

COLLECTING CANCER DATE: THYROID AND ADRENAL GLAND

2017-2018 NAACCR WEBINAR SERIES

Q&A

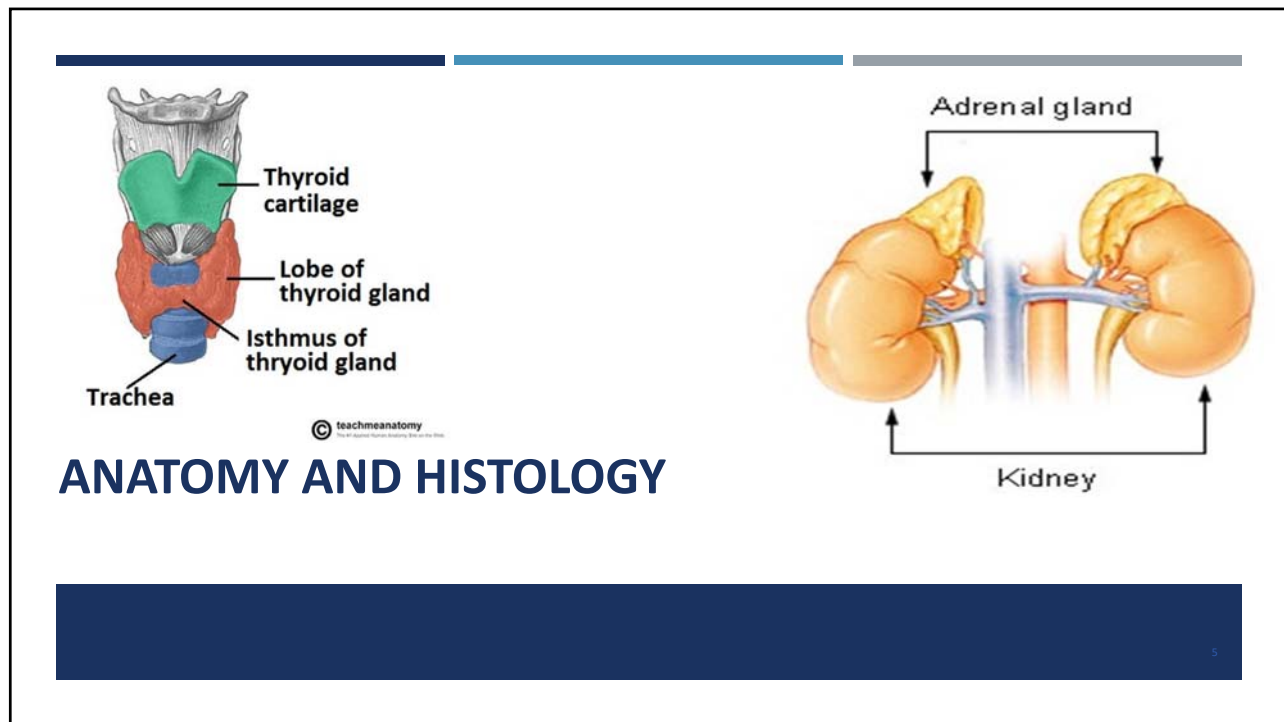
- Please submit all questions concerning webinar content through the Q&A panel.
- Reminder:
- If you have participants watching this webinar at your site, please collect their names and emails.
- We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

Fabulous Prizes



AGENDA

- Anatomy
- Epi Moment
- Grade
- ICD-O-3
- Solid Tumor Rules (Multiple Primary and Histology Rules)
- Seer Summary Stage and AJCC Staging



THYROID

- Endocrine gland
- Anterior neck
- Divided in two lobes
 - NOT a paired site
- Sternohyoid/Sternothyroid muscles
 - In front of thyroid, important for Staging

The diagram shows a cross-section of the neck with the thyroid gland highlighted in red. Labels include: Thyroid cartilage (green), Lobe of thyroid gland (red), Isthmus of thyroid gland (blue), and Trachea (blue).

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The #1 Applied Human Anatomy Site on the Web

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THYROID

- Follicular cells
 - Thyroid hormone (thyroxine + triiodothyronine)
- C cells (parafollicular cells)
 - Calcitonin
- Lymphocytes
- Stromal cells

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TYPES OF MALIGNANT THYROID TUMORS

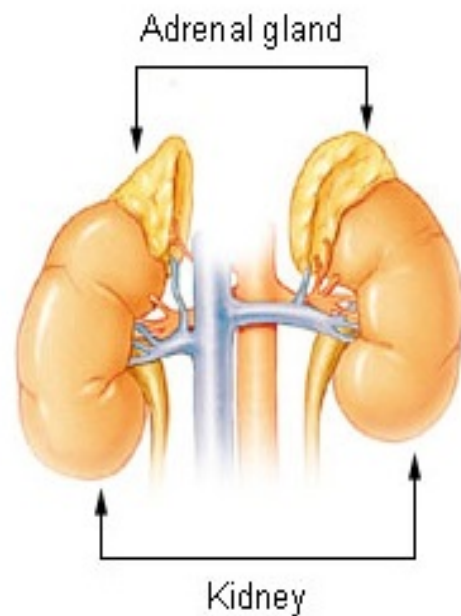
- Papillary
- Follicular
- Hürthle Cell
- Medullary
 - Sporadic vs Familial
- Anaplastic

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ADRENAL GLAND

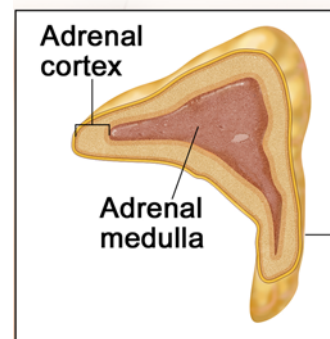
- Endocrine glands
- Above the kidneys
- Epinephrine (adrenaline), and norepinephrine
- Aorta and Vena Cava
 - Important for staging



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ADRENAL GLAND MEDULLA

- Extension of the nervous system
- Produces Hormones
 - Epinephrine
 - Norepinephrine
- Pheochromocytomas, Neuroblastomas

