

79 - Hyper an Hypothyroidism

BioBalance Podcast — Dr. Kathy Maupin and [Brett Newcomb](#)

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Kathy Maupin: Welcome to Biobalance health cast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. And normally on these podcast we talk about various elements of hormones and hormone replacement and conversational topics because we're trying to understand the topic of hormones and how they work in the body. Today we're not going to talk about testosterone we're going to talk about another element in the puzzle. We're going to talk about the thyroid. Because what has emerged is a lot of information that says the thyroid, whether it's under functioning, over functioning or appropriately functioning, is just as critical in a healthy stable life after menopause. And so we want to talk about the thyroid because a lot of time issues with the thyroid are not diagnosed or not identified. Sometimes the lab results don't give a clear picture or an accurate picture. I mean there are a lot of issues that can occur. And the reason we want to talk about this today is April 23 just two days ago an article came out in the archives of internal medicine looking at sub-clinical hypothyroidism and fatal or nonfatal cardiovascular events. So first let's define some terms. Talk us through hypothyroidism, hyperthyroidism and subclinical. What do those terms mean?

KM: Hypothyroidism is a very low thyroid. Your thyroid is in your neck, it runs your metabolism. It runs how warm you are how you metabolize your calories.

BN: So I'm not really fat, I just have a low metabolism.

KM: Yea, see? Or your thyroid's low, causing that. And thyroid patient who have a low thyroid have swelling all over. They look very swollen in general. Or they also have a very slow intestine. So they usually have constipation, unless they have some other GI disease. They also gain weight rapidly and don't lose it. They feel cold when others are hot. Their basal temperatures are low. Usually they stop having periods or have irregular cycles if they're premenopausal. They have infertility. The thyroid manages everything in your body. It's not as universal as the pituitary that runs every single gland in your body. But the most universal gland the thyroid. Thyroid takes care of every single cell in your body, and has receptor sites on every cell. So having a thyroid that works optimally is very important for your lipids. Your cholesterol goes up if you have low thyroid. So if you have high cholesterol in the old days we used to check for low cholesterol with a low thyroid when we got results back that showed a low thyroid. And if the cholesterol was elevated we treated thyroid and the cholesterol came down. So it affects everything.

BN: And now they just treat they cholesterol and they don't assess the thyroid.

KM: Right, and it's bothersome because it's not really treating the problem, it's treating a symptom of the problem.

BN: Yea it's like putting a gas additive in your car to get better mileage instead of tuning your car up.

KM: That's right and thyroid affects so many other things. They could kill 20 birds with one stone. They could help people lose weight. You know doctors could actually tend to what's really bothering the patient. Which is I can't lose weight even when I exercise every day and eat very little. That's really what thyroid patients say.

BN: So medicine by symptom management is more expensive.

KM: Well if you're looking at one symptom.

BN: Well you treat that one and they come back for the next one.

KM: That's right, it is. And it's many more drugs, because cholesterol drugs are very expensive. And thyroid is very cheap. So for us to actually treat symptoms and prevent illness it's much more economical to treat with a thyroid medication if that's the problem. Now hyperthyroidism is different. Hyperthyroidism is the reverse. Patients are very nervous and anxious their hearth rate goes up. They lose weight quickly they're hot all the time. They move around all the time. It's kind of like an A.D.D. kind of thing in general.

BN: They're wired.

KM: They're wired, but it's not a psychological problem it's a thyroid problem. And often time it's misdiagnosed. Because if you don't take a temperature you can't find a fever, if you don't test the thyroid you can't find hyperthyroidism. But when it is found usually drugs are giving to shut it down, or radiation's given.

BN: You just used some terminology you're talking about testing it. Earlier in the conversation you're going through a list of symptoms that come out of a clinical interview. If you sit down with a patient and you say tell me what's going on you with you. Are you constipated, do you get cold easily? And you go through this checklist in your head that tells you as an experienced physician, I need to be looking at a thyroid problem. Then you get a lab test? But sometime the lab test doesn't say thyroid problem but all the symptoms do. Then what do you do with that?

KM: Well that's called subclinical hyperthyroidism.

BN: That's what we're talking about oddly enough.

KM: And inversely it is if you have a thyroid test that shows hyperthyroidism but no symptoms. This study says that should be treated as well. But lab tests that show hypothyroidism without symptoms and symptoms without the lab test are considered subclinical and they should be treated and they should be treated for many reasons but studies have to be honed down usually to one variable. And this variable was the rate of heart disease and can replacing thyroid, the question they wanted to answer was, can we prevent heart disease and heart attacks and fatal heart problems by replacing thyroid? Now that's very conservative in terms of money and that's, for the patient, that's awesome, that's preventative medicine. So that's what this study was asking. That's the question they were asking.

BN: For hypo not for all thyroids. For hypothyroid.

KM: Yes and there's lots of other diseases that you can have associated with the thyroid. But we're talking about a slow or a low or inactive thyroid. And that is what's most dangerous in terms of heart disease.

