Managing Thyroid Disease in Primary Care – Tips & Tricks

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THIS IS MODERN MEDICINE

Topics

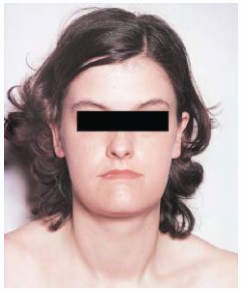
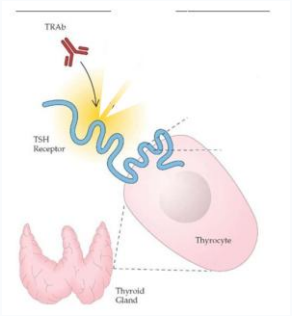
1. New Thyrotoxicosis – what to do

2. Hypothyroidism – Tips on common issues

3. Pregnancy issues

1. New Thyrotoxicosis

New Thyrotoxicosis – Graves' Disease

	Cause	Notes/Clues	Treatment
 Graves' disease	 Antibodies to TSH Receptor (TRAb)	F>M 20-50 y.o Family Hx of TD Previous Graves' Goitre +/- Eye disease TRAb positive (>95%)	Anti-Thyroid Drugs (ATD) Course 18months Trial off: 50% relapse Consider RAI/Surgery if relapses

Managing Graves' disease

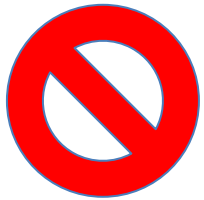
FT4 level	20-30 pmol/L	30- 40 pmol/L	> 40 pmol/L
Carbimazole	10mg od	20mg od	20mg bd

Side effects

Rash – use anti-histamine, usually settle within a few days
Birth Defects – not common, but advise not to conceive
Severe liver abnormalities, pancreatitis - rare
Agranulocytosis Advice

STOP medication if:

- Sore throat
- Flu-like illness
- Mouth ulcers
- Fever



Have FBC within 24 hours – if normal WCC, restart

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Managing Graves' disease – additional advice

Advice

Thyroid Eye Disease

EUGOGO TED Atlas

Stop smoking
Ensure in sinus rhythm
Consider beta blocker (propranolol 10mg tds – 20mg tds)

Repeat TFTs

4-6 weeks; if FT4 mid range or lower*, halve carbimazole dose

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*TSH stays low!!!

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New Thyrotoxicosis – Other Causes

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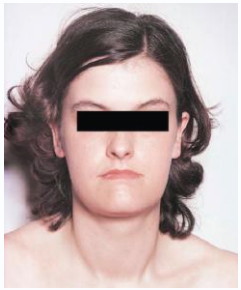
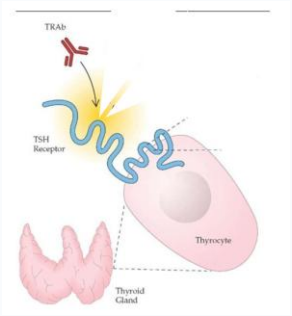
 Graves' disease	 Antibodies to TSH Receptor (TRAb)	F>M 20-50 y.o Family Hx of TD Previous GD Goitre +/- Eye disease TRAb positive (>95%)	Anti-Thyroid Drugs (ATD) Course 18months Trial off: 50% relapse Consider RAI/Surgery if relapses
Thyroid Nodule(s)	One or more autonomous thyroid nodules	F>M, Older Nodular gland +/- TRAb negative	ATD….but… Never remit RAI > Surgery

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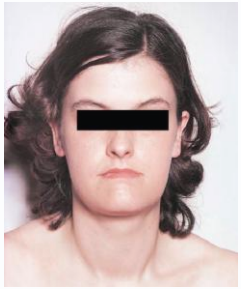
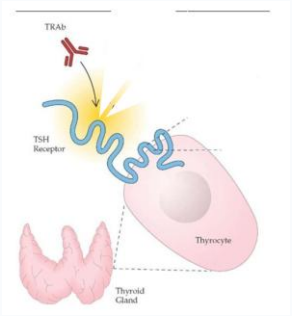
 Graves' disease	 Antibodies to TSH Receptor (TRAb)	F>M 20-50 y.o Family Hx of TD Previous GD Goitre +/- Eye disease TRAb positive (>95%)	Anti-Thyroid Drugs (ATD) Course 18months Trial off: 50% relapse Consider RAI/Surgery if relapses
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Thyroiditis	Inflammation - Viral - Post-partum (PPT) - Drugs (Lithium, oncology)	Recent viral illness/ Neck pain/ High ESR/abn LFT OR Post-partum (<6m) TRAb negative	See following slide….

