Table 1. Comparison of recommendations of American Thyroid Association and Endocrine Society on the time and target group for screening for hypothyroidism before and during pregnancy

Who should be screened?	
American Thyroid Association guideline (2011)	**Endocrine Society guideline (2012)**
There is insufficient evidence to recommend for or against universal TSH screening at the first trimester visit	Some members recommended screening of all pregnant women for serum TSH abnormalities by the 9th week or at the time of their first visit. Others recommended against universal screening of pregnant women at the time of their first visit and instead supported aggressive case finding to identify high-risk women
A case-finding approach targeting thyroid function testing in high-risk groups has been advocated	The same
Who are the high risk group?	
Women with a history of thyroid dysfunction and/or thyroid surgery, Family history of thyroid dysfunction goiter, Women with anti-thyroid antibodies, having symptoms or clinical signs suggestive of hypothyroidism. type I diabetes or autoimmune disorders, history of either miscarriage or preterm delivery, infertility, prior therapeutic head or neck irradiation, morbid obesity, age 30 or older, treated with amiodarone or lithium, a recent (in the past 6 weeks) exposure to iodinated radiological contrast agents, Residing in an area of known moderate to severe iodine insufficiency	The same
When should high risk women be screened?	
There is insufficient evidence to recommend for or against TSH testing preconception in women at high risk for hypothyroidism	Test high-risk women for elevated TSH concentrations by the ninth week or at the time of their first visit before or during pregnancy
All pregnant women should be verbally screened at the initial prenatal visit for any history of thyroid dysfunction and/or use of thyroid hormone (LT4) or anti-thyroid medications (MMI, carbimazole, or PTU). Level B-USPSTF	All women considering pregnancy with known thyroid dysfunction and receiving levothyroxine should be tested for abnormal TSH concentrations before pregnancy
Serum TSH values should be obtained early in pregnancy in women at high risk for overt hypothyroidism	
The same	All women considering pregnancy with known thyroid dysfunction and receiving levothyroxine should be tested for abnormal TSH concentrations before pregnancy as well as during the first and second trimesters of pregnancy

Table 2. Comparison of recommendations of the American Thyroid Association and the Endocrine Society on the management of hypothyroidism before and during pregnancy

Treatment of hypothyroidism (Overt or subclinical) in pregnancy	
American Thyroid Association guideline (2011)	**Endocrine Society guideline (2012)**
Overt hypothyroidism should be treated in pregnancy	The same
Isolated hypothyroxinemia should not be treated in pregnancy	No recommendation
Due to the lack of randomized controlled trials there is insufficient evidence to recommend for or against universal LT4 treatment in TAB negative pregnant women with SCH	T4 replacement in women with SCH who are TPO-Ab negative subjects
Women who are positive for TPOAb and have SCH should be treated with LT4	The same
The recommended treatment of maternal hypothyroidism is with administration of oral LT4. It is strongly recommended not to use other thyroid preparations such as T3 or desiccated thyroid	The same
The goal of LT4 treatment is to normalize maternal serum TSH values within the trimester-specific pregnancy reference range (first trimester, 0.1–2.5 mIU/L; second trimester, 0.2–3 mIU/L; third trimester, 0.3–3 mIU/L)	The same
Women with SCH in pregnancy who are not initially treated should be monitored for progression to OH with a serum TSH and FT4 approximately every 4 weeks until 16–20 weeks gestation and at least once between 26 and 32 weeks' gestation	No recommendation
Treated hypothyroid patients (receiving LT4) who are newly pregnant should independently increase their dose of LT4 by ~25%–30% upon a missed menstrual cycle or positive home pregnancy test and notify their caregiver promptly. One means of accomplishing this adjustment is to increase LT4 from once daily dosing to a total of nine doses per week (29% increase)	The same
There exists great interindividual variability regarding the increased amount of T4 (or LT4) necessary to maintain a normal TSH throughout pregnancy, with some women requiring only 10–20% increased dosing, while others may require as much as an 80% increase	Almost the same

Table 3. Follow-up of pregnant women with overt or subclinical hypothyroidism with LT4 during

Monitoring of pregnant women being treated for hypothyroidism	
American Thyroid Association guideline (2011)	**Endocrine Society guideline (2012)**
In pregnant patients with treated hypothyroidism, maternal serum TSH should be monitored approximately every 4 weeks during the first half of pregnancy because further LT4 dose adjustments are often required and, maternal TSH should be checked at least once between 26 and 32 weeks gestation	The same
Following delivery, LT4 should be reduced to the patient's preconception dose. Additional TSH testing should be performed at approximately 6 weeks postpartum	The same
In the care of women with adequately treated Hashimoto's thyroiditis, no other maternal or fetal thyroid testing is recommended beyond measurement of maternal thyroid function (such as serial fetal ultrasounds, antenatal testing, and/or umbilical blood sampling) unless for other pregnancy circumstances	No recommendation