Correct answers to CME questions in March 2007 issue

1. **d** This woman's symptoms and signs suggest Graves disease. Total T3 and T4 may be elevated in pregnancy because thyroid binding globulin production is stimulated by oestrogen. Ultrasound scanning and fine needle aspiration of the thyroid are not indicated in Graves disease. TSH receptor antibodies are specific for Graves disease.

2. **e** Treatment with antithyroid medication is frequently ineffective in men with severe toxicity or large goitre. Though the patient may show a response to carbimazole (commenced at a high dose and gradually tapered), he may not have a complete remission with antithyroid medication alone. Treatment with radioiodine after the patient has been made euthyroid is the most effective management option.

3. **b** This woman is clinically and biochemically hypothyroid and has been started on low dose of thyroxine as she has ischaemic heart disease. Adequacy of the dose should be assessed with TSH assays at least 6 weeks later, and if the TSH remains high, the thyroxine dose should be increased in increments of 25-50 μg. This stepwise adjustment should be continued till the TSH is normal. Thyroxine should be lifelong.

4. **b** Indeterminate cytology means that the cytopathological nature of the nodule is inconclusive despite examination of an adequate specimen, so repeating FNAC is not helpful. An ultrasound scan will not help to differentiate between a benign and malignant lesion. Long term thyroxine therapy is not a management option here. Referral to a surgeon is necessary since the patient has cosmetic concerns. The most appropriate next step would be to get a radioisotope scan to determine the functional status of the nodule, which in turn will help to decide whether surgery is needed.