

Hyperthyroidism

Symptoms Causes Diagnosis Treatment

What is hyperthyroidism?

The term *hyperthyroidism* refers to any condition in which there is too much thyroid hormone in the body. In other words, the thyroid gland is overactive.

What are the symptoms of hyperthyroidism?

Thyroid hormone generally controls the pace of all of the processes in the body. This pace is called your *metabolism*. If there is too much thyroid hormone, every function of the body tends to speed up. It is not surprising then that some of the symptoms of hyperthyroidism are nervousness, irritability, increased perspiration, heart racing, hand tremors, anxiety, difficulty sleeping, thinning of your skin, fine brittle hair, and muscular weakness—especially in the upper arms and thighs. You may have more frequent

bowel movements, but diarrhea is uncommon. You may lose weight despite a good appetite and, for women, menstrual flow may lighten and menstrual periods may occur less often.

Hyperthyroidism usually begins slowly. At first, the symptoms may be mistaken for simple nervousness due to stress. If you have been trying to lose weight by dieting, you may be pleased with your success until the hyperthyroidism, which has quickened the weight loss, causes other problems.

In Graves' disease, which is the most common form of hyperthyroidism, the eyes may look enlarged because the upper lids are elevated. Sometimes, one or both eyes may bulge. Some patients have swelling of the front of the neck from an enlarged thyroid gland (a goiter).

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What causes hyperthyroidism?



The most common cause (in more than 70% of people) is overproduction of thyroid hormone by the entire thyroid gland. This condition is also known as Graves' disease (see the [Graves' Disease brochure](#) for details). Graves' disease is caused by antibodies in the blood that stimulate the thyroid to grow and secrete too much thyroid hormone. This type of hyperthyroidism tends to run in families, and it occurs more often in young women. Little is known about why specific individuals get this disease. Another type of hyperthyroidism is characterized by one or more nodules or lumps in the thyroid that may gradually grow and increase their activity so that the total output of thyroid hormone into the blood is greater than normal. This condition is known as *toxic nodular* or *multinodular goiter*. Also, people may temporarily have symptoms of hyperthyroidism if they have a condition called *thyroiditis*. This condition is caused by a problem with the immune system or a viral infection that causes the gland to leak thyroid hormone. It can also be caused by taking too much thyroid hormone in tablet form.

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How is hyperthyroidism diagnosed?

If your physician suspects that you have hyperthyroidism, diagnosis is usually a simple matter. A physical examination usually detects an enlarged thyroid gland and a rapid pulse. The physician will also look for moist, smooth skin and a tremor of your fingertips. Your reflexes are likely to be fast, and your eyes may have some abnormalities if you have Graves' disease.

The diagnosis of hyperthyroidism will be confirmed by laboratory tests that measure the amount of thyroid hormones— thyroxine (T₄) and triiodothyronine (T₃)—and thyroid-stimulating hormone (TSH) in your blood. A high level of thyroid hormone in the blood plus a low level of TSH is common with an overactive thyroid gland. If blood tests show that your thyroid is overactive, your doctor may want to obtain a picture of your thyroid (a *thyroid scan*). The scan will find out if your entire thyroid gland is overactive or whether you have a toxic nodular goiter or thyroiditis (thyroid inflammation). A test that measures the ability of the gland to collect iodine may be done at the same time.



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How is hyperthyroidism treated?



No single treatment is best for all patients with hyperthyroidism. Your doctor's choice of treatment will be influenced by your age, the type of hyperthyroidism that you have, the severity of your hyperthyroidism, and other medical conditions that may be affecting your health. It may be a good idea to consult with a physician who is experienced in the treatment of hyperthyroid patients. If you are unconvinced or unclear about any thyroid treatment plan, a second opinion is a good idea.

Antithyroid drugs

Drugs known as *antithyroid agents*—methimazole (Tapazole®) or propylthiouracil (PTU)—may be prescribed if your doctor chooses to treat the hyperthyroidism by blocking the thyroid gland's ability to make new thyroid hormone. These drugs work well to control the overactive thyroid, bring prompt control of hyperthyroidism, and do not cause permanent damage to the thyroid gland. In about 20% to 30% of patients with Graves' disease, treatment with antithyroid drugs for a period of 12 to 18 months will result in prolonged remission of the disease. For patients with toxic nodular or multinodular goiter,

antithyroid drugs are used in preparation for either radioiodine treatment or surgery.

