CASES (THYROID AND ADRENAL DISORDERS)

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Case#1

- All of the following etiologies of thyrotoxicosis can cause increased thyroid iodine uptake EXCEPT:

A. Graves' disease

B. Toxic Multi-nodular goiter

C. Hyperthyroidism due to thyrotropin secretion (TSH-oma).

D. Iatrogenic thyrotoxicosis

Exogenous thyroid suppresses TSH thus gland activity and iodine uptake goes down
Another Ex: Subacute Thyroiditis D

Case#2

- 22 y/o female with no known medical problems, presented to endocrinology clinic for further evaluation of a newly diagnosed thyrotoxicosis which was confirmed per repeat labs, on PE she was noted to have a mild bilateral exophthalmus. The most likely cause of her thyrotoxicosis is:

A. Graves' Disease
B. Toxic MNG
C. Iatrogenic thyrotoxicosis
D. TSH-oma

Pathognomonics
- ophthalmopathy
- Pretibial Myxedema
- Nails acropachy
- Thyroid bruit

Case#3

- 18 y/o pregnant female, currently 8 weeks pregnant, presented with thyrotoxicosis, exam showed diffuse goiter and pretibial myxedema, labs with suppressed TSH and high Free T4. What is the best next step in management?

A. Proceed with thyroid uptake and scan.

B. Start her on propylthiouracil, repeat thyroid labs after 4 weeks.

C. Start her on carbimazole, repeat thyroid labs after 4 weeks.

D. Proceed with empiric I131 treatment.

E. Proceed with total thyroidectomy.

Graves dz remember, She is pregnant: choices A and D r not safe. While (E) Thyroidectomy is not preferred in early pregnancy. PTU is safe in first 12 weeks. Carbimazole safe after 12 weeks Also in thyroid storm we prefer PTU
If pt is unpregnant, multiple answers will be correct

Normal Ranges r Repr in the exam
TSH (0.5-5)

Case#4

An 85 y/o man with known history of CAD s/p CABG one year ago, current weight is 70 kg, he was found to have primary hypothyroidism per recent routine labs, TSH was 18.0, Free T4 was slightly low, unremarkable thyroid exam, no previous TFTs were available for comparison. The best next step in management is:

A. Start levothyroxine 25 mcg daily
B. Start levothyroxine 100 mcg daily
C. Do not start levothyroxine and repeat TFTs after 4-6 weeks
D. Proceed with thyroid ultrasound before making decision on treatment

dx is 1° hypothyroidism in old ppt especially w/ cardiac dzs we gradually ramp w/ low dose T4. Ultrasound (D) is not an option bcs thyroid is unremarkable. Repeat exam
A

Case#5

A 70 y/o man with history of colon cancer, presented with incidentally found 4 cm right thyroid nodule per carotid Doppler. The best next step in management is:

A. Check TSH
B. Proceed with CT neck
C. Proceed with right thyroid nodule FNA
D. PET/CT scan

from workup diagram in ac Hypothyroid Nodule - TSH

Case#6

- 36 y/o female presented with palpable left thyroid nodule and hyperthyroidism, thyroid scan was as shown in the figure. The best next step in management:

A. I131 ablation
B. Left thyroid nodule FNA
C. No treatment but repeat thyroid US and scan after 6 months
D. Total thyroidectomy

Case#7

- The thyroid cancer type with the worst prognosis is:

A. Papillary
B. Follicular
C. Medullary in the settings of MEN syndrome
D. Anaplastic

Case#8

- All of the following can cause pseudo Cushing's syndrome except:

Pseudo cushing is increased cortisol but not as high as cushing

A. Obesity
B. Alcoholism
C. Depression
D. Type 1 diabetes

Case#9

All of the following are considered as screening tests for Cushing's syndrome, EXCEPT:

A. High dose Dexamethasone suppression test. 8mg
B. Low dose Dexamethasone suppression test 1mg
C. 24 hour urine free cortisol
D. Late night salivary cortisol

Case#10

- All of the following clinical features can been seen in central (secondary) adrenal insufficiency, EXCEPT:

A. Hypotension
B. Hyperpigmentation
C. Nausea
D. Hypothyroidism

Hyperpigmentation first to show in Palmar creases, oral buccal mucosa

B

Case#11

- 90% of cases of Congenital Adrenal Hyperplasia (CAH) are due to:

A. 11 Beta hydroxylase deficiency
B. 21 Hydroxylase deficiency
C. 17 Hydroxylase deficiency
D. 3 Beta-HSD deficiency

Case#12

- 45 y/o man with history of depression on tricyclic antidepressant, presented with intermittent episodes of headaches, sweating and palpitations. The best next step in management is:

A. Check plasma metanephrines
B. Check 24 hour urine catecholamines and metanephrines
C. Check TSH
D. Stop the tricyclic antidepressant and re-evaluate symptoms after 4-6 weeks.

Triad of pheochromocytoma. could be pseudopheochromocytoma. so according to me, exclude other effect before going the hyping.

Case#13

- 30 y/o female with history of resistant HTN, currently on spironolactone, lisinopril, nifedipine, and HCTZ. Which of the following medications has to be stopped before screening for hyperaldosteronism:

A. Lisinopril
B. HCTZ
C. Nifedipine
D. Spironolactone

Always check for medications
Stop for 4-6 weeks

There's always a Q on Incidentalomas

Case#14

- 40 y/o female was found to have a 3 cm left adrenal incidentaloma per CT abdomen done due to LLQ pain, she reports no recent weight gain, she has hx of mild HTN. All of the following biochemical tests are indicated as part of the biochemical work up except:

A. 24 hour urine catecholamines

B. Low dose DST

C. Serum aldosterone with plasma renin activity

D. ACTH stimulation

imp: u won't check for Aldo and renin activity if there is NO HTN and NO HTN medications this is sometimes tricky for exams

Case#15

- 55 y/o man with history of lung cancer, he was found bilateral large adrenal masses suggestive of metastasis per CT done due to complaints of abdominal pain. The best next step in management is:

A. CT guided biopsy of one of the adrenal masses.

B. 24 hour urine catecholamines

C. PET/CT

D. Palliative treatment

since Dx'd lung cancer, u need biopsy to know if metastatic or not

Pt's adrenal mass, never since a needle. Init evaluate it exclude pheochromocytoma bcz stimulate, u will have Adrenalin release → HTN crisis.
After ruling out, u do FNA.
PET won't help.
B