Diagnosis of subclinical central hypothyroidism in patients with hypothalamic–pituitary disease by Doppler echocardiography

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Abstract

Objective: The diagnosis of subclinical central hypothyroidism in hypothalamic–pituitary patients cannot be established by serum markers of thyroid hormone action. Myocardial function by echocardiography has been shown to reflect thyroid hormone action in primary thyroid dysfunction. We evaluated the performance of echocardiography in diagnosing subclinical central hypothyroidism.

Design: Cross-sectional and before and after.

Methods: Echocardiography and serum thyroid hormones were assessed in overt primary (n=20) and central (n=10) hypothyroidism, subclinical primary hypothyroidism (n=10), hypothalamic–pituitary disease with normal free thyroxine (FT4; n=25), and controls (n=28). Receiver operating characteristic (ROC) curves were generated using overt hypothyroidism patients and selected cut-off values were applied to detect both primary and central subclinical hypothyroidism. After levothyroxine (L-T4) intervention, patients were echocardiographically reevaluated at predefined targets: normal thyrotropin (TSH) in primary hypothyroidism, normal FT4 in overt central hypothyroidism, and higher than pretreatment FT4 in echo-defined subclinical central hypothyroidism.

Results: Parameters with highest areas under the ROC curves (area under the curve (AUC) ≥0.94) were as follows: isovolumic contraction time (ICT), ICT/ejection time (ET), and myocardial performance index. Highest diagnostic accuracy (93%) was obtained when at least one parameter was increased (positive and negative predictive values: 93%). Hypothyroidism was echocardiographically diagnosed in eight of ten patients with subclinical primary hypothyroidism and in 14 of 25 patients (56%) with hypothalamic–pituitary disease and normal serum FT4. Echocardiographic abnormalities improved significantly after L-T4 and correlated (0.05 < P < 0.001) with changes in FT4 (r=0.62) and TSH (r=0.63) in primary hypothyroidism and with FT4 in central hypothyroidism (r=0.72).

Conclusion: Echocardiography can be useful in diagnosing subclinical central hypothyroidism in patients with hypothalamic–pituitary disease.

European Journal of Endocrinology 166 631–640
Serum FT4 (ng/dl) 1.02
Diastolic BP (mmHg) 77
Isovolumic relaxation time (ms) 80
ET (ms) 298
ICT/ET ratio 0.13
ICT (ms) 39
Serum TSH (mU/l) 1.70
MPI 0.40
Systolic BP (mmHg) 118
Heart rate (bpm) 67
Female sex (no.) 16 16 5 8 13 0.13

Table 1 Baseline clinical and hormonal characteristics of controls and patients with overt primary hypothyroidism, overt central hypothyroidism, subclinical primary hypothyroidism, and hypothalamic–pituitary disease with normal FT4 levels. Plus–minus values are means ± s.d.

<table>
<thead>
<tr>
<th></th>
<th>Controls (n=28)</th>
<th>Overt primary hypothyroidism (n=20)</th>
<th>Overt central hypothyroidism (n=10)</th>
<th>Subclinical primary hypothyroidism (n=10)</th>
<th>Hypothalamic–pituitary normal FT4 (n=25)</th>
<th>P valuea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>35.8 ± 8.8</td>
<td>40.7 ± 13.8</td>
<td>31.0 ± 9.8</td>
<td>35.7 ± 8.8</td>
<td>33.0 ± 11.0</td>
<td>0.11</td>
</tr>
<tr>
<td>Female sex (no.)</td>
<td>16</td>
<td>16</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>0.13</td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td>67 ± 9</td>
<td>66 ± 11</td>
<td>62 ± 8</td>
<td>70 ± 13</td>
<td>65 ± 11</td>
<td>0.74</td>
</tr>
<tr>
<td>Systolic BP (mmHg)</td>
<td>118 ± 11</td>
<td>117 ± 12</td>
<td>121 ± 9</td>
<td>115 ± 8</td>
<td>117 ± 12</td>
<td>0.80</td>
</tr>
<tr>
<td>Diastolic BP (mmHg)</td>
<td>77 ± 10</td>
<td>78 ± 10</td>
<td>81 ± 9</td>
<td>75 ± 7</td>
<td>78 ± 9</td>
<td>0.67</td>
</tr>
<tr>
<td>Serum FT4 (ng/dl)</td>
<td>1.02 ± 0.15</td>
<td>0.29 ± 0.13c</td>
<td>0.45 ± 0.14c</td>
<td>0.94 ± 0.24</td>
<td>0.95 ± 0.14</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Serum TSH (mU/l)</td>
<td>1.70 ± 1.03</td>
<td>97.17 ± 53.75c</td>
<td>3.26 ± 3.35</td>
<td>14.28 ± 5.59c</td>
<td>0.99 ± 1.08</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

BP, blood pressure; FT4, free thyroxine; TSH, thyrotropin.
aP values are for the comparisons between all groups by ANOVA, except for sex distribution (χ² test).

