Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

AMERICAN THYROID ASSOCIATION®
Optimal Thyroid Health for All

EDITOR'S COMMENTS 2

THYROID IN PREGNANCY 3

2026 American Thyroid Association guidelines for thyroid disease in pregnancy: Hypothyroidism

Thyroid hormone plays a major role in brain development of the baby during pregnancy. The 2026 ATA guidelines for thyroid disease in pregnancy represent a meaningful shift from reflex treatment toward confirming persistent hypothyroidism and individualized decision-making. The key aspects in the section on hypothyroidism have been outlined here.

Korevaar TIM, et al. American Thyroid Association 2026 guidelines for thyroid disease in preconception, pregnancy, and postpartum. Thyroid 2026;36(5):481–544; doi: 10.1177/10507256261445624. PMID: 42219800.

HYPOTHYROIDISM 5

Does starting levothyroxine treatment in older adults with subclinical hypothyroidism help their heart?

The association between heart disease and subclinical hypothyroidism in older adults remains unclear. Several studies suggest that subclinical hypothyroidism is associated with increases in several cardiometabolic biomarkers. However, findings remain inconsistent. The aim of this study was to evaluate the effects of levothyroxine on cardiometabolic biomarkers in older adults with subclinical hypothyroidism.

Ao L, Noordam R, Trompet S, et al. Levothyroxine treatment response of cardiometabolic biomarkers in older adults with subclinical hypothyroidism. J Clin Endocrinol Metab 2026;111(9):2445–2455; doi: 10.1210/clinem/dgag155. PMID: 41965091.

THYROID CANCER 7

Am I supposed to decide my thyroid cancer treatment?

Shared decision making is the standard of care in cancer settings. It is especially important in the field of thyroid cancer, since less invasive treatment methods are being recommended with recent guidelines. The goal of this study was to see if communication training by physicians and decision aids for patients helped with the practice of shared decision making.

Koot A et al. Effect of a patient decision aid on shared decision making in patients with differentiated thyroid cancer: a randomized controlled trial. Oncologist 2026;31(5)

THYROID CANCER 9

2025 ATA Thyroid Cancer guidelines: Percutaneous thyroid ablation—who, when, why?

Percutaneous thermal ablation, a procedure where radiowave-based (RFA) or microwave-based (MWA) heat delivered by a needle is used to destroy abnormal thyroid tissue. Recently, studies have been reported using RFA to treat small thyroid cancers without surgical resection. The 2025 guidelines formally recognize ultrasound-guided percutaneous ablation as an alternative to active surveillance or surgical resection for selected patients with small, low-risk thyroid cancer.

Ringel MD et al. 2025 American Thyroid Association management guidelines for adult patients with differentiated thyroid cancer. Thyroid 2025;35(8):841-985.

THYROID CANCER 11

When is the best time to remove the thyroid in children with MEN? – balancing the risks of cancer and surgery

Patients with MEN2 have a high risk of developing medullary thyroid cancer. The best approach is to remove the thyroid before the cancer develops and is usually done in childhood. However, surgery in very young children has risks. In this study, researchers evaluated the results and risks of preventive thyroid surgery in children with MEN2.

Morard I et al. Surgical morbidity and short-term oncologic status after prophylactic-intent thyroidectomy in a cohort of children with MEN2 from the multicentre GTE ENDO-CAN-RENATEN study. Thyroid 2026;36(10):1137–1141; doi: 10.1177/10507256261477167. PMID: 42565336.

THYROID CANCER 13

Fine-tuning cancer risk and response: Practical implications of the 2025 ATA Thyroid Cancer Guidelines

The 2025 ATA guidelines make several important adjustments to risk stratification from the 2015 guidelines. However, the clinical practice implications of these new guidelines remain unknown. The present study aimed to compare cancer classification between the 2015 and the 2025 guidelines for papillary thyroid cancer and whether cancer risk redistribution corresponded with final disease outcome.

Moneta C, et al. Validation of the 2025 ATA risk stratification system in a cohort of patients with papillary thyroid carcinoma. J Clin Endocrinol Metab 2026;111(10):2883–2889

ATA® ALLIANCE FOR THYROID PATIENT EDUCATION 15

Friends of the ATA 16

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

www.thyroid.org

Editor
Alan P. Farwell, MD
Boston Medical Center
Boston University Chobanian & Avedisian School of Medicine, Section of Endocrinology, Diabetes, Nutrition and Weight Management
72 East Concord St., C3, Boston, MA 02118

American Thyroid Association®
Email: thyroid@thyroid.org
www.thyroid.org/patients/ct/index.html

Editorial Board
Gary Bloom, New York, NY
Aysegul Bulut, MD, Boston, MA
Maria Brito, MD, Dallas, TX
Susana Ebner, MD, Boston, MA
Poorani Goundan, MD, San Francisco
Alina Gavrila, MD, MMSC, Boston, MA
Sun Lee, MD, Boston, MA
Joanna Miragaya, MD, Atlanta, GA
Stephanie Smooke Praw, MD, Los Angeles, CA
Marjorie Safran, MD, Worcester, MA
Phillip Segal, MD, Toronto, ON, Canada
Vibhavasu Sharma, MD, Albany, NY
Pinar Smith, MD, Chicago, IL
Ebru Sulanc, MD , Detroit, MI
P. Joseph Tobias, MD, Boston, MA
Whitney Woodmansee, MD, Gainesville, FL

American Thyroid Association®

President
M. Regina Castro, MD (2025–2026)

Secretary/Chief Operating Officer
Chris J. McCabe, PhD (2023–2027)

Treasurer
Mark E. Zafereo, Jr., MD (2025–2029)

Past-President
Jacqueline Jonklaas, MD, PhD (2025–2026)

President-Elect
Anthony N. Hollenberg, MD (2025–2026)

Executive Director
Pam Mechler, CAE
American Thyroid Association®
2000 Duke Street, Suite 300
Alexandria, VA 22314
Telephone: 703-998-8890
Fax: 703-998-8893
Email: thyroid@thyroid.org

Designed by
Karen Durland, kdurland@gmail.com

Clinical Thyroidology® for the Public
Copyright © 2026 by the American Thyroid Association, Inc. All rights reserved.

