Median-lower normal levels of serum thyroxine are associated with low triiodothyronine levels and body temperature in patients with central hypothyroidism

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Abstract

Objective: Although it has been recommended that serum free thyroxine (FT\(_4\)) levels should be targeted to middle-upper normal levels during levothyroxine (L-T\(_4\)) replacement therapy in patients with central hypothyroidism (CeH), the rationale has not been clarified.

Methods: A retrospective single-center study enrolled 116 patients with hypothyroidism (CeH, \(n=32\); total thyroidectomy (Tx), \(n=22\); primary hypothyroidism (PH), \(n=33\); and control benign thyroid nodule (C), \(n=29\)). The patients had received L-T\(_4\) therapy at the Kobe University Hospital between 2003 and 2013. They were stratified according to serum FT\(_4\) level (\(\geq 1.10\) or \(< 1.10\) ng/dl), and body temperature (BT), serum free triiodothyronine (FT\(_3\)) levels, FT\(_3\)/FT\(_4\) ratio, and lipid profiles were compared. The effect of GH replacement therapy on thyroid function was also analyzed.

Results: FT\(_3\) levels and FT\(_3\)/FT\(_4\) ratios were significantly lower in patients with CeH than in patients with PH (\(P<0.05\)) or C (\(P<0.05\)). In patients with FT\(_4\) < 1.10 ng/dl, BT was significantly lower in patients with CeH (\(P=0.002\)) and Tx (\(P=0.005\)) than in patients with PH, whereas no differences were found in patients with FT\(_4\) \(\geq 1.10\) ng/dl. In patients with CeH, FT\(_3\) levels were higher in those with GH replacement therapy (\(P=0.018\)).

Conclusion: In CeH, patients with median-lower normal levels of serum FT\(_4\) exhibited lower serum FT\(_3\) levels and lower BT. These results support the target levels of serum FT\(_4\) as middle-upper normal levels during L-T\(_4\) replacement therapy in patients with CeH.

Introduction

Central hypothyroidism (CeH) is caused by various hypothalamic–pituitary diseases and frequently combined with other deficiencies of pituitary hormones such as adrenocorticotropic hormone (ACTH), growth hormone (GH), and gonadotropins (Gn). The administration of levothyroxine (L-T\(_4\)) is standard therapy not only for patients with primary hypothyroidism (PH) but also for patients with CeH. However, despite L-T\(_4\) replacement therapy, it has been reported that some of the patients still complain of symptoms related with hypothyroidism and
impaired quality of life (QOL) (1, 2, 3). Generally, serum thyroid-stimulating hormone (TSH) level is used as a marker for dose adjustment of i-T4 replacement therapy (4, 5, 6). However, in patients with CeH, TSH secretion does not often accurately reflect the changes in serum free thyroxine (FT4) levels. In patients with CeH, it has been recommended that serum FT4 levels should be targeted within the middle to upper limit of the reference range during i-T4 replacement therapy (7, 8). However, little evidence supports the rationale for these target FT4 levels (9).

The replacement therapy of other pituitary hormones may affect the free triiodothyronine (FT3)/FT4 ratio in patients with CeH associated with hypopituitarism. GH replacement therapy promotes peripheral T4 to T3 conversion (10, 11), whereas high-dose glucocorticoid replacement therapy inhibits deiodinase activity (12, 13), indicating that the status of replacement therapy is also important in determining the FT3/FT4 ratio. Recently, it has been reported that serum FT3 levels to FT4 levels ratio (FT3/FT4 ratio) is lower in patients with CeH than in control subjects (C) (14). In addition, patients who underwent total thyroidectomy (Tx) exhibited relatively lower FT3 levels compared with FT4 levels (15, 16). These results suggest that T3 secretion from the thyroid gland plays an important role in the regulation of serum FT3 levels.

To clarify the optimal levels of serum FT4 during i-T4 replacement therapy in patients with CeH, we assessed serum FT3 levels and FT3/FT4 ratio, and the physiological effects of thyroid hormones such as BMI, heart rate (HR), body temperature (BT), and the parameters of lipid metabolism (17) and compared these with those in patients with Tx and PH.

