# OMA

ONTARIO MEDICAL ASSOCIATION

# Complementary & Integrative Medicine Medical Interest Group

CIM-MIG

Summer 2022

## Our Mission

Our mission is to support physicians, residents, and medical students who have an interest in complementary and integrative medicine (CIM) therapies. We will do this by sharing information, news and events, by providing recommendations for safe, responsible and professional practice, and by communicating with stakeholders about

CIM as a valuable tool that can help Ontario's doctors deliver better healthcare.

## Our Vision

Our vision is an inclusive healthcare system in Ontario, in which patients can explore their interest in complementary and integrative medicine with doctors, to ensure their safety and support their efforts to achieve better health outcomes.

## In This Edition…

# CIM MIG Survey Results

Last year we sent a survey out to the CIM MIG members. Although we are late in reporting the results, we believe that the results remain relevant and are helping to guide our executive committee's vision for the future of Integrative Medicine in Ontario.

We currently have about 400 members. Of our 400 members we received 29 responses, a small sample size to be sure, but quite illuminating none-the less. To see the results click the link here. Below we will review the questions, the results and actionable items for our executive and hopefully further membership engagement.

**Q1** *Please rate the importance of the following issues pertaining to integrative medicine in Ontario: Recognition as a domain of focused practice, i.e. by the CFPC program for certificate of added competence. In addition, if members have other suggestions for promotion of a regulated title in Ontario, please make your suggestions below.*

**Results:**

Extremely important - 9

Very important - 10

Somewhat important - 6

Not so important - 4

Not at all important - 0

TOTAL - 29

It appears that the majority of respondents believe that official recognition of Integrative Medicine would be desirable.

Actionable item: We have written a white paper setting the stage for official recognition and have submitted it to a peer reviewed journal. If it gets published we will share it with you. Additionally, we have been in touch with the Royal College which appears to have an avenue for a certificate of added competency in Integrative Medicine. We are in the early stages of the process and will keep you appraised of our progress.

**Q2** *Please rate the importance of the following issues pertaining to integrative medicine in Ontario:Advocacy to the Ministry of Health for designated billing codes for integrative medicine so that services would be covered by OHIP (as opposed to allowing integrative medicine physicians to bill privately in a way that works best for their individual practice).*

**Results:**

Extremely important - 8

Very important - 4

Somewhat important - 7

Not so important - 5

Not at all important - 5

TOTAL – 29

There did not seem to be consensus. In the comments section, respondents were concerned that compensation would not be adequate under OHIP.

Actionable item: The executive has decided to not pursue OHIP coverage for Integrative Medicine at this time.

**Q3** *We are considering creating a platform for sharing integrative medicine practice documents for members. These can be shared on the CIM MIG members exchange forum. Please indicate which resources would be of interest to you (select all that apply):*

**Results:**

Intake documents -29

Consent forms -23

EMRs that accommodate Integrative medicine practice -16

Any other items a member would like to recommend we consider -2

Total Respondents: 29

It appears that the majority of respondents would like a forum where they could access colleague's intake documents and consent forms.

Actionable item: We are in the process of sharing the executive members' intake and consent forms. Please share yours with us as well. Email to: oma.cim.mig@gmail.com. We will be posting the documents on our exchange forum here and on our webpage here.

# CIM MIG Survey Results Continued…

The commentary for the next 3 questions will follow the third question and results:

**Q4** *We recognize that billing practices for integrative medicine services are variable among our membership. We'd like to better understand how our members earn their income in their integrative medicine practices. Please select one of the following:*

**Results:**

I primarily bill OHIP for my integrative medicine services - 11

I primarily bill privately for my integrative medicine services – 8

I earn income from a blend of OHIP-covered and private pay services - 10

TOTAL – 29

**Q5** *Do you receive income from any of the following sources, in addition to OHIP billing? Please select any that apply, by indicating the corresponding percentage value( the first number is the average percentage, the second number is the number of responses.)*

**Results:**

| | | |
|---|---|---|
| Natural Health Products from your clinic dispensary | 2 | 22 |
| Compounded prescription medicines from your clinic dispensary | 1 | 21 |
| Annual practice fees | 21 | 22 |
| Additional visit fees | 10 | 20 |
| Uninsured procedures (acupuncture, injections, etc.) you deliver during visits | 35 | 22 |
| Uninsured services delivered by other independent providers in your clinic | 0 | 19 |
| Uninsured services delivered by providers working under your supervision | 3 | 20 |
| Other/Not-Applicable | 62 | 22 |

