PE1463/EE

Christina Icke Letter of 20 December 2013

Dear Sir / Madam,

In response to the replies by the BTF's medical advisors, regarding the various points of the Scottish Thyroid Petition, #PE 01463, please allow me to submit my own comment in support of the Petitioners.

To Point 1) I beg to differ with the medical advisors' opinion that testing for FT3 and rT3 is not useful. Would the doctors please give a more detailed response of how they have come to their conclusion that FT3 and rT3 parameters are not needed in the interpretation of a TFT … preferably in their own words – thank you.

Thyroid patients are aware that FT3 is a fast moving parameter which is influenced by many factors, not least the last time of T3 ingestion. However, the FT3 and rT3 figures are very helpful when looked at in conjunction with the other parameters of a thyroid panel; and since there is no differentiation in a normal FT3 measurement between FT3 and rT3, the inclusion of measuring both parameters separately could, for instance, identify non-conversion and/or cell receptor resistance.

To Point 2) It is part of the petition's aim to make the medical profession aware that adrenal fatigue does exist. Millions of people worldwide are suffering debilitating symptoms as a result of weak adrenal function. The "evidence" that doctors so vehemently deny to see, is there for all to see – the patient, their family and friends – except perhaps the doctor looking at the computer screen during a consultation instead of looking at the patient, turning blind and deaf to the poorly patient in front of him/her.

The BTF's medical advisors are deliberately(?) twisting the point the petitioners are making. Salivary adrenal testing obviously is not meant to diagnose or rule out adrenal insufficiency (Addison's disease), but it does not "purport" to evaluate adrenal function and fluctuations in the circadian rhythm… it actually does what it says on the tin.

The statement of BTF that information from a salivary adrenal profile can be misleading *is* misleading; if the medical profession would care to simultaneously do a salivary profile, a 24 hour urinary test and 2 hourly blood cortisol check over 24 hours, they would find that the respective graphs and figures will all correspond with each other.

Nobody is claiming that a salivary adrenal profile is used for diagnosing the thyroidal status of a patient. But it can be safely concluded that low cortisol levels are hampering the utilisation of thyroid hormone … surely, the medical advisors to the BTF won't dispute that ??

Dr Toft has acknowledged at the last meeting with the petitioners that cortisol levels in a patient with untreated hypothyroidism will be lowered; that admission was a step in the right direction. However, he subsequently claimed that treatment with

levothyroxine will restore the adrenal's cortisol secretion rate to normal. Such statement is at best optimistic, at worst wrong. This approach may work in the early stages of thyroiditis, but not for those who have suffered low thyroid for years, unrecognized and untreated. For patients with severe adrenal fatigue (deficient cortisol levels over a 24 hour period) simply giving Levothyroxine will not result in normalized cortisol levels for the patient. For efficient conversion from T4 to T3 and uptake of T3 into the cells the body needs sufficient levels of cortisone. If sufficient cortisol is not available, utilization of thyroid hormone will not be happening. Such a patient on T4 mono-therapy will become thyrotoxic as the unused T4 and rT3 are building up in the body and the patient will feel very ill; yet the biochemical results will look "normal", as only thyroid levels in the blood – not thyroid levels inside the cells – are measured …..

To Point 3) Sympathizing alone is not enough, I'm afraid. The notion that there are "issues" with the solutions the petitioners propose, is unfounded. In fact, their proposals make perfect sense. Obviously, all thyroid patients should be carefully monitored by their doctors, but nothing out of the ordinary is required when treating with a combination of T4 and T3 – be it synthetic or natural hormone – to treating with T4 only. Whichever treatment, the doctor should –

a) make sure the patient does not display hyperthyroid symptoms and

b) check that the FT4 and FT3 stay in between the upper third and the top of their respective reference ranges and do not exceed the upper level – but the physical assessment of a patient should always have priority to bio-chemical "evidence" and the doctor should be mindful that there can be individual variances in biochemistries (please see below)

The TSH will, of course, by that time be slightly suppressed, which is neither worrying nor dangerous; it is perfectly logical to expect that the pituitary gland is *not* producing any TSH when the body receives optimal thyroid hormone replacement. Several studies have proven that a suppressed TSH is NOT causing a loss of bone density or heart disease - to quote just one:

http://www.ncbi.nlm.nih.gov/pubmed/21757236

It has already been proven beyond doubt in various clinical trials that a TSH alone is unsuited as a tool to titrating thyroid medication. A suppressed TSH in a medicated hypothyroid patient does NOT automatically indicate Hyperthyroidism, nor does it cause bone density loss or heart disease; thyroid patients are annoyed that doctors are still using such outdated myths as scare tactics to frighten patients into lowering their medication.

