Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Thyroid Cancer Be Found Early?
- Signs and Symptoms of Thyroid Cancer
- Tests for Thyroid Cancer

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- Thyroid Cancer Stages
- Thyroid Cancer Survival Rates, by Type and Stage

Questions to Ask About Thyroid Cancer

Get some questions you can ask your cancer care team to help you better understand your diagnosis and treatment options.

- What Should You Ask Your Health Care Team About Thyroid Cancer?

Can Thyroid Cancer Be Found Early?

Many cases of thyroid cancer can be found early. In fact, most thyroid cancers are now found much earlier than in the past and can be treated successfully.

Most early thyroid cancers are found when patients see their doctors because of neck
lumps or nodules they noticed. If you have unusual symptoms such as a lump or swelling in your neck, you should see your doctor right away.

Other cancers are found by health care professionals during a routine checkup. There is no recommended screening test to find thyroid cancer early. Some doctors also recommend that people examine their necks twice a year to look and feel for any growths or lumps.

Early thyroid cancers are also sometimes found when people have ultrasound tests for other health problems, such as narrowing of carotid arteries (which pass through the neck to supply blood to the brain) or for enlarged or overactive parathyroid glands.

Blood tests or thyroid ultrasound can often find changes in the thyroid, but these tests are not recommended as screening tests for thyroid cancer unless a person is at increased risk, such as because of a family history of thyroid cancer.

People with a family history of medullary thyroid cancer (MTC), with or without type 2 multiple endocrine neoplasia (MEN 2), might have a very high risk for developing this cancer. Most doctors recommend genetic testing for these people when they are young to see if they carry the gene changes linked to MTC. For those who may be at risk but don’t get genetic testing, blood tests can help find MTC at an early stage, when it may still be curable. Thyroid ultrasounds may also be done in high-risk people.

- **References**
  See all references for Thyroid Cancer

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**Signs and Symptoms of Thyroid Cancer**

Thyroid cancer can cause any of the following signs or symptoms:

- A lump in the neck, sometimes growing quickly
- Swelling in the neck
- Pain in the front of the neck, sometimes going up to the ears
• Hoarseness or other voice changes that do not go away
• Trouble swallowing
• Trouble breathing
• A constant cough that is not due to a cold

If you have any of these signs or symptoms, talk to your doctor right away. Many of these symptoms can also be caused by non-cancerous conditions or even other cancers of the neck area. Lumps in the thyroid are common and are usually benign. Still, if you have any of these symptoms, it’s important to see your doctor right away so the cause can be found and treated, if needed.

• **References**
See all references for Thyroid Cancer

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## Tests for Thyroid Cancer

Thyroid cancer may be diagnosed after a person goes to a doctor because of symptoms, or it might be found during a routine physical exam or other tests. If there is a reason to suspect you might have thyroid cancer, your doctor will use one or more tests to find out. Signs and symptoms might suggest you have thyroid cancer, but you will need tests to confirm the diagnosis.

### Medical history and physical exam

If you have any signs or symptoms that suggest you might have thyroid cancer, your health care professional will want to know your complete medical history. You will be asked questions about your possible risk factors, symptoms, and any other health problems or concerns. If someone in your family has had thyroid cancer (especially medullary thyroid cancer) or tumors called pheochromocytomas, it is important to tell your doctor, as you might be at high risk for this disease.

Your doctor will examine you to get more information about possible signs of thyroid cancer and other health problems. During the exam, the doctor will pay special attention to
to the size and firmness of your thyroid and any enlarged lymph nodes in your neck.

**Biopsy**

The actual diagnosis of thyroid cancer is made with a biopsy, in which cells from the suspicious area are removed and looked at under a microscope. However, this might not be the first test done if you have a suspicious lump in your neck. The doctor might order other tests first, such as blood tests, an ultrasound exam, or a radioiodine scan to get a better sense of whether you might have thyroid cancer. These tests are described below.

If your doctor thinks a biopsy is needed, the simplest way to find out if a thyroid lump or nodule is cancerous is with a *fine needle aspiration* (FNA) of the thyroid nodule. This type of biopsy can usually be done in your doctor’s office or clinic.

