This three-page article is NOT a research paper, but a commentary written by Anthony Weetman. The reason it finds a place in “Thyroid Update” is that it has been published in an international scientific Journal and deals with a fascinating and important topic.

A group of patients in the UK has just lodged a petition with a Member of Parliament and the UK General Medical Council, as ‘a formal complaint against the clinical practice of the majority of the medical profession with regard to the diagnosis and management of hypothyroidism on four counts:

1. Over-reliance on thyroid blood tests and a total lack of reliance on signs, symptoms, history of the patient and a clinical appraisal.

2. The emotional abuse and blatant disregard by the majority of practitioners and endocrinologists over the suffering experienced by untreated/incorrectly treated thyroid patients and their lack of compassion over the fate of these patients.

3. Stubbornness of general practitioners and endocrinologists to treat patients suffering from hypothyroidism with a level of medication that returns the patient to optimum health. In addition the unwillingness to prescribe alternate thyroid treatment for patients on individual grounds .... such as Armour thyroid.

4. The ongoing reluctance to encourage debate or further research on hypothyroidism.’

This has led the Member of Parliament to take the matter up with the Royal College of Physicians in London.

**COMMENT**

Dr Weetman discusses the background of the petition in the UK. A thyroid patient advocacy group lists on its website (www.tpa-uk.org.uk) the campaign it is mounting calling on the UK government “to raise awareness ... of the dangers of misdiagnosing an under-active thyroid”. The same website makes the startling assertion that “approximately 25% of the total population of the UK suffers from hypothyroidism and also supports the wider use of Armour thyroid extracts”.

Dr Weetman discusses the reasons why some patients are dissatisfied with and so mistrustful of standard medical advice and practice. He brings up several arguments to answer these questions. One argument is that we live in an era of post-modern medicine, implicating evidence-based medicine and scientific certainty to base our medical decisions. Another argument is the easy access to information by patients, having increased vastly due to the Internet. The point is that – by definition – anything can be found on the Internet and patients are not trained to distinguish between valid and unreliable ‘pseudo-scientific’ information. Dr Weetman argues that the majority of patients who demand thyroid hormone treatment for multiple symptoms, despite normal thyroid function tests, have functional somatoform disorders, which in the post-modern world can understandably be misdiagnosed as hypothyroidism. Another issue raised in Dr Weetman’s commentary is that of
“healthism”. Healthism is characterized by the following features: high health awareness and expectations, information seeking, self-reflection, distrust of doctors and scientists, healthy and often alternative lifestyle choices, and a tendency to explain illness in terms of folk models of invisible germ-like agents and malevolent science. The advance of healthism has its roots in postmodernism and accounts for the increasing number of bilaterally unsatisfactory consultations with patients who have an unshakeable self-diagnosis or a demand for ‘natural’ rather than ‘synthetic’ treatment. Another way of looking at this issue is to recognize the constantly increasing number of patients who often practice ‘medical shopping’, especially in the thyroid field. Dr Weetman discusses another reason for the unhappiness of some patients, arising from an innate sense of disbelief in science, heightened by the lack of consensus among endocrinologists, particularly with regard to the diagnosis of subclinical hypothyroidism and the need for treatment. Yet another concern for patients is the recent debate about narrowing the serum TSH reference range (say from 0.4-4.0 to 0.4-2.5 mU/L). As with the treatment of subclinical hypothyroidism, this is a complex area, demanding a sophisticated knowledge of laboratory medicine and experience in clinical endocrinology to interpret correctly lab results and then integrate these data into an adequate assessment of thyroid function and finally translate this intellectual pattern into everyday clinical practice.

Finally, Dr Weetman asks: what can be done? The scientific debate must continue; more research is needed to answer the dark corners of our lack of knowledge; areas of scientific uncertainty must be communicated in an open manner; medical care providers should retain a sense of perspective, scepticism and humility when facing the range of educational, social, and cultural differences that can exist between doctor and patient. Communication lies at the heart of managing patients whose health problems cannot be rationally explained and the focus should be on the patient’s concern, the relief of symptoms and the avoidance of alienation. As functional somatoform disorders are dissected further by new knowledge, innovative and evidence-based ways of managing these common and troublesome disorders will undoubtedly become established. In the mean time, we must avoid endocrinological collusion as a strategy, which in turn requires the avoidance of thyroid hormone treatment in euthyroid individuals. Physicians must do what they have to so often when evidence is incomplete: use their own best judgment about the optimal management for their individual patients.

(Daniel Glinoer MD, PhD)
Production of the thyroid hormones, thyroxine (T4), and triiodothyronine (T3), increases by nearly 50%, in conjunction with a separate 50% increase in the daily iodine requirement. These physiological changes happen seamlessly in healthy women, but thyroid dysfunction can occur in many pregnant women because of pathologic processes. For these reasons thyroid function is frequently assessed during the gestation period. In 2011, the American Thyroid Association (ATA) first published guidelines on the diagnosis and management of thyroid disease during pregnancy and postpartum (1). There has been a substantial amount of new literature in this area since that publication. Answering Key Questions About Thyroid Treatment. Hormone Replacement Therapy Hypothyroidism Men Thyroid Women. by Charlotte October 22, 2019. by Charlotte. When Robert was first diagnosed with hyperthyroidism, he felt a huge sense of relief. Many of us hesitate before making permanent changes to our bodies—rightfully so. Why would it be necessary to permanently disable or remove the thyroid gland? In some cases, the truth is that it isn’t a necessity, but a personal choice; some people decide, for a variety of reasons, that radioactive iodine or thyroidectomy is preferable to other forms of treatment. In other cases, the individual may not respond well to other therapies, and serious intervention is necessary in order to prevent their condition from progressing. Do you even need thyroid hormone replacement? Hashimoto’s accounts for 90 percent of hypothyroidism cases in the United States. When the autoimmune disease is successfully managed, thyroid hormones may not be necessary. However not taking them when you truly need them can have disastrous consequences for your health and well-being. People who have difficulty converting T4 to T3, or whose cells have become resistant to thyroid hormones, do better with thyroid hormones that include T3. However some people develop hyperthyroid symptoms with T3 support—feeling wired, nervousness, insomnia, heart palpitations, etc. Even when thyroid hormone replacement is used, it is still vitally important to manage the autoimmune condition.