世界中医药学会联合会国际组织标准

国际中医临床实践指南 桥本甲状腺炎

编制说明

Formulation Explanations

立 项 单 位 ：北京中医药大学孙思邈医院

项目承担单位：北京中医药大学孙思邈医院

项 目 负 责 人 ：丁治国

目录

一、工作简况

主要起草单位：北京中医药大学孙思邈医院、海南医科大学、北京中医药大学东直门医院、北京中医药大学

参与起草单位：陕西中医药大学西安附属医院（西安市中医医院）、北京中医药大学深圳医院（龙岗）、海南省人民医院、海南医科大学第一附属医院、海南医科大学第二附属医院、成都中医药大学附属医院、贵州中医药大学第一附属医院、南京中医药大学第二附属医院、陕西中医药大学附属医院、云南中医药大学第一临床医学院、安徽中医药大学第一附属医院、辽宁中医药大学附属医院、北京中医药大学东方医院、山西省中西医结合医院、长春中医药大学附属医院、湖南中医药大学第二附属医院（湖南省中医院）、浙江中医药大学附属第二医院、芜湖市中医医院、北京中医药大学东直门医院厦门医院、山东中医药大学附属医院（山东省中医院）、首都医科大学附属北京世纪坛医院、陕西中医药大学第二附属医院、青岛大学附属青岛市海慈医院、西安医学院第一附属医院、北京中医药大学东直门医院洛阳医院、北京中医药大学第三附属医院、吉林省中医药科学院第一临床医院、新疆医科大学第七附属医院、黑龙江中医药大学附属第一医院、浙江中医药大学附属第一医院（浙江省中医院）、江苏省中医院重庆医院（重庆市永川区中医院）、青海省中医院、首都医科大学附属北京中医医院、上海中医药大学附属市中医医院、天津中医药大学第一附属医院、内蒙古自治区中医医院、广西中医药大学第一附属医院、北京中医药大学房山医院、陕西省中医医院、南昌大学第一附属医院、北京中医药大学东方医院秦皇岛医院、海南省中医院、甘肃省中医院、中国中医科学院西苑医院、湖北省中医院（湖北中医药大学附属医院）

项目负责人：丁治国

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二、标准起草过程简介

1 项目背景

桥本甲状腺炎由日本学者 Hashimoto 于 1912 年首先报道。桥本甲状腺炎的发病率在不同国家和地区存在差异，其患病率受地理区域和环境因素的影响；发病机制尚不明确。现代医学以随访为主，无特殊治疗方式，如继发甲状腺毒症、继发甲状腺功能减退症，需进行抗甲状腺药物或激素补充治疗。

中医学对桥本甲状腺炎领域临床研究较多，但中西医结合诊治方面存在诸多争议点，且尚未建立系统的指南和标准。现行版西医指南为 2008 年中华医学会内分泌学分会发布的《中国甲状腺疾病诊治指南-甲状腺炎》，期间已有多项科学证据有待更新。在中西医结合领域，主要为 2021 年北京中西医结合学会甲状腺病专业委员会发布的《桥本甲状腺炎中西医结合诊疗北京专家共识（2021，北京）》、《桥本氏甲状腺炎中西医结合质量控制指标体系北京专家共识（2021 版）》，对桥本甲状腺炎患者所处疾病阶段未进行具体阐述，且多以共识为主，缺乏高质量的循证证据支持，难以满足目前临床需求。随着中医药国际影响力的日益提升，优化中医药防治桥本甲状腺炎的诊疗方案与推荐意见，推动其国际化应用，成为亟需规范和落实的重点任务。

2 主要工作过程

2.1 启动部署阶段

2023 年 10 月 16 日本指南立项工作小组正式成立。2023 年 10 月完成本指南的初步工作梳理和工作计划，期间召开多次指南研制筹备会。初步形成立项申请书及立项草案，后经立项小组多次组内讨论修改。

2.2 正式立项

2023 年 11 月 23 日正式提交项目立项申请及草案。2023 年 11 月 28 日世界中医药联合会回馈专家评审意见，接受专家反馈修改意见共 19 条，同日修改完成。2023 年 12 月 4 日正式收到立项通知。

2023 年 12 月 08 于铜川市举行“甲状腺疾病国际标准研讨会”，本次会议围绕中医甲状腺疾病外治法国际标准的制定展开深入讨论。王丽丽主任介绍了参会领导和专家，并介绍了世界中联国际标准的研制情况。李靖教授和丁治国教授分别就项目背景、立项方案及预期规划进行了汇报。与会专家围绕标准制定的范围、外治法的国际化推广、循证证据的提升、标准操作规范等关键问题展开讨论，强调标准应兼具临床实用性和国际适应性，并充分考虑知识产权保护。会议总结指出，标准制定需凝聚海内外专家智慧，确保可实施性，并以此推动中医外治法的全球化发展。

2023 年 12 月 19 日正式成立指南工作组；随后并分别成立了指南研制工作组微信群、指南研制专家组微信群，本文件工作组根据分配任务，制定了指南研究计划，确定了编制时间节点，项目负责人定时督促工作组研制进程，并阶段性汇报指南进展情况。

2.3 起草阶段

2.3.1 专家访谈

本指南工作组对 3 名权威专家进行一对一访谈，主要探讨中西医治疗桥本甲状腺炎等总体思路、治疗经验以及对于桥本甲状腺炎不同甲状腺功能阶段患者中医证候与西医治疗结合的理解。本指南制订团队从桥本甲状腺炎西医诊疗疑难点和中医药干预或中西医结合治疗优势出发，设计中西医临床专家调研问卷并发放。

2.3.2 广泛临床调研确定临床问题

在指南制定过程中，为充分纳入临床医生最关心的问题，工作组基于桥本甲状腺炎的西医诊疗难点及中医药干预或中西医结合治疗的优势，通过前期文献预检索和临床经验总结，多次组内讨论，初步形成了 16 个临床问题。

自 2023 年 12 月至 2024 年 2 月，工作组开展了覆盖全国七大地区（华中、华东、华南、华北、西南、东北、西北）的临床调研工作，参与机构包括社区医院、村卫生室、二级医院、三级医院等各级医疗机构，共 61 名临床医生、护士和患者对 16 个临床问题的重要性进行了评估。

调研过程中，采用票选率作为重要性评估的主要指标。最终，票选率超过 60%的条目被纳入指南的基础问题、临床问题与结局指标清单；票选率≤60%的条目未纳入讨论。

根据调研结果，16 个临床问题的票选率均高于 60%。指南工作组就形成的 16 个临床问题向方法学专家进行咨询，最终根据调研结果及咨询结果将 15 个临床问题(5 个基础问题和 10 个 PICO 化临床问题)和 5 个结局指标纳入初步的指南问题清单，进一步开展德尔菲法专家调查以确定指南问题。

2.3.3 临床问题确定以及关键结局指标筛选

为确定本指南的临床问题和结局指标，工作组采用德尔菲法对来自全国 14 个省市、25 家三甲医院的 25 位领域内专家进行了专家意见调查。通过计算各临床问题和结局指标的专家积极系数、均值、满分比及变异系数，对其重要性进行评价：临床问题采取 5 分制：很重要（5 分）、重要（4 分）、一般（3 分）、不重要（2 分）、很不重要（1 分）；结局指标采取 9 分制：7~9 分为关键结局，4~6 分为重要结局，1~3 分为一般结局。纳入指南的条目需满足以下标准：临床问题均分≥3 分；结局指标均分≥7 分；满分比≥50%；变异系数<25%。同时，工作组以专家积极系数≥70%、肯德尔和谐系数>0.7、格朗巴赫系数>0.7 为质量控制标准，评估问卷的协调性和一致性。

本次共发放问卷 25 份，回收率为 100%（25/25），专家积极系数达到 100%，肯德尔和谐系数为 0.723，格朗巴赫系数 0.891，因此，本次无需进行第 2 轮投票。最终，经课题组专家讨论，并对相似的临床问题进行总结归纳后，确定 14 个临床问题（包括 5 个基础问题和 9 个 PICO 化临床问题）及 4 个关键结局指标。

编号	临床问题清单
1	桥本甲状腺炎的西医诊断标准是什么？
2	桥本甲状腺炎如何进行鉴别诊断？
3	桥本甲状腺炎的中医辨证分型是什么？各证型的常见证候及辨证要点是什么？
4	桥本甲状腺炎的中西医结合诊治原则是什么？
5	桥本甲状腺炎患者生活方式的改善包括哪些具体内容和方法？
6	桥本甲状腺炎甲功正常时，中西医结合治疗能否有效降低 TPOAb 滴度？
7	桥本甲状腺炎甲功正常时，中西医结合治疗能否更好改善患者的临床症状（如颈前压迫感，咽部异物感等）和甲状腺肿？
8	桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否有效降低 TPOAb 滴度？
9	桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否更快改善甲状腺功能？
10	桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否更好改善患者的临床症状（如颈前压迫感、咽部异物感、心慌手抖等）和甲状腺肿？
11	桥本甲状腺炎继发甲减时，中西医结合治疗能否有效降低 TPOAb 滴度？
12	桥本甲状腺炎继发甲减时，中西医结合治疗能否更快改善甲状腺功能？
13	桥本甲状腺炎继发甲减时，中西医结合治疗能否更好改善患者的临床症状（如咽部异物感、疲劳乏力、黏液性水肿等）和甲状腺肿？
14	中医外治法能否改善桥本甲状腺炎患者的临床症状（如颈前压迫感、咽部异物感）和甲状腺肿？

表 1 指南临床问题清单

2.3.4 证据的检索、筛选和综合

（1）检索说明

为了能够尽可能检索到所有桥本甲状腺炎相关临床问题的文献，文献初步检索并未设定具体的研究类型。下载文献题录后，建立数据库，进行分类。优先考虑已发表的系统评价/Meta 分析，从时效性、临床问题匹配度和质量 3 个方面看能否被本指南纳入。如不能纳入，则开展新的系统评价/Meta 分析。如果 RCT 数量较少或无法回答目前的临床问题，则进一步酌情考虑其他类型的研究结果，如队列研究、病例对照研究等。

（2）根据 PICO 确定检索策略

明确临床问题后，本指南对于临床证据通过计算机和手工相结合的方法进行检索。检索时间均从各数据库建库至 2024 年 10 月 31 日。检索国内外原始研究数据库，主要数据库包括：PubMed，中国知网(CNKI)、维普数据库(VIP)、中国生物医学文献数据库(CBM)、万方全文数据库(WanFang)。检索方式以主题词和自由词相结合。遵循 PICO 原则，分别从“P”（患者，即病种）、“I”（干预）两方面确定中、英文检索词，包括“P”：“慢性淋巴细胞性甲状腺炎”“桥本氏甲状腺炎”“桥本甲状腺炎”“慢性淋巴细胞甲状腺炎”“自身免疫性甲状腺炎”“Hashimoto's thyroiditis”“chronic lymphocytic thyroiditis”“autoimmune thyroiditis”、以及“I”：“中医”、“中药”、“中医药”、“方剂”、“汤”、“散”、“丸”、“膏”、“丹”、“中成药”、“外治法”、“中医外治”、“针刺”、“针灸”、“灸”、“穴位敷贴”、“Traditional Chinese Medicine (TCM)”、“Chinese herbal medicine”、“Chinese medicine and pharmacology”、“formulae”、“decoction”、“powder”、“pill”、“paste”、“elixir”、“proprietary Chinese medicine”、“external therapy”、“TCM external therapy”、“acupuncture”、“needle therapy”、“moxibustion”、“intradermal needle”、“acupoint application”。

经查阅中英文数据库共检索到 1468 篇文献（PubMed 219 篇，中国知网 588 篇、维普数据库 216 篇、中国生物医学文献数据库 183 篇、万方全文数据库 262 篇），剔除重复文献，

通过查阅全文最终纳入 68 篇 RCT 研究。手工检索涉及相关内容的书籍类文献 24 部，包括科学出版社“十四五”普通高等教育研究生规划教材《中西医结合甲状腺病学》、全国中医药行业高等教育“十四五”规划教材《中西医结合外科学》、全国中医药行业高等教育“十四五”规划教材《中医外科学》以及国内相关的专家共识、标准与指南。

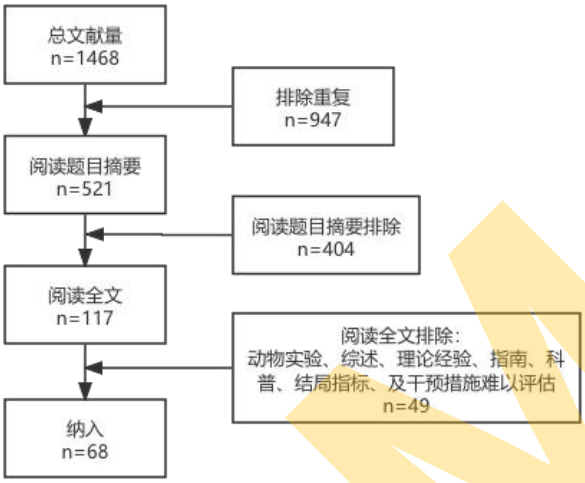

图 1 文献检索结果

2.3.5 证据评价与分级

（1）文献质量评价

为明确纳入指南的 68 篇 RCT 研究的偏倚风险及文献质量情况，本指南采用 Cochrane 偏倚风险评价工具对纳入的文献进行偏倚风险评估(随机序列的生成、分配隐藏、结局评价者盲法、不完整数据、选择性报告结局以及其他偏倚)。最终大部分的条目评价为风险偏倚不清楚，而整体质量评价为低风险偏倚的较少。纳入的数据采用 Review Manager5.4 软件进行分析，计数资料采用相对危险度(Relative Risk，RR)、计量资料采用均数差(Mean Difference，MD)作为效应量指标，当各研究间存在统计学异质性(P≤0.1，I^2≥50%)时，则分析其异质性来源，对可能导致异质性的因素开展亚组分析；若研究结果存在统计学异质性而无临床异质性，则采用随机效应模型进行合并分析。

（2）GRADE 评价

本指南采用 GRADE 标准对证据体的质量进行评价，得出证据级别，形成 GRADE 证据概要表、证据总结表，并将所形成的证据概要表、证据总结表以附件形式存档。证据概要描述见附件 1。GRADE 证据表见附件 2。

证据分级	具体描述	研究类型
高质量/A ⊕⊕⊕⊕	我们非常确信真实的效应值接近效应估计	RCT，质量升高 2 级的观察性研究
中等质量/B ⊕⊕⊕◯	对效应估计值我们有中等强度的信心：真实值有可能接近估计值，但仍存在二者大不相同的可能性	质量降低 1 级的 RCT，质量升高 1 级的观察性研究
低质量/C ⊕⊕◯◯	我们对效应估计值的确信程度有限：真实值可能与估计值大不相同	质量降低 2 级的 RCT，观察性研究
极低质/D ⊕◯◯◯	我们对效应估计值几乎没有信心：真实值很可能与估计值大不相同	质量降低 3 级的 RCT，质量降低 1 级的观察性研究，系列病例观察，个案报道

表 2 证据质量描述

推荐强度	说明
强推荐	明显利大于弊
弱推荐	可能利大于弊
不推荐	利弊相当或不确定

表 3 GRADE 推荐强度分级

2.3.6 推荐意见/共识意见形成

（1）第一次专家推荐意见征集

指南制订团队于 2025 年 1 月 2 日在线上召开推荐意见与共识建议会议。

会议邀请了来自全国 29 个省、自治区、直辖市的 55 位专家参与，涵盖甲状腺病科、内分泌科、甲状腺外科、循证方法学等多个领域的中医、中西医结合及西医临床专家。会议由指南制订团队牵头专家向与会专家详细介绍本指南的背景、目的及拟定的推荐意见与共识建议。由指南工作组介绍指南制订的科学流程，并向专家提供证据概要表、推荐意见/共识建议投票单等相关材料。

本次专家意见征求，设定专家积极度超过 70%视为有效投票。投票内容包括 20 条推荐意见征求和 9 条共识建议，推荐条目主内容针对各中医证型辩证施治以及中医外治法。共识建议内容主要涉及诊治原则、生活干预，以及桥本甲状腺炎、桥本甲状腺炎继发甲状腺毒症、桥本甲状腺炎继发甲状腺功能减退症辩证分型。

对有临床证据支持的条目，设立 5 个选项："强推荐"、"弱推荐"、"不确定"、"弱不推荐"、"强不推荐"。若除"不确定"以外任意一格票数超过 50%，则视为达成共识，可直接确定推荐方向和推荐强度； 若"不确定"一侧的两格总票数超过 70%，则视为达成共识，推荐方向确定，推荐强度直接为"弱"；其余情况视为未达成共识，需进入下一轮投票（最多 3 轮）。无临床证据的共识建议，设立 3 个选项："同意"、"不确定"、"不同意"。若"不确定"以外任意一项票数超过 50%，则视为达成共识，并确定建议方向和强度；其余情况视为未达成共识，共识建议进入下一轮投票（最多 3 轮）。

至截止时间，共有 50 名专家完成投票，专家积极度达到 90.9%，符合有效投票标准。根据投票规则，20 条推荐条目，"强推荐"率均超过 50%，投票结果为："20 项条目均达成强推荐共识"；9 项共识条目同意率均超过 50%，投票结果为："同意 9 项共识条目纳入指南"。

此次所有条目均达成决策，无需进入下一轮投票。投票结果公布后，与会专家均未提出异议，所有推荐/共识条目均按照推荐强度纳入指南。

指南条目	证据等级	投票结果	推荐强度
临床问题 5/6：甲功正常阶段肝郁气滞证推荐柴胡疏肝散加减	C	强推荐 36/50 弱推荐 12/50 不确定 2/50	强推荐
临床问题 5/6：甲功正常阶段肝郁化热证推荐清肝散结消瘿方	B	强推荐 35/50 弱推荐 14/50 不确定 1/50	强推荐
临床问题 5/6：甲功正常阶段肝郁痰凝证推荐四逆散合半夏厚朴汤加减	B	强推荐 35/50 弱推荐 14/50 不确定 1/50	强推荐
临床问题 5/6：甲功正常阶段肝郁脾虚证小柴胡汤合当归芍药散加减	C	强推荐 32/50 弱推荐 11/50 不确定 7/50	强推荐

临床问题 7-9：甲状腺毒证阶段肝郁化火证推荐丹栀逍遥散加减	C	强推荐 38/50 弱推荐 8/50 不确定 4/50	强推荐
临床问题 7-9：甲状腺毒证阶段心肝热盛证推荐栀子清肝汤加减	B	强推荐 38/50 弱推荐 11/50 不确定 1/50	强推荐
临床问题 7-9：甲状腺毒证阶段阴虚火旺证推荐当归六黄汤加减	B	强推荐 37/50 弱推荐 11/50 不确定 2/50	强推荐
临床问题 7-9：甲状腺毒证阶段气阴两虚证推荐天王补心丹合补中益气汤加减	C	强推荐 32/50 弱推荐 12/50 不确定 6/50	强推荐
临床问题 10-12：1 甲减阶段痰结血瘀证推荐解郁通络消瘿汤	C	强推荐 33/50 弱推荐 12/50 不确定 5/50	强推荐
临床问题 10-12：2 甲减阶段痰结血瘀证推荐化痰祛瘀消瘿汤	C	强推荐 31/50 弱推荐 15/50 不确定 4/50	强推荐
临床问题 10-12：3 甲减阶段痰结血瘀证推荐消瘿散结方	C	强推荐 31/50 弱推荐 10/50 不确定 8/50 弱不推荐 1/50	强推荐
临床问题 10-12：甲减阶段肝郁脾虚证推荐柴胡疏肝散或逍遥散加减	C	强推荐 35/50 弱推荐 11/50 不确定 4/50	强推荐
临床问题 10-12：甲减阶段脾肾阳虚证推荐参苓白术散合金匮肾气丸加减	C	强推荐 35/50 弱推荐 12/50 不确定 3/50	强推荐
临床问题 10-12：甲减阶段心肾阳虚证推荐真武汤加减联合西医常规治疗	C	强推荐 31/50 弱推荐 14/50 不确定 5/50	强推荐
临床问题 13-1:中药外敷-HT 甲功正常阶段气郁痰阻证，推荐药物：消瘿散结方	C	强推荐 34/50 弱推荐 10/50 不确定 6/50	强推荐
临床问题 13-1:中药外敷-HT 继发甲减阶段，推荐药物：消瘿方	C	强推荐 28/50 弱推荐 15/50 不确定 6/50 弱不推荐 1/50	强推荐
临床问题 13-1:中药外敷-HT 继发甲减阶段：推荐药物：消瘿膏	C	强推荐 28/50 弱推荐 15/50 不确定 5/50 弱不推荐 2/50	强推荐
临床问题 13-2:桥本甲减者，手阳明经透刺推荐取穴：三间、合谷、曲池、臂臑、肩髃、人迎、足三里	B	强推荐 28/50 弱推荐 20/50 不确定 2/50	强推荐

临床问题 13:桥本甲减者，肝郁肾虚证推荐取穴：关元、太溪、悬钟、太冲、合谷、三阴交、内关、丰隆、人迎、扶突	C	强推荐 28/50 弱推荐 17/50 不确定 5/50	强推荐
临床问题 13:桥本甲减者，脾肾阳虚证温针灸推荐取穴：脾俞（双侧）、肾俞（双侧）、命门、丰隆（双侧）、太冲（双侧）	C	强推荐 29/50 弱推荐 16/50 不确定 5/50	强推荐

表 4 第一次专家推荐意见投票结果（1）

指南条目	投票结果	推荐强度
临床问题 3:中西医结合诊治原则	建议 50/50	建议
临床问题 4：甲功正常阶段：肝郁气滞证、肝郁化热证、肝郁痰凝证、 肝郁脾虚证	建议 47/50 不确定 3/50	建议
临床问题 4：甲状腺毒症阶段：肝郁化火证 、心肝热盛证、 阴虚火旺证、气阴两虚证	建议 44/50 不确定 5/50 不建议 1/50	建议
临床问题 4： 甲减阶段： 痰结血瘀证、肝郁脾虚证、脾肾阳虚证、 心肾阳虚证	建议 48/50 不确定 2/50	建议
临床问题 14：饮食有节，营养均衡	建议 50/50	建议
临床问题 14：调畅情志，心理健康	建议 48/50 不确定 2/50	建议
临床问题 14：起居有常，不妄作为	建议 49/50 不确定 1/50	建议
临床问题 14：适度运动，增强体质	建议 49/50 不确定 1/50	建议
临床问题 14：早期发现，适时干预	建议 49/50 不确定 1/50	建议

表 5 第 1 次专家推荐意见投票结果（2）（共识建议清单）

（2）第二次专家推荐意见征集

2025 年 1 月 13 日，进行第二轮问题的专家意见征求。指南工作组再次邀请专家组（共 55 名）专家进行投票，投票内容包括 1 条征求意见和 6 条推荐条目，推荐条目主要针对中成药推荐。

至截止时间，共有 42 名专家完成投票，专家积极度达到 76.4%，符合有效投票标准。根据投票规则，6 条推荐条目，“强推荐+弱推荐”率两总和均超过 70%，所有条目均达成共识（强推荐 0 条、弱推荐 6 条），无未达成共识条目，投票结果为：“6 项条目均达成弱推荐共识”，6 条推荐条目均依据推荐强度纳入指南。1 条征求意见按照同意率超过 50%的选项进行采纳。

指南条目	**证据等级**	**投票结果**	**推荐强度**
桥本甲状腺炎与甲状腺毒症/甲状腺功能减退症的衔接词选择	/	“继发”23/42 “…期”17/42 “合并/伴”2/42	表述方式： 桥本甲状腺炎 桥本甲状腺炎继发甲状腺毒症 桥本甲状腺炎继发甲状腺功能减退症

桥本甲状腺炎甲功正常：在生活方式干预的基础上，推荐使用百令胶囊降低 TPOAb 抗体滴度。	D	强推荐 10/42 弱推荐 20/42 不确定 10/42 弱不推荐 2/42	弱推荐
桥本甲状腺炎甲功正常:在生活方式干预的基础上，推荐使用逍遥丸（降低 TPOAb 抗体滴度	D	强推荐 11/42 弱推荐 20/42 不确定 10/42 弱不推荐 1/42	弱推荐
桥本甲状腺炎继发甲状腺功能减退症：在生活方式干预的基础上，推荐使用百令胶囊联合左甲状腺素，降低 TPOAb 抗体滴度，改善甲状腺功能。	D	强推荐 11/42 弱推荐 24/42 不确定 6/42 弱不推荐 1/42	弱推荐
桥本甲状腺炎继发甲状腺功能减退症：在生活方式干预的基础上，推荐使用夏枯草制剂，联合左甲状腺素，降低 TPOAb 抗体滴度，改善甲状腺功能。	D	强推荐 10/42 弱推荐 26/42 不确定 3/42 弱不推荐 3/42	弱推荐
桥本甲状腺炎继发甲状腺功能减退症:在生活方式干预的基础上，推荐使用金水宝胶囊联合左甲状腺素，降低 TPOAb 抗体滴度，改善甲状腺功能。	C	强推荐 11/42 弱推荐 19/42 不确定 11/42 弱不推荐 1/42	弱推荐
桥本甲状腺炎继发甲状腺功能减退症:在生活方式干预的基础上，脾肾阳虚证推荐使用右归丸联合左甲状腺素，降低 TPOAb 抗体滴度，改善临床症状。	D	强推荐 12/42 弱推荐 19/4 不确定 10/42 弱不推荐 1/42	弱推荐

表 6 第 2 次专家推荐意见投票结果

（3）第三次专家推荐意见征集

按照专家组意见修订草案后，2025 年 01 月 23 日将草案再次邀请专家组（共 55 名专家）进行意见征求，本次征求意见内容为草案中 13 处修订内容（包括结构性修订 8 处，内容修订 5 处）。

本次专家意见征求投票表设立 3 个选项：“同意”、“不确定”、“不同意”。具体决策规则如下：专家积极度需大于 70%；若“不确定”以外任意一项的票数超过 50%，视为达成决策；若未达成决策，则需进入下一轮投票，最多不超过 3 轮。至截止时间，共有 50 名专家完成投票，专家积极度达到 90.9%，符合有效投票标准。根据决策规则，13 项修订条目同意率均超过 50%，决策结果为：“同意 13 项修订”。此次所有条目均达成决策，无需进入下一轮投票。

类型	序号	标准条文	修订内容	投票结果
结构性	1	“诊断”部分	将“临床表现”和“中医证候”置于前部	50/50 同意

	2		“西医诊断”和“诊疗流程”移至“附录 B”	47/50 同意 3/50 不确定
	3	“治疗”部分	“西医治疗”调整至“附录 C”	47/50 同意 3/50 不确定
	4		“关键结局指标”调整至“附录 D”	48/50 同意 2/50 不确定
	5		将“中医辨证要点”与“治疗推荐方药”合并	49/50 同意 1/50 不确定
	6	“正文”部分	删除“证据描述”，将证据相关内容移至文件“草案编制说明”	48/50 同意 1/50 不确定 1/50 不同意
	7	“引言”部分	删除“2 确定并构建关键问题”，将相关内容移至文件“草案编制说明”	50/50 同意
	8	“前言”“附录 A 编制方法”	修改“前言”背景信息，以及“附录 A 编制方法”	49/50 同意 1/50 不确定
内容性	1	“引言”部分	在“背景信息”中将流行病学数据由国内统计改为全球数据	50/50 同意
	2	“范围”部分	删除“本文件使用者为西医临床医师”	48/50 同意 2/50 不确定
	3	“术语和定义”	增加“温针灸”“助透剂”“巴布剂”“赋形剂”的定义	50/50 同意
	4	“5.3 中医外治法”	1. 增加引用（如 GB/T 334142016），以补充外用药制作、使用、贮藏的原则。 2. 补充“注意事项”	50/50 同意
	5	“附录 E”	新增“附录 E 摘要性快速推荐表”	50/50 同意

表 7 第 3 次专家推荐意见投票结果

2.3.7 内部审查评议

指南制订团队于于 2025 年 1 月 2 日通过线上会议形式审查草案，共收获 29 条修改建议，采纳 19 条意见，未采纳 10 条；根据采纳专家意见修改草案，未予采纳的条目反馈未采纳原因。

按照专家组意见修订草案后，2025 年 01 月 23 日将草案通过线上方式进行草案内部二次审查评议工作。共收到 2 条意见/建议，未采纳 2 条。

经过 2 轮内部审查后，向国际标准部反馈审查意见。草案依据投票结果进行相应修订后，递交世界中联。

序号	标准条文号	意见内容	提出专家	处理意见及原因
1	前言	“现代医学以随访为主，无特殊治疗方式，如继发甲状腺毒症、甲状腺功能减退，进行抗甲状腺药物或激素补充治疗。”桥本甲状腺炎发生甲减、甲亢都是原发性的，写继发是否不太合适，建议改成桥本“伴发”甲减，桥本“伴发”甲状腺毒症。	胡天赤	未采纳。 原因：依据专家投票结果：“继发”VS“…期”VS“合并/伴”=23:17:2，故选用“继发”一词。
2	前言	“进行”改为“需进行”。	卢雪玲	采纳

3	辨证分型	桥本甲状腺炎本身就会有甲功正常，甲减或甲亢这几种结局，“继发”这个词是不是不太合适，考虑是否将“继发”换为“伴”这个词。	胡天赤	未采纳。 原因：依据专家投票结果：“继发”VS“…期”VS“合并/伴”=23:17:2，故选用“继发”一词。
4	术语和定义	建议在术语和定义部分增加“缩略语”有利于进行基层推广。	孙鲁英	采纳
5	具体描述部分	TGAb 中的 G 使用 g。TGAb→TgAb	陈开宁	采纳
6	第 6 页桥本甲状腺炎诊断标准	伴有峡部锥体叶肿大，可改为锥状叶，锥状叶名词用的较多。	郭志芹	采纳
7	辨证分型	在辩证分型时，无论是甲功正常继发甲状腺毒性还是继发甲减，关于这个颈部的描述，我们甲功正常的时候。临床上可能颈部肿大不多见，除了第一个肝郁气滞写的颈部多无明显肿大，其他都是有肿大的，建议具体明确各阶段各证型哪些是肿大的，哪些是萎缩的。	郭志芹	采纳
8	西医诊断	在桥本病诊断中，建议改为：甲状腺细针穿刺不作为常规诊断手段，对特殊类型桥本甲状腺炎等可行甲穿细针穿刺细胞学检查；	范逸飞	采纳
9	中药外敷	在甲状腺炎中药外敷中，建议增加黄药子外用，其在《本草纲目》中地位很高，外用较内服安全。	范逸飞	未采纳。 原因：未检索到相应文献作为证据支持黄药子外敷治疗桥本甲状腺炎，将继续关注，如有证据更新，将在指南修订时进行补充。
10	治疗方案	中西医结合治疗部分是否增加对特殊人群用药禁忌症的描述，例如桥本甲减妊娠期妇女，涉及的活血药。甲状腺毒症期，西药的不良反应及副作用。	夏仲元	采纳
11	治疗方案	是否考虑增加中成药和单味中药制剂。	夏仲元	采纳
12	辨证分型	在具体描述部分对“结合中药辨证论治”需要斟酌语言	夏仲元	采纳
13	桥本甲状腺炎诊断标准部分	血清 TPOAb 和 TgAb 阳性，诊断即可成立，是仅仅是阳性就可以，或没有相应的一个标准，比如说三倍或者五倍可以诊断。	黄延芹	未采纳。 原因：本指南涉及的桥本甲状腺炎诊断标准参考 2008 年《中国甲状腺疾病诊治指南—甲状腺炎》的相关表述进行书写。

