



Nutritional Therapy in General Practice

Nutritional Therapy can be defined as a therapeutic system in which special diets and nutritional products are prescribed to individuals, with a view to halting, retarding or reversing any damage to that individual's physiological and biochemical function which may have been caused by any of the following factors:

1. Food or environmental allergy or intolerance.
2. Toxic overload due to heavy metals or chemicals in the environment, dysbiosis, poor eliminative ability or poor liver function.
3. Nutritional deficits due to poor diet, special needs or malabsorption.

The patient's nutritional needs are assessed by examination and symptom analysis, and by the use of laboratory investigations. State-of-the-art laboratory tests, developed by specialists in this field, and which measure nutrients or nutrient-dependent enzymes in blood, hair, sweat, white cells and other tissues or fluids are preferred to ordinary blood levels, which are well known to be lacking in the sensitivity required to diagnose nutritional deficiency states other than frank scurvy, beri-beri and similar overt diseases.

1. Food allergy/intolerance

The role of idiosyncratic food allergy/intolerance in diseases such as irritable bowel syndrome, migraine, urticaria and rheumatoid arthritis is now widely acknowledged in the literature.

2. Nutritional deficits

Earlier this century, nutritional investigations were restricted to specific clinical pictures such as that of scurvy. Lately there has been an explosion of interest in the role of the so-called sub-clinical nutritional deficiency states in the onset and/or promotion of diseases as diverse as Aids, schizophrenia, birth defects and acne .

Official indicators of adequacy (RDAs and DRVs) are not designed to represent optimal values, but intakes which healthy groups of people should find adequate to prevent overt deficiency disease. They are not intended to make any allowance for additional needs due to infection, disorders of the gastrointestinal tract or metabolic abnormalities. These limitations are recognised by COMA.

Bearing in mind:

- 1) The great wealth of research in which nutrient repletion (by supplementation) has resulted in the reversal of diverse chronic disease states hitherto not known to be associated with nutritional deficiency, and
- 2) The equally great wealth of research revealing that individuals who eat a nutrient-poor diet high in sugar and fat have consistently higher rates of heart disease, cancers,

cataracts and other diseases, than those consuming diets rich in fruit and vegetables, routine investigations into nutritional status seem warranted for most patients at risk of or suffering from chronic diseases.

Many biochemical pathways may be disrupted when the intake or absorption of a nutrient or nutrients is inadequate or when utilisation and/or excretion are increased. As organ reserves become depleted, the ultimate result in the long term may be multiple functional insufficiencies which affect the immune, nervous or detoxification systems, and promote the onset of disease states. While some success has been obtained in preventing or reversing a number of diseases using single nutrients - for instance neural tube defects with folic acid, and premenstrual syndrome (PMS) with vitamin B6 - the success of such treatments may well be "hit or miss" unless the individual patient's nutritional status is first investigated with test methods capable of detecting a functional deficiency.

Nutritional Therapists generally have a high level of awareness of this sector of research, and use the literature as a guide to identifying possible micronutrient deficiencies in their patients. They have access to a range of suitable tests.

3. Toxic overload

Little research has been done to identify links between endo- and exotoxic exposure and common chronic diseases. Some notable exceptions are multiple sclerosis and parkinsonism, where results have been variable. The outcome of the functional impairment which can be caused by toxic damage is often so similar to conditions diagnosed as neurological diseases or chronic fatigue syndrome, for instance, that this lack of research is lamentable in the face of such a promising avenue of investigation. It is probably explained by the relative lack of commercial potential for the appropriate treatments. The research that *is* available notably links hyperactivity disorder in children with excess environmental lead. Likewise, elevated levels of toxic metals in hair samples have been linked with delinquent behaviour in adults.

Nutritional counselling can help reduce the intake and absorption of toxic metals into the body, for example by advocating a diet high in calcium and selenium, which compete with lead and mercury for absorption and uptake into cellular systems. Nutrients such as methionine, magnesium, taurine and antioxidants play an important role in the biotransformation of endo- and exotoxins, and clinical practice suggests that an increased supply of such nutrients may considerably aid the process, in time resulting in the loss of associated symptoms. Such symptoms may be not only due to the toxic overload itself, but to nutritional

deficits induced as a result of the over-use of nutrients for detoxification processes, leaving a relative lack of these nutrients for other metabolic functions.

Functional nutrient deficits can also be induced by the impairment of cellular nutrient uptake mechanisms as a result of the presence of excess levels of endo- or exotoxins.

The Therapeutic Trial

If the Nutritional Therapist believes, on the basis of the available literature, the therapist's experience and the patient's history, symptoms and diet, that the patient is suffering from a food intolerance, toxic overload or nutritional deficit(s) as described above, then the Nutritional Therapist will normally prescribe an intervention programme in the form of a therapeutic trial. This is justified by the fact that such programmes are non-toxic, low in cost, and most patients in the author's experience find them acceptable in the short term if the rationale is fully explained.

The intervention consists of nutritional health education, a short-term diet and, if necessary, a course of dietary supplements. The response to the therapeutic trial normally supports or refutes the diagnosis. If a response is obtained, the patient and therapist then work together to modify the programme so that minimum intervention is required to achieve or maintain the desired therapeutic effects.

Products used to supplement dietary regimes

Dietary supplements used by nutritional therapists include vitamins, minerals, amino acids, probiotics, evening primrose oil, fish oil, and a small range of common herbs. They are used to augment the repletive effects of a therapeutic diet, yielding faster, better results.

Nutritional Therapists welcome referrals from GPs. As specialist practitioners, they relieve a GP who is interested in this area from being an expert in it. Any GP who wishes to employ a Nutritional Therapist, on a part-time or full-time basis, or for a trial period, or requires further information, should contact Linda Lazarides at the Society for the Promotion of Nutritional Therapy at the address given overleaf. The society is working towards the highest possible standards in Nutritional Therapy and seeks to provide GPs with therapists matching their requirements as closely as possible.

It should be noted that Nutritional Therapy is a completely different discipline from Dietetics: Nutritional Therapists and Dietitians do not have the same training, and there should be no confusion between them. A summary of the main differences between Nutritional Therapists and Dietitians is available from the SPNT.

Linda Lazarides, 2000

