Sure shot treatment of Jaundice

CASE 1: OBSTRUCTIVE JAUNDICE

Mr DM, 42 yr, from Varanasi.

CHIEF COMPLAINTS: Fever with chills.

Physicals: Urine: dark yellow, eyes: yellow.

Diarrhoea: 4-5 time/day with mucus < summer

F/H: No major illness.

P/H: Mandibular Abscess-1974. Jaundice-1992. Malaria-1994. Jaundice again in 1994- investigated at Govt Hospital, Varanasi S bilirubin: raised. Abdominal sonography showed abdominal mass. Biopsy of 9th March '94 at RN Cooper hospital, Mumbai. Histopath report Tata Memorial Hospital: Adenometous hyperplasia, well differentiated adeno-carcinoma of pancreas.

17-03-94 operated for Cholecystojejunostomy and tube inserted.

March1996: had Jaundice again.

INVESTIGATIONS:

Histo Pathological Report:

C T Abdomen 13/3/96: Total obstruction of distal CBD due to a peri ampullary mass measuring 4.3 x 4.2 cm. The CBD, intrahepatic biliary radicles and gallbladder are consequently dilated. An endo-prosthesis is also seen within CBD.

SGOT: 155 IU. S Bilirubin: 2.9 mgm%. S Alk phos: 1408

Laparotomy performed at R N Cooper hospital: large mass in the abdomen-obstructing duodenum. Patient was discharged as nothing could be done. At this last stage, he opted for homoeopathic treatment.

PATIENT AS A PERSON:

Appearance: Average build. Lips thin, teeth regular, gap between the teeth. Nails: clubbing.

Habit: Pan with tobacco chewing 2-3/day. Tea 4-5 cups. Cooks food in Aluminum utensils. Thirst: Normal. Appetite: increased. Desire: Pungent spicy food.

Thermals: Sweat in summer.

MIND: No mental tension/worries. A Govt employee, Happy go lucky life. No financial problems. Six children (2 sons & 4 daughters).

Physical examination: Pulse & BP normal.

DIAGNOSIS: Obstructive Jaundice due to Adeno-carcinoma of Pancreas.

After nine months of HOMOEOPATHIC TREATMENT:

CTScan of Abdomen:

26/12/96: Compared with previous scan dt13/3/96 showed significant regression of the periampullary mass; CBD diameter decreased and now normal in size.

PRESCRIPTIVE TOTALITY: Syphilitic miasm. Endoderm and mesoderm involvement. Involvement of connective tissues- Group IIA abnormal function. Group IIB (*Mag-fl* for tumor and *Merc-sulph* for Liver and dysentry). Involvement of Liver, pancreas heavy abdominal organs Group VIII. {Deeper to *Ferrum*- (RBC – haemoglobin breakdown) and *Osmium*}

TREATMENT:

9/4/96		*Merc-sulph* 30 *Osmium* 6X+ *Mag-fl.* 6X *Chelidonium* Q
23/5/96		ctall
11/7/96	No Jaundice & No fever	ctall
12/9/96	>> No jaundice. No fever	*Osmium* + *Mag-fl* 6X
20/11/96	No mass.	ctall
26/12/96	No complaints.	No medicine

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CASE 2: INFECTIVE HEPATITIS B

Mrs SP, 52 yr, from Mumbai

History given by patient's relative, as the patient was semiconscious in the Hospital.

CHIEF COMPLAINTS: Abdomen: Dull pain in Right hypochondrium since 2-3 months. < lying on left side; > lying on right side and rest.

GIT: Appetite decreased: no desire for food, empty sensation in stomach.

Constipation: Stool dry, hard difficult to pass > after eating and passing stool.

Urine: Dark yellow^{+3}, burning in urine

Joints: Bone pain since 5-6 years.- all joints painful, shifting dull pain > warmth < change of weather,

Weight loss- about 10-12 kg in last 3 months.

PATIENT AS A PERSON: Appearance: Thin.

Skin: Pale yellow. Teeth – artificial denture.

Thermal modality: Chilly patient.

P/H: GUT: Profuse bleeding during menses.

F/H: Husband: Hypertension, IHD.

Three sons and two daughters – all healthy

PHYSICALS: Appetite: decreased, cannot remain hungry. Thirst: Ice cold water frequently.

Bowels: C/C; Flatulence, heaviness in whole abdomen.

Urine: Burning, dark yellow.

Sweat: Palms Burning of palms and soles.

Sleep: Normal. Short sleep ameliorates.

Dreams: Fearful.

O/E: Temperature: 101^{0}F, intermittent. Pulse: 108/min. B.P: 90 / 60 mm/Hg. Liver: Palpable. Spleen- not palpable. RS/CVS: NAD.

Tongue: Pale. Eyes: Sclera yellow.

Patient was admitted twice in the hospital, under treatment of different physicians. All had lost hope that patient would survive and discharged her from the hospital on 5-4-92. She came for homoeopathic treatment as a last resort on 6/4/82. (See Chart for Remedy and Follow Up).

