

## LETTER TO THE EDITOR

# Relationship between vestibular syndrome and autoimmune thyroiditis<sup>☆</sup>



## Relación entre el síndrome vestibular y la tiroiditis autoinmune

Dear Editor,

For years, autoimmune hypothyroidism has been associated with the development of other diseases, demonstrating the possible role that antithyroid antibodies could play at the systemic level. Some of these diseases are coeliac disease, type 1 diabetes mellitus, pernicious anaemia, multiple sclerosis, vitiligo, dermatitis herpetiformis and chronic urticaria.<sup>1</sup> There are also studies that show the association between autoimmune thyroid disease and vestibular dysfunction (Ménière's disease, benign positional paroxysmal vertigo, etc.), although to date they are scarce, with discordant results, and they do not clarify the role of antithyroid antibodies in the pathogenesis of vestibular dysfunction.<sup>2–4</sup> The objective of this work is to assess the relationship between peripheral vestibular syndrome and autoimmune thyroiditis.

For this, an observational, descriptive, retrospective, cross-sectional epidemiological study was carried out between 1 November 2017 and 31 October 2018, at the Hospital Universitario Los Arcos del Mar Menor, in Murcia. The study analysed 52 patients who presented positive antiperoxidase and antithyroglobulin antibodies, or pathological data suggestive of lymphocytic thyroiditis after biopsy or surgical excision of the gland due to symptomatic multinodular goitre or suspicious thyroid nodules. In all of them, the history or presence of vertiginous symptoms was investigated, that is, the sensation that you or everything around you is spinning or moving, associated or not with nausea and vomiting, in the last year. Those excluded were patients with a history of previous otological problems or surgery, vascular or neurological disorders that could simulate vestibular symptoms (stroke, transient ischaemic attack, multiple sclerosis, etc.) and consumption of drugs that could have vestibular alterations as a secondary effect. Quantitative plasma levels of the hormones free T4 and TSH and antithyroid antibodies were determined by electro-

chemiluminescence immunoassay (ECLIA). And for the data analysis, the statistical software IBM SPSS Statistics 24<sup>®</sup> was used.

Of the 52 patients included in the study, 19 presented clinical criteria compatible with vestibular dysfunction (36.5%), of whom 15 were women and four were men, with a mean age of 56.5 years. Patients with vestibular symptoms had significantly higher levels of TSH ( $18 \pm 33.9$  IU/ml) and lower levels of plasma T4 ( $0.95 \pm 0.37$  ng/dl) compared to those who did not, with p values of 0.039 and 0.04, respectively. No statistically significant relationship was found between the levels of antithyroid antibodies and the presence or absence of vestibular symptoms. However, 45% and 57% of patients with levels of antiperoxidase and antithyroglobulin antibodies greater than 700 IU/ml, respectively, had symptoms of dizziness. Of the 18 patients (34.6%) who underwent total thyroidectomy, all presented pathological characteristics indicative of lymphocytic thyroiditis. However, 22.2% of them had data suggesting multinodular goitre and 39% papillary thyroid cancer. Ten of the thyroidectomised patients also presented with a vertiginous syndrome and 70% of them reported clear clinical improvement after surgery.

Despite the limited sample size, our results show an increased prevalence of hypothyroidism in patients with vestibular dysfunction, compared to the general population (15–20%),<sup>5</sup> and better control of vertigo after thyroidectomy, which could be explained by the role played by thyroid autoimmunity in these patients. To date, the role of thyroid surgery in vestibular control in patients with autoimmune thyroiditis has not been described in the literature. That is why we believe it is necessary to propose new care protocols that include the study of thyroid function in patients who consult for vertigo, and also to highlight the anamnesis regarding the presence of symptoms compatible with peripheral vestibular disease in patients with autoimmune thyroiditis as well as the continuation or resolution of the vertiginous symptoms after thyroidectomy. With this, we could contribute to an early diagnosis of both diseases and it would give us the opportunity to carry out large-scale prospective randomised studies to clarify the involvement of antithyroid antibodies in vestibular disorders and the role of thyroid surgery in the treatment of severe vestibular dysfunction secondary to thyroid autoimmunity.

