XXXV
Congreso Nacional de la Sociedad Española de Medicina Interna (SEMI)
IV Congreso Ibérico de Medicina Interna
II Congreso de la Sociedad de Medicina Interna de la Región de Murcia

19-21 Noviembre 2014
Auditorio y Centro de Congresos Víctor Villegas
Murcia

Pacientes con enfermedades endocrinológicas distintas a la diabetes

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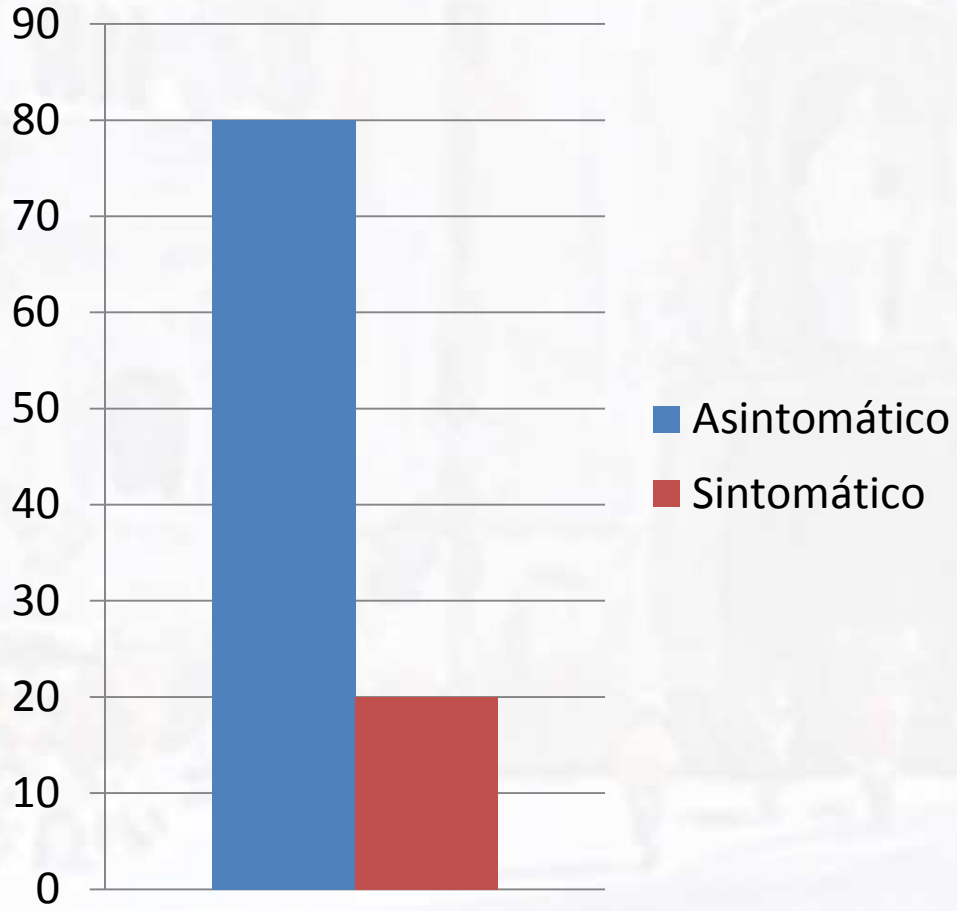
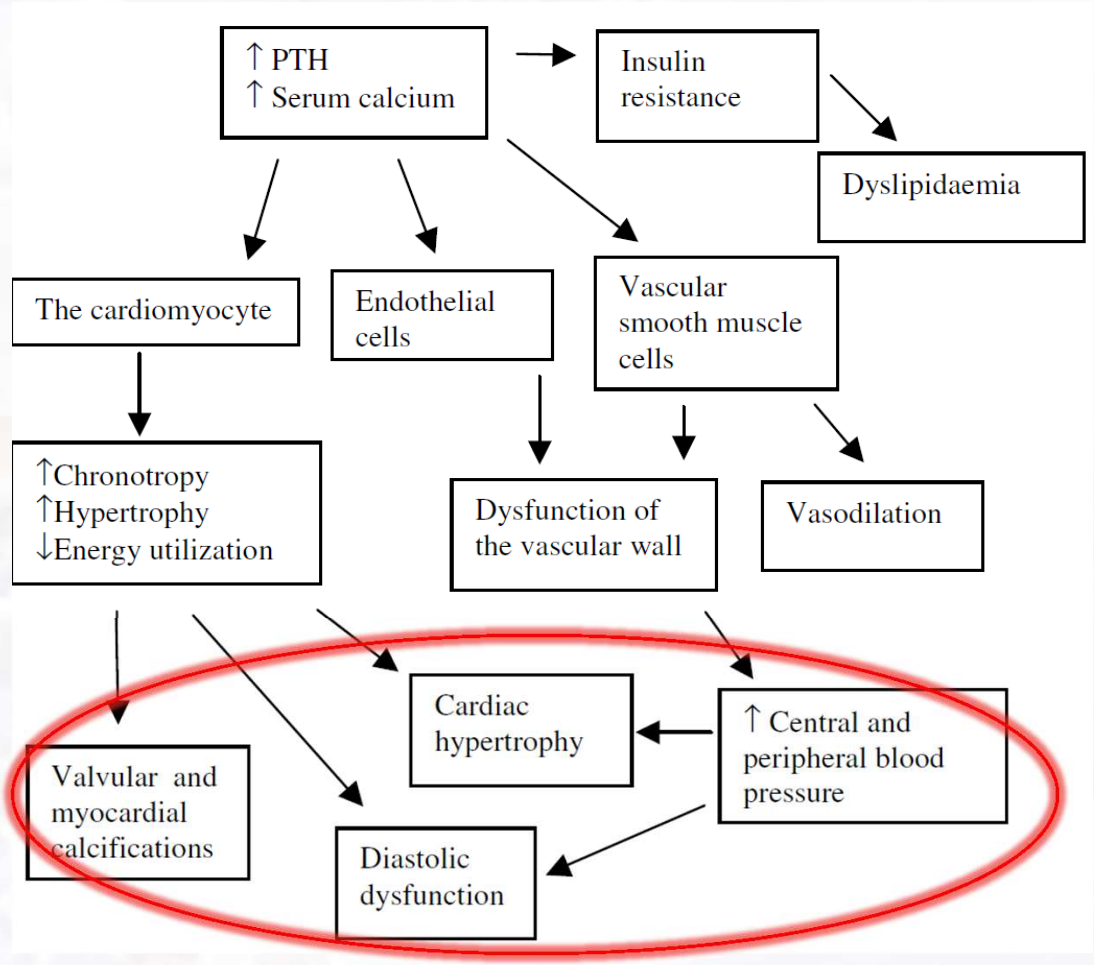
- HIPERPARATIROIDISMO PRIMARIO
- SÍNDROME DE CUSHING
- HIPOTIROIDISMO SUBCLÍNICO

Hiperparatiroidismo primario

- Hipercalcemia
- Nefrolitiasis
- Afectación ósea
- Hipertensión
- Afectación digestiva
- Manifestaciones neuropsiquiátricas



Hiperparatiroidismo primario



European Heart Journal (2004) 25, 1776–1787

Hiperparatiroidismo primario

Table 1 Clinical data regarding mortality studies among pHPT patients

Author (ref no.)	*N* (controls)	*N* (patients)	Mean age (patients)	Serum-calcium (mmol/l)	Mean follow-up time (years)	Relative risk of death vs. controls	Risk ratio for CVD
Hedbäck[5]	ES	896	57 ± 13	3.03 ± 0.50/ 2.81 ± 0.27[c]	12.9 ± 6.1	1.67 ($p < 0.001$)	1.66 ($p < 0.001$)
Hedbäck[6]	ES	915	61 ± 14	NP	3.5 (0—8)	1.30 ($p = 0.0099$)	1.71 95% CI (1.34—2.15)[d]
		3446	65 ± 13	NP	3.6 (0—8)	1.61 ($p < 0.001$)	1.85 95% CI (1.62—2.11)[d]
Palmer[26]	ES	441	58 ± 13	2.87 ± 0.30	7.7	1.06	1.17 ($p = 0.06$)[a]
Uden[29]	NP	282	59 (16—88)	2.91 (2.44—5.31)	8 ± 2	NP	1.18 (NS)
Palmer[31]	344	172	59 ± 12	2.72 ± 0.14	14	2.21 ($p = 0.0135$)	1.43 (NS)
Wermers[34]	ES	435	57 (16—89)	2.72 ± 0.12	NP	0.69 95% CI (0.57—0.83)[d]	0.60 95% CI (0.45—0.79)[d,b]

European Heart Journal (2004) 25, 1776–1787

Hiperparatiroidismo primario

Table 2 Clinical data regarding LVM studies

Author (ref no.)	*N* (patients)	*N* (controls)	Mean age of the patients (years)	BP patients vs controls	Calcium (mmol/l)	PTH (pg/ml)	LVMI patients	LVMI controls	P LVMI
Längle[70]			57 ± 16						
Asymptomatic	7	NP		NP	2.83 ± 0.17	123 ± 47	LVMI NP	LVMI NP	
Minimal symptoms	48	NP		NP	3.03 ± 0.36	174 ± 127	LVMI NP	LVMI NP	
Symptomatic	77	NP		NP	3.08 ± 0.47	279 ± 263	LVMI NP	LVMI NP	
Stefenelli[19]	69	NP	64 ± 10	NP	2.98 ± 0.41	209 ± 120	11.5 ± 2.0[c]	10.1 ± 2.2[ce]	<0.05
Stefenelli[20]	54	50	61 ± 11	NS	2.99 ± 0.28	231 ± 208	12.2 ± 1,4[cd]	10.8 ± 1.7[cd]	<0.001
Dalberg[71]	44	23	61 (52–70)[a]	NS	2.78 (2.69–2.92)[a]	82 (73–102)[a]	11.0[c]	9.5[c]	0.03
Piovesan[21]	43	43	60 ± 13	NS	2.81 ± 0.30	161 ± 73	136.1 ± 24	114 ± 15	<0.05
Almqvist[22]	25	25	70 ± 8/68 ± 9[b]	NS	2.62 ± 0.11	82 ± 34	112 ± 27[b]	131 ± 34[b]	<0.05
Dominiczak[17]	23	23	54 ± 3	NS	2.73	5.8 (units/l)	123 ± 10	100 ± 6	0.03
Nilsson[75]	30	30	64 ± 12	NS	2.64 ± 0.11	77 ± 24	124 ± 5	114 ± 4	0.06
Barletta[52]	14	20	60 ± 11	NS	2.88 ± 0.26	215 ± 188	91 ± 18	89 ± 19	NS
Nuzzo[9]	20	20	53 ± 9	NS	3.04 ± 0.22	280 ± 165	113 ± 13	111 ± 11	NS

