



THYROID FLYER

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Newsletter of Thyroid Australia

Volume 1 No 1 January 2000

Feature - Doctor-Patient Relationships

Editorial

By Megan Stevens

I hope you had a wonderful Christmas and that you will have a healthy and prosperous 2000!

Thyroid Australia has had a good beginning, and is growing slowly. Since our inception in late June 1999 we have provided information to over 170 people about their thyroid concerns, and now have 30 members from all over Australia. We hope we will continue to meet your needs. Please let us know how we can do so.

We have established contact with all the other thyroid support organisations who are members of the Thyroid Federation International, and others. These organisations have been most helpful, and many of them have given us permission to use their material. Our thanks go to all at the Thyroid Federation International, the Thyroid Foundation of Canada, the Thyroid Foundation of America, the TED Association (UK), the British Thyroid Foundation, the National Graves' Disease Foundation (USA), the American Foundation of Thyroid Patients, Associazione Italiana Basedowiani e Tiroidei, Stor-Stockholms Sköldkörtelförening, Schilddrüsen-Liga Deutschland, Thyreoidea Landsforeningen (Denmark), and Mary Shomon (the thyroid guide at About.com).

Our thanks too to the doctors in Australia who have helped us in so many ways. Thanks for your support.

Cleo magazine

Some of our readers might have caught the November 1999 issue of *Cleo* magazine, and the article on page 59 entitled "Feel less than groovy? Think Thyroid." We received a number of calls in response to this article, and hope that we have helped those who called.

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THINK THYROID Your GP and Your Thyroid

By David Dammery

Dr. David Dammery, Chairman of Faculty of the Royal Australian College of General Practitioners, Victoria, spoke at Thyroid Australia's first public meeting on 20 November 1999. This is an edited transcript of his talk.

I must first thank Thyroid Australia for asking me to be part of the meeting today. It is a great pleasure for me to be here among you and to have the chance to represent not only the Royal Australian College of General Practitioners but also the whole discipline of General Practice.

My own first interest in thyroid disorders came from my mother. She did not instruct me, except by example. She was born in Queensland which, like Tasmania and parts of Victoria, is a state where iodine deficiency is common and she had a goitre. She later developed an overactive thyroid - thyrotoxicosis - when I was a medical student, so I had the opportunity to observe at first hand the effects of the thyroid hormones.

The subject given to me for this talk was "your thyroid and your GP". I would like to turn this around and make it "your GP and your thyroid". There are two reasons for this. The first reason is that you may need to know more about general practice and your GP before you can choose a GP who will help you to look after your thyroid. The second reason is that it gives me an excuse to put the GP first in my discussion.

General practice is something of a catch-all as a discipline within medical practice. The general practitioner is sometimes called a provider of "primary medical care" and sometimes called a "family medicine practitioner". The GP may even be called a "doctor of first contact". Each of these names tells us something about the nature of the discipline. General practice covers the whole range of medical care and is often defined as providing "continuing, comprehensive, whole-person care". So, arising from this definition, we GPs are doctors who see you when you are first ill, who begin to make the diagnosis of your illness, who continue to look after you throughout your illnesses and who provide ongoing explanation and support to you the patient and to your family.

What is it then that you, as patients or the associates of those who are patients with thyroid problems should look for in your family doctor? What makes the ideal GP?

We GPs come in all sizes, shapes and flavours. There is a model available to suit all tastes and expectations. It is up to you to shop around until you find what suits you then, if you are smart, "if you're on a good thing, stick to it". For myself, the ideal GP is a person with whom you, the patient, feel comfortable. He or she should be a person whom you can trust, whom you can talk to and who will give you the care that you need and want.

The ideal GP, then, is a good diagnostician, a good carer and a good communicator. Although each of us will have our own priority, to me communication is often the most important of these three criteria. I sometimes suggest that we GPs speak two languages - the language of the specialist, which is the language of medicine, and the language of the patient, which is our normal everyday English. The good GP can help

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THINK THYROID: Your GP and Your Thyroid *from Page 1*

the patient communicate with the specialist - in the case of the thyroid this will be the endocrinologist or the surgeon - both of whom can use some pretty big words with a highly esoteric meaning. Even a relatively simple word like "hormone" can

is more active on the metabolism while T4 is more active in the biofeedback regulation of the thyroid gland. That is why we can use TSH levels as the screening test for thyroid diseases. A high TSH indicates a low level of thyroid activity and

for an ultrasound examination of the thyroid and for the hormone tests on the blood. These will tell me quickly if the goitre is nodular and whether the thyroid is overactive, underactive or "just right". It is from this point that the road begins to fork. Any further tests are dependent on the results of the first round of tests.