CHARITY NAVIGATOR
Four Star Charity

Editor's Comments

Welcome to another issue of *Clinical Thyroidology for the Public*! In this journal, we will bring to you the most up-to-date, cutting edge thyroid research. We also provide even faster updates of late-breaking thyroid news through X (previously known as Twitter) at @amthyroidassn and on Facebook. Our goal is to provide patients with the tools to be the most informed thyroid patient in the waiting room. Also check out our friends in the **Alliance for Thyroid Patient Education**. The **Alliance** member groups consist of: the *American Thyroid Association®, Bite Me Cancer, the Graves' Disease and Thyroid Foundation, the Light of Life Foundation, MCT8 – AHDS Foundation, ThyCa: Thyroid Cancer Survivors' Association,* and *Thyroid Federation International, Thyroid Cancer Canada, Thyroid Cancer Alliance and Thyroid Federation International.*

We invite all of you to join our **Friends of the ATA** community. It is for you that the American Thyroid Association® (ATA®) is dedicated to carrying out our mission of providing reliable thyroid information and resources, clinical practice guidelines for thyroid detection and treatments, resources for connecting you with other patients affected by thyroid conditions, and cutting edge thyroid research as we search for better diagnoses and treatment outcomes for thyroid disease and thyroid cancer. We thank all of the *Friends of the ATA* who support our mission and work throughout the year to support us. We invite you to help keep the ATA® mission strong by choosing to make a donation that suits you — it takes just one moment to give online at: www.thyroid.org/donate and all donations are put to good work. The ATA® is a 501(c)3 nonprofit organization and your gift is tax deductible.

November is Hyperthyroidism Awareness Month.

In this issue, the studies ask the following questions:

- Should every woman with hypothyroidism be treated during pregnancy?
- Does starting levothyroxine treatment in older adults with subclinical hypothyroidism help their heart?
- Am I supposed to decide my thyroid cancer treatment?
- Can I choose RFA to get rid of my cancer?
- When is the best time to remove the thyroid in children with MEN?
- Did the 2025 thyroid cancer guidelines give me a worse cancer?

We welcome your feedback and suggestions. Let us know what you want to see in this publication. I hope you find these summaries interesting and informative.

— Alan P. Farwell, MD

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

THYROID IN PREGNANCY

2026 American Thyroid Association guidelines for thyroid disease in pregnancy: Hypothyroidism

BACKGROUND

Thyroid hormone plays a major role in brain development of the baby during pregnancy. During the 1st trimester, all the thyroid hormone that the baby gets comes from the mother. After that, the baby's thyroid starts working, but the baby still needs some thyroid hormone from the mother. Hypothyroidism is common in women who are pregnant or are planning pregnancy. While overt hypothyroidism (high TSH and low FT4) clearly requires treatment with levothyroxine, it is less clear that subclinical hypothyroidism (High TSH, normal FT4) needs to be treated. Because some studies have associated hypothyroidism in the mother with miscarriage, preterm birth, and impaired brain development in the baby, doctors have traditionally had a low threshold for starting levothyroxine treatment. However, the evidence has changed substantially since the 2017 American Thyroid Association (ATA) guidelines. Trials of treatment for subclinical hypothyroidism have highlighted the importance of timing during pregnancy and the possibility of overtreatment. Further, trials treating pregnant women with normal thyroid levels but positive TPO antibodies have generally failed to show any benefit.

The 2026 ATA guidelines represent a meaningful shift from reflex treatment toward confirming persistent hypothyroidism and individualized decision-making. The key aspects in the section on hypothyroidism have been outlined here.

THE FULL ARTICLE TITLE

Korevaar TIM, et al. American Thyroid Association 2026 guidelines for thyroid disease in preconception, pregnancy, and postpartum. Thyroid 2026;36(5):481–544; doi: 10.1177/10507256261445624. PMID: 42219800.

SUMMARY OF THE STUDY

The 2026 ATA guidelines on hypothyroidism in pregnancy outlines recommendations depending on the timing (prior to pregnancy or during pregnancy) and the degree of hypothyroidism (subclinical or over hypothyroidism).

In individuals with subclinical hypothyroidism, it is suggested that TPO antibody status is not required to guide the decision to treat. Levothyroxine therapy may be considered for persistent subclinical hypothyroidism prior to pregnancy or during the first trimester of pregnancy. Studies have not demonstrated improvement in the risk of pregnancy related complications or brain development of the child with starting levothyroxine after the first trimester for subclinical hypothyroidism. It is also suggested to repeat testing for confirmation of subclinical hypothyroidism (or for mild overt hypothyroidism with TSH <6 mU/L) prior to starting levothyroxine therapy as a significant proportion of patients may have normalization of their TSH levels on repeat testing. If treatment is started, low doses of levothyroxine (25 to 75 mcg) should be considered to avoid over replacement.

