Commentary

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Toward Dynamic and De-escalated Care: Insights from the ATA 2025 DTC Guidelines

Ali Bayram[1], Görkem Eskiizmir[2], Society for Head and Neck Surgery; Scientific Group

[1]University of Health Sciences Türkiye, Kayseri City Hospital, Department of Otorhinolaryngology, Head and Neck Surgery, Kayseri, Türkiye
[2]Manisa Celal Bayar University Faculty of Medicine, Department of Otorhinolaryngology, Head and Neck Surgery, Manisa, Türkiye

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Since the publication of the first guidelines addressing thyroid nodules and differentiated thyroid cancer (DTC) in 1996, the American Thyroid Association (ATA) has released four subsequent revisions (1-5). The presented commentary aimed to highlight the major conceptual and practical differences between the 2015 and 2025 ATA guidelines with special reference to clinically relevant updates.

General Aspects of the 2025 ATA Guidelines for DTC

In contrast to previous editions, the 2025 ATA guidelines for DTC solely focus on DTC and guidelines for thyroid nodules will now be published separately. Therefore, the number of recommendations is reduced from 101 (2015) to 84 (5). The quality of evidence and strength of recommendations are revised, and the categories include: "strong," "conditional," and "no recommendation" according to the GRADE recommendation grid. For the first time, a patient representative was included in the guideline development process. Additionally, patient-focused assessments such as psychosocial support and treatment-related financial burden or toxicity are added for the first time, while long-term survival issues and quality of life are also emphasized.

A Dynamic, Risk-Adaptive Management Framework (DATA Model)

The 2025 ATA guidelines adopt a dynamic disease management framework rather than a static strategy, encapsulated by the acronym DATA: "Diagnosis, risk/benefit Assessment, Treatment decisions, and response Assessment." This approach emphasizes the selection of optimal treatment strategies by balancing risks and benefits while incorporating individual patient characteristics. Following initial intervention, the 2025 ATA risk assessment tool is used to guide subsequent management decisions, including additional therapy and/or ongoing surveillance, with an individualized and adaptive care model. In addition to graded recommendations, the guidelines introduce the concept of a good practice statement (GPS), applied in selected scenarios with unanimous expert consensus.

ORCID IDs of the authors:
A.B. 0000-0002-0061-1755
G.E. 0000-0002-3125-8288

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Corresponding Author:
Ali Bayram, MD. Prof.;
dralibayram@gmail.com

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Although supported by low or insufficient evidence, GPS-labeled recommendations are considered to provide clear clinical benefit and are intended to be followed as strong guidance.

De-escalation as a Guiding Principle

Perhaps the most striking evolution from the 2015 to 2025 ATA guidelines is the formal endorsement of "active surveillance" (AS) as a first-line management strategy for carefully selected patients. Patients with cT1aN0M0 papillary thyroid carcinoma (PTC) are now recognized as candidates for AS through shared decision-making between the patient and the clinical team, with careful consideration of risks and benefits. Patients who are eligible for AS are recommended to undergo ultrasound evaluation every 6 months for 1-2 years, followed by annual surveillance by an experienced radiologist, with transition to surgery based on disease progression or patient preference. In addition, ultrasound-guided percutaneous tumor ablation is introduced as an alternative management option for selected patients with cT1aN0M0 PTC, again emphasizing shared decision-making.

The 2025 ATA guidelines place clear emphasis on surgeon volume, recommending that thyroid cancer surgery be carried out by high-volume surgeons, defined as those undertaking at least 25 thyroidectomies annually. Lobectomy is endorsed as the initial surgical approach for tumors ≤2 cm without extrathyroidal extension (ETE) or metastases and may be considered in selected patients with tumors >2 cm and ≤4 cm (cT2N0M0). Tumors >4 cm, or those with ETE or nodal involvement, should be managed with total thyroidectomy and appropriate neck dissection. Intraoperative nerve monitoring may be utilized to facilitate identification of the recurrent laryngeal nerve (RLN) and the external branch of the superior laryngeal nerve, particularly during total or completion thyroidectomy. Routine placement of surgical drains is discouraged and should be reserved for selected cases such as very large (predominantly retrosternal) glands, excessive intraoperative bleeding, or coagulopathies. Patients undergoing total thyroidectomy and/or central lymph node dissection, as well as completion thyroidectomy, should receive parathyroid hormone–guided calcium and vitamin D supplementation, either routinely or selectively. Furthermore, patients with documented postoperative RLN injury should be promptly referred to a speech-language pathologist or a voice-specialized physician.

