THYROGLOBULIN LEVEL IN POSTMORTEM BLOOD SAMPLES AS A DIAGNOSTIC TOOL FOR CAUSE OF DEATH

By

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ABSTRACT

There were many conflicting results about the significance of postmortem thyroglobulin (Tg) level as a biomarker in forensic diagnosis. This work aimed to assess the relation between postmortem blood Tg level and the cause of death. Sixty cadavers received at Cairo Department of Forensic Medicine, (Zenhum Morgue), Egypt, were classified into two groups; 1st group included 30 cadavers died by different types of asphyxia, and 2nd group included 30 cadavers died by causes other than asphyxia. In all cases, right heart blood (RHB) and left heart blood (LHB) Tg levels were measured using chemiluminescence immunometric assay and thyroid tissues were histopathologically examined. Thyroglobulin level was high in 76.6% of 1st group cases and in 83.3% of 2nd group cases. In fatal traumatic brain injury cases, there was a significant positive correlation between Tg level and survival period. The mean value of RHB Tg levels was higher than that of LHB Tg levels in both studied groups; Tg was high in all cases with skin discoloration as a sign of putrefaction regardless of the cause of death. In conclusion, thyroglobulin level is unreliable as a diagnostic tool for cause of death because it may be affected by postmortem changes.

Keywords: Thyroglobulin, postmortem, diagnostic tool, cause of death.

INTRODUCTION

Biochemical analysis of postmortem blood may help to evaluate pathological status and to determine the cause of death in forensic diagnosis (Ishikawa et al., 2008; Uemura et al., 2008; Maeda et al., 2011).

There are numerous studies conducted on human body fluids in the field of postmortem chemistry. Among these, the postmortem thyroglobulin levels are frequently encountered in the literature (Katsumata et al., 1984; Şenol et al., 2008).
Thyroglobulin (Tg), a glycoprotein synthesized in normal or malignant thyroid follicular cells, is an important marker for residual or recurrent differentiated thyroid cancer (Cooper et al., 2009; Ahn et al., 2013). It is well known that under physiological conditions, Tg molecule is the substrate for the hormones triiodothyronine and thyroxine. Its function outside the thyroid gland is unknown. Under certain pathologic conditions, an increase in Tg concentrations in the blood can occur (Dressler and Mueller, 2006).

While some previous studies confirmed that Tg levels in the heart blood were high in cases of asphyxia by neck compression such as hanging, strangulation, and throttling, as confirmed by Şenol et al. (2008) and Maeda et al. (2011), and in those with traumatic injuries to the head, as confirmed by Dressler and Mueller (2006). Other studies, however, recorded cases in which there were high Tg levels without such previous findings (Hayakawa et al., 2014).

For these conflicting results about the significance of Tg level in postmortem blood samples as a biomarker for diagnosis in forensic autopsy; this work was conducted to study the relation between thyroglobulin (Tg) level in postmortem blood samples and the cause of death, to assess if Tg level in postmortem blood samples can be used in forensic practice as a reliable biomarker for diagnosis of certain causes of death, e.g., cases of asphyxia by neck compression, and those with traumatic brain injuries.

**SUBJECTS AND METHODS**

**1- Subjects:**

This study was carried out on 60 cadavers, on which medico-legal autopsies were conducted at Cairo Department of Forensic Medicine.
(Zenhum Morgue), Ministry of Justice, Egypt. The studied cases were classified into two groups:

- **The 1st group** included 30 cadavers who died due to different types of asphyxiation especially fatal pressure on the neck (hanging, throttling and ligature strangulation).

- **The 2nd group** included 30 cadavers who died due to any causes other than asphyxiation including fatal traumatic brain injury (TBI).

**Exclusion criteria:** (1) cases with any evidence of thyroid disorders, that may affect thyroglobulin (Tg) levels such as hyperthyroidism or thyroid cancer “diagnosed by medical history if any, gross examination and microscopic examination of thyroid tissue” (2) cases with a postmortem interval >48 hours, or those with signs of advanced putrefaction, and (3) cases in which samples cannot be collected such as infants, charred bodies and severely mutilated bodies.