Antithyroid drugs cause allergic reactions in about 5% of patients who take them. Common minor reactions are red skin rashes, hives, and occasionally fever and joint pains. A rarer (occurring in 1 of 500 patients), but more serious side effect is a decrease in the number of white blood cells. Such a decrease can lower your resistance to infection. Very rarely, these white blood cells disappear completely, producing a condition known as *agranulocytosis*, a potentially fatal problem if a serious infection occurs. If you are taking one of these drugs and get an infection such as a fever or sore throat, you should stop the drug immediately and have a white blood cell count that day. Even if the drug has lowered your white blood cell count, the count will return to normal if the drug is stopped immediately. But if you continue to take one of these drugs in spite of a low white blood cell count, there is a risk of a more serious, even life-threatening infection. Liver damage is another very rare side effect. You should stop the drug and call your doctor if you develop yellow eyes, dark urine, severe fatigue, or abdominal pain.

Radioactive iodine

Another way to treat hyperthyroidism is to damage or destroy the thyroid cells that make thyroid hormone. Because these cells need iodine to make thyroid hormone, they will take up any form of iodine in your blood stream, whether it is radioactive or not. The radioactive iodine used in this treatment is administered by mouth, usually in a small capsule that is taken just once. Once swallowed, the radioiodine gets into your blood stream and quickly is taken up by the overactive thyroid cells. The radioiodine that is not taken up by the thyroid cells disappears from the body within days. It is either eliminated in the urine or transformed by radioactive decay into a nonradioactive state. Over a period of several weeks to several months (during which time drug treatment may be used to control hyperthyroid symptoms), radioactive iodine damages the cells that have taken it up. The result is that the thyroid or thyroid nodules shrink in size, and the level of thyroid hormone in the blood returns to normal. Sometimes patients will remain hyperthyroid, but usually to a lesser degree than before. For them, a second radioiodine treatment can be given if needed. More often, *hypothyroidism* (an

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underactive thyroid) occurs after a few months. In fact, most patients treated with radioactive iodine will become hypothyroid after a period of several months to many years. Hypothyroidism can easily be treated with a thyroid hormone supplement taken once a day (see the [Hypothyroidism brochure](#)).

Radioactive iodine has been used to treat patients for hyperthyroidism for over 60 years. Because of concern that the radioactive iodine might somehow damage other cells in the body, produce cancer, or have other long-term unwanted effects such as infertility or birth defects, the physicians who first used radioiodine treatments were careful to treat only adults and to observe them carefully for the rest of their lives. Fortunately, no complications from radioiodine treatment have become apparent over many decades of careful follow-up of patients. As a result, in the United States more than 70% of adults who develop hyperthyroidism are treated with radioactive iodine. More and more children are also being treated with radioiodine.

Surgery

Your hyperthyroidism can be permanently cured by surgical removal of most of your thyroid gland. This procedure is best

performed by a surgeon who has much experience in thyroid surgery. An operation could be risky unless your hyperthyroidism is first controlled by an antithyroid drug (see above) or a beta-blocking drug (see below). Usually for some days before surgery, your surgeon may want you to take drops of nonradioactive iodine—either Lugol's iodine or supersaturated potassium iodide (SSKI). This extra iodine reduces the blood supply to the thyroid gland and thus makes the surgery easier and safer. Although any surgery is risky, major complications of thyroid surgery occur in less than 1% of patients operated on by an experienced thyroid surgeon. These complications include damage to the parathyroid glands that surround the thyroid and control your body's calcium levels (causing problems with low calcium levels) and damage to the nerves that control your vocal cords (causing you to have a hoarse voice).

After your thyroid gland is removed, the source of your hyperthyroidism is gone and you will likely become hypothyroid. As with hypothyroidism that develops after radioiodine treatment, your thyroid hormone levels can be restored to normal by treatment once a day with a thyroid hormone supplement.

Beta-blockers

No matter which of these three methods of treatment you have for your hyperthyroidism, your physician may prescribe a class of drugs known as the *beta adrenergic blocking agents* that block the action of thyroid hormone on your body. They usually make you feel better within hours, even though they do not change the high levels of thyroid hormone in your blood. These drugs may be extremely helpful in slowing down your heart rate and reducing the symptoms of palpitations, shakes, and nervousness until one of the other forms of treatment has a chance to take effect. Propranolol (Inderal®) was the first of these drugs to be developed. Some physicians now prefer related, but longer-acting beta-blocking drugs such as atenolol (Tenormin®), metoprolol (Lopressor®) and nadolol (Corgard®), and Inderal-LA® because of their more convenient once- or twice-a-day dosage.

Other family members at risk

Because hypothyroidism, especially Graves' disease, may run in families, examinations of the members of your family may reveal other individuals with thyroid problems.