

# Interrelationships among Serum Thyroxine, Triiodothyronine, Reverse Triiodothyronine, and Thyroid-Stimulating Hormone in Iodine-Deficient Pregnant Women and Their Offspring: Effects of Iodine Supplementation

J. ENRIQUE SILVA\* AND SERGIO SILVA

Department of Endocrinology, Hospital del Salvador, University of Chile, East School of Medicine (J.E.S.), and the Department of Obstetrics and Gynecology, Hospital Sotero del Rio, National Health Service, Santiago, Chile

**ABSTRACT.** Adaptation to iodine deficiency (ID) requires changes in thyroid and pituitary function that have been well characterized in animals. The present studies were undertaken to analyze the relationships between serum thyroid hormones and TSH concentrations in iodine-deficient pregnant women as well as their newborns. The broad range of iodine intake of the population studied, from very low to adequate, allowed us to describe quantitatively the relationships among iodine intake, thyroid hormones, and TSH. The interpretation of the data was supported by the effects that iodine supplementation had on these various hormones and is consistent with animal observations. About 250 pregnant women from an iodine-deficient area were studied. Fifty percent had a urinary iodine excretion of 50  $\mu\text{g}$  I/g creatinine (cr) or less; 25% had 50–100  $\mu\text{g}$  I/g-cr, and about 20% had 100–200  $\mu\text{g}$  I/g cr. Baseline serum hormone concentrations on first examination (mean  $\pm$  SD) were:  $T_4$ ,  $8.0 \pm 0.7 \mu\text{g}/\text{dl}$ ;  $T_3$ ,  $179 \pm 45 \text{ ng}/\text{dl}$ ;  $rT_3$ ,  $25 \pm 9 \text{ ng}/\text{dl}$ , and TSH,  $2.9 \pm 1.7 \mu\text{U}/\text{ml}$ . All values were independent of the age of gestation between 10–40 weeks. Serum  $T_4$  and urinary I correlated linearly in a double reciprocal plot ( $r = 0.90$ ;  $P < 0.001$ ). Serum TSH correlated with the reciprocal of serum  $T_4$  ( $r = 0.76$ ;  $P < 0.005$ ). In 36 women, oral iodine supplementation (OIS; 300  $\mu\text{g}$  I/day for 4–16 weeks) increased total serum  $T_4$  from  $8.7 \pm 2.4$  to  $12.5 \pm 1.8 \mu\text{g}/\text{dl}$  ( $P < 0.001$ ), decreased TSH from  $2.8 \pm 1.4$  to  $1.5 \pm 0.8 \mu\text{U}/\text{ml}$  ( $P < 0.001$ ), and increased  $rT_3$  from  $21 \pm 7$  to  $25 \pm 9 \text{ ng}/\text{dl}$  ( $P < 0.02$ ;

all by paired  $t$  tests); serum  $T_3$  remained unchanged ( $187 \pm 25$  and  $180 \pm 46 \text{ ng}/\text{dl}$ ), as did  $T_4$  and  $T_3$  free fractions. The free  $T_4$  concentration, which was lower than that in nonpregnant adults before treatment ( $1.63 \pm 0.4$  vs.  $2.30 \pm 0.4 \text{ ng}/\text{dl}$ ;  $P < 0.001$ ), increased to  $2.3 \pm 0.4$  with OIS ( $P < 0.001$ ). No change in any of these variables was observed in 10 untreated controls followed for similar lengths of time. Cord serum  $T_4$  and  $rT_3$  were higher in the offspring of OIS mothers ( $11.3 \pm 1.5 \mu\text{g}/\text{dl}$  and  $226 \pm 55 \text{ ng}/\text{dl}$ ) than in those of untreated mothers ( $9.3 \pm 1.7 \mu\text{g}/\text{dl}$  and  $183 \pm 37 \text{ ng}/\text{dl}$ ;  $P < 0.001$  and  $P < 0.005$ , respectively). Newborn serum  $T_4$  correlated with the mothers' value ( $P < 0.001$ ) but was found to be less affected by iodine intake than the mothers' results.

We conclude that: 1) the decrease in TSH observed with OIS was due to the increase in serum  $T_4$ , since serum  $T_3$  was unchanged, this stressing the critical role of the reduced serum  $T_4$  in the adaptation to ID; 2) the small difference in serum TSH was physiologically significant, since this was associated with a compensatory increase in thyroïdal  $T_3$  secretion during ID; 3) the larger increase in serum  $T_4$  induced by OIS in maternal as opposed to corresponding cord sera suggests that the fetus is relatively protected against ID; and 4) these findings are in agreement with previous animal studies, suggesting applicability of the latter to human thyroid physiology (*J Clin Endocrinol Metab* 52: 671, 1981)

**I**ODINE deficiency (ID) is known to cause alterations in plasma thyroid hormone levels. Characteristically, plasma  $T_4$  is low,  $T_3$  is normal, and TSH is elevated (1–4). Iodine-deficient animals show no evidence of hypothyroidism (3, 4), probably a reflection of the normal serum  $T_3$  concentration (1, 2). The latter seems to be the result

of increased thyroïdal  $T_3$  secretion that compensates for the decreased extrathyroïdal production consequent to the diminished availability of  $T_4$  (3, 5). The elevated TSH and the low degree of iodination of the thyroglobulin account for this quantitative change in the source of plasma  $T_3$  (6). Furthermore, the reduced level of  $T_4$  seems to be responsible for the elevated serum TSH concentration (4, 7). There is evidence that this adaptive mechanism may be operative in humans as well, since, except for extremely deficient areas, subnormal serum  $T_3$  concentrations are seldom seen in areas affected by endemic goiter (8–13).