With regards to overt hypothyroidism, the guidelines recommend treating an established diagnosis prior to pregnancy. The goal treatment target is a TSH in the normal range; however a TSH less than 2.5 mU/L can be targeted to create a safety margin for remaining in the normal range during pregnancy. Individuals using liothyronine (T3) or desiccated thyroid preparations (which contain T3 as well as T4) are recommended to switch to levothyroxine only to avoid the risk of insufficient thyroid hormone availability to the developing baby.

Similarly, overt hypothyroidism identified during pregnancy, particularly with a TSH of 6 mU/L or higher, is an indication for initiation of levothyroxine. Most individuals on levothyroxine for overt hypothyroidism will require an increase in the dose (by approximately 25% and 50% by weeks 12 and 20 respectively) to maintain thyroid hormone levels in the normal range. Finally, following delivery levothyroxine can be switched back to the prepregnancy dose and thyroid function checked after six weeks.

THYROID IN PREGNANCY, continued

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

Compared to the prior guideline published in 2017, the 2026 guideline predominantly retains the same key approaches to the management of hypothyroidism with a few exceptions. While TPO antibody levels can be helpful in identifying the cause of thyroid hormone abnormalities, it is no longer used for treatment decisions in patients who have normal thyroid function or subclinical hypothyroidism. Another difference is that the current guideline emphasizes retesting mild elevation in TSH levels prior to initiation of levothyroxine to avoid over treatment.

Shared decision making between the patient and the treating provider is important to help patients navigate the management of hypothyroidism during pregnancy with the goal to treat appropriately and to avoid over treatment and treatment related anxiety.

— Poorani Goundan, MD

ATA RESOURCES

Thyroid Disease in Pregnancy: https://www.thyroid.org/thyroid-disease-pregnancy/
Hypothyroidism (Underactive): https://www.thyroid.org/hypothyroidism/
Thyroid Hormone Treatment: https://www.thyroid.org/thyroid-hormone-treatment/

ABBREVIATIONS & DEFINITIONS

Hypothyroidism: a condition where the thyroid gland is underactive and doesn't produce enough thyroid hormone. Treatment requires taking thyroid hormone pills.

Subclinical Hypothyroidism: a mild form of hypothyroidism where the only abnormal hormone level is an increased TSH. There is controversy as to whether this should be treated or not.

Overt Hypothyroidism: clear hypothyroidism an increased TSH and a decreased T4 level. All patients with overt hypothyroidism are usually treated with thyroid hormone pills.

TPO antibodies: these are antibodies that attack the thyroid instead of bacteria and viruses, they are a marker for autoimmune thyroid disease, which is the main underlying cause for hypothyroidism and hyperthyroidism in the United States.

Levothyroxine (T4): the major hormone produced by the thyroid gland and available in pill form as Synthroid™, Levoxyl™, Tyrosint™ and generic preparations.

Thyroid hormone therapy: patients with hypothyroidism are most often treated with Levothyroxine in order to return their thyroid hormone levels to normal. *Replacement therapy* means the goal is a TSH in the normal range and is the usual therapy.

Desiccated thyroid extract: thyroid hormone pill made from animal thyroid glands. Currently desiccated thyroid extract is made from pig thyroids and is available as Armour Thyroid™ and Nature-Throid™.

Triiodothyronine (T3): the active thyroid hormone, usually produced from thyroxine, available in pill form as liothyronine or Cytomel™.

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

HYPOTHYROIDISM

Does starting levothyroxine treatment in older adults with subclinical hypothyroidism help their heart?

BACKGROUND

Hypothyroidism is common and is diagnosed with increased TSH and low FT4 levels. This is called overt hypothyroidism and is usually treated with thyroid hormone in the form of levothyroxine. Mild, or subclinical hypothyroidism, is diagnosed when the TSH is increased but the FT4 is normal. Treating subclinical hypothyroidism is not as clear. Subclinical hypothyroidism affects up to 20% of adults, being more common in women and older individuals.

The association between heart disease and subclinical hypothyroidism in older adults remains unclear. It is challenging to conduct studies that directly investigate whether patients with subclinical hypothyroidism have a higher risk of developing heart problems, since a large number of patients would need to be followed over many years. Cardiometabolic biomarkers, such as the cholesterol levels, may serve as a sensitive indicator of heart disease, as changes in these parameters could predict long-term clinical risk of heart disease. Several studies suggest that subclinical hypothyroidism is associated with increases in several cardiometabolic biomarkers, including elevated total cholesterol (Total-C), low density lipoprotein cholesterol (LDL-C), apolipoprotein (ApoB), and triglycerides (TG). However, findings remain inconsistent. Further, evidence on the effects of levothyroxine treatment in subclinical hypothyroidism on these cardiometabolic biomarkers in older adults is limited.

The aim of this study was to evaluate the effects of levothyroxine on cardiometabolic biomarkers in older adults with subclinical hypothyroidism.

THE FULL ARTICLE TITLE

Ao L, Noordam R, Trompet S, et al. Levothyroxine treatment response of cardiometabolic biomarkers in older adults with subclinical hypothyroidism. J Clin Endocrinol Metab 2026;111(9):2445–2455; doi: 10.1210/clinem/dgag155. PMID: 41965091.

