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.

Stabbing Gut Pains, Fatigue, Disrupted Sleep all 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 nutritionally focused approach to the resolution of a case of a young female patient who suffered from regular stabbing pains in her abdomen, along with a range of other digestive symptoms plus marked fatigue and interrupted sleep. She also experienced very painful menstruation.

Non pathological digestive complaints are common however; the stabbing pains experienced by this young woman are outside typical symptoms.

Irritable Bowel Syndrome (IBS) is characterised by abdominal pain and bloating, distention, excess wind, belching, cramping, constipation, diarrhoea, lack of satisfactory evacuation, mucus, fatigue, suppressed mood and depression. This patient had been diagnosed with IBS but no prior treatment had been effective, and the IBS itself did not fully explain the stabbing pains.

Medical treatment of IBS conditions can involve antibiotics, motility agents, anti-diarrhoeal agents, anti-depressants and anti-inflammatories, as well as CBT.

Abdominal discomfort is also a common feature of menstruation with some females believing this is normal.

With the implementation of a relatively straightforward change in her diet, combined with some short-term supplementation over four months, this young woman transformed her health and became free of all digestive symptoms and painful menstruation.

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

Stabbing pains, IBS, abdominal pains, burping, constipation, diarrhoea, fatigue, wheat, fructose malabsorption, menstrual pains.

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

This 17 year old young woman, Miss F.M., sought my help after having experienced a variety of gut symptoms for the previous 4 years.

When she was 13 yrs old, her abdominal pains had been attributed as a side effect of menstruation.

As time passed, and the gut symptoms became more overt and separate in time to her menstruation, it became clear that she had some dysfunction within with her digestive system. She was diagnosed with IBS and was prescribed a muscle relaxant to help resolve constipation but this led to diarrhoea. She was prescribed anti-depressants but these made her feel very spacey and these were stopped. She was prescribed Colpermin capsules (peppermint extract) which helped soothe the bloating marginally but she then experienced some burning in her gut so these were stopped. After these experiences, and at the age of 14, she was advised to learn to live with it.

She used painkillers for her period pains. These reduced the pain but always worsened the bloating and upset her bowels.

Miss F.M.'s energy gradually declined, and having been a resident team member of all sports at school, she became someone who rarely could engage in physical activity due to her fatigue.

When she was 16 yrs old, she began to experience stabbing pains in her right side, under her rib cage, and sometimes underneath her stomach, and sometimes under her left side ribs. The doctor referred her to the gastroenterologist and an ultrasound ruled out gallstones or any other inflamed organ. No causation was identified and pain killers and muscle relaxants were again prescribed. These did not suit F.M. and she only took a few of them.

F.M. lived with the discomfort of the gut symptoms and the stabbing pains became more frequent, and she also had started to burp a lot more.

The stabbing pains also increased in duration from 4-5 minute episodes to 30-40 minutes and this prompted her mother to seek an alternative approach.

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 F.M. is a white, Caucasian, Home Counties teenager of 17 years of age. She is 5' 4' (162.56 cm), and weighs 9 stone 4 lbs (57.78 kg). F.M. lives with her parents and her younger brother and sister in Hertfordshire. Her brother and sister are in good health and have no digestive complaints. They all sit and share dinner together and consume the same food at breakfast.

F.M. experienced digestive discomfort every day and the stabbing pains occur on average every other day and are more frequent at menstruation. When she has the stabbing pains she needs to sit still or curl up a bit, and if at home use a hot water bottle to try to reduce the severity of the pains.

Most nights, F.M.'s sleep is interrupted and she often takes a while to fall asleep again.

F.M. has no real acute stresses in her life other than her current health issues, but because of the fatigue she has under-performed at school and has been unable to participate in school sports which has left her feeling pretty miserable. So, rather than feeling stress, it is more accurate to say that F.M. generally felt pretty flat, de-

motivated, fed up and in a grey state. This also made her feel sad, but she had believed the GP when she was advised to learn to live with it and understands others have worse things to deal with on a daily basis.

F.M. tended to keep the fact that she had stabbing pains to herself, and she also kept herself to herself after meals which is when she would burp a lot which she found quite embarrassing. This meant that she was more isolated in terms of her friendships and interaction with others, including at home, than she had been.

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.*

F.M. was the only member of her family of 5 to suffer from any long term health complaint. In the course of taking the case history and preparing a time line, it was discovered that F.M. had a kidney infection when she was 9 years old for which she took antibiotics for one week at that time. Some years later, F.M. had an abscess on her back and this also required a longer course of antibiotics.

It was when she started secondary school that the gut symptoms had become more frequent and notable, which is when she had been taken to both the school doctor and her GP. The standard medications had not been effective and were very short-lived. There was one mention, F.M.'s mother told me, that it was believed that it may have been the stress of starting a new school.