Table 2 Baseline echocardiographic parameters in patients with overt primary hypothyroidism, overt central hypothyroidism, and controls. Plus–minus values are means ± s.d.

<table>
<thead>
<tr>
<th></th>
<th>Controls (n=28)</th>
<th>Overt primary hypothyroidism (n=20)</th>
<th>Overt central hypothyroidism (n=10)</th>
<th>P valuea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left ventricle ejection fraction</td>
<td>0.67 ± 0.04</td>
<td>0.63 ± 0.05b</td>
<td>0.61 ± 0.05b</td>
<td>0.003</td>
</tr>
<tr>
<td>MPI</td>
<td>0.40 ± 0.05</td>
<td>0.65 ± 0.15b</td>
<td>0.51 ± 0.10b</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>ICT (ms)</td>
<td>39 ± 10</td>
<td>74 ± 23b</td>
<td>75 ± 24b</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>ICT/ET ratio</td>
<td>0.13 ± 0.03</td>
<td>0.26 ± 0.11b</td>
<td>0.25 ± 0.08b</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>ET (ms)</td>
<td>298 ± 16</td>
<td>271 ± 24b</td>
<td>298 ± 25</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Isovolumic relaxation time (ms)</td>
<td>80 ± 13</td>
<td>99 ± 23b</td>
<td>77 ± 16</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

ICT, isovolumic contraction time; ICT/ET, ICT/ejection time; MPI, myocardial performance index.
aP values are for the comparisons between all groups by ANOVA.
bP value < 0.05 for comparisons between patients and controls (Dunnett’s multiple comparison test).

Materials and methods

Patients and controls

The study included 35 patients with hypothalamic–pituitary disease (ten macroprolactinomas, six craniopharyngiomas, six idiopathic hypopituitarism, five Sheehan’s syndrome, five nonfunctioning pituitary macroadenomas, one sarcoidosis, one Langerhans cell histiocytosis, and one brain traumatic injury), irrespective of previous surgery, radiotherapy, pharmacological treatment, or hormone replacement therapy (including T4), and 30 patients with primary hypothyroidism, diagnosed by high serum TSH, and normal serum FT4. Patients were carefully evaluated to exclude hypertension or coexisting primary cardiac disease which could interfere with the echocardiographic results; patients with acromegaly or Cushing’s disease were not included due to the frequent association with hypertension and/or cardiac hypertrophy.

Patients with hypothalamic–pituitary disease and low serum FT4 were classified as overt central hypothyroidism; patients with primary thyroid disease, high serum TSH, and low serum FT4 as overt primary hypothyroidism; and patients with primary thyroid disease, high TSH, and normal serum FT4 as subclinical primary hypothyroidism. Patients with hypothalamic–pituitary disease and normal serum FT4 were further classified as subclinical central hypothyroidism or euthyroidism according to echocardiography.

Twenty-eight healthy subjects were included as controls. Patients and controls were studied after informed consent and study approval by the Ethic Committee.

Study design

Baseline assessment Patients were submitted to physical exam and baseline hormonal and echocardiographic assessment. Fasting morning blood collection for hormone measurements and echocardiographic evaluation were performed on the same day.

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**T4 intervention** Patients with overt primary hypothyroidism, overt central hypothyroidism, subclinical primary hypothyroidism, and hypothalamic–pituitary disease with normal serum FT4 and echocardiographically defined hypothyroidism (subclinical central hypothyroidism) were started on levothyroxine (L-T4; 1.0–1.7 mg/kg of body weight per day) and/or increased by 25 mg every 4–6 weeks until reaching the following: normal serum TSH in overt and subclinical primary hypothyroidism; normal serum FT4 in overt central hypothyroidism (mid-range/high-normal); and a higher than baseline serum FT4 (mid-range/high-normal) in subclinical central hypothyroidism. Patients were monitored for signs and symptoms of thyrotoxicosis; patients with hypothalamic–pituitary disease were also monitored through serum triiodothyronine (T3) measurements. Echocardiography was repeated when hormonal targets were reached. Replacement of other hormone deficiencies was kept constant for at least 6 months before and during the study.

