Indicazioni all'intervento e responsabilità medico-legali

Marco Attard - Gianfranco Iadecola

AGENDA

- Indicazioni all'intervento chirurgico
- La scelta del Chirurgo
- La scelta del tipo d'intervento chirurgico

Indicazioni alla terapia chirurgica: elementi da valutare

- Dimensioni del gozzo
- Caratteristiche ecografiche e citologiche
- Numero, localizzazione topografica e dimensioni delle lesioni nodulari
- Problemi compressivi sulla trachea
- Estrinsecazione mediastinica
- Funzionalità della ghiandola
- Rilievi anamnestici

- ……..Età del paziente, stato generale, comorbidità….

Principali indicazioni chirurgiche di necessità

- Citologia (su nodulo o linfonodo) positiva per neoplasia
- Compressione tracheale con riduzione di calibro e sintomi soggettivi di ingombro

-

- Citologia "sospetta"

Principali indicazioni chirurgiche di elezione

- M. di Basedow resistente alla terapia medica e non eleggibile al radioiodio (gozzo voluminoso, noduli, oftalmopatia attiva…..)
- Nodulo iperfunzionante non trattabile con radioiodio
- Gozzo multinodulare tossico
- Sospetto clinico-ecografico

Indicazioni alla chirurgia e pianificazione dell'intervento

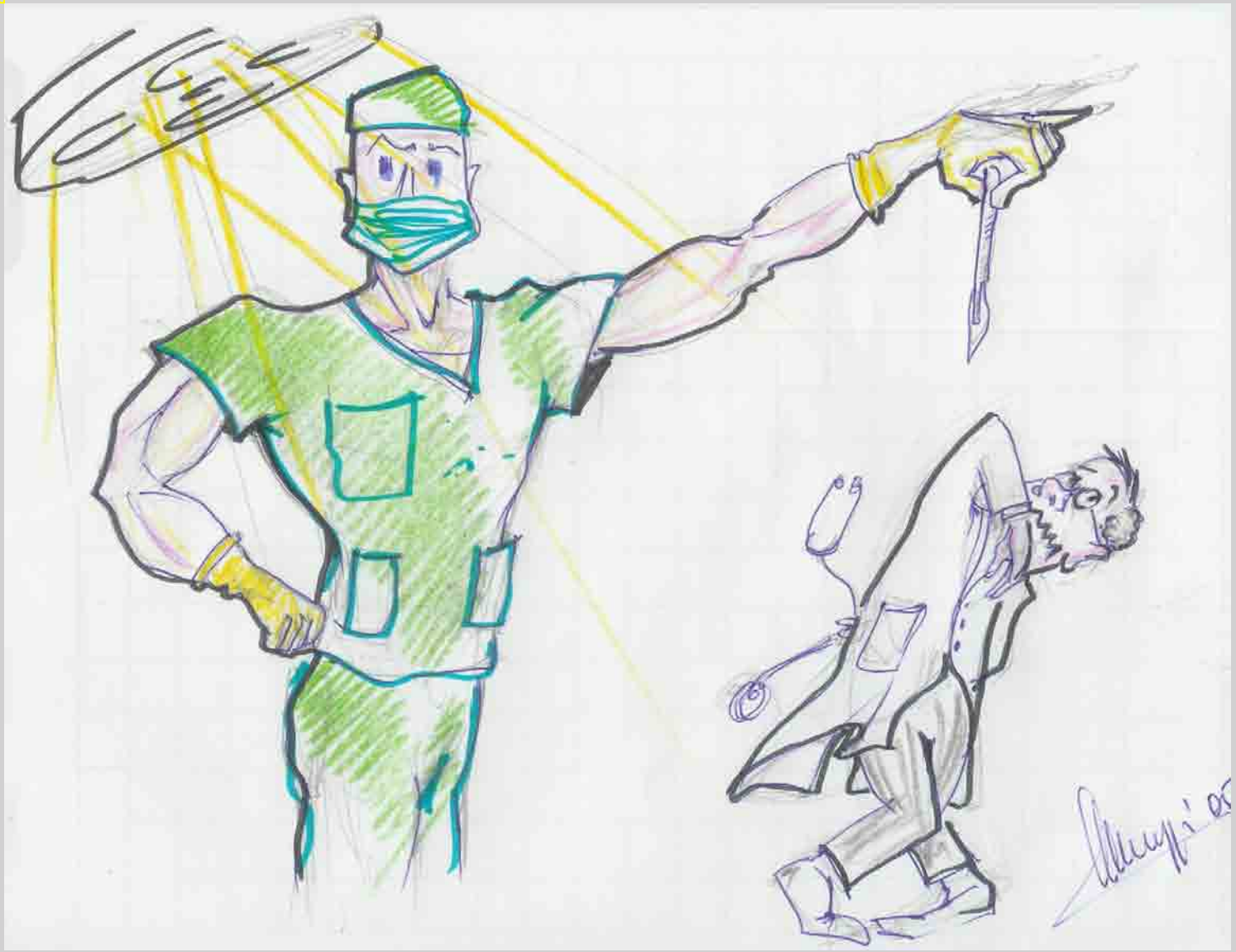
Ogni singolo caso deve essere oggetto di valutazione in modo da personalizzare la scelta terapeutica (tailoring treatment).

