Activation of the Hypothalamic-Pituitary-Gonadal Axis in Infancy: Minipuberty

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Abstract
The hypothalamic-pituitary-gonadal (HPG) axis is active in the midgestational foetus but silenced towards term because of the negative feedback effects mediated by the placental hormones. This restraint is removed at birth, leading to reactivation of the axis and an increase in gonadotrophin levels. Gonadotrophin levels are high during the first 3 months of life but decrease towards the age of 6 months except for FSH levels in girls that remain elevated until 3–4 years of age. After this, the HPG axis remains quiescent until puberty. The postnatal gonadotrophin surge results in gonadal activation in both sexes. In boys, testosterone levels rise to a peak at 1–3 months of age and then decline following LH levels. Postnatal HPG axis activation is associated with penile and testicular growth and therefore considered important for the development of male genitalia. In girls, elevated gonadotrophin levels result in the maturation of ovarian follicles and an increase in oestradiol levels. Biological significance and possible long-term consequences of this minipuberty remain elusive, as do the mechanisms that silence the HPG axis until puberty. However, the first months of life provide a ‘window of opportunity’ for functional studies of the HPG axis prior to pubertal development.

Introduction

The onset of puberty is preceded by two periods of activity in the hypothalamic-pituitary-gonadal (HPG) axis: the first during the foetal life and the second during the first postnatal months (fig. 1). After the postnatal HPG axis activity, also referred to as minipuberty, the axis is silenced for the childhood years by mechanisms that still remain elusive. The biological significance of foetal HPG axis activation is not completely understood, but in males it has a central role in the development of the genitalia. This is evidenced by the underdevelopment of the penis and maldescent of the testes at birth in boys with congenital hypogonadotrophic hypogonadism. The role of the second (postnatal) HPG axis activation is even less...
well understood, especially in females. In this review, we first briefly discuss the foetal activation of the HPG axis, then focus on postnatal HPG axis activation, and finally summarize the current knowledge of the changes in the pituitary and gonadal hormones and associated hormone effects on target tissues in infants.

Foetal HPG Axis Activity

GnRH neurons migrate from the nasal placode to the hypothalamus during early embryogenesis and GnRH is detected in the foetal hypothalamus at around 15 weeks of gestation [1]. Factors involved in the regulation of foetal GnRH neuron activity include kisspeptin and KISS1R [1]. LH and FSH are detected in the anterior pituitary and general circulation by 12–14 weeks of gestation [2, 3]. The exact phase when the pituitary gonadotrophin secretion becomes dependent on the control of the hypothalamic GnRH is not fully elucidated. Vascular connections are already present at the end of the first trimester of pregnancy, but the maturation of the portal vascular system continues after this [for review, see 4]. In anencephalic foetuses that lack the hypothalamus but have an intact pituitary, gonadotrope development is normal up to 17–18 weeks of gestation but thereafter the cells are involuted [5]. After 32 weeks of gestation they are almost absent, suggesting that hypothalamic input is required for the maintenance of the gonadotropes from midgestation onward.

During the first half of pregnancy, female foetuses have a higher pituitary content of gonadotrophins [1, 3] and higher serum LH and FSH levels [2, 3, 6] than male foetuses. This sex difference has been suggested to be due to the negative feedback effects of foetal testicular hormones. At midgestation, LH and FSH levels in female foetuses are very high, resembling the levels of agonadal adults or postmenopausal women [1, 6–9]. In male foetuses, LH levels exceed those of FSH [1, 7–9]. The placenta secretes hCG, the third gonadotrophin, which is structurally similar to LH and has similar biological effects. The foetal levels of hCG rise early in gestation, peak at 8–12 weeks and then decrease towards term but remain at considerable levels until late gestation [2, 9, 10]. LH and FSH levels decrease towards the end of gestation [1, 9] and are low at term in both sexes [7–9]. In contrast, placental oestrogen production increases towards the end of gestation and oestrogen levels are high in both maternal and foetal circulation [11]. These high levels probably suppress the activity of the foetal HPG axis, resulting in low foetal gonadotrophin levels by the end of gestation.

