Childrens’ Conference a great success!

Venturing into central London on a hot summer’s weekend isn’t an easy feat but that’s exactly what the families did who made it to our Families’ Conference on 13 May at the Abbey Centre in Westminster.

Dr Catherine Peters, Consultant Paediatric Endocrinologist, Great Ormond Street Hospital (GOSH) started the day speaking about the processes and mechanism of the thyroid, hypothyroidism, and an overview of symptoms and treatments. Shirley Langham, Clinical Nurse Specialist at GOSH then spoke about congenital hypothyroidism (CHT) and screening. Dr Jane Chudleigh, Lecturer in the Child and Adolescent Nursing Department, City University reported on her Newborn Bloodspot Screening Programme.

In the afternoon Dr Nadia Schoenmakers, Wellcome Intermediate Clinical Fellow and Honorary Consultant Endocrinologist, University of Cambridge and Greta Lyons, Thyroid Research Nurse Specialist, University of Cambridge gave a fascinating insight into what genetic research is teaching us about the thyroid. Dr Schoenmakers commented: ‘The meeting was so worthwhile and really opened my eyes to some of the issues faced by patients that we (or I) just don’t think about at all in clinic.’ We are very grateful to our excellent speakers who gave up their time and presented such interesting and helpful information.

Parents raised many interesting questions throughout the day that were answered clearly and thoughtfully by the speakers. During one session almost all of the 26 children met to talk about their own experiences and frustrations with their diagnosis. Some of the insights about what they have to cope with – particularly with regard to the way schools deal with the impact of their diagnosis – has given us an important steer as to next steps for the BTF Childrens’ Project.

Barbara Neve whose four year-old daughter Olivia has CHT, gave an insightful talk from a parent’s perspective and Joe Straw shared his moving experience of growing up with CHT, (see Joe’s ‘My Story’ on page 8). Julia Priestley, BTF Development Officer, one of the conference organisers, said: ‘We were delighted to have given everyone this valuable opportunity to learn so much and to meet up with others in a similar situation. One mum told me “I wasn’t really prepared for how good it would be just to meet people in a similar situation and the talks were all so informative and interesting. I was so glad we came.” In an age when so much is available online it’s easy to forget how much can be gained by actually meeting others in a similar situation’.

We would like to thank all who attended to make the meeting a success. We would also like to thank the British Society for Paediatric Endocrinology and Diabetes (BSPED) for their grant towards the cost of the meeting.
Welcome to...

Our new trustee Krishna Chatterjee, who is Professor of Endocrinology at the University of Cambridge, where he undertakes research in rare thyroid disorders.

Professor Chatterjee was elected a Fellow of the Royal Society in May 2017, one of 50 elected this year for their outstanding contributions to science.

ElaTION trial – volunteers needed for trial on a new thyroid nodule examination technique

In BTF News 93 we published an article on a trial called ElaTION that is investigating the potential benefit of using a technique called Real Time Elastography (RTE) alongside the standard ultrasound-guided Fine Needle Aspiration (FNAC) in the examination of thyroid nodules. The project leaders are still looking to recruit as many patients as possible so they can be sure that numbers are big enough to make the eventual results reliable.

Who can take part?

- If you are aged 18 or over
- Have at least one thyroid nodule
- Have not had a previous FNAC in the last 12 months

The trial is taking part in hospitals nationwide. Please visit www.birmingham.ac.uk/elation for a full list of ElaTION hospitals. Please speak to your GP or current hospital consultant to arrange a referral to your nearest ElaTION hospital.

Next issue of BTF News: October 2017

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Newsletter Disclaimer: The purpose of the BTF newsletter is to provide information to BTF members. Whilst every effort is made to provide correct information, it is impossible to take account of individual situations. It is therefore recommended that you check with a member of the relevant medical profession before embarking on any treatment other than that which has been prescribed for you by your doctor. We are happy to forward correspondence between members, but do not necessarily endorse the views expressed in letters forwarded.

Medical comments in the newsletter are provided by members of the medical profession and are based on the latest scientific evidence and their own individual experiences and expertise. Sometimes differing opinions on diagnosis, treatment and management of thyroid disorders may be reflected in the comments provided, as would be the case with other fields of medicine. The aim is always to give the best possible information and advice.

If you have any comments or queries regarding this publication or on any matter concerning the British Thyroid Foundation we would be pleased to hear from you.

Welcome to...

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Where our money comes from and how your membership fee is used

**BTF Income 2016 - 2017**

- Subscriptions
- General donations
- Research donations
- Goods sold
- Fundraising
- Legacies and grants
- Other

**BTF Expenditure 2016 - 2017**

- Awareness and promotion
- Fundraising
- Research
- Telephone helpline
- Newsletter
- Projects
- Office costs

**Christmas card volunteers needed**

If you are based in the Harrogate or York area and would be able to spare a few hours to help us sell Christmas cards between mid-October and mid-December we would love to hear from you. Email info@btf-thyroid.org with the subject heading Christmas cards.

**Visit by medical students**

A group of medical students from the University of Leeds School of Medicine recently visited us at BTF HQ to find out about our work. Julia Priestley and Cheryl McMullan talked them through the range of support the charity provides and the benefits to patients that organisations like BTF can offer. Barry Ewart, Community Education Development at the School of Medicine said after the visit: ‘Thank you for helping our students to think holistically and helping them to understand the importance of the voluntary sector as potential partners in healthcare delivery. We hope these visits will help to build links with the voluntary sector and GP practices.’

**Email addresses**

We would be grateful if you could provide us with your email address to keep our membership database up-to-date. Please email info@btf-thyroid.org with the subject heading ‘Email address’, and include your membership number if possible, or your name, and postcode. (Please note we will never pass on your details to a third party.)
left or right button when images appear on the screen. The test is completely non-invasive, you will not be given any medications, nor have to wear any special glasses or eye patches to take the test. All travel costs will be reimbursed.

For more information or to find out how to take part please contact: Dr. Matteo Rizzi, m.rizzi@ucl.ac.uk tel. 07835164303

Webinar for GPs

The BTF took part in a webinar for GPs on Graves’ disease and thyroid eye disease in February 2017. BTF Director Janis Hickey conveyed the patient perspective of these diseases, while participants were informed of the clinical aspects by thyroid specialist, Professor Colin Dayan. There was a high attendance and feedback was positive with participants stating they particularly enjoyed hearing presentations from the clinical and patient aspect.

