case reports
THE CARE GUIDELINES

CASE REPORT

To encourage other practitioners to consider submitting a case report for the E – News, we have restructured the format in line with recommendations from July 2014 and have left in the key guides – should you be interested just e mail info@nutri-linkltd.co. We will send you the word doc.

Case reports are profesional narratives that outline the diagnosis, treatment, and outcomes of the medical problems of one or more patients. Information from case reports can be shared for medical, scientific, or educational purposes. They provide a framework for early signals of effectiveness adverse events, and cost. Case reports and the systematically collected data from which they are written also provide feedback on clinical practice guidelines.

Case Report of a 56 year old lady's long term fatigue, anxiety, detached state & palpitations resolve with targeted NT

Abstract. *Summarise the following information if relevant: (1) Rationale for this case report, (2) Presenting concerns (eg, chief complaints or symptoms, diagnoses), (3) Interventions (eg, diagnostic, preventive, prognostic, therapeutic exchange), (3) Outcomes, and (4) Main lesson(s) from this case report.*

This case explores a nutritional focused approach to the resolution of the associated symptoms of fatigue, anxiety, a detached state akin to feeling spaced out and separated from the world around her, dizziness and sometimes wooziness (physically out of sorts) as well as occasional heart palpitations in a slim 56-year-old lady.

Mrs S.W. had visited her doctor on at least five occasions in order to get help in addressing these symptoms over the past decade but had not been successful. The two medications prescribed had made her feel worse.

Investigations into her heart health had all proved that she was in good cardiovascular health. In spite of this, a beta blocker was prescribed but after two days, Mrs S.W. felt such an exaggerated sense of her symptoms she discontinued it. She recovered to her normal state of health within a few days. On another occasion, she had been prescribed an anxiolytic and it had resulted in similar sensations, a magnification of her existing symptoms so discontinued that after two days.

There was no diagnosis ascribed to the range of symptoms experienced by Mrs S.W. which increased the anxiety and worry. She could not tell her friends what was wrong with her so she simply put up with it, bottled it up inside and lived with it, but it certainly affected the way she led her life, as will be described below.

Mrs S.W. has a high quality of life, wanted for nothing and acknowledged that she had nothing about which to worry. Some years ago she had engaged a psychotherapist in order to address her anxiety but there was nothing in particular that arose from the weekly sessions over 3 months. S.W. also ate really well, slept well requiring about 9 hours a night. Although her blood pressure was low, this was never identified as playing a role in her anxiety, or other sensations. No one had yet to investigate any biochemical or biological contributors to her anxiety.

Key Words. *Provide 3 to 8 key words that will help potential readers search for and find this case report.*
Anxiety, detached feelings, spaciness, wooziness, fatigue, tiredness, lack of energy, palpitations.

Introduction. *Briefly summarise the background and context of this case report.*

Mrs. S.W. had been well for the whole of her life. She had a lovely family and many brothers (3) and sisters (3) with whom she had grown up. None had any issues other than induced by over-drinking (one brother) and overweight (one sister, probably due to poor food choice, carbohydrate addiction and over-eating). She had always been slim, just like her mother, and like 2 of her sisters, so there was no specific or obvious connection with her weight and the way she felt. Three of her close family members were of similar build and did not have the same symptomology.

S.W. had 4 children herself when she was quite young and had managed to cope reasonably well when bringing them up. However, she did report the onset of fatigue when she was about 40-41 years old which was somewhat ironic because this was when her children were more independent. Her youngest was 10 at this time. Since then she had been tired. She reported an absence of energy or fatigue almost every day. S.W. had accommodated by changing her lifestyle.

As time passed from 15 years ago to the current day, she had experienced an increasing series of symptoms which included a sense of detachment from reality, feeling woozy or spaced out, and an increased anxiety. She had first experienced continuous anxiety about 2 years ago, whereas the palpitations only first occurred 18 months prior. She had seen various doctors and specialists who could find nothing wrong, and the strong implication she picked up was that they thought it was all “just psychological” which made her clam up and not report how she felt to anyone.

