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.

Acute Eczema Resolves 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 focused approach to the resolution of a case of a female patient who was hospitalised and then diagnosed with acute and severe eczema which became infected.

Eczema is characterised by itchy, erythematous, vesicular, weeping, and crusting patches of the skin. The term eczema is also commonly used to describe atopic dermatitis or atopic eczema, and in some countries dermatitis is synonymous with eczema, while in other languages dermatitis implies an acute condition and eczema a chronic one.

The term eczema is broadly applied to a range of persistent skin conditions. These include dryness and recurring skin rashes that are characterised by one or more of these symptoms: redness, skin swelling, itching and dryness, crusting, flaking, blistering, cracking, oozing, or bleeding. Areas of temporary skin discolouration may appear and are sometimes due to healed injuries. Scratching open a healing lesion may result in scarring and may enlarge the rash.

Eczema can often affect the hands and the face, as well as the crooks of the elbows and knees.

Medical treatment is typically with moisturisers and steroid creams and if these are not effective, creams based on calcineurin inhibitors can be used. In 2010 the disease was estimated to affect 230 million people globally which is 3.5% of the population. Eczema is a relatively common presenting sign in those seeking help from Nutritional Therapists.

In the past 10 years it has been identified that bacterial infections can contribute to the condition, especially that of Staphylococcus aureus. The percentage rate of positive cultures in those with atopic dermatitis eczema has been as high as 97.5% or higher in studies conducted since 2005.

It is also documented that herpes simplex virus is the cause of eczema in at least a subset of patients with the condition. It is possible that in some patients there may be multiple infections that activate each other magnifying the expression of one or more of the bacteria or viruses.

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

Eczema, dermatitis, broken skin, inflammation, redness, dryness, antibiotics, stress, eczema herpeticum, Staphylococcus aureus, herpes virus.

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

Miss C.H. sought my help after having been hospitalised recently for severe eczema and after receiving oral and IV antibiotics and was using steroid cream. She remained in hospital for 3 nights.

Miss C.H. had experienced some eczema some 20 years before this outbreak but this was a very different manifestation, and the historical eczema resolved within a week but with a 'healing crisis' after taking homeopathic remedies. C.H. had not experienced any eczema since, so it was quite a surprise that it should be so severe. This current outbreak was also rapid in onset. Within a single week, her skin changed from being quite normal to being very red, swollen, itchy, very dry and broken. The broken skin probably explained the infection which responded to the IV antibiotics, followed by a course of oral antibiotics. Her eyelids and skin around her eyes to the side and upper cheeks were markedly swollen - C.H. showed me photographs of how she looked, and she was barely recognisable as the woman that sat opposite me.

All over her body she had dry skin, it was worse on her face, but also in the crooks of her elbows and behind her knees and on her hands and to some degree all over her body.

Due to the success of the homeopathic intervention 20 years ago, and given that she still lived in the same area and the same homeopath was still in practice, she sought his help. However, after two weeks of treatment, admittedly alongside steroid creams and oral antibiotics, there was no sign of any change, even though she was overall much improved compared to the first day she presented herself to hospital. Her mother had a good friend who had been a patient of mine so she and her daughter, C.H., decided to seek nutritional advice.

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.*

Miss C.H. is a white, Caucasian, London-born and bred woman of 31 years of age. She is 5' 5' (165.10 cm), and weighs 9 stone 12 lbs (61.33 kg). C.H. lives with her husband in Greater London, close to her parents and where she was brought up, and travels a short distance to the school at which she teaches five days a week.

Her two brothers live within a 10 mile radius and her sister lives an hour away, so she has a relatively close-knit family, and she stays in touch on a weekly basis with her family.

C.H. faces the daily stresses of teaching, which she found considerable, she was also in charge of and organising a fund-raising event at the school for all parents and children which required a significant amount of time of each week. The event was two and a half months away from the first appointment, being at the end of November 2014 and the pressure was perceived by her to be all on her own shoulders even though there was a school committee which she headed.

Other than these obvious stressors in her life, she was extremely happy.

Not surprisingly, she told me, she felt tired most evenings, and this was usual, she would typically 'crash' for the first week or two of holidays, and had been living her last 5 years in this pattern.

