Your Brain Isn’t Broken — It’s Out of Balance: Rethinking Neurodegeneration Transcript

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Opening on patient-centered medicine

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Clint, tell me what brings you in. I understand you have a lot of headaches, for example. Oh, yeah. Well, when did they start? Well they started two years ago, I had an accident, got, it cracked my head pretty hard, concussion, ever since that, what we call the history of present illness, right?

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So I still get that kind of medical history. Welcome to My MD Unscripted, where healthcare gets personal and the script gets tossed. I'm Dr. Clint Carter, ER doctor turned direct primary care freedom fighter on a mission to challenge how our healthcare system treats patients in America.

In every episode, my expert guest and I dive into real conversations about what's broken and how we can fix it by making healthcare about people, not just managing disease.

It's time to rethink what healthcare should be and we how can make it better together. Welcome to the Fight Gas. Hello and welcome back to the MyMD Unscripted Podcast.

I'm your host, Dr. Clint Carter, and I am truly honored today to be joined by Dr Ken Charlin. He's a neurologist, functional medicine practitioner, he does research, is an author of a number one bestseller book called The Healthy Brain Toolbox.

everywhere that's good from Emory to UVA to Vanderbilt and then eventually, of course, IFM for functional medicine. So this is really an honor. This is going to be fun.

You know, sort of the opening question that maybe that makes the most sense for us to get started with is what if Alzheimer's isn't really just a one-way dead-end street that you can't do anything about, but really more of a systemic problem that we've mislabeled all along.

Introducing Dr. Ken Charlton and the podcast

And I can wait to dig into this with you, Ken. Thanks for coming on the show. Well, so I don't know if that introduction does you justice. What sort of pushed you from, you know, the neurology classic neurologic track into the functional medicine track?

You know it's probably kind of similar. to your situation and many other providers just in a slightly different flavor. Meaning, as you know, we have a lot of burnout right now in medicine, a of doctors very unhappy, very happy with the system, third party payer, very unhappy with the entire model.

And likewise, of course we have, you know, we're all, I always say, look, i'm a patient too, right? So it's cause i am a doctor. I mean, don't need a Doctor occasionally.

But my point is that even from the patient care side, it is a tremendous amount of dissatisfaction. You know I know that many people have arrived to the space we call functional and even regenerative medicine.

From the point of view of a health crisis, I'm fortunately blessed that I never had that health crises. It was just tremendous dissatisfaction with what I am doing that just didn't align with why I chose to go into medicine in the first place.

But for me as well, you just to make a long story short, I had gotten interested in endurance sports back around 2006, 2007, eventually getting involved specifically in the sport of triathlon and finishing a few Ironman triathlons.

But the real thing here is that in doing this, these physical feats, if you will, 140.6 miles in a day, swim, bike, run. Well, you don't just get up one day and do it, right?

And even to say you have a training plan, a workout, whatever, that's not enough. Because in order to execute, You have to have your sleep dialed in. You to your nutrition dial in the whole time, but also, of course, on race day, the full time.

Yeah. you to be able to evaluate your body's stress response system because there's something called overtraining. And you can actually really break down from that.

So I was, for lack of a better term, sort of geeking out on all this stuff and learning the science and it's just the way I think and not just following a formula.

and realizing that I was making all these changes and thinking, my goodness, this really follows the principles of what I should be doing in my office as well.

I didn't have a name for it at that point in time, but I felt like that should in toolbox. Not getting everyone, of course, to do an Iron Man Triathlon, thinking sleep makes a difference, food makes the difference.

From neurology to functional medicine

Lo and behold, it was about the time that Dave Perlmutter published his book, Grain Brain, which put him on the map. And I read it and I heard him interviewed in podcast and it just changed my world.

I thought this is exactly what I've been looking for. And, I was ready to quit. My wife encouraged me, just go, whatever their next conference is, it doesn't really matter.

And it was one of their more advanced modules, was a hormone module. I went and it transformative and I checked that box for hormones, but I did all their courses are foundational.

course called AFMCP, applying functional medicine, clinical practice, and went on and finished all the modules and connected with the right people. That was important to me.

David Perlmutter, Terry Walls, Dale Bredesen, the people who were working in my space, looking at it from a different perspective than here's your diagnosis, here is the pill.

Right. Yeah. Oh, well, you know, it's quite a list and I would put, to that point, I'd put you on that list with them. And from my getting into the game after you did, and really, You know I'm thankful for what you're doing in the space and how you take care of your patients.

The contrast is really with, in my area, It's nine to 12 months wait to get in with a neurologist and you get this, You know, you get this diagnosis, it's scary.

