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Dr. Allwyn Pais

Professor and Head,
Department of Pathology and
Microbiology, Yenepoya
Homoeopathic Medical College
and Hospital, Yenepoya
Deemed to be University,
Naringana, Mangalore,
Karnataka, India

Corresponding Author:

Dr. Allwyn Pais

Professor and Head,
Department of Pathology and
Microbiology, Yenepoya
Homoeopathic Medical College
and Hospital, Yenepoya
Deemed to be University,
Naringana, Mangalore,
Karnataka, India

Hypothyroidism: Homeopathic panorama two cases of hypothyroidism cured by lithium carbonate

Dr. Allwyn Pais

DOI: <https://doi.org/10.33545/26164485.2023.v7.i2a.805>

Abstract

Lithium Carbonate is one of the most widely used and studied medications for treating bipolar mood disorders. It works by stabilizing the mood and reduces extremes in behavior by restoring the balance of certain 'neurotransmitters' in the brain.

Lithium carbonate is also used as a long-term prophylaxis for bipolar disorders, but its long term use is associated with thyroid abnormalities that has been widely reported in the medical literature over the last six decades. These include hypothyroidism, hyperthyroidism, autoimmune thyroiditis and goiter.

Lithium Carbonate side effects include

- Increasing iodine content within the thyroid gland.
- Reducing thyroid's ability to produce thyroxine (T4) and thyronine (T3).
- Blocking the release to thyroid hormones from thyroid.
- Altering the release of thyroid hormones from thyroid.
- Altering the structure of thyroglobulin, a protein responsible for making thyroid hormone. ¹

The thyroid gland is one of the most important glands in the body with a far-reaching influence. It is one of the endocrine, hormone-producing gland that has an effect on immunity, energy levels, circulation and sugar regulation. Also plays an important role in mood.

Essentially, thyroid gland makes hormones thyroxine (T4), tri-iodothyronine (T3) and calcitonin that effects calcium metabolism. Ninety percent of body's iodine is contained in the thyroid gland in organic form that is needed to manufacture thyroid hormones.

The thyroid hormones function via a "feedback loop," the hypothalamus in the brain is affected by circulating level of the thyroid hormones, if the levels is low than it should be, then it pumps out a hormone, called thyrotropin releasing hormone (TRH) that stimulates the pituitary to produce more thyroid stimulating hormone (TSH) that causes the thyroid to produce more thyroxin until it achieves the adequate levels.

Hence, this research study is to evaluate the action of "Potentized Lithium Carbonate" on the 'Hypothalamus- Pituitary-Thyroid Axis' that has become dysfunctional or disturbed due to the effects of pharmacological action of 'Crude Lithium Carbonate' during its therapy in the treatment of mood disorders.

Keywords: Lithium carbonate, thyrotropin releasing hormone (TRH), thyroid stimulating hormone (TSH)

Introduction

Homoeopathic approach to treatment of Malfunctioning Thyroid

- In homoeopathic system of medicine the above action of crude Lithium Carbonate is termed as the "Primary Action" of the drug which is due to the deranged vital force resulting from the damaging and destructive mechanism of the crude remedy administered for treating mood disorders ^[2].
- On administration of potentized homoeopathic remedy Lithium Carbonate in minute dosage, stimulates the "production of antibodies" by rejuvenating the deranged vital force which then initiates the repair mechanism by rousing itself again opposite to the condition of health (Counteraction) that is termed as the "Curative Action or Secondary Action" ^[3].
- For example a hand bathed in hot water is at first warmer than the other hand that has not been so treated (Primary action) but when it is withdrawn from the hot water and again thoroughly dried, it becomes cold in a short time and much colder than the other (secondary action).

Similarly excessive vivacity follows the use of strong coffee (primary action) but sluggishness and drowsiness remain for a long time afterwards (secondary action) unless removed by imbibing fresh supplies of coffee (Palliative) [4].

Homoeopathic Management of Hypothyroidism

- Homoeopathy remedies in potentized form “reverts” the damaging process –“Primary Action” caused due to crude medicines by effecting a “Secondary Action” which is the defensive and automatic reaction of vital force against the primary action of medicine, the vital force now being revitalized by the homoeopathic dosage, to make its ‘super power’ available in the extinction of disease, and restoration of normal health. (Aphorism 66, Organon of Medicine)⁵
- In clinical practice, potentized Lithium Carbonate restores the normal secretions of thyroxine (T4) and thyronine (T3) that has been altered due to damage of thyroid follicles by administration of crude lithium carbonate in the treatment of mood disorders. (Aphorism 67, Organon of Medicine) [6]. “Potentized lithium carbonate in homoeopathic dosage can also restore cases not treated by crude lithium carbonate” that could be proved by corrected parameters of TSH, T3 and T4.

43-year old married female with one daughter and suffering from:

- Tendency to gain weight since the last one year.
- Puffiness of face, tiredness and fatigue. associated complaints
- Irregular uterine bleeding.
- Pain / numbness in digits of right hand < right, lying down.
- Hoarseness of Voice.
- Weight 70.0 kilograms.

A) Past History

- Nothing Significant

B) Medical (Treatment History) Blood pressure- 92/60mm; Pulse – 64/m

- On Thyronorm (Levo-thyroxine 100mcg)

