

Ekvivalent: Trendovi učestalosti i smrtnosti od karcinoma štitnjače u Hrvatskoj u razdoblju od 1988. do 2010. godine

Vučemilo, Luka

Professional thesis / Završni specijalistički

2023

Degree Grantor / Ustanova koja je dodijelila akademski / stručni stupanj: **University of Zagreb, School of Medicine / Sveučilište u Zagrebu, Medicinski fakultet**

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:105:236460>

Rights / Prava: [In copyright](#)/[Zaštićeno autorskim pravom.](#)

Download date / Datum preuzimanja: **2024-12-04**



Repository / Repozitorij:

[Dr Med - University of Zagreb School of Medicine Digital Repository](#)



Sveučilište u Zagrebu

Medicinski fakultet

Luka Vučemilo

**TRENDOVI UČESTALOSTI I SMRTNOSTI
OD KARCINOMA ŠTITNJAČE U
HRVATSKOJ U RAZDOBLJU OD 1988. DO
2010. GODINE**

Završni specijalistički rad

Zagreb, srpanj 2023. godine

Sveučilište u Zagrebu

Medicinski fakultet

Luka Vučemilo

**TRENDOVI UČESTALOSTI I SMRTNOSTI
OD KARCINOMA ŠTITNJAČE U
HRVATSKOJ U RAZDOBLJU OD 1988. DO
2010. GODINE**

Završni specijalistički rad

Zagreb, srpanj 2023. godine

Ovaj rad objavljen je u časopisu *Acta Clinica Croatia* te je ekvivalent završnog specijalističkog rada.

Rad je izrađen na Zavodu za otorinolaringologiju Kliničke bolnice Merkur u Zagrebu u suradnji s Odjelom za maligne bolesti Službe za epidemiologiju i prevenciju kroničnih nezaraznih bolesti Hrvatskog zavoda za javno zdravstvo te Školom narodnog zdravlja “Andrija Štampar”.

Voditelj rada: doc. dr. sc. Mario Šekerija, dr. med.

Redni broj rada:

Zahvala

Ovim putem izražavam zahvalnost svim dobrim ljudima koji me prate na životnom i profesionalnom putu.

THYROID CANCER INCIDENCE AND MORTALITY TRENDS IN CROATIA 1988-2010

Luka Vučemilo¹, Tin Znaor¹, Tomislav Kuliš², Mario Šekerija³ and Ariana Znaor^{3,4}

¹Department of Ear, Nose and Throat Diseases and Head and Neck Surgery, Merkur University Hospital;
²Department of Urology, Zagreb University Hospital Center; ³Croatian National Institute of Public Health;
⁴Andrija Štampar School of Public Health, School of Medicine, University of Zagreb, Zagreb, Croatia

SUMMARY – The aim of our study was to describe and interpret national trends in thyroid cancer in Croatian men and women during the 1988-2010 period, to better understand the incidence and mortality trends in comparison with other populations, and to determine the proportion of certain histologic subtypes of thyroid cancer and their impact on these trends. Using information from the Croatian National Cancer Registry and WHO Mortality Database, we estimated trends in the age-standardized incidence and mortality rates by joinpoint regression analysis. Thyroid cancer incidence increased in both women and men during the study period, with the estimated annual percent change (EAPC) of 6.4% and 5.5%, with no joinpoints identified. A significant decrease in mortality (EAPC -2.1%) was observed in women, while in men mortality rates decreased nonsignificantly (EAPC -1.3%). A statistically significant incidence increase was observed only for papillary carcinomas with annual incidence increase by 6.7% for women and 7.9% for men. During the study period, thyroid cancer showed an incidence increase in Croatia with persistent and steady decrease in mortality in women and statistically nonsignificant decrease in mortality in men. The increase in papillary carcinomas led to the thyroid cancer incidence increase and also affected the thyroid cancer mortality decrease in women. The trends observed are similar to those in other European countries and require additional analysis to determine all factors that have an effect on them.

Key words: Thyroid neoplasms – epidemiology; Thyroid neoplasms – trends; Croatia

Introduction

Thyroid cancer is the most common malignant disease of the endocrine system^{1,2}, making thyroid gland the ninth most common site of all cancers in women in the world and in Europe^{3,4}. According to the EUCAN estimates for 2012, there were around 53 000 new cases and more than 6000 deaths from thyroid cancer in Europe, with women accounting for 77% of all new cases and 67% of deaths⁴. The trends observed are in favor of an increase in thyroid cancer

incidence and a decrease in mortality⁵⁻⁸. In the US, thyroid cancer is the fastest increasing cancer in both sexes². The risk factors for thyroid cancer are exposure to ionizing radiation, especially in childhood, having a history of goiter or thyroid nodules, family history of thyroid cancer, radioactive exposure, certain rare genetic syndromes, and female gender^{2,9-11}.

