Thyropause: The Second Menopause Nobody Warned You About Transcript

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Introduction and guest welcome

Hello, ladies. Welcome back to the Future of Menopause Medicine Summit. We changed the name this year. So I'm always like, what's the name? But we are very happy to be here with you.

I'm your host, doctor Sharon Stills, and we have unapologetic, unconventional, uncensored conversations here. And I'm super happy to have Doctor Amie Hornaman in the house with me today.

The thyroid fixer, you can see her, her book, her new book. If you haven't read it, you got to grab a copy the thyroid fix in the background. And one of the things I love about Doctor Amie is that the very first time I interviewed her because she has been on the summit prior, was that I was like, finally, I don't have to like, say anything or correct anything.

Like, this woman understands thyroid just the way I practice thyroid medicine. And she has centered her whole career, her whole life about spreading the word.

She has a making podcast, she's very vocal and she is changing lives constantly, constantly, constantly from women who are told your labs are normal. That's too much thyroid medication for you and all the things.

So like get a pen, get paper, we're going to get truth bombs. You're going to get the lowdown on what you need to know about how your thyroid should be checked, how it should be monitored, how it should be prescribed for all the things.

Because, you know, this is the future of menopause medicine. But when we go through menopause, there's something that happens at the same time called thyroid pause.

And that's happening almost. It's pretty much at this point in my clinic. It's like a rarity, like if I'm seeing a woman from menopause and she doesn't have thyroid pores going on, I'm kind of like, what kind of human unicorn are you?

It's very common, and you may or may not know what's happening to you, but we're going to talk today with Doctor Amie about symptoms, how you can know all the things.

So this is going to be doctor Amie's a clinician and this is going to be very practical. So this is like this. There's going to be a good half hour. So thrilled to have you here.

Thank you so much for taking time. Well Doctor Sharon, I truly believe that you and I are the only ones in the country that Duke I read, write, and that's why we love each other.

Honestly. I mean, we have the best conversations about it because what we see come into our clinics from other places and other functional and natural pathway practitioners.

It's just mind blowing. So I, I love and appreciate you and your brain and all things thyroid. We have great conversations. Yes, I know, I know, I had a patient fly down to see me from Seattle and she was seeing a natural path turned.

It was a natural path.

What thyroid pause is and why it happens

I was in my class that I went to school with. And so it just goes to show, like what Doctor Amie's saying, like just

because someone is a functional practitioner or a natural doctor, like, yes, that's typically always better than seeing an allopathic or your regular primary care.

But just because they're more natural doesn't mean they truly understand thyroid. And what I find is most of them unfortunately, don't. So let's dig in.

Let's start off just, you know, Thira, pause. Like, what is it? The women who are listening. What are some signs? Symptoms? How can they know this is actually happening to them?

Absolutely. And I love what you said about your clinic, too, that when you see women and you're treating them for pairing menopause, menopause, 99% maybe have maybe 100% have thyroid pause in addition to that.

So what do we mean? So thyroid pause is my definition is when your thyroid gland basically craps the bed after the age of 40 due to fluctuating hormones.

So as we move through paramita pause menopause, we know that progesterone is going to tank. Testosterone is going to follow. Estrogen is going to go on to wild roller coaster ride before it falls off a cliff to and during that hormonal, chaotic time.

That is often a time where the thyroid will be affected as well, because those fluctuating hormones. Just like in pregnancy, pregnancy is another time that we see thyroid conditions.

It's hormonal fluctuations that are wild and really, really stressful for the body. Even though it's natural to have a baby, even though it's natural to go through menopause.

And menopause is not fun for your body to do. And it's really, really stressful. And that stress can do something to the thyroid. Number one, it can just down regulate it where the thyroid just kind of goes, you know, I just can't work so well.

I don't have my friends in this sandbox with me to help me produce enough thyroid hormone and to work properly. I don't have the support. But the other thing that we see happen during that time in a woman's life is Hashimoto's.

