



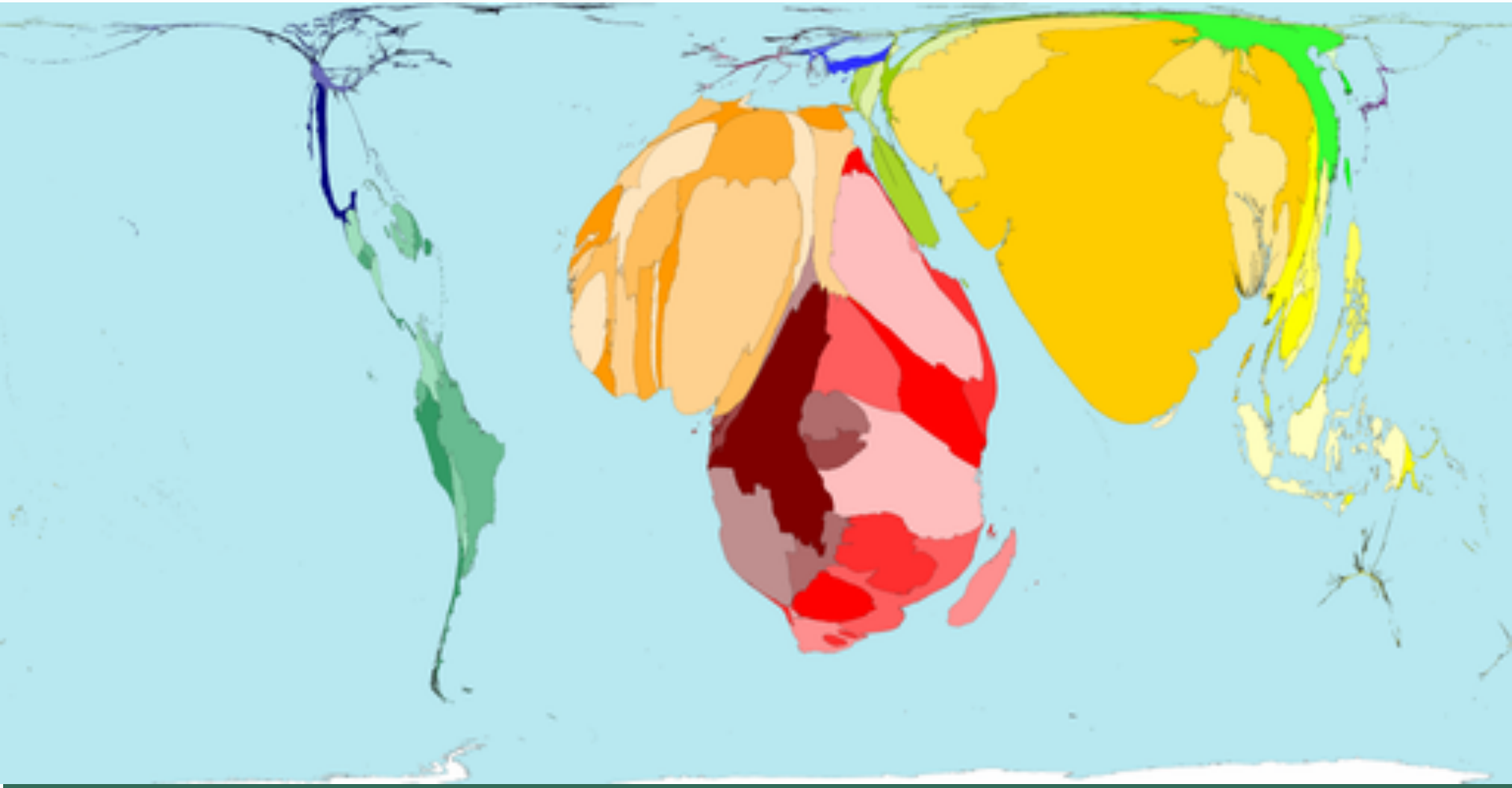
**International Federation of Gynecology and Obstetrics**

# FIGO Mission

- The International Federation of Gynecology and Obstetrics (FIGO) is a unique organization, being the only international professional body that brings together 130 obstetrical and gynecological associations from all over the world.

- FIGO is dedicated to the improvement of women's health and rights and to the reduction of disparities in health care available to women and newborns as well as to advancing the science and practice of obstetrics and gynecology. The organization pursues its mission through advocacy, programmatic activities, capacity strengthening of member associations and education and training.

FIGO



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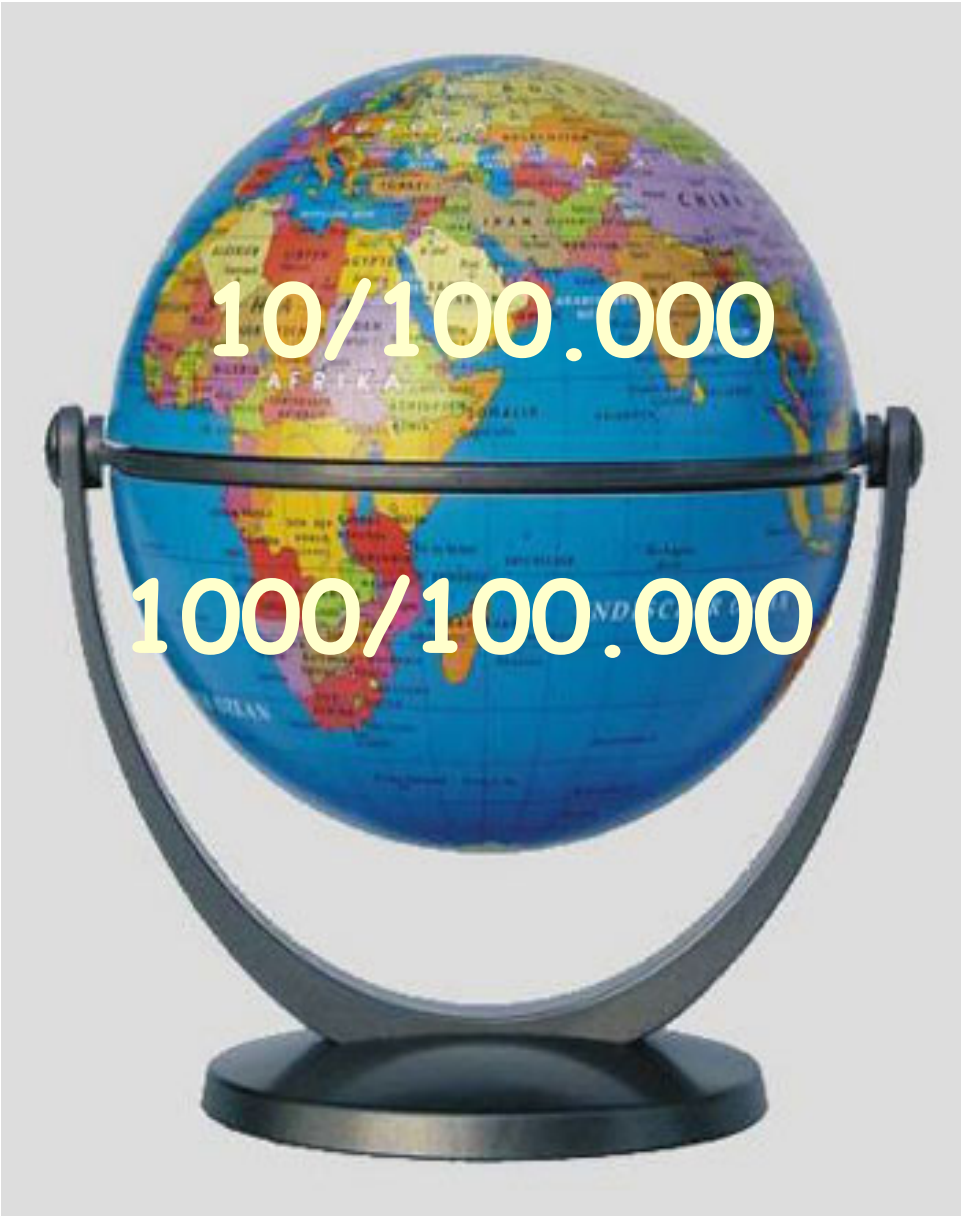


INEQUITIES

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*International Federation of Gynecology and Obstetrics*
*Working Group on Good Clinical Practice in Maternal-Fetal Medicine*

**Chair: G C Di Renzo**

**Expert members:**
E Fonseca, Brasil
E Gratacos, Spain
S Hassan, USA
M Kurtser, Russia
F Malone, Ireland
S Nambiar, Malaysia
M Sierra, Mexico
K Nicolaides, UK
H Yang, China

**Expert members ex officio:**
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M Hod, EAPM
GH Visser, SM Committee
E Castelazo , CBET Committee
L Cabero, WG GDM
V Berghella, SMFM
Y Ville, ISUOG
M Hanson, DOHaD, WG Nutrition
PP Mastroiacovo, Clearinghouse
JL Simpson, March of Dimes
D Bloomer, GLOWM

