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 email info@nutri-link.co.uk. We will send you the word doc.

Case reports are professional narratives that outline the diagnosis, treatment, and outcomes of the medical problems of one or more patients. Information from case reports can be shared for medical, scientific, or educational purposes. They provide a framework for early signals of effectiveness adverse events, and cost. Case reports and the systematically collected data from which they are written also provide feedback on clinical practice guidelines.

Case Report of a 32 year old woman with ulcerative colitis whose 9 years of severe digestive non-UC discomfort throughout her GI tract resolved very swiftly with specific nutritional therapy.

Abstract. *Summarise the following information if relevant: (1) Rationale for this case report, (2) Presenting concerns (e.g., chief complaints or symptoms, diagnoses), (3) Interventions (e.g., 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 multiple GI symptoms of a young woman, Miss T.C. whose life had been plagued with pain for up to 9 years, but severely so for the past 5 years. 9 years prior she had been diagnosed with ulcerative colitis, but 5 years later her symptoms extended to her stomach and upper small intestine.

In addition to her gut symptoms, T.C. suffered from daily, constant fatigue and depression.

There is little or no research which provides an integrated and broad scope of those with symptoms throughout their digestive tract when pathology has been ruled out (i.e. there is a functional imbalance). This leaves “nothing to treat” due to the lack of diagnosis. There is, however, an abundant number of papers on the subject of ulcerative colitis (UC) itself. That being said, there are only a relatively small number which focus on this inflammatory bowel disease (IBD) and the impact diet/modification has.

Crohn's Disease and Ulcerative Colitis are the two main forms of Inflammatory Bowel Disease, affecting more than 300,000 people in the UK. The incidence and prevalence of IBD are increasing with time and in different regions around the world, indicating its emergence as a global disease.[1]

UC is a condition that causes inflammation and ulceration of the inner lining of the rectum and colon (the large bowel). In UC, tiny ulcers develop on the surface of the lining and these may bleed and produce pus. The inflammation usually begins in the rectum and lower colon, but it may affect the entire colon. If UC only affects the rectum, it is called proctitis, while if it affects the whole colon it may be called total colitis or pancolitis.

[1] Molodecky NA, Soon IS, Rabi DM, Ghali WA, Ferris M, Chernoff G, Benchimol EI, Panaccione R, Ghosh S, Barkema HW, Kaplan GG. Increasing incidence and prevalence of the inflammatory bowel diseases with time, based on systematic review. Gastroenterology. 2012 Jan;142(1):46-54.e42 View Abstract

The conventional medical view is that UC is ongoing and life-long, although one may have periods of good health (remission), as well as times when symptoms are more active (relapses or flare-ups).

UC is a very individual condition and its symptoms will vary from person to person. They range from mild to severe and may also change over time.

Some people remain well for a long time, while others have frequent flare-ups. However, the most common symptoms are:

- Diarrhoea
- Cramping pains in the abdomen
- Tiredness and fatigue
- Feeling generally unwell or feverish
- Loss of appetite and weight loss
- Anaemia (a reduced level of red blood cells).

It's estimated that UC affects about one in every 420 people in the UK (roughly 146,000 people).

UC is more common in urban areas and in northern developed countries, although there is now an increase in numbers in developing and Asian nations.

UC is also more common in white people of European descent, especially those descended from Ashkenazi Jews (those who lived in Eastern Europe and Russia).

It can start at any age, though it often appears for the first time between the ages of 15 and 25. It affects men and women equally. https://www.crohnsandcolitis.org.uk

Typical medical treatment involves drugs and or surgery. There is a range of drugs used to treat Inflammatory Bowel Disease (IBD). Initially, the aim of drug treatment is to reduce inflammation in the gut to bring relief from symptoms are induce remission. Once the condition is under control, the doctor will usually continue to prescribe drugs to maintain remission and prevent relapse – this is called maintenance treatment.
In some cases, if medical treatment is not effective, then surgery may be required

Many of the drugs used to help control IBD are anti-inflammatory drugs. These include steroids, 5ASAs, immunosuppressants such as azathioprine, methotrexate and ciclosporin, and biological drugs like infliximab and adalimumab.

