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THE BUTTERFLY EFFECT

Small fluctuations in thyroid function can have body-wide consequences. But is that really what's troubling you? And if so, what's best to do? *Catherine Guthrie* investigates one of the hottest topics in women's health.



ILLUSTRATIONS BY *Chris Gash*

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ONE MORNING in 2011, Cathy Newman woke up in a stupor. “It was like a hangover minus the alcohol,” says the now-34-year-old assistant professor of biology at the University of Louisiana at Monroe. She tried to sleep it off, but fatigue dogged her like a shadow. She’d been sluggish from stress and work before, but this was different—her exhaustion went “bone-deep.”

After blood tests for mononucleosis, anemia, and thyroid-stimulating hormone (TSH) all came back normal, Newman settled into a diminished version of her old life: Since childhood she had been a focused, ambitious morning person; now her thinking was fuzzy, her motivation flagged, and she had to drag herself from bed.

But Newman had her thyroid checked twice more, and in 2014, the results put her in the range for mild, also known as subclinical, hypothyroidism. Her thyroid—the butterfly-shaped gland at the base of the throat that governs how the body’s cells use energy—didn’t seem to be producing enough thyroid hormone to keep her metabolism functioning normally.

The standard treatment for hypothyroidism is levothyroxine, a synthetic hormone most patients take daily for life. Newman’s doctor told her it wasn’t guaranteed to work, but they decided to give it a try. Although the drug typically takes a few weeks to have an effect, Newman’s fatigue lifted completely the morning after she took the very first pill. “I felt so good, I cried!” she says.

Then there’s Jenn Krusinski of Oak Park, Illinois. She also had hard-to-ignore symptoms, starting after she had her first child at 29: cold hands and feet, extremely dry skin, frequent constipation, numbing fatigue. Like Newman’s, her diagnostic tests—for anemia, mono, and thyroid dysfunction—came back normal. But



TSH TEST 101

This test measures levels of thyroid-stimulating hormone, which tells the thyroid gland to do its job.

0.4–4.0
NORMAL

< 0.4
SUBCLINICAL
HYPERTHYROIDISM

4.0–9.9
MILD OR
SUBCLINICAL
HYPOTHYROIDISM

10+
(in combination
with a test that
measures another
thyroid hormone)
OVERT
HYPOTHYROIDISM

Some experts point out that a “normal” range may be skewed because it’s based on the results of people who get tested—meaning they already feel ill. In 2002, the American Association of Clinical Endocrinologists recommended narrowing the normal range to 0.3 to 3.04; some practitioners use that as their guideline.



after ten years of physical ailments, plus unexplained weight gain and depression, Krusinski went to a series of endocrinologists until she was finally diagnosed with mild hypothyroidism—as well as Hashimoto’s disease, an autoimmune disorder in which the body attacks the thyroid (the most common cause of hypothyroidism). Anticipating a miracle, Krusinski, too, tried levothyroxine. In her case, though, not much happened. Over the next three years, her doctor increased her dose three times; each time, Krusinski got a surge of energy, then returned to her listless, moody self. In 2012, she went off the drug.

These days, you hear a lot about the thyroid, especially if you’re a woman (we’re five to eight times more inclined than men to develop thyroid problems, according to the American Thyroid Association). It’s the likely cause of your weight gain, exhaustion, and thinning hair, not to mention your persistent malaise.

Or so many people believe.

The truth is, there’s overlap in the

symptoms of mild hypothyroidism and perimenopause, which can begin as early as the mid-30s. “Thyroid disease also often starts during times of radical hormonal fluctuations,” says Alan Christianson, a naturopath specializing in thyroid function and coauthor of *The Complete Idiot’s Guide to Thyroid Disease*. So when symptoms strike, says Mary Jane Minkin, MD, professor of obstetrics and gynecology at Yale School of Medicine, “initially it’s hard to know which to blame—estrogen or thyroid hormone.” Many women, faced with the incurable condition of “getting older” (which is what Krusinski’s primary care doctor attributed her complaints to), would rather blame their thyroid.

The gland’s most common glitch is hypothyroidism, in which its inability to make enough hormones results in a slow metabolism. The best estimates say that hypothyroidism affects around 12.7 million people in the U.S., though they’re based on data from the 1980s and ’90s. The actual number is likely higher, says Elizabeth N. Pearce, MD, president-elect of the

American Thyroid Association and an endocrinologist at Boston Medical Center. The reasons? An aging population and, to a lesser extent, the fact that the average American's iodine intake has dropped 50 percent in the past four decades due to widespread changes in food processing (the thyroid requires iodine to make hormones). On top of that, autoimmune diseases like Hashimoto's may be on the rise.