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*International Federation of Gynecology and Obstetrics*
*Working Group on the Challenges of Labour and Delivery*

**Chair: R Romero**

**Expert members:**
**D Farine, Canada**
**MT Gervasi, Italy**
**J M. Robson, Ireland**
**T Duan, China**
**S Rosales, Mexico**
**T Kimura, Japan**
**L Yeo, Korea-USA**

**Expert members ex officio:**
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**G C Di Renzo, FIGO**
**M Stark, NESA**
**GH Visser, SM Committee**
**E Castelazo , CBET Committee**
**C Lees, RCOG**
**A Conde' Agudelo, NIH NICHD**
**D Bloomer, GLOWM**

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march of dimes

*International Federation of Gynecology and Obstetrics*
*March of Dimes*
*Working Group on Preterm Birth Prevention*

**Chairs: J L Simpson**
**G C Di Renzo**

**Expert members:**
**Ernesto Castelazo**
**Mary D'Alton**
**Eduardo Fonseca**
**Chris Howson**
**Bo Jacobsson**
**James Martin**
**Jane Norman**
**T Y Leung**

**Expert members ex officio:**
**CN Purandare, FIGO**
**J Howse, March of Dimes**
**G Visser, SM Committee**
**D Bloomer, GLOWM**
**Jim Larson BCG**
**David Ferrero, BCG**

FIGO

International Diabetes Federation

*International Federation of Gynecology and Obstetrics*
*GDM initiative*

**Chair: M Hod**

**Expert members:**
**Mukesh Agarwal**
**Blami Dao**
**Gian Carlo Di Renzo**
**Hema Divakar**
**Eran Hadar**
**Anil Kapur**

**Expert members ex officio:**
**CN Purandare, FIGO**
**GH Visser, SM Committee**
**D Ayres do Campo, SM Comm**
**L Cabero, CBET Committee**
**D Bloomer, GLOWM**
**R Fabienke, Novo Nordisk**

# Good practice advice

- *Folic acid supplementation*
- *Prediction and prevention of preterm birth*
- *Non invasive prenatal diagnosis and testing*

# Good practice advice

- *Thyroid diseases in pregnancy*
- *MgSO4 use in obstetrics*
- *Appropriate use of ultrasound in pregnancy*
- *Hyperglycemia and pregnancy*

# Good practice advice

finalised in June 2016

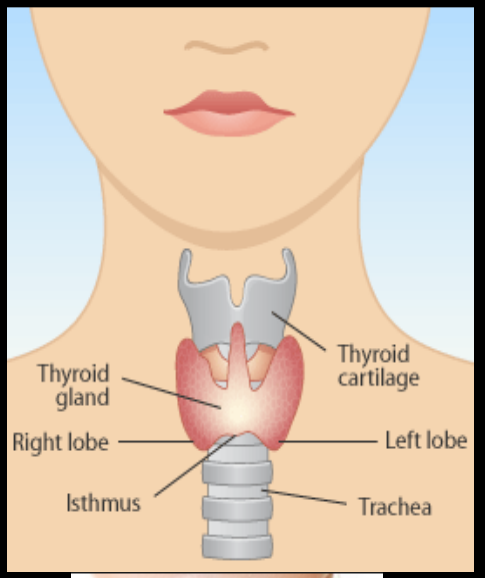
- *Aspirin Use in Pregnancy*
- *Iron deficiency anaemia*
- *Management of Twin Pregnancy*
- *Micronutrients in Pregnancy*

# Good practice advice

to be discussed on December 2016

- *Intrauterine growth restriction*
- *Recurrent Miscarriage*
- *Prediction of pre eclampsia*

# Thyroid Gland




**One of the largest endocrine gland**

**2 inch long, Butterfly shaped gland**

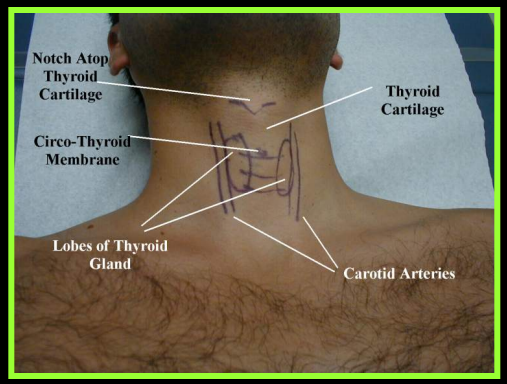
**Located front of the neck, below the larynx**