14	辨证分型	桥本继发甲减时有没有阴虚证出现	黄延芹	未采纳。 原因：桥本继发甲减的辨证分型依据文献研究结果及专家投票决定。
15	结局指标部分	桥本主要看抗体，是否将抗体放在甲功前面，将抗体的地位往上提高	黄延芹	采纳
16	鉴别诊断	鉴别诊断部分毒性弥漫性甲状腺肿，大家更习惯的说法是弥漫性毒性甲状腺肿，可调整说法。	王振刚	采纳
17	辨证分型	甲状腺毒证阶段肝郁化火证与心肝热盛证症状重复性较高，是否可将两个证型进行浓缩为一个。	王振刚	未采纳。 原因：桥本继发甲状腺毒症证型分类依据依据文献研究结果及专家投票决定。
18	治疗方案	可用β受体阻滞剂（如普萘洛尔）治疗，普萘洛尔10～40mg/次，每日6～8h口服1次。40mg剂量相对来说有些高，桥本甲状腺毒症是一过性的，激素水平达不到Graves病的水平,持续时间也比Graves病短，剂量方面需要再进行斟酌。	王振刚	采纳
19	辨证分型	桥本继发甲状腺毒症属于一过性阶段，是否可以减少甲状腺毒症的中医证型，比如放两个证型	雷烨	未采纳， 原因：桥本继发甲状腺毒症证型分类依据依据文献研究结果及专家投票决定。
20	辅助检查第5条	建议病理学检查放在前面①细胞病理学②组织病理学	狄红杰	采纳
21	诊断标准	诊断标准血清TSH水平降低，和/或FT4、FT3水平升高。“和/或”是否放FT3、FT4中间。	狄红杰	未采纳。 原因：本部分参照中华医学会《中国甲状腺功能亢进症和其他原因所致甲状腺毒症诊治指南》中相关表述确定。
22	鉴别诊断	摄碘率与吸碘率，统一为摄碘率，或存在多年的甲状腺肿块在短期内迅速增大，甲状腺癌要么是低分化的或者未分化的，要么就是一般的乳头障碍。乳头状癌一般是良性的，不会变成恶性的。而那些低分化的，短期之内就会增大。存在多年的甲状腺肿这句话是否可以删除，以免引起歧义	狄红杰	采纳
23	诊断	明确诊断部分的术语描述	张东鹏	采纳
24	治疗方案	在治疗方案里是否增加酌情进行甲状腺超声检查	李宇鹏	采纳

25	流程图	流程图内辨证论，少了一个“治”字。	李宇鹏	采纳
26	随访管理	长期随访与管理在指南内体现的相对少，是否增加长期随访与管理的篇幅。	李宇鹏	未采纳。 原因：目前未检索到与与之相关的明确共识性或指导性文献，将继续关注该方向，如有更新数据，将在指南修订时增加此部分描述。
27	中医病因病机	现代人群熬夜原因也会引起桥本发病等，是否在中医病因病机中加一条生活起居失度，导致脾肾的亏虚，导致痰凝气滞等。	胡剑卓	未采纳。 原因：目前未检索到与与之相关的明确共识性或指导性文献，将继续关注该方向，如有更新数据，将在指南修订时增加此部分描述。
28	治疗方案	目前含碘的药物、食物是否使用影响最大的就是这个亚临床甲减的发生率增高，而对于甲亢以及甲状腺结节是有明显的下降的，含碘的药物对甲状腺炎有什么样的影响，建议在下一次的指南修订中，可以有更多的循证证据进行探讨。	胡剑卓	采纳
29	治疗方案	建议在中药部分补充有哪些中药是富碘中药，在桥本甲状腺炎内应当避免使用富碘中药，生活饮食方面强调减少碘的摄入量。	郭翔宇	采纳
30	中医外治法	部分针刺治疗取穴时的坐卧位可以再宽松些，比如第一个处方，完全可以坐位取穴或治疗。	张东鹏	未采纳：暂未检索到相关证据支持此项修改，目前治疗体位依据现有证据文献制定。我们将持续关注，若有新的证据支持，将在后续指南修订中进行更新。
31	正文	意见 2：建议正文里有简要证据体关键设计及数据陈述，以及有关键的数量和质量表述。	费宇彤	未采纳：经与世界中联沟通，将证据描述相关内容移至文件“草案编制说明”，以符合世界中联指南撰写规范要求。

表 8 内部审查意见汇总

三、主要技术内容介绍

1 指南制定原则

本文件的起草程序依据世界中医药学会联合会发布的 《SCM1.1-2021 标准化工作指导导则 第 1 部分：标准制修订与发布》的要求进行，同时参考《GB/T 1.1-2020 标准化工作导则（第 1 部分：标准化文件的结构和起草规则）》的相关规定进行编制。

在指南制订过程中，严格遵循相关证据质量评价、证据分级及推荐意见形成的原则和标准，确保指南编制的科学性和严谨性。系统评价方法学的质量评价采用 AMSTAR2 工具；随机对照试验（Randomized Controlled Trial, RCT）的方法学质量通过 Cochrane 偏倚风险评估工具进行评价；证据质量评价和分级采用 GRADE 系统。

技术内容主要遵循以下原则：①针对循证证据分级的方法，总体思想为基于国际指南通用的 GRADE 标准，纳入相关临床随机对照试验类研究，结合相关公开出版教材、既往指南/共识/标准，以 GRADE 为主保持国际化，以权威客观资料为辅减少证据偏移。 ②针对专家共识推荐强度，结合 GRADE 内容，基于科研经验、理论分析、文献记载等，权衡利弊，分别于问卷中各条目勾选“强推荐（一定利大于弊）”、“弱推荐（可能利大于弊）”、“不确

定（利弊关系不确定，或无明显差异）”、“弱不推荐（可能弊大于利）”、“强不推荐（一定弊大于利）”，综合相关资料形成专家共识推荐。③专家共识是中医临床诊疗指南形成推荐意见的重要依据，基于此，本指南在起草过程中专家共识的形成主要基于“德尔菲”法。④制定计划按照目前国际上发布的指南更新报告规范，在未来 2-3 年进行更新。

2 指南制定技术路线

本指南的编制严格按照规范步骤进行。

第一阶段：成立指南起草组并签署利益声明；对国内外桥本甲状腺炎中西医相关指南与临床研究进行梳理，确定指南的题目、范围和目的；规划指南研究方案并撰写申报材料。正式立项后，通过访谈权威专家及线上临床医师调研，全面收集临床实践中的关键问题，以初步构建指南问题和结局指标清单；通过德尔菲法优化指南所拟解决的临床问题和疗效评价指标重要性分级问题，最终形成指南临床问题清单。

第二阶段：依据已确定的临床问题清单，进行证据的检索、筛选、综合及评价。针对有循证医学证据支撑的临床问题，采用 GRADE 方法对证据质量进行评价和分级，形成证据概要表；对于证据不足的临床问题，初步形成专家共识推荐意见，并通过多轮专家投票，最终达成一致共识。

第三阶段：完成指南草案后，由编写工作组内部专家进行自评，并对草案进行修改和完善。随后，将草案上报至世界中医药学会联合会，进行网络公示广泛征求意见；在公示期满并经学会审查通过后，根据反馈意见进行最终修订、确认与发布。

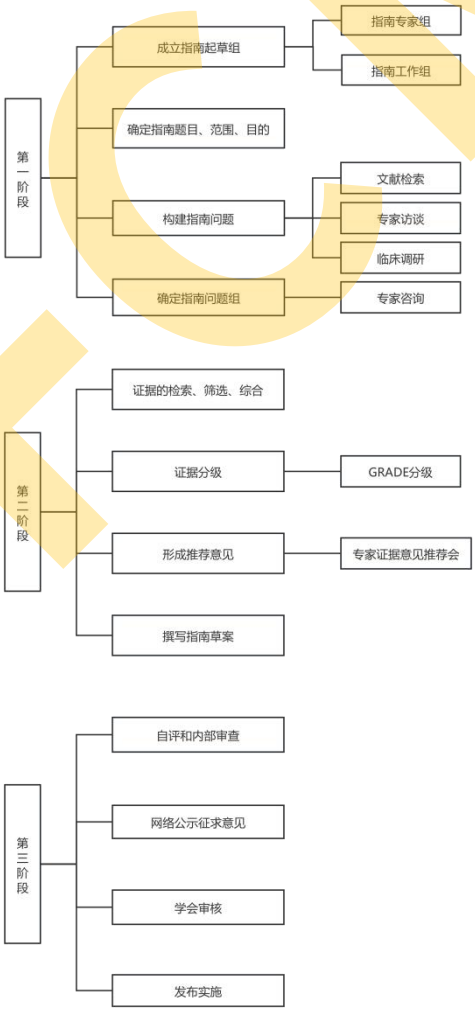

图 2 《国际中医临床实践指南 桥本甲状腺炎》技术路线

3 总体内容

本指南以甲状腺功能水平为依据，对桥本甲状腺炎不同疾病阶段（桥本甲状腺炎甲状腺功能正常阶段、桥本甲状腺炎继发甲状腺毒症、桥本甲状腺炎继发甲状腺功能减退症）分别进行推荐治疗建议。

本指南正文共设 7 部分，主要技术内容包括：第 1-3 部分明确了本指南的范围、规范性引用文件和术语定义；第 4 部分明确了桥本甲状腺炎的临床表现，第 5 部分为西医诊断以及中医辩证分型；第 6 部分明确了桥本甲状腺炎治疗原则，以及辨证论治、中成药治疗、其他疗法、生活干预；第 7 部分明确了桥本甲状腺炎的诊疗核心结局指标集；第 8 部分为附录及参考文献，并描述了本指南的编制方法。

4 与相关法律、法规、强制性标准和临床实践指南的关系

本指南所推荐的相关治疗药物，均遵循国家最新《国家基本医疗保险、工伤保险和生育保险药品目录》、《国家基本药物目录》和《中国药典》所记载的内容。

本指南西医诊断标准、西医治疗以及中医辩证分型等内容，重点参考了《桥本甲状腺炎中西医结合诊疗北京专家共识（2021，北京）》、《桥本氏甲状腺炎中西医结合质量控制指标体系北京专家共识（2021 版）》、《中国甲状腺疾病诊治指南—甲状腺炎（2008）》、《中国甲状腺功能亢进症和其他原因所致甲状腺毒症诊治指南（2022）》、《成人甲状腺功能减退症诊治指南（2017）》。

四、重大分歧意见的处理经过和依据

本指南在制定过程中，未出现重大分歧意见。

五、其他应说明的事项

本项目受财政部办公厅、国家中医药管理局“中医药传承创新发展示范试点项目”资助。

本项目组成员在项目正式启动前均签署了“利益冲突声明书”，且存档。本指南制订过程中不存在利益冲突，为此不会成为本指南制订的偏倚来源，所有参与本指南制订的成员均和药品生产企业没有任何经济利益往来。

附件 1 证据概要说明

临床问题 1：桥本甲状腺炎的西医诊断标准是什么？

证据描述：参考2008年《中国甲状腺疾病诊治指南—甲状腺炎》、2021年《桥本甲状腺炎中西医结合诊疗北京专家共识2021》、2017年《成人甲状腺功能减退症诊治指南》、2022年《中国甲状腺功能亢进症和其他原因所致甲状腺毒症诊治指南》。

临床问题 2：桥本甲状腺炎如何进行鉴别诊断？

证据描述：参考2008年《中国甲状腺疾病诊治指南-甲状腺炎》、2021年《桥本甲状腺炎中西医结合诊疗北京专家共识2021》、科学出版社“十四五”普通高等教育研究生规划教材《中西医结合甲状腺病学》。

临床问题 3：桥本甲状腺炎的中医辨证分型是什么？各证型的常见证候及辨证要点是什么？

证据描述：经查阅中英文数据库中建库至 2023 年 12 月的报道类文献 8835 篇，剔除重复文献，根据纳排标准最终纳入桥本甲状腺炎 16 篇、甲状腺毒症 248 篇，甲状腺功能减退症 67 篇文献进行研究，并手工检索涉及相关内容的书籍类文献 24 部，包括科学出版社“十四五”普通高等教育研究生规划教材《中西医结合甲状腺病学》、全国中医药行业高等教育“十四五”规划教材《中西医结合外科学》、全国中医药行业高等教育“十四五”规划教材《中医外科学》以及国内相关的专家共识、标准与指南。对检索得到的 331 篇报道类文献和 24 部书籍类文献中的证候类型、各证型的证候要素分别进行频数统计，并对其进行专家共识，对证候类型、各证型的证候要素进行选择并排序，形成桥本甲状腺炎的证候要素。

临床问题 4：桥本甲状腺炎的中西医结合诊治原则是什么？

证据描述：参考 2021 年《桥本甲状腺炎中西医结合诊疗北京专家共识 2021》，科学出版社“十四五”普通高等教育研究生规划教材《中西医结合甲状腺病学》。

结局指标制定：

证据描述：参考科学出版社“十四五”普通高等教育研究生规划教材《中西医结合甲状腺病学》、国家卫生健康委员会“十三五”规划教材《内科学》、国家卫生健康委员会“十三五”规划教材《诊断学》、2002 版《中药新药临床研究指导原则》相关内容确定疗效评价指标。

TPOAb 作为评价指标：TPOAb 是桥本甲状腺炎的特异性抗体，几乎存在于所有 HT 患者中，主要是由甲状腺周围浸润的淋巴细胞产生[1]，无论是否存在甲状腺功能减退，TPOAb 均能反应甲状腺淋巴细胞浸润的严重程度[k=0.55，95%CI(0.493-0.615)][2-5]，在存在甲状腺功能减退的 HT 患者中 TPOAb 的滴度水平与 TSH 水平呈正相关[OR=40，95%CI(12-136)[6-7]；血清 TPOAb 水平的测定不仅在疾病诊断中发挥重要作用，它还是对疾病治疗效果的评价指标，在评估患者的临床治疗效果上具有重要地位[8-10]。

甲状腺疾病生活质量简明量表（ThyPRO-39）：一项系统评价[11]，经检索英文文献数据库共确定 904 项研究，根据纳排标准最终纳入 64 项研究 16 个不同问卷，其中 4 份问卷涉及良性甲状腺疾病（ThyPRO、ThyPRO-39、Thy-R-HRQoL 和 Thy-D-QOL），研究结果显示 ThyPRO 和 ThyPRO-39 可靠性及内部一致性均>0.75，是更适合评估良性甲状腺疾病的问卷，相较于 ThyPRO 量表的 85 个项目，ThyPRO-39 量表的 39 个项目更短小，在完成时间(14min VS 4min)方面更有优势，且 ThyPRO-39 量表排除了具有文化差异的项目[11-13]。

临床问题 5：桥本甲状腺炎甲功正常时，中西医结合治疗能否有效降低 TPOAb 滴度？

临床问题 6：桥本甲状腺炎甲功正常时，中西医结合治疗能否更好改善患者的临床症状（如颈前压迫感，咽部异物感等）和甲状腺肿？

肝郁气滞证：柴胡疏肝散加减（证据级别：C，强推荐）。

证据描述：1项RCT[14]（n=69）评估柴胡疏肝散治疗HT的临床疗效，对照组予硒酵母，观察组予柴胡疏肝散加减联合硒酵母，结果显示，在降低血清TPOAb抗体滴度水平、改善临床症状方面，观察组疗效明显优于对照组，血清TPOAb（MD=-16.20，95%CI[-85.97,53.57])，中医证候积分（MD=-6.34，95%CI[-8.52,-4.16])。研究未报告不良事件。

②肝郁化热证：清肝散结消瘿方（证据级别：B，强推荐）。

证据描述：1 项 RCT[15]（n=90）评估清肝散结消瘿方治疗 HT 的临床疗效，对照组予限碘饮食，观察组予清肝散结消瘿方联合限碘饮食，结果显示，在降低血清 TPOAb 抗体滴度水平、改善临床症状及改善甲状腺肿方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-13.55，95%CI[-71.12,44.02])，中医证候积分（MD=-5.58，95%CI[-7.94,-3.22])，甲状腺体积（MD=-0.30，95%CI[-2.68,2.08])，HAMA 焦虑评分（MD=-4.00，95%CI[-5.53,-2.47])，HAMD 抑郁评分（MD=-2.50，95%CI[-4.07,-0.93])，匹兹堡睡眠质量指数(PSQI) (MD=-4.14，95%CI[-5.38,-2.91])，疲劳严重程度测评量表(FSS)（MD=-6.19，95%CI[-10.85,-1.53])。研究未报告不良事件。

③肝郁痰凝证：四逆散合半夏厚朴汤加减（证据级别：B，强推荐）。

证据描述：1 项 RCT[16]（n=63）评估四逆散合半夏厚朴汤加减治疗 HT 的临床疗效，对照组予硒酵母，观察组予四逆散合半夏厚朴汤加减联合硒酵母，结果显示，在改善甲状腺肿方面，观察组疗效明显优于对照组，甲状腺体积（MD=-2.04，95%CI[-3.97,-0.11])。2 项 RCT[16,17]（n=157）评估半夏厚朴汤加减治疗 HT 的临床疗效，对照组予硒酵母，观察组予半夏厚朴汤加减联合硒酵母，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，中医证候积分（MD=-6.23，95%CI[-7.27,-5.18])。3 项 RCT[[16-18]（n=217）评估半夏厚朴汤加减加减治疗 HT 的临床疗效，对照组予硒酵母，观察组予半夏厚朴汤加减联合硒酵母，结果显示，在降低血清 TPOAb 抗体滴度水平、改善临床症状方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-58.3，95%CI[-72.6,-4.4])，颈前肿大（MD=-1.3，95%CI[-1.79,-0.8])，咽部异物感（MD=-1.15，95%CI[-1.49,-0.81])，情志抑郁（MD=-1.39，95%CI[-1.85,-0.093])。研究均未报告不良事件。

④肝郁脾虚证：小柴胡汤合当归芍药散加减（证据级别：C，强推荐）。

证据描述：1项RCT[19]（n=63）评估小柴胡汤合当归芍药散加减治疗HT的临床疗效，对照组予硒酵母，观察组予小柴胡汤合当归芍药散加减联合硒酵母，结果显示，在降低血清TPOAb抗体滴度水平、改善临床症状方面，观察组疗效明显优于对照组，血清TPOAb（MD=-40.59，95%CI[-57.53,-23.65])，中医证候积分（MD=-4.45，95%CI[-7.51,-1.39])。研究未报告不良事件。

2 项 RCT[20,21]（n=120）评估疏肝健脾消瘿方[20]、芪草方[21]治疗 HT 的临床疗效，对照组予硒酵母/夏枯草口服液，观察组予疏肝健脾消瘿方(柴胡、黄芪、夏枯草、白术、白芍、当归、莪术、牡蛎、浙贝、玄参、防风)，芪草方（黄芪、夏枯草、柴胡、香附、陈皮、郁金、白术、桔梗、浙贝母，甘草）联合硒酵母/夏枯草口服液，结果显示，在降低血清 TPOAb 抗体滴度水平、改善临床症状方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-52.91，95%CI[-68.16,-36.66])，中医证候积分（MD=-8.53，95%CI[-9.53,-7.53])，颈前肿大（MD=-0.81，95%CI[-1.06,-0.57])，颈前胀闷感（MD=-0.82，95%CI[-1.13,-0.51])，烦躁易怒（MD=-0.51，95%CI[-1.09,-0.07])，疲劳乏力（MD=-0.32，95%CI[-0.48,-0.15])，食少纳呆（MD=-0.93，95%CI[-1.74,-0.12])。研究均未报告不良事件。

桥本甲状腺炎推荐中成药：

百令胶囊（证据级别：D，弱推荐）或逍遥丸（证据级别：D，弱推荐）

证据描述：一项纳入 2 项 RCT（n=152）的 Meta 分析[22]，评估百令胶囊治疗 HT 的临床疗效，对照组予限碘饮食，观察组予百令胶囊联合限碘饮食，结果显示，在降低血清 TPOAb 抗体滴度水平方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-407.37，95%CI[-448.6,-366.14])。1 项 RCT[23]（n=80），评估逍遥丸治疗 HT 肝郁脾虚证的临床疗效，对照

组予限碘饮食，观察组予逍遥丸联合限碘饮食，结果显示，在降低血清 TPOAb 抗体滴度水平方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-198.06，95%CI[-275.84,-120.28]）。研究均未报告不良事件。

桥本甲状腺炎继发甲状腺毒症

临床问题 7.桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否有效降低 TPOAb 滴度？

临床问题 8.桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否更快改善甲状腺功能？

临床问题 9.桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否更好改善患者的临床症状（如颈前压迫感、咽部异物感、心慌手抖等）和甲状腺肿？

①肝郁化火证：丹栀逍遥散加减（证据级别：C，强推荐）。

证据描述：1项纳入14个RCT（n=1062）的Meta分析[24]，观察组予丹栀逍遥散联合西医常规药物治疗，对照组予西医常规药物治疗，13个RCT比较了临床疗效，结果显示，试验组临床有效率高于对照组[RR=1.25，95%CI(1.19,1.33)]；10个RCT比较了FT3、FT4水平，结果显示，试验组FT3水平低于对照组[MD=-3.63，95%CI(-6.13,-1.12)]，试验组FT4水平低于对照组[MD=-9.96，95%CI(-15.91,-4.02)]；7个RCT比较了TSH水平，结果显示，试验组TSH水平高于对照组[MD=0.42，95%CI(0.09,0.75)]；6个RCT报道了不良反应，试验组白细胞减少、皮疹发生率低于对照组，差异有统计学意义，白细胞减少[RR=0.45，95%CI(0.21,0.96)；皮疹[RR=0.24，95%CI(0.08,0.76)]。

1项RCT[25]（n=55）评估丹栀逍遥散加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规治疗，观察组予丹栀逍遥散加减联合西医常规治疗，结果显示，在降低血清TPOAb抗体滴度水平、改善临床症状方面，观察组疗效明显优于对照组，血清TPOAb（MD=-159，95%CI[-221.69,-96.31]），中医证候积分（MD=-3.17，95%CI[-5.27,-1.07]），颈前肿大（MD=-1.17，95%CI[-2.17,-0.17]），心悸不宁（MD=-0.31，95%CI[-1.11,-0.49]），多汗（MD=-1.08，95%CI[-1.88,-0.28]）。2项RCT[25,26]（n=125）评估丹栀逍遥散加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规治疗，观察组予丹栀逍遥散加减联合西医常规治疗，结果显示，在改善甲状腺功能方面，观察组疗效明显优于对照组，血清FT3（MD=-1.42，95%CI[-2.14,-0.7]），血清FT4水平（MD=-4.64，95%CI[-5.61,-3.67]），血清TSH（MD=0.05，95%CI[-0.04,0.13]）。2项研究[25,26]报告不良反应，对照组出现白细胞减少、皮疹、胃肠道不适等，观察组不良反应发生率低于对照组，差异有统计学意义（RR=0.25，95%CI[0.38,0.12]）。

②心肝热盛证：栀子清肝汤加减（证据级别：B，强推荐）。

证据描述：4项RCT[27,30]（n=380）评估栀子清肝汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予栀子清肝汤加减联合西医常规药物治疗，结果显示，在改善甲状腺功能方面，观察组疗效明显优于对照组，血清FT3（MD=-0.58，95%CI[-0.75,-0.40]），血清FT4（MD=-0.56，95%CI[-0.68,-0.45]），血清TSH（MD=0.08，95%CI[0.04,0.11]）。1项RCT[27]（n=120）评估栀子清肝汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予栀子清肝汤加减联合西医常规药物治疗，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，中医证候积分（MD=-1.10，95%CI[-1.45,-0.75]）。1项RCT[48][30]（n=80）评估栀子清肝汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予栀子清肝汤加减联合西医常规药物治疗，结果显示，在改善临床症状、改善甲状腺肿方面，观察组疗效明显优于对照组，手足心热（MD=-0.21，95%CI[-0.33,-0.09]），手指震颤（MD=-0.25，95%CI[-0.37,-0.13]）。2项RCT[27,28]（n=240）报

告了不良反应，对照组出现白细胞减少、皮疹、胃肠道不适、肝功能异常等，观察组不良反应发生率低于对照组，差异有统计学意义（RR=0.58，95%CI[0.35,0.97]）。

2项RCT[31,32]（n=150）评估清火解毒消瘿汤[31]、清肝泻火消瘿方[32]治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予清火解毒消瘿汤、清肝泻火消瘿方联合西医常规药物治疗，结果显示，在降低血清TPOAb抗体滴度水平、改善甲状腺功能、改善临床症状及甲状腺肿方面，观察组疗效明显优于对照组，血清TPOAb（MD=-174.11，95%CI[-205.68,-142.53]），血清FT3（MD=-0.08，95%CI[-0.63,-0.48]），血清FT4（MD=-1.46，95%CI[-2.08,-0.84]），甲状腺峡部厚度（MD=-0.41，95%CI[-0.84,-0.03]），颈前压迫感（MD=-0.57，95%CI[-0.92,-0.21]），心悸不宁（MD=-1.5，95%CI[-1.82,-1.19]），怕热多汗（MD=-1.43，95%CI[-1.81,-1.05]），口干口苦（MD=-1.33，95%CI[-1.72,-0.94]）。研究均未报告不良事件。

③阴虚火旺证：当归六黄汤加减（证据级别：B，强推荐）。

证据描述：11项RCT[33-43]（n=996）评估当归六黄汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予当归六黄汤加减联合西医常规药物治疗，结果显示，在改善甲状腺功能(血清FT3、FT4、TSH)方面，观察组疗效明显优于对照组，血清FT3（MD=-2.69，95%CI[-2.79,-2.59]），血清FT4（MD=-6.40，95%CI[-6.77,-6.02]），血清TSH（MD=0.38，95%CI[0.37,0.40]）。5项RCT[33,35-38]（n=374）评估当归六黄汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予当归六黄汤加减联合西医常规药物治疗，结果显示，在改善甲状腺功能(血清TT3、TT4)方面，观察组疗效明显优于对照组，血清TT3（MD=-1.54，95%CI[-1.62,-1.47]），血清TT4（MD=-6.00，95%CI[-7.33,-4.67]）。7项RCT[35,37-41,43]（n=676）评估当归六黄汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予当归六黄汤加减联合西医常规药物治疗，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，中医证候积分（MD=-2.61，95%CI[-2.69,-2.54]）。2项RCT[41,43]（n=200）评估当归六黄汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予当归六黄汤加减联合西医常规药物治疗，结果显示，在提高生活质量方面，观察组疗效明显优于对照组，ThyPRO-39量表（MD=11.56，95%CI[10.04,13.08]）。1项RCT[37]（n=200）评估当归六黄汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予当归六黄汤加减联合西医常规药物治疗，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，颈前肿大（MD=-1.50，95%CI[-1.82,-1.19]），烦躁易怒（MD=-1.06，95%CI[-1.14,-0.98]），手足心热（MD=-1.13，95%CI[-1.24,-1.02]）。4项RCT[37-39,41]（n=296）报告了不良反应，对照组出现白细胞减少、皮疹、肝肾功能异常等，观察组不良反应发生率低于对照组，差异有统计学意义（RR=0.21，95%CI[0.10,0.44]）。

④气阴两虚证：天王补心丹合补中益气汤加减（证据级别：C，强推荐）。

证据描述：4项RCT[44-48]（n=254）评估天王补心丹加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予天王补心丹加减联合西医常规药物治疗，结果显示，在改善甲状腺功能方面，观察组疗效明显优于对照组，血清FT3（MD=-2.80，95%CI[-3.06,-2.54]），血清FT4（MD=-1.10，95%CI[-1.52,-0.68]），血清TSH（MD=0.35，95%CI[0.23,0.48]）。3项RCT[44-46]（n=194）评估天王补心丹加减加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予天王补心丹加减联合西医常规药物治疗，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，中医证候积分（MD=-19.35，95%CI[-20.62,-18.12]）。1项RCT[46]（n=60）评估天王补心丹加减加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予天王补心丹加减联合西医常规药物治疗，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，心悸不宁（MD=-0.08，95%

CI[-0.60,-0.44])，手指震颤（MD=-0.85，95%CI[-1.27,-0.43]）。2项RCT[46,47]（n=120）报告了不良反应，表现为白细胞减少、肝功能异常等，观察组不良反应发生率低于对照组，差异有统计学意义（RR=0.42，95%CI[0.16,1.10]）。

3项RCT[48-50]（n=170）评估补中益气汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予补中益气汤加减联合西医常规药物治疗，结果显示，在改善血清TPOAb抗体滴度水平方面，观察组疗效明显优于对照组（MD=-55.46，95%CI[-57.78,-53.14]）。2项RCT[48,49]（n=100）评估补中益气汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予补中益气汤加减联合西医常规药物治疗，结果显示，在降低血清FT3、FT4水平方面，观察组疗效明显优于对照组，血清FT3（MD=-0.14，95%CI[-0.39,0.11]），血清FT4（MD=-0.48，95%CI[-0.97,0.01]）。1项RCT[49]（n=40）评估补中益气汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予补中益气汤加减联合西医常规药物治疗，结果显示，在升高血清TSH水平、改善临床症状方面，观察组疗效明显优于对照组，血清TSH（MD=1.86，95%CI[0.92,2.80]），颈前肿大（MD=-1.03，95%CI[-1.27,-0.79]），咽喉不利（MD=-0.96，95%CI[-1.22,-0.70]），失眠多梦（MD=-0.85，95%CI[-0.99,-0.71]），情志不畅（MD=-1.07，95%CI[-1.25,-0.89]）。1项RCT[48]（n=60）评估补中益气汤加减治疗HT继发甲状腺毒症的临床疗效，对照组予西医常规药物治疗，观察组予补中益气汤加减联合西医常规药物治疗，结果显示，在改善临床症状及甲状腺肿方面，观察组疗效明显优于对照组，中医证候积分（MD=-5.43，95%CI[-7.56,-3.30]），甲状腺峡部厚度（MD=-0.80，95%CI[-1.00,-0.60]）。研究均未报告不良事件。

