Garrod, in 1908, introduced the term ‘inborn errors of metabolism’ to describe biochemical abnormalities which were genetically determined, present throughout life and relatively non-lethal. He suggested that it would ultimately be possible to attribute the biochemical aberrations found in these conditions to specific enzyme defects. Recent work has confirmed the validity of Garrod’s ideas to a remarkable extent, and has extended them to a considerably greater range of conditions than the four originally considered by him (albinism, alcaptaunuria, cystinuria and pentosuria). One of the most fruitful of these extensions has been to certain types of thyroid disease. These defects (collectively known as ‘sporadic goitrous cretinism’) conform extremely well to Garrod’s definition, for they are hereditary, congenital, persist through life, and are relatively non-lethal. The fact that they are accompanied by gross structural changes (goitre, cretinism) does not by any means exclude them from the group defined by Garrod, for these structural changes are merely anatomical reflections of the underlying biochemical defect. Although existing evidence cannot be regarded as conclusive, most authors are agreed that the biochemical defects consist essentially of absence or inadequacy of one or more of the enzyme systems which collectively enable the thyroid gland to produce its hormones (thyroxine and triiodothyronine).

Clinical Aspects

It is easy enough to deduce from physiological principles what the clinical effects of a block in thyroxine synthesis will be. The first effect of the resulting low levels of circulating thyroxine is stimulation of the anterior pituitary to produce more of its thyroid-stimulating hormone (T.S.H.). This causes hyperplasia and hypertrophy of the thyroid, and a goitre is formed. Hence the goitre may not unreasonably be regarded as an attempt to compensate for the block in thyroxine synthesis. In the cases described as sporadic goitrous cretins, this attempt at compensation has clearly failed, and the usual manifestations of hypothyroidism during the growing period can be plainly seen. When the degree of hypothyroidism is severe the child’s whole development, physical and mental, is drastically slowed down; and the characteristic puffy face, thick lips, large tongue and dry, coarse skin appear. The extent to which thyroxine synthesis is interfered with may, however, vary within wide limits in this group of cases. Occasionally one of the less severely affected cases may escape detection during childhood, and present during adult life with the evidence of past hypothyroidism clearly shown by the infantile proportions, distorted femoral head and enlarged pituitary fossa.

The cases with the grossest metabolic errors were naturally enough the first to be studied and described. More recently, however, it has become apparent that the biochemical defect need not be severe enough to cause manifest hypothyroidism. In fact, the compensatory hypertrophy and hyperplasia of the thyroid may enable the gland to produce normal quantities of thyroxine. In that case, the only manifestation of the inborn error is a goitre which is not clinically distinguishable from any other type of simple goitre. Like other goitres it is initially diffuse, but with the passage of time it becomes nodular. The best example of this type of euthyroid goitre, caused by an inborn error of metabolism, is to be found in the group of cases in which it is associated with congenital deafness. The first cases of this type were described by Pendred in 1896 and are most conveniently referred to by his name. Persons afflicted with Pendred’s syndrome are usually euthyroid, but may be hypothyroid. The goitre usually appears in middle childhood, histologically shows marked hyperplasia and has an inverterate tendency to recur after a partial thyroidectomy. The deafness is present from birth, usually symmetrical and most marked for high tones, and may be severe enough to cause deaf-mutism.

It is extremely probable that there are other types of defect capable of causing goitre without hypothyroidism. Pendred’s syndrome is unusually
easy to identify merely because the associated deafness provides a convenient 'marker.' We can, however, from a study of Pendred's syndrome, deduce certain characteristics of a goitre due to an inborn error of metabolism, which should enable us to suspect this type of defect even in the absence of hypothyroidism. These are the presence of marked histological hyperplasia, a tendency for the goitre to recur after partial thyroidectomy and the occurrence of goitre in the patient's sibs. Any of these features should suggest that detailed biochemical studies of thyroid function might be rewarding.