Before the biopsy, local anesthesia (numbing medicine) may be injected into the skin over the nodule, but in most cases an anesthetic is not needed. Your doctor will place a thin, hollow needle directly into the nodule to aspirate (take out) some cells and a few drops of fluid into a syringe. The doctor usually repeats this 2 or 3 more times, taking samples from several areas of the nodule. The biopsy samples are then sent to a lab, where they are looked at under a microscope to see if the cells look cancerous or benign.

Bleeding at the biopsy site is very rare except in people with bleeding disorders. Be sure to tell your doctor if you have problems with bleeding or are taking medicines that could affect bleeding, such as aspirin or blood thinners.

This test is generally done on all thyroid nodules that are big enough to be felt. This means that they are larger than about 1 centimeter (about 1/2 inch) across. Doctors often use ultrasound to see the thyroid during the biopsy, which helps make sure they are getting samples from the right areas. This is especially helpful for smaller nodules. FNA biopsies can also be used to get samples of swollen lymph nodes in the neck to see if they contain cancer.

Sometimes an FNA biopsy will need to be repeated because the samples didn’t contain enough cells. Most FNA biopsies will show that the thyroid nodule is benign. Rarely, the biopsy may come back as benign even though cancer is present. Cancer is clearly diagnosed in only about 1 of every 20 FNA biopsies.

Sometimes the test results first come back as “suspicious” or “of undetermined significance” if FNA findings don’t show for sure if the nodule is either benign or
malignant. If this happens, the doctor may order tests on the sample to see if the \textit{BRAF} or \textit{RET/PTC} genes are mutated (changed). Finding these changes makes thyroid cancer much more likely, and may also play a role in determining the best treatment for the cancer.

If the diagnosis is not clear after an FNA biopsy, you might need a more involved biopsy to get a better sample, particularly if the doctor has reason to think the nodule may be cancerous. This might include a core biopsy using a larger needle, a surgical “open” biopsy to remove the nodule, or a lobectomy (removal of half of the thyroid gland). Surgical biopsies and lobectomies are done in an operating room while you are under general anesthesia (in a deep sleep). A lobectomy can also be the main treatment for some early cancers, although for many cancers the rest of the thyroid will need to be removed as well (during an operation called a \textit{completion thyroidectomy}).

**Imaging tests**

\textbf{Imaging tests} may be done for a number of reasons, including helping find suspicious areas that might be cancer, to learn how far cancer may have spread, and to help determine if treatment is working.

People who have or may have thyroid cancer will get one or more of these tests.

**Ultrasound**

Ultrasound uses sound waves to create images of parts of your body. For this test, a small, wand-like instrument called a \textit{transducer} is placed on the skin in front of your thyroid gland. It gives off sound waves and picks up the echoes as they bounce off the thyroid. The echoes are converted by a computer into a black and white image on a computer screen. You are not exposed to radiation during this test.

This test can help determine if a thyroid nodule is solid or filled with fluid. (Solid nodules are more likely to be cancerous.) It can also be used to check the number and size of thyroid nodules. How a nodule looks on ultrasound can sometimes suggest if it is likely to be a cancer, but ultrasound can’t tell for sure.

For thyroid nodules that are too small to feel, this test can be used to guide a biopsy needle into the nodule to obtain a sample. Even when a nodule is large enough to feel, most doctors prefer to use ultrasound to guide the needle.

Ultrasound can also help determine if any nearby lymph nodes are enlarged because
the thyroid cancer has spread. Many thyroid specialists recommend ultrasound for all patients with thyroid nodules large enough to be felt.

**Radioiodine scan**

Radioiodine scans can be used to help determine if someone with a lump in the neck might have thyroid cancer. They are also often used in people who have already been diagnosed with differentiated (papillary, follicular, or Hürthle cell) thyroid cancer to help show if it has spread. Because medullary thyroid cancer cells do not absorb iodine, radioiodine scans are not used for this cancer.

For this test, a small amount of radioactive iodine (called \( I-131 \)) is swallowed (usually as a pill) or injected into a vein. Over time, the iodine is absorbed by the thyroid gland (or thyroid cells anywhere in the body). A special camera is used several hours later to see where the radioactivity is.

