Identification of Novel Genetic Loci Associated with Thyroid Peroxidase Antibodies and Clinical Thyroid Disease


¹Department of Internal Medicine, Erasmus Medical Center Rotterdam, Rotterdam, The Netherlands, ²Istituto di Ricerca Genetica e Biomedica (IRGB), Consiglio Nazionale delle Ricerche, c/o Cittadella Universitaria di Monserrato, Monserrato, Cagliari, Italy, ³Division of Genetics and Cell Biology, San Raffaele Scientific Institute, Milan, Italy, ⁴Interfaculty Institute for Genetics and Functional Genomics, University Medicine and Ernst-Moritz-Arndt-University Greifswald, Greifswald, Germany, ⁵Department of Endocrinology and Diabetes, Sir Charles Gairdner Hospital, Nedlands, Western Australia, Australia, ⁶Division of Cardiovascular Health Research Unit, Departments of Medicine, Epidemiology and Health Services, University of Washington, Seattle, Washington, United States of America, ⁷Institute for Genetic Epidemiology, Helmholtz Zentrum München, Munich/Neuherberg, Germany, ⁸Department of Endocrinology and Internal Medicine, University Hospital Ghent and Faculty of Medicine, Ghent University, Ghent, Belgium, ⁹Department for Health Evidence, Radboud University Medical Centre, Nijmegen, The Netherlands, ¹⁰Institute of Clinical Chemistry and Laboratory Medicine, University Medicine Greifswald, Greifswald, Germany, ¹¹Department of Respiratory Medicine, Sir Charles Gairdner Hospital, Nedlands, Western Australia, Australia, ¹²Institute of Laboratory Medicine, Clinical Chemistry and Molecular Diagnostics, University Hospital Leipzig, Leipzig, Germany, ¹³Institute of Medical Epidemiology, Biostatistics, and Informatics, Martin-Luther-University Halle-Wittenberg, Halle, Germany, ¹⁴Comprehensive Cancer Center, Ohio State University, Columbus, Ohio, United States of America, ¹⁵Department of Epidemiology, Erasmus Medical Center Rotterdam, Rotterdam, The Netherlands, ¹⁶Departments of Medicine, Human Genetics, Epidemiology and Biostatistics, Lady Davis Institute, McGill University, Montreal, Canada, ¹⁷Institute of Twin Research and Genetic Epidemiology, King’s College London, London, United Kingdom, ¹⁸University Hospital Stralsund, Greifswald, Germany, ¹⁹Pathwest Laboratory Medicine WA, Nedlands, Western Australia, Australia, ²₀Research Unit of Molecular Epidemiology Helmholtz Zentrum München - German Research Center for Environmental Health, Neuenberg, Germany, ²¹School of Medicine and Pharmacology, the University of Michigan, Ann Arbor, Michigan, United States of America, ²²Department of Chronic Disease Prevention, National Institute for Health and Welfare, Helsinki, Finland, ²³Vaasa Health Care Centre, Diabetes Unit, Vaasa, Finland, ²⁴Department of Respiratory Medicine, Sir Charles Gairdner Hospital, Nedlands, Western Australia,
Australia, 42 Institute for Molecular Medicine Finland (FIMM), University of Helsinki, Helsinki, Finland, 43 Institute of Human Genetics, Helmholtz Zentrum Munich, Munich, Germany, 44 Institute of Human Genetics, Technische Universität München, Munich, Germany, 45 Department of Cardiology and Internal Medicine, University Hospital Ghent and Faculty of Medicine, Ghent University, Ghent, Belgium, 46 Wellcome Trust Sanger Institute, Wellcome Trust Genome Campus, Cambridge, United Kingdom, 47 Department of Medical Genetics, University of Helsinki and University Central Hospital, Helsinki, Finland, 48 Diagnostica Stago, Doncaster, Victoria, Australia, 49 Institute for Translational Genomics and Population Sciences, Los Angeles Biomedical Research Institute, Torrance, California, United States of America, 50 Department of Pediatrics, Harbor-UCLA Medical Center, Torrance, United States of America, 51 Institute for Community Medicine, University Medicine Greifswald, Greifswald, Germany, 52 Department of Twin Research and Genetic Epidemiology, King’s College London, London, United Kingdom, 53 School of Clinical and Experimental Medicine, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham, United Kingdom, 54 Diabetes, Endocrinology and Vascular Health Centre, Royal Devon and Exeter NHS Foundation Trust, Exeter, United Kingdom, 55 BIOMIB Lab. for Bioinformatics and Computational Genomics, Dept. of Mathematical Modelling, Statistics and Bioinformatics. Faculty of Bioscience Engineering, Ghent University, Ghent, Belgium, 56 Faculty of Health Science, University of Copenhagen, Copenhagen, Denmark, 57 Department of General Practice and Primary Health Care, University of Helsinki, Helsinki, Finland, 58 Helsinki University Central Hospital, Unit of General Practice, Helsinki, Finland, 59 Folkhalsan Research Centre, Helsinki, Finland, 60 Vasa Central Hospital, Vasa, Finland, 61 Curtin Health Innovation Research Institute, Curtin University of Technology, Bentley, Western Australia, Australia, 62 Institute of Epidemiology I, Helmholtz Zentrum Munich, Munich, Germany, 63 Group Health Research Institute, Group Health Cooperative, Seattle, Washington, United States of America, 64 Department of Internal Medicine, Diabetes & Endocrinology Unit, San Raffaele Scientific Institute and Vita-Salute San Raffaele University, Milan, Italy, 65 Laboratory of Genetics, National Institute on Aging, Baltimore, Maryland, United States of America, 66 Institute for Maternal and Child Health - IRCCS “Burlo Garofolo”, Trieste, Italy, 67 University of Trieste, Trieste, Italy, 68 Biopharmacy, Department of Pharmaceutical Sciences, University Basel, Basel, Switzerland, 69 Netherlands Consortium for Healthy Aging, Netherlands Genomics Initiative, Leiden, The Netherlands, 70 Department of Internal Medicine, VU Medical Center, Amsterdam, The Netherlands, 71 Division of Endocrinology, Diabetes, and Metabolism, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, Pennsylvania, United States of America, 72 Institute of Molecular Genetics-CNR, Pavia, Italy

Abstract

Autoimmune thyroid diseases (AITD) are common, affecting 2-5% of the general population. Individuals with positive thyroid peroxidase antibodies (TPOAbs) have an increased risk of autoimmune hypothyroidism (Hashimoto’s thyroiditis), as well as autoimmune hyperthyroidism (Graves’ disease). As the possible causative genes of TPOAbs and AITD remain largely unknown, we performed GWAS meta-analyses in 18,297 individuals for TPOAb-positivity (1769 TPOAb-positives and 16,528 TPOAb-negatives) and in 12,353 individuals for TPOAb serum levels, with replication in 8,990 individuals. Significant associations ($P<5 \times 10^{-8}$) were detected at TPO-rs11675434, ATXN2-rs6533178, and BACH2-rs10944479 for TPOAb-positivity, and at TPO-rs11675434, MAG3-rs1230666, and KALRN-rs2100999 for TPOAb levels. Individual and combined effects (genetic risk scores) of these variants on (subclinical) hypo- and hyperthyroidism, goiter and thyroid cancer were studied. Individuals with a high genetic risk score had, besides an increased risk of TPOAb-positivity ($OR: 2.18$, $95\% CI 1.68–2.81$, $P = 8.1 \times 10^{-10}$), a higher risk of increased thyroid-stimulating hormone levels ($OR: 1.51$, $95\% CI 1.26–1.82$, $P = 2.9 \times 10^{-7}$), as well as a decreased risk of goiter ($OR: 0.77$, $95\% CI 0.66–0.89$, $P = 6.5 \times 10^{-7}$). The MAG3 and BACH2 variants were associated with an increased risk of hyperthyroidism, which was replicated in an independent cohort of patients with Graves’ disease ($OR: 1.37$, $95\% CI 1.22–1.54$, $P = 1.2 \times 10^{-7}$ and OR: $1.25$, $95\% CI 1.12–1.39$, $P = 6.2 \times 10^{-5}$). The MAG3 variant was also associated with an increased risk of hypothyroidism ($OR: 1.57$, $95\% CI 1.18–2.10$, $P = 1.9 \times 10^{-4}$). This first GWAS meta-analysis for TPOAbs identified five newly associated loci, three of which were also associated with clinical thyroid disease. With these markers we identified a large subgroup in the general population with a substantially increased risk of TPOAbs. The results provide insight into why individuals with thyroid autoimmunity do or do not eventually develop thyroid disease, and these markers may therefore predict which TPOAbs-positives are particularly at risk of developing clinical thyroid dysfunction.