Iodine requirements are expected to increase during

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Address requests for reprints to: Dr. J. E. Silva, Thyroid Diagnostic Center, Brigham and Women's Hospital, 75 Francis Street, Boston, Massachusetts 02115.

\* Associate Investigator, Howard Hughes Medical Institute Laboratory, Brigham and Women's Hospital, and Harvard Medical School, Boston, MA.

pregnancy, since the fetal iodine pool is being formed and the renal clearance of iodide is elevated (14). It is thus possible that the above-described compensatory mechanism could be overcome, the mother, the fetus, or both could be affected by the lack of  $T_3$  in the tissues. Although there are many reports on the levels of  $T_4$  and TSH in mothers and newborns of endemic goiter areas, there are only three in which  $T_3$  has been measured (15–17). In one of these studies, serum  $T_3$  concentrations were found to be low in some women (16), but in the other studies this was not observed (15, 17). The difference might be due to the extremely low iodine intake and the presence of goitrogens in the Ubangi, Zaire subjects (16).

It was of interest to us to see whether moderate or mild iodine deficiency, such as that prevalent in Chile, has a detectable influence on serum thyroid hormone and TSH concentrations. We were particularly interested in the role of serum  $T_4$  in TSH regulation and that of the slightly elevated serum TSH in increasing thyroidal  $T_3$  secretion. The rather wide range of iodine intake in Chile would allow a quantitative analysis of the relationships among these various hormones which could be complemented by evaluating the effects of iodine supplementation in some of these subjects.

## Methods

### Subjects

Blood samples were obtained at different gestational ages in 250 pregnant women in prenatal out-patient clinics in eastern greater Santiago. These women came from various suburban and rural areas so that there were some differences in iodine intake due to factors such as iodine content in the water, sea food consumption, and access to iodized salt.<sup>1</sup>

After obtaining blood and urine samples, the subjects were given 10 drops daily of a 785  $\mu\text{g}/\text{ml}$  potassium iodide (KI) solution so as to provide approximately 300  $\mu\text{g}$  I/day. One of every four women was not treated, forming a control group. Blood samples and urine were obtained at subsequent visits and at delivery when a cord blood sample was also collected. The shortest time interval between samples during iodide supplementation was 4 weeks and the longest was 16 weeks (Table 1). In only 36 of the 160 mothers given iodide was the protocol completed successfully and adherence to the regimen validated by urinary iodine excretion. A similar proportion of controls was lost.

Serum samples were frozen until the assays were performed.  $T_3$ ,  $T_4$ , and  $rT_3$  were measured by RIA using specific antibodies and dextran-coated charcoal to separate bound and free fractions (18, 19).  $T_3$  and  $T_4$  antibodies were kindly provided by P. R. Larsen (Boston, MA). The anti- $rT_3$  antibody was raised in

<sup>1</sup> Not all of the salt is iodized in Chile. Fifty salt samples from southern and eastern Santiago ranged from 0–135  $\mu\text{g}/\text{g}$  salt; more than 50% were below 10, and only 12% of the samples were between 60–135 (Silva, J. E., and P. Michaud, unpublished observations).

our laboratory and had less than 1:8000 cross-reactivity with  $T_4$ . The normal  $rT_3$  serum concentration in nonpregnant adults is  $13 \pm 4$  ng/dl, a figure somewhat lower than that usually reported. The within-assay variation was less than 10% for all three iodothyronine RIAs, and the interassay variation was 15%. All samples from an individual mother and her infant were analyzed simultaneously. Free  $T_4$  and free  $T_3$  concentrations were estimated from total plasma hormone and the dialyzable fraction as measured by equilibrium dialysis (20). TSH was quantitated by RIA using standard and antibodies generously provided by the National Pituitary Agency. Iodine was measured in the urine by the sodium arsenite-ceric acid method in a Technicon Autoanalyzer (Technicon Instrument Co., San Francisco, CA). Total creatinine (cr) was determined in the urine by conventional methods (21).

Statistical analysis was done by paired or unpaired Student's *t* test as appropriate. Correlation analyses were done on a Hewlett-Packard calculator (model 9815A, Hewlett-Packard Co., Palo Alto, CA). Linear transformations were performed to fit the data to nonlinear functions when appropriate. Our working hypotheses were: 1) that the iodine intake was the independent variable influencing the secretion of  $T_4$  and, therefore, serum  $T_4$  (3, 4), and 2) that the low level of the latter was a very important, if not the most important, signal to increase TSH secretion in these women. Therefore, in fitting the data to a given general equation, urinary iodine or serum  $T_4$  was taken as the independent variable *x*, and the values were arbitrarily divided into small intervals. The variable *y* was then averaged for each *x* interval (22). Provided the scatter of *y* around the line was reasonably uniform, the points were fitted to the model that gave the highest coefficient of correlation. This approach makes weighting of the points unnecessary (22). The variation of *y* is not equally dependent on the variation of *x* in the whole range of *x*, but there is no way to determine when other factors different from the change in *x* begin to significantly influence the variation of *y*. These other factors might have been overestimated by weighting the data by the number of observations at each *x* interval.

## Results

The distribution of iodine excretion in the population examined is shown in Fig. 1. As expected, it varied widely. Since total cr in the 24-h urine in this population ranges between 0.8–1.2 g/day, the I to cr ratios are a good approximation of daily intake. Fifty percent of the analyzed population had 50  $\mu\text{g}$  I/g cr or less, indicating a significant degree of ID. About 25% excreted between 50–100  $\mu\text{g}$  I/day, which can be considered a moderate deficiency, and only 15% had an adequate iodine intake (23).

The serum iodothyronine and TSH concentrations are presented in Fig. 2. It is apparent that none of the variables measured between 10–40 weeks was influenced by the duration of pregnancy.

