Diabetes and Endocrinology

University Hospitals of Leicester NHS Trust
NHS

Metabolic Medicine
Department of Diabetes and Endocrinology

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Thyrotoxicosis Shared-Care Scheme Outline Protocol

Shared Care 'Hot-Line': 0116 258 5702 **18 August 2011**

Thank you for referring your patient to the endocrine clinic.

I agree that your investigations confirm the diagnosis of thyrotoxicosis, and I would like to invite you to participate in the thyrotoxicosis shared-care scheme / protocol. The protocol below is based on our experience of managing thyrotoxic patients in this way in shared-care over the last decade.

Aim of Shared-Care Scheme

- To ensure prompt and effective medical management of thyrotoxicosis with carbimazole, while minimising the number of hospital attendances required for the patient

Phase 1: Commencing Carbimazole

Whether or not you agree to participate in the shared-care scheme, we think that it would be beneficial to commence therapy with carbimazole as soon as possible. Unless the patient is already on treatment, I have written to the patient asking them to visit you for a prescription, and sent them an information sheet (copy enclosed). This part of the protocol is my routine practice, and is an effective regime to start carbimazole in the vast majority of patients:

- Commence Carbimazole 40mg o.d (two x **20mg** tablets), continue this dose for 4 weeks and then reduce to 20mg o.d.
- If you have already started carbimazole in another dose then we will have noted this in the attached letter. If you have used a lower dose (say 15-20mg) and the patient is improving clinically then there may be no need to increase the dose now.
- Please arrange to recheck the thyroid function tests (free T4, TSH) 6 weeks after commencing carbimazole, we will send the first advics letter based on these results.
- If the dose of carbimazole does not follow this protocol and/or if you change the dose after your intial letter please let us know so that we can give the correct advice with the first shared care letter
- We will arrange to see the patient in the clinic as a routine new patient, typically 1-2 months after referral at present. However will will advise and adjust the dose if necessary on the basis of the thyroid function tests at 6 weeks and subsequently.

Phase 2: Maintenance on Carbimazole (Shared-Care Scheme)

- At their initial clinic visit the patient will usually be seen by the Nurse Practitioner in Endocrinology who will go through the history and explain the diagnosis, the treatment and the workings of the shared care team. Options for treatment will be discussed - including radioactive iodine and thyroid surgery as well as a course of carbimazole. The patient will then be reviewed and examined by myself, or by a senior medical member of the Endocrinology team.
- After the clinic visit, we propose that the patient remains on Carbimazole 20mg o.d (a single tablet) and that *thyroid function tests (freeT4, TSH) are measured in your surgery every 2 months while the patient remains part of the scheme.* (You will probably wish to assess the patient clinically yourself but, if the patient is well, then it may simply be appropriate for your practice nurse to obtain the sample).
- **We will send a printed blood test form with each results letter - and the first form has been sent to your patient.**
- We will arrange to obtain these results directly from the laboratory, and we will then write to you and the patient with a recommendation for on-going treatment.

- We will also maintain a telephone and email 'hot line' to answer any queries you or the patient may have about their treatment with carbimazole.
- If the patient's thyrotoxicosis is uncontrolled on 20mg then we will recommend increasing the carbimazole to 40mg o.d
- When the serum TSH rises above the normal range or free T4 falls below the normal range, then we will titrate the dose of carbimazole downwards (a '**carbimazole titration regime'**).
- Ultimately we aim to achieve a normal TSH (but levels may remain suppressed for several months on treamtnet even when free T4 and free T3 are normal)
- Occasionally we may recommend the addition of Thyroxine 50-100mcg o.d whilst continuing the same dose of carbimazole. (This is a **'block and replace regime**' which can be useful in patients where TFTs are unstable).
- We will aim to reduce the dose of carbimazole to 5mg before the end of the 18 month course of carbimazole if TFTs allow.
- If the thyrotoxicosis remains uncontrolled, or unstable, or if tests are difficult to interpret then we will arrange to review the patient in the clinic at the earliest opportunity to review overall management options.
- We will review the patient again routinely in the Endocrine clinic one year after their first visit (but would be pleased to review them at any time before then if you or the patient request a visit)
- **The intention will be an 18 month course of carbimazole.** Treatment will therefore be routinely discontinued at that stage (unless the patient remains thyrotoxic) - we will confirm this recommendation at the second clinic visit, and will explain the arrangement for on-going monitoring of thyrotoxicosis. After the blood test at 18 months, we will confirm the advice to stop treatment in a further letter

- If relapse occurs after carbimazole is stopped then our usual recommendation (having discussed the issue with the patient) will be radioactive iodine therapy, unless there are individual contraindications, and we will arrange to review the patient in the clinic to discuss this.

- We will **not** review the patient again routinely in the Endocrine clinic but suggest that thyroid function tests continue to be measured in your surgery every 2 months for the first 6 months and then at increasing intervals. We will arrange to review these results in the usual way and will write to you and the patient about the results. If the patient remains biochemically euthyroid after 3 years then we will usually arrange to monitor thyroid function annually via the shared-care scheme or the Leicestershire thyroid register.

This shared-care protocol has proved very successful in managing uncomplicated cases of thyrotoxicosis since 1994, and seems to be very popular with the vast majority of our patients. I therefore propose to assume that you are happy to participate in this shared-care scheme with the patient identified in the enclosed letter. If not, then please contact me immediately by letter so that other follow-up can be arranged.

We think this scheme represents an improvement in the medical management of thyrotoxicosis, and achieves greater convenience for our patients - we hope that you will agree.

Yours sincerely,

Dr Trevor A Howlett, MD, FRCP Dr Miles Levy, MD, FRCP Dr Helena Gleeson, MD, MRCP
Consultant Physicians & Endocrinologists

A Note on Terminology:

- The Thyrotoxicosis Shared-Care Scheme is intended for patients with, or at risk of, thyrotoxicosis during the active phase of medical management, or in the early years of remission after medical treatment, and after surgery or radioactive iodine. Patients initially managed in this scheme may continue to be monitored long-term. This scheme is run by medical and nursing staff within the Department of Diabetes & Endocrinology, who maintain a 'hot line' for clinical advice to the patient or GP
- The Leicestershire Thyroid Register is intended primarily for long-term monitoring of patients with stable hypothyroidism on replacement with thyroxine – although a few patients who are off treatment but at risk of hypothyroidism are included. The Register is run by Dr James Falconer-Smith in Chemical Pathology.
- These schemes work closely together and clinical review for both schemes takes place in the Endocrinology Clinic at LRI, however, referral to the appropriate scheme will result in more prompt clinical advice to yourself and to the patient
- Neither scheme is appropriate for patients with thyroid cancer on suppressive doses of thyroxine – these patients need clinical review in the outpatient clinic.