European Heart Journal (2004) 25, 1776–1787

Hiperparatiroidismo primario

Table 3 Clinical data regarding diastolic function among pHPT patients

Author (ref no.)	*n*	BP pre-op vs. post-op	E/A pre-op	E/A post-op	*p*
Dalberg[71]	44	$p < 0.01$[c]	[a]	[a]	<0.02
Näppi[23]	15	NP	1.028 ± 0.373	0.909 ± 0.278	NS
Stefenelli[19]	16	NS	NP	NP	NS
I-L Nilsson[75]	30	NS	0.99 ± 0.07	1.0 ± 0.06	NS
Ohara[78]	14	NS	1.51 ± 0.51[b]	1.12 ± 0.32[b]	<0.01
Almqvist[22]	50	NS	0.81 ± 0.20	0.95 ± 0.38	<0.05
Barletta[52]	14	NS	0.94 ± 0.18	0.96 ± 0.16	NS

European Heart Journal (2004) 25, 1776–1787

Hiperparatiroidismo primario

Table 4 Clinical data regarding cardiac calcifications among pHPT patients

Author (ref no.)	*n*	Aortic valve (%)	Mitral valve (%)	Myocardial (%)	Calcium (mmol/l)	PTH (pg/ml)
Längle[70]	132					
Asymptomatic	7	14	14	86	2.83 ± 0.17	123 ± 47
Minimal symptoms	48	33	4	58	3.03 ± 0.36	174 ± 127
Symptomatic	77	14	16	61	3.08 ± 0.47	279 ± 263
Stefenelli[20]	54	63	49	69	2.99 ± 0.28	231 ± 208
Stefenelli[19]	69	54	39	74	2.98 ± 0.41	209 ± 119

European Heart Journal (2004) 25, 1776–1787

Hiperparatiroidismo primario

Table I. Symptoms and end-organ damage in PHPT patients ($n = 56$)

Symptoms		*%*
Bone pain	42	75
Bone swelling/deformity	11	19.6
Fractures	10	17.8
Osteoporosis (t score < -2.5)	33	58.9
Muscle weakness	23	41.1
Nephrocalcinosis/Nephrolithiasis	25	44.6
Behavioral problems	14	25
Acute or chronic pancreatitis	9	16.1
Acid peptic disease	28	50

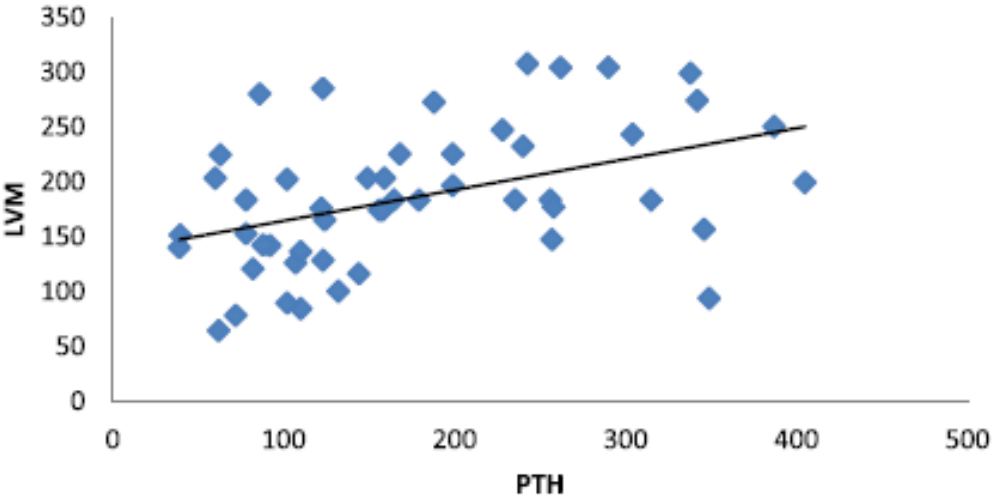
	Controls (n = 25)	*PHPT* (n = 56)	P *value*
s. calcium, mg/dL	8.7 ± 0.5	11.5 ± 1.3	.001
s. NT-proBNP, pg/mL	58 ± 49	463 ± 1,130	.002
Two-dimensional echocardiographic indices			
LVEDD, mm	43.7 ± 5.2	43.5 ± 6.5	.95
LVESD, mm	26.6 ± 4.3	26.6 ± 6.9	.63
LVEDV, mL	63.6 ± 18.3	67.3 ± 23.0	.63
LVESV, mL	27.1 ± 8.5	25.2 ± 11.3	.34
LVM, g	148.9 ± 44.1	192 ± 70.1	.006
IVS, mm	9.0 ± 1.6	10.8 ± 2.5	.001
PW, mm	8.6 ± 2.2	9.9 ± 2.0	.004
LVEF, %	64 ± 6	62 ± 9	.10
E/A ratio	1.3 ± 0.4	1.1 ± 0.5	.01
IVRT, ms	89.5 ± 25	87 ± 23	.44
Calcification, %	8	26.7	.05
Tissue Doppler imaging, m/s			
Eα	0.13 ± 0.05	0.11 ± 0.0	.02
Aα	0.11 ± 0.04	0.26 ± 0.9	.19
S	0.74 ± 3.1	0.14 ± 0.1	.33
Vasodilatory response studies, %			
FMD	12 ± 6	9 ± 9	.03
NMD	24 ± 11	20 ± 18	.01

(Surgery 2013;154:1394-404.)

Hiperparatiroidismo primario

Table IV. Pearson's product moment correlation analysis on biochemical parameters and left ventricular mass in PHPT patients

	Left ventricular mass	
	R value	P *value*
s. PTH	0.502	<.001
s. Calcium (total)	0.061	.680
s. 25 hydroxy vitamin D	−0.194	.177
s. NT-pro BNP	0.039	.790



(Surgery 2013;154:1394-404.)

Hiperparatiroidismo primario

Table VII. Linear changes in biochemical, two-dimensional echocardiographic, tissue Doppler imaging, and vasodilatory response indices in hypertensive primary hyperparathyroidism patients after parathyroidectomy

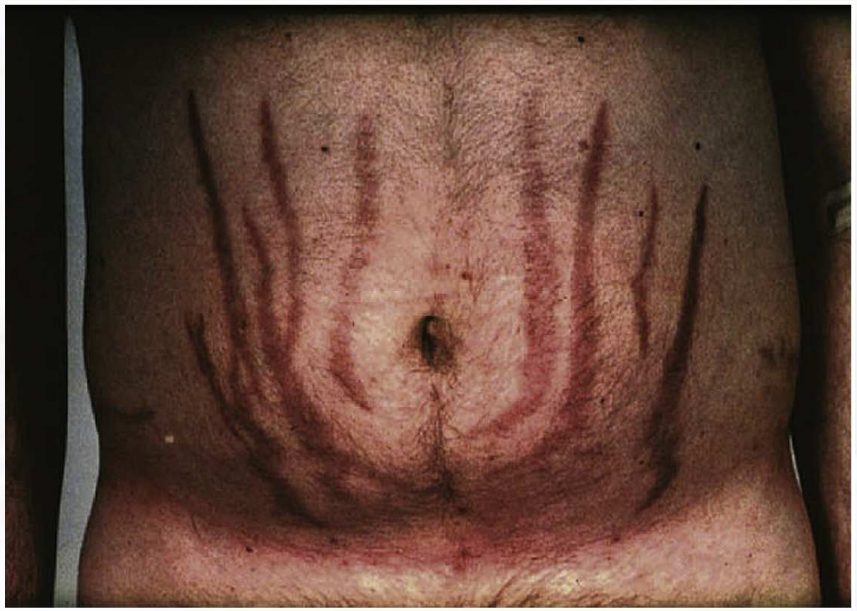
	Baseline value	*3 month after PTx*	P *value*	*6 month after PTx*	P *valu*
s. calcium, mg/dL	11.5 ± 1.2	9.1 ± 1.1	<.001	9.1 ± 0.7	<.001
s. NT-proBNP, pg/mL	399 ± 695	236 ± 363	0.211	231 ± 372	.272
Two-dimensional echocardiographic indices					
LVEDD, mm	45.2 ± 4.5	43.6 ± 7.3	.020	42.1 ± 3.9	.001
LVEDS, mm	27.2 ± 3.7	27.7 ± 3.9	.605	27.0 ± 4.1	.872
LVEDV, mL	67.5 ± 25.4	65.3 ± 22.6	.551	68.9 ± 25.6	.626
LVESV, mL	25.3 ± 11.5	25.5 ± 15.4	.944	21.6 ± 11.4	.037
IVS, mm	11.8 ± 2.3	11.6 ± 2.0	.454	11.3 ± 2.9	.189
PW, mm	10.2 ± 1.6	10.3 ± 1.7	.806	9.7 ± 1.6	.150
LVEF, %	60 ± 9	65 ± 12	.117	68 ± 14	.011
Stroke volume, mL	42.0 ± 17.1	38.7 ± 18.9	.535	47.3 ± 19.6	.071
LVM, g	215.0 ± 59.9	202.7 ± 61.3	.059	171.3 ± 63.6	.014
E/A ratio	1.1 ± 0.4	1.1 ± 0.4	.043	1.2 ± 0.4	.001
IVRT, ms	88.3 ± 23.1	89.7 ± 18.2	.778	91.1 ± 15.9	.471
Tissue Doppler imaging, m/s					
Eα	0.098 ± 0.04	0.11 ± 0.04	.034	0.12 ± 0.02	.003
Aα	0.58 ± 1.7	0.10 ± 0.02	.31	0.10 ± 0.02	.02
S	0.17 ± 0.21	0.10 ± 0.03	.26	0.11 ± 0.04	.09
Vasodilatory response studies, &					
FMD	10 ± 10	12 ± 8	.28	11 ± 6	.77
NMD	21 ± 16.5	21 ± 16	.56	26 ± 17	.036

(Surgery 2013;154:1394-404.)

