Rx FOR SUCCESS

Thyroid Cancer

The incidence of thyroid cancer is increasing, probably due to increased detection and clinical awareness.

Subtypes

The types of thyroid cancer are papillary, papillary-follicular, follicular, medullary, and anaplastic. The long-term prognosis varies with the cell type and the stage:

Papillary is most common. Papillary, papillary-follicular, and follicular are considered "differentiated" and have a good prognosis, particularly at ages 20 to 40. Unfavorable pathological subtypes of thyroid cancer include tall cell, columnar, solid (trabecular), clear cell, and diffuse sclerosing.

Follicular cancer that is "widely invasive" (as opposed to "minimally invasive") through the capsule or showing vascular invasion tends to be more aggressive at presentation. Hurthle (oxyphilic) and insular cancer are more aggressive forms of follicular cancer.

Medullary cancer appears sporadically, as part of familial medullary cancer, or as part of multiple endocrine neoplasia (MEN) 2a and 2b. Stage I medullary cancer has a good prognosis while higher stages do not.

Anaplastic type of any thyroid cancer has a grave prognosis.

Staging

There are multiple staging systems for thyroid cancer, but TNM (tumor, nodes, metastasis) is preferred.

TNM classification for differentiated (a.k.a papillary and follicular) thyroid cancer	
T1	<2cm
T2	2-4cm
T3	>4cm but limited to the thyroid or with minimal extra-thyroid extension
T4	Tumor of any size that extends beyond the capsule into subcutaneous soft tissues and nearby structures
NO	No nodes
N1a	Nodes involved in pre-trachea, para-trachea, and pre-laryngeal regions
N1b	Nodes involved in cervical or superior mediastinal regions
MO	No distant metastases
M1	With distant metastases

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0180142-00002-00 Ed. 03/2013 Exp. 03/01/2015 Rx 085

Staging for differentiated (a.k.a papillary and follicular) thyroid cancer		
Stage	**Age at diagnosis <45**	**Age at diagnosis >45**
I	Any T, any N, M0	T1, N0, M0
II	Any T, any N, M1	T2, N0, M0
III	NA	T3, N0, M0; T1-3, N1a, M0
IV	NA	Others

Medullary cancer stage for all ages is the same as papillary age >45.

Anaplastic cancers are all considered Stage IV disease.

Treatment

Surgical excision (with or without node and neck exploration, depending on stage) followed by radioisotope (I^{131}) is typical. Stage I well differentiated tumors less than 1cm do not need radioiodine ablation; surgery is adequate for small tumors.

Surveillance

Surveillance after treatment includes lifetime followup with high resolution ultrasound, radioisotope (I^{123} or I^{131}) scan, and thyroglobulin (with or without stimulation) levels. One year after curative treatment (ablation or total thyroidectomy), thyroglobulin levels become undetectable. Calcitonin levels are checked in cases of medullary cancer. Serial testing is more valuable that one test.

Recurrences are common in thyroid cancer, but prognosis remains good in young patients (less than 45 years) with limited disease treated by additional surgery and/or radioisotope therapy (I^{131}).

Underwriting

- Completion of therapy is recovery from surgery and/or radioisotope treatment.
- Latest diagnostic radioisotope scan (I^{123} or I^{131}) is negative. A positive test suggests recurrent or residual tumor so would be postponed.
- Applicant is well followed by endocrinologist.
- For papillary and follicular types after ablation or total thyroidectomy, the blood test thyroglobulin is undetectable. For medullary type, calcitonin levels are non-rising.

Rating

Rating of thyroid cancer is based on the cell type and the stage or TNM classification. The prognosis is worse with higher stages. Papillary thyroid cancer is the most common and has a good prognosis. Clients who are less than 60 years old with Stage I papillary thyroid cancer resected, no vascular invasion and no evidence of recurrence may be taken without a rating after recovery from treatment. Other stages and other types of thyroid cancer are rated higher.

For example, ratings for papillary and papillary-follicular thyroid cancer without vascular invasion or extensive capsular invasion (excluding high risk sub types) are given below:

Age at diagnosis	T1	T2	T3 Tumor size < 8 cm	T3 Tumor size < 8 cm
<45	0	0	Cancer table D	Cancer table D
46-59	0	Cancer table D	Cancer table D	Cancer table D
>60	Cancer table D	Cancer table D	Cancer table D	Postpone 5 years, then IC

Papillary thyroid cancer stage T4 or with wide capsular invasion is postponed for 5 years, then given individual consideration.

To get an idea of how a client with a history of thyroid cancer would be viewed in the underwriting process, use the Ask "Rx"pert Underwriter on the next page for an informal quote.

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Ask "Rx"pert Underwriter (Ask Our Expert}

After reading the *Rx for Success* on Thyroid Cancer, please feel free to use this Ask "Rx"pert Underwriter for an informal quote.

Producer _____ Phone _____ Fax _____

Client _____ Age/DOB _____ Sex _____

If your client has had Thyroid Cancer, please answer the following:

1. When was this diagnosed?

_____ (years)

2. Please check the type(s):

☐ Papillary or Papillary/follicular ☐ Medullary ☐ Hurthle

☐ Follicular ☐ Anaplastic

3. What was the stage of the tumor?

_____

4. Have any of the following treatments been given?

Surgery ☐ Yes ☐ No. If yes, describe: _____

I^{131} treatment ☐ Yes ☐ No

Chemotherapy ☐ Yes ☐ No

External radiation treatment ☐ Yes ☐ No

5. Is there a history of metastatic disease?

☐ Yes. Please give details: _____

☐ No

6. Have additional studies been completed? (Check all that apply.)

☐ Radioisotope scans _____ (date)

☐ Ultrasound _____ (date)

☐ Thyroglobulin _____ (date)

☐ Calcitonin _____ (date)

7. Is your client on any medications?

☐ Yes. Please give details: _____

☐ No

8. Has your client smoked cigarettes in the last 12 months?

☐ Yes ☐ No

9. Does your client have any other major health problems (cancer, etc.)?

☐ Yes. Please give details: _____

☐ No