Kent and Medway Cancer Collaborative

Thyroid Tumour Site Specific Group meeting
Thursday 26th March 2026
Lecture Theatre, Postgraduate Centre, William Harvey Hospital, Ashford
09:30 - 12:30

Final Meeting Minutes

Present	Initials	Title	Organisation
Chris Theokli **(Chair)**	**CT**	Consultant ENT Thyroid Surgeon	EKHUFT
Eranga Nissanka-Jayasuriya	**ENJ**	Consultant Head & Neck Histopathologist	EKHUFT
Vikram Dhar	**VD**	ENT / Head and Neck Consultant Surgeon	EKHUFT
Susan Honour	**SH**	Macmillan Lead Head & Neck & Thyroid CNS	EKHUFT
Muhammad Eraibey	**ME**	Consultant Radiologist	EKHUFT
Robert Hone	**RH**	Head & Neck Otolaryngology Consultant	EKHUFT
Alistair Balfour	**AB**	Consultant ENT, Head & Neck & Thyroid Surgeon	EKHUFT
Eliza Grigoras	**EG**	Consultant	EKHUFT
Nicola Chaston	**NC**	Consultant Pathologist	EKHUFT
Kate Hulley	**KH**	Consultant Radiologist	MTW
Solly Thomas	**ST**	Consultant Clinical Oncologist	MTW
Siva Sivappriyan	**SS**	Consultant Physician, Diabetes & Endocrinology	MTW
Serena Gilbert	**SG**	Cancer Performance Manager	KMCA
David Osbourne	**DO**	Data Analyst	KMCA
Karen Glass	**KG**	PA & Business Support Manager	KMCA & KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams **(Minutes)**	**SW**	Administration & Support Officer	KMCC
Navdeep Upile	**NU**	Consultant Otolaryngologist Head and Neck Surgeon	MFT & QVH
Adam Gaunt	**AG**	Consultant ENT Surgeon	MFT
Claire Newbury	**CB**	Faster Diagnosis Head & Neck CNS	MFT
Maria Acosta	**MA**	Consultant Physician in Nuclear Medicine	MFT
Debbie Hannant	**DH**	Macmillan Head & Neck CNS	MFT
Bincey Joseph	**BJ**	CNS	QVH
Apologies			
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT

Pippa Enticknap	**PE**	Deputy General Manager - Cancer, Clinical Haematology & Haemophilia	EKHUFT
Nicola Chaston	**NC**	Consultant Pathologist	EKHUFT
Elizabeth Hall	**EH**	Principal Clinical Scientist, Clinical Biochemistry & Immunology	EKHUFT
Carol Hammond	**CH**	Biomedical Scientist – Cytology	EKHUFT
Marie Payne	**MP**	Macmillan Lead Cancer Nurse	DVH
Jonathan Bryant	**JB**	Clinical Lead / GP	KMCA
Ritchie Chalmers	**RC**	Medical Director	KMCA
Ann Courtness	**AC**	Primary Care Nurse Facilitator	KMCA
John Schofield	**JS**	Consultant Pathologist	MTW
Ann Fleming	**AF**	Consultant Histopathologist	MTW
Nadine Caton	**NC**	Consultant ENT	MTW
Aoife Scammell	**AS**	Head & Neck Oncology Clinical Nurse Specialist	MTW
Bindu George	**BG**	Head & Neck CNS	MTW
Gemma McCormick	**GM**	Consultant Oncologist	MTW
Laura Mullens	**LM**	Rare Cancers Clinical Nurse Lead	MTW
Supriya Joshi	**SJ**	Consultant Chemical Pathologist	MTW
Phoebe Brown	**PB**	Assistant General Manager – Cancer Performance	MTW
Louise Black	**LB**	Macmillan Deputy Lead Cancer Nurse	MFT
Suzanne Bodkin	**SB**	Cancer Service Manager	MFT
Basim Wahba	**BW**	ENT/Head & Neck Consultant	MFT
Sabita Pokharel	**SP**	Clinical Research Practitioner/Nurse	MFT
Deborah Owen	**DA**	Macmillan Head & Neck CNS	MFT
Helen Graham	**HG**	Research Delivery Manager	NIHR