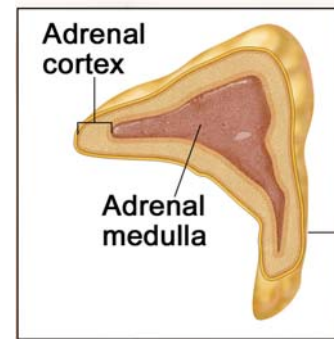


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ADRENAL GLAND CORTEX

- Most tumors develop
- Produces steroids
 - Cortisol, aldosterone, adrenal androgens



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ADRENAL GLAND CANCERS

- Adrenal Cortical Carcinoma
 - Adrenal Cancer, Adrenocortical cancer, Adrenocortical carcinoma
 - Found on imaging tests done for something else
 - Makes hormones that cause changes
 - Weight gain, fluid retention, early puberty in children or excess facial or body hair growth in women

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COLLECTING CANCER DATA: THYROID

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JUNE 8TH, 2018

theme song: Tom Waits: The Piano Has been Drinking

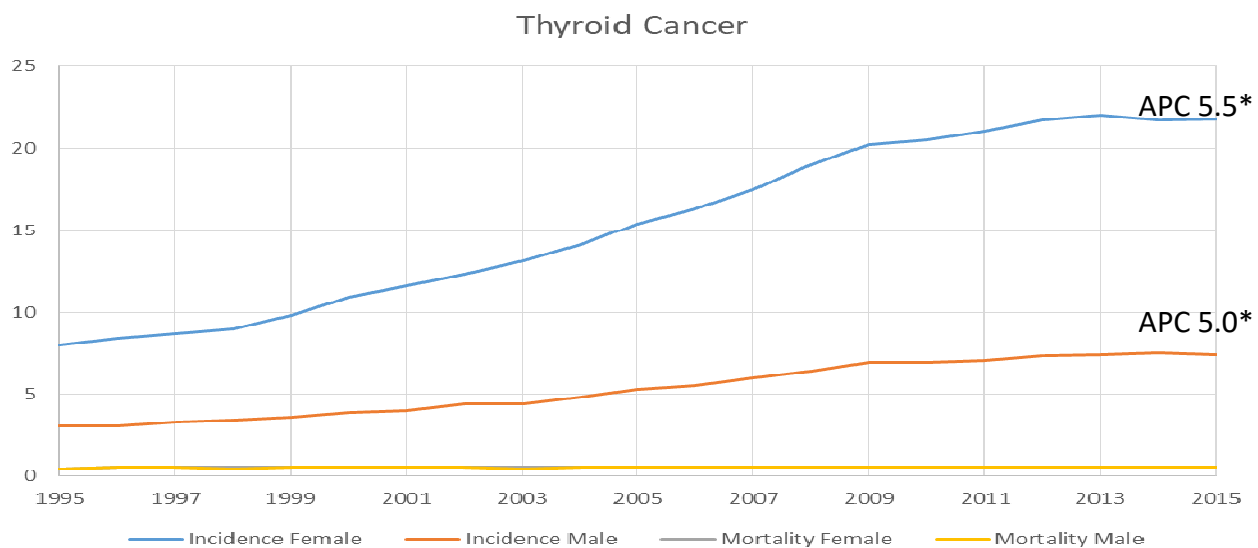
EPIDEMIOLOGY OF THYROID CANCER

- Analyzed alone (subsite of Endocrine System)
- Rare, 14.7 per 100,000 (mortality 0.5 per 100,000)
- Survival high, 5-year survival 98%
- Incidence 3x higher in women (21.8 versus 7.4 per 100,000)
- 4 major histologies
 - 70-80% are papillary
 - 30 – 60 yo; more aggressive in older pts
 - 10-15% are follicular
 - 40 – 60 yo; may be more aggressive in older pts
 - 5%- 10% medullary
 - 40 – 50 yo; effects men & women equally; often familial
 - Anaplastic—very rare (<2%), aggressive, 65+, slightly more common among women than men

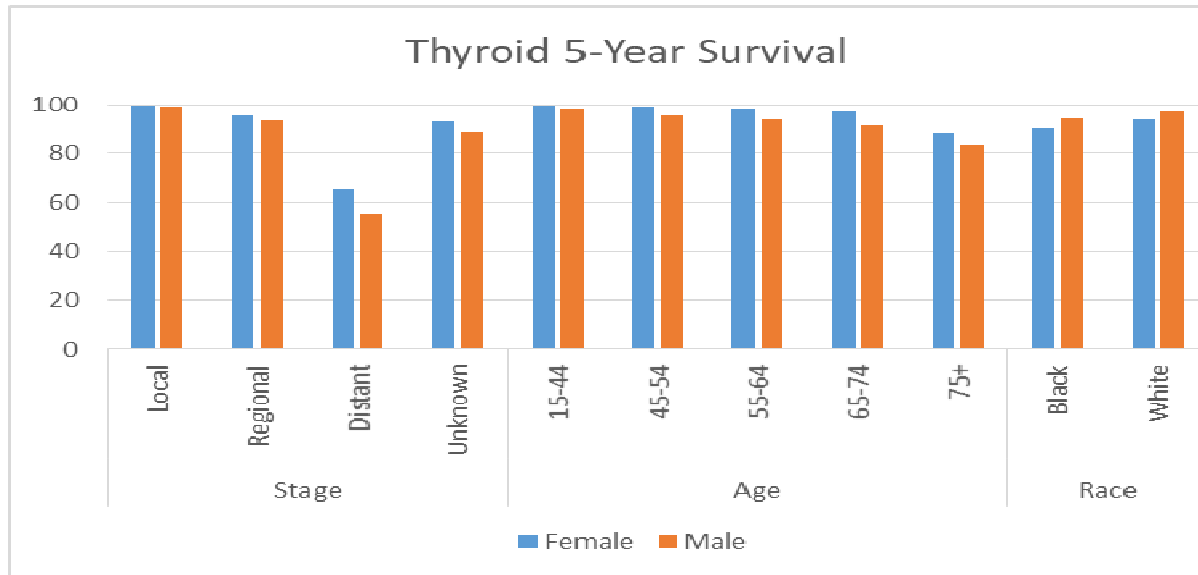
SYMPTOMS & RISK FACTORS: THYROID

- Symptoms
 - Lump/swelling neck
 - Pain neck & throat (often in front, up to ears)
 - Voice changes, trouble swallowing or breathing, constant cough
- Risk Factors
 - High dose ionizing radiation (rx tx may increase risk)
 - Low iodine diet
 - Benign thyroid or breast conditions
 - Hereditary conditions (MTC)
 - Diabetes medication (MTC)
 - Highest rates in Iceland, Philippines, Hawai'i and in Filipino immigrant populations in us (LA area and Hawai'i)