Solo una stretta ed affiatata collaborazione fra endocrinologo e chirurgo può aiutare ad assumere una impostazione equilibrata ed obiettiva.
Dalla collaborazione scaturiscono protocolli terapeutici e di comportamento che garantiscono al paziente la migliore "gestione" della malattia.

Indicazioni alla chirurgia e pianificazione dell'intervento

Indicazioni alla chirurgia e pianificazione dell'intervento

Roma,
9-11 novembre 2012

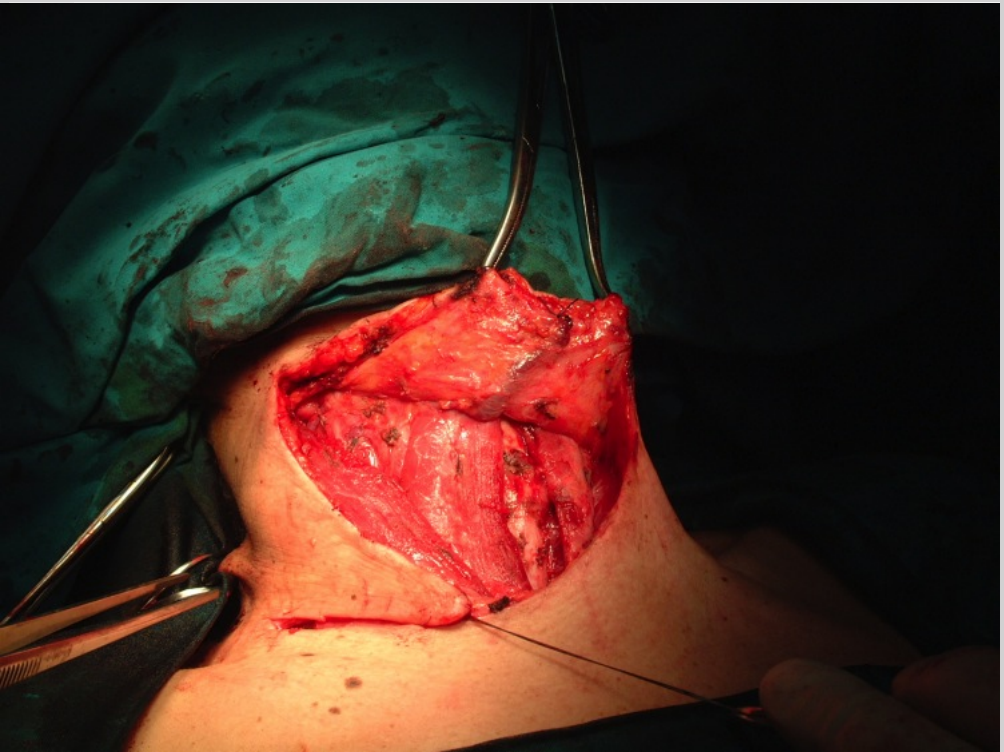


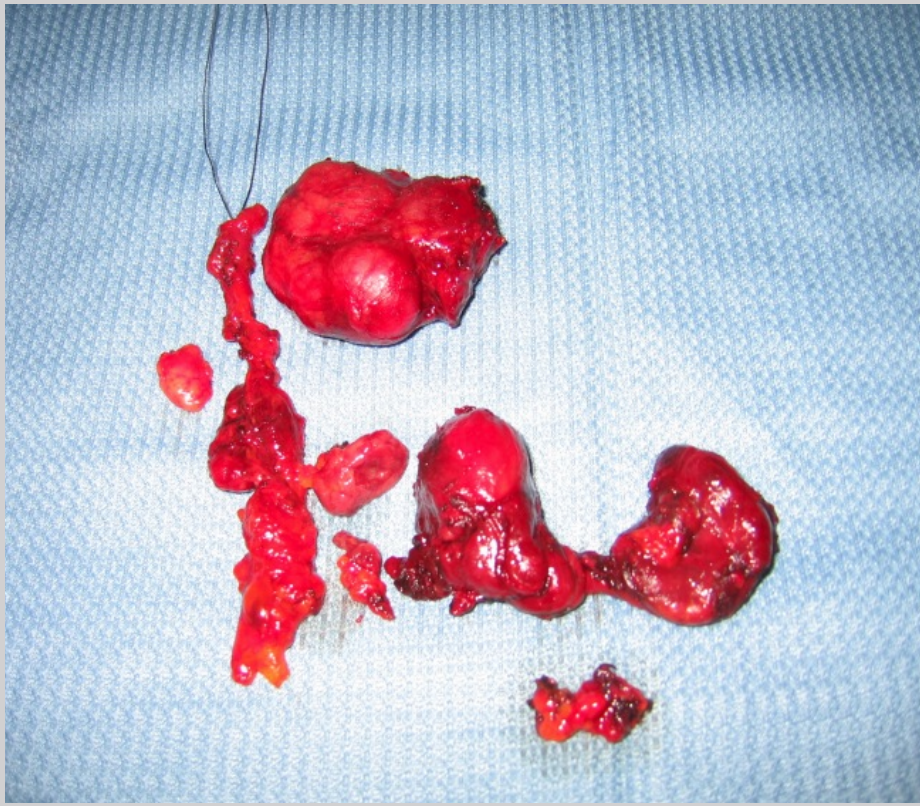
Indicazioni alla chirurgia e pianificazione dell'intervento

CHIRURGHI ED ENDOCRINOLOGI

Roma,
9-11 novembre 2012

…. DEVONO LAVORANO IN EQUIPE, CONCORDARE SULL'INDICAZIONE CHIRURGICA E PIANIFICARE tecnica e strategia operatoria per realizzare un intervento radicale, quando necessario ….





Indicazioni alla chirurgia e pianificazione dell'intervento

Tutte le ragioni che possono indirizzare verso l'opzione chirurgica vanno esposte al paziente al quale spetta la decisione consapevole di accettare o meno l'intervento prospettato, ben conoscendone i vantaggi ed il rischio di complicanze che, ancorché modesto, è sempre inevitabilmente presente.

Va inoltre prospettata la necessità di una terapia ormonale sostitutiva per tutta la vita.

Complicanze della chirurgia

Minori

- Raccolte siero-ematiche
- Emorragia tardiva
- Ematoma dei piani superficiali
- Esiti cicatriziali

Maggiori

- Emorragia
- Insufficienza respiratoria (malacia della trachea, edema laringeo)
- Lesione ricorrenziale
- Lesione branca esterna del laringeo superiore
- Ipoparatiroidismo

Indicazioni alla chirurgia e pianificazione dell'intervento

La scelta del Chirurgo

The extirpation of the thyroid gland for goiter typifies perhaps better than any other operation the supreme triumph of the surgeon's art.

