



## EDITOR'S CORNER

### HYPOTHYROIDISM: FOCUS ON PREVENTION (AUGUST 2009)

Q: After doing the Hypothyroidism module [Volume 17(7), August 2009], we are still confused about when to use thyroid antibody testing.

A: As stated in the module, most cases of hypothyroidism can be diagnosed by testing TSH and free T4 **without** the need for any thyroid antibody testing. The presence or absence of antibodies rarely change our management.

So when **would** we order thyroid antibodies? Since few empirical studies are available to guide us about when antibody testing may be useful, we must rely primarily on expert opinion and our own clinical judgment. The situations when antibody testing **may** be helpful include:

- In patients with "subclinical hypothyroidism" (TSH of between 5 and 10 mIU/L, who have a normal free T4 and T3), those with anti-TPO antibodies are more likely to convert to overt hypothyroidism than those without anti-TPO.<sup>1,2</sup> It has been recommended that these individuals be screened with an annual TSH.<sup>3</sup>
- When considering starting a patient on a drug that has associated risks of developing hypothyroidism, the risk increases when thyroid peroxidase antibodies are present (such as lithium, amiodarone, interferon alpha, or interleukin-2).<sup>4</sup>
- When hypothyroid patients have a goiter and nodules, thyroid autoantibody testing can help identify individuals with chronic autoimmune thyroiditis—which is important because of the high risk of a false-positive finding of follicular neoplasm with fine-needle aspiration biopsy in these individuals (owing to thyrocyte damage). However, although high anti-TPO titers have a high specificity for chronic autoimmune thyroiditis, the test has a low sensitivity (significant false-negative rate), and a biopsy specimen of enlarging or suspicious nodules should be obtained if anti-TPO is negative.<sup>5</sup>
- In pregnancy, *neither* routine TSH *nor* antibody screening is recommended at this time. Associations between thyroid disease and obstetrical outcomes have been reported as mentioned in the module; however, results are

conflicting. Guidance about universal screening must await results of larger studies which are currently underway.<sup>3</sup>

The bottom line? The use of thyroid antibody tests should be based on clinical judgement. They usually are not needed, but they **may** help with management decisions in selected patients.<sup>3</sup>

-- LS/LC/JW

#### References:

1. Downs H, Meyer AA, Flake D, Solbrig R. Clinical inquiries: How useful are autoantibodies in diagnosing thyroid disorders? *J Fam Pract* 2008; 57(9):615-616
2. Lock RJ, Marden NA, Kemp HJ, Thomas PH, Goldie DJ, Gompels MM. Subclinical hypothyroidism: a comparison of strategies to achieve adherence to treatment guidelines. *Ann.Clin Biochem.* 41[Pt 3], 197-200. 2004
3. Baskin HJ, Cobin RH, DUick DS, Gharib H, Guttler RB, Kaplan MM et al., American Association of Clinical Endocrinologists medical guidelines for clinical practice for the evaluation and treatment of hyperthyroidism and hypothyroidism. *Endocr Pract* 2002; 8(6):457-469, PM: 15260011
4. Saravanan P, Dayan CM. Thyroid autoantibodies. *Endocrinol Metab Clin North Am.* 2001 Jun;30(2):315-37. PMID: 11444165
5. Dayan CM, Daniels GH: Chronic autoimmune thyroiditis. *N Engl J Med* 335:99, 1996.

### ADULT ATTENTION DEFICIT DISORDER (ADHD) (NOVEMBER 2009)

Q: We would like more information on the Weiss Symptom Record, including where to access this, as the link in the module is incorrect.

A: Our apologies for the incorrect link. As of April, 2010, the link to the Canadian Attention Deficit Hyperactivity Disorder Resources Alliance (CADDRA) is [www.caddra.ca](http://www.caddra.ca). The Weiss record can be found by clicking on Canadian ADHD Practice Guidelines located on the left-hand side of the home page, and then scrolling down to the appendices. The Weiss symptom record is Appendix 4. Clicking on "Appendix 4" gives an introduction, the Record, and an explanation for all of the abbreviations used (which will help with its interpretation). The scale is designed to be used with the patient, or with close contacts (family, friends, teachers). Based on DSM-IV criteria, it can help to identify comorbidities and differentiate ADHD from other conditions where there may be symptom overlap. It is currently undergoing validation. [Note: If you want printable

versions, be sure to click on the pdf links for **both** "Instructions" and "Scales".]

