Legacies fund pioneering thyroid research

Thanks to two recent legacies the BTF has been able to guarantee funding for the BTF Research Award for the next four years. Doris Godfrey (featured in BTF News 88) left the BTF £48,000 in her will and another donor, Miss Powell left £46,000 specifically for research into hypothyroidism. These generous gifts enable pioneering research into thyroid disorder causes and potential new treatments.

The Award was set up in 1997 to enable researchers to get research ideas started or to help top up existing projects. Winners of the annual £20,000 Award are chosen by an expert panel for the quality of their research proposal, value for money and for how relevant the outcome of their research will be to the aims of the BTF.

Below are some examples of the research work carried out by previous winners:

The 2015 and 2010 Awards were won by Dr Carla Moran, Consultant Endocrinologist at Addenbrooke’s Hospital, Cambridge to continue to fund her work on Resistance to Thyroid Hormone (RTH). Dr Moran discovered that patients with RTHβ have high cholesterol and insulin levels, possibly increasing risk of cardiovascular disease. She is now investigating ways to diagnose and manage the newly identified genetic disorder RTHα which causes a rare form of hypothyroidism. Dr Moran has spoken at conferences around the world on her research and is due to publish her findings next year.

Dr Petros Perros and Professor Simon Pearce won the Award in 2013 for their research into new ways to reliably test for the recurrence of thyroid cancer in all papillary thyroid cancer patients (the current test does not work for all). The new test they piloted detects chemicals in the blood called ‘microRNAs’, thought to be released by circulating cancer cells. Dr Perros commented: ‘This study has identified 18 potential peripheral blood microRNA markers and further studies of a larger group are planned’.

Long term patient benefit

Professor Chris McCabe received two awards - in 2000 and 2008 - for research into genes associated with thyroid cancer. He explains, ‘The award was extremely useful in providing funding to start a series of experiments which otherwise would not have been done. Those experiments in turn led to larger grant applications and fed into scientific papers. He goes on to say, ‘Research is a long and extensive process and breakthroughs can take many years. However, without the basic science driving the discovery process, there would be no long term patient benefit. So awards such as the BTF Research Award are critical to improve the lives of people with thyroid disease.’

The 2016 Award is being judged this month (February) and the winner will be posted on the BTF website and featured in the next BTF Newsletter.

More information on the BTF Research Award and previous winners can be found at www.btf-thyroid.org/professionals/5-btf-awards

This issue of BTF News has been sponsored by Amdipharm Mercury Company Limited (AMCo). AMCo were not involved in the production or editorial content of this newsletter.
News from BTF

Happy New Year to all our members!

Christmas cards
Thank you to everyone who bought BTF Christmas cards and accessories. We had a fantastic response this year and raised over £1700.

Thank you also to everyone who sent Christmas cards to the BTF Head Office.

Welcome to...
Mary Newton, BTF local coordinator and telephone volunteer who has become a BTF Trustee.

Mary’s career has included working with the Health and Safety Executive and teaching science and psychology at schools, sixth form colleges and the Open University.

Mary was diagnosed with hyperthyroidism (over-active thyroid) and had radioactive iodine therapy in 2006. Her particular interests include helping people learn about their thyroid disorders in order to communicate with medical professionals, and also in the psychological effects of thyroid disorders. She is also a member of the NHS East of England Citizens’ Senate, an organisation of experienced professionals aiming to influence regional NHS strategy by presenting patient, carer and family perspectives.

Farewell and thanks to...

Nikki Kieffer, BTF Trustee for two years. Nikki, a specialist endocrine nurse based in Leicester Royal Infirmary has stepped down due to work commitments.

We are moving!

We will be moving offices on 21 March 2016. Our new address will be: Suite 12, One Sceptre House, Hornbeam Business Park, Hornbeam Avenue, Hookstone Road, Harrogate HG2 8PB

Recycling for charity

Do you have any unwanted items that could be sold to raise money for the BTF? Enclosed in this newsletter is a leaflet explaining how the scheme works together with a freepost label to use. All you have to do is parcel up any unwanted jewellery including costume, odd earrings, broken chains, watches – they can be made of any material: plastic, wood, bronze, gold, silver etc, as well as old or current UK and foreign banknotes. Cut out the freepost label on the back of the leaflet, stick it to your parcel and post. The BTF will receive 75% of the profit.

BTF members help with patient literature

BAETS (British Association of Endocrine and Thyroid Surgeons) have produced patient leaflets on thyroid operations on adults and the consequences of thyroid surgery. BAETS asked the BTF for comments on the leaflets and we’d like to thank our members’ panel, local coordinators and telephone contacts for...
Their constructive feedback, which was taken on board. Ashu Gandhi, Secretary of BAETs passed on his thanks for the help and commented: ‘The leaflets are nothing without patient input. I hope that future patients will find them useful’.

The leaflets can be found at: www.baets.org.uk/useful-links/patients

**Thyroid medical information review – feedback wanted**

We have been contacted by the organisation that writes the medical guidance which is published on the National Institute for Health and Care (NICE) CKS website. They are looking for patients to provide feedback to ensure that the patient’s voice is being heard during the development of this information. They will be writing guidance for hypothyroidism and hyperthyroidism.

If you would like to review the information written by doctors to help ensure that patients’ needs are being properly considered and understood please contact Julia Priestley at BTF Head Office (info@btf-thyroid.org) using the subject heading ‘Clinical Info Review’.

**Great North Run places**

For the first time we are delighted to have been allocated some places for this iconic race. The run on 11 September 2016 in Newcastle-upon-Tyne attracts world class athletes like Mo Farah and Haile Gebrselassie, is televised by the BBC, and has over 57,000 other runners of all standards taking part in an electric atmosphere. All you need to do is pay £25 registration fee and pledge to raise a minimum of £300. Email fundraising@btf-thyroid.org for more information.

**Membership Survey Feedback**

Thank you to all those members who replied to our Member Feedback Survey. Over 250 members responded and told us about their experiences of BTF’s services with suggestions and comments as to how we can improve. We also had responses from people who found the survey through the BTF website.

The results will help the BTF Trustees develop a strategic plan for the BTF, which will lead the charity through the next three years. We will share the plan with members once it has been agreed.

We have listened to the members who asked that BTF News should include more medical letters and practical information and so in this News you’ll find more members’ letters and also a feature on thyroid and weight, including some tips on weight loss.

Some members raised questions about BTF’s core services and so here’s a reminder of what is available:

- If you have a medical query you can write to us by letter or email (medical-query@btf-thyroid.org) and your question will be answered by one of our medical advisers.
- A list of telephone contacts (BTF volunteers who will speak to you and offer support and information) is on the back of each newsletter and on our website.
- The recently revised and updated BTF leaflets are now available online to read, download and print. Once we have moved to our new premises in March the leaflets will be printed to send out to enquirers.
- If you would like a copy of our leaflet about Legacy Giving or about how to join the BTF Lottery please contact the office. They are also available on the website.