So what do we know about autoimmune? We know that that switch, that autoimmune switch can stay in the off position for years, if not decades. And then that stressor, i.e.

therapies i.e. fluctuating hormones can flip that switch on. And now all of a sudden this perimenopausal woman now has Hashimoto's at the same time. And nobody's checking. Nobody's looking at her.

They're blowing her off, telling her her labs look normal. And, you know, she's getting older. This is just perimenopause. You just have to deal with it.

This is the life change for you. And that's not the case. Because as you know, as I know, we can treat everything. We can treat the thyroid, we can treat the hormones.

But first we have to discover it by testing you properly. So let's talk about testing and some lab levels, because this is one of those things that I see naturopaths, functional medicine doctors like optimal ranges.

And so like they look at a free T3, which is I'll have you take us through all the thyroid test, but free T3, which is the optimal the active hormone.

And the range is usually like 2 to 4.4. And so someone will come in at like 3.2 and they'll be told, oh, look at you. You're right smack dab in the middle of the range.

You're optimal. So I'd love for you to really dive into that and dive into reverse T3 and dive into the antibodies and dive into TS and what happens to it.

And so all the markers. So I love it I love this I love this is my jam. And real quick before we go into that I apologize. I forgot to answer your question about symptoms.

So for the listener, basically from head to toe the thyroid runs the show. So any symptom you have can literally be tied back to the thyroid. And that's not an exaggeration.

So we're talking about hair loss, brain function, mood, cognition, memory obviously your metabolism, your ability to burn fat, your heart rhythm, blood pressure, cardiovascular system, your lipids, lipid control, insulin control, glucose control, digestion.

It's all controlled by the thyroid. So the main I would say symptoms that we see especially during thyroid pause, is that weight gain and inability to lose weight.

We see that fatigue, brain fog, mood changes, anxiety, depression. And most women will say like, well, isn't that what's supposed to happen? That's what all my girlfriends said that happened to them when they went through menopause.

Yeah, those are the symptoms. And they do overlap with hormonal decline and thyroid decline. But you definitely don't have to accept them and you don't have to live with them. So what do we do?

We test first.

Thyroid testing and optimal lab ranges

So when we're looking at those tests there's that stimulating hormone. That's a brain hormone. We're checking to see basically how well your your brain is sensing the thyroid hormone levels in your body.

Now this is not really an accurate gold standard test. It is in the conventional system but not for us. We'll glance at TSA, we'll look at it. And if it's screaming at us off the paper, yeah, we'll pay attention to it.

But we're not going to tell you that you're normal and everything is fine. If your TSA falls within normal limits W and L within that standard lab value range, we're not going to say in school for now for within normal limits.

They used to they used to teach us that really means we never looked. Oh that nails it doesn't it. Yes, yes. Because unless your lab value is colored red or has a little H or unless x to it, your doctor probably isn't going to stop and look, they're not going to be looking to see where you fall like you said Doctor Sharon in the in the optimal range.

So we look at TSA, but then we move down the ladder and then we go to free T4. Now we're looking at the inactive thyroid hormone T4. We want I actually want to look at that and see if you have too much of it.

Because if I see that free T4 elevated like that 1.61.7, I immediately in my mind I go, oh, this person's going to have an elevated reverse T3. And sure enough I drop down and they do.

So we want to look at that optimal. Or we want to look at the optimal range for that free T4, which for me is really 0.8 to 1.2. I like it a little bit lower because I don't want you to have too much T4.

Why is that? Well, T4 has this choice. It basically has two paths. It can go down. It can go down the one path and become T3, the active thyroid hormone.

And how we know we test your free T3 or your unbound active thyroid hormone levels. And we want those optimal as well. We want the I like it in the upper quadrant of the range or even over.

I'm fine if you're flagged high on the free T3. If you're feeling like a rock star, that's fantastic. We're going to leave that alone. We're not going to call you a hypothyroid.