For a **thyroid scan**, the camera is placed in front of your neck to measure the amount of radiation in the gland. Abnormal areas of the thyroid that have less radioactivity than the surrounding tissue are called **cold nodules**, and areas that take up more radiation are called **hot nodules**. Hot nodules usually are not cancerous, but cold nodules can be benign or cancerous. Because both benign and cancerous nodules can appear cold, this test by itself can’t diagnose thyroid cancer.

After **surgery for thyroid cancer**, whole-body radioiodine scans are useful to look for possible spread throughout the body. These scans become even more sensitive if the entire thyroid gland has been removed by surgery because more of the radioactive iodine is picked up by any remaining thyroid cancer cells.

Radioiodine scans work best if patients have high blood levels of thyroid-stimulating hormone (TSH, or thyrotropin). For people whose thyroid has been removed, TSH levels can be increased by stopping thyroid hormone pills for a few weeks before the test. This leads to low thyroid hormone levels (hypothyroidism) and causes the pituitary gland to release more TSH, which in turn stimulates any thyroid cancer cells to take up the radioactive iodine. A downside of this is that it can cause the symptoms of hypothyroidism, including tiredness, depression, weight gain, sleepiness, constipation, muscle aches, and reduced concentration. One way to raise TSH levels without withholding thyroid hormone is to give an injectable form of thyrotropin (Thyrogen®) before the scan.

Because any iodine already in the body can affect this test, people are usually told not to ingest foods or medicines that contain iodine in the days before the scan.
Radioactive iodine can also be used to treat differentiated thyroid cancer, but it is given in much higher doses. This type of treatment is described in the section Radioactive iodine (radioiodine) therapy.

**Chest x-ray**

If you have been diagnosed with thyroid cancer (especially follicular thyroid cancer), a plain x-ray of your chest may be done to see if cancer has spread to your lungs.

**Computed tomography (CT) scan**

The CT scan is an x-ray test that produces detailed cross-sectional images of your body. It can help determine the location and size of thyroid cancers and whether they have spread to nearby areas, although ultrasound is usually the test of choice. A CT scan can also be used to look for spread into distant organs such as the lungs.

One problem using CT scans is that the CT contrast dye contains iodine, which interferes with radioiodine scans. For this reason, many doctors prefer MRI scans for differentiated thyroid cancer.

For more information about CT scans, see Imaging (Radiology) Tests for Cancer on our website.

**Magnetic resonance imaging (MRI) scan**

Like CT scans, MRI scans can be used to look for cancer in the thyroid, or cancer that has spread to nearby or distant parts of the body. But ultrasound is usually the first choice for looking at the thyroid. MRI can provide very detailed images of soft tissues such as the thyroid gland. MRI scans are also very helpful in looking at the brain and spinal cord.

For more information about MRI scans see Imaging (Radiology) Tests for Cancer on our website.

**Positron emission tomography (PET) scan**

This test can be very useful if your thyroid cancer is one that doesn’t take up radioactive iodine. In this situation, the PET scan may be able to tell whether the cancer has spread.
For more information about PET scans see [Imaging (Radiology) Tests for Cancer](#) on our website.

**Blood tests**

Blood tests are not used to find thyroid cancer. But they can help show if your thyroid is working normally, which may help the doctor decide what other tests may be needed. They can also be used to monitor certain cancers.

**Thyroid-stimulating hormone (TSH)**

Tests of blood levels of thyroid-stimulating hormone (TSH or thyrotropin) may be used to check the overall activity of your thyroid gland. Levels of TSH, which is made by the pituitary gland, may be high if the thyroid is not making enough hormones. This information can be used to help choose which imaging tests (such as ultrasound or radioiodine scans) to use to look at a thyroid nodule. The TSH level is usually normal in thyroid cancer.

**T3 and T4 (thyroid hormones)**

These are the main hormones made by the thyroid gland. Levels of these hormones may also be measured to get a sense of thyroid gland function. The T3 and T4 levels are usually normal in thyroid cancer.

**Thyroglobulin**

Thyroglobulin is a protein made by the thyroid gland. Measuring the thyroglobulin level in the blood can’t be used to diagnose thyroid cancer, but it can be helpful after treatment. A common way to treat thyroid cancer is to remove most of the thyroid by surgery and then use radioactive iodine to destroy any remaining thyroid cells. These treatments should lead to a very low level of thyroglobulin in the blood within several weeks. If it is not low, this might mean that there are still thyroid cancer cells in the body. If the level rises again after being low, it is a sign that the cancer could be coming back.

