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Review Article

**HYPOTHYROIDISM IN FAMILY MEDICINE DIAGNOSIS AND
MANAGEMENT**

Amnah Ahmed Alhuwayji

MBBS, Faculty of Medicine, King Faisal University

Abstract:

Hypothyroidism is defined as failing of the thyroid gland to produce sufficient thyroid hormone to fulfill the metabolic demands of the body. In this review we discuss the proper diagnostic and management methods in primary care. Without treatment, hypothyroidism can lead to high blood pressure, dyslipidemia, infertility, cognitive impairment, and neuromuscular disorder. We conducted a narrative review over the literature using electronic databases as; MEDLINE, and EMBASE for studies involving data on treatment hypothyroidism in primary care by family doctors, published in English language up to 2018. Hypothyroidism is dealt with by recommending an oral thyroid hormone preparation (typically levothyroxine, a T4 preparation). The dosage should suffice enough to recover regular thyroid hormone levels without creating poisoning from receiving too much of thyroid hormone. TSH levels are monitored to help optimize the dose of T4. TSH is created by the pituitary gland in reaction to thyroid hormone degrees. So when thyroid hormonal agent degrees are reduced (as in hypothyroidism), TSH levels respond by enhancing, in an effort to "whip" a lot more thyroid hormone out of the thyroid gland. When hypothyroidism is adequately dealt with, TSH levels generally drop back down into the typical range. So, a mainstay in identifying the best dosage of T4 is measuring TSH degrees.

Keywords: *hypothyroidism, TSH, hypothyroidism diagnosis, hypothyroidism management***Corresponding author:**

Amnah Ahmed Alhuwayji,

Almubarkiah, Alhufof, Alahssa,

Kingdom of Saudi Arabia

E-mail: amyahmed335@gmail.com

Phone: 00966594909065

QR code



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INTRODUCTION:

Hypothyroidism affects between 4% and 10% of the population, and the prevalence of subclinical hypothyroidism is reported to be as high as 10% in different studies [1]. Hypothyroidism is identified when reduced degrees of the thyroid hormonal agents result in elevated degrees of thyroid-stimulating hormone (TSH), whereas subclinical hypothyroidism is diagnosed when TSH degrees rise over the upper limit of the assay reference range with regular thyroid hormonal agent degrees. Thyroid hormonal agents play an essential function in the normal function of heart and vascular physiology, and hypothyroidism produces extensive cardiovascular effects. Hypothyroidism exists in concerning 2- 5% of the populace and is consistently managed as a whole technique [1]. Uncorrected illness lugs substantial morbidity and is associated with a raised threat of lipid disorders, cardiovascular disease, osteoporosis, and cognitive dysfunction. A lot of instances result from chronic autoimmune thyroiditis, and are adhered to by destructive therapy of the thyroid gland with radioactive iodine or surgical treatment [2]. The frequency of spontaneous hypothyroidism increases with age and is 10 times extra typical in females than in men [1]. In primary hypothyroidism the earliest biochemical abnormality is a boost in serum thyrotropin (TSH) level with normal free T4 (FT4) and free T3 (FT3) concentrations (subclinical hypothyroidism) [2]. A proportion of individuals with subclinical hypothyroidism (about 2- 4% per annum) will proceed to obvious hypothyroidism (lowered FT4 connected with raised serum TSH) [1]. Patients with obvious ailment typically manifest signs and symptoms and generally benefit from thyroid hormonal agent therapy. [1]

Hypothyroidism is defined as failing of the thyroid gland to produce sufficient thyroid hormone to fulfill the metabolic demands of the body. In this review we discuss the proper diagnostic and management methods in primary care. Without treatment hypothyroidism can lead to high blood pressure, dyslipidemia, infertility, cognitive impairment, and neuromuscular disorder.

PATIENTS AND METHODS:

We conducted a narrative review over the literature using electronic databases as; MEDLINE, and EMBASE for studies involving data on treatment hypothyroidism in primary care by family doctors, published in English language up to 2018. Keywords were used in our search as following: “Hypothyroidism”, “family doctors, family physicians”, “management, treatment” We then reviewed the references lists of included studies to find more relevant articles to be for additional evidence.

