PITUITARY (ANTERIOR) DYSFUNCTION

The following information pertains only to **anterior pituitary hypofunction**. Anterior pituitary hyperfunction is an uncommon problem and when present, tumor must be ruled out. With hyperfunction, one or more of the pituitary hormones will be elevated (especially prolactin) and the blood pressure will often be elevated. If anterior pituitary hyperfunction is present consider treatment with **Mn-Zyme**, **Acti-Mag Plus** and **B6 Phosphate**. Use this protocol if a benign pituitary adenoma has been identified and add **DopaTropic Powder**.

1. Pre-Disposing Factors and Clinical Indicators: Common serum changes include androgens decreased, cholesterol increased, phosphorus decreased, progesterone decreased, insulin increased, T-4 decreased, TSH decreased below 2.5 (see a. and b. below) and either increased or decreased cortisol.

a. Reduced thyroid stimulating hormone (TSH). Note: The subjective indications of anterior pituitary hypofunction and thyroid hypofunction secondary to pituitary hypofunction are similar. When in doubt, complete a serum TSH. If the result is below 2.5, anterior pituitary hypofunction is probable, if the result is above 2.5, primary thyroid hypofunction is probable (symptoms must be present for this guide to be accurate).
b. Patient will generally exhibit symptoms of thyroid hypofunction (weight gain, decreased energy, hair loss, poor skin tone, headaches in the a.m. that wear off as the day goes on, inability to concentrate, poor memory, hearing loss, ringing in the ears, poor circulation, low axillary temperature, constipation, depression, etc.).
c. Diabetes and/or carbohydrate sensitivity.
d. Toxic element exposure.
e. Biliary insufficiency resulting in reduced hormonal conjugation.
f. Manganese deficiency.

2. Dietary Suggestions:

a. Drink and cook only with pure water (no well water or city water).
b. Eliminate refined carbohydrates, alcohol, processed foods and caffeine.
c. Increase raw foods and quality proteins. If the patient is overweight and renal function is not compromised, limit daily carbohydrate intake to 60 grams or less.
d. Eliminate dairy, gluten containing and fermented food.
d. Eliminate hydrogenated fats and oils. Increase raw and fresh oils.

Continued On The Following Page:

3. **Primary Supplemental Support in order of need:**

a. **Cytozyme PT/HPT** – 2-5 bid in the a.m. and at noon.
b. **Thyrostim** – 2 bid in the a.m. and at noon and **Bio-Ashwaganda** – 1 tid.
c. If adrenal cortical hyperfunction is present add **ADHS** at 2-3 bid in the a.m. and at noon, **Berberine HCL** – 1 tid and **GlucoBalance** – 2-3 tid.. If adrenal cortical hypofunction is present add **Cytozyme-AD** at 2-4 bid in the a.m. and at noon or **ADB5-Plus** – 3 bid in the a.m. and at noon and **Bio-Glycozyme Forte** at 2 tid between meals. If the patient is unable to tolerate **Bio-Glycozyme Forte** on an empty stomach, take with meals with 1 capsule of **Betaine Plus HP**.
d. **Iodizyme-HP** – 1 tablet daily.

4. **Other Considerations:**

a. If a need for DHEA can be demonstrated add **DHEA** – 5-10 mg a day.
b. If adrenal cortical hyperfunction is present and the problem is severe (significantly increased cortisol and/or triglycerides) add **Phosphatidylserine** – 4 at bedtime.
c. Toxic element exposure is common with anterior pituitary hypofunction, rule out with RBC, urinary and/or hair mineral analysis. A document describing the common sources for toxic elements and their treatment is available by e-mail from hoejr6998@gmail.com.
d. Manganese deficiency is common with anterior pituitary dysfunction. If present, add **Mn-Zyme** – 1 bid..
e. Fatty acid need is a constant finding with both thyroid hypofunction and anterior pituitary hypofunction. Use **Optimal EFAs** – 2-3 tid.

Pituitary hypofunction resulting in thyroid hypofunction can cause an increase in prolactin. Therefore, pituitary hypofunction with resulting thyroid hypofunction is one of the reasons the probability of pregnancy is reduced with primary or secondary thyroid hypofunction.