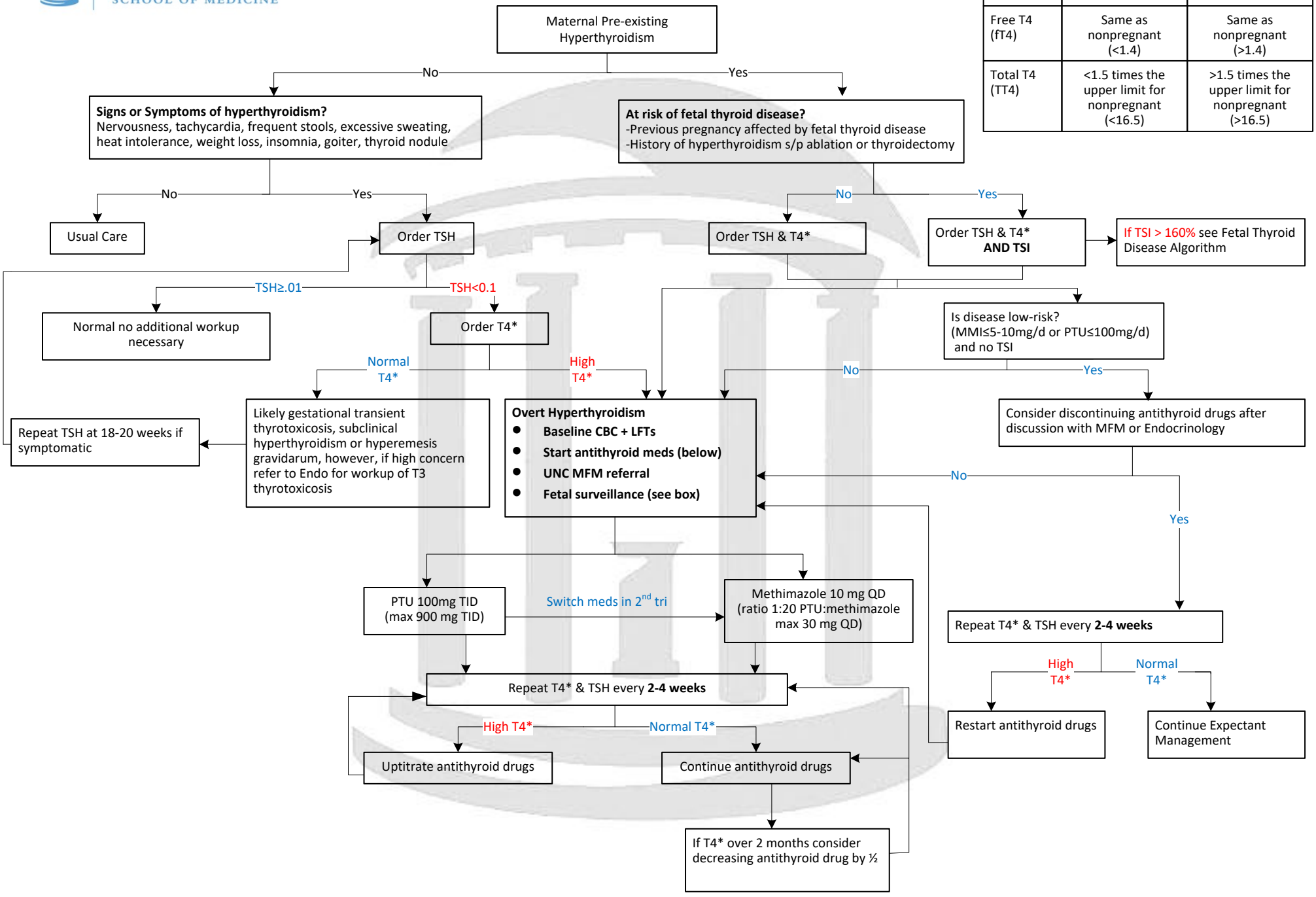
UNC SCHOOL OF MEDICINE

Hyperthyroidism

Thyroid hormone levels in pregnancy*		
	Normal	High
Free T4 (fT4)	Same as nonpregnant (<1.4)	Same as nonpregnant (>1.4)
Total T4 (TT4)	<1.5 times the upper limit for nonpregnant (<16.5)	>1.5 times the upper limit for nonpregnant (>16.5)



*Automated fT4 assays are sensitive to alterations in binding proteins that occur in pregnancy and can falsely elevate or lower the fT4 assay result. In lieu of measuring fT4, total TT4 (with a pregnancy-adjusted reference range) is a highly reliable means of estimating hormone concentration.

Hyperthyroidism

Maternal Antithyroid medication safety:

- If maternal symptoms of fever or sore throat develop, stop PTU or Mathimazole and order CBC with differential to rule out agranulocytosis
- If weakness, jaundice, dark urine, light colored stool, or nausea and vomiting develop, stop PTU and order LFTs and bilirubin to rule out PTU-associated hepatoxicity
- If case of PTU or MMI toxicity with continued maternal hyperthyroidism requiring treatment, refer to endocrinology/surgery for consideration of possible thryrodectomy

Antepartum fetal surveillance:

- FHR at each visit
- Targeted anatomy ultrasound at 18-20 weeks
- Monthly ultrasound for growth and surveillance for signs of fetal thyroid disease starting at 28 weeks
- Weekly NST or BPP at 32 weeks

Postpartum Care:

- Continue antithyroid medication
- OK to breasfeed
- Refer to PCP or Endocrinology for continual care
- Repeat TSH and Free T4 at 4-6 week postpartum visit

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These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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