Halsted WS: The operative story of Goitre. John Hopkins Hosp Rep 19:71, 1920

La scelta del Chirurgo

quello dell'azienda

quello abile per i linfonodi

quello esperto

l'amico

quello che lavora in casa di cura

quello che usa la NIM

quello che fa la MIVAT

La scelta del tipo d'intervento chirurgico

J. Endocrinol. Invest. 35 (Suppl. to no. 6): 10-15, 2012

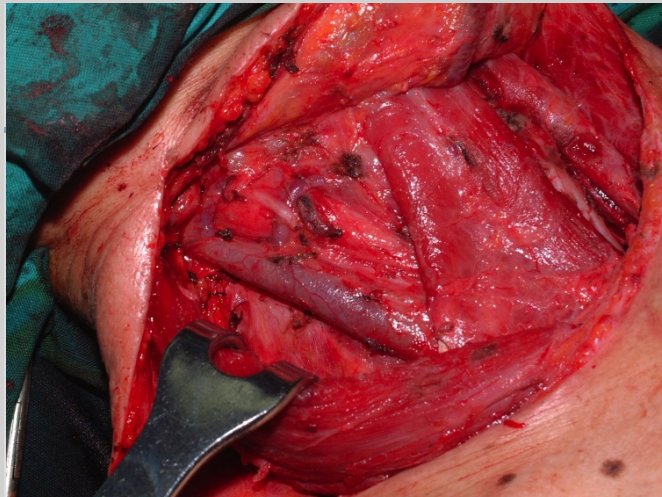
Primary surgery for differentiated thyroid cancer in the new millennium

H. Dralle and A. Machens

Department of General, Visceral and Vascular Surgery, Medical Faculty, University of Halle-Wittenberg, University Hospital, Halle/Saale, Germany

La scelta del tipo d'intervento chirurgico

- Loboistmectomia
- Tiroidectomia totale
- Tiroidectomia "di completamento"
- Tiroidectomia totale in due tempi (……da evitare)
- Tiroidectomia totale + linfoadenectomia del comparto centrale
- Tiroidectomia totale + linfoadenectomia cervicale radicale funzionale
- Reinterventi sui linfonodi ("guidati")



La scelta del tipo d'intervento chirurgico

La storia naturale del gozzo inizia di solito con un'ipertrofia diffusa che successivamente si complica con la comparsa di nodi, i quali con il passar del tempo tendono a diventare autonomi o possono esitare in una citologia atipica. Ciò dimostra che si tratta di una "patologia d'organo" e quindi dovremmo accettare l'idea che:

La tiroidectomia totale è il trattamento di scelta per qualsiasi patologia che interessi globalmente il parenchima tiroideo.

La scelta del tipo d'intervento chirurgico

Il coinvolgimento totale della ghiandola rende poco razionale qualsiasi tentativo di curare chirurgicamente queste affezioni mediante exeresi parziali, destinate, in tempi più o meno brevi, ad evolvere in una *continuazione* di malattia nodulare a carico del parenchima residuo.

Allo stesso modo e per gli stessi principi, affezioni autoimmuni diffuse nel parenchima tiroideo, quando di pertinenza chirurgica, devono essere trattate definitivamente con l'asportazione totale della ghiandola.

La scelta del tipo d'intervento chirurgico

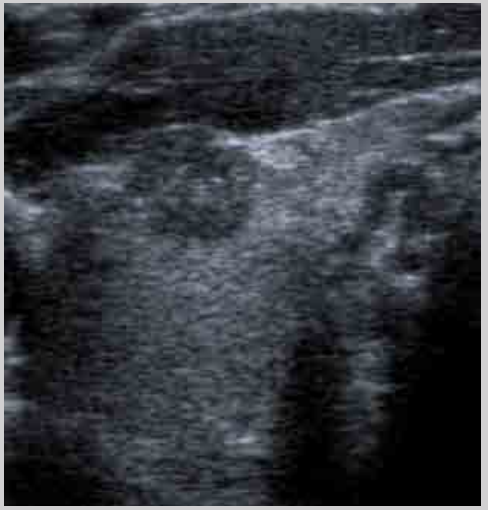
Problemi "aperti"

- Il nodulo singolo voluminoso
- L'adenoma
- Il nodulo indeterminato (Thyr3)
- Il microcarcinoma

La scelta del tipo d'intervento chirurgico

Papillary thyroid microcarcinomas: big decisions for a small tumor.

Haymart MR, Cayo M, Chen H.
Ann Surg Oncol. 2009 Nov;16(11):3132-9.



…the clinical significance of papillary thyroid microcarcinoma (PTMC) is debated, and therefore the rise in incidence of PTMC creates management dilemmas.

……the decision tree in the management of PTMC is beginning at the time of surgery, and referral to endocrinology is associated with a more aggressive course.

La scelta del tipo d'intervento chirurgico

Roma,
9-11 novembre 2012

Treatment strategy for patients with papillary microcarcinoma.

