

# THYROID PATIENT ADVOCACY NEWSLETTER

Autumn 2011



**You have had to wait some time for the 2011 Autumn Newsletter, and I apologise for this. There is no excuse other than to say it has been a very busy year for TPA, not forgetting the time taken in responding to hundreds of messages being sent by our members every month to our very busy Internet Thyroid Support Forum. Membership now stands at 2535... and growing!**

Because of the sheer volume of work involved, we have decided that instead of a quarterly Newsletter, we will make this biannual, and give you a bumper pack of information to keep you going – as we have given you in this edition.

For those new members who know little about what Thyroid Patient Advocacy (TPA) is all about, we became a registered Charity in October 2010, so we are still very new, and still finding our feet and we are not ashamed to say it....but we need help.

Thyroid Patient Advocacy - 'Real Solutions for Real Suffering' is looking for volunteers who wish to become part of the 'Solution', so - if you feel you have experience in this field and believe you have something to offer, or you would like to learn how to help TPA and all those left suffering, please contact us at [info@tpa-uk.org.uk](mailto:info@tpa-uk.org.uk) and tell us why you feel you could make a difference. **BE THE SOLUTION!** Help us to help all those left suffering with thyroid and related diseases.

TPA has been successfully run on a completely voluntary basis since July 2007. In just over 4 years, we have seen a steady growth in membership and an increased activity in the campaigning work we are involved in which is being undertaken



The TPA June 2011 Conference

by our team of great volunteers, most of whom suffer with thyroid disease, but who wish to be actively involved in helping others.

Our charity objects are specifically restricted to the following: The relief of sickness and preservation of health of persons suffering from thyroid-related disease and related conditions, particularly but not exclusively by educating and promoting good practice in the treatment of thyroid-related disease and related conditions amongst health professionals, service providers and the public, and promoting high standards and professional competence in the provision of patient care.

TPA is the only Thyroid charity actively campaigning for such changes to be made in the diagnosis and management of all those suffering with thyroid disease within the UK and worldwide.

Our vision is that within 5/10 years, we expect to see every county in the UK and every country throughout the world, with health service professionals who will be diagnosing and treating all thyroid hormone related conditions and who

will prescribe all forms of thyroid hormone when required, without the difficulties associated with this today. There will be ample expertise and resources in the health service to uncover and treat people who have been diagnosed with ME, FM, CFS and other conditions and who have relatively normal serum levels of thyroid hormone, but who have underlying thyroid hormone issues. There will no longer be a need for the TPA organisation at all.

TPA is also actively involved in the process of setting up a number of local thyroid support groups, and is seeking to increase this network, which is vital, especially for those without access to the Internet. You can read more about the present list of groups elsewhere in this Newsletter. Also, our local thyroid support groups would welcome your assistance and encouragement. Please do let us know if you would like to become involved in this project, and perhaps give a little back to TPA if you feel you have been helped yourself.

We are keen to encourage membership of TPA, not only from

Registered as a Charity Number: 1138608.

Registered Office: Squirrel Cottage, Ickornshaw, Cowling, N.Yorks. BD22 0DH

Trustees: Dr Barry Durrant-Peatfield (Patron), Sheila Turner (Chair), Gill Bell (Secretary) Marie Holloway, Jenny Stenning

people with a thyroid disorder, but also from amongst the medical profession. If you wish to learn more about the work of TPA, please see our web site [www.tpa-uk.org.uk](http://www.tpa-uk.org.uk) and/or join our Internet Thyroid Support Group. As a member of TPA you will receive our free biannual newsletter containing articles by our medical advisers and other professionals on various aspects of thyroid and thyroid related disease, plus details of our local support group's activities and reports of our Annual Conferences, which are becoming very popular events.

As well as becoming a member of Thyroid Patient Advocacy, we hope you may be able to help us in several ways:

- by informing other sufferers about the support we can offer them;
- by displaying our TPA poster in public areas, i.e. surgeries, hospital waiting rooms,
- slimming clubs, libraries, WI venues etc;
- by distributing patient brochures (these are in the process of being created). You may also wish to contribute to our newsletter.

We welcome and support involvement from anybody willing to help our cause. TPA will provide a professional support system, using a network of people who can volunteer their time, skills, and expertise to our cause. As we transform our charity, we hope to transform the lives of all those who

need our help.

Financially we intend to fund our projects by promotion, fundraisers and sponsors and we are confident that we can achieve so much with the strength and support of the wider community.

The most immediate projects we are looking to fund over the coming year, which will help us fulfill the above projects are:

- The creation and maintenance of a brand new professional web site
- Publishing of thyroid related pamphlets/brochures/posters
- Publishing biannual newsletters
- Publishing and disseminating of 'Thyroid Problems: The TPA Guidebook' for those with no access to the Internet.
- Creation of a European Hypothyroid Patient Survey
- Practical training of staff/volunteers
- Advertisements
- Telephone helpline
- Essential administrative costs for the day to day running of the charity.

The projects requiring funding will, of course, be changing over time. Funding of research activities is also a very important area for TPA.

For all those of you who have so kindly donated to us in the past, and to all those who will be donating in the future, a very big THANK YOU from all at TPA. Your donations are helping to save lives. Please see 'Gift Aid' form at the end of this Newsletter.

### Thyroid Jokes

*Thanks to Don:*

Recently, I had a sonogram done on my thyroid. I have six lumps, two of them quite large. While I was in the testing room, a nurse asked me what I thought of the scan. I told her that I didn't care whether it was a boy or a girl, I just wanted it to be healthy. The nurses sure got a good laugh from that.

*Janet Glassberg in Arizona  
Highways, June 1998*

Prior to treatment with thyroid they used an unusual therapy for goiters in the old west. They wrapped a snake around the neck and let it slither over the goiter to shrink it!

*Thanks to Dr. Nancy Patterson of the  
National Graves' Disease  
Foundation:*

Two women were walking down the street and a talking frog said, "Kiss me and I'll turn into an endocrinologist." One of the women scooped up the frog and put him in her shopping bag. The other women said, "Aren't you going to kiss him?" Her friend replied, "Hell, no. A talking frog will talk to me more than my endocrinologist!"

What did the radiologist nuclear medicine doctor say to the Graves' Disease patient? The pellet with the poison is in the flagon with the dragon."

*Thanks to RitaB:*

My daughter was recently diagnosed with Graves' disease. When she went in for her radioactive iodine treatment, the nurse went over do's and don't's. Do sleep alone, do flush the toilet 3 times after using, etc. The last thing she said was, "Get up at 3 a.m." When my daughter asked why -- the nurse replied, "Don't you want to see if you're glowing in the dark?"

### PLEASE SUPPORT OUR WORK

Do you have any legal experience and would you be happy to help us with some of the finer points of our campaigning? If so, WE NEED YOU! please contact us at [info@tpa-uk.org.uk](mailto:info@tpa-uk.org.uk) and tell us about yourself and your work

Once again, yet another great success with our TPA Annual Conference, attended by approximately 100 people who travelled from all corners of the UK. The Conference Suite of The Black Bull Hotel was a great venue, set close to the top of the High Street, behind the hustle and bustle of the Saturday Market stalls in the beautiful little market town of Skipton in North Yorkshire. Its quiet charm, community spirit, lack of ugly modern development and flourishing independent retailers saw Skipton sneak the top award for the best High Street of the year in the UK, beating its far more famous rivals, High Street Kensington and Portobello Road, both in west London.

