A Koch's Case

This case has been selected from Dr Ram's children hospital, Mulund where Dr Dilip Dixit is a consultant. Case was initially taken in Feb 97 where the similimum arrived was *Calc-Phos* and Intercurrent was *Tub-b.* Patient was managed for 2 years. The complete understanding of the totality and the overall assessment of the follow ups are given on page No. 5

CURRENT SITUATION: Review: 21/04/99

Date of Birth: 6/5/91.
Age: 8 y. Sex: male
Occupation: Student 3rd Std
Status: single Religion: Maratha. Diet: Non veg.
Fa: 55 yrs, Estate agent. Mo: 45 yrs, housewife.
Sisters S1=20 y Sy B Com./S2=15 SSC /S3=12y 7th
Address Res: Bhandup

Chief Complaints:

Location Area Direction	Sensation & Pathology	Modalities AF	Accompaniments Strict time Relation
Respiratory system			Lachrymation during
Throat	Hoarseness of voice	< 4-5 am	Fever
Onset 11/4/99	Chilliness(goose flesh)	< 11.30 pm	App-Decreased
Since 14/4/99	Fever (up to 103°F)		Thirst-Decreased
Since 16/4/99	High grade fever		Sleepy during fever
Twice in a day			Weakness during fever
			Talks in sleep
			Lips red during fever
Since 18/4	Wet cough	< Morning	Vomiting twice, offensive
Frequency 1/5-10 mins		Not better with Mox,	Eyes open during sleep
1 bout=2 to3 cough		Nivaquine, Reziz, etc	
On 19/4 S Q			Starts during sleep

O/E: Temp+. Throat – N. Chest – crepts +
P/A: L 2 ½ Finger palpable (FP), (Lt) lobe 2 FP SNP
(1) CBC MP (2) Urine (3) SG PT
(4) Widal (5) MT (6) X-RAY CHEST-
X-RAY CHEST – haziness LLL with effusion
Hb-11.5 gm%, WBC – 8700,
M62, L36, MP-No
Urine – NAD, SGPT-36
Widal-O-1:20, H – 1:20

Patient as a person:

Lean++, fingers long, skin clear, wheatish complexion

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Homoeopathic **Dr Dilip Dixit**

Perspiration; Moderate^{2}, Neck^{2}, upper lip^{2}
Odor-socks^{2}, offensive^{2}
Cr: sweets^{2}, tomatoes^{2}, Av: milk^{3}

Development and growth

Birth wt 3.2 Kg, Milestones – within normal limits
Thermal Modality: C3H2
F/H/O: Koch's-MGM & PU, Allergic Rhinitis– Fa
MI – PGF
P/H/O: recurrent RRI – Pt (self)
Sleep: eyes remain half open during sleep
Dreams: Ghosts2, cricket2

Life Space:

The patient is an 8 year old, male child belonging to a Hindu Maratha family. He is the youngest in the family with 3 elder sisters: S1 = 20 y, S Y Bcom, S2=15 y– S S C, S3= 12 y 7th Std. Father is an estate agent and a

ASSOCIATED COMPLAINTS:

1) H/O: at 2 months of age (lasted for 8 days)	Mild coryza & cough	> Allopathy	
6.9.91 (for 2 days)		> *Ipecac/Antim-tart* > Solexin & Bisol Pant	
From 91-97 Since Sept'96-Feb'97 Frequency: 1/month From 1997-99 3 times in 2 years	Cold, breathlessness Sneezing Nose block Breathlessness	A/F cold food, cold drinks	Dull Thirst –N App – N
NOSE since 20/2/97 to 18/1/99 4 times until now Cough	Yellowish, nasal Discharge[2] Nose block+	A/F C O W[3] < fried food	Restless[2] Weakness[2] Thirst- Normal
2) Skin	Papules	A/F Pollens in Native Place (Sangli) Post-pigmentary lesions	
3) Anus since 6 years on & off	Itching ++	< night[2]	

loving and caring person while Mother is a house wife-caring, anxious[2] and co-operative by nature.

