

1 PATIENT INFORMATION**1 PATIENT DETAILS**

NAME

Bernadette I. Oyelaran-Whitcombe

DOB

12/03/1964

AGE / SEX

61 yrs / Female

MRN / PATIENT ID

IM-8873460

DATE OF SERVICE

08/13/2026

PROVIDER

Marisol E. Quintanilla, MD

CREDENTIALS

MD, ABOIM

PRIMARY CARE PROVIDER

P. Achterberg, MD — Ridgeway Primary Care

VISIT TYPE

Integrative Medicine Consultation — supportive care alongside rheumatology treatment

CARE SETTING

Outpatient integrative medicine clinic, co-located with rheumatology

REFERRAL SOURCE

Rheumatology — Dr. H. Vasquez-Lindberg, for
supplement safety review and non-pharmacologic
pain support

INTERPRETER USED

No

CC CHIEF COMPLAINT**2 PRIMARY REASON FOR VISIT**

"My joints are the best they have been in years, but I am exhausted by two in the afternoon and I ache all over in a way the rheumatologist says is not my arthritis. I have also been taking a shelf of things I read about online, and my daughter — she is a pharmacist — told me to have someone actually look at them."

S SUBJECTIVE**3 SYMPTOMS, GOALS, CONVENTIONAL CARE & COMPLEMENTARY THERAPY USE****3a GOALS & PRESENTING CONCERNS****Reason for integrative medicine evaluation**

Referred by rheumatology for supportive care of persistent fatigue and diffuse non-inflammatory pain in seropositive

rheumatoid arthritis that is now in low disease activity on a biologic, and for a formal safety review of a self-assembled supplement regimen taken alongside methotrexate and warfarin. This visit is explicitly adjunctive to, not a substitute for, her rheumatologic care — stated to the patient and documented.

Patient health goals and priorities

Her own order: (1) enough afternoon energy to keep her part-time bookkeeping work; (2) relief from the diffuse aching she distinguishes clearly from her joint pain; (3) to know which of her nine supplements are safe, useless, or dangerous; (4) to return to the choral society she left in 2024. She is not seeking to reduce her biologic and says so unprompted.

Current symptom concerns

Fatigue is the dominant complaint — a reliable trough between 1 and 3 PM, unrefreshing sleep, and post-activity heaviness. Diffuse aching across the shoulder girdle, upper back, hips and thighs, present most days, distinct in character and location from her joint pain. Non-restorative sleep with 4 AM waking. Low mood without anhedonia. Mild bilateral hand numbness at night. No new joint swelling.

Symptom timeline and triggers

Rheumatoid arthritis diagnosed 05/2019, initially poorly controlled on methotrexate alone. Adalimumab added 03/2024 with a clear response — morning stiffness fell from two hours to fifteen minutes and DAS28 from 5.4 to 2.6. **The paradox she has come with: as her joints improved, her fatigue and diffuse pain did not.** Both worsened through 2025. Flares are now infrequent and clearly distinguishable. Diffuse pain is worse after poor sleep and in cold weather; better with warmth, gentle movement and rest days. Aggravated by the two nights weekly she cares for her grandson.

3b CONVENTIONAL CARE & COMPLEMENTARY THERAPY USE

Conventional medical history and current care

Seropositive erosive rheumatoid arthritis (RF and anti-CCP positive), low disease activity. Atrial fibrillation since 2021, rate-controlled, **anticoagulated with warfarin** — INR target 2.0–3.0, stable for 14 months until recently. Hypothyroidism. Hypertension. Prior methotrexate-related transaminitis in 2020, resolved with folate adjustment. Osteopenia on 2023 DEXA. Current regimen: adalimumab 40 mg subcutaneously every 2 weeks, methotrexate 15 mg weekly with folic acid 5 mg, warfarin per anticoagulation clinic, levothyroxine 100 mcg, amlodipine 5 mg, calcium and colecalciferol. Rheumatology 4-monthly, anticoagulation clinic monthly. **She is fully adherent to all of it.**

Complementary and integrative therapy use

Self-directed and largely unsupervised. Massage monthly, which she finds genuinely helpful for the diffuse pain. Attempted a hot yoga class twice in 2025 and stopped after both sessions left her flat for two days. No acupuncture. No chiropractic. No meditation or breathwork practice. Nine oral products, below. Declines cannabis. No homeopathy or energy therapies.

