TSH and free triiodothyronine concentrations are associated with weight loss in a lifestyle intervention and weight regain afterwards in obese children

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Abstract

Objective: The impact of thyroid hormones on weight loss in lifestyle interventions and on weight regain afterwards is unknown. Therefore, we studied the relationships between TSH, free triiodothyronine (fT3), free thyroxine (fT4), and weight status, as well as their changes during and after a lifestyle intervention in obese children.

Materials and methods: We evaluated the weight status as BMI–SDS in 477 obese children (mean age 10.6 ± 2.7 years, 46% male, mean BMI 28.1 ± 4.5 kg/m²) participating in a 1-year lifestyle intervention in a 2-year longitudinal study. Changes in BMI–SDS at 1 and 2 years were correlated with TSH, fT3, and fT4 concentrations at baseline and their changes during the intervention.

Results: A decrease in BMI–SDS during the intervention period (−0.32 ± 0.38; P < 0.001) was significantly positively associated with baseline TSH and fT3 in multiple linear regression analyses adjusted for age, sex, pubertal stage, and baseline BMI–SDS. An increase in BMI–SDS after the end of the intervention (0.05 ± 0.36; P = 0.011) was significantly related to the decreases in TSH and fT3 during the intervention in multiple linear regression analyses adjusted for change in BMI–SDS during the intervention. In contrast to children with weight maintenance, children with weight regain after the end of the intervention demonstrated a decrease in their TSH levels (−0.1 ± 1.6 vs +0.2 ± 1.6 mU/l; P = 0.031) and fT3 (−0.2 ± 1.1 vs +0.3 ± 1.6 pg/ml; P < 0.001) during the intervention.

Conclusions: The decreases in TSH and fT3 concentrations during the lifestyle intervention were associated with weight regain after the intervention. Future studies should confirm that the decreases in TSH and fT3 levels associated with weight loss are related to the change in metabolism such as resting energy expenditure.

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Introduction

A moderate elevation of TSH concentrations, which is associated with triiodothyronine (T3) values in or slightly above the upper normal range, is frequently found in obese humans (1, 2, 3, 4, 5, 6, 7, 8, 9). These changes are reversible in weight loss independent of whether weight loss is obtained through diet or bariatric surgery (2, 7, 8, 10, 11, 12). Furthermore, a positive correlation between weight gain during 5 years and a progressive increase in serum TSH has also been reported (13). These findings suggest that the increase in TSH and T3 concentrations in obese subjects seems to be a consequence rather than a cause of obesity (1, 8, 10).

The underlying mechanisms of the increases in TSH and free T3 (fT3) levels in obesity are largely unknown (1, 14). For example, a derangement in the hypothalamic–pituitary axis, an impaired feedback due to a lowered number of T3 receptors in the hypothalamus (thyroid hormone resistance), and a decrease in peripheral deiodinase activity have been postulated (2). Furthermore, non-synonymous mutations in the TSHR gene have been reported as a cause of increased TSH levels in obesity, but these mutations are rare (15). Additionally, seronegative autoimmune thyroiditis has been suggested since thyroid hypoechogenicity at ultrasound has been reported and antithyroid antibodies are frequently negative in obese children with elevated TSH and fT3 levels (2, 15, 16). However, cytological samples obtained in obese children with elevated TSH levels, hypoechogenicity in ultrasound, and negative for thyroid autoantibodies have been reported to be normal, and, thus, excluded an autoimmune disorder (16). A possible explanation for thyroid hypoechogenicity at ultrasound observed in obese children could be the existence of a low-grade inflammation, a known characteristic of obesity (2). However, the most favored hypothesis of increased TSH
levels in obesity is an increased leptin-mediated production of pro-TRH (1, 2).

It has been suggested that this moderate increase in TSH and consequently fT3 levels in obesity is an adaptation process to increase resting energy expenditure (REE) (1, 2). It is well known that basal metabolic rate, total energy expenditure, and sleeping energy expenditure are positively correlated with the serum total or fT3 concentrations, while the underlying pathways are not fully understood (1, 2, 8, 10, 12).

As a consequence of the increased REE, the availability of accumulated energy for conversion into fat is diminished. Since weight loss is associated with a decrease in thyroid hormones (1, 3, 4, 7, 8, 10), the resulting decrease in REE may contribute toward difficulties in maintaining weight loss.