For the analysis of the influence of iodine intake on plasma levels of  $T_4$ ,  $T_3$ , and TSH, urinary iodine was

TABLE 1. Effect of iodine supplementation on serum thyroid hormones and TSH concentrations during pregnancy (mean  $\pm$  SD)

	Urinary iodide ( $\mu\text{g/g cr}$ ) <sup>a</sup>	T <sub>4</sub> ( $\mu\text{g/dl}$ )	T <sub>3</sub> (ng/dl)	rT <sub>3</sub> (ng/dl)	TSH ( $\mu\text{U/ml}$ )	Time since conception (weeks)	Observation time interval (weeks)
Treated mothers (n = 36)							
Basal	53 $\pm$ 33	8.7 $\pm$ 2.4	187 $\pm$ 25	21 $\pm$ 7	2.8 $\pm$ 1.4	9-32	
KI <sup>b</sup>	376 $\pm$ 456	12.5 $\pm$ 1.8	180 $\pm$ 46	25 $\pm$ 9	1.5 $\pm$ 0.8	15-40	4-16
Change	+323 $\pm$ 450	+3.8 $\pm$ 2.2	-7 $\pm$ 46	+4 $\pm$ 10	-1.3 $\pm$ 1.5		
P <sup>c</sup>	<0.001	<0.001	NS	<0.02	<0.001		
Untreated controls (n = 10)							
Basal	54 $\pm$ 36	9.4 $\pm$ 2.2	179 $\pm$ 33	22 $\pm$ 7	3.0 $\pm$ 2.1	11-30	
End observation	56 $\pm$ 25	9.3 $\pm$ 2.6	165 $\pm$ 36	24 $\pm$ 8	2.6 $\pm$ 1.6	21-40	4-16
Change	+2 $\pm$ 18	-0.1 $\pm$ 2.8	-14 $\pm$ 43	+2 $\pm$ 9	-0.4 $\pm$ 0.25		
P <sup>c</sup>	NS	NS	NS	NS	NS		

<sup>a</sup> Micrograms of iodine per g urinary cr.

<sup>b</sup> Potassium iodide ( $\sim 300 \mu\text{g I/day}$ ).

<sup>c</sup> By paired *t* test.

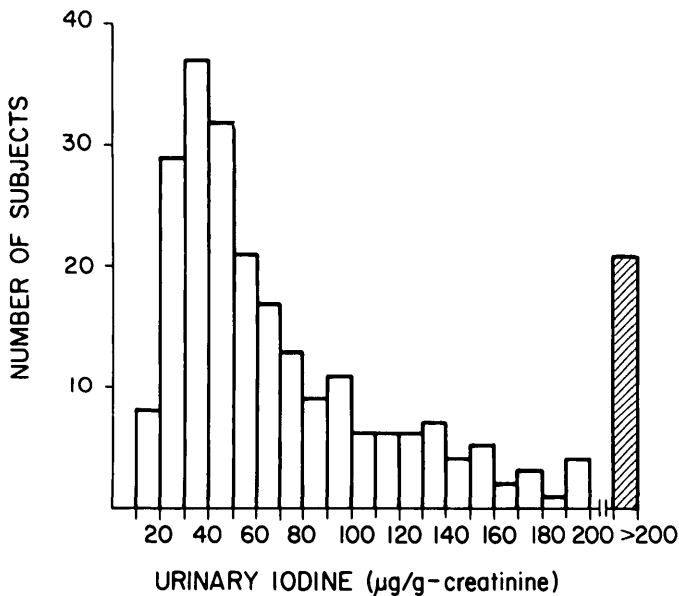


FIG. 1. Urinary iodine excretion in 250 pregnant women in an iodine-deficient area. ▨, About 8% of the subjects who had a urinary iodine level greater than  $200 \mu\text{g/g cr}$ .

arbitrarily divided into  $10 \mu\text{g/g cr}$  intervals. The average serum T<sub>3</sub>, T<sub>4</sub>, and TSH concentrations for each interval were then plotted against the average urinary iodine for the interval in the abscissa. The results are shown in Fig. 3. The serum T<sub>4</sub> concentrations did not bear a linear relationship to urinary iodine. Thus, T<sub>4</sub> values plateaued at around  $100 \mu\text{g I/g cr}$ . Since it has been shown that thyroidal T<sub>4</sub> synthesis is dependent on iodine supply and is saturable (24), it seemed reasonable to analyze these data in a double reciprocal plot. In this plot (Fig. 3A), a high degree of correlation was found ( $r = 0.90$ ;  $P < 0.001$ ). The y-intercept of Fig. 3A represents the reciprocal of the maximal T<sub>4</sub> concentration attainable in pregnancy at optimal iodine intake. This value was  $10.4 \pm 1.3 \mu\text{g/dl}$  (SD). From the same analyses, it can be calculated that

at a urinary iodine of  $11 \mu\text{g/g cr}$ , the concentration of T<sub>4</sub> in the serum should be half the maximal value. The regression curve relating T<sub>4</sub> and urinary iodine in the lower portion of Fig. 3 was calculated using these parameters.

The data in Fig. 3 also suggested that decreasing iodine supply was associated with a progressive increase in serum TSH, whereas at higher iodine intake, the serum TSH level was not influenced by further increases in iodine supply. According to the criteria described in *Materials and Methods*, the relationship was best described by a hyperbolic model:  $\text{TSH} = a + b/I^-$  ( $r = 0.60$ ;  $P < 0.05$ ), where  $a = 2.2 \mu\text{U/ml}$  and  $b = 12.2$ . The parameter  $a$  represents the lowest concentration of TSH attainable by correcting the ID.

