Thyroid Disease : scope workshop discussions – Group 2 Date: 19/09/17		
Scope details	**Questions for discussion**	**Stakeholder responses**
Groups that will be covered • Children and adults with thyroid disease • Specific consideration will be given to pregnant woman Groups that will not be covered • Neonates	• Should both children and adults be considered? • Is there a big difference in management and identification in those groups? • Difference in evidence likely to be found between the 2 groups?	• Important to consider both adults and children, as there is a big difference in identification and management. • Elderly should be considered separately • Pregnancy should be included separately: fertility, pre, during and post pregnancy • Exclude: 1. Rare thyroid conditions (congenital defects, mutations, abnormalities) 2. Neonates

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Settings that will be covered • All settings in which NHS-funded healthcare is received. Settings that will not be covered • None		Look at all settings: primary, secondary and tertiary.

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Key areas that will be covered: 1 Investigation of thyroid dysfunction/thyroid enlargement • Indications for thyroid function tests • Indications for other tests or imaging		• Pregnancy: screening pre and post important • Indications: T3, T4, TSH and antibody tests. Three main tests although due to cost implications T3 not used frequently. • Hyperthyroidism has different definitions which makes it difficult to diagnosis. • Imagining includes: ultrasound, radio nuclear tide, PET/CT • There was a consensus for the need to standardise antibody testing (when and where to use antibody testing) <u>Question 1.5:</u> • This was seen as a good question to help recommend UK best practice and suggest reference points, which can help control the number of biopsy requests. • How to interpret results was also important

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2 Management of non-malignant thyroid enlargement • Referral for surgery • Non-surgical treatment • Monitoring of non-malignant thyroid enlargement		Case by case treatments for multi-lump goitre which usually requires no treatment, also depends on the rate of growth. Therefore options can be surgery vs do nothing or discharge vs keep on records.

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3 Management of hypothyroidism • Treatment options: T4; T3; combination of both • Monitoring of hypothyroidism		Treatment options: • Different modality of treatment cost/effect. • T3 available but with the wrong doses available which is different in other countries, also brand vs generic • Clinical examinations which might include testing reflux and neck. • Biochemical assistance (20-30% of patients on thyroxine are not in range) • NDT important to mention, not to be used as first line but GPs should test and monitor before changing them to different treatment option. Monitoring: • Early vs late monitoring • TSH targets (frequency and by whom), referral should be made to the correct reference range.

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4 Management of thyrotoxicosis • Treatment options: antithyroid drugs; radioiodine; surgery • Monitoring of thyrotoxicosis		• Need a definition for Graves' disease and hyperthyroidism… confusion over definitions • If Graves' disease is managed then you avoid developing thyrotoxicosis • Management should be done for different subgroups as it varies i.e. 60-80% Graves ' disease, 10% hyperthyroidism, 6-10% thyrotoxicosis, drug induced and rare conditions. • Graves 1st line is anti-thyroid drugs and the surgery or iodine • For the other conditions its usually anti thyroid drugs and the iodine but surgery not an option • When comparing different treatments these sub groups should be considered and maybe further stratify them according to outcome i.e. morbidity, how fast they work, risk reduction. • Short course of anti-thyroid drug results in 50% relapse

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5 Management of subclinical thyroid dysfunction • Treatment of subclinical hypothyroidism • Treatment of subclinical thyrotoxicosis • Monitoring of subclinical thyroid dysfunction		• Subclinical is a judgement term, define?? • Who should be treated< age and TSH abnormalities • TSH testing

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6 Thyroid dysfunction in pregnancy 7 Information for patients and families and carers		• Screening • Identification, management for pre, during and post pregnancy • What TSH do you treat? Was still unclear 7) • Vitamins and minerals • NDT advice • Post-surgery information

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Areas that will not be covered 1. Thyroid eye disease 2. Thyroid cancer (except preliminary investigation) 3. Natural thyroid extracts (not licensed) 4. Screening for congenital hypothyroidism Is there anything not on the list that is a higher priority than the items listed?		1. Eye disease is a complication that people need to be aware off as it affects management 2. People can become hypo after cancer and therefore dose of T4 id based on the severity of the cancer Other exclusions: 1. Selenium 2. Iodine deficiency 3. Drug induced thyroid 4. Rare thyroid 5. Pregnancy 6. Screening populations

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Health economics An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Which practices will have the most marked/**biggest cost** implications for the NHS? • Are there any **new practices** that might **save the NHS money** compared to existing practice? • Do you have any further comments on economics?	• Hypothyroidism will carry a high cost, managing hypo (T4, T3, and combination) • Iodine use: QALYs, tariff and cost benefit • Thyroid nodules intervention which are not surgical

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Main outcomes 1. Quality of life 2. Mortality 3. Resource use 4. Adverse effects of treatment		

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GC membership Full committee members: • Chair • Lay member x2 • Endocrinologists x3 • Specialist nurse x1 • Paediatrician/paediatric endocrinologist x1 • GP x2 • Thyroid surgeon x1 • Radiologist x1 • Pharmacist x1 Co-opted members: • Clinical biochemist co-optee • Pathologist co-optee • Ultra sonographer co-optee • Obstetrician co-optee		Nuclear medicines 2 paediatricians endocrinologist 3 Radiation protection officer