Liothyronine (Triiodothyronine)

Newborn use only

2024

Alert	**NOT** a choice for maintenance thyroid replacement due to its short duration of action. Liothyronine is to be used only after consultation with and approval from a paediatric endocrinologist. Intravenous liothyronine is available in Australia via Special Access Scheme. Liothyronine ADVANZ Pharma, UK – contains dextran 110, which is contraindicated in patients with glucose-galactose malabsorption. Safety of Dextran 110 in neonates is uncertain.
Indication	1. Hypothyroidism - In whom oral levothyroxine is contraindicated for a prolonged period e.g. following bowel surgery. 2. Sick euthyroidism (low T_4/T_3 with no significant elevation of TSH), particularly after cardiac surgery – consider treatment if free T_3 concentration is <1.5 picomol/L or if free T_3 is <3.5 picomol/L and on inotropic support or haemodynamic instability is present.[1]
Action	Exogenous thyroid hormone increases the metabolic rate of body tissues. The biological action of liothyronine (L-T_3) is qualitatively similar to that of levothyroxine (T_4) but the effect develops in a few hours and disappears within 24–48 hours of stopping treatment.
Drug Type	Liothyronine is a synthetic form of triiodothyronine (T_3), a thyroid hormone.
Trade Name	Thyrotardin-inject (Medsurge, UK) – Preferred. Liothyronine (ADVANZ Pharma, UK – Contains Dextran 110)
Presentation	Thyrotardin-inject - 103.4 micrograms of sodium liothyronine powdered vial and solvent for solution for injection- equivalent to 100 microgram liothyronine Liothyronine (ADVANZ Pharma UK) 20 microgram liothyronine powdered vial and solvent for solution for injection – Contains Dextran 110, which is contraindicated in patients with glucose-galactose malabsorption. Safety of Dextran 110 in neonates is uncertain.
Dose	**IV bolus** Starting dose: 0.4 microgram/kg. Subsequent doses: 0.2 microgram/kg every 3 to 12 hours (titrated to free T_3 level – normal is 4.5 to 7.8 picomol/L in neonates[1] and 2.3 to 9.2 picomol/L in 1 month to 7 years of age[2]) **Discontinuing IV T_3 treatment** • In infants with sick euthyroid syndrome in whom T_3 has been started as an adjunct to inotropic support, IV T_3 therapy can be weaned over 24 hours or simply stopped once inotropic support is no longer required. • IV T_3 can be ceased when FT_3 levels reach the normal range. • If hypothyroidism is expected to be an on-going problem, the infant should be started on oral levothyroxine (T_4) treatment as soon as possible. Levothyroxine should commence before T_3 is discontinued. Intravenous T_3 can only be stopped when T_4 concentrations are within the normal range (10–20 picomol/L). This may take a few days.
Dose adjustment	Therapeutic hypothermia – Not applicable. ECMO – No information. Renal impairment – No specific dose adjustment. Hepatic impairment – No specific dose adjustment.
Route	IV
Maximum Dose	
Preparation	**Thyrotardin-Inject vial - Preferred** Add 5mL of water for injection (supplied solvent) to the vial to make 20 microgram/mL solution. Shake gently to dissolve. Further dilute 1 mL of reconstituted solution (20 micrograms) with 19 mL of water for injection to a final concentration of 1 microgram/mL. **Liothyronine Advanz Pharma vial** Add 2 mL of water for injection to 20 microgram vial to make 10 microgram/mL solution. Shake gently to dissolve. Further dilute 2 mL of reconstituted solution (20 micrograms) with 18 mL of water for injection to a final concentration of 1 microgram/mL.
Administration	IV slow bolus injection over 20 minutes.
Monitoring	**Prior to starting therapy** - Reverse T_3 (as well as TSH, T_3 and T_4).