**Calcitonin**

Calcitonin is a hormone that helps control how the body uses calcium. It is made by C cells in the thyroid, the cells that can develop into medullary thyroid cancer (MTC). If
MTC is suspected or if you have a family history of the disease, blood tests of calcitonin levels can help look for MTC. This test is also used to look for the possible recurrence of MTC after treatment. Because calcitonin can affect blood calcium levels, these may be checked as well.

**Carcinoembryonic antigen (CEA)**

People with MTC often have high blood levels of a protein called carcinoembryonic antigen (CEA). Tests for CEA can help monitor this cancer.

**Other blood tests**

You might have other blood tests as well. For example, if you are scheduled for surgery, tests will be done to check your blood cell counts, to look for bleeding disorders, and to check your liver and kidney function.

Medullary thyroid carcinoma (MTC) can be caused by a genetic syndrome that also causes a tumor called pheochromocytoma. Pheochromocytomas can cause problems during surgery if the patient is under anesthesia. This is why patients with MTC who will have surgery are often tested to see if they have a pheochromocytoma, as well. This can mean blood tests for epinephrine (adrenaline) and a related hormone called norepinephrine, and/or urine tests for their breakdown products (called metanephrines).

**Other tests**

**Vocal cord exam (laryngoscopy)**

Thyroid tumors can sometimes affect the vocal cords. If you are going to have surgery to treat thyroid cancer, a procedure called a laryngoscopy will probably be done first to see if the vocal cords are moving normally. For this exam, the doctor looks down the throat at the larynx (voice box) with special mirrors or with a laryngoscope, a thin tube with a light and a lens on the end for viewing.

- **References**

See all references for Thyroid Cancer

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Thyroid Cancer Stages

Staging is the process of finding out if and how far a cancer has spread. The stage of a cancer is one of the most important factors in choosing treatment options and predicting your chance for cure.

Staging is based on the results of the physical exam, biopsy, and imaging tests (ultrasound, radioiodine scan, CT scan, MRI, chest x-ray, and/or PET scans), which are described in Tests for thyroid cancer.

The American Joint Committee on Cancer (AJCC) TNM staging system

A staging system is a standard way to sum up how large a cancer is and how far it has spread.

The most common system used to describe the stages of thyroid cancer is the American Joint Committee on Cancer (AJCC) TNM system. The TNM system is based on 3 key pieces of information:

- **T** indicates the size of the main (primary) tumor and whether it has grown into nearby areas.
- **N** describes the extent of spread to nearby (regional) lymph nodes. Lymph nodes are bean-shaped collections of immune system cells to which cancers often spread first. Cells from thyroid cancers can travel to lymph nodes in the neck and chest areas.
- **M** indicates whether the cancer has spread (metastasized) to other organs of the body. (The most common sites of spread of thyroid cancer are the lungs, the liver, and bones.)

Numbers or letters appear after T, N, and M to provide more details about each of these factors. Higher numbers mean the cancer is more advanced. The letter X means a category can’t be assessed because the information is not available.

**T categories for thyroid cancer (other than anaplastic thyroid cancer)**
**TX:** Primary tumor cannot be assessed.

**T0:** No evidence of primary tumor.

**T1:** The tumor is 2 cm (slightly less than an inch) across or smaller and has not grown out of the thyroid.

- **T1a:** The tumor is 1 cm (less than half an inch) across or smaller and has not grown outside the thyroid.
- **T1b:** The tumor is larger than 1 cm but not larger than 2 cm across and has not grown outside of the thyroid.

**T2:** The tumor is more than 2 cm but not larger than 4 cm (slightly less than 2 inches) across and has not grown out of the thyroid.

**T3:** The tumor is larger than 4 cm across, or it has just begun to grow into nearby tissues outside the thyroid.

**T4a:** The tumor is any size and has grown extensively beyond the thyroid gland into nearby tissues of the neck, such as the larynx (voice box), trachea (windpipe), esophagus (tube connecting the throat to the stomach), or the nerve to the larynx. This is also called *moderately advanced disease*.

**T4b:** The tumor is any size and has grown either back toward the spine or into nearby large blood vessels. This is also called *very advanced disease*.

