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.*

# Menopausal Symptoms Resolve 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 48 year old woman who had been experiencing a range of signs and symptoms during the transition into menopause. Mrs H.N. had also been diagnosed with hypothyroidism five years before we met, and required thyroid support.

Pre-menopause is a term used to mean the years leading up to the last menstrual period, when the levels of reproductive hormones are already becoming more variable and lower, and the effects of hormone withdrawal are present. It often starts some time before the monthly cycles become noticeably erratic in timing. Peri-menopause refers to the menopause transition years, a span of time both before and after the date of the final episode of flow. Post-menopause is the term that describes women who have not experienced any menstrual flow for a minimum of 12 months.

Menopause is the cessation of a woman's reproductive ability, the opposite of menarche. Menopause is usually a natural change and typically occurs in women in midlife, during their late 40s or early 50s, signaling the end of the fertile phase of a woman's life. Menopause is commonly defined by the state of the uterus and the absence of menstrual flow or periods, but it can instead be more accurately defined as the permanent cessation of the primary functions of the ovaries.

The average age of a woman who goes through the menopause in the UK is 51. The span of time from peri-menopause to menopause is from 2 to 8 years. There are over 4 million women in the UK within this age range.

The transition from a potentially reproductive to a non-reproductive state is normally not sudden or abrupt but occurs over a number of years. It is a natural process of biological aging. For some women, there can be accompanying signs and effects which includes lack of energy, hot flushes, night sweats, and mood changes, vaginal dryness or atrophy, incontinence, osteoporosis, and heart disease. These signs and symptoms are attributed, quite correctly, to the effects of lower levels and withdrawal of the oestrogenic hormones and progesterone.

Hormone Replacement Therapy (HRT), using synthetic hormones, has been recommended to women to smooth the symptoms that can occur during the transition between the reproductive to non-reproductive state. HRT is also believed to offer other benefits to health particularly on bone health and potentially for cardiovascular health. The emergence of bio-identical hormones has occurred over recent years for those women who wish to choose a hormone replacement therapy that provides the very same molecular structure as hormones that naturally occur in the body. All HRT carries increased risk of promoting certain types of cancer. HRT is controversial in that it is seen by some as a medical intervention for an entirely natural process of biological aging.

Menopausal and perimenopausal symptoms are extremely common and can have a significant impact on a woman's quality of life.

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

Menopause, peri-menopause, hot flushes, fatigue, depression, weight, body fat, cravings, thyroid, adrenals.

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

H.N. is a 48 year old woman who had been experiencing an irregular menses for a year before we met. She was suffering from a range of vasomotor symptoms from moments of warmth to full blown sweats, including night sweats. Most days she felt uncomfortable at best, and simply did not know what to do with herself due to the poor temperature control she went through every day. She was fatigued, probably from the interrupted sleep pattern induced by the night sweats, and had felt increasingly depressed. She had more cravings than ever before and had gained weight through satisfying those cravings with sweet foods or carbs.

H.N. had struggled with her weight over the past ten years, and was about 2 stone over her ideal weight when we first met. Five years prior, she had been diagnosed with hypothyroidism and been prescribed thyroxine. This had generally helped somewhat but made no significant difference except in her sensitivity to the cold which was resolved by taking the hormone replacement.

H.N. worked in an office setting but had flexible hours, although her responsibilities remained consistent, and she also travelled with her work domestically and in Europe.

H.N. had two adult children who lived away from home, but with whom she was extremely close with weekly contact.

Health had never been an issue throughout her life and had not interrupted any aspect of it, until more recently. The slow weight gain troubled her, and then an increased sense of feeling flat, less buoyant than before had prompted a visit to her GP who had conducted blood tests and identified a need for thyroxine. Whilst the flatness had improved, her weight had not, and now she was experiencing symptoms and signs of the menopause.

