



Thry'vors News



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This is the 20th in a series of seasonal newsletters, from the Canadian Thyroid Cancer Support Group (Thry'vors) Inc. Your comments and suggestions are most welcome.

Please direct your comments to Newsletter Committee at thryvors@sympatico.ca

Is Thyroid Cancer Associated with Depression and Mood Disorders? Evidence from the Literature and Patients

by: Zahra Punja, PhD and Jacques Abourbih, MDCM, FRCS(C)

It is not uncommon in conversations between thyroid cancer survivors to hear of their personal experience and struggle with depression, mood swings and/or anxiety prior to, during or after their diagnosis of thyroid cancer. Some survivors report having experienced symptoms of sadness, insomnia, worry, fatigue, anger, anxiety, feelings of unhappiness, episodes of panic attacks, trouble sleeping, feelings of fear, loss of appetite and feelings of despair.

Recently, some *Thry'vors* members offered comments about their experiences through a brief survey. Chelsie from Brampton reported "For most of my adult life I have felt a generalized anxiety, and at times, even depressed. I often worried more than the next person. Once I was diagnosed with thyroid cancer, these feelings amplified." Jane from the Philippines stated, "I would easily get irritated, cry for small issues. When my sister and I had a fight, I was really emotional and I said nasty things that I normally don't say". Similarly, Rochelle from Mississauga experienced the following symptoms: "I felt like I was constantly in crisis mode; any change was overwhelming; any suggested change seemed like a disaster. I felt drained of any emotion at all. I couldn't stop crying".

For some, these feelings were temporary and existed during the first year after their thyroidectomy. For others the symptoms persisted over longer periods of time and some-

Thry'vors News Seeks an Editor

This newsletter needs your help. We are seeking a volunteer to help coordinate each quarterly issue, by assembling the monthly features and choosing a lead article for each. For more information call Rita Banach 416-487-8267

times reoccurred, to the point that counselling and/or medications were required. In discussing these feelings with their doctors, the survey respondents said that they had not been told by their doctors that there may be an association between their thyroid cancer and their depressive symptoms. Most of our members offering comments uncovered the potential connection through their own reading and research, through internet sites and through sharing their stories within their peer network.

Patients whose treatment involves a total thyroidectomy and radioactive iodine ablation may have to undergo a temporary period of hypothyroidism. As well, any time that replacement

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Offering information and support

hormone is not at sufficient levels, patients may experience some symptoms associated with hypothyroidism. In some scientific studies, researchers experimented with withdrawal of levothyroxine medication to determine how the patients' moods were altered¹. One study found that patients experienced increased sadness and anxiety as a result of being off their medicine². Additionally, these studies showed high correlation between hypothyroidism and depression and anxiety on many relevant mood tests³.

In a study published recently, it was found that the hypothyroid differentiated thyroid cancer (DTC) patients in the study "suffered an even more pronounced decline in psychosocial health related quality of life (HRQL) than frequently is seen in patients with other cancers"⁴. It seems that lack of sufficient thyroid hormone disturbs one's emotional and cognitive functions. In extreme cases, patients experience "depression with paranoid flavour" and may at times "appear schizophrenic, losing touch with reality and becoming delirious or hallucinating"⁵. "In some extreme cases, patients were diagnosed and treated for depressions that were associated with symptoms of paranoia, delirium, hallucinations, a general loss of touch with reality and cognitive impairment."⁶

The question then is what is the connection between thyroid cancer mood disturbances, depression, anxiety, and sometimes severe psychosis? To understand these processes, we must review what the thyroid gland is responsible for and what happens in the absence of one. Additionally, we need to understand how an enlarging tumour(s) in the thyroid gland prior to the diagnosis of thyroid carcinoma, may disrupt the function of the thyroid.

The functions of the thyroid gland are well studied, and include its ability to take iodine from food and convert it into two thyroid hormones: thyroxine (T4) and triiodothyronine (T3). These hormones affect behaviour and thinking. The thyroid gland is under the control of the pituitary gland, a small gland in the brain. When the level of thyroid hormones (T3 & T4) drops too low, the pituitary gland produces Thyroid

Stimulating Hormone (TSH) which stimulates the thyroid gland to produce more hormones. However, in the case of thyroid cancer, most patients have had either a partial or complete thyroidectomy, and so in the absence of a thyroid gland, the TSH has little or no effect. The end result can be subclinical hypothyroidism with decreased mood states and increased depressive symptoms if the patient is not properly balanced with replacement hormone.