**T categories for anaplastic thyroid cancer**

All anaplastic thyroid cancers are considered T4 tumors at the time of diagnosis.

**T4a:** The tumor is still within the thyroid.

**T4b:** The tumor has grown outside the thyroid.

**N categories for thyroid cancer**

**NX:** Regional (nearby) lymph nodes cannot be assessed.

**N0:** The cancer has not spread to nearby lymph nodes.

**N1:** The cancer has spread to nearby lymph nodes.
- **N1a**: The cancer has spread to lymph nodes around the thyroid in the neck (called pretracheal, paratracheal, and prelaryngeal lymph nodes).
- **N1b**: The cancer has spread to other lymph nodes in the neck (called cervical) or to lymph nodes behind the throat (retropharyngeal) or in the upper chest (superior mediastinal).

### M categories for thyroid cancer

**MX**: Distant metastasis cannot be assessed.

**M0**: There is no distant metastasis.

**M1**: The cancer has spread to other parts of the body, such as distant lymph nodes, internal organs, bones, etc.

### Stage grouping

Once the values for T, N, and M are determined, they are combined into stages, expressed as a Roman numeral from I through IV. Sometimes letters are used to further divide a stage. Unlike most other cancers, thyroid cancers are grouped into stages in a way that also considers the subtype of cancer and the patient’s age.

**Papillary or follicular (differentiated) thyroid cancer in patients younger than 45**

Younger people have a low likelihood of dying from differentiated (papillary or follicular) thyroid cancer. The TNM stage groupings for these cancers take this fact into account. So, all people younger than 45 years with these cancers are stage I if they have no distant spread and stage II if they have distant spread.

**Stage I (Any T, Any N, M0)**: The tumor can be any size (any T) and may or may not have spread to nearby lymph nodes (any N). It has not spread to distant sites (M0).

**Stage II (Any T, Any N, M1)**: The tumor can be any size (any T) and may or may not have spread to nearby lymph nodes (any N). It has spread to distant sites (M1).

**Papillary or follicular (differentiated) thyroid cancer in patients 45 years and older**
Stage I (T1, N0, M0): The tumor is 2 cm or less across and has not grown outside the thyroid (T1). It has not spread to nearby lymph nodes (N0) or distant sites (M0).

Stage II (T2, N0, M0): The tumor is more than 2 cm but not larger than 4 cm across and has not grown outside the thyroid (T2). It has not spread to nearby lymph nodes (N0) or distant sites (M0).

Stage III: One of the following applies:

T3, N0, M0: The tumor is larger than 4 cm across or has grown slightly outside the thyroid (T3), but it has not spread to nearby lymph nodes (N0) or distant sites (M0).

T1 to T3, N1a, M0: The tumor is any size and may have grown slightly outside the thyroid (T1 to T3). It has spread to lymph nodes around the thyroid in the neck (N1a) but not to other lymph nodes or to distant sites (M0).

Stage IVA: One of the following applies:

T4a, any N, M0: The tumor is any size and has grown beyond the thyroid gland and into nearby tissues of the neck (T4a). It might or might not have spread to nearby lymph nodes (any N). It has not spread to distant sites (M0).

T1 to T3, N1b, M0: The tumor is any size and might have grown slightly outside the thyroid gland (T1 to T3). It has spread to certain lymph nodes in the neck (cervical nodes) or to lymph nodes in the upper chest (superior mediastinal nodes) or behind the throat (retropharyngeal nodes) (N1b), but it has not spread to distant sites (M0).

Stage IVB (T4b, Any N, M0): The tumor is any size and has grown either back toward the spine or into nearby large blood vessels (T4b). It might or might not have spread to nearby lymph nodes (any N), but it has not spread to distant sites (M0).

Stage IVC (Any T, Any N, M1): The tumor is any size and might or might not have grown outside the thyroid (any T). It might or might not have spread to nearby lymph nodes (any N). It has spread to distant sites (M1).

Medullary thyroid cancer

Age is not a factor in the stage of medullary thyroid cancer.

Stage I (T1, N0, M0): The tumor is 2 cm or less across and has not grown outside the thyroid (T1). It has not spread to nearby lymph nodes (N0) or distant sites (M0).
**Stage II:** One of the following applies:

**T2, N0, M0:** The tumor is more than 2 cm but is not larger than 4 cm across and has not grown outside the thyroid (T2). It has not spread to nearby lymph nodes (N0) or distant sites (M0).

