



**A cross sectional study on the thyroid profile of neonates born to hypothyroid mothers
in a tertiary care centre in Chennai**

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Abstract

Retrospective study was done to estimate the prevalence of congenital hypothyroidism (CH) among new born babies born to hypothyroid mothers on thyroxine in ACS Medical College & Hospital. Datas were collected from the case sheets in medical record department. The prevalence of CH was 1 in 2500 live births with no gender difference.

Keywords: Congenital neonatal hypthyroidism, new borns, hypothyroidism in antenatal mothers, no gender difference.

Introduction

Congenital Hypothyroidism (CH) occurs approximately 1:2000 to 1:4000 new borns. The clinical manifestations are often subtle and not present at birth. This is likely to due to the tranplacental passages of some maternal thyroid hormones while many infants have some thyroid production of there own. CH is one of the most common preventable cause of mental retardation. Among thyroid hormones if free T4 level is low and TSH level is elevated a diagnosis of CH is confirmed. The prevalence of CH generally has no relationship with

maternal hypothyroidism state and treatment with thyroxine in antenatal mothers. New borns can have devastating neuro developmental consequences if not detected and treated promptly. Screening procedures for CH have developed in many countries and it has virtually eradicated intellectual disability due to severe CH. Screening has resulted in increased detection of mild CH. The underlying cause remains obscure in many cases. Thyroid hormone is essential for normal growth and neurological development particularly in first few years of life. Hypothyroidism during this period may damage the growth and development.

Materials and Method

From new borns blood is taken by prick method for screening. Blood is collected between 2-5 days preferably after 72 hours. Estimation is done by ELISA method. New borns with abnormal results are reviewed and venepuncture blood sample are drawn for confirmation. Free T4, TSH results are compared to age normal reference ranges and treatment should be started as early as possible.

The present study was conducted in the department of paediatrics and in neonatal intensive care unit. ACS Medical College & Hospital from January 2016 to September 2019. It was a retrospective study of congenital hypothyroidism Proforma was used to record information on age, sex, birth weight, mode of delivery, antenatal mother on thyroxine (regular/irregular) treatment. Investigations like free T3, T4, TSH levels were estimated.

Table 1: Background variables of the study subjects

Variable	Classification of Variable	Number (out of 80)	Percentage (%)
Mode of birth	Vaginal	8	10
	C- section	72	90
Gender	Male	39	48.8
	Female	41	51.2
Birth weight	< 3 kgs	61	76.3
	3 kgs	19	23.7

Table 2: Thyroid profile of the study subjects

Parameter	Mean	Standard Deviation, Standard Error	95% C. I
T-3	1.09	0.53, 0.06	0.97 – 1.21
T-4	7.75	3.47, 0.39	6.99 – 8.51
TSH	3.79	3.53, 0.39	3.03 – 4.52

Figure 1: Graphical representation of the birthweight of the babies

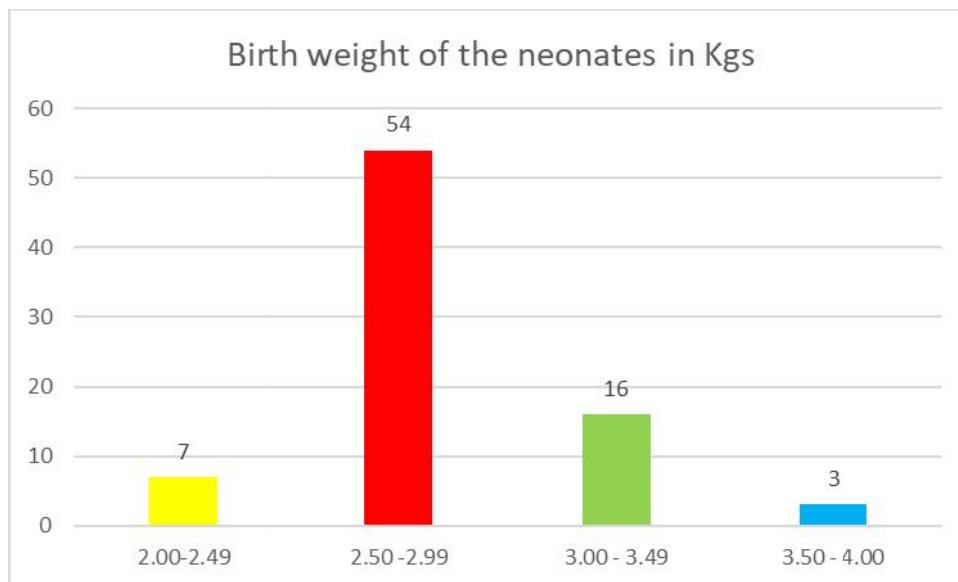


Table 3: Prevalence of hypothyroidism in neonates born to mothers with hypothyroidism

