RETURNING TO OUR ROOTS:
Integrating Functional Medicine Into Pharmacy Practice

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OBJECTIVES:
Upon completion of the session, the participant shall be able to:

• Distinguish the difference between the (learned, traditional) allopathic medicine and functional medicine models

• Utilize the basic tools to determine root causes of common chronic diseases

• Recognize the advantages of diversifying the practice with FM consultations

• Discuss why Functional Medicine is critical to your practice
What is FUNCTIONAL MEDICINE?

“Functional Medicine is defined as a HEALING-ORIENTED MEDICINE that takes into account the whole person, including all aspects of lifestyle. It emphasizes the THERAPEUTIC RELATIONSHIP between the patient, the practitioner and the pharmacist; it is informed by EVIDENCE, and makes use of ALL APPROPRIATE THERAPIES”
How Relevant is Functional Medicine?
"It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has."

William Osler

"The good physician treats the disease; the great physician treats the patient who has the disease."

"If you listen carefully to the patient, they will tell you the diagnosis."

Sir William Osler, one of the first professors at Johns Hopkins University School of Medicine and later its Physician-in-Chief
Why Did You Become a Pharmacist?

Insert

CLASS

PARTICIPATION

here
What Were We Taught in School?  
(excluding chemical structures & the Krebs Cycle)

- We were taught how to **IDENTIFY** potential side effects of medications

- We were taught to **MAKE RECOMMENDATIONS** based on patient symptoms

- We were taught to **MANAGE/TREAT** diseases; not PREVENT them
Heart Disease
Cancer
Allergies
Irritable Bowel
Auto Immune Disease
Diabetes
Chronic Fatigue
Anxiety
Depression
Thyroid Issues
Hormone Imbalances
High Blood Pressure
But What If There Was MORE?

- What if the *methylation pathway*, that is so intricately involved in common diagnoses like, depression, miscarriage, anxiety and insomnia was emphasized as much as the Krebs Cycle?

- What if you were trained on *genetic SNPs* and the triggers that express them?

- What if you knew of *more advanced testing* that might uncover underlying problems?
But What If There Was **MORE**?

- What if you could **empower patients** by bringing them the latest studies that *may* discredit current treatment guidelines?

- What if you could teach patients how lifestyle and nutrition could **arrest** if not **reverse** some chronic diseases?

- What if you became an expert in **optimal reference ranges**?
Functional medicine hopes to reduce these costs:

- **Total national health expenditures (2011):** $2.7 trillion
- **Total costs of heart disease and stroke (2010):** $315.4 billion
- **Total estimated cost of diagnosed diabetes (2012):** $245 billion
- **Total estimated costs linked to obesity (2008):** $147 billion
- **Per capita national health expenditures (2011):** $8,680

84% of all health care spending in 2006 was for the 50% of the population who have one or more chronic medical conditions.
Differences Between Allopathic and Functional Medicine

**ALLOPATHIC MEDICINE:**
- Based on SYMPTOMS
- Treats the DISEASE
- DOCTOR centered
- Cost effective
- INSURANCE model
- Focuses on ADDING
- Asks WHAT?

**FUNCTIONAL MEDICINE:**
- Based on SYSTEMS
- Treats the UNDERLYING CAUSE
- PATIENT centered
- More expensive
- CASH model
- Focuses on REMOVING
- Asks WHY?
Obstacles That Independents Face Today

- Historically, independent pharmacists have profited from PRESCRIPTIONS and FRONT END MERCHANDISE

- Under current economic conditions, patients are easily persuaded to use MAIL ORDER or big box stores to save money

- Profits are decreasing due to poor reimbursements and DIR Fees
Advantages to Integrating Functional Medicine into Pharmacy Practice

- Functional Medicine strengthens the $\text{patient} - \text{pharmacist}$ relationship

- Functional Medicine $\text{bridges the gap}$ in the continuum of care that traditional roles have created