THYROID TRENDS 1995-2015

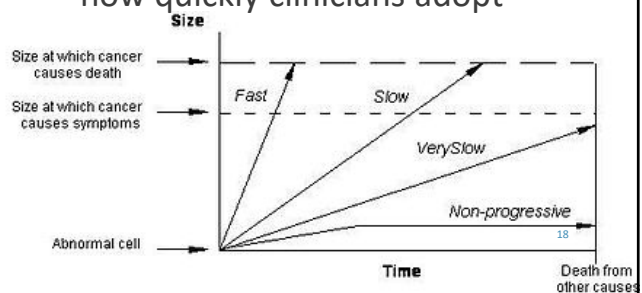


THYROID SURVIVAL (FOLLOW-UP THROUGH 2014)



THYROID SCREENING & OVERDIAGNOSIS

- Encapsulated follicular variant of papillary thyroid carcinoma (EFVPTC) re-classed to non-malignant condition
 - non-invasive follicular thyroid neoplasms with papillary-like nuclear features or NIFTP
- Consensus-based, histopathologic diagnostic criteria to appropriately distinguish NIFTP from malignant thyroid cancer
- Paper: JAMA Oncology, August 2016 (Nikiforov)
 - Nomenclature Revision for Encapsulated Follicular Variant of Papillary Thyroid Carcinoma A Paradigm Shift to Reduce Overtreatment of Indolent Tumors**
- We will see a decline in thyroid cancer incidence 2016+
 - How rapid will depend upon how quickly clinicians adopt



2018 GRADE – THYROID AND ADRENAL GLAND

[HTTPS://APPS.NAACCR.ORG/SSDI/LIST/](https://apps.naaccr.org/ssdi/list/)



2018 GRADE DATA ITEMS

- Previous single grade/Differentiation data item and coding instructions discontinued for cases diagnosed 2018+
- Former SSFs which collected chapter specific grades (e.g., Breast, Prostate, Soft Tissue, etc) discontinued for 2018+
- **Beginning with 2018+ cases**
 - Grade definitions have expanded
 - Classification of grade varies by tumor site and/or histology
 - Grading systems may use a two, three or four grade system
 - No longer will all grades be converted to a four-grade system

GRADE CLINICAL

- Grade of tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant)
 - FNA, needle core biopsy, TURB, endoscopic biopsies
- Cannot be blank
- Highest grade assessed during clinical time frame
- Code 9 when:
 - Grade not documented
 - clinical workup is not done
 - Cannot determine if clinical, pathological or post therapy code as clinical, code 9 for pathological and blank for post-therapy grade
 - *Adrenal: Code 9 Grade checked "not applicable on CAP Protocol, no other grade available"*

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GRADE CLINICAL - CODES

Code	Grade Description
L	LG: Low grade (≤ 20 mitoses per 50 HPF)
H	HG: High grade (> 20 mitosis per 50 HPF)
M	TP53 or CTNNB Mutation
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed; Unknown

Adrenal Gland
Grade ID 26

Thyroid
Grade ID 98

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GRADE PATHOLOGICAL

- Grade of tumor that has been resected and for which no neoadjuvant therapy was administered
- Cannot be blank
- Highest grade, if clinical grade is higher than the grade form pathological time frame then use the clinical grade
- Code 9 when:
 - Grade not documented
 - no resection of primary site
 - Neoadjuvant therapy followed by resection
 - Clinical case only
 - Cannot determine if clinical, pathological or post therapy
 - *Adrenal: Grade checked "not applicable on CAP Protocol, no other grade available"*



GRADE PATHOLOGICAL - CODES

Code	Grade Description
L	LG: Low grade (≤ 20 mitoses per 50 HPF)
H	HG: High grade (> 20 mitosis per 50 HPF)
M	TP53 or CTNNB Mutation
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed; Unknown

Adrenal Gland
Grade ID 26

Thyroid
Grade ID 98



GRADE POST-THERAPY

- Grade of tumor that has been resected following neoadjuvant therapy
- Leave blank when
 - No neoadjuvant therapy
 - Clinical or pathological case only
 - Only one grade available, cannot determine if clinical, pathological or post-therapy
- Highest grade from the resected primary tumor assessed after the completion of neoadjuvant therapy
- Code 9 when:
 - Surgical resection is done after neoadjuvant therapy and grade is not documented
 - *Adrenal: Grade checked "not applicable on CAP Protocol, no other grade available"*

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GRADE POST-THERAPY - CODES

Code	Grade Description
L	LG: Low grade (≤ 20 mitoses per 50 HPF)
H	HG: High grade (> 20 mitosis per 50 HPF)
M	TP53 or CTNNB Mutation
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed; Unknown

Adrenal Gland
Grade ID 26

Thyroid
Grade ID 98

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POP QUIZ 1

A patient was found to have hypertension which was unresponsive to medical therapy. Three weeks prior to admission he began experiencing very severe right flank pain while on the job. Sonogram and CT revealed an adrenal mass which also appeared to extend into the inferior vena cava at the level of the right adrenal gland just below the hepatic vein. No enlarged lymph nodes or other abnormalities were identified. Resection was performed. Final diagnosis: Moderately differentiated adrenal cortical carcinoma with adrenal vein invasion (10 cm, 250 gm)

Grade Clinical	9
Grade Pathological	B
Grade Post-Therapy	blank

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POP QUIZ 2

Patient with the complaint of a neck mass first noticed two weeks ago. The mass has increased in size and is palpable. Ultrasound of the thyroid and lateral neck showed a large mass of the left thyroid, but no right or left neck lymphadenopathy. Fine needle aspiration (FNA) of neck mass was performed and the pathology report indicated a diagnosis of carcinoma. Patient will be admitted for total thyroidectomy. Final diagnosis from total thyroidectomy: Left thyroid lobe with papillary carcinoma, 8 cm in size.

