HYPERTHYROIDISM IN THE OLDER PATIENT
A Report of Two Cases in Males

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The absence in the older patients of the cardinal diagnostic features of hyperthyroidism that are usually present in younger patients and for which reason it has been called "apathetic", "masked" and "burned-out" is well known (1-9). The manifestations are referrable to the cardiovascular and, often times, to the gastrointestinal system. Those referrable to the cardiovascular system are tachycardia, atrial fibrillation and in the advanced case, heart failure which is not responsive to digitalization; those referrable to the gastrointestinal system include anorexia, substantial weight loss and diarrhea. In a patient belonging to the older age group these symptoms, especially those referrable to the cardiovascular system, can easily be attributed to the process of getting old both by an unsympathetic relative and an unsuspecting physician.

The incidence of this condition has not been established but it is believed that it occurs more frequently than is reported (1). This is understandable because of the ease in missing the diagnosis and this is not well emphasized. Within a period of five years, from June, 1955 to May, 1960 there was not a single case reported among the 9,677 admissions of the Department of Medicine of the Philippine General Hospital (10).

This report deals with a recent experience in two cases encountered within a period of 9 months in the Department of Medicine, Philippine General Hospital. Both cases were males, 53 and 68 years of age.

CASE REPORTS

Case 1 A 53 year old Filipino from Manila was hospitalized for diarrhea, easy fatigability, palpitations, pedal

edema, anorexia and marked loss of weight. He claimed that he had lost almost half of his weight. Except for the diarrhea which developed recently, his other symptoms were of about two years duration. He also complained of insomnia and generalized body weakness.

Physical examination revealed a fairly developed, emaciated patient who looked 20 years older than his age. His hair was all white. The significant findings were a somewhat enlarged cardiac area of dullness, irregularly irregular rhythm of the heart and pedal edema. His blood pressure was 110/60 mm. Hg. The heart was verified to be enlarged by X-ray of the chest. An electrocardiogram revealed atrial fibrillation.

His complaints were at best only slightly relieved during his stay in the hospital. He was allowed to go home upon his request after about a month. A protein-bound-iodine determination was requested before he was sent home and when it was found to be 16.3 gamma % he was advised to be re-admitted. It was only after his PBI was found elevated that attention was focused on his thyroid gland and some of those who saw him started feeling that it was suspiciously diffusely enlarged.

He was placed on 30 mg. of Tapazole daily and after about a month his PBI dropped to 15.4 gamma %. The Tapazole was increased to 60 mg. daily and after about a week the PBI further dropped to 14.6 gamma %. However, his symptoms persisted.

While in the hospital he developed what appeared to be a cerebral embolism which rendered him hemiparetic and with slurred speech. He also developed some personality changes. He went home again under 300 mg. of prophythiouracil aside from 60 mg. of tapazole daily. He developed another stroke at home and from then on he deteriorated rapidly. He died about one and a half months later. The total duration of illness was about two and a half years.

Case 2. An 86 year old Filipino was hospitalized for a suspected malignancy of the stomach. His main complaints were anorexia, marked loss of weight and general body weakness of only about a month duration.

Physical examination revealed a fairly developed, rather poorly nourished, ambulant male patient. His thyroid gland was normal. The cardiac area of dullness was enlarged, the rhythm of the heart beat was regular and a grade II soft blowing systolic murmur was appreciated at the mitral area. The liver was palpated one centimeter below the right costal arch. His blood pressure ranged from 140-170 mm. Hg. systolic and 80 mm. Hg. diastolic.

While he was waiting for a gastrointestinal study, an irregularity in the rhythm of his heart was noted. An electrocardiogram revealed atrial fibrillation which reverted to normal sinus rhythm a number of times. A PBI showed 14.2 gamma %. He left the hospital before treatment could be started or his studies done and he has not been heard from ever since.

DISCUSSION

In the absence of the diagnostic features generally seen in the classical case, the recognition of hyperthyroidism in an older patient will depend largely on the awareness of the attending physician of the possibility of its occurrence. In Case 1 the condition was never suspected until after a month in the hospital. On the basis of a picture of intractable cardiac decompensation with persistent atrial fibrillation in a patient above 50 the possibility of its occurrence was suggested. In case 2 attention was focussed on the thyroid gland when the patient developed paroxysmal atrial fibrillation while awaiting studies for a suspected malignancy of the stomach which was based on the anorexia and marked loss of weight.

