Choosing Wisley in der Endokrinologie

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Choosing Wisely Gruppe Endokrinologie

Mitglieder des ÖGES Vorstandes (ohne Sektionsleiter) und je 2 Vorstandsmitglieder (bevorzugt President, Past-President, President elect) der ÖDG, OSDG, ÖGKM = 15 Mitglieder

Vorstand der ÖGES:

Stefan Pilz, Greisa Vila, Florian Kiefer, Anton Luger, Michael Krebs, Thomas Scherer, Sabina Baumgartner-Parzer, Stefan Riedl, Vinzenz Stepan

Vorstand der OSDG:

Wolfgang Buchinger, Georg Zettinig

Vorstand der ÖDG:

Martin Clodi, Harald Sourij

Vorstand der ÖGKM:

Christian Muschitz, Hans Peter Dimai

Top 5 Empfehlungen nach 2 Voting Runden

Empfehlung 1:
Keine Behandlung mit L-Thyroxin bei Knoten in der Schilddrüse,
außer in ausgewählten Fällen

Quelle

Italian Association of Medical Endocrinologists (AME)
https://choosingwiselyitaly.org/en/raccomandazione-prof/thyroid-nodules-patients-should-not-be-treated-with-l-thyroxine-except-in-selected-cases/

2023 European Thyroid Association Clinical Practice Guidelines for thyroid nodule management

https://etj.bioscientifica.com
https://doi.org/10.1530/ETJ-23-0067

Cosimo Durante[1,*], **Laszlo Hegedüs**[2,*], **Agnieszka Czarniecka**[3], **Ralf Paschke**[4], **Gilles Russ**[5], **Fernando Schmitt**[6], **Paula Soares**[7], **Tamas Solymosi**[8] and **Enrico Papini**[9]

Thyroid hormone treatment is not indicated in euthyroid individuals with nodular thyroid disease (*Strength of recommendation: 1; quality of evidence: ØØØO. Agreement: 9/9 (100%); round: 1*)

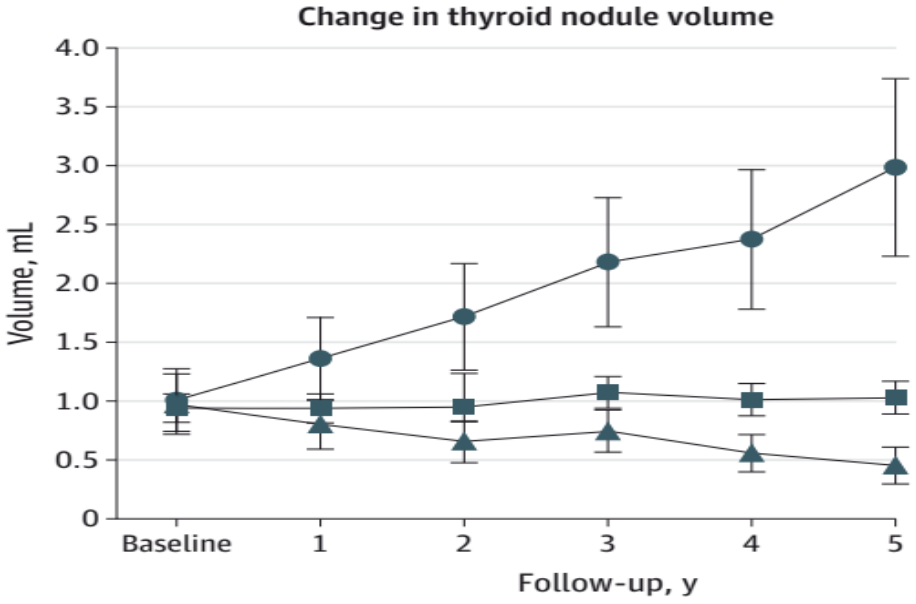
> Most benign thyroid nodules are incidentally diagnosed and asymptomatic (4). In the absence of elevated TSH, the use of thyroid hormone in order to decrease TSH should be discouraged in order to limit the increased morbidity and mortality seen with such therapy (101, 102), but mainly because of its lack of efficacy in adequately decreasing size in symptomatic nodules (103).

Original Investigation

The Natural History of Benign Thyroid Nodules

Cosimo Durante, MD, PhD; Giuseppe Costante, MD; Giuseppe Lucisano, MScStat; Rocco Bruno, MD; Domenico Meringolo, MD; Alessandra Paciaroni, MD; Efisio Puxeddu, MD, PhD; Massimo Torlontano, MD; Salvatore Tumino, MD; Marco Attard, MD; Livia Lamartina, MD; Antonio Nicolucci, MD; Sebastiano Filetti, MD

JAMA. 2015;313(9):926-935.



No. of nodules that						
Grew	174	174	170	157	144	131
Remained stable	1188	1188	1170	1155	1115	1096
Shrank	205	205	197	188	173	161
No. of patients	992	992	963	946	902	875

Thyroid cancer was diagnosed in 5 original nodules (0.3% [95% CI 0.0%-0.6%]). Only 2 had grown.

CONCLUSIONS AND RELEVANCE Among patients with asymptomatic, sonographically or cytologically benign thyroid nodules, the majority of nodules exhibited no significant size increase during 5 years of follow-up and thyroid cancer was rare. These findings support consideration of revision of current guideline recommendations for follow-up of asymptomatic thyroid nodules.

Thyroxine Suppressive Therapy in Patients with Nodular Thyroid Disease

Ann Intern Med. 1998;128:386-394.

Hossein Gharib, MD, and Ernest L. Mazzaferri, MD

Table 4. Response Rates in Eight Randomized, Controlled Trials of Thyroid Hormone Suppressive Therapy for Nodular Thyroid Disease*

Study, Year, Country (Reference)	Single or Multiple Nodules	L-Thyroxine Recipients	Controls	Patients with Suppressed Nodules			Mean Nodule Shrinkage	Duration of Therapy
				L-Thyroxine Recipients	Controls	*P* Value		
		n		%			%	*mo*
Gharib et al., 1987, United States (30)	Single	28	25†	50	60	>0.2	50	6
Cheung et al., 1989, Hong Kong (31)	Single and multiple	37	37	38	35	>0.2	50	18
Berghout et al., 1990, Netherlands (32)	Multiple	26	26†	58	5	0.001	13	9
Diacinti et al., 1992, Italy (33)	Single and multiple	16	19	30.7	0	0.01	25	9
Reverter et al., 1992, Spain (34)	Single	20	20	20	15	NS	50	11
Papini et al., 1993, Italy (35)	Single	51	50†	45	26	0.05	50	12
La Rosa et al., 1995, Italy (36)	Single	23	22†	39	0	0.004	40	12
Mainini et al., 1995, Italy (37)	Single	45	10	17.8	0	NS	50	21

* NS = not significant. (Modified with permission from Gharib H. Management of thyroid nodules: another look. Thyroid Today. 1997;1:1-11. [Gem Communications])
† Controls received placebo.

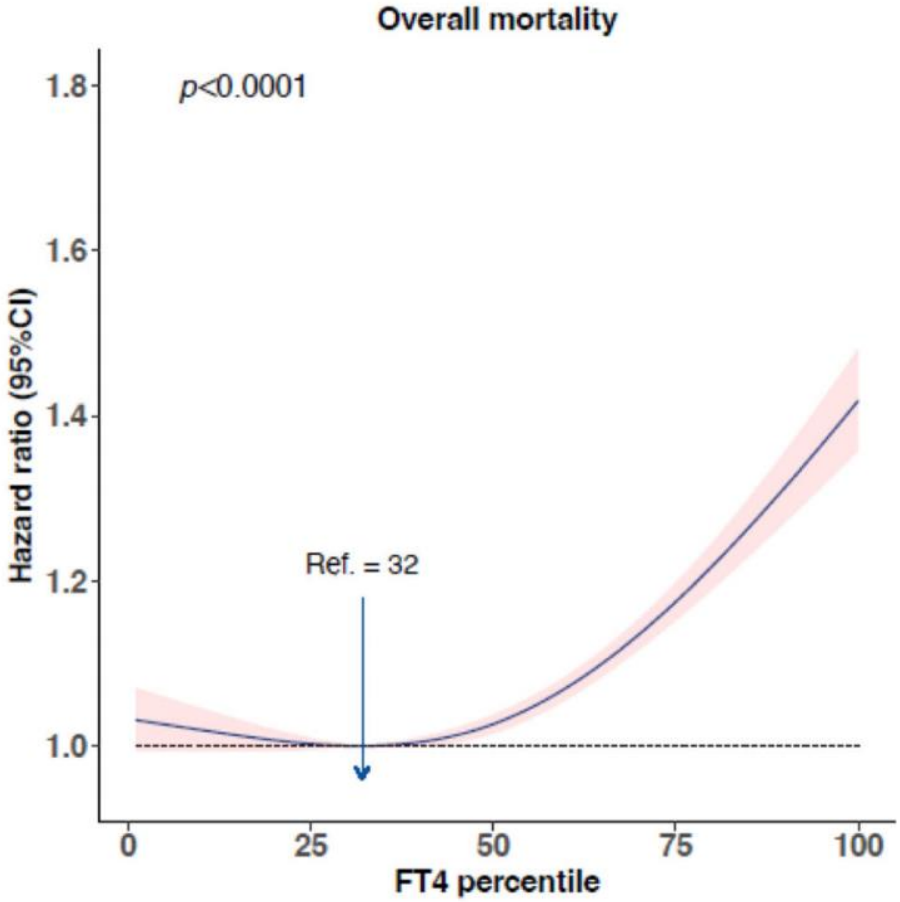
Data Synthesis: The evidence suggests that thyroxine suppressive therapy fails to shrink most nodules: Only 10% to 20% of nodules responded to this treatment.