**It has two lobes (Right & Left)**

**Average weight 25-30g in adults** (slightly more in women)

**The thyroid makes two thyroid hormones**

- **Thyroxine (T4)**
- **Triiodothyronine (T3)**

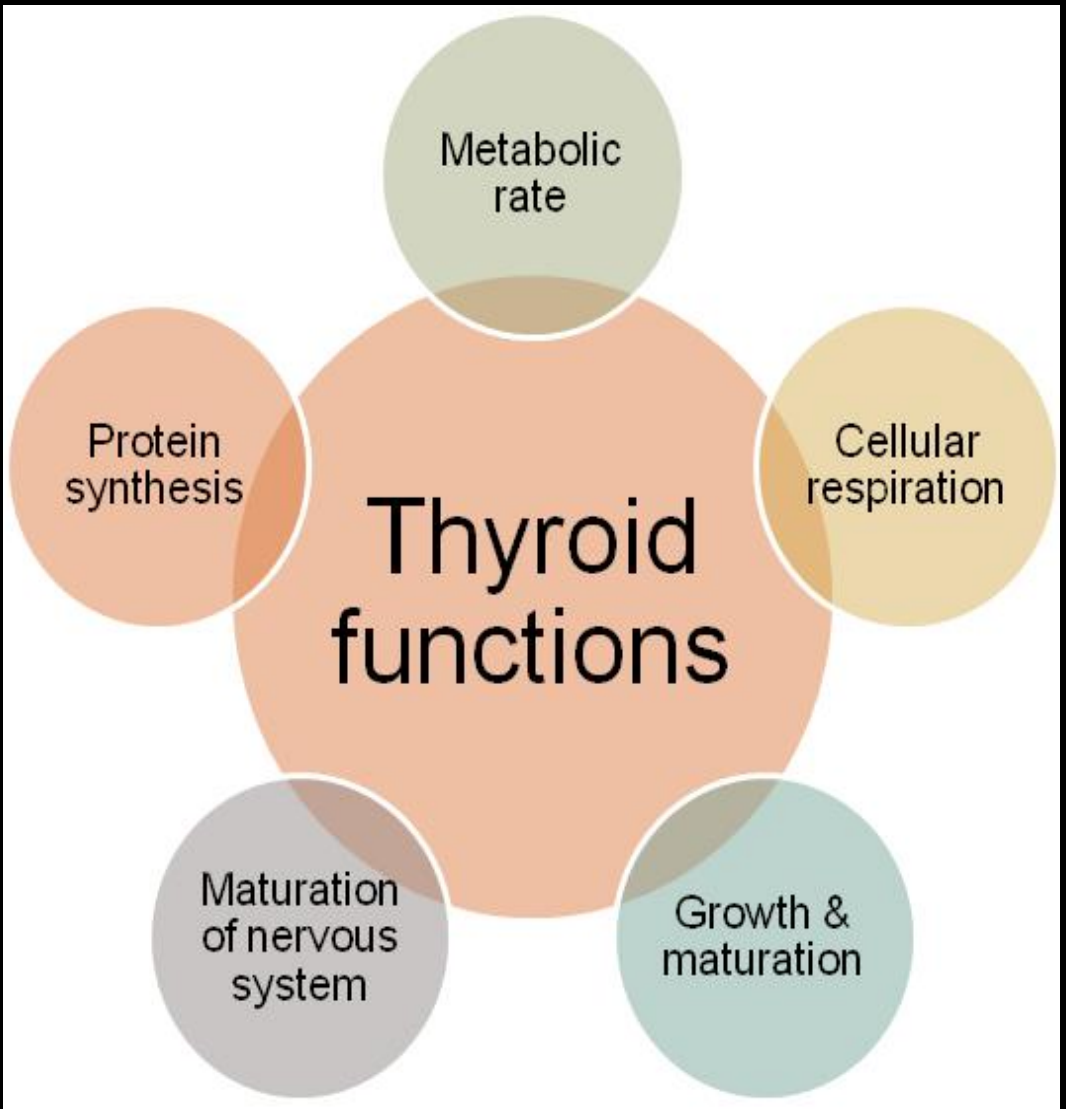



International Journal of Health Sciences & Research.2013;3(5):29

# Thyroid Gland Functions

**One of the largest endocrine gland The thyroid makes two thyroid hormones**

- **Thyroxine (T4)**
- **Triiodothyronine (T3)**




**MOST OF FUNCTION DUE TO T3**

Growth & development

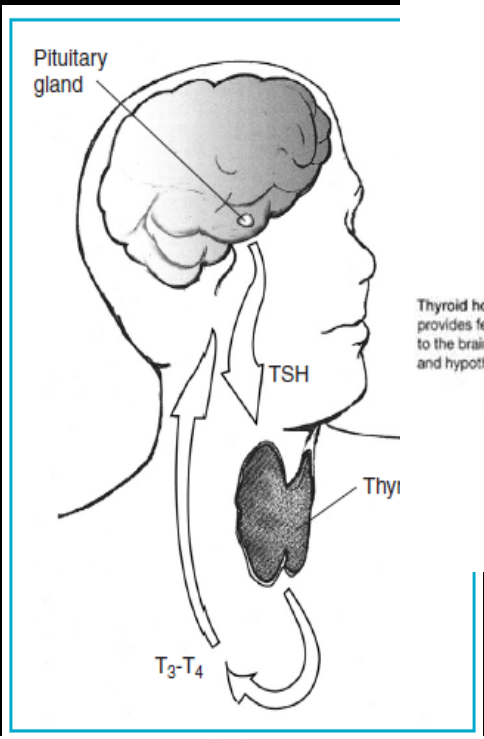
Increasing rate of metabolism

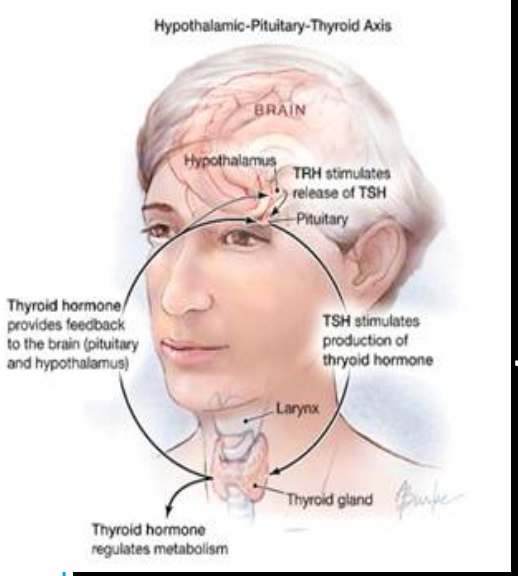
Increase metabolic rate in CVS → blood flow

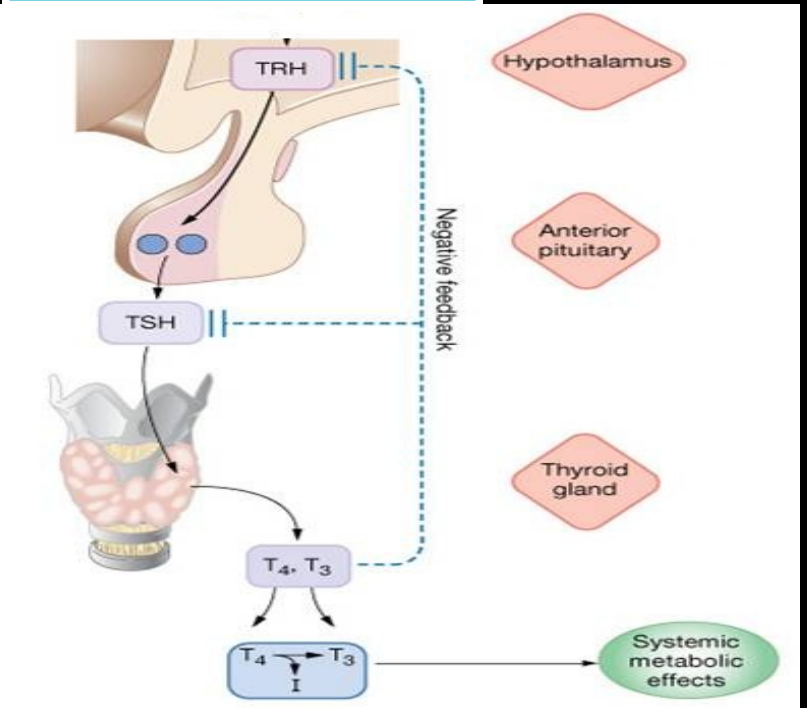
Regulating cerebral conducion in cns

Sleep

Lipid metabolism




## Points to be remembered....

**When thyroid hormone levels in the blood are low, the pituitary releases more TSH.**
(↓ T4 & T3 ---↑ TSH)

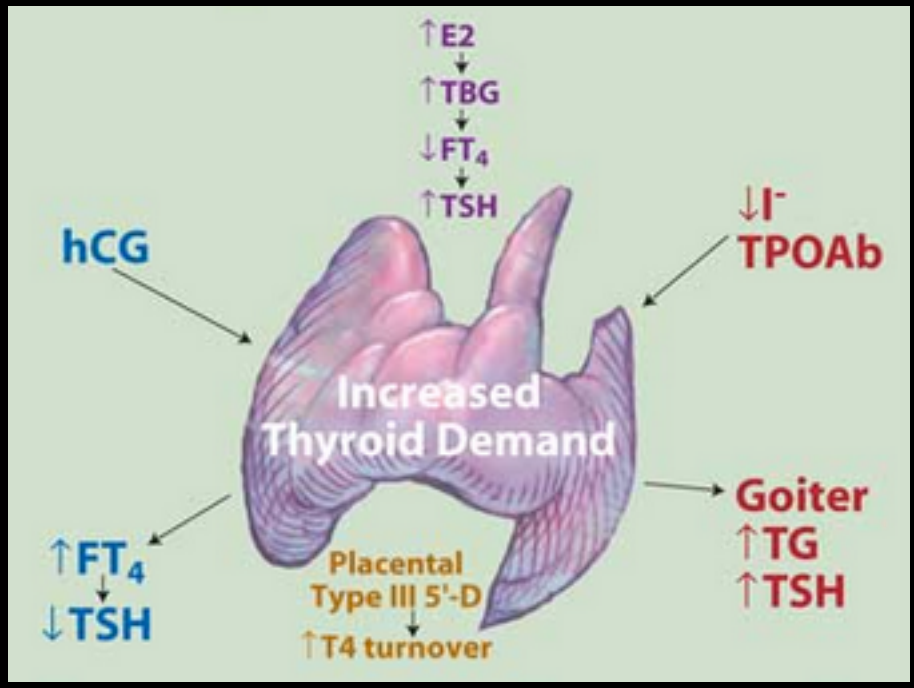
**When thyroid hormone (T4, T3) levels are high, the pituitary decreases TSH production.**
(↑ T4 & T3 --- ↓ TSH)

**Increased TSH levels indicates.....**
**Pituitary gland working extra hard to maintain normal circulating thyroid hormones !**

Early Pregnancy

Serum Thyrotropin level decreases

Weak TSH effect of HCG
*'Spill over'*
Increase in free Thyroxine




**TSH: decreases in first trimester**

**TSH increases in second & third trimester**

**TT3 & TT4 : rise in preg**
**FT3 & FT4 : less altered**

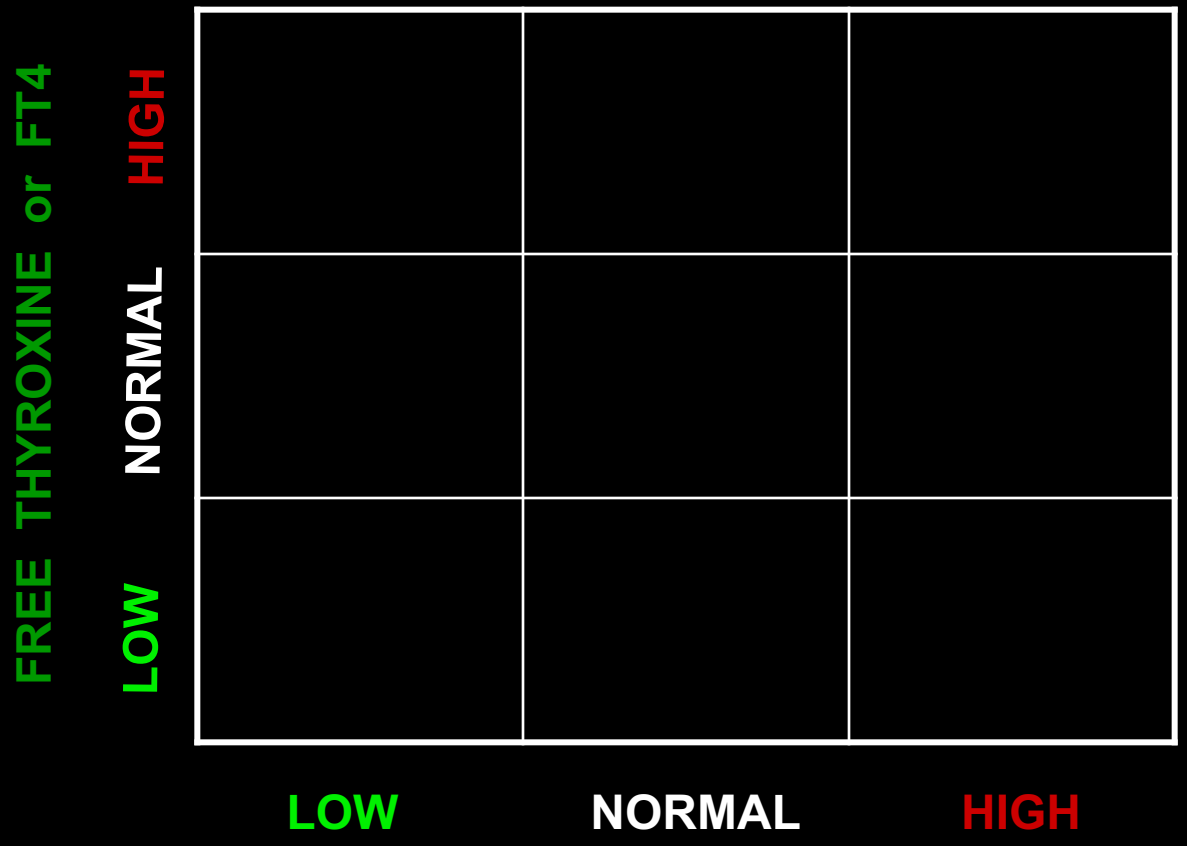
1.Lazarus JH. *British Medical Bulletin*. 2010;1-12.
2.Galofre JC. *J Womens Health (Larchmt)*. 2009;18(11):1847-185
3.Thyroid disease and pregnancy. American Thyroid Association website

