NEO TY - GHID UK 2014 + ETA 2015

5% noduli desc clinic, 20-60% din ty au noduli la eco.

din ei 7-15% neo

incidenta 17/100000 persoane in principal prin k papilar si mck papilar

forme familiale de DTC 5-10%, minim 2 rude afectate

posibil cu debut mai devreme si mai agresive, dar nu se stie dc are sens sa se faca screenig eco. Minim monitorizare clinica

examinare - atentie la raguseala, imobil, adenopatii

- crestere rapida.

APP/AHC - neo ty, sind asoc cu neo, radioterapie la niv gatului sau radioterapie din mediu

apoi TSH.

□ supresat - scinti ○ cald = ok

● rece/ izofixant = investig suplimentare

■ normal sau crescut = investig suplimentare

FGF- PET - noduli disticti > 1cm -> FNAB. 35% sunt neo. Captare difuza ok - tiroidita (dar fac totusi eco pt a nu rata un nodul. Si evaluez fctia ty).

factori de risc pt cancerul de ty:

iradiere gat in copilarie

gusa endemica

tiroidia Hashimoto

APP/AHC de adenoame ty

sndr Cowden: macroencefalie, dificultati usoare de invatare, tumori benigne sau maligne mamare, limba "carpet-pile"

polipoza colonica familiala

obezitate

cancer ty familial

PROGNOSTIC: risc mai mare

-dupa 40 ani

- copil inainte de 10 ani

- barbatii mai rau

- papilar mai bine decat folicular ( similar pt tumori similare ca dimensiuni si invazie sau adenopatii)

PTC cu cel inalte sau columnar sau difuz scerozant -》 mai prost

invazie vasculara mare sau extracapsulara mare mai prost

nediferentiat sau Hurtle cell (oncocitic)-》 mai prost

- invazie extra ty, meta ggl sau la distanta, tumori mari -》 prognostic prost

STADIALIZARE - pt supravietuire la 10 ani 99% i std I-III, 60-75% in std IV.

papilar sau folicular <45 ani

stadiu I: orice T, orice N, M0

stadiul Ll: orice T, orice N, M 1

papilar sau folicular >45 ani

stadiul I: T1, N0, M0

stadiul II: T2, N0, M0

stadiul III

- T3 ( limitat in ty), N0,M0

- T1-3, N1a (ggl centali), M0

stadiul IV A

- T4A( extensie extraty), orice N0, M0

- T 1-3, N1b ( ggl extracentrali), M0

stadiul IV B

- T4B ( extensie locala dar la mai mult decat struct de vecinatate), orice N, M0

stadiul IV C

orice T, orice N, M1

STRATIFICARE RISC

Low-risk:

•No local or distant metastases

•Allmacroscopictumourhasbeenresectedi.e.R0orR1resection (pathologicaldefinition) •Notumourinvasionofloco-regionaltissuesorstructures •Thetumourdoesnothaveaggressivehistology(tallcell,or columnarcellPTC,diffusesclerosingPTC,poorlydifferentiated elements),orangioinvasion Intermediate-riskpatientshaveanyofthefollowingcharacteristics: •Microscopicinvasionoftumourintotheperithyroidalsofttissues (T3)atinitialsurgery •Cervicallymphnodemetastases(N1aorN1b) •Tumourwithaggressivehistology(tallcell,orcolumnarcellPTC, diffusesclerosingPTC,poorlydifferentiatedelements)or angioinvasion

High-riskpatientshaveanyofthefollowingcharacteristics: •

Extra-thyroidalinvasion •Incompletemacroscopictumourresection(R2)

Distantmetastases(M1)

La 1 an dupa iod dinamic risk stratification in functie de raspuns

Recurenta dupa cancer diferentiat ty

patul ty 20 %

ggl laterocervicali 60-75%, in principal in compartimentul III, IV (50%), VI (50%).

Tireoglobulina in lichidul de punctie

< 1ng/ punctie - normal

1 -10 ng/ punctie - de corelat cu datele clinice

> 10 ng/ punctie - meta

tiroglobulina sgv, chiar si stimulata poate fi normala in cazul tumorilor prostdiferentiate

Ecografie la minim 3 luni postoperator. Leziuni suspecte in patul thy:

▪ hipoecogene

▪ taller than wide

▪ contur neregulat, fara halou hipoecogen

▪ vascularizatie prezenta intanodular

▪ microcalcificari si chiste

Pentru adenopatii

Normal

– Hilum preserved. --》 exclude meta ggl

– Ovoid shape and normal size.

– Absent or hilar vascularization.

-- No other suspicious signs.

Indeterminate

– Absence of a hilum and at least one of the following characteristics:

-- Round shape;

-- increased short axis,

-- ≥ 8 mm in level II and ≥ 5 mm in levels III and IV;

-- increased central vascularization.

Suspicious for malignancy (at least one of the following characteristics)

– Microcalcifications.

– Partially cystic appearance.

– Peripheral or diffusely increased vascularization

– Hyperechoic tissue looking like thyroid

!! Ggl mici < 7mm pot fi urmariti conservator, raman stabili mult timp.

Dozez si TGL in punctie, fie ggl fie ty( dg dif granulom de fir sau recidiva).

Metastaze musculare sau in t moi: formatiuni solide, prost delimitate, vascularizate

Cand fac eco

☆ daca c thy e o descoperire intamplatoare postop sau daca nu am o evaluare preop.

☆ la evaluarea de la 6 luni, impreuna cu TGL stimulata sau sub LT4 ( daca nu a facut radioiod)

☆ La pc cu risc mic si foarte mic, daca la 6 luni totul e ok, nu mai e nevoie

☆ la pc cu risc mare de recurenta, anual, si in functie de TGL.

☆ dupa 5 ani, la pc cu risc mic, o eco de control , cu TGL bazala, apoi nu mai e nevoie

☆la pac cu risc mare, reanalizare risc dupa 5 ani si in functie de risc, anual

☆ lobectomie - eco la 6 luni apoi la 2-3 ani

☆ la 3 luni dupa operatie incompleta cu radioiod pt tumori cu invazie in structurile de vecinatate, pt restadializare poate reinterventie

ANAPLAZIC = NEDIFERENTIAT

1-3% neo ty; dupa 60 ani

Supravietuire medie 5-7 luni, 10 % supravietuire la 1 an

Stadializare--》 stadiu IV

IV A - intraty

IV B - extins doar la struct din gat

IV C - metastaze la distanta