Editor: Chris Cotsapas, Yale School of Medicine, United States of America

Received August 22, 2013; Accepted December 3, 2013; Published February 27, 2014

This is an open-access article, free of all copyright, and may be freely reproduced, distributed, transmitted, modified, built upon, or otherwise used by anyone for any lawful purpose. The work is made available under the Creative Commons CC0 public domain dedication.

Funding: The Asklepios Study was supported by a Fonds voor Wetenschappelijk Onderzoek-Vlaanderen FWO research grant G.0427.03 and G.0838.10N (Asklepios Study). The 1994-5 Busselton Health Survey was funded by Healthway, Western Australia. The Busseton Health Studies are supported by the National Health and Medical Research Council of Australia and the Great Wine Estates Auctions. The CHS research reported in this article was supported by NHLBI contracts HHSN268201200036C, N01HC85239, N01HC85222, N01HC85079, N01HC85080, N01HC85081, N01HC85082, N01HC85083, N01HC85086; and NHLBI grants HL80295, HL87652, HL105756 with additional contribution from the National Institute of Neurological Disorders and Stroke (NINDS). Additional support was provided through AG03629 from the National Institute on Aging (NIA), DNA handling and genotyping at Cedars-Sinai Medical Center was supported in part by the National Center for Research Resources, grant UL1RR033176, and is now at the National Center for Advancing Translational Sciences, CTSA grant UL1TR000124; in addition to the National Institute of Diabetes and Digestive and Kidney disease grant DK063491 to the Southern California Diabetes Endocrinology Research Core. Additional funding was provided by the Cedars-Sinai Board of Governors’ Chair in Medical Genetics (JIR). The CARLA Study was founded by a grant from the Forschungsgemeinschaft als part of the Collaborative Research Center 598 “Heart failure in the elderly - cellular mechanisms and therapy” at the Medical Faculty of the Martin-Luther-University Halle-Wittenberg, by a grant of the Wilhelm-Roux Programme of the Martin-Luther-University Halle-Wittenberg; by the Ministry of Education and Cultural Affairs of Saxony-Anhalt; and by the Federal Employment Office. The Exeter Family Study of Childhood Health (EFSOCH) was supported by South West NHS Research and Development, Exeter NHS Research and Development, the Darlington Trust, and the Peninsula NHIR Clinical Research Facility at the University of Exeter. Genotyping of EFSOCH DNA samples was supported by the Endocrine Research Fund. ATH and BMS are employed as core members of the Peninsula NIHR Clinical Research Facility. RMF is funded by a Sir Henry Wellcome Postdoctoral Fellowship (Wellcome Trust grant: 085412/ Z. The Health2006 Study is funded by grants from The Velux Foundation; The Danish Medical Research Council, Danish Agency for Science, Technology and Innovation; The Aase and Ejner Danielsen Foundation; ALK-Abelló A/S (Harsholm, Denmark), Timber Merchant Vilhelm Bangs Foundation, MEXOS Laboratories (Denmark), The Danish Health Insurance Foundation, and Research Centre for Prevention and Health, the Capital Region of Denmark, Helsinki Birth Cohort Study has been supported by grants from the Academy of Finland, the Finnish Diabetes Research Society, Finnish Society for Cardiovascular Research, Fokhålsan Research Foundation, Novo Nordisk Foundation, Finska Läkaeässäskapet, Signe and Ane Gyllenberg Foundation, University of Helsinki, European Science Foundation (EUROSTRESS), Ministry of Education, Athokas Foundation, Emil Aaltonen Foundation, Juho Vainio Foundation, and Welcome Trust (grant number WT089062). This work was supported by KORA, which is a research platform initiated and financed by the Helmholtz Center Munich, German Research Center for
Environmental Health, by the German Federal Ministry of Education and Research and by the State of Bavaria. The work of KORA is supported by the German Federal Ministry of Education and Research (BMBF), in the context of the German National Genome Research Network (NGFN-2 and NGFN-plus). The present research was supported within the Munich Center of Health Sciences (MC Health) as part of LMUinnovativ.

Thyroid autoimmunity develops clinical thyroid disease [27,28]. It is not known why not all individuals with TPOAbs, nor is it known why not all individuals with TPOAb-positive persons also have an increased risk of developing autoimmune hyperthyroidism (Graves' disease) [18,30,31]. Furthermore, different pathophysiological processes may be involved in the initiation and severity of the autoimmune response. We therefore performed a GWAS meta-analysis of TPOAbs in the general population in 18,297 individuals from 11 populations. Newly identified genetic variants were studied in relation to subclinical and overt hypo- and hyperthyroidism, goiter, thyroid autoimmunity during pregnancy and thyroid cancer risk.

Results

Characteristics of the studied populations are shown in Table 1 and the Supplementary Material S1. Heritability estimates in the family-based cohorts SardiNIA, TwinsUK and Val Borbera were, respectively, 0.65, 0.66, and 0.54 for TPOAb-positivity, and 0.43, 0.66, and 0.30 for TPOAb levels.

Loci associated with TPOAb-positivity and TPOAb levels

See Table 1 and Supplementary Figure S1 for TPOAb measurements and Supplementary Table S1 for genotyping procedures. In most autoimmune diseases, both the presence and the level of autoantibodies are relevant for the disease onset [18,30,31]. Furthermore, different pathophysiological processes may be involved in the initiation and severity of the autoimmune response. We therefore performed a GWAS on TPOAb-positivity (including 1769 TPOAb-positives and 16,528 TPOAb–negatives), as well as a GWAS on continuous TPOAb levels (including 12,353 individuals) in stage 1. See Supplementary Figures S2 and S3 for QQ (quantile-quantile) and Manhattan plots.

In stage 2, we followed-up 20 stage 1 SNPs (P<5×10^{-6}; 13 TPOAb-positivity and 10 TPOAb level SNPs, with 3 SNPs overlapping) in 5 populations, including up to 8,990 individuals for TPOAb-positivity (922 TPOAb-positives and 8068 TPOAb–negatives) and 8,159 individuals for TPOAb level analyses (see Supplementary Material S1). Results of the combined stage 1 and 2

Introduction

Autoimmune thyroid disease (AITD), including Hashimoto’s thyroiditis and Graves’ disease, is one of the most common autoimmune diseases, affecting 2–5% of the general population [1,2,3]. Thyroid dysfunction has been associated with osteoporosis, depression, atrial fibrillation, heart failure, metabolic syndrome, and mortality [4,5,6,7,3,9,10,11]. High serum antibodies against the enzyme thyroid peroxidase (TPO), which is located in the thyroid and plays a key role in thyroid hormone synthesis, are present in 90% of patients with Hashimoto’s thyroiditis [12,13], the most frequent cause of hypothyroidism and goiter. Although TPO antibodies (TPOAbs) are a useful clinical marker for the detection of early AITD, it remains controversial if these antibodies play a causative role in the pathogenesis of Hashimoto’s thyroiditis [14,15,16].

