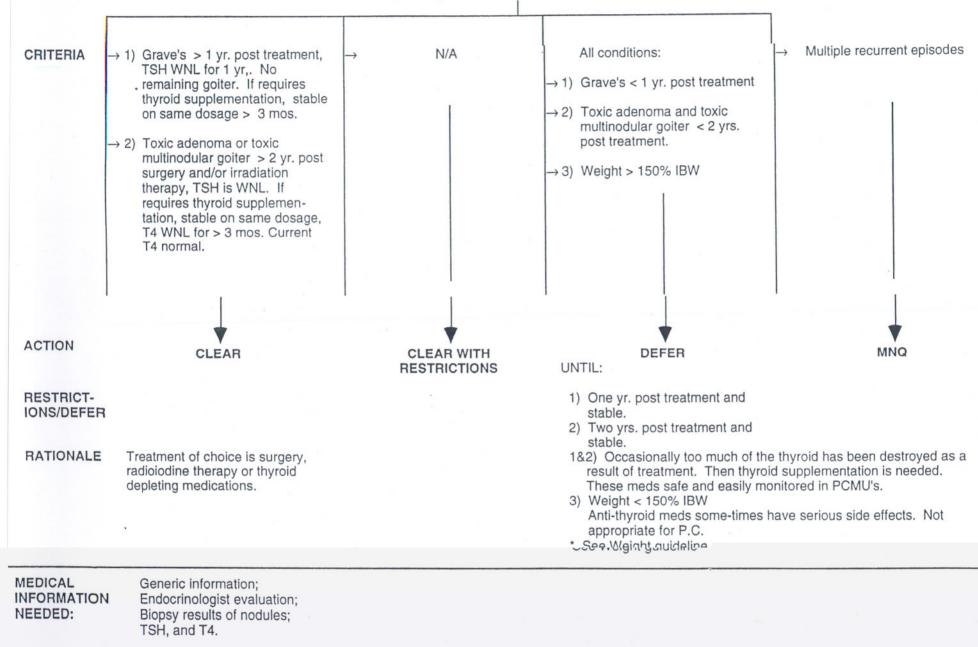
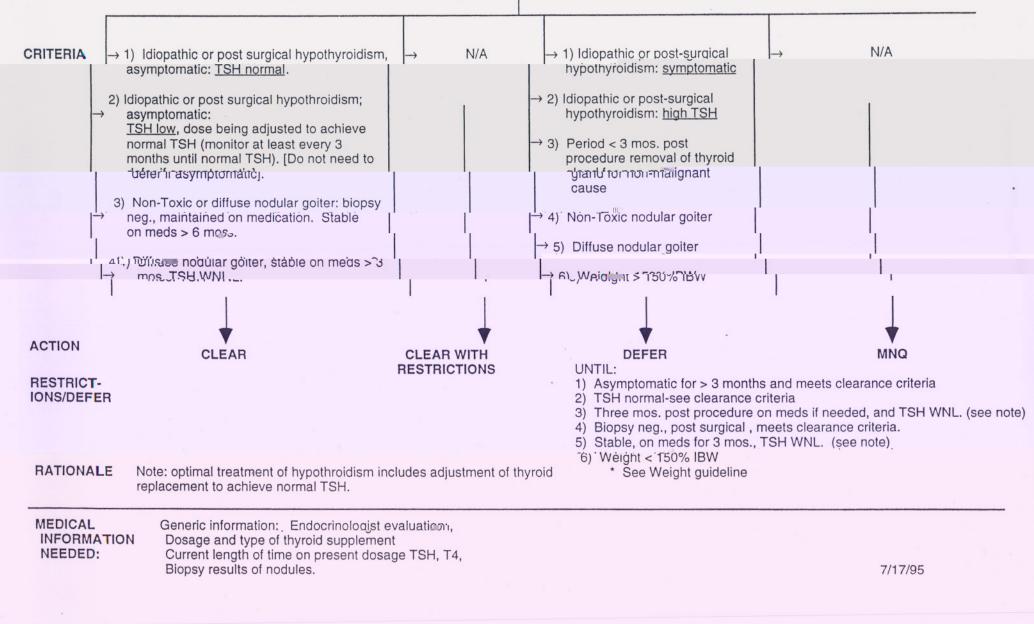
# HYPERTHYROIDISM: GRAVE'S DISEASE (242.0), TOXIC ADENOMA (242.3), TOXIC MULTINODULAR GOITER (242.2)

