Understanding Your Thyroid:

A Special Interview with Dr. Jonathan Wright

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola

JW: Dr. Jonathan Wright

DM: Thyroid disease is one of the most common health problems that we face. The practical aspect of this is there are so many different ways to approach this. This is Dr. Mercola, helping you take control of your health. I’m joined today by Dr. Jonathan Wright, who is a pioneer in natural medicine and has really established some very effective protocols to address thyroid dysfunction. We’re here today to discuss that. Welcome and thank you for joining us today, Dr. Wright.

JW: Thank you, Dr. Mercola. I appreciate it.

DM: I’m wondering if you could put into perspective for our listeners what your experience is in your clinic in Washington on the prevalence of this disease, thyroid dysfunction.

JW: Thyroid dysfunction of the underactive sort is quite common. One of the reasons – and there are many reasons – for it has to do with chlorinated water, fluoridated water, and how those two particular minerals being in the same family as iodine displace or take the place, I should say, of iodide in the thyroid gland, so that the iodine can’t be as effective as it should be.

Secondly, many of us, unless we’re paying attention, simply don’t have that much iodine intake in the first place. The amount that comes in iodized salt is just barely enough to prevent anybody from getting a goiter. But as far as is it going to help us to achieve, I should say, optimal thyroid function, well, that really has never been studied. It’s just, “We’ll put this little iodine in salt. They don’t get goiters anymore, so they must be okay,” which is like saying, “Well, your car goes at 25 to 30 miles an hour now. That’s fine. You don’t need to run any faster. You won’t need to pay any attention because now your car goes.”

DM: That’s certainly a common challenge for many health disorders, thyroid being one of them. Do you find in your experience that more women are afflicted with underactive [thyroid] or hypothyroidism?

JW: Yes. Part of that is because more women are. But part of it is also, as you know, Dr. Mercola, from your years in practice, women pay more attention to their health. They come in and see the doctor more than men do. Some of us guys, well, we practically got to get hit over the head with a health problem to go see the doctor.

DM: That seems to be the case. Now, is it your belief that most of the thyroid dysfunction is related to chlorinating or fluorinating the water?

JW: It’d have to.

DM: How big of a component do you believe it is?
JW: I’d say in the communities that have that, it’s probably at least 30 to 50 percent. But do remember that the iodide intake is another big problem. Why, before the iodine went to the salt, some folks know that the whole Midwest of the United States was known as a goiter belt. There just wasn’t enough iodine or iodide.

Now, contrast that with countries where there’s more iodine. For example, somebody did some periodic careful calculations and found that in Japan, the combined iodide and iodine intake is between two and three milligrams a day. That’s not micrograms. What was recommended to stick into the salt will give people micrograms of iodine. Just to cite, in Japan, they seem to have much less problems with, among other things, hypothyroidism than most places in the world. Oddly enough just as a news note, they also have the lowest risk of breast cancer among those who still follow the traditional Japanese diet, too. Iodine plays many roles. It helps prevent that one, too.

But back to the thyroid, probably the lack of iodide going in is the biggest thing, followed fairly closely by the iodine block with the chloride and the fluoride.

DM: Ideally, it would be best to avoid the chloride and fluoride as a wise preventative strategy, but in addition to make sure that you’re receiving enough iodine or iodide in your diet. What do you believe is the ideal dose? Is it somewhere, as you were saying, that the Japanese were doing, at two or three milligrams?

JW: Yeah. I’d like to see a minimum of what the Japanese do, which is roughly two to three milligrams – again, 2,000 to 3,000 micrograms – simply because it seems to be quite safe for the Japanese. Now, there is an argument about bigger doses than that. Let’s just stay with what human beings in Japan have been eating ever since there have been human beings in Japan (that is, in the coastal regions). I got to admit, up in the mountains, they get less, but not near as little as many other mountainous regions in the world.

DM: There’s one clinician specifically who has sort of taken the… The champion for this is Dr. Brownstein, who is recommending 12.5 milligrams at higher doses on a regular basis. Do you have any concerns?

JW: Not terribly. The reason I don’t is that I, like Dr. Brownstein, have followed the lead of Guy Abraham, who is an ob-gyne and an endocrinologist at the University of Southern California and who wrote lots and lots of things on iodine. Oddly enough, a lot of these publications, he didn’t release them much. He didn’t publicize them much until he retired from the University of Southern California. Funny thing. But after that, he came out with a wonderful website where people can read a lot of stuff for free. Do you mind if I mention the website? It’s not mine, Joe.

DM: Oh, sure. That’s fine.

JW: Okay. It’s Optimox.com. O-P-T-I-M-O-X.com. Just click over here for iodine research, and up comes this whole list of things published by Dr. Abraham. In one of those publications, a footnote to another paper shows this. There’s some fairly careful study that showed that the thyroid gland does not start to downregulate for nearly everybody until we get to 14 or 14½ milligrams of total iodine and iodide. This is probably why Dr. Abraham first and then others have designed both liquids and tablets that come out with 12 or 12½.

But oddly enough (this is a coincidence, isn’t it), in 1829, Dr. Lugol put together a combination of iodine and iodide. Two drops of that stuff equals exactly to 12 ½ milligrams. How did Dr. Lugol know? We don’t know. But it works so well for people ever since 1829 that it’s still available in all the drugstores as Lugol’s iodine.

DM: With a prescription, isn’t it?
**JW:** You’re correct, with a prescription in the drugstores (I didn’t say) and also the compounding pharmacies. Let me put that.

**DM:** Right.

**JW:** Now, what Dr. Abraham did was to put it out in tablet form with the same content closely followed by some other companies that also put it out in a tablet form achieving 12 ½. Okay, getting to my experience with that. When it was first out, I asked folks, “Would you please check your thyroid function after you’ve been using that for a while? Let’s see how you do.” At least in the people I checked, which were a couple of dozen before I gave up, nobody suppressed their thyroid gland. No, if somebody wants to go to the Dr. Abraham level, I’m not at all uncomfortable with it simply because I’ve done a lot of checking.

But you probably know, right, Dr. Mercola, that a lot of my background is in anthropology. I take a look at, well, what have people done in different areas of the world at different times, as far as it’s known anyway, and let’s follow that. Because we know that there are people who did well or did not do well, depending with it – in which case we don’t follow it. That’s why I go back to Japan and say, “Usually three milligrams or if you want to have it up to 12 ½.” Let’s see if you have a family history of breast cancer. Oh, boy! That might be a reason to consider it.

