Errors in Modern Thyroid Endocrinology

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Slides Available At: http://jeffreydachmd.com
A Different Perspective
The Information War Against Natural Thyroid

Slides Available at: http://jeffreydachmd.com
War Between Patented Drugs and Natural Medicine (no Patent)

- Mainstream Medicine is Based on Synthetically Altered Patented Drugs.
- Excludes Natural Substances which Cannot be Patented
I Receive No Financial Compensation from any manufacturer of thyroid meds, such as Levothyroxine, Cytomel or NDT.
$6.5 billion in payments since 2013

Is Your Doctor Being Bribed by Big Pharma?
Find Out NOW

✓ OpenPaymentsData.CMS.gov.
ATA itself receives substantial financial support from three drug companies.

Pfizer, AbbVie, and Akrimax

They make Levothyroxine, the drug that the Guidelines claim are the “standard of care”.
Funding for the Endocrine Society

"In general, desiccated thyroid hormone or thyroid extract, combinations of thyroid hormones, or triiodothyronine should not be used as thyroid replacement therapy."

(Quote from 2006 Endocrine Society Position Statement.)
Industry Conflict of Interest
American Association of Endocrinologists and the ATA (American Thyroid Association) regarding the use of natural desiccated thyroid, which says:

“There is no evidence to support using desiccated thyroid hormone in preference to L-thyroxine monotherapy in the treatment of hypothyroidism and therefore desiccated thyroid hormone should not be used for the treatment of hypothyroidism.” (quote)
“We recommend that levothyroxine (T4 only) be considered as routine care for patients with primary hypothyroidism, in preference to use of thyroid extracts (NDT).”
My Endocrinologist Won’t Listen to Me

Impaired cognition,
Fatigue
Difficulty losing weight
T4 Only Meds

Unfortunately therapy with L-T4 alone does not resolve symptoms in all hypothyroid patients, with approximately 12% of the patients remaining symptomatic despite normalization of serum TSH and TH levels (2, 3).

Impaired cognition, fatigue, and difficulty losing weight are the main residual symptoms of these patients, for which we lack understanding and have no mechanistic explanation.

Nature-Throid – RLC labs

- Natural Desiccated Thyroid - Porcine
- One Grain Tab (65mg)
- 38 Mcg T4 - T1/2 = 7 Days
- 9 Mcg T3 - T1/2 = 1 day
- Dosage 1-4 grains/day
- TSH, FT4, FT3, Abs
Normal Thyroid Gland
Microscopic View of Thyroid

colloid

lymphocytes
Production of Thyroid Hormone

Iodine

80%

20%

Same Ratio as NDT T4/T3 80/20
TPO enzyme
Oxidizes Iodine with H2O2 as substrate, Organifies Iodine to Thyroglobulin. Blocked by Methimazole. HD Iodine Prevents H2O2, Prevents organification.
Various thyroid pathologies can be explained by overproduction and lack of degradation of H2O2, such as thyroiditis, cancer.

H2O2 Detoxification – Seleno-Proteins

- Intracellular H2O2 detoxification
- Selenoproteins: GSH peroxidases and thioredoxin reductases
- Catalase

Excess Iodine in Selenium Deficiency

- Excessive iodine intake:
  - Induce Goiter,
  - lead to thyroiditis,
  - worsen lymphocytic infiltration,
  - Damage to the thyroid follicular structure in a dose-dependent manner in autoimmune-prone NOD.H-2h4 mice.

Supplemental Selenium alleviates the toxic effects of excessive Iodine on thyroid."

(Xu, Biol Trace Element Res 141.1-3 (2011): 110-118.)
Iodine Suppresses Thyroid Function

- Elevation of TSH.
- Reverses after stopping iodine.
- Reduces TPO activity
- Reduces Iodine Uptake
- Reduces Iodine Organification
- Hashimotos, Graves more sensitive to suppressive effect of iodine.