The identification of goitres due to inborn errors is not merely an academic exercise, for even in the absence of hypothyroidism treatment with thyroxine is well worth while. This treatment is effective in reducing thyroid size, provided the goitre is still in the diffuse stage. Even when it has become nodular (as is usually the case in adult subjects) it is very probable that treatment with thyroxine will prevent further growth of the goitre. If a nodular goitre of this type has to be dealt with by partial thyroidectomy on account of pressure symptoms it is essential that the patient should be treated with thyroxine subsequently to prevent recurrence. Hence it can be said that thyroxine (or thyroid extract) should be given to any patient with a goitre caused by one or other type of inborn error. This therapy should be given whether signs of hypothyroidism are present or not, and should be maintained throughout life. The best guide to dosage is to find the smallest dose which will completely inhibit radio-iodine uptake. Our practice is to start with l-thyroxine 0.1 mg. daily (a more reliable preparation than dried thyroid) and to measure $^{131}I$ uptake after about a month. If uptake is still present the daily dose is increased by 0.1 mg. per month until suppression is achieved.

**Biochemical Aspects**

A simplified version of the main pathways of iodine metabolism is shown in Fig. 1. The three sites at which genetically-determined enzyme failure is thought to occur are indicated at A, B and C.

The defect at site A is both the best understood and the easiest to demonstrate. It is widely accepted that iodide has to be oxidized to iodine before it can form organic compounds, such as iodotyrosines. The enzyme responsible for this oxidation has never been isolated, but is generally believed to be a peroxidase. If this enzyme is defective iodide necessarily accumulates within the thyroid. Its presence there is readily demonstrable in patients by giving an oral or intravenous tracer dose of radio-iodine followed 1-4 hours
chlorate is a partial discharge (without cretinism) of iodine could be by action of incomplete enzyme. However, of the oxidative capacity was explained. The thyroid's capacity to oxidize iodide to iodine is severely limited. When this defect occurs naturally it is generally presumed that the oxidative enzyme ('peroxidase') is absent or inadequate. In the cases described as goitrous cretins by Stanbury and Hedge it seems likely that the enzyme was entirely missing, for all the radioiodine could be discharged from the thyroid. However, incomplete defects of the same type (without cretinism) are much more common; a partial discharge of radio-iodine following perchlorate is a characteristic feature of Pendred's syndrome. It should be noted that the same type of biochemical defect can be induced temporarily in any type of subject by thiourea derivatives, or other anti-thyroid drugs with a similar action. Hence it is possible that the inefficiency of the oxidative enzyme in Pendred's syndrome might be the result of a circulating metabolite, having a thiourea-like action, rather than to an actual deficiency of the enzyme itself. This hypothesis is not as yet supported by any direct evidence.

A defect at site B in the diagram is much more difficult to identify by current techniques. Here it is supposed that mono- and di-iodothyrosines are formed in the normal way, but are unable to couple together to form tri-iodothyronine and thyroxine. A fundamental difficulty is that we do not know whether a specific enzyme is required for this step or not; the coupling of di-iodothyrosine derivatives can occur in vitro in the absence of enzymes. It will be obvious from the diagram that a defect at site B will be revealed by a 'build-up' of mono- and di-iodothyrosines within the thyroid. This indeed occurred in the two cases in which site B defects have been postulated. Unfortunately, a similar build-up of iodothyrosines is also seen in site C defects. There is therefore no critical test available now for the identification of site B defects.

Site C defects, due to absence of the deiodinating enzyme, are more securely established, but some puzzling features still remain unexplained. The existence of an enzyme which specifically de-iodinates mono- and di-iodothyrosine...
is well established (deiodinase, dehalogenase). It can be seen from Fig. 1 that the coupling of iodothyronines occurs within the thyroglobulin molecule. However, not all the iodothyronines are actually converted into mono- and di-iodothyronines; when the thyroglobulin molecule is hydrolysed by thyroid protease, much free mono- and di-iodothyronine is released within the gland. The deiodinase acts on these free iodothyronines and liberates their iodine as iodide. This iodide then re-enters the synthetic cycle. Absence of deiodinase obviously has two effects: it diminishes the amount of iodide available for hormone synthesis, and it floods the gland with free mono- and di-iodothyronine, which also appear in excess in the blood and urine. It is not clear which of these effects is the more important from the point of view of hormone production; one would not expect that iodine deficiency induced in this way would be severe enough to cause hypothyroidism. Proof that a patient lacks deiodinase can only be afforded by direct demonstration that his excised goitre cannot deiodinate iodothyronines; this has been shown to be so in two cases.\(^7\), \(^8\), \(^12\) However, lack of thyroid deiodinase can be inferred if exogenous labelled mono- or di-iodothyroline is not deiodinated by the tissues generally, so that a substantial proportion of the administered material appears unchanged in the urine.\(^7\), \(^8\), \(^14\)

