The Sessional GP

October 2025

nasgp National Association of Sessional GPs

Thyroid disease in pregnancy

Digital therapies for tic disorders and Tourettes in children

Forthcoming NHS pension feature on NASGP locum platform

CONTENTS

nasgp

National Association of Sessional GPs

Dr Richard Fieldhouse,
NASGP Chairman

Editorial

Autumn is upon us and we have some great news for members, whose tireless efforts and dedication has encouraged so many practices to sign up for and utilise NASGP's own unique platform, LocumDeck.

In many areas, especially where we have strategic partners at Suffolk and North East Essex, and Gloucestershire ICBs' GP Training Hubs, this has been instrumental in helping GP locums to secure work, ensuring a buoyant and sustainable locum eco-system in these areas. And of course, it's also helped practices secure much-needed GP appointments.

This has created a fantastic way for practices to hire GP locums on a footing that is advantageous not only to our GP locum members but also to the practices and their patients.

This recognition highlights the vital importance of empowering GPs and giving practices the support they need.

Good luck with your bookings over the next couple of months! We'll be back with more news in December.

Don't lose out
when you are unable to work

with specialist
locum absence insurance
for NASGP members

- 2 types of policy to fit your needs
- 2 levels of cover to help you budget
- Worldwide protection
- Seamless transfer from your current provider
- Accident & Illness cover
- Stress cover
- Death benefit from £50,000 or more
- Medical Expenses cover

and many more benefits

GP required a hip resurfacing procedure and was unable to work for 6 weeks, with a total payment of

£5,914

GP suffered from COVID 19 with complications resulting in 10 months unable to work and a total payment of

£52,071

The wife of a GP unexpectedly became ill causing the GP to suffer a mental health condition, which resulted in an absence from work of 12 months.

Total amount claimed:

£55,600

medical insurance consultants

Contact us for your free, no obligation quote

E: enquiries@m-i-c.co.uk
T: 0800 163 870

www.m-i-c.co.uk

Digital therapies for tic disorders and Tourettes in children (NICE, 2025)

This is a new guideline from NICE advising that a new digital therapy for tic disorders can be used in the NHS. It was published in May 2025.

I should explain that this is a health technology appraisal. It is looking at a couple of very specific treatments for tic disorders and doesn't give advice on overall management of tics.

There is some information on managing tics in young people in the NICE guideline on neurological disorders.

What is the new technology that can be used?

It is called ORBIT. This stands for Online Remote Behavioural Intervention for Tics. This is online guided self-help. It is age-appropriate. It is designed for both patients and their carers. It uses video, animations and clips. It also includes psychoeducation. There is therapist contact each week (about 10 to 20 minutes). The therapist promotes engagement and answers questions, rather than providing the actual therapy.

Basically the programme teaches children and young people to suppress their tics, whilst tolerating the urge to tic.

Who can it be used for?

Children and young people aged 9 to 17. It is also intended for parents to use alongside their child.

It is important to note that ORBIT can be used with 'standard care' in the NHS during the 'evidence generation period'. Evidence has to be generated during this time to work out how effective it is. At the end of this time (probably about 3 years), NICE will then decide whether it can continue to be used.

Why may it be helpful?

There is obviously a long wait for therapist support in the UK at present. An online programme should give faster access to treatment. It is also very easy for people to access, however remotely they may live.

NICE don't mention this, but I see a lot of people who would rather engage with an online platform than with a face to face therapist.

How will it fit into current treatment pathways?

That isn't very clear as this isn't a guideline – just a technology appraisal.

However, they do make it clear that the first line treatment should be psychoeducation (eg resources to inform the patient, carers and school about the condition). For many children this will be enough.

In their guideline on neurological symptoms, they advise that children with simple motor tics that aren't bothersome to them, do not need referring.

Only refer if it is having a significant impact on their quality of life.

At present, it isn't clear if we in primary care will be referring for use of ORBIT, or if patients will be referred by specialist services.

Is it effective?

From what I can see from the guideline, the studies have shown that there is lower tic severity in the intervention groups, but that there was no significant difference in tic related impairment and in distress. The committee felt that more evidence was needed to be certain of the clinical efficacy. It hasn't been compared to more conventional therapy.

Are there any other technologies out there that may help?

Neupulse is a wrist worn neuro-modulation device that is also looked at in the guideline. It can be used in young people over 12 and in adults. It targets the brains sensorimotor networks by providing impulses to the median nerve. It will be available to buy over the counter. It isn't yet available, but may be from 2026. Because it does not yet have marking approval, NICE can't make any recommendation as to whether it should be used or not. From what I can see, it is unclear as to how effective it is.

Is there any other useful information out there that we can signpost patients to?

NICE doesn't list any advice to give to patients and carers as this isn't a guideline.

The following are resources that I have found helpful to share.

- Great Ormond Street. Has information on tics and leaflets to share with teachers.
- NHS information on tics.
- Hampshire CAMHS.
- Tourettes Action tips for managing tics (but good for those without Tourette Syndrome too).
- Health for Teens. Good information written for young people.

These summaries should be checked against the original resource in focus and are in themselves not a clinical reference

Medical Protection

I am protected by experts who put me first

Moving from training into independent practice involves lots of 'firsts'. That's why it's good to know Medical Protection membership can give me the support I need to practise with confidence.

Membership for newly qualified GPs

- 24/7 advice and access to medicolegal assistance
- discretionary indemnity for patient claims where required
- independent counselling service
- online courses and webinars for CPD and revalidation

Save up to 50% on your **first year's subscription*** when you qualify

medicalprotection.org/nqgp

*Membership rates vary depending on individual circumstances. Please visit **medicalprotection.org/nqgp** for more information.

I am a GP **I am with Medical Protection**

THYROID DISEASE IN PREGNANCY

This is a new guideline from RCOG on managing thyroid disease in and around pregnancy. It was published in 2025.