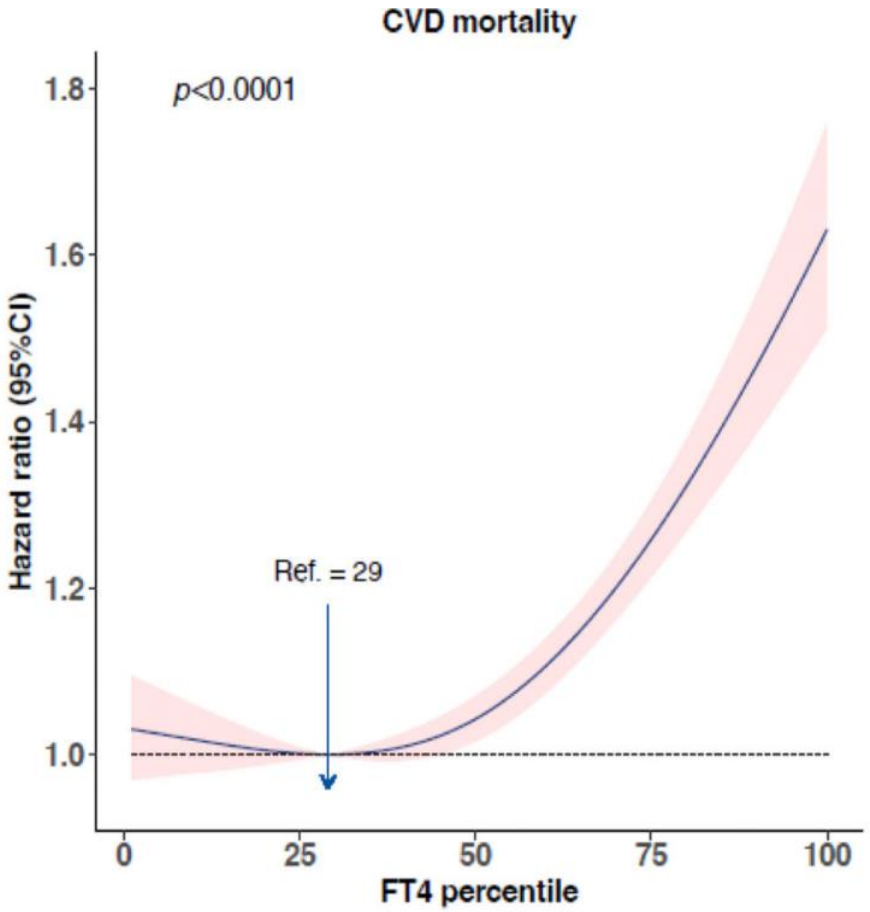
Conclusions: Patients with cytologically benign nodules are best followed without thyroxine treatment. Most benign nodules remain stable in size and remain benign

The optimal healthy ranges of thyroid function defined by the risk of cardiovascular disease and mortality: systematic review and individual participant data meta-analysis

Lancet Diabetes Endocrinol. 2023 October ; 11(10): 743–754.

We included IPD on 134 346 participants





Empfehlung 2:
Zu häufige Knochendichtemessungen vermeiden: Intervalle von weniger als zwei Jahren sind selten notwendig

Quelle

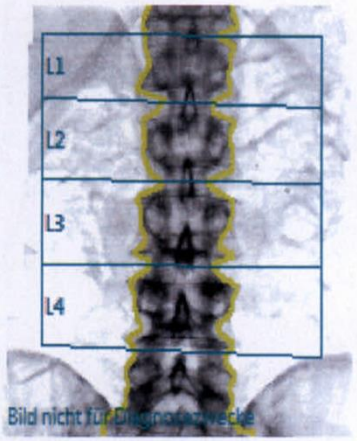
Italian Association of Medical Endocrinologists (AME)

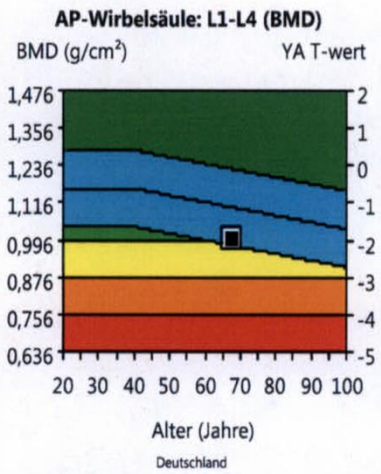
Referenzmethode zur Osteoporose Diagnostik:
Knochendichtemessung mittels **„dual-energy X-ray absorptiometry (DXA)“** (deutsch: Dual-Röntgen-Absorptiometrie), eine Röntgenaufnahme bei der die Knochenmineraldichte (KMD; englisch: bone mineral density [BMD]) in g/cm² in bestimmten Skelettregionen ermittelt wird.

Operationale Definition der Osteoporose gemäß WHO 1994:
Basiert auf dem T-score, der anzeigt um wie viele Standardabweichungen (SD) die aktuell gemessene BMD von den Werten eines 20-29 jährigen weiblichen Referenzkollektivs abweicht.

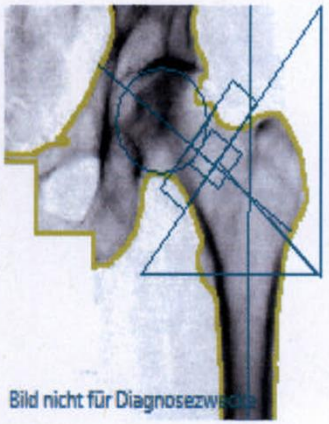
Eine Osteoporose wird diagnostiziert bei einem T-score ≤ -2,5

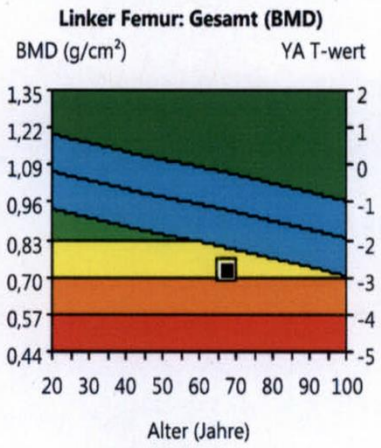
DXA Osteodensitometrie





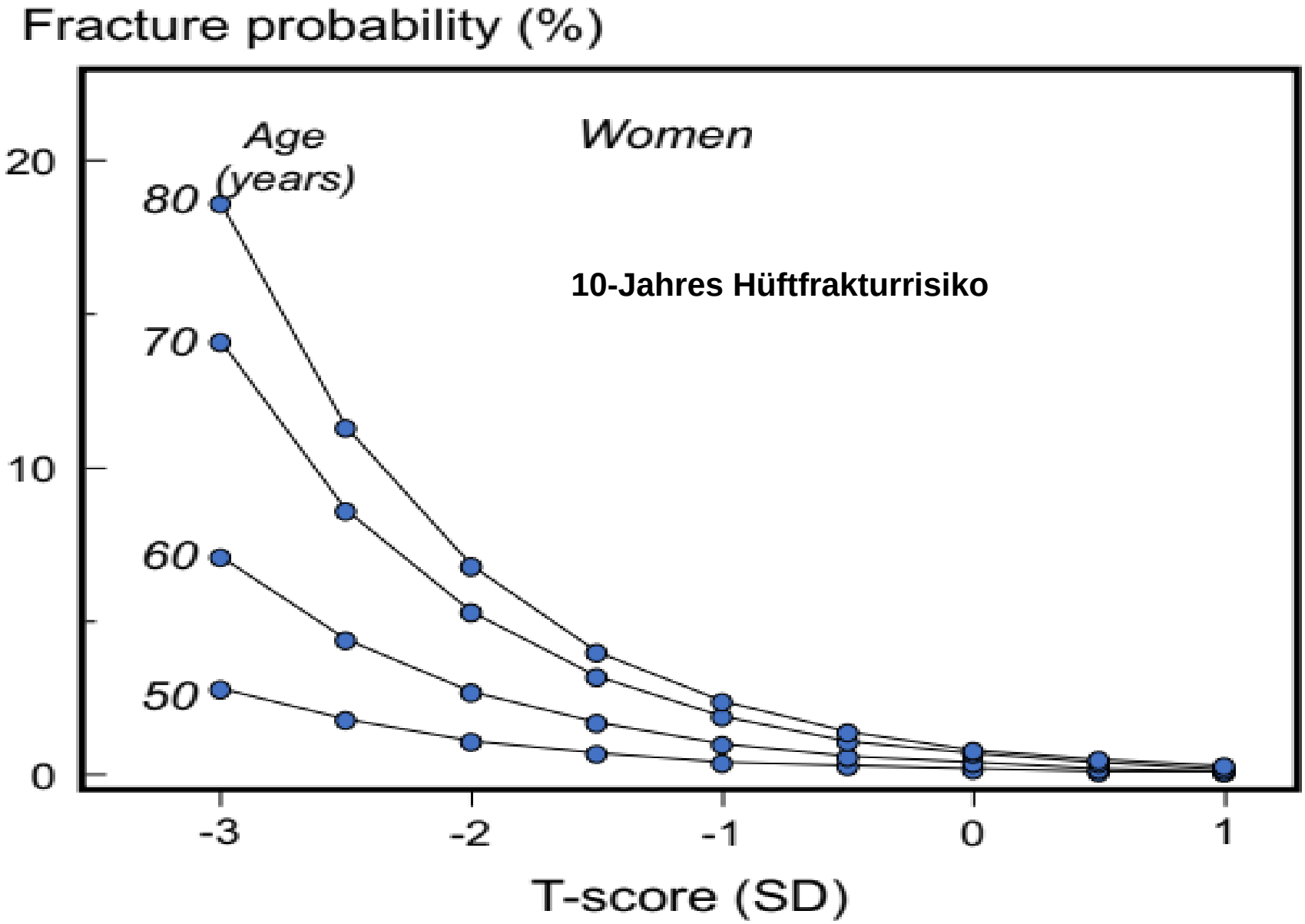
Bereich	BMD (g/cm²)	YA (%)	YA T-wert	AM (%)	AM Z-wert
L1	0,901	77	-2,2	87	-1,1
L2	0,872	70	-3,1	78	-2,0
L3	1,069	85	-1,5	95	-0,4
L4	1,117	89	-1,1	99	0,0
L1-L2	0,886	73	-2,7	82	-1,6
L1-L3	0,953	78	-2,2	88	-1,1
L1-L4	1,002	81	-1,9	91	-0,8
L2-L3	0,975	78	-2,3	87	-1,2
L2-L4	1,028	82	-1,8	92	-0,8
L3-L4	1,094	87	-1,3	97	-0,2