Other drugs used for IBD include antibiotics such as metronidazole and ciprofloxacin, and symptomatic drugs such as anti-diarrheal and bulking agents.

Functional digestive imbalances are considerably more common than IBD's and may co-exist with IBD, as in this case.

Key Words. Digestive & abdominal pain, ulcerative colitis, proctitis, pancreatitis, constipation, fatigue, hypoglycaemia, depression.

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

For 9 years, since the age of 22, Miss T.C. had been suffering from colonic gut pains, but mostly proctitis. For at least 6 years she had suffered constipation, fatigue, and depression. Upper abdominal pains under her ribs commenced 5 years after the onset of the lower colonic pains and the formal diagnosis of UC, which was made within weeks of the start of her symptoms.

The upper abdominal pains, which couldn't be, and have not been, formally diagnosed by the gastroenterologists, despite multiple tests & attempts, resulted in a complete change in life for T.C. Every time she eats she suffers extreme and severe pain under her ribs. Compared to the lower abdominal pains which are UC related, the upper abdominal pains are much worse; 9-10/10 vs 3/10 for the proctitis.

Her appetite diminished because she felt so full up she could barely eat anything. She needed to force herself to eat in order not to lose too much weight, and still does.

After meals, at variable intervals afterwards, she would experience a marked dip in energy which she understood to be reactive hypoglycaemia and she needed to sleep to feel better. For this reason, she sleeps after lunch to be able to function for the rest of the afternoon.

Her whole life is focused on her bowels and attempting to move them. This permits her to be able to eat, even though the eating then induces severe discomfort. She would dearly love to find any means by which to alleviate the upper abdominal pain, especially after eating.

Presenting Concerns. *Describe the patient characteristics (eg, relevant demographics—age, gender, ethnicity, occupation) and their presenting concern(s) with relevant details of related past interventions.* Miss T.C. is a Caucasian woman aged living in Hertfordshire with her partner. She works in the City of London, and commutes daily. She has been obliged to maintain her role for some years and not progress or accept promotions due to her poor health. This is something she has accepted, but it took years of stress before she could do so, but now she has accepted that she can only do what she can do.

T.C. has not engaged in multiple dietary or naturopathic approaches to ameliorate her colonic or digestive symptoms, and had not seen any other nutritionists or non-medical practitioners. She had been steered away from seeking such advice by more than one of her doctors. However, a friend of hers had read about a functional medicine approach which is what prompted her to make an appointment. She has not implemented a gluten or dairy free diet. She has, however, learned that greasy or fatty foods aggravate her abdominal pains. She also knows that bran, such as All Bran, or anything with skin on it, like a grape even or a nut or seed, aggravate her lower colon pains.

Miss T.C. presented with ongoing fatigue, persistent pain under her ribs particularly after eating which lasted for hours, and constipation. She also had what she described as 'horrific trapped wind', which was likely exacerbated by the constipation, which was both uncomfortable and noisy, as it gurgled loudly through her gut (borborygmus). She felt that she was stuck in a vicious cycle. She also admitted that she worried all the time. This was due to a number of things; the duration of her poor health, the anticipation of pain which would last for hours after she ate, the uncertainty of how long her poor health and gut pains would last, the prospects of maintaining her relationship because she could do so little in life and needed to sleep in the middle of the day every day, as well as the future of her career. For these reasons, T.C. felt depressed much of the time, even though she put on a brave face.

The post prandial hypoglycaemia was greatly lessened if she slept after lunch. However, this was and is clearly restrictive on her life at work and at home.

The prescribed drugs she had taken had not really helped her proctitis and she did not want to go on long-term medication, since she felt ill when she had taken them for a short time only. An antacid medication was prescribed for the upper abdominal pain, but this made T.C. worse, so she stopped it after 3 days, and this was about 4.5 years ago.

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.*
Miss T.C. has one sister who is in good health and has just started her own family. T.C. reported an absence of any health conditions within her family. Her parents are in good health and have been as long as she can recall. She acknowledges that it is not likely that her condition is an inherited one.

