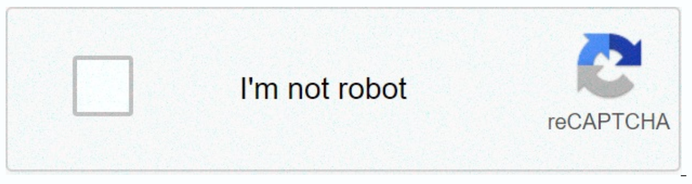

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American thyroid association guidelines pregnancy 2018 pdf

Updated guidelines for managing thyroid disease during pregnancy and after childbirth have just been released by the American Thyroid Association,1 in collaboration with researchers from Boston University School of Medicine and Brigham and Women's Hospital contain more than 100 clinical recommendations to provide clearer guidelines for physicians. An estimated 300,000 pregnancies a year in the U.S. are affected by thyroid disease. The 162-page document, with recommendations and data backed up by more than 600 links, contains some substantial changes, Elizabeth Pearce, M.D., MSc, associate professor of medicine, Boston University School of Medicine, told EndocrineWeb. Dr Pearce co-chaired the committee drafting the guidelines and is the corresponding author. The new recommendations were published online in January 2017 in the issue of Thyroid. Dr Pearce discussed 4 areas with EndocrineWeb that she said was worth highlighting for doctors. · The normal upper limit for thyroid function in pregnancy is increased to 4.0 The main and substantial change in the new guidelines involves an increase in the upper limit in normal tests of thyroid function. For thyroid stimulating hormone (TSH), the upper limit was 2.5 in 2011 guidelines; Now it's 4.0. Experts looked at the question of what should be the normal reference range for serum TSH concentrations in pregnant women. A downward shift of the TSH reference range during pregnancy is observed in both the lower and upper limits of maternal TSH compared to the typical non-pregnant reference range, according to the new guidelines. The greatest decrease in TSH serum is observed during the first trimester, due to rising levels of hCG serum stimulating the TSH receptor and an increase in thyroid hormone production. This downward shift varies widely between different racial and ethnic groups. Initially, a study of pregnant women in the U.S. and Europe led to earlier recommendations for TSH upper reference limit of 2.5 mU/L in the first trimester, then 3.0 in trimesters 2 and 3. However, recent studies have looked at women in Asia, India and the Netherlands and found only a slight reduction in the upper reference limits. Looking at the body of evidence, the upper reference limit should be set at 4.0 for a typical patient in early pregnancy, with a gradual return to non-pregnant levels later. The recommendation is to first look at population-specific information, Dr. Pearce said, then use the 4.0 upper limit if it is not available. The recommendation reads: Where possible, the population-specific reference range for serum TSH should be defined on the basis of an assessment of local population data representative of the healthcare provider's practice. · Subclinical hypothyroidism: To treat or not? This has been highly controversial in pregnant women, Dr Pearce said about whether to treat women with slightly increased maternal TSH concentrations. As indicated in the guidelines, this is particularly true for TPOAb [antibody thyropractor] Women. Much research has focused on subclinical hypothyroidism and pregnancy outcome, finding an increased risk of pregnancy complications, especially in positive women with TPOAb, according to the guidelines.1 However, Dr. Pearce said, there are few studies that have examined whether treatment with levothyroxine (LT4) can have an effect. After looking at the research, experts concluded that treatment can reduce miscarriage in TPOAb positive women; treatment can potentially benefit from selected subgroups of women during pregnancy. The recommendation is: women with a TSH concentration greater than 2.5 mU/L are evaluated for TPO antibody status. Treatment with LT4 is strongly recommended in women with positive for antibodies with TSH higher than the pregnancy reference limits and in women with negative antibodies with TSH levels higher than 10. Treatment can also be considered different, depending on the levels of TSH. · Treatment of Graves hyperthyroidism in pregnancy In the latest guidelines, experts recommended that women with methimazole hyperthyroidism (MMI) switch to propylthiouracil (PTU) during the first trimester, explained Dr Pearce. Now we say we don't know if it's the right approach,' she said. Studies have found that PTU is also associated with birth defects, although apparently less severe than MMI-related defects. Several options are proposed in the new guidelines. When pregnancy is diagnosed in a woman on antithyred therapy, which appears to be in