The Owners of The Black Horse laid out a wonderful buffet and even took into consideration those of you on a special diet and laid out a separate table for those on a gluten free diet, it seemed nothing was too much trouble. We will certainly be using this venue for future Yorkshire Meetings. It was decided that because people from 'down South!' found Yorkshire a tad too far to travel, that one year, we would hold our Conference in the Midlands (probably Birmingham) and alternate years in Yorkshire, for those 'up North!'

### TPA JUNE 2011 CONFERENCE - SKIPTON, YORKSHIRE



We started our Lunch at 12.00 noon prompt, which proved very enjoyable, after which, everybody settled down after much chatting between our members, and introducing themselves to each other, and we started the meeting at 2.00p.m.

Because the typing out of speeches proved to be quite a hefty task in the past, and because the quality of the recordings this year by Mike is excellent, we are giving links to the Sound Files, so you can sit back in comfort, make yourself a cuppa (or something even more stimulating, like coffee \*grin\*),

put your feet up, sit back, and listen.

Dr Peatfield gave a talk about 'The Diagnosis of Thyroid and Adrenal Illnesses and ME and A Few Notes on Peripheral Thyroid Hormone Resistance' [Dr Peatfield's speech 44m 54s.mp3](#)



Our second Speaker was Dr John Roberts – the title of his speech being "Never in the Field of Health and Healing Have so Few Done so Much Harm to so Many" – or alternatively – "Only Your Dentist is Allowed to Poison You" [Dr Robert's Reconstructed Total 28m 52s.mp3](#)

Our third Speaker was Dr Gordon Skinner and the title of his speech is a little more tricky as he covers quite a few topics, including 'There was once an Englishman, a Scotsman, an



From Right to left Dr John Roberts, Dr Barry Peatfield, Dr Gordon Skinner and Sheila Turner

Irishman, a Welshman and a Famous Endocrinologist' – plus 'An Update on the Thyroid Register' plus - [Dr Skinners speech 20m 46s.mp3](#)

The fourth speech was given by Sheila Turner, talking about her quest to find some answers as to why the NHS continue to leave so many patients suffering so badly Sheila's Talk [Before the Diet Speech 14m 40s.mp3](#).



Sheila carried on to talk about "The Incredible Diet that Really Works...", which many of our members are finding is proving to be so very successful. This hCG Diet (Human Chorionic Gonadotrophin) is in the form of homeopathic drops which are taken with a very low calorie diet. Unfortunately, the whole of the



speech could not be recorded and put on our web site because of legal reasons - more of which you can see elsewhere in this Newsletter [Sheila's hCG Diet Talk 15m 55s.mp3](#). However, if you wish to know more about this amazing diet, and you are not a member of our Chat forum, please ask Lilian or myself to send you an invitation and you can ask questions about the diet protocol there.

One of our members, Helen Humphries, followed Sheila's speech by talking about her own personal experience of using this hCG and VLCD. She had, at that time, managed to lose over 3 1/2 stone [Helens HCG diet speech 7m 19s.mp3](#). This was followed by a very interesting Question and Answer Session:

[Q1 Why do Desiccated Thyroid preparations have unsuitable fillers.mp3](#)  
[Q2 How to Cope with Doctors who dismiss a patient's request .mp3](#)  
[Q3 Why Do I need T4 if I take T3 & can't convert T4 anyway.mp3](#)  
[Q4 Advice Requested on Daughter's Health.mp3](#)  
[Q5 Are there links between Fibromyalgia & Hypothyroidism.mp3](#)  
[Q6 What are the panel's views on Low Dose Naltrexone & Autoi.mp3](#)  
[Q7 Is a 'high' antibody level and indication of severity of.mp3](#)

We have not yet arranged dates for our 2012 Conference which we hope will be held in either Birmingham or elsewhere in the Midlands, but as soon as we have more information about this, we will let you all know.

## “AN UPDATE ON THE INCREDIBLE DIET THAT REALLY WORKS...”

...it really does... no matter what others may try to make you believe. However, The Medicines and Health Care Products Regulatory Agency (MHRA) received a complaint from "...a concerned member of the general public" about an Email response to our 'Chat' forum messages regarding the hCG homeopathic drops and very low calorie diet. The MHRA stated:

"The complainant is concerned that an email posted by TPA to members contained a lot of information on the benefits of hCG which is an unlicensed medicine in the UK and

suggests that it can treat cancer. We recognise the important work carried out by patient organisations and support the provision of information provided it is factual and educational and compliant with the UK legislation. As you are aware the Advertising Regulations prohibit the promotion of unlicensed medicines. The Cancer Act 1939 (enforced by Trading Standards) prohibits claims that a product will treat cancer. Please see the following link for further information <http://www.legislation.gov.uk/ukpga/Geo6/2-3/13/section/4>

We would like to advise you in future to ensure that information sent out to patients or posted on your website is compliant with the UK legislation. In particular, you should ensure that any information on unlicensed medicines is factual and balanced. You should review your website and forum postings against MHRA guidance to ensure compliance with the Advertising Regulations and Cancer Act. Please confirm you will be doing so with any comments you wish to make by 3 August 2011"

We have now complied with their

request and the MHRA have stated that they are happy for us to carry on promoting that there is a clinical trial running for a weight loss treatment and that TPA members who are already participating in this trial, or wishing to take part can carry on doing so, and that Gill can continue as the UK co-coordinator.

Anybody wishing to take part in the clinical trial running for a weight loss treatment should contact Jenny in Australia for further details [freemangoldcoast@hotmail.com](mailto:freemangoldcoast@hotmail.com). The effect this has had on many of our members has been truly amazing, resulting in many losing several stones in weight and feeling very healthy into the bargain.

Previous to this particular complaint, the MHRA had received a letter "...from a concerned member of the general public" who had listed no less than 17 complaints about information and statements made in our web site [www.tpa-uk.org.uk](http://www.tpa-uk.org.uk). I was asked to respond to each complaint within 7 working days. Most of the complaints were about the natural thyroid extract Armour Thyroid, but some about other matters. With the help of Dr Skinner, Eric Pritchard and Julie Cameron, I responded to each separate complaint in detail. On receipt, The MHRA then re-examined

our web site. I was delighted when they wrote to tell me (and the complainant) that they could find no cause for concern and dismissed all 17 complaints. This complaint came in just after the article in the Mail on Sunday 3rd July 2011 "For 12 Years, I was a Victim of The Great Thyroid Scandal". More about this article on our web site [http://www.tpa-uk.org.uk/mail\\_on\\_sunday.pdf](http://www.tpa-uk.org.uk/mail_on_sunday.pdf)

The Mail on Sunday article brought in hundreds of emails from sufferers from around the UK asking for further information and membership of our forum shot up. Our web statistics show the number of visitors to our web site every 7 days and on average, the number of unique visitors each week is between 3000 and 3500, but, from the 3rd to 10th July, there were no less than 8272.

Dr Peatfield's clinics were rapidly filled up and he is now booked up into the middle of January. There's a very serious problem out there that MUST be addressed.

### THE BIG QUESTION – IS THERE AN ANTI-T3 CONSPIRACY?

By Eric K. Pritchard, M.Sc.

