Hypothyroidism in Pregnancy Primary Care Guidance		
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NHS
Nottinghamshire Area Prescribing Committee

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

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.

Nottingham University Hospitals NHS Trust and Sherwood Forest Hospital Trusts have different guidelines on the management of hypothyroidism in pregnancy.

The SFHT guideline is 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.

The NUH Guideline **states that most women with hypothyroidism can be managed in the community** and should receive more frequent monitoring by Primary Care.

Abbreviations
TSH – Thyroid Stimulating Hormone
TFT – Thyroid Function Tests
CMW – Community Midwife

mU/l – Micro-international unit/litre (may be written as miu/L)

It is recommended to keep TSH < 2.5 mU/l in 1st trimester and < 3mU/l in 2nd and 3rd trimester (British Thyroid Foundation)

	Nottingham University Hospitals	Sherwood Forest Hospitals
Pre-conception	Adjust levothyroxine to achieve TSH between **0.2 and 2.8 mU/l.**	Adjustment of the preconception levothyroxine dose with aim to keep TSH **<2.5 mU/L.**
Once pregnancy confirmed	**Immediately increase levothyroxine by 25micrograms daily while awaiting up to date TFT results.** Initial TFT's undertaken by CMW with booking bloods if not already done by GP. Note - specify pregnancy and gestation on biochemistry request forms to ensure gestational reference ranges are presented. **Referral to antenatal endocrine clinic is recommended for women hypothyroid after**: • thyroidectomy or radio-iodine treatment for thyrotoxicosis or • if there are difficulties with management.	**Immediately increase current dose of levothyroxine by 25 -30%** (by taking two extra daily doses during each week or increasing daily dose by 25%) TFT's undertaken by CMW with booking bloods. **CMW will refer all hypothyroid patients to obstetric-endocrine clinic.**
Management plan during pregnancy	**GP led management** GP to: • **Check TSH every 4-6 weeks until 20 weeks' gestation**, • **Check TSH once more at 30 weeks' gestation.** GP to: • **Titrate levothyroxine** to achieve TSH within trimester specific reference range (0.2 – 2.8 mU/l if range not specified) Refer to antenatal endocrine clinic if there are concerns	**Antenatal Endocrine clinic led management** Patient managed via shared care between CMW and obstetric-endocrine clinic
Following delivery	GP to: • **Reduce levothyroxine to pre-pregnancy dose**. • If not on replacement therapy pre-pregnancy, reduce by 50mcg (stop if on 50mcg or less). • **Check TSH 6 weeks after delivery** and adjust levothyroxine if required. Refer to antenatal endocrine clinic if there are concerns	GP to: • **Revert to pre-pregnancy dose** • **Check TFT's 6 weeks after delivery** and adjust levothyroxine if required.
	Patients with thyroid antibodies are at greater risk of post-partum thyroiditis, usually presenting around 3-4 months post-partum. Consider further repeat TFT's if concerned.	

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

Written by APC Interface Team with local GP contributions: May 2022. Review date: May 2024.