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.

Dumping Syndrome 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 patient diagnosed with, and experiencing multiple symptoms of, 'Dumping Syndrome'.

Dumping Syndrome is associated with post bariatric surgery. Approximately 10% of those who have had gastric surgery experience this. The condition is also referred to as Gastric Dumping Syndrome or rapid gastric emptying, which refers to a condition where ingested foods bypass the stomach too rapidly and enter the small intestine largely undigested.

The small intestine expands too quickly due to the presence of hyperosmolar contents from the stomach. This causes symptoms due to the fluid shift into the gut lumen with plasma volume contraction and acute intestinal distention. "Early" dumping can occur within 15 to 30 minutes from ingestion of a meal. Symptoms of this early dumping include nausea, vomiting, bloating, cramping, diarrhoea, dizziness, and fatigue. "Late" dumping happens one to three hours after eating. Symptoms of late dumping include weakness, sweating, and dizziness. Late dumping symptoms are a consequence of a reactive hypoglycaemia, which results from an exaggerated insulin and glucagon-like peptide-1 release. Many people suffer both types.

The diagnosis of dumping syndrome can reliably be made with the aid of a provocation test using 50 g glucose orally.

Whilst the syndrome is most often associated with gastric bypass surgery, it is not a conditional pre-requisite.

Medical treatment involves dietary measures and then the use of acarbose, a starch blocker, and inhibiter of alpha glucosidase. Acarbose is often added for patients with hypoglycaemia, whereas several studies advocate guar gum or pectin to slow gastric emptying.

Another treatment is octreotide which acts through its inhibitory effects on insulin and gut hormone release, a delay of intestinal transit time and inhibition of food-induced circulatory changes. Its long-term use is somewhat limited by side effects, particularly diarrhoea and steatorrhoea.

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

Dumping Syndrome, hypoglycaemia, rapid gastric emptying, distention, bloating, diarrhoea, fatigue.

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

Mr R.H. had been struggling with digestive symptoms for over a decade. Over the prior 9 months, however, the immediacy of his symptoms after eating had worsened and he had sought specialist help. With a gastroenterologist assessment, he was diagnosed with Dumping Syndrome.

In spite of engaging in the recommended dietary and lifestyle changes R.H. had not experienced any noticeable improvements. He had been prescribed Acarbose but this had not suited him, so it was stopped after two weeks.

R.H. had dedicated some time and effort to research his condition and was fluent in the basics of macronutrients and understood the possibility of food intolerances / sensitivities. He was aware of the connection with sympathetic stress and admitted that stress at work and home no doubt contributed to his disruptive, uncomfortable and often distressing symptoms.

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.*

Mr. R.H. is a 33 year old caucasian man from the south of England, close to London. R.H. is 6 foot tall (182.88 cm), and weighs 11 stone 2 lbs (69.33 kg). R.H. lives with his partner 20 miles from central London, and commutes to work in the City.

R.H. had experienced bloating in his stomach and abdomen for as long as a decade, when he first started full time work after university. He had known for some years that if he wanted to feel well and be free of abdominal discomfort and be able to feel comfortable in his trousers, without needing to undo his belt, then he would be best not to eat anything at all. The trouble with this is that he then often felt tired and then he tended to over-eat at the evening meal, after which he crashed and fell asleep on the sofa, only to have to wake up, get up and go to bed properly.

Certain patients take some time to seek advice or help about their health condition and R.H. is a good example of this. He is male, young, and quite fit, and generally has been in good health for all of his life until his digestive symptoms started when he was about 23 years old.

In more recent years, in addition to the distention of both stomach and abdomen after eating any meal, R.H. had suffered from cramps and then sudden onset fatigue with a concomitant inability to concentrate and be productive at work. For this reason, he learned fast that the only way to get through the day and function in his stressful job was to NOT eat anything.

In the past few years R.H. had experienced diarrhoea which prompted his first visit to his G.P. He had been given a diagnosis of I.B.S. and some anti-diarrhoea medication but this had not helped at all. On a second visit some months later, R.H. had been told that he had stress related IBS and was prescribed an anti-depressant, which he did not take. Whilst he did not disagree with the assessment that he was under stress, he simply did

not believe that anti-depressant would resolve the symptoms which were completely resolved when he did not eat.