# The Nine Square Game

To evaluate our Thyroid patient

As per the AACE and ITS Guidelines

# BASIC THYROID EVALUATION



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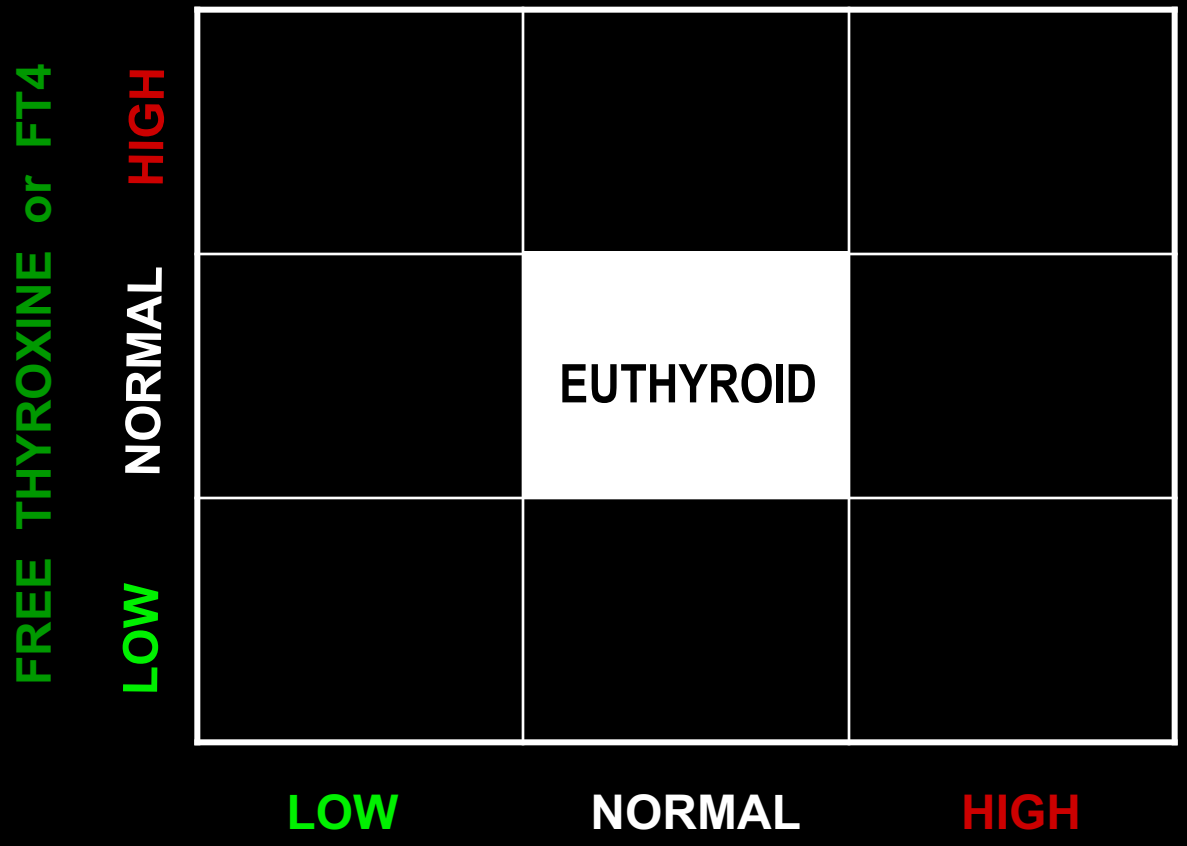

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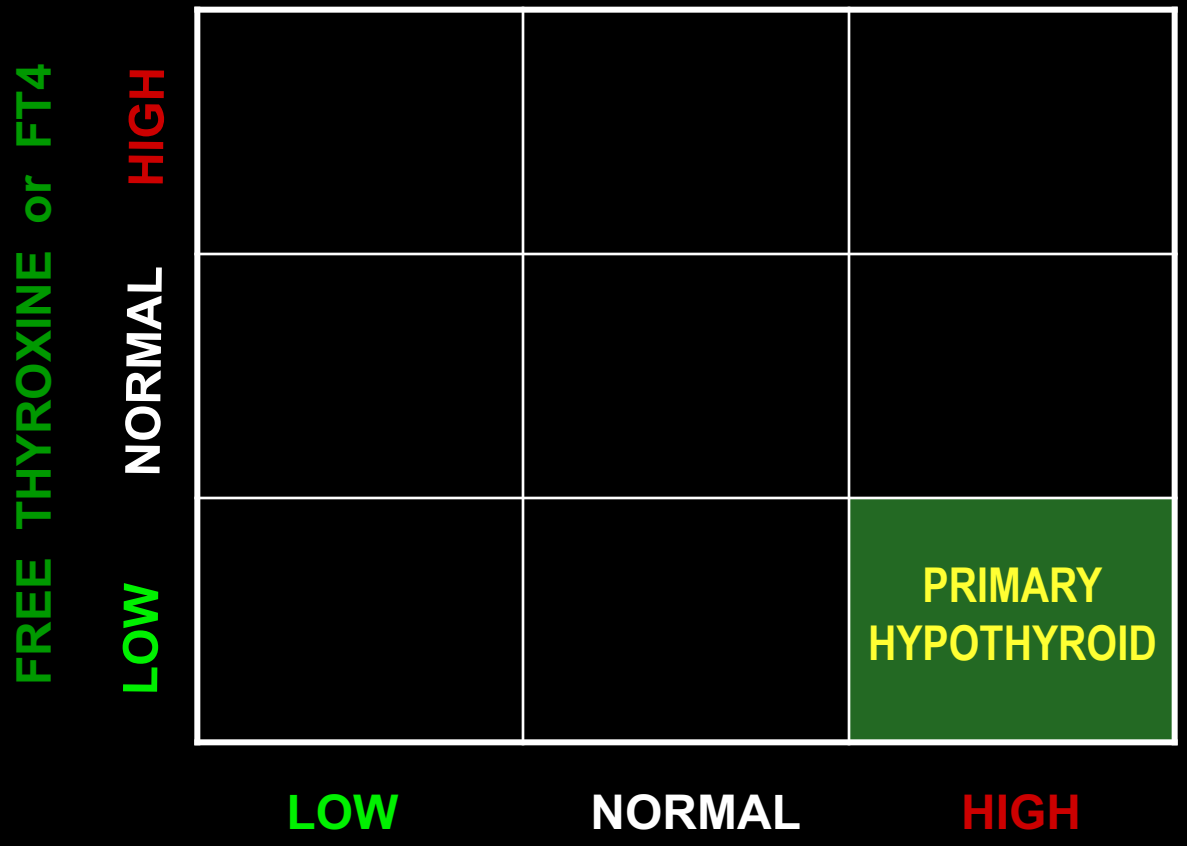

