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This is the 8th in a series of seasonal newsletters, from the *Canadian Thyroid Cancer Support Group (Thy'vors) Inc.* Your comments and suggestions are most welcome. Please direct your comments to the Listserv Committee at [thyvors@sympatico.ca](mailto:thyvors@sympatico.ca)

## Current Findings in Thyroid Cancer Research

by Rita Banach,  
reviewed by Drs. Tuttle and Ezzat

It was my pleasure to attend the *One Day Course on Functional and Structural Diseases of the Thyroid*, on June 11, 2005. This event was organized by the Temmy Latner/Dynacare Chair In Head and Neck Oncology, Dr. Jeremy Freeman. It was held at Mount Sinai Hospital, Toronto and attended by at least 100 people. As an accredited course, almost all present were thyroid cancer specialists or student doctors, and I felt very privileged to have been invited to attend.

This event was chock-full of information new to me. I strained my brain to take in the medical lingo and concepts -- especially

in regards to pathology and cytology of tumours, and likely 60% of it flew right over the top of my head. Here are some highlights of the research presentations that I found enlightening and would like to share with you.

Dr. Christina MacMillian gave a fascinating presentation on the pathology of the thyroid showing among other things, slides of the various forms of thyroid cancer (thyca) under a microscope. I was in awe of how she could say that one group of swiggly lines "obviously" represented papillary cancer while others "clearly"

*(Continued on page 2)*

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**Canadian Thyroid Cancer Support Group (Thy'vors) Inc.**

PO Box 23007  
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Toronto, ON  
M5N 3A8



One Day Course on Functional and Structural Diseases of the Thyroid



## Current Findings in Thyroid Cancer Research ... continued

*(Continued from page 1)*

represented follicular, or hürthle, or tall cells, or whatever the case may have been. She spoke of the various factors used to identify cancerous cells gleaned from Fine Needle Aspirations (FNA) and/or Frozen Sections (that is, the sample taken during thyca operations). She spoke of at least 6 cell variables which help pathologists identify a papillary cancer, for example.

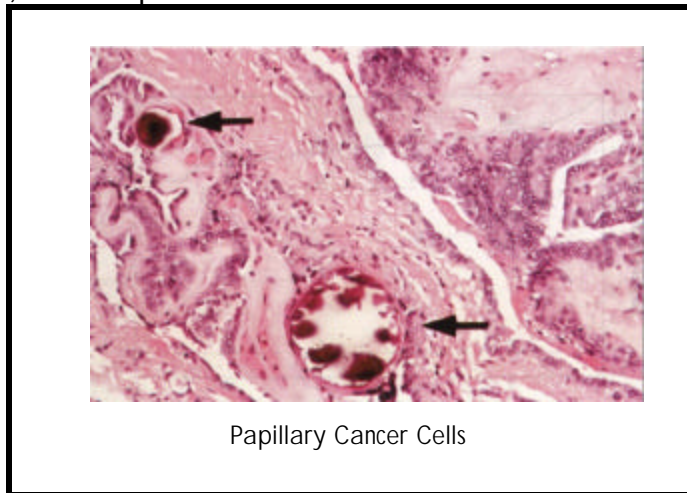
Drs. Ted Kassel and Tanya Chawla spoke of the advances made very recently in radiology of thyroid masses. In regards to CT scanning, they spoke of recent advances

including the use of a MDCT type of CT machine which offers 64 "slices", very high resolution, and short duration of the test. These machines are 128 times faster and more efficient than the ones used in 1992. CT, and to a lesser extent MRI, have an important role to play in helping to diagnosis thyca and especially in assessing recurrent disease -- particularly where the mass is less than 2cm. CTs are an important option as up to 25% of masses may not be detected by iodine 131 uptake. And, a combination CT-PET offers "the best correlative uptake and the localization of recurrent lesions". One of the points that both the pathologist and the radiologists emphasized, is that it is very important to have experienced thyroid cancer specialists interpret your slides and scans. For example, what may not be seen on one magnification of the

microscope may be seen clearly on another.