It is obvious from Fig. 1 that there are other possible sites at which enzyme blocks might occur. For instance, before hormone synthesis can begin iodide must be held within the thyroid at a considerably higher concentration than in blood. This process must require energy, and probably the help of an enzyme. No defect of this mechanism has as yet been identified. Similarly, the final step in hormone production is the enzymic proteolysis of thyroglobulin, with the release of thyroxine and triiodothyronine into the blood. Defects of this enzyme have not yet been found either.

Another biochemical aberration, not as yet related to any known or suspected enzyme system, has been described by DeGroot and Stanbury.\(^1\) They described five patients with goitrous cretinism, and referred to reports of probably similar cases in the literature. This variety, which also seems to be genetically determined, is characterized by the presence in the serum of an iodine-
containing substance, probably a polypeptide, which is insoluble in butanol. The existence of this substance may indicate a defect in thyroglobulin synthesis resulting in the formation of a precursor or variant which is metabolically inert, and which leaks out readily into the circulation. Iodine is thus diverted from the normal pathway leading to thyroglobulin into a metabolic blind alley.

**Genetic Aspects**

Site A defects are inherited in a strictly recessive fashion.\(^5\), \(^9\), \(^13\) Cases occur only in single generations, and (after allowing for inadequate ascertainment) the ratio of affected : unaffected sibs is very near to the expected 1 : 3. There seems to be an excessive consanguinity rate among the parents of cases. There is no evidence of sex linkage and the abnormal consanguinity is able to manifest itself with equal facility in males and females. In Pendred's syndrome it is probable that a gene defect at the same locus is responsible for both deafness and the thyroid enzyme defect. Heterozygotes for the defective gene cannot at present be identified. A typical pedigree of two families with Pendred's syndrome is shown in Fig. 3.

Nothing useful can be said about the inheritance of site B defects because insufficient cases have been described.

Site C defects are inherited in the same manner as site A defects, i.e. as an autosomal recessive.\(^16\) Hutchison and McGirr\(^6\) have described no less than ten goitrous cretins in a group of intermarried Scottish tinkers, and subsequent studies confirmed that the underlying biochemical defect was a lack of deiodinase.\(^7\), \(^8\) This highly inbred isolated community provided an ideal setting for the manifestation of a gene of recessive type. Although heterozygotes carrying the defective gene could not be identified clinically, McGirr et al.\(^7\), \(^8\) think they have been able to recognize them by their slightly impaired ability to deiodinate an oral dose of labelled mono-iodotyrosine. Stanbury et al.\(^14\) found that some relatives of a Dutch goitrous cretin (with the same type of biochemical defect) had goitres and also were unable to deiodinate iodotyrosines as completely as other people.

**Discussion**

When goitrous cretins were first shown to belong to Garrod's group of inborn errors of metabolism, they were regarded as extreme rarities. It is indeed clear that genetically-determined defects severe enough to cause nearly complete hypothyroidism are exceedingly uncommon. However, it now seems certain that the same (or at least a closely related) defect can cause Pendred's syndrome. The site A defect in this syndrome is not usually severe enough to cause hypothyroidism. The occurrence of a convenient 'marker' in the form of congenital deafness makes it possible to form some estimate of the population frequency of this condition; this is of the order of 15 to 30 per million. We cannot as yet assess the prevalence of other types of inherited thyroid defect, and it may well be that there are others still to be discovered. It is, however, unlikely that the sum total of inborn errors of metabolism will ever account for a substantial proportion of simple goitres. The main reason for this inference is that such goitres rarely recur after partial thyroidectomy; hence it is unlikely that the thyroid is under the constant T.S.H. stimulation, which is the inevitable sequel of a block in thyroxine synthesis. It is of some practical importance to be able to recognize goitres due to inborn errors, because they are so readily controlled with thyroxine. The main interest of these conditions is, however, that they provide an opportunity for studying the long and complex sequence of events which leads from mutant gene to specialized enzyme.

**REFERENCES**

10. PENRED, V. (1896), Ibid., ii, 532.