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.

Case Report of a woman who was overweight, had fatigue & a lack of confidence all improve when she followed a thyroid support NT programme

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 cluster of related symptoms and signs which are extremely common in the 21st Century, namely: overweight, fatigue, low self-esteem and confidence, poor sleep and abdominal bloating. In this case, these were all experienced after childbirth.

In the UK, Europe and USA these symptoms are extremely common, as is being overweight. Current estimates identify that 64% of the adults in the UK are either overweight or obese, and the percentage is increasing in children and adults. Fatigue is also very common but with less well defined statistics, as is a sense of lack of confidence. However, abdominal bloating comprises part of the symptomology of irritable bowel syndrome (IBS) and 50% of all visits to gastroenterologists are for IBS.

The blame for these symptoms and excess weight is placed on the shoulders of modern living and lifestyle choices, including being sedentary, poor food choices, poor sleep patterns and chronic sympathetic overdrive, or simply put, stress as well as others.

These symptoms appear more likely to occur after childbirth for obvious reasons of lack of sleep and the demands of a newborn and the resources required for breast-feeding and other associated activities.

For each individual there may be a variety of these commonly appreciated contributory factors, as well as more unique but nonetheless common metabolic imbalances which may include sub-clinical hypothyroidism or an adrenal hormone excess or insufficiency amongst others.

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

Overweight, fatigue, lack of confidence, thyroid, stress, insomnia, bloating, cravings, childbirth.

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

Mrs T.D. is a 42 year old mother of 3 children, who used to have a high profile job in London before having children. She had been able to maintain a slim figure all of her life until motherhood (which is not uncommon). However, she now presented with excess weight, a lack of confidence and suppressed energy levels. She suffered from insomnia, and experienced abdominal bloating and cravings. In addition, which may well be linked to the self-confidence, she found that her will-power which had in her past been almost 'legendary', she told me, was simply hopeless now.

T.D. told me that she had tried various 'diets' but they simply made matters worse because as soon as she tried to reduce her food intake, she only ate more rubbish after her meals due to hunger. She had gained weight since the birth of her first son just over four and a half years before. Now, after having three boys in that time, she told me she was 2 stone heavier than she had been for her adult life.

She used to have high confidence in what she did and in social settings, but now she found that she felt so low that she began to make excuses to avoid meeting friends. Her brain didn't work like it used to, and this frustrated her immensely, although it did seem to me that she was very able to focus in our consultation. She told me the multi-tasking of life with her kids had really 'frazzled' her brain.

Her main health goals were to lose weight, improve her energy and regain her self-confidence and brain function.

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.*

T.D. is a 42 year old caucasian woman who is now a full time mother, having worked in the City of London. T.D. had achieved a number of academic and career successes and had always kept a fit physique. T.D. told me she had hardly had a day off work in her life.

She had been told by her doctor that nothing was wrong with her blood test results when she visited him 6 months after her 3rd child, and this was reiterated after a more recent meeting with the GP, based on blood tests.

T.D. presented with fatigue, lack of confidence, poor sleep, dulled brain function, inability to resist her food cravings and was 2 stone overweight. She had only been able to lose weight by reducing food intake significantly and this proved to be unsustainable as her fatigue worsened and then she had begun to over eat what she called rubbish food. T.D. was seeking an explanation and a plan to restore her health to the way it had been for the vast majority of her life.

Clinical Findings. *Describe: (1) the medical, family, and psychosocial history including lifestyle and genetic information; (2) pertinent co-morbidities and relevant interventions (eg, self-care, other therapies); and (3) the physical examination (PE) focused on the pertinent findings including results from testing.*

Mrs T.D. is a 42 year old mother of three young boys. She is 5 foot 8 tall, and weighs 12 stone 5 lbs (172.72 cm, 77 kg). Her parents are alive and well in their late 70's. Her one brother is very well. There is no evident family history of any particular type of condition, with her grandparents on both sides living well beyond the average age. T.D. grew up and has lived in the south of England, close to London, other than a two year stint in New York in her late 20's.

T.D. looked tired in that she had dark rings under her eyes, and it was evident that she was carrying excess weight which she put her hands on demonstrably to show me what she did not want. Other than this, there were no other signs of any health issues.