Changes in thyroid cancer incidence trends in particular countries have so far been associated with better medical diagnosis⁵ and were attributed to the increase of papillary carcinomas^{5,11}, although not all changes could be explained so¹².

The aim of this study was to describe and interpret trends in the incidence and mortality of thyroid cancer in Croatian men and women during the 1988-2010 period, to compare them with trends in other

Correspondence to: *Luka Vučemilo, MD*, Department of Ear, Nose and Throat Diseases and Head and Neck Surgery, Merkur University Hospital, Zajčeva 19, HR-10000 Zagreb, Croatia
E-mail: lukavučemilo@yahoo.com

Received April 3, 2014, accepted January 12, 2015

populations and to identify possible changes, as well as to determine the proportion of certain histologic subtypes of thyroid cancer and their impact on the incidence trends in the Croatian population.

Methods

Data sources

Thyroid cancer has been defined in the International Classification of Diseases as ICD-9 code 193 and ICD-10 code C73¹³. Incidence data for the study period were obtained from the Croatian National Cancer Registry that includes the entire Croatian population (approximately 4.4 million persons)¹⁴. Data are collected as mandatory cancer notifications from primary and secondary health care sources and death certificates from the Croatian Bureau of Statistics¹⁴. The Registry has contributed data to the last three volumes of the Cancer Incidence in Five Continents series¹⁵⁻¹⁷. The numbers of cancer deaths were obtained from the WHO mortality database¹⁸. For calculating age-specific rates we used the United Nations population estimates¹⁹.

Data on histologic subtypes were available in the Croatian National Cancer Registry for the period from 1998 to 2010. Histologic subtype diagnosis was available in 94.5% of cases in this period and it was coded using the International Classification of Diseases for Oncology, third edition (ICD-O-3)²⁰. To further analyze the impact of each histologic diagnosis on the incidence trends in our study, thyroid cancer was divided into three groups: papillary carcinoma (ICD-O-3 codes 8050, 8052, 8260, 8340), follicular carcinoma (ICD-O-3 codes 8290, 8330, 8331, 8332), and others. For these three histologic subgroups, age-specific rates were calculated and used in further statistical analysis. Data on tumor size could not be obtained from the Croatian National Cancer Registry.

Statistical analysis

Age-standardized rates (ASR) and truncated ASR (for ages 30-64) of cancer incidence in Croatia were calculated by the direct standardization method using the world standard population as a reference²¹. To describe the incidence and mortality trends by calendar period, we carried out joinpoint regression

analysis using the Joinpoint Regression Program, Version 4.0.4., May 2013²². The analysis included logarithmic transformation of the rates, standard error, maximum number of five joinpoints, and minimum of four years between two joinpoints. All other program parameters were set to default values. The aim of this approach is to identify possible joinpoints, where a significant change in the trend occurs. The method identifies joinpoints based on regression models with 0-5 joinpoints. The final model selected was the most parsimonious of these, with the estimated annual percent change (EAPC) based on the trend within each segment²³. The same approach was used to calculate incidence trends of ASR for three histologic groups (papillary, follicular and others) in the 1998 to 2010 period. Joinpoint regression analysis was also used to calculate incidence trends for age-specific rates of ten-year age groups (30-39, 40-49, 50-59, 60-69, 70-79 and >80 years).

On describing trends, the terms "significant increase" or "significant decrease" denote that the slope of the trend was statistically significant ($p < 0.05$). For statistically nonsignificant trends ($p > 0.05$), we used the terms "stable" (for EAPC between -0.5% and 0.5%), "statistically nonsignificant increase" (for EAPC > 0.5%), and "statistically nonsignificant decrease" (for EAPC < -0.5%). All statistical tests were two-sided.

Results

From 1988 to 2010, thyroid cancer was diagnosed in 5453 women and 1355 men (female-to-male ratio, 4 to 1), while 542 women and 282 men died from this malignant disease (female-to-male ratio, 2 to 1). The median age at diagnosis could have been calculated only for the 1998-2010 period. We compared two three-year periods; in the first period (1998-2000), median age at diagnosis was 50 years, with interquartile range of 40-62 years, and for the 2008-2010 period, median age at diagnosis was 52 years, with interquartile range of 39-62 years.