As a child, aged 11 years old, C.H. had suffered relatively minor eczema on a single occasion and had visited the nearby homeopath who had prescribed some pillules. They had brought her out in a bad rash and worse eczema for a few days and then it subsided and did not return. Her family was very much into modes of natural healing and so understood that there could be Herxheimer type reactions and rarely had the need or inclination to visit their GP.

At the time, there was no need to investigate or question anything else such as diet or lifestyle or infection as the eczema fully resolved. The whole family ate the same food and all were fine, so this overall wellness prevented any questions about what foods may or may not be involved in C.H.'s health or skin condition.

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.*

Medically speaking, C.H., along with her family as she grew up, had all been in robust health. She had moved to a small apartment within 2 miles of her parents when she started to teach and now shared that with her husband of one year, although they did plan to move into a larger flat within the next year.

Her parents were fit and well and her grandparents had only relatively recently passed away in their late 80's and early 90's. They had been quite well until later in life, and had died from heart disease (strokes / heart attacks). All of her family were and are relatively lean, and tended to be on the leaner side of average weight, with long toes and fingers. C.H. did tell me that her brothers had allergies to cats and dogs but this rarely occurred so it was not something she often thought about. She, however, seemed to be asymptomatic in the company of the country's most common pets.

C.H.'s skin certainly appeared dry and as if she had had eczema all of her life, with varying shades of redness or dry white patches. This was the aftermath of antibiotics and steroid creams, she told me, and again we had a look at the photos of what she looked like a few weeks before.

C.H.'s blood pressure was normal, her pulse was a little raised at 72 bpm but this could readily have been due to the initial meeting and talking about her recent need to be in hospital, which meant missing some school time at the beginning of the start of a new academic year, which was itself a source of distress.

All other aspects of her health, including her digestive system appeared to be normal and well.

The additional burden of organising the fund-raising event for her school was the only out-of-the-ordinary thing in her case, when applying the magnifying glass of the detective to see what antecedents, mediators and triggers may be present. Stress, or excessive stress, could have had a role in compromising her immune system and then this somehow manifested in the presentation ofeczema was the most obvious line of enquiry.

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

In 1994, when she was 11 years old, C.H. had a very short period of time when she suffered from eczema which was resolved with homeopathic remedies. She had had the usual childhood illnesses and had hardly ever needed antibiotics.

From 1994 to 2005, C.H. had been in pretty good health, with nothing remarkable. As she had begun to do her teaching practice and start her teaching, she had become more and more sedentary and had given up any organised team sports that she had played and then no longer played any individual sport nor did she keep fit, other than walking which she did do every week.

From 2005, C.H. began her teaching career, and experienced the stress of this job. She stated that she always needed the holidays to get over the stress and fatigue of term time. However, she had not been ill and had recovered with more sleep and rest, which appeared to be a common theme in the Common Room at school.

From 2005, whilst C.H. had not been 'ill' from the stress or fatigue of her work, she had certainly caught the colds brought in by the kids in her class and at school, just like every other teacher she knew. However, it did seem that C.H. was quite resilient and hardly ever had to take a day off school, which she really did not like to do, although she did tell me that she would sometimes dedicate whole weekends to staying in bed to recover enough so that she could make it to class. She did really love her work and the children in her class. The kids were aged from 9 to 12.

In 2013 she married her long-time boyfriend, and continued to live in the same small apartment with a view to moving into a larger one in the near future.

June & July 2014
Whilst engaging C.H. in this time-line, she appeared to have a revelation, and she told me that in June this year, just a few months ago, a child in her class had been asked to go home because he had shingles. Then, shortly before the beginning of the summer holidays, a girl had also had to go home with a bad 'flu. At that time, C.H. had felt like she caught that 'flu and spent the first week of the summer holidays at the end of July either in bed or on the sofa. Her ability and familiarity with resting at this time anyway had perhaps helped her to overcome the 'flu sooner than perhaps otherwise might have been the case. She never planned to travel in those first few weeks anyway.

August 2014
At the end of August, C.H.'s skin manifested in sudden onset eczema and upon seeing her GP 2 days into the episode, she was referred at once to hospital because of the multiple areas of broken skin and the evident risk of infection. By the time she got there later that day, only 3 days into the condition, her whole face swelled up, her body shape changed and she became even itchier and felt very unwell. It transpired from culture tests that she was suffering from a Staph aureus infection. The IV antibiotics had already been administered, however, and she was on the road to recovery. She was given oral antibiotics and steroid creams as well, along with Aqueous Cream.

