Bret Stephens, We Worry

A kind of rubbernecking morbid fascination with Bret Stephens' gastrointestinal health makes for a revealing case study in systems biology

June 28, 2021 By Mike Barr

I've developed this morbid fascination with Bret Stephens' the New York Times columnist cryptic or not so cryptic chronic health complaints confessions. While many or most of his ideas I find unappealing or down right noxious, I keep kind of secretly waiting/hoping for him to discover his shared humanity with the wider world. I have succeeded in abstaining from his and Ms. Collins' banterish columns ever since I suppose adults returned to the Casa Blanca, never quite being able to decide if their quippish back and forth merits the space reserved for it, but somehow today I woke feeling overly generous (I suppose it was the joy from seeing all the kids decked out in colorful outfits and lack thereof foraging all around the East and West villages yesterday) and I guess decided to give their weekly Conversation column, especially him, another chance. It was admittedly a bad call on my part, but I was again intrigued about how he sprinkles personal chronic health complaints within his kind of libertarian and One Market Under God opinions.

If I have the time over this tropical holiday weekend just to earn my morbid fascination bona fides, I will chronicle the GI references from his columns I came across during all of this sheltering in place of the past four hundred and six days. Or so counts Stephen Colbert (03:30).

Soaking in so early on this aggressive, even oppressive summer morning some of his more aggressive and oppressive Republican sounding ideas and beliefs (he has proposed denying health care to unvaccinated Covid catchers, as he would and apparently has proposed earlier, denying medical care to smokers and former smokers who develop lung cancer), a clearer picture of his own personal health history comes into focus.

I'm not one to wish ill on others (well mostly), but part of me suspects a good personal crisis-- possibly a midlife health scare-- might do him good.

Almost invariably his columns are sprinkled with bizarre personal asides that reference his apparent exuberant flatulence, chronic constipation (it may alternate with loose stools and/or explosive diarrhea; I have to go back and re-read his past columns now) and, intra alia, I guess what one would characterize as dyspepsia, possibly even postprandial bloating.

This morning the journalistic personal health confession that caught my eye was his hypertension.

So here's I suppose a typical middle aged, mostly sedentary white male. All he's missing (maybe he'll share in future columns or already did so and I missed them?) I suppose is a concern about his high LDL a borderline high fasting blood glucose, or a prescription for a PPI.

For someone so aggressively, oppressively clever, doesn't he realize that all these seemingly disparate bits are part and parcel of an interconnected whole?

Yes, I'm not so stealthily laying the groundwork for a self-serving segue into a pitch for systems-based biology or what is also called functional medicine.

And also just to note that when he begins to develop cognitive decline, even full-on Parkinson's or "Alzheimer's" (I put Alzheimer's in quotes not to be annoying but because it is almost impossible to definitely diagnosis while the afflicted is still alive and also because I have seen way to many cases diagnosed as the Big A that were really something else) maybe even colon cancer five or ten years from now, should we deny him care for his behavioral induced morbidity?

If Mr. Stephens or someone who loves him (I have tried but so far am failing) is listening, I have inserted his name into this summary of a similar sounding case presentation just so maybe he and we all might see how he or his medical team might begin to "zoom out" and think of/see these things:

Bret, a 54-year old male, came to me complaining of inability to lose weight, mild hypertension (155/85 mm Hg), abdominal bloating, alternating constipation and loose stools, and decreased exercise endurance. He also experiences strong food cravings (primarily for carbs and expensive wine), headaches, sometimes itchy hands and feet. His BMI was 32.9 which put him in the moderately obese category (although BMI is not always an accurate gauge of obesity, especially in aggressively muscular guys, but doubtful that a NYT columnist could be described thusly).

About a year prior to coming in, Mr. Stephens had started a low-carb Paleo type diet and had lost about 20 pounds. But he quickly put them back on. Confused by this, he reduced his carbs even further until they were accounting for less than 10% of his total calories.

At his first visit we took an extensive health and life history and ran both routine blood tests as well as tests for small intestinal bacterial overgrowth, a comprehensive stool analysis, a urinary organic acids test, and a nutrient analysis.

Bret's fasting glucose (NB: fasting insulin is the preferred marker to look at, as it can reveal glucose management issues 5-10 years before aberrant fasting glucose values), hemoglobin A1c, uric acid, serum triglycerides, triglycerides to HDL ratio, hs-CRP and HDL were all consistent with pre-diabetes. His 25-hydroxyvitamin D level at 14.8 ng/mL was quite low (we aim for 50-70 ng/mL). Low 25(OH)D levels are associated with, among other things, diabetes and metabolic syndrome. His GGT (gamma glutamyl transferase) was also well outside the optimal range. Studies show than in increase in GGT predicts onset of metabolic syndrome, incident cardiovascular disease and total mortality in a linear fashion.

His liver aminotransferases, ALT and AST, were mildly elevated. When other causes (such as hepatitis, Wilson's disease and hemochromatosis, sometimes medication caused) are ruled out, and especially when signs of metabolic dysfunction are present, the most likely cause of mildly elevated aminotransferases is non-alcoholic fatty liver disease (NAFLD).

Bret's serum B12 levels were also borderline low, and his homocysteine levels were borderline high, suggesting possible deficiency of active B12. His BUN/creatinine was slightly elevated. In the absence of other markers of kidney dysfunction, the most common cause of a mildly elevated BUN/creatinine ratio is dehydration or simply a high-protein diet (where it is rarely pathological).

His breath test results were positive for combined methane and hydrogen, the signature of an overgrowth of bacteria in the small bowel where their numbers should be much more sparse, typically caused by low stomach acid (due to chronic stress, medications, nutritional deficits, even unknown H. pylori infection) over time. This was likely contributing to his abdominal bloating and overall GI discomfort.

Bret's stool results indicated what we call insufficiency dysbiosis: the balance of beneficial and pathogenic or potentially pathogenic microbes lacking a robustness of the former. In three separate stool samples, there was no growth of Lactobacillus or Bifidobacter bacteria (another caveat here: as a particularly finicky anaerobe, it is not entirely unusual for Lactobacillus to be slow to grow in the aerobic environment of these tests, but since there were three samples one would expect at least one to show some growth if they were there in any reasonable quantity)-- the two most important genera of beneficial bacteria. On the flip side, there was evidence of mild fungal overgrowth (usually but not always a Candida species) as well as the presence of a parasite, Blastocystis hominis, which can cause diarrhea, abdominal pain, constipation, gas, or even dermatological symptoms-- or produce no symptoms at all!

Insufficient friendly gut bacteria coupled with the overgrowth of yeast and the presence of a parasite very likely contribute to Mr. Stephens' symptoms.

In the next post, I'll share the results of his (hypothetical) urinary organic acids test and the proposed action plan.

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