

Overview

Useful For

Reporting of accurate thyroglobulin results, depending on the antithyroglobulin antibodies status of the patient

Accurate measurement of serum thyroglobulin in patients with known or suspected antithyroglobulin autoantibodies or possible heterophile antibodies

Reflex Tests

Test Id	Reporting Name	Available Separately	Always Performed
HTGT	Thyroglobulin, Tumor Marker, IA, S	No	No
TGMS	Thyroglobulin, Mass Spec., S	Yes	No

Testing Algorithm

This test begins with the analysis of thyroglobulin antibody by immunoassay. If the thyroglobulin antibody result is negative (<1.8 IU/mL), then thyroglobulin testing will be performed by immunoassay.

If the thyroglobulin antibody result is positive (> or =1.8 IU/mL), then thyroglobulin testing will be performed by mass spectrometry.

Method Name

Immunoenzymatic Assay

NY State Available

No

Specimen

Specimen Type

Serum Red

Specimen Required

Patient Preparation: For 12 hours before specimen collection do not take multivitamins or dietary supplements containing biotin (vitamin B7), which is commonly found in hair, skin, and nail supplements and multivitamins.

Collection Container/Tube: Red top (serum gel/SST are **not acceptable**)

Submission Container/Tube: Plastic vial

Specimen Volume: 2 mL

Collection Instructions: Centrifuge and aliquot serum into a plastic vial.

Forms

[If not ordering electronically, complete, print, and send an Oncology Test Request \(T729\)](#) with the specimen.

Specimen Minimum Volume

1.25 mL

Reject Due To

Gross hemolysis	Reject
Gross lipemia	OK
Gross icterus	Reject

Specimen Stability Information

Specimen Type	Temperature	Time	Special Container
Serum Red	Refrigerated (preferred)	7 days	
	Frozen	30 days	
	Ambient	72 hours	

Clinical & Interpretive

Clinical Information

Thyroglobulin (Tg) is a thyroid-specific glycoprotein (approximately 660 kDa) that serves as the source for thyroxine (T4) and triiodothyronine (T3) production within the lumen of thyroid follicles. For T4 and T3 release, Tg is reabsorbed into thyrocytes and proteolytically degraded, liberating T4 and T3 for secretion.

Small amounts of intact Tg are secreted alongside T4 and T3 and are detectable in the serum of healthy individuals, with levels roughly paralleling thyroid size (0.5-1.0 ng/mL Tg per gram thyroid tissue, depending on thyrotropin [TSH] level). In situations of disordered thyroid growth (eg, goiter), increased thyroid activity (eg, Graves disease), or glandular destruction (eg, thyroiditis) larger amounts of Tg may be released into the circulation.

Clinically, the main use of serum Tg measurements is in the follow-up of differentiated follicular cell-derived thyroid carcinoma. Because Tg is thyroid-specific, serum Tg concentrations should be undetectable, or very low, after the thyroid gland is removed during treatment for thyroid cancer.

Current clinical guidelines consider a serum Tg of more than 1 ng/mL in an athyrotic individual as suspicious of possible residual or recurrent disease. To improve diagnostic accuracy, it is recommended this measurement be initially obtained after TSH stimulation, either following thyroid hormone withdrawal or after injection of recombinant human TSH. Most patients will have a relatively low risk of recurrence and thereafter, will only require unstimulated Tg measurement.

If unstimulated (on thyroxine) serum Tg measurements are less than 0.1 to 0.2 ng/mL, the risk of disease is below 1%. Patients with higher Tg levels, who have no demonstrable remnant of thyroid tissue, might require additional testing,

such as additional stimulated Tg measurements, neck ultrasound, or isotope imaging. A stimulated Tg above 2 ng/mL is considered suspicious.

The presence of anti-thyroglobulin autoantibodies (TgAb), which occur in 15% to 30% of thyroid cancer patients, could lead to misleading Tg results. In immunometric assays, the presence of TgAb can lead to false-low measurement, whereas, it might lead to false-high results in competitive assays.