Women

In women, the number of new cases ranged from 99 to 409 annually in the study period, with the significantly increasing trend, EAPC of 6.4% (95% con-

Table 1. Thyroid cancer incidence and mortality in Croatian women 1988–2010

Year	Incidence			Mortality		
	N	Crude rate	ASRW*	N	Crude rate	ASRW*
1988	133	5.7	4.5	28	1.2	0.7
1989	119	5.1	4.1	23	1.0	0.5
1990	144	6.2	4.7	29	1.2	0.7
1991	111	4.7	3.7	20	0.9	0.4
1992	99	4.2	3.1	25	1.1	0.6
1993	164	6.8	5.0	27	1.1	0.5
1994	123	5.1	3.8	26	1.1	0.6
1995	179	7.4	5.7	16	0.7	0.3
1996	166	6.9	5.4	24	1.0	0.5
1997	172	7.2	5.4	18	0.8	0.4
1998	184	7.7	5.8	30	1.7	0.6
1999	261	11.1	8.5	26	1.1	0.5
2000	253	10.8	8.3	19	0.8	0.5
2001	258	11.1	8.1	15	0.6	0.2
2002	268	11.6	8.6	25	1.1	0.4
2003	282	12.2	9.1	25	1.1	0.5
2004	293	12.7	9.4	22	0.9	0.4
2005	331	14.4	10.2	22	1.0	0.4
2006	325	14.1	10.3	27	1.2	0.5
2007	374	16.3	11.8	17	0.7	0.4
2008	403	17.6	12.8	32	1.4	0.6
2009	402	17.6	13.2	22	1.0	0.3
2010	409	17.9	13.2	24	1.1	0.4

*ASRW = age-standardized rate per 100 000 (using world standard population)

confidence interval [CI], 5.5 to 7.2), with no joinpoints identified (Tables 1 and 2, Fig. 1). Significant increasing trends in the incidence were observed in all 30–79 age groups, with the most prominent increase (EAPC 10%) in the 50–59 age-group (Table 2). A significant decrease in mortality (EAPC -2.1%, 95% CI, -3.6 to -0.6) was observed in women in general; however, there was no significant change in age-specific mortality trends (Table 2).

Men

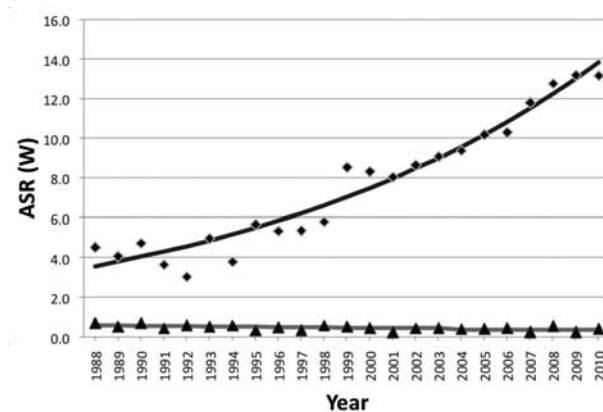
In men, the number of new cases ranged from 23 to 114 annually, with the significantly increasing EAPC

Table 2. Joinpoint analysis of age-specific and age-standardized rates of thyroid cancer incidence and mortality in Croatian women 1988–2010

Age (years)	Trend	
	years	EAPC† (%95 CI)
Incidence		
30–39	1988–2010	6.3* (4.7 to 8.0)
40–49	1988–2010	4.7* (3.0 to 6.5)
50–59	1988–2010	10.0* (8.1 to 11.9)
60–69	1988–2010	7.0* (5.4 to 8.7)
70–79	1988–2010	4.6* (2.8 to 6.4)
>80	1988–2010	-0.5 (-3.0 to 2.1)
Age-standardized		
overall	1988–2010	6.4* (5.5 to 7.2)
truncated (30–64)	1988–2010	6.4* (5.5 to 7.4)
Mortality		
30–39	1988–2010	N/A
40–49	1988–2010	N/A
50–59	1988–2010	N/A
60–69	1988–2010	-2.6 (-5.6 to 0.4)
70–79	1988–2010	-2.3 (-4.4 to 0.0)
>80	1988–2010	-0.5 (-3.0 to 2.1)
Age-standardized		
overall	1988–2010	-2.1* (-3.6 to -0.6)
truncated (30–64)	1988–2010	N/A

N/A = not applicable due to insufficient number of cases; *statistically significant trend; †EAPC = estimated annual percent change

Fig. 1. Joinpoint analysis of thyroid cancer incidence and mortality in Croatian women 1988–2010.