临床问题 10：桥本甲状腺炎继发甲状腺功能减退症时，中西医结合治疗能否有效降低 TPOAb 滴度？

临床问题 11：桥本甲状腺炎继发甲状腺功能减退症时，中西医结合治疗能否更快改善甲状腺功能？

临床问题 12：桥本甲状腺炎继发甲状腺功能减退症时，中西医结合治疗能否更好改善患者的临床症状（如咽部异物感、疲劳乏力、黏液性水肿等）和甲状腺肿？

①痰结血瘀证：解郁通络消瘿汤（证据级别：C，强推荐）或化痰祛瘀消瘿汤（证据级别：C，强推荐）或消瘿散结方（证据级别：C，强推荐）。

证据描述：3项RCT[51-53]（n=192）评估解郁通络消瘿汤[51]、化痰祛瘀消瘿汤[52]、消瘿散结方[71]治疗HT继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予解郁通络消瘿化痰祛瘀消瘿汤、消瘿散结方联合左甲状腺素，结果显示，在降低血清TPOAb抗体滴度水平方面，观察组疗效明显优于对照组（MD=-100.26，95%CI[-107.92,-96.60]）。2项RCT[51,52]（n=134）评估解郁通络消瘿汤、化痰祛瘀消瘿汤治疗HT继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予解郁通络消瘿汤、化痰祛瘀消瘿汤联合左甲状腺素，结果显示，在改善血清FT3、FT4、TSH水平方面，观察组疗效明显优于对照组，血清FT3（MD=-0.10，95%CI[-0.41,0.21]），血清FT4（MD=-0.17，95%CI[-1.37,1.04]），血清TSH（MD=-1.75，95%CI[-2.46,-1.05]）。1项RCT[52]（n=60）评估化痰祛瘀消瘿汤治疗HT继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予化痰祛瘀消瘿汤联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，中医证候积分（MD=-1.20，95%CI[-1.93,-0.47]）。1项RCT[52]（n=60）评估消瘿散结方治疗HT继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予消瘿散结方联合左甲状腺素，结果显示，在改善甲状腺肿方面，观察组疗效明显优于对照组（MD=-11.7，95%CI[-11.18,-11.59]）。研究均未报告不良事件。

②肝郁脾虚证：柴胡疏肝散或逍遥散加减（证据级别：C，强推荐）。

证据描述：6 项 RCT[54-59]（n=641）评估柴胡疏肝散治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予柴胡疏肝散加减联合左甲状腺素，结果显示，在降低血清 TPOAb 抗体滴度水平方面，观察组疗效明显优于对照组（MD=-6.38，95%CI[-7.84,-4.93]）。4 项 RCT[54,55,58,59]（n=318），评估柴胡疏肝散治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予柴胡疏肝散加减联合左甲状腺素，结果显示，在改善甲状腺功能、改善临床症状方面，观察组疗效明显优于对照组，血清 FT3（MD=0.77，95%CI[0.62,0.92]），血清 FT4(MD=2.80，95%CI[2.34,3.25])，血清 TSH（MD=-1.18，95%CI[-1.48,-0.88]），中医证候积分水平（MD=-0.31，95%CI[-0.43,-0.34]）。2 项 RCT[58,59]（n=87）评估柴胡疏肝散治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予柴胡疏肝散加减联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，颈部不适（MD=-0.35，95%CI[-0.39,-0.30]），情志抑郁（MD=-0.44，95%CI[-0.49,-0.39]），疲劳乏力（MD=-0.25，95%CI[-0.30,-0.20]）。研究未报告不良事件。

1 项 RCT[60]（n=62）评估逍遥散治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予逍遥散加减联合左甲状腺素，结果显示，在降低血清 TPOAb 抗体滴度水平、改善甲状腺功能血清 FT3、FT4、TSH 水平、改善临床症状方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-57.58，95%CI[-155.48,-40.32]），血清 FT3（MD=0.08，95%CI[-0.11,0.28]），血清 FT4（MD=0.07，95%CI[-0.08,0.21]），血清 TSH（MD=-1.36，95%CI[-2.07,-0.64]），中医证候积分（MD=-5.03，95%CI[-6.47,-3.59]），颈部不适（MD=-0.06，95%CI[-0.75,-0.63]），情志抑郁（MD=-0.51，95%CI[-1.09,-0.07]），疲劳乏力（MD=-0.97，95%CI[-1.58,-0.36]）。研究未报告不良事件。

③脾肾阳虚证：参苓白术散合金匮肾气丸加减（证据级别：C，强推荐）。

证据描述：1 项 RCT[61]（n=68）评估参苓白术散治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予参苓白术散加减联合左甲状腺素，结果显示，在降低血清 TPOAb 抗体滴度水平、改善甲状腺功能血清 FT3、FT4、TSH 水平、改善甲状腺肿及临床症状方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-67.39，95%CI[-96.41,-40.17]），血清 FT3（MD=0.73，95%CI[0.44,1.02]），血清 FT4（MD=0.28，95%CI[0.11,0.45]），血清 TSH（MD=-1.39，95%CI[-1.91,-0.87]），甲状腺体积（MD=-3.12，95%CI[-4.60,-1.64]），颈部不适（MD=-0.47，95%CI[-0.79,-0.15]），急躁易怒（MD=-0.53，95%CI[-0.8,-0.26]），疲劳乏力（MD=-0.53，95%CI[-0.83,-0.23]），畏寒肢冷（MD=-0.35，95%CI[-0.63,-0.07]）。研究均未报告不良事件。

5 项 RCT[62-66]（n=372）评估金匮肾气丸加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予金匮肾气丸加减联合左甲状腺素，结果显示，在降低血清 TPOAb 抗体滴度水平、改善血清 FT3、FT4、TSH 水平方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-17.44，95%CI[-19.98,-14.97]），血清 FT3（MD=0.26，95%CI[0.14,0.39]），血清 FT4（MD=2.27，95%CI[1.92,2.61]），血清 TSH（MD=-1.34，95%CI[-1.53,-1.14]）。1 项 RCT[64]（n=104）评估金匮肾气丸加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予金匮肾气丸加减联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，颈前肿大（MD=-0.31，95%CI[-0.44,-0.18]），疲劳乏力（MD=-0.47，95%CI[-0.58,-0.36]），畏寒肢冷（MD=-0.29，95%CI[-0.38,-0.20]）。研究均未报告不良事件。

④心肾阳虚证：真武汤加减（证据级别：C，强推荐）。

证据描述：2 项 RCT[67,68]（n=160）评估真武汤加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予真武汤加减联合左甲状腺素，结果显示，在降低血清 TPOAb 抗体滴度水平方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-58.88，95%CI[-62.71,-55.06]）。4 项 RCT[67-70]（n=268）评估真武汤加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予真武汤加减联合左甲状腺素，结果显示，在改善血清 FT3、FT4、TSH 水平方面方面，观察组疗效明显优于对照组，血清 FT3（MD=0.1，95%CI[-0.05,0.25]），血清 FT4（MD=0.22，95%CI[-0.03,0.47]），血清 TSH（MD=-0.21，95%CI[-0.34,-0.07]）。2 项 RCT[68,70]（n=120）评估真武汤加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲

状腺素，观察组予真武汤加减联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，中医证候积分（MD=-2.88，95%CI[-3.37,-2.39]）。2 项 RCT[69,70]（n=108）评估真武汤加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予真武汤加减联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，神疲乏力（MD=-1.02，95%CI[-1.43,-0.6]），肢体浮肿（MD=-1.05，95%CI[-1.39,-0.72]）。1 项 RCT[70]（n=60）评估真武汤加减治疗 HT 继发甲减患者的临床疗效，对照组予左甲状腺素，观察组予真武汤加减联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，畏寒肢冷（MD=-0.4，95%CI[-1.13,-0.33]）。研究均未报告不良事件。

桥本甲状腺炎继发甲状腺功能减退症推荐中成药：百令胶囊（证据级别：D，弱推荐）或夏枯草制剂（证据级别：D，弱推荐）或金水宝胶囊（证据级别：C，弱推荐）

证据描述：一项纳入 5 项 RCT（n=276）的 Meta 分析[22]，评估百令胶囊治疗 HT 继发甲减患者的临床疗效，对照组予优甲乐，观察组予百令胶囊联合优甲乐，结果显示，在降低血清 TPOAb 抗体滴度水平方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-158.19，95%CI[-222.44,-93.94]）。一项纳入 11 项 RCT（n=1215）的 Meta 分析[71]，评估夏枯草制剂治疗 HT 继发甲减患者的临床疗效，对照组予优甲乐，观察组予夏枯草制剂联合优甲乐，结果显示，治疗总有效率观察组高于对照组(RR=1.15，95%CI[1.09,1.21])，能够显著降低血清 TPOAb 滴度(SMD=-0.91，95%CI[-1.40,-0.41])，缩小甲状腺左叶(MD=-1.46，95% CI［-1.82，-1.11])、甲状腺右叶(MD=-1.45，95% CI［-1.96，-0.94])、甲状腺峡部厚度(MD=-1.08，95% CI［-1.20，-0.95])。

3 项 RCT[72-74]（n=340），评估金水宝胶囊治疗 HT 继发甲减的临床疗效，对照组予优甲乐，观察组予金水宝胶囊联合优甲乐，结果显示，在降低血清 TPOAb 抗体滴度、改善甲状腺功能方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-133.57，95%CI[-149.81,-117.33]，血清 FT4（MD=5.21，95%CI[4.79,5.63]），血清 FT3（MD=-0.32，95%CI[-0.44,-0.20]），血清 TSH（MD=-1.48，95%CI[-1.64,-1.32]）。1 项 RCT[75]（n=63），评估逍遥丸治疗 HT 继发甲减脾肾阳虚证的临床疗效，对照组予优甲乐，观察组予右归丸联合优甲乐，结果显示，在降低血清 TPOAb 抗体滴度、改善临床症状方面，观察组疗效明显优于对照组，血清 TPOAb（MD=-61.20，95%CI[-135.80,13.40]），中医证候积分（MD=-1.48，95%CI[-3.10, 0.14]）。研究均未报告不良事件。

中医外治法

证据描述：

中药外敷：1 项 RCT[76]（n=54）评估中药外敷治疗 HT 气郁痰阻证临床疗效，对照组予限碘饮食，观察组予消瘿散结方外敷（夏枯草、连翘、姜半夏、陈皮、土贝母、三棱、莪术、牡丹皮、乳香、没药、丹参、赤芍、白芍、生牡蛎、水蛭、郁金、芒硝）联合限碘饮食，结果显示，在改善临床症状方面，观察组疗效明显优于对照组（MD=-8.68，95%CI[-9.73,-7.63]），主症（颈前肿大、颈部梗塞感、情志抑郁、憋闷不舒）积分（MD=-5.40，95%CI[-10.97,-0.07]），次症（食少纳呆，善太息，脘胀纳呆，便溏不爽，胸胁胀痛）积分（MD=-4.45，95%CI[-5.81,-3.09]）。研究未报告不良事件。

2项RCT[77,78]（n=150）评估中药外敷治疗HT继发甲减临床疗效，对照组予左甲状腺素，观察组予消瘿方[77](黄芪、夏枯草、猫爪草、柴胡、香附、莪术、丁香、冰片)、消瘿膏[78]（黄芪、柴胡、黄芩、夏枯草、郁金、山慈菇、红花、天葵子、川芎、赤芍、当归、肉桂、菊花、金银花、杜仲、莪术、半夏、川楝子、浙贝、芒硝）联合左甲状腺素，结果显示，在改善临床症状方面，观察组疗效明显优于对照组（MD=-1.31，95%CI[-1.59,-1.03]）。1项RCT[78]（n=60）评估中药外敷治疗HT继发甲减临床疗效，对照组予左甲状腺素，观察组予消瘿膏联合左甲状腺素，结果显示，在改善甲状腺肿方面，观察组疗效明显优于对照组甲状腺峡部厚度（MD=-1.40，95%CI[-1.88,-0.92]），甲状腺左叶厚度（MD=-2.40，95%CI[-3.19,-1.61]），甲状腺右叶厚度（MD=-4.0，95%CI[-4.66,-3.34]）。研究均未报告不良事件。

针刺：1项RCT[79]（n=60）评估手阳明经透刺疗法治疗HT继发甲减临床疗效，对照组予左甲状腺素，观察组予手阳明经透刺疗法（取穴）联合左甲状腺素，观察周期为16周，结果显示，在提高生活质量方面，观察组疗效明显优于对照组，甲状腺疾病生活质量简明量表（ThyPRO-39）（MD=-2.83，95%CI[-7.83,-2.17]），健康自测量表（SF-36）（MD=6.39，95%CI[0.77,13.55]）。研究未报告不良事件。

1项RCT[80]（n=60）评估针刺疗法治疗HT继发甲减肝郁肾虚证临床疗效，对照组予左甲状腺素，观察组予针刺疗法联合左甲状腺素，观察周期为12周结果显示，在改善临床症状方面，观察组疗效明显优于对照组，颈前肿大（MD=-1.00，95%CI[-1.59,-0.41]），神疲乏力（MD=-0.53，95%CI[-1.01,-0.05]），情志不畅（MD=-0.49，95%CI[-1.40,-0.48]），腰膝酸软（MD=-0.80，95%CI[-1.30,-0.30]）。研究未报告不良事件。

1项RCT[81]（n=60）评估温针灸疗法治疗HT继发甲减脾肾阳虚证临床疗效，对照组予左甲状腺素，观察组予温针灸疗法联合左甲状腺素，观察周期为12周，结果显示，在改善临床症状方面，观察组疗效明显优于对照组，颈前肿大（MD=-0.36，95%CI[-0.65,-0.07]），颈前压迫感（MD=-0.33，95%CI[-0.58,-0.08]），神疲乏力（MD=-0.36，95%CI[-0.66,-0.06]），畏寒肢冷（MD=-0.40，95%CI[-0.76,-0.04]），腰膝酸软（MD=-0.37，95%CI[-0.69,-0.05]），浮肿（MD=-0.36，95%CI[-0.61,-0.11]）。研究未报告不良事件。

临床问题14：桥本甲状腺炎患者生活方式的改善包括哪些具体内容和方法？

证据描述：2021年《桥本甲状腺炎中西医结合诊疗北京专家共识2021》、科学出版社“十四五”普通高等教育研究生规划教材《中西医结合甲状腺病学》、2021年《僵本相应论：甲状腺疾病中医诊疗新思路》。

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附件 2 GRADE 证据概要表

临床问题 5.桥本甲状腺炎甲功正常时，中西医结合治疗能否有效降低 TPOAb 滴度？
临床问题 6.桥本甲状腺炎甲功正常时，中西医结合治疗能否更好改善患者的临床症状（如颈前压迫感，咽部异物感等）和甲状腺肿？
肝郁气滞证

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	柴胡疏肝散+硒酵母	硒酵母	相对(95% CI)	绝对(95% CI)	
柴胡疏肝散加减											
TPOAb											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	35	34	-	MD 16.2 更低 (85.97 更低到 53.57 更高)	⊕⊕◯◯ 低[a,b]
中医证候积分											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	35	34	-	MD 6.34 更低 (8.52 更低到 4.16 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. 纳入研究样本量太小

肝郁化热证

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	清肝散结消瘿方	限碘饮食	相对(95% CI)	绝对(95% CI)	
TPOAb											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 13.55 更低 (71.12 更低到 44.02 更高)	⊕⊕⊕◯ 中等[a]
中医证候积分											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 5.58 更低 (7.94 更低到 3.22 更低)	⊕⊕⊕◯ 中等[a]

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	清肝散结消瘿方	限碘饮食	相对 (95% CI)	绝对 (95% CI)	
甲状腺体积											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 0.3 更低 (2.68 更低到 2.08 更高)	⊕⊕⊕◯ 中等[a]
下肢沉重感											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 4 更低 (4.97 更低到 3.03 更低)	⊕⊕⊕◯ 中等[a]
HAMA 焦虑											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 4 更低 (5.53 更低到 2.47 更低)	⊕⊕⊕◯ 中等[a]
HAMD 抑郁											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 2.5 更低 (4.07 更低到 0.93 更低)	⊕⊕⊕◯ 中等[a]
PSQI 评分											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 4.14 更低 (5.38 更低到 2.91 更低)	⊕⊕⊕◯ 中等[a]
FSS 评分											
1	随机试验	严重[a]	不严重	不严重	不严重	无	46	44	-	MD 6.19 更低 (10.85 更低到 1.53 更低)	⊕⊕⊕◯ 中等[a]

CI: Confidence interval; MD: Mean difference
说明：
a. 未对结局评估者实施盲法

肝郁痰凝证

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	半夏厚朴汤+限碘饮食	限碘饮食	相对(95% CI)	绝对(95% CI)	
半夏厚朴汤											
TPOAb											
3	随机试验	严重[a]	不严重	不严重	不严重	无	109	108	-	MD 58.3 更低 (72.6 更低到 44 更低)	⊕⊕⊕◯ 中等[a]
中医证候积分											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	79	78	-	MD 6.23 更低 (7.27 更低到 5.18 更低)	⊕⊕◯◯ 低[a,b]
甲状腺体积											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	32	31	-	MD 2.04 更低 (3.97 更低到 0.11 更低)	⊕⊕◯◯ 低[a,b]
颈前肿大											
3	随机试验	严重[a]	不严重	不严重	不严重	无	109	108	-	MD 1.3 更低 (1.79 更低到 0.8 更低)	⊕⊕⊕◯ 中等[a]
咽部异物感											
3	随机试验	严重[a]	不严重	不严重	不严重	无	109	108	-	MD 1.15 更低 (1.49 更低到 0.81 更低)	⊕⊕⊕◯ 中等[a]
情志抑郁											
3	随机试验	严重[a]	不严重	不严重	不严重	无	109	108	-	MD 1.39 更低 (1.85 更低到 0.93 更低)	⊕⊕⊕◯ 中等[a]

肝郁脾虚证

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	疏肝健脾法	限碘饮食	相对(95% CI)	绝对(95% CI)	
小柴胡汤合当归芍药散加减+硒酵母 VS 硒酵母											
TPOAb											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	32	31	-	MD 40.59 更低 (57.53 更低到 23.65 更低)	⊕⊕◯◯ 低[a,b]
中医证候积分											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	32	31	-	MD 4.45 更低 (7.51 更低到 1.39 更低)	⊕⊕◯◯ 低[a,b]
疏肝健脾法											
TPOAb											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	60	60	-	MD 52.91 更低 (69.16 更低到 36.66 更低)	⊕⊕◯◯ 低[a,b]
中医证候积分											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	60	60	-	MD 8.53 更低 (9.53 更低到 7.53 更低)	⊕⊕◯◯ 低[a,b]
颈前肿大											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	60	60	-	MD 0.81 更低 (1.06 更低到 0.57 更低)	⊕⊕◯◯ 低[a,b]
颈前胀闷感											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	60	60	-	MD 0.82 更低 (1.13 更低到 0.51 更低)	⊕⊕◯◯ 低[a,b]
烦躁易怒											

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	疏肝健脾法	限碘饮食	相对(95% CI)	绝对(95% CI)	
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	60	60	-	MD 0.86 更低(1.13 更低到 0.59 更低)	⊕⊕◯◯低[a,b]

体倦乏力

2	随机试验	严重[a]	不严重	不严重	严重[b]	无	60	60	-	MD 0.32 更低(0.48 更低到 0.15 更低)	⊕⊕◯◯低[a,b]

食少纳呆

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.93 更低(1.74 更低到 0.12 更低)	⊕⊕◯◯低[a,b]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. 纳入研究样本量太小

中成药

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	逍遥丸	限碘	相对(95% CI)	绝对(95% CI)	

TPOAb

1	随机试验	严重[a]	不严重	不严重	非常严重	无	40	40	-	MD 198.06 更低(275.84 更低到 120.28 更低)	⊕◯◯◯极低[a]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

临床问题 7.桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否有效降低 TPOAb 滴度？
临床问题 8.桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否更快改善甲状腺功能？
临床问题 9.桥本甲状腺炎继发甲状腺毒症时，中西医结合治疗能否更好改善患者的临床症状（如颈前压迫感、咽部异物感、心慌手抖等）和甲状腺肿？
肝郁化火证

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	丹栀逍遥散+甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
丹栀逍遥散加减											
TPOAb											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	29	26	-	MD 159 更低 (221.69 更低到 96.31 更低)	⊕⊕◯◯ 低[a,b]
FT3											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	59	56	-	MD 1.42 更低 (2.14 更低到 0.7 更低)	⊕⊕◯◯ 低[a,b]
FT4											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	59	56	-	MD 4.64 更低 (5.61 更低到 3.67 更低)	⊕⊕◯◯ 低[a,b]
TSH											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	59	56	-	MD 0.05 更高 (0.04 更低到 0.13 更高)	⊕⊕◯◯ 低[a,b]
中医证候积分											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	29	26	-	MD 3.17 更低 (5.27 更低到 1.07 更低)	⊕⊕◯◯ 低[a,b]
颈前肿大											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	29	26	-	MD 1.17 更低 (2.17 更低到 0.17 更低)	⊕⊕◯◯ 低[a,b]
心悸不宁											

证据评估							№；患者的		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	丹栀逍遥散+甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	29	26	-	MD 0.31 更低(1.11 更低到 0.49 更高)	⊕⊕◯◯低[a,b]

多汗

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	29	26	-	MD 1.08 更低(1.88 更低到 0.28 更低)	⊕⊕◯◯低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小

心肝热盛证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	栀子清肝汤+甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	

栀子清肝汤加减

FT3

4	随机试验	严重[a]	不严重	不严重	不严重	无	190	190	-	MD 0.58 更低(0.75 更低到 0.4 更低)	⊕⊕⊕◯中等[a]

FT4

4	随机试验	严重[a]	不严重	不严重	不严重	无	190	190	-	MD 0.56 更低(0.68 更低到 0.45 更低)	⊕⊕⊕◯中等[a]

TSH

4	随机试验	严重[a]	不严重	不严重	不严重	无	190	190	-	MD 0.08 更高(0.04 更高到 0.11 更高)	⊕⊕⊕◯中等[a]

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	栀子清肝汤+甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
中医证候积分											
1	随机试验	严重[a]	不严重	不严重	不严重	无	60	60	-	MD 1.1 更低(1.45 更低到 0.75 更低)	⊕⊕⊕◯ 中等[a]
甲状腺体积											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	40	40	-	MD 0.18 更低(0.29 更低到 0.07 更低)	⊕⊕◯◯ 低[a,b]
手足心热											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	40	40	-	MD 0.21 更低(0.33 更低到 0.09 更低)	⊕⊕◯◯ 低[a,b]
手指震颤											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	40	40	-	MD 0.25 更低(0.37 更低到 0.13 更低)	⊕⊕◯◯ 低[a,b]
清心泻肝法（清火解毒消瘿汤+赛治 VS 赛治）											
TPOAb											
2	随机试验	严重[a]	不严重	不严重	不严重	无	75	75	-	MD 174.11 更低(205.68 更低到 142.53 更低)	⊕⊕⊕◯ 中等[a]
FT3											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	50	51	-	MD 0.08 更低(0.63 更低到 0.48 更高)	⊕⊕◯◯ 低[a,b]
FT4											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	栀子清肝汤+甲巯咪唑	甲巯咪唑	相对 (95% CI)	绝对 (95% CI)	
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	50	51	-	MD 1.46 更低 (2.08 更低到 0.84 更低)	⊕⊕◯◯ 低[a,b]
甲状腺峡部											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	51	50	-	MD 0.41 更低 (0.84 更低到 0.03 更高)	⊕⊕◯◯ 低[a,b]
颈前压迫感											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	75	75	-	MD 0.57 更低 (0.92 更低到 0.21 更低)	⊕⊕◯◯ 低[a,b]
心悸不宁											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	75	75	-	MD 1.5 更低 (1.82 更低到 1.19 更低)	⊕⊕◯◯ 低[a,b]
怕热多汗											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	75	75	-	MD 1.43 更低 (1.81 更低到 1.05 更低)	⊕⊕◯◯ 低[a,b]
口干口苦											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	75	75	-	MD 1.33 更低 (1.72 更低到 0.94 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小

阴虚火旺证

证据评估	受试者人数	效果	证据质量

研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	当归六黄汤+甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
当归六黄汤加减											
FT3											
11	随机试验	严重[a]	不严重	不严重	不严重	无	498	498	-	MD 2.69 更低 (2.79 更低到 2.59 更低)	⨁⨁⨁◯ 中等[a]
FT4											
11	随机试验	严重[a]	不严重	不严重	不严重	无	498	498	-	MD 6.4 更低 (6.77 更低到 6.02 更低)	⨁⨁⨁◯ 中等[a]
TT3											
5	随机试验	严重[a]	不严重	不严重	不严重	无	187	187	-	MD 1.54 更低 (1.62 更低到 1.47 更低)	⨁⨁⨁◯ 中等[a]
TT4											
5	随机试验	严重[a]	不严重	不严重	不严重	无	187	187	-	MD 6 更低 (7.33 更低到 4.67 更低)	⨁⨁⨁◯ 中等[a]
TSH											
11	随机试验	严重[a]	不严重	不严重	不严重	无	498	498	-	MD 0.38 更高 (0.37 更高到 0.4 更高)	⨁⨁⨁◯ 中等[a]
中医证候积分											
7	随机试验	严重[a]	不严重	不严重	不严重	无	338	338	-	MD 2.61 更低 (2.69 更低到 2.54 更低)	⨁⨁⨁◯ 中等[a]
生活质量											
2	随机试验	严重[a]	不严重	不严重	不严重	无	100	100	-	MD 11.56 更高 (10.04 更高到 13.08 更高)	⨁⨁⨁◯ 中等[a]
颈前肿大											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	当归六黄汤+甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	28	28	-	MD 1.13 更低(1.23 更低到 1.03 更低)	⊕⊕◯◯ 低[a,b]

烦躁易怒

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	28	28	-	MD 1.06 更低(1.14 更低到 0.98 更低)	⊕⊕◯◯ 低[a,b]

手足心热

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	28	28	-	MD 1.13 更低(1.24 更低到 1.02 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小

气阴两虚证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	天王补心丹+甲巯咪唑 VS 甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
天王补心丹加减											
FT3											
4	随机试验	严重[a]	不严重	不严重	不严重	无	127	127	-	MD 2.8 更低(3.06 更低到 2.54 更低)	⊕⊕⊕◯ 中等[a]
FT4											
4	随机试验	严重[a]	不严重	不严重	不严重	无	127	127	-	MD 1.1 更低(1.52 更低到 0.68 更低)	⊕⊕⊕◯ 中等[a]
TSH											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	天王补心丹+甲巯咪唑 VS 甲巯咪唑	甲巯咪唑	相对(95% CI)	绝对(95% CI)	
4	随机试验	严重[a]	不严重	不严重	不严重	无	127	127	-	MD 0.35 更高(0.23 更高到 0.48 更高)	⊕⊕⊕◯ 中等[a]

中医证候积分

3	随机试验	严重[a]	不严重	不严重	不严重	无	97	97	-	MD 19.37 更低(20.62 更低到 18.12 更低)	⊕⊕⊕◯ 中等[a]

心悸不宁

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.08 更低(0.6 更低到 0.44 更高)	⊕⊕◯◯ 低[a,b]

手指震颤

1	随机试验	严重[a]	不严重	不严重	严重[c]	无	30	30	-	MD 0.85 更低(1.27 更低到 0.43 更低)	⊕⊕◯◯ 低[a,c]

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	补中益气汤+硒酵母	硒酵母	相对(95% CI)	绝对(95% CI)	

补中益气汤加减

TPOAb

3	随机试验	严重[a]	不严重	不严重	不严重	无	85	85	-	MD 55.46 更低(57.78 更低到 53.14 更低)	⊕⊕⊕◯ 中等[a]

FT3

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	补中益气汤+硒酵母	硒酵母	相对(95% CI)	绝对(95% CI)	
2	随机试验	严重[a]	不严重	不严重	非常严重[b]	无	50	50	-	MD 0.14 更低 (0.39 更低到 0.11 更高)	⊕◯◯◯ 极低[a,b]

FT4

2	随机试验	严重[a]	不严重	不严重	非常严重[b]	无	50	50	-	MD 0.48 更低 (0.97 更低到 0.01 更高)	⊕◯◯◯ 极低[a,b]

TSH

1	随机试验	严重[a]	不严重	不严重	非常严重[c]	无	20	20	-	MD 1.86 更高 (0.92 更高到 2.8 更高)	⊕◯◯◯ 极低[a,c]

中医证候积分

1	随机试验	严重[a]	不严重	不严重	严重[c]	无	30	30	-	MD 5.43 更低 (7.56 更低到 3.3 更低)	⊕⊕◯◯ 低[a,c]

甲状腺峡部

1	随机试验	严重[c]	不严重	不严重	严重[c]	无	30	30	-	MD 0.8 更低 (1 更低到 0.6 更低)	⊕⊕◯◯ 低[c]

颈前肿大

1	随机试验	严重[a]	不严重	不严重	严重[c]	无	20	20	-	MD 1.03 更低 (1.27 更低到 0.79 更低)	⊕⊕◯◯ 低[a,c]

咽部不利

1	随机试验	严重[a]	不严重	不严重	严重[c]	无	20	20	-	MD 0.96 更低 (1.22 更低到 0.7 更低)	⊕⊕◯◯ 低[a,c]

失眠多梦

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	补中益气汤+硒酵母	硒酵母	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[c]	无	20	20	-	MD 0.85 更低(0.99 更低到 0.71 更低)	⊕⊕◯◯ 低[a,c]

