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Yearly Stepwise Increments of the Growth Hormone Dose Results in a Better Growth Response after Four Years in Girls with Turner Syndrome*

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ABSTRACT
To optimize the growth promoting effect of growth hormone (GH), 65 previously untreated girls with Turner syndrome (TS), chronological age (CA) 2–11 yr, were randomized into 3 dosage regimen groups: A, B, and C, with a daily recombinant-human GH dose during 4 study years of 4-4-4-4, 4-6-6-6, and 4-6-8-8 IU/m² b.s.

The first GH dosage increase in groups B and C resulted in a significantly higher mean height velocity (HV) compared with constant dose group A. During the third year, when the dose was raised again only in group C, mean HV was significantly higher in groups B and C than in group A, and in group C compared with group B. In year 4 only group C mean HV remained significantly higher than group A. The pattern of change in HSDSca (Dutch-Swedish-Danish Turner reference) was identical; however, in year 4 mean HSDSca in group B also remained significantly higher than group A. After 4 yr GH treatment, the following was determined. 1) The mean HSDSca was significantly higher for groups B and C compared with group A, but not significantly different between groups B and C. 2) Although significantly higher compared with estimated values for untreated Dutch girls with TS, bone maturation of the GH treated girls was not significantly different between groups. 3) It was positively related with the degree of bone age (BA) retardation at start of study and negatively with baseline CA. 4) Both the modified Index of Potential Height (mIPHRUS) and a recently developed Turner-specific final height (FH) prediction method (PTS$(H%$), based on regression coefficients for H, CA, and bone age, showed significant increases in mean FH prediction, without significant differences between groups. PTS$(H%$ values were markedly higher than the mIPHRUS values.

Dose dependence could be shown for the area under the curve (AUC) for GH, but HSDSca was not linearly related with AUC. Baseline GH binding protein (BP) levels were in 84% of the cases within the normal age range; the decrease in mean levels after 6 months GH was not significant. Mean insulin-like growth factor I (IGF-I) and IGFBP-3 plasma levels increased significantly, without significant differences between groups. HSDSca during GH was dependent on IGF-I plasma levels at baseline and during the study period, $\beta = 0.002$ and $\beta = 0.004$. Thus, a stepwise GH-doing approach reduced the “waning” effect of the growth response after 4 yr treatment without undue bone maturation. FH prediction was not significantly different between treatment groups. Irrespective of the GH dose used, initiation of GH treatment at a younger age was beneficial after 4 yr GH when expressed as actual cm gained or as gain in FH prediction, but was not statistically significant when expressed as HSDSca over the study period. (J Clin Endocrinol Metab 81: 4013–4021, 1996)

STUNTED growth is an almost invariable hallmark of girls with Turner syndrome (TS). Although these girls are not clearly GH-deficient (GHD) (1–4), GH therapy results in a marked increase of height velocity (HV) (5–7). Studies in GHD patients (8–10) and in TS (5–7, 11–13) have shown that the growth response to GH treatment is dependent on the dose and frequency of administration. Frasier el al. (14) reported in a 1 yr, parallel study in prepubertal GHD children that doubling the GH dose of 30 mU/kg thrice weekly im resulted only in a 1.3-fold increase of the first year HV. Also in TS, daily GH injections were more effective than the same weekly dosage in two or three weekly injections (12). In the past years, the most commonly used GH dosages in TS varied from 2–4 IU/m² body surface/day sc (5–7, 12, 15), where 4 IU/m² is equivalent to 0.045 mg/kg. In studies using GH dosages only, up to 4 IU/m²/day, the growth rate outweighed the accelerated bone maturation (13, 16), and thus.

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final height (FH) prediction improved more than with lower GH doses (5, 7, 12, 15). An earlier GH treatment study of girls with TS in the Netherlands (16) showed a doubling of the HV in the first year of treatment with 4 IU GH/m²/day compared with pretreatment values. However, this increase could not be maintained during the subsequent years of treatment. This so-called “waning” effect has also been reported by others (10, 17). In GHD patients, a similar effect is observed, which can be overcome by a 2- to 3-fold increase of the GH dose (10, 18).

