NUTRI-SPEC

THROUGH
SPECIFIC NUTRITION
89 Swamp Road
Mifflintown, PA 17059
800-736-4320
717-436-8988
Fax: 717-436-8551
nutrispec@embarqmail.com
www.nutri-spec.net

THE NUTRI-SPEC LETTER

Volume 14 Number 3

From:
Guy R. Schenker, D.C.
March, 2003

Dear Doctor,

After reading the last two issues of this Letter, you are aware of just how …

THYROID DYSFUNCTION FITS INTO YOUR NUTRI-SPEC ANALYSIS.

Here is a summary of what you have learned:

- The thyroid gland produces T4 (the storage form of thyroid hormone) and T3 (the active form of the hormone).

- Under ideal circumstances T4 is converted to T3 as needed by the liver, and also to some extent by the kidney and other tissues.

- An insignificant amount of T4 is converted into reverse T3 (RT3).

- RT3 binds with T3, which blocks the action of T3.

- A stress response that involves excess cortisol output will inhibit the conversion of T4 to T3 while simultaneously favoring the conversion of T4 to RT3.

- RT3 dominance is a condition that is far more common than is recognized by most health care professionals.

- Synthroid and most other thyroid medications are pure T4 (with no active hormone).

- Synthroid can actually decrease thyroid activity by providing more T4 to be converted into reverse T3.

- Synthroid can also inhibit thyroid activity or mask a thyroid problem by providing enough feedback to the pituitary that the pituitary decreases TSH output, which subsequently results in less thyroid gland output of T3.

- Serum tests for thyroid function are frequently worthless, and often misleading.

- To do your most complete serum evaluation of thyroid function you must perform four tests: TSH, T4, T3, and Thyroid Microsomal Antibodies.

- If the four serum tests are normal you still cannot rule out thyroid insufficiency in your patient.

- A far more reliable way to evaluate thyroid activity is with functional considerations such as those built into a complete history and your NUTRI-SPEC test procedures. These include:

    - elevated cholesterol accompanied by normal or close to normal triglycerides.

    - fatigue and/or somnolence

    - insomnia

    - hypertonic muscles and muscle cramps

    - fluid retention

    - elevated percent body fat

    - Fibromyalgia

    - apathy or depression

    - a parasympathetic imbalance that resists correction with NUTRI-SPEC, indicating a possible primary thyroid insufficiency

    - an anaerobic, ketogenic or parasympathetic imbalance that fails to respond sufficiently to NUTRI-SPEC, suggesting the presence of reverse T3 dominance

- A Pulse 1 of less than 68

- Low body temperature

- A deep tendon reflex recovery failure

For a detailed explanation of the above points of information regarding thyroid function review the last two NUTRI-SPEC Letters.

Now, let us take what you have learned about evaluating thyroid function in your NUTRI-SPEC patients and see how it applies to some clinical cases.

Here is a case you will find quite interesting I am sure.

Janet, a 47 year old school teacher, came to my office with the following conditions and complaints.

- probable multiple sclerosis
- Crohn's Disease
- Hypertension and irregular heartbeat
- Degenerative disc disease
- Fatigue and weakness
- Blurred vision
- Gastric reflux
- Inability to concentrate
- Depression
- Pain and numbness on the left side of the face and head

The medications she was taking included:

- Effexor to treat depression
- Nexium to treat her gastric reflux
- Avapro (an angiotension II blocker) to treat her high blood pressure
- Lipitor to treat her high (310) cholesterol
- Premarin (a whopping .925) because she had had a hysterectomy 6 years ago
- Neurontin to treat who knows what. It was prescribed by the Neurologist who thinks she probably has multiple sclerosis and was likely prescribed just because it is a toy neurologists seem compelled to play with when they don't know what else to do. (-- Actually it was for her head pain, but even though it provided no relief, she was kept on it.)

Her history included:

- use of birth control pills for 3 years when she was first married years ago (which made her "fat and nasty")
- a long history of heavy bleeding and cramps with her menses, often accompanied by migraine headaches
- during a pregnancy 19 years ago she experienced vomiting for the first 5 months and then required bed rest during the last half of the pregnancy
- one year later she experienced severe bloody diarrhea and after 2-3 years was finally given a diagnoses of Crohn's Disease. She was then given steroids and sulfa drugs for years to treat her Crohn's Disease.
- Though she is no longer being treated with steroids and sulfa drugs for Crohn's, she still has symptoms of extreme diarrhea any time she is under the least bit of stress
- Six years ago the severity of her menstrual bleeding increased dramatically to the point that she had 5 months of continuous bleeding. A uterine fibroid was found and a complete hysterectomy was performed.
- Immediately after the hysterectomy she was put on Premarin (.625). RED FLAG!
- In March of 2001 she was put on Celexa, an SSRI, for depression. RED FLAG!
- In December of 2001 she experienced extreme pain on the left side of her head; her face dropped and went totally numb, yet she tested negative for Bells Palsy. At the same time her blurred vision, which she had experienced off and on before, became much worse, as did her fatigue, weakness, and inability to concentrate.
- It is now 10 months later in September 2002 that she walks in to my office, and the Neurologist is still trying to prove that she has MS.
- In December 2001 when the symptoms became so severe the Celexa was discontinued (fortunately). However, she has more recently been put on Effexor which is probably just about as bad.
- Four months ago, in May of 2002, after 6 months of severe and inexplicable symptoms, one of her doctors increased her Premarin from .625 to .925, apparently because he didn't know what else to do and somehow thought more estrogen could help all these estrogen stress symptoms.