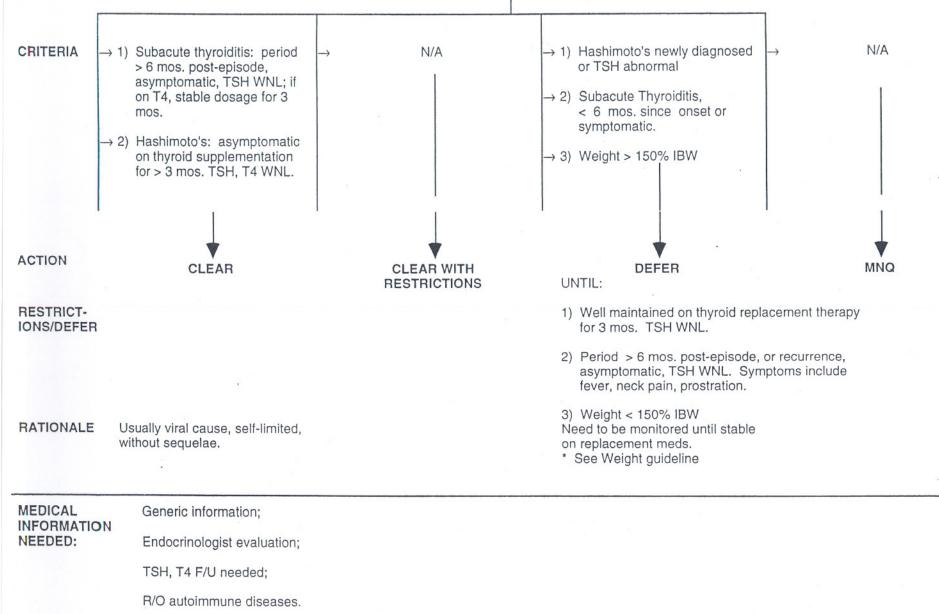


7/17/95

### 'HYPOTHYKUID: 'DIFFUSE'NUDUL'AR GUITER (240.'9),'HYPOTHYKUID, NON-SPECIFIC (244.9), NON-TOXIC NODULAR GOITER (241), THYROIDECTOMY: NON-MALIGNANT CAUSE (06)

