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THE NUTRI-SPEC LETTER

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From:
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Dear Doctor,

In the last four months you have learned more about thyroid function and dysfunction than you ever dreamed there was to know. You are now aware that even though thyroid insufficiency is not nearly as universal as estrogen stress, it is still …

A MAJOR CLINICAL PROBLEM THAT GOES FREQUENTLY UNDIAGNOSED OR IS INAPPROPRIATELY TREATED.

When the thyroid is involved, nothing will reveal its effects more directly and more quickly than will your NUTRI-SPEC test procedures. In the last two issues of this Letter, you have seen what you learned about evaluating thyroid function demonstrated in two very interesting clinical cases. You saw that in both cases thyroid supplementation was undeniably essential. Yet, one had perfectly normal thyroid blood tests. The other was normal on T4 and TSH (the tests typically considered by most physicians as diagnostic for thyroid dysfunction) yet showed low T3.

Both cases clearly revealed thyroid insufficiency based upon the test procedures you now know how to employ when NUTRI-SPEC imbalances suggest the likelihood of either primary thyroid insufficiency or reverse T3 dominance.

Here is another interesting case history that will give you even more insight into how to recognize and work with thyroid problems in your practice.

The patient was a 37 year old woman who came to my office looking like a classic case of rheumatoid arthritis. She had pain and extreme swelling in both knees, both elbows, both wrists, her left ankle, and both hands, as well as pain in the left TMJ and throughout her neck. All the pain and swelling except her left knee had come on suddenly, less than two months ago. The left knee she had hyper-extended about a year ago. (From the way she described it she probably damaged her cruciate ligament.) The knee was painful and swollen for a long time. She was given cortisone shots and had fluid removed from the knee twice. It did remain swollen, however, throughout the past year.

The rest of the pains had come on suddenly and inexplicably. The patient had been to her family physician and then to a long series of specialists without being given a clue to what her problem might be.

She had tested negative for rheumatoid arthritis, negative for lupus, and negative for Lymes disease. A long list of anti-inflammatory medications had been tried with absolutely no impact on her symptoms whatsoever. When I say this patient was in pain, I mean serious pain. None of the medications had even touched it.

What did NUTRI-SPEC testing reveal? The patient was <u>extremely</u> anaerobic. She was given an anti-anaerobic treatment regimen along with the prostaglandin dietary recommendations. The only additional findings from the NUTRI-SPEC exam were that she had an extremely slow (52) pulse one; and also was found to have pitting edema in both ankles (not just the swollen and inflamed left ankle of which she complained). Also --- I had learned from her history that her joint inflammation was always at its worst when she was premenstrual, and, that she suffered from other PMS symptoms.

On the patient's first follow-up visit, it was found that her anaerobic imbalance had improved a little but was still very much in evidence. The patient's quantity of Oxy A-Plus was doubled. On that first follow-up visit the patient was informed that there was some chance that there was an auto-immune component to her pathology even though she had tested negative for both rheumatoid arthritis and lupus. It was explained that her anaerobic metabolic imbalance was consistent with the presence of estrogen stress, and how that tied in well with her PMS related flare ups of her inflammatory symptoms. Furthermore, it was explained that excess estrogen predisposes women to auto-immune diseases.

It was also explained to the patient that based on some of our clinical findings (the pitting edema, the extremely slow pulse 1, and the strong anaerobic test pattern) that there may be a thyroid insufficiency

contributing to her problem. I went ahead and did the supplemental tests associated with thyroid insufficiency, taking her temperature and examining her deep tendon reflex recovery. She failed both tests miserably. Her body temperature was 97.4, and I rated her deep tendon reflex recovery failure as a +3.

The patient informed me that among her many tests in the last two months were blood tests for the thyroid. She said she would get those test results for me by her next visit, which was scheduled in two weeks.

Two weeks later the patient showed some further improvement in the anaerobic test pattern but the pattern was still definitely not broken. Subjectively, the patient reported perhaps a little improvement in symptoms until she had become premenstrual, at which point she felt as bad or worse than ever. With the obvious estrogen stress symptoms accompanying a persistent anaerobic imbalance I added Calcium D-Glucarate supplementation to decrease the patient's estrogen burden. I also had a chance to review the patient's recent thyroid blood work, which showed both TSH and T4 well within normal limits.

I was also treating this patient chiropractically, and had found that her "I hurt all over" pain was more extensive than the pathological joints. She clearly had what many clinicians would refer to as fibromyalgia. As NUTRI-SPEC practitioners we know that fibromyalgia involves a constellation of clinical factors including leaky gut syndrome (resulting from a major physical or emotional stress) along with some degree of either estrogen stress, cortisol stress, and or thyroid insufficiency. Sialex was added to this patient's nutrition regimen to help restore normal integrity of the intestinal mucosa.

Adding Sialex gave the patient the first obvious and sustained symptomatic relief of her pain. As two months passed, her PMS symptoms (other than her joint inflammation) had improved dramatically as did her fibromyalgia pain. Her joint pain and swelling had not improved measurably, nor had the pitting edema.

What time was it? As you can imagine, it was time to seriously consider the thyroid. I had taken the patient as far as she could go with an anti-anaerobic regimen, plus additional assistance from Calcium D-Glucarate to reduce estrogen stress, and Sialex to restore normal intestinal mucosa. The fact that the patient had presented normal serum TSH and T4 meant nothing to me. As you know, serum tests for thyroid function are most often meaningless. We rechecked all the functional thyroid indicators and found her temperature had plunged even lower and on this particular visit was 96.1. Her pulse this day was

54 and had never in the preceding two months exceeded 60. The pitting edema was as bad as ever and so was her deep tendon reflex recovery.