**Campaign to reach GPs**

There is a loud call from members that BTF should do more to raise the profile of thyroid disorders, with the general public and, in particular, with GPs.

As mentioned in BTF News 90 (page 3) we have signed up to take part in a year-long campaign which aims to reach GPs through their practice managers. A BTF poster has gone out to 96.7% of surgeries throughout the UK and we hope that some of those posters will be displayed in waiting areas. Please let us know if you have seen one in your surgery.

If your surgery will display a BTF poster please contact BTF HQ and we will send you one.

Another suggestion made by members is that you could take old copies of BTF News to your GP surgery for patients (or GPs) to read in the waiting room.
BTF attends British Endocrine Society annual meeting

The BTF attended the annual Society for Endocrinology British Endocrine Society (BES) conference in November in Edinburgh. This is the largest UK meeting on hormone research and includes some of the best of British and international science and research, clinical investigation and clinical practice in endocrinology.

The BTF was invited to exhibit in the patient support area and we are grateful to BTF Edinburgh local coordinator Margaret McGregor and her husband Mike, who manned our stand. Over the course of the three days the stand was visited by a large number of attendees, many requesting further information to display in their thyroid clinics.

There were a number of sessions about thyroid disorders and related topics. British Thyroid Association President, Dr Mark Vanderpump gave a lecture on iodine deficiency and chaired a debate on the use of combination treatment with T3 and T4 for patients who do not respond to levothyroxine (see below).

T3 and T4 Debate by Dr Buchi Okosieme, member of the executive committee of the British Thyroid Association

Perhaps no single issue has engendered as much debate in the management of hypothyroidism as the value of combination treatment with Liothyronine (LT3) and Levothyroxine (LT4). In a packed evening session superbly chaired by Dr Mark Vanderpump, this long-standing controversy was revisited at the Society for Endocrinology 2015 annual scientific conference.

To argue for and against the motion that ‘patients with hypothyroidism should be offered combination treatment with LT3 and LT4 if they do not respond to LT4’ were two seasoned thyroid experts: Colin Dayan, Professor of Clinical Diabetes and Metabolism at Cardiff University and Anthony Weetman, Professor of Medicine and Pro Vice Chancellor at the University of Sheffield.

In a series of carefully constructed arguments Professor Dayan laid down the case for the motion on the basis that patients on LT4 have impaired psychological well-being and cannot maintain normal T3 levels with LT4 therapy alone. Furthermore the majority of patients who receive combination therapy express a preference for this therapy over LT4 monotherapy. Citing data from his own published research Professor Dayan argued that common genetic variations in the molecules that convert T4 to the active T3 compound may influence the response to LT4 therapy. In particular, individuals with variations in the gene encoding the deiodinase enzyme, D2, involved in converting T4 to T3 in the brain, (comprising about 12–15% of the population) have impaired psychological well-being on LT4. Lastly, by offering LT3 to well selected patients, endocrinologists would reduce unregulated use of LT3.

In an equally thoughtful and engaging presentation, Professor Weetman urged the house to vote against the motion on the grounds that current T3 formulations do not mimic the body’s natural pattern of T3 production, and at best, available data show no convincing evidence for or against a benefit from combination treatment. Professor Weetman argued that dissatisfaction with LT4 has many plausible roots including co-morbidity (i.e. the presence of one or more additional disorders or disease), the autoimmune state itself, and the likelihood that dissatisfied individuals are more likely to acquire a diagnostic label of hypothyroidism. For hypothyroid patients who feel unwell with a normal TSH, he urged clinicians to exclude other causes and to give empowering explanations for symptoms, rather than rejection or collusion by prescribing LT3.

Both speakers agreed that further research is needed and that until such research is available the controversy is likely to rumble on.

Evelyn Ashley Smith Award for Nurses

Applications are invited from nurses, endocrine nurses, midwives and healthcare professionals with a special interest in thyroid disorders. Applicants must demonstrate that the activity supported by the award is aimed at enhancing the care of patients with thyroid disorders.

The Evelyn Ashley Smith £1000 Award can be used for a specific project lasting one year or an on-going project. The Evelyn Ashley Smith £500 Award can be used for training needs and travel expenses or conference registration fees and travel expenses.

For an application form, go to: www.btf-thyroid.org, email nurse-award@btf-thyroid.org

The closing date for receipt of applications is 1 July 2016.
BTF Projects Update

The BTF is currently involved in several key thyroid related areas with the aim of improving knowledge, assisting with research and improving the patient’s experience. The BTF is currently focusing on developing a hypothyroidism care strategy, 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.

Iodine

UK iodine members Professor John Lazarus and Dr Sarah Bath were interviewed by medical journalist Becky McCall concerning iodine deficiency in pregnancy for The Guardian (December 7 2016). In it she refers to the iodine situation in the UK and notes the important research conducted by UK Iodine Group members in relation to the adverse effects of maternal iodine deficiency and subsequent school performance of their children. The article discusses ways to ensure adequate intake (including whether supplements should be taken by pregnant women).

Members of the UK Iodine Group including Professor Lazarus, Professor Margaret Rayman, Professor Kate Jolly, Mr Michael Marsh and Dr Mark Vanderpump, will be speaking at a symposium on Iodine in Pregnancy at the Iodine Global Network international meeting in London in March. This is an annual meeting of international experts from around the world brought together to discuss current guidelines, experiences from other countries and the way forward for iodine policy.

Thyroid cancer

The group meets by telephone conferencing three to four times a year and has been involved in a number of projects including representing the BTF in producing the British Thyroid Association guidelines on treatment of thyroid cancer. One of the group’s next projects is to find out about the provision of radioactive iodine treatment rooms throughout the UK and, if necessary how they can be improved.

To share your experiences of radioactive iodine please contact info@btf-thyroid.org

Children

The BTF was represented at the British Society for Paediatric Endocrinology and Diabetes (BSPED) that took place in Sheffield in November. This was an excellent opportunity to speak to the specialist doctors and nurses who support children and families and to give out copies of the BTF information leaflets and DVDs, which can be helpful at diagnosis. (International Thyroid Awareness Week 2016 (23 May- 30 May) will focus on children this year.)

Thyroid eye disease - an award winning team!

TEAMeD (Thyroid Eye Disease Amsterdam Declaration Implementation Group), formed in 2010 to improve prevention, care and access to care for thyroid eye disease (TED) and made up of representatives from key organisations including the BTF, was awarded the Judges’ Special Award at the Bayer Ophthalmology Honours 2015. The Awards recognise and celebrate, on an annual basis, the outstanding work being carried out by multi-disciplinary teams in ophthalmology throughout the UK. TEAMeD’s application – ‘Improving outcome for patients with thyroid eye disease (TED) through prevention, early diagnosis and early intervention’ described work carried out since 2010 and highlighted TEAMeD’s key aims which are: provision of good quality information for patients; implementation of preventive measures; early diagnosis; timely access to eye/endocrine care; promotion of research in the field.

