Nursing Alert

If an infant is born with a goiter, immediate precautions are instituted for emergency ventilation, such as supplemental oxygen and a tracheostomy set nearby. Hyperextension of the neck often facilitates breathing.

Immediate surgery to remove part of the gland may be lifesaving in infants born with a goiter. When thyroid replacement is necessary, parents have the same needs regarding its administration as discussed for the parents of children who have hypothyroidism.

Lymphocytic Thyroiditis

Lymphocytic thyroiditis (**Hashimoto disease**, **chronic autoimmune thyroiditis**) is the most common cause of thyroid disease in children and adolescents and accounts for the largest percentage of juvenile hypothyroidism. It accounts for many of the enlarged thyroid glands formerly designated *thyroid hyperplasia of adolescence* or *adolescent goiter.* Although lymphocytic thyroiditis can occur during the first 3 years of life, it occurs more frequently after 6 years old, with peak incidence occurring during adolescence. The presence of a goiter and elevated thyroglobulin antibody with progressive increase in both thyroid peroxidase antibody and TSH may be predictive factors for future development of hypothyroidism (Radetti, Gottardi, Bona, et al, 2006).

An enlarged thyroid gland is often detected during routine examination. Parents may notice it when a child swallows. In most children, the entire gland is enlarged symmetrically (although it may be asymmetric) and is firm, freely movable, and nontender. There may be manifestations of moderate tracheal compression (sense of fullness, hoarseness, and dysphagia). However, it is extremely rare for a nontoxic diffuse goiter to cause airway obstruction. Most children are euthyroid, but some display symptoms of hypothyroidism. Other signs suggestive of thyroiditis are found in Box 28-6.

Box 28-6