M2 - Endocrine, Winter 2008

Lash, R.; Hammer, G.; Menon, R.; Oral, E.

<http://hdl.handle.net/2027.42/64949>
http://hdl.handle.net/2027.42/64949
Unless otherwise noted, the content of this course material is licensed under a Creative Commons Attribution - Non-Commercial - Share Alike 3.0 License.

Copyright 2006, Arno Kumagai, Ron Koenig, Robert Lash.

The following information is intended to inform and educate and is not a tool for self-diagnosis or a replacement for medical evaluation, advice, diagnosis or treatment by a healthcare professional. You should speak to your physician or make an appointment to be seen if you have questions or concerns about this information or your medical condition. You assume all responsibility for use and potential liability associated with any use of the material.

Material contains copyrighted content, used in accordance with U.S. law. Copyright holders of content included in this material should contact open.michigan@umich.edu with any questions, corrections, or clarifications regarding the use of content. The Regents of the University of Michigan do not license the use of third party content posted to this site unless such a license is specifically granted in connection with particular content objects. Users of content are responsible for their compliance with applicable law.
Lecture 1: Regulation of Thyroid Follicular Cell Function

Goals/Objectives

- Understand the structure and metabolism of thyroid hormone
- Understand the structure and function of the thyroid follicle
- Understand homeostatic control of plasma thyroid hormone levels
Thyroxine (T4)  
(3,5,3’,5’ tetraiodo-L-thyronine)

- Derived entirely from the thyroid gland
- Is a pro-hormone
T3 (3,5,3’ triiodo-L-thyronine)

- Is the biologically active thyroid hormone
- 20% of plasma T3 comes from thyiodal secretion
- 80% comes from T4 5’-deiodination in peripheral organs

Source: Undetermined
Three Iodothyronine Deiodinases

- Types 1 and 2 deiodinases convert T4 to T3
  - D1 primarily in liver and kidney, supplies plasma T3
  - D2 in pituitary, brain, placenta, brown fat, muscle and thyroid; produces T3 for “local” use as well as plasma T3
- Type 3 deiodinase (D3) removes an inner ring iodine
  - Converts T4 to reverse T3, and T3 to T2
  - D3 inactivates thyroid hormone
Thyroid Follicle: Functional unit of the thyroid gland

Normal thyroid gland illustrating the histologic structure, including colloid-filled (C) follicles of varying size lined by cuboidal follicular cells
Thyroid hormone synthesis (1)

- Plasma iodide enters the thyroid cell through the sodium iodide symporter (NIS).
- Thyroglobulin (Tg), a large glycoprotein, is synthesized within the thyroid cell.
- Thyroid peroxidase (TPO) sits on the lumenal membrane. It iodinates specific tyrosines in Tg, creating mono- and di-iodotyrosines.
- The iodotyrosines combine to form T3 and T4 within the Tg protein.
Thyroid hormone synthesis (2)

- Each mature Tg molecule contains ~3 T4’s, but only 1 in 4 Tg’s contains a T3 molecule.
- Colloid is largely composed of Tg, and is basically a storage depot of thyroid hormone.
Thyroid hormone synthesis (3)

- In response to TSH, pseudopodia form and endocytose colloid.
- In the cell, colloid droplets fuse with lysosomes and thyroid hormone is cleaved enzymatically from Tg.
- T4 and T3 are released into the circulation.
- TSH stimulates iodide trapping, as well as thyroid hormone synthesis and secretion.
Sodium Iodide Symporter (NIS)

- Co-transporters iodide and sodium
- 65 kDa protein with 13 putative trans-membrane domains
- Structurally similar to other Na+ cotransporters, e.g. Na+/glucose transporter
- Allows for use of radioiodine as a specific and effective agent in the diagnosis and therapy of multiple thyroid disorders
Endemic Goiter
Dietary Iodide: Thyroid function and endemic goiter

- Intake of >200 μg/d is ideal. Less than 50 μg/d impairs thyroid gland function and T4 secretion, resulting in elevation of TSH and goiter (thyroid enlargement).
- “Endemic Goiter” implies ≥10% of the population is affected.
Dietary Iodide: Thyroid function and endemic goiter

- Iodine deficiency is virtually non-existent in the US. However, worldwide it is the leading cause of goiter and hypothyroidism.
Endemic Cretinism

On the left, a euthyroid 6 year old Ubangi girl at the 50th height %ile (105 cm). On the right, a 17 year old girl with a height of 100 cm, mental retardation, myxedema and a TSH of 288 (normal 0.3-5.5).