	During therapy – Regular plasma free T3 levels as per paediatric endocrine team: Aim is to titrate the infusion rate/dose to achieve a normal plasma free T_3 (4.5 to 7.8 picomol/L in neonates, 5.2–8.0 picomol/L in 31–60 days old and 4.1–7.9 picomol/L in 61 days–12 months).
Contraindications	Hypersensitivity to liothyronine. Untreated hyperthyroidism.
Precautions	Patients with cardiovascular disorders. Untreated adrenal cortical insufficiency.
Drug Interactions	**Anticoagulants:** Liothyronine therapy may potentiate the action of anticoagulants by increasing the catabolism of vitamin K-dependent clotting factors. **Anticonvulsants:** Initiation or discontinuation of anticonvulsant therapy may alter liothyronine dose requirements. Phenytoin concentrations may be increased by liothyronine. Carbamazepine and phenytoin enhance the metabolism of thyroid hormones and may displace them from plasma proteins. **Cardiac glycosides:** Thyroid hormones may potentiate digitalis toxicity. The increased metabolic rate following liothyronine therapy may increase digitalis requirements. **Cholestyramine:** Reduces gastrointestinal absorption of liothyronine by binding liothyronine within the gut lumen. **Catecholamines:** Liothyronine increases receptor sensitivity to catecholamines, thus potentially increasing the risk of cardiac arrhythmias. **Ketamine:** Concomitant use may cause hypertension and tachycardia. **Insulin or oral hypoglycaemics:** Requirements of insulin or oral hypoglycaemics may increase in patients receiving therapy with liothyronine. **Amiodarone and iodinated contrast media** – Due to high iodine content, cause both hyperthyroidism and hypothyroidism. Dose adjustment of liothyronine may be necessary. Enzyme-inducing drugs, barbiturates, rifampicin, carbamazepine and other drugs with hepatic enzyme properties, can increase the hepatic clearance of liothyronine.
Adverse Reactions	Tachycardia, tachyarrhythmia, hypertension. Overtreatment: Hyperactivity, bone-age advancement and craniosynostosis. Excessive dosage may also cause diarrhoea, ischaemic cardiac pain, sweating, muscle cramps and muscle weakness. Late-onset circulatory collapse has been reported in preterm infants treated with thyroid hormones particularly in the context of cortisol insufficiency.
Overdose	Overdose cause tachycardia, tachyarrhythmia, hypertension. It may also cause diarrhoea, ischaemic cardiac pain, sweating, muscle cramps and muscle weakness.
Compatibility	Fluids: No information for other fluids. Y-site: No data. In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.
Incompatibility	In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.
Stability	Thyrotardin – The reconstituted solution should be used immediately. Liothyronine (ADVANZ PHARMA)[32] – Use immediately after reconstitution.
Storage	Thyrotardin: Store in a refrigerator between 2 and 8°C. Protect from light. The reconstituted solution must be protected from direct sunlight. Liothyronine (ADVANZ Pharma): Do not store above 25°C. Protect from light.
Excipients	Liothyronine Advanz Pharma: Contains dextran 110 Thyrotardin: disodium phosphate dihydrate, mannitol, sodium chloride, phosphoric acid 10% and sodium hydroxide
Special Comments	
Evidence	**Background** Liothyronine is the synthetic form of T_3 and, although usually administered IV, it may also be administered enterally; but absorption may be less predictable.

Congenital hypothyroidism (CH): Untreated CH leads to intellectual disabilities. Prompt diagnosis by newborn screening (NBS) leading to early and adequate treatment results in grossly normal neurocognitive outcomes in adulthood. The initial treatment of CH is levothyroxine, 10 to 15 mcg/kg daily. The goals of treatment are to maintain consistent euthyroidism with normal thyroid-stimulating hormone and free thyroxine in the upper half of the age-specific reference range during the first 3 years of life.[3]

Efficacy

Triiodothyronine for hypothyroidism: No report was found of use of liothyronine alone for treatment of congenital hypothyroidism or hypothyroidism of other causes.

Triiodothyronine in addition to levothyroxine for hypothyroidism: In a small RCT (n = 14) of infants with congenital hypothyroidism, triiodothyronine plus levothyroxine treatment resulted in slower TSH normalisation compared to levothyroxine alone.[5]
2023 Consensus statement by American Academy of Pediatrics (AAP), AAP Council on Genetics, Pediatric Endocrine Society, American Thyroid Association: Some infants with congenital hypothyroidism (CH) have persistent serum TSH elevation despite FT4 levels at or above the upper limit of the reference range. This is refereed to central resistance to thyroid hormone (TH). This may be due to alteration of pituitary-thyroid feedback caused
by intrauterine hypothyroidism. Resistance to TH is more common in infants younger than 1 year and typically resolves over time but may persist in up to 10% of children with
CH. In patients with CH and resistance to TH, the addition of liothyronine (L-T3) to L-T4 monotherapy (only in consultation with a paediatric endocrinologist) may normalize both
TSH and FT4, but there is no evidence that this improves patient outcomes.[3] **Conclusion:** There is insufficient evidence to support the use of liothyronine alone or in combination with levothyroxine for treatment of congenital hypothyroidism or hypothyroidism of other causes.

