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THE NUTRI-SPEC LETTER

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From:
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Dear Doctor,

Suppose that next week a new patient comes to your office having heard of your expertise in clinical nutrition. Prior to doing your NUTRI-SPEC testing you take your customary complete case history, during which you find that the patient has a long and fascinating history of thyroid disease. Ten years ago he experienced many disease symptoms including enlargement in his throat. He sought medical help and, of course, the first thing the doctor did was check his thyroid. Blood tests for thyroid were perfectly normal. After a period of confusion, a biopsy was finally done on the thyroid, revealing a goiter associated with Hashimoto's auto-immune thyroid disease.

Blood tests for thyroid hormones were repeated and still found to be normal. Nevertheless, a large portion of the thyroid was removed, after which thyroid blood tests were repeated to determine what level of thyroid hormone replacement therapy the patient needed; but thyroid tests were found to be normal once again. The patient was started on a trial dose of Synthroid which was followed shortly by a follow-up thyroid hormone blood test in an attempt to determine whether the clinical trial had approximated the appropriate dose of T4. All thyroid tests were again normal --- so --- the patient was kept on that dose of Synthroid indefinitely. Periodically he went for thyroid hormone tests, which always came back within normal limits.

Five years later the patient experienced another sudden increase in the size of his thyroid gland. Thyroid blood tests were performed and found to be within normal limits. Biopsy of the thyroid showed a tumor of the thyroid, which was removed surgically. After the surgery, thyroid blood tests were repeated and, surprisingly, found to be within normal

limits. The patient's dosage of Synthroid was adjusted upward on the assumption that with very little thyroid gland left after two surgeries he would need more. Shortly thereafter another blood test was done which revealed perfectly normal serum T4 and TSH. The patient was instructed to take that dose of thyroid medication indefinitely, and was monitored periodically for changes in T4 and TSH, but no abnormalities were ever found.

Meanwhile, through this entire ordeal, and up through the present day, the patient experienced horrendous symptoms for which no cause could ever be found. The one thing his doctors were absolutely sure of was that the thyroid could not be involved --- after all, his thyroid tests were always normal.

Think of it --- the patient went through two episodes of rapidly enlarging thyroid, two thyroid surgeries, plus shot-in-the-dark trial and error T4 prescriptions over a period of 10 years, and not once in that entire time did he show a single abnormal blood test relating to thyroid function.

Interesting.

Now suppose another new patient comes your way very soon. This woman is obese, lethargic, has dry skin and brittle thinning hair, edema, high cholesterol, insomnia accompanied by severe muscle cramps of the legs at night, and has recently been diagnosed with fibromyalgia. She has been in this pitiful state of health for years. Her history reveals that she is taking Synthroid, so you ask when the thyroid came into the clinical picture. She tells you that her doctor checked her thyroid years ago and found it to be normal, concluding that the thyroid wasn't part of her problem.

Her symptoms continued to grow worse, so two years later he repeated the thyroid tests, still found them to be normal, but, not really knowing what to do, decided to give her a prescription for Snythroid as a clinical trial. After beginning the Synthroid her thyroid tests were re-done and found to still be normal. However, the patient had experienced a very nice decrease in symptoms. Her cholesterol had dropped significantly, she had much more energy and a positive attitude, she was sleeping better, and she had dropped about 10 pounds.

Regrettably, within about 6 months the symptoms began to return despite the thyroid medication, and eventually became worse than they had ever been. Throughout this return of symptoms her thyroid tests were perfectly centered in the normal range, so her doctor assured her

that her thyroid was perfectly normal; he maintained her on the same dosage of the thyroid medication.

You read these two case histories prefaced by the word "suppose." You need not make any supposition that such cases will be coming your way, because it is a certainty they will. In fact, you have probably already seen them. The man you read about first was not your every day patient but you will, or perhaps already have, encountered such cases. The woman described in the second history is probably already among your patients. In fact you probably have several such cases. As you may have guessed, these were two case histories from my own practice, and, I could have picked out dozens more to make the point. And just what is the point?