Rhomb = incidence; triangle = mortality; ASR(W) = age-standardized rate per 100 000 (using world standard population)

Table 3. Thyroid cancer incidence and mortality in Croatian men 1988-2010

Year	Incidence			Mortality		
	N	Crude rate	ASRW*	N	Crude rate	ASRW*
1988	42	1.9	1.9	21	1.0	0.7
1989	23	1.1	0.9	13	0.6	0.5
1990	35	1.6	1.2	8	0.4	0.3
1991	29	1.3	1.1	11	0.5	0.4
1992	27	1.2	1.0	8	0.4	0.2
1993	40	1.8	1.5	10	0.5	0.3
1994	32	1.4	1.2	9	0.4	0.5
1995	51	2.3	1.8	10	0.4	0.3
1996	41	1.8	1.4	18	0.8	0.5
1997	52	2.3	1.8	12	0.5	0.4
1998	43	1.9	1.4	8	0.4	0.2
1999	65	3.0	2.3	13	0.6	0.4
2000	70	3.2	2.3	19	0.9	0.5
2001	51	2.4	1.7	8	0.4	0.2
2002	59	2.7	2.0	12	0.6	0.3
2003	68	3.2	2.3	11	0.5	0.3
2004	82	3.8	2.7	16	0.7	0.4
2005	82	3.8	2.7	13	0.6	0.3
2006	86	4.0	3.0	9	0.4	0.2
2007	73	3.4	2.4	12	0.6	0.3
2008	94	4.4	3.2	15	0.7	0.4
2009	114	5.4	3.8	7	0.3	0.2
2010	96	4.5	3.2	19	0.9	0.6

*ASRW = age-standardized rate *per* 100 000 (using world standard population) ledra in

of 5.5% (95% CI, 4.4 to 6.6), with no joinpoints identified (Tables 3 and 4, Fig. 2). The age-specific incidence trends were significantly increasing in the 30-69 age groups analyzed, with the most prominent increase of EAPC (8.1%) for incidence in the youngest 30-39 age group (Table 4). The age-standardized mortality rates decreased nonsignificantly with EAPC -1.3% (95% CI, -3.5 to 1.0) (Table 4, Fig. 2). There were no significant changes in mortality trends in men in any age group (Table 4).

Histologic groups

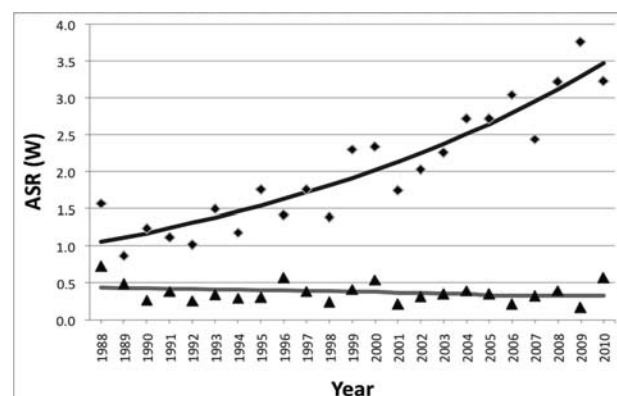
The number of new papillary carcinoma cases doubled between the first and the last three-year period

Table 4. Joinpoint analysis of age-specific and age-standardized rates of thyroid cancer incidence and mortality in Croatian men 1988-2010

Age (years)	Trend	
	years	EAPC† (%95 CI)
Incidence		
30-39	1988-2010	8.1* (5.2 to 11.0)
40-49	1988-2010	5.3* (3.0 to 7.6)
50-59	1988-2010	7.3* (5.2 to 9.5)
60-69	1988-2010	5.7* (3.3 to 8.2)
70-79	1988-2010	N/A
>80	1988-2010	N/A
Age-standardized		
overall	1988-2010	5.5* (4.4 to 6.6)
truncated (30-64)	1988-2010	6.0* (4.7 to 7.2)
Mortality		
30-39	1988-2010	N/A
40-49	1988-2010	N/A
50-59	1988-2010	N/A
60-69	1988-2010	-1.3 (-4.3 to 1.8)
70-79	1988-2010	N/A
>80	1988-2010	N/A
Age-standardized		
overall	1988-2010	-1.3 (-3.5 to 1.0)
truncated (30-64)	1988-2010	-1.0 (-4.0 to 2.0)

N/A = not applicable due to insufficient number of cases; *statistically significant trend; †EAPC = estimated annual percent change

Fig. 2. Joinpoint analysis of thyroid cancer incidence and mortality in Croatian men 1988-2010.