Werner & Ingbar’s The Thyroid, 8th Edition, page 744.
Endemic Cretinism

- Children born to women with endemic goiter
- Mental retardation, abnormalities of hearing, gait and posture, short stature
- Consequence of fetal/neonatal hypothyroidism, possibly with maternal hypothyroidism contributing
- Despite being readily preventable by iodized salt, mental retardation due to iodine deficiency is still common worldwide
Feedback regulation of thyroid function

Hypothalamus

TRH

Pituitary gland

TSH

Thyroid gland

T4 → T3

T4 + T3

CC:BY 3.0
BY: Regents of the University of Michigan
Thyrotropin (TSH; Thyroid Stimulating Hormone)

- 28 kDa glycoprotein dimer composed of non-covalently linked alpha and beta chains.
- The alpha chain is shared by TSH, FSH, LH and CG.
- The biological specificity of each glycoprotein hormone is conferred by the beta chain.
TSH: Mechanism of Action

- Binds to specific receptors on thyroid follicular cells.
- TSH receptors are members of the large family of G-protein coupled receptors.
- The major second messenger is cAMP, although activation of phospholipase C also may be involved.
Thyrotropin Releasing Hormone (TRH)

- A tripeptide: pyroGlutamate-histidine-proline-amide
- Synthesized from a 29 kDa precursor protein that contains 5 copies of TRH flanked by basic amino acids.
- A specific protease cleaves the precursor to yield TRH. The intervening peptides also may have hormonal function.
~99.97% of plasma T4 and 99.7% of T3 are non-covalently bound to proteins.

Thyroxine Binding Globulin (TBG) is the major binding protein for T4 and T3. TBG’s affinity for T4 is ~10-fold greater than for T3.

Do not confuse TBG with thyroglobulin, the precursor protein from which T4 and T3 derive.
Plasma thyroid hormone binding proteins

- Transthyretin also carries some T4. Albumin carries small amounts of T4 and T3.
- TBG, transthyretin and albumin are made in the liver.
Importance of free versus protein-bound hormone

- Only free T4 and free T3 are biologically active and regulated by feedback loops.
- Therefore conditions that alter TBG levels alter total T4 and T3, but do not alter free T4 and free T3.
  - Pregnancy (elevated estrogen)
  - Acute hepatitis
  - Chronic liver failure
Lecture 2: Actions and Pharmacology of Thyroid Hormones

Goals/Objectives

- Understand the molecular basis of thyroid hormone action and its relevance to clinical medicine
- Understand the appropriate use of laboratory tests to evaluate thyroid function
Molecular basis of thyroid hormone action

- Thyroid hormone binds to nuclear receptor proteins.
- T3 binds with 10-fold greater affinity than T4.
- T3 receptors bind to specific DNA sequences (hormone response elements) generally located in the 5’ flanking regions of target genes.
Nuclear Receptor Superfamily

Source: Undetermined
Molecular basis of thyroid hormone action

- T3 receptors are related to receptors for steroids, retinoids and vitamin D.
- T3 receptors bind DNA as heterodimers with retinoid X receptors.
  - RXRs are nuclear receptors that dimerize with numerous members of this superfamily (RARs, VDR, PPARs and others), but not with steroid receptors.
Molecular basis of thyroid hormone action

- T3-occupied T3 receptors activate many genes and repress others (e.g. TRH, TSH).
- Unliganded T3 receptors are not “neutral” - they repress genes that are activated by T3, and activate genes that are repressed by T3.
- This may explain why hypothyroidism causes greater abnormalities than does the absence of T3 receptors (in mice).
How does T3 induce transcription?

- Unliganded TRs bind to a co-repressor complex which deacetylates histones, tightening chromatin structure and thereby impeding transcription.

- T3 binding causes a conformational change in the TR. Co-repressors fall off and co-activators now bind. These include histone acetyltransferases, which loosen chromatin to allow access to critical transcription factors.
Mechanisms of gene regulation are similar for all nuclear receptors

- Co-activators are recruited by estradiol-occupied estrogen receptors, etc.
- Although unliganded steroid receptors do not bind co-repressors, receptor antagonists alter the receptor structure to recruit co-repressors (tamoxifen-bound estrogen receptor; RU486-bound progesterone receptor, etc.).
- Aberrant histone deacetylation underlies some cancers, and histone deacetylase inhibitors show promise as therapies.
Inotropic Action of T3

- Cardiac myosin is a hexamer that contains either $\alpha$ or $\beta$ heavy chains.
- The velocity of cardiac contraction correlates with myosin ATPase activity, which is greater for MHC $\alpha$ than $\beta$.
- T3 induces transcription of MHC $\alpha$ and represses MHC $\beta$, thereby increasing ATPase activity and inotropy.
T3 Regulates MHC Transcription in Rats

Source: Gustafson, et al.