Immediately after arrival of cadavers to the morgue, external postmortem (PM) examination was done for each case included in the study to determine the PM interval. The PM intervals of all cases were within 48 hours, and the bodies were kept in cold storage at 4°C. Fractionated blood samples showed that under these conditions, no breakdown of Tg occurred for up to 7 days (*Muller et al., 1997*).

In cases of fatal TBI, survival time was recorded from the hospital report of each case.

The study was approved by the local research ethical board of Faculty of Medicine, Benha University, Egypt. All results obtained from the subjects were registered in special sheets of study in which confidentiality was secured.

**II- Sampling:**

*Madboly et al., 2016*  
*January 2016*
Two whole blood samples (each 3 ml), from right heart blood “RHB” and left heart blood “LHB” separately, were collected during forensic autopsy of each case included in the study (1st and 2nd groups). Blood samples were collected by the researchers. All samples used for measurement of Tg levels were collected within 48 hours of time of death. Samples were put immediately in vacationer tubes containing ethylene diamine tetra acetic acid (EDTA), placed on ice bag and then transported to the laboratory. In suspicious toxic deaths, toxicological analysis was done for expected toxins; this was done beside routine toxicological analysis for each case included in the study.

III- Thyroglobulin (Tg) level measurement:

Thyroglobulin levels were measured by chemiluminescence immunometric assays technique, as described by (Bohuslavizki et al., 2000; Hayakawa et al., 2014). Using commercial kit IMMULITE® 2000 Thyroglobulin (L2KTY2), Diagnostic Products Corporation, U.S.A., reference value = (0.73 - 84 ng/ml) for male and female. The accepted standard value of elevated Tg level was 200 ng/ml.

IV- Histopathological study of thyroid gland:

To exclude any thyroid gland diseases that may affect Tg levels; thyroid tissue specimens were taken from all cadavers included in the study after they were totally or sub-totally removed from their location during autopsy. They were fixed in 10% neutral buffered formalin and were cut at 2–5 µm thickness and were stained using the routine pathological technique “haematoxylin & eosin” stain (Dressler and Mueller, 2006; Şenol et al., 2008). Any case with a diseased thyroid was excluded from the study.

V-Statistical design:
The collected data were tabulated and analyzed using statistical package for the social sciences (SPSS) version 16 for windows (SPSS Inc., Chicago, USA). Data were expressed as mean and standard deviation. Wilcoxon test and Mann Whitney U test were used as tests of significance. The accepted level of significance in this work was stated at 0.05, (P <0.05 was considered significant).

RESULTS

I- Demographic data:

The present work was carried out on 60 cases; the mean age of them was 41.1 years (SD±19.6), ranging from three to 77 years, the majority (61.7%) of them were males.

II- Autopsy findings:
A. 1\textsuperscript{st} group:

The present study showed that in 23 (76.6%) cases, thyroglobulin (Tg) levels of both RHB and LHB were higher than 200 ng/ml {all died due to fatal pressure of the neck (throttling, ligature strangulation & hanging)}. The mean Tg levels of RHB was 4717.8 (17.4 – 23716.2) ng/ml, whereas that of LHB was 963.2 (13.2 – 9423) ng/ml. The difference between them was statistically highly significant (p <0.001), as illustrated in table (1).