**Hormone assays**

Serum TSH was measured in duplicate by an in-house sensitive third-generation immunofluorometric assay (intra- and interassay coefficients of variation (CV), 4 and 6% respectively; sensitivity, 0.03 mU/l; and normal reference values: 0.4–5.0 mU/l). Serum FT4 was measured in duplicate by an immunofluorometric assay (Delfia; Wallac Oy, Turku, Finland; intra- and interassay CV, 4.4 and 6.1% respectively; sensitivity, 0.16 ng/dl; and normal reference values: 0.7–1.54 ng/dl). Serum T3 (total) was measured by an immunofluorometric assay (Delfia; Wallac Oy; intra- and interassay CV, 3.0%; sensitivity, 20 ng/dl; and normal reference values, 80–210 ng/dl).

**Echocardiographic assessment**

A complete two-dimensional Doppler echocardiographic examination was performed using an ATL-5000 ultrasound machine (Philips, Andover, MA, USA) with a 2.0–2.5 MHz transducer according to standard technique (12). Left ventricle ejection fraction was obtained by Teichholz method (18). Assessment of the myocardial performance index (MPI) (19), defined as the sum of isovolumic contraction time (ICT) and isovolumic relaxation time divided by left ventricle ejection time (ET), was carried out by sequential recording of the mitral inflow (from the apical four-chamber view with the pulsed wave Doppler sample volume positioned at the tips of the mitral leaflets during diastole) and of the left ventricle outflow tract (from the apical long axis view with the sample volume positioned just below the aortic valve). Measurements of Doppler tracings were performed with simultaneous electrocardiogram recording in five consecutive heart beats and expressed as the mean value as previously described.

![Figure 1 ROC curves and the corresponding AUC for (A) the isovolumic contraction time (ICT), (B) the ratio between ICT and ejection time, and (C) the myocardial performance index (MPI) as markers of hypothyroidism in patients with overt primary and central hypothyroidism. An AUC value of 0.5 is no better than expected by chance and a value of 1.0 indicates a perfect diagnostic marker. Arrows indicate the chosen diagnostic cut-off values.](https://www.eje-online.org)
(20). Measurements were made by a single observer (FCD) uninformed of patients’ data.

**Statistical analysis**

Comparisons between more than two groups were made by ANOVA, followed by paired or unpaired parametric or nonparametric post hoc tests. Correlations were calculated using Pearson’s (r) or Spearman’s (r_S) coefficients. Comparison between frequencies were calculated by χ² or Fisher’s exact test. Receiver operating characteristic (ROC) curves were generated using selected echocardiographic parameters from controls and patients with biochemical overt hypothyroidism according to currently accepted diagnostic gold standards: low serum FT4 with low, normal, or slightly increased TSH in patients with hypothalamic–pituitary disease for central hypothyroidism; and low serum FT4 with high TSH in patients with primary thyroid disease. Echocardiographic parameters from patients with subclinical primary hypothyroidism or hypothalamic–pituitary disease with normal serum FT4 were not used to generate the ROC curves and served as application groups. P values <0.05 were considered significant. Statistical analyses were performed using GraphPad Prism version 5.00 for Windows (GraphPad Software Inc., San Diego, CA, USA, www.graphpad.com). Data were expressed as mean ± S.D.

**Results**

No significant differences were found in age, sex distribution, heart rate, or blood pressure between patients with overt primary hypothyroidism, overt central hypothyroidism, subclinical primary hypothyroidism, hypothalamic–pituitary disease with normal serum FT4, and controls (Table 1).

**Baseline assessment in overt hypothyroidism**

As expected, serum FT4 was significantly lower in both overt primary and overt central hypothyroidism as compared with controls, and serum TSH was significantly higher in overt primary hypothyroidism but not in overt central hypothyroidism as compared with controls (Table 1).

As shown in Table 2, left ventricle ejection fraction, MPI, ICT, and ICT/ET ratio were significantly different from controls in both overt primary and overt central hypothyroidism. Left ventricle ET and isovolumic relaxation time were significantly different only in overt primary hypothyroidism. No significant differences in ventricular dimensions and left ventricle mass index were observed (data not shown). One patient with primary hypothyroidism presented mild pericardial effusion.