remiss, one option is to withdraw the medication and closely monitor it. Another option would be bias surgery or radioiodine ablation. What's new is the recognition that both antithyroid drugs can cause birth defects and the risk is higher than we thought, Dr. Pearce said. In one Danish study, up to 3% of children exposed to PTU developed birth defects. Typically, these were cysts of the face and neck, or, in boys, urinary tract abnormalities. The new evidence, he admits, "doesn't lead to a simple answer. The risk of relapse after withdrawal of the drug should be considered, the guidelines suggest; If this risk is high, PTU is the drug of choice. The guidelines also reflect the fact that answers to some questions are still evolving despite the fact that research has grown over the past few years, according to Dr Pearce. · Universal screening remains a gray area Experts have concluded is "basically a lack of evidence" to recommend universal screening of thyroid function for all pregnant women, Dr Pearce said. Professional organisations have diverse recommendations with counter-advice. In the U.S., we know the practice is mixed, she said. Some doctors do universal screening; others don't. A clinician's view of the new guidelines guidelines for treating thyroid disease during pregnancy seems to emphasize more information than in the past, said Melissa D. Katz, M.D., assistant professor of medicine in endocrinology at Weill Cornell Medicine, who for EndocrineWeb. He believes that one of the most important points in the instructions is to individualize treatment. That's not necessarily a change, she said. I think it's always been critical. One of the standard tests in her own practice is an antibody test. I find it useful,' she said. This will tell you what the basic condition is. It also gives you insight into thyroid health. Depending on the results, she said, it can alert her that a woman needs thyroid hormone. Another critical point highlighted in the updated guidelines, she said, is that optimal thyroid hormone levels are very different for pregnant versus non-pregnant women. Best advice for doctors? I feel like the instructions are there for a reason, Dr. Katz said. You individualize them for your patients based on your clinical judgment. Updated: 06/05/18 15th International Thyroid Congress, 85th Annual Meeting of the American Thyroid Association Background: Thyroid disease in pregnancy is a common clinical problem. Since guidelines for managing these disorders by the American Thyroid Association (ATA) were first published in 2011, significant clinical and scientific advances have occurred in this area. The aim of these guidelines is to inform doctors, patients, researchers and health policy makers about published evidence on the diagnosis and management of thyroid disease in women during pregnancy, prejudice and postpartum periods. Methods: The specific clinical issues addressed in these guidelines were based on previous versions of the guidelines, stakeholder contributions and contributions from working group members. The working group members were educated on methods of knowledge synthesis, including electronic database search, review and selection of relevant citations and critical evaluation of selected studies. Published articles in English were eligible for inclusion. The American College of Physicians Guideline Grading System has been used for critical evaluation of evidence and grading strength recommendations. The working group had complete editorial independence from the ATA. The counter-interests of the working party members at the front line have been regularly updated, managed and communicate to the members of the ATA and the Working Party. Results: Revised guidelines for the treatment of thyroid disease in pregnancy include recommendations regarding the interpretation of thyroid function tests in pregnancy, Iodine nutrition, thyroid autoantibodies and pregnancy complications, thyroid aspects in infertile women, hypothyroidism in pregnancy, thyritoxicosis in pregnancy, thyroid nodes and cancer in pregnant women, fetal and neonatal considerations, thyroid disease and lactation, screening for thyroid dysfunction in pregnancy and guidelines for future research. Conclusions: We have developed evidence-based recommendations to inform clinical decision-making in the treatment of thyroid disease in pregnant and postpartum women. While all it must be individualized, such recommendations, in our opinion, provide optimal paradigms of care for patients with these disorders. Keywords: postpartum thyroiditis; pregnancy; thyroid gland and pregnancy; thyroid function tests. Tests.