Furthermore, studies in GHD patients have demonstrated the importance of early diagnosis and therapy. GH treatment prevented further loss of stature but could not make up the deficit at diagnosis (19). The previous Dutch studies of Turner syndrome confirmed that the growth response in younger girls was better than in older girls (12, 13, 16). In contrast to the logarithmic relationship between GH dose, given thrice weekly im, and HV in GH children, the effect of GH on insulin-like growth factor (IGF)-I plasma levels has been shown on a linear scale between 0 and 3 IU GH/m²/day in GHD adults (20). In the present study of TS, this concept is extended to the 4–8 IU/m²/day GH range.

To optimize GH treatment in TS, we investigated whether 1) a yearly stepwise increment of the GH dose could maintain or augment the initial increase in HV and thereby improve FH prediction. In addition, we investigated whether 2) treatment from a young age onwards could improve FH prediction. Moreover, in a subgroup of 12 girls the GH-IGF-I axis was studied in detail under GH treatment.

**Subjects and Methods**

**Study group**

Sixty-eight previously untreated girls with TS were enrolled in a 4-yr, multicenter GH dose-response study. The diagnosis was confirmed by lymphocyte chromosomal analysis. Clinical data and karyotype of the girls are listed in Table 1. Inclusion criteria were: a chronological age (CA) between 2 and 11 yr, height below the 50th percentile for Dutch children (21), and a normal thyroid function. Exclusion criteria were: associated endocrine and/or metabolic disorders, growth failure caused by other disorders or emotional deprivation, hydrocephalus, previous use of drugs that could interfere with GH therapy, and Tanner puberty stage of at least B2 (22). No provision was made with regard to the baseline GH stimulation tests.

**Study design**

The girls were randomized into three GH dosing groups with stratification according to CA and height standard deviation score (HSDS<sub>CA</sub>):

A. \[ (n = 23) \] 4 IU/m² body surface (equivalent to 0.045 mg/kg)/day for 4 yr.
B. \[ (n = 23) \] 4 IU/m² in the first year, followed by 6 IU/m²/day during the second through fourth yr.
C. \[ (n = 22) \] 4 IU/m² in the first year, 6 IU/m² in the second year, and 8 IU/m²/day during the third and fourth yr.

Biosynthetic (B)-hGH (Norditropin, Novo Nordisk A/S, Denmark) was given sc at bedtime by means of a pen injection system (Nordject 24). None of the girls received estrogens during the 4-yr study period. Written, informed consent was obtained from the parents or custodians of each child. The study protocol was approved by the Ethics Committee of each participating center.

**Growth evaluation**

Height measurements were determined at baseline and three times per month by one investigator (A.T.) according to the methods of Cameron (23), using a Harpenden stadiometer. Height was expressed as sD-score for CA (HSDS<sub>CA</sub>, HVSDS<sub>CA</sub>) using the Dutch-Swedish-Danish (DSD) Turner data (24) or reference data of normal Dutch (21) girls. The gain in height for untreated girls with TS was estimated from the equations of the DSD Turner data (24), in which the height of an average girl with TS is indicated by her CA. Midparental height (MPH) was adapted for Dutch reference data (21) with the addition of 3 cm for secular trend: MPH = 1/2 × (H<sub>mother</sub> + H<sub>father</sub> - 12) + 3 cm. The degree of obesity was expressed as body mass index (BMI) sD score (25). Bone age (BA) was determined by one investigator (A.T.) according to Tanner & Whitehouse radius, ulna, short-bones (RUS) score (26). Bone maturation (ΔBA/CA) was compared with estimated values from the equations of untreated Dutch Turner girls (27); in these equations the BA of an average girl with TS is indicated by her CA. FH prediction was estimated using the modified Index of Potential Height (mIPHRUS) method (28,29) and a recently developed Turner-specific method (PTSRUS) (29). Both methods comprise Dutch Turner references. Analogous to the Tanner and Whitehouse mark 2 FH prediction method for normal children, the PTS method gives smoothed regression coefficients for H, CA, and BA.

**Biochemical parameters**

At baseline all girls underwent a GH provocation test. Arginine 0.5 g/kg body weight was infused in 30 min. Blood samples were drawn at 15-min intervals from −15 to +60 min and every 30 min during the second hour.

