Postpartum Thyroiditis Presents Dx Challenges

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MINNEAPOLIS — In classic-course postpartum thyroiditis, the hyperthyroid phase is often missed, and it's much more common to identify women in the hypothyroid phase that follows, Dr. Erin Keely said.

"In my experience we miss the hyperthyroid phase clinically all the time because it's a little bit like the army—don't ask, don't tell," she said. The symptoms—anxiety, insomnia, fatigue, weight loss, and irritability—are normal for most new moms. The classic course of postpartum thyroiditis (PPT) is hyperthyroidism—which starts at about 6 weeks post partum and may last a few months—followed by hypothyroidism and then normalization.

More commonly, women present in the hypothyroid phase, which typically occurs 4-8 months after delivery and may last up to 9–12 months, said Dr. Keely, chief of endocrinology and metabolism at the Ottawa Hospital. Typical symptoms include fatigue, weight gain, constipation, dry skin, depression, and poor exercise tolerance. Women tested in the transition period might appear to have normal thyroid function, however. About 30% of women remain hyperthyroid.

However, because PPT can cause both thyrotoxicosis (high thyroid hormone levels in the blood) and hypothyroidism (low thyroid hormone levels in the blood) in the first year post partum, "you can't make a diagnosis of permanent thyroid disease" at that time, said Dr. Keely.

The exception is for any woman with overt thyroid disease before pregnancy.

To complicate matters, Graves' disease can flare in the postpartum period, making it difficult to tell if a woman is having a flare or PPT. However, Graves' disease is much less common than postpartum thyroiditis, said Dr. Keely. "So, if you were a betting person, you would bet that it's postpartum thyroiditis."

If the diagnosis is really unclear, radioiodine uptake tests can be performed but most women will likely choose to wait and see, she said.

There are insufficient data currently to recommend screening all women for PPT, according to clinical guidelines from the Endocrine Society (J. Clin. Endocrinol. Metab. 2007;92:s1-s47 [doi:10.1210/jc.2007-0141]). Women who are known to be positive for autoantibodies to thyroid peroxidase (TPO-Ab) should have a thyroid-stimulating hormone (TSH) test performed at 3 and 6 months post partum.

Notably, the prevalence of PPT in women with type I diabetes is threefold greater than in the general population; postpartum screening (TSH test) is recommended for these women at 3 and 6 months post partum.

When it comes to treating PPT, "there is no one answer for all women," said Dr. Keely. However, in 2002, Dr. Alex S. Stagnaro-Green, now the senior associate dean for education at George Washington University, Washington, proposed a treatment algorithm for PPT (J. Clin. Endocrinol. Metab. 2002;87:4042-7).

In this algorithm, treatment is indicated for a TSH level of 4 mU/mL or greater in the first year post partum.

Dr. Keely added that "one of the most important aspects is to continue the treatment until [the woman] has completed her family."

If autoantibodies to thyroid peroxidase (TPO-Ab) are found in the first trimester, there is a 30%-55% risk of PPT. "It's interesting though, that 25% of women who are positive in the first trimester become negative by the third trimester," she said.

Women may become negative for TPO-Ab by term but will rebound in the postpartum period. If TPO-Ab is positive in the third trimester, the risk of PPT is greater than 80%—but if negative the risk is only 0%-5%.

Importantly, "postpartum thyroiditis is a very strong predictor of long-term Hashimoto's thyroiditis," said Dr. Keely. About 30% of these women develop Hashimoto's thyroiditis within 3 years.

Dr. Keely reported that she had no relevant financial relationships. ■