**Comment on “Challenges of Shared Decision-making by Clinicians and Patients With Low-risk Differentiated Thyroid Cancer”**

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Yang et al1 have extoled the virtues of shared decision-making due to the high number of treatment options for low risk differentiated thyroid cancer and recommend the establishment and evaluation of decision-making tools for clinicians and patients. This is an important contribution to the debate on morbidity of total thyroidectomy for thyroid carcinoma. Although this condition affects a significant number of people worldwide, varying rates in different regions are still being explored. In the UK the prevalence is 5 per 100,000 women and 2 per 100,000 men2, in Africa, rates can be lower or higher, with research reporting incidence between 0.48 and 17.49 per 100,000, whilst one estimate of East Asia suggested 44.77 per 100,0003. “Overdiagnosis” could have significant financial and scientific burdens for all regions particularly regarding measurement of Disability adjusted life years (DALYs) and the potential for misuse of health care resources in an era of increasing concern of sustainability and environmental impact of health systems.

In Yang et al’s systematic review, all studies in the final synthesis are anglophone and from high resource settings in North America, Australia and the Netherlands. Although this may represent a dearth of qualitative enquiry on this topic from other regions, the true breadth of the treatment options and decision-making complexity can only be appreciated by also considering the views of patients and clinicians in low resource settings.

One of the themes identified in the review was clinician anxiety regarding patient concerns around consent. The review cites multiple international guidelines to suggest de-escalation in treatment strategies but all the cited guidelines are from North America or Europe.

In the creation of the African Head and Neck Cancer Society clinical practice guidelines4, recommendations for thyroid cancer placed emphasis on harms vs benefits looking at patient and contextual factors. Where radioiodine, calcium and thyroxine are not available or unaffordable, risk and surveillance strategies will inevitably be weighed differently. Kakudo5 provides a summary and debate about the potential to reclassify borderline “precursor cancers” such as papillary microtumors and other tumors likely to have no clinical significance.

Understanding commercialization of health and impacts on varying healthcare systems worldwide will require more knowledge sharing inclusive of the Global South. Different solutions may be needed for different regions, but sharing experiences can help promote better healthcare delivery for all. Patient-centered care should be prioritized to achieve equitable treatment and outcomes for thyroid cancer and ultimately, universal health coverage.

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