Síndrome de Cushing

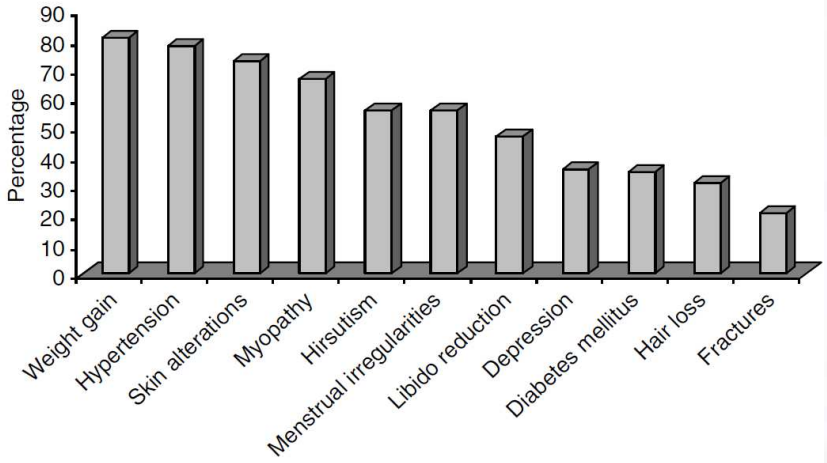
Clinical features of Cushing's syndrome

- Obesity
- Moon facies
- Hypertension
- 'Buffalo hump'
- Thin skin[a]
- Hirsutism
- Oligomenorrhoea/amenorrhoea
- Purple striae
- Impaired glucose tolerance/diabetes mellitus
- Proximal muscle atrophy[a]
- Psychiatric disturbance
- Osteoporosis
- Bruising[a]
- Acne
- Hypokalaemia



Medicine 2013; 41, 9

EUROPEAN JOURNAL OF ENDOCRINOLOGY (2011) **165**



	PIT-CS	ADR-CS	ECT-CS	OTH-CS	Overall
General practitioner	198/260 (76)	90/114 (79)	18/22 (82)	5/10 (50)	311/406 (77)
Diabetologist	58/236 (25)	19/98 (19)	9/22 (41)†	2/9 (22)	88/365 (24)
Gynaecologist	47/193 (24)*	21/85 (25)*	1/11 (9)	2/8 (25)	71/297 (24)
Psychiatrist/psychologist	28/226 (12)	10/97 (10)	2/22 (9)	2/10 (20)	42/355 (12)
Rheumatologist/orthopaedist	25/224 (11)	10/96 (10)	2/22 (9)	2/10 (20)	39/352 (11)
Dermatologist	18/227 (8)	5/97 (5)	1/22 (5)	2/10 (20)	26/356 (7)
Other [a]	121/229 (53)	47/90 (52)	10/18 (56)	6/9 (67)	184/346 (53)

European Journal of Endocrinology 165 383–392

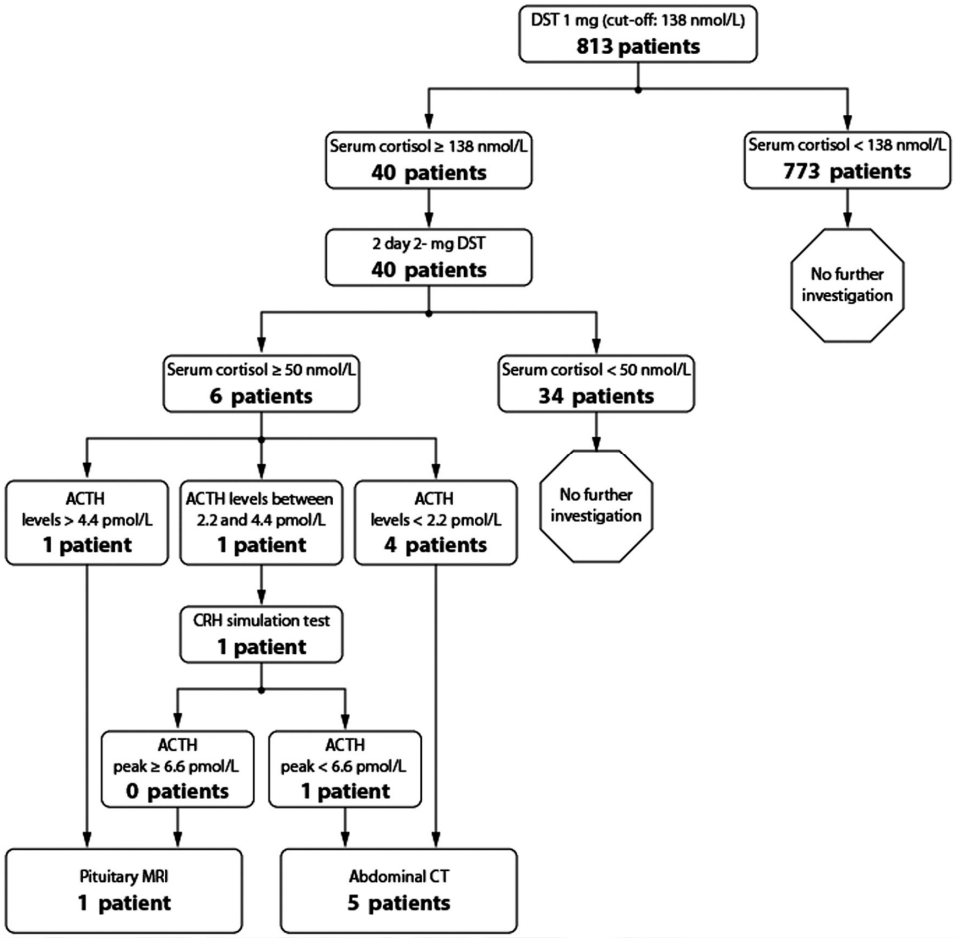


TABLE 2. Comparison of patients with post-DST cortisol 5 μg/dl or less (DST suppressors) and post-DST cortisol greaster than 5 μg/dl (DST nonsuppressors)

	DST suppressors (n = 773)	DST nonsuppressors (n = 34)[a]	*P* value
Age (yr)	58.6 ± 8.8	56.4 ± 9.8	NS
BMI (kg/m^2)	32.1 ± 6.1	30.9 ± 4.6	NS
Duration of disease (yr)	9.8 ± 7.9	8.9 ± 5.2	NS
Fasting glucose (mg/dl)	172.5 ± 65.1	236.8 ± 100.8	<0.0001
HbA1c (%)	8.4 ± 1.9	9.2 ± 2.0	0.01
Systolic blood pressure (mm Hg)	137.9 ± 17.2	147.7 ± 16.4	0.04
Diastolic blood pressure (mm Hg)	82.6 ± 10.1	80.7 ± 10.9	NS

(J Clin Endocrinol Metab 97: 3467–3475, 2012)

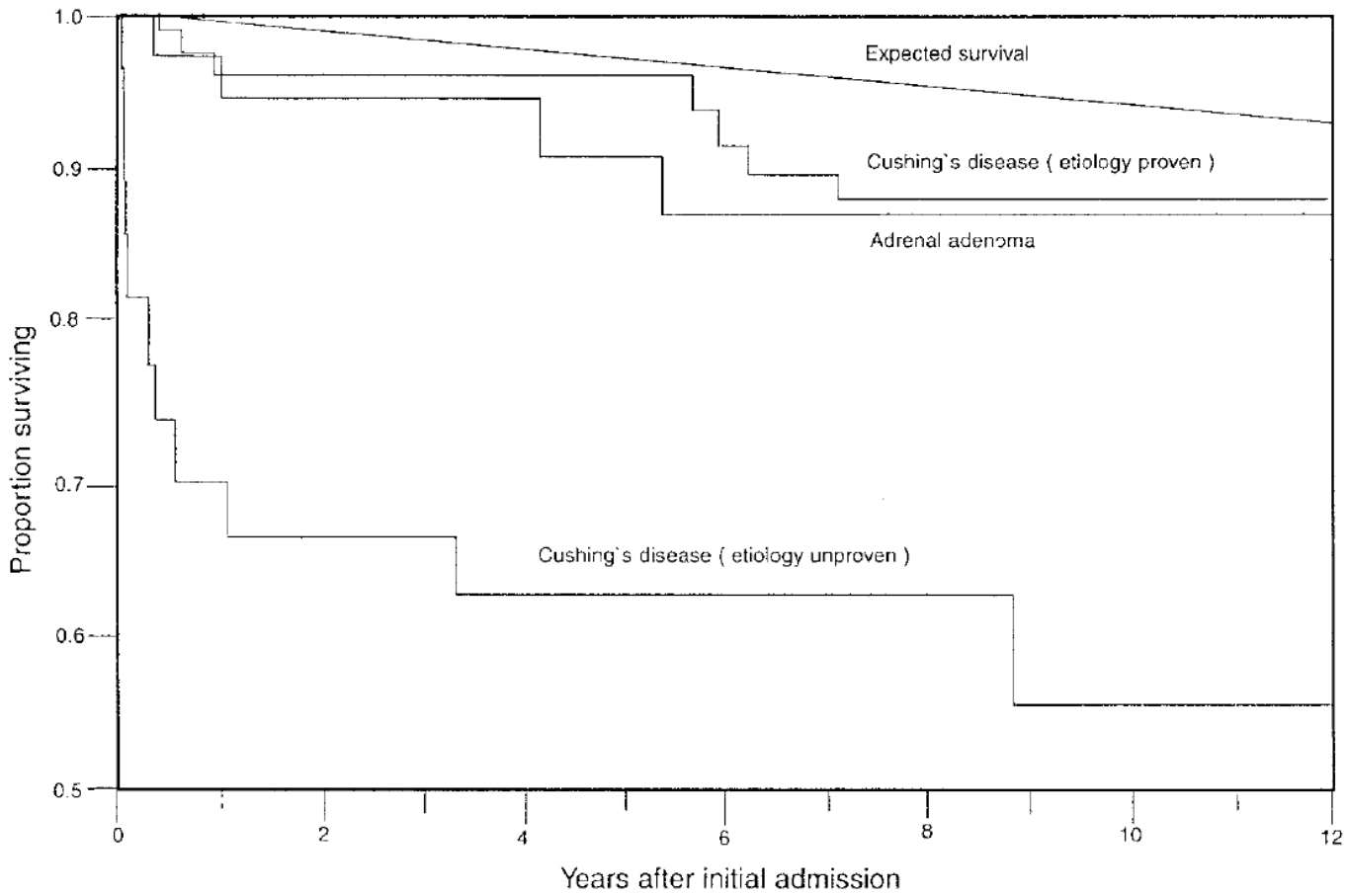
Incidence and Late Prognosis of Cushing's Syndrome: A Population-Based Study