Six months ago, however, R.H. sought further advice and was referred to a gastroenterologist. The diagnosis was made by the consultant verbally and then supported by a 50 gm glucose test. R.H. received dietary advice which essentially was for him to eat refined food, no raw food, and to chew his food at least 25 times before swallowing, alongside the drug Acarbose. He felt very odd, light-headed and dizzy after taking Acarbose, and his diarrhoea worsened, so the medication was stopped.

He followed the food recommendations and had relaxed before he ate and chewed his food well, and did not allow any raw food such as salad or a piece of fruit past his lips. However, his symptoms remained almost identical.

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, R.H. was just fine and 'normal'. His haematology and CBC were all within the medical normal range, although the MCV and MCH were elevated in the normal range which was suggestive of a potential need for vitamin B12, and possibly folic acid. This standard blood testing does not seek to find markers associated with insulin levels, other than triglycerides and cholesterol which were both normal. This suggested neither insulin resistance nor excessive insulin response in spite of his post-prandial fatigue occurring 20-30 mins after eating. This happened after eating anything, as far as R.H. could tell. Perhaps this was why the medication Acarbose was not well tolerated.

None of his family, including his parents and two brothers and one sister had any digestive complaints. His father was overweight and experienced a myocardial infarction at the age of 55 and was now on a beta blocker and statins – he was 61 years old. His mother was anxious most of the time, but this did not affect her gut functioning or symptoms. She was quite thin and found it difficult to put on weight, but she was always on the go. His brothers both worked in London and they were fine in their health, even though they also had stressful jobs. His sister worked as a teacher and whilst she also found the job stressful, this did not cause her any GI upset, except she did report to her brother, R.H. that if she did not eat anything at lunch time then her belly was flatter and felt less bloated in the evening time.

R.H. was a little underweight. He knew this but found it difficult to put on weight. His abdomen and stomach felt sore if palpated and when they were distended. He needed to undo his trousers on the train home and to cover this up; he told me that he wore a light-weight sweater so that he could hide this from view. His bowels moved after each meal he ate, and he often needed to go again upon arriving home in the evening. If he ever went out after work then he would often need to find the bathroom at the start of the evening as well.

R.H. had become more and more keen to resolve his GI symptoms and described himself as 'desperate' to make a difference since it was ruling his life. His specific goals were to be free of diarrhoea after eating, be free of stomach and abdominal distention / bloating and to be able to feel fine after eating.

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

In 2004, R.H. first noticed digestive symptoms, the same year that he commenced working for the first time in London, after leaving university.

In 2005, R.H. was learning to become accustomed to symptomatic reaction to eating. His stomach and abdomen used to get bloated and he had discomfort if ever the size of the meal was larger than moderate.

From 2007, R.H. experienced additional extra-gastrointestinal symptoms after meals which included sudden fatigue and loss of brain power and concentration. R.H. learned that he needed to avoid eating lunch so that he could make meaningful contributions in meetings in the afternoon.

In 2008-11 R.H. found ways to manage and live with his symptoms but, interestingly, he did not investigate his condition nor make any dietary changes to determine if specific food change would make a difference. He had been told by his GP very clearly that food volume was the issue and that he would need to learn to live with it, but that his condition had nothing to do with allergy or intolerance or a specific food trigger. R.H.'s experience matched what he had been told and he therefore believed this. He was also one of those people who did not have an inclination to explore his own health issues.

From 2011-2013 R.H.'s symptoms were daily and entrenched, and he found that skipping lunch was the only reliable way to be free of symptoms of all kinds. However, this led to fatigue and weight loss that was challenging to reverse, in spite of over-eating in the evening.

At the end of 2013, R.H.'s diarrhoea became urgent and occurred within minutes of eating any meal. He sought medical advice and this was when he was referred to the gastroenterologist and was diagnosed with Dumping Syndrome. In spite of now having an understanding of the nature of his condition, it made no difference to his symptoms. The related advice about lifestyle and diet, relaxation before eating, and the thorough chewing of food made no difference.