Sugitani I, Fujimoto Y, Yamada K.
Nippon Rinsho. 2007 Nov;65(11):2045-8

Recently incidental detection of papillary microcarcinoma (PMC) by means of ultrasonography (US) has increased. It is still controversial how to deal with PMC in this situation. The mortality rate of patients with PMC is generally very low, and most PMC is regarded as "innocent" cancer. However, there are a few patients with PMC that show unfavorable outcome associated with clinically evident nodal metastasis, extrathyroidal invasion and/or distant metastasis. It is important to classify patients with PMC into high-risk and low-risk group when determining the treatment method. In this paper, we introduce our strategy for patients with asymptomatic PMC, including non-surgical follow-up based on patients' informed decision.

La scelta del tipo d'intervento chirurgico

Roma,
9-11 novembre 2012

Three distinctly different kinds of papillary thyroid microcarcinoma should be recognized: our treatment strategies and outcomes.

Sugitani I, Toda K, Yamada K, Yamamoto N, Ikenaga M, Fujimoto Y.
World J Surg. 2010 Jan 12.

Papillary microcarcinoma of the thyroid generally follows a benign clinical course. However, treatment strategies remain controversial.

……nonsurgical observation seems to represent an attractive alternative to surgery for asymptomatic PMC. Almost 95% of asymptomatic PMC patients are type I, and another 5% are type II and can be treated with conservative surgery. A small number of PMCs with bulky lymph node metastasis or extrathyroidal invasion are high-risk type III and require aggressive treatment.

La scelta del tipo d'intervento chirurgico

Roma,
9-11 novembre 2012

An observational trial for papillary thyroid microcarcinoma in Japanese patients.

Ito Y, Miyauchi A, Inoue H, Fukushima M, Kihara M, Higashiyama T, Tomoda C, Takamura Y, Kobayashi K, Miya A.
World J Surg. 2010 Jan;34(1):28-35.

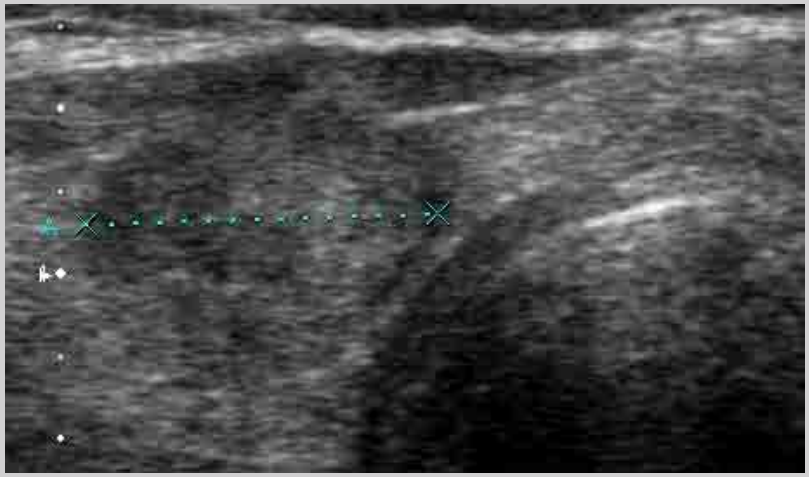
The marked difference in prevalence between clinical thyroid carcinoma and PMC detected on mass screening prompted us to observe PMC unless the lesion shows unfavorable features, such as location adjacent to the trachea or on the dorsal surface of the thyroid possibly invading the recurrent laryngeal nerve, clinically apparent nodal metastasis, or high-grade malignancy on FNAB findings.

……..papillary microcarcinomas that are not associated with unfavorable features can be candidates for observation regardless of patient background and clinical features. If there are subsequent signs of progression, such as tumor enlargement and novel nodal metastasis, it would not be too late to perform surgical treatment. Even though the primary tumor is small, careful surgical treatment including therapeutic modified neck dissection is necessary for N1b PMC patients.

La scelta del tipo d'intervento chirurgico

Papillary thyroid carcinoma and microcarcinoma: is there a need to distinguish the two?

Arora N, Turbendian HK, Kato MA, Moo TA, Zarnegar R, Fahey TJ 3rd.
Thyroid. 2009 May;19(5):473-7.



