Mildly increased thyroid-stimulating hormone (TSH) in pregnant women has been widely associated with reduced IQ testing results in the offspring (1,2). Yet we still do not know whether levothyroxine treatment of pregnant women with mildly increased TSH levels improves IQ outcomes for the children. Despite all the publications and all the reviews and all the talking, there have been no prospective studies completed yet (although I am told that two are at last ongoing). Furthermore, now one study has suggested that treating women with normal TSH levels but positive antibodies to thyroid peroxidase may reduce their miscarriage rate—something well known for many years to be increased in such women (3–5). We find ourselves confused and searching for advice on the management of thyroid disease in pregnancy.

Seven years ago I wrote an editorial in Thyroid complaining that the ATA, AACE and the Endocrine Society were confusing us over the issue of screening pregnant women for thyroid dysfunction (6). Seven years later it is depressing to find the same confusion reigning supreme. At this years’ annual Endocrine Society meeting in Toronto, we heard from Dr. Leslie DeGroot, the effective chairman of a difficult joint task force (ATA, ETA, Endocrine Society and AACE), which is about to publish the official joint societies’ guidelines for the management of thyroid disease in pregnancy, and we also heard from some of his colleagues. While many of the recommendations presented were indeed sensible, and some were even evidence based, there still remained a real problem with the amazing lack of a recommendation for screening all pregnant women for thyroid dysfunction.

There also remains for me a great problem with the whole concept of guidelines—something I have also written about previously (7). For example, the very idea that a thyroid nodule 0.8 centimeters in size should not be biopsied while a nodule 0.2 cm larger should be biopsied has no logic whatsoever (8). It now looks as if the same problem will apply to such women (3–5). We find ourselves confused and searching for advice on the management of thyroid disease in pregnancy.

Nevertheless, guidelines do have some role to play. That role is to lead the way in the good management of patients and their diseases based on the best evidence and combined with common sense. Such guidelines have to overcome the belief that everything they say has to be evidence based—because that evidence is not always there—and we still have to give a common sense opinion based on the information available, hence the ratings of recommendations.

But it is leadership that people want and deserve. We are trained from childhood to accept the word of our leaders (our parents), and evidence shows that we accept such advice most often when it is logical and understandable. To suggest that we should “case find” in our pregnant-patient population when it has been clearly shown that we miss 30 percent of patients with this approach (9) is beyond my understanding. And then to list so many reasons for testing women in this case-finding approach, such that almost all women would be included, is so less satisfactory than leading and stating clearly that it is not appropriate to let pregnant women proceed without thyroid function testing. I doubt a single physician present at the Endocrine Society presentation would fail to screen a pregnant woman for thyroid disease. And that means that every obstetrician should be doing the same thing and we should be offering this advice.

You cannot sit on the fence forever. It is very uncomfortable for the backside.

References

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—Terry F. Davies, M.D.
Editor-in-Chief
New York, NY