Traditionally, there have been no reliable means to obtain accurate Tg measurements in patients with TgAb. However, recently, trypsin digestion of serum proteins, which cuts both antibodies and Tg into predictable fragments, has allowed accurate quantification of Tg in samples with antibody interferences through measurement of Tg-specific tryptic peptides by mass spectrometry.

Reference Values

Thyroglobulin Antibody: <1.8 IU/mL

THYROGLOBULIN< TUMOR MARKER

Athyrotic: <0.1 ng/mL

Intact thyroid: < or =33 ng/mL

Interpretation

Current guidelines recommend measurement of thyroglobulin (Tg) using a sensitive immunoassay (limit of quantification less than 1 ng/mL); for measurements of unstimulated Tg, the detection limit should be in the 0.1 to 0.2 ng/mL range.

In all cases, serum anti-thyroglobulin autoantibodies (TgAb) should also be measured, preferably with a method that allows detection of low concentrations of TgAb. If TgAb are detected, the laboratory report should alert the ordering provider to the possibility of false-low Tg results. If the apparent Tg concentration is below 1.0 ng/mL, the sample should be remeasured by liquid chromatography tandem mass spectrometry (LC-MS/MS). This will allow confident detection of Tg in the presence of TgAb down to 0.2 ng/mL (risk of residual/recurrent disease <1%-3%).

Samples from patients with Tg concentrations above 1.0 ng/mL might not require Tg measurement by mass spectrometry because current guidelines suggest further work-up may be necessary above this threshold. However, the positive predictive value for residual/recurrent disease is modest when Tg is just above this threshold (3%-25%) in athyrotic patients. Above 10 ng/mL, the risk of residual/recurrent disease is at least 25%, with many studies showing 60% to above 90% risks. In selected patients, it might also be useful to test TgAb positive samples by mass spectrometry, even if the Tg concentration is above 1.0 ng/mL but has not yet passed the 10 ng/mL threshold. These considerations are even more relevant in patients with a known thyroid remnant of a few grams, who may always have serum Tg concentrations of 1.0 to 10 ng/mL, owing to remnant Tg secretion, regardless of the presence or absence of residual/recurrent cancer.

It has been determined that the presence of anti-thyroglobulin autoantibodies (TgAb) in serum can lead to underestimation of Tg concentration by immunometric methods. When TgAb are present in samples with detectable Tg, the Tg values may be underestimated by up to 60% in immunoassays. In addition, some specimens containing TgAb, which are negative for Tg by immunoassay, tested positive by LC-MS/MS. Therefore, measuring of Tg by LC-MS/MS is the preferred method in TgAb positive patients. The listed decision levels are for thyroid cancer follow-up of athyrotic patients and apply to unstimulated and stimulated thyroglobulin measurements. Decision levels are based on best practice guidelines and the literature, which includes Mayo Clinic studies.

Decision levels have not been established but are likely to be somewhat higher for thyroid cancer patients who are not completely athyrotic (ie, patient has some remnant normal thyroid tissue); remnant normal thyroid tissue contributes to serum Tg concentrations 0.2 to 1.0 ng/mL per gram of remnant tissue, depending on the thyrotropin (TSH) level.

Thyroglobulin by Mass Spectrometry:

Tg <0.2 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Undetectable Tg levels in athyrotic individuals on suppression therapy indicate a minimal risk (<1%-2%) of clinically detectable recurrent papillary/follicular thyroid cancer.

Tg > or =0.2 ng/mL to 2.0 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels of 0.2-2.0 ng/mL in athyrotic individuals on suppressive therapy indicate a low risk of clinically detectable recurrent papillary/follicular thyroid cancer.

Tg 2.1 ng/mL to 9.9 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels of 2.1-9.9 ng/mL in athyrotic individuals on suppression therapy indicate an increased risk of clinically detectable recurrent papillary/follicular thyroid cancer.

Tg > or =10 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels of 10 ng/mL or above in athyrotic individuals on suppressive therapy indicate a significant (>25%) risk of clinically detectable recurrent papillary/follicular thyroid cancer.