We wonder why there is such an anti-T3, pro-T4-only belief in medical practice particularly since such beliefs are not totally sustained by medical science. Is there a conspiracy against prescribing T3? The answer to this may be found by applying an aspect of American case law. The US Supreme Court recognized the reality of conspiracies. They are not documented. The written conspiracy contract is quite rare. However, there is the question of what would the conspirators do if there were no conspiracy? In particular, what would medical practice do? This essay explores this question with numerous answers:

### Medical Ethics.

There are several sources of statements of medical ethics, the World Medical Association, The Declaration of Geneva, The UK General Medical Council, The American Medical Associations, etc. These views of ethics are quite different from the reality of medical practice.

*A Physician Shall Owe His/Her Patients Complete Loyalty and all the Scientific Resources Available to Him/Her, (World Medical Association, 1949, 1968, 1983) which was echoed by the UK General Medical Council: Provide a Good Standard of Practice and Care. Keep Your Professional Knowledge and Skills up to Date.*

The scientific resources have made many contributions against the T4-only therapy dictate and for the consideration of T3-containing therapies. As early as 1947, Drs. Kirk and Kvorning warned that synthetic T4 (levothyroxine sodium) was not treating the symptoms of hypothyroidism in all patients. This was confirmed by Dr. Means in 1954. Drs. Gross and Pitt-Rivers found, in 1953, T3 to be substantially more active than T4. In 1960, Dr. Goldberg made a case for a disease (euthyroid hypometabolism) that caused the same symptoms as hypothyroidism even when the thyroid gland was functioning normally. Of 500 subjects he found this to be true in 32 and successfully treated them with a T3-only therapy. Medical science later discovered the relevant physiology. Dr Refetoff and staff discovered peripheral cellular hormone reception in 1967 and refined this concept in later years. Dr. Braverman and his staff discovered peripheral metabolism of the relatively inactive T4 to the active T3 in 1970. Drs. Baisier, Hertoghe, and Eeckhaut studied endocrinology's failed patients to find they did have basically the same symptoms, as noted by Dr. Goldberg, this underlying disease



Hmm...the symptoms are fatigue, weight gain, memory problems... that sounds vaguely familiar

could be detected better with different tests, even a clinical test, and they could be treated properly with the much maligned desiccated thyroid. Nonetheless, medical practice ignores this and supporting science.

“If a scientist does several experiments on the basis of a hypothesis and they all fail, he will abandon the hypothesis. Why are we so reluctant to do this in medicine?” - Dr. David Smith, *Lancet*.

The improper ignoring of counterexamples by medical practice is the answer to Dr. Smith’s question. According to the concepts of inductive logic, which is used in all scientific research, all science is subject to counterexamples. For example the law of gravity discovered by Newton was refined by Einstein when masses move near the speed of light. Einstein’s counterexample refined, not replaced, Newton’s theory. We must note that Dr. Goldberg produced 32 patient counterexamples to the T4-only diagnostics and therapy and Dr. Baisier, et al., produced another 40. Physicians who do give their loyalty to their patients with the continuing symptoms of hypothyroidism and do treat these failures of endocrinology with a T3-containing therapy also produce patient counterexamples. The TPA-UK registry has found more than 1200 patient counterexamples.

Sir Karl Popper, a famous philosopher on the nature of science, claimed that science is not proven as well by confirming studies as by the lack of counterexamples. Thus, counterexamples trump confirming studies or at least limits, their logical “jurisdiction.”

The ignoring of counterexamples has greater implications. Some counterexamples have become triples by getting a T3-containing therapy, being denied it, and then getting a T3 therapy again. Aside from having positive results instead of negative results, these triples fit the medically accepted CDR (challenge, de-chal-

lenge, re-challenge) test for causality. In other words, triples demonstrate the good health is caused by T3 in some patients. Specifically, they were prescribed T3 and developed good health. They were subsequently denied T3 with a return of bad health, and still later they were prescribed T3 again with a return of good health. Indeed, this proof of causality, at least for some, is substantiated by relevant medical science as noted above.

A Physician Shall Be Honest in all Professional Interactions. American Medical Association (2001)

My first impression of endocrinology dishonesty appeared in a critique of Wilson’s Syndrome. This declaration against the prescription of any T3-containing hormone therapy cited the highly regulated conversion of the relatively inactive hormone T4 to the active T3. However, that regulation had to be more than just highly regulated. It had to be perfect. If T3 is not to be prescribed for anyone at anytime, then this conversion could not fail or become deficient in anyone at any time. The idea that any bodily function remains operable in all people for all their lives stretches medical credibility beyond the breaking point.

Nonetheless, endocrinology cites numerous anti-T3 studies to make this dishonest point. An analysis (Dr. Grozinsky-Glasberg, et al.) of these studies finds that this point is indeed the case. On the surface, these studies have claimed T3, the active hormone, is ineffective while T4, the relatively inactive hormone, is effective. Considering, the findings by Dr. Gross and Pitt-Rivers, this can only exist in a special case. That special case is exposed by a further analysis of these studies. In general, the subjects did not have continuing symptoms of hypothyroidism. Further, the therapeutic value (US National Institutes of Health) of the T3 was not as great as the T4 it replaced in these studies. So, how could these subjects feel better?

Logically, the extension of these studies to those with continuing symptoms of hypothyroidism is not valid and dishonest.

Endocrinology’s emphasis on T4 is misplaced because “T3 is the active ingredient, and it’s the thing that accounts for the thyroid hormone action. As I’ve been reminded many times, there are no intracellular events that we know that can be described by T4 at the level of the nucleus. Only T3. T4 is not the active compound.” (Dr. E. Chester Ridgway at a Food and Drug Administration hearing) So, if T3, not T4, is the one that is ultimately used, why isn’t T3 part of the diagnostics used? So, if action is T3 in the cells’ nuclei, not T4 in the blood, why isn’t the use of T3 by the cells part of the diagnostics used? Why?

Endocrinology claims that the continuing symptoms of hypothyroidism are merely “nonspecific symptoms” that medical science cannot fathom. However, as noted above, medical science does provide explanations and produced patient counterexamples. As discovered by the counterexample registry, their numbers are substantial.

Endocrinology also claims that the continuing symptoms of hypothyroidism are also “functional somatoform disorders.” Endocrinology claims victims merely imagine their suffering. Since these continuing symptoms do have at least some causes known to medical science, these causes must be tested per the Differential Diagnostic protocol. So, such untestable diagnoses must be reserved until after all physical potentials have been eliminated. The patient counterexamples indicate there are physical potentials that have not been eliminated.

So why does endocrinology make excuses? These excuses for endocrinology’s failures do not meet the standard of ethics for honesty.

A Physician Shall Act Only in the Patient’s Interest When Providing

Medical Care Which Might Have the Effect of Weakening the Physical and Mental Condition of the Patient. (Emphasis added) World Medical Association (1949, 1968, 1983)

Maintaining the T4-only therapy, even for patients with continuing symptoms, as Dr. Grozinsky-Glasberg, et al. recommend, has the effect of weakening patients with continuing symptoms since they do reflect the reduction in the patient's natural ability to fight disease, particularly life's great killers, diabetes and heart disease. Why would medicine continue to recommend a therapy that has failed the patient? Why?

### *Clarity in Language.*

Clarity in both written and spoken language has been demanded for centuries. A 1990 requirement for medical guidelines by the Institute of Medicine requires "unambiguity." Later, the American Association of Clinical Endocrinology demands guidelines "Define terms that are unfamiliar, critical, or subject to misinterpretation." The Royal College of Physicians requires recommendations be "specific and unambiguous." But guidelines are not unambiguous.