The judges commented: ‘The performance of this team is outstanding and a thorough service is being provided which is something that patients will really benefit from. We believe that one day every Trust will be using their guidelines.’

www.btf-thyroid.org/projects/teamed/226-teamed-workstreams
Fundraising and Donations

Thank you to our fundraisers!

The Inner Wheel Club of Ipswich Orwell has chosen the BTF as their charity of the year. Their President, Linda Smith, has an under-active thyroid and helped organise a coffee morning in which a fantastic £450 was raised. The Club is holding a dinner in aid of the BTF in February where BTF Research Award winner 2015 Dr Carla Moran will give a talk on thyroid issues. They are also organising a fundraising garden party in the summer.

Naish Estate Agents & Solicitors nominated the BTF as their chosen charity at the annual York Sportsman’s Lunch and raised an amazing £4000.

Ethan Mitchell raised £20 at his school for the BTF by selling second hand books, thyroid badges and holding a lucky dip in his lunch hour over two days.

Year 2 at Brockmoor Primary School in Brierley Hill raised £65.45 for the BTF.

Eileen Guppy (former BTF Trustee and BTF News Editor) donated £50.

Cicely Carr and her family decorated a Christmas tree with gold thyroids for their local Christmas tree festival in Alvestoke for the second year, and spread the word about the support the BTF provides.

Helana Saunders raised a fantastic £360 by completing a 20km walk through London.

Cheryl McMullan from the BTF office gave a talk on thyroid disorders at the Martin-cum-Grafton Women’s Institute in November. The group held a carol singing fundraising event at Christmas and kindly donated £120 they raised from this.

Jason Cook, the comedian and creator of BBC sitcom Hebburn, raised an amazing £1500 for the BTF by taking part and winning Celebrity Mastermind in January.

He said he was delighted to be asked to go on the celebrity special of the famous quiz show, in which he chose his hero - fellow comedian Billy Connolly as his specialist subject.

Jason said: ‘I’ve always loved the show. Everyone likes trying to answer the questions and seeing if they know something the contestant doesn’t, so I was delighted when they asked me to go on it - and to be able to raise such a great amount for a charity close to my heart was amazing’.

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.

The Tuesday Fellowship at Norton Methodist Church donated £100 in memory of Mrs Norma Taylor.

Eileen Guppy (former BTF Trustee and BTF News Editor) donated £50.

Future fundraisers

Corrine Neill and her family are going to climb Ben Nevis in June for the BTF. Corrine’s sister Gwen is terminally ill with thyroid cancer and they aim to raise £500.

www.justgiving.com/Corinne-neill

James Sazek who has an under-active thyroid is taking part in the Colchester Half Marathon in March.

www.justgiving.com/SarekHalfMarathon

Lotty Brand is undertaking a 7 day silence in February (as we go to press) for the BTF following the removal of half her thyroid.

www.justgiving.com/Lotty-Brand

Steve Foulkes is cycling from London to Paris in September 2016 for the BTF.

www.justgiving.com/steven-foulkes

Run for the BTF

We still have places left in the British 10k in London on Sunday 10 July 2016. This run, now in its 16th year takes in all the greatest sights of London – email fundraisers@btf-thyroid.org for a registration form

For the first time, the BTF also has places available in the Great North Run (see page 3 for more details).

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My Story

*Rae was diagnosed with Graves’ disease nearly thirty years ago. She explains how she has managed to lead a normal life after taking radioiodine treatment.*

Before doctors understood the endocrine system and developed medicines for thyroid disorders I would have died around the age of 46. Now in my 70s I recall living life in high revs in fifth gear in the 1980s thinking that was normal. For me anyway! One morning before leaving for my teaching job (and later, on reflection) I counted 22 tasks that I had done in preparing for the day and preparing my husband and our four children for theirs. The fact that I never needed many layers of clothes, even in winter, were signs of something but reasons could always be found for life as it was.

Thyroid disorders like lots of other conditions were not heard of as they are today so I never considered having any part of me malfunctioning. It wasn’t until I was sitting in front of the bedroom mirror looking at the wrinkles on my neck (which incidentally did not exist as I now know, as I really have them now!), that I saw an egg-shaped lump on the front of my neck. My parents were staying at the time and reacted to the lump by saying ‘Your grandma had a goitre. You had better see the GP’. I had never heard this about my maternal grandma before.

I consulted the doctor within a couple of days who checked my pulse, which was 86, and I had a hand tremor. My pulse was normally 56 as I had taken up running for fitness when I was 35, I was now 45. The doctor referred me to the Christie Hospital, which was in my local area. I was seen two weeks later by a wonderful consultant whose name, unfortunately, I cannot remember, which is strange to me because I can remember every other minute detail of that day - what I was wearing, the consulting room, the scan room etc etc.

The consultant arranged a scan so with a short walk to the scanner, a short scan and a vivid printout of my thyroid, it was obvious that I had an over-active thyroid. I walked straight back into the consulting room, no waiting, where the consultant told me I had Graves’ disease. I was given three options: an operation to remove some of my thyroid, medication, or radioactive iodine. I have always had and still have the utmost respect for the medical profession so I asked for his recommendation. He favoured the third option and saying he had a quiet day, he phoned ahead and actually walked with me through part of the grounds and part of the hospital to the radioiodine room. I sat behind a screen, was given a tumbler with a centimetre of clear liquid in it and was instructed to drink every drop with a straw……and that was it. I walked out within half a day of walking in. As I had had no qualms I had travelled alone but on driving home the enormity of what had happened hit me and I broke down in tears when I stopped at traffic lights. A normal reaction perhaps, but with hindsight there was no need for upset.

At home, life was completely normal except for having to stay off work for four days as I worked with under fives, and having to take 150mcg levothyroxine daily to keep me alive. Initially I had two-weekly checks and since then I have had six-monthly blood tests. In the late 1990s my medication was decreased from 150mcg to 125mcg daily and recently to 100mcg daily. These check-ups, and having to take medication for the rest my life, ensure that my body, and my life, are not affected by having an under-active thyroid.

I have led a very active life, raising four children, helping with 10 grandchildren, teaching full time until retirement and being an active, competitive orienteer since 1977. Orienteering has involved competing most weekends at home and abroad and it has kept my mind and body active, brought me in touch with many, many people I would not have met otherwise and it is a sport that I would recommend for young and old and particularly families.

I can say that my thyroid has not affected my lifestyle in any way so maybe I was lucky. I have lost some of my eyebrows, my pubic hair and gained a little weight recently but otherwise there are no signs that I have one of the twelve illnesses that have entitled me to free prescriptions. I do feel that immediate action on discovery of an abnormality and the efficiency of the NHS made my outcomes so positive and enabled me to live a completely normal life.