Nodular goitres, especially those that are overactive, require an isotope scan. In this test, radioactive iodine is given and the thyroid is looked at using a nuclear scanner to look for "hot spots" in the thyroid. These are areas of increased isotope uptake indicating overactive nodules in the goitre. Similarly, "cold spots" are areas of reduced uptake that are underactive. Thyroid cancer may produce both hot and cold areas.

There are clearly about six or eight combinations that can occur. The decision on further investigation and treatment will then depend on which combination comes up. I shall not elaborate the various combinations at this stage.

Hypothyroidism is characterised clinically by a reduced metabolism. This condition is sometimes called myxoedema but that term really describes the false swelling of the tissues due to the laying down of various infiltrates into the skin leading to a puffy appearance of the face and swelling of other parts of the body. The clinical picture of hypothyroidism is often quite slow to develop. All of us GP's have had the embarrassment of a patient whom we have known for years developing hypothyroidism without us being aware of the changes. I certainly can recall a couple of instances of this. The doctor often misses the general slowing down of the patient, and their apparent depression is blamed on psychological factors. (Sometimes it seems as if a GP who doesn't know you can actually pick up hypothyroidism better than the GP who does know you.)

It is for this reason, at least, that I am a strong advocate of regular thyroid screening, especially where depression does not quite seem to fit the pattern or is slow to resolve.

Hypothyroidism may follow thyroid surgery or radiotherapy but in many cases it is due to Hashimoto's autoimmune thyroiditis. In these circumstances, the investigations include the assessment of thyroid antibodies. Antibodies may form to both the thyroid microsomes or to thy-

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Dr Dammary with the Thyroid Australia committee
Kay Horley, Karen Latimer, Alun Stevens, Megan Stevens, Dr David Dammary, Christopher McDermott, Colleen Dean

be readily misinterpreted. Thyroxine is a hormone; the use of thyroxine is a form of hormone replacement therapy - as is the use of insulin in diabetes. However, we do not usually think of HRT in that way. Your GP can give you that sort of explanation as well as monitor the progress of your condition.

The Thyroid

I hardly need tell you what the thyroid gland is and what it does. You probably know it even better than I do. It is a gland in the neck that acts as the metabolic regulator - a sort of energy traffic cop. What you may be less certain of is the three things that we use to measure thyroid function. They are called the TSH, T3 and T4.

The thyroid stimulating hormone or TSH is the regulating hormone put out by the pituitary gland at the base of the brain. T3 is tri-iodothyronine, a three-iodine protein complex. T4 is thyroxine, a four-iodine protein complex that is the classical thyroid hormone. Incidentally, it is the T3 that is the more metabolically active hormone. It is largely made from the T4 in the cells of the body, not in the thyroid gland itself. In turn the levels of T3 and T4 control the level of TSH by a biofeedback mechanism. The more T3 and T4 there is, the less TSH there will be. The less T3 and T4, the more TSH there is. T3

vice-versa. So, if you have a goitre and a normal TSH, we would say that you have normal thyroid activity or are "euthyroid". Likewise, high TSH and low levels of T3 and T4 indicate underactive thyroid or hypothyroidism. The reverse picture is true of an overactive thyroid; a condition also called hyperthyroidism or thyrotoxicosis.

Thyroid Disorders

There are properly speaking only four conditions of the thyroid that may result in thyroid disease. They are simple goitre, cancer, and both overactive and underactive thyroid disorders. We screen for thyroid disorders by the use of TSH estimations. If the TSH is abnormal, we proceed to measure T3 and T4. If someone presents with goitre, the thyroid ultrasound is my next line of approach.

Goitre is the name given to any enlargement of the thyroid gland, whatever the cause. This enlargement of the gland may be nodular or just vague and diffuse. Many patients come to me with a swelling of the thyroid gland. The swelling is usually not painful and they are often aware of it only because of the appearance, or because of a tight feeling in their neck. How do I test and investigate such a swelling?

The first things that I do are to arrange

Where Has All Our Iodine Gone?