Total Respondents: 29

**Q6** *What percentage of patient visits do you do via:*

**Results:**

videoconferencing - 30

telephone - 33

in-person - 46

Total Respondents: 29

Actionable items: The last 3 questions were a survey of practice styles which were meant to be shared with members to provide information on what their Integrative Medicine Colleagues were doing in their practices. From the survey it is evident that there are a wide variety of billing styles, sources of income and platforms used to see patients.

In summary, based on the survey results our CIM MIG executive will be moving forward with gaining recognition for Integrative Medicine in Ontario and Canada. We will also be providing a space to share intake and informed consent forms.



By, Dr. Esther Konigsberg

# Clinical Resources

## Low Dose Naltrexone for Fibromyalgia Pain, Auto-Immunity and Cancer

Low dose what? Yes you heard it right, naltrexone, an opioid-*blocking* medication for the treatment of pain and even other conditions. Naltrexone is the cousin of naloxone, our hero injectable medication that takes persons in an opioid overdose situation out of a coma. Like naloxone, nal*trex*one also blocks endogenous opioid receptors, although it's use in acute opioid overdose has been replaced with the use of naloxone.

Currently, naltrexone is used in conventional medicine at 50mg doses for treatment of alcohol and opioid addiction, and is also used in conjunction with Wellbutrin for weight loss (Contrave). At this dose, the effects of naltrexone last throughout the day to produce it's therapeutic effects for addiction management. When used at much lower doses, such as 1.5mg to 4.5mg, it's effects last only a short amount of time before the medication is metabolized by the liver (half-life ~4h). This is just long enough to stump our body's physiology into thinking that it's not making quite enough of its *own* opioids to get the message across. As a result, the body starts to synthesize *more* endogenous opioids in order to overcome the blockade.

The use of low dose naltrexone (LDN) has been expanding among integrative and functional medicine physicians and nurse practitioners due to repeatedly observed clinical benefits. While poorly researched, a few preliminary case series indicate that LDN can be used in patients with fibromyalgia (PMID 23359310, 19453963, 28325149), possibly due to disordered central opioid regulation in such patients (PMID 27420606). Opioids also play a role in immune system regulation, which could be the reason why some auto-immune disorders seem to respond to this therapy. Case reports exist in the literature for benefits in lichen planopilaris (PMID 29141063), multiple sclerosis (PMID 18728058, 20534644, 20695007, 26203498), Crohn's disease (especially pediatric; PMID 20014017, 17222320, 23188075), and postural orthostatic tachycardia syndrome (PMID 29326369). This clinician's experience also points to stability of other auto-immune diseases such as Hashimoto's hypothyroidism, myasthenia gravis and scleroderma.

Additionally, LDN has been used as an adjunct therapy in some types of cancer (PMID 16484716, 20042414, 17761642, 29258346, 21887861, 27279602).

LDN is typically taken in the evening, to stimulate a gentle opioid blockade during sleep time when our body's natural opioids are most active in its rest and repair mode. Doses usually begin at 1.5mg HS for 1 week, followed by 3.0mg HS for 1 week, followed by 4.5mg HS thereafter. It will need to be filled at a compounding pharmacy but financially-challenged patients can self-compound the cheaper 50mg tablets at home in water.

LDN is usually well tolerated although the main side effects include increased sleepiness, vivid dreams, and occasional gastrointestinal upset or mild constipation. Some individuals prefer to stay at one of the lower doses if they develop side effects during the dose escalation. Individuals who encounter insomnia with this medication can dose it during the day instead. There is a theoretical interaction with the use of opioids however it is not a contraindication to taking opioids; this clinician recommends simply stopping LDN transiently if opioids need to be taken for an important reason, such as surgery. Patients should be advised that physicians may not be familiar with its off-label use and may make the assumption that it is for treating alcohol or drug addiction.

It is important to note that the effects of this medication may take several months to manifest. A trial of at least 3 months is recommended for fibromyalgia pain and longer durations, such as 6-18 months, are likely necessary for auto-immune conditions.