Interestingly, TPOAb-positive persons also have an increased risk of developing autoimmune hyperthyroidism (Graves’ disease) [17,18], which is caused by stimulating antibodies against the thyroid stimulating hormone (TSH) receptor [19]. Numerous studies have shown that Graves’ hyperthyroidism and Hashimoto’s thyroiditis show co-inheritance [17,20,21]. Finally, thyroid autoimmunity is the most common autoimmune disorder in women of childbearing age, and TPOAb-positive women have an increased risk of developing pregnancy complications such as miscarriage and pre-term delivery [17,18,22,23,24,25,26].

The prevalence of TPOAb-positivity in the general population ranges from 5–24%, but it is currently unknown why these people develop TPOAbs, nor is it known why not all individuals with thyroid autoimmunity develop clinical thyroid disease [27,28]. It is estimated that around 70% of the susceptibility to develop thyroid autoantibodies is due to genetic factors [29]. In this context it is remarkable to note that little is known about the genetic factors that determine TPOAb-positivity and the risk of AITD.
**Novel Thyroid Antibody and Disease Loci**

Individuals with thyroid peroxidase antibodies (TPOAbs) have an increased risk of autoimmune thyroid diseases (AITD), which are common in the general population and associated with increased cardiovascular, metabolic and psychiatric morbidity and mortality. As the causative genes of TPOAbs and AITD remain largely unknown, we performed a genome-wide scan for TPOAbs in 18,297 individuals, with replication in 8,990 individuals. Significant associations were detected with variants at TPO, ATXN2, BACH2, MAGI3, and KALRN. Individuals carrying multiple risk variants also had a higher risk of increased thyroid-stimulating hormone levels (including subclinical and overt hyperthyroidism), and a decreased risk of goiter. The MAGI3 and BACH2 variants were associated with an increased risk of hyperthyroidism, and the MAGI3 variant was also associated with an increased risk of hypothyroidism. This first genome-wide scan for TPOAbs identified five newly associated loci, three of which were also associated with clinical thyroid disease. With these markers we identified a large subgroup in the general population with a substantially increased risk of TPOAbs. These results provide insight into why individuals with thyroid autoimmunity do or do not eventually develop thyroid disease, and these markers may therefore predict which individuals are particularly at risk of developing clinical thyroid dysfunction.

**Associations with thyroid disease in independent populations**

**a) Graves’ disease.** As MAGI3 - rs1230666 and BACH2- rs10944479 showed promising associations (i.e., P≤0.05) with hyperthyroidism in our meta-analyses, we tested these SNPs in an independent population of 2478 patients with Graves’ disease and 2682 controls (see Supplementary Material for further details). Both were associated with an increased risk of Graves’ disease (MAGI3- rs1230666: OR, 1.37 [95% CI, 1.22–1.54]; BACH2- rs10944479: OR, 1.25 [1.12–1.39]; P=6.2 × 10⁻⁷).

**b) Thyroid cancer.** Supplementary Table S6 shows the associations of the 5 GWAS significant SNPs with thyroid cancer. No statistically significant associations were detected, but a borderline significant signal with an increased risk of thyroid cancer was observed at ATXN2- rs653178 (OR, 1.32 [95% CI, 1.02–1.70], P=0.03).

**Pathway analyses**

Ingenuity Pathway Analyses (IPA; Ingenuity Systems, Ca, USA) and GRAIL analyses [32] were performed to identify potential pathways involved in AITD, the results of which are shown in Supplementary Tables S7 and S8, and Figure S6. The identified top pathways involved cell death, survival, movement, and OX40 signalling.

**Discussion**

This is the first GWAS meta-analysis investigating the genetics of TPOAbs in the normal population in up to 18,297 individuals from 11 populations with replication in up to 8,990 individuals from 5 populations. We identified 5 GWAS significant loci associated with TPOAb-positivity and/or levels.

The most significant hit for both TPOAb-positivity and TPOAb levels was located near the TPO gene itself. TPO is a membrane-bound protein located on the apical membranes of the thyroid follicular cell, catalyzing key reactions in thyroid hormone synthesis [33]. Mutations in TPO have been found in patients with congenital hypothyroidism [34,35]. Although TPOAbs are increased TSH levels as well as overt hyperthyroidism (P=0.011 and P=0.012), and at the KALRN-rs2100099 SNP with a lower risk of decreased TSH levels (P=0.010).

Furthermore, a higher genetic risk score was associated with a higher risk of increased TSH levels (Supplementary Table S5). No effects of the genetic risk score on the risk of overt hyperthyroidism, hyperthyroidism or decreased TSH levels were observed.

**Associations with goiter**

Individuals with a high genetic risk score had a 30.4% risk of sonographically-proven goiter, compared to 35.2% in subjects with a low score (P=6.5 × 10⁻⁷) (Table 5). None of the individual SNPs was significantly associated with goiter risk.
## Table 1. Population characteristics and serum TPOAb, TSH, and FT4 level measurements specifications.