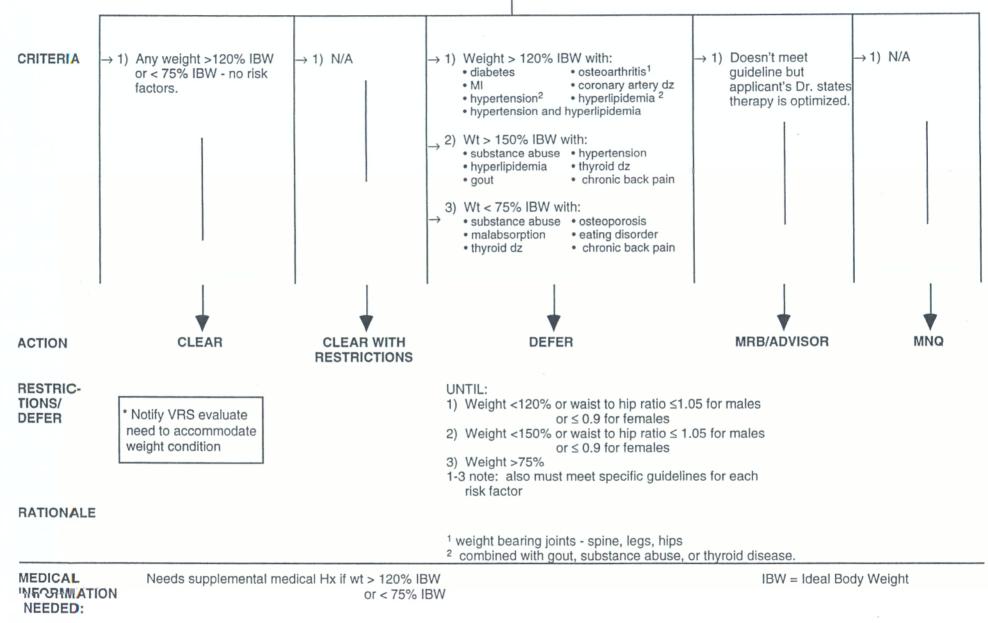


## THYROIDITIS (245), HASHIMOTO'S (245.2), SUB-ACUTE THYROIDITIS (245.1)



7/17/95

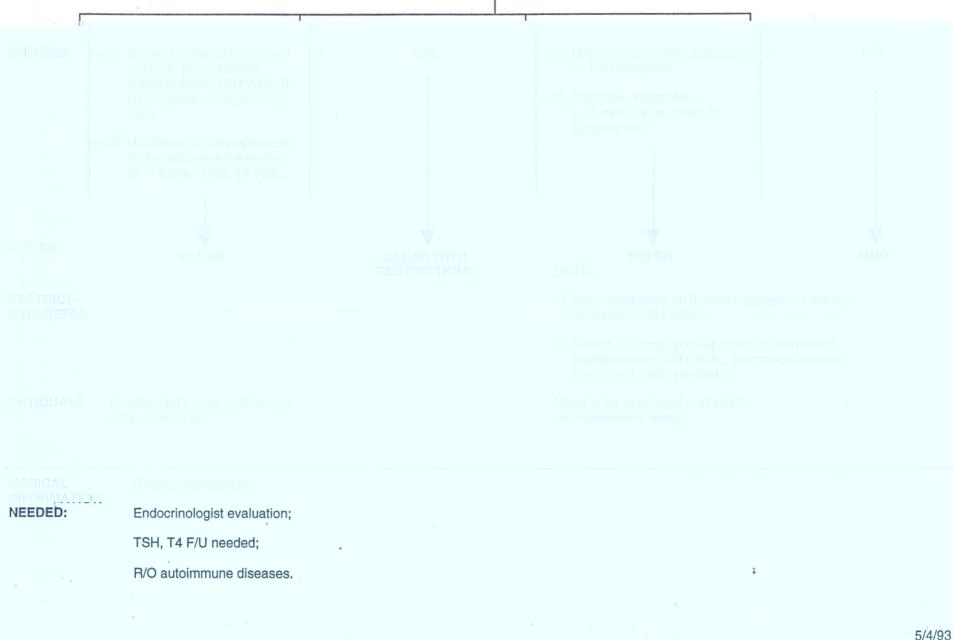




# HYPOTHYROID: DJEFUSE NODJUAR GOITER (240.9), HYPOTHYROID, NON-SPECIFIC (244.9), NON-TOXIC NODULAR GOITER (241), THYROIDECTOMY: NON-MALIGNANT CAUSE (06)

-				
-	<ul> <li>→ 1) Idiopathic Hypothyroid: asymptomatic, T4 normal or high normal; TSH normal or dose is being adjusted (see note).</li> <li>→ 2) Partial or complete thyroid- ectomy (benign cause) &gt; 6 weeks post op and stable on supplementation &gt; 3 mos.</li> <li>→ 3) Non-Toxic or diffuse nodular goiter: biopsy neg.,</li> </ul>	→ N/A	<ul> <li>→ 1) Non-Toxic nodular goiter</li> <li>→ 2) Diffuse nodular goiter</li> <li>→ 3) Period &lt; 3 mos. post procedure removal of thyroid gland for non-malignant cause</li> <li>→ 4) Idiopathic hypothyroid, symptomatic or low T<sub>4</sub>.</li> </ul>	→ N/A
	maintained on medication. Stable on meds > 6 mos. → 4) Diffuse nod. goiter, stable on meds 3 mos.TSH,T4 WHL.			
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER UNTIL:	MNQ
RESTRICT- IONS/DEFER	Note: optimal treatment of hypothroidism includes adjustment of thyroid replacement to achieve normal TSH. Can accept slightly low TSH if stable for > 1 year and no adjustment of dosage advised by endocrinologist.	•	meds for 3 mos., TSH WNL. (se 2) Stable, on meds for 3 mos., TSI 3) Three mos. post procedure on r (see note)	H WNL. (see note) meds if needed, and TSH WNL.
RATIONALE			4) Until asymptomatic for 3 mo or	T4 within normal range.
MEDICAL INFORMATION NEEDED:	Generic information; Endocri N Dosage and type of thyroid su Current length of time on pres ອີກງອະນາຄອະໄທລະດຳກາດໃນໃກອນ.	pplement		572734
Endocrinology		ENDO-1	1	<i>JIZI</i> 94