Her menstrual cycle had been irregular over the previous 12 months, and the vasomotor symptoms were becoming more and more problematic, and were a definite interruption in her life. She felt censored in all aspects of her life, at work and socially, as a result. In addition she felt uncomfortable in her skin during most days even if she was not in the midst of a hot flash. She had night sweats, and laughed when she told me that she had day sweats too.

**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.*

H.N. is a 48 year old, married Caucasian lady who lives in the south of England. She is 5' 5'' tall (165 cm) and weighs 12 stone 12 lbs (80 kg).

She had held the same job for many years that was specifically related to facilitating the relocation of high salaried staff from one country to the next, almost exclusively coming into the UK, and sometimes into other major capitals in Europe. She was the person who met with the incoming individuals, found the suitable rental properties and introduced them and their families to their new country and immediate environment.

H.N. felt that she was in someone else's body most of the time because no matter what she wore and no matter what the outside temperature was, she felt at best clammy, then too hot and then too cold, and had a real challenge in being able to know what was best to wear. Unannounced and for no obvious reason she could also experience a day sweat and she almost always awoke with night sweats which varied in their intensity and duration.

H.N.'s energy was flagging, which was a new experience for her, and she felt that her mood was significantly altered by the hormonal symptoms and she had even allowed the word depression to enter her vocabulary, something she never thought would happen. She was also all too aware of her weight that had been creeping up and this bothered her every day.

Five years ago, H.N. had started on 100 mcg thyroxine and had expected her weight to drop off but it had not changed. She tried restricting her calories but this did not seem to help and she then had strong cravings for sweets and chocolate so she decided against keeping on this kind of 'diet'. The thyroxine did mean that she was no longer sensitive to the cold and had helped her to feel less flat but it had not helped her weight which was frustrating for H.N.

Over the past year she had had a menstrual cycle in 8 out of the past 12 months. She realised that she was going through the menopause but was frankly against ever taking HRT. She had not engaged in any specific means by which to address her current symptoms; she was unused to needing to find help for anything, and she was usually the person who sorted things in her life and work not others. However, her body was in such a persistent state of what she perceived to be hormonal flux that had not come and gone as she had hoped, that now she was seeking help from Nutritional Therapy.

**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.*

H.N.'s parents were reasonably fit & healthy and lived within 25 miles of her family's home. She had no idea what her mother experienced in her menopause; the conversation had never been had. There was no particular condition that family members, grandparents or great aunts and uncles had suffered from.

H.N. had a single brother who was a few years older and he was apparently fit & well but she did not really know. They were close but never really discussed health in the same way that she never really discussed her current health issues with anyone. She was very used to being in control.

H.N. enjoyed her work and whilst sometimes there were demands on her time out of hours and away from home and office too, she did not feel anxious at all by it. My perception was that as long as H.N. felt in control of the situation then she was not stressed by it. Her menopausal symptoms were not in her control and in addition to being physically challenging they created anxiety within her due to the lack of control.

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

H.N. was born in the south of England in 1966. She experienced good health for all of her life, having the usual childhood illnesses. She cannot recall taking antibiotics as a child but believe that she may have done on at least one occasion.

H.N. played sports and engaged in outdoor pursuits both at school and at university. She rowed, she ran, she played netball, she played tennis. She also worked hard and overdid alcohol at university as all of her peers did.

H.N. had not experienced any hormonal symptoms until after the birth of her two children, in 1991 and 1993, when she had PMT symptoms for a day or two each month. She had become used to them and they were not severe. She found that if she avoided all caffeine and alcohol and ate lots of vegetables and drank more water that this generally prevented most of the symptoms.

When H.N. was 43, she visited her doctor complaining of weight gain and the blood test showed a need for thyroxine, although it is not known which thyroid hormones were assessed. Since that time she has an annual TSH test which confirms the dose of 100 mcg being suitable for her. I am aware that in the view of very experienced doctors and practitioners who specialise in thyroid hormone health, that the use of TSH or even with the blood testing for Free T4 and Free T3 as well, does not give all the information about the efficacy of the thyroid hormones.