There were no other test results that had been conducted.

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

T.D. had been very well for all of her life. She had been fit & well as a child engaging in all school and sports activities. She and her older brother had been very active and lived outdoors when they could. In her teens, T.D. had also been healthy and not experienced some of the hormonal challenges that her friends had been through. She played a variety of sports and had achieved academic success and attended a highly ranked university. Here she had played lots of sports and worked hard at her studies. She told me that she had made mistakes with eating the wrong food, but since this had made her feel less energetic on the sports field and on the track she had found a healthier diet suited her. She also had rarely drunk excess alcohol.

She married when she was 34 and kept on working in her successful career. She then started a family and had her first of three boys when she was 37 yrs old. Her 2nd son was born when she was 39 yrs and the 3rd was born 18 months later when she was 40 yrs old. She had gained weight since the birth of her first son and now, after having three boys in four and a half years, she was 2 stone heavier than she had been for her adult life.

Although her pregnancy had been a very good one, her energy had been noticeably lower after her first son was born when she was breast feeding, and had never really recovered. An unusual lethargy fell on her and she found motivation to do all the things that needed to be done was distinctly lacking. She began to lose confidence in herself at this time, she was able to identify in hindsight. One of her friends had said “welcome to motherhood” and she told me she now fully understood this whereas at the time she rejected the notion that her health could be compromised by having children, or refused to accept that it might be different.

She found it difficult to lose weight after her first boy. Her weight increased gradually over the next few years and in between being pregnant and breast feeding and more recently, since her youngest son was two years old, she had tried a variety of calorie restricted diets. She had lost some weight but the cravings for carbohydrates and sweet foods had become too much and she had developed a biscuit habit which she really disliked.

The GPs tests had shown nothing out of the normal range, and she was not anaemic. She felt sluggish, brain dulled, unable to choose the food she used to eat and on which she felt so well, and felt colder on the inside generally, and a lot less confident in social settings.

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*.

T.D. had had the standard haematology and complete blood chemistry (CBC) done via her GP a few years ago and then again 4 months prior to our first meeting. All was normal, although we did not have a set of the results to examine. These results included TSH, which meant that on a pathological level at any rate, her thyroid hormone level was deemed to be normal.

I carefully examined her NAQ questionnaires and the section for her thyroid and adrenal both scored highly. I asked her about these symptoms in particular to gauge the degree of severity and time of onset. It appeared that after her first son was born that she experienced a cluster of symptoms that fit within the classic list that associated with thyroid hormone levels and function.

I showed T.D. a list of 20 signs and symptoms associated with under-active (subclinically under-active) thyroid-related symptoms that she was experiencing and she could identify with over half on the list.

T.D. did not want to go back to her GP whom she did not believe could help her, and when we discussed undertaking a private test she said she would consider it. Her friend, who had referred her, also had a similar health scenario and had had much improved health by following the recommendations made to her and T.D. was keen to get started. We agreed, however, that if there was no progress after one month that T.D. would do a comprehensive thyroid hormone profile, privately.

Thyroid tests can often return with results within the normal medical range whereas the actual hormone function may be less than optimal.

T.D. agreed to proceed with a nutrition programme that focused on supporting a healthy function of her thyroid hormones. This also meant she would be taking some action now, rather than awaiting a test result, which is what she wanted.

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).*

We agreed that T.D. would follow a two phased approach, one involving thyroid support supplements only with no dietary change for one month, and the next phase would involve the same supplements but with a gluten free diet, ensuring also an improved ratio of protein and carbs and vegetables at lunch & dinner.

She was very keen to know what had been going on within her metabolism and could see that the two phases would help to provide distinctions in terms of the information that could be learned.

The first phase involved supplements specifically geared to support healthy thyroid hormone production and function.

First Supplement Programme	
Thyrostim (BRC)	2 with breakfast & 1 with lunch
GTA Forte II (BRC)	2 with breakfast & 1 with lunch
MedaStim (BRC)	2 with breakfast & 2 with lunch

We had a telephone appointment after 4 weeks and then we met for a 2nd face to face appointment after a further 4 weeks. We then met 6 weeks after that. In spite of her complaint that her brain was not functioning as it was, she was a patient who certainly could stick to a programme without contact and help and simply meet at the arranged appointment times.