The possible re-emergence of iodine deficiency in Australia needs to be investigated in national surveys (Editorial - *Medical Journal of Australia*)

By **Creswell J Eastman, AM**

Most countries in the world, including Australia, are signatories to the United Nations-sponsored "Declaration for the Survival, Protection and Development of Children", which states that "every child has the right to an adequate supply of iodine to ensure its normal development".¹ One teaspoon of iodine is all a person requires in a lifetime, yet iodine deficiency at critical stages of development in fetal life and early childhood remains the world's single most important and preventable cause of mental retardation.²

For the past three to four decades iodine deficiency has not been of significant concern in Australia (except in Tasmania); it was considered largely a problem of developing countries. That is what we thought until Gunton and colleagues give us a wake-up call with their article in this issue of the *Journal*.³ They found evidence of mild to moderate iodine deficiency in pregnant women, patients with diabetes and a small group of volunteers attending a Sydney teaching hospital. In their study, median urinary iodine concentrations ranged from 64 µg/L in the volunteers to 104 µg/L in pregnant women. The World Health Organization's standard for iodine-deficiency disorders in population surveys recommends that a median urinary iodine concentration above 100 µg/L is evidence against significant iodine deficiency in that population.⁴ Other population indicators of iodine deficiency, including total goitre rates in school-age children and serum thyrotropin (TSH) levels in the newborn, were not assessed in the Sydney study. The data of Gunton and colleagues indicate that the pregnant women they tested are ingesting less than half the recommended iodine intake in pregnancy of 200 µg/day. Although this study was not a national survey, and the sample size was small, the findings are alarming and raise concern that a major public health problem may be developing in the Australian community which could put future generations at risk of iodine-deficiency disorders.

The key factor in the genesis of iodine-deficiency disorders is decreased production of thyroxine from the thyroid gland. While endemic goitre is the most

easily recognised and best-known consequence of iodine deficiency, it is probably the least important. At critical periods in fetal development and in early childhood, biochemical hypothyroidism, due to iodine deficiency, results in a wide range of devastating and irreversible effects now known as iodine-deficiency disorders.⁵ More recently, we have come to appreciate that there is a general diminution in intelligence in iodine-deficient communities such that iodine deficiency is considered to be the commonest cause of preventable intellectual disability worldwide.² Further, there is now very good evidence that a small decrease in serum free thyroxine level during pregnancy, either because of iodine deficiency or thyroid disease, is an important risk factor for impaired psychomotor development in infants.^{6,7} The recent demonstration of intellectual impairment in the children of American women who had mild hypothyroidism in pregnancy highlights the need for better detection and treatment of hypothyroidism in early pregnancy, irrespective of its cause.⁸

Tasmania is the only Australian State where regular surveillance of iodine nutrition is undertaken and records are maintained. Other data are available from the Australian Centre for Control of Iodine Deficiency Disorders (ACCIDD), located at Westmead Hospital, which has performed sporadic surveys of urinary iodine excretion levels in small samples of Australians for the past two decades. In 1992 we reported that the mean urinary iodine excretion level in Sydney residents was 180 µg/L, and over 200 µg/L in Tasmanian children.⁹ Since then, our sporadic surveys have shown a gradual but sustained decline in urinary iodine excretion levels in Sydney residents. We recently found similar results to those of Gunton et al³ in a survey of primary schoolchildren from western Sydney who had a median urinary iodine concentration of 84µg/L, and in 16% of whom the iodine concentration was less than 100 µg/L. Further, unpublished results we obtained in healthy pregnant women were also very similar to those of Gunton et al, indicating that widespread mild iodine deficiency threatens to affect the most vulnerable in our community.

Why is our iodine intake decreasing in Australia?

Gunton and colleagues implicate a combination of factors. Firstly, for over three decades, we have been dependent on iodine in milk contaminated by cleaning solutions used in the dairy industry; these solutions are gradually being replaced by others which leave less iodine in milk. Secondly, we seem to be using less iodised salt, through a combination of purchasing uniodised salt for domestic consumption, probably decreasing our salt consumption, and consuming most of our salt in processed foods, which, as far as we can ascertain, is uniodised. The problem is not unique to Australia, as similar downward trends in iodine intake have recently been noted in other developed countries such as the United States¹⁰ and New Zealand.¹¹

What actions should be taken in response to these findings?

