Learning from our Failures

I am sharing with you my experiences through case studies, of four amongst many, which are still alive in my memory related to management of fever in Homoeopathic practice. These 4 aptly demonstrate what Hahnemann has stated in first six Aphorism of Organon, especially:

Aphorism 3- Knowledge of the Physician.

Aphorism 4-5 Fundamental cause, Precipitating cause, Maintaining cause, Case receiving: Acute – Chronic.

The first Case is an acute exacerbation of chronic Disease (SLE) Systemic Lupus Erythematosus which demonstrates how stress and strain of life precipitates illness (fever).

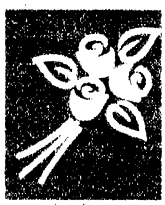
CASE 2: Acute illness, acute episode and its management.

CASE 3 and.4: Story, family background: Fundamental Miasm and dominant Miasm, how it influences evolution of disease. Minor complaints developing into life threatening illness and finally proving fatal..

These cases are used to demonstrate how we, as physician, deal with these situations- success and failures, shocking experiences and maintain our balance to be "unprejudiced" which is required in Homoeopathic practice (Aphorism 6). Then only we can produce "Cure" (Aphorism 2) and achieve our Mission (Aphorism 1): "The physician's high and only mission is to restore the sick to health, to cure as it is termed."

CASE 1

38 yr, Mrs T, Bengali, known case of SLE. Husband 40, working in Air India as Mechanical Engineer. Married since 7 years. Nullipara. SLE diagnosed five years back and is under control. She has been advised not to conceive as pregnancy may exacerbate SLE.



Dr N L TIWARI LCEH (Bom),
Consulting Homoeopath
Director, Rural Health Service,
Dr M L Dhawale Memorial Trust, Palghar.
Tel: 23863479

She is basically very sensitive and gets easily hurt. Anxious, nervous temperament. Strong attachment to maternal family. She still wanted to have child at the risk of her life. The difference of opinion on this issue resulted in marital discord leading to a lot of stress and strain for last one year. The patient came to know her husband was attracted towards a woman who happens to be his friend's wife. The friend had gone abroad for two years. The woman has a 4- yrs old child. The friend had asked patient's husband to take care his family. The woman and her husband had a close relationship. This shock precipitated the condition and she came down with acute exacerbation of SLE.

II) She developed fever 103-104, profound weakness and was hospitalized. Not passed stools since 2 days. We visited the Hospital and noted the following.

1) The patient was totally confused, disoriented, semiconscious, replied to questions but lacking clarity.
2) Low muttering delirium says that no desire to live.
3) Paretic weakness: can not lift her leg or hand.
4) Pulse: 120/ min, BP: 130/80, RS/CVS: NAD.

HIGHER FUNCTIONS: Confusion^3, disorientation^3, speech incoherent answer but low note

SENSORY: Pupils reactive to light normally, No neck rigidity, planters flexor.

MOTOR: Paretic weakness cannot lift hand and feet.

NUTRITION: No emaciation.

The patient's brother was chairman of a Pharmaceutical Company. He was insisting on shifting her to Allopathic treatment and steroid for short term, as there was danger to life. He was strongly opposed to Homoeopathic treatment. However patient's husband had full faith in Homoeopathy and gave his consent to continue even against brother-in-law's threat to take both husband and Physician to court anything happened to his sister.

TOTALITY: Confusion[3], disorientation[3] Will weak. No desire to live. Paretic weakness, Constipation.
SELECTION OF THE REMEDY: *Plumbum-metallicum* 200, 1 powder 6 hrly.
FOLLOW-UP: AFTER 24 HOURS: Confusion better, disorientation less, speech better, Temp- 100- 101, she passed stools, asked for tea and bread.
AFTER 48 HOURS: Speech: talks coherently, normal talking. Able to take both liquid and solid, could sit in bed and talk to visitors.
AFTER 3 DAYS: Patient fully conscious, no confusion, no disorientation. Can get out from bed and move around with support.
Patient was discharged after 7 days.
[Editor: I do wish we could see the brother-in-law's face or get some word out of him!]