**Subjects and methods**

**Subjects and design**

This was a retrospective observational single-center study involving 116 consecutive patients with hypothyroidism (36 men and 80 women; mean age, 56.1 ± 17.4 years) who had been treated with i-T4 replacement therapy at Kobe University Hospital between 2003 and 2013. These four groups were stratified (FT4 ≥ 1.10, or < 1.10 ng/dl) according to the median value (1.10 ng/dl) of the normal range of serum FT4 levels (0.70–1.48 ng/dl) (FT4 ≥ 1.10 ng/dl group: CeH, n = 12; Tx, n = 14; PH, n = 19; and C, n = 17; FT4 < 1.10 ng/dl group: CeH, n = 20; Tx, n = 8; PH, n = 14; and C, n = 12). The following parameters were compared between these groups; BMI, systolic blood pressure (sBP), diastolic blood pressure (dBP), HR, BT, serum FT3 level, FT3/FT4 ratio, and lipid profiles (total cholesterol (T-Chol), LDL cholesterol (LDL-C), HDL cholesterol (HDLC), and triglycerides (TG)). All BT measurements were performed at 10 am in the hospital during hospitalization by using an axillary digital thermometer in a single evaluation (Topnic ET-16, TOP Corporation, Tokyo, Japan). In the CeH group, patients who showed organic hypothalamic damage by tumor invasion or treatment including surgery and/or radiotherapy were excluded. In the Tx group, patients with TSH levels < 0.4 μiu/ml who had received suppression therapy were excluded as previously described (15). Control subjects were recruited from among patients with non-functioning benign thyroid nodules (< 20 mm diameter), whose TSH levels were within the reference range (0.35–4.94 μiu/ml). Most of the patients in the CeH group had panhypopituitarism as etiology, including GH deficiency (GHD) caused by various pituitary injuries, and some patients received GH replacement therapy. The status of pituitary function, the number of patients who had received pituitary hormone replacement therapy and etiology of CeH, including CeH subgroups, were summarized in Table 1. The hypothalamic–pituitary–thyroid axis, hypothalamic–pituitary–adrenal axis, and hypothalamic–pituitary–gonadal axis were evaluated as previously described (18). For the diagnosis of GHD, each patient was subjected to an insulin tolerance test or GH-releasing peptide 2 test. All of the patients in this study were studied after informed consent.

**Biochemical assays**

Serum FT4, FT3, and TSH levels were measured by using chemiluminescent immunoassay (ARCHITECT; CLIA, Abbott Japan). The reference ranges were 0.70–1.48 ng/dl for FT4, 1.71–3.71 pg/ml for FT3, and 0.35–4.94 μiu/ml for TSH. The intra- and inter-assay coefficients of variation (CV) were 2.79–4.23% and 2.78–4.11% for FT4, 2.29–2.49% and 2.81–4.20% for FT3, 1.52–2.65% and 4.16–4.71% for TSH respectively. Serum T-Chol, LDL-C, HDL-C, and TG levels were measured by using enzymes or the direct method (Kyowa Medex, Tokyo, Japan). The reference ranges were 146–219 mg/dl for T-Chol, 0–139.99 mg/dl for LDL-C, 40–60 mg/dl for HDL-C, and 28–149 mg/dl for TG. The intra- and inter-assay CV were 0.64–0.65 and 1.16–1.72% for T-Chol, 0.60–0.63 and 1.72–1.76% for LDL-C, 0.42–0.43 and 1.43–1.79% for HDL-C, 0.47–0.51 and 1.32–1.51% for TG respectively.
Statistical analysis

All data were expressed as mean ± S.D. values. Comparisons between the two groups were performed by using Student’s t-test. The \( \chi^2 \) test was used to analyze differences between categorical variables. A multiple linear regression analysis was used to evaluate the following independent variables associated with BT: serum FT4, FT3, and TSH levels, FT3/FT4 ratio, age, BMI, the dose of L-T4 replacement therapy, and the dose of L-T4 per kilogram of body weight. The stepwise method entered the predictors sequentially. The tested factors including serum FT4 and FT3 levels, and FT3/FT4 ratio were followed by a variance inflation factor analysis. Comparisons between more than two groups were performed by using the ANOVA, followed by Bonferroni’s multiple comparison test between each of the two groups. \( P \) values <0.05 were considered as statistically significant. Data were analyzed by using the SPSS Software package (Dr SPSS II for Windows, Nankodo Co., Ltd, Japan).