Grade Clinical	9
Grade Pathological	9
Grade Post-Therapy	blank

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ICD-O-3



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IMPORTANT REMINDER

Please check the 2018 ICD-O-3 Update Table first to determine if the histology is listed. If the histology is not included in the update, then review the ICD-O-3 and/or Hematopoietic and Lymphoid Database and/or Solid Tumor (MP/H) rules.

USING TABLE 1

- Status
- ICD-O-3 Morphology Code
- Term
- Reportability (Reportable Y/N)
- Comment

Status	ICD-O-3 Morphology Code	Term	Reportable Y/N	Comments
New code/term	8519/2	Pleomorphic lobular carcinoma in situ (C50. _)	Y	ICD-O-3 rule F DOES NOT APPLY to code 8519. Invasive pleomorphic lobular carcinoma is coded 8520/3

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NEW ICD-O-3 TERMS

Status	ICD-O-3 Code	Term	Reportable Y/N	Comments
New Term	8343/3	Encapsulated follicular variant of papillary thyroid carcinoma, NOST (EFVPTC, NOS) (73.9)	Y	Cases diagnosed 1/1/2017 forward
New Code/term	8339/3	Follicular Thyroid Carcinoma (FTC), encapsulated angioinvasive (73.9)	Y	
New Term	8343/3	Invasive encapsulated follicular variant of papillary thyroid carcinoma (Invasive EFVPTC) (73.9)	Y	Cases Diagnosed 1/1/2017 forward

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NEW ICD-O-3 TERMS

Status	ICD-O-3 Code	Term	Reportable Y/N	Comments
New Term	8343/2	Non-invasive EFVPTC (73.9)	Y	Cases diagnosed 1/1/2017 forward
New Term	8343/2	Non-invasive encapsulated follicular variant of papillary thyroid carcinoma (non-invasive EFVPTC) (73.9)	Y	Cases diagnosed 1/1/2017 forward
New Term	8343/2	Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) (73.9)	Y	Cases diagnosed 1/1/2017 forward
New Term	8343/2	Non-Invasive FTP (73.9)	Y	Cases diagnosed 1/1/2017 forward

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MEDULLARY THYROID CARCINOMA

- For cases diagnosed 2018+
 - Code Medullary Thyroid Carcinoma to 8345/3
 - 8345/3 Medullary carcinoma [FOR THYROID 2018+. FOR BREAST USE 8510] (preferred)
 - 8510/3 Medullary carcinoma, NOS [DO NOT USE FOR THYROID 2018+, USE 8345] (preferred)

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SOLID TUMOR RULES

*MULTIPLE PRIMARY & HISTOLOGY RULES



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USING THE DRAFT 2018 SOLID TUMOR RULES

- Use the draft rules for 2018 cases, but flag cases to review when final rules are posted
- Do not use draft rules for 2018 cases. When final rules are posted, review those cases that you have abstracted and make changes as specified in the final rules

<https://seer.cancer.gov/tools/solidtumor/>

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NEW IN 2018

Code subtypes/variants when definitively described (no modifiers)

Do not code a histology (*including subtypes/variants) when described as:

- Differentiation
- Features
- Terms modified by ambiguous terminology
- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Example: Well-differentiated neuroendocrine tumor 8240.

Note: Definitively described means there are no modifiers such as neuroendocrine differentiation.

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IMPORTANT INFORMATION FOR CODING HISTOLOGIC TYPE FOR CASES DIAGNOSED 1/1/2018 FORWARD

The North American Association of Central Registries (NAACCR) has released Guidelines for ICD-O-3 Histology Code and Behavior Update effective for cases diagnosed 1/1/2018 forward. The update includes new ICD-O-3 codes, changes in behaviors for existing ICD-O-3 codes as well as new preferred terminology. As the World Health Organization (WHO) has no plans to release an updated ICD-O-3 or ICD-O-4, the Solid Tumor Editors recommend using ICD-O-3 jointly with the ICD-O-3 Histology and Behavior Update histology tables along with the 2018 Solid Tumor Rules to accurately code histologic type. The updated histology tables can be found at: <https://seer.cancer.gov/icd-o-3/>

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OTHER SITES MULTIPLE PRIMARY RULES

Unknown If Single or Multiple Tumors

- Rule M1: when it is not possible to determine if there is a single tumor or multiple tumors opt for a single tumor and abstract as a single primary

Single Tumor

- Rule M2 A single tumor is always a single primary

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OTHER SITES MULTIPLE PRIMARY RULES

Multiple Tumors

- Rule M6: Follicular and papillary tumors in the thyroid within 60 days of diagnosis are a single primary
- Rule M10 Tumors diagnosed more than one year apart are multiple primaries

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RADIATION

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I-131: WHOLE BODY OR THYROID?

How do we code data item Radiation Treatment Volume when a patient has received I-131?

- Some registrars favor the 33 (Whole body) code on the basis that I-131 is injected and thus has the opportunity to travel anywhere in the body.
- Some registrars favor 50 (Thyroid) on the basis the treatment is targeting residual thyroid tissue, that the rest of the body takes up little or none of the I-131, and that it is soon eliminated from the body.
- Some registrars favor 98 (Other) on the basis none of the other codes say "Code I-131 thyroid ablation here".

<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/radiation/77471-coding-i-131-thyroid-ablation-rt-volume-current-coc-position-and-rationale>

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I-131: WHOLE BODY OR THYROID?