Q: We think that information point 17, which refers to the DSM-IV criteria for ADHD, is inaccurate-could you please confirm?

A: Information point 17 states: "The DSM-IV criteria consists of nine inattention symptoms and nine hyperactivity-impulsivity symptoms. To qualify for a diagnosis of ADHD, patients must display six symptoms from each category and impairment in two or more distinct settings." You are correct that this could be confusing. Individuals can be EITHER hyperactivity-impulsivity predominant or, more commonly in adults, inattention predominant—in which case they need to have only 6 of the 9 symptoms for that subtype. As these criteria were not specifically developed for adults (Info point 18), however, it would be important to consider both symptoms and the level of functional impairment when making the diagnosis. This is the rationale for tools like the Adult ADHD Self-Report Scale (Appendix 1) and the Weiss Symptom Record. LS

[Note: If you do not have access to the DSM-IV manual, the symptoms by category are summarized in Appendix 1 of the module ADHD in Children and Adolescents. Educational Module Vol. 16(4):1-18, February 2008.]

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000:85-93.

## ERECTILE DYSFUNCTION (NOVEMBER 2009)

Q: Could you provide us with a working definition of erectile dysfunction?

A: Male erectile dysfunction is a complex condition involving both biological and psychological factors and has been defined as the persistent inability to achieve or maintain a penile erection sufficient for satisfactory sexual performance. This definition is preferred over the term "impotence", as it is more precise. LS/JF/LC

Diagnosis and treatment of erectile dysfunction.  
Agency for Healthcare Research and Quality, Rockville, MD  
<http://www.ahrq.gov/clinic/tp/erecdystp.htm>  
Accessed April 12, 2010

**RESEARCH NEWS** contact Stefanie Roder at 905.525.9140 ext. 22223 [roders@mcmaster.ca](mailto:roders@mcmaster.ca)

**THANK YOU to all PBSG members who completed the "PBSG Membership survey 2010."** The survey was mailed to 500 randomly selected PBSG members to provide feedback on the PBSG Learning Program. Also, **THANK YOU to all PBSG and PBIL members who have signed up for the research project on self-assessment and practice change.** Participants in this three-year research project will study two educational modules (determined by a needs assessment) in the setting of their usual practice-based learning sessions (PBSG or PBIL). In addition, each participant will complete a self-assessment questionnaire, based on patient cases, and will answer questions about the value of feedback, as presented in the context of those two modules.

For further information and/or to sign up for the PBSG Membership survey 2010 or the research project on self-assessment and practice change, please contact Stefanie at 905-525-9140 ext. 22223 or [roders@mcmaster.ca](mailto:roders@mcmaster.ca).

## FOUNDATION NEWS AND NOTICES

**Dr. Heather Armson** received the CAME Certificate of Merit Award which is awarded to faculty committed to medical education in Canadian medical schools.

Note: For our PBSG and our PBIL September start dates, please watch for our email to confirm your mailing address for the upcoming fall renewal season.

**FACILITATOR TRAINING WORKSHOPS** contact Heather Haywood 800.661.3249 [haywood@mcmaster.ca](mailto:haywood@mcmaster.ca)

**IMPORTANT:** There are still a few spots left for our October 2010 Workshops. Please contact us to see if there is an opening in your area.

### SPRING 2011

(TENTATIVE DATES - MINIMUM REGISTRATION REQUIRED TO PROCEED)

Saturday, April 16 Hamilton – <i>Open</i>	Saturday, April 30 Ottawa – <i>Open</i>	Sunday, April 10 Vancouver - <i>Open</i>	<b>To avoid disappointment Book Early!</b>
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**UPCOMING MODULES** Do you have a module topic suggestion? Send to: [fmpe@mcmaster.ca](mailto:fmpe@mcmaster.ca)

- BORDERLINE PERSONALITY DISORDER ▪ COMPLICATED GRIEF ▪ CROUP AND BRONCHIOLITIS ▪ NON-MIGRAINE HEADACHE
- VENOUS THROMBOEMBOLISM ▪ REVIEW – WHAT PRACTICE CHANGES HAVE WE MADE?

Visit our Website at [www.fmpe.org](http://www.fmpe.org) or call 800.661.3249