Firstly, we need more information through a national survey of urinary iodine excretion and goitre rates to determine the status of iodine nutrition throughout Australia. Secondly, we need to educate the population and healthcare providers about the insidious and harmful effects of iodine deficiency, especially during pregnancy and early childhood. Finally, we must institute effective and sustainable means of iodine supplementation to our whole community through legislating for universal salt iodisation, so that all salt used for human and animal consumption in Australia is iodised. Iodising all edible salt will cost less than 10 cents per person annually. In the past this intervention has been viewed as politically unacceptable, but the debate was conducted with a view to eliminating endemic goitre without any real understanding of the often subtle, but devastating, consequences of impaired brain development. In the interim, every effort should be made to ensure every pregnant woman ingests an adequate amount of iodine to ensure her unborn child experiences normal mental development. Until we have educated the population as a whole about the risks

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Where Has All Our Iodine Gone? from Page 3

of iodine deficiency and instituted mandatory iodisation of all salt for human and animal consumption, it may be prudent to recommend supplementary iodine for all pregnant women from the time of conception until weaning of the infant.

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BOOK REVIEW

By Colleen Dean

THE THYROID SOLUTION:

A mind-body program for beating depression and regaining your emotional and physical health

By **Ridha Arem M.D.**

(Associate Professor of Medicine in the Division of Endocrinology and Metabolism of Baylor College of Medicine in Houston, Texas; Chief of Endocrinology and Metabolism of Ben Taub General Hospital, Houston)

Ballantine Books, New York, 1999.

At last a comprehensive book with a holistic view. It explains why the body behaves as it does and how essential the thyroid hormone is to normal brain chemistry. An intriguing endocrine gland, the thyroid's sensitivity is such that it affects our whole being - our mind, body and spirit.

The aims of the book are two fold:

Firstly, it emphasises the importance of the thyroid hormone as a key brain chemical, this being the important link of communication between our body and mind, thus affecting everything from metabolism, weight, appetite, sexuality, fertility and mental health.

The second aim is to provide practical information, having recognised the mind-body connection. *The Thyroid Solution* provides programmes that will help you take control and halt the escalation of the disease, and to achieve a balance in your life.

It is a tribute to Dr, Ridha Arem that he has turned this subject into compelling reading. He has achieved this by dividing the book into sections and by using real life case studies to graphically illustrate the suffering some have encountered on the road to diagnosis. It is a book that will take you from disillusion to wellbeing. It will inspire you to seek answers and the treatment you need.

As Dr. Mona Lisa Schulz states, "If you're a woman, get this book. If you're a man with a woman in your life, get this book. If you're a man, get this book. The idea is - get this book."

UPCOMING MEETINGS

Join us for a
BYO PICNIC
at the Melbourne Zoo

Sunday 13 February 2000

11.30am - 3.00pm

And while you're there, visit the Ulysses Butterfly at the Butterfly House, and stay for the Army Band performance at the Zoo Twilight!

Address

Pavilion 6, Melbourne Zoo
Elliott Ave, Parkville
(Melway 29 D12)

Admission:

Adults \$14.50
Children (4-15) \$7.20
Family (2 adults & 4 children) \$39.30
(Unfortunately Group Discounts don't apply on Sundays.)

For more details on the Zoo, visit their website at <http://www.zoo.org.au>

Thyroid Disease at a Glance

Thyroid disease has many faces, yet all of its symptoms originate with trouble in the thyroid gland. The thyroid gland is a small, butterfly-shaped gland weighing only an ounce. But it is also command central for many organs in the body, including the heart, brain, and liver. The thyroid gland also regulates metabolism and cell growth.

The thyroid gland secretes two major hormones, T4 (thyroxine) and T3 (triiodothyronine). These hormones travel to the organs of the body via the bloodstream. When all systems are go, Thyroid Stimulating Hormone (TSH) is released by the pituitary gland, which triggers the production of T3 and T4.

When T3 and T4 are at the appropriate levels, TSH will level off as it should. However, if there is too little T4 and T3, TSH will be elevated. If there is too much T4 and T3, TSH will be suppressed. In this way, TSH is a marker of thyroid function and thyroid hormone levels.

Hypothyroidism - occurs when the thyroid gland is underactive and produces insufficient thyroid hormone. It is the most common thyroid disorder, occurring more frequently in women than in men. Hypothyroidism affects 6%-10% of women over the age of 65.

Treatment for hypothyroidism is straightforward. Synthetic levothyroxine (LT4) is a safe and effective thyroid hormone replacement therapy. In fact, it is one of the top three most commonly prescribed drugs in North America.