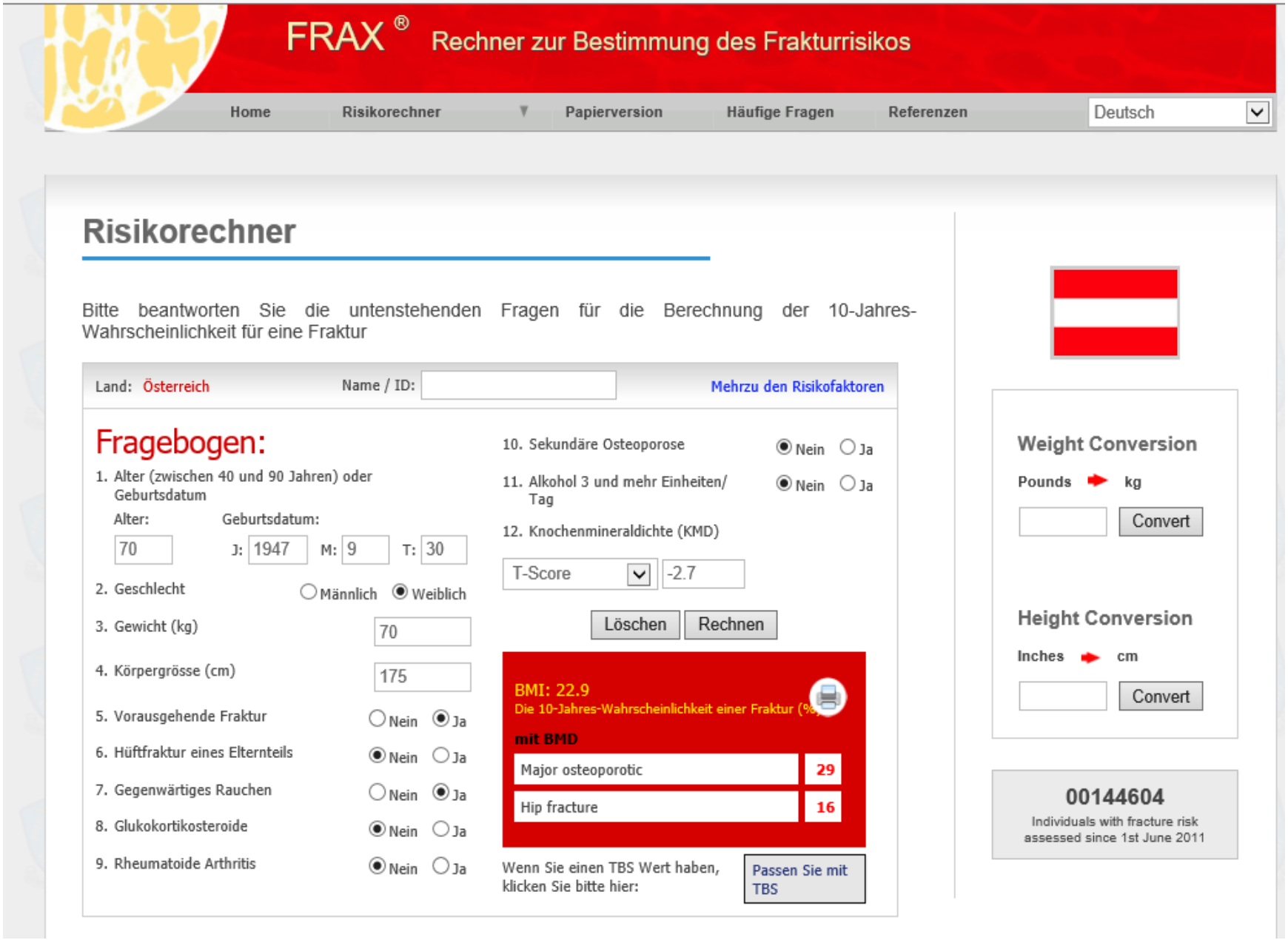
Bereich	BMD (g/cm²)	YA (%)	YA T-wert	AM (%)	AM Z-wert
Hals	0,652	61	-3,2	75	-1,7
Gesamt	0,726	67	-2,8	78	-1,6

Osteoporose



Osteoporosis International (2019) 30:3–44

www.shef.ac.uk/FRAX



Osteoporose – Definition, Risikoerfassung, Diagnose, Prävention und Therapie (Update 2024)

Leitlinie der Österreichischen Gesellschaft für Knochen- und Mineralstoffwechsel

Hans Peter Dimai · Christian Muschitz · Karin Amrein · Rosemarie Bauer · Daniel Cejka · Rudolf Wolfgang Gasser · Reinhard Gruber · Judith Haschka · Timothy Hasenöhrl · Franz Kainberger · Katharina Kerschan-Schindl · Roland Kocijan · Jürgen König · Norbert Kroißenbrunner · Ulrike Kuchler · Christine Oberforcher · Johannes Ott · Georg Pfeiler · Peter Pietschmann · Paul Puchwein · Alexander Schmidt-Ilsinger · Ralf Harun Zwick · Astrid Fahrleitner-Pammer

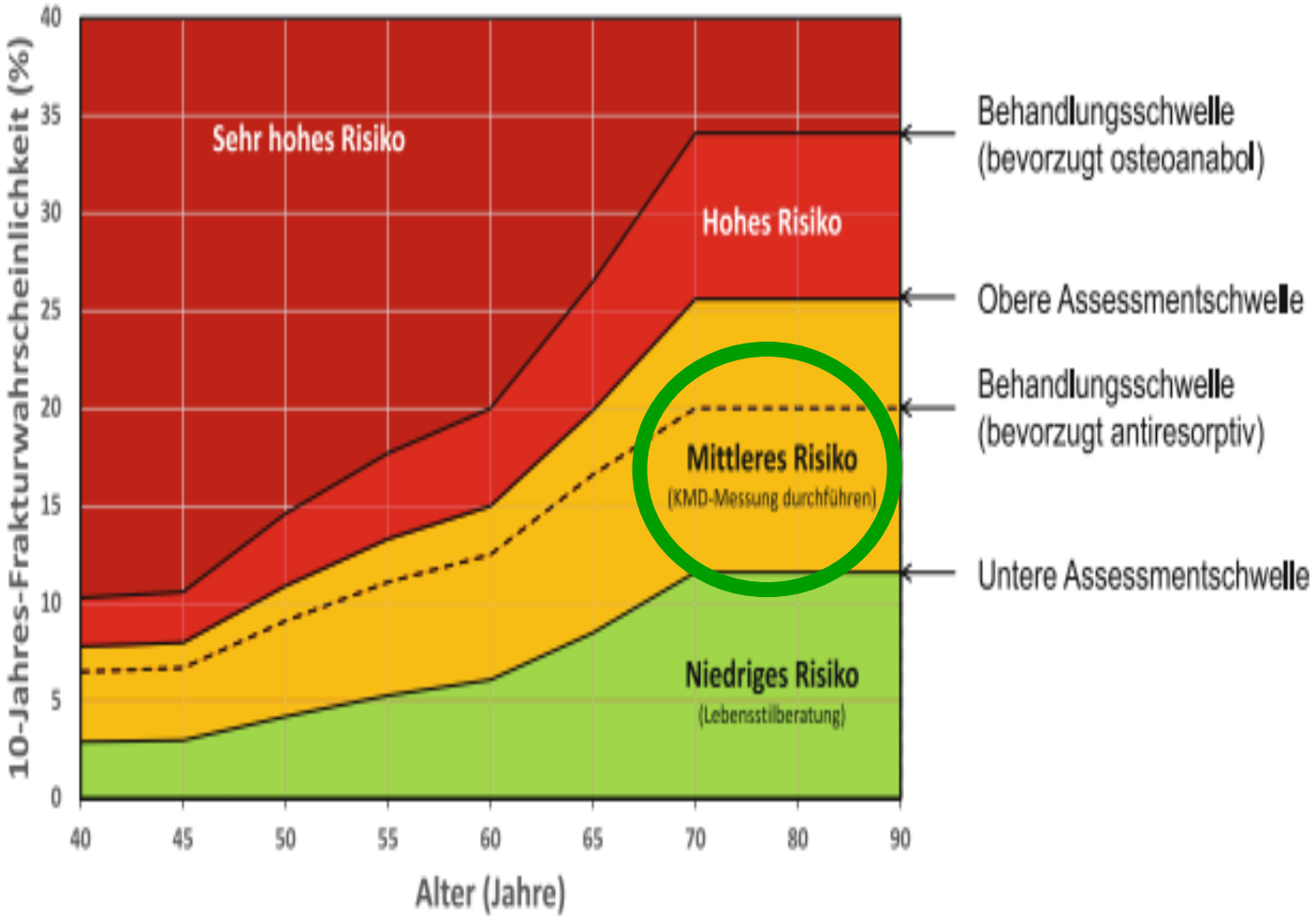


Abb. 2 *FRAX®-basierte Assessment-, Risiko- und Interventionsschwellen. FRAX* Fracture Risk Assessment Tool, *KMD* Knochenmineraldichte. KMD ist in dieser Abbildung nicht berücksichtigt. (Mod. und übersetzt unter einer Creative-Commons-Lizenz von [195])

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Osteoporosis to Prevent Fractures

US Preventive Services Task Force Recommendation Statement

JAMA. 2018;319(24):2521-2531. doi:10.1001/jama.2018.7498

US Preventive Services Task Force

Screening Intervals

Some observational and modeling studies have suggested screening intervals based on age, baseline BMD, and calculated projected time to transition to osteoporosis. However, limited evidence from 2 good-quality studies found no benefit in predicting fractures from repeating bone measurement testing 4 to 8 years after initial screening.[4]

9.3 Wiederholung von Knochendichtemessungen ohne spezifische Therapie

Therapierelevanz T-Score Abnahme von	Empfohlener Zeitpunkt erneuter DXA Messung nach Erstmessung
0,5 SD T-Sore	12 Monate
1,0 SD T-Score	2 Jahre

Bei T-Score Ergebnis > -1,0 SD	>5 Jahre

Leitlinie des Dachverbands der Deutschsprachigen Wissenschaftlichen Osteologischen Gesellschaften e.V.