She made a decision not to be depressed but admitted that she felt she could readily slide into such a state, which was made all the more possible by the uncertainty about her condition and the perception of being patronised by the doctors she had met.

The detailed case history revealed some common functional imbalances which responded rapidly to targeted nutritional therapy. Mrs S.W. recovered her cognitive functions, felt significantly better all round, and resolved completely being anxious or tired during the day. She has now re-engaged in all of the activities that she had been holding back from, some for years. She now understands that she had a functional and biological health imbalance which has been successfully rectified with nutritional therapy and that she has no need for any medication or psychotherapy.

Presenting Concerns. *Describe the patient characteristics (eg, relevant demographics—age, gender, ethnicity, occupation) and their presenting concern(s) with relevant details of related past interventions.*

Mrs S.W. is a 56 year old, evidently slim lady and mother of 4 adult children. She is a white Caucasian lady who was brought up in a catholic family, as one of 7 children. She is a housewife and lives at home with her husband.

She has never been hospitalised, nor has she ever been on medication for anything more than a course of antibiotics in the past (excepting the 2 medications as described above).

She has always been slim, and in this way is very similar to her mother and 2 of her sisters.

In the past 2 years, the medical intervention for her anxiety and intermittent palpitations involved a beta-blocker and an anxiolytic, both of which caused an exaggeration of her anxiety and wooziness and required a rapid cessation of both drugs. She did not return to obtain different medications. She was frustrated by the lack

of support provided and felt patronised by the doctors she met. She made a firm decision, however, not to let that affect her. In spite of her strong will power she still experienced the 'head' sensations.

No other family member experienced these symptoms.

Her husband was very supportive, however, and was very accommodating as their lives needed to be arranged in such a way as to prevent S.W. from being in a situation where she needed to be excused when in company. Since their lives involved regular social events this proved to be inconvenient but needed in order for S.W. "to get by". S.W. confided that 'white lies' were needed on occasion in order to hide the real reason why she could not attend a certain dinners or functions.

Due to the lack of diagnosis and understanding of the cause of her symptoms, S.W. felt embarrassed and ashamed of the way she felt and it compressed her self-esteem.

Clinical Findings. *Describe: (1) the medical, family, and psychosocial history including lifestyle and genetic information; (2) pertinent co-morbidities and relevant interventions (eg, self-care, other therapies); and (3) the physical examination (PE) focused on the pertinent findings including results from testing.*

S.W. had no medical history of which to speak. She had a robust up-bringing which had been explored in detail by the psychotherapist. She had been strong enough to have four children and they were all very well, now in their adulthood.

Her parents were alive and in good health. There was no obvious theme in terms of ill health in her family, and in the two instances where a brother and sister had diminished health, it was lifestyle related.

S.W. is an omnivore but rarely eats red meat, sometimes eats white meats, regularly has fish, and sometimes has cheese, for example. She eats a high plant food diet with vegetables at lunch and dinner. She rarely drinks any alcohol. When I conducted a review of her typical 3 days' food consumption, it was readily evident that she consumed too little protein, which I proposed would not be supporting her energy levels and likely other functions.

She is very comfortable in her life and does not want for anything, and she very much appreciates this. She spends much of her time working for charitable causes and travels to visit countries in which these charities operate. Much of the events and functions that she had used to attend were precisely the environment in which she felt the worst. This means a reduced level of responsibility in her roles which greatly saddened her, as she really valued the contribution she could make to these causes as well as the friendships of her friends and colleagues in those organisations.

The case history details were taken, as usual, in the form of questionnaires and a time-line health history and verbal questioning in the first appointment. The sections for the adrenals and thyroid in particular scored highly, and were suggestive of under-functioning adrenal and thyroid hormones. S.W. then told me that she had had a blood test 18 months ago and it was all normal and that this included thyroid function. My understanding was that her TSH was in the normal range and in my experience (& as is well appreciated) this does not automatically mean that her T4 and T3 were at optimal levels.

