Thyroid Cancer

	PTC	FTC	HTC	MTC	ATC
Pre-OP : USS	Yes. Contralateral lobe, Central and Lateral Compartments FNA if it would change management Send FNA tissue for cytology and Tg			Yes. Contralateral lobe, Central and Lateral Neck +/- FNA Do RET, CEA, Calcitonin Calcium & Phaeo screen CT neck/chest/abdo/pelvis if: - neck nodes +ve - or calcitonin >400 And consider liver MR, bone scan	*Almost nothing you can do to make a difference*
Pre-OP : CT/MRI/PET	No.	No.	No.		
Pre-OP : Markers	No.	No.	No.		
OPERATE (after pre-op laryngoscopy)	**FNA Suspicious for PTC or Malignant PTC** **Often - Total** though "lobectomy may be sufficient for low risk tumours"; ie: - <1 cm - unifocal - intrathyroid - no radiation - no nodes	**Indeterminant FNA Follicular FNA** (Same Pathway) *Low risk Features* **Lobectomy** (Including isthmus / pyramidal) High Risk / >1cm Low Risk (as for ptc) **Completion**	**Indeterminant FNA Hurthle FNA** (Same Pathway) *High Risk Features* - tumour >4cm - marked atypia - family hx - radiation hx OR Bilateral nodules **Total Thyroidectomy**	**Total Thyroidectomy**	OK in rare situation where confined to gland
Prophylactic Neck Dissection? ***-ve nodes clinically***	*Central may be ideal in Experience Hands - if T3+ (>4cm)* … but no RCT evidence and risky / I do not have this skill so do not.	No.	No.	Central Routine in Specialist Hands	
Therapeutic Neck Dissection? ***+ve nodes clinically***	Yes. Central if +ve node. Full lateral if +ve node. Refer to H&N unit	Yes. Central if +ve node. Full lateral if +ve node. Refer to H&N unit	Yes. Central if +ve node. Full lateral if +ve node. Refer to H&N unit	Yes. Also complete lateral neck if central positive	
RAI Ablation	Yes if: - all pts with metastatic disease (incl. LNs), extrathyroid extension, primary tumour >4cm - selected pts with 1-4cm tumours and LNs, or 1-4cm with concerning histology or high risk - in Aus many >1cm will get radioI ablation. No if : <1cm and low risk, possibly if multi-focal			No	No
Other	TSH suppression for intermediate and high-risk pts				Chemo, Radio

* Advantages: a) allows Tg monitoring; b) allows effective radioiodine therapy; c) lowest recurrence; d) eliminates rare risk of anaplastic emergence or multifocal disease in remnant thyroid; e) low risk.