Do we need to assess the thyroid function in the infants of mothers with Hashimoto's thyroiditis?

We read with interest the recent comprehensive review of neonatal thyroid disorders, which gave evidence-based answers to many important questions. The author recommended that all babies born to mothers with Hashimoto's thyroiditis should be reviewed at 10 days to 2 weeks and a thyroid function test taken because infants may develop transient hypothyroidism or, very rarely, hyperthyroidism.[1]

As paediatricians, in a hospital with a paediatric endocrine caseload similar to some tertiary centres and a subregional neonatal intensive care unit with local deliveries of 6000 per annum, we think that the potential benefits of this practice are difficult to justify. We do understand that such practice will help in identifying babies who may develop transient congenital hypothyroidism caused by maternal thyrotropin receptor blocking antibodies. However, the incidence of this form of hypothyroidism has been estimated to be 1 in 180 000 normal infants (~2 % of congenital hypothyroidism) and the majority of them will have raised thyroid stimulation hormone levels that can be detected by the current neonatal screening.[2] Based on a simple calculation, in a unit of our size only one baby will be detected every 30 years. We feel that there would be major disadvantages if we are to adopt the author's recommendation. Firstly, an extra hospital visit for babies and parents; secondly the need to bleed many healthy infants; and finally the potential for confusion and unnecessary anxiety. Until objective evidence emerges about the significance of subtle thyroid dysfunction in early life we feel that the current screening programme should not be extended.

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References

1 **Ogilvy-Stuart AL**. Neonatal thyroid disorder-review. *Arch Dis Child Fetal Neonatal Ed* 2002;**87**:F165–71.
2 **Brown RS**, Bellisario RL, Botero D, *et al*. Incidence of transient congenital hypothyroidism due to maternal thyrotropin receptor-blocking antibodies in over one million babies. *J Clin Endocrinol Metab* 1996;**81**:1147–51.

CORRECTIONS

In the CD Review (*Arch Dis Child Fetal Neonatal Ed* 2003;**88**:F164) reviewed by C Wren, please note that the affiliation of the authors is published incorrectly. This should have read Royal Prince Alfred Hospital, Sydney. Also, the web address in the final paragraph is incomplete. The correct address is: http://www.cs.nsw.gov.au/rpa/neonatal/default.htm. The errors are much regretted.

The authors would like to acknowledge and apologise for an error in our article Socioeconomic status and preterm birth: New Zealand trends, 1980 to 1999. ED Craig, JMD Thompson, EA Mitchell (*Arch Dis Child Fetal Neonatal Ed* 2002;**86**:F142–6).

Paragraph four in the Results section should read "Figure 2 summarises changes in preterm birth rates by Deprivation Index decile between 1980 and 1999. During this period rates rose from 5.2% to 5.9% among those living in the most deprived areas (a 13.5% increase), from 4.0 to 5.5% amongst those living in average areas (a 37.5% increase) and from 3.1% to 5.4% amongst those living in the least deprived areas (a 74.2% increase). Thus while in 1980 a marked social gradient in preterm birth existed, by 1999 this had diminished markedly." Table 2 and table 3 are amended. These errors do not significantly change the reported trends in preterm birth or the interpretation of the findings previously published.

Table 2 Multivariate odds ratios for preterm birth by gestational age category and Deprivation Index decile; New Zealand singleton live births 1980, 1990, and 1999

		Gestational age category			
Year	NZDep Index Decile	All preterm (n=51 711) OR*	20–27 weeks (n=2697) OR**	28–33 weeks (n=12 703) OR*	34–36 weeks (n=36 311) OR*
1980	1	1.00	1.00	1.00	1.00
1980	5	1.15	1.08	1.16	1.15
1980	10	1.36	1.18	1.39	1.36
1990	1	1.30	1.31	1.21	1.33
1990	5	1.44	1.45	1.34	1.47
1990	10	1.63	1.66	1.52	1.67
1999	1	1.64	1.67	1.44	1.72
1999	5	1.76	1.91	1.53	1.84
1999	10	1.93	2.25	1.64	2.02

Multivariate analysis adjusted for gender, maternal age, parity, birth year, decile and birth year*decile, year*age, year*parity, decile*age, decile*parity.
*Odds ratios (OR) with reference category Deprivation Index decile 1, 1980.
**Odds ratios for the 20–27 week category did not reach statistical significance.

Table 3 The "social gradient in preterm birth"; risk of preterm birth amongst decile 10 women compared to decile 1 women (same year), New Zealand singleton live births 1980, 1990, and 1999

		Gestational age category		
Year	All preterm (n=51 711) OR*	20–27 weeks (n=2697) OR**	28–33 weeks (n=12 703) OR*	34–36 weeks (n=36 311) OR*
1980	1.36	1.18	1.39	1.36
1990	1.26	1.27	1.25	1.26
1999	1.17	1.35	1.14	1.17

Multivariate analysis adjusted for gender, maternal age, parity, birth year, decile and birth year*decile, year*age, year*parity, decile*age, decile*parity.
*Odds ratios (OR) for preterm birth amongst decile 10 women compared to those in decile 1 for each particular year reflects the social gradient for that year.
**Odds ratios for the 20–27 week category did not reach statistical significance.