R.H. made the decision to seek help from complementary medicine, which he did in January 2014. R.H. attended follow ups on a monthly basis for 6 months.

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, R.H. showed me that the formal letter written by the gastroenterologist which described the diagnosis of Dumping Syndrome and also indicated the prescription for Acarbose. There was also a copy of a blood test (haematology & CBC) which revealed low potassium levels and slightly low levels of WBCs. A gastroscopy had come back negative and H. pylori antibody tests in serum were also negative.

R.H. was now ready, after so many years to make a change in his health, which meant that he was prepared to do anything. He had no restrictions financially and told me that he could implement anything on a practical level, especially since living with his condition meant he had to make daily sacrifices. His time however, may be limited due to his work commitments.

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).*

January 2014
Based on R.H.'s long history of gut symptoms, his lifestyle and food likes and dislikes, but also accounting for his preparedness to do anything that it took to resolve his bowel urgency and diarrhoea, dietary changes and specific supplements were recommended.

R.H. had yet to ever engage in an elimination or exclusion diet but I recommended a 100% wheat free diet, combined with healthy eating hygiene, which was a reiteration of the medical / dietetic advice he had received. R.H. consumed relatively little dairy (cow's products) and this was not addressed in the first instance. Protein was recommended to be consumed in the first 5 mouthfuls of each and every meal. At this stage, there was no recommendation that R.H. ate lunch, since this would only result in his feeling fatigue and needing the bathroom again.

I also recommended these supplements to R.H. to take on a daily basis.

Programme One Supplement Name & Brand	Dose
Mastica (ARG)	1 caps 20 mins before each food intake
GamOctaPro (BRC) protein powder	1 rounded tbspn in liquid 20 mins before each food intake
Sano Gastril Lozenge (ARG)	Suck & chew 1 lozenge 20 mins before each food intake
Lactobacillus P, R, S (ARG)	1 caps 20 mins before each food intake
Kristazyme (PMN) (enzymes)	1 caps with each meal

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.*

February 2014
R.H. met me a month later. He had followed the instructions to the letter, and his partner had also been involved in the process and had also joined him in wheat free eating when they ate at home or together. She was extremely keen for R.H. to achieve his health goals for him and them both, because his symptoms really did rule both of their lives to some extent.

Breakfast had been transformed from a daily wheat dominant meal into a protein first meal with a non-grain carbohydrate where possible. R.H. had tried a whole variety of proteins from eggs, to chicken to fish, to last night's meatballs with quinoa pasta. He had eaten kippers and potatoes and Spanish omelettes. He was narrowing down the ones he liked the most and the ones that were most practical.

R.H. had taken the supplements before his two meals each day.

In terms of R.H.'s symptoms, he reported that he sensed a shift in the timing of his symptoms, which he still had. His belly still distended after eating, and he still needed to move his bowels after a meal, and he still had diarrhoea but something felt like it was less severe a process, with subtly less urgency. He and his partner had been looking out for any change to occur and whilst they were disappointed in one sense, they were also heartened in another. The number of years that he had been affected made is extremely unlikely that he would see any rapid improvements, and they acknowledged this, and this is why the sense that he had of a more delayed reaction in gut and with less uncomfortable bloating maintained his and their motivation to continue.

The very same supplements were recommended for the second month.

March 2014
R.H. attended the third appointment with his girlfriend, and they both appeared to be happy and enthusiastic to report what had occurred during the previous month.

R.H. had continued to follow the dietary recommendations, had continued to relax before eating and to chew food well and to take the supplements 20 mins before the two meals he ate during the week and the three meals he ate at the weekend.

The supplements had tended to make him less hungry and he had to take extra care to ensure that he consumed sufficient calories so as not to lose weight. However, he also reported that his physique had changed. Whilst he weighed the same weight, he had lost fat and gained muscle and this was noticeable to himself and his girlfriend. The amount of exercise had not changed, and R.H. said he felt it was the combination of consuming the GamOctaPro soy protein (BRC) as well as eating more protein at breakfast.