<table>
<thead>
<tr>
<th>Study</th>
<th>Ethnic group (origin)</th>
<th>N with TPOAb and GWAS data</th>
<th>N using thyroid medication</th>
<th>N case-control approach (cases/controls)</th>
<th>N continuous approach</th>
<th>Men (%)</th>
<th>Age (yrs) Mean (SD)</th>
<th>TPOAb-positivity (%)</th>
<th>TPOAb-positivity cut off</th>
<th>Assay (Detection range)</th>
<th>TSH Median (IQR)</th>
<th>Assay (normal range)</th>
<th>FT4 Mean (SD)</th>
<th>Assay (normal range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHS</td>
<td>Caucasian (Australia)</td>
<td>1363</td>
<td>47</td>
<td>1316 (197/1119)</td>
<td>1316</td>
<td>43%</td>
<td>53.0 (17.2)</td>
<td>15.0%</td>
<td>0.9 (0.9-1.9) mU/L</td>
<td>Immulite 2000 chemiluminescent immunoassay (5-5000)</td>
<td>1.3 (0.9-1.9) mU/L</td>
<td>Immulite 2000 chemiluminescent immunoassay (0.4 - 4.0 mU/L)</td>
<td>16.9 (2.5) pmol/L</td>
<td>Immulite 2000 chemiluminescent immunoassay (9 – 23 pmol/L)</td>
</tr>
<tr>
<td>CHS</td>
<td>Caucasian (USA)</td>
<td>2024</td>
<td>0</td>
<td>2024 (281/1743)</td>
<td>1817</td>
<td>41%</td>
<td>74.8 (5.1)</td>
<td>13.9%</td>
<td>1.5 (3.5) mU/L</td>
<td>Chemiluminescent immunoassay (5-600)</td>
<td>2.3 (1.5-3.5) mU/L</td>
<td>Chemiluminescent immunoassay (0.27-4.2 mU/L)</td>
<td>1.2 (0.2) ng/dL</td>
<td>Chemiluminescent immunoassay (0.93-1.7 ng/dL)</td>
</tr>
<tr>
<td>HBCS</td>
<td>Caucasian (Finland)</td>
<td>526</td>
<td>29</td>
<td>497 (75/422)</td>
<td>497</td>
<td>50%</td>
<td>61.0 (2.8)</td>
<td>15.1%</td>
<td>0.6 (0.4-2.4) mU/L</td>
<td>Chemiluminescent immunoassay (0-1000)</td>
<td>2.0 (1.2-2.4) mU/L</td>
<td>Chemiluminescent immunoassay (0.49-4.67 mU/L)</td>
<td>14.1 (1.6) ng/dL</td>
<td>Chemiluminescent immunoassay (0.71–1.85 ng/dL)</td>
</tr>
<tr>
<td>KORA</td>
<td>Caucasian (Germany)</td>
<td>1765</td>
<td>49</td>
<td>1475 (74/1401)</td>
<td>1475</td>
<td>45%</td>
<td>60.5 (8.9)</td>
<td>5.0%</td>
<td>0.6 (0.6-2.5) mU/L</td>
<td>Chemiluminescent immunoassay (1-3000)</td>
<td>1.5 (0.6-2.5) mU/L</td>
<td>Chemiluminescent immunoassay (0.4-4.3 mU/L)</td>
<td>19.8 (2.6) pmol/L</td>
<td>Chemiluminescent immunoassay (11–25 pmol/L)</td>
</tr>
<tr>
<td>NBS</td>
<td>Caucasian (Netherlands)</td>
<td>1829</td>
<td>26</td>
<td>1829 (287/1542)</td>
<td>1829</td>
<td>50%</td>
<td>61.5 (10.3)</td>
<td>15.7%</td>
<td>0.9 (0.9-2.0) mU/L</td>
<td>Fluoro-immunometric assay (2.6-10000)</td>
<td>1.3 (0.9-2.0) mU/L</td>
<td>Immuno-luminometric assay (0.4-4.0 mU/L)</td>
<td>13.5 (2.4) pmol/L</td>
<td>Chemiluminescent immunoassay (8.0–22.0 pmol/L)</td>
</tr>
<tr>
<td>RS</td>
<td>Caucasian (Netherlands)</td>
<td>1627</td>
<td>50</td>
<td>1577 (137/1440)</td>
<td>710</td>
<td>40%</td>
<td>70.2 (5.6)</td>
<td>8.7%</td>
<td>0.6 (0.6-2.5) mU/L</td>
<td>Chemiluminescent immunoassay (5-5000)</td>
<td>1.2 (0.6-2.5) mU/L</td>
<td>Chemiluminescent immunoassay (0.4-4.3 mU/L)</td>
<td>18.4 (2.4) pmol/L</td>
<td>Chemiluminescent immunoassay (11–25 pmol/L)</td>
</tr>
<tr>
<td>SardiNIA</td>
<td>Caucasian (Italy)</td>
<td>4686</td>
<td>154</td>
<td>972 (108/864)</td>
<td>1257</td>
<td>49%</td>
<td>56.9 (12.5)</td>
<td>11.1%</td>
<td>0.8 (0.2-0.8) mU/L</td>
<td>Chemiluminescent immunoassay (5-1000)</td>
<td>1.3 (0.8-2.0) mU/L</td>
<td>Chemiluminescent immunoassay (0.4-4.0 mU/L)</td>
<td>1.3 (0.2) ng/dL</td>
<td>Chemiluminescent immunoassay (0.3-2.4 ng/dl)</td>
</tr>
<tr>
<td>SHIP</td>
<td>Caucasian (Germany)</td>
<td>4096</td>
<td>293</td>
<td>3803 (265/3538)</td>
<td>1818</td>
<td>52%</td>
<td>49.3 (16.3)</td>
<td>7.0%</td>
<td>0.4 (0.4-1.0) mU/L</td>
<td>Chemiluminescent immunoassay (1-3000)</td>
<td>0.7 (0.4-1.0) mU/L</td>
<td>Chemiluminescent immunoassay (0.3-3.0 mU/L)</td>
<td>12.8 (3.8) pmol/L</td>
<td>Chemiluminescent immunoassay (7.7–23.2 pmol/L)</td>
</tr>
<tr>
<td>SHIP-Trend</td>
<td>Caucasian (Germany)</td>
<td>986</td>
<td>99</td>
<td>887 (36/851)</td>
<td>887</td>
<td>46%</td>
<td>49.5 (13.7)</td>
<td>4.1%</td>
<td>0.8 (0.8-1.6) mU/L</td>
<td>Chemiluminescent immunoassay (1-3000)</td>
<td>1.2 (0.8-1.6) mU/L</td>
<td>Chemiluminescent immunoassay (0.36–3.74 mU/L)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TwinsUK</td>
<td>Caucasian (UK)</td>
<td>2455</td>
<td>86</td>
<td>236 (46/1893)</td>
<td>774</td>
<td>0%</td>
<td>46.9 (12.5)</td>
<td>19.5%</td>
<td>0.9 (0.9-1.8) mU/L</td>
<td>Chemiluminescent immunoassay (0.5-1000)</td>
<td>1.3 (0.9-1.8) mU/L</td>
<td>Chemiluminescent immunoassay (0.4-4.0 mU/L)</td>
<td>13.6 (1.9) pmol/L</td>
<td>Chemiluminescent immunoassay (9-19 pmol/L)</td>
</tr>
<tr>
<td>Valborbera</td>
<td>Caucasian (Italy)</td>
<td>1661</td>
<td>90</td>
<td>1571 (161/1410)</td>
<td>452</td>
<td>46%</td>
<td>54.3 (18.4)</td>
<td>10.2%</td>
<td>0.9 (0.9-2.0) mU/L</td>
<td>Two chemiluminescent immunoassays (5.5-3000 ; 6-7500)</td>
<td>1.4 (0.9-2.0) mU/L</td>
<td>Chemiluminescent immunoassay (0.34–5.60 mU/L)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Study</td>
<td>Ethnic group (origin)</td>
<td>N with TPOAb and GWAS data</td>
<td>N using thyroid medication</td>
<td>N case-control approach (cases/controls)</td>
<td>N continuous approach</td>
<td>Age (yrs) Mean (SD)</td>
<td>TPOAb-positivity cut-off (%)</td>
<td>TPOAb-positivity cut-off (Assay [Detection range])</td>
<td>TSH specifications</td>
<td>TSH Median (IQR)</td>
<td>Assay (normal range)</td>
<td>FT4 specifications</td>
<td>FT4 Mean (SD)</td>
<td>Assay (normal range)</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------</td>
<td>-------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Asklepios</td>
<td>Caucasian (Belgium)</td>
<td>2418</td>
<td>109</td>
<td>2309 (245/2064)</td>
<td>2185</td>
<td>50%</td>
<td>45.9 (5.9)</td>
<td>10.6%</td>
<td>Chemiluminescent immunoassay (5–600)</td>
<td>1.5 (1.1;2.1) mU/L</td>
<td>Chemiluminescent immunoassay (0.3–4.2 mU/L)</td>
<td>1.31 (0.2) ng/dL</td>
<td>Chemiluminescent immunoassay (0.9–1.7 ng/dL)</td>
<td></td>
</tr>
<tr>
<td>CARLA</td>
<td>Caucasian (Germany)</td>
<td>1753</td>
<td>270</td>
<td>1483 (186/1297)</td>
<td>1190</td>
<td>60%</td>
<td>64.2 (10.2)</td>
<td>12.5%</td>
<td>Chemiluminescent immunoassay (5–600)</td>
<td>0.9 (0.6;1.2) mU/L</td>
<td>Chemiluminescent immunoassay (0.4–3.8 mU/L)</td>
<td>16.3 (2.5) pmol/L</td>
<td>Chemiluminescent immunoassay (12.8–20.4 pmol/L)</td>
<td></td>
</tr>
<tr>
<td>EFOSCH</td>
<td>Caucasian (UK)</td>
<td>1289</td>
<td>-</td>
<td>1289 (97/1192)</td>
<td>1233</td>
<td>64%</td>
<td>34.2 (5.9)</td>
<td>7.5%</td>
<td>Chemiluminescent immunoassay (5–600)</td>
<td>1.9 (1.3;2.6) mU/L</td>
<td>Chemiluminescent immunoassay (0.4–4.5 mU/L)</td>
<td>16.0 (2.4) pmol/L</td>
<td>Chemiluminescent immunoassay (11–24 pmol/L)</td>
<td></td>
</tr>
<tr>
<td>Health2006 Study</td>
<td>Caucasian (Danish)</td>
<td>3287</td>
<td>-</td>
<td>3287 (204/3083)</td>
<td>3285</td>
<td>45%</td>
<td>49.3 (13.0)</td>
<td>6.2%</td>
<td>Chemiluminescent immunoassay (1–3000)</td>
<td>1.7 (1.0;2.0) mU/L</td>
<td>Chemiluminescent immunoassay (0.4–3.7 mU/L)</td>
<td>12.4 (1.8) pmol/L</td>
<td>Chemiluminescent immunoassay (9.8–18.8 pmol/L)</td>
<td></td>
</tr>
<tr>
<td>SardiNIA2</td>
<td>Caucasian (Italy)</td>
<td>1387</td>
<td>30</td>
<td>765 (104/661)</td>
<td>375</td>
<td>41%</td>
<td>46.6 (17.4)</td>
<td>13.6%</td>
<td>Chemiluminescent immunoassay (5–1000)</td>
<td>1.6 (1.0;2.2) mU/ml</td>
<td>Chemiluminescent immunoassay (0.4–4.0 mU/L)</td>
<td>1.3 (0.2) ng/dL</td>
<td>Chemiluminescent immunoassay (0.3–2.4 ng/dL)</td>
<td></td>
</tr>
</tbody>
</table>
valid clinical biomarkers ofAITD, they are generally considered to be secondary to the thyroid damage inflicted by T-cells. The FOXE1 gene has been previously associated with hypothyroidism [36,37] and is known to regulate transcription of TPO [38]. In this context it is interesting to note that we did not find any associations of the variant near TPO with hypothyroidism. Most genes that have been associated withAITD (predominantly Graves’ disease) by candidate gene and GWAS studies so far are located in the HLA class I and II regions, or in genes involved in T-cell (i.e., CTLA-4, PTPN22) or other autoimmune responses [28,39]. Until now, the TPO gene itself had not been associated withAITD, except in one recent candidate gene analysis in a small cohort (n = 188) without replication [40]. A variant near TPO (rs11675434), which is in LD with rs11675434 (r2 = 0.97 in HapMap2), has previously been associated withTSH levels by Gudmundsson et al [41]. However, various other GWAS on serum TSH and FT4 levels have not found any significant associations in or near this locus, including a recent smaller sized GWAS by Porcu et al [42].

