The relationship between thyroid autoantibody positivity and abnormal pregnancy outcomes and miscarriage in euthyroid patients

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Abstract

Introduction: The aim of this study is to determine the relationship between autoantibodies against TPO (TPOAb) and thyroid receptor antibody (TRAb) autoantibody positivity and abnormal pregnancy outcomes and miscarriage in euthyroid pregnant women.

Material and methods: This study is a retrospective case-control study conducted by examining the data of 16,876 women who applied to Adıyaman Training and Research Hospital for regular obstetric examination between December 2017 and March 2020. Analyses were performed to compare the risks of gestational diabetes mellitus (GDM), preeclampsia, placenta previa, placenta abruption, foetal growth restriction (FGR), foetal distress, stillbirth, preterm birth, and miscarriage. \( P < 0.05 \) was considered statistically significant.

Results: In the group with TPO +/TRAb–, placenta previa risk (odds ratio (OR) = 2.26, 1.61–3.17, \( p < 0.001 \)), placenta abruption risk (OR = 4.24, 2.14–8.41, \( p < 0.001 \)), FGR risk (OR = 1.28, 1.11–1.48, \( p < 0.001 \)), and miscarriage risk (OR = 1.63, 1.38–1.92, \( p < 0.001 \)) increased. In the group with TPO–/TRAb+, risk of preeclampsia (OR = 2.58, 2.08–3.20, \( p < 0.001 \)), risk of placenta previa (OR = 2.40, 1.51–3.80, \( p < 0.001 \)), and risk of miscarriage (OR = 1.29, 1.01–1.66, \( p = 0.004 \)) increased. In the group with TPO+/TRAb+, GDM risk (OR = 1.86, 1.44–2.41, \( p < 0.001 \)), placenta previa risk (OR = 4.76, 3.30–6.86, \( p < 0.001 \)), and miscarriage risk (OR = 1.67, 1.31–2.11, \( p < 0.001 \)) increased.

Conclusions: Thyroid autoantibody positivity is associated with negative perinatal outcomes such as miscarriage, placenta previa, GDM, and preeclampsia, regardless of thyroid hormone levels. Thyroid autoantibody detection in early visits of pregnant women should be a warning for the clinician.

Key words: diabetes, gestational, abortion, spontaneous, foetal membranes, preterm delivery, preeclampsia, pregnancy complications, thyroiditis, autoimmune, TPO protein, human, thyroid stimulation-blocking antibody.

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Introduction

Approximately 10% of the general population and at least 2–3% of pregnant women suffer from autoimmune thyroid diseases (ATD) [1]. Thyroid receptor antibody (TRAb) is an important autoantibody detected in patients with autoimmune thyroid disease [2]. Thyroid peroxidase (TPO) is a key enzyme involved in thyroid hormone synthesis [3]. The presence of autoantibodies against TPO (TPOAb) and the secondary developing response are considered as indicators of thyroid autoinflammation and can be detected in 10–20% of women in the reproductive period [4, 5]. It is widely known that negative perinatal outcomes are associated with thyroid dysfunction in pregnancy [6]. Moreover, thyroid autoimmunity appears to be associated with some pregnancy complications, including miscarriage and preterm birth [7]. In addition, women with recurrent foetal loss, infertility, or miscarriage are more likely to have thyroid autoantibodies than women without thyroid autoantibodies positivity [8]. It has been shown that the presence of thyroid autoantibodies causes changes in the immune system at the foetal maternal interface, causing miscarriage, preterm labour, and adverse advanced pregnancy results [9]. Therefore, it is important to raise awareness of autoimmune thyroid diseases and the prevention of complications related to their treatment during pregnancy.

The aim of this study is to determine the relationship between TPOAb and TRAb autoantibody positivity and abnormal pregnancy outcomes such as gestational diabetes mellitus, preeclampsia, abnormal placental localisation, and miscarriage in euthyroid pregnant women.