Unfortunately, for those with the continuing symptoms of hypothyroidism, there are two classes of definitions for "hypothyroidism," linguistically proper and popular. The proper definition is limited to the clinical consequences of deficient secretion by the thyroid gland. The popular definition is the clinical consequences of deficient levels of thyroid hormones in the body. However, as medical science demonstrates, such a definition implicates deficient secretion by the thyroid gland and the post thyroid functions of peripheral conversion and peripheral cellular hormone reception and the energy production of the peripheral cells.

If hypothyroidism guidelines were "specific and unambiguous" as well

as logically consistent, then either definition would change the patient-physician relationship from win-lose to win-win. If the proper definition were stipulated, then the post thyroid functions of peripheral conversion and hormone reception would be beyond the "jurisdiction" of the guideline. Then physicians would be free to use reasonable medical care such as demonstrated by medical science to treat such deficiencies. On the other hand, if the broad definition were stipulated, then the guideline would explain post thyroid functions and how to diagnose and treat their deficiencies. Then physicians would not be liable for investigation by the General Medical Council or any other board of medicine.

However, endocrinology continues with its ambiguity at the expense of all those with continuing symptoms of hypothyroidism. Why?

### *Custom.*

Physicians, like other skilled workers, are supposed to follow the customs of their profession or craft, except when that mythical "reasonable man" would not. Indeed, no reasonable man would continue the T4-only therapy when the patient is suffering with the continuing symptoms of hypothyroidism. A "reasonable man" would do, has physicians must, consult medical science for the answers, such as a T3 therapy, adrenal deficiencies, and/or deficiencies in supporting chemistry. However, such alternatives are not suggested. The T3 therapy is effectively banned as if it were law. Why?

### *Mandatory Guidelines.*

The enforcement of guidelines changes them from being voluntary to being mandatory because the enforcement creates liabilities far beyond the potential value of alternatives to the guidelines. Indeed, physicians have lost their license to practice and their career by straying from guidelines enforced the General Medical Council

or boards of medicine. Even the fear of investigation is too costly to risk. Consequently, enforced guidelines are effectively mandatory and have the general character of law.

### *Liability to the Law.*

The mantra of tort law is "knew or should have known." Indeed, endocrinology knew or should have known all of the following:

1. Medical science warned endocrinology the T4-only therapy did not always mitigate the symptoms of hypothyroidism. (Kirk, Kvorning, and Means)
2. Medical science demonstrated a malady that was not caused by thyroid gland deficiency yet presented the same symptoms. (Goldberg)
3. Medical science discovered the functions which could present the same symptoms. (Refetoff, Braverman, et al.)
4. According to inductive logic, the basis of all science including medicine, scientific conjectures are subject to counterexamples. Indeed counterexamples do trump, at least in part, confirming studies.
5. According to deductive logic, conjectures can not be extended beyond their premises.

By ignoring the above, endocrinology created tort liabilities. Why? Indeed, why have medical ethics been violated? Why are demands for clarity ignored? Why is an unreasonable custom enforced? We can only assume some human frailty. Greed? Ego? Fear? ....**What?**

### REGISTER OF COUNTEREXAMPLES TO THYROXINE-ONLY THERAPY

As many of you will be aware, TPA is in the process of creating a World Register of Counterexamples to levothyroxine-only (T4) therapy. This short survey is applicable only to those who continued to suffer symptoms on T4-only therapy, and who found those symptoms disappeared once they were started on a T3 hormone containing product, whether synthetic or natural thyroid extract.

The objective of this Register of Counterexamples to T4-only therapy is to draw to the attention of those responsible authorities throughout the world, the dire need for an urgent re-examination of the existing protocol for the diagnosis and management of the symptoms of hypothyroidism. The patient counterexamples stand at the present time at 1301.

(A counterexample is a situation which fits the concept or premise of an idea but produces a different

result. To be responsible, a scientist who finds a counterexample to his idea, must limit or abandon his idea as unworkable or not reliable. The T4-therapy does not work for all.)

If you fit this category, please will you complete the 3 questions with either 'YES', 'NO' or N/A here [http://www.tpa-uk.org.uk/register\\_of\\_counterexamples.php](http://www.tpa-uk.org.uk/register_of_counterexamples.php). All responses will be collated online, and your email address (if you provide one) will be used ONLY to contact you at a later date should this become necessary.

In a survey of 1500 hypothyroid patients undertaken by TPA-UK in 2005-2006, the dissatisfaction of many patients is highlighted. When asked of those patients undergoing L-thyroxine therapy, "Do you feel that you have fully regained your optimal state of health?" 1176 (78.4%) Answered "No"!

### TPA LOCAL SUPPORT GROUPS

#### *Bristol*

Delyth [pOshbint@yahoo.co.uk](mailto:pOshbint@yahoo.co.uk)

#### *Surrey*

Maya [tangerinedream\\_uk2000@yahoo.co.uk](mailto:tangerinedream_uk2000@yahoo.co.uk)

#### *York*

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#### *London*

Julian [julianj@totalise.co.uk](mailto:julianj@totalise.co.uk)

### URGENT NOTICE: YOU CAN HELP US AND HELP YOURSELF

1. Do you live in the UK and been given a diagnosis of hypothyroidism and prescribed L-thyroxine (T4-only)?
2. Was your dose titrated according to thyroid function blood test results, without your symptoms being resolved?
3. Did you ask your GP/consultant for a trial of either synthetic T3 (Liothyronine), either in combination with T4, T3 alone or a natural thyroid extract (NDT)? Did your GP:
  - Refuse to give you a trial of Liothyronine?
  - Refuse to refer you to an endocrinologist? – and/or
  - Did your local Primary Care Trust refuse to fund NDT after your doctor requested this?
4. Did you feel forced into taking your thyroid health into your own hands and purchased some form of T3 (either synthetic or NDT) from Internet Pharmacies to treat your remaining symptoms?
5. Did you find your symptoms were mitigated or resolved completely?
6. Does your GP/Consultant still refuse you a prescription for any T3 containing hormone?
7. Would you be willing to testify to the above?

If we can get sufficient people from one particular Primary Care Trust answering 'YES' to the above questions, we have a solicitor who may be able to take our case forward. Please write to me privately giving me your answers and the name of your local Primary Care Trust at [sheila@tpauk.com](mailto:sheila@tpauk.com)

### **WHY I BELIEVE T<sub>3</sub> SHOULD BE THE VERY LAST TREATMENT THAT THYROID PATIENTS CONSIDER**

By TPA Member, Paul Robinson

I developed thyroid disease over twenty years ago. I suffered during the early years as many thyroid patients do. I was given the standard levothyroxine (T<sub>4</sub>) thyroid treatment and when I was told “you’re cured!” I asked “why do I still have all the symptoms of hypothyroidism then?”

The answers to the question were varied depending on the doctor I spoke to. I was told I had some unknown disease that appeared to have symptoms reminiscent of hypothyroidism. I was told that I had a psychological problem - possibly depression. I was consistently told I could no longer have any problems with thyroid hormones because my thyroid hormone levels were ‘normal’ as determined by laboratory testing.

Far too many thyroid patients who do not feel well on the T<sub>4</sub> thyroid hormone medication have encountered these ridiculous attempts to justify poor diagnostic work and even poorer treatment.