**ROC curves analysis of echocardiographic parameters in the diagnosis of hypothyroidism**

Figure 1 shows the echocardiographic parameters with the highest areas under the ROC curves. The chosen cut-off values for the diagnosis of hypothyroidism were the following: ICT > 53 ms (sensitivity, 83%; confidence interval (CI), 65–94%; specificity, 96%; CI, 82–100%); ICT/ET ratio > 0.18 (sensitivity, 83%; CI, 65–94%; specificity, 96%; CI, 82–100%); and MPI > 0.46 (sensitivity, 90%; CI, 74–98%; specificity, 93%; CI, 77–99%). For ICT and ICT/ET ratio, cut-off values showed identical accuracy, positive, and negative predictive values of 90, 96, and 84% respectively. For MPI, accuracy, positive, and negative predictive values were 91, 93, and 90% respectively. A highest diagnostic accuracy of 93% was obtained when at least one parameter was increased (positive and negative predictive values, 93%). Intra- and interobserver variability (percent of mean value) for MPI, ICT, and ICT/ET ratio were 2.7 ± 2.2, 5.9 ± 5.9, 4.1 ± 2.9, 6.3 ± 7. and 9.1 ± 5.6, 9.4 ± 4% respectively.

**Echocardiographic diagnosis of hypothyroidism in patients with normal serum FT4**

Serum FT4 levels in patients with subclinical primary hypothyroidism and in patients with hypothalamic–pituitary disease with normal FT4 were not significantly different from controls. As expected, serum TSH levels

<p>| Table 3 Baseline echocardiographic parameters in patients with subclinical primary hypothyroidism, hypothalamic–pituitary disease with normal serum FT4 and controls. Plus–minus values are means ± S.D. |
|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Controls (n=28)</th>
<th>Subclinical primary hypothyroidism (n=10)</th>
<th>Hypothalamic–pituitary normal FT4 (n=25)</th>
<th>P valuea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left ventricle ejection fraction</td>
<td>0.67±0.04</td>
<td>0.67±0.04</td>
<td>0.62±0.03b</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>MPI</td>
<td>0.40±0.05</td>
<td>0.48±0.09b</td>
<td>0.43±0.07</td>
<td>0.005</td>
</tr>
<tr>
<td>ICT (ms)</td>
<td>39±10</td>
<td>53±11b</td>
<td>55±17b</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ICT/ET ratio</td>
<td>0.13±0.03</td>
<td>0.19±0.04b</td>
<td>0.18±0.06b</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ET (ms)</td>
<td>298±16</td>
<td>288±27</td>
<td>302±16</td>
<td>0.12</td>
</tr>
<tr>
<td>Isovolumic relaxation time (ms)</td>
<td>80±13</td>
<td>84±16</td>
<td>78±16</td>
<td>0.50</td>
</tr>
</tbody>
</table>

FT4, free thyroxine; ICT, isovolumic contraction time; ICT/ET, ICT/ejection time; MPI, myocardial performance index.

aP values are for the comparisons between all groups by ANOVA.
bP value <0.05 for comparisons between patients and controls (Dunnett’s multiple comparison test).
were significantly higher in subclinical primary hypothyroidism, but not in hypothalamic–pituitary disease with normal FT₄, as compared with controls (Table 1). No significant differences in ventricular dimensions and left ventricle mass indexes were observed among these groups (data not shown).

**Subclinical primary hypothyroidism**

As shown in Table 3, all three diagnostic echocardiographic parameters were significantly increased in subclinical primary hypothyroidism. Eight of ten patients with subclinical primary hypothyroidism were also diagnosed as hypothyroid by echocardiography (Fig. 2).

**Hypothalamic–pituitary disease with normal serum FT₄**

As shown in Table 3, both ICT and ICT/ET ratio were significantly increased, and left ventricle ejection fraction was significantly decreased in hypothalamic–pituitary disease with normal serum FT₄.