Hyperthyroidism - is a less common disorder affecting approximately 2% of women and .02% of men. It occurs when the thyroid gland is overproductive. The elevated T3 and T4 levels can have a dramatic impact on body functions, speeding up metabolism by 60%-100%. Patients with hyperthyroidism have sometimes been described as being anxious to a point of not making sense.

There are a range of treatments avail-

able for hyperthyroidism, including anti-thyroid drugs, radioiodine treatment, and surgery. All are effective, though no one treatment ever results in a complete cure.

Thyroid cancer - fortunately, is extremely rare, accounting for less than 1% of all cancers. Total or partial thyroidectomy is the only treatment option. If the cancer has spread to the lymph nodes, these must also be removed.

Nodules - about 5% of the population have 'bumps' on the thyroid gland known as nodules. They are more common in women than in men and are probably caused by low T3 and T4. Provided they are solitary, nodules have just a 5%-10% chance of being malignant.

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What Should You Expect From Your Doctor? What Should Your Doctor Expect From You?

By **Elliot G. Levy, M.D.**

You would think it is all quite simple. The thyroid gland is a small organ, located in the front of the neck. It is a factory that is designed to produce one product - thyroid hormone. It usually makes just the right amount of hormone to meet the body's needs. Occasionally it can make too much hormone. More often, it can produce too little hormone. It can grow lumps, some of which can contain thyroid tumors, including thyroid cancer.

It all sounds very simple, and so it seems, until you suddenly discover that you or someone you know has a thyroid problem. Then you realize that what sounds so simple at first actually can be quite complicated and very confusing.

The purpose of this article is not to advise you what to do about any specific area - there have been, and will continue to be, informational articles in this publication addressing all of these areas - but to help you understand the nature of the relationship between you the patient, and your doctor.

What should you expect from your doctor?

Nowadays, the traditional role of "the doctor" may seem different, especially to those of you who remember the "good ol' days of medicine," when your doctor was your friend, took lots of time with you, got to know you and your entire family, took care of all aspects of your care, saw you when you were sick in the hospital, maybe even came to your house for a house call, and, certainly, never hesitated to refer you to a specialist. Things are just not that way any more.

Whether it was caused by the rising cost of health insurance to employers, or the total cost of health care to the government, or the influence of profit-driven "big business" into the health care industry, or some other cause, there is a very different approach to health care today. The influence of Managed Care has greatly changed the doctor-patient relationship of years ago. Doctors are constantly scrutinized over how much they are spending to evaluate a patient's illness and treatment. Hospital stays are

shorter, and fewer tests are ordered. The overhead of a medical practice is constantly rising, yet doctors in most parts of the country are not able to raise fees because of contracts with insurance companies or with Medicare. There is a tendency for doctors to have to see more and more patients each day to cover their office overhead. There is great pressure on primary care doctors to "do everything" including, often, holding back early referral to specialists.

In the area of thyroid disorders, this fact is very evident. Often patients are referred very late in the course of their illness and often with many inappropriate (and expensive) tests having already been done. Who suffers the most when this style of medicine is continued? The patient is always the victim.

Nowadays, I personally recommend that the patient become her or his own advocate in her or his relationship with the physician. I hope to provide some tips to improve this relationship to seek the

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What Should You Expect From Your Doctor? *from Page 5*

ultimate endpoint of a satisfied and healthy patient.

Patients deserve to know what is wrong with them and deserve to have all of their questions answered in a prompt manner. The word "doctor" is derived from the Latin word "docere" or "to teach". The primary role, therefore, of a physician is to teach his or her patient what is wrong and how to improve or fix the problem.

It is said that the three major complaints that patients have about their doctors are that:

- 1) My doctor is always late.
- 2) My doctor does not spend enough time with me.
- 3) My doctor does not listen to me.

Perhaps you should anticipate these three areas and be prepared to deal with them individually or change doctors if you cannot find one who meets these needs.

Doctors, especially primary care doctors who work in large clinics, are often forced to see large numbers of patients per day. The amount of time you need might not fit into the doctor's schedule. Thyroid diseases can often be very complicated, involving undergoing many types of evaluations, including physical examinations, blood tests, nuclear tests, ultrasounds, and biopsies, and often require detailed explanations.

Many doctors who do formal training (i.e. residencies) in either family practice, general practice, or internal medicine do not spend much time in the Endocrinology Department. In addition, most patients with thyroid problems do not have to enter hospital for anything except thyroid surgery, so young doctors who have learned mostly from hospital experience often have not had much experience in diagnosing or treating thyroid problems.