We're going to say, okay, that's your optimal. This is where you feel your best. So I want we ultimately want that T4 to go down that free three path.

However it can also go down this other path called reverse T3. And reverse T3 is not such a great thing when you're walking around trying to live life.

Now, listen, if you're fighting for your life in the ICU, the E. R., you've been in a major accident. Reverse T3 is there for a reason. Because our bodies are so smart, it knows that when you're in trauma, when you're in an injury state, and healing needs to occur at that point of time, you don't have to burn fat.

You don't have to make major decisions. You don't have to have sex, and you don't even have to poop. You have to lie there and survive. So it shuttles all the resources to healing and survival and kind of pulls energy away from fat burning, decision making, digestion.

And the issue with that, it's great that that's built into us if we are in that trauma state. But reverse T3 often kicks in when that T4 goes down that path, and now your body thinks that you're dying when you're not, when you're trying to live life every single day and do all the things and run a business and be a good mom and and daughter and spouse and friend and all the things.

So we don't want that T4 to go down that reverse T3 path. But we test it. We test it to see how well you convert. Now with reverse T3, I like it under a 12.

That range goes all the way up to a 25 on those labs. I like it low. I like it under a 12. Then we move down to the antibodies and we check thyroid peroxidase and thyroid globulin antibodies to see if you have Hashimoto's.

Now I'm very curious as to your take to Doctor Sharon, but for me, I like antibodies at zero. I don't care that the standard lab value range says TPO needs to be less than 34.

I don't even know who came up with 34. It's a ridiculous number. If you have 20 soldiers, 20 antibodies. I call them soldiers because they're going out and they're attacking your thyroid gland on a daily basis.

So according to LabCorp, we have to have 35 soldiers to get the official diagnosis of Hashimoto's thyroiditis. Well, I'm sorry if I have 20 soldiers that are going out and beating up my theory gland every day, it's probably not going to work at its best.

And if I have those 20 soldiers and I know that and we call it okay, we have Hashimoto's here, this is a Hashimoto's autoimmune situation. Now we can start doing things about it to calm down that auto immune response and push those antibodies to zero, instead of waiting until you gain another 20 pounds and can't get off the couch.

But oh, now you have 35 antibodies, so now we can treat you. No, no, that's not the case. That's not the case. It's like, you know, like anything like blood glucose or hemoglobin A1.

See like, oh you're at 5.6. You're fine. We're going to wait till you're, you know, 5.7 and then you're pre-diabetic like right. So it is. And so I wanted to circle back.

And then I want to talk about what you just said because that's important. So I just want to like pull out and emphasize or maybe you can do for us. But like with the blood testing, because you just said a lot of important stuff and this is where so many women are misled.

So she said reverse T3, which first of all, most doctors don't even run. So you got to ask for it. You got to advocate. Yep. You know, the range is usually like 8 to 25.

So below 1212 or below. So if you have a reverse T3 of 18 that's like in the middle of the range. So again you get doctors telling you look at you. You're right in the middle of the range. No to high.

So already a problem. So but if you can kind of talk about where treatment goes awry, where someone's reverse T3 is too high and their T4 is too high and their T3 is low, and then even in the natural world, they get given armor and P.

Why that cannot go well. Yes, yes, you're speaking of a language, girl, I love you. Okay, so most of you listening, if you actually have had the diagnosis of hypothyroidism now, now this talk is for those who are walking around with symptoms too.

So we're trying to actually enlighten you that you might have hypothyroidism, but for the listeners that they already know, you already have that diagnosis, I would bet money that if you're seeing conventional medicine, you're going to your your OBGYN or an endocrinologist.

You are on T4 only you're on synthroid Lebow thyroxine LaVonne Terezin. You are just taking T4 because your doctor told you there's there's nothing else that you need.

You just take this medication and your body will convert it just fine. It'll be fine weather. Even if your doctor even talked about conversion, he might have just told you.

