Functional Hypothyroid Management

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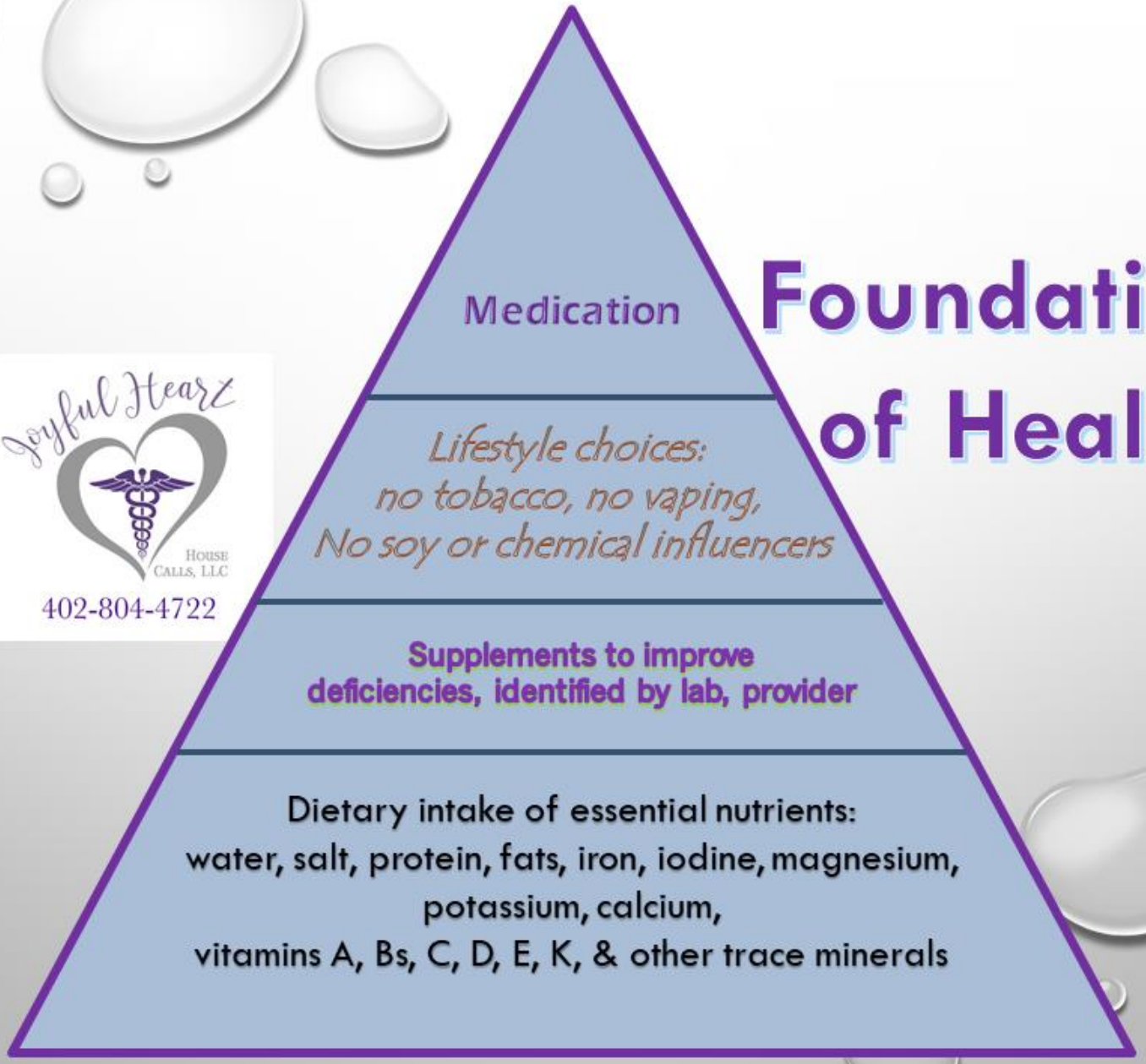
JOYFUL HEART HEALTH CARE

Foundation of Health



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Thyroid Health

Thyroid dysfunction = metabolic dysfunction

Insulin levels often influence thyroid hormone

Initially, always get:

- TSH, Free T4, Free T3, Reverse T3, TgAB, & TPO
- F/U labs likely only need FT3, FT4, and RT3

Grain intake blocks absorption of

IRON

T3

Zinc

SOME PROTEINS

Various other nutrients

Grain intake also raises inflammation

Essential Ingredients for Thyroid

Iodine

Vitamin D

Iron

Protein

Healthy gut/digestion/absorption

Proper nutrient support is required for healthy thyroid function

Your health is a 3-legged stool

Food choices

Vitamins/ supplements

MEDICATION PRESCRIPTION(S)

Your health sits upon a 3-legged stool, with each leg serving as a MAJOR part of your treatment.

Omit just one "small" part, and your treatment fails.