An inverse relationship between T<sub>4</sub> and TSH concentrations is suggested by Fig. 3, but the relationship does not seem to be a simple linear one. A plot between TSH and the reciprocal of T<sub>4</sub> ( $\text{TSH} = a + b/T_4$ , where  $a = 2.4 \mu\text{U/ml}$ ) described the relationship ( $r = 0.76$ ;  $P < 0.005$ ) and is shown in Fig. 4. Thus, a steep increase in TSH would be expected in pregnant women when serum T<sub>4</sub> decreases below  $6 \mu\text{g/dl}$ , while as the serum T<sub>4</sub> concentration approaches normal, TSH would not decrease greatly and would approach the value of  $a = 2.4 \mu\text{U/ml}$ .

Table 1 shows the effect of oral iodine supplementation (OIS) on serum concentrations of T<sub>4</sub>, T<sub>3</sub>, rT<sub>3</sub>, and TSH. In the same table are shown the duration of the treatment period as well as the time since conception when the KI was started. Since the changes in T<sub>4</sub>, TSH, and rT<sub>3</sub> did not correlate with the length of KI supplementation (all  $\geq 4$  weeks) or the duration of pregnancy at the time iodine was begun, all data were pooled. There was a significant increase in serum T<sub>4</sub> and rT<sub>3</sub>, a decrease in plasma TSH, and no change in plasma T<sub>3</sub>. In the untreated controls, there was no significant change in any

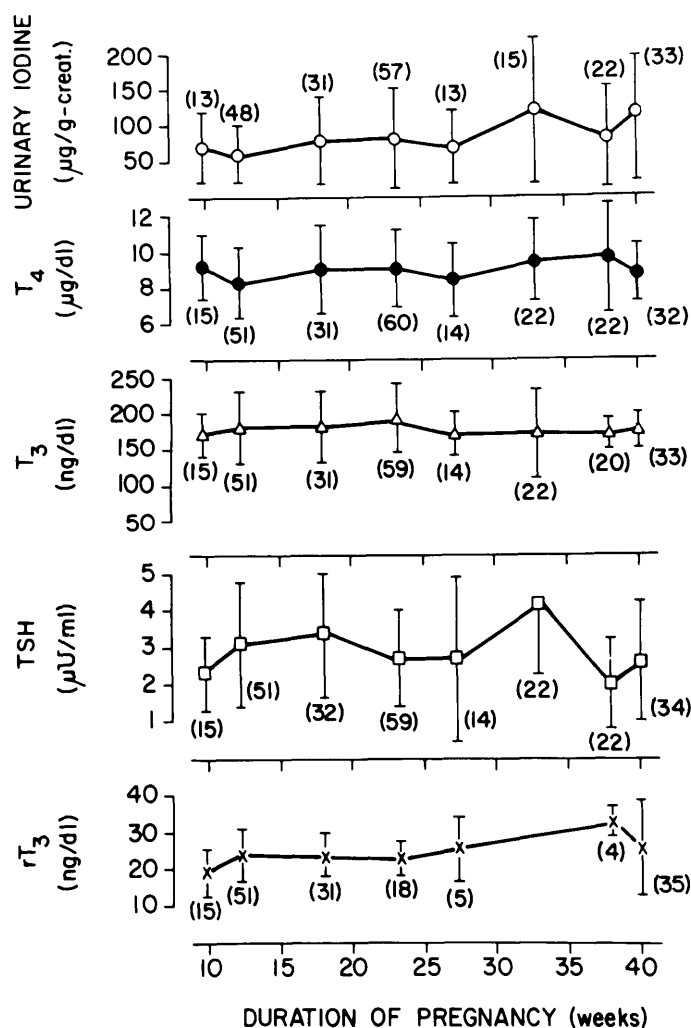


FIG. 2. Urinary iodine excretion and serum thyroid hormone and TSH concentrations as a function of time after conception in pregnant women in an iodine-deficient area. The subjects were grouped according to the duration of pregnancy at 5-week intervals. The mean  $\pm$  1 SD of each variable were plotted against the mean within each interval of time. The figures in parentheses represent the number of women at each interval.

of the variables studied. The agreement between the two urinary iodine measurements supports the idea that the I to cr ratio is a reproducible reflection of the iodine intake.

Table 2 shows the serum free  $T_4$  and  $T_3$  concentrations in 16 mothers and 14 nonpregnant euthyroid adults. In the untreated pregnant subjects, the free  $T_4$  was reduced compared with that of nonpregnant subjects ( $P < 0.001$ ), while serum  $T_3$  was not different. After KI treatment, serum free  $T_4$  increased ( $P < 0.001$ ), becoming equal to that of nonpregnant controls. Since there was no change in the dialyzable fraction, the increase was accounted for by the increase in total serum  $T_4$ . The serum free  $T_3$  was unaffected by iodine supplementation. In the same patients, serum TSH fell significantly from  $3.0 \pm 1.3$  to  $1.2$

