

## Supplement Reductions Application Guide

### Clinical Context

When the patient improves enough to establish a better functioning baseline, they often want to know if they can reduce the number of supplements they're taking. You want to give them guidance about how to figure out which supplements are ok to reduce and which ones they should continue without changes. The patient will also want to know which foods they can reintroduce.

#### Supplement reductions should be done before food reintroductions

This gives the clearest opportunity to understand what it looks like when the patient is functioning at their best, with the smallest set of supports, but also without the extra burdens presented by problematic foods. This is a better approach than re-burdening a patient with inflammatory foods, for example, but also keeping the doses of anti-inflammatory supplements high enough that the patient is tolerating those foods. See the *Food Reintroductions Application Guide* for information on food reintroductions.

Broadly, it's reasonable to expect that the patient can maintain their improvement with less influence from supplements than it took to get the body to shift toward improvement in the first place. The question you want to answer is, "What subset of what it took to get your improvement does it take to keep it?" It makes sense that it would take less, but you and the patient need to find out together what turns out to be true. As with many things, "makes sense" and "turns out to be true" aren't always the same.

Be cautious and systematic in figuring this out. Chronic illness is typically characterized by multiple factors, connected into a biological tangle that promotes the chronic illness manifestation that they were hoping you'd help them with in the first place. It's important that the patient understands that they likely still have a vulnerability to the same chronic illness(es) that they had initially, the same underlying genetics, the same ditches in the landscape of their biology. The difference is that you've helped them get out of the ditches and helped them move far enough away from the ditches that they're not teetering on the edge of falling back into a more fully manifest version of their illness patterns.

For example, if a patient has SIBO and also has ASCA antibodies, which are predictive of inflammatory bowel disease, the patient may not understand the importance of dietary accuracy, once the SIBO has been properly addressed. The patient may think, "ok, I took care of that, now I can go back to eating whatever I want." Their misunderstanding might lead them to make choices that lead to a full expression of Crohn's disease or ulcerative colitis. So, it's crucial that you clearly explain the implications of their current biological status for the broader arc of the patient's case. That puts them into a more empowered position, where they can make choices with a clearer sense of what's at stake.

As with everything you learn in Cogence Immunology, your use of this information should be guided by your expertise, in the context of your training and your license to practice. These approaches are in addition to, rather than instead of, conventional approaches to care. Interactions between supplements and medications, as well as the effect of patient improvement on their responses to current doses of medications, need to be considered by the clinician. Cogence, LLC member terms of use apply to this document.

### Step 1: No Changes for 3 Months

The first step is that if the patient is asking about supplement reductions the first day they feel restored, they need to spend three months changing nothing. Biology resists change. It took a lot of hard work to get to the level of improvement they're currently occupying. But they haven't yet established a center of gravity there. That means it will be too easy to perturb their function by making changes. If they ask about changes to the plan too close to when they start to feel better, my instruction is always to **change nothing** for three months. Once they've gone three months, then we do the rest of what's described below.

### Key Navigation Points

1. The patient shouldn't try to figure out what foods can be brought back into consumption at the same time they're trying to figure out which supplements can be reduced/eliminated. That creates chaos that makes it impossible to determine what's going on. I'll discuss reintroducing supplements in another Application Guide.
2. Some supplements may simply not be able to be reduced. If I have a short leg, I'll need a heel lift in the shoe on that side. How long will I need it? As long as that leg is shorter than the other one. Genetic factors, inflammatory or microcirculatory injury or fibrosis in organs, chronic exposure to pollutants or other factors, dietary issues, etc., can yield a situation in which persistent support for weaker components of patient biology may simply be necessary.
3. The patient will often benefit from the specification of a "Flare Protocol" that they can put into practice as soon as they realize that their autoimmune or other dysfunction is flaring up. That saves them the cycle of work involved in getting in touch with you to get guidance, by which time the flare has had extra time to build up and cause damage.

### Figuring It Out

The right approach to supplement reductions will teach you and the patient a lot about what they will need to do, in order to maintain their improvement. It will show you both what can be reduced, what can be eliminated, and what's essential to keep in. That will give you and your patient another layer of information about the patient's underlying biology that's a crucial piece of perspective on the ongoing flow of the case. It's important to set that expectation for this part of your work together. If you work the process well together, you've got a great opportunity here to sharpen your understanding of the case.