**T3, N0, M0:** The tumor is larger than 4 cm or has grown slightly outside the thyroid (T3), but it has not spread to nearby lymph nodes (N0) or distant sites (M0).

**Stage III (T1 to T3, N1a, M0):** The tumor is any size and might have grown slightly outside the thyroid (T1 to T3). It has spread to lymph nodes around the thyroid in the neck (N1a) but not to other lymph nodes or to distant sites (M0).

**Stage IVA:** One of the following applies:

**T4a, any N, M0:** The tumor is any size and has grown beyond the thyroid gland and into nearby tissues of the neck (T4a). It might or might not have spread to nearby lymph nodes (any N). It has not spread to distant sites (M0).

**T1 to T3, N1b, M0:** The tumor is any size and might have grown slightly outside the thyroid gland (T1 to T3). It has spread to certain lymph nodes in the neck (cervical nodes) or to lymph nodes in the upper chest (superior mediastinal nodes) or behind the throat (retropharyngeal nodes) (N1b), but it has not spread to distant sites (M0).

**Stage IVB (T4b, Any N, M0):** The tumor is any size and has grown either back toward the spine or into nearby large blood vessels (T4b). It might or might not have spread to nearby lymph nodes (any N), but it has not spread to distant sites (M0).

**Stage IVC (Any T, Any N, M1):** The tumor is any size and might or might not have grown outside the thyroid (any T). It might or might not have spread to nearby lymph nodes (any N). It has spread to distant sites (M1).

**Anaplastic (undifferentiated) thyroid cancer**

All anaplastic thyroid cancers are considered stage IV, reflecting the poor prognosis of this type of cancer.

**Stage IVA (T4a, Any N, M0):** The tumor is still within the thyroid (T4a). It might or might not have spread to nearby lymph nodes (any N), but it has not spread to distant sites (M0).
Stage IVB (T4b, Any N, M0): The tumor has grown outside the thyroid (T4b). It might or might not have spread to nearby lymph nodes (any N), but it has not spread to distant sites (M0).

Stage IVC (Any T, Any N, M1): The tumor might or might not have grown outside of the thyroid (any T). It might or might not have spread to nearby lymph nodes (any N). It has spread to distant sites (M1).

Recurrent thyroid cancer

This is not an actual stage in the TNM system. Cancer that comes back after treatment is called recurrent (or relapsed). If thyroid cancer returns it is usually in the neck, but it may come back in another part of the body (for example, lymph nodes, lungs, or bones). Doctors may assign a new stage based on how far the cancer has spread, but this is not usually as formal a process as the original staging. The presence of recurrent disease does not change the original, formal staging.

If you have any questions about the stage of your cancer or how it affects your treatment options, be sure to ask your doctor.

- References

See all references for Thyroid Cancer

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Thyroid Cancer Survival Rates, by Type and Stage

Survival rates tell you what portion of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after their cancer is diagnosed. These numbers can’t tell you how long you will live, but they may help give you a better understanding about how likely it is that your treatment will be successful. Some people will want to know the survival rates for their cancer type and stage, and some people
won’t. If you don’t want to know, you don’t have to.

**What is a 5-year survival rate?**

Statistics on the outlook for a certain type and stage of cancer are often given as 5-year survival rates, but many people live longer – often much longer – than 5 years. The 5-year survival rate is the percentage of people who live at least 5 years after being diagnosed with cancer. For example, a 5-year survival rate of 50% means that an estimated 50 out of 100 people who have that cancer are still alive 5 years after being diagnosed. Keep in mind, however, that many of these people live much longer than 5 years after diagnosis.

**Relative survival rates** are a more accurate way to estimate the effect of cancer on survival. These rates compare people with cancer to people in the overall population. For example, if the 5-year relative survival rate for a specific type and stage of cancer is 50%, it means that people who have that cancer are, on average, about 50% as likely as people who don’t have that cancer to live for at least 5 years after being diagnosed.

But remember, survival rates are estimates – your outlook can vary based on a number of factors specific to you.

**Survival rates don’t tell the whole story**

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can’t predict what will happen in any particular person’s case. Your doctor can tell you how the numbers below may apply to you, as he or she is familiar with the aspects of your particular situation.