Five years later, aged 48, H.N. felt the first signs and symptoms of the menopause which emerged and then became persistent. The most unpleasant, and what took dominance, was the vasomotor symptoms of hot flushes, poor temperature control, mostly too hot, too clammy, too sweaty, too much ‘glistening’. Sometimes, however, she felt shivery cold, probably due to the loss of heat by conduction of the perspiration. She also had some emotional and mood changes, and most notably a lack of her bounce that she could usually rely on.

In addition, her energy was generally less and the ability to wake up and get up in one motion was gone, and she felt like she always wanted to spend five more minutes under the covers.

She tried to do the same thing for the menopausal symptoms as she had done for the PMT symptoms in the past, and cleaned up her diet, ate more veggies, drank more water, stopped all alcohol and took a walk every day. This had not made any difference, unfortunately.

The recommendations and progress that H.N. made over the next months 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*.

As with all clients, we established the health goals at the first appointment, which were:

1. To be free of hot flushes & menopausal symptoms.
2. To lose body fat
3. To have my bounce back - all the time
4. To be in good mood all the time
5. To have great energy all day
6. To spring out of bed like I used to

H.N. had already provided me with completed questionnaires as well as a chronological history of her health in bullet point format and a 5 day diet diary.

Within these questionnaires, the adrenal and thyroid sections scored highly suggesting an involvement with these hormones and her current menopausal signs and symptoms.

I decided not to conduct a thyroid profile for two reasons. Firstly, the test results may well be normal, given that her TSH had been normal (around 2.0) in the previous few tests she had had. Secondly, if the tests were normal then this could dissuade intervention to support the thyroid, and there were plenty of symptoms associated with less than ideal thyroid function to warrant some nutritional support. This included easy flushing, intolerance of high temperatures, difficulty losing weight, mental sluggishness with reduced initiative, easily fatigued, seasonal sadness, cracked skin on heels, coarse hair and dry skin.

We discussed the adrenal hormone cortisol, and the potential value of measuring this, but this would be called on depending on how H.N. fared with the first phase of the nutrition programme. At that time, I believed that a focus on the cortisol levels was not necessary beyond supporting her body against stress or rather improving her stress tolerance in the face of her work load and distress about the vasomotor symptoms.

H.N. had already committed to eating more healthily than she had done in years and therefore there was little change to her diet other than to explain the 'why' she would benefit from abiding by each of the specific aspects of the way she ate. I explained the importance of ensuring she had some protein with each meal with a measured portion of carbs to help support a minimal insulin response and to support energy and cortisol levels. I explained the many potential benefits of consuming lots of veggies with lunch & dinner, something she had returned to. We discussed coffee and caffeine and it seemed that 1 cup a day would be fine. We agreed that alcohol avoidance was probably best, although she had already tried this to no avail with regard to her hot flushes and mood and energy. In fact, she said that a glass of champagne had helped her to feel better in herself, and we then discussed that this may be due to some sense of relaxation induced by the bubbly.

**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).*

**June 2014**

The first appointment in early June 2014 revealed what we have already read about, in that H.N. was in the midst of peri-menopause that blighted her life. H.N. had already changed her diet and cut our refined foods and bought sugary snacks and reduced her coffee to one per day and only drank alcohol on Saturday nights.

I recommended that she take a 5-10 minute brisk walk before or after each meal to help support post-prandial glucose disposal and thereby minimise insulin and blood glucose upset.

I also recommended a supplement programme to H.N. to take on a daily basis. The focus of the supplements was initially on supporting her thyroid hormone activity and to improve stress tolerance and give her adrenal and blood glucose balance support. I also added lipoic acid (ALA Release) to support her antioxidant status and blood glucose & insulin levels.

| Programme One<br>Supplement Name & Brand | Dose |
|---|---|
| **Stabilium (ARG)** | 4 softgels with breakfast |
| **Super Adrenal Stress Formula (Dr W)** | 2 with each meal |
| **Thyrostim (BRC)** | 2 with breakfast & 1 with lunch |
| **Meda-Stim (BRC)** | 2 with breakfast & lunch |
| **ALA Release (ARG)** | 1 with each meal |

As the months went by, and as H.N.'s symptoms changed the specific target for therapeutic intervention changed with it. The sequence of her health progress is described below.