Supplement / herbal product history

Nine products, reviewed individually with all containers present. (1) High-dose fish oil, 3 g EPA/DHA daily, for “inflammation” — started 01/2026. (2) Turmeric-curcumin with piperine, 1500 mg daily, 02/2026. (3) Ginkgo biloba 120 mg, for “brain fog,” 03/2026. (4) High-dose vitamin E 800 IU, 2025. (5) Garlic concentrate, 2025. (6) Glucosamine-chondroitin, since 2019. (7) A multivitamin. (8) Magnesium glycinate 200 mg nightly. (9) **St John’s wort 300 mg three times daily, started 06/2026 for low mood — not disclosed to any other clinician.** Combined cost approximately \$140 monthly, which she describes as “more than I spend on food some weeks.” No product has a stated stopping point. Two are unbranded and lack third-party testing marks.

3c LIFESTYLE, MIND-BODY & CONTEXT

Nutrition and eating pattern

Breakfast skipped on work days. Lunch a sandwich at her desk. Main meal at 7 PM, generally home-cooked. Protein estimated at 50–55 g daily, well below requirement for her age and disease. Fiber low. Two to three vegetable servings. **Vitamin K intake highly variable — leafy greens in large amounts some weeks, none in others,** which is directly relevant to her INR instability and has never been discussed with her. Alcohol: one glass of wine weekly, appropriately limited on methotrexate. Caffeine three cups before noon. Fluid 1.5 L.

Physical activity and movement

Walks 15–20 minutes most days. No resistance training since 2019 — she stopped after diagnosis on the belief that it would damage her joints, a belief no one has corrected. No stretching or mobility work. Sedentary 6 hours on work days. Hot yoga twice, abandoned. Fatigue rather than joint pain is her limiting factor. She is willing to try again if given something specific and paced.

Sleep and restorative practices

In bed 10:30 PM, asleep by 11, wakes at 4 AM most nights and rarely resettles. Total 4.5–5.5 hours. Non-restorative. Snoring denied by her husband. Naps 20 minutes in the afternoon. No relaxation or wind-down routine. Screens in bed. Nocturia twice.

Stress / mind-body health

Perceived Stress Scale 21 — moderate-high. Stressors: her mother’s dementia and placement in care in 2024, two nights weekly of grandchild care, and financial concern about her supplement spending. No current relaxation, breathing, mindfulness or meditation practice; she volunteers that she prays daily and finds it steadying. Left the choral society in 2024 — she names this as her single greatest loss. No trauma history disclosed. No therapy history. Husband supportive.

Pain and functional impact

Two distinct pains, which she separates without prompting. **Joint pain:** 2/10, MCPs and wrists, brief morning stiffness — well controlled. **Diffuse pain:** 5/10, shoulder girdle, upper back, hips, thighs; aching, non-articular, worse with poor sleep. Function limited more by fatigue than by either pain. Prior treatments: NSAIDs (stopped — contraindicated on warfarin), paracetamol (partial), massage (helpful), physical therapy 2019 for hands only.

Mental health and emotional well-being

PHQ-9 11, GAD-7 8. Low mood since her mother’s placement, with loss of two social roles. Denies anhedonia toward family. No panic. Socially contracted. Denies suicidal ideation and self-harm thoughts on direct questioning. No therapy, no psychiatric medication — the St John’s wort was her own attempt to address this.

Women’s / hormonal health

Post-menopausal since 2013, no hormone therapy, no vasomotor symptoms. Hypothyroidism stable on levothyroxine. No genitourinary symptoms raised.

Environmental and social context

Part-time bookkeeper, 20 hours weekly, mostly seated. Owns her home. Caregiving two nights weekly plus visits to her mother. No food insecurity, but supplement spending is straining her budget. Reliable transport. Good health literacy — her difficulty is source quality, not comprehension. Daughter is a pharmacist and a useful ally.