It sounds like, like I said, a one-way dead-end street to nowhere-ville and misery. And I'm like well, there's just not that many neurologists because it is a diagnostic field in which there aren't a lot of treatments that actually make a difference in people's lives.

You can diagnose way more than you can fix and it a hard specialty and blah, blah. Ultimately, we have a really

good medical community for, you know, a 150,000 person town or whatever, but neurology is not our strong suit.

And, the stance on it when they finally do good and see them, it's like, well, okay, there's some medicines that can push your symptoms back or minimize them for a while, this train, It doesn't stop.

So it is this irreversible progressive, description of their condition. And I guess, you know, it's hard to blame them because they don't know what you do.

They don' do what y'all do in this space, but do you feel like, as we get into your slightly different approach, do feel mainstream neurology is making any moves in that direction?

Oh, definitely. A lot has changed over the years. I actually had lunch with a gentleman who's been in the MS space for a long time and, you know, affiliated with one of the pharmaceutical companies.

And I do work with meds, right? And where appropriate, about half of my MS patients take medication, that half don't. But the point is that, he's old enough.

He said, He was involved with really one the first The earlier sort of really breakthrough drugs had changed the face of MS and it's called Jeleni or Fingolimod.

And he said, you know, when I started working that space and I'd see people with MS, everybody's in walkers, wheelchairs, et cetera. And things have changed so much in the MS space and now, you know, it's kind of like…

I don't want to say that… When I say this, I want anybody to think… I'm just drawing an analogy that, things are changed a lot in a world of AIDS and HIV.

When was in training, HIV is just terrible, AIDS is terrible. But now you can be on medication and CD4 counts normal and viral load is zero and people live with the virus, right?

Yeah. And it's not a cure, but they have their lives. And, it is very similar with MS where, yes, of course, their folks are very disabled by MS, But we know that early intervention with high efficacy therapy can offer the hope that really, you know, sort of like, I have MS but MS doesn't have me.

So there are areas, you know, we have a lot of drugs that treat Parkinson's disease. Unfortunately, none of them are definitively what I call disease modifying.

So they're all, all of, them all have them revolve around pretty much not all the, but most of the revolved around, somehow stimulating dopamine in the brain.

Yeah. There are a few exceptions, Alzheimer's disease. Well, you know, we have two approved drugs that they're not great by any means, but do they slow disease progression a little bit?

Yes. Do they restore memory? No. But you, know a lot of strides are being made. There's a, lot a research is a big growth area. So I don't want to say, you know, things are stagnant, but I would say that I believe either consciously or unconsciously, we've created a sort of working myth.

And that is, first of all, You name the disease, right? Got to name that disease because if you don t name it disease then you won't have the pill or the drug to sign to the In contrast to where we actually are with the technology, we're really not practicing personalized precision medicine.

And that kind of goes back to your original point in the introduction. Like not all people with Alzheimer's are the same.

Why mainstream neurology feels limited

Not all P with MS are same if we have 27 or 28 different drugs to treat MS that fall into some different categories in terms of mechanism of action, we should be thinking about if the drug is appropriate, what drug appropriate for you and your MS, and not because it's a pill or an IV or a subcutaneous injection where people are thinking what's more convenient.

And I get that, but actually understand genetically, biochemically, physiologically, right? What is the best match? We do this for cancer. Right? We get a biopsy, we characterize tissue.

We look at all the tissue markers and then the actual treatment for the cancer is individualized, but we aren't doing it in the neurology space. And it's a big, big mistake that has led to a lot of suffering.

Yeah. You know, the insurance based system for a long time. You know, its built-in flaw is, from my perspective, because that's what I do, I'm outside that space and, you know obviously you are too now largely, is that, it treats the fruit, right?

You name the disease, You treat the diseases. For the most part, It's all based on giant randomized controlled trials, which are informative and helpful, but they are assuming that your patient or you, are somehow an average and amalgam, some combination of that.

50,000 people, 10,00 people or 5,0000 people whatever, and it misses the opportunity to personalize it. And things in so many ways that are much simpler than say, you know, neurodegenerative conditions that is super hard and complicated and we don't have that many resources for, but on the simple stuff, I have I'm the medical director at my place and I've got folks that are pretty stringently stuck.

Some of my providers love the guidelines and i'm like, okay, I guess. I mean, the guideline, there's value there, they're not useless. They were established by someone who was making money on the outcomes, i am sure, but we'll take that, you know, with a grain of salt.

It's not personalized. And I got patients that aren't going to. fit in that box and they certainly don't want to fit into that. So I love the way that you're describing, you know, cancer and some of the other things that are getting more personalized to the point that now you really should be doing genetic testing as you do biopsy, path and all the things with cancer as well.

