Longitudinal study of thyroid function in Down’s syndrome in the first two decades

P A Gibson, R W Newton, K Selby, D A Price, K Leyland, G M Addison

Aims and Methods: Thyroid function tests were initially carried out on 122 children with Down’s syndrome aged 6–14 years and then repeated four to six years later in 103 adolescents (85% of the group of 122) when they were aged 10–20 years (median 14.4 years). At the second test two were hypothyroid and two with isolated raised thyroid stimulating hormone (IR-TSH) were receiving thyroxine.

Results: At the first test there were 98 (80%) euthyroid children: 83 were retested and four (5%) had IR-TSH. At the first test 24 had IR-TSH: 20 were retested and 14 (70%) had become normal. Seventeen with IR-TSH on initial testing had a thyrotrophin releasing hormone test within three months; TSH had become normal in eight (47%) of these children. There was no association between reported clinical symptoms and IR-TSH, but there were clear symptoms in one of the two with definite hypothyroidism.

Conclusions: The likelihood ratio for a positive result on second testing when raised TSH and positive antibody status on first testing are combined is 20. This suggests initial testing results could be used as a basis to select a subgroup for further testing at say five yearly intervals unless new symptoms emerge in the interim. It also suggests that yearly screening (as recommended by the American Academy of Pediatrics, 2001) is probably not justified in the first 20 years of life.
40. Thyroid autoantibodies were shown to be commonly raised where they were measured.\textsuperscript{8–11}

One pattern of thyroid abnormality in Down’s syndrome is isolated raised thyroid stimulating hormone (IR-TSH). Other terminology used for this pattern of abnormality includes isolated hyperthyrotrophinaemia, compensated hypothyroidism, and subclinical hypothyroidism.\textsuperscript{13–14} There are no absolute thresholds between hypothyroidism, IR-TSH, and euthyroidism. The study of van Trotsenburg and colleagues\textsuperscript{15} of neonates with Down’s syndrome indicates that the Gaussian distribution of thyroxine and TSH values are skewed to the left and right respectively, and that there may be a Down’s syndrome specific thyroid (regulation) disorder. Variability in definitions as well as laboratory techniques and population identification in part explain the wide range in quoted rates of thyroid dysfunction in Down’s syndrome.

**METHODS**

Between 1973 and 1980, Cunningham,\textsuperscript{16} working at the Hester Adrian Research Centre, University of Manchester, recruited a population based cohort of 180 children with Down’s syndrome in Manchester, England. These children and their families were studied prospectively in detail. Study population details are described by Selby and colleagues\textsuperscript{17} and summarised in fig 1.

Blood was first collected from 122 of this cohort when they were aged 6–14 years (median 9.8 years). Blood samples were analysed for thyroid stimulating hormone (thyrotrophin, TSH), thyroid binding globulin, total thyroxine (T4) (quoted according to thyroid binding globulin), and the two autoantibodies thyroglobulin and thyroid microsomal antibody. The more specific anti-thyroperoxidase assay was not available at first testing and was not pursued at second testing.

The investigating team usually performed blood sampling and analysis. Occasionally blood had already been taken by the local paediatric team; in these cases results were collated from the participating hospital.

At the time of the initial sampling, clinical data were collected on height, weight, and family history of autoimmune disease.

For the purposes of this study the following definitions are used:

- **Hypothyroidism**: low thyroxine and TSH of 6 \(\mu\)/ml or more
- **Isolated raised TSH (IR-TSH)**: normal thyroxine and TSH of 6 \(\mu\)/ml or more
- **Euthyroid**: normal thyroxine and TSH less than 6 \(\mu\)ml
- **Positive autoantibodies**: titre greater than 1:64.

We assessed whether testing aspects of thyroid function in the first decade (“first testing” in table 1) was predictive of hypothyroidism in the second decade. We express results in terms of the following functions to help guide clinical decision making.

The properties of tests are defined as follows:

- **Sensitivity** is the proportion of children with hypothyroidism aged 10–20 positive at first testing, \(a/(a+c)\)
- **Specificity** is the proportion of children with normal thyroid function aged 10–20 negative at first testing, \(d/(b+d)\)
- **Positive predictive value** is the proportion of children with hypothyroidism aged 10–20, of all children positive at first testing, \(a/(a+b)\)
- **Negative predictive value** is the proportion who are normal aged 10–20, of all children negative at first testing \(d/(c+d)\)
- **Likelihood ratio for a positive test result** is the likelihood that a positive first test predicts hypothyroidism aged 10–20 compared to the likelihood that a positive first test predicts normal thyroid function aged 10–20, \([a/(a+c)]/[b/(b+d)]\)
- **Likelihood ratio for a negative test result** is the likelihood that a negative first test predicts hypothyroidism aged 10–20 compared to the likelihood that a negative first test

<table>
<thead>
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<th>Table 1 Testing of thyroid function in the first decade</th>
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<td><strong>Hypothyroidism, 2nd test (aged 10–20)</strong></td>
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predicts normal thyroid function aged 10–20, \[\frac{c/(a+c)}{d/(b+d)}\].

Likelihood ratios can be used in clinical practice to influence management decisions. Referring to Fagan’s nomogram \(^{18}\) (fig 2) it can be seen that a likelihood ratio of unity makes the probability of a positive or negative result aged 10–20 the same as the pretest probability. Likelihood ratios greater than unity magnify the probability of a like result on testing aged 10–20. Likelihood ratios less than unity diminish the probability of a like result on testing aged 10–20.