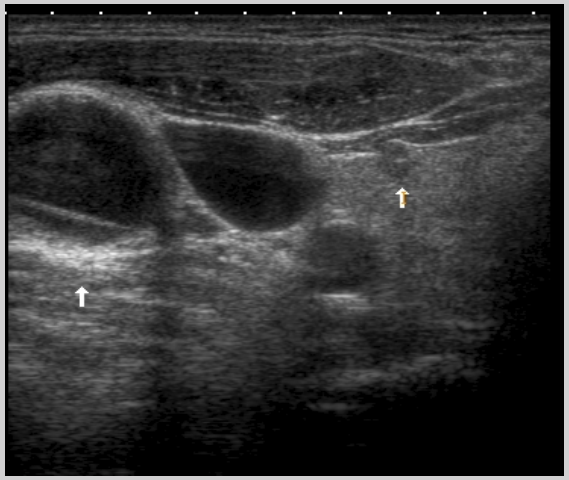
…the clinical significance of papillary thyroid microcarcinoma (PTMC) tumors < or =1 cm is widely debated.

…….nonincidental PTMC can have aggressive tumor features and disease recurrence similar to conventional PTC. These tumors should be managed like any other papillary thyroid malignancy.

La scelta del tipo d'intervento chirurgico

'Aggressive papillary' thyroid microcarcinoma.

Page C, Biet A, Boute P, Cuvelier P, Strunski V.
Eur Arch Otorhinolaryngol. 2009 Dec;266(12):1959-63.



…the objective of this study is to highlight the fact that papillary thyroid microcarcinoma can be aggressive, requiring therapeutic management similar to that of other differentiated thyroid cancers.

…the optimal management of thyroid papillary microcarcinoma is still controversial. "Aggressive" papillary thyroid microcarcinoma is not rare and may justify aggressive treatment depending on the presence or absence of prognostic risk factors.

La scelta del tipo d'intervento chirurgico

REVISED ATA THYROID CANCER GUIDELINES

[A1] THYROID NODULE GUIDELINES

…attempts to diagnose and treat all small thyroid cancers in an effort to prevent these rare outcomes would likely cause more harm than good.

La scelta del tipo d'intervento chirurgico

Roma,
9-11 novembre 2012

■ **RECOMMENDATION 21**

Preoperative neck US for the contralateral lobe and cervical (central and especially lateral neck compartments) lymph nodes is recommended for all patients undergoing thyroidectomy for malignant cytologic findings on biopsy. US-guided FNA of sonographically suspicious lymph nodes should be performed to confirm malignancy if this would change management. Recommendation rating: B

REVISED ATA THYROID CANCER GUIDELINES

The goals of initial therapy of DTC are follows:

1. To remove the primary tumor, disease that has extended beyond the thyroid capsule, and involved cervical lymph nodes. Completeness of surgical resection is an important determinant of outcome, while residual metastatic lymph nodes represent the most common site of disease persistence/recurrence (116–118).
2. To minimize treatment-related morbidity. The extent of surgery and the experience of the surgeon both play important roles in determining the risk of surgical complications (119,120).
3. To permit accurate staging of the disease. Because disease staging can assist with initial prognostication, disease management, and follow-up strategies, accurate postoperative staging is a crucial element in the management of patients with DTC (121,122).
4. To facilitate postoperative treatment with radioactive iodine, where appropriate. For patients undergoing RAI remnant ablation, or RAI treatment of residual or metastatic disease, removal of all normal thyroid tissue is an important element of initial surgery (123). Near total or total thyroidectomy also may reduce the risk for recurrence within the contralateral lobe (124).
5. To permit accurate long-term surveillance for disease recurrence. Both RAI whole-body scanning (WBS) and measurement of serum Tg are affected by residual normal thyroid tissue. Where these approaches are utilized for long-term monitoring, near-total or total-thyroidectomy is required (125).
6. To minimize the risk of disease recurrence and metastatic spread. Adequate surgery is the most important treatment variable influencing prognosis, while radioactive iodine treatment, TSH suppression, and external beam irradiation each play adjunctive roles in at least some patients (125–128).

Quale chirurgia?