The foetal testes secrete testosterone and anti-müllerian hormone (AMH) at the 8th week of gestation. Testosterone production at this stage is essential for the masculinization of the foetus and testosterone induces the development of the male internal genitalia. Formation of the active metabolite of testosterone, dihydrotestosterone, by the enzyme 5-α reductase 2 (SRD5A2) is required for the development of the prostate, penis and scrotum. AMH causes the regression of the müllerian ducts, preventing the formation of a uterus and fallopian tubes. Testosterone levels are high in male foetuses between 10 and 20 weeks of gestational age, reaching adult values, and decrease thereafter towards term [9, 12].

Initial testicular development is intra-abdominal and the descent of the testes into the scrotum occurs in two phases. The first, transabdominal, phase is completed by 15 weeks of gestation. This phase is independent of an-
drogents but dependent on another Leydig cell product, insulin-like peptide 3 (INSL-3). The second, inguinoscro-
tal, phase is usually completed by the end of the 35th week of gestation and this phase is androgen dependent [for review, see 13].

Ovaries are not required for the differentiation of fe-
male internal or external genitalia. In the absence of AMH, müllerian ducts develop into fallopian tubes, uter-
us and the upper portion of the vagina. Folliculogenesis is initiated in the foetal ovary around 15 weeks after con-
ception when the first primordial follicles are formed [14]. The first primary follicles develop at around 20
weeks of foetal life and maturation to the antral stage is observed during late pregnancy [14, 15]. The role of pitu-
itary gonadotrophins in ovarian development and function during foetal life is not well understood. In an-
encephalic female foetuses, normal follicular development up to 34 weeks of gestation is observed but, thereafter,
large growing follicles that are common in healthy foe-
tuses are not seen in anencephalic female foetuses [16].
This finding suggests that ovarian development up to the 7th month of pregnancy occurs independently of stimu-
lation by the foetal hypothalamus, but pituitary gonado-
trophins later have a role in follicular growth. The onto-
gensis of steroid production in foetal human ovaries is
not completely understood. Ovarian oestrogen produc-
tion during foetal life is considered minimal and negligi-
ble compared to high placental oestrogen production.

Postnatal Activation of the HPG Axis: Minipuberty
Postnatal Pituitary Activation
At birth, gonadotrophin levels are low in both sexes [7,
10, 17]. Placental hormones are cleared from the circula-
tion of the newborn during the first postnatal days [17,
18]. Aroudn 1 week of age, FSH and LH levels start to in-
crease and peak between 1 week and 3 months [17, 19–
22]. At this time, FSH levels are higher in girls and LH
levels predominate in boys [19, 22–24]. In boys, LH and
FSH levels decrease by 6–9 months of age, but in girls,
FSH levels remain elevated longer – up to 3–4 years of life
[17, 19–21]. LH levels decrease at the same time as in boys
[17, 19–21].

Postnatal Testicular Activation
Testosterone levels in boys are low in the cord blood
but start to increase after 1 week of age, peak to pubertal
levels at 1–3 months and then decline to low prepubertal
levels by approximately 6 months of age [19, 20, 22, 25,
26]. These changes in the peripheral blood testosterone
levels mirror the changes in the number of Leydig cells
[27] and testosterone concentrations in the testicular tis-
sue [28]. The biological activity of the increased testoste-
one levels in infancy has been questioned, since the levels
of SHBG increase concomitantly, leading to a less signif-
icient increase in free rather than total testosterone levels
[26]. However, androgen effects such as penile growth
[20, 29] and prostatic activity [20] unequivocally demon-
strate concomitant androgen actions with the increasing
androgen levels. Furthermore, postnatal testosterone lev-
have been associated with male-type behaviour in 14-month-old infants, suggesting a role for postnatal an-
drogens in neurobehavioral development [30]. The post-
natal gonadotrophin surge is also associated with increas-
eses in the levels of Leydig cell product INSL-3 [31] and
Sertoli cell markers inhibin B [19] and AMH [32].
Testicular size increases during the first months after
birth [20, 28, 33], together with an increase in the number of germ cells [34], Leydig cells [27] and Sertoli cells [35].
This increase is followed by a decrease in size towards the
2nd year of life [20]. The androgen receptor is not ex-
pressed in the Sertoli cells during infancy and therefore
spermatogenesis is not initiated [36–38]. The lack of an-
drogen receptor explains the AMH levels, which remain
elevated despite the high testosterone level during the
postnatal surge [32, 37–39].

