Serum negative autoimmune thyroiditis displays a milder clinical picture compared with classic Hashimoto’s thyroiditis

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Abstract

Background: Despite high sensitivity of current assays for autoantibodies to thyroperoxidase (TPO) and to thyroglobulin (Tg), some hypothyroid patients still present with negative tests for circulating anti-thyroid Abs. These patients usually referred to as having seronegative autoimmune thyroiditis (seronegative CAT) have not been characterized, and definite proof that their clinical phenotype is similar to that of patients with classic chronic autoimmune thyroiditis (CAT) is lacking.

Objective: To compare the clinical phenotype of seronegative CAT (SN-CAT) and CAT as diagnosed according to a raised serum level of TSH with negative and positive tests for anti-thyroid Abs respectively.

Methods: A case–control retrospective study enrolling 55 patients with SN-CAT and 110 patients with CAT was performed. Serum free triiodothyronine (FT3), free thyroxine (FT4), TSH, Tg Abs, and TPO Abs were measured in all patients.

Results: Patients with SN-CAT displayed significantly lower mean levels of TSH (6.6 ± 3.4 vs 10.2 ± 9.8 μU/ml; P = 0.009), higher mean FT4 levels (1.1 ± 0.2 vs 0.9 ± 0.2 ng/dl; P = 0.0002), and similar FT3 levels when compared with CAT patients. Mean thyroid volume was significantly greater in patients with CAT when compared with SN-CAT patients (11.2 ± 6.5 vs 8.1 ± 3.7 ml; P = 0.001). Logistic regression demonstrated that FT4 (0.123 (0.019–0.775); P = 0.026) and thyroid volume (1.243 (1.108–1.394); P = 0.0002) were significantly and independently related to the diagnosis (CAT/SN-CAT). Patients with SN-CAT had a similar prevalence of thyroid nodules and female gender but a lower prevalence of overt hypothyroidism (5.4 vs 20.9%; P = 0.012) as opposed to patients with CAT.

Conclusions: These results suggest an autoimmune etiology of SN-CAT, which, however, seems to have a milder clinical course when compared with CAT.

Introduction

Chronic autoimmune thyroiditis (CAT) is the main cause of hypothyroidism in the general population (1). Autoantibodies to thyroperoxidase (TPO) and to thyroglobulin (Tg) are the circulating hallmark of this autoimmune thyroid disease (1, 2). Positive tests for TPO Abs are present in ~90% (TPO Abs) and 50% (Tg Abs) of hypothyroid patients with CAT (1, 3, 4). Their prevalence in the general population is highly variable, given the strong gender and age effect, but it may reach a rate of 12–15% in females in their third to fourth decade of life (5, 6). Early studies supported the hypothesis that TPO Abs would play a pathogenic role in the development of autoimmune thyroiditis (7). Indeed, they fix complement and, at least in vitro, can produce antibody-dependent cell cytotoxicity (8). However, the high prevalence of positive tests for TPO Abs in euthyroid subjects and the observation that neonates born to mothers with circulating TPO Abs have a normal thyroid gland (9) have made it clear that TPO Abs
Subjects and methods

Subjects

The study group encompassed 55 patients who received a diagnosis of SN-CAT in the Outpatient Clinic of the Unit of Internal Medicine and Endocrinology of the Fondazione S. Maugeri I.R.C.C.S. (Pavia, Italy) between 2008 and 2011. The diagnosis of SN-CAT was based on the following criteria: i) presence of subclinical and/or overt hypothyroidism, as assessed by a serum TSH level >4.0 mU/ml associated with either normal or low FT₄ levels respectively; ii) negative tests for circulating Tg Abs and TPO Abs on at least two consecutive measurements; and iii) a US scan of the thyroid showing a hypoechoic pattern of its parenchyma. The study group encompassed seven males and 48 females. Their median (and range) age was 47.7 (17–80) years.

The control group was composed of a double number of patients (110; 12 males and 98 females) who had received a diagnosis of CAT. Control patients with CAT were consecutively and retrospectively selected using a computerized database. Inclusion criteria were positive tests for either TG Abs, TPO Abs, or both, accompanied by clinically overt or subclinical hypothyroidism.