Because there’s now wonderful evidence that iodine itself – not iodide – combines with a lipid called [inaudible 08:21], forming an iodolactone, and those molecules kill breast cancer cells. Really cool. If we have enough iodine, it sorted breast [cancer]. Did you know that breasts – and people out there, Dr. Mercola certainly knows – are big sponges for iodine? Not iodide so much; that’s the thyroid gland. If we have enough iodine, why, those molecules are just sitting there ready waiting to kill new breast cancer cells! That’s why they have the lowest risk of breast cancer in the world, Japan. Oh, but Iceland has the second highest intake.

Back to the thyroid. Usually, in my practice, I’ll say, “One drop of Lugol’s, which is six milligrams, six and a quarter.” Or for the guys, who don’t have as much massive breast tissue, let’s stay with three milligrams. Now, I would say in there, though, of course, I’m thinking, “Cancer – let’s prevent cancer. I want more than three milligrams for the ladies.”

**DM:** Sure. Those three milligrams would be most likely one drop every other day?

**JW:** There you go.

**DM:** For the men?

**JW:** Yeah.

**DM:** Because I’m thinking that it equilibrates pretty well in the tissue and doesn’t have to be taken ‘round the clock.

**JW:** No, it does not. You’re quite right.

**DM:** Is Lugol’s your favorite form of supplementation in your practice? Or do you recommend any food sources like seaweeds? If it’s seaweeds…

**JW:** Oh, absolutely. Seaweed is a very good source. One thing I recommend folks do if they should say, “My pill count, my supplement count is so high. How can I do this with food?” (Thank you for bringing that up, Dr. Mercola), is to say, “You can get kelp right down at your natural food store in a powder. You
can put it in a shaker. You can shake it into your cooking and shake it into your salads. If you want to go perhaps a step further, you can do what at least the herbalists… I respect the most they do.

[----- 10:00 -----]

They recommend the particular type of seaweed called bladderwrack. I didn’t make the name up. I don’t know where that name comes from. In Latin, it’s *Fucus vesiculosus*. But in English, it’s called bladderwrack. They say that in their expert experience – not being an expert herbalist I follow the experts – that one does the most to help our thyroids. One can get some of that in a powdered form or in capsules. Break up the capsules to get the powder and sprinkle it on stuff. It just tastes like a mildly salty spice that we put into things. No strong taste. That’s one of the easiest ways to go: to put it in cooking. Thank you for bringing that up.

**DM:** How much do you need to achieve the two to three milligrams that you think might be optimal?

**JW:** You do need quite a little bit. That’s one of the problems. You’d have to use – now here, I’m just estimating; I haven’t looked at it in a long time – at least a couple of teaspoons a day. That’s the thing.

**DM:** And the other concern that many people have is the Fukushima reactor radiation issue contaminating much of the seaweed. Is there a…

**JW:** Oh, you bet. You’d have to look at the source of your seaweed. Try to get it there from the Norwegian Coast or something, as far away from Japan as you can get.

**DM:** Or are there approaches… I mean, it’s relatively simple, I think, to purchase a Geiger counter and measure the stuff before you bottle it. Is there some way that companies certify that as radiation-free?

**JW:** I haven’t yet seen any label saying “radiation-free.” I bet we will start seeing them, but I haven’t personally. But yes, it is simple to check it with a Geiger counter.

**DM:** Yeah. There are a number of them that’s on the market that range anywhere from a few hundred to a thousand or even more than that. But pretty much one that’s close to a thousand would be more than sufficient for that.

Well, let’s go with the initial person who comes to see you with a concern for hypothyroidism. Can you advise or describe your program of how you would work them up? What type of blood testing and differential diagnosis would you pursue to confirm that it’s safe to supplement with iodine?

**JW:** Yeah. The first thing is we really have to respect the paper put out by a Dr. St. John O'Reilly (I believe it was in 2010) where he went through the whole history of thyroid testing and points out that the best thing to do is a physical exam. Look for such things as dry skin, maybe the latter margins of the eyebrows are getting a little thinner, maybe look for some subtle accumulation of fluid in the ankles, and ask that person about, hmm, let’s see, “Are you gaining weight easily?” There’s that old thing – it’s not that old, it’s from the 20th century – of taking your temperature every morning and observing if it’s up close to 98.6. Now, I’ll pause on that particular point.

Dr. Broda Barnes back in the ‘30s and ‘40s, Dr. Barnes, was doing that routinely and found that it was fairly reliable that if the temperature was low, that person was hypothyroid. These days, with all the other things going on, I find that sign useful in some people but not in others. But I do want it for everybody. Let’s take the temperature every morning before we get out of bed and all these physical things, and then let’s combine it with a laboratory, and make a judgment.
What laboratory do we combine it with? Oh, my goodness. As Dr. St. John O'Reilly said, “Do not trust the thyroid-stimulating hormone (TSH).” What he had to say, oh, my goodness. He’s an expert in thyroid, by the way. That’s his thing. He’s at the University of Scotland. He goes up one side to thyroid TSH test and down the other, showing that it was never ever, ever correlated with the clinical condition of the patient. There were two major studies: one for the male and one for somewhere else. Because they were from prestigious centers, everybody just fell into line. But Dr. St. John O'Reilly points out that the normals were calculated normals; they were not correlated with the physical condition of the person.

He points out one other very telling thing. Now, we all know that thyroid therapy has been around since the 1890s. No kidding. First, that’s why it comes in grains. It’s an ancient British measurement. Anyway, it’s been around since the 1890s. Until the TSH was out there and pushed by all the major medical journals, as Dr. St. John O'Reilly points out, the average dose of thyroid given (if you average it for a large number of people) was exactly twice or almost exactly twice of what the average dose became when everybody started paying attention to the lab and not to the patient.

In other words, they’re all, “You’ve got to look at the TSH. Never mind what the patient says. Never mind about what the patient’s body says.” It’s the old story that we’re all told in medical school, “Treat the patient not the laboratory.” With the TSH, we’re treating the laboratory. That’s what he points out. We’re not treating the patient. After that, the doses became half. Did you know that a group of people over in the UK, in England, actually organized a lawsuit against the National Health Service for trying to get them to prescribe more thyroid and saying we’re underprescribed?

Okay, so where do we go with that? Dr. St. John O'Reilly, he says that physical exam and the Free T3. Because the Free T3 is, of course, the free hormone, not the one bound up on the thyroid globulin, where it’s temporarily inactive. But the Free T3 is the one that – and certainly Dr. Brownstein, Dr. Mercola, know this better than I do – helps us to burn the energy, it’s the active hormone, and all that sort of thing. The Free T4, well, it’s just sort of waiting to become active, but it’s not active. It does some signaling. Funny thing, it signals back to the TSH. But the Free T3 doesn’t signal back to the TSH as much as the Free T4 does.

