



Hypothyroidism

Hypothyroïdie

Hypothyroidism, or underactive thyroid, occurs when the thyroid gland fails to produce sufficient amounts of the thyroid hormones T4 and T3. There are four main causes:

- 1) treatment of Graves' hyperthyroidism with radioactive iodine or by thyroidectomy;
- 2) end result of Hashimoto's thyroiditis, an inflammatory process of the thyroid gland; this may occur spontaneously during the course of Graves' disease;
- 3) a baby born without a thyroid gland (congenital hypothyroidism);
- 4) surgical removal of the thyroid gland as a treatment for thyroid cancer.

Hypothyroidism can also be caused by disease of either the pituitary gland or the hypothalamus. This is because normal function of the thyroid gland depends on the carefully regulated secretion of thyroid stimulating hormone (TSH) from the pituitary gland and thyrotropin releasing hormone (TRH) from the hypothalamus. Another important, but transient form of hypothyroidism occurs with postpartum thyroiditis or subacute thyroiditis.

Clinical Features

Hypothyroidism affects approximately 2 persons in 100. The signs and symptoms of overt hypothyroidism are opposite to those of hyperthyroidism since there is a *deficiency* of thyroid hormone secretion and all metabolic processes "slow down". The patient has poor appetite, intolerance to cold, dry, coarse skin, brittle hair, tiredness, a croaky, hoarse voice, constipation, and muscle weakness. Examination may reveal an absence of the thyroid gland, dry scaly, cold, pale skin, a thickening of the

L'hypothyroïdie (activité insuffisante de la thyroïde) se manifeste par la production insuffisante d'hormones thyroïdiennes T4 et T3. Elle peut avoir quatre causes principales:

- 1) traitement du goitre exophtalmique par iode radioactif ou par thyroïdectomie;
- 2) stade terminal de la thyroïdite chronique d'Hashimoto (inflammation de la glande thyroïde); cela peut se présenter spontanément au cours du goitre exophtalmique;
- 3) défaut congénital (absence de glande thyroïde à la naissance);
- 4) ablation chirurgicale de la glande thyroïde (traitement du cancer de la thyroïde).

L'hypothyroïdie peut également provenir d'une affection de l'hypophyse ou de l'hypothalamus, le fonctionnement normal de la glande thyroïde reposant sur l'équilibre délicat de la sécrétion d'hormone thyroïdienne (TSH) par l'hypophyse et de l'hormone de libération de la thyroïdostimuline (TRH) par l'hypothalamus. Une autre forme importante, mais éphémère, de l'hypothyroïdie se présente avec la thyroïdite post-partum.

Tableau clinique

L'hypothyroïdie affecte environ deux pour cent de la population. Les signes et symptômes de cette maladie diffèrent de ceux de l'hyperthyroïdie: la sécrétion d'hormones thyroïdiennes est *insuffisante*, et le métabolisme est "ralenti". Le patient n'a pas d'appétit, ne supporte pas le froid, a la peau sèche et rugueuse, les cheveux cassants, se fatigue vite, a la voix rauque, souffre de constipation et de faiblesse musculaire.

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skin and underlying tissues (called myxedema), very slow reflexes and a slow heart rate. The patient can have poor memory retention. The diagnosis of hypothyroidism is confirmed by finding very low levels of thyroid hormones (T4 and T3) in the blood.

Neonatal Hypothyroidism

Newborn babies are tested using a "heelpad bloodspot test". Neonatal hypothyroidism is caused, for unknown reasons, by an absence of the baby's thyroid gland at birth. Thyroid hormones are essential for brain development and growth. Newborn infants with hypothyroidism that is not treated, are called cretins and have severe body and mental defects. These include mental retardation, poor vision, thick, dry skin, protrudent tongue, muscle weakness, severe lethargy and tiredness. If diagnosed and treated soon after birth, growth and mental development can proceed relatively normally.

Much of the research work in making an early diagnosis of neonatal hypothyroidism was carried out in Canada by Dr. J.H. Dussault at Laval University.

Monthly Draw

Renew your Membership now and become eligible for our Monthly Draw.

Every month one renewing member receives a book on thyroid disease.

Our June 2002 winner was:

Ms. Stephanie Bach

Seaforth, Ontario

who received

"How your Thyroid Works"

by H. J. Baskin

Our July 2002 winner was:

Mrs. Elizabeth Middleton

Victoria, British Columbia

who received

"The Thyroid Gland

A Book for Thyroid Patients"

by Joel I Hamburger, MD, FACP

Our August 2002 winner was:

Ms. Rae Odishaw

Saskatoon, Saskatchewan

who received

"The Thyroid Gland

A Book for Thyroid Patients"

by Joel I Hamburger, MD, FACP

"Borderline Hypothyroidism" (Compensated Hypothyroidism)

Borderline Hypothyroidism (Compensated Hypothyroidism) is quite common, and almost impossible to diagnose clinically. The hallmark is that of an elevated TSH concentration, with normal or only slightly reduced thyroid hormone levels. There may be no symptoms, or very vague symptoms, associated with this condition.

It is important to make the correct diagnosis because once treatment is started it usually continues for life as it becomes very difficult to stop treatment to determine whether the original diagnosis was correct. The measurement of TSH in the blood helps to define even minor degrees of hypothyroidism.

Treatment

Treatment of hypothyroidism is to take thyroid hormone replacement in the form of a small pill, daily, for life. This is now given in the form of thyroxine ("Eltroxin" or "Synthroid"), a synthetic hormone which has few impurities, very few side effects and produces almost no allergic reaction. The dose of thyroxine in adults ranges from 0.1 to 0.2 mg per day. Most patients require between 0.125-0.15 mg but a few require less and a few require more. There is no need to add T3, since T4 breaks down to T3, and the dosage is set to provide a normal T3 level. Once the dose has been established, it is usually stable for life and patients treated with thyroxine need only have blood tests once a year. Major stress or illness can sometimes increase the need for thyroid hormone. Infants and children require smaller doses. Adult doses are given for teenage patients. Too much thyroxine causes symptoms of hyperthyroidism whereas symptoms of hypothyroidism persist with too little. The correct dose is determined from blood tests of thyroid hormone levels, particularly the total serum triiodothyronine and TSH tests, and from clinical examination.

Other Forms of Thyroid Hormone

There are many other forms of thyroid hormone but it is very unusual to prescribe any of these. Impure preparations such as thyroid extract, thyroglobulin, and crude thyroid preparations contain variable amounts of thyroid hormones. They produce variable effects and an unpredictable response to treatment. Triiodothyronine (T3), which is much more potent than thyroxine is also given on occasion. This drug has a short

life span in the blood and causes irregular stimulation of the heart. Therefore, T3 ("cytomel") should not be given to patients with heart disease or to older patients.

Duration of Treatment

Assuming that the diagnosis of hypothyroidism was correct, treatment for thyroid hormone should almost always be continued for life. The cause of thyroid failure is likely to be progressive and permanent.

Many patients are given thyroxine for the wrong reasons (such as obesity or tiredness). Therefore, it is essential that blood tests be carried out and that thyroid hormone levels are clearly shown to be below the normal range. Additionally, patients must have symptoms and signs of hypothyroidism.

Hypothyroid patients should not stop taking thyroid hormone. Thyroid hormone treatment must be continued even when the patient develops other illnesses, although the dosage may have to be altered.

Treatment of Pituitary or Hypothalamic Hypothyroidism

The treatment of hypothyroidism caused by failure of the pituitary or the hypothalamus is also thyroxine. Pituitary or hypothalamic failure are both very rare compared to failure of the thyroid gland. In these cases, other hormone deficiencies may exist which must be identified and treated as well.