Rhomb = incidence; triangle = mortality; ASR(W) = age-standardized rate *per* 100 000 (using world standard population)

Table 5. Incidence trends of thyroid cancer according to subgroups and sex 1998-2010

1998-2010	Women	Men
	EAPC† (95% CI)	EAPC† (95% CI)
Papillary	6.7* (5.8 to 7.7)	7.9* (5.0 to 10.9)
Follicular	2.1 (-2.0 to 6.3)	-0.7 (-8.4 to 7.6)
Others	-0.7 (-5.7 to 4.5)	0.3 (-6.0 to 7.0)

*Statistically significant trend; †EAPC = estimated annual percent change

(1998-2000 and 2008-2010). The number of follicular and medullary carcinoma cases increased 1.1- and 1.6-fold, while the number of anaplastic carcinoma was unchanged. The proportion of papillary carcinoma in overall thyroid cancer rose from 81% to 87%, while the proportion of other subgroups decreased from 12.8% to 8.1% for follicular carcinoma, from 4.5% to 4.1% for medullary carcinoma, and from 1.7% to 0.9% for anaplastic carcinoma.

Joinpoint analysis of three broad histologic groups of thyroid cancer (papillary, follicular and other specified or not otherwise specified carcinomas) indicated a statistically significant incidence increase in the study period only for papillary carcinomas (Table 5). The annual incidence increase was 6.7% in women (95% CI, 5.8 to 7.7) and 7.9% in men (95% CI, 5.0 to 10.9).

Discussion

Time trends of thyroid cancer incidence and mortality were for the first time systematically analyzed in Croatia by joinpoint regression modeling that is the optimal method to detect and depict sharp changes in trends, reflecting changes in cancer prevention and care policies.

Our results indicated an increase in thyroid cancer incidence in Croatia in both sexes between 1988 and 2010, with persistent and steady decrease in mortality in women and statistically nonsignificant decrease in mortality in men. The most prominent incidence increase was observed in the 50-59 age group in women and in the youngest 30-39 age group in men.

From the 1970s, incidence rates increased in most European countries, although a decrease was recorded in some countries, such as Sweden and Norway²⁴. Rising incidence trends are also observed in non-European countries, such as US and Canada^{5,25}. In the last

fifty years (1960-2004), mortality from thyroid cancer declined in Europe in both sexes and the falls tended to be larger in women²⁶.

According to the observed thyroid cancer incidence of ASR 11.4/100 000, Croatia is ranked as the fourth European country with the highest thyroid cancer incidence. Higher incidence rates than in Croatia are registered only in Lithuania (15.5/100 000), Italy (13.5/100 000) and Austria (12.4/100 000)⁴. With the observed thyroid cancer mortality of ASR 0.5/100 000, Croatia is ranked the 17th of 40 European countries⁴. The highest mortality ASR in Europe was observed in Russia (1.1/100 000), Iceland (0.8/100 000) and Lithuania (0.7/100 000)⁴.

When analyzing trends by sex, we can claim that Croatia, compared to other European countries from the EUCAN database, has a high female and male thyroid incidence and moderate mortality⁴. Countries with the highest incidence rates among women are Lithuania (24.2/100 000) and Italy (18.7/100 000) and with the highest mortality rates Russia (1.3/100 000) and Latvia (0.9/100 000)⁴. Similar country order applies to men; by incidence, Croatia ranks fifth after Italy, Austria, Luxembourg and France, while by mortality of thyroid cancer in men, Croatia ranks ninth after Iceland, Russia, Cyprus, Lithuania, Slovenia, Hungary, Italy and Austria⁴.

Despite various explanations in the past, recent studies suggest that the reasons for increase in the incidence are not completely understood¹² and that the cause is most likely multifactorial²⁷. Liu *et al.* suggest etiologic heterogeneity between women and men in the pathogenesis of thyroid cancer⁵. The majority of authors are in favor of more intensive diagnostics as the reason for the increasing trends. Advanced medical procedures such as ultrasound and fine-needle aspiration biopsy have contributed to detection of thyroid cancer, especially smaller ones. Against these claims are results such as the increase of thyroid cancers larger than 4 cm^{24,28}. Also, our results suggest that despite the incidence increase, there is no increase in thyroid cancer mortality. These findings could be explained in two ways. One is that cancer treatment in Croatia is at a high level. The second possible answer is that carcinomas, mostly microcarcinomas that make the majority of newly diagnosed thyroid cancers, are clinically nonsignificant²⁹. The size of tumors could not be obtained

from the Croatian National Cancer Registry and therefore trends in tumor size were not part of our analysis. Iodine intake was also analyzed as a possible explanation for changes in thyroid cancer trends, and increase in the incidence of thyroid cancer in Croatia cannot be attributed to the increased iodine intake^{30,31}.

