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 65 year old lady who loses weight & improves her energy & joie de vivre with 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 approach to the resolution of a number of health conditions in a semi-retired 65 year old lady, Mrs. G.C., including the achievement of weight loss, increased energy, improvement in her respiratory health and recapturing her 'joie de vivre'.

Mrs. G.C.'s summarised her health status her own words. She told me "I'm a fat, old, tired, depressed woman with no interest in life, or sex". She currently had no diagnosis, other than her almost-lifelong asthma which she managed with ventolin.

At just over 14 stones in weight and with a height of 5 ft 4 inches Mrs. G.C. was technically obese with a BMI of 33.1 (a score of over 30 is termed 'obese'.) Being obese puts one at raised risk of health problems such as heart disease, stroke and type 2 diabetes. Losing weight has been identified as an outcome that will bring significant health improvements.

Mrs. G.C. is not alone in being overweight; it is universally recognised that populations in the westernised world are increasingly overweight or obese. In March 2015 Simon Stevens, Chief Executive of NHS England said: "Obesity is the new smoking. It is a slow-motion car crash in terms of avoidable illness and rising health care costs."

According to estimates from Public Health England, two thirds of adults and a quarter of children between two and 10 years old are overweight or obese. Obese children are more likely to become overweight adults and to suffer premature ill health and mortality, and by 2034, 70 per cent of adults are expected to be overweight or obese.

Research has highlighted that the food choices we make are more relevant to obesity than the genes we inherit, and in this way are not prisoners of our genes.

This case is one account of how this 65 year old woman lost weight and felt an much better in herself, by making specific food choices & taking supplements as recommended by an experienced NT.

Key Words. *Provide 3 to 8 key words that will help potential readers search for and find this case report.*

Obesity, weight, fat, depressed, tired, fatigue, asthma, joint pain, heartburn, constipation, wheat, gluten.

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

Mrs. G.C. presented with numerous long term health complaints. She attended the appointment with her husband (her second) in order to try to find a way of feeling better. She had been referred to me by her husband's employer, who had himself benefited from nutritional advice, but lived over 100 miles from London. She rarely travelled more than the few miles to do the shopping, let alone take the trip to the capital.

Mrs. G.C.'s goals help to express the state of health in which she found herself:

1. To have more energy
2. To lose at least 2 stone of body fat
3. To have more interest in daily life
4. To get sex back on track
5. To get my bowels sorted out
6. To be free of painful joints
7. To see life in colour
8. To be free of infections

She had been very aware of her poor state of health for some time (years) and had been meaning to do something about it, and so took the opportunity at the recommendation that she come to visit his RNT in London.

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 G.C. is an English, Caucasian woman with all known ancestors being born in England. She is a mother of 3 children, all now adults. She lives with her husband in Somerset, on a small farm, and does some part-time desk work for her husband's employer who runs a local factory.

Mrs. G.C. presented with many long term health issues. She disliked her physical being because she was overweight, she felt tired almost all of the time, she felt depressed and had no motivation to get up and do anything. Her painful joints definitely did not help matters. G.C. also stated that her digestive system did not work properly, suffering from a variety of symptoms including constipation & heartburn, for which she had been prescribed an antacid.

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.*

Mrs G.C.'s mother had suffered from arthritis and was also overweight, but this only really had been evident in the latter years of her life. She had died of a stroke aged 78. Her father had died young, aged 59, from a heart attack, just weeks before her first son had been born, over 30 years ago. He had smoked all of his life,

however. She recalls that her grandparents lived until their late seventies, but did not know what their health status had been.

Mrs. G.C. has suffered from asthma since childhood and then later had regular bronchitis. She had smoked, as many as 15 – 20 cigarettes a day since her teens but had stopped during her pregnancies and breast-feeding and then given up altogether about 24 years ago, at 41. The bronchitis was strongly associated with the smoking. It was at this time, somewhat ironically, that her health deteriorated, which is detailed in the timeline below.

Two years after she had stopped smoking and her health had declined, she was identified as having an underactive thyroid and was put on thyroxine which she had been taking ever since. However, even with a dose of 150 mcg daily this had not made any difference to her symptoms.

Her first marriage had been an unhappy one. She had two children with her first husband and one with her second husband. It was difficult for Mrs G.C. to express how much stress she had been through in that first marriage, but her tears and facial expression and body language conveyed enough to see that this had had a big impact on her life and health.

On a review of her medications it was learned that she had also been prescribed an antacid; omeprazole, and she was taking a small aspirin (75 mg) as well as citalopram and thyroxine.