Pertinent negatives

Denies chest pain, dyspnea, palpitations beyond her known atrial fibrillation, syncope, focal neurologic deficit, GI bleeding, melena, haematuria, unexplained weight loss, persistent fever, night sweats, new joint swelling, and suicidal ideation. **Reports easy bruising and two episodes of prolonged gum bleeding in the past month** — volunteered only when specifically asked.

ROS

INTEGRATIVE MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fatigue, low energy, fever, night sweats, appetite or weight change	Positive — marked fatigue with a 1–3 PM trough. No fever, night sweats or weight loss.
Pain, stiffness, headache, neuropathy, joint pain, muscle pain	Positive — diffuse non-articular pain 5/10; joint pain 2/10 and controlled; nocturnal hand numbness.
Sleep disturbance, insomnia, snoring, sleepiness, non-restorative sleep	Positive — 4 AM waking, 4.5–5.5 hrs, non-restorative. Snoring denied.

Anxiety, depression, stress, grief, irritability, burnout, coping	Positive — PHQ-9 11, GAD-7 8, PSS 21; grief over mother's decline and role loss.
Digestive symptoms — bloating, reflux, nausea, bowel change, food reactions	Positive — mild nausea on methotrexate day only. No bleeding, no bowel change.
Skin, rashes, itching, flushing, hair or nail changes, inflammation	Positive — easy bruising and two episodes of prolonged gum bleeding.
Hormonal symptoms, hot flashes, menstrual change, libido, thyroid	Negative — post-menopausal, thyroid stable.
Medication, supplement, herbal or complementary therapy side effects	Positive — bleeding tendency; nine unsupervised products including St John's wort.
Functional limitation, exercise intolerance, activity restriction, QoL	Positive — fatigue-limited; abandoned choir and hot yoga.

O

OBJECTIVE

5

OBSERVED FINDINGS

V

VITALS

TEMPERATURE	BLOOD PRESSURE
97.8 °F	132/78 mmHg
HEART RATE	RESPIRATORY RATE
74 bpm, irregularly irregular	15 /min
OXYGEN SATURATION	HEIGHT
98% RA	5 ft 4 in
WEIGHT	BMI
152 lb	26.1
WAIST CIRCUMFERENCE	PAIN SCORE
35 in	2/10 joints · 5/10 diffuse

General appearance

Well-groomed, tired-appearing woman, no acute distress. Alert and articulate. Rises from the chair without difficulty. Brought all nine supplement containers in a carrier bag as requested.

Head / eyes / ears / nose / throat

Conjunctiva pink. Sclera anicteric. Oral mucosa moist. **Gingival margins mildly inflamed with two small areas of recent bleeding.** Dentition in good repair. No oral ulceration — relevant on methotrexate. Pharynx clear. No signs of nutrient deficiency at the tongue or commissures.

Neck

Supple, full range of motion. Thyroid impalpable, no nodule. No lymphadenopathy. No bruit.

Cardiovascular

Irregularly irregular at 74. Normal heart sounds, no murmur. Peripheral pulses present, capillary refill under 2 seconds. No peripheral edema. No calf tenderness.

Pulmonary

Normal effort, clear to auscultation bilaterally, no crackles — specifically assessed given methotrexate. No wheeze.

Abdomen

Soft, non-tender. Bowel sounds normal. **No hepatomegaly** — relevant to methotrexate and to her supplement burden. No mass, no ascites.

Musculoskeletal

Joints: no synovitis, no warmth, no effusion in any joint. Ulnar deviation of both hands with established erosive change, MCP flexion mildly reduced, no active inflammation. **Diffuse pain assessment:** tender to moderate palpation at the bilateral occiput, low cervical, trapezius, supraspinatus, gluteal and greater trochanteric sites — 13 of 18 classic tender points, in the absence of any synovitis. Grip strength 18 kg bilaterally, reduced. Unable to complete five unsupported chair rises. Gait normal. Posture kyphotic.

Skin

Multiple ecchymoses of varying age on both forearms and the left shin, more than expected for warfarin alone at a therapeutic INR. Skin thin and dry. No rheumatoid nodules. No vasculitic lesions. Injection sites on both thighs clean without induration or erythema.