According to the data obtained, it can be concluded that the incidence increase is almost entirely due to the increase in papillary carcinoma. Similar trends are observed by other authors^{5,11,12,32}. In the study by Howlader *et al.*, as well as in our study, six of seven thyroid cancers were papillary carcinomas³³. The increase of papillary carcinomas, which have better clinical outcome in comparison with other histologic subtypes of thyroid cancer, also has influenced the mortality decrease in women in Croatia.

An interesting fact was found when Croatia was compared with other countries in southeast Europe. Croatia as a country with high incidence rates is an exception, since other countries in this part of Europe have the lowest incidence rates in all Europe, EAPC <3.6/100 000⁴. More than 20 years ago, the majority of these countries were parts of former Yugoslavia and were involved in the war in the 1990s. These countries have the same geographical position, in Yugoslavia had shared similar health care system, and had similar exposure to external factors. Griniatsos *et al.* have discussed the Chernobyl accident from 1986 and depleted uranium weapons during the 1990s war on the former Yugoslavia territory as the possible factors influencing thyroid cancer trends in Greece, however, with no proven correlation¹⁰. All the above mentioned imposes further thoughts. If the reason for incidence increase is intensive diagnostics, does it mean that Croatia has the most optimal diagnostics, even better than some developed EU countries? If the reasons for high incidence are external factors such as Chernobyl and war, why are there such differences between geographically neighboring countries that had the same or similar exposure? Another possible explanation for the observed difference between Croatia and other countries in southeast Europe could possibly be found in cancer registries of these countries, the way they are organized and differences in data collection. These differences are striking and demand thorough investigation and further analysis.

Among European countries, there is certain regularity in mortality distribution; the highest rates are

recorded in the east of Europe and these rates decrease toward countries in the west of Europe, with few exceptions⁴. Whether this is so because of better thyroid cancer treatment or earlier diagnosis in western European countries, or there are other factors, is yet to be analyzed.

In Croatia, thyroid cancer showed an incidence increase in both sexes during the 23-year study period, with a significant decrease in mortality in women and nonsignificant decrease in mortality in men. The incidence increase of thyroid cancer can be attributed to the increase of papillary carcinomas. The trends observed are similar to those in other European countries and require additional analysis to determine the factors influencing these trends.

Acknowledgment

The authors would like to thank Nino Sinčić for data collection.

References

1. Siegel R, Naishadham D, Jemal A. Cancer statistics, 2012. *CA Cancer J Clin.* 2012;62:10-29.
2. American Cancer Society. *Cancer Facts & Figures 2013.* Atlanta: American Cancer Society; 2013.
3. Ferlay J, Shin HR, Bray F, Forman D, Mathers C, Parkin DM. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon, France: International Agency for Research on Cancer; 2010 [cited 2013 Jul 21]. Available from: <http://globocan.iarc.fr>.
4. Steliarova-Foucher E, O'Callaghan M, Ferlay J, Masuyer E, Forman D, Comber H, Bray F. European Cancer Observatory: Cancer Incidence, Mortality, Prevalence and Survival in Europe. European Network of Cancer Registries, International Agency for Research on Cancer; 2012 [cited 2013 Jul 21]. Available from: <http://eco.iarc.fr>.
5. Liu S, Semenciw R, Ugnat AM, Mao Y. Increasing thyroid cancer incidence in Canada, 1970-1996: time trends and age-period-cohort effects. *Br J Cancer.* 2001;85:1335-9.
6. Lukas J, Drabek J, Lukas D, Dusek L, Gatek J. The epidemiology of thyroid cancer in the Czech Republic in comparison with other countries. *Biomed Pap Med Fac Univ Palacky Olomouc Czech Repub.* 2013;157:266-75.
7. Olaleye O, Ekrikpo U, Moorthy R, Lyne O, Wiseberg, Black M, Mitchell D. Increasing incidence of differentiated thyroid cancer in South East England: 1987-2006. *Eur Arch Otorhinolaryngol.* 2011;268:899-906.
8. Smailyte G, Miseikyte-Kaubriene E, Kurti-naitis J. Increasing thyroid cancer incidence in Lithuania in 1978-2003. *BMC Cancer.* 2006;6:284.