Results

Clinical characteristics, clinical parameters, and L-T4 doses

The clinical characteristics of the patients in the four groups are described in Table 2. No significant differences were found in age, sex distribution, blood pressure (BP), HR, and BT between the groups. BMI was higher in patients with CeH than in those with PH or C (CeH; 26.5 ± 7.6 vs PH; 23.0 ± 5.9 kg/m²; \( P = 0.045 \), CeH; 26.5 ± 7.6 vs C; 21.6 ± 3.9 kg/m²; \( P = 0.003 \)) respectively. Serum T-Chol, LDL-C, HDL-C, and TG levels were comparable between the groups (Table 2).

The dose of L-T4 replacement therapy was greater in patients with Tx than in those with CeH or PH (Tx; 108.0 ± 24.9 vs CeH; 68.9 ± 32.0 mg/day; \( P < 0.001 \), Tx; 108.0 ± 24.9 vs PH; 40.9 ± 43.7 mg/day; \( P < 0.001 \)). The dose in patients with CeH was greater than in those with PH (CeH; 68.9 ± 32.0 vs PH; 40.9 ± 43.7 mg/day; \( P < 0.001 \)). The dose of L-T4 per kilogram of body weight showed similar results (Tx; 1.9 ± 0.6 vs CeH; 1.1 ± 0.6 mg/day per kg; \( P < 0.001 \), Tx; 1.9 ± 0.6 vs PH; 0.7 ± 0.6 mg/day per kg; \( P < 0.001 \), CeH; 1.1 ± 0.6 mg/day per kg; \( P = 0.023 \); Table 2).

Serum FT3 levels and FT3/FT4 ratios

Serum FT4, FT3, and TSH levels, and FT3/FT4 ratios were compared between the four groups. Serum FT4 levels were comparable between patients with CeH, PH, and C (CeH; 1.04 ± 0.25 vs PH; 1.15 ± 0.20 ng/dl; \( P = 0.306 \), CeH; 1.04 ± 0.25 vs C; 1.13 ± 0.15 ng/dl; \( P = 0.612 \), PH; 1.15 ± 0.20 vs C; 1.13 ± 0.15 ng/dl; \( P = 1.000 \); Fig. 1A). In contrast, serum FT3 levels were lower in patients with CeH than in those with Tx, PH, or C (CeH; 2.08 ± 0.51 vs Tx; 2.55 ± 0.51 pg/ml; \( P = 0.007 \), vs PH; 2.78 ± 0.40 pg/ml; \( P < 0.001 \), vs C; 2.80 ± 0.43 pg/ml; \( P < 0.001 \); Fig. 1B). In addition, the mean FT3/FT4 ratios were significantly lower in patients

Association between serum thyroid hormone levels and clinical parameters

Next, we analyzed the association between serum thyroid hormone levels and clinical parameters such as HR and BT, which are regulated by thyroid hormone action. In the multiple linear regression analysis, no significant association was observed between the serum thyroid hormone levels and HR (data not shown). Serum FT₃ value was an independent factor associated with BT ($\beta = 1.051$, 95% CI 0.012 to 2.089, $P = 0.045$; Table 3). However, no significant association was observed between serum FT₄ levels and BT ($\beta = -2.027$, 95% CI $-4.146$ to 0.093, $P = 0.07$; Table 3).

Therefore, we stratified the subjects according to the median value of the normal range of serum FT₄ levels ($\geq 1.0$ or $<1.0$ mg/dl), and analyzed the association between serum thyroid hormone levels and BT. Clinical characteristics are summarized in Table 4. The dose of l-T₄ was greater in patients with Tx than in those with CeH or PH, both in the FT₄ $\geq 1.10$ and FT₄ < 1.10 ng/dl groups. Intriguingly, in the FT₄ < 1.10 ng/dl group, patients with CeH and Tx exhibited lower BT than those with PH (CeH; Table 4).