Hypothyroidism was diagnosed by echocardiography in 14 of 25 patients (56%) with hypothalamic–pituitary disease and normal serum FT₄ (Fig. 2). These patients were younger than patients echocardiographically defined as euthyroid (28 ± 8 vs 40 ± 11 years, P = 0.004, t-test), but no significant differences were found in sex, heart rate, blood pressure, serum FT₄ and

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**Figure 2** Selected diagnostic echocardiographic parameters in patients with overt and subclinical primary hypothyroidism, overt central hypothyroidism, hypothalamic–pituitary disease with normal serum free thyroxine (FT₄), and controls. Each circle represents one patient. Dashed horizontal lines indicate the chosen cut-off values: 53 ms for the ICT, 0.18 for the ratio between ICT and ET, and 0.46 for the MPI. Patients with hypothalamic–pituitary disease and normal FT₄ that had at least one of the three parameters above the cut-off value were diagnosed as subclinical central hypothyroidism and are represented by solid circles.

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Table 4 Clinical and hormonal parameters in patients with or without echocardiographically defined subclinical central hypothyroidism. Plus–minus values are means ±s.d.

<table>
<thead>
<tr>
<th>Subclinical central hypothyroidism</th>
<th>Yes (n=14)</th>
<th>No (n=11)</th>
<th>P valuea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>28±8</td>
<td>40±11</td>
<td>0.004</td>
</tr>
<tr>
<td>Female sex (no.)</td>
<td>6</td>
<td>7</td>
<td>0.43</td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td>65±9</td>
<td>64±9</td>
<td>0.79</td>
</tr>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>118±14</td>
<td>117±11</td>
<td>0.85</td>
</tr>
<tr>
<td>Diastolic blood pressure (mmHg)</td>
<td>79±8</td>
<td>76±10</td>
<td>0.41</td>
</tr>
<tr>
<td>Serum FT4 (ng/dl)b</td>
<td>0.96±0.14</td>
<td>0.95±0.15</td>
<td>0.87</td>
</tr>
<tr>
<td>Serum T3 (ng/dl)c</td>
<td>114±25</td>
<td>105±9</td>
<td>0.27</td>
</tr>
<tr>
<td>Untreated GH deficiency (no.)</td>
<td>9</td>
<td>9</td>
<td>0.41</td>
</tr>
<tr>
<td>Hypogonadism (no.)</td>
<td>5</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Glucocorticoid deficiency (no.)</td>
<td>3</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

aP values for comparisons between groups by unpaired t-test (age, heart rate, blood pressure, serum FT4, and T3) or Fisher’s exact test (sex, untreated GH deficiency, hypogonadism, and glucocorticoid deficiency).
bTo convert serum FT4 from nanograms per deciliter to picomole per liter multiply by 12.87.
cTo convert serum T3 from nanograms per deciliter to nanomole per liter multiply by 0.0154.

T3, prevalence of untreated GH deficiency, or other pituitary hormone deficiencies (Table 4).

Baseline echocardiographic and hormonal correlations

In primary hypothyroidism, as expected, the highest correlation was found between serum TSH and serum FT4 (rS = −0.70, P < 0.001); serum TSH was also correlated with ICT (rS = 0.53, P = 0.003), ICT/ET ratio (rS = 0.54, P = 0.002), and MPI (rS = 0.55, P = 0.002). FT4 correlated with ICT (rS = −0.54, P = 0.002), ICT/ET ratio (rS = −0.55, P = 0.002), and MPI (rS = −0.62, P < 0.001).

In central hypothyroidism, diagnosed either biochemically or echocardiographically, the highest correlation was between serum FT4 and the MPI (r = −0.79, P < 0.001); serum FT4 also correlated with ICT (r = −0.52, P = 0.02) and ICT/ET ratio (r = −0.60, P = 0.006).

Changes after T4 intervention

Fifty-four patients met the criteria for T4 intervention; 43 completed the study (Fig. 3 and Table 5). Two thyroidectomized patients were not included because TSH levels were suppressed after l-T4 and four patients were not available on recall. Five patients were excluded due to poor compliance. No patient developed clinical signs and/or symptoms of excessive T4 replacement.

\( \text{\( \frac{T4}{T3} \)} \) significantly increased serum FT4 in all groups, but did not significantly change heart rate and blood pressure. Mean serum TSH decreased to the normal range in primary hypothyroidism and serum T3 increased within the normal range in all patients with hypothalamic–pituitary disease.