In all patients and controls, the diagnosis of subclinical hypothyroidism was confirmed on at least two separate TSH measurements at time intervals ranging from 2 to 6 months. Common exclusion criteria were: i) pregnancy at diagnosis and/or within 1 year from study entry; ii) a history of irradiation of the neck; iii) current and/or previous i-thyroxine (T₄) treatment; iv) treatment with corticosteroids, amiodarone, lithium, oral contraceptives, or other thyroid interfering drugs; v) inter-current chronic illnesses; vi) a previous diagnosis of thyroid disease, in particular Graves’ disease and subacute thyroiditis; and vii) presence of obesity (BMI level ≥ 30 kg/m²).

The family history, as well as the co-morbidity for other allergic or autoimmune (allergic rhinitis or asthma, thyroid diseases, type 1 diabetes mellitus, psoriasis, vitiligo, alopecia, celiac disease, Crohn’s disease, rheumatoid arthritis, atrophic gastritis, and lupus) and non-autoimmune (thyroid diseases) disorders, was recorded. The study was approved by the Local Ethics Committee.

Serum assays

Serum concentrations of free triiodothyronine (FT₃, normal range 1.5–4.1 pg/ml), free T₄ (FT₄, normal range 0.8–1.9 ng/dl), and TSH (normal range 0.4–4.0 mIU/l) were measured using immunochemiluminescent assays by an automated analyser (Immulete 2000, DPC Cirrus, Los Angeles, CA, USA) employing commercially available kits (all from Diagnostic Products Corporation, Los Angeles, CA, USA). The intra-assay coefficient of variation (CV) values for these hormones ranged from 4.3 to 8.4% for FT₃, from 5.2 to 7.5% for FT₄, and from 5.1 to 12.5% for TSH. Inter-assay CV values ranged from 5.4 to 10.0% for FT₃, from 7.7 to 9.0% for FT₄, and from 6.4 to 12.5% for TSH. The analytical sensitivities were 1.0 pg/ml for FT₃, 0.3 ng/dl for FT₄, and 0.004 mU/l for TSH (third-generation TSH assay). The serum
concentrations of Tg Abs (normal range <60 U/ml) and TPO Abs (normal range <60 U/ml) were measured using immunochemiluminescent assays employing commercially available kits (Brahms, Hennigsdorf, Germany). The sensitivity of the assay was 33 U/ml for TgAb and 50 U/ml for TPO Abs. The intra- and inter-assay CV values were 2.6 and 13% respectively for Tg Abs and 3.9 and 8% respectively for TPO Abs. Samples were assayed in duplicate. Quality control pools at low, normal, and high concentrations for all parameters were present in each assay.

Setting the reference limit for thyroid autoantibodies positivity

Considering that the manufacturer’s cutoff (<60 U/ml for both antibodies) might not be adequate, a control group of 55 age- and sex-matched subjects in whom thyroid disorders had been excluded by a complete thyroid work-up (history, physical examination, TSH, FT3, FT4, and thyroid US) was recruited. The results obtained when the whole study group (formed after exclusion of these six patients confirmed the Abs and TPO Abs respectively. Statistical analysis per-

Results

The clinical and anthropometric data of patients with SN-CAT and of those with classic CAT are shown in Table 1. The two groups had a similar M:F ratio (12:98 for CAT vs 7:48 for SN-CAT), age at first diagnosis (47.3 ± 14.7 vs 47.7 ± 16.6 years), height (161.0 ± 7.8 vs 161.2 ± 8.4 cm), weight (62.7 ± 10.8 vs 60.7 ± 10.4 kg), and BMI (24.1 ± 3.4 vs 23.2 ± 2.9 kg/m²). As also shown in Fig. 1, patients with SN-CAT displayed significantly lower levels of serum TSH (6.6 ± 3.4 vs 10.2 ± 9.8 μU/l; P = 0.009) and higher FT4 levels (1.1 ± 0.2 vs 0.9 ± 0.2 ng/dl; P = 0.0002) compared with those having CAT. The circulating concentrations of FT3 were similar in the two groups (3.2 ± 0.7 vs 3.4 ± 0.9 pg/ml). The prevalence of overt hypothyroidism was significantly (P = 0.012) higher in

Table 1 Anthropometric and clinical parameters in patients with CAT and SN-CAT. Data are shown as mean ± S.D. unless otherwise stated.