If you sense that you are not getting your questions answered, your doctor seems defensive in answering your questions, defers the answers to his staff, does not supply you with written material when you ask for it, does not know what web sites contain the most reliable patient information, gives advice that seems far fetched or confusing, perhaps it is time to seek consultation with a specialist. This is always a very delicate and sensitive issue, but sometimes patients just have to yell and scream loud enough to be heard.

I personally advocate early referral to a specialist for all forms of hyperthy-

roidism, all thyroid lumps (nodules), all pregnancy-related thyroid problems, all cases of thyroid tumors, and any time the thyroid blood tests are confusing. Specialists (i.e., endocrinologists or thyroidologists) should be able to do all of the above. The specialist should have the time and experience to answer all your questions, explain to your understanding even the most complicated thyroid problems, be able to arrange the best place for your diagnostic tests, hospitalization, lab testing, and surgeon if you need thyroid surgery (within the limitations of your insurance company). He or she should provide you with written material, recommend support groups (like the TFA), inform you about web sites (such as www.tsh.org), and make notes for you to explain to your family at home. You are entitled to all of this.

In addition, I feel your doctor should help you make decisions. You come to your doctor to understand what is wrong, be tested (but not too much), and to feel better. Your doctor should keep up on all the latest developments in the field. Your doctor should provide for you the treatment options, where they exist, but should not turn to you to make a decision without your being properly informed. It is my personal feeling, that patients come to medical doctors for advice on what to do. Doctors should be expected to provide guidance to the proper decision, not leave it to the patient to decide alone.

How Often You Should Be Seen

It is hard to predict how often thyroid patients need to be seen by an endocrinologist. Certainly, it depends on the activity of the disease, whether the problem was newly discovered, partially treated, or recurrent. The frequency may depend upon the age of the patient, as well as how compliant the patient is. A rough guide might be:

Hypothyroidism:

- Initially to establish the diagnosis
- First follow-up visit in one to three weeks to review the test results
- Follow-up visits every 6 to 8 weeks until the TSH is normalized
- Follow-up visit in 6 months
- Follow-up visit yearly thereafter

Hyperthyroidism (Graves' disease):

- Initially to establish the diagnosis
- First follow-up visit in one to three weeks to review the test results
- If radioactive iodine is used, treatment at the next visit in either the

doctor's office or at the nuclear medicine facility of the medical center or diagnostic center

- Follow-up monthly (for first 6 months) or until hypothyroidism is discovered
- Follow recommendations for hypothyroidism, above
- If anti-thyroid drugs are used, follow-up every 1-2 months for the duration of the anti-thyroid drug treatment

Thyroid Nodule:

- Initially to establish the diagnosis
- First follow-up in one to three weeks to review the test results
- If surgery is recommended, follow-up within one month after surgery
- If no surgery, and thyroid hormone suppression is used, then follow-up visits every 3 to 6 months for the first 3 years, then yearly thereafter

What should your doctor expect from you?

Please be on time for the visit, or call if you know you are going to be late to see if rescheduling is appropriate. If you must have an authorization number or form before you can see the specialist, make sure that the specialist has this paper, or you should stop by your primary care physician's office to pick it up.

If you are supposed to be on medications, please take them at the proper time every day. They are for your own good. If you are not so good at taking medicine, please inform your doctor. Sometimes the strength of a drug is readjusted based on the assumption that you are compliant. If you do have a problem remembering to take the pills, perhaps a simpler schedule can be arranged.

If you have a lot of questions, please write them down on a list and have it ready for the doctor when she or he enters the examination room. Sometimes seeing the list makes it easier for the doctor to answer the questions.

If you become sick, require an operation, or other family members of your family are concerned about you and want to speak to the doctor, please designate one family member to be the spokesperson for the family. Try not to make the doctor have to go over the same explanations and facts on several occasions. If possible, try to have someone at the patient's bedside when the doctor makes

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THINK THYROID: Your GP and Your Thyroid *from Page 2*

roxine itself. That is, there is an autoimmune reaction or allergy either to the thyroid tissue (the microsomal antibodies) or to the thyroid hormone. The result is underproduction of thyroxine or damage to the thyroid tissue, or both. Ninety percent of patients with Hashimoto's thyroiditis will show one or both antibodies in their blood.