Dr. Shereen Ezzat, endocrine oncologist and member of Thry'vors medical advisory panel, gave a talk on assessment of nodules -- the various factors taken into account and some misconceptions. He said that the literature indicates that hormone suppression is not always effective in arresting growth of a nodule or in

preventing recurrence. He also said that a small size nodule (less than 1 cm) does not necessarily mean that it is less likely to be thyca. The chances are independent of size. Instead other factors are important, such as whether calcification is



Papillary Cancer Cells

found within the nodule (e.g. detected on CT scan), as this indicates a higher likelihood of thyca. As well, the cytologic features (i.e. the features the pathologist looks at under a microscope following an FNA) are the most important in making a diagnosis, even if FNAs have to be repeated many times in order to get enough information. He believes that many nodules should be followed. FNA samples are also useful in making genetic analyses, as the field of genetic links in thyca is quickly evolving. They are finding, for example, that there is a series of progressive genetic mutations that uniquely characterize thyca cells. Because of recent developments within this area of investigation they will soon have medications to treat poorly-differentiated thyca (eg. Hürthle Cell, Medullary, etc.)

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that are no longer amenable to surgical resection.

Dr. Jonathan Irish, surgeon at Princess Margaret Hospital reviewed the literature regarding total thyroidectomies (TT) and partials. He spoke of the biases in various studies that have been done in the past and made the point that it is extremely difficult to do definitive research on surgical outcomes as the population of thyca patients is relatively small for statistical analysis.

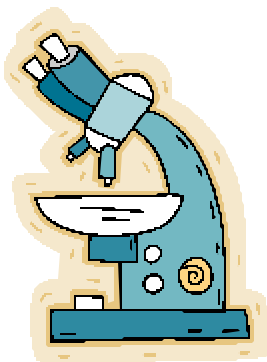
Dr. Ian Witterick, surgeon Mt. Sinai Hospital, spoke about neck dissections. He showed various slides depicting where lymph nodes are located in the neck and how they are categorized by sections of the neck. He said that there is significance in terms of recurrence and mortality in regards to which part of the neck need be dissected. He also made the point that it is important to take out all lymph nodes in a section of the neck rather than “berry pick”, in order to improve the chances of a good outcome. He reported on a study done at Mt. Sinai where 29% of patients who had a dissection of their neck had a recurrence (on average at 8.6 years after their original surgery). This was regardless of whether their original neck dissection was central, lateral or combined. The conclusion of this study was that it is only necessary to dissect the region involved, as a larger area of dissection does not improve outcome.

Dr. Jeremy Freeman, Head of Otolaryngology at Mt. Sinai, gave a talk about re-operations. He said various patient conditions must be looked at in making decisions about surgery -- that is, some conditions put the patient at higher risk for recurrence than others. Many of these we are familiar with such as age, metastases, tumour size, type of thyca, etc. Dr. Freeman also showed a fascinating short film segment of a TT surgery, which by that point in the day

(after seeing and hearing some slides usually only meant for the eyes of fellow doctors), I actually had little trouble viewing -- it didn't make me squeamish but rather it renewed my awe in what surgeons are able to achieve. He also reviewed various research studies some of which were contradictory. For example, while most of the literature indicates that surgery combined with Radioactive Iodine (RAI) decreases chances of recurrence, other studies indicate that RAI does not ultimately improve a patient's outcome. Another study he reviewed indicated that on average \$231,044 is saved to the medical system by patients having a total thyroidectomy initially, rather than having a partial and returning for a completion. Other studies indicated that while having one recurrence may not be significant in effecting a patient's lifespan, 2 or 3 recurrences do not hold as much promise. His conclusion was that a thorough search for metastases (mets) during the initial surgery must be done, that total thyroidectomies should always be done with high risk patients, and that RAI is important. He said thyca is a disease treated most importantly and effectively in the long term with good initial surgery.

Dr. Jonathan Clark a clinical fellow in Head and Neck Surgical Oncology spoke about Medullary thyca. There is a strong genetic component to Medullary and he spoke of Calcitonin hormone and the RET receptor. His comments concluded with the following points: there is an early and high frequency of regional metastases associated with Medullary, early surgical treatment is key to controlling it, it is a slowly progressing disease, neck re-operation can normalize Calcitonin in 20-35% of cases, and the known genetic basis holds promise for improving early diagnosis, treatment and outcome.

