Evaluation of Effects of Subclinical Hypothyroidism on Pregnancy and Its Outcome

Sreelakshmi U1, Divya J Tekani2
Obstetrics and Gynecology Department, Vydehi Institute Of Medical Sciences And Research Centre, Bangalore, Karnataka, India

Abstract: Objective: To evaluate the effects of subclinical hypothyroidism on pregnancy, pattern of obstetric complications and its outcome. Materials and methods: This prospective observational study conducted from Feb 2011 to Nov 2014 in obstetrics and gynecology department, Vydehi Institute of Medical Sciences and Research Centre, Bangalore. At first antenatal visit pregnant women were screened for TSH and further evaluated for FT4 and FT3 if found elevated TSH above 2.5 milli international units (mIU)/L in first trimester and above 3 mIU/L in second trimester. Following confirmed subclinical hypothyroidism, treatment was initiated with Levothyroxine. Maternal outcomes were studied. Results: Prevalence of subclinical hypothyroidism in pregnancy was 2.07%. TSH was found less than 6 m IU/L in 41 cases, between 6-10 mIU/L in 37 cases, more than 10 m IU/L in 23 cases. Threatened abortion was observed in (44.55%) 45 cases, 25 (24.75%) cases had preterm delivery. Cesarean section rate was 27.7% (28). Intra uterine growth retardation was seen in 5 (5%) cases. Intrauterine death was seen in 15 (15%) cases. Conclusion: Subclinical hypothyroidism in pregnancy is significantly associated with obstetric complications. Early diagnosis, active intervention, multidisciplinary team approach i.e. endocrinologist, skilled obstetrician, physician, anesthetist, and proper facilities for ante partum and intrapartum care is required for the management of hypothyroidism and its complications.

Keywords: Subclinical hypothyroidism, complications, pregnancy, maternal outcomes

1. Introduction
Maternal thyroid undergoes significant physiological changes during pregnancy. Early in pregnancy increased demand for thyroid hormone secretion owing to fetal thyroid gland becomes functional in the second trimester of gestation. Thyroxin is essential for fetal neurodevelopment, maternal delivery of thyroxin to the fetus is essential early in gestation. Pregnant women are also more likely to be iodine deficient due to increased iodine excretion1. The hypothalamic-pituitary-thyroid axis set-point is genetically determined; it's varied in different individuals. These genetic variants have the effect on both blood pressure and serum TSH levels. Therefore, inter individual differences in the hypothalamic-pituitary-thyroid axis set-point might explain the different signs and symptoms. Many of the symptoms and signs of hypothyroidism can overlap with pregnancy akin to lethargy, weakness, weight gain, muscle cramps, constipation, and hair loss etc. Thus it is difficult to rely on symptoms to make a diagnosis of hypothyroidism in pregnancy2. This study has been undertaken to analyze the maternal problems associated with subclinical hypothyroidism, evaluation of effects of hypothyroidism in pregnancy and its outcome.

2. Materials and Methods
This was a prospective observational study conducted from February 2011 to November 2014, in the department of obstetrics and gynecology, VIMS&RC, Bangalore. At first antenatal visit pregnant women attending to outpatient department with elevated TSH above 2.5 mIU/L in first trimester and above 3 mIU/L from second trimester were included. Patients with known thyroid disease, overt hypothyroidism, hyperthyroidism, family history of thyroid problems, previous history of thyroid surgery, neck radiation exposure excluded from this study. Detailed history was taken at first ante natal visit. Thorough general and physical examination was done. Other investigations included were blood grouping and Rh typing, hemoglobin, random blood sugar, FT4, FT3, urine for routine and microscopy, ultrasonography. In case of elevated TSH has found FT4 and FT3 were also carried out. The diagnostic criteria for subclinical hypothyroidism were based on Endocrine Society and the American Thyroid Association guidelines3 (normal serum TSH reference range up to 2.5 mIU/L in the first trimester and up to 3.0 mIU/L in the second and third trimesters). According to the need of the patients liver function tests and renal function tests were done. All patients attained euthyroid state after initiation of treatment. Drop outs not included in this study. Anti-TPO Abs measurement was not done to all patients due to lack of resources. Informed consent has taken from all patients.

All subclinical hypothyroid patients were referred to endocrinologist for full evaluation and medical treatment, and treatment with Levothyroxine was initiated. Dose adjustments were guided by serum TSH level every 6–8 weeks following initiation of therapy and followed until delivery. Pregnancy was continued till term gestation, unless termination was indicated for maternal or fetal indications. All forms of maternal outcomes were studied, which included but not limited to threatened abortion, recurrent pregnancy loss, preterm delivery, gestational hypertension, gestational diabetes, intra uterine growth retardation, intra uterine death, prolonged pregnancy (beyond expected date of delivery >40 weeks) and mode of delivery.