情志不畅

1	随机试验	严重[a]	不严重	不严重	严重[c]	无	20	20	-	MD 1.07 更低(1.25 更低到 0.89 更低)	⊕⊕◯◯ 低[a,c]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小、可信区间较宽

c. 纳入研究样本量太小

临床问题 10.桥本甲状腺炎继发甲减时，中西医结合治疗能否有效降低 TPOAb 滴度？

临床问题 11.桥本甲状腺炎继发甲减时，中西医结合治疗能否更快改善甲状腺功能？

临床问题 12.桥本甲状腺炎继发甲减时，中西医结合治疗能否更好改善患者的临床症状（如咽部异物感、疲劳乏力、黏液性水肿等）和甲状腺肿？

痰结血瘀证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	理气化痰消瘿法+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	

TPOAb

3	随机试验	严重[a]	不严重	不严重	不严重	无	96	96	-	MD 100.47 更低(108.13 更低到 92.81 更低)	⊕⊕⊕◯ 中等[a]

FT3（解郁通络消瘿汤/化痰祛瘀消瘿汤+优甲乐 VS 优甲乐）

2	随机试验	严重[a]	不严重	不严重	严重[b]	无	66	66	-	MD 0.1 更低(0.41 更低到 0.21 更高)	⊕⊕◯◯ 低[a,b]

FT4（解郁通络消瘿汤/化痰祛瘀消瘿汤+优甲乐 VS 优甲乐）

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	理气化痰消瘿法+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	66	66	-	MD 0.17 更低(1.37 更低到 1.04 更高)	⊕⊕◯◯低[a,b]

TSH（解郁通络消瘿汤/化痰祛瘀消瘿汤+优甲乐 VS 优甲乐）

2	随机试验	严重[a]	严重[c]	不严重	严重[b]	无	66	66	-	MD 1.75 更低(2.46 更低到 1.05 更低)	⊕⊕◯◯低[a,c]

中医证候积分（化痰祛瘀消瘿汤+优甲乐 VS 优甲乐）

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 1.2 更低(1.93 更低到 0.47 更低)	⊕⊕◯◯低[a,b]

甲状腺体积（消瘿散结方）

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 11.7 更低(11.81 更低到 11.59 更低)	⊕⊕◯◯低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小

c. I^2>50%

肝郁脾虚证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	柴胡疏肝散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	

柴胡疏肝散加减

TPOAb

6	随机试验	严重[a]	不严重	不严重	不严重	无	221	220	-	MD 6.38 更低(7.84 更低到 4.93 更低)	⊕⊕⊕◯中等[a]

TGAb

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	柴胡疏肝散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
6	随机试验	严重[a]	不严重	不严重	不严重	无	221	220	-	MD 4.87 更低(6.09 更低到 3.66 更低)	⊕⊕⊕◯ 中等[a]
FT3											
4	随机试验	严重[a]	严重[b]	不严重	不严重	无	159	159	-	MD 0.77 更高(0.62 更高到 0.92 更高)	⊕⊕◯◯ 低[a,b]
FT4											
4	随机试验	严重[a]	严重[b]	不严重	不严重	无	159	159	-	MD 2.8 更高(2.34 更高到 3.25 更高)	⊕⊕◯◯ 低[a,b]
TSH											
4	随机试验	严重[a]	不严重	不严重	不严重	无	159	159	-	MD 1.18 更低(1.48 更低到 0.88 更低)	⊕⊕⊕◯ 中等[a]
中医证候积分											
4	随机试验	严重[a]	严重[b]	不严重	不严重	无	159	159	-	MD 0.39 更低(0.43 更低到 0.34 更低)	⊕⊕◯◯ 低[a,b]
颈部不适											
2	随机试验	严重[a]	严重[b]	不严重	不严重	无	87	87	-	MD 0.35 更低(0.39 更低到 0.3 更低)	⊕⊕◯◯ 低[a,b]
情志抑郁											
2	随机试验	严重[a]	严重[b]	不严重	不严重	无	87	87	-	MD 0.44 更低(0.49 更低到 0.39 更低)	⊕⊕◯◯ 低[a,b]
神疲乏力											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	柴胡疏肝散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
2	随机试验	严重[a]	严重[b]	不严重	不严重	无	87	87	-	MD 0.25 更低(0.3 更低到 0.2 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. I^2>50%

肝郁脾虚证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	逍遥散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
逍遥散加减											
TPOAb											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	31	31	-	MD 57.58 更低(155.48 更低到 40.32 更高)	⊕⊕◯◯ 低[a,b]
FT3											
2	随机试验	严重[a]	不严重	不严重	严重[c]	无	81	81	-	MD 0.08 更高(0.11 更低到 0.28 更高)	⊕⊕◯◯ 低[a,c]
FT4											
2	随机试验	严重[d]	不严重	不严重	严重[c]	无	81	81	-	MD 0.07 更高(0.08 更低到 0.21 更高)	⊕⊕◯◯ 低[c,d]
TSH											
2	随机试验	严重[a]	严重[d]	不严重	不严重	无	81	81	-	MD 1.36 更低(2.07 更低到 0.64 更低)	⊕⊕◯◯ 低[a,d]
中医证候积分											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	逍遥散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	31	31	-	MD 5.03 更低(6.47 更低到 3.59 更低)	⊕⊕◯◯ 低[a,b]

颈部不适

1	随机试验	严重[a]	不严重	不严重	非常严重[c]	无	31	31	-	MD 0.06 更低(0.75 更低到 0.63 更高)	⊕◯◯◯ 极低[a,c]

情志抑郁

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	31	31	-	MD 0.51 更低(1.09 更低到 0.07 更高)	⊕⊕◯◯ 低[a,b]

疲劳乏力

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	31	31	-	MD 0.97 更低(1.58 更低到 0.36 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小

c. 纳入研究样本量太小、可信区间较宽

d. I^2>50%

脾肾阳虚证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	参苓白术散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	

参苓白术散加减

TPOAb

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 67.39 更低(94.61 更低到 40.17 更低)	⊕⊕◯◯ 低[a,b]

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	参苓白术散+优甲乐	优甲乐	相对 (95% CI)	绝对 (95% CI)	
FT3											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 0.73 更高 (0.44 更高到 1.02 更高)	⊕⊕◯◯ 低[a,b]
FT4											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 0.28 更高 (0.11 更高到 0.45 更高)	⊕⊕◯◯ 低[a,b]
TSH											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 1.39 更低 (1.91 更低到 0.87 更低)	⊕⊕◯◯ 低[a,b]
甲状腺体积											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 3.12 更低 (4.6 更低到 1.64 更低)	⊕⊕◯◯ 低[a,b]
颈部不适											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 0.47 更低 (0.79 更低到 0.15 更低)	⊕⊕◯◯ 低[a,b]
急躁易怒											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 0.53 更低 (0.8 更低到 0.26 更低)	⊕⊕◯◯ 低[a,b]
疲劳乏力											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	参苓白术散+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 0.53 更低(0.83 更低到 0.23 更低)	⊕⊕◯◯ 低[a,b]

畏寒肢冷

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	34	34	-	MD 0.35 更低(0.63 更低到 0.07 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. 纳入研究样本量太小

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	金匮肾气丸+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	

金匮肾气丸加减

TPOAb

5	随机试验	严重[a]	不严重	不严重	不严重	无	188	184	-	MD 17.47 更低(19.98 更低到 14.97 更低)	⊕⊕⊕◯ 中等[a]

FT3

5	随机试验	严重[a]	严重[b]	不严重	不严重	无	188	184	-	MD 0.26 更高(0.14 更高到 0.39 更高)	⊕⊕◯◯ 低[a,b]

FT4

5	随机试验	严重[a]	严重[b]	不严重	不严重	无	188	184	-	MD 2.27 更高(1.92 更高到 2.61 更高)	⊕⊕◯◯ 低[a,b]

TSH

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	金匮肾气丸+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
5	随机试验	严重[a]	严重[b]	不严重	不严重	无	188	184	-	MD 1.34 更低(1.53 更低到 1.14 更低)	⊕⊕◯◯ 低[a,b]

颈前肿大

1	随机试验	严重[a]	不严重	不严重	不严重	无	52	52	-	MD 0.31 更低(0.44 更低到 0.18 更低)	⊕⊕⊕◯ 中等[a]

神疲乏力

1	随机试验	严重[a]	不严重	不严重	不严重	无	52	52	-	MD 0.47 更低(0.58 更低到 0.36 更低)	⊕⊕⊕◯ 中等[a]

畏寒肢冷

1	随机试验	严重[a]	不严重	不严重	不严重	无	52	52	-	MD 0.29 更低(0.38 更低到 0.2 更低)	⊕⊕⊕◯ 中等[a]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. I^2>50%

心肾阳虚证

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	真武汤+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	

真武汤加减

TPOAb

2	随机试验	严重[a]	不严重	不严重	严重[b]	无	80	80	-	MD 58.88 更低(62.71 更低到 55.06 更低)	⊕⊕◯◯ 低[a,b]

FT3

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	真武汤+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
4	随机试验	严重[a]	严重[c]	不严重	不严重	无	134	134	-	MD 0.1 更高(0.05 更低到 0.25 更高)	⊕⊕◯◯ 低[a,c]
FT4											
4	随机试验	严重[a]	严重[c]	不严重	不严重	无	134	134	-	MD 0.22 更高(0.03 更低到 0.47 更高)	⊕⊕◯◯ 低[a,c]
TSH											
4	随机试验	严重[a]	严重[c]	不严重	不严重	无	134	134	-	MD 0.21 更低(0.34 更低到 0.07 更低)	⊕⊕◯◯ 低[a,c]
中医证候积分											
2	随机试验	严重[a]	不严重	不严重	不严重	无	60	60	-	MD 2.88 更低(3.37 更低到 2.39 更低)	⊕⊕⊕◯ 中等[a]
神疲乏力											
2	随机试验	严重[a]	不严重	不严重	严重[b]	无	54	54	-	MD 1.02 更低(1.43 更低到 0.6 更低)	⊕⊕◯◯ 低[a,b]
肢体浮肿											
2	随机试验	严重[a]	严重[c]	不严重	严重[b]	无	54	54	-	MD 1.05 更低(1.39 更低到 0.72 更低)	⊕◯◯◯ 极低[a,b,c]
畏寒肢冷											
1	随机试验	严重[a]	不严重	不严重	严重[d]	无	30	30	-	MD 0.4 更低(1.13 更低到 0.33 更高)	⊕⊕◯◯ 低[a,d]

CI: Confidence interval; MD: Mean difference

说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. 纳入研究样本量太小
c. I^2>50%
d. 纳入研究样本量太小、可信区间较宽

中成药

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	金水宝胶囊+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
TPOAb											
3	随机试验	严重[a]	严重[b]	不严重[b]	不严重	无	170	170	-	MD 133.57 更低 (149.81 更低到 117.33 更低)	⊕⊕◯◯ 低[a,b]
FT3											
3	随机试验	严重[a]	严重[b]	不严重[b]	不严重	无	170	170	-	MD 0.32 更低 (0.44 更低到 0.2 更低)	⊕⊕◯◯ 低[a,b]
FT4											
3	随机试验	严重[a]	严重[b]	不严重	不严重	无	170	170	-	MD 5.21 更高 (4.79 更高到 5.63 更高)	⊕⊕◯◯ 低[a,b]
TSH											
3	随机试验	严重[a]	严重[b]	不严重	不严重	无	170	170	-	MD 1.48 更低 (1.64 更低到 1.32 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. I^2>50

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	右归丸+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
TPOAb											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	右归丸+优甲乐	优甲乐	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	非常严重[b]	无	32	31	-	MD 61.2 更低(135.8 更低到 13.4 更高)	⊕◯◯◯ 极低[a,b]

中医证候积分

1	随机试验	严重[a]	不严重	不严重	非常严重[b]	无	32	31	-	MD 1.48 更低(3.1 更低到 0.14 更高)	⊕◯◯◯ 极低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小、可信区间较宽

临床问题 13：中医外治法能否改善桥本甲状腺炎患者的临床症状（如颈前压迫感、咽部异物感）和甲状腺肿？

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	中药外敷	西医基础治疗	相对(95% CI)	绝对(95% CI)	

桥本甲减（中药外敷+优甲乐 VS 优甲乐）

中医证候积分

2	随机试验	严重[a]	不严重	不严重	不严重	无	75	75	-	MD 1.31 更低(1.59 更低到 1.03 更低)	⊕⊕⊕◯ 中等[a]

峡部厚度

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 1.4 更低(1.88 更低到 0.92 更低)	⊕⊕◯◯ 低[a,b]

甲状腺左叶厚度

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 2.4 更低(3.19 更低到 1.61 更低)	⊕⊕◯◯ 低[a,b]

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	中药外敷	西医基础治疗	相对(95% CI)	绝对(95% CI)	
甲状腺右叶厚度											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 4 更低(4.66 更低到 3.34 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. 纳入研究样本量太小

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	中药外敷	西医基础治疗	相对(95% CI)	绝对(95% CI)	
桥本甲功正常（气郁痰阻证）（中药外敷 VS 限碘饮食）											
中医证候积分											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	28	26	-	MD 8.68 更低(9.73 更低到 7.63 更低)	⊕⊕◯◯ 低[a,b]
气郁痰阻证主症积分											
1	随机试验	严重[a]	不严重	不严重	非常严重[c]	无	28	26	-	MD 5.45 更低(10.97 更低到 0.07 更高)	⊕◯◯◯ 极低[a,c]
气郁痰阻证次症积分											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	28	26	-	MD 4.45 更低(5.81 更低到 3.09 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚
b. 纳入研究样本量太小
c. 纳入研究样本量太小、可信区间较宽

临床问题 13.桥本甲状腺炎采用哪些中医外治疗法可以更好的改善临床症状（如颈前压迫感、咽部异物感）和甲状腺肿？

证据评估	受试者人数	效果	证据质量

研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	针刺疗法	西医基础治疗	相对(95% CI)	绝对(95% CI)	

桥本甲减（针刺疗法+优甲乐 VS 优甲乐）

甲状腺疾病生活质量评价量表（TPRo39）

1	随机试验	不严重	不严重	不严重	严重[a]	无	30	30	-	MD 2.83 更低 (7.83 更低到 2.17 更高)	⊕⊕⊕◯ 中等[a]

健康自测量表 SF-36

1	随机试验	不严重	不严重	不严重	严重[a]	无	30	30	-	MD 6.39 更高 (0.77 更低到 13.55 更高)	⊕⊕⊕◯ 中等[a]

CI: Confidence interval; MD: Mean difference
说明：
a. 纳入研究样本量太小

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	针刺疗法	西医基础治疗	相对(95% CI)	绝对(95% CI)	

桥本甲减（肝郁肾虚证）（针刺疗法+优甲乐 VS 优甲乐）

颈前肿大

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 1 更低 (1.59 更低到 0.41 更低)	⊕⊕◯◯ 低[a,b]

神疲乏力

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.53 更低 (1.01 更低到 0.05 更低)	⊕⊕◯◯ 低[a,b]

情志不畅

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.94 更低 (1.4 更低到 0.48 更低)	⊕⊕◯◯ 低[a,b]

腰膝酸软

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	针刺疗法	西医基础治疗	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.8 更低(1.3 更低到 0.3 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究在随机、分配隐藏和盲法方面存在较大偏倚

b. 纳入研究样本量太小

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	针刺疗法	西医基础治疗	相对(95% CI)	绝对(95% CI)	
桥本甲减（脾肾阳虚证）温针灸+优甲乐											
甲状腺肿大											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.36 更低(0.65 更低到 0.07 更低)	⊕⊕◯◯ 低[a,b]
颈前压迫感											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.33 更低(0.58 更低到 0.08 更低)	⊕⊕◯◯ 低[a,b]
神疲乏力											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.36 更低(0.66 更低到 0.06 更低)	⊕⊕◯◯ 低[a,b]
腰膝酸软											
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.37 更低(0.69 更低到 0.05 更低)	⊕⊕◯◯ 低[a,b]
畏寒肢冷											

证据评估							受试者人数		效果		证据质量
研究数量	研究设计	偏倚风险	不一致性	间接性	精确性	其他考虑因素【注意事项】	针刺疗法	西医基础治疗	相对(95% CI)	绝对(95% CI)	
1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.4 更低(0.76 更低到 0.04 更低)	⊕⊕◯◯ 低[a,b]

浮肿

1	随机试验	严重[a]	不严重	不严重	严重[b]	无	30	30	-	MD 0.36 更低(0.61 更低到 0.11 更低)	⊕⊕◯◯ 低[a,b]

CI: Confidence interval; MD: Mean difference

说明：

a. 纳入研究样本量太小

International clinical practice guidelines of Chines e Medicine Hashimotos thyroiditis

Formulation Explanations

A、summary of work

Main drafting units: Sun Simiao Hospital, Beijing University of Traditional Chines e Medicine, Dongzhimen Hospital, Beijing University of Traditional Chinese Medicine, Beijing University of Traditional Chinese Medicine

Other drafting organizations: Xi'an Affiliated Hospital of Shaanxi University of Chi nese Medicine (Xi'an Hospital of Traditional Chinese Medicine), Shenzhen Hospital (L onggang) of Beijing University of Chinese Medicine, Hainan Provincial People's Hospit al, The First Affiliated Hospital of Hainan Medical University, The Second Affiliated H ospital of Hainan Medical University, Dongzhimen Hospital of Beijing University of Ch inese Medicine, Affiliated Hospital of Chengdu University of Traditional Chinese Medic ine, The First Affiliated Hospital of Guizhou University of Traditional Chinese Medicin e, The Second Affiliated Hospital of Nanjing University of Chinese Medicine, Hainan Medical University, Affiliated Hospital of Shaanxi University of Chinese Medicine, The First Clinical Medical School of Yunnan University of Traditional Chinese Medicine, T he First Affiliated Hospital of Anhui University of Traditional Chinese Medicine, Affilia ted Hospital of Liaoning University of Traditional Chinese Medicine, Oriental Hospital of Beijing University of Chinese Medicine, Shanxi Integrated Traditional Chinese and Western Medicine Hospital, Affiliated Hospital of Changchun University of Traditional Chinese Medicine, The Second Affiliated Hospital of Hunan University of Chinese Me dicine (Hunan Provincial Hospital of Traditional Chinese Medicine), Beijing University of Chinese Medicine, The Second Affiliated Hospital of Zhejiang University of Traditi onal Chinese Medicine, Wuhu Traditional Chinese Medicine Hospital, Xiamen Hospital of Dongzhimen Hospital of Beijing University of Chinese Medicine, Affiliated Hospital of Shandong University of Traditional Chinese Medicine (Shandong Provincial Hospital of Traditional Chinese Medicine), Beijing Shijitan Hospital Affiliated with Capital Med ical University, The Second Affiliated Hospital of Shaanxi University of Chinese Medici ne, Haici Hospital Affiliated with Qingdao University, The First Affiliated Hospital of Xi'an Medical University, Luoyang Hospital of Dongzhimen Hospital of Beijing Universi ty of Chinese Medicine, The Third Affiliated Hospital of Beijing University of Chinese Medicine, The First Clinical Hospital of Jilin Academy of Traditional Chinese Medicin e, The Seventh Affiliated Hospital of Xinjiang Medical University, The First Affiliated Hospital of Heilongjiang University of Chinese Medicine, The First Affiliated Hospital of Zhejiang University of Traditional Chinese Medicine (Zhejiang Provincial Hospital o f Traditional Chinese Medicine), Chongqing Hospital of Jiangsu Provincial Hospital of Traditional Chinese Medicine (Yongchuan District Traditional Chinese Medicine Hospit al of Chongqing), Qinghai Provincial Hospital of Traditional Chinese Medicine, Beijing Hospital of Traditional Chinese Medicine Affiliated with Capital Medical University, Fa ngshan Hospital of Beijing University of Chinese Medicine, Shanghai Municipal Hospit al of Traditional Chinese Medicine Affiliated with Shanghai University of Traditional C hinese Medicine, The First Affiliated Hospital of Tianjin University of Traditional Chin ese Medicine, Inner Mongolia Autonomous Region Hospital of Traditional Chinese Me dicine, The First Affiliated Hospital of Guangxi University of Chinese Medicine, Fangsh an Hospital of Beijing University of Chinese Medicine, Shaanxi Provincial Hospital of Traditional Chinese Medicine, The First Affiliated Hospital of Nanchang University, Qi nhuangdao Hospital of Oriental Hospital of Beijing University of Chinese Medicine, Ha inan Provincial Hospital of Traditional Chinese Medicine, Gansu Provincial Hospital of Traditional Chinese Medicine, Xiyuan Hospital of China Academy of Chinese Medical

Sciences, Hubei Provincial Hospital of Traditional Chinese Medicine (Affiliated Hospital of Hubei University of Chinese Medicine).

Project leader: Ding Zhiguo

Principal Drafters: Zhiguo Ding, Jing Li, Shuo Qi, Jingwei Zhou, Yutong Fei

Co-drafters: (in alphabetical order of last name) Bai Xiaolin, Bao Yuxiao, Chen Kaining, Chen Xiaopan, Chen Zongcun, Chen Xiaohang, Chen Qiu, Dai Fang, Di Hongjie, Duan Yuhong, Fan Yuan, Fang Zhaohui, Ge Yaxue, Gong Chengjun, Guo Xiangyu, Guo Zhiqin, He Ze, Hu Jianzhuo, Hu Jiang, Hu Suying, Hu Tianzhi, Tou Rui, Huang Yanqin, Jiang Min, Lei Ye, Li Guangshan, Li Huilong, Li Lu, Li Ya, Li Yupeng, Li Zhe, Lin Yan, Liu Meijun, Lou Xion, Lu Dan, Lu Xueling, Ma Jian, Ni Haixiang, Ou Chang, Pu Comfortable Rong, Qian Jiahui, Shang Jianwei, Shang Juju, Sun Luying, Tao Feng, Wang Bin, Wang Dong, Wang Quan, Wang Xiaoping, Wang Zhengang, Wei Shufeng, Xiao Yang, Xia Zhongyuan, Xu Jiezhi, Xu Jianghong, Yang Wenkui, Zhang Dongpeng, Zhou Chunyu, Zou Benliang, Zuo Xinhe.

B、Brief introduction to the standard drafting process

1 Background

Hashimoto's thyroiditis was first reported by Japanese scholar Hashimoto in 1912. The incidence of Hashimoto's thyroiditis varies in different countries and regions, and its prevalence is affected by geographic regions and environmental factors; the pathogenesis is still unclear. Modern medicine focuses on follow-up without specific treatment, such as secondary thyrotoxicosis and secondary hypothyroidism, which require antithyroid drugs or hormone supplementation.

There are many clinical studies in the field of Hashimoto's thyroiditis in Chinese medicine, but there are many controversial points in the combined diagnosis and treatment of Chinese and Western medicine, and no systematic guidelines and standards have been established. The current version of the Western medicine guidelines is the “China Thyroid Disease Diagnosis and Treatment Guidelines - Thyroiditis” issued by the Chinese Society of Endocrinology of the Chinese Medical Association (CSEA) in 2008, during which time there have been a number of scientific evidences that need to be updated. In the field of combined Chinese and Western medicine, the main ones are the Beijing Expert Consensus on Combined Chinese and Western Medicine Diagnosis and Treatment of Hashimoto's Thyroiditis (2021, Beijing) and the Beijing Expert Consensus on the Quality Control Indicator System for Hashimoto's Thyroiditis Combined with Chinese and Western Medicine (2021 Edition) issued by the Beijing Association of Combined Chinese and Western Medicine and Thyroid Disease Specialized Committee in 2021, which do not provide specific elaboration on the stage of the disease that Hashimoto's Thyroiditis patients are in and are more The consensus-based approach lacks the support of high-quality evidence-based evidence, which makes it difficult to meet the current clinical needs. With the increasing international influence of TCM, optimizing the diagnostic and treatment protocols and recommendations of TCM for the prevention and treatment of Hashimoto's thyroiditis and promoting its international application have become the key tasks that need to be regulated and implemented urgently.

2 Main work processes

2.1 Start-up and Deployment Phase

On October 16, 2023, the project team of this guideline was formally established, and the preliminary work of this guideline and the work plan were completed in October 2023, during which a number of preparatory meetings for the development of the guideline were held. The preliminary application and draft of the project were formed, and then discussed and revised by the project team for several times.

2.2 Formalization of the project

November 23, 2023 Formal submission of project application and draft, and on November 28, 2023, WFCM gave back the experts' comments, and accepted the experts' feedback on a total of 19 comments, which were revised on the same day.

On December 08, 2023, the “Workshop on International Standards for Thyroid Diseases” was held in Tongchuan City, China: the discussion included the following aspects: 1) general principles, objectives, and scope of application of the guideline development, 2) general flow of the guideline development, 3) general time schedule of the guideline development, and 4) key considerations in the process of guideline development.

The guideline working group was formally established on December 19, 2023; subsequently, the WeChat group of the guideline development working group and the WeChat group of the guideline development expert group were set up respectively. The working group of this document has formulated the guideline research plan according to the assigned tasks and determined the time nodes for the preparation of the guideline, and the project leader has supervised the working group's development process at regular intervals and has reported on the guideline's progress at regular intervals.

2.3 Preparation process

2.3.1 Expert Interviews

The guideline working group conducted one-on-one interviews with three authoritative experts, mainly discussing the general ideas of Chinese and Western medicine in treating Hashimoto's thyroiditis, treatment experience, and understanding of the combination of Chinese medicine and Western medicine for patients with Hashimoto's thyroiditis at different stages of thyroid function. The guideline development team designed and distributed questionnaires to Chinese and Western medicine clinical experts from the point of view of the difficulties of Western medicine in the diagnosis and treatment of Hashimoto's thyroiditis, as well as the advantages of Chinese medicine interventions or the combination of Chinese and Western medicine.

2.3.2 Extensive clinical research to identify clinical problems

In the process of guideline development, in order to fully incorporate the most concerned issues of clinicians, our team finally formed 16 clinical questions based on the difficulties of western medicine diagnosis and treatment of Hashimoto's thyroiditis and the advantages of Chinese medicine intervention or combined treatment of Chinese and western medicine, through the preliminary pre-searching of the literature and the summarization of the clinical experience, as well as many discussions within the group.

From December 2023 to February 2024, the working group conducted clinical research covering seven regions of China (central China, eastern China, southern China, northern China, southwestern China, northeastern China, and northwestern China), and the participating organizations included community hospitals, village health offices, secondary hospitals, tertiary hospitals, and other levels of healthcare, with a total of 61 clinicians, nurses, and patients to Assessment.

During the research process, the vote rate was used as the main indicator for the importance assessment. In the end, entries with a vote rate of more than 60% were included in the list of basic questions, clinical questions and outcome indicators of the guidelines; entries with a vote rate of ≤60% were not included in the discussion.

According to the findings, all 16 clinical questions had a ballot rate of more than 60%. The guideline working group consulted with methodology experts on the 16 clinical questions formed, and ultimately 15 clinical questions (5 foundational and 10 PICOized clinical questions) and 5 outcome indicators were included in the initial list of guideline questions based on the research results and consultation, and further Delphi method expert surveys were conducted to identify guideline questions.

2.3.3 Clinical question identification and screening of key outcome indicators

To identify the clinical questions and outcome indicators for this guideline, the working group used the Delphi method to conduct an expert opinion survey on December 10, 2024, with 25 experts in the field from 14 provinces and cities and 25 ter

tiary hospitals across China. The importance of each clinical problem and outcome indicator was evaluated by calculating the expert positive coefficient, mean, full score ratio, and coefficient of variation: a 5-point scale was adopted for the clinical problem: very important (5 points), important (4 points), general (3 points), unimportant (2 points), and very unimportant (1 point); and a 9-point scale was adopted for the outcome indicator: 7-9 points for critical endings, 4-6 points for important endings, and 1-3 points for general Endings. The entries included in the guideline had to fulfill the following criteria: mean score of clinical problems ≥3; mean score of outcome indicators ≥7; full score ratio ≥50%; and coefficient of variation <25%. Meanwhile, the working group assessed the harmonization and consistency of the questionnaire using the expert positive coefficient ≥75% and Kendall's harmony coefficient >0.7 and Glanbach coefficient > 0.7 as quality control criteria.

A total of 25 questionnaires were distributed, with a response rate of 100% (25/25). The expert agreement coefficient reached 100%, the Kendall harmony coefficient was 0.723, and the Cronbach's alpha coefficient was 0.891, indicating a high level of consistency in expert opinions. Therefore, a second round of voting was not required. Ultimately, after discussion among the project team experts and summarizing similar clinical issues, 14 clinical questions (including 5 basic questions and 9 PICO-based clinical questions) and 4 key outcome indicators were determined.

number	List of clinical questions
1	What are the Western diagnostic criteria for Hashimoto's thyroiditis?
2	How is the differential diagnosis of Hashimoto's thyroiditis made?
3	What is the traditional Chinese medical diagnosis of Hashimoto's thyroiditis? What are the common symptoms and key points of diagnosis for each type of Hashimoto's thyroiditis?
4	What are the principles of combined Chinese and Western medicine diagnosis and treatment of Hashimoto's thyroiditis?
5	What are the specific components and methods of lifestyle improvement for patients with Hashimoto's thyroiditis?
6	Is a combination of Chinese and Western medicine effective in reducing TPOAb titers in Hashimoto's thyroiditis with normal thyroid function?
7	When the thyroid function of Hashimoto's thyroiditis is normal, can a combination of Chinese and Western medicine improve the patient's clinical symptoms (e.g., pressure in the front of the neck, foreign body sensation in the pharynx, etc.) and goiter better?
8	Is combined Chinese and Western medicine treatment effective in reducing TPOAb titers in Hashimoto's thyroiditis secondary to thyrotoxicosis?
9	Can a combination of Chinese and Western medicine improve thyroid function more rapidly in Hashimoto's thyroiditis secondary to thyrotoxicosis?
10	In Hashimoto's thyroiditis secondary to thyrotoxicosis, can a combination of Chinese and Western medical treatments better improve the patient's clinical symptoms (e.g., anterior cervical pressure, foreign body sensation in the pharynx, and panicky hand tremors) and goiter?
11	Is a combination of Chinese and Western medicine effective in reducing TPOAb titers in hypothyroidism

	secondary to Hashimoto's thyroiditis?
12	Can a combination of Chinese and Western medicine improve thyroid function more quickly when hypothyroidism is secondary to Hashimoto's thyroiditis?
13	In Hashimoto's thyroiditis secondary to hypothyroidism, can a combination of Chinese and Western medical treatments better improve the patient's clinical symptoms (e.g., pharyngeal foreign body sensation, fatigue and weakness, mucous edema, etc.) and goiter?
14	Can external Chinese medicine treatments improve clinical symptoms (e.g., anterior neck pressure, pharyngeal foreign body sensation) and goiter in patients with Hashimoto's thyroiditis?