After four weeks on the first supplement programme we had a telephone appointment. T.D. told me on the phone after 4 weeks on the programme that she had lost 5 lbs in weight. She sounded disappointed so I asked

her how she felt about that. She said that she had thought she might lose more. I asked her what she had done differently, and she confirmed that she had just taken the supplements as I had recommended.

I repeated this back to her; that she had consumed the same food as before and just taken the supplements and lost 5 lbs of weight and then translated that into calories which is about 3,500 kcals per pound of fat which equals 17,500 kcals. It then dawned on her that her body was able to utilise approximately 17,500 kcals of energy over and above that which she had been able to the month before. This information definitely helped her to feel more upbeat about the result.

Her energy was improved, she said, definitely, by a good 25% up, and her mood was improving but she could not quantify it. We discussed the dietary changes for some time and she agreed to them, to be taken alongside the supplements, the same as the first programme.

It was agreed, due to the improvements on the supplements alone, to postpone a thyroid hormone blood test.

The second phase was implemented and involved the same supplements but with some dietary changes. The dietary recommendations were as follows:

- Eat 3 meals a day, as usual.
- Gluten free diet.
- Eat a protein at breakfast (which she did not), as well as lunch and dinner (which she normally did).
- Reduce her carbs to minimise insulin.
- Drink water throughout the day (she tended to neglect water).
- Relax before eating and afterwards (she tended to eat in a rush).
- Avoid all cheese for now (she tended to eat a lot of cheese, in my opinion)

Minimise all alcohol so that she would only consume 3 glasses over 7 nights, maximum.

When we met for the second face to face appointment, 8 weeks after the first appointment, I could see the difference in her weight. T.D. reported that she had lost a further 7 lbs, making 12 lbs in those 8 weeks. She was very pleased, especially as everyone she knew had been commenting. Her energy was also improved to about 50% higher than before. She was sleeping better and she did feel better within herself. She cited incidences which reflected that she had been more ‘solid’ within herself and more confident.

She questioned whether confidence could be related to thyroid hormones, and I explained that it was possible and how low thyroid hormones could lead to lowered energy and then poor mood and low confidence. This was news to her, but because of the weight loss that she had experienced along with the improved energy she could identify with and understand the connection.

She then followed the same programme for another 6 weeks when we met for the third time. T.D. was beaming when she entered the clinic room, and was clearly a leaner woman than she had been when we first met. She had lost 12 pounds after 8 weeks and then she had lost another 6 lbs in the following 6 weeks resulting in a total of 1 stone and 4 lbs. She still wanted to lose another half stone, but she was thrilled that it had all happened so swiftly. This positive feedback from her efforts also really helped her to abide by the gluten free diet and healthier food choices.

Energy had improved 75-80% from what it had been and she was sleeping through the night on occasion, and if not it was mostly due to one of her boys waking her up. She was able to commence a training programme with

a personal trainer three times a week and was finding this manageable whereas 2 or so months before that she could not have imagined doing this kind of physical work.

Her abdominal bloating was significantly less. She was returning to the self-confident woman she had been, she told me. She also felt warmer, she reported.

We discussed the need to remain gluten free and she was going to experiment, when out for dinner as opposed to at home, and report back to me if there were any untoward symptoms. No tests were conducted for gluten sensitivity and I was aware that there may need to be a longer avoidance, and possibly for life. We also did not have evidence of thyroid antibodies either. T.D. was in so much better health at this stage that she certainly felt no need for investigation.

The supplements were changed to this programme, which essentially involved stopping the Thyrostim (BRC) product.

Second Supplement Programme	
GTA Forte II (BRC)	2 with breakfast & 1 with lunch
MedaStim (BRC)	2 with breakfast & 2 with lunch

We then had a telephone appointment 4 weeks after the 3rd face to face appointment. This involved a total time span of 18 weeks / 4 months.

T.D. continues with a reduced supplement programme, a similar way of eating and with occasional gluten consumption if out.

She is a client who now understands the difference between pathology assessment and functional medicine assessment; that you can have quite a lot that feels wrong in your health and yet you have 'nothing wrong with you' medically speaking but you can have quite a lot wrong with you on a functional level. As a result of this, she has referred quite a number of friends to me, friends who have witnessed the changes that have occurred in T.D.