Overt hypothyroidism

After treatment, all diagnostic echocardiographic parameters decreased significantly in overt hypothyroidism. In overt primary hypothyroidism, these three
Diagnosis of subclinical central hypothyroidism

Table 5: Clinical, hormonal, and echocardiographic parameters before and after T_4 intervention in patients with overt primary hypothyroidism, overt central hypothyroidism, subclinical primary hypothyroidism, and echocardiographically defined subclinical central hypothyroidism. Plus–minus values are means ± s.d.

<table>
<thead>
<tr>
<th>T_4 intervention</th>
<th>Overt primary hypothyroidism (n=15)</th>
<th>Overt central hypothyroidism (n=9)</th>
<th>Subclinical primary hypothyroidism (n=9)</th>
<th>Subclinical central hypothyroidism (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
<td>Before</td>
<td>After</td>
</tr>
<tr>
<td>Heart rate (bpm)</td>
<td>67±11</td>
<td>69±11</td>
<td>62±8</td>
<td>68±9</td>
</tr>
<tr>
<td>Systolic BP (mmHg)</td>
<td>117±11</td>
<td>117±12</td>
<td>122±10</td>
<td>118±19</td>
</tr>
<tr>
<td>Diastolic BP (mmHg)</td>
<td>77±10</td>
<td>77±12</td>
<td>78±13</td>
<td>77±5</td>
</tr>
<tr>
<td>Serum FT_4 (ng/dl)a</td>
<td>0.29±0.12</td>
<td>1.14±0.18b</td>
<td>0.45±0.15</td>
<td>1.22±0.43b</td>
</tr>
<tr>
<td>Serum T_3 (ng/dl)</td>
<td>NA</td>
<td>NA</td>
<td>82±26</td>
<td>127±29b</td>
</tr>
<tr>
<td>Serum TSH (mU/l)</td>
<td>100.30±59.10</td>
<td>2.43±1.34b</td>
<td>NA</td>
<td>3.61±3.34 NA</td>
</tr>
<tr>
<td>Left ventricle ejection fraction</td>
<td>0.62±0.05</td>
<td>0.66±0.04b</td>
<td>0.61±0.05</td>
<td>0.63±0.04</td>
</tr>
<tr>
<td>MPI</td>
<td>0.67±0.05</td>
<td>0.44±0.10b</td>
<td>0.53±0.08</td>
<td>0.38±0.08b</td>
</tr>
<tr>
<td>ICT (ms)</td>
<td>76±21</td>
<td>45±23b</td>
<td>79±21</td>
<td>38±13b</td>
</tr>
<tr>
<td>ICT/ET ratio</td>
<td>0.30±0.12</td>
<td>0.16±0.10b</td>
<td>0.27±0.07</td>
<td>0.13±0.04b</td>
</tr>
<tr>
<td>ET (ms)</td>
<td>266±24</td>
<td>285±26b</td>
<td>296±26</td>
<td>293±20</td>
</tr>
<tr>
<td>Isovolumic relaxation time (ms)</td>
<td>99±23</td>
<td>81±20b</td>
<td>78±16</td>
<td>73±16</td>
</tr>
</tbody>
</table>

BP, blood pressure; FT_4, free thyroxine; T_3, triiodothyronine; TSH, thyrotropin; NA, not applicable; ICT, isovolumic contraction time; ICT/ET, ICT/ejection time; MPI, myocardial performance index.

To convert serum FT_4 from nanograms per deciliter to picomole per liter multiply by 12.87.

To convert serum T_3 from nanograms per deciliter to nanomole per liter multiply by 0.0154.

In central hypothyroidism, ΔFT_4 correlated (0.05 < P < 0.01) with ΔICT (r = -0.51), ΔICT/ET ratio (r = -0.50), and ΔMPI (r = -0.72).

As shown in Fig. 4, when all patients with both primary and central overt and subclinical hypothyroidism were analyzed together, ΔFT_4 correlated significantly with ΔICT (r = -0.54), ΔICT/ET ratio (r = -0.64), and ΔMPI (r = -0.70).

Subclinical hypothyroidism

T_4 intervention significantly decreased all diagnostic echocardiographic parameters in both subclinical primary and subclinical central hypothyroidism, and corrected 28 of 29 (97%) abnormal parameters in subclinical primary hypothyroidism, and 21 of 29 (72%) in subclinical central hypothyroidism. Low echocardiographic measurements (< mean − 2 s.d.) were observed in two of 18 patients.