Two days later, whilst still in hospital she had returned to the recognisable picture of herself. She spent a further day being monitored and was then allowed to go home, but not to school which had just started.

She did return at the start of the second week of term, in the second week of September 2014. She sought my advice towards the end of September 2014, two weeks after leaving the hospital.

The recommendations and progress made are described below.

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*.

At the first meeting, C.H. and I spent over an hour together, and I had already read the detailed questionnaires about her health and a bullet point summary of her health and the paragraphs she had written about her recent experience. She had not had more than a 2 minute conversation with any doctor at the hospital and only a 4 minute one with the GP that referred her to the hospital in the first instance. A sound recommendation that turned out to be, given the way her face and body had swollen up with the Staph aureus infection.

On checking out of the hospital there had been no conversation about her condition, what had caused it, what to do in the future and so on. It was all a whirlwind, and whilst she was very grateful for the care she had received, there was no engagement with anyone of the 15 or so medical staff with whom she had shared time. C.H. was clueless as to what had happened and why.

She was now under the explicit impression that she had caught a Staph aureus infection and this had caused her eczema.

On going through the time-line she realised that she could not have had this infection when she was 11 years old and in this sense this was largely irrelevant to her very recent experience. She could not understand why or how she had caught the bacteria. On tracking back, she identified the two children that had needed to go home and stay away from school, one with shingles and one with bad 'flu, the latter she had caught, she thought. However, she had overcome that, and why or how that might have turned into eczema. The affected child had not had eczema.

We reflected on the development of the eczema, which had been a dramatic process, and on how her skin was now, since any patch that she omitted to rub the steroid cream on became angry and red again. She had had no contact with her Dr and was dutifully applying the steroid cream and Aqueous Cream, but had now finished the oral antibiotics. She told me she had eaten live yogurt every day in an attempt to correct the negative impact of the antibiotics in her gut.

On careful examination, not literally of her actual skin, but on how her skin was without the steroid cream, it appeared that the eczema would return within a matter of hours. We initially thought that the Staph aureus had been resistant to the antibiotics, but C.H. had been told that both skin culture and blood culture had shown that its presence was no longer. There was something else involved.

The presence of the herpes zoster virus in this child with shingles could have been a factor, and I wondered could be a viral factor involved, as well as the Staph aureus. C.H. had never had a cold sore and was not aware that she had the herpes virus in any form up until this incident. I recommended that her GP conduct a blood test for HSV-1 and HSV-2 since she was meeting him the next day for a check up. The GP did the tests and within 3 days the results came back with raised antibody levels indicating a current infection of HSV-1.

The focus of the nutritional intervention for C.H. was on inhibiting the herpes virus with dietary and supplemental means. This is described below.

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 nutritional programme that she followed was specifically geared at inhibiting the herpes virus, but also at supporting her innate immunity too.

The first nutritional programme which C.H. commenced on the last day of September, a Tuesday, involved NOT eating her favourite peanut butter, which she used to enjoy every day, to eating less fruit than she had been used to, and to swallowing natural supplements designed to inhibit the virus. She persisted in the short term with the steroid cream, to which I agreed, since otherwise her skin was going to break out.

Each meal was carefully discussed and the healthiest options within her repertoire of meals were selected, and alternatives to snacking on fruit and peanut butter were found. Nuts and seeds are richer in arginine than lysine and therefore potentially food for viruses.

Here are the specific supplements C.H. took in the first phase.

Programme One Supplement Name & Brand	Dose
Humic Acid (ARG)	1 caps with each meal
ProLive (ARG)	1 tab with each meal
L-Lysine (500 mg) (ARG)	1 caps in between meals, mid a.m. and mid p.m.
Immuno-GG (BRC) (colostrum)	4 caps with breakfast & dinner
S. Boulardii (ARG)	1 caps with each Lysine capsule, away from food
Evening Primrose Oil (BB) (1,300 mg)	2 softgels with breakfast & dinner

Follow-up and Outcomes. *Please describe the clinical course of this case including all follow-up visits as well as (1) intervention modification, interruption, or discontinuation, and the reasons; (2) adherence to the intervention and how this was assessed; and (3) adverse effects or unanticipated events. Please describe (1) patient-reported outcomes, (2) clinician-assessed and -reported outcomes, and (3) important positive and negative test results.*

October 2014
We met in early October, a month after C.H. had started the nutritional programme. She had faithfully abided by all of the recommendations.

