



Guidance - Prescribing of Liothyronine

**Regional Medicines Optimisation Committee
(RMOC)**

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Document Control

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Approvals

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Summary Advice

NHS England guidance states that prescribers in primary care should not initiate liothyronine (L-T3) for any new patient, and that individuals currently prescribed liothyronine should be reviewed by a consultant NHS endocrinologist with consideration given to switching to levothyroxine (L-T4) where clinically appropriate. Prescriptions for individuals receiving liothyronine should continue until that review has taken place.

The majority of patients suffering from hypothyroidism can be treated effectively with levothyroxine alone, but liothyronine is perceived to be an important medicine for a small proportion of patients in order to maintain health and wellbeing. The prescribing of liothyronine is only supported if initiated by, or considered appropriate following a review by, an NHS consultant endocrinologist. The withdrawal or adjustment of liothyronine treatment should also only be undertaken by, or with the oversight of, an NHS consultant endocrinologist. Where General Practitioners (GPs) are involved in such treatment changes this should be with NHS consultant endocrinologist support. This advice applies to both liothyronine monotherapy and combination therapy with levothyroxine.

As noted by the British Thyroid Association (BTA) Executive Committee (1), 'clinicians have an ethical responsibility to adhere to the highest professional standards of good medical practice rooted in sound evidence. This includes not prescribing potentially harmful therapies without proven advantages over existing treatments'. Also 'If a decision is made to embark on a trial of L-T4/L-T3 combination therapy in patients who have unambiguously not benefited from L-T4 then this should be reached following an open and balanced discussion of the uncertain benefits, likely risks of over-replacement and lack of long-term safety data. Such patients should be supervised by accredited endocrinologists with documentation of agreement after fully informed and understood discussion of the risks and potential adverse consequences. Many clinicians may not agree that a trial of L-T4/L-T3 combination therapy is warranted in these circumstances and their clinical judgement must be recognised as being valid given the current understanding of the science and evidence of the treatments'.

The RMOC therefore recommends that strict criteria are applied to ensure that liothyronine is only prescribed in the situations where alternative treatments have been found to be inadequate. In such circumstances, an ongoing shared care arrangement may be appropriate if agreed by local commissioners. If a patient is initiated on treatment, prescribing responsibility should remain with the hospital consultant for at least 3 months.

Clinical and biochemical monitoring of treatment and for potential side-effects is to be undertaken by the clinician supervising the treatment. TSH levels should be monitored, and free L-T4 / free L-T3 levels measured where clinically appropriate. The risks of over-treatment with thyroid hormones include atrial fibrillation, osteoporosis and bone fractures, and the risks of under treatment are also significant.

RMOC advice is summarised in the following table:

| Indication and treatment regimen | Action for General Practitioners (GPs) and NHS Consultants |
|---|--|
| <p>Hypothyroidism</p> <ul style="list-style-type: none"> ● Patients currently receiving liothyronine monotherapy: See section 3.1.1 / 3.1.2 / 3.1.3 ● Patients currently receiving liothyronine and levothyroxine combination therapy: See section 3.1.2 / 3.1.3 | <p>Patients currently prescribed liothyronine, or levothyroxine and liothyronine combination therapy, for hypothyroidism should be reviewed to consider switching to levothyroxine monotherapy where clinically appropriate. In some cases a retrospective review of the basis for the original diagnosis of hypothyroidism may be necessary. Arrangements should be made for switching to be undertaken by a consultant NHS endocrinologist, or by a GP with consultant NHS endocrinologist support. Patients who are currently obtaining supplies via private prescription or self-funding should not be offered NHS prescribing unless they meet the criteria in this guidance. The consultant endocrinologist must specifically define the reason if any patient currently taking liothyronine should not undergo a trial titration to levothyroxine monotherapy, and this must be communicated to the GP.</p> |
| <p>Hypothyroidism</p> <ul style="list-style-type: none"> ● Levothyroxine + liothyronine combination therapy for new patients: See section 3.1.2 / 3.1.4 | <p>In rare situations where patients experience continuing symptoms whilst on levothyroxine (that have a material impact upon normal day to day function), and other potential causes have been investigated and eliminated, a 3 month trial with additional liothyronine may be appropriate. This is only to be initiated by a consultant NHS endocrinologist. Following this trial the consultant NHS endocrinologist will advise on the need for ongoing liothyronine. Many endocrinologists may not agree that a trial of levothyroxine / liothyronine combination therapy is warranted in these circumstances and their clinical judgement is valid given the current understanding of the science and evidence of the treatments.</p> |
| <p>Oncology - Thyroid disease</p> <ul style="list-style-type: none"> ● Liothyronine monotherapy: See section 3.2 | <p>Prescribing of liothyronine in thyroid cancer, where it is used as an adjuvant to radioactive iodine treatment, should only be addressed by specialists in secondary / tertiary care. Thyroid cancer patients who have completed their treatment usually need to take levothyroxine for life and should be managed in the same way as patients with hypothyroidism.</p> |
| <p>Resistant depression</p> <ul style="list-style-type: none"> ● Liothyronine monotherapy or combination therapy: See section 3.3 | <p>All patients currently receiving liothyronine for a psychiatric indication should be reviewed by a consultant NHS psychiatrist, who should consider switching to an alternative treatment where clinically appropriate, or levothyroxine monotherapy where hypothyroidism is diagnosed. Patients continuing to receive ongoing liothyronine should be overseen by a consultant NHS psychiatrist.</p> |
| <p>Use of unlicensed thyroid extracts (e.g. Armour thyroid, ERFA Thyroid), plus compounded thyroid hormones, iodine containing preparations, dietary supplementation: See section 3.4</p> | <p>The prescribing of unlicensed liothyronine and thyroid extract products is not supported.</p> |