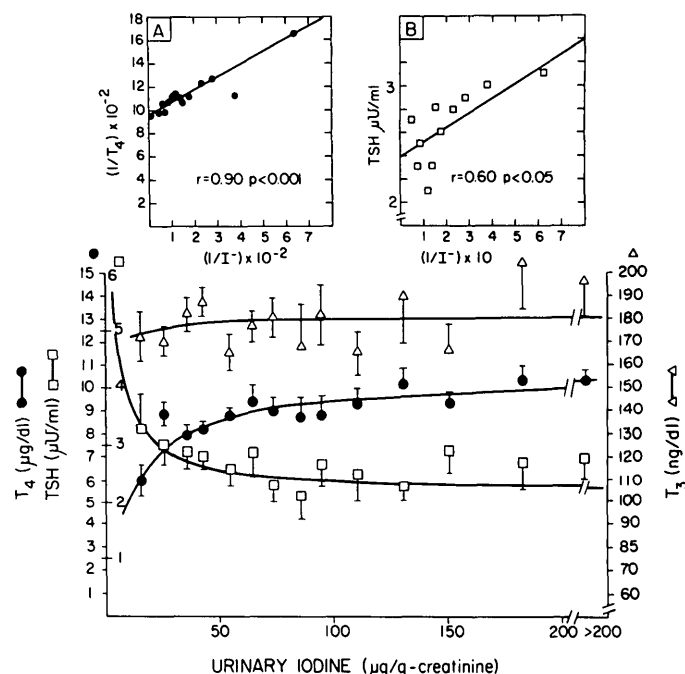


FIG. 3. Serum  $T_3$ ,  $T_4$ , and TSH concentrations as a function of urinary iodine excretion in pregnant women of an iodine-deficient area. Urinary iodine secretion was arbitrarily divided in  $10 \mu\text{g/g cr}$  intervals, and the mean  $\pm$  1 SEM of each variable were plotted against the mean within each interval. The insets are plots of the reciprocal of  $T_4$  (A) and TSH values (B) (in the ordinates) vs. the reciprocal of the urinary iodine (in the abscissa). The equations obtained from these analyses were used to construct the lines shown at the bottom. The number of subjects at each interval of the abscissa can be obtained from Fig. 1.

$\pm 0.6 \mu\text{U/ml}$  ( $P < 0.001$ ).

The effect of maternal iodine supplementation on the levels of thyroid hormones and TSH in the newborn are shown in Table 3. The newborns whose mothers received iodine supplementation had higher serum  $T_4$  and  $rT_3$  concentrations but showed no difference in serum  $T_3$ . The difference in serum TSH was not significant because of the large dispersion of the values, presumably due to the rapid increase of TSH which occurs during the first 30 min of extrauterine life (25). There was a significant correlation between maternal serum  $T_4$  and the corresponding value in the cord (Fig. 5). The slope of the regression line was 0.38, significantly less than 1.0 ( $P < 0.001$ ), suggesting that the increases induced in serum  $T_4$  by iodine intake were smaller in the fetus than in the respective mothers.

## Discussion

The overall pattern of thyroid hormones and TSH found in these studies is similar to that in many previous reports of ID (8-13). Serum  $T_4$  is low, serum TSH is increased, and serum  $T_3$  is normal. Fewer studies have dealt with these parameters in pregnancy (15-17), but the trend is the same as that in nonpregnant adults.

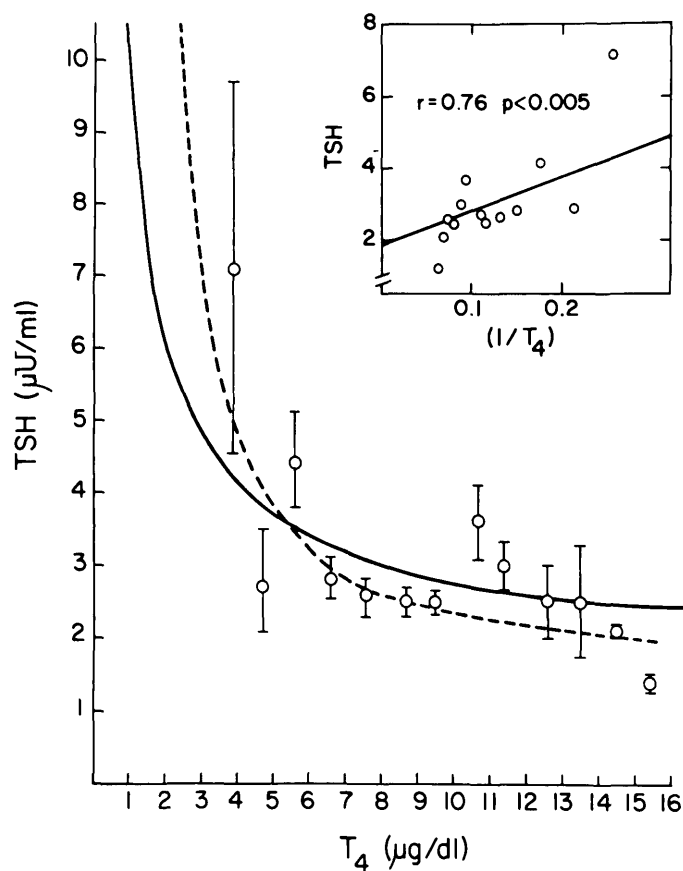


FIG. 4. Relationship between serum TSH and  $T_4$  concentrations in pregnant women from an iodine-deficient area. Total serum  $T_4$  was arbitrarily divided in  $1 \mu\text{g}/\text{dl}$  intervals, and the mean  $\pm 1$  SD of serum TSH were plotted against the mean  $T_4$  within each interval. The continuous curve was calculated from the linear regression shown in the inset. ---, Calculated from a double reciprocal plot of both variables (not shown).