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## Current Findings in Thyroid Cancer Research continued

*(Continued from page 3)*

Dr. Paul Walfish, endocrinologist, Mt. Sinai, spoke of the use of Iodine-131 treatment. He said that most treatment centres agree on a combination of total thyroidectomies and ablative RAI treatment as a routine course of action for thyca. At Mt. Sinai hospital they do not do diagnostic or dosimetric scans (scans that help calculate the exact amount of  $I^{131}$  needed for the ablative RAI), as starting with an ablative treatment is more cost effective and it avoids the problems of stunning the cells and of dosimetry. The reason for ablation is that it enhances the utility of serum Thyroglobulin (Tg) as a marker, improves the impact of the TT and has long-term results as good or better than would be achieved without a treatment dose of RAI. He spoke of his research whereby patients had a 22 day withdrawal from thyroid replacement hormone (T4) to test for Tg. He found that 10% of patients had a significant rise in Tg indicating the need for further treatment. He agreed with what Dr. Freeman had said earlier, that is, a good surgical outcome makes for a better RAI outcome and therefore less chance of recurrence. Dr. Walfish also spoke of the negative effects of RAI including the effect on testicular function and male fertility. He said males should wait at least 4-6 months after RAI before starting a family, and consider banking sperm if high dose therapy is to be given. Good hydration and frequent

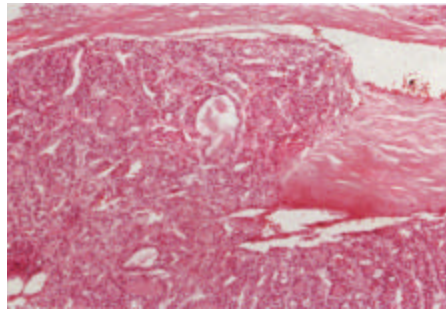
urination are important during RAI treatment. He also said that the literature shows a slight increase in chances of bladder cancer after a patient has received 1,055 mci of RAI, and of breast cancer after receiving 960 mci (cumulatively).

Dr. Jay Silverberg, endocrinologist at Sunnybrook Hospital, spoke of the treatment of hyperthyroidism and hypothyroidism. He cited a study of the use of Cytomel (T3) to supplement T4

which found that there was no significant improvement in hypothyroid symptoms, mood, depression, life satisfaction or cognitive function. He also spoke of the effects of hypothyroidism on pregnancy. He said that there is a need for thyca patients to be less suppressed during pregnancy --

for the health of the baby. For women without a thyroid gland, the weight gain during pregnancy balances with one's usual dose of T4, increasing the TSH without changing the prescription of hormone replacement. He also said that although pregnancy can cause a recurrence of thyca, it is thyca that existed anyways and would have 'shown itself' eventually anyways (i.e. pregnancy brings it on sooner).

Dr. Jeffrey Hurwitz, ophthalmologist at Mt. Sinai spoke of thyroid eye disease associated with Graves disease, most notably showing us photos of some unfortunate people with this condition including some who had been misdiagnosed.



Follicular Cancer Cell

**Males should wait at least 4-6 months after RAI before starting a family.**

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The special guest speaker of the day-long meeting was Dr. Michael Tuttle, noted endocrinologist of Memorial Sloan-Kettering Cancer Centre in New York City. He gave two talks; the first entitled "On Whom do we Operate?" In this lecture he emphasized the need for the physician to look at multiple variables in the patient. These variables aid the doctor to assess the situation using "risk stratification". Those with what then appear to have a high risk thyroid nodule under this evaluation, would be followed with aggressive evaluation, good cytological diagnosis and a look at other risk factors (including gender, age, size, previous thyca, familial syndromes, radiation exposure, vocal cord paralysis, firm fixed nodules and abnormal FNA). Those who appear to have low risk thyroid nodules (very small nodules without other worrisome features) can be reassured and followed with repeat neck ultrasound in a few months to assess for any interval change in the size of the nodule.

In Dr. Tuttle's second presentation ("Follow up of Patients with Thyroid Cancer"), he further elaborated on the use of Risk Stratification as a means of assessment, adding that once thyca is established, the extent of the tumour, the grade and distant mets also become important factors. Based on this analysis, patients can be categorized into three groups – low, intermediate and high risk. Factors that put thyca patients at low risk are tumours which are small, well differentiated, make Tg very well (i.e.. without Tg antibodies) and concentrate RAI very well.

Dr. Tuttle explained that there has been a paradigm shift. Until recently, patients

routinely were given follow-up scanning doses of RAI (following withdrawal from T4) as a means to assess possible recurrence and/or mets. 80% of the time this is a reliable means of finding mets and Thyrogen is equally effective in this regard. Recently, it has been found that following patients' Tg is a more reliable means of assessment. One of the best tests for detection of recurrent disease is a TSH stimulated thyroglobulin measurement because 15-20% of patients in which the Tg is undetectable on levothyroxine suppression will have a measurable Tg when stimulated with Thyrogen or hypothyroid withdrawal. Fortunately, these low level Tg values detected with TSH stimulation often decrease slowly over many years in about 2/3 of patients. Therefore, TSH stimulated Tg values less than 10 ng/ml are usually observed without additional RAI therapy. Dr Tuttle often recommends consideration of additional RAI therapy if the Tg rises above 10 ng/mL, but this must be individualized for each patient based on the specific risk factors of each case.