What did I do with this patient? The same thing you would do --- performed the NUTRI-SPEC test procedures.

Knowing full well that the medications in this case would likely make QRG test interpretation almost impossible, I considered getting this patient started on the Diphasic Nutrition Plan. However, since the tests did lean a little toward the dysaerobic side, and since she had such an extreme predominance of dysaerobic conditions including:

- high cholesterol
- diarrhea with bloody stools
- diagnoses of Crohn's Disease (an auto-immune disease)
- a tentative diagnosis of MS (another dysaerobic, auto-immune disease)
- hysterectomy at an early age, leaving her with absolutely no progesterone, a deficiency of which makes a woman dysaerobic.

So, I decided to do a clinical trial treating her as dysaerobic. Even though I suspected an electrolyte stress was being masked by her blood pressure medication I didn't really feel the need to treat the electrolyte stress pattern because her blood pressure was really quite low already and I expected to be able to get her off her blood pressure medication without addressing an electrolyte stress imbalance.

Having made that decision, I had to look through the history for as much information as I could find to guide my recommendations. The first thing I considered, of course, was the presence of two red flags --- an SSRI drug, and an outrageous dosage of estrogen. The patient was given the handout we have on the damage done by SSRI's, with the advice to discontinue taking it immediately.

She was also given the information on the damaging effects of estrogen stress. It was explained to her that many of the symptoms that she had experienced throughout her life, including the menstrual and premenstrual symptoms, plus the negative reaction to birth control pills, plus the extremely stressful pregnancy she had had, plus the uterine fibroid, were all the result of a hormone imbalance involving excess estrogen and/or too little progesterone. She was given the protocol for slowly backing off the estrogen.

Her dysaerobic regimen included Diphasic P.M. due to the severity of the oxidative stress she was suffering, and, because chronic diarrhea was part of her dysaerobic state, she was given glutamine as part of her NUTRI-SPEC regimen, plus a temporary recommendation for Sialex as an adjunct to assist glutamine in the rebuilding of the structure and function of her intestinal mucosa. She was also given the natural progesterone she so desperately needed.

I also noted the presence of some potential thyroid insufficiency indicators in her history. First, there was the cholesterol of 310, accompanied by triglycerides of 147. Triglycerides of 147 is definitely above normal but not nearly as far above normal as her cholesterol level.

The patient was also over weight and retaining fluid. This could very well have been exclusively due to the Premarin she was taking, but I

noted it nonetheless. Adding in the fatigue, inability to concentrate, and depression, I decided that while I was going to make the dysaerobic imbalance and the estrogen/progesterone imbalance my top clinical priorities, I would nevertheless keep the thyroid in mind.

I went ahead on that first office visit and checked her body temperature, finding it to be sub-normal. I also preformed the deep tendon reflex recovery test that I explained to you in last month's Letter and found the most extreme positive response I had ever seen. When I tapped her forearm with the reflex hammer her fingers popped up in the air and then literally stuck there, dropping slowly and in distinct steps back to normal over a period of many, many seconds. Nothing was done about the thyroid in that first visit other than to mention to the patient that it could be a complicating factor that we would have to address at a later date.

The patient followed my recommendations to the letter. Within 4 weeks she was feeling better than she had in years. She had quit the Effexor and the Lipitor immediately after her first visit. She had also immediately begun the protocol for getting off Premarin and by now, four weeks later, she was down to taking it only 3 days per week. Her diarrhea of years, and years duration had stopped completely. In fact, we had already cut back on the glutamine because she actually experienced a little constipation. She now had very little facial pain, and her fatigue, weakness, and poor concentration had all improved dramatically.

Though the patient and I were pleased with the progress in four weeks with her severe symptoms and conditions, many of the little nagging things were still there. She was still retaining a tremendous amount of fluid. She, despite following the NUTRI-SPEC Fundamental Diet and radically decreasing her carbohydrate intake, had not lost any weight; her body temperature had improved somewhat but was still sub-normal; and, the deep tendon reflex recovery no longer failed to such an extreme, but was still quite evident.

So --- it was time to seriously consider the possibility of thyroid involvement. You'll read the happy ending to this story in next month's Letter. Meanwhile, look for those thyroid signs (they are often indistinguishable from signs of estrogen stress) and begin to assess which of your patients are suffering from either primary thyroid insufficiency or reverse T3 dominance. Never forget --- we welcome your calls for assistance on difficult cases.

Sincerely,