TABLE 2. Standard mortality ratios (SMR) in patients with Cushing's syndrome

Diagnosis	No. of patients	Age[a] (yr), median, range	No. of deaths	Time at risk (yr)	Expected no. deaths	SMR (95% CI)	P^b
Cushing's disease (etiology proven)	73	41.1, 7.6–69.7	7	560.0	4.12	1.70 (0.68–3.50)	0.14
Cushing's disease (etiology unproven)	26	51.1, 24.9–74.1	11	153.1	0.96	11.48 (5.73–20.5)	<0.001
Adrenal adenoma	37	38.3, 3.6–77.7	4	255.2	1.15	3.48 (0.95–8.90)	0.04

CI, Confidence interval.
[a] Age at first admission.
[b] Compared to the expected from national mortality rates.

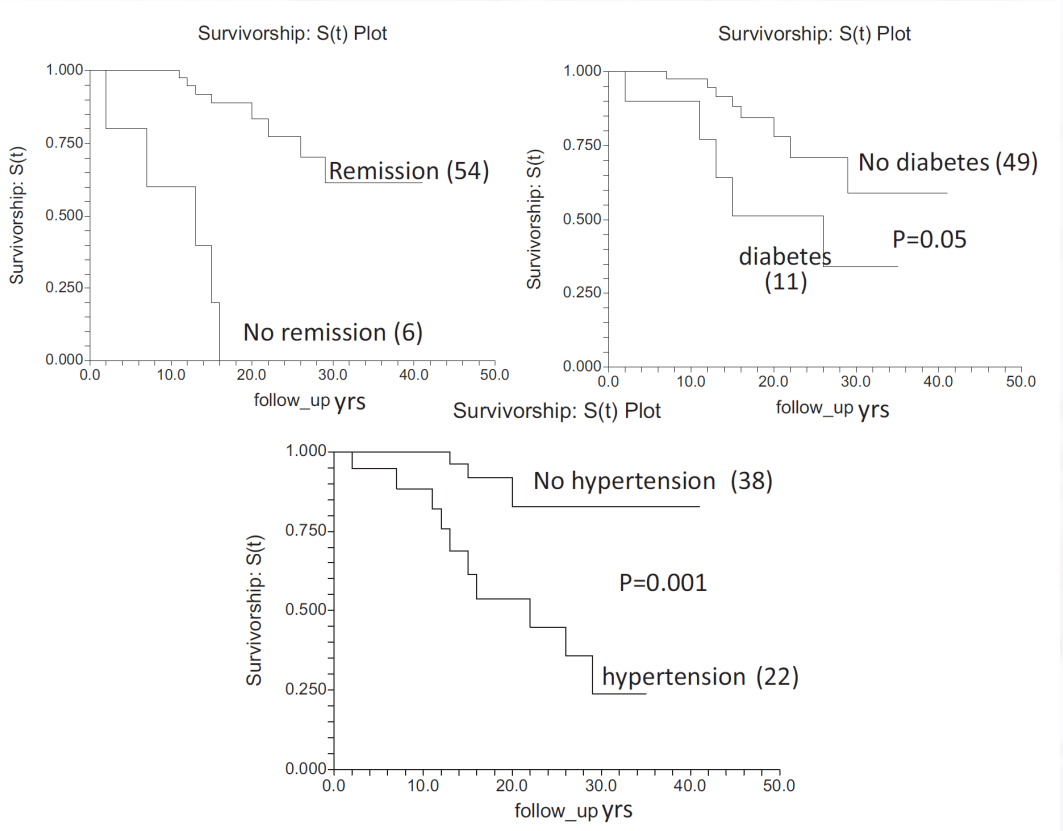
J Clin Endocrinol Metab 86: 117–123,



J Clin Endocrinol Metab 86: 117–123,

TABLE 2. SMRs for Stoke Cushing's patients

	No. of deaths	Expected no. of deaths	SMR (95% CI)	*P* value
Overall	13	2.7	4.8 (2.8-8.3)	<0.0001
Vascular	9	0.65	13.8 (7.2-26.5)	<0.0001
Remission	8	2.4	3.3 (1.7-6.7)	0.0006
Persistent	5	0.3	16.0 (6.7-38.4)	<0.0001
Diagnosis before 1985	10	1.6	6.1 (3.3-11.4)	<0.0001
Diagnosis after 1985	3	1.1	2.8 (0.9-8.6)	0.076



J Clin Endocrinol Metab 96: 632–642, 2011)

Predictors of Mortality and Long-term Outcomes in Treated Cushing's Disease: A Study of 346 Patients

- 346 pax
- 6.3 años seguimiento
- Mortalidad total 9% (independiente de GC y dependiente depresión)
- 30 eventos CV (incluye ETEV).

Table 4. Predictors of Cardiovascular Events in the Total Cohort

Variable	HR (95% CI)	*P* Value
Age at diagnosis	1.056 (1.026–1.088)	0.000
Male sex	2.969 (1.026–6.215)	0.004
Depression	2.315 (1.057–5.068)	0.036
Diabetes	2.645 (1.270–5.505)	0.009

Multivariate regression model included age at diagnosis, sex, preoperative diabetes, and depression. Total number of subjects = 345, number of events = 30.

J Clin Endocrinol Metab 98: 1022–1030, 2013

Risk of cardiovascular events in people prescribed glucocorticoids with iatrogenic Cushing's syndrome: cohort study

Table 5| **Adjusted hazard ratios (95% confidence intervals) of cardiovascular events in patients with iatrogenic Cushing's syndrome**

	Compared with patients without iatrogenic Cushing's syndrome (n=3231)				Compared with patients not prescribed glucocorticoids (n=3282)			
Cardiovascular events	Crude hazard ratio (95% CI)	P value	Adjusted hazard ratio* (95% CI)	P value	Crude hazard ratio (95% CI)	P value	Adjusted hazard ratio† (95% CI)	P value
All (n=341)	2.33 (1.73 to 3.14)	<0.001	2.74 (2.06 to 3.62)	<0.001	3.70 (2.63 to 5.22)	<0.001	4.16 (2.98 to 5.82)	<0.001
Coronary heart disease (n=177)	1.96 (1.29 to 2.97)	0.002	2.27 (1.48 to 3.47)	<0.001	2.97 (1.91 to 4.64)	<0.001	2.68 (1.62 to 4.44)	<0.001
Cerebrovascular event (n=63)	2.26 (1.06 to 4.81)	0.02	2.23 (0.96 to 5.17)	0.07	1.79 (0.85 to 3.76)	0.12	2.14 (0.97 to 4.73)	0.06
Heart failure (n=101)	2.97 (1.82 to 4.84)	<0.001	3.77 (2.41 to 5.90)	<0.001	9.74 (4.98 to 19.06)	<0.001	13.31 (7.24 to 24.51)	<0.001

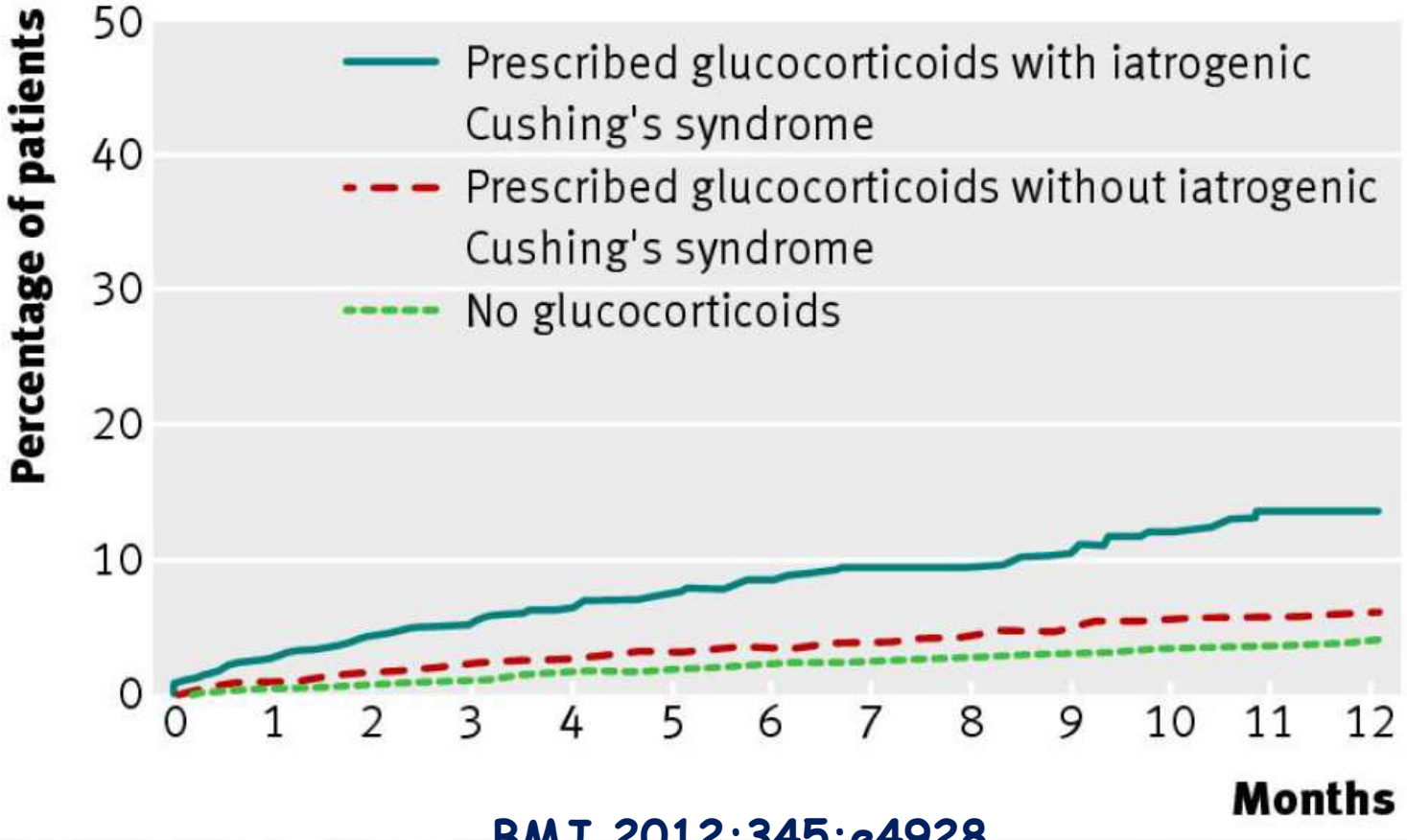
*Adjusted for age, sex, initial dosage of glucocorticoids and duration of use, underlying disease, smoking status, and use of aspirin, oral anticoagulants, diabetes drugs, antihypertensive drugs, and cholesterol lowering drugs.