She had used the steroid creams where necessary, and this had been needed in the first few weeks. At the start of the third week C.H. discovered that she could use less and less of the steroid cream to achieve the same effect. She then began experimenting with omitting the cream on certain patches of her skin and they did not flare up as they had done. By the time she saw me, she was only using a face-only steroid cream and only intermittently.

The EPO is a seed oil but does not contain a source of arginine. Omega 6 fatty acids are vital for the skin, and especially in cases of eczema, and much more effective and important than omega 3 fatty acids.

C.H. had not had any experience of Herxheimer-type symptoms. She was working just as hard as usual, and the impending fund-raising event was drawing closer, and the stress was mounting. She was religious about the

supplements. She understood that if she took them all and it worked that she would not longer need to do so; that this was not a forever programme.

The dose of the colostrum and the oil of Evening Primrose were halved, as C.H. was making progress.

Programme Two Supplement Name & Brand	Dose
Humic Acid (ARG)	1 caps with each meal
ProLive (ARG)	1 tab with each meal
L-Lysine (500 mg) (ARG)	1 caps in between meals, mid a.m. and mid p.m.
Immuno-GG (BRC) (colostrum)	4 caps with dinner
S. Boulardii (ARG)	1 caps with each Lysine capsule, away from food
Evening Primrose Oil (BB) (1,300 mg)	1 softgel with breakfast & dinner

We agreed to meet after four weeks.

We met at the very end of October 2014, and C.H. proudly rolled her sleeves up and showed me her flawless skin in the crooks of her elbows. Her face was eczema free, and steroid cream free too. She had not used any at all for at least two weeks. She looked really well, although she admitted she was tired and stressed a bit more than usual given the event in the following month to raise funds for the school and local community.

Her GP had examined her physically and declared that he could not see any sign of eczema and was very pleased with the outcome. He recalled that the viral tests were positive and C.H. told him that she had taken some anti-virals that were recommended by a 'consultant' and he accepted that, unaware that these were non-drug remedies recommended by a Nutritional Therapist. C.H. made a judgement call in the less-than-10-minute appointment not to go into the detail with her GP.

We reduced the schedule of supplements which is what she continues to take. This schedule permits her not to have to take anything to school which is practical.

Programme Three Supplement Name & Brand	Dose
Humic Acid (ARG)	2 caps with breakfast & dinner
ProLive (ARG)	1 tab with breakfast & dinner
Evening Primrose Oil (BB) (1,300 mg)	1 softgel with breakfast & dinner

C.H. has had comments from others that she looks very well from those who have no idea of what she has gone through recently, and recognised that the EPO is probably helping her to have healthier skin than she had before. The intention is for C.H. to continue with the current programme beyond the fund raising event which is a source of stress and she cannot on any level afford to be unwell from any virus in any way before or during this event.

Additionally, since she has been promised a holiday by her husband at Christmas time, she told me that she wanted to continue beyond that time so that she can enjoy what will be the first summer holiday in Winter time of her career.

C.H. was delighted with the outcome and the ability to resolve her skin condition and prevent it from recurring. She was also extremely pleased to be in a position to be free of medications of all kinds which she really did not like at all, something her whole family share.

We plan to meet in January 2015 to review her needs.

Supplement Information

Humic Acid (ARG)
2 capsules contain 750 mg of humic acid. Humic acids are the organic components of soil, peats, brown coals, shales, and lake sediments, formed from decomposed plant material. This humic acid can bind to cell surfaces with no adverse effects on the cell itself or on cell growth, and can stimulate normal, healthy resistance and immune response. In clinical terms, this humic acid can bind to viruses and inhibit their replication, which results in potent anti-viral activity. Do view these articles on our website: 'Great Moments in Humic History' and 'Earth's Gift: Ancient Soil Deposits Yield Potent Antiviral Potential'.

ProLive with Antioxidants (ARG)
Olive leaf possesses a variety of properties which potentially support balanced intestinal microbiology & circulation. Of particular relevance to this case, olive leaf extract has anti-viral properties.