Material and methods

This study is a retrospective case-control study conducted by examining the data of 16,876 women who applied to Adıyaman Training and Research Hospital for regular obstetric examination between December 2017 and March 2020. Local Ethics Committee approval was received for the study. This study was conducted in accordance with the principles of the Helsinki Declaration.

Patients with clinical symptoms of hypothyroidism and hyperthyroidism [10], whose thyroid hormone levels were not within normal limits, had a history of antithyroid drug therapy or a history of thyroid hormone replacement, patients with non-thyroid autoimmune disease clinics (rheumatoid arthritis, systemic lupus erythematosus etc.), and patients with immunosuppressive therapy in the preceding 6 months, were excluded from the study. The criteria for inclusion in the study were to have performed all controls in our centre during pregnancy, to have determined the values of thyroid autoantibodies (TPOAb and TRAb) at the first visit, and to be in the 18–40 years age range. One thousand eight hundred and thirty-one patients with a diagnosis of hypothyroidism, 463 patients with a diagnosis of hyperthyroidism, 934 patients with a diagnosis of subclinical hypothyroidism, and 217 patients with a diagnosis of subclinical hyperthyroidism were excluded from the study.

TSH and FT4 concentrations were within normal ranges in all selected women [11]. Specifically, thyroid stimulating hormone (TSH) and free T4 hormone (FT4) values were 0.09–3.47 mIU/l and 6.00–12.25 ng/l in early pregnancy, respectively; 0.20–3.81 mIU/l and 4.30–9.74 ng/l in middle pregnancy; and 0.67–4.99 mIU/l and 4.56–8.50 ng/l in late pregnancy. TPOAb > 50 IU/ml and TRAb > 1.75 IU/l were considered positive.

As a result, 13,431 euthyroid [12] patients were included in the study. The patients were divided into four groups according to serum TPOAb and TRAb results. TPOAb-/TRAb– (83.4%, 11,204/13,431), TPOAb+/TRAb– (8.8%, 1181/13,431), TPOAb–/TRAb+ (4.1%, 544/13,431), and TPOAb+/TRAb+ (3.7%, 502/13,431) (Figure 1). The TPOAb–/TRAb– group was determined as the control group.

![Flowchart of study population](image-url)

Figure 1. Flowchart of study population

*Figure 1. Flowchart of study population*

$n$ – number of patients, TPOAb – thyroid peroxidase autoantibody, TRAb – thyroid receptor autoantibody.
Abnormal pregnancy outcome assessment

We searched for nine abnormal pregnancy results defined as below. Gestational diabetes mellitus (GDM): oral glucose tolerance test (OGTT) was performed using 75 g of oral glucose solution; fasting plasma glucose 92 mg/dl (5.1 mmol/l), 1-hour plasma glucose 180 mg/dl (10 mmol/l), 2-hour plasma glucose 153 mg/dl (8.5 mmol/l) [12]. Preeclampsia: systolic blood pressure 140 mm Hg or diastolic blood pressure ≥ 90 mm Hg after 20 weeks in a pregnant woman without a history of hypertension and the coexistence of one or more of the following new onset conditions: proteinuria, renal insufficiency (creatinine > 90 µmol/l), liver involvement (elevated transaminases and/or severe right upper quadrant or epigastric pain), neurological complications (headaches, altered mental status; examples include eclampsia, stroke, blindness, hyperreflexia or clonus, when accompanied by hyperreflexia), and haematological complications (thrombocytopenia, haemolysis, disseminated intravascular coagulation). Placenta previa: the placenta advances to the lower uterine segment, partially or completely covering the entrance to the cervix. Abruptio placentae: the placental membrane is partially or completely separated from the uterus endometrium before birth. Foetal growth restriction (FGR): a newborn who is small for gestational date. Foetal distress: worsening of the foetus in antepartum or intrapartum period due to foetal hypoxia. Stillbirth: foetal death after 20 weeks of pregnancy. Preterm delivery: a baby born before 20th gestational week.