To support the hypothesis that a decrease in TSH and T3 concentrations during a lifestyle intervention is associated with weight regain afterwards, we analyzed the impact of TSH and thyroid hormones and their changes during weight loss on the outcome of a lifestyle intervention in nearly 500 obese children. We hypothesize that increased basal TSH and T3 levels are associated with greater weight loss in a lifestyle intervention since REE is increased in these children. Furthermore, we hypothesize that a decrease in TSH and T3 concentrations during a lifestyle intervention is associated with difficulties in maintaining weight loss after the end of the intervention.

Materials and methods

The Local Ethics Committee of the University of Witten/Herdecke approved this prospective study. Informed consent was obtained from all subjects and their parents. This study is registered at ClinicalTrials.gov (NCT00435734).

We examined 477 obese children (mean age 10.6 ± 2.7 years, 46% male, mean BMI 28.1 ± 4.5 kg/m2) completing the lifestyle intervention ‘Obeldicks’. Children with endocrine or metabolic disorders including goiter and autoimmune thyroiditis were excluded from the study. Furthermore, we excluded children with TSH levels >10 mU/l. Smokers and children taking any medication including oral contraceptives were also excluded. Weight status was determined at baseline, at the end of the 1-year intervention, and 1 year later (= 2 years after baseline). TSH, T3, and thyroxine (T4) concentrations were examined at baseline and 1 year later (= end of the intervention). Our study protocol does not include a blood measurement at follow-up to avoid lost-to-follow-up rate after the end of the intervention.

Measurements

Weight status was determined as BMI. Height was measured to the nearest centimeter. Weight was measured in underwear to the nearest 0.1 kg using a calibrated balance scale. The degree of overweight was quantified using Cole’s least mean square method, which normalizes the BMI skewed distribution in childhood and expressed BMI as a BMI–SDS (17). Obesity was defined as BMI > 97th percentile according to the definition of the International Obesity Task Force (18) using population-specific reference data for German children (19).

Pubertal stage according to Marshall and Tanner was determined by well-trained physicians. Pubertal developmental stage was categorized into three groups based on breast and genital stages (prepubertal: boys with genital stage I, girls with breast stage I; early pubertal: boys with genital stages II and III, girls with breast stages II and III; late/postpubertal: boys with genital stage >III, girls with breast stage >III).

TSH, fT3, and free T4 (fT4) concentrations were determined in the fasting status. TSH, fT3, and fT4 were measured by high-specific, solid-phase technique chemiluminescence immunoassays (Immulite; DPC, Los Angeles, CA, USA). Intra- and interassay variations were <10%. The normal values range between 0.2 and 3.0 mU/l for TSH, between 3.0 and 5.4 pg/ml for fT3, and between 0.9 and 2.3 ng/dl for fT4.

In all children with TSH levels >3 mU/l, autoimmune thyroiditis was excluded by measuring antithyroidal peroxidase and thyroglobulin antibodies.

Intervention

The 1-year lifestyle intervention ‘Obeldicks’ has been described in detail elsewhere (20, 21). Briefly, this intervention is based on physical exercise, nutrition education, and behavior therapy including the individual psychological care of the child and its family. Exercise therapy consists of sports, instructions in physical exercise as part of all-day life, and in the reduction of the amount of time spent watching television. The nutritional course is based on the prevention concept of the ‘Optimized mixed diet’ which is both fat and sugar reduced containing 30% energy intake (E) of fat, 15 E% proteins, and 55 E% carbohydrates including 5 E% sugar.

Statistical analysis

Statistical analysis was performed using WinSTAT for Excel. All variables were normally distributed as tested by the Kolmogorov–Smirnov test. Correlations were calculated by Pearson’s correlation. Multiple linear regression analyses were calculated with a reduction in BMI–SDS during the intervention or with a change in BMI–SDS between the end of the intervention and 1 year later as dependent variables, and age, sex, pubertal stage, baseline BMI–SDS, and TSH, fT3, and fT4 respectively as independent variables. Sex was used as a classified variable. T-tests for paired observations were
used to compare the variables. The changes in TSH and thyroid hormones were analyzed separately for children with and without a reduction of >0.5 BMI–SDS in the lifestyle intervention since this amount of overweight reduction was associated with an improvement in cardiovascular risk factors (22, 23). Furthermore, children were divided into children with weight regain defined by an increase in BMI–SDS after the end of the intervention and children with weight maintenance defined by stable or decreasing BMI–SDS after the end of the intervention. Corrections for multiple testing were performed by Bonferroni’s adjustment. A P < 0.05 was considered as statistically significant. Data are presented as means and s.d.s.

