Myxedema coma treatment guidelines pdf

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A mixedema coma is a medical emergency that requires immediate attention. If a diagnosis is suspected, immediate management is necessary before confirming the diagnosis due to the high associated mortality rate. Patients with mixed coma should be managed in the intensive care unit with continuous cardiac monitoring. Initial steps in management include the items below. Airway control Maintaining adequate airways is crucial, as most patients have a depressed mental state along with respiratory failure. Mechanical ventilation is usually required within the first 36-48 hours, but some patients need long-term respiratory support as long as 2-3 weeks. The ideal method of therapy and doses of thyroid hormone therapy in a coma remains controversial due to the rarity of the condition and the lack of clinical trials. Some clinicians favor the administration of levothyroxine (T4), while others prefer a combination of T4 and lyoteronine (T3). The American Thyroid Association recommends combination therapy with T4 and T3. Intravenous hormone therapy is recommended due to reduced absorption of the gastrointestinal tract. The intravenous dose of 300-600 micrograms of levothyroxine (T4) is followed by a daily intravenous dose of 50-100 micrograms. Large doses of T4 probably have no advantage and can be dangerous. The lower end of dosing is recommended in elderly patients at risk of heart complications such as myocardial infarction and arrhythmia, as well as in patients with coronary heart disease, as a full dose of T4 therapy can worsen myocardial ischemia by increasing myocardial oxygen consumption. Since the rate of conversion of T4 into the active hormone T3 can be reduced in these patients, it was recommended that the addition of T3 along with T4. T3 has a faster onset of action than T4, since the increase in body temperature and oxygen consumption is reported to be faster with T3 therapy compared to T4. T3 therapy is given as a bolus of 5-20 micrograms intravenously and should be continued at a dosage of 2.5-10 micrograms every 8 hours depending on the age of the patient and coexisting heart risk factors. Intravenous treatment with levothyroxine in severely hypothyroid patients usually leads to improved cardiovascular, renal, pulmonary and metabolic parameters within a week. Concentrations of serum T4 and T3 may improve or normalize with similar durations, with a more gradual improvement in TSH serum. Thus, the therapeutic endpoints in the myxedema coma should be improved mental state, improved cardiac function, and improved pulmonary function. Measurement of thyroid hormones every 1-2 days is proposed. TSH to reduce or increase thyroid hormone levels suggests the need to increase the dose of T4 and/or the addition of T3. Treatment changed to oral form after can take medication through the mouth. A review of the literature of Borze et al. reported that while the mycedem coma may develop in older people in whom hypothyroidism is not treated or underdrliced, weakness, polypharmacy, and a high risk of developing symptoms of over-treatment should be taken into account when substitution therapy is administered to older patients. The researchers also said that hypothyroidism is more common in older adults, with the aging process affecting the hypothalamic-pituitary axis and its hormones. Glucocorticoid therapy Patients with primary hypothyroidism may have concomitant primary adrenal insufficiency, while patients with secondary hypothyroidism may have associated hypopituittarism and secondary adrenal insufficiency. Another rationale for the treatment of corticosteroids is the potential risk of deposition of acute adrenal insufficiency caused by accelerated cortisol metabolism, which follows T4 therapy. Stress doses of intravenous glucocorticoid should be administered until the possibility of adrenal insufficiency is ruled out by the occasional serum cortisol, which is only useful if very low, or, better, ACTH stimulation test. Hydrocortisone in a dose of 50-100 mg every 8 hours is administered. The alternative is dexamethasone at a dose of 2-4 mg every 12 hours. Dexamethasone has the advantage of not affecting the concentration of cortisol in the serum and can be used immediately without affecting the results of the ACTH stimulation test, which can be performed at any time. If the test is normal, corticosteroids can be stopped without narrowing. The study of Ren et al. has shown that pretibial mixedema can be effectively treated with multipoint intralesial injections of the betametazone compound. Researchers found that after one treatment, 21.7% of patients achieved complete remission, while two, three and four treatments followed complete remission of 34.8%, 17.4%, and 17.4% of patients, respectively. Treat hypothermia with passive rearmament with the help of ordinary blankets and a warm room. Active reuse of external devices carries the risk of vasodilation and exacerbation of hypotension and should be avoided. Using a rectal probe helps to determine the true temperature of the nucleus and control the re-enhancement. Treat a related infection. Given the severity of the condition, the infection should