Dr. Tuttle warned that it is vital to have your Tg measured at the same lab at all times, as American research indicated

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***It's vital to have your Tg measured at the same lab at all times.***



## Current Findings in Thyroid Cancer Research ...continued

(Continued from page 5)

that Tg assays varied from 10 to 3 ng/mL from the same patient's blood sample at 14 different labs! He also said that Tg indicates where the mets are likely located – that is, a higher Tg is more likely to indicate distant mets, whereas a low Tg is more likely to indicate localized disease. And interestingly, he said that Tg can also be a useful measure in patients who have had partial thyroidectomies – with the understanding that the scores will be relatively higher than they would be in a patients who have had totals. In regards to treatment, Dr. Tuttle also spoke of the fact that Lithium can effectively be used in conjunction with RAI especially in patients with distant mets. Lithium enhances the retention of RAI within metastatic lesions and can result in as much as 50% higher

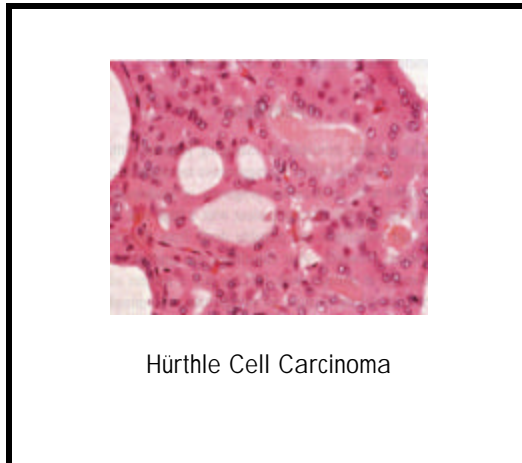
radiation doses within individual metastatic lesions.

He also spoke of the importance of PET scanning in some cases, as a PET scan

only picks up cells that are not RAI receptive. Thus a PET scan would be important for patients with RAI-resistant mets. Dr. Tuttle concluded by making the point that although the risk stratification is a useful method of patient assessment, there is no agreed upon method of

categorizing or “staging” patients after time has passed. He pointed out that time passing without recurrence downgrades the risk to the patient.

All-in-all, a very worthwhile series of lectures. I am very grateful to have had the opportunity to attend Dr. Freeman's course.



Hürthle Cell Carcinoma

*PET scans are important for patients with RAI-resistant mets.*

## Thry'vors AGM & Mini-Conference in Ottawa

On May 14, 2005 Thry'vors held a Mini-conference at the Ottawa Hospital. About 35 people enjoyed the morning Annual General Meetings (AGM) and the afternoon sessions -- some travelled from as far away as the Maritimes and Alberta to be there.

The highlights of the AGM included the election of our 2005-2006 Board of Directors and the President's Report. In the business meeting that followed, the members decided to not ask for set membership fees at this time but rather to begin an annual campaign of soliciting donations from our members, starting

with June 2006. As well, a decision was made that Thry'vors will accept funding from pharmaceutical companies for capital expenses, such as to help cover the costs of publications, and that up to 30% of our operational budget can be obtained from these sources. Shali Manuel, a new member of the board from Halifax, offered to continue the work started on developing our Strategic Plan. Various committee reports were received. An announcement was made that DVDs are available which contain copies of media reports and forums that Thry'vors members have been

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involved in. Copies of committee reports and DVDs are available by request.

We also thanked our outgoing board members. Dianne Dodd and Kim McNally are both individuals who were founding members of Thy'vors. Their contributions have been great. Kim was there for our birth, as we first started as a group through our early relationship with the Thyroid Foundation in Kingston. Dianne helped create our initial group policies and was instrumental in the development and writing of our booklet. We don't say goodbye as they will continue as members of Thy'vors, we just thank them for the contributions they have made to the board of directors.

We extend a warm welcome to our new board members, Louise Beggs, Ann Dreger, Myra Fan and Shali Manuel. They have already made great contributions to our group and we are sure we will see more wonderful things in 2005-2006.

Following the meetings' lunch break, we were privileged to have as our guest speaker, Dr. Irving Rosen, surgeon, Mt. Sinai Hospital, Toronto. Dr. Rosen gave the first *Wally Patching Memorial Lecture* his topic being *Thyroid Cancer and its Recurrence*. The lecture was very interesting and informative, citing various studies including some with diverse results. For example, some studies suggest the recurrence rate is as low as 6%, while others concluded that it is in fact as high as 40%.