Inotropic Action of T3 (2)

- Sarcoplasmic reticulum ATPase removes Ca^{++} from the cytosol during diastole, leading to myocardial relaxation.
- T3 induces transcription of this Ca ATPase, thus increasing the speed of relaxation.
Atrial RNA from control (C) or hypothyroid (Tx) mice was assayed for HCN2 and HCN4 expression. Heart rates were 472±26 (C) and 335±21 (Tx) beats/min.

T3 Receptor β-specific ligands have potential as cholesterol lowering agents

- GC-1 treatment of cholesterol-fed rats
- GC-1 vs atorvastatin (Lipitor) treatment of monkeys

Heart rate

% CHANGE FROM VEHICLE

Cholesterol

nmol/kg/day

Source: Grover, et al.

Source: Baxter, et al.


JD Baxter, et al. TEM 15:154, 2004
A mother wheeled her daughter in a stroller into clinic...
...and lifted the child onto the examining table

What is this girl’s age?
T3 and Growth Hormone

- Humans and rodents with hypothyroidism have low growth hormone levels and do not grow as rapidly as normal.
- The rat growth hormone gene contains a T3 response element. How T3 regulates human growth hormone is uncertain.
Laboratory Evaluation of Thyroid Function
Serum Thyroxine (T4)

- Measure free T4, not total T4
  - Only free T4 is biologically active
  - Conditions that alter TBG alter total T4 but not free T4
    - Pregnancy raises total T4
    - Chronic liver failure lowers total T4
- High in hyperthyroidism
- Low in hypothyroidism
Serum Triiodothyronine (T3)

- High in hyperthyroidism
- Low in hypothyroidism
  - But generally not worth measuring in hypothyroidism because T3 is less sensitive and less specific than the decrease in free T4
- Not as influenced by changes in TBG as is T4, but measurement of free T3 is still preferable to total T3
Serum Thyrotropin (Thyroid Stimulating Hormone; TSH)

- Low in hyperthyroidism
  - Hyperthyroidism secondary to excess TSH secretion is too rare to be worth considering
- High in primary hypothyroidism; inappropriately “normal” or low in secondary and tertiary hypothyroidism
- Most sensitive screening test for hyperthyroidism and primary hypothyroidism
  - TSH within the normal range excludes these diagnoses
Antithyroid Antibodies

- Antimicrosomal antibodies - the antigen is TPO
- Antithyroglobulin antibodies
- Present in ~95% of Hashimoto’s and ~60% of Graves’ patients at the time of diagnosis
- Usually not very helpful in making a diagnosis or guiding therapy
Radioiodine Uptake

- Used to evaluate the cause of hyperthyroidism
  - High if the thyroid is hyperfunctioning e.g. Graves’ disease
  - Low if thyroid hormone is leaking out of damaged thyroid cells (subacute thyroiditis) or the patient is taking excess exogenous thyroid hormone
- Used to calculate the dose of I-131 to treat hyperfunctioning thyroid tissue or cancer
Thyroid Scan (nuclear medicine)

- Primary use is to determine whether palpated nodules are functional or non-functional.
  - “Hot” nodules concentrate the radionuclide and are essentially always benign.
  - “Cold” nodules are usually benign but are sometimes malignant.
- The majority, perhaps 90%, of palpable nodules are cold.
Lecture 3: Hyperthyroidism and the Non-thyroidal Illness Syndrome (Sick Euthyroid Syndrome)

Goals/Objectives

- Understand the etiology, epidemiology, clinical features and therapy of the various forms of hyperthyroidism
- Understand the basis for and characteristics of the non-thyroidal illness syndrome
Graves’ Disease: Epidemiology

- Most common cause of hyperthyroidism
- Female/Male ~10/1
- Peak onset 3rd-4th decade, but can occur at any age
- ~1-2% of women in the United States
Graves’ Disease: An Autoimmune Disease

- Thyroid Stimulating Immunoglobulins (TSIs) bind to the TSH receptor and mimic the action of TSH.
- Underlying defect probably lies with T lymphocytes, perhaps CD8 cells.
- Increased risk of other autoimmune diseases.
Graves’ Disease: Genetic Factors

- MHC class II antigen HLA-DR3 increases risk ~3 fold
- ~50% concordance in monozygotic twins, ~5% concordance in dizygotic twins
# Hyperthyroidism: General Symptoms

**Younger Patients**
- Nervousness
- Diaphoresis
- Heat intolerance
- Palpitations; tachycardia
- Insomnia
- Weight loss
- Hyperdefecation

**Older Patients**
- Angina
- Atrial fibrillation
- Weakness
- Cachexia
Hyperthyroidism: General Signs

- Goiter (symmetric in Graves’ disease)
- Tremor
- Diaphoresis
- Tachycardia
- Rapid DTR relaxation
- Lid lag
- Systolic hypertension
- Atrial fibrillation
Graves’ Disease

