

Prevalence and Presentation of Thyrotoxicosis at Sialkot

Saleh Muhammad¹, Asif Javed², Mansoor Hassan¹ and M. Awais³

ABSTRACT

Objective: To assess the Prevalence and Presentation of Thyrotoxicosis at Sialkot.

Study Design: Prospective Study.

Place and Duration of Study: This study was conducted at the Idris Teaching Hospital (SMS) Sialkot and Allama Iqbal Memorial Teaching Hospital (KSMC) Sialkot from January 2014 to April 2017.

Materials and Methods: We included in this prospective study 100 newly diagnosed patients of. Patients were examined for their signs and symptoms as well as their clinical and family history of thyroid disorders. The blood samples of these patients were drawn and preserved at -80C. Patients were clinically diagnosed into hyperthyroidism by thyroid function test utilizing RIA. Patients having clinically visible enlarged swelling in front of neck were subjected to 99Tc Pertechnetate thyroid imaging. Patients in this study were of all ages and both genders. An informed consent was obtained from each individual participant. The data was recorded on designed performa. Initial screening included complete thyroid profile to identify thyrotoxicosis.

Results: In this study the prevalence of the patients of Thyrotoxicosis was higher (31 %) n=31 at the age group of 41-50 years as compared to other age groups. Maximum (90%) n=90 patients were females as compared to male (10%) n=10. The patients of Thyrotoxicosis from rural population were (68%) n=68 & (32%) n=32 from urban population. Loose stools were present in (49%) n=49, (7%) in male and (42%) in female, anxiety was present in (85%)n=85 patients (10%) in male & (75%) in female, hair loss was present in (35%) n=35 patients, (05%) male & (30%) in female. Menstrual irregularities was present in (45%) n=45 of the female, heat intolerance was present in (64%) n=64 of the patients (4%) in male & (60%) in female, periorbital edema was present in (24%) n=24 of the patients, (01%) in male and (23%) in female, hoarseness was present in (38%) n=38 of the patients, (03%) in male and (35%) in female, sweating was present in (68%) n=68 of the patients, (05%) male & (63%) in female, exophthalmos was present in (49%) n=49 of the patients, (06%) in male & (43%) in female, tremors were present in (74%) n=74 of the patients, (10%) in male & (64%) in female, shortness of breath was present in (70%) n=70 of the patients, (05%) in male & (65%) in female, increased appetite was present in (53%) of the patients, (06%) in male & (47%) in female, polyuria was present in (40%)n=40 of the patients, (04%) in male & (36%) in female, goiter was present in (75%) n=75 of the patients, (09%) of male & (66%) in female of the Thyrotoxicosis. The mean age was 40±13SD. The mean ±SD of BMI was 23.65±3.70, 19.66±3.78 in male & 25.67±4.70 in female, free T3 was 7.25±1.9nmol/l as total 7.3±1.8 nmol/l in male & 6.85±2.4 nmol/l in female, total TSH(uU/ml) was 0.63±0.17(uU/ml), 0.63±0.15(uU/ml) in male & 0.59±0.29(uU/ml) in female.

Conclusion: People awareness about the dietary iodine intake is necessary in our country to overcome the increased prevalence of the thyroidal dysfunction in our population. It is observed that hyperthyroid state is more common in our population.

Key Words: Thyrotoxicosis, RIA, Goiter, Prevalence.

Citation of articles: Muhammad S, Javed A, Hassan M, Awais M. Prevalence and Presentation of Thyrotoxicosis at Sialkot. Med Forum 2017;28(7):115-118.

INTRODUCTION

Changes in the hypothalamus-pituitary-thyroid axis (HPT) usually affects the whole body mechanisms by disturbing thyroid function¹.

¹. Department of Medicine, Sialkot Medical College, Sialkot.

². Department of Medicine M. Islam MC, Gujranwala.

³. Department of Medicine, Khawaja M. Safdar Medical College, Sialkot.

Correspondence: Prof Dr. Abdul Hamid, Sialkot Medical College, Daska Road Sialkot.

Contact No: 0323-9824782

Email: hrd.smcs@yahoo.com

Received: May 16, 2017;

Accepted: June 10, 2017

Thyroidal disease and diabetes mellitus are most common glandular disorders all around the world, irrespective of the gender and age². Most thyroid hormone derangements may vary from subclinical which is asymptomatic with abnormal TSH level and normal free T3 and T4 levels to clinically symptomatic with abnormal T3 and T4 levels³. Besides this, common thyroid dysfunctions include subclinical phases, goiter, iodine deficiency disorders, Hashimoto's thyroiditis, Graves disease and thyroid cancer. The thyroid disorders have been reported in over 110 countries of the world with 1.6 billion people at risk⁴.

