VMG Endocrine pearls re: referrals and pre-visit labs.

From stuart:

HYPOTHYROID:

- I don't see any reason for Endocrine to see a routine hypothyroid patient. If PCP has difficulty getting TSH into target range (Baystate's guidelines are a reasonable option), then perhaps it might be helpful to the patient.
- Notably PCPs should be discouraged from referring patients because they have (+) TPO AB with normal TSH and fT4.
- I also think we are treating way too many patients with subclinical hypothyroidism (mildly high TSH and normal T4)
- I see no reason to check T3 in routine hypothyroidism.
- I usually wait closer to 8-10 weeks before checking labs- especially if the TSH is very high. It takes 2-3 months for TSH to really equilibrate. I'll use 8-10 weeks if I'm starting at a lower-than-expected dose to decide if a dose change is needed. I would NOT adjust a T4 dose if the patient is clinically well and the TSH is 6-8 after 8 weeks of treatment. I've seen that backfire- a lot.
- I agree with the "start low and go slow" for patients over 60 or with known/suspected CVD.
- While pregnancy is a reason for an urgent referral, most OBs will screen and know to increase current dose by 2 pills per week. That lets Endocrine see them in 4-6 weeks. The bigger issue is for PCPs to ask patients about pregnancy planning. I had a patient last week who had not had TSH done in over a year and showed up 6+ weeks pregnant with a TSH over 20. That has severe ramifications for the risk of the baby.

HYPERTHYROIDISM:

- Patients who are unstable (tachycardia or with clear significant sx) should be referred for urgent evaluation. A patient case in addition to the referral would be helpful.
- Propranolol works mostly on sx of tachycardia and tremor and nervous/jittery. Won't always help some of the other sx. But generally a good idea to use if any tachycardia/tremor/insomnia present.

Thyroid nodules:

- Ultrasound reports often provide guidance about whether a nodule is sufficiently large or has enough high-risk characteristics to warrant further evaluation. See TIRADS calculator (which I don't always agree with, but it's a good place to start and used by Radiology)
- It would be helpful to have PCPs agree to follow-up benign nodules in a consistent fashion (Baystate document could be a good place for further discussion)

For Vitamin D deficiency:

- There is debate about what qualifies as "low" (threshold of 20 vs. threshold of 30).
- If the PTH is high and vit D is <30, I will treat to get levels over 30.
- If Vit D is less than 20, I use prescription for weekly vitamin D x 12 weeks, retest level (with PTH) and, if still low, repeat for another 3 months.
- If D deficiency is persistent, referral may be reasonable.
- Could suggest screening for malabsorption issues.

Osteoporosis:

- If TSH is low, needs evaluation for hyperthyroidism. If TSH is high, would continue discussion on treating for osteoporosis (high TSH shouldn't impact decisions about treating osteoporosis).
- For ALL meds that have risk of osteonecrosis (ONJ)- I've suggested that patients contact their dentist to ask them if there are suggestions that they might need more invasive dental work (extractions, implants, etc.) over the next 6-12 months. Please note that this is not just for bisphosphonates.
- The GI problems of oral bisphosphonates are usually esophageal, not gastric. If they don't tolerate, I tend to look to switch to Reclast or Prolia or have another discussion about anabolics
- For "severe" osteoporosis, might be worth referring. Especially if the question regards anabolics (Forteo/Tymlos or Evenity)
- Referrals might also be appropriate if patient has "failed" therapy (worsening BMD at follow-up)

Uncontrolled T2 Diabetes:
I find this a very difficult discussion. If a patient is not going to change behaviors or consider other therapies (e.g., short-acting meal-time insulin), then I'm not sure that I'm going to be able to help them. I recognize that sometimes having the "specialist" or "expert" tell the patient they need to do that is persuasive, so I'm not totally excluding the benefit. This is where I'm asking PCPs to know their patients and think about whether seeing Matt or me would be helpful (as opposed to just moving it out of their in-box). In the past, I would have suggested having diabetes nurses help evaluate these types of patients- they have an excellent ability to figure out who would benefit most.

For T1DM: If the patient has a1c's at goal, no complications and PCP is comfortable with the therapy, then I guess I don't need to see them. But I think the number of patients with T1DM who (a) have a1c's under 7%, (b) have no complications (hyper-related or hypo-related) and (c) have PCPs who understand how to manage insulin pumps is a pretty small number.