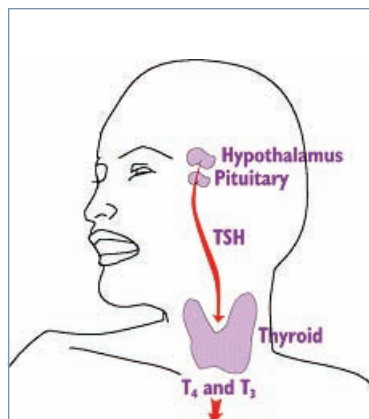
Hypothyroidism, specifically defined as thyroid hormone deficiency can result in profound global neuropsychiatric and cognitive disorders that are well recognized and characterized. Symptoms include lethargy, fatigue, cold intolerance, dry skin, constipation, and decreased exercise tolerance. Sometimes these symptoms may mimic or be difficult to distinguish from depression. Usually these symptoms come first before the emotional and mental ones set in. An attentive physician hopefully would pick up on these clinical features long before the patient slips into the neuropsychological and cognitive disorders of hypothyroidism.

Other symptoms of hypothyroidism include social withdrawal, slow movement, depressed mood, and apathy. Less commonly and in extreme cases, hypothyroidism presents with other neuropsychological symptoms including psychosis, confusion, and disorientation; this syndrome has been called "Myxoedema Madness"^{7,8,9}.

The power of these T3 and T4 hormones is well documented, where in the past they were used in treating depression — before the invention of synthetic forms of thyroxine (eg.

Eltroxin and Synthroid). Specifically, "thyroid extract", extracted from the thyroid gland of a pig or cow, was used in the late 1800's to treat hypothyroidism. In fact, in 1891, George Redmayne Murray used thyroid extract to treat a patient with Myxoedema Madness and subsequently published the success of this treatment in 1920¹⁰.

It is important for the thyroid cancer patient not to forget to take their medication. Research has found that patients who were without medication experienced more



Source:
www.life-enhancement.com/images/Thyroid.gif

feelings of sadness and depressive symptoms. Thus, it is very important to comply with your doctor and stay on your medications. If mood changes occur or patients notice any changes to their emotional state, consulting their doctor about how one's medication dosage can be altered should be carried out.

Second, exercise was reported to have significant benefits to the thyroid cancer patient in improving and sustaining quality of life measures. Research suggests thyroid cancer patients engage in "endurance and strength training performed in groups to help improve stamina in daily housework and in assisting in physical performance"¹¹.

Third, psychological support network of friends, family and if necessary a counsellor or psychotherapist will help deal with the ups and downs of thyroid imbalances. According to research, the most critical time of emotional difficulty occurs during the first year after surgery when the body is adjusting due to the absence of a thyroid gland. With the help of a psychotherapist, patients can better achieve desired health outcomes such as "improved mental health, emotional functioning and social competence"¹². Patients can locate a MD Psychotherapist in their city by searching on the General Practice Psychotherapist Association website at www.gppaonline.ca/wb/

In conclusion, although relatively rare, several factors can lead to increasing emotional disturbances in thyroid cancer patients. The absence of a thyroid gland can change the hormone balance creating a degree of hypothyroidism which in turn can increase the risk of the occurrence and reoccurrence of mental illness in thyroid cancer patients. The removal of levothyroxine or T4 medication from the thyroid cancer survivor's life can increase sadness and depressive symptoms. Furthermore, the disease may have psychological and social implications, including the fear of recurrence and impairment in occupational functioning that may also contribute to depression. Psychological assistance may sometimes help to relieve or prevent depressive symptoms in patients with thyroid cancer. Further, complying with the doctor and taking medicine on time and regularly is an important way to maintain wellbeing and to decrease chances of having depressive

symptoms. Additionally, rehabilitation requires one to change one's lifestyle by exercising regularly and developing a strong social support network. These combined medical and complementary therapies will improve a patient's resilience to the onset of mental health problems.