She had regular but not frequent blood tests to monitor her need for thyroxine, but she had no idea what the tests were since they were kept on her file with her GP. She told me that she had told her Dr that the thyroxine had not made any difference to how she felt, and that she was tired all of the time, but was not given any other help.

She met the doctor every 6 months or so to review the anti-depressant medication;citalopram, which she had been taking for over 4 years. She had taken a variety of other anti-depressants for many years prior to that. She did not like taking it, and it was not really benefiting her in any way.

Diet
Mrs. G.C.'s diet consisted of two meals a day; she had not eaten breakfast for many years. She drank 5 cups of coffee a day and very little water, ate bread or some form of wheat with each meal, ate packaged or ready meals about half of the time (lack of energy & interest led to this), drank the odd glass of brandy, and did not like eggs or any fish except tuna and salmon but they had to be tinned. She did eat vegetables of some kind every dinner time.

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

She had been ill as a child and had also been unhappy for much of her childhood.

Her father had passed away just weeks before her son was born. Her first marriage was a very unhappy time for her. She had two boys with her first husband and a girl with her second husband. Since the birth of her third child, G.C. had suffered from depression in varying degrees and had been on a number of different anti-depressants since 1979.

G.C. described her life as muddling along, and she never had a sense of well-being since she became a mum of three, which was also quite close in time to when she had stopped smoking permanently.

She had suffered from asthma as a child and had been prescribed ventolin for many decades.

She used to smoke 15-20 per day but stopped promptly in 1991 (she understood its risks with asthma!). At this time, she gained weight, became bloated, constipated and felt very tired all of the time.

In 1993 she was started on thyroxine having been identified as having hypothyroidism, but the taking 150 mcg of thyroxine had never any appreciable difference to her symptoms.

Since the late 1990's, G.C.'s joints began to hurt and now she had pains in her knees, ankles, hips and shoulders. The discomfort was present every day and moved around at random.

She had also suffered from long term bronchitis which had improved to some degree with the cessation of smoking, but her chest was still her weak point and she readily caught infections.

For the past 5 years her sex drive had dropped to zero and she had no interest whatsoever.

She took no exercise at all.

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*.

I examined the diet diary that Mrs. G.C. had provided for me, along with the detailed questionnaires she had completed in advance of the first appointment. She and her husband, who accompanied her to the appointment, were both adamant that she did not overeat, and he could not understand why she did not lose. It is true that the volume of food she consumed was by no means excessive, and in fact represented approximately 1,200 kcals a day when I made an estimated calculation for one day.

I noted the high coffee and wheat intake which, in my opinion, needed to be managed.

In tears again, she reminded me that she was a fat, old, tired & depressed woman with no interest in life.

Her husband insisted that they could afford to meet for a number of appointments, in spite of the fact that Mrs G.C. appeared unwilling to spend money on herself. Ultimately, however, Mrs. G.C. followed a variety of supplement programmes over 5 months and now continues to take the maintenance programme as shown below. We met a total of five times face to face, and had email contact in between as well as since the last meeting. We also had several phone calls.

There were no lab tests recommended.

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).*

The strategy was to remove foods or drinks that were inappropriate and to increase foods that were more favourable for her vitality (i.e. more veg and wholefood).

Given her medications and the length of time she had been feeling this way, she needed to make changes that were significant enough to make a difference.

With her motivation being low for anything, in spite of her husband's support, there was a need to make a difference in a short period of time in order to help maintain compliance because I anticipated that she would need to maintain changes over a period of many months and then continue with healthy eating for her remaining years.

Without any need for testing, I decided to make these changes to G.C.'s diet. I asked her to reduce coffee from 5 per day to 1 cup only, with that cup being at breakfast time. I also directed her to avoid all wheat completely. This was because it was a large component of her diet, she ate it at every meal and because she had digestive, energy and mood issues, all of which could be influenced by wheat. Furthermore, the logic dictated that she needed to make a significant change to whatever she had been doing for decades.

I asked her to find a herbal tea she liked and have this and water throughout the day.

I asked her to eat a protein at each of the two meals she had, which she often did, but to limit this to a single protein so as to support optimal digestion of that protein.

I taught her about the insulin response to carbs and reduced her carb intake and emphasised the importance of vegetables telling her that they contained the most vital energy.

If she ever felt like a snack, I replaced the orange and banana she may have had, with biscuits to a sliced, chilled pear with sprinkled cinnamon. She did not like nuts so this was not an option anyway.