Total Number of Neonates	Number with Hypothyroidism	Percentage	95% C. I
80	2	2.5	-0.92 – 5.92

Table 3: Association between birthweight of the baby and certain factors

Variable	Classification of variable (number of people in the group out of 80)	Number of subjects who had babies with birthweight less than 3 kgs (out of 61)	Odds ratio (95% C. I of odds ratio)	Chi – square value	P – value
Gender	Male (39)	32	1.89 (0.66-5.45)	1.41	0.23
	Female (41)	29	1.00		
Mode of birth	Vaginal (8)	7	2.33 (0.27 – 20.28)	0.12	0.73
	C- section (72)	54	1.00		

Inclusion Criteria

New borns between 2-5 days born to hypothyroid mothers were included.

Exclusion Criteria

New borns below 48 hours and above 5 days were excluded.

Discussion

The thyroid gland is the largest single organ in the body specialized for endocrine hormone production. Its function is to secrete an appropriate amount of thyroid hormone, Tetra (T4) & Tri iodothyronine (T3). Iodine is trapped by thyroid and produce thyroglobulin and converted to tri iodo & di iodo thyroxine. Coupling with thyroglobulin occurs. Block in the synthesis at any level will lead to congenital hypothyroidism. In Primary Hypothyroidism T4 decreases and high TSH is seen. Secondary Hypothyroidism free T4 is decreased and low TSH. TSH is secreted by hypothalamus and regulated by thyrotrophic hormone. There is physiological surge in TSH in the first 48 hours of life because of cooling, cord clamping and stress of birth. Hence screening using either cord blood or heel prick after 72 hours of life should be done to avoid false positive results. Maternal thyroxine may mask the clinical features of hypothyroidism in neonates. Hence it is mandatory to screen all neonates for congenital hypothyroidism as it is a preventable cause of mental retardation. Since the screening test is a sensitive test primary TSH approach is followed in our country. Maternal antibodies and iodine can cross the placenta and block neonatal thyroid function. Hence watch the babies

for transient hypothyroidism. Only 0.25% of T4 and 0.35% of T3 are free. Hence free T3 hormone concentration correlates with the thyroid state.

Levothyroxine is the treatment of choice 10-15 µg / kg /day as the initial dose given as single dose in the morning crushed and mixed with breastmilk or water. Neonatal hypothyroidism if not treated immediately it will produce irreversible injury. The incidence is higher in Asian individuals & lower in Blacks. The incidence is greater in females than males. Down syndrome babies are at risk. 85% of cases are due to thyroid dysgenesis and 15% are due to dyshormonogenesis. Thyroid radionuclide uptake & scanning are the most accurate imaging tests to define the size and location of any thyroid tissue. Family hypothyroidism, mother or close relatives taking thyroid tablets, undergone thyroid surgery or physical signs & symptoms of hypothyroidism should be evaluated by paediatrics & endocrinologist. Definitive ones are increased TSH and decreased T4 levels.

Observation

On analysis of 100 cases 90% of the deliveries were caesarian section, 10% was vaginal delivery. That is due to mainly because of large babies. Regarding sex distribution males 49% and females 51%. Almost no gender difference, it was very marginal. Birth weight was more than 3 kg in 76% and less than 3 kg in 24%. Only 2 neonates were found to be in hypothyroid state. Male : Female 1 : 1

Conclusion

During the followup, monitor growth & development, compliance, symptoms, free T4 & TSH. Thyroid hormone enhances the growth with growth hormone. Increased BMR, increased heart rate, decreased cholesterol level and maintaining thermogenesis. Hence children with hypothyroidism have poor growth, hypothermia, lethargy and bradycardia.

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