AWMF-Register-Nr.: 183/001

Prophylaxe, Diagnostik und Therapie der OSTEOPOROSE

2023

Empfehlung	
Nach Beginn/Wechsel einer Osteoporose-Therapie sollte vor Ablauf von 5 Jahren eine Knochendichte-Verlaufskontrolle durchgeführt werden.	**Empfehlungsgrad** B **Evidenzgrad** 2 **Konsensstärke** 15/2/2 (19) Konsens

Sondervotum der DEGAM: kann statt sollte

Begründung: O. g. Studie von Leslie zeigte nur Assoziationen und die Übertragbarkeit auf andere Gesundheitssysteme ist unklar. Diese Messungen sind auch nicht Kassenleistung* und stellen eine – wenn auch geringe – zusätzliche Strahlenbelastung dar. Die vorhandenen Kapazitäten sollten vorrangig für die Erkennung von Hochrisiko-Patientinnen und -Patienten sowie geteilte Entscheidungsfindung und Unterstützung bei der Adhärenz (siehe vorausgegangene Kapitel) eingesetzt werden.

* https://www.g-ba.de/beschluesse/1655/

Intravenöse Bisphosphonatherapie:
- Nach 3 Jahren (Entscheidung ob 3 oder 6 Jahre Therapiedauer)

Orale Bisphosphonatherapie:
- Nach 5 Jahren (Entscheidung ob 5 oder 10 Jahre Therapiedauer)

Therapiepause von Bisphosphonathen:
- Nach 2 bis 3 Jahren Kontrolle

Empfehlung 3:
Keine Testosterontherapie bei älteren Männern außer in Fällen mit nachgewiesenem Hypogonadismus

Quelle

Australasian Chapter of Sexual Health Medicine

https://www.choosingwisely.org.au/recommendations/achshm5

Male hypogonadism: pathogenesis, diagnosis, and management

Lancet Diabetes Endocrinol
2024; 12: 761–74

Nipun Lakshitha De Silva, Nikoleta Papanikolaou*, Mathis Grossmann, Leen Antonio, Richard Quinton, Bradley David Anawalt, Channa N Jayasena*

	Clinical features
Foetal life	
Early	Disorders or differences of sexual differentiation (eg, female external genitalia, atypical genitalia, bifid scrotum, and hypospadias)
Late	Micropenis; cryptorchidism; and features mentioned under pre-pubertal and post-pubertal
Pre-pubertal	Delayed puberty (no secondary sexual characteristics or virilisation); high-pitched voice; small testicular volume; eunuchoid body habitus (longer limbs, upper body or lower body ratio of less than 1, and arm span exceeding height by 6 cm or more); and features mentioned under post-pubertal
Post-pubertal	
Specific or suggestive of hypogonadism	Deficient male-type body hair (in severe hypogonadism); low libido and loss of morning erections; hot flushes; gynaecomastia; infertility due to azoospermia, oligospermia or poor semen quality; height loss of more than 6 cm or minimal trauma fractures; and unexplained anaemia
Non-specific	Erectile dysfunction; lower muscle mass; gynaecoid fat distribution; fatigue, reduced energy; and depressive mood

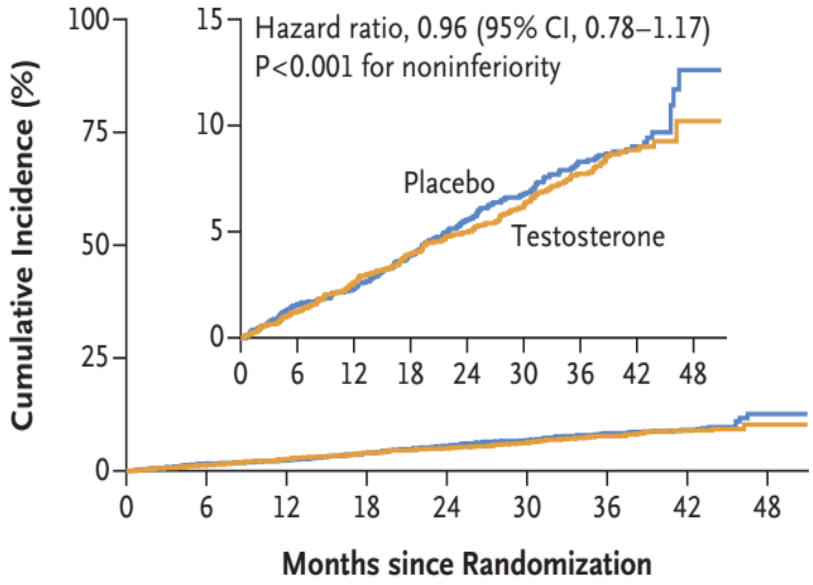
Table 2: **Clinical features depending on the onset of male hypogonadism**

Cardiovascular Safety of Testosterone-Replacement Therapy

A.M. Lincoff, S. Bhasin, P. Flevaris, L.M. Mitchell, S. Basaria, W.E. Boden, G.R. Cunningham, C.B. Granger, M. Khera, I.M. Thompson, Jr., Q. Wang, K. Wolski, D. Davey, V. Kalahasti, N. Khan, M.G. Miller, M.C. Snabes, A. Chan, E. Dubcenco, X. Li, T. Yi, B. Huang, K.M. Pencina, T.G. Travison, and S.E. Nissen, for the TRAVERSE Study Investigators*

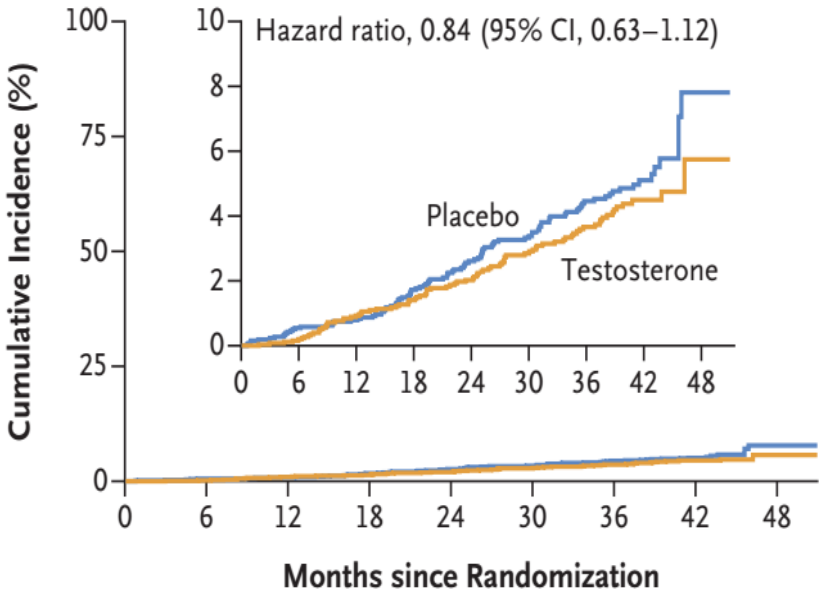
N Engl J Med 2023;389:107-17.
DOI: 10.1056/NEJMoa2215025

A Primary Cardiovascular Composite Safety End Point: Safety Population



No. at Risk									
Placebo	2602	2507	2323	2088	1792	1568	1337	598	33
Testosterone	2596	2504	2339	2120	1829	1605	1380	653	39

D Death from Cardiovascular Causes: Safety Population



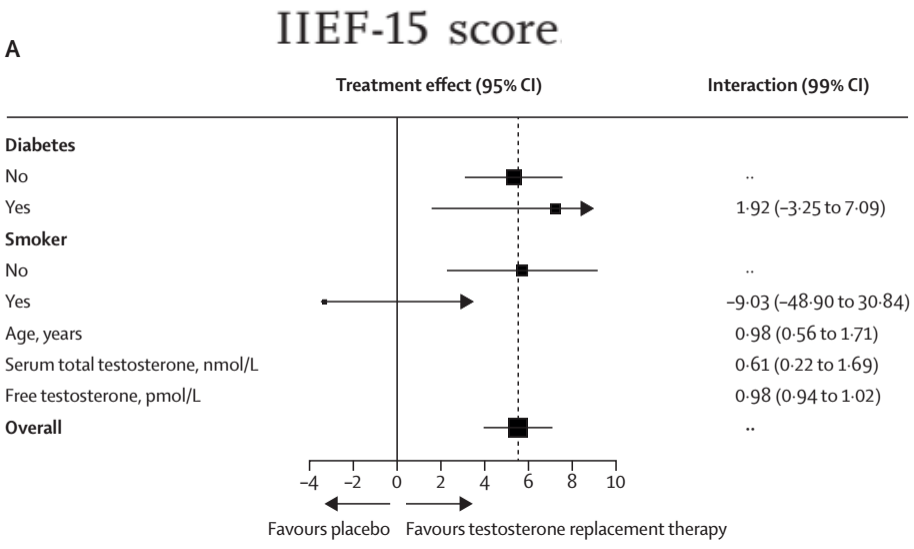
No. at Risk									
Placebo	2602	2533	2360	2130	1845	1624	1390	619	34
Testosterone	2596	2529	2375	2167	1875	1647	1423	672	40

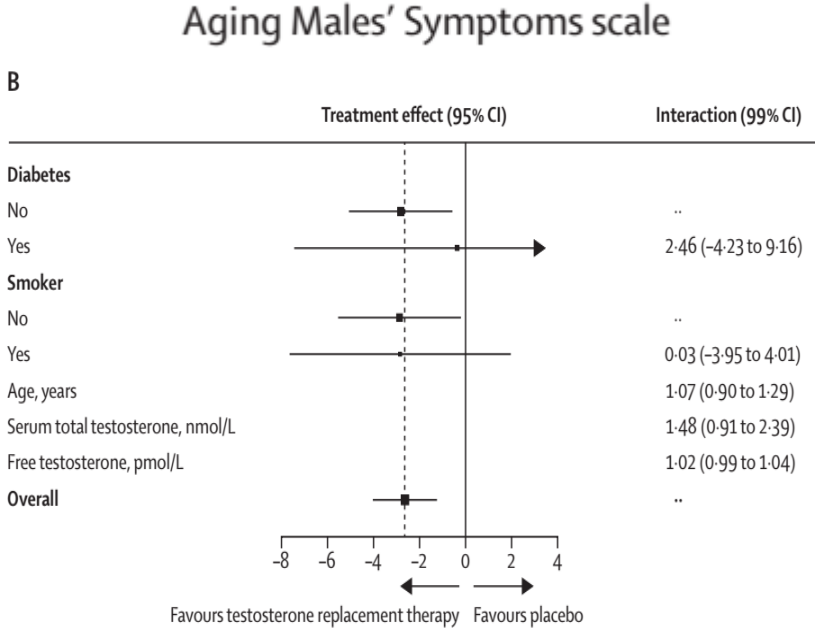
CONCLUSIONS

In men with hypogonadism and preexisting or a high risk of cardiovascular disease, testosterone-replacement therapy was noninferior to placebo with respect to the incidence of major adverse cardiac events. (Funded by AbbVie and others; TRAVERSE ClinicalTrials.gov number, NCT03518034.)