Lastly, her ability to carry out what she has set her mind to do has returned to its previous state, and no longer does she suffer from a lack of will power.

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 an effective products to support healthy thyroid hormone levels.

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)
This is a vegetarian formula designed to provide the nutrients to convert T4 to T3. In my experience with this product over the years, it has successfully improved T3 conversion from T4 when patients have had re-tests, as well as in their symptoms.

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 opportunity of having a detailed case history with a time line to see the sequence of events and put this into the context of T.D.'s life was vital to the understanding of what may be imbalanced within her metabolism. Simply meeting her without knowing her health history (a very healthy history) she may not appear any different to the next patient, and with 7 or 8 minutes of assessment for example, with normal blood test results, but without lifestyle, family and dietary information it may be very difficult to identify what may be needed in order to help resolve the signs and symptoms that T.D. presented with.

The willingness of T.D. to engage in the phased nutrition programme based on her understanding of the aim of the programme and her witnessing her friend's improvements supported her ability to follow the recommendations closely.

It may not be a limitation in itself, since the outcome has been successful in a relatively short time for this lady, but it would have been ideal if there had been blood test evidence of thyroid hormone imbalances when she started and then blood test evidence of the restoration of more optimal levels after the programme was followed.

The literature relevant to this case report
It has been estimated by some healthcare practitioners that as many as 10% of mothers may experience thyroid hormone problems after childbirth. That the thyroid may be affected by pregnancy and postpartum is has been recognised in a relatively large prospective study.

- Truijens SE, Meems M, Kuppens SM, Broeren MA, Nabbe KC, Wijnen HA, Oei SG, van Son MJ, Pop VJ. The HAPPY study (Holistic Approach to Pregnancy and the first Postpartum Year): design of a large prospective cohort study. BMC Pregnancy Childbirth. 2014 Sep 8;14:312. doi: 10.1186/1471-2393-14-312.

The rationale for your conclusions
The detailed case history combined with a focus on the typical signs and symptoms of sub clinical hypothyroid hormonal imbalances in addition to clinical experience of witnessing the relatively high frequency of recent Mums having thyroid hormone problems led to the rationale for the approach used.

A review after one month, at which time it was agreed to conduct testing if there had been no progress, was put in place to ensure that any appropriate lab testing would not be missed.

The outcome of the nutrition programme supported and supports the theory that there were thyroid hormone imbalances.

The main findings of this case report: What are the take-away messages?

As with other recent mothers, T.D. experienced sub-clinical hypothyroidism after giving birth. The normal blood tests from the GP led T.D. to feel it was all psychological, whereas there was a real thyroid hormone issue within her body. Certainly, the change from full time work to motherhood no doubt had a role to play in how she felt about herself, but in this instance, the speed of recovery matches the nutritional support for her thyroid and her weight loss which helps to provide very robust evidence for what was 'wrong' with her metabolism.

Her family and friends all know what she has gone through and she can speak eloquently about the distinction between a medical condition and a sub-clinical condition for which another type of therapist to a GP is required. She has become an advocate for functional medicine and related nutritional therapy.

The ability to conduct a thorough case history with a time line, and be in appreciation of possible likely imbalances that could be present in such as case led to identifying the nature of the imbalances within T.D. who now is enjoying life considerably more as a result of having corrected this functional imbalance.

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.

T.D. told me that she knew there must be something chemical going wrong, since she had not ever felt like she had since childbirth. I agreed and re-phrased that as a biochemical and hormonal imbalance. She acknowledged that she really had no idea what it would be like to have three children and had been naïve, but still firmly believed that she could regain her good health back.

Even if T.D. had not been speaking to her friend about her experience on a nutritional programme she would have sought out an answer one way or the other and not accepted that she should learn to live with this. She was, however, delighted to have found someone who had been able to identify the specific imbalance and correct it and told me that it completely makes sense and wants to help other recent mums with their fatigue, poor mood and so on.

Lastly, for T.D., she is just so pleased to be able to have the energy and focus for her children and not be lost in a spacey existence, feeling disconnected, as she had been.

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.D. 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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