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The "Mad Protocol Syndrome." 10. A Case of Subclinical Hypothyroidism: The Unnecessary Treatment of a Lab Number

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Abstract

The "Mad Protocol Syndrome" is a condition in physicians who rigidly or normatively apply clinical guidelines or protocols. This syndrome, understudied but widespread, is seriously dangerous because it generates iatrogenic effects, promotes polypharmacy and drug interactions, is frequently based on controversial, unsound, and rapidly changing foundations due to the rapid emergence of new studies, fails to consider patient-centered care, is not developed collaboratively by medical specialties and patients, is often influenced by powerful interest groups (such as the relationship of almost all panelists on clinical guideline development committees with the pharmaceutical industry), always maintains an exclusively biomedical perspective ignoring broader biopsychosocial viewpoints, and because there are hundreds or thousands (or perhaps millions?) of clinical guidelines that contradict each other in their recommendations. The patient is a biographical, social, and spiritual reality, never an isolated analytical value. No laboratory target (HbA1c, LDL, or blood pressure) justifies destroying a human being's autonomy, lucidity, or daily well-being. "The Mad Protocol Syndrome" ultimately represents the dehumanization of medicine through bureaucracy. To break this absurd cycle of over-prescription and alienation, 21st-century medicine doesn't need to generate more guidelines from distant experts, but rather urgently reclaim the sovereignty of clinical judgment, safe deprescribing tools, and critical methodological approaches that return control to the primary care physician and dignity to the patient. Studying and reflecting on these concepts is the first step toward transforming clinical practice and rescuing the humane, critical, and sensitive medicine that patients so desperately need. Here is an example of clinical guidelines and protocols for Subclinical Hypothyroidism (The Unnecessary Treatment of a Lab Number).

Keywords: Guidelines; Methodology; Applicability, Evidence-based medicine; Patient-centered; Personalized medicine, General practice

INTRODUCTION

Clinical practice guidelines provide evidence-based recommendations to optimize patient care, while protocols dictate rigid, step-by-step procedures. In general medicine, these tools are designed to reduce practice variation and translate complex scientific research into actionable, patient-specific encounters (1, 2). However, clinical guidelines face significant systemic challenges. Key problems include a one-size-fits-all approach that fails to account for individual variations, a lack of universal applicability, and potential conflicts of interest. Misuse of guidelines can sometimes lead to suboptimal care (3-5).

The concept we describe as the “Mad Protocol Syndrome” perfectly defines the phenomenon of the tyranny of clinical guidelines or normative biomedical reductionism. This refers to the growing concern that modern medicine focuses too rigidly on treating isolated biological pathways and rigid, one-size-fits-all algorithms. This severely limits personalized care and ignores the complex, multifaceted realities of human illness (6).

In the scientific and critical medical literature, promoted by movements such as Choosing Wisely, evidence-based medicine without conflicts of interest, and quaternary prevention (7-10), there are blatant examples of guidelines that exhibit these characteristics: medicalization of risk factors, rigid objectives that induce massive polypharmacy in patients with multiple pathologies, a high rate of panelists with conflicts of interest with the pharmaceutical industry, and a complete disconnection from the biopsychosocial model. Below is an example of clinical guidelines and protocols for **Subclinical Hypothyroidism (The Unnecessary Treatment of a Lab Number)**

CLINICAL CASE: The "Mad Protocol Syndrome" Applied to Subclinical Hypothyroidism (Treating a Lab Number)

Sylvia, 69 years old. A routine blood test reveals a TSH of 6.2 mIU/L (slightly elevated) with a completely normal free T4. Sylvia has no symptoms; she feels her energy level is normal for her age.

The "Mad Protocol" Approach (Treating a Lab Number)

The laboratory's computer protocol marks the result as "abnormal." The physician, following dogmatic guidelines that suggest normalizing TSH to "prevent future risks," diagnoses subclinical hypothyroidism and initiates treatment with Levothyroxine 50 mcg/day. The dose proves excessive for Sylvia's body (therapeutic inertia). After six months, the patient begins to experience palpitations and weakness. One night, she suffers a syncopal episode at home. At the hospital, Sylvia was diagnosed with atrial fibrillation with rapid ventricular response (a serious cardiac arrhythmia) caused by iatrogenic hyperthyroidism (induced by the medication). She must remain on anticoagulants for life to prevent a stroke due to the arrhythmia caused by the treatment itself.

DISCUSSION

The automatic prescription of levothyroxine to patients (frequently middle-aged or older women) with slightly elevated thyroid-stimulating hormone (TSH, for example, between 4.5 and 10 mIU/L) and completely normal levels of free thyroid hormone (free T4) and without clear symptoms of disease is not uncommon.

In Sylvia's case, the doctor suffers from the "Mad Protocol Syndrome":

Iatrogenesis and overdiagnosis: Treating an isolated laboratory value in asymptomatic patients necessitates lifelong daily medication and perpetual blood tests. If the dose is exceeded even slightly (a very common occurrence), subclinical iatrogenic hyperthyroidism is induced, which drastically increases the risk of atrial fibrillation (a serious cardiac arrhythmia) and bone loss (osteoporosis) (11)

TSH levels naturally rise with age. Applying standard reference ranges to older adults often leads to misclassifying normal, age-adjusted thyroid function as subclinical hypothyroidism (12). TSH can temporarily spike due to non-thyroidal illnesses, stress, or recovery from other conditions. Testing during these periods often results in a false-positive diagnosis (13). It has been reported that up to 49% of people previously diagnosed with subclinical hypothyroidism were reclassified as having normal thyroid function after accounting for age-, sex-, and race-specific differences (14).

This scenario facilitates the risks of overtreatment: 1) Thyrotoxicosis: Over-prescribing levothyroxine can push a patient into iatrogenic subclinical or overt hyperthyroidism; 2) Cardiovascular and Skeletal Impact: Prolonged suppression of TSH is linked to an increased incidence of heart failure, atrial fibrillation, reduced bone mineral density, and osteoporosis (15). And on the other hand, better guidelines advise against universal screening for thyroid dysfunction in asymptomatic, non-pregnant adults (16).

2) Controversial and Changing Foundations: Large recent clinical trials (17) have conclusively demonstrated that levothyroxine treatment in patients over 65 years of age with subclinical hypothyroidism provides no benefit in terms of thyroid symptoms, quality of life, fatigue, or cognitive function. Despite the evidence, physicians continue to apply outdated therapeutic practices.

3) Contradictory Recommendations: Dozens of endocrinology society guidelines disagree on the thresholds for initiating

treatment (some recommend treatment based on antibody levels, others on age, and still others on the exact TSH value), plunging clinical practice into confusion that often leads to preventive over-prescription due to fear of inaction. The primary contradiction across endocrinology societies stems from the treatment threshold of TSH between 4.5 and 10.0 mIU/L (15, 18-21).

What would a Patient-Centered Intervention Plan look like?

The physician is aware of the current evidence, such as the TRUST study (17): treating a TSH < 10> 10 mIU/L, those who are symptomatic, or specific populations such as pregnant women (15, 16). And even only for patients with unusually high TSH levels (>20 mIU/L with normal T4 levels) (25). As a result, Sylvia avoids taking an unnecessary daily medication. Her heart rhythm remains stable, and she avoids the cascade of blood tests and specialist visits.

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