There is information on CKS for managing both hyperthyroidism and hypothyroidism in pregnancy and in those planning to conceive, but there isn't much in the main NICE guidance. It would appear that this new RCOG guideline is the most up to date resource on managing thyroid disease in pregnancy.

If you think that we don't need to be doing much of this in GP, then read on – as this guideline suggests that we can do a lot.

Is there much that is new for us in this guideline?

There is quite a lot that is new here. I have put the headlines below, but will go into more detail in the main blog below. I was rather hazy around some of the science involved here, so I have added some of the background that was in the guideline, as it helps to make sense of the recommendations.

Although the bare bones of this aren't new (ie pregnant ladies need close monitoring and more thyroxine), the details of how we do this are much more specific. The levels that we are aiming for in TSH / T4 are also more specific. I think this is very helpful as it means that we can confidently do a lot more of this in general practice. This guideline does suggest that we can be doing most of this ourselves. Again this is quite new as previously the onus was on getting the initial tests done, then deferring to endocrinology.

If you want a quick guide to management, just jump straight to Appendix E (for hypothyroidism) and Appendix F (for hyperthyroidism) in the guideline. I have also copied these into this blog.

What is new for us?

- Normal values should be based on the trimester of pregnancy and also on manufacturer specific levels. Normal values are different throughout pregnancy and for different test manufacturers.
- Patients with specific risk factors for overt thyroid disease should have their thyroid function tested as soon as possible in pregnancy, ideally in the first trimester.

Hypothyroidism

- For those with hypothyroidism and those with severe subclinical hypothyroidism (they define this as TSH > 10 but a normal T4), titrate levothyroxine to achieve a TSH of ≤ 2.5 mU/L.
- Pre-pregnancy we should counsel women with hypothyroidism that as soon as they have a positive pregnancy test, they should self-initiate an increase in their levothyroxine dose. They should do this by doubling their dose of levothyroxine on 2 days of the week.
- For women with hypothyroidism who are pregnant and who are treated with levothyroxine, we should monitor their TSH and T4 every 4 to 6 weeks until 20/40, then should check it again at 28/40.
- Aim to keep TSH ≤ 2.5 whilst keeping T4 normal for trimester and manufacturer specific ranges.
- Women can convert back to their pre-conception dose 2 weeks after delivery and thyroid function should be checked 6 to 8 weeks thereafter.

Subclinical hypothyroidism

- In women with subclinical hypothyroidism, especially in those who are thyroid peroxidase antibody (TPOAb) positive, consider starting levothyroxine preconception. You should aim for a TSH ≤ 2.5 mU/L.
- In women diagnosed with subclinical hypothyroidism in pregnancy, consider using levothyroxine, especially when they are in the first trimester.
- If women were started on treatment during pregnancy, they should stop it post delivery and their thyroid function should be checked after 6 weeks.

Hyperthyroidism

Hopefully your patients will be under the specialist, but…

- If women are on carbimazole and are < 10/40, we need to initiate a change to PTU ASAP (I would suggest after talking to an endocrinologist on the phone).
- Women who are hyperthyroid or are on antithyroid drugs are going to need lots of close monitoring and obstetric involvement.
- At 20/40 a swich back to carbimazole should be considered due to PTU toxicity.
- Women in remission from Graves' disease who are no longer on medication and who have very low levels of thyroid receptor antibody will need regular testing throughout pregnancy.
- Thyroid receptor antibodies need checking in women with hyperthyroidism – even if it is in remission and they are not on medication. This should be done early in pregnancy then again at 20/40 and at 28/40.

Other situations

- In women who are TPOAb positive, but are euthyroid, check their thyroid function in the first trimester (at first contact) and then again at 20/40.
- In women with nausea and vomiting during pregnancy, they may need to split their daily dose into two, or have parenteral liothyronine (after specialist consultation).
- There is something called Gestational Transient thyrotoxicosis, that I hadn't heard of.
- There is also something called isolated hypothyroxinaemia that I hadn't heard of either (where T4 is low, but TSH is normal).

Postpartum thyroiditis is another new condition for me.

Why is it so important that we manage thyroid disease properly in pregnancy?

This guideline explains that "maternal thyroid hormones are essential for maintaining a pregnancy and may influence placental development". The fetus can't make its own T4 initially and so is reliant on maternal T4 crossing the placenta. It also relies on maternal iodine crossing the placenta. T4 is necessary for normal fetal development, including neurodevelopment in the first half of gestation. If we don't manage maternal thyroid conditions adequately, we can't be certain that the fetus will be getting what it needs.

What happens to maternal thyroid function during pregnancy?

Useful to understand what is going on and why the ranges vary in pregnancy – but not essential reading!

There is a 50% increase in the demand on the maternal thyroid hormone production during pregnancy. This relies on an adequate supply of iodine and also on adequate levels of maternal thyroid hormones. In the first trimester, hCG (human chorionic gonadotrophin) transiently increases free T4 and T3 and decreases TSH. From mid-gestation, hCG falls and free T4 and T3 gradually decrease, whilst TSH increases a bit. Oestrogen also causes an increase in thyroxine binding globulin from early in pregnancy until around 18-20/40. To maintain free thyroxine levels, production of T4 and T3 goes up during this time. After 18-20/40, production goes back to normal.

What reference ranges should be used in pregnancy?

There are different reference ranges during pregnancy. These vary between different manufacturers and also at different stages of pregnancy. If you use the wrong reference range, then you run the risk of over treating or under treating. I don't know if labs in reality do take account of this, but as they may not know if a woman is pregnant or not, it is important to state on any requests that the woman is pregnant and how many weeks she is.

They do have some of the manufacturer specific ranges in the guideline, though how useful this would be is unclear as we don't normally know what manufacturer is used for the assay.

