Live Case Recordings #3: Case Review Part Three

Chris: Okay, we made it through. Do you have any questions, you or your parents, about anything that we've talked about or the treatment?

Jonathan: I'll let them ask if they have any first.

Male: The only comment that I have—hi, Chris. How are you?

Chris: Hello. Nice to meet you.

Male: On the thyroid medication, that's been an up and down series of events over the last two to three years, but most recently, he was on a higher dose of the WP-Thyroid, I think 1 grain. He came down to one-half grain. Jon, you correct me because you know those amounts better than I do. Then when we went back in for the testing, we've been working with an endocrinologist. Her protocol is you change your dosage. You stay on that dosage for eight weeks, and then I'll retest you. Never will agree to retest in between. We went from the half a grain, and that was when the TSH was too high. We went up the smallest amount that he could go up on the WP-Thyroid, so I think he's now at—

Jonathan: I'm at 48.5 mg, so it's like three-fourths of a grain.

Chris: Yes. I think the hard thing to do at this point is it is really hard to treat to TSH when there is still active immune dysregulation because that causes the TSH to just fluctuate, not independently of the thyroid hormone dose, but it's not completely tied to it. It's kind of like playing whack-a-mole. It's really difficult to get it perfectly tuned until we've addressed these sources of immune dysregulation that are causing that relapsing–remitting immune attack. One of the reasons we don't first of all focus on thyroid is that. We want to try to address some of these other underlying issues. We want to make sure that the patient isn't frankly hypothyroid or frankly hyperthyroid, but we would probably be more inclined to treat toward the T3 level than we would to the TSH level initially until we've addressed those things.

Male: Okay.

Chris: Does that make sense?

Male: It does. So, to that point, will you guys—how often will you test the thyroid levels since he's on the thyroid medication and work with him on adjusting that? Because we've been up, down, and changed different thyroid medications. We fully agree that there's got to be something else going on, and the endocrinologist made the comment one time, "Well, it's just thyroiditis. Your

thyroid can't figure out what it wants to do," which lines up with some of the things that you've said with it changing. We're scheduled to go back in and meet with the endocrinologist soon again, probably in about four weeks, and have those tests done. I guess I'm looking for direction as to what we should do.

Chris: I think since the last reading that we had was when he was on a lower dose, and that was August 24, I think we could go ahead—he could get the retest through us or through his endocrinologist. It doesn't matter to me, but I think it's definitely time to have the levels retested to see where they are at, but I would just be looking more particularly at the T3 and the free T3 level, most importantly, rather than the TSH level as an indication of whether to continue with the current dose or whether to decrease or increase.

Male: Okay. Thank you, sir.

Jonathan: A question that brings up for me or something that I've been wanting to talk to somebody about is it seems like as my dose of thyroid hormone goes up, I start to have symptoms that to me feel like hyperthyroidism, based on what I've heard about it.

Chris: Yep.

Jonathan: It kind of feels like I'm on edge.

Chris: Yep.

Jonathan: Like I can't think straight, but I can't stop.

Chris: That's pretty classic hyperthyroid.

Jonathan: I also notice—I think it's from this. I hope so. It seems like my hair starts falling out as I get to a higher dose. At first I thought, "Oh no. Maybe I'm just balding." But it was like my eyelashes and my eyebrows, so it seemed like it was more just coming out everywhere. And my face gets kind of puffy too.

Chris: It's interesting because those are hypothyroid symptoms more than they are hyperthyroid, but I've definitely seen that in cases of overmedication. I don't know whether it's because the thyroid just really shuts down because of the excess external thyroid hormone that is in the system. This is a reason why it's really so important to focus on the underlying cause. When we have a patient, and this happens all the time, we have a patient who comes in. You're really kind of describing the textbook case for us of a patient with Hashimoto's who is on continually increasing levels of thyroid hormone medication but doesn't feel better and, in fact, actually feels worse. The reason for that is because the underlying causes, which is the immune dysregulation, is not addressed by the thyroid hormone medication. That doesn't mean that I don't think it's necessary. I think it is in many cases, but it's only part of the treatment. If you think of it like a tree, the

branches are the symptoms, and then the roots are the cause. In some cases, you have to address both the branch and the root in order to make the tree healthy again. Conventional medicine almost exclusively focuses on the branch. So, in this case, the branch is the thyroid hormone treatment, and the root is addressing all of the immune dysregulation. Patients with Hashimoto's you generally have to do both in order for them to feel better.

Jonathan: That's very helpful.

Chris: Great. Anything else?

Jonathan: As far as questions that I've got, I don't have anything really pressing coming to mind. I guess I just thought how often do you see patients who have CIRS, and how do treatments go for them usually?