9. Shore RE, Woodard E, Hildreth N, Dvoretzky P, Hempelmann L, Pasternack B. Thyroid tumors following thymus irradiation. *J Natl Cancer Inst.* 1985;74:1177-84.
10. Griniatsos J, Tsigris C, Kanakis M, Kaltsas G, Michail O, Dimitriou N, Argyrakopoulou G, Delladetsima I, Kyriakou V, Syriou V, Alexandraki K, Pikoulis E, Giannopoulos A, Kouraklis G, Diamanti-Kandaraki E, Felekouras E. Increased incidence of papillary thyroid cancer detection among thyroidectomies in Greece between 1991 and 2006. *Anticancer Res.* 2009;29:5163-9.
11. Kilfoy BA, Devesa SS, Ward MH, Zhang Y, Rosenberg PS, Holford TR, Anderson WF. Gender is an age-specific effect modifier for papillary cancers of the thyroid gland. *Cancer Epidemiol Biomarkers Prev.* 2009;18:1092-100.
12. McLeod DS, Sawka AM, Cooper DS. Controversies in primary treatment of low-risk papillary thyroid cancer. *Lancet.* 2013;381:1046-57.
13. World Health Organization. International statistical classification of diseases and related health problems. Tenth revision, Vol. 2. Geneva, Switzerland: WHO; 1993.
14. Croatian National Cancer Registry. Cancer incidence in Croatia 2008. Bulletin No. 33. Zagreb: Croatian National Institute of Public Health; 2010.
15. Curado MP, Edwards B, Shin HR, Storm H, Ferlay J, Heanue M, Boyle P, editors. Cancer incidence in five continents, Vol. IX (IARC Scientific Publications No. 160). Lyon, France: International Agency for Research on Cancer; 2007.
16. Parkin DM, Whelan SL, Ferlay J, Teppo L, Thomas DB, editors. Cancer incidence in five continents, Vol. VIII (IARC Scientific Publications No. 155). Lyon, France: International Agency for Research on Cancer; 2002.
17. Parkin DM, Whelan SL, Ferlay J, Raymond L, Young J, editors. Cancer incidence in five continents, Vol. VII (IARC Scientific Publications No. 143). Lyon, France: International Agency for Research on Cancer; 1997.
18. World Health Organization. World Health Organization mortality database. WHO Statistical Information System [cited 2013 Jul 21]. Available from: <http://www.who.int/whosis/mort/download/en/index.html>.
19. United Nations. World population prospects, the 2010 revision. United Nations Population Division Department of Economic and Social Affairs [cited 2013 Jul 21]. Available from: <http://www.un.org/esa/population/unpop.htm>.
20. World Health Organization. International Classification of Diseases for Oncology. Third edition. Geneva, Switzerland: WHO; 2000.
21. Doll R, Payne P, Waterhouse JAH, editors. Cancer incidence in five continents, Vol. I. Geneva, Switzerland: Union Internationale Contre le Cancer; 1966.
22. Joinpoint Regression Program, Version 4.0.4. May 2013 [Internet]; Statistical Methodology and Applications Branch, Surveillance Research Program, National Cancer Institute [cited 2013 Jul 21]. Available from: <http://surveillance.cancer.gov/joinpoint/>.
23. Kim HJ, Fay MP, Feuer EJ, Midthune DN. Permutation tests for joinpoint regression with applications to cancer rates. *Stat Med.* 2000;19:335-51.
24. Kilfoy BA, Zheng T, Holford TR, Han X, Ward MH, Sjodin A, Zhang Y, Bai Y, Zhu C, Guo GL, Rothman N, Zhang Y. International patterns and trends in thyroid cancer incidence, 1973-2002. *Cancer Causes Control.* 2009;20:525-31.
25. Davies L, Welch HG. Increasing incidence of thyroid cancer in the United States, 1973-2002. *JAMA.* 2006;295:2164-7.
26. Levi F, Lucchini F, Negri E, Boyle P, La Vecchia C. Cancer mortality in Europe, 1995-1999, and an overview of trends since 1960. *Int J Cancer.* 2004;110:155-69. Erratum in: *Int J Cancer.* 2004;111:981.
27. Pellegriti G, Frasca F, Regalbuto C, Squatrito S, Vigneri R. Worldwide increasing incidence of thyroid cancer: update on epidemiology and risk factors. *J Cancer Epidemiol.* 2013;2013:965212.
28. Enewold L, Zhu K, Ron E, Marrogi AJ, Stojadinovic A, Peoples GE, Devesa SS. Rising thyroid cancer incidence in the United States by demographic and tumor characteristics, 1980-2005. *Cancer Epidemiol Biomarkers Prev.* 2009;18:784-91.
29. Iyer NG, Morris LG, Tuttle RM, Shaha AR, Ganly I. Rising incidence of second cancers in patients with low-risk (T1N0) thyroid cancer who receive radioactive iodine therapy. *Cancer.* 2011;117:4439-46.
30. Jukić T. The impact of iodine intake on epidemiological and clinical-histopathological features of thyroid cancer [dissertation]. Zagreb: University of Zagreb; 2008. (in Croatian)
31. Poljak NK, Kontić M, Čolović Z, Jerončić I, Lukšić B, Mulić R. Iodine intake and epidemiological characteristics of thyroid cancer: comparison between inland and littoral Croatia. *Acta Clin Croat* 2011;50:329-39.
32. Hakala T, Kellokumpu-Lehtinen P, Kholova I, Holli K, Huhtala H, Sand J. Rising incidence of small size papillary thyroid cancers with no change in disease-specific survival in Finnish thyroid cancer patients. *Scand J Surg.* 2012;101:301-6.
33. Howlader N, Noone AM, Krapcho M, Garshell J, Neyman N, Altekruse SF, Kosary CL, Yu M, Ruhl J, Tatalovich Z, Cho H, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA, editors. SEER Cancer Statistics Review, 1975-2010. Bethesda: National Cancer Institute [update 2013 Apr; cited 2013 Jul 21]. Available from: http://seer.cancer.gov/csr/1975_2010/.