**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.*

**End of July 2014**

We met for the first follow up at the end of July 2014. H.N. admitted that she had found the continued adherence to the dietary recommendations a challenge but had stuck with them. She had not eaten protein at breakfast for the third week after we met and experienced a decline in energy and a real dip mid-afternoon. On re-instating the protein at breakfast she felt noticeably better.

Her lifestyle had been very similar to normal, and now August was approaching, she was looking forward to a three week holiday.

She had felt pretty well, and in fact better than she had done generally and her mood had improved. Her main concerns centred on the hot flushes and her weight and both had improved over the 7 weeks since we had first met. When I checked the symptoms that were associated with thyroid hormone imbalance, the majority had improved at least somewhat. This reflected that the thyroid support in the face of normal TSH levels (as at the last test she had had) was being effective.

She was still experiencing vasomotor symptoms but they were less frequent and the intensity of the sweats was at least 25% less. This was a real positive for H.N. but it had not changed things because fundamentally she was still feeling uncomfortable and sweaty, albeit less so than before.

She had lost 5 lbs in weight too which she was pleased with but also reported that she felt her body shape had reverted a bit to her normal adult shape.

H.N.'s energy was pretty good, but the early morning spring was not there. She was hoping she would recuperate whilst on holiday.

The supplement programme was changed in that the thyroid support shifted from Thyrostim (BRC) to GTA Forte II (BRC) and I changed the Super Adrenal Stress Formula for another multi vit & min called ProMulti Plus which has a higher level of vitamin B12, folic acid and vitamin D. (H.N. was not one for tanning and kept out of the sun, and preferred to be kept cool with her hot flush disposition, and their holiday was in Scandinavia in August).

| Programme Two<br>Supplement Name & Brand | Dose |
|---|---|
| **Stabilium (ARG)** | 4 softgels with breakfast |
| **Meda-Stim (BRC)** | 2 with breakfast & lunch |
| **ALA Release (ARG)** | 1 with breakfast & dinner |
| **ProMulti Plus (BRC)** | 2 with breakfast, 1 with lunch & 1 with dinner |
| **GTA Forte II (BRC)** | 2 with breakfast & 1 with lunch |

**November 2014**

We met for our third appointment in mid-November 2014. H.N. told me that she had made further progress with her hot flushes and general mood and energy. Everything was about 60% better on the programme than when we met, she estimated, which she was pretty pleased about. The extreme 'damp' moments (or rather blocks of time!) were no longer, and she was very grateful for that. She still had disturbed sleep though but she was getting back to sleep more quickly.

She had drunk more alcohol whilst on holiday in Sweden and had not felt worse for it. She had then continued to drink on Friday and Saturday nights and this had not caused any change in her mood or energy or weight.

She had lost more weight, but less than the first 7 week period of time, but she was now a full stone lighter than when we first met, and she believed she had another stone to go. She realised that if she had been as diligent as she might have been that she would have lost more weight – namely, not having so much alcohol and not having what she called an 'unnecessary' snack during the day. She had habituated the high veg intake and was eating well, and had the tendency to have more than a single cup of coffee per day but it was always before noon. It was not known if this was a negative and since there was no immediate flushing or loss of temperature control, it was not evident that this was inappropriate for her.

She had some bad news that she was upset about she told me. She proceeded to tell me that she had experienced vaginal dryness, that this had resulted in painful sex and she now worried that this would require her to use some sort of HRT to resolve. She told me that she would seek her GPs advice and had considered a lubricant. She asked me to look into what might be able to help this, and I began to look for natural remedies to support this aspect of her health.

