

CONVERSATIONS

Jeffrey Dach, MD: The Transition to a Natural Medicine Practice

Interview by Craig Gustafson

Jeffrey Dach, MD, was originally trained in clinical medicine and worked as an emergency room doctor in Illinois. He is specialty board-certified in diagnostic and interventional radiology and has 25 years of experience serving the Memorial Healthcare System in Hollywood, Florida, with Radiology Associates of Hollywood. After retiring from radiology in 2004, Dr Dach returned to clinical medicine and founded a new clinic specializing in bioidentical hormones, natural thyroid care, and a variety of inflammatory and autoimmune conditions. He is a member of the American Academy of Anti-Aging Medicine and the American Academy for the Advancement of Medicine. He has authored 2 free e-books, Natural Medicine 101 and Bioidentical Hormones 101, which are available through his Web site at <http://www.drdach.com>. (Altern Ther Health Med. 2014;20(4):52-57.)

Alternative Therapies in Health and Medicine (ATHM): How did you get started in medicine and end up in radiology?

Dr Dach: I was interested in going into medicine. I was very good at math and science and the MCAT exam was all math and science.

So, for me, this was fairly easy. I attended medical school at the University of Illinois in Chicago where I was taught medicine there by some of the medical greats such as Morton Bogdonoff, MD, who was dean and chief of internal medicine. Clifford Pilz, MD, was chief of medicine at the VA West Side Hospital. These were old-time docs who were great clinicians. They had tremendous expertise and skill in examining patients and coming up with these physical findings that you see in books, like DeGowin's textbook of physical examination, which I think is on its ninth edition. I was impressed with the way they practiced medicine at the university hospital. I went through their program and was trained to be a clinician.

After medical school, I went into radiology. I did a radiology residency after a medical surgical internship at Rush University Medical Center in Chicago. After rotating through radiology as a medical student, I realized I could do this. Radiology involves working with medical images. I seemed to have a talent for that, which served me well for many years.

In the late 1970s, in Chicago, Rush was the first hospital to introduce CAT scanning. This was a brand-new technology—the first CAT scanner was an EMI scanner from England. It was slow and cranked out little Polaroid images of the brain. They got 10 slices of the brain in half an hour. The images were low resolution, something like 80 by 80 pixels. Over the years, the technology got better and better, as we all know. It was an exciting time in imaging because the technology was racing forward so quickly.

I had a knack for interventional procedures and had some manual dexterity, as well as the image interpretation ability. I quickly started doing all of the department's angiographic procedures. They were doing vascular radiology and neuroradiology with Michael Huckman, MD, who was the chief of neuroradiology. He had imaging rooms set up to do cerebral arterial imaging. In those days, they were doing direct carotid puncture cerebral angiograms—which in retrospect was somewhat barbaric: to puncture the carotid artery with a needle and then inject some contrast in it. That is what they were training the residents to do, and I was able to learn that quickly and do the routine studies. I could walk right up to a patient lying on a table, all draped, and palpate the carotid artery and stick a needle into it—just go through the front wall and the needle is perfectly placed—inject a little contrast under fluoroscopic observation to show the contrast flowing up into the cerebral arteries. Then, tape the angiographic catheter into place and connect the injector. They had these big power injectors on a remote switch so you can walk outside the room and synchronize the injection with the radiographic imaging device.

They were doing rapid filming in those days. Of course, now, it is all digital imaging. After the filming, the cerebral angiogram films would pop out of the film processor and then were loaded on a mechanized film viewer to be read by the neuroradiologist. That was all part of my radiology training.

After I finished that, I came down to Florida—to Jackson Memorial Hospital at the University of Miami—to do a fellowship. It was 6 months of ultrasound and 6 months of angiography. We did not do cerebral angiography. There was another neuro section that did cerebral, so we did only body angiography. It was mostly gunshot wounds in the middle of the night because that was the time of the Cuban boat lift. There were a lot of drug dealers shooting each other, so a lot of gunshot injuries came into the hospital. They all needed angiograms to see if there was vascular damage. That was in 1980 and 1981.