Echocardiographic and hormonal correlations after T_4

Significant correlations were found between changes (Δ = posttreatment minus pretreatment values) in serum thyroid hormones and changes in diagnostic echocardiographic parameters in patients with primary and central hypothyroidism (overt and subclinical).

In primary hypothyroidism, ΔTSH correlated (0.01 < P < 0.001) with ΔFT_4 (r = -0.67), ΔICT (r = 0.63), ΔICT/ET ratio (r = 0.68), and ΔMPI (r = 0.66); ΔFT_4 correlated (0.01 < P < 0.001) with ΔICT (r = -0.60), ΔICT/ET ratio (r = -0.55), and ΔMPI (r = -0.62).

Discussion

In this study, we have shown that echocardiography is a simple and accurate method to detect tissue hypothyroidism, which was especially useful in diagnosing subclinical central hypothyroidism in patients with hypothalamic–pituitary disease and normal serum FT_4. As opposed to subclinical primary hypothyroidism, which is easily diagnosed by increased serum TSH with normal serum FT_4 levels, the diagnosis of subclinical central hypothyroidism has been elusive in clinical practice. Selected myocardial function parameters including the systolic time intervals—ICT and ICT/ET ratio—and the MPI, which are largely independent of heart rate (11, 21), have shown high diagnostic accuracy as demonstrated by ROC curve analysis using only patients with overt central and primary hypothyroidism and controls. When applied to patients with subclinical primary hypothyroidism, these markers were in diagnostic agreement with serum TSH levels in 80% of cases. In patients with hypothalamic–pituitary disease and normal serum FT_4 who were considered at risk for subclinical central hypothyroidism, these markers indicated tissue hypothyroidism in 56% of patients. The specificity of these measurements to detect...
tissue thyroid hormone deficiency was further supported by their reversal or improvement after T₄, without any clinical or biochemical sign of excessive T₄ replacement, in both biochemical and echocardiographically defined hypothyroidism.

The pathophysiology of disturbed myocardial performance in hypothyroidism, as reflected by alterations in several echocardiographic parameters, involves both direct and indirect effects of thyroid hormone in the heart. At the molecular level, these disturbances have been shown to result from both genomic and non-genomic effects of thyroid hormone in the cardiovascular system (6). Thyroid hormone regulates the expression of structural proteins, like α- and β-myosin heavy chains in cardiac myocytes, and of key regulatory proteins through binding of T₃ to nuclear receptors that activate or repress transcription of several specific genes. Intracellular calcium cycling via sarcoplasmic reticulum calcium-activated ATPase and its inhibitor, phospholamban, which are regulated by thyroid hormone in opposite ways, is thought to be largely responsible for enhanced contractile function and diastolic relaxation (22). These mechanisms underlie the reduced velocity of shortening and rate of tension development observed in papillary muscle from hypothyroid animals (23). Hypothyroidism, at any end-diastolic volume, blunts the development of myocardial force in early systole, which lengthens the time required for the intraventricular pressure to reach the arterial diastolic pressure and initiate the ejective phase.

Impaired development of myocardial force plays a major role in the abnormalities found in ICT and ICT/ET ratio, both in primary and central hypothyroidism, which improved after T₄ replacement in correlation with changes in serum thyroid hormone levels. In addition, left ventricle ejection fraction, a much less sensitive marker of tissue hypothyroidism, was significantly decreased in overt hypothyroidism and also improved after treatment. Although diastolic function, as reflected by the isovolumic relaxation time, was significantly impaired only in overt primary hypothyroidism, it was improved by T₄ replacement in both overt and subclinical primary hypothyroidism. MPI, an index that combines both systolic (ICT and ET) and diastolic (isovolumic relaxation time) time intervals, was also increased in hypothyroidism and improved in correlation with changes in serum thyroid hormones.

Although other pituitary hormone deficiencies like GH, glucocorticoid, and sex steroids were highly prevalent in our patients with hypothalamic–pituitary disease, they are unlikely to have had a major influence in the echocardiographic diagnosis of subclinical central hypothyroidism. First, these deficiencies, either treated or untreated, were equally distributed between patients with and without echocardiographically defined hypothyroidism. Second, similar abnormalities were also found in subclinical primary hypothyroidism with similar serum FT₄ levels, which also improved after

Figure 4 Correlations between changes (Δ = posttreatment minus pretreatment values) in serum FT₄ and each echocardiographic diagnostic parameter after levothyroxine in patients with primary (solid circles) and central (open circles) overt and subclinical hypothyroidism (n = 42). Slanting lines represent linear regression lines between parameters. FT₄, free thyroxine; ICT, isovolumic contraction time; ICT/ET, ICT/ejection time ratio; MPI, myocardial performance index.