I sent a letter to the patient's physician explaining her functional thyroid findings. He couldn't have been less interested. So, I referred the patient to another doctor who would more likely listen to reason. At the same time I ordered the tests for serum T3 and for thyroid microsomal antibodies.

The physician to whom we referred the patient prescribed 30 milligrams of Armour Thyroid as I had requested. That was before I even had the results from the blood tests. The blood tests came back shortly thereafter and showed the patient's serum T3 at the low end of normal reference range. The thyroid auto antibodies, however, were sky high. The reference range for this particular lab was less than 35 and the patient's result was 489.

So --- as suspected all along from this patient's NUTRI-SPEC tests, there definitely was auto-immune disease in this patient. At the patient's next visit I re-examined all the thyroid indicators to find that they still indicated the need for more thyroid supplementation. I sent a letter back to the physician explaining that signs of functional thyroid insufficiency were still there. It was suggested to the physician that since the literature shows that serum T3 and T4 fluctuate in auto-immune thyroid cases irrespective of physiological thyroid function, the patient's clinical response to Armour Thyroid should be monitored by <u>functional</u> signs of thyroid activity rather than solely by changes in the serum tests.

Deep tendon reflex recovery still indicated excess neuro muscular calcium infiltration. The pitting edema was still very much in evidence, yet the sub-normal body temperature had improved dramatically on just 30 milligrams of Armour Thryoid, but was still below normal. We requested an increase in Armour Thyroid form 30 to 60 milligrams daily.

Since I now knew for certain I was dealing with an auto-immune disease process, and, since the patient's anaerobic imbalance and estrogen stress were well under control, I added to the patient's NUTRI-SPEC regimen Diphasic P.M. in the declining dose of 10, 9, 8, 7, 6, 5, 4, 3 to assure as much antioxidant protection as possible. The patient's needs, as indicated by NUTRI-SPEC testing, were now being met by a regimen consisting of: Oxy B, Oxy A-Plus, Calcium D-Glucarate, Sialex, Armour Thyroid, and Diphasic P.M.

You have now seen three cases illustrating thyroid involvement in patients whose histories did not necessarily even hint at thyroid

problems. Not one doctor in a thousand would even begin to suspect the thyroid in any of these three cases, yet your NUTRI-SPEC procedures took you straight to consideration of the thyroid as a causative factor in the symptom picture. Two of these three cases involved auto-immune diseases. One was a case of Crohn's Disease and likely Multiple Sclerosis; the one you just read was some un-named pathology, but one that definitely had an auto-immune component as evidenced by the auto-immune thyroid. Each of these three cases had left a long list of "specialists" totally puzzled and grasping at straws. Without NUTRI-SPEC all three of these women would have been sentenced to a lifetime of heavier and heavier medication with virtually no symptomatic relief.

Your understanding of how to evaluate thyroid insufficiency in your NUTRI-SPEC patients is now complete. All that remains is for you to learn how to make recommendations based upon your findings. The most important questions left unanswered are:

- What form of thyroid supplementation do you recommend that will be the most specific and most effective for each individual case?

- How do you incorporate blood tests into your evaluation process?

First, consider that you have three forms of thyroid supplementation to choose from. First, there is the pure T4 products such as Synthroid; then you have the pure T3 (Cytomel is the best known pharmaceutical source --- but most compounding pharmacies can put together a T3 supplement exactly to your specifications at a reasonable cost); and the third is a concentrated whole animal thyroid such as Armour Thyroid. Recall that T3 is the active form of thyroid hormone, while T4 is the storage form which is (under ideal conditions) converted into T3 as needed. Finally, recall that we are categorizing thyroid insufficiency into two general types, a primary thyroid deficiency associated with insufficient production of T4 and or T3, and, reverse T3 dominance, which involves excess conversion of T4 into reverse T3, an anti-thyroid metabolite.

As you have already learned, you do not under any circumstances want to give T4 to someone with reverse T3 dominance. Which patients are those? You can't tell for certain. You know that persistent anaerobic and parasympathetic imbalances may often be a primary thyroid insufficiency but there is nothing to say that they can't just as well be a reverse T3 dominance. This is where the thyroid blood tests come in.

You may be wondering how you can possibly make use of thyroid blood tests when we have emphasized over and over again the fact that

they are almost always worthless as a means to diagnose thyroid disease. That is true. So, what you must understand is that you do not rely on thyroid blood tests in most cases to identify thyroid disease, but you do use those tests to categorize the thyroid problem. Your functional tests that you do in conjunction with your NUTRI-SPEC testing are the fundamental means by which you conclude that the thyroid is a problem. (And, remember, before you can make conclusions about the thyroid you must have clinically addressed any sex hormone imbalances first.)

Here is the bottom line: When you have NUTRI-SPEC imbalances persisting that suggest the possibility of thyroid involvement that are confirmed by slow P1, low body temperature, high cholesterol to triglycerides ratio, or a failure of deep tendon reflex recovery (and assuming estrogen, progesterone, and androgen balance has already been addressed) then you will use these guidelines to make thyroid recommendations:

- If T3 is low or even at the low end of normal range the patient needs T3.

- A patient that has elevated thyroid auto-immune antibodies needs T3.

- A patient with TSH low or near the low end of normal range should never take T4.

- A patient with elevated TSH needs T4.

- A patient with TSH in the upper normal range accompanied by T4 in the lower normal range will probably benefit from T4 supplementation.

If you put all these guidelines together you will find that many patients need T3, and about an equal number benefit from T3 and T4. There are only a few that benefit from T4 by itself. And in these cases when T4 (such as Synthroid) as prescribed, you always have to be on the alert for a secondary development of reverse T3 dominance.

Don' t hesitate to put your knowledge of thyroid function to work. You have patients in your practice right now who desperately need the help only you can give them. (If you want help on any of these cases just give us a call.)

Sincerely,