Eventually, I fully recovered through the careful use of the far less frequently prescribed active thyroid hormone T<sub>3</sub>. T<sub>3</sub> is the shorthand for the thyroid hormone triiodothyronine. T<sub>3</sub> is made in small amounts by a healthy thyroid gland but most of the T<sub>3</sub> in body is produced by the conversion of the mainly inactive T<sub>4</sub> in the liver, kidneys and other tissues. T<sub>3</sub> exists in medication form as a compound called liothyronine sodium. For the purpose of this article I’ll just call it T<sub>3</sub>.

Having been on T<sub>4</sub> for many years I was eventually given short trials of T<sub>4</sub>/T<sub>3</sub> in combination and natural desiccated thyroid (NDT). Any treatment that included T<sub>4</sub>

failed to eliminate my symptoms but once I began to use T<sub>3</sub> correctly my symptoms vanished. For me the use of T<sub>3</sub> was like someone had thrown a switch - it was that dramatic a response. I have now been using only T<sub>3</sub> for around fifteen years and I still feel healthy.

I have spent the past five or six years taking part in many hundreds of discussions amongst thyroid patients on Internet forums in various parts of the world. When I first began to discuss T<sub>3</sub> on these forums I frequently met ignorance, defensiveness, incredulity and even abuse from other thyroid patients. There was so little discussion about T<sub>3</sub> and so few people who had good experiences of using it that I found the Internet forums to be quite difficult places to inhabit.

The situation is quite different today. More and more thyroid patients in the UK and the USA are trying to gather information about T<sub>3</sub>. In the past couple of years I have spoken to dozens of thyroid patients who have managed to recover their health using T<sub>3</sub> and many patients are now hungry for information about this relatively unknown and under-prescribed thyroid medication.

However, increasingly I get questions from people who want to know if they might be able to get well by taking T<sub>3</sub> instead of T<sub>4</sub>. Some people even consider switching directly from their current T<sub>4</sub> medication to T<sub>3</sub>. This increasing trend has provided me with the title of this short article.

T<sub>3</sub> is not an easy drug to use and any patient and doctor who begins to introduce T<sub>3</sub>, whether on its own or in combination with T<sub>4</sub> or NDT, must know quite a lot about it before commencing its use. My own personal view is that some of these thyroid medications are more difficult to use than others. I believe that the order goes like this (with increasing

difficulty):

1. T<sub>4</sub> (levothyroxine)
2. T<sub>4</sub> / T<sub>3</sub> in combination
3. Natural desiccated thyroid (NDT)
4. NDT / T<sub>3</sub>
5. T<sub>3</sub> on its own (pure T<sub>3</sub>)

I’m prepared to debate where 2 and 3 are relative to each other and possibly even 4. What is clear to me is that 1 is definitely easier to use than 2-4 and 5 is definitely a lot harder to use than any of them.

Why should I say this? Once the nature of the T<sub>3</sub> hormone is understood and the reasons why people resort to it is also taken into account, then it should become clear why T<sub>3</sub> is a medication that should not be seen as a simple panacea.

Endocrinologists have told me that the typical daily T<sub>3</sub> replacement dosage for adults is between 40 and 60 micrograms per day. However, I can find no scientific research evidence to support the recommended 40 to 60 micrograms per day range. I have located case studies that suggest the required daily dosage of T<sub>3</sub> may need to be in the range 75 - 162.5 micrograms. Some patients have even needed 250 or 300 micrograms of T<sub>3</sub>.

Most of the thyroid patients I have communicated with that are on T<sub>3</sub> replacement therapy use between 40 and 175 micrograms of T<sub>3</sub> per day, with a few requiring even higher T<sub>3</sub> dosages. This potentially wide replacement dosage range clearly presents some risks if someone was to inadvisably raise their T<sub>3</sub> dosage.

In the human body, the biological half-life of T<sub>4</sub> is approximately seven days, which means a patient could take their entire daily dosage of synthetic T<sub>4</sub> in one go, without any issues, because it is used up relatively slowly.

In contrast, the biological half-life of T<sub>3</sub> is believed to be twenty-four hours. Therefore, a dose of T<sub>3</sub> remains in the body for a far shorter period of

time than T4.

A single dose of T3, taken on an empty stomach, is rapidly absorbed and reaches peak circulating concentration in just two to three hours after ingestion. Blood serum concentrations of T3 are elevated for six to eight hours. After this, blood serum concentrations then decline again, unless another dose of T3 is ingested.

The other interesting fact about T3 when taken as a medication is because it arrives in the body extremely quickly it has the effect of rapidly suppressing the TSH. Therefore, patients who are receiving only T3 replacement therapy should expect unusual laboratory tests of thyroid hormone levels. Low FT4 levels should be expected. FT3 results could be low, normal or elevated, depending on how much T3 is being prescribed and the exact time of the thyroid blood test, in relation to the time that the last dose of T3 was taken. TSH could be highly suppressed or at the very least TSH is likely to fluctuate far more with the use of T3 medication than with T4.

The above information, on the rapidity with which T3 achieves peak serum concentrations and then declines again and the potential for unusual TSH, FT4 and FT3 results, is very important. This means that laboratory tests that attempt to assess the adequacy of replacement with T3 are extremely difficult to make sense of, because of the wide and rapid fluctuations of T3 in the bloodstream.

Patients that are using T3 on its own will certainly struggle to get any value at all from thyroid blood test results. Those that are using T3 in combination with T4 may also see some distortion of their thyroid blood test results depending on how much T3 is being used. This means that other methods need to be used to manage the T3 treatment and set the correct level of T3 medication. Symptoms and signs may be used

but this is not easy by any means.

Unfortunately, many doctors appear to not be aware of any of this and still cling on to the idea that they can use thyroid blood test results to monitor T3 replacement and manage their patient's T3 level.

Someone new to T3 replacement therapy may believe that the medication can be taken in a single daily dose, just like synthetic T4. This may work for a few people but for others, the daily dosage of T3 will need to be split up and taken in smaller doses, known as divided doses.

This divided dose approach enables T3 to be taken at various intervals throughout the day, in order to provide a steady supply of T3 to the body. The use of divided doses also ensures that no single dose of T3 creates an exceptionally high peak level of T3 in the tissues of the body.

I have now communicated with many patients who use T3 replacement therapy. There are a small number of patients who do manage on one or two divided doses of T3 per day. However, the vast majority of patients using T3 replacement therapy appear to be using between three and five divided doses of T3 per day.

Using divided doses of T3 clearly adds a lot of complexity to the life of thyroid patients. A further complication of the use of T3 is due to the suppressive effect that it can have on TSH. The level of TSH influences the conversion of T4 to T3. A high TSH results in the maximum level of conversion of T4 to T3. A fully suppressed TSH will result in the conversion rate of T4 to T3 being reduced to the minimum level.

For the patient on a combined therapy with T4 and T3 then this is very significant indeed. Some doctors attempt to perform simple mathematical calculations when they add T3 to their patient's T4. They reduce their patient's T4 dosage

when T3 is added. Often there is no understanding that the added T3 is likely to have a suppressive effect on TSH and this is likely to downgrade any T4 to T3 conversion rate. Taking some of the patients' T4 away as well is only likely to make things worse. So, finding the right balance of T4 and T3 can be an extremely challenging task.

In summary, the use of T3 has a number of difficulties:

The wide range of T3 dosages means that great care needs to be taken to avoid causing tissue over-stimulation by thyroid hormone.

The half-life if T3 is short and the drug is very potent. T3 generally needs to be taken in at least three divided doses per day and sometimes four or five work better for some people. Some people do find that they do better with one of two divided doses. These options require considerable work for everyone who starts to use T3.