- The official answer: Code I-131 for thyroid to 50 (thyroid) in the data item Radiation Treatment Volume, NAACCR Item #1540. The thyroid absorbs ALMOST ALL iodine that enters a body. It is NOT a whole body treatment.
- This will be clarified in STORE Manual 2018.

<http://cancerbulletin.facs.org/forums/forum/forums-national-cancer-data-base/forums-first-course-of-treatment/radiation/77471-coding-i-131-thyroid-ablation-rt-volume-current-coc-position-and-rationale>

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Levothyroxine Sodium

Name

Levothyroxine Sodium

Alternate Names

Alti-Thyroxine
 Eltroxin
 Euthroid
 Euthyrox
 L-Thyroxine
 L-Tyrosine
 Levo-T
 Levotabs
 Levothroid
 Levothyroxine
 Levoxine
 Levoxyl
 Proloid
 Sodium Levothyroxine
Synthroid
 Synthrox
 Thyroid USP
 Thyrolar
 Thyroxine
 Thysin
 Tirosint

THYROXIN SUPPRESSION OF THYROID STIMULATING HORMONE (TSH)

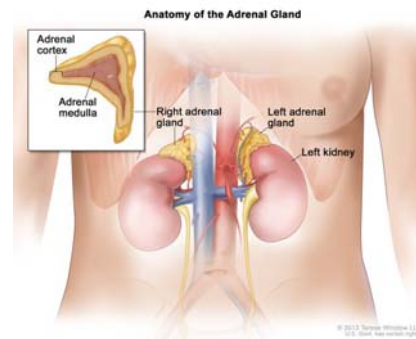
- *Synthroid* should be coded as hormonal treatment for thyroid cancer.
- This drug has two benefits:
 - It supplies the missing hormone the thyroid would normally produce
 - It suppresses the production of thyroid-stimulating hormone (TSH) from the pituitary gland. High TSH levels could conceivably stimulate any remaining cancer cells to grow.

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STAGE

TNM 8TH EDITION, SUMMARY STAGE 2018, SSDI



ADRENAL GLAND

Secure | [https://staging.seer.cancer.gov/eod_public/input/1.2/adrenal_gland/ss2018/?breadcrumbs=\(-schema_list-\),\(-view_schema-,-adrenal_gland~\)](https://staging.seer.cancer.gov/eod_public/input/1.2/adrenal_gland/ss2018/?breadcrumbs=(-schema_list-),(-view_schema-,-adrenal_gland~))

Bookmarks Collaborative Staging Google NAACCR Outlook Web App NAACCR / IMS, Inc. [https://www.naacr-](https://www.naacr-secure.com/) Secure Sign In NAACCR V

Summary Stage 2018: Adrenal Gland

Summary Stage 2018

Notes
Adrenal Gland
 8000-8700, 8720-8790, 9700-9701
 C740-C741, C749, C755
 C740 Cortex of adrenal gland
 C741 Medulla of adrenal gland
 C749 Adrenal gland, NOS
 C755 Aortic body and other paraganglioma (*Histologies 8680, 8690, 8692-8693, 8700 only*)

Note 2: See the following chapters for the listed histologies

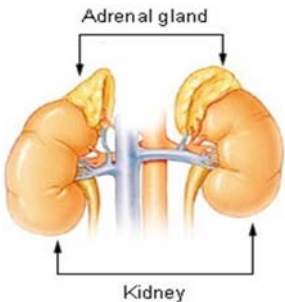
- > 8710-8714, 8800-8934, 8940-9137, 9141-9582: *Soft Tissue*
- > 8935-8936: *GIST*
- > 9140: *Kaposi Sarcoma*

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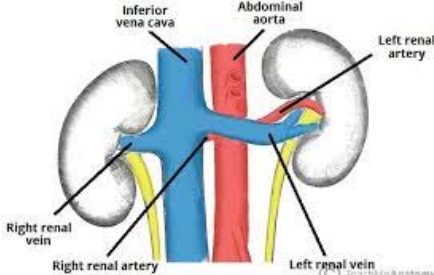
SUMMARY STAGE 2018

SS2018	Description
0	In situ: noninvasive, intraepithelial
1	Localized only (localized, NOS) > Confined to adrenal gland, no extra-adrenal invasion
2	Regional by direct extension only > Adjacent connective tissue > Gerota's fascia > Invasion of adjacent organs > Blood vessels (large) > Renal vein > Vena cava > Kidney > Retroperitoneal structures including > Great vessels (aorta, inferior vena cava)



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3	<p>Regional lymph node(s) involved only</p> <ul style="list-style-type: none"> > Aortic, NOS <ul style="list-style-type: none"> > Para-aortic > Periaortic > Pericaval, NOS <ul style="list-style-type: none"> > Paracaval > Precaval > Retrocaval > Retroperitoneal, NOS > Regional lymph node(s), NOS <ul style="list-style-type: none"> > Lymph node(s), NOS 	
4	<p>Regional by BOTH direct extension AND regional lymph node(s) involved</p> <ul style="list-style-type: none"> > Codes (2) + (3) 	
7	<p>Distant site(s)/lymph node(s) involved</p> <ul style="list-style-type: none"> > Distant site(s) (including further contiguous extension) <ul style="list-style-type: none"> > Bone > Diaphragm > Liver > Lung > Pancreas > Spleen > Distant lymph node(s), NOS > Distant metastasis, NOS <ul style="list-style-type: none"> > Carcinomatosis > Distant metastasis WITH or WITHOUT distant lymph node(s) 	

AJCC 8TH CHAPTER REVIEW

- Adrenal Cortical Carcinoma Chapter 76
- Adrenal-Neuroendocrine Chapter 77 (New)
- Errata
 - 1st and 2nd printing-Primarily related to histologies eligible for staging.
 - 3rd printing-None
- SSDI's
 - None for either schema

RULES FOR CLASSIFICATION

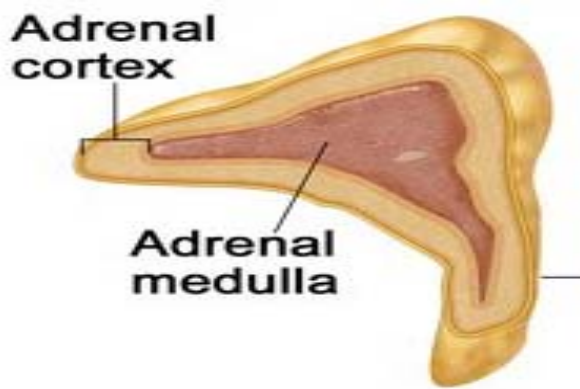
- General rules apply
 - Must have a diagnosis of cancer and some kind of work-up for clinical stage.
 - Must have resection of the primary tumor or pathologic confirmation of distant metastasis for pathological stage.
 - No site specific allowance for using clinical values in pathological fields.