Levothyroxine (T4 Only)

4-Iodines Attached to 2 Tyrosines
Conversion of T4 to T3 – De-Iodinase Enzyme
Errors in Thyroid Endocrinology
Doing the Wrong Lab Tests

- **NDT Model**
  - TSH
  - Free T3
  - Free T4
  - TPO Thyro Abs
  - TSI TBII
  - Hold Meds, Fasting, Early

- **Insurance Model**
  - TSH, FT4 Only
  - Keep TSH in Range
  - Adjust Dosage of Synthroid Up or Down Keeping TSH in Range.
Errors in Thyroid Endocrinology

Omitting Lab Tests

- **NDT Model**
  - Spot Iodine
  - Serum Selenium
  - Anti-Gliadin Abs
  - Serum B12
  - Fe/Ferritin
  - D3
  - Follow TPO Abs

- **Insurance Model**
  - TSH, FT4 Only
  - Look at TSH, Adjust Dosage of Synthroid Up or Down
NDT - How I Do It
Dosage Based on Body Weight

Start Low and Gradually Increase Dosage

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-120 Pounds</td>
<td>1 tab</td>
</tr>
<tr>
<td>120-140 pounds</td>
<td>2 tabs</td>
</tr>
<tr>
<td>140-180 pounds</td>
<td>3 tabs</td>
</tr>
<tr>
<td>Over 200 pounds</td>
<td>4 tabs</td>
</tr>
<tr>
<td>etc</td>
<td></td>
</tr>
</tbody>
</table>

- One Grain Tab (65 mg.)
- Half tab daily x one week
- One tab daily x one week
- 1 1/2 tabs daily x one week
- Two tabs daily
NDT - How to Do Thyroid Labs

- Check labs at 6 weeks after starting NDT.
- Hold Thyroid Meds in AM before LABS – This Avoid Spikes in Free T3 and Free T4!
- Do Labs Early. Pt Arrives 15 min before lab opens
- Expect to see TSH Suppression. This is OK.
- Free T3 Above 310
- Free T4 Above 1.0
- Clinical Findings – Patient Should Experience No Resting Tachycardia.
NDT -How I Do It -Important Review Symptoms of Thyroid Excess

- Spend 5-10 minutes with patient reviewing symptoms of thyroid excess
- Looking For: Resting Tachycardia
  Will be Obvious to Patient, Instruments not needed
- Upon Awakening in AM – Good time to check !
- Exercise induced Tachycardia Does Not Count !
- Hold Thyroid Pill in Am if Resting Tachycardia Noted
- Resume NDT Next day at Reduced Dosage
- You Must Screen Patient for Ability to Do this !
- Dementia pts are NOT Candidates for NDT !!
Adverse Effects of Thyroid Pills

Thyroid Excess

- Tachycardia, Palpitations, Fluttering, Atrial fibrillation
- Nervousness, Panic Attacks
- Insomnia
- Loose Stools, Diarrhea
- Dreaded Atrial Fibrillation
NDT vs. Levo-Thyroxine

1 Grain (65 mg)
38 mcg T4
9 mcg T3

100 Mcg T4
<table>
<thead>
<tr>
<th>NDT</th>
<th>Levo-T4 Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shorter Half life by virtue of T3 Content</td>
<td>Levo T4 – Longer Half life 7 days</td>
</tr>
<tr>
<td>24 hrs Half Life.</td>
<td>Less Safe</td>
</tr>
<tr>
<td>Safer.</td>
<td>Excess Symptoms Resolves after Days.</td>
</tr>
<tr>
<td>Excess Symptoms resolve Within Hours</td>
<td>Fourth most prescribed drug in America with 70 million prescriptions.</td>
</tr>
</tbody>
</table>
Safety of NDT vs. LevoThyroxine (T4-only)

Half Life of Thyroid Hormones

- T4 - 7 days
- T3 – 1 to 1.5 days

NDT is safer because of shorter half life. If pt. experiences tachycardia at rest instructed to hold NDT for the day.
<table>
<thead>
<tr>
<th>NDT</th>
<th>Levo-Thyroxine</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Grain (65 mg)</td>
<td>100 Mcg T4</td>
</tr>
<tr>
<td>38 mcg T4</td>
<td>T1/2 -7 days</td>
</tr>
<tr>
<td>9 mcg T3</td>
<td></td>
</tr>
<tr>
<td>T1/2 1 day</td>
<td></td>
</tr>
</tbody>
</table>
### Medical Model Determines Thyroid Usage

