

PRIMARY HYPOTHYROIDISM – DIAGNOSIS AT THE JOINT OF TWO SPECIALITIES

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ABSTRACT

Hypothyroidism is a condition with an estimated prevalence in the general population of 0.3% - 3.7% in the USA and 0.2%-5.3% in Europe, depending on the definition used (1). Approximately 12% of the adult population has subclinical hypothyroidism (2, 3). The diagnosis and treatment of (subclinical) hypothyroidism has traditionally been considered rather straightforward. On closer examination, however, many unresolved issues remain and patient satisfaction in terms of symptom relief is often suboptimal (4). Several factors may contribute to this situation.

Keywords: hypothyroidism, autoimmune thyroiditis, pathology, ultrasound.

INTRODUCTION

Hypothyroidism is a condition with an estimated prevalence in the general population of 0.3% - 3.7% in the USA and 0.2%-5.3% in Europe, depending on the definition used (1). Approximately 12% of the adult population has subclinical hypothyroidism (2, 3). The diagnosis and treatment of (subclinical) hypothyroidism has traditionally been considered rather straightforward. On closer examination, however, many unresolved issues remain and patient satisfaction in terms of symptom relief is often suboptimal (4). Several factors may contribute to this situation. First, common symptoms of overt hypothyroidism including weight gain and fatigue are non-specific and may result from factors other than a shortage of thyroid hormone. In this situation, thyroid hormone replacement can be expected to be less effective in terms of restoring well-being than anticipated. Second, persons with subclinical hypothyroidism experience thyroid disease-related symptoms as often as euthyroid subjects as shown

in a recent study. This may explain why symptomatic relief following levothyroxine (L-T4) substitution in this patient group is often disappointing (5). Third, over the past decades it has become clear that the impact of thyroid disease on quality of life is an important disease aspect that is best investigated by patient-reported outcomes (PROs) such as the thyroid-related quality of life patient-reported outcome measure (ThyPRO) (6), whereas 'classic' symptoms of hypothyroidism may be less reliable to assess thyroid hormone status. The impact of primary hypothyroidism on quality of life has recently been reviewed by Hegedüs et al. (7).

Target: consider a clinical case of hypothyroidism (HT), which has a "erased" course; evaluate the management tactics for a particular patient.

MATERIALS AND METHODS

medical documentation, supervision results. The information was analyzed, summarized, and conclusions were formulated.

RESULTS

patient G., 53 years old, in November 2023. was admitted to the local clinic in Samarkand with complaints of weakness, muscle pain, drowsiness, constant numbness and impaired sensitivity of the fingers and toes, constipation, dry skin, and memory loss. From the medical history: he considers himself sick for the last 2 years, when the above-described complaints first appeared. Over the past 2 years, weight gain has been 10 kg. I first filed these complaints on September 22, 2023. To a neurologist, a diagnosis was made: "Sensory-motor polyneuropathy of unknown origin," and the use of pathogenetic drugs was recommended. The ongoing therapy has no effect. In connection with this, he was consulted by an endocrinologist. During the examination: TSH = 98.22 μ IU/l, free T4 = 1.4 nmol/l, a/t to TPO = 1117 units. Ultrasound of the thyroid gland: signs of chronic thyroiditis. Taking these data into account, a diagnosis was made: "Autoimmune thyroiditis (AIT). Primary manifest GT." L-thyroxine (150 mcg), treatment of concomitant pathology, and a balanced diet were prescribed. Positive dynamics were noted, but TSH was higher than normal (34.2 μ IU/l). The dose of L-thyroxine was increased to 250 mcg. However, neurological symptoms persisted; was examined and therapy was adjusted. From the beginning of 2023 his condition worsened: memory loss, drowsiness, chilliness, muscle pain, numbness in his fingertips. In this connection, 02/08/2023 was hospitalized in the city hospital of Samarkand. From a history of non-life: Concomitant diseases - arterial hypertension (2006), morbid obesity (resection of 2/3 of the stomach in 2006), cholecystectomy, appendectomy (2007), chronic B12-deficiency anemia, chronic iron deficiency anemia (2016) Infectious diseases There were no injuries or blood transfusions. Allergy and hereditary history are not burdened. Denies bad habits and occupational hazards. Objectively: General condition avg. Art. gravity. Hypersthenic physique; weight=117

kg, height=180 cm. body=36.7°C. The skin is pale, dry, no swelling. Muscle tone in the legs is reduced. Muscle strength in the arms = 5b, in the legs = 3b. Decreased sensitivity in the limbs. The thyroid gland is not visually enlarged, has a dense elastic consistency, and is mobile. In the lungs, breathing is vesicular, there are no wheezes, respiratory rate = 22 per minute. Heart sounds are muffled, the rhythm is correct, there are no noises, heart rate = 65 beats. per minute, blood pressure = 120/80 mmHg. The abdomen is soft and painless. The liver is not enlarged. Stool with a tendency to constipation, urination without any peculiarities.

On examination: CBC: hypochromic anemia. Immunochemistry: TSH, free T4, free T3 – normal, vit. B12 – reduced. ECG: sinus bradycardia 60 beats. per minute
Diagnosis: “AIT. Primary manifest HT, drug subcompensation. Constitutional-exogenous obesity, stage II. (BMI = 36.1 kg/m2).” In treatment: L-thyroxine (250 mcg); therapy aimed at treating concomitant pathologies. Dynamics: improvement in well-being and clinical and laboratory parameters.

CONCLUSIONS

PIT was found that the course of HT can be “erased.” Carrying out specific therapy not only compensates for HT, but also serves as a preventive measure against organ disorders.

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