Race	1960–64	1968–72
Chinese	19.9	12.3
Hawaiian	11.8	17.0
Filipino	8.8	18.4
Japanese	6.1	6.3
Caucasian	4.9	9.4

the remaining cell types was follicular (18 percent), medullary (three percent), anaplastic (three percent), sarcoma (less than one percent), lymphoma (two percent) and other (11 percent) (Table III). Follicular carcinoma has a peak incidence in the fifth decade of life, and occurs with greater frequency in women. Anaplastic carcinoma tends to be diagnosed at a later age than the differentiated carcinomas, and occurs about equally in men and women. Russell et al.[22] found a differentiated component in all anaplastic carcinomas, and concluded that the undifferentiated foci were derived from the more differentiated papillary and follicular elements. It is reasonable to assume that in the bimodal age-incidence curve evidenced by women, the first mode is comprised predominantly of papillary and, to a lesser extent, follicular carcinomas, and the second mode is comprised of predominantly anaplastic and, to a lesser extent, papillary and follicular carcinomas.

The prognosis in patients with thyroid carcinoma is variable and correlates with histologic type, extent of disease, age at diagnosis and sex. The survival rate for papillary carcinoma is significantly higher than for follicular carcinoma, and is lowest for the spindle and giant cell carcinomas (Table IV).[22,23] In follicular carcinoma, the encapsulated subtype with minimal vascular and capsular invasion is characterized by a 10-year survival rate that is almost twice that of non-encapsulated, primary, operable follicular carcinoma.

The survival rate in women as reported by the End Results Group of the National Cancer Institute was consistently better than that noted in men (Table V). During 1955-1964, 54 percent of women as contrasted with 39 percent of men were diagnosed as having localized disease. Relative survival rates at five and 10 years in men and women decreased with increasing age (Table VI). Women and the younger age groups are characterized by a higher prevalence of papillary and follicular carcinomas and earlier stage of disease.[24] Relative survival rates at three and five years for women and men have improved substantially between 1940-1949 and 1960-1964. If these data can be generalized, then the declining age-adjusted mortality in the face of increasing age-adjusted incidence since 1950 in the United States has occurred because of more significant gains in survival and in average duration of disease.

Medullary carcinoma or solid carcinoma with amyloid stroma is typified by a lack of follicular and papillary differentiation, colloid formation and radioiodine

Type	All races Total No.	%	Male No.	%	Female No.	%
Papillary carcinoma	1434	64	364	61	1070	66
Follicular carcinoma	403	18	96	16	307	19
Medullary carcinoma	59	3	28	5	31	2
Anaplastic carcinoma	55	3	21	4	34	2
Lymphoma	34	2	11	2	23	1
Sarcoma	4	<1	1	<1	3	<1
Other†	236	11	74	12	162	10
Total number of patients	2225	100*	595	100	1630	100

Type	White Total No.	%	Male No.	%	Female No.	%
Papillary carcinoma	1334	65	344	62	990	66
Follicular carcinoma	358	17	85	15	273	18
Medullary carcinoma	56	3	28	5	28	2
Anaplastic carcinoma	55	3	21	4	34	2
Lymphoma	33	2	11	2	22	2
Sarcoma	4	<1	1	<1	3	<1
Other†	218	11	67	12	151	10
Total number of patients	2058	100*	557	100	1501	100

Type	Black Total No.	%	Male No.	%	Female No.	%
Papillary carcinoma	63	52	11	41	52	55
Follicular carcinoma	40	33	11	41	29	31
Medullary carcinoma	3	3	—	—	3	3
Anaplastic carcinoma	—	—	—	—	—	—
Lymphoma	1	1	—	—	1	1
Sarcoma	—	—	—	—	—	—
Other†	14	12	5	19	9	10
Total number of patients	121	100*	27	100*	94	100

†Other includes carcinoma or adenocarcinoma (not otherwise specified), carcinoma simplex, clear cell adenocarcinoma, squamous carcinoma and malignant neoplasm (not otherwise specified).
*Does not total 100 percent because of rounding.