Neurologic

Alert and fully oriented. Cranial nerves intact. Power 5/5 throughout. Sensation intact; **Phalen positive bilaterally at 40 seconds**, reproducing her nocturnal hand numbness. Reflexes 2+ symmetric. Coordination and gait normal. No tremor.

Psychiatric

Mood low by her own account, affect reactive with brief tearfulness on discussing her mother. Speech normal. Thought process linear. Insight good — she initiated the supplement review herself via her daughter. Judgment intact. No suicidal ideation.

IH INTEGRATIVE HEALTH ASSESSMENT

6 WHOLE-PERSON CONTRIBUTORS & TREATMENT DOMAINS

CONVENTIONAL DIAGNOSES & STANDARD CARE

Seropositive erosive RA in low disease activity on adalimumab and methotrexate; atrial fibrillation on warfarin; hypothyroidism; hypertension; osteopenia. Standard care is appropriate, effective and fully adhered to — nothing here should be substituted or reduced.

PATIENT GOALS AND VALUES

Afternoon energy, relief of non-articular pain, supplement safety, return to choir. Explicitly wishes to continue her biologic.

MOVEMENT, MOBILITY AND RECOVERY

No resistance training for 7 years on a mistaken belief; hot yoga produced 2-day payback; walking preserved

STRESS PHYSIOLOGY & MIND-BODY PRACTICES

PSS 21; no formal practice; daily prayer is an existing and usable resource

SOCIAL CONNECTION AND CAREGIVER CONTEXT

Dual caregiving load; two social roles lost; husband

NUTRITION AND HYDRATION

Protein 50–55 g against ~90 g needed; low fiber; erratic vitamin K intake destabilising INR; fluid 1.5 L

SLEEP AND CIRCADIAN RHYTHM

4.5–5.5 hrs with 4 AM waking, non-restorative; ISI 17; OSA unlikely

PAIN, FUNCTION, QUALITY OF LIFE

Two distinct pains correctly distinguished by the patient; function fatigue-limited; PROMIS interference 63

ENVIRONMENTAL / OCCUPATIONAL CONTRIBUTORS

Sedentary seated work; no exposure concerns

and pharmacist daughter are strong supports

COMPLEMENTARY THERAPY USE AND SAFETY

Nine unsupervised products, four with bleeding risk, one with a major biologic interaction

MEDICATION, SUPPLEMENT & HERB INTERACTION RISK

High — see safety review. This is the principal actionable finding of the visit.

READINESS FOR CHANGE

High; asks for a short, bounded, affordable plan and is already spending \$140 monthly she would rather not

SS SUPPLEMENT / HERBAL SAFETY REVIEW

7 NON-PRESCRIPTION THERAPY SAFETY

- **St John's wort 300 mg TDS — STOP TODAY. The most serious finding of this consultation.** A potent CYP3A4 and P-glycoprotein inducer: it reduces warfarin exposure and destabilises INR, and it has documented serotonergic risk. Undisclosed to her anticoagulation clinic and rheumatology. Anticoagulation clinic telephoned during the visit.
- **Fish oil 3 g EPA/DHA daily — reduce to 1 g or stop.** Antiplatelet effect additive to warfarin; a plausible contributor to the bruising and gum bleeding. There is no evidence that 3 g adds benefit over 1 g in RA already controlled on a biologic.
- **Turmeric-curcumin 1500 mg with piperine — stop.** Antiplatelet activity plus piperine-enhanced absorption that also raises exposure to co-administered drugs. Bleeding risk on warfarin outweighs a modest and uncertain analgesic effect.
- **High-dose vitamin E 800 IU — stop.** Antiplatelet at this dose, no indication, and associated with harm at high doses.
- **Garlic concentrate — stop.** Antiplatelet; no indication.
- **Ginkgo biloba 120 mg — stop.** Antiplatelet with case reports of serious bleeding on anticoagulants; no evidence for her "brain fog," which is far more likely sleep- and mood-related.
- **Glucosamine-chondroitin — stop.** No evidence in rheumatoid arthritis (its evidence base is osteoarthritis, and modest there), plus reported INR interference.
- **Multivitamin — stop.** No deficiency demonstrated; variable vitamin K content adds another INR variable.
- **Magnesium glycinate 200 mg nightly — CONTINUE.** Reasonable for sleep, no interaction, inexpensive. The one product worth keeping.
- **Cumulative risk:** six products with additive antiplatelet effect plus warfarin, and one CYP3A4 inducer. Two products are unbranded with no third-party testing. **Net effect of the changes: eight products stopped, one continued, roughly \$130 monthly saved, and a materially reduced bleeding risk.**
- Counselling provided on why "natural" does not mean inert, on additive rather than individual risk, and on checking any future product with her pharmacist daughter or this clinic before starting. She accepted every recommendation.