Collect adequate s/s from patient

Mood swings

Menses mood changes

Depression s/s

Irritability, “on-edge” all the time

Fatigue, waking tired, poor sleep, daytime nap

Use caffeine to stay alert

Thinning hair, eyebrows, lashes

Dry, itchy skin, rough/scaly elbows

Frequent early AM h/a, brain fog, loss of focus

Neck feel swollen/full/knotty

GI problems, esp IBS, constipation,

Muscle aches, pain, weakness, cramping

Numbness in hands/feet or PF, CPTS – frozen shoulder

Patient Name_____ **Thyroid Symptom Questionnaire** Patient Date of Birth _____

This questionnaire helps determine the function of thyroid hormone in your body. It does not matter if you have had lab tests that say your thyroid is OK or that you may be taking prescription thyroid medication, you still may have problems with metabolism that directly relates to how thyroid hormone is functioning in your body.

Scoring: enter the following score:
10 – If this is a noticeable issue or significant problem
5 – If this is a problem, but not a major issue
2 – If this happens every now and then, but you don't notice it too much
0 – If you seldom or never have this issue. *Make sure to TOTAL ALL POINTS at the bottom right of chart.*

			10	5	2	0
GENERAL		Are you cold? Do your hands/feet feel cold a lot?				
		Are you overweight/obese? (10 if over 20 lbs, 5 if 10-19 lbs, 2 if 5-9 lbs)				
		Do you gain weight easily or struggle to lose weight?				
		Do you have abnormal cholesterol levels? (10 if over 250, 5 if 220-249, 2 if 201-219, OR 10 if under 140, 5 if 141-160) ***Or elevated triglycerides?*** (10 if >350, 5 if 250-349, 2 if 150-249)				
MOOD	WOMEN:	Are your moods noticeably worse with/near your menstrual cycle or transition?				
LIBIDO	MEN	Do you lack a morning erection? (never get one=10, sometimes=5, occasionally=2)				
		Do you struggle with depression in the winter/spring/fall?				
		Are you easily depressed, prone to depression, or feel less communicative or more withdrawn?				
		Does stress increase your irritability; keep you "on-edge" often?				
FATIGUE		Are you always tired? Do you awaken tired?				
SLEEP		Do you need a lot of sleep and then still not reel rested?				
		If you sit/slow down in the daytime, do you tend to doze/nap or lose your energy when you stop?				
		Does your energy suddenly drop in the afternoon?				
		Do you rely on caffeine or other stimulants to stay awake during your day?				
SKIN/HAIR		Are your eyebrows thinning on the outside portions?				
NAILS		Do you have dry/itchy skin? Do you have dry/brittle hair?				
		Are your elbows rough or scaly?				
		Is your hair falling out, thinning, or breaking? Have less body hair in general?				
HEAD/NECK		Are you prone to facial swelling, especially around the eyes, maybe more often in the morning?				
THROAT		Do you have frequent early morning headaches that generally improve over time?				
		Does your head feel heavy? Do you have "brain fog" or struggle with memory/concentrating?				
		Do you have a sore throat? Feel like your voice is hoarse or coarse?				
		Do you feel like your neck is swollen or feels full?				
Stomach/digestion:		Do you have reflux/poor appetite/constipation? Strain to have a BM?				
Extremities:		Do you get muscle cramps, charley horses, or general muscle weakness?				
		Do you have numbness in hands/feet or carpal tunnel syndrome?				

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TOTAL POINTS _____+_____+_____=_____

Lab ranges – Unmedicated healthy

TSH is ideally less than 2

Free T4 around 1 ng/dL

Free T3 around 3.5 – 4 ng/dL

Reverse T3 is 15 ng/dL or less

If the FT3 & RT3 are both in ideal range, pt is NOT hypothyroid – NEITHER are they HYPERTHYROID

Reverse T3 – Medicated pts

Ideal RT3 is 10-12 ng/dL
- Fewest s/s
- Improved energy

If RT3 is 15 or less, no need for T4 dosing

Driven by T4 dosing
- Levothyroxine, Synthroid, Armour, NP
- Inflammation, illness, injury CAN raise RT3

Free T3 - Thyronine

The only thyroid ingredient that enters the cell for use in energy production

Normal process

- FT4 is converted via complex enzymatic process to FT3
- Deiodinase enzyme deficiencies will stop normal process
- MTHFR has some impact as well

NDT – Armour or NP

Natural desiccated thyroid = porcine products

Combo of T4 and T3

- Levothyroxine & Liothyronine
- Levo = T4
- Lio = T3

Levothyroxine/Synthroid

Singular T4 treatment is becoming less effective

- If FT3 is around 3.5 – 4, T4 dosing is likely adequate
- If RT3 is higher than 15, the likelihood of poor/no conversion is HIGH
- Therefore, these pts will need T3 rx

If RT3 is holding steady between 9-15, T4 may be all that's needed, IF free T3 is also above 3.5

- These pts are adequate "converters"

Using FT3

If FT3 is less than 3.5 & RT3 is 15 or higher, pt is poor “converter”