<table>
<thead>
<tr>
<th></th>
<th>CAT (Ab+)</th>
<th>SN-CAT (Ab−)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>110</td>
<td>55</td>
<td>0.730</td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td>12/98</td>
<td>7/48</td>
<td>0.869</td>
</tr>
<tr>
<td>Age at diagnosis (years)</td>
<td>47.3 ± 14.7</td>
<td>47.7 ± 16.6</td>
<td>0.261</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>62.7 ± 10.8</td>
<td>60.7 ± 10.4</td>
<td>0.875</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>161.0 ± 7.8</td>
<td>161.2 ± 8.4</td>
<td>0.101</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>24.1 ± 3.4</td>
<td>23.2 ± 2.9</td>
<td>0.097</td>
</tr>
<tr>
<td>FT3 (pg/ml)</td>
<td>3.2 ± 0.7</td>
<td>3.4 ± 0.9</td>
<td>0.009</td>
</tr>
<tr>
<td>FT4 (ng/dl)</td>
<td>0.9 ± 0.2</td>
<td>1.1 ± 0.2</td>
<td>0.0002</td>
</tr>
<tr>
<td>TSH (μU/ml)</td>
<td>10.2 ± 9.8</td>
<td>6.6 ± 3.4</td>
<td>0.0007</td>
</tr>
<tr>
<td>Thyroid volume (ml)</td>
<td>6.8 (4.2–58.0)</td>
<td>5.8 (4.1–27.0)</td>
<td>0.012</td>
</tr>
<tr>
<td>Overt/subclinical hypothyroidism</td>
<td>23/87 (20.9%)</td>
<td>3/52 (5.4%)</td>
<td>0.009</td>
</tr>
<tr>
<td>Thyroid volume (ml)</td>
<td>11.2 ± 6.5</td>
<td>8.1 ± 3.7</td>
<td>0.001</td>
</tr>
<tr>
<td>Thyroid volume (ml)</td>
<td>10 (3–62)</td>
<td>8 (2–20)</td>
<td>0.00003</td>
</tr>
<tr>
<td>Nodule (yes/no)</td>
<td>25/88 (22.7%)</td>
<td>14/41 (25.4%)</td>
<td>0.697</td>
</tr>
<tr>
<td>Goiter &gt; 20 ml</td>
<td>3 (2.7%)</td>
<td>0 (0%)</td>
<td>0.551</td>
</tr>
</tbody>
</table>

Bold characters indicate significant differences.
patients with CAT (23/110, 20.9%) as opposed to those with SN-CAT (3/55; 5.4%). Mean thyroid volume, as measured by US, was significantly greater in patients with CAT when compared with those having SN-CAT (11.2 ± 6.5 vs 8.1 ± 3.7 ml; \( P = 0.001 \)). Although the statistical significance was not reached, three patients with CAT and none with SN-CAT had goiter (diagnosed when the thyroid volume was >20 ml). A similar prevalence of thyroid nodules was found in patients with CAT (22.7%) when compared with those having SN-CAT (25.4%).

To test the independent effect of each variable, a logistic regression model was constructed with the diagnosis (CAT/SN-CAT) as a dependent variable and all factors showing significant differences in the univariate analysis (TSH, FT_4, and thyroid volume) entered as covariates. The results shown in Table 2 demonstrated that only FT_4 and thyroid volume were significantly and independently related to the diagnosis of CAT and SN-CAT.

A positive family history for thyroid diseases was present in 33.6% of patients with CAT and 43.6% of those with SN-CAT (\( P = 0.21 \)). However, patients with CAT displayed a significantly higher prevalence of positive family history for autoimmune diseases when compared with patients having SN-CAT (44.5 vs 25.4%; \( P = 0.017 \)).

The thyroid disease-free control group also served to assess whether patients with SN-CAT had a higher than normal frequency of autoimmune diseases (including autoimmune thyroid diseases) or non-autoimmune thyroid diseases in their family. A positive family history of autoimmune diseases was present in 14.5% of thyroid disease-free control subjects. The correspondent figure for a positive family history of non-autoimmune thyroid diseases was 10.9%. When these family histories were compared with those observed in SN-CAT patients, a strong significant difference (10.9 vs 43.6%; \( P = 0.00012 \)) emerged for a positive family history of non-autoimmune thyroid diseases. On the other hand, despite an ~1.5-fold increase, the rate of positive family history for autoimmune diseases in patients with SN-CAT did not reach significance compared with controls (25.4 vs 14.5%; \( P = 0.153 \)).

As a further step, co-morbidities were taken into account. Patients with SN-CAT showed a significantly lower rate of co-morbidities for non-thyroid autoimmune diseases compared with those having CAT (21.8 vs 44.5%; \( P = 0.004 \)).

Table 2 Results of logistic regression analysis using the diagnosis (SN-CAT and CAT) as a dichotomous dependent variable.