Hypogonadism.

- The first thing is to make sure that patients get labs done at the proper time of day. There is a strong circadian influence on testosterone. Labs should be done early (I believe they should be done before 8AM) and two abnormal levels need to be documented. If that occurs, then a referral to find out the etiology of low testosterone may be worthwhile. It would be helpful if PCPs would not refer because of symptoms and the idea that "I think my testosterone should be higher than it is". I see that a lot.

Primary are Pre-endocrine work
Osteoporosis:
Screen patients starting at 65 unless other risk factors: smoker, underweight, h/o eating disorder, chronic steroids

Osteoporosis identified on bone density:
Primary care providers should check: "_osteoporosis"
labs cmp, phos, magnesium, vit d, cbc, PTH, tsh if normal and gfr >35 start oral bisphosphonate

If labs abnormal:
vitamin D low-treat with drisdol and recheck in 3 months?
If pth elevated and D low treat with drisdol and recheck. if still elevated refer to endo?
If PTH elevated and calcium elevated and on hctz stop and recheck in 3 months?
TSH abnormal manage and treat osteoporosis.

Do you ever choose Evista over bisphosphonate?
Do you recommend patients seen dentist prior to starting oral bisphosphonates?
When should you get CTX or 24 hour urine calcium/creatinine? "bone markers"

If patient doesn't tolerate oral bisphosphonate based on GI side effects add PPI and continue to try. And if still not tolerating refer to endo for reclast or prolia?

If patient with severe osteoporosis on dexa refer to endo.

New onset DM in patient with weight loss and polyuria:
r/o Type I with Gad65 antibodies. When do you also do CPeptide and insulin?
"test for autoimmune diabetes antibodies"

Uncontrolled DM Type II
Patients should have been tried on GLP-1 agonists (if appropriate) and long acting insulin prior to referral?

Type I DM Refer to endocrine for pump management etc.

Newly elevated TSH
When would you need to see these patients?
Check tsh, t4 free t3 and tpo.
Start replacement. Repeat labs in 6-8 weeks and titrate dose.
Start low for patients over 60 or with cardiac issues.

R/O Cushings:
Patient with symptoms concerning for cushings:htn, stria, weight gain, moon facies
Provider should check what labs?
Should they confirm with dexamethasone suppression test or send to you first?

Thyroid nodule:
PCP orders TSH T4 and ultrasound.
Refer for evaluation always or only if >1 cm?

Hypogonadism/ED:
Order: "lowtconfirmationmale"
Do you want FP to start meds or after we get confirmation labs should we refer to you?
Do you always get MRI or only if labs are abnormal?
If testosterone remains quite low and LH/FSH are not high, I usually will consider a pituitary MRI and then start testosterone injections weekly 0.3 to 0.4mL 60 to 80mg subcut weekly or gel 50mg topically daily with repeat labs in 2 to 3mo. Sildenafil or tadalafil may often be helpful too.

Gender Dysphoria with interest in HT.
Should we have patients see providers in FP that are comfortable starting meds first? and then refer to you?

What would be your recommendations for a patient seeking hormone therapy?

Use "transmale"
Use "transwoman monitoring labs"

Hyperthyroidism-new dx
Provider should order "new thyroidtoxicosis"
Start propranolol if tachycardic?
Urgent referral?

Hypothyroidism Pregnancy:
Urgent referral to endo?
or manage tsh to goal <2 with tsh check q6 weeks?

Irregular periods/PCOS/Ammenorrhea
PCP orders: "_irregularperiods"
If results are normal start metformin? ocps?

Elevated PTH-hyperparathyroidism

Order "_primaryhyperparathyroidism"
treat low vitamin D
When should PCP refer vs monitor?
Why do you get kidney u/s?
Do you ever get thyroid u/s to look for adenoma on parthyroid?

Hypocalcemia:
PCP orders "hypocalcemia initial testing"
Then refer
Hypercalcemia:
PCP orders "_hypercalcemia"

Adrenal incidentaloma

PCP orders "_adrenal_incidentaloma_htn
When should they do dexamethasone suppression test?

Patients that should always continue to be monitored by ENDO for:

Any patients with history of cancer

Complex DM patients
severe osteoporosis on IV or injectable treatments
hyperthyroid