He studies in 3rd standard. Always stands 2nd in his class. Very particular about his studies, and will not sleep till his homework is complete. Mother finds it very difficult to convince him as she is not educated and hence keeps awake to help him out. Mother has never to bother, as he does his work well. While writing if he makes a mistake, he will erase it nicely and re-write things. He is very friendly and obedient, hence he is the pet of the class teacher. He likes to wear new clothes but will never make a fuss about it. The reason given by him was that if I wear different clothes whenever I come to doctor, she will think I am a good boy. As soon as he comes from somewhere out, he will immediately change his clothes. He wants others to play perfectly with him. If a boy drops a catch, he will immediately go and explain to him how important it is to play nicely. Keeps awake till midnight watching cricket on TV when studying, but the moment the channel is changed he sleeps.

He starts weeping if scolded. If teacher scolds the entire class, he will come home and repeatedly tell the incident to his mother. Though she will try to convince him otherwise, he will reply that it was definitely their mistake and they should not behave in this manner. While playing also he does not like colleagues misbehaving. If he finds no one is listening to him, he will come back home.

While walking, if he finds small photographs of Gods, he will immediately pick them up and keep them in his book. If in case, it is dropped by anyone, he will immediately start scolding them-will keep the photograph to his chest. If he sees a Mandir, he will join his hands, and ask his mother to do the same. He says: everyone in the house performs pooja but none of us has such religious feelings.

He will take money from parents but not spend a single rupee for buying a chocolate for himself. He likes outside food but does not eat it, as it is bad, text books say. He obeys everyone, shares a good relationship with his sisters, often fights with his younger sister, but most of the time scolds her for eating chocolates etc.

He gets anxious and restless before exams and if anybody is unwell at home.

Our approach and **Chronic Totality** after review. As we had many qualified mentals, Kent's approach was selected.

Differential Remedies:

Lyco was ruled out on the basis of sensitivity, behavior and conscientious and physical hard data.

Understanding of Intercurrent

FM: Tubercular
DM: Tubercular
– Tubercular constitution: Lean, long fingers
- a Hypersensitive response which is now unpredictable
-a rapid progressive pathology can go into complication
- anal itching

Understanding Of CLinico-Pathological Co-Relation

Initially hypersensitive response to food allergens has been noted where the inflammation has been restricted to the level of Bronchus, Pace has been rapid and duration of 1-2days
Now since 11/04/99
Inflammation in the Lungs → exudation → pressure effect. Hepatomegaly. Clinical impression being: Koch's with pleural effusion.
Susceptibility: low pace-rapid characteristics++,
Pathology – deep seated and progressive
Sensitivity – High
MANAGEMENT:Specific

Homoeopathic Planning & Programming:

(A) Remedy Selection

→ *Silica* was chosen since we were dealing with deep-seated progressive pathology
→ Was *Silica* the similimum force – according to R T (Repertorial Totality)
→ Indication of the constitutional – because characteristic and structuralization acute form was absent.

(B) Potency – 30 was chosen because
(a) of clinico-pathological dimension,
(b) cautious approach as the sensitivity is high and we do not know how this system will behave.

(C) Repetition- 1P → 7P
→ Cautious repetition as we have combination of low susceptibility and High sensitivity.
→ A hypersensitive response of the system and deep seated pathology

Repertorial totality	Potential	Differential Field
1) A/F: cold food	Lean	
2) A/F: cold drinks	Av: milk	
3) A/F: Sour food	Desires-sweets,	
4) A/F: anxiety	Perspiration: nape of the neck	
5) A/F: Anger	Perspiration: odor-offensive², feet	
6) Weepy- after admonition		
7) Conscientious about trifles		
8) Dream- Ghosts+		

Silica was selected on the basis of hierarchy in the reportorial analysis and structuralisation

Structuralisation	Physical Generals	Pathology
Mind		
Anxious	Lean	
Tearful	Long fingers	
Sensitive to reprimand	Perspiration:socks²	
Conscientious	Feet+	
Drive++	Av: Milk	
Perfectionist	Cr: sweets	Koch's
	Eyes-Half open during sleep	
	Behavior	
	Obedient/perfectionist	

Totality of *Calc-phos* in Feb'97

→ Fearful child – fears of crackers, dogs, ghosts
→ Affectionate²-when anyone is sick in the family, will go and inquire.
→ Mixes easily with everyone
→ Likes to go out & play³
→ Irritable if demands are not fulfilled and calms down quickly.