CASE 2

A 22-yr-old boy living as a paying guest near our consulting rooms, called for an urgent visit for.
Fever 105. Was under Allopathic treatment but no response.
On visit, the following observation were made:
The patient was restless, anxious, rolling on the bed, asking for small quantity of water, wanted to cover whole body except the head. Profound perspiration and weakness[3], prostration, no relief after perspiration.
Patient conscious answers properly. Fever: 104° F, Pulse- 130, BP 120/80. RS/PS/CNS- NAD
ODP: Fever starts with chill around 2 pm lasts for ½ hour. Fever range 103° F at 2.30 pm, 104° F at 3 pm. Profuse perspiration after giving anti-pyretic but no relief.
TOTALITY
Restlessness. Anxious. Small quantity of water, thirst? Perspiration SQ. *Chin-ars* 200 1p 6 hrly.
NEXT DAY:. No fever. Anxiety and restlessness reduced. Got up from bed feeling hungry and took bread and tea.

Diagnosis: Viral Fever / Malaria or Mixed Infection. Patient did not do Investigations!!

CASE 3

Mr Z an old man brought his 11 mth old grandson, with complaint of cold, cough and fever 102.
[AN INTERESTING ASIDE: He himself had received Homoeopathic treatment from us in critical life threatening illness, diagnosed as lung abscess. He was admitted to another Hospital, took discharge against medical advice as he was not satisfied with the care given. His family brought him to us and he took Homoeopathic treatment and was saved. Lung Abscess is a life threatening illness and its prognosis is poor even under modern system of medicine and usually requires a Hospital set-up ICU. We had managed him without ICU.

The infant had fever 101 with cold and cough. Strong family history of Tubercular miasm.
Mother 28 yrs, had Pleurisy before marriage.
Father 35 yrs, an embroidery artist, suffered from recurrent Bronchitis.
Grand father suffered from lung abscess.
The family resides in suburban area of Mumbai. Low income group, hand-to-mouth existence on daily income basis. In the locality, Tuberculosis, malnutrition, malaria, pneumonia, bronchitis, bronchiectasis are common. It is an infection prone locality.
OBSERVATION: Infant, chubby dark haired and active.
O/E: Fever 101, heart rate 130, PS/CVS/CNS: NAD, throat slightly congested, tongue- white yellow coated,
FIRST PRESCRIPTION: *Merc-i-f* 200 1P=6 (4 hrly) and asked to report next day.
FOLLOW UP: The fever 100 but had crepitations both bases. The child was drowsy, dull. Pulse-130 per min, RR 50-60 per min.
SECOND PRESCRIPTION: *Antimony-tart* 200 1P=6 4 hourly
3rd day 1.30 pm received phone call: patient dull, not accepting feeds, stool and urine not passed, not responding to stimulus
VISIT: 2.30 pm: the child was gasping; unconscious; respiration shallow, body cold, cyanotic. Chest Rales[3]

Advised the family to urgently hospitalize the child. They refused and informed us child expired at 3.00 pm.

For us, this was a shocking experience & raised the following issues:

1) Error occurred in the observation?
2) Error occurred in clinical assessment?
3) Should infant have been hospitalized on day 1?
4) The patient had strong history of Tubercular miasm. Hence the evolution was rapid resulting in damage to the vital organs.
5) This case is presented here only to highlight the difficulties of not having continuous observation. Of course on day 1 with 102, it is not possible to admit every case? But more frequent contact is possible, if we are alert to the underlying miasm.

CO-ORDINATING EDITOR: Dr C H ASRANI:

In an acute febrile illness, with such significant chest signs, one has to keep poor prognosis in mind. Four conditions must be ruled out in a child – Meningitis, Pneumonia, Typhoid and Otitis media. Agreed that ALL febrile children can not be admitted but we need to do minimum investigations. CBC & X-ray chest or it can amount to medical negligence.

CASE 4

A one yr old son of a close friend, an Homoeopathic Physician himself, was brought cold, cough and fever for 3 days. Chubby infant, short neck, head big compared to body. The father 30 yrs old, mother 25 yr.F/H grandmother suffered from Pleurisy, Ascitis, Depression.

Maternal GM: DM Type 2, Maternal GF: Alcoholism Mother suffered from Tubercular adenitis (cervical)and was advised by family physician to take Anti Koch's treatment. Mother took partial treatment for 3 months and stopped. The family physician had told her that she has a Tubercular diathesis and her children will face problems if total treatment in not taken.

O/E Fever 101°F. Running nose, Occasional cough, HR: 120 per min. Anterior fontanelle open. RS/CVS/CNS: NAD. No Neck Rigidity.

He was given *Puls* 30 and asked to report next day.

