

# Jury Out on Routine Thyroid Disease Screening

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WASHINGTON — Thyroid disease screening has not yet been proved useful in the general population, but the issue of early detection of thyroid dysfunction deserves further exploration, Dr. Paul Ladenson explained at a meeting jointly sponsored by the American Thyroid Association and Johns Hopkins University.

Dr. Ladenson, director of the division of endocrinology and metabolism at Johns Hopkins University, Baltimore, said that in general, screening programs should be for diseases:

- ▶ With significant prevalence.
- ▶ With significant clinical consequence.
- ▶ For which clinical diagnosis often is inaccurate.
- ▶ For which delayed diagnosis and treatment have consequences that could be avoided by earlier diagnosis.

▶ For which there is an accurate, safe, and inexpensive diagnostic test.

▶ For which there is a safe, effective, inexpensive therapy.

At first glance, mild thyroid dysfunction—particularly mild thyrotoxicosis and mild hypothyroidism—would easily meet many of these criteria, Dr. Ladenson said. “These are disorders with highly significant prevalences, particularly subclinical hypothyroidism.”

In addition, data such as that from the

Colorado Thyroid Disease Prevalence Study show that clinical diagnosis of these disorders lacks in specificity and sensitivity, “and certainly measurement of TSH and thyroxine therapy easily fulfill the final two criteria” of an accurate, safe, and inexpensive diagnostic test and having an effective, safe, and inexpensive therapy.

And thyroid testing has another thing going for it: It is relatively cheap in terms of cost effectiveness, according to Dr. Ladenson.

For example, studies have found that the cost of screening all women 35 years and older for thyroid dysfunction was \$9,000 per each year of restoration to perfect health and life expectancy, which is inexpensive, compared with other interventions.

But Dr. Ladenson asked, “Are these disorders that have significant clinical consequences, and does it matter if we wait to

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diagnose and treat them [or] if we wait until patients come to us with complaints that might well be reversible?”

Various groups have tried to address the issue.

The American Thyroid Association looked at the issue in 2000 and determined that adults should

be screened every 5 years beginning at age 35; those with symptoms and signs of a possible thyroid problem should be screened more frequently (Arch. Int. Med. 2000;160:1573-5). Dr. Ladenson, who said the conclusions were “aggressive in retrospect,” was the lead author of the guideline.

In 2003, a 13-member joint task force named by the American Thyroid Association, the Endocrine Society, and the American Association of Clinical Endocrinologists performed a structured literature review of 195 articles on thyroid disease screening; the group also attended a symposium on the topic with 12 expert presenters.

In its report, the task force concluded that there was insufficient evidence to support population-based thyroid disease screening, although they conceded that “aggressive case-finding” was recommended for pregnant women, women over 60 years, and others at high risk of thyroid dysfunction (JAMA 2004;291:228-38).

Just a month later, the U.S. Preventive Services Task Force published its recommendations on the issue—again using a literature review and deliberation by a panel of experts—and concluded that the evidence was insufficient to recommend for or against routine screening (Ann. Int. Med. 2004;140:125-7).

## A D V E R T I S E M E N T

### Millions of American men suffer from symptomatic BPH.<sup>1-3</sup> And many remain undiagnosed.

Benign prostatic hyperplasia (BPH), also known as an enlarged prostate, can lead to restricted urine flow. Of the 20 million American men who have symptomatic BPH, only 5 million have been diagnosed.

Symptoms of BPH include:

- Frequent urination during the day and night
- Difficulty starting urination
- A weak and/or interrupted urine stream
- Inability to completely empty the bladder

While in most men these symptoms are caused by BPH, it is important to rule out prostate cancer as part of the diagnostic process.

#### Who is at risk for BPH?

Men over the age of 40 are primarily at risk for BPH.<sup>4</sup>

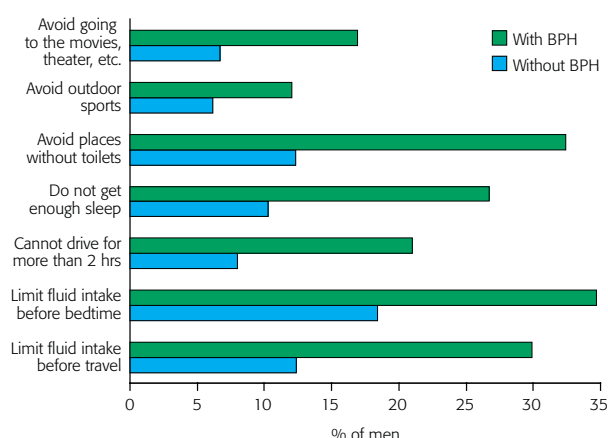
Age	% exhibiting symptoms of BPH
40 to 50	27
51 to 60	50
61 to 70	69
71 to 80	79

Unfortunately, the vast majority of men with BPH suffer in silence, often due to their embarrassment broaching the subject with their physicians or because they assume it is simply part of aging and that nothing can be done about it.

#### BPH can have a major impact on their lifestyle

Men with symptomatic BPH report disruptions in their lifestyle. BPH can create anxiety, interfere with routine activities and leisure pursuits, limit sexual activity, and cause sleep deprivation.<sup>5</sup>

#### % of men whose daily living was affected at least some of the time\*



BPH can also have an impact on the partners of men with BPH. One survey found that 86% of partners experience a lifestyle disruption. Forty-one percent were regularly awakened by their husbands' frequent urination at night.<sup>6</sup>

The symptoms caused by BPH can be managed. But first, the patient must overcome his reluctance to discuss the topic with his physician.

**By using probing questions like the ones below, physicians can initiate a successful conversation about BPH<sup>3,7</sup>**

- Do you get up several times at night to urinate?
- Do you find it difficult to hold off urination?
- Do you have difficulty starting urination?

Once BPH has been diagnosed, the physician can then determine the best course of treatment.

#### Treatment options

Standard treatment options for BPH include watchful waiting, medical therapy with alpha blockers and/or 5-ARI inhibitors, and various surgical procedures. Treatment is typically driven by both the severity of symptoms and patient perception of lifestyle disruptions.

#### References:

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