There are currently 3 sets of guidelines that outline the management of thyroid nodules. A case in point here.

A 55-year-old woman comes to your office and tells you that she has been worried about a “lump in her throat” for the past 3 months. You examine her neck and find a firm mobile nodule (1 cm in diameter) in the thyroid area.

The patient has a history of mantle field radiation for a childhood cancer. Her TSH level is normal. You refer her for ultrasonography, which shows a 1.2-cm hypoechoic solid nodule.

In this patient—with a solid hypoechoic nodule larger than 1 cm on an ultrasonogram and a high-risk clinical feature (ie, a history of radiation therapy), immediate referral for a fine-needle aspiration biopsy is warranted.

**Discussion**

Palpable thyroid nodules occur in 4% to 7% of the population (10 to 18 million persons). However, the prevalence of nodules found incidentally on ultrasonography may be as high as 67%. Thyroid carcinoma is ultimately found in roughly 5% to 10% of palpable nodules. Accurate diagnosis of thyroid nodules is thus critical to the detection of thyroid carcinoma.

There are currently 3 sets of guidelines for the management of thyroid nodules that have been published during the past 4 years:

- The American Thyroid Association (ATA)
- The American Association of Clinical Endocrinologists (AACE), in collaboration with the Associazione Medici Endocrinologi (AME) and the European Thyroid Association (ETA)
- The Korean Society of Thyroid Radiology (KSTR)

There is some overlap among these guidelines, but there are also significant differences.

**Comparisons**

The AACE-AME-ETA guidelines recommend biopsy of any solid and hypoechoic nodule larger than 1 cm in diameter. Other high-risk features that necessitate a biopsy include a history of irradiation, a family history of medullary carcinoma or multiple endocrine neoplasia syndrome, a history of partial thyroidectomy for thyroid cancer, or presence of an elevated calcitonin level.

The ATA guidelines recommend against biopsy for thyroid nodules smaller than 5 mm in diameter. Biopsy of solid nodules smaller than 1 cm is discouraged if no clinical risks or microcalcifications are present. Similarly, the AACE guidelines do not recommend biopsy of solid nodules that are smaller than 1 cm in diameter if the patient has no clinical risks and there are no suspicious features on an ultrasonogram. Nodules that appear hyperfunctioning on scintigraphy can also escape biopsy.

**References**