Her cycles were further apart than they had been with her last being at the end of August.

We also discussed the nature of the changes in her symptoms which all had improved whilst she followed a programme to support her thyroid hormone, to support her blood glucose and energy balance and nutritional status. However, a classic sign of low oestrogen was the dryness she had experienced.

I recommended that she consume more nuts and seeds and natural sources of fats in her diet and to slightly reduce the carbs she had been eating so that now the ratio was more on a 1:1 level with protein.

The thyroid support, multi nutrient that supported blood glucose balance along with the lipoic acid were maintained, along with a reduced intake of the Garum Armoricum fish extract that supports stress tolerance.

I made some minor changes to the supplement programme and reviewed what might be able to support her vaginal dryness.

| Programme Three<br>Supplement Name & Brand | Dose |
|---|---|
| **Meda-Stim (BRC)** | 2 with breakfast & lunch |
| **ALA Release (ARG)** | 1 with each meal |
| **ProMulti Plus (BRC)** | 2 with breakfast, 1 with lunch & 1 with dinner |
| **GTA Forte II (BRC)** | 1 with breakfast & 1 with lunch |
| **Stabilium (ARG)** | 4 with breakfast on Monday, Wednesday & Friday |

**February 2015**
When we met in early February for the fourth time. H.N. recounted how she had been. Overall, she had been pretty well, and probably better than previously, so things had certainly not worsened. She had consumed too much alcohol over Christmas but this had not manifest in anything other than a plateaued weight. She was now about 9 lbs offer her target, having lost one stone and 3 lbs from her original weight.

Her hot flushes and associated vasomotor symptoms were less but still present on a minor level every day which was frustrating, having come so far with reducing them. She had not had a period since last August.

Her energy was pretty good as was her mood, and her vaginal dryness had disappeared for almost two months shortly after we had met, and she hoped that would be that. She had consumed seeds and avocadoes and nuts and coconut oil every day for this. However, the dryness had recently returned and she was distressed about this.

She was also still having some sleep disturbance and therefore her energy was not as it might be.

Overall, she had made great strides with her original goals but still was not there yet. She told me that her get up and go was too low considering the other improvements she had made, and really wanted me to focus on her mental and cognitive 'uupmh' please !

With the new points of focus in mind, the supplement programme was changed. Thyroid support of GTA Forte II (BRC) was maintained. However, the other products were changed. L-Tyrosine was added to support dopamine levels, combined with an active B vitamin formula of Bio-3B-G (BRC) which can help cognitive function and mental clarity and evening primrose oil and magnesium were added to support her omega-6 status with the intention of helping reduce the vaginal dryness albeit without any certainty. I have a number of patients in whom this has had some positive effect.

| Programme Four<br>Supplement Name & Brand | Dose |
|---|---|
| **GTA Forte II (BRC)** | 1 with breakfast & 1 with lunch |
| **L-Tyrosine (ARG)** | 2 mid morning on empty stomach for 2 weeks,<br>then 1 mid afternoon as well |

| | |
|---|---|
| **Bio-3B-G (BRC)** | 3 with each meal, 2 at bedtime |
| **Evening Primrose Oil (ARG) (500 mg)** | 2 with breakfast |
| **Mg-Zyme (BRC)** | 2 with dinner |

**July 2015**
We met for the fifth time in July 2015, and some months had passed between visits.

H.N. was used to the structure of the appointments and started by telling me all that had been different since last time we met in her life, diet and symptoms. She had been eating well, yes, and had alcohol just once a week now which was a new resolution. She had been feeling overall pretty well but still the disposition to feeling clammy, to hot, too 'flushy' and still night sweats occurred. She told me that she would have thought they would be over by now.

The vaginal dryness reduced after met last, but whether it was due to the changed supplements she did not know. However, the main reason for seeing me at this time, was because the vaginal dryness had recently become much more pronounced and her hot flushes seemed to be gathering strength too. "Quick, do something!" was her gentle urging to me.