The foregoing information appears in TFC's Health Guide #3. For a complete list of Health Guides available from the national office or your local chapter, see page 15.

NOTICE TO ALL MEMBERS

Your membership in the Foundation expires on the date that is printed on the address label on your *thyrobulletin*.

Please use the

Membership/Donation Form

on page 15 or our secure payment system at www.thyroid.ca/english/membership.html.

You may renew early – and for one or two years! You will be credited with renewal on the date that you are due to renew.

Donations are always welcome.

Hypothyroïdie . . . suite de la page 1

L'examen peut révéler les symptômes suivants: atrophie de la glande thyroïde, peau sèche, écaillée, froide et pâle, épaissement de la peau et des tissus sous-cutanés (myxœdème), ralentissement des réflexes et des pulsations cardiaques, parfois même une mauvaise mémoire. Le diagnostic d'hypothyroïdie peut être confirmé par le taux réduit des hormones thyroïdiennes (T4 et T3) dans le sang.

Hypothyroïdie néonatale

Une épreuve laboratoire (heelpad bloodspot test) permet de dépister chez les nouveau-nés l'hypothyroïdie néonatale, causé par l'absence inexplicable de la glande thyroïde à la naissance. Les hormones thyroïdiennes sont essentielles à la croissance et au développement du cerveau. Si l'hypothyroïdie n'est pas traitée, les nouveau-nés, appelés crétins, souffrent de déficiences physiques et mentales graves: arriération mentale, mauvaise vision, peau sèche et épaisse, langue proéminente, faiblesse musculaire, léthargie grave et fatigue. Si la maladie est diagnostiquée et traitée dès la naissance, la croissance et le développement mental de l'enfant se font de façon normale.

Au Canada, le docteur J.H. Dussault, de l'Université Laval, a effectué de nombreux travaux de recherche portant sur le dépistage précoce de cette maladie.

Cas limites d'hypothyroïdie (l'hypothyroïdie compensée)

Les cas limites sont tout à fait communs et presque impossibles à diagnostiquer médicalement. La marque est celle d'un niveau élève de TSH avec les niveaux normaux ou seulement légèrement réduits d'hormones thyroïdiennes. Parfois, aucun symptôme ne se présente ou il ne se présente que des vagues symptômes associés à cette condition.

Il est très important de faire un diagnostic correct; une fois le traitement commencé, on doit le continuer à vie puisqu'il est très difficile de l'arrêter pour déterminer si le diagnostic original était correct. La mesure des taux sanguins de TSH aide à diagnostiquer même dans les cas peu graves d'hypothyroïdie.

Traitement

L'hypothyroïdie se traite par l'administration quotidienne d'hormones thyroïdiennes, sous forme de comprimés, à vie. On administre aujourd'hui de la thyroxine synthétique (Eltroxin ou Synthroid) qui contient peu d'impuretés, a très peu d'effets secondaires et ne produit presque jamais de réaction allergique. La dose quotidienne pour un adulte est de 0,1 à 0,2 mg. La plupart des patients requièrent entre 0,125 et 0,15 mg, plus ou moins selon le cas. Il n'est pas nécessaire d'ajouter le T3 puisque le T4 se dégage en T3 et le dosage est fixé pour fournir un niveau T3 normal. La dose établie reste généralement toujours la même, et les patients n'ont pas besoin de passer une épreuve sanguine qu'une fois l'an. Un stress important ou une maladie peut parfois accroître la quantité d'hormones thyroïdiennes nécessaire. Chez les nouveau-nés et les enfants, la dose est plus faible; les adolescents reçoivent une dose d'adulte. Si la dose est trop forte, la thyroxine provoquera une hyperthyroïdie; si elle est trop faible, les symptômes d'hypothyroïdie persisteront. La dose exacte est déterminée à partir du dosage sanguin d'hormones thyroïdiennes, particulièrement des examens du TSH et de la thyroxine totale, et d'un examen médical.

Autres types d'extraits thyroïdiens

Il existe bien d'autres types d'hormones thyroïdiennes, qui sont rarement prescrits: préparations comportant des impuretés (extrait de thyroïde), thyroglobuline et préparations brutes de thyroïde (comportant des quantités variables d'hormones, thyroïdiennes). Leurs effets sont variables et imprévisibles. On administre parfois de la triiodothyronine (T3), bien plus puissante que la thyroxine mais qui a une demi-vie beaucoup plus courte dans le sang et entraîne la stimulation irrégulière du cœur. Ce produit (Cytomel) ne convient donc pas aux patients atteints de troubles cardiaques, ni aux patients âgés.

Durée du traitement

Si le diagnostic d'hypothyroïdie est juste, le traitement à l'hormone thyroïdienne se poursuit durant toute la vie du patient; l'insuffisance thyroïdienne est généralement progressive et permanente.

Dans certains cas, comme l'obésité ou la fatigue, de la thyroxine est administrée à tort aux malades. Il importe donc d'avoir recours à des épreuves sanguines et de déterminer clairement si le taux d'hormones thyroïdiennes est inférieur à la normale. Les patients doivent également présenter les signes et symptômes de l'hypothyroïdie.

Les patients atteints d'hypothyroïdie ne doivent pas interrompre leur médication. Le traitement doit se poursuivre, même si le malade est atteint d'autres affectations, bien que la posologie puisse être modifiée.

Traitement de l'hypothyroïdie hypophysaire ou hypothalamique

La thyroxine permet aussi de traiter l'hypothyroïdie provoquée par une insuffisance hypophysaire ou hypothalamique. Ces affections sont cependant très rares par rapport aux déficiences de la glande thyroïde elle-même. Dans ces cas, le patient peut souffrir d'autres déficiences hormonales qui doivent être dépistées et traitées.

Les informations précédentes sont contenues dans les dépliants santé de la FCT. Pour une liste complète des dépliants disponibles au bureau national ou de votre section locale, voyez la page 15.

thyrobulletin is published four times a year: the first week of May (Spring), August (Summer), November (Autumn) and February (Winter).

Deadline for contributions are:

March 15, 2003 (Spring)
June 15, 2003 (Summer)
September 15, 2003 (Autumn)
December 15, 2002 (Winter)

Contributions to:

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**Thyroid Foundation of Canada
La Fondation canadienne de la Thyroïde**

Founded in/Fondée à Kingston, Ontario, in 1980

Founder

*Diana Meltzer Abramsky, CM, BA
(1915 – 2000)*

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La date limite pour les articles pour le prochain numéro: le 15 décembre, 2002

Contributions to/à – Editor/Rédacteur:

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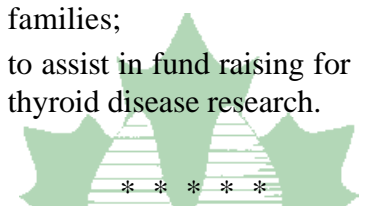
The information in *thyrobulletin* is for educational purposes only. It should not be relied upon for personal diagnosis, treatment, or any other medical purpose. For questions about individual treatment consult your personal physician.

Notez bien:

Les renseignements contenus dans le *thyrobulletin* sont pour fins éducationnelles seulement. On ne doit pas s'y fier pour des diagnostics personnels, traitements ou tout autre raison médicale. Pour questions touchant les traitements individuels, veuillez consulter votre médecin.

**The objectives of the
Foundation are:**

- to awaken public interest in, and awareness of, thyroid disease;
- to lend moral support to thyroid patients and their families;
- to assist in fund raising for thyroid disease research.



**Les buts de la
Fondation sont:**

- éveiller l'intérêt du public et l'éclairer au sujet des maladies thyroïdiennes;
- fournir un soutien moral aux malades et à leur proches;
- aider à ramasser les fonds pour la recherche sur les maladies thyroïdiennes.