Just take this pill and we'll see you in six months. Good luck. Now in the functional and integrative world, Doctor Sharon and I see this all the time as well that, you know, there's this thought that if you're functional naturally, that you just have to prescribe natural desiccated thyroid because there's natural in the title and it's and it's more natural and everybody does well on it.

Well, that's not the case because I mean, listen, it's a step up from synthroid from T4 only because it does contain 20% T3. But the problem is it contains 80% T4.

And we have to look at each individual person to see how well your body in this day and age takes that T4, whether it's in the form of synthroid or whether it's in the form of armor or not.

Thyroid. How well is your body taking that T4 and pushing it down the right path to convert to T3? Or does it take all that T4? And I don't care if it's in a pill that has natural in the title, your body can still push that T4 down the reverse T3 pathway, and taking natural designated thyroid medication could make you worse because you just don't convert.

The reality is, we're living in a totally different environment than we than our parents lived in and our grandparents lived in. So your doctor went to school and this is being taught still today.

Nothing has changed in the curriculum that you test. If H is high, you give synthroid or levo and then you retest in six months. That is it. That is a linear model that is standard of care.

That is what you are going to experience. And that whole paradigm is just so narrow focus and so wrong. The the world we're living in right now has more toxins, more stress, more EMF exposure, you know, more pesticides than ever, more Frankenstein ingredients in our food.

How can our bodies possibly do an amazing job at converting T4 to T3 when those very things that I just rattled off, including nutrient depletion, high cortisol, estrogen dominance, low progesterone, all of those things play a role in helping your body convert T4 to T3.

So if you have a lot going on, and most of us do, and most of us have been exposed to to everything I just said, you're going to have a hard time converting that T4 to T3, and I don't know about you, but I see reverse T3 elevated probably in 80% of our patients.

When I see a beautiful reverse T3, I'm like, oh, look at that.

Why standard thyroid treatment often fails

That's a rarity. That's a unicorn right there, right? I get excited, right? Because then you're like, oh, this is easy. We could just give you some NTP, right?

I know, I know, it's so true. It's so true. So yeah, I mean, this is just so important that I always wonder, like what did the endocrinologist do in like four years of medical school, four years of residency.

Like this is supposed to be their specialty. You think they would have branched out. But, you know, you talk about this to typical endocrinologists and they tell you reverse T3 isn't a reliable or necessary test.

You don't need to check the free T3. You only need to check. It's like and I'm sure you I know you see this to, but it's like how many women have come into my office, to your office and they're like, oh no, my roids.

Fine. You know, I was told it was fine and I'm on synthroid and I'm like, fine and dandy. And then, you know, we have our thyroid symptom checklist which has like 100 things on it because like you said, everything from heartburn to even asthma, like everything can be implicated in a low thyroid.

And then they're like, oh, I have that, I have that, I have that, you know, they check, check, check. And it's like, well then no, your thyroid is not optimized.

If you're symptomatic, your thyroid is not optimized. I don't care what your TS looks like. And I don't care if you have a free T3 like you said it for.

Some of my patients have to have free T3 at six or you know, they just I need to run higher for me to feel my best. So it's just so this is like such a public service announcement to everyone listening, because I know there's so many of you listening who are either on thyroid and told you're fine and you're optimized, but you're still symptomatic or weren't even given any thyroid and told you're fine and you have all the symptoms.

And this is such a when you get the right kind of treatment, it's my patients always describe it as like a light switch. Right. It's like it's like to do, you know, heaven sings and the angels ring and it's like life comes back to you and your brain turns on and your energy turns on and your desire turns on.

And so, like, this is such an important, important topic. So now I want to cycle back to Hashimoto's, because that's the other thing patients get told if they even get told because so many doctors don't even check the antibodies.

But if you do get told you have Hashimoto's, then a lot of doctors just give you thyroid hormone and they never go. Why do you have Hashimoto? Right. So can you talk a little bit about that?

