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.

13 year cough resolves in 59 year old lady with targeted NT.

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

This case explores a nutritional focused approach to the resolution of a chronic and life-changing cough in a 59-year-old lady who also experienced significant differences in her energy, aching legs, brain fog, interrupted sleep, night sweats, and intestinal wind. Significantly, her anxiety which was associated with being in a public space and coughing, disappeared once she had confidence that her cough would not occur.

Mrs. J.F. developed her cough some 13 years before I met her. In spite of frequent, but not recent, visits to her GP, and a number of courses of antibiotics the cough persisted. No amount of cough suppressant medication worked and Mrs. J.F.'s health declined during this time in many different ways on a physical, emotional and social level. She developed anxiety in any situation that meant she would be in the company of others, particularly in a quiet setting such as the theatre or cinema. She was previously an avid theatre-goer, so this was very distressing.

Frequent coughing usually indicates the presence of a disease. Many viruses and bacteria benefit evolutionarily by causing the host to cough, which helps to spread the disease to new hosts. Most of the time, irregular coughing is caused by a respiratory tract infection but can also be triggered by choking, smoking, air pollution, asthma, gastroesophageal reflux disease, post-nasal drip, chronic bronchitis, lung tumours, heart failure and medications such as ACE inhibitors.

None of the environmental factors applied to Mrs J.F. and she was cleared of asthma, bronchitis, G.E.R.D., and heart condition in previous assessments, although these were conducted more than 10 years previously. It was not ruled out that there was an ongoing infection.

After 13 years of daily coughing, and with significant adverse consequences on her health, Mrs. J.F. was resigned to her status, and frankly, was depressed by it. However, after some months on a targeted nutritional programme, the cough was resolved and changed J.F.'s life completely.

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

Chronic & persistent cough, hidden infection, anxiety, fatigue, wind, aching legs, interrupted sleep, brain fog, hot flushes.

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

Mrs J.F. Developed her cough over 13 years ago, but it did not resolve. Then aged 46, Mrs. J.F. has been in good health, engaging fully in life with two teenage children at home. She enjoyed all activities, kept fit, and loved to visit the theatre, one of her favourite past-times. If ever she had caught a cough before, it had always been something that cleared up in a matter of a week or two. This time, it was different.

Mrs J.F. could not accurately recount to me the exact number of visits to her GP and chest specialists she had made, but it was over twenty. She had taken at least 3 courses of antibiotics but they had not been effective, and had created a windier digestive tract, she reported. She had suffered from excess flatulence ever since, and this varied depending on what she ate.

Mrs. J.F. told me how it was incredible from her perspective that so many years had passed since she had the started with this wretched cough. She had no idea that any other therapy could be effective, once she had been examined and tested by the medical doctors. From time to time she had been on holiday to warm and hot climates elsewhere in the world but noted there had been no more than a fleeting difference.

Her whole life had been affected for over a decade, the details of which are presented more fully below. However, after a number of months of specific and targeted nutritional therapy intervention the cough ultimately resolved and Mrs. J.F. is now actively engaging in all manner of activities she has longed to be doing without a cough.

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.*

J.F. is a white Caucasian woman, a housewife, mother of two children who live away from home now, and wife to her husband with whom she shares a home in south west England. She was 59 when we met and is now 60 years of age as this case report is being written.

Mrs. J.F. does not present as a bitter and frustrated woman suffering from daily anxiety and frank depression about her health. Whilst she did cough during the first appointment, she did not convey the breadth of impact that the cough has had. It was only on reading the questionnaires and her time line document and hearing her describe how her health had been affected by the cough, both directly and indirectly, that it was possible to appreciate what she had been through.

J.F. still coughed every day and it was not possible to suppress. She was fatigued, which may have been due to chronic interrupted sleep as well as the physical effort of the coughing itself. She also had ‘brain fog’ most days so that not only was she tired but she also had extra difficulty in engaging her brain. It was like she was in neutral most of the time and could not move through the gears.

J.F. also presented with excess wind which had become worse as time had passed and which was triggered by the antibiotics originally prescribed 13 years before. She had taken a few courses of probiotics (brands & strains cannot be recalled) but these had no impact on the wind. When she had visited her GP about this he had not given any advice about what to do other than to consider a medication to improve gut motility, which she declined.

J.F's sleep pattern had also altered since she had the cough, as she woke coughing in the night. Since the first year, however, she found that she awoke at other times, seemingly not triggered by coughing. She had not had more than one or two nights over the past 12 years that she had slept all the way through. She fell back to sleep again but it took its toll on her energy.