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# Clinical Resources Continued…

Benefits in fibromyalgia typically manifest as a reduction of baseline pain, burning and myalgias, while in auto-immunity there is less volatility observed in the condition (fewer or milder flares). If benefits are uncertain after an initial trial, a cessation of therapy "cold-turkey" style should help the user determine if there was any benefit, in retrospect.

LDN is an interesting orphan drug with off-label uses in pain, auto-immunity and cancer that is gaining increased use among integrative health practitioners. It can be administered easily and inexpensively and typically has few side effects. Clinicians may want to consider a trial of LDN use in select patients.


By,
Dr. Adriane Junek

2022-09-30 - 2022-09-30 (Virtual!)

6th Annual Integrative Health Symposium

In this one-day virtual symposium, attendees will learn about integrative health in the pediatric primary care setting. The Symposium content will address how integrative health approaches the treatment and management of common pediatric conditions addressed in primary care including behavioral health, sleep, skin conditions, GI, nutrition and headaches, for example. Attendees will be provided with practical skills and tools to promote health and well-being for both the patient and the provider.

Check the website for more information

DOWNLOAD more information.

**Save the Date! 2022 Food is Medicine Conference September 23-24**

The Food is Medicine Conference, hosted by the University of Utah Center for Community Nutrition, is designed for healthcare professionals. Lectures, expert panel discussions and hands-on culinary experiences will explore the prescriptive power of nutrition to advance the prevention and treatment of chronic illness. Early Bird registration ends **July 30.**

READ MORE AND REGISTER

# Clinical Resources Continued…

## Lyme Disease: Evidence, Epidemiology, Diagnosis and Treatment
## A Personal Perspective

As an internal medicine specialist, starting out in the Canadian Forces Medical Service, I was referred military members with chronic unexplained symptoms; most commonly fatigue, “brain fog”, light-headedness and body pains.

Just prior to my retirement in 2003 I was referred a 40 year old sergeant from Cdn Forces Base Kingston who was perfectly healthy until she was bitten by a tick and developed all the above symptoms in addition to dramatic lability of heart rate and blood pressure. These symptoms had persisted for more than two years despite extensive investigations and various diagnoses and treatments. She gave additional history that her symptoms would abate every time she received antibiotics for some other indication. Also her sixteen year old daughter had been diagnosed with Lyme arthritis by a local rheumatologist. Both the mother and daughter had NEGATIVE public health serologic test results for Borrelia Burgdorferi, the agent of Lyme disease. The military sergeant was, however, convinced this was her diagnosis and implored me to treat her with longer term antibiotics. She also advised that she knew of many military members posted to Kingston who were suffering similar symptoms.

While I had been trained in tropical medicine and vector-borne disease by the military, and have since completed a Masters Degree in Public Health, I did not know very much about tick-borne illnesses in Canada at that time. I did some research and could find very little “evidence” to support the long-term use of antibiotics, but she had never even received a standard course of antibiotic for 28 days to treat presumed Lyme, so I started her with that. She improved dramatically, but a few weeks after the antibiotics stopped her symptoms recurred. I wrote to the Surgeon General my opinion that she most likely had chronic Borreliosis in the absence of any other I wrote to the Surgeon General my opinion that she most likely had chronic Borreliosis in the absence of any other medical explanation for her symptoms and recommended that she be referred to a “Lyme specialist” to be considered for additional testing and treatment. I also advised the Surg. Gen. that Kingston and environs were becoming endemic for ticks carrying Lyme disease and co-infections and that the military needed to be careful about exposing troops to these during field exercises.

I then retired and lost contact with this patient until she was referred back to me nearly ten years later. She had been released from the military for medical reasons, thought to be somatoform disorder. At her own expense, she sought care from a Canadian doctor practicing in New York state exclusively in the area of chronic Lyme disease, was confirmed to have this diagnosis and
ultimately had durable resolution of symptoms after receiving combinations of antibiotics for over a year. Her case is what has compelled me to try to help similar patients.