Symptomatic benefits of testosterone treatment in patient subgroups: a systematic review, individual participant data meta-analysis, and aggregate data meta-analysis

Jemma Hudson, Moira Cruickshank, Richard Quinton, Lorna Aucott, Frederick Wu, Mathis Grossmann, Shalender Bhasin, Peter J Snyder, Susan S Ellenberg, Thomas G Travison, Gerald B Brock, Emily J Gianatti, Yvonne T van der Schouw, Marielle H Emmelot-Vonk, Erik J Giltay, Geoff Hackett, Sudarshan Ramachandran, Johan Svartberg, Kerry L Hildreth, Kristina Groti Antonic, Joyce Lisa Tenover, Hui Meng Tan, Christopher Ho Chee Kong, Wei Shen Tan, Leonard S Marks, Richard J Ross, Robert S Schwartz, Paul Manson, Stephen A Roberts, Marianne Skovsager Andersen, Line Velling Magnussen, Magaly Aceves-Martins, Katie Gillies, Rodolfo Hernández, Nick Oliver, Waljit S Dhillo, Siladitya Bhattacharya, Miriam Brazzelli, Channa N Jayasena**





Interpretation In men aged 40 years or older with baseline serum testosterone of less than 12 nmol/L, short-to-medium-term testosterone treatment could provide clinically meaningful treatment for mild erectile dysfunction, irrespective of patient age, obesity, or degree of low testosterone. However, due to more severe baseline symptoms, the absolute level of sexual function reached during testosterone treatment might be lower in older men and men with obesity.

Male hypogonadism: pathogenesis, diagnosis, and management

Lancet Diabetes Endocrinol
2024; 12: 761–74

Nipun Lakshitha De Silva, Nikoleta Papanikolaou*, Mathis Grossmann, Leen Antonio, Richard Quinton, Bradley David Anawalt, Channa N Jayasena*

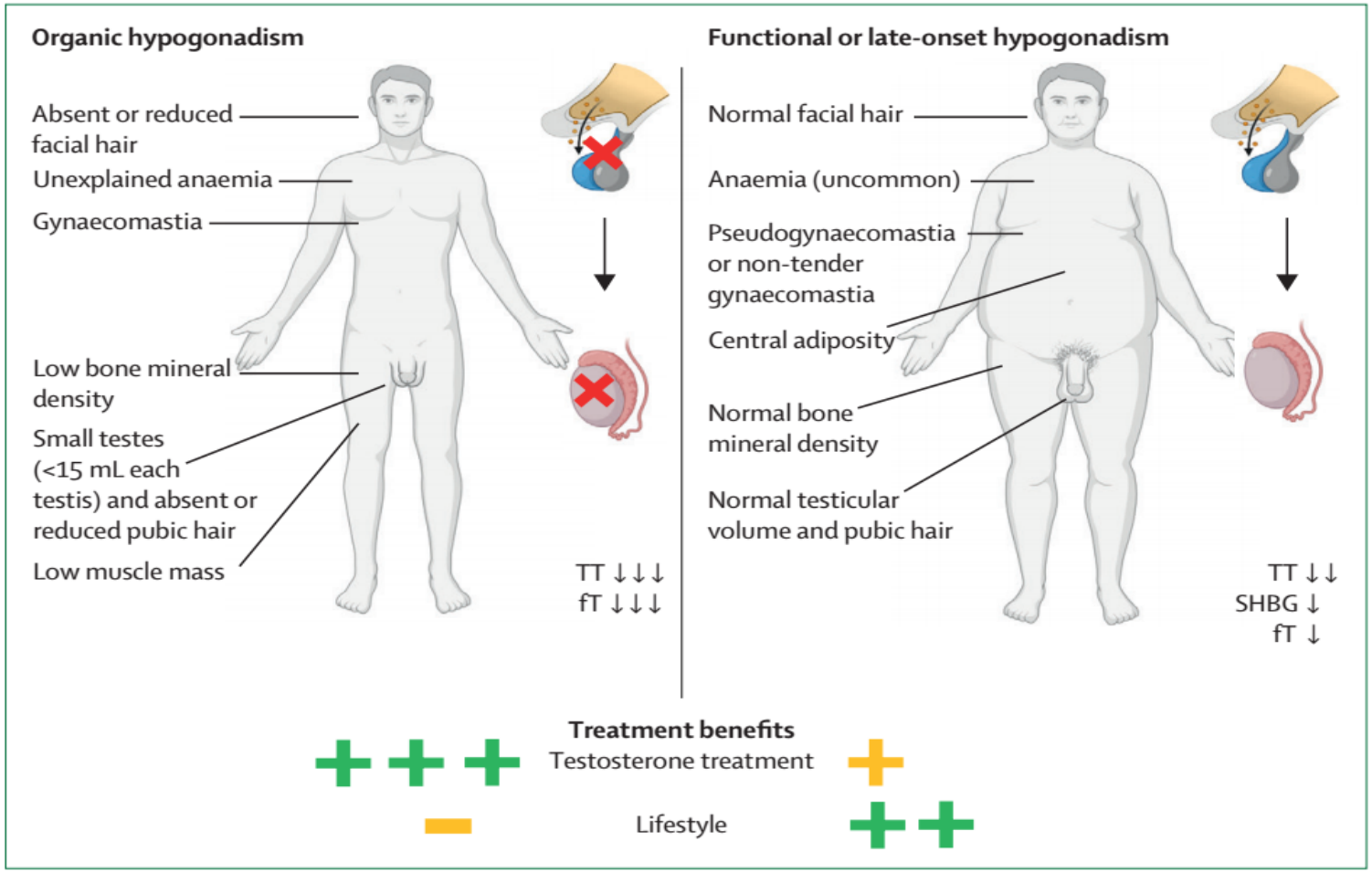


Figure 2: **Comparison between organic and functional hypogonadism**
Clinical presentation, pathophysiology, biochemistry and treatment approach in men with organic and functional hypogonadism are summarised. fT=free testosterone. SHBG=sex hormone-binding globulin. TT=total testosterone. –=no effect. Figure created with Biorender.com.

Testosterone Therapy in Men With Hypogonadism: An Endocrine Society* Clinical Practice Guideline

J Clin Endocrinol Metab, May 2018, 103(5):1715–1744

Shalender Bhasin,[1] Juan P. Brito,[2] Glenn R. Cunningham,[3] Frances J. Hayes,[4] Howard N. Hodis,[5] Alvin M. Matsumoto,[6] Peter J. Snyder,[7] Ronald S. Swerdloff,[8] Frederick C. Wu,[9] and Maria A. Yialamas[10]

Diagnosis of men with suspected hypogonadism

1.1 We recommend diagnosing hypogonadism in men with symptoms and signs of testosterone deficiency and unequivocally and consistently low serum total testosterone and/or free testosterone concentrations (when indicated). (1|⊕⊕⊕O)

Screening and case detection for hypogonadism

1.2 We recommend against routine screening of men in the general population for hypogonadism. (1|⊕⊕OO)

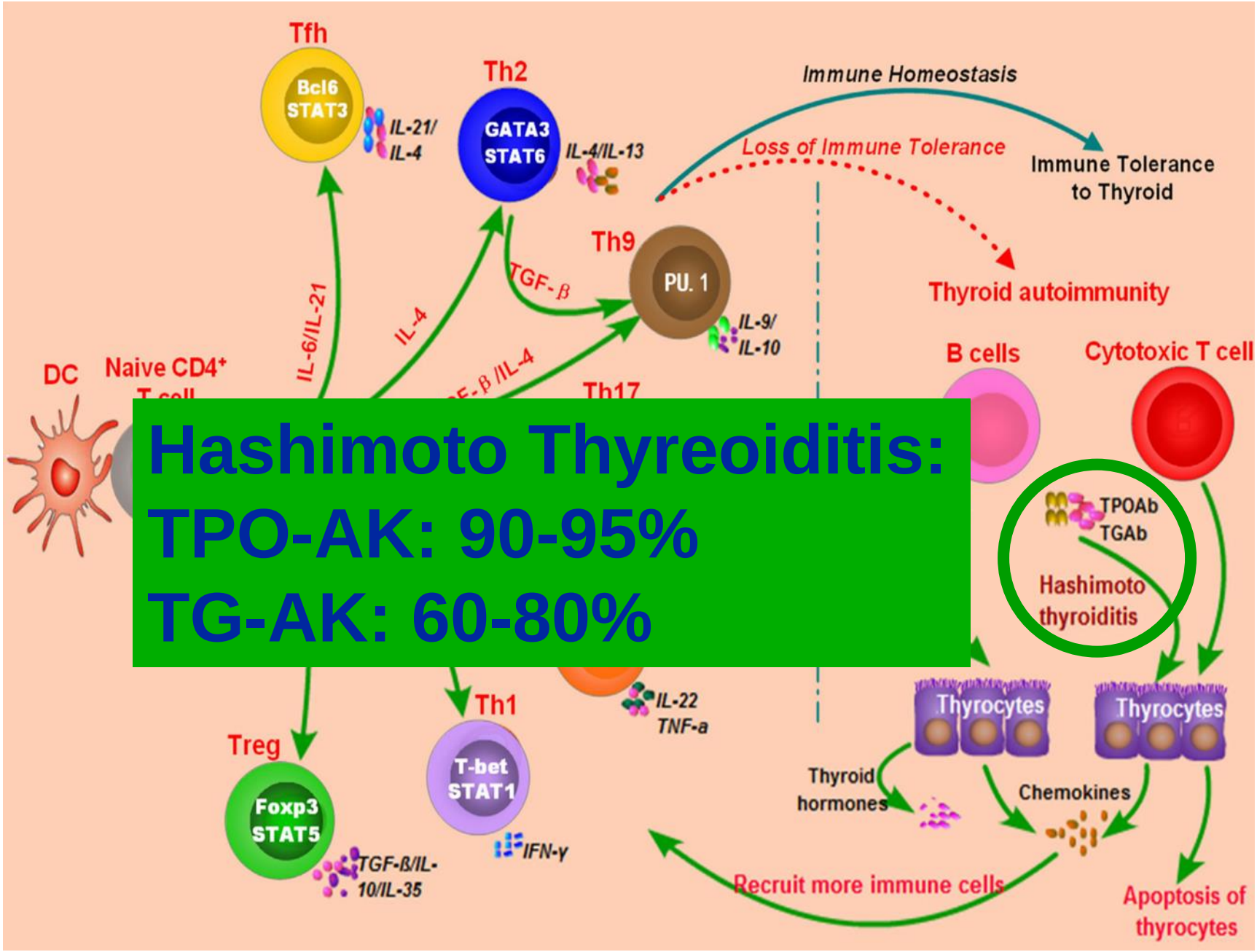
Older men with age-related decline in testosterone concentration