The first supplement programme for 5 weeks was this:

First Supplement Programme	
Stabilium (ARG)	4 with breakfast
Stamina Caps (BRC)	1 every 3 hours from 8 am til 5 pm (i.e. 4 per day)
Meda Stim (BRC)	1 with each meal (i.e. 1 with lunch & 1 with dinner)

G.C. arranged a call with me just 3 days after the first appointment. My initial thought was that she wanted to seek clarification over something, perhaps wondering if a certain food was wheat free for example. However, this was not the case. Nor did she want to tell me how bad her headaches had been from reducing the coffee from 5 cups to a single one. She wanted to tell me just how amazing she felt in just 3 days of being wheat free and from reducing the coffee, and eating two meals only and no snacks and from taking the supplements for 2 days.

She reported that a heavy and thick veil had been lifted off her head and she had mental clarity like she didn't know she could have. She lost 2 lbs in weight and had been urinating frequently. Previously, she could have dieted for two weeks and gained a pound. That diet or those diets had never asked her to be wheat free and they had not regulated the coffee intake either. Her energy was not so much improved as the fact that the troughs in her day were now no longer present! She used to grab a nap in the afternoon and now she noticed that for these 3 days it was not needed. She still had a long way to go to improve her energy, it was true, but the lack of the head-dropping sleepiness in the day was a great result so early on. She told me that her life

already had more colour in it, and she recognised that she had been living in grey for so many years. She wept on the phone.

This fantastic start was as much as I could have hoped for, given the many decades of less than ideal health combined with decades of health issues and metabolic imbalances.

As you might imagine, the compliance to the advice was now 100%. A sliced, chilled pear with sprinkled cinnamon was the only snack she consumed if she needed one.

However, this was not the only contact I had with G.C. before the first follow up appointment. She emailed and texted about 10 days later reporting that she had an unbearable headache. She had maintained one coffee a day, and therefore I believed that it was due to the avoidance of wheat. She took painkillers which made the headache only marginally more bearable. She said her head felt like it was in a vice and her neck was like a stiff plank. This lasted for 6 days, during which time she was confined to her bedroom. I explained that this was most likely a transient withdrawal type reaction, the reasoning for which was supported by the rapid symptomatic benefits after she had stopped all wheat. We kept in touch, via her husband, who called the emergency doctor for a home visit.

The high of the early few days had come crashing down for almost a whole week. Naturally enough, the husband challenged me about the supplements and whether they could be causing the headache. I reassured him and strongly recommended that she continue them at this time so as to best support her and also not to introduce another variable (i.e. the stopping of the supplements). I explained how the length of time that his wife, G.C., may have had a negative reaction to wheat may have been for years and the pain on withdrawal may be a compressed reflection of that reactivity, with a release of inflammatory immune complexes leading to inflammation and pain. Towards the end of the 6th day, the vice like grip was relinquished and she could see a light at the end of the very painful tunnel.

On the morning of the 7th day after the headache began, it went away, leaving her feeling like she had a bruised brain. A week after that and it was a distant memory, and she still maintained the same nutritional intake, which confirmed that it was nothing that she was currently consuming, and therefore had to be something she had avoided.

We met after 5 weeks for the first follow up, and about two weeks after she had emerged from the splitting headache. G.C. had experienced further improvements after the pain episode, and she had lost more weight, had an increased level of energy, improved her pallor, her bowels were improving and she felt warmer in general. Her joint pains had not changed much at all, and strangely had not really worsened during the week of pain. I recommended a collagen powder, Arthred, for her to take and this served as at least something she could consume in the morning, which was an intention – that she start eating something for breakfast.

Second Supplement Programme	
Stabilium (ARG)	4 with breakfast
Stamina Caps (BRC)	2 with lunch & 2 at 5 pm
Meda Stim (BRC)	2 with lunch, 1 with dinner
Arthred Collagen Powder (ARG)	1 scoop first thing, 1 scoop before dinner

We met again 6 weeks later and never was there a drama like the week of pain again. She felt like she had been pulled through the barbed wire hedge backwards. She had me explain what had happened a number of times and I did my best to convey what mechanisms were likely involved and their consequences. Curiously, she

never really had any cravings for bread or wheat, which I find is very common. Perhaps the negative effect of it outweighed any transient endorphin-like effect it might have elicited.

G.C.'s weight kept on dropping, even though she was eating the same amount of food as before. She had a much more balanced energy and it was gradually improving. The colour of her face and skin had become more flesh like and less grey, and everyone who knew her had commented on it. She had lost her depression which she noticed one day and realised she had been without it for a week. This was between the 2nd and 3rd appointments.