Roma,
9-11 novembre 2012

REVISED ATA THYROID CANCER GUIDELINES

■ **RECOMMENDATION 24**

For patients with an isolated indeterminate solitary nodule who prefer a more limited surgical procedure, thyroid lobectomy is the recommended initial surgical approach. Recommendation rating: C

■ **RECOMMENDATION 25**

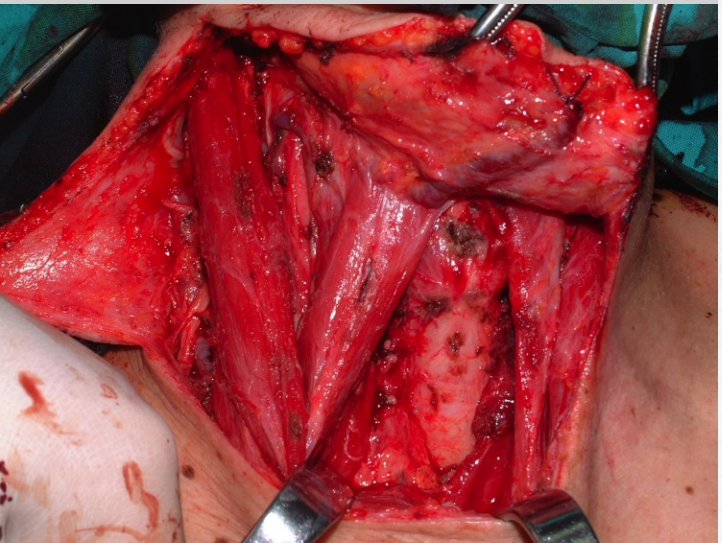
(a) Because of an increased risk for malignancy, total thyroidectomy is indicated in patients with indeterminate nodules who have large tumors (>4 cm), when marked atypia is seen on biopsy, when the biopsy reading is "suspicious for papillary carcinoma," in patients with a family history of thyroid carcinoma, and in patients with a history of radiation exposure. Recommendation rating: A

(b) Patients with indeterminate nodules who have bilateral nodular disease, or those who prefer to undergo bilateral thyroidectomy to avoid the possibility of requiring a future surgery on the contralateral lobe, should also undergo total or near-total thyroidectomy. Recommendation rating: C

Quale chirurgia?

Roma,
9-11 novembre 2012

REVISED ATA THYROID CANCER GUIDELINES



RECOMMENDATION 27*

(a) Therapeutic central-compartment (level VI) neck dissection for patients with clinically involved central or lateral neck lymph nodes should accompany total thyroidectomy to provide clearance of disease from the central neck. Recommendation rating: B

(b) Prophylactic central-compartment neck dissection (ipsilateral or bilateral) may be performed in patients with papillary thyroid carcinoma with clinically uninvolved central neck lymph nodes, especially for advanced primary tumors (T3 or T4). Recommendation rating: C

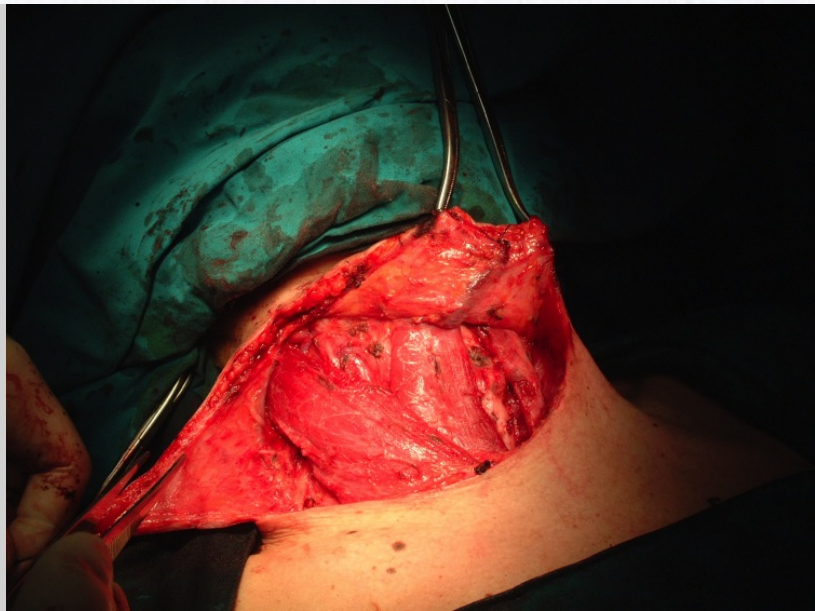
(c) Near-total or total thyroidectomy without prophylactic central neck dissection may be appropriate for small (T1 or T2), noninvasive, clinically node-negative PTCs and most follicular cancer. Recommendation rating: C

Quale chirurgia?

