M2 - Endocrine, Winter 2008

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Abnormalities of Growth & Development

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To understand the
- determinants of normal growth
- common variations in normal growth
- diagnostic approach to a child with abnormal growth
- principles of management of a child with abnormal growth
Topics **NOT** covered in today’s discussion

- Sexual differentiation
- Ambiguous genitalia and disorders of sexual differentiation
- Pubertal development
- Disorders of pubertal development - delayed / precocious
- Physiology of hormone secretion / action
Determinants of Normal Growth

Normal growth is the aggregate of hormonal, environmental, nutritional, and genetic factors.

Hormonal Factors

- **Thyroid** - essential for normal growth
  - hypothyroidism is a common cause of severe growth delay
- **Sex steroids** - bone maturation is dependent on estrogen
  - testosterone can enhance GH secretion
- **Glucocorticoids** - potent inhibitor of growth
GH/IGF-1 Axis

Image of GH/IGF-1 Axis removed
### Determinants of Normal Growth

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Growth Rate $\text{cms/yr}$</th>
<th>Adult Height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Steroids $\uparrow$</td>
<td>Increase</td>
<td>Diminished</td>
</tr>
<tr>
<td>Sex Steroids $\downarrow$</td>
<td>Normal</td>
<td>Increased</td>
</tr>
<tr>
<td>Thyroxine $\uparrow$</td>
<td>Normal/$\pm$ incr</td>
<td>Normal</td>
</tr>
<tr>
<td>Thyroxine $\downarrow$</td>
<td>Decreased</td>
<td>Diminished</td>
</tr>
<tr>
<td>GH $\uparrow$</td>
<td>Increase</td>
<td>Increased</td>
</tr>
<tr>
<td>GH $\downarrow$</td>
<td>Decrease</td>
<td>Diminished</td>
</tr>
<tr>
<td>Cortisol $\uparrow$</td>
<td>Decrease</td>
<td>Diminished</td>
</tr>
<tr>
<td>Cortisol $\downarrow$</td>
<td>Normal</td>
<td>Normal</td>
</tr>
</tbody>
</table>
Normal Growth

Anthropometric parameters

- Weight
- Measurement of height - Stadiometer
  - less than 2 yrs of age - length (supine)
  - greater than 2 yrs of age - height (erect)
- Head circumference
- Span
- Upper segment / lower segment ratio
Upper / Lower Segment Ratio

Lower segment: symphysis pubis to floor
Upper segment: Ht (-) lower segment

Normal Growth
Anthropometric parameters

<table>
<thead>
<tr>
<th>2m</th>
<th>5m</th>
<th>Birth</th>
<th>2yr</th>
<th>6yr</th>
<th>12yr</th>
<th>25yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal</td>
<td></td>
<td>Post-natal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Normal Growth

Growth Velocity

- measured in cms/yr
- should be measured over at least a 6-12 month period
- more the # of height points used to calculate GV - more reliable is the interpretation
- assessment of pubertal status is critical for interpretation of GV
- Normal GV - is a strong argument AGAINST a significant hormonal abnormality
Girls 2-18 yrs

Source: JM Tanner, et al.
Boys 2-18 yrs

Source: JM Tanner, et al.
Normal Growth

- Chronological age
- Dental age
- Bone Age (skeletal maturation)

beyond the neonatal age - X-ray of L wrist

comparison with published standards (Greulich & Pyle)

Usefulness - prediction of final height

- age of onset of puberty closely linked to bone age
- corroborates diagnosis, but is never diagnostic

Caveats - imprecise / ethnic variability
SHORT STATURE

- Definition
- Classification
- Etiology
- Evaluation / Diagnostic Approach
- Treatment
Short Stature
height < 3rd percentile

Growth Retardation
growth velocity < 3rd percentile
SHORT STATURE

Definitions

- Short Stature
  height < 3rd percentile
- Growth Retardation
  growth velocity < 3rd percentile

Etiology

Normal Variant ↔ Pathological
Familial / Genetic

final ht appropriate for parental ht
normal size at birth
GV may be ↓ in 0-3 yrs of age
BA = CA

