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DEVELOPMENTAL COORDINATION DISORDER

Developmental Coordination Disorder (DCD) is characterized by poor coordination and clumsiness. Symptoms of DCD include clumsiness and delays in development. The child may have delays in reaching certain developmental hallmarks, like sitting, crawling and walking. He or she may have problems with sucking and swallowing during the first year of life. There may also be problems with fine motor coordination (small precise movements), like tying of shoelaces or using scissors. There may also be problems with gross motor activities (using larger muscle groups in a coordinated fashion) like jumping, running, balancing on one foot, or hopping. The child may "trip over his (or her) own feet", have an unsteady gait, or have trouble holding onto objects. It is estimated that 6% of school-age children have some degree of DCD. A child with DCD may also have a learning disability, communication disorders or problems writing (poor handwriting, spelling, and difficulty with grammar and pronunciation).

A study appearing in *Pediatrics* (2005; 115(5): 1360-6) looked at 117 children with developmental coordination disorder (DCD) between the ages of five and 12. The children were randomly assigned to receive either a placebo or a supplement containing a combination of evening primrose oil and fish oil (both omega -3 and omega-6 essential fatty acids). At the end of three months, the children receiving the essential fatty acids had significant improvements in reading, spelling and behavior. During a second three month interval, the children who were originally in the placebo group received the essential fatty acid supplement, and enjoyed improvements similar to the original treatment group.

IBS AND FOOD SENSITIVITY

A study was performed and published in the *Lancet* (November 20, 1982:1115-1117); containing three parts and looked at food sensitivity and its role in IBS. In one study, 25 patients with IBS followed a strict elimination diet. For one week their entire diet consisted of one kind of meat and a single fruit. If the IBS symptoms abated, they were to reintroduce one food per day until symptoms occurred. If it seemed that the food created the symptoms, the subjects were challenged with it on three different occasions.

Six of the IBS patients were symptom free while on the elimination diet in the first part of the study. They were hospitalized for four days and given only foods that did not cause IBS symptoms, eating the same menu each day. Breakfast was given as a double-blind food challenge.

In the third part of the study, five of the patients were admitted for four days on two different occasions that were four weeks apart. Twice each day the subjects received the food that triggered symptoms disguised and hidden in a soup. Foods that commonly triggered symptoms included wheat, corn, dairy, coffee, tea and citrus. The double-blind and single-blind challenges in the second and third parts of the study confirmed that the foods triggered symptoms. Plasma glucose, histamine, immune complexes, haematocrit, eosinophil count, or breath hydrogen excretion did not change after challenge or control foods. Rectal prostaglandin E2 (PGE2) did increase, and in a further 5 patients rectal PGE2 correlated with wet faecal weight. Food intolerance associated with prostaglandin production is an important factor in the pathogenesis of IBS.

Research appearing in the *Journal of the American College of Nutrition* (2006; 25(6): 514-22) combined food elimination with probiotics to treat 20 subjects with IBS (according to Rome II criteria). The patients had not responded to standard medical therapies. The elimination diet was based on results from IgE and IgG blood tests for allergies. A stool analysis was also performed. All of the patients had food sensitivities and dysbiotic bacteria according to these tests. In a one-year follow-up, it was found that following a rotation diet was beneficial to these patients.

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IBS AND SMALL INTESTINE BACTERIA

Irritable bowel syndrome (IBS) may be due to bacterial overgrowth. Between 11% and 14% of Americans suffer from IBS. An article appearing in the *Journal of the American Medical Association* (August 18, 2004;292(7):852-858) looked into the possibility of bacteria overgrowth in the small intestine. The lactulose breath test (a way of testing for bacterial overgrowth) is abnormal in 84% of patients with IBS. Furthermore, there is a 75% improvement in symptoms when small intestine bacterial overgrowth is treated. In research that appeared in the *American Journal of Gastroenterology* (December 2000;95 (12):3503-3506), the effect of killing small intestine bacteria was tested on IBS patients. The subjects were 202 people suffering from IBS. According to the results of a lactulose hydrogen breath test, 157 had small intestine bacterial overgrowth and 45 patients did not have bacterial overgrowth. Those with the bacterial overgrowth were treated with antibiotics. During a follow-up visit, 47 of those patients no longer had bacterial overgrowth and 48% of those patients no longer had IBS symptoms (according to Rome criteria). The subjects who tested for bacterial overgrowth during the follow-up visit did not experience improvement in symptoms. The researchers concluded that there is a link between small intestine bacterial overgrowth and IBS