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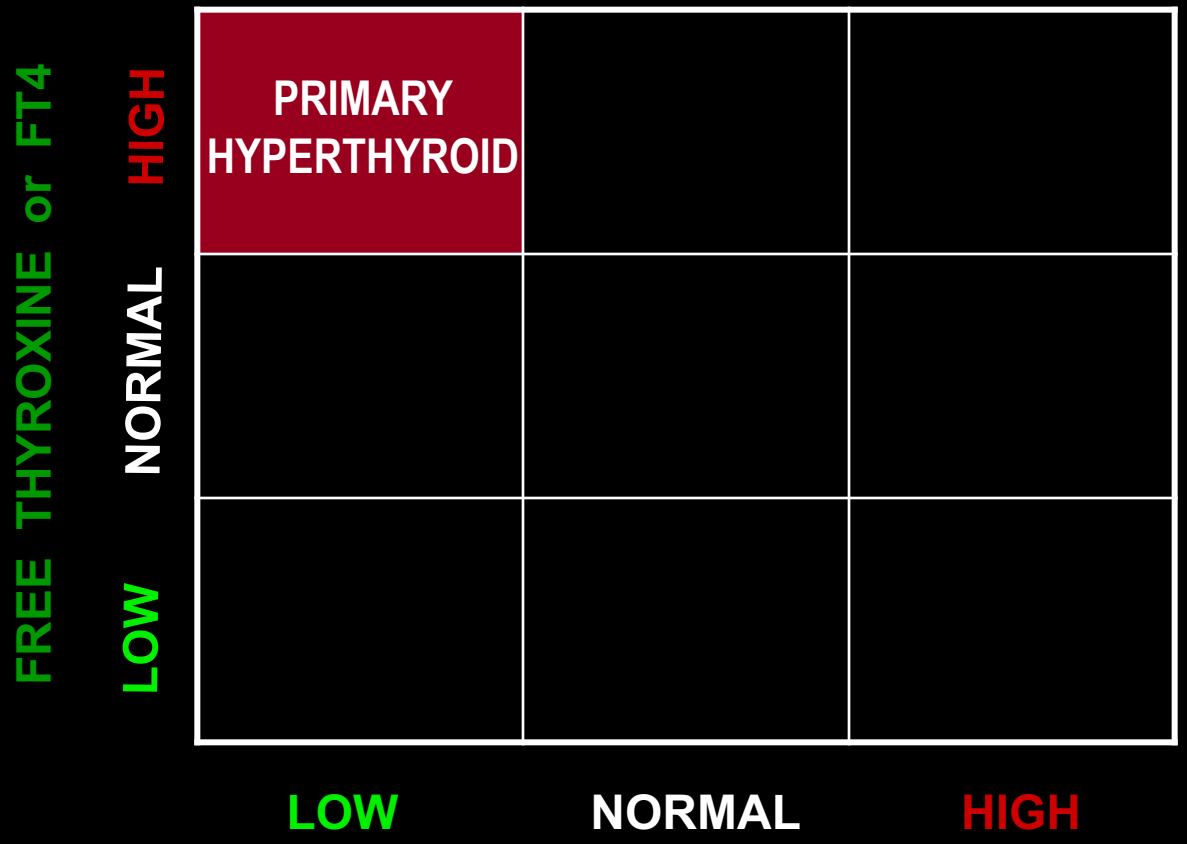

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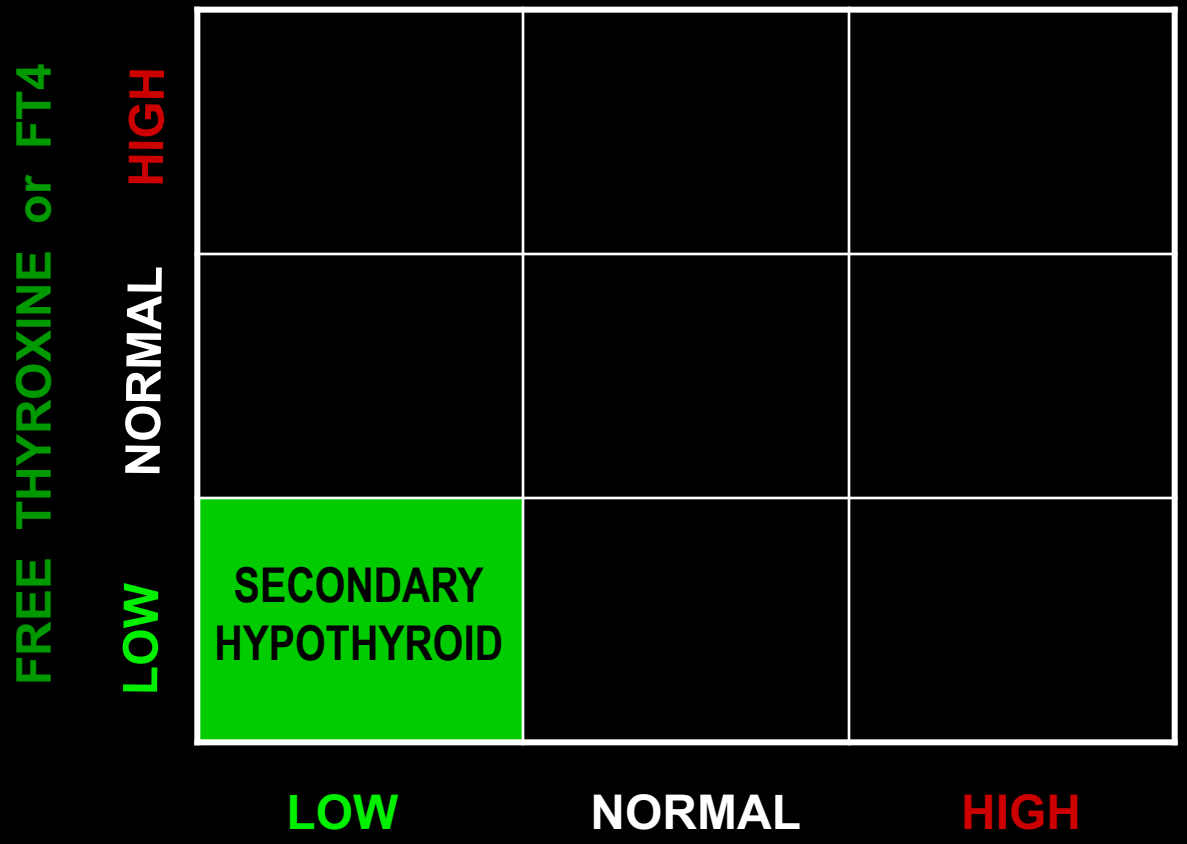

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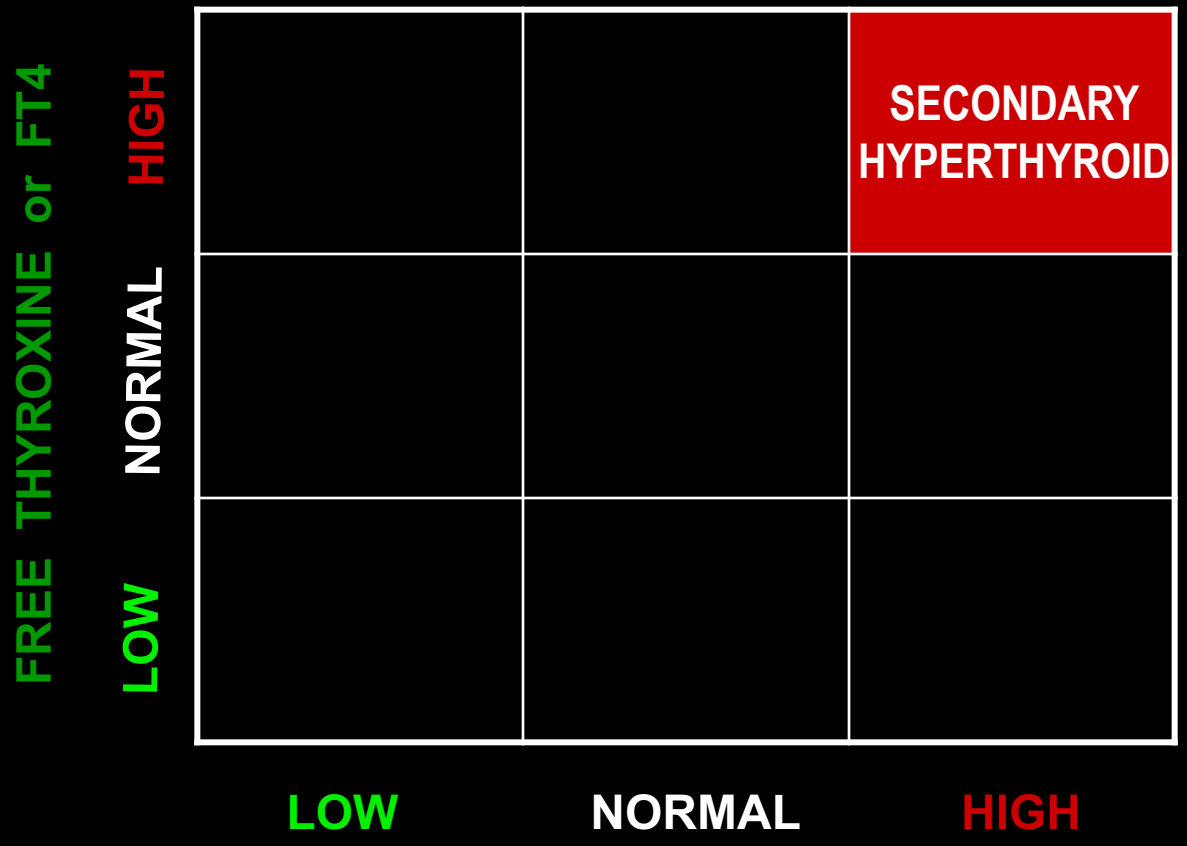