- Functional Medicine positions pharmacists as an $\text{equal partner}$ in the physician-pharmacist relationship
Advantages to Integrating Functional Medicine into Pharmacy Practice

- Functional Medicine creates diversification
- Drastically increases vitamin/supplement sales
- Creates MORE opportunity for custom compounds
Barriers to Integrating Functional Medicine into Pharmacy Practice

- Changing **YOUR** thought process
- Changing the perception of **YOUR WORTH**
- Creating an **OPERATIONALMODEL/WORKFLOW** in your practice setting
- **BUDGETING** for the time and expense of a more specialized continued education
Where Do I Start?

Rediscover your PASSION & become an EXPERT in that area

- If THYROID has always interested you then take a new approach when dispensing levothyroxine

Start asking your patients questions

- When was the last time you felt GOOD?
- What do your labs look like?
- How have your symptoms changed since you’ve received therapy?
Where Do I Start?

Recognize trends & ask YOURSELF “WHY?”

- Why does everyone have the same ‘catch-all’ diagnosis?
- Why is hypothyroidism more common in women?
- Why do patients remain symptomatic despite therapy?
- Why have so many patients remained on the SAME dose for SO many years?

(What are we **ALL** doing, eating, breathing or ingesting that is common to **ALL** patients with thyroid imbalance?)
Where Do I Start?

Equip yourself with the proper tools & resources to answer those questions

- Find free webinars
- Find *credible* sources that use *credible* studies
- Find supporting studies on your own
- Become an expert in testing
- Find & enroll in a certification program
- Read, READ, READ!!!
Where Do I start?

Assign a value to the effort you put forth in acquiring the answers

Re-brand your image

Be prepared to defend yourself with studies in hand
The DO’s of Re-Branding

- Have an **office procedure** on how to handle questions about your new practice features
- **Train support staff** to uphold your *new* image
- **Empower & equip your staff** to answer questions
- Have a **packet** that goes into further detail (your mission statement, why you are changing your practice, pricing, time frame, etc.)
The DON’Ts of Re-Branding

- **Don’t** be the first one to answer the phone

- **Don’t** rush to the counter for anything more than a direct answer to a specific medication related question (*excluding your obligations to OBRA*)

- **Don’t** give away your specialty for free
Let’s Get This Started

KNOW the PATIENT

KNOW the DRUGS

KNOW the DIAGNOSIS

KNOW the TRIGGERS

KNOW the LABS
Case Study
AVERAGE HISTORY & PHYSICAL

• **Hx:** 44yo peri-menopausal, wife and mother of a teenager and a pre-teen; c/o *chronic fatigue, daily headaches and unable to lose weight; debilitating joint pain.* She was an emergency room RN by trade – quit her job 5 years ago when trying to juggle caring for ailing mother and aging step-dad

• **Social Hx:** Smoker (1/2 ppd); occasional etoh; sedentary; multiple drug allergies

• **Medical Hx:** Mononucleosis (at 16yo); cholecystectomy (at 22yo); 2 C-sections

• **FmHx:** Mother died at 67 d/t sepsis (complications from a 40 year old mesh bladder sling)  
  **Significant for:** obesity; diabetes; hypertension; hyperlipidemia; thyroid imbalance; depression, CVD

• **Meds:** phentermine 37.5mg QD; IBU 800mg Q8h prn HA; Excedrin Migraine 2 po q6-8h prn HA; omeprazole 20mg QD-BID prn
See?

**ALL NORMAL;**

“You’re just fine!”

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**Standard lab tests ordered:**

- **LIPID PANEL WITH REFLEX TO DIRECT LDL**
  - **Desirable range** <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.
  - **Total Cholesterol (105)**
  - **LDL-Cholesterol (103)**
  - **LDL-Cholesterol target**

- **CHOL/HDL RATIO**
  - Desired ratio 2:1

- **NON HDL CHOLESTEROL**
  - **Target for non-HDL cholesterol** is 30 mg/dL higher than LDL cholesterol target.