They do point out that the reference range is just the normal range for that trimester and manufacturer – it is not a target for treatment.

Are there different ranges for those with a multiple pregnancy?

Yes. When hCG will be higher, eg in multiple pregnancies, then TSH will be lower.

What about iodine and why is that important?

It isn't really such an issue for us in this country, as we generally get plenty of iodine in our diets, but this can be relevant for those from other countries. You need iodine to make thyroid hormones, so as the thyroid hormone production increases, so does iodine use.

Iodine requirements also go up in pregnancy as:

- iodine gets excreted from the kidneys at a higher rate during pregnancy.
- the placenta may also store some iodine.
- from about 10/40, the fetus also starts to take up iodine.
- breast milk starts to be produced in the second half of gestation and this also uses iodine.

Do we need to worry about iodine in the UK?

The recommended daily intake of iodine when planning a pregnancy, during a pregnancy and during breastfeeding is 200 to 250g a day. The guideline advises that there isn't clear evidence on the benefits and harms of routine iodine supplementation. There is some evidence suggesting that a significant proportion of pregnant women in the UK may not have enough iodine.

Their summary advises that women should consider increasing their dietary intake of iodine or having 150 g supplement a day in the form of potassium iodide. This is commonly found in pre-conception and pregnancy vitamin supplements. It is safe for those with thyroid disease to use.

The British Dietetic Association has a useful sheet on this. They mention that women not eating fish and dairy products may struggle to get enough iodine. The NHS advice on vitamins and supplements in pregnancy doesn't talk about iodine.

Should we be screening women for thyroid problems in pregnancy?

Universal screening isn't recommended. There is still controversy over whether a risk-based screening approach should be taken. There is also controversy over what risks should be taken into account if such screening were done. Despite this, the advice in this guideline is that we should be doing targeted testing as soon as possible during pregnancy.

So who should we be testing?

Women with or who have had the following conditions should be tested:

Autoimmune conditions associated with obstetric complications

- T1DM
- SLE
- Anti-Ro / Anti-La positivity
- Anti-phospholipid syndrome.

Previous late pregnancy loss

- Still-birth
- Second trimester miscarriage

Previous history of a thyroid condition or previous thyroid insult.

As well as known previous overt or subclinical thyroid disease, the latter includes:

- Previous thyroid surgery
- Goitre
- Thyroid nodule
- Previous thyroiditis
- Known TPOAb (thyroid peroxidase antibody) positive
- Previous radioiodine ablation
- Recent or current medications that can affect the thyroid (eg amiodarone / lithium)
- Previous head or neck irradiation
- Current signs or symptoms of thyroid disease

How should we manage patients with hypothyroidism in pregnancy?

Appendix E in the guideline has a really helpful flow chart. I have added this in here and it is pretty self-explanatory:

It is very important that we adequately manage hypothyroidism right from the start of pregnancy. Ideally thyroid management is optimised pre-conception. Risks of inadequate management include early pregnancy loss, premature delivery, low birth weight and impaired neurodevelopment.

There is some uncertainty regarding the risks of subclinical hypothyroidism, but the evidence does suggest worse pregnancy outcomes, which is why treatment is advised.

How often should we be monitoring women with hypothyroidism during pregnancy?

Thyroid requirements change throughout pregnancy. Anyone treated with levothyroxine needs their levels checking every 4 to 6 weeks until 20/40 and then again at 28/40.

After the initial self-initiated increase in levothyroxine (see below), about 40% of women will need an increase in their dose at some point in pregnancy.

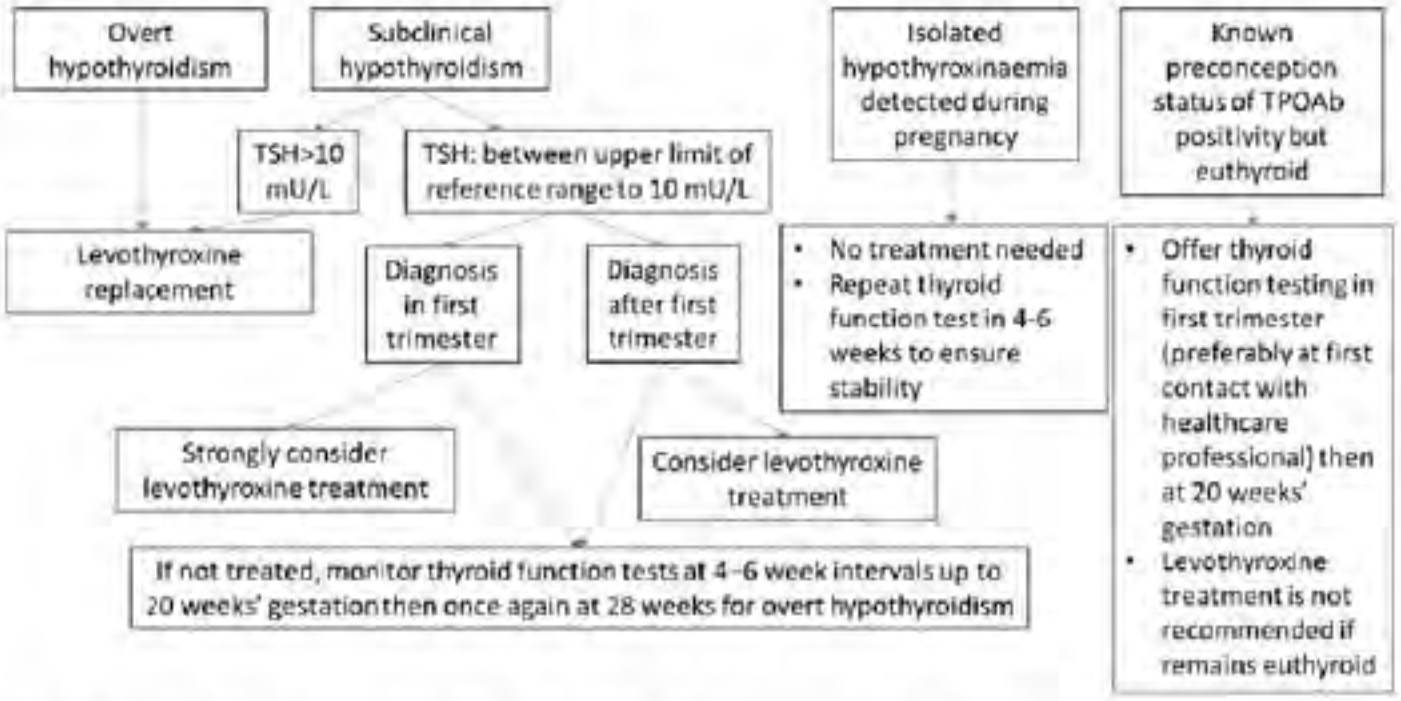
What target should we use in the treatment of hypothyroidism?