Physically, F.M. looked tired, with a pale complexion and dark rings under her eyes. She told me she had been very fit and had strong leg muscles but this was some years ago. She found it noticeable that when she climbed the stairs her legs ached a bit.

Rather remarkably the notion that food choice maybe contributing to F.M.'s symptoms had yet to be brought up in conversation. F.M.'s diet was the same as the rest of her family and the same as her class mates who apparently were fine and free from GI complaints. It was quite common, however, for her class mates to complain of menstrual pains for which pain killers were a first resort. These girls did not report ongoing gut symptoms, as far as F.M. knew.

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

In 2006, when F.M. was 9 she had a kidney infection which was at least in part related to a very low water consumption and hot weather. Antibiotics were prescribed and taken and this resolved the kidney infection which did not recur.

Since her menarche, aged 12 in 2009, F.M. had experienced some discomfort or other when menstruating. She had taken pain-killers on at least one day every month for this. This was also the time when the gut symptoms were at their worst.

In 2010, F.M. had an abscess form on her back for an unknown reason, and this required antibiotics for two weeks. This did not recur, but F.M. did report that her skin on her face and her body was less clear after this time.

Since 2010, F.M.'s gut symptoms had become more regular and more severe and she had implemented a quieter approach to dealing with her symptoms and did not complain loudly about it.

Since 2013, however, the stabbing pains emerged and became more frequent, and in spite of medical investigation nothing abnormal was found and pain-killers and anti-spasmodic medicine was prescribed. However, this did not work.

The recommendations and progress made are described below.

Diagnostic Focus and Assessment. *Provide an assessment of the (1) diagnostic methods (eg, PE, laboratory testing, imaging, questionnaires, referral); (2) diagnostic challenges (eg, financial, patient availability, cultural); (3) diagnostic reasoning including other diagnoses considered, and (4) prognostic characteristics (eg, staging) where applicable*.

Miss F.M. and I met with her mother at each of the consultations. Her mother took a passive observer role and allowed her daughter to recount the events. Only when F.M. was unsure of matters, did her mother make a contribution, and when it came to her earlier childhood, of which she had no recollection. In this way, F.M.'s mother was unobtrusive, but was clearly concerned about the condition her daughter was in.

We established her specific health goals at the outset, as with every patient, and then went through the nutrition and health questionnaires and I asked about any other symptom unrelated to those goals. I then examined her diet diary which showed me that she ate what I consider to be a standard English diet. With the use of two colour of highlighter pens I covered the wheat containing products in fluorescent yellow and the dairy products in fluorescent pink. I also underlined the fructose content of the juices and fruits that she ate, in a red ink.

Having spent more time focusing on the FODMAPs content (fermentable oligo, di- monosaccharides and polyols) content of foods for the training day that Nutri-Link put on in November (14.11.14), I was all the more aware of the possible maldigestion and then subsequent malabsorption of fructose, and I noticed that F.M. did consume juices or fruit on 4 or more occasions each day.

I showed the diet diary page to F.M. and her mother and it was a sea of fluorescent pink and yellow and red underlines. If these foods were problematic then she was consuming a food which could lead to digestive problems at every single occasion she consumed any food, as well in between times when she drank juice.

I am very aware of the low FODMAPs diet, as well as of the breath testing for hydrogen (H2) and methane (CH4), and I am also aware that there are also some food intolerance tests too that could all provide more or less relevant information about what was going on within F.M.'s digestive tract. I also considered the possibility of H. pylori being involved, and perhaps exacerbating a raised pH state in her stomach, which led to excessive burping. However, the gold standard of food intolerance is the elimination and re-introduction approach. This is the route that I decided upon, and specifically in regard to wheat, dairy products (both lactose and casein related) and fructose.

Therapeutic Focus and Assessment. *Describe: (1) the type(s) of intervention (eg, preventive, pharmacologic, surgical, lifestyle, self-care) and (2) the administration and intensity of the intervention (eg, dosage, strength, duration, frequency).*

The nutritional programme that was recommended for F.M. was one that excluded all wheat, all dairy products, all fructose and all refined sugar. The latter is probably better digested than fructose and lactose, but it is not suitable for the support of energy balance, quite apart from its zero nutrient content.

Alternatives for each and every one of her meal ingredients and foods were made, along with fluid intake suggestions. This involved a total re-construction of her diet, as can be imagined given her regular and high intake of these foods.

In addition to the complete dietary overhaul, I recommended a limited number of supplements; it was going to be a challenge for this 17 year old girl to engage in anything more than a small number.

Here are the specific supplements F.M. took in the first phase.