Statistical analysis

Statistical analyses were performed using SPSS 22 (International Business Machines Corp., Armonk, New York). Qualitative data were expressed as frequency, percentage, median (minimum-maximum), and mean ± standard deviation. Pearson's \( \chi^2 \) test was used to determine the significance of the difference between the two percentages, and the paired t-test was used for binary dependent groups fitting the normal distribution. Pearson's \( \chi^2 \) test was used to calculate the differences of the groups for GDM, preeclampsia, placenta previa, placenta abruption, FGR, foetal distress, stillbirth, preterm delivery, and miscarriage, compared to the control group.

Using univariate conditional logistic regression analysis, we calculated the odds ratio (OR) and 95% confidence intervals (CI) for each variable. A multivariate logistic regression analysis was used to adjust potential contradictions and calculate the corrected adjusted odds ratio (AOR). \( P \leq 0.050 \) was considered statistically significant.

Results

The incidence of adverse pregnancy outcomes by groups is given in Table I.

There is no statistically significant difference between the groups for the risk of preterm delivery, foetal distress, or stillbirth (\( p > 0.05 \)) (Table I).

In the group with TPO+/TRAb–, placenta previa risk (\( OR = 2.26, 1.61–3.17, p < 0.001 \)), placenta abruption risk (\( OR = 4.24, 2.14–8.41, p < 0.001 \)), FGR risk (\( OR = 1.28, 1.11–1.48, p < 0.001 \)), and abortion risk (\( OR = 1.63, 1.38–1.92, p < 0.001 \)) increased (Table II).

In the group with TPO+/TRAb+, risk of preeclampsia (\( OR = 2.58, 2.08–3.20, p < 0.001 \)), risk of placenta previa (\( OR = 2.40, 1.51–3.80, p < 0.001 \)), and risk of abortion (\( OR = 1.29, 1.01–1.66, p = 0.004 \)) increased (Table II).

In the group with TPO+/-TRAb+, GDM risk (\( OR = 1.86, 1.44–2.41, p < 0.001 \)), placenta previa risk (\( OR = 4.76, 3.30–6.86, p < 0.001 \)), and abortion risk (\( OR = 1.67, 1.31–2.11, p < 0.001 \)) increased (Table II).

Discussion

According to the results of this study, TPOAb and TRAb positivity increase the risk of placenta previa and miscarriage. TPOAb positivity increases the risk of FGR, FGR

| Parameter | TPOAb–/TRAb– | TPOAb+/TRAb– | TPOAb–/TRAb+ | TPOAb+/TRAb+ |
|-----------|--------------|--------------|--------------|--------------|
| Number of subjects | 11204 | 1181 | 544 | 502 |
| GDM | 933 (8.3%) | 82 (7%) | 57 (10.5%) | 73 (14.6%) |
| Preeclampsia | 1074 (9.6%) | 109 (9.2%) | 117 (21.5%) | 44 (8.7%) |
| P. previa | 184 (1.7%) | 43 (3.7%) | 21 (3.9%) | 37 (7.4%) |
| A. placenta | 27 (0.3%) | 12 (1.01%) | – | – |
| FGR | 2127 (18.9%) | 274 (23.2%) | 41 (7.5%) | 49 (9.8%) |
| Foetal distress | 311 (2.8%) | 44 (3.7%) | 19 (3.5%) | 17 (3.4%) |
| Stillbirth | 11 (0.1%) | 3 (0.3%) | – | – |
| Preterm delivery | 1819 (16.2%) | 153 (13%) | 64 (11.8%) | 76 (15.1%) |
| Miscarriage | 1264 (11.3%) | 203 (17.2%) | 77 (14.2%) | 88 (17.5%) |

TPOAb – thyroid peroxidase autoantibody; TRAb – thyroid receptor autoantibody; GDM – gestational diabetes mellitus; FGR – foetal growth restriction; P – placenta; A – abruptio.
positivity preeclampsia, and TPO and TRAb positivity increases the risk of GDM.