Risk Stratification: From Three to Four Tiers and Beyond

The 2025 ATA Risk Stratification System is strongly recommended and represents a central component of contemporary DTC management. This system integrates histopathologic tumor features, cervical lymph node involvement, AJCC staging, postoperative imaging, and serum thyroglobulin (Tg) and anti-thyroglobulin antibody (TgAb) measurements (when appropriate) to estimate the risk of structural disease persistence or recurrence and disease-specific survival. Notably, the risk-of-recurrence (ROR) framework has been refined from a three-tier to a four-tier system, comprising "low," "low–intermediate," "intermediate-high," and "high" ROR categories. This subdivision of the former intermediate-risk group enables improved alignment between surgical extent and recurrence risk, more precise tailoring of radioactive iodine (RAI) therapy, and more accurate counseling regarding prognosis and follow-up intensity. Although routine postoperative molecular profiling is not recommended, molecular features are more explicitly incorporated into risk assessment when such data are available.

The 2025 ATA guidelines extend the recommended timing for postoperative Tg and TgAb measurement to 6-12 weeks rather than 3-4 weeks, reflecting improved understanding of postoperative Tg nadir kinetics for the assessment of ROR. Updated Tg thresholds have also been introduced for patients undergoing total thyroidectomy without RAI therapy: Tg <2.5 ng/mL defines an "excellent response," 2.5-5 ng/mL an "indeterminate response," and >5 ng/mL a biochemically "incomplete response."

Histopathologic evaluation is further aligned with the latest World Health Organization classification of thyroid tumors (6). The reclassification of noninvasive encapsulated follicular variant of papillary thyroid carcinoma as noninvasive follicular thyroid neoplasm with papillary-like nuclear features effectively downgrades this entity to a low-risk neoplasm, eliminating the need for completion surgery or RAI. Encapsulated follicular variant of papillary thyroid carcinoma with minimal capsular invasion is now regarded as a variant with a favorable prognosis. In contrast, oncocytic thyroid carcinoma and high-grade follicular cell-derived non-anaplastic thyroid carcinoma are recognized as distinct subtypes associated with poorer outcomes. Collectively, these changes reinforce a biologically informed, outcome-driven approach to postoperative risk assessment.

The updated risk stratification framework tightly aligns RAI recommendations with the 2025 ATA guidelines. It is strongly discouraged in low-risk patients based on high-quality evidence. When compared with the 2015 guidelines, a more flexible and individualized approach is advocated for patients in the low–intermediate and intermediate–high risk categories, underscoring the importance of pretreatment counseling.

Long-Term and Advanced Disease Management

Several clinically meaningful refinements are introduced in the long-term management of DTC. TSH suppression strategies have been simplified, with targets categorized

as either within or below the normal reference range. Maintaining TSH levels within the normal range is recommended for patients with excellent or indeterminate responses after total thyroidectomy, while suppression below normal is reserved for patients with biochemical or structural incomplete responses. Prolonged TSH suppression is no longer recommended for low- or intermediate-risk patients without evidence of recurrence, reflecting a deliberate shift toward less aggressive and more individualized therapy.

Recognizing the cumulative burden of long-term surveillance, the guidelines introduce a formal recommendation for stepwise de-escalation. Low-risk patients with a durable excellent response may end ultrasound surveillance after 5-8 years and continue follow-up with thyroglobulin monitoring every 1-2 years. After 10-15 years of persistent excellent response, patients may be considered in complete remission, permitting discontinuation of biochemical surveillance.

Ongoing, iterative response-to-therapy based risk stratification is emphasized as a cornerstone of long-term follow-up, guiding both surveillance intervals and therapeutic decision-making. Management of radioiodine-refractory metastatic DTC is increasingly individualized, balancing observation with timely systemic therapy based on disease kinetics and molecular features. Integration of targeted therapies, immunotherapy, and selective local interventions enables tailored treatment while minimizing unnecessary toxicity.

Conclusion

The 2025 ATA guidelines reflect a measured shift away from uniformly aggressive treatment toward more individualized, risk-adapted care. The updated guidance acknowledges DTC as a generally indolent disease in many patients, while emphasizing the importance of robust risk stratification and careful long-term surveillance to maintain oncologic safety.

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Footnotes

Authorship Contributions

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