Dr. St. John O'Reilly said the physical exam and the Free T3. That’s what we do at our clinic. We do the physical exam. We follow the Free T3. We say hello to the TSH. But having read Dr. St. John O'Reilly’s paper, we don’t pay much attention to it.

DM: Yeah. For those who aren’t aware of those measurements, the T4 is the type of thyroid replacement that is typically and traditionally given by almost every conventional physician. In my experience, it’s one of the primary ways you can differentiate between a natural medicine physician and a traditional conventional physician: the type of thyroid replacement their prescribing. T3, of course, is an important component of that.

I’m wondering, though, with respect to the TSH measurements, if you find that there’s some type of threshold over which becomes a really helpful tool. I think the higher it is, the more suppressed the thyroid is because it’s a negative feedback loop. Typically, I believe the normal range is up to 1.5. Or is it?

JW: Many laboratories these days are saying 3. They will say 4.5.

DM: Okay, 4.5. Do you find that if it’s above, let’s say, 5 or 10, that it’s a significant test aside from the laboratories?

JW: If it’s up to 5 to 10, it’s very, very likely that that person is hypothyroid. I’m still going to want to do the physical exam. But there is where we’ll find a strong correlation between the physical and the TSH whether it gets up to 5 to 10. The problem, though, is that our local endocrinology people, the
mainstream, and the internal medicine people, if that TSH is at 3, they consider it normal. Only if it goes above 3 is it a problem. Really, a TSH of 3 for some people uses to take a look at their physical condition. Excuse me, that’s not good enough. Their Free T3 is on the low side. Anyway, 3 is a cutoff point. As you say, when you get to 5 or 10, you very likely have some problem.

**DM:** Taking the numbers on the other side, do you find that there’s a certain threshold, that if the TSH is suppressed below 1.5 or lower, hypothyroidism decreases substantially or some number other than 1.5?

**JW:** Not really. Here’s why: there’s something else being ignored. That’s particularly as you get older. That is the TSH is not the be-all and end-all for stimulating the thyroid gland. There’s another hormone called the TRH. I’m sorry but I’ll copy Dr. Mercola and explain what that is. The TSH comes from the pituitary gland. It tells the thyroid gland, “Okay, you should make hormones.” But before the pituitary gland can even make TSH, there has to be another little hormone released from the area above the pituitary gland (above if we’re standing on our feet, of course), called the hypothalamus. That one is called TRH for thyrotropin-releasing hormone.

The sequence goes: the hypothalamus has to make the TRH, which goes to the pituitary that makes the TSH, which goes to the thyroid gland, which says you guys make thyroid hormone. I don’t know why it was created or designed that way, but that’s just the way it is. It sounds like Rube Goldberg but it isn’t. Okay. Well, we did have about 10 to 15 years ago a test available to practicing doctors called the TRH stimulation test.

**DM:** Absolutely.

**JW:** When we have that available, one of the things I learned was that in low TSH… In fact some of the ones that were accountably suppressed, they go, “Look at that, look how low that is,” and yet this person shows all the signs of hypothyroidism.

When we would do the TRH stimulation test, we’d inject some TRH, we measure the TSH before, and we measure the TSH after. What do you know, some of those low TSHs did not mean too much feedback from the thyroid to the pituitary, indicating, “We’ve got enough. You don’t have to send us a signal.” But instead, some of those low TSHs were [low] because they weren’t getting any stimulation. That was revealed by the TRH injection and, wee, up goes the TSH. We got to be careful with those low-end ones, particularly the ones that don’t quite fit the clinical picture.

**DM:** This TRH stimulation test is not a common test. I wasn’t aware. It sounds that it’s not available to be done anymore.

**JW:** It isn’t available anymore. My compounding pharmacy told me, “We don’t know why but it’s become available.”

**DM:** Yeah, because when I was practicing it was definitely an option. Let’s go to other components. Just mentioning some physical symptoms that you didn’t mention that I think would be helpful to acknowledge, too…

**JW:** Oh, please do. Thank you.

**DM:** Would be lack of sweating. It seems to be a really significant issue. Especially it’s one of the clinical signs that you can tell if you’re exercising hard enough, if you’re doing high-intensity exercises. But if you’re hypothyroid, you just won’t have the ability to sweat. You can’t use that.
**JW:** Right.

**DM:** Constipation is another common cause. The last one, if it’s really extremely hypothyroid, would be high cholesterol so much so that, as you very well know, in the early days thyroid hormone extracts were used to treat high cholesterol levels.

**JW:** Oh absolutely. Just last week, a lady told me, “Well, I was adjusting my thyroid the way you told me.” By the way, the way I tell folks is watch out for just what you said – too much sweating. Watch out for rapid heartbeat. Watch out for palpitations in your heart. If you get any of those, there’s too much thyroid for you. Don’t do that.

Anyway, she was adjusting her thyroid. She did back off because she took too much. She wanted to see how much she could take. But even though she backed off from the amount I gave her – in her case, too much sweating – she said, “I better settle on something that my body feels good with.” Of course, I said, “Yup, good idea.” She says, “My cortisol went down!” That’s where I was going with that. It still goes down even with just a dose the person needs. It doesn’t have to be an overdose.

**DM:** That’s definitely a fairly strongly correlated function of thyroid hormone. Lastly, of course, if your type… An important one for many but actually not a primary factor for most people who have this condition is they’re being overweight.

**JW:** Oh, yeah.

**DM:** It seems that people, most of the time, it’s due to not follow an ideal diet. But if a person is following an ideal diet and they’re not responding appropriately, that’s certainly clearly something that has to be looked at.

**JW:** Well, you’re absolutely right about that. It used to be that a higher percentage of people who are overweight, one of their major problems was the thyroid. These days, as we both know, it’s metabolic syndrome.

**DM:** Right.

**JW:** That’s far and away the biggest cause of overweight. If people don’t want the appropriate diet for that, they’re just going to stay fat. But still, we got to watch out for thyroid, too.

**DM:** I couldn’t agree more. I think just to review the symptoms that we just did would be probably far more beneficial for someone considering that diagnosis than having a blood test.

**JW:** Yes, absolutely. If you’re going to have a blood test, why not save your money and do the Free T3 as the thyroid expert from Scotland tells us?

**DM:** That’s really good advice. Now, the vast majority of people listening to this are not in that stage. But I think it’s an important stage to discuss; thank you for doing that for us. Whether they’re considering a diagnosis or concern that they may have hypothyroidism, probably 95 percent of the people listening to this, if it’s an issue for them, they already have the condition. They’re on some type of thyroid hormone replacement.