Having reached out to colleagues for help in terms of nutritional influences on her symptomology, although perhaps vaginal dryness is more of a sign than a symptom, a naturopath colleague shared with me a newly formulated supplement with one of the ingredients within it having been used in a randomised control trial (RCT) with positive outcomes for menopausal symptoms including vaginal dryness. The supplement is called EstroPrime Plus™ by Allergy Research. This was ideal timing for integration into H.N.'s supplement programme.

| Programme Five<br>Supplement Name & Brand | Dose |
|---|---|
| **GTA Forte II (BRC)** | 1 with breakfast |
| **Bio-3B-G (BRC)** | 3 with each meal |
| **EstroPrime Plus (ARG)** | 2 with breakfast & 2 with dinner |
| **Evening Primrose Oil (ARG) (500 mg)** | 2 with breakfast |
| **Mg-Zyme (BRC)** | 2 with dinner |
| **Tocomin SupraBio Tocotrienols (ARG)** | 1 with breakfast & 1 with dinner |

**September 2015**
We met for the sixth time in September 2014. H.N. told me that within two weeks of taking the EstroPrime Plus™ that she had not had a single hot flush! She had not had the usual daily sense of discomfort either, and had slept well for the first time in over a year. Her vaginal dryness was also improving from within a week of taking the new supplement and now there was very little discomfort and she did not feel that there was any need for further help in this regard. Her libido was improved too she told me.

She was feeling more spring in the morning, she had consistently good energy. She was really feeling well and was delighted with the changes that had occurred since she started to take the EstroPrime Plus™ (ARG). (The ingredients of EstroPrime Plus™ (ARG) are provided at the end of this case report.)

Furthermore, she had lost some weight and was not hovering at 2 lbs above the original goal, and weighed 11 stone.

As a result of the overall improvements and the achievement of the original health goals, I prepared a programme of reduced supplements but maintaining the EstroPrime Plus™ (ARG) which she is still taking as this case report is prepared in December 2015.

| Programme Six<br>Supplement Name & Brand | Dose |
|---|---|
| **GTA Forte II (BRC)** | 1 with breakfast |
| **Bio-3B-G (BRC)** | 2 with each meal |
| **EstroPrime Plus (ARG)** | 2 with breakfast & 2 with dinner |
| **Mg-Zyme (BRC)** | 1 with dinner |
| **Tocomin SupraBio Tocotrienols (ARG)** | 1 with breakfast & 1 with dinner |

The introduction of this carefully formulated product, the ingredients of which have all been the subject of robust study, has definitely added to the impact of the overall nutritional programme that H.N. had been following.

What started off as a thyroid and adrenal and insulin supportive approach changed to one that maintained thyroid support but focused on cognitive function and then lastly, supported specific symptomology associated with lower oestrogen levels. With a high safety profile, it is expected that H.N, will be able to take these nutritional supplements for as long as she needs them. We plan to meet to review her needs in the New Year of 2016.

**Supplement Information**

**Thyrostim (BRC)**
This combination formula of vitamin and mineral co-factors for the thyroid gland's production of its hormones, combined with pituitary and hypothalamus glandular is one of the most effective products to support thyroid hormone levels. GTA Forte II (BRC) (thyroid glandular with accessory nutrients) and Meda Stim (BRC) (vegetarian formula to support conversion of T4 to T3) complete the trio of typical thyroid-support products I so frequently see results from.

**Stabilium (ARG)**
An ancient North-Western Europe remedy derived from a ling fish called Garum Armoricum. It has been clinically trialed in USA Medical students and been found to reduce anxiety, improve sleep and improve resilience.

**Super Adrenal Stress Formula (Dr W)**
This is a multi vit & min that provides many nutrients that support adrenal function. It supports a healthy blood glucose balance.