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- 12 Crevenna, R., *ibid.*

With special thanks to Jacques Abourbih, MDCM, FRCS(C), a retired surgeon and currently an Assistant Professor at the Northern Ontario School of Medicine at Laurentian University in Sudbury Ontario. Dr. Abourbih brings a depth and breadth of knowledge on medicine and medical education. Dr. Abourbih is also the "unofficial" Rabbi for the Jewish Synagogue in Sudbury.

Thry'vors Listserv is now Thry'vors Online Forum

We've changed the name of our online community/support group to *Thry'vors Online Forum*. It's got a new name but it is the same great place to meet up in cyberspace with other members of our group -- sharing information, questions, experience and support. Our Online Forum is monitored by an Online Forum Committee with help from our Medical Advisory Panel as need be. It is a private forum, accessible only to thyroid cancer patients and their families.

We welcome you to join us at:
<http://health.groups.yahoo.com/group/Thryvors/>
or for more information, contact us at
thryvors@sympatico.ca

Thriving Thy'vors

This issue features Lynda Murtha

by Rita Banach

Since the word "Thry'vors" is a contraction of three words – "thriving", "thyroid" and "survivors" – it is only fitting that we honour some of our own "thriving survivors".

This is a series of articles about our own exciting and thriving members.



If you have ever participated in *Thry'vors Online Forum*, you very likely know and love Lynda Murtha. Her posts which invariably contain kindness, warmth, sincerity and sage advice – are hard to miss. She has a knack for not only patiently explaining the 'ins and outs' of a medical procedure (even if she has explained it a dozen times before), but also doing so with incredible empathy with the person who made the inquiry.

Lynda, one of *Thry'vors* extremely valued volunteers, is a person who can be counted on as a friend even as she continues to manage her own thyroid cancer issues.

Lynda describes her dealings with her own thyroid cancer very eloquently. She says that once any procedure (i.e. tests, surgeries, treatment, etc.) is over and done with, she puts the thoughts and emotions that go along with it into a metaphorical box, ties a ribbon around it, and puts it up on a very high shelf in the closet of her mind. When it's time for more tests, she brings down the box, deals with it, and then puts it away again. How wise and sensible.

Lynda was born in Ottawa. She married her spouse Tom, 42 years ago and they raised their three daughters in Toronto. Before she retired 12 years ago, Lynda worked as an administrator and later an assistant to the chairman of the board of a publicly traded investment banking firm. As well as being a *Thry'vors* volunteer, Lynda also enjoys being a grandparent to Abby age 4, and Joshua 3. Lynda and Tom also do some traveling and spend a few months a year in Florida. For the last several years she's also been taking courses and writing non-fiction. Her articles have been published, for example, in the *Globe and Mail*, *Woman's World*, and *Stitches Medical Humour* magazine and she is currently working on a book.

Poem

by Deirdre Tanaka

Radioactive Tears

What about tears?
They talk about
saliva
and sweat
and urine
and all these things,
but what about the tears
and the howls
that come?
Where do I put these
and WHO will I irradiate with them
in this solitary space?
Will the garbage man die
from the bag of tissues soaked in tears?
As I worry about everyone,
everyone I love so much,
what do I do about my radioactive tears?

**Send us your poems.
Email thryvors@sympatico.ca**

Lynda's thyroid cancer journey began in 1994 when she was 50 years old. Like many of us, Lynda's nodules were found via a series of happenstance occurrences. She happened to meet a family doctor in a social situation. Because her previous doctor had moved out of the county, Lynda asked if the doctor would take her on as a new patient. She did, and Lynda was seen by her soon after for an overdue annual medical check-up.

"She was kind and gentle as she ran her hands down the sides of my neck, checking for nodes, checking the size of my thyroid. Then she hesitated. "You have a very tiny node on your thyroid", she said. "Likely nothing."

She ordered appropriate bloodwork and scans, and eventually sent me to see a surgeon. He felt it, but commented also that it was very small...less than a centimetre, but thought a biopsy was in order. The biopsy came back inconclusive.

"Strictly because of my age, he felt he should remove half the thyroid, but he warned me that if he got in there and didn't like anything he saw, he'd take the whole thing.