Of course, the majority of people in the country (maybe not the majority of people listening to this) are placed on synthetic thyroid hormone, which is typically T4, commonly prescribed as Synthroid or Levothroid, which should be the brand names. That’s T4. That’s a challenge because that’s clearly less than ideal. As I said earlier, that’s one of the ways that you can differentiate between a natural medicine clinician and a traditional clinician – it’s the type of hormone. The traditional guys are almost always
prescribing this. Anyone who doesn’t prescribe that is actually pretty severely criticized and may actually be taken before the medical board.

It actually happened to me, and I wasn’t even prescribing it. I have stopped seeing patients and have written an article about it on my website. I was called before the medical board to defend that position even though it was an article with a study reference in the New England Journal of Medicine, a very prestigious journal.

I’m wondering if you could describe your process when someone comes into your clinic on synthetic hormone. I mean, what is the process? Just maybe two cases: the person coming in or the newly diagnosed person.

**JW:** A newly diagnosed person who’s newly diagnosed with weak thyroid either by physical exam, a lab [inaudible 26:36], or by both, which is usually the best combination – look at the patient and look at the lab. Don’t be treating the lab. Treat the patient but consider the lab.

Anyway, if they’re already diagnosed but not treated, and they have no sign of autoimmune disease (we have to throw that in here), I’ll just go right ahead with what’s called whole thyroid. Whole thyroid is usually derived from animal sources – either cow, sheep, or pork. These days more and more of the people who are supplying it are going to New Zealand sources because we have less chance of toxins in the animals taken care of over New Zealand. But anyway, the whole thing.

Now, why the whole thyroid as opposed to the T4, which conventional does? I have this textbook. It’s De Groot’s textbook called *Endocrinology*. It’s one of the prestigious books in endocrinology. It has in it a page, which lists all of the iodine-containing compounds that they knew up to that date, which indeed is few years ago. But even so, all the iodine-containing compounds made by the thyroid gland. Guess what? There’s a dozen of them. There’s T4.

**DM:** I always thought there was more of it. I didn’t know there was a dozen.

**JW:** Oh, De Groot lists 12 of them.

**DM:** Wow.

**JW:** Yeah. And there’s not only the T4. By the way, all these numbers, folks: T4 is thyroid with four iodines. T3 is a thyroid molecule with three iodines. But there’s also T2 and T1, there’s reverse T3, and there’s regular T3. Look, when we get down to this, Dr. Mercola, let me detour back to another principal cause of hypothyroidism that I totally skipped. My fault. That’s elevated reverse T3. Let me go back to that in a moment. Maybe you can do some really cool editing and splice it in the right place.

**DM:** Okay.

**JW:** Regardless. Getting back to the whole thyroid, let’s just isolate out here T2. Did you know that there are studies showing that T2 significantly improves metabolic syndrome? T2 (diiodotyrosine). That’s never prescribed unless you’re using whole thyroid. Because in the whole thyroid are all the things that nature and creation put into whole thyroid. That’s what we should be using unless (and the only unless) we happen to have an autoimmune problem. Many people with autoimmune problems – and there’s many more women than men who have this – unfortunately part of what they’ve got is something called Hashimoto’s disease, where they’re making antibodies to thyroid.

If we’re making antibodies to thyroid, I’m not sure that we should be putting in right away – notice that I said “right away”; maybe later – the whole thyroid. This is where the natural thyroid comes from. It’s
from whole thyroid. It’s one grain, which is roughly 65 milligrams of whole thyroid. Because there is a small chance – it’s not a large chance – that we’re going to somehow stimulate more antibody formation.

So, there, if I’m going to use it in somebody who, let’s say, she’s got autoimmune history in her family. She’s not known as being autoimmune herself. But even so, she’s got an autoimmune history in her family. Type 1 diabetes, folks, by the way, is autoimmune. That’s one but there are many others. She’s hypothyroid. I want to check her antibodies first, her Hashimoto’s antibodies, just to make sure that she’s not making antibodies to thyroid before I put her on the whole natural thyroid. If she is making antibodies, then we got a little trial ahead of this, i.e. let’s get rid of her Hashimoto’s disease, which is entirely doable but it takes months.

Let’s get rid of those antibody formations, and then let’s go ahead and switch to whole thyroid. Notice I said “switch.” What do I use to start with for somebody who has antibodies of Hashimoto’s disease? Well, yeah. That’s why I am going to start with T4 and T3, which are only two of the 12 iodinated substances the thyroid gland makes. But it turns out that T3 is far and away the most active thyroid hormone. We can get by with it. I don’t like getting by, but we can get by with it as well as with the T4, which by the way, isn’t very active except as a signaling molecule and as a source for T3.

Why it’s used exclusively by conventional medicine doctors, I don’t have a clue. They seem to be so trusting that the T4 is going to turn into T3 just like it should. Nature and creation have designed it to do so, but that’s only if we’ve got enough selenium in our bodies. There are many areas – let’s take Eastern Washington – that’s known to be selenium-depleted. We can get all the T4 we want to. If we’re living in Eastern Washington and not taking selenium supplements, it’s not going to turn into T3. It’s not going to the job it should, which is why we shouldn’t start with just T4. That’s that on that scenario.

DM: Before we finish up on that, do you check every person for these antibodies for autoimmune thyroid?

JW: No, only if there’s an autoimmune history in the family.

DM: Okay, all right.

JW: We have a fairly large questionnaire. We scan that and see.

DM: Okay. Because those antibodies are a little more expensive to test for.

JW: Yeah, they are. I’ll wait until [they say,] “Oh, yes. My sister had lupus. My grandma had type 1 diabetes, etc.” And then [I’ll go], “Okay, fine. We’re going to check it for you. We’re going to have to check for antibodies.”

DM: Okay. You’re going to talk about reverse T3 as being a cause of...

JW: Oh, I sure was. Now, my colleague out here, Dr. Davis Lamson, he’s a naturopathic doctor. He was a professor at the Bastyr University. He’s retired from there now. He practices at Tahoma Clinic. He did the most wonderful piece of research accumulating over 200 people who were diagnosed clinically as hypothyroid. He ran what he called a complete thyroid panel on everybody. The complete thyroid panel is a TSH, the total T4, the free T4, the total T3, the free T3, and the reverse T3. He ran that compete thyroid panel on everybody.

The thing that correlated the best with hypothyroidism, far and away the best, was the reverse T3 being elevated. Now, the reverse T3 was elevated in just about precisely half of the people clinically diagnosed
as hypothyroid, whereas the TSH only correlated something like 12.5 percent. There’s a much smaller percent. I’m sorry I don’t have the study in front of me. It was wonderfully well-done. That reverse T3 predicted hypothyroidism more than anything. Notice this isn’t the free T3 even, folks.