Ophthalmopathy

Dermopathy

Image of patient removed

Image of patient removed
Signs and symptoms specific for Graves’ hyperthyroidism

- Graves’ ophthalmopathy
- Graves’ dermopathy (pretibial myxedema)
- Thyroid thrills or bruits
  - Increased thyroid blood flow causes turbulence
Graves’ Ophthalmopathy

- Clinically evident in <50% of patients
- Exophthalmos
- Periorbital edema
- Extraocular muscle weakness
- Corneal ulceration
- Optic nerve damage (compression)
Graves’ Ophthalmopathy: Symptoms

- Gritty, dry eyes
- Periorbital puffiness
- Diplopia
- Decreased vision
Graves’ Ophthalmopathy: Pathogenesis

- Presumed autoimmune, likely due to shared antigens on thyroid and retroorbital tissue (possibly the TSH receptor).
- Extraocular muscles enlarge with edema, glycosaminoglycan deposition, mononuclear cell infiltrate, and fibrosis.
Graves’ Ophthalmopathy

- Course independent of hyperthyroidism
- Generally not influenced by treatment of hyperthyroidism
- Therapy includes artificial tears, taping lids closed at night, glucocorticoids, orbital XRT, and decompression surgery
Graves’ Dermopathy (Pretibial Myxedema)

- Violaceous induration of pretibial skin
- Glycosaminoglycan deposition
- Rare, generally accompanied by eye disease
- Usually asymptomatic
- Therapy typically topical glucocorticoids
Graves’ Disease: Onycholysis

(separation of the distal margin of the nail plate from the nail bed)

Most commonly begins on the 4th digit of the hands (honest!)
Graves’ Disease: Laboratory Evaluation

- TSH low (always measure this)
- Free T4, free T3 elevated (measure one or both if TSH is low)
- Radioiodine uptake increased (excludes subacute thyroiditis and allows Rx with radioiodine)
- Thyroid stimulating antibodies present (could measure instead of RAIU)
- Antithyroid (anti-TPO and Tg) antibodies often present (generally don’t measure)
Graves’ Disease: Medical Therapy

- Antithyroid drugs (thionamides)
  - Methimazole, Propylthiouracil (PTU)
- Beta adrenergic blockers
- Iodide
Antithyroid Drugs (thionamides)

- Propylthiouracil
- Thiourea
- Methimazole

Source: Undetermined
Antithyroid Drugs: 
Mechanism of Action

- Inhibit organification of iodine by TPO
- PTU (high dose) inhibits type 1 deiodinase
  - PTU is preferred in severe hyperthyroidism
  - In typical hyperthyroidism PTU and methimazole are equally good
- Do not influence the long term course of Graves’ disease.
  - ~30% of Graves’ patients undergo spontaneous remission within ~1 year of diagnosis. Patients treated with antithyroid drugs are hoping to be in the lucky 30%.
Antithyroid Drugs: Toxicity

- **Common (1-5%)**
  - Rash, urticaria, fever, arthralgias

- **Rare**
  - Agranulocytosis
  - Liver damage, vasculitis, lupus-like syndrome
Medical therapy of Graves’ disease: Beta adrenergic blockers

- Improve sympathetic overdrive type symptoms
- Propranolol at high doses modestly inhibits T4 to T3 conversion (other β blockers don’t)
- Do not lower serum T4 levels
- Usual contraindications apply
Medical therapy of Graves’ disease: Iodide

- Rarely indicated
- Rapidly lowers serum T4 and T3 by blocking thyroidal secretion
- Can cause hyperthyroidism
  - Iodine can both cause and cure both hyperthyroidism and hypothyroidism!
- Blocks radioiodine uptake
Graves’ Disease: Definitive Therapy

- **Radioiodine (I-131)**
  - Advantages: safe, outpatient, painless
  - Disadvantages: slow, hypothyroidism, radiation

- **Surgery**
  - Advantages: rapid (but must pre-treat with antithyroid drugs or β-blockers), may not cause hypothyroidism
  - Disadvantages: inpatient surgery, general anesthesia, complications (hypoparathyroidism, recurrent laryngeal nerve palsy)
Autonomously Functioning Adenoma (Hot Nodule)

Palpable nodule in left lobe of thyroid is “hot” by radionuclide scan

Image of nodule removed
Autonomously Functioning Adenoma (Hot Nodule)

- Less common cause of hyperthyroidism than Graves’ disease
- In most patients, the nodule produces too little thyroid hormone to cause hyperthyroidism
- Generally must be >2.5 cm to cause clinical hyperthyroidism (‘toxic adenoma’)
- Constitutively activating mutations of the TSH receptor are causative in many cases
TSH Receptor: Loss or gain of function mutations

Extracellular domain → Image of THS Receptor removed

Cell membrane → Dark circles indicate activating mutations; Light circles indicate inactivating mutations.