L-Lysine (ARG)
This amino acid has been nick-named 'herpes killer', and is a supplement I have used for the past 20+ years as a means of controlling outbreaks of cold sores and other herpes related infections. I have used this with many patients over that time and found consistently good results with supporting a capable immune response for inhibiting herpes virus outbreaks.

Immuno-gG (BRC)
Colostrum has proven its worth in countless patients. It can help to reduce intestinal inflammation, to heal the gut lining and promote a stronger immune system. Colostrum is of importance in the majority of those patients seen with immune compromise of any kind.

S. Boulardii (ARG)
The well-known probiotic yeast that supports SIgA levels, and can also reduce inflammation, and is the choice probiotic to counter clostridium species, and protects the GI tract from potential negative effects of antibiotics.

EPO (BB)
Evening Primrose Oil 1,300 mg – provides 10% of its fats as GLA. Each person varies in how they respond to fatty acids and in this case C.H.'s skin fared well whilst using the EPO. The LA in EPO is also an important structural fat in cell membranes in skin cells.

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 main strength of this case lies in the ability to spend time with the patient, C.H., and to listen to the time-line and history and also to the immediate situation of her skin condition when not taking the steroid cream.

Then there was a rapid ability to access serum antibody testing which was fortuitous and speedy ability to implement an anti-viral programme. It is not known what may have occurred had she not sought and found the help that ultimately completely resolved her eczema.

There are a few limitations, which include the length of time that C.H.'s skin has remained well. The longer her skin is free from eczema the better. There are also other aspects of her nutritional status which could be tested and corrected if out of balance and this includes her vitamin D status, her SIgA levels, her gut flora, and her WBCs too. There may also be a burden on her body of food sensitivities which is common in those with eczema, which includes dairy products (casein, lactose) and wheat and gluten. These may be contributory factors to a lowered innate immunity, possibly involved altered intestinal permeability, but this remains unknown at this time.

The literature relevant to this case report
There is a solid body of evidence linking both Staph aureus and the herpes virus to eczema or dermatitis conditions. It may be the case that C.H. suffered a bout of eczema herpeticum.

The rationale for your conclusions
The careful detail of the case history revealed that in spite of the dramatic improvement in her skin with IV antibiotics, and the confirmed presence of Staph aureus in her skin, there was a rapid re-emergence of eczema within hours of stopping the steroid cream. This alerted C.H. and me to other causative factors, which could still have been Staph aureus, but helpfully the hospital tests confirmed its absence, leaving another hitherto unknown cause still at large.

With the exposure to a member of the herpes family from a child at school, followed by a viral 'flu in recent times, and the knowledge that eczema can be caused by a herpes virus, the decision to have antibodies measured was a straightforward one. On finding the positive results, the action plan was akin to many others that I have engaged in over the past few years in order to address this, or any other, virus.

The main findings of this case report: What are the take-away messages?
In my opinion in hindsight, it is the careful case history taking, the time spent with the patient with careful listening, and pursuing avenues of conversation that reveal the truth about what is going on that are the real lessons. Certainly a degree of knowledge of the causes of eczema was helpful, and yes, the knowledge of an effective anti-viral nutritional programme proved to be of great value. However, this was all secondary to identifying the need for the viral anti-body test.

As has been already stated, it was fortunate that the patient was visiting her GP the very next day and that he was amenable to recommending the test.

It would appear likely that increased stress lowered C.H.'s innate immune system sufficiently that she a virus infected her. This was followed by another infection, a 'flu, which may have enabled the herpes virus to get a hold within her body. Then, the stresses described lowered immunity sufficiently for the herpes virus to manifest itself in the skin, at the same time as a bacterial infection, Staph aureus.

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.

C.H. was unaware of the causes of her eczema. However, she had the information in her own health time line story to reveal what the causes must be. The medical intervention appears very much needed, and she appreciated their help, but it was as if she were "just another body".

The nutritional solution to her eczema and the blood test evidence of the viral antibodies and the ability to stop the steroid cream combine to help C.H. all the more appreciate of natural non-drug medicine, and she is so convinced of its efficacy she is gladly following the programme for the coming months to ensure she is well during a very busy time for her, and so that she can be well to enjoy a holiday in the sun this Christmas.

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. C.H. 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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