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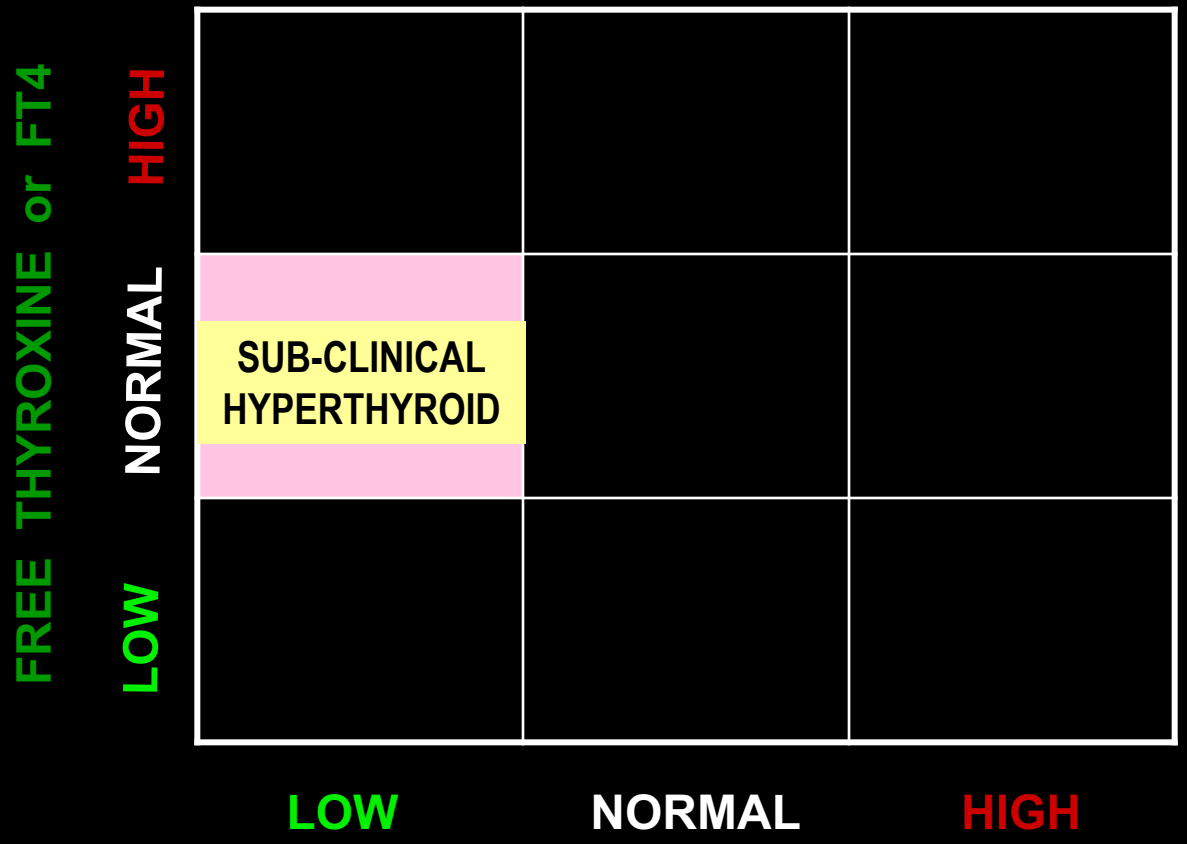

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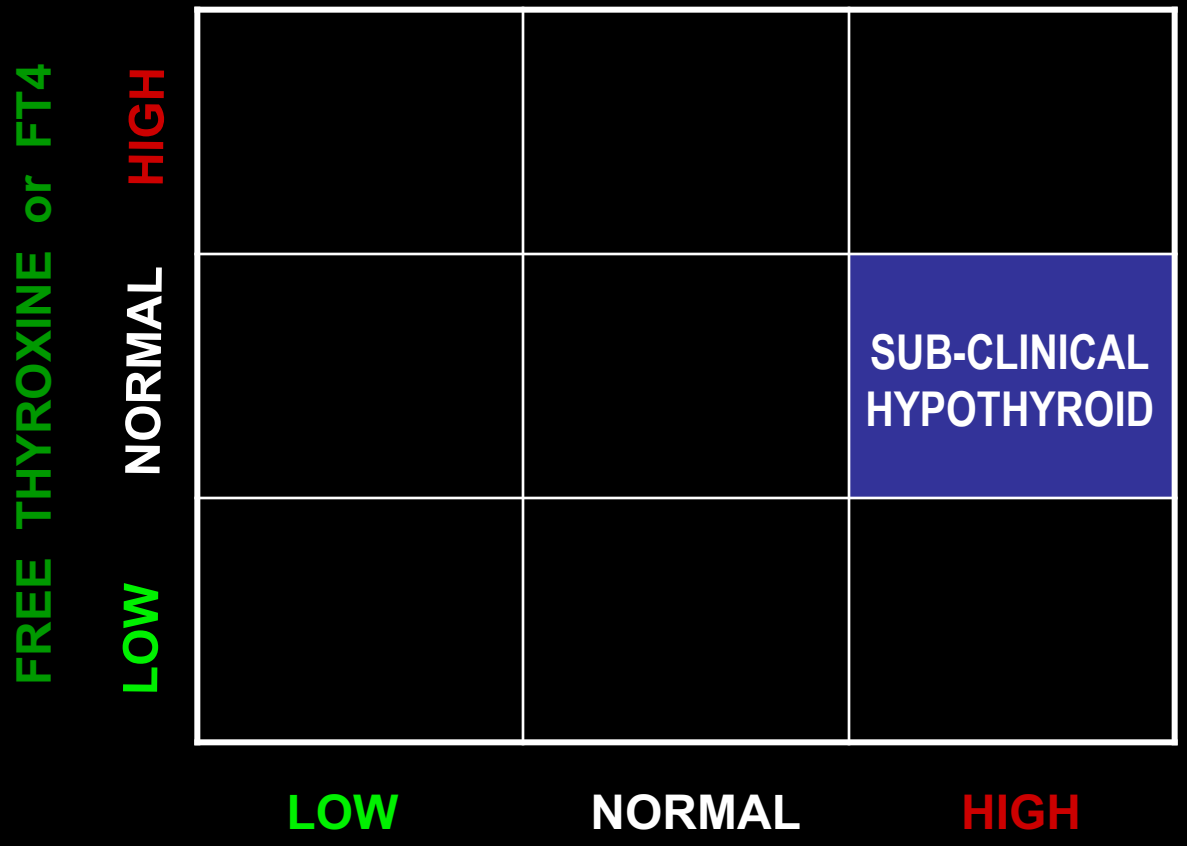

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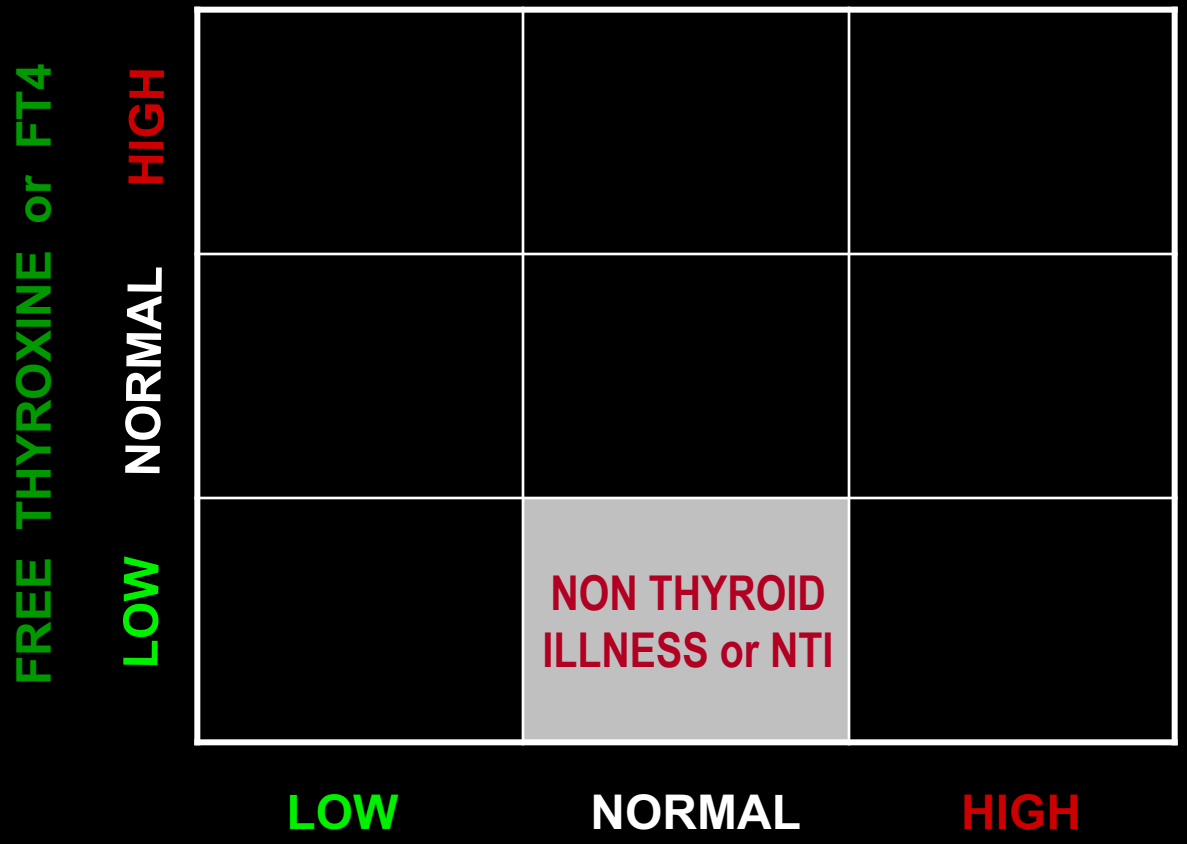