- **COMPREHENSIVE METABOLIC PANEL**
  - **Glucose:** 97 (65-99 mg/dL)
    - **OPTIMAL:** <85
  - **Urea Nitrogen (BUN):** 15
  - **Creatinine:** 0.61
  - **eGFR Non-AFR American:** 110
  - **eGFR African American:** 128
  - **BUN/Creatinine Ratio:** NOT APPLICABLE
  - **Sodium:** 133 L
  - **Kali:** 3.9
  - **Chloride:** 104
  - **Carbon Dioxide:** 9.4
  - **Calcium:** 7.4
  - **Albumin:** 4.3
  - **Globulin:** 3.1
  - **Albumin/Globulin Ratio:** 0.3
  - **Phosphorus:** 86
  - **AST:** 18
  - **ALT:** 17
  - **TSH:** 1.77

- **CBC (H/H, RBC, INDICES, MCH, PLT)**
  - **White Blood Cell Count:** 16.3 H
  - **Red Blood Cell Count:** 14.5
  - **Hemoglobin:** 45.1
  - **Smoker:** Yes

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Not only ‘normal’, but this **TSH** is actually **OPTIMAL**!
<table>
<thead>
<tr>
<th>Test Name</th>
<th>In Range</th>
<th>Out Of Range</th>
<th>Reference Range</th>
<th>Lab</th>
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<tbody>
<tr>
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<td>92.7</td>
<td>99.4</td>
<td>80.0-100.0 fL</td>
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<tr>
<td>MCH</td>
<td>29.7</td>
<td></td>
<td>27.0-33.0 pg</td>
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<tr>
<td>MCHC</td>
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<tr>
<td>RDW</td>
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<td>15.4 H</td>
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<td>PLATELET COUNT</td>
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<td>140-400 Thousand/uL</td>
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<tr>
<td>IRON, TOTAL</td>
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<td></td>
<td>40-190 mcg/dL</td>
<td>DLO</td>
</tr>
<tr>
<td>C-REACTIVE PROTEIN</td>
<td>0.44</td>
<td></td>
<td>&lt;0.80 mg/dL</td>
<td>DLO</td>
</tr>
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</table>

Please be advised that patients taking Carbapenem antibiotics may exhibit falsely decreased C-Reactive Protein levels due to an analytical interference in this assay.

**Iron:** 79 (40-190 mcg/dL)

**OPTIMAL:** 110 (40-190 mcg/dL)
BUT WAIT!!!
REMEMBER:

“ABNORMAL” is DYSFUNCTIONAL
and
“NORMAL” is ONE step away from

chronic disease
new

**AVerAGE HISTORY & PHYSICAL**

- 44yo peri-menopausal, wife and mother of a teenager and a pre-teen; c/o chronic fatigue, daily headaches and unable to lose weight; debilitating joint pain. She was an emergency room RN by trade – quit her job 5 years ago when trying to juggle caring for ailing mother, aging step-father and the family farm.

- **Social Hx:** Smoker (1/2 ppd); occasional etoh; sedentary; multiple drug allergies

- **Medical Hx:** Mononucleosis (at 16yo); cholecystectomy (at 22yo); 2 C-sections

- **FmHx:** Mother died at 67 d/t sepsis (complications from a 40 year old mesh bladder sling)
  
  Significant for: obesity; diabetes; hypertension; hyperlipidemia; thyroid imbalance; depression, CVD

- **SUMMARY:**
  - Mother’s health declines rapidly (uncontrolled DM & obesity) after knee replacement (over 1.5 years)
  - Aging step-father had a stroke
  - Tragically loses step-brother in MVA
  - Mother is placed in a nursing home; becomes unresponsive shortly after arrival; is hospitalized and within 24 hours dies from sepsis (culprit: mesh bladder sling from 40 years ago)
  - Tragically loses niece in MVA

- **Meds:** phentermine 37.5mg QD; IBU 800mg Q8h prn HA; Excedrin Migraine 2 po q6-8h prn HA; omeprazole 20mg QD-BID prn
Married, mother of two teenagers, sole care-taker for step-dad (bills, laundry, groceries, cooking, etc.), helps on family farm, endured significant loss in the last 4 years, responsible for the ‘closing’ of her mother’s estate.