Since iodine requirements are expected to increase during pregnancy (14), iodine-deficient women might not be expected to increase their total  $T_4$  normally in response to the pregnancy-induced increase in thyroxine-binding globulin (26). The data in Table 2 show that while serum  $T_4$  is not higher in pregnant women than in nonpregnant controls, serum  $T_3$  is. The failure of  $T_4$  to increase results in a lower free  $T_4$  concentration than that in nonpregnant controls, but, interestingly, the free  $T_3$  concentration is not different. The assumption has been made that the fall in free  $T_4$  is related to ID. The data shown in Fig. 3 suggest a nonlinear type of relationship between urinary iodine and serum  $T_4$ . The model that fits the data ( $r = 0.90$ ) is in agreement with the fact that the rate of synthesis of  $T_4$ , as a function of iodine availability, is a saturable phenomenon (24). Pretell *et al.* (15), plotting data from different geographical areas and from endemic goitrous patients treated with iodized oil, observed that there was a correlation between urinary iodide and total serum  $T_4$  only when the former was less than  $50 \mu\text{g}/\text{g}$  cr,

which is consistent with Fig. 3. The data in Fig. 3 also show that higher serum TSH concentrations are found with lower urinary iodine excretion, and further, that the low serum  $T_4$  may be the signal for the elevated TSH secretion, since serum  $T_3$  did not change over the observed range of iodine excretion. An inverse relationship (probably not linear) would be expected between serum  $T_4$  and TSH concentrations. The model that best described this relationship was hyperbolic:  $\text{TSH} = a + b/T_4$ , as shown in Fig. 4.

The interactions among dietary iodine supply, plasma  $T_4$ , and TSH, suggested by the observations described in this study, were further supported by the effects that iodine supplementation had on these various hormones. Observing Fig. 3 and considering the basal level of iodine intake of the women given OIS, one would predict only a modest increase in serum  $T_4$  and free  $T_4$  concentrations and only a slight fall in plasma TSH with iodine supplementation in this population. Thus, the highest predictable serum  $T_4$  and the lowest predictable serum TSH levels based on Fig. 3 are  $10.5 \mu\text{g}/\text{dl}$  and  $2.2 \mu\text{U}/\text{ml}$ , respectively. In addition, the lowest predictable TSH based on the relationship it bears to serum  $T_4$  is  $2.4 \mu\text{U}/\text{ml}$ , which is internally consistent with Fig. 4. With OIS, serum  $T_4$  increased to  $12.5 \mu\text{g}/\text{dl}$ , and serum TSH decreased to  $1.5 \mu\text{U}/\text{ml}$ . By looking at the effect of OIS in the same subjects, the individual variation and the influence of factors other than iodine intake on  $T_4$  and TSH alluded to in *Materials and Methods* are all minimized. Considering that these sources of variation were present in the mathematical analysis, the agreement between both observed and calculated figures is very good. On the other hand, the post-OIS values of  $T_4$  and TSH are virtually the same as those recently found by Harada *et al.* (27) in pregnant women with sufficient iodine intake.

Since serum  $T_3$  does not change with iodine supplementation, the increase in  $T_4$  appears to be responsible for the decrease in TSH. The slightly increased pretreatment serum TSH ( $1.3 \mu\text{U}/\text{ml}$ ; Table 1) disclosed only by iodine treatment is apparently sufficient to increase the thyroïdal secretion of  $T_3$  enough to compensate for the reduced extrathyroïdal  $T_3$  production from  $T_4$ . In iodine-deficient rats, the metabolic clearances of  $T_3$  and  $T_4$  are unchanged (3), and the increase in the intrathyroïdal ratio of  $T_3$  to  $T_4$ , due in part to the increased TSH (6), can account for the elevated  $T_3$  to  $T_4$  ratio in the serum (1).

Since thyroid hormones do not cross the placenta (28), the increases in cord serum  $T_4$  levels in infants of iodine-supplemented mothers are probably the consequence of the change in maternal plasma  $I^-$ . However, the increase in the maternal serum  $T_4$  is greater than was apparent in the newborns. In part, this observation may be due to the difference in thyroxine-binding globulin levels in

TABLE 2. Serum free T<sub>4</sub> and T<sub>3</sub> concentrations in iodine-deficient pregnant women: effect of iodine supplementation (mean ± SD)

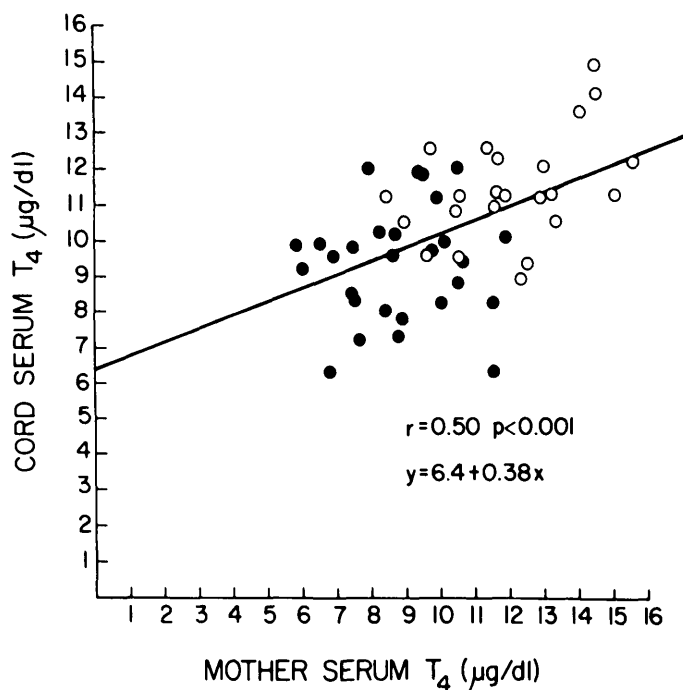
	T <sub>4</sub> (μg/dl)	Free fraction (% × 10 <sup>-3</sup> )	Free T <sub>4</sub> (ng/dl)	T <sub>3</sub> (ng/dl)	Free fraction (% × 10 <sup>-2</sup> )	Free T <sub>3</sub> (ng/dl)	TSH (μU/ml)
1. Nonpregnant adult (n = 14)	7.7 ± 1.8	30 ± 5	2.3 ± 0.4	124 ± 26	28 ± 4	0.34 ± 0.14	≤5
2. Pregnant before OIS (n = 14)	8.1 ± 2.5	20 ± 4 <sup>a</sup>	1.5 ± 0.4 <sup>a</sup>	184 ± 25 <sup>a</sup>	18 ± 4 <sup>a</sup>	0.33 ± 0.06	3.0 ± 1.3
3. Pregnant after OIS	12.2 ± 1.9 <sup>a</sup>	19 ± 3 <sup>a</sup>	2.3 ± 0.4	177 ± 38 <sup>b</sup>	17 ± 2 <sup>a</sup>	0.30 ± 0.06	1.2 ± 0.6
P 2 vs. 3 (paired)	<0.001	NS	<0.001	NS	NS	NS	<0.001

<sup>a</sup> P < 0.001 vs. nonpregnant control.<sup>b</sup> P < 0.005 vs. nonpregnant control.

