

surgery for thyroid carcinoma between 1970 and 2000 at the Mayo Clinic, of whom 303 received postoperative radioiodine therapy and 224 did not. At an average follow-up of 20 years, death rates were identical, with one death apiece in both groups. Recurrence rates also were the same at 20% in both groups.

Morbidity also occurs from radioiodine therapy, although it is uncommon and not severe in many cases, he said. However, a study of 6,841 patients with thyroid cancer, who received an average dose of 162 mCi, found a significantly increased risk of secondary primary malignancy of 27%, and a dose-dependent increase in salivary

gland, bone, soft tissue, and colorectal cancers (Br. J. Cancer 2003;89:1638-44).

Dosages of radioactive iodine used to treat patients with no evidence of residual thyroid cancer reached an alarming high of 250 mCi in a separate series of consecutive thyroid cancer patients referred to the Mayo Clinic in 2002-2003, Dr. McIver reported. All of the 100 patients in this series had a score of less than 6 on the MACIS—Metas-

tasis, Age, Completeness of Excision, Invasiveness, and Size—prognostic scoring system, placing them in a “low-risk” group,

**‘The absence of strong data on both sides is a terrible indictment ... that we haven’t done the studies for a treatment that is so often viewed as being standard.’**

he said. Of these patients, 22 were referred for consideration of <sup>131</sup>I therapy. Among the remaining 78 patients, 69 (88%) received <sup>131</sup>I ablation; the average radiation dose was 79 mCi with a median of 100 mCi. Dr.

McIver called the finding “troubling.”

The American Thyroid Association rec-

ommends radioiodine therapy for patients aged 45 years and older with stage III and IV disease, for patients aged 44 years or younger with stage II disease, for most older patients with stage II disease, and for selected patients with stage I disease.

Dr. McIver recommends using <sup>131</sup>I therapy for patients who have residual thyroid cancer after the best surgical treatment, for those with metastatic spread (stage II if younger than 45 years or stage IV if older than 45 years), and for those at high risk from their disease (those with follicular and Hurthle cell cancer and papillary cancer with a MACIS score greater than 6). ■

## Consensus a Must For Managing Thyroid Nodules

CHICAGO — As the prevalence of thyroid nodules diagnosed on ultrasound increases, clinicians trying to decide whether to biopsy a particular nodule should consider adding a serum TSH test to their work-up, Dr. R. Brooke Jeffrey Jr. said at the annual meeting of the Radiological Society of North America.

At the moment, “what is driving our approach to thyroid diagnosis is money and patient hysteria,” said Dr. Jeffrey of the department of radiology at Stanford (Calif.) University. In addition, the lack of clinical findings that indicate with certainty which nodules are more likely to be malignant contributes to a high biopsy rate.

Deciding which patients to biopsy is “a very contentious issue,” he added, noting that different medical societies have issued guidelines that often conflict. Though thyroid nodules are commonly detected, few thyroid cancers are diagnosed. But clinicians do not want to miss a cancer diagnosis, and thyroid biopsies can be lucrative.

A recent review indicated that thyroid cancer mortality has not changed in 30 years, despite the increased incidence of thyroid cancer, a result Dr. Jeffrey attributed to overdiagnosis (JAMA 2006;295:2164-7).

He also concluded that ultrasound, which has become much more widely available in the past 30 years, has not contributed to a decrease in mortality. Ultrasound gives information about many features of thyroid cancer, such as whether a mass is solid, hypoechoic, taller than it is wide, and whether it has microcalcifications and irregular margins. But because no single feature has a high sensitivity and specificity, clinicians cannot rely on ultrasound to rule out cancer, so they order biopsies.

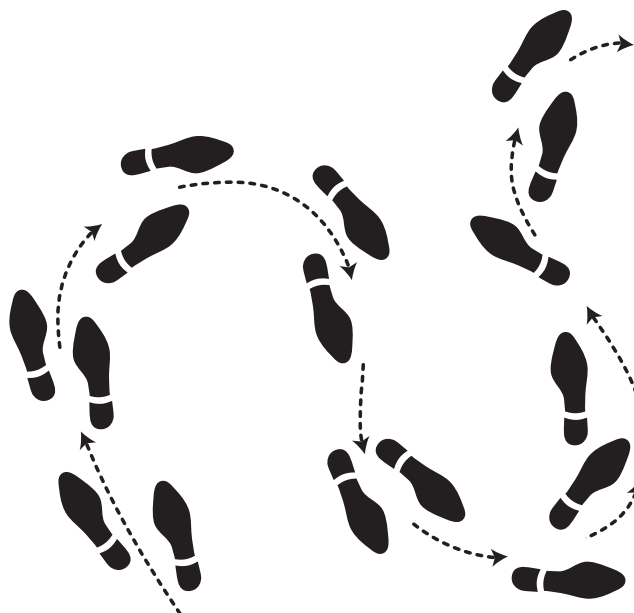
However, recent data indicated that patients with clinically detected goiters and high normal TSH values had a higher incidence of thyroid cancer (J. Clin. Endocrinol. Metab. 2006;91:4295-301). By “combining ultrasound features and laboratory values, we might be able to come up with an algorithm,” Dr. Jeffrey said.

Even if TSH levels prove useful, clinicians will still confront difficult issues when deciding whether to biopsy thyroid nodules: how long to track the nodules before biopsy and what sort of interval growth might indicate a benign or a worrisome condition.

—Sarah Pressman Lovinger

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Please see accompanying Brief Summary of Prescribing Information.

\*Results of a 12-week, placebo-controlled, randomized, double-blind, fixed-dose-treatment trial to assess the efficacy and safety of MIRAPEX vs placebo in the treatment of moderate to severe primary RLS (MIRAPEX n=254; placebo n=85). Measurement parameters included the International Restless Legs Syndrome Rating Scale (IRLS) and the Clinical Global Impressions-Improvement (CGI-I) scale. IRLS is an internationally validated scale that is the standard instrument for evaluation of severity of RLS. Total score ranges from 0 to 40, with 0 being absence of RLS symptoms and 40 the most severe symptoms. CGI-I is widely accepted for measuring improvement in RLS symptoms.

Reference: 1. Data on file, Boehringer Ingelheim Pharmaceuticals, Inc.



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