Short Cases

CASE 1. THE CASE OF A HOMOEOPATH: We affirm we too use homoeopathic medicines only

On a well-appointed day, at 4 pm, a colleague took his wife and son on an outing. On the way back, he stopped at the left of a 90 ft road to get his bearings. In the mirror he saw another motor bike coming at break neck speed, and thought why is he leaving such a wide road and driving on the left side. The last thing he remember saying is 'Ohe Ohe Ohe! Do you want to bang me or what??'

And the next moment the speeding motorbike rammed into his stationery bike.

Then, according to the accounts of the bystanders, he was thrown 10 ft up in the air. His wife and son just fell on either side, unhurt. On crashing down, he was immediately unconscious and only came to, when people lifted him from the road. *The case will now continue in his own words.*

"I had this benumbed feeling, as if I was floating with no sensation at all. They lifted me to my feet, I remember feeling imbalanced and immediately being put in an auto, and taken to the doctor. I must have been quite a sight. With injuries on my face, Rt cheek and forehead. A big gaping wound on the Rt foot. But bleeding was moderate, mainly from the teeth

On the way or within ½ hr, I started *Arn* 1M every 10 mins. (In any such accident and head injury the main fear is of concussion: if a clot has formed, it needs to be absorbed at the earliest. After 2 hrs, I reduced the repetition to 2 hrly.

By 6 pm the wound on the face etc was sutured up. A CT scan could only be taken by 12 midnight. By this time I had no complaints ie no pain, except numbness of blunt injury. The foot injury seemed to be of ligament strain - it was swollen[3] like a balloon, with an open gaping wound, but no fracture (no, not as good as it seems as we will see later) no pain, except a kind of stretching pain. *Arn* was now continued 2 hrly.

NEXT DAY: Face was in bad shape forehead and Rt cheek wounds, teeth all loose and shaking. I could barely open the jaw. Eating was the most difficult. I could only drink with a straw. It was to be a further 2 days before I could eat soft food. But otherwise I seemed fine, no pain, except that because of the plaster, I had to hobble to the bathroom (without it I am sure I could have marched!) and managed my own affairs. I could not attend clinic for a week, mainly because of the difficulty in going up and down without a lift. I consulted by telephone from the 3rd day though the speech was pretty unclear–mainly because the teeth were loose, shook while talking. My assistant needed to get used to it. From the 9th day, I started attending clinic. When the plaster was removed in the 3rd week, the foot was swollen and oedematous, and red; felt better with Hot fomentation. There was periosteal tenderness and it was then found that some ligaments were torn and crushed. Painful. At that time *Bellis-per* 1M started 4 hrly which I took for 1 wk. Better. 4 wks later I could walk normally and even ride my motor bike. Today everything has healed without any marks on the face. But there is still a mark and thickening on the foot with some numbness, which I suppose, will go gradually. Not one single pain killer was used throughout. Teeth are almost firm.

After 3 mths, the whole accident seems like a remote memory of that day of 22-10-02."

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CASE 2: One word of advice can change a life

Introduction: This is a continuation of the study we did of Staph in a previous issue. Cases of different types help consolidate our understanding and usage of a remedy.

A young man of 28, Mohan Sharma, married with a 9-mth daughter, came to me in the Palghar hospital OPD on 20-11-02, with complaints of Hyperacidity, heartburn, sour eructations; which come on 1 hr after food, very frequently at least 2/d. This had started after marriage.

Chilly patient.

He was a strong, strapping young man 63 kg, ht 5' 7", with a square jaw, and yet mild demeanor, with 1 wart on corner of Lt eye. Perspiration palms and soles, but no odour.

Appetite poor. Cravings: sweet. Tobacco [3] Tea [3].

DAILY SCHEDULE: He wakes at 5.30am, goes jogging for 2 km then has bath. He works with his brother– they have a shop. They live jointly with brother and his wife and a nephew. Originally he hails from Jharkhand, where father was a labourer with carpentry company.

Clue: His demeanor and look were in sharp contrast to his physique. And he hesitatingly said that sex was poor. That was the clue. We went in to the sexual history. He had been masturbating for 20 yrs before his marriage in 1996, since age of 22y. And he felt probably guilty. Also such people normally have a fear of being discovered when they feel they have done something wrong. That could be the only possible explanation for his problem. And we explained to him how this was normal in the life of every man, and not wrong and not to feel guilty, but just to forget about it.

