



FOGSI Endocrinology Committee

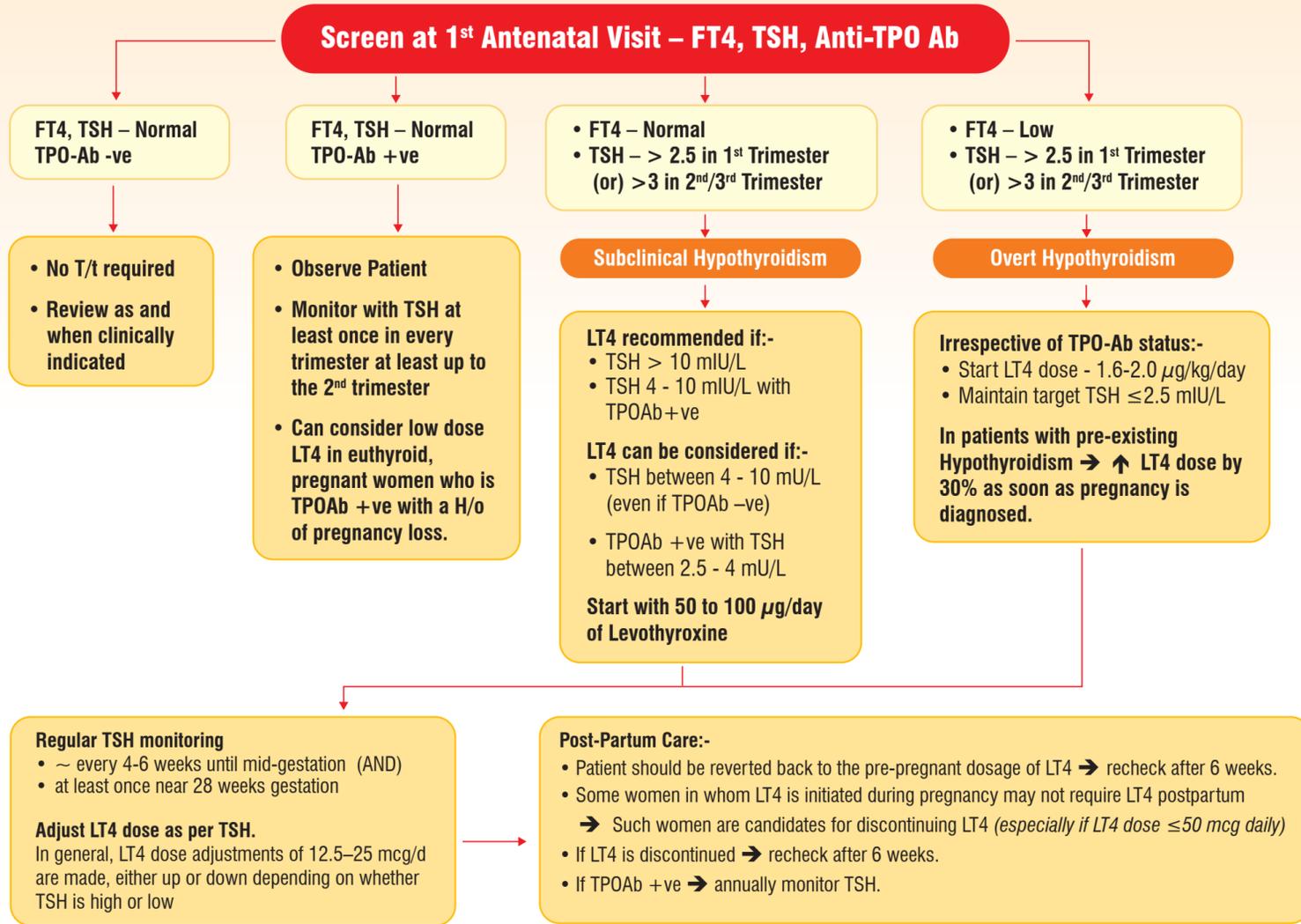


Hypothyroidism in Pregnancy

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Disease Burden of Hypothyroidism in Pregnancy	Trimester Specific TSH cut-offs		Risks of Hypothyroidism in Pregnancy	
	Trimester	Upper limit of TSH Range	Maternal	Foetal & Neonatal
Worldwide = 1.5 – 4%	1 st Trimester	2.5 mIU/L	Anemia	Preterm Birth
India = 11%	2 nd Trimester	3 mIU/L	Gestational Hypertension	Low Birth Weight
	3 rd Trimester	3 mIU/L	Abruption Placentae	Respiratory Distress
			Post Partum Haemorrhage	Neurocognitive Impairment
			Abortion	

Approach to a Case



Other Key Practice Points

- TPOAb testing in pregnancy should be done only once.
- LT4 to be taken 60 minutes before breakfast or at bedtime (> 3 hrs after evening meal) for optimal, consistent absorption.
- In hypothyroid women treated with LT4 who are planning pregnancy, serum TSH should be evaluated preconception, and LT4 dose adjusted to achieve a TSH value between the lower reference limit and 2.5 mIU/L
- In patients in whom LT4 dose requirements are much higher than expected, evaluation for GI disorders such as Helicobacter pylori-related gastritis, atrophic gastritis, or celiac disease should be considered. Furthermore, if such disorders are detected and effectively treated, re-evaluation of thyroid function and LT4 dosage is recommended.
- Use of different levothyroxine products may be associated with altered serum TSH levels. A change in brand should be followed by a re-evaluation of the serum TSH levels at steady state.
- Postpartum thyroiditis (PPT) occurs in upto 10% of all pregnancies and may have a hyperthyroid phase. It may begin from 6 weeks to 6 months post delivery and sometimes a year later. It may also be triggered by a miscarriage occurring as early as 6 weeks. Women who have T1DM or are TPO +ve during the 1st trimester or postpartum depression should have their TSH monitored at 3 and 6 months post-partum.

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