### Table 2  Comparison of clinical characteristics between four groups. Data are expressed as mean ± s.d.

<table>
<thead>
<tr>
<th></th>
<th>CeH</th>
<th>Tx</th>
<th>PH</th>
<th>C</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>54.5 ± 19.3</td>
<td>56.9 ± 15.3</td>
<td>53.9 ± 16.9</td>
<td>62.8 ± 13.9</td>
<td>0.09</td>
</tr>
<tr>
<td>Gender (male/female)</td>
<td>10/22</td>
<td>9/13</td>
<td>6/27</td>
<td>11/18</td>
<td>0.70</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>20.4 ± 2.0</td>
<td>23.8 ± 4.2</td>
<td>23.0 ± 5.9</td>
<td>23.0 ± 5.9</td>
<td>0.004</td>
</tr>
<tr>
<td>sBP (mmHg)</td>
<td>118.8 ± 20.4</td>
<td>127.7 ± 20.6</td>
<td>125.9 ± 19.2</td>
<td>125.7 ± 21.6</td>
<td>0.27</td>
</tr>
<tr>
<td>dBP (mmHg)</td>
<td>69.9 ± 13.2</td>
<td>72.1 ± 11.3</td>
<td>72.2 ± 9.6</td>
<td>66.8 ± 9.5</td>
<td>0.21</td>
</tr>
<tr>
<td>HR (bpm)</td>
<td>72.9 ± 13.0</td>
<td>71.2 ± 9.7</td>
<td>74.6 ± 11.8</td>
<td>73.9 ± 12.8</td>
<td>0.79</td>
</tr>
<tr>
<td>BT (°C)</td>
<td>36.0 ± 0.7</td>
<td>35.9 ± 0.7</td>
<td>36.3 ± 0.4</td>
<td>36.0 ± 0.8</td>
<td>0.22</td>
</tr>
<tr>
<td>T-Chol (mg/dl)</td>
<td>216.6 ± 53.2</td>
<td>226.3 ± 38.0</td>
<td>194.0 ± 49.4</td>
<td>194.9 ± 47.5</td>
<td>0.06</td>
</tr>
<tr>
<td>LDL-C (mg/dl)</td>
<td>127.6 ± 37.9</td>
<td>138.2 ± 26.1</td>
<td>112.4 ± 42.5</td>
<td>112.9 ± 39.6</td>
<td>0.14</td>
</tr>
<tr>
<td>HDL-C (mg/l)</td>
<td>58.0 ± 20.0</td>
<td>66.0 ± 13.5</td>
<td>62.0 ± 17.1</td>
<td>60.1 ± 24.7</td>
<td>0.64</td>
</tr>
<tr>
<td>TG (mg/dl)</td>
<td>140.0 ± 77.3</td>
<td>135.8 ± 72.6</td>
<td>130.1 ± 63.9</td>
<td>152.5 ± 113.0</td>
<td>0.49</td>
</tr>
<tr>
<td>l-T₄ dose (µg/day)</td>
<td>68.9 ± 20.0</td>
<td>108.0 ± 24.9</td>
<td>40.9 ± 43.7</td>
<td>–</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>l-T₄ dose (µg/day/kg) (per body weight)</td>
<td>1.1 ± 0.6</td>
<td>1.9 ± 0.6</td>
<td>0.7 ± 0.6</td>
<td>–</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*P < 0.05, †P < 0.01, ‡P < 0.001.

*P values are for the comparisons between all groups by ANOVA, followed by Bonferroni’s multiple comparison test between each of the two groups.

*With CeH than in those with PH, whereas no difference was found between patients with CeH and Tx (CeH; 2.10 ± 0.67 vs PH; 2.49 ± 0.52; $P = 0.045$, vs Tx; 2.12 ± 0.44; $P = 1.002$; Fig. 1C).

In patients with CeH and PH, the remaining function of TSH secretion from the pituitary, and the T₃ and/or T₄ secretion from the thyroid, which may affect the FT₃/FT₄ ratio, had to be considered. Therefore, the subjects were stratified according to l-T₄ dose per kilogram of body weight ($\geq 1.0$ or $<1.0$ µg/day per kg), and the serum thyroid hormone levels were compared between the groups. The serum FT₄ levels were comparable between patients with CeH and PH, whereas the serum FT₃ levels were lower in patients with CeH than in those with PH, both in the l-T₄ $\geq 1.0$ and l-T₄ < 1.0 µg/day per kg groups (data not shown).