DISCUSSION:

• Cellular and biochemical pathophysiology

Thyroxin (T4) and triiodothyronine (T3) are created from the thyroid gland. T4 is produced just from the thyroid, whereas T3 from the thyroid and from T4 deiodination in extra thyroidal tissues. T3 deficiency is responsible for the clinical and biochemical indications of hypothyroidism. Thus, basic intracellular functions such as oxygen usage by the mitochondria and calorigenesis are decreased. The decline in energy metabolism and heat processing is reflected in the reduced basal metabolic rate, reduced appetite, cold intolerance, and a little low basic body temperature. [3]

T4, which is the major item of the thyroid and flows in plasma, is transformed to T3, T4 remaining in lots of aspects thought about as a prohormone for the more effective T3. This is carried out in the cytoplasm and the nuclei of target tissue cells by three specific deiodinases with the reduction of a molecule of iodine from the peripheral ring of T4 [3]. Deiodinases have a diverse localization in tissues, diverse substrates and varied actions in various medications and disorders. It is believed that the result of T3 in target tissues is moderated genomically by T3 binding to one of the T3 receptor isoforms [4].

There is raising proof for non-genomic effects of T3 along with the transcriptional results moderated by the nuclear receptors [5].

• Etiology

The most widespread reasons that are in charge for the development of primary and secondary or central hypothyroidism are revealed in Table 1.

Table 1. Causes of primary and secondary (central) hypothyroidism [3-5].

Primary	Secondary
Chronic autoimmune thyroiditis	a.Pituitary
Iodine deficiency or excess	Pituitary adenomas
Thyroidectomy	History of pituitary surgery
Therapy with radioactive iodine	History of head trauma
External radiotherapy	History of pituitary surgery or radiotherapy
Drugs	b. hypothalamus
Thyroid agenesis or dysgenesis	Hypothalamus or suprasellar tumors
	History pf hypothalamic surgery or radiotherapy

- **Clinical Presentation**

Thyroid hormonal agent receptors regulate numerous essential physiologic processes. Consequently, hypothyroidism may result in a myriad of medical signs and symptoms. The intensity of these indications usually reflects the degree of thyroid dysfunction and the time course of development of hypothyroidism. Symptoms commonly connected with hypothyroidism are typically nonspecific (Table 2). These consist of weight gain, tiredness, inadequate focus, clinical depression, diffuse muscle mass ache, and menstrual irregularities. Symptoms with high uniqueness for hypothyroidism consist of irregular bowel movements, cool intolerance, completely dry skin, proximal muscular tissue weakness, and hair thinning or loss [6].

Table 2. Common Symptoms of Hypothyroidism [6].

Arthralgia
Cold intolerance
Constipation
Depression
Difficulty concentrating
Dry skin
Fatigue
Hair thinning/hair loss
Memory impairment
Menorrhagia
Myalgia
Weakness

Signs and symptoms of hypothyroidism might vary with age and sex. Babies and youngsters may offer regularly with sleepiness and failing to thrive. Females who have hypothyroidism might present with menstrual irregularities and the inability to conceive. In older patients, cognitive decrease may be the single manifestation. Examination discoveries connected with hypothyroidism include however are not restricted to goiter, delayed relaxation phase of deep tendon reflexes, slim or brittle hair, dry skin, and peripheral edema (Table 3). Common electrocardiography discoveries include bradycardia, flattened T waves, and low voltage. Patients with serious hypothyroidism might present with pericardial effusion, pleural effusion, mega colon, hemodynamic instability, and coma. The medical discussion is frequently confused with septic shock. Myxedema coma, which stands for serious physiologic decompensation arising from hypothyroidism, occurs rarely, with a yearly incidence of 0.22 per million [7]. Laboratory discoveries in hypothyroidism might consist of hyponatremia, hypercapnia, hypoxia, normocytic anemia, elevated creatine kinase, hyperprolactinemia, and hyperlipidemia [8].

Table 3. Clinical Signs of Hypothyroidism [7], [8].

Bradycardia
Coarse facies
Cognitive impairment
Delayed relaxation phase of deep tendon reflexes
Diastolic hypertension
Edema
Goiter
Hypothermia
Laboratory results
Elevated C-reactive protein
Hyperprolactinemia
Hyponatremia
Increased creatine kinase
Increased low-density lipoprotein cholesterol
Increased triglycerides
Normocytic anemia
Proteinuria
Lateral eyebrow thinning
Low-voltage electrocardiography
Macroglossia
Periorbital edema
Pleural and pericardial effusion

the context of the laboratory-specific normative array for every test. Diurnal variants exist in TSH secretion such that the lowest degree will usually be gotten with a morning laboratory draw [13]. Free T4 is generally determined by automated analog immunoassays. In many instances, this assay will yield accurate results. Nevertheless, irregular types or quantities of binding healthy proteins might exist in some patients and might disrupt the precise measurement of free T4 by analog immunoassays. These troubles can be gotten over by measuring free T4 using balance dialysis [14].

Family doctor will most commonly run into patients with primary hypothyroidism. Second hypothyroidism is present in just 5 percent of instances [15].

• Therapy

Hypothyroidism treatment is done with the administration of thyroxin, which is transformed by 80% in outer tissues to T3 [16].