President's message

Message du président

The Thyroid Foundation of Canada has reached an age where self-examination and possibly a transformation in some areas is warranted. As you know our mandate is that of education and research. We certainly are doing a responsible job of maintaining research endeavours, but could we be doing a better job in fund raising and in the delivery of education? In order to answer these questions satisfactorily we need to take a good hard look at how we are currently doing things. To this end, the executive committee struck a sub-committee to report back on these issues.

At the national level, our education function is to publish thyrobulletin, maintain our website, provide educational material and support the chapters. At the local level, help lines, chapter meetings and special events constitute the major part of our educational services. Can we do more? Is there a better way to get the information in thyrobulletin to the public? How can we reach more people? What can we do to better support the chapters? Should our chapters have a different mandate?

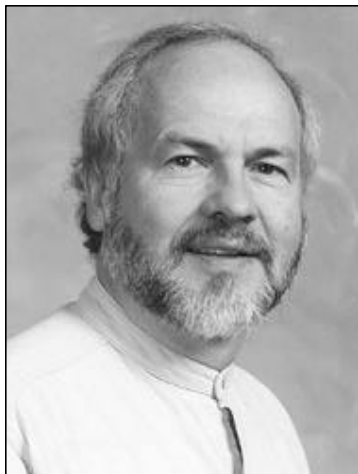
Please don't hear me suggesting that the Foundation should be restructured. However, I do think we need to examine where we are going and how we are going to get there. That doesn't mean we should do away with a structure which has served us so well all these years.

In this issue you will find an article, *The torch has passed* addressing the financial crisis we are facing at the operational level. Gary Winkelman (VP Publicity and Fund-raising) is heading up a team whose task is to look at fund-raising. We hope to have a long-term plan in place by the end of our fiscal year. In the shorter term, Ted Hawkins, newly retired President and CEO of Theramed Corporation, is working on a project to raise \$30,000 over the next 18 months to cover the cost of production, printing and distribution of thyrobulletin.

We are doing more than asking for money. On the publicity side, Gary Winkelman has arranged for the folks at COSTCO to publish an article on thyroid disease in the new year. Their newsletter has over one million readers. Also a small article on *Thyroid disease in women of childbearing age* will appear in an upcoming issue of Chatelaine magazine.

We are now in November and I have the distinct pleasure of being the first to convey seasons greetings to you.

To all our members, families and friends, from staff, the national board and myself, I wish you a happy holiday and a prosperous and healthy new year. To all, the Best of the Season.



Ed Antosz, National President/
Président national

La Fondation canadienne de la Thyroïde est d'un âge où un examen de soi et possiblement une transformation dans certains domaines sont dus. Comme vous le savez sans doute, notre mandat est l'éducation et la recherche. Nous faisons certainement un travail responsable dans nos efforts d'entretien vers la recherche mais pourrions nous peut-être en faire mieux dans les domaines de ramassage de fonds et de la distribution d'éducation? Pour bien répondre à ces questions nous devons bien examiner comment nous faisons les choses maintenant. Dans ce but, le comité a établi un sous-comité enfin de faire un rapport sur ces questions.

Au niveau national, notre fonction éducative est de publier le thyrobulletin, maintenir notre

site web, fournir les matériaux éducationnels et de supporter les sections. Au niveau local, les lignes de soutiens, réunions de sections et les évènements spéciaux constituent la part majeure de nos services éducationnels. Pouvons-nous en faire plus? Y a-t-il une meilleure manière de faire parvenir les informations du thyrobulletin au publique? Comment pouvons nous atteindre le plus grand nombre de personnes? Que pouvons nous faire pour porter plus de support aux sections? Est-ce que nos sections devraient avoir un mandat différent?

Ne pensez pas que je suggère restructurer la Fondation. Mais je pense que nous devons examiner où nous allons et comment s'y rendre. Ceci ne veut pas dire que nous devrions éliminer une structure qui nous a si bien servi pendant toutes ces années.

Dans ce numéro vous trouverez un article *The torch has passed* adressant la crise financière que nous faisons face au niveau d'administration. Gary Winkelman (vp publicité et ramasseur de fonds) est à la tête d'une équipe qui a pour tâche d'adresser le ramassage de fonds. Nous espérons avoir un plan à long terme en place à la fin de notre année fiscale. Au cours terme, Ted Hawkins, ancien président de Theramed Corporation, maintenant en retraite, travail sur un projet qui pourrait ramasser 30 000\$ durant les prochains 18 mois pour recouvrir les coûts de production, d'imprimerie et de distribution du thyrobulletin.

Nous faisons plus que de demander de l'argent. Gary Winkelman arrangea pour les gens chez COSTCO de publier un article sur les affections thyroïdiennes dans le nouvel an. Leur bulletin a plus d'un million de lecteurs. Aussi, un petit article sur «les affections thyroïdiennes dans les femmes d'âge d'accouchement» apparaîtra dans un prochain numéro de la revue Chatelaine.

Nous sommes maintenant au mois de novembre et j'ai le plaisir d'être premier à vous communiquer nos meilleurs vœux de la saison.

Je souhaite de joyeuses fêtes et une nouvelle année prospère et saine à tous nos membres, familles, amis et amies de la part de notre personnel, le conseil national et de moi-même. A tous, nos meilleurs vœux de la saison.





Letters to the doctor

Robert Volpé, MD, FRCPC, MACP, Medical Adviser to the Foundation

The following questions were provided by thyroid cancer patients.

Psychological Impact of Thyroid Cancer Diagnosis

The diagnosis of cancer in combination with the hormonal changes that occur with thyroid cancer treatment can have many emotional impacts. What kinds of symptoms are a normal part of treatment and when should a patient seek additional professional support for depression?

The diagnosis of cancer, whether in combination with other hormonal changes or not, can have major emotional impact, and this depends upon the patient's own initial temperament more than on the type of surgery, its magnitude, or other hormonal changes. It is relatively common for there to be at least some degree of depression, and in patients who are emotionally fragile, this can be quite severe. Depending on the patient's reaction to being told about the diagnosis, the attending physician should make a judgment as to whether the patient requires additional professional support for depression.

Radioactive iodine (RAI)

When a patient's TSH rises quickly, why must they wait 6 weeks for RAI? Is this just for treatment scheduling reasons? Is there any danger for patients to have an elevated TSH for longer than absolutely necessary? What can be done to minimize the time a patient must be hypothyroid before treatment?

If the TSH rises quickly, there is no need to wait six weeks. However, generally speaking, it does take about six weeks for maximal elevations of the TSH, and this is why a six-week interval has been selected as a reasonable time to wait for all patients. This is largely because

patients cannot be seen every day, and beds have to be scheduled well in advance. There is no danger for patients to have an elevated TSH for any length of time; it is only the severity of the hypothyroidism that brings about symptoms. This is also why patients are given Cytomel (Triiodothyronine, T3) for the initial four of these six weeks, which keeps the patient feeling quite well, and thus there is only a relatively brief period of time when they are off all thyroid hormones.

How is the RAI dose determined? Are doses below 100 mCi used in Canada? Why or why not?

A dose of 100 millicuries has been shown to cause virtually complete destruction of all of the remaining thyroid tissue, and it is for this reason that this dosage has been selected. Doses below 100 millicuries have been employed in Canada, but such doses are associated with less severe destruction of thyroid tissue.

Why do some physicians recommend the low iodine diet prior to RAI and others don't feel that it is useful?

A low iodine diet will, of course, increase the uptake of the radioactive iodine into the thyroid gland and thus maximize the effect of such doses on thyroid function. However, this is not a major effect and thus many physicians do not bother to prescribe a low iodine diet in this fashion.

If a patient wishes to follow the low iodine diet, which calcium supplements are permitted on the diet?