Will benefit from liothyronine (T3) rx

Using Liothyronine

Prior to rxing Lio:

- Make certain the ferritin level is ABOVE 45 ng/mL
  - Or risk cardiac complications, palpitations, heart racing, etc.
  - If ferritin is low, iron becomes major priority
  - Treat low ferritin first
- Educate on grain elimination 2/2 phytates
  - Phytates block/impair T3 absorption

RX Liothyronine (T3) – TEACH pts:

Usual release of FT3 is early AM, prior to/during awakening

Highest amount is released at that time and is used over early part of day

Resulting in steady decline of FT3 in bloodstream/cells

Rx 1 tab per day x 3 weeks

Increase dose every 3 weeks

Rx Lio – Dose to mimic the body

Build a dosing pattern
- 3 tabs early AM
- 2 tabs 10-11 am,
- and 1 tab around 1-2 pm
- No max dose, no target dose – TEACH pt !!!

Keep the lowest dose of Lio in early afternoon

Late in day doses will impair sleep for most

Pattern also helps with lab draw f/u

Rx liothyronine

No target dose, no goal dose

Treat symptoms

Monitor labs for safety

Aim for FT3 around 4 ng/dL, or slightly above

- Goal FT3 is very top of range for most
- Elders, over age 65, Goal may be around 3.5 instead
- Use symptoms to guide your dosing regimen

Safety tips to teach

Patients need to know the lio IS cardiac stimulant

Checking HR & BP is vital

- About twice weekly
- PLOT on graph paper for optimal understanding
- Notify clinician of any s/s of hyperstimulation
- Drop dose back ASAP, even before calling office

If following instructions to gradually increase, hyperstimulation s/s should NOT occur

Cheat Sheet


Optimal Free T3 = 3.5 - 4.2 ng/dL
Optimal Reverse T3 = 10-12 ng/dL
Free T4 goal during pregnancy is > 1.0 ng/dL
Newly diagnosed hypothyroidism treatment suggestions
If RT3 is 10 or higher, no need for a T4 med bc it will push RT3 higher; start liothyronine only ONLY if ferritin is greater than 45 ng/mL
If RT3 is 9 or less, start NP thyroid at 30-60 mg QD

If FT3 is less than 3.0,
add lio 5mcg QD &
increase 1 tab Q3WK,
building dosing pattern that's
highest in early AM,
and lowest/last dose by 2pm.

Recheck FT3, FT4, & RT3
q 8-10 wks while titrating med dose.

Lio WILL SUPPRESS TSH!!!

If FT3 is 3.1 - 3.5, consider correcting deficiencies and
recheck labs in 4-6 mos.
Vit D, iron/ferritin, protein;
eliminate grains.

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Lab follow-up

Perform VISITS for Lio mgmt due to risks
- NOT a phone call

TSH will be suppressed; no need to continue drawing it when Liothyronine is rxed

Repeat thyroid studies every 8-10 weeks while titrating lio dose

Continue reducing T4 dose until RT3 is 9-13 ng/dL

Continue increasing T3 dose until FT3 is around 4

Long term f/u

Once labs are optimized & pt is feeling good, increase time to f/u

- Always see these pts every 6 mos or less
- Cardiac risks if left without adequate f/u & assessment

Once ferritin level is above 45-ish, start same tx plan

- Recheck iron every 4-6 mos until levels remain stable
- Decrease lio dose if ferritin falls back down

Optimal thyroid management

Requires thorough nutritional assessment
- Treatment & lab f/u

Hormones required
- Iron, D, protein

Adequate pt education, CYA documentation

Pt willingness to cooperate with all recommendations & f/u

Frequent f/u – Q 8 wks – Q4 mos – Q6 mos

What about Hashimoto's?

Same tx as discussed

EXCEPT: inflammation MUST be addressed

- Eliminate all sources of dietary inflammation
  - Grains, seed oils, dairy, oxalates, uric acid, tobacco, vaping, etc

Vitamin C, black cumin seed, CoQ10, luteolin, chlorella, berberine, B complex(methylB)

Monitor AB every 6 mos – slow to respond

Encourage reading The Thyroid Pharmacist

LDN?

Low dose naltrexone – possible aid

Start 0.5 mg HS x 30 days

Increase by half to whole mg Q 30 days

Most pts do well around 4-7 mg QD

Not a first line tx

- Need to eliminate all inflammation causes
- Fighting a losing battle – with a round robin of inflammation and anti-inflammation

References

BOOK: Recovering with T3 Treatment, by Paul Robinson

https://paulrobinsonthyroid.com/more-t4-t3-thyroid-medication-might-not-always-raise-patients-ft3-levels-in-thyroid-hormone-treatment/

BOOK: Hashimoto's Protocol, by Isabella Wentz

Dr. Westin Childs' blog: https://www.restartmed.com/blog/

Blog: https://stopthethyroidmadness.com/

THANK YOU!

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