In adults, two systematic reviews found combined T_4 and T_3 treatment does not improve well-being, cognitive function or quality of life compared with T_4 alone. T_4 alone may be beneficial in improving psychological or physical well-being. According to the current evidence, T_4 alone replacement may remain the drug of choice for hypothyroid patients.[6,7] (Adults LOE I GOR B)
Recommendation: The European Thyroid Association guidelines, 2012 concluded there is insufficient evidence that T_4 + T_3 combination therapy is better than T_4 monotherapy, and it is recommended that T_4 monotherapy remain the standard treatment of hypothyroidism. T_4 + T_3 combination therapy should be considered solely as an experimental treatment modality.[8]

Thyroid hormones in infants undergoing cardiac surgery: Thyroid hormone has been tested during and after cardiac surgery with the hypothesis that it may enhance cardiac contractility of the uninjured or failing myocardium in situations where thyroid metabolism is impaired. Several RCTs have assessed the effect of liothyronine in infants and children undergoing cardiac surgery.[9-15] A systematic review, updated in 2010, concluded there is a lack of evidence concerning the effects of triiodothyronine supplementation in infants undergoing cardiac surgery.[16] Individual trials reported on different doses and variable clinical effects.

Triiodothyronine trials: Several RCTs have assessed the effect and safety of T_3 for infants undergoing cardiac surgery. Bettendorf et al 2000 in 40 children aged 2 days to 10 years undergoing cardiac surgery compared a daily infusion of triiodothyronine 2 microgram/kg on day 1 after surgery then 1 microgram/kg daily until 12 days after surgery with placebo.[8] In all patients, postoperative plasma concentrations of TSH, T_4, free T_4 and T_3 were abnormally low and plasma concentrations of reverse T_3 were raised. After start of treatment, T_3 was significantly higher in patients given T_3 whereas TSH, T_4, free T_4 and rT_3 remained similar. Infants given T_3 had a higher mean cardiac index, improved systolic cardiac function (particularly in patients with longer cardiopulmonary bypass operations) and had lower mean treatment scores. Portman et al 2000 in 14 infants <1 year age undergoing VSD or

