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## From the Townsend Letter [November 2015](#)



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**Letter from the Publisher**  
by Jonathan Collin, MD

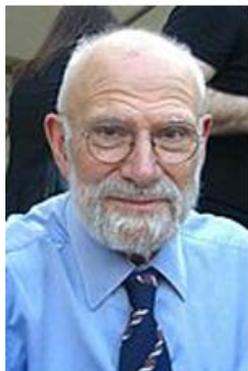


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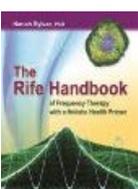
### My Farewell Thoughts for Dr. Oliver Sacks

It is nearly two months since Dr. Oliver Sacks died at age 82 from cancer, and the media have trumpeted his outstanding work as a neurologist and writer. I have little to add to the many tributes that he has received – but I could not let this opportunity pass without offering my own goodbye.



I regret that I never had the chance to listen to Sacks in the classroom. His lectures at medical school were just as intriguing and entertaining as his book writing. He was very well received at Albert Einstein School of Medicine in New York City; after 42 years there, in his 70s, he moved from the Bronx, where he frequently swam in the East River, across town to Columbia Medical School, and then moved downtown in Manhattan to NYU School of Medicine. In February of this year, he wrote an op-ed in the *New York Times* titled "My Own Life," when he revealed that the eye melanoma that had been treated 10 years earlier had metastasized to his liver. Sacks never stopped examining his patients; in "My Own Life," he was the patient, and he was sanguine and content with his life and enjoying the moment. He knew that he was dying and he compared his experience to that of philosopher David Hume, who wrote about dying two centuries earlier in an essay titled "My Own Life."

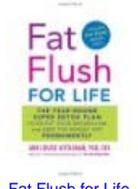
Sacks grew up in war-stricken London in an orthodox Jewish household, the youngest child of two physicians. He spent his grade-school days in an academy far from home where he was routinely beaten by the headmaster and bullied by older classmates. When he returned home, he fled to the basement, where his uncle introduced him to chemistry; Sacks refers to him as Uncle Tungsten in his book (2001) of the same name. Sacks's love of chemical reactions and the periodic table led him to undergraduate work in chemistry, but then he studied medicine. In the 1960s he did his neurology residency at UCLA, but also participated in the hippie revolution, experimenting with drugs and riding his motorcycle with the Hells Angels. Sacks thought that



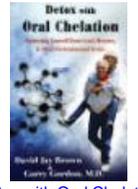
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California was a wonderful life but he thought he would be given a better chance to see life's rough edges in New York City; as a neurologist he was seeing Tourette's syndrome everywhere while walking the streets.

In the 1970s, medicine did not offer many drugs for treating neurological conditions, but Sacks thought that the Parkinson's drug L-dopa might be of benefit to a group of catatonic patients in the Bronx hospital ward where he was working. His work experience became the basis for his 1973 book as well as the 1990 Hollywood movie of the same name, *Awakenings*. The book that brought me under Dr. Sacks's spell was *The Man Who Mistook His Wife for a Hat* (1986). In that book of clinical vignettes, Sacks describes a musician who had lost the ability to see objects and people for what they were, even though his visual acuity was normal. Sacks discusses the case in a manner understandable to the physician and the nonprofessional, the pathophysiology that led to this individual's inability to distinguish his wife's head from a hat. Sacks's knowledge of medicine and science, as well as his attention to portraying clinical details, in the language of storytelling rather than case presentation, reads like he is a doctor and a poet. I have noticed in my local hospital that at least one neurologist has come to grand rounds, detailing a case much like Dr. Sacks did, and the physician audience has appreciated the presentation greatly. While Sacks had his critics, one wonders if sometimes the naysayers criticize just for the sake of needling those who have become accomplished.

Sacks provides me the example of a doctor who would not treat a patient simply as a case, described merely by the name of a disease. Sacks wanted to explore and investigate, not just by scans and lab numbers, but by understanding the patient's overall complexity, the fullness of the disease. He was wary of the first impression – he wanted to delve into all the aspects until he had a full and complete diagnostic understanding. And if that meant working through many wrong diagnoses, he was compelled, even obsessive, to find the underlying story.

Up until the time that he became sickened, Sacks continued to see patients and lecture. I thank Dr. Sacks for being such a wonderful role model – a path worth following!