The daily dosage of thyroxin in the initiation of substitution treatment depends upon numerous elements, such as body weight, age, the presence of coronary artery disease and cardiac arrhythmias. In grownups the dose has to do with 1.8 µg/ kg body weight, is higher in neonates and young children (3.8 µg/ kg) and lower in the senior (0.5 µg/ kg) [16]. The dose is higher in individuals having undergone thyroidectomy than those with chronic autoimmune thyroiditis, as in those there are remnants of functioning thyroid tissue. In subclinical

• Screening and Diagnosis

Family doctor ought to examine for thyroid dysfunction in all patients with signs and symptoms of hypothyroidism. The American Academy of Family Physicians does not advise screening for hypothyroidism in asymptomatic adults, and the U.S. Preventive Services Task Force located insufficient proof for routine screening in this population [9]. Testing of asymptomatic patients may be considered in those with risk elements for hypothyroidism, such as a background of autoimmune disorder, background of head or neck irradiation, previous radioactive iodine treatment, visibility of a goiter, family history of thyroid disease, or treatment with medicines understood to affect thyroid function. [10] The most effective lab evaluation of thyroid function, and the favored examination for diagnosing primary hypothyroidism, is a serum TSH examination [11]. If the serum TSH level is elevated, screening ought to be repeated with a serum free thyroxin (T4) measurement [12]. Obvious primary hypothyroidism is suggested with a raised serum TSH degree and a low serum free T4 degree. An elevated serum TSH level with a typical array serum free T4 level is consistent with subclinical hypothyroidism. A low serum free T4 level with a reduced, or wrongly typical, serum TSH level follows second hypothyroidism and will normally be connected with further evidence of hypothalamic-pituitary insufficiency.

It is necessary to analyze these measurements within

normal dosages. During the very first day of therapy hydrocortisone 100 mg every 8 hours is likewise administered and hypothermia, hypoglycemia, hypotension, hyponatremia and hypercalcemia are properly dealt with [18].

Great care is needed in replacement therapy with thyroxin as dosage overestimation has repercussions. It has actually been observed that more than one fifth of the patients have medical or subclinical hyperthyroidism. These effects are atrial fibrillation, aggravation of coronary artery ailment and a decrease in bone mineral thickness, fractures of the spinal column and the hip being observed in women > 65 years.

Hypothyroidism is not always properly dealt with by the administration of thyroxin, as there are distinctions in the activity, stability and bioavailability in between different batches of thyroxin which might also be supplied by the very same manufacturer. Koutrascommenting on the previously mentioned problems suggests the following: a) authorities ought to demand bioavailability studies of thyroxin preparations, b) medical professionals must instruct their patients to take thyroxin while fasting for a minimum of 4 hours, and avoid food for at least 20-30 minutes, in addition to stay clear of other medications for at least 30 min after the thyroxin tablet and know food products or fruit juices that may interfere with thyroxin absorption, c) medical professionals should not frivolously change from one thyroxin brand to one more on the assumption that 100 µg thyroxin from brand name A amounts to 100 µg from brand B d) physicians need to report to the authorities if they have questionable lead to several patients [20].

Hypothyroidism is not always permanent and a percentage of patients exists in whom thyroid function might be regular after thyroxin discontinuation. The normalization of thyroid function may be a lot more related to the antibodies to TSH receptor than to anti-TPO or anti-Tg antibodies, the titles of which extremely little might be affected by thyroxin administration. The portion of hypothyroidism normalization after thyroxin management is between 0-24percent, indicate 10%.

• Complications

Myxedema coma is a presentation of serious hypothyroidism and is an endocrine emergency. Early recognition and timely treatment in the intensive care unit (ICU) is vital, and even then, mortality reaches 25% to 60% [21].

Myxedema situation should be believed in patients that have encephalopathy, hypothermia, seizures,

hypothyroidism the dose is low (0.5 µg/ kg). In maternity, finally, a bigger dose is needed (2 µg/ kg). During pregnancy the increase in dosage that might be required is 25-47% more than the one before pregnancy and it is observed throughout the 4th to 6th week [16].

In young and healthy grownups therapy may be started with the total dosage and not always with tiny doses. However, in the senior or patients with coronary artery illnesses 25-50 µg are administered every day and the dose is enhanced by 12.5 or 25 g every 2 weeks. TSH measurement after the initiation of treatment is executed every 4-6 weeks up until TSH comes to be typical. The follow-up is performed by TSH measurement as soon as annually. In maternity the very first TSH measurement need to be carried out when maternity is detected and thereafter every 3-4 weeks during the initial one-half of the maternity and every 6 weeks afterwards. TSH in primary hypothyroidism on alternative treatment should remain in the mean levels to reduced regular limitations (roughly 1.0 mU/l), whereas in second TSH dimension does not assist. FT4 and occasionally FT3 measurement is performed and the values ought to be in the top one-half of the normal variety.

