

Gut Diagnosis: Stool Testing Case Assignments - Answers

Case 1 - Answer

For some additional context, this patient has had eczema since age 4, a history of thinning hair, periods of amenorrhea, has been diagnosed with polycystic ovary syndrome, and recently started an autoimmune protocol (AIP) diet after speaking with the nutritionist. She has alternating constipation with diarrhea but is more prone to constipation.

You can see that her GI Effects stool test shows high levels of secretory immunoglobulin A, low abundance of beneficial bacteria, low/normal levels of short-chain fatty acids, low products of protein and fat breakdown, and a parasitic infection with *Blastocystis* subtype III, detected by polymerase chain reaction (PCR) parasitology.

While we aren't 100 percent sure that *Blastocystis* causes symptoms in every person, with the combination of her lab markers and symptom presentation, I would opt to treat this patient with an antimicrobial protocol focused on treating the parasite, supporting the gut immune system, and improving digestion.

Case 2 - Answer

This patient reports significant food intolerances, fatigue, and diarrhea. He also had a positive hydrogen sulfide small intestinal bacterial overgrowth (SIBO) breath test on top of these stool findings. To be transparent, this was the third round of stool testing that we had done over a one-year period. We successfully treated the SIBO and other gut imbalances with improvements in some symptoms like diarrhea, bloating, and fatigue, but the food intolerances were persistent (although slightly improved with SIBO resolution). We kept digging, and with two positive *Helicobacter pylori* PCR tests on the GI-MAP, we decided to order another confirmatory test with stool antigen testing before deciding to continue treating the gut or not. I will either do the stool antigen or breath test to confirm a positive PCR *H. pylori* test.

You can see that the GI Effects stool antigen confirmed *H. pylori* activity in the stool. This was enough to push me in the direction of additional gut treatment to specifically target *H. pylori*. For this particular patient, I may consider prescription treatment since he had already done a

couple of antimicrobial protocols over the last year. Be sure to pay attention to the antibiotic resistance reporting so you can strategically guide your treatment decisions.

Case 3 - Answer

This patient came to us with a diagnosis of Crohn's disease and wanted to avoid being prescribed medications. She initially took prednisone, Uceris (budesonide, a corticosteroid), and Lialda (mesalamine, a non-steroidal anti-inflammatory drug [NSAID]) that controlled her symptoms initially. She subsequently went off the steroids and was able to maintain with diet for a couple of years until she started college and was double majoring with a high stress level and collegiate workload. She has been in a flare ever since.

She is working with a gastroenterologist who has recommended that she go back on medications and introduce Remicade. She has been having significant fatigue and reports small amounts of mucus and blood in the stool.

She has markers of dysbiosis, low levels of *Rhodotorula* (likely a consequence of dysbiosis and not the driver of gut issues but worth noting), low levels of *Dientamoeba fragilis* and *Entamoeba coli*, presence of occult blood, and high calprotectin levels that are representative of an active inflammatory bowel disease flare.

You can also see that she has an elevated sedimentation rate, high/normal copper levels (can be an acute phase reactant and suggestive of inflammation), and significant iron deficiency anemia that we have been trying to control with Proferrin, spleen and liver capsules, and iron-rich meals (although admittedly, she is not great about this portion of the treatment plan), but her levels remain low. I would treat her for mild dysbiosis with an antimicrobial protocol and support immune system function with supplements and herbs. I started her on low-dose naltrexone for immune regulation right away, considering her symptoms. I referred her back to her gastroenterologist for a blood transfusion and iron infusions, considering her levels. We plan to put her on an AIP diet, as well.