At baseline, 6 months after initiation of GH, and 6 months after each GH dosage increase, a 24-h GH profile was performed in a subgroup of 12 girls of group C. Starting at 0830 in the morning, blood was withdrawn from an indwelling venous catheter with a heparin lock. Blood was collected every 20 min for GH measurement, and at the start a single additional sample was obtained for measurement of IGF-I and IGFBP-3. The girls kept normal diets served at hospital meal times and kept normal activity and sleeping habits. GH was injected before going to bed. At the above study time points blood was collected from all girls for the determination of IGF-I and IGFBP-3.

**Hormone assays**

The RIA measurements of plasma GH, IGF-I, and IGFBP-3 were performed as described previously (30–32). The 95th percentile for peak pubertal levels in a normal female population for IGF-I and IGFBP-3 are
700 μg/L and 5 mg/L, respectively. Plasma GH binding protein (GHBP) was determined by ligand-mediated immuno-functional assay (LIFA) (33, 34). All measurements were performed in the same laboratories.

Statistical analyses

Results are expressed as mean (SD), unless indicated otherwise. Differences between groups were tested by Student’s t-tests or by a oneway ANOVA (followed by the Student-Newman-Keuls test for multiple comparisons between groups at the P = 0.05 level). Differences between points in time were tested by paired Student’s t-tests. The Kruskal-Wallis model (adjusted for dose-increment steps and duration of treatment) was used to test for differences between stimulated maximum GH levels and Tanner breast-stage groups, the Chi-square test for differences between karyotype groups (45,X, and others). Correlations were tested with Pearson’s linear correlation coefficient. For this purpose, IGFI and IGFBP-3 plasma levels were transformed into log-values. To study the relation between growth response variables (the change in HSDSCA, IGFBP-3 plasma levels were transformed into log-values. To study the relation between growth response variables (the change in HSDSCA, HVSDS, bone maturation, or PTSRUS) and growth parameters measured at baseline (CA, BA, BA retardation (= CA-BA), HV, maximal GH peak after stimulation, SD scores for BMI, H, and HV), adjusted for the dose regimen (i.e., group), multiple linear regression (MLR) analyses were used. Statistical procedures were performed using the SPSS/PC+ program version 4.0 (SPSS Inc, Chicago, IL). A repeated measures ANOVA model (adjusted for dose-increment steps and duration of treatment) was used to determine the influence of baseline IGFI levels on those during GH therapy and of IGFI levels (at baseline and during GH therapy) on HSDSCA during GH therapy, using BMPD module 5V. A P value of less than 0.05 was considered significant.

The spontaneous 24-h GH profiles at baseline were analyzed with the Pulsar program developed by Merriam and Wachter and described previously (30). The area under the curve (AUC) was determined after the GH injection at 1600 h using the trapezoidal rule. The total body clearance was calculated from the injected dose divided by the AUC. The time interval from GH injection to maximum GH levels was recorded as T \text{max}. To determine the elimination half-time (t_{1/2}) a linear regression analysis was performed on the GH levels starting from 1 h after T \text{max}.

Results

Clinical data

In each group only one girl dropped out of the study for the following reasons: noncompliance, alleged increase of muscle mass and decline in school performance, and desire to initiate estrogen therapy before the end of the study period. Eight girls changed during the course of the study from Tanner puberty stage B1 to B2, at a median age of 13.2 (range 10.9-15.0) yr. Their distribution among the treatment groups A, B, and C was 2, 4, and 2 girls, and among karyotypes (45, X, and others) 4 and 4 girls, respectively. There were no significant differences between these girls and the girls without signs of endogenous estrogen production with respect to growth response and bone maturation after 4 yr GH therapy within each dose group. The number of adverse events was small, all were mild and transient.

Growth response

Compared with pretreatment, mean HV increased significantly for all three groups from about 6 cm/yr to 10 cm/yr in the first year of GH therapy. Thereafter, a waning of the growth response was observed (Fig. 1). In the second year mean HV in groups B and C on a 50% higher GH dose were significantly higher compared with group A. When subsequently, in group C only, the dose was increased once again, mean HV in groups B and C were both significantly higher than in group A, but in group C also significantly higher compared with group B. In the fourth year of GH treatment only in group C the mean HV remained significantly higher than group A. During the first year of treatment 29% of all girls managed to double their HV.

