How I Practice Now

by Jacob Schor, ND, FABNO

I spent my first year of practice sucking on pellets of homeopathic *Lycopodium*, a remedy often prescribed for those who fall ill from the strain of keeping up pretenses, of struggling to maintain an image of self-assuredness when behind the façade they feel insecure.

Nothing in my four years of naturopathic school quite prepared me for the patients whom I began seeing immediately after opening our practice in an unlicensed state. None were those easy cases that I had come to expect in the school clinic; no kids with earaches, no women with yeast infections, no sore throats. Twenty years later, I still recall in detail the woman who presented with a chronic bladder infection. She questioned why I kept smiling at her and I had to confess that she was my first patient whom I knew how to treat.

I found a new mantra, a phrase that rarely left my workday consciousness: "They never taught this in school."

A patient called those first months to ask if I could treat her sciatica: she described her pain as originating in her left piriformis, a condition that supposedly I had learned to deal with in a physical medicine class the year before. It wasn't until she was on my table and I was about to jab my elbow into her posterior that she mentioned the massive tumor that was mashing her pelvis apart from the inside. My recollection is that she survived barely a week after seeing me.

Thinking back, it's hard to believe that we stuck it out and didn't toss the towel in, so to speak. Perhaps it was the loans, the new baby, and the fact that patients would write a check as they were about to leave the office. Even if I didn't know what to do.

Twenty years later and I still don't know what to do much of the time, but I'm used to it. It's part of the job. If it were easy, the patient's "regular doctor" would have figured out what to do. Every workday there's another surprise quiz. Somehow, I've found a rhythm, a routine for dealing with the unknown, a way to work that doesn't involve pretending I know what I'm doing when I don't.

Let me use a recent patient as an example. To hide his identity I'll call him the kid. He's 16 years old, and comes in to the office with his mom. He's a swimmer, working the summer as a lifeguard, and his chief complaint is high blood pressure. My assumption that it is just a little bit elevated is wrong.

"How high are we talking about?" I ask innocently enough as I fiddle in the cupboard to find my stethoscope and the sphygy thing.

"About 160 over 120" the mom responds. I sit down and get the full story.

Just after the kid was born, he was diagnosed with hydronephrosis. "It got better," his mom tells me. When his hypertension was first detected a few months back, he had the benefit of a full medical work-up. Both kidneys were working but one at half throttle. … His left kidney was doing about 75% of the work and his right only 25%. The docs prescribed a beta blocker to the kid and sent him home. The kid tried the drug for a few weeks and couldn't stand the way he felt so stopped taking it. The drug made activities like competitive swimming or lifeguarding difficult.

My immediate reaction in my first years in practice would have been to adopt a trout face, my mouth wide open, staring blankly at the patient and waiting for inspiration. Now I've learned to hide my ignorance; I turn to my computer, click my way to PubMed.gov, all the while chattering away that we "are going to the National Library of Medicine …" and chanting inside my head, "It's an open-book test." In this case also crossing my fingers that the current hypertension is somehow related to the earlier hydronephrosis. Step 1: this is an open-book test: learn what you can.

Indeed this seems to be the case. In 2010 Mattias Carlström described the "Causal link between neonatal hydronephrosis and later development of hypertension."[1] Together, the three of us, mom, me, and the kid, read the big words of the Carlström's abstract. Since 2000,"… the surgical management of non-symptomatic hydronephrosis in children has become more conservative, but the long-term physiological consequences of this new policy are unclear. … In … complete ureteral obstruction, tubular atrophy and interstitial inflammation occur rapidly." But in "… chronic partial ureteral obstruction, … hydronephrosis is associated with renal injuries and is causally related to hypertension. …"

In other words, if the kid had had major nephrosis, his obstructed kidney would have atrophied, died, and been surgically removed. In his case, the kidney has been partially obstructed and this chronic injury led to his hypertension.

Thus often my first step in treating a patient is to see if modern medicine/science offers any suitable explanation for the patient's situation. These days I lean heavily on PubMed to find this information. Kidney physiology was complicated when Dr. Anna Macintosh tried to teach it to me back in the 1980s. It hasn't gotten any simpler. Still, to try and treat the kid, I want to understand the mechanisms by which his wayward kidney is raising blood pressure.

"The mechanisms underlying the development of hypertension in … hydronephrosis are complex and involve changes in both the renin-angiotensin system and renal sympathetic nerve activity. Furthermore, oxidative stress and nitric oxide deficiency in the diseased kidney, with consequent resetting of the tubuloglomerular feedback mechanism, appear to play a pivotal role in the development and maintenance of hypertension" (Carlström).

"Oxidative stress" and "nitric oxide deficiency"; these words are familiar, something I kind of understand. And things we might control.

A 1999 paper by Chevalier et al. that used rats to model the long-term response to temporary hydronephrosis in rats is of interest as well. Rats were subjected to "temporary unilateral ureteral obstruction (UUO)" during the first two days of life. Removing the obstruction did not reverse kidney damage that occurred while things were blocked and a 40% reduction in