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The formal Apologies are listed above. **<u>Introductions</u>** • CT welcomed the members to today's face to face meeting and the group introduced		

		themselves. • If you attended this meeting and are not captured on the attendance list above please contact Samantha.williams23@nhs.net directly and the distribution list will be amended accordingly. **Review Action Log** • The Action Log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review Previous Minutes** • The final minutes from the previous meeting which took place on the 3rd September 2025 were reviewed and agreed as a true and accurate account of the meeting. • RH raised an objection regarding Thy3a under 4cm statement (under AOB) on previous minutes and does not agree with this pathway.		
2.	**Surgical Hypoparathyroidism – an Endocrinologist Perspective.**	**Presentation provided by Eliza Grigoras** • The presentation provided an overview of the following :- • Definition of Chronic Hypoparathyrodism i) Hypocalcaemia in the presence of an undetectable, low or inappropriately "normal" PTH on 2 occasions at least 2 weeks apart. ii) Additional abnormalities caused by a low PTH that support the diagnosis: elevated serum phosphorus, low 1,25 (OH) vitamin D and elevations in the urinary excretion of calcium. iii) Permanent postsurgical hypoparathyroidism: if the hypoparathyroidism persists > 12 months after surgery. • Epidemiology and Financial Burden		**Presentation circulated to the group on 27th March 2026.**

i) Rare condition 0.8-2.3/100 000 person-years.
ii) Post-surgical hypoPTH 75%.
iii) Mortality: reported to be increased in some studies, but not in others.
iv) HypoPTH is associated with major financial burden due to increased healthcare utilization, significant symptom and comorbidity resulting in increased healthcare costs and healthcare resources, increased number of OP visits and A&E visits.
v) US study: 79% of patients with hypoPTH required hospitalization or A&E visits and 72% experiencing >10 symptoms.
vi) Hypoparathyroidism is associated with major detrimental impact on the lives of patients with hypoPTH

- Etiology

  i) Post-surgical hypoPTH 75%.
  ii) Nonsurgical HypoPTH (autoimmune APS type 1, genetic, maternal hyperparathyroidism, idiopathic, infiltrative, mineral deposition: iron, copper, metastatic, functional (Mg deficiency or excess), transient (severe burns or acute illness), radiation.

- Postsurgical HypoPTH – Risk Factors included - Patient Factors (Vitamin D Deficiency), Underlying Disease and Operative Factors. A recent study has shown an increased risk of hypoPTH in patients who underwent parathyroid auto transplantation (not recommended anymore).

- Serum Calcium and PTH Post-Op. If early PTH >1.05 pmol/litre 12-24 hours post-surgery, then hypoPTH is unlikely, no long-term need for treatment with active vitamin D and calcium. NB: Many patients with PTH <1.05 pmol/litre 24 hours post-op still recover from temporary HypoPTH.

- Symptoms and Complications of Hypo PT included – Cataract (17%), Nephrocalcinosis/Nepthrolithiasis (15%), Renal insufficiency (12%), Depression (12%), Infection (11%), Ischemic heart disease (7%) and Arrythmias (7%): prolonged QT.