Table 1 Guidelines Clinical Questionnaire

2.3.4 Retrieval, Screening and Synthesis of Evidence

(1) Description of the search

In order to be able to retrieve as much literature as possible on all clinical issues related to Hashimoto's thyroiditis, the initial search of the literature did not set a specific study type. After downloading the literature titles, a database was created and categorized. Priority was given to published systematic evaluations/Meta-analyses to see if they could be included in this guideline in terms of 3 dimensions: timeliness, match to clinical question, and quality. If inclusion was not possible, new systematic evaluations/Meta-analyses were conducted. If the number of RCTs was low or could not answer the clinical question at hand, the results of other types of studies, such as cohort studies, case-control studies, etc., were further considered as appropriate.

(2) Determine search strategy based on PICO

After clarifying the clinical question, this guideline for clinical evidence was searched by a combination of computerized and manual methods. The search time were from the construction of each database to October 31, 2024. Domestic and foreign original research databases were searched, mainly including English databases: PubMed, EMbase, Cochrane Library; Chinese databases: China Knowledge Network (CNKI), Chinese Science and Technology Journal Full-text Database (VIP), China Biomedical Literature Database (CBM), Wanfang Full-text Database (WanFang). Domestic and foreign clinical trial registration platforms and domestic and foreign guideline libraries: U.S. Clinical Trial Registration Platform, International Guideline Registration Platform, National Institute for Health and Clinical Excellence (UK), New Zealand Clinical Practice Guidelines Network, China Clinical Guidelines Library, and Medical Pulse.

The search was based on a combination of subject terms and free terms. Following the PICOS principle, Chinese and English search terms were identified from “P” (patient, i.e., disease) and “I” (intervention), including “P”: “慢性淋巴细胞性甲状腺炎”“桥本氏甲状腺炎”“桥本甲状腺炎”“慢性淋巴细胞甲状腺炎”“自身免疫性甲状腺炎”“Hashimoto's thyroiditis”“chronic lymphocytic thyroiditis”“autoimmune thyroiditis”,and “I”: “中医”、“中药”、“中医药”、“方剂”、“汤”、“散”、“丸”、“膏”、“丹”、“中成药”、“外治法”、“中医外治”、“针刺”、“针灸”、“灸”、“穴位敷贴”、“Traditional Chinese Medicine (TCM)”、“Chinese herbal medicine”、“Chinese medicine and pharmacology”、“formulae”、“decoction”、“powder”、“pill”、“paste”、“elixir”、“proprietary Chinese medicine”、“external therapy”、“TCM external therapy”、“acupuncture”、“needle therapy”、“moxibustion”、“intradermal needle”、“acupoint application”。

After searching both Chinese and English databases, a total of 1,468 articles were retrieved (219 from PubMed, 588 from CNKI, 216 from VIP, 183 from CBM, and 262 from Wanfang). After excluding duplicates and reviewing the full texts, 68 RCT studies were finally included. Additionally, 24 book references related to the topic were manually searched, including the "Integrated Traditional Chinese and Western Medicine in Thyroidology" textbook published by Science Press, the "Integrated Traditiona

l Chinese and Western Medicine Surgery" textbook under the national higher educati on “14th Five-Year Plan” for Traditional Chinese Medicine, the "Traditional Chinese S urgery" textbook under the same plan, as well as domestic expert consensus, standar ds, and guidelines.

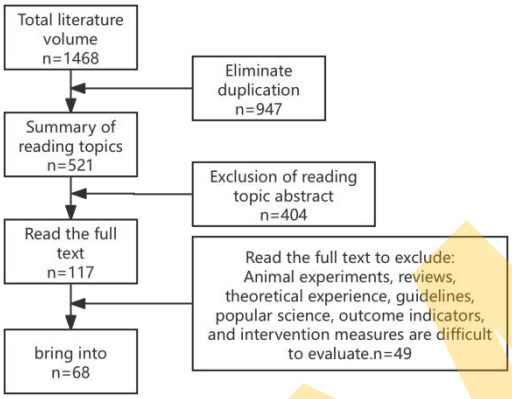

Figure 1: Literature Search Results

2.3.5 Evidence evaluation and grading

(1) Literature quality evaluation

In order to clarify the risk of bias and the quality of the literature of the 68 R CT studies included in the guideline, this guideline used the Cochrane Risk of Bias E valuation Tool to assess the risk of bias of the included literature (generation of ran domized sequences, allocation concealment, blinding of the outcome evaluator, incom plete data, selective reporting of outcomes, and other biases). The majority of entries were ultimately evaluated as having an unclear risk of bias, while fewer were evalu ated as having a low risk of bias for overall quality. The included data were analyze d using Review Manager 5.4 software, with Relative Risk (RR) for count data and M ean Difference (MD) for measure data as the effect size indicators, and when there was statistical heterogeneity between studies ($P \leq 0.1$, $I^2 \geq 50\%$), the source of heteroge neity, and subgroup analysis was carried out for factors that might lead to heteroge neity; if there was statistical heterogeneity but no clinical heterogeneity in the study results, a random-effects model was used for combined analysis.

(2) GRADE evaluation

This guideline uses the GRADE system to evaluate the quality of the evidence b ody, determine the level of evidence, and create the GRADE evidence summary table and evidence summary chart. These tables will be archived as attachments. The evi dence summary description can be found in ANNEX 1, and the GRADE evidence tabl e is provided in ANNEX 2.

Grading of evidence	Specific descriptions	Type of study
high quality/A ⊕⊕⊕⊕	We are pretty sure that the true effec t value is close to the effect estimate	Observational study of RCT mass el evation grade 2
medium quality/B ⊕⊕⊕◯	We are moderately confident in the e ffect estimates: it is possible that the true values are close to the estimate s, but there is still a possibility that t hey are very different.	RCT with 1 level of quality reducti on, observational study with 1 leve l of quality increase
low mass/C ⊕⊕◯◯	We have limited confidence in the est imates of the effects: the true values may be quite different from the estim ates.	RCTs with quality reduction level 2, observational study
low mass/D	We have little confidence in the effect	RCTs with quality reduction level

⊕◯◯◯	estimates: the true values are likely to be very different from the estimates	3, observational studies with quality reduction level 1, case series observations, case reports

Table 2 Description of quality of evidence

Recommended strength	Instructions
Highly recommended	Clearly the pros outweigh the cons.
Weakly Recommended	The pros may outweigh the cons.
Not recommended	Equal or uncertain advantages and disadvantages

Table 3 GRADE Recommended Strength Classification

2.3.6 Recommendation/Consensus Formation

(1) First Expert Recommendation Opinion Solicitation

The guideline development team held a meeting of recommendation opinions and consensus suggestions on January 2, 2024 online.

Fifty-five experts from 29 provinces, autonomous regions, and municipalities directly under the central government were invited to participate in the meeting, covering Chinese medicine, integrated Chinese and Western medicine, and Western medicine clinical experts in a variety of fields, including thyroidology, endocrinology, thyroid surgery, and evidence-based methodology. The lead expert of the guideline development team introduced the background and purpose of the guideline, as well as the proposed recommendations and consensus suggestions to the participating experts. The guideline working group introduced the scientific process of guideline development and provided the experts with relevant materials such as the evidence summary table and the voting list of recommendations/consensus suggestions.

In this expert opinion solicitation, it was set that the positive degree of experts exceeded 70% to be considered as a valid vote. The voting content includes 20 recommendations and 9 consensus recommendations. The main content of the recommended entries is for the dialectical treatment of each TCM evidence type and the external treatment method of TCM. The consensus recommendations were mainly related to the principles of diagnosis and treatment, life interventions, and the dialectical typing of Hashimoto's thyroiditis, Hashimoto's thyroiditis secondary to thyrotoxicosis, and Hashimoto's thyroiditis secondary to hypothyroidism.

For entries supported by clinical evidence, five options were created: “Strongly recommended,” “Weakly recommended,” “Uncertain,” “Weakly not recommended ”, and “Strongly Not Recommended”. If the number of votes in any cell other than “not sure” exceeds 50%, it is regarded as a consensus, and the direction and strength of recommendation can be determined directly; if the total number of votes in the two cells on the side of “not sure” exceeds 70%, it is regarded as a consensus, and the direction of recommendation is determined, and the strength of recommendation is determined directly as “weak”. If the total number of votes on the “uncertain” side exceeds 70%, then consensus is considered to have been reached, the direction of recommendation is determined, and the strength of recommendation is directly “weak”; in the remaining cases, it is considered that no consensus has been reached, and it is necessary to go to the next round of voting (maximum 3 rounds). For consensus recommendations without clinical evidence, there are 3 options: “Agree”, “Unsure”, and “Disagree”. If more than 50% of the votes are cast for any of the options other than “not sure”, a consensus is considered to have been reached and the direction and strength of the recommendation is determined; in the remaining cases, a consensus is considered not to have been reached, and the consensus recommendation proceeds to the next round of voting (up to 3 rounds).

By the deadline, a total of 50 experts had completed the voting, and the positive degree of the experts reached 90.9%, which meets the criteria for effective voting. According to the voting rules, for the 20 recommended entries, the rate of “strong recommendation” exceeded 50%, and the voting result was: “All 20 entries reached a strong recommendation consensus”; the agreement rate of 9 consensus entries exceeded 50%, and the voting result was: “Agree with 9 consensus entries to be included

in the guideline".

This time, all entries reached a decision and did not need to enter the next round of voting. After the voting results were announced, none of the participating experts raised any objections, and all recommended/consensus entries were included in the guideline according to the strength of recommendation.

Guideline Entry	Level of Evidence	Voting Results	Strength of Recommendation
Clinical Question 5/6: Hashimoto's thyroiditis (normal thyroid function stage) Liver Qi Stagnation Syndrome, Recommended Prescription: Modified Chaihu Shugan Powder.	C	Strong Recommendation36/50 Weak Recommendation12/50 Uncertainty 2/50	Strong Recommendation
Clinical Question 5/6: Hashimoto's thyroiditis (normal thyroid function stage) Liver Depression and Heat Syndrome, Recommended Prescription: Qinggan Sanjie Xiaoying Formula.	B	Strong Recommendation35/50 Weak Recommendation14/50 Uncertainty 1/50	Strong Recommendation
Clinical Question 5/6: Hashimoto's thyroiditis (normal thyroid function stage) Liver Depression and Phlegm Coagulation Syndrome, Recommended Prescription: Modified Sini San combined with Banxia Houpu Decoction.	B	Strong Recommendation35/50 Weak Recommendation14/50 Uncertainty 1/50	Strong Recommendation
Clinical Question 5/6: Hashimoto's thyroiditis (normal thyroid function stage) Liver Stagnation and Spleen Deficiency Syndrome, Recommended Prescription: Modified Xiao Chai Hu Decoction combined with Danggui Shaoyao San.	C	Strong Recommendation32/50 Weak Recommendation11/50 Uncertainty 7/50	Strong Recommendation
Clinical Question 7-9: Thyrotoxicosis stage, Liver Depression transforming into Fire Syndrome, Recommended Prescription: Modified Dan Zhi Xiao Yao San.	C	Strong Recommendation38/50 Weak Recommendation 8/50 Uncertainty 4/50	Strong Recommendation
Clinical Question 7-9: Thyrotoxicosis stage, Heart and Liver Heat Syndrome, Recommended Prescription: Modified Zhi Zi Qing Gan Decoction.	B	Strong Recommendation38/50 Weak Recommendation11/50 Uncertainty 1/50	Strong Recommendation
Clinical Question 7-9: Thyrotoxicosis stage, Yin Deficiency Fire Exuberance Syndrome, Recommended Prescription: Modified Danggui Liu Huang Decoction.	B	Strong Recommendation37/50 Weak Recommendation11/50 Uncertainty 2/50	Strong Recommendation
Clinical Question 7-9: Thyrotoxicosis stage, Qi and Yin Deficiency Syndrome, Recommended Prescription: Tian Wang Bu Xin Dan combined with Buzhong Yiqi Decoction.	C	Strong Recommendation32/50 Weak Recommendation12/50 Uncertainty 6/50	Strong Recommendation
Clinical Question 10-12: Hypothyroid stage, Phlegm-Blob and Blood Stasis Syndrome, Recommended Prescription: Jieyu Tongluo Xiaoying Decoction.	C	Strong Recommendation33/50 Weak Recommendation12/50 Uncertainty 5/50	Strong Recommendation
Clinical Question 10-12: Hypothyroid stage, Phlegm-Blob and Blood Stasis Syndrome, Recommended Prescription: Huatan Quyu Xiaoying Decoction.	C	Strong Recommendation31/50 Weak Recommendation15/50 Uncertainty 4/50	Strong Recommendation
Clinical Question 10-12: Hypothyroid stage, Phlegm-Blob and Blood Stasis Syndrome, Recommended Prescription: Xiaoying Sanjie Formula.	C	Strong Recommendation31/50 Weak Recommendation10/50 Uncertainty 8/50 Weakly Not Recommended1/50	Strong Recommendation

Clinical Question 10-12: Hypothyroid stage, Liver Stagnation and Spleen Deficiency Syndrome, Recommended Prescription: Chaihu Shugan Powder or Xiaoyao Powder with modifications.	C	Strong Recommendation35/50 Weak Recommendation11/50 Uncertainty 4/50	Strong Recommendation
Clinical Question 10-12: Hypothyroid stage, Spleen and Kidney Yang Deficiency Syndrome, Recommended Prescription: Shenling Baizhu Powder combined with Jin Gui Shenqi Pill with modifications.	C	Strong Recommendation35/50 Weak Recommendation12/50 Uncertainty 3/50	Strong Recommendation
Clinical Question 10-12: Hypothyroid stage, Heart and Kidney Yang Deficiency Syndrome, Recommended Prescription: Modified Zhenwu Tang combined with conventional Western treatment.	C	Strong Recommendation31/50 Weak Recommendation14/50 Uncertainty 5/50	Strong Recommendation
Clinical Question 13-1: Topical Chinese Medicine for Hashimoto's Thyroiditis (normal thyroid function stage), Qi Stagnation and Phlegm Obstruction Syndrome, Recommended Prescription: Xiaoying Sanjie Formula.	C	Strong Recommendation34/50 Weak Recommendation10/50 Uncertainty 6/50	Strong Recommendation
Clinical Question 13-1: Topical Chinese Medicine for Hashimoto's Thyroiditis (secondary to hypothyroidism), Recommended Prescription: Xiaoying Decoction.	C	Strong Recommendation28/50 Weak Recommendation15/50 Uncertainty 6/50 Weakly Not Recommended1/50	Strong Recommendation
Clinical Question 13-1: Topical Chinese Medicine for Hashimoto's Thyroiditis (secondary to hypothyroidism), Recommended Prescription: Xiaoying Gao.	C	Strong Recommendation28/50 Weak Recommendation15/50 Uncertainty 5/50 Weakly Not Recommended2/50	Strong Recommendation
Clinical Question 13-2：For Hashimoto's hypothyroidism, the recommended acupoints for needling along the Yangming Hand Meridian are: Sanjian, Hegu, Quchi, Binao, Jianyu, Renying, and Zusanli.	B	Strong Recommendation28/50 Weak Recommendation20/50 Uncertainty 2/50	Strong Recommendation
Clinical Question 13: For Hashimoto's hypothyroidism with Liver Qi Stagnation and Kidney Deficiency syndrome, the recommended acupoints are: Guanyuan, Taixi, Xuanzhong, Taichong, Hegu, Sanyinjiao, Neiguan, Fenglong, Renying, and Futu.	C	Strong Recommendation28/50 Weak Recommendation17/50 Uncertainty 5/50	Strong Recommendation
Clinical Question 13: For Hashimoto's hypothyroidism with Spleen and Kidney Yang Deficiency syndrome, the recommended moxibustion acupoints are: Spleen Shu (bilateral), Kidney Shu (bilateral), Mingmen, Fenglong (bilateral), and Taichong (bilateral).	C	Strong Recommendation29/50 Weak Recommendation16/50 Uncertainty 5/50	Strong Recommendation

Table 4 First Expert Recommendation Voting Results (1)

Guideline Entry	Voting Results	Strength of Recommendation
Clinical Issue 3: Integrated Traditional Chinese and Western Medicine Treatment Principles	Recommendation 50/50	Recommendation

Clinical Issue 4: Normal Thyroid Function Stage: Liver Qi Stagnation Syndrome, Liver Depression and Heat Syndrome, Liver Depression and Phlegm Coagulation Syndrome, Liver Stagnation and Spleen Deficiency Syndrome	Recommendation 47/50 Uncertainty 3/50	Recommendation
Clinical Issue 4: Thyrotoxicosis Stage: Liver Depression Transforming into Fire Syndrome, Heart and Liver Heat Syndrome, Yin Deficiency Fire Exuberance Syndrome, Qi and Yin Deficiency Syndrome	Recommendation 44/50 Uncertainty 5/50 Not Recommendation 1/50	Recommendation
Clinical Issue 4: Hypothyroidism Stage: Phlegm-Blob and Blood Stasis Syndrome, Liver Stagnation and Spleen Deficiency Syndrome, Spleen and Kidney Yang Deficiency Syndrome, Heart and Kidney Yang Deficiency Syndrome	Recommendation 48/50 Uncertainty 2/50	Recommendation
Clinical Issue 14: Balanced diet and nutrition	Recommendation 50/50	Recommendation
Clinical Issue 14: Emotional regulation and mental health	Recommendation 48/50 Uncertainty2/50	Recommendation
Clinical Issue 14: Regular lifestyle, avoiding excessive actions	Recommendation 49/50 Uncertainty 1/50	Recommendation
Clinical Issue 14: Moderate exercise to strengthen the body	Recommendation 49/50 Uncertainty 1/50	Recommendation
Clinical Issue 14: Early detection and timely intervention	Recommendation 49/50 Uncertainty 1/50	Recommendation

Table 5 Results of the First Expert Recommendation Voting (2) (Consensus Recommendation List)

(2) Second call for expert recommendations

On January 13, 2025, an expert opinion solicitation for additional questions was conducted. The guideline working group once again invited experts from the expert group (55 in total) for opinion solicitation, and the voting included one solicited opinion and six recommended entries, and the recommended entries were mainly for the recommendation of pCms.

By the deadline, a total of 42 experts had completed the voting, and the positive degree of the experts reached 76.4%, meeting the criteria for effective voting. According to the voting rules, for the 6 recommended entries, the sum of the two rates of “strong recommendation + weak recommendation” exceeded 70%, and all entries reached consensus (0 strong recommendations, 6 weak recommendations), with no non-consensus entries, and the voting result was: “6 entries reached a weak recommendation consensus ”, all 6 recommended entries were included in the guidelines based on the strength of recommendation. 1 solicited opinion was adopted according to the option with an agreement rate of more than 50%.

Guideline Entry	Level of Evidence	Voting Results	Strength of Recommendation
Hashimoto's thyroiditis and its connection with thyrotoxicosis/hypothyroidism	/	Here is the translation for the terms: “secondary”(23/42) “stage/phase” (17/42) “with/associated with”(2/42)	Here is the translation using the phrasing you provided: Hashimoto's thyroiditis Hashimoto's thyroiditis secondary to thyrotoxicosis Hashimoto's thyroiditis secondary to hypothyroidism
Hashimoto's thyroiditis with normal thyroid function: On the basis of lifestyle intervention, the use of Bailing capsule is recommended to reduce the TPOAb antibody titer.	D	Strong recommendation 10/42 Weak recommendation 20/42 Uncertain10/42 Weak not recommended 2/42	Weak recommendation
Hashimoto's thyroiditis with normal thyroid function: On the basis of lifestyle intervention, the use of Xiaoyao pill is recommended to reduce the TPOAb antibody titer.	D	Strong recommendation11/42 Weak recommendation20/42 Uncertain10/42 Weak not recommended1/42	Weak recommendation
Hashimoto's thyroiditis secondary to hypothyroidism: On the basis of lifestyle intervention, the use of Bailing capsule in combination with levothyroxine is recommended to reduce the TPOAb antibody titer and improve thyroid function.	D	Strong recommendation 11/42 Weak recommendation 24/42 Uncertain 6/42 Weak not recommended1/42	Weak recommendation
Hashimoto's thyroiditis secondary to hypothyroidism: On the basis of lifestyle intervention, the use of Xiaohu Cao preparation in combination with levothyroxine is recommended to reduce the TPOAb antibody titer and improve thyroid function.	D	Strong recommendation 10/42 Weak recommendation 26/42 Uncertain 3/42 Weak not recommended3/42	Weak recommendation
Hashimoto's thyroiditis secondary to hypothyroidism: On the basis of lifestyle intervention, the use of Jin Shui Bao capsule in combination with levothyroxine is recommended to reduce the TPOAb antibody titer and improve thyroid function.	C	Strong recommendation 11/42 Weak recommendation 19/42 Uncertain 11/42 Weak not recommended1/42	Weak recommendation
Hashimoto's thyroiditis secondary to hypothyroidism: On the basis of lifestyle intervention, in cases of spleen and kidney yang deficiency, the use of Rightrestoring pill in combination with levothyroxine is recommended to reduce the TPOAb antibody titer and improve clinical symptoms.	D	Strong recommendation 12/42 Weak recommendation 19/4 Uncertain 10/42 Weak not recommended1/42	Weak recommendation

Table 6 Results of the Second Round of Expert Recommendation Voting

(3) Third call for expert recommendation opinions

After revising the draft in accordance with the opinions of the expert group, the

draft was invited to the expert group again (a total of 55 experts) for opinion solicitation on January 23, 2025, and this solicitation of opinions was for the 13 revisions in the draft (including structural revisions of 8, and content revisions of 5).

The voting form for this expert opinion solicitation has three options: “Agree”, “Uncertain” and “Disagree”. The specific decision-making rules are as follows: the positive degree of the experts should be more than 70%; if the number of votes for any item other than “not sure” exceeds 50%, the decision is considered to be reached; if the decision is not reached, it is necessary to go to the next round of voting, with a maximum of no more than three rounds. By the deadline, a total of 50 experts had completed the voting, and the positive degree of the experts reached 90.9%, meeting the criteria for effective voting. According to the decision-making rules, the agreement rate of the 13 revised entries exceeded 50%, and the decision-making result was: “Agree to the 13 revisions”. Decision-making was reached on all entries and there was no need to enter the next round of voting.

Typology	Serial No.	Standard Provisions	Revised Content	Voting result
structural	1	"Diagnosis" Section	Move "Clinical Manifestations" and "Traditional Chinese Medicine (TCM) Syndromes" to the front.	50/50agree with
	2		Relocate "Western Medicine Diagnosis" and "Diagnosis and Treatment Process" to "Appendix B."	47/50agree with 3/50uncertain
	3	"Treatment " Section	Move "Western Medicine Treatment" to "Appendix C."	47/50agree with 3/50uncertain
	4		Adjust "Key Outcome Indicators" to "Appendix D."	48/50agree with 2/50uncertain
	5		Merge "Key Points of TCM Syndrome Differentiation" with "Recommended Treatment and Formula."	49/50agree with 1/50uncertain
	6	"Main Body" Section	Remove "Description of Evidence" and relocate relevant content to the document "Draft Compilation Instructions."	48/50agree with 1/50uncertain 1/50 不 agree with
	7	"Introduction" Section	Remove "2. Identification and Construction of Key Issues" and move related content to the document "Draft Compilation Instructions."	50/50agree with
	8	"Preface""Appendix A: Preparation	Modify the background information in the "Preface" and "Appendix A: Compilation Method."	49/50agree with 1/50uncertain
informative	1	"Introduction" Section	Change the epidemiological data in the "Background Information" from domestic statistics to global data.	50/50agree with
	2	"Scope" Section	Remove the statement "This document is for use by Western medical clinicians."	48/50agree with 2/50uncertain
	3	"Terminology and Definitions"	Add definitions for "Moxibustion with Needle," "Penetration Enhancers," "Cataplasm," and "Excipients."	50/50agree with

	4	"5.3: External Treatment Methods in Traditional Chinese Medicine"	1.Add references (e.g., GB/T 33414-2016) to supplement the principles of external medicine production, usage, and storage. 2.Supplement with "Precautions."	50/50agree with
	5	"Appendix E"	Add a new "Appendix E: Summary Quick Recommendation Table."	50/50agree with

Table 7 Results of the third poll on expert recommendations

2.3.7 Internal Review

The guideline development team reviewed the draft through online meeting on January 2, 2025, and gained a total of 29 suggestions for modification, adopted 19 comments, and did not adopt 10; revised the draft according to the adopted experts' comments, and provided feedback on the reasons for non-adoption of those entries that were not adopted.

After revising the draft in accordance with the comments of the Expert Group, the draft was put through an online second review and comment process of the draft internally on 01/23/2025. A total of 2 comments/suggestions were received and 2 were not accepted.

After 2 rounds of internal review, the review comments were sent back to the Ministry of International Standards. The draft was revised accordingly based on the voting results and submitted to WFCMS.

Serial No.	Standard Provisions	Content of comments	Proposed experts	Disposition and reasons
1	Preamble	“Modern medicine is based on follow-up, no special treatment, such as secondary thyrotoxicosis, hypothyroidism, anti-thyroid drugs or hormone supplementation.” Hashimoto's thyroiditis occurs with hypothyroidism and hyperthyroidism are primary, write secondary whether it is not appropriate, suggest to change to Hashimoto “with” hypothyroidism, Hashimoto “with” thyrotoxicosis.	WU Tian Chi	Not adopted: Based on expert vote: “secondary” vs. “...period” vs. “combined/companion” = 23:17:2, therefore the word “secondary” was chosen. The term “secondary” was chosen.
2	Preface	The word “proceed” should be changed to “need to proceed”.	Lu Xue Ling	Adopted
3	Identification and Staging	Hashimoto's thyroiditis itself can have normal, hypothyroid, or hyperthyroid outcomes. The word “secondary” is not appropriate, so consider whether to replace “secondary” with the word “associated”. Consider whether to replace the word “secondary” with the word “concomitant”.	Hu Tianzhi	Not adopted: According to the expert's voting result: “secondary” vs. “...period” vs. “combined/companion” = 23:17:2, so the word “secondary” is chosen. The term “secondary” was chosen.
4	Terms and Definitions	It is suggested that “abbreviations” be added to the terminology and definitions section to facilitate grassroots promotion.	Sun Luying	Adoption

5	Specific descriptive sections	G in TGAb uses g. TGAb → TgAb.	Chen Kaining	Adoption
6	Page 6 Diagnostic Criteria for Hashimoto's Thyroiditis	TGAb → TgAb is accompanied by enlargement of the isthmus conus lobe, which can be changed to conus lobe, and the term conus lobe is used more often.	Guo Zhiqin	Adoption
7	Identification and staging	In dialectic typing, either normal thyroid function secondary to thyrotoxicity or secondary to hypothyroidism, regarding this neck description, when we have normal thyroid function. Clinically, it may be uncommon for the neck to be enlarged, except for the first liver depression and stagnation of qi written in the neck more than no obvious enlargement, the other are enlarged, it is recommended to specify the stages of each type of evidence which is enlarged, which is atrophic.	Guo Zhiqin	Adoption
8	Western medicine diagnosis	In the diagnosis of Hashimoto's disease, it is recommended to read: fine needle aspiration of the thyroid gland is not used as a routine diagnostic means, for special types of Hashimoto's thyroiditis, such as feasible fine needle aspiration of the thyroid gland for cytological examination;	Fan Yifei	Adopted
9	external application of traditional Chinese medicine	In the external application of traditional Chinese medicine for thyroiditis, it is suggested to add the external application of Huang Yao Zi, which has a high status in the Compendium of Materia Medica, and is safer to use externally than to take internally.	Fan Yifei	Not Adopted: The corresponding literature was not retrieved as evidence to support the external application of Huang Yao Zi for the treatment of Hashimoto's thyroiditis, and will continue to be watched, and if the evidence is updated, it will be added when the guideline is revised.
10	Treatment Options	Whether to add descriptions of contraindications to the use of drugs for special populations in the section on combined Chinese and Western medicine treatment, for example, women with Hashimoto's hypothyroidism during pregnancy, the blood activating drugs involved. Adverse reactions and side effects of western medicines during thyrotoxicosis.	Xia Zhongyuan	Adopted
11	Treatment Programs for Hashimoto's Thyroiditis	Whether to consider adding proprietary Chinese medicines and single-flavored Chinese medicinal preparations.	Xia Zhongyuan	Adopted

12	Diagnostic Criteria for Hashimoto's Thyroiditis	Language in the specific descriptive section on “combining with Chinese herbal medicine to recognize and treat” needs to be considered.	Xia Zhongyuan	Adopted
13	Hashimoto's Thyroiditis Diagnostic Criteria	Is the diagnosis established by a positive serum TPOAb and TgAb, or is it simply positive, or is there no corresponding criterion, such as a triple or quintuple diagnosis?	Huang Yanqin	Not adopted: The diagnostic criteria for Hashimoto's thyroiditis covered in this guideline are written with reference to the relevant statements in the 2008 Chinese Guidelines for the Diagnosis and Treatment of Thyroid Diseases - Thyroiditis.
14	Diagnosis and staging	Is there any Yin deficiency present in Hashimoto secondary to hypothyroidism?	Huang Yanqin	Not adopted: The identification and typing of Hashimoto's secondary hypothyroidism is based on the results of literature research and expert voting.
15	Endpoint Indicators section:	Hashimoto mainly depends on the antibody, whether the antibody is placed in front of the thyroid function, and the status of the antibody is upgraded.	Huang Yanqin	Adopted
16	Differential Diagnosis	Differential diagnosis of partially toxic diffuse goiter, people are more accustomed to the term diffuse toxic goiter, can adjust the term.	Wang Zhengang	Adopted
17	Diagnostic Staging	There is a high degree of symptomatic overlap between the Liver Depression and Fire Evidence and the Heart and Liver Heat Evidence in the Toxic Thyroid Evidence stage, whether the two evidence types can be condensed into one.	Wang Zhengang	Not adopted: the classification of Hashimoto's secondary thyrotoxicosis evidence is based on the results of literature research and expert voting.
18	Treatment Options	It can be treated with beta-blockers (e.g. propranolol), propranolol 10-40mg/dose, orally once a day for 6-8h. The 40mg dose is relatively a bit high, and Hashimoto's thyrotoxicosis is transient, with hormone levels less than those of Graves' disease, and shorter in duration, so the dose needs to be reconsidered.	Wang Zhengang	Adopted
19	identification and staging	Hashimoto's secondary thyrotoxicosis is a transient stage, is it possible to reduce the Chinese medicine evidence of thyrotoxicosis, for example, by putting two signs	Lei Ye	Not adopted: the classification of Hashimoto's secondary thyrotoxicosis evidence type is based on literature findings and expert voting.
20	Ancillary tests Article 5	Suggested pathology tests are placed in front ① cytopathology ② histopathology	Di Hongjie	Adopted

21	Diagnostic Criteria	Diagnostic criteria serum TSH level decreased, and/or FT4, FT3 level increased. Whether to put “and/or” in the middle of FT3, FT4.	Dee Hongjie	Not adopted: This section is based on the Chinese Medical Association's Guidelines for the Diagnosis and Treatment of Hyperthyroidism and Other Causes of Thyrotoxicosis in China.
22	Differential Diagnosis	Iodine uptake rate and iodine absorption rate, unified as iodine uptake rate, or a thyroid mass that has existed for many years increases rapidly in size in a short period of time, thyroid cancer is either poorly differentiated or undifferentiated, or it is a general papillary disorder. Papillary carcinomas are generally benign and do not become malignant. Those that are poorly differentiated, on the other hand, increase in size in a short period of time. Can the phrase goiter that has existed for many years be removed to avoid ambiguity	Hongjie Di	Adopted
23	Diagnosis	Clarify the description of terms in the diagnosis section	Zhang Dongpeng	Adopted
24	Treatment Program	Whether to add thyroid ultrasound as appropriate to the treatment plan	Li Yupeng	Adopted
25	Flowchart	The word “treatment” is missing in the flowchart for evidence-based management.	Li Yupeng	Adopted
26	Follow-up Management	Long-term follow-up and management is relatively less reflected in the guideline, whether to increase the space for long-term follow-up and management.	Li Yupeng	Not adopted.
27	Chinese Medicine Etiology and Pathogenesis	Hashimoto's disease can be caused by modern people staying up late at night. Is it possible to add a clause in the etiology of Chinese medicine to the list of causes and pathogenesis of Hashimoto's disease, such as the deficiency of the spleen and kidneys due to excessive lifestyle, which leads to phlegm congealment and stagnation of qi?	Hu Jianzhuo	Reason: no clear consensus or instructive literature related to this was retrieved; will continue to focus on this direction and will add this section of the description to the guideline revision if updated data are available.
28	Treatment Program	At present, iodine-containing medications and foods have the greatest impact on the incidence of subclinical hypothyroidism, while hyperthyroidism and thyroid nodules have decreased significantly. What impact do iodine-containing medications have on thyroiditis?	Hu Jianzhuo	Not Adopted: No clear consensus or guideline literature was retrieved, will continue to focus on this direction, and will add this section of the description to the guideline revision if updated data are available.