SUMMARY OF THE STUDY

This study pooled data from two large studies conducted in Europe: TRUST (Thyroid Hormone Replacement for Untreated Older Adults with Subclinical Hypothyroidism Trial) and IEMO80+ (Institute for Evidence-Based Medicine in Old Age 80-Plus Thyroid Trial). Both studies included older adults with subclinical hypothyroidism (TSH 4.6–19.9 mIU/L and normal free T4) who were 65 years or older (TRUST) or 80 years or older (IEMO80+). Patients were assigned either the levothyroxine treatment or no levothyroxine group. The levothyroxine dose was progressively increased as needed every 6-8 weeks based on blood TSH levels, with the goal to normalize the TSH. Patients were followed for 12 months and had blood collected at the beginning and end of the study to measure cardiometabolic biomarkers.

A total of 286 participants (48% women, average age 75 years, average baseline TSH 6.4 mIU/L) were randomized to levothyroxine (142 patients) or no levothyroxine (144 patients). Overall, the levothyroxine treatment showed no significant improvement in cardiometabolic biomarkers in this patient population. However, further subgroup analysis indicated that participants with more severe subclinical hypothyroidism (baseline TSH ≥10 mIU/L) treated with levothyroxine had potentially beneficial reductions in most cardiometabolic biomarkers, including Total-C, LDL-C, apoB, and TG. Similarly, further analysis showed potentially favorable reductions in apoB-containing lipoproteins (LDL and very low-density lipoprotein/VLDL), as well as other cardiometabolic biomarkers, with levothyroxine treatment in patients with a baseline TSH ≥10 mIU/L.

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

This evaluation of two large clinical trials showed that levothyroxine treatment has no significant effect overall on cholesterol levels and other cardiometabolic biomarkers in the general older adult population with subclinical hypo-

HYPOTHYROIDISM, continued

thyroidism. Potentially favorable changes were noted only in patients with a baseline TSH ≥10 mIU/L; however, these changes were small and of uncertain clinical effect. The study findings support current clinical guidelines recommending that treatment decisions in older adults with subclinical hypothyroidism should be individualized based on baseline TSH levels. Further larger clinical trials are needed to confirm the potential benefits in patients with a baseline TSH ≥10 mIU/L.

— Elie Naous, MD, Alina Gavrila, MD, MMSC

ATA RESOURCES

Hypothyroidism (Underactive): https://www.thyroid.org/hypothyroidism/

Thyroid Hormone Treatment: https://www.thyroid.org/thyroid-hormone-treatment/

ABBREVIATIONS & DEFINITIONS

Hypothyroidism: a condition where the thyroid gland is underactive and doesn't produce enough thyroid hormone. Treatment requires taking thyroid hormone pills.

Subclinical Hypothyroidism: a mild form of hypothyroidism where the only abnormal hormone level is an increased TSH. There is controversy as to whether this should be treated or not.

Thyroid stimulating hormone (TSH): hormone produced by the pituitary gland that regulates thyroid function; also, the best screening test to determine if the thyroid is functioning normally.

Levothyroxine (T4): the major hormone produced by the thyroid gland and available in pill form as Synthroid™, Levoxyl™, Tyrosint™ and generic preparations. Patients with hypothyroidism are most often treated with Levothyroxine in order to return their thyroid hormone levels to normal.

Lipids: the general term used to describe fat molecules in the blood. Examples of blood lipids include cholesterol, HDL ("good) cholesterol, LDL ("bad") cholesterol, and triglycerides.

LDL-C: low density lipoprotein cholesterol, the type of cholesterol that has been associated with atherosclerosis and heart disease.

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

THYROID CANCER

Am I supposed to decide my thyroid cancer treatment?

BACKGROUND

Shared decision making is a process in which both the patient and their doctor work together to decide the best plan of care for the patient. Often, shared decision making is more complicated than getting permission for a procedure or making a medical decision. The patient and physician know that a decision needs to be made, so the physician collects and presents prior studies and data about treatment options and takes into consideration the patient's wishes for the final medical decision. Shared decision making is the standard of care in cancer settings. It is especially important in the field of thyroid cancer, since less invasive treatment methods are being recommended with recent guidelines. Even though making clinical decisions with the input of patient's decisions is standard of care, this practice can be hard to observe, measure, and compare.

The goal of this study was to see if communication training by physicians and decision aids for patients helped with the practice of shared decision making.

THE FULL ARTICLE TITLE

Koot A et al. Effect of a patient decision aid on shared decision making in patients with differentiated thyroid cancer: a randomized controlled trial. Oncologist 2026;31(5)

SUMMARY OF THE STUDY

A total of 26 physicians (8 endocrinologists, 6 oncologists (cancer doctors), and 12 surgeons) underwent 5 hours of communications training, then they performed visits with patients. The patients were divided into 2 groups: one group who reviewed online patient decision aids prior to the discussion with the physician and the other group who did not have access to these online decision aids. All patients had their care previously discussed in thyroid tumor boards, which are professional discussions with endocrinologists, oncologists, pathologists and surgeons. The patients were divided into 3 disease categories: 1) total thyroidectomy or lobectomy for low risk of recurrence thyroid cancer; 2) proceeding with completion thyroidectomy or continuing to monitor with lobectomy for low risk of recurrence thyroid cancer or 3) cessation of chemotherapy for more aggressive thyroid cancer. The decision aids were guided by the International Patient Decision Aid Standards, and patients shared their responses with the physicians. From recordings of the visits, it was determined whether several treatment options were presented, a partnership was established, options were described, and patient's preferred option were asked and incorporated into the ultimate medical treatment decision. In addition, it was determined whether the provider asked about patient's general health and cancer worries, gained the trust of the patient, appeared to have both subjective and objective knowledge, and presented treatment options in a balanced way.