always be considered and an empirical wide range of antibiotics be considered until the relevant crops have proven negative. Fix severe hyponatremity with saline solution and restriction of free water. Proper hypoglycemia with intravenous dextrose. Hypotension is usually corrected with hormone therapy of the thyroid gland. If blood pressure continues to remain low, careful use of intravenous with normal saline solution. Fire-resistant hypotension can be treated with vasopressors such as dopamine, but patients should be taught to be taught vasopressor as soon as possible due to the risk of ischemic event caused by the press. Patients who do not sleep are no longer dependent on the ventilator and can be transferred from the intensive care unit to the medical unit with a medical environment. These agents are used to replace the thyroid hormone. View full information about the drug Lyotyronine is a synthetic form of the natural thyroid hormone (T3), converted from thyroxine (T4); Its short duration of activity allows for a quick dose adjustment in the event of an overdose. See the full information about Levothyroxine also known as T4; many doctors prefer a more gradual onset of this form of thyroid hormone. The use of levothyroxine in hospitalized patients is dedicated to or oral therapy of levothyroxine should be considered in non-critically ill hospitalized patients with pre-existing hypothyroidism, according to the American Thyroid Association (ATA) guidelines. Patients should be evaluated for the possibility of adrenal insufficiency before starting levothyroxine therapy. The aim of the treatment should be the long-term normalization of the thyredotropic serum hormone (TSH) with a stable state of thyroid hormone levels. While oral levothyroxine is recommended in these patients, an enteral route can be used if oral therapy is not possible. In addition, intravenous injection (75% of oral dose) can be used if the patient cannot tolerate the enteral pathway. Treatment of patients with Mixedema Coma ATA recommends patients with mixed coma should first get an empirical glucocorticoid coating with intravenous glucocorticoid administration (in doses corresponding to stress condition). Further, these patients should be given an intravenous dose of 200 to 400 micrograms of levothyroxine, with lower doses for patients who are less tall, older, or who have a history of coronary disease or arrhythmia. After that, it should be given a daily dose of body weight of 1.6 micrograms/kg, reduced to 75% in patients who were injected intravenously. Therapeutic endpoints of levothyroxine therapy in patients with mixed coma should be improved mental state, improved cardiac function, and improved pulmonary function. Thyroid hormones can be measured every 1 to 2 days. It is unclear what the optimal level for TSH serum and thyroid hormones should be in this population. However, high levels of triiodothyronine in serum may indicate the need to lower the dose. Similarly, increasing the dose or adding liotyronine may be considered in patients who are unable to respond to levothyroxine therapy. Initial dose of lyotyrine from 5 to a mcg can be given and then a supportive dose of 2.5 to 10 micrograms every 8 hours, in addition to levothyroxine therapy. As with the liothyronine administration, lower doses of liotronine should be given to patients who are less tall, older, or who have history of coronary disease or arrhythmia. Non-tyreoid disease syndrome For hospitalized patients with critical disease with non-tythyroid syndrome, ATA does not recommend the use of levothroxin or lyoteronine due to the lack of randomized controlled trials supporting this approach. In addition, left-cshinoxin was associated with security issues. Heart dysfunction In hospitalized patients with cardiac dysfunction (e.g. progressive heart failure) and low concentration of triiodothyronine in serum, ATA does not recommend treatment of lyoteronine, given the lack of long-term randomized trials in this population. The analogues of the thyroid hormone ATA recommends against the use of an analogue thyroid hormone or thymomicetic (i.e. thyroid hormone analogues with specific tr-beta) therapy in patients with eutiroid with non-hypothyroidism associated with diseases (e.g. dyslipidemia) due to lack of evidence of the benefits or side effects of this use. In patients with genetic thyroid hormone resistance syndromes, the purpose of therapy is to improve symptoms caused by excessive TR-alpha signaling, while minimizing symptoms caused by a deficiency of TR-beta signaling. The use of the analogue thyroid hormone triiodtidiaceptic acid is not currently recommended for these thyroid hormone resistant patients due to the lack of clinical research. March 12, 2015 American Thyroid Association Hypothyroidism Summary Continues on: Part I: American Thyroid Association Continues to Recommend Levetithyroxin as First Line Therapy of Hypothyroidism Part II: American Thyroid Association Guide to Treatment of Hypothyroidism Part III: American Thyroid Association Guide: Treatment of Hypothyroidism Other Than Left-Tyrotty Monotherapy Updated at: 03/12/15 03/12/15/12/15 myxedema coma treatment guidelines pdf

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