CLINICAL STUDY

Variations in urinary iodine excretion and thyroid function. A 1-year study in healthy men

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Abstract

Objective: The iodine intake level in a population is determined in cross-sectional studies. A fraction of samples with iodine content below a certain level, e.g. 25 μg/l, may suggest iodine deficiency in part of the population. However, urinary iodine varies considerably from day to day and the fraction of low samples caused by dispersion remains unsettled.

Design: A longitudinal study of 16 healthy men living in an area of mild to moderate iodine deficiency.

Methods: We measured urinary iodine and creatinine concentrations, and serum TSH, total thyroxine (T4), free T4 index and total tri-iodothyronine (T3) in samples collected monthly for 1 year.

Results: Average urinary iodine excretion was 57.0 μg/l (49.1 μg/24 h (corrected for creatinine excretion)) and varied from 29 to 81 μg/l (28 to 81 μg/24 h) between participants. Individual samples varied between 10 and 260 μg/l, and the variation around the mean was 2.4 times larger when calculated for the 180 individual samples compared with the 15 average annual values (1.7 times larger for estimated 24 h iodine excretion values). The fraction of individual samples below 25 μg/l was 6.7% (7.2%, <25 μg/24 h), whereas none of the participants had average iodine excretion below 25 μg/l or 25 μg/24 h. Participants with average annual iodine excretion below 50 μg/24 h had a negative correlation between iodine excretion and TSH, whereas a positive correlation was observed when average annual iodine excretion was above this level.

Conclusions: Seven per cent of individual urine samples indicated severe iodine deficiency without this being present in the group studied. Dispersion was reduced by 24% when using estimated 24 h urinary iodine excretion rather than urinary iodine concentration. Participants with moderate iodine deficiency (average annual urinary iodine excretion 25–50 μg/24 h) showed clear signs of substrate deficiency for thyroid hormone synthesis while participants with mild iodine deficiency (50–100 μg/24 h) did not.

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Introduction

The iodine intake level has a marked influence on the incidence and prevalence of thyroid abnormalities in a population (1, 2) and iodine exerts a number of effects on the normal and the sick thyroid gland (3, 4). The most severe consequences of extremes in iodine intake, with developmental brain damage and endemic goitre, are seen in areas with a very low iodine intake (below 20 or 25 μg/day) (5–7). The iodine intake of a population is often assessed by measurements of iodine in urine in cross-sectional studies of selected cohorts (5, 6). This provides information on the average iodine intake and on the frequency of low iodine excretion values. However, in individual subjects urinary iodine excretion to a considerable extent reflects iodine intake over a short period prior to collection (8–10). On the other hand, the thyroid gland has the capacity to store considerable amounts of iodine in thyroglobulin (4, 6) and a short period of low iodine intake is not necessarily an indicator of iodine deficiency in a subject.

In areas with severe iodine deficiency the thyroid gland lacks iodine, a main substrate for thyroid hormone synthesis, and an increase in iodine intake causes an increase in thyroid hormone levels in serum and a decrease in serum thyrotrophin (TSH) (11, 12). Conversely, in iodine replete areas, an increase in iodine intake causes a decrease in thyroid hormone levels in serum and an increase in serum TSH (13–15) due to autoregulatory iodine inhibition of the thyroid (4). In areas with mild or moderate iodine deficiency, iodine supplementation programmes have been initiated (16) or intensified (17). However, the exact level of iodine intake where the shift between these different mechanisms occur remains unsettled (5, 6).

We studied urinary iodine excretion in a group of healthy men living in an area with mild to moderate
iodine deficiency with monthly sampling for 1 year to approach an estimation of the true iodine excretion level. The aim was to evaluate the relationship between average annual iodine excretion and iodine excretion in single samples. Furthermore, we studied the association between urinary iodine and thyroid function in individual subjects and the importance of average annual iodine excretion for this association.

Subjects and methods
Sixteen healthy Caucasian men, age 24–52 years (median age 38 years) participated. Participant number 7 had subclinical hyperthyroidism with permanently suppressed serum TSH and normal thyroxine (T4), triiodothyronine (T3) and free T4 index (FTI) in serum. He was excluded. Of the remaining 15, none had clinical goitre, and none had previous or present thyroid disorders. All had serum TSH, T4, T3 and FTI within the laboratory reference range. None took regular medication or iodine-containing vitamin/mineral preparations. None had undergone examinations with contrast media within 6 months prior to or during the study. Five were non-smokers and 11 present smokers (5–25 cigarettes/day). The characteristics of the individual participants are listed in Table 1.