Intracellular domain →

Hyperthyroidism due to Toxic Adenomas (hot nodules)

- Labs are similar to Graves’ disease except TSI and anti-thyroid Abs are negative.
- Spontaneous remissions are very rare.
- Thionamides will lower T4 and T3, but will not lead to cure.
- Therefore, preferred therapy is surgery or radioiodine.
  - The patient can be followed without therapy if she/he is euthyroid (normal TSH).
Multinodular Goiter (1)

- Thyroid has multiple nodules, some of which may be too small to palpate.
- Some of the nodules function autonomously.
- “Toxic” multinodular goiter signifies that the level of autonomous function is sufficient to cause hyperthyroidism.
Multinodular Goiter (2)

- Usually occurs in an older age group than Graves’ disease.
- Generally the cause is not known, although some nodules have activating mutations of the TSH receptor.
- Treat with radioiodine or surgery, as spontaneous remissions do not occur.
Thyrotoxicosis by a totally different mechanism

- A 30 y.o. woman had a respiratory illness a week ago, and now c/o rapid heart beat, sweating and neck pain, especially noting tenderness to touch.
- This is typical of subacute thyroiditis.
- Leakage of thyroid hormone from damaged thyroid cells, rather than increased synthesis, is the cause of thyroid hormone excess.
  - Therefore, the radioiodine uptake is low.
- Resolves spontaneously after 2-3 months.
- Thyrotoxic phase may be followed by a hypothyroid phase, also lasting 2-3 months.
Subacute thyroiditis

- The thyrotoxic and/or hypothyroid phases may be asymptomatic.
- If needed, use beta blockers to treat the thyrotoxic phase.
- If needed, use levothyroxine to treat the hypothyroid phase.
- If needed, use NSAIDs for neck pain.
- This disease also is called subacute painful thyroiditis, De Quervain’s thyroiditis, subacute granulomatous thyroiditis, and giant cell thyroiditis.
Painless Subacute thyroiditis

- Silent, or painless, subacute thyroiditis is similar in clinical course to painful subacute thyroiditis, except there is no neck pain.
- Autoimmune etiology with lymphocytes infiltrating the thyroid.
- Since a small, symmetric goiter is common, painless subacute thyroiditis must be distinguished from Graves’ disease by laboratory testing.
Non-thyroidal Illness Syndrome

- Also called the sick euthyroid syndrome.
- Definition: decreased serum T3 (total and free) caused by non-thyroidal illness rather than thyroid dysfunction.
- TSH usually is normal but can be low in severe cases.
- T4 and free T4 usually are normal but can be low in very severe cases.
Non-thyroidal Illness Syndrome

- Occurs with virtually any acute or chronic illness, e.g. infections, myocardial infarction, chronic renal failure, surgery, trauma.
- Inhibition of 5’ deiodinase causes the low serum T3.
- TSH secretion is “inappropriately” normal.
- Underlying mechanisms are poorly understood.
Non-thyroidal Illness Syndrome

- Prognosis: Full recovery when the non-thyroidal illness resolves.
- Therapy: It is currently felt that patients do not benefit from attempts to normalize serum T3 levels.
- It is important to know of this syndrome so as not to confuse it with secondary hypothyroidism.
Lecture 4: Hypothyroidism, thyroid nodules and thyroid cancer

Goals/Objectives

- Understand the etiology, epidemiology, clinical features and therapy of Hashimoto’s thyroiditis
- Understand the etiology, epidemiology, differential diagnosis, evaluation and therapy of thyroid nodules and cancer
Hashimoto’s Thyroiditis: Epidemiology

- Most common cause of hypothyroidism in the United States.
- Female/male ~10/1.
- ~5% of females, increasing with age.
Hashimoto’s Thyroiditis: An Autoimmune Disease

- Anti-TPO (microsomal) and anti-Tg Abs
- Intrathyroidal CD8 (cytotoxic) T cells
- Increased incidence of HLA-DR5
- Increased risk of other autoimmune diseases
  - Type 1 diabetes mellitus
  - Addison’s disease (adrenal insufficiency)
  - Pernicious anemia
  - Etc.
Hypothyroidism: Symptoms

- Fatigue
- Lethargy
- Weakness
- Cold intolerance
- Mental slowness
- Depression
- Dry skin
- Constipation
- Muscle cramps
- Irregular menses
- Infertility
- Mild weight gain
- Fluid retention
- Hoarseness
Hypothyroidism: Signs