Any calcium supplement that does not also contain iodine can be permitted with the low iodine diet.

What are the possible side effects of RAI? What can patients do to minimize these side effects? How long can these symptoms last? Can some of them be permanent - (e.g. salivary gland damage, gastric upset, nausea)?

Radioactive iodine can be associated with early nausea and vomiting, and later

dryness of the mouth due to damage of the salivary glands. The nausea and vomiting generally last only 24 hours or less and are not permanent. However, damage to the salivary glands can be permanent.

I run about 10 km per week and lift weights 3 times a week. While preparing for a RAI scan, when or how should I modify my workout schedule?

There is no need to modify an exercise regimen while preparing for a radioactive iodine scan.

External Beam Radiation/Chemotherapy

Under what circumstances is external beam radiation a treatment option for thyroid cancer?

Where the thyroid carcinoma has been shown to be highly aggressive historically, with evidence of local metastases, external beam radiation might be considered a reasonable treatment option.

Under what circumstances is chemotherapy a treatment option for thyroid cancer? What type of chemotherapy is used and what are the success rates?

Chemotherapy is generally a treatment option for very aggressive or anaplastic thyroid carcinoma. It has not been considered very successful under these circumstances.

Recurrence

How is thyroid cancer recurrence detected? Is it possible to have a clean scan but elevated thyroglobulin? What diagnostic steps are indicated in this case of contradictory findings?

Thyroid cancer may be considered to be recurring when it can be shown by palpation or by imaging to have recurred. However, a rising serum thyroglobulin, even in the absence of an abnormal scan, would be sufficient evidence. Such laboratory aids as CAT scans or MRI's would be useful.

The torch has passed or did Diana do it all for nothing?

The Christmas movie *It's a Wonderful Life* is about the power of one individual doing something 'ordinary' over a period of time, and the power of many 'ordinary' people to make a seemingly impossible difference in a crisis. Diana Meltzer Abramsky realized a need and in a few years she had created a Canada-wide Thyroid Foundation, a model for the world.

She wanted money for research primarily, but also for education and support for thyroid sufferers. "Operations" were simply carried out on her old typewriter in her modest home. She soon surrounded herself with a dedicated and visionary pioneer group who gathered others one by one (you!) and put in place the structure and mode of operation that any organization needs, first the national organization and then the chapters. Some of those pioneers are still carrying the 'torch'. It is this formal organization that allows us to continue to attract funds from public and government sources.

by
Rita and Dr. Roger Wales

We seem to have a great deal of money but most of it is in the Research Fund. We still have a crisis in the Education and Services Fund. What can we do individually? There are upwards of 3,500 members in the Thyroid Foundation. If we each contributed \$10 annually, over and above membership, that would produce \$35,000 minimum to keep the Foundation going. That is easy to say, but we are human. We all have bills to pay, think our contribution would not make much difference or just keep putting it off.

So here are small but powerful steps that we can all take to make a big difference. Do not say this is silly or insulting unless you just want to go straight to Step 6.

1. **DECIDE** to help (vital).
2. **WRITE** down your goal.
3. **GET** a small container and put it where you will see it.

4. **MAKE** a sacrifice (actually go without that cup of coffee or simply pay double for it). Decide against a small impulse purchase.
5. Actually **PUT** the dollar, five dollars or whatever in the container.
(**TELL** friends what you are doing and why. Invite them to give a dollar (they may give you five).
6. After **TWO** weeks maximum, put a money order or a cheque in an envelope and mail it to the national office.
7. Include a stamped self-addressed envelope for your receipt. This would save the Foundation about \$1,700 in postage alone. Think that **YOU** personally donated that much. You all did!
8. Feel **GOOD!** (very important).
9. **WAIT** to hear the results.
10. Maybe do it **AGAIN**.

It is **YOUR** Foundation now – remember why you joined! It is not up to someone else to fix it if we want it to be there for others in the future.

Your thyroid factory

There is a tiny little factory in the front of your neck called your thyroid gland. It makes mysterious little chemical messengers called thyroid hormones which travel in the bloodstream to every cell in the body. If it sends out too many, or not enough of these hormones, you will get sick. You will have too much energy when you want to rest, or not enough energy when you want to have fun. You will feel too tired and sleepy to play or too jumpy when you want to sleep. Sometimes your hair and nails are affected, sometimes you get so thin people think you don't have enough to eat. They would be surprised to know that you almost never stop eating. A really strange thing happens when your thyroid isn't doing what it is supposed to do. In the summer time, on the hottest days, you feel cold and need a sweater or in the winter, when everyone is freezing

cold, you walk around with your coat open, you feel too warm. Can you imagine turning up the furnace thermostat in your home in the summer, and turning it down in the winter? That is what is happening to your body when your thyroid factory needs repairs; a lot of other things can happen too, but they can all be fixed up by your doctor, without too much trouble.

*Diana Meltzer Abramsky, Founder
Thyroid Foundation of Canada
This explanation, written by Diana, was enclosed in the program of a children's concert sponsored in the 1980's by the Kingston Area Chapter*



In Memoriam

Diana Hains Meltzer Abramsky
1915 - 2000

*A loving wife, mother and
grandmother.*

Member Order of Canada
Founder, Thyroid Foundation of Canada

Passed away October 9, 2000

*Her good deeds and vision
benefitted all humanity.*

My thyroid/parathyroid adventure



Theresa de Jeu with her niece Claire

by
Theresa de Jeu

me that was conclusive evidence that they couldn't be cancerous.

In the spring of 2000, a year and a half later, my endocrinologist again asked me to have the largest nodule biopsied. My mind started racing. It didn't make any sense, especially now, since they weren't growing. But I agreed to go as a precaution.

I had an ultrasound guided fine needle aspiration biopsy (FNAB). I had to wait several weeks for the appointment, but when I arrived at the hospital, it suddenly dawned on me that I wasn't prepared, that I couldn't handle the results. I felt really vulnerable.

Being told that it was likely benign didn't help. I had already heard from my co-worker that she had been told the same thing, but wasn't so lucky. If it could happen to her, it could definitely happen to me. I wanted to believe them, but kept thinking, "That's what they tell everyone!" Obviously someone thought there was a good chance it could be cancer or I wouldn't be here.

Although I knew by this time that thyroid cancer is usually survivable, I didn't want to go for surgery, have treatment, or spend time in the hospital. I didn't want any disruption in my life.

I had assumed the diagnosis would be either benign or malignant, so when the outcome was "inconclusive", I didn't know what to make of it. I was completely bewildered. But by the time my second biopsy turned out to be "suspicious", I was ready to deal with the results.

I was lucky because I had people to answer my questions, even if they didn't always give me the answers I wanted. It was comforting to know someone who had had the surgery, but finding out she was left with permanent hypoparathyroidism (HPTH) increased my anxiety level tremendously.

Doctors quote really low levels of permanent HPTH, but hearing some real life stories made me nervous. If it's so rare, then what are the odds that I would work with someone who not only has it, but has also met others with the same thing? I questioned whom to believe more

– doctors or patients, and I became frustrated because no one really knows the answer. I've concluded that the parathyroids must be one of the least understood glands in the entire body.

I had a total thyroidectomy in September of 2000, at the age of 32. I spent a lot of time worrying about what the scar was going to look like, how to hide it, and whether I could handle having temporary or permanent HPTH, the symptoms of which range from tingling and numbness in the extremities (lips, hands and feet) to seizures. I accepted that a lot of patients have temporary problems, but permanent problems? When and how do you know it's permanent? How bad is this going to be?