Thyroglobulin by Immunoassay:

Tg <0.1 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels below 0.1 ng/mL in athyrotic individuals on suppressive therapy indicate a minimal risk (<1%-2%) of clinically detectable recurrent papillary/follicular thyroid cancer.

Tg > or =0.1 to 2.0 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels 0.1 to 2.0 ng/mL in athyrotic individuals on suppressive therapy indicate a low risk of clinically detectable recurrent papillary/follicular thyroid cancer.

Tg 2.1 ng/mL to 9.9 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels 2.1 to 9.9 ng/mL in athyrotic individuals on suppressive therapy indicate an increased risk of clinically detectable recurrent papillary/follicular thyroid cancer.

Tg > or =10 ng/mL: Tg levels must be interpreted in the context of TSH levels, serial Tg measurements, and radioiodine ablation status. Tg levels 10 ng/mL or above in athyrotic individuals on suppressive therapy indicate a significant risk (>25%) of clinically detectable recurrent papillary/follicular thyroid cancer.

Cautions**Thyroglobulin by Mass Spectrometry:**

Rare normal amino acid sequence variations within thyroglobulin (Tg) can cause a false-low result in the Tg mass spectrometry assay if they happen to be present in the Tg proteotypic peptides that are used for Tg quantification. While the exact prevalence of such changes is unknown, the validation data on large sample numbers indicate that this affects less than 1% of samples. In the heterozygote state, the result would be an apparent reduction in Tg concentration by

about 50%, while the homozygous state (<0.01%) is predicted to result in total loss of signal. Therefore, if the results of the mass spectrometry measurement are much lower than those obtained previously (within 3-6 months) with an immunometric immunoassay, this possibility should be considered. In this event, alert Mayo Clinic Laboratories as soon as possible, and an attempt will be made to resolve the discrepancy.

Thyroglobulin by Immunoassay:

The test is most sensitive for detection of thyroid cancer recurrence when patients are off thyroid replacement long enough to have an elevated thyrotropin (TSH) prior to collecting the specimen. This test can also be used to follow patients with normal TSH; however, Tg values from specimens with high TSH should not be compared with values with normal TSH, because TSH stimulation changes the baseline determinations.

Thyroglobulin autoantibodies (TgAb) may interfere with the measurement of Tg. All specimens are prescreened for TgAb, and a comment appended to the report if they are present. Undetectable levels of Tg should be interpreted with caution if TgAb are present. A Tg antibody result of less than 1.8 IU/mL is unlikely to cause clinically significant Tg assay interference. It is recommended that the Tg result be reviewed for concordance with clinical presentation.

Specimens with Tg concentrations greater than 250,000 ng/mL may "hook" and appear to have markedly lower levels.

Tg and TgAb values determined by different methodologies might vary significantly and cannot be directly compared with one another. Some patients might be antibody-positive by some methods and antibody-negative by others. Comparing values from different methods might lead to erroneous clinical interpretation.

In rare cases, some individuals can develop antibodies to mouse or other animal antibodies (often referred to as human anti-mouse antibodies [HAMA] or heterophile antibodies), which may cause interference in some immunoassays. Caution should be used in interpretation of results, and the laboratory should be alerted if the result does not correlate with the clinical presentation.

Clinical Reference

1. Grebe SKG: Diagnosis and management of thyroid carcinoma: A focus on serum thyroglobulin. *Expert Rev Endocrinol Metab.* 2009;4(1):25-43. doi: 10.1586/17446651.4.1.25
2. American Thyroid Association (ATA) Guidelines Taskforce on Thyroid Nodules and Differentiated Thyroid Cancer; Cooper DS, Doherty GM, Haugen BR, et al: Revised American Thyroid Association management guidelines for patients with thyroid nodules and differentiated thyroid cancer. *Thyroid.* 2009 Nov;19(11):1167-1214. doi: 10.1089/thy.2009.0110
3. Pacini F, Catagana MG, Brillì L, Pentheroudakis G, on behalf of the ESMO Guidelines Working Group: Thyroid cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol.* 2010 May;21 Suppl 5:v214-9. doi: 10.1093/annonc/mdq190
4. National Comprehensive Cancer Network (NCCN) guidelines for treatment of cancer by site: version 2.2022: Thyroid Carcinoma. Accessed June 7, 2022. Available at www.nccn.org/professionals/physician_gls/default.aspx#site
5. Tuttle RM: Differentiated thyroid cancer: Role of serum thyroglobulin. In: Cooper DS, Ross DS, Mulder JE, eds *UpToDate*. Updated July 15, 2021. Accessed June 7, 2022. Available at: www.uptodate.com/contents/differentiated-thyroid-cancer-role-of-serum-thyroglobulin

