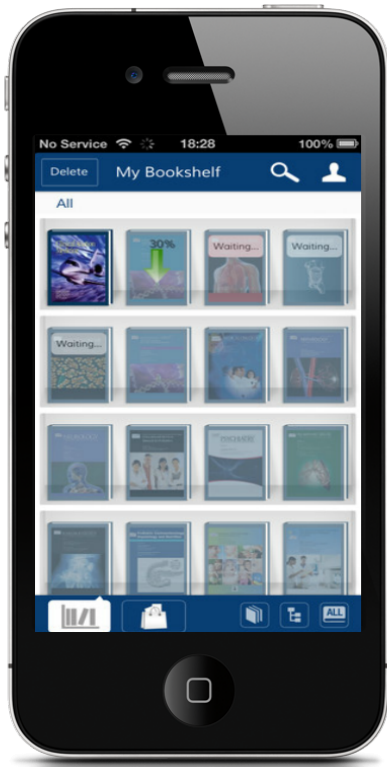


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CCGMP app for iPhone and iPad

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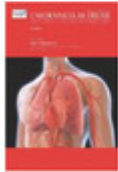

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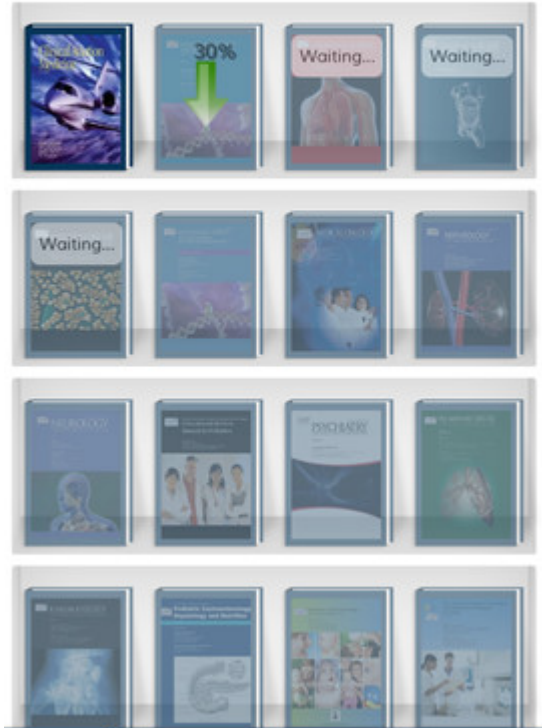
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Thyroid Cancer

Although cancer of the thyroid gland is not particularly common in the general population, it is sometimes detected during routine aviation physical examinations. Most cases present with a lump in the neck, although patients with more advanced disease may have symptoms of dyspnea, dysphagia, dysphagia, or pain. For metastatic lesions, there is a predilection for the lung and bone. Besides spontaneous development of this disease, there is also an apparent association with therapeutic x-ray of the head and neck, that in previous decades was prescribed for enlarged tonsils, adenoids, and thyroid gland. For all these reasons careful palpation of the neck should be a part of any physical examination.

If a mass or nodule is palpated in the thyroid gland, it must be determined if the lesion is benign or malignant. This usually cannot be done by examination or laboratory tests alone—most patients with thyroid cancer are clinically and chemically euthyroid. Thus other tests such as ultrasound, scanning, and needle biopsy must be done, the latter being the most reliable with more than 90% sensitivity.¹⁷

There are four major histologic types of thyroid cancer: papillary, follicular, medullary, and undifferentiated. The papillary and follicular types are the most common, accounting for 90% of all thyroid malignancies with an overall 10-year survival rate of 90%-95%.¹⁸ Prognosis worsens with age, particularly beyond age 45. On the other hand, the medullary and undifferentiated types, while less common are far more malignant, with a propensity to rapidly invade adjacent structures and to metastasize to distant organs: 5-year survival for the medullary type is 40%-75% depending on stage and treatment, and for the undifferentiated type, long-term survival is <20%.¹⁹ Thus the prognosis depends largely on the histologic type, the extent of spread at the time of diagnosis, and the patient's age.

The basic treatment of thyroid cancer is surgery, ranging from simple nodular removal to thyroidectomy and radical neck dissection, depending on the extent of disease. Some patients suffer complications including hypoparathyroidism and injury to the recurrent laryngeal nerve. Other treatment modalities for the more aggressive cancers are radioactive iodine, external radiation, and chemotherapy (bleomycin, doxorubicin, and vinorelbine). For patients receiving radiotherapy, the AME/P should keep in mind that side effects may include bone marrow suppression with leukopenia, thrombocytopenia, and anemia, as well as pulmonary fibrosis for those with pulmonary lesions.

Aviators found to have a thyroid mass or nodule must be fully investigated to rule out a malignant lesion and treated accordingly. The criteria for determining aeronautical disposition should be the histologic type of lesion, the extent of spread, the patient's age, and the posttherapeutic course. If the lesion is successfully removed, there is no evidence of metastasis, and the patient has no significant posttreatment complications, a return to flight duty would be reasonable. Even if there is recurrence with metastasis, the risk of sudden incapacitation is very low. As with any type of malignancy, frequent follow-up is advisable with serum thyroglobulin, chest x-ray, and thyroid ultrasound or MRI for at least a few years following treatment.