<table>
<thead>
<tr>
<th>Type of asphyxia</th>
<th>No.</th>
<th>Tg level (RHB) Mean (± SD)</th>
<th>Tg level (LHB) Mean (± SD)</th>
<th>Wilcoxon test</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smothering</td>
<td>4</td>
<td>53.9 (14.30)</td>
<td>25.5 (7.2)</td>
<td>1.83</td>
<td>0.068</td>
</tr>
<tr>
<td>Choking</td>
<td>3</td>
<td>138.1 (100.9)</td>
<td>48.1 (30.7)</td>
<td>1.07</td>
<td>0.27</td>
</tr>
<tr>
<td>Throttling</td>
<td>9</td>
<td>5052.7 (8470.7)</td>
<td>775.4 (1387.7)</td>
<td>2.67</td>
<td>0.002 (*)&amp;</td>
</tr>
<tr>
<td>Ligature strangulation</td>
<td>6</td>
<td>6187.8 (9496.6)</td>
<td>954.1 (1304.6)</td>
<td>2.2</td>
<td>0.028 (*)&amp;</td>
</tr>
<tr>
<td>Hanging</td>
<td>8</td>
<td>7288.1 (8827.4)</td>
<td>1993.3 (3107.4)</td>
<td>2.52</td>
<td>0.012 (*)&amp;</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>4717.8 (7850.3)</td>
<td>963.2 (1914.9)</td>
<td>4.7</td>
<td>&lt;0.001 (*)</td>
</tr>
</tbody>
</table>

* RH B= right heart blood, LHB= left heart blood, ± SD= standard deviation, *= significant

_Madboly et al., 2016_ January 2016
Skin discoloration due to putrefaction was observed in 12 (40%) cases of the 1st group upon external examination, and in all 12 cases Tg levels of both RHB and LHB were above the standard value. The statistical differences of Tg levels were significant (p<0.05), as shown in Fig. (1).

![Figure (1): Relation between thyroglobulin level (ng/ml) of RHB "right heart blood" & LHB "left heart blood" and skin discoloration as a sign of putrefaction among the 1st group (n= 30).](image)

The present study illustrated that cases with evidences of classical signs of asphyxia (congestion, cyanosis, petechial haemorrhages of the skin of the face), and those with severe neck pressure (assessed at autopsy by the presence of significant hemorrhages in the neck muscles under the pressure mark &/or fractures of the laryngohyoid complex), had high Tg levels in both RHB & LHB, in comparison with the negative cases. These differences were statistically significant (p<0.05), as illustrated in table (2).

<table>
<thead>
<tr>
<th>Parameter</th>
<th>No.</th>
<th>Tg level (RHB) Mean (± SD)</th>
<th>Tg level (LHB) Mean (± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classical signs of asphyxia: congestion, cyanosis, petechial haemorrhages of the skin of the face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>11</td>
<td>2259.4 (6027.7)</td>
<td>192.8 (346.3)</td>
</tr>
<tr>
<td>Positive</td>
<td>19</td>
<td>6141.1 (8559.8)</td>
<td>1409.2 (2295.3)</td>
</tr>
<tr>
<td>Mann Whitney U test</td>
<td></td>
<td>2.56</td>
<td>3.25</td>
</tr>
<tr>
<td>P value</td>
<td></td>
<td>0.01 (*)</td>
<td>&lt;0.001 (*)</td>
</tr>
<tr>
<td>Neck autopsy: Significant hemorrhages in the neck muscles under the pressure mark:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>11</td>
<td>2154.9 (6057.7)</td>
<td>165.5 (350.4)</td>
</tr>
<tr>
<td>Positive</td>
<td>19</td>
<td>6201.6 (8518.4)</td>
<td>1425.1 (2286.0)</td>
</tr>
</tbody>
</table>
Mann Whitney U test | 3.21 | 3.51
P value | 0.001 (*) | <0.001 (*)

Neck autopsy: Fractures of the laryngohyoid complex:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>19</td>
<td>2599.9 (6152.1)</td>
</tr>
<tr>
<td>Positive</td>
<td>11</td>
<td>8376.1 (9346.1)</td>
</tr>
</tbody>
</table>

Mann Whitney U test | 2.78 | 3.34
P value | 0.006 (*) | 0.001 (*)

RHB= right heart blood, LHB= left heart blood, ± SD= standard deviation, *= significant

B. 2\textsuperscript{nd} group:

The present work confirmed that in 25 (83.3\%) cases, Tg levels of both RHB and LHB were higher than 200 ng/ml. The mean Tg levels of RHB was 7679.7 (2.8 – 45865) ng/ml, whereas that of LHB was 1043.4 (2.5 – 7530) ng/ml. The difference between them was statistically highly significant (P <0.001), as illustrated in table (3).

