

The ugly truth emerges about synthetic thyroid medication



A new study confirms something that I've believed from the very start of my medical career: For many patients, standard synthetic thyroid medication (Synthroid, levo-thyroxine) doesn't work well. About 15 percent of the 10-12 million people in the U.S. with hypothyroidism, or an underactive thyroid, continue to feel sick despite following the standard of care recommended by the American Thyroid Association.

Additionally, the study revealed that patients taking conventional thyroid medication had higher body mass index despite consuming fewer calories per day and were more likely to require beta-blockers, statins, and anti-depressants. It's



likely they required these meds because they were more prone to high cholesterol, metabolic syndrome and high blood pressure, with their associated malaise.

The researchers looked at patients prescribed synthetic thyroid, dosed according to mainstream guidelines. That is, doctors measured their TSH—thyroid stimulating hormone—as a guide to how much medication they should get.

What TSH measures is how strongly the pituitary gland—located in the brain—is signaling to the thyroid to pump out more

thyroid hormone. So a high TSH denotes inadequate functioning of the thyroid (hypothyroidism), while a low TSH indicates either thyroid hyperactivity (hyperthyroidism) or over-medication.

Trouble is, the “norms” for TSH are entirely arbitrary, representing a best-guess as to normal thyroid functioning. Critics of the TSH test point to the fact that it was based on a population survey of individuals said to have well-functioning thyroids. But with such a high percentage of the population suffering from borderline hypothyroidism, who’s to say the original sample represented *optimal* thyroid function?

Additionally, as demonstrated in the recent study, a high percentage of patients said to be correctly dosed according to TSH measurements continue to feel lousy. They feel better on doses of thyroid medication that suppress the TSH to what are still thought to be impermissibly low levels.

Admittedly, putting a ceiling on thyroid replacement is important, because overzealous medication can prompt dangerous heart arrhythmias, and even strokes, especially among more vulnerable older patients.

And, since women are especially prone to thyroid problems, over-medication (but not reasonable replacement) can prompt accelerated bone loss. I recently saw a 56 year-old woman who consulted me for severe, unexplained osteoporosis who had none of the classic risk factors: use of steroid medication, acid-blockers, family history, celiac disease, or premature menopause. She had no family history of early fractures and was quite physically active. But she had been given an inappropriately high dose of natural thyroid by a “holistic” doctor for a period of twenty years, which leached the calcium from her bones. I adjusted her thyroid medicine downward and her energy was none the worse for it.

Natural thyroid has the advantage of supplying the body with

both T4 and T3, the active form of thyroid that powers energy metabolism. By contrast, synthetic thyroid consists only of T4 which the body must convert to T3. But many individuals don't efficiently biotransform T4 to "body-ready" T3. Hence, blood tests may seem deceptively normal while the cells are underpowered with T3.

I've been a proponent of natural thyroid replacement for over 30 years. I've done so in the face of criticism from my medical colleagues that my use of "piggy thyroid" was outmoded, unscientific, and even dangerous. So intense is the opprobrium against anything but "correct" Synthroid or levothyroxine that I consider myself fortunate never to have been brought up on charges of medical misconduct; others among my colleagues have faced investigations and penalties at the hands of their state medical boards merely for prescribing unconventional natural thyroid.

Once, I referred a family member to a mainstream endocrinologist to make sure her enlarged thyroid was not cancerous. Upon meeting with her, the doctor inquired "Who is your primary care?" When she answered "Dr. Ronald Hoffman," the doctor brusquely replied: "That quack? You should find yourself another primary care!" Startled, my relative blurted out "But he's my father-in-law!" and abruptly got up and walked out. Needless to say, she sought out another less judgmental doctor who confirmed that her out-sized thyroid was just a benign goiter.

I have never regretted my decision to step outside the cookie-cutter paradigm for thyroid prescribing, despite incidents like this. So many patients have benefitted over the years that it's clearly been worth it. And I feel a certain measure of pride that my controversial views are being vindicated by new studies.

A typical example was a 40 year-old male attorney I saw several years ago. After having his thyroid removed for

cancer, his endocrinologist placed him on Synthroid, which left him feeling tired and “out of it.” His work productivity was suffering. After unsuccessfully trying 3 or 4 different dosages of Synthroid, he came to see me. I prescribed Armour Thyroid which completely restored his focus and stamina.

Endocrinologists worry—not without some justification—that lowering the TSH to 0.1 or less, as sometimes happens when you prescribe natural thyroid, courts the risk of overdosing. But we prescribers of natural thyroid keep an eye on T3 and freeT3, not commonly followed by mainstream doctors, as better indicators of medication sufficiency or excess.

Once a proper dose of natural thyroid is ascertained, patients need to be followed carefully to make sure there’s no change in their status. As patients age, or if they manage to lose significant weight—as often happens when optimal metabolism is properly restored—thyroid medication doses may need to be adjusted downward.

Benefits for pregnancy can be particularly profound. One patient of mine was struggling with fertility issues. Repeated bouts of IVF failed to “take.” Upon questioning, she reported always being cold, and struggled with her weight. Her doctors assured her that her thyroid was “normal”—which it was, if looked at in the conventional sense. But additional tests revealed borderline low T3 and freeT3, so I gave her a small trial dose of Armour Thyroid.

Within a month she was pregnant, and she took thyroid medication throughout her successful pregnancy and continues it now to good effect.

Why the strong bias against natural thyroid? Some in the orthodox medical community will cite safety, ease of testing and prescribing, or consistency of dosing of the medication (which is harder to achieve with a glandular extract). But I think there’s an element of hidebound resistance to thinking

“out-of-the-box” in mainstream medicine that keeps doctors from prescribing something different, even if patients benefit.

I’ve written more on this topic in a previous article: “The Truth About Thyroid Function That Doctors Always Seem to Get Wrong”