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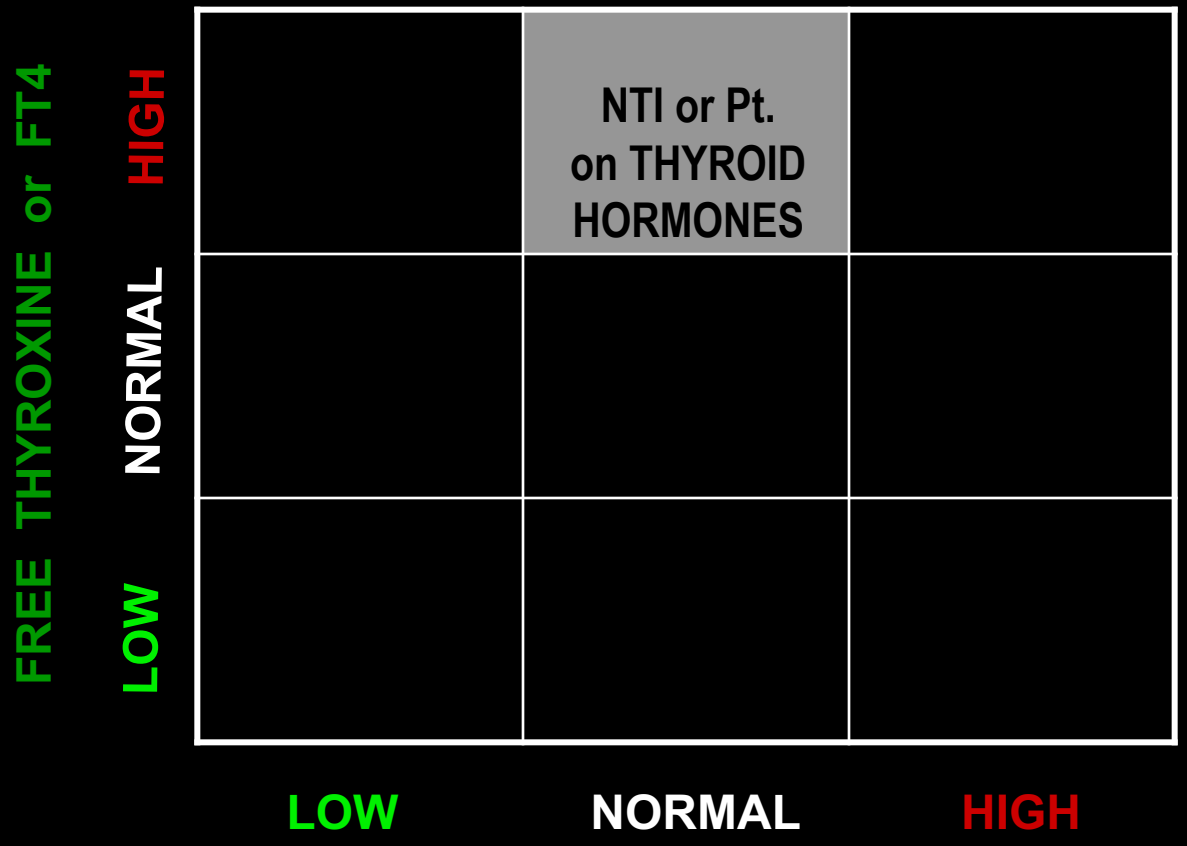

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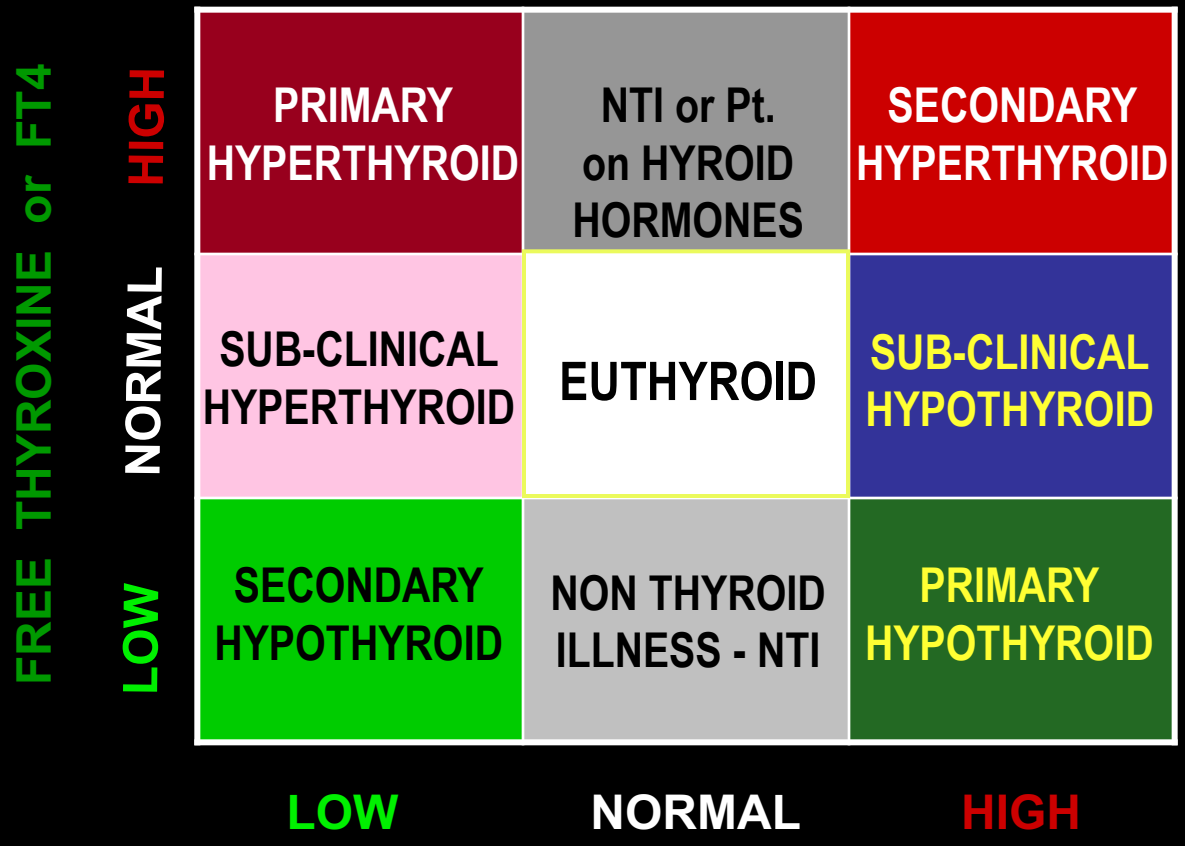
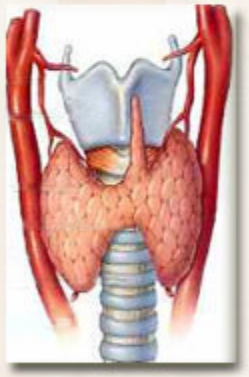


# THYROID HORMONES

| TEST | REFERENCE RANGE |
| --- | --- |
| TSH | Normal Range 0.3 - 4.0 mU/L |
| Free $T_4$ | Normal Range 0.7-2.1 ng/dL |

**TSH upper limit has been revised to 2.5 mU/L**

# Thyroid Disorder



| | |
|---|---|
| HYPERTHYROIDISM | HYPOTHYROIDISM |
| SOLITARY NODULE /GOITRE | POSTPARTUM THYROIDITIS |

Thyroid disease is the second most common cause of endocrine dysfunction in women of child bearing age.