S.W.'s blood pressure was low at 84 / 48 with a pulse of 48. I double checked these figures and she confirmed that these were consistent with the last few years at any rate. A BP of 90 / 60 was a good day for her, she told me.

Timeline. *Create a timeline that includes specific dates and times (table, figure, or graphic).*

1959 - S.W. was born into a growing family.

1965 – S.W. was now one of 7 children, with 3 brothers and 3 sisters in a large catholic family, living in North London.

1987 – S.W. gave birth to the first of her 4 children.

1989 – S.W. gave birth to twins.

1992 – S.W. gave birth to her 4th child.

2002 – having been well for the whole of her life, and having regained her slim figure, this was the first year that she had felt under par. Fatigue was the hallmark of her reduced quality of health.

2003-4 – the fatigue persisted and she visited a doctor who described absence of pathology.

2012 – S.W. had first felt woozy and spacey and a sense of detachment from life.

2014 – S.W. began to experience more anxiety.

2015 – S.W. was anxious every day, had intermittent palpitations and her default state of health was one of feeling spacey, disconnected and fatigued.

2016 – S.W.'s sensations persisted and her life and lifestyle changed in order to accommodate the decline in her ability to function as before. Her whole family were very supportive and made the changes necessary. She could no longer join her family on the boat trips nor the longer car journeys in Europe that they had engaged in on a yearly basis. She was obliged to catch the plane and meet her family at the destination. These changes started in 2014 and she had not travelled with her family nor for the charities since then.

2016 – S.W. remained upbeat and very positive but was clearly very much affected by the impact of her health on her lifestyle and involvement with family matters and charity work.

Diagnostic Focus and Assessment. *Provide an assessment of the (1) diagnostic methods (eg, PE, laboratory testing, imaging, questionnaires, referral); (2) diagnostic challenges (eg, financial, patient availability, cultural); (3) diagnostic reasoning including other diagnoses considered, and (4) prognostic characteristics (eg, staging) where applicable*.

S.W. had a very low BP and combined with the strong indicators for a need for adrenal and thyroid support, my primary choice was to assess S.W.'s adrenal hormones with a salivary cortisol and DHEA test and a blood test for a comprehensive thyroid test (TSH, TT4, FT4, FT3 RT3).

However, S.W. reported that she needed to have some support right there and then due to an impending family trip to the Mediterranean on their yacht. This trip was a week away. If I could help her to feel strong enough for this trip then that would be her strong wish. She agreed that she would do the tests on her return.

She did not want to have to fly out to the Amalfi coast (Italy) on her own and await her family, as she had done in the 2 previous years.

I explained how it may very well not be possible to bring about any significant change in such a short time, and we agreed that the intervention would either work or it would not and then she could fly down to Italy as planned. In this way, circumstance led to no lab evidence of her adrenal hormone status and nor her thyroid hormone status.

I prepared some simple and limited recommendations for S.W. who ordered the supplements immediately after leaving the clinic room, to be received the next day. We agreed that S.W. would contact me to let me know the outcome once she was in Italy, via one route or another.

Therapeutic Focus and Assessment. *Describe: (1) the type(s) of intervention (eg, preventive, pharmacologic, surgical, lifestyle, self-care) and (2) the administration and intensity of the intervention (eg, dosage, strength, duration, frequency).*

There were a handful of recommendations for S.W. which were specifically aimed at supporting her adrenal and thyroid hormones.

Firstly, in terms of her diet, I recommended she consume a protein food at each meal, a reasonable portion that would provide at least 20 gm of high biological value protein. This was to support her adrenals and thyroid and overall energy and resilience.

I recommended that she add Himalayan salt to all of the water she drank to support her blood pressure to be higher than it currently was.