At 1.30 pm. Temp: 100. Before feeding the patient was dull; movements of the hands and feet stopped. Paralysis of all the four limbs, body became cold, cold perspiration, but pupils reacting to light.

Advised Hospitalization.

At 2.30 pm, before they could take the patient to hospital, child expired.

These four experiences I have shared with you, both where we could succeed in helping the patients to come out from grave condition and in two other cases we have failed to stop progression of disease, which started as minor complaint and resulted in grave condition.

1) The patient of SLE suffered from acute exacerbation
2) The second case of viral fever mimiced malarial fever or mixed infection.
3) Viral Encephalitis to Tubercular base.
4) Tubercular meningitis

These cases, raise a number of issues in management of fevers.

The difficulties in cases of infants

(1) Observing cases
(2) Receiving
(3) Perceiving
(4) Management planning and programming.

LEARNING FROM THESE CASES

CASE 1

The pressures which Homoeopathic Physician experiences

i) While handling
ii) Perceiving totality→ by OBSERVATION
iii) From observation→ interpretation and building of totality at abstraction level
iv) Complete definition of case gives clarity, confidence, scientific base and artistic prescribing and ability to withstand the pressure from inside and out side.

CASE 2

(i) Early intervention with similimum - aborts the evolution of disease.
(ii) Importance of PQRS in the prescribing
(iii) Effectiveness and efficiency of Physician is tested in these type of cases.

CASE 3 AND CASE 4

1) Difficulties when tubercular miasm is the fundamental and dominant miasm.
2) Cases with minor acute complaints may result in life threatening illness ultimately.
3) These case should be treated in the Hospital with ancillary measure rather than OPD.
4) Cases where we missed the clinical diagnosis due to poor clinical co-relation?
5) Update one's own knowledge of clinical medicine, miasms and clinico-pathologico- miasmatic correlation.
6) Bed-side study of Clinical Medicine and Materia Medica to handle these type of cases effectively. ❑

Advantage of Homoeopathic IPD

CASE 1

Smt TR, 48 yrs Housewife Married since 32 yrs, Illiterate, Bengali, H 50 yrs, working in Pvt Co, Mo Expired 10 yrs back, Br 5, Sis 1 (all younger to patient), Sons 2, Daughter 1

Patient was seen in the Diabetic OPD on 16th July 04 with UTI. H/o DM since 4 yrs . She has gradual weight loss since 4 yrs and complained of burning soles since 4 yr. This indicates peripheral neuritis.

On 10/7/04 FBS:225, PPBS 362.8mg/dl

She was irregular in treatment. She was given *Puls* 30 on 2/4/04 and *Merc-cor* on 9/9/04. Apart from this; patient was taking oral hypoglycemic agents for 2 yrs, which she had discontinued on her own since 2 months. Patient had consulted MD physician who is attached to our hospital, for fever, off and on since one month. On evaluation she had:

FBS: 307.5 with urine sugar ++++

PPBS: 371.8 with urine sugar ++++ and traces of acetone

Dr DINESH RAO BHMS
CMO MLD Trust's Rural Homoeopathic Hospital,
Palghar.
Tel: 28914796
26208361(R)

Looking at the high blood sugar levels and presence of acetone in urine, which indicates patient's compromised metabolism and indicates that she can go into Ketoacidosis. Advised hospitalization.

PATIENTS STATUS ON ADMISSION 21/9/04

1. Fever on and off since 3 months. Chills +. Fever < 5 am 5-6 pm. Accompanied by headaches.
2. Month ago, she had fever with chilliness without rigors. Subsided by itself.
3. Since 3 days fever with chills and rigors 1/day.
4. Rigors start at 10-11 am and continue for 30 min.
5. Rigor is followed by chill, which starts from the back and then spreads to the abdomen and chest. Patient feels sleepy with chills. Dryness of mouth and thirst increases, large quantity 2-3 glasses at frequent intervals.
6. Chill is followed by heat sensation all over the body; lasting for 30 min. Thirst is normal and patient experiences mild headaches.
7. This is followed by profuse perspiration, drenching her. She experiences intense weakness during and after perspiration. In apyrexia, patient has reduced appetite and a bitter taste in mouth.
8. Patient also complained of burning soles.

O/E: Looks Weak. GC: Fair. Temp: 99.2 F. Pulse: 80/min regular, good volume, BP: 130/70, R: 20/