Rae talks about her experience of Graves’ disease in a short BTF film on hyperthyroidism: www.btf-thyroid.org/information/video-index/10-patient-journeys-hyperthyroidism

‘I lived life in high revs in fifth gear in the 1980s thinking that was normal.’
What is the relationship between thyroid and weight?
It has been appreciated for a very long time that there is a complex relationship between thyroid disease, body weight, and metabolism. Thyroid hormone regulates metabolism in both animals and humans. Metabolism is determined by measuring the amount of oxygen used by the body over a specific amount of time. If the measurement is made at rest, it is known as the basal metabolic rate (BMR). In fact, measurement of the BMR was one of the earliest tests used to assess a patient’s thyroid status. Patients whose thyroid glands were not working were found to have low BMRs, and those with over-active thyroid glands had high BMRs. Later studies linked these observations with measurements of thyroid hormone levels and showed that low thyroid hormone levels were associated with low BMRs and high thyroid hormone levels were associated with high BMRs. Most doctors no longer use BMR due to the complexity in doing the test and because the BMR is subject to many other influences other than the state of the thyroid.

What is the relationship between BMR and weight?
Differences in BMRs are associated with changes in energy balance. Energy balance reflects the difference between the amount of calories eaten and the amount of calories the body uses. If a high BMR is induced by the administration of drugs, such as amphetamines, animals often have a negative energy balance which leads to weight loss. Based on such studies many people have concluded that changes in thyroid hormone levels, which lead to changes in BMR, should also cause changes in energy balance and similar changes in body weight. However, BMRs are not the whole story relating weight and thyroid. For example, when metabolic rates are reduced in animals by various means (for example by decreasing the body temperature), these animals often do not show the expected excess weight gain. Thus, the relationship between metabolic rates, energy balance, and weight changes is very complex. There are many other hormones (besides thyroid hormone), proteins, and other chemicals that are very important for controlling energy expenditure, food intake, and body weight. Because all these substances interact on both the brain centers that regulate energy expenditure and tissues throughout the body that control energy expenditure and energy intake, it is difficult to predict the effect of altering only one of these factors (such as thyroid hormone) on body weight as a whole. As a consequence, at this time, it is impossible to predict the effect of a changing thyroid state on any individual’s body weight.

Why do I gain weight when hyperthyroidism is treated?
Because being hyperthyroid is an abnormal state, any weight loss caused by the abnormal state would not be maintained when the abnormal state is reversed, and this is what is found. On average, any weight lost during the hyperthyroid state is regained when the hyperthyroidism is treated. One consequence of this observation is that the use of thyroid hormone to treat obesity is not very useful. Once thyroid hormone treatment is stopped, any weight that is lost while on treatment will be regained after treatment is discontinued.

What is the relationship between hypothyroidism and weight gain?
Since the BMR in a person with hypothyroidism is decreased, an under-active thyroid is generally associated with some weight gain. The weight gain is often greater in those individuals with more severe hypothyroidism. However, the decrease in BMR due to hypothyroidism is usually much less dramatic than the marked increase seen in hyperthyroidism, leading to smaller alterations in weight due to an under-active thyroid. The cause of the weight gain in a hypothyroid person is also complex, and not always related to excess fat accumulation. Most of the extra weight gained in hypothyroid individuals is due to excess accumulation of salt and water. Massive weight gain is rarely associated with hypothyroidism. In general, 5-10 pounds of body weight may be attributable to the thyroid, depending on the severity of the hypothyroidism. Finally, if weight gain is the only symptom of hypothyroidism that is present, it is less likely that the weight gain is solely due to the thyroid.

How much weight can I expect to lose once the hypothyroidism is treated?
Since much of the weight gain in hypothyroidism is accumulation in salt and water, when the hypothyroidism is treated one can expect a small (usually less than 10% of body weight) weight loss. As in the treatment with hyperthyroidism, treatment of the abnormal state of hypothyroidism with thyroid hormone should result in a return of body weight to what it was before the hypothyroidism developed. However, since hypothyroidism usually develops over a long period of time, it is fairly common to find that there is no significant weight loss after successful treatment of hypothyroidism. Again, if all of the other symptoms of hypothyroidism, with the exception of weight gain, are resolved with treatment with thyroid hormone, it is less likely that the weight gain is solely due to the thyroid. Once hypothyroidism has been treated and thyroid hormone levels have returned to the normal range of thyroid hormone, the ability to gain or lose weight is the same as in individuals who do not have thyroid problems.

Can thyroid hormone be used to help me lose weight?
Thyroid hormones have been used as a weight loss tool in the past. Many studies have shown that excess thyroid hormone treatment can help produce more weight loss than can be achieved by dieting alone. However, once the excess thyroid hormone is stopped, the excess weight loss is usually regained. Furthermore, there may be significant negative consequences from the use of thyroid hormone to help with weight loss, such as the loss of muscle protein in addition to any loss of body fat. Pushing the thyroid hormone dose to cause thyroid hormone levels to be elevated is unlikely to significantly change weight and may result in other metabolic problems.

This information is reproduced from the American Thyroid Association
FAQ on Thyroid and Weight: www.thyroid.org/thyroid-and-weight/

The American Thyroid Association (ATA) has lots of up-to-date and accessible information on thyroid disorders
Go to www.thyroid.org
whereas I used to weight eight and a half. Friends and family had begun to think that I was anorexic and were trying to coax me to eat. I tried to explain that I was actually eating like a horse - no one believed me - even though they were sometimes at the table with me sharing a meal and saw the amount I ate. Then they started following me to the bathroom if I got up after a meal - obviously thinking I had become bulimic!

My GP referred me to the Leeds General Infirmary where a series of tests were done but no blood tests as, I can only assume, they thought my GP had done one! In the clinic I was told ‘We think you have a tumour but don’t know where yet’. I was sent for yet another scan.

Sitting in a room waiting for the results, a junior doctor came in. She apologised for me not seeing my usual consultant and went on to explain that they still couldn’t find the cancer. ‘What did your blood tests say?’ She asked, looking through my thick wad of notes. When I tried to think back as to what blood tests she was referring to, she became impatient. ‘You have had blood tests, haven’t you?’ she now asked suspiciously. I shook my head slowly, I honestly couldn’t remember. So many tests and probes, what was one blood test amongst all the many procedures I had had? She handed me a form and told me to follow the red line on the floor from her office to the clinic for a blood test. Two hours later I was told I had an over-active thyroid and I cried with relief. Suddenly I had a life again. Treatment followed, the weight steadily went back on and I felt normal for the first time in well over a year. Six months later, however, I became unwell again. Blood tests followed which showed I had become under-active and I now take levothyroxine. My weight thankfully isn’t an issue now although I do find I have to be careful not to let it creep up.