Three of the four loci identified here are located in or are in linkage disequilibrium (LD) with genes previously associated with other autoimmune diseases. Rs1230666 is located in intron 9 of MAGI3, encoding a protein that modulates activity of AKT/PKB. AKT/PKB is expressed in the thyroid and regulates apoptosis [43], which seems to play an important role in the development ofAITD [44,45]. In addition, rs1230666 is in LD with rs2476601 (r2 = 0.70 in HapMap2), a variant causing a R620W substitution in PTPN22. PTPN22 is a lymphoid-specific intracellular phosphatase involved in the T-cell receptor signaling pathway. Variations in PTPN22, and specifically R620W, are associated with various autoimmune disorders including type 1 diabetes, rheumatoid arthritis, systemic lupus erythematosus and Graves’ disease [46,47,48,49]. The associations of the MAGI3 locus with TPOAb-positivity and Graves’ disease may therefore also be explained by linkage with disease-associated variants in PTPN22 [50]. Of note, the association signal at rs2476601 is one order weaker than that of the top variant rs1230666.

The BACH2 locus has been implicated in the susceptibility to several autoimmune diseases, including celiac disease, type 1 diabetes, vitiligo, Crolin’s disease, and multiple sclerosis [46,51,52,53,54]. A recent candidate gene analysis associated the BACH2 locus with an increased risk ofAITD, including Hashimoto’s thyroiditis and Graves’ disease [55]. However, the associations were not significant when Hashimoto’s thyroiditis and Graves’ disease were studied separately. BACH2 is specifically expressed in early stages of B-cell differentiation and represses different immunoglobulin genes [56]. Interestingly, BACH2 can bind to the co-repressor SMRT (silencing mediator of retinoid and thyroid receptor), which may suggest a more direct effect on thyroid hormone secretion and action as well.

Polymorphisms in ATXN2 have been associated with multiple neurodegenerative diseases, including spinocerebellar ataxia and Parkinson’s disease [57,58,59]. Different epidemiological studies have associated thyroid dysfunction with cerebellar ataxia [60,61]. Furthermore, the identified SNP in ATXN2 has been previously associated with renal function, serum urate levels and blood pressure [62,63,64]. However, this SNP is in high LD with rs3184504 (r2 = 0.873), a variant causing a Trp262Arg substitution in SH2B3 that may suggest a function in the immune response or the autoantigen, the thyroid receptor), which may suggest a more direct effect on thyroid hormone secretion and action as well.

Whereas the above four loci are located in genes involved in the immune response or the autoimmune system, the KALRN (Kalirin) gene encodes a multi-domain guanine nucleotide exchange factor for GTP-binding proteins of the Rho family. The relation of KALRN with levels of TPOAbs is unclear. This gene has recently been found to be associated with megakaryopoiesis and platelet formation [67], which may suggest a function in the immune system [68]. We furthermore performed pathway analyses on the stage 1 TPOAb-positivity and TPOAb level lead SNPs, and identified the cell death, survival and movement pathway as an important pathway for TPOAbs. This finding is supported by previous studies, which show an important role for apoptosis in the

### Table 2. Newly identified loci associated with TPOAb-positivity and/or serum TPOAb levels reaching genome wide significance.

<table>
<thead>
<tr>
<th>Alleles</th>
<th>Stage 1 + 2 meta-analysis: up to 2691 cases and 24,596 controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPOAb-positivity</td>
<td>SNP Chr. Position (Build 36) Risk Other RARb Nearby gene OR (95% CI) P value</td>
</tr>
<tr>
<td>rs11675434 2</td>
<td>1386822 T C 0.39 TPO 1.21 (1.15–1.28) 1.5 x 10^-16</td>
</tr>
<tr>
<td>rs653178 12</td>
<td>110492339 C T 0.40 ATXN2 1.14 (1.08–1.19) 9.9 x 10^-10</td>
</tr>
<tr>
<td>rs10944479 6</td>
<td>90937114 A G 0.16 BACH2 1.25 (1.14–1.37) 4.0 x 10^-8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alleles</th>
<th>Stage 1 + 2 meta-analysis: up to 20,512 subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPOAb levels</td>
<td>SNP Chr. Position (Build 36) Risk Other RARb Nearby gene OR (SE) P value</td>
</tr>
<tr>
<td>rs11675434 2</td>
<td>1386822 T C 0.39 TPO 0.0202 (0.0046) 7.4 x 10^-13</td>
</tr>
<tr>
<td>rs1230666 1</td>
<td>113974933 A G 0.16 MAGI3 0.0269 (0.0064) 1.8 x 10^-8</td>
</tr>
<tr>
<td>rs2010099 3</td>
<td>125782947 C T 0.91 KALRN 0.0240 (0.0076) 3.1 x 10^-8</td>
</tr>
</tbody>
</table>

Chr., chromosome

bAdjusted for age and gender

*Expressed in sd of natural logarithm transformed serum TPOAb level, adjusted for age and gender

doi:10.1371/journal.pgen.1004123.t002
development of AITD [44,45]. Another top pathway involved was the OX40 signalling pathway, and it is of interest to note that OX40 is a T-cell activator promoting the survival of CD4+ T-cells at sites of inflammation [69].