We should aim for a TSH in the lower half of the range (0.1 to 2.5 mU/L). Free T4 should be normal.

There is some evidence that over-treating women could lead to harm.

Appendix E

Management of Hypothyroidism and Related Disorders in Pregnancy



Note: Universal testing for thyroid dysfunction and TPOAb is not recommended in pregnancy.

What drug should we use to treat hypothyroidism in pregnancy?

We should use levothyroxine. If other forms of thyroxine replacement are being used (including combinations of levothyroxine and liothyronine) then they should be switched to just levothyroxine. This is because the fetus needs the form of T4 given by levothyroxine.

How is subclinical hypothyroidism affected in pregnancy?

Women may have subclinical hypothyroidism before pregnancy. They may also be found to have subclinical hypothyroidism during pregnancy. If they are diagnosed during pregnancy, then the trimester and manufacturer specific ranges should be used. This means that a patient that did not meet the criteria for treatment before pregnancy, may now need treatment.

In those who aren't pregnant, being TPOAb positive and having a TSH of > 10 gives a higher risk of progression to overt hypothyroidism.

During pregnancy, in those who have subclinical hypothyroidism, several factors increase the risk of progression to overt hypothyroidism:

- TPOAb positive
- post hemi-thyroidectomy
- having been treated with radioiodine

In these patients, the thyroid gland may not be able to adequately increase the thyroid hormone production that is necessary in pregnancy.

When should we treat subclinical hypothyroidism?

See the chart above (eg Appendix E).

For those with severe subclinical hypothyroidism (eg TSH > 10), then strongly consider levothyroxine treatment. Most of our patients would already be being treated at this level anyway.

For those with subclinical hypothyroidism with TSH ≤ 10, especially those who are TPOAb positive, 'strongly consider' using levothyroxine in the first trimester and consider using levothyroxine treatment after the first trimester.

If you aren't treating patients with subclinical hypothyroidism, then monitor TSH / T4 every 4 to 6 weeks until 20/40 and then again at 28/40.

What is isolated hypothyroxinaemia and how should we manage it?

This is where TSH is normal, but T4 is low (ie < 2.5th percentile), though there is a lack of a formal definition

Iodine deficiency is the most common cause, but obesity, iron deficiency and exposure to some pesticides may also cause it.

Current evidence hasn't shown any definite benefits from treatment with levothyroxine and there are potential risks from overtreatment. Current advice is therefore to recheck TFT after 4 to 6 weeks to check that they are stable.

How should we manage people diagnosed with overt hypothyroidism or subclinical hypothyroidism during pregnancy?

Overt hypothyroidism or severe subclinical hypothyroidism (TSH > 10):

- Start levothyroxine at a dose of 1.6mcg per kg per day.

Subclinical hypothyroidism with TSH ≤ 10:

- Consider starting levothyroxine at a dose of 1 to 1.2mcg per kg per day (strongly consider treating in the first trimester).

For less severe subclinical hypothyroidism, treatment is especially important in the first trimester and especially if they are already known to be TPOAb positive. They advise that there is insufficient evidence on using TPOAb testing to guide care when subclinical hypothyroidism is found in pregnancy. Waiting for TPOAb could also delay treatment.

What should we advise if women have nausea and vomiting in pregnancy?

Women should be advised to take their levothyroxine at the time of day that they are most likely to tolerate it. Alternatively the daily dose can be split into two separate doses to try to increase the chance of adequate absorption. You may need to seek specialist advice. There are parenteral options.

How should we manage people with overt or subclinical hypothyroidism pre-pregnancy?

For those with overt hypothyroidism and severe subclinical hypothyroidism (TSH > 10), treat with levothyroxine and aim for TSH ≤ 2.5 and normal T4.

For those with subclinical hypothyroidism with TSH ≤ 10 with normal T4, particularly if TPOAb positive, consider treatment with levothyroxine and aim for TSH ≤ 2.5 and normal T4.

As I explained above, people with subclinical hypothyroidism have better outcomes if they are treated. As there is also a risk of overt hypothyroidism during pregnancy in this group, pre-conception treatment can be considered.

What advice should we give to women with overt hypothyroidism pre-pregnancy?

Women with overt hypothyroidism should be advised to self-initiate an increase in their thyroxine as soon as they find out that they are pregnant (ie have a positive pregnancy test).

They can do this in one of two ways:

By doubling the dose of their levothyroxine on 2 days of the week OR Taking more levothyroxine every day

- 25mcg more if they are taking 100mcg or less.

- 50mcg more if they are taking > 100mcg.

Because the increase thyroxine requirements during pregnancy start very early (eg 4-6/40), increasing up the levothyroxine straight away reduces the risk of under treatment. There is information for patients on doing this on the British thyroid foundation.