T.C. had a happy childhood, growing up with her sister and family in a small town, just north of London. She fared well at school, and was physically active like all the other children in her class. She enjoyed swimming as a regular sport. At university she kept reasonably fit and swam regularly. She was not a big drinker at university at all, and felt well throughout her three years of study.

A few months after graduating, T.C. came down with glandular fever. She does not recall what the analytes were in the blood test conducted by the doctor but she recalls the diagnosis was made based on the blood tests. She thinks is was a positive test to Epstein Barr Virus (EBV). One month or so after the glandular fever episode, which lasted for about 6 weeks, and after taking a week's course of antibiotics (although she does not know why she took them specifically), she experienced the first symptoms of what was very soon to be diagnosed as UC.

After some 5 years of proctitis symptoms, T.C. suffered from symptoms higher up in her GI tract. This included her stomach (burping & pain), in her small intestine (pain, some bloating, trapped wind, gurgling, some nausea), in addition to the pains in her rectum, which she knew as proctitis.

T.C. had been investigated with colonoscopies on more than ten occasions, and at least three endoscopies in an attempt to understand her severe pain after eating. She had had ultrasound scans of her abdomen and internal organs (including the liver and pancreas) but nothing has been identified as 'wrong with her'. She explained that she had been patronised on more than one occasion, which made her weep when she recounted this to me, when the doctors had questioned whether what she had was psychosomatic and wanted to refer her to a psychiatrist. She did not feel very strong generally, but she felt very confident that this was not a psychosomatic phenomenon.

She had been advised by a dietician about 8 years ago about a low residue, low fibre diet and the omission of roughage-type (insoluble) fibre such as bran and fibre cereals had definitely been helpful to her. She discovered that the avoidance of nuts and seeds also helped to reduce the proctitis pain. She candidly told me that she had wished many times that she would gladly live with the proctitis if she could be free of the abdominal pain under her ribs after she ate.

On meeting T.C. it was not evident that she was under-nourished, although she was slim, weighing 50 kg (8 stone) at 5'5". She is pale, but not so white as to draw attention. She did have noticeable dark rings under her eyes, however. She told me that she was not anaemic from the various blood tests that she had had, and she had never lost noticeable amounts of blood due to the proctitis. It was not really possible to tell

from being with her in the consultation that here was a woman who suffered with severe pain every day and had done for some years.

Her health goals were these:

1. To be free of the upper abdominal gut pain.
2. To eat and be totally unware of my gut.
3. To have great energy all day.
4. To be free of colitis / proctitis.
5. To feel well and be in good mood naturally, every day.
6. To optimise digestion and be free of constipation.

Timeline. *Create a timeline that includes specific dates and times (table, figure, or graphic).*
T.C. had not suffered from any remarkable illness or injury before 2008, the year she graduated.

In 2008, T.C. suffered from glandular fever. Four weeks after this, T.C. was diagnosed with UC, and she was prescribed a course of antibiotics. She did not have UC before the glandular fever.

The change in her health since that time was still something that she was coming to terms with, since she identified herself as someone who was well and very capable. She performed well at the sciences and maths at school and university and was on track for a career of her choice at the age of 22 years.

The proctitis was, in hindsight, quite manageable although at the time it was painful and inconvenient. For years, T.C. experienced proctitis pain as her only source of pain. This pain was persistent, but varied in intensity. Steroids had been prescribed but were not very effective. T.C. did not tolerate any other medication for more than a week. In total, T.C. estimates that she had taken two months' of medications and was adamant that she would not take any drugs, especially as they only offered palliative effects.

After five years of almost daily proctitis pain, in 2013, T.C. began to experience symptoms including constipation, indigestion, a sense of fullness, burping, and diminished appetite. She became more and more fatigued, particularly after eating. After visits to her doctor, she was then diagnosed with Rapid Gastric Emptying with severe hypoglycaemia. She had an extended glucose intolerance test conducted which showed that her glucose dropped to 2.5 mmol/L after 3.5 hours. This helped to explain her fatigue after eating, although she felt equally tired soon after eating and not just when the blood glucose dropped before 3.0 mmol/L.

