comprehensive oncological audit strategy based on the available literature.

References

1. Morton DL, Thompson JF, Cochran AJ et al. Final trial report of sentinel-node biopsy versus nodal observation in melanoma. N. Engl. J. Med. 2014; 370: 599–609.

2. Carlino M, Atkinson B & Long G et al. What is the role of adjuvant systemic therapy in patients with resected stage II and stage III melanoma? 2017. [Cited 20 Sep 2021]. Available from URL: https://wiki.cancer.org.au/australia/Clinical_question:What_is_the_role_of_adjuvant_systemic_therapy_in_patients_with_resected_melanoma%3F

3. Gyorki D, Barbour A, Mar V, Sandhu S, Hanikeri M & Cancer Council Australia Melanoma Guidelines Working Party. When is a sentinel node biopsy indicated? 2015. [Cited 20 Sep 2021]. Available from URL: https://wiki.cancer.org.au/australia/Clinical_question:When_is_a_sentinel_node_biopsy_indicated%3F

4. Varey AHR, Madronio CM, Cust AE et al. Poor adherence to national clinical management guidelines: a population-based, cross-sectional study of the surgical management of melanoma in New South Wales, Australia. Ann. Surg. Oncol. 2017; 24: 2080–8.

5. Read RL, Pasquali S, Haydu L et al. Quality assurance in melanoma surgery: the evolving experience at a large tertiary referral centre. Eur. J. Surg. Oncol. 2015; 41: 830–6.

6. Pasquali S, Sommariva A, Spillane AJ, Bilimoria KY, Rossi CR. Measuring the quality of melanoma surgery—highlighting issues with standardization and quality assurance of care in surgical oncology. Eur. J. Surg. Oncol. 2017; 43: 561–71.

7. Spillane AJ, Haydu LE, Lee NC et al. Evaluation of incomplete sentinel node biopsy procedures and sentinel node positivity rates as surgical quality-assurance parameters in melanoma patients. Ann. Surg. Oncol. 2012; 19: 3919–25.

8. Lee NC, Spillane AJ, Pang TC, Haydu LE, Uren RF. Incomplete sentinel node biopsy is not clearly related to survival or regional recurrence in cutaneous melanoma patients. Ann. Surg. Oncol. 2012; 19: 280–6.

9. Richtig E, Komericki P, Trapp M et al. Ratio of marked and excised sentinel lymph nodes and scintigraphic appearance time in melanoma patients with negative sentinel lymph node. Eur. J. Surg. Oncol. 2010; 36: 783–8.

10. Scoggins CR, Martin RC, Ross MI et al. Factors associated with false-negative sentinel lymph node biopsy in melanoma patients. Ann. Surg. Oncol. 2010; 17: 709–17.

11. Lee DY, Huynh KT, Teng A et al. Predictors and survival impact of false-negative sentinel nodes in melanoma. Ann. Surg. Oncol. 2016; 23: 1012–8.

12. Valsecchi ME, Silbermins D, De Rosa N, Wong SL, Lyman GH. Lymphatic mapping and sentinel lymph node biopsy in patients with melanoma: a meta-analysis. In: Database of Abstracts of Reviews of Effects (DARE): Quality-Assessed Reviews. UK: Centre for Reviews and Dissemination, 2011.

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doi: 10.1111/ans.17338

Thyroid cancer clinicians’ views and experiences of delayed treatment during the COVID-19 pandemic: an international cross-sectional survey

In March 2020, the World Health Organization declared the coronavirus outbreak a global pandemic.1 Since then, countries worldwide have taken unprecedented measures in response to the outbreak and its demand on healthcare resources. One strategy has been delaying non-urgent surgery—one example being surgery for low-risk thyroid cancer. However, there are currently no data to inform how clinicians discuss and manage delayed treatment due to reasons beyond their own or the patients’ control or decision-making.2 During the pandemic, patients with lower risk thyroid cancer may have had to ‘sit’ with knowledge of their cancer for a prolonged period of time while awaiting surgery. For patients with higher risk cancers, surgical treatments including completion thyroidectomy, radioactive iodine (RAI) therapy and use of systemic therapies may also have been delayed. The aim of this study was to quantitatively examine the views and experiences of clinicians managing patients with thyroid cancer before and during the COVID-19 pandemic.

The study recruited thyroid cancer surgeons and endocrinologists who managed patients during the COVID-19 pandemic with ethics approval from the University of Sydney. Clinicians were invited to participate through email from the membership of the Australian New Zealand Endocrine Surgeons; Endocrine Society of Australia; Australian Society of Otolaryngology, Head and Neck Surgery; Asian Association of Endocrine Surgeons; and The American Thyroid Association. Data were collected between July and November 2020. The survey was administered through the online platform Qualtrics and took <10 min to complete. Quantitative analyses were carried out using Stata/IC v16 (StataCorp LP, USA). Descriptive statistics summarised the sample characteristics and the proportion of clinicians endorsing items on types of treatments delayed, worry about delays in treatment, and confidence in discussing delays in treatment. Multivariable linear regression models were used to examine the association of demographic and clinical practice characteristics with...
comfort delaying treatment generally, and specifically during the COVID-19 pandemic (controlling for comfort in general). Two-tailed p-values less than .05 were considered statistically significant.