I could tell my calcium level had dropped (hypocalcemia) while in recovery. My surgeon and his residents reported seeing two parathyroid glands during the surgery and that neither had turned gray, something that parathyroid glands often do. None of my parathyroid glands were removed (later confirmed by the pathology report), so it is really unexplainable why my calcium level dropped so low. While in the hospital, I had intravenous calcium, but also started taking calcium supplements with a drug called Rocaltrol (synthetic calcitriol), the most activated known form of vitamin D3. Normally the vitamin D3 that the body produces from sunlight or absorbs from milk is inactivated and needs to be converted into calcitriol in the liver and kidneys. If the body has insufficient levels of parathyroid hormones, which aid this process, then supplementation with Rocaltrol may be necessary.

Not only do I have to worry about my calcium level dropping too low, but I've also been warned not to let it get too high. Parathyroid hormones help the kidneys keep calcium from filtering out of the blood. With insufficient parathyroid levels, too much calcium flows out of the blood, causing the possibility of kidney stones.

Over the next several months, I suffered from paresthesias, a burning sensation that felt like a bug crawling on my lips, a lot of twitching, especially in my legs, and some obscure symptoms such as tremors inside my eyeballs, and

continued on page 9

When I was in my mid 20's, my thyroid became swollen, but my TSH was still in the normal range. My family doctor didn't know what was wrong. No one knew it at the time, but I had started developing antibodies (Hashimoto's autoimmune thyroiditis).

A few years later, in 1998, I was referred to an endocrinologist for an elevated prolactin level. When he sent me for a thyroid ultrasound, the results showed that I had several nodules (multinodular goiter). The largest was 2 cm. I had never heard of thyroid nodules before and barely even knew what a thyroid was. Although I could feel a soft mass beside my trachea, I resisted the suggestion of going for a biopsy out of fear. Besides, he told me the chances of it being malignant were remote and that was good enough for me. As far as I knew, cancer didn't often happen to someone in their 30's.

Only a few days later, I discovered that I was working with someone who had had thyroid cancer surgery three years earlier, just months before I joined the department. I was stunned. She was only a few years older than I was. Listening to her story really hit close to home.

I went back for an ultrasound every 6 months. My nodules didn't grow and to

Correction – Dr. Mazzaferri Article



Ernest L. Mazzaferri, MD, MACP

Correction – article du Dr. Mazzaferri

In the recent article by Ernest L. Mazzaferri (cover story Summer 2002, Volume 23, No.2) entitled Thyrogen – Recombinant Human Thyrotropin in the management of papillary and follicular thyroid cancer, there is a typographical error in the second paragraph. It should read:

“The good news is that while the incidence of thyroid carcinoma has increased by 50%, thyroid cancer mortality rates among persons living in the United States have declined nearly 20% (not 50% as stated) over the past 30 years.”

Dans un article récent par Ernest L. Mazzaferri (article de la première page, été 2002, Vol 23, No 2) intitulé Thyrogen – recombinaut humain Thyrotropin dans la gestion du cancer papillaire et folliculaire, il y a une erreur typographique dans le 2ième paragraphe. On aurait du dire :

« La bonne nouvelle est que, pendant que l'incidence de carcinome thyroïdien augmentait de 50%, le taux de mortalité par le cancer thyroïdien, parmi les personnes demeurant aux États Unis, diminuait de presque 20% (et non pas de 50% comme déclaré) durant les 30 années passées. »

My thyroid . . . continued from page 8

seizures in my tongue and nose. Even though I was taking large amounts of calcium and Rocaltrol, I still suffered. I spent a lot of time asking my colleague questions like: what her symptoms were after surgery; how long it took her body to stabilize; whether she still has symptoms while taking medication; how long before she develops symptoms if she forgets to take her medication, etc.

At first I wanted to hear stories about people whose temporary hypocalcemia disappeared, who were able to get off their medication, but as time wore on, I realized I had a permanent problem. I didn't want to hear any more about the "lucky" ones. It wasn't fair.

I started taking levothyroxine (T4) right after surgery. I wasn't sure I was willing to have radioactive iodine (RAI). My final pathology report indicated that my lump actually measured 1.5 cm, papillary thyroid cancer, follicular variant. Because I was generally considered to be borderline low risk, I wondered if I would be able to skip RAI treatment altogether, without having a recurrence. I worried about the side effects, and was in no hurry to add to my suffering.

My parathyroid problems bothered me for a long time. It was an emotional roller coaster. I couldn't get away from the twitching and it drove me to distraction. At one point, I was thinking about timing

the seconds between twitches because I was sure that I had a twitch somewhere in my body every 30 seconds. Months had gone by and I still didn't want to think about RAI treatment and luckily, no one tried to push me into it. There was no rush. The one thing I knew was that if I decided to have it, I wanted to take Thyrogen, a new drug I heard about from my endocrinologist.

In general, patients preparing for RAI treatment try to increase their TSH to stimulate 131I absorption and enable a more accurate measurement of thyroglobulin (Tg), a protein produced by thyroid cells. In the past, the only way patients could increase their TSH was to stop taking T4 and suffer through hypothyroidism ("hypo-hell"), but now there is a new synthetic drug called Thyrogen or recombinant TSH that elevates patients' TSH level without stopping T4.

In the fall of 2000, Thyrogen was neither fully approved nor widely used in Canada, but I was fortunate to live in a city that has a nuclear medicine specialist who is familiar with it. Although the best course of action is anyone's guess, I opted to have RAI in February of 2001.

My diagnostic scan (about 2 mCi RAI, with Thyrogen) showed I had remnants of thyroid tissue in my thyroid bed which were likely normal cells left behind during surgery. A week later, I underwent RAI remnant ablation (about 100 mCi 131I, again with Thyrogen). I didn't have

to stay in the hospital. I was able to go home as long as I arranged to be in isolation for three days. I had stocked up on lemon candy because I knew that sucking on something sour was the best way to prevent damage to my salivary glands. I also drank a lot of water to flush the excess RAI out of my system as quickly as possible. I didn't suffer from any side effects.

Normally, thyroglobulin (Tg) blood tests are done to determine if there are still thyroid cells left somewhere in the body; but doctors are unable to rely on Tg tests in the presence of antibodies. My antibody levels are still high, but appear to be receding, which is a good sign. It could take years for them to disappear. In the meantime, we have to rely entirely on RAI scanning, ultrasounds and physical exams.

Over time, I have been able to get on with my life and have come to accept my hypoparathyroidism. As long as I take my medication on time, I have few, but occasional symptoms. My scar is no longer noticeable, so the pills I take are really my only reminder of the whole ordeal.

I learned a lot from my experience and as a way of helping others, I have been volunteering with the newly incorporated Canadian Thyroid Cancer Support Group (Thy'vors) Inc. Thy'vors can be reached at thryvors@sympatico.ca or by writing PO Box 23007, 550 Eglinton Ave. West, Toronto ON M5N 3A8

A moment with Carl Lewis

Since the 1984 Los Angeles Olympic Games, when Carl Lewis matched Jesse Owens' record of winning four gold medals during one Olympiad, Lewis had demonstrated seemingly boundless energy and strength. As an Olympic and World championship medalist in the long jump, the 100 and 200 metre races, and the 4 x 100 relay, the record-setting Lewis has won the attention and admiration of fans around the world. His amazing physical abilities and his longevity in a field where the average participant's age is 26, have kept sport writers and commentators buzzing.

Five months before he was to compete at the relatively old age of 35 in his fifth and final Olympics, Carl Lewis received some unexpected news. Blood work ordered by his endocrinologist revealed that Lewis had hypothyroidism, or, as some people refer to it, an underactive thyroid. In his recently released book *One More Victory Lap* Lewis said he felt, "... a moment of panic...when I wondered if my season was about to be declared over ... I was much less concerned about running and jumping than I was about my basic health."