For the past ten years my practice has included increasing numbers of patients referred for Chronic Fatigue Syndrome / Myalgic Encephalitis / Exertional Intolerance / Chronic Pain /Fibromyalgia and Chronic infections with Lyme, Bartonella and other bacteria, Epstein Barr and other viruses, Babesiosis and other parasites as well as mold. This latter group with underlying infections has been renamed MSIDS – Multiple Systemic Infectious Diseases Syndrome by Dr. Richard Horowitz.

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# Clinical Resources Continued…

He has dedicated a 40 year career to such patients in upstate New York close to Lyme Connecticut and has researched extensively fifteen thousand of them. Many other microbiology groups and clinicians around the world have been researching these conditions over the past decade and the body of literature available to inform etiology, diagnosis and management of these patients is now extensive. I have attended annual meetings of ILADS – International Lyme and Associated Diseases Society, for many years and have been impressed by the quality and quantity of presentations by global academic experts. I was also a member of the Ontario government Task Force on Lyme Disease and Tick-borne Illness (see the report at https://www.health.gov.on.ca/en/common/ministry/publications/reports/lyme_18/ldtf_final_report_2018.pdf.)

Over the course of the past decade I have become one of the small number of experts in tickborne illness in Canada, and have managed more than two thousand such patients. While a small percentage of patients with these illnesses also endorse extreme sensitivity to environmental exposures including chemicals, smells, light, sound and ElectroMagnetic Fields (EMF) and, therefore, carry the label MCS (Multiple Chemical Sensitivity) also known in the literature as IEI (Idiopathic Environmental Intolerance), I do not consider myself a specialist in managing this group. A much higher percentage of my patients have allergic symptoms, and, with appropriate testing can be confirmed to have Mast Cell Activation Syndrome. MCAS is also being actively researched by immunologists and allergists.

**SUMMARY OF RESEARCH FINDINGS**

**A. EPIDEMIOLOGY / ETIOLOGY**

 Tick-borne illness is endemic in many parts of Ontario and Canada. Ticks can bite and pass disease in ambient temperatures of 4 C or higher and therefore can be a problem almost year round

 There are more ticks each year, and increasing numbers of them are carrying Lyme disease as well as tick co-infections including Babesiosis, Bartonellosis, Rickettsial disease (Rocky Mountain Spotted Fever, Anaplasmosis, Ehrlichiosis)

 Ticks are moving northward due to global warming and migration of their hosts

 The number of cases of tick-borne illness in Ontario and Canada are rising significantly.

A systematic review just released (BMJ Global Health https://gh.bmj.com/content/7/6/e007744 ) suggests that 14% of the world's population has had or currently has Borreliosis!

 Acute exposure to Lyme with a witnessed tick attached and classic erythema migrans rash is readily managed with short course antibiotics and this standard of care is not controversial

 However, a significant percentage of patients who develop chronic symptoms following a tick-bite: 1) never saw the tick 2) had no rash or an atypical rash 3) did not receive antibiotics. Unfortunately, many doctors believe that their patients can't have acquired Lyme disease unless they saw an attached tick and / or had an EM rash and this leads to missed diagnoses frequently

 Patients who receive standard antibiotic therapy for Lyme and who go on to have chronic symptoms have been termed PTLDS (Post-Treatment Lyme Disease Syndrome). PTLDS arises in 10 – 20% of patients with Lyme.

 There has been controversy over the etiology of PTLDS: is it persistent infection or is it a sequelae of past infection due to inflammation, immune derangement or other (many patients are informed that it is a mental health problem!)

 On balance, recent research supports the persistent infection theory. An excellent overview of this research by Dr. Sam Donta – peer reviewed in Frontiers of Public Health Jan 2022 outlines the evidence for chronic persistent Lyme infection and the lack of -evidence for a non-infectious cause.

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# Clinical Resources Continued…

https://www.frontiersin.org/articles/10.3389/fpubh.2021.819541/full?&utm_source=Email_to_rerev_&utm_medium=Email&utm_content=T1_11.5e4_reviewer&utm_campaign=Email_publication&journalName=Frontiers_in_...

 A paradigm shift to acknowledge that Borreliosis is a persistent infection with capacity for latent / dormant phases similar to other spirochetes (syphilis) and mycobacteria (Tuberculosis) is required if the health system is to successfully manage the suffering and disability of patients with chronic Lyme.

