Eyal Kraut, MD

Department of Medicine, Division of Endocrinology and Metabolism, Sinai Health System,
Endocrine Oncology and Thyroid Clinic, 600 University Avenue, Suite 413 Toronto, ON
Phone: (416) 586-4437 Fax: (416) 586-8861

2025-Oct-22

LMC Diabetes & Endocrinology - Referrals
106-1929 Bayview Ave
Toronto, ON M4G 3E8

Patient:	Mr. Bruce KRELL
PHN:	5205 619 157LG
MRN:	903344372
Birthdate:	1956-Jan-25
Phone:	**H:** (647) 299-3673 **C:** (647) 299-3673
Address:	3617 Riva Avenue Innisfil, ON L9S 0L5

REQUEST FOR CONSULTATION

Problem History:	HYPOPARATHYROIDISM [Treated post surgical hypoparathyroidism], Papillary thyroid cancer [Oncocytic papillary thyroid carcinoma with extensive cystic degeneration, 2.5 cm, no invasive features]
Risk Factors:	None Recorded
Active Medications:	ROCALTROL 0.5 MCG CAPSULE [1 Capsule(s) Once daily X 100 Day(s)] , APO-GLICLAZIDE MR 60 MG TABLET [2 Tablet(s) Once daily X 90 Day(s)] , Blood Glucose Test Strips [for blood glucose monitoring], SYNTHROID 25 MCG TABLET [1 Tablet(s) Once daily X 100 Day(s)] [Total 137 mcg OD], SYNTHROID 112 MCG TABLET [1 Tablet(s) Once daily X 100 Day(s)] [Total 137 mcg OD], SYNTHROID 137 MCG TABLET [1 Tablet(s) Once daily X 100 Day(s)] [Take 1 tablet qam ac]
External Medications:	amlodipine besylate 5 mg Oral Tablet [1/2 tab daily], atorvastatin calcium 20 mg Oral Tablet, OZEMPIC 1 MG/DOSE (4 MG) PEN [once a week- 1.5], INVOKANA 300 MG TABLET, TEVA-GLICLAZIDE 80 MG TABLET [BID], calcium [calcium carbonate 1000 mg [400 mg elemental daily]], COVERSYL 8 MG TABLET [BID], metformin HCL 500 mg Oral Tablet [2 tabs BID]
Known Allergies:	Drug - Allergy - None Known
Lifestyle Notes:	None Recorded
Family History:	Hypothyroidism (Mother), Prostate Cancer (Father), Coronary artery disease (Grandparent)
Endocrine Problem History:	None Recorded
Investigations:	Neck US - Several mildly enlarged but benign appearing lymph nodes

Response to Therapy:	Biochemical - Undetectable nonstimulated thyroglobulin: <0.1, Structural - No evidence of disease-US neck, Biochemical - Stimulated Tg level <1 mcg/L
Treatment History:	Radioactive Iodine - 88 mCi - Mount Sinai Hospital, Thyroidectomy - Total: Mount Sinai Hospital

Referral: LMC Barrie

Reason for referral: Poorly- controlled type 2 diabetes

Mr. Krell has a recent HgA1c of 11.9%.

Current diabetes medications:
1. Metformin 1000 mg BID (I told him he could take 2500 mg/d)
2. Gliclazide IR 80 mg BID (I changed this today to gliclazide MR 120 mg OD)
3. Invokana 300 mg daily

He was previously taking Ozempic, titrated up to 1.5 mg weekly, but stopped this due to GI intolerance (nausea) and he also didn't feel it was effective for him.

He is on ODB with no private insurance, so Mounjaro is not an option. He would be open to considering Rybelsus. I discussed that likely insulin is needed, and he will start monitoring his blood sugars.

He is becoming more motivated to optimize his diabetes, through diet and exercise, especially as he has early-stage neuropathy.

He is actually leaving for the winter in a few weeks for Florida. He will return to Canada in May.