Part 1: Introduction

The national NHS England and NHS Clinical Commissioners' guidance: 'Items which should not routinely be prescribed in primary care: Guidance for CCGs' was published in November 2017. This is available at <https://www.england.nhs.uk/wp-content/uploads/2017/11/items-which-should-not-be-routinely-prescribed-in-pc-ccg-guidance-v2.pdf>. One of the products detailed in this guidance is the oral formulation of liothyronine. The guidance published concerning liothyronine (in section 4.9 of the national guidance) is detailed in part 2 of this document.

The Regional Medicines Optimisation Committee has been tasked with providing additional guidance for the NHS in England regarding arrangements for on-going prescribing of liothyronine, and this is summarised above and documented in part 3.

The purpose of this guidance is therefore to provide advice on the prescribing of liothyronine (triiodothyronine; L-T3), and on the review of NHS patients who are being prescribed liothyronine. It is recognised that there is a cohort of patients who require liothyronine, so the aim is to support CCGs and Area Prescribing Committees in local decision making, and enable a consistent approach for the circumstances in which on-going treatment is provided. This is important due to the evidence of benefit being limited to anecdotal reports and not supported by randomised clinical trials, the potential risks of treatment, and the significant cost involved.

Parts 4 to 6 of this document provide additional information and useful appendices, and links to relevant supporting literature including guidelines from the British Thyroid Association.

Part 2: National Guidance Concerning Liothyronine

The NHS England and NHS Clinical Commissioners' guidance states the following:

Section 4.9

Liothyronine (including Armour thyroid and liothyronine combination products):

Background and Rationale

Liothyronine (sometimes known as T3) is used to treat hypothyroidism. It has a similar action to levothyroxine but is more rapidly metabolised and has a more rapid effect. It is sometimes used in combination with levothyroxine in products.

The price (NHS Drug Tariff) of liothyronine has risen significantly and there is limited evidence for efficacy above levothyroxine.

The British Thyroid Association, in their 2015 position statement, state "There is no convincing evidence to support routine use of thyroid extracts, L-T3 monotherapy, compounded thyroid hormones, iodine containing preparations, dietary supplementation and over the counter preparations in the management of hypothyroidism".

Due to the significant costs associated with liothyronine and the limited evidence to support its routine prescribing in preference to levothyroxine, the joint clinical working group considered liothyronine suitable for inclusion in this guidance. However during the consultation we heard and received evidence about a cohort of patients who require liothyronine and the clinical working group felt it necessary to include some exceptions based on guidance from the British Thyroid Association.