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T₄ replacement. Third, these echocardiographic abnormalities in patients with hypothalamic–pituitary disease and low serum FT₄ were not more severe than in overt primary hypothyroidism.

A role for GH in heart morphology and function has been supported by clinical and experimental evidence (24, 25, 26, 27). Echocardiographic assessment of patients with GH deficiency has shown reduced cardiac mass, especially in childhood-onset deficiency, but the functional abnormalities have been reportedly subtle and best shown by radionuclide angiography (27). A meta-analysis of the echocardiographic effects of GH replacement in adults has shown improvement in left ventricle mass and stroke volume, but not in fractional shortening (28). However, none of these reports assessed the echocardiographic parameters selected in our study. Notwithstanding, the interaction between GH and thyroid hormones has relevant diagnostic and therapeutic implications in patients with hypothalamic–pituitary disease (29). Accordingly, GH replacement has been shown to decrease serum FT₄ and reverse T₃ and to increase serum T₃ by improving peripheral T₄ to T₃ conversion (30). In practice, the T₄-lowering effect of GH has been shown to unmask biochemical hypothyroidism in 36–47% of patients with hypothalamic–pituitary disease (31, 32). On the other hand, since untreated GH deficiency is a state of decreased T₃ generation and GH improves T₄ biological effects, thyroid status can be influenced by GH replacement or withdrawal. In fact, we have shown that biologically appropriate target levels of serum FT₄ during l-T₄ replacement should be higher in untreated GH deficiency (33).

The main limitation to the use of echocardiographic parameters in the diagnosis of hypothyroidism is the coexistence of cardiac disease. Accordingly, patients with positive clinical history of cardiac disease, hypertension, acromegaly, and Cushing’s disease were not included and those with structural echocardiographic abnormalities were excluded by our study protocol. Nevertheless, further studies are necessary to elucidate whether these exclusion criteria could be less stringent in order to include hypertensive, acromegalic, and Cushing’s disease patients with controlled hypertension who do not show any structural abnormalities in the echocardiographic evaluation. Another potential limitation is the use of drugs that could influence the diagnostic echocardiographic parameters via changes in circulating volume and/or peripheral vascular resistance, such as diuretics and some antihypertensive drugs, although their effects are reportedly small (34). Another potential, albeit limited influence is the age-related physiological impairment of myocardial relaxation that may increase MPI, but not ICT, especially after the sixth decade (35).

Patients with hypopituitarism have increased all-cause mortality with cardiovascular disease as the leading etiology (36). Analysis of mortality in hypopituitary cohorts has been challenging due to diversity of underlying etiologies, treatment modalities, hormone deficiencies, and hormone replacements (37). Subclinical primary hypothyroidism, on the other hand, has been associated with increased risk of coronary heart disease events and mortality (38). In this context, our results indicate that echocardiography should have a major role in assessing thyroid status in patients with hypothalamic–pituitary disease and normal serum FT₄ levels.

Declaration of interest

The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

Funding

The study was partially supported by the research grant of Centro de Estudos de Endocrinologia da Escola Paulista de Medicina (CENEPAM). The funding organization had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Acknowledgements

The authors are grateful for the support from Erika Barbosa Ribeiro on the patients’ selection work.

References

3 Shimon I, Cohen O, Lubetsky A & Ochovskaya D. Thyrotropin suppression by thyroid hormone replacement is correlated with thyroxine level normalization in central hypothyroidism. Thyroid 2002 12 823–827. (doi:10.1089/105072502760339406)
8 Taylor RR, Covell JW & Ross J Jr. Influence of the thyroid state on left ventricular tension-velocity relations in the intact, sedated dog. Journal of Clinical Investigation 1969 48 775–784. (doi:10.1172/JCI106015)
F C Doin and others

Journal of the American Society of Echocardiography: Guidelines and Standards Committee and the Chamber Quantification Writing Group, developed in conjunction with the European Association of Echocardiography, a branch of the European Society of Cardiology. American Journal of Echocardiography 2005 18 1440–1463. (doi:10.1016/j.echo.2005.10.005)


Received 20 October 2011 Revised version received 21 December 2011 Accepted 20 January 2012