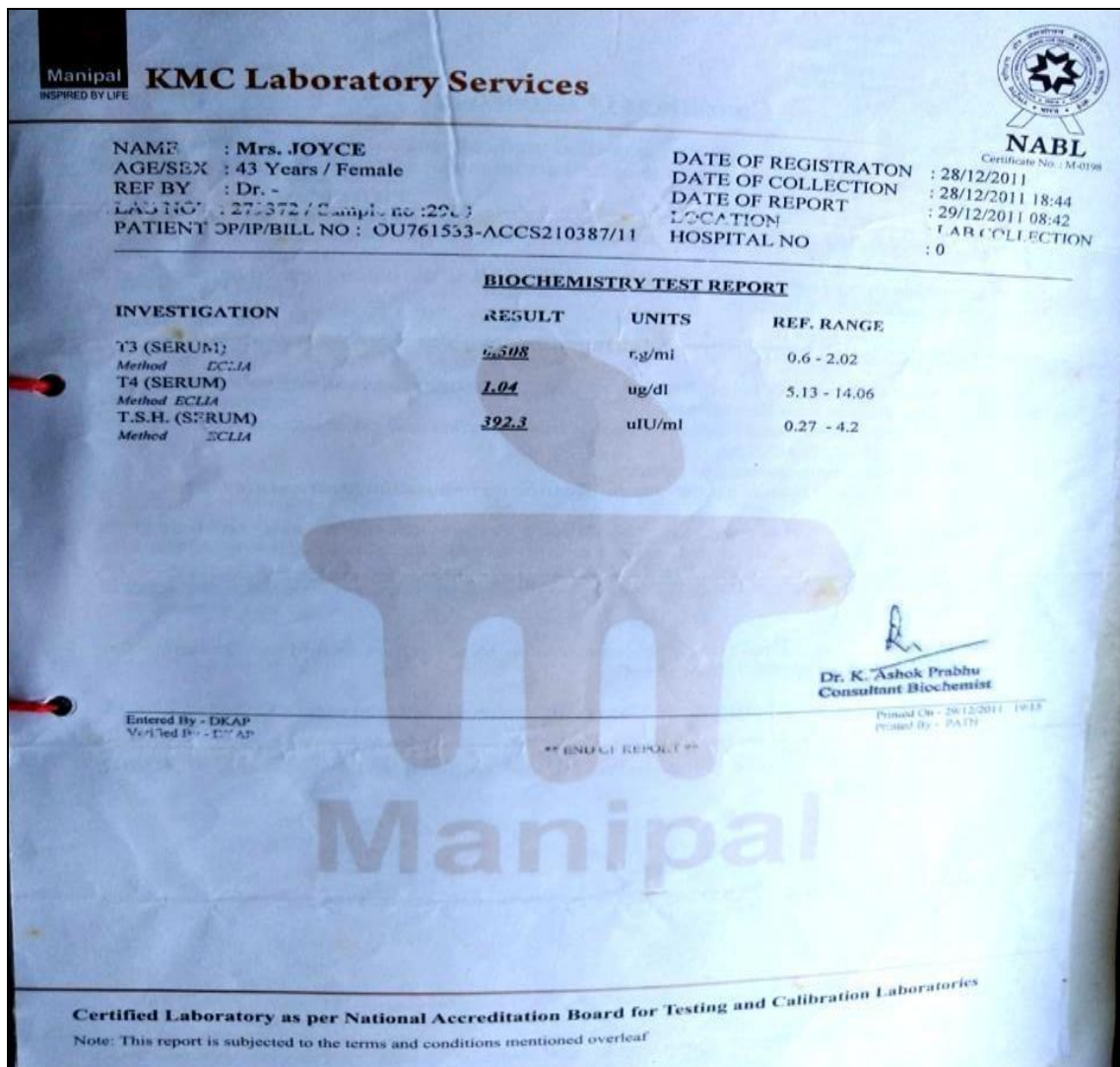
Family History

- Strong history of Hypothyroidism in the family (Father, Brother and Sister)

Investigation

- Thyroid function test (29.12.2011)
- T3 -0.508 ng/ml, T4- 1.04 ug/dl, TSH – 392.3 µIU/ml.

**Case I: 30.12.2011
Chief Complaints**




- Medicine Prescribed
- Lithium Carbonate 200 weekly x 2 months
- βovista 30 daily x 2 weeks


Follow Ups Date wise-10/03/2012

KMC Hospital
Mangalore

KMC Laboratory Services



An ISO 9001:2008
Certified Hospital



NABL
Certificate No. : M-019

NAME : Mrs. JOYCE AGE/SEX : 43 Years / Female REF BY : Dr. GANESH H K LAB NO : 348590 / Sample no :2203 PATIENT OP/IP/BILL NO : OU797854-ACC8264989/11	DATE OF REGISTRATON : 05/03/2012 DATE OF COLLECTION : 05/03/2012 18:21 DATE OF REPORT : 06/03/2012 09:03 LOCATION : HOSPITAL NO : 0
--	---

INVESTIGATION	RESULT	UNIT	REF. RANGE
T.S.H. (SERUM) <small>Method - ECLIA</small>	1.06	uIU/ml	0.27 - 4.2
ANTIBODIES TO THYROID PEROXIDASE (Anti-TPO) (SERUM) <small>Method - Eclia</small>	159.0		IU/ml UPTO 34

[Signature]
Dr. K. Ashok Prashu
Consultant Biochemist

Printed On : 06/03/2012 18:31
Printed By : P311

** END OF REPORT **


Mani

Certified Laboratory as per National Accreditation Board for Testing and Calibration Laboratories


Note : * This report is subjected to the terms and conditions mentioned overleaf
* Tests parameters marked by asterisks (*) are excluded from the scope of NABL accredited tests

TSH – 1.06 u/u/nl, Anti TPO -159

- Patient much better overall.
- Menstrual cycle regular
- Pain around right wrist joint (Carpal Tunnel)
- Numbness in fingers better by 50%
- Lithium Carb 1m weekly x 2 months.
- βovista 30 and Caulophyllum 30 alternate days for 2 weeks.



Accu - LABS
Hope comes with comforting care



VALENCIA
Health Care & Diagnostic Centre

NAME : Mrs. JOYCE
 AGE/SEX : 47 yrs / F
 REFERRED BY : Dr. GANESH.H.K MD, DM(Endocrinology)

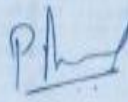
REG.LAB NO : 15020110 / MN03061
 DATE OF COLLECTION : 17-08-16 AT 07:28 AM
 DATE OF REPORT : 17-08-16 AT 02:35 PM
 CONTACT : 9480503049

TEST PARAMETER	RESULT	NORMAL RANGE
THYROID STIMULATING HORMONE (TSH) <small>(Thyrotropin)</small>	13.86 μ U/ml	0.4 - 5.5 μ U/ml


TSH: A high TSH result often means an under active thyroid gland that is not responding adequately to the stimulation of TSH due to some type of acute or chronic thyroid dysfunction. Rarely, a high TSH result can indicate a problem with the pituitary gland, such as a tumor producing unregulated levels of TSH. A high TSH value can also occur when someone with a known thyroid disorder or who has had their thyroid gland removed is receiving too little thyroid hormone medication. A low TSH result can indicate an overactive thyroid gland (hyperthyroidism) or excessive amounts of thyroid hormone medication in those who are being treated for an under active (or removed) thyroid gland. Rarely, a low TSH result may indicate damage to the pituitary gland that prevents it from producing adequate amounts of TSH. Whether high or low, an abnormal TSH indicates an excess or deficiency in the amount of thyroid hormone available to the body, but it does not indicate the reason why. An abnormal TSH test result is usually followed by additional testing to investigate the cause of the increase or decrease.

Disseminated by: CHDTHI
**** End of Report ****
Printed by: CHDTHI on 17-08-16 AT 02:35 PM


Note : Laboratory results are not always reproducible. Intra laboratory and Inter-Laboratory variations in estimations do occur. The Laboratory results should be interpreted by treating doctor.



Dr. ARAVIND.P
M.D. (PATH)
PATHOLOGIST



Dr. SUCHETHA SHETTY
M.Sc., Ph.D.
BIOCHEMIST



TECHNOLOGIST

Head Office : Belvue Apartments, Opp. Axis Bank, Valencia, Mangaluru -575 002.
 Ph : 0824-4256578. www.valenciahealthcare.co.in
Appointments for lab sample collection at your door step : 9739698989

Thyronorm reduced to 75 mcg (Patient relocated to Kolkatta due to husband's job. Returned back after 4 years, did not continue homoeopathy medicines regularly but taking Thyronorm 50 mcg)

18.08.2016

- Patient clinically better but experiences severe headache (Occipital region) with chronic constipation

once in a month. Head ache comes like a flash.

- Had missed periods twice in last one year.
 - TSH - 13.86 u /u/ml.
 - BP- 100/80mmhg. Pulse -72/m.
- Prescription- 1. Lithium carbonate 200Thrice a week x 15 days.
 2. Sanguinaria Can. 200
 Thrice a week x 15 days.