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ADRENAL CORTICAL CARCINOMA

- Only applies to carcinomas arising in the cortex of the adrenal gland (C74.0).

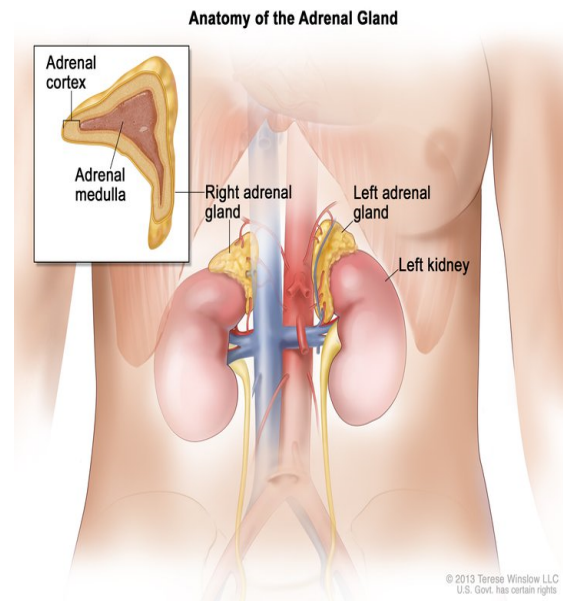


8010	Carcinoma, NOS
8290	Oncocytic carcinoma
8370	Adrenal cortical carcinoma
8680	Paraganglioma, malignant

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PRIMARY TUMOR

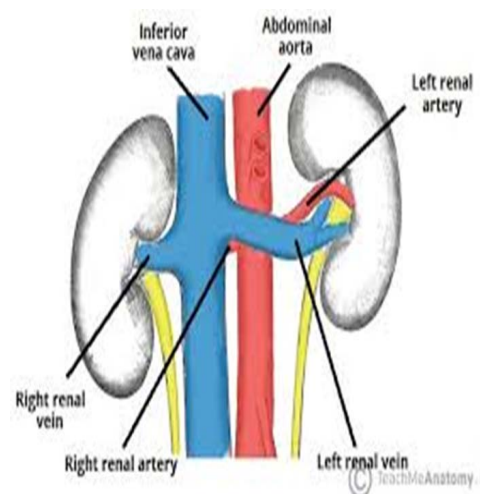
- Is the tumor confined to the adrenal gland?
 - Is the tumor greater than or less than 5cm?
- Is the tumor invading into the surrounding connective or adipose tissue?
- Is the tumor invading surrounding organs or large blood vessels?



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REGIONAL LYMPH NODES

- Are lymph nodes in the aortic or retroperitoneal node basins positive for metastasis?
- Positive lymph nodes above the diaphragm are considered distant metastasis.



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DISTANT METASTASIS

- Is there metastasis to the:
 - Liver
 - Lung
 - Bone
 - Peritoneum?
- Is there metastasis to the brain (more common in children).

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STAGE GROUPING

- Stage 1 and stage 2 confined to the adrenal gland.
 - The difference is the size of the tumor.
- Tumors confined to the adrenal gland, but with lymph node metastasis are stage 3.
- Tumors with extension beyond the adrenal gland are stage 3 or higher.
- Patients with distant metastasis are always stage 4.

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POP QUIZ 3

- A patient was found to have a large right adrenal gland tumor on CT. The tumor measured 6cm and invaded into the surrounding Gerota's fascia. No enlarged nodes were identified.
- A core biopsy of the mass was positive for adenocarcinoma.

Data Item	8 th ed
Clinical T	cT3
Clinical T Suffix	
Clinical N	cN0
Clinical N Suffix	
Clinical M	cM0
Stage	3

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POP QUIZ 3 (CONT.)

- The patient went on to have a right adrenalectomy and pericaval node dissection.
 - Adenocarcinoma of the adrenal cortex measuring 6.4cm's and extending into the Gerota's fascia.
 - 2 pericaval nodes positive for metastasis.

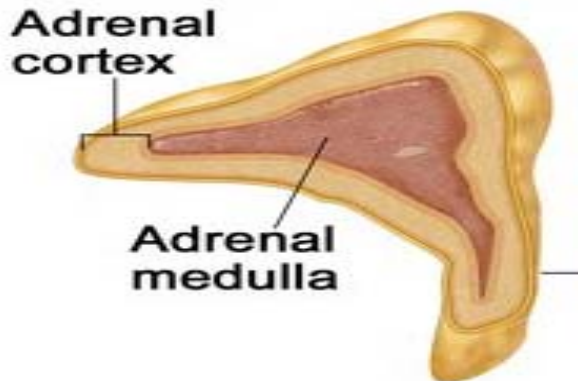
Data Item	8 th ed
Pathological T	pT3
Pathological T Suffix	
Pathological N	pN1
Pathological N Suffix	
Pathological M	cM0
Pathological Stage	3

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ADRENAL-NEUROENDOCRINE TUMORS

- Only applies to neuroendocrine tumors arising in the medulla of the adrenal gland (C74.1) or the paraganglia (C75.5)



8680	Paraganglioma, malignant
8690	Jugulotympanic paraganglioma
8692	Carotid body paraganglioma
8693	Composite paraganglioma
8693	Laryngeal paraganglioma
8693	Sympathetic paragangliomas
8693	Vagal paraganglioma
8700	Composite pheochromocytoma
8700	Pheochromocytoma

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PRIMARY TUMOR

- Is the tumor a pheochromocytoma (PH) or paraganglioma (PG)?
 - Pheochromocytoma-Tumors arising from the adrenal medulla
 - Paraganglioma-Tumors arising from the autonomic nervous system ganglia (paraganglia).
- If PH, how big is the tumor?
- Is the tumor confined to the adrenal gland or is there invasion into surrounding tissues?