What should we do if women have a low fT4, but normal TSH and are planning a pregnancy?

They should be referred to endocrinology for further investigation.

What should women do with their levothyroxine doses after delivery?

If women were on levothyroxine and were well controlled pre-conception, they can revert to their preconception dose of levothyroxine at 2 weeks after delivery. It can take a few weeks for the thyroxine binding globulin to return to normal, so you don't want to drop the dose down immediately. Their thyroid function should be checked 6 to 8 weeks after their dose returns to normal.

If women were not on levothyroxine pre-conception, they should stop it following birth. Their thyroid function should then be checked at 6 weeks post-partum.

Why is managing hyperthyroidism in pregnancy so important?

Higher maternal thyroxine levels may cause higher fetal thyroxine levels. There can also be transfer of TSH receptor antibodies to the fetus from the mother. Drugs used to treat the mother can also have an impact on the fetus, both causing direct toxicity or causing fetal hypothyroidism.

Studies have suggested increased risks of pre-eclampsia, maternal admission to ITU, maternal heart failure, pre-term birth, lower birthweight, stillbirth and higher rates of ADHD and autism in children. The more severe the hyperthyroidism, the worse the outcomes. The quicker in pregnancy that a woman can become euthyroid, the better the outcomes are.

How should we manage hyperthyroidism in pregnancy?

Appendix F in the guideline has a really helpful flow chart. I have added this in here:

Who should manage women with Graves' disease or other forms of hyperthyroidism?

There is a fair bit of detail in the guideline on how women with Graves' hyperthyroidism should be counselled pre-pregnancy and managed during pregnancy.

A lot of this is going to be specialist led, so I won't summarise it all, but there are a few key points for us to be aware of. I am not suggesting that we should be managing these patients on our own, but we may be involved in some aspects of their care and we may need to initiate some medication changes in some circumstances, so we need to be aware of the advice.

How should we manage women who are hypothyroid after treatment for hyperthyroidism?

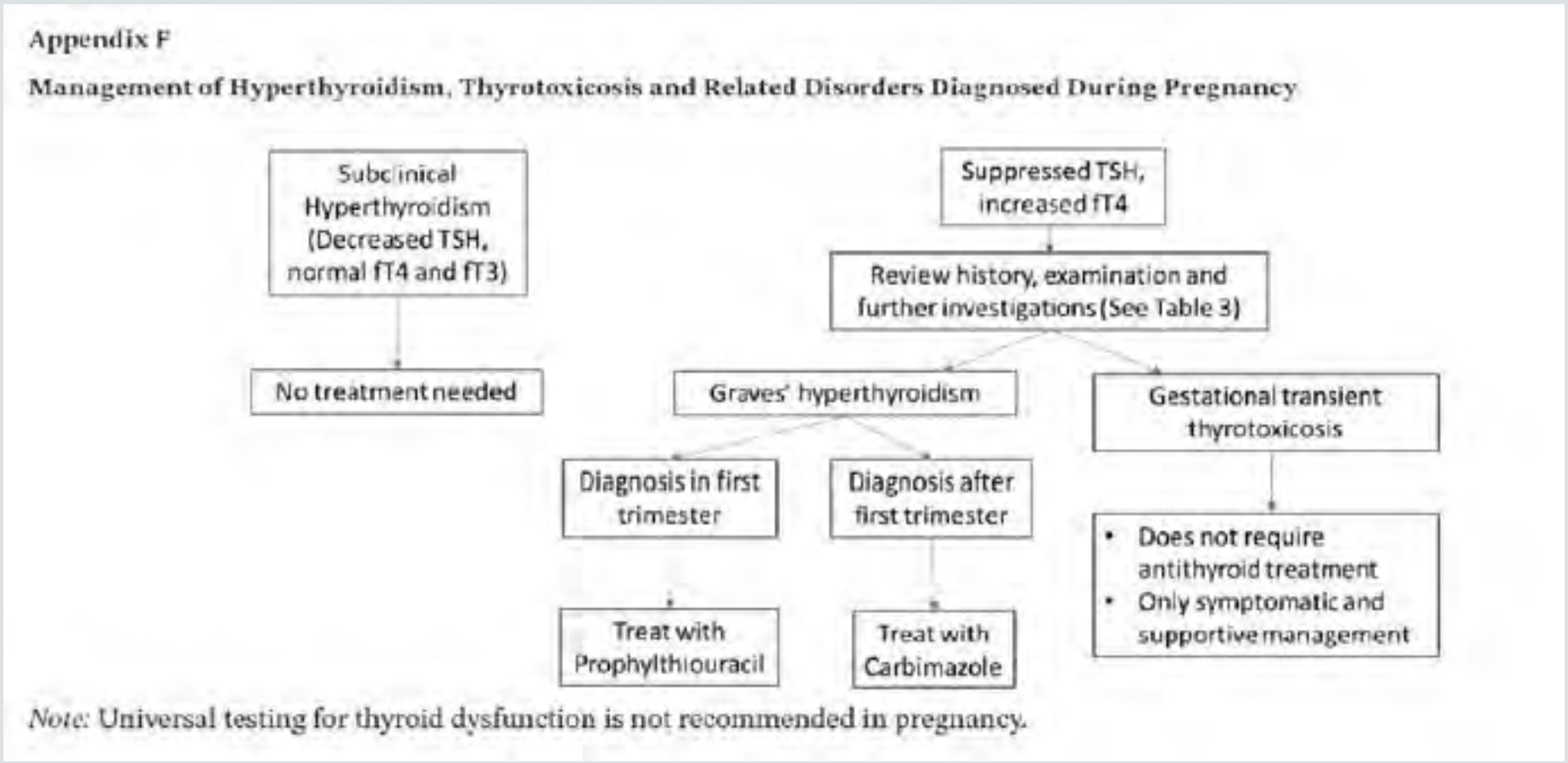
When a woman has had definite treatment for hyperthyroidism (eg ablation or thyroidectomy), then ideally they should be euthyroid prior to conception. If they are on levothyroxine treatment, they should empirically increase their dose in the same way as other hypothyroid patients should as above.