29	Treatment Program	It is recommended that the section on traditional Chinese medicine be supplemented with information on which herbs are iodine-rich, that iodine-rich herbs should be avoided within Hashimoto's thyroiditis, and that the dietary aspects of life emphasize the reduction of iodine intake.	Guo Xiangyu	Adopted
30	Traditional Chinese Medicine External Treatment	The sitting position for some of the acupuncture treatments could be more relaxed, such as the first prescription, which allows for a fully seated position for acupuncture or treatment.	Zhang Dongpeng	Adopted
31	Text	Comment 2: It is recommended that there be a brief body of evidence for key design and data statements, as well as key quantitative and qualitative statements in the body of the text.	Fei Yutong	Not Adopted: No evidence has been retrieved to support this modification, and the current treatment position is based on existing evidence-based literature. We will continue to monitor the situation and will update the guideline if new evidence is available.

Table 8 Summary of Internal Review Comments

C、Introduction of Main Technical Contents

1 Principle of guideline development

The drafting procedure of this document is based on the requirements of SCM1. 1-2021 Guidelines for Standardization Work Part 1: Standard Formulation, Revision a nd Publication issued by the World Federation of Societies of Traditional Chinese Me dicine (WFTC), while referring to the relevant provisions of GB/T 1.1-2020 Guideline s for Standardization Work (Part 1: Structure of Standardized Documents and Draftin g Rules).

In the process of guideline formulation, the principles and standards of relevant evidence quality evaluation, evidence grading and recommendation formation are stric tly followed to ensure the scientific and rigorous nature of guideline preparation. Th e quality evaluation of systematic evaluation methodology was carried out using the AMSTAR2 tool; the methodological quality of Randomized Controlled Trial (RCT) was evaluated through the Cochrane Risk of Bias Assessment Tool; and the GRADE syste m was used for the evaluation and grading of evidence quality.

The technical content mainly follows the following principles: ① For the method of grading evidence, the general idea is to include relevant clinical randomized cont rolled trial studies based on the GRADE standard commonly used in international gui delines, combined with relevant published textbooks and previous guidelines/consens us/standards, to maintain internationalization with GRADE as the main method, and t o reduce the bias of the evidence with the assistance of authoritative and objective i nformation. ② For the strength of the expert consensus recommendation, combined with the content of GRADE, based on scientific experience, theoretical analysis, literat ure, etc., weighing the pros and cons, respectively, in the questionnaire, each entry c heck “Strongly Recommended (definitely outweighs the disadvantages)”, “Weakly Reco mmended (may outweigh the disadvantages)”, “Not Recommended”, “Weakly Recomm ended (may outweigh the disadvantages)”, “Not Recommended”, and “Not Recommend ed”. ”, “Uncertain (the relationship between advantages and disadvantages is uncertai n, or there is no significant difference)”, “Weakly do not recommend (may outweigh the advantages)”, “Strongly do not recommend (certainly outweigh the advantages) ”, synthesize relevant information to form an expert consensus recommendation. ③ E xpert consensus is an important basis for the formation of recommendations for TC M clinical diagnosis and treatment guidelines. Based on this, the formation of expert

consensus in the drafting process of this guideline is mainly based on the “Delphi” method. (iv) It is planned to be updated in the next 2-3 years in accordance with the current international standards for guideline updating reports.

2 Technical route of guideline development

The preparation of this guideline is carried out in strict accordance with the standardized steps.

Stage 1: Establishing a guideline drafting group and signing a declaration of interest; sorting out domestic and international Hashimoto's thyroiditis Chinese and Western medicine-related guidelines and clinical studies to determine the topic, scope and purpose of the guideline; planning the guideline research program and writing the declaration materials. After the project was formally established, key issues in clinical practice were comprehensively collected through interviews with authoritative experts and online clinician research in order to initially construct a list of guideline issues and outcome indicators; the clinical issues to be addressed by the guideline and the grading of the importance of the efficacy evaluation indexes were optimized through the Delphi method to ultimately form a list of clinical issues for the guideline.

Stage 2: Based on the identified list of clinical problems, searching, screening, synthesizing and evaluating the evidence were carried out. For clinical problems supported by evidence-based medicine, the GRADE method is used to evaluate and grade the quality of evidence, and a summary table of evidence is formed; for clinical problems with insufficient evidence, an expert consensus recommendation is initially formed, and a consensus is finally reached through multiple rounds of expert voting.

Stage 3: After completing the draft guideline, experts within the writing working group will conduct self-assessment, and revise and improve the draft. Subsequently, the draft was submitted to the World Federation of Societies of Traditional Chinese Medicine (WFTCM) for online publicity to solicit opinions; after the expiration of the publicity period and review and approval by WFTCM, the final revision, confirmation and release were carried out according to the feedback.

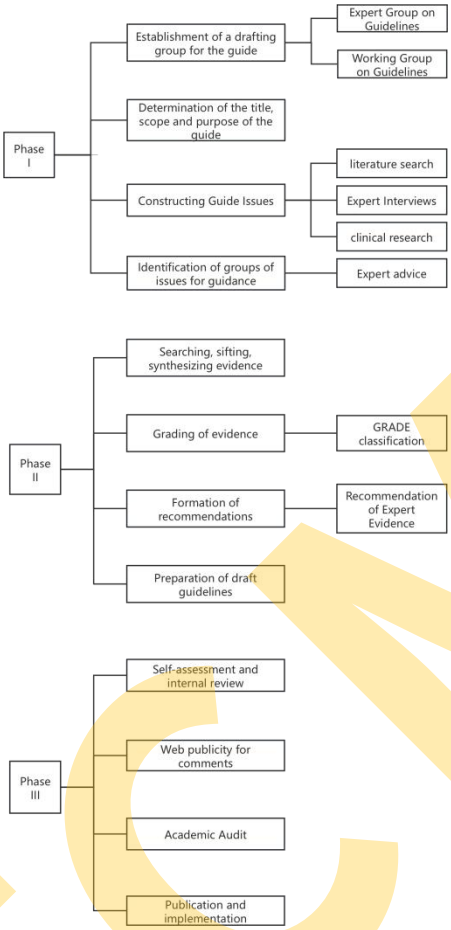

Figure 1 International Clinical Practice Guidelines for Traditional Chinese Medicine (TCM) Hashimoto's Thyroiditis (Hashimoto's Thyroiditis) technical route

3 General content

This guideline provides treatment recommendations for different stages of Hashimoto's thyroiditis (normal thyroid function stage of Hashimoto's thyroiditis, secondary hyperthyroidism in Hashimoto's thyroiditis, and secondary hypothyroidism in Hashimoto's thyroiditis) based on thyroid function levels.

The guideline consists of seven sections. The main technical content includes: Sections 1-3 specify the scope of the guideline, normative references, and definitions of terms; Section 4 clarifies the clinical manifestations of Hashimoto's thyroiditis; Section 5 covers the Western medical diagnosis and Traditional Chinese Medicine (TCM) diagnostic classification; Section 6 outlines the treatment principles for Hashimoto's thyroiditis, including TCM syndrome differentiation and treatment, Chinese herbal medicine, other therapies, and lifestyle interventions; Section 7 defines the core outcome indicators for the diagnosis and treatment of Hashimoto's thyroiditis; Section 8 includes appendices and references, along with a description of the guideline development process.

4 Relationship with relevant laws, regulations, mandatory standards and clinical practice guidelines

The recommended therapeutic medications in this guideline all comply with the latest contents recorded in the National Essential Medicine List, National List of Medicines for Basic Medical Insurance, Work Injury Insurance, and Maternity Insurance, and the Pharmacopoeia of the People's Republic of China.

The contents of this guideline, including Western medical diagnostic standards, Western medical treatments, and Traditional Chinese Medicine (TCM) diagnostic classi

fication, are primarily based on the following references: Thyropathy Committee of Beijing Association of the Integrating of Traditional and Western Medicine (2021, Beijing), The Consensus on Quality Control Indicators for the Integrated Diagnosis and Treatment of Hashimoto's Thyroiditis (2021 edition, Beijing), Guideline for Diagnosis and Treatment of Thyroid Diseases in China—Thyroiditis (2008), Guideline for Diagnosis and Treatment of Hyperthyroidism and Other Causes of Thyrotoxicosis in China (2022), and Guideline for Diagnosis and Treatment of Hypothyroidism in Adults (2017).

D、Process and basis for handling major disagreements

There were no major disagreements during the development of this guideline.

E、Other Matters to be Explained

This project is funded by the General Office of the Ministry of Finance and the State Administration of Traditional Chinese Medicine under the "Demonstration and Pilot Project of Traditional Chinese Medicine Inheritance and Innovation Development". The members of the project team signed a "Declaration of Conflict of Interest" before the official launch of the project, which is on file. There is no conflict of interest in the development of this guideline, which will not be a source of bias in the development of this guideline, and all the members involved in the development of this guideline have no financial interests with drug manufacturers.

ANNEX 1 Summary description of the evidence

Clinical Question 1: What are the western medical diagnostic criteria for Hashimoto's thyroiditis?

Evidence description: refer to the 2008 Chinese Guidelines for the Diagnosis and Treatment of Thyroid Diseases-Thyroiditis, the 2021 Beijing Expert Consensus on the Combined Chinese and Western Medicine Diagnosis and Treatment of Hashimoto's Thyroiditis 2021, the 2017 Guidelines for the Diagnosis and Treatment of Hypothyroidism in Adults, and the 2022 Chinese Guidelines for the Diagnosis and Treatment of Thyrotoxicosis Due to Hyperthyroidism and Other Causes.

Clinical Question 2: How is the differential diagnosis of Hashimoto's thyroiditis made?

Evidence description: Refer to the 2008 Chinese Guidelines for the Diagnosis and Treatment of Thyroid Diseases - Thyroiditis, the 2021 Beijing Expert Consensus on Combined Traditional Chinese and Western Medicine Diagnosis and Treatment of Hashimoto's Thyroiditis, and the Science Publishing House Fourteenth Five-Year Plan for Postgraduate Students in General Higher Education, Combined Traditional Chinese and Western Medicine and Thyroid Disease.

Clinical question 3: What is the TCM diagnosis of Hashimoto's thyroiditis? What are the common symptoms and key points of diagnosis for each type of Hashimoto's thyroiditis?

Evidence description: After reviewing 8,835 articles of reported literature in the Chinese and English databases built up to December 2023, duplicates were excluded, and 16 articles of Hashimoto's thyroiditis, 248 articles of thyrotoxicosis, and 67 articles of hypothyroidism were finally included in the study according to the nerfing criteria, and 24 articles of book-type literature involving the relevant contents were manually searched, including the Science Press "The 14th Five-Year Plan for Postgraduates in General Higher Education, Chinese and Western Medicine Thyroid Disease, the 14th Five-Year Plan for Higher Education in Traditional Chinese Medicine, Chinese and Western Medicine Surgery, and the 14th Five-Year Plan for Higher Education in Traditional Chinese Medicine. The textbook of "14th Five-Year Plan" for higher education in Chinese medicine industry, "Surgery of Chinese Medicine Combined with

Western Medicine", "Surgery of Chinese Medicine Combined with Western Medicine", "Surgery of Chinese Medicine Combined with Western Medicine", "Surgery of Chinese Medicine Combined with Western Medicine", and the relevant expert consensus, standards and guidelines in China. Frequency counts of the types of evidence and the elements of evidence for each type of evidence in the 331 report-type literatures and 24 book-type literatures obtained from the search were conducted respectively, and expert consensus was conducted on them, and the types of evidence and the elements of evidence for each type of evidence were selected and ranked to form the elements of evidence for Hashimoto's thyroiditis.

CLINICAL QUESTION 4: What are the principles of integrating Chinese and Western medicine in the diagnosis and treatment of Hashimoto's thyroiditis?

Evidence description: Refer to the Beijing Expert Consensus 2021 on Combined Chinese and Western Medicine Diagnosis and Treatment of Hashimoto's Thyroiditis, and the Combined Chinese and Western Medicine Thyroid Disease, a postgraduate planning textbook for general higher education of the 14th Five-Year Plan of the Science Publishing House.

The outcome indicators were developed:

Evidence description: The indicators of efficacy evaluation were determined with reference to the "Fourteenth Five-Year Plan" postgraduate planning textbook for general higher education of the Science Publishing House, "Combined Traditional Chinese and Western Medicine Thyroid Disease", the "Thirteenth Five-Year Plan" textbook of the National Health and Health Commission, "Internal Medicine", the "Thirteenth Five-Year Plan" textbook of the National Health and Health Commission, "Diagnostics", and the 2002 version of "Guidelines for Clinical Research of New Chinese Medicines". The relevant contents of the 13th Five-Year Plan textbook "Diagnostics" and the 2002 version of "Guidelines for Clinical Research of New Chinese Medicines" were used to determine the evaluation indexes of efficacy.

TPOAb as an evaluation index: TPOAb is a specific antibody for Hashimoto's thyroiditis, which is present in almost all patients with HT, and is mainly produced by lymphocytes infiltrating around the thyroid gland [1], regardless of the presence or absence of hypothyroidism, TPOAb can respond to the severity of the lymphocytic infiltration of the thyroid gland [k=0.55, 95% CI (0.493-0.615)] [2-5], and the titer level of TPOAb was positively correlated with the TSH level in HT patients with hypothyroidism [OR=40, 95% CI (12-136) [6-7]; the measurement of serum TPOAb level not only plays an important role in the diagnosis of the disease, but it is also an indicator of the evaluation of the effectiveness of the disease treatment, which is of great importance in the assessment of the patient's clinical treatment outcome [8-10].

The Thyroid Disease Quality of Life Brief Scale (ThyPRO-39): a systematic evaluation [11], a total of 904 studies were identified by searching the English literature database, and 64 studies with 16 different questionnaires were finally included according to the nerfing criteria, of which 4 questionnaires were related to benign thyroid disease (ThyPRO, ThyPRO-39, Thy-R-HRQoL, and Thy-D- QOL), the results of the study showed that ThyPRO and ThyPRO-39 reliability and internal consistency were >0.75, which were more suitable questionnaires for assessing benign thyroid disorders, and that the 39 items of ThyPRO-39 scale were shorter and smaller compared to the 85 items of ThyPRO scale, which was superior in terms of the time to complete (14min vs. 4min), and that the ThyPRO-39 scale excludes items with cultural differences [11-13].

Clinical Question 5: Is combined Western and Chinese medicine treatment effective in reducing TPOAb titers when Hashimoto's thyroiditis has normal thyroid function?

Clinical question 6: Can combined Chinese and Western medicine treatment better improve patients' clinical symptoms (e.g., anterior neck pressure, pharyngeal foreig

n body sensation, etc.) and goiter when Hashimoto's thyroiditis has normal thyroid function?

①**Liver qi stagnation syndrome**: Bupleurum Liver-Soothing Powder plus or minus (Level of Evidence: C, Strongly Recommended).

EVIDENCE DESCRIPTION: One RCT [14] (n=69) evaluated the clinical efficacy of Bupleurum Liver-Soothing Powder in the treatment of HT, with selenium yeast in the control group and Bupleurum Liver-Soothing Powder plus combination with selenium yeast in the observation group, which showed that, in terms of lowering serum TPOAb antibody titer levels and improving clinical symptoms, the efficacy of the observation group was significantly better than that of the control group in terms of serum TPOAb (MD=-16.20, 95% CI [-85.97,53.57]) and Chinese medicine evidence points (MD=-6.34, 95% CI [-8.52,-4.16]). No adverse events were reported in the study.

②**Liver depression heat syndrome**: Qinggan Sanjie Xiaoying Formula (Level of Evidence: B, Strong Recommendation).

Evidence description: One RCT [15] (n=90) evaluated the clinical efficacy of the Qinggan Sanjie Xiaoying Formula for the treatment of HT, with an iodine-restricted diet in the control group and a combination of iodine-restricted diet in the observation group. The results showed that the observation group was significantly more effective than the control group in reducing the serum TPOAb antibody titer level, improving clinical symptoms and improving goiter, with the serum TPOAb (MD=-13.55, 95% CI[-71.12,44.02]), Chinese medicine symptom score (MD=-5.58, 95% CI[-7.94,-3.22]), thyroid volume (MD=-0.30, 95% CI[-3.22]), and thyroid volume (MD=-0.30, 95% CI[-3.22]) significantly higher than that of the control group. 95%CI[-2.68,2.08]), HAMA anxiety score (MD=-4.00, 95%CI[-5.53,-2.47]), HAMD depression score (MD=-2.50, 95%CI[-4.07,-0.93]), Pittsburgh Sleep Quality Index (PSQI) (MD=-4.14, 95%CI[- 5.38,-2.91]), and Fatigue Severity Scale (FSS) (MD=-6.19, 95% CI [-10.85,-1.53]). No adverse events were reported in the study.

Description of evidence: One RCT [16] (n=63) evaluated the clinical efficacy of Powder for regulating liver and spleen combined with Pinelliae and magnoliae officinalis decoction plus and minus in the treatment of HT, with selenium yeast in the control group and Powder for regulating liver and spleen combined with selenium yeast in the observation group. regulating liver and spleen combined with Pinelliae and magnoliae officinalis decoction plus and minus combined with selenium yeast, the results showed that the efficacy of the observation group was significantly better than that of the control group in terms of improvement of goiter, and the volume of the thyroid gland (MD=-2.04, 95% CI[-3.97,- 0.11]). 2 RCTs [16,17] (n=157) assessed the clinical efficacy of Pinelliae and magnoliae officinalis decoction plus or minus treatment for HT, in which selenium yeast was given to the control group, and the observation group was given Pinelliae and magnoliae officinalis The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of improving clinical symptoms, and the Chinese medicine syndrome score (MD=-6.23, 95% CI [-7.27,-5.18]). 3-item RCTs][16-18] (n=217) assessed the clinical efficacy of Pinelliae and magnoliae officinalis decoction plus and minus in treating HT. officinalis decoction plus or minus plus or minus in the treatment of HT. The control group was given selenium yeast, and the observation group was given Pinelliae and magnoliae officinalis decoction plus or minus combined with selenium yeast, and the results showed that, in terms of lowering the level of serum TPOAb antibody titer and improving clinical symptoms, the observation group The efficacy was significantly better than that of the control group in terms of serum TPOAb (MD=-58.3, 95% CI [-72.6,-4.4]), anterior neck enlargement (MD=-1.3, 95% CI [-1.79,-0.8]), pharyngeal foreign body sensation (MD=-1.15, 95% CI [-1.49,-0.81]), and affective depression (MD=-1.39, 95% CI [-1.85,-0.093]). No adverse events were reported in any of the studies.

④**Liver stagnation and spleen deficiency syndrome**: Modified Xiaochaihu Decoction and Danggui Shaoyao Powder (Level of Evidence: C, Strong Recommendation).

EVIDENCE DESCRIPTION: One RCT [19] (n=63) assessed the clinical efficacy of Modified Xiaochaihu Decoction and Danggui Shaoyao Powder in the treatment of HT, with selenium yeast in the control group and Modified Xiaochaihu Decoction and Danggui Shaoyao Powder in the observation group. The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of lowering the antibody titer level of serum TPOAb, improving clinical symptoms, and reducing serum TPOAb (MD=-40.59, 95% CI[-57.53,-23.65]), Chinese medicine syndrome score (MD=-4.45, 95% CI[-7.65]), and Chinese medicine syndrome score (MD=-4.45, 95% CI[-4.45, 95% CI[-4.45]). CI [-7.51,-1.39]). No adverse events were reported in the study.

Two RCTs [20,21] (n=120) were conducted to assess the clinical efficacy of Shugan Jianpi Xiaoying Decoction [20], Qicao Decoction [21] for the treatment of HT. The control group was given selenium yeast/Xiakoucao Oral Liquid, and the observation group was given Shugan Jianpi Xiaoying Decoction Gall Elimination Formula (Chai Hu, Astragalus, Xia Ku Cao, Atractylodes Macrocephalae, Paeonia lactiflora, Angelica sinensis, Curcuma longa, Oyster, Zhe Bei, Xuan Shen, Fang Feng), Qicao Decoction (Astragalus, Xia Ku Cao, Chai Hu, Xiang Fu, Chen Pi, Yu Jin, Atractylodes Macrocephalae, Platycodonopsis, Zhe Bei Mu, Licorice) combined with selenium yeast/xia ku Cao oral liquid, the results showed that, in terms of lowering the level of antibody titer of serum TPOAb, Improvement of clinical symptoms, the efficacy of the observation group was significantly better than that of the control group in terms of serum TPOAb (MD=-52.91, 95% CI [-68.16,-36.66]), Chinese medicine evidence points (MD=-8.53, 95% CI [-9.53,-7.53]), anterior cervical swelling (MD=-0.81, 95% CI [-1.06,-0.57]), anterior neck swelling (MD=-0.82, 95%CI[-1.13,-0.51]), irritability (MD=-0.51, 95%CI[-1.09,-0.07]), fatigue (MD=-0.32, 95%CI[-0.48,-0.15]), poor appetite and dullness (MD=-0.93, 95%CI[-1.74 ,-0.12]). No adverse events were reported in any of the studies.

Recommended Chinese medicines for Hashimoto's thyroiditis:

Bailing capsule (level of evidence: D, weak recommendation) or Xiaoyao pill (level of evidence: D, weak recommendation)

EVIDENCE DESCRIPTION: A Meta-analysis [22] incorporating 2 RCTs (n=152) evaluating the clinical efficacy of Bailing capsule in the treatment of HT, with iodine-restricted diet in the control group, and Bailing capsule combined with an iodine-restricted diet in the observation group, showed a significantly better efficacy in reducing the level of antibody titers to serum TPOAb than in the control group. Serum TPOAb (MD=-407.37, 95% CI [-448.6,-366.14]). 1 RCT [23] (n=80) was conducted to evaluate the clinical efficacy of Xiaoyao pill in the treatment of HTLiver stagnation and spleen deficiency syndrome, with iodine-restricted diet in the control group and Xiaoyao pill in the observation group. diet, and the observation group was given Xiaoyao pill combined with iodine-restricted diet. The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of lowering the level of serum TPOAb antibody titer, serum TPOAb (MD=-198.06, 95% CI [-275.84,-120.28]). No adverse events were reported in any of the studies.

Hashimoto's thyroiditis secondary to thyrotoxicosis

Clinical Question 7: In Hashimoto's thyroiditis secondary to thyrotoxicosis, is a combination of Chinese and Western medicine effective in reducing TPOAb titers?

Clinical Question 8: In Hashimoto's thyroiditis secondary to thyrotoxicosis, can the combination of Chinese and Western medicine improve thyroid function more quickly?

Clinical Question 9: In Hashimoto's thyroiditis secondary to thyrotoxicosis, can the combination of Chinese and Western medicine improve the clinical symptoms (e.g., pressure in the front of the neck, foreign body sensation in the pharynx, panic and hand tremor, etc.) and goiter of the patients?

①**Liver depression transforming into fire syndrome**: addition and subtraction of Danzhi Xiaoyao Powder (Level of Evidence: C, Strongly Recommended).

Evidence description: 1 Meta-analysis [24] that included 14 RCTs (n=1062), the observation group was treated with Danzhi Xiaoyao Powder combined with conventional Western medicine drugs, and the control group was treated with conventional Western medicine drugs; 13 RCTs compared the clinical efficacy, and the results showed that the clinical efficacy rate of the trial group was higher than that of the control group [RR=1.25, 95% CI (1.19,1.33)]; 10 RCTs compared the FT3 and FT4 levels, and the results showed that the FT3 level of the experimental group was lower than that of the control group [MD=-3.63, 95% CI (-6.13,-1.12)], and the FT4 level of the experimental group was lower than that of the control group [MD=-9.96, 95% CI (-15.91,-4.02)]; 7 RCTs compared the TSH level, and the results showed that the clinical efficiency of the experimental group was higher than that of the control group [RR =1.25, 95% CI (-6.19,1.33)]. TSH levels, and the results showed that the TSH levels in the test group were higher than those in the control group [MD=0.42, 95% CI (0.09,0.75)]; 6 RCTs reported adverse reactions, and the incidence of leukopenia and rash was lower in the test group than in the control group, and the difference was statistically significant, leukopenia [RR=0.45, 95% CI (0.21,0.96); rash [RR = 0.24, 95% CI (0.08,0.76)].

Two RCTs [31,32] (n=150) assessed the clinical efficacy of The clear fire detoxification xiaoying decoction [31], qinggan xiehuo xiaoying formula [32] for the treatment of HT secondary to thyrotoxicosis, and the control group was given the conventional Western medicine medications. The observation group was treated with The clear fire detoxification xiaoying decoction, Clearing liver and purging fire gall elimination formula combined with conventional western medicine. The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of reducing the levels of serum TPOAb antibody titers, improving thyroid function, improving clinical symptoms and goiter, and decreasing the levels of serum TPOAb (MD=-174.11, 95% CI [-205.68,-142.53]), serum FT3 (MD=-0.08, 95% CI [-0.63,-0.48]), serum FT4 (MD=-1.46, 95% CI [-2.08,-0.84]), thyroid isthmus thickness (MD=-0.41, 95% CI [-0.84,-0.03]), anterior neck pressure (MD=-0.57, 95% CI [-0.92,-0.21]), palpitations (MD=-1.5, 95% CI [-1.82,-1.19]), pyrexia and sweating (MD=-1.43, 95% CI [- 1.81,-1.05]), and dry mouth and bitter mouth (MD=-1.33, 95% CI [-1.72,-0.94]). No adverse events were reported in any of the studies.

③**Yin deficiency fire exuberant card**: Danggui liuhuang soup plus and minus (Level of Evidence: B, Strongly Recommended).

Evidence description: 11 RCTs [33-43] (n=996) evaluated the clinical efficacy of Danggui liuhuang soup plus and minus in the treatment of HT secondary to thyrotoxicosis. The control group was treated with conventional western medicine, and the observation group was treated with Danggui liuhuang soup plus and minus in combination with conventional western medicine, and the results showed that, in terms of the improvement of thyroid function (serum FT3, FT4, TSH), the observation group was able to improve thyroid function (FT3, FT4, TSH). FT3, FT4, and TSH), the efficacy of the observation group was significantly better than that of the control group in terms of serum FT3 (MD=-2.69, 95% CI [-2.79,-2.59]), serum FT4 (MD=-6.40, 95% CI [-6.77,-6.02]), and serum TSH (MD=0.38, 95% CI [0.37,0.40]). Five RCTs [33,35-38] (n=374) assessed the clinical efficacy of Danggui liuhuang soup plus and minus in the treatment of HT secondary to thyrotoxicosis. The control group was treated with conventional Western medicine drugs, and the observation group was treated with Danggui liuhuang soup plus and minus combined with conventional Western medicine drugs. The results showed that in terms of improving thyroid function (serum TT3, TT4), the efficacy of the observation group was significantly better than that of the control group in terms of serum TT3 (MD=-1.54, 95% CI [-1.62,-1.47]) and serum TT4 (MD =-6.00, 95% CI [-7.33,-4.67]). 7-item RCTs [35,37-41,43] (n=676) assessed the efficacy

of Danggui The clinical efficacy of liuhuang soup plus and minus in the treatment o f HT secondary to thyrotoxicosis was assessed by 7 RCTs[35,37-41,43] (n=676).The clinic al efficacy of liuhuang soup plus and minus in the treatment of HT secondary to thy rotoxicosis was assessed by 7 RCTs[35,37-41,43] (n=676). -The clinical efficacy of Danggui liuhuang soup plus and minus in the treatment of HT secondary to thyrotoxicosis was assessed by 2 RCTs [41,43] (n=200), in which the control group was treated with conventional western medicine and the observation group was treated with Danggui liuhuang soup plus and minus in combination with conventional western medicine, a nd the results showed that the observation group had significantly better efficacy tha n the control group in improving clinical symptoms. In terms of improving quality of life, the efficacy of the observation group was significantly better than that of the c ontrol group, ThyPRO-39 scale (MD=11.56, 95% CI [10.04,13.08]). 1-item RCT [37] (n= 200) assessed the clinical efficacy of the Danggui liuhuang soup plus or minus treat ment for HT secondary thyrotoxicosis in the control group, which was given convent ional Western medicine medication. The observation group was treated with Danggui liuhuang soup plus and minus combined with conventional western medicine. The r esults showed that the efficacy of the observation group was significantly better than that of the control group in terms of the improvement of clinical symptoms, anterio r neck enlargement (MD=-1.50, 95% CI [-1.82,-1.19]), irritability (MD=-1.06, 95% CI [-1.14,-0.98]), irritability (MD=-1.06, 95% CI [-1.14,-0.98]), and heat of hands, feet, an d heart (MD=-1.14,-0.98]).), hot hands and feet (MD=-1.13, 95%CI[-1.24,-1.02]).Four RCTs[37-39,41] (n=296) reported adverse reactions, with leukopenia, rash, and abnormali ties of liver and renal functions in the control group, and the incidence of adverse r eactions in the observation group was lower than that of the control group, and the difference was statistically significant (RR=0.21, 95%CI[0.10,0.44]).