MB MIND-BODY / LIFESTYLE ASSESSMENT

8 PRACTICES & PREFERRED FIRST STEPS

Current relaxation or stress-reduction practices

None formal. Daily prayer, which she describes as steadying — an existing practice to build on rather than replace.

Breathing, mindfulness, meditation, yoga, tai chi, guided imagery

No current practice. Hot yoga was tried and produced a two-day symptom payback — the intensity and heat were the problem, not the modality. Open to gentle chair-based or restorative forms.

Exercise, sleep routine and restorative practices

Walking 15–20 min preserved. No resistance or mobility work. No wind-down routine; screens in bed; 20-minute afternoon nap acceptable and protective.

Nutrition goals and dietary barriers

Willing to raise protein and to make vitamin K intake *consistent* rather than restricted — a distinction she had not previously understood. Barrier is desk lunches on work days.

Pain coping skills, emotional support, therapy involvement

No formal coping strategies beyond rest. Massage helps and is affordable if supplement spending stops. No therapy; open to bereavement-focused counselling for her mother’s decline.

Patient confidence, readiness and preferred first steps

Confidence 7/10. Her chosen first steps, in her words: rejoin the choir in September, and start the strength exercises “now that someone has told me I am allowed to.”

ST SCREENING / ASSESSMENT TOOLS

9 SCORES, INTERPRETATION & COMPARISON

NUMERIC PAIN RATING SCALE

2/10 articular · 5/10 diffuse non-articular

PROMIS PAIN INTERFERENCE

63 — moderately elevated

GAD-7

8 — mild anxiety

INSOMNIA SEVERITY INDEX

17 — moderate clinical insomnia

WIDESPREAD PAIN INDEX / SYMPTOM SEVERITY

WPI 12, SSS 8 — meets 2016 fibromyalgia criteria

DAS28-CRP (RHEUMATOLOGY, 07/2026)

2.6 — low disease activity (was 5.4 pre-biologic)

READINESS-TO-CHANGE

Action stage for supplements and movement; contemplation for sleep

PEG SCALE

5 / 6 / 7 — mean 6.0

PHQ-9

11 — moderate depressive symptoms

PERCEIVED STRESS SCALE-10

21 — moderate-high

FACIT-FATIGUE

24 / 52 — severe fatigue

TENDER POINTS

13 of 18, with no synovitis on examination

30-SECOND CHAIR STAND

Unable to complete 5 unsupported rises — marked deconditioning

SOCIAL DETERMINANTS SCREENING

Positive only for supplement-related financial strain and caregiver burden

INTERPRETATION

The scores separate two problems that had been conflated. DAS28 of 2.6 confirms the rheumatoid arthritis is controlled; WPI 12 with SSS 8, 13 tender points and no synovitis identify a separate centralised pain syndrome.

Treating the fatigue and diffuse pain as residual RA activity — and escalating immunosuppression for it — would have been the wrong move.

L

LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED OR ORDERED

Routine / conventional labs

Ordered today: CBC, CMP with liver and renal function, TSH with free T4, ferritin and iron studies, vitamin D, B12, folate, magnesium, albumin. Rheumatology labs 07/2026 reviewed — hemoglobin 11.4 g/dL, MCV 89, platelets 232 k, ALT 32, creatinine 0.94, albumin 3.8, TSH 1.9.

Cardiometabolic markers

Lipids 02/2026 — total cholesterol 208, LDL 121, HDL 52, triglycerides 158. hs-CRP 2.4 mg/L. Blood pressure 132/78, marginally above target. ASCVD risk elevated by RA as an independent risk multiplier — flagged to primary care.