What do women who have had radioiodine treatment need to be aware of pre-conception?

After radioiodine treatment, women should wait 6 months before trying to conceive. This is because there can be a transient rise in TRAb (thyroid receptor antibodies) after treatment. These can pass to the fetus.

If a woman is on drug treatment, how should they be counselled?

PTU (propylthiouracil) is the preferred antithyroid drug in both pre-conception and in the first trimester as it is less teratogenic during organogenesis. The pros / cons of stopping treatment once the patient has been euthyroid for at least 6m should be discussed.



The main adverse effects of carbimazole would take place around 6 to 10/40, which is why switching women over preconception is so important.

Even PTU brings risks to the fetus and these should be discussed with the woman. The dose of drugs required during pregnancy is likely to change and many women will need reduced doses as pregnancy progresses.

Although this guideline doesn't specify it – I suspect that most of us would want women with hyperthyroidism to be under the specialist clinic pre-conception (and most of them will be anyway) and we would not feel confident to be making these changes ourselves.

If a woman falls pregnant on carbimazole, what should we advise?

If a woman is on carbimazole and consults at < 10/40, she should be changed to PTU at the first contact with a medical professional. There is no benefit of swapping to PTU after 10/40. The guideline explains how carbimazole should be switched to PTU.

We do need to make this switch ASAP and the guideline does suggest that whoever first sees the patient should do it, but I suspect I may be on the phone to an endocrinologist prior to doing this.

However – after 20/40, carbimazole is the preferred option because of PTU related hepatotoxicity, so a switch back to carbimazole should be considered. Again I suspect we will all be delegating this decision to the specialists.

What monitoring do women on antithyroid drugs need?

TFTs every 2 to 4 weeks in the first 20/40 weeks. After 20/40, testing every 4 to 8 weeks may be adequate. If stopping drugs, switching drugs or changing doses, TFTs should be checked after 2 weeks.

Thyroid receptor antibodies (TRAb) need checking in early pregnancy and then again at 20/40 and 28/40. High TRAb levels can cause more issues for the fetus.

If women are stable after stopping their medication (normal free T4 on two occasions 2 to 4 weeks apart), they may be able to reduce monitoring to 4 to 8 week intervals for the rest of the pregnancy.

Both TSH and free T4 should be checked when TFTs are done. This guideline advises that there is no role for free T3 or total T3 in this scenario.

What monitoring do women who have a history of hyperthyroidism need if they are not on medication?

Women in remission from Graves' hyperthyroidism should have TFTs checked every 4 weeks until 20/40 if:

- They are not taking antithyroid drugs AND
- They have low or undetectable TRAb preconception or at booking.

If they are still euthyroid at 20/40, they should be monitored every 4 to 8 weeks for the rest of the pregnancy.

TRAb need checking early in pregnancy and at 20/40 and at 28/40. Those with higher levels have a higher risk of problems for the fetus.

What target should we be aiming for if women are on antithyroid drugs?

Free T4 should be maintained in the upper half of the trimester and manufacturer reference range. A low TSH would be acceptable in this case. As thyroid drugs can cross the placenta, you want an adequate free T4 in order to prevent hypothyroidism in the fetus.

Do women need specialist obstetric follow up?

Yes – they need to be referred to the obstetric team. They may need extra fetal monitoring.

Those especially likely to need extra monitoring are those:

- Who have had uncontrolled Graves' disease at any point in pregnancy
- Who required antithyroid medications in pregnancy
- Who had a TRAb (thyroid receptor antibody) over 3 times above the threshold for positivity (as there is a higher risk of fetal or neonatal Graves' disease).

Will babies of mothers with Graves' disease need any special care?

Yes. Obviously, we won't be doing this, but they will need their thyroid function monitoring.

Do women with toxic nodular hyperthyroidism need managing differently from those with Graves' hyperthyroidism?

Management is essentially the same. However, women with toxic nodular hyperthyroidism don't have the thyroid receptor antibodies. In Graves' disease these pass to the fetus and stimulate the fetal thyroid gland. As this doesn't happen in toxic nodular hyperthyroidism, the fetus is at higher risk of hypothyroidism, so careful management is even more important.

What is Gestational transient thyrotoxicosis?

This is caused by high hCG stimulating the thyroid gland receptors. This causes low TSH and high free T4. It is more common when hCG is higher (eg multiple pregnancies, hydatidiform mole or choriocarcinoma). As hCG levels normally peak around 10/40, gestational transient thyrotoxicosis normally settles by around 18 to 20/40. It is normally transient, self-limiting and doesn't lead to any adverse pregnancy outcomes. Women are sometimes treated with b-blockers, but most treatment is supportive. Antithyroid medication isn't needed.

There are quite a lot of features that can help to distinguish gestational transient thyrotoxicosis from other forms of hyperthyroidism (these are outlined in the guideline), but I suspect we are going to be calling for advice in this situation.

How do we manage women post-partum?

Women with a history of hyperthyroidism prior to pregnancy should have TFTs checked at 6 to 8 weeks post-delivery. There is a higher risk of relapse after delivery as there is increased autoimmunity at this time. Both carbimazole and PTU can be used during breast-feeding. There is minimal transfer to breast milk. Sometimes the advice would be to split the dose into smaller BD or TDS doses – but this would be specialist led.

How should we manage women with a new or enlarging thyroid nodule in pregnancy?