07.09.2016

KMC Hospital
Mangaluru

KMC Laboratory Services

NAME : Mrs. JOYCE
AGE/SEX : 48 Years / Female
REF BY : GANESH H K
LAB NO : 220288 / Sample no :5651
PATIENT OP/IP/BILL NO : O1222614-ACOCSS122763/16

DATE OF REGISTRATON : 05/09/2016
DATE OF RECEIPT : 05/09/2016 07:12
DATE OF REPORT : 05/09/2016 10:43
LOCATION : LAB COLLECTION
HOSPITAL NO : 000551959

INVESTIGATION	BIOCHEMISTRY TEST REPORT		
	RESULT	UNIT	REF. RANGE
T.S.H. (SERUM) Method ECLIA	5.44	uIU/ml	0.27 - 4.2

Entered By - Dr. Vinod Chandran
Verified By - Dr. Vinod Chandran

Dr. Vinod Chandran
Consultant Biochemist

Printed On - 06/09/2016 : 14:48
Printed By - Manjunath

Manipal

Certified Laboratory as per National Accreditation Board for Testing and Calibration Laboratories.
Note : This report is subjected to the terms and conditions mentioned overleaf
*In Vitro (I) are excluded from the scope of NABL accredited tests.

TSH – 5.44 µu/ml

- Patient clinically asymptomatic. Same prescription, Lithium carbonate 200Thrice a week repeated for 2 months.
- But Sanguinaria Can. 200 only SOS for Headache (Climacteric)
- Thyronorm reduced to 25 mcg.

23.11.2016

Accu - LABS
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NAME : Mrs. JOYCE
AGE/SEX : 47 yrs / F
REFERRED BY :

REG/LAB NO. : 15020110 / MNG05179
DATE OF COLLECTION : 17-11-16 AT 07:45 AM
DATE OF REPORT : 17-11-16 AT 01:09 PM
CONTACT : 9480503049

TEST PARAMETER	RESULT	NORMAL RANGE
THYROID STIMULATING HORMONE (TSH) (Chromoluminescence)	2.862 µIU/ml	0.4 - 5.5 µIU/ml

TSH : A high TSH result often means an under active thyroid gland that is not responding adequately to the stimulation of TSH due to some type of acute or chronic thyroid dysfunction. Rarely, a high TSH result can indicate a problem with the pituitary gland, such as a tumor producing unregulated levels of TSH. A high TSH value can also occur when someone with a known thyroid disorder or who has had their thyroid gland removed is receiving too little thyroid hormone medication. A low TSH result can indicate an overactive thyroid gland (hyperthyroidism) or excessive amounts of thyroid hormone medication in those who are being treated for an under active (or removed) thyroid gland. Rarely, a low TSH result may indicate damage to the pituitary gland that prevents it from producing adequate amounts of TSH. Whether high or low, an abnormal TSH indicates an excess or deficiency in the amount of thyroid hormone available to the body, but it does not indicate the reason why. An abnormal TSH test result is usually followed by additional testing to investigate the cause of the increase or decrease.

Dispatched by: CHOTHI
**** End of Report ****
Printed by: PRASAD SHETTY M.D. (P) (M) (M) (M)

Note : Laboratory results are not always reproducible. Intra laboratory and Inter-Laboratory variations in estimations do occur. The Laboratory results should be interpreted by treating doctor.

Dr. ARAVIND.P
M.D. (PATH)
PATHOLOGIST

Dr. SUCHETHA SHETTY
M.Sc., Ph.D.
BIOCHEMIST

TECHNOLOGIST

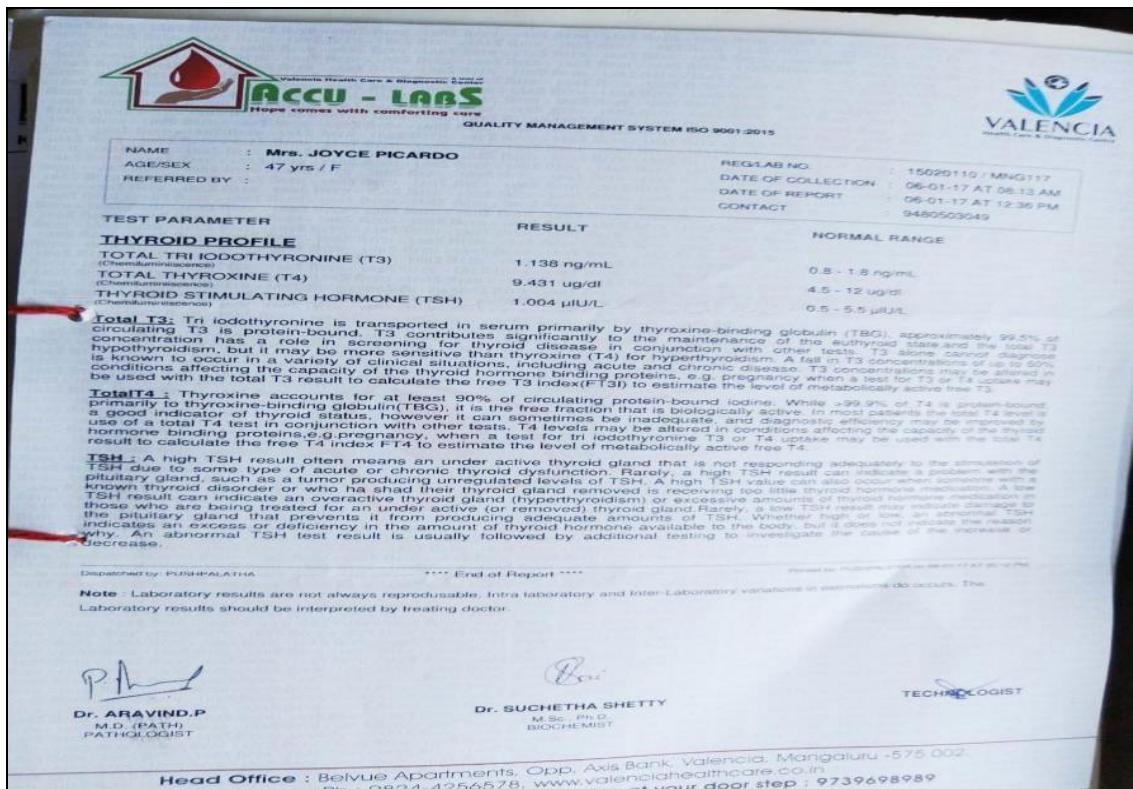
TSH – 2.862 µu/ml.

Patient overall very much better.

Weight- 62.0kgs. to 63.0kgs. over the last 6 months. No

6.01.2017

complaints around this time. Lithium Carbonate 1m weekly x 2 months.



T3 – 1.138 ng/ml,

T4- 9.431 µg/dl, TSH -1.004 u/u/ml,

Weight – 64.2 kgs.

27.07.2017

Patient asymptomatic, hence medicine prescribed for 6 months. Lithium carbonate 1m fortnightly x 6 months, asked to consult only if any complaints.