TABLE 3. Effect of iodine supplementation during pregnancy on serum thyroid hormones and TSH concentrations in maternal and cord blood at delivery (mean ± SD)

	Maternal			Cord		
	Untreated	Treated	P	Untreated	Treated	P
T <sub>4</sub> (μg/dl)	8.8 ± 1.7 (32)	12.1 ± 1.9 (24)	<0.001	9.3 ± 1.7 (32)	11.3 ± 1.5 (24)	<0.001
T <sub>3</sub> (ng/dl)	172 ± 26 (33)	157 ± 34 (23)	NS	50 ± 23 (33)	58 ± 8 (23)	NS
rT <sub>3</sub> (ng/dl)	26 ± 12 (34)	24 ± 16 (25)	NS	183 ± 37 (34)	226 ± 55 (25)	<0.005
TSH (μU/ml)	2.9 ± 1.8 (34)	2.2 ± 1.2 (25)	NS	8.3 ± 7.8 (34)	5.7 ± 3.4 (25)	NS
Urinary I <sup>-</sup> μg/g -cr)	127 ± 94	493 ± 586	<0.005			

The number of cases is in parentheses.

FIG. 5. Linear regression between maternal and cord serum T<sub>4</sub> levels in subjects living in an iodine-deficient area. ●, Untreated mother-newborn pairs; ○, those who received iodine supplementation.

mothers and newborns (26), but it may also reflect the participation of compensatory mechanisms that partially protect the fetus from the low maternal iodine intake. Whereas after correction of ID, the ratio of cord serum T<sub>4</sub> to maternal serum T<sub>4</sub> was 0.96 ± 0.16 (SD), the same ratio in the untreated controls was significantly higher (1.12 ± 0.25; P < 0.025, calculated from the individual

data presented in Table 3). Therefore, at a same low iodine intake, fetal serum T<sub>2</sub> is less reduced than that of the mother. The ability of the placenta to concentrate iodine, demonstrated in other species, may be the mechanism (29).

The increases observed in maternal and cord serum rT<sub>3</sub> with iodine supplementation are probably a reflection of the higher serum T<sub>4</sub> concentration. In both cases, the relative increase in rT<sub>3</sub> was similar to that of T<sub>4</sub>. This indicates that iodine did not induce a change in the capacity of the tissues to convert T<sub>4</sub> to T<sub>3</sub>, since the enzyme that regulates this reaction seems to be the same 5'-monodeiodinase that catalyzes the degradation of rT<sub>3</sub> to 3,3'-diiodothyronine (30).

The data and their interpretation are consistent with experimental studies showing that unless the ID is extreme, plasma T<sub>3</sub> remains constant, probably accounting for the lack of detectable manifestations of hypothyroidism other than an elevation of TSH (3, 4, 31, 32). The fall in T<sub>4</sub> is likely to be responsible for the elevation of TSH, and the latter is probably the cause of the compensatory increase in thyroidal T<sub>3</sub> secretion. However, the lower plasma T<sub>4</sub> level in the fetus might not be without consequences, since it has been recently shown that, at least in the rat, plasma T<sub>4</sub> is an important source of intracellular T<sub>3</sub> in the brain (33).