The sleep after lunch permitted T.C. to function, and as one might imagine, she had needed to communicate her health issues to her employers in order to engage in this much-needed habit. She had been forced to decline promotions over the years due to her physical inability to function at the level that this would have required.

T.C. had been struggling for years with her painful condition which had been exaggerated by frustration of not knowing where to turn to get the help she needed.

The constipation issue really troubled T.C. and she recalled the scans that showed faecal matter was present virtually throughout her colon. When she felt so clogged up, she could hardly eat a thing. She used laxatives as little as possible since they caused an even more sluggish bowel after use.

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*.

Several possible therapeutic considerations presented themselves, when considering T.C.'s case history and presenting symptoms. To my mind, it was possible that she had, in no particular order of relevance these imbalances: gut dysbiosis (Broadly defined, dysbiosis is an imbalance in microbiota structure and/or function that disrupts host microorganism homeostasis and induces and sustains inappropriate inflammation), insufficiency dysbiosis (too few bacteria to support or create a healthy microbiome), food sensitivities, compromised gut lining, elevated levels of endotoxins Inc LPS), insufficient digestive juices including stomach acid, pancreatic enzymes and bile, a lack of natural gut motility (peristalsis and haustral churning), SIBO, imbalanced neurotransmitter balance, insufficient adrenal hormone output (i.e. low cortisol), possible under-active thyroid hormones. It may even be possible that she was still being affected by a viral burden since she had caught EBV.

<u>Possible / probable imbalances within T.C.</u>

- gut dysbiosis
- insufficiency dysbiosis
- food sensitivities
- compromised gut lining
- elevated levels of endotoxins
- a lack of digestive juices including stomach acid, pancreatic enzymes and bile
- a lack of natural gut motility
- SIBO
- imbalanced neurotransmitter balance
- insufficient adrenal hormone output
- under-active thyroid hormones
- viral burden

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).*
These options for nutritional intervention were re-presented and briefly discussed with T.C.

It had become evident from her diet diary that she still ate gluten and wheat and dairy products every day. The marked improvements in so many patients' health that I have witnessed on the exclusion of these foods / food groups made it challenging for me not to make the recommendation at the outset for T.C. to follow an elimination diet. There was justification for a stool test which may also give some indication of digestive function. An intestinal permeability test, whether urine or blood test, may have been positive. In my professional opinion, it would also have been likely for T.C.'s cortisol to be below the reference range, and for her neurotransmitters to be out of balance as well.

There was potentially so much to consider changing in her diet and so many tests to do to gather more evidence, that made it far from straightforward in deciding what to recommend to T.C.

I focused on the fact that no matter what T.C. ate, it caused the pain. If she ate fatty foods she felt worse, and had more nausea. This suggested that it was not food sensitivity (Food sensitivities are immune-

mediated reactions to some nutrients; these reactions (intestinal and extraintestinal) do not always occur in the same way when people ingest that particular nutrient. Non coeliac gluten sensitivity (NCGS) is an example of food sensitivity) that was driving her symptoms. There was strong evidence of poor digestion. It was highly likely that there was an imbalanced gut microbiota due to the daily excess wind, and irregular burping.

T.C. had not felt the same since she had suffered from glandular fever. However, it was a full 5 years afterwards that saw the symptoms spread to other parts of her colon, and then affect her energy and mood. For this reason, I was not of the opinion that we needed to focus on an anti-viral programme.

After ruling out all other options using an exclusionary process of logic, I decided to support T.C. with a minimal intervention programme. This was going to suit her because she had such little energy. It was also going to be a minimal-variable-experiment to help shed light on whether my conclusions had been correct.

