Thyroid Masterclass	
Question	**Answer**
Middle aged woman, Multinodular goitre on USS (TiRADS 3), TFT normal, Thyroid antibodies -ve, On weekly GLP1a for weight loss 1. Management guidelines for MNG 2. Is it safe to continue with GLP1a	Management of nodules depends on size. There are FNA guidelines depending on TIRADS and size, we will go through this in the slides but they are available often at the end of the radiology report. I would be happy from my perspective that she continues on GLP1a
Middle aged woman, Multinodular goitre on USS (TiRADS 3), TFT normal, Thyroid antibodies -ve, On weekly GLP1a for weight loss 1. Management guidelines for MNG 2. Is it safe to continue with GLP1a	GLP1 agonist not known to increase risk of thyroid cancer and I would be happy for this woman to continue it for weight loss. I would use it cautiously in someone with a history of medullary thyroid cancer or MEN2 due to animal studies that show possible C-cell stimulation and increased theoretical MTC risk.
When iodine supplements are indicated for thyroid disease ?	I would recommend iodine supplements in women who are planning for pregnancy and breast feeding who are not hyperthyroid. I would not routinely recommend it for people with thyroid disease.
Middle age women, positive thyroid antibodies for some time however TSH WNL Is symptomatic of hypothyroidism. What further investigations are needed?	TSH is a very sensitive marker of thyroid function. If it is normal, the patient is euthyroid. The presence of thyroid antibodies do indicate that they have increased risk of developing overt hypothyroidism in their lifetime so I would recommend annual TFTs for this woman. Symptoms of hypothyroidism can be general so would look for other causes other than the thyroid.
Hi, thanks very much for the session. I didn't see postpartum thyroiditis on the intro list so my apologies if this outside of the scope of the talk! Would you recommend considering an uptake scan for a woman with sweats and fatigue 3mo post partum found to have suppressed TSH and elevated T3/T4 on initial bloods, normal examination no palpable thyroid nodules and no tenderness, with negative TRAb?	Dr Annabel Jones may cover this and if she doesn't I can discuss it at the end. Is the patient breastfeeding?
What is cold nodule vs hot nodule ? Management options for cold nodule vs hot nodule?	This is the uptake on the thyroid nuclear med scan. In the past, prior to ultrasound, they used to use this to work out if a nodule is worrisome for cancer (if cold). If the nodule is hot (ie enhances on the thyroid) it suggests that it is a toxic adenoma (over functioning nodule causing thyrotoxicosis) and the likelihood of this being a cancer is very low
Thanks I-Lynn, yes she is breastfeeding. I also performed TPOAbs at the same time which were positive (which perhaps I now regret as I have confused myself!). Current bloods after 6wks of propranolol/monitoring sx show TSH recovering slightly and near normal T3/T4 now	IF she is breast feeding, then hesitant to do uptake scan which will help to differentiate thyroiditis vs Graves. TPOAb is often positive in this setting even in Graves' and thyroiditis. She likely has post partum thyroiditis and you have done the right thing with just treating symptoms. She may go into hypothyroid phase before normalising T3/T4, 90%

	will normalise so sit tight if they go into the hypothyroid phase.
Thank you so much!!	
Once we cease thionamide, how often to check TFT	I would do it every 3 months for one year and then extend to annual TFTs or when symptomatic.
Where can I gain access to nuclear scan for thyroid nodules in NWH catchment area, both public and private ?	Many private radiology companies will offer a nuclear service. Capital radiology does nuclear scans at the Sunshine Private Hospital. FMIG offers this in St Albans. Lumus Imaging offers it at Werribee Mercy Hospital. Public hospital will be at Sunshine Hospital, Footscray Hospital.
Can you talk a bit on patients with previous thyroid cancer and total thyroidectomy, how GPs should monitor their thyroxine replacement as in some cases they need to be kept hyperthyroid?	TSH is a growth factor for thyroid cancer, so keeping the TSH low can reduce the risk of recurrence but keeping a patient hyperthyroid can decrease quality of life, poor sleep and anxiety and cause osteoporosis.
Can you talk a bit on patients with previous thyroid cancer and total thyroidectomy, how GPs should monitor their thyroxine replacement as in some cases they need to be kept hyperthyroid?	Essentially we only need to suppress high risk thyroid cancers, for moderate risk thyroid cancer and low risk thyroid cancers a TSH around 1 is ok.
Can you talk a bit on patients with previous thyroid cancer and total thyroidectomy, how GPs should monitor their thyroxine replacement as in some cases they need to be kept hyperthyroid?	For high risk thyroid cancer we aim for TSH of 0.1
I understand the block and replace approach for Grave's/ hyperthyroidism is out of favour, but is there still any situation we need to consider this? In case we see any patients on this regimen, should we consider switching back to the titration approach?	Block and replace has definitely fallen out of practice and we would never do it. I have weaned them both just to see what the thyroid is doing before deciding whether they need blocking or replacing. And if they are still hyperthyroid, then definitive treatment should be considered.
I have a 64 year old female patient with TSH 0.4 persistently over the last 6months. T4 low normal range (11-12). History of paroxysmal AF, had ablation. Symptoms of PAF and anxiety pre date change in thyroid function tests. TSH last in normal in October 2025. No features on examination. Should she be having a thyroid USS or nuclear scan? Or just monitor?	With such a mild suppression of TSH, you could just monitor with repeat TFTs in 3-4 months. If TSH continues to go down with normal FT4 and FT3, and their age is >65, I would Ix with a BMD (subclinical hyperthyroidism untreated could accelerate bone loss. I would be more inclined to treat subclinical hyperthyroidism with they have low BMD or history of AF
TRAb is negative	order t3 and tc uptake scan
Thank you all so much - fantastic! Could I please clarify with postpartum thyroiditis in the hypothyroid phase and treating with thyroxine, do you suggest treating for a certain time before trialling withdrawal of thyroxine and testing TSH after 6wks to see if resolved? And if not resolving and presence of TPO Abs - when would I call it Hashimotos?	If they are very symptomatic in hypothyroid phase, you can treat with thyroxine if their TSH is very high >30. Otherwise recheck it in 2 weeks to see that the TSH is improving for which it will in 90% of patients with thyroiditis. If they are symptomatic and very biochemically hypothyroid, you can trial a small dose of thyroxine 50-75mcg to tie them through.
Thank you all so much - fantastic! Could I please clarify with postpartum thyroiditis in the	Post partum thyroiditis often resolves in 90% of cases. In the hypothyroid phase, which can last 3-

hypothyroid phase and treating with thyroxine, do you suggest treating for a certain time before trialling withdrawal of thyroxine and testing TSH after 6wks to see if resolved? And if not resolving and presence of TPO Abs - when would I call it Hashimotos?	4 months, you can give them a low dose thyroxine 50-75 mcg if they are very symptomatic. Otherwise you can monitor every 4 weeks to see that TSH is recovering. If they have TPO Ab. Hashimoto's thyroiditis is the presence of thyroid peroxidase and/or thyroglobulin antibodies, causing lymphocytic inflammation. On ultrasound, the thyroid has a diffuse inflammatory pattern.
when radiol reports retrosternal growth and asymptomatic, test done for another organ… do we refer all of these patients?	Retrosternal goitres/nodules are hard to monitor so worth referral to consider thyroidectomy.