- Goiter (primary hypothyroidism only)
- Bradycardia
- Nonpitting edema
- Dry skin
- Delayed DTR relaxation
- Hypertension
- Slow speech
- Slow movements
- Hoarseness
Hashimoto’s Thyroiditis: Goiter

- Usually but not always present
- Generally firm, non-tender
- May be irregular or asymmetric
Hypothyroidism: Laboratory Evaluation

- Increased TSH is the most sensitive test
  - Primary hypothyroidism only
  - Always measure unless you know the patient has defective TSH secretion
- Decreased free T4
  - probably should measure at diagnosis if TSH high
- Decreased FT3
  - Less sensitive and less specific than decreased FT4 (don’t measure)
- Anti-TPO and anti-Tg Abs (Hashimoto’s)
Hypothyroidism: Therapy

- L-Thyroxine (levothyroxine; T4)

Goals

- Alleviate symptoms
- Normalize TSH (primary hypothyroidism) or free T4 (secondary and tertiary hypothyroidism)
Relationship between hypothyroidism and freedom of speech

- http://www.greenwillowtree.com/the-380/superb-thyroid-support%2C-low/Detail.bok
- http://www.alvidar.com/
- http://www.naturallydirect.net/thyroid-supplement.htm
- http://www.usmedicalresearch.org/he_thy/
Thyroid Nodules

- ~5% of adults have thyroid nodules, with a 5:1 female:male ratio
- ~95% of thyroid nodules are benign
- The differential diagnosis is large, but the most important thing is to distinguish benign from malignant causes
## Thyroid Nodules: Differential Diagnosis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoma</td>
<td>Metastasis</td>
</tr>
<tr>
<td>Carcinoma</td>
<td>Lymphadenopathy</td>
</tr>
<tr>
<td>Cyst</td>
<td>Thyroglossal duct cyst</td>
</tr>
<tr>
<td>Multinodular Goiter</td>
<td>Parathyroid cyst/adenoma</td>
</tr>
<tr>
<td>Hashimoto’s Thyroiditis</td>
<td>Cystic hygroma</td>
</tr>
<tr>
<td>Subacute Thyroiditis</td>
<td>Aneurysm</td>
</tr>
<tr>
<td>Prior thyroid surgery</td>
<td>Bronchocele</td>
</tr>
<tr>
<td>Thyroid hemiagenesis</td>
<td>Laryngoele</td>
</tr>
</tbody>
</table>
Thyroid Nodules: History

- Childhood Irradiation
- Age
- Gender (malignancy more likely in males)
- Duration and Growth (thyroid cancer can be very slow growing)
- Local symptoms (hoarseness worrisome)
- Hyper- or hypothyroidism (suggest benign)
- Family history (MEN2)
Thyroid Nodules: Physical Exam

- Size
- Fixation
- Consistency
- Adenopathy
- Vocal cord paralysis
- Multiple nodules (multinodular goiter) does not imply the nodules are benign
Thyroid Nodules:
Laboratory Evaluation

- TSH
- Ultrasound
- Fine needle aspiration biopsy
- Radionuclide Scan (usually not needed)
Thyroid Nodules: why measure TSH?

- A low TSH suggests the nodule is “hot”, which would indicate it is benign but causing hyperthyroidism.
- A high TSH suggests hypothyroidism due to Hashimoto’s thyroiditis. The nodule may disappear with levothyroxine Rx to normalize TSH.
- However, TSH will be normal in most cases.
Thyroid Nodules: why ultrasound?

- Ultrasound provides objective confirmation of your physical exam (or refutes it).
- Ultrasound is the most accurate way to determine the size of a nodule, and hence is the best way to assess whether it is growing over time.
- Ultrasound cannot distinguish benign from malignant, but some ultrasound features are more common in malignant nodules.
Thyroid Nodules: Fine Needle Aspiration Biopsy

- Most accurate and cost effective means to predict whether a nodule is benign or malignant.
- However, well differentiated follicular carcinomas are difficult to distinguish from follicular adenomas.
- No serious morbidity.
- In patients with a normal TSH, nodules greater than ~1.0-1.5 cm are biopsied.
Non-functioning (Cold) Thyroid Nodule

Palpable nodule in right lobe of thyroid is “cold” by radionuclide scan.

