**Q&A Session for Thyroid**

December 4, 2020

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| # | Question | Answer |
|  | I understand that there is still an increase in the Hispanic population. Do you see evidence of that? | I ran the trends by race and ethnicity and all categories are seeing the same decrease. See graph below. |
|  | Can Recinda answer how they will explain when researchers use the data that NIFTP was collected by registrars when physicians stated back in 2016 that they were NOT cancer. The code changed in 2016 but registrars didn't accept the changes until now. | Researchers use specific inclusion/exclusions criteria for any research. So it will depend upon what the specific research question is. Generally, /2 cases are excluded for most sites. For instance, standard rates are composed of only invasive cancers are included so any /2 will be excluded regardless of time (unless bladder cancer). What we can’t adjust for is advanced/changes in interpretation by the pathologist—which is why we are seeing the effect of that as a decrease in recent incidence numbers. |
|  | I can’t seem to find multiple medullary tumors in scenario number two only one medullary carcinoma and one papillary carcinoma. Am I missing something? | They did the right thyroidectomy on 2/19 and then a second completion thyroidectomy (left thyroid lobe) on 4/2. |
|  | For Rule M6 Follicular and Papillary tumors in the thyroid within 60 days of dx are a single primary. Would this rule include one tumor that has a mixed medullary follicular histology 8346/3 and one with papillary carcinoma with follicular variant 8340/3? | So the question is if mixed medullary and follicular histology is considered follicular or medullary? If it is considered follicular rule M6 applies. If not, then we would probably end up with rule M17 (2 primaries). We can send this into SEER to get their opinion. |
|  | Do you want to mention that thyroid cancer can never be in situ. The physicians have stated that anatomically there cannot be in situ cancer in thyroid. | Thank you Donna! |
|  | I thought that there was no formal grading system in thyroid? | You are correct, but that doesn’t mean we don’t assign a grade valued in the grade fields. There is not a formal grading system for thyroid. Since there is no formal grading system we use the standard 4 grade system (well, mod, poorly, undiff). |
|  | In case 2 if MPH indicates these are two primaries would we still use the m suffix being that the path states single focus medullary single focus of papillary? | I coded p suffix for the papillary as (s). I coded the p suffix for the medullary as (m). There was a second medullary tumor found in the left lobe. |
|  | What is surgery code for hemithyroidectomy? | First, read the body of the operative report and assign the surgery code based on what is removed.  If the isthmus is not specified, then query the surgeon and code appropriately.  If that is not possible, then you should use the NOS code 20 (lobectomy and/or isthmectomy).  Hemithyroidectomy means removing half of the thyroid, so in essence one lobe but you need to know if the isthmus was removed as well. |
|  | When a patient has a total thyroidectomy then goes somewhere else for remaining treatment can hormone therapy be assumed to be given if no other treatment information can be obtained? | It is typical treatment for the patient to receive HRT following a total thyroidectomy, but we as registrars can’t just assume that it was administered. If you know where the patient went for follow up or continued care, then I would contact that facility to inquire about HRT. If you can’t do that, then I would code it as unknown (99) because you can’t confirm that this was administered to the patient. |
|  | Shouldn't the histology for case 1 be 8260/3? | Yes, it should be. |
|  | To clarify a bit more can follicular tumors include all the histologies with a follicular morphology and papillary tumors all histologies with a papillary histology even if there is a mixture with medullary? | This question has been submitted to SEER for clarification. This document will be updated with response when we hear back from SEER. |
|  | I am curious as to why rules H11 & H23 come before rules H14 & H23. Since rules H14 & H23 instruct us to code 8260 for papillary ca of the thyroid. It would seem to me that these two rules would be better placed before the general one histology rule specified in rules H11& 23. What are your thoughts? | This question has been submitted to SEER for clarification. This document will be updated with response when we hear back from SEER. |
|  | Why would you code the I-131 for the medullary ca when it has no effect on the cancer? | Knowing that the patient in the scenario had two thyroid cancers per the STR/MPH rules and received treatment to include the I-131 without mention that it was for one and not the other. Granted it is typically not administered, but it doesn’t mean that it can never be given. Since the physician did not specify which tumor the I-131 was targeting it is better to go ahead and code for both. If this were a case in a facility I would contact the Rad Onc to inquire if this was for both tumors or just the one and code accordingly. |