T3 acts quickly and can distort thyroid blood test results of TSH, FT4 and FT3. For someone using only T3 the thyroid blood test results are virtually impossible to use for managing the treatment. Dosage management therefore becomes quite complex, as symptoms and signs need to be used to determine the appropriate T3 medication level.

T3 used in combination with T4 can also prove difficult. Blood test results can be distorted, divided doses of T3 need to be used and the conversion rate of T4 can deteriorate.

All of the above difficulties mean that using T3 on its own is not something that anyone should want to do unless everything else had been tried and failed. Using T3 in combination with T4 is simpler but has its own issues. As well as bearing the above in mind, investigations into deficient nutrients or low cortisol levels should be thoroughly performed and ruled out before ever considering the use of T3.

T3 is just too hard to use to

consider using it without exploring everything else first. I have been known to refer to T3 as the thyroid hormone treatment of last resort - I believe it should be viewed like that.

However, if all the necessary investigations have been performed and all the thyroid hormone therapies have all been tried and shown to fail then T3 can be a way of recovering your health. I know - I've done it!

### AN ODE TO TPA

By - Sue Purcell:

*Feeling so tired, hair falling out,  
Never been this weepy, heads  
full of doubt,  
Hate the cold and hate the heat,  
Pains in the hands, pains in the  
feet,  
Your eyes feel dry, your skin  
does too,  
You find it hard to go to the loo,  
It feels like your gaining weight  
by the hour,  
It's even a struggle to go for a  
shower,  
The pain in the neck is a pain in  
the arse,  
Even the eyebrows have gone so  
sparse,  
If this is you without a doubt  
Go to the TPA to help sort you  
out.*

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Now THAT'S WHAT I CALL AN OVERACTIVE THYROID!

## MEMBERS' SUCCESS STORIES

### Story 1

"I've read a few threads on here about taking T3 meds early in the morning, and wanted to share my early experiences of trialling this.

Briefly, I am self-diagnosed hypo, with low cortisol output. I did not respond to Armour, and have been on T3-only for nearly 2 years. Although much improved, I was still not as well as I would wish, and had OK days and bad days, general tiredness and joint & muscle pain. Although I've lost a bit of weight whilst on T3, I still don't shift weight like a "normal" person.

I also took 5mg Prednisone with top-up doses of HC as and when needed (stress-dosing up to 20mg a day). I also took 4xNAX.

After reading some of the research and ideas on taking T3 at about 4.30 a.m. I decided to see if it did anything for me. I began by moving my first T3 dose (25mcg) from waking time (7.30), to 7.00, then 6.30 etc. I set my alarm clock to make sure I stuck to the time. After working back to 4.45 a.m. over the period of a week, I became well. I have been completely well for the last three weeks.

I stopped the Pred, NAX and HC within a few days of feeling well. I know this is not advisable, generally speaking, but I knew I didn't need them any more.

I now take 25mcg T3 at 4.45am, 12.5mcg at 1.30pm and 6.25mcg at 6pm. I've started weight training and walking. I walked 3 miles today. I feel fantastic.

When I say I'm well I mean the best I can ever remember being. I have no pain, no digestive issues, my bowels move first thing on a morning, I have masses of energy, no breathlessness (I'm surprised how cardiovascularly fit I am considering I haven't exercised for 4 years), no waking headaches, my eyesight has improved(!), my clarity of thinking has improved, and my sugar cravings have vanished.

One of the major revelations is how my attitude has altered. I used to "look after myself" constantly, building rest into my day and pacing myself to ensure I didn't suffer after a "heavy day". Now I'm so active my kids can't keep up, and I have an "up and at 'em" approach to life.

I know I am only 3 weeks into this, but they've been the best 3 weeks of my life for the last 20 years (when I first started to experience hypo symptoms). I'm absolutely amazed, delighted and thankful for Paul Robinson's posts and all the research he has done (see article WHY I BELIEVE T3 SHOULD BE THE VERY LAST TREATMENT THAT THYROID PATIENTS CONSIDER by Paul)

I don't pretend to understand everything about why this has worked. It just did. I know it is to do with the adrenals needing thyroid hormone to function properly, which is why the dose is timed to fit in with the adrenals kicking in the early morning.

My only concern is that thyroid recovery can be a cruel thing, and it crosses my mind that I might regress somewhat. But right now things are fantastic, and I hope it continues.

I'll let you know!"

### Story 2

"I apologise for the long post, but i'm hoping that where i've got to now from where i was in my life will bring hope to other hypo (hashis) sufferers.

January 2004 my illness really kicked in after my husband was on life support, I became terribly poorly couldn't lift my head, couldn't get any answers, was told thyroid was healthy and it was all in my head. I went for help on another group at the time sent my bloods to them that confirmed hashis, went back to the docs with the info i'd received and they agreed to send me to a specialist and for a scan. The scan actually showed i'd been poorly for a long time but just coped with it and my husband's life support had pushed it over the edge, so i can probably take my illness right back to being aged 19 when i had pnd after giving birth to my son.

I was still told after starting on levothyroxine and the symptoms were still bad that it was in my head, or i was jealous of my husband's illness and even to the point they said i was drinking too much water and making myself ill. I carried a bottle everywhere with me because i had this awful lump in my throat and was permanently trying to shift it.

My eyesight deteriorated and was staying awake for around only 4 hours a day. Repeated blood tests just put my thyroxine up and the symptoms got worse.

I was then sent to professor P the leading professor in M.E/fibro in the UK, i was lucky that i lived in his area of work, who diagnosed severe M.E, from that day on the medication started rolling in, antidepressants, massive pain relief, anti sickness drugs, anti migraine drugs, false tears, gaviscon, omeprazole and a whole lot more.

I lived like this for years, until i went back to the site i'd used all those years ago and started reading stories about what was like reading about my self. So from January of this year i decided i must try everything one last time to get well.

March of this year visited my Endo for the first time who started me on T3 and T4 replacement, and there was a massive glimmer of hope the changes were fast and unreal but something was still not quite right so i requested that i go onto T3 only and they let me do it.

So with some amazing advice and help i began my T3 journey, each and everyday things started improving but were still not perfect. so I went for the vitamins and supplements road and with major help and advice started on them.

Basically i wanted to write this to show what a success T3 has been for me, i call it my magic little pill. Because i've been so poorly for so long i still have to pace but i'm starting to do a little graded exercise and am hoping that a year from now i'll be a very happy and well 40 year old, well 41 next year but shhhh hehehe.

So for anyone on here who has been diagnosed with M.E/Fibro and feeling like hell on earth, Try ANYTHING and don't underestimate the power of the little T3 tablet. I'm now discharged from the endo as he feels i'm now on the right path to full health.

I hope this helps at least one person to feel like i do today. And stick with these lovely people on here they will get you all the help you could possibly need. And a special thankyou to P.

Have a great day everyone."



### A GIFT FROM YOU TO HELP OTHER SUFFERERS

For those of you who have benefited from the TPA Internet Thyroid Support Forum who would like to help others, please consider donating a Thyroid Information Book (i.e. Dr Barry Durrant-Peatfield's 'Your Thyroid and How to Keep it Healthy' or Dr Gordon Skinner's 'Diagnosis and Management of Hypothyroidism' or any other such book) to your own local library.