But, so once you were naming the problem, right, and to keep from getting in the box, The beauty of functional medicine is root cause, right? So how do you look at these conditions?

You know, when something comes in, and when you start getting personal, you want to personalize it. How so? Where do start? Yeah, I think it's essentially a two-pronged approach.

Just the basic methodology of medicine, if somebody comes to see you, and I'm talking about in general, you're going to sit down. You say, hey, Dr. Clint, tell me what brings you in.

I understand you have a lot of headaches, for example. Oh, yeah. Well, when did they start? Well they started two years ago. had an accident, got it, you know, it cracked my head pretty hard as concussion ever since that, what we call the history of present illness, right?

Standard medicine 101. So that's still important. We still, my belief is sort of like quantum, physics or quantum reality. We have to know the disease, but we have.

The person who has the. So I still get that kind of medical history. But then, you know, functional medicine, at least through IFM teaches something called a timeline, which says, okay, well, tell me a little bit about where were you born and.

Are your parents still alive? Tell me about your dad. I usually start with dad because mom plays such a huge role, I want to get dad out of the way a little bit.

But anyway, how is his health? What did he do for a living? what was your relationship with your your parent's like? Was your household like and then mother, similar kinds of questions.

And then we get into birth, you know, pregnancy history, birth history. Were you born by, traditionally by a vaginal delivery or cesarean section? Because we know that impacts a person's future health.

Be breastfed or bottle fed. Tell me about your early childhood, tell me that your grade school years, you know, we just go through this. Were you ever sick?

Were ever treated with antibiotics? You ever have any head injuries? Do you have environmental exposures? We just work through that all the way up into the present day.

And what that tells us in the language of functional medicine is we organize the information as into what is called the antecedents. Kind of the things that you're the family, when we say the, family history of things, that, you didn't, they came into the world with you and then triggers.

And then finally, When we reach that tipping point where the illness itself, the focus of why you came to see me becomes apparent. What are the mediators?

What other things are keeping you on that trajectory? And then I'll take a lifestyle medicine history. I want to know about your sleep, I wanna know your food, your movement, about stress.

And I ask that in different ways. Like I tell people, think of a car that has an idling speed. What's your idlings speed when it comes to stress? What do you do to relax, to unwind?

Do you have any formal practices? I ask them about the relationships. Of course, again, I asked about environmental exposures and do they have any concerns if they're men, that their testosterone may be low?

If they are women, are they postmenopausal? So I get all of that and we organize that to really start to understand the unique nature of the person. Where are their strengths?

Where their weaknesses? What do we need to work on? And then we add to that a very deep dive into labs.

Personalized medicine and the functional timeline

It helps me understand really at the cellular and subcellular level. What's going on biochemically, genetically, looking at drivers of inflammation, oxidative stress, and so forth, the things that are critical to understanding neurological disease.

I have my own sort of proprietary panel that I've developed and have used it for years. And we start to put it all together and we say, okay, this is the big picture.

This is what we need to be working. Man, that's a loaded question. Then where do you start? I mean, all of it, everything. Everything you can't ignore it.

You can, we'll just start with the gut. Okay. Start with a guy. Yeah. But don't move or don' care about your sleep. No, you kind of have to hit all the things, but obviously we're going to give them this to the areas where the person needs the most help.

And I use a team based approach. So I have a dietician. I. Have a health coach. We have somebody that does what I call neuro fitness. And we start to change a few habits.

We correct the imbalances. Will use drugs if drugs need to be used, right. And it's personalized precision medicine. Yeah. But to ignore those lifestyle factors to, to say, well, how many people, and I'm sure you see them as well.

We all most there, there are a few people say I admit my diet's not very good, but you know, on the other hand, that most people will say. I think I eat pretty healthy.

Well, I still go to McDonald's a couple of times a month, like that doesn't tell me anything. Right. You have to take a detailed nutrition history and look at their nutrient levels, calculate their macros, really take deep dive into nutrition and fix the things that need to be fixed.

And you know, you're getting into, inflammation is such a buzzword really in health these days, but in your world, like neuro-inflammation is. You know, it's real.

Yeah. And it a downstream effect of the other inflammation a lot of time. You're having to look, you've got someone comes in, they're coming in with a specialist level problem and you're starting at the basics to just, You got to figure out where the fires are.

So you can, if you need to help with the gut, help the diet, the exercise, sleep, stress, God, that Makes perfect sense. Okay. And then, so you start putting the puzzle together.

You know, I don't know. Alzheimer's is such a buzzword. Not really buzzwords. It's just, it's on everyone's mind because our parents, you know in my case, my grandparents are just finishing this up and my parents are next.