In a prospective cohort study by Liu et al. including subclinical hypothyroid pregnancies and euthyroid pregnancies with TPO antibody positivity, the risk of miscarriage increased in euthyroid patients with TPO antibody positivity [13]. In addition, another study reported that TPO positivity was associated with miscarriage [14]. However, in another study, although the rate of miscarriage was high in patients with TPOAb elevation, there was no statistically significant difference [15]. Li et al. in a recent study found that TRAb positivity were significantly higher in women with pregnancy loss [16]. In this study, the risk of miscarriage in patients with TPOAb elevation, there was no statistically significant but weak relationship between GDM and thyroid autoantibody positivity [28]. However, in a recent cohort study there was no relationship between TPOAb positivity and GDM [26]. It was reported in another study that women with GDM had higher prevalence of TPOAb and TgAb, and it was reported that autoimmune thyroid diseases can be triggered by hyperglycaemia [27]. Moreover, another study stated that hypothyroidism is a risk factor for GDM, but autoantibody positivity is not associated with GDM risk [28]. In this study, the risk of GDM was increased in pregnant women with TPOAb and TRAb positivity. There is a significant but weak relationship between GDM and thyroid autoantibody positivity, and thyroid autoantibody positivity may not be a risk factor for GDM in euthyroid patients. These data should be considered in the follow-up of patients with thyroid autoantibody positivity [29].

In a study conducted in a group of patients with high TSH levels and TPOAb positivity, it was reported that TPOAb positivity increased the risk of GDM [24]. In addition, it has been reported that TPOAb prevalence is high in GDM patients [25]. However, in a recent cohort study there was no relationship between TPOAb positivity and GDM [26]. It was reported in another study that women with GDM had higher prevalence of TPOAb and TgAb, and it was reported that autoimmune thyroid diseases can be triggered by hyperglycaemia [27]. Moreover, another study stated that hypothyroidism is a risk factor for GDM, but autoantibody positivity is not associated with GDM risk [28]. In this study, the risk of GDM was increased in pregnant women with TPOAb and TRAb positivity. There is a significant but weak relationship between GDM and thyroid autoantibody positivity, and thyroid autoantibody positivity may not be a risk factor for GDM in euthyroid patients. These data should be considered in the follow-up of patients with thyroid autoantibody positivity [29].

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Adverse results such as abnormalities in lipid metabolism, coagulation disorders, impairment in endothelial functions, and arterial intimal thickening have been reported in patients with positive thyroid autoantibody. These adverse developments in the placental vascular bed may increase the risk of abruptio placentae [30]. There are some studies showing that a relationship between TPOAb
positivity and placenta abruptio [31, 32]. Similarly, in this study, the risk of placenta abruption was increased in pregnant women with TPOAb positivity. In a study investigating the positivity of TPOAb and TgAb with perinatal outcomes in euthyroid patients, there was no relationship between placenta previa and autoantibody positivity [33]. In addition, in a meta-analysis investigating the perinatal results of patients with subclinical hypothyroidism, it was stated that there was no relationship between hypothyroidism and placenta previa [34]. In this study, the risk of placenta previa was found to be increased in pregnant women with TPOAb and TRAb positivity.

This study has some limitations. First of all, this study is a retrospective study, so it can be biased. However, we tried to eliminate this by obtaining the data from recorded and written results. Secondly, this is a single-centre study, and the number of patients in the case group is low compared to the control group population. These limitations should be considered before generalising the results of the study to the society. Large, multicentre, and prospective studies may be needed.

Conclusions

Thyroid autoantibody positivity is associated with low perinatal outcomes such as low levels of thyroid hormones and negative perinatal outcomes such as placenta previa and miscarriage. Thyroid autoantibody positivity in early visits of pregnant women should be a warning for the clinician. The adverse effects of thyroid autoantibody positivity should not be ignored, and the clinician should determine thyroid autoantibody values in early pregnancy visits and take precautions against adverse pregnancy outcomes.

Conflict of interest

The authors declare no conflict of interest.

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