After I finished the fellowship, I was looking around for a radiology job. I ended up with a group at Hollywood Memorial Hospital in Hollywood, Florida, which is right here in South Florida. It is about a 45-minute drive north from Jackson Hospital, just south of Fort Lauderdale. That is where I have been since I finished my fellowship. I worked there at Memorial's radiology department doing diagnostic radiology, general radiology, ultrasound, CT, and nuclear medicine. I also did all of the interventional procedures: biopsies, drainages, angiograms, you name it. I worked there for 25 years.

ATHM: Why did you leave radiology?

Dr Dach: I developed some eye trouble about 10 years ago and had a detached retina, so I had to retire from radiology. My visual acuity was not good, and I had trouble seeing the faint nodules on the images. I took a few years off and got back into some leisure activities, playing tennis and doing photography and hobbies.

ATHM: How did you get interested in natural medicine?

Dr Dach: I went to the meetings of the American College for the Advancement of Medicine, or ACAM; the American Academy of Anti-Aging Medicine, or A4M; and the International College of Integrative Medicine, or ICIM. There was also functional medicine. I discovered that there were a zillion of these little meetings and that there are basically 2 worlds in medicine. There is the hospital-based medicine—this is where I was coming from: This is the mainstream, hospital-based, institutional medicine—the mega corporate medicine, which is of course controlled by the pharmaceutical industry and health insurance industry.

Then there are all these other splinter organizations, like ACAM, A4M, and ICIM. One of the organizations is called the International Society for Orthomolecular Medicine. Of

course, there was Abram Hoffer, MD, PhD, who was still alive at the time I was going to the meetings. One year we went to Toronto to an orthomolecular medicine meeting, the year that Dr Hoffer was receiving his lifetime achievement award. He was 90 years old. He looked great.

They had a big dinner and I was there with my wife. They put us at Dr Hoffer's family table. We had a nice conversation with some of his family members. That was a very charming experience. Then, at the end of the dinner, they gave everybody a copy of *Adventures in Psychiatry*, which was

Dr Hoffer's biographical book about his career. We chatted with him briefly. He was going strong.

ATHM: How did you end up back in clinical practice?

Dr Dach: I started going to medical meetings, thinking, "Maybe I will go back to being a clinician," since I was originally trained as a clinician. Even when I was doing radiology, I was practicing radiology as a clinician. A lot of diagnostic radiology involves interacting with clinicians, interpreting images, helping the attending physician with the differential diagnosis, suggesting further testing, and in some cases assisting with the management of difficult clinical problems. Since I was originally trained in clinical medicine, I thought I would return to being a clinician.



During the first part of this transition, I attended a number of A4M meetings. That is a big organization. I thought to myself, "Well, maybe I should get A4M board certification. That would give me some credentials and get me going." I did that. I went to the meetings and followed their criteria for getting the A4M board certification. I read all the materials and I took the written examination; they do it in sequence. Then, I applied for and took the oral examination. I eventually passed and got the board certification, which, of course, is not recognized in the state of Florida. In the state of Florida, you cannot even put the board certification on your Web site because it is not recognized by the Florida state board. So it is not all that useful to me from that point of view, but I did learn a lot.

One of the things that we learned about was bioidentical hormones, because at that time that was a big part of what A4M did. They had separate seminars on how to prescribe bioidentical hormones, how to run a bioidentical hormone practice—how to do this, how to do that. I said to myself, "This is fairly straightforward and easy to do. Bioidentical hormones: That is what I will do." I opened up an office and started doing that.

ATHM: How did your practice grow from there?

Dr Dach: I quickly realized that bioidentical hormones are great, but that is just a little, tiny part of what is wrong with the typical patient. Their medical problems were more complex than that. One of the more common medical problems was the low thyroid condition. My medical practice quickly became a thyroid practice. Perhaps South Florida is a magnet for people with thyroid problems because they cannot tolerate the cold and migrate from north to south looking for a warmer climate. These low thyroid patients have already seen a succession of endocrinologists without any improvement, and they end up in my office asking for help. I call these people "escapees" or "refugees" from the endocrinology office.