Hyperthyroidism, or thyrotoxicosis, is characterised by an increased metabolism. Symptoms include weight loss despite an increased appetite, diarrhoea, intolerance of heat, trembling of the extremities, increase in heart rate, and, in women, reduced menstrual flow. The most common cause of hyperthyroidism is the autoimmune condition known as Graves' Disease. There can also be eye involvement, which is characterised by dry and/or protruding eyes. However, Graves' or thyroid eye disease (also known as exophthalmos) would be the subject of another talk altogether.

Treatment

The treatment of thyroid conditions depends on a number of factors. I will only mention these briefly as these too are subjects which really need to be addressed separately at another time.

For overactive thyroid, we have a choice of tablets, surgery or radioactive iodine, monitored by TSH and T3 and T4 levels.

For underactive thyroid, we have thyroid hormone replacement, monitored by TSH and T3 and T4 levels.

For nodular goitres, especially those that have had a bleed into a nodule, surgery is the only choice. This type of bleeding is a potentially life-threatening condition because the thyroid may enlarge to such a degree that it can press upon

the other structures in the neck - such as the windpipe or gullet - and cause serious complications.

Thyroid cancer should be treated by surgical removal of the gland, with or without radiotherapy.

Screening -Think Thyroid

A few years ago I used one of those throwaway lines that sometimes take on a life of their own. I said that "you have to THINK THYROID". The message is that it is important for us GPs to remember the thyroid as its activity can mimic many other conditions. Thyroid disorders are the great masquerade. The thyroid hormones affect every part of the body - as most of you will be very aware - and so, like diabetes, thyroid problems can present as all sorts of conditions. I have seen thyroid disorders mimic everything from anorexia nervosa and atrial fibrillation to Alzheimer's Disease.

So we GPs need to add thyroid screening tests to those other routine blood tests we do as part of the general health check. The TSH is the test that we normally use. It is a simple blood test that can be added to the other blood tests wherever appropriate. We do not need to do the T3 and T4 estimations as first line tests. They are more useful as tests to assess the results of treatment than they are to screen for thyroid function.

There are certain rules for routine screening tests. They are:

- * The test should be looking for a common condition.
- * The test should be simple.
- * The test should be cheap.
- * The test should be accurate and specific for the condition.
- * The test should be as non-invasive as possible.

- * There should be an agreed line of treatment for the condition.

Thyroid disorders and thyroid screening fulfil all of the criteria outlined above.

Perhaps it is time for Thyroid Australia to begin to lobby for thyroid screening in the way that Diabetes Australia has for blood glucose measurement. Perhaps it is time for the development of easy TSH assays.

What Should You Expect From Your Doctor? *from Page 5*

rounds, if the questions are about a hospitalized patient.

Cooperate with your physician when she or he recommends a test which cannot be done at the doctor's office and have it done promptly. Make sure you tell the hospital or diagnostic center to send a copy of the results to your primary doctor, and also to the specialist.

If you are seeing a specialist for the first time, try to gather up copies of all your recent lab results and bring them with you to your appointment. In addition, if you have had any recent thyroid scans, sonograms, or CAT scans, please bring the original x-ray films with you. Call ahead to the hospital or diagnostic center. They should release them to you.

Please learn as much as possible about your thyroid disorder because the more informed you are, the easier you can be treated.

Patients, nowadays, deserve to be better informed than they used to be. There are many resources available (including the TFA). But use the resource most easily available and the one that you need to trust the most - your doctor. In turn, cooperate with the doctor so that you can return to good health as quickly as possible.

Dr. Levy is Clinical Professor of Medicine, University of Miami School of Medicine, in Miami, Florida.

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The audience listening to Dr Dammary

Editorial from Page 1

Thyroid material in LOTE

In our previous newsletter we asked for assistance in providing material in languages other than English (LOTE). We have since received permission from the Associazione Italiana Basedowiani e Tiroidei (AIBAT) to use their Italian material, for which we are most grateful.

We also have French material from the Thyroid Foundation of Canada, which is also gratefully acknowledged.

The Multicultural Health Communication Service of the Department of Health in New South Wales have also recently published an excellent leaflet, entitled *How thyroid problems can affect your health*. This leaflet is available in Arabic, Chinese, Croatian, English, Greek, Italian, Khmer, Korean, Laotian, Macedonian, Portuguese, Russian, Spanish, Thai, Turkish, and Vietnamese. We have permission to provide copies of this leaflet to those who require it.

Other initiatives are also in the offing, particularly relating to Russian material - but more of that in another newsletter!

The Thyroid Australia Committee

It gives me great pleasure to introduce some of the members of the Thyroid Australia Committee.