Sažetak

TRENDOVI U INCIDENCIJI I SMRTNOSTI KARCINOMA ŠTITNJAČE U HRVATSKOJ U RAZDOBLJU OD 1988. DO 2010. GODINE

L. Vučemilo, T. Znaor, T. Kuliš, M. Šekerija i A. Znaor

Cilj ovoga rada bio je opisati i protumačiti trendove incidencije i smrtnosti karcinoma štitnjače u Hrvatskoj u razdoblju od 1988. do 2010. godine, usporediti ih s trendovima u drugim zemljama te odrediti udio histoloških tipova karcinoma štitnjače i njihov utjecaj na trendove. Koristeći podatke iz Registra za rak Hrvatske i iz baze podataka Svjetske zdravstvene organizacije učinjena je regresijska analiza uz pomoć točaka spajanja za procjenu trendova incidencije i smrtnosti. Incidencija karcinoma štitnjače porasla je i kod žena i kod muškaraca u promatranom razdoblju s procijenjenim godišnjim postotkom promjene (engl. *estimated annual percent change*, EAPC) od 6,4% i 5,5%, bez identificiranih točaka spajanja. Kod žena je zabilježen značajan pad smrtnosti (EAPC -2,1%), dok se kod muškaraca smrtnost smanjila, ali statistički neznačajno (EAPC -1,3%). Statistički značajan porast incidencije zabilježen je samo kod papilarnih karcinoma s godišnjim postotkom promjene od 6,7% za žene i 7,9% za muškarce. Incidencija karcinoma štitnjače porasla je u promatranom razdoblju uz stalan i umjeren pad smrtnosti kod žena te uz statistički neznačajan pad smrtnosti kod muškaraca. Incidencija karcinoma štitnjače je porasla zbog porasta broja papilarnih karcinoma, što je također utjecalo na pad smrtnosti od karcinoma štitnjače kod žena. Zabilježeni trendovi su slični trendovima u drugim europskim zemljama i zahtijevaju dodatnu analizu svih čimbenika koji na njih utječu.

Ključne riječi: *Štitnjača, tumori – epidemiologija; Štitnjača, tumori – trendovi; Hrvatska*

Životopis

Luka Vučemilo diplomirao je 2009. godine na Medicinskom fakultetu Sveučilišta u Zagrebu. Od 2012. godine radi na Zavodu za otorinolaringologiju Kliničke bolnice Merkur u Zagrebu. Od 2014. godine sudjeluje u nastavi iz predmeta Temelji liječničkog umijeća na Medicinskom fakultetu Sveučilišta u Zagrebu. Na Medicinskom fakultetu Sveučilišta u Zagrebu 2015. godine obranio je doktorsku disertaciju «Uvažavanje prava bolesnika na obaviještenost o medicinskom postupku tijekom bolničkoga liječenja u Hrvatskoj». Tijekom poslijediplomskog doktorskog studija dobio je Dekanovu nagradu za znanstvenu produktivnost tijekom izrade disertacije. 2016. godine izabran je u znanstveno zvanje znanstveni suradnik za znanstveno područje Biomedicina i zdravstvo. 2018. godine položio je specijalistički ispit iz otorinolaringologije.