		• Neuropsychiatric Complications and Features i) Patients with hypoPTh have an increased risk of neuropsychiatric disease. ii) Increase incidence of anxiety, depression and bipolar affective disorder. iii) Reduction in the QoL with significant negative impact on physical, mental or emotional health. iv) Neuromuscular manifestations: seizures, tetany, muscle stiffness (40-60% of HypoPTH patients). v) Numbness and tingling of the face are common symptoms. • Monitoring i) Serum creatinine, eGFR, albumin adjusted Ca, magnesium, Phosphorus (F/U 3-12 m) ii) 25 hydroxyvitamin D (F/U 6-12 M). iii) 24 hour urine for creatinine and calcium (F/U 6-12 M.) iv) Baseline assessment for presence of renal calcifications or stone with renal imaging (new proposal). v) Monitor serum Ca within several days of a significant change in medical treatment. EG added that some patients have shown bad results and there is a need to check these patients on a regular basis, checking their kidney function every 3 months plus carrying out the above tests. • Management Goals i) Treat with calcium and active vitamin D analogue aiming for a target calcium in the lower half of the normal reference range or just below the normal reference range (**2.0-2.2 mmol/litre**) Unclear how is best to balance the doses of calcium relative to those of active vitamin D analogue. ii) Alleviate symptomatic hypocalcaemia whilst avoiding hypercalciuria (aim for low normal calcium levels.) iii) Achieve 24-hour urine ca <6.25 mmol/24 hours in women and <7.5 mmol/24 hours in men. iv) Avoid hyperphosphatemia (prescribe calcium supplements **with** meals). v) Normalise Magnesium level.		

vi) Achieve 25(OH)vitamin D in the normal range (75-100 mmol/litre).
vii) Consider treating hypercalciuria with thiazide diuretics.

- Management

i) Conventional therapy: oral calcium and active vitamin D – this is first line therapy.
ii) If PTH <1.05 pmol/litre after total thyroidectomy then prescribe medical therapy with 2-3 grams of elemental calcium daily and 0.5-1.5 mcg calcitriol/day.
iii) Cholecalciferol or ergocalciferol are often required to maintain 25(OH)vitamin D level within the normal range.
iv) Thiazide diuretics can be used to lower urine calcium (needs monitoring of electrolytes as can cause low K, low Mg and low Na), can cause low BP!
v) NB: Must tell patient to take calcium supplements WITH meals to enhance phosphate binding effects

- Emergency Management of Hypocalcaemia

i) Severe hypocalcaemia: serum calcium <1.75 mmol/L and/or significant symptoms at any level below the reference range.
ii) This is a medical emergency. Administer I.V.Calcium Gluconate.
iii) Initially, give 10–20 mL 10% calcium gluconate in 50–100 mL of 5% dextrose i.v. over 10 min with ECG monitoring. This can be repeated until the patient is asymptomatic. It should be followed up with a calcium gluconate infusion and initiation of oral therapy with calcium and calcitriol. Vitamin D Deficiency or hypomagnesaemia should be treated.

- PTH Replacement in Clinical Studies

i) Clinical trials of Synthetic PTH (1-34) has proven efficient in increasing serum Ca, lowering urine Ca and increasing phosphate excretion.
ii) BD doses (short half-life) or continuous s/c infusion pump. Full length molecule rhPTH (1-84). OD (half-life 3 hours). Mixed bag of results from clinical trials with PTH.

		• Palopegteriparatide - Prodrug with 3 components: i) PTH (1-34), identical to the first 34 N-terminal amino acids of endogenous human PTH required for receptor activation. ii) An inert carrier that inactivates the parent drug (PTH [1-34]) to prevent receptor binding, renal clearance and enzymatic degradation. iii) A linker that binds PTH (1-34) to the carrier and autocleaves upon exposure to physiologic pH and temperature. Not yet NICE Approved. • Yorvipath (palopegteriparatide) TransConPTH Chart. • PTH Therapy in UK. A few cases have received funding. Patients who are inadequately controlled with conventional therapy, patients with fluctuating calcium levels requiring hospitalization for hypoCa or hyperCa. To consider in patients with: hypercalciuria, nephrocalcinosis, poor absorption, GI effects from high doses of Ca and active vitamin. EG explained that it is a rare condition and is difficult to treat and manage and went through three Case Studies. Support groups are available for these patients. It is important for patients to take Vitamin D supplements before thyroidectomy surgery. EG suggested providing high doses of calcium and Vitamin D for patients early on with hypoparathyroidism. CT will check all Vitamin D levels of their patients going forwards. NU advises his patients to take Vitamin D.		
2.	**Dashboard**	**<u>Update provided by David Osborne</u>** • DO provided an overview of the Live Dashboard and encouraged everyone to gain access. • FDS performance is 41.0& at EKHUFT, 67.2% at MT and 39.9% at MFT. • 62 Days performance is 51.9% at EKHUFT, 85.4% at MTW and 58.2% at MFT. • Histology Data – turnaround times are around 50%, which is below the target of 90%. MTW are consistently delivering the FDS and 62-day pathways and is much more consistent than MFT and EKHUFT. Data around Surgery and length of stay patients showed they are discharged quicker at MTW than at EKHUFT. Referrals were initially coded as Head and		**Data Pack circulated to the group on 20th March 2026**