Performance

Method Description

The Access Thyroglobulin Antibody II assay (TgAb) is a sequential 2-step immunoenzymatic (sandwich) assay, performed on a Beckman Coulter Unicel Dxl 800 system. A sample is added to a reaction vessel with paramagnetic particles coated with the thyroglobulin protein. The serum TgAb binds to the thyroglobulin. After incubation in a reaction vessel, materials bound to the solid phase are held in place by a magnetic field, while unbound materials are washed away. The thyroglobulin-alkaline phosphatase conjugate is added and binds to the TgAb. After the second incubation, materials bound to the solid phase are held in place by a magnetic field, while unbound materials are washed away. Then, the chemiluminescent substrate, Lumi-Phos 530 is added to the reaction vessel, and light generated by the reaction is measured with a luminometer. The light production is directly proportional to the concentration of thyroglobulin antibody in the sample. (Package insert: Access Thyroglobulin Antibody II. Beckman Coulter Inc; 04/2020)

Thyroglobulin by immunoassay is performed using a Beckman Coulter Unicel Dxl 800 system. The Access Thyroglobulin (Tg) assay is a simultaneous 1-step immunoenzymatic (sandwich) assay. A sample is added to a reaction vessel, along with a biotinylated mixture of 4 monoclonal anti-Tg antibodies, streptavidin-coated paramagnetic particles, and monoclonal anti-Tg antibody alkaline phosphatase conjugate. The biotinylated antibodies and the serum Tg bind to the solid phase, while the conjugate antibody reacts with a different antigenic site on the Tg molecule. After incubation in a reaction vessel, materials bound to the solid phase are held in a magnetic field, while unbound materials are washed away. Then, the chemiluminescent substrate Lumi-Phos 530 is added to the vessel, and light generated by the reaction is measured with a luminometer. The light production is directly proportional to the concentration of Tg in the sample. (Package insert: Access Thyroglobulin. Beckman Coulter Inc; 06/2021)

Thyroglobulin by mass spectrometry is performed as follows: serum is fractionated by a salting out method. Fractionated serum is then reduced, alkylated, and digested with trypsin. Tryptic fragments are further purified by immunocapture with antibodies specific to the individual fragments. Finally, these fragments are analyzed by liquid chromatography tandem mass spectrometry. (Unpublished Mayo method)

PDF Report

No

Day(s) Performed

Monday through Friday, Sunday

Report Available

1 to 6 days

Specimen Retention Time

30 days

Performing Laboratory Location

Jacksonville

Fees & Codes

Fees

- Authorized users can sign in to [Test Prices](#) for detailed fee information.
- Clients without access to Test Prices can contact [Customer Service](#) 24 hours a day, seven days a week.
- Prospective clients should contact their account representative. For assistance, contact [Customer Service](#).

Test Classification

This test has been cleared, approved, or is exempt by the US Food and Drug Administration and is used per manufacturer's instructions. Performance characteristics were verified by Mayo Clinic in a manner consistent with CLIA requirements.

CPT Code Information

86800

84432 (if appropriate)

LOINC® Information

Test ID	Test Order Name	Order LOINC® Value
HTGR	Thyroglobulin Reflex to MS or IA	56536-6

Result ID	Test Result Name	Result LOINC® Value
TGABR	Thyroglobulin Antibody, S	56536-6