BN: Ok, so they're trying to isolate the variables out in terms of looking at the heart disease issues, either fatal or non fatal heart disease and we'll differentiate among those in a minute, and why there's a concern. But if we're looking at heart disease issue and we identify one variable, the thyroid and if the thyroid is under performing, is there more likelihood of a heart issue over time? And if you treat the underperforming thyroid, do you alleviate the risk of the heart issues?

KM: Right because when you do a study, just because you find out that a low thyroid causes this, doesn't mean that treating that low thyroid will prevent it.

BN: So it could be a corollary as opposed to causation. It could be just simultaneous events. So they look for the linkage.

KM: They look for the linkage and that's a very good study to look for the linkage and they found that not only does hyperthyroidism cause non fatal and fatal heart events but they also found out by giving and replacing thyroid to an optimal level will also prevent this and that's very important because it added the variable of thyroid and heart disease and tied them together because now we can prevent it.

BN: Right and fairly inexpensively and fairly easily because thyroid medicines are not that expensive and they're pretty easy to take with side effects not being an issue and then it increases the odds that you won't have an ischemic heart disease.

KM: Ischemic means that you won't have apoxy or no oxygen going to the heart itself. Usually that means a blockage of a blood vessel with arthrosclerosis or cholesterol deposits. But it can be any kind of low oxygen level that causes damage to the heart muscle.

BN: So obviously or I think obviously fatal heart disease is self-explanatory and we know why that's an issue. But what about non fatal heart issues? What's the concern there?

KM: Most people don't realize that when you have a heart attack that a heart attack means that part of your heart muscle has been damaged. The vessel going to it was blocked so that you could not get enough oxygen to an area of the heart. There are many vessels that go to feed the heart. Even if one of them is blocked it can cause that muscle to die. And the heart muscle depends on an entire circumference of muscle squeezing. So if part of that doesn't squeeze as well then you end up not getting the blood flow to your legs, not getting blood flow to your brain. It decreases your cardiac output. It makes the work of the heart harder. What's present and accounted for has to work harder to get blood to the rest of the body. And your kidneys won't work as well, you won't feel as good, and you'll be tired. So often times if you have a non fatal heart attack from lack of oxygen to the muscle, you're debilitated. And that's a terrible outcome to have, especially after menopause. Especially even in men who are older their testosterone is down, women's testosterone is down. By the time we usually have the hearts problems, we are post-menopausal, post-andropausal.

BN: Yea, typically.

KM: And then the muscle doesn't grow back and so then we're left with a life that is confined to a chair, you can't exercise, you may have to use oxygen. And that's a terrible way to live. It takes productivity away from us. It takes the joy of life and the joy of just being able to produce something, go to work, take care of our kids. So that's a huge deal and if we can prevent that through giving levothyroxine which is the generic of synthroid or armour thyroid or cytomel there are many different forms of thyroid they just use levothyroxine in there tests because it was a generic and most inexpensive. But if we can use that and replace what's missing in terms of our other hormones like testosterone and estrogen then we have ea much lower risk of dying of heart disease or even damaging our heart because it's also known that testosterone helps us repair the heart even after hypoxia which is low oxygen. So we are able then to take what we know and add it to this to create the most preventive situation for a patient. Give them back their thyroid, give them back their testosterone, give them back their estrodial if they're women and that puts them in the best place to resist having a fatal or non fatal debilitating heart attack.

BN: So the quality of life is a factor here because you tend to think heart attack people die. But most people don't die from a heart attack.

KM: I'd rather die than have a debilitating heart attack. Because that to me my life would be over as I know it. And that would be very, very difficult but the fact that I take testosterone and I take estrodial, that would help me recover from that. In fact I have one patient who is male and is 64. And he had a terrible heart attack and he had just started taking testosterone. And it damaged so much of his heart that they said he

would only get a certain amount of his cardiac output back. And he may not be able to exercise and he may not be able to live his life.

BN: And his cardiac doc looking at what you proposed for him looked at it from a standpoint of what Dr. Maupin wants to do going to cause any damaging side effects? And he couldn't find any so he said I don't believe it's going to hurt him but it's not going to help. So you put him on this treatment protocol. How did he change?

KM: This was continuing to replace his testosterone. We had already started that but he hadn't been on it long enough to protect his heart. So when he had this heart attack. He said I really want testosterone it makes me feel better, it makes me leaner it's going to help me recover he didn't really think about the heart muscle. He thought about all the other muscles. But what it did was help repair his heart muscle.

BN: That's awesome.

KM: I know. It's amazing. And his doctor, I sent all of the research; I sent tons of paper so his cardiologist could make a decision on his own. And I waited on that decision. I know him also socially and I see him out and he is just as energetic and awesome as ever was

BN: Your patient, not his doctor.

KM: No, no, no, sorry, my patient. And his doctor is amazed. He's never seen anyone with the damage he had come back to normal. And he's normal.