2.4 We suggest against routinely prescribing testosterone therapy to all men 65 years of age or older with low testosterone concentrations (1|⊕⊕OO). In men > 65 years who have symptoms or conditions suggestive of testosterone deficiency (such as low libido or unexplained anemia) and consistently and unequivocally low morning testosterone concentrations, we suggest that clinicians offer testosterone therapy on an individualized basis after explicit discussion of the potential risks and benefits. (2|⊕⊕OO)

Empfehlung 4:
Kein routinemäßiges Testen auf Anti-TPO-Antikörper

Quelle

Canadian Society of Endocrinology and Metabolism
https://choosingwiselycanada.org/recommendation/endocrinology-and-metabolism/



Autoimmunity Reviews 19 (2020) 102649

Age-Specific Distribution of Serum Thyrotropin and Antithyroid Antibodies in the U.S. Population: Implications for the Prevalence of Subclinical Hypothyroidism

Martin I. Surks and Joseph G. Hollowell

The Journal of Clinical Endocrinology & Metabolism 92(12):4575–4582

TABLE 2. Disease-free population: distribution of antibodies within specific age groups by TSH concentration, NHANES III (1988–1994)[a]

Age (yr)	Sample	Total	Percent in category with positive antibodies			
			<0.4[b]	0.4–2.49	2.5–4.5	>4.5
B. Antibodies not excluded						
Total	16533[d]	14.7	12.7[e]	10.3	26.6	52.6
12–19	2,431	8.0	11.5	6.3	17.0	19.1
20–29	3,186	9.7	7.3	7.5	27.4	30.8
30–39	2,981	13.8	6.9	11.3	21.7	56.3
40–49	2,290	16.5	29.5	9.9	30.9	67.4
50–59	1,554	18.3	24.0	12.4	27.4	61.9
60–69	1,834	20.9	2.6	14.4	29.1	63.8
70–79	1,333	24.6	31.4	15.9	31.4	50.4
80+	924	27.8	30.6	22.5	32.2	40.5

[a] Disease-free population are people who did not report having thyroid disease or taking thyroid medications.
[b] TSH concentration group (milliinternational units per liter).
[c] Number in population with antibodies. Percentages cited are the relative frequencies in the population represented by the sample.
[d] Number in total disease-free population. Percentages cited are the relative frequencies in the population represented by the sample.

The Prevalence of Undiagnosed Thyroid Disorders in a Previously Iodine-Deficient Area

THYROID
Volume 13, Number 8, 2003

Henry Völzke,[1] Jan Lüdemann,[2] Daniel M. Robinson,[3] Knut W. Spieker,[3] Christian Schwahn,[4] Axel Kramer,[5] Ulrich John,[1] and Wieland Meng[3]

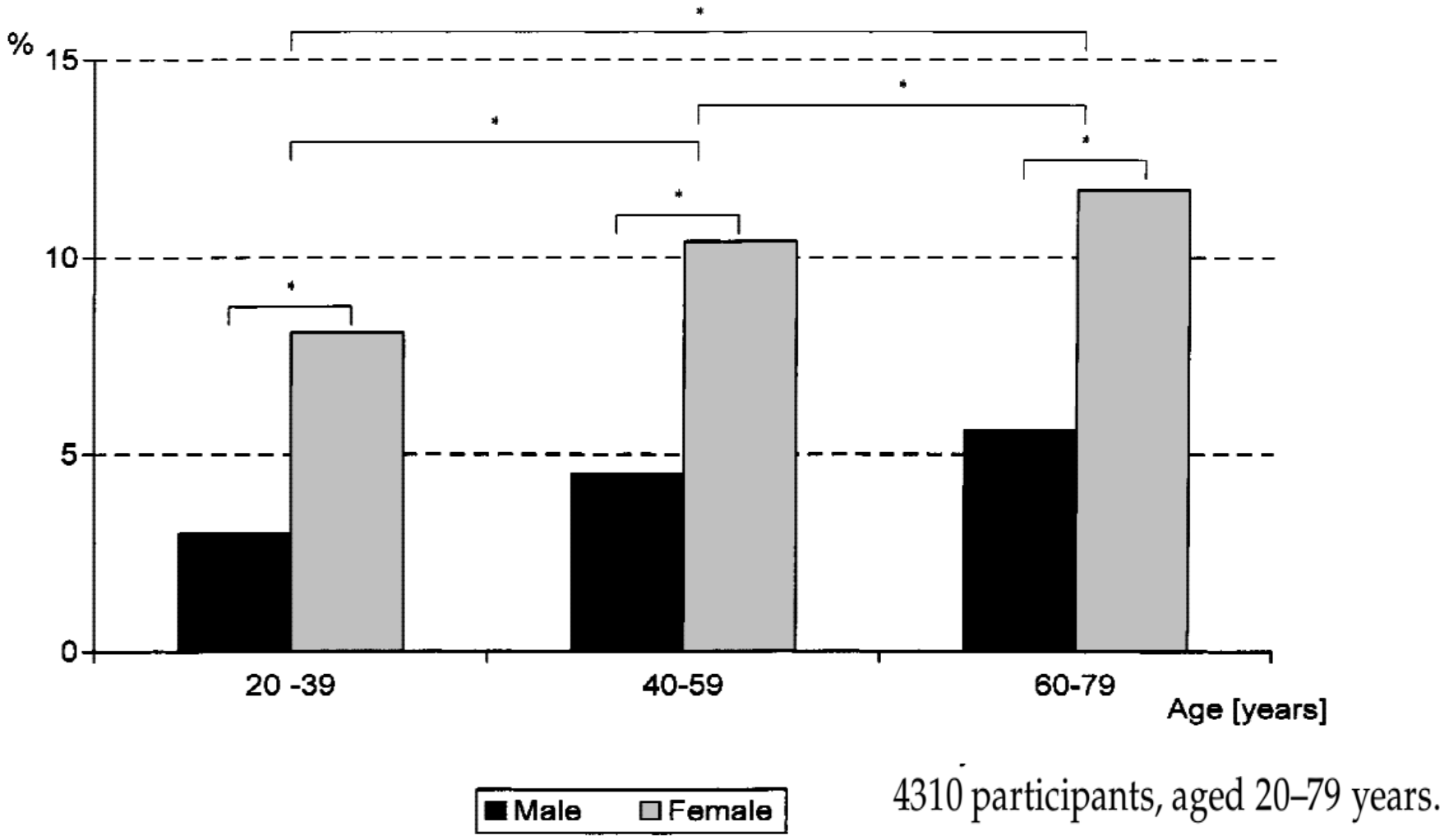


FIG. 4. Elevated serum autoantibodies to thyroperoxidase (TPOAb) levels with respect to age and gender. $*p < 0.05$.

