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PE1463/F

To: Andrew Howlett

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Written Comments and Response on behalf of the Petition PE1463

1 What are your views on what the petition seeks?
2 What are your views on the discussions that took place at the Committee meeting on 5 February?
3 What evidence is there that the conditions to which the petitioners refer are currently misunderstood or being misdiagnosed by medical practitioners, or that the treatment being prescribed is not effective in a significant proportion of cases?

1 "Calling on the Scottish Parliament to urge the Scottish Government to take action to ensure GPs and endocrinologists are able to accurately diagnose thyroid disease and adrenal disorders and provide the most appropriate treatment" seems to be an adequate message. There are many patients treated because of thyroid disorders.
2 If I understand your situation properly, in Scotland you have a shortage of GPs and endocrinologist as well?
3 There are not seldom patients claiming that they have been consulting physicians for a long-term period before the diagnose hypothyroidism finally has been settled. The diagnos is sometimes difficult, particularly in the early course of the disease. There are groups of patients that are at higher risk, particularly those suffering from Diabetes mellitus Type 1, pernicious anemia, rheumatoid arthritis, Mb Addison among others. Hereditary factors are important. It is a cause of infertility, may mimic depressive disorders, and start with myalgia symptoms, therefore it is very important to exclude or settle diagnose before alternative and often useless treatments are started. It is also extremely important to exclude suprarenal insufficiency (incidence 1-2/250 000 inhabitants and year) before treatment with L-thyroxine is initiated. It may even be lethal in these patients. In case of long-standing and severe hypothyroidism an associated suprarenal insufficiency may occur demanding an initial and intermittent administration of steroids together with L-thyroxine. Patients with pituitary adenomas, before and after surgical therapy, and others with pituitary disorders is another group sometimes misunderstood because TSH gives no reliable indication if primary thyroid hormone disturbance is present or not. The normal physiological TSH response is inappropriate in these patients. The possibility for the suffering patient on L-thyroxine to have a second opinion by an endocrinologist should probably be increased and should in many cases be enough to get a plausible explanation for their condition. There are patients

with chronic treatment with L-thyroxine who are consulting doctors because they are not are feeling well. How many those are is unknown. The statement that “70% patients are not symptom free on T4 alone” seems high to my opinion, 5-10-(20) % might be more appropriate. The reason for it may be associated diseases in some cases. Sometimes functional somatoform disorders. An extended investigation may be indicated to exclude other reasons for their symptoms. There are no simple solutions for all of them. The constellation of their primary thyroid disease, hereditary predisposition, associated disease, laboratory results including concentration of free T4 together with present symptoms thought to be of hypothyroid origin will be the base for decision whether or not the present therapy is considered adequate or not. They have to be handled individually and with respect, in some cases the dose has to reconsidered and occasionally it may be indicated to try medication with liothyronine 10-20microgram per day together with l-thyroxine. However, it is only a small part which is benefited from this. Some are getting better for a short-term others for longer periods. My knowledge or experience from treatment with natural desiccated thyroid is none. The problem before the synthetic L-thyroxin was available (1960) was the great variation in bioavailability using the natural desiccated thyroid drugs, at that time thought to be the reason for drug failure not resolving all their hypothyroid symptoms. I am not using rT3 test and therefore no opinion on the matter. Personally, my experience of using free T3 analysis in daily practise is far limited for making any statement. It is possible that these patients, chronically diseased sometimes are in need of more time-consuming consultations than may be offered them by GPs? They are under continuous and acute pressure from patients suffering from many different diseases, which in combination with a shortage of doctors would enhance the problem? There are no clinical trials of good quality comparing L-thyroxine treatment with natural desiccated thyroid.

In summary: There are need of continuous education and further and extended clinical research using randomised trials designed with a power, to significantly found out whether or not there is a favour to treat with L-thyroxin in combination with liothyronine or with L-thyroxine in monotherapy. Furthermore, studies using dessicated thyroid may be performed to elucidate their clinical effect. Since there are no new pharmaceutical drugs on the market, the research in this field is dependent on grants from governements.

Yours faithfully

Halmstad 7th March 2013

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