Results

At baseline, 39% of the children demonstrated TSH levels above 3.0 mIU/l for TSH, 5.1% of the subjects showed fT3 concentrations > 5.4 pg/ml, while only 1.2% had fT4 levels > 2.3 ng/dl (see also Table 1). None of the children with TSH levels > 3 mU/l had fT3 or fT4 levels below the normal range. A total of 20 children (11%) with TSH levels > 3 mU/l had fT3 > 5.4 pg/ml and one child (0.5%) with TSH levels > 3 mU/l had fT4 levels > 2.3 ng/dl. A total of 20 children (83%) with fT3 > 5.4 pg/ml showed TSH levels > 3 mU/l and one child (17%) with fT4 levels > 2.3 ng/dl demonstrated TSH levels > 3 mU/l.

The changes in weight status during the 1-year intervention period and in the course of 1 year after the end of the intervention are demonstrated in Table 1. Children had a significant reduction in their BMI–SDS during the intervention, K0.5 in the intervention period (baseline BMI–SDS, 2.49 ± 0.40; change in BMI–SDS during the intervention, −0.15 ± 0.22) showed no significant changes in their TSH and thyroid hormone concentrations during the intervention period.

In the entire study population, TSH and thyroid hormones did not change significantly during the lifestyle intervention (see Table 1). The 119 children with a decrease in BMI–SDS > 0.5 in the intervention period (baseline BMI–SDS, 2.48 ± 0.39; change in BMI–SDS during the intervention, −0.78 ± 0.27) demonstrated a significant decrease in their TSH (−0.4 ± 1.7 mU/l; P = 0.014) and fT3 (−0.3 ± 1.4 pg/ml; P = 0.018) concentrations, while fT4 levels remained stable (P = 0.507). Children with a decrease in BMI–SDS < 0.5 in the intervention period (baseline BMI–SDS, 2.49 ± 0.40; change in BMI–SDS during the intervention, −0.05 ± 0.32) had no significant changes in their TSH and thyroid hormone concentrations during the intervention period.

The 119 children with a reduction in BMI–SDS > 0.5 in the intervention period demonstrated significantly higher TSH and fT3 concentrations at baseline when compared with the 358 children without a BMI–SDS reduction > 0.5, while fT4 levels did not differ significantly between these groups (see Fig. 1).

The changes in BMI–SDS in the intervention period were significantly associated with baseline TSH (r = 0.21; P < 0.001) and fT3 (r = 0.22; P < 0.001), but not with fT4 (r = 0.05; P = 0.151). The associations between TSH and thyroid hormones at baseline and changes in weight status during the intervention in multiple linear regression analyses adjusted for age, sex, pubertal status, and baseline BMI–SDS are presented in Table 2. Higher baseline TSH and fT3 concentrations were significantly related to a greater BMI–SDS reduction in the intervention period.

The changes in BMI–SDS during the intervention period were significantly related to the changes in TSH (r = 0.21; P < 0.001) and fT3 (r = 0.22; P < 0.001), but not to the changes in fT4 (P = 0.150).

Children with weight regain after the end of the intervention demonstrated a decrease in TSH and fT3 concentrations during the lifestyle intervention in contrast to children with weight maintenance after the end of the intervention, while fT4 levels did not differ significantly between these groups (see Fig. 2).