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If, for example, you try to reduce support for optimal brain function, but the patient's newly improved baseline starts to erode, you'll know they still need support for that function. That will tell you that either the need is deeply baked into their biology, or that you have more work to do to figure out why that function is still suboptimal. A patient with persistent low level body inflammation may have residual persistent low level CNS inflammation that still needs attention. A different patient might be homozygous for the defect for rs6265, a BDNF gene, so they will tend to make less BDNF. They may always need some level of support for that function.

For things like vitamin D or glutathione, you'll determine the ongoing dose directly with lab work. Those supplements aren't part of this process. For others, curcuminoids for example, you may have lowered a lab marker like hsCRP, so you'll determine the dose based on changes in signs/symptoms plus labs, this time seeing if the hsCRP level that you brought down with curcuminoids stays down when you lower the curcumin dose. For most supplements, you'll also rely upon patient reports of symptom reemergence.

### The Steps

I always give my patients a spreadsheet of their supplements. Every line looks like this:

Balanced Immune	3 caps twice daily	Reduce inflammation
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This tells the patient the specific supplement, dose, and purpose, which helps the patient stay on track. It's also easy to update and resend to the patient. When it's time to start reducing doses, I do two things: 1) I add a column to the left and put a number next to the supplements I want them to try to reduce. That tells the patient the order in which they should reduce the supplements. 2) I tell them how much to change the dose. So the line looks like this:

1	Balanced Immune	Reduce to 2 twice from 3 twice	Reduce inflammation
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I typically have the patient go through most of their supplements, reducing doses by one third (down from 2 TID to 2 BID, for example), or by half (down from 1 BID to 1 QD, for example). Again, for items where dose is based on lab levels of the substance itself (D, E, A, glutathione, iron), this process typically doesn't apply, unless you're looking to see if lab levels are sustained on lower doses, as perhaps if absorption may have improved.

Each reduction is done on its own, for four days. At the end of four days, if they feel just as good, that's the new dose, and they go on to the next one. If they don't feel as good, if their improved baseline begins to erode, we've both learned something. They note it on their plan, wait a few days to return to their improved baseline, and try reducing the next one.

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1	Balanced Immune	2 2x, down from 3 2x	Reduce inflammation
4	Perilla Extract	1 2x, down from 2 2x	Downregulate IL-4
3	Coriolus Extract	1 2x, down from 2 2x	Support WBC #'s and function
2	Epi-Integrity	1 scoop 2x, down from 2 scoops 2x	Repair GI tract
	Vitamin D	10,000iu - 1 cap daily	Reduce inflammation

When they get to the end of the list, they've identified some supplements that they know are not ok to reduce. For the others, reducing the dose was ok. Now the question is, "Can they reduce the dose further or eliminate any of those?" The patient repeats the process, with another round of reductions of the ones that were ok to reduce in the first round.

They repeat the process until they've identified which ones need to stay at the original level, which ones can be reduced but not eliminated, and which ones they were able to eliminate. It's key to do the eliminations one at a time, so you're able to see any changes as clearly as possible and discern information about the patient's biology from those changes.

Be sure to tell the patient that, if their biology starts to shift, if their stress level gets very high, or they get into some bad food, or have some other perturbation, it may be necessary to bring something back in, or raise the dose of something, to reestablish their improvement. Some patients will take that to mean they can do whatever they want, and you'll be able to clean up. Make sure they know that's not what you mean.

Some patients will be frustrated that they need to keep taking supplements. What I say to patients about these supplements is, "If one of your legs is shorter than the other and your orthopedist gives you a heel lift to wear in your shoe on the side of the short leg, do you ask the orthopedist how long you'll need the heel lift?" They typically understand.

As always, you're just the guide through the territory. You don't determine what's necessary or how long it will take to see improvement. You can give them guidance based on your expertise and experience. That's not the same thing as you having the power to determine the outcome. Never claim you know you can help. Never claim you know how the process of reductions will go. How in the world would you know those things? Being good at predicting which horse will win a race is not the same thing as knowing. The nice thing about the process I've described is that it's essentially a way to run the same race multiple times, to derive information about what turns out to be true. You and the patient will discover together what turns out to be useful, through the process you craft for them.

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