tetralogy of Fallot repair assessed IV 0.4 microgram/kg immediately before the start of cardiopulmonary bypass and again with myocardial reperfusion.[13] T_3 and FT_3 were maintained, heart rate was transiently elevated and peak systolic pressure-rate product was increased after 6 hours. Chowdhury et al 2001, in 75 patients aged from birth to 18 years undergoing cardiac surgery, compared a continuous T_3 infusion 0.05–0.15 microgram/kg/hour to no treatment to maintain serum T_3 within the normal range.[10] Infants had normalised serum T_3 concentrations and reduced use of inotropes in the neonatal strata only. There was no difference in mechanical ventilation or duration of stay. Mackie et al 2005, in 42 infants undergoing a Norwood procedure or two-ventricle repair of interrupted aortic arch and VSD, used a continuous T_3 infusion 0.05 microgram/kg/hour.[11] T_3 and free-T_3 were increased above baseline, negative fluid balance was attained more rapidly but cardiac index did not change. There was no difference in ECMO use, extubation time or mortality. Portman et al 2010, in 193 children <2 years old undergoing heart surgery with cardiopulmonary bypass, compared a bolus of 0.4 microgram/kg immediately before CPB, 0.4 microgram/kg on the release of the aortic cross-clamp, and then 0.2 microgram/kg at 3, 6, and 9 hours after cross-clamp release.[13] Overall, treatment did not reduce extubation time. There were no significant differences between T_3 and placebo for heart rate, mean arterial blood pressure or mean arterial blood pressure times heart rate over the first 24 hours. The inotropic scores were not significantly different. Age stratification found T_3 supplementation reduced extubation time for infants <5 months but increased it for infants ≥5 months. Marwali et al 2013, in infants <2 years of age undergoing congenital heart surgery, assessed oral T_3 0.5 microgram/kg every 12 hours versus placebo.[17] Total and free triiodothyronine levels were maintained within normal limits. There was no difference in cardiovascular or clinical outcomes. Marwali et al 2017, in infants <3 years age undergoing congenital heart surgery, assessed oral T_3 1.0 microgram/kg or placebo by nasogastric tube every 6 hours for 60 hours after induction of anaesthesia.[12] TSH was suppressed in the T_3 group during treatment. There was a marginal decrease in extubation time in the T_3 group and significantly more sepsis in the placebo group. **Conclusion:** In infants undergoing cardiac surgery, particularly those with low T_3, there is some evidence that T_3 administration improves cardiac function and reduces inotrope and treatment needs, particularly in infants <5 months age. It is unclear whether there are significant improvements in morbidity or duration of care. **Recommendation:** The Pediatric Cardiac Intensive Care Society 2014 Consensus Statement reported studies suggest a positive outcome of normalising T_3 levels acutely in newborns after cardiac surgery. However, they concluded adequately powered studies are needed before a uniform recommendation can be made. Until then, therapeutic decisions should be made based on individual circumstances, taking into account the severity of the T_3 deficiency, as well as the symptoms that might be attributable to thyroid dysfunction (e.g. bradycardia, hypothermia and increased SVR), and in consultation with paediatric endocrinology.[4]. [LOE I GOR D]

Triiodothyronine for prevention or treatment of hypothyroxinaemia: No study has reported the effect of liothyronine in preterm infants with transient hypothyroxinaemia (normal TSH, low T_4).

Triiodothyronine for prevention or treatment of respiratory distress: Systematic review found 2 studies that enrolled preterm infants with respiratory distress.[18] Amato et al 1988 allocated infants to levothyroxine 50 microgram/dose at 1 and at 24 hours or to no treatment.[19] Amato et al 1989 allocated infants to triiodothyronine 50 microgram/day in two divided doses for two days or to no treatment.[20] Neither study reported any significant benefits in neonatal morbidity or mortality from use of thyroid hormones. There is no evidence from controlled clinical trials that postnatal thyroid hormone treatment reduces the severity of respiratory distress syndrome, neonatal morbidity or mortality in preterm infants with respiratory distress syndrome.[17] (LOE II GOR C)

Prophylactic triiodothyronine in preterm infants: A systematic review of prophylactic thyroid hormones in preterm infants to reduce neonatal mortality, neonatal morbidity or improve neurodevelopmental outcomes[20] found four studies enrolling 318 infants, with a single study (Valerio 2004) that reported the effect a single dose of triiodothyronine 0.5 microgram/kg at 24 hours then levothyroxine 8 microgram/kg/day for 6 weeks versus levothyroxine alone versus placebo.[22] Overall, the review found no evidence that prophylactic thyroid hormones in preterm infants reduced neonatal mortality, neonatal morbidity or improved neurodevelopmental outcomes. Valerio et al 2004 reported no effect of T_3 0.5 microgram/kg on the cardiovascular system. The review does not support the use of prophylactic thyroid hormones in preterm infants.[22] [LOE I GOR D] A second trial in infants 24 to 27 weeks gestation compared placebo vehicle versus glucose 5% versus potassium iodide 30 microgram/kg/day versus continuous daily infusions of either 4 or 8 microgram/kg/day of T_4 for 42 days versus bolus daily infusions of either 4 or 8 microgram/kg/d of T_4. T_4 was accompanied by T_3 1 microgram/kg/day during the first 14 postnatal days. Combined T_4 and T_3 treatment resulted in suppression of TSH to <0.4 mIU/L in >80%.[23] **Conclusion:** There is no evidence of benefit from prophylactic thyroid hormones in preterm infants. Combined T_4 (4 or 8 microgram/kg/day) and T_3 (1 microgram/kg/day) treatment resulted in excessive suppression of TSH.