The changes in TSH and thyroid hormone concentrations during the intervention period were significantly negatively related to the changes in BMI–SDS

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Changes in weight status (as BMI–SDS) and TSH, fT3, and fT4 concentrations in 477 obese children participating in the 1-year lifestyle intervention ‘Obeldicks’ in the course of 2 years. Data are presented as mean and s.d. Values that are significant after multiple testing corrections are highlighted in bold.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI–SDS</td>
<td>Baseline  2019±0.40</td>
</tr>
<tr>
<td>TSH (mU/l)</td>
<td>3.0±1.4</td>
</tr>
<tr>
<td>fT3 (pg/ml)</td>
<td>4.2±0.8</td>
</tr>
<tr>
<td>fT4 (ng/dl)</td>
<td>1.2±0.3</td>
</tr>
</tbody>
</table>

ND, not determined; BL, baseline.
after the end of the intervention (TSH, \( r = -0.11 \); \( P = 0.010 \); \( r_T^3, r = -0.16; P < 0.001 \); \( r_T^4, r = -0.06; P = 0.101 \)). The associations between the changes in TSH and thyroid hormone levels in the intervention period and the changes in weight status after the end of the intervention in multiple linear regression analyses adjusted for age, sex, pubertal stage, and baseline BMI–SDS. Values that are significant after multiple testing corrections are highlighted in bold. Positive values of the effect size for the changes (\( \Delta \)) indicate a reduction in BMI–SDS.

Table 2  Associations between TSH, \( r_T^3 \), and \( r_T^4 \) levels at baseline and weight changes during a 1-year lifestyle intervention in the 477 obese children. The b-estimators were derived from linear regression models (adjustment for age (linear), sex, pubertal stage, and baseline BMI–SDS). Values that are significant after multiple testing corrections are highlighted in bold. Positive values of the effect size for the changes (\( \Delta \)) indicate a reduction in BMI–SDS.

<table>
<thead>
<tr>
<th>( \Delta )BMI–SDS b-estimator</th>
<th>TSH (mU/l)</th>
<th>( r_T^3 ) (pg/ml)</th>
<th>( r_T^4 ) (ng/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% CI</td>
<td>0.05</td>
<td>0.06</td>
<td>0.01</td>
</tr>
<tr>
<td>( P ) value</td>
<td>0.03</td>
<td>0.07</td>
<td>-0.09</td>
</tr>
<tr>
<td>( \Delta )</td>
<td>0.13</td>
<td>0.11</td>
<td>0.08</td>
</tr>
<tr>
<td>( 1.8 \times 10^{-5} )</td>
<td>0.02</td>
<td>0.06</td>
<td>0.795</td>
</tr>
</tbody>
</table>

For each thyroid hormone effect size (b-estimators), their 95% confidence interval (95% CI), the \( P \) values, and the \( r^2 \) are listed.
1 IU/l of serum TSH concentrations, within normal range limits, is accompanied by a reduction in energy expenditure of 75–150 kcal/day. This reduction corresponds to 8–17 g stored fat, equivalent to several kilograms over a period of years (32).

Since i) the decrease in BMI–SDS in the lifestyle intervention was associated with the decrease in TSH and fT₃ levels, and ii) fT₃ levels and the BMI–SDS reduction during the lifestyle intervention were a predictor of weight regain after the end of the intervention and of BMI–SDS increase after the end of the intervention, one might speculate whether weight regain after the lifestyle intervention is caused by greater weight loss and not by the decrease in TSH and fT₃ levels. However, even after adjustment for changes in BMI–SDS in the intervention period in multiple linear regression analyses, the decrease in TSH and fT₃ concentrations during the intervention was related to weight regain after the end of the intervention.

We need to keep in mind that the explained variances of BMI–SDS change during the intervention and of BMI–SDS increase after the end of the intervention by thyroid changes were only low to moderate in multiple linear regression analyses, suggesting that other factors such as eating and exercise behavior, social or genetic background might be more important for the outcome of a lifestyle intervention. However, the significant relationships between TSH and fT₃ concentrations and their changes and the changes in BMI–SDS during and after a lifestyle intervention are an important finding: no success in a lifestyle intervention and weight regain is not only caused by the behavior of obese children but also by their metabolism. Therefore, it is not adequate to blame unsuccessful participants of lifestyle interventions.