In congenital hypothyroidism according to Rose et al the measurement and treatment need to be executed throughout the first 2 weeks of life for the avoidance of the repercussions of hypothyroidism [17]. This measurement has been instituted in different places of the world, and in Greece, however not all over. In neonates the preliminary dose is 10-15 µg/ kg. After that regular TSH measurement is required, which should be regular and T4 or FT4, which should remain in the top one-half of normal values during the first 3 years of life.

In subclinical hypothyroidism there is no agreement regarding whether thyroxin should be carried out. In guidelines from numerous organizations and universities of physicians as to whether therapy is required or not for subclinical hypothyroidism, all agree, aside from the American College of Physicians, which does not hold a definitive position, that thyroxin ought to be carried out if antibodies declare [19], [18].

In myxedema coma, which is one of the most serious type of hypothyroidism and happens in long-lasting not treated hypothyroidism the threat of death was 60-70% in 1985 however it has actually reduced to 20-25%, owing to the timely medical diagnosis and the recommendation of patients to acute care units. Intravenous thyroxin is administered at a dose of 200-400 g throughout the initial 2 days and afterwards at

therapy of co-existing acute illness, and hypothermia [21].

Thyroid replacement treatment is with intravenous hydrocortisone at stress and anxiety doses complied with by intravenous levothyroxine then changed to oral levothyroxine after scientific enhancement. If effective, this should cause cardiopulmonary and cognitive renovation [22]. There ought to likewise be an associated enhancement in laboratory derangements including a down trending of TSH which needs to be measured every 1 to 2 days during the first therapy period. Intravenous liothyronine (T3) can be considered until first renovation [22].

Endocrinology reference is advised for all patients with believed myxedema coma and other signs listed in Table 4 [23].

severe hyponatremia, hypoglycemia, cardiogenic shock and arrhythmias, breathing failing, and symptoms of fluid retention [21]. A mix of couple of or all of these symptoms and various other signs of moderate to extreme hypothyroidism as stated above can be present.

Factors resulting in increased danger of myxedema dilemma consist of poor doses of thyroid hormonal agent, interruption in treatment, undiagnosed hypothyroidism, or existence of acute illness such as sepsis possibly as a result of increased metabolic needs [21].

Encouraging therapy ought to be offered in the intensive care unit with liquid and electrolyte management, ventilator assistance, vasopressors,

Table 4. Reasons for Endocrinology Consultation in Patients with Hypothyroidism^[23].

Age younger than 18 years
Cardiac disease
Coexisting endocrine diseases
Myxedema coma suspected
Pregnancy
Presence of goiter, nodule, or other structural thyroid gland abnormality
Unresponsive to therapy

CONCLUSION:

Hypothyroidism is a clinical disorder frequently encountered by the primary care doctor. Untreated hypothyroidism can lead to hypertension, dyslipidemia, inability to conceive, cognitive disability, and neuromuscular dysfunction.

Hypothyroidism is a constant ailment, impacting more females than males. The negative effects of hypothyroidism, which are regular, dictate its prompt medical diagnosis. The measurement of thyroid hormonal agents in females after the age of 50, in maternity and after delivery, in women and males with hypercholesterolemia, in patients having had neck radiotherapy, in patients having actually been offered drugs, such as amiodarone and lithium, shows up suitable. Therapy is long term, typically life lengthy and is performed by the management of

thyroxin.

The TSH examination is the primary test made use of for the medical diagnosis and management of hypothyroidism. But various labs usually have slightly various worths wherefore is called the "TSH recommendation variety." At several labs, the TSH reference variety runs from 0.5 to 4.5. A TSH value of less than 0.5 is considered hyperthyroid, while a TSH value of more than 4.5 is considered possibly hypothyroid.

Hypothyroidism is dealt with by recommending an oral thyroid hormone prep work (typically levothyroxine, a T4 preparation). The dosage should suffice enough to recover regular thyroid hormone levels without creating poisoning from way too much thyroid hormone. TSH levels are monitored to help

optimize the dose of T4. TSH is created by the pituitary gland in reaction to thyroid hormone degrees. So when thyroid hormonal agent degrees are reduced (as in hypothyroidism), TSH levels respond by enhancing, in an effort to "whip" a lot more thyroid hormone out of the thyroid gland. When hypothyroidism is adequately dealt with, TSH levels generally drop back down into the typical range. So, a mainstay in identifying the best dosage of T4 is measuring TSH degrees.

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