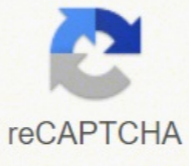




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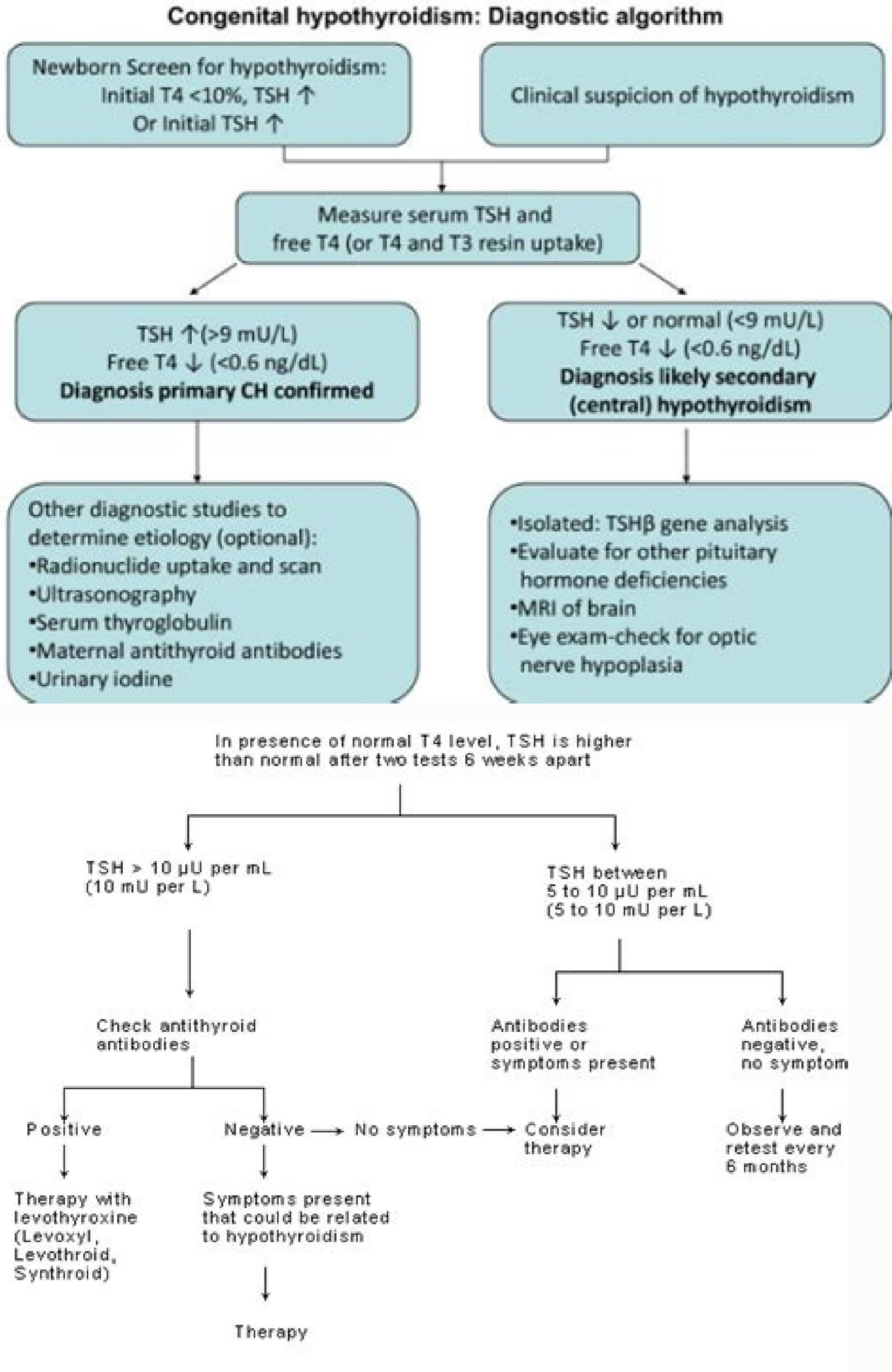
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What tests should I order ?

As per the Guidelines of the AACE and ATA, ITS

- TSH alone if Hypothyroidism is suspected
- TSH and Free T₄ only if Hyperthyroidism suspected
- Free T₃ if T₃ toxicosis is suspected
- For follow-up of treatment only TSH
- Don't order for Total T₄ or Total T₃
- Never order RIU in pregnancy or lactation



Congenital hypothyroidism indian guidelines. Congenital hypothyroidism screening guidelines.