 Chronic Lyme disease is underdiagnosed in Canada by up to 90% with an estimated case incidence of 60,000 annually. See article by Dr. Ralph Hawkins and Dr. Vett Lloyd "Under-Detection of Lyme Disease in Canada" *Healthcare* Oct 2018 https://pubmed.ncbi.nlm.nih.gov/30326576/

 One of the most important global clinical practice guidelines regarding Lyme disease is from ILADS – International Lyme and Associated Diseases Society. These guidelines have been endorsed by the US Federal Government clearing house for CPGs. See https://www.tandfonline.com/doi/full/10.1586/14787210.2014.940900 The ILADS guidelines emphasize the importance of patient choice in the setting of uncertainty and controversy, but also that recent research supports the use of long-term antibiotic therapy for chronic persistent Lyme infection in certain patients with refractory symptoms.

**B. DIAGNOSIS**

 Diagnosing acute Lyme disease is challenging if there is no witnessed tick or compatible rash.

 In New York state and Connecticut, any patient presenting with the worst headache of their life (and a normal CT scan) is presumed to have Lyme disease and is given antibiotics. (personal communication Dr. R. Horowitz). Unfortunately that is NOT the case in Ontario.

 Chronic symptoms of Lyme disease mimic many other conditions and if combined with co-infections can present with symptoms in every organ system. Most of my patients have already seen, on average 8 to 10 specialists including neurologist / cardiologist / rheumatologist / internist / infectious disease specialist and psychiatrist.

 Serologic testing carries high specificity but low sensitivity. In some studies sensitivity of the two step test (standard at CDC and Ministry of Health Ontario) is as low as 10% ie. 90% of those with the disease test negative. The article by Dr. Hawkins above outlines the issues with this approach to testing. Similar to Tuberculosis, the Lyme bacteria can escape humoral immunity. The conventional approach to diagnosis of active TB abandoned serologic testing for this reason. Currently there are no robust tests available to identify active Borrelia infection and research is active in this area. See https://www.frontiersin.org/articles/10.3389/fmed.2021.666554/full "Recent Progress in Lyme Disease and Remaining Challenges" Aug 2021 for a review of diagnostic testing research.

 In view of the paucity of accurate tests available, clinical diagnosis remains the foundation in chronic Lyme. Dr. Horowitz has published a validated questionnaire that can effectively discriminate tick-borne illness from other chronic conditions. Patients who score higher than 60 (out of a maximum score of 180) have a positive predictive value of tick-borne infection greater than 90%. He weights heavily some symptoms that are unique to Lyme disease including migratory arthralgia / myalgia and, most importantly, migratory polyneuropathy for which there are no other known causes. See http://www.lymeactionnetwork.org/wpcontent/uploads/2015/06/MSIDS.pdf for an explanation of MSIDS and the questionnaire and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5590688/ for the published study entitled "Empirical Validation of the Horowitz Multiple Systemic Infectious Disease Syndrome Questionnaire for Suspected Lyme Disease" *Int J Gen Med* 2017

**C. TREATMENT**

 From the time that Dr. Wilhelm Burgdorfer identified the spirochete agent of Lyme disease in Lyme Connecticut, treatment with antibiotics of the tetracycline group were considered to be the drugs of choice.

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# Clinical Resources Continued…

However, even Dr. Burgdorfer opined, at the time of his landmark research, that the bacteria had a persister form and this has now been confirmed in vitro in numerous academic microbiology laboratories.
Furthermore it has been shown that the non-cell wall, intracellular persister form responds poorly to tetracycline, doxycycline and most other conventional antibiotics. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6521364/ "Metamorphoses of Lyme Disease Spirochetes: phenomenon of *Borrelia* persisters".

 Dr. Zhang of the Bloomberg School of Public health at John's Hopkins has conducted seminal research in identifying therapies that can eradicate Lyme persisters. He reported in 2015 that a combination of Daptomycin, Cefoperazone and Doxycycline was effective in vitro https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4373819/ and in 2018 published that the combination of Daptomycin, Ceftriaxone and Doxycycline was effective in a mouse model https://publichealth.jhu.edu/2019/three-antibiotic-cocktail-clears-persister-lyme-bacteria-in-mouse-study. Human studies are underway.