Most interesting was Dr. Rosen's summary of his own 1,095 cases, resulting from many years of specializing in thyroid cancer. He said the 94% of his patients had a well-differentiated

form of thyca (i.e., papillary or follicular). 80% of his patients were female and his patients ranged in age from 21 to 90 years old. Within his own patient-population there was a 6% recurrence rate, and 84% of those with recurrences had them within lymph nodes. Dr. Rosen will be writing a separate article on his presentation for the Thy'vors website.

Later in the afternoon we enjoyed break-out sessions. There was a choice between Art Therapy and a "Making Connections" session – both of which were well attended.

To end the day, we had a multi-disciplinary panel discussion and question & answer period. Our guests were Dr. Chamberlain, Nuclear Medicine physician at Ottawa Hospital, Michele Holwell, Social Worker, Ottawa Regional Cancer Centre and Kim McNally, thyroid cancer survivor. The panel generated a lot of discussion and seemed to meet the needs of Thy'vors members for information.



Wally Patching

The 2005 organizing committee hopes this is the beginning of a new trend with the AGM including a mini-conference.

We thank Genzyme and MDS Nordion who helped sponsor the day's activities. We also thank Dagmar Vanbeselaere and the Ottawa chapter of the Thyroid Foundation of Canada, who were our partners in this event and had many of their members in attendance ([http://ottawa\\_thyroid.ncf.ca/](http://ottawa_thyroid.ncf.ca/)). And, we thank our volunteers Liz Dodd-Moher, Kathleen Dodd-Moher and Amber Erratt who did a great job keeping everything running smoothly throughout the day. We also express gratitude to Michael Moher who looked after technical support.

#### Our organizing

committee:

Louise Beggs

Lorilea Errat

Dianne Dodd

**Congratulations to Ted Hawkins, President  
and the Board of The Thyroid Foundation of Canada  
on the 25<sup>th</sup> anniversary of the formation of the Foundation.**

The Thyroid Foundation of Canada was founded in Kingston by Diana Meltzer Abramsky in 1980 in order to:

- To awaken public interest in, and awareness of, thyroid disease;
- To lend moral support to thyroid patients and their families;
- To assist in fund raising for thyroid disease research.

For more information on the Thyroid Foundation of Canada and local chapter offices in your area, please visit their website at [www.thyroid.ca](http://www.thyroid.ca).

## ASK THYR'VORS – Replies to Your Questions

ASK THYR'VORS is a pilot project we launched recently. We invite our members to participate by asking a question of our Medical Advisory Panel.

While our medical advisors can respond to questions of a general nature, understandably they will not be able to respond to questions specific to your particular health issues.

Please send your questions to: [askthyrvors@sympatico.ca](mailto:askthyrvors@sympatico.ca)

Our thanks to:

Mr. George Gascoigne, R.Ph, BSc.PhM, BSc.;  
Dr. A.A. Driedger, MD, Ph.D., FRCP (C), FACP, FCPE  
and Dr. Shereen Ezzat, MD, FRCP(C), FACP,  
for their replies to our summer newsletter questions.

### AVAILABILITY OF CYTOMEL IN CANADA

**Question:** Is there a shortage of Cytomel (T3) in Canada?

**Answer** from Mr. George Gascoigne:

I have been asked to respond to an article written in the Toronto Star titled "Why money can't buy you this drug". Unfortunately, I am not able to explain the reason for the Cytomel® shortage described in the article. I also cannot explain the actions of the various pharmaceutical companies involved. I do, however, know the following:

Cytomel® 5ug tablets are not available. The manufacturer has told me there is "*no release date*" which means they do not know when the tablets will be available again.

Cytomel® 25ug tablets are available. I checked with my supplier (McKessen Canada) on June 13, 2005 and I could order one

hundred bottles of the medication, if I so desired. The cost of a bottle of one hundred tablets is \$112.07, but a consumer is more likely to pay \$139.00 after a mark-up and dispensing fee has been added.

If someone would like to discuss this issue further, with one of the pharmaceutical companies, I would start by calling Theramed Corporation in Mississauga at 1-(800) 305-4441 (Theramed is the Canadian distributor of Cytomel®)

### STORAGE OF THYROID HORMONE PILLS

**Question:** How should I store my thyroid medications?

**Answer** from Mr. George Gascoigne:

The best rule to follow for storing thyroid medications (i.e. Eltroxin®, Synthroid®, Cytomel®) is:

Store medication at controlled room temperature between 15-30C. Protect from light and moisture.