<table>
<thead>
<tr>
<th>CASH Model-NDT</th>
<th>Insurance Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Time w Pt.</td>
<td>Less Time w Pt.</td>
</tr>
<tr>
<td>30 -60 min.</td>
<td>3-10 min.</td>
</tr>
<tr>
<td>Suppressed TSH</td>
<td>Keep TSH in Range, Adjust T4 Dosage</td>
</tr>
<tr>
<td>Look at FT3, FT4</td>
<td>No time to explain adverse effects</td>
</tr>
<tr>
<td>5 min explaining risks and adverse effects</td>
<td>• 5 min explaining risks and adverse effects</td>
</tr>
</tbody>
</table>
Errors in Modern Thyroid Endocrinology
Refugees and Escapees from Modern Endocrinology
Errors in Thyroid Endocrinology
T4 Monotherapy and TSH

Reliance of T4 Only-Monotherapy (Levo or Synthroid) (Gullo, 2011)

Reliance on TSH Only to Monitor Treatment. (Peterson, Bianco 2016)

TSH Suppression may be needed for Adequate Treatment. (Ito 2012)

NDT – Natural Dessicated Thyroid Better Choice. (Hoang, 2013)

Shorter Half Life makes NDT safer choice.

NDT Combines T3 and T4 - more robust for poor converters.
More than 20% of these patients, despite normal TSH levels, do not maintain FT3 or FT4 values in the reference range, reflecting the inadequacy of peripheral deiodidation to compensate for the absent T3 secretion.”


Ito, Mitsuru, et al. "TSH-suppressive doses of levothyroxine are required to achieve preoperative native serum triiodothyronine levels in patients who have undergone total thyroidectomy." European Journal of Endocrinology 167.3 (2012): 373-378.


HPA and TSH

TSH Unreliable in Hypothalamic Dysfunction, Chronic Fatigue, Fibromyalgia Pts.

T4-Monotherapy Explained

T4-Monotherapy Results in:

- Suppressed Pituitary Production of TSH-Hypothalamus and Pit. Relatively Insensitive to D2 Inactivation by T4.
- Peripheral Hypothyroidism from Decreased Peripheral Conversion of T4 to T3.
- D2 is Inactivated by T4 in Peripheral Tissues

Pituitary D2 -Deiodinase and TSH


Thyrotroph –Pituitary cell
T4 inactivates D2 in peripheral tissues
Thyrotroph less sensitive to T4 inactivation of D2
D2 is a selenoprotein
Hypothalamic D2 Less Sensitive to T4 Inactivation

- In most tissues, exposure to T4 inactivates D2 Deiodinase and decreases conversion of T4 to T3 and peripheral T3 production.
- Similar in Brain where the elevated serum T4/T3 ratio results in Hypothyroid Brain Cells.

**BUT NOT IN the Hypothalamus**

- Hypothalamic D2 is Less Susceptible to T4-induced inactivation and is so effective in this tissue that T4-induced D2 inactivation is insignificant.
- (This Suppresses TSH) whereas T3 production via D2 is easily inhibited in the periphery. (Creating Hypothyroid State)
- This explains the discrepancy between normalization of TSH secretion and (Reduced) peripheral T3 production observed in L-T4–treated Tx rats.

---

Both T3 and T4 Needed

‘in contrast to other D2-expressing tissues, the hypothalamus is wired to have increased sensitivity to T4’

“only constant delivery of L-T4 and L-T3 fully normalizes T3-dependent metabolic markers and gene expression profiles in Thyroidectomized rats.”

T4-only Levothyroxine cannot guarantee normal thyroid function in all patients, even with a TSH in the “normal range”.

Quote: “More than 20% of these patients, despite normal TSH levels, do not maintain FT3 or FT4 values in the reference range, reflecting the inadequacy of peripheral deiodination to compensate for the absent T3 secretion.”

469 LT4 Only -treated pts. Were compared to controls
Levo treated more likely to have :
15–20% lower serum T3:T4 ratios
Higher BMI(Weight)
Taking Beta-Blockers, Statins, and SSRI Anti-depressants
Cognitive Impairment

Despite normal TSH tests, these patients still have many nagging symptoms of hypothyroidism. “Patients complain of being depressed, slow and having a foggy mind,” said Rush’s Antonio C. Bianco, MD, PhD, an immediate past president of the American Thyroid Association that is professor of medicine at Rush. “They have difficulty losing weight. They complain of feeling sluggish and have less energy.