Exposures: mold, cigarette smoke, BPA, MRI, root canals, Standard American Diet, chlorine, pesticides, etc.
WHAT STANDS OUT?
Case Study #1:

• 44yo peri-menopausal, wife and mother of a teenager and a pre-teen; c/o chronic fatigue, daily headaches and unable to lose weight; debilitating joint pain. She was an emergency room RN by trade – quit her job 5 years ago when trying to juggle caring for ailing mother, aging step-father and the family farm.

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• Timeline SUMMARY:
  • Mother’s health declines rapidly after knee replacement (over 1.5 years)
  • Aging step-father has a stroke
  • Tragically loses step-brother in MVA
  • Mother is placed in a nursing home; becomes unresponsive shortly after arrival; is hospitalized and within 24 hours dies from sepsis (culprit: mesh bladder sling from 40 years ago)
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We have evolved to accept symptoms that are “COMMON” as “NORMAL”.

When referring to labs results - there are several opinions & authorities on ‘what is optimal’ –
I encourage you to find your comfort zone when defining these ranges.
American Diabetes Association - Blood glucose goals for people with diabetes:
  ▪ Before eating (pre-prandial) 70-130mg/dl
  ▪ 1-2 hours after eating (peak post-prandial) <180mg/dl
  ▪ A1c blood glucose test (3 month blood glucose indicator) <7 percent

American Association of Clinical Endocrinologists - Blood glucose goals for people with diabetes:
  ▪ Before eating (pre-prandial) <110mg/dl
  ▪ 2 hours after eating (post-prandial) <140mg/dl
  ▪ A1c blood glucose test < 6.5 percent

Read more: http://www.diabetescare.net/management/blood-glucose#ixzz4FiWa84wo
**CURRENT GUIDELINES**

Information obtained from Joslin Diabetes Center's Guidelines for Pharmacological Management of Type 2 Diabetes.

<table>
<thead>
<tr>
<th>Time of Check</th>
<th>Goal plasma blood glucose ranges for people without diabetes</th>
<th>Goal plasma blood glucose ranges for people with diabetes</th>
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<tbody>
<tr>
<td>Before breakfast (fasting)</td>
<td>&lt; 100</td>
<td>70 - 130</td>
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<tr>
<td>Before lunch, supper and snack</td>
<td>&lt; 110</td>
<td>70 - 130</td>
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<tr>
<td>Two hours after meals</td>
<td>&lt; 140</td>
<td>&lt; 180</td>
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<tr>
<td>Bedtime</td>
<td>&lt; 120</td>
<td>90- 150</td>
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<tr>
<td>A1C (also called glycosylated hemoglobin A1c, HbA1c or glycohemoglobin A1c)</td>
<td>&lt; 6%</td>
<td>&lt; 7%</td>
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<td>0745</td>
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<td>1900</td>
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<td>1950</td>
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<td>2200</td>
<td>92</td>
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<td>2200</td>
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<td>102 AC</td>
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<td>1000</td>
<td>101 AC</td>
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<tr>
<td>1920</td>
<td>108 AC</td>
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</tr>
<tr>
<td>2300</td>
<td>99 HS</td>
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FSBS

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<td>0915</td>
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<td>1000</td>
<td>153 -after pancakes/bacon</td>
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<tr>
<td>1113</td>
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<tr>
<td>2330</td>
<td>95 HS</td>
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</tbody>
</table>

Not TOO bad, RIGHT?
At first glance – these symptoms look “normal” for someone in perimenopause
IF: We lose 1-3% of our testosterone production each year after we hit our 30s AND… (14-42% reduction for this pt)

IF: OCPs (and a history of OCPs) suppress our natural hormone production AND increases SHBG (sex hormone BINDING globulin) AND…

IF: SHBG has a higher affinity for androgens (but will also bind estrogens) THEN…

WHY does this patient have higher than optimal estrogen levels (optimal <2.5) AND an above average testosterone level for her age?