RNIB factsheet

The BTF was invited by the Royal National Institute of Blind People (RNIB) to help review and revise their factsheet on thyroid eye disease. Patients, endocrinologists and ophthalmologists took part in the exercise. The revised version was posted on the RNIB website in March 2017: https://www.rnib.org.uk/eye-health-eye-conditions-z-eye-conditions/thyroid-eye-disease

Early TED referral programme being developed

The Thyroid Eye Disease Amsterdam Declaration Implementation Group UK (TEAMeD), in which the BTF was a founding member and plays a key role, was established in 2010 to increase awareness of thyroid eye disease (TED) and improve patient care. TEAMeD has recently published the results of an audit of new referrals for TED to specialist UK clinics over a three-month period: Mellington FE et al. Management of thyroid eye disease in the United Kingdom: A multi-centre thyroid eye disease audit. Thyroid Eye Disease Amsterdam Declaration Implementation Group (TEAMeD).Orbit. 2017 Mar 15:1-11

Based on audits, questionnaires and data collection carried out over the past seven years, TEAMeD is now developing a ‘care bundle’ – ‘TEAMeD-5’ – an evidence-based programme to prevent and/or detect TED early and to promote appropriate and early referral to expert care. It seeks to improve outcomes for patients with TED through:

- accurate diagnosis
- screening of Graves’ patients for TED
- alerting Graves’ patients to the risks of TED
- prevention of TED
- referral to a specialist clinic

We would like to thank all the people with TED who have contributed to our work. TEAMeD-5 will be rolled out nationally during 2017-2018

BTF Projects Update

The BTF is currently focusing on several key thyroid related areas with the aim of improving knowledge, assisting with research and improving the patient’s experience. We are developing strategies for hypothyroidism care, iodine deficiency and subsequent thyroid problems, children with thyroid issues, thyroid cancer and thyroid eye disease. Each project group meets regularly to discuss progress, although we do not always have updates available for every newsletter.

Children

Graves’ disease study continues

The Medical Research Council (MRC) funded study that is looking at whether a single dose of Rituximab will improve remission rates in young people aged 12 to 20 years with newly diagnosed Graves’ thyrotoxicosis is continuing (see BTF News 92 page 5). Centres that are recruiting patients include Newcastle-upon-Tyne, Birmingham and Sheffield, whilst the units in Doncaster, Edinburgh and Leeds are expected to take part in the very near future. It is expected that the units in Cardiff and Southampton will be able to recruit later in the year. For further details please contact Tim Cheetham tim.cheetham@nuth.nhs.uk

Thyroid eye disease (TED)

Volunteers needed

Moorfields Eye Hospital is looking for volunteers who have been diagnosed with thyroid receptor dysfunction to come along and take part in a research project. This research is trying to identify the mechanism by which thyroid receptor dysfunction impacts on vision and in particular, people’s colour vision. This will be a key step towards finding treatments for this and similar genetic eye disorders.

If you are interested in taking part, you would need to be free to attend Moorfields for a short visit (about one hour) in the coming months. The test involves sitting at a computer and clicking either a
Thyroid cancer

The third edition of the ‘Thyroid Cancer: For Patients, By Patients’ is due to be published imminently. The 68-page booklet, which is designed to help patients facing a diagnosis of thyroid cancer, has been revised and updated with the latest medical and practical information, new photos and patient quotes.

The BTF is grateful to Sanofi Genzyme who supported this booklet with a grant. The text was written independently and Sanofi Genzyme had no editorial control over its content.

‘Once again the BTF have raised the bar for the quality of their patient information. This well researched and written information booklet will, I am sure, be of great benefit to patients diagnosed with thyroid cancer.’ Mr Mark Lansdown, President, British Association of Endocrine and Thyroid Surgeons.

‘Patients will be able to relate to this booklet with ease as it is straightforward and has been written by patients who know and understand how it feels to be affected by this disease.’ Kate Farnell MBE, CEO, Butterfly Thyroid Cancer Trust.

Hypothyroidism

The BTF has supported and given feedback during a study to explore clinical, behavioural, and genetic determinants of inadequate thyroid hormone replacement and dissatisfaction with therapy in patients with hypothyroidism. The CATHRINE project is a study investigating the clinical and genetic determinants of thyroid hormone replacement in general practice: an in-depth qualitative interview study’. Researchers from the University of Sunderland, involved qualitative interviews with patients with hypothyroidism, exploring their attitudes and perceptions towards treatment of hypothyroidism in general practice: an in-depth qualitative interview study.

Findings from the study revealed that excellent levothyroxine compliance was reported by the majority of patients, and the main benefits of good levothyroxine treatment perceived by patients were improved wellbeing and day-to-day performance. However, patients generally were less confident about the consequences of poor thyroid hormone control with levothyroxine treatment, and found it difficult to obtain clear and reliable information about hypothyroidism and treatment for hypothyroidism. It was also felt by most patients that focusing only on having a normal thyroid hormone reading rather than symptoms and concerns is not a good way to measure patient wellbeing, and it often meant that discussion with their GP about improving their levothyroxine treatment did not happen. The team commented that outcomes may be improved by the provision of better quality information for patients regarding the consequences of having thyroid hormone levels that are too high or too low, together with an approach by their GP that addresses patients’ symptoms and concerns, alongside their thyroid hormone readings.

The CATHRINE study is still underway, and findings from qualitative interviews with GPs, practice nurses and pharmacists who are involved in the management of hypothyroidism are currently being written up to be published in an academic journal, while genetic research involved in the CATHRINE study is also still ongoing. An article from the findings of patient interviews has been published in the BJGP Open - an online journal for GPs called ‘Patients’ attitudes and perceptions towards treatment of hypothyroidism in general practice: an in-depth qualitative interview study’.

Trial electronic protocol to improve thyroid replacement in general practice

Dr Anh Tran, a GP with an interest in endocrinology and diabetes and a member of the BTF, British Thyroid Association and the Society for Endocrinology (SIE), has conducted many clinical studies in the care of hypothyroid patients by GPs. She is the author of seven studies on diabetes and endocrine problems in primary care, including four on hyper- and hypothyroidism, and has given presentations on endocrine disorders in primary care.

Dr Tran presented a poster at the recent British Thyroid Association Annual Meeting on her development of an electronic Protocol for Monitoring Patients on Thyroxine in General Practice (e-prompt GP). e-Prompt GP is an electronic alert system in EMIS web to prompt GPs to test, and also to address out-of-range thyroid function in patients with hypothyroidism treated with levothyroxine. The BTF helped with the study by providing feedback. Dr Tran and her colleagues concluded that an electronic protocol resulted in small improvements in both TSH monitoring and the adequacy of thyroid hormone therapy in two GP practices in this preliminary study, and that further studies are needed in a wider variety of UK general practices.