†Adjusted for age, sex, underlying disease, smoking status, and use of aspirin, oral anticoagulants, diabetes drugs, antihypertensive drugs, and cholesterol lowering drugs.

BMJ 2012;345:e4928

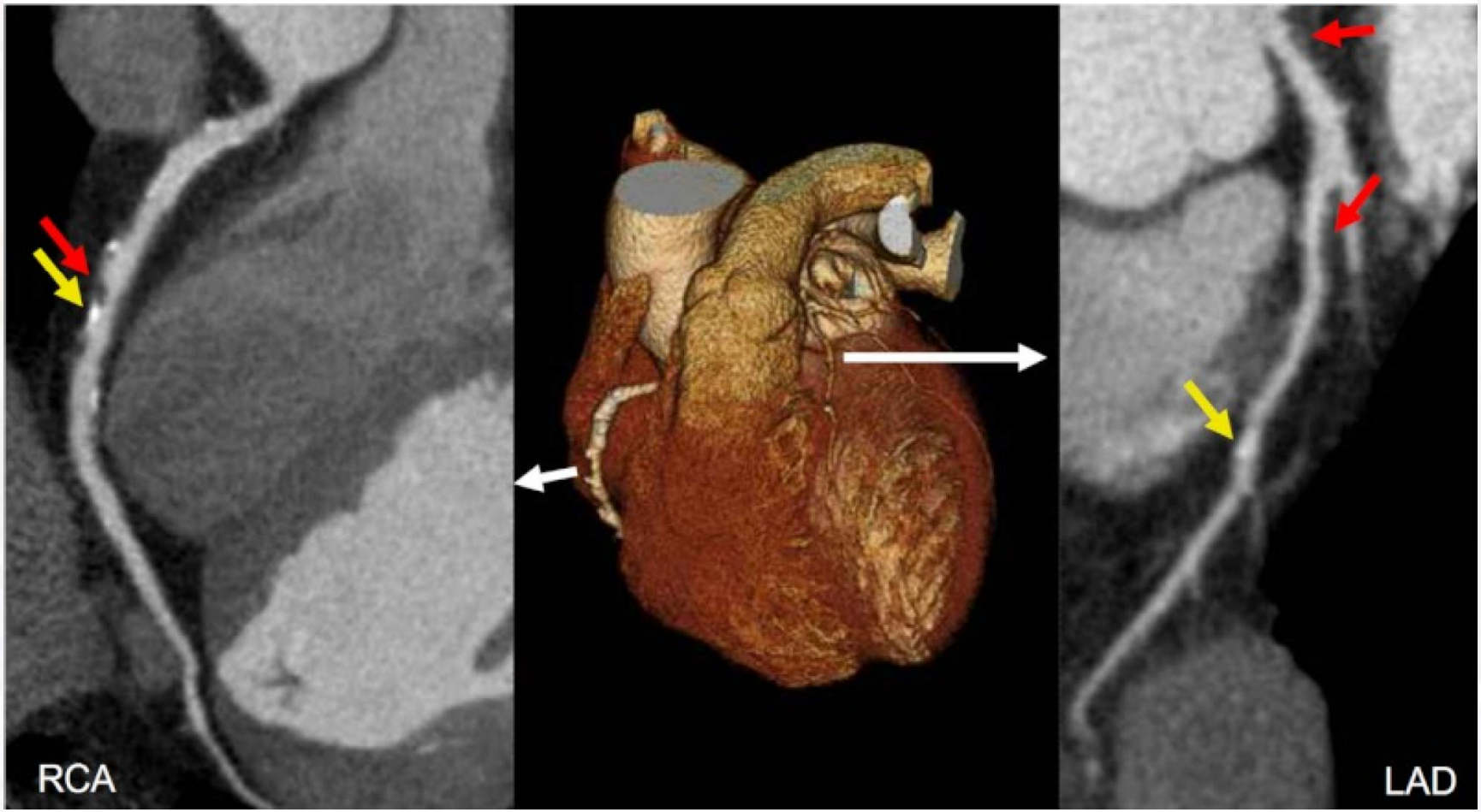
Risk of cardiovascular events in people prescribed glucocorticoids with iatrogenic Cushing's syndrome: cohort study

Kaplan-Meier survival curves showing cumulative incidence of cardiovascular events over time in the three study groups