Part of the nature of the problem is that mainstream endocrinology has been mistreating thyroid patients for decades now with minuscule doses of Synthroid, a T_4 -only thyroid medication, which does not work all that well for 20% of the patients, who continue to suffer from a low thyroid condition. In addition, the mainstream endocrinologist relies solely on the TSH test to monitor treatment, which can be unreliable. Most of these patients end up undertreated and continue to feel miserable. These people eventually end up in our office and we give them natural thyroid, called Nature-Throid—from RLC Labs—a desiccated porcine thyroid. We have converted a lot of these people over from Synthroid to natural thyroid, and they almost always report that they are doing much better with the natural thyroid. In my experience, natural thyroid is a much more robust and clinically superior medication, but the endocrinologists will not even look at it. The wheel of change turns slowly. Maybe that is a good thing, because otherwise, I would have nothing to do.

So this is how we unintentionally ended up with a large thyroid medical practice. It happened because these patients are unhappy with the Synthroid and the conventional approach, which relies solely on the TSH test. These poor souls drag themselves from one endocrinologist to another, trying to get some kind of treatment that is going to work for them. They eventually end up in my office, we get them going with the right dosage of natural thyroid, and they do feel better.

ATHM: You mentioned that TSH does not provide a complete picture of thyroid status. What other markers do you feel are important to assess?

Dr Dach: We do a full panel. I have to mention that one of the things that I did around the same time that I opened up the little office is I wrote a couple of books—did a lot of reading and research. My first book is *Natural Medicine 101*, which is available on Amazon. The second is *Bioidentical Hormones 101*. Both books are free on the Internet. In terms of thyroid, all this information is in the book. Also, I have a monthly newsletter, which is free, and a blog where you can find all of the new material. Everything we do in the office is available in these articles. You can read up on it.

We have a very sophisticated lab panel that looks at free T_3 , free T_4 , and TSH. We check thyroid antibody levels in everybody, because we find that antibodies are very commonly elevated. We also look at serum selenium, because selenium is a very important mineral for protecting the thyroid from oxidative damage.

Then we also look at a spot urinary iodine excretion, which is routinely done by Quest and LabCorp, the 2 major national labs we use. The spot urinary iodine level is the one used by the World Health Organization, or WHO. That is the test they use when they go into a country and add iodine to the water or give iodine supplements to local people. Iodine deficiency is a huge health problem globally and that is a large part of what WHO does. They give iodine supplements to people in third-world countries.

There are more elaborate ways to test for iodine. There is the 24-hour collection, and there is an iodine-loading test, which is the one that David Brownstein, MD, and Jorge Flechas, MD, talk about in the iodine project. That was a good test. But we do the spot urine for iodine, which is more convenient because the patient is already at the lab for a blood draw and is usually covered by their insurance. For the normal range for iodine level, we use the WHO guidelines: Anything below 100 micrograms per liter is considered iodine insufficiency. Below 50 is iodine deficiency. The major reason we are interested in testing levels and supplementing with iodine is because iodine deficiency is a risk factor for breast cancer. In our patients on bioidentical hormone replacement, we want to reduce as much as possible the risk for breast cancer and iodine supplementation is the single most important way to accomplish reduction in breast cancer risk. That has been very well established in the medical literature and a number of books exist on the topic.

For example, there is an excellent book by David Derry, MD, PhD, on iodine and breast cancer. There's a book by Dr Brownstein called *Iodine: Why You Need It, Why You Can't Live Without It*. There is also a new book by Lynne Farrow, which just came out, called *The Iodine Crisis*. She is a breast cancer survivor who, about 10 or 15 years ago, decided on her own to research iodine and became an incredible expert. She eventually wrote this book. I consider iodine testing and supplementation a very big part of our program—very important.

We also check for selenium, and there are 4 chapters in my book on selenium. I think serum selenium should be checked in everyone routinely, and mainstream medicine really has not started doing that yet. I consider myself, maybe, 5 or 10 years ahead of everybody else in this regard. I think selenium will be eventually included on your routine chemistry panel—at least for the outpatient—because low selenium is associated with increased risk for cancer and other health problems. Selenium is the cheapest mineral you can get. You can get a bottle of selenium tablets for \$5. It is extremely important, especially for thyroid function.