Overall, 38 visits included the decision aids and 40 did not. The decision aids did not appear to improve shared decision making. Although the communications training and decision aids did not improve shared decision making, patients prefered their use in their medical care. The weakest categories were forming a physician-patient partnership and using patient's preference in the final medical decision in both groups of the study. Treatment preferences were voiced by 92% of patients, and 61% of those patients desired less aggressive treatment options. Of the patients who participated in the study, 82% felt as if the decision aids improved their knowledge, and all would recommend the decision aid to other patients.

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

Even though making clinical decisions with the input of patient's decisions is standard of care, there can be communication differences among physicians and patients. The physicians who participated in the study were likely motivated to practice shared decision making. Shared decision making is a quality measure in cancer care, and the communications training completed by the physicians might have been more useful than the decision aids used by the patients. Most patients felt as if the decision aids improved their knowledge, and all would recommend them to other patients.

— Pinar Smith, MD

THYROID CANCER, continued

ATA RESOURCES

Thyroid Cancer (Papillary and Follicular): https://www.thyroid.org/thyroid-cancer/

Older Patients and Thyroid Disease: https://www.thyroid.org/thyroid-disease-older-patient/

Thyroid Disease in Pregnancy: https://www.thyroid.org/thyroid-disease-pregnancy/

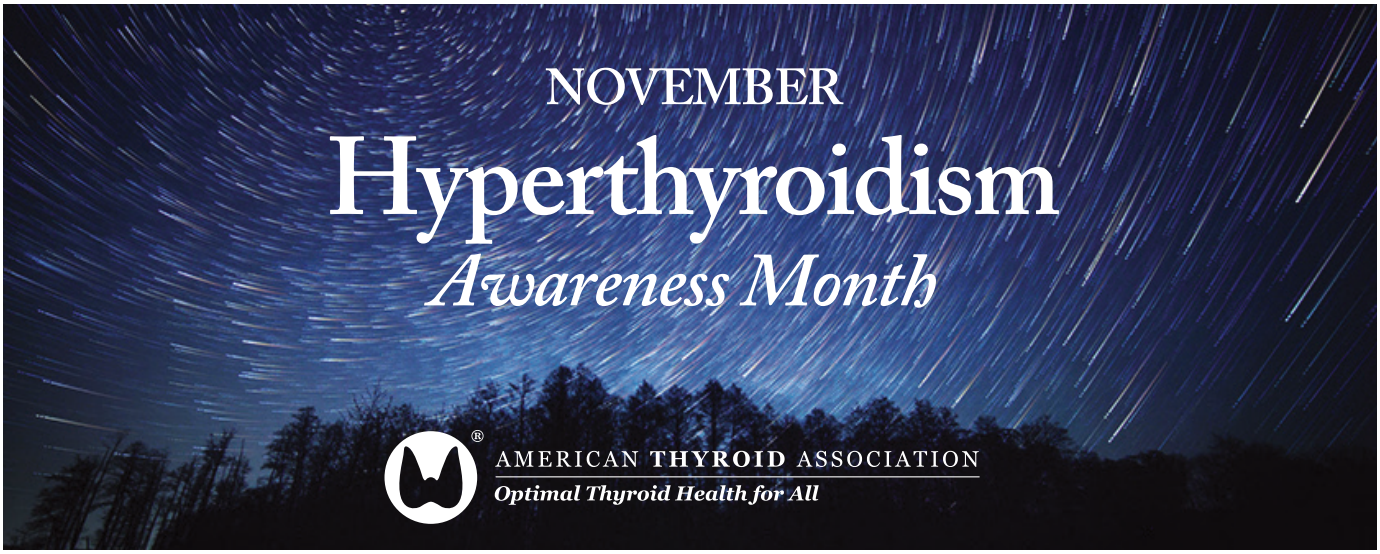
ABBREVIATIONS & DEFINITIONS

Differentiated thyroid cancer: the most common type of thyroid cancer, includes papillary, follicular and oncocytic thyroid cancer

Thyroidectomy: surgery to remove the entire thyroid gland. When the entire thyroid is removed it is termed a *total thyroidectomy*. When less is removed, such as in removal of a lobe, it is termed a *partial thyroidectomy*.

Lobectomy: surgery to remove one lobe of the thyroid.

Completion thyroidectomy: surgery to remove the remaining thyroid lobe in thyroid cancer patients who initially had a lobectomy.



AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

THYROID CANCER

2025 ATA Thyroid Cancer guidelines: Percutaneous thyroid ablation—who, when, why?

BACKGROUND

The majority of patients with thyroid cancer do very well. Indeed, almost 40% of thyroid cancers are less than 1 cm and have an excellent prognosis. This is because thyroid cancer is usually very slow growing and we have excellent treatment options, usually starting with surgery to remove the cancer. Indeed, small, low-risk thyroid cancers can often be followed by serial ultrasounds before moving to surgery if they grow, a treatment plan called active surveillance.