For the previous 7 or 8 years, J.F. had aching legs with no obvious explanation. This did not change whether she had a brisk walk, cycled or sat down all day. They simply ached most of the time.

Anxiety had also caused J.F. to become more isolated from the social environment she had been used to. She used to frequently attended the theatre, locally and in London, before the cough. Now that she could not help coughing she could not attend without becoming an auditory irritant to the audience. This was what she missed the most. However, the worry about being in a public space, quiet spaces, affected her every day. All in all, whenever she considered where she was in her life with her health constraints she candidly told me that she felt depressed about it, so she had decided not to think about it wherever possible.

She told me about the visits to her GP, the 3 courses of antibiotics and the referral to the lung specialist and then the heart specialist. The scans had not shown anything sinister or pathological and all of the doctors had held their hands up and declared that they did not know what was wrong with her. She was told by one doctor that she may not have anything wrong physically, but it may be an emotional or psychological tic. Her last visit to a medical doctor had been 10 years prior.

Since then, she had received a course of massage therapy and whilst she felt better in herself because the cough led to a certain degree of muscle tension, this had no impact on the cough.

In spite of the impact of the cough on her life, she had not explored other avenues but had taken the doctors' words to heart when they had said that she would need to learn to live with it. When she met with an old friend, who had a positive health outcome after implementing recommendations I had made to her, she was strongly recommended to seek my help. Mrs J.F. eventually came to visit my clinic for the first time in May 2016.

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 J.F. has an older sister who is in good health, aged 62. Her parents have both passed away in recent years when they were in their 80's. The cause of death had been given as heart disease in both cases, after her mother had a stroke and her father had a heart attack a few years before her mother passed away. Her two children were in their 20's and were in fine health. There was no family history of any respiratory conditions such as asthma, and no one in the family as far as is known had experienced a chronic cough. In fact, neither J.F. herself nor her husband had ever met or heard of anyone with a cough that persisted for 13 years.

Mrs J.F. had no other conditions which had been present prior to the cough, but she had suffered from the subsequent effects of the cough which are described above. They are fairly represented by the health goals that Mrs J.F. had at the outset.

1. To be free of my chronic cough
2. To feel well and energetic again

3. To be free of anxiety in social settings
4. To visit the theatre again
5. To sleep well through the night without interruption
6. To have a clear head and be free of brain fog
7. To be free of aching legs
8. To be free of the excess wind
9. To be free of hot flushes and night sweats

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

In 2002, Mrs J.F. was fit and well, cough free, bringing up her two teenage children.

In 2003, Mrs. J.F. caught a chest infection and developed a cough. The cough never went away and persisted. She received 3 courses of antibiotics in 2003-4. Her digestive wind had started after the antibiotics.

In 2003-4 she also visited specialists in lung / respiratory health and cardiovascular health and was given a clean bill of health. The scans and X-rays were all clear. She was beginning to feel the effects of interrupted sleep and was experiencing fatigue.

In 2006 she visited the doctor for the last time when previous visits had been to no avail in terms of identifying the cause nor offering treatment for her cough. By this time, J.F. was fatigued, not able to go to the theatre or cinema, had interrupted sleep virtually every night, suffered from wind, and had 'brain fog'. She had begun to experience hot flushes at this time.

In 2008, or thereabouts, aching legs were first experienced, and whilst they started off in an intermittent fashion, the aching then became permanent. She was still experiencing all of the other symptoms along with what she perceived to be menopausal symptoms of hot flushes.

In 2008-9 she had a series of massages which alleviated tension in her back and chest but had no impact on her cough.

From 2003-2016, J.F. remains almost completely free of any other illnesses, and self-limiting infections.

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*.

Mrs J.F. provided me with the completed questionnaires and time line information before we met for the first time, in May 2016. We had originally planned to meet in February but this was postponed, then March but that was postponed and then April but that too was postponed. Whilst events and family matters had come up Mrs J.F. told me at the third appointment that she had not been expecting any improvement from a nutritional appointment because she was fairly convinced her cough was not food related. In this way, she had not made is a priority to make the appointments she had made, as well as the fact that it was some distance to London from where she lived. Her old friend had been in touch with her and continued to encourage her to keep an appointment.

After the thorough and careful assessment, the most likely cause of the cough was either something in the environment like dust, for example, or a low grade chronic infection. As it happens I am quite familiar with the latter, finding those in many patients who seek advice, particularly about auto-immune conditions. However, J.F. had no other ailments or conditions other than those directly or indirectly caused by the cough.