Of 269 clinicians who consented and began the survey, 199 completed it and were included in the analysis (Table 1). The main treatment clinicians reported being delayed during the COVID-19 pandemic was thyroidectomy ($n = 114$; 57.3%), followed by surveillance imaging ($n = 100$; 50.3%), hemi-thyroidectomy ($n = 92$; 46.2%), adjuvant RAI ($n = 87$; 43.7%), therapeutic RAI for metastatic or recurrent disease ($n = 40$; 20.1%) and systemic therapies ($n = 14$; 7.0%). Only 10.6% ($n = 21$) of clinicians reported not delaying any treatments. The majority of these ($n = 12$; 57.1%) were from Australia and New Zealand.

For all types of thyroid cancer, when asked on a 5-point Likert scale (from very much to not at all) whether clinicians were ‘worried about having to delay treatment for their patients’ during the COVID-19 pandemic, 48 (24.1%) reported being very much or quite a bit worried, 127 (63.8%) reported being somewhat or a little bit worried and 24 (12.1%) reported being not at all worried. The most common reported reason for clinician worry was patient anxiety ($n = 54$; 27.1%). Only 27 clinicians (13.6%) reported worry that their patient may need more invasive surgery, it demonstrates that worry was not excessive and may indicate a growing appreciation of the shift towards active surveillance for those with low-risk thyroid cancer. We found clinicians were most worried about patient anxiety, with only a small proportion of clinicians being worried about the risk of disease progression and the need for more invasive treatments. This suggests that while clinicians understand thyroid cancer biology, some still find it difficult to explain this to patients, or feel patients will find it difficult to accept.3,4 Although temporarily delaying treatment is different to management through active surveillance, these internationally based findings provide insights into how clinicians offer treatment choices for thyroid cancer. It will be of interest to see if treatment delays and clinician experience with delays related to the pandemic alter patient management choices and patient-reported concerns, and affect attitudes to treatment in the future.

### Table 1 Clinician characteristics

| Characteristic ($n = 199$) | No. of clinicians, $n$ (%) |
|---------------------------|----------------------------|
| **Region**                |                            |
| United States             | 83 (41.7)                  |
| Australia/New Zealand     | 62 (31.2)                  |
| North/South America other than United States | 9 (4.5) |
| Europe/Middle East        | 23 (11.6)                  |
| Asia                      | 22 (11.1)                  |
| **Specialty**             |                            |
| Surgeon                   | 107 (53.8)                 |
| Endocrinologist           | 81 (40.7)                  |
| Other†                    | 11 (5.5)                   |
| **Years of experience**   |                            |
| <10                       | 53 (26.7)                  |
| 10–19                     | 75 (37.7)                  |
| 20–29                     | 37 (18.6)                  |
| 30+                       | 34 (17.1)                  |
| **Number of thyroid cancer patients/month** | | |
| <10                       | 95 (47.7)                  |
| 10–19                     | 45 (22.6)                  |
| 20–29                     | 20 (10.1)                  |
| 30–39                     | 13 (6.5)                   |
| 40–49                     | 4 (2.0)                    |
| 50+                       | 22 (11.1)                  |
| **Practice setting**      |                            |
| Academic (US)             | 77 (38.7)                  |
| Public only               | 29 (14.6)                  |
| Private only              | 41 (20.6)                  |
| Both public and private   | 50 (25.1)                  |
| Other                     | 2 (1.0)                    |
| **Gender**                |                            |
| Male                      | 124 (62.3)                 |
| Female                    | 73 (36.7)                  |
| Other/prefer not to say   | 2 (1.0)                    |

†Including nuclear medicine physician, radiation oncologist and endocrine nurse.

### Table 2 Clinician comfort for delaying treatment

| Comfortable | $n$ (%) |
|-------------|---------|
| Evidence from peer-reviewed studies | 115 (57.8) |
| Previous professional experience | 114 (57.3) |
| Current clinical guidelines | 110 (55.3) |
| Support from practice/hospital/clinic/colleagues | 61 (30.7) |
| Patient preference | 24 (12.1) |
| Just a feeling I have | 8 (4.0) |

| Not comfortable | $n$ (%) |
|----------------|---------|
| Patients not comfortable with it | 31 (15.6) |
| Risk of progression or metastases | 19 (9.5) |
| Lack of current evidence | 11 (5.5) |
| Current clinical guidelines | 11 (5.5) |
| Never thought about delaying or not providing immediate treatment | 10 (6.0) |
| Little to no previous experience | 7 (3.5) |
| Lack of support from practice/hospital/clinic/colleagues | 2 (1.0) |

†Response options were provided, and clinicians could choose more than one response.
Archived content:

Otolaryngology-head and neck surgery patient information leaflets produced by the Royal Australasian College of Surgeons: time for a re-think?

Introduction

Patient information leaflets (PILs) are important tools that help to educate patients about their health, and so can be useful in gaining informed consent for surgery. Face-to-face discussion between doctor and patient is essential, but PILs allow patients to reflect and understand their options outside of the consultation. PILs empower patients with autonomy in the decision-making of their health care.

PILs should therefore provide unbiased, accurate and reliable information, and be written at a reading level appropriate for the target population.

Studies have demonstrated that PILs are often too complex to read, difficult for patients to understand and the content can be of variable quality.1,2 This may have negative implications in Australia and New Zealand (NZ), where sizable proportions have below average literacy skills.3 PILs that are written at higher