Building Trust with a Patient Utilizing Complementary and Alternative Medicine

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Introduction

- Complementary medicine is defined as an addition of nontypical medical approaches to conventional medicine[1].
- Alternative medicine *replaces* conventional therapies.
- The use of complementary and alternative medicine (CAM), has increased in the United States in recent years[2], suggesting a need for further investigations into their health effects and medication interactions.
- Two out of three patients who utilize CAM do not disclose its use to their medical providers[3].
- Non-disclosure is driven largely by communication style. Patients disclose more when they perceive acceptance and non-judgment but withhold after discouraging or dismissive responses from providers[3,4].
- This case describes a 23 year old woman with a complex social history presenting with sinusitis and left-lower lobe pneumonia. She had made efforts to self-treat using multiple CAM therapies.

Initial Presentation

A 23 year old female with no known medical history at the time presented to the emergency department (ED) via ambulance after having a syncopal event. Patient had been sick with a productive cough and congestion over the previous ten days. She also endorsed shortness of breath, subjective fevers, and chest discomfort. Prior to the EMS call, she had stood up at work, developed a discomfort in her chest, along with numbness and tingling in her extremities and lost consciousness. At presentation to he ED, she did not feel that her breathing had returned to baseline.

In the ED, workup first included cardiac labs and D-dimer. While D-dimer was elevated, subsequent CT angiography did not show evidence of pulmonary embolism. However, it did suggest left-sided pneumonia. CT head showed demonstrated bilateral sphenoid sinusitis. She was initially admitted to the ED observation service for telemetry monitoring with echocardiogram, which showed transient prolonged QTC. After the patient endorsed symptoms of blurry vision, paresthesia, and muscle weakness, patient was admitted to the floor and started on azithromycin and Rocephin.

Hospital Course

Day 1: On the first day after ED presentation, the patient met with neurology where she discussed a history of trigeminal neuralgia and headaches, diagnosed by a chiropractor at age three. The description was considered atypical without dermatomal distribution and tearing, and including bilateral occipital headaches. She had not sought conventional medical treatment for these symptoms, relying on chiropractic adjustments for relief. She also endorsed a history of paresthesia, tingling, and a recent episode of urinary incontinence. Neurological exam showed intact sensation, reflexes and cranial nerve exam, with low suspicion for demyelinating process. Lumbar puncture was recommended to rule out fungal involvement.

Day 2: Lumbar puncture was unremarkable. The patient met with a social worker to express concerns regarding sibling safety in the care of her parents. On discussion, the patient noted that her father is a chiropractor and has, in the past, discouraged her to meet with neurologists for her headaches and paresthesia. Patient discussed times of harsh discipline and abuse in the home, along with more instances of possible medical neglect in siblings. Upon further questioning, the patient disclosed use of multiple CAMs when she first got sick with upper respiratory symptoms upon the advice of her parents. These substances included chlorine dioxide, hydroxychloroquine, Cognaplex, echinacea, methylene blue, and general homeopathy, all provided by her father. She suggested that he may have pressured her to use the various CAMs.

Day 3: The patient met with the toxicology team. It was determined that the chlorine dioxide flushes likely caused mucosal irritation and dislocated bacteria from nose to sinus. Hydroxychloroquine was implicated for prolonged QTC on presentation. Her clinical course had stabilized, and plans for discharge were made

The patient was discharged the following morning, with two more days of antibiotics. She was advised to discontinue CAMs and encouraged to meet with a neurologist.

Follow-up

The evening after discharge, the patient returned to the ED for bilateral arm numbness and generalized weakness, headache, problems speaking and blurred vision. Physical exam, including neuro, was unremarkable. CT scan was clear. She was discharged home. Within the month following discharge, she came to the ED 6 more times, mostly with headaches and seizure-like activity, which was eventually diagnosed as migraines with psychogenic non-epileptic seizures, possibly exacerbated by extreme familial stress. The patient was placed in the care of a multidisciplinary team including social workers, psychiatrists, psychologists, neurologists, and her primary care doctor. Her care is on-going, focusing on mental health care, migraine control, anxiety management, and psychogenic seizure monitoring.

Discussion

The patient in this case had pathologic manifestations of sinusitis and pneumonia possibly related to CAM use. Furthermore, the patient presented with neurological symptoms suggesting migraines with psychogenic non-epileptic seizures. Her complex social history contributed to few encounters with health care, and contributed to extensive use of CAM[5]. This patient's course reflects the vitality of non-judgmental, systematic approaches when caring or patients who use CAM, particularly those who turn to alternate therapies due to perceived ineffectiveness or dismissiveness from the healthcare system[3]. Because CAM can exert real pharmacological effects, cause direct toxicity, and interact with prescription drugs, undisclosed use, a common consequence of a poor patient-provider relationship, is a genuine safety hazard. This patient had multiple risk factors for utilizing alternative therapies and required a non-judgmental approach alongside frequent visits with her care team to find effective therapies and management modalities.

References

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