As the number of tired, puffy patients has increased, so—exponentially—has the number of levothyroxine prescriptions. Between 2006 and 2016, this figure shot up 146 percent, to 123 million—surpassing scrips for high blood pressure, high cholesterol, and type 2 diabetes.

But is medication the right answer?

For pregnant women, doctors say, it's unequivocally yes; untreated hypothyroidism can increase risk of miscarriage, preterm delivery, and developmental delays in children. For all other women, national guidelines say yes if the condition is severe—known as overt—because it can lead to infertility, heart failure, high cholesterol, and high blood pressure. Here's the catch: Overt hypothyroidism is much less common. (See "TSH Test 101," page 74.)

Whether doctors choose to prescribe medication for someone in the subclinical range—or even the normal range—is up to them. Says Pearce, "Put seven endocrinologists in a room and ask them how to treat subclinical hypothyroidism, and you'll get seven different answers." That inconsistency has caused some people to lose faith in the TSH test and, sometimes, in their doctors.

Many women refuse to believe it when their TSH test comes back normal, says John C. Morris III, MD, an endocrinologist at the Mayo Clinic in Rochester, Minnesota. Levels also fluctuate throughout the day, so these patients may find that a different

doctor on a different day will recommend addressing their very real, very miserable symptoms with a prescription for levothyroxine.

Treating symptoms with synthetic hormones isn't a guaranteed solution, though, and can lead to a letdown like Krusinski's. Moreover, in 2015, a report by the U.S. Preventive Services Task Force noted that around one in four people on levothyroxine take too much. "Thyroid hormones are like a key to a car," says Christianson. "Without a key, the car doesn't work, but ten keys don't make the car go faster." Clinical trials to find out whether levothyroxine improves symptoms for mild hypothyroidism would be prohibitively expensive, says Pearce, "because you would need an enormous sample size to detect the likely subtle effects."

Since levothyroxine mimics your body's thyroid hormones, there should be little to no adverse effect when properly dosed. Yet higher doses are associated with thinning bones and may be a cardiac risk for those who already have underlying heart conditions. That risk may not be worth it—especially when you consider that in 37 percent of patients, mild hypothyroidism resolves on its own.

When the levothyroxine failed Krusinski, she took matters into her own hands. While scrolling through online forums for people with Hashimoto's, she saw posts about the curative powers of diet. Within two weeks of cutting out gluten, her energy was back and her brain fog lifted. Six weeks later, she had her first full night's sleep in 12 years. She found a new physician to monitor her Hashimoto's and was in remission within 18 months. "My doctor said to keep doing whatever I was doing," she says. Of course, if she'd stayed on the levothyroxine, she may never have started doing anything new at all—and never have known the peace of mind that comes with a happy thyroid.

Think It's YOUR THYROID?

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IRST, ASK YOUR DOCTOR for a thyroid-stimulating hormone (TSH) test. If the results put you in the no-woman's-land of mild hypothyroidism (and you aren't pregnant), consider making a few diet and lifestyle changes before going on synthetic

hormones. "Many of my clients find me after they've been taking levothyroxine for several years, are maxed out on their dosage, and still have full-blown symptoms," says Jill Grunewald, a functional-nutrition coach who specializes in thyroid health. Here's what to try:

Eat with your thyroid in mind. Load up on whole foods high in minerals such as iodine, iron, selenium, and zinc. Seafood is an excellent source of iodine; Grunewald suggests putting sustainably sourced scallops, cod, shrimp, salmon, or sardines on your plate twice a week. Add extra iodine with sea veggies like dulse, wakame, and nori. If you tend to eat lunch and dinner on the go, make breakfast your iodine-rich meal and choose potatoes (with the skin on), eggs (with yolks), and strawberries.

Talk to your ob-gyn. "Because of the body's extreme fluctuations in hormonal levels during perimenopause, one blood test won't get you the answer much of the time," says Mary Jane Minkin, MD. She'll often put a patient on a low-dose estrogen pill for a menstrual cycle or two. "If all her symptoms resolve, I'll assume the complaints are related to her estrogen fluctuations." If not, that's the time to refocus on the thyroid.