Like most people when they are first told they have a thyroid disease, Lewis asked, "Who would even know about the thyroid gland unless something goes wrong with it?" The thyroid gland, located in the neck, produces, stores, and secretes two thyroid hormones, thyroxine (T4) and triiodothyronine (T3). These hormones travel through the blood and tell the body how fast to work and use energy. When there is too little thyroid hormone circulating in the bloodstream, hypothyroidism occurs.

The wide range of signs and symptoms of hypothyroidism can vary from patient to patient and can be confused easily with the symptoms of other diseases. Symptoms develop slowly and can easily be dismissed or attributed to other factors. An individual hypothyroid patient may have none, some, or all of the signs and symptoms of hypothyroidism, depending on the severity of the disease. In Lewis' case, he had been unaware of any signs or symptoms, he simply went for a routine check-up, and blood work revealed his condition. However, a few weeks after his diagnosis, Lewis realized that he had put on a few pounds. He knew that hypothyroidism could be responsible

for some of the weight gain, but he also knew he had been lifting weights, which can cause an increase in muscle development, and eating more. He immediately went on a diet regimen he had used successfully in the past. Within two weeks he lost seven pounds.

Hypothyroidism can be permanent and require a lifetime of treatment, or it may be temporary and require little, if any, treatment. Further laboratory tests revealed that Hashimoto's thyroiditis, a chronic inflammation of the thyroid gland, was the underlying cause of Lewis' condition, and therefore, the condition would be permanent. Hashimoto's thyroiditis is an autoimmune disease and the most common cause of hypothyroidism in the United States, affecting 5% of the adult population. When someone has an autoimmune disease, their body's immune system incorrectly identifies the cells of normal body tissue as 'invaders' and then produces antibodies to attack these cells. In the case of Hashimoto's thyroiditis, auto-antibodies are formed against chemicals in the thyroid gland. The result of this attack is painless inflammation and enlargement of the thyroid gland. Eventually the inflammation subsides, and the thyroid gland decreases in size. At any stage in this process, the patient may become hypothyroid.

Although no one knows the exact cause of autoimmune diseases such as Hashimoto's thyroiditis, studies indicate that they:

- Tend to run in families
- Affect women five to ten times more often than men
- Sometimes occur together, e.g: diabetes, pernicious anaemia

The incidence of Hashimoto's thyroiditis increases with age, especially among women. One in five women over the age of 75 have antithyroid antibodies. Because Hashimoto's thyroiditis tends to run in families, patients diagnosed with it should tell members of their family especially their mothers, sisters, aunts and nieces so that they will be aware that there is a hereditary disease in the family.

As Carl Lewis discovered, the treatment for hypothyroidism is simple, safe, and very effective – thyroid hormone replacement. He began taking brand-name levothyroxine once a day, every day on an empty stomach. Being a

true champion, he continued his strenuous schedule of training, participating in meets and promotional activities. He had some of the same concerns as other patients. He worried about how long it would be before he was 100% recovered and if, indeed, he would ever completely recover. In addition, Lewis had the added pressure of wondering if he could effectively compete in such a demanding arena. Would he be able to fulfil his dream of leaving the track and field events at the Atlanta Olympics, "on my own terms ... with a bang, with passion" so that people (will) always remember me at my best"?

Reading more about the thyroid gland and hypothyroidism reinforced what Lewis' doctors had told him and also helped him develop a better understanding of his condition. He found Dr. Sheldon Rubinfeld's book *Could It Be My Thyroid?* extremely reassuring. Within four weeks of beginning levothyroxine, he started feeling better, and after six weeks of taking this thyroid hormone replacement, he realized he felt as good as ever. Hypothyroid patients should not expect immediate improvement. Just as the symptoms of hypothyroidism develop slowly, a full response to treatment occurs gradually, it can take six weeks or longer. If the initial dose of levothyroxine needs to be adjusted, improvement takes longer.

Lewis decided he would not talk publicly about his thyroid disease until after the Olympic Games in Atlanta. He did not want the added distraction of his whole year being turned into a medical story. He is also not the type of person to make excuses. And, as he showed the whole world on July 28, 1996, five months after being diagnosed with hypothyroidism, he needed no excuses, he was back. Soaring through the air in the long jump to fulfil his dream and win one more gold medal, he became one of only two people in the history of the games to win nine gold medals during an Olympic career.

You can read more about Carl Lewis' Olympic preparation and his experience with hypothyroidism in his book *One More Victory Lap: My Personal Diary of an Olympic Year*, published by Athletics International

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Doctor-Patient communication

Practical advice for improving the conversations you have with your doctor

These days health-care can be viewed as a partnership between patient and provider, with both parties responsible for ensuring a constructive relationship. Patients – also now referred to as health-care consumers – are taking a more active role than ever in this regard.

Good communication is essential, of course, to any positive doctor-patient relationship, whether it involves your family physician or a specialist recommended by him or her. Following are some ways you can do your part to make the most of medical visits.

Before an appointment

- Make a list of things you want to discuss, in order of priority. Also jot down any symptoms you are experiencing, including their frequency, duration and intensity, and how they are affecting your daily life. Note, too, any treatments you have tried. Always take a list of the medications you're taking – prescription and over-the-counter drugs as well as any natural remedies – including the dose.
- Take along note pad and pen to jot down key information.
- Consider asking a good friend or family member to accompany you, they can help with processing information and remembering instructions. They may also have questions that hadn't occurred to you.

During the visit

- If you have a hearing or visual impairment, let the doctor know at the outset of the visit. If you have a language impairment from a stroke or other condition, such that it's hard for others to understand you, bring along someone who knows you well and can interpret your responses if necessary, or ask questions on your behalf.
- Share information. Provide as much detail as possible about any problems you are experiencing and how these are affecting you. Don't leave anything out – let the doctor decide what's relevant. Share your list of medications, too.

by
Lisa M. Petsche

- Be honest about your lifestyle and habits. For example, if you're diabetic, but you don't stick to the recommended diet, or you haven't been taking medications as prescribed. Let the doctor know about anything going on in your life that may be contributing to your situation – for example, a recent loss or other traumatic event that's causing significant stress.
- Write down important information provided to you. If you have brought someone along ask him or her to do this so you can give the doctor your undivided attention.
- Ask for details. If you're diagnosed with a medical condition, inquire about what to expect, including how long it's likely to last, treatment or management options, and where you can get more information. For any recommended test or treatment, inquire about cost, where it must be done, what's involved, benefits and risks, and alternatives.
- Request a layman's explanation if you don't understand the medical jargon used by the doctor. Summarize aloud the information he or she gives you, to check if you have interpreted it correctly.
- Don't try to be an expert. While there's a wealth of medical information readily available to consumers these days (especially over the Internet), and it's good to be informed, don't act as if you know more than the doctor does. Be tactful if you wish to challenge findings or recommendations. For example, it's much less threatening to say, "I've read about a new medication called X; what do you think of it for my situation?" rather than, "Why aren't you prescribing X?"
- Don't hesitate to voice your doubts, worries or fears. If, after your doctor addresses them you're still uncomfortable with a diagnosis or the treatment options presented to you, request a second opinion.

- Don't worry about taking up too much of your doctor's time. Ask all of your questions and express any concerns. However, prioritize your issues (lower priority ones may have to wait for another appointment), be concise and don't get off topic.
- Before leaving, make sure you are clear about any next steps – for example, whether you should schedule another appointment, when and how you'll learn of test results, and what you should do if your condition worsens or you experience an adverse reaction to a new medication.
- Ask about the best time to call if any more questions occur to you after you leave the office.