THINK BACKWARDS!!
Hormone testing can help us get to a **ROOT CAUSE**

**IMPLIED** Insulin Resistance

Blood Sugar → Insulin → SHBG → Testosterone
SIX WEEKS LATER
Insulin: 18.6 (2.0 – 19.6 uIU/mL)

**OPTIMAL:** 5-6

Glucose: 110 (65-99 mg/dL)

**OPTIMAL:** <85

Hgb A1c: 6.0 (<6.4%)

**OPTIMAL:** <5.4

"...The proposed criteria (of American Diabetes Association) missed 70% of individuals with DIABETES, 71-84% with DYSGLYCEMIA and 82-94% with PRE-DIABETES..."
“...apo B, apo A-1 and the apo B / apo A-1 ratio have been reported as better predictors of cardiovascular events than LDL –C...”
Iron:

<table>
<thead>
<tr>
<th>Value</th>
<th>Reference Range</th>
<th>Optimal</th>
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<tbody>
<tr>
<td>132 mcg/dL</td>
<td>40-190 mcg/dL</td>
<td>110-130</td>
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Ferritin:

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<th>Reference Range</th>
<th>Optimal</th>
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</thead>
<tbody>
<tr>
<td>38 ng/mL</td>
<td>10-232 ng/mL</td>
<td>70-80</td>
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</tbody>
</table>

Vitamin D 25(OH)D:

<table>
<thead>
<tr>
<th>Value</th>
<th>Reference Range</th>
<th>Optimal</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 ng/mL</td>
<td>30-100 ng/mL</td>
<td>50-60</td>
</tr>
</tbody>
</table>

"Optimal vitamin D concentrations for reducing insulin resistance were shown to be 80-119 nmol/L, (around 50ng/mL) providing further evidence for an increase in the recommended adequate levels."
 Thyroid Panel

**Free T4:** 0.9 (0.8 – 1.8)  
**OPTIMAL:** 1.55

**Free T3:** 2.9 (2.3 – 4.2)  
**OPTIMAL:** 3.73

**Reverse T3:** 18  
**OPTIMAL:** <11

**fT3/rT3 ratio:** 16.1  
**OPTIMAL:** >20
In this simple depiction you will find 16 places for the thyroid to malfunction. Nutrition, sleep and stress management are CRITICAL for optimal function.

This is why having the FREE T4 & FREE T3 labs are critical for thyroid function assessment.

95% of T4 & T3 is unavailable & bound to TBG at any given time.
WHAT BLOCKS THYROID FUNCTION?

Thyroid stimulating hormone (TSH) is produced in the pituitary and is regulated by intra-pituitary T3 levels, which often does not correlate or provide an accurate indicator of T3 levels in the rest of the body. Using the TSH as a indicator for the body’s overall thyroid status assumes that the T3 levels in the pituitary directly correlate with that of other tissues in the body and that changes directly correlate with that of T3 in other tissue of the body under a wide range of physiologic conditions. This, however, is shown not to be the case; the pituitary is different than every other tissue in the body.

D1 is suppressed & downregulated by physiological and emotional stress; depression; dieting; weight gain and leptin resistance; insulin resistance, obesity and diabetes; inflammation from autoimmune disease or systemic illness; chronic fatigue syndrome and fibromyalgia; chronic pain and exposure to toxins and plastics

In addition, D1 activity is also lower in females, making women more prone to tissue hypothyroidism, with resultant depression, fatigue, fibromyalgia, chronic fatigue syndrome, and obesity despite having normal TSH levels.

