Hypothyroidism in Pregnancy Primary Care Guidance (INTERIM GUIDANCE WHILST TRUST PATHWAYS ARE BEING REVIEWED)

NHS
Nottinghamshire Area Prescribing Committee

Inadequately treated maternal hypothyroidism during pregnancy is associated with increased maternal and foetal complications. Hypothyroidism (including subclinical hypothyroidism) occurs in about 2.5% of pregnancies.

SFHT adopt a shared care service between community midwives and the obstetric-endocrine clinic. Patients should be referred to the obstetric-endocrine clinic as soon pregnancy is confirmed.

For **NUH** patients; **most women with hypothyroidism can be managed in the community** and can receive monitoring and dose titration in Primary Care.

A patient information leaflet and alert card (guidance for patients) is available via the British Thyroid Foundation.

Trimester	TSH (mU/L)
1st	<2.5 mU/l
2nd	<3mU/l
3rd	<3mU/l

	Process	Further information
Pre-conception ***FOR ALL***	Adjustment of the preconception levothyroxine dose with aim to keep **TSH <2.5 mU/L.** If opportunity arises, make a plan with patients so they can self-initiate an agreed increase in dose whilst they wait to see a GP and have TFT levels checked.	Refer patients with persistent clinical or sub-clinical hyperthyroidism (<0.35mU/L) to endocrine pre-conception as per NICE guidance. All women with **clinical/sub-clinical pregestational thyrotoxicosis** should be referred to endocrine pre-conception if possible.
Once pregnancy confirmed ***FOR ALL***	**Increasing the levothyroxine dose is recommended as early as possible in pregnancy and if possible, should not wait until the booking appointment.** **Immediately on notification of pregnancy:** • Arrange TFT's (specify pregnancy and gestation on ICE request to ensure correct gestational reference ranges are applied) **and** • Immediately increase levothyroxine as per table opposite whilst awaiting up to date TFT results. Advise patients to self-refer to midwifery services promptly. Initial TFT's will be undertaken by CMW with booking bloods if not already done by GP (usually at 8-10 weeks). **Remember to specify pregnancy and gestation on ICE request.**	**Dose in micrograms (mcg)** Pre-pregnancy dose / Dose increase / Resulting dose 50mcg / 12.5mcg (25%) / 62.5mcg 62.5mcg / 12.5mcg (20%) / 75mcg 75mcg / 25mcg (33.3%) / 100mcg 87.5mcg / 25mcg (28.6%) / 112.5mcg 100mcg / 25mcg (25%) / 125mcg 112.5mcg / 25mcg (22.2%) / 137mcg 125mcg / 25mcg (20%) / 150mcg 150mcg / 27.5mcg (25%) / 187.5mcg 175mcg / 37.5mcg (21%) / 212.5mcg 200mcg / 50mcg (25%) / 250mcg 225mcg / 50mcg (22.2%) / 275mcg 250mcg / 50mcg (20%) / 300mcg
Management plan during pregnancy	***GP led management at NUH*** **Referral to antenatal endocrine clinic is recommended for women**: • with sub-clinical/clinical hyperthyroidism (not on levothyroxine), • who are hypothyroid after thyroidectomy or radio-iodine treatment for thyrotoxicosis. **GP to:** • **Check TSH every 4-6 weeks until 20 weeks' gestation** • **Check TSH once more at 28-30 weeks' gestation** • **Titrate levothyroxine** to achieve TSH as per laboratory gestational reference range. If there are difficulties with management, ask CMW to refer to antenatal endocrine clinic (GP to provide up to date management information).	***Antenatal Endocrine clinic led management at SFH*** Patient managed via shared care between CMW and obstetric-endocrine clinic.
Following delivery ***FOR ALL***	• Reduce to pre-pregnancy dose on next dose after pregnancy ends. • If not on replacement therapy pre-pregnancy, reduce in 50mcg increments (stop if on ≤50mcg). • If on levothyroxine preconception solely for TSH optimisation/sub-clinical hypothyroidism, levothyroxine should be stopped completely. • **Check TFTs 6 weeks after delivery for all women** prescribed levothyroxine during pregnancy and adjust levothyroxine dose if required.	Patients with thyroid antibodies are at greater risk of **post-partum thyroiditis**, usually presenting around 3-4 months post-partum with symptoms of hyperthyroidism followed by a period of hypothyroidism before returning to normal (usually within 1 year of birth). Consider further repeat TFT's if concerned. Post-partum thyroiditis Patient Information Leaflet Thyroid UK.
Anytime	Refer to antenatal endocrine clinic if there are concerns	

Abbreviations: TSH – Thyroid Stimulating Hormone
TFT – Thyroid Function Tests
CMW – Community Midwife
mU/l – Micro-international unit/litre (may be written as miu/L)

Written in collaboration with LMNS group and local endocrinologists.
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