

TABLE 1. Guidelines for the Medical Treatment of Graves' Disease in Pregnancy

- 1 Monitor clinical signs (heart rate, weight gain, thyroid size, etc.) and serum free T4 and T3, TSH every 2-4 weeks.
 - 2 Use the lowest dose of ATD to maintain the patient in a euthyroid or mildly hyperthyroid state. ATD dosage can usually be lowered after the first trimester and often discontinued during the last trimester.
 - 3 Do not attempt to normalize serum TSH. Serum TSH concentrations between 0.1 and 0.4 mIU/L are appropriate. Lower – or undetectable – TSH levels are acceptable if the patient's clinical condition remains satisfactory.
 - 4 Concerning the choice of ATD, the use of PTU is preferable during the first trimester (remember the potential risk of liver injury).
 - 5 With PTU (or its equivalent dosage for MTZ/CMZ), doses as low as 100-200 mg/d may still affect fetal thyroid function. However, there are many reports of PTU dosages as high as 400 mg/d in the literature (without serious side effects).
 - 6 Consider thyroidectomy (in the second trimester) if the patient is non-compliant or cannot tolerate the administration of ATD, or when persistently elevated doses of ATD are required (PTU >600 mg/d or MTZ >40 mg/d).
 - 7 When ATD have been withdrawn in the last weeks of gestation, keep in mind that a rebound of thyrotoxicosis may occur in early postpartum with the need to reinstitute (or increase) ATD dosage after delivery.
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