Inflammatory cytokines (IL-1, IL-6, CRP, TNF-α, SIGNIFICANTLY DECREASES D1 activity & reduces tissue T3

Whereas D2 is stimulated and up-regulated (increased activity) in response to such conditions, increasing intra-pituitary T4 to T3 conversion while the rest of body suffers from diminished levels of active T3. This causes the TSH to remain normal despite the fact that there is significant cellular hypothyroidism present in the rest of the body.

As T4 decreases, D2 activity increases

D2 converts intra-pituitary T4 to T3 – leaving TSH to appear normal
TSH: 2.53 (increased from 1.77)

OPTIMAL: between 1.5-1.9 mIU/L

Excerpts from STOP THE THYROID MADNESS:

“Most labs sample the last 100 people that had any given test and assume that 95% of them are “normal” and just post the bell curve data as the range…”

“...Most labs set the normal result range for a particular test so that 95% of their healthy patients fall WITHIN the normal range. This means that 5% of the healthy subjects fall OUTSIDE the normal range even when nothing is wrong with them. Thus, a “normal” result does NOT necessarily mean that nothing is wrong with you...”
REMEMBER:

Our patients are NOT 22,000 SYMPTOMS; they are 7 biological SYSTEMS
Communication: cancer, heart disease, obesity, diabetes, kidney disease, thyroid problems, psychiatric disorders, depression, irritable bowel syndrome, substance abuse, anxiety, ovarian cysts, irritable bowel syndrome, chronic pain, Breast feeding issues, Hot flashes, Mood swings, Concentration or Memory problems, Weight gain, cold intolerance, daytime sleepiness, fatigue, canâ€™t remember dreams, migraine, muscle spasms, difficulty concentrating, difficulty with thinking, difficulty with memory, irritability, leaking or incontinence, canâ€™t lose weight, salt cravings, caffeine dependency, pre-menstrual bloating, pre-menstrual breast tenderness, pre-menstrual carbohydrate craving, pre-menstrual fatigue, pre-menstrual irritability, menstrual cramps, menstrual heavy periods, breast tenderness, Current Smoker, Regular Exposure to Second-Hand Smoke

Structural Integrity: stroke, arthritis, ovarian cysts, gerd or reflux, gallstones, chronic pain, migraines, Breast feeding issues. Headaches, Weight gain, Loss of control of urine, cold hands & feet, ear ringing or buzzing, headache, migraine, back muscle spasm, joint stiffness, muscle pain, muscle spasms, leaking or incontinence, foods repeat-reflux, hemorrhoids, cellulite, lackluster skin, smokers, Tylenol

Assimilation: allergies, irritable bowel syndrome, adhd, irritable bowel syndrome, gerd or reflux, chronic pain, Weight gain, fatigue, muscle pain, muscle spasms, constipation, diarrhea, passing gas, foods repeat-reflux, hemorrhoids, easy bruising, salt cravings, frequent dieting, sweet cravings, caffeine dependency, pre-menstrual bloating, bitten nails, brittle nails, ragged cuticles, soft nails, thickening of toenails, dryness of skin, scalp or hair, NSAIDs, Tylenol, Acid Blocking Drugs, Bottle-fed
PLAN:

PHASE I
- Support adrenals
- Balance Pg/E2 ratio
- Support liver detoxification
- Focus on sleeping
- Encourage patient to draw boundaries
- Add T3
- Add thyroid-boosting micro- & macronutrients

PHASE II
- Focus on ‘nutritional RE-balancing’
- Moderate exercise
- Fix gut
- Calm inflammation
- SIBO & Comprehensive GI (plus parasitology) stool testing
- IgG Food Sensitivity testing

PHASE III
...TO BE CONTINUED
why, I’d be delighted to put my needs last again

2012 Calendar by Anne Taintor