As for the *necessity* of "bio-chemical evidence"- this is debatable. As the petitioners rightly point out, poor diagnostic ref ranges do not take into account the variances in individuals biochemistry. The following study (published in the British medical Journal 293: 808-810) supports that stance:

http://www.hormoneandlongevitycenter.com/thyroidtreatments1/ - scroll down to -

“Standard thyroid tests lack accuracy to determine proper dose of thyroid replacement”

To Point 4) Such sweeping statement about the use of natural desiccated thyroid are complete and utter nonsense. True, natural desiccated thyroid is not licensed in the UK, but there are no objections raised by the MHRA for doctors in the UK to prescribe the hormone.

Forest Pharmaceuticals – who manufacture Armour thyroid - state that the amount of thyroid hormone present in the thyroid gland may vary from animal to animal, and to ensure that Armour tablets are consistently potent from tablet to tablet and lot to lot, analytical tests are performed on the thyroid powder and on the tablets to measure actual T4 and T3 activity. Different lots of thyroid powder are mixed together and analyzed to achieve the desired ratio of T4 to T3 in each lot of tablets. This method ensures that each strength of Armour will be consistent with the USP official standards.

Yes, the T4:T3 ratio in natural desiccated thyroid is different from the ratio a healthy thyroid gland would produce, but people with autoimmune thyroiditis or fully developed hypothyroidism do not have healthy, “normal functioning” bodies. Our endocrine- and immune systems do not work as well as those of our healthy counterparts. Due to a variety of handicaps such as low cortisol levels, failure of the 5 dei-iodinase enzymes, cell receptor resistance, food allergies, yeast problems, low levels of specific nutrients and general hormone imbalances our systems need all the help they can get, and a higher proportion of the active thyroid hormone T3 is often needed to get the body working normally again…. natural desiccated thyroid or a combination of synthetic T4 and T3 are proven to work for Millions of people around the globe where a mono-therapy with Levothyroxine has failed.

On a personal note, I am one of those patients who has regained thyroid health on natural desiccated thyroid after Levothyroxine proved to be a total disaster. I am now 62 years of age, suffer from Hashimoto’s and have been taking natural desiccated thyroid for the past 5+ years. I have a permanent TSH of 0.03 mU/L and optimal FT figures near the top of their ref ranges and my bones are so strong that my orthopaedic surgeon told me he had a hell of a time sawing off my femur head when I was undergoing a hip replacement earlier this year. In his nearly 40 years of orthopaedic surgery he cannot recall ever coming across such high bone density in a woman my age. I sailed through the operation, was walking unaided 9 days after the operation and have never looked back. Perhaps I should mention that 6 years ago, *before* I started on Armour, a test result showed that my bone density was *below* average for my age ….
[this para could be dropped if necessary, although it does rather demonstrate that Calcitonin in NDT is very valuable in retaining and rebuilding bone density]

To state that monitoring treatment is more difficult in patients taking NDT is equal nonsense. Would the advisors to BTF please care to explain why on earth - in their opinion - it should be “difficult” to medically evaluate such a patient, or what they expect to be “different” when interpreting their TFT panel compared to one from a patient taking Levothyroxine only?

There will always be people who misuse drugs and abuse their bodies. But to infer that thyroid patients use thyroid hormone as “slimming aids” is an impertinent, insulting and patronizing remark. If doctors in the UK were better educated in thyroid disease and worked *with* the thyroid patient, rather than blindly follow the dictates of RCP and BTA for fear of getting reported to the GMC when not toeing the party line, then it would not be necessary for patients to attempt self- treatment. In fact, there would be no need for organizations like yours… healthy people do not need support organizations!

Thyroid patients do NOT WANT to self-medicate. They do NOT WANT to buy their medication online. They want to spend their time and money on things they can enjoy! They are driven to self-medication by the ignorance and incompetence of their doctors. Patients WANT a doctor who will listen to them, one they can trust to know what s/he is doing …. Sadly, often that trust has broken down because of the rigid stance of the medical profession and consequent poor – and sometimes dangerous – thyroid treatment received from our doctors.

Christina Icke