Lisa M. Petsche is a geriatric social worker and freelance writer who lives in Stoney Creek, Ontario

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Points to consider when talking to your doctor

When you go for a regular check-up, your doctor will ask you the same series of questions each time. The next time you're at the doctor's office, be ready with answers. Here's what to think about before the appointment date.

- Activity level
- Smoking habits
- Diet changes
- Alcohol consumption
- Blood pressure measurements
- Cholesterol and triglycerides tests
- Diphtheria, tetanus, polio booster (when was the last time you received a booster shot?)
- Changes in skin
- Weight
- Stressful situations
- Height and body type
- Blood sugar testing

Source: City of Ottawa

Chapter news

Avalon/St. John's

Amelia Hodder and a few volunteers are working to restore the Avalon Chapter to an active status. Anyone willing to help, please contact Amelia by telephone at 709-726-5479 or by e-mail: ahodder@roadrunner.nf.net

Burlington/Hamilton

On Sunday, July 14, the chapter held a used book sale in conjunction with a major Neighbourhood Community Garage Sale. In spite of the 95 degree weather our volunteers did a wonderful job. The site provided great exposure for our chapter and we are planning to repeat the sale next year. Thanks to all who donated books; the unsold books were donated to seniors' homes and other groups.

Our special series *Living Well with Thyroid Medication* sponsored by Dell Pharmacies has been a great success. This past September the chapter held its first public education meetings in St. Catharines and Brantford. These meetings were warmly received and we are looking forward to repeating them again next year.

As of June 02, our membership had increased 23% over last year. We would be pleased to hear from any of our members with suggestions for topics they would like to hear. Suggestions for fundraising are always welcome. We wish everyone all the best for the holidays. Please feel free to contact me, Tammy (your president) 905-304-1464.

Gander

Marilyn Anthony and Mabel Miller are very pleased to have the Gander Area Chapter up and running again. Activity has not been very brisk the past couple of years due to unforeseen circumstances.

Monday, September 30, Heather Paul, a psychologist and a thyroid patient herself, very aptly relayed her experiences in dealing with thyroid disease and the coping skills she uses. Those in attendance appreciated her story, her advice of looking after yourself and knowing about your condition. After Heather's talk, she answered questions and discussed the many ways of coping, especially for those whose medication for

thyroid disease has not been stabilized. Education materials were distributed, especially to those who were new to the organization.



Heather Paul, Psychologist speaking on "Living and Coping with Thyroid Disease" at a meeting of the Gander Area Chapter on September 30, 2002.

Kingston

M. Sara Rosenthal's Thyroid Town Meeting, September 17, was most interesting and generated a great deal of lively discussion. Much of the discussion was about depression. Sara put forth the suggestion that, in addition to taking medication, those suffering from depression might find it helpful to go for counselling.

Kitchener/Waterloo

The chapter held a successful 20th anniversary party on October 15. Former and current members and many new people enjoyed a delicious dinner. Prior to dining the guests heard an excellent talk entitled *Questions and answers about common thyroid disorders* by Dr. Daniel Drucker, Endocrinologist, Toronto General Hospital, University Health Network. The evening concluded with a silent auction and the distribution of door prizes.

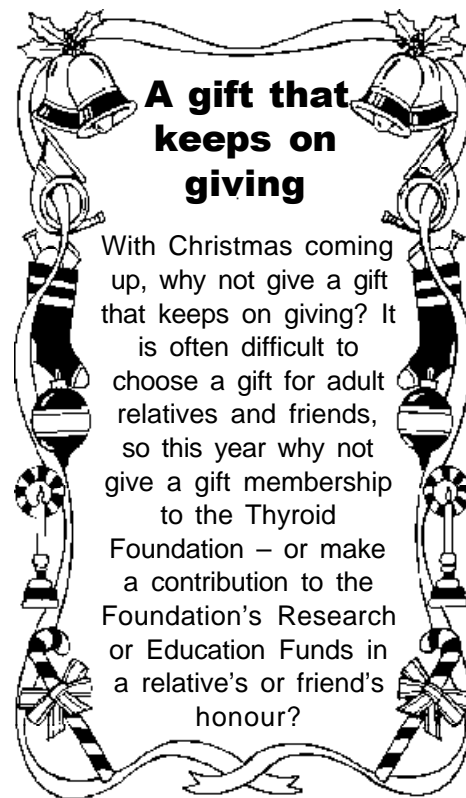
Ottawa

After some difficult times the Ottawa Chapter of the Thyroid Foundation of Canada is back in business again. We opened our public education meeting with an innovative presentation by Dr. Anna Bunda on naturopathic medicine. Dr

Bunda gave her presentation on Tuesday October 22, 2002 in the amphitheatre of the Civic Campus, Ottawa Hospital. Her topic was an introduction to naturopathic medicine and support for your thyroid. The new approach generated considerable interest and attendance. Volunteers are desperately needed to help us continue with our excellent programs. Please help. Call 613-729-9089.

Toronto

At the fall meeting, October 19, Toronto members had the pleasure of hearing Dr. William Singer, Endocrinologist, St. Michael's Hospital, Toronto speak on *Thyroid dysfunction: when, how and how often to test?*



The National Office

will be closed from

Friday

December 20, 2002

at 4:30 pm to

Thursday

January 2, 2003

at 9:00 am

Chapter coming events

Free admission – everyone welcome

Burlington/Hamilton

Location: Joseph Brant Memorial Hospital, Bodkin Auditorium, 1230 North Shore Blvd, Burlington.

- Tuesday November 12, 2002, 7:30 pm
Dr. G. Perez, Internist. Hamilton Health Sciences. Topic: *A general overview of hypo and hyper thyroid disease*. Please bring parking ticket for validation.

For information call 905-304-1464.

Gander

Gander Chapter hopes to visit other towns in the area soon to provide education materials and general information regarding the Thyroid Foundation of Canada. The next meeting of the Gander Chapter will be in November. Information will be available through the local media. Anyone willing to assist with the programs or help in any way is asked to get in touch with Mabel at 709-256-3073 or Marilyn at 709-256-7687.

Kingston

Location: Ongwanada Resource Centre, 191 Portsmouth Avenue, Kingston

- Tuesday, November 19, 2002, 7:30 pm.
Speaker TBA.

For information call 613-545 2327.

Monthly thyroid discussion

Location: Loblaws Market, Upstairs, Kingston Centre

- Fourth Sunday of each month, 3:00 - 4:00 pm. Discussion led by pharmacist Bozica Popovic, Manager. Sponsored by Loblaws Pharmacy.

For information call 613-530-3414.

Kitchener-Waterloo

Location: Community Room, Albert McCormick Arena, 500 Parkside Drive, Waterloo.

- Tuesday, November 26, 2002, 7:30 pm.
Dr. Merrill Edmonds, Endocrinologist, St. Joseph's Health Centre,

London. Topic: *Alternative therapies for the thyroid*.

For information call 519-884-6423.

London

Location: NEW! Central Library, Galleria, 251 Dundas Street, London. Two hours free parking for library patrons

- Tuesday, November 19, 2002, 7:30 pm.
Dr. Merrill Edmonds, Endocrinologist, St. Joseph's Health Centre, London. Topic: *Alternate therapies for the thyroid*.

For information call 519-649-5478.

London Spring Fundraiser

Location: Hellenic Community Centre, Southdale Road West, London

- **3rd Annual Fashion Show**, Thursday, April 10, 2003, Dinner and Fashion Show.

A wonderful evening, lots of fun, join us in supporting this worthwhile event. Tickets available for Christmas Gifts. For ticket information call 519-649-1145.

Montreal

- Please reserve the following dates for public education meetings:

- November 13, 2002,
- February 12, 2003,
- March 12, 2003.

Speakers and topics TBA.

- The annual art show will take place April 5 to April 11, 2003.

For information call 514-482-5266.