TSH – 1.665 IU/ml

No complaints except occasional headache occipital region and posterior neck especially before menses. Patient asked to “Discontinue Tablet Thyronorm” since consistent TSH

values observed over the last one year.
BP 102/70 mmhg, Pulse -72/m
Lithium carbonate 10m, once a month x 6 months.

07.12.2017

ACCU - LABS
Hope comes with comforting care

ISO
AN ISO 9001:2015 CERTIFIED LABORATORY

VALENCIA
Health Care & Diagnostic Centre

NAME : Mrs. JOYCE PICARDO
AGE/SEX : 48 yrs / F
REFERRED BY :
CENTER : ACCU - LABS MANGALORE / OP

REG/LAB NO. : 15020110 / MNG8607
DATE OF COLLECTION : 06-12-17 AT 07:58 AM
DATE OF REPORT : 06-12-17 AT 12:14 PM

TEST PARAMETER	RESULT	NORMAL RANGE
THYROID PROFILE		
TOTAL TRI IODOTHYRONINE (T3) (Chemiluminescence)	0.931 ng/mL	0.8 - 1.8 ng/mL
TOTAL THYROXINE (T4) (Chemiluminescence)	6.541 ug/dl	4.5 - 12 ug/dl
ULTRATHYROID STIMULATING HORMONE (TSH) (Chemiluminescence)	8.490 uIU/L	0.5 - 5.5 uIU/L

Total T3: Tri iodothyronine is present in serum primarily by thyroxine-binding globulin (TBG), approximately 99.5% of circulating T3 is protein-bound. T3 contributes significantly to the maintenance of the euthyroid state, and the total T3 concentration has a role in screening for thyroid disease in conjunction with other tests. T3 alone cannot diagnose hypothyroidism, but it may be more sensitive than thyroxine (T4) for hyperthyroidism. A fall in T3 concentrations of up to 50% is known to occur in a variety of clinical situations, including acute and chronic disease. T3 concentrations may be altered in conditions affecting the capacity of the thyroid hormone binding proteins, e.g. pregnancy, when metabolically active free T3.

Total T4: Thyroxine accounts for at least 90% of circulating protein-bound iodine. While ~99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients the total T4 level is a good indicator of thyroid status, however it can sometimes be inadequate, and diagnostic efficiency may be improved by use of a total T4 test in conjunction with other tests. T4 levels may be altered in conditions affecting the capacity of the thyroid hormone binding proteins, e.g. pregnancy, when metabolically active free T4.

TSH: A high TSH result often means an under active thyroid gland that is not responding adequately to the stimulation of TSH due to some type of acute or chronic thyroid dysfunction. Rarely, a high TSH result can indicate a problem with the pituitary gland, such as a tumor producing unregulated levels of TSH. A high TSH value can also occur when someone with a known thyroid disorder or who has had their thyroid gland removed is receiving too little thyroid hormone medication. A low TSH result can indicate an overactive thyroid gland (hyperthyroidism) or excessive amounts of thyroid hormone medication in those who are being treated for an under active (or removed) thyroid gland. Rarely, a low TSH result may indicate damage to the pituitary gland that prevents it from producing adequate amounts of TSH. Whether high or low, an abnormal TSH indicates an excess or deficiency in the amount of thyroid hormone available to the body, but it does not indicate the reason why. An abnormal TSH test result is usually followed by additional testing to investigate the cause of the increase or decrease.

Dispatched by: CHOTHI
**** End of Report ****
Printed by: PUSHPA on 06-12-17 AT 04:11 PM

Note: Laboratory results are not always reproducible. Intra laboratory and Inter-Laboratory variations in estimations do occur. Turn around time may vary due to various technical reasons. The Laboratory results should be interpreted by treating doctor. Duplication of this report in any form is prohibited. Test results are not valid for Medico-Legal purposes.

Dr. ARAVIND.P
M.D. (PATH)
PATHOLOGIST

Dr. SUCHETHA SHETTY
M.Sc., Ph.D.
BIOCHEMIST

TECHNOLOGIST

Head Office : Belvue Apartments, Opp. Axis Bank, Valencia, Mangaluru -575 002.

- T3 0.931 ng/ml, T4-6.541 ug/dl, TSH -8.490 uIU/ml.
- ‘Elevated TSH’ probably due to “rebound effect” of discontinuation of Thyronorm.
- BP – 114/82 mmHg, Pulse 72/m, Patient complaining of sleeplessness after 4am. Tingling and numbness bilateral hands/ fingers aggravated at night / bed-time only.
- Lithium carbonate CM, 1 dose stat. and fortnightly for 2 months;
- Bovista 200 and Caulophyllum 200 on alternate 15 days.

05.02.2018

Apollo DIAGNOSTICS
Clinical Engineering and

Mangalore Satellite Lab
Shop No 002, Ground Floor,
Jantavi Plaza,
New Bus Stand Road Circle,
Mangalore 575003
☎ 0824-4909903

Patient Name : Mrs. JOYCE
Age/Gender : 48 Y / F
UPO/AM No : DMNL 0000031648
Visit No : DMNL00002227
Ref Doctor : Dr GANESH
R/De App :

Collector : 04/Feb/2018 07:34AM
Received : 04/Feb/2018 09:27AM
Reported : 04/Feb/2018 12:14PM
Client Name : SL MANGALORE
Client Code : 85023

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (TOTAL T3, TOTAL T4, TSH) - SERUM				
TRI-iodothyronine (T3, TOTAL)	0.97	ng/ml	0.87-1.78	CLIA
THYROXINE (T4, TOTAL)	9.20	ug/dl	6.00-12.23	CLIA
THYROID STIMULATING HORMONE (TSH)	0.1	uIU/mL	0.35-5.5	CLIA

Comment:
Serum TSH concentrations exhibit a diurnal variation with the peak occurring during the night and the nadir occurring between 10 a.m. and 4 p.m. In primary hypothyroidism, thyroid-stimulating hormone (TSH) levels will be elevated. In primary hyperthyroidism, TSH levels will be low. Elevated or low TSH in the context of normal free thyroxine is often referred to as subclinical hypo- or hyperthyroidism, respectively. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
Recommended not for T3 and T4 is unbound fraction or free levels as it is metabolically active.