<sup>☆</sup> Please cite this article as: Giribet Fernández-Pacheco A, Tomás Pérez MA, Almela Rojo MT, García-Purriños García FJ. Relación entre el síndrome vestibular y la tiroiditis autoinmune. Endocrinol Diabetes Nutr. 2022;69:76–77.

## Conflicts of interest

The authors declare that they have no conflicts of interest.

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- 25 June 2020
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## Gender detransition in Spain: Concept and perspectives<sup>☆</sup>



### Detransición de género en España: Concepto y perspectivas

Dear Editor,

The publications by Becerra Fernández<sup>1</sup> and Pazos Guerra et al.<sup>2</sup> demonstrate the growing interest that *gender detransition* has aroused among teams working in Spanish gender identity clinics (GICs). Although it is not a genuinely new phenomenon,<sup>3</sup> the experiences of these people have received little attention in the scientific literature until recently. The scarcity of information in Spanish has prevented the establishment of a consistent and shared definition of the concept, hampering understanding and communication between health professionals dedicated to this topic. My aim is to offer some suggestions and reflections that contribute to consolidating a common language for the investigation and development of this quandary.

The first issue that I would like to address is of a morphological nature, and has to do with how the English term “detransition” is translated into Spanish. Since in our language the prefixes *de-* and *des-* are often used interchangeably to indicate the negation or the opposite of something, “detransition” could be translated either as “detransición” or as “destransición”. The cited authors opt for the first option, which is a textual translation of the term in English. However, as it is a neologism, perhaps the most correct thing would be to use the prefix *des-*, which is not only the variant most frequently used in medicine, but also coincides with the most correct form at the etymological level (from the Latin *dis-*).<sup>4</sup>

The second issue is of a conceptual nature, and alludes to the differences that exist between gender detransition and another related, but qualitatively different, phenomenon: *desistance*. According to the data, between 60% and 90% of boys and girls diagnosed with gender dysphoria (GD) stop showing the criteria established for this condition when they reach adolescence.<sup>5</sup> The term “*desistance*” is the one that has been used in the specialised literature to refer to this phenomenon of remission of GD, and constitutes one of the most significant factors in the study of its evolutionary trajectories.<sup>6</sup> Contrary to what happens in *desistance*, gender detransition does not necessarily imply remission from GD, since some people who detransition may continue to meet the criteria to receive such a diagnosis (for example, strong desire to be of the other sex, strong desire to get rid of one's own sexual characteristics, strong desire to possess the sexual characteristics of the opposite sex)<sup>7</sup> long after having decided to detransition.<sup>8</sup> In contrast, the concept of *desistance* is used to designate those cases in which the GD subsides *without having initiated any type of gender transition*, while detransition occurs when stopping and reversing a *previously started* process of gender transition (social, legal and/or medical). It is important not to confuse the two concepts or use them interchangeably, as they denote different realities.

Thirdly, it would be convenient to establish a specific criterion that would allow for distinguishing between “genuine” cases of gender detransition and other types of situations that are similar in appearance, but with a different origin. My suggestion is that, instead of interpreting any interruption of a transition process as a detransition (without delving into its particular causes), this concept be reserved exclusively for those cases in which there is a *cessation or modification of the identification with the gender transitioned to*. This criterion offers us the possibility to differentiate those people who wish to stop and reverse their transition processes because their main motivation for transitioning (their gender identity) has changed, from those who are forced to stop their transition processes for reasons beyond their control (unwanted side effects, lack of social/family support, etc.) or who stop because they have

<sup>☆</sup> Please cite this article as: Expósito-Campos P. Detransición de género en España: Concepto y perspectivas. *Endocrinol Diabetes Nutr*. 2022;69:77–78.