**DM:** Sure.

**JW:** Now, why I was so dumb so as to not mentioned the reverse T3 before, I don’t know. Because I make sure it’s run on everybody in initial evaluation because it’s abnormal so often. Now, reverse T3 is nature’s way of keeping us from starving to death as fast. Huh? Where do you go with that? If you’ve seen those pictures of starving children, they have big bellies, they’re sitting there looking down, and they got no energy and so forth. Aha, no energy. Because if we burn energy and there’s no food available, why, we’re going to die sooner. When there’s no food intake at all for a long time, our bodies start making more and more and more reverse T3.

Reverse T3 is to free T3 (regular T3) as the right hand is to the left hand. Four fingers and a thumb, but the thumb and the fingers are in different position and relationship to each other. Therefore, I can’t fit my right hand in the left-hand glove, and I can put my left hand in the right-hand glove. The reverse T3 does not fit into the T3 receptor. The system blocks it. If we’ve got the receptor blocked, even if we’ve got enough free T3, a lot of it can’t get into the receptors. In effect, we are hypothyroid because we are partially blocking our free T3.

Now, that applies to starving people. Neither Dr. Mercola, nor Dr. Brownstein or I see many starving people. How come Dr. Lamson in his study – which, by the way, is adopted by all 11 doctors at Tahoma Clinic because it worked so well – found 50 percent of those who he suspected hypothyroid had an elevated reverse T3? They weren’t starving.

Well, we’ve figured that one out at Tahoma Clinic, too. Ninety-five percent of the time, if we do a chelation test with ethylene diamine tetra-acetic acid (EDTA) and 2,3-dimercaptopropane-1-sulfonate (DMPS), when we do that chelation trial, oh boy! Here comes the mercury, here comes the cadmium, here comes the lead, and here comes the toxic metals. Those people are full of toxic metals. When we get that toxic metal chelated out of there, funny thing, the reverse T3 subsides to normal.

Now, it’s very well-known that lead and cadmium interfere with testosterone production. What’s not so well-known – but thank you, Dr. Lamson, you got it started – is that reverse T3 is stimulated by toxic metals and up it goes. In effect, we can have levels – not quite as high as the person who’s been starving for six weeks – that are so high, they weigh outnumber the regular T3. We’re functionally hypothyroid even though our TSHs and our free T3s happen to be normal. Boy, did I make a bad mistake when I left out that reverse T3. Let me thank you for letting me go through that, Dr. Mercola.

**DM:** You’re welcome. I’m sure it’s going to help a lot of people. I’m wondering, you’ve got that test on so people can help differentiate that. The treatment for it if you find that it’s elevated before you start therapy, it sounds like you’re doing some process to detoxify the person of heavy metals.

**JW:** Yeah, we have to do that.

**DM:** Do you do the EDTA and DMPS? How long do you typically find it’s necessary to do that before you can start the treatment?

**JW:** It really varies according to the level of lead, cadmium, mercury, and so forth. There are some people who get these efficiently out of their bodies within 10 to 15 chelation treatments. There are other people, particularly those who lived in major, major, metropolitan areas all their lives, where it takes (I’m not kidding) 30 or 40 chelation treatments to pull out all the chelation toxic metal. When we’re doing that,
we have to make sure we’re seeing a doc who follows the procedure put out by what’s called the American Board of Chelation Therapy (ABCT).

Chelation pulls out toxic minerals. But folks, I’m sorry, nobody has yet discovered a chelation material that pulls out toxic metals without pulling out normal metals, too – calcium, magnesium, zinc, and copper, the whole works. The doctors doing the chelation must be reinventing normal minerals periodically according to his or her reading of the initial chelation test. Now, the initial chelation test on page one shows all the toxic metals that are or not coming out. The page two, which should never be omitted because it expands, should always be done. It shows the normal minerals.

Now, why should it never be omitted if they all come out anyway? Unfortunately, some folks have been eating so poorly and/or have not been paying attention to their health well that on that second page, where we should see a lot of magnesium coming out, only a little bit comes out. Or one of the classic ones is something called molybdenum. It’s a key essential mineral. We don’t hear about it much, but [it’s] an essential mineral for, among other things, sulfur metabolism. Over and over again, I’m seeing that the molybdenum is not only not coming out very well but even with chelation, the person’s low in it.

If the person just took a chelation and the stool’s not putting out much of the essential mineral, wow, they’re deficient. Because what we expect if the person’s replete with all the normal minerals is that every one of it is going to come out in excess of what it does if they’re not taking chelation. That’s what we’re shooting for. We have to make sure that one, too.

In the meantime, what does the poor hypothyroid person do? Because we’re trying to clear these toxic metal stores to bring the reverse T3 down, oh, dear, well, let’s just put that one in opinions. Some doctors just pile in more regular T3 and say, “We’re going to get them going faster. We’ll give them the regular T3.” There, if we’re looking at what usually belongs in the body, it’s usually an agglomeration of free T3 and reverse T3. Reverse T3 is always in us, folks. We’ve always had a little bit. That’s the way nature and creation have designed it. It’s a safety valve again for living longer if we’re going to starve.

But if we have a balance now between our regular T3 and our reverse T3, and then we add more free T3 just to get the person going, are we somehow just going to have just too much of a good thing in that person’s system, namely too much free T3? How are we going to taper that down as we pull the toxic metals out? Some doctors will do that. Some will say, “Let’s wait until we pulled your reverse T3 down a lot further and then let’s put in whole thyroid, of course, if there are no autoimmune in your family. Or at that point, let’s put in some T3 and maybe a little bit of T4.” That simply takes the doctor’s judgment and skill in deciding which way to go.

DM: Yeah. Ideally, this is a process you’re not going to be able to do by yourself. You really do need to have a health coach, a trusted and respected healthcare clinician, who has the capacity to perform these tests, operations, or procedures and also prescribe the appropriate supplements because thyroid hormone replacement is a prescription item; it’s not something you can get over the counter.

JW: Right. Absolutely. You see, the toxic metal thing is something that the whole human race has had to worry about since the days of the Roman Empire when everybody was drinking lead in their water. It’s a process that has happened to everybody in the last century, and it has further complicated thyroid issues for everybody.

DM: What do you think of the Hubbard Protocol that involves using niacin, high-intensity exercises, and sauna on a regular basis to help mobilize and eliminate these toxins?
**JW:** Sweating, which is basically what we’re talking about here, [whether] niacin-induced, sauna-induced, etc., is really pretty darn good for getting rid of carbon-based toxins such as herbicides, pesticides, etc., which are stored in fat cells. The fat cells are the main [inaudible 42: 53] sweating, right? Again, there are all these fat cells.

Actually, there’s a study out there (it’s an old one and I can’t find my copy; but I read it and I know what it says), where fat biopsies were done. People were asked to do 30 heavy sweats for 30 to 40 minutes apiece. By the way, those were in a sauna. They didn’t have to be every day, though – it was just 30 to 40 heavy sweats. They did another fat biopsy. That second fat biopsy showed that the burden of chemicals stored in fat cells was down by two-thirds. I know that sweating is going to get rid of those. The problem is that we don’t sweat out that much toxic metal.