I woke to find he'd removed my whole thyroid. Ten days later he called to confirm it was thyroid cancer that had spread to my lymph glands. I think he was as surprised as I was. Six weeks later I had RAI, and went back to my active life."

Her pathology report indicated that the less-than one centimetre, barely palpable nodule was in fact malignant and that her papillary thyroid cancer had spread to several lymph nodes.

Lynda says that for her initially, thyroid cancer was a lonely disease. Nobody she knew, nor anyone she'd even heard about, had the disease. In 1994 there was no internet and her only source of information was the public library. Her endocrinologist at the time wasn't very forthcoming with information, so anything she learned came from dusty medical books in the back of the library. Lynda said "I remember how I wished there was just one other person who understood what was happening to me; what an upheaval it was to my world to have to go off meds for scanning; how lonely it felt to be in isolation; how fearful I was of having to have further surgeries."

Lynda has not had an easy time of it. Four years after her thyroidectomy, her Thyroglobulin (Tg) measure was elevated. After ultrasounds, CT scans, and then a biopsy on some nodes, it was determined that she had a malignancy again. She had a second surgery (a central neck dissection) followed by another round of Radioactive Iodine treatment (RAI) - this time a large 200 millicurie dose. Besides nodules in her neck, some were also found to be malignant down in the mediastinum area of her chest.

Another four years later (she says that seems to be an unlucky number for her) the same thing happened. Her Tg climbed, and this time she and her surgeon (Dr. Jeremy Freeman) opted for a modified radical neck dissection to remove all the nodes on that side, and to get a jump on any further malignancy. Radical neck dissections are more difficult to recover from and like many others who have had this procedure; Lynda has lost some feeling and mobility in her neck.

It was determined after the second RAI that she was RAI-resistant (that is, she had a "clean" scan [WBS] combined with an elevated Tg). Because of that, she has

"We all deal with a cancer diagnosis differently. I needed information, and had no one to turn to who had first-hand experience with thyroid cancer. After my journey began, I realized I could be that person for others - it wasn't that I was an expert on the disease, but I was an expert on my own experience, and I was willing to share what I knew. That's all it really takes. I receive a great deal of gratification in helping and I'm honored to be an active volunteer with Thry'vors."

Lynda Murtha

had no further RAI treatment after that. Her Tg has remained slightly, albeit consistently, elevated.

Needless to say, Lynda is monitored very closely and sees her endocrinologist twice a year. Her TSH is kept very suppressed at .01.

Following a few months after her second neck dissection, Lynda was back in the hospital for surgery on a totally unrelated intra-dural tumour (a large, potentially deadly tumour inside her spinal column). This last surgery was a great blow to her both physically and emotionally, but again she pulled down her metaphorical box, dealt with it as best she could, and then replaced the box back on the shelf. Besides, at the time her first granddaughter was about to be born and she didn't want to miss out on any of that!

Lynda was a very early participant in *ThyCa: Thyroid Cancer Patients' Association* (USA) and was a founding member of *Thry'vors* as well. She has watched both organizations grow exponentially over the years, especially participating on their *Online Forums* as a supporter.

"I never greet a newly diagnosed patient that I don't remember my own early struggle. I'm thrilled to be a regular on Thry'vors Online Forum because it's easy to see the difference we can make as we help to educate the new members. You can almost see their shoulders relax, their breath slow as they start chatting with us and become more comfortable, knowing they are no longer alone."

Lynda is not only a cyber-friend, but she has also visited some of our members in the hospital, and has attended doctor's appointments with them. Sadly, she also became one of the only supporters to a member while she was in palliative care. Lynda modestly explains her generosity of spirit by saying:

"I know the value in simply being there for someone. I don't know how to describe this part of being a volunteer without saying I am privileged."

The way I see it, it is *Thry'vors* who is privileged to have Lynda as a member.

Ask Thry'vors Q & A

The members of Thry'vors Medical Advisory Panel are available to answer YOUR general questions about every aspect of thyroid cancer. A list of our Medical Advisory Panel members appears on our website at: (www.thryvors.org/AboutThryvors.html)

IN THIS ISSUE:

We explore the advantages of different imaging modalities in regards to thyroid cancer. Dr. A.A. Driedger, Professor of Nuclear Medicine/Oncology, at the University of Western Ontario, London Health Sciences in London ON, and member of Thry'vors Medical Advisory Panel assists us with his answers.