The thyroid gland is palpable in only 3% of cases above the age of 60 (1). In both cases presented it was normal. This is another reason why the thyroid gland is often overlooked and the condition altogether missed.

An insiduous onset and delay in its recognition has been found to be a feature of this disease (1, 3-6). In Case 1 the symptoms had been present for two years. The early recognition of the condition in Case 2 was due mainly to the experience in the first case.

In both cases the gastrointestinal symptoms, namely anorexia and diarrhea associated with marked weight loss were

prominent so much so that Case 2 was being worked up as a suspected case of malignancy of the stomach. The diarrhea in Case 1 was thought to be infectious at first and it proved quite difficult to manage.

This condition has been found to respond well to the antithyroid drugs (1, 3-6). The first case was a disappointment in this regard because although his PBI started going down he never showed any sign of improvement. It was while he was under tapazole that he developed his first cerebral embolism.

The causes of death in this condition has not been well described. Levit (3) encountered embolism in 15 of 2,114 cases. Eleven of these had atrial fibrillation. Five (33%) of those cases died of pulmonary and cerebral embolisms. Embolism into the femoral and brachial arteries were also found. The first case presented died most likely of repeated cerebral embolism. This arouses interest in the 613 cases above the age of 50 out of 9,677 cases admitted into the Department of Medicine, Philippine General Hospital from June, 1955 to May, 1960 who had cerebral strokes (10).

SUMMARY

Two cases of "masked" hyperthyroidism in males are presented. The belief that the condition occurs more frequently than is reported and the unawareness of the possibility of its occurrence because of the ease with which the symptoms can easily be attributed to the process of aging both by an unsympathetic relative and an unsuspecting physician are emphasized.

In the absence of the cardinal diagnostic features seen in the younger patients its recognition depends largely on the consciousness of the physician of its occurrence . Helpful leads are tachycardia, atrial fibrilation and/or heart failure, anorexia, substantial weight loss and diarrhea in a patient above 50.

Attention was called to the possibility of an underlying hyperthyroidism in older patients who develop cerebral embolism.

REFERENCES

1. BARTELS, E. C. : Hyperthyroidism in Patients Over the Age of Sixty, The Surg. Clin. North Am., 3 : 673-680 (June), 1954.
2. LEVINE, S. : Clinical Heart Disease, 5th Ed., W. B. Saunders Co., Philadelphia and London, 1958.
3. LEVITT, T. The Thyroid : A Physiological, Pathological, Clinical and Surgical Study, E. & S. Livingstone, Ltd., Edinburgh and London, 1954.
4. MEANS, J. H. : The Thyroid and Its Diseases. 2nd Ed. J. B. Lippincott Co., Philadelphia, London & Montreal, 1948.
5. CRILE, G., JR. : Practical Aspects of Thyroid Disease W. B. Saunders Co., Philadelphia & London, 1949.
6. McGAVAK, T. H. : The Thyroid. The C. V. Mosby Co., St Louis, Missouri, 1951.
7. SOFFER, L. J. : The Thyroid in Diseases of the Endocrine Glands. 2nd Ed., Lea & Febiger, Philadelphia, 1956.
8. STANBURY, J. B. : Diseases of the Thyroid Gland in Cecil & Loeb A Textbook of Medicine, 10th Ed., W. B. Saunders Co., Philadelphia & London, 1959.
9. HILL, S. R., JR. and SELENKOV, H. : Diseases of the Thyroid Gland in Principles of Internal Medicine. Harrison, T., Adams, R. A., Bennett, I. L., Jr., Resnik, W. H., Thorn, G. W. and Wintrobe, M. M. (Editors), 3rd Ed., The Blakiston Division, McGraw-Hill Book Co. Inc., New York, Toronto & London, 1958.
10. The Daily Physician-on-Duty Report, Department of Medicine, Philippine General Hospital, June, 1955 to May, 1960.