Yet we doctors keep telling them, ‘I’m giving you the right amount of medication and your TSH is normal. You should feel fine.’”

Antonio Bianco MD 12-Oct-2016
Hypothyroidism Symptoms Linger Despite Medication and Normal Blood Tests

“Better medications (than Levo) are needed to treat hypothyroidism, Dr Antonio Bianco believes.”

“Patients who continue to have symptoms on Levothyroxine monotherapy might try a pill that contains both T3 and T4.”

Antonio Bianco MD 12-Oct-2016
TSH Suppression May be Needed for Adequate Treatment

135 consecutive patients with papillary thyroid carcinoma, who underwent total thyroidectomy.

“Our study indicated that a
moderately TSH-suppressive dose of L-T4 is required
to achieve the preoperative native serum T3 levels in postoperative L-T4 therapy”

Ito, Mitsuru, et al. “TSH-suppressive doses of levothyroxine are required to achieve preoperative native serum triiodothyronine levels in patients who have undergone total thyroidectomy.” European Journal of Endocrinology 167.3 (2012): 373-378.
Center for Excellence in Thyroid Care, Kuma Hospital, 8-2-35, Shimoyamate-Dori, Chuo-Ku, Kobe-City, Hyogo
TSH Suppression Benefits and Adverse Effects

- Long-Term Study (7 years) in Cancer Pts. On T4 Therapy with TSH Suppression. Conclusion:

  - No Evidence of Lower Bone Mineral Density


51 patients with thyroid nodule.
- TSH suppressed below 0.3 to shrink nodule
- Conclusion:

“NO significant decrease in BMD after 1 yr of treatment with suppressive doses of T4.”

TSH Suppression – Lack of Harm

Post-Menopausal Women

- Bioidentical Hormone Program, Vit K2 (MK-7), Vit D3, Calcium, Magnesium, etc.

- Bone Density Improves Even With Suppressed TSH.

- Schneider, Diane L., Elizabeth L. Barrett-Connor, and Deborah J. Morton. "Thyroid hormone use and bone mineral density in elderly women: effects of estrogen." Jama 271.16 (1994): 1245-1249. Women taking both thyroid hormone and estrogen had BMD levels comparable with those observed in women taking only estrogen.
Deception vs. Reality

Deception - TSH Suppression Causes Osteopososis

Reality – This is true for Graves, but not for Routine NDT Treatment.
Errors – Hashimotos’ Auto-Immune Thyroid Disease

1) Ignoring Selenium – Reduces antibody levels. (Drutel, 2013)
2) Ignoring TSH Suppression with Thyroxine or NDT. (Rink 1999)(Padberg, 2001)
3) Ignoring Iodine -- start low dose 225 mcg - Important for child bearing ages to prevent low IQ in baby.
4) Iodine will Suppress Thyroid Function. (Dayan, 1996)
5) Ignoring Gluten Free Diet (Hadithi 2007)
6) Ignoring LDN - Low Dose Naltrexone
7) Dealing with Hashi-toxicosis Fluctuating thyroid function (Alzahrani 2005)


“Levothyroxine and Selenomethionine Exhibit Similar Anti-Inflammatory Effects in Euthyroid Females with Hashimoto’s Thyroiditis.

This Correlates with Reduction in TPO Antibodies and Clinical Benefits in Hashimoto's, particularly in subjects receiving both agents.”

Errors in Thyroid Endocrinology

Hashimotos’

- Ignoring Low Dose Naltrexone (LDN)
- Ignoring Vitamin D3
- Ignoring Gluten Free Diet
- Ignoring Selenium
- Ignoring Thyroxine/NDT in Many Pts.
Reduction in TPO Ab after selenium 200 mcg /d. 9mo.

Iodine for Hashimotos’

- Hashimotos pts are very sensitive to Iodine, which will suppress thyroid function leading to elevation of TSH.
  

- Firstly, start Selenium supplementation (200-400 mcg/d) for 2-4 weeks.

- After which, low dose (225mcg/d) iodine supplementation may be started.

- Pregnancy-Developing Fetus Needs Iodine.