④ **Qi and Yin deficiency syndrome**:Tianwang buxin minipills combined with B uzhong yiqi decoction plus and minus (Level of Evidence: C, Strongly Recommended).

EVIDENCE DESCRIPTION: Four RCTs [44-48] (n=254) assessed the clinical efficacy of Tianwang buxin minipills plus or minus in the treatment of HT secondary to thyr otoxicosis. The control group was treated with conventional Western medication, and the observation group was treated with Tianwang buxin minipills plus or minus co mbined with conventional Western medication. The results showed that in terms of i mproving thyroid function, the efficacy of the observation group was significantly bet ter than that of the control group in terms of serum FT3 (MD=-2.80, 95% CI [-3.06, -2.54]), serum FT4 (MD=-1.10, 95% CI [-1.52,-0.68]), and serum TSH (MD=0.35, 95% CI [0.23,0.48]). 3 RCTs [44- 46] (n=194) assessed the clinical efficacy of Tianwang buxi n minipills plus/minus plus/minus in the treatment of HT secondary to thyrotoxicosi s. The control group was treated with conventional Western medicine drugs, and the observation group was treated with Tianwang buxin minipills plus/minus combined with conventional Western medicine drugs. The results showed that in terms of impr oving clinical symptoms, the efficacy of the observation group was significantly better than that of the control group in terms of improving clinical symptoms, and the Ch inese medicine syndrome score (MD=-19.35, 95% CI [-20.62,-18.12]). 1 RCT [46] (n=60) assessed the clinical efficacy of Tianwang buxin minipills plus/minus plus/minus in the treatment of HT secondary to thyrotoxicosis, in which the control group was giv en conventional Western medication, and the observation group was given Tianwang The control group was treated with Tianwang buxin minipills plus/minus plus/minu s combined with conventional western medicine. The results showed that the efficacy of the observation group was significantly better than that of the control group in t erms of the improvement of clinical symptoms, palpitations (MD=-0.08, 95% CI [-0.60, -0.44]), finger tremor (MD=-0.85, 95% CI [-1.27,-0.43]). 2 RCT [46,47] (n=120) reported adverse reactions in the form of leukopenia, liver function abnormalities, etc., and t he incidence of adverse reactions in the observation group was lower than that in t

he control group, and the difference was statistically significant (RR=0.42, 95% CI [0.16,1.10]).

Three RCTs [48-50] (n=170) assessed the clinical efficacy of Buzhong yiqi decoction plus and minus in the treatment of HT secondary to thyrotoxicosis. The control group was treated with conventional western medicine, and the observation group was treated with Buzhong yiqi decoction plus and minus combined with conventional western medicine. The results showed that in improving the serum TPOAb antibody titer, the observation group had significantly better efficacy than the control group (MD=-55.46, 95% CI [-57.78,-53.14]). 2 RCTs [48,49] (n=100) were conducted to evaluate the clinical efficacy of Buzhong yiqi decoction plus or minus in the treatment of HT secondary to thyrotoxicosis, with the control group being given the usual western medicine, and the observation group being given the usual western medicine. Buzhong yiqi decoction plus and minus combined with western medicine conventional drug treatment, the results showed that the efficacy of the observation group was significantly better than that of the control group in terms of lowering the levels of serum FT3 and FT4, with a decrease in the levels of serum FT3 (MD=-0.14, 95% CI [-0.39, 0.11]) and serum FT4 (MD=-0.48, 95% CI [-0.97, 0.01]). 1 RCT [49] (n=40) assessed the clinical efficacy of Buzhong yiqi decoction plus and minus in the treatment of HT secondary to thyrotoxicosis, in which the control group was treated with conventional Western medication and the observation group was treated with Buzhong yiqi decoction plus and minus combined with conventional Western medication, and the results showed that, in terms of elevating serum TSH levels, The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of elevating serum TSH levels and improving clinical symptoms, and that serum TSH (MD=1.86, 95% CI[0.92,2.80]), anterior cervical enlargement (MD=-1.03, 95% CI[-1.27,-0.79]), unfavorable pharyngeal condition (MD=-0.96, 95% CI[-1.22,-0.70]), and insomnia with excessive sleepiness (MD= -0.85, 95% CI [-0.99,-0.71]), and dysphoria (MD=-1.07, 95% CI [-1.25,-0.89]).1 RCT [48] (n=60) assessed the clinical efficacy of Buzhong yiqi decoction plus and minus in the treatment of HT secondary to thyrotoxicosis.The control group was given the conventional medication of Western medicine. In the observation group, Buzhong yiqi decoction plus and minus were combined with conventional Western medicine. The results showed that the observation group was significantly more effective than the control group in improving clinical symptoms and goiter, and the Chinese medicine syndrome score (MD=-5.43, 95% CI [-7.56,-3.30]), the thickness of the isthmus of the thyroid (MD=-0.80, 95% CI [-1.00,-0.30]), and the thickness of the thyroid were significantly higher than that of the control group. 1.00,-0.60]). No adverse events were reported in any of the studies.

Clinical Question 10: Is combined Western and Chinese medicine treatment effective in reducing TPOAb titers in Hashimoto's thyroiditis secondary to hypothyroidism?

Clinical Question 11: In hypothyroidism secondary to Hashimoto's thyroiditis, can the combination of Chinese and Western medicine improve thyroid function more quickly?

Clinical Question 12: In Hashimoto's thyroiditis secondary to hypothyroidism, can the combination of Chinese and Western medicine improve the clinical symptoms (e.g., pharyngeal foreign body sensation, fatigue and weakness, mucous edema, etc.) and goiter of the patients?

①**Phlegm and blood stasis syndrome**: Jieyu Tongluo Xiaoying Decoction (Level of Evidence: C, Strongly Recommended) or Hua Tan Qu Yu Xiaoying Decoction (Level of Evidence: C, Strongly Recommended) or Xiaoying Sanjie Formula (Level of Evidence: C, Strongly Recommended).

EVIDENCE DESCRIPTION: Three RCTs [51-53] (n=192) assessed the clinical efficacy of Jieyu Tongluo Xiaoying Decoction [51], Hua Tan Qu Yu Xiaoying Decoction [52], and Xiaoying Sanjie Formula [71] in treating patients with hypothyroidism secondary to H

T. In the control group, levothyroxine was given to the control group, and in the observation group, Hua Tan Qu Yu Xiaoying Decoction and Xiaoying Sanjie Formula combined with levothyroxine were given to relieve depression and pass the channels to eliminate the galls, and the results showed that in terms of lowering the level of serum TPOAb antibody titer, the observation group's efficacy was significantly better than that of the control group (MD=-100.26, 95% CI[-100.26, 95% CI[-7.5]). 95% CI [-107.92,-96.60]). 2 RCTs [51,52] (n=134) were conducted to assess the clinical efficacy of Jieyu Tongluo Xiaoying Decoction and Hua Tan Qu Yu Xiaoying Decoction in treating patients with hypothyroidism secondary to HT, with levothyroxine given to the control group, and the observation group given levothyroxine. In the control group, levothyroxine was given to the control group, and in the observation group, Jieyu Tongluo Xiaoying Decoction and Hua Tan Qu Yu Xiaoying Decoction combined with levothyroxine were given to the observation group. 0.41,0.21]), serum FT4 (MD=-0.17, 95% CI [-1.37,1.04]), and serum TSH (MD=-1.75, 95% CI [-2.46,-1.05]). 1 RCT [52] (n=60) evaluated the Hua Tan Qu Yu Xiaoying Decoction for HT The clinical efficacy of patients with secondary hypothyroidism was assessed in the control group, who were given levothyroxine, and in the observation group, who were given Hua Tan Qu Yu Xiaoying Decoction combined with levothyroxine. The results showed that in terms of the improvement of clinical symptoms, the observation group's efficacy was significantly better than the control group's, and the Chinese medicine evidence score (MD =-1.20, 95% CI [-1.93,-0.47]).1 RCT [52] (n=60) assessed the clinical efficacy of Xiaoying Sanjie Formula in the treatment of patients with hypothyroidism secondary to HT. The control group was given levothyroxine, and the observation group was given Xiaoying Sanjie Formula in combination with levothyroxine, and the results showed that, in terms of the improvement of goiter, the efficacy of the observation group was significantly better than that of the control group (MD=-11.7, 95% CI [-11.7]). 95% CI [-11.18,-11.59]). No adverse events were reported in any of the studies.

②**Liver stagnation and spleen deficiency syndrome**: Bupleurum Liver-Soothing Powder or Xiaoyao power plus or minus (Level of Evidence: C, Strong Recommendation).

EVIDENCE DESCRIPTION: Six RCTs [54-59] (n=641) evaluating the clinical efficacy of Bupleurum Liver-Soothing Powder in the treatment of patients with hypothyroidism secondary to HT, with levothyroxine in the control group and Bupleurum Liver-Soothing Powder plus or minus in combination with levothyroxine in the observation group, showed that in The efficacy of the observation group was significantly better than that of the control group in lowering the serum TPOAb antibody titer level (MD =-6.38, 95% CI [-7.84,-4.93]). 4 RCTs [54,55,58,59] (n=318) were conducted to assess the clinical efficacy of Bupleurum Liver-Soothing Powder in the treatment of patients with hypothyroidism secondary to HT. The control group was given levothyroxine, and the observation group was given Bupleurum Liver-Soothing Powder plus or minus combined with levothyroxine. The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of the improvement of thyroid function and the improvement of clinical symptoms, and the serum FT3 (MD=0.77, 95% CI [0.62,0.92]), serum FT4 (MD=2.80, 95% CI [2.34,3.25]), serum TSH (MD=-1.18, 95% CI [-1.48,-0.88]), and Chinese medicine evidence score level (MD=-0.31, 95% CI [-0.43,-0.34]). 2 RCTs [58,59] (n=87) assessing Bupleurum Liver-Soothing Powder in the treatment of patients with hypothyroidism secondary to HT. The control group was given levothyroxine, and the observation group was given Bupleurum Liver-Soothing Powder plus or minus combined with levothyroxine. The results showed that the observation group had significantly better efficacy than the control group in terms of improvement of clinical symptoms, and that the neck discomfort (MD=-0.35 , 95% CI [-0.39,-0.30]), affective depression (MD=-0.44, 95% CI [-0.49,-0.39]), and fatigue (MD=-0.25, 95% CI [-0.30,-0.20]). No adverse events were reported in the study.

One RCT [60] (n=62) assessed the clinical efficacy of Xiaoyao power in the treatm ent of patients with hypothyroidism secondary to HT. The control group was given le vothyroxine, and the observation group was given Xiaoyao power plus or minus com bined with levothyroxine, and showed that in terms of lowering serum TPOAb antibo dy titer levels, improving thyroid function serum FT3, FT4, and TSH levels, and impr oving clinical symptoms, the efficacy of the observation group was significantly better than that of the control group in terms of serum TPOAb (MD=-57.58, 95% CI [-155. 48,-40.32]), serum FT3 (MD=0.08, 95% CI [-0.11,0.28]), serum FT4 (MD=0.07, 95% C I [-0.08,0.21]), serum TSH (MD=-1.36, 95% CI [-2.07,-0.64]), Chinese medicine evidenc e points (MD=-5.03, 95% CI [-6.47,-3.59]), neck discomfort (MD=-0.06, 95% CI [-0.75, -0.63]), and affective depression (MD=-0.51, 95% CI [-1.09,- 0.07]), and fatigue and m alaise (MD=-0.97, 95% CI [-1.58,-0.36]). No adverse events were reported in the stud y.

③**Spleen and kidney yang deficiency syndrome**: powder of ginsengporia and atractylodis macrocephalae combined with Jin Gui Shenqi Pill plus or minus (Level of Evidence: C, Strong Recommendation).

EVIDENCE DESCRIPTION: One RCT [61] (n=68) assessed the clinical efficacy of p owder of ginsengporia and atractylodis macrocephalae in the treatment of patients w ith hypothyroidism secondary to HT, with levothyroxine in the control group and po wder of ginsengporia and atractylodis macrocephalae in the observation group. In the control group, levothyroxine was given to the control group, and in the observation group, powder of ginsengporia and atractylodis macrocephalae plus or minus levothyr oxine was given to the observation group. The results showed that in terms of lower ing the titer level of serum TPOAb, improving the levels of thyroid function serum F T3, FT4, TSH, and improving the goiter and clinical symptoms, the observation group 's therapeutic efficacy was significantly better than the control group's, and the seru m TPOAb (MD = -67.39, 95% CI) was significantly higher than the control group. [-9 6.41,-40.17]), serum FT3 (MD=0.73, 95%CI[0.44,1.02]), serum FT4 (MD=0.28, 95%CI[0. 11,0.45]), serum TSH (MD=-1.39, 95%CI[-1.91,-0.87]), thyroid volume (MD=-3.12 95% CI[-4.60,-1.64]), neck discomfort (MD=-0.47, 95%CI[-0.79,-0.15]), irritability (MD=-0.53, 95%CI[-0.8,-0.26]), fatigue (MD=-0.53, 95%CI[-0.83,-0.23]), coldness and limb coldnes s (MD= -0.35, 95% CI [-0.63,-0.07]). No adverse events were reported in any of the studies.

Five RCTs [62-66] (n=372) assessed the clinical efficacy of Jin Gui Shenqi Pill plus or minus in the treatment of patients with hypothyroidism secondary to HT. The con trol group was given levothyroxine, and the observation group was given Jin Gui She nqi Pill plus or minus in combination with levothyroxine, which showed that in term s of lowering the level of serum TPOAb antibody titer, improving serum FT3, FT4, T SH levels, the efficacy of the observation group was significantly better than that of t he control group, with a decrease in serum TPOAb (MD=-17.44, 95% CI [-19.98,-14.9 7]), serum FT3 (MD=0.26, 95% CI [0.14,0.39]), serum FT4 (MD=2.27, 95% CI [1.92,2. 61]), serum TSH (MD=-1.34, 95% CI [-1.53,-1.14]). 1 RCT [64] (n=104) assessed the cl inical efficacy of Jin Gui Shenqi Pill plus and minus in treating patients with hypothy roidism secondary to HT, with levothyroxine in the control group and Jin Gui Shenqi Pill plus and minus combined with levothyroxine in the observation group. clinical s ymptoms, the observation group was significantly more effective than the control gro up in terms of anterior neck enlargement (MD=-0.31, 95% CI [-0.44,-0.18]), fatigue (MD=-0.47, 95% CI [-0.58,-0.36]), and chills (MD=-0.29, 95% CI [-0.38,-0.20]). No adv erse events were reported in any of the studies.

④**Heart kidney yang deficiency syndrome**: Zhenwu Tang's addition and subtra ction (Level of Evidence: C, Strongly Recommended).

EVIDENCE DESCRIPTION: 2 RCTs [67,68] (n=160) assessed the clinical efficacy of Zhenwu Tang plus or minus in the treatment of patients with hypothyroidism second ary to HT, with levothyroxine in the control group and Zhenwu Tang plus or minus

combined with levothyroxine in the observation group, and the results showed that t he observation group had significantly better efficacy than the control group in lower ing the level of antibody titer to serum TPOAb, and that serum TPOAb (MD=-58.88, 95% CI [-62.71,-55.06]). 4-item RCT [67-70] (n=268) assessed the clinical efficacy of Zhe nwu Tang plus or minus in treating patients with hypothyroidism secondary to HT, with the control group being given levothyroxine, and the observation group being gi ven Zhenwu Tang plus or minus in combination with levothyroxine. The results show ed that the efficacy of the observation group was significantly better than that of the control group in terms of improving serum FT3, FT4, and TSH levels, serum FT3 (MD=0.1, 95% CI [-0.05,0.25]), serum FT4 (MD=0.22, 95% CI [-0.03,0.47]), serum TS H (MD=-0.21, 95% CI [-0.34,-0.07]). 2.]). 2 RCTs [68,70] (n=120) assessed the clinical efficacy of Zhenwu Tang plus and minus in treating patients with hypothyroidism sec ondary to HT. The control group was given levothyroxine, and the observation group was given Zhenwu Tang plus and minus in combination with levothyroxine, and the results showed that, in terms of the improvement of clinical symptoms, the observat ion group's efficacy was significantly better than that of the control group, and the C hinese medicine evidence score (MD=-2.88. 95% CI [-3.37,-2.39]). 2 RCTs [69,70] (n=10 8) were conducted to evaluate the clinical efficacy of Zhenwu Tang plus or minus in the treatment of patients with hypothyroidism secondary to HT, with levothyroxine i n the control group and Zhenwu Tang plus or minus combined with levothyroxine in the observation group. The results showed that the observation group was significan tly more effective than the control group in improving clinical symptoms, fatigue (MD =-1.02, 95% CI [-1.43,-0.6]), and swelling of limbs (MD=-1.05, 95% CI [-1.39,-0.72]). 1 RCT [70] (n=60) assessed the clinical efficacy of the treatment of patients with hy pothyroidism secondary to HT with Zhenwu Tang plus or minus, in which levothyrox ine was given to the control group and Zhenwu Tang plus or minus combined with l evothyroxine was given to the observation group. Zhenwu Tang plus and minus comb ined with levothyroxine. The results showed that the efficacy of the observation grou p was significantly better than that of the control group in terms of improvement of clinical symptoms, chills and cold limbs (MD=-0.4, 95% CI [-1.13,-0.33]). No adverse events were reported in any of the studies.

Recommended proprietary Chinese medicines for hypothyroidism secondary to Ha shimoto's thyroiditis: Bailing capsule (level of evidence: D, weak recommendation) or prunella preparation (level of evidence: D, weak recommendation) or Jin Shui Bao ca psule (level of evidence: C, weak recommendation)

EVIDENCE DESCRIPTION: A meta-analysis [22] of 5 RCTs (n=276) evaluating the cl inical efficacy of Bailing capsule in the treatment of patients with hypothyroidism sec ondary to HT, with eugenol in the control group and Bailing capsule in combination with eugenol in the observation group, showed that the efficacy of the observation g roup was significantly better than the control group in terms of lowering serum TPO Ab antibody titer levels, with serum TPOAb antibody titers significantly higher than t he control group. control group, serum TPOAb (MD=-158.19, 95% CI [-222.44,-93.94]). A Meta-analysis [71] including 11 RCTs (n=1215) evaluating the clinical efficacy of pr unella preparation in the treatment of patients with hypothyroidism secondary to HT, with eugenol in the control group and prunella preparation combined with eugenol in the observation group, showed that the total treatment efficacy rate of the observ ation group was higher than that of the control group (RR=1.15, 95%CI=1.15, 95%CI =222.44,-93.94]). 1.15, 95% CI [1.09,1.21]), significantly reduced serum TPOAb titer (SMD=-0.91, 95% CI [-1.40,-0.41]), shrunk the left lobe of the thyroid gland (MD=-1.4 6, 95% CI [-1.82,-1.11]), the right lobe of the thyroid gland (MD=-1.45, 95% CI [-1.9 6,-0.94]), and the right lobe of the thyroid gland (MD= -1.45, 95% CI [-1.96,-0.94]). 1.96, -0.94]), and thyroid isthmus thickness (MD=-1.08, 95% CI [-1.20, -0.95]).

Three RCTs [72-74] (n=340) were conducted to assess the clinical efficacy of Jin S hui Bao capsule for the treatment of hypothyroidism secondary to HT. The control gr

oup was given eugenol, and the observation group was given Jin Shui Bao capsule in combination with eugenol, which showed that the efficacy of the observation group was significantly better than the control group in terms of lowering the titer of serum TPOAb antibody and improving thyroid function The results showed that the efficacy of the observation group was significantly better than that of the control group in reducing the titer of serum TPOAb and improving thyroid function, and the efficacy of the observation group was significantly better than that of the control group in decreasing the titer of serum TPOAb (MD=-133.57, 95% CI [-149.81,-117.33]), serum FT4 (MD=5.21, 95% CI [4.79,5.63]), serum FT3 (MD=-0.32, 95% CI [-0.44,-0.20]) and serum TSH (MD=-1.48, 95% CI [-1.64]). [-1.64,-1.32]). 1 RCT [75] (n=63) evaluated the clinical efficacy of Xiaoyao pill for the treatment of HT secondary to hypothyroidism Spleen and kidney yang deficiency syndrome, with eugenol in the control group, and Right-restoring pill combined in the observation group. The results showed that the efficacy of the observation group was significantly better than that of the control group in terms of lowering the serum TPOAb antibody titer and improving the clinical symptoms, serum TPOAb (MD=-61.20, 95% CI [-135.80, 13.40]), and Chinese medicine symptom score (MD=-1.48, 95% CI [-3.10, 0.14]). No adverse events were reported in any of the studies.

Traditional Chinese Medicine External Treatment

Evidence Description:

External application of traditional Chinese medicine: 1 RCT [76] (n=54) assessed the clinical efficacy of external application of traditional Chinese medicine in the treatment of HTQi stagnation an phlegm obstruction syndrome; the control group was given an iodine-restricted diet, and the observation group was given external application of Xiaoying Sanjie Formula (Xia Gu Cao, Lian Qiao, Jiang Han Xia, Chen Pi, Tu Bei Mu, Sanjie, Curcuma longa, Mudanpi, Frankincense, Myrrh, Salvia miltiorrhiza, Radix Paeoniae Alba, Radix Paeoniae Alba, Raw Oyster, Leeches, Ulmus, and Manganese Nitrate) combined with iodine-restricted diet, and the results showed that, in terms of the improvement of the clinical symptoms, the observation group's efficacy was significantly better than that of the control group (MD=-8.68, 95% CI[-9.73,-7.63]), and the points of the main symptom (anterior cervical enlargement, feeling of infarcts on the neck, depression, and suffocating discomfort) (MD=-5.40, 95% CI [-10.97,-0.07]), and secondary symptoms (low food intake, good taiyin, epigastric distension and nausea, loose stools, chest distension and pain) points (MD=-4.45, 95% CI [-5.81,-3.09]). No adverse events were reported in the study.

Two RCTs [77,78] (n=150) assessed the clinical efficacy of external application of traditional Chinese medicine for the treatment of hypothyroidism secondary to HT. The control group was given levothyroxine, and the observation group was given the Gall Elimination Formula [77] (astragalus, xiakoucao, cat's claw, chaihu, shangshu, zhujiao, curcuma longa, clove, and ice tablet), Gall Elimination Paste [78] (astragalus, chaihu, scutellariae baicalensis, xiakoucao, tulip, shanzui mushrooms, safflower, tiankui zi, ligustici, qinghaonian, angelica sinensis , cinnamon, chrysanthemum, honeysuckle, eucommia, curcuma longa, galbanum, neem, zhenbei, and mancozeb) in combination with levothyroxine, the results showed that, in terms of the improvement of clinical symptoms, the observation group's efficacy was significantly better than that of the control group (MD=-1.31, 95% CI [-1.59,-1.03]).One RCT [78] (n=60) assessed the clinical efficacy of the topical application of Chinese medicines for the treatment of hypothyroidism secondary to HT, the The control group was given levothyroxine, and the observation group was given gall-eliminating cream combined with levothyroxine. The results showed that in improving goiter, the efficacy of the observation group was significantly better than that of the control group in terms of thickness of the isthmus of the thyroid gland (MD=-1.40, 95% CI [-1.88,-0.92]), thickness of the left lobe of the thyroid gland (MD=-2.40, 95% CI [-3.19,-1.61]), and thyroid gland right lobe thickness

(MD=-4.0, 95% CI [-4.66,-3.34]). No adverse events were reported in any of the studies.

Acupuncture: 1 RCT [79] (n=60) assessed the clinical efficacy of Hand Yangming Meridian Penetration Therapy for the treatment of hypothyroidism secondary to HT. The control group was given levothyroxine, and the observation group was given Hand Yangming Meridian Penetration Therapy (acupoints) combined with levothyroxine, and the observation cycle was 16 weeks, and the results showed that, in terms of improvement of the quality of life, the observation group's efficacy was significantly better than the control group's, and the Brief Scale of Quality of Life in Thyroid Disease (ThyPRO-39) (MD=-2.83, 95% CI [-7.83,-2.17]), and Self-measurement of Health Scale (SF-36) (MD=6.39, 95% CI [0.77,13.55]). No adverse events were reported in the study.

One RCT [80] (n=60) assessed the clinical efficacy of acupuncture therapy for the treatment of HT secondary to hypothyroidism Liver depression and kidney deficiency syndrome, with levothyroxine in the control group and acupuncture therapy combined with levothyroxine in the observation group, with an observation period of 12 weeks The results showed that, in terms of the improvement of clinical symptoms, the observation group was significantly better than the control group, with a significant improvement of clinical symptoms in the anterior cervical region, and a significant improvement of clinical symptoms in the anterior cervical region. The results showed that in terms of improving clinical symptoms, the efficacy of the observation group was significantly better than that of the control group in terms of enlargement of the anterior cervical region (MD=-1.00, 95% CI[-1.59,-0.41]), fatigue (MD=-0.53, 95% CI [-1.01,-0.05]), dysphoria (MD=-0.49, 95% CI[-1.40,-0.48]), lumbar and knee soreness and tenderness (MD=-0.80, 95% CI[-1.30,-0.48]) and weakness of lumbar and knee (MD=-1.30,-1.30, -1.30, -1.30, -0.48]). -1.30,-0.30]). No adverse events were reported in the study.

One RCT [81] (n=60) evaluated the clinical efficacy of warm acupuncture therapy for the treatment of HT secondary to hypothyroidism Spleen and kidney yang deficiency syndrome. The control group was given levothyroxine, and the observation group was given warm acupuncture therapy in combination with levothyroxine, and the observation cycle was 12 weeks, and the results showed that, in terms of the improvement of clinical symptoms, the observation group's efficacy was significantly better than the control group, with anterior neck enlargement (MD=-0.36, 95% CI [-0.65,-0.07]), anterior neck pressure (MD=-0.33, 95% CI [-0.58,-0.08]), fatigue (MD=-0.36, 95% CI [-0.66,-0.06]), chills and cold limbs (MD=-0.40, 95% CI [-0.76,-0.06]), and a feeling of coldness and limb coldness (MD=-0.40, 95% CI [-0.76,-0.07]). 0.76,-0.04]), lumbar and knee tenderness (MD=-0.37, 95% CI [-0.69,-0.05]), and edema (MD=-0.36, 95% CI [-0.61,-0.11]). No adverse events were reported in the study.

CLINICAL QUESTION 14: What specific components and methods are included in lifestyle improvement for patients with Hashimoto's thyroiditis?

Evidence description: Beijing Expert Consensus 2021 on Combined Chinese and Western Medicine Diagnosis and Treatment of Hashimoto's Thyroiditis, Science Publishing House's “14th Five-Year Plan” Postgraduate Planning Textbook for General Higher Education, Combined Traditional Chinese and Western Medicine Thyroid Pathology, and Ye-Ben correspondence: New ideas on Chinese medicine diagnosis and treatment of thyroid disorders, 2021. New Thoughts on Diagnosis and Treatment of Thyroid Diseases”.

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ANNEX 2 GRADE Summary of evidence table

Clinical question 5. When Hashimoto's thyroiditis is normal, can integrated Chinese a nd Western medicine effectively reduce TPOAbtiters?

Clinical question 6. When Hashimoto thyroiditis is normal, can integrated Chinese an d Western

medicine better improve the patient's clinical symptoms (such as anterior cervical pr essure, foreign body sensation in the pharynx, etc.) and goiter?