Table (3): Thyroglobulin (Tg) levels (ng/ml) of RHB and LHB in cases of the 2\textsuperscript{nd} group (n=30) “those died from causes other than asphyxia”.

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>No.</th>
<th>Tg level (RHB) Mean (± SD)</th>
<th>Tg level (LHB) Mean (± SD)</th>
<th>Wilcoxon test</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic brain injury</td>
<td>8</td>
<td>8302.6 (10390.1)</td>
<td>1373.3 (1950.2)</td>
<td>2.38</td>
<td>0.017 (*)</td>
</tr>
<tr>
<td>Organophosphorus poisoning</td>
<td>5</td>
<td>47.1 (15.9)</td>
<td>31.6 (14.1)</td>
<td>1.98</td>
<td>0.049 (*)</td>
</tr>
<tr>
<td>Stab wound</td>
<td>12</td>
<td>11403.1 (15260.7)</td>
<td>1515.7 (2203.9)</td>
<td>3.06</td>
<td>0.002 (*)</td>
</tr>
<tr>
<td>Gunshot injury</td>
<td>5</td>
<td>5379.7 (8729.0)</td>
<td>393.7 (548.9)</td>
<td>2.02</td>
<td>0.043 (*)</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>7679.7 (11904.0)</td>
<td>1043.4 (1781.5)</td>
<td>4.6</td>
<td>&lt;0.001 (*)</td>
</tr>
</tbody>
</table>

RHB= right heart blood, LHB= left heart blood, ± SD= standard deviation, *= significant

Skin discoloration due to putrefaction was observed in 14 (46.6\%) cases of the 2\textsuperscript{nd} group upon external examination, and in all 14 cases Tg levels of both RHB and LHB were above the standard value. The statistical differences of Tg levels were significant (p<0.05), as shown in Fig. (2).
In the studied cases of fatal traumatic brain injury (TBI) (n=8), Tg levels of both RHB and LHB were above the standard value (200 ng/ml) in 5 (62.5%) cases. There was a significant (p<0.05) positive correlation between Tg levels and the length of survival period of TBI cases, as shown in table (4).

Table (4): Correlation between thyroglobulin (Tg) level (RHB & LHB) and the survival time of fatal traumatic brain injury (TBI) cases (n= 8).

<table>
<thead>
<tr>
<th>Traumatic brain injury (TBI), (n= 8)</th>
<th>Tg level (RHB)</th>
<th>Tg level (LHB)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>rho</td>
<td>P</td>
</tr>
<tr>
<td>Survival time</td>
<td>0.761</td>
<td>0.028 (*)</td>
</tr>
</tbody>
</table>

*= significant (p value <0.05)

C. Histopathological study of thyroid gland:

The present work showed that in all cases included in the study either in the 1st or the 2nd groups, the histopathological examination of the thyroid gland revealed normal thyroid histological structure.

DISCUSSION

The present work included 60 cases ranging in age from three to 77 years, with a mean age of 41.1 years and 19.6 SD; the majority (61.7%) of them were males.
The present study showed that in 23 (76.6%) of 1st group cases {all died due to fatal pressure of the neck (throttling, ligature strangulation & hanging)}; thyroglobulin (Tg) levels of both RHB and LHB were higher than the standard level (200 ng/ml).

This was in accordance with Tamaki et al. (1987) who stated in their study, using enzyme-linked immunosorbent assay (ELISA) method for the measurement of blood Tg levels, that 12 (85.7%) out of 14 cases of mechanical asphyxia (hanging, manual strangulation, ligature strangulation) showed plasma Tg levels higher than 200 ng/mL (2100 ± 3450 ng/ml). Also, Tamaki and Katsumata (1990) confirmed that plasma Tg levels in all of their studied victims of asphyxia (n= 42) were significantly higher than 200 ng/ml. Later on Şenol et al. (2008) found that high Tg levels were encountered in 14 (58.3%) out of 24 hanging cases.