### **Physician Burnout, Physician Heal Yourself**

It has been nearly 40 years since I completed my training in medicine, but in some ways it seems almost like yesterday. Examining patients, collaborating on medical rounds, reading medical journals, spending hours on paperwork, attending medical lectures, responding to insurance carriers and quality control committees, seem little different now than when I started. Of course, medical knowledge, diagnosis, treatment, procedures, and surgery have greatly changed, mostly for the better. But in many ways we approach medicine now much the same way that we did in the 1970s; in fact, doctors work much the same as they did in 1910. Not only is training in internship and residency long and rigorous, it is exhausting, tedious, and fraught with sleepless nights and bullying by older attending physicians. Medical faculty concede that the lack of sleep and the lengthy on-call duties are necessary not only to harden the physician, but to secure competency. No one disputes that the endless on-call duties are a hazing, and as with most hazing, individuals suffer physically and mentally. The physician who completes his/her residency is accomplished and a specialist. Too bad that more than a quarter of them become depressed and anxious, and not a few are suicidal.

In a special feature in August, *Time* magazine followed a surgical resident at Stanford Hospital for 72 hours. Her morning starts at 3 a.m. awakening to get ready for her work. By 5 a.m. she has



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made her own rounds on the surgical floor, so that by 6 o'clock, she can do rounds with the attending physician, her other residents, and interns. By 8 she has scrubbed into surgery – there are a few surgeries that morning. But the schedule is thrown off by some emergencies; her last surgery takes her into the evening hours. She grabs some lunch and dinner on the run; hospital food is not necessarily organic or the most nutritious. There are late surgery rounds, and then she is on call with another resident. During the night there are neither emergencies nor surgical complications, and she is able to grab a few hours' sleep. She meets the surgical team in the morning and once again, after rounds, she scrubs into surgery. Then after another lunch on the run, there are afternoon surgery clinics. Finally, evening arrives, late surgery rounds, and then she signs off to the resident on call. She heads home at 10 p.m.

No wonder young doctors, laden down with debt from their medical schooling, beholden to a medical system that demands long, brutal hours on call, eating poorly, unable to do much fitness, with nary a moment for relaxation, begin to become angry, frustrated, physically and mentally tired, and then anxious and depressed. Some doctors resign when it becomes too overwhelming. But others internalize, pushing their feelings deep into themselves. And a few have more than suicidal thoughts; a chief resident of surgery at Stanford, whom his attending thought of as a "bright star," committed suicide several years after his stellar Stanford work. That surgical professor learned surgery himself four decades earlier with the same rigorous on-call training required today. However, he recognizes that doctors need a better system, or at least a system that accommodates the physical and mental needs of the residents. Stanford has begun to provide these doctors with more time for meal breaks and higher-quality food. The doctors are required to meet as teams with a psychologist to discuss what is going on with them emotionally. There is talk about breaks for workouts, meditation, and walking.

Of course, following residency and postgraduate training, physicians are not subject to grueling on-call schedules. Still, many approach their practices, in or out of the hospital, with the same work ethic. Doctors work hours doing surgery and procedures, seeing patients in clinic, answering patient questions after hours, and then there is the endless paperwork. Electronic records have made the paperwork more efficient; on the other hand, physicians now spend more time looking at the computer than the patient in the 15-minute appointment. Now insurance companies require preauthorization for not only surgery and procedures but also many of the new wonder drugs (and some not so wonderful ones). The doctor's time is eaten up daily and much of the weekend. And when the overhead of the practice, the burden of school education debt, and the occasional malpractice case bite the doctor, many become fed up and burned out.

What to do?

Doctors break away from their practices to attend medical conventions for CME credit. Not a few of these breakaways are beginning to focus on refreshing the physician. At least one group, the American Holistic Medical Association, has always focused not only on healing the patient but also on healing the doctor. Doctors are beginning to include their sports or physical fitness as part of their daily schedule. Many are learning meditation and incorporate a period of meditation time daily. Not a few are beginning to incorporate regular massages, acupuncture, yoga, tai chi, and similar de-stressing activities. Despite the sarcasm of their colleagues, doctors are engaging in special diets, supplementation use, and seeing the naturopathic physician, the integrative doctor, the chiropractor, and even the alternative medicine physician. Perhaps the most important activity for the burned-out doctor is to take part in a physician counseling group, a group of docs who

share their knowledge and activities, but also their emotional difficulties.

Burnout is part of the physician experience, but doctors can take steps to de-stress and heal!

