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Professor G Gill, MD, FRCP,
Joint Speciality Committee of Endocrinology and Diabetes,
The Royal College of Physicians,
11 St Andrews Place,
London NW1 4LE

Dear Professor Gill,

I note your recent documentation and press release entitled RCP: Thyroxine is the only treatment for primary hypothyroidism; I respectfully submit the following comments on the contents thereof.

I have no formal training in terms of College further education in this specific field and I trust you will indulge my solicitation. In 'mitigation' I have published on the subject of hypothyroidism and have seen many patients during the last fifteen years and I think provided reasonable service to these patients. In a sense, the absence of formal training issue has motivated my note; I am concerned that the contents of the RCP document will be incorporated into future 'formal training' of medical practitioners with (I believe) detrimental consequence to the diagnosis and management of hypothyroidism.

I should like to provide evidence in two sections.

1. General comments.

i) There should surely be an acknowledgement of alternative views on these issues; there is a significant body of 'contrary opinion'. Admittedly this is not from what might be viewed traditionally as the 'Establishment' but the Establishment do not have a monopoly over truth and unilateral somewhat cavalier pronouncements do – or perhaps should - engender a measure of incertitude in those who are in receipt of this kind of communication; I respectfully refer to my document which has been lodged in a number of appropriate Institutions including the Royal College of Physicians and Royal College of General Practitioners. I have enclosed a copy which I hope provides a reasonable balanced counter-argument to some of the views expressed in the RCP document (Enclosure A).

ii) Secondly, it would be insensitive person indeed who would not detect a measure of adversiality to (presumably) private practice perhaps not in the words but 'within the spirit' vaguely implying poor practice 'outside the NHS'. The College represents both public and private sectors and if this is a College view, they should stand up and enter public debate if the College believe that private medical practitioners are serving their

patients to a poorer level than in the public sector. I would remind the College that Mr Bevan introduced the NHS with a clear mandate to work with the private sector.

(iii) Thirdly, the document presents material in journalese mode where, for example, 'overwhelming evidence' on the value of thyroxine alone is purported albeit there is no evidence at all, the proportion of thyroid hormone in Armour Thyroid is receiving disapprobium while contemporaneously advocating T4 alone which has infinite proportion of T4 over T3; this is hardly good enough in a formal document from the Royal Colleges.

(iv) Finally there is - to the easy observer at least - an anonymity in this documentation which is unacceptable in a matter of such critical importance for the future health of the nation.

2 Specific contentions.

i)) Armour Thyroid/T3 should not be used

I am unaware of any clinical trials comparing the efficacy of T4, T3 and/or Armour Thyroid. There is in fact theoretical advatages in Armour Thyroid and in my experience it has a role and value in certain patients particularly patients (for obvious reasons) who have had thyroidectomy. May I beg preemption of the tired old mantra that this last contention is anecdotal, the "overwhelming" evidence that T4 is preferable is not anecdotal, it does not exist at all.

(ii) Diagnosis of hypothyroidism should be made by validated by blood tests

Hypothyroidism was not defined by thyroid chemistry but by clinical criteria. It is astonishing intellectual servility to assume that a Gaussian interval – particularly when TSH values are manifestly not distributed according to Gaussian distribution but have a distinct left sided skewed distribution – will precisely define the frequency of hypothyroidism but even more astonishing – and never validated – an inviolate criterion for excluding diagnosis if TSH or FT4 values lie within 95% interval. This will only obtain if the condition was defined ab initio by biochemical criteria for example hypercholesteraemia or other conditions thus defined. I have seen thousands of patients over many years with unequivocal clinical evidence of hypothyroidism and thyroid chemistry within 95% reference intervals who were returned to optimal health by thyroid replacement and have yet to see a significant irreversible adverse effect of this practice.

I contend that this non-validated and unproven position is presently resulting in a poor quality existence for many patients in not only the national but international arena.

(iii) Laboratory tests must be validated

One naturally applauds this view albeit presented in a somewhat unwelcoming 'facon de parler'. There is a certain imbalance in that the present blood tests of thyroid chemistry have not been validated in terms of their relation to disease frequency and treatment outcome and one would imagine that the author (anonymous) of the document would welcome a less invasive investigation for example saliva or urine; I

do feel that an academic institution has a duty to inspire proper investigative research rather than dampen with faint anticipatory condemnation which is rather the spirit of the document.

I sincerely urge reconsideration by the College of this document. It will cause untold damage to the future diagnosis and management with unnecessary and unproven restriction of the therapeutic armamentarium. The views advanced are not even consonant with Endocrinological practice which I have indicated from my small pilot survey (Enclosure B). This Document from the College will I fear be considered one of the great 'howlers' within the next ten years and I beg your reconsideration with further discussion in an open forum taking proper and wider representation on these issues.

I so advise.

Yours sincerely,

Gordon RB Skinner MD DSc FRCOG FRCPath