Chris: We see quite a few patients with CIRS these days. I'll say that I think in many of those cases, CIRS is a contributing factor to their symptoms. I don't, at this point, believe that it is the only contributing factor in all of the cases where we find it. In some situations, we treat the CIRS. The lab markers improve and normalize, and the patient feels better, but they don't feel all better. In those cases, it's probable that CIRS was part of the picture but not the whole picture. In other cases, we treat, and the patient feels significantly better, and it seems that was one of the main problems that they were dealing with. In still other cases, we treat, and the markers don't improve. It becomes an investigation, and why are the markers not improving? Is there ongoing exposure to biotoxins? Sometimes that means they're still living in a building that has mold, and perhaps the initial testing that they did missed it. We have to dig a little bit deeper to find what the source of that exposure is. It can take a little bit longer to see what is actually happening. Even though neither Dr. Nett nor myself are certified Shoemaker protocol clinicians, it's something that we see and treat on a regular basis.

Jonathan: Okay. How much time are we scheduled to have from here? I'm confused. My computer is still on Georgia time.

Chris: That's okay. We have about 10 more minutes if we need it.

Jonathan: Okay. Let me think while I've got you on the computer just about specifically the things that you were talking about.

Male: Do you want to go into diet now? I know that one of the things he mentioned was that he'll give you—let's talk about that a little bit because I know this is going to be a struggle for Jon. He's lived by a very strict food regimen now for three or four years. You guys have not done any food sensitivity testing. I understand you don't feel like the IgG—is that the correct name for that test?—is always accurate. We've had our concerns about that as well because every year that we've had it done, it changes. We even talked about having one done back to back to see if we got the same

results. That's one of the things. He's been following the autoimmune Paleo diet since the initial consultation. So, what's included in the dietary items to increase the proper methylation?

Chris: All of that falls within the context of a Paleo or even autoimmune Paleo diet. For example, organ meats such as liver are very high in folate and B12, which are important methylation nutrients. Dark, leafy greens are very high in those nutrients. Choline from egg yolks, which you're not eating right now if you're on autoimmune Paleo, is important for methylation. The handout just identifies what foods within that template of Paleo and/or autoimmune Paleo are the highest sources of the nutrients that you need for methylation. In terms of where diet fits into this picture and food intolerance testing, the reason that I don't know that it would be helpful at this point is that you've already removed the most important offenders by doing Paleo and autoimmune Paleo, which would be gluten, wheat, and dairy—in the case of autoimmune, dairy, eggs, and strict grain removal.

Any additional food intolerance testing we would do to look at intolerance of things such as vegetables, fruits, and things that you are still eating, in my opinion, is premature because we know that there is immune dysregulation right now. If we do that, I wouldn't be surprised to see that you are intolerant of some foods because you have SIBO. You have gut inflammation. There are all these other markers of immune dysregulation. If we were to do that test, what would we do with the results? One thing to do would be to further restrict your diet and remove those foods, but that is addressing the symptom more than the cause, and you have to eat something. I'm just not a big fan of extremely restrictive approaches, especially when we haven't addressed the underlying causes, and I've found that generally they don't lead to good outcomes. They lead to just a kind of unhealthy, obsessive relationship around food and weight loss, particularly in young men. I just don't see a lot of great outcomes with that approach.

What I would suggest is we address some of these mechanisms and treat your gut. If you still are having problems at that point, we may go on to do food intolerance testing as a jumping-off point or a springboard for some provocational elimination testing where we say, "Okay, you're still reacting. Maybe there is some ongoing leaky gut," even though we have addressed most of the underlying gut issues, so maybe we do need to remove a few foods from your diet for a period of time to fully resolve this. Then we would use the food intolerance testing as a way of identifying what those foods would be that we would first try to remove. I don't tend to look at it like, "Okay, so you're reacting to strawberries, lettuce, and carrots, so we're just going to take those out of your diet for the rest of your life." I don't think that's a good approach.

Jonathan: Okay. That helps us. Actually, one question I have is the diet that you recommend for somebody dealing with autoimmune problems, is it basically the autoimmune protocol?

Chris: I recommend that as a starting place, but not everyone who has autoimmunity needs to be on an autoimmune protocol. I think everyone who has autoimmunity should try an autoimmune protocol and then reintroduce the foods that were removed to see if you are reacting to them. I have plenty of patients who have autoimmune disease who do just fine with dairy, do just fine with eggs, do just fine with nightshades, and do just fine with nuts. Again, I'm not typically a fan of

removing foods indefinitely when there is no evidence that you're reacting adversely to them because many of those foods are actually quite healthy and beneficial when they are well tolerated, including full-fat dairy. Most of the research shows that full-fat and fermented dairy can be extremely beneficial, associated with a lower risk of heart disease, diabetes, and other metabolic and cardiovascular conditions.