Hypothyroidism

Lancet 2024; 404: 1347–64

Peter N Taylor, Marco M Medici, Alicja Hubalewska-Dydejczyk, Kristien Boelaert

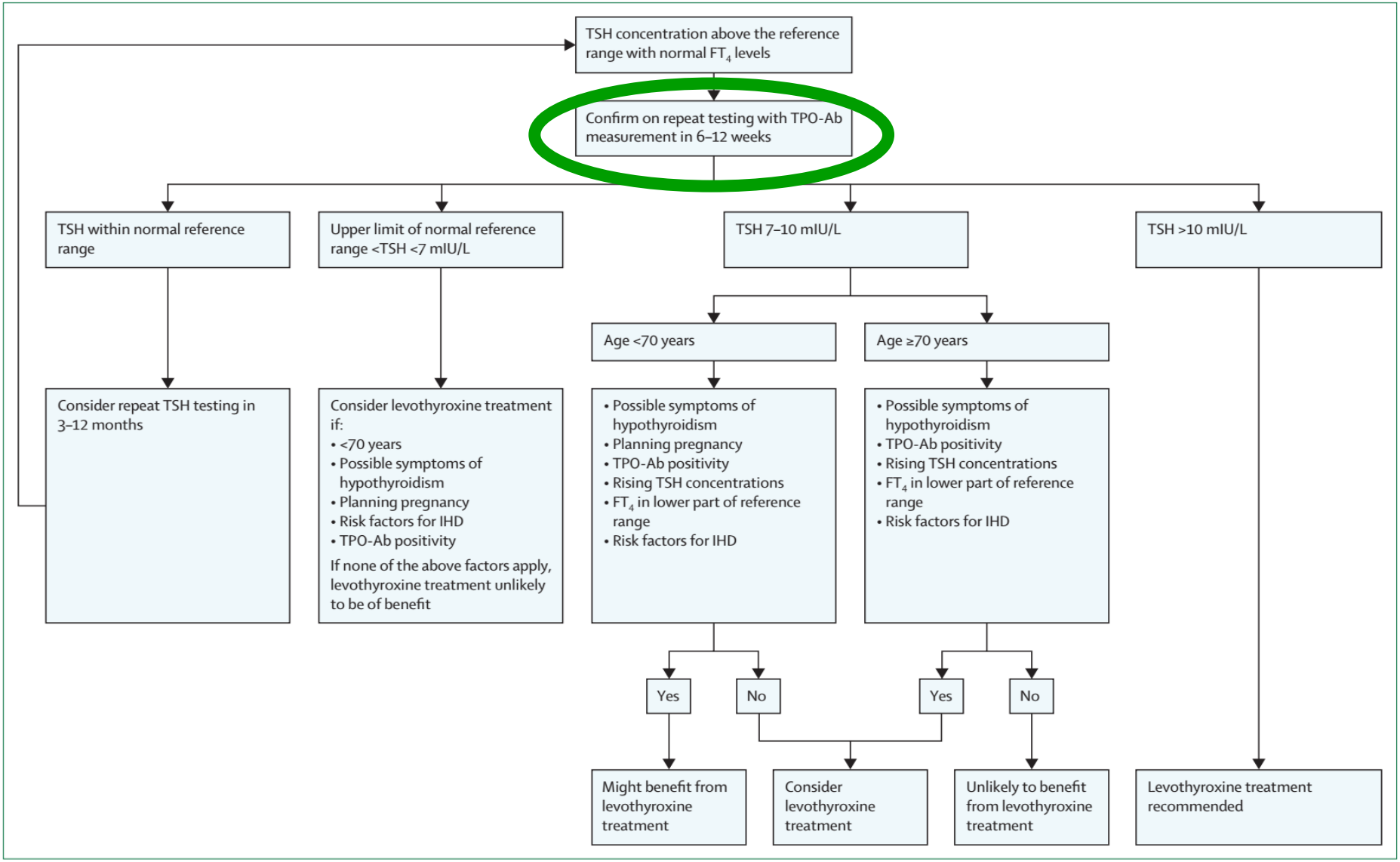


Figure 2: **Considerations and treatment thresholds for starting thyroid hormone replacement in patients with subclinical hypothyroidism**
Recommendations are based on guidelines from the American Thyroid Association,[109] European Thyroid Association,[142] and the UK National Institute of Health and Care Excellence.[107] FT_4=free thyroxine. IHD=ischaemic heart disease. TPO-Ab=thyroid peroxidase antibodies. TSH=thyroid-stimulating hormone.

TPO-Antikörper nur bei Hypothyreose bestimmen

TPO-Antikörper Positivität ist ein Hinweis aber kein Beweis für eine Hashimoto Thyreoiditis

TPO-Antikörper positive Personen mit latenter Hypothyreose haben ein etwa doppelt so hohes Risiko von einer latenten in eine manifeste Hypothyreose überzugehen

Wiederholte Bestimmungen der TPO-Antikörper bei Hashimoto Thyreoiditis sind nicht empfohlen da sie keinen diagnostischen Wert im Rahmen einer chronischen Schilddrüsenerkrankung haben

Pilz S, et al. J Klein Endokrinol Stoffw 2020;13:88-95

Empfehlung 5:

Keine routinemäßige Schilddrüsensonographie ohne Anzeichen/Symptome einer Schilddrüsenerkrankung, außer bei Risikopersonen für Schilddrüsenkrebs. Bei Knoten mit geringem Risiko die Indikation/Durchführung von Feinnadelaspirationen einschränken

Quelle

Italian Association of Medical Endocrinologists (AME)

JAMA | US Preventive Services Task Force | EVIDENCE REPORT

Screening for Thyroid Cancer

Updated Evidence Report and Systematic Review for the US Preventive Services Task Force

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends against screening for thyroid cancer in asymptomatic adults. (D recommendation)

Prevalence of Thyroid Disorders in the Working Population of Germany: Ultrasonography Screening in 96,278 Unselected Employees

THYROID
Volume 14, Number 11, 2004

Christoph Reiners,[1] Karl Wegscheider,[2] Harald Schicha,[3] Peter Theissen,[3] Renate Vaupel,[4] Renate Wrbitzky,[5] and Petra-Maria Schumm-Draeger[6]

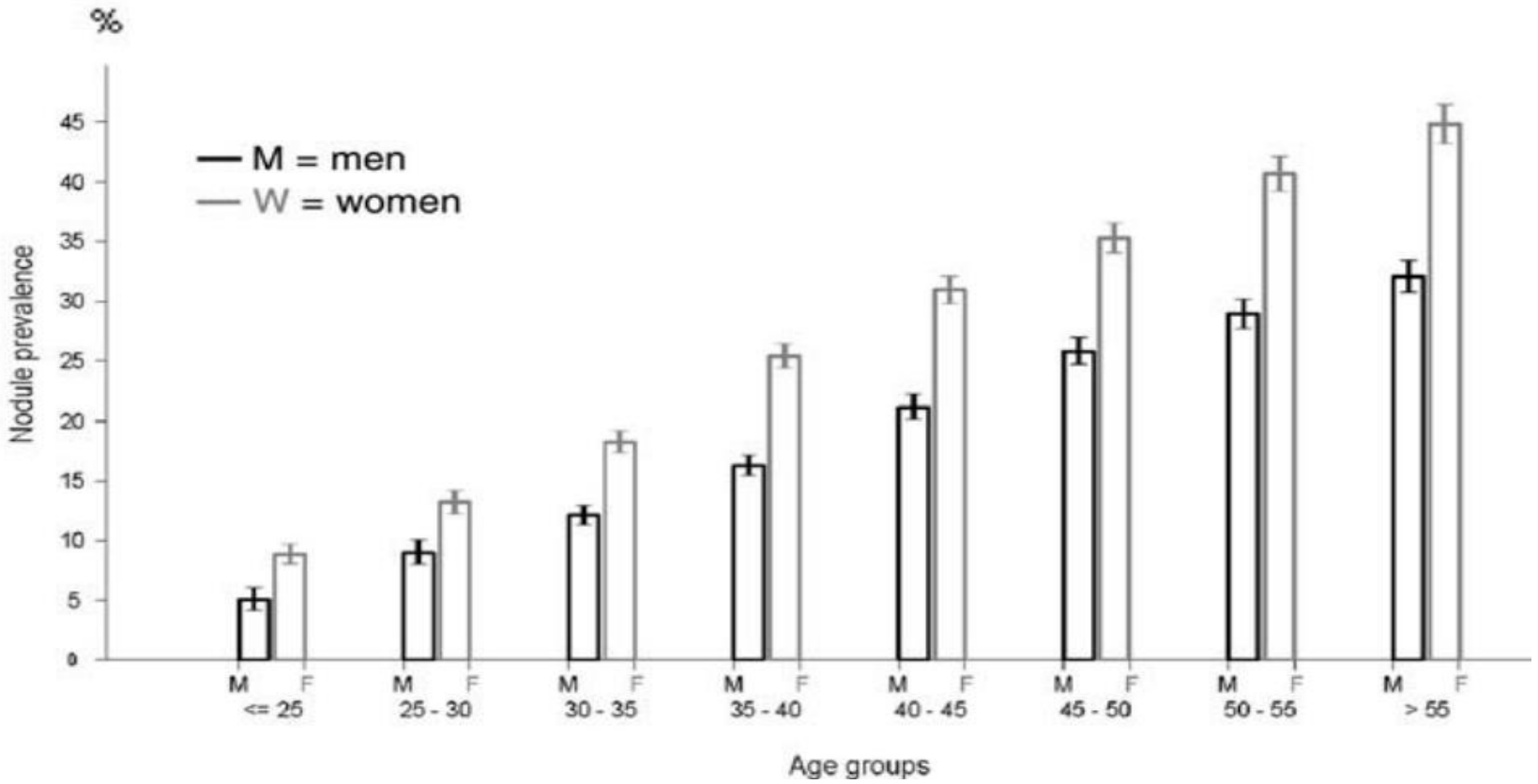


FIG. 2. Nodule prevalences by gender and age group. The column heights represent observed prevalences. The column tops are surrounded by 95% confidence limits for true prevalences.

Geographic variations in the frequency of thyroid disorders and thyroid peroxidase antibodies in persons without former thyroid disease within Germany

C Meisinger[1,2], T Ittermann[3], H Wallaschofski[4], M Heier[1,2], H Below[5], A Kramer[5], A Döring[6], M Nauck[4] and H Völzke[3]