### Figure 1

Serum FT₃ (A) and FT₄ (B) levels, FT₃/FT₄ ratios (C), and serum TSH levels (D) between four groups. Serum FT₄ levels were comparable between patients with CeH, PH, and C. Serum FT₃ levels were lower in patients with CeH than in those with Tx, PH, and C. FT₃/FT₄ ratios were lower in patients with CeH than in those with PH, whereas no difference was found between patients with CeH and Tx. Data are expressed as mean ± s.d. $P$ values are for the comparisons between all groups by ANOVA, followed by Bonferroni’s multiple comparison test between each of the two groups. *$P < 0.05$, **$P < 0.01$, ***$P < 0.001$, NS, not significant.
patients with CeH, whose serum FT4 levels were lower.

The activity of the thyroid hormone is not sufficient in

PH; 2.76

ficant differences were found in the FT4

G

36.3

0.5

C

p

G

0.5

35.9 ± 0.5 vs PH; 36.4 ± 0.3 °C; P = 0.002; Tx; 35.8 ± 0.4 vs

PH; 36.4 ± 0.3 °C; P = 0.005; Table 4), whereas no signifi-

G

C

0.35 pg/ml; 2.87

G

0.3

C

0.41;

G

0.47 pg/ml, Tx; 2.71

G

0.44 vs PH; 2.82

G

0.42 pg/ml; P = 0.018; Fig. 3 A). In contrast, no

significant difference in serum FT4 levels was found

between the groups (GH (−); 1.04 ± 0.26 vs GH (+); 1.13 ± 0.26 ng/dl; P = 0.150; Fig. 3B). Furthermore, the
dose of L-T4 tended to be higher in the GH (+) group

than in the GH (−) group (GH (−); 69.4 ± 26.5 vs GH (+); 80.9 ± 36.0 μg/day; P = 0.075; Fig. 3C).

We also analyzed the influence of obesity, menopause,

and other pituitary hormone deficiency on BT or serum

thyroid hormone levels in CeH. We stratified the CeH

subjects according to BMI (BMI ≥ 25 kg/m²: n = 15; BMI

< 25 kg/m²: n = 17), the presence or absence of menopause

(menopause (−): n = 14; menopause (+): n = 18), ACTH
deficiency (ACTH deficiency (−): n = 4; ACTH deficiency

(+): n = 28), and hypogonadism (hypogonadism (−):
n = 7; hypogonadism (+): n = 25), and compared the

following parameters between these groups: BT, serum

FT4 and FT3 levels, FT3/FT4 ratios, the dose of L-T4

replacement therapy, and the dose of L-T4 per kilogram

of body weight (Table 5). However, no significant
differences were observed between these groups.

Discussion

In this study, we demonstrated that patients with CeH,

who exhibited median-lower normal levels of serum FT4,

revealed low BT with relatively low serum FT3 levels.

Although serum FT4 levels have been recommended to
target within the middle to upper limit of the reference

range in patients with CeH, few evidences have been

shown to support the rationale of this target. Considering

that a low BT represents a state of hypothyroidism (17), the

relatively lower serum FT3 levels with decreased BT in the

present study suggest that median-lower normal levels of

serum FT4 are not sufficient to maintain normal thyroid

hormone action in patients with CeH. We also compared

serum FT3 levels or FT3/FT4 ratios in four different
etiologies of hypothyroidism including patients with

CeH, Tx, PH, and C simultaneously, and showed that

serum FT3 levels were lower in patients with CeH

compared with the other three groups.

Physiologically, serum T4 is secreted by the thyroid

gland (~100%), and serum T3 is derived from both the

thyroid gland (20%) and extra-thyroidal tissues, where T4

is converted to T3 (80%) (19). Meanwhile, owing to the

lack of TSH stimulation, T3 produced by the thyroid gland

will decrease in patients with CeH, resulting in lower

serum FT3 levels.