Absolutely. And everything you said prior to. Oh it's just it's amazing how when you speak, it literally could be my words because we say the same thing.

I mean, yeah, the, the it's like a public service announcement. Just please listen because this can literally save your life. So do not dismiss this conversation just because you were told that you were normal.

I love that, yes, exactly. And of bodies, you know, I see two sides of the coin. So on the one side I see the doctors who. Yes, you have Hashimoto's, here's a pill, here's your synthroid, or you have Hashimoto's, but we're just going to watch and wait and see.

We're just going to keep an eye on your thyroid. Right. And they do absolutely nothing. And obviously they don't dig deeper to even have that conversation with that person about what antibodies are, what they mean for the body, how autoimmune can turn into another autoimmune condition, and what they need to do lifestyle wise to help reduce those antibodies or to not build up their antibodies and produce more soldiers.

And that's the conversation that you and I have with patients, something as simple as going gluten free. And I know, don't roll your eyes, people. I know you hear gluten free all the time, but like I talk about in the book, gluten free is not a fad.

It has science behind it in that when we look at gluten under a microscope, oh my goodness. It looks like the roid gland. So what happens in autoimmunity?

What happens in Hashimoto's is how I call those antibodies soldiers. I call them confused soldiers. It's like they're they're missed at the core level to think that your thyroid is a bad guy.

So now when whenever we eat gluten, those soldiers see it coming in and they go, wait a minute, doesn't that look like the that's the thyroid. That's the that's the bad guy that we go in attack.

And I'm like, come on Bob. Come on Jim, let's go. And they rally the troops and they launch an attack on your thyroid just because you ate gluten. That's why we tell you to go gluten free when you have Hashimoto's, because there is science behind it.

We ultimately want to keep those soldiers calm down in their barracks. And let's not build an army. Let's reduce your army to zero. And that conversation just isn't being had with people.

The other thing I see are patients that they look at their antibodies and let's say they raised by, you know, 50 or 100 points from last labs to these labs, and they freak out.

They're like, oh, I must be horrible what's going on with my body? And sometimes we have to be like, it's okay, Jane, your free T3 is good. Your verse T3 is good.

You just told me that all your symptoms are gone, so maybe you got gluten at a restaurant. I don't know, maybe you are fighting off a virus. It's okay. We're going to take care of the antibodies.

The antibodies don't necessarily dictate how you feel because we could see someone with high antibodies, beautiful numbers, and they feel great. We could see someone with zero antibodies and jacked up reverse T3 and low free T3, and they feel horrible.

So it's about looking at the whole picture, the whole picture that's chuckling, he said. I just took my granddaughters to see Toy Story five and they had like the, you know, the little soldier Toy Story.

Oh yeah. Yeah. Like the little ads on, like the little animated soldiers. And they were like on the mission to look at the birthday gifts. But I'm like, no, that's what I'm going to see when I look at that's it, that's it.

They're just going after the thyroid and and gluten free. I just want to I always say I'm like the OG of gluten free. I went gluten free in like 1995 when I don't even think anyone.

It helped me cure my asthma. And it was like, I remember being at a restaurant and I was like, I'd like a burger with no bun. And it created this whole commotion.

The chef came out of his kitchen. It was like they didn't know what to do. I was like, just put it on the plate with the fork and a knife and I'll be fine.

Hashimoto's, gluten, and antibody management

And they didn't understand. And obviously we live in very different times now, but I see a lot of patients who like, say they're gluten free. And then whether we're checking it through blood antibodies to gluten or gliadin or we're looking in the stool and we see elevated antibodies.

So what Doctor Amie said, like I always tell, you know, it's not nice to lie, but when you go out to a restaurant, it's okay to tell a white lion, say you have celiac disease, because then they will take you because it is a fad now and everyone and their mother is gluten free.

And so they don't take it as seriously. But if you say you have celiac, they will take it seriously. They don't want to

get sued and have you have a major reaction and you will prevent that cross-contamination.