Her joints still pained her but perhaps less than before, and on investigating their nature more, I learned that she had muscle pains that she had referred to as joint pains. He pattern was akin to that of fibromyalgia, although I did not tell her such. It did prompt me to consider that this may be a factor and may also have explained the reason why the pains did not worsen when the splitting headache was present. FM is not an inflammatory condition, although it may be triggered by inflammation. It requires amongst many interventions a comprehensive set of antioxidants, according to Dr Marty Pall who has focused on this condition for a number of years.

Her bowels were moving daily now which she could hardly believe.

The third supplement programme was ironically more numerous than the first or second, and yet she was feeling so much better, almost a different person. It included FibroBoost (ARG) a specific antioxidant which I have found to be the most effective product to counter FM aches and pains, and whey protein which was to be added to yogurt, which she could tolerate, and some berries for a smoothie to have at breakfast.

Third Supplement Programme	
Stabilium (ARG)	2 with protein smoothie (breakfast)
Stamina Caps (BRC)	2 with smoothie, 2 with lunch & 2 at 5-6 pm
Meda Stim (BRC)	2 with smoothie, 1 with lunch
Arthred Collagen Powder (ARG)	1 scoop in the smoothie & 1 scoop before dinner
FibroBoost (ARG)	2 caps 30 mins before smoothie and 2 caps 30 mins before dinner
Whey Protein Isolate (BRC)	2 scoops in natural yogurt with a handful of berries

We then met after a further six weeks with two email contacts in between. In one of them, she said that she was so pleased that her husband's boss had recommended her to visit me, even though she lived over 100 miles away.

She expressed how she wished she had met me many years before, which is something that I am sure other NTs have heard from patients. It crossed my mind that we may not have been here had it not been for the marked improvement in the first week. If there had been no change and then the week of pain, she may have given up on it all and never achieved the state of health she was moving towards now.

The news had spread to everyone who knew her and it was acknowledged that it was a miraculous change. She had lost over 2 stone by this stage and looked completely different. Her energy was so much better and lasted all day, and she was so much more productive. A few of her friends had also booked appointments as a result.

The only change in the fourth supplement programme was my decision for Mrs G.C. to stop the Arthred powder.

Fourth Supplement Programme	
Stabilium (ARG)	2 with protein smoothie (breakfast)
Stamina Caps (BRC)	2 with smoothie, 2 with lunch & 2 at 5-6 pm
Meda Stim (BRC)	2 with smoothie, 1 with lunch
FibroBoost (ARG)	2 caps 30 mins before smoothie and 2 caps 30 mins before dinner
Whey Protein Isolate (BRC)	2 scoops in natural yogurt with a handful of berries

We then met after just a month of the fourth programme and I was then able to reduce the schedule to a maintenance programme, and her aches and pains had reduced by 50% so we kept on with the FibroBoost (ARG). For a woman who had never taken supplements before and did not like to take pills, G.C. was now completely convinced they had made a massive difference to her health and wanted to keep on taking whatever it took to maintain the way she felt. As with all patients, I explained that the ideal was to find the lowest level of supplementation that maintained health improvements.

Fifth Supplement Programme	
Stamina Caps (BRC)	2 with lunch & 2 at 5-6 pm
Meda Stim (BRC)	2 with smoothie, 1 with lunch
FibroBoost (ARG)	2 caps 30 mins before smoothie
Whey Protein Isolate (BRC)	2 scoops in natural yogurt with a handful of berries

We have had email contact since and at the time of writing she has lost over 3.5 stone (50 lbs in fact). She had changed her clothes, changed her hairstyle, has much more colour in her cheeks and can be found smiling most of the time, a far cry from before she attended her first appointment. Her husband ate wheat free too and he had stopped all caffeine and alcohol and felt better too. He has also asked me to give him advice on what supplements he could take.

Mrs G.C. was and is quietly obsessed about avoiding all wheat and therefore has not been an ideal guest on occasion, when she did not eat a meal that was served to her at friends' houses for fear that there may have been wheat flour in the gravy or sauce. We agreed that having been so very poorly she was utterly determined to remain as well as she could and catch up on lost time, as far as her health was concerned. She was very appreciative and kept thanking me, and I had her acknowledge that whilst I had made the recommendations she was the one who implemented it every day.

Mrs G.C. now has a smoothie every morning and eats very well at the two other meals and rarely needs a snack. She drinks plenty of water and herb teas and has a cup of coffee 3 – 4 times a week.
She is virtually free of all pain, has been infection free and appears far more immunologically resilient and experiences a high quality of life.

She has stopped all medications, including her ventolin (which she reduced & then stopped of her own accord) and citalopram (which she discussed with her doctor) except her thyroxine.