Look at Hashimoto's thyroiditis, which is the autoimmune thyroid disorder. That is the one of the more common thyroid disorders that we see. We have seen evidence published in the mainstream endocrinology literature showing that giving selenium supplements to patients with Hashimoto's reduces the thyroid antibodies over time—it's incredible to think that this can be done just by giving selenium supplements. To me, this is mind-boggling, and yet the endocrinologists ignore it. They do not even test for selenium status or even think about it.

We do. We test everyone for selenium levels and we give them selenium. For the most part, we see thyroid antibodies declining over time in our Hashimoto's patients. We had a patient yesterday—her TPO antibody was 760 about 6 months ago and now it is half of that—it is about 300. That is with selenium supplementation. Her selenium was low and we gave her selenium and, of course, thyroid hormone—the natural thyroid pills.

Those are the 2 most significant interventions that reduce antibody levels in Hashimoto's patients: suppressing TSH below the reference range with thyroid medication—either Synthroid or natural thyroid—and selenium supplementation. We also give iodine supplementation, which is somewhat controversial, but in almost all of our cases we see the antibody levels declining and they do quite well with that.

I am currently writing a chapter for a book on Hashimoto's. I am going to put all these case reports together and try to make some sense out of our data that we have collected over the last 10 years or so.

ATHM: In what other directions has your practice grown?

Dr Dach: A few years ago, a pharmacist called me and said, "You should look at low-dose naltrexone," which is LDN for short. I said, "I have never heard of that. What is it?" He said, "You should look into that." I started looking into the infor-

mation on LDN and it turns out that naltrexone is an opioid receptor blocker and it has been around for a long time. There was a doctor in New York by the name of Bernard Bihari, MD, who has since passed away. Dr Bihari was one of the pioneers using naltrexone as an immune modulator.ⁱ

The way it works is you take a small LDN capsule orally, just before going to sleep at night. The LDN drug blocks the opioid receptors in the brain while you are sleeping. During sleep is when the brain makes most of its endorphins. Since the opioid receptors are blocked, there is a rebound increase in endorphin production that persists for the next 24 hours, which somehow balances the immune system. It was found to be very beneficial for patients with autoimmune disease—for example, ulcerative colitis, Crohn's disease, and inflammatory bowel disease.

There was a study done by Jill Smith, MD, at Penn State University College of Medicine. It was published in the mainstream journal, *American Journal of Gastroenterology*,² in which she had a series of roughly 20 or so severe inflammatory bowel disease patients and had a 70% remission rate with LDN, which was shown with endoscopic findings. That was very impressive.

The other impressive groups were the multiple sclerosis patients, who seemed to respond very well to LDN. In many cases the multiple sclerosis progression is arrested with the use of LDN. I thought that was impressive.

I wrote a few articles on LDN on my blog. We started getting phone calls from patients with MS and inflammatory bowel disease, saying, "We'd like to get a prescription for LDN and nobody in our local area—none of the doctors in our local community will give us a prescription for LDN." I said, "Sure, No problem. I will give you one." They would come in and we would do the usual workup and they would leave with their prescription for LDN.

We started following these patients and, sure enough, the vast majority did quite well. Not all of them but, again, it is about a 70% rate where they actually do remarkably well. The MS patients would have the progression of their symptoms halted, which is very dramatic. For inflammatory bowel disease patients, most of them would have remissions and do well. Not all of them, but most of them. Then for the MS patients, we would also add in things like testing for B₁₂ levels and I put them on a gluten-free diet—things like that. There are other things that we do for the inflammatory bowel disease patients.

Of course we were still doing the bioidentical hormones for pre- and postmenopausal women. Then we also began treating men for testosterone deficiency syndrome, giving them testosterone and other things. Over the years, we perfected and tweaked our testing and treatment.

One of the things that really changed the way I practice is realizing the impact of wheat gluten on the population. Of course, you have the recent book by William Davis, MD,

i. Editor's Note: For more about Dr Bihari, see our Conversations interview published in *ATHM* Vol. 19, No. 2 (2013).¹

Wheat Belly, and the book by David Perlmutter, MD, *Grain Brain*. Of course there is Alessio Fasano, MD, at the University of Maryland, a pediatric gastroenterologist who has done most of the recent research on gluten sensitivity and leaky gut, which is published in the mainstream gastroenterology literature. It is pretty much ignored by mainstream medicine at the moment.

