

Editorial

# My experience with a major hospital stroke team—What’s wrong with “Modern” medicine

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Recently, I had an experience with one of the negative manifestations of modern medicine, an event that should teach us all some important lessons concerning health care. It all began when my wife and I received a phone call from my wife’s sister that my mother-in-law, who is 91-year-old, had just experienced an ischemic stroke involving her right carotid following a minor eye procedure for glaucoma. She was rushed to a local hospital in Covington, Louisiana. I spoke to the nurse caring for her in the emergency room and she asked if I wanted her treated with tissue plasminogen activator (tPA). I gave permission without hesitation. After the tPA was administered, she was airlifted to a major hospital in New Orleans. At the time, this was considered one of the top hospitals in the country and is a major teaching center in New Orleans. They also advertise themselves as a major “stroke center.”

My wife and I drove from our home in Mississippi to see what we could do to help. Once her mother arrived at the hospital, the admitting neurologist performed an intravascular thrombectomy. By the next day, she demonstrated an excellent return of function of her previously hemiparetic left side, with only slight facial weakness. We arrived on day 2 after her thrombectomy treatment. Her neurological condition improved rapidly over the next 3 days.

At the time we arrived, they had her on a regular diet, but she was eating only very small amounts as the food was salt-free—that is, tasteless, and she just would not eat it. I asked the nurse why she was on a salt-free diet, and she told me that it was a standard “cardio-diet”. She had never been on a salt-free diet before and had no history of heart disease. The real irony was that she was getting D50.9 saline intravenous (IV) at the same time, certainly more salt than a normally salted diet would supply.

I recall many elderly patients of mine having incredibly low salt levels secondary to similar salt-free diets and the

difficulties, it cause during treatment of their neurological condition, especially reactive brain swelling associated with fluid replacement.

By day 4, I was becoming concerned that she was receiving essentially no nutrients (none were added to the IV and no magnesium was added). In addition, her IV fluids were running at 35 cc/h, not sufficient for her fluid replacement, especially since she was taking very little orally.

Especially, disconcerting was that the doctor never met with us or communicated with us in any way up until that time. When I practiced neurosurgery, I made sure that I spoke to the family each day and if a family member was a physician, I extended the courtesy of keeping them fully informed.

Frustrated, I asked the nurse to have the doctor come to the room and talk to me that I was a neurosurgeon and wanted to have some sort of communication. Instead, he

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sent his physician's assistance, a very nice young woman. I voiced my concerns that my mother-in-law was getting essentially no nutrients and that the IV had been removed the night before, and she was made nil per os (NPO) at the same time so that now she was also becoming significantly dehydrated. I once again asked to speak to the doctor. She said that the doctor who did her thrombectomy was no longer on the case and that a new neurologist was now assigned. So I asked to meet with him.

He arrived, dressed in his perfectly clean, starched white coat, accompanied by an obvious condescending attitude. I explained to him my concerns for her nutrition and that she was becoming dehydrated and explained further that this could lead to another stroke. He then told me the most unbelievable thing I have ever heard from a physician. He said that while nutrition was important, there were other priorities that took precedence. I said—"Like what?" He stammered and could not come up with a rational suggestion, other than the need for physical therapy and speech therapy (she had no problem with her speech). None of these things would have precluded supplying nutrition at the same time. I once again explained to him that following a stroke the brain was hypermetabolic and in need of nutrition in the form of vitamins, minerals, and other nutrients. He agreed that the infarcted brain was indeed hypermetabolic, yet he expressed no concern for her lack of nutrients. Explanations concerning the high level of free radical involvement and the need for replenishing the antioxidant network likewise had no effect.

I then mentioned the importance of magnesium in such cases, and he made up some idiocy about a magnesium-containing diet product that caused some problems in some undocumented case. I explained that I was talking about mere replacement only of magnesium and not in massive doses. He would not yield and refused to order even replacement levels of magnesium. At that point, my mother-in-law had no testing for magnesium levels. The following day that was done and her blood levels were on the borderline of lower normal.

I attempted, without success, to explain to the nurse that magnesium was an intracellular ion (99% of the total magnesium level is intracellular) and that blood levels did not accurately reflect magnesium nurture. Further, I explained, studies have shown that when blood levels are low, tissues levels are often drastically depleted. This was met with complete puzzlement on the part of the nurse. The doctor never reappeared during the rest of her stay or communicated in any way.

During my previous discussion with the neurologist, keeping in mind that he made her NPO at the very time he removed her IV, I asked him to explain how she could live on virtually no food or hydration—as it had

already been 6 days without these essentials? Finally, he suggested a nasogastric (NG) tube or percutaneous endoscopic gastrostomy. I suggested the NG tube, wanting to avoid the risk of further surgical procedures. I asked why she had been made NPO, as I was able to give her some water and some small amount of food—that is, she could swallow well. He explained that the speech therapist felt that she could not swallow well enough and might develop "silent aspiration." They told me that they had scheduled a barium swallow to evaluate her ability to swallow on Monday—and this was Friday morning. I shook my head, struggling to control my anger. I then turned to the doctor and said "how do you expect her to survive with no food or water for the next 3 days—after all, it has already been 6 days with insufficient fluids and nutrition." Then, he agreed to restart her IV fluids. Ironically, he ordered the IV to run at 25 cc/h.