Our results have potential clinical relevance for several reasons. Genetic risk scores based on these novel common (risk allele frequencies: 9–40%) TPOAb-associated SNPs enabled us to identify a large subgroup in the general population with a two-fold
increased risk of TPOAb-positivity (10.4% vs 5.4%). These individuals also have a higher risk of increased TSH levels and a lower risk of goiter, suggesting an advanced stage of destruction of the thyroid due to autoimmune processes. Furthermore, pregnant women with high genetic risk scores had a 2.4 times increased risk of TPOAb-positivity during pregnancy. In this context it is interesting to note that TPOAb-positive pregnant women have an increased risk of miscarriages and preterm births independent of thyroid function [70].

Associations with thyroid disease were also found on an individual SNP level. The MAGI3 SNP was associated with a substantially increased risk of hypothyroidism, and the BACH2 SNP showed a borderline significant association ($P = 0.011$) with a higher risk of increased TSH levels, which includes subjects with subclinical and overt hypothyroidism. Furthermore, both loci were significantly associated with an increased risk of Graves’ hyperthyroidism in an independent population. To predict which patients with first or second degree relatives with documented Hashimoto’s or Graves’ disease will develop clinical thyroid disease, a clinical algorithm has been developed (i.e., the THEA score) [18]. Future studies should analyze if these genetic markers increase the sensitivity of the THEA score. Graves’ hyperthyroidism and Hashimoto’s thyroiditis co-segregate in families and subjects with TPOAbs have an increased risk of both diseases [17,18,20,21,22,26]. The current study provides insight into this phenomenon by showing that specific loci associated with TPOAbs and (subclinical) hypothyroidism, i.e. MAGI3 and BACH2, are also associated with Graves’ hyperthyroidism in an independent case-control study.

The prevalence of TPOAb-positivity in the general population is high (5–24%), but it is currently unknown why part of the individuals with thyroid autoimmunity develop clinical thyroid disease whereas others do not [27,28]. In this context it is interesting to note that the TPOAb-associated SNPs located in TPO and ATXN2 were not associated with clinical thyroid disease. This suggests that the TPOAbs in these individuals may be of less clinical relevance, providing insight into why TPOAb-positive individuals do or do not eventually develop clinical thyroid disease.

Our study has some limitations. The validity of the results is restricted to individuals from populations of European ancestry. Future GWASs in populations from non-European descent will be required to determine to which extent our results can be generalized to other ethnic groups. Secondly, we did not perform conditional analyses to further identify secondary association signals within the identified loci, nor did we perform functional studies for the identified variants. Further research is therefore needed to unravel the exact biological mechanism behind the observed associations. The fact that various TPOAbs assays were used across the participating cohorts could lead to bias. We

<p>| Table 3. Genetic risk score and the risk of TPOAb-positivity. |
|-----------------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>GRS Quartile</th>
<th>% TPOAb-positivity</th>
<th>OR (95% CI)*</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (reference)</td>
<td>5.4% (89/1637)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>7.0% (114/1637)</td>
<td>1.29 (0.98–1.69)</td>
<td>0.07</td>
</tr>
<tr>
<td>3</td>
<td>9.0% (152/1695)</td>
<td>1.64 (1.26–2.13)</td>
<td>1.3×10^{-4}</td>
</tr>
<tr>
<td>4</td>
<td>10.4% (158/1523)</td>
<td>2.18 (1.68–2.81)</td>
<td>8.1×10^{-8}</td>
</tr>
</tbody>
</table>

GRS, genetic risk score (based on rs11675434, rs653178, rs10944479, rs1230666, rs2010099).
*Adjusted for age and gender

doi:10.1371/journal.pgen.1004123.t003

<p>| Table 4. Newly identified TPOAb associated loci and the risk of thyroid disease in stage 1 and 2 populations. |
|-----------------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Alleles</th>
<th>Increased TSH (1110 cases/19,189 controls)</th>
<th>Hypothyroidism (173 cases/15,940 controls)</th>
<th>Decreased TSH (967 cases/19,297 controls)</th>
<th>Hyperthyroidism (78 cases/14,901 controls)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNP</td>
<td>Risk</td>
<td>Other</td>
<td>OR (95% CI)*</td>
<td>P value</td>
</tr>
<tr>
<td>TPO rs11675434</td>
<td>T</td>
<td>C</td>
<td>1.08 (0.99–1.18)</td>
<td>0.08</td>
</tr>
<tr>
<td>ATXN2 rs653178</td>
<td>T</td>
<td>C</td>
<td>1.01 (0.96–1.06)</td>
<td>0.68</td>
</tr>
<tr>
<td>BACH2 rs10944479</td>
<td>A</td>
<td>G</td>
<td>1.17 (1.04–1.32)</td>
<td>0.011</td>
</tr>
<tr>
<td>MAGI3 rs1230666</td>
<td>A</td>
<td>G</td>
<td>1.23 (1.09–1.39)</td>
<td>0.010</td>
</tr>
<tr>
<td>KALRN rs2010099</td>
<td>C</td>
<td>T</td>
<td>1.05 (0.90–1.23)</td>
<td>0.52</td>
</tr>
</tbody>
</table>

GRS, genetic risk score (based on rs11675434, rs653178, rs10944479, rs1230666, rs2010099).
*Adjusted for age and gender

doi:10.1371/journal.pgen.1004123.t004

Novel Thyroid Antibody and Disease Loci
Phenotype definitions

Study cohorts

In conclusion, this first GWAS for TPOAbs identified five newly associated loci, three of which were also associated with clinical thyroid disease. Furthermore, we show that carriage of multiple risk alleles is associated with an increased risk of thyroid dysfunction, which underlines the clinical importance of our findings.

In conclusion, this first GWAS for TPOAbs identified five newly associated loci, three of which were also associated with clinical thyroid disease. Furthermore, we show that carriage of multiple risk alleles is associated with an increased risk of thyroid dysfunction, which underlines the clinical importance of our findings.

Materials and Methods

Study cohorts

For the TPOAb GWAS stage 1 and 2 analyses, and the hypothyroidism, hyperthyroidism and goiter analyses, individuals were recruited from 16 independent community-based and family studies. For the Graves’ disease analyses, cases were recruited from the United Kingdom Graves’ disease cohort and controls from the British 1958 Birth Cohort. Thyroid cancer cases and controls were recruited from the Nijmegen and Ohio thyroid cancer cohorts. A detailed description of the original cohorts contributing samples is provided in Table 1 and in the Supplementary Material. All participants provided written informed consent and protocols were approved by the institutional review boards or research ethics committees at the respective institutions, and conducted according to the Declaration of Helsinki.

Phenotype definitions

Table 5. Newly identified TPOAb associated loci, genetic risk scores and the risk of goiter.

<table>
<thead>
<tr>
<th>Nearby gene</th>
<th>SNP</th>
<th>Risk allele</th>
<th>Other allele</th>
<th>OR (95% CI)*</th>
<th>P value</th>
<th>GRS Quartile</th>
<th>% Goiter (N cases/total)</th>
<th>OR (95% CI)*</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPO</td>
<td>rs11675434</td>
<td>T</td>
<td>C</td>
<td>0.95 (0.88–1.02)</td>
<td>0.17</td>
<td>1 (reference)</td>
<td>35.2% (588/1669)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ATXN2</td>
<td>rs653178</td>
<td>C</td>
<td>T</td>
<td>0.95 (0.88–1.03)</td>
<td>0.22</td>
<td>2</td>
<td>33.7% (570/1691)</td>
<td>0.92 (0.79–1.06)</td>
<td>0.21</td>
</tr>
<tr>
<td>BACH2</td>
<td>rs10944479</td>
<td>A</td>
<td>G</td>
<td>0.94 (0.85–1.05)</td>
<td>0.28</td>
<td>3</td>
<td>31.6% (530/1675)</td>
<td>0.84 (0.72–0.98)</td>
<td>0.03</td>
</tr>
<tr>
<td>MAGI3</td>
<td>rs1230666</td>
<td>A</td>
<td>G</td>
<td>0.90 (0.81–1.00)</td>
<td>0.05</td>
<td>4</td>
<td>30.4% (517/1702)</td>
<td>0.77 (0.66–0.89)</td>
<td>6.5×10&lt;br&gt;^-4</td>
</tr>
<tr>
<td>KALRN</td>
<td>rs2010099</td>
<td>C</td>
<td>T</td>
<td>0.93 (0.81–1.05)</td>
<td>0.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GRS, genetic risk score (based on rs11675434, rs653178, rs10944479, rs1230666, rs2010099).