Toxic metal, unfortunately, gets itself stored in bone, in brain, and in other places that aren’t susceptible to a great deal of sweating. Certainly, it comes out of there with chelation. As we pull the chelation out of some of the other areas, more and more will come out of (let’s call it) its sequestered repository.

But for example, some docs published on an instrument they have. The silly thing cost over a hundred thousand dollars. I checked it because I wanted one. You can hold it up against the shinbone, and it will tell you just how much lead you got in your shinbone. Because the little frequency it puts out is only reflected by lead molecules. They found that there was a very good correlation between the lead in the shinbone and the cognitive decline in the large group of men, and there was zero correlation between the lead in the blood or the fat, and the cognitive decline.

**DM:** That’s really great information. It sounds like, from your experience, you’re not going to be able to mobilize those toxic metals out. Even though that protocol using niacin, exercise, and sauna is helpful to radically reduce the amount of toxic burdens from these carbon-based chemicals, it’s wise to consider something a little bit more aggressive if you’ve got this condition going on.

**JW:** If you find all those toxic metals, right now that’s the best alternative. Now, if they can’t do it because they simply can’t afford it, as Dr. Mercola just said, please, please work with your doctor because the chelation pulls out not just bad minerals but good ones, too. We don’t want to pull out the remaining good ones and not know it. There is an alternative process where we can use the chelation material in a suppository. They put that together at the compounding pharmacy. Suppositories go – yup, that’s where they go.

Why do we want to do that rather than swallow it? Well, obviously, if we’re swallowing it we have to keep it away from meals. It’s going to grab the normal minerals out of our lunch before it goes very much further. Who needs that? Nobody absorbs many normal minerals from the rectal area, to put it bluntly. That’s a place where things are on their way out. But funny enough, if you put a suppository in there, those get absorbed in the system, it helps you take out your toxic metals, and you don’t have to worry as much about chelating lunch.

However you do have to worry about taking your normal minerals from time to time because it is going to pull the normal minerals out of the body if not out of the lunch. That’s how it gets the lead out. It goes to the area of the body where the lead is and grabs it. It’s going to grab some calcium, too, I’m sorry. That’s why you got to be working with a doctor on this, folks. But that takes a lot longer. I’ve seen some people who have to do rectal suppository stuff for a couple of years to get all their toxic metals out. Yeah, we check their normal minerals fairly routinely every couple of months just to make sure it’s not being overdone that way.

**DM:** Oh, terrific. Once these minerals are addressed, reverse T3 is normalize, the autoimmune issues are addressed, you can supply them with the thyroid hormone replacement. I’m wondering if you can review
that because there are several on the market. The primary one is Armour Thyroid, which has sort of been the standard for a long time. But then there are other ones like Nature-Throid. Those seem to be the two most common. I’m wondering if we can have your perspective on those.

**JW:** There’s Armour Thyroid, there’s Westhroid, and then there’s Nature-Throid. Those are the three that I know about and there are probably more. But those three I know about. The Armour Thyroid has one disadvantage: despite it being practically a generic now, it costs twice as much as the others. Sometimes people want to pay attention to the cost factor. Now, what I like to pay attention to is what’s compatible with you.

There is a type of testing – in fact there are several types of testing – that one can do for compatibility testing. Sometimes all three types of thyroid will pass that compatibility testing, and sometimes just one of them will. But we’ve all heard of muscle testing. No, we don’t have to employ that. But some doctors are very skilled at it. I can tell you what’s compatible and what isn’t. We use other sorts of compatibility testing to check for energy flow in the acupuncture meridians and how it’s impaired or not impaired by certain types of thyroid. We’ll go with the one that’s compatible with that individual.

But we do respect if people say, “Look, I’ve heard that Westhroid and Nature Throid are half the price of Armour Thyroid. Let’s stick with those if we can.” We do respect that.

**DM:** Okay. Perfect. The last scenario, which is probably the most common, are the massive amounts of individuals who have been to conventional physicians, because they don’t know any better. They trust them for this process. There are lots of reasons why that’s not such a wise decision. But nevertheless, they’ve done that and they are now taking synthetic thyroid, most commonly Synthroid. But Levothroid is certainly up there and others. There are generics. How do you approach the patient who comes in to you taking a synthetic thyroid hormone replacement, who is not doing that well, and who wants to finetune their program?

**JW:** Right. I’ll explain the difference between the synthetic and the natural. We got 12 vitamins over here. We’ve got one or at most two over there. T2 has been found to work against metabolic syndrome. There must be a reason for all of these things in our bodies or probably it wouldn’t be there. We’re getting over this idea of junk DNA, for example. It was only called junk because we weren’t smart enough to know what it was doing. Now we’re knowing more of what it’s doing, and now it’s no longer junk? How silly. If something has been in the human bodies for as long as there have been human bodies, there’s probably a purpose to it. We just don’t know about it.

I’ll explain the difference between the two. Most people say, “Give me the natural stuff,” just like that. And that’s what we do.

**DM:** Is there a special process, though, that you wean them over or just switch them over initially? Do you find that the length of time they’ve been on the synthetic makes it difficult to take the person off?

**JW:** No, very rarely. I’ll just use your equivalent in the natural, switch off the one you’ve got, and let me know if you didn’t feel right with it. There’s a number of times that either I or one of the medical assistants hear back that the person isn’t feeling right by just switching one day to the next from synthetic to natural. The number of times is really very, very small.

[----- 50:00 -----]

**DM:** It’s interesting. The half-life of thyroid is relatively long. It’s not like many medications that are prescribed, where it’s a few hours. I mean, it’s days I believe. Isn’t that the half-life of thyroid hormone?
JW: Yeah, you’re right. As they’re building up the half-life on all the 12 natural ones, the half-life on the other one is slowly going down. I think that’s why they can switch too easily.

DM: Yeah. That’s actually one of the reasons why you just can’t adjust thyroid hormones really quickly. You have to wait a few weeks before you could make a decision because you won’t see the full benefit for a few weeks.

JW: Yeah.

DM: I guess the finetuning of this is that the same symptom list that we reviewed initially that diagnosed those, you use that to monitor them for the right dose to make sure that all those symptoms are optimized or gone at that point.

JW: Right. For those who are interested, Dr. David Brownstein has a book out there called *Overcoming Thyroid*. He’s got a checklist in there. Dr. Mark Starr has another very good book out, and he’s got a checklist in his. And then there’s a Dr. Arem from Texas. He’s got a checklist in his. There are several good books for the public (they’re not textbooks for the medical profession), where you can find that checklist. See if you think you might have a problem.