Dr Tran said: ‘I would like to thank the BTF for providing feedback and input, and Dr Onyebuchi Okosime and Dr Steve Hyer and their respective departments for their help and support in the completion of this study and with finalising the ‘e-Prompt GP’ alerts.’

Dr Onyebuchi Okosime and Dr Anh Tran presenting the poster at the British Thyroid Association Annual Meeting in May 2017
Older patients and thyroid disease

Liz Clegg BTF News Editor writes about how thyroid disorders affect the elderly.

How common are thyroid disorders in older people and how do symptoms differ in the elderly?
Several studies referring to those over 65 years show that thyroid illness is very much a disease of the elderly and that it often goes undiagnosed. Although the incidence of thyroid problems increases with age, it is sometimes difficult to diagnose as symptoms are not always as widespread or obvious as those in younger patients.

While some of the symptoms of hyperthyroidism and hypothyroidism in older patients are similar to those in younger patients, symptoms of both disorders often manifest in subtle ways in older patients, masquerading as diseases of the bowel or heart or a disorder of the nervous system.

The difficulty in diagnosing older people is that thyroid abnormalities can appear much differently from the way they are supposed to. Whereas hyper- and hypothyroidism present very differently in younger patients, in older patients there are similarities between the two disorders.

In both conditions in older people there can be confusion, depression, falling, heart failure and changes in bowel habits. Not only do these signs make it difficult to distinguish hyper- from hypothyroidism in this age group, but they are also signs of common illnesses of older people.

Hyperthyroidism (over-active thyroid) in older people
As in all hyperthyroid patients, if there is too much thyroid hormone, every function of the body tends to speed up. However, while younger people with thyroid disorders often experience multiple symptoms related to the over-active thyroid (weight loss, palpitations, sweating, nervousness, tremors) older people may only have a few symptoms, for example some heart palpitations and chest discomfort on climbing stairs. Others may have a tremor and feel depressed but not have any other symptoms.

Treatment of older people with hyperthyroidism
As with younger people, treatment of hyperthyroidism in older people includes antithyroid drugs and radioactive iodine. Surgery is rarely recommended due to increased risks associated with operations in older people. While Graves’ disease is still a common cause of hyperthyroidism in this age group, toxic nodular goitre (either in the form of multiple nodules or a single over-active nodule), resulting in hyperthyroidism, is more frequent than in younger individuals. The latter is not associated with the eye problems that are sometimes seen in Graves’ disease.

During treatment for an over-active thyroid, the effects of change in thyroid function on other body systems are closely monitored, due to an increased likelihood of co-existing diseases – cardiac, central nervous system and thyroid – in older patients. Most often, thyroid function is brought under control first with antithyroid drugs before definitive treatment with radioactive iodine is considered.

During the initial phase of treatment, doctors will check heart function closely due to the effect of changing thyroid hormone levels on the heart. Symptoms of hyperthyroidism may be brought under control with other medications alongside the antithyroid drugs such as beta-blockers, which are often given to slow a rapid heart rate. Definitive treatment with radioactive iodine is considered once thyroid function is maintained in the normal range with oral medication.

Hypothyroidism in the older patient
Hypothyroidism is the most common thyroid condition in patients over 60 years of age and steadily increases with age. A screening study that evaluated more than 25,000 individuals attending a health fair in Colorado USA revealed that 10% of men and 16% of women age 65-74 had TSH levels that were increased above the upper limit of the reference range, while 16% of men and 21% of women age 75 and older had increased TSH levels.

![Percentage with High Serum TSH (>4.5 mU/L)](image)

*Excluding persons with reported histories of thyroid disease, goiter, or treatment with thyroid medications **Excluding persons with reported histories of thyroid disease, goiter, or treatment with thyroid medications, conditions predisposing to thyroid function test abnormalities, or positive antithyroid antibodies [2].

Unlike symptoms of hyperthyroidism (particularly in younger people), the symptoms of hypothyroidism are very non-specific in all patients, and even more so in older people. The severity and extent of symptoms also depend on the degree of hypothyroidism. As with hyperthyroidism, the frequency of multiple symptoms (dry skin, thinning hair, constipation, weight gain, low mood, tiredness) decreases with age. For example, memory loss or a decrease in cognitive functioning, often attributed to advancing age, may be the only symptom of severe hypothyroidism in an older person. Clues to the possibility of hypothyroidism include a positive family history of thyroid disease, past treatment for hyperthyroidism, or a history of extensive surgery and/or radiotherapy to the neck.
Treatment of older people with hypothyroidism

If older patients have symptoms of hypothyroidism and treatment is needed, the dose of levothyroxine is started gradually and increased cautiously, so as not to put any strain on the heart and central nervous system. Treatment will usually begin with 25 to 50mcg of levothyroxine daily, and the dose increased in steps every 4-6 weeks until the blood tests show a gradual return of thyroid hormone and thyroid-stimulating hormone (TSH) levels to the normal range. Older patients with no evidence of heart disease, stroke or dementia may be started on larger doses (for example, half of the anticipated full replacement dose) and proceed to full hormone replacement more quickly.

Thyroid reference ranges for older patients

It is well known that thyroid hormone requirements change with age and there is currently a debate as to whether the practice of treating everyone with an under-active thyroid in a uniform fashion, regardless of their age, is appropriate. Currently, an increasing number of older people are diagnosed with a mild under-active thyroid (subclinical hypothyroidism) when their blood thyroid hormone levels (T3 and T4) are normal and their TSH levels are high. However, it has been found that TSH levels increase in older people (70+ years of age) and this is not always associated with poorer health. In addition, the standard TSH reference range used has been obtained from mainly younger people and therefore may not be suitable to make a diagnosis of hypothyroidism in older people.

There are a number of studies currently being undertaken to try and pinpoint what TSH levels for older people with an under-active thyroid should be. The SORTED study (Study of Optimal Replacement of Thyroxine in the Elderly) led by Dr Salman Razvi, Senior Lecturer and Consultant Endocrinologist, Newcastle University, was an attempt to assess whether targeting a slightly higher TSH reference range in the elderly (over 80 years) is possible and to see if it would lead to any adverse effects on symptoms and quality of life (See BTF News 88).

Results so far have shown that a slightly lower dose of levothyroxine did not lead to any detrimental effect on symptoms or quality of life over a six month period.