Pre-existing nodules can increase in size in pregnancy. If women have goitre or new nodules, or enlarging nodules, they need specialist referral for assessment. Be aware of the possibility of compressive effects from a goitre or nodule and the risk this could pose if an anaesthetic were required.

What is post-partum thyroiditis?

Post-partum thyroiditis occurs within 12m of pregnancy. It is the development of thyroid dysfunction in a woman who was previously euthyroid. It is caused by 'a reactivation of the immune system following the relative immune suppression during pregnancy'. It is an autoimmune disorder. You see antibodies to TPO and thyroglobulin. It is more common in women with other autoimmune disorders, including those with previous Graves' disease or Hashimoto's thyroiditis or those with a family history of thyroid disorders. It is quite common, affecting 5 to 10% of all pregnancies and up to 50% of those women who are positive for TPO antibodies. It also affects about 70% of those who have had it after a previous pregnancy.

What pattern does postpartum thyroiditis take?

Classically women become hyperthyroid, then hypothyroid then euthyroid.However many women just become hyperthyroid with it and many just become hypothyroid with it. About 50% of women will remain persistently hypothyroid.

How do you know if a woman has postpartum thyroiditis instead of another thyroid disorder?

This guideline has some advice on that, but I suspect in reality that we will be asking the endocrinology team to review these patients and to make that decision.

How should you manage a patient with postpartum thyroiditis?

Again – I suspect we will be seeking advice on this…

Hyperthyroid phase - Antithyroid drugs aren't used. If women are symptomatic then b-blockers can be considered. Propranolol and metoprolol are safe in breastfeeding.

Hypothyroid phase - Use levothyroxine if women are 'very symptomatic'. If women are trying to become pregnant, they should use levothyroxine. In women who aren't pregnant or who aren't trying for another pregnancy, you can try tapering off the levothyroxine dose after 12m. If they are pregnant or trying for another pregnancy, you shouldn't stop the levothyroxine.

Monitoring - If patients aren't being treated, then monitor TFTs every 6 weeks until they are euthyroid. Patients who become euthyroid need annual monitoring as they are at higher risk of becoming hypothyroid later. They should also be tested when planning a future pregnancy and early in any pregnancy.

These summaries should be checked against the original resource in focus and are in themselves not a clinical reference.

Feature Focus

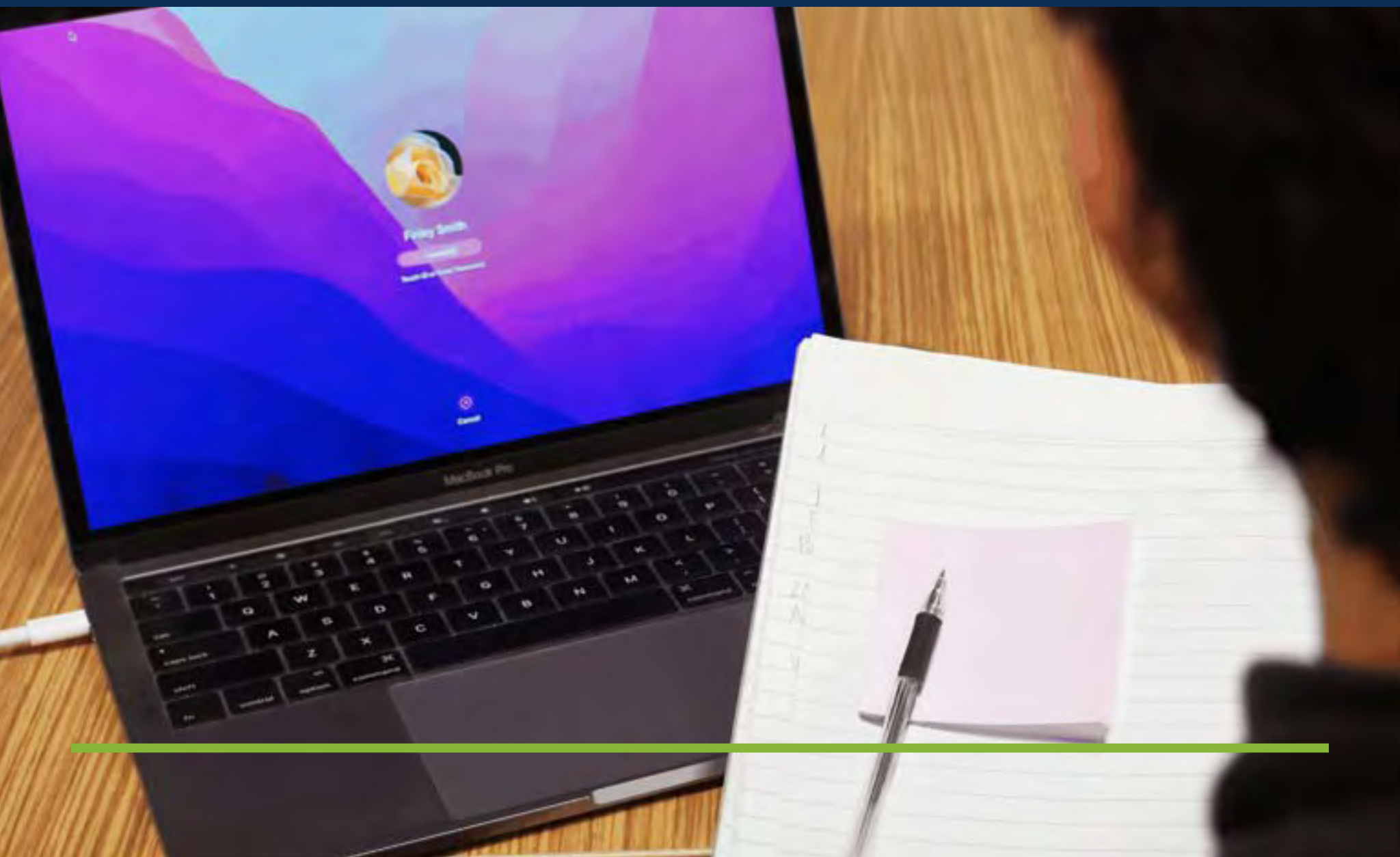
If you're a self-employed GP earning over £50,000 a year, you'll need to comply with HMRC's new digital tax rules from next April – less than six months away.