Interestingly, fT₄ levels or their changes were not related to the changes in BMI–SDS during or after the end of the intervention in contrast to fT₃ and TSH levels. Furthermore, fT₄ levels did not decrease in substantial weight loss in contrast to TSH and fT₃ levels. These findings suggest an increase in reverse T₃ (rT₃) in weight loss. It has been reported that fT₃ levels are increased in obesity also due to changes in the monodeiodination pathway (1). Approximately 80% of the circulating T₃ is derived by extrathyroidal mono-deiodination of T₄, whereas rT₃ is almost completely produced by extrathyroidal T₄ monodeiodination. In normal-weight humans, monodeiodination of T₄ produces approximately equal amounts of T₃ and rT₃. However, in obesity, production of rT₃ is decreased, while production of T₃ is increased (1).

Table 3 Associations between the changes in TSH, fT₃, and fT₄ concentrations during the intervention and weight regain after the end of the lifestyle intervention in the 477 obese children. The b-estimators were derived from linear regression models (adjustment for age (linear), sex, pubertal stage, and change in BMI–SDS during the intervention). Values that are significant after multiple testing corrections are highlighted in bold. Negative values of the effect size for the changes (Δ) indicate a weight regain (increase in BMI–SDS after the end of the intervention).

<table>
<thead>
<tr>
<th>ΔTSH (mU/l)</th>
<th>ΔfT₃ (pg/ml)</th>
<th>ΔfT₄ (ng/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ΔBMI–SDS b-estimator</td>
<td>-0.02</td>
<td>-0.04</td>
</tr>
<tr>
<td>95% CI</td>
<td>-0.03, -0.01</td>
<td>-0.06, -0.02</td>
</tr>
<tr>
<td>P value</td>
<td>0.009</td>
<td>0.003</td>
</tr>
<tr>
<td>ρ</td>
<td>0.04</td>
<td>0.05</td>
</tr>
</tbody>
</table>

For each thyroid hormone effect size (b-estimators), their 95% confidence interval (95% CI), the P values, and the ρ are listed.
Since other mechanisms than obesity per se are discussed to be the underlying mechanisms of the increase in TSH and thyroid hormone levels, we need to consider that the relationships between TSH, T₃, and weight change may represent an epiphenomenon caused by a third factor. For example, if inflammation is the driver of changes in TSH and thyroid hormone levels in obesity as discussed (2), then a change in weight status is likely to be associated with a change in the grade of inflammation and may explain the relationships between the change in weight status and TSH respective thyroid hormones.

The strengths of this study are the longitudinal design including not only the intervention period but also a follow-up period after the end of the intervention as well as the large study sample. However, this study has a few potential limitations. First, BMI percentiles were used to classify overweight. Although BMI is a good measure for overweight, one needs to be aware of its limitations as an indirect measurement of adiposity. Measurement of body composition would be ideal. However, the gold standards such as dual-energy X-ray absorptiometer or indirect calorimetry are very difficult to perform in a large collection of obese children. We evaluated changes in BMI in relation to TSH and thyroid hormones, whereas it might have been more appropriate to evaluate, or at least include, measurements of lean body mass. Lean body mass appears to be a major determinant of thyroxin requirement (33). Furthermore, we did not measure REE, which is very laborious in a large collection of children. Second, we did not perform ultrasound measurement to exclude seronegative autoimmune thyroiditis. However, a recent study has excluded autoimmune disorders by cytological samples obtained in obese children with elevated TSH levels and hypoechogenicity in ultrasound (16). Finally, we did not differentiate the effect of diet, increased physical exercise, and weight loss on TSH and thyroid hormones and weight regain due to our study protocol. In contrast to exercise-induced weight loss, diet-induced weight loss has been reported to be associated with changes in thyroid hormone production (34).

In summary, we found moderately increased TSH and T₃ concentrations in obese children, which normalized in substantial weight loss. Since both baseline TSH and T₃ levels as well as the decrease in these hormones during weight loss were associated with changes in BMI–SDS, we put forward the hypothesis that increased TSH and T₃ concentrations may represent an adaptation process of obesity, increasing the REE to reduce the availability of energy for conversion to fat. Future studies should confirm that the decrease in TSH and T₃ during a successful lifestyle intervention is associated with a decrease in REE, representing a negative predictive factor for weight maintenance after the lifestyle intervention.

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.

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Author contribution statement
T Reinehr developed the study design and wrote the first draft of the paper and performed the statistical analyses. N Lass and B Wolters performed the anthropometrical measurements. All authors discussed the findings.

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