- **RECOMMENDATION 28***

  Therapeutic lateral neck compartmental lymph node dissection should be performed for patients with biopsy-proven metastatic lateral cervical lymphadenopathy. Recommendation rating: B

REVISED ATA THYROID CANCER GUIDELINES



La scelta del tipo d'intervento chirurgico

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J. Endocrinol. Invest. 35 (Suppl. to no. 6): 10-15, 2012

Primary surgery for differentiated thyroid cancer in the new millennium

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Department of General, Visceral and Vascular Surgery, Medical Faculty, University of Halle-Wittenberg, University Hospital, Halle/Saale, Germany

Table 1 - *Surgery for differentiated thyroid cancer.*

Tumor type	Extent of disease	Preferred extent of surgery (primary or completion)	Alternative
PTC	<10 mm (MPTC), and solitary, without extrathyroidal invasion, LNM, or DM	Lobectomy	TT for concomitant MNG
	>10 mm, or multiple, or with extrathyroidal invasion, LNM, or DM	TT plus CND	TT without CND for cN0cM0 PTC
FTC	MIFTC without vascular invasion or metastases	Lobectomy	TT for concomitant MNG
	MIFTC with vascular invasion or metastases, or WIFTC	TT without routine CND	TT with routine CND for oncocytic variant (Hurthle cell cancer)

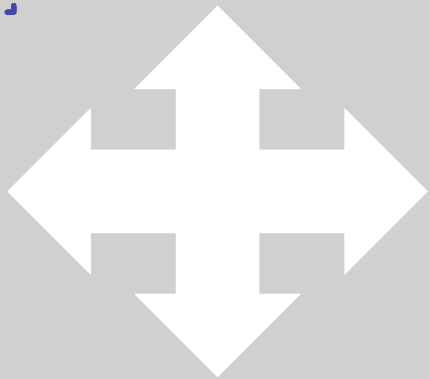
PTC: papillary thyroid cancer; FTC: follicular thyroid cancer; cN0cM0: clinically node-negative without distant metastasis; CND: central node dissection; MIFTC: minimally invasive follicular thyroid cancer; MNG: multinodular goiter; mPTC: papillary microcarcinoma; TT: total thyroidectomy; WIFTC: widely invasive follicular thyroid cancer.

Chi decide cosa fare ??

Roma,
9-11 novembre 2012

medico di famiglia

endocrinologo

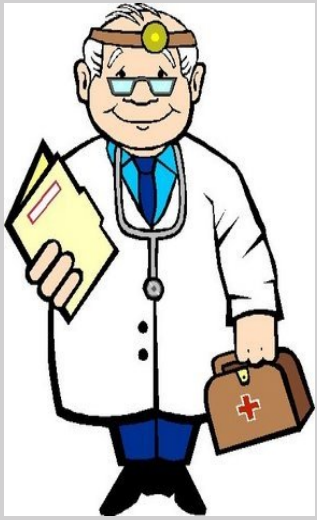


chirurgo

paziente

Chi decide cosa …… si doveva fare ??

Aspetti Medico legali



Informare il paziente in maniera completa e veritiera circa le "incertezze della situazione", discutendo le opzioni e quindi coinvolgendolo nella decisione finale (*shared decision making*)

Caso 1

P.G. anni 57

Occasionale riscontro ecografico (CDU vasi epiaortici) di piccolo gozzo nodulare con lesione predominante (16 mm) a destra ed altre subcentimetriche non sospette bilaterali. L'esame citologico del nodulo prevalente è compatibile con patologia benigna (Thyr2): viene consigliato monitoraggio periodico.
A distanza di sei mesi comparsa di fastidi al collo; un altro Endocrinologo consultato consiglia la tiroidectomia. L'esame istologico evidenzia nel lobo sinistro tre focolai di microcarcinoma papillifero.

……. …. ——> La paziente denuncia il primo Endocrinologo

Caso 2

F.P. anni 47

Gozzo nodulare noto da oltre 10 anni; l'ecografia rileva almeno due lesioni focali sospette (lobo destro 17 mm; lobo sinistro 18 mm). L'esame citologico è diagnostico per neoplasia; viene consigliata tiroidectomia totale con linfectomia del comparto centrale.
L'esame istologico conferma carcinoma papillifero multifocale bilaterale senza metastasi nei 18 linfonodi asportati.
Paralisi ricorrenziale monolaterale ed ipoparatiroidismo.

..... ⟶ La paziente denuncia Endocrinologo e Chirurgo