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METASTASIS

- Is there regional node metastasis?
- Is there distant metastasis?
 - If yes, where does the metastasis occur?

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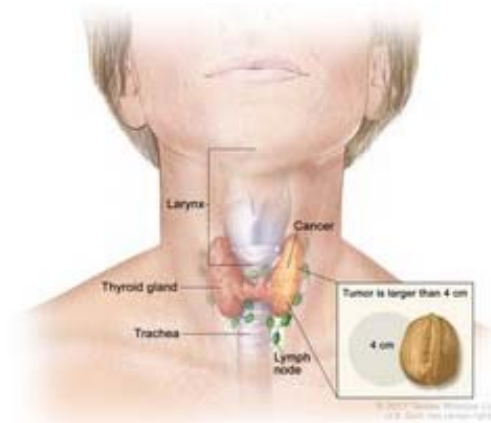
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QUESTIONS?

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THYROID

THYROID-DIFFERENTIATED AND ANAPLASTIC CARCINOMA
 THYROID-MEDULLARY



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Summary Stage 2018: Thyroid

Summary Stage 2018

Notes

Thyroid

8000-8700, 8720-8790, 9700-9701

C739

C739 Thyroid gland

Note 2: See the following chapters for the listed histologies

- › 8710-8714, 8800-8934, 8940-9137, 9141-9582: *Soft Tissue*
- › 8935-8936: *GIST*
- › 9140: *Kaposi Sarcoma*

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SS2018	Description
0	In situ: noninvasive, intraepithelial
1	<p>Localized only (localized, NOS)</p> <ul style="list-style-type: none"> ‣ Confined to thyroid, NOS ‣ Into thyroid capsule, but not beyond ‣ Multiple foci confined to thyroid ‣ Single invasive tumor confined to thyroid

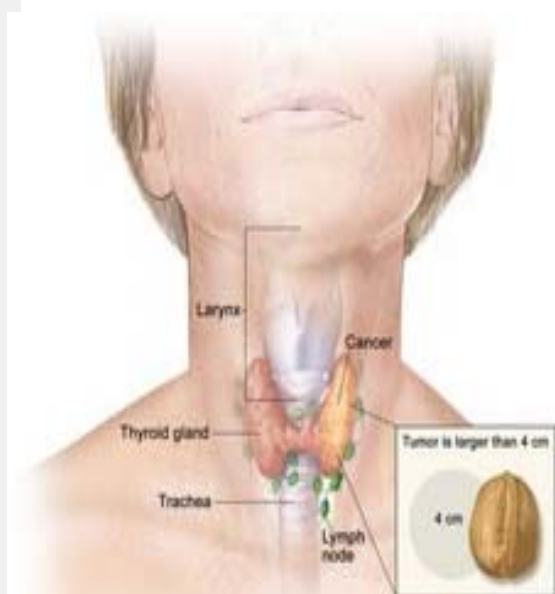
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Regional by direct extension only

- Blood vessel(s) (major)
 - Carotid artery (encased)
 - Jugular vein
 - Thyroid artery or vein
- Cricoid cartilage
- Esophagus
- Extrathyroidal extension (microscopic, macroscopic, NOS)
- Larynx
- Nerves
 - Recurrent laryngeal
 - Vagus nerve
- Parathyroid
- Pericapsular soft tissue/connective tissue
- Sternocleidomastoid muscle
- Strap muscle(s)
 - Omohyoid
 - Sternohyoid
 - Sternothyroid
 - Thyrohyoid
- Subcutaneous soft tissue
- Thyroid cartilage
- Trachea
- Tumor described as "FIXED to adjacent tissues"



REGIONAL LYMPH NODES

- Levels 1-7
- Other Groups of head and neck.



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Distant site(s)/lymph node(s) involved

- › Distant site(s) (including further contiguous extension)
 - › Gross extrathyroidal extension invading
 - › Bone
 - › Mediastinal tissues
 - › Prevertebral fascia
 - › Skeletal muscle, other than strap or sternocleidomastoid muscle
- › Distant lymph node(s), NOS
- › Distant metastasis, NOS
 - › Carcinomatosis
 - › Distant mets WITH or WITHOUT distant lymph node(s)

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AJCC 8TH CHAPTER REVIEW

- Errata
 - Thyroid - Differentiated and Anaplastic-Chapter 73
 - 1st and 2nd print-T4.... beyond the strap muscles
 - Thyroid Medullary-Chapter 74
 - 1st and 2nd-updates to T2, T3, T3a, and T4b
- Rules for Classification-General Rules
- SSDI's-None

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THYROID - DIFFERENTIATED AND ANAPLASTIC

- Applies to thyroid (C73.9)