As a Slimming World consultant I have so many members with thyroid issues and it is those who go with the mentality of ‘I won’t let it stop me’ and follow the plan, make healthy habit changes, who get the results.’

As a Slimming World consultant I have so many members with thyroid issues and it is those who go with the mentality of ‘I won’t let it stop me’ and follow the plan, make healthy habit changes, who get the results.’

**Tips and advice on diet and thyroid**

*BTF advice is to stick to a healthy balanced diet that includes all food groups. Be aware of the following if you have a thyroid disorder though:*

**Calcium**

Some calcium rich foods (milk, cheese, yoghurt) and supplements interfere with levothyroxine absorption. Try and leave a gap of four hours between the two to ensure optimum absorption of your tablet. Levothyroxine is in fact best taken on an empty stomach at least half an hour before any food. So if you take your tablet in the morning, leave at least half an hour before eating. Your breakfast should then not be made up of calcium rich foods (porridge, yoghurt, lots of milk), stick to toast or cereal with a little milk or take your tablet last thing at night instead. Note that lower fat milks (i.e. semi-skimmed or skimmed) remain high in calcium despite being lower in fat.

**Soya**

Soya interferes with thyroxine absorption, therefore if you are taking levothyroxine you should try to avoid soya. If you wish to take soya, there should be as long a time interval as possible between eating the soya and taking levothyroxine.

**Iodine and Iodine supplements**

Avoid products that are very high in iodine such as kelp (seaweed), including kelp supplements, as they may interfere with thyroid function and wellbeing.

**Iron Tablets**

Some medications such as iron tablets (ferrous sulphate) can interfere with the absorption of levothyroxine. Most doctors recommend a two-hour interval between taking levothyroxine and the iron. Be aware that some multi vitamin tablets contain iron.

**Brassicas**

Brassicas (cabbage, cauliflower, kale etc) may contribute to formation of a goitre (enlargement of the thyroid gland) in some cases, but you would need to eat a huge amount before this is a real concern.
Tips on weight loss

Losing weight, particularly if you have an under-active thyroid, is not always easy. At this time of year, we are bombarded with articles on the latest miracle diets, super foods and extreme exercise regimes.

Members regularly ask for tips on weight loss. The British Dietetic Association (BDA) www.bda.uk.com have produced a very helpful information sheet packed full of sensible tips on losing weight successfully. Here are some of them:

- Keep a food and mood diary for a week. In this diary record everything you eat and drink, at what times and how you were feeling. For example, ‘a cup of tea with one teaspoon of sugar and semi-skimmed milk at 3pm (feeling stressed)’. By looking back over this you will be able to see how times, places, people and your mood affect your food intake.
- Choose two or three small changes you can start with and write yourself an action plan with clear goals to follow, for example: I will increase my fruit intake and do this by having two pieces of fruit per day. When you have achieved these, you can move on to more changes or build on the ones you’ve already established.
- Make a list of non-food related tasks that will distract you from thinking about eating to use when you fancy a snack or because you’re bored. For example, reading a chapter of your book.
- Ask for the right support - from a friend, partner, health professional, group or website. This not only keeps you inspired but also helps you through tough times.

Set yourself realistic goals:

A weight loss of between 0.5 to 2lb a week is a safe and realistic target.

- Think about goals you would like to achieve that are not weight orientated - being more active with your children, taking the stairs without getting out of breath.
- It’s not just about weight - losing inches from your waist helps to lower the risk of conditions like type two diabetes and high blood pressure.
- Keep active everyday - this will help you burn more calories and can boost mood and improves long-term success.

Did you know?

One pound of fat contains 3,500 calories, so to lose one pound a week you need to eat 500 less calories a day. If you ate 100 extra calories than you needed each day by the end of the year you could have gained up to 5kg or 11lb. One and a half plain digestive biscuits contains approximately 100 calories.

Follow a healthy eating plan:

Plan ahead to help ensure you have the right foods to hand, at the right times:

- Start the day with a healthy breakfast. People who eat breakfast find it easier to control their weight and are slimmer than those who don’t.
- Eat three regular, planned and balanced meals a day. Only include snacks if you are physically hungry.
- Aim to eat more fruit and vegetables – include at least five portions of fruit and vegetables each day.

- Half fill your plate with vegetables/salad and divide the other half between meat, fish, egg or beans and starchy foods like potatoes, rice, pasta or bread.
- Choose foods and drinks that are low in fat and sugar and limit sweet, fatty and salty snacks.
- If you drink, moderate your alcohol intake. Alcohol is high in calories and dissolves your good intentions.
- Watch your portion sizes especially when eating out.
- Avoid eating at the same time as doing something else, for example when working, reading or watching TV, as this can cause you to overeat.
- Eat slowly, concentrate on and really taste the food you are putting in your mouth.
- Aim to drink two litres of fluid per day, choosing low calorie, non caffeinated drinks.
- Don’t ‘diet’. Diets are often extreme, strict and nutritionally unbalanced and dictate what you should and shouldn’t eat resulting in you not sticking to them for very long.
- And finally, it takes time for your brain to know your stomach is full so wait at least fifteen to twenty minutes before deciding you need more food.

While you are on your weight loss journey:

- Accept that the occasional slip-up is normal. Don’t let a slip make you lose sight of your overall goals and the progress you have made, instead learn from it.
- Keep some form of food diary. It helps you to stay aware of what you are doing and deal with any problems like emotional eating. It also helps you feel more in control of your eating.
- Track your progress; perhaps weigh yourself once a week or measure your waist, or see what goals you have achieved at the end of each month.
- Plan for events like eating out. Decide what your plan of action will be and stick to it. For example: decide to have two courses instead of three or share a pudding.
- Have a plan for your high-risk situations to help prevent any slip-up. The plan must be specific and detailed, for example: I am at high risk of stopping my healthy eating when I’m busy. My plan to handle this situation is to do menu plans weekly, write shopping lists, cook in bulk and freeze individual portions.
- Making changes to your lifestyle can require a lot of effort. When you achieve a goal reward your achievement with something you value that is non food-related (e.g. trip to the cinema).
- Get the support that is right for you - it makes all the difference. Decide who can help you and tell them the best way they can do it, maybe ask a friend to go to an exercise class with you or ask your partner not to buy you food as a gift.

Remember there is no quick fix. People who successfully lose weight and keep it off stay realistic and develop techniques to make their new lifestyle and activity habits an enjoyable way of life.

Further information

This information is reproduced from the British Dietetic Association Food Fact Sheet Weight Loss. This and other fact sheets are available to download free of charge at: www.bda.uk.com/foodfacts

Visit www.bdadigestwise.com for more help and advice on how to keep weight off, how to get back on track and for helpful resources such as a downloadable food diary and progress chart.
Research News

BTF Nurse Award Winner

Winner of the BTF Evelyn Ashley Smith Nurse Award 2015 was Bridget Knight, Research Midwife, NIHR Exeter Clinical Research Facility. She used the £500 to travel to the recent British Endocrine Society conference in Edinburgh (see page 4) where she presented findings of the project she has been involved in: Breech presentation in pregnancy and risk of maternal hypothyroidism.