In addition to active testicular androgen production,
some weaker androgenic steroids, mainly dehydroepiand-
drosterone, its sulphate conjugate and androstenedione,
are secreted during the first postnatal months from the
involuting foetal zone of the adrenal cortex both in girls
and boys [25, 40]. These hormones possess little if any
androgenic potential, but they can be converted into po-
tent androgens by peripheral target tissues such as the
skin. Androgenic skin manifestations, such as sebaceous
gland hypertrophy and acne, are common findings dur-
ing the first postnatal months and are associated with urin-
ary levels of testosterone and DHEAS in both sexes [40].

Postnatal Ovarian Activation
Oestradiol levels are high in the cord blood of both
sexes and decrease rapidly during the first postnatal days
[18, 41]. At 1 week of age oestradiol levels are low in both
sexes, but after this they increase in girls [42] and are then
higher than in boys during the following months [42, 43].
This is due to endogenous oestrogen production and is
associated with a temporary increase in ovarian follicular
development [21, 42]. Large ovarian follicles are seen
more often during the 1st than the 2nd year of life [21,
44]. In postmortem ovarian samples, the oestradiol con-
tent is higher during the first 6 months of life than in

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later infancy [45]. Ovarian granulosa cell products inhi-
bin B [19] and AMH transiently increase at the time of
the postnatal gonadotrophin surge [21, 46]. Unlike tes-
tosterone levels in boys that show a clear peak at 1–3
months of age and then decrease steadily towards the age
of 6 months, oestradiol levels in girls fluctuate (fig. 2)
[42], which probably reflects cyclic maturation and atro-
phy of ovarian follicles. Oestradiol levels decrease during
the 2nd year of life [42, 45], but higher oestradiol levels in
girls than in boys can also be seen with sensitive assays
during the prepubertal years [47].

Placental oestrogen stimulates the oestrogen target tis-
sues in the foetus, and at birth most full-term infants have
some breast tissue [48]. Although there is no sex differ-
ence in the mammary gland size at birth, later in infancy
the mammary gland size is larger in girls than in boys,
suggesting biological effects of endogenous oestrogens in
girls [42, 43, 48]. Uterine growth is also stimulated prena-
tally, and after birth, its size rapidly decreases during the
first months of life [42, 49]. This reflects the withdrawal
of high intrauterine oestrogen levels. Premature girls lack
the highest intrauterine oestrogen exposure of late preg-
nancy, and their mammary glands and uterus are less
stimulated than in full-term girls at birth [42]. Conse-
quently, the effects of postnatal endogenous oestrogen
levels in premature girls are more visible and postnatal
oestradiol levels are associated with simultaneous mam-
mary gland growth and uterine size [42].

**Postnatal HPG Axis Activation in Premature Infants**

At birth, gonadotrophin levels are higher in premature
than in full-term infants [24]. Prematurity appears not to
influence the timing of the onset of the postnatal gonado-
trphin surge as the gonadotrophin levels begin to in-
crease at the same time after birth as in full-term infants
[20, 21]. However, the gonadotrophin surge is augmented
in magnitude and also prolonged in premature infants
compared to full-term infants, and more clearly in girls
than in boys [20, 21, 24, 50]. According to our recent lon-
gitudinal data, postnatal pituitary activity declines at ap-
proximately the same postmenstrual age in full-term and
premature infants, suggesting that the activity of the hy-
pothalamic-pituitary unit in infancy is developmentally
regulated [20, 21]. The difference in hypothalamic-pitu-
itary axis activity between full-term and preterm infants
during the perinatal period is depicted in figure 3.