I saw him at my Mount Sinai Hospital clinic regarding follow-up post-thyroid cancer (very remote surgery, low risk for recurrence), complicated by hypoparathyroidism. This is stable and does not need to be followed at MSH any more. He has moved to Innisfil, so I suggested that going to LMC Barrie would be most appropriate. He currently has no family MD, and his family MD was previously managing his diabetes.

My latest note and selected documents are attached.

Please book for after he returns from Florida, after May 2026.

Sincerely,

Eyal Kraut, MD
Electronically Reviewed to Expedite Delivery

Enclosures (10)

Patient:	**Mr. Bruce KRELL**	**Appointment Date:**	**2025-Oct-22**
Title:	**EK thyroid function**		
Provider:	**Kraut, Eyal**	**Referred By:**	**None**

No current family MD

Bruce KRELL was assessed through the Mount Sinai Thyroid Clinic on 2025-Oct-22, accompanied again by his wife Sharon. Mr. KRELL is a 69-year-old male with a history of hypothyroidism and hypoparathyroidism post-remote thyroidectomy for a thyroid malignancy. We last met a year ago.

Problem History:

2000-Jul-27 HYPOPARATHYROIDISM [Treated post surgical hypoparathyroidism]
2000-Jul-27 Papillary thyroid cancer [Oncocytic papillary thyroid carcinoma with extensive cystic degeneration, 2.5 cm, no invasive features]

Active Medications:

SYNTHROID 137 MCG TABLET **[**1 Tablet(s) QD X 100 Day(s)**]** **[**Take 1 tablet qam ac**]** - *taken optimally*
ROCALTROL 0.5 MCG CAPSULE **[**1 Capsule(s) QD X 100 Day(s)**]**
calcium [calcium carbonate 1000 mg [400 mg elemental daily**]**, 1 tab daily
atorvastatin calcium 20 mg Oral Tablet
INVOKANA 300 MG TABLET
TEVA-GLICLAZIDE 80 MG TABLET **[**BID**]**
COVERSYL 8 MG TABLET **[**BID**]**
metformin HCL 500 mg Oral Tablet **[**2 tabs BID**]**
Amlodipine 2.5 mg daily

Interim Progress:
He has stopped Ozempic since we last met, as he felt that this was not effective for him (for both glycemic control and weight) while causing nausea. He now feels back to normal, and much better off of it.

He no longer has a family MD, and has no one looking after his diabetes.

He is trying to eat more vegetables, and do more walking.

Physical Exam: No palpable thyroid tissue, nodules, or cervical / supraclavicular lymphadenopathy.

Laboratory Investigations:
Aug 15, 2023:
- TSH 2.28
- Tg <0.1, anti-Tg Ab 13
- Ca 2.27, Alb 41, Phos 1.3
- PTH 1.3
- Cr 91, eGFR 75

Oct 10, 2024:
- TSH 2.32
- Ca 2.14, Alb 40, Mg 0.82, Phos 1.3
- iCa (corr) 1.17
- 25-OH-Vitamin D 72.8
- Cr 87, eGFR 84
- 24hr urine 2.1 L
  - Cr 7.8 mmol/d (7.8-20.0), Ca 2.56 mmol/d (2.50-7.50)

Oct 14, 2025:
- TSH 2.62
- Tg <0.1, anti-Tg Ab 18
- Ca 2.22, Phos 1.5
- iCa (corr) 1.17

- PTH 1.3
- Vitamin B12 831

Issues and Plan:

1. **Hypothyroidism:** Mr. KRELL is euthyroid on the current dose of levothyroxine. The current dose is appropriate, and was not changed today. Continue Synthroid 137 mcg daily, which I refilled today.
2. **Thyroid cancer recurrence risk:** There is no evidence of recurrence. Thyroglobulin was undetectable, and there is no interfering thyroglobulin antibody.
3. **Hypoparathyroidism:** His total calcium and ionized calcium levels were both in target, as was his phosphate level. The low PTH indicates ongoing (permanent) hypoparathyroidism, but the calcium levels are in target, indicating that his current regimen is appropriate. Continue the same: Rocaltrol 0.5 mcg daily and calcium at the dose listed above.
4. **Vitamin B12:** His level was now quite well-supplemented. He can stay on the same supplement as before.
5. **Type 2 diabetes:** This is a major issue for him. His HgA1c is markedly high. He reports neuropathy. He has stopped Ozempic. I reviewed that there are limited options at this point. He does not have coverage for Mounjaro. Rybelsus is a possibility, but would be cumbersome with the Synthroid and he didn't tolerate Ozempic. He would like to avoid insulin, though this might be necessary. For now, Mr. Krell will increase metformin to 2500 mg/d, switch gliclazide IR 80 mg BID to gliclazide MR 120 mg OD, and stay on Invokana 300 mg daily. He will also focus on dietary and exercise factors, and start to monitor his blood sugar. He also recently spoke with a dietician. I am referring him also to LMC Barrie for ongoing diabetes care.
6. **Follow-up:** Repeat labs and follow-up in May, after he returns from his winter in Florida. Ongoing follow-up then TBD, if he is indeed seen at LMC Barrie.

Ontario Medical Imaging – Chalmers Gate X-Ray And Ultrasound

DR. GOMEZ-HERNANDEZ, KAREN
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TORONTO, ONTARIO, M5G 1X5
Tel: (416) 586-4437, **Fax:** (416) 586-8861

RE:	KRELL, BRUCE FORD
DOB:	25-Jan-56 62y 7m Sex: M
Phone:	(905) 660-3673
Encounter ID:	RH4880161
DOS:	18-Aug-2018

NECK ULTRASOUND:

The salivary glands appear unremarkable, no mass is seen. There are several benign appearing lymph nodes in the neck bilaterally the largest on the right seen in the upper cervical chain, 16 x 6 mm in size and on the left also upper cervical chain, 25 x 9 mm in size.

IMPRESSION: Several mildly enlarged but benign appearing lymph nodes in the neck bilaterally likely reactive lymph nodes.

DICTATED BUT NOT READ

W.RESLAN,MD., F.R.C.P.(C)

25-Aug-18 13:53
Status: D:WR 20/08/2018 13:16 T:LUIS 25/08/18 13:55

MOUNT SINAI HOSPITAL
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Department of Medicine

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Paul Walfish
C.M., O.Ont., M.D.,
F.R.C.P.(C), F.A.C.P.

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Metabolism
Thyroid and Parathyroid
Diseases Endocrine
Oncology Clinics

University of Toronto
Faculty of Medicine
Professor Emeritus,
Medicine, Paediatrics,
Otolaryngology and
Pathology & Laboratory
Medicine

Dear Dr. David Birbrager

October 28, 2016

Re: KRELL, Bruce

This patient was referred for a problem of a 60 year old man with previously treated stage 1 papillary thyroid cancer was examined on October 26, 2016. From a review of the relevant clinical and available laboratory information:

History and Physical Examination: This man was treated with stage 4 papillary thyroid cancer with surgery and one dose of radioactive iodine November 2013. Subsequently there has been no evidence of recurrent thyroid cancer on long-term follow-up monitoring with neck ultrasound and thyroglobulin studies. In addition he has had post surgical hypoparathyroidism requiring long-term Rocaltrol and Calcium supplementation. Over the last several years there has been a problem of chronic refractory obesity leading to borderline diabetes mellitus as well as hypertension and hypercholesterolemia. Unfortunately he has not been able to lose weight and subsequently he has had suboptimal diabetic control and possible early development of peripheral neuropathy. Examination revealed a weight of 225lbs; Blood pressure 124/82; Heart rate 84/min and regular. There was a healed thyroidectomy scar with no palpable thyroid nodules or cervical lymph nodes. However there has been generalized persistent obesity. Cardiovascular status is stable.

Laboratory investigations and/or procedures indicated:
Laboratory showed TSH = 0.05; Free T4 = 21; Free T3 = 4.7; Thyroglobulin = <0.1; Anti-thyroid antibody interference = negative; Ionized calcium = 1.17; PTH = 1.8; pc Glucose = 10.6; Hemoglobin A1c = 0.077; Microalbumin/Creatinine ratio = 2.2. Previous neck ultrasounds have been entirely negative for residual thyroid cancer.