Percutaneous thermal ablation is a procedure where radiowave-based (radiofrequency ablation, RFA) or microwave-based (microwave ablation, MWA) heat delivered by a needle is used to destroy abnormal thyroid tissue. This has mainly been used to treat benign thyroid nodules, with the advantage being the lack of a scar. Recently, studies have been reported using RFA to treat small thyroid cancers without surgical resection. The 2015 ATA guidelines did not include thermal ablation as an initial management option for thyroid cancer. However, the 2025 guidelines formally recognize ultrasound-guided percutaneous ablation as an alternative to active surveillance or surgical resection for selected patients with small, low-risk thyroid cancer.

THE FULL ARTICLE TITLE

Ringel MD et al. 2025 American Thyroid Association management guidelines for adult patients with differentiated thyroid cancer. Thyroid 2025;35(8):841-985.

SUMMARY OF THE STUDY

The 2025 ATA thyroid cancer guidelines refer to patients with differentiated thyroid cancer, almost all of which are papillary thyroid carcinoma.

New in these guidelines is the recommendation that ultrasound-guided percutaneous ablation may be considered as an alternative to active surveillance or surgical removal for selected patients with small, low-risk thyroid cancer. This recommendation is conditional and emphasizes shared decision-making. Percutaneous ablation is less likely to result in hypothyroidism than lobectomy, but provides less certainty of complete cancer destruction, with no tissue to examine after the ablation. Studies have shown favorable results, with low recurrence rates and low complication rates, including major complications. A review of 36 studies taken together reported complete disappearance after RFA in approximately 91% of these small cancers, with local recurrence rates of approximately 2 to 3% and spread to the lymph nodes occurring in 1 to 2% of cases.

Longer-term series have also shown favorable results. A large study of 1613 patients with cancer ≤2 cm treated with RFA reported cancer progression in 4.3% of patients over almost 5 years. Outcomes were less favorable with larger cancers and multiple cancers within the thyroid.

Overall, patient selection is critical. The most favorable outcomes are reported in small, single cancers within the thyroid without spread to the lymph nodes. Patients treated with percutaneous ablation still require long-term ultrasound surveillance. Finally, outcomes are operator-dependent. Thyroid cancer ablation should be performed by clinicians with experience in thyroid ultrasonography, biopsy, thyroid ablation, and management of procedural complications.

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

The 2025 ATA guidelines recognize percutaneous ablation as a reasonable option for selected patients with small thyroid cancers. Cancer progression and complication rates are low in experienced centers, but long-term remission data remain less established than for surgery.

— Alan P. Farwell, MD

THYROID CANCER, continued

ATA RESOURCES

Thyroid Cancer (Papillary and Follicular): https://www.thyroid.org/thyroid-cancer/

ABBREVIATIONS & DEFINITIONS

Radiofrequency ablation (RFA): a procedure using radiowave-based heat delivered by a needle to destroy abnormal tissue or lymph nodes containing cancer.

Microwave ablation (MVA): a procedure where a very thin needle is inserted into a thyroid nodule then uses microwave-based heat delivered by a needle to destroy abnormal tissue or lymph nodes containing cancer.

Thermal ablation: using heat delivered by a needle to destroy abnormal tissue or lymph nodes containing cancer. There are 3 types of thermal ablation: radiowave-based heat (radiofrequency ablation, RFA), microwave-based heat and laser-based heat.

Active Surveillance: following a small, low-risk thyroid cancer with ultrasound and deferring surgery until the cancer grows significantly.

Papillary thyroid cancer: the most common type of differentiated thyroid cancer. There are 4 variants of papillary thyroid cancer: classic, follicular, tall-cell and noninvasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP).

Thyroidectomy: surgery to remove the entire thyroid gland. When the entire thyroid is removed it is termed a *total thyroidectomy*. When less is removed, such as in removal of a lobe, it is termed a *partial thyroidectomy*.

Thyroid Ultrasound: a common imaging test used to evaluate the structure of the thyroid gland. Ultrasound uses soundwaves to create a picture of the structure of the thyroid gland and accurately identify and characterize nodules within the thyroid. Ultrasound is also frequently used to guide the needle into a nodule during a thyroid nodule biopsy.

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

THYROID CANCER

When is the best time to remove the thyroid in children with MEN? — balancing the risks of cancer and surgery

BACKGROUND

Multiple Endocrine Neoplasia 2 (MEN2) is a rare genetic condition caused by mutations in a gene called RET. Patients with MEN2 have a high risk of developing medullary thyroid cancer (MTC). MTC develops in the C-cells in the thyroid which produce the hormone calcitonin. MTC is more dangerous than the more common thyroid cancers and surgery is the only effective treatment. The best approach is to remove the thyroid before the cancer develops. This is called "prophylactic thyroidectomy" and usually done in childhood. On the other hand, surgery in very young children has risks. Surgery can damage the parathyroid glands which control our calcium levels. This damage can cause low calcium levels and may need lifelong treatment.

In this study, researchers evaluated the results and risks of preventive thyroid surgery in children with MEN2.

THE FULL ARTICLE TITLE

Morard I et al. Surgical morbidity and short-term oncologic status after prophylactic-intent thyroidectomy in a cohort of children with MEN2 from the multicentre GTE ENDOCAN-RENATEN study. Thyroid 2026;36(10):1137–1141; doi: 10.1177/10507256261477167. PMID: 42565336.

SUMMARY OF THE STUDY

The study was done at 13 medical centers in France. Researchers reviewed medical records of children with MEN2 and found 89 children who had their thyroid removed before the age of 15 between 2010 and 2020. They excluded children with missing records, those who refused to participate in the study or had cancer that was detectable before surgery. The final study included 64 children. The average age at surgery was 4.6 years. Children with higher risk RET gene changes usually had surgery at a younger age.