BN: Yea and the reason we're talking about this part and we've shifted back into testosterone and testosterone replacement is the study that was reported in the archives of internal medicine did find a positive uptick in treating hypothyroidism in younger patients. But for those 70 and older the incident of heart disease issues didn't improve. It didn't get worse but it didn't get better. So what they said was that if we catch you young enough and we treat your thyroid, we can avoid or delay these events. If you're older then we can't say the same thing. We don't know what to do with that but we can't say the same thing. And your argument is that if they replace in the elderly population in the elderly population that replaces testosterone their overall quality of life and muscle strength will get better.

KM: And muscles of the heart.

BN: And particularly the muscle of the heart, because this man is a good example of that.

KM: Yea he's an excellent example and I'm hoping to see more patients from this cardiologist who now has seen it work sending me patients who I can then help get back to the usual life. Because we identify with patients who we're very much like. And the patients that come to see me want to be productive and they want to go back to

work and they want to exercise and they want to have a healthy life so they're looking for that. And I don't want to have a heart attack, or something like that, impair them from their life. They need it all. They need their thyroid if they've lost it or if it's decreased. They need their testosterone and they need their estrodial because estrodial is also cardio protective.

BN: You know it must be phenomenally pleasing and comforting to you to make that kind of impact like that in somebody's life. I mean this guy comes in. He's nearly dying, he's not able to walk he's not able to exercise.

KM: He literally looked gray.

BN: His skin color is off because his oxygen content is off. And in a few months of treatment he's walking, he's exercising, his color is good, his heart muscle is stronger.

KM: He was dancing to the Beatles the last time I saw him. And he was amazing. So he looks like he did, actually he looks better than he did because he lost weight. This scared him, he lost weight and so he looks even better than he did three years ago. So this study for me is documenting what I always believed. That if someone has symptoms of thyroid without the lab or the lab without the symptoms they should be treated. And there's many more reason, losing weight and decreasing you're swelling and decreasing your cholesterol.

BN: Regulating body temperature, comfort, all those things. And you know it's not a new topic. Cardiologists are looking at it now, but gynecologists were looking at it as long ago as 2006. You were talking about a study in the gynecological journals about hypothyroidism but you had an interesting twist to your understanding of why they were looking at it.

KM: Well in OBGYN the center of attention is on fertility and on young women. And the questions was should we even look for low thyroid in young women and it was for fertility. Because if you have.

BN: So if you're not fertile and you're not trying to be fertile than they are not as focused on or concerned about you.

KM: I mean, I'm a OBGYN and I'm board certified and I'm a fellow in the American College of OBGYN and I had very little training in post menopausal care. It was just give them hormones or don't give them hormones, that was it. And hormones meant estrogen and progesterone or just estrogen.

BN: So it didn't mean thyroid. And it didn't mean testosterone.

KM: It didn't mean testosterone. And there was very little about caring for people after the age of 40 something when they stopped producing. Because we do deliver babies

and we treat infertility so that's primarily one of the things we are trained to do and we have lots of hours in those areas. But we have very few hours in clinical management in the menopausal patient. And when I read this study and I pulled it I pulled it because it's hypothyroidism and I treat hypothyroidism of all ages and I always have because I've had this problem myself since I was in my 20's. So for me this is a near and dear subject and I've read all the literature on it to make sure that my being replaced was proper and being replaced does solve all my problems, all the symptoms of hypothyroidism. I can always tell if I didn't take my thyroid because in a day I'll know if I have those symptoms. So this is a big topic. And it's not just big for people trying to have babies. It's big for all of us. And it's a huge impact on how we live daily and how we're going to live when we're older so for me looking back at 2006 when OBGYN looked at this, they have all the information. But they don't have the information that's centered on women who are post-menopausal thyroid replacement. It's more about women who are cycling. Because you can stop cycling altogether if you don't have thyroid. I mean women stop having periods. That's one of the signs in young women.

BN: Yea. They stop or they have breaks or they have a period for three months and then you don't have one and then you have another one or it stops or what?

KM: It effects ovulation. So in general ovulation is what stimulates a menstrual cycle. So without thyroid they tend to not ovulate therefore not have a period for months at a time and then bleed heavily. Or they have irregular bleeding all the time. Because there's no ovulation there's just estrogen production, there's no progesterone and so they're just bleeding all the time so it's an irregular cycle and that makes it very hard to get pregnant if you're not making an egg every month. But the signs are very upsetting to patients because see this and they're put on the pill just to give them a period, just to manage that. But they're managing once again, the symptom not the cause. And it can be just without hypothyroidism you can have irregular cycles but at least it should be evaluated and that was one of the things they were looking at, should we look at this and of course they came up with the conclusion that they should.

BN: Well as long as they're looking at fertility, in women who want to be or are expected to be capable of getting pregnant.

KM: That's primarily the interest.

BN: And now we have an interest for people who are getting older who aren't looking at getting pregnant but are looking at avoiding heart issues general debilitation general decline that whole cascade of aging deficits that lessen quality of life and survivability.

KM: That's what we're here for. That's what we're here to open the door to all of this research that is out there but no one's really talking about.

BN: So if you are interested in learning more about this, if you have questions and want to contact us generally, you can certainly do that.

KM: You can go online to podcast@biobalancehealth.com or you can go to my website at biobalancehealth.com or you can call my office at 314-993-0963.

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