Iodine is essential for producing T3 and T4^{6,7}. Iodine deficiency usually prevails over one third part of the world. The prevalence of goiter in areas of severe iodine deficiency can be up to 80%⁸. Iodine deficiency

is the basis of high prevalence of thyroid disorders in South Asian population as well⁹. In many cases mainly goiter is the sole reason for patient to screen for thyroid disorder by their physician. Prevalence as high as 12% and 23% of goiter has been reported in India in adults and children¹⁰ respectively. In Pakistan, the prevalence of hyperthyroidism is reported to be 5.1%. It is also perceived that the prevalence of both hyperthyroidism and hypothyroidism (subclinical or overt) is higher in females than males¹¹.

Hence, improved public awareness about thyroidal ailments is one of the important factor to cope with this disorder.

MATERIALS AND METHODS

This prospective study was conducted at the Idris Teaching Hospital Sialkot and Allama Iqbal Memorial Teaching Hospital Sialkot from January 2014 to April 2017. We included in this prospective study 100 newly

diagnosed patients of. Patients were examined for their signs and symptoms as well as their clinical and family history of thyroid disorders. The blood samples of these patients were drawn and preserved at -80C. Patients were clinically diagnosed into hyperthyroidism by thyroid function test utilizing RIA. Patients having clinically visible enlarged swelling in front of neck were subjected to ⁹⁹Tc Pertechnetate thyroid imaging. Patients in this study were of all ages and both genders. An informed consent was obtained from each individual participant. The data was recorded on designed performa. Initial screening included complete thyroid profile to identify thyrotoxicosis.

RESULTS

In our study the prevalence of the patients of Thyrotoxicosis was higher (31 %) n=31 at the age of 41-50 years as compared to other age groups as shown in table no. 01 .

Table No.1: Age & Sex Distribution in Patients of Thyrotoxicosis

Sr No	Age (Years)	No of Patients (%)	Male (%)	Female (%)
1	10-20	10	1 (1%)	9 (9%)
2	21-30	14	3 (3%)	11 (11%)
3	31-40	23	1 (1%)	22 (22%)
4	41-50	31	2 (2%)	29 (29%)
5	51-60	10	1 (1%)	9 (9%)
6	61-70	12	2 (2%)	10 (10%)
	Total	100 (100 %)	10 (10 %)	90 (90%)

Table No. 2: Area Distributions in Patients of Thyrotoxicosis

Sr No	Area	No of Patients	Male %	Female %
1	Urban	32 (32%)	3 (3%)	29 (29%)
2	Rural	68 (68%)	7 (7%)	61 (61%)
	Total	100 (100%)	10 (10%)	90 (90%)

Table No. 3: Distributions of Clinical Signs and Symptoms in Patients of Thyrotoxicosis

Sr No	Signs and Symptoms	Male %	Female %	Total %
1	Loose stools	7 (7%)	42 (42%)	49 (49%)
2	Anxiety	10 (10%)	75 (75%)	85 (85%)
3	Hair loss	5 (5%)	30 (30%)	35 (35%)
4	Menstrual irregularities	-	45 (45%)	45 (45%)
5	Heat intolerance	4 (4%)	60 (60%)	64 (64%)
6	Hoarseness	3 (3%)	35 (35%)	38 (38%)
7	Sweating	5 (5%)	63 (63%)	68 (68%)
8	Exophthalmos	6 (6%)	43 (43%)	49 (49%)
9	Tremors	10 (10%)	64 (64%)	74 (74%)
10	Increased Appetite	6 (6%)	47 (47%)	53 (53%)
11	Polyuria	4 (4%)	36 (36%)	40 (40%)
12	Goiter	9 (9%)	66 (66%)	75 (75%)

Table No. 4: Biochemical Parameters in patients of Thyrotoxicosis

Sr No	Biochemical Parameters	Male Mean±SD	Female Mean±SD	Total Mean±SD
1	BMI (kg/m ²)	19.66±3.78	25.67±4.70	23.65±3.70
2	FreeT3 (nmol/l)	7.3±1.8	6.85±2.4	7.25±1.9
3	FreeT4 (nmol/l)	202.0±19.2	199.1±23.6	201.7±19.5
4	TSH (uU/ml)	0.63±0.15	0.59±0.29	0.63±0.17