If the growth response is represented as change in HVSDSCA relative to prestudy values (see Table 1), ∆HVSDSCA in groups B and C was significantly higher than in group A in the second through fourth year of GH therapy. However, in the third and fourth year ∆HVSD in group C was not significantly different from group B.

After the first dose-increment for both groups B and C, the change in HSDSCA from the first year was significantly higher for the combined groups B and C compared with group A (P < 0.0001). The second dose-increment in the third year of treatment, as well as in the combined third and fourth year, resulted in a significantly higher change from year 2 in HSDSCA for group C compared with group B, P values 0.04 and 0.02. The increase in mean HSDSCA was highest in the first year of GH (>1 sds), without a difference between groups (Fig. 2). In the subsequent years of treatment, the change in mean HSDSCA showed the same pattern as that of HV. The mean increment in HSDSCA over 4 yr was significantly higher for groups B and C compared with group A. However, the gain was not significantly different between groups B and C (Table 2). The change in HSDSCA after 4 yr was unrelated to karyotype. When the gain in height was corrected for the estimated gain for untreated girls, the re-
TABLE 2. Mean (SD) change during 4 yr of GH treatment for every treatment regimen

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>ΔHSDS&lt;sub&gt;CA&lt;/sub&gt; (DSD)</td>
<td>2.46 (0.53)</td>
<td>2.91 (0.54)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.07 (0.57)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.004</td>
</tr>
<tr>
<td>height gain (cm)</td>
<td>12.4 (2.8)</td>
<td>15.3 (3.1)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>15.7 (2.5)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.0004</td>
</tr>
<tr>
<td>HVSDS&lt;sub&gt;CA&lt;/sub&gt; (DSD)</td>
<td>1.60 (0.97)</td>
<td>2.43 (1.22)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.62 (0.99)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.007</td>
</tr>
<tr>
<td>ΔBA/ΔCA (y/4y) with GH</td>
<td>5.2 (0.7)</td>
<td>5.4 (0.9)</td>
<td>5.3 (1.0)</td>
<td>NS</td>
</tr>
<tr>
<td>ΔBA/ΔCA (y/4y) untreated</td>
<td>4.0 (0.5)</td>
<td>3.8 (0.6)</td>
<td>3.9 (0.6)</td>
<td>NS</td>
</tr>
<tr>
<td>ΔmIPH&lt;sub&gt;RUS&lt;/sub&gt; (cm)</td>
<td>4.9 (4.8)</td>
<td>6.6 (3.1)</td>
<td>7.1 (4.5)</td>
<td>NS</td>
</tr>
<tr>
<td>ΔPTS&lt;sub&gt;RUS&lt;/sub&gt; (cm)</td>
<td>12.3 (3.8)</td>
<td>14.1 (3.1)</td>
<td>14.7 (3.5)</td>
<td>NS</td>
</tr>
</tbody>
</table>

P, level of significance in a oneway ANOVA; Δ, change during a period of time for a variable; height gain, gain in cm over estimated untreated values; HV, height velocity; S<sub>SD</sub>, standard deviation score; DSD, Dutch-Swedish-Danish Turner references; ΔBA/ΔCA, bone maturation (RUS-score); change in BA during 4 yr of GH treatment; untreated values were estimated using Dutch Turner references; mIPH<sub>RUS</sub>, modified Index of Potential Height; PTS<sub>RUS</sub>, Turner-specific final height prediction using RUS bone age.

* Significantly different from group A.

**GH measurements**

Baseline Arginine-stimulated GH plasma levels ranged from 3–74 mU/L (Table 1). The stimulated GH levels (mU/L) were subdivided in the following level-ranges: less than 10, at least 10 and less than 20, and at least 20, with 9, 28, 31 girls, respectively. These numbers were similarly distributed among the 3 treatment groups. The girls with maximum stimulated GH levels below 20 mU/L did not differ significantly from those with normal stimulated levels (>20 mU/L) in their growth response expressed as the change in HSDS<sub>CA</sub> after 4 yr of GH treatment. Maximum stimulated GH levels were significantly negatively correlated with BMI-sd score at baseline (r = −0.31, P = 0.01). At baseline, the spontaneous and stimulated maximum GH levels in group C were not significantly different and were positively correlated (r = 0.5, P = 0.05).