Bridget explains: "A breech presentation (head or feet first) occurs in 3 to 5% of all full-term pregnancies and can cause problems for both mother and baby. Reasons include the mother going into labour early (before 37 weeks of pregnancy), the baby being small, or being a twin or triplet. Recently research has also suggested that thyroid deficient mothers are also at increased risk, possibly because thyroid deficiency is known to reduce muscle tone (making the uterus more relaxed), or may impact on the reflexes involved in the baby moving and changing its position. We wanted to explore this in more detail.

'We recruited a group of mothers with no known thyroid problems to establish if there is in fact a link between thyroid function and a breech presentation. We recruited two groups of mothers from clinic during their routine 36-38 week antenatal visit: 156 mothers with a single baby in the breech position, and 154 with a single baby in the cephalic (normal head first) position. They all provided a one-off blood sample for routine thyroid function tests. We then looked for differences between the breech and cephalic groups. First we compared 'baseline' information: this included the mother’s age, her body mass index (BMI), did she smoke, did she take vitamins, and was it her first baby? There was no difference in any of the measurements. This was important as it meant we could then safely compare the results from the thyroid tests and be confident any differences seen were not because of other differences between the groups.

Within this group of 310 women with no history of known thyroid diseases, we actually found that 5% were TPO-Ab positive (antibodies present), 11% had hypothyroidism (most with subclinical hypothyroidism) and 15% had isolated hypothyroxinaemia (subnormal thyroxine level in the blood). When we compared these rates of reduced thyroid function in the two groups there was no difference. Our study suggests that a breech presentation in late pregnancy is not associated with known markers of maternal thyroid dysfunction. While thyroid problems may cause problems in pregnancy unless carefully managed during pregnancy, it is unlikely that these mothers are at extra risk of having a breech birth.

Thyroid eye disease assessment tool proving a success

The award winning (see page 5) TEAMeD (Thyroid Eye Disease Amsterdam Declaration Implementation Group UK) formed in 2010 to improve prevention, care and access to care for thyroid eye disease (TED) and made up of representatives from key organisations including the BTF, has developed DiaGO (Diagnosis of Graves’ Orbitopathy), a clinical assessment tool, to guide doctors in making a possible diagnosis of thyroid eye disease (TED) in patients with Graves’ disease. TED is an inflammatory condition of the eyes associated with Graves’ disease (the commonest cause of an over-active thyroid). TED is also known as Graves’ orbitopathy (GO). In its most severe forms, TED can cause blindness. The earlier TED is treated the better the results. However, recognising TED can be challenging for doctors and delays in diagnosis are unfortunately common.

DiaGO is a set of questions and a simple examination of the eyes that can be done quickly by health professionals. Dr Anna Mitchell, from the Institute of Human Genetics, Newcastle, and member of TEAMeD explained: 'We tested DiaGO on 104 people with Graves’ disease with and without known TED. In this initial pilot study, we have found that DiaGO can be used to accurately identify TED in patients with Graves’ disease whose eye condition was previously undiagnosed, prompting referral, early diagnosis and specialist treatment.

'TEAMEd has received additional funding from Fight for Sight and the Thyroid Eye Disease Charitable Trust to carry out further tests on DiaGO. We plan to test DiaGO in a larger study, across multiple UK hospitals, so that we can determine whether it can be used widely in outpatient endocrinology clinics (where Graves’ disease patients are commonly seen regularly) to help detect TED in patients at an early stage, so that they can be offered treatment to prevent progression to more severe TED.'

Studies suggest even borderline hypothyroidism in pregnant women should be treated

Dr Peter Taylor, winner of the BTF Research Award 2014, is currently undertaking research into thyroid hormone screening in pregnancy, following further support from the BTF. The study has produced some interesting findings so far.

Dr Taylor explains: ‘Borderline thyroid function in pregnant women can cause problems for the unborn child. However it remains unclear whether screening during pregnancy and treating borderline hypothyroidism with levothyroxine improves outcomes. This is an important issue to address as potentially substantial benefits might be achieved including reducing the risk of miscarriages and premature delivery.

‘It is particularly challenging to conduct trials of this nature in pregnancy; however we studied a large previously conducted trial - the Controlled Antenatal Thyroid Study (CATS). This measured thyroid function at the end of the first trimester and treated women with borderline thyroid hormone levels with levothyroxine to see if that improved neurological development in offspring. Using advanced data linkage methods we were able to electronically capture key pregnancy outcomes. As a result we had effectively a free trial of thyroid hormone screening and treatment in pregnancy.

‘Our results were supportive of undertaking thyroid screening in pregnancy as we established a link between sub-optimal maternal thyroid function and adverse pregnancy outcomes. Furthermore we also showed that levothyroxine treatment improved birth-weight and reduced the risk of premature delivery and also may have some protective impact on stillbirths and the number of emergency caesarean sections needed.’
Weight issues

C asks: I have an under-active thyroid that was diagnosed approximately five years ago. I am on levothyroxine and my levels are allegedly acceptable now. My query is that I am on levothyroxine and my levels are determined by many things other than thyroid hormone levels, so there may be other factors that are at play here. We suggest you make an appointment to see your GP to discuss the way you are feeling and request that they look into the problem further for you. (See page 10 for our feature on thyroid and weight.)

Is radioiodine treatment safe?

E asks: I suffer from an over-active thyroid/Graves’ disease. I’m at the stage now that I’m being pushed in the direction of radioactive iodine treatment. I have been speaking with many people on a Facebook group that are all telling me not to do it - the things I have heard are awful and I’m petrified that this could happen to me, the biggest worry being that I’m also bipolar so the depression worries me a lot. The ‘specialists’ are not helping me, they will not tell me much or advise me. I don’t know if it’s possible to speak to anyone that might be able to help me with my decision, or just give me a little more info. If there are any telephone numbers or other places I could go to get this please let me know.

Our medical adviser replies: Over 50 years of experience with radioiodine worldwide shows that it is a safe and effective treatment for an over-active thyroid gland. It can be given to people with additional illnesses such as depression or bipolar disease. A tiny number of patients develop a mild short-lived sore throat after treatment but most people notice nothing at all.

There are some restrictions to follow after radioiodine treatment however and your hospital will give you specific instructions to avoid exposing people around you to radioactivity in the weeks after treatment. It is also important that women do not conceive for at least six months after treatment.

Most patients who receive radioiodine will subsequently develop an under-active thyroid gland so it is crucial that thyroid tests are carried out starting from 4-6 weeks after treatment. Failure to detect and treat an under-active thyroid afterwards is one reason why some people feel unwell after radioiodine.