This would be at minimum cost to each of us, but we could cover vast areas. TPA could tell the media that our members are doing this which would be very beneficial highlighting thyroid concerns and helping direct those without Internet access towards the help and support they may need. If you would like to do this, please copy the 'Donation Notice' printed below and paste it in the front of the book to help readers to access their library internet resource to the Thyroid Patient Advocacy web site and forum to learn more.

Those of you wishing to participate should go to their local book store, or order online (by using the TPA Link) from Amazon (where we earn 5%) to buy the book of your choice, stick the donation note inside and give it to your local Librarian during Thyroid Awareness Week (TAW) sometime in October (I will let you know the date for TAW as soon as I have this – OR – If you have a good clean copy you no longer need, again, stick in the 'Donation Form' and take it to your local Library. The books would be re-read many times.

Perhaps those of you who would like to participate in this scheme could let me know. We can make a difference - and if we arrange to do this during the UK TAW - we may get media coverage for maximum exposure. I realise that many of our members and readers are from all over the globe, and different countries have

### TPA MEMBERS LENDING LIBRARY

Please see our Yahoo Internet Thyroid Support Forum for details on how to borrow these books <http://health.groups.yahoo.com/group/thyroidpatientadvocacy> under the FILES SECTION.

- "From Fatigued to Fantastic" By - Jacob Teitelbaum, MD
- "Living Well with Hypothyroidism" By - Mary J. Shomon
- "Tears Behind Closed Doors" By - Diana Holmes
- "Living Well With Hypothyroidism" By - Mary Shomon
- "The Thyroid Diet" By - Mary Shomon
- "The Thyroid Solution" By - Ridha Arem
- "Solved, the Riddle of Illness" By Steven Langer
- "Your Guide to Metabolic Health" By - Dr, Gina Honeyman-Lowe/Dr. John Lowe.
- "Safe Uses of Cortisol"-By - William McK. Jefferies
- "Hypothyroidism: The Unsuspected Illness" By - Broda Barnes
- "Your Thyroid and How to Keep it Healthy" By - Dr. Barry Durrant-Peatfield
- "Adrenal Fatigue: 21st Century Stress Syndrome" By - James Wilson
- "Coping with Thyroid Problems" By - Joan Gomez
- "Take Control of Your Health and escape the sickness industry" By - Elaine Hollingsworth
- "Diagnosis and Management of Hypothyroidism" By - Dr. Gordon Bruce Skinner
- "From Fatigued to Fantastic" By: Jacob Teitelbaum
- "The Super Hormone Promise" By - William Regelson, MD & Carol Colman
- "Thyroid Problems" By - Dr John Smith
- "Candida, M.E & Allergies - The Way Back to Good Health" By - Jo Hamptom
- "Cooking for Candida - Recipes & Diet Plans" By - Jo Hamptom
- "Thyroid Disease - The Facts" By - R.O.S Bayliss and W.M.G.Tunbridge
- "Natural Hormone Balance for Women" By - Dr. Uzzi Reiss MD OB-GYN
- "What Your Doctor May Not Tell You About Pre-Menopause" By - Dr John Lee
- "Why do I Still Have Symptoms When my Thyroid Function Tests are Normal" By - Dr Datis Kharrazian "Hypothyroidism - Type 2" By - Mark Starr
- "Adrenal Fatigue - The 21st Century Syndrome" By - James Wilson
- "Stop the Thyroid Madness" By - Janie Bowthorpe
- "The Lactose Free Cookbook" By - Sheri Updyke

different dates for their own TAW, but this is something you could do at your particular time.

Below is a suggested Donation

Notice to be pasted in the book as well as a suggested Media Release, which you could also print out to send to your local newspaper.



"Why do you call it a thyroid 'problem' when it's giving me an excuse for the 20 pounds I gained this year???"

### MEDIA RELEASE

During October's UK Thyroid Awareness Week, Thyroid Sufferers around the UK are donating selected books to their local library to assist other Thyroid sufferers of thyroid disease and teach them more about their illness. As many as 1 in 4 people are currently striving to overcome Thyroid Disease or researching a suspected associated

condition. Thyroid Patient Advocacy (TPA) has just over 2535 members who meet up on their Internet Thyroid Support Forum [www.tpa-uk.org.uk](http://www.tpa-uk.org.uk) where they share their experiences and offer help and support to others. Many members have found answers to their thyroid concerns. TPA realises that not everyone has access to the Internet, or that many are not happy

using a computer, and that these people are missing out on valuable information, so members believe that by donating either brand new, or used thyroid books to their Local Library which they found have personally helped them to recovery, they can help fellow sufferers in a very practical way.

### REVISED AND UPDATED TPA INFORMATION PACK - NOW RENAMED 'THYROID PROBLEMS: THE TPA GUIDEBOOK'

Since the Mail on Sunday published the article 'For Twelve Years I was a Victim of The Great Thyroid Scandal', we have been inundated with requests for our Information Pack.

Within the first week of publication, our stocks were totally wiped out. I therefore took the opportunity to revise and update this document as it was over 6 years old, and wrote

more articles, and this has now grown from 56 to 70 pages. It has taken some time to get to this stage and I would like to thank everybody who has been 'waiting in the wings' to receive their 'Guidebook' but I am now delighted to tell you that this has now been printed and if you would like a copy, please visit our web site [www.tpa-uk.org.uk](http://www.tpa-uk.org.uk) and in the right hand column under

TPA News, scroll down to 'TPA Information Pack Online ordering Now Available' for payment details.

I can promise you that this is a very smart document and something TPA can be proud of. We have had to increase the cost from £7.00 to £10 but this includes cost of postage and package, and the information in 'The TPA Guidebook' is unique.

The contents include:

- About Thyroid Patient Advocacy
  - o What's it all About...
  - o Thyroid Problems and Solutions.
- Hypothyroidism: Symptoms Checklist
  - o Commonly Reported Signs of Hypothyroidism.
  - o Standard Tests for Thyroid Disease
  - o Low Vitamins and Minerals and Thyroid Connection
  - o The Basal Temperature Test
  - o An Explanation about the 'Normal Reference Ranges' of Thyroid Function Tests
  - o Having Thyroid Problems?
  - o Medical practice ignores the Science
  - o Getting a Second Opinion
  - o Free or Reduced Cost prescriptions

- Nutrition: An overview
  - Supplements: Things you can do to help your recovery
  - Food: What's good and What's Bad for your Thyroid
- Draft Letter you may wish to send to your Doctor
- Suggestions for an Approach to the Management of Thyroid Deficiency
- Why Thyroid Hormone Replacement may not be working for you
- Thyroid and Adrenal Dysfunction
  - The Diagnosis and Treatment of an Endemic Syndrome
- Fluoride: The Effects of Fluoride on the Thyroid Gland
- Candida Albicans
- Some Background Information on Thyroid Treatments for Hypothyroidism
- MHRA Confirmation re Natural Desiccated Thyroid Extract
- How to Treat Using Natural Thyroid Extract
- Going it Alone
- Hyperthyroidism –
  - Treatment of Hyperthyroidism
  - Graves' Disease and Hyperthyroidism – When things go Wrong
  - Surgery versus Radioiodine Therapy in the Treatment of Hyperthyroidism.
- Thyroid Cancer
- TPA Lending Library of Thyroid Books
- TPA's Internet Thyroid Support Forum
- Article in the Mail on Sunday 3rd July 2011