## ASK THYR'VORS – Replies to Your Questions ...continued

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*True allergies to thyroid hormones are rare.*

It is best not to store medications in the bathroom or kitchen. After taking a hot shower, or cooking a lovely roast, the kitchen and bathroom can be the hottest, and most humid rooms in the entire house. It is also a good idea to keep medications in drawers or cupboards; leaving medications exposed on shelves maximizes their exposure to light.

If one is unable to follow these rules, one should limit the on-hand supply of medication that they have at home. For example, instead of ordering a 3-month supply of medication to store at their home, only order a 1-month supply. It is less likely that a medication's potency will decrease after 30 days of light exposure, for example, versus 90 days ... and remember to always store your medications safely. Use child resistant vials and keep the medication out of reach of your children and visiting children.

### TSH SUPPRESSION AND OVERALL HEALTH

**Question:** How do doctors determine what the ideal readings of TSH & T4 are to ensure that the thyroid cancer patients are suppressed enough to prevent recurrence but at the same time not compromise their overall health.

**Answer** from Dr. A. Driedger:

The goal for the TSH level following ablation is about 0.1mU/L. One should also measure the free T3 to ensure that the patient is not over replaced. The T4 (blood test) is not the most helpful in this assessment because patients vary in the ability to convert the T4 to T3. In most patients, the T4 will be above the normal range when the TSH is adequately suppressed.

**Answer** from Dr. S. Ezzat:

There is no general consensus on how low the TSH should be suppressed in

patients with papillary forms of thyroid cancer. Classical practice indicated that TSH levels should be suppressed (generally under 0.1) irrespective of T4 levels in patients who are at high-risk of thyroid cancer recurrence. Only a small subset of patients who have had aggressive forms of papillary thyroid cancer would fall into that category. Moreover, thyroid hormone excess can cause deleterious effects on heart rhythm & function in those over 50. It is, therefore, advisable to balance the risks versus benefits of the need for and the extent to which the TSH should be suppressed. This decision needs to be made on an individualized basis in consultation with the thyroid cancer-treating physician.

### ALLERGY TO THYROID MEDS

**Question:** Are there any new thyroid hormone replacement drug studies pertaining to thyroidectomy patients that are allergic to both Levothyroxine and Liothyronine?

**Answer** from Dr. Ezzat:

There are experimental molecules that look like T4 (thyroxine) or T3 tri-iodothyronine) however whether they would result in the same allergic reaction is not known. Generally speaking, true allergies to thyroid hormones are rare. The patient might be advised to consult with a clinical immunologist regarding assessment and possible desensitization to thyroid hormone.

### PRECAUTIONS AFTER SCAN DOSE OF RAI USING THYROGEN

**Question:** Is a patient technically hypo during the week of Thyrogen® injections for a scan only? And if so, what precautions should be taken. We've had several questions wondering if being around children (especially from one member who is a school bus driver) during this time would put the children at risk.

## ASK THYR'VORS – Replies to Your Questions ...continued

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**Answer** from Dr. A. Driedger:

Thyrogen® injections do not render one hypothyroid. So, the bus driver will be alert and safe to drive the children following the injections. If the usual protocol is followed, she will receive the injections on Mon and Tues followed by a small dose of radioactive iodine on Wed. Given the seating arrangements on the bus, she would also be safe from the radiological perspective to drive the children.

### MEDULLARY THYROID CANCER

#### Lab values and TSH suppression

**Question:** I'm trying to find out if there is a way to compare calcitonin tests from November 2004 and February 2005 done in Toronto. The earlier calcitonin tests said that normal was less than 100. The new one says less than 7. Does that mean I have to multiply my numbers by 10 or is there any way to compare them at all?

**Answer** from Dr. Ezzat:

From time to time, clinical laboratories re-examine their normative values based on new current samples. Around November of 2004, the major laboratory in the Toronto area that measures calcitonin changed their reference range. This was the result of reanalysis using samples from normal subjects. It was found that normal subjects have much lower levels of calcitonin than previously reported. Hence, no multiplication factor is required.

**Question:** I was also wondering if there is a definitive answer as to whether medullary patients have to be on suppression levels of thyroid medication?

**Answer** from Dr. Ezzat:

There is no evidence that thyroid hormone excess or suppression of TSH is required in patients with medullary types of thyroid cancer.