3. Results
Of 4,864 pregnant women screened 101 pregnant women had subclinical hypothyroidism, with prevalence 2.07%. Mean gestational age at which subclinical hypothyroidism diagnosed was 13.86 weeks. Figure 1 showing shows TSH level distribution in study subjects. 23 patients had severe subclinical hypothyroidism. Figure 2 showed distribution of
age in study subjects. Majority of the patients were in the age group of 20-30 years. Mean age of these cases was 26.6 years. Figure 3 showing literacy statuses. Figure 4 showing gravida statuses. Subclinical hypothyroidism observed more in second gravida. Figure 5 showing maternal complications and outcome. Sharp raise of spontaneous abortions observed in 20-30 years age group women. 45 (44.55%) women had abortions, 25 (24.75%) women had preterm delivery. Cesarean section rate was 28 (27.7%). Intra uterine growth retardation was seen in 5 (5%) cases. Intrauterine death was observed in 15 (15%) cases.

4. Discussion

Subclinical hypothyroidism is the commonest of the gestational thyroid disorders. Increased demand for thyroxin production and iodine intake led the WHO to recommend a daily iodine intake of 250μg for pregnant women, considerably higher than the recommended 150μg a day for the general adult population. Many studies have reported maternal complications and adverse perinatal outcomes with subclinical hypothyroidism, so early detection and initiation of treatment are very important. Adverse outcomes varied from study to study.

The estimated prevalence of subclinical hypothyroidism in pregnancy is 2-3%. Though, prevalence depends upon several factors such as TSH cut off used to define Subclinical hypothyroidism and dietary iodine deficiency state etc. Prevalence of subclinical hypothyroidism in pregnancy was very high in Dhanwal et al study 14.3% compared to present study 2.07%. Many studies reported that high maternal TSH levels were associated with an increased risk of pregnancy loss. Nirmala C et al study showed subclinical hypothyroidism was associated with increased risk of developing threatened abortion, gestational hypertension and increased rate of caesarian section. In this study rate of caesarian section was 27.7%. Study conducted by Guducu et al showed significant associations between low-weight neonates with high first trimester TSH levels. In the present study after achieving euthyroid state also in the second trimester with higher TSH levels in the early first trimester had lower birth weight infants in 4.9% of cases. This may be due to mechanism acting earlier, at the time of the trophoblastic invasion. In this study complications may be due to late diagnosis, unawareness of the patients, inadequate treatment, and irregular follow ups.

Management of subclinical hypothyroidism is shrouded with controversies. Treatment of subclinical hypothyroidism is not universally advocated as there are limited data demonstrating a beneficial effect of thyroid hormone therapy on health outcomes. In 2010 Cochrane review provided information about women with subclinical hypothyroidism that is also antithyroid antibody positive with exoegenous thyroid hormone in an attempt to improve pregnancy outcomes. Targeted screening of pregnant women will lead to missing of 30–80% of women with overt or subclinical hypothyroidism. The majority of cases of subclinical hypothyroidism in pregnancy are transient, so treatment with L-thyroxin in these patients may not be acceptable after pregnancy. There are no data to indicate whether the treatment for these conditions should be limited only to during the pregnancy or continued long-term, and no advice is provided in the current guidelines. Limitations of this study were thyroid examination using ultrasound, Anti TPO Abs, lack of control group, autoimmunity for other causes of hypothyroidism in these women not done and study was done at single centre.

5. Conclusion

Studies on benefits of universal screening and treatment intervention for subclinical hypothyroidism on obstetric and perinatal outcomes are still lacking. Pre natal counseling, screening for thyroid disorders, early detection and timely initiation of thyroid replacement therapy adequately for hypothyroidism will improve the perinatal outcome. A multidisciplinary team approach i.e. endocrinologist, obstetrician, physician, anesthetist, pediatrician and proper facilities for ante partum and intrapartum care are required for the management of hypothyroidism and its complications.

References


Figures

**Figure 1:** Thyroid stimulating hormone (TSH) level in study subjects

**Figure 2:** Age distribution in n=101 of cases

**Figure 3:** Literacy status in n=101 of cases

**Figure 4:** Gravida(G) status in study subjects
Figure 5: Showing maternal complications and outcome.

Author Profile

Dr. Sreelakshmi U, Ex Assistant professor, Obstetrics and Gynecology Department, VYDEHI Medical College, Bangalore, Karnataka, India

Dr. Divya J Tekani, Assistant professor, Obstetrics and Gynecology Department, VYDEHI Medical College, Bangalore, Karnataka, India