**ALA-Release (ARG)**
Advanced sustained-release formula, with stabilised R-lipoic acid and biotin. ALA has important antioxidant functions. It also helps restore or recycle other antioxidants to their active states, including vitamins C and E, Coenzyme Q10, and glutathione.

**GTA Forte II (BRC)** - (thyroid glandular with accessory nutrients).
This is a hormone-free glandular derived from porcine sources, combined with accessory nutrients of zinc, selenium & copper. It has been designed by Dr David Brownstein, an authority on nutritional support for the thyroid and its hormones.

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

**ProMulti Plus® (BRC)**
Multi vit & min formulated by Dr Alex Vasquez, this comprehensive multi provides useful levels of vitamin D, folic acid and vitamin B12 in addition to the other essential vitamins and minerals. On its own, it has been used clinically to support healthy blood glucose and triglyceride levels.

**Bio-3B-G (BRC)**
A low dose yet active B vitamins for B1, B2 & B6) which can help support energy levels, and can serve as a very effective adjunct to any adrenal or thyroid hormone support programme. It also supplies the B vitamins required for the metabolism of neurotransmitters.

**Evening Primrose Oil (ARG)**
Each softgel provides 500 mf of EPO which supports the omega-6 pathway to the anti-inflammatory prostaglandin series 1.

**Mg-Zyme (BRC)**
This capsule provides 100 mg in the form of three amino acid chelates of magnesium, which helps to ensure good absorption of the mineral.

**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 botanical mix called EstroG-100® (*Phlomis umbrosa*, *Cynanchum wilfordii*, *Angelica gigas* Nakai) which has been the subject of the RCT in menopausal women and it also provides a registered Female hops cone extract which possesses mild phyto-oestrogenic effects.

**Tocomin SupraBio Tocotrienols (ARG)**
This product offers enhanced absorption of the 4 tocotrienols, which offer antioxidant support. They have been shown to have benefits in a number of different conditions from helping to support a healthy response to stroke risk to supporting the resolution of a fatty liver, to lowering cholesterol and more. Do view this article (one of a number on the subject of tocotrienols) on our website: Tocotrienols and their Benefits.

**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 strengths of this case report lie in the detailed case and health history combined with the length of time for the first appointment, being an hour. The case history information is what gave me the indications for the focus of the nutritional programmes over time.

This specific case highlights the need to change the focal point of the nutritional programme; there was not simply and thyroid need or a need to support her blood glucose or adrenals or indeed her female hormones either. This changed in time, and with careful listening the nutritional advice accommodated those changes.

**The literature relevant to this case report**
There is not much literature on the need for an integrated intervention approach to an individual with menopausal symptoms. In my opinion, the combination of hormonal support at the very least is what needs to be considered when faced with such a client.

There is scientific evidence to support the use of the ingredients within the EstroPrime Plus™ which has produced some very clear positive health outcomes for H.N. – and for other patients.

**The rationale for your conclusions**
The awareness that the thyroid and adrenal hormones strongly influence the manifestation of menopausal symptoms was essential in order to be able to direct support for these hormones, and not just focus on oestrogens and progesterone, for example.

Experience has taught me that most often there is a need for combined support for the major hormones of the adrenals and thyroid in a woman with menopausal symptoms, and since H.N. already had hypothyroidism and was taking thyroxine, this highlighted that her thyroid hormone efficacy may well need support.

**The main findings of this case report: What are the take-away messages?**
The main findings in this case report are that menopausal symptoms and signs can be improved with nutritional therapy, and in particular by focusing on the thyroid hormones, as well as the adrenal hormones.

However, the additional support of key remedies that can target important symptoms without the need for HRT, which carries a cancer risk, is a valuable thing to know.

**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.

H.N.'s views have been expressed within this case report. However, she could not be more pleased with the final improvements of getting her life back in the way that she wanted. She had more confidence for her future health now and this has a big impact on the quality of her life.

**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. H.N. 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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