The participants lived in Jutland, Denmark, where the iodine intake is moderately low (18). We made no restrictions to their daily or yearly routines and sampling procedures were designed to copy the procedures used in cross-sectional studies of urinary iodine excretion to describe the dispersion included in such studies. The study period of 1 year was chosen to include also seasonal differences in the estimate of iodine excretion. This estimate was based on measurement of creatinine concentration and the average 24 h urinary creatinine excretion in an age- and gender-matched group of Danes (1.52 g/24 h) (22) as suggested previously (23, 24).

Dispersion was evaluated by CV% and interquartile range. Pearson’s coefficient of correlation was used to evaluate relations between estimated 24 h iodine excretion and serum TSH after logarithmic transformation because the distributions were moderately positively skewed, and ANOVA for comparing monthly means. Mann–Whitney U test or paired t-test were used for comparison of groups and Kendall’s tau was used when testing for a trend in the association between estimated 24 h urinary iodine excretion and TSH. A P value of less than 0.05 was considered significant. All data were processed and analysed using Corel Quattro Pro 8 and the statistical package for the social sciences (SPSS), version 8.0.

Analytical techniques
Serum TSH was measured using immunochemiluminometric technique and a third generation assay (Brahms, Berlin, Germany). Serum total T3 and serum total T4 were measured by RIAs (Amerlex-M T3, RIA Kit and Amerlex-M T4 RIA Kit, Johnson & Johnson, Cardiff, UK) and T3 uptake for calculation of FTI using reagents from Farmos Diagnostica, Helsinki, Finland. Urinary creatinine was measured by a kinetic Jaffé method (19). Iodine was determined by the ceri/arsen method after alkaline ashing (20) as described previously (21) and urinary iodine excretion was expressed in μg/l or as an estimate of 24 h urinary iodine excretion. This estimate was based on measurement of creatinine concentration and the average 24 h urinary creatinine excretion for this association.

Table 1 Baseline characteristics of individual participants.

<table>
<thead>
<tr>
<th>Participant no.</th>
<th>Age (years)</th>
<th>BMI (kg/m²)</th>
<th>Smoking (cigarettes/day)</th>
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<td>35</td>
<td>27.8</td>
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<tr>
<td>2</td>
<td>28</td>
<td>21.5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>38</td>
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</tr>
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<td>4</td>
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</tr>
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<td>24.2</td>
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</tr>
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</table>

Results
The average annual urinary iodine concentration (mean of 12 monthly samples) in the 15 participants varied from 29 to 81 μg/l (mean 57.0 μg/l; median 50.0 μg/l). Iodine concentration in individual urine samples varied from 10 to 260 μg/l and the estimated 24 h urinary iodine excretions in individual samples varied from 18 to 142 μg/24 h. The 12 estimated 24 h urinary iodine excretions for each of the 15 participants are depicted in Fig. 1. They were, in general, low but with considerable individual differences in levels (from 28 to 81 μg/24 h) and variability (CV% from 20.1 to 70.5). The average estimated 24 h
The mean urinary iodine concentration was 2.4 times the average of 12 monthly samples. The variation around iodine excretion for the individual samples and for the iodine concentration and of estimated 24 h urinary iodine excretion was calculated from the measured urinary iodine and creatinine in spot urine samples. Correlations are Pearson's correlation coefficients on ln-transformed data.

Table 2 shows calculations of the spread of urinary iodine concentrations and estimated 24 h urinary iodine excretion in individual samples and in average annual values over 1 year. For comparison they are expressed as both CV% and interquartile range.

Table 2 Variation of urinary iodine concentrations and estimated 24 h urinary iodine excretions in individual samples and in average annual values over 1 year. For comparison they are expressed as both CV% and interquartile range.