Observation: Patient: delicate look with long eyelashes

This case was the 1st case taken

by the physician on the 1st day of her posting. Only father was interviewed. Overall assessment after 2 years of treatment from 97 – 99.

Tub-b 1M followed by *Calc-phos* 200 weekly. initially for 2 months and then once in 15 days. After 1 year *Calc-phos* 200 (3P) once in 15 days, interspersed with *Tub-b* in the 2nd year.

In all the patient Acutes – Allergic Bronchitis, URTI or viral fever, the picture which emerged was of *Arsenic-alb*. Therefore *Arsenic-alb* 200 QDS was prescribed for 2 days and patient was >3 in Acutes.

In 1997: child had 2 episodes of viral fever, 1 episode of URTI & 2 episodes of Allergic Bronchitis.

In 1998 – 1 episode of all Bronchitis & 4 episodes of URTI.

In 1998 – 1 episode of all URTI and 1 episode of Allergic Bronchitis Until Feb 99.

The last episode in Feb 99 of Allergic Bronchitis required *Ars-alb* 200 QDS x 2 days and then with a partial response we had to go for *Ars-alb* 1M QDS x 2 days for a complete response.

C/o and itching had a fluctuating response

C/o skin urticaria came up once when they went to Sangli >3 with allopathic Rx in 5-6 days.

LEARNING ACHIEVED BY TEAM AFTER THE FOLLOW-UPS

1) Retrospectively the understanding of the totality defined in Feb'97 was inadequate.
2) *Calc-phos* was a partial similar force which has shown response in the reduction of the frequency of allergic Bronchitis.
3) The question arose why should Koch's with Pleural effusion come up if *Calc-phos* was the simlimum. Therefore a review was conducted.
4) In a 8-yr old child with H/O fever for 8-10 days, liver 2 ½ FP especially Lt. Lobe with crepts on chest examination, how fast we seek an urgent x-ray and 2nd opinion of the chest physician. Learning was how an opinion taken at the right time enhances our clinical knowledge.
5) Pleural tapping was advised for diagnostic as well as therapeutic purpose to relieve the pressure effects.
6) How a clear understanding of susceptibility and sensitivity helps us in Planning & Programming.
7) On 24/04/99 we see aggravation coming up, therefore on 24/04/99 night *Sil* (30) 3rd dilution has been used.

FOLLOW UP

19/04 patient was admitted in the hospital from 19/04 to 29/04 wt: 22kg

20/4	Sleep	Weakness	App	Thirst	Fever	Dry	O/Examination	AKT
		Dullness	++		3 spikes	cough	RR-40/min	started
	Restless entire night, talking ↑		↓↓	?	(around 102°F)	>+	Short & rapid Ch- Rh + Air entry ↓↓ On LL2 L2FPSNP	

S/by Dr Rupwate- Advised Tapping Done at 2 pm – 200 ml of transudate removed-straw colored

On 20/4 night AKT was started because of parental anxiety up till 21/4 night after which father decided to take homoeopathy Rx.

21/4	G Case	SQ **Reviewed**	>		Only 1 spike (102°F) at 2 pm	>+	RR-WNL Chest A-E ↓↓ LL Zone Creps-Lt. side	**Omit AKT** *Silica* 30 (1P) HS
22/4 G	G Talking (o) Restless (o)	Dullness> M.T +ve	- -16mm	- Induration	1 spike 4.45 pm (102°F)	>+	RR-16/min RS-creps LL Z L2FP SNP	Placebo
23/4 Morn. Night	G Now sleeps more	Dull+	Impr+		100.8°F once at 8 am 101°F 8 am	< 1 bout=5-10 min 1 bout=2-3 cough ↑	RR-16/min Ch -A.E↓LL2 LIFP SNP	Silica 30 (1P) Hs

Adenosine Deaminase (Pleural) - 86.90

Pleural fluid: Poly 04, RBC - 26,00 L:90 M: 6 WBC- 1,580 Glucose: 63 Protein 5.54