Table 3 includes some of the calculated variables of the spontaneous 24-h GH profiles of 12 girls of Group C (at baseline). There was no correlation between any of these characteristics and prestudy HSDS<sub>CA</sub>. Furthermore, the characteristics of the 24-h GH profile tests 6 months after each dose-increment are shown. There was a significant, dose-dependent increase of the maximum GH level and the AUC. In contrast, the T<sub>max</sub> the clearance, and the elimination half-life were not significantly different between the 3 GH doses. The latter is indicated by the parallelism between the curves after the maximum has been reached (Fig. 4).

**GH binding protein (GHBP)**

Baseline measurements showed no differences between groups (Table 4), the mean (sd) for all girls being 229.4 (127.1) pmol/L. Compared with girls in a normal population (34), 85% of the study group had GHBP levels within the normal age range, 9 girls (14%) had levels that were above normal, and only 1 girl (1%) had levels below normal. Baseline GHBP levels as well as the change from baseline after 6 months were not significantly different between the girls with stimulated GH levels above or below 20 mU/L. GHBP levels after 6 months treatment did not differ significantly from baseline.
TABLE 3. Median (range) values for characteristics of the 24-h GH profile tests for the 12 girls of Group C at baseline (determined by Pulsar) and 6 months after each dose-increment step (see Methods section)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>4 IU/m²/day</th>
<th>6 IU/m²/day</th>
<th>8 IU/m²/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of peaks</td>
<td>10 (8;13)</td>
<td>6 (27;127)</td>
<td>113 (57;174)&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mean GH (mU/L)</td>
<td>4.3 (1.64;6.78)</td>
<td>63 (195;157)</td>
<td>412 (305;568)&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td>Max GH (mU/L)</td>
<td>28.5 (8;42)</td>
<td>240 (224;680)</td>
<td>3.2 (1.3;6.0)</td>
</tr>
<tr>
<td>Clearance (mL/min)</td>
<td>0.5 (0.2;0.7)</td>
<td>0.6 (0.3;0.7)</td>
<td>0.5 (0.2;0.9)</td>
</tr>
<tr>
<td>AUC (mU/L × 24 h)</td>
<td>9.1 (3.9;180.3)</td>
<td>412 (305;568)&lt;sup&gt;f&lt;/sup&gt;</td>
<td>962 (554;1530)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>T&lt;sub&gt;max&lt;/sub&gt; (hrs)</td>
<td>2.9 (1.3;4.3)</td>
<td>3.2 (1.3;6.0)</td>
<td>3.2 (1.7;5.3)</td>
</tr>
<tr>
<td>T&lt;sub&gt;1/2&lt;/sub&gt; (hrs)</td>
<td>0.5 (0.2;0.7)</td>
<td>0.6 (0.3;0.7)</td>
<td>0.5 (0.2;0.9)</td>
</tr>
</tbody>
</table>

No of peaks, number of peaks; mean GH, overall mean GH plasma concentration; max GH, maximum GH plasma concentration; AUC, area under the time-concentration curve; clearance, total body clearance; T<sub>1/2</sub>, elimination half-time; T<sub>max</sub>, time to peak value. Values in parentheses are high and low.

<sup>a</sup> Significantly greater compared with 4 IU/m²/day at P < 0.05 level.

<sup>b</sup> Significantly greater compared with 6 IU/m²/day at P < 0.05 level.

The ratio of IGF-I and IGFBP-3 levels showed an increase over time, but there were no significant differences between groups. Log-values of IGF-I and IGFBP-3 levels both at baseline and their change after 30 months revealed a significant correlation (r = 0.76, P < 0.0001 and r = 0.25, P = 0.04, respectively).