Dr Salman Razvi and Professor Marian Ludgate, Professor of Molecular Endocrinology, Cardiff University are the joint winners of the 2017 BTF Research Award. They are aiming to study the underlying mechanism of the increase of blood TSH levels with age, which could lead to more age-appropriate TSH reference ranges in the future. (see page 12)

Two other recent studies have indicated that older people with mild hypothyroidism may not be at a disadvantage or do not benefit from treatment with levothyroxine. The Newcastle 85+ study (a large study of the elderly (85 years and over) in the North East (see BTF News 93, page 9) has indicated that a slightly high blood TSH level – the blood test used to diagnose hypothyroidism – is not associated with worse outcomes.

A further study led by Professor David Stott of Glasgow University of hundreds of older adults across Europe with mild hypothyroidism has shown that this group does not benefit from being treated with levothyroxine in respect of improving symptoms or quality of life.

Summary

Diagnosis and treatment of thyroid disorders in older people is not always easy. Symptoms are not necessarily as obvious and other factors (such as symptoms of other diseases present along with thyroid disorders and interactions with other drugs) further complicate matters.

Older patients with thyroid disorders should be offered gradual and careful treatment, and, as always, require lifelong follow-up.

References

American Thyroid Association www.thyroid.org/thyroid-disease-older-patient/

Thyroid disease in Late Life, Leslie M.C. Goldenberg www.thyroid.ca/e4g.php

Study of Optimal Replacement of thyroxine in the elderly (SORTED) – results from the feasibility randomised controlled trial https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5057427/

Thyroid Hormone therapy for older adults with subclinical hypothyroidism, David J Stott www.nejm.org/doi/full/10.1056/NEJMoa1603825

Hypothyroidism in the Elderly

Matthew I Kim, M.D.
Division of Endocrinology, Diabetes, and Hypertension, Brigham and Women’s Hospital, HIL-651, 77 Avenue Louis Pasteur, Boston, MA 02115
www.ncbi.nlm.nih.gov/books/NBK279005/
Joe was diagnosed with congenital hypothyroidism aged just one week old after routine newborn screening and a physical examination. Joe explains his sometimes difficult journey through his childhood and teens: 'It was a very anxious time for my parents and close family, most of whom hadn’t even heard of a thyroid gland let alone the problems that can occur when one malfunctions! They recall a lack of information being available to them around the time.

'I was put on levothyroxine and referred to Doctor Jerry Wales, an endocrinologist at Sheffield Children’s Hospital and my hypothyroidism was generally very well controlled throughout my childhood. My mum or dad would make sure I took my levothyroxine every morning by giving it to me first thing before breakfast. I enjoyed playing football and most other sports. Growing up in the Peak District I have a love of the outdoors and thanks to the care I received, I was able to do the things I enjoyed just like everybody else my age and progressed well at school. However, my condition was kept very much a secret - in hindsight this was not a good thing and I should have embraced the importance of my condition from a young age, as I’m sure this would have been the case if I’d had a more ‘common’ health condition.

'I visited Sheffield Children’s Hospital and saw Dr Wales very frequently especially in the first few years of my life. These visits were every two weeks early on and then became every month and then every two to three months as I grew into childhood and developed normally. The visits became less frequent and after the age of five I visited Dr Wales once per year and just like in my first few years, his care was excellent. He always listened to my own or my parents’ concerns and was very clear about my progress and whether I needed a dose change or not. My memories of visiting him are very happy. I have memories of slight under-treatment and over-treatment, which were rectified by Dr Wales. He reassured me through the problems I experienced and they were always resolved. I continued to see Dr Wales until I was around 15 years old, when I was placed under the care of a GP.

‘Unfortunately, the good care that I had received in my childhood did not continue under the GP and a huge decline in the control of my congenital hypothyroidism started. I began feeling very unpleasant physical, psychological and emotional symptoms in my final year of school, which wiped me out and meant I withdrew from social interaction and stopped me progressing academically. These symptoms included severe headaches, lethargy and anxiety. I also stopped playing football, my passion, and became very disinterested in life. I ultimately failed my GCSEs and left school with no qualifications. The GP, however, completely and utterly failed to recognise that my now uncontrolled condition was the cause.

My symptoms worsened as I turned 16. I was lethargic, had a short temper, headaches, bowel issues, dizziness and I was very anxious, apathetic and depressed. I couldn’t hold down a job and my self-esteem hit rock bottom. By Christmas 2009 at 17 I was very poorly and instead of the GP performing a thyroid blood test, I was given antidepressants, sent on my way and the symptoms I had been experiencing for such a long time progressed further. The antidepressants changed my personality and my behaviour became very reckless and self-destructive. I would do anything to make myself feel better and began to self-medicate in an effort to forget my symptoms or the feelings that I had. This continued for two to three years.

'I requested a change of GP and this proved to be pivotal. As soon as I told the new GP of my symptoms and the problems that I had been having, a TSH test was conducted - my T4 was nearly undetectable and my TSH had reached a value of 100. My dose was increased but still the problems continued. My hair then became very patchy and was falling out so I began to shave it off completely. My new GP was excellent and referred me urgently to Professor Tony Weetman at Sheffield Hallamshire Hospital. Professor Weetman discovered that my levothyroxine wasn’t being absorbed and that it wasn’t merely the dose that was the problem. He asserted in no uncertain terms that we must take immediate action to avoid potentially serious long-term effects.

'Professor Weetman reduced my dose to 125 mcg whilst we agreed that I must take my levothyroxine well away from any food, supplements or medicines. A blood test was then conducted and my TSH was slightly raised. In response to this Professor Weetman raised my levothyroxine to 175mg. We settled on this dosage and I am delighted to say that I have been well ever since. The symptoms that I was plagued with for three years are long gone and my TSH/T4 have been consistent for four years. This would never have been possible had I not complied with Professor Weetman, whilst also educating myself so that I could understand the functions of the thyroid and levothyroxine.

‘Now adequately treated at 19, I was able to retake my GCSEs and then my A Levels, aged 20-22, achieving 3 A*s and progressing to university to study Physical Activity, Health & Sport which is my passion. I could also now work, and have worked for Sheffield United FC, Doncaster Rovers FC and my current place of work is Sheffield Wednesday (my team!). In my roles I have worked with over a thousand young people aged 15-17 on the National Citizen Service programme. Alongside my studies and work I have been able to do what I love and play sport again, even competing in boxing for four years! Boxing helped give me discipline and served as a great metaphor for overcoming the illness that I’d had. I also love running, swimming, walking, participating in most sports and fly-fishing! I live a very active life once again and can now make up for lost time’.

