Toxic medicine taken on an empty stomach? Rule of one hour post-meal

Chun (George) Yang, MD, PhD

A senior patient with lung cancer is taking her targeted medicines, dabrafenib and trametinib. They have been quite effective reducing tumor size and tumor markers, and patient's cancer symptoms, including pain, are quickly improving. However, at the same time, the toxic effects of her medicines are emerging. For instance, the patient develops swelling on bilateral lower extremities (BLE), excluding prolonged seating induced pit swelling. And the patient also has increased heart rate (from her normal 80's to 90's then around 100 bpm). During a discussion with a nurse in charge, the nurse mentions, "Don't the chemos need to be taken after meals to reduce toxicity?" Why? We couldn't get an answer. This discussion strikes me. Immediately, I felt that I couldn't agree with her more. However, we changed the order from empty stomach or two hours after meal to one hour post-meal. The patient's BLE swelling was gone and heart rate returned to the 80s bpm. However, for several months, I had tried to figure out the reason but couldn't. But now, I have an answer.

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Standard of care fails to stop a patient's worsening condition?
Rule of care with innovation

Chun Yang, MD, PhD

In most conditions, standard of care should be always carried out for patients, as they have been proven with better or best outcome. However, when it comes to lung cancer, which is the leading cause of death in cancer patients, one may need to think twice of its standard of care. Should we stick to standard of care, or should we care with innovation for certain types of lung cancer patients? Here, we present an example of prototypes of care with innovation. A patient's lung cancer with Braf v600e mutation had developed into a condition that standard of care was worsening. Thus, care with innovation deserves to be recognized, appreciated, and credited. The patient was hospitalized at a major university teaching hospital. Under standard of care, painkiller, anticoagulant, laxative, and antibiotics, were all given to the patient with her targeted medicines (dabrafenib and trametinib) as well as multiple vitamins and vitamin D3. Stage III pressure ulcers developed, and no sign of improvement. Her targeted medicines worked well - tumor sized reduced, clinical symptoms including pain etc, lab tests, and images were all improved. Unfortunately however, side effects were also emerging. For example, the patient developed bilateral lower extremities (BLE) swelling, and her heart rate also increased from normally 80's to 90's to around 100 bpm. Her bed sores were getting worse. We have reported that taking her medicines one hour after meal has eliminated her adverse effect of BLE swelling and argument of heart rate. (YANG C. Toxic Medicine Taken at Empty Stomach? Rule of One Hour Post-meal. 2018) Here, we report how we have developed new approaches to heal her stage III bed sores and at the same time to improve her general well being.

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Senior Patient with Memory Impairment? Rule of Caution in Diagnosis

Chun (George) Yang, MD, PhD

Aging or dementia? Differentiating memory impairment from dementia in elderly patients is critically important. Here we present a case of a patient who should be diagnosed with Partially Impairment in Short Term Memory (Aging Related). The patient does not fall into the criteria of Dementia. A patient with her husband is in her own patient room. An unknown female patient with an unknown bottle in hand walks into the room and is sitting on the patient's bed. This immediately causes discomfort for both the patient and her husband. Repeatedly asking the intruder to go away has not worked and medical staff have to be called to remove her (August 2, 2018). This is among the many times that both the patient and her husband have suffered from harassing and insulting by various intruders. This is simply due to the fact that the patient has been admitted into the dementia / Alzheimer unit at a skilled nursing facility (SNF). Initial and repeated requests to transfer the patient to a different and safer floor (out of the dementia unit) have been denied by the SNF. The reason they say, is that the patient is diagnosed with dementia with altered mental status. This is a trigger for us to search for fundamentally better care for the patient - is the patient's diagnosis of dementia correct? We evaluated the patient's history, clinical presentation, lab tests, diagnosis, and treatments.

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Is Aging Patient's Memory Impairment Reversible? Rule of Treatment Trial

Chun (George) Yang, MD, PhD

A senior patient speaks mandarin with a hometown dialect. The patient has a partially short term memory impairment which we found is significantly improvable. For example, initially, the patient could not correctly tell us about what year, month, and date it is when we asked her. The patient did not know what state she was residing in initially, though she could correctly tell us what country she was in and she knew the name of her hometown. She could not tell us the name of the current town she lives in after reminding her, though she would show her desire to recall this information. The patient could not remember her doctor's name, he did not frequently interact with her though. The patient remembers her family members, friends, students, and some of her care providers. We have argued against her diagnosis of dementia and suggested a diagnosis of aging with partially short term memory impairment earlier. (YANG C. Senior patient with memory impairment? Rule of caution in diagnosis. 2018). We have been trying to see if her memory impairment is reversible. We now report that after a period of conference calls with the patient (for about two months), her short term memory impairment is significantly improvable.

(Full essay is available on request. A draft communicated since October 12, 2018)

Patient cannot make an informed decision?
Rule of presenting issues processable

Chun (George) Yang, MD, PhD

Whether a patient is able or unable to make an informed decision at times can be a challenging medical matter. A patient is evaluated by at least a dozen physicians over the past year. A team of physicians has concluded that the patient is able to make her own decisions. However, due to complicated medical issues that are incomprehensible by the patient, a healthcare proxy (HCP) is appointed. On the opposite side is that several individuals or groups of physicians have concluded that the patient is unable to make an informed decision. Some of them submitted three medical certificates to court for applications for Guardianship / Conservatorship for an incapacitated person (resubmitted after the court dismissed their first submission). However, two independent medical examiners (IME) appointed by the court both have not discovered any evidence to support a diagnosis of dementia. One IME has concluded that the patient is able to make her only decisions and the patient is NOT incapacitated. However, the other IME has concluded the patient is UNABLE to make an informed decision. Seeing a truly unhealthy condition in a dementia / Alzheimer's unit in which the patient is placed, an argument against the diagnosis of dementia is presented. (YANG C. Senior patient with memory impairment? Rule of caution in diagnosis. 2018). Later, a report that the patient's partially short term memory impairment is improvable is also generated. (YANG C. Is an aging patient's memory impairment reversible? Rule of treatment trial. 2018). Now, we continue to report that this patient is NOT unable to make an informed decision. Since the patient is intellectually competent, the critical issue is how to present medical issues at the patient's level of comprehension. We illustrate this with specific examples.

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