**Determinants of growth response**

Multiple Linear Regression analyses showed that there were no significant relationships between 1) HVSDS<sub>CA</sub> in the fourth year GH (dependent variable) and pretreatment HVSDS; 2) the change in HSDS<sub>CA</sub> after 4 yr GH (dependent variable) and baseline: CA, BA RUS, BA retardation, HSDS<sub>CA</sub> or Arginine-stimulated maximum GH levels (β = −0.008; P = 0.07); and 3) prestudy HV or HVSDS and baseline IGF-I, or IGFBP-3 levels, or between the IGF-I to IGFBP-3 ratio. However, the 4-year change in HSDS<sub>CA</sub> was significantly, negatively related to baseline IGF-I and IGFBP-3 levels and their ratio (β-values −0.006, −0.32, and −0.015, respectively); even when the baseline IGF-I and IGFBP-3 concentrations were expressed as sd score relative to CA only for the girls with a baseline CA below 10 yr (n = 64). The change in HSDS<sub>CA</sub> after 30 or 48 months GH treatment was also significant, positively related to the change in IGF-I, and IGFBP-3 levels after 30 months of GH treatment, but not to their ratio. The repeated measures model with dose-increment steps and duration of treatment as covariates also showed that the change in HSDS<sub>CA</sub> during GH therapy was dependent on IGF-I plasma levels at baseline and during the study period (β = −0.002 and β 0.0004). The gain in height over estimated untreated values at the end of the study (dependent variable) was significantly negatively correlated (P < 0.0001) with age at start of treatment. The change in PTS<sub>RUS</sub> after 4 yr GH (dependent variable) was significantly negatively related with CA or BA retardation at the start of the study, as well as with bone maturation during the study period. Finally, there was no linear relationship between 1) the change in HSDS<sub>CA</sub> and in the plasma GH AUC at each corresponding point in time; 2) the change in IGF-I or IGFBP-3 plasma levels, or in the IGF-I to IGFBP-3 ratio and the change in AUC at each corresponding point in time; and 3) baseline GHBP levels and baseline CA, HSDS<sub>CA</sub>, HV, stimulated GH1 levels. Only GHBP levels and BMI-SDS at the start of treatment were related (r = 0.45, P = 0.003).
The present study shows that raising the GH dose in subsequent years results in a significant, dose-dependent increase of linear growth expressed as HV or HSDSCA. After 4 yr of GH treatment only the higher dose groups B and C differed significantly from the constant-dose group A, in terms of gain in cm, and expressed as the change in HSDSCA (relative to baseline) and in HSDSCA; however, after 4 yr, group C was no longer different from group B. Although during the course of the study bone maturation proceeded significantly faster than that estimated in untreated girls, there was no significant difference between the treated groups. Bone maturation was negatively related with baseline CA and positively with the degree of BA retardation. The gain in height outweighed the increase in bone maturation, therefore FH prediction improved markedly, the magnitude being dependent on the method used, but not significantly different between groups. Age, BA RUS, BA retardation, or HSDSCA at start of therapy was not related to the change in HSDSCA over 4 yr in this study group aged 2–11 yr. On the other hand, the gain in height over estimated untreated values as well as the change in PTSRUS after 4 yr of GH treatment were negatively related to prepuberty CA, BA RUS, or to the change in bone maturation. A repeated measures model showed that each yearly change in HSDSCA significantly correlated with IGF-I plasma levels.

Discussion

Growth response

Dose-response relationships in GH-deficient patients have been described earlier (20). De Muinck Keizer-Schrama et al. (10) reported in GHD children a significantly higher HVSDS and HSDSCA in 17 transfer patients (previously treated with 12 IU GH/m²/week) on 4 vs. 2 IU GH/m²/day. Preliminary reports in TS indicated that the increase in HV outweighed the increase in bone maturation and therefore FH prediction was more marked and sustained with higher GH dosages (5, 7, 15). However, a comparison with other studies is difficult because of the differences in design and GH dose, entry criteria (e.g. a lower limit for GH provocative testing), age at start of treatment, variables and duration of study reported, and reference populations used. Takano et al. (15) investigated two constant GH dosage regimens in prepubertal girls with TS, 0.5 and 1.0 IU/kg/week (comparable with 2 and 4 IU/m²/day). Dose-dependency was shown by the significantly higher mean change in HVSDS (Japanese references) during the first 4 yr in the highest dose group, in which the dose was similar to group A in the present study, compared with the lower dose group. In the fourth year of treatment HV in the highest dose-group was no longer significantly higher compared with the lower dose-group. The same phenomenon might also develop in our study, since after a prolonged period on fixed doses, only the HV in group C remained significantly higher compared with group A in year 4. Nonetheless, this may already have resulted in a substantial difference in height gain. Since the mean change in HVSDS during the fourth year (see Table 2) was well above zero, the girls still exerted catch-up growth. Only 8 girls showed signs of pubertal development at a median age of 13.2 (range 10.9–15.0) yr. There were no significant differences between this group and the prepubertal girls with respect to growth response and bone maturation after 4 yr GH therapy.