However, this was all minor news compared to what they told me next.

R.H. had experienced a lack of a need to have a bowel motion after eating on more than a few occasions, and in particular in the two weeks prior to this third appointment. He could not fathom the reasons for this, but it was very out of the ordinary.

His bloating felt less painful, and his fatigue after eating was less 'coma-causing' and more brain fog inducing. His energy levels were also better on a typical day.

In terms of the supplements, I made a change in the probiotic so that his programme consisted of these supplements.

Programme Three Supplement Name & Brand	Dose
Mastica (ARG)	1 caps 20 mins before each food intake
GamOctaPro (BRC) protein powder	1 rounded tbspn in liquid 20 mins before each food intake
Sano Gastril Lozenge (ARG)	Suck & chew 1 lozenge 20 mins before each food intake
BioBifidoBacT Powder (BRC)	1 level tspn 20 mins before two meals a day

Kristazyme (PMN) (enzymes)	1 caps with each meal

May 2014
We met again in early May, just over a month since the previous appointment. R.H. was alone this time.

He reported definite improvements. Although not predictable, he was not having to visit the bathroom so often, and he estimated that the need was about 20-25% less than before which was a definite blessing. His bloating was less dramatic and delayed in time, and he found that his cognitive function and energy were steadily improving, and less affected after a meal. He was so hopeful that this approach could continue and he could be normal, something he had not ever expected a few months beforehand.

He had eaten lunch at work on one occasion but this had not been well tolerated; he had needed to find a bathroom pronto and felt bloated and tired all afternoon. However, at the weekend, when he normally ate lunch anyway, he did feel less tired in the afternoon.

The colour of his stools had become darker, which he took to be a good sign. It suggested to me that there was more impact of bile within his GI tract.

The supplement programme was altered to omit the probiotic and to introduce a bile support supplement (Beta-Plus).

Programme Four Supplement Name & Brand	Dose
Mastica (ARG)	1 caps 20 mins before each food intake
GamOctaPro (BRC) protein powder	1 rounded tbspn in liquid 20 mins before each food intake
Sano Gastril Lozenge (ARG)	Suck & chew 1 lozenge 20 mins before each food intake
Kristazyme (PMN) (enzymes)	1 caps with each meal
Beta-Plus (BRC)	1 tab with lunch (if eaten) & dinner

June 2014
R.H. reported for the next follow up appointment a month after his previous one. He was committed to the process of resolving his digestive symptoms and to him this meant a monthly meeting to go through his signs and symptoms, what he ate, and what supplement he had taken, even though for the past few months, I had suggested meeting after 8-9 weeks in between appointments.

R.H. was successfully wheat free and although his family thought that it was absurd and frankly impractical for him to eat in such a way, they could see and hear from R.H. that he had experienced improvements like never before by abiding by such an approach. Most of the time, R.H. ate a gluten free diet, but he did have some oats and some barley extracts in some foods and so on, from time to time. There was no obvious manifestation of his symptoms at such times.

By now, R.H. reported that his urgent need to go to the bathroom was 50% better than before, when it had occurred 100% of the time after eating, and his bloating was about 50% less uncomfortable but still present.

His energy and brain function was better during the day but it still dropped after eating, which was mainly at weekends, when it did not matter so much.

The stool colour was darkening to a normal brown colour and this had occurred more rapidly after taking the Beta-Plus (BRC) supplement.

R.H.'s weight had also increased, and he had lost the more distinctive muscle definition but had gained weight and not lost any muscle. He was very pleased with this since it showed him he was digesting and absorbing food better.

The supplements remained very similar, but I recommended that he stop the Sano Gastril Lozenge now, after months on this product.

Programme Five Supplement Name & Brand	Dose
Mastica (ARG)	1 caps 20 mins before each food intake
GamOctaPro (BRC) protein powder	1 rounded tbspn in liquid 20 mins before each food intake
Kristazyme (PMN) (enzymes)	1 caps with each meal
Beta-Plus (BRC)	1 tab with lunch (if eaten) & dinner

July 2014
R.H. reported for 'duty' in July and reported continued improvements. He had developed an obsessive streak in himself in order to manage his condition, and he noticed how this characteristic served him well when it came to avoiding wheat and taking the supplements.