Recommendations

- *Advise CCGs that prescribers in primary care **should not initiate liothyronine for any new patient.***
- *Advise CCGs that individuals **currently prescribed liothyronine should be reviewed by a consultant NHS endocrinologist** with consideration given to switching to levothyroxine where clinically appropriate.*
- *Advise CCGs that a local decision, involving the Area Prescribing Committee (or equivalent) informed by National guidance (e.g. from NICE or the Regional Medicines Optimisation Committee), should be made regarding arrangements for on-going prescribing of liothyronine. This should be for individuals who, in exceptional circumstances, have an on-going need for liothyronine as confirmed by a consultant NHS endocrinologist.*

Exceptions and Further Recommendations

The British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction.

In these circumstances, where levothyroxine has failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least 3 months duration of liothyronine.

Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. In these situations it is appropriate for patients to obtain their prescriptions from the centre undertaking the treatment and not be routinely obtained from primary care prescribers.

Note: The NHS England and NHS Clinical Commissioners' joint clinical working group considered the consultation feedback and decided that liothyronine should still be prescribed for a small cohort of patients. The joint clinical working group changed the recommendations so that initiation of prescribing of liothyronine in appropriate patients should be undertaken by a consultant endocrinologist in the NHS, and that deprescribing in 'all' patients is not appropriate due to the recognised exception in the British Thyroid Association Guidelines of patients who have unambiguously not benefited from levothyroxine.

Part 3: RMOC Guidance – Prescribing of Liothyronine

The following RMOC guidance supports a consistent approach for the exceptional circumstances in which patients have an on-going need for liothyronine.

3.1 Prescribing of Liothyronine in Endocrinology: Hypothyroidism

3.1.1 Prescribing of Liothyronine in Endocrinology: Hypothyroidism Liothyronine Monotherapy

In accordance with the third recommendation of the national guidance (above), the RMOC has considered on-going prescribing of liothyronine and advises the following:

- Liothyronine monotherapy is not recommended in hypothyroidism; prescribing would be in exceptional circumstances only, such as clearly distinguishable specific levothyroxine medication intolerance including extremely rare cases of levothyroxine induced liver injury. Or potentially for patients who do not effectively metabolise levothyroxine to liothyronine, if a specialist assessing the patient according to these guidelines agrees.
- In accordance with NHS guidance on 'Defining the Boundaries between NHS and Private Healthcare', patients who are currently obtaining supplies via private prescription or self-funding should not be offered NHS prescribing unless the guidelines in this document are met. Patients who have been seen privately retain the option of being referred back to the private service for private prescription.
- Individuals currently prescribed liothyronine for hypothyroidism are to be referred to a consultant NHS endocrinologist to consider transition to levothyroxine through a trial titration where clinically appropriate (see guideline 3.1.2 and 3.1.3 below).
- The consultant NHS endocrinologist should identify when and why liothyronine was initiated, and must specifically define the reason if any patient currently taking liothyronine should not undergo a trial titration to levothyroxine; this is to be communicated to the GP.
- If a previous trial titration has proved unsuccessful, the consultant endocrinologist should decide whether there is any good reason to consider a further review, and inform the GP accordingly.
- The review of NHS patients presently receiving liothyronine is to be managed locally and scheduled according to service capacity. Local commissioners should consider providing advice to GPs to support the gradual conversion of current patients to levothyroxine, where clinically appropriate, with NHS endocrinologist support, and with appropriate arrangements for endocrinologist review.
- The abrupt withdrawal of liothyronine therapy from patients who have been stabilised on treatment for hypothyroidism is inappropriate.
- Treatment changes are to be under consultant NHS endocrinologist review or in circumstances where a GP is fully supported by a consultant NHS endocrinologist.
- Where liothyronine is prescribed, GP repeat prescribing would be reasonable after completion of a 3 month or longer review by an NHS consultant endocrinologist.
- Where liothyronine is so prescribed, prescribers and commissioners should consider the most appropriate means of meeting the patients' needs, and any arrangements for shared care are to be agreed within the local health economy.
- All shared care arrangements are to be authorised by the local commissioner.