This case shows you that just because you are in your sixties it does not mean that you cannot make BIG improvements in your health.

The elimination of one of the most common 'culprit' foods resulted in major health changes for Mrs G.C., and the supplements helped to restore her energy and then resolve her aches and pains. Her weight, skin colour, mood, energy and bowels all returned to the healthiest that she could ever remember having.

The early 'amazing' improvements kept Mrs G.C. going through the worst week of pain in her life, and both were attributable to the same thing – the avoidance of wheat. None of this could have been achieved with anti-depressants, pain killers or any drug at all.

Lastly, and it is not a subject that a 65 yr old wants to talk about at all, but I did find out that the more delicate issue was also back on track.

Supplement Information

Stabilium (ARG)
Contains a high concentration of small peptides similar to pituitary and hypothalamic stimulating peptides which act as hormone precursors to neurotransmitters such as GABA, encephalins and endorphins which can all support the nervous system and help to adapt to stressful conditions. It has been used clinically to support 'get up and go'.

Stamina Caps (BRC)
This formula provides thiamin, pantothenic acid, L-Carnitine, octacosanol, coenzyme Q10 & OOrganik-15™, which may serve to aid in energy production and to increase stamina. In my clinical experience this formula has made a positive contribution to energy and also helped to stabilise appetite too.

Meda-Stim (BRC)
A vegetarian formula of nutrients designed to convert T4 into T3. Useful in many weight loss programmes and does not alter TSH levels.

Arthred Powder (ARG)
A patented, pre-digested collagen powder that has been proven to reduce articular joint arthritic pains and reduce the need for pain medications. In addition, it has also been useful to heal the gut lining and support skin health.

FibroBoost (ARG)
A clinically trialled natural sea-vegetable derived antioxidant that is 40% fat soluble and remains active in the body for 12 hours, some 24 times longer than most water soluble antioxidants. It has been studied and found to improve fibromyalgic pains and improve sleep and energy, (and sex function too).

Whey Protein Isolate (BRC)
Cold-processed whey protein from Biotics Research. Supplies the highest BV protein, together with active immunoglobulins. This product also support glutathione levels and supports the majority of phase two hepatic detox conjugation pathways.

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 careful listening to the patient was vital in this case. This was helped by the completed questionnaires and summary health history of her life. Specifically, the assessment of her diet in terms of caloric content and specifically what she was eating and drinking helped to lead me to make what turned out to be very pertinent changes.

As with many cases, there is potential for a number of lab tests to be conducted including a food reactivity test and an adrenal hormone test. In this instance, I chose for a clinical exclusion diet approach.

The literature relevant to this case report
In and of itself, there is no mass of medical, scientific research which highlights the connection between weight gain and wheat consumption but there has been an awareness of this in lay publications for many years, even decades. In the same way, there is not a mass of research connecting wheat consumption with the other health complaints that Mrs G.C. experienced. However, again, there are an increasing number of books written by doctors on the subject including Grain Brain by Dr David Perlmutter and Wheat Belly by Dr William Davis.

The rationale for your conclusions
The decisions made were relatively straightforward because of the experience of what impact wheat and gluten can have on a person's health. It was also evident that Mrs G.C.'s over-consumption of tea and lack of food before lunch-time were less than ideal. So, in my professional opinion, these things are very straightforward decisions for all NTs to make. It is a shame that they had not been spotted sooner, as she said herself.

The main findings of this case report: What are the take-away messages?
There are three main take-away messages form this case report. Firstly, it is never too late to make a very real positive difference in someone's health, no matter how old they are.

Secondly, the food we eat has a significant impact on all aspects of health and if there are multiple imbalances in health then look to change what is being eaten in order to influence many aspects of health. The calories we consume are not linearly linked to body weight by any means; a calorie for one person may not be the same calorie for another.

Thirdly, the impact of therapeutic supplementation cannot be overlooked in how it can benefit someone's health, particularly when health conditions are chronic. They help to support the nutritional intervention so that the therapy achieves a threshold level of impact (i.e. makes a real difference to the person).

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.

Mrs G.C. was in a state of disbelief at the change in her health. She is now coming to terms with what has happened.

She could not thank her husband's employer enough, for it was he who had made the recommendation to come and see me for nutritional advice.

Interestingly, G.C.'s husband, who already had a very good relationship with his employer, now reported that there is a different quality to that relationship, one that includes a deep appreciation for being involved in helping his wife achieve a level of health he had never yet seen in all the years he had known her. It has changed his life with his wife completely.

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. G.C. 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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