Several factors can affect serum FT3 and FT4 levels, and

the FT3/FT4 ratio in patients with CeH, including other

pituitary hormone deficiency, hormone replacement

therapy for central hypothyroidism

Table 3  Associations between BT and serum thyroid hormone levels by multiple linear regression analysis. Serum FT3 level was independently associated with BT. However, there was no significant association between serum FT4 level and BT.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>β (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FT4</td>
<td>−2.027 (−4.146 to 0.093)</td>
<td>0.07</td>
</tr>
<tr>
<td>FT3</td>
<td>1.051 (0.012 to 2.089)</td>
<td>0.045</td>
</tr>
<tr>
<td>FT3/FT4 ratio</td>
<td>−1.021 (−2.086 to 0.037)</td>
<td>0.06</td>
</tr>
<tr>
<td>TSH</td>
<td>0.004 (−0.034 to 0.047)</td>
<td>0.89</td>
</tr>
<tr>
<td>Age</td>
<td>−0.001 (−0.009 to 0.008)</td>
<td>0.77</td>
</tr>
<tr>
<td>BMI</td>
<td>0.019 (−0.009 to 0.049)</td>
<td>0.19</td>
</tr>
<tr>
<td>L-T4 dose</td>
<td>−0.004 (−0.013 to 0.008)</td>
<td>0.37</td>
</tr>
<tr>
<td>L-T4 dose (per body weight)</td>
<td>0.107 (−0.473 to 0.683)</td>
<td>0.74</td>
</tr>
</tbody>
</table>

CeH patients with GH replacement therapy

To clarify the effect of GH replacement therapy on the

pituitary–thyroid axis, serum FT4 and FT3 levels, and the
dose of L-T4 in CeH patients with GH replacement therapy

(GH (+)) or without (GH (−)) were compared. In the GH

(+) group, serum FT3 levels were significantly higher than

those in the GH (−) group (GH (−); 2.01 ± 0.53 vs GH (+);
2.48 ± 0.42 pg/ml; P = 0.018; Fig. 3 A). In contrast, no

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| Table 4 Clinical characteristics (subjects stratified by the median-normal value of serum FT₄). Data are expressed as mean ± s.d. |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                   | CeH             | Tx              | PH              | C               | P value a       |
| Age (y)           | 46.6 ± 16.9 b   | 55.9 ± 14.4 b   | 51.9 ± 18.9 b   | 65.7 ± 11.0 b   | 0.006           |
| Gender (male/female) | 39/19     | 19/9             | 9/12            | 8/12            | 0.81            |
| BMI (kg/m²)       | 25.8 ± 4.7 *   | 21.7 ± 2.7 *   | 22.1 ± 4.5 *   | 22.3 ± 3.0 *   | 0.01            |
| sBP (mmHg)        | 112.5 ± 16.9 G | 128.7 ± 24.1 G | 121.4 ± 19.9 G | 128.1 ± 21.5 G | 0.13            |
| dBP (mmHg)        | 69.9 ± 9.7 G   | 72.9 ± 12.9 G   | 69.9 ± 9.9 G   | 69.3 ± 8.8 G   | 0.78            |
| HR (bpm)          | 71.0 ± 15.8 G  | 68.4 ± 9.8 G   | 74.8 ± 10.4 G  | 74.2 ± 11.1 G  | 0.46            |
| BT (°C)           | 36.0 ± 0.7 G   | 36.0 ± 0.8 G   | 36.3 ± 0.5 G   | 36.0 ± 0.6 G   | 0.54            |
| T-Chol (mg/dl)    | 213.8 ± 73.9 G | 219.7 ± 29.9 G | 204.9 ± 55.1 G | 204.6 ± 51.7 G | 0.83            |
| LDL-C (mg/dl)     | 125.8 ± 30.8 G | 139.0 ± 26.1 G | 117.9 ± 46.7 G | 125.3 ± 41.5 G | 0.68            |
| HDL-C (mg/dl)     | 61.6 ± 24.7 G  | 66.8 ± 15.2 G  | 68.8 ± 19.5 G  | 62.3 ± 19.7 G  | 0.84            |
| TG (mg/dl)        | 138.9 ± 71.3 G | 126.1 ± 61.8 G | 124.6 ± 78.0 G | 156.1 ± 127.8 G | 0.78            |
| T₄ dose (µg/day)  | 79.8 ± 35.1 *  | 108.9 ± 30.4 * | 51.3 ± 46.2 * | -               | <0.001          |
| T₄ dose (µg/day per kg) (per body weight) | 1.2 ± 0.7 b | 2.1 ± 0.7 * | 0.9 ± 0.6 | - | <0.001 |

* P values are for the comparisons between all groups by ANOVA, except for sex distribution (χ² test), followed by Bonferroni’s multiple comparison test between each of the two groups. ** P < 0.05, †, ‡ P < 0.01, †, ‡ P < 0.001.