<table>
<thead>
<tr>
<th>Sample Description</th>
<th>CV%</th>
<th>Interquartile range</th>
</tr>
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<tbody>
<tr>
<td>Average annual urinary iodine concentration (n = 15)</td>
<td>23.6%</td>
<td>11.7 µg/l</td>
</tr>
<tr>
<td>Urinary iodine concentration in individual samples (n = 180)</td>
<td>57.3%</td>
<td>32.0 µg/l</td>
</tr>
<tr>
<td>Average annual estimated 24 h urinary iodine excretion (n = 180)</td>
<td>27.0%</td>
<td>13.8 µg/24 h</td>
</tr>
<tr>
<td>Estimated 24 h urinary iodine excretion in individual samples (n = 180)</td>
<td>45.0%</td>
<td>23.7 µg/24 h</td>
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</table>

When comparing monthly means of urinary iodine excretion, serum TSH and thyroid hormones, no statistically significant differences were observed. Between seasons, however, minor differences were observed (ANOVA for iodine excretion, P = 0.077; for TSH and thyroid hormones, not significant). Estimated 24 h iodine excretion was higher in spring and summer than in autumn (23% and 18%) (t-test, P = 0.02 and 0.01) and winter (17% and 12%) (P = 0.08 and 0.03). Serum total T3 was 5% higher in autumn and winter than in summer; serum total T4 was 4% higher in
autumn and winter than in summer; serum free T₄ index showed the same pattern but differences were below 2%; serum TSH was 8% higher in autumn and winter than in spring and summer.

**Discussion**

The iodine intake of a population is usually evaluated by measuring urinary iodine excretion in a sample of the population. The most important value obtained is the median or mean urinary iodine concentration or 24 h urinary iodine excretion (5, 6). It has been suggested that not only mean urinary iodine concentration but also the fraction of samples below a certain value is important for evaluation of iodine intake in a population (7).

The results of the present study demonstrate that the distribution of iodine measured in single spot urine samples from a population is much broader than the distribution of average iodine excretion in urine in an individual over 1 year. This implies that a certain percent of individual values in the range of, for example, severe iodine deficiency does not necessarily indicate that a similar proportion of the population is severely iodine deficient. In this study 7% of individual samples were below 25 μg/l while none of the participants had such low iodine excretion when evaluated over 1 year. Under the circumstances of the present study the distribution of average annual values as estimated by CV% and interquartile range was only 40% of the distribution of single values. It cannot be excluded, however, that more heterogeneous populations than this may include subgroups with severe iodine deficiency even if the median population iodine excretion is normal. A way to identify subgroups at risk is by evaluation of dietary habits or by repeated measurements of urinary iodine in subjects with low values.

Estimated 24 h urinary iodine excretion has been preferred to crude urinary iodine excretion by some authors (23, 24) as this was more precise in determining the 24-h urinary iodine excretion. In the present study, the use of estimated 24-h iodine excretion reduced the dispersion of measures of iodine excretion by 24% compared with crude urinary iodine. Such a reduction is especially important when the group investigated is small.

Iodine deficiency is often graded into mild and moderate by urinary iodine excretion above or below 50 μg/24 h (5, 6). The results of this study imply that this is a reasonable level to use as a separator. The group of subjects investigated lived in an area with mild to moderate iodine deficiency and, by the definition indicated, seven subjects were mildly and eight were moderately iodine deficient. Participants with average annual urinary iodine excretions below 50 μg/24 h (moderately iodine deficient) had signs of variation in thyroid function dependent on availability of the substrate iodine, as a distinct negative correlation between urinary iodine and serum TSH was observed. Conversely, subjects with an annual urinary iodine excretion above 50 μg/24 h (mildly iodine deficient) had no correlation or a positive correlation between urinary iodine and TSH, suggesting no lack of substrate for thyroid hormone synthesis. Thus, the mechanism by which iodine influences thyroid function changes around 50 μg/24 h.
In conclusion, variations in average levels of iodine intake between individuals is much more narrow than indicated by variations between samples obtained in cross-sectional studies. This is important for risk estimation in evaluation of population iodine intake. The present study supports the use of estimated 24 h urinary iodine excretion rather than measurements of urinary iodine concentration as dispersion was reduced by 24%. Subjects with moderate iodine deficiency evaluated over 1 year showed signs of substrate availability by 24%. Subjects with moderate iodine deficiency had a reduced urinary iodine concentration as dispersion was reduced by 24%. Subjects with moderate iodine deficiency evaluated over 1 year showed signs of substrate availability by 24%.

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References

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