

Thyroid Cancer

(Papillary and Follicular)

WHAT IS THE THYROID GLAND?

The thyroid gland is a butterfly-shaped endocrine gland that is normally located in the lower front of the neck. The thyroid's job is to make thyroid hormones, which are secreted into the blood and then carried to every tissue in the body. Thyroid hormone helps the body use energy, stay warm and keep the brain, heart, muscles, and other organs working as they should.

CANCER OF THE THYROID

Thyroid cancer is relatively uncommon compared to other cancers. In the United States, it is estimated that in 2021 approximately 44,000 people will receive a new diagnosis of thyroid cancer, compared to over 280,000 with breast cancer and over 150,000 with colon cancer. However, despite this, approximately 2,000 patients die of thyroid cancer each year. In 2018, the last year for which statistics are available, almost 900,000 patients were living with thyroid cancer in the United States. Thyroid cancer is usually very treatable and is often cured with surgery (see [Thyroid Surgery brochure](#)) and, if indicated, radioactive iodine (see [Radioactive Iodine brochure](#)). Even when thyroid cancer is more advanced, effective treatment is available for the most common forms of thyroid cancer. Even though the diagnosis of cancer is terrifying, the prognosis for most patients with papillary and follicular thyroid cancer is excellent.

WHAT ARE THE TYPES OF THYROID CANCER?

PAPILLARY THYROID CANCER. Papillary thyroid cancer is the most common type, making up about 70% to 80% of all thyroid cancers. Papillary thyroid cancer can occur at any age. It tends to grow slowly and often spreads to lymph nodes in the neck. Papillary cancer has a generally excellent outlook, even if there is spread to the lymph nodes.

FOLLICULAR THYROID CANCER. Follicular thyroid cancer makes up about 10% to 15% of all thyroid cancers in the United States. Follicular cancer can spread through the blood to distant organs, particularly the lungs and bones.

Papillary and follicular thyroid cancers are also known as well-Differentiated Thyroid Cancers (DTC). The information in this brochure refers to these differentiated thyroid cancers. The other types of thyroid cancer listed below will be covered in other brochures.

MEDULLARY THYROID CANCER. Medullary thyroid cancer (MTC), accounts for approximately 2% of all thyroid cancers. Approximately 25% of all MTC runs in families and is associated with other endocrine tumors (see [Medullary Thyroid Cancer brochure](#)). In family members of an affected person, a test for a genetic mutation in the RET proto-oncogene can lead to an early diagnosis of medullary thyroid cancer and, as a result, to curative surgery. 75% of patients with Medullary thyroid cancer do not have a hereditary form.

ANAPLASTIC THYROID CANCER. Anaplastic thyroid cancer is the most advanced and aggressive thyroid cancer and the least likely to respond to treatment. Anaplastic thyroid cancer is very rare and is found in less than 2% of patients with thyroid cancer (See [Anaplastic Thyroid Cancer brochure](#)).

WHAT ARE THE SYMPTOMS OF THYROID CANCER?

Thyroid cancer often presents as a lump or nodule in the thyroid and usually does not cause any other symptoms (see [Thyroid Nodule brochure](#)). Blood tests generally do not help to find thyroid cancer and thyroid blood tests such as TSH are usually normal, even when a cancer is present. Neck examination by your doctor is a common way in which thyroid nodules and thyroid cancer are found. Often, thyroid nodules are discovered incidentally on imaging tests like CT scans and neck ultrasounds done for completely unrelated reasons. You may have found a thyroid nodule by noticing a lump in your neck while looking in a mirror, buttoning your collar, or fastening a necklace. Rarely, thyroid cancers and nodules may cause symptoms. You may complain of pain in the neck, jaw, or ear. If a nodule is large enough to compress your windpipe or esophagus, it may cause difficulty with breathing, swallowing, or cause a "tickle in the throat" sensation. Even less commonly, you may develop hoarseness if a thyroid cancer invades the nerve that controls your vocal cords.

Cancers arising in thyroid nodules generally do not cause symptoms, and thyroid function tests are typically normal even when you have cancer. The best way to find a thyroid nodule is to make sure that your doctor examines your neck as part of your periodic check-up.



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WHAT CAUSES THYROID CANCER?

Thyroid cancer is more common in people who have a history of exposure to high doses of radiation, have a family history of thyroid cancer, and are older than 40 years of age. However, for most people, we don't know why thyroid cancer develops.

High dose radiation exposure, especially during childhood, increases the risk of developing thyroid cancer. Radiation therapy used to treat cancers such as Hodgkin's disease (cancer of the lymph nodes) or breast cancer has been associated with an increased risk for developing thyroid cancer if the treatment included exposure to the head, neck or chest. Routine X-ray exposure such as dental X-rays, chest X-rays and mammograms are not associated with a high risk of thyroid cancer. As always, you should minimize radiation exposure by only having tests which are medically necessary.