Hypothyroidism is more common during pregnancy than hyperthyroidism.

# CONCLUSIONS
# Pearls for Practice

## Thyroid dysfunction

### Hypothyroidism

- T4 essential for early fetal development
- Little T4 crosses placenta after 1st trim
- Adequate treatment – good outcome

### Hyperthyroidism

- Careful D/D at early weeks
- Untreated- poor preg. Outcome
- drugs cross placenta: lowest optimal dosage
- Cord blood - Thyroid function

### Postpartum Thyroiditis

- Occurs 3-4 mths postpartum
- Autoimmune disorder
- Phases of hyper-hypo-recovery
- Annual thyroid function tests

### Thyroid nodule & Cancer

- Defer preg. For 1 year after trt. With radioactive iodine
- Nodule identified beyond 20 weeks- biopsy after delivery
- Large goitre – anesthetic complications

# FIGO recommends the following:

•Screening for thyroid function is recommended in the first trimester particularly in countries with a deficient iodine diet and in symptomatic patients

•TSH is the superior method for screening. Free T4 and TPO Ab testing are not recommended for screening. The best reliable tests for TSH are by C.I.A or 3rd generation R.I.A (Radio Immuno Assay). Notably normal thyroid test values change in pregnancy

•Treatment for hypothyroidism is recommended when TSH levels are >2.5 and >3,0 IU/L during the first and second/third trimesters respectively. The only replacement therapy is L-thyroxine. The starting does of L-thyroxine are presented in fig. 4. Instead treating subclinical hypothyroidism, in the presence of negative thyroid auto-antibodies, is still debatable. Importantly, women on L-thyroxine before pregnancy should increase their dosage by 30-50% when they first recognize the pregnant state.

•Treatment of Hyperthyroidism due to Grave's disease is by anti thyroid drugs (Propylthiouracil (PTU) or Carbimazole/Methimazole (MMI) ). It is not recommended to change drugs during pregnancy Symptomatic (fig-1) treatment with beta- blockers for short term may be needed.

•Primary, prevention of hypothyroidism is by a healthy diet and Iodised fortified salt (especially in iodine deficient areas).

•If the patient has a thyroid nodule she should be evaluated and treated during pregnancy. The first steps are perfomance of a thyroid ultrasonogram and a fine needle aspiration (FNA) as needed. Surgery should be preferably deferred to the postpartum period.

Follow up and postpartum TSH evaluation and reduction of L-thyroxine dose to pre- pregnant levels in patients with hypothyroidism.

# CONCLUSIONS

# FOCUS ON GLOBAL STRATEGIES

AMELIORATE OUR PROFESSION OVERCOMING THE LIMITS OF NATIONAL SOCIETIES GUIDELINES: THE BEST PRACTICE ADVICE

GLOBAL STRATEGIES FOR:

PRETERM BIRTH PREVENTION

NON COMMUNICABLE DISEASES

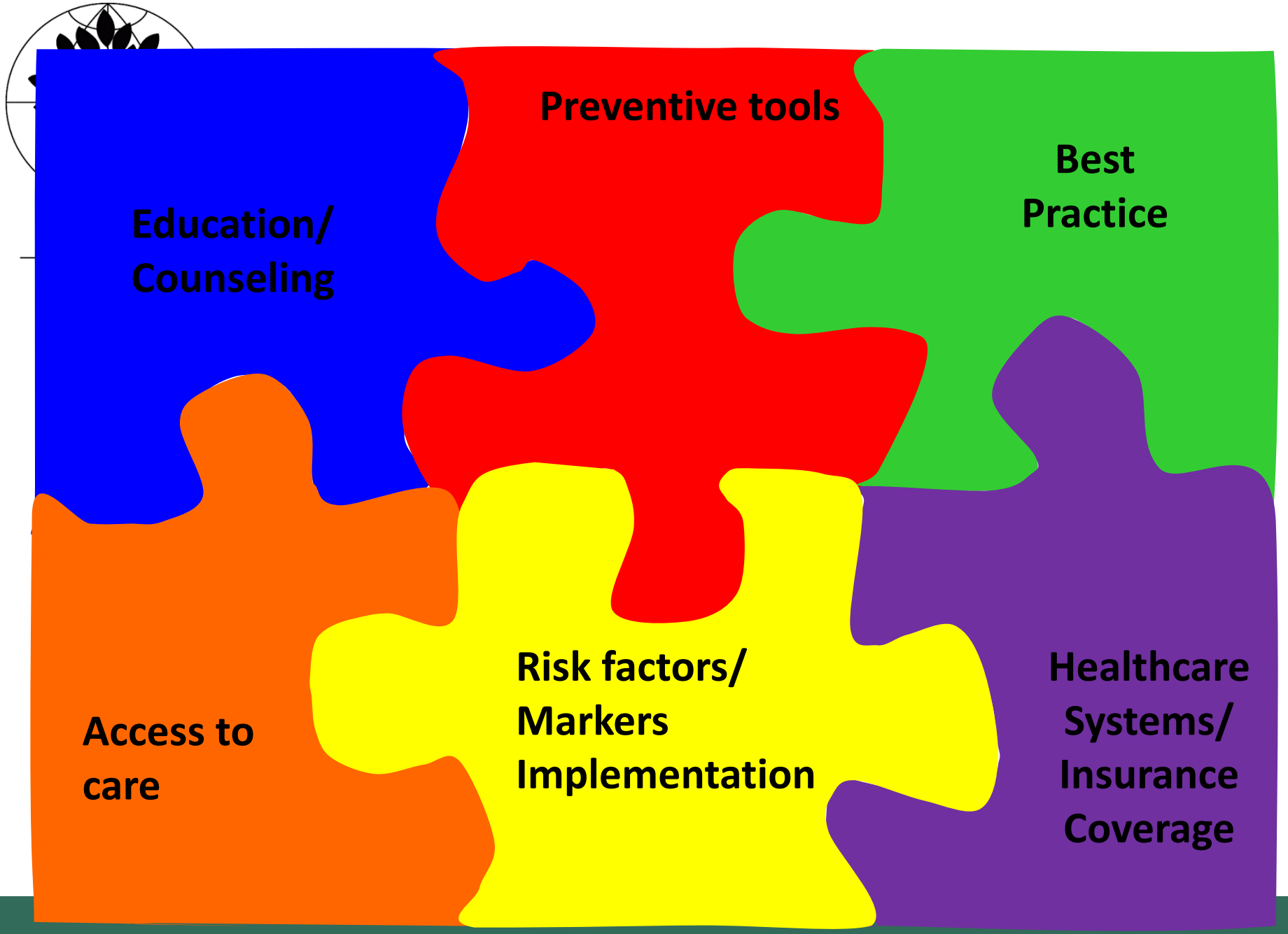
PREVENTING EXPOSURE TO TOXIC CHEMICALS

# FIGHTING THE INEQUITY

Gathering data on maternal mortality and maternal health is notoriously difficult.

However, one thing is clear from all the statistics: although maternal and perinatal mortality and morbidity is falling globally

the perspectives for women-infants in poor resources countries are much worst than for those in industrialised countries.


Education/
Counseling
Preventive tools
Best
Practice
Access to
care
Risk factors/
Markers
Implementation
Healthcare
Systems/
Insurance
Coverage

# Window of Opportunity

Pregnancy offers a window of opportunity to provide maternal care services to mother and offspring

Reduce traditional maternal and perinatal morbidity and mortality indicators

Address intergenerational prevention of preterm birth and NCDs, such as diabetes, hypertension, cardiovascular disease, and stroke.

On Sept 2015 the UN General Assembly adopted the **"Agenda 2030: Transforming our World"**, with a consensus of the World Government Community - introduced 17 sustainable development goals SDGs**.**

Many of the suggested SDG's have Environmental and Reproductive health embedded in their goals

It is a sheer co-incidence that September 2015 witnessed the 20th anniversary of the Beijing World Conference on Women under the slogan -**"Planet 50-50 by 2030: Set it up for Gender Equality"**.

**'The Agenda 2030; Transforming our world' or Planet 50-50 by 2030' i.e. SDGs** will not materialise without the contribution of 50% of its population i.e. women - This can be achieved only with gender equality, equal education and employment opportunities + providing sexual reproductive health and rights.

Reproductive Health and Rights will not be complete unless we improve environmental Health

**FIGO was not and will not be a passive observer to bring about this required change and will act to make these dreams real for women.**


FIGO


EFCNI
european foundation for
the care of newborn infants


GLOWM
Global Library of Women's Medicine


IPPF


BILL & MELINDA
GATES foundation


March
of Dimes
Saving babies, together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