If you have severe thyroid eye disease radioiodine may not be right for you and it may be worthwhile discussing this with your endocrinologists. We hope the above information will be helpful to you.

Are there any new treatments for Graves’ disease?

C asks: I have Graves’ disease and have now had a second recurrence of a very overactive incident. I am back on carbimazole, which I respond to very well. I’m exploring longer-term options with my endocrinologist and one of the newer treatments I’m hearing about is low dose naltrexone. I’d be interested to know what research has been done on this and if you are aware of any trials being done with autoimmune thyroid patients.

Our medical adviser replies: I have heard about this low-dose naltrexone from another source and I looked into it about a year ago. As far as I can tell, there is no plausible mechanism why it might help people with Graves’ disease, nor any evidence that it actually does help the condition. If carbimazole is working well for you it would be wise to stick to this tried and tested treatment.

There will be a trial next year of another possible treatment - B cell depletition therapy in Newcastle, Birmingham, Edinburgh and Sheffield, but the requirement is for people under 20 years old who have been on carbimazole for less than six weeks.

The BTF has a closed Facebook Group for people with hyperthyroidism. Search for BTF Hyperthyroidism on Facebook. It is often helpful to be in contact with others who have been through a similar experience.

Letters from parents about their child’s thyroid disorder

If you are a parent who would like information or have a question about a thyroid disorder you can write in to Children’s Editor (BTF), Second Floor, 3 Devonshire Place, Harrogate HG1 4AA or email children@btf-thyroid.org. We will ask our children’s medical expert Dr Tim Cheetham to reply to you and may publish your letter (with your permission) in the newsletter.

Struggling to normalise levels in my baby

E asks: Our daughter was born last June and five days after her birth, she was diagnosed with congenital hypothyroidism (no thyroid gland present). We have her bloods checked every two months, but rarely get a satisfactory result. We have been advised to change her dose on different occasions, but it is starting to concern us. Is it usual to struggle to get the right dose in early years? Her dose has been as high as 50mcg to as low as 25mcg.
We live over half the year in the Middle East due to work, and we wonder if the labs there are making mistakes (we understand that it is a difficult test). Certainly, there was a mistake with the last test we had in the Middle East as it came back with a high TSH and a high T4 result! Any insights you can provide would be gratefully received.

Dr Tim replies: The reason frequent tests are required is because frequent dose adjustments may be needed – sometimes down initially and then often up thereafter. One of the problems is that the tablet increments are quite large (the smallest tablet is 25mcg) so small adjustments are not always straightforward. A high TSH and high FT4 doesn’t necessarily indicate a laboratory problem – this picture is quite common because a high FT4 level may be needed to normalise TSH – particularly in children with agenesis (no gland). This reflects the fact that the normal gland makes FT4 and the active T3 (in babies with CHT a reflection of the fact that the normal gland makes 

children with agenesis (no gland). This relatively high FT4 in blood is required to be needed to normalise TSH – particularly in tablet increments are quite large (the smallest tablet is 25mcg) so small adjustments are not always straightforward. A high TSH and high FT4 doesn’t necessarily indicate a laboratory problem – this picture is quite common because a high FT4 level may be needed to normalise TSH – particularly in children with agenesis (no gland). This reflects the fact that the normal gland makes FT4 and the active T3 (in babies with CHT a relatively high FT4 in blood is required to generate equivalent T3 in the tissues) – and there are also data to suggest that the thyroid axis is slightly different in babies with agenesis that can also give rise to this biochemical picture.

In summary –
1. Don’t worry about the ups and downs – the main thing is that she is being checked regularly.
2. Try and give the levothyroxine at the same time each day.
3. Make sure, if possible, that you are being advised by one expert only – too many doctors can be worse than too few!
4. The blood test results will get more stable as your daughter grows less rapidly over the next few years – it will get easier!

Higher than average TSH

S asks: When I had my son 12 years ago I was diagnosed with a thyroid problem, they thought it would right itself after a few months but it never did and I have been on medication ever since.

My son, Jack has always been an extremely active child, has never been able to sit still, always has to be on the go. He has always struggled to sleep right from a baby and since the age of eight he has been suffering with anxiety which has got worse as he has got older and also affects his behaviour and mood swings. For a long time I kept raising the issue of his thyroid but the doctors did not want him to have blood tests as they thought he was too young and there was nothing to suggest he had a problem with his thyroid. Eventually back in 2012 they did some tests and found there was an issue with his thyroid. His TSH level was 8.6 so he was given a small dose of levothyroxine. He was taken off the medication in November 2014 and the last TSH reading he had in August 2015 was 7.5. Our doctor has said to repeat the blood test again in three months and then decide what to do.

What has puzzled me from day one of him being diagnosed with a problem with his thyroid is the doctors say that the readings point to him being under-active, so really he should be sluggish and tired but he is totally the opposite. Can problems with your thyroid affect your behaviour and cause anxiety? I know he is getting to the age where hormones will be causing a lot of changes in his body but what impact does the thyroid have?

Dr Tim replies: Lots of people have TSH values that are less than 10 (but more than 4) and the vast majority don’t experience symptoms (I am one of them!) with TSH values at that level. It is important to know if your son has antibodies to the thyroid gland – if so then the chance of the TSH rising and him getting symptoms is much greater.

One problem is that TSH levels go up and down with things like illness – so a common scenario is that someone feels a bit out of sorts, has their bloods checked and – lo and behold – TSH is up a little. It is then assumed to be the CAUSE of the symptoms when in reality it is actually more likely to be a CONSEQUENCE - a temporary issue that will settle spontaneously.

I think the fact that your son is not sluggish and tired really confirms that his symptoms are unlikely to be due to his thyroid. There are quite a lot of people who have persistently ‘high-normal’/slightly high TSH values like your son and knowing how to manage these young people is difficult. However, if he was no ‘better’ on the thyroid medicine then stopping it makes good sense to me…. I suspect that his thyroid hormone level in the blood is entirely normal off levothyroxine?

To summarise – the vast majority of people who are ‘hyper’ and the vast majority of people who are a bit sluggish do not have a thyroid problem. However, the thyroid is often checked by doctors when faced with people with these symptoms (quite rightly). The normal range of values (and recognition that numbers normally fluctuate) is not well understood – hence it can be argued that quite a lot of people end up on levothyroxine who may not actually need it.

There are also people like your son with slightly ‘high-normal’ values and there is no good evidence at the moment to suggest that they will benefit from levothyroxine treatment. This is an area where a lot more ‘evidence’ is needed. If your son has thyroid antibodies then he will need to be watched more closely and is more likely to need thyroid replacement in the longer term.

Thinning hair

B asks: My daughter of 11 has just been diagnosed with hypothyroidism. I was first concerned about seven months ago about her flaky scalp and thinning of her hair. She was finally diagnosed after taking her to our GP three times over six months and finally having a blood test done. She started taking 50mcg levothyroxine three weeks ago. After a second blood test she is now on 75mcg although she never showed any other signs of other symptoms; apart from hair thinning we would not have been aware of anything untoward. Her hair loss is continuing and we are very concerned about this, is this common and will she regain her hair? It is mostly around the hairline and the top area of her head.

