AMERICAN ASSOCIATION OF ENDOCRINE SURGEONS

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As the country contemplates how to resume daily activities in a safe and responsible fashion, many healthcare institutions have begun to think about re-opening operating rooms to non-emergency cases. The leadership of the AAES has been discussing this issue and thought it would be helpful to share our thoughts as a group on one potential rubric of how to prioritize our backlog of cases. **Please note that these thoughts are NOT meant to constitute a position statement, standard of care, or evidence-based/best practice guideline, but rather are the opinions of a selected group of senior surgeons.** In deciding the timing of surgery, each surgeon and institution must consider their individual patient within the context of her/his organization's specific circumstances and available resources.

Category 1:

Thyroid- poorly differentiated cancer, locally invasive thyroid cancer, goiter causing airway compromise or significant impingement, severe thyrotoxicosis
Parathyroid- calcium > 13
Adrenal- adrenocortical cancer, adrenal incidentaloma over 6 cm or suspicious for malignancy
Medically refractory endocrine disorders (ex. Medically refractory pheochromocytoma)
Endocrine disorders in pregnant patient that are dangerous to the health of the mother or fetus that cannot be controlled medically

Category 2:

Thyroid- cancer > 4 cm, positive cervical lymphadenopathy, cancer invading into surrounding structures
Parathyroid- calcium 12-13
Adrenal- pheochromocytoma/paraganglioma, Cushing's, adrenal metastases

Category 3:

Thyroid- thyroid cancer other than category 1 or 2, potential cancer, Graves' disease, symptomatic goiter, large goiter
Parathyroid- calcium 11-12
Adrenal- primary hyperaldosteronism, adrenal incidentaloma <6 cm

Category 4:

Thyroid- benign goiter
Parathyroid- calcium <11
Adrenal- other adrenal lesions