Note:
For pregnant females
Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)

First trimester	0.1-2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

*** End Of Report ***

Dr. SUPRIYA P
M.B.B.S., M.D.(PATH)
Consultant Pathologist

- T3- 0.97ng/ml, T4 -9.00 ug/dl, TSH – 0.1 uIU /ml
- Irritability and drowsiness increased after discontinuation of Thyronorm, as reported by patient. Menses has been irregular, once in two months since

- last 3-4 months.
- Lithium carbonate 0/3 prescribed twice a week x 2 months.
- Bovista 1M stat. (Irregular menses and neuritis)

06.03.2018

Apollo DIAGNOSTICS
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Patient Name : Mrs. JOYCE
Age/Gender : 49 Y O M D D /F
UHD/MR No : DMSL000001648
Visit ID : DMSLOPV11083
Ref Doctor : Dr. GANESH H K
IP/OP NO :

Collected : 04/Mar/2018 07:23AM
Received : 04/Mar/2018 08:13AM
Reported : 04/Mar/2018 10:41AM
Status : Final Report
Client Name : SL MANGALORE
Client Code : SLO018

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (TOTAL T3, TOTAL T4, TSH) , SERUM				
TRI-IODOTHYRONINE (T3, TOTAL)	0.8	ng/mL	0.87-1.78	CLIA
THYROXINE (T4, TOTAL)	8.50	µg/dL	6.09-12.23	CLIA
THYROID STIMULATING HORMONE (TSH)	4.39	µIU/mL	0.35-5.5	CLIA

Comment:
Serum TSH concentrations exhibit a diurnal variation with the peak occurring during the night and the nadir occurring between 10 a.m. and 4 p.m. In primary hypothyroidism, thyroid-stimulating hormone (TSH) levels will be elevated. In primary hyperthyroidism, TSH levels will be low. Elevated or low TSH in the context of normal free thyroxine is often referred to as subclinical hypo- or hyperthyroidism, respectively. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.

Note:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

*** End Of Report ***

DR. SUPRIYA P
M.B.B.S., M.D.(PATH)
Consultant Pathologist

Page 2 of 2

Apollo DIAGNOSTICS
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Patient Name : Mrs. JOYCE
Age/Gender : 49 Y O M D D /F
UHD/MR No : DMSL000001648
Visit ID : DMSLOPV11083
Ref Doctor : Dr. GANESH H K
IP/OP NO :

Collected : 04/Mar/2018 07:23AM
Received : 04/Mar/2018 08:13AM
Reported : 04/Mar/2018 08:47AM
Status : Final Report
Client Name : SL MANGALORE
Client Code : SLO018

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE , SERUM				
TOTAL CHOLESTEROL	202	mg/dL	<200	CHE/CHO/POD
TRIGLYCERIDES	70	mg/dL	<150	Enzymatic
HDL CHOLESTEROL	41	mg/dL	>40	CHE/CHO/POD
NON-HDL CHOLESTEROL	161	mg/dL	<130	Calculated
LDL CHOLESTEROL	147	mg/dL	<100	Calculated
VLDL CHOLESTEROL	14	mg/dL	<30	Calculated
CHOL / HDL RATIO	4.93		0-4.97	Calculated

Comment:
Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	<200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal <100 Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220

Measurements in the same patient can show physiological and analytical variations.
NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.

Page 1 of 2

Dr. Ganesh H.K, MD; DM Endocrinologist, at Pumpwel, Mangalore, whom the patient has been consulting occasionally since the last 7 years, as per my advice, requested for a lipid profile which showed elevated levels of

LDL.
Irritability and drowsiness reduced.
Same prescription-Lithium Carb. 0/3, twice a week, repeated for 6 months as patient was travelling abroad.

06.11.2018

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TOUCHING LIVES

Patient Name : Mrs. JOYCE
Age/Gender : 49 Y 0 M 0 D /F
UHID/MR No : DMSL000001648
Visit ID : DMSLOPV24816
Ref Doctor : DR. GANESH H K
IP/OP NO :

Collected : 04/Nov/2018 07:52AM
Received : 04/Nov/2018 09:12AM
Reported : 04/Nov/2018 09:47AM
Status : Final Report
Client Name : SL MANGALORE
Client Code : SL0018

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, FASTING, NAF PLASMA	95	mg/dL	70 - 100	GOD - POD
TOTAL CHOLESTEROL, SERUM	177	mg/dL	<200	CHE/CHO/POD

Apollo DIAGNOSTICS
Expertise. Empowering you.

TOUCHING LIVES

Patient Name : Mrs. JOYCE
Age/Gender : 49 Y 0 M 0 D /F
UHID/MR No : DMSL000001648
Visit ID : DMSLOPV24816
Ref Doctor : DR. GANESH H K
IP/OP NO :

Collected : 04/Nov/2018 07:52AM
Received : 04/Nov/2018 09:12AM
Reported : 04/Nov/2018 10:15AM
Status : Final Report
Client Name : SL MANGALORE
Client Code : SL0018

DEPARTMENT OF IMMUNOLOGY

THYROID PROFILE (TOTAL T3, TOTAL T4, TSH), SERUM

Test Name	Result	Unit	Bio. Ref. Range	Method
TRI-IODOTHYRONINE (T3, TOTAL)	0.91	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL)	10.20	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	1.41	µIU/mL	0.35-5.5	CLIA

Comment:
Serum TSH concentrations exhibit a diurnal variation with the peak occurring during the night and the nadir occurring between 10 a.m. and 4 p.m. In primary hypothyroidism, thyroid-stimulating hormone (TSH) levels will be elevated. In primary hyperthyroidism, TSH levels will be low. Elevated or low TSH in the context of normal free thyroxine is often referred to as subclinical hypo- or hyperthyroidism, respectively. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.

Note:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

*** End Of Report ***

Supriya P
DR. SUPRIYA P
M.B.B.S., M.D.(PATH)
Consultant Pathologist

- Patient returned from abroad
- Total Cholesterol - 177 (down from 202)
- T3-0.91 ng/ml, T4-10.20ug/dl, TSH-1.41 uIU/ml.

- Patient feeling much better.
- BP- 110/80mmhg, Pulse- 78/m
- Lithium Carbonate 0/6, thrice a week x 6 months.

11.05.2019

Apollo DIAGNOSTICS
Expertise. Empowering you.

Patient Name : Mrs. JOYCE
Age/Gender : 49 Y 0 M 0 D / F
UHD/MB No : DMSL-000001648
Visit ID : DMSLOPV34601
Ref Doctor : Dr. SELF
IP/OP NO :

Collected : 08/May/2019 07:08AM
Received : 08/May/2019 08:13AM
Reported : 08/May/2019 09:02AM
Status : Final Report
Client Name : SL MANGALORE
Patient location : Mangalore, Mangalore

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE, SERUM				
TOTAL CHOLESTEROL	178	mg/dL	<200	CHF/CHO/POD
TRIGLYCERIDES	72	mg/dL	<150	Enzymatic
HDL CHOLESTEROL	40	mg/dL	>40	CHF/CHO/POD
NON-HDL CHOLESTEROL	138	mg/dL	<130	Calculated
LDL CHOLESTEROL	123.6	mg/dL	<100	Calculated
VLDL CHOLESTEROL	14.4	mg/dL	<30	Calculated
CHOL / HDL RATIO	4.45		0-4.97	Calculated

Comment:
Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	<200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal < 100 Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220

Measurements in the same patient can show physiological and analytical variations.
NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.

Page 2 of 3

Apollo DIAGNOSTICS
Expertise. Empowering you.