### **Thiamine: 'New' Wonder Drug for Fibromyalgia?**

Antonio Constantini, MD, a professor of neurology at the Viterbo, Italy, campus of Cattolica University of Rome, reports in the May 20, 2013, issue of the *British Medical Journal* that high-dose thiamine improves the symptoms of fibromyalgia (FM).<sup>1</sup> Kirk Hamilton, author of *Clinical Pearls*, interviewed Constantini last year about the remarkable benefits seen in fibromyalgia. Constantini had been studying inflammatory bowel disease and hypothesized that the fatigue seen in IBD may be an intracellular thiamine deficiency due to an enzyme impairment such as a deficiency of a thiamine receptor transporter. He thought that such a mechanism might be involved in a broad range of autoimmune disease. He conjectured that the fatigue of fibromyalgia might also be affected by a similar cause. Constantini's literature review found a 1998 study by Monroe suggesting a relationship between thiamine deficiency and FM.

Constantini distinguishes the "milder" symptoms of FM, such as fatigue, insomnia, depression, and anxiety that are due to a moderate thiamine "deficiency" from the severe pain of FM (chronic widespread pain [CWP]) that is due to a severe thiamine deficiency. The pain of CWP is manifested by diffuse thiamine deficiency in the spinal cord and brain that control sensory input. He conjectures that patients experience CWP because the thiamine enzyme impairment is much greater in the neurologic circuitry.

Unfortunately, biochemical testing is not very helpful. One can measure thiamine and thiamine pyrophosphate (TPP), the active form of thiamine, before initiating therapy. Generally these blood measurements are normal, even in patients requiring treatment. Lab testing of patients being treated with high-dose thiamine will show, as expected, high doses of thiamine and TPP, not a reason for discontinuation of treatment.

Constantini has found that thiamine hydrochloride is more effective than bioactive forms of thiamine, such as benfotiamine. High doses are required for FM starting at 600 mg/day orally, and gradually increasing the dose by 300 mg/day, each week. For CWP much higher doses of thiamine may be required, such as 1500 to 4000 mg daily. Side effects are generally not encountered. It is possible that these high doses may reduce the level of other B vitamins, particularly folic acid, and it is recommended to include B complex, particularly vitamin B12 and folic acid.

Injection therapy, as is usually the case, is more effective. Generally 100 mg/day, given twice weekly, of IM thiamine is comparable to 1800 to 2400 mg of oral thiamine. Thiamine dosing is determined both by effect on symptomatology as well as the patient's weight – heavier patients need higher doses.

Constantini's *BMJ* case report revealed greater than 50% improvement in fatigue and pain using thiamine. Kirk's interview of Constantini is not available here but a summary is online. (Search: "Fatigue Helped with High Dose Vitamin B1," a YouTube video.)

### **Axelrod and Teitelbaum Discuss Fibromyalgia**

In this issue, Leslie Axelrod, ND, LAc, professor at Southwest College of Naturopathic Medicine, reviews the primary aspects of fibromyalgia. Axelrod reminds us that the new diagnostic criteria

of FM have led to an increase in its diagnosis in the population. Most fibromyalgia patients face difficulties with insomnia. Axelrod offers her recommendations for the best botanicals and supplements supporting sleep disorders. She prescribes the Myers cocktail, a short intravenous injection of vitamin C, magnesium, B vitamins, and other nutrients as a general support for the fatigue and pain. Axelrod emphasizes that mind/body approaches are very important for the fibromyalgia patient. Interestingly, she suggests that wearing long woolen underwear is helpful in managing chronic pain.

The *Townsend Letter* is pleased to include **Dr. Jacob Teitelbaum's** thoughts on treating CFS and FM. Teitelbaum tantalizes us here with "35 Treatments for Tough Cases." Teitelbaum starts with assessing the patient's hormone status. He reminds us that we cannot depend strictly on hormone levels and must diagnose hormone dysfunction based on symptomatology as well. He likes to employ botanicals and nutrient therapy to support insomnia, fatigue, and pain, but if needed he will use drugs. Restless leg syndrome and nocturnal nasal congestion must be treated to support insomnia. Bioidentical hormone treatment is critical for helping fatigue. In addition to considering treatment for infection, including candida and Lyme disease, HHV-6 and CMV virus should be evaluated and treated. Teitelbaum emphasizes that fungus, particularly mycotoxin, is frequently present, perhaps needing home remediation as well as patient detoxification. Energetic therapies, available in a variety of modalities, are helpful in pain reduction.

Jonathan Collin, MD

#### Notes

1. Constantini A. High-dose thiamine improves the symptoms of fibromyalgia. *BMJ Case Rep.* May 20, 2013;50480.



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