Prevalence was maximum (90%) n=90 females patients as compared to male (10%) n=10 as shown in table no .01. The patients of Thyrotoxicosis from rural area were (68%) n=68 & (32%) n=32 from urban population as shown in table no. 02. Loose stools were present in (49%) n=49, (7%) in male and (42%) in female, anxiety was present in (85%)n=85 patients (10%) in male & (75%) in female, hair loss was present in (35%) n=35 patients, (05%) male & (30%) in female. Menstrual irregularities was present in (45%) n=45 of the female, heat intolerance was present in (64%) n=64 of the patients (4%) in male & (60%) in female, periorbital edema was present in (24%) n=24 of the patients, (01%) in male and (23%) in female, hoarseness was present in (38%) n=38 of the patients, (03%) in male and (35%) in female, sweating was present in (68%) n=68 of the patients, (05%) male & (63%) in female, exophthalmos was present in (49%) n=49 of the patients, (06%) in male & (43%) in female, tremors were present in (74%) n=74 of the patients, (10%) in male & (64%) in female, shortness of breath was present in (70%) n=70 of the patients, (05%) in male & (65%) in female, increased appetite was present in (53%) of the patients, (06%) in male & (47%) in female, polyuria was present in (40%)n=40 of the patients, (04%) in male & (36%) in female, goiter was present in (75%) n=75 of the patients, (09%) of male & (66%) in female of the Thyrotoxicosis as shown in table no. 03. The mean age was 40 ± 13 SD. The mean $\pm$ SD of BMI was 23.65 ± 3.70 , 19.66 ± 3.78 in male & 25.67 ± 4.70 in female, free T3 was 7.25 ± 1.9 nmol/l as total 7.3 ± 1.8 nmol/l in male & 6.85 ± 2.4 nmol/l in female, total TSH(uU/ml) was 0.63 ± 0.17 (uU/ml), 0.63 ± 0.15 (uU/ml) in male & 0.59 ± 0.29 (uU/ml) in female as shown in table no. 04.

DISCUSSION

Thyroid hormone is necessary for normal growth, development, metabolic regulation neuronal differentiation, in mammals and are required for metamorphosis in amphibians¹². These actions are most apparent in conditions of thyroid hormone deficiency leading to hypothyroidism, or hyperthyroidism a condition arise due to excess of thyroid hormone production¹³. Thyroidal events are usually the result of different contributing factors like geographical distribution, food habits, dietary iodine consumption and genetic predisposition¹⁴.

The present study was aimed to determine the pathophysiological manifestations and prevalence Thyrotoxicosis in Sialkot. In our study, among 100 Thyrotoxicosis patients, 90% were females and 10% were males, which showed that females are more prone to have Thyrotoxicosis. Thyrotoxicosis is reported to be more common in women (2% to 5%) with female to male ratio up to 5:1 between the ages of 20-40¹⁵. However, in our study this investigation female to male

ratio is 9:1, there is increased prevalence of Thyrotoxicosis state especially in females. In our study peak age for Thyrotoxicosis is 31-40 years. Many studies have also reported the increase in the prevalence of thyroid disorders in middle age. High prevalence of hyperthyroidism in Pakistani population is reported by several studies. Being an iodine deficient region the increased prevalence of hyperthyroidism might be due to autoimmune disorder or due to inconsiderate use of iodized salt in the diet due to which thyroid gland becomes hyper functional leading to the state of hyperthyroidism¹⁶.

Most thyroid dysfunctions are autoimmune in nature; Graves's diseases accounts for the thyrotoxicosis and Hashimoto's thyroiditis for hypothyroidism. Goiter is one of the leading outcomes of the altered thyroid biology. In our data Thyrotoxicosis, 90% female and 10% male. The occurrence of goiter and thyroid disease is determined by complex interplay among gender, environmental and genetic factors, and the major environmental factor that determines the goiter dominance is iodine intake status. In addition to this, higher prevalence of goiter among female is attributed to proliferative effect of estrogen on thyrocytes in the thyroid gland¹⁷.

In our investigation, common symptoms observed in thyrotoxicosis state were heat intolerance (64%), anxiety (85%), menstrual irregularities (45%), and hoarseness (38%).

Clinically profound symptoms of the hyperthyroidism are weight loss, increased hunger, weakness, and tremors of hands, elevated heartbeat, goiter, loose stools, anxiety, exophthalmos, increased sweating, and heat intolerance¹⁸. In this study, clinical symptoms of thyrotoxicosis were loose stools (49%), and heat intolerance (64%), tremors (74%), sweating (68%), anxiety (85%) and increased appetite (53%).