Exposure to radioactivity released during nuclear disasters (1986 accident at the Chernobyl power plant in Russia or the 2011 nuclear disaster in Fukushima, Japan) has also been associated with an increased risk of developing thyroid cancer, particularly in exposed children, and thyroid cancers can be seen in exposed individuals as many as 40 years after exposure.

You can be protected from developing thyroid cancer in the event of a nuclear disaster by taking potassium iodide (see [Nuclear Radiation and the Thyroid brochure](#)). This prevents the absorption of radioactive iodine and has been shown to reduce the risk of thyroid cancer. The American Thyroid Association recommends that anyone living within 200 miles of a nuclear facility be given potassium iodide to take if a nuclear accident occurs. If you live near a nuclear reactor and want more information about the role of potassium iodide, check the recommendations from your state at the following link: www.thyroid.org/web-links-for-important-documents-about-potassium-iodide/.

HOW IS THYROID CANCER DIAGNOSED?

If your doctor suspects from your physical exam and ultrasound that you may have cancer, you will need to have a fine needle aspiration biopsy. The results of the biopsy can be highly suggestive of thyroid cancer and will prompt surgical treatment. Thyroid cancer can only be diagnosed with certainty after the nodule is removed surgically (see [Thyroid Nodule brochure](#)). Thyroid nodules are very common, but less than 1 in 10 will be a thyroid cancer.

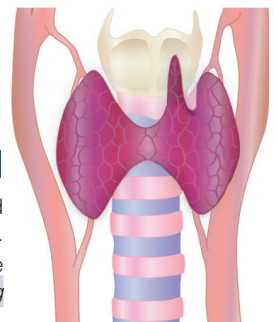
WHAT IS THE TREATMENT FOR THYROID CANCER?

Surgery. The first step in treatment for all types of thyroid cancer is surgery (see [Thyroid Surgery brochure](#)). The extent of surgery for differentiated thyroid cancers may be removing only the lobe involved with the cancer, called a lobectomy, or removing the entire thyroid, called a total thyroidectomy. The extent of surgery will depend on the size of the tumor and whether or not the tumor has spread beyond the thyroid gland. If your tumor involves both lobes of the thyroid gland or it is found on testing to have spread beyond the gland, a total thyroidectomy will be recommended. If you have thyroid cancer present in the lymph nodes of the neck (lymph node metastases), these lymph nodes can be removed at the time of the initial thyroid surgery or sometimes, as a second procedure. However, if your cancer is small, only in one lobe of the gland and if it has not spread to lymph nodes, a lobectomy may be a good option. Recent studies even suggest that if you have a small tumor measuring less than 1cm across, called papillary thyroid microcarcinoma, you may be observed very safely without surgery. If you have a total thyroidectomy, you will need to take thyroid hormone medication for the rest of your life (see [Thyroid Hormone Treatment brochure](#)). However, if you have a lobectomy, you may not need to take thyroid hormone replacement. Thyroid cancer is often cured by surgery alone, especially if the cancer is small. If your cancer is larger, if it has spread to lymph nodes, or if your doctor feels that you are at high risk for recurrent cancer, radioactive iodine may be used after the thyroid gland is removed.

FURTHER INFORMATION

Further details on this and other thyroid-related topics are available in the patient thyroid information section on the American Thyroid Association® website at www.thyroid.org.

For information on thyroid patient support organizations, please visit the [Patient Support Links](#) section on the ATA website at www.thyroid.org





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Radioactive iodine therapy (Also referred to as I-131 therapy). Thyroid cells and most differentiated thyroid cancers absorb iodine so radioactive iodine can be used to eliminate all remaining normal thyroid tissue and potentially destroy residual cancerous thyroid tissue after thyroidectomy (see [Radioactive Iodine brochure](#)). The procedure to eliminate residual thyroid tissue is called radioactive iodine ablation. Since most other tissues in the body do not efficiently absorb or concentrate iodine, radioactive iodine used during the ablation procedure usually has little or no effect on tissues outside of the thyroid. However, in some patients who receive larger doses of radioactive iodine for treatment of thyroid cancer metastases, radioactive iodine can affect the glands that produce saliva and result in a dry mouth. If higher doses of radioactive iodine are necessary, there may also be a small risk of developing other cancers later in life. This risk is very small, and increases as the dose of radioactive iodine increases. The potential risks of treatment can be minimized by using the smallest dose possible. Balancing potential risks against the benefits of radioactive iodine therapy is an important discussion that you should have with your doctor if radioactive iodine therapy is recommended.

If your doctor recommends radioactive iodine therapy, your TSH level will need to be elevated prior to the treatment. This can be done in one of two ways.