His bowel urgency was now not occurring after about 70% of the meals he consumed, and his bloating was much less drum-like and his abdomen was softer and less painful when palpated when it was bloated. He was now attempting small snacks for lunch at work and this was working for him, he told me, even though he was not taking the supplements before the snacks, only the meals (i.e. breakfast & dinner).

His diet was carefully reviewed, as at each and every appointment, to ensure that there was nothing obviously aggravating to his stomach. He ate wholefood, and his veggies were almost always cooked and very rarely raw, something he had been advised to do by the dietician. He still ate slowly and chewed his food well, and automatically he would relax and zone out for a few minutes before eating anything.

His weight was as high, and healthy, as it had been for many years, and this one fact confirmed to his mother that he was doing well, so he had her unconditional support as a result of this. He now weighed 11 stone 10 lbs, up 8 lbs from the first appointment, which was spread over his whole body, and not just around his waist.

The supplements were amended slightly, with a rationalised dose of GamOctaPro (BRC) and the Kristazyme (PMN) digestive enzyme. This programme was to be for 2 months because the next appointment was arranged for September 2014.

Programme Six Supplement Name & Brand	Dose
Mastica (ARG)	1 caps 20 mins before each food intake
GamOctaPro (BRC) protein powder	1 rounded tbspn in liquid 20 mins before the evening meal only
Kristazyme (PMN) (enzymes)	1 caps with dinner only
Beta-Plus (BRC)	1 tab with lunch (if eaten) & dinner

September 2014
R.H. had taken a holiday in August and it was unlike any other he had taken in a decade. He had not needed to search out the nearest toilet, he was much less pre-occupied with his health and he enjoyed a much more relaxed time than he could remember. He and his girlfriend had chosen a Thailand resort where they also knew that wheat-free food would be served, to make it as simple as possible to abide by his wheat-free diet.

The bloating was significantly less, so that he had even worn swimming shorts without a top or shirt. He had gone swimming in the pool with his girlfriend, something he had not done in the past because he so often looked 'pregnant' (in his own words). He reported a 90% improvement overall in all of his gut symptoms. His energy was good, and he could eat a small lunch with no adverse effects. His bowels were changed and he found that he had become a little constipated on occasion and for this reason I had recommended the use of a specific supplement to help with this.

The protein powder was stopped, and it was suggested that R.H. gradually, bit by bit, reduce the existing supplements over time to determine how he would feel as a result. He was resistant to this idea and naturally there was a positive association with having taken the supplements and his life-changing improvements. There was no pressure applied and he told me he would make the reductions over time when he felt comfortable with them.

He was also nervous about not seeing me in a month's time and I told him that if need be we could arrange an appointment at short notice should he need one, otherwise to meet in 2 months' time.

Programme Seven Supplement Name & Brand	Dose
Mastica (ARG)	1 caps 20 mins before each food intake
Kristazyme (PMN) (enzymes)	1 caps with dinner only
Beta-Plus (BRC)	1 tab with lunch (if eaten) & dinner

Supplement Information

Mastica (ARG)
A chios gum extract designed to coat the stomach and health the stomach lining. It is used to resolve H. pylori infections. Combined with the other supplements to be taken before meals, it was designed to reduce inflammation and help change the stomach environment in which there had been an automatic triggering of gastric emptying.

GamOctaPro (BRC)
A soy protein which, in this case, was designed to coat the stomach with protein and minimise a triggering of smooth muscle peristalsis and or insulin output, if this happened, and in the earlier months to ensure that R.H. was ingesting sufficient and digestible protein. Also the protein was designed to support sustained energy balance.

Sano Gastril Lozenges (ARG)
A unique soy bean derived fermented product producing lactobacillus bulgaricus LB51, designed to support the healthy production of protective gastric mucus. It can help to reduce inappropriate levels of stomach acid which could irritate the stomach lining and then trigger rapid gastric emptying. Usually it is employed to resolve heart burn or GORD (GERD). In this case, it was used as a stomach protective remedy.