*Should medullary patients have their TSH suppressed?*

## PET Scanning Policy – Ontario Minister of Health Comments

PET (positron emission tomography) scans are used to detect thyroid cancers that do not pick up radioactive iodine. The Toronto Star ran an article on June 21, 2005 highlighting how Ontario is falling behind other countries and provinces already offering the scans, credited with the ability to see some cancers better than MRIs and CT scans.

PET scan access awaiting studies: Minister Smitherman denies delay is to save money  
Decisions may take until 2009, MD warns by Rob Ferguson and Richard Brennan

[http://www.thestar.com/NASApp/cs/ContentServer?pagename=thestar/Layout/Article\\_Type1&c=Article&cid=1119304212329&call\\_pageid=970599119419](http://www.thestar.com/NASApp/cs/ContentServer?pagename=thestar/Layout/Article_Type1&c=Article&cid=1119304212329&call_pageid=970599119419)

For the background information on the PET Policy issue as well as links to web articles & government agencies see message number 7762 in our Thyrvors listserv archive -

<http://health.groups.yahoo.com/group/Thryvors/message/7762>

## New Thyroid Cancer Patient Resources

### In print:

#### ***Thyroid Cancer: A Guide for Patients***

by Douglas Van Nostrand, Gary Bloom and Leonard Wartofsky, (Keystone Press, 2004) ISBN 0-9746239-0-3

<http://www.thyca.org/TCGuide.htm>

### On the web:

#### ***Why Levothyroxine brands are not interchangeable.***

A Joint Position Statement on the Use and Interchangeability of Thyroxine Products by the American Thyroid Association, the American Association of Clinical Endocrinologists and the Endocrine Society

[http://www.thyroid.org/professionals/advocacy/04\\_12\\_08\\_thyroxine.html](http://www.thyroid.org/professionals/advocacy/04_12_08_thyroxine.html)

#### ***The Importance of Consistent Thyroid Hormone Therapy – Patient Education Sheet***

[http://www.thyroidtoday.com/PatientResources/english/Thyroid%20Hormone\\_E05.pdf](http://www.thyroidtoday.com/PatientResources/english/Thyroid%20Hormone_E05.pdf)

#### ***Levothyroxine Bioequivalence and Its Impact on Treatment of High-Risk Thyroid Cancer Patients,***

by Dr. R. Michael Tuttle

<http://www.thyroidtoday.com/ExpertOpinions/LevoBioequivalence.asp?page=1>

#### ***Diagnosis and Management of Thyroid Cancer***

by Dr. E. Chester Ridgway

<http://www.thyroidtoday.com/ExpertOpinions/S320ThyroidCancerTreatment.pdf>

#### ***Thyrogen in Canada***

– Dr. Daniel Drucker  
<http://www.mythyroid.com/thyrogeninCanada.html>

<http://www.mythyroid.com/tsh.html>

## Low Iodine Diet (LID) Sources of Information and Recipes

With over 100 new member since January 2005, there are many Thry'vors newbies preparing for radioactive iodine treatment or scanning and the low iodine diet has been a popular topic on the Thry'vors listserv.

Each treatment centre may have a slightly different protocol for RAI and nuclear medicine departments sometimes provide written instructions for their patients undergoing radioactive iodine. If you are looking for more information on the LID or recipes, here are some sources:

### Information on the Low Iodine Diet:

#### ***Thry'vors Info Sheet –Frequently Asked***

***Questions About the Low Iodine Diet*** by Julie Lacasse, MSc, RD and Nancy Schwartz Williams, PhD, FDC

[http://www.thryvors.org/pdf/Thryvors\\_LIDFAQ.pdf](http://www.thryvors.org/pdf/Thryvors_LIDFAQ.pdf)

#### ***The Low Iodine Diet – US Thyroid Cancer Survivors' Association***

<http://www.thyca.org/rai.htm#diet>

#### ***Dr. Daniel Drucker's website mythyroid.com***

<http://www.mythyroid.com/radioactiveiodinecancer.html>

### Low Iodine Diet — Sources of Free Recipes:

***The Low Iodine Diet Cookbook (in PDF format)*** – US Thyroid Cancer Survivors' Association (ThyCa).

<http://www.thyca.org/ThyCa%20Cookbook%20011804.pdf>

***US ThyCa Listserv Recipe Index*** (hundreds of recipes) available at the ThyCa listserv homepage  
<http://www.groups.yahoo.com/group/thyca/files>

***Thry'vors Recipe Index*** (150+ recipes) available at the Thry'vors listserv homepage and updated regularly

<http://www.groups.yahoo.com/group/thryvors/files>

Recipes added to the Thry'vors index are listed on page 13 of this newsletter.