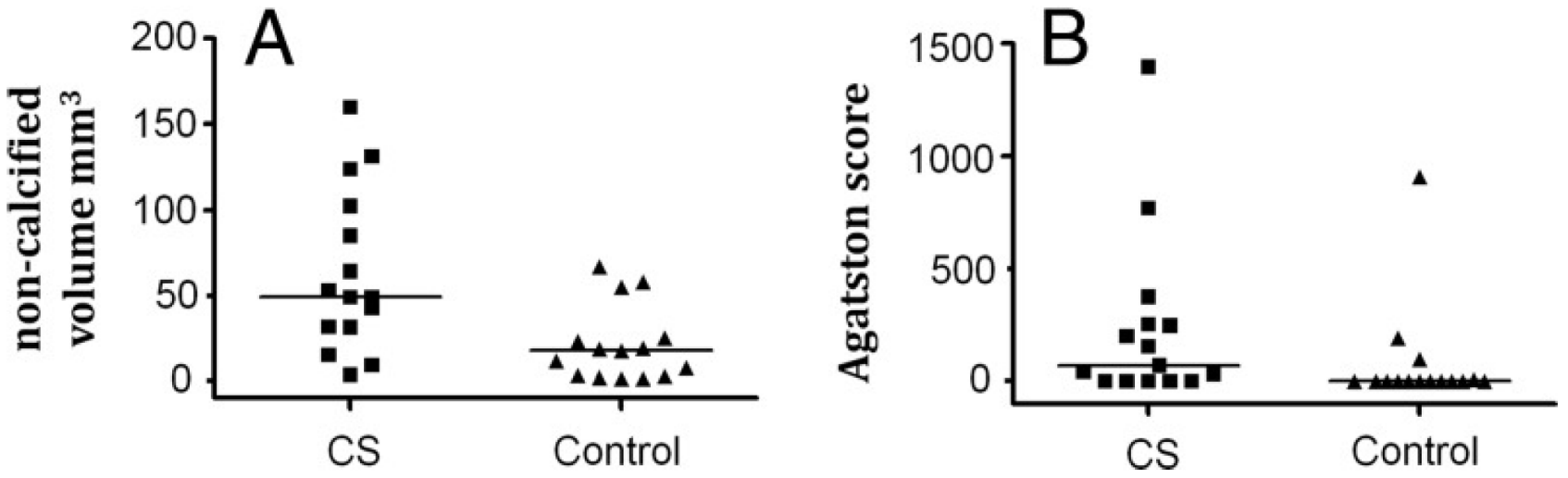
BMJ 2012;345:e4928

Hypercortisolism Is Associated With Increased Coronary Arterial Atherosclerosis



J Clin Endocrinol Metab. May 2013; 98(5): 2045–2052

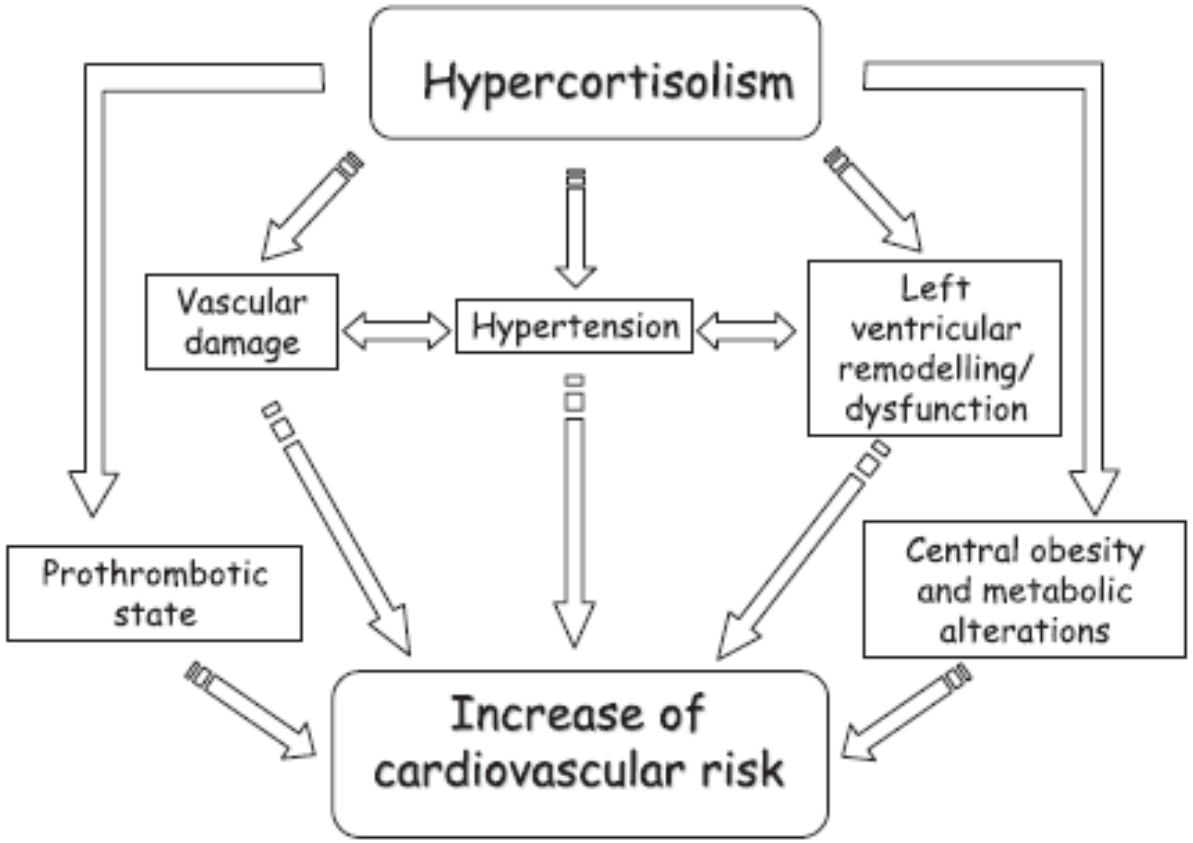
Hypercortisolism Is Associated With Increased Coronary Arterial Atherosclerosis



Scatter plots in patients with CS and age-, sex-, and BMI-matched controls of (A) noncalcified plaque volume ($P < .001$ between groups) and (B) Agatston score, a measure of calcified plaque volume ($P < .05$ between groups). The horizontal lines represent the median value for each group.

J Clin Endocrinol Metab. May 2013; 98(5): 2045–2052

Mechanisms of increased cardiovascular risk mediated by hypercortisolism



Clinical Endocrinology (2009) 71, 768–771

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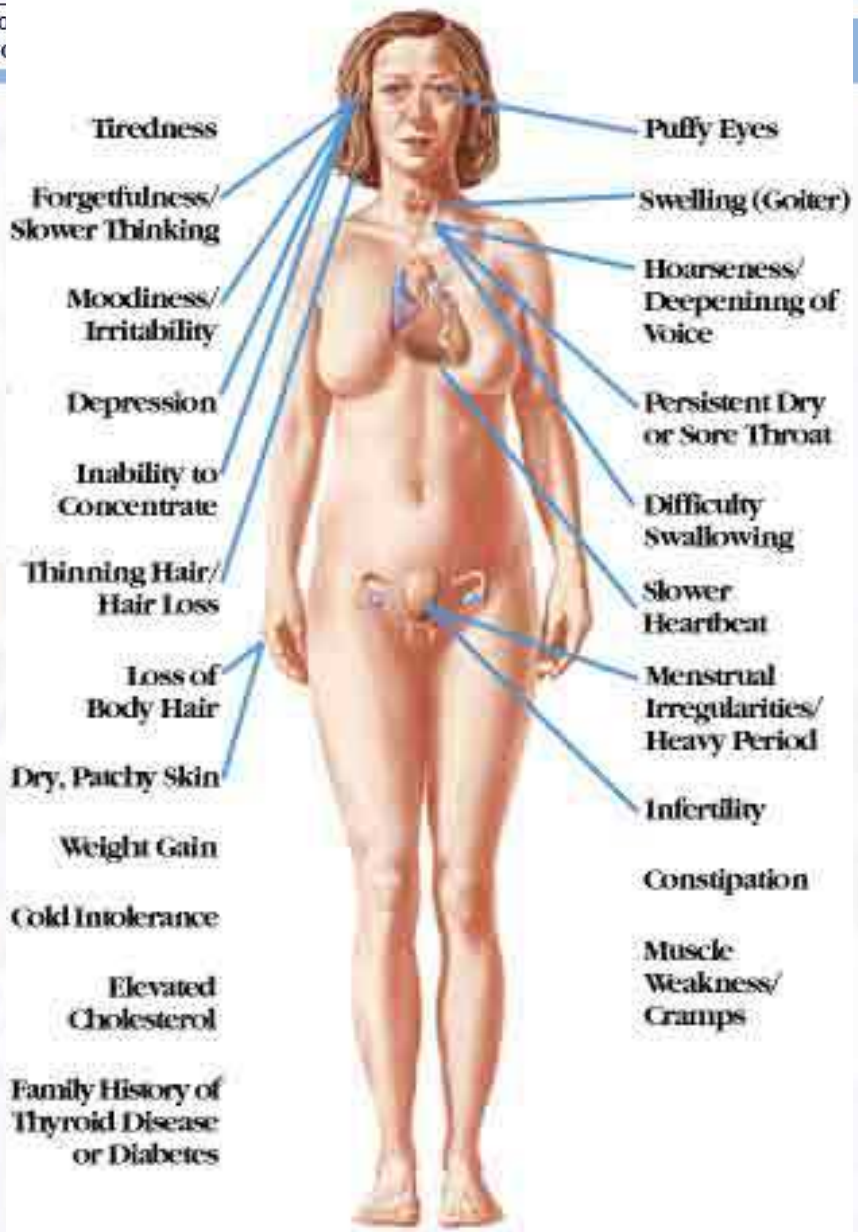
Signs and Symptoms of HYPOTHYROIDISM



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DE LA PERSONA ENFERMA

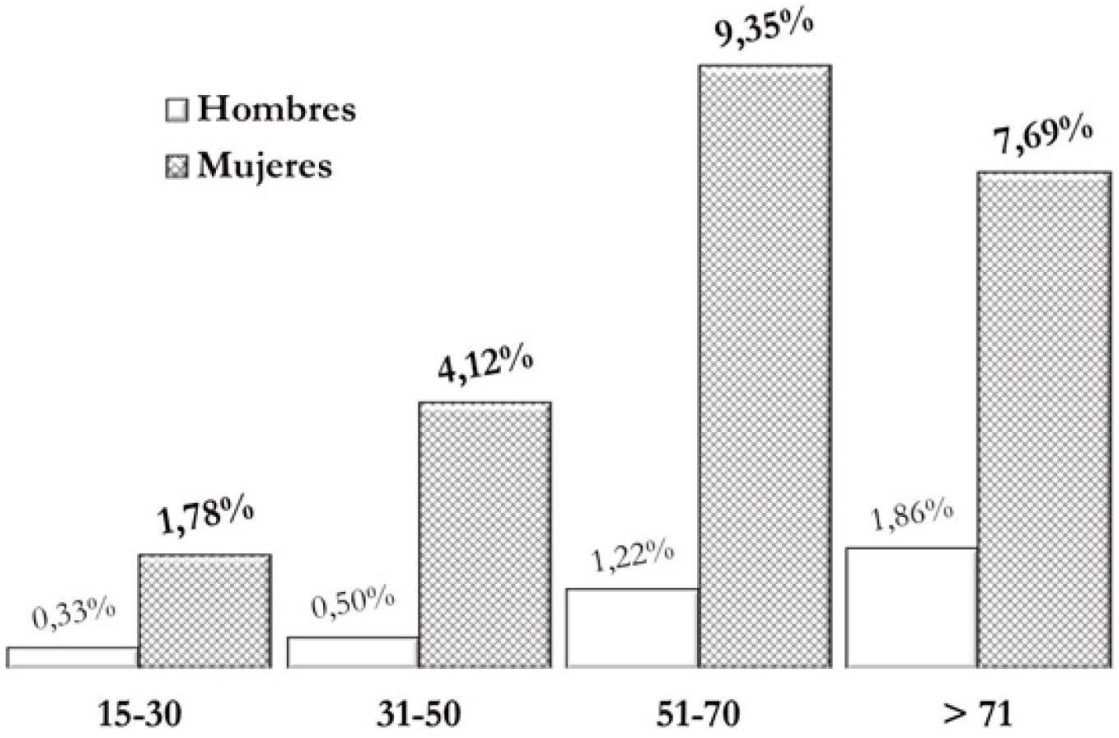
Sociedad Murciana de Medicina Interna

SMI

19-21 Noviembre 2014
Auditorio y Centro de Congresos Víctor Villegas
Murcia

Hipotirodismo

Prevalencia de HT en la provincia de Cádiz para la población mayor de 15 años, estratificada por sexo y grupos de edad, estimada únicamente por el Registro de Pacientes Tratados (RPT)



Rev Esp Salud Pública 2014; 88:629-638.