<table>
<thead>
<tr>
<th>Variable</th>
<th>P value</th>
<th>Exp(( \beta ))</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum FT_4 (ng/dl)</td>
<td>0.026</td>
<td>0.123</td>
<td>0.019</td>
</tr>
<tr>
<td>Serum TSH (mU/ml)</td>
<td>0.085</td>
<td>1.102</td>
<td>0.987</td>
</tr>
<tr>
<td>Thyroid volume (ml)</td>
<td>0.0002</td>
<td>1.243</td>
<td>1.108</td>
</tr>
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</table>

Covariates were chosen on the basis of \( P \) values (<0.05) as a result of the univariate analysis.
Discussion

The results of this study, which investigated the so far largest series of patients with SN-CAT, indicate significant differences in the clinical presentation of patients with SN-CAT compared with those having classic CAT.

First, a prevalence of female gender was observed both in patients with SN-CAT and in those with CAT. This is a strong argument pointing toward an autoimmune etiology of SN-CAT. Indeed, in conditions such as morbid obesity, in which the raised serum levels of TSH are not sustained by an autoimmune process, no gender effect is observed.

Secondly, the age at presentation was similar in patients with SN-CAT and those with CAT. This finding would contrast with the common belief that a hypoechoic pattern of the thyroid at US anticipates the appearance of circulating thyroid Abs (17, 18, 19, 20).

Thirdly, lower serum TSH levels and higher serum FT₄ levels are found in patients with SN-CAT when compared with patients having classic CAT, even if the results of the multivariate analysis clearly indicate that the effect should be mainly ascribed to FT₄. Although the cross-sectional design of this study does not allow drawing conclusions as to the natural history of SN-CAT, given that the age at diagnosis was similar in the two groups, it could be speculated that the course of SN-CAT is less aggressive than that of CAT. This hypothesis would be further supported by the significantly lower rate of overt hypothyroidism observed among patients with SN-CAT. The absence of goiter in patients with SN-CAT and the observation that their thyroid volume was smaller might suggest that the autoimmune inflammatory infiltrate is less severe. Indeed, in the classical description of autoimmune thyroiditis by Hashimoto (21), most patients had goiter.

Fourthly, patients with SN-CAT had the same prevalence of thyroid nodules when compared with patients having CAT. This observation implies that, compared with CAT, no nodule-dependent selection bias affected the recruitment patients with SN-CAT.

The last finding to be discussed is the lower prevalence of a positive family history for autoimmune diseases and associated autoimmune conditions in patients with SN-CAT as opposed to those with classic CAT. Given that autoimmune diseases result from the interplay between genetic and environmental factors, it could be speculated that patients developing SN-CAT would have a weaker genetic predisposition, while environmental factors play a more relevant role in their pathogenesis (22, 23). In this regard, it is also important to recall that two previously described cases of patients with SN-CAT were found to be associated with serum negative rheumatoid arthritis (14, 15). Thus, it could be speculated that patients with SN-CAT might be more prone to develop other serum negative autoimmune diseases, the diagnosis of which might be more cumbersome.

The retrospective design of this study does not allow grading the echogenicity of the thyroid parenchyma at US, and this can be viewed as a limitation of this study. Therefore, it is impossible to compare the degree of hypoechogeticity in patients with SN-CAT with those with CAT. Future specifically designed studies will be required to address this issue.

The design of this study does not allow drawing firm conclusions about the prevalence of SN-CAT, but the following consideration could be proposed. The prevalence of SN-CAT can so far be estimated indirectly at ~5% according to the rate of positive tests for thyroid Abs reported by previous clinical studies in patients with hypothyroidism (3, 4, 11). However, these early studies enrolling patients with raised serum levels of TSH did not take into account the presence of clinical conditions associated with an increase in circulating TSH levels recently proven not to be indicative of thyroid failure. In particular, morbid obesity has recently been identified to cause an increase in the serum levels of TSH often associated with the presence of a hypoechoic pattern of the thyroid at US, which do not imply that hypothyroidism is present (24, 25, 26, 27). Taking into account the above concepts, it would be reasonable to assume that the prevalence of SN-CAT might have been overestimated by earlier studies.

In conclusion, the results of the current study, performed in the largest series of patients with SN-CAT investigated so far, suggest an autoimmune etiology of the disease. Although SN-CAT displays similar clinical features when compared with CAT, serum negative patients appear to have a less aggressive disease.

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
This research did not receive any specific grant from any funding agency in the public, commercial or not-for-profit sector.
References


Received 18 February 2014
Revised version received 14 April 2014
Accepted 15 April 2014