Prophylactic triiodothyronine and hydrocortisone in preterm infants: A single trial in 253 infants born <30 weeks gestation compared routine hydrocortisone 1 mg/kg and T_3 6 microgram/kg versus placebo.[23] No beneficial effects of T_3 and hydrocortisone were shown. Although FT_3 concentrations were doubled by the treatment infusion, FT_4 was significantly suppressed.

Pharmacokinetics

The bioavailability of enteral levothyroxine is erratic ranging from 40% to 80% and dependent on dosage form and the presence of food. When administered in a fasting state, the bioavailability can be increased by about 20%. Time to peak occurs at 2 hours post-administration. Conversely, enteral liothyronine (T_3) bioavailability is 85–95%. Levothyroxine is over 99% protein bound to plasma proteins, such as albumin, TBG and transthyretin. Levothyroxine is deiodinated and metabolised to T_3 in the blood, liver, kidney and many other tissues. In addition, levothyroxine is metabolised through glucuronidation, conjugation and enterohepatic recirculation. Liothyronine is further metabolised in the liver to inactive metabolites. The onset of action of T_3 is within a few hours, peaking at 48–72 hours and duration of action up to 72 hours.

The half-life of T_4 reported in adults is much longer than that of T_3, approximately 1.5–2 days compared with 7 hours, respectively.[8]

Stability of continuous liothyronine infusion: The stability of thyroid hormones was tested during continuous infusion via polypropylene tubing using the same conditions that would be applied to treating patients in a hospital setting. The diluted thyroid hormones were prepared using aseptic technique, stored at 2-8°C and tested within 24 hours of preparation for stability and percent recovery from within plastic tubing. Experiments were done in duplicate with triplicate sets of readings for each assay point. Only T(4) prepared with 5% dextrose water (D5W) containing 1 mg/mL albumin remained constant, stable, predictable and accurate over time under various conditions. Other methods of preparation lost drug by adhering to the plastic containers and tubing by as much as 40% of starting concentration. T(3) recovery in the presence of 1 mg/mL of albumin was 107±2% (mean±standard error of the mean) of anticipated drug concentrations. It can be concluded from this experiment that to maintain an accurate and stable dosing of patients receiving intravenous thyroid hormones, 1 mg/mL of albumin must be added to the infusate to prevent lost on the plastic intravenous tubing.[34]

Safety

In the context of clinical trials of T_3 there have been few reported adverse events[8,10-15, 17] Thyroid hormone treatment in newborn infants has been associated with late onset circulatory collapse[25] which has also been associated with concomitant cortisol deficiency.[26] Overtreatment may cause hyperactivity, bone age advancement and craniosynostosis. There are case reports of premature craniosynostosis27 and pseudotumour cerebri[28] with thyroid hormone treatment. Long-term levothyroxine treatment in young adults with congenital hypothyroidism has been associated with