I was fortunate to go to a meeting, held locally in Fort Lauderdale, a couple of years ago. All 3 of those doctors were speakers at the meeting: Fasano, Davis, and Perlmutter, as well as others. There was a whole list of excellent speakers. They talked about wheat gluten and how it affects health in terms of the link with autoimmune disease.

Of course, Hashimoto's is one of the autoimmune diseases at the top of the list. So a gluten-free diet is advisable for all Hashimoto's thyroiditis patients. There's a long list of autoimmune diseases thought to be associated with gluten sensitivity, such as systemic lupus, rheumatoid arthritis, dermatomyositis, psoriasis, and Sjögren's syndrome. The list is quite lengthy and it goes on and on. All these are listed as autoimmune diseases. Type 1 diabetes is now considered an autoimmune disease. Celiac disease is the autoimmune form of gluten sensitivity. Multiple sclerosis is an autoimmune disease.

I have been dealing with all these autoimmune diseases for many years in my clinical practice. All of a sudden, my eyes were open to "you know what?" It is all connected to wheat sensitivity. Of course, there is genetic testing available for this genetic predisposition. We started testing many of our patients for gluten sensitivity, the antigliadin antibody, etc, and finding that many people were testing positive and feeling better after going gluten-free. A few weeks after starting a gluten-free diet, they call back and say: "Oh, thank you so much. I feel so much better."

Especially in the Hashimoto's patients, we have found this to be true in our clinical practice. If you look in the medical literature, you find that there is a huge correlation between gluten sensitivity and Hashimoto's thyroiditis—8 to 15 times increased incidence of gluten sensitivity among Hashimoto's patients. So we advise them to go gluten-free.

At this Alessio Fasano gluten autoimmune medical meeting, there were doctors who stood up and said things like their entire day at the office is spent dealing with health issues from wheat consumption. I guess I have to say that a lot of what I do in my office is the same sort of thing. We are dealing with the health consequences of wheat consumption.

We also have integrated a lot of food sensitivity testing. For example, we use Enterolabs for the antigliadin antibody and genetic testing. We also used ALCAT, which is a lab in Deerfield Beach, Florida, that does the white blood cell reactivity. What they do is isolate the white cells from the patient's blood and allow the white cells to interact with 200 different foods. Then they run the white cells through an analyzer to see if there is any change in size or shape of the white cell. If the white cell reacts, it does change because it is releasing oxidized granules. When the white cell has an immune response, it self-destructs. The test will pick up

white cell reactivity to various substances and that has been a very useful test for a lot of patients.

There are other labs that are excellent. Cyrex is excellent and Immuno Laboratories does the antibody test, and Metamatrix has some excellent testing also.

A lot of times we learn these things from patients. They come in and they will tell us what they are doing and which lab that they went to and found X, Y, or Z. One of the things that we do that is a little different from other primary care offices or specialty offices is a very careful patient follow-up. We actually call the patient every 3 to 6 weeks for follow-up to find out if their symptoms are better, worse, or the same. Are they utilizing the treatment program? If they are, what dosages are they currently taking? We keep very careful notes on everything. Then we have repeat labs every 6 months, or sometimes more frequently. If you look through our patient charts, there is a wealth of clinical information in there, which could probably go into multiple publications, I would think, if I ever have time to do that.

ATHM: Besides some of these organizations that were holding meetings, what other experiences and resources helped you the most in your transition to natural medicine?

Dr Dach: It is a very tough transition because you are pretty much left to your own devices. In general, doctors keep their cards pretty close to their chest. They are jealously guarding their knowledge because they do not want to create their own competition. There are a lot of trade secrets in medicine, especially in the world of clinical medicine of private practice. You simply do not see doctors sharing knowledge with each other to any great extent.

You go to the meetings and theoretically they are sharing knowledge, but when it comes right down to it, they are just scratching the surface—a place to start. It takes years of experience to get to the point where you know what you are doing. That is what happened with radiology. I did 4 or 5 years of training as a resident and a fellow. Then you come out of training, and then it still takes 3, 4, 5 years before you have the experience to know what you are doing.

