

OK, so you've committed to using DTE in your patients. In so doing, how do you monitor them? How do we follow up with them? Well, in doing labs, I will follow up-- prior to that I'm going to look at their TSH, free T4, and look at a T3 level.

I'm going to check it again in about three to four weeks, if I can get them in there, and I'm going to look at them. TSH, free T4, and I'm going to be looking at that T3 level. And you can do free T3 as well, but you'd be looking at and watching that go up. You should see it rise a little bit, and that's going to be important feedback to you.

But again, as you've heard throughout this whole discussion, TSH, and free T4, and sometimes the levels of T3, may not be telling you how they are doing at a tissue level. We do not have biomarkers for that. So, while I'm doing that I recheck in three to four weeks. If I need to make changes in doses I'll do it within four to six weeks. I will make some of those changes at that time, and monitor those lab values, certainly, and subjective symptoms.

I want to pause right here. When you send somebody to the lab who's on DTE, this T3, please, please, keep this in mind. It has been found that the T3 component of DTEs, certainly even more than you see in synthetics, tend to drop TSH levels for about five hours. I don't know why. It just does. So, five hours TSH will be down.

It takes 13 hours for the TSH to come back to what it should be, or where it actually is. The peak T3, after taking this drug, is 4 hours. So it's very important to understand when the patient should take it. First, the main point is they should get the labs done before they take their morning pill.

And well, there's a way of taking-- you know, with thyroid medicine they have to take it a half an hour, 60 minutes before they eat or drink coffee or anything. That is, ideally. Or two hours after they eat. And that way-- But, it's very important for a lab-- they need to not take it when they do it.

Think of this. If you send a patient who's taken their DTE dose into the lab and it's about three hours, four hours, what's going to happen? That lab is going to come back and show an elevated TSH. Or show a depressed TSH. It's down. It's down.

So they see a depressed TSH. They're going to see a free T-- or a T3 level that's elevated, or maybe normal, high normal, in the presence of a low TSH.

What are they thinking? Overtreated. You've got a patient in somewhat of a mild thyrotoxicosis, a T3 thyrotoxicosis. So you think, oh my goodness, oh my goodness, they're overtreated. No. It's just the rhythm, the patterns, of these rise and falls of these parameters.

What if the patient did the same thing. Took it, went in three to four hours later, and what they saw was normal labs, normal TSH, reasonable T3. What are you thinking? Perfect, we got this dialed in. Uh-uh.

What you're seeing is that you're actually undertreating the patient. So you can get false overtreatment and undertreatment if you do not do it the time--

So the best way-- there is no best way. When you look at T3 and DTEs they tend to be quite variable. Synthetics are a little bit more-- studies say it, but there is some variability in patients. It feels good for patients brains, somehow they like the feeling of that.

But that's one thing I have to say, is that ideal? No. But that's something you have to be aware of. Because patients have gotten into trouble, and so have providers, for not understanding that fact about labs. So that is one point I want to make.

So the other thing when we do the labs, make sure the labs are accurate we can make it. Then we have to look at symptomatology And colleagues, there's a lot of ways to do it. You should have written down what are their main symptoms. So the big thing I'm looking at, is I look at that blood pressure. I look at that heart rate. Do not minimize that. I look at that body temperature.

I think it's so funny, everybody is checking their temperatures now, but if they've got hypothyroidism they're not generating a temperature very much, because of altered thermogenesis. But you're looking at that. You're going to look at--

The big thing is how depressed, how motivated. I keep saying, patients, they have-- you want to have umph, and get-up-and-go, and they have neither umph, like the will to do anything, and they don't have the get-up-and-go. They're just fatigued. Depressed and fatigued. And how are they? And they will tell you there's a lot of things that can change.

And also I mentioned sleep and heart rate. Very big. And blood pressure. Because sleep, heart rate, and that, will tell you about the T3 penetration a little bit in the myocardium, but the rest you're going to be looking at subjective symptoms.

And they'll tell you. They'll tell you. I let them know, some of them may lose weight. I make sure they know that's not a parameter. But you will see some of those metabolic markers for metabolic syndrome actually improve when you get the patients into a better control with that DTE. So that's one of the biggest things that we look at, is the subjective, which we have been pressing and stating are related to this.

So safety, efficacy, which is both lab and symptomatology. So that would be the big things to take home with this. Happy journey with DTEs.