IBS STRATEGIES

Research on natural therapies for IBS is kind of a mixed bag. There are various natural approaches that help, but no single therapy helps all of the patients. Sometimes it is best to classify a disease by mechanism and not by symptoms. The symptoms of IBS include gas, bloating, abdominal pain and diarrhea, but effective treatment varies from patient to patient. Sometimes allergy elimination is effective, sometimes probiotics help and other times killing bacteria in the small intestine is an effective strategy.

There are studies showing that elimination of gluten from the diet does improve the symptoms of at least some IBS sufferers. Scientists are quick to point out that the symptoms of celiac disease match the symptoms of IBS. As many as 75% of the patients suffering from celiac sprue have IBS symptoms. A pair of studies, one published in the *Lancet* (November 3, 2001;358:1504-1508), and another in *Gastroenterology* (2004;126(7):1721-1732) both recommend screening for celiac disease in IBS patients. Other studies have shown that some IBS patients benefit from eliminating other foods. Clearly, finding and eliminating food sensitivities will help at least some of your IBS patients--but not all of them.

Another mechanism worth looking at is bacterial overgrowth in the small intestine. This issue has been covered in research published in the *Journal of the American Medical Association* (August 18, 2004;292(7):852-858) and the *American Journal of Gastroenterology* (December 2000;95(12):3503-3506). Addressing bacterial overgrowth helps some IBS sufferers, but not all of them (see the article on page 3).

Ultimately, a comprehensive approach that looks at both hidden food sensitivities and bacterial overgrowth may be the best approach. Testing the patient for food sensitivity, do a trial avoidance of the common problem foods (gluten, dairy, peanuts, eggs and citrus for example), or have the patient undergo a stricter elimination program is a good start. But don't stop there, give a good probiotic, which will help to kill small intestine bacteria. Also, consider that a patient who has overgrowth of bacteria in the small intestine may not be digesting well to begin with. He or she may need an HCl or pancreatic enzyme supplement. Frequently this problem is the result of eating too much carbohydrate and it may be necessary to cut down on the consumption of them. Testing for yeast overgrowth or parasites in the stool may also be necessary. Not all IBS patients are alike, so it is wise to treat the patient who has the disease and not the disease that has the patient.

Keeping your body healthy is an expression of gratitude to the whole cosmos—the trees, the clouds, everything.

Thich Nhat Hanh

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VITAMIN K AND ANTICOAGULANT THERAPY

Anticoagulation medication (preventing clots) works by blocking the body's utilization of vitamin K. Generally, people on the medication are advised to avoid food and supplements that contain vitamin K. Research appearing in *Blood* (1 November 2004, Vol. 104, No. 9, pp. 2682-2689) looked at the effect vitamin K supplementation had on healthy subjects who were stably taking anticoagulant medication. The subjects were given vitamin K1 supplements, starting with 50 mcg per day for a week and gradually increasing the dosage each week. They found that doses of less than 150 mcg per day had no effect on the drug therapy and that meals containing foods high in vitamin K also had no effect. At doses greater than 150 mcg per day, the "International Normalized Ratio" would decrease. A reduction in the INR means that the blood is clotting more readily. The authors concluded that eating foods high in vitamin K (like spinach and broccoli) or taking a multiple vitamin that was high in vitamin K, did not interfere with anticoagulant drugs.

Other research appearing in *Blood* (15 March 2007, Vol. 109, No. 6, pp. 2419-2423.) found that patients who were not stable on warfarin treatment (meaning that there was great variation in INR values) tended to be deficient in vitamin K. In the study, patients were given either a placebo or 150 mcg of vitamin K for six months. The group receiving the vitamin K experienced a lower variation in the PNI compared to the placebo group. Of course, those on warfarin therapy should discuss these issues with a doctor and not try to self medicate with supplements.