Because I see so many patients who are like, no, zero gluten in the house, but then they have levels. So you've got to just really be careful because you'll be surprised at where gluten sneaks in or gets cross contaminated.

And that can, you know, cause your spike in your antibodies. So, oh my God, I want to talk to you for like 17 hours. So can you just real quick because we're really at a time, but we're going to talk a little longer like can you talk about T3 dosing and like even what you take because, you know, we prescribe very what's considered high and like doctors would never do it.

But we do this because this is how our patients get better, feel better, stay better. So I think if the audience can just hear some actual like numbers, or if you have a patient story or something just to show them that, like, yeah, five micrograms of cytometry once in the morning is probably not going to cut it for you.

In fact, I always say the baby doses of T3 do more harm than good because you're bringing that T3 in and it's going to signal your brain, your hypothalamus and your pituitary to drop your TS, and then your own thyroid gland is going to be like, oh, I guess I don't really have to produce thyroid hormone right now.

And so now your thyroid gland shuts down, but you don't have enough of the active thyroid hormone coming in to feed your 37 trillion cells that need it.

So I don't if your doctor isn't going to optimize your T3, just don't even don't take the baby dose. You want to work with somebody. And I swear to God, I think Doctor Sharon and I are the only people in the United States that don't have a cap on T3.

So yeah, work with somebody that personalizes your health. So story I am T3 only I don't convert at all. So I used to take 75 micrograms twice a day. Now I'm down to 50 micrograms twice a day.

And I always say listen when I say my doses and I say that I just, you know, drop my T3 dose. The last year, there's no gold star for taking the least amount of fired hormone.

You know, you want to take what works for your body. I have another patient who is on. It's a female. She's like five one, 105 pounds and she takes 100 micrograms of T3 twice a day.

So she's on 200 micrograms a day. You are right, Sharon. Most doctors and even functional and integrative doctors would fall over with a heart attack if they saw those doses and they would yell at us, you're going to cause AFib.

No we're not. We're actually improving their cardiovascular system because now instead of having to get that heart ablation that their cardiovascular surgeon wants to do, we gave them T3 and now they don't need it.

You know, I mean, it's amazing what it does. And it's all about personalizing the dose I would say the the lowest dose that I've seen actually optimize someone is probably around like ten micrograms twice a day.

You know, we usually have to hit that sweet spot. Now you're going to have some sensitive people that might have to go lower and slower to reach that.

It might take them six months to get to that mark. But then I would say, you know, when people ask me the average, it's so hard to say because it's across the board.

So ten twice a day or 100 twice a day and anything in between. Yeah, I know exactly. I tell patients like, you're going to go on a journey and it might take six months especially.

Can you speak to those patients who are, you know, they can't tolerate it and you know, they can tolerate one microgram to start and why that is and what they can do about it.

Yeah. You know, there are just they know who they are, those sensitive people. It's the people that react to a drop of caffeine. They get the reverse reaction to Benadryl, you know, like all the things they might because T3 has a little bit of a like a simulating, enlightening effect.

Sensitive people can be sensitive to it. So we just have to start lower and slower. So in those groups of people we will use slow release. We use slow release T3 so that it's dripped into your body.

Instead of one wall being punched with like a 2.5 or a five microgram tablet. Maybe we're giving you one microgram this hour, one microgram two hours from now, and it's slowly releasing your system, and sometimes that makes it more tolerable.

We also want to look at some other factors that can play a role in how your body tolerates T3, ferritin levels, cortisol levels. All of those play a role.

Low ferritin will make someone more sensitive to T3.

T3 dosing, sensitivity, and personalized treatment

They won't be able to increase their dose or get to their optimal dose as quickly. If the ferritin level is coming in at, you know, like a ten. So we have to look at that.

If somebody is really stressed out there pumping cortisol or if they've gone the other way and they've been so stressed out that now they're in adrenal fatigue and they have flatline, low cortisol, that can be a problem because cortisol needs T3 and T3 needs cortisol.

