Delays to Low-risk Thyroid Cancer Treatment During COVID-19—Refocusing From What Has Been Lost to What May Be Learned and Gained

Since the World Health Organization declared the novel coronavirus disease 2019 (COVID-19) a global pandemic in March 2020,1 countries around the world have taken unprecedented health measures in response to the outbreak. One of the measures that has been implemented is delaying nonurgent surgical procedures, including those of patients diagnosed with low-risk thyroid cancers. Other treatments, including radioactive iodine, and follow-up appointments have also been delayed along with diagnostic procedures, such as new patient consultations and ultrasound-guided fine-needle aspiration biopsies.

A number of important articles have now been published suggesting how to best manage patients in this uncertain and uncharted territory. However, there has been little said in relation to the “opportunity” this natural experiment brings in relation to understanding how patients, clinicians, and the health care system at large will cope with having cancer care delayed for an extended period due to reasons beyond one’s control or decision-making. The delay in low-risk thyroid cancer operations in particular can offer unique insights into the acceptability of active surveillance—a management option that has yet to be robustly assessed or documented in countries outside of Japan and more recently the US.2 This predicament may be a chance to understand and reflect on who may benefit from missing out on care that is not happening but normally would, and whether any patients experience physical or psychological harm.

In recent years, a worldwide increase3 in the incidence of thyroid cancer has been acknowledged and has primarily been attributed to overdiagnosis of small, low-risk papillary thyroid cancers.4 Observational evidence5 suggests that active surveillance is a safe and effective management option for carefully selected patients with low-risk papillary thyroid cancers. In light of this contemporary data, guidelines now include more conservative treatment options for patients diagnosed with papillary thyroid cancer.6 Ultimately, these guidelines help to avoid potential overtreatment and improve quality-of-life outcomes. Yet despite all this, the willingness to accept less invasive management options, specifically the uptake and acceptability of active surveillance, seems to still be quite low and varied. Once a diagnosis of thyroid cancer is made, some patients and clinicians still seem to have strong beliefs that immediate surgery is required.6–8

Take, for example, a hypothetical patient incidentally diagnosed with papillary microcarcinoma (<1 cm) immediately before or during the early stages of the COVID-19 pandemic. It is a completely unexpected diagnosis for the patient; the patient is scared, and her first thought is “I want it removed as soon as possible.” In a normal situation this preference would not be an issue.

The thyroid surgeon would likely discuss the management options with the patient, which may or may not include active surveillance, and would be happy to perform surgery for this patient if that was her preference. The patient would be getting what she thought she wanted, and the surgeon would be performing their job and providing surgery to the patient. However, does the normal situation allow patients to take time to reflect on their diagnosis, gain a better understanding through discussions with their clinicians and further research about the low-risk nature of their diagnosis, and ultimately weigh the benefits and harms of each management option? Perhaps, but also, perhaps, the typical “act now” mentality that is ingrained in us and the societal fear of cancer is not conducive to in-depth patient and clinician discussions and data-driven decision-making.

During this COVID-19 pandemic, the patient is told by her surgeon that she will not be able to proceed with immediate surgery and will have to wait (for an unknown period perhaps). The surgeon takes more time to reassure her of the low-risk nature of the diagnosis and points her toward specific evidence from active-surveillance trials to show that “waiting” or not proceeding to immediate treatment is safe. Does this provide reassurance to the patient? Will she be more receptive to the idea of active surveillance? Or is the patient more worried than before, with an overwhelming thought that the cancer will progress during this time? Varied responses are a product of multiple factors, including previous experiences, personality, and confidence in the discussions and evidence provided by the surgeon.

On the other side of the consultation is the thyroid surgeon (or endocrinologist), who is now forced to tell the patient that the surgery must be delayed. Although clinicians are equipped with knowledge and evidence of the low-risk nature of the patient’s condition, they are also worried about how the patient will react to this news and about the potential, albeit low, for the cancer to progress during this delay in surgery. This may all be uncharted territory. Some clinicians may have never offered or provided active surveillance management for a patient with low-risk thyroid cancer, and this situation may allow them to have more confidence in this management option and gain valuable experience.

Though not ideal, the current COVID-19 situation can provide unique real-life health care experiences and insights that otherwise may not have been experienced. It may make patients—and clinicians in particular—more receptive to the idea of active surveillance and may allow clinicians to feel more comfortable accepting and recommending this option to future patients. Alternatively, the situation may amplify anxiety. Conducting both