Ed: Joe gave a talk at the recent BTF Children’s Conference in London in May (see front page) and added:

‘I am delighted to be involved with the BTF and I hope that I can give back some of the help that I have received in recent years.’
Fundraising and Donations

If you want to fundraise for us please get in touch! Email fundraising@btf-thyroid.org. We can provide you with publicity material and a BTF t-shirt/running vest for your big day!

Fundraisers

Joe Plater, who was diagnosed with thyroid cancer in 2016, has raised over £3500 for the BTF by organising a sponsored gaming live stream. He started a YouTube channel in May 2016 and said: ‘I threw myself in to the channel whilst recovering from operations. I had what I thought would be a tough target to hit of £1000 but it was smashed within seven hours!’

Hayley Montgomery raised £340 for the BTF by running the St David’s Day 10k run in March.

Gavin Raby ran the Silverstone Half Marathon in March and raised £345.

Charlotte Kerr, who has several family members with thyroid problems, ran the Vitality Bath Half Marathon in March and raised nearly £250.

Tracy Gray, whose husband and daughter both have thyroid disorders, ran the Fleet Half Marathon in March with her sister and cousin, and they managed to raise nearly £1500!

Daniel Holborn has raised over £400 by shaving off his beard! http://bit.ly/2MzSO7 Daniel’s wife Katie has Graves’ disease and thyroid eye disease and they are keen to help raise awareness. Daniel works for Santander and the money he raised will be matched by the bank.

Daniel is also cycling in the 140km Velothon Wales in July to raise even more money. www.justgiving.com/Daniel-Holborn

Clare Duffy, who has an under-active thyroid, took on the Tough Mudder Scotland Half in June and raised over £300.

Kim Mellor and a group of friends took part in the (very muddy!) Born Survivor and raised nearly £1000! Kim has a few family members that suffer from thyroid problems and a close family friend has Graves’ disease.

Neil Millen cycled the vertical height of Mount Everest (29,029 feet!) in the Alps with his local cycling club the Kentisbeare Oldies Cycling Society (KOCs) and raised £890! Neil’s family have been severely affected by Graves’ disease over the last five years.

Hilary Burns took part in the Northumberland coastal challenge marathon on 1 May and raised £200.

Virgin Money London Marathon 2017

David Swan our selected BTF runner, raised an incredible £5700! David said: ‘The support along the route from Greenwich all the way to the Mall was phenomenal. The highlight of the day was seeing my wife and children at mile nine and managing to stop to give them all a big hug. I would like to thank everyone who has supported BTF and me. The day was truly amazing and I feel exceptionally lucky to have been given this opportunity to run the best race in the world.’

Paul Davis (who also attended the Children’s Conference, see front page) gained his own place in the London Marathon and raised £620. He said: ‘It was an incredible day, and made possible because of my amazing family and friends. Even better was having the chance to raise a little bit of money for the BTF.’

Future fundraisers

Heather Maltman will be running the Edinburgh marathon...

Cameron Whitelaw will be taking part in the Great West Run Exeter Half Marathon 2017. www.justgiving.com/CameronWhitelaw

Lauren Worthy and her mum will be running the Leeds 10k in July. www.justgiving.com/fundraising/Lauren-Worthy1

Faith Beswick is running the Brighton Half Marathon in February 2018. www.justgiving.com/fundraising/FaithBeswick

Simplyhealth Great North Run
Katherine Storey www.justgiving.com/Katherine-Storey2
Alisa Macmillan www.justgiving.com/fundraising/alisa-macmillan
Clare Lonsdale www.justgiving.com/fundraising/Clare-Lonsdale
Susan McPherson and Mike Holliday-Williams

Vitality British 10k London Run We have three runners taking part in July: Brigita Vaskelyte www.justgiving.com/fundraising/Brigita-Vaskelyte.
Anastasia Pinches www.justgiving.com/fundraising/Anastasia-Pinches1
and Katja Gomer

Donations

Many thanks for your generous donations. We are grateful for them all, including those donated online, often in response to advice and support from our telephone contacts, local coordinators and BTF head office, and also for donations by members at the time of joining BTF or at renewal time.

Apitope for their £500 donation towards newsletter costs.

£186 received in memory of Mrs Emily Boughen.

A legacy gift of £500 left by Mrs Patricia Martin, a keen supporter of the BTF. Twenty four pounds was also donated in memory of Mrs Martin to Much Loved, the online tribute charity.
Flame retardants and thyroid cancer

The Daily Mail published an article on 9 April 2017 claiming that toxic chemicals used to fireproof sofas and mattresses have caused a surge in thyroid cancer. The article claimed substances used to fireproof settees and mattresses are linked to a 74% rise in thyroid tumours. Scientists from Duke University (an American private research university) found the patients had a high exposure to brominated diphenyl ethers (PBDEs).

The article goes on to say that flame retardants are feared to be making families ill after being exposed to them through household dust. It continues that although the chemicals have been widely restricted, experts warn the measures do not go far enough.

Julie Ann Sosa MD, of Duke University Medical Center, Durham, North Carolina, reporting the findings at the US annual Endocrine Society Annual Meeting said: ‘What’s really novel about this study is that it’s the first time we’ve seen a signal like this, but it should just be seen as a first study. We really need to do additional research, to understand mechanisms... and to validate our findings.’

Comment from our medical adviser Dr Petros Perros:

This work has not yet been published in a medical peer-reviewed journal, but was presented in the recent annual meeting of the Endocrine Society. The most informative comment on this can be found in an Endocrine Society press release (https://www.endocrine.org/news-room/current-press-releases/exposure-to-common-flame-retardants-may-raise-the-risk-of-papillary-thyroid-cancer). The popular press has selected this piece of news and transformed it into interesting headlines: ‘Your sofa can give you cancer’, ‘Toxic sofas linked to surge in thyroid cancer’, ‘Thyroid cancer rates are skyrocketing from flame retardants’. These are unhelpful comments and do nothing to promote understanding of public health issues. The observations made by Sosa and colleagues are interesting and concerning and should be taken seriously. They took a sample of people who had a diagnosis of cancer and another who did not, matched closely for age, sex and various other parameters and compared them in terms of exposure to chemicals used as fire retardants. They found an association between the probability of having been diagnosed with thyroid cancer and high levels of exposure to fire retardant chemicals, with a probability of thyroid cancer being twice as high in those people with high exposure. This was the main finding. Further sub-analyses of their data showed that those with the highest levels of one particular chemical called tris (2-chloroethyl) phosphate (TCEP) were over four times more likely to have large more aggressive tumours, while those with the highest levels of the chemical decabromodiphenyl ether (BDE-209) were 14 times more likely to have a particular variant of papillary thyroid cancer (BRAF mutation) which is associated with more aggressive thyroid cancer.