They play in the same sandbox. Yes. Yes. So you can see it's it's nuanced and I know. So I do you know when I see patients or know when I like when if I'm doing a second consult and someone can't fly out to establish care and be mine or Doctor Ben's patients and we're talking about thyroid, I just say go to Doctor Amie, listen to her podcast.

She's got, you know, programs you can do. She's got prescribers all over like, and she you're really the only one that I even can say that about because I know and it is I you know, I never see patients coming in on like adequate T3 or getting twice a day dosed or having there.

So it's like, yeah, here we are. We are the thyroid. We are the thyroid contingency. So, you know, show this to your doctors like she wrote a book about it.

She's got a great podcast about five roid. You know, you can just go and like, be like, what does she think about reverse T3? What? You know, you can just pick it out and show her book to your doctor.

Like, we don't we don't want to be the only ones like we want every we want everyone to understand, you know, we can't possibly see enough women and change the world.

Like we need your doctors to get educated. So, like, take this information. You know, if you want to come see me, you want to go see her. That's fantastic.

But if that's not in your plan, like, give the book to your doctor and say, hey, can you read this? Like, that's how I got into prescribing bioidentical hormones back in 2002, when I first opened up my clinic, like a patient came with a book.

I was going to be a pediatrician and a patient with the book, Suzanne Somers, you know, and was like, can you read this? And I was like, seriously, you want me to read Chrissy from Three's Company?

The blond. Right? I was like, you know, I have an open mind. I'll read it. And I read it and I was like, oh, Christine's so dumb after all. And it like, changed the whole trajectory of who I serve and how I serve.

So, like, find a doctor, you know, break it down for them. Like, now we have, you know, AI like get the highlights of the book, make them a document. You know, maybe asking your doctor to read a whole book is too much.

But get like the thyroid fix highlights. Take out a chapter that you know and like just like that's a reasonable ask of a doctor. Could you could you read this for 15 or 20 minutes and a good doctor is going to be like, yeah, oh, maybe I can learn something.

Maybe I can help my patients better. So like, she's written the Bible of thyroid. They're so like, let's let's get it into as many people's hands as possible.

So with that being said, how do they find you? Your podcast, your book, I'm assuming, is just anywhere.

Where to find Dr. Amie and closing remarks

Anywhere books are sold. Amazon allows you to choose, you know, hardcover, Kindle, audible. I added bonus chapters at the end of each chapter on the audible, but like Doctor Sharon said by a copy for your doctor, because I did.

I wrote it for the undiagnosed, the diagnosed, and I wrote it for the clinician too, because it literally gives guides based on your reverse T3 level of what you have to do with your medication to change that up.

So read the book and then you can go to Doctor Amie. From there. You can book a free call if you're interested in working with us. We prescribed to all 50 states.

We do thyroid hormones. That's our jam. And you can also connect with the Thyroid Fixer podcast. Doctor Sharon's been a guest on that as well. So that's the best place to find all the things.

Doctor Amie. And just you spell Amie uniquely. So spell your name. Yes. Amie. So you're going to go to dramie.com perfect. Well, I love you, my thyroid sister.

Thank you so much for birth in the book and for, you know, changing all the lives that you do. It's just beautiful work you do. So I told you, ladies, this was an important one.

So you've got homework. Go get the book. Go educated clinician, please help us to not be the only doctors who understand how to prescribe thyroid. So we will be back with another talk.

I don't know if it'll be as riveting as this, but I'm sure it will be. But I'm just so partial to this one because, you know, 25 years in practice and it's like day in and day out.

No, your thyroid isn't optimized even though you've been told that. So it's like it's such a passion. I know of yours and mine to, like, really change this conversation and just to allow you to feel your best, because we got a lot of living left to do, ladies.

And with a functioning thyroid, it's just not going to be optimized. So love to you all and we'll be back soon.