**RESULTS**

In 1986–87, of 122 children, one child had been commenced on thyroxine by a local paediatrician prior to the first test. We reviewed this 13 year old’s data: TSH 9.2 mu/l, T4 93 nmol/l, thyroid binding globulin 26.3 mg/l. We identified this as a case of IR-TSH.

Ninety-eight of the remaining 121 children had normal thyroid function and 23 had IR-TSH. Between first sampling and resampling in 1990–93, 18 cases were lost to follow up, and the individual on thyroxine was excluded from further analysis because she remained on thyroxine (fig 1). Of the group of 103 individuals resampled, 91 had normal thyroid function, 10 had IR-TSH (one of whom had been commenced, in our view unnecessarily on thyroxine by her local paediatrician), and two cases of definite hypothyroidism were identified. Treatment was commenced on the two newly identified cases (one from the 1986–87 normal thyroid function group and one from the IR-TSH group).

Table 2 compares thyroid function on second testing with thyroid function on first testing. Data are available on 101 at initial testing (data missing on two of the 103, one of whom developed hypothyroidism) and eight were positive (all eight for antimicrosomal antibody and two of these additionally for antithyroglobulin antibody). Between first and second testing groups aged 10–20 as “normal”.

Table 4 shows the autoantibody status at first and second testing. Data are available on 101 at initial testing (data missing on two of the 103, one of whom developed hypothyroidism) and eight were positive (all eight for antimicrosomal antibody and two of these additionally for antithyroglobulin antibody). Between first and second testing three became normal, and two initially negative became positive. For the eight with positive autoantibodies on first testing, five were still positive on second testing, three retained IR-TSH, and one developed hypothyroidism. The association between positive autoantibodies on first testing and a second abnormal test (combining hypothyroidism, IR-TSH, and positive antibodies) was significant (Fisher’s exact \(p < 0.05\), but not with hypothyroidism on its own (Fisher’s exact \(p < 0.5\)). There was no significant sex difference in autoantibody status.

Table 5 shows the results of 101 children with available results at 10–20 years and their combined thyroid function and antibody status at initial testing.

**DISCUSSION**

The study confirms the high prevalence of thyroid dysfunction in Down’s syndrome with 12 of 103 showing abnormal results on second testing. The cause of the IR-TSH has not been elucidated. The results may indicate a predisposition in young people with Down’s syndrome to a self-limiting autoimmune process resulting in IR-TSH without clinical symptoms. However, autoantibodies were only seen in nine at first testing and in seven at second testing. On both occasions a positive association was seen with IR-TSH but not with hypothyroidism. There are other possible mechanisms for self-limiting subclinical thyroid dysfunction. Possible explanations include an inappropriate release of TSH related to a central disorder, the production of a less active form of TSH, or some form of TSH insensitivity in the thyroid gland. It is not clear how this would involve a self-limiting course but slow maturation of negative feedback control systems in the hypothalamo-pituitary axis in Down’s syndrome is possible. Van Trotsenburg and colleagues \(^{15}\) reported similar findings in neonates with Down’s syndrome and recommended more functional and molecular studies where autoimmunity was not involved.

To justify the introduction of a screening programme the condition to be identified should be relatively common, cause a significant health risk if not identified, be distinguished by a test that is relatively specific, reliable, acceptable, and
There is no association between reported clinical symptoms and IR-TSH. There were clear symptoms in one of the children, and one child had definite symptomatology.

We therefore propose that a decision on retesting is based on the initial test results. In our first decade group of 122, regular retesting could have been confined to 25. This would have been cost effective and minimised inconvenience and distress for the majority. Our results challenge the validity of population based screening programmes for thyroid dysfunction in Down's syndrome. The vast majority of those young people with thyroid dysfunction were shown to have a self-limiting condition and those with definite hypothyroidism in our series had definite symptomatology.

Conclusions
Hypothyroidism in Down’s syndrome should not be over-diagnosed. Knowledge of IR-TSH and its frequent self-limiting natural history needs dissemination. Treatment and frequent retesting of IR-TSH is not indicated. Our data suggest that early positive results for autoantibodies or high frequency for screening, there remains no clear health gain from treating the group with IR-TSH. We note that the natural history of the condition for many young people is one of recovery. While the debate continues over the best screening method and frequent retesting of IR-TSH is not indicated. Our study shows three potentially important points for clinical practice:

- Where the development of age specific normal ranges for TSH and T4 in Down’s syndrome is one possible approach for the future, we note that there are only small variations where this has been done for the general population. We recommend the simpler approach of recognising that IR-TSH in Down’s syndrome is frequently self-limiting without the need for treatment.
- There is no association between reported clinical symptoms and IR-TSH. There were clear symptoms in one of the two with definite hypothyroidism. Clinicians should pay particular attention to symptoms explainable on the basis of hypothyroidism when parents or the young people with Down’s syndrome themselves report these, remembering some of these symptoms can at times be features of Down’s syndrome.
- We emphasise that the positive likelihood ratio for the combined abnormal autoantibody status and IR-TSH result on first testing is 20 (and 14 for autoantibody alone). The clinical relevance of this can be seen from the use of Fagan’s nomogram. Before a child with Down’s syndrome has a first decade test, the probability of needing thyroxine in the second decade is, say, 2%. After testing positive for autoantibodies alone the probability of hypothyroidism in the second decade is 28%, which rises to 34% when IR-TSH is also identified and included. It is equally important to note that testing negative for autoantibodies with a normal TSH causes the probability of hypothyroidism in the second decade to become exceptionally small.

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IR-TSH can be used as a basis to select a subgroup for further testing at, say, five yearly intervals unless new symptoms emerge in the interim. They also suggest yearly screening as recommended by the American Academy of Pediatrics,24 is probably not justified in the first 20 years of life.

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