The Alzheimer is just kind of, or dementia in general, is kind It just seems so daunting. It's so multifactorial. So many things. When you start putting something together and someone comes in and says, Hey, I think I'm slipping or my spouse is definitely slipping and a lot of times that's the same conversation.

How do you, you know, obviously you just answered the question of how, where do start? You start, with at the beginning, how does your approach to all summers differ?

Once you've kind of gotten there with the labs and the history, what's next? Right. And, you know, let me just say this. The interesting thing is these principles really aren't that new in the sense that, if you go to the National Library of Medicine, that's PubMed online, as you probably know.

Just put in a search box, like, for example, studies of nutrition, diet, Alzheimer's disease. Find lots and lots of published studies. Now I always say, there's sort of some divide where we've got these wonderful, brilliant folks in academics that do these research studies, no criticism, but where does it go from there?

Why are we, why are they getting all these NIH grants and their vowel? Don't get me wrong, I'm not saying they shouldn't, But what I am saying is there has to be some translational medicine here that we take this information that, we as Americans or worldwide are spending billions of dollars probably on and put it in the clinic.

How do you implement these principles? And it's well known that not only does an anti-inflammatory type diet prevent, help to prevent cognitive decline, but it's also well known that if you take people with mild cognitive impairment or early stage Alzheimer's disease, use the same kind of diet, that you can not only slow progression, exercise data is there, sleep data's there.

It's just a matter of how do we get it from the theoretical and the research and put it in every clinic around the country, period. That is true healthcare.

So what do do? We work with folks. There's a lot of psychology involved because you have to be willing to change. Have to, be open kinds of things that we're talking about doing, and then you need support.

And that's why I'm a huge believer in coaching fundamentally. It's the same thing kinds of things that make us sick, whether we're talking about, you know, heart disease or brain disease, we have an epidemic, anabolic syndrome, hypertension, dyslipidemia, obesity, that waist to hip ratio, but look, if you go to the emergency room in your local town with a clipboard and piece of paper and a pencil, just make a hash mark every time somebody comes in with the heart attack or stroke and say, Hey, Are you on medicine for diabetes?

Are your medicines for high blood pressure? I mean, that's every single one of them, right? Pretty much every one. Yeah. So should the question of what exactly are we doing?

Not saying you shouldn't treat some of these high pressure if it's that high. But why does the conversation end there instead of saying, look, Clint, what I like to do is I'm really concerned you're running blood pressures, 150 over 95. It's not good for you.

I'm going to get you on some medication, but I also going be referring you to my dietitian. We're going work on this and I may be tracking you very closely on.

This. What I want to see is in the next six months, you know, a number of changes going happen in your life. You're gonna be very grateful that you did it.

And frankly, You won't need that blood pressure medicine anymore. Right. But that doesn't happen. In yet the same things that put people at risk for cardiovascular disease, put People at Risk for Alzheimer's disease.

It's not.

Alzheimer's, lifestyle, and root-cause care

We're so used to giving and assign. We have to have the diagnosis so we can figure out what pill to give a person. But in reality, the pill is universal.

The pill as food, The Pill is movement, that pill, is sleep. That pill has stress resilience. And I'm not saying it fixes everything, but it sure does put a major dent in disease.

Most disease is environment and lifestyle driven, not genetic, just because it runs in your family. The reality is a lot of things that run in the family are really there because cultures, there are many cultures.

Families eat a certain way. I learned this pattern growing up. You know, I do it because my parents did it consciously or unconsciously. I mean, you could say, well, there's Alzheimer's genes, aren't there?

Well, yeah, they're Alzheimer genes. And some are a little more hardwired than others. But, we also know that you can carry that gene and never get the disease.

So how do you explain that? But why is it in clinical trials that we study a drug, if everybody was exactly the same, then you would have exactly same outcome for every single person.

But you don't, that's reality. I told three different people in clinic today. Sorry, sorry. Today was a long clinic day and I saw three people that I was explaining.

Yes, you have bad genetics for this or that, but have you ever heard of epigenetics? Right? Like, not every gene is turned on all the time. You're turning on different genes when you're in survival mode and you are not sleeping and, you know, eating whatever is in front of you just because you have to get by.

And you turn on a different gene when your eating clean and exercising and sleeping, and handling your stress. It's just different. And so what I like about this approach though, and number one, it's not sexy.

It doesn't make anybody any, It does make drug companies any money. Insurance has a really hard time reimbursing for this kind of stuff. Quite frankly, lifestyle modification is more of a punchline in my classic primary care training.

I was like, well, yes, they need to eat better. We never defined what better meant, but they needed to be better in exercise, never to find what exercise meant.

But they're not really going to do that. So, you know, then we're going give them this medicine and this, medicine, and I think what you're doing is What's beautiful about it is it gives hope.