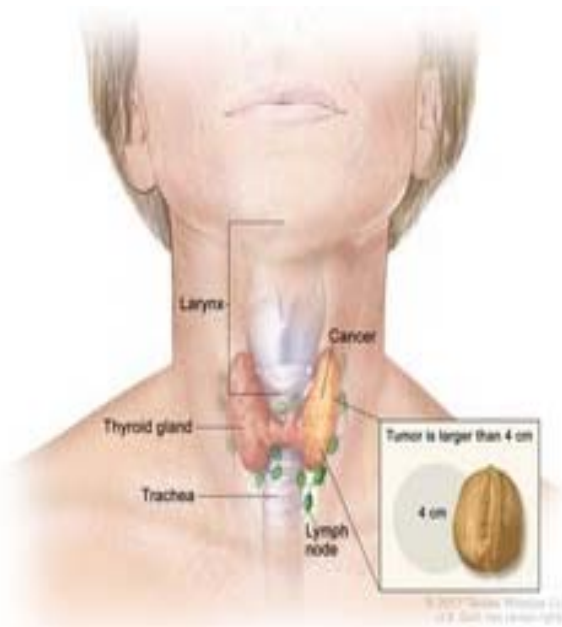
8000	Neoplasm, malignant		Follicular thyroid carcinoma (FTC), encapsulated angioinvasive
8010	Carcinoma, NOS	8339	
8050	Papillary carcinoma, NOS	8340	Follicular variant of papillary thyroid carcinoma (PTC)
8230	Solid carcinoma, NOS	8341	Papillary microcarcinoma
8260	Papillary carcinoma		
8290	Hürthle cell carcinoma	8342	Papillary thyroid carcinoma (PTC), oncocytic variant
8330	Follicular thyroid carcinoma (FTC), NOS	8343	Papillary thyroid carcinoma (PTC), encapsulated variant
8331	Follicular carcinoma, well differentiated		Papillary thyroid carcinoma (PTC), columnar cell variant
	Follicular thyroid carcinoma (FTC), minimally invasive	8344	
8335		8020	Anaplastic thyroid carcinoma
8337	Poorly differentiated thyroid carcinoma	8021	Carcinoma, anaplastic, NOS

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PRIMARY TUMOR

- How big is the tumor?
- Are the strap muscles involved (gross involvement)?
- Is their gross extension beyond the strap muscles?
- Is there more than one tumor?



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T SUFFIX

- (m) for multiple synchronous tumors OR For thyroid differentiated and anaplastic only, multifocal tumors
- (s) For thyroid differentiated and anaplastic only, solitary tumor
- Leave this field blank if (m) or (s) do not apply.

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METASTASIS

- Have the nodes been biopsied?
- Are level 6 or 7 nodes involved?
- Are level 1-5 or retropharyngeal nodes involved?
- Is there distant metastasis?



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STAGE GROUPING-DIFFERENTIATED

- How old was the patient at the time of diagnosis?
 - 54 and younger are staged very differently than 55 and older!
- pNX may be used to calculate stage group if patient has cN0 in the cN data item

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STAGE GROUPING-ANAPLASTIC

- Age doesn't matter for stage grouping
- pNX may be used to calculate stage group if patient has cN0 in the cN data item
- All cases are stage 4A or higher.

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POP QUIZ 4

- A 57 year old patient presents with a nodular thyroid.
 - Ultrasound shows 3 nodules in the left lobe of the thyroid.
 - The largest nodule measures 1.2cm's.
 - All nodules are confined to the thyroid.
 - No enlarged lymph nodes were identified.
- An FNA confirms papillary carcinoma.

Data Item	8 th ed
Clinical T	cT1b
Clinical T Suffix	(m)
Clinical N	cN0b
Clinical N Suffix	
Clinical M	cM0
Stage	1

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POP QUIZ 4 (CONT)

- The patient went on to have a total thyroidectomy.
- Left lobe of the thyroid included 3 nodules
 - Nodule 1-infiltrative papillary carcinoma follicular type measuring 1.5x1.2 cm.
 - Nodule 2-infiltrative papillary carcinoma follicular type measuring 1x.08
 - Nodule 3- infiltrative papillary carcinoma follicular type measuring 0.4x.03
- Extrathyroid extension-Not identified
- No lymph nodes removed

Data Item	8 th ed
Pathological T	pT1b
Pathological T Suffix	(m)
Pathological N	pNX
Pathological N Suffix	
Pathological M	cM0
Pathological Stage	1

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THYROID-MEDULLARY

- Applies to thyroid (C73.9)

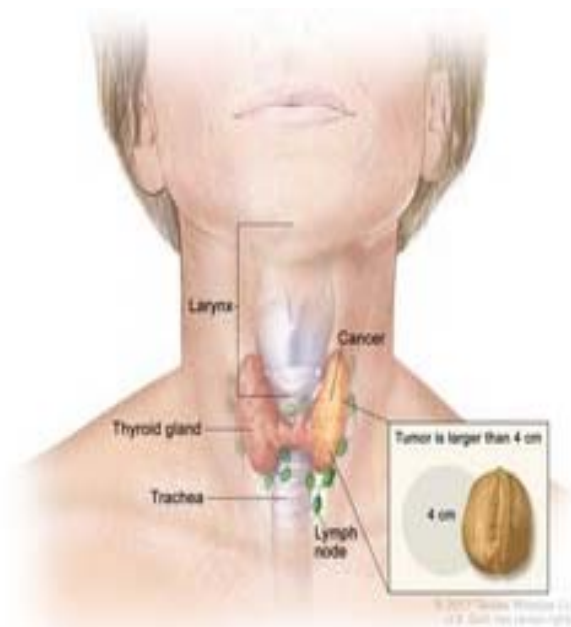
8345	Medullary thyroid carcinoma
8346	Mixed medullary and follicular thyroid carcinoma
8347	Mixed medullary-papillary carcinoma

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PRIMARY TUMOR

- How big is the tumor?
- Are the strap muscles involved (gross involvement)?
- Is their gross extension beyond the strap muscles?
- Is the tumor “advanced”?
- Is there more than one tumor?



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METASTASIS

- Have the nodes been biopsied?
- Are level 6 or 7 nodes involved?
- Are level 1-5 or retropharyngeal nodes involved?
- Is there distant metastasis?



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STAGE GROUPING

- Age doesn't matter for stage grouping
- pNX may NOT be used to calculate stage group if patient has cN0 in the cN data item

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QUESTIONS?

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QUIZ 2

ICD-O 3



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COMING UP....

- Make the Most of Cancer Data
 - 07/12/2018
- Multiple Primary and Histology Rules
 - 08/02/2018

Fabulous Prizes Winners



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CE CERTIFICATE QUIZ/SURVEY

- Phrase

Cortex

- Link

<https://www.surveygizmo.com/s3/4402251/Thyroid-and-Adrenal-Gland-2018>

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