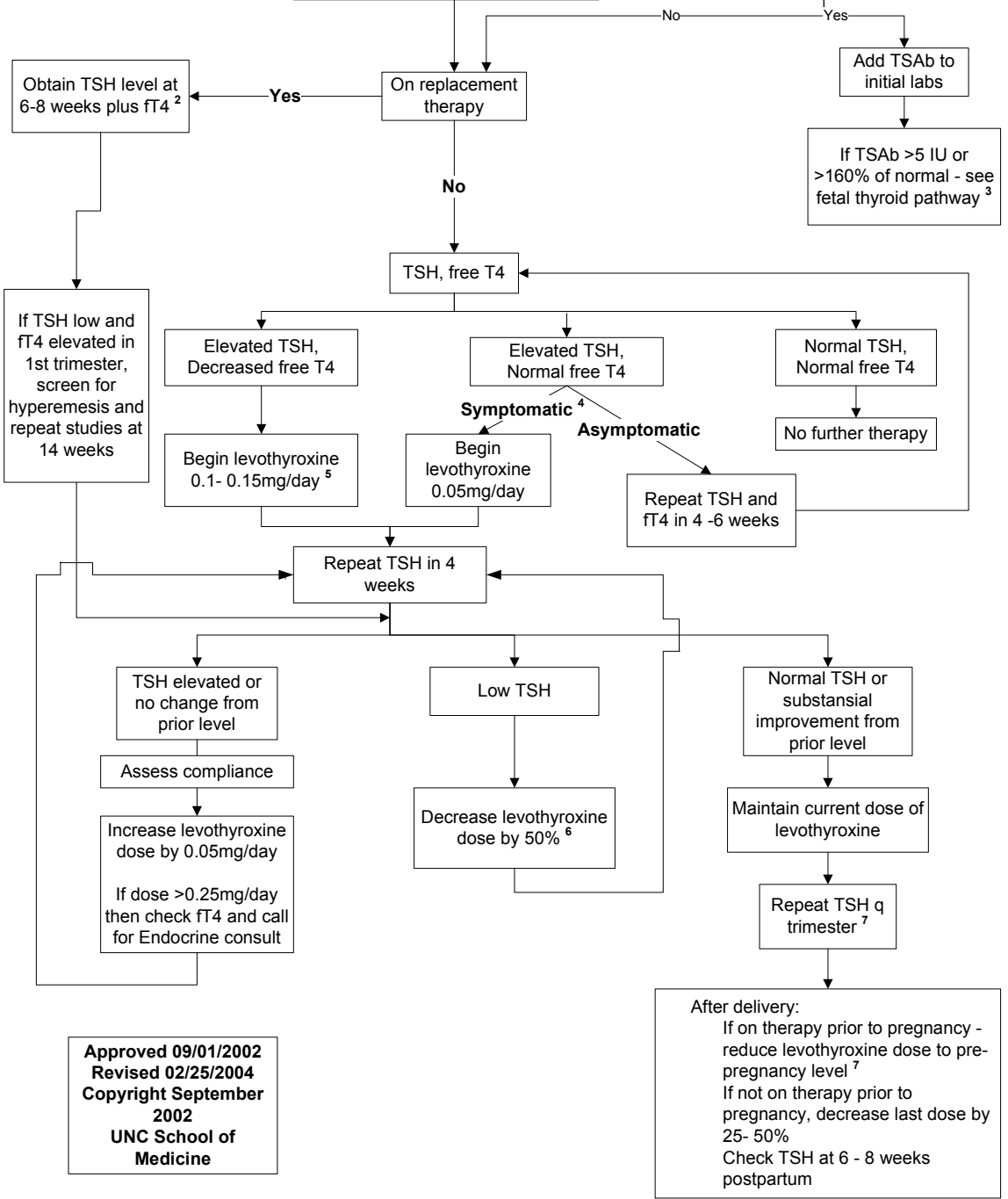


HYPOTHYROIDISM

History of thyroid disease
 New onset symptoms: cold intolerance, fatigue, weight gain, goiter
 Type I Diabetes
 FH of autoimmune thyroid disease¹

History of Graves disease with ¹³¹I ablation or previous neonatal thyrotoxicosis



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Hypothyroid References:

- 1) Mestman JH. Diagnosis and management of maternal and fetal thyroid disorders. **Curr Opin Obstet Gynecol 1999;11:167-75.** *Indications for thyroid testing in pregnancy.*
- 2) Mandel SL, Larsen PR, Seely EW, Brent GA. Increased need for thyroxine during pregnancy in women with primary hypothyroidism. **N Engl J Med 1990; 323:91 -6.** *For patients with a history of thyroid disease, a free T4 measurement is indicated in addition to the TSH. Mild elevations of TSH are frequently found in hypothyroid women on replacement therapy after conception because of the increased demand for thyroid hormones in pregnancy.*
- 3) Kilpatrick S. Umbilical blood sampling in women with thyroid disease in pregnancy: Is it necessary? **Am J Obstet Gynecol 2003;189:1-2.** *TSAb should be done on women with history of treatment with ¹³¹I or with a previously affected neonate. PUBS should be offered to pregnant women with Graves' disease if any one of the following are present: a) a history of a prior affected baby, b) a history of maternal ¹³¹I treatment and a high TSAb level (>5IU or >160%), c) the fetus displays fetal tachycardia, growth restriction, fetal goiter, hydrops or cardiomegaly.*
- 4) Mestman JH. Endocrine Diseases in Pregnancy. **Obstetrics: Normal and Problem Pregnancies. 4th ed Churchill Livingstone: Philadelphia: 2002.** *Symptoms include tiredness, cold intolerance, fatigue, muscle cramps, constipation and deepening of the voice.*
- 5) Mestman JH. Endocrine Diseases in Pregnancy. **Obstetrics: Normal and Problem Pregnancies. 4th ed Churchill Livingstone: Philadelphia:2002, 1152.** *Most pregnant women tolerate an initial dose of 0.15mg/day of thyroxine. The maintenance dose required by most patients is between 0.125 and 0.25mg daily.*
- 6) Wiersinga WM. Thyroid hormone replacement therapy. **Horm Res 2001;56:74-81.** *If the patient is overtreated, it is reasonable to start with a decrease in the replacement dose by half. An accurate prediction of the finally required levothyroxine dose can be obtained by the equation:
Levothyroxine (daily dose in µg) = -14 + (4.1 x TSH mU/l)*
- 7) Seely BL, Burrow GN. Thyroid Disease and Pregnancy. **Maternal Fetal Medicine 4th ed. WB Saunders Co. Philadelphia:1999, 1009.** *Women with thyroid disease prior to pregnancy commonly require increases in their dosage as the pregnancy progresses. Checking TSH each trimester is recommended to monitor dosage adjustments. After delivery, restart the initial dose prior to pregnancy.*

NOTIFICATION TO USERS

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur in pregnancy. They should not be interpreted as *standard of care* but instead represent *guidelines* for the management of these patients. Variation in practice should be taken into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities. The algorithms remain the intellectual property of the University of North Carolina School of Medicine at Chapel Hill. They cannot be reproduced in whole or part without the *expressed* permission of the school.

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