It shares hope if you tell someone, yeah, it looks like you got, you've got early stage dementia. You know, I give you, they're like, well, how many years do I have doc?

Because it's, You now, as a death sentence, It's a quality of life sentence. And then the death. And you're like, well, you know, I'll tell you what, let's change some things.

Let's put a modicum of control back on your side of this situation. And, but you are more than Alzheimer's, lets see what you can do to change all of these.

That's beautifully powerful. I've got a patient right now, early cognitive decline. He's aware of it. His wife's is aware it, he's got the gene. And they used to be really into eating clean and exercising and they're sort of, they are not really medicine type people.

But lately, you know, life's just, get older and he is like, yeah, we kind of for the last nine months have been eating whatever we want. Kind of been a lot of ice cream and a little less exercise.

I mean, at least you what you're doing wrong right now, let's start working on that. But there's so much more that I mean, I would love to maybe tuck them in with you at some point here.

So man, what a sweet message to give someone though. Hey, i'm going to hook you up with my dietitian. I'm gonna hook ya up my life coach. We're going follow you closely and you are going thank me for it later.

And it's going be kind of hard at first because you've been doing the wrong things for a long time. It really is. You know, the giving of, there's two kinds of bad news in medicine, right?

And you got to be good at delivering both of them. There's the bad diagnosis. But then there was the like, I got bad new, this is going to hard, but we're going get through it.

Kind of you know bad. Yeah. And they have to be willing to do it, right? There's stages of change and things like that. You have have people that are open to this idea.

And, you know, lifestyle is a huge, huge part of it. If folks are just gonna do a sort of a self-directed approach, there's a lot that can be accomplished by, low-carbohydrate, when I say low, refined carbohydrate.

Mediterranean style diet or even potentially a ketogenic diet, at least off and on, you know, getting some exercise, make sure, in these days, most everybody has some kind of like an Apple watch or a ring.

You'd track your sleep, know what's going on. Get that fixed up. Then it's the next level, take a deep dive into labs, figure out what needs to be optimized.

You know, we have, you know people like Andrew Huberman and other folks out there doing podcasts that are, the hackers and the optimizers and everybody, there are lots of companies out where you can get your labs done.

I mean, it is not perfect. It is probably not for people who are really, really sick, right? Because you need a lot more direction and handholding. But nothing like prevention.

So work on that stuff. Get your labs, figure out what you need. What do you to correct? What supplements are right for you? But, you know, we still love we love the technology.

We love that the magic, whatever. You know what we just say, We Love the Magic. Well, should I be doing hyperbaric oxygen? Should I do a neuro-infrared therapy?

And all those things have value for sure. They are more targeted treatments in general, so you're not going to get any benefit out of stem cells if you don't work on the things that led to you needing stem cell in the first place, but stem can still be valuable.

We have to know that the other stuff is still a critical part of the equation. No, I've got so many patients coming in these days asking about peptides because it's so hot right now.

And we of course do peptide and prescribe them all the time because they're fun. But I'm like, no, yeah, you don't get peptids yet. You're not ready for peptid.

Peptides are the icing on the cake in this situation and your cake is a disaster. Let's, let's start like yeah. Peptide sounds like a great idea here in a little while, but let us start with the basics.

you're going to get way more bang for your buck brother. And that's someone who's been listening to a podcast who wants to optimize who is otherwise relatively healthy.

Hope, coaching, and behavior change

If you take someone whose got a potentially neurodegenerative terrible diagnosis that they're scared you're going to say, yeah, you have it type, they come to you scared.

I can only imagine that it's a bit more, it, a hard pill to swallow at the same time. It's enough hope that I'd be willing to put into work myself, I think.

So is there, have you found, there's subset of patients that are, that hear this and there is a subset patients who just aren't ready for it. You know, by the time they get to you, are they, preselected kind of just by they kind repetition you have, people that ready to be a little outside the box.

By and large, I do see a lot of folks in my clinic on a monthly basis, fairly traditional neurology, maybe informed by functional medicine, and some of them I can already tell they're kind of got their mindset they've got, they understand, and I'll have that discussion with them.

But I would say for the vast majority of folks, this is where something comes into play. And I will name that something, but I just want, you know, traditional doctors don't use the word sales, right?

They don t use marketing. In reality, what I learned early on is that when you don't sell people things, you exchange value, right? Yeah. And that's really an important distinction.

So we have to give people value. We have do the podcasts, we to have the YouTube channel, the Facebook, social media is a really big platform in general for this.

Send out your newsletters, have people connect with you. Say, I'm interested in Alzheimer's, or I am interested Parkinson's. And then when you're communicating back through an email list, hopefully, you are then saying, yeah, the person is interested is Parkinson, so I won't send them things about MS.