Before surgery, 59 children had a calcitonin blood test. Calcitonin level can rise when the thyroid's C-cells become abnormal or develop into MTC. The calcitonin level was high in 26 (44%). All 64 children had their whole thyroid removed, and some also had lymph nodes removed. Researchers followed the children for an average of 6 years, with blood tests and neck imaging to look for any sign of cancer. A parathyroid gland problem was called permanent if the child still needed calcium and vitamin D more than 6 months after surgery.

The children were on average 5 years old when they had surgery. Overall, 52% had abnormal cells that could later become cancer, 34% had a very small thyroid cancer and 3% had cancer in nearby lymph nodes. At the last follow up, no child had any detectable cancer. One child still had an abnormal blood-test result, but no cancer was found. One child had cancer return and needed another operation. Low calcium caused by damage to the parathyroid glands occurred in 31% of the children, 16% had this problem permanently. Permanent problems happened mostly in children who had surgery before the age of 5.

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

Removing the thyroid early worked well at preventing serious thyroid cancer during the years studied. However, younger children had a greater risk of damage to the parathyroid glands especially when the surgery was done before age of 5. This study shows that there is no single best age for surgery that is right for every child. Waiting longer may give cancer time to grow and spread, while earlier surgery may risk lifelong calcium problems. The decision should consider the child's age, RET gene change, calcitonin level, and ability to regularly follow-up. A medical team experienced in treating MEN2 should help each family decide the safest age and type of surgery for their child. Longer follow-up is needed to learn how well surgery protects these children throughout their lives.

— Ebru Sulanc, MD

THYROID CANCER, continued

ATA RESOURCES

Thyroid Cancer (Medullary): https://www.thyroid.org/medullary-thyroid-cancer/

ABBREVIATIONS & DEFINITIONS

Mutation: A permanent change in one of the genes.

Genes: a molecular unit of heredity of a living organism. Living beings depend on genes, as they code for all proteins and RNA chains that have functions in a cell. Genes hold the information to build and maintain an organism's cells and pass genetic traits to offspring.

Cancer-associated genes: these are genes that are normally expressed in cells. Cancer cells frequently have mutations in these genes. It is unclear whether mutations in these genes cause the cancer or are just associated with the cancer cells. The cancer-associated genes important in thyroid cancer are BRAF, RET/PTC, TERT and RAS.

Medullary thyroid cancer: a relatively rare type of thyroid cancer that often runs in families. Medullary cancer arises from the C-cells in the thyroid.

Parathyroid glands: usually four small glands located around the thyroid that secrete parathyroid hormone (PTH) which regulates the body's calcium levels.

C-cell hyperplasia: An abnormal growth of parafollicular (C-cells) cells that usually occurs before the development of familial forms of medullary thyroid cancer and is considered a pre-cancerous condition

Calcitonin: a hormone that is secreted by cells in the thyroid (C-cells) that has a minor effect on blood calcium levels. Calcitonin levels are increased in patients with medullary thyroid cancer.

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

THYROID CANCER

Fine-tuning cancer risk and response: Practical implications of the 2025 ATA Thyroid Cancer Guidelines

BACKGROUND

The majority of patients with thyroid cancer do very well. Indeed, almost 40% of thyroid cancers are less than 1 cm and have an excellent prognosis. To further assist clinicians with the rational targeting of treatment and monitoring, the 2025 ATA guidelines introduced an updated cancer risk stratification system that recommends continuing risk assessment after each treatment decision and subsequent action to reassess the risk of cancer recurrence. The appropriate future monitoring and treatment is therefore based on the new risk assessment, rather than the initial risk assessment driven largely by the initial diagnosis and cancer staging data.

The 2025 ATA guidelines make several important adjustments to risk stratification from the 2015 guidelines: (1) they create a visual separation between risk stratification for different types of thyroid cancer (papillary, follicular, and oncocytic), (2) they add multiple cancers within the thyroid and remove molecular profile from recurrence risk approximation, and (3) they introduce an "additive" approach to risk when multiple risk features are identified. However, the clinical practice implications of these new guidelines remain unknown.

The present study aimed to compare cancer classification between the 2015 and the 2025 guidelines for papillary thyroid cancer and whether cancer risk redistribution corresponded with final disease outcome.

THE FULL ARTICLE TITLE

Moneta C, et al. Validation of the 2025 ATA risk stratification system in a cohort of patients with papillary thyroid carcinoma. J Clin Endocrinol Metab 2026;111(10):2883–2889

SUMMARY OF THE STUDY

This was a study of consecutive adult patients diagnosed with papillary thyroid cancer between January 1969 and December 2024. All patients underwent initial surgical treatment followed by radioactive iodine treatment, if indicated. Patients were clinically evaluated at 3- to 12-month intervals with blood cancer markers and neck ultrasound, with additional imaging as needed. Each patient was classified according to both the 2015 and 2025 risk stratification system.

The study group was composed of 670 patients. The average age at diagnosis was 47 years; 90% (602) had undergone total thyroidectomy, 31% (207) had undergone lymph node dissection, and 43% (288) had received radioactive iodine therapy. Cancer characteristics included the following: primary cancer with an average size of 1.2 cm, vascular invasion in 11.3% (76), extrathyroidal extension in 26.3% (176), multiple cancers in 30% (200), presence of spread to the lymph nodes in 18% (121) and spread outside of the neck in 0.7%.