DM: Okay, great. All right.

JW: One other thing, Dr. Mercola.

DM: Sure.

JW: Have you [got] time to go over an effective treatment for hyperthyroidism?

DM: Oh, yeah. Just to give our listeners a perspective. I believe it’s 20 to one of the people with thyroid disease would have the hypothyroidism, whereas maybe out of 20 would have hyperthyroidism. Is that your experience? Or is it even more?

JW: I’d be voting for one to 30, one to 40, or one to 50 really.

DM: Okay, so it’s even less than that. Yeah, it’s not common.

JW: It’s not common. No. But we should let everybody know that there is an effective treatment out there. Just in case a relative has it, a friend or whatever, they can tell them. This effective treatment originated at Walter Reed Army Medical Center (WRAMC), at their department of thyroid. They actually had a department of thyroid. They published in 1984, but it’s pertinent now. Now, they had enough people with hyperthyroidism that they were able to divide into four troops or groups. Imagine that. I hardly see four people with hyperthyroidism in three or four years.

DM: Sure.

JW: Maybe that’s why I don’t see that many. They’re all going to the endocrinology clinic. Too bad.

DM: Well, it’s a scary condition. It will actually kill you and so with hypothyroidism. But hyperthyroidism [does it] a little more quickly.

JW: That’s right. Anyway, they divided [them] into four groups. What they have them take was the group over here (Group 1) took lithium. Yes, I did say “lithium.” Group 2 took iodine, Lugol’s iodine in fact. Group 3 took lithium first and then three or four days later, started iodine. Group 4 took up Lugol’s iodine first, and then three or four days later, started lithium. We had the lithium group, the Lugol’s group, the lithium-followed-by-Lugol’s group, and the Lugol’s-followed-by-lithium group. All four groups.
When the statistical dust settled, what they found was that the group that started with the Lugol’s iodine and finished, and then four or five days later brought in the lithium, did significantly better than all of the other groups in getting the hyperthyroidism under rapid control. Notice I said “rapid.” Right. Now I’m going to detour for a moment for rapid control.

The Mayo Clinic no less published over two decades ago at least one article—and it may have been two—on the treatment of hyperthyroidism with lithium alone. They were able to get the abnormal T3 and T4 numbers, which go way high in hyperthyroidism because it’s overactive, down to normal within a week to 10 days, Dr. Mercola, with just lithium. It didn’t work on everybody. So I’m going to go back to Walter Reed now, who came up with a more sophisticated system. I’ve used that treatment ever since I read about it. It came out in 1984. I think I read about it the same year or the next year. Of all the people I’ve treated with hyperthyroidism—and for me that’s about 40 and the rest of the doctors of the clinic here (we do have 11 docs)–there have been only two failures since 1984.

DM: Wow, that’s impressive.

JW: Just two. For the record, what the doctors at Walter Reed Army Medical Center—this isn’t some quack-health-food-store person talking—did was they had people start with five drops of Lugol’s iodine three times a day. After four or five days, they have to bring in lithium carbonate, which is the same stuff given to people who have bipolar disease. They have them take that in 300 milligram capsule, one three times a day. I’ve got some PowerPoint thingies (we don’t call them slides anymore, I guess) that show an example case—here’s a sample case of somebody who went from screaming high free T4 and free T3 to normal within 10 days. I am not kidding.

Yes. Can lithium go too high and give you problems? It can’t. It never did in the Walter Reed studies. But just to be safe, it turns out that one can prevent or even treat lithium toxicity with a tablespoon of omega-3 fatty acid over here and a tablespoon of omega-6 fatty acid over there. Have some vitamin E please, the mixed tocopherols. You got to do that when you take all that oil. We’ve actually also helped old people out of lithium-induced toxicity by having these oils in vitamin E. I learned that from David Horrobin. I got to thank my sources because otherwise I might be one of those quack medical doctors. David Horrobin is a very prominent researcher in the UK.

Anyway, hyperthyroidism can be successfully treated in nearly all cases with the Walter Reed Army Medical Center protocol. But people, you got to work with your doctor on it.

DM: Sure. Well, that’s a great pearl of wisdom. Do you have any speculations as to why the lithium would work? I mean, there’s not an obvious reason that I would know because this is an autoimmune disease. Does it impact it in some way?

JW: Yes, hyperthyroidism is an autoimmune disease. But where the Mayo Clinic got their thought about this lithium was a psychiatrist treating people with bipolar disease had noticed that higher percentage of what they would have expected were going hypothyroid. They were going hypothyroid after being treated with lithium. The Mayo people said, “If they go hypothyroid with lithium, let’s try it on hyperthyroid. Maybe it’ll work.”

DM: No one has an idea how it works. It just works.

JW: It just works, yeah.

DM: Okay. It’s an uncommon condition. But boy, if you’ve got it, this is going to be a lifesaver because the options are literally pretty poor. I mean, you’re looking at radioactive iodine (which is a disaster) or surgery. I think there’s… Is there an option other than those two?
**JW:** Yes. It’s blocking drugs.

**DM:** Oh, blocking drugs. That’s right. Yeah, that’s right. I never even used them. I just blocked them out of my mind. That’s never a possible consideration. But that may be one of the most common that people use actually.

**JW:** Yup. That is. It is. Before they start the radioactivity, they’ll use the blocker drug.

**DM:** It’s actually a common condition in cats, I believe, too.

**JW:** This, I couldn’t tell you.

**DM:** Yeah, I think it is. I know a lot of people who have pets that have this. It never occurred to me that this could be a possible solution. I’m sure it’s probably good for most mammals – if it’s going to work for humans – with a similar condition. Obviously different dosages would work for this.

**JW:** Obviously different dosages. But I’m guessing you’re correct that it would be effective.

**DM:** All right. Are there any other words of wisdom you’d like to share from your many decades of useful and practical clinical experience?

**JW:** Having to do with thyroid?

**DM:** Uh-huh.

**JW:** Here’s what I learned from a country doc when I was at the University of Michigan. That was back in the Dark Ages, my children tell me and my grandchildren, too – 1960s, good grief. They let the junior and senior medical students go out to work with the doctors somewhere for a few weeks on rotation. And probably you did that, Dr. Mercola.

**DM:** Uh-huh.

[----- 1:00:00 -----]

**JW:** This ‘ole country doc said, “You know, from time to time when you see a lady…” We’ve just seen one. We’ve seen a younger lady who’s just having irregular menstrual periods and she’s been having irregular menstrual periods most of her life. She’s 34. It doesn’t mean you don’t mean she’s an older lady. He said, “You know, son, I know they tell you at the medical school that you’ve got to run thyroid tests before you give thyroid.” But he said, “In the case of a young woman with irregular menstrual periods, forget that. Just give her half a grain of thyroid or a grain of thyroid if the half grain didn’t work. Don’t go any higher than that. You might get her in trouble.”

