

subclinical. All patients with

toxicity can be overt or

TFTs, recognising that the Confirm the diagnosis with

symptomatic toxicity should be

**Nuclear Thyroid Scan TSH Receptor Abs** Other Bloods Ultrasound

and TSH receptor antibodies

(TRAb) are used to determine Nuclear medicine thyroid scar

Nodule Ax (overleaf)

- Thyrotoxicosis Common Causes of
- Toxic MNG Graves' disease

w

Any nodule detected in a

12

thyrotoxicosis needs to be patient presenting with

assessed as per usual.

about the gland.

morphological information treatment.. US gives useful preparation for further blood tests (esp FBE, LFT) in toxicity. It is useful to add other the underlying cause of the

- loxic adenoma
- Early Thyroiditis
- Exogenous
- For Surgical Mx:

For Medical Mx:

compressive symptoms disease without o First-line for Graves

0000

Failed medical tx Toxic MNG

Thyroiditis

desired / urgency Pregnant or pregnancy Compressive symptoms

Malignancy not ruled

Patient preference

antithyroid drugs or Contraindication for

Thyroid eye disease

Small toxic adenoma

- Poor surgical candidate

- V Carbimazole / PTU

Medical Options:

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decisions for patient care should be made on a case-by-case basis. The contents of this chart is for educational purposes only,

- Radioactive Iodine (RAI)

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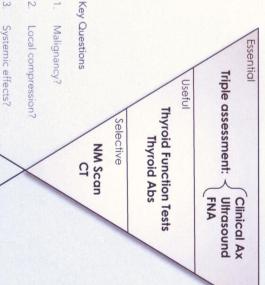


subjected to the same assessment initially detected, it needs to be

Regardless of how the nodule is

A multinodular goitre (MNG) has the





same as a benign FNA result.

TFTs and thyroid antibodies are not

A non-diagnostic FNA is not the

microcalcifications, internal

vascularity, etc.

include hypoechogenicity, irregular

Suspicious ultrasonic features

margins, disruption of tissue plains

history and exposure to external

effects, systemic effects, family

Clinical assessment includes local

as a normal thyroid gland. same risk of harbouring malignancy

irradiation.

Other blood tests to consider include Ca<sup>++</sup>, PTH, FBE, CUE, LFT

information.

nodules, but they provide useful essential in the work-up of thyroid

## For observation if:

- No suspicions on clinical Benign FNA
- ax or imaging
- Asymptomatic
- Euthyroid

### For further mx if:

surrounding structures is suspected

retrosternal or invasion of

indicated if the TSH is suppressed

Nuclear medicine scan is only

CT scan is indicated if the goitre is

- 0000 Malignancy not ruled out Obstructive symptoms
  - Thyrotoxicity
- Retrosternal goitre
- Patient request Unusual pathology
- 00 Uncertain diagnosis

#### Surveillance:

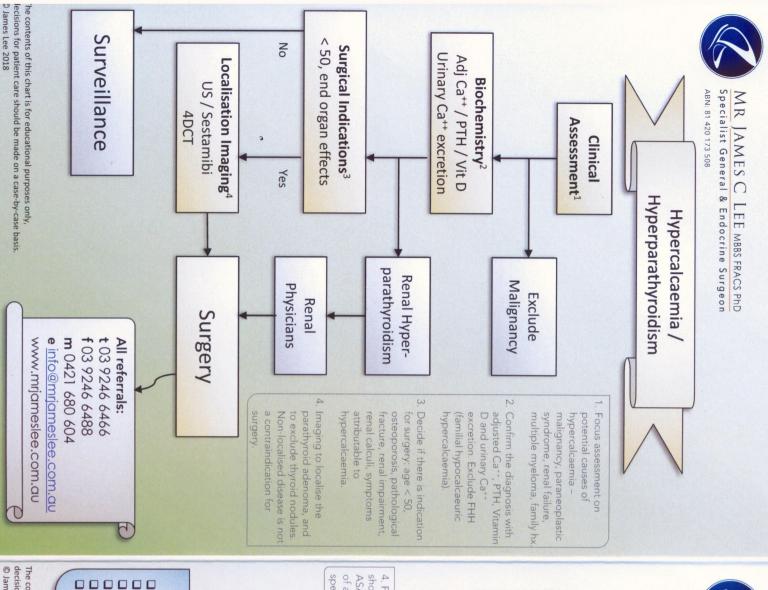
- for 3 5 years Yearly clinical ax & US
- Repeat work-up if symptoms change

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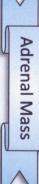
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1. Looking for history of

neoplasia syndrome multiple endocrine in the patient or



There are many

ones I routinely start tests. These are the different screening

Clinical Ax1

3. AKA Primary

### Functional Screening Tests<sup>2</sup>: Hyperaldosteronism

24-hr urinary cortisol excretion (Cushing Syndrome) or Plasma Metanephrines (Phaeochromocytoma) 24-hr urinary Catecholamines & Metanephrines Aldosterone: Renin Ratio (Conn's Syndrome<sup>3</sup>) DHEAS (Sex hormones)

Malignant features **Hounsfield Units** 

Washout %

**CT Features** 



# Indications for Surgery:

@ 12 mths

Then 1 yr

- **Functional lesions**
- Evidence of growth Solitary metastasis Malignancy suspected
- Pressure effect

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been ruled out

phaeochromocytoma has diagnosis, and a metastasis is the most likely is considered is when a biopsy of an adrenal lesion

e info@mrjameslee.com.au m 0421 680 604

www.mrjameslee.com.au