Image of nodule removed.
Thyroid Nodules: Radionuclide Scan

- Hot nodules are virtually always benign.
- Cold nodules have ~5% risk of malignancy.
- Since ~90% of nodules in euthyroid patients are cold, a scan rarely permits one to rule out cancer.
- Therefore a scan is not usually a cost effective test in the evaluation of thyroid nodules in euthyroid individuals.
- Perform a scan if the TSH is low, to confirm the nodule is the cause.
Thyroid Nodules: Therapy

- Benign nodules:
  - Generally nothing
  - Sometimes T4
  - Occasionally surgery

- Malignant nodules
  - Surgery
  - T4 to suppress TSH
  - Radioiodine (I-131)
Thyroid Cancer

- Papillary
- Follicular
- Medullary
- Anaplastic
- Lymphoma
- Metastases
Papillary Thyroid Cancer

- Most common type
- Excellent prognosis
- Spreads first to local cervical lymph nodes; also can spread to lung and bone
- Therapy: surgery, T4, radioiodine
- Thyroglobulin is an excellent tumor marker
Papillary Thyroid Cancer: Ras-MAPK pathway activation

- BRAF V600E mutation in ~50% of cases
- RET/PTC chromosomal translocation in ~20% of cases
- Ras mutations in ~15% of cases

A Fusco, et al. JCI 115:20, 2005
Importance of BRAF V600E mutation in papillary thyroid cancer

- Diagnosis: PCR of biopsy specimens may be useful.
- Prognosis: tumors tend to be more aggressive than other papillary cancers.
- Treatment: An experimental BRAF inhibitor is in a clinical trial for papillary thyroid cancer. There currently are no effective chemotherapeutic agents to treat thyroid cancers.
Papillary Thyroid Cancer: RET oncogene mutations

- ~20% of papillary cancers are caused by translocations involving the RET proto-oncogene.
- RET is a plasma membrane receptor with a cytoplasmic tyrosine kinase domain.
Papillary Thyroid Cancer: RET oncogene mutations

- RET is not normally expressed in thyroid follicular cells. A chromosomal inversion juxtaposes sequences of another gene (called PTC) with the tyrosine kinase domain of RET, resulting in inappropriate RET expression.

- Detection of RET rearrangements by PCR of thyroid biopsies and peripheral blood may become important diagnostic tests.
Thyroid Cancer and the Chernobyl Nuclear Accident

- The 1986 Chernobyl accident released a large amount of radioiodine into the atmosphere.
- New cases of thyroid cancer began to increase in 1990, and rose 50-fold by 1993.
- Virtually all cases are papillary cancer, and most have RET/PTC rearrangements.
- Most cases occurred in children <5 years of age at the time of the accident.
New cases of thyroid cancer in Belarus, 1986-1995

Fig. 2. New cases of childhood (■) and adolescent (□) thyroid carcinoma in Belarus, registered yearly from 1986 to 1995.

Source: Undetermined
Age of Belarus patients at the time of the accident

Fig. 3. Age distribution of Belarus thyroid cancer patients at the time of the accident (1986). The black column (■) and the white column (□) represent patients diagnosed during childhood and during adolescence, respectively.

Source: Undetermined
Thyroid Cancer from Nuclear Accidents

- May be preventable by ingestion of iodide (non-radioactive).
- The American Thyroid Association recommends that nuclear power plants stock NaI or KI for emergency administration to local residents.
Follicular Thyroid Cancer

- Less common than papillary
- Prognosis probably not quite as good as papillary, but still excellent
- Greater tendency than papillary to spread to lung and bone, with less to cervical lymph nodes
- Therapy: surgery, T4, radioiodine
- Thyroglobulin is an excellent tumor marker
Follicular Thyroid Cancer

- Often caused by a chromosomal translocation fusing the genes encoding Pax8 and \( \text{PPAR}_\gamma \).
- Pax8 is a transcription factor that controls the development of the thyroid and the expression of many thyroid specific genes.
- \( \text{PPAR}_\gamma \) is a nuclear receptor (it is the target of the insulin sensitizing drugs thiazolidinediones).
Pax8/PPARγ fusion protein and follicular thyroid cancer

- The mechanism of oncogenesis is unclear.
- PCR-based assays of thyroid biopsies and peripheral blood may become important diagnostic tests.
- Whether PPARγ ligands (thiazolidinediones) affect follicular thyroid cancer is an important but unanswered question.
Medullary Thyroid Cancer

- Only ~5% of thyroid cancers
- Derived from parafollicular C cells, not follicular cells
- Calcitonin is an excellent tumor marker
- Can be sporadic or part of MEN2a or 2b
- Therapy - surgery (radioiodine ineffective)
Multiple Endocrine Neoplasia Type 1

- MEN 1
  - Pituitary adenoma
  - Parathyroid (usually 4 gland hyperplasia)
  - Pancreas (gastrinoma, insulinoma)
Multiple Endocrine Neoplasia Type 2

- **MEN 2A**
  - Medullary carcinoma of the thyroid
  - Parathyroid (usually 4 gland hyperplasia)
  - Pheochromocytoma (usually bilateral)

- **MEN 2B**
  - Medullary carcinoma of the thyroid
  - Pheochromocytoma (usually bilateral)
  - Mucosal neuromas, Marfanoid habitus, ganglioneuromas
RET proto-oncogene