What I decided upon was that she needed digestive support, and that both her liver and pancreas needed support, but particularly her pancreas. I hypothesised that her upper abdominal pain was the result of a dysfunctional pancreas. Why it should not have shown up in any blood markers or ultrasound scan, I do not know. Her symptoms resembled those of other patients of mine who did have confirmed pancreatitis. In those cases, I typically used a specific mix of antioxidants that have proven very effective in reducing symptoms, namely a formula called “BioProtect”. However, in this case, I recommended digestive enzymes in the form of a porcine glandular and a fat emulsifier in the form of phosphatidyl choline, which also offers support for the intestinal lining, and is hepatoprotective.

To help to keep her bowels moving, something of utmost importance, I recommended a supplement providing magnesium oxide, a poorly absorbed form of magnesium but one which acts as a natural laxative.

Diet-wise, I proposed that T.C. eat familiar meals to her that were naturally gluten and dairy free where possible, although this was going to pose a challenge for her lunch.

First Supplement Programme	
Phosphatidyl Choline (ARG)	2 with each meal
Pancreas (pork) (ARG)	2 with each meal
Lipid-X (BRC)	1 with breakfast & lunch & 2 with dinner

T.C. took the supplements as directed, and we met again 4 weeks later, by which time she had taken them for 25 consecutive days.

As with all patients at follow up, I aim to establish what changes have been made in terms of diet, supplements and lifestyle before learning about any health changes. T.C. told me that her life had been the same as usual in terms of work. She had not traveled anywhere during the previous weeks, and she had not changed her diet other than choosing the foods that were naturally gluten and dairy free. This resulted in about a 60% reduction in gluten and dairy.

T.C. then shared with me how she had fared with the minimal intervention supplement programme. She reported that after just 3 days of taking the 3 supplements, that her abdominal pain had reduced to virtually nothing. The pain had literally disappeared after 3 days on the supplements and her bowels were moving well. She was almost unaware of her gut after eating. She was stunned at the difference she had

experienced, which was a very good surprise to me as well. “I’m ecstatic!” she declared. She had also experienced considerably less wind compared to before and her proctitis was noticeably less. She felt much happier.

Her energy levels were still very low, but nonetheless T.C.’s energy was about 20% improved compared to when we had met 4 weeks’ earlier. However, and she still needed to sleep in the day. She also had mouth ulcers develop which gave her an overall sore mouth. Comparatively, this was much less discomfort than the previous abdominal pains, but it was something that made her feel poorly, in spite of the amazing improvement in her upper gut pains.

She told me that there was about 50% less mucus in her stool, which we had no really discussed in the first appointment. She had become so used to it, that she had not brought it up. It was only on the reduction that she thought to share the information.

Evidently, a big step in the right direction had been taken, and the digestive enzymes and emulsifiying, liver protective phosphatidyl choline had transformed T.C.’s life. She told me not to forget the benefits of the Lipid-X which sometimes allowed her to move her bowels twice a day.

She could not help but be very excited and recounted conversations with her partner, who had witnessed first-hand the changes, and her parents and sister. They were all in disbelief. She began to ask me about why such a simple approach was not recommended to her by her doctors, and I replied that it may be better to ask them directly and that it was likely that they had no training in functional imbalances vs pathological imbalances.

There is much consolidation work to be done, and for this reason, I explained that the chronic nature of her condition warranted many months of therapeutic intervention. I now felt that her body and digestive system could receive more in terms of concentrated supplements to being about healthy functioning. I introduced a formula for her gut lining and a free form amino acid formula to support all protein construction in the body, and specifically in her liver, and to support energy because a number of the amino acids are glucogenic amino acids, supporting liver energy.

Second Supplement Programme	
Phosphatidyl Choline (ARG)	2 with each meal
Pancreas (pork) (ARG)	2 with each meal
Lipid-X (BRC)	1 with breakfast & lunch & 2 with dinner
IPS Caps (BRC)	3 at the start of each meal
Free Aminos (ARG)	2 at each meal

We met again after 5 weeks and T.C. was still free of the severe abdominal pain. Her bowels moved every day and she was so much happier than she had been, she was literally brimming with new possibilities for her life. It was very moving to see. She had gone away for a weekend with her partner for the first time in years. She could eat whatever food she wanted, including gluten and dairy without any ill effects.