		Neck and not Thyroid – which is now improving the data. • ENJ quoted 10 days for the turnaround times in Histopathology and DO confirmed that this data showed Thyroid biopsies and that thyroid conditions are recorded as diagnosis. • CT asked for data on the national average and DO will look into this if it is available. MTW are seeing patients, delivering ultrasound and giving a diagnosis faster. • CT asked DO for numbers rather than percentages going forwards. **How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards** • Register for access to Kent and Medway ICB Power BI reports by completing the form at https://forms.office.com/r/svyPSvktHw. • Email David.Osborne11@nhs.net to inform him that you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access. • Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the **KM ICB Main** app and you will see **Cancer in Primary Care** and **Cancer Pathways** listed on the left-hand menu.		
3.	**Clinical Reference Group Discussions**	Not discussed.		
4.	**Thy 3a Sampling Audit**	**Presentation provided by Chris Theokli** • The presentation provided an overview of the following :- • CT went through the NICE Guidance Thyroid Cancer – Assessment and Management that was published in December 2022 outlining the Initial FNAC Result, Management and Further Sampling.		

		• There was money from the Canadian Health Economic Study in 2005. Cost per patient – Repeat FNAC and HT = £3,078. CNB and HT = £3,018.Net Monetary Benefit – Repeat FNAC and HT = £334, 992 and CNB and HT = £335,079. Probability of cost effectiveness - 64% vs 36%. The decision is made solely due to finance and no clinical effectiveness studies were identified to carry out a core needle biopsy repeat compared to FNAC. • Comparison of core-needle biopsy and repeat fine-needle aspiration biopsy for thyroid nodules with initially inconclusive findings: a systematic review, diagnostic accuracy meta-analysis, and meta-regression - Journal of the American Society of Cytopathology Volume 14, Issue 3, May–June 2025, Pages 159-169. • Summary - 9 studies incorporated (8 Korean, 1 Chinese) • Analysis of repeat FNAC vs CNB in cases of inadequate or indeterminate original FNAC. • Original FNAC outcome - non-diagnostic: 6% - 36%, indeterminate: 10% - 20%. • Rates of Non-Diagnostic and Rate of AUS were tabled. • Diagnostic accuracy for malignancy - Sensitivity (minimise the false negatives) – correctly identify those with the condition; ensure no one who is positive is missed (true positive rate). • Specificity (minimise false positives) – correctly identify those without the condition; ensure no one who is negative is wrongly flagged (true negative rate). • CB: sensitivity = 75.1%, specificity = 99.9% • rFNAC: sensitivity = 56.5%, specificity = 99.7% • Summary - CNB shows reduced rates of non-diagnostic and AUS results compared with repeat FNAC. • CNB demonstrated greater sensitivity and is less reliant on the proficiency of the radiologist • No observable difference in adverse events. RH mentioned that West Kent were carrying out more core biopsies. CT added that NICE Guidelines state that the first investigation should be an FNA, if it is a Thy 1a or Thy 3a, then offer core needle		