Inflammatory / autoimmune testing

ESR 14 mm/hr and CRP 3.1 mg/L on 07/2026 — both normal. RF 128 IU/mL and anti-CCP 210 U/mL, historically positive, not repeated (no clinical value in monitoring). The normal inflammatory markers are central to today's reasoning: her fatigue and diffuse pain are not driven by active inflammation.

Hormonal / endocrine testing

TSH 1.9 on levothyroxine 100 mcg — euthyroid. Free T4 requested with today's panel to confirm. No indication for reproductive hormone testing at 61 with no symptoms.

GI / nutrition testing

No indication for stool or breath testing — no GI red flags. Nutrient levels requested within the panel above given her protein inadequacy.

Sleep / diagnostic testing

No sleep study indicated — snoring denied, no witnessed apneas, Epworth 7. Her insomnia is a maintenance pattern, not respiratory. EKG on file 07/2026: atrial fibrillation, rate controlled, no ischemia.

Anticoagulation monitoring

INR trend reviewed with the anticoagulation clinic during the visit: stable 2.1–2.8 through 05/2026, then 1.7 on 06/24 and 1.6 on 07/22, prompting two warfarin dose increases. The timing coincides exactly with starting St John's wort in early June. Neither the patient nor the clinic had connected the two.

Prior records reviewed

Rheumatology notes 2019–2026 including DAS28 trend and the 03/2024 biologic initiation, anticoagulation clinic INR log for 18 months, 2023 DEXA (T-score –1.9 femoral neck), 2020 transaminitis episode, primary care notes, and the pharmacy dispensing record.

A

ASSESSMENT

11 INTEGRATIVE MEDICINE CLINICAL INTERPRETATION

- **Seropositive erosive rheumatoid arthritis in low disease activity on adalimumab and methotrexate (M05.79).** DAS28–CRP 2.6, no synovitis on examination, normal ESR and CRP. Conventional treatment is working and must continue unchanged. Nothing in this plan substitutes for it.

- **Secondary fibromyalgia / centralised pain syndrome (M79.7) — the diagnosis this visit adds.** WPI 12, SSS 8, 13 of 18 tender points, diffuse non-articular pain, unrefreshing sleep and fatigue, all with normal inflammatory markers and no synovitis. Common in controlled RA and frequently misread as residual disease activity. Recognising it prevents an unnecessary escalation of immunosuppression and redirects treatment to sleep, graded movement, mood and pain-coping — where the evidence actually lies.
- **Clinically significant drug-supplement interactions with a demonstrated consequence (T88.7XXA, Z91.128).** St John's wort induces CYP3A4 and P-glycoprotein; her INR fell from a stable 2.1–2.8 to 1.7 and 1.6 within weeks of starting it, and two warfarin increases followed without anyone identifying the cause. **This is a documented interaction, not a theoretical one.** Separately, six products carry additive antiplatelet activity alongside warfarin, matching the new bruising and gum bleeding.
- **Chronic insomnia, maintenance type (G47.00)** — ISI 17, 4 AM waking, 4.5–5.5 hours, non-restorative. In fibromyalgia this is not merely a consequence of pain; it is a driver of it, and it is the highest-yield target in the plan.
- **Moderate depressive symptoms with grief (F32.1, Z63.79)** — PHQ-9 11 in the context of her mother's dementia and placement, plus the loss of the choral society and her caregiving role strain. Interwoven with the pain and fatigue rather than separate from them.
- **Marked deconditioning from a correctable misbelief.** Seven years without resistance training because she believed strengthening would damage her joints — she was never told otherwise. Unable to complete five chair rises. Graded resistance training is both safe and indicated in controlled RA, and this single correction may do more for her fatigue than any supplement she has bought.
- **Inadequate protein intake (50–55 g against ~90 g)** with erratic vitamin K intake independently destabilising her INR — a nutrition issue with an anticoagulation consequence, never previously discussed with her.
- **Bilateral carpal tunnel syndrome (G56.03)** — positive Phalen bilaterally, reproducing her nocturnal symptoms. A discrete, treatable contributor she had attributed to her arthritis.
- **Osteopenia (M85.80) with RA, methotrexate and post-menopausal status** — DEXA is three years old and due; resistance training serves this too.
- **Elevated cardiovascular risk** — RA is an independent multiplier; LDL 121 and blood pressure 132/78 both merit primary care attention. Flagged rather than managed here.
- **Red flags assessed and absent:** no synovitis, no weight loss, no fever, no night sweats, no lymphadenopathy, no GI bleeding, no methotrexate pneumonitis signs, no hepatomegaly. The bleeding tendency is explained by the interactions and does not require haematology referral at this stage.
- **On evidence limitations, stated to the patient:** of her nine products, one has a reasonable rationale, several have no evidence for her condition, and six carry real risk in her specific circumstances. She had been sold plausibility, not evidence.

