

CONCLUSION

Painful Hashimoto's thyroiditis should be considered in pregnant patients with known autoimmune thyroid disease presenting with acute thyroid pain despite normal thyroid function. Diagnosis requires integration of clinical, biochemical, and imaging findings to guide appropriate management.

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THE HIDDEN HAZARD AFTER TOTAL PARATHYROIDECTOMY: A CASE REPORT

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INTRODUCTION

Palpation thyroiditis is an underrecognized condition that occurs after parathyroidectomy. Symptoms range from mild to overt thyrotoxicosis that may result in life-threatening cardiac arrhythmias and acute coronary syndrome. Diagnosis is made by having suppressed thyroid-stimulating hormone (TSH) and elevated free thyroxine 4 (fT4) or free thyroxine 3 (fT3) and low radionuclide uptake on thyroid scan.

CASE

We report a case of a 72-year-old female with underlying end-stage renal disease on regular hemodialysis who underwent total parathyroidectomy for tertiary hyperparathyroidism. Her thyroid function test (TFT) pre-operatively was normal, and cardiac assessment showed normal echocardiogram findings and sinus rhythm on electrocardiogram. Her operation was uncomplicated, involving neck exploration and all 4-gland removal. Postoperatively, she had new-onset atrial fibrillation (AF) with rapid ventricular response at day 5, requiring electrical and chemical cardioversion. She had recurrent tachyarrhythmias on day 6. Her repeated TFT showed suppressed TSH, 0.036 mIU/L (NR 0.38–5.33) and raised fT4, 35.4 pmol/L (NR 7.9–14.4), fT3–fT4 ratio 0.26 (<0.3), consistent with thyrotoxicosis. She was treated as thyroid storm (Burch-Wartofsky Point Scale 45), after ruling out other causes. She was started on glucocorticoids, propylthiouracil, and Lugol's iodine. Despite biochemical improvement, she continued to develop recurrent AF up till Day 12 post-op, requiring multimodal treatment, including beta-blocker and antiarrhythmic agents. She was later discharged well on low-dose carbimazole. Her ultrasound neck showed a normal thyroid gland, and her thyroid antibodies were negative.

CONCLUSION

A high level of suspicion is needed to detect thyroiditis post-parathyroidectomy due to its potential adverse impact on surgical outcomes. Treatment is mainly symptomatic, and the disease is self-limiting. Risk factors identified include secondary/tertiary hyperparathyroidism and bilateral neck exploration that involves manipulation of the thyroid gland.

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SUBACUTE HYPOTHYROID MYOPATHY AS AN ATYPICAL PRESENTATION FOLLOWING RADIOIODINE THERAPY

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INTRODUCTION

Hypothyroidism is the most common outcome following radioiodine (RAI) therapy for Graves' disease, affecting up to 80% of patients, usually within 6 months. While symptoms are often nonspecific, musculoskeletal complaints may be the predominant or sole manifestation. Hypothyroid myopathy occurs in 30–80% of patients, typically causing myalgias, cramps, fatigue, and slowly progressive, symmetric proximal weakness with delayed reflex relaxation. We report an atypical case with subacute and evolving weakness after levothyroxine initiation.

CASE

A 43-year-old female with Graves' disease underwent RAI therapy (25 mCi) and developed hypothyroidism 7 weeks later. She was started on levothyroxine 50 mcg daily. Two weeks into treatment, she presented with progressive proximal lower limb weakness (power 4/5), while distal strength and reflexes remained intact. Labs revealed elevated creatine kinase (259 U/L), hypokalemia (3.3 mmol/L), creatinine (57 µmol/L), and severe hypothyroidism (thyroid-stimulating hormone [TSH] 52.88 mIU/L, free thyroxine 4 [FT4] 7.79 pmol/L). Levothyroxine was increased to 100 mcg daily. Two weeks later, she developed proximal upper limb weakness (power 4/5), while lower limb strength had normalized. Nerve conduction studies and electromyography were unremarkable. Labs showed creatine kinase (244 U/L) and creatinine (58 µmol/L). As she remained hypothyroid (TSH 20.85 mIU/L, FT4 11.61 pmol/L), levothyroxine 100 mcg daily was continued. Her symptoms gradually improved alongside biochemical recovery (TSH 8.83 mIU/L, FT4 15.90 pmol/L) after 4 weeks, consistent with hypothyroid myopathy.