Constitutional Delay of Growth & Puberty
“Late Bloomer”

family history
normal size at birth
normal GV
delayed puberty
BA < CA

BA = bone age
CA = chronological age
14 yr old boy
h/o “shortest in his class”
h/o “always a small boy”
h/o father did not “grow” till he entered college

Prepubertal
GV = 5.0 cm/yr
Normal BUN / ESR
Normal Free T₄ & TSH
Low-normal IGF-1
Normal IGFBP3 (for Tanner stage)
Bone age = 11.5 yrs

MRI
Normal

Testosterone 50 mg / q 4wks x 3 doses

Source: Undetermined
**Short Stature**
- height < 3rd percentile
- Growth Retardation
  - growth velocity < 3rd percentile

**Definitions**
- Proportionate
- Disproportionate

**Etiology**
- Normal Variant
- Pathological
  - Proportionate
  - Disproportionate
**SHORT STATURE**

**Endocrinopathies**
- Hypothyroidism
- GH deficiency
- Cushing's syndrome

**GI**
- Malabsorption
- Inflammatory bowel disease
- Celiac disease

**Renal**
- Chronic renal failure
- Renal tubular acidosis

**Chronic Systemic Illness**
- Cardiac
- Pulmonary
- Liver
- Infection

**Psychosocial Dwarfism**
- Emotional Deprivation Syndrome

**Pathological Proportionate**
- IUGR
- Malnutrition
4 yr old boy
Voracious appetite / drinks urine - toilet bowl
Withdrawn / flat affect
No dysmorphic features
Chaotic home situation - abusive father
All lab tests normal
4 yr old boy
No dysmorphic features
Chaotic home situation - abusive father

Emotional deprivation syndrome
Psychosocial dwarfism

Admitted to hospital for observation

Source: Undetermined
6 yr old girl
GV = 3.0 cm/yr
No dysmorphic features
Chaotic home situation – parent incarcerated – shuttled through couple of foster homes

All lab tests normal

Emotional deprivation syndrome
Psychosocial dwarfism

Adopted by a family
Stable home environment

Source: Undetermined
Skeletal Abnormalities
- Dysplasia
- Achondroplasia
- Rickets
- Vertebral anomalies

Dysmorphic Syndromes
- Turner
- Down
- Russell-Silver
- Prader-Willi
- Pseudo-hypoparathyroidism

SHORT STATURE
Pathological Disproportionate
<table>
<thead>
<tr>
<th>Category</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>maternal infection, alcohol</td>
</tr>
<tr>
<td>Pattern of growth</td>
<td>birth wt and length</td>
</tr>
<tr>
<td>Family History</td>
<td>onset of puberty</td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
</tr>
<tr>
<td>Systemic Disease</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>steroids</td>
</tr>
<tr>
<td>Neurological</td>
<td>headache, vision, enuresis</td>
</tr>
<tr>
<td>Psychosocial</td>
<td></td>
</tr>
</tbody>
</table>
First sign of puberty on PE:
♀ breast dev / ♂ incr in testicular volume

Anthropometric
ht, wt, head circ., arm span, U/L ratio

Nutritional state

Tanner Staging for Pubertal Development

Dysmorphic Features

Neurological exam

Thyroid Gland
Target Height (in cms)
girl = \frac{[\text{father's ht} + \text{mother's ht}] - 13}{2}

boy = \frac{[\text{father's ht} + \text{mother's ht}] + 13}{2}

normal range is ± 8 cms
SHORT STATURE

Key Parameter - Growth Velocity

Normal GV
- Familial
- Constitutional

Impaired GV
- Malnutrition
- Chronic systemic illness
- IUGR
- Psychosocial
- Chromosomal abnormalities
- Endocrine
- Malabsorption
- Bone dysplasias
Screening Tests

- CBC, ESR, BUN
- FT$_4$, TSH
- IGF-1, IGFBP3
- Tissue Transglutaminase ab

KARYOTYPE
- in girls to exclude TURNER
- dysmorphic features

RADIOLOGICAL
- bone age
- skeletal survey
SHORT STATURE

Growth Hormone Deficiency (GHD)
短线身材

**GH Deficiency (GHD)**

**Signs & Symptoms**

- Neonatal - normal size / hypoglycemia / jaundice / micropenis / midline defect
- Decreased growth velocity
- Delayed dentition / mid-facial hypoplasia
- Increase in adiposity
SHORT STATURE

