2020 ATA® Guidelines for Management of Patients with Anaplastic Thyroid Cancer

Initial Preoperative Evaluation and Establishing Goals of Care

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Initial Preoperative Evaluation

Labs/Imaging

- A **comprehensive laboratory evaluation** should be performed including CBC, CMP, calcium/phosphorus, TSH/FT4, PT/PTT, Type/screen, +/- Tg.

- Initial **radiological tumor staging** should include cross-sectional imaging, in particular, CT neck, chest, abdomen and pelvis with contrast (or MRI), and, if available, FDG PET/CT. Contrast enhanced imaging of the brain (MRI preferred) should also be performed, if clinically indicated (R. 6)

Evaluation

- In the event that biopsy of a suspected metastatic disease site is clinically indicated, primary management of ATC should not be delayed until biopsy is obtained (GPS 1)
  - Biopsy of distant lesions is often unnecessary if primary tumor material is sufficient to make a diagnosis and sufficient for molecular testing.
- All **critical appointments and assessments** that are required prior to primary treatment of ATC **should be prioritized** and completed as rapidly as possible (GPS 2)
- **Every patient with anaplastic thyroid cancer should undergo evaluation of the vocal cords** at initial presentation, and thereafter based upon changing symptoms (R.7)

Establishing Goals of Care

Multidisciplinary approach

- **Comprehensive disease specific multidisciplinary input should be attained before defining "goals of care"** or undertaking therapeutic discussions with patients. Those involved in management decisions should include specialists highly experienced in treating anaplastic thyroid cancer (R. 8)

Capacity/Advanced Directives

- **Patients must have understanding and decision-making capacity to consent to treatment or to make particular medical decisions.** Concerns about diminished or impaired capacity should prompt mental health and/or clinical ethics consultation to assess barriers to capacity (GPS 3)

- Patients should be encouraged to draft both an Advance Directive in which they name a surrogate decision maker and list code status and other end-of-life preferences including POLST or MOST document. Circumstances where suspension of DNR may occur must be discussed with the patient as well (GPS 4)

Goals of care discussion

- **A "goals of care" discussion should be initiated with the patient as soon as possible**. In consultation with a multidisciplinary team, a candid session should be conducted in which there is full disclosure of the potential risks and benefits of various treatment options, updated frequently, including how such options will impact the patient's life. Treatment options discussed should include all end of life options, such as hospice and palliative care. **Patient preferences should guide clinical management** (GPS 5)

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Palliative care- Hospice

- **The treatment team should include palliative care expertise at every stage of patient management** to help with pain and symptom control, as well as addressing psychosocial and spiritual issues (R. 9)
- **The treatment team should engage hospice care for ATC patients who decline therapies against their tumor intending to prolong life**, yet who still require symptom and pain relief spanning the remainder of their illness (R.10)
- At all stages of palliative care and hospice care in ATC patients, practitioners should be aware of Family Systems, and how they affect patient decision-making (R.11)