The first is by stopping thyroid hormone pills (levothyroxine) for 3-6 weeks. This causes high levels of TSH to be produced by your body naturally. This results in hypothyroidism, which may involve symptoms such as fatigue, cold intolerance and others, that can be significant. To minimize the symptoms of hypothyroidism your doctor may prescribe T3 (Cytomel®, liothyronine) which is a short acting form of thyroid hormone that is usually taken after the levothyroxine is stopped until 2 weeks before the radioactive iodine treatment.

Alternatively, TSH can be increased sufficiently without stopping thyroid hormone medication by injecting a synthetic form of TSH into your body. Recombinant human TSH (rhTSH, Thyrogen®) can be given as two injections in the days prior to radioactive iodine treatment. The benefit of this approach is that you can continue taking the thyroid hormone medication and avoid possible symptoms related to hypothyroidism.

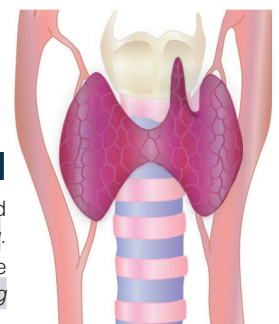
Regardless of whether you become hypothyroid (stop thyroid hormone) or use recombinant TSH therapy, you may also be asked to go on a low iodine diet for 1 to 2 weeks prior to treatment (see [Low Iodine Diet FAQ](#)), which will result in improved absorption of radioactive iodine, maximizing the treatment effect.

TREATMENT OF ADVANCED THYROID CANCER

Thyroid cancer that spreads (metastasizes) outside the neck area is rare but can be a serious problem. Surgery and radioactive iodine remain the best way to treat such cancers as long as these treatments continue to work. However, for more advanced cancers, or when radioactive iodine therapy is no longer effective, other forms of treatment are needed.

Medications have now been approved for the treatment of advanced thyroid cancer. These drugs rarely cure advanced cancers that have spread widely throughout the body, but they can slow down or partially reverse the growth of the cancer. These treatments are usually given by an oncologist (cancer specialist) and often require care at a regional or university medical center. These agents can also be used to change a tumor that stopped responding to radioactive iodine to respond to this treatment again. This is called redifferentiation therapy.

External beam radiation directs precisely focused X-rays to areas that need to be treated. This may be tumor that has recurred locally in the neck or spread to bones or other organs. This can kill or slow the growth of those tumors.



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WHAT IS THE FOLLOW-UP FOR PATIENTS WITH THYROID CANCER?

Periodic follow-up examinations are essential for all patients with thyroid cancer, because the thyroid cancer can return—sometimes several years after successful initial treatment. These follow-up visits include a careful history and physical examination, with particular attention to the neck area. Neck ultrasound is an important tool to view the neck and look for nodules, lumps or cancerous lymph nodes that might indicate the cancer has returned. Blood tests are also important for thyroid cancer patients. Most patients who have had a thyroidectomy for cancer require thyroid hormone replacement with levothyroxine once the thyroid is removed (see [Thyroid Hormone Treatment brochure](#)). The dose of levothyroxine prescribed by your doctor will in part be determined by the initial extent of your thyroid cancer. More advanced cancers usually require higher doses of levothyroxine to suppress TSH (lower the TSH below the low end of the normal range). In cases of minimal or very low risk thyroid cancer, it is typically recommended to keep TSH in the normal range. The TSH level is a good indicator of whether the levothyroxine dose is correct and should be followed periodically by your doctor.

Another important blood test is measurement of thyroglobulin (Tg). Thyroglobulin is a protein produced by normal thyroid tissue and differentiated thyroid cancer cells. The test is useful if you have had a thyroidectomy and radioactive iodine ablation, when the thyroglobulin levels usually become very low or undetectable. If your level is low and then starts to rise, it is concerning for possible cancer recurrence. If you have thyroglobulin antibodies (TgAb) the Tg blood test can be more difficult to interpret.

In addition to routine blood tests, your doctor may want to check a whole-body iodine scan to determine if any thyroid cancer cells remain. These scans are only done for high risk patients and have been largely replaced by routine neck ultrasound and thyroglobulin measurements that are more accurate to detect cancer recurrence, especially when done together.

WHAT IS THE PROGNOSIS OF THYROID CANCER?

Overall, your prognosis with differentiated thyroid cancer is excellent, especially if you are younger than 55 years of age and have a small cancer. If your papillary thyroid cancer has not spread beyond the thyroid gland, patients like you rarely if ever die from thyroid cancer. If you are older than 55 years of age, or have a larger or more aggressive tumor, your prognosis remains very good, but the risk of cancer recurrence is higher. The prognosis may not be quite as good if your cancer is more advanced and cannot be completely removed with surgery or destroyed with radioactive iodine treatment. Nonetheless, even if this is your situation, you will likely be able to live a long time and feel well, despite the fact that you are living with cancer. It is important to talk to your doctor about your individual profile of cancer and expected prognosis. It will be necessary to have lifelong monitoring, even after successful treatment.



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