SERUM TESTS FOR THYROID FUNCTION ARE FREQUENTLY WORTHLESS AND OFTEN MISLEADING.

You simply cannot rely on serum TSH and T4 to evaluate thyroid function. Even a serum T3 does not complete the picture. These tests give entirely too many false negatives. Another way to say this is that if you see an abnormal TSH, T4, or T3 you know your patient has a thyroid problem and it is extreme. But in the absence of any abnormal tests you cannot assume normal thyroid function.

The fact that these tests are most often worthless or even misleading does not mean they needn't be done. You must order them in any case of suspected thyroid dysfunction. However, there is a 4th test that must be run, the test for auto-immune thyroid disease, microsomal antibodies.

For reasons explained in last month's Letter, the pharmaceutical industry has "educated" the medical profession to believe that TSH is generally the only test needed to evaluate thyroid function. You learned, on the contrary, that the T4 sold by the pharmaceutical industry will normalize TSH very quickly, thus creating the illusion that thyroid function has been normalized. So, both the doctor and the drug company have a customer to provide a life-long stream of income, while the patient continues to suffer. A physician thinks he is doing an extremely thorough job if he orders a T4 along with TSH. Testing for T3 is considered to be superfluous, and very few ever consider doing so.

In a perverse kind of way we cannot blame physicians for not seeing any value in T4 and T3 tests since, as we have already illustrated with the two case histories above, they so rarely reveal a problem.

If blood tests are not a reliable indication of thyroid function, just how do you evaluate the thyroid? The clues to thyroid dysfunction are built into your NUTRI-SPEC system. First, consider your case history. Here are some of your signs of potential thyroid dysfunction:

- Elevated cholesterol accompanied by normal or close to normal triglycerides. When you see this pattern of serum lipids, think either dysaerobic imbalance or thyroid insufficiency.

- Fatigue and/or somnolence. Obviously, these symptoms are not specific to thyroid dysfunction as they can be associated with almost any of your NUTRI-SPEC imbalances. Yet fatigue or somnolence virtually always accompany thyroid insufficiency.

- Insomnia. Again, this is a symptom that is not specific to the thyroid, yet is very frequently part of the picture when the thyroid is involved. A patient with thyroid insufficiency is typically fatigued or sleepy by day yet has insomnia at night. The reason for the insomnia is the inability of nerves and neuromuscular connections to relax. It takes energy (ATP) to actively pump calcium out of nerve and muscle tissue. The deficient oxidative metabolism typical of thyroid insufficient patients results in inadequate energy to maintain this pump. Calcium accumulates (at the expense of magnesium). Nerves simply will not calm down and muscles simply will not stop firing impulses in the presence of excess calcium.

- Hypertonic muscles and muscle cramps. Nothing about these muscular symptoms are specific for the thyroid, but they occur commonly in thyroid insufficient patients for the reasons just described relative to insomnia. Neuro muscular junctions are always either at or above threshold resulting in extreme stiffness, hypertonicity of muscles, and muscles that frequently cramp.

- Fluid retention. When you see edema think either dysaerobic, parasympathetic, anaerobic imbalance associated with estrogen stress and/or excess cortisol, ketogenic imbalance associated with excess cortisol, glucogenic imbalance in a patient that eats a lot of flour and not enough protein, or, thyroid insufficiency.

- Elevated percent body fat. Thyroid insufficiency is only one of many, many causes of percent body fat increase. However, the classic picture of a thyroid insufficient patient is one who is obviously obese. You must understand, however, that many people who appear to be thin, are actually carrying a very high percent body fat. (Note: The "classic" picture of thyroid insufficiency is frequently not valid, as many low thyroid patients are lean.)

- Fibromyalgia. Fibromyalgia always involves leaky gut syndrome. The intestinal mucosa loses its functional integrity, and must be rebuilt with mucin and perhaps with glutamine. The breakdown in secretory immunogloubin A of the intestinal lining is generally the result of a stress response involving either excess cortisol, excess estrogen, or insufficient thyroid.