 In view of its similarity to mycobacterial persistent diseases: tuberculosis and leprosy, several studies have co-opted TB treatments for chronic Lyme. These include dapsone, pyrazinamide and rifampin. Furthermore, the model of combination of three and four medications over prolonged periods that is now standard for treating mycobacteria may also be required in chronic Lyme.
Dr. Horowitz first reported on the use of Dapsone to eradicate chronic Lyme in 2016 and has subsequently shown that double doses of the medication can be more effective and well tolerated. See https://www.mdpi.com/2227-9032/6/4/129, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7690415/, https://bmcresnotes.biomedcentral.com/articles/10.1186/s13104-020-05298-6\
I began using dapsone in combination with usual antibiotics in 2017 and noted more durable responses.

 In 2016, microbiology researchers at Stanford published their approach to screening in vitro cultures of Borrelia bacteria "persisters" with a library of medications already used in humans. See https://pubmed.ncbi.nlm.nih.gov/27103785/ The most active one was determined to be Disulfiram (Antabuse), that appears to have an effect on preventing persister bacteria from utilizing copper, an essential factor for its survival. Disulfiram's action is unrelated to its primary role in alcohol metabolism, though patients must abstain from alcohol while using it. Shortly after, Dr. Kenneth Liegner published on successful use of Disulfiram in three patients and in 2020 released a follow-up study of 71 patients receiving the medication. He reported that over 92% of patients had some degree of improvement of symptoms and fully 1/3 had enduring remission (no symptoms of chronic Lyme for six months while taking no anti-infective medications). See https://pubmed.ncbi.nlm.nih.gov/33291557/

 In my own experience over the past three years, with nearly three hundred patients suffering chronic Lyme disease, the combination of antibiotics covering the fast growth form of Lyme concurrently with Dapsone and / or Disulfiram has produced even higher success rates, even in patients who had suffered from symptoms for many years and had previously taken multiple courses of other antibiotics.

To conclude, I firmly believe that once the COVID-19 pandemic is behind us, public health and conventional medicine will have to address the burgeoning burden of suffering from tick-borne illnesses. Education of primary care and specialists as well as the public will be essential first steps to address this suffering. Distinguishing long-haul COVID from chronic NeuroBorreliosis and acknowledging that chronic disabling symptoms can arise in a significant percentage of patients with these exposures will be critical components of this education. And, more importantly, that effective treatments exist that should not be denied to these patients. Dismissing their symptoms as somatoform or mental health issues or treating symptoms such as chronic pain without addressing the upstream cause is a disturbing failure of our health system and must be guarded against.

*By,*
Timothy Cook MD, FRCPC, MPH,
LCol (Ret'd), CD (Canadian Decoration)

# An invitation to members

## Share something with us!

The Medical Interest Group for Complementary and Integrative Medicine has over 400 members. Some of you may feel passionate about one specific modality, whether it be nutrition, movement, mind-body practices, natural health products, manual therapy, or acupuncture. Perhaps you have an interest in a specific condition, or some aspect of functional medicine that you want to share with us. Some of you may have insights or personal experiences that have shaped your perspective on healthcare.

Whatever you want to contribute, we want to read it and share it with the Ontario Integrative MD community. We would love to receive submissions, whether they are in the form of a single paragraph or a full-length article, with references or without. Help us all to grow and learn together. Email submissions to: oma.cim.mig@gmail.com

# Please Support Our Work- Pay Your Constituency Fees

Your CIM MIG Executive is focused on advocating for physicians who practice Complementary and Integrative Medicine. We are intent on gaining recognition for our field in Ontario and Canada. We need your support to help us continue our work and to help us create a safe regulatory environment for Ontario's doctors. We have made significant progress towards this goal, by engaging stakeholders, providing a consistent message about our members' aspirations and concerns, and drafting submissions that offer real solutions.

By paying your $50 Constituency Fee, you will help ensure that our work can continue. We are working to support you, but we cannot do it unless You support us. Follow the instructions below to pay your dues:

Step 1: Log into the OMA
Step 2: Click on "My Account"
Step 3: Click on "Pay dues & fees"
Step 4: Click "Next Step" at the bottom of the page
Step 5: Click on "Complementary & Integrative Medicine Medical Interest Group"
Step 6: Click on "Next Step" at the bottom of the page
Step 7: Follow instructions on the page to finish the payment

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