QUESTION

What are the advantages of different imaging modalities in regards to thyroid cancer? For example, what is imaged in an ultrasound vs. a CT scan vs. an RAI scan? Why is a MRI sometimes considered more advisable than the previously named scans? In which cases is a PET scan called for, and why is it advantageous to combine it with a CT scan at the same time (i.e. PET-FDG/CT fusion study)?

ANSWER

Each of the imaging modalities addresses a unique set of tissue characteristics and that is why they are not interchangeable.

1. Ultrasound uses echoes from tissue planes and from moving objects, such as blood, to make its images. Therefore, ultrasound will recognize the tissue disorganization of a tumour or a cyst and it will also recognize alterations of blood flow that might distinguish between a normal lymph node or one with cancer within it.
2. A CT scan makes images that are based on differences in the density of normal and abnormal tissues and the distribution of injected radiographic contrast (dye) in the tissues. A CT scan will easily recognize the presence of calcium in a tumour and the distribution of contrast will demonstrate the distribution of blood volumes within an organ.
3. Nuclear scans, of which RAI is one example, image the distribution of targeted functions within the body. In the

case of RAI, one is able to image the distribution of tissues that concentrate radioactive iodine; ie, normal thyroid and, under special circumstances, thyroid cancers.

4. MRI is another way to image the anatomy of the body through imaging of the distribution of water within the body. Here one uses complex, controlled magnetic fields to influence the nuclear spins of hydrogen in order to create the image. MRI is not used often as an imaging technique in relation to thyroid diseases.

5. PET is a special form of nuclear scan that uses a specific type of radioactive isotopes known as "positron emitters". The most commonly used PET isotope is fluorine-18 and it is bound to a sugar molecule known as glucose; the complete sugar complex is known as FDG. Most cancers are more dependent on a supply of glucose for their energy than normal tissues. Thus, when FDG is injected into the blood, it is strongly bound to cancers in an irreversible reaction and we are able to make images of the FDG distribution.

These days PET scanners come with a CT scan so that the anatomic and functional images can be co-registered on each other. This enables us to distinguish more accurately between cancer and non-cancerous forms of disease and it enables us to locate the cancers more accurately (eg, for the surgeons and radiation oncologists). Thus, all PET scans are now done as combined PET and CT.

In thyroid cancers the PET/CT scan is needed in a select set of cases when the patient has an elevated level of Thyroglobulin in the blood and the RAI scan has failed to demonstrate a site of disease. The results of the PET/CT scan are useful for the patient whether they are normal or abnormal. In our experience, abnormal scan results identified the location of disease accurately so that the surgeons were able to remove it in many cases. Normal scans in these patients indicate that the disease will progress very slowly, if at all and avoid further invasive treatments at the time.

REPLY BY: A.A. Driedger MD, Ph.D., FRCP (C), FACP, FCPE

Special thanks to Dr. A. A. Driedger, Professor of Nuclear Medicine/Oncology, University of Western Ontario, London Health Sciences, for his participation in this edition of Ask Thry'vors.

Article Review

The Role of the Low Iodine Diet in Preparation for Radioactive Iodine Therapy

by: Charna Gord, BASc, MEd, RD

Charna Gord is a Registered Dietitian working as an Education Coordinator in a large urban health unit. She underwent a total thyroidectomy for thyroid cancer in December 2007. This is the second in a series of thyroid cancer related journal article and other resource reviews that Charna has undertaken for Thry'vors News.

How is Thyroid Cancer Treated?

Thyroid cancer is typically treated with either a partial or complete thyroidectomy (surgical removal of part or all of the thyroid gland). Surgery is often followed with I-131 Remnant Ablation (Radioactive Iodine Therapy or RAI). In order to prepare for the RAI treatment, you may be told by your doctor to follow a Low Iodine Diet (LID) for one to two weeks prior to, during and for about two days after RAI. Thyroid cancer treatment guidelines vary and thyroid cancer patients are not always prescribed the LID. Studies since the mid-1960's which have investigated use of the LID in preparation for RAI generally conclude that using the LID before, during and just after RAI will improve the effectiveness of the treatment.