CONCLUSION

People awareness about the dietary iodine intake is necessary in our country to overcome the increased prevalence of the thyroidal dysfunction in our population. It is observed that hyperthyroid state is more common in our population.

Author's Contribution:

Concept & Design of Study:	Saleh Muhammad
Drafting:	Asif Javed, M. Awais
Data Analysis:	Asif Javed, M. Awais
Revisiting Critically:	Mansoor Hassan
Final Approval of version:	Saleh Muhammad

Conflict of Interest: The study has no conflict of interest to declare by any author.

REFERENCES

1. O'keefe LM, Conway SE, Czap A, Malchoff CD, Benashski S, Staff I, et al, Thyroid hormones and functional outcomes after ischemic stroke, *Thyroid Res* 2015;8:9.
2. Zoofishan B, Kabir A, Amir S, Faryal R. Relationship of symptoms with demographic features in case of thyroid disorders in Pakistani population. *Asian J Biomedical Pharmaceutical Sci* 2012;2(12):37-40.
3. Hage M, Zantout MS, Azar ST. Thyroid Disorders and Diabetes Mellitus. *J Thyroid Res* 2011;1-7.
4. Krishnamoorthy S, Narain R, Creamer J. Unusual presentation of thyrotoxicosis as a complete heart block and renal failure: A Case Report. *J Med Case Report* 2009;3:9303.
5. Yadav NK, Thanpari C, Shrewastwa MK, Sathian B, Mittal RK. Socio demographic wise risk assessment of thyroid function abnormalities in far western region of Nepal: A hospital based descriptive study. *Asian Pac J Trop Dis* 2013; 3(2):150-154.
6. Lamfon HA. Thyroid Disorders in Makkah, Saudi Arabia. *Ozean J Appl Sc* 2008;1(1):52-58.
7. Khan A, Khan MM, Akhtar S. Thyroid disorders, etiology and prevalence. *Pak J Med Sci* 2002;2: 89-94.
8. Zimmerman MB. Iodine deficiency. *Endocr Rev* 2009;30:376-408.
9. Reza S, Shaukat A, Arain TM, Riaz QS, Mahmud M. Expression of Osteopontin in Patients with Thyroid Dysfunction. *PLoS ONE* 2013;8(2)1-7.
10. Bielecka-Dabrow A, Mikhailidis DP, Rysz J, Banach M. The Mechanism of Atrial Fibrillation in Hyperthyroidism. *Thyroid Research* 2009;2:4.
11. Doeker B, Reinehr T, Andler W. Autoimmune thyroiditis in the children and adolescents: clinical and laboratory findings in 34 patients. *Klin Padiatrie* 2000;212(3):103-107.
12. Cheng SY, Leonard JL, Davis PJ. Molecular aspects of thyroid hormone actions. *Endocr Rev* 2010;31(2):139-170.
13. Williams GR. Neurodevelopmental and neuro-physiological actions of thyroid hormone. *J Neuro-endocrinol* 2008;20(6):784-794.
14. Tata JR. The road to nuclear receptors of thy-roid hormone. [published online ahead of print March 17, 2012]. *Biochim Biophys Acta* doi:10.1016/j.bbagen.2012.02.017. Furlow JD. Neff ES. A developmental switch induced by thyroid hormone: *Xenopus laevis* metamorphosis. *Trends Endocrinol Metab* 2006;17 (2):40-47.
15. Bahn RS, Burch HB, Cooper DS, Garber JR, Greenlee MC, Klein I, et al. Hyperthyroidism and Other Causes of Thyrotoxicosis: Management Guidelines of the American Thyroid Association and American Association of Clinical Endocrinologists. *Thyroid* 2011;21(6):593-646.
16. Aryal M, Gyawali P, Rajbhandari N, Aryal P, Pandeya DR. A prevalence of thyroid dysfunction in Kathmandu University Hospital, Nepal," *Biomedical Res* 2010;21(4):411-415.
17. Rasheed H, Elahi S, Syed Z, Rizvi NB. Trend of thyroid dysfunction associated with visible goiter. *J Sci Res* 2009;XXXIX(2):42-47.
18. Knudsen N, Bulow I, Laurberg P, Ovesen L, Perrild H, Jorgensen T. Low socio-economic status and familial occurrence of goitre are associated with a high prevalence of goiter. *Eur J Epidemiol* 2003;18(2):175-181.