## Taking Time-Off from the Thry'vors Listserv?

If you are going to be away for summer vacation or would like to change your method of listserv message delivery, here's what you need to do:

- Sign-in at the listserv homepage <http://www.groups.yahoo.com/group/thryvors> using your Yahoo ID and password
- Click EDIT MY MEMBERSHIP at the top of the screen in blue print
- Select the type of message delivery you prefer – individual messages, daily digest, special notices only (you will receive the newsletter and special notices from moderators), or no mail.
- Click SAVE CHANGES at the bottom of the screen
- It make a few days for your new delivery settings to be operational.

## NEW Mini-bios Project – Share Your Experiences and Help Others

Our listserv members often post messages to learn from the experiences of others in similar situations. In order to document member experiences, and help with the sharing of information, the Listserv Committee has developed a new project to collect mini-bios and helpful hints from our members.

Nola has developed a new format for the mini-bios that will be distributed to the listserv following this newsletter. Members who wish to participate are asked to submit their completed mini-bios to [thryvors@sympatico.ca](mailto:thryvors@sympatico.ca) by

Sunday August 14, 2005. If you don't want to participate in the mini-bio project by sharing your own experiences, please feel free just to submit some helpful hints that you found useful during your treatment and recovery.

The mini-bios will be stored in our listserv homepage files. The helpful hints will form a second document that will be available on our website. Please participate ! The more completed mini-bios we have, the more useful the resources will be.



### Website Update

New and available for order - Thry'vors DVD Library of Visual Presentations, Lectures and TV Appearances.

For more info, visit —

[http://www.thryvors.org/pdf/Thryvors\\_DVD.pdf](http://www.thryvors.org/pdf/Thryvors_DVD.pdf)

## New Recipes Added to the Thry'vors LID Recipe Index

Our Thry'vors index contains over 150 recipes. The recipes below have been added to our recipe folder at the Thry'vors listserv homepage:

<http://www.groups.yahoo.com/group/thryvors/files>

[in the LID FAQ & RECIPES – 4th folder]

### **Breads, Tortillas & Sandwiches:**

Quick Summer Sandwiches & Wraps

### **Meat & Poultry:**

Bahamas Chicken, Balsamic Steaks, Citrus Glazed Chicken Wings, Lemon-Herb Grilled Meat (chicken, steak, pork), Nasi Goreng (Indonesian meat and rice dish), Sweet and Sour Chicken, Tex-Mex Chicken

### **Dips & Salsas:**

Spicy Peach and Plum Salsa

### **Vegetables, Pastas and Grains:**

Crunchy Celery Salad, Green Apple and Walnut Salad, Italian Tomato and Bread Salad (Pappa al Pomodoro), Mango-Tomato Salad, South Seas Rice Salad, Spinach-Pear Salad with Cashew Nuts, Tomato & Cilantro Salad

### **Desserts:**

Banana and Strawberry Ice Cream, Fruit Sorbets

### **Beverages:**

Iced Jasmine Green Tea, Pink Lady (red grapefruit & hibiscus or berry tea), Smoothies (Berry Blaster, Blueberry, Mango, Orange & Banana, Raspberry-Peach, Strawberry & Banana), Zinger Iced Tea

**Please post your favourite recipes to the listserv and they will be added to our index.**



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*Offering information  
and support*

## Upcoming Events

### London Chapter of the Thyroid Foundation of Canada Public Education Meeting – Tuesday September 20, 2005

Speaker: Dr. Tom McDonald, Endocrinologist,  
St. Joseph's Health Centre

Topic: Thyroid Cancer

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

Time: 7:30 PM - 9:00 PM

All welcome. Open to the public. Free admission.  
For more information call (519) 649-5478 or visit  
<http://www.thyroidlondon.ca/>

## What's New at Thry'vors

### Thry'vors welcomes the 2005-2006 Board of Directors

Rita Banach	President/Officer
Louise Beggs	Director
Ann Dreger	Director
Lorilea Erratt	Director
Myra Fan	Director
Shali Manuel	Director
Beth Rajnovich	Vice-President/Officer
Gilda Tarantino	Director
Grace Wright	Secretary-Treasurer/Officer

### Coming Up in the Autumn Edition of *Thry'vors News*

- More Q & As from **Ask Thry'vors**
- Update on Thyrogen®