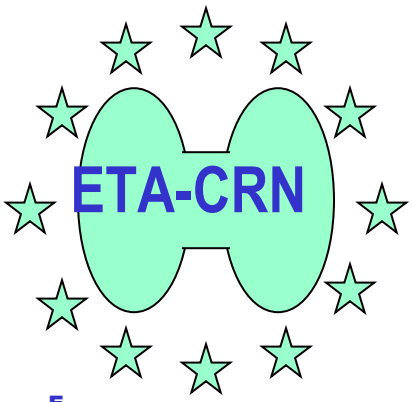

EUROPEAN THYROID ASSOCIATION CANCER RESEARCH NETWORK

8TH ETA-CRN MEETING

20TH SEPTEMBER, 2008

CHALKIDIKI, GREECE

PRESIDENT: DR. ROSSELLA ELISEI, UNIVERSITÀ DEGLI STUDI DI PISA, ITALY
SECRETARY: DR. ULLA FELDT-RASMUSSEN, NATIONAL UNIVERSITY HOSPITAL, COPENAGHEN, DK
TREASURER: DR. GERRY THOMAS, SOUTH WEST WALES CANCER INSTITUTE, SWANSEA, UK

7TH ETA-CRN MEETING
Chalkidiki, Saturday, 20th September 2008

PROGRAMME

09.30-10:00 **Registration and Coffee**

10:00-10:10 **Welcome and Opening**
President ETA-CRN, Rossella Elisei (Pisa, Italy)
Secretary ETACRN, Secretary ETA, Ulla Feldt-Rasmussen (Copenhagen, Denmark)

10:10-12:00 Basic/translational Scientific Session

Chairpersons: **Barbara Jarzab, Poland**
Lars Bastholt, Odense, Denmark

ANGIOGENESIS IN THYROID CANCER

10:10 - 10:40 TETRAC AS A POTENTIAL CHEMOTHERAPEUTIC AGENT IN THYROID CANCERS
PAUL J. DAVIS ,ALBANY, NY, US

10.40 – 11.05 TYROSINE KINASE INHIBITORS FOR TREATMENT OF THYROID CARCINOMA.
Massimo Santoro, Naples, Italy

11:05 – 11:25 Hypoxia in thyroid cancer
Georg Brabant, Manchester, UK

11:25 – 11:45 **Coffee Break**

11:45 - 12:10 Translation of mechanism of anti-angiogenic action into clinical use
Martin Schlumberger, Paris, France

12.10 –12.30 General discussion with speakers in panel

12:30-13:00 **GENERAL ASSEMBLY -** transition from network to working group of ETA

13:00 – 14:00 **Lunch break**

14:00 - 15:35 **Clinical Scientific Session**

Chairpersons: **Rosella Elisei, Pisa, Italy**
Jan Smit, Leiden, The Netherlands

Risk assessment of Thyroid Cancer: Which is the best approach?

14:00 - 14:25 Introduction – different prognostic risk assessments of thyroid cancer
Jan Smit, Leiden, The Netherlands

14:25 – 14: 45 Evidence based use of staging classifications in practice – is it possible?
Catharina Ihre-Lundgren, Stockholm, Sweden

14:45 – 15:05 Post-therapy risk assessment – is it better?
Furio Pacini, Siena, Italy

15:05 - 15:35 GENERAL DISCUSSION

15:35 - 15:50 **Closure**

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ABSTRACTS

Evidence based use of staging classification in practise- is it possible?

Catharina Ihre Lundgren, M.D, PhD, Department of Surgery, Karolinska University Hospital, 171 76 Stockholm, Sweden

Thyroid cancer represents 1 % of all the malignancies. It is a heterogenous group regarding histopathology, clinical treatment and prognosis. The main groups are papillary (PTC), follicular (FTC), medullary (MTC) and anaplastic (ATC) thyroid cancer. The most common forms are PTC and FTC. For both these groups the prognosis is excellent with an overall 10-year survival of 90 %.

An ideal evaluation of the effects of treatment should not be based on observational data, but on a randomised controlled trial this would be difficult to conduct in practice, due to the low mortality of the disease.

A population-based study from the Swedish Cancer Registry identified 5,554 individuals diagnosed with PTC or FTC during 1958-1987. The patients were followed for a minimum of 12 years. Within this cohort, a nested case-control study was conducted to evaluate the effect of prognostic factors in PTC and FTC mortality.

The data suggests that there may exist a class of thyroid tumours that are diagnosed in women during the fertile part of life with a superior prognosis. Clinically important prognostic factors were histopathological subgroup, TNM staging, including lymph-node metastases and distant metastases, as well as completeness of the surgical excision. However, the *EXTENT* of surgery did not influence the patients' survival. Loco-regional recurrence increased the mortality risk significantly. Postoperative treatments (radioiodine, external radiation and chemotherapy) were not associated with better survival in this study.

From the literature it has been suggested that the most important prognostic variables are age (cut-off value 45-50 years) and extracapsular invasion of the thyroid gland. These two factors have also been found to be associated with a poor clinical outcome in several commonly used staging systems. Other risk factors have been proposed over the years such as tumour grading, DNA ploidy, nuclear atypia, gross lymph node involvement, microscopic and macroscopic tumour multifocality, histologic PTC variants, Ki67, size of lymph node metastases, and tumour angioinvasion. However, due to the complexity of these staging systems they have not been utilized routinely in clinical practice. It is well known that thyroid cancer with distant metastases at the time of diagnosis has a negative effect on survival. This may in itself be related to other factors, such as age, which not only influence long-term survival in patients with existing distant metastases, but also predict the development of such metastases.

In practise, prognostic factors such as age, tumour size, metastases, Ki 67 and histopathology could influence the final outcome for patients with differentiated thyroid cancer. With this information staging in an evidence based setting would be possible.

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CHALKIDIKI, GREECE

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