Although FH prediction methods all have their inadequacies, it has been shown in a previous report (29) that the mIPHRUS and PTSRUS methods have the lowest mean error compared with the FH actually reached by girls with TS. Furthermore, FH prediction methods should not be used during growth promoting therapy, since they are based on spontaneous growth. However, since mIPHRUS and PTSRUS both include CA, BA (RUS), and height for the estimation of FH, they reflect the influence of GH on growth as well as bone maturation. In the present study both methods showed significant increases in mean FH prediction after 4 yr of GH therapy, without significant group differences. Only a trend towards higher values could be observed in the higher dose-groups (B and C) for both the actual and estimated (FH prediction) cm gained.

Chaussain et al. (6) performed a study in TS (CA ranged from 5–15 yr) with a GH dose of 0.7 IU/kg/week (about 3 IU/m²/day). If HV after 6, 12, or 24 months had not doubled, this dose was increased by the same amount (to a maximum of 2.1 IU/kg/week). Fourteen of those 24 girls (58%) and 49% of all girls in the present study were unable to double their HV on 4 IU GH/m²/day after 6 months, and 71% not after 1 yr (data not shown). After 3 yr, 12 out of the 22 girls (55%) were on the maximum GH dose. In agreement with the present study, increasing the GH dose did not lead to an
acceleration of bone maturation, and FH prediction was therefore improved.

**GH, IGF-I, and their main binding proteins**

In general, spontaneous as well as stimulated (3, 35, 36) GH levels in prepubertal girls with TS have been reported as being near normal (2, 4, 35, 37-39). Despite differences in the assays used, both spontaneous and stimulated GH plasma levels were comparable with those in prepubertal Dutch TS girls in another study (4). In the present study the maximum GH levels after arginine stimulation were similar between groups, but the range was very wide (3-74 mU/L). Fifty-four percent of the girls had a maximum level below 20 mU/L, the cut-off point generally accepted to define GH deficiency. Although the mean BMI-score was close to zero in these girls (Table 1), obesity could explain the rather low maximal GH levels in these girls (3, 40, 41), since a negative correlation between stimulated GH levels and baseline BMI-SDS was found. Although representing only a single test, stimulated GH levels were related to the change in HS.DS<sub>ca</sub> after 4 yr GH treatment at the 0.07 level of significance. This is in agreement with a report in normal children (42) and in disagreement with a Japanese report in TS (3).

At baseline, a good correlation between spontaneous and stimulated maximum GH levels was observed in a subgroup of 12 girls of group C, in accordance with a previous report (41). Compared with prepubertal Dutch TS girls in an earlier study (4), and assuming a conversion factor from μg/L to mU/L of 2, maximum GH levels were comparable (25.6 vs. 27.6 mU/L), mean 24-h GH levels were rather low (4.3 vs. ± 6.0 mU/L), and the mean number of peaks was high (10.2 vs. 4.5) in the present study. It has been suggested (4) that an elevated spontaneous pulse frequency pattern might be associated with relatively low IGF-I levels and slow baseline growth and that these girls might benefit most from GH treatment. This seems in line with the present study. Furthermore, the change in HS.DS<sub>ca</sub> after 4 yr GH treatment was negatively related to baseline IGF-I and IGFBP-3 levels (or their scores for CA) or their ratio.

In agreement with earlier short-term findings in GHD patients (20), a clear-cut increase in maximum GH plasma levels and AUC values was observed during GH treatment with increasing dosages. The elimination half-time, however, was similar between the three GH dosage regimens, suggesting that increasing the GH dose results in a higher bioavailability of GH without accumulation. In addition, injection of higher dosages (and volume) did not result in a delayed time to maximum plasma GH levels. Nevertheless, in this small subgroup of girls the change over time of the plasma GH AUC was not significantly related to the corresponding growth response expressed as change in HS.DS<sub>ca</sub> nor to the corresponding change in IGF-I or IGFBP-3 levels or their ratio.