Patient Name : Mrs. JOYCE
Age/Gender : 49 Y 0 M 0 D / F
UHD/MB No : DMSL-000001648
Visit ID : DMSLOPV34601
Ref Doctor : Dr. SELF
IP/OP NO :

Collected : 08/May/2019 07:08AM
Received : 08/May/2019 08:13AM
Reported : 08/May/2019 10:32AM
Status : Final Report
Client Name : SL MANGALORE
Patient location : Mangalore, Mangalore

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (TOTAL T3, TOTAL T4, TSH), SERUM				
TR-IODOTHYRONINE (T3, TOTAL)	0.98	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL)	8.70	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	0.670	µIU/mL	0.35-5.5	CLIA

Comment:
Serum TSH concentrations exhibit a diurnal variation with the peak occurring during the night and the nadir occurring between 10 a.m. and 4 p.m. In primary hypothyroidism, thyroid-stimulating hormone (TSH) levels will be elevated. In primary hyperthyroidism, TSH levels will be low. Elevated or low TSH in the context of normal free thyroxine is often referred to as subclinical hypo- or hyperthyroidism, respectively. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.

Note:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

*** End Of Report ***

DR. SUPRIYA P
M.B.B.S., M.D.(PATH)
Consultant Pathologist

T3-0.98ng/ml, T4-8.70 ug/dl, TSH -0.570 uIU/ml.

- Patient advised to stop treatment as she has been asymptomatic for the last 6 months. Patient menstruating every 2 months (Climacteric phase) Asked to do thyroid profile every six months and report in case of any trouble.
- A very, very difficult case of Hypothyroidism cured by Homoeopathy !!!!!

Case II: 13.04.2018

Chief Complaints

37 year old married female with two daughters complained of:

- Tiredness and weight gain since one year.
- Left sided headache since six months.
- Menses early and profuse since six months.
- Pain in left breast since six months.
- Constipation with dry, hard stools since 1 year.
- Diagnosed with hypothyroidism a year ago by Endocrinologist at Falnir, Mangalore.
- Prescription given Thyronorm (Levo-thyronine 125 mcg) increased from 50 mcg since last one year.

Associated complaints

- Allergic Rhinitis, sneezing aggravated on waking in

morning, change of weather and use of air conditioner.

Past History

- Nothing significant.

Menstrual History

- Menarche at 13 years of age, menstrual cycle -28 days with 2-3 days of flow.
- Early and profuse menses since 6 months lasting for 5-6 days.

Physical Generals

- Fair Complexion, short in stature (5'1")
- Appetite normal, Thirst normal, Bowels- constipated.

Mental Generals

- Irritable
- Angry whey contradicted.

General Examination

- Weight - 66 kgs
- BP-110/70mmhg, P-70/m, S1/S2 normal, RS-NAD

Local Examination

- Thyroid Gland – Slight swelling of gland noted on empty swallowing.

Investigations

TEST REPORT

COLLECTION DATE : 12/04/2018 07:42 AM
 ACCESSION NO : S023RD004050
 PATIENT NAME : MRS. SHAMEEM
 REFERRED BY : SELF

REPORTING DATE : 12/04/2018 05:49 PM
 PERM ID : SHAMP1204805023
 AGE / SEX : 38 Years / Female
 CENTRE : WALK IN - IDEAL

TEST	ENDOCRINOLOGY	RESULT	BIOLOGICAL REFERENCE RANGE	UNIT
THYROID FUNCTION TEST				
TOTAL T3 (TRIIODDOTHYRONNIE)		0.83	0.80 - 1.80	ng/ml
TOTAL T4 (THYROXINE)		4.60	4.50 - 11.50	µg/dl
TSH (THYROID STIMULATING HORMONE)		14.0	0.40 - 5.50	µIU/ML

Dr. Chandraya MD (Path) Consulting Pathologist

G.S. Balasubramanyam M.Sc. (Medical) MIBMS (Lon)
 Dr. Chandraya MD (Path) Consulting Pathologist

K.V. Shetty M.Sc. (Medical Micro) Consulting Microbiologist

SRL Diagnostics - Ideal
 Ground Floor, Vittal Darshan, Opp. Hotel Moti Mahal, Falnir Road, Mangalore - 575 001 T +91824 2422 612, 2426 771.
 E customercare.mangalore@srl.in W www.srliagnostics.com

T3-0.83ng/ml, T4-4.60ug/dl, TSH- 14uIU/ml.
 Medicine Prescribed (First Prescription)
 Lithium Carbonate 200 stat. and biweekly for 3months. SL

for other days.
 Nux Vomica 200 SOS for headache.

Follow-ups (date wise): 13/08/2018

Patient Name : Mrs. SHAMEEM
 Age/Gender : 38 Y 0 M 0 D / F
 UHID/MR No : DMSL0000018092
 Visit ID : DMSLOPV19251
 Ref Doctor : Dr. SELF
 IP/OP NO :

Collected : 13/Aug/2018 07:40AM
 Received : 13/Aug/2018 09:19AM
 Reported : 13/Aug/2018 12:01PM
 Status : Final Report
 Client Name : SL MANGALORE
 Client Code : SL0018

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (TOTAL T3, TOTAL T4, TSH)				
TRI-IODOTHYRONINE (T3, TOTAL)	1.24	ng/mL	0.7-2.04	CLIA
THYROXINE (T4, TOTAL)	9.10	µg/dl	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	1.33	µIU/mL	0.35-5.5	CLIA

Comment:
 Serum TSH concentrations exhibit a diurnal variation with the peak occurring during the night and the nadir occurring in 10 a.m. and 4 p.m. In primary hypothyroidism, thyroid-stimulating hormone (TSH) levels will be elevated. In hyperthyroidism, TSH levels will be low. Elevated or low TSH in the context of normal free thyroxine is often refer subclinical hypo- or hyperthyroid-ism, respectively. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in on steroid therapy.
 Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.

Note:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

SIN No:IM00351922
 This test has been performed at Apollo Health and Lifestyle Ltd/Mangalore Lab, Mangalore - 575001

SIN No:IM00351922
 This test has been performed at Apollo Health and Lifestyle Ltd/Mangalore Lab, Mangalore - 575001

Patient Name : Mrs. SHAMEEM
 Age/Gender : 38 Y 0 M 0 D / F
 UHID/MR No : DMSL0000018092
 Visit ID : DMSLOPV19251
 Ref Doctor : Dr. SELF
 IP/OP NO :

Collected : 13/Aug/2018 07:40AM
 Received : 14/Aug/2018 09:31PM
 Reported : 15/Aug/2018 05:42PM
 Status : Final Report
 Client Name : SL MANGALORE
 Client Code : SL0018

DEPARTMENT OF IMMUNOLOGY

ANTITHYROID ANTIBODIES (ANTI TPO AND ANTI THYROGLOBULIN ANTIBODY)

Test Name	Result	Unit	Bio. Ref. Range	Method
ANTI THYROGLOBULIN ANTIBODY (ESIM)	0.1	IU/mL	< 4.0	CLIA

Comment:
 This test is used as an adjunct in the diagnosis of autoimmune thyroid disease: Hashimoto disease, postpartum thyroiditis, neonatal hypothyroidism, and Graves disease. In individuals with autoimmune hypothyroidism, 30% to 50% will have detectable anti-Tg autoantibodies, while 50% to 90% will have detectable anti-TPO autoantibodies. In Graves disease, both types of autoantibodies are observed at approximately half these rates.
 The presence of anti-Tg, which occurs in 15% to 30% of thyroid cancer patients, could result in misleading Tg results. Anti-Tg may result in both falsely-low and, less commonly, falsely-high serum Tg measurements. Therefore, in anti-Tg-positive patients, serum Tg measurements should not be used as the sole measurement for thyroid cancer follow-up and should be interpreted with caution.