Increased HPG axis activity in premature boys is as-
associated with higher postnatal testosterone levels [20, 25,
50] and faster penile and testicular growth after birth
compared to full-term boys [20]. In premature girls, go-

![Fig. 2. Patterns of postnatal gonadotrophin and sex steroid secre-
tion in boys (a) and girls (b). Gonadotrophin levels start to in-
crease during the 1st week of life, peak at 1–3 months, and then
decline towards the age of 6 months. In boys, LH levels are higher
than in girls, and in girls, FSH levels predominate and remain el-
evated until 3–4 years of age. Testosterone levels in boys increase
following the LH levels and show a clear peak at 1–3 months of age,
but in girls, estradiol levels fluctuate, probably reflecting ovarian
follicular growth and atrophy. Estradiol levels in girls decline in the
2nd year of life.](https://example.com/fig2.png)
In girls, higher oestradiol levels have been reported in SGA than in AGA girls after a leuprolide (GnRH agonist) test, although non-stimulated levels have not been significantly different. The reason for the increased HPG axis activity following intrauterine growth restraint is not known.

Postnatal HPG Axis Activation in Reproductive Disorders

Postnatal HPG axis activation has been studied in several disorders affecting sexual development and these observations provide insight into the potential role of minipuberty in reproductive physiology. Furthermore, the first months of life provide a window of opportunity to examine the function of the HPG axis before puberty.

Infants with complete androgen insensitivity syndrome present lower-than-normal postnatal LH and testosterone levels, whereas in partial androgen insensitivity syndrome, testosterone and LH levels are normal or high. Consequently, androgen signalling appears to have a role in postnatal HPG axis activation. In aromatase deficiency, leading to low oestrogen levels, gonadotrophin levels in infancy are elevated in girls but not in boys, suggesting a more important role for oestrogens in the HPG axis negative feedback effects in females than in males.

In Turner syndrome, the pattern of FSH level in infancy is related to karyotype: in infant girls with 45,X, FSH levels are higher than normal and remain elevated up to 6 years of age. In contrast, girls with other karyotypes or mosaicism have close-to-normal FSH levels, suggesting retained ovarian feedback effects on pituitary FSH secretion. Infant boys with Klinefelter syndrome have also been reported to have normal levels of inhibin B, AMH and INSL-3, suggesting normal Sertoli and Leydig cell function in infancy, although elevated LH and FSH levels have also been reported. Testosterone levels in these boys have been reported to be normal or slightly elevated.

Mutations in the NR0B1 gene lead to congenital adrenal hypoplasia, a disorder characterized by adrenal failure, impaired sexual development at puberty (because of hypogonadotrophic hypogonadism) and infertility. However, postnatal HPG axis activation appears to be normal in boys with this disorder.

In cryptorchid boys, higher FSH and LH levels, lower inhibin B levels and reduced levels of INSL-3 in relation to LH have been observed at 3 months of age compared to healthy controls, while testosterone levels were normal.

In congenital hypogonadotrophic hypogonadism, both foetal and postnatal pituitary gonadotrophin secretion is low. During foetal life, placental hCG is able to stimulate the foetal testis, resulting in masculinization of the external genitalia. However, LH is needed for further growth of the penis and testicular descent. Consequently, boys with congenital hypogonadotrophic hypogonadism present a micropenis and often also undescended testes at birth. In boys with hypogonadotrophic hypogonadism, the lack of postnatal HPG axis activation has been associated with involution of the ex-
ternal genitalia after birth [61]. Hormone therapy has been used to induce penile growth and descent of the testes in infant boys with hypogonadotropic hypogonadism [62].

Conclusions

The hypothalamic-pituitary axis is active in the mid-gestational foetus and the diminishing activity during the latter part of pregnancy results from the suppressive effects of placental hormones on the foetal hypothalamus and pituitary. This restraint is removed at birth, leading to reactivation of hypothalamic-pituitary activity and increased levels of gonadotrophins. As a consequence, gonadal hormone production is activated in both sexes. Gonadal steroid levels are increased in a sex-specific manner: testosterone levels peak in boys at 1–3 months of age and decline at 6 months of age, whereas in girls oestradiol levels fluctuate and remain elevated longer. Elevated gonadal steroid levels are able to stimulate the target tissues in both sexes. However, the exact role of this transient activity for further reproductive development still remains uncertain, although in the context of the perinatal programming theory, this period might be important for further reproductive health and disease. In this regard, the possible effects of the altered postnatal HPG axis activity observed in premature or SGA infants in comparison to healthy full-term infants need further attention. Finally, the mechanism that leads to quiescence of the HPG axis after infancy for the rest of the childhood years remains still unknown.

References


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