I then recommended 3 supplements. Licorice supports against a low blood pressure due to the fact the glycyrrhizic acid contained can have an effect on aldosterone which results in a renal retention of sodium. I also recommended a whole adrenal glandular to be taken 3 times during the day to support her adrenal output. I also recommended a thyroid glandular to support her thyroid hormone levels and function.

First Supplement Programme	
Licorice Solid Extract (ARG)	Half tspn at breakfast time & at lunch time
Adrenal Natural Glandular (ARG) (whole adrenal glandular, 300 mg)	1 with breakfast, 1 at lunch and 1 at 5pm
GTA Forte II (BRC)	1 with breakfast & 1 with lunch

13 days later, I received a text message from S.W. who did not have access to a computer whilst on holiday in Italy. She had succeeded in travelling by boat (the yacht) all the way to Italy without having to be dropped off because she could not cope with the rigours of such a trip. Her family were all 'amazed' at her sudden improved health and strength and energy. She had not experienced any of her symptoms except at the end of the hard day on the boat. However, she was recovered in the morning time, after sleeping well. She had managed the 6 day trip which had been unthinkable just a week or so beforehand.

We had a brief telephone appointment from Italy on the day before she was due to head back to the UK, which was about a month after we had first met. She was in such good spirits and kept on telling me over the phone what a transformation there had been, and when could her husband and at least one of her children come for

an appointment. She had even walked up the incredibly long stairs from the sea to the top of the coast on the island of Capri. She had a new lease of life, she declared. We agreed to meet in August.

However, when it came to August S.W. had gone on another trip so we only met in September for the first follow up.

S.W. reported that she had been having some reappearance of her symptoms (fatigue, spaciness) which brought her to tears thinking that she had found her good health again only for it to slip away. It was a very emotional meeting for S.W. I checked that she was eating as I had directed, and was adding the salt to her water and she confirmed this. I then decided to make a few subtle changes to the supplements and for her to report back to me in a matter of 4-5 days (given the speed of the effects of the first programme).

I added a low dose, but active form, B vitamin formula which I have found clinically effective for nervous system support and for energy levels, particularly when taken during the day. I asked S.W. to stop the licorice for now. I then exchanged the previous adrenal glandular (whole) for a neonatal glandular which I am aware has a stronger effect than the non-neonatal one she had been taking.

Second Supplement Programme	
Bio-3B-G (BRC)	3 with each meal (9 per day)
Cytozyme AD (BRC) (whole adrenal glandular, 80 mg but neonatal source)	1 with breakfast, 1 at lunch
GTA Forte II (BRC)	1 with breakfast & 1 with lunch

S.W. texted me in 4 days after she had commenced the second supplement programme and we established a telephone consultation that evening. She told me how she had completely recovered her energy and her head was clear and there was no wooziness at all. She was relieved, naturally. We agreed to have another teleconsult in a week's time to ensure that she was still feeling 'better', with good energy and an absence of any spacey feelings or dizziness and so on.

We spoke in a week's time and she had been consistently well and just as she had been whilst on holiday in Italy and the Mediterranean and the boat trips. She repeated to me how in awe her family had been to see her in this kind of form given the previous two years of withdrawal from so many activities she would normally have engaged in.

In October, we met for the third time S.W. reported that she was back to a state of good health with energy and clear mental focus and good vision, no spaciness at all. She had measured her BP which was 98 / 64 which was as high as it had been that she could recall. Her pulse was 59 bpm. Her weight remained the same.

I recommended she continue with the existing supplements and for us to meet in December before she travelled again.

S.W. was thrilled and delighted to be able to engage in her charity work, in events with her husband and family and have the get up and go to do the things she wanted.