THYROID PEROXIDASE ANTIBODIES (ANTI MICROSOMAL ANTIBODIES)

THYROID PEROXIDASE (TPO) / MICROSOMAL ANTIBODY	Result	Unit	Bio. Ref. Range	Method
THYROID PEROXIDASE (TPO) / MICROSOMAL ANTIBODY	295.3	IU/mL	0-9	CLIA

Comment:
 Thyroperoxidase (TPO) antibodies are positive in approximately 95% of cases of Hashimoto disease and approximately 85% of Graves disease. Very high titer is suggestive of Hashimoto thyroiditis but absence does not exclude Hashimoto thyroiditis. High levels of anti-TPO antibodies, in the context of the clinical presentation of hypothyroidism, confirm the diagnosis of Hashimoto disease.
 It may be occasionally positive in papillary-follicular carcinoma of the thyroid, subacute thyroiditis (briefly), and lymphocytic (painless) thyroiditis (in approximately 60% of patients). Low titers are present in >10% of normal population, increasing with age.

*** End Of Report ***

Dr. ZEHRAIUS QURESH MBBS, DCP, MD (Bio)
 Dr. SUPRIYA P M.B.B.S., M.D. (PATH) Consultant Pathologist

SIN No:IM00351922
 This test has been performed at Apollo Health and Lifestyle Ltd/Mangalore Lab, Mangalore - 575001

- T3 – 1.24ng/ml, T4 -9.10ug/dl, Anti TPO-295.3 u/ml
- TSH – 1.33.
- Weight 64.0kgs, BP-104/66mmhg, P-68/m
- Slight pain in (L) breast persists during and before menses.
- Menses regular since 2 months, flow normal x 3 days.
- Stools still hard but no episodes of headache like before.
- Lithium carbonate 10m biweekly x 3 months
- SL for other days.
- Thyronorm reduced to 50mcg.

18/12/2018

Patient Name : Mrs.SHAMEEM Age/Gender : 38 Y O M O D /F UHID/MR No : DMSL.0000018092 Visit ID : DMSLOPV27097 Ref Doctor : DR.ALWYN PAIS IP/OP NO :		Collected : 17/Dec/2018 09:02AM Received : 18/Dec/2018 02:22PM Reported : 18/Dec/2018 03:31PM Status : Final Report Client Name : SL MANGALORE Patient location : Mangalore, Mangalore		
DEPARTMENT OF IMMUNOLOGY				
ANTITHYROID ANTIBODIES (ANTI TPO AND ANTI THYROGLOBULIN ANTIBODIES)				
Test Name	Result	Unit	Bio. Ref. Range	Method
ANTI THYROGLOBULIN ANTIBODY SERUM	0.2	IU/mL	< 4.0	CLIA
Comment: This test is used as an adjunct in the diagnosis of autoimmune thyroid diseases: Hashimoto disease, postpartum thyroid hypothyroidism, and Graves disease. In individuals with autoimmune hypothyroidism, 30% to 50% will have detectable autoantibodies, while 50% to 90% will have detectable anti-TPO autoantibodies. In Graves disease, both types of autoantibodies are observed at approximately half these rates. The presence of anti-Tg, which occurs in 15% to 30% of thyroid cancer patients, could result in misleading Tg results. The presence of anti-Tg may result in both falsely-low and, less commonly, falsely high serum Tg measurements. Therefore, in anti-Tg-positive patients, serum Tg measurements should not be used as the sole measurement for thyroid cancer follow-up and should be interpreted with caution.				
THYROID PEROXIDASE ANTIBODIES (ANTI MICROSOMAL ANTIBODIES)				
THYROID PEROXIDASE (TPO) / MICROSOMAL ANTIBODY	407.8	IU/mL	0-9	CLIA
Comment: Thyroperoxidase (TPO) antibodies are positive in approximately 95% of cases of Hashimoto disease and approximately 50% of cases of Graves disease. Very high titer is suggestive of Hashimoto thyroiditis but absence does not exclude Hashimoto disease. High levels of anti-TPO antibodies, in the context of the clinical presentation of hypothyroidism, confirm the diagnosis of Hashimoto disease. It may be occasionally positive in papillary-follicular carcinoma of the thyroid, subacute thyroiditis (briefly), and painless (painless) thyroiditis (in approximately 60% of patients). Low titers are present in >10% of normal population, including pregnant women.				
*** End Of Report ***				
DR. SUPRIYA P M.B.B.S., M.D.(PATH) Consultant Pathologist		K. Aruna Dr Katiki Reddy Aruna Reddy MD Biochemistry Consultant Biochemist		

- Anti TPO- 407.6 IU/ml.
- Patient overall better but headache has returned (may be “rebound effect” of reduced thyronorm.
- Pain in breast reduced.
- Stool normal and soft (Probable side effects of Thyronorm – reduced)
- Menses regular and flow x 2-3 days.
- Other basic parameters – Normal.
- Lithium Carbonate 50M Stat. and fortnightly x 2 months SL on other days.
- Thyronorm reduced to 25mcg /day.

15.02.2019

Kodialball, Mangalore - 575,003
Tel : 91 824 423 88 55
Fax : 91 824 249 68 00
E-mail : hospital@yenepoya.org

epoya
Specialty Hospital
NABH Accredited

Request No : 306017
Name : Mrs SHAMEEMA
Reg No : 139423 /
Ref. By Dr : Dr DIRECTOR MEDICAL

Reg.Date : 09-10-2017/18:34
Age / Sex : 38 Years / Female
Reporting Date : 12-02-2019/16:01

Specimen : SERUM
Received Date/Time : 12-02-2019/11:16

BIOCHEMISTRY	RESULTS	Reference Range		Units
FT3	2.56	2.3	4.2	pg/ml
FT4	0.82	0.89	1.8	ng/dl
TSH	11.1	0.3	4	uIU/ml

End Of Report

GIREESH NAYAK M.SC(Medical) BIOCH
Lab InCharge

RESULT ENTERED BY : Bent902 GIREESH NAVYA - 12-02-2019 / 10:03
RESULT VERIFIED BY : Bent902 GIREESH NAVYA - 12-02-2019 / 10:03

Emergency Contact No. : 0824 - 423 88 55

Ambulance No. : 0824 - 249 55 44 OPD No. : 9008518855 MRI Appointment No. : 9108984300

Rev.1-18-05-2018

T3- 2.56 ng/ml, T4-0.82ug/dl, TSH – 11.1 uIU/mL,
Bp-114/80mmhg, p-64/m, RS-NAD, Weight – 64.0kgs
▪ Patient clinically asymptomatic, Lithium Carbonate CM

Stat. and fortnightly x 3 months
▪ SL on other days.