He said, “It works nearly every time. The period’s regularized and that’s that.” I said, “But that’s thyroid, you know, periods, ovaries, estrogens, progesterone.” He looked at me and said, “Son, you should know that there’s a back and forth between the thyroid and the ovaries all the time.” He said, “I don’t know what the heck it’s doing, but it works. I’m out here to take care of my patients in the least expensive way we can.” We’re out in a farming area.

“Look, I’m not going to hurt them. I know what they tell you at the university, and you do that when you’re at the university. But when you’re out in practice, try the half-grain-thyroid thing or a whole grain, and see what happens.” You know what, Dr. Mercola? It does work every time.
DM: That’s pretty interesting. Now, I neglected to ask you when we were discussing iodine as a source about some of the other benefits that it has, because we just really focused on the thyroid. But I know you also use it for cystic ovaries, I believe, and breast cysts, because it has a benefit here.

JW: Yeah. Well, there are a few treatments that work 100 percent of the time. But the one for fibrocystic breast disease, oh, my, I learned that from Dr. John Myers. He gave us all – 30 of us here in Seattle – a seminar on how to get rid of fibrocystic breast disease. When he’s all done with the seminar, he says, “Now, you guys all go home and do that. You let me know if it doesn’t work.” This is a study group we had. This was back in the ‘70s. And about 30 would attend most of the time. We get together every 60 days. When we got back together [after] 60 days, everybody had success with treatment of fibrocystic breast disease with Dr. Myers’ protocol. It worked. It worked every time.

At our clinic we must have seen every woman with fibrocystic breast disease in the surrounding, who knows, five-mile radius or something. We got to the point where we’re having the nurses do the treatment because so many people were demanding it. And then of course, it tapered down as people got better. We showed them how to keep it better. What Dr. Myers taught us was that iodine was the key thing – not iodide. He was real big on iodine for the breasts and iodide for the thyroid.

DM: Not Lugol’s?

JW: Well, actually no. He used what was called diatomic iodine. “Diatomic” just means two iodine molecules stuck together. That’s five percent of Lugol’s.

DM: Okay.

JW: But he liked to use it without the iodide. Unfortunately, guess what became unavailable? The iodine. Isn’t that funny how that happens? We’re using Lugol’s now. And you know, it does work well. Now, a really bad case of fibrocystic disease, you do need a doctor for it. Because in Dr. Myers’ protocol, he would have the entire cervix swabbed with his diatomic iodine. Why put it there? Well, because Dr. Myers was a surgeon and he worked with a dog lab. There’s a species of doggie – beetles, I don’t mean the singers – I mean beagles (I said that wrong) that get fibrocystic breast disease all the time.

What he did was he had this group of lady beagles. Half of them he removes the ovaries, half of them he does what’s called a sham surgery. They do that a lot to make sure you’re not using the psychological effect here. He did a sham surgery. They all got fibrocystic breast disease. Everybody gets the iodine. In the ones that have their ovaries with fibrocystic breast disease, over time – it usually takes two weeks – it cleared up and went away. The ones who didn’t have their ovaries, excuse me, it didn’t work. It’s really darn. He says, “You got to have your ovaries for this to work.” Okay.

DM: Interesting.

JW: That’s why he says, “And look, if you put that iodine, if you swallow it, some of it is going to get to your breast. But excuse me, it apparently has to be processed by the ovaries first.” That’s why he did this swab of the cervix. It’s just like if you do a pap smear, you have to use an iodine swab. He said, “That’s going to be a lot more efficient.” For the bad cases, you got to work with your doctor. Get the iodine swab done.

Dr. Myers, his demonstration of that, you could feel the difference in rock-hard… It feels like little rock marbles inside of the breasts. It’s hard, it hurts, and ooh, you see it when you palpate the breast and everything. He did that swab. Wait half an hour and those single ladies will be smiling at you when you palpated their breast because they had so much pain relief with just one treatment.
But the pain relief was because it wasn’t rock-hard anymore. It still would take several weeks’ worth of treatment. The worse the fibrocystic breast disease is, the more treatment it takes. But that one, I can almost read like, “A money-back guarantee if we don’t cure your fibrocystic breast disease. You can have all your money back,” because I never would have to give you guys your money back.

**DM:** That’s another really great pearl. But I’m wondering, with respect to your recommendation of iodine and your use of it, if it’s only good for preventive, or if you ever find that it’s useful for borderline hyperthyroid patients just to go on the iodine replacement…

**JW:** Yes.

**DM:** Rather than the natural hormone preparations.

**JW:** Yes, indeed. You’re quite right. Some people ask that very question. They’re close enough to normal and they say, “I could feel a little better. My test could be a little better. But after all this stuff, can I just try some iodine?” I’ll say, “Sure. Hey, it’s your body.” I’ll say that any time it won’t hurt anybody, that is. They try and sometimes it succeeds. You’re completely correct. That’s another option. I should have mentioned it. But sometimes you could normalize with nothing more.

**DM:** In your experience, it’s probably the minority of people who develop the full-blown syndrome.

**JW:** That’s right. It’s the minority.

**DM:** Okay.

**JW:** It’s the minority. But it’s still the case. I should mention one other thing before I shut up, and I really should shut up. I’m sorry, Dr. Mercola. That is the World Health Organization tells us – occasionally I believe them after I go check the data (remember, it’s a government agency, so you always have to check your data) – truly this time that the major cause of mental retardation out there is lack of maternal iodine when she’s pregnant. No kidding. That’s what they tell us. They put up billboards about it because it’s so important. They’re trying to get people to donate, of course, to saving the children, which isn’t a bad idea if we got the money.

But moms, if you’re planning on getting pregnant or if you are pregnant, no don’t go take iodine drugs, especially not in the first trimester. The food has got iodine in it. Foods naturally got iodine. It’s called seafood. That’s not going to hurt anybody’s baby. If it can prevent mental retardation, come on.

**DM:** Sure.

**JW:** Iodine has a lot of uses in the body. There’s one of them – preventing low IQ points.

**DM:** All right. Well, I can’t thank you enough for sharing your many decades of clinical experience and wisdom. It’s going to help a lot of people. I really appreciate your time and comments on this topic.

**JW:** You’re welcome. Thank you so much, Dr. Mercola, for having the world’s most terrific natural medicine site and getting the word out for all of us.

**DM:** That’s one my passions: to help people and empower them so that they can truly take control of their health. This is an important area that affects so many women.

**JW:** You bet.