If you would like to purchase a copy for yourself, or you know of somebody who would benefit from our TPA 'Guidebook', please check purchasing details on our web site [http://www.tpa-uk.org.uk/info\\_pack.php](http://www.tpa-uk.org.uk/info_pack.php)

### COULD IT BE DOWN TO YOUR THYROID?

By – Stephanie Trolle

*If you start to feel tired every day of your life, with no reason why you are having such strife- Could it be down to your Thyroid!*

*When you can only do stairs one step at a time and it begins to feel like an Everest climb- Could it be down to your Thyroid?*

*Your heart may start racing as if a thief you've been chasing, when all you have done is sit in the sun- Could it be down to your Thyroid?*

*And now when you look in the mirror the reflection you see is not the person you used to be- Could it be down to your thyroid?*

*If the doctors can't help you and you are filled with dismay, I can tell you something to set you on your way - Cos it could be all down to your thyroid!*

*Join lovely Sheila and her Thyroid Friends Band; you will soon have the tools to put health in your hand. Do not feel sad without any delay, just get on the net - join TPA to-day.*

*You soon will have help with your Thyroid!!*

### “THYROID PATIENTS HAVE COME A LONG WAY, BABY...BUT WE STILL HAVE A WAY TO GO!”

By Janie A. Bowthorpe, M.Ed. (Owner/ Author “Stop The Thyroid Madness”)

Ten years ago, I was completely and totally miserable. How was my misery defined? Being unable to leave the house without paying a huge price in debilitating fatigue, a pounding heart rate, and weakness that left me in bed for days. I was forced to hand all grocery shopping and house cleaning to my husband. I laid aside all my career aspirations and hobbies, and I became as housebound as an invalid. Twenty years of progressive misery.

And years of medical testing simply implied I was healthy, and it couldn't possibly be related to my hypothyroidism, which, said one doctor after another, was adequately treated.

“I need help filling out Social Security Disability forms”, I said to my husband.

But nothing less than a miracle occurred just a few months later. In 2002, I found out about natural desiccated thyroid, found a practitioner to give me a prescription, corrected many problems due to being on the inadequate T4-only meds, and saw my life make a complete 180 degree turnaround. Back then, I was a part of a small but growing body of patients who were treading a new path and learning in leaps and bounds.

Today, our situation is different than it was for me ten years. There are numerous thyroid patient groups to join on the internet, important books to read on the thyroid topic, and good

informational websites like <http://www.tpa-uk.org.uk/> and [www.stop-thethyroidmadness.com](http://www.stop-thethyroidmadness.com) and others.

Yes, patients have come a long way baby.....But what still lags behind...are doctors.

Doctors all over the world hold firm to the dark age view that levothyroxine is an adequate treatment, just as is the TSH lab test can adequately diagnose hypothyroidism, or is ideal to dose by. Yet patient experience with both reveal them to be abject failures. T4-only meds like Eltroxin, Oroxine, Synthroid, Levothyroxine and other brands have proven endlessly to cause hypothyroidism to remain in each person's unique way.

The TSH lab test can look “normal” for years before it rises high enough to

reveal what has been there all along. And Doctors choose to remain blind to obvious clinical presentations of hypothyroidism in their patients who are on these T4-only medications, or dosed by the TSH lab test.

Patients will enter the doctor's office with rising cholesterol and blood pressure, depression, aches and pains, hair loss, "fibromyalgia", easy fatigue, weight gain---all classic symptoms of hypothyroidism. Yet, because the ink spot on a piece of paper called the TSH is "normal", it can't possibly be your thyroid, says one's clueless doctor.

On Sheila's TPA-UK site, the question is asked: Why do the GMC, the RCP, the BTA et al. deliberately choose to ignore the scientific evidence that has been available for over 40 years?

It's no different in the US, where the American Thyroid Association and the American Association of Clinical Endocrinologists continue to produce

papers and studies about the so-called efficacy of the TSH and levothyroxine in spite of loud-and-clear patient experience that neither works! And to the contrary, there really are research studies which back what patients already know by experience: <http://www.stopthethyroidmadness.com/medical-research/>

So in spite of thyroid patients worldwide who are more informed and wise than they ever have been, and in spite of millions of clear patient-experience examples of how poor levothyroxine treatment really is (causing poor nutrient absorption, low iron levels, adrenal dysfunction, and immune irregularities thanks to continued hypothyroidism while on levothyroxine), it's doctors who have a long way to go.

Doctors need to get off their medical school thrones and duffs and LISTEN, LISTEN to patient experi-

ence, besides the amount of research which actually does underscore what we know by experience. And when you do start listening, you will be joining one of the most important and life-changing medical movements in history!

"First they ignore you, then they laugh at you, then they fight you, then you win." —

Mahatma Gandhi

(Found on both Sheila's and Janie's websites, because patients know the truth!)

Janie A. Bowthorpe M.Ed. is creator of numerous patient groups on Yahoo and Facebook, owner of the patient-to-patient website [www.stopthethyroidmadness.com](http://www.stopthethyroidmadness.com), author of the revised book edition of "Stop the Thyroid Madness": a Patient Revolution Against Decades of Inferior Thyroid Treatment, speaker, and patient consultant/coach.

### DR GORDON SKINNER AND THE NEXT GMC HEARING

The GMC have now scheduled the dates for Dr Skinner's review hearing, following the adjournment in July. The hearing will run from Monday the 14th of November to Friday the 18th of November – again a total of 5 days.

As before, the hearing will be held in Manchester at St James's Building, 79 Oxford Street, Manchester, M1 6FQ and again you might wish to let the GMC know of your intention to attend the hearing.

Please could you consider attending as many of the above days as possible and also if you or family and friends haven't had a chance to do so yet, send in your testimonials in support of Dr Skinner to the GMC. The reason that testimonials are needed is that the testimonials which everyone sent for the FTP in 2007 will not be included in the evidence submitted for this hearing, so new ones are needed.

For ease of reference the relevant persons and addresses to send testimonials to are:- Heather Cook, Investigation Officer, Fitness to Practise Directorate, General Medical Council, 3 Hardman Street, Manchester, M3 3AW and copied to Dr Afshan Ahmad at 22 Alcester Road, Moseley, Birmingham B13 8BE and to Mr Ralph Shipway of RadcliffesleBrasseur [Solicitors], 5 Great College Street, Westminster, London, SW1P 3SJ. Alternatively, send these by Email to [Afshin@vri.org.uk](mailto:Afshin@vri.org.uk)

In the meantime, the transcript from the adjourned hearing is now available and it makes very interesting reading. To catch up with what happened on both days, here are the links [http://www.tpa-uk.org.uk/skinner\\_transcript\\_day1.pdf](http://www.tpa-uk.org.uk/skinner_transcript_day1.pdf) and [http://www.tpa-uk.org.uk/skinner\\_transcript\\_day2.pdf](http://www.tpa-uk.org.uk/skinner_transcript_day2.pdf)

Please could you pass this information on to any supporters of Dr Skinner – many thanks again to you all and we look forward to meeting you at the GMC.



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You must pay an amount of income tax and/or capital gains tax at least equal to the tax that the charity reclaims on your donations in the tax year (currently 25p for each £1 you give). You can cancel this declaration at any time by notifying the charity.

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If you pay tax at the higher rate you can claim further tax relief in your Self- Assessment tax return. If you are unsure whether your donations qualify for Gift Aid tax relief, ask the charity. Or ask your local tax office for leaflet IR 65. Please notify us if you change your name or address.

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