- Apathy or depression. Here are more symptoms that are not specific for thyroid insufficiency yet are one clue to its existence.

Now you have completed your case history. If you found several of the above symptoms and conditions, then you simply say to yourself, "Hmm, I wonder if the thyroid is part of this picture."

Proceed with your NUTRI-SPEC testing.

If the patient shows a sympathetic imbalance or an electrolyte stress with an obvious sympathetic component, then you can almost certainly rule out thyroid insufficiency.

If a patient who gave thyroid insufficiency clues in the history tests as parasympathetic, then continue to think thyroid. Treat the parasympathetic imbalance as per your QRG analysis, but tell yourself (and the patient) that there is the definite possibility that a thyroid insufficiency is part of the imbalance you are finding. If the parasympathetic imbalance does not respond positively within 3 weeks, then proceed with thyroid blood tests for this patient.

If your patient tests anaerobic, ketogenic, or parasympathetic, then suspect the reverse T3 dominance that you read about in last month's Letter. These are the three imbalances associated with an excess cortisol stress reaction, and as you have read, excess cortisol is what triggers the excess conversion of T4 into reverse T3. Treat the imbalances you find as per your QRG analysis, and tell the patient, "There may be an underlying thyroid problem which will not require any action initially. If after several weeks we are not making the clinical progress we expected, then we will investigate the thyroid further."

Another clue to thyroid insufficiency to be gleaned from your NUTRI-SPEC testing is to carefully consider the first of your four pulses. If P-1 is less than 68 in a patient whose history leads you to suspect thyroid insufficiency there is a pretty good chance the thyroid is involved. A slow P-1 will generally indicate either thyroid insufficiency, parasympathetic imbalance, ketogenic imbalance, or dysaerobic imbalance. (Note, that in an obese patient there may be enough

cardiovascular stress that P-1 is elevated despite the presence of one or more of the above listed causes of bradycardia.)

A history suspicious of thyroid involvement should also lead you to perform two additional tests. The first is body temperature. Almost any of your NUTRI-SPEC imbalances can be associated with low body temperature. Low body temperature can also be associated with insufficient progesterone, or with excess estrogen --- but, low body temperature almost always accompanies thyroid insufficiency. If you find an elevated body temperature the patient is probably in an anaerobic defense as part of the anaerobic phase of the diphasic immune response to a viral or bacterial pathogen. In that case the elevated body temperature could be hiding a thyroid insufficiency.

The second test you want to add to your NUTRI-SPEC procedures in suspected thyroid cases is the test for deep tendon reflex recovery. As described above, a neuromuscular junction needs to be able to produce enough energy to pump calcium out, and allow magnesium in, to relax. Thyroid insufficient patients cannot produce this required energy. So, when a miotatic stretch reflex elicits a muscular contraction, that muscle will show a delayed relaxation time.

When you tap a patient in the appropriate spot with a reflex hammer, the muscle reflexly contracts (and often does so as well in a thyroid insufficient patient as anyone else). What you are looking for in this test is the time it takes the muscle to relax again. So swing the hammer, watch the muscle twitch, and then see how long it takes it to fall back into its resting position. It is a delayed recovery time from the contraction, in other words a delayed return to the resting position, that is a strong indication of thyroid insufficiency.

Summary:

- Be aware of thyroid signs when taking your history.
- If your patient is Sympathetic, don't worry about the thyroid for now.
- If your patient tests Parasympathetic, give your NUTRI-SPEC regimen 3 weeks to break the test pattern. If the Parasympathetic test pattern persists, order TSH, T4, T3 and microsomal antibodies, body temperature, and deep tendon reflex recovery, and take a close look at P1.
- If your patient is Parasympathetic, Anaerobic or Ketogenic, follow your thyroid investigation procedure suspecting reverse T3 dominance.

More next month.