Lactobacillus P, R, S (ARG)
The salivarius strain has a role to play in the stomach itself, and offers anti-inflammatory actions in the stomach and small intestine, thereby intending to minimise triggers that may result in the rapid gastric emptying.

KristaZyme (PMN)
A vegetarian digestive enzyme formula which a useful level of amylases to help digest carbohydrates properly to help support the production of SCFAs for R.H.'s gut lining.

BioBifidoBacT Powder (BRC)
A bifidus-only strain probiotic powder with cellulose in the powder not FOS or inulin, in order not to support inappropriate fermentation of growth of lactic acid favouring bacteria.

Beta-Plus (BRC)
Ox bile with pancreatic enzymes to support the digestion of fat and to encourage a healthy bile flow.

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
R.H. had been formally diagnosed after an appointment and investigation by a gastroenterologist consultant. On the one hand the Dumping Syndrome diagnosis appeared logical but the blood test results indicating the need for Acarbose appeared less than helpful.

There was no formal immunological antibody testing to identify that wheat was a problem food, but rather empirical experience that wheat is so often the most significant trigger food for gastric upset, let alone GI upset.

The elimination diet proved to be very helpful alongside the commitment of observation from the patient, R.H. and his girlfriend.

After many years of a non-involved state, R.H. had made a very strong commitment to resolve his long term gut issues, which was primarily prompted by almost immediate diarrhoea after eating.

The regular appointments over six months proved to be needed and helpful for R.H. Whilst there was little overall change to his nutritional programme over this time, each meeting built on the previous one and his ever-improving state of health.

The literature relevant to this case report
There is a paucity of literature to support the specific intervention that I recommended to R.H. Wheat is appreciated to be a source of a multitude of GI symptoms, but not necessarily from medical sources.

The rationale for your conclusions
R.H. had not engaged in much change at all over the prior ten years, and therefore there needed to be some significant change to his diet based on the ever-worsening of his symptoms, combined with the medical investigation that ruled out any observable pathology, for example, as well as the absence of H. pylori.

The support for the recommendations grew as each month passed by, as R.H.'s symptoms steadily improved.

The main findings of this case report: What are the take-away messages?
Whilst many thousands of patients have found their way into my consulting room with a prime motive being to ameliorate and resolve digestive complaints, few cases have presented in the way that R.H. did. He had not had any gastric surgery which is the most common precursor for the diagnosis of Dumping Syndrome.

In hindsight, I hypothesise that an intolerance or sensitivity to wheat resulted in daily and chronic and perpetuated rapid gastric emptying followed by stomach and abdominal discomfort, and then over time, rapid transit and then diarrhoea. The irritation and inflammation caused by the negative response to wheat needed to be addressed at the same time as the elimination of wheat. It is not know what might have occurred if the supplemental support had not been provided. In my opinion, there may have been no improvement and then an understandable lack of compliance by the patient, resulting in apparent failure of nutritional therapy.

Even without direct experience of Dumping Syndrome in a patient without a history of gastric surgery, and little experience of the condition after such surgery as well, I had the confidence to know what dietary changes may be more required, alongside what remedial intervention was going to be required.

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.

R.H.'s views have been expressed within this case report. However, here is a summary of his views of his experience.

"The change in my diet combined with the supplements taken for my stomach have changed my whole life and pretty much totally resolved the Dumping Syndrome. I am certainly going to take care about what I eat in the future, but it has been an undeniably positive outcome and experience. I can see my future in a totally different light now, and I look forward to my life without the need to be close to the bathroom wherever I go!

I feel so much better, I look so much better, and I never knew for so long that it was something I was eating that was ultimately to blame for my gut symptoms. It's amazing that no one told me before that wheat could cause or trigger Dumping Syndrome, and I guess that I should not have learned to live with the symptoms as I did and sought help earlier. But I am so so pleased now that I am liberated to lead my life in a completely different way."

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

The patient is not aware his case history is being used, and all identifiable data has been removed. M.T. are not his 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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