		biopsy. **ACTION – CT asked ME to present a West Kent Audit at the next TSSG.** KH reported that there was not a Cytologist at MTW. RH added that this is a service level issue and MTW needs to outsource. CT highlighted that sex and age of patients were a factor. **ACTION - NU mentioned Active Surveillance - requires an evidence-based discussion and recommended taking this through the CRG and bringing this back to next TSSG. CT would like to look at research for justification and bring this back to next meeting.**		**ME** **CT**
5.	**MDT Streamlining**	Not discussed.		
6.	**Follow-Up Pathways across different Trusts**	**<u>Updates provided by Maria Acosta, Sue Honour & Solly Thomas</u>** • CT highlighted that the actual Patient Pathway is different across the Trusts. **<u>EKHUFT</u>** • GP's refer a patient with a thyroid issue to the Surgeon, patient is discussed at MDT and then referred to nuclear medicine, with nurse follow-up for low risk cancer. • Post completion of treatment. MDM discussion of DRS. • Low risk - option of Nurse Led follow- Up / Supported Self-Management. CNS able to request Bloods and USS / FNA. • Moderate risk – Consultant follow up / Shared care. • High Risk – Surgical Consultant Led follow up. Oncology Consultant. • CNS Involvement included :- • Diagnostic pathway – repeat USS and FNA. Contact post FNA for results and action. • Advice and Guidance for other Tumour site CNS teams. • Support following diagnosis – point of contact. • Holistic Needs Assessments – at diagnosis and 1-year post treatment		

		• Treatment Summaries to be implemented. **MFT** • MA at MFT highlighted that they see patients, investigate, ultrasound, FNA and have CN their STT Nurse who triages all USC referrals for Head & Neck and sends them to MA to vet for either Thyroid or ENT. Claire will carry out a telephone nurse led call which counts as the first appointment and they can request an FNA or book a first face to face appointment for the patient to have an examination. They triage within 28 hours and CN triages 2 week waits. • NU explained that it has taken 2 years to obtain CN. The Cancer Alliance funded CN's role initially for a 1 year but it is now fully funded by MFT. DH provides a nurse led clinic alongside MA. **MTW** • ST provided a flow chart, detailing the Thyroid Cancer Pathway – Radical Treatment. They carry out 3-month follow-ups, risk stratification and this is handed to the surgical follow-up team. Any high risks are referred to St Thomas's. MTW have an Oncologist Nurse Specialist for Head and Neck and Thyroid but works on Thyroid for high risk patients on a Thursday only. MA added that they require a pathway for low risk cancer patients and CT highlighted the need to set up a pathway for self-supported management. MTW and MFT need to boost their service. **Action - East Kent would benefit from having a Clinical Nurse to triage 2ww/USC Referrals as they are valuable for all Trusts (this works well at MFT). CT to ask Alexis Warman to bid for funding/ ask Cancer Alliance if they can fund the post initially.** SG advised EKHUFT to talk to Alexis Warman and then they can bid for funding up to the end of March/beginning of April.		**CT**

7.	**CNS Updates**	**EKHUFT** • SH stated that they have 12 patients on self-supported management pathway and are pushing forwards with Treatment Summaries. **MFT** • DH advised that they are carrying out Holistic Nursing Assessments (HNA's) and electronic assessments at home. They are making reminder phone calls to patients but are struggling with electronic discharges. Each tumour site now has a Padlet and all the patient information is on-line and patients are given a barcode. MFT are trying to stop physical paperwork/hardcopy leaflets. **MTW** - No update provided.		
8.	**Clinical Audit & Research Updates**	Not discussed.		
9.	**AOB**	• NU asked if future TSSSG Meetings can be rotated on different days and locations and didn't feel they get the quality of engagement holding the meeting virtually on Teams. • CT also felt that this does not recognise value to the patients and objects to having the next meeting on Teams and would like the meeting face to face. It was decided to hold the next meeting at either MFT or MTW (but never hold the meetings on a Friday).		
10.	**Next Meeting Date**	• Wednesday 18th November 2026 – 9.30am to 12.30pm, Lecture Theatre, Postgraduate Centre, William Harvey Hospital.		