Ottawa

Location: Amphitheatre, Civic Campus, Ottawa Hospital

- Tuesday November 19, 2002, 7:30 pm.
Don't miss thyroid quiz evening with Dr. Mark Silverman, Endocrinologist.

For information call 613-729-9089.



Men's thyroid problems

Women have eight to ten times the thyroid problems that men do. But men have their difficulties.

Being sub-thyroid (hypothyroidism) means the whole system is dragging, lethargy and depression are common, and a decreased libido is part of that. Muscles sometimes look bigger but they are weaker. If caused by a thyroid problem, these problems go away with proper treatment.

Having too much thyroid hormone (hyperthyroidism) can lead to muscle wasting and weakness, especially in thighs and upper arms. It can also upset the balance between the principal male sex hormone (testosterone) and the female sex hormone (estradiol) in the body; Sperm production may be impaired. There may be breast tenderness or enlargement. Libido is reduced and difficulty with erection is common. If the thyroid gland is the culprit, these problems clear up when the thyroid hormone balance is restored to normal.

Thyroid cancer is rare, 1.6% of all cancers in women, and 0.6% of all cancers in men. However, if there are nodules in the thyroid gland, in men they are more likely to be cancerous.

Be sure your physician examines your thyroid (in the front of your neck) and orders a thyroid stimulating hormone (TSH) blood test if it seems possible your thyroid is not working right. This is especially true if you have a close relative with a thyroid problem or related immune disorder such as pernicious anaemia, rheumatoid arthritis or Type 1 diabetes. It is also likely that your risk is also higher if you or a close relative begin to get gray hair before age 30.

*Published by The Thyroid Foundation of America Inc. Reproduced with permission from **Thyroid Flyer**, newsletter of Thyroid Australia Ltd.*

Foundation's mailbox

Dear Eileen Davidson:

Two days ago I received the Summer 2002 *thyrobulletin*. I joined the Thyroid Foundation of Canada from the first advertisement in the *Montreal Star*. During all those years I read and bought most of the books that used to be available, and I remember when I returned in 1986 to Israel and saw my GP and told him all my knowledge of the thyroid he told me, "You know more than me".

Now I was happy to read that you are a stamp collector and pen friend. For over 28 years I had, and still have, pen friends all over the globe, and I used to collect used stamps. I will be happy to send you a lot of stamps for you and your club members, and I would be happy to get in return Canadian used stamps. Please send me the address where to send the used stamps.

Also I would like to have some Canadian Pen Friends. Sorry, I don't write or speak French although I lived in Montreal from 1953 to 1986.

I think that next year it would be nice for the Thyroid Foundation of Canada to wish all its Jewish members a Happy New Year – September 6, 2002 – 5763 years. Shalom

Betty Pivko, PO Box 6952,
Ramat-Gan 52168, Israel

To the Foundation:

I wish to respond to the letter from Emilia Moon-de-Kemp (*thyrobulletin* Summer 2002). I hope this makes sense to the reader in support of this publication. If it does not perhaps it's because I do not feel too well!

As a member I regret that you feel you have not benefitted from *thyrobulletin* and have chosen not to renew your membership. On the contrary, I feel I have benefitted enormously from my membership and all copies of *thyrobulletin*. I have renewed since 1995.

The knowledge and education I have received regarding my disease came over a period of time in each edition. I feel I did gain something from each publication. I did not gain everything I have learned from one issue but over several years of renewing my

membership. I read each copy thoroughly even though it may not have applied to me specifically, took what was applicable and useful to me in managing this disease and stored it in my memory bank. The time came when I was able to impart that useful information to someone who did not have my specific type of thyroid condition and did not know this source of valuable information was available to them. Hopefully it helped to provide them with the answers they were looking for, as their doctor did not provide them with either.

The information sharing is priceless! Not all of it applies to me as an individual but to a membership of several people who share common concerns.

Medical professionals impart knowledge to me in a very inexpensive way through *thyrobulletin*. Any information I have gained through *thyrobulletin* about my disease did not come through my family physician or the specialist who treated me. Had I not received *thyrobulletin* through my membership I would not have known, for example, the following:

- Education in understanding this disease helps me to manage it effectively. No doctor provided this to me at the time of diagnosis.
- Iron supplements – the two hour absorption time in conjunction with thyroxine intake can affect how you feel. Patients have been known to supplement with iron to counteract symptoms of fatigue associated with thyroid disease. No doctor told me this.
- Diet and nutrition advice contained in *thyrobulletin* is very important in managing this disease. I took what was applicable to my condition and try to follow it. It helps to offset the cost of health care so my physical and mental well-being are not affected by poor diet and nutrition.
- Support through little tidbit articles from other members interspersed throughout the pages of *thyrobulletin* make it interesting to read.
- Medication management through contributory articles by professionals in research relate the importance of knowing how drug interactions from

other medication you may be taking can affect your thyroid condition, requiring adjustments in thyroxine intake. This is extremely important to know in managing this disease or we can become desperately ill without knowing the reasons. Learn your drug profiles.

- Any medical information I have gained regarding self-care and management of my thyroid condition did not come from the doctor who diagnosed my thyroid condition in 1994. It came from doctors, other medical professionals and information sharing from the memberships who contributed articles to *thyrobulletin*.

As a constructive project of my own, I have taken my several years collection of *thyrobulletins*, extracted those articles applicable to myself, making it a little easier to keep track of managing my specific condition by making a small booklet of my own. I find it very helpful.

In support of the Thyroid Foundation of Canada who provide *thyrobulletin* to me at a relatively inexpensive annual cost of only \$20 I have gladly renewed my membership. I could not manage my disease without it.

Thank you for allowing me to express my opinion and experiences through the Foundation Mailbox.

Sharon A. Lloyd, Hamilton

Sincere Condolences

to
Dr. and Mrs. Paul Walfish
upon the accidental death
of their daughter Marci
July 5, 2002

Dr. Walfish is the author of several of the Foundation's *Health Guides on Thyroid Disease*, a long-time member of the Peer Review Committee and a strong supporter of the Foundation.

Thyroid Foundation of Canada

Health Guides on Thyroid Disease

The following Health Guides on Thyroid Disease are available in English and French.

The information in these Health Guides was provided by Drs. Jody Ginsberg, Ian R. Hart, Irving B. Rosen, Sonia R. Salisbury, Robert Volpé, Paul G. Walfish and Jack R. Wall. The medical information in these brochures is for general patient education. For individual treatment or diagnosis consult your personal physician.

1. *The Thyroid Gland: A General Introduction*
2. *To Confirm the Clinical Diagnosis*

3. *Hypothyroidism*
4. *Thyroid Nodules*
5. *Thyroiditis*
6. *Graves' Hyperthyroidism (Thyrotoxicosis)*
7. *Graves' Eye Disease (Ophthalmopathy)*
8. *Thyroid Disease, Pregnancy and Fertility*
9. *Thyroid Disease in Childhood*
10. *Thyroid Disease in Late Life*
11. *Surgical Treatment of Thyroid Disease*
12. *Thyroid Cancer*

13. *Common Concerns of Thyroid Patients*

All Health Guides are available through the Foundation's national office or from your local chapter (see back page). Please send a self-addressed business size envelope stamped with two 48 cents stamps.

Tous les Dépliants Santé sur les affections thyroïdiennes sont disponibles auprès du bureau national de la Fondation ou de votre section locale. Veuillez nous faire parvenir une enveloppe d'affaires adressée à soi et affranchie de deux timbres de 48 cents.

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New memberships run for one or two years from the receipt of this membership application.
All members receive *thyrobulletin*, the Foundation's quarterly publication.

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Helen Smith, Membership Services Coordinator/Coordinatrice des services aux membres

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