Syndrome of liver-qi stagnation

Assessment of evidence							Number of patients		Effects		
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Bupleurum Liver-Soothing Powder+Selenium yeast	Selenium yeast	Relative (95% CI)	Absolute (95% CI)	Quality of evidence
Bupleurum Liver-Soothing Powder											
TPOAb											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	35	34	-	MD 16.2 lower (85.97 lower to 53.57 higher)	⊕⊕◯◯ Low[a,b]
TCM syndrome score											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	35	34	-	MD 6.34 lower (8.52 lower to 4.16 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference

Explanations

a. Included studies have large biases in randomization, assigned hiding, and blind methods

b. The sample size of the included study was too small

Liver depression heat syndrome

Assessment of evidence							Number of patients		Effects		
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Qinggan Sanjie Xiaoying Formula	Restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	Quality of evidence
TPOAb											
1	Randomized trials	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 5.58 lower (7.94 lower to 3.22 lower)	⊕⊕⊕◯ medium[a]
TCM syndrome score											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 5.58 lower (7.94 lower to 3.22 lower)	⊕⊕⊕◯ medium[a]
Thyroid volume											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 0.3 lower (2.68 lower to 2.08 higher)	⊕⊕⊕◯ medium[a]
heaviness in the lower limbs											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 4 lower (4.97 lower to 3.03 lower)	⊕⊕⊕◯ medium[a]
HAMA anxieties											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 4 lower (5.53 lower to 2.47 lower)	⊕⊕⊕◯ medium[a]
HAMD depressed											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 2.5 lower (4.07 lower to 0.93 lower)	⊕⊕⊕◯ medium[a]
PSQI score											

1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 4.14 lower (5.38 lower to 2.91 lower)	⊕⊕⊕◯ medium[a]

FSS score

1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	46	44	-	MD 6.19 lower (10.85 lower to 1.53 lower)	⊕⊕⊕◯ medium[a]

CI: Confidence interval; MD: Mean difference
Explanations
b. No blinding of outcome assessors

Liver depression and phlegm coagulation syndrome

Assessment of evidence							Number of patients		Effects		
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Pinelliae and magnoliae officinalis decoction +restricted-diet iodine	restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	Quality of evidence

Pinelliae and magnoliae officinalis decoction

TPOAb

3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	109	108	-	MD 58.3 lower (72.6 lower to 44 lower)	⊕⊕⊕◯ medium[a]

TCM syndrome score

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	79	78	-	MD 6.23 lower (7.27 lower to 5.18 lower)	⊕⊕◯◯ Low[a,b]

Thyroid volume

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	32	31	-	MD 2.04 lower (3.97 lower to 0.11 lower)	⊕⊕◯◯ Low[a,b]

Anterior neck enlargement

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Pinelliae and magnoliae officinalis decoction +restricted-diet iodine	restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	
3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	109	108	-	MD 1.3 lower (1.79 lower to 0.8 lower)	⊕⊕⊕◯ medium[a]

Foreign body sensation in the throat

3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	109	108	-	MD 1.15 lower (1.49 lower to 0.81 lower)	⊕⊕⊕◯ medium[a]

depressed

3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	109	108	-	MD 1.39 lower (1.85 lower to 0.93 lower)	⊕⊕⊕◯ medium[a]

Liver stagnation and spleen deficiency syndrome

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Liver soothing and spleen strengthening	restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	

Modified Xiaochaihu Decoction and Danggui Shaoyao Powder+ Selenium yeast VS Selenium yeast

TPOAb

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	32	31	-	MD 40.59 lower (57.53 lower to 23.65 lower)	⊕⊕◯◯ Low[a,b]

TCM syndrome score

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Liver soothing and spleen strengthening	restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	32	31	-	MD 4.45 lower (7.51 lower to 1.39 lower)	⊕⊕◯◯ Low[a,b]
Liver soothing and spleen strengthening											
TPOAb											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	60	60	-	MD 52.91 lower (69.16 lower to 36.66 lower)	⊕⊕◯◯ Low[a,b]
TCM syndrome score											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	60	60	-	MD 8.53 lower (9.53 lower to 7.53 lower)	⊕⊕◯◯ Low[a,b]
Anterior neck enlargement											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	60	60	-	MD 0.81 lower (1.06 lower to 0.57 lower)	⊕⊕◯◯ Low[a,b]
Swelling sensation in the front of the neck											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	60	60	-	MD 0.82 lower (1.13 lower to 0.51 lower)	⊕⊕◯◯ Low[a,b]
Irritability											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	60	60	-	MD 0.86 lower (1.13 lower to 0.59 lower)	⊕⊕◯◯ Low[a,b]
tiredness and fatigue											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	60	60	-	MD 0.32 lower (0.48 lower to 0.15 lower)	⊕⊕◯◯ Low[a,b]

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Liver soothing and spleen strengthening	restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	
Have poor appetite and a sluggish body											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.93 lower (1.74 lower to 0.12 lower)	⊕⊕◯◯ Lower[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Proprietary Chinese medicines

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Xiaoyao Pills	Restricted-diet iodine	Relative (95% CI)	Absolute (95% CI)	
TPOAb											
1	RCT	Severe[a]	Not serious	Not serious	Very serious	No	40	40	-	MD 198.06 lower (275.84 lower to 120.28 lower)	⊕◯◯◯ Extremely low[a]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies

Clinical Question 7: In Hashimoto's thyroiditis secondary to thyrotoxicosis, can the combination of Chinese and Western medicine effectively reduce the TPOAb titer?
Clinical Question 8: In Hashimoto's thyroiditis secondary to thyrotoxicosis, can the combination of Chinese and Western medicine improve thyroid function more quickly?
Clinical Question 9: In Hashimoto's thyroiditis secondary to thyrotoxicosis, can the combination of Chinese and Western medicine improve the clinical symptoms (such as pressure in the front of the neck, foreign body sensation in the pharynx, panic attacks and hand tremors) and goiter of the patients?

Liver depression transforming into fire syndrome

Assessment of evidence	Number of patients	Effects	Quality of evidence

Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Danzhi Xiaoyao Powder+Methimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	
Danzhi Xiaoyao Powder											
TPOAb											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	29	26	-	MD 159 lower (221.69 lower to 96.31 lower)	⊕⊕◯◯ Low[a,b]
FT3											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	59	56	-	MD 1.42 lower (2.14 lower to 0.7 lower)	⊕⊕◯◯ Low[a,b]
FT4											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	59	56	-	MD 4.64 lower (5.61 lower to 3.67 lower)	⊕⊕◯◯ Low[a,b]
TSH											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	59	56	-	MD 0.05 higher (0.04 lower to 0.13 higher)	⊕⊕◯◯ Low[a,b]
TCM syndrome score											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	29	26	-	MD 3.17 lower (5.27 lower to 1.07 lower)	⊕⊕◯◯ Low[a,b]
Anterior neck enlargement											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	29	26	-	MD 1.17 lower (2.17 lower to 0.17 lower)	⊕⊕◯◯ Low[a,b]
Tachycardia											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	29	26	-	MD 0.31 lower (1.11 lower to 0.49 higher)	⊕⊕◯◯ Low[a,b]

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Danzhi Xiaoyao Powder+Methimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	
Hyperhidrosis											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	29	26	-	MD 1.08 lower (1.88 lower to 0.28 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Heart and liver heat syndrome

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Zhizi qinggan decoction+Methimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	
Zhizi qinggan decoction											
FT3											
4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	190	190	-	MD 0.58 lower (0.75 lower to 0.4 lower)	⊕⊕⊕◯ medium[a]
FT4											
4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	190	190	-	MD 0.56 lower (0.68 lower to 0.45 lower)	⊕⊕⊕◯ medium[a]
TSH											

4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	190	190	-	MD 0.08 higher (0.04 higher to 0.11 higher)	⊕⊕⊕◯ medium[a]

TCM syndrome score

1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	60	60	-	MD 1.1 lower (1.45 lower to 0.75 lower)	⊕⊕⊕◯ medium[a]

Thyroid volume

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	40	40	-	MD 0.18 lower (0.29 lower to 0.07 lower)	⊕⊕◯◯ Low[a, b]

Heat in the hands and feet

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	40	40	-	MD 0.21 lower (0.33 lower to 0.09 lower)	⊕⊕◯◯ Low[a, b]

tremor of the fingers

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	40	40	-	MD 0.25 lower (0.37 lower to 0.13 lower)	⊕⊕◯◯ Low[a, b]

Qingxin Xiegan method (Qinghuo Jiedu Xiaoying methimazole VS methimazole)

TPOAb

2	RCT	Severe[a]	Not serious	Not serious	Not serious	No	75	75	-	MD 174.11 lower (205.68 lower to 142.53 lower)	⊕⊕⊕◯ medium[a]

FT3

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	50	51	-	MD 0.08 lower (0.63 lower to 0.48 higher)	⊕⊕◯◯ Low[a, b]

FT4

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	50	51	-	MD 1.46 lower (2.08 lower to 0.84 lower)	⊕⊕◯◯ Low[a, b]

Isthmus of the thyroid gland

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	51	50	-	MD 0.41 lower (0.84 lower to 0.03 higher)	⊕⊕◯◯ Low[a, b]

Anterior neck pressure

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	75	75	-	MD 0.57 lower (0.92 lower to 0.21 lower)	⊕⊕◯◯ Low[a, b]

Tachycardia

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	75	75	-	MD 1.5 lower (1.82 lower to 1.19 lower)	⊕⊕◯◯ Low[a, b]

Afraid of heat and sweating

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	75	75	-	MD 1.43 lower (1.81 lower to 1.05 lower)	⊕⊕◯◯ Low[a, b]

Dry mouth and bitter taste

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	75	75	-	MD 1.33 lower (1.72 lower to 0.94 lower)	⊕⊕◯◯ Low[a, b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Yin deficiency fire exuberant card

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Danggui liuhuang soup+Methimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	

Danggui liuhuang soup

FT3

11	RCT	Severe[a]	Not serious	Not serious	Not serious	No	498	498	-	MD 2.69 lower (2.79 lower to 2.59 lower)	⊕⊕⊕◯ medium[a]

FT4

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Danggui liuhuang soup+Methimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	
11	RCT	Severe[a]	Not serious	Not serious	Not serious	No	498	498	-	MD 6.4 lower (6.77 lower to 6.02 lower)	⊕⊕⊕◯ medium[a]
TT3											
5	RCT	Severe[a]	Not serious	Not serious	Not serious	No	187	187	-	MD 1.54 lower (1.62 lower to 1.47 lower)	⊕⊕⊕◯ medium[a]
TT4											
5	RCT	Severe[a]	Not serious	Not serious	Not serious	No	187	187	-	MD 6 lower (7.33 lower to 4.67 lower)	⊕⊕⊕◯ medium[a]
TSH											
11	RCT	Severe[a]	Not serious	Not serious	Not serious	No	498	498	-	MD 0.38 higher (0.37 higher to 0.4 higher)	⊕⊕⊕◯ medium[a]
TCM syndrome score											
7	RCT	Severe[a]	Not serious	Not serious	Not serious	No	338	338	-	MD 2.61 lower (2.69 lower to 2.54 lower)	⊕⊕⊕◯ medium[a]
Quality of life											
2	RCT	Severe[a]	Not serious	Not serious	Not serious	No	100	100	-	MD 11.56 higher (10.04 higher to 13.08 higher)	⊕⊕⊕◯ medium[a]
Anterior neck enlargement											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	28	28	-	MD 1.13 lower (1.23 lower to 1.03 lower)	⊕⊕◯◯ Low[a,b]

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Danggui liuhuang soup+Methimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	
Irritability											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	28	28	-	MD 1.06 lower (1.14 lower to 0.98 lower)	⊕⊕◯◯ Low[a,b]
Heat in the hands and feet											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	28	28	-	MD 1.13 lower (1.24 lower to 1.02 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Qi and Yin deficiency syndrome

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Tianwang buxin minipills+Methimazole VSMethimazole	Methimazole	Relative (95% CI)	Absolute (95% CI)	
Tianwang buxin minipills											
FT3											
4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	127	127	-	MD 2.8 lower (3.06 lower to 2.54 lower)	⊕⊕⊕◯ medium[a]
FT4											
4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	127	127	-	MD 1.1 lower (1.52 lower to 0.68 lower)	⊕⊕⊕◯ medium[a]
TSH											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Tianwang buxin minipills+Methimazole	VSMethimazole	Relative (95% CI)	Absolute (95% CI)	
4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	127	127	-	MD 0.35 higher (0.23 higher 到 0.48 higher)	⊕⊕⊕◯ medium[a]

TCM syndrome score

3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	97	97	-	MD 19.37 lower (20.62 lower to 18.12 lower)	⊕⊕⊕◯ medium[a]

Tachycardia

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.08 lower (0.6 lower to 0.44 higher)	⊕⊕◯◯ Low[a,b]

Tremor of the fingers

1	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	30	30	-	MD 0.85 lower (1.27 lower to 0.43 lower)	⊕⊕◯◯ Low[a,c]

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Buzhong yiqi decoction+ Selenium yeast	Selenium yeast	Relative (95% CI)	Absolute (95% CI)	

Buzhong yiqi decoction

TPOAb

3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	85	85	-	MD 55.46 lower (57.78 lower to 53.14 lower)	⊕⊕⊕◯ medium[a]

FT3

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Buzhong yiqi decoction+ Selenium yeast	Selenium yeast	Relative (95% CI)	Absolute (95% CI)	
2	RCT	Severe[a]	Not serious	Not serious	Very serious[b]	No	50	50	-	MD 0.14 lower (0.39 lower to 0.11 higher)	⊕◯◯◯ Extremely low[a,b]
FT4											
2	RCT	Severe[a]	Not serious	Not serious	Very serious[b]	No	50	50	-	MD 0.48 lower (0.97 lower to 0.01 higher)	⊕◯◯◯ Extremely low[a,b]
TSH											
1	RCT	Severe[a]	Not serious	Not serious	Very serious[c]	No	20	20	-	MD 1.86 higher (0.92 higher to 2.8 higher)	⊕◯◯◯ Extremely low[a,c]
TCM syndrome score											
1	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	30	30	-	MD 5.43 lower (7.56 lower to 3.3 lower)	⊕⊕◯◯ Low[a,c]
Isthmus of the thyroid gland											
1	RCT	Severe[c]	Not serious	Not serious	Severe[c]	No	30	30	-	MD 0.8 lower (1 lower to 0.6 lower)	⊕⊕◯◯ Low[c]
Anterior neck enlargement											
1	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	20	20	-	MD 1.03 lower (1.27 lower to 0.79 lower)	⊕⊕◯◯ Low[a,c]
Pharyngeal dysphagia											
1	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	20	20	-	MD 0.96 lower (1.22 lower to 0.7 lower)	⊕⊕◯◯ Low[a,c]
Sleeplessness and nightmares											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Buzhong yiqi decoction+ Selenium yeast	Selenium yeast	Relative (95% CI)	Absolute (95% CI)	
1	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	20	20	-	MD 0.85 lower (0.99 lower to 0.71 lower)	⊕⊕◯◯ Low[a,c]
Disordered in body and mind											
1	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	20	20	-	MD 1.07 lower (1.25 lower to 0.89 lower)	⊕⊕◯◯ Low[a,c]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small、wide confidence interval
c. Sample size of included studies too small

Clinical Question 10: Can a combination of Chinese and Western medicine effectively reduce TPOAb titers in hypothyroidism secondary to Hashimoto's thyroiditis?
Clinical Question 11: Can combined Chinese and Western medicine treatments improve thyroid function faster in hypothyroidism secondary to Hashimoto's thyroiditis?
Clinical Question 12: Can the combination of Chinese and Western medicine improve the clinical symptoms (e.g. foreign body sensation in the throat, fatigue and lack of strength, mucous edema, etc.) and goiter of patients with hypothyroidism secondary to Hashimoto's thyroiditis?

Phlegm and blood stasis syndrome

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Liqi Huatan Xiaoying method + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
TPOAb											
3	RCT	Severe[a]	Not serious	Not serious	Not serious	No	96	96	-	MD 100.47 lower (108.13 lower to 92.81 lower)	⊕⊕⊕◯ medium[a]

FT3（Jieyu Tongluo Xiaoying Decoction/Huatan Quyu Xiaoying Decoction+ eugenolVS eugenol）

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Liqi Huatan Xiaoying method + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	66	66	-	MD 0.1 lower (0.41 lower to 0.21 higher)	⊕⊕◯◯ Low[a,b]

FT4（Jieyu Tongluo Xiaoying Decoction/Huatan Quyu Xiaoying Decoction+ eugenolVS eugenol）

2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	66	66	-	MD 0.17 lower (1.37 lower to 1.04 higher)	⊕⊕◯◯ Low[a,b]

TSH（Jieyu Tongluo Xiaoying Decoction/Huatan Quyu Xiaoying Decoction+ eugenolVS eugenol）

2	RCT	Severe[a]	Severe[c]	Not serious	Severe[b]	No	66	66	-	MD 1.75 lower (2.46 lower to 1.05 lower)	⊕⊕◯◯ Low[a,c]

TCM syndrome score（Huatan Quyu Xiaoying Decoction+ eugenolVS eugenol）

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 1.2 lower (1.93 lower to 0.47 lower)	⊕⊕◯◯ Low[a,b]

Thyroid volume（Xiaoying Sanjie Prescription）

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 11.7 lower (11.81 lower to 11.59 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small
c. I^2>50%

Liver stagnation and spleen deficiency syndrome

Assessment of evidence	Number of patients	Effects	Quality of evidence

Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Buplerum Liver-Soothing Powder+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
Bupleurum Liver-Soothing Powder											
TPOAb											
6	RCT	Severe[a]	Not serious	Not serious	Not serious	No	221	220	-	MD 6.38 lower (7.84 lower to 4.93 lower)	⊕⊕⊕◯ medium[a]
TGAb											
6	RCT	Severe[a]	Not serious	Not serious	Not serious	No	221	220	-	MD 4.87 lower (6.09 lower to 3.66 lower)	⊕⊕⊕◯ medium[a]
FT3											
4	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	159	159	-	MD 0.77 higher (0.62 higher to 0.92 higher)	⊕⊕◯◯ Low[a,b]
FT4											
4	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	159	159	-	MD 2.8 higher (2.34 higher to 3.25 higher)	⊕⊕◯◯ Low[a,b]
TSH											
4	RCT	Severe[a]	Not serious	Not serious	Not serious	No	159	159	-	MD 1.18 lower (1.48 lower to 0.88 lower)	⊕⊕⊕◯ medium[a]
TCM syndrome score											
4	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	159	159	-	MD 0.39 lower (0.43 lower to 0.34 lower)	⊕⊕◯◯ Low[a,b]
Neck discomfort											
2	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	87	87	-	MD 0.35 lower (0.39 lower to 0.3 lower)	⊕⊕◯◯ Low[a,b]
depressed											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Buplerum Liver-Soothing Powder+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
2	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	87	87	-	MD 0.44 lower (0.49 lower to 0.39 lower)	⊕⊕◯◯ Low[a,b]
Fatigue											
2	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	87	87	-	MD 0.25 lower (0.3 lower to 0.2 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. I2>50%

Liver stagnation and spleen deficiency syndrome

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Xiaoyao powder+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
Xiaoyao powder											
TPOAb											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	31	31	-	MD 57.58 lower (155.48 lower to 40.32 higher)	⊕⊕◯◯ Low[a,b]
FT3											
2	RCT	Severe[a]	Not serious	Not serious	Severe[c]	No	81	81	-	MD 0.08 higher (0.11 lower to 0.28 higher)	⊕⊕◯◯ Low[a,c]
FT4											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Xiaoyaopowder+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
2	RCT	Sev ere[d]	Not serious	Not serious	Seve re[c]	No	81	81	-	MD 0.07 higher (0.08 lower to 0.21 higher)	⊕⊕◯◯ Low[c,d]
TSH											
2	RCT	Sev ere[a]	Seve re[d]	Not serious	Not serious	No	81	81	-	MD 1.36 lower (2.07 lower to 0.64 lower)	⊕⊕◯◯ Low[a,d]
TCM syndrome score											
1	RCT	Sev ere[a]	Not serious	Not serious	Seve re[b]	No	31	31	-	MD 5.03 lower (6.47 lower to 3.59 lower)	⊕⊕◯◯ Low[a,b]
Neck discomfort											
1	RCT	Sev ere[a]	Not serious	Not serious	Very serious[c]	No	31	31	-	MD 0.06 lower (0.75 lower to 0.63 higher)	⊕◯◯◯ Extremely low[a,c]
depressed											
1	RCT	Sev ere[a]	Not serious	Not serious	Seve re[b]	No	31	31	-	MD 0.51 lower (1.09 lower to 0.07 higher)	⊕⊕◯◯ Low[a,b]
Fatigue and lack of strength											
1	RCT	Sev ere[a]	Not serious	Not serious	Seve re[b]	No	31	31	-	MD 0.97 lower (1.58 lower to 0.36 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small
c. Sample size of included studies too small、wide confidence interval
d. I2>50%

Deficiency of yang in the spleen and kidney

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Powder of ginsengporia and atractylodis macrocephalae+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
Powder of ginsengporia and atractylodis macrocephalae											
TPOAb											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 67.39 lower (94.61 lower to 40.17 lower)	⊕⊕◯◯ Low[a,b]
FT3											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 0.73 higher (0.44 higher to 1.02 higher)	⊕⊕◯◯ Low[a,b]
FT4											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 0.28 higher (0.11 higher to 0.45 higher)	⊕⊕◯◯ Low[a,b]
TSH											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 1.39 lower (1.91 lower to 0.87 lower)	⊕⊕◯◯ Low[a,b]
Thyroid volume											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 3.12 lower (4.6 lower to 1.64 lower)	⊕⊕◯◯ Low[a,b]
Neck discomfort											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 0.47 lower (0.79 lower to 0.15 lower)	⊕⊕◯◯ Low[a,b]
Irritable											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Powder of gins engporia and atractylodis macrocephalae+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 0.53 lower (0.8 lower to 0.26 lower)	⊕⊕◯◯ Low[a,b]

Fatigue and lack of strength

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 0.53 lower (0.83 lower to 0.23 lower)	⊕⊕◯◯ Low[a,b]

Cold fear and cold limbs

1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	34	34	-	MD 0.35 lower (0.63 lower to 0.07 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	JinKuiShenQiWan+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
JinKuiShenQiWan											
TPOAb											
5	RCT	Severe[a]	Not serious	Not serious	Not serious	No	188	184	-	MD 17.47 lower (19.98 lower to 14.97 lower)	⊕⊕⊕◯ medium[a]
FT3											
5	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	188	184	-	MD 0.26 higher (0.14 higher to 0.39 higher)	⊕⊕◯◯ Low[a,b]
FT4											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	JinKuiShenQiWan+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
5	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	188	184	-	MD 2.27 higher (1.92 higher to 2.61 higher)	⊕⊕◯◯ Low[a,b]
TSH											
5	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	188	184	-	MD 1.34 lower (1.53 lower to 1.14 lower)	⊕⊕◯◯ Low[a,b]
Anterior neck enlargement											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	52	52	-	MD 0.31 lower (0.44 lower to 0.18 lower)	⊕⊕⊕◯ medium[a]
Fatigue											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	52	52	-	MD 0.47 lower (0.58 lower to 0.36 lower)	⊕⊕⊕◯ medium[a]
Cold fear and cold limbs											
1	RCT	Severe[a]	Not serious	Not serious	Not serious	No	52	52	-	MD 0.29 lower (0.38 lower to 0.2 lower)	⊕⊕⊕◯ medium[a]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. I2>50%

Heart kidney yang deficiency syndrome

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Zhenwu soup + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Zhenwu soup + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
Zhenwu soup											
TPOAb											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	80	80	-	MD 58.88 lower (62.71 lower to 55.06 lower)	⊕⊕◯◯ Low[a,b]
FT3											
4	RCT	Severe[a]	Severe[c]	Not serious	Not serious	No	134	134	-	MD 0.1 higher (0.05 lower to 0.25 higher)	⊕⊕◯◯ Low[a,c]
FT4											
4	RCT	Severe[a]	Severe[c]	Not serious	Not serious	No	134	134	-	MD 0.22 higher (0.03 lower to 0.47 higher)	⊕⊕◯◯ Low[a,c]
TSH											
4	RCT	Severe[a]	Severe[c]	Not serious	Not serious	No	134	134	-	MD 0.21 lower (0.34 lower to 0.07 lower)	⊕⊕◯◯ Low[a,c]
TCM syndrome score											
2	RCT	Severe[a]	Not serious	Not serious	Not serious	No	60	60	-	MD 2.88 lower (3.37 lower to 2.39 lower)	⊕⊕⊕◯ Moderate[a]
Fatigue											
2	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	54	54	-	MD 1.02 lower (1.43 lower to 0.6 lower)	⊕⊕◯◯ Low[a,b]
Body swelling											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Zhenwu soup + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
2	RCT	Severe[a]	Severe[c]	Not serious	Severe[b]	No	54	54	-	MD 1.05 lower (1.39 lower to 0.72 lower)	⊕◯◯◯ Very low[a,b,c]

Cold fear and cold limbs

1	RCT	Severe[a]	Not serious	Not serious	Severe[d]	No	30	30	-	MD 0.4 lower (1.13 lower to 0.33 higher)	⊕⊕◯◯ Low[a,d]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small
c. I^2>50%
d. Sample size of included studies too small、wide confidence interval

Prepared prescription

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	JinShuiBaoJiaoNang + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
TPOAb											
3	RCT	Severe[a]	Severe[b]	Not serious[b]	Not serious	No	170	170	-	MD 133.57 lower (149.81 lower to 117.33 lower)	⊕⊕◯◯ Low[a,b]
FT3											
3	RCT	Severe[a]	Severe[b]	Not serious[b]	Not serious	No	170	170	-	MD 0.32 lower (0.44 lower to 0.2 lower)	⊕⊕◯◯ Low[a,b]
FT4											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	JinShuiBaoJiaoNang + eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
3	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	170	170	-	MD 5.21 higher (4.79 higher to 5.63 higher)	⊕⊕◯◯ Low[a,b]
TSH											
3	RCT	Severe[a]	Severe[b]	Not serious	Not serious	No	170	170	-	MD 1.48 lower (1.64 lower to 1.32 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. I2>50

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Right-restoring pill+ eugenol	eugenol	Relative (95% CI)	Absolute (95% CI)	
TPOAb											
1	RCT	Severe[a]	Not serious	Not serious	Very serious[b]	No	32	31	-	MD 61.2 lower (135.8 lower to 13.4 higher)	⊕◯◯◯ Extremely low[a,b]
TCM syndrome score											
1	RCT	Severe[a]	Not serious	Not serious	Very serious[b]	No	32	31	-	MD 1.48 lower (3.1 lower to 0.14 higher)	⊕◯◯◯ Extremely low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies

b. Sample size of included studies too small、wide confidence interval

Clinical Question 13: Can external Chinese medicine treatments improve clinical symptoms (e.g., anterior neck pressure, pharyngeal foreign body sensation) and goiter in patients with Hashimoto's thyroiditis?

Assessment of evidence							Number of patients		Effects		
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Apply herbal medicine externally	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	Quality of evidence
Hashimoto's thyroiditis hypothyroidism（Apply herbal medicine externally+ eugenolVS eugenol）											
TCM syndrome score											
2	RCT	Severe[a]	Not serious	Not serious	Not serious	No	75	75	-	MD 1.31 lower (1.59 lower to 1.03 lower)	⊕⊕⊕◯ medium[a]
Thickness of the isthmus											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 1.4 lower (1.88 lower to 0.92 lower)	⊕⊕◯◯ Low[a,b]
Thickness of the left thyroid lobe											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 2.4 lower (3.19 lower to 1.61 lower)	⊕⊕◯◯ Low[a,b]
Thickness of the right thyroid lobe											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 4 lower (4.66 lower to 3.34 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Assessment of evidence	Number of patients	Effects	Quality of

Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Apply herbal medicine externally	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
Hashimoto's thyroiditis with normal thyroid function（Syndrome of stagnant qi and phlegm obstruction）（Apply herbal medicine externallyVSrestricted-diet iodine）											
TCM syndrome score											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	28	26	-	MD 8.68 lower (9.73 lower to 7.63 lower)	⊕⊕◯◯ Low[a,b]
Syndrome of stagnant qi and phlegm obstruction 主症积分											
1	RCT	Severe[a]	Not serious	Not serious	Very serious[c]	No	28	26	-	MD 5.45 lower (10.97 lower to 0.07 higher)	⊕◯◯◯ Extremely low[a,c]
Syndrome of stagnant qi and phlegm obstruction 次症积分											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	28	26	-	MD 4.45 lower (5.81 lower to 3.09 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small
c. Sample size of included studies too small、wide confidence interval

Clinical Question 13: Can external Chinese medicine treatments improve clinical symptoms (e.g., anterior neck pressure, pharyngeal foreign body sensation) and goiter in patients with Hashimoto's thyroiditis?

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Acupuncture therapy	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
Hashimoto's thyroiditis hypothyroidism（Acupuncture therapy+ eugenolVS eugenol）											
Thyroid Disease Quality of Life Rating Scale（TPRo39）											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Acupuncture therapy	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
1	RCT	Not serious	Not serious	Not serious	Severe[a]	No	30	30	-	MD 2.83 lower (7.83 lower to 2.17 higher)	⊕⊕⊕◯ medium[a]
Health Self-Measurement ScaleSF-36											
1	RCT	Not serious	Not serious	Not serious	Severe[a]	No	30	30	-	MD 6.39 higher (0.77 lower to 13.55 higher)	⊕⊕⊕◯ medium[a]

CI: Confidence interval; MD: Mean difference
Explanations
b. Sample size of included studies too small

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Acupuncture therapy	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
Hashimoto's thyroiditis hypothyroidism（Depletion of the liver and deficiency of the kidneys）（Acupuncture therapy+ eugenolVS eugenol）											
Anterior neck enlargement											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 1 lower (1.59 lower to 0.41 lower)	⊕⊕◯◯ Low[a,b]
Fatigue											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.53 lower (1.01 lower to 0.05 lower)	⊕⊕◯◯ Low[a,b]
Disordered in body and mind											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.94 lower (1.4 lower to 0.48 lower)	⊕⊕◯◯ Low[a,b]

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Acupuncture therapy	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
Pain and weakness in the lower back and knees											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.8 lower (1.3 lower to 0.3 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
a. Large bias in randomization, allocation concealment and blinding in included studies
b. Sample size of included studies too small

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Acupuncture therapy	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
Hashimoto's thyroiditis hypothyroidism（Deficiency of yang in the spleen and kidney ）moxibustion with needle+ eugenol											
Swelling of the thyroid gland											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.36 lower (0.65 lower to 0.07 lower)	⊕⊕◯◯ Low[a,b]
Anterior neck pressure											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.33 lower (0.58 lower to 0.08 lower)	⊕⊕◯◯ Low[a,b]
Fatigue											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.36 lower (0.66 lower to 0.06 lower)	⊕⊕◯◯ Low[a,b]
Pain and weakness in the lower back and knees											

Assessment of evidence							Number of patients		Effects		Quality of evidence
Number of studies	Research Design	Bias risk	Inconsistency	Indirectness	precision	Other Considerations [Caution]	Acupuncture therapy	Basic Western Medicine	Relative (95% CI)	Absolute (95% CI)	
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.37 lower (0.69 lower to 0.05 lower)	⊕⊕◯◯ Low[a,b]
Cold fear and cold limbs											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.4 lower (0.76 lower to 0.04 lower)	⊕⊕◯◯ Low[a,b]
Swollen											
1	RCT	Severe[a]	Not serious	Not serious	Severe[b]	No	30	30	-	MD 0.36 lower (0.61 lower to 0.11 lower)	⊕⊕◯◯ Low[a,b]

CI: Confidence interval; MD: Mean difference
Explanations
b. Sample size of included studies too small