

The strength of the study is its prospective nature, with annual assessments during 5 years of follow-up in a selected population; the authors stated that they are not aware of studies assessing the transition from euthyroidism to overt autoimmune hypothyroidism or hyperthyroidism in a structured, prospective manner.

The authors proposed a model for the natural history of AITD, arising from the interplay between a particular genetic background involving multiple genes, accounting for 70% of the risk of AITD and a variety of environmental factors, accounting for about 30% of the risk. Smoking and a low iodine intake favor development of hyperthyroidism, whereas not smoking and a high iodine intake favor development of hypothyroidism. The transition from euthyroidism to overt hyperthyroidism occurs in months, provoked, for example, by stress and pregnancy, whereas the transition from euthyroidism to overt hypothyroidism

may take several years, triggered by pregnancy (postpartum period) and by quitting smoking.

The dilemma for practicing endocrinologists from this and previous studies on the management of subclinical hypothyroidism is if and when thyroid therapy is indicated, since the vast majority of patients are asymptomatic. The recommendations suggested in the literature are controversial (4), because there are no robust data favoring T₄ therapy, with the exception perhaps of pregnancy or for women planning a pregnancy. If thyroid replacement therapy is not given, how often do these patients need to be tested?

Similar questions arise in the treatment of women with euthyroid chronic thyroiditis. There are no clear answers, but it would depend on several factors, among them age and planning a pregnancy.

— Jorge H. Mestman, MD

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