The thing is to figure out how you respond to them, and that is why removing them for a period of time and then adding them back in can be helpful. The question of when to do that is the next one. It probably doesn't make sense to do a lot of dietary experimentation when you're just starting a new protocol of supplements because then if you react or have some reaction when you add something back in that you had removed previously, you don't know whether you're reacting to the supplement that you just started or to the food that you just reintroduced.

For now, I would probably suggest continuing with your current diet and keeping that stable so that you're not changing another bunch of variables there. After the SIBO treatment, perhaps you can start with a reintroduction of foods.

Male: Will any of this cause him to crave salt? He puts a tremendous amount of salt on food and has even put salt in water at times and drank it and said this makes me feel better.

Chris: Low cortisol. We talked about how on the DUTCH test, the dried urine test, how your cortisol—even though your free cortisol is high, your total cortisol was actually quite low. That can lead to salt cravings for sure. I'm not opposed to you doing that, especially because your free cortisone was not high, and your free cortisol is only slightly elevated, but I think as we address your—one thing that might happen is as your thyroid function improves, we'll get a clearer picture of what is going on with the cortisol. Your free cortisol may drop because your ability to clear it will improve, but if your metabolized cortisol at that point doesn't go up, then we'll know that you actually do have low cortisol, and we'll take steps to address it at that point. We're just not doing that now because it is possible and plausible even that as your thyroid function improves your free cortisol will go down, your metabolized cortisol will go up, and it will be normal, in which case giving you things to increase your cortisol is probably not the best idea.

Male: Yes.

Chris: So, for now, just salt your food to taste as you've been doing, and if you occasionally feel like you want to add some salt to water in the morning or whatever, that's fine too.

Jonathan: I haven't had any water with salt in a long time, but it's something that a doctor had mentioned to me in the past, so I tried it. The taste wasn't necessarily good, but I did notice I acted a little different.

Chris: It is something we recommend to people with very low cortisol, particularly if they have postural hypotension where they get dizzy when they stand up quickly. That can be a sign that salt will help.

Male: That is a past symptom.

Jonathan: It has been. Actually, on that vein, I see maybe we have one or two minutes, it just reminds me of a quick question that I think would be really helpful, especially when talking about things and nutritional advice that is a little unconventional. For me and for my parents, it's fun and interesting to do research, but just from your experience, what are some good resources for me and for my parents just to learn more about nutrition from your perspective? I've read a lot of your articles, and those have been helpful. I've found some other good stuff, but what do you think?

Chris: I guess it depends on what specifically you're interested in because, of course, nutrition is such a large topic. There are a lot of good books that have been written on Paleo nutrition and the theory behind it and even autoimmune Paleo, such as Sarah Ballantyne's work, for example, although I don't agree with her on everything. I think it's a good overview of why the autoimmune Paleo approach is at least worth trying as a starting place. I think the contribution that I would make here is just that in many of these cases of more complex illness or people like you who are already doing a really good diet, and they've certainly improved somewhat, the diet may not be the key factor, quite frankly. That's kind of the role we play here at CCFM. A lot of patients who make it to see me or Dr. Nett are people who have already tried a Paleo diet or an autoimmune Paleo diet or a low-FODMAP diet. Our typical patient has already jumped through those hoops. We don't typically get people who are coming and are on a Standard American Diet and just want a checkup. We get people who have already tried a lot of those interventions, and they haven't been helpful. They need more help going to the next level deeper to see what's going on. It doesn't mean that diet isn't part of the solution. Just intuitively, my feeling is that further tweaks in your diet may be helpful, but they're not going to be the key factor in terms of you recovering. Identifying and addressing some of these other things that have not yet been identified or addressed is what is going to make the bigger difference for you. That's just what I've found in my experience with patients like yourself.

Jonathan: Okay. I appreciate that insight.

Male: Very good.

Chris: Great. Nice to meet you all. Thank you so much for agreeing to do this. It was really helpful, and it will be a huge help to all the clinicians whom I'm training to be able to see how this actually works in practice. Of course, your privacy will be preserved, and none of the personal details will be available to them, but they will be able to hear the audio and to see the test results and the report of findings with all the personal information removed. It's going to be enormously helpful to them, and I really thank you for your willingness to do it.

Jonathan: You're welcome. We enjoyed being able to do it.

Chris: Great. Okay. Good luck.

Male: Thank you.

Chris: Take care. All right. Bye-bye.

Jonathan: Good-bye.