GH Deficiency (GHD) Causes

- Tumor - craniopharyngioma
- Trauma - surgery / irradiation
- Idiopathic
- Congenital Aplasia / Hypoplasia / Septic-optic dypslasia
- Genetic Defects -
  - Isolated Growth Hormone Deficiency (IGHD)
  - PROP1 / POU1F1 (Pit1)
Criteria for diagnosing GH deficiency

- Clinical (NOT laboratory) diagnosis
  - GV < 2 SD
  - Low IGF-1 & IGFBP-3
  - Provocative GH Level < 7-10 ng/ml

Corroborative evidence

- Delayed BA
- Related pathology
Spontaneous pulsatility of GH precludes random measurement

- Provocative test after overnight fast
  - Insulin induced hypoglycemia is the “Gold standard”

**IGF-1 / IGFBP3**
- Altered by nutritional status
- Normal range related to age & pubertal status
Growth hormone deficiency
Turner syndrome
Renal disease, before transplant
Small for gestational age
Prader-Willi syndrome
Idiopathic short stature
SHORT STATURE

Treatment
GH Replacement Therapy

s/c injection
7 days/wk

Side Effects
- Secondary/tertiary hypothyroidism
- Worsening of scoliosis
- Slipped capital femoral epiphysis
- Pseudotumor cerebri

Monitor
GV, Free T4, IGF-1, IGFBP3
8½ yr old girl
h/o poor growth x 12-18 months
recent h/o vague headaches
school performance has recently deteriorated
recent episodes of enuresis

Prepubertal
GV = 1.5 cm/yr
Low Free T₄, Normal TSH
Low IGF-1 & IGFBP3
Karyotype = 46 XX
Bone age = 6 yrs

MRI
cranioopharyngioma

Source: Undetermined
8½ yr old girl
h/o poor growth x 12-18 months
h/o vague abdominal discomfort

Prepubertal
GV = 2.5 cm/yr
Normal Free T4 & TSH
Low IGF-1
Normal IGFBP3
Karyotype = 46 XX
Bone age = 7.5 yrs

Decreased serum albumin, microcytic anemia
ESR - 30

Tissue transglutaminase antibodies +ve
Small Intestine Biopsy - CELIAC DISEASE

Source: Undetermined
5 yr old girl

GV = 3.0 cm/yr

subtle dysmorphic features - clinodactyly,
webbing of neck ±, t carrying angle

GV = 3.0 cm/yr
Normal Free T₄ & TSH
Normal IGF-1
Normal IGFBP3
Bone age = 5.0 yrs

Karyotype = 45,X

TURNER SYNDROME

Source: Undetermined
Turner Syndrome
Described in 1938 by Dr. Henry Turner

Most common sex chromosomal abnormality in females -- X chromosome

Frequency 1:1500 to 1:2500 in live born infant girls

15% of spontaneous abortions = TS
Turner Syndrome

Karyotype 45, X

Image of Turner Syndrome
Karyotype removed
Turner Syndrome

Clinical Features - Postnatal

- Growth Failure 80-100%
- Gonadal Dysgenesis 80-100%
- Inverted/widеспaced nipples 60%
- Nail dysplasia 60-80%
- High narrow palate 60-80%
- Cardiac malformation 40-60%
- Renal dysplasia 40-60%
- Low hairline/webbing 30-40%
- Pigmented nevi common
Turner Syndrome

CC BY 2.0
BY: Johannes Nielsen, et al.
Lymphedema at birth is highly correlated with 45,X karyotype and congenital heart abn.
Growth velocity (and NOT height) is the key anthropometric parameter.
Normal growth velocity virtually excludes a pathological cause for short stature.
Always exclude Turner’s synd in a girl with short stature.
Diagnosis of a child with growth problems is made more on CLINICAL and less on laboratory criteria.