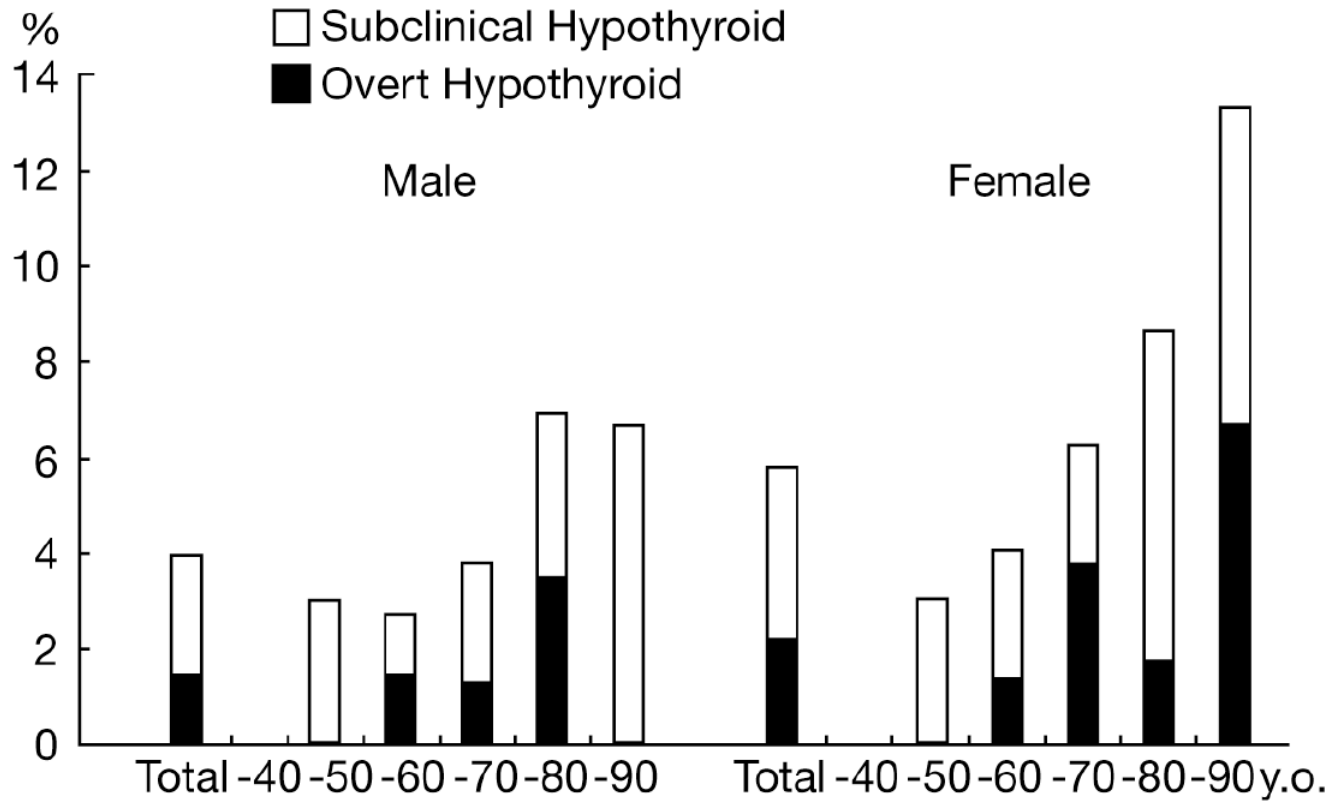
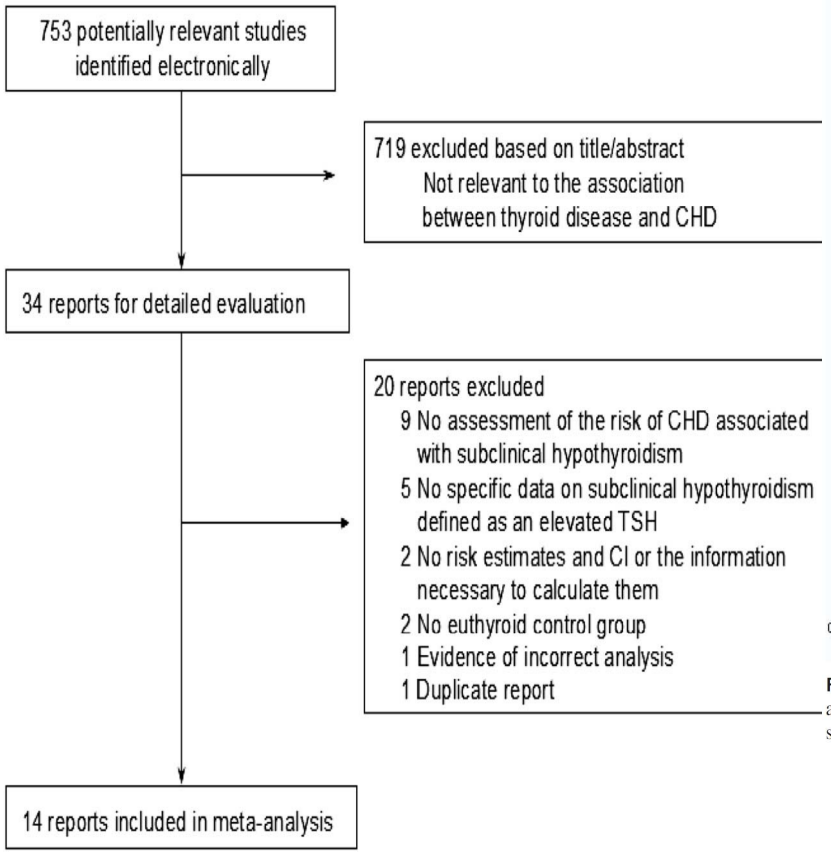


Fig. 4 The prevalence of primary hypothyroidism in each age group.

Endocrine Journal 2011, 58 (6), 449-457

Subclinical Hypothyroidism and the Risk of Coronary Heart Disease: A Meta-Analysis



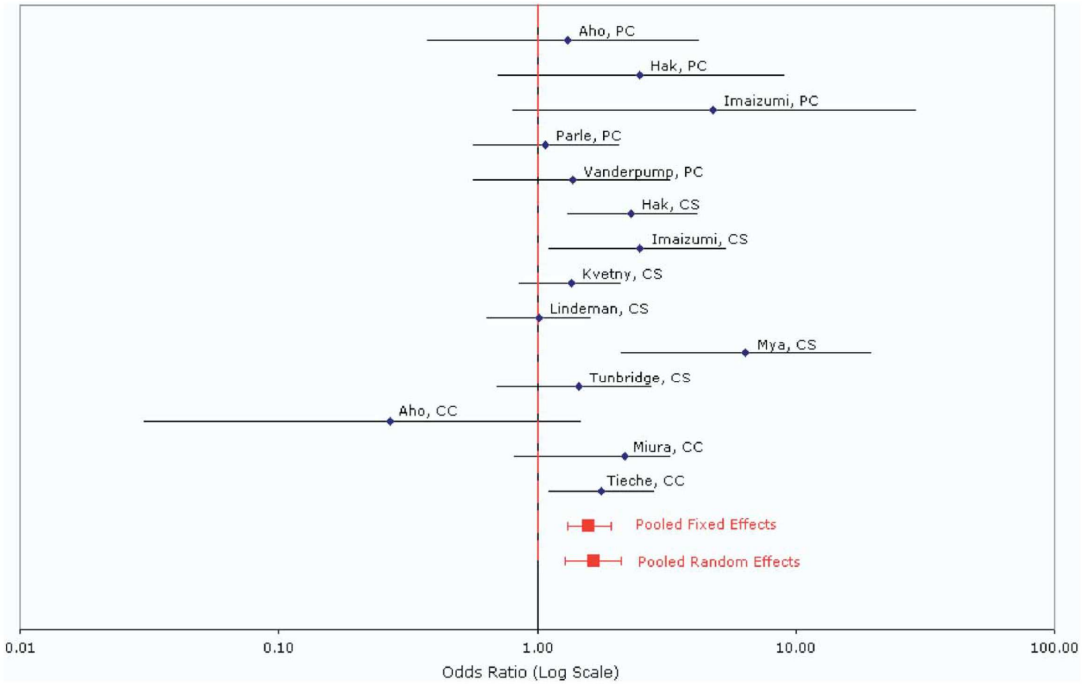


Figure 1 Forest plot of odds ratios (ORs) of coronary heart disease (CHD) associated with subclinical hypothyroidism. ORs (diamonds) and 95% confidence intervals (CIs) (horizontal lines) of the effect of subclinical hypothyroidism on the risk of CHD. CC = case-control study; CS = cross-sectional study; PC = prospective cohort study.

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Figure 1. Subclinical Hypothyroidism vs Euthyroidism for Coronary Heart Disease (CHD) Events, CHD Mortality, and Total Mortality[a]

	Subclinical Hypothyroidism		Euthyroidism				
CHD Events[b]	No. of Events	No. of Participants	No. of Events	No. of Participants	HR (95% CI)	Weight, %	Decreased Risk / Increased Risk
Cardiovascular Health Study,[6] 2006	180	492	955	2511	1.00 (0.85-1.17)	22.9	
Health, Aging, and Body Composition Study,[7] 2005	62	335	493	2325	0.89 (0.68-1.16)	17.4	
EPIC-Norfolk Study,[32] 2010	109	720	1575	11897	1.09 (0.89-1.33)	20.8	
Leiden 85-plus Study,[27] 2004	7	35	76	449	1.29 (0.59-2.80)	4.5	
Pisa cohort,[8] 2007	20	228	148	2647	1.72 (1.07-2.74)	9.7	
Whickham Survey,[17,18] 1996, 2010	27	121	438	2239	1.32 (0.89-1.96)	11.9	
Busselton Health Study,[9] 2005	31	89	355	1889	1.78 (1.22-2.58)	12.8	
Total (I^2=59%)	430	2020	4040	23957	1.18 (0.99-1.42)	100.0	
CHD Mortality[c]							
Cardiovascular Health Study,[6] 2006	75	491	365	2511	1.09 (0.85-1.40)	33.8	
Health, Aging, and Body Composition Study,[7] 2005	19	335	156	2325	0.85 (0.53-1.37)	9.2	
Birmingham Study,[26] 2001	11	92	113	1006	1.21 (0.64-2.29)	5.2	
EPIC-Norfolk Study,[32] 2010	31	720	422	11897	1.19 (0.83-1.72)	15.6	
HUNT Study,[33] 2008	24	814	375	23776	1.09 (0.72-1.65)	12.1	
Leiden 85-plus Study,[27] 2004	3	35	41	446	0.87 (0.27-2.82)	1.5	
Pisa cohort,[8] 2007	14	228	92	2647	1.91 (1.08-3.36)	6.6	
Whickham Survey,[17,18] 1996, 2010	16	124	223	2282	1.08 (0.64-1.81)	7.8	
Busselton Health Study,[9] 2005	13	89	144	1892	1.67 (0.94-2.97)	6.3	
Nagasaki Adult Health Study,[34] 2004	4	420	27	2171	0.67 (0.23-1.91)	1.9	
Total (I^2=0%)	210	3348	1958	50953	1.14 (0.99-1.32)	100.0	
Total Mortality							
Cardiovascular Health Study,[6] 2006	310	492	1514	2511	1.07 (0.95-1.21)	13.8	
Health, Aging, and Body Composition Study,[7] 2005	92	335	699	2325	0.89 (0.72-1.11)	11.0	
Birmingham Study,[26] 2001	32	92	435	1006	0.92 (0.64-1.33)	7.1	
EPIC-Norfolk Study,[32] 2010	108	720	1716	11897	0.97 (0.80-1.18)	11.6	
HUNT Study,[33] 2008	116	814	2159	23776	0.99 (0.82-1.19)	11.9	
Leiden 85-plus Study,[27] 2004	26	35	364	451	0.85 (0.57-1.27)	6.4	
Pisa cohort,[8] 2007	39	228	238	2647	2.13 (1.52-3.00)	7.6	
Whickham Survey,[17,18] 1996, 2010	49	124	681	2282	0.98 (0.73-1.31)	8.7	
Busselton Health Study,[9] 2005	36	89	479	1895	1.44 (1.02-2.03)	7.6	
Nagasaki Adult Health Study,[34] 2004	94	420	409	2171	1.04 (0.83-1.31)	10.8	
Brazilian Thyroid Study,[35] 2010	13	101	55	876	1.96 (1.07-3.61)	3.6	
Total (I^2=66%)	915	3450	8749	51837	1.09 (0.96-1.24)	100.0	