How should the public react to this information?

Families with young children or with a family member or friend who has gone through treatment for thyroid cancer will no doubt be concerned, so it may help to put this into some context. For sure this kind of finding needs to be taken seriously as the public health consequences are significant. It was such observations made by Richard Doll back in the 1950s about the link between smoking and lung cancer that laid the foundations for proving the causative effect of smoking and lung cancer and the subsequent public health measures that led to reductions in lung cancer. Furthermore, there is laboratory evidence that the chemicals TCEP and BDE-209 have an effect on thyroid cells in tissue culture, so there are potential mechanisms through which they could possibly predispose to cancer, which makes this theory plausible. On the other hand, the observations by Sosa and colleagues, if true, are only associations; they don’t prove cause (Post Hoc Ergo Propter Hoc: ‘I saw a magpie and ten minutes later, I crashed my car, therefore, magpies are bad luck’). The sample size in Sosa’s study was very small (70 patients with thyroid cancer and 70 controls) and the increased risk was modest (two-fold). To prove the causative effect of smoking and lung cancer, it required observations from 40,000 people over 20 years and the risk for heavy smokers was 50 times greater than non-smokers. What is also inconsistent in Sosa’s observations is the association with larger more aggressive thyroid cancers. Such cancers have been known not to have increased in incidence for more than 20 years, long before the introduction of fire retardant chemicals.

What should a sensible but concerned person do in the meantime?

If there is a risk of fire retardant chemicals causing thyroid cancer, it is likely to be small and highly unlikely to lead to a premature death.

The really difficult question is how do we react to this news now? It may take years to prove or disprove the theory and we would rather not be idle and complacent. I don’t have the answer, but I cannot but think that if I definitely want to improve my health and avoid a premature death, I could make a much bigger impact on my chances by paying attention to diet, and exercise, rather than get rid of sofas.
Clinical Trials Day in Newcastle

Patients and the public were invited to learn about the latest developments in thyroid research at an event to mark International Clinical Trials Day on 18 May 2017.

The meeting, held at the Royal Victoria Infirmary in Newcastle, drew patients, students and parents from across the UK and focused on treatments for Graves’ disease, teenagers with Graves’ disease and thyroid eye disease. Dr Petros Perros, Dr Tim Cheetham and Professor Simon Pearce presented fascinating insights into past and current clinical trials that highlighted the huge progress that had been made, but also how much was yet to be learnt. It was also an important reminder that no valuable research could take place without the support of patients who put themselves forward to participate in studies.

BTF Founder Janis Hickey led a session that looked at the unmet needs and common challenges of thyroid patients and introduced workshop sessions led by Dr Perros and Professor Pearce.

Successful trial on new drug for thyroid eye disease

An exciting new study was published in the New England Journal of Medicine in May. An international multicentre trial has found that Teprotumumab is a highly effective treatment for active Thyroid Eye Disease if administered within the first nine months of the onset of the disease. In addition to switching off the activity of the disease, this treatment has been shown, for the first time, to also reverse proptosis (bulging forward of the eye). A second trial is currently being planned to confirm these findings.

New trial started for locally advanced thyroid cancer

A new trial for people with thyroid cancer that has grown outside the thyroid (locally advanced) or spread to another part of the body (metastatic) is under way. It is for those with a type of thyroid cancer called iodine refractory differentiated thyroid cancer.

Thyroid cancer is often treated with radioactive iodine. The cancer can sometimes cause cells to stop taking up radioactive iodine. This is iodine refractory thyroid cancer. If this happens it can be harder to treat thyroid cancer. Selumetinib is a targeted cancer drug. It works by blocking certain proteins that tell cancer cells to divide and grow. Researchers think Selumetinib could make refractory thyroid cancer cells sensitive to radioactive iodine again.

Everybody taking part in this trial is given Selumetinib for up to six weeks, followed by scans to find out how much iodine their thyroid is picking up. If the thyroid starts picking up iodine again, then patients might be given further radioactive iodine treatment, hoping that this will control the cancer for a longer period of time.

The study will be running at eight centres around the UK. The first centre, the Royal Marsden Hospital, London, has recently opened to recruitment.

Society for Endocrinology Clinical Update Meeting

The BTF had a stand at the annual Clinical Update meeting in March. The meeting is a three-day event for trainee doctors, newly qualified consultants and endocrine nurses and is structured through lectures and interactive small-group workshops that focus on discussing best clinical practice based on day-to-day case scenarios. BTF Trustee Dr Petros Perros presented a session on preventative measures and new therapies for thyroid eye disease. Over the three days there was a lot of interest in the BTF stand and many attendees took samples of BTF information leaflets for their clinics.
An underactive thyroid, diagnosed when blood thyroid hormones are low and the pituitary thyroid stimulating hormone (TSH) is elevated, is more common in older individuals and in women. Mild forms of underactive thyroid are increasingly being diagnosed when blood TSH levels are high but thyroid hormones are within the normal range. But TSH levels increase in older people (over 70 years) and are not always associated with any harmful effects on health. Moreover, the TSH normal range has been obtained from mainly younger people and may therefore not be suitable to diagnose thyroid disease in older individuals. In addition, it is unclear why TSH levels increase with age and what the underlying mechanism is. This project intends to study a group of 200 carefully selected individuals without thyroid disease that have had their full thyroid function measured a few years ago (between 2007 and 2010) with a more recent thyroid function measurement. This will provide us with information on changes in TSH levels over time in the same person along with any effect on thyroid hormone concentrations. The impact of other important factors such as gender, smoking and blood markers of immune-activity against the thyroid will also be assessed. Finally, in a smaller sub-group of 50 people from the main study, laboratory tests will study if the stimulatory action of TSH changes with age. The results of this project will increase our understanding of the changes in thyroid function with age, and will enhance the debate on using age-appropriate reference ranges to assess thyroid function. This could ultimately lead to better and more suitable management of under-active thyroid disease in older people.
Is there a link between polycystic ovaries and thyroid disease?

TP asks: Six weeks ago, my 15-year-old daughter was diagnosed with autoimmune hypothyroidism and is now on levothyroxine. At the same time a scan showed she has polycystic ovaries (PCOS).