I'll send things to them about Parkinson. So you have to build that, what we call, as I sure you know, in the language of marketing, that know like trust.

You have show people that you were genuine, and you care, then you get results for folks. And once people have been saturated enough with that they're open to it.

They want to learn so give people Learning like give your give you your knowledge away Teach people they like this is the authority. This is a person I trust this Is who I want see and then they are ready to work with me because Reality is, it's kind of like January 1 and New Year's resolutions that I have all the best of intentions, but it is really, really hard to do it on your own.

And then, especially when you're dealing with a diagnosis, there's also specialized knowledge. How do you integrate all of these things together? How you create that personalized precision medicine plan?

That still can integrate peptides and the cool technology and all those other things, but still has to be foundational at the same time. And then how do you know when to say, you're doing a great job, Clint, You're really hitting everything.

But the reality is even with this bigger toolbox. That we have to really take a deep dive with you. It's still not perfect following your biological markers.

And what I'm seeing is a trend that I don't like, and I am going to recommend that we layer in a medication, right? So it's integrate neurology. I love that.

Yep. Yep, because, you know, so many, and, gosh, man, functional medicine offers so much and there's so may men and women out there doing it so well with a chiropractic background or a naturopath background, or even just a generalist background.

And it still pays to be able to the specialist in the room that knows everything about what You know, standard medicine, you know insurance based practices have to offer as well as the functional medicine approach and can put those together properly and help.

shared decision-making wise help the patient decide when it's time to take the next step, in which direction. Because it is not without value. It's just so incomplete within the system because you can only treat the fruit.

You don't really get paid to treat root with a traditional insurance system as much as you'd like. And so the value that you add just with the combination of knowledge that have is super powerful.

And it's a nice tool to have when you have someone who's not quite ready to make all the changes because making all of the change at once is, first, it is impossible.

And secondly, super daunting and people might give up before they start. But to be like, along, kind of like you said, here's your blood pressure medicine until you don't need it anymore while we work on all these other things.

Hopefully, we'll see. We'll follow your pressure and find out. You can do that with Alzheimer's and Parkinson's, and you know, MS. I've got a curve balls, a little curve ball throw.

We'll finish with this, I think, is that, so I had after COVID, you know, was an ER doctor during COVID by choice. I have my practice as well, but I wanted to help out.

And so, You know I, had COVID multiple times. So I got the vaccine a couple of times early, maybe just once. Maybe, maybe twice. Anyway, early on, you know, just trying to do the right thing.

The right things wasn't clear at the beginning. And I was working at ER where we got to all of the outside the box things and we made a big difference.

It was fun. A couple years later, I get transverse myelitis. Okay. Interesting. You know, that's random. Okay, I got a little Hashimoto's, otherwise I'm not really an autoimmune, you know disaster that I know of.

And for the listeners, transverse myelitis is where a section of my spinal cord just sort of, the insulation came off the wires for a Little section across, sideways in there.

I had some numbness and tingling in one leg, kind of came all the way up, but nothing else. functional approach, did some gluten-free, some low-dose naltrexone, you know, tried to really clean up the diet, do some things, solved neurology.

They didn't have a lot to add other than hopefully this goes all the way away. You know and hopefully it's isolated. And it did go all away and after a while I just kind of went back to life as normal and thought, chalked it up as abnormal.

A year later, I get it somewhere else. Similar symptoms said, oh no, it is back. So, you know, after about a week of mild symptoms, I couldn't deny it anymore.

I had to tell my wife. So I went MRI'd it again, transverse myelitis in a different spot, which for the listeners is very rare, but the MRI showed really a subacute and an acute lesion.

And a thing that's supposed to just pop up once. So now I'm like, and I did MRIs of the brain too going, all right, is this MS? What are we dealing with here?

Right.

Integrating medications with functional strategies

Because that the big fear. And then there's MOG and some other things that are outside, which is probably more like where I am at. But it was like is, this, you know, I, did some spike cleanse, spike protein cleanses and things.

It's like this just an autoimmune response to having a lot of COVID exposure. and vaccine exposure to the point that when I got the, the double hit there at the end, my doc's like, you might should get on Rituximab and sort of play proactive ball here on top of everything.

So I've stayed gluten-free and the low-dose naltrexone and all the things that I can kind of control. And then I go on this. Infusion medication that's twice a year that I don't have insurance because I usually just take care of things.

So, you know, they wanted to charge me a hundred thousand dollars per infusion at the hospital and I was able to get it and do it in my office with an ER doctor friend and a vial of Epi next to me just in case I had anaphylaxis.

And all has been well. I'm probably about to do my third or fourth six month dose here in the office. But, and I've been, that's it so far with that and staying, trying to do all the right things all as well.