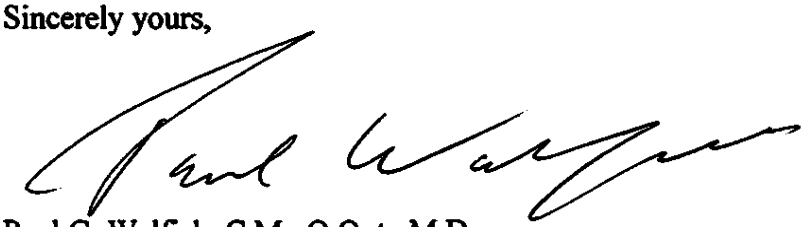
Clinical Impression:
1) Treated stage 1 papillary thyroid cancer with no residual disease.
2) No need for high dose TSH suppression therapy with thyroxine that show result in a lower dose.
3) Eucalcemia for post surgical hypoparathyroidism on therapy.
4) Non-insulin diabetes mellitus fair control but refractory obesity.
5) Treated hypertension.

Management Recommendations:
1) The L-thyroxine dose was reduced slightly from .175mg 5 days/wk and .15mg 2 days/wk to 0.175mg MWF and .15mg TTSS.
2) Continuing Rocaltrol .5mcg daily and Calcium 650mg bid.
3) Continuing Coversyl 8mg daily for control of hypertension and Lipitor 10mg daily.
4) Continuing weight reduction efforts with low carbohydrate diet and exercise in association with Metformin 500mg x 2 bid adding Januvia 100mg daily and continuing Glucizide 5mg bid to attempt to control of non-insulin diabetes mellitus.

Follow-up Recommendations:
A follow-up appointment in 6 months was booked.

Thank you for referring this patient and if there are any further details you require, please contact me.

Sincerely yours,



Paul G. Walfish, C.M., O.Ont., M.D.

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

July-22-14
905-886-3597

Paul G. Walfish,
C.M., O.Ont., M.D.,
F.R.C.P.(C), F.A.C.P

Division of Endocrinology and Metabolism
Thyroid and Parathyroid Diseases
Endocrine Oncology Clinics

University of Toronto
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pwalfish@mtsinai.on.ca

Dear Dr. David Birbrager

July 22, 2014

Re: KRELL, Bruce

This patient was referred for a problem of a 58 year old man previously treated cystic Hurthle cell/papillary thyroid cancer stage 1 by a total thyroidectomy followed by one dose of radioactive iodine in November of 2000 and surgical hypocalcemia in association with treated borderline non-insulin dependent diabetes mellitus, obesity and hypertension was examined on July 21, 2014. From a review of the relevant clinical and available laboratory information:

Clinical Impression:

1) Treated Hurthle cell variant of papillary thyroid cancer stage 1.
2) No definite clinical or laboratory evidence of residual thyroid cancer.
3) Euthyroid on TSH suppression therapy.
4) Refractory obesity and uncontrolled non-insulin dependent diabetes mellitus.
5) Treated post surgical hypoparathyroidism by Rocaltrol and Calcium replacement.

Laboratory investigations and/or procedures indicated:

TSH = 0.06; Free T4 = 23; Free T3 = 4.4; Anti-thyroid antibodies = negative; Ionized calcium = 1.16; PTH = 1.8; Thyroglobulin by an ultrasensitive method = <0.1 (undetectable); pc Glucose = 11.5; Hemoglobulin A1c = 0.084 (normal < .059 showing poor diabetic control); Urine Microalbumin/Creatinine ratio = 0.4 (WNL); pc Cholesterol = 4.5; Serum electrolytes = WNL; Creatinine = 82.

Management Recommendations:

1) Continue Synthroid .175mg 5 days/wk and .15mg only 2 days/wk.
2) Continue Rocaltrol 0.5mcg one daily and Calcium 650mg bid.
3) Continue Coversyl 8mg daily for control of hypertension.
4) Contact regarding poor diabetic control with inadequate weight reduction and low carbohydrate diet as well as continuing Metformin 500mg x 2 bid but will also require adding Januvia 100mg daily to determine if this will improve the diabetic control.