I read in various journal articles that autoimmune hypothyroidism and PCOS are associated with each other but have not been able to track down a reliable explanation for a) why this is, b) any medium-term implications of having both Hashimoto’s and PCOS. Could you please point me in the direction of reliable information? Thank you.

Separately, since starting on levothyroxine she has felt hungry all the time, despite maintaining her previous eating and exercise levels. This does not appear as a side effect on the leaflet that comes with the medication. Is there any possible connection? If so, what should one do? (So far we have made sure that her weight remains constant.)

Our medical adviser replies: One third of the population are found to have ‘polycystic ovaries’ in some studies – hence many people have ovaries with this appearance without any symptoms. It seems to be a normal finding in some people and hence isn’t necessarily of any significance.

There is a potential link with autoimmune hypothyroidism however; if TSH levels are markedly raised they can ‘stimulate’ the follicle-stimulating hormone (FSH) receptor on the ovary and make the ovaries cystic. This settles with thyroid treatment/as TSH levels fall. Try looking up Grumbach syndrome!

Regarding the constant hunger, people who have been hypothyroid can notice a change in appetite when commenced on levothyroxine but this should settle to normal with time – it makes sense really because thyroid hormone levels are linked to metabolic rate to some extent.

Should I be taking blood pressure tablets with an under-active thyroid?

JC asks: I have an under-active thyroid gland. This was diagnosed in 2005 and since then I have been prescribed levothyroxine but also blood pressure tablets. My doctor explained the reason for the blood pressure tablets was to ‘protect my kidneys’ but a practice nurse has recently seemed surprised by this and on research, I have not noted this as a common treatment for an under-active thyroid gland. I do not - and never have had - high blood pressure. I would be interested in your views.

Our medical adviser replies: Blood pressure tablets are not indicated in people with hypothyroidism except if they have a high blood pressure in addition to hypothyroidism. It is certainly not part of the routine treatment of hypothyroidism. Where blood pressure tablets are indicated they are effective in reducing the risk of strokes, heart problems, and kidney problems, but they do this by reducing blood pressure. However, for people who do not have a high blood pressure, the blood pressure tablets have no benefit and may even carry some risk. Therefore I suggest that you discuss this issue again with your health care practitioner; you may want to take a printout of this response to your doctor.

Can a positive test for antibodies affect my fertility?

AW asks: I had Graves’ disease about ten years ago and have struggled to conceive. After tests it turns out my TSH levels are normal but I have antibody levels at 456 (should be 50 to be in the in normal range). I am currently waiting for an NHS appointment. Should I be concerned with a long wait time? I have read this could destroy my thyroid gland and needs sorting ASAP. What does this actually mean? Is it easily treated? Is this solved by tablets?

Our medical adviser replies: The antibodies are a hallmark of autoimmune disease and it is possible that the thyroid may fail in the future (but not inevitable). Meanwhile, the TSH is normal indicating no thyroid failure and no relapse of the Graves’ disease.

There is nothing you need to do at present. It is true that the presence of antibodies increases the risk of miscarriage and that should be discussed if you get pregnant.

Can I take soy-based menopause treatments with levothyroxine?

CD asks: I’m 55 and take 75mcg of levothyroxine for an under-active thyroid. I’m also struggling with the menopause and have read about plant oestrogens but they seem to interfere with levothyroxine. Would a moderate amount of soy be ok? I don’t want to go on HRT but need to balance the side effects of menopause.

Our medical adviser replies: My understanding is that soy protein binds levothyroxine in the stomach and reduces absorption, so if you do take soy protein it would be advised to leave a big gap after you have taken your levothyroxine tablets. Modern thinking about the menopause is now that if you have severe symptoms, unless you have a personal or strong family history of breast cancer, thrombosis etc. then you should consider oestrogen hormone replacement. Transdermal preparations are the safest and I would seriously think about it. Depending on your uterus (present or absent) you may need to take cyclical progesterone too. Drugs such as venlafaxine, citalopram and gabapentin may reduce flushes and are more suitable than oestrogen preparations if you are older than 60 years old. There is also a little evidence that red clover and black cohosh are partially beneficial.
Leaving a legacy to the BTF

Help to make a real difference by remembering BTF in your Will. Any gift, large or small, makes a real difference. Legacy donations allow us to continue providing life-changing support to people with thyroid disorders.

If you do decide to remember BTF in your Will, your gift will mean that BTF will still be here for people who need our support in years to come. By leaving a legacy you can take advantage of the reduced rate of inheritance tax of 36% (previously 40%) that came into effect from April 2012 for estates leaving a legacy to charity. Call 01423 810093 or email legacies@btf-thyroid.org for an information pack.

Shop online and raise money!

easyfundraising.org.uk

Have you heard about easyfundraising yet? It’s the easiest way to help raise money for the BTF! If you already shop online with retailers such as Amazon, M&S, Argos, John Lewis, Comet, Vodafone, eBay, Boden and Play.com then we need you to sign up for free to raise money while you shop!

So how does it work?

You shop directly with the retailer as you would normally, but if you sign up to http://www.easyfundraising.org.uk/causes/btf for free and use the links on the easyfundraising site to take you to the retailer, then a percentage of whatever you spend comes directly to us at no extra cost to yourself.

How much can you raise?

Spend £100 with M&S online or Amazon and you raise £2.50 for us. £100 with WH Smith puts £2.00 in our pocket and so on. There are over 2,000 retailers on their site, and some of the donations can be as much as 15% of your purchase.

Save money too!

easyfundrasing is FREE to use plus you’ll get access to hundreds of exclusive discounts and voucher codes, so not only will you be helping us, you’ll be saving money yourself.

JustTextGiving from Vodafone

You can support people with thyroid disorders by donating via your mobile phone. Just text THYR01 and the amount you would like to donate to 70070.

Unity Lottery

Play the Unity Lottery and win up to £25,000 and many more prizes every week!

Directly supporting the British Thyroid Foundation, Unity is a lottery with a difference. We receive profits directly from the number of lottery players we recruit, so we need your support. For every £1 entry, 50p comes directly to the BTF as profit.

Win up to £25,000

Help support the BTF

PRIZES

- £25,000 6 digits
- £1000 5 digits
- £25 4 digits
- £5 3 digits

For just £1 per week you will be allocated a six digit Unity lottery number. You can purchase more than one entry if you wish. Every Saturday, the lucky winners are selected at random and the prize cheques issued and posted directly to you, so there is no need for you to claim. You must be 16 over to enter. Winners have to match 3, 4, 5 or all 6 digits of the winning number in the correct place in the sequence.

