_\_\_\_\_ is being discharged from the endocrine/thyroid cancer clinic.

Rationale for discharge from Endocrine Care:

Your patient has been found to be low risk for recurrence based on the American Thyroid Association (ATA) Guidelines Risk Stratification of differentiated thyroid cancer and has had an excellent response to therapy meeting the following criteria:

* 1. No concerning sonographic findings on neck US (structurally complete response)
	2. Low thyroglobulin (<0.2ng/ml) and negative anti-thyroglobulin antibodies (biochemically complete response)

Summary of Thyroid Cancer History:

**Thyroid cancer pathology:**
- Cell type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
- TNM stage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
- Extrathyroidal extension: Yes No
- Lymphatic Invasion: Yes No
- Vascular invasion: Yes No

**Treatment:**
- Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
- RAI dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mCi Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Complications of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Complications of RAI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current levothyroxine dose: \_\_\_\_\_\_\_ mcg/day

Summary of Current Test Results

Current Test Results

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Thyroid U/S | Thyroglobulin | Thyroglobulin antibody | TSH |
|  |  |  |  |  |
|  |  |  |  |  |
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Surveillance:

As the patient remains stable now X years post treatment for well differentiated thyroid cancer, we have discharged from our clinic and recommend the following for surveillance:

1. Clinically neck exam yearly
2. Year TSH check – target TSH should be lower limit of normal to 2.0 *(target TSH can be higher in elderly, coronary artery disease, atrial fibrillation, osteoporosis to 1.0-3.0)* and levothyroxine dosing should be adjusted to keep TSH at target.
3. Yearly thyroglobulin and anti-thyroglobulin antibodies at \_\_\_\_\_\_\_\_\_ laboratory. Please ensure all repeat measurements are done at the same lab for comparison purposes.
4. Suggest neck and thyroid bed ultrasound (at the same institution for comparison purposes) – every year following surgery for 5 years, and then every 2 years for 10 years or sooner if any concerning findings on physical exam. *Updated recommendations on repeat USS intervals will become available in the 2024 ATA guidelines.*

Refer Back:

1. Thyroglobulin is greater than XX *(suggest >1 ng/ml)*
2. Anti-thyroglobulin is greater than XX (*suggest > 20 kIU/l using Roche Cobas Elecsys Electrochemiluminescence immunoassay which is used at Lifelabs, Dynacare, alpha labs and medhealth*)
3. Any concerning findings on neck ultrasound