Except for the 30 months time-point in group B, IGF-I levels showed a progressive significant increase during the 4 treatment years, which in part can be explained by the age-dependency of this measurement. At 48 months only group C still had significantly higher IGF-I levels (adjusted for baseline) than group A (P = 0.008). In a report after 3 yr in Japanese girls with TS (43), mean IGF-I levels were statistically higher with 1 IU GH/kg/wk than with 0.5 IU/kg/wk. In the present study the change in IGF-I levels after 4 yr GH therapy was dependent on the dose, the duration of treatment, and the baseline IGF-I level. Thirty-one percent of the girls had plasma IGF-I levels after 4 yr GH of more than P95 for normal girls at the pubertal peak, without significant differences between groups. Only two of these girls were younger than 10 yr. At a lower GH dose than used in group A in the present study (0.68 IU/kg/wk) Ranke et al. (44) reported 15% of the TS girls to have IGF-I plasma levels above the pubertal peak after 1 yr. Moreover, baseline IGFBP-3 plasma levels in that study hardly deviated from the normal range, but after 1 yr of GH therapy more than 20% of the girls had IGFBP-3 levels above the pubertal peak. In the present study, determined in the same laboratory, at baseline only 3, and after 30 months 23, girls (35%) had IGFBP-3 levels greater than 5 mg/L (P95 at peak pubertal level), with a similar distribution between the groups. IGFBP-3 was not determined at 42 and 48 months, but a plateau seemed to have been reached after 6 months of therapy, despite age-dependency of this binding protein and a further increase of the GH dose. Baseline log-values of IGF-I vs. IGFBP-3 levels showed a significant positive correlation (r = 0.75; P < 0.0001), but also the change of these values after 30 months from baseline was significantly positively correlated (r = 0.25; P = 0.01). This is in line with earlier findings in TS (44, 45), and not unexpected, since both proteins are GH dependent. A progressive rise of the IGF-I to IGFBP-3 ratio could be an indicator of the growth response (44). However, after 30 or 48 months of treatment neither was a significant relationship observed between the change in IGF-I to IGFBP-3 ratio and the change in HS.DS<sub>ca</sub>, nor was there a significant difference between groups of the change in this ratio, although a trend was apparent after 30 months: the mean change in IGF-I to IGFBP-3 ratio was 60, 82, and 81, for group A, B, and C. Also, neither IGF-I nor IGFBP-3 levels, nor their ratio were related to the pretreatment HV(sd score). Taken together, there is little evidence to support an explanation of the differences in growth response between the groups by a change in the IGF-I to IGFBP-3 ratio. Nevertheless, a repeated measures model, with the dose-increment steps and duration of treatment as covariants, showed that each change in HS.DS<sub>ca</sub> correlated significantly with IGF-I plasma levels. Thus, free IGF-I might still be a determining factor.

In contrast to an earlier study with an older group of girls with TS (32), but in agreement with another report in TS (46), the decrease in GHBP levels after 6 months treatment was not significant from baseline. This might be because of a large interindividual variation. At baseline there were no differences between groups. Most of the girls had GHBP levels within the normal age range, as shown previously (34). At baseline a linear relationship between GHBP levels and age or stimulated GH levels at start of treatment in the present group of girls with TS was not observed, in contrast to earlier reports in normal children (34). In agreement with the latter
report, however, GHBP levels at baseline correlated positively with BMI-so score.

In conclusion, a stepwise GH-dosing approach reduced the waning effect of the growth response after 4yr treatment without undue bone maturation. The increase in FH prediction was not significantly different between treatment groups. Irrespective of the GH dose used, initiation of GH treatment at a younger age is beneficial in terms of cm gained either, at end of study or in terms of predicted FH, but not when expressed as the change in HSDS_{CA} over the study period. The lower the baseline IGF-I and IGFBP-3 plasma levels as well as their ratio, and the higher the change in IGF-I and IGFBP-3 plasma levels, the greater is the change in HSDS_{CA}. The ultimate proof of the effect of the three GH treatment regimens is FH. Therefore, the present treatment protocol will be extended until FH is reached.

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