To join go to: www.btf-thyroid.org/support-us/3-play-the-btf-lottery
Local Groups

Please check the BTF website (www.btf-thyroid.org) for the latest details. Please also check before you attend a meeting that it has not had to be cancelled due to poor weather conditions.

Bristol

Next meeting: Every second Wednesday of the month. 12 July 2017 from 7pm to 9pm. New members please arrive at 6.30pm

Programme: Professor Colin Dayan will join us for a question and answer session on thyroid medications.

Location: The Old Library, Muller Road Eastville BSS 6XP

Contact: Michelle on 07759 150727 or email: Michelle.Griffiths@live.uwe.ac.uk

Michelle is the BTF Local Area Coordinator for Bristol and a trainee on the Professional Doctorate in Health Psychology at the University of the West of England.

What is Health Psychology?

Michelle explains: ‘Health Psychology uses knowledge of psychology and health to promote general well-being, and understand physical illness. My work focuses on the impact of modern lifestyles upon our general and thyroid health, and ways to combat this. I also examine the impact that chronic illness has upon the commitments and responsibilities we have, our relationships, and upon our wider sense of self. I run the Bristol Local Group every second Wednesday of the month and welcome all people with thyroid diseases whether you are newly diagnosed or have lived with thyroid disease for a long time. I am particularly keen to hear from BTF members about what you would like covered in a local group’. Please feel free to contact Michelle on Michelle.Griffiths@live.uwe.ac.uk

Cambridge

Next meeting: TBA. Check the BTF website for further details.

Location: TBA

Programme: TBA

Contact: Mary on 01223 290263 or email: butterflyecho@hotmail.com

Edinburgh

Next meeting: The Edinburgh BTF Support Group meets on the last Tuesday of the month except for school holidays. Check the BTF website for further details.

Location: Liberton High School, Gilmerton Road, Edinburgh, EH17 7PT.

Contact: Margaret Tel: 0131 664 7223 or email: M2mcgregor@aol.com

Leeds (Wharfedale)

Next meeting: 26 July 2017 at 7.30pm

Programme: Lorna Pankethman, Orthoptist and BTF volunteer will be speaking about her experiences of working in a joint thyroid and eye clinic and what she has learnt since becoming a volunteer medical query coordinator with the BTF. Followed by a question and answer session.

Entrance is free, but donations are welcome.

Location: Harewood Village Hall, Church Lane, LS17 9LJ (Muddy Boots Cafe is at the rear)

Contact: Caroline on 0113 288 6393 or email: cfields237@btinternet.com

Start a support group!

Are you interested in bringing people together to start a BTF support group in your area? We would particularly like to set up new groups in the North East, North West and South coast. Email info@btf-thyroid.org

Cambridge

Next meeting: TBA. Check the BTF website for further details.

Location: TBA

Programme: TBA

Contact: Mary on 01223 290263 or email: butterflyecho@hotmail.com

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Support for thyroid patients online

We have successful Facebook groups for hyperthyroidism, parents of children with thyroid disorders, thyroid eye disease and thyroid cancer that you can join and share experiences and information. (These are ‘closed’ groups for approved members and only group members can see posted content.) To join, go to Facebook, search for the group you would like to become a member of and send a request. (You will need a basic Facebook profile.) Alternatively email info@btf-thyroid.org with the name of the group you would like to join and your reasons for joining.

Buy a teddy and support the BTF

Buy one of these adorable teddies for £7.50 and all the profit will go towards the BTF.

Go to http://www.btf-thyroid.org/support-us/awareness-merchandise to order online.
**BTF LOCAL COORDINATORS**

Our voluntary local coordinators organise meetings but will also be happy to take calls on thyroid disorders that they have experienced. Please see the key below

- **Bristol** Michelle (U) - 07759 150727
- **Cambridge** Mary (O,R,I,U) - butterflyecho@hotmail.com - 01223 290263
- **Edinburgh** Margaret (PC) - 0131 6647223
- **Leeds** (Wharfedale) Caroline (O,U) - 0113 2886393

**BTF TELEPHONE SUPPORT CONTACTS**

Our telephone contact volunteers are happy to take calls on thyroid disorders that they have experienced. Please see the key below

- **Dave** (PC,CS,RAI) - 07939 236313
- **Jackie** (PC,CS) - 01344 621836
- **Gay** (G,TS) - 020 8735 9666
- **Angela** (U) - 01943 873427
- **Karen** (U) - 01628 529212
- **Maria** (U) - 020 87934360
- **Colin** (O,R,I,U) - 07973 861225
- **Olwen** (O,R,I,U) - 01536 513748
- **Jane** (GR,RI,TED,G,U) - 01737 352536
- **Peter** (TED,GR) - 01200 429145
- **Penny** (Ch) - 01225 421348

**KEY**

- CH Thyroid disorders in children
- C Cancer of the thyroid
- PC Papillary cancer of the thyroid
- CS Thyroid cancer surgery
- RAI Radioactive iodine (I-131) ablation
- G Goitre
- T Thyroid Surgery (non-cancer)
- U Under-active thyroid
- O Over-active thyroid
- GR Graves’ disease
- RI Radioactive iodine treatment for an over-active thyroid
- TED Thyroid eye disease
- PH Post-operative hypoparathyroidism

**OUR PARTNER ORGANISATIONS**

- **AMEND** The Association for Multiple Endocrine Neoplasia Disorders Tel: 01892 516076 [www.amend.org.uk](http://www.amend.org.uk)
- **Butterfly Thyroid Cancer Trust** Tel: 01207 545469 [www.butterfly.org.uk](http://www.butterfly.org.uk)
- **Cancer52** [www.cancer52.org.uk](http://www.cancer52.org.uk)
- **Hypopara UK** Helpline: 01342 316315 [www.hypopara.org.uk](http://www.hypopara.org.uk)
- **Thyroid Cancer Support Group Wales** Tel: 08450 092737 [www.thyroidsupportwales.co.uk](http://www.thyroidsupportwales.co.uk)
- **Irish Cancer Society** [www.cancer.ie](http://www.cancer.ie) email info@thyroidcancersupport.ie

**CURRENT MEMBERSHIP RATES**

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<th>Members living overseas £25 (electronic newsletter only)</th>
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Concession: If you are retired you may wish to pay the concessionary rate. Please help us by ensuring that you pay the correct subscription.

**Recycle for the BTF!**

Fill an envelope with any of the items pictured and affix the freepost label enclosed with this newsletter.