Royal Cornwall Hospitals
NHS Trust

Thyroid Disorders in Pregnancy Clinical Guideline

V1.0

September 2026

1. Aim/Purpose of this Guideline

1.1. This guideline is applicable to all health professionals caring for antenatal and post-partum women with thyroid disorders. The purpose of the guideline is to help practitioners provide the best possible information and support for pregnant patients.

1.2. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women, but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

1.3. This guidance is based on the RCOG Greentop Guideline No. 76: Management of Thyroid Disorders in Pregnancy': For more detailed advice or references, see this guideline.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. Testing for Thyroid Dysfunction

2.1.1. Universal screening for thyroid dysfunction is not recommended.

2.1.2. Testing for thyroid dysfunction, by measurement of TSH / fT4 levels, is recommended in women who have risk factors (such as type 1 diabetes) or symptoms of overt thyroid disorders

2.1.3. All women with a history of thyroid disorders should have their TSH and fT4 tested at the time of the standard booking blood tests.

2.2. Management of Hypothyroidism

2.2.1. Women with simple autoimmune hypothyroidism do not need referral to an obstetrician for this reason alone, and management should take place in the community between the community midwife and GP. However more complex cases need referral to Endocrinology via the Obstetric / Diabetes clinic, for example:

2.2.1.1. Previous history of Graves' disease (even if now euthyroid or hypothyroid).

2.2.1.2. Past thyroidectomy (e.g. for thyroid cancer).

2.2.1.3. Severe or poorly managed cases, i.e. TSH > 10 at booking.

2.2.2. Pre-conception, women should be helped to adjust their thyroxine dose to achieve a TSH of 2.5 or less

2.2.3. At the positive pregnancy test, or at booking, women should be counselled to increase their Levothyroxine dose by:

2.2.3.1. 25mcg per day from the start of pregnancy if taking 100mcg or less daily.

2.2.3.2. 50mcg if taking over 100mcg daily.

2.2.4. TSH and fT4 should be monitored every 4 to 6 weeks until 20 weeks then once again at 28 weeks, and the dose of Levothyroxine adjusted to maintain a TSH of 2.5 or less.

2.2.5. Women should be advised to return to their pre-conception dose of Levothyroxine 2 weeks following delivery and have their TSH rechecked 6-8 weeks postnatally.

2.2.6. Women with Subclinical hypothyroidism (Raised TSH, normal fT4), should be advised to take Levothyroxine (with monitoring and treatment aims as above) if initial TSH over 10, and treatment can be considered for those with TSH under 10.

2.3. Management of Hyperthyroidism (Most commonly due to Graves' disease)

Management of hyperthyroidism should be predominantly undertaken by the endocrinology team: Refer women with current or past history of Hyperthyroidism to the Endocrinology for ongoing management.

2.3.1. Pre-conception counselling is recommended for all women of reproductive age with hyperthyroidism, to ensure that management is optimized pre-pregnancy.

2.3.2. Women with hyperthyroidism require growth scans monthly from 28 weeks.

2.3.3. Women will be tested for TRAb antibodies to guide counselling and those testing positive should be referred to Fetal medicine.

2.4. Other scenarios:

2.4.1. If women have been started on Levothyroxine by subfertility services, it is reasonable to continue the medication, monitor and titrate to achieve a TSH of 2.5 or below. Post-partum the Levothyroxine can be stopped with retesting of TFTs 6 to 8 weeks postnatally.

2.4.2. Thyroid function tests can be abnormal in the presence of Hyperemesis Gravidarum: routine testing of TFTs is not advised in the absence of clinical features of overt hypo/hyperthyroidism.

2.4.3. Thyroid nodules / cancer. Suspected thyroid nodules / cancer should be referred to endocrinology and managed as per the non-pregnant patient.

2.4.4. Goitre: Women with overt goitre should be referred for review by the Obstetric anaesthetist, in view of potential difficulties with intubation.

2.4.5. Postpartum Thyroiditis: Women with symptoms of thyroid dysfunction in the year following delivery may have postpartum thyroiditis, but this needs to be distinguished from new onset thyroid disease. Women with symptoms should have their TFTs tested and be referred to endocrinology if abnormal.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Monitoring Tool
Lead	Audit Midwife
Tool	Percent of women with Primary Hypothyroidism having TSH <2.5 in the third trimester. Percent of women with Grave's disease being referred to endocrinology.
Frequency	1% or 10 sets, whichever is the greatest, of all health records of women who have delivered, will be audited over the lifetime of the guideline or earlier if identified through Patient Safety process.
Reporting arrangements	A formal report of the results will be received at the Maternity Patient Safety or Audit Review Team (ART).
Acting on recommendations and Lead(s)	• Any deficiencies identified on the annual report will be discussed at the Maternity Patient Safety Meeting or Clinical ART. • Action leads will be identified, and a time frame set for the action to be completed. • The action plan will be monitored by the Maternity Patient Safety Forum or ART.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	• A lead member of the forum will be identified to take each change forward where appropriate. • Patient Safety Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity and Inclusion Policy or the Equality and Diversity website.

4.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Thyroid Disorders in Pregnancy Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	September 2026
Date Valid From:	September 2026
Date Valid To:	September 2029
Directorate/Department responsible (author/owner):	Rob Harper, Consultant Obstetrician
Contact details:	01872 252361
Brief summary of contents:	The purpose of the guideline is to help practitioners provide the best possible information and support for antenatal and post-partum women with thyroid disorders.
Suggested Keywords:	Thyroid, pregnancy, Graves' disease.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	RCOG Greentop Guideline No. 76: Management of Thyroid Disorders in Pregnancy
Related Documents:	None required
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
September 2026	V1.0	Initial issue	Rob Harper, Consultant Obstetrician

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

E11 QEIA Policy

For guidance, please see the QEIA Essentials – Quick Reference Guide or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net