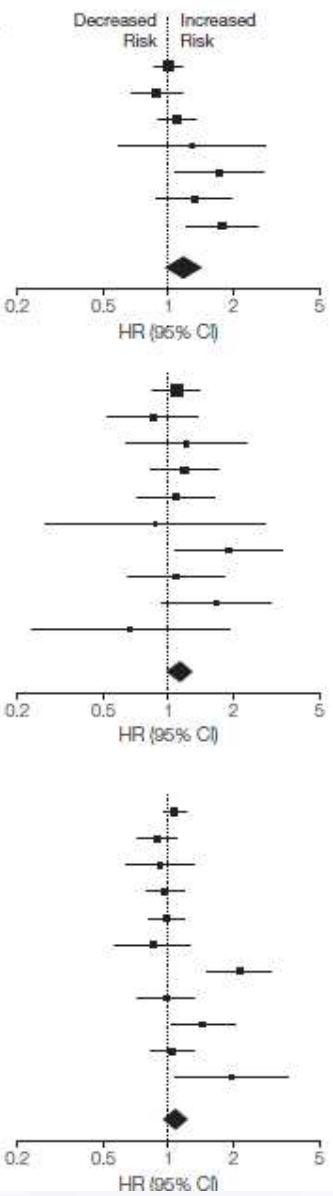

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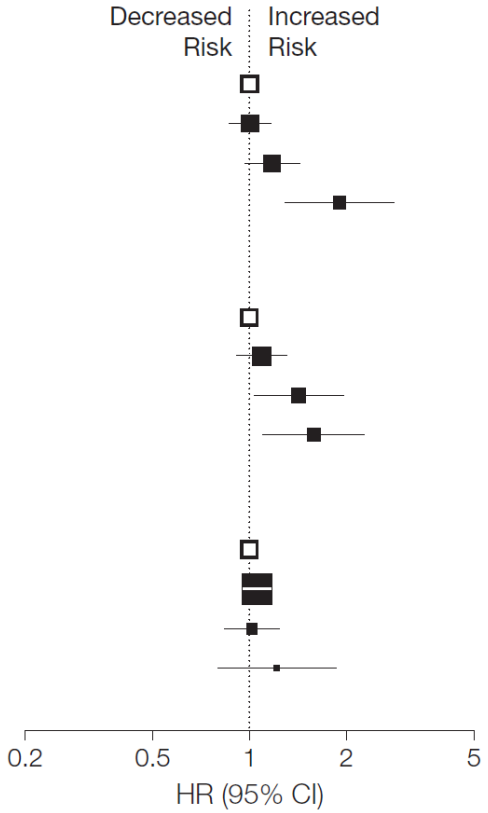
Figure 2. Hazard Ratios (HRs) for Coronary Heart Disease (CHD) Events, CHD Mortality, and Total Mortality According to Elevated Thyroid-Stimulating Hormone (TSH) Categories and Subclinical Hypothyroidism Stratified by Age vs Euthyroidism[a]

CHD Events by TSH Level, mIU/L[b]	No. of Events	No. of Participants	HR Ratio (95% CI)
0.5-4.49	4040	23 957	1 [Reference]
4.5-6.9	264	1344	1.00 (0.86-1.18)
7.0-9.9	96	441	1.17 (0.96-1.43)
10-19.9	70	235	1.89 (1.28-2.80)
			P<.001 for trend
CHD Mortality by TSH Level, mIU/L[c]			
0.5-4.49	1958	50 953	1 [Reference]
4.5-6.9	132	2363	1.09 (0.91-1.30)
7.0-9.9	50	652	1.42 (1.03-1.95)
10-19.9	28	333	1.58 (1.10-2.27)
			P = .005 for trend
Total Mortality by TSH Level, mIU/L[d]			
0.5-4.49	8749	51 837	1 [Reference]
4.5-6.9	640	2431	1.06 (0.96-1.17)
7.0-9.9	170	672	1.02 (0.84-1.24)
10-19.9	105	347	1.22 (0.80-1.87)
			P = .39 for trend



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Thyroid hormone replacement for subclinical hypothyroidism (Review)

Villar HCCE, Saconato H, Valente O, Atallah ÁN

Authors' conclusions

In current RCTs, levothyroxine replacement therapy for subclinical hypothyroidism did not result in improved survival or decreased cardiovascular morbidity. Data on health-related quality of life and symptoms did not demonstrate significant differences between intervention groups. Some evidence indicates that levothyroxine replacement improves some parameters of lipid profiles and left ventricular function.

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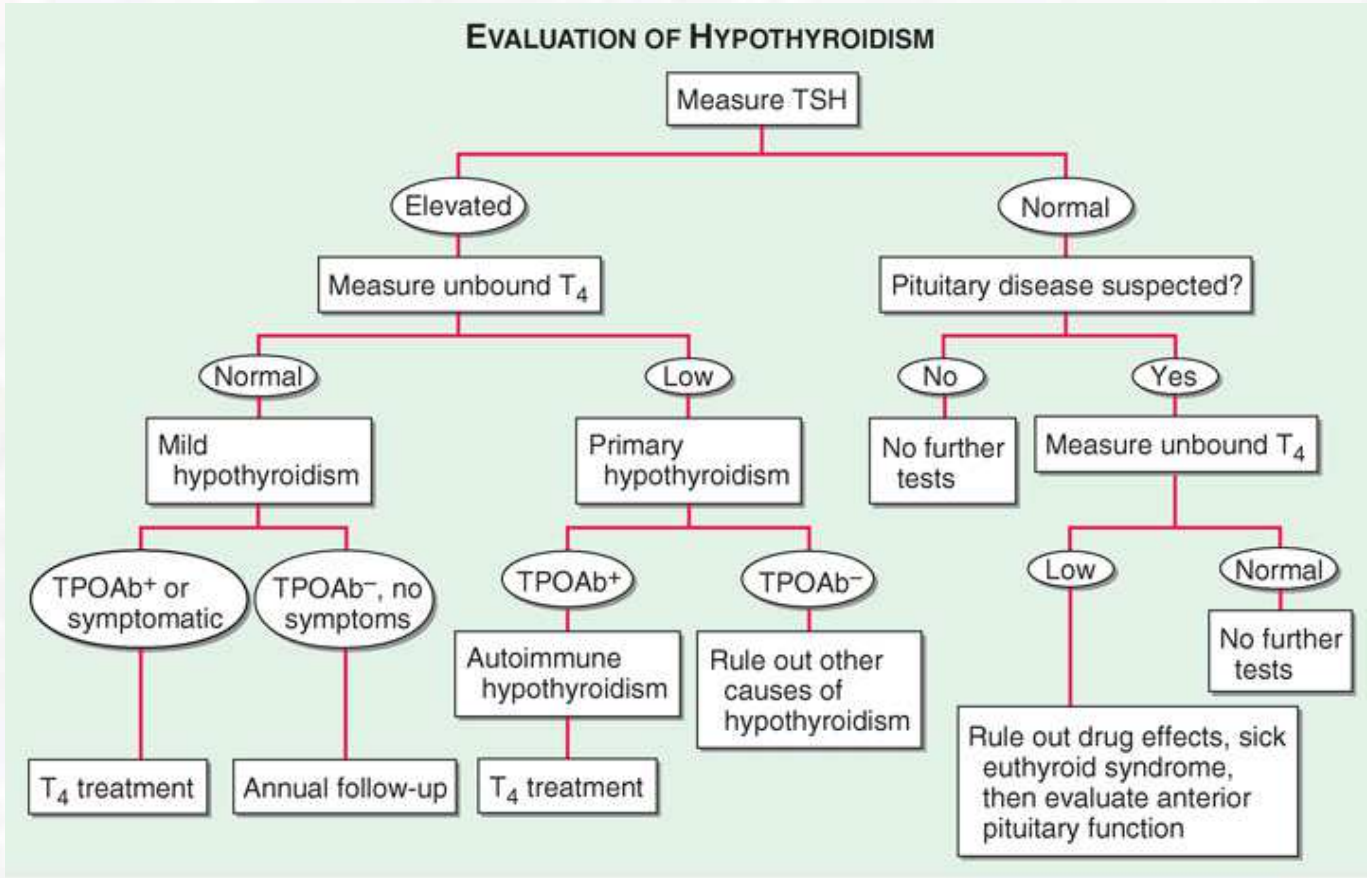

Source: Longo DL, Fauci AS, Kasper DL, Hauser SL, Jameson JL, Loscalzo J: *Harrison's Principles of Internal Medicine, 18th Edition*: www.accessmedicine.com

Conclusiones

- Las enfermedades aquí incluidas se acompañan de un incremento de la morbilidad y mortalidad coronarias
- La expresión clínica de las enfermedades endocrinas va cambiando a expensas de las formas subclínicas
- El tratamiento “curativo” de la enfermedad no siempre revierte los cambios funcionales o estructurales.

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