Draft Guidelines for Grave's Tx Stress Options

BY JOYCE FRIEDEN

New draft hyperthyroidism treatment guidelines from the American Thyroid Association and the American Association of Clinical Endocrinologists emphasize that although radioactive iodine is a good treatment for the disorder, patients need to consult with their physicians about all three available treatment options: radioactive iodine, surgery, and antithyroid medications, according to Dr. Rebecca Bahn.

"Physicians in the United States have long considered radioactive iodine [RAI] be the preferred treatment for Grave's disease," Dr. Bahn, chair of the guideline task force, said in an interview. "We're recommending that the patient and the physician have a careful and clear discussion about the three treatment options, and that any of the three options are viable. It's really a decision between the patient and the physician." Dr. Bahn presented the draft guidelines in September at the annual meeting of the American Thyroid Association in Palm Beach, Fla.

That is not to say that there aren't some situations in which one procedure is preferable to another, said Dr. Bahn, professor of medicine and a consultant in endocrinology at the Mayo Clinic, Rochester, Minn. For example, "pregnant women should not receive radioactive iodine, and patients with medical problems that put them at high risk for surgery should not choose surgery. But our overall recommendation is that the patient and the physician should make the decision following a careful discussion."

Another major change in the guidelines deals with antithyroid drug thera-

py. "It used to be that propylthiouracil (PTU) or methimazole could be used interchangeably, but there's now good evidence that there's a very serious hepatic necrosis associated with PTU; it's rare, but it's not at all associated with methimazole," she said. "So our guidelines will say that if you're going to use antithyroid drugs you should use methimazole except in certain instances."

On the other hand, women who have Grave's disease that is diagnosed in the first trimester of pregnancy should be started on PTU, because methimazole is associated with certain birth defects, Dr. Bahn said. "Also, if the patient is found to have minor side effects with methimazole, in some cases PTU might be used. But the overall drug of choice in most instances is methimazole."

In the case of hyperthyroidism caused by nodules, "for definitive treatment we don't recommend antithyroid drugs because the patient would have to be on those essentially forever," she said. "In some instances, such as patients with a relatively short life expectancy or iodine-induced disease, these medications may be used, but in general, the treatment is surgery or RAI." In particular, the task force is recommending that for toxic multinodular goiter, near-total or total thyroidectomy should be performed. If the toxic adenoma is in the thyroid isthmus, an ipsilateral thyroid lobectomy or isthmectomy should be performed.

The guidelines also address the treatment of hyperthyroidism in patients with Grave's ophthalmopathy. "For the 50% of Grave's patients who have evidence of mild eye disease, any [Grave's disease] treatment option is fine, but if RAI is chosen, then the physician and patient need to talk about the risk-benefit ratio of using prednisone" for 6-8 weeks to prevent the eye disease from worsening as a result of RAI. Patients who are at higher risk of worsening eye disease include smokers and patients with high anti-TSH receptor antibodies, she said. "They are most likely to progress if not given concurrent steroids."

Dr. Bahn said she expects the task force will give a final draft of the guidelines to the boards of both the ATA and AACE for their approval in late fall and hopes that the guidelines will be ready for publication in early 2010. Dr. Bahn said she had no conflicts to declare with regard to the guidelines. ■