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**Figure 2**

Serum FT₄ levels (A and C) and FT₄/FT₃ ratios (B and D) between CeH, Tx, PH, and C. Patients with CeH and Tx exhibited lower FT₄ and FT₄/FT₃ ratios compared to those with PH and C, respectively. The FT₄ levels were higher in subjects with GH replacement therapy than those without it in our study. In addition, we should consider an influence of Gn on BT when serum FT₄ levels were below the median value of the group. However, we did not find any differences in BT or serum thyroid hormone levels between CeH patients with and those without menopause or hypogonadism. In particular, GH replacement therapy promotes peripheral inactivating hypothalamic AMPK (22) and reduces BT (23, 24) via inactivating hypothalamic AMPK (22). Furthermore, it is well known that high-dose glucocorticoid replacement therapy inhibits deiodinase activity (12, 13). However, there were few patients who had received such high-dose glucocorticoid treatment in our study and we did not find serum FT₄ levels were higher in subjects with GH replacement therapy than those without it in our study.

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**Clinical Study**

Y Hirata and others L-T₄ therapy for central hypothyroidism

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therapy and the degree of TSH deficiency. Other pituitary hormone deficiency and their replacement therapy have been shown to affect the T₄ to T₃ conversion (10, 11). Indeed, in patients with central hypothyroidism (CeH), FT₄ levels were higher in subjects with GH replacement therapy than those without it in our study. Cushing syndrome might decrease serum FT₄ levels by increasing ACTH (20, 21). However, we did not find any differences in serum thyroid hormone levels between CeH patients with and those without menopause or hypogonadism.
It is also well known that hypothalamic damage can contribute to BT via the autonomic nervous system. However, in our study, patients who might suffer with hypothalamic damage by tumor invasion or treatment including surgery and/or radiotherapy were excluded. Furthermore, it has been reported that obesity is associated with BT or serum thyroid hormone levels (23, 24).

Table 5  BT and thyroid parameters according to BMI, menopausal status, and other pituitary hormone deficiency in CeH. Data are expressed as mean±S.D.  *P values are for the comparisons between two groups by non-paired t-test. *P<0.05, NS, not significant.

<table>
<thead>
<tr>
<th></th>
<th>BMI</th>
<th>Menopause</th>
<th>ACTH deficiency</th>
<th>Hypogonadism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≥ 25</td>
<td>&lt;25</td>
<td>(–)</td>
<td>(+)</td>
</tr>
<tr>
<td>BT (°C)</td>
<td>36.1±0.8</td>
<td>36.0±0.6</td>
<td>0.62</td>
<td>36.2±0.5</td>
</tr>
<tr>
<td>FT4 (mg/dl)</td>
<td>1.09±0.25</td>
<td>0.98±0.25</td>
<td>0.21</td>
<td>1.12±0.23</td>
</tr>
<tr>
<td>FT3 (mg/dl)</td>
<td>2.25±0.53</td>
<td>1.94±0.47</td>
<td>0.09</td>
<td>2.30±0.51</td>
</tr>
<tr>
<td>FT3/FT4 ratio</td>
<td>2.19±0.80</td>
<td>2.04±0.56</td>
<td>0.55</td>
<td>2.16±0.77</td>
</tr>
<tr>
<td>l-T4 dose (µg/day)</td>
<td>78.3±26.5</td>
<td>61.8±35.8</td>
<td>0.14</td>
<td>78.6±37.8</td>
</tr>
<tr>
<td>l-T4 dose (µg/day per kg)</td>
<td>1.0±0.3</td>
<td>1.2±0.7</td>
<td>0.21</td>
<td>1.1±0.8</td>
</tr>
</tbody>
</table>
We analyzed the influence of obesity on BT or thyroid parameters in CeH but found no significant differences between CeH patients with and those without obesity.

Thyroid hormone is one of the key regulators of thermal homeostasis (25). T₃ induces uncoupling protein-1 (UCP-1) expression and mitochondrial biogenesis in human adipocytes, and the effects of T₃ on UCP-1 induction are dependent on the thyroid hormone receptor-β (26). BAT is specialized for energy expenditure through thermogenesis (27), mediated by UCP-1 expression (28). It is also known that the type 2 iodothyronine deiodinase (DIO2), an important enzyme to convert T₄ to T₃, is essential for adaptive thermogenesis in BAT (29). These findings along with our results indicate that BT might be reduced by relatively low serum FT₃ levels through low UCP-1 expression levels in BAT.