The most logical approach to consider for J.F. was to assume that she had a low grade, chronic infection. However, I could not explain why this should remain for such a long period of time, and nor be susceptible to one of the courses of antibiotics. It could be that the antibiotics could not reach her lungs through the mucus in them, I offered as a possible mechanism.

We discussed conducting blood tests for chlamydia pneumoniae and mycoplasma pneumoniae in particular, and also the running of a viral panel to rule out the presence of herpes viruses. However, Mrs. J.F. was adamant that she did not want to have blood tests done. I did not get to the bottom of the reason why, and was sensitive to the fact that it had taken quite a long time and re-arranging of appointments to get her in the clinic room in the first instance. I realised that if we had agreed to get a blood test done, then she may very well not have ever arranged it and then the visit would be of no benefit. Therefore, in order to be in a position to make recommendations that would be complied with, I managed to have J.F. agree to follow a course of natural anti-bacterial supplements together with an upgrade of her diet.

J.F. was quite certain that the food she ate made no difference to her cough, and this appeared to be correct on face value. Therefore, the explanation I gave to her to make positive changes to her diet was based on immune support. With regard to the supplements I explained how they could achieve things that no changes in diet ever could, and this had more appeal to her.

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).*

I recommended a wider variety of food intake to J.F. using a healthy plate example from the Alliance for Natural Health (ANH) as a basis. I emphasised the reasons for the expanded variety of foods and focused on their nutrient content and how that nutrient content supported a healthy immune system.

I prepared a simple supplement programme and carefully explained what each one contained and what its functions were, being careful not to make any claims about her condition & symptoms. It was clear that J.F. wanted me to give her as much confidence in the programme as possible but making such claims and offering high expectations was not something I could do, and I advised her of this.

I included an emulsified and sustained release oil of oregano extract to J.F. In addition, I recommended Saccharomyces Boulardii to her to support mucosal immunity and secretory immunoglobulin A (SIgA) and this was to be taken at least 2 hours away from the oregano oil extract in case of competitive inhibition. I also recommended support for her gut lining in the form of butyric acid (enteric coated) and a bespoke formula that has been designed for this including gamma oryzanol, intestinal glandular extract, glutamine and Jerusalem artichoke. The target of the supplement programme was to inhibit a wide array of bacteria, and yeast, that may be contributing to her cough, as well as support mucosal immunity and ensure that her intestinal lining integrity was supported in an effective way.

First Supplement Programme	
ADP Oregano (BRC)	2 with each meal
S. Boulardii (ARG)	1 caps >2 hours away from the ADP, twice daily
ButryEn (ARG)	2 with lunch & dinner
I.P.S. Caps (BRC)	2 caps at the start of each meal

The first follow up appointment was five weeks after we had first met in May. This appointment was via Skype because it was challenging for J.F. to make the trip very often to London. She had sent me an email summary of the changes she had noticed since she commenced the supplement programme in advance of this follow up call.

However, 2 weeks into the programme, J.F. had called me to report that she had tummy aches and as a result, I reduced the dose of the ADP Oregano (BRC) extract to 1 with each meal, after a 2 day break from it. This appeared to resolve the tummy aches and she was able to take the whole programme after that without any further abdominal discomfort.

She reported that there had been some changes. Her cough had varied more than it usually had, first improving and then worsening and then improving before it resumed to a similar state before we had met. She noted this with interest, since it was the first time in many years that this had occurred.

Separately, she noticed that her wind was less and so were her aching legs and she wondered if the two were connected. Her sleep was also a little improved in that she had a few nights where she did almost sleep through, which was rare for her.

Overall, there was not that much change within her but those changes gave us both confidence to continue. I explained how it may be some months before the ADP Oregano could achieve the desired effect at inhibiting the possible trigger, a chronic infectious agent / bacterium.

I amended the programme a little, but emphasised the importance of taking a sufficient dose of the ADP Oregano in order to achieve a minimum inhibitory concentration (MIC) of the active ingredient, carvacrol, in order to successfully resolve the chronic infection.

I explained to J.F. that by inhibiting the bacteria or yeast that created the digestive wind, that there may now be less inflammatory signals & cytokines in her blood thereby resulting in a reduced achiness in her legs.

Her energy, anxiety and mood were little changed at this point.

We agreed to have a further skype appointment four weeks after that.