3.1.2 Prescribing of Liothyronine in Endocrinology: Hypothyroidism

Combination Levothyroxine and Liothyronine General Guidance:

- The guidance in 3.1.1 above for liothyronine monotherapy is also applicable when a patient converts to combination therapy.
- Combination levothyroxine / liothyronine should not be used *routinely* in the management of hypothyroidism as there is insufficient population based clinical evidence to show that combination therapy is superior to levothyroxine monotherapy.
- There is insufficient evidence at present to specify the quality of life measures to be adopted during a trial of combination levothyroxine and liothyronine, or during a trial titration from liothyronine to levothyroxine. Further work is ongoing to develop a validated quality of life measurement tool in advance of the NICE thyroid disease guidelines planned for release in 2019. In the interim, NHS consultant endocrinologists should document the range and severity of hypothyroid symptoms experienced by the patient prior to and during the assessment period.
- Specialist endocrinology oversight therefore requires review of both blood biochemistry and patient symptoms as recommended by the British Thyroid Association Executive Committee (1).

3.1.3 Prescribing of Liothyronine in Endocrinology: Hypothyroidism

Trial Titration to Levothyroxine:

- There is no defined conversion factor, and conversion of patients from liothyronine to levothyroxine monotherapy will require a reduction in the dose of liothyronine and an increase in levothyroxine. A reduction of dose of liothyronine by 10 micrograms will probably require an increase in dose of levothyroxine of 50 micrograms. Once on levothyroxine monotherapy, patients will need to have adjustment in the dose as per standard practice by monitoring of the TSH on a 6 weekly basis. Blood tests should not be undertaken more often than 6 weekly because the TSH will not have reached steady state until 6 weeks after any change. Free T4 / free T3 levels should also be measured where clinically appropriate.
- The withdrawal of liothyronine should occur gradually in line with NHS consultant endocrinologist recommendations, and may take many months to complete.
- If ongoing treatment with liothyronine is required, any shared care arrangement for continuation (to be agreed with the local commissioner) must incorporate dosage guidance and monitoring arrangements. Strict control of prescribing is warranted with, at minimum, 3 months prescribing responsibility taken by the NHS consultant endocrinologist.

3.1.4 Prescribing of Liothyronine in Endocrinology: Hypothyroidism

New Patients Whose Symptoms Persist on Levothyroxine Therapy:

- As noted by the British Thyroid Association Executive Committee (1), it is acknowledged that a proportion of individuals on levothyroxine are not satisfied with therapy and have persistent symptoms despite a serum TSH within the reference range. Such symptoms should be investigated and patients thoroughly evaluated for other potentially modifiable conditions (see box 1 below) before the potential commencement of liothyronine is considered. In some cases a retrospective review of the original diagnosis of hypothyroidism may be necessary. If there is no biochemical evidence of hypothyroidism a gradual withdrawal of all thyroid hormone preparations would be indicated.

Box 1: Some possible causes of persistent symptoms in euthyroid patients on levothyroxine:

| Endocrine /autoimmune | Haematological | End organ damage | Nutritional | Metabolic | Drugs | Lifestyle | Other |
|--|-----------------------------|---|---|--|-------------------------------------|--|---|
| Diabetes mellitus Adrenal insufficiency Hypopituitarism Coeliac disease Pernicious anaemia | Anaemia Multiple myeloma | Chronic liver disease Chronic kidney disease Congestive cardiac failure | Deficiency of any of the following: Vitamin B12 Folate Vitamin D Iron | Obesity Hypercalcaemia Electrolyte imbalance | Beta-blockers Statins Opiates | Stressful life events Poor sleep pattern Work-related exhaustion Alcohol excess | Obstructive sleep apnoea Viral and postviral syndromes Chronic fatigue syndrome Carbon monoxide poisoning Depression and anxiety Polymyalgia rheumatic Fibromyalgia |

- Levothyroxine dose titration and patient adherence should be fully assessed prior to consideration of combination therapy, as profound differences in response to small adjustments in levothyroxine dosage have been observed.
- It is recognised that a proportion of patients may have persistent unexplained symptoms despite adequate replacement using levothyroxine, evidenced biochemically by serum Thyroid Stimulating Hormone (TSH) being between 0.4 - 1.5mU/L. As part of the overall holistic management of these patients, consultant NHS endocrinologists may start a trial of combination levothyroxine and liothyronine in order to restore wellbeing in circumstances where other potential causes of symptoms have been excluded and all other treatment options have been exhausted.
- As specified by the British Thyroid Association Executive Committee (1), 'If a decision is made to embark on a trial of levothyroxine and liothyronine combination therapy in patients who have unambiguously not benefited from levothyroxine then this should be reached following an open and balanced discussion of the uncertain benefits, likely risks of over-replacement and lack of long-term safety data. Such patients should be supervised by accredited endocrinologists with documentation of agreement after fully informed and understood discussion of the risks and potential adverse consequences. Many clinicians may not agree that a trial of levothyroxine / liothyronine combination therapy is warranted in these circumstances and their clinical judgement must be recognised as being valid given the current understanding of the science and evidence of the treatments'.
- Prescribing responsibility should remain with the endocrinologist until there is a formal assessment of the safety and benefit of treatment within 6 months of starting therapy, evidenced by quality of life improvements and biochemical markers.
- If there is no evidence of ongoing clinical benefit from combination levothyroxine and liothyronine, treatment with liothyronine is to be discontinued and the patient converted back to levothyroxine alone. It should be noted that the majority of randomised clinical trials have indicated a pronounced placebo effect.