The following survival statistics were published in 2010 in the 7th edition of the AJCC Cancer Staging Manual. They are based on the stage of the cancer when the person is first diagnosed.

**Papillary thyroid cancer**

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<th>Stage</th>
<th>5-Year Relative Survival Rate</th>
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<tr>
<td>I</td>
<td>near 100%</td>
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<tr>
<td>II</td>
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<tr>
<td>III</td>
<td>93%</td>
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<td>IV</td>
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*Based on patients diagnosed 1998 to 1999

**Follicular thyroid cancer**

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<th>5-Year Relative Survival Rate</th>
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<td>near 100%</td>
</tr>
<tr>
<td>II</td>
<td>near 100%</td>
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<tr>
<td>III</td>
<td>71%</td>
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<td>IV</td>
<td>50%</td>
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*Based on patients diagnosed 1998 to 1999

**Medullary thyroid cancer**

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<th>5-Year Relative Survival Rate</th>
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</thead>
<tbody>
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<td>near 100%</td>
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<tr>
<td>II</td>
<td>98%</td>
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<tr>
<td>III</td>
<td>81%</td>
</tr>
<tr>
<td>IV</td>
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**Based on patients diagnosed between 1985 and 1991

**Anaplastic thyroid cancer**

The 5-year relative survival rate for anaplastic (undifferentiated) carcinomas, all of which are considered stage IV, is around 7% (based on patients diagnosed between 1985 and 1991).

- References
  See all references for Thyroid Cancer

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What Should You Ask Your Health Care Team About Thyroid Cancer?

As you deal with thyroid cancer and the process of treatment, you need to have honest, open discussions with your cancer care team. You should feel free to ask any question on your mind, no matter how minor it might seem. Some of the questions you might want to ask are:

**When you’re told you have thyroid cancer**

- What kind of thyroid cancer do I have?
- Has my cancer spread beyond the thyroid gland?
- What is the stage of my thyroid cancer? What does this mean in my case?
- Are there other tests that need to be done before we decide on treatment?
- Is this form of thyroid cancer hereditary? Should my family be tested?
- Will I need to see other doctors?
- If I’m concerned about the costs and insurance coverage for my diagnosis and treatment, who can help me?

**When deciding on a treatment plan**

- How much experience do you have treating this type of cancer?
- How much surgery do I need? Should I get other treatments as well?
- What are my treatment choices?
- Should I get a second opinion? How do I do that? Can you recommend a doctor or cancer center?
- What should I do to be ready for treatment?
- What are the risks and possible side effects of treatment?
- Will I need to take thyroid hormone for the rest of my life?
- How long will treatment last? What will it involve? Where will it be done?
- Will treatment affect my daily activities?
- When can I go back to my normal activities after treatment?
- Will this treatment affect my ability to have children? Do I need to avoid pregnancy for a while?
- What are the chances that my cancer will come back after treatment?
What will we do if the treatment doesn’t work or if the cancer recurs?

**During treatment**

Once treatment begins, you’ll need to know what to expect and what to look for. Not all of these questions may apply to you, but getting answers to the ones that do may be helpful.

- How will we know if the treatment is working?
- Is there anything I can do to help manage side effects?
- What symptoms or side effects should I tell you about right away?
- How can I reach you on nights, holidays, or weekends?
- Do I need to change what I eat during treatment?
- Are there any limits on what I can do?
- Should I exercise? What should I do, and how often?
- Can you suggest a mental health professional I can see if I start to feel overwhelmed, depressed, or distressed?

**After treatment**

- Are there any limits on what I can do?
- What symptoms should I watch for?
- What kind of exercise should I do now?
- How often will I need to have follow-up exams and tests?
- How will we know if the cancer has come back? What should I watch for?
- What will my options be if the cancer comes back?
- What type of follow-up will I need after treatment?

No doubt you will have other questions about your situation. Be sure to write your questions down so that you remember to ask them during each visit with your cancer care team. For example, you might want to ask about clinical trials you may be eligible for. Keep in mind, too, that doctors are not the only ones who can give you information. Other health care professionals, such as nurses and social workers, may have the answers to your questions. You can find more information about communicating with your health care team in our document about talking with your doctor.

**References**

[See all references for Thyroid Cancer](#)