- Breast Cancer Prevention- iodine.
Iodine Suppressive Effect

“Iodine reduces thyroid secretion in both subjects with and without thyroid antibodies, iodine acts by inhibiting biosynthesis and release of thyroid hormone rather than by augmenting thyroid autoimmunity.

Euthyroid patients with (subclinical) chronic autoimmune thyroiditis are more susceptible to the anti-thyroid effects of iodine. “ Quote From:

Hashi-Toxicosis

Transient Episodes of Hyperthyroidism

Sporadic bouts of worsening inflammation
Damaged thyrocytes release thyroid hormone into circulation.
Usually self-limited and subsides after a week or so,
Pt. resumes hypothyroid state.
Roller-Coaster Effect
Multiple Doctor Merri-Go Round
Hashi-Toxicosis

May occur early during treatment IF:
1. Aggravated by Selenium Deficiency.
2. Aggravated by High TSH.
3. Check Selenium Level Routinely!
4. Aggravated by Wheat Gluten intake in Sensitive individuals which Triggers Immune System.
5. Unlikely if pts’ TSH suppressed with thyroid meds.

Hold Thyroid Meds - NDT SAFER HERE !!
Beta- Blocker for Tachycardia
Selenium, D3, Gluten Free Diet, Wait
Iodine as Breast Cancer Preventive

• **Safety**- FDA recommends 130 mg of Iodine for adults in case of Radiation Emergency to protect the population from thyroid cancer. (Guidance on Potassium Iodide as a Thyroid Blocking Agent in Radiation Emergencies, U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER), December 2001)

• **Iodine Deficiency Causes Breast Cancer** (Dietary Iodine Deficiency as a Tumor Promoter and Carcinogen in Male F344/NCr Rats Masato Ohshima and Jerrold M. Ward. Cancer Research 46, 877-883, February 1, 1986)


Iodine Prevents Breast Cancer in DMBA Model

Control Red Arrow Breast Cancer

Iodine Treated

Errors

Graves’ Hyper-Thyroidism

- Relying On: Methimazole, Radioactive Iodine, Surgery as Only Treatment - Not the Only Options.
- Iodine Treats Graves. (Wartofsky, JCI 1970)
- Lithium Carbonate Treats Hyperthyroidism (Boehm, ACTA Endo 1980) (Temple, JCI 1972)
- Iodine Contra-Indicated Toxic Nodular Goiter or Autonomous Nodule- TSI Receptor Mutation- Thyrotoxicosis (Redisch W, Perloff WH. “Medical treatment of hyperthyroidism.” Endo 1940)
Graves vs. Multi-Nodular Goiter

TSI, TBII Abs Elevated in Graves
Iodine Suppresses Thyroid Function

TSH Receptor Mutation- Iodine Causes Thyrotoxicosis
Toxic Multi-Nodular Goiter and Autonomous Nodule

**MultiNodular**

Iodine Contra-Indicated Causes Thyrotoxicosis and Thyroid Storm.

Must Differentiate Graves’ from Autonomous Nodule, and Toxic-Nodular Goiter

Errors in Thyroid Endo- Case Report

AACE 2017 Annual Meeting, Sarah Fishman, MD, PhD, of Lenox Hill Hospital, New York case report:

Patient developed thyroid disease when taking an unregulated dietary supplement containing excessive iodine (2,000 mcg/day).

39-year old male patient negative for TSH Receptor and Thyroglobulin Abs, positive TPO Abs (56 IU/mL).

Thyroid US "multiple nodules, a left-sided sub-centimeter nodule, and two nodules in the right lobe, the largest of which was 1.3cm”

Suppressed TSH <0.03 IU/mL), FT4 2.88ng/dL, T3 level 470ng/dL (Thyro-toxic)
Error in Case Report:

Conclusion:

This Case Report is deceptive and misleading.
The authors are so focused on Vilifying Iodine, they miss the correct diagnosis.
Iodine did not cause the patient’s underlying thyroid disease of toxic nodular goiter with autonomous nodule.
Yes, Iodine did cause the thyrotoxicosis episode which resolved upon withdrawing the iodine.
Iodine is contra-indicated in these rare cases, and generally safe for the remainder of the population.
Broda Barnes, MD (1976). Hypothyroidism: The Unsuspected Illness
Errors in Thyroid Endocrinology Ignoring Cardiac and Immune Risks


Thyroid and the Heart
TSH in 17,000 women, no thyroid or heart disease.
All patients had “normal TSH” 0.5 to 3.5
Lower TSH, Intermediate and Upper TSH levels
Mortality from heart disease over an 8 years.

