**Ethno-Specific Endocrinology**
Endocrinology has progressed rapidly in India over the past few decades. In tandem with advances made by colleagues across the world, Indian researchers and clinicians have fine-tuned the screening, diagnosis, and management of endocrine dysfunction. One major area of research has the establishment of ethno-specific guidelines in diabetology and obesity.

**Trimester-Specific Thyroid Function Interpretation**
In thyroidology, too, there is a need for local evidence to create population-based normative data for thyroid function tests. This is especially true for trimester-specific reference ranges of thyroid-stimulating hormone (TSH), as management of thyroid dysfunction is dependent on these values. Maintenance of euthyroidism during pregnancy improves not only maternal and fetal health but also neonatal and long-term offspring health. At the same time, one must guard against unwarranted pharmacological therapy in “nonhypothyroid” pregnant women, keeping the philosophy of quaternary prevention in mind.

**Data From India**
Over the past two decades, various Indian endocrine and obstetric units have published center-based trimester-specific data for thyroid function tests. Their aim has been to create normative ranges which are of relevance to the entire country and perhaps subcontinent. However, the wide variation in research methodology, research tools, statistical analysis, and publication strategy has meant that these efforts have not gained their due recognition.

**Joining the Dots**
In this issue of the Indian Journal of Endocrinology and Metabolism (IJEM), Kannan et al. and Kalra et al. set out to correct this anomaly. Using a systematic and structured approach, Kannan et al. identify 56 studies and select eight of them to describe normative thyroid function tests in Indian cohorts of antenatal women. Kalra et al. limit their analysis to six studies which used modern immunoassays to measure TSH. Both authors emphasize the need for India-specific trimester-based normative data. While appreciating the diligence of pioneer workers, they point out that outcome-based studies and harmonization of
assays/research methodology are needed to confirm accurate trimester-specific thyroid function ranges.

**United in Diversity**

Kannan et al. underscore the relatively high upper range of normal limits of TSH in most Indian studies. The 95th percentile for TSH in third trimester, for example, is 1.93 mIU/ml in Manipur, 4.64 mIU/ml in Haryana, 4.60 mIU/ml in West Bengal, and 5.70 mIU/ml in New Delhi. Kalra et al. point out that Marwaha et al.’s study from New Delhi has been conducted with robust methodology, employing comprehensive clinical, immunological, and ultrasonographic inclusion/exclusion criteria. It is noteworthy, therefore that the upper range of TSH in this study extends to 10.8 mIU/ml in the first, 10.85 mIU/ml in the second, and 9.55 mIU/ml in the third trimester. At the opposite end of the spectrum is data from Manipur which reports 95th percentile values of 1.82, 1071, and 1.73 mIU/ml of TSH in the first, second, and third trimesters, respectively. Kalra et al. acknowledge the opinion of Jebasingh et al., who remind us of the multiethnic nature of India and the need to respect this while formulating national guidance.

The heterogeneity in the data published from India is reflected in the recommendations proposed by the IJEM reviews. Kannan et al. suggest a diagnostic threshold of TSH 4.5–5 mIU/L, which is similar to that of nonpregnant states. They suggest that the therapeutic threshold in pregnancy is based on antibody status. While antenatal women with positive thyroid antibodies should be treated if TSH is ≥3 mIU/L, the therapeutic threshold can be raised to 5 mIU/l in antibody-negative women. Kalra et al. propose a more conventional approach, preferring to concur with existing international guidelines.

**The Road Ahead**

This heterogeneity, however, should not distract us from the main message of this editorial. These analyses are a step forward in improving thyroid care for the 24 million Indian women who become antenatal every year.

We need universal screening for thyroid dysfunction in pregnancy in India. Screening is of no value if it is not followed by appropriate clinical action. To ensure that clinical intervention is correct, it must be based on well-defined parameters. These parameters must be relevant to the population being treated. To ensure this, we need robust, harmonized research to establish normative trimester-specific data for thyroid function tests in India.

We appreciate the work of pioneering seniors and colleagues and call for these efforts to be duplicated, in a harmonized manner, across the country.

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