European Journal of Endocrinology (2012) **167** 363–371

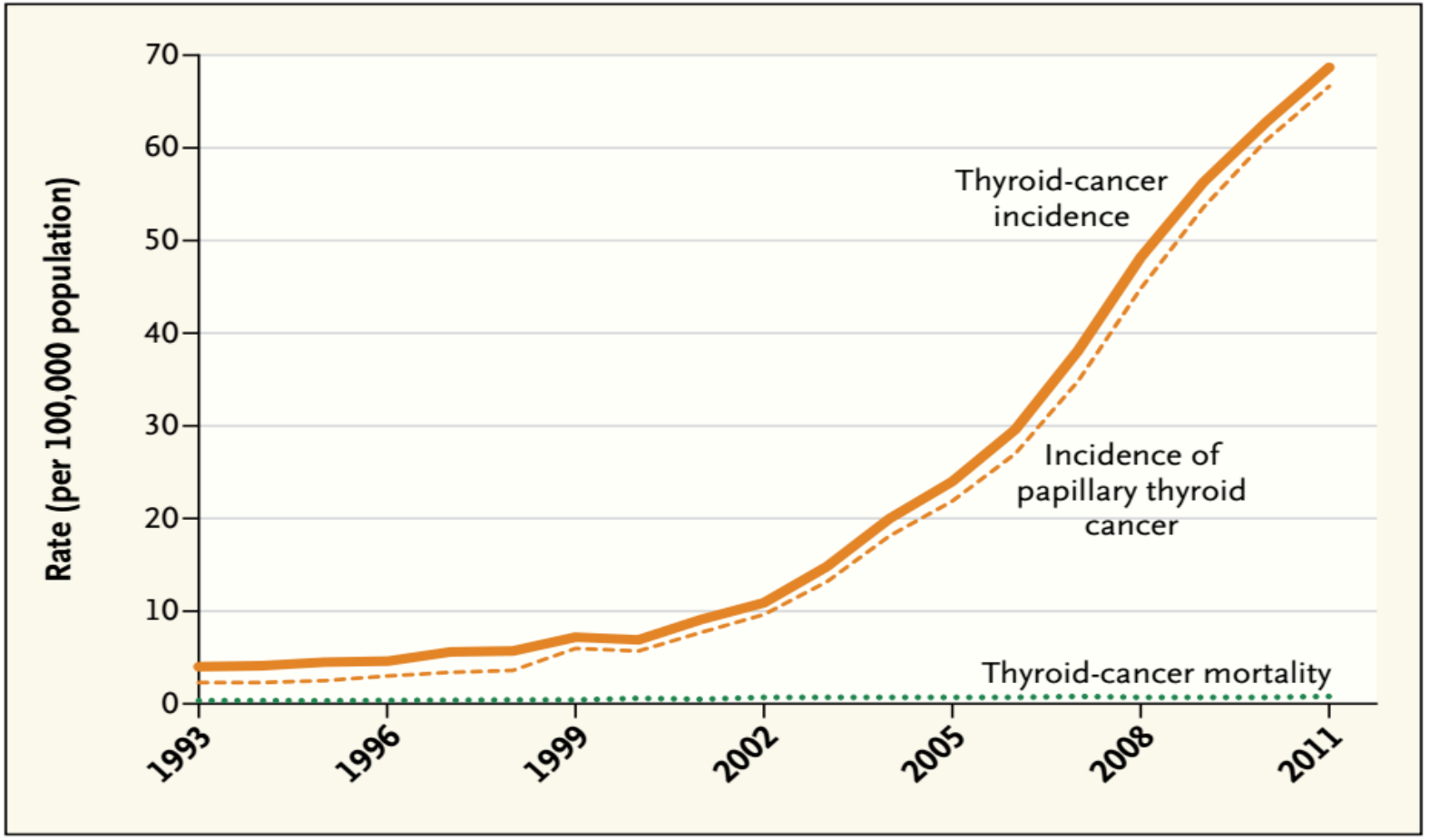
Table 2 Ultrasonographic findings in men stratified by study. Data are expressed as median and inter-quartile range (continuous variables) and as frequency in percentage (dichotomous variables).

	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	75–88 years
Thyroid volume (ml)						
SHIP	18.9 (15.7–22.4)	20.6 (17.4–26.0)	23.2 (18.5–28.5)	22.4 (18.1–28.2)	26.0 (19.8–33.2)	24.9 (19.3–35.1)
KORA	17.5 (15.2–22.1)	18.2 (14.7–23.9)	20.7 (16.5–28.0)	22.6 (17.7–29.0)	22.8 (18.1–30.5)	20.6 (17.4–29.3)
Goiter						
SHIP	15.0	31.4	40.8	37.4	53.7	49.7
KORA	19.5	21.6	34.2	37.2	45.1	36.9
Thyroid nodules						
SHIP	12.5	21.4	29.5	37.3	53.3	51.7
KORA	30.4	40.7	52.0	65.0	70.4	68.9

Korea's Thyroid-Cancer "Epidemic" — Screening and Overdiagnosis

N ENGL J MED 371;19 NEJM.ORG NOVEMBER 6, 2014

Hyeong Sik Ahn, M.D., Ph.D., Hyun Jung Kim, M.P.H., Ph.D., and H. Gilbert Welch, M.D., M.P.H.



Thyroid-Cancer Incidence and Related Mortality in South Korea, 1993–2011.

Data on incidence are from the Cancer Incidence Database, Korean Central Cancer Registry; data on mortality are from the Cause of Death Database, Statistics Korea. All data are age-adjusted to the South Korean standard population.

Korea's Thyroid-Cancer "Epidemic" — Screening and Overdiagnosis

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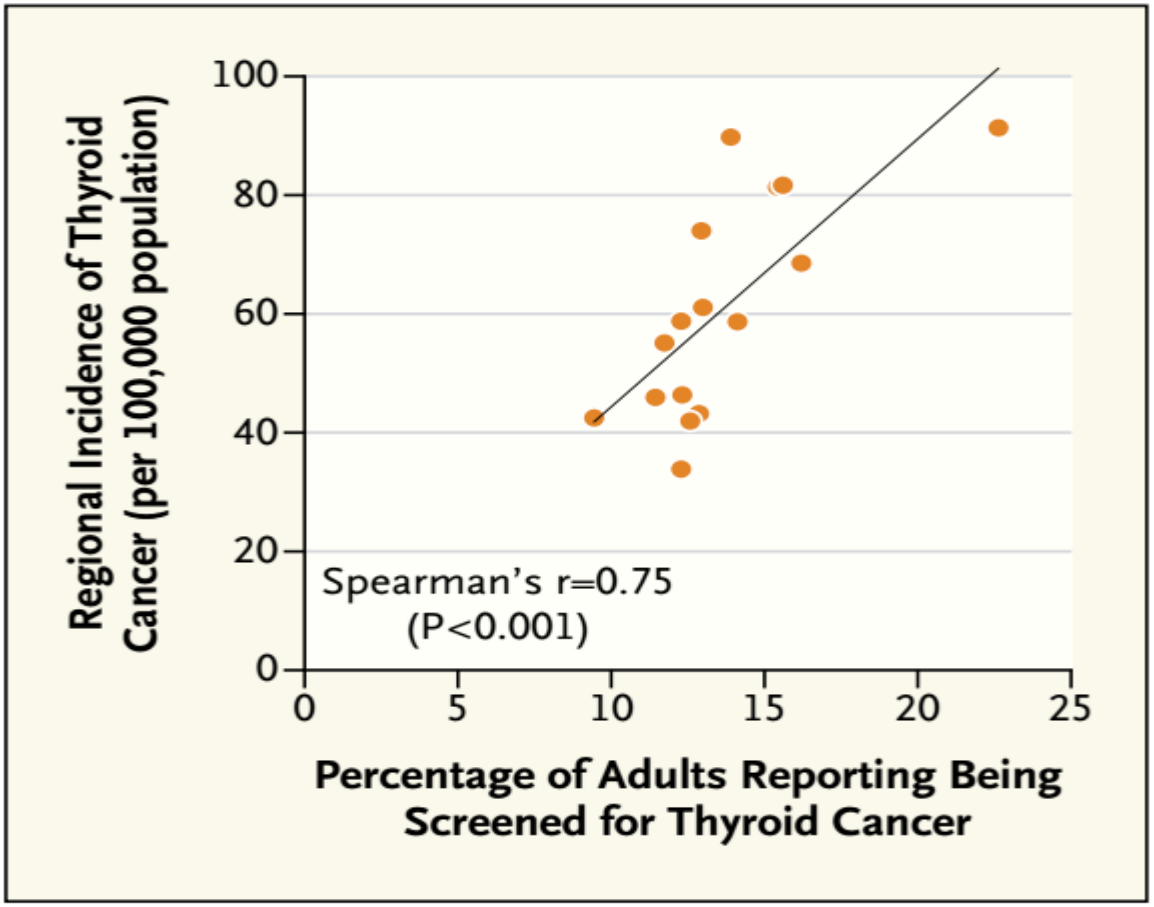

Penetration of Thyroid-Cancer Screening (2008–2009) and Incidence of Thyroid Cancer (2009) in the 16 Administrative Regions of South Korea.

The epidemiological landscape of thyroid cancer worldwide: GLOBOCAN estimates for incidence and mortality rates in 2020

Lancet Diabetes Endocrinol
2022; 10: 264–72

Margherita Pizzato, Mengmeng Li, Jerome Vignat, Mathieu Laversanne, Deependra Singh, Carlo La Vecchia, Salvatore Vaccarella

	Incidence				Mortality			
	Women		Men		Women		Men	
	Cases	ASR	Cases	ASR	Death	ASR	Death	ASR
World	448 915*	10·1	137 287*	3·1	27 740*	0·5	15 906*	0·3
Very high HDI	162 780	15·5	49 863	4·5	8166	0·4	4951	0·3
High HDI	247 066	13·6	74 559	4·1	12 465	0·6	6469	0·3
Medium HDI	30 832	2·7	10 393	0·9	4728	0·4	3640	0·4
Low HDI	8068	2·5	2440	0·9	2375	0·9	845	0·4

ASR=age-standardised rate. HDI=Human Development Index. *The estimated numbers of cancer cases and cancer deaths in a given region might not correspond to the sum of the estimated numbers of cancer cases and deaths in the individual countries of that region; the population of a region might include some small country populations for which it was not possible to provide estimates.

Table: **Numbers and rates per 100 000 of incidence and mortality for thyroid cancer by sex, according to the HDI 2020**

Implications of all the available evidence

The evidence from this study highlights that overdiagnosis of thyroid cancer has become a major public health issue in many settings worldwide. Monitoring epidemiological patterns is crucial to develop tailored prevention strategies to limit overdiagnosis, with its clinical and financial implications.

CLINICAL PRACTICE

Caren G. Solomon, M.D., M.P.H., *Editor*

N Engl J Med 2017;376:2556-65.
DOI: 10.1056/NEJMcp1611144

Subclinical Hypothyroidism

Robin P. Peeters, M.D., Ph.D.

ultrasonography is not recommended routinely for the evaluation of subclinical hypothyroidism.

DANKE

…allen Kolleg*innen der Choosing Wisely Gruppe

…allen Kolleg*innen des Institut für Allgemeinmedizin und evidenzbasierte Versorgungsforschung (Carolin Zipp, Andrea Siebenhofer-Kroitzsch, Karl Horvath, Klaus Jeitler, etc.)


ASK QUESTIONS
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memegenerator.net


27. JAHRESTAGUNG DER ÖGES
gemeinsam mit der OSDG und ANETS
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