Thyroid Thyroid Res Pract 2017;14:99-105 Congenital hypothyroidism (CH) is an important preventable cause of mental retardation.[1] Since the clinical manifestations of CH are often subtle or absent at birth, many newborns remain undiagnosed and may later suffer from mental retardation.[1],[2],[3] The inclusion of newborn screening (NBS) in India's public health policy is strongly advocated by the Indian Academy of Pediatrics (IAP).[4] The current review focuses on various guidelines-driven screening and treatment modalities being used for the early CH detection and management in an Indian context. The overall incidence of CH ranges from 1:3000 to 1:4000 globally. BMC Pregnancy Childbirth 2012;12:34-41. Mesai MP, Desai MP, Bhatia V, Menon PS. These data emphasize the importance of long-term follow-up when assessing cognitive outcome.[36] Although they are provocative, the magnitude of the observed impairment seems quite large for the mild degree of FT4 elevation in overtreated patients, and these findings await validation in additional studies.[36] Preterm and LBW infants commonly manifest a pattern of low T4 and normal TSH termed as transient hypothyroxinemia of prematurity (THOP). Although THOP has been associated with poor medical and neurodevelopmental outcomes, a causal relationship has not been established, and the few existing trials on treatment for THOP have not demonstrated a clear benefit. Next generation newborn screening for congenital hypothyroidism? All authors have indicated that they have no other conflicts of interest regarding the content of this article. Newborn screening in India. Eur J Endocrinol 2005;153:765-73. Kamath SS. A study conducted among urban Delhi population in 2014 reported 53% home births in Nagpur and 16.3% in Belgaum. Am J Med Genet 1997;71:29-32. Kumarasamy J, Raut Y, Rajan MG. have shown that optimal absorption of L-T4 occurs while fasting, whereas its absorption is found to reduce by 40% after food/drink intake. New York: McGraw-Hill, Inc.; 1995. morning levothyroxine intake: A randomized double-blind crossover trial. Horm Res Paediatr 2014;81:50-4. Grãters A, Krude H. Indian Pediatr 2008;45:331-2. Gopalakrishnan V, Joshi K, Phadke S, Dabadghao P, Agarwal M, Das V, et al. J Clin Endocrinol Metab 2014;99:363-84. Desai MP. Clin Endocrinol (Oxf) 1988;28:325-33. Wassner AJ, Brown RS. Moreover, levo-T4 (L-T4) treatment should be adjusted based on the type of CH.[30],[31] In India, infants assessed with borderline T4 or TSH values should be followed up biweekly or on monthly basis until both reach to normal levels.[7] Table 3: Follow-up treatment guideline recommendations Click here to view Treatment strategies and dosage Many children with CH remain undetected and sustain mental retardation with moderate-to-severe learning difficulties, which could be a result of inadequate screening.[20] Guidelines from international organizations recommend T4 as the first-line treatment for CH.[32] Furthermore, as per ESPE guidelines, use of T4 in liquid formulations is only allowed if it is pharmaceutically produced.[20] At present, in India, only oral/tablet form of L-T4 is used which is crushed and given with mother's feed, boiled cooled water, or formula milk.[20] Dose of thyroxine International guidelines recommend that L-T4 treatment should be initiated as early as possible.[33] According to ESPE guidelines, an initial dose of 10 μg/kg/day should be given. Indian J Pediatr 2015;82:61-70. Vassart G, Dumont JE, Refetoff S. Newborn screening: Need of the hour in India. A study comparing morning versus bedtime administration of L-T4 reported lower serum TSH levels in fasting state than in nonfasting conditions, thereby DNA. Epse, Paa ot gndroccanoitsimda enxoworyhtovel fo Edom] 73 (1) 100.0 34 mIU/L during 24 h of life and >20 mIU/L after 48 h on repeat filter paper TSH and >40 mIU/L at any age.[21] TSH-immunoradiometric assay (IRMA) kit with whole blood is used for TSH measurement in India.[23] For detecting infants with delayed TSH rise, repeated screening after few weeks is Econsnoper 7102-tco-9nitacil Bew F ITAd Aidni, Newarum, Ediukin Teobaaid NeBraaid Neidhc, Ygulonircopt Totenegnoc about 501-99: Egap Å ö | L.3: Esse Å O, | Å € 4102: Rayy Elcitra Weh Å ä, .snootalumfof 4T-L Duuqil DNA Telnitto Hc Rof ElbaTA HC ROF DEDNEMMÓVA STIIGNORTS HC ROOFTNORCUTS HC ROOFTNORCUT HC ROOFTOT HCE HC ROOFTLON HC ROOFTATS HC ROOGNNMUTS HC ROOFTOTS HC ROOIMTAVA HC ROOFTNORCUT.) 100.0

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