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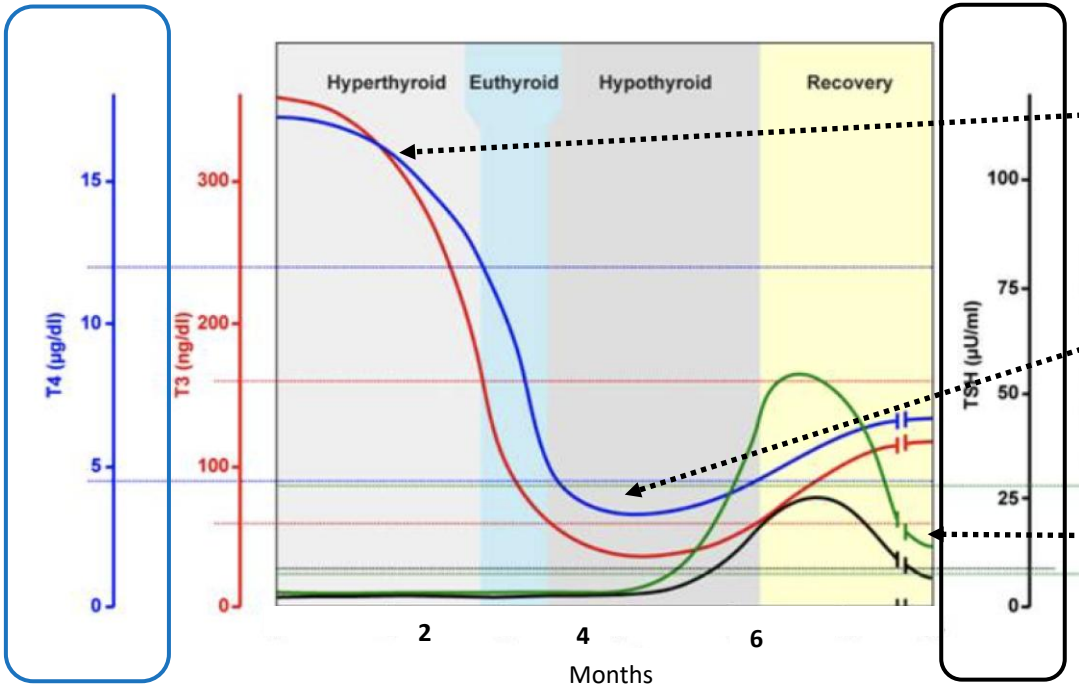
Thyroiditis - Dynamic Course of Thyroid Dysfunction



Beta blockade
& Reassurance
NO ATDs!

Monitor
Thyroxine - only if severe
or prolonged

Trial off thyroxine (if used) at 1 year
Viral Thyroiditis does not recur

Post-partum Thyroiditis can recur (up to 70%)
PPT - annual TSH;
at risk of hypothyroidism (~50%)

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2. Hypothyroidism

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TSH remains high on thyroxine

1. Check administration is correct
    - First thing in morning
    - On empty stomach
    - Do not eat or drink anything other than water for at least 30 mins
    - Some medications require further time spacing; calcium, iron, sevelamer, cholestyramine
2. Increase dose by 25mcg daily
3. Consider anti-TTG (even if no symptoms)
4. Repeat TSH in 6-8 weeks
5. If remains high following numerous dose adjustments, refer to endocrinology

Other Tips

- No need to repeat TPO antibodies if previously positive
- No need to reduce thyroxine dose if TSH normal and FT4 high
- If misses dose, can take double next day

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3. Pregnancy

3. Women ON THYROXINE - Hypothyroidism Prior to/in Pregnancy

If <u>already on thyroxine</u> and planning pregnancy OR pregnant,
aim TSH <2.5mU/L
(irrespective of anti-TPO status)

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Women ON THYROXINE - Hypothyroidism Prior to/in Pregnancy

Prior to conception	Check TSH; aim TSH 2.5mU/L or lower; check q3m Inform pt to increase dose if positive pregnancy test

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Trimester 1	Positive Test: **PATIENT** should **increase** thyroxine by 30% (25mcg – 50mcg daily; “dbl dose on 2 days per week”) Check TSH; aim TSH 2.5mU/L or lower Repeat TSH every 4 weeks

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Trimester 2 & 3	Check TSH once per trimester
Post-partum	Reduce Thyroxine dose by 25-50mcg Recheck TFTs at 6 weeks

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Women NOT ON THYROXINE – Pre-Pregnancy & Pregnancy

Planning Pregnancy Not on Thyroxine	TSH Normal range mU/L	TSH ULN – 10mU/L	TSH >10mU/L
TPO + OR Neg	NO LT4	+/- LT4*	Rx LT4

ULN= Upper limit normal

*Could repeat before treating; personally, I treat

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RCOG Guidelines 2025, PMID: 40240075

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Planning Pregnancy Not on Thyroxine	TSH Normal range mU/L	TSH ULN – 10mU/L	TSH >10mU/L
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If NOT on thyroxine and planning pregnancy OR pregnant, Only start thyroxine if TSH elevated (irrespective of anti-TPO status)

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Key points

1. Thyrotoxicosis:

Graves' disease

- Most likely to be Graves' disease
- If checking any antibody; check TRAb
- Consider starting carbimazole; counsel re: agranulocytosis & Repeat thyroid function in 4-6 weeks & adjust dose

Thyroiditis

- Watch for expected dynamic course
- Manage symptomatically
- PPT patients at risk of relapse & later hypothyroidism

2 & 3. Hypothyroidism & Pregnancy

- Administration of thyroxine important
- Only start thyroxine if TSH elevated peri-conception/pregnancy
- If on LT4 peri-conception/pregnancy, aim for TSH </=2.5mU/L & increase immediately on + test

Useful website:

British Thyroid Foundation

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Referral Information

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carla.moran@beaconhospital.ie

Beacon Thyroid Fellowship Programme

Dr Martin-Grace
Thyroid Fellow
July 24 to July 25

Dr Samah Idriss
Thyroid Fellow
July 25 to July 26

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Thank you

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