The experience is very similar to that of starting a clinical medical practice. It takes 3 or 4 years of experience and learning on the job. You have to learn on your own and you have to try to learn from the patients, and you have to try to learn from any place you can: meetings, other doctors. It is not that easy because, as I said, other doctors who could be sources of knowledge and information might be excellent as mentors but most of those people are holding their cards close to their chest. It is almost like the formula for Coca Cola. It is a trade secret. They do not want anybody to know what the Coca Cola formula is. I have to be honest with you—I am sort of the same way.

What happens, as we get older and older and closer to the final year in practice, where we know that we are going to hang up our stethoscope on that hook on the wall—you get to the point where you might write a book or release this informa-

tion out to the public or other doctors. I think that is where you have the other doctors sharing information more openly.

There is a wealth of that kind of information published in books. For example, *Adventures in Psychiatry* by Dr Hoffer is one of those excellent types of books. Dr Brownstein writes great books, and he shares a lot of information. He has been a personal friend of mine and a great mentor. I sometimes call him. He will give me advice—clinical case advice and things like that. Jonathan Wright's books and newsletter are excellent sources of information.

Maybe some of us can find mentors more easily than others and they can connect with other sources of information and other doctors and health professionals and find mentors. I found that difficult. I was not good at finding and maintaining mentors for myself in my early training years. I think it would be easier if somebody starting out had 1 or 2 good mentors—mentoring-type doctors. What I found to be very important and very useful was the Internet.

ATHM: What methods did you use to build your new practice?

Dr Dach: One of the skills that I have is that I am a writer. I can use media to express myself. People read my material and I try to make it interesting and entertaining. For me, writing a newsletter or blog is a way to connect with the general public. I may have 3000 or 4000 subscribers to my newsletter. I have a certain amount of traffic to my blog, which is international. People are reading my articles on the blog and newsletter. You also have social media now, which we did not have 10 years ago. It can create hype or a buzz about your material—your content—on the Internet.

You said that you have read some of my articles on <http://GreenMedInfo.com>. That is really the idea—to get content out on the Internet and get as much exposure as possible. In the olden days, you had to be on television or in the newspapers. That is older technology. Now, everything is on the Internet, message boards, and social media. The vast majority of my patients are self-referred from word of mouth—often from family members and neighbors who recommend me. Or even other health care professionals, like acupuncturists or health professionals who subscribe to my newsletter and read my material on the Internet—they will recommend me to a client or customer. I know personally most of the doctors in my area and my office is in the same geographic area as the hospital where I worked for 25 years, so most of the older doctors know me from my hospital days. I refer patients to other doctors in the area, whom I know personally, but none refers patients back to me. I am not in their referral network. When it comes to maintaining a practice office, you need a certain amount of volume. You need patients calling and making appointments or you have nothing to do. Since it does not come from a physician referral network, it comes from the Internet. Message boards and blogs—things like that.

For somebody looking to get started, the answer is that

you have got to get out there on the Internet with content exposure, writing blogs, contributing to message boards, and things like that. I think most of the patients are self-referred.

ATHM: Do you think that the population that is willing to pay out of pocket for their care, outside of the insurance reimbursement system, is so small that doctors really need to protect their niche in the field?

Dr Dach: I wish I could answer that. It is a very competitive field. Half the patients will switch around a lot. Even my patients will leave and go someplace else—to competitors locally. Some of them do come back and say, "There is nothing like coming back home," which is very encouraging, but some do not. For some, they are not happy and go someplace else. It is almost like the restaurant business. You have a bad experience in a restaurant and you do not go there anymore. If you have a good experience, you keep going back.

Cash medical practice, as a business model, is a very tough model. It is based on results. If patients feel better and get results, then the practice will flourish. It is very different from the business model of mainstream medicine, in which results are really secondary to insurance reimbursement. A cash practice is more difficult, but it can be done.

REFERENCES

1. Bihari, Bernard. Low-dose naltrexone for normalizing immune system function. *Alt Ther Health Med*. 2013;19(2):56-65.
2. Smith JP, Stock H, Bingaman S, Mauger D, Rogosnitzky M, Zagon IS. Low-dose naltrexone therapy improves active Crohn's disease. *Am J Gastroenterol*. 2007;102(4):820-828.