Adjusted for age, gender, and body surface area.

ATXN2=rs653178 is in high LD with SN283-rs2184504.

MAGI3=rs1230666 is in high LD with PTEN22-rs24756601.

doi:10.1371/journal.pgen.1004123.t005

Therefore used TPOAb-positivity cut-off values as provided by the respective assay manufacturer, instead of using one fixed cut-off value. This is also of clinical importance as in clinical practice most institutions rely on the TPOAb-positivity cut-off as provided by the assay manufacturer. Furthermore, we did not detect heterogeneity in our results, supporting the fact that results obtained with different assays can be combined across cohorts using the z-score based meta-analysis. Finally, as AITD coincides with other autoimmune diseases, our results could be driven by indirect associations with other autoimmune diseases. However, AITD is the most common autoimmune disease in the general population. We furthermore show that carriage of multiple risk alleles is associated with an increased risk of thyroid dysfunction, which underlines the clinical importance of our findings.

In conclusion, this first GWAS for TPOAbs identified five newly associated loci, three of which were also associated with clinical thyroid disease. Furthermore, we show that carriage of multiple risk variants is not only associated with a substantial increased risk of TPOAb-positivity, but also with a higher risk of increased TSH levels (including subclinical and overt hypothyroidism) and a lower risk of goiter. These genetic markers not only help to identify large groups in the general population with an increased risk of TPOAb-positivity, but may also predict which TPOAb-positive persons are particularly at risk of developing clinical thyroid disease.

Genotyping

Samples were genotyped with a range of GWAS genotyping arrays (Supplementary Table S1). Sample and SNP quality control procedures were undertaken within each study. For each GWAS, over 2.5 million SNPs were imputed using CEU samples from Phase 2 of the International HapMap project (www.hapmap.org). Genotyping procedures in the stage 2, Graves’ disease and thyroid cancer populations are described in the Supplementary Material.

Association analyses

The heritabilities of TPOAb-positivity and serum TPOAb levels were estimated, as described in the Supplementary Material.

In stage 1, we performed a GWAS on TPOAb-positivity as well as a GWAS on continuous TPOAb levels. Persons taking thyroid medication were excluded. Each SNP was tested for association with TPOAb-positivity using logistic regression analyses, adjusting for age and sex. For cohorts with family structure, we approximated the probability of being affected with a linear mixed model adjusting for age and sex. The produced model was used to predict the expected proportion of “risk” (effective) alleles in cases and controls, hence giving the means to estimate odds ratios. Only unrelated individuals were considered for the SardiNIA cohort. For the GWAS of continuous TPOAb levels, samples with a TPOAb level lower than the minimum TPOAb assay detection limit (Table 1) were excluded. TPOAb levels were natural log-transformed, and sex-specific, age adjusted standardized residuals were calculated. Each SNP was tested for association with these TPOAb level residuals using linear regression analyses (additive model), above the assay-specific TPOAb-positivity cut-off, as defined by the manufacturer (Table 1). Serum TSH and free thyroxine (FT4) levels were determined using a range of assays (Table 1). Assay-specific TSH and FT4 reference ranges were used, as provided by the manufacturer (Table 1). Overt hypothyroidism was defined as a high TSH (i.e., a TSH level above the TSH reference range) and a low FT4. Increased TSH was defined as a high TSH, including persons with overt hypothyroidism or subclinical hypothyroidism (i.e., high TSH with a normal FT4). Overt hyperthyroidism was defined as a low TSH and a high FT4. Decreased TSH was defined as a low TSH, including persons with subclinical or overt hyperthyroidism.

The diagnosis of goiter is described in the Supplementary Material, and the diagnosis of Graves’ disease and thyroid cancer in the respective cohorts have been described previously [41].
correcting for relatedness in studies with family structure. See Supplementary Table S1 for the software used for these analyses.

Before meta-analysis, SNPs with a minor allele frequency (MAF) <1% or a low imputation quality were excluded (Supplementary Material). Results from stage 1 and 2 came in a population size weighted z-score based meta-analysis using METAL [71]. Genomic control was applied to individual studies if $\lambda > 1.0$.

In stage 2, we followed-up stage 1 GWAS significant SNPs, as well as promising SNPs not reaching GWAS significance, in an attempt to reach GWAS significant associations by increasing sample size (Supplementary Material). Results from stage 1 and 2 were combined in a population size weighted z-score based meta-analysis using METAL [71]. A z-score based meta-analysis was used to reduce bias that might be induced by different assays. As this method does not provide betas, and we wanted to provide a rough estimate of the actual effect sizes for convenience, we calculated betas using the fixed effects (inverse variance based) meta-analysis method. Heterogeneity was tested, applying bonferroni based $P$-value thresholds of $P = 0.004$ for the TPOAb-positivity analyses and $P = 0.005$ for the TPOAb level analyses.

All studies assessed and, if present, corrected for population stratification using principal-component analysis (PCA) and/or multidimensional-scaling (MDS), with the exception of SardiNIA and ValBorbera where the high isolation substantiates a lack of stratification (Table S1) [72,73]. Lambda values were all $\sim 1$, indicating that population stratification was overall properly accounted for (Table S1). To fully remove residual effects, we applied genomic correction to studies were lambda was $>1$. The final meta-analyses reported a lambda of 1.01 for both the TPOAb-positivity and the TPOAb level GWAS, thus no genomic correction was applied.

The variances explained by the GWAS significant SNPs were calculated. We subsequently studied the individual as well as the combined effects of the GWAS significant SNPs on the risk of clinical thyroid disease, as specified in the Supplementary Material. In short, to study combined effects, a genetic risk score was calculated for every person as the weighted sum of TPOAb risk alleles. The associations between the individual SNPs, genetic risk scores and the risk of abnormal thyroid function tests were studied using logistic regression analyses. Logistic regression analyses were used to study the associations with goiter, Graves’ disease and thyroid cancer (Supplementary Material). The results of each study were combined in a population size weighted z-score based meta-analysis using METAL [71].

Various bioinformatic tools were searched for evidence for functional relevance of the GWAS significant SNPs and pathway analyses were performed on the Stage 1 lead SNPs (see Supplementary Material).

Supporting Information

Figure S1  TPOAb level distributions in persons with detectable TPOAb levels in stage 1 and 2 populations. (PPTX)

Figure S2  Quantile-quantile (QQ) plots for the TPOAb-positivity and TPOAb level stage 1 meta-analyses. (PPTX)

Figure S3  Manhattan plots for stage 1 meta-analyses for TPOAb-positivity (a) and TPOAb levels (b). SNPs are plotted on the x-axis according to their chromosomal position against TPOAb-positivity (a) or TPOAb levels (b) (shown as $–\log_{10} P$ value) on the y-axis. The horizontal grey line indicates the threshold for genome-wide statistical significance ($P < 5 \times 10^{-8}$).