- RET point mutations (single amino acid changes) cause MEN2A and 2B.
- Similar RET mutations also are found in some sporadic medullary cancers. RET translocations cause some papillary cancers.
- RET mutations that cause thyroid cancer are gain of function mutations, and hence MEN2A and 2B are autosomal dominant.
RET Mutations in MEN2A and 2B

- **MEN2A** - RET mutations occur in extracellular domain cysteines.
  - Results in intermolecular RET dimerization, leading to inappropriate kinase activation.
- **MEN2B** - RET amino acid 918 is mutated from methionine to cysteine.
  - Mutation lies within the kinase domain and presumably alters enzyme specificity.
- Patients with medullary thyroid cancer and family members can be tested for RET mutations.
RET Mutations and MEN2A and 2B

Mutation of extracellular domain cysteine causes MEN2A

Mutation of amino acid 918 within the tyrosine kinase domain causes MEN2B
Straightforward Clinical Thyroid Cases

(You should be able to figure these out from the lectures)
26 y.o. female c/o irregular periods, insomnia, rapid heart beat and feeling hot

- What is the likely diagnosis?
- What should you look for on exam?
- What lab test(s) would you order?
- How would you treat the patient?
You make the diagnosis of Graves’ disease and treat the patient with PTU

- How quickly will the drug work and why?
- Three weeks after starting the PTU, the patient develops fever and tachycardia. How should you proceed?
On routine exam, a 40 y.o. man is found to have a 2 cm thyroid nodule

- What are the key points to ask in the history?
- What should you focus on in the exam?
- What is the differential diagnosis?
- How should the work up proceed?
A 56 y.o. woman c/o being tired and cold, and notes a 5 pound weight gain

- What is the likely diagnosis?
- What should you look for on exam?
- What lab test(s) would you order?
- How would you treat the patient?
Not so straight forward thyroid cases

(But you should be able to deduce the answers from the lecture material)
Goiter is c/w hypothyroidism due to which of the following?

- Hashimoto’s thyroiditis
- Inactivating mutation of TSH receptor
- Inactivating mutation of Iodide transporter
- Dietary Iodine deficiency
- X-Ray Rx of a brain tumor
A 55 y.o. man receives the antiarrhythmia drug amiodarone, which inhibits the type 1 deiodinase

What would happen to the serum T4, T3 and TSH shortly after starting this drug?

What would be the effect of chronic amiodarone on T4, T3 and TSH?

How would you diagnose hypothyroidism or hyperthyroidism in this man?
A 25 y.o. hypothyroid woman has the following lab tests while taking thyroxine:

- **Free T4 1.90** (normal 0.73 - 1.79 ng/dl)
- **TSH 0.6** (normal 0.3 - 5.5 mU/L)

How do you interpret these results and what should you do?
Bonus Thyroid Cases

(Uncommon genetic thyroid diseases that teach us about thyroid function)
A 6 wk old boy with a large hepatic hemangioma was found to have a TSH of 156 (normal 0.3-6.2 mU/L), and low T4 and T3 levels.

Huge doses of intravenous T4 and T3 were required to normalize the TFTs.

Why?

SA Huang, et al. NEJM 343:185, 2000
Consumptive Hypothyroidism

Adult T3 production rate = 32 mcg/d

SA Huang, et al. NEJM 343:185, 2000
Consumptive Hypothyroidism is due to over-expression of type 3 Deiodinase (D3)

SA Huang, et al. NEJM 343:185, 2000
Consumptive hypothyroidism

- Hemagioma D3 degrades T4 and T3 so fast the thyroid cannot keep up.
- Demonstrates the role of D3 in regulating thyroid hormone levels.
- Infants with large hemangiomas could be at risk for mental retardation due to consumptive hypothyroidism, unless diagnosed and treated.
X-linked psychomotor retardation

- A boy with severe mental retardation and other neurological symptoms was found to have a TSH of 8.8 (normal 0.3-4.0) and a Total T3 of 6.1 (normal 1.4-2.7; free T3 was equally elevated).
- Several families with similar findings in boys have been described.
- What is the cause of this syndrome?
TFTs in X-linked psychomotor retardation

The syndrome of X-linked psychomotor retardation, elevated serum T3 and elevated TSH was found to be due to mutations in the gene $MCT8$. $MCT8$ was found to encode a thyroid hormone transporter highly expressed on the surface of neurons as well as several other cell types.
X-linked psychomotor retardation

- T3 does not simply diffuse into cells, but must enter through specific transporters.
- *MCT8* is one of several potential T3 and T4 transporters.
- Neuronal hypothyroidism may explain the phenotype of X-linked psychomotor retardation.