

QUESTION

1. A 60-year-old male with a long history of hypertension and hyperlipidemia presents with a 2-week history of increasing fatigue, weight loss, and decreased appetite. He reports feeling "down" and "tired" most of the time. He has lost approximately 10 pounds (4.5 kg) over the past 2 months. He has no chest pain, shortness of breath, or palpitations. He has no recent travel, sick contacts, or exposure to tuberculosis. He has no history of alcohol or drug use. He is currently on lisinopril and atorvastatin.

2. The patient's physical examination is unremarkable. His vital signs are stable. There is no tachycardia, tachypnea, or rales. His lungs are clear to auscultation. His heart rate is regular and within normal limits. There is no jugular venous distention. His abdomen is soft and non-tender. There is no lower-extremity edema.

3. The patient's laboratory workup is as follows:

- Hemoglobin: 12.5 g/dL
- Hematocrit: 38%
- Hemoglobin A1c: 5.8%
- TSH: 0.05 mIU/L
- Free T4: 4.5 pmol/L
- Free T3: 3.5 pmol/L
- T3 uptake: 25%
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- TSH receptor antibody: Negative
- Thyroid ultrasound: Normal