The effect of combined therapy with L-T₄ and liothyronine (l-T₃) has been investigated for patients with hypothyroidism, whose QOL has been impaired with l-T₄ monotherapy. Several studies have compared the effect of l-T₄/l-T₃ combined therapy and that of l-T₄ monotherapy in patients with hypothyroidism. Bunevicius et al. (30) reported that partial substitution of l-T₃ for l-T₄ might improve mood and neuropsychological function in patients with both PH and Tx, suggesting the significance of additional l-T₃ administration. However, l-T₄/l-T₃ combined therapy demonstrated no beneficial changes in body weight, lipid profiles, and symptoms of hypothyroidism compared with l-T₄ monotherapy in patients with hypothyroidism (31). Overall, l-T₄/l-T₃ combined therapy provided no advantage when compared with standard l-T₄ monotherapy in a meta-analysis of randomized controlled trials (32). However, because patients with CeH have not been included in these studies, l-T₄/l-T₃ combined therapy in patients with CeH is worth investigating.

To date, no consensus guidelines on the management of patients with CeH have been established. Several studies have been performed to investigate the optimal dose of l-T₄ in patients with CeH. It has been shown that l-T₄ dose based on body weight and aiming at serum FT₄ levels in the upper reference range is superior to aiming at the middle of normal FT₄ levels (2). In clinical practice, it has been recommended that serum FT₄ levels should be targeted within the middle to upper limit of the reference range in patients with CeH (7, 8, 9). However, there has been little evidence supporting the target levels in patients with CeH by using clinical markers of hypothyroidism, such as HR, BT, and lipid profiles during l-T₃ replacement therapy. Our results show that median-lower normal levels of serum FT₄ are associated with both low serum FT₃ levels and low BT, suggesting that these parameters could be clinically useful markers in patients with CeH, in addition to serum FT₄ levels. To confirm these findings, further investigations are required based on the other clinical markers such as basal metabolic rate measured by using an expiration gas analyzer or patient well-being assessed by using hypothyroid specific QOL questionnaires.

Our study has several limitations. First, the sample size, especially after stratification, was relatively small. Therefore, we could not exclude coincidental results. However, the association between low serum FT₃ levels and BT in patients with CeH strongly suggests a functional relevance. Second, various l-T₄ doses were used for replacement therapy, suggesting that patients with varied degrees of the remaining function of the pituitary’s TSH secretion and the thyroid’s T₃ or T₄ secretion were included, which might have affected the FT₃/FT₄ ratio. Third, although significant differences in serum FT₃ levels and FT₃/FT₄ ratios were observed in the patients with CeH and FT₄ < 1.10 ng/dl, a similar tendency was found in the patients with CeH and FT₄ ≥ 1.10 ng/dl, suggesting that the threshold may not be the median-normal value of serum FT₄. In this aspect, the optimal replacement dose should be considered based on individual conditions. Fourth, several other confounding factors, including DIO2 polymorphism, may influence BT or serum thyroid hormone levels (33). Finally, the selection bias in each group needs to be considered. In particular, higher serum TSH levels were observed in patients with Tx because of the exclusion of subjects with TSH levels < 0.4 μiU/ml, in whom TSH suppression therapy for thyroid cancer was performed.

In conclusion, patients with CeH who exhibited median-lower normal levels of serum FT₄ revealed low BT with relatively low serum FT₃ levels. GHD might have contributed to the serum FT₃ attenuation in these patients. These data support the previously recommended target levels of serum FT₄ at the middle to upper limit of the reference range in patients with CeH. It is not known whether the middle-upper normal levels of serum FT₄ would improve low BT and maintain well-being during l-T₄ replacement therapy in patients with CeH. Further large-scale, prospective, interventional studies are needed to determine the optimal replacement therapy in patients with CeH.

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

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Author contribution statement

Y Hirata drafted the manuscript, and assembled and analyzed the data. H Fukuoka and Y Takahashi were responsible for the conception and design of the study. The other coauthors contributed by collecting the data or caring for the patients. H Fukuoka was responsible for the critical revision of the manuscript for important intellectual content.

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