I considered asking him if he could go 6 days with very little food or water, but then I was attempting to be civil and not too confrontational. An attempt was made to put in the NG tube, but she pulled it out, unable to tolerate the sensation of gagging—a sign that her gag reflex was fully intact and that she could swallow without difficulty. Despite this, no vitamins, minerals (especially magnesium) were given—nothing but IV dextrose, water, and saline.

I could not believe that a neurologist, a so-called expert in stroke management, totally ignored hydration and nutrition as part of the standard treatment of strokes. This is a hospital that proudly advertises its expertise in comprehensive, advanced stroke treatment.

I literally had to instruct this neurologist on the brain's essential need for vitamins and minerals and described to him that under such conditions the water-soluble vitamins are depleted within hours following such stress. Further informing him that these vitamins were used by the brain for neurotransmitter formation, energy metabolism, construction of proteins and complex lipids, and also used by the body to maintain organ function and immune function. I asked him how he expected the injured brain to reestablish its synapses and dendrites without these essential nutrients. He would not look at me and I could tell he was displeased to have someone challenge his superior position.

I told him that if my mother-in-law were not to be given magnesium, she would deteriorate neurologically and would have an increased risk of seizure or could lapse into a coma. This had no effect on his decision to withhold magnesium.

By the next day, she was significantly worse in terms of her cognition and physical strength. In fact, she had deteriorated to the point she was back to the condition, we found her in when we first arrived—extremely weak and lethargic.

Fortunately, the “stroke team” also had an internal medicine physician cover the patients. That evening, the covering physician did order a gram of magnesium to be given as a piggyback solution. The following morning I met with the internal medicine doctor that replaced the original internists, and she agreed to continue the magnesium, as the first doctor had ordered only a single 1-g dose.

The following day, my mother-in-law looked dramatically better and was cognitively remarkably improved. Her strength was much better as noticed by the physical therapist. On that Monday, she had her barium swallow, which we were told demonstrated perfectly normal swallowing and no aspiration. Her improvement continued, and 2 days later, she was discharged to a rehabilitation nursing home close to her home. The battle now continues with the nursing home for her to be provided with her nutritional supplementation, which they have also refused.

This event demonstrates a major problem with medicine. Far too many doctors have become glorified pharmacologist and technicians and know little about the metabolic care of patients. A number of studies have noted this lack of appreciation for their patients’ nutrition. The surgeons seem to know very little about pre- and post-operative nutritional care and immune support. One can only wonder how many expertly done surgical procedures are ruined by poor postoperative care. Preoperative nutritional care—that is, preparation of the patient for surgery—is never even considered.

I have seen time and time again how physicians, especially surgeons, treat magnesium as if it were a highly toxic substance. While they would never hesitate to add potassium to an IV, they cannot be cajoled into putting magnesium in an IV—even moderate doses. Numerous studies have shown the safety, even of relatively high-dose magnesium use. Potassium is infinitely more toxic than magnesium, yet they treat magnesium as if it were arsenic.

Few seem to understand how many commonly used pharmaceutical drugs deplete magnesium and that stress causes significant depletion of magnesium. Magnesium

depletion is especially common in the elderly because of poor diets and the use of many magnesium-depleting pharmaceutical drugs.

At one point, the physician’s assistant told me that my mother-in-law was having occasional atrial arrhythmias. The patient’s electrocardiograms (EKGs) are displayed on a screen outside the room and I told her I had been watching her EKG pattern daily, and it has been perfectly normal and that she had two EKGs before coming to the hospital, and they were perfectly normal. I then told her that the recent appearance of the atrial arrhythmia was most likely caused by her progressing magnesium deficiency, something that is well known. All I got was another blank stare.

Our medical literature is filled with excellent studies on the presence of severe nutritional deficiency in postsurgical patients and on the effects of nutritional depletion and insufficiency on, not only brain function but also systemic organ function, wound healing, and especially immunity. Likewise, several studies have shown that a significant number of patients enter the hospital with borderline nutritional deficiencies in one or even multiple nutrients and that following admission their nutritional status frequently deteriorates over time. This is especially so for patients in Intensive Care Units.

In these modern times, the medical elite never hesitates using the term “evidence-based medicine” and constantly tell their patients and the media that they practice “scientific” medicine. Unfortunately, a great deal of this science is ignored on a regular basis—that is, the science of human nutrition.

It is time for all doctors, especially surgeons, to appreciate the importance, not only of postoperative nutrition but also more importantly preoperative nutritional support. My colleagues and myself will publish a number of such papers on these subjects in the near future.

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