Programme One Supplement Name & Brand	Dose
Colon Cleanze (ARG) with NutriGut®	2 caps with each meal
Stabilium (ARG)	4 with breakfast
Bio-3B-G (BRC)	3 at each meal

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

July 2014

The first appointment was at the start of June 2014. The first follow up was in mid July. F.M. had done her best to follow the dietary recommendations and had, in fact, been successful with notable exceptions which she recognised at the time. She took the supplements daily but managed only 80% compliance, she estimated.

The first week on the change of foods was very interesting. She had felt almost euphoric after about 2 days and experienced the old energy return and thought, as one might, that she was 'cured'. She over-did things and was more physically active than she had been for so long and stayed up later than usual. After all, she felt great! Then the next day things felt less exhilarating and the day after that, she crashed. She could barely get out of bed and had to miss school for that day. She felt like she had the 'flu and had a low-grade thumping headache, and her body felt like she had been through an assault course the day before. Her bowels were more sluggish and she felt, in her words, 'toxic'. It was a different kind of drained energy than her usual state, she reported.

She was in contact with me at that time, and I explained what may have been going on related to immunological responses to wheat and diary no longer occurring and then an inflammatory response as the body clears immune complexes (antibodies bound to wheat and dairy proteins) and this overwhelms the hepatic and gut detoxification and elimination pathways, and that of the lymphatic system.

Fortunately, the crash was short-lived. After two days she felt a gradual improvement of her energy, and having spoken with me was confident that she was on the right track, albeit that she did not really understand since she had felt cured and could not really understand why she should feel so awful whilst remaining on the same dietary changes.

By the time we met, which was over 5 weeks since the first appointment, F.M.'s stabbing pains occurred 60% less and were much shorter in duration, her other gut symptoms were all at least 60% better too, and she felt a return of her previous good energy. She had an outbreak of spots when we met. She also had bad menstrual

pains which were even worse than normal. I told her that I suspected this was likely part of the elimination of stored immune-complexes to proteins she was no longer consuming.

F.M.'s sleep was also much less interrupted than it had been, and she felt more refreshed in the morning, upon awakening.

On occasion, F.M. had eaten wheat knowingly and on the three times this occurred she had more obvious gut symptoms than at any other time in the whole month. No stabbing pains though. Whilst this was not planned it served as an important confirmation that wheat avoidance was the correct thing for her to be doing. The stabbing pains were becoming less and less and less, and the process was giving her a renewed lease of life. You should have seen her mother's face as I opened the clinic door to welcome them. Evidence of life-changing improvements, with no words spoken.

I reiterated an explanation of what each of the supplements were targeting and how they functioned. I added one - oil of evening primrose - in order to help reduce PMS symptoms and menstrual pains as well, by increasing PGE1 levels.

The second phase of supplements were the same as previously with an addition of Evening Primrose Oil

Programme Two Supplement Name & Brand	Dose
Colon Cleanze (ARG) with NutriGut®	2 caps with each meal
Stabilium (ARG)	4 with breakfast
Bio-3B-G (BRC)	3 at each meal
Evening Primrose Oil (BB) (1,300 mg)	1 softgel with breakfast & dinner after ovulation until day 3 of the cycle

We agreed to meet after six weeks.

September 2014

We met in mid September, the three of us. F.M. was looking so much better, with a rosy complexion and less noticeable dark rings under her eyes. F.M. confirmed that her stabbing pains were completely gone, that her gut symptoms were negligible, that her energy was much higher than it had been.

In one moment, when she was discussing how her health had turned around, when she described it as a momentous thing, and how fortunate it was that she had met me and we had found the way forward for her, I recognised the maturity that comes with suffering (no matter how small or large, it is all relative) because she was talking to me as if she were 27 or 37, not simply a young 17 years of age.

F.M.'s menstrual pains were significantly less than before, and her PMS was still present but less severe than before. I could not determine readily if this was because of the EPO supplement or a continued extension of improved energy and reduction in immune-reactivity driven inflammation that had been omitted from her body through the exclusion diet.

It is clear to me that all of the NTs who read this case history would engage in an identical or close to identical way forward for this young woman. The yellow, pink and red under-linings tell the story, and when combined with our understanding of how the human digestive system works, it seems like a very straightforward

approach, and it is. Yet, for years F.M. had been advised to either learn to live with it or take this drug, or that drug, and NOT ONE medical professional had even mentioned the food she ate.

So, what might appear almost too simple a thing to observe and then on which to base recommendations, do remember that the lenses through which we look at health and at a patient's history are fundamentally different to that of a medically trained doctor.

F.M.'s mother raised the question of why the most evident thing, namely the food that her daughter was eating, had not been discussed or even asked about when she had taken her to the doctors' appointments and the gastroenterologist specialist. I asked how long any single doctor had spent on discussing and investigating F.M.'s symptoms. She estimated that it must be 10 minutes maximum, albeit that there were three doctors who had spent about that much time each on her case asking questions. I described the reductionist medical model and how little time is spent on the training of a doctor on nutrition education, let alone the impact of different foods on gut health. I then reminded both F.M. and her mother that we had spent an hour together at the first meeting, after I had read the questionnaires, health history and diet diary which provided over 500 pieces of health data within them.