	impaired diastolic function and exercise capacity and increased intima-media thickness.[29] In patients on long-term levothyroxine therapy, those with a high or suppressed TSH had an increased risk of cardiovascular disease, dysrhythmias and fractures, whereas patients with a low but unsuppressed TSH did not.[30]
Practice Points	
References	1. Strich D, Edri S, Gillis D. Current normal values for TSH and FT3 in children are too low: evidence from over 11,000 samples. J Pediatr Endocrinol Metab. 2012;25:245-8. 2. Soldin OP, Jang M, Guo T, Soldin SJ. Pediatric reference intervals for free thyroxine and free triiodothyronine. Thyroid. 2009;19:699-702. 3. Rose SR, Wassner AJ, Wintergerst KA, Yayah-Jones NH, Hopkin RJ, Chuang J, Smith JR, Abell K, LaFranchi SH, SECTION ON ENDOCRINOLOGY EXECUTIVE COMMITTEE Wintergerst Kupper A. MD, FAAP Bethin Kathleen E. MD, FAAP Brodsky Jill L. MD, FAAP Jelley David H. MD, FAAP Marshall Bess A. MD, FAAP Mastrandrea Lucy D. MD, PhD, FAAP Lynch Jane L. MD, FAAP Laskosz Laura MPH. Congenital hypothyroidism: screening and management. Pediatrics. 2023 Jan 1;151(1):e2022060420. 4. Soto-Rivera CL, Agus MS, Sawyer JE, Macrae DJ. Pediatric Cardiac Intensive Care Society 2014 Consensus Statement: Pharmacotherapies in Cardiac Critical Care Hormone Replacement Therapy. Pediatr Crit Care Med. 2016;17:S59-68. 5. Cassio A, Cacciari E, Cicognani A, Damiani G, Missiroli G, Corbelli E, Balsamo A, Bal M, Gualandi S. Treatment for congenital hypothyroidism: Thyroxine alone or thyroxine plus triiodothyronine? Pediatrics. 2003;111:1055-60. 6. Chao M, Jiawei X, Xia H, Guoming W, Yangang W, Xufu W, Shuyao Z. Thyroxine alone or thyroxine plus triiodothyronine replacement therapy for hypothyroidism. Nuclear Medicine Communications. 2009;30:586-93. 7. Grozinsky-Glasberg S, Fraser A, Nahshoni E, Weizman A, Leibovici L. Thyroxine-triiodothyronine combination therapy versus thyroxine monotherapy for clinical hypothyroidism: Meta-analysis of randomized controlled trials. Journal of Clinical Endocrinology and Metabolism. 2006;91:2592-9. 8. Wiersinga WM, Duntas L, Fadeyev V, Nygaard B, Vanderpump MP. 2012 ETA Guidelines: The Use of L-T4 + L-T3 in the Treatment of Hypothyroidism. Eur Thyroid J. 2012;1:55-71. 9. Bettendorf M, Schmidt KG, Grulich-Henn J, Ulmer HE, Heinrich UE. Tri-iodothyronine treatment in children after cardiac surgery: A double-blind, randomised, placebo-controlled study. Lancet. 2000;356:529-34. 10. Chowdhury D, Djamaa K, Parnell VA, McMahon C, Sison CP, Klein I. A prospective randomized clinical study of thyroid hormone treatment after operations for complex congenital heart disease. Journal of Thoracic and Cardiovascular Surgery. 2001;122:1023-5. 11. Mackie AS, Booth KL, Newburger JW, Gauvreau K, Huang SA, Laussen PC, DiNardo JA, del Nido PJ, Mayer JE, Jr., Jonas RA, McGrath E, Elder J, Roth SJ. A randomized, double-blind, placebo-controlled pilot trial of triiodothyronine in neonatal heart surgery. J Thorac Cardiovasc Surg. 2005;130:810-6. 12. Marwali EM, Boom CE, Budiwardhana N, Fakhri D, Roebiono PS, Santoso A, Sastroasmoro S, Slee A, Portman MA. Oral Triiodothyronine for Infants and Children Undergoing Cardiopulmonary Bypass. Ann Thorac Surg. 2017;104:688-95. 13. Portman MA, Fearneyhough C, Ning XH, Duncan BW, Rosenthal GL, Lupinetti FM. Triiodothyronine repletion in infants during cardiopulmonary bypass for congenital heart disease. Journal of Thoracic and Cardiovascular Surgery. 2000;120:604-8. 14. Portman MA, Slee A, Olson AK, Cohen G, Karl T, Tong E, Hastings L, Patel H, Reinhartz O, Mott AR, Mainwaring R, Linam J, Danzi S, Investigators T. Triiodothyronine Supplementation in Infants and Children Undergoing Cardiopulmonary Bypass (TRICC): a multicenter placebo-controlled randomized trial: age analysis. Circulation. 2010;122:S224-33. 15. Priest JR, Slee A, Olson AK, Ledee D, Morrish F, Portman MA. Triiodothyronine supplementation and cytokines during cardiopulmonary bypass in infants and children. J Thorac Cardiovasc Surg. 2012;144:938-43.e2.

