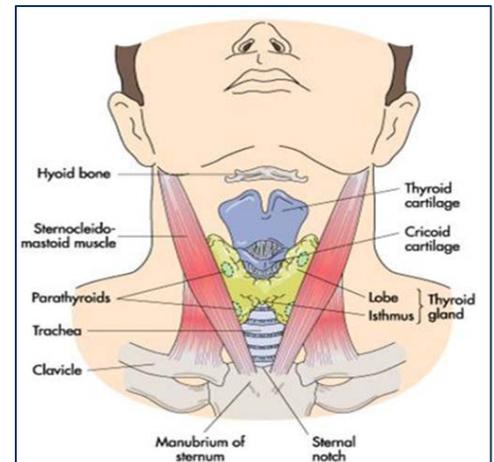


THYROID CANCER

- ① **Suspicious Cytology & Date of Diagnosis:** Reminder - a suspicious FNA cytology may not be used for the date of diagnosis unless there is confirmation by MD statement the FNA was diagnostic of cancer or there is definitive evidence from imaging or other diagnostic procedures confirming a diagnosis of cancer.

- Example: 3/1/16 Thyroid FNA suspicious for carcinoma. No MD statement or other clinical documentation this was definitive DX of cancer. 3/18/16 Patient undergoes left thyroid lobectomy and pathology confirms papillary carcinoma. The date of diagnosis would be 3/18/16.



- ② **Histology** - Code the following Histologies to ICD-O-3 code **8260**:

- **Papillary carcinoma NOS:** If a thyroid tumor is papillary carcinoma, code to 8260 (papillary adenocarcinoma).
 - Reference SINQ 20071036 and the Other Sites Histology Coding Rules, MPH Rule H14:
- **Micropapillary carcinoma or Papillary microcarcinoma:**
 - The terms micropapillary or papillary microcarcinoma refer to a papillary carcinoma where the papillary portion of the tumor is minimal or occult (1.0 cm or less). The correct histology code is 8260.
 - Reference SINQ 20150023

- ③ **Coding Tumor Extension when there is a statement of “capsular invasion”:** The thyroid gland does not have a well-defined capsule. When a path report refers to capsular invasion, the College of American Pathologist (CAP) protocol is referring to invasion of the **tumor capsule**. The pathologist is assessing invasion of the tumor capsule, along with lymphovascular invasion, as a measure of the tumor’s aggressiveness.

- Assume capsular invasion is referring to the “tumor capsule” unless the invasion is described in relation to extrathyroidal extension into soft tissues such as adipose tissue, skeletal muscles, or blood vessels and nerves.
- Tumors invading “tumor capsule” are *still confined to the thyroid* and staged as T1-T2 depending on size.
 - Reference CANSWER Forum: <http://cancerbulletin.facs.org/forums/forum/collaborative-stage/larynx-and-trachea/thyroid/664-cs-extension-thyroid>. An AJCC Expert Panel Member reviewed and concurred.
 - Reference CAP Protocol Thyroid: Background Documentation, “Criteria for Capsular Invasion” and Note K: “Extrathyroidal Extension”.

- ④ **Surgery Codes:** Often thyroid cancer is first treated with a unilateral surgical procedure in code range 25-40. Based on the pathologic extent of disease, a second surgical procedure may be done to remove all remaining thyroid gland tissue, resulting in total thyroidectomy. In this instance, the second surgical procedure should always be coded to the **cumulative surgical effect of treatment** which is total thyroidectomy, Code 50, even if the surgery is described as a “lobectomy”.

continued...

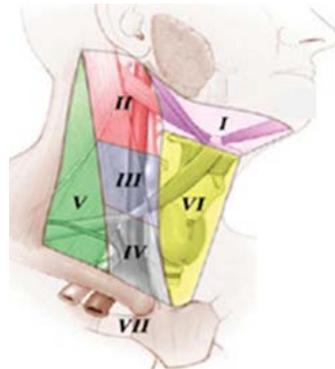


Thyroid Surgery Codes continued:

- Example: Surgical procedure 1: Left lobectomy code 20. Surgery procedure 2: Right “lobectomy” and removal of remaining thyroid gland. Do not be confused by the term “lobectomy”. Read the description of tissues removed and if the second procedure removes all remaining thyroid tissue, code to the cumulative surgical effect of **Total Thyroidectomy, Code 50**.

5 Regional Lymph Nodes:

- Central Compartment lymph nodes, also known as Level VI lymph nodes are closest in proximity to the thyroid and usually the first area where LN mets occur.
- “Parathyroid” lymph nodes are not LNs specific to the parathyroid glands. Parathyroid or peri-thyroidal lymph nodes are level VI lymph nodes. Be sure to include them in LN counts.



LYMPH NODE DESCRIPTIONS		Thyroid TNM 7 th Edition
Level I	Submental (Level IA)	N1b
	Submandibular (Level IB)	
LATERAL COMPARTMENT		
Level II	Upper Jugular group:	N1b
	Superior spinal accessory	
	Superior jugular	
	Jugulo-digastric (subdigastric) Upper deep cervical	
Level III	Middle Jugular group:	N1b
	Midjugular Middle deep cervical	
Level IV	Lower Jugular group:	N1b
	Jugulo-omohyoid inferior jugular Lower jugular	
Level V	Posterior Triangle group:	N1b
	Inferior spinal accessory	
	Posterior cervical	
	Transverse cervical	
	Supraclavicular	
ANTERIOR CENTRAL COMPARTMENT		
Level VI	Laterotracheal	N1a
	Paralaryngeal/Prelaryngeal	
	Paratracheal	
	Pretracheal	
	Perithyroidal or parathyroid	
	Precricoid (Delphian)	
	Recurrent Laryngeal	
SUPERIOR MEDIASTINAL		
Level VII	Infraclavicular	N1b
	Anterior mediastinal (Thymic)	
	Paratracheal -below suprasternal notch	
	Pretracheal -below suprasternal notch	
	Retropharyngeal	
	Superior mediastinal	

6 TNM Clinical Stage special situations:

- If the diagnosis of thyroid cancer is not established prior to surgery, either by needle biopsy, or open biopsy, the case cannot be staged clinically.
 - Leave T, N, M categories *blank*. Assign Stage Group as 99
 - This is a site-specific rule for thyroid cancer; AJCC TNM Manual 7th Edition, page 88.
 - CAnswer forum reference below*
- If FNA or biopsy on Dx workup confirms only a non-specific histology such as carcinoma NOS, you cannot assign a specific cT category.
 - Assign cTx.
 - Assign cN and cM per clinical findings as usual.
 - Assign Stage Group as 99.
 - *A Stage cannot be assigned without knowledge of the specific thyroid histology, because the TNM tables are ordered by histologic type.*

*CAnswer Forum:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/head-and-neck- chapters-3-9/64952-assignment-of-clinical-stage-for-thyroid-without-prior-positive-biopsy>