<table>
<thead>
<tr>
<th>Group</th>
<th>TSH</th>
<th>Death from Heart Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>0.50-1.4</td>
<td>baseline risk</td>
</tr>
<tr>
<td>Group 2</td>
<td>1.5-2.4</td>
<td>40% higher than baseline</td>
</tr>
<tr>
<td>Group 3</td>
<td>2.5-3.5</td>
<td>70% higher than baseline</td>
</tr>
</tbody>
</table>

Sub-Clinical Hypothyroidism Defined as:

- Serum thyrotropin 5 - 10 mIU/L
- Normal Free T3 (thyroxine) level.

Sub-Clinical Hypothyroidism
Heart Disease

- Treatment with Levothyroxine was associated with **Fewer** ischemic heart disease (IHD) events and **Reduced** all-cause mortality during an 8-year period of observation in 40 to 70–year-old individuals with subclinical hypothyroidism.

References SCH and Heart Disease


Thyroid and the Immune System
Thyroid Enhances Immune System

Mouse Model Endotoxemia
IP INJ LPS.

- **Green Line** 70% survival in Thyroxine treated mice.
- **Red Line** 10% survival in Hypothyroid Mice

Perrotta, Am J Path (2014)
T3 significantly protected mice against Endotoxemia induced by I.P. LPS (lipopolysaccharide) injection.

experimental hypothyroidism leads to a general depression of the immune system. Thyroid hormones are implicated in the impairment of T-cell–mediated immunity and the enhancement of tumor progression induced by chronic restraint stress in a murine model of lymphoma. Potential therapeutic action of thyroxin in the adjuvant treatment of stress-related disorders such as immunosuppression and cancer Frick, 2009.
Errors in Thyroid Endocrinology: PREGNANCY

- Ignoring: Maternal Anti-Thyroid Antibodies and Subclinical Hypothyroidism Associated with Increased Miscarriage, Prevented with Thyroxine. (Negro, J Clin Endo Metab 2006)

- Ignoring: Maternal Iodine Deficiency Associated with Reduced Educational Outcome in Offspring. (Hynes, J Clin Endo Metab 2013)
Safe Uses of Cortisol

William M. Jefferies MD

SAFE USES OF CORTISOL

Third Edition

SAFE USES OF CORTISOL

Second Edition

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Adrenal Fatigue: The 21st Century Stress Syndrome

Adrenal Fatigue: The 21st Century Stress Syndrome  Jan 1, 2001
by James L. Wilson

What it is and how you can recover
- Energy
- Immune Resistance
- Vitality
- Enjoyment of Life

James L. Wilson, N.D. D.C. Ph.D.
Foreword by Jonathan V. Wright, M.D.
Errors in Thyroid Endocrinology

Ignoring Adrenal Fatigue

- Hypothyroid, Yet Cannot Tolerate Thyroid
- Testing-
  Low AM Serum Cortisol,
  Low AM Salivary Cortisol (Laudat, 1988)
- Adrenal Support with HC, Vit C, B5, Adaptogens. (Cleare, 2001)
- Low dose HC Hydrocortisone (CORTEF)
The Thyroid Nodule Epidemic

Dr Cronan: "Thyroid Nodules: Is It Time to Turn Off the US Machines?"
Thyroid Cancer Incidence and Mortality

(Davies and Welch, 2014)
Thyroid Cancer Epidemic

“Not an Epidemic of Disease but Rather an Epidemic of Diagnosis.”

(Davies and Welch, 2014)
Errors in Thyroid Endocrinology
The Thyroid Nodule Epidemic

Dr Cronan Radiology 2008:
Turn Off the Ultrasound Machines – STOP Screening Normal Healthy Women

Young women with **clinically insignificant** small thyroid cancers are being treated with thyroidectomy and I-131 radio-ablation.

Test and Supplement with Iodine.
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Thank You – Any Questions?

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