Supplement Information
Licorice Solid Extract (ARG)
¼ tspn provides 1.5 gms of licorice extract providing 4:1 extract, supplying 150 mg of glycyrrhizic acid - which inhibits 11B-HSD enzyme involved in the catabolism of cortisol to cortisone, thereby resulting in a longer

duration of action of cortisol. Licorice can also result in an increase level of aldosterone thereby influencing BP, and caution is required when taking BP with patients who may have too high a BP as a result of taking it.

Adrenal Natural Glandular (ARG)
A bovine glandular (lyophilized) from free range & grass fed cattle, from the whole adrenal gland, supplying 300 mg per capsule.

GTA Forte II (BRC)
A hormone free thyroid glandular with accessory nutrients for the thyroid. It is one of the most effective supplemental supports for thyroid hormone function that I have used.

Bio-3B-G (BRC)
A low dose but active form B vitamin formula (4 of the B vits are in their active form). These nutrients support energy production and the nervous system in particular.

Cytozyme-AD (BRC)
A neonatal glandular of the whole adrenal gland, from animals owned by the USDA, providing more potency than glandulars from more mature animals.

Discussion. *Please describe (1) the strengths and limitations of this case report including case management, (2) the literature relevant to this case report (the scientific and clinical context), (3) the rationale for your conclusions (eg, potential causal links and generalizability), and (4) the main findings of this case report: What are the take-away messages?*

Strengths and limitations of this case report including case management
The detailed case history and questionnaires proved extremely useful in terms of identifying the needs of S.W. The adrenal and thyroid sections of one of the questionnaires scored very highly and pointed in this direction, which was then validated by the accounts of how she had felt and by her low blood pressure and pulse.

It was a shame that we did not obtain evidence of her cortisol, DHEA and thyroid hormones to see the before and after levels; before she started the supplements and after some time on them. However, she had such a distinct improvement that it was clear that the adrenal and thyroid support was a correct point of intervention.

The literature relevant to this case report
It was an understanding from clinical experience and education about the signs and symptoms of adrenal and thyroid dysfunction that led to the straightforward decision to support these hormones and glands, not medical or scientific papers on the subject. SWs rapid improvement confirms, the functional needs of these tissues and their impact on health despite the absence of pathology.

The rationale for your conclusions
The evidence of S.W.'s symptoms and signs was compelling in this case to implement adrenal and thyroid support, as well as the addition of complex salt to support her BP.

The main findings of this case report: What are the take-away messages?
This case highlights the place for a wholistic, functional medicine perspective with an appreciation of sub-clinical symptoms and signs in the absence of disease (as far as we know) for which medications may have no place or be very low on the list of requirements.

For me, as her NT, I learned that even when there are chronic symptoms of sub-clinical adrenal and thyroid hormones, they may be resolved in a very short time when the appropriate interventions. Knowing the effect and impact of a range of supplements that support the adrenals proved vital. Although it is not certain, I believe that S.W. had a requirement for the whole adrenal glandular (medulla and cortex) as opposed to simply the cortex glandular that I use with most patients who have an adrenal need. The neonatal glandular has a very supportive effect and has promoted her recovery.

The licorice is not a direct adrenal gland support nutrient but provides the adrenals a reduced need to produce cortisol. In this way, the licorice provides an opportunity for the adrenals to recover.

Patient Perspective. The patient should share his or her experience or perspective of the care in a narrative that accompanies the case report whenever appropriate.

S.W. has been thrilled to have regained her health beyond any level she thought possible. She has told everyone she knows.

Informed Consent. *Did the patient give the author of this case report informed consent? Provide if requested.*

The patient is not aware her case history is being used, and all identifiable data has been removed. S.W. are not her real initials.

Case Report Submission Requirements for Authors

1. Competing interests. *Are there any competing interests?*

None Known

2. Ethics Approval. *Did an ethics committee or Institutional Review Board give approval? If yes, please provide if requested.*

This case was not presented to an ethics committee.

3. De-Identification. *Has all patient related data been de-identified?*

All patient data has been re-identified

4. Author. *Name of Author and practice*

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