One dose of *Staph* 1M was given on 20-11-03. With that everything cleared. No acidity. Gave up completely on the tobacco and tea. Sex we could not really know as his wife was in village. But he felt it was better. His wt also increased

In Jan 29, he said he was fine and was going to village for 1 mth. The look had vanished, he seemed eager to go to village, probably to test whether the medicine had worked.

CASE 3: TRACING THE CAUSE

Mrs LN, 60y a widow, Hindu, lives with the daughter, rather daughter lives with her. Earlier she would work for Lijjat Papad. Her husband died in 1999 at 75y. Brother died at 32 in 1990 of an accidents and other brother is 52. Sisters are 64, 62 and 58

Sons are 40, 37 and daughters are 35, 33, and 30

She came for Rt knee pain which started in 2001, after a fall on the railway lines while crossing, worse winter, evening, walking and after much exertion.

O/E Cracking of joint.

XR Rt knee joint and Rt patella show degenerative changes.

Other complaints were distension after retirement, breathlessness since Feb 02, since does not go for walks etc, worse walking and climbing.

Lt Backaches since Sept 02, worse bending and evening to night. BP was 220/90 on examination; wt 46.1.

Lt Middle finger is black? After suppuration/paronychia

Vision dull but manages without classes.

PT AS A PERSON:

App poor, stools once in 2-3 days, urine 3/2 D/N

O/H: 10 children–3 male and 2 female died at ages 3 m to 1yr.

LIFE STORY:

1942 Born in Udipi, Karnataka. Father was a farmer and Mo helped him. Pt is the third child with 2 elder sisters, 1 younger sister and brother. Married at the young age of 9y and had her first child at 14y. H was employed in the mill after coming to Mumbai in 1971. Mill closed down. Since then he has never worked and became an alcoholic. Often quarreled. Very hard life, patient did zari work or whatever gave her a living and eventually she joined Lijjat Papad.

1980 and 85 the 2 sons got married and moved out.

1984 Da 1 married in village. In 1985 she brought her

to Mumbai for delivery. Since then she is staying here. 1999 Da 3 also married and stayed with patient.
Whole life patient has worked and now the daughters give her the money and she runs the house and looks after the children.
MIND: Affectionate. Fastidious. Motivation, will, drive+++.
Performance in the family is good and she has been efficient at work.
Pleasant dreams.Brooding[3], weepy3. All life she has had worries due to circumstances, depressive over past events.
Now too, Sons have left her and are living their own lives. Do not even come to see her. This upsets her even now. Even while narrating, she had tears in her eyes. *Here some counseling was effective. Daughters are like sons. And they are there. You have done so much, all by yourself, now why do you need their support? This line of thinking seemed to help her.*

REMEDY: In this case only *Arnica* with the causative factor of Injury was useful in solving the whole case From 19-7 to 3-11-01: *Arn* 30 then 200 BD and then HS. On 3-11 a dose of *Nat-m* was given to complete the cure, mainly at the emotional level. ❑

Look for the Cause

CASE 1

A Marwari Jain Housewife, Mrs LLJ, 30 yr, came on 10/4/87, for recurrent urinary tract infection. She improved on her constitutional medicine *Phos* 30–200.
On 17/11/90 she reported that she fell down from the bike. She got an injury on the head and received couple of stitches. There was no H/O unconsciousness or vomiting.
Following the injury, she lost the sense of smell- total anosmia. She also lost all sense of taste. She feels hungry and eats normally, except sweets.
She underwent thorough investigations from neurological point of view. Neurologists advised to wait for 3-4 weeks as her scan was normal.
No sector totality was developing, so I prescribed the constitutional medicine–*Phos* 200 (3P)
1/12/90
All above complaints remained same. Since head injury, she noticed that she does not like to meet people, relatives etc. In the last week, she kept herself in a dark room and avoided people. If somebody comes to see her, she avoids them and asks them to go away. She remains alone and keeps quiet; her sleep is also disturbed; sleeps only for 2-3 hrs.
Feels "*Ghabrahat*" vague fear of going out with sensitiveness to draft of air. App: N. Doing her household work as usual.
AF Head Injury, Aversion to Company, avoids the sight of people (K-12), chilly patient; *Rx - Cicuta* 30 TDS (3P) (selected 30 potency as clinically the condition was not very clear).
6/12/90
Mental state improved, sleep improved, Ghabrahat > but +. Rx – *Cicuta* 30 TDS (5p)
8/1/91
Patient did not report for few weeks, in which period her mental state totally improved. She started interacting with people and remained in company of family members, not avoiding guests and relatives. Taste improved, can make out all tastes. Can sense some difference in nose, but can't make out smell.
Rx - *Cicuta* 30 TDS (7p)

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