Second Supplement Programme	
ADP Oregano (BRC)	2 with each meal
S. Boulardii (ARG)	1 caps >2 hours away from the ADP, twice daily
ButryEn (ARG)	2 with lunch & dinner
I.P.S. Caps (BRC)	2 caps at the start of breakfast & dinner

At the third appointment in July, on Skype again, J.F. reported that her cough had reduced after 10 days of the higher dose of ADP Oregano but had then returned a week after that to the worst it had ever been. Her husband had expressed concern and wanted her to visit the GP but she turned that idea down, and persevered. The worsened cough lasted a week or so and then returned to its usual state.

Her wind was becoming less than it had been, over time, and her aching legs were much better than they had been. Her energy was slightly improved, in spite of the bad episode of coughing. Her brain fog was also diminished. Her hot flushes remained as they had been and because they affected her sleep, I decided to focus on this with a specific herbal extract supplement for the next time period.

I offered an explanation that the oregano extract could have been successfully inhibiting a bacteria, and possibly a yeast, that may have been the cause of the cough and the worsened cough could be a result of the killed bacteria eliciting an inflammatory response in her lungs, thereby making the cough worse temporarily on the way to achieving the result we both wanted.

J.F. had been eating a wider variety of foods and had found pinning up the ideal food plate in her kitchen was a helpful guide and prompt. Her husband had complained a few times about the new healthy menu but he had also noticed some positive changes in his wife, so he was supportive in general.

She had noticed that with more pulses that she had more wind, which was a shame given the previous improvements. To me, that indicated a need for digestive support so I included a digestive enzyme in her third supplement programme.

The third supplement programme was amended to include the female hormone support to help counter the hot flushes.

Third Supplement Programme	
ADP Oregano (BRC)	2 with each meal
Full Spectrum Digest (ARG)	1 caps at start of each meal
ButryEn (ARG)	2 with dinner
EstroPrime Plus (ARG)	2 with breakfast & dinner

Since we were meeting by Skype and not in person, I ensured that the gaps between appointments were not longer than a month. I recommended that we meet again face to face, but J.F. was not able to travel to London at that time so we spoke again via Skype.

At the fourth appointment, in August, this was the time when J.F. first reported that she had most definitely noticed her cough was less than it had been. She was feeling slightly more energetic, and her sleep was less interrupted. The hot flushes were much better which may have helped her sleep.

After 10-12 days on taking the digestive enzymes she felt tummy aches and I advised her, by telephone to stop that supplement and to replace it with apple cider vinegar in order to offer digestive support. The tummy aches resolved after this change. I am not aware of why this might have occurred, especially since I had believed that the mucosal immune and gut lining support had been effective over the previous months. I increased the butyric acid dose.

The brain fog was less, the aching legs were almost entirely better. From J.F.'s perspective, things were looking up.

I recommended her to continue with a very similar programme and for us to speak again in September.

Fourth Supplement Programme	
ADP Oregano (BRC)	2 with each meal
ButryEn (ARG)	2 with lunch & dinner
EstroPrime Plus (ARG)	2 with breakfast & dinner

In September 2016, at our fifth appointment, J.F. reported that she had been to the theatre and not coughed during the performance. She was thrilled! I asked her to slow down and take me through the time sequence but she carried on excitedly to tell me that she had then gone twice more and to the cinema and had felt and been just fine throughout and not coughed. Her cough, evidently was considerably better than it had been for 13 years.

J.F. allowed me to go back to August and take me through what had happened. She reported that the cough had, in a seven day period, reduced and reduced and reduced until there was barely a day she coughed at all. Her sleep was oh-so-much better and she felt much more energy than she had. Her hot flushes were gone, her brain fog was gone. Her wind only occurred after a lentil or bean meal. Her anxiety about public environments such as the theatre was still present but she told me that even when she greatly feared that she would cough, she did not.

It was categorically life-changing. She was now planning all of the things she wanted to go and do and was full of the joys of life. She said she planned to come and visit me when she next visited London and we have set a date. In the meantime, just to be sure, I recommended she continue for a further period of time on the oregano oil extract.

Fifth Supplement Programme	
ADP Oregano (BRC)	2 with breakfast & dinner
EstroPrime Plus (ARG)	2 with breakfast & dinner

Shortly before writing this case report, I had contact with J.F. who has not coughed since we spoke earlier in September. She is loving the opportunity of getting out and about and feels so much better. She is absolutely delighted at the resolution of her chronic cough.

All of her goals have been achieved, or very close to being fully achieved.

Supplement Information

A.D.P. Oregano (BRC)
This patented oregano extract is a very effective broad-spectrum anti-microbial, and is a product used in a variety of auto-immune conditions, in which there is an infectious agent involved, with successful outcomes reported in the majority of patients.