Follow-up Recommendations:

Contact for a follow-up 3-6 months to stabilize. Subsequently should you wish further assessments please do not hesitate to request a consultation next year.

Thank you for referring this patient and if there are any further details you require, please contact me.

Sincerely yours,

Paul G. Walfish, C.M., O.Ont., M.D.

Mount Sinai Hospital
Department of Medical Imaging

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Tel: (416) 586-4411
Fax: (416) 586-5967

DR. PAUL G. WALFISH
600 UNIVERSITY AVENUE
TORONTO Ontario CA M5G1X5
DEPARTMENT OF MEDICINE

Patient: **KRELL, BRUCE F** **M.R.N.:** **903344372**
Location: DI **Birth Date:** Jan 25, 1956
A#: **000128197** **Performed:** **Nov 10, 2000**
Procedures: Nuclear Medicine: I-131 Metastatic Survey **Visit #:** 2001134718

Clinical History: 80 millicuries of I-131 administered on November 3, 2000.

Residual activity is seen in the thyroid bed.

No suspicious foci of increased activity are noted.

INTERPRETATION: Residual thyroid activity. No evidence for distal metastases.

Dictated by: STANIETZKY, NIR **Reviewed with: HENDLER, AARON**

Transcribed: Nov 11, 2000

***** END OF REPORT *****

cc:

MOUNT SINAI HOSPITAL

Final Summary

600 University Avenue
Toronto, Ontario, Canada, M5G 1X5
Telephone: (416) 596-4200

Transcribed by Health Records Services
Telephone: (416) 586-4597

MSID #:	903 344 372
Last Name:	KRELL
First Name:	BRUCE
Date of Birth:	1956/01/25
Sex:	M
Visit ID #:	2001 - 128408
Visit Type:	SD
Room #:	1735
Atten. MD:	DR. PAUL WALFISH

Admitted:	**2000/11/03**
Discharged:	**2000/11/06**

Final Diagnosis:

1. **Radioactive iodine remnant ablation therapy**
2. **Hürthle cell thyroid cancer**
3. **Post-surgical hypothyroidism after total thyroidectomy**
4. **Co-existing iritis and sacroiliitis problem**

This 25-year-old man, who presented with recurrent cystic hemorrhagic thyroid nodule underwent total thyroidectomy on July 27th, 2000. The final pathology indicated a class I Hürthle/papillary thyroid cancer, class I with no extrathyroidal extension. In preparation for radioactive iodine therapy, he was withdrawn from L-T3 therapy and placed on a low iodine diet. He was admitted to receive on November 3rd, 2000, a radioactive iodine therapy dose of 88 mCi, and was isolated until cleared for discharge by Nuclear Medicine. Several days after discharge, a regular diet and L-T3 therapy was administered, while continuing on calcium and Rocaltrol therapy for post-surgical hypocalcemia. Follow up will be arranged with a total body scan one week after discharge and then further management at the Mount Sinai Hospital Endocrine/Oncology Clinic, Dr. P. G. Walfish, at regular intervals until stabilized on long-term L-thyroxine suppression therapy.

PAUL WALFISH, MD., FRCPC
Senior Consultant, Department of Medicine and Endocrinology
Head/Neck Oncology Program
Authenticated 10 days after distribution date

Dictated by:	Paul Walfish MD*, FRCPC
Dictated:	2001/05/05 17:46
Transcribed:	2001/05/09 15:06
Distributed:	2001/05/10 12:09
Event Type:	T
Job #:	9422 hb
cc:	Dr. D. Virbrager, 9019 Bayview Ave., Toronto, ON Jeremy L. Freeman, MD*

Dr. P. Walfish
& Gl

PATHOLOGY AND LABORATORY MEDICINE
MOUNT SINAI HOSPITAL
600 University Avenue, Toronto, Ontario, Canada M5G 1X5
Telephone: (416) 586-4857 Fax: (416) 586-8628