The mucus in her stool was lessening, week by week. She had less proctitis symptoms.

The mouth ulcers still persisted but were now about one third of their original number and severity.

Her energy levels had increased bit by bit, unlike the radical changes within her gut. She still benefited from a sleep after lunch, but was gradually reducing its duration.

She could now go walking on most days and had even gone to her local pool a few times, albeit for a non-arduous swim.

The dark rings under her eyes were visibly reduced.

We agreed that this second supplement programme would be best continued for a further 3 months to consolidate the improvements, at which time we would meet again. We agreed that if there was a decline in any symptoms, especially her GI symptoms, then she would contact me at once. To date, 2 months after the second appointment, I have received no contact, signifying ongoing improvement.

Supplement Information

Pancreas (pork) (ARG)
Per capsule, provides 425 mg of lyophilised pork pancreas, supporting digestive processes as well as the pancreas itself.

Phosphatidyl Choline (ARG)
A fat emulsifier, providing overall cell membrane integrity support, and hepatoprotective.

Lipid-X (BRC)
Provides 200 mg of magnesium oxide and citrate in a vegetable culture base.

I.P.S. Caps (BRC)
Provides nutrients shown to be needed for healing the intestinal lining including: glutamine, epithelial growth factor, Jerusalem artichoke, glucosamine sulphate, gamma oryzanol.

Free Aminos (ARG)
Provides 17 free form amino acids, many of which support phase II biotransformation pathways, as well as supporting gluconeogenesis.

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 detail of the case history, with the ability to read T.C.'s case in advance of the first appointment helped to provide the key relevant information on which to base clinical decisions. Experience of patients with similar symptoms helped me to identify a pancreatic issue, even in the face of the absence of any lab or ultrasound test evidence.

The literature relevant to this case report
There is no specific literature which supported the decisions on what T.C. would be best off doing to achieve her health goals. Rather, it was the careful listening to her case that led to the ability to discern what may be effective for her.

The rationale for your conclusions
The severe abdominal pain, which was located in and around the pancreas, occurred with all food. This suggested a fundamental digestive issue. That fatty foods always made he feel worse, alerted me to the need for support for fat digestion. As a result, digestive enzymes which also support the pancreas itself (because the enzymes came in the form of a glandular product), and phosphatidyl choline were recommended. The latter is both a fat emulsifier and a liver protective nutrient.

The main findings of this case report: What are the take-away messages?
Unlike conventional medicine, which can only realistically treat something it has tested and shown to be "out of range", nutritional therapy and functional medicine (& all wholistic and integrative approaches) are ideally suited to engaging the patient in interventions that are supportive of organ functions and health to promote improvements, rather than treat a 'disease' or a 'diagnosis'.

At the risk of repetition, it is the careful listening over a period of an hour's consultation which allows for sufficient information to be learned in order to make apt recommendations. It is true that the outcome far exceeded that which I conceived to be possible, and that it has been maintained from the 4th day of nutritional therapy is very rewarding indeed.

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.

Miss T.C. was "ecstatic", in her own words and could not have dreamt of such an outcome especially in such a short time.

The process of the consultation felt very natural and logical to her, and she felt that she was the centre of attention and that it was her that was being "treated" rather than a label of a condition. After all, the only label she had was UC and this is clearly not a case of UC that has spread into her entire colon. When it was explained to her what could be occurring, it did seem sensible, and she agreed with ease to pursue the first supplement programme.

T.C. still questions why on earth this kind of advice could not have been given to her before, since she had been led to believe that changes to her diet and the food she ate and alternative practitioners would not be effective at all in helping her.

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

The patient is not aware her case history is being used, and all identifiable data has been removed. T.C. are not her real initials.

Case Report Submission Requirements for Authors

1. Competing interests. *Are there any competing interests?*

None Known

2. Ethics Approval. *Did an ethics committee or Institutional Review Board give approval? If yes, please provide if requested.*

This case was not presented to an ethics committee.

3. De-Identification. *Has all patient related data been de-identified?*

All patient data has been re-identified

4. Author. *Name of Author and practice*

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