Is the LID safe and how does it work?

The LID is a safe, short-term diet used to prepare for nuclear medicine thyroid imaging. It is not intended for long-term use. Calcium supplementation is suggested since the LID is deficient in calcium. If you do take calcium while on the LID, consult with your doctor or pharmacist to ensure the supplement is iodine-free.

The LID works by emptying the body of its natural iodine stores. This makes any leftover thyroid cells 'hungry' for iodine. Obtained primarily from dietary sources, iodine is an essential mineral which the body uses to make thyroid hormones. The RAI puts radioactive iodine into the body and the thyroid cells pick them up. The radioactive iodine destroys any residual thyroid tissue, benign or malignant. This therapy can be compromised however if a substantial amount of natural iodine is present in the body when radioactive iodine is given. The presence of natural iodine will compete with radioactive iodine for entry into the thyroid cells, and may block uptake and limit the effectiveness of the RAI.

What does recent research tell us?

The 2003 Dutch retrospective study by Pluijmen et al published in Clinical Endocrinology looked at two groups

of thyroid cancer patients who had been previously treated during RAI with either a standard diet (those treated from 1986-91) or a LID (those treated from 1992-98). Patients from both groups subsequently followed the LID during RAI. They conclude that a LID improves the efficacy of RAI. However their findings recommend that a four-day LID is sufficient and perhaps preferable as compliance with the LID is difficult for many patients.

Park and Hennessey published their American research in Thyroid in 2004. They measured the effectiveness of the LID while taking levothyroxine medication and the effect of the length of the diet period. They found that patients who followed the LID for a two-week period were able to achieve an iodine deficient status. A one-week LID may be appropriate with patients under study conditions benefiting from a dietitian or packaged meal plan.

Tomoda et al published an article in 2005 in Endocrine Journal showing the effectiveness for patients of following a two-week LID as compared to the conventional, one-week 'restricted iodine diet' that had been traditionally used at a Japanese outpatient clinic.

Hinds et al reported in Clinical Nuclear Medicine, April 2008 that the "importance of maintaining a LID for optimal results on nuclear medicine thyroid imaging is widely known and accepted". This American case-study concludes that "proper guidance and emphasis on the implementation of the diet needs to be provided to patients. Non-compliance may lead to false negative imaging results, misleading the medical professionals and patient. Potentially inadequate management of the patient's thyroid cancer may follow."

Where does that leave us?

Although some medical debate continues about specific aspects of treatment, research has proven the important role that the LID has to play in patient preparation for effective RAI. If you are preparing for RAI, remember to speak with your doctor about the LID. Thry'vors has helpful LID information which you can take with you to help in your discussion with your doctor. Also available by request are: the Thry'vors Low Iodine Diet, LID Menu Planner, and LID Shopping List.

For more information: For journal article citations and more information on the LID, please refer to the Thry'vors background document which can be found at:

Low Iodine Diet Project 2006: Purpose, References, Writers and Reviewers
www.thryvors.org/pdf/LID_2006_REFERENCES.pdf

Upcoming Events

Patients Forums

The following events are being held by Genzyme Canada Inc. Thryvors is a partner organization and we hope to greet you as you attend one of the following in your community:

Montreal, QC

Speakers: Drs. M Hier, Surgeon; T. Kader, endocrinologist; R. Payne, surgeon; C. Rush, nuclear medicine; M. Tamilia, endocrinologist. Also S. Sherman, clinical dietitian and S. Raymer, peer mentor

Topic: Thyroid Cancer: The Journey Continues

Place: SMBD – Jewish General Hospital, Block Amphitheatre – Room B – 106, 5750 Côte des Neiges

Date: September 17, 2008

Time: 5:30pm – 9:00pm

Free registration: 514-340-8255

Calgary, AB

Speakers: Drs. Bernie Corenblum, endocrinologist; Denise Chan, nuclear medicine. Also Guy Pelletier, clinical psychologist