Among these patients, 2015 risk stratification yielded 61% in the low-risk group, 29% in the intermediate-risk group, and 10% in the high-risk group. Using the 2025 risk system, these patients were categorized as 48% low risk, 22% low–intermediate risk, 19% intermediate–high risk, and 12% high risk. Overall, the proportion of patients with low risk classification decreased by 22%, intermediate risk (composed of low–intermediate and intermediate–high risk classes) increased by 42%, and high risk increased by 15%.

There was no difference in persistent cancer among 2015 and 2025 low-risk groups (4.1% vs. 4.9%). The 2025 low–intermediate-risk group had lower persistent cancer compared to 2015 intermediate-risk (12.2% vs. 22.7%), and persistent cancer was similar between the 2015 intermediate-risk and 2025 intermediate–high-risk groups (22.7% vs. 22.1%) as well as between the 2015 and 2025 high-risk groups (47.8% vs. 48).

THYROID CANCER, continued

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

This study shows that the risk stratification system in the 2025 American Thyroid Association guidelines for thyroid cancer defines a clinically meaningful low-intermediate risk category. However, the reclassification of 2015 low-risk patients to 2025 low-intermediate risk does not necessarily indicate benefit from more intensive therapy. The new categorizations also may have an impact on how patients perceive their disease and may add a layer of anxiety to those reclassified to a higher risk category.

— Alan P. Farwell, MD

ATA RESOURCES

Thyroid Cancer (Papillary and Follicular): https://www.thyroid.org/thyroid-cancer/

ABBREVIATIONS & DEFINITIONS

Papillary thyroid cancer: the most common type of differentiated thyroid cancer. There are 4 variants of papillary thyroid cancer: classic, follicular, tall-cell and noninvasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP).

Follicular thyroid cancer: the second most common type of differentiated thyroid cancer.

Oncocytic thyroid cancer: least common type of differentiated thyroid cancer, which has a higher rate of recurrence outside of the neck. Further, oncocytic thyroid cancer is more resistant to radioactive iodine therapy than other forms of differentiated thyroid cancer.

Thyroidectomy: surgery to remove the entire thyroid gland. When the entire thyroid is removed it is termed a *total thyroidectomy*. When less is removed, such as in removal of a lobe, it is termed a *partial thyroidectomy*.

Radioactive iodine (RAI): this plays a valuable role in diagnosing and treating thyroid problems since it is taken up only by the thyroid gland. I-131 is the destructive form used to destroy thyroid tissue in the treatment of thyroid cancer and with an overactive thyroid. I-123 is the non-destructive form that does not damage the thyroid and is used in scans to take pictures of the thyroid (*Thyroid Scan*) or to take pictures of the whole body to look for thyroid cancer (*Whole Body Scan*).

AMERICAN THYROID ASSOCIATION
Optimal Thyroid Health for All

Volume 19 | Issue 11 | November 2026

Clinical Thyroidology® for the Public

ATA® Alliance for Thyroid Patient Education

GOAL The goal of our organizations is to provide accurate and reliable information for patients about the diagnosis, evaluation and treatment of thyroid diseases. We look forward to future collaborations and continuing to work together toward the improvement of thyroid education and resources for patients.

ATA® *Optimal Thyroid Health for All*

GRAVES' DISEASE & THYROID FOUNDATION®

ThyCa: Thyroid Cancer Survivors' Association, Inc.℠ www.thyca.org

Light of Life Foundation checkyourneck.com

MCT8 - AHDS Foundation

BITE ME CANCER!

Thyroid Federation International

American Thyroid Association®
www.thyroid.org
ATA® Patient Resources:
www.thyroid.org/thyroid-information/
Find a Thyroid Specialist: www.thyroid.org
(Toll-free): 1-800-THYROID
thyroid@thyroid.org

Bite Me Cancer
www.bitemecancer.org
info@bitemecancer.org

Graves' Disease and Thyroid Foundation
www.gdatf.org
(Toll-free): 877-643-3123
info@ngdf.org

Light of Life Foundation
www.checkyourneck.com
info@checkyourneck.com

MCT8 – AHDS Foundation
mct8.info
Contact@mct8.info

Thyca: Thyroid Cancer Survivors' Association, Inc.
www.thyca.org
(Toll-free): 877-588-7904
thyca@thyca.org

Thyroid Federation International
www.thyroid-federation.org
tfi@thyroid-federation.org

AMERICAN THYROID ASSOCIATION
ATA | *Founded 1923*

Friends of the ATA

FOUNDED 2005

Get the latest thyroid health information. You'll be among the first to know the latest cutting-edge thyroid research that is important to you and your family.

Become a Friend of the ATA!
Subscribe to *Friends of the ATA e-news*



By subscribing to *Friends of the ATA Newsletter*, you will receive:

- ✔ *Friends of the ATA e-news*, providing up-to-date information on thyroid issues, summaries of recently published articles from the medical literature that covers the broad spectrum of thyroid disorders, and invitations to upcoming patient events
- ✔ Updates on the latest patient resources through the ATA® website and elsewhere on the world wide web
- ✔ Special e-mail alerts about thyroid topics of special interest to you and your family

We will use your email address to send you *Friends of the ATA e-news* and occasional email updates. We won't share your email address with anyone, and you can unsubscribe at any time.

www.thyroid.org