We're working on some LocumDeck changes around Making Tax Digital and while we develop some new features, we have two webinars for members coming up.

On 4 December Anna Tyler from Honey Barrett hosts 'What GPs need to know about MTD' – a 101-style introduction to upcoming tax changes.

Then on 5 February 2026 Luke Wheal from Azets hosts 'Making Tax Digital for Sessional GPs', another chance to learn and ask questions about MTD.

In the meantime members can read 'Making Tax Digital for sessional GPs' on Knowledgebase to get started.



Member focus

We're now a five-star business on Google

Read our reviews and if you have time please leave us your own.

"I have been using NASGP since starting locuming four years ago. Ali and Richard are incredibly supportive and responsive. I have benefitted hugely from their newsletters, pre-populated locum form A and Bs and peer support groups. In addition to this I managed to secure lots of remote working which was amazing for work-life balance.

Dr Laura Naidoo

The service is excellent. The platform works very well. The organisation is supportive and helpful for sessional doctors. There are some very useful features for jobbing locums especially the assistance with billing and sorting out what pension contributions are needed. It's important that ICS continue to support NASGP otherwise they will lose their pool of local doctors, because Locums often become salaried doctors or Partners. The Chambers model is useful for peer support and education, also very useful in event of significant event or complaint. Great service.

Dr Michael Watts"

Team focus

Meet our Head of Memberships Richard Curno

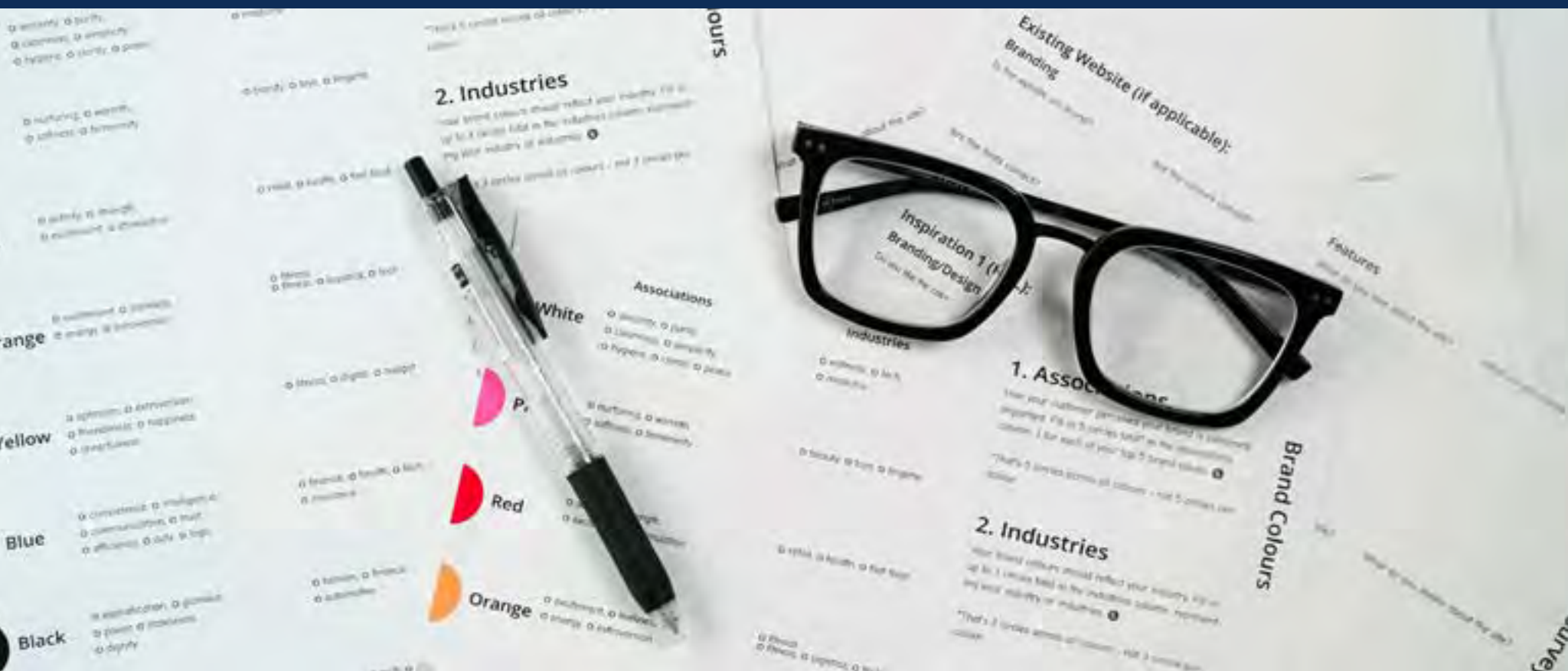
Richard comes to NASGP from the Chief of Staff Association and brings years of experience into his new role with us.

Richard has over 20 years of experience working with membership organisations, bringing professionals together to foster learning, share insights and drive meaningful change.

He has held senior roles in both national and international contexts, including as Deputy CEO of the United Nations Association and Director of Network at the thinktank New Local.

As Director of Membership at NASGP, Richard applies his expertise with a collaborative and strategic approach, supporting sessional GPs across the UK.

Meet the team



National Association of Sessional GPs
Amelia House,
Crescent Road,
Worthing,
BN11 1QR

info@nasgp.org.uk
nasgp.org.uk