ButryEn (ARG)
ButyrEn is an enteric-coated, extended shelf-life formulation of the calcium and magnesium salts of butyric acid, designed specifically for delayed release in the gastrointestinal tract. Butyric acid (BA) is a short-chain fatty acid (SCFA) produced by certain commensal bacteria and their metabolic breakdown of fibre, and appears to support mucosal integrity as the epithelial cells utilise it. Butyric acid may support the integrity of the colonic

mucosa by acting as a primary fuel for the colonic epithelium (colonocytes). Butyric acid ("butyrate" when in salt form) is an important SCFA for this reason. BA also supports the maintenance of bifidobacterium species in the large intestine.

Although more indicated for the large intestine, I find this product is a useful supplement for helping to heal the small intestines and correct altered intestinal permeability. It also helps to reduce ammonia, supports commensal bacterial growth and encourages bile flow, and has in my practice been a contributory factor to reducing 'brain fog' caused by GI issues.

EstroPrime Plus™ (ARG)
The EstroPrime Plus™ (ARG) provides a grape seed proanthocyanidin which has been trialled in menopausal women, it provides succinic acid which has shown benefits for menopausal symptoms, it provides a mix called EstroG-100® (*Phlomis umbrosa*, *Cynanchum wilfordii*, *Angelica gigas* Nakai) which has been the subject of a RCT in menopausal women and it also provides a registered Female hops cone extract which possesses phytooestrogenic effects.

Full Spectrum Digest (ARG)
Full spectrum, vegan, clinical strength digestive enzyme with the ability to degrade casein, whey, soy, gluten and gliadin. Provides, per capsule, Glutalytic® (endo & exopeptidase) 189 mg, Protease 75,000 HUT, Aspergillopepsin 500 SAPU, Protease DPP IV 125 DPP IV, Amylase 15,000 DU 125 mg, Lactase 4500 ALU 60 mg, Lipase 2500 FIP 11 mg, Alpha-Galactosidase 150 GalU 6 mg. The Glutalytic® provides a special Exo & Endopeptidase blend – the Exo digests terminal peptide bonds to release amino acids and the Endo digests internal peptide bonds. Only to be taken with food.

I.P.S. Caps (BRC)
Provides L-glutamine, glucosamine, gamma oryzanol, glutathione, lamb intestine concentrate with epithelial growth factor, & Tillandsia which contains many vitamins, minerals and other compounds such as coumarin and resins that support healthy intestinal mucosa.

S. Boulardii (ARG)
The well-known and well-studied 'probiotic' yeast that supports SIgA levels which is integral to mucosal immunity, and can also reduce inflammation, and supports gut lining integrity.

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 case history detail taken with this patient, as standard, provided vital information about Mrs J.F. that helped to support my clinical experience with chronic infections. The limitation was the lack of testing for the bacteria/virus (presumed) that was the cause of the cough. This was due to the patient's lack of willingness to engage in testing and my appreciation that the test may pose a hurdle to the engagement of Mrs J.F. in a therapeutic programme.

The regular contact with Mrs J.F., especially as our meetings were not face to face after the first appointment, was of importance to maintain compliance through explanation of the process that she was going through.

The literature relevant to this case report
Clinical experience rather than literature evidence informed this case, along with CPD attendance at seminars presented by microbiologists who confirm that they find the presence of bacteria such as chlamydia and mycoplasma pneumoniae in many chronic sufferers, and that when addressed, the patients achieve positive health outcomes.

The rationale for your conclusions
The rationale appears extremely straightforward in this case. I surmised that Mrs J.F. had been suffering from a long-term bacterial infection, and I made the recommendations for therapeutic intervention accordingly. I could not explain why this should be the case, however.

The main findings of this case report: What are the take-away messages?
Common sense strikes me as being the most important take-away message. Simply having taken 3 courses of antibiotics does not necessarily mean that a bacterial chest or lung infection would be resolved. Listening to the case history led me to believe the infection was still present. The outcome confirms this was the case, albeit we do not have the name of the bacteria nor objective evidence.

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 J.F. is now focused on making up for lost time, and is in a state of excitedly good health. She has not expressed herself in any way to me about the regret of the past 13 years but rather on what she is planning to do now, which is a very good example of positive mental attitude. At first, J.F. had no conception that anything nutritional would make any difference, but she was unaware of the possibility that there were therapeutic options through natural, nutritional supplements.

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. J.F. 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*

Antony Haynes, RNT, practices in London W1.