15.06.2019

Patient Name : Mrs.SHAMEEM Age/Gender : 38 Y O M O D /F UHID/MR No : DMSL0000018092 Visit ID : DMSL0P35880 Ref Doctor : Dr.SELF IP/OP NO :	Collected : 11/Jun/2019 07:48AM Received : 11/Jun/2019 08:55AM Reported : 11/Jun/2019 09:50AM Status : Final Report Client Name : SL MANGALORE Patient location : Mangalore,Mangalore
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DEPARTMENT OF IMMUNOLOGY
FREE AND TOTAL THYROID PROFILE (T3,T4, FT3, FT4,TSH)

Test Name	Result	Unit	Bio. Ref. Range	M
TRI-IODOETHYRONINE (T3, TOTAL) <small>uI</small>	0.8	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL) <small>uRUM</small>	7.70	ug/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH) <small>SERUM</small>	17.96	uIU/mL	0.35-5.5	CLIA

Comment:
TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH is a labile hormone & is secreted in a pulsatile manner throughout the day and is subject to several non-thyroidal pituitary influences. Significant variations in TSH occur due to circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies. It is important to confirm any TSH abnormality in a fresh specimen drawn after – 3 weeks before assigning a diagnosis. The cause of an isolated TSH abnormality.

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

FREE T3 (FT3) <small>SERUM</small>	Result	Unit	Bio. Ref. Range	M
FREE T3 (FT3) <small>SERUM</small>	2.69	pg/mL	2.5-3.9	CLIA

Comment:
Free T3 gives corrected values in patients in whom the total T3 is altered on account of changes in serum protein binding sites (e.g., pregnancy), drugs (e.g., androgens, estrogens, birth control pills, phenytoin [Dilantin]), altered liver function (e.g., nephrosis). Elevated concentrations of T3 occur in Grave's disease and most other classical causes of hyperthyroidism. Decreased concentrations occur in primary hypothyroid diseases such as Hashimoto thyroiditis and neonatal/secondary hypothyroidism due to defects at the hypothalamohypophysial level. It may decrease by ≤25% in hyperthyroidism while FT4 remains normal.

- T3-0.8ng/ml ML, T4-7.70 ug/dL, TSH -17.96uIU /ml.
- Basic Parameters – NAD
- Weight 65.0kg

Patient better but claims TSH increased due to excess consumption of raw cruciferous vegetables cabbage, cauliflower, broccoli as advised by relatives !??

- Lithium Carbonate 0/3 stat. and thrice / week for 4

- months (Patient travelling to HAJ pilgrimage)
- SL on other days. Patient better but claims TSH increased due to excess consumption of raw cruciferous vegetables cabbage, cauliflower, broccoli as advised by relatives !??
- Lithium Carbonate 0/3 stat. and thrice / week for 4 months (Patient travelling to HAJ pilgrimage)
- SL on other days.

30.10.2019

MR. SHAMITH ABDULLA SAKHAI
 ATYAVAR ROAD, MANGALORE
 PIN No. 576222
 PH No. 979001
 PCO No. 9790000000
 Age: 38.0 Years Sex: Female

Reference: In SELF
 Sample Collected At: Mangalore
 METROPOLIS HEALTH CARE LABORATORY, GROUND FLOOR, 10-A, 2ND CROSS, AGARA ROAD NEAR RAILWAY STATION, MANGALORE, KARNATAKA, INDIA
 576001

28/10/2019 DEPT. Collected On
 28/10/2019 8:33AM Reported On
 28/10/2019 12:47 AM


Investigation	Observed Value	Unit	Biological Reference Interval
Thyroid panel: T3/T4/TSH			
T3 (Total) (Serum,CMIA)	81.97	ng/dL	70-204 First Trimester : 81-190 Second Trimester : 100-260 Third trimester : 100-260
T4 (Total) (Serum,CMIA)	7.51	ug/dL	5.0-12.5 First Trimester : 8.0-17.1 Second Trimester : 8.0-17 Third Trimester : 8.0-20.1
TSH(Ultrasmall) (Serum,ELISA)	11.75	uIU/mL	0.45-4.5 First Trimester : 0.1-0.5 Second Trimester : 0.2-3 Third trimester : 0.3-3.0

INTERPRETATION

TSH	T3 / FT3	T4 / FT4	Suggested Interpretation for the Thyroid Function Tests Pattern
Within Range	Decreased	Within Range	- Isolated Low T3 - often seen in elderly & associated Non-Thyroidal illness - elderly the drop in T3 level can be upto 35%
Raised	Within Range	Within Range	- Isolated High TSH especially in the range of 4.7 to 10 mIU/ml is common associated with Physiological & Biological TSH Variability. - Subclinical Autoimmune Hypothyroidism - Intermittent T4 therapy for hypothyroidism - Recovery phase after Non-Thyroidal Illness*
Low	Decreased	Decreased	- Chronic Autoimmune Thyroiditis - Post thyroidectomy/Post radioactive iodine therapy phase of transient hypothyroidism*
Low or within range	Raised	Raised or within range	- Interfering antibodies to thyroid hormones (anti-TPO antibodies) - Interrupted T4 therapy or T4 overdose - Drug interference: Amiodarone, Heparin, Beta blockers, steroids, anti-epileptics*
Low	Raised or within range	Raised or within range	- Isolated Low TSH - especially in the range of 0.1 to 0.4 often seen in associated with Non-Thyroidal Illness. - Subclinical Hyperthyroidism - Thyrotoxic periodic paralysis*
Low	Decreased	Decreased	- Central Hypothyroidism - Non-Thyroidal Illness - Incomplete treatment for Hyperthyroidism (TSH remains suppressed)*
Low	Raised	Raised	- Primary Hyperthyroidism (Graves' disease), Multinodular goitre, Toxic nodule - Transient thyroiditis: Postpartum, Silent (lymphocytic), Postviral (granulomatous, subacute, DeQuervain's), Gestational thyrotoxicosis with hyperemesis gravidarum*
Low or within range	Raised	Within Range	- T3 toxicosis - Non-Thyroidal Illness

References: 1. Interpretation of thyroid function tests. Dayan et al. THE LANCET - Vol 357 - February 24, 2001
 2. Laboratory Evaluation of Thyroid Function, Indian Thyroid Guidelines, JAPI, January 2011, vol. 59

-- End of Report --


Dr. Arvind P
 MD Path Consultant Pathologist

Page 1 of 1

- T3 = 81.97 ng/dl, T4-7.51 ug/ml, TSH – 11.75 uIU/ml.
- NO acute complaints reported. BP- 108/68mmhg, Pulse- 66/m, Weight- 65 kgs.
- Lithium carbonate 0/6 stat. and thrice a week for 3 months.
- SL on other days.

Conflict of Interest
Not available

Financial Support
Not available

References

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2. Arya MP, Boericke W. Aphorism 63, In A study of Hahnemann's Organon of Medicine: Based on the English translation of the 6th edition by dr. William

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 4. Arya MP, Boericke W. Aphorism 65, in A study of Hahnemann's Organon of Medicine: Based on the English translation of the 6th edition by dr. William Boericke, M.D. New Delhi, India: B. Jain Publishers; c2008.
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 6. Arya MP, Boericke W. Aphorism 67, in A study of Hahnemann's Organon of Medicine: Based on the English translation of the 6th edition by dr. William Boericke, M.D. New Delhi, India: B. Jain Publishers; c2008.

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