Like, you know, with this kind of thing, your completely asymptomatic until you're symptomatic, until it you get an episode. So that what I hate about it is the loop, the decision loop.

Okay, is this the thing? Am I doing the things? Well, I don't know. If I ever get it again, do I just keep doing this same thing forever? Kind of thought process and knowing that we don' have time to go back to my birth history and I was a vaginal delivery and was breastfed.

That helps. But where do you think, you know, how, it's a loaded question. You can't answer all these questions, but you get someone like that. It's like.

Well, that's weird. And thank goodness I haven't had any more episodes and thank God that I never had brain lesions and maybe I don't have MS, right? But kind of in the context of everything we talked about, are there take-home points that you would give a patient like me in a situation like this?

I didn't catch you with a curve ball right at the end. Well, sure. And, and, you know, of course I'm wearing my doctor hat now, so I'd wonder, hopefully you check.

By the way, this could get a little complicated on the podcast, but there's some antibodies I would like to know whether they were checked. Aquaporin-4 and one called MOG antibody.

This is related to a disease that is very similar to MS in some ways, but it's called neuromyelitis optica. So I'd want to know, was there any evidence either by MRI of the optic, because you can get close up views the optics.

nerves or do what's called a visual evoked potential, any evidence of demyelination of the optic, one or both optic nerves as well, and certainly rituximab.

from a conventional perspective would be a very good treatment for that. But then the other piece of it that I love, and it's really, again, very much part of what I call first century medicine, is biological markers that not only are helpful on the diagnosis side, but are very helpful these tracking side.

Have we shut this down? And then are you in remission? How long? Do you need to be utilizing rituximab before you say, you know what, Clint? Because for folks listening or watching this, this as you said, but I just want to reinforce it, that this is an infusion of it's in biological therapy.

First of all, it is not a drug in the traditional sense. It's an antibody. These antibodies are targeting what are called a CD20 positive B cells. These are the ones that are aggressively reactive, you know, in this case, targeting the nerve cells in the spinal cord.

And it just eliminates it literally sort of like blows up this particular subset of B-cells, right? Yeah. But what happens is. After six months, you know, by six month you're starting to regenerate those B cells that you infuse again.

But the actual antibodies that are involved, and for those who know MS, this is really the… We have drugs called, a few drugs, one called Ochrolizumab or Okravis.

Then we have Ophatumib or Qicemta. There's also Ubiliximab. These are all really iterations of the same drug, Rituximib, just more humanized antibodies.

They would all work. And they're all more or less the the drug. But the point is that with most of them, with the exception being Ofutumab, they are in every six month infusion, the antibodies do their job within the first six weeks or so, and then they're actually out of your system.

And what's the therapeutic aspect is just the fact that you don't have all these autoreactive B cells around to do the damage. Point being that we should be able to then also track disease activity and say, hey, really, you're close to that six-month mark.

What's going on? Do you still have a lot of, do you have high levels of inflammatory and neurodegenerative markers? If you say yes, we treat. If he say no, say, well, Clint, you've been really stable for several years.

Maybe we let's go eight months. Let's see what happens. Repeat the test. That's not treat you right now. Give it a couple, three more months, let retest.

What are your biomarkers now? Well, they're still low, still the same, unchanged. Well how would you feel about going another three months? We'll retest, right?

At a certain point, you say, guess what? I bet you're in remission. Let's move this test out to maybe once every six months instead of once ever three, once, every 12, eventually say guess, what, this is behind you now.

So that's essentially conventional medicine, but the problem is that too often these technologies, which are widely available, commercially available covered by insurance, they're not being used in the clinic.

That would be an all functional medicine side that would definitely be a way to start to get a handle on the problems. We could, of course, bring in all those medicine principles.

Let's take a deep dive. Look at your nutrients. Oxidative stress, inflammatory drivers, dyslipidemia, metabolic markers, hormones, toxins. All of these things have to be evaluated.

You've got to figure out what's covered, what is optimal, out of range, suboptimal, deficient, toxic level.

Autoimmune case discussion and biomarker tracking

Get all of those things corrected. Then we have another layer of reassurance that we're covering our bases and yes, with the help of Tux and Nab, hopefully you will go into remission and we can confidently track this in a way that does not put you at risk.

If I say, well, Clint, don't change anything, just stop the drug. Isn't that the definition of insanity, right? Yeah. So that's how I would see it. Stakes are too high.

And it's ultimately an autoimmune condition. So all of the functional medicine strategies to decrease inflammation and, you know, auto sensitivity, they all apply.