Colleen Dean has been a nurse for thirty years and has a keen interest in endocrinology and the immune system. Although not a thyroid sufferer, she has a strong family history of thyroid disease, diabetes, MS, ADD and arthritis. Her mother developed heart disease as a result of a chronic untreated hypothyroid condition and her father's thyroid condition was drug induced. She feels that support groups such as Thyroid Australia give access to information, and individuals can then develop a better understanding of their condition enabling them to take charge and move on with their lives.

Kay Horley is married to Ed and they have a 14 year old son, Ben. She has Hashimoto's Thyroiditis. In hindsight she thinks her mother had thyroid disease, but was never diagnosed - she did however have diabetes.

Christopher McDermott has lived in Melbourne for almost two years and works in arts administration. In late 1997, just before moving, he was diagnosed as hav-

ing an over-active thyroid gland, resulting from Graves' disease. His older brother had been similarly diagnosed only a few years before and his uncle, on his father's side, had also had the same diagnosis in the 1960's. Aunties and great-aunts on both sides of his family had suffered from underactive thyroids. With this family history, and growing up in Tasmania, developing a thyroid condition seemed almost inevitable.

Megan Stevens came to Australia from South Africa in 1981, with a BA, a librarianship diploma, and her husband, Alun, in hand. She was diagnosed with Hashimoto's Thyroiditis in November 1994, 9 years after the birth of their second child. Since then she has tried hard to understand her thyroid condition, and all other aspects of thyroid disease. When she is not reading up on matters thyroid, she is working (well, trying to) on her MA History thesis on the Commissariat in the Crimean War.

Alun Stevens came to Australia with Megan. He only suffers the side effects of thyroid disease. He is an actuary and management consultant and is helping establish Thyroid Australia.

Features

In this newsletter we are concentrating on the relationship you have with your doctor, and how best to foster that relationship. Our thanks to Dr. David Dammary for his input, and for his wonderful talk on *Your GP and Your Thyroid* at our first public meeting on 20 November 1999. (Thanks too to those who attended - it was great meeting you all!) We also include a great article by Dr. Elliot Levy, who talks about doctor/patient expectations of each other.

And, following our feature on Iodine Deficiency Disorder (IDD) in our last newsletter, we are providing an editorial by Prof. Cres Eastman which was recently published in the *Medical Journal of Australia*. We had wanted to include in our last newsletter an article written by Prof. Eastman in 1993, in which he suggested that there was "no evidence for IDD in Australia". However, Prof. Eastman asked us not to do so, and informed us that that information was out of date, and that IDD is in danger of having a resurgence here in Australia, which is a matter of grave concern.

Recommended Books

The Thyroid Solution: A Mind-Body Program for Physical Health, Ridha Aren, (Ballantine Books, New York) 1999. (ISBN 0 345 42919 2.)

How Your Thyroid Works, H Jack Baskin, 4th ed., (Adams Press, Chicago) 1995. (Also available on the internet at <http://www.thyrolink.com/baskin/index.htm>)

Thyroid Disease: The Facts, RIS Bayliss & WMG Tunbridge, 2nd ed. (OUP, Oxford) 1991. (ISBN 0 19 262103 3.)

The Thyroid Gland: A Book for Thyroid Patients, Joel I Hamburger & Michael M Kaplan, 7th rev. ed., 1997 (Available through the Thyroid Foundation of America or Amazon.com)

Thyroid Disorders, Rowan Hillson, (Macdonald Optima, London) 1993. (ISBN 0 356 18686 5).

Understanding Your Thyroid Problem, Mark Ragg, (Gore & Osment, Sydney) 1993.

The Thyroid Sourcebook: Everything You Need to Know, Sara M Rosenthal, 3rd ed. (Lowell House, Los Angeles) 1998. (ISBN 0 7373 0014 0)

The Thyroid Book: A Book for Patients, Martin I. Surks., (Consumer Reports Book, New York) 1993. (Available from Dr MI Surks, Montefiore Medical Center, Div of Endocrinology, 111 East 210th Street, Bronx, New York 10467; or by internet at <http://www.thethyroidbook.com>)

Thyroid Problems: A Guide to Symptoms and Treatments, Patsy Westcott, (Thorsons, London) 1995. (ISBN 0 7225 3164 8).

Your Thyroid: A Home Reference, Lawrence C. Wood et al, 3rd ed. (Ballantine Books, New York) 1995. (ISBN 0 345 39170 5).

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