and a previous diagnosis of autoimmune thyroid disease, and were under proper treatment when this study was performed. The diagnosis of thyroid disease preceded the diagnosis of sarcoidosis in all patients but one, in whom hypothyroidism due to Hashimoto’s thyroiditis was diagnosed simultaneously.

We did not observe any case of clinical or subclinical AITD in the control group. The relationship between gender and thyroid disorders is well established, thus we stratified the two study groups according to gender.

**Female subjects (Table 2)**

Thyroid disease was present in 17 female sarcoidosis patients; 10 had autoimmune (Hashimoto’s) thyroiditis with hypothyroidism, 2 had multinodular goiter, 3 had solitary thyroid nodule, 1 had Graves’ disease and 1 had papillary follicular thyroid cancer. Thyroidectomy was performed in the patient with a history of thyroid cancer and the 3 patients with a history of multinodular goiter before this study was performed. We did not observe any new case of subclinical hypo- and/or hyperthyroidism in either of the groups.

**Laboratory measurements**

There were no significant differences in TSH, FT4 and T3 levels in female patients compared to healthy volunteers (Table 2). Clinical AITD was present in 11 patients; 10 patients had Hashimoto’s thyroiditis with hypothyroidism and 1 had Graves’ disease. The TSH, FT4, AbTg, TPOAbs and TRAb values of the patients with Hashimoto’s thyroiditis are 1.36±0.67, 1.30±0.27, 309.5±649.47, 264.5±324.59 and 1.91±1.33, respectively. As for the patient with Graves’, the TSH, FT4, AbTg, TPOAbs and TRAb values were 0.374, 1.17, 33.51, 69.66 and 6.17, respectively.

Female sarcoidosis patients exhibited higher incidence of serological autoimmunity (defined as the presence of increased titers of at least one thyroid antibody) vs controls (68.8% vs 22.03%, p<0.001). TRAbs levels were significantly elevated in female sarcoidosis patients compared to healthy volunteers (p=0.001) (Table 2) with 40% of the patients having positive TRAbs versus 0% of the controls (p<0.001). Interestingly, of the 18 female patients presenting positive TRAbs titers, only 1 suffered from Graves’ disease and 7 had Hashimoto’s thyroiditis with hypothyroidism. The TSH, FT4, TGAbs, TPOAbs and TRAbs values of TRAb positive patients are 1.63±1.94, 1.29±0.38, 143.53±501, 156.82±272.86 and 3.52±3.12, respectively. TPOAbs and TGAbs were higher in sarcoidosis patients; however, this did not reach statistical significance (Table 2). The frequency of positive TPOAbs was significantly increased in sarcoidosis vs healthy subjects (28.8% vs 11.86%, respectively, p=0.029). Of the 13 patients with elevated TPOAbs, 7 had Hashimoto’s thyroiditis with hypothyroidism and 1 had Graves’ disease. TGAbs were not significantly different when patients were compared with controls (6.6% vs 5.08%, respectively, p>0.05).

Serum ACE levels were not different between patients with and without serological autoimmunity (46.94±17.74 vs 42.28±18.30, respectively).

**Ultrasonography**

A higher percentage of female sarcoidosis patients presented with hypoechoic and dyshomogeneous echogenecity pattern of the thyroid gland when compared with controls (75.6% vs 28.8%, respectively,