Topic: Thyroid Cancer Update

Place: Tom Baker Cancer Centre, Auditorium (Main Floor), 1331-29 Street NW

Date: September 25, 2008

Time: 5:30pm – 9:00pm

Free registration: info@thyroidupdate.ca

Ottawa, ON

Speakers: Dr. Heather Lochnan, MD, FRCPC Division of Endocrinology & Dr. Eugene Leung, MD, FRCPC Division of nuclear medicine

Topic: “Thyroid Cancer: an overview of the treatment and follow up of the thyroid Cancer Patient: addressing your concerns” and “An overview of the radioiodine treatment for the Thyroid Cancer”

Place: Chimo Hotel, 1199 Joseph Cyr, Baffin/Cabot room

Date: September 30, 2008

Time: 6:30pm – 9:00pm

Free registration: info@thyroidupdate.ca

Halifax, NS

Speakers: Ali Imran, MBBS, FRCP (Edin) endocrinologist, FRCPC & Mal Rajaraman, MD, nuclear medicine

Topic: “An Overview of the Treatment and Follow-Up of the Thyroid Cancer Patient: Addressing Your Questions and Concerns”

Place: Future Inns, 30 Fairfax Drive

Date: October 23, 2008

Time: 6:30pm – 9:00pm

Free registration: info@thyroidupdate.ca

Windsor, ON

Speaker: Dr. Joseph A. Shaban, Endocrinology and Metabolism, Windsor Regional Hospital

Topic: Thyroid Cancer Update

Date: November 11, 2008

Place: Caboto Club, 2175 Parent Avenue, Windsor

Time: 6:30pm

Free registration: info@thyroidupdate.ca

St. John's, NL

Speakers: TBA

Topic: Thyroid Cancer Update

Place: Delta St John's Hotel, 120 New Gower Street

Date: November 26, 2008

Time: TBA

Free registration: info@thyroidupdate.ca

Thyroid Foundation of Canada

The following events will be held by the Thyroid Foundation of Canada, please contact them directly for more details (Katherine Keen 1-800-267-8822)

London, ON

www.thyroidlondon.ca

Public Education Meeting

Speaker: Dr. Terri Paul, Endocrinologist, St. Joseph's Health Centre, London

Topic: What patients need to know about thyroid cancer

Place: Central London Public Library (Galleria) 1st Floor Stevenson & Hunt Meeting Room, 251 Dundas Street, London

Date: September 16, 2008

Time: 7:30pm – 9:00pm

ALL WELCOME! OPEN TO THE PUBLIC! FREE ADMISSION!

For more information: 519-649-5478.

Public Education Meeting

Speaker: Dr. Jason Franklin, Head & Neck Oncology & Reconstructive Microsurgery, St. Joseph's Health Centre, London

Topic: Thyroid Surgery from a Patient's Perspective

Place: Central London Public Library (Galleria) 1st Floor, Stevenson & Hunt Meeting Room, 251 Dundas Street, London

Date: November 18, 2008

Time: 7:30pm – 9:00pm

ALL WELCOME! OPEN TO THE PUBLIC! FREE ADMISSION!

For more information: 519-649-5478.

Kitchener/Waterloo, ON

Speakers: Dr. M. U. Chaudhry, Consultant Endocrinology & Internal Medicine, Kitchener and Dr. Terri Paul, Endocrinologist, St. Joseph's Health Care, London

Topics: “Advances in the Management of Thyroid Cancer”, and “Thyroid Cancer London - A new multidisciplinary initiative”

Place: Kitchener Public Library, 85 Queen St. N., Lower Level, Kitchener, ON

Date: Wednesday Oct 8, 2008

Time: 6:00 table displays and refreshments served

6:30 Thyroid Foundation of Canada, K-W Chapter Business Meeting

7:00-9:00pm Lectures & questions from the audience

Free admission. Wheelchair accessible. For information call 519-884-6423

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Like you, we have been touched by thyroid cancer. We are a non-profit organization and we are all volunteers. If you would like to donate or to become a volunteer please visit Thryvors.org.

Donation cheques can be made payable to: Canadian Thyroid Cancer Support Group (Thryvors) Inc.

Mail to: Canadian Thyroid Cancer Support Group (Thryvors) Inc.
PO Box 23007, 550 Eglinton Ave. West
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