We have only been seen by a paediatric GP and not a specialist and we are really worried. Your advice would be gratefully received.

Dr Tim replies: Changes in hair texture/thickness are common in young people with thyroid problems. Unfortunately it can take quite a while (months not weeks) for noticeable changes to occur post-treatment with levothyroxine. This reflects the fact that hair follicle ‘cycle’ or activity is relatively slow. A minority of people with thyroid problems (where antibodies attack the thyroid gland) can also lose hair because the antibodies attack the hair cells as well. I suspect this is not the case in your daughter but is something to watch out for.

In other words, if the hair isn’t returning to normal in approximately six months or if there are bald areas then it might be worth asking to see a skin specialist at that point in time. My overall feeling is that everything is likely to get back to normal (the body responds very well to thyroid hormone replacement) but it may take longer than you would both ideally like which is a nuisance.
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 709707 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!

easyfundraising 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.

Buy a teddy and support the BTF

Buy one of these adorable teddies for £6.99 + £2.50 postage per order and all the profit will go towards the BTF. Go to the BTF website to order online or by cheque by downloading and sending with the order form on the website.

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.

Directly support the BTF by playing the Unity lottery and be in with the chance of winning £25,000!

How it works

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

PRIZES

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

Birmingham
Next meeting: Saturday 12 March 2016
2pm to 4pm
Location: Yardley Baptist Church, Rowlands Road, South Yardley, B26 1AT, off the A45 Coventry Road. Free parking available.
Programme: Patient Group, Information and Support Meeting Head & Neck Disease (including the thyroid)
Professor Hisham Mehanna Chair of Head and Neck Surgery, School of Cancer Sciences. Director, Institute of Head and Neck Studies and Education, University of Birmingham
Dr Kate Reid BSc(hons) PhD Head of Speech and Language Therapy, University Hospitals Birmingham NHS Foundation Trust
Donation: £2 voluntary donation.
Contact: Janet Tel: 0121 628 7435 or email: janetdmp@googlemail.com

Cambridge
Next meeting: Saturday 19 March 10am-1pm
Location: Weston Colville Reading Room CB21 5NX
Programme: Professor Chatterjee from the Endocrine department at Addenbrooke’s Hospital, Cambridge will be speaking about current research at Addenbrooke’s and general information on thyroid disorders and Lucy Malby, patient and researcher will give a talk on ‘My thyroid and me’.
Tea, coffee and biscuits provided
Donation: Suggested minimum donation: £4 to cover costs.
Contact: Mary on 01223 290263 or email butterflyecho@hotmail.com
Please call or email if you are thinking of attending the meeting to give us an idea of numbers.

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: See the BTF website for more details
Contact: Caroline on 0113 288 6393 or email: cfields237@btinternet.com

London
Next meeting: 27 February 2016 10am to 1pm.
Location: Crown Court Church, Russell Street, Covent Garden, London WC2B 5EZ
http://www.crowncourtchurch.org.uk/where-to-find-us/
Programme: This is a support meeting - all welcome!
Donation: Suggested min donation £3.
Contact: Denise on 07984 145343 or email: denisesims@btf-thyroid.org

Milton Keynes
Next meeting: Saturday 5 March 2016
Location: The Pavilion, Open University, Milton Keynes, MK7 6AA.
Donation: £2 voluntary donation.
Programme: Dr Sohere Roked author of The Tiredness Cure: How to beat fatigue and feel great for good.
Contact: Wilma Tel: 01908 330290 or see www.thyroidmk.co.uk or find us on Facebook.
Milton Keynes group hold many fundraising and information events for the BTF throughout the year and have been able to buy a BTF branded gazebo to keep them dry (essential at the moment!). Here it is below set up for a recent event.
Milton Keynes group have also set up a new webpage for their many fundraising events. Check it out at www.thyroidmk.co.uk

Yeovil
Next meeting: See BTF website for details
Contact: Janet on 01935 827794 or email: janet.neale4@btinternet.com

Are you interested in bringing people together to start a BTF support group in your area?
In particular we would welcome new groups anywhere in the North East, the North West, the South Coast, the Bath/Bristol area and Wales. Training and support from BTF HQ is available. Email ltc@btf-thyroid.org
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.

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.

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<td>London</td>
<td>Denise</td>
<td>07984 145343</td>
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<td>Yeovil</td>
<td>Janet (GR,TS)</td>
<td>01935 827794</td>
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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.**

**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.

**KEY**

- **Ch**: Thyroid disorders in children
- **C**: Cancer of the thyroid
- **FC**: Follicular cancer of the thyroid
- **PC**: Papillary cancer of the thyroid
- **HCN**: Hürthle Cell Neoplasm
- **CS**: Thyroid cancer surgery
- **RAI**: Radioactive Iodine (I-131) ablation
- **G**: Goitre
- **TS**: Thyroid Surgery (non-cancer)
- **U**: Under-active thyroid
- **ITSH**: Isolated TSH deficiency
- **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**: Association for Multiple Endocrine Neoplasia Disorders
  Tel: 01892 516076 [www.amend.org.uk](http://www.amend.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)
- **Butterfly Thyroid Cancer Trust**: Tel: 01207 545469 [www.butterfly.org.uk](http://www.butterfly.org.uk)
- **CancerS2**: [www.cancer52.org.uk](http://www.cancer52.org.uk)
- **Thyroid Cancer Support Group Ireland**: [www.thyroidcancersupport.ie](http://www.thyroidcancersupport.ie)
- **British Thyroid Association**: [www.british-thyroid-association.org](http://www.british-thyroid-association.org)
- **British Association of Endocrine and Thyroid Surgeons**: [www.baets.org.uk](http://www.baets.org.uk)

**CURRENT MEMBERSHIP RATES**

<table>
<thead>
<tr>
<th>Members living in the UK</th>
<th>By cheque</th>
<th>By standing order</th>
<th>Lifetime membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full: £20 per year</td>
<td>£10 per year</td>
<td>£17 per year</td>
<td>£200 by cheque</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members living overseas</th>
<th>By cheque from a UK bank account</th>
<th>By standing order through a UK Bank</th>
<th>By sterling bank draft drawn on a UK Bank</th>
</tr>
</thead>
<tbody>
<tr>
<td>£25 Europe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£35 Outside Europe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Concession: unwaged and children under 18. 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 - see page 2 for more details.

The British Thyroid Foundation, 2nd floor, 3 Devonshire Place, Harrogate, North Yorkshire HG1 4AA
Tel: 01423 709707 or 01423 709448 website: www.btf-thyroid.org Office enquiry line open: Mon - Thurs: 11am-2pm.