- If ongoing combination treatment is warranted, any shared care arrangement (as detailed above) must incorporate regular monitoring and dose adjustment guidance, with referral to an endocrinologist if symptoms recur.

Note: Shared Care Agreements are to be prepared in accordance with 'Responsibility for Prescribing between Primary and Secondary/Tertiary Care, NHS England (2018) (<https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf>).

3.2 Prescribing of Liothyronine in Oncology: Thyroid Disease

Liothyronine is recommended as part of the management of thyroid cancer in preparation for radioiodine remnant ablation (RRA) or radioiodine therapy (¹³¹I).

The prescribing is considered for short term use as part of the endocrine management and therefore prescribing responsibilities should be retained by the specialist endocrine / oncology team involved with the management of the patient.

Short term use of liothyronine is sometimes also advised in preparation for a sestamibi parathyroid scan.

Prescribing in such situations should be addressed in the specialist hospital environment only.

Thyroid cancer patients who have completed their treatment usually need to take levothyroxine for life, so should be managed in the same way as patients with hypothyroidism (see section 3.1).

3.3 Prescribing of Liothyronine in Psychiatry: Resistant Depression

- Liothyronine is incorporated in some local treatment pathways for resistant severe depression, this being an off-label indication. Where this is the case, such pathways should be reviewed by the local prescribing committee to confirm that prescribing guidance is appropriate.
- It should be noted that the current (May 2018) draft NICE guideline 'Depression in adults: treatment and management' incorporates the augmentation of an antidepressant with thyroid hormones under 'strategies that should not be used routinely as there is inconsistent evidence of effectiveness'.
- Due to the very limited evidence for use of thyroid hormones in depression, a more holistic approach should be adopted when the initial treatment of depression is inadequate. Where thyroid hormones are necessary due to hypothyroidism, treatment should be initiated with standard levothyroxine.
- Where liothyronine is used off-label for resistant severe depression, this must be initiated by a consultant NHS psychiatrist.
- All psychiatric patients currently receiving liothyronine should be reviewed by a consultant NHS psychiatrist. A psychiatrist recommending ongoing treatment with liothyronine for depression should justify why an alternative treatment is not appropriate.
- All patients receiving ongoing liothyronine should be overseen by a consultant NHS psychiatrist; consultant NHS endocrinology advice is also recommended for such patients.
- It is unlikely that ongoing treatment with liothyronine would be under a shared care arrangement, but if this is considered, it is to be agreed with the local commissioner as detailed in section 3.1 above.

3.4 Products That are Not Recommended for Prescribing

- Thyroid extracts (e.g. Armour thyroid, ERFA Thyroid), compounded thyroid hormones, iodine containing preparations, and dietary supplementation are not recommended. The prescribing of unlicensed liothyronine and thyroid extract products are not supported as the safety, quality and efficacy of these products cannot be assured.

Part 4: Further RMOc Statements

Patient Safety

Increases in serum free T3 levels arising from liothyronine administration may provoke cardiac arrhythmias in susceptible individuals, and it is contraindicated in patients with angina of effort or cardiovascular disease.

TSH levels should be monitored during treatment, and also free T3 and free T4 levels where clinically appropriate in order to reduce the risk of over- or under-treatment. The risks of over-treatment include atrial fibrillation, osteoporosis and bone fractures, and the risks of under treatment are also significant.

General Practitioner (GP) Advice

GPs should not independently withdraw or adjust liothyronine treatment for patients who are stable and well on therapy. Review or adjustment of treatment must be either by, or under the guidance of, a consultant endocrinologist.

