Hashimoto auto-immune tyroiditis with different clinical manifestations

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Abstrak

In the year 1912, Hashimoto first reported four women with diffuse struma which under anatomic pathology demonstrated four unique findings of diffuse lymphocyte infiltration, the formation of lymphoid follicles, destruction of thyroid epithelial cells, and formation of fibrous tissue; thus called lymphomatous struma.1-2 Forty years later, an anti-thyroid antibody was found in the serum of the patients introduced by Hashimoto. Since then, clinical conditions of diffuse struma with the presence of anti-thyroid antibodies are known as Hashimoto disease, or Hashimoto autoimmune thyroiditis.1

With further developments, there were many diseases with the same histological findings, and the presence of anti-thyroid antibodies are not always associated with diffuse struma such as that in the classical Hashimoto disease. Thus, the more common name used nowadays is chronic autoimmune thyroiditis. Clinically, chronic autoimmune thyroiditis is classified into two forms, first with diffuse enlargement of the thyroid gland (goitrous form) known as Hashimoto disease or Hashimoto autoimmune thyroiditis, and the second without thyroid gland enlargement, known as chronic atro-phic thyroiditis.123

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The incidence rate of Hashimoto autoimmune thyroiditis is quite high and has a tendency to increase in uncertain numbers. The average incidence rate is 3.5 cases in 1000 females and 0.8 cases in 1000 males.4 The prevalence of chronic autoimmune thyroiditis in Western countries such as the United States and the United Kingdom was reported to be 5-15% in females and 1-5% in males.1 In Indonesia, cases of Hashimoto autoimmune thyroiditis cases are very rare. A histopatho-logical examination analysis of thyroid operation cases

in Surabay a for 2 years only found 28 cases of Hashimoto autoimmune thyroiditis out of 2185 thyroid specimens, or 1.3%,5 while data from the Department of Pathologic Anatomy of the Faculty of Medicine of Hasanuddin University found 3 cases of Hashimoto autoimmune thyroiditis out of all thyroid samples in 3 years.6

A diagnosis of Hashimoto autoimmune thyroiditis should always be considered when finding patients with diffuse struma with or without complaints or clinical signs of hypothyroidism, accompanied by increased levels of serum thyrothropine (thyroid stimulating hormone = TSH). Increased levels of one of the anti-thyroid antibodies, such as the anti-microsomal antibody (AMA), anti-thyroid peroxidase antibody (anti-TPO), or anti-thyroglobu-lin (anti-Tg) are needed to prove the presence of an autoimmune process. Histopathological or cytological examination would further support the diagnosis of Hashimoto autoimmune thyroiditis.3'4