24/4	G Sleep	Dull during fever2 Dullness	↑ App	? Th	1 spike 6.30 am Fever	SQ Cough	R.R - 44/min R.S - creps LLZ O/Examination	*Silica* 30 3rd dil (1P) HS
25/4	G	>3	Impr	?	1 spike	>	RR - 16/min RS-chest creps LIFP SNP	*Sil* 30 3rd dil. HS
26/4	G	O	"	"	O	>	O/E like 25/4	*Sil* 30 3rd dil HS
From 27/4-29/4	No fever	Spike, cough	> 50%	App -	Improved	& creps	Also reduced prominent	*Sil* 30 3rd dil daily HS
10/5	G Wt-22 kg	O	↓+	N	O>90%	O/E Ch clear	lung markings	*Sil* 30 (3P) 3rd dil

XRC=small effusion left side (smaller than before)

21/5 Mild Asthmatic Bronchitis episode 17/5 20/5 > AA 200 (4P) Ct all				
28/5 No C/O except occ. cold & cough		O/E Ch=clear	Ct all	
4/6	G	O G N O Occ. O/E NAD	Ct all	wt 23.5
11/6		XRC = definite improvement (patient effusion is smaller in size) Occ. In morn 2 or 4 bouts	Ct all	
19/6		Occ. Cold and cough Chest = clear		
10/7	wt= 24.5kg			

21/7	URTI on 19/7 > *Hep s* 200 tds x 2 days since yesterday → cold & cough occ. Chest pain Lt side with fever once in ½ hr sleep=N App=N Restless (o) lips red + lips dry+							Temp-101.3°F Thr=(rt) tonsil follicle Ch + clear	*Sil* 30 (3P) dil
24/7	Yesterday afternoon → Fever 104°F with chilliness LN Bl++ Th=↓↓ Since 3 days-swelling neck, nose block (S), since yesterday chilly Lips red² +dry² Weakness²							O/E T=102.6°F LIFP SNP Ch=clear:	Intermittent fever >3 with Placebo x 3 d
26/7	Admitted for 2 days – kept on medicines Repeat investigation Hb=11.5 TC-14,800 N-84 L-15 MP-Neg SGPT=12 XRC = partial regression of the lesions							WIDAL-WNL	
2/8 Mo Infor matiom	Sleep	Activity Sleep throughout day	App	Th during heal	Wt	Fever Since 1/8 Once 104 F with chills	Dry cough	O/Examination ?	*Tub bov* 1M (1P) HS *Sil* 30 3rd dil (3P) HS
Feet and hand icy cold² head heaviness in occiput since 1 week									
9/8	All C/o's > except headache – occipital								*Sil* 30 3rd dil (3P) Hs
13/8	Sleepiness			↓+			+	O/E RS-clear	*Ars alb* (200) 1P=4 (2P)
14/8	C/o's >80%							Ch=Rh occ+	Ct all
16/8	>2								*Sil* 30 3rd dil (3P) Hs
19/8	Similar C/O like on 2/8 & breathlessness							T=99.4 O/E – creps Based+	*Ars-alb* 200 qds X 2 days
21/8	Weakness > 50% coryza (SQ) breathlessness occ.						>3	>50%	Ct all
23/8	Cold+ cough SQ Nose block SQ							O/E Ch=clear	*Sil* 30 3rd
30/8									dil (7P) Hs
29/9		Dull+		25.5 kg		Mild today	In	O/E Ch=occ creps RF post	*Tub bov* 1M (1P Hs *Sil* 30 bd

3/10 Up till 7/12	Patient is coming weekly, had acute in 5/9 >2 AA 200 x 2 dy > 80% Once on 17/10 slight breathless with O/E Rh+ > AA 200 weekly Rx is going on Ct all But cold + lingering & cough in with occ. Sneezing
Up till 6/2/2k	Patient was >2 except slight 25kg O/Exam-clear On 19/12/99 Hb=13 gm% WBC – 11,500 ESR=48 N58 L25 E13 M4 X-ray → pleural parenchymal lesions seen of Koch's Patient has stopped Homoeopathic Rx since 6/2/2000
24/9/2k Telephone	Since 7 months patient had Occ. URTI (2-3 times) >3 on its own and once viral fever (>3 All Rx) Father feels 100 % >3, his recurrences of RRI is under control now & wt is also improving.