The present study illustrated that cases with evidences of classical signs of asphyxia (congestion, cyanosis, petechial haemorrhages of the skin of the face), and those with severe neck pressure (assessed at autopsy of the neck by the presence of significant hemorrhages in the neck muscles under the pressure mark &/or fractures of the laryngohyoid complex), had high Tg levels in both RHB & LHB, in comparison with the negative cases.

Maxeiner and Bockholdt (2003) concluded that classical signs of asphyxia, in spite of being nonspecific, it is an indicator of prolonged agonal stage and vital reaction before death. Muller et al. (1997) stated that in the majority of asphyxial deaths, thyroid gland is more or less exposed to trauma and mechanical forces, and levels of the hormones and thyroglobulin secreted from this gland, are increased at the agonal stage.

In the present work, the direct proportion between Tg levels and severity of neck pressure was in agreement with Şenol et al. (2008) who
found in their study on 24 cases of hanging, that Tg level was progressively increased in relation to the severity of mechanical forces applied to the neck, they explained this by the fact that Tg as a glycoprotein synthesized and stored in normal thyroid follicular cells will be released into the circulation if the thyroid gland is squeezed by any mechanical force applied to the neck as in cases of fatal pressure on the neck.

The present study confirmed that in 25 (83.3%) of the 2nd group (cases died by different causes of death other than asphyxia); Tg levels of both RHB and LHB were higher than the standard level (200 ng/ml). This was in accordance with Hayakawa et al. (2014) who studied Tg level measured by the electrochemical luminescence immunoassay method (ECLIA) in 44 cadavers, excluding cases of asphyxia by neck compression, they found high Tg concentrations of both RHB and LHB in 43% of cases.

In the studied cases of fatal traumatic brain injury (TBI) (n=8), Tg levels of both RHB and LHB were above the standard value (200 ng/ml) in 5 (62.5%) of cases, and there was a significant positive correlation between Tg levels and the length of survival period of TBI cases.

This was in agreement with Dressler and Mueller (2006) who found raised Tg blood concentrations in about 57% of TBI studied cases. They also confirmed the presence of significant positive correlation between Tg concentrations and the length of survival period of TBI cases.

Marino and McCluskey (2000) stated that a latency period of at least 30 minutes must elapse between the TBI and the occurrence of death, before Tg markers can be detected. They assumed that a correlation exists, since the biosynthesis and secretion of Tg is regulated and controlled by centers in the hypothalamus and hypophysis (pituitary gland). Damage to these hierarchical structures through trauma causes disturbances in the
feedback mechanism, so that an abnormal amount of Tg is secreted from the thyroid into the blood stream.

Another explanation of this positive correlation is that the hypophyseal necrosis, which is the main mechanism of post mortem elevation of Tg level in TBI cases, occurs always due to circulatory disturbances, which mainly occur as a result of trauma and oligemic shock, this would require the lapse of a certain period of time between the trauma and the state of shock thus produced and the tissue response being actually observable (Sandtke et al., 2000; Dressler and Mueller, 2006).

Upon external examination, skin discoloration due to putrefaction was observed in 12 (40%) cases of the 1st group and in 14 (46.6%) cases of the 2nd group, in all of these cases, regardless of the cause of death, Tg levels of both RHB and LHB were above the standard value. There were highly significant differences of Tg levels in these cases and in cases without skin discoloration in both studied groups.

These findings were confirmed by Hayakawa et al. (2014), who detected high Tg concentrations (above the standard value) of the RHB and LHB in cases with evidences of skin discoloration due to decomposition, in contrast, in cases where no skin discoloration was detected, the Tg concentrations of both RHB and LHB were below the standard value. Based on this observation, they suggested that Tg concentrations increased as a result of postmortem changes.