P

PLAN

12 MANAGEMENT BY PROBLEM & THERAPEUTIC DOMAIN

- **Conventional care coordination — first and unambiguous:** continue adalimumab 40 mg every 2 weeks, methotrexate 15 mg weekly with folic acid, warfarin, levothyroxine and amlodipine, all unchanged. Letter to rheumatology and to primary care today, and a same-visit telephone call to the anticoagulation clinic. **Documented explicitly that no integrative measure is offered as a substitute for any of this.**
- **Supplement changes (today):** stop St John's wort, ginkgo, high-dose vitamin E, garlic, turmeric-curcumin, glucosamine-chondroitin and the multivitamin. Reduce fish oil to 1 g or stop. Continue magnesium glycinate 200 mg nightly. Containers of the discontinued products removed with her consent. Written list given, copied to her

daughter with permission. **Anticoagulation clinic to check INR in 5–7 days — expect it to rise as the enzyme induction resolves, with a likely warfarin dose reduction, and she has been warned not to be alarmed by that.**

- **Fibromyalgia — explained before it is treated:** 12 minutes spent explaining that this is a real, mechanistically understood centralised pain condition, that it is not her arthritis flaring, and that it will not respond to more immunosuppression. Written explanation given. In her words afterward: "so I am not imagining it and I am not getting worse." That reframing is itself part of the treatment.
- **Sleep — the highest-yield target:** referral for cognitive behavioural therapy for insomnia, the first-line treatment and the intervention most likely to reduce both pain and fatigue. Interim measures: fixed 6:30 AM rise time, no screens in bed, wind-down routine, afternoon nap capped at 20 minutes, last caffeine by noon. Continue magnesium. No hypnotic — sedatives worsen fibromyalgia outcomes and add fall risk.
- **Movement — correcting the misbelief:** referral to physical therapy for a graded resistance and aerobic program, with the explicit brief that strengthening is safe and indicated in controlled RA. Start at twice weekly, 15 minutes, body-weight and band work, progressing by no more than 10% weekly with a 48-hour symptom check. Target: five unsupported chair rises within 8 weeks. Continue daily walking. **No hot yoga** — heat and intensity caused her post-exertional payback; gentle or chair-based yoga is offered instead once her baseline improves.
- **Nutrition:** dietitian referral. Protein raised toward 90 g daily with a specific focus on breakfast and desk-lunch options. **Vitamin K made consistent rather than restricted** — a steady daily amount of greens, not avoidance, explained in detail as the way to stabilise her INR without giving up vegetables. Fiber increased gradually. Alcohol remains limited on methotrexate.
- **Mood and grief:** referral to bereavement-informed counselling for her mother's decline — anticipatory grief, not a death. **No antidepressant started today**, deliberately: St John's wort is being withdrawn and starting an SSRI simultaneously would confound both the mood picture and the INR. Repeat PHQ-9 in 4 weeks; if still ≥ 10 , discuss duloxetine, which has the advantage of treating fibromyalgia pain and mood together. Prayer acknowledged and encouraged as an existing resource.
- **Pain and mind-body:** continue monthly massage — effective for her, and now affordable from the supplement saving. Add a 10-minute daily breathing or body-scan practice, taught in the room. Paracetamol 1 g up to three times daily as the only appropriate simple analgesic; **NSAIDs remain contraindicated on warfarin**. Consider acupuncture at 3 months if diffuse pain persists — deferred now to avoid changing too many variables at once, and to be reviewed against her bleeding risk once the supplements have cleared.
- **Carpal tunnel:** nocturnal neutral wrist splints supplied today. Reassess at 6 weeks; nerve conduction studies and hand-surgery referral if symptoms persist. Corticosteroid injection would be an option but is deferred while her bleeding tendency is being corrected.
- **Bone health:** repeat DEXA ordered (last 2023). Continue calcium and colecalciferol. Resistance training serves this purpose too. Bisphosphonate decision deferred to the DEXA result and primary care.
- **Cardiovascular risk:** flagged to primary care — RA as an independent risk multiplier, LDL 121, blood pressure 132/78. Not managed here, but explicitly handed over rather than left unowned.
- **Social re-engagement:** choral society rejoining in September set as a dated goal, not an aspiration. Carer support and respite information given for her mother's care and her grandson nights.
- **Education and red flags:** written summary of all changes. Counselling to seek urgent care for unusual or unstoppable bleeding, black stools, sudden severe headache, breathlessness or new cough (methotrexate pneumonitis), fever, or new joint swelling with warmth. Instructed to check any future supplement with her pharmacist daughter or this clinic *before* starting it.

