

Endocrinology eConsult



PCP

33-year-old female with prior dx of Hashimoto's with worsening temperature intolerance and major depression recurrence. Depression/anxiety improved with start of SSRI, then worsened during COVID19 pandemic. Strong family history of Hashimoto's thyroiditis with multiple family members now hypothyroid. Multiple thyroid nodules noted on US (US report and labs attached). TSH 0.11 (slightly suppressed). Normal thyroglobulin total and thyroglobulin antibody testing.

This patient is currently not in the area due to the pandemic, however I would like to clarify the urgency for follow up.

Current plan is to wait 2-3mo to refer for FNA. Would you recommend sooner re-evaluation with referral for FNA, repeat labs and thyroid scan?



Specialist

If a patient like this presented to me, these would be my general thoughts: This patient has two issues. 1, she is hyperthyroid and two she has thyroid nodules. It is possible that she has nodules and also mild graves hyperthyroidism or she has functioning nodules causing mild hyperthyroidism. To solve the above, an uptake and scan is helpful. It is a functional imaging test and will determine if a nodule is functioning or not. Typically functioning nodules do not require biopsy given the risk of malignancy is so low. Keep in mind we don't use uptake and scan to assess if a nodule is malignant or not as it is just not sensitive enough for that. Regarding the nodules, the mixed cystic and solid 3 cm was tirads 5 and should be biopsied however if the uptake and scan shows a functioning nodule then perhaps it can simply be monitored along with the other nodules as noted depending on whether you decide to treat the hyperthyroidism or not. regarding the hyperthyroidism, the TSH was suppressed to 0.09 but has improved to 0.11. this is a young patient and likely has low risk of cardiac or bone disease. In patients over 65 yrs of age I typically assess the bone status with DEXA scan and also cardiac status. Treatment of subclinical hyperthyroidism is based on the below information:

- 1)the annual loss of femoral neck bone density is greater among those with TSH <0.1 mU/L compared with those who are euthyroid.
- 2)lower TSH levels (<0.10 mU/L) are associated with higher fracture rates as well.
- 3)With respect to cardiac disease, serum TSH values <0.1 mU/L, 0.1 to 0.4 mU/L, or within the normal range, the cumulative incidence of atrial fibrillation was 28, 16, and 11 percent, respectively
- 4)Patients with TSH levels <0.10 mU/L have a higher risk of heart failure than euthyroid patients.
- 5)Subclinical hyperthyroidism is also associated with increased coronary heart disease risk. In light of the above, I would recommend treatment when the TSH is < 0.1 especially if a reversible cause is found and/or the patient is symptomatic.

IN SUMMARY: --I recommend uptake and scan to determine if nodules are hyperfunctioning. if they are you have found to cause of the hyperthyroidism and perhaps can avoid FNA of hyperfunctioning nodules. --if nodules are not hyperfunctioning get TSI and TRAB to assess for graves disease (uptake and scan may show diffuse hyperthyroidism which is also graves disease --if nodules are not hyperfunctioning then consider biopsy based on tirads per report (i agree) --I dont recommend FNA before the above eval. --if you dont decide to treat the hyperthyroidism then check tft's q6 months. Hope that helps!