Liothyronine Supply

The current number of market authorisation holders may change. Patients should be informed that this is a rarely used product and there is the potential for instability in supply.

NICE Guideline

The National Institute for Health and Care Excellence is scheduled to publish a Clinical Guideline on 'Thyroid disease: assessment and management' in November 2019.

Patient Outcomes

This guidance focuses on the safe, appropriate and cost-effective use of medicines and should support patients to get the best outcomes from their medicines by enabling patients to make informed choices and agreeing treatment plans.

Part 5: Useful Links

- Management of primary hypothyroidism: statement by the British Thyroid Association Executive Committee – 2015 (https://www.british-thyroid-association.org/sandbox/bta2016/bta_statement_on_the_management_of_primary_hypothyroidism.pdf)
(See reference below - reference 1)
- [British Thyroid Association Guidelines](#)
- <https://www.sps.nhs.uk/articles/what-clinical-evidence-is-there-to-support-the-use-of-desiccated-thyroid-extract/>

Part 6: Appendix - An example of a Shared Care Guideline for Liothyronine is appended below

Note and acknowledgement:

This guidance has been prepared by the South of England Regional Medicines Optimisation Committee.

Clinical input and the example Shared Care Guideline has been provided through Mr Philip Newland-Jones, Consultant Pharmacist Diabetes and Endocrinology, University Hospital Southampton NHS Foundation Trust

Reference

1. Okosieme, Gilbert J, Abraham P, et al. Management of primary hypothyroidism: statement by the British Thyroid Association Executive Committee. *Clin Endocrinol (Oxf)*. 2016;(84):799-808.

Shared Care Guideline for Liothyronine for a selected cohort of adults with Hypothyroidism (GP Summary)

It is essential that a transfer of care only takes place with agreement of the GP and when sufficient information has been received. If the GP does not agree to share care they will inform the Consultant responsible for the patient's care.

**Basingstoke,
Southampton
&
Winchester
District
Prescribing
Committee**

| Specialist Contact Details | Patient ID Label |
|----------------------------|----------------------|
| Name: _____ | Surname: _____ |
| Location: _____ | Forename: _____ |
| Date: _____ | NHS Number: _____ |
| Tel: _____ | Date of Birth: _____ |

| | |
|-----------------------------|---|
| Indications | <p>Combination levothyroxine / liothyronine should not be used <i>routinely</i> in the management of hypothyroidism as there is insufficient population based clinical evidence to show that combination therapy is superior to levothyroxine monotherapy. As part of the overall holistic management of patients with hypothyroidism, NHS consultant endocrinologists may start a trial of combination levothyroxine and liothyronine in circumstances where all other treatment options have been exhausted.</p> <ol style="list-style-type: none"> 1. Where symptoms of hypothyroidism persist despite optimal dosage with levothyroxine. (TSH 0.4-1.5mU/L) 2. Where alternative causes of symptoms have been excluded, <i>see box 1 below</i>. |
| Exclusions | <ol style="list-style-type: none"> 1. Patients with thyroid cancer who need liothyronine as part of their investigation and treatment will remain under the specialist care. 2. Women who are planning pregnancy who are taking liothyronine should remain under specialist care as it is not recommended in pregnancy. 3. In rare cases where liothyronine is used for resistant depression, therapy should be supervised by a consultant psychiatrist. <i>This is off licence and not approved locally.</i> |
| Dose & response | <p>Liothyronine is only prescribed as part of a combination treatment with levothyroxine</p> <p>When liothyronine is commenced a reduction in levothyroxine dose will be required. Specialists should individualise approach to dose changes, however typically, for every 10microgram of liothyronine (half tablet of 20microgram preparation) the levothyroxine dose should be reduced by 50micrograms. (E.g. levothyroxine 125microgram each morning would become 75microgram levothyroxine each morning and 10microgram liothyronine each morning).</p> <p>Response is assessed via pre and post symptom scoring or quality of life questionnaire.</p> |
| Specialist responsibilities | <ol style="list-style-type: none"> 1. To ensure the patient fulfils the criteria for treatment. 2. To ensure that all alternative causes of symptoms have been excluded. 3. To prescribe, monitor and assess response biochemically and assess physical and psychological wellbeing after at least 3 months of treatment and until treatment dose is stabilised. |
| GP responsibilities | <p>Key roles to be undertaken in primary care once a decision to work under shared care is made</p> <ol style="list-style-type: none"> 1. To agree to prescribe liothyronine in line with the shared care guideline once a stable dosing regimen has been determined by specialist care. 2. Ensure no drug interactions with concomitant medicines that are added at a later time. 3. Monitor biochemistry periodically as recommended by the specialist. 4. Report to and seek advice from the specialist on any aspect of patient care, which is of concern and may affect treatment. 5. Report adverse events to the MHRA on a Yellow Card www.mhra.gov.uk/yellowcard and to the specialist. |
| Primary care monitoring | <ul style="list-style-type: none"> • Initial biochemical monitoring will be undertaken by the specialist until a regimen is established • Monitoring is by TSH levels measured from blood tests taken prior to the morning medication. • Initially and following a dose change a repeat test will be required at 6-8weeks. After dose stabilisation, monitoring should only be required annually unless there is a change in symptoms that may warrant the checking of TSH levels. • The aim of the treatment is to maintain TSH of 0.4-2.5mU/L with the T3 and T4 in the normal range. |