F

FOLLOW-UP

Follow-up

INR at the anticoagulation clinic in 5–7 days with a dose reduction anticipated as the St John's wort effect resolves, then weekly until stable. Laboratory results reviewed within 5 days. Clinic review at 4 weeks for bleeding and bruising resolution, sleep and PHQ-9 reassessment, splint response and physical therapy engagement. Twelve-week review with repeat WPI, SSS, ISI, FACIT-Fatigue and chair-stand testing, and a decision on duloxetine and acupuncture. Physical therapy within 2 weeks, dietitian and CBT-I within 4 weeks, counselling within 4 weeks, DEXA within 6 weeks. Rheumatology continues 4-monthly, unchanged. Urgent contact for unusual bleeding, black stools, severe headache, breathlessness, new cough, fever, or new joint swelling.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

78 minutes — 62 face to face, 16 coordination and documentation

NUTRITION COUNSELING TIME

11 minutes — protein and vitamin K consistency

SUPPLEMENT / MEDICATION REVIEW TIME

22 minutes — nine products reviewed individually with interaction analysis

RECORDS REVIEW TIME

9 minutes — DAS28 trend and 18-month INR log

E/M LEVEL

99205 — new patient, high complexity MDM; total time 78 minutes documented

PROLONGED SERVICES

99417 × 1 — 15 minutes beyond the 60-minute threshold

NUTRITION / LIFESTYLE COUNSELING

Referred out — 97802 to be billed by the dietitian

CHRONIC CARE MANAGEMENT

Not applicable — initial consultation

BASIS FOR BILLING

High-complexity medical decision making — a new diagnosis, extensive drug and supplement management with an identified clinically significant interaction affecting anticoagulation, and independent interpretation of outside records including the INR trend

PRIMARY DIAGNOSIS ICD-10

M79.7 — Fibromyalgia

SECONDARY ICD-10

M05.79 rheumatoid arthritis with RF, multiple sites, without organ involvement · T88.7XXA unspecified adverse effect of drug or medicament, initial encounter · Z91.128 patient's intentional underdosing of medication regimen for other reason · G47.00 insomnia · F32.1 major depressive disorder, single episode, moderate · G56.03 carpal tunnel syndrome, bilateral upper limbs · M85.80 other specified disorders of bone density · I48.20 chronic atrial fibrillation · Z79.01 long term anticoagulant use · Z63.79 other stressful life events affecting family · R53.83 other fatigue

LIFESTYLE COUNSELING TIME

14 minutes — movement and sleep

MIND-BODY COUNSELING TIME

9 minutes — breathing practice taught, pain reframing

CARE COORDINATION TIME

13 minutes — anticoagulation clinic call, rheumatology and primary care letters

LAB REVIEW TIME

6 minutes

PREVENTIVE COUNSELING CODE(S)

96127 × 2 — PHQ-9 and GAD-7 with documented scoring

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Marisol E. Quintanilla

CREDENTIALS

MD, ABOIM

SPECIALTY

Integrative Medicine

DATE

08/13/2026

TIME

12:07 PM