In the both studied groups the mean value of RHB Tg levels was higher than the mean value LHB Tg levels & the differences between them were more than 600 ng/ml in cases with positive skin discoloration as a sign of putrefaction. In the studies done by Tamaki et al. (1987); Dressler and Mueller, (2006); Tg level was measured using blood collected from the
heart, without separating the RHB from the LHB. However, Tamaki and Katsumata (1990) in their studies collected RHB and LHB separately and measured the Tg concentration in each sample; they found that the mean Tg concentration of RHB was significantly higher than that of LHB in cases both with and without neck compression. Later on Hayakawa et al. (2014) also found similar results in their study of 44 non asphyxia deaths. They explained the increase in Tg concentrations after death by the mechanism that Tg in the thyroid follicular lumen leaks into the vessels around the thyroid gland and diffuses into the circulation as postmortem changes progress. Therefore Tg spreads mainly through the veins, which retain blood volume more than arteries during the postmortem period, producing significant differences between Tg levels of the RHB and LHB.

Histopathological examination of thyroid gland specimens, taken from all cases included in the study revealed normal thyroid structure. Tg levels are known to be high in cases of hyperthyroidism or differentiated thyroid cancer, whereas Tg is rarely secreted into the circulation in healthy individuals (Guyton and Hall, 2011).

CONCLUSION & RECOMMENDATIONS

1. Thyroglobulin (Tg) level is unreliable as a postmortem diagnostic tool for the cause of death because the postmortem blood Tg level may be affected by many factors such as the severity of neck pressure in asphyxia deaths, the length of survival period in fatal TBI cases and the postmortem changes whatever the cause of death.

2. It is necessary to collect RHB and LHB separately and measure their Tg levels individually when the Tg level is used as a biomarker for postmortem diagnosis of the cause of death.
ACKNOWLEDGMENT

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REFERENCES


الملخص العربي

متوسط الثيروجلوبين في عينات الدم بعد الوفاة كأداة لتشخيص سبب الوفاة

تمكّننا من التضامن حول أهمية ودلالته مستوي الثيروجلوبين في الدم بعد الوفاة، وواعد هذا التعاون بين مستوي الثيروجوبين في الدم بعد الوفاة، وتساعد في التشخيص سبب الوفاة في مجال الطب الشرعي. ويفيد هذا العمل تقييم العلاقة بين مستوي الثيروجوبين في الدم بعد الوفاة وسبب الوفاة، وقد استخلص البحث على 60 حالة من الوفيات التي وردت إلى قسم الطب الشرعي بالفاحرة (مشتركة)، وتم تصنيف هذه الحالات إلى مجموعتين؛ المجموعة الأولى (30 حالة) وشملت الحالات المتوفرة نتيجة الأنواع المختلفة من الأسباب، و группа الثانية (30 حالة)، وشملت الحالات المتوفاة نتيجة أسباب أخرى غير الأسباب. وفي جميع هذه الحالات تم قياس مستوى الثيروجوبين بالدم في الجهة اليمنى واليسرى من القلب باستخدام تقنية التهيج الكيميائي، وتم فحص أنسجة الغدة الدرقية "هستولوجيا" لكل الحالات لتتأكد من سلامتها وعدم وجود أسباب أخرى تؤثر على مستوى الثيروجوبين. وأثبتت الدراسة أن مستوى الثيروجوبين في الدم كان عالياً في 76.6% من حالات المجموعة الأولى، و في 83.3% من حالات المجموعة الثانية. ووجد أن الظروف الصحية المتميزة هنا علاقة إيجابية ذات دلالة إحصائية بين مستوى الثيروجوبين بالدم ووقت البقاء على قيد الحياة بعد الوفاة. وقد كان نتائج مستوي الثيروجوبين بالدم في الجهة اليمنى من القلب أعلى من مستوي الثيروجوبين بالدم في الجهة اليمنى من القلب في كل المجموعتين، وكان مستوي الثيروجوبين عالياً في جميع الحالات التي ظهر بها البخار بالجلد على التغذية بين الفروع. وقد خلصت الدراسة إلى أن مستوى الثيروجوبين بالدم لا يمكن الاعتماد عليه كأداة تشخيصية لسبب الوفاة لأنه قد يتغير بين التغييرات الرمية بعد الوفاة.