I raised the issue of a re-introduction of the offending items, and we all agreed together all at once and at the same time that this was NOT going be a wise idea; it was amusing. F.M. was more than willing to continue to be wheat and dairy free. We had discussed just how many different foods she had consumed as a result of NOT eating these staples of the English diet. I described the importance of consuming as diverse a diet as possible, from as wide as possible a source of foods.

The third phase supplement programme was reduced as shown here, with a planned three month graduated reduction in the supplements as long as F.M. continued to feel as well as she had.

Programme Three Supplement Name & Brand	Dose
Colon Cleanze (ARG) with NutriGut®	2 caps with breakfast & dinner for 4 weeks, then 2 caps with breakfast for 4 weeks, then stop
Stabilium (ARG)	4 with breakfast for 4 weeks, then 2 with breakfast for 4 weeks, then stop
Bio-3B-G (BRC)	3 at each meal for 4 weeks, then 2 with each meal for 4 weeks, then 1 with each meal
Evening Primrose Oil (BB) (1,300 mg)	1 softgel with breakfast & dinner after ovulation until day 3 of the cycle

We planned to have contact in January 2015, some months ahead to ensure that F.M. was in good health, sleeping through the night as she was now, and with energy intact and GI symptom free.

Supplement Information
Colon Cleanze with NutriGut® (ARG) – provides Perilla seed extract which is clinically proven to reduce symptoms of IBS, and supports optimal motility, and is combined with synergistic ingredients that support gut health and a healthy elimination of potentially inflammatory substances from the gut.

Stabilium (ARG) **-** an ancient North-Western European remedy derived from a ling fish called Garum Armoricum. It has been clinically trialled and been found to reduce anxiety, improve sleep and improve resilience, and in most cases improve energy levels.

Bio-3B-G (BRC) – a low dose B vitamin formula with 3 active B vits, which supports energy, neurotransmitter levels and functions and nervous system resilience.

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

Discussion. *Please describe (1) the strengths and limitations of this case report including case management, (2) the literature relevant to this case report (the scientific and clinical context), (3) the rationale for your conclusions (eg, potential causal links and generalizability), and (4) the main findings of this case report: What are the take-away messages?*

Strengths and limitations of this case report including case management
As was identified with the patient and her mother, a main strength was the length of time and sheer volume of relevant information that was learned about the patient, F.M.

The nutritional approach had not previously been explored and it was logical that something other than what she had done; which was very limited and mainly involved medications, be implemented. Within this nutritional approach, the most obvious culprit foods were avoided (ie wheat and dairy products) together with fructose which is increasing in its frequency of causing digestive symptoms due to maldigestion and malabsorption.

It is likely that there was a beneficial synergy of the food eliminations combined with the action of the supplements.

The literature relevant to this case report
There is a solid body of nutritionally oriented clinical evidence linking wheat and dairy products with GI symptoms. There is a gathering body of scientific research showing that fructose intolerance is increasing in its frequency.

The rationale for your conclusions
As has already been stated, it is my opinion that most if not all NTs would have reached the same conclusions as I did. It may be true that NTs all over the country have case histories which are very similar to this one, but not shared like this one is.

The main findings of this case report: What are the take-away messages?
This case history did not require minute, detailed analysis. It did take an appraisal of over 600 pieces of health data, but it did not take much deductive thinking to reach the conclusions and ultimately find the way for F.M. to change her health trajectory, and one could say life trajectory as well. She is on quite a different course now than she was.

Surviving off just 3 food sources for the majority of one's calories is a risky thing when it comes to optimal health. If there are 195,000 edible plants on the planet, and we are the most sophisticated creature on the surface of the planet requiring the greatest diversity of nutrient sources, and then we end up consuming 80% plus of daily energy intake in the form of just 3 foods, and refined and processed as well, it is not a recipe for healthy living.

The food we eat is the most likely contributor to gut symptoms. Throughout the ages of man this has been the case and is likely to be such in the future. This common sense approach may not be so common to all health practitioners.

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.

F.M. had been led to believe that her gut symptoms were something to live with. It is true that she was different to the rest of her family and her class mates at school. However, the food she put into her mouth every day resulted in her 4 years of suffering, with emotional and psychological and educational impacts.

F.M. now knows very differently, to the information she heard and believed when she was a young teen; that it was just one of those things. F.M. willingly and decisively follows her wheat free, dairy free and fructose free diet and enjoys a level of health she had almost entirely forgotten. Altered health and life trajectory is almost a certainty.

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. F.M. 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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