16. Dimmick S, Badawi N, Randell T. Thyroid hormone supplementation for the prevention of morbidity and mortality in infants undergoing cardiac surgery. Cochrane database of systematic reviews (Online). 2004:CD004220.
17. Marwali EM, Boom CE, Sakidjan I, Santoso A, Fakhri D, Kartini A, Kekalih A, Schwartz SM, Haas NA. Oral triiodothyronine normalizes triiodothyronine levels after surgery for pediatric congenital heart disease. Pediatric Critical Care Medicine. 2013;14:701-8.
18. Osborn DA, Hunt RW. Postnatal thyroid hormones for respiratory distress syndrome in preterm infants. Cochrane Database Syst Rev. 2007:CD005946.
19. Amato M, Pasquier S, Carasso A, Von Muralt G. Postnatal thyroxine administration for idiopathic respiratory distress syndrome in preterm infants. Horm Res. 1988;29:27-30.
20. Amato M, Guggisberg C, Schneider H. Postnatal triiodothyronine replacement and respiratory distress syndrome of the preterm infant. Horm Res. 1989;32:213-7.
21. Osborn DA, Hunt RW. Prophylactic postnatal thyroid hormones for prevention of morbidity and mortality in preterm infants. Cochrane Database Syst Rev. 2007:CD005948.
22. Valerio PG, van Wassenaer AG, de Vijlder JJ, Kok JH. A randomized, masked study of triiodothyronine plus thyroxine administration in preterm infants less than 28 weeks of gestational age: hormonal and clinical effects. Pediatric Research. 2004;55:248-53.
23. La Gamma EF, Van Wassenaer AG, Ares S, Golombek SG, Kok JH, Quero J, Hong T, Rahbar MH, Morreale De Escobar G, Fisher DA, Paneth N. Phase 1 trial of 4 thyroid hormone regimens for transient hypothyroxinemia in neonates of <28 weeks' gestation. Pediatrics. 2009;124:e258-e68.
24. Biswas S, Buffery J, Enoch H, Bland M, Markiewicz M, Walters D. Pulmonary effects of triiodothyronine (T3) and hydrocortisone (HC) supplementation in preterm infants less than 30 weeks gestation: Results of the THORN trial - Thyroid hormone replacement in neonates. Pediatric Research. 2003;53:48-56.
25. Kawai M, Kusuda S, Cho K, Horikawa R, Takizawa F, Ono M, Hattori T, Oshiro M. Nationwide surveillance of circulatory collapse associated with levothyroxine administration in very-low-birthweight infants in Japan. Pediatr Int. 2012;54:177-81.
26. Yagasaki H, Kobayashi K, Nemoto A, Naito A, Sugita K, Ohyama K. Late-onset circulatory dysfunction after thyroid hormone treatment in an extremely low birth weight infant. J Pediatr Endocrinol Metab. 2010;23:153-8.
27. Penfold JL, Simpson DA. Premature craniosynostosis-a complication of thyroid replacement therapy. J Pediatr. 1975;86:360-3.
28. Raghavan S, DiMartino-Nardi J, Saenger P, Linder B. Pseudotumor cerebri in an infant after L-thyroxine therapy for transient neonatal hypothyroidism. J Pediatr. 1997;130:478-80.
29. Salerno M, Oliviero U, Lettiero T, Guardasole V, Mattiacci DM, Saldamarco L, Capalbo D, Lucariello A, Sacca L, Cittadini A. Long-term cardiovascular effects of levothyroxine therapy in young adults with congenital hypothyroidism. J Clin Endocrinol Metab. 2008;93:2486-91.
30. Flynn RW, Bonellie SR, Jung RT, MacDonald TM, Morris AD, Leese GP. Serum thyroid-stimulating hormone concentration and morbidity from cardiovascular disease and fractures in patients on long-term thyroxine therapy. J Clin Endocrinol Metab. 2010;95:186-93.
31. MerativeTM Micromedex® Complete IV Compatibility (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: Aug/01/2024).
32. Liothyronine Sodium 20 micrograms Powder for Solution for Injection. Product information by ADVANZ Pharma, updated 15-Nov-2023. Accessed on 5 Aug 2024.
33. ASHP Injectable Drug Information 2021 ed. Bethesda, MD: American Society of Health-System Pharmacists; 2021. 2b Monograph in IV index. Trissel's 2 Clinical Pharmaceutics Database (Parenteral compatibility). Greenwood Village, Colorado: Thomson Reuters (Healthcare). 2022.
34. Golombek SG, Alpan G, Frey M, Corbi D, Lagamma EF. Stability of thyroid hormones during continuous infusion. J Perinat Med. 2011 Jul;39(4):471-5.

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