| | | |
|--|---|--|
| Actions to be taken in response to monitoring | TSH Level | Action for GPs |
| | More than 5 mU/L | Increase levothyroxine dose by 25microgram |
| | 0.4 – 5.0 mU/L | No change required |
| | Less than 0.4 mU/L | Seek specialist advice, likely resume at lower dose. |
| Contra-indications | Liothyronine is contraindicated in: (Discuss with NHS Endocrinologist) <ul style="list-style-type: none"> • Known hypersensitivity to the drug or any of its excipients • Thyrotoxicosis • Cardiac arrhythmias • Angina • Pregnancy | |
| Cautions | Use with caution in patients with: <ul style="list-style-type: none"> • Ischaemic heart disease: any new presentation or significant worsening of existing ischaemic heart disease should be discussed with the specialist endocrinology team. • Breast feeding: an increase in monitoring of thyroid function tests may be required, discuss with specialist endocrinology team. | |
| Important adverse effects & management | Specialist to detail below the action to be taken upon occurrence of a particular adverse event as appropriate. Most serious toxicity is seen with long-term use and may therefore present first to GPs. | |
| | Adverse Event | Action to be taken |
| | Angina, arrhythmia | Stop Liothyronine, check TSH |
| Other symptoms of excessive dose: | By whom | |
| Palpitations, restlessness, tremor, diarrhoea, headache, muscle cramps | Continue liothyronine, check TSH | GP |

Box 1: Some possible causes of persistent symptoms in euthyroid patients on levothyroxine T4:

| Endocrine / autoimmune | Haematological | End organ damage | Nutritional | Metabolic | Drugs | Lifestyle | Other |
|--|-----------------------------|---|---|--|-------------------------------------|--|---|
| Diabetes mellitus Adrenal insufficiency Hypopituitarism Coeliac disease Pernicious anaemia | Anaemia Multiple myeloma | Chronic liver disease Chronic kidney disease Congestive cardiac failure | Deficiency of any of the following: Vitamin B12 Folate Vitamin D Iron | Obesity Hypercalcaemia Electrolyte imbalance | Beta-blockers Statins Opiates | Stressful life events Poor sleep pattern Work-related exhaustion Alcohol excess | Obstructive sleep apnoea Viral and postviral syndromes Chronic fatigue syndrome Carbon monoxide poisoning Depression and anxiety Polymyalgia rheumatic Fibromyalgia |

The manufacturer's summary of product characteristics (SPC) and the most current edition of the British National Formulary should be consulted for full information on contraindications, warnings, side effects and drug interactions.

References

1. Summary of product characteristics for Liothyronine
2. British National Formulary January 2018.
3. Wiersinga W, M, Duntas L, Fadeyev V, Nygaard B, Vanderpump M, P, J, 2012 ETA Guidelines: The Use of L-T4 + L-T3 in the Treatment of Hypothyroidism. Eur Thyroid J 2012;1:55-71
4. Okosieme, Gilbert J, Abraham P, et al. Management of primary hypothyroidism: statement by the British Thyroid Association Executive Committee. Clin Endocrinol (Oxf). 2016;84):799-808.