



Thyroid Cancer

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

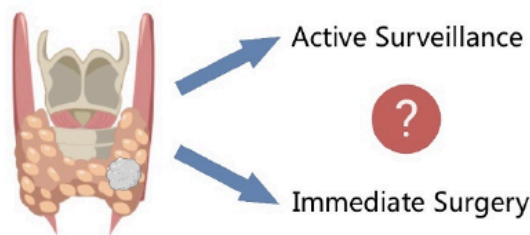
Definition: Thyroid cancer is a malignancy of the thyroid gland comprising **four principal histologic types:** papillary (PTC, ~**80%** of cases), follicular (FTC, ~**15%**), medullary (MTC, ~**3%**), and anaplastic (ATC, ~**2%**), each with distinct biological behavior, prognosis, and treatment approach.^{1,2} PTC and FTC together comprise **differentiated thyroid cancer (DTC)**, which is typically slow-growing and highly curable.^{1,3} ATC carries a median survival of **3-5 months** and requires immediate multidisciplinary evaluation.¹ The 2025 ATA guidelines introduced the **DATA framework** (Diagnosis, risk/benefit **A**ssessment, **T**reatment decisions, response **A**ssessment) to standardize individualized, shared decision-making; a paradigm **closely aligned with value-based care.**⁴

ICD-10 Codes:

Primary tumor = C73, malignant neoplasm of thyroid gland, covers **all histologic subtypes** (no separate ICD-10 codes for papillary, follicular, medullary, or anaplastic).⁵ Use **D44.0** for neoplasm of uncertain behavior pending definitive diagnosis; **E04.1** for confirmed benign thyroid nodule. Post-treatment codes: **E89.0** (postprocedural hypothyroidism), **E89.2** (postprocedural hypoparathyroidism). **Z85.850** (personal history of thyroid malignancy) applies **only after definitive treatment with no active disease**; patients under active surveillance retain C73.

Prevalence and Burden: The American Cancer Society estimates approximately **45,240** new thyroid cancer diagnoses in the United States in 2026 (**13,240** in men; **32,000** in women), with about **2,320** deaths (**1,100** men; **1,220** women).² Thyroid cancer is nearly **3 times more common in women than men**, and **40-50%** less common in Black patients than in any other racial or ethnic group.¹ The overall 5-year relative survival is **98.5%**, having risen from **92%** in the mid-1970s.⁶ The average age at diagnosis is **51 years**, younger than most other adult cancers, yet thyroid cancer carries **particular clinical significance for the Medicare population:** SEER-9 documents incidence of **13.15** per **100,000** in patients aged 60-79 versus 8.00 per **100,000** in those 20-39, with incidence-based mortality 10-fold higher in the older group (0.22 vs. 0.02 per **100,000** person-years).^{1,7} Age ≥ 55 is an independent predictor of structural relapse (**HR 1.78**, 95% CI 1.23-2.56).⁸

The intensity of workup and intervention for thyroid nodules should be **balanced against the favorable outcomes obtained with active surveillance alone.**^{4,9,10} U.S. incidence increased approximately **250%** since 1990 while **mortality remained essentially unchanged**, driven primarily by detection of small papillary thyroid microcarcinomas (PTMC) that **may never cause symptoms or death.**^{1,7} SEER-based estimates (2000-2019) indicate that a substantial proportion of detected papillary thyroid cancers in both women and men may not require immediate intervention.¹¹ Autopsy studies confirm that approximately 10% of adults harbor **subclinical PTCs** and die without ever knowing.¹ **For the PCP in a value-based care setting**, the central task is **accurate risk stratification:** detecting clinically significant disease while avoiding unnecessary surgical harm in elderly patients with indolent tumors, recognizing that **active surveillance is an established management option** for appropriately selected low-risk cases.^{1,4,10}



Balancing Active Surveillance vs Immediate Surgery for Thyroid Microcarcinomas

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