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### References

- Abrams GM, Larsen PR 1973 Triiodothyronine and thyroxine in the serum and thyroid glands of iodine-deficient rats. *J Clin Invest* 52:2522
- Fukuda H, Yasuda N, Greer MA, Kutas M, Greer MA 1975 Changes in plasma thyroxine, triiodothyronine and TSH during adaptation to iodine deficiency in the rat. *Endocrinology* 97:307
- Silva JE 1972 Disposal rates of thyroxine and triiodothyronine in iodine-deficient rats. *Endocrinology* 91:1430
- Larsen PR, Frumess RD 1977 Comparison of the biological effects of thyroxine and triiodothyronine in the rat. *Endocrinology* 100:980
- Silva JE, Pineda G, Stevenson C 1974 The importance of triiodothyronine as a thyroid hormone. In: Dunn JT, Medeiros-Neto GA (eds) *Endemic Goiter and Cretinism: Continuing Threats to World Health*, PAHO scientific publication 292. Pan American Health Organization, Washington DC, p 52
- Studer H, Greer MA 1965 A study of the mechanisms involved in the production of iodine-deficiency goiter. *Acta Endocrinol (Copenh)* 49:610
- Larsen PR, Silva JE 1979 Sources of pituitary nuclear T<sub>3</sub> and its influence on TSH release. In: Ekins R, Faglia G, Penisi F, Pinchera A (eds) *International Symposium on Free Thyroid Hormones*, Excerpta Medica, Amsterdam, p 55
- Delange F, Camus M, Ermans AM 1972 Circulating thyroid hormones in endemic goiter. *Metabolism* 34:891
- Pharoah POD, Lawton NF, Ellis SM, Williams ES, Ekins RP 1973 The role of triiodothyronine (T<sub>3</sub>) in the maintenance of euthyroidism in endemic goitre. *Clin Endocrinol (Oxf)* 2:193
- Patel YC, Pharoah POD, Hornabrook RW, Hetzel BS 1973 Serum triiodothyronine, thyroxine and thyroid-stimulating hormone in endemic goiter: a comparison of goitrous and nongoitrous subjects in New Guinea. *J Clin Endocrinol Metab* 37:783
- Gosling BM, Djokomoeljanto R, Docter R, Van Hardeveld C, Hennemann G, Smeenk D, Querido A 1977 Hypothyroidism in an area of endemic goiter and cretinism in central Java, Indonesia. *J Clin Endocrinol Metab* 44:481
- Chopra IJ, Hershman HM, Hornabrook RW 1975 Serum thyroid hormone and thyrotropin levels in subjects from endemic goiter regions of New Guinea. *J Clin Endocrinol Metab* 40:376
- Kochupillai N, Karmarkar MG, Weightman D, Hall R, Deo MG, McKendrick M, Evered DC, Ramalingaswami V 1973 Pituitary-thyroid axis in Himalayan endemic goitre. *Lancet* 1:1021
- Hollingsworth D, Fisher DA, Pretell EA 1980 The fetal maternal relationship with respect to the thyroid. In: Stanbury JB, Hetzel BS (eds) *Endemic Goiter and Endemic Cretinism*. John Wiley and Sons, New York, p 423
- Pretell EA, Palacios P, Tello L, Wan M, Utiger RD, Stanbury JB 1974 Iodine deficiency and the maternal-fetal relationship. In: Dunn JT, Medeiros-Neto GA (eds) *Endemic Goiter and Cretinism: Continuing Threats to World Health*, PAHO scientific publication 292. Pan American Health Organization, Washington DC, p 143
- Thilly CH, Delange F, Lagasse R, Bourdoux P, Ramioul L, Berquist H, Ermans AM 1978 Fetal hypothyroidism and maternal thyroid status in severe endemic goiter. *J Clin Endocrinol Metab* 47:354
- Medeiros-Neto GA, Walfish PG, Almeida F, Maia E, Gomes EF, Kiy Y, Knobel M, Binsberg J, Chopra IJ 1978 3,3',5'-Triiodothyronine levels in maternal and cord blood sera from endemic goiter regions of Brazil. *J Clin Endocrinol Metab* 47:508
- Larsen PR 1972 Direct immunoassay of triiodothyronine in human serum. *J Clin Invest* 51:1939
- Larsen PR, Dockalova J, Sipula D, Wu FM 1973 Immunoassay of thyroxine in unextracted human serum. *J Clin Endocrinol Metab* 37:177
- Oppenheimer JH, Squef R, Surks MI, Haur H 1963 Binding of thyroxine by serum proteins evaluated by equilibrium dialysis and electrophoretic techniques. Alterations in non-thyroidal illness. *J Clin Invest* 42:1769
- Chattaway FW, Hullin RP, Odds FC 1969 The variability of creatinine excretion in normal subjects. Mental patients and pregnant women. *Clin Chim Acta* 26:567
- Riggs DS 1963 *The Mathematical Approach to Physiological Problems*. Williams and Wilkins, Baltimore, pp 57-66
- Matovinovic J, Child MA, Nicham MZ, Trowbridge FL 1974 Iodine and endemic goiter. In: Dunn JT, Medeiros-Neto GA (eds) *Endemic Goiter and Cretinism: Continuing Threats to World Health*, PAHO scientific publication 292. Pan American Health Organization, Washington DC, p 67
- Inoue K, Taurag A 1968 Acute and chronic effects of iodide on thyroid radioiodine metabolism in iodine-deficient rats. *Endocrinology* 83:279
- Fisher DA, Odell WD 1969 Acute release of thyrotropin in the newborn. *J Clin Invest* 48:1670
- Stubbe P, Gatz J, Heidemann P, von zur Mühlen A, Hesch R 1978 Thyroxine-binding globulin, triiodothyronine, thyroxine and thyrotropin in newborn infants and children. *Horm Metab Res* 10:57
- Harada A, Hershman JM, Reed AW, Braunstein GD, Digman WJ, Derzko C, Friedman S, Jeweewicz R, Pekary AE 1979 Comparison of thyroid stimulators and thyroid hormone concentrations in the sera of pregnant women. *J Clin Endocrinol Metab* 48:793
- Fisher DA, Dussault JH, Sack J, Chopra IJ 1977 Ontogenesis of hypothalamic-pituitary-thyroid function and metabolism in man, sheep and rat. *Recent Prog Horm Res* 33:59
- London WT, Money WL, Rawson RW 1964 Placental transfer of 131 I-labelled iodide in the guinea pig. *J Endocrinol* 28:247
- Kaplan MM, Utiger RD 1978 Iodothyronine metabolism in rat liver homogenates. *J Clin Invest* 61:459
- Silva JE, Larsen PR 1978 Contributions of plasma triiodothyronine and local thyroxine monodeiodination to triiodothyronine to nuclear triiodothyronine receptor saturation in pituitary, liver and kidney of hypothyroid rats. Further evidence relating saturation of pituitary nuclear triiodothyronine receptors and the acute inhibition of thyroid-stimulating hormone release. *J Clin Invest* 61:1247
- Silva JE, Dick TE, Larsen PR 1978 The contribution of local tissue thyroxine monodeiodination to the nuclear 3,5,3'-triiodothyronine in pituitary, liver and kidney of euthyroid rats. *Endocrinology* 103:1196
- Crantz FR, Larsen PR 1980 Rapid thyroxine to 3,5,3'-triiodothyronine conversion and nuclear 3,5,3'-triiodothyronine binding in rat cerebral cortex and cerebellum. *J Clin Invest* 65:935