And I have Hashimoto's for short, we're sort of like 40% of people that I see. You know, that's at least one auto, you know. Sensitive sensitivity and I don't want to drag this whole thing on all the way, but I think it brings back to the point that my best shot at getting off this IV that doesn't have that, it's pretty, I've had very low side effect potential with it, unless of course I get.

you know, some sort of white blood cell cancer or something down the line because I've been screwing with my cell. I mean, it's not, unheard of. So the idea is that there's a risk reward to taking it.

There's risk rewards to not taking. And if I can control the variables with as much as possible with functional medicine, lifestyle type, you obviously you're just going to be healthier for doing them.

Then that's exactly where I want to. And that's kind of the same way that our patients want with whatever condition. It just so happens that this one's in your wheelhouse and I'd love to get in to your opinion.

I probably would like to know which markers you would recommend. Well, we can talk about that. We'll probably have you email that later. All of this is based on something called systems biology.

It's really, you know, in the framework of functional medicine, there are, about seven different things in these systems that we talk, essentially your immune system, your mitochondria, and your whole system of assimilating, bringing nutrients into your body and breaking them down, digesting them, assimulating them into who you are food.

We are truly what we eat. And then of course, eliminating them. So there's kind of the, the focus on we call biotransformation and elimination that both the exposure to toxins and then how do we detoxify?

How does the body naturally handle metabolic waste or actually environmental toxin exposure? There's, you know, we have to understand vascular disease, what they call transport and functional medicine.

We have understand hormones. And I often hear people who've been exposed to functional medicine say, well, I first I start with the mitochondria, then I treat the gut, Then I address the hormones.

And that's okay. But the problem is everything is connected. First of all, right? There's no, we don't really, these systems don' operate like in traditional medicine.

If you're a cardiologist, you have the heart. if you are a neurologist, your the brain. You know, if your GI doctor is the guy, that is not how functional medical works.

Secondly, If I said, okay, here are those systems. Now, what I want you to do as an intellectual exercise is let's talk about food. And then I wanted you tell me how food affects the assimilation system.

How food effects your mitochondria. hormones, your transport system, you know, how does food go all the way around what they call the functional medicine matrix?

And not surprisingly, food or nutrition affects every single one of these systems. Yep. Sleep affects, every, single, one, of, these, systems, right? Movement affects.

Every, a drug is like a targeted missile right yeah it's meant to get one thing which could be very powerful And certainly drug companies look for those pivot points where if we disrupt it here, then everything else, we stop the whole process.

We're slow the process, but we still have to be. I mean, you talk about peptides and I don't, I do use the like GLP ones in my practice. But I'm not a big peptide guy, but peptides are drugs for the most part.

And, you know, there's peptids that modulate growth hormone. There's peptides that, specifically target mitochondria in a certain way. We can call it what we want, they're still drugs.

They may be the secret of the functional medicine doctor that you can go down the road to the conventional clinic, they're not using the peptides that you and I are talking about.

They might be using Ozempic, but we have to be careful because if you're going to use that kind of therapy and folks have understand what is the research behind them, what do they actually do?

What do we understand about their safety? How well have they been studied? I think you have ask those questions. What does the FDA say about them? You should at least be informed about that.

Then you have to decide, okay, this is the fine paintbrush for the big canvas. It's not going to, it's big, thick swaths going across. We just need to fix one thing, right?

And then you still have work on the other stuff. Yeah. I tell my patients all the time, like peptides, you know, It, your DNA makes RNA, which makes a protein, Which does something.

And we've decided, someone has decided I want more of that.

Closing thoughts on systems biology and hope

I don't want that result. So I won't more than that protein. Okay. Here you go. It's basically something your body makes anyway, or as close to it as we can do and let's do that one thing.

Right. But what we're talking about is. you know, the pillars of functional medicine and health and wellness of movement and diet and stress and sleep and, you No, that's, every system that that I don't do PEP tests for people that have the need help in all those other areas.

And so I know we got to wrap this up, Ken. Thank you so much for coming on and for what you do and just for the hope that you give people in a situation that feels otherwise hopeless, man.

I mean, the reality is. You're bringing in as a modicum of control in a powerless, hopeless, you know, otherwise powerless hopeless situation. So thanks, thanks for your time, man.

I really appreciate your advice for little old me as well. That was fun. Sorry for putting that curve ball on you at the end, but I knew you could handle it.

Yeah, my pleasure. Thanks a lot. All right, we'll talk again soon. Thank you for coming on. Thanks for joining me today on My MD Unscripted. I hope today's conversation opened your mind and inspired you to imagine a better path for your health and therefore life.

If you found value in this episode, be sure to subscribe, leave a review, and share it with someone passionate about transforming healthcare. Real change starts with real conversation, so let's keep them going.

Until next time, stay well,