Communications

Subacute Thyroiditis in a Primary Care Clinic

Dan L. Tritch, MD, and Joseph C. Muhler, MD
Fort Wayne, Indiana

The past two decades have witnessed increased attention in the medical literature to the entity described as subacute thyroiditis.[1] Subacute thyroiditis is a distinct disease of the thyroid gland that appears to be viral in origin and often follows upper respiratory tract infections. It is unrelated to other forms of thyroiditis. Previously considered to be an uncommon thyroid disease, subacute thyroiditis is now increasingly recognized as a relatively frequent affliction of the thyroid gland. Recognition of this entity has been hampered by erroneous notions regarding its prevalence, misdiagnosis (mistaking it for pharyngitis or cervical lymphadenitis), and unavailability or underutilization of ^{131}I uptake studies. The majority of widely quoted studies on the prevalence of this disorder come from thyroid clinics or other tertiary care centers where few cases are seen because the condition is usually self-limited and benign.

This paper presents a five-year experience in a primary care setting in recognizing subacute thyroiditis.

Methods

The study took place during the years 1975 through 1980 in a family practice outpatient facility in the Midwest. During this time 25,000 patient contacts occurred, with 4,200 new patient visits. Case finding was enhanced by careful evaluation of patients with complaints of neck, ear, or throat pain, particularly those individuals with protracted symptoms or symptoms refractory to previous antibiotic therapy.

Diagnostic studies in patients with thyroid pain and protracted symptoms included measurement of free triiodothyronine (T_3) by radioimmunoassay (RIA), free thyroxin (T_4) by RIA, ^{131}I uptake, and thyroid imaging and sedimentation rate. Thyroid autoantibodies (generally absent or transiently present in subacute thyroiditis) were not routinely measured. For the purpose of this study, suppression of ^{131}I uptake to less than 7 percent in 24 hours in the absence of previous administration of exogenous thyroid hormones or iodine, in addition to diffuse or localized diminution of imaging on scan, was taken as indicative of subacute thyroiditis. Patients were treated with salicylates or corticosteroids according to the severity of symptomatology.

Results

Thirty-three patients (19 female, 14 male) were recognized by these clinical and laboratory criteria. Their characteristics correspond to the slight preponderance of women and middle-age range reported in other studies.[2] Some of the major findings in these patients are presented in Table 1. Laboratory testing consistently demonstrated marked suppression of ^{131}I uptake with normal or modestly hyperactive thyroid function. During the period of this study, nine cases of lymphocytic (Hashimoto's) thyroiditis and 22 cases of Graves' disease were recognized. No viral epidemics were noted during this time in the community, and the

From the Department of Family Practice, Indiana University, Fort Wayne, Indiana. Requests for reprints should be addressed to Dr. Dan L. Tritch, 3601 Brooklyn Avenue, Fort Wayne, IN 46809.

0094-3509/82/050989-02$00.50

Table 1. Findings in 33 Cases of Subacute Thyroiditis

Symptom	Number
Pharyngeal pain	28
Thyroid tenderness	26
Unexplained fatigue	24
Neck pain	21
Refractory to antibiotic therapy	12
Ear pain	11

clinic was not located in an area endemic for thyroid disease.

Comment

Woolner[3] reported in 1957 a review of surgical specimens typical of subacute thyroiditis collected at the Mayo Clinic over 27 years, as well as cases diagnosed clinically over a five-year period. A total of 108 cases of subacute thyroiditis were found over the 27-year surgical experience review. During the years 1952 through 1956, 125 clinical diagnoses of subacute thyroiditis were recorded. During the same five-year period, 1,250 patients were seen with Graves' disease. McWhinney[4] collected 10 cases of subacute thyroiditis in his general practice from 1954 to 1963 and encountered only one instance of autoimmune thyroiditis. In 1956 Detweiler[2] reported 38 cases of subacute thyroiditis among 2,000 patients.

The incidence of subacute thyroiditis reported in the present study reflects the frequency of subacute thyroiditis in relation to other thyroid diseases and suggests that subacute thyroiditis is, in fact, among the more common of thyroid disorders. Underrecognition or misdiagnosis of subacute thyroiditis has undoubtedly contributed to the low incidence figures reported elsewhere.[5] The similar experience of Detweiler further suggests that most cases of subacute thyroiditis are either treated at the primary care level or resolve spontaneously and are consequently underrepresented in the case materials of secondary and tertiary care centers. Appreciation by primary care physicians of the frequency of subacute thyroiditis should enhance appropriate diagnostic efforts and therapy.

References

1. Volpe R: Subacute or DeQuervain's thyroiditis. Clin Endocrinol Metab 6:81, 1979
2. Detweiler JA: Thyroiditis: Private practice compared with community hospital and university hospital. JAMA 192:1098, 1965
3. Woolner LB, McConahey W, Beahrs OH: Granulomatous thyroiditis. J Clin Endocrinol 17:1202, 1957
4. McWhinney IR: Incidence of DeQuervain's thyroiditis: Ten cases from one general practice. Br Med J 1:1225, 1964
5. Greene JW: Subacute thyroiditis. Am J Med 51:97, 1971

Evaluation of the Patient-Centered Pelvic Examination

Ronald J. Feldmann, MD, and Charles E. Driscoll, MD
Iowa City, Iowa

The pelvic examination is a common office procedure in family practice that may be perceived by the patient as an unpleasant, uninteresting, and anxiety-provoking experience. A perceived negative attitude by women toward the pelvic examination, along with women demanding more basic information concerning their bodies today, has aroused the interest and concern of many health care professionals.

This communication presents the results of a

From the Department of Family Practice, College of Medicine, University of Iowa, Iowa City, Iowa. Requests for reprints should be addressed to Dr. Charles Driscoll, Department of Family Practice, College of Medicine, University of Iowa, Iowa City, IA 52242.

Continued on page 992

0094-3509/82/050990-03$00.75