## THYROIDITIS (245), HASHIMOTO'S (245.2), SUB-ACUTE THYROIDITIS (245.1)



## ENDOCRINOLOGY.

#### Diabetes

- Mellitus: All diabetics need to be within a day's travel of decent medical facilities if they become sick. Any diabetic can go into keto acidosis if they are not taking their oral hypoglycemics or insulin when ill. Both insulin dependent and diabetics taking oral hypoglycemics need to have insulin with them at all times in case of emergencies and know how to treat themselves with injectable insulin if they get ill. The optimum indicator for long term control of blood glucose levels is glycohemoglobin; it measures the amount of glucose adhering to the cell and gives a picture of blood sugars over time. Glycohemoglobin is more informative than an FBS. Normal range is 5-6%. A diabetics should be no more than 8%. A reading of >8% indicates poor control over time. Any applicant with a severe life-threatening hypoglycemic episode should be deferred for 2 years until his/her diabetes is well controlled control. For the 10-20% of diabetics with renal complications, the usual time frame from onset of renal disease in diabetics to dialysis is only 5 years.
- Gout: Gout is considered well controlled if there is no episode in 6 months and a Uric Acid level < 6 mg/dl. All PCV's with a history of Gout should take medications for both an acute attack and for suppression. Colchicine and NSAID's are the treatment of choice for an acute attack. Then the PVC should start on Allopurinol for suppression. Neither medication requires special F/U and the PCV should be able to monitor his/her own medications.
- Hypoglycemia: True reactive hypoglycemia is very rare. Documented blood glucose < 50 while symptomatic is diagnostic. Most symptomatic individuals have blood glucose > 50 while having symptoms. Hypoglycemia is sometimes caused by a insulinoma or other neoplasm. These and other diseases should be r/o'd. Current research is suggesting that a condition (Post Prandial Syndrome) may exist. The syndrome occurs when a large amount of carbohydrates are dumped in the gut. The body responds by producing high levels of cathecolamine. The symptoms that have been associated with hypoglycemia result.

#### Addison's

Disease: A person with Addison's Disease, well maintained on replacement cortisone, is not in any additional risk for developing infections. The dose of steroids is a replacement dose malibrizing the browned better within a room and Manary disiduals with Addison's are truthy to ever brothenese been when six a Three sudards creight is to self inject with steroid dose while ill to meet the increased demands of the body. Another options for the individual with Addison's when they become ill is to self inject with Dexamethasone. The dexamethasone prevents Addisonian Crisis. The effect of the injection lasts three days and provides time for the individual to travel to medical treatment, if necessary. As long as the individual is responsible and reliable, they are considered more stable than IDDM individuals. Most individuals with Addison's live normal lives and have normal life expectancy.

### Pituitary

Adenomas: Patients with Micro or Macro adenomas are usually released from medical treatment two years after treatment with a clear MRI or CT scan. The patients need an MRI or CT scan 1, 2 and 4 or 5 years after surgery to r/o recurrence. The patients also require yearly prolactin levels, T4 and TSH.

### Carcinoma of the Thyroid and

Thyroidectomy: Individuals 3 years post treatment for small (<2 cm.) thyroid cancers (papillary or follicular type) with a clear thyroid scan are considered cured after 3 years. Larger growths need longer f/u. Every year as f/u they require a chest X-ray, T4 and TSH. Anaplastic Thyroid CA is fatal. Mcdullary CA is a slow growing CA with no known

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Endocrinology

treatment, but patients remain well and active for many years. Thyroid CA has been known to recur up to 20 years and mutan reatment. request, ..., supplementation is needed after treatment.

## Hyperthyroidism:

### Grave's Disease,

Toxic Adenoma, Toxic MULTINODULAR

Crotter: Troin reduction the nodule is causing hyperthyroid symptoms. Treatment consists of thyroidectomy, radiation therapy or medication to destroy the overactive thyroidene tissue. The medications, Tapazole or PTU, have serious side effects such as Agranulocytosis, leading to septicemia and death in 3/1000. During medication treatment, the patients require very close f/u. The criteria for well controlled disease is post treatment one year with a stable Thyroid Stimulating Hormone level (TSH), are the criteria for well controlled. Yearly f/u of TSH and T4 is required. Toxic Adenoma and Toxic Multinodular goiter have a high recurrence rate and require close f/u for 1 year post treatment.

# Hypothyroidism:

## Idiopathic, Non-Toxic

Nodular Goiter, Diffuse

Nodular Goiter: All nodules require a biopsy to r/o Ca. Non-toxic means no hyperthyroid symptoms are present. Individuals with Idiopathic Hypothyroid are usually considered stable after 3 months on thyroid supplementation with normal thyroid levels. All people with a history of goiters or hypothyroidism need f/u of yearly exam of their thyroid, T4 and TSH. Nodular Goiter, with a neg biopsy and TSH WNL, is considered controlled after 6 months.

Thyroiditis: Hashimoto's is occasionally congenital, but frequently the cause is unknown. It is easily treated with thyroid medication and is non-progressive and benign. It is very rare to have it associated with other autoimmune disorders.