Genome-wide significant associations were observed near TPO (Chr 2p25; $P = 1.5 \times 10^{-12}$), at ATXN2 (Chr 12q24.1; $P = 1.6 \times 10^{-10}$) and near HCP5 (Chr 6p21.3; $P = 4.1 \times 10^{-8}$) for TPOAb-positivity, and near TPO (Chr 2p25; $P = 5.4 \times 10^{-13}$) and at ATXN2 (Chr 12q24.1; $P = 1.1 \times 10^{-8}$) for TPOAb levels. (PPTX)

Figure S4  Regional association plots of stage 1 lead loci for TPOAb-positivity (panels a-m). The y-axis on the left indicates the $–\log_{10} P$ value for the association with TPOAb-positivity. SNPs are plotted on the x-axis according to their chromosomal position. The most significant stage 1 SNP is indicated in purple. The combined stage 1 and 2 result of this SNP is indicated in yellow. The SNPs surrounding the most significant SNP are color-coded to reflect their LD with this SNP. Symbols reflect functional genomic annotation, as indicated in the legend. The blue y-axes on the right of each plot indicate the estimated recombination rates (based on HapMap Phase II); the bottom of each panel shows the respective annotated genes at the locus and their transcriptional direction. Mb, megabases. (PPTX)

Figure S5  Regional association plots of stage 1 lead loci for TPOAb levels (panels a-j). The y-axis on the left indicates the $–\log_{10} P$ value for the association with TPOAb levels. SNPs are plotted on the x-axis according to their chromosomal position. The most significant stage 1 SNP is indicated in purple. The combined stage 1 and 2 result of this SNP is indicated in yellow. The SNPs surrounding the most significant SNP are color-coded to reflect their LD with this SNP. Symbols reflect functional genomic annotation, as indicated in the legend. The blue y-axes on the right of each plot indicate the estimated recombination rates (based on HapMap Phase II); the bottom of each panel shows the respective annotated genes at the locus and their transcriptional direction. Mb, megabases. (PPTX)

Figure S6  GRAIL results for the stage 1 TPOAb-positivity and TPOAb level lead SNPs. GRAIL circle plot of locus connectivity where each locus is plotted in a circle, where significant connections ($P < 0.05$) based on PubMed abstracts are drawn spanning the circle. Analyses were based on the 20 stage 1 TPOAb-positivity and TPOAb level lead SNPs. (PPTX)

Table S1  Study sample genotyping, quality control and association analyses for stage 1 populations. (DOCX)

Table S2  Associations of stage 1 lead SNPs with TPOAb-positivity in stage 1 and 2. (DOCX)

Table S3  Associations of stage 1 lead SNPs with serum TPOAb levels in stage 1 and 2. (DOCX)

Table S4  Stage 1 TPOAb-positivity and TPOAb level meta-analyses results for GWAS significant SNPs reported in previous GWAS on thyroid related phenotypes. (XLSX)

Table S5  Genetic risk score and the risk of increased TSH levels. (DOCX)

Table S6  Newly identified TPOAb associated loci and the risk of thyroid cancer. (DOCX)
Table S7: Top IPA associated canonical pathways for the Stage 1 TPOAb-positivity and TPOAb level lead SNPs.

Table S8: Top IPA associated canonical pathways for the Stage 1 TPOAb-positivity and TPOAb level lead SNPs.

Text S1: Supplementary methods.

Acknowledgments

We thank all study participants, volunteers and study personnel that made this work possible.

The Asklepios study is indebted to Femke van Hoek, Bianca Leytens, and Caroline van Dale, and the residents and general practitioners of Erpe-Mere and Nieuwerkerken for their help in completing the study.

The Busselton Health Study thanks the Busselton Population Medical Research Foundation for approving the study. We thank Siemens Ltd, Australia and New Zealand Healthcare Sector for donating assay reagents.

The Rotterdam Study thanks Pascal Arp, Mila Jhamai, Marin Verkerk, Lizbeth Herrera and Marjolein Peters for their help in creating the GWAS database, and Karol Estrada and Maxim V. Struchalin for their support in creation and analysis of imputed data. The authors are grateful to the study participants, the staff from the Rotterdam Study and the participating general practitioners and pharmacists. We would like to thank Karol Estrada, Dr. Fernando Riva, Dr. Tobias A. Knoch, Anis Aburiziq, Luc V. de Zeeuw, and Rob de Graaf [Erasmus MC Rotterdam, The Netherlands], for their help in creating GRIMP, and BigGRID, MediGRID, and Services@MediGRID/D-Grid for access to their grid computing resources. We would like to thank Symen Ligthart for his help with the IPA and GRIMP pathway analyses.

The SardiNIA study thanks the many individuals who generously participated in this study, Monsignore Piscitell, Bishop of Ogliastra, the mayors and citizens of the Sardinian towns (Lanusei, Ilbono, Arzana, and Elini), and the head of the Public Health Unit ASL4 for their cooperation and teamwork; the team also thanks the physicians, Marco Ortú, Maria Grazia Pilìa, Liana Ferrelli, Francesco Loi, Stefano Angius, nurses Paola Manna, Monica Lac and Anna Cau who carried out participant physical exams, and the recruitment personnel Susanna Murino. We thank Francesco Cucca, PI of the SardiNIA study.

The SHIP study is grateful to the contribution of Florian Ernst, Anja Weichert and Astrid Petermann in generating the SNP data.

The SHIP-Trend study is grateful to Mario Stanke for the opportunity to use his Server Cluster for the SNP imputation as well as to Holger Proksch and Thomas Meitinger (Helmholz Zentrum München) for the genotyping of the SHIP-TREND cohort.

TwinUK thanks the staff from the Genotyping Facilities at the Wellcome Trust Sanger Institute, UK, for sample preparation, quality control, and genotyping; Le Centre National de Génompage, France, for genotyping; Duke University, NC, USA, for genotyping; and the Finnish Institute of Molecular Medicine, Finnish Genome Center, University of Helsinki. We thank the volunteer twins who made available their time.

The United Kingdom (UK) Graves’ disease cohort would like to thank all principle investigators (Amit Allahabadia, Northern General Hospital; Sheffield, UK; Mary Armitage Royal Bournemouth Hospital, Bournemouth, UK; Krishna V. Chatterjee, University of Cambridge, Aldenbrookes Hospital, Cambridge, UK; John H. Lazarus Centre for Endocrine and Diabetes Sciences, Cardiff University, Cardiff, UK; Simon H. Pearce, Institute of Human Genetics, Newcastle University, Newcastle-upon-Tyne, Newcastle, UK and Bijay Vaidya, Royal Devon and Exeter Hospital, Exeter, UK), doctors and nurses for recruitingAITD subjects into the AITD National Collection.

Val Borbera thanks the inhabitants of the Val Borbera for participating in the study, the local administrations and the ASL-Novigére for support and Emanetta Viganò for technical help. We also thank Prof. Clara Camaschella, Prof Federico Caligaris-Cappio and the MDs of the Medicine Dept. of the San Raffaele Hospital for help with clinical data collection.

Author Contributions

Conceived and designed the experiments: MM SJR RAJ RR AA HJG ER JIR HH LC DT Di BV TdM TJ JGE BMP AHo DS HW AdIC TMF AL KR LAK AGU Jpw KS Ewa CMe Mdh TJV TDS Sgw HV AC Dto SS SN RPP. Performed the experiments: MM EP GP AT LC SJR RAJ RR GLR TSP SHV JL MJ S LLNHF RMS Bg CS YA AL TJV SS SN RPP. Analyzed the data: MM EP GP AT SJR RAJ RR GLR TSP SHV JL MJ S LLNHF RMS Bg CS YA AL TJV SS SN RPP.

References


