



THYROID FLYER

Inside

FEATURE:

	Page
Congenital Neonatal Thyrotoxicosis	1
Open Letter to Husbands	4
A Sister's View	5
Emotional Impact of Thyroid Cancer	8
Scientific Review	7
Public Meetings	11
Telephone Contacts	11
Medicines Line	12

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Feature - The Impact on Families

Editorial

By Christopher McDermott

Welcome to the Spring and fourth edition of the *Thyroid Flyer* for 2002. The theme for this newsletter is thyroid and families. We have done this recognising the fact that our thyroid conditions have affected not only ourselves but our loved ones and those closest to us. Many of us are so grateful for the support of family and partners in helping us through our times of poor health - and also their patience with us waiting for us to improve - and be back to our "normal" selves which can take months or years.

We thought it would be good to hear some stories from the perspective of other family members.

Of course it is very important to have family members in mind given that it appears that thyroid conditions have strong genetic links.

On the committee of Thyroid Australia, we are having a busy time. We have only just recovered from organising our second annual one-day seminar at Monash. It was another very successful day with over 200 people tuning up at the Monash Rotunda to hear our guest speakers: A/Prof Peter Colman, Mr Bill Johnson and Dr Alla Turlakow. Our thanks to those speakers who gave up most of their Sunday. Not only was each talk fascinating and informative but each speaker was surrounded at the end of their sessions with people with extra questions. It was an excellent opportunity for people to get answers to questions and extra information from the experts. We are planning to publish Bill Johnson's and Alla Turlakow's articles in future newsletters, so keep posted.

I would like to thank committee members and the extra volunteers who helped on the day. The large number of people arriving in the morning can be

[Continued Page 12](#)

Congenital neonatal thyrotoxicosis and previous maternal radioiodine therapy

By C M Smith, J Gavranich, A Cotterill, C P Rodda

The risk of congenital thyrotoxicosis may well be apparent when a pregnant woman has florid thyrotoxic Graves' disease (figure). A maternal history of Graves' disease, however, may be overlooked, especially if the mother is taking thyroxine replacement after radioablation or surgery. Maternal thyroid stimulating antibodies may persist,¹ and consequently a woman's newborn infant is still at risk. Thyroid stimulating antibodies can be quantified by measuring the "thyroid stimulating hormone binding inhibiting immunoglobulin" (TBI) index.² This competitive radioreceptor assay measures binding to a porcine thyroid stimulating hormone receptor of the patient's immunoglobulin, compared with labelled thyroid stimulating hormone. A high maternal TBI index is a useful measure to indicate increased likelihood of disease developing in the infant. Although certain prediction of an infant being affected is not possible antenatally,^{2,4} a maternal TBI index of more than 30 units predicts, and more than 70 units strongly predicts, that the infant will be more likely to be affected. Therefore all infants of mothers with a history of Graves' disease must be carefully monitored, both clinically and biochemically, for up to seven days postnatally.

Maternal radioiodine therapy does not protect against congenital thyrotoxicosis — a blood test helps to predict those at risk

Although Graves' disease complicates 0.1-0.2% of all pregnancies, congenital thyrotoxicosis is rare, occurring in 1 in 70 of these pregnancies, and its development may be irrespective of either maternal disease or antibody status alone. Congenital thyrotoxicosis is transient, lasting up to three months or more, and is due to the transplacental passage of the stimulating (infrequently inhibitory) maternal antibodies of the IgG class, which may cause substantial neonatal morbidity or death if untreated.² We present two cases, the first illustrating the antenatal use of the TBI index in the mother, and the second showing morbidity in a premature infant in whom maternal Graves' disease was initially unrecognised.

Case reports

Case 1

A male infant was born at 36 weeks by spontaneous vaginal delivery to a mother with Graves' disease. The mother had received radioiodine (iodine-131; 248 MBq) shortly after conception, at which time her pregnancy test had been negative and she had denied the possibility of pregnancy on specific questioning. She elected to continue with the pregnancy and experienced a recurrence of her hyperthyroidism in the first trimester; she had to restart taking propylthiouracil (50 mg every eight hours), and she continued this treatment throughout her pregnancy. Her thyroid function remained normal while taking propylthiouracil until delivery.

[Continued Page 2](#)

Public Meeting 23 November 2002.
See Page 11.

THYROID AUSTRALIA

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Membership is not expensive and your money goes towards the costs of maintaining and hosting this site, staffing our office, producing our newsletter and researching thyroid problems and treatments.

Please visit the About Us section of our web site for details of how you can join Thyroid Australia and help us help others just like you.