Health Card#: 5205-619-157-XH
Facility:
Location: 11L
Room: P129
Physician: DR. JEREMY FREEMAN
Copies to:
Date of Procedure: 00/07/27

Medical Record#: 90334372
Case#: 2001061248

Last Name: KRELL
First Name: BRUCE
Date of Birth: 56/01/25 Sex: M
Date and Time of Report: 00/08/09 16:52

SURGICAL PATHOLOGY REPORT SP-00-09928

Clinical history:
Thyroid mass

Specimen:
1) THYROID GLAND RIGHT LOBE
2) THYROID GLAND LEFT LOBE

INTRAOPERATIVE CONSULTATION:
IFS1: Cystic change with marked cellular atypia (BM)

Gross Description:

1. The specimen container labelled with the patient's identification and as "right lobe" contains a right hemithyroidectomy specimen that weighs 17.5 gms and is oriented with sutures. The specimen measures 4 cm SI x 2 cm ML x 2 cm AP and including the isthmus, which measures 2 cm SI x 1.5 cm ML x 0.5 cm AP. The external surfaces have fibrous adhesions. No parathyroid glands are identified. The margins are painted with silver nitrate. On section, the majority of the upper right lobe is replaced by a large cystic nodule that measures 2.5 x 1.2 x 1.5 cm and has a thickened white fibrous rim. The cyst lumen is trabeculated with adherent red soft material. The remainder of the cut surfaces show unremarkable thyroid parenchyma. A representative section of the nodule is frozen as "IFS1". The specimen is submitted in toto:

-1 IFS1 resubmitted
-2 to -10 right lobe from superior to inferior
-11 & -12 isthmus from right to left

2. The specimen container labelled with the patient's identification and as "left lobe thyroid" contains a left hemithyroidectomy specimen that weighs 5 gms and is oriented with sutures. The left lobe measures 3 cm SI x 1.5 cm ML x 1 cm AP. The isthmus measures 2 cm SI x 1.4 cm ML x 0.5 cm AP. The external surfaces have fibrous adhesions. No parathyroid glands are identified. The margins are painted with silver nitrate. The cut surfaces show no focal lesion. The specimen is submitted in toto:

-1 to -6 right lobe from superior to inferior
-7 & -8 isthmus from left to right

PATHOLOGY AND LABORATORY MEDICINE
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600 University Avenue, Toronto, Ontario, Canada M5G 1X5
Telephone: (416) 586-4467 Fax: (416) 586-8628

Health Card#: 5205-619-157 XL
Facility:
Location: 11L
Room: 1129
Physician: DR. JEREMY FREEMAN
Copies to:
Date of Procedure: 00.07.27

Medical Record#: 903344372
Case#: 2001061248

Last Name: KRELL
First Name: BRUCE
Date of Birth: 56.01.25 Sex: M
Date and Time of Report: 00.08.09 16:52

SURGICAL PATHOLOGY REPORT

SP-00-09928

Microscopic Description:

1. The thyroid contains a solitary Hurthle cell nodule that is largely infarcted with fibrosis and cystic change. The Hurthle cells show significant cytologic atypia but the tumour is well delineated and does not exhibit invasive behaviour. One perithyroidal lymph node is unremarkable.

2. The specimen consists of normal thyroid tissue and an unremarkable parathyroid gland.

Immunohistochemistry:

1. The Hurthle cell tumour exhibits focal staining for HBME-1 and ret and there is diffuse weak positivity for CK19 associated with stronger staining in the areas of degeneration.

DIAGNOSIS:

1. Hurthle cell papillary carcinoma with extensive cystic degeneration - Thyroid
   No pathological diagnosis - Lymph node, 1, perithyroidal
   - Right hemithyroidectomy specimen.

2. No pathological diagnosis - Thyroid
   No pathological diagnosis - Parathyroid
   - Left completion thyroidectomy specimen.

Code Summary:
M-82903 M-80503 M-30000

SYLVIA L. ASA, MD, FRCPC, PATHOLOGIST