INVESTIGATIONS:	19/3/82	22/3/82	6/4/82	21/4/82
S.Bilirubin Total mg%	23.3	15.4	23.7	7.0
Direct	16.0	12.6	16.0	4.5
Indirect	7.3	3.8	7.7	2.5
SGOT	217	570	690	220
SGPT	237	720	219	200
Alk Phosphatase	10.6	7.5	189	10
Icteric Index			150	40 (Normal)
Australia Antigen (HBsAg)			Detected	Not Detected

(Bombay Hospital Pathological Laboratory)

TREATMENT:

Date	Observation	Remedy
6/4/82		*Phos* 30 TDS
8/4/82	S Q	ctall
12/4/82	slightly >; regained consciousness	ctall
16/4/82	>	
21/4/82	> > Australia antigen negative	ctall

Treatment continued for another 15 days and then stopped. No further medicine.

Patho-physiology of the above case was similar to the patho-physiology of *Phos.*

***COMMENTS:** Co-ordinating Editor Dr C H Asrani; I reteirate: 60% of Eliza positive cases of Australia Antigen spontaneously revert to normal in 6 months. Of course the clinical improvement cannot be denied in this case.*

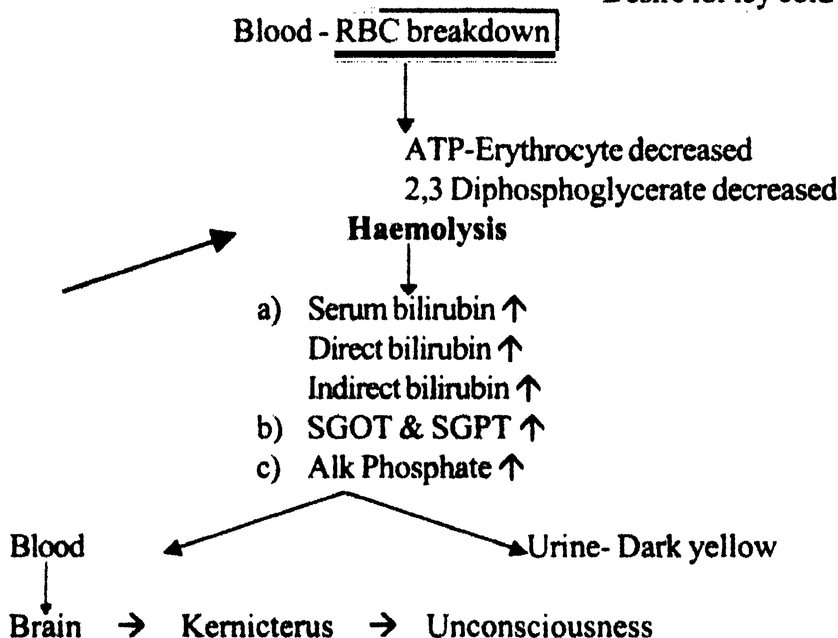
Phosphorus

Chief Component Required For

Bones — RBC cell membrane strength — Liver cell -repair & strength

Energy storage

Loose motion (Lack of energy)
Chilly patient – ATP decreased → Tissue burning → Burning of palms & soles and GIT
(> warm) — Desire for icy cold water



Bony pain, Joint pain
(Osteitis-fibrosa)
< Change of weather

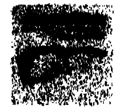
Liver cell damage

Phosphorus strengthens the bony cells, Liver cells and RBC's. Prevents haemolysis and breakdown of the cells. Australia Antigen. Not Detected.

Case 3: Infective Hepatitis

Mr OM (20 years) held Infective hepatitis Viral A on symptoms prescribed > Rx *Phos* 30 *Cardus-mar* + *Chelid* Q

Investigation	1/7/92	14/7/92	31/7/92
Urine			
Bile salt	+ + +		
Bile pigment	+ + +		
SGOT	3000		
SGPT	2900	179	32
Alk. phosphatase	180		
S. Bilirubin	6.7	3.6	1.2 mg%
Total Direct	5.8	2.4	0.6



PRESCRIPTIVE TOTALITY: Prescription based on patho-physiology of medicine. Disease of infective origin therefore disease development from periphery to centre. Destruction of RBC's, chilly patient, lack of energy, liver involvement.

CONCLUSION:

Many such cases were successfully treated by late Dr R D Jain. We have similarly treated many cases of Infective Jaundice (Total bilirubin less than 2.5) with *Nat-sulph* and *Nat-phos* 6X 4 tablets six times daily and *Chelidonium* & *Cardus-mar* Q (or other Homoeopathic Liver tonic) 10 drops in half cup of water four times daily till urine becomes clear and then three times till blood reports show normal bilirubin. With this treatment, diet and other regimen is prescribed as an important adjunct:

1. Complete rest in airy quiet room.
2. Oral Glucose with pinch of salt or lemon juice 6-8 glasses/day.
3. Light diet. No oily/fried, spicy food.
4. Eat more sugar cane pieces and grams.

Homeopathy: For Hepatitis B & C

Editor: The author had given us some general aspects also, but since general aspects have already been covered by other authors, in this paper we shall focus ON HOMOEOPATHIC ASPECTS:

Conium has won laurels for very painful liver tumour, which matches with the clinical picture of Hep-C; *Conium* is a deep psoric and sycotic, anti-cancerous drug, a good oncologist in dynamic doses, particularly when the predominant cause of cancer is sycosis (suppressed gonorrhoea).

Flouric-acid has similar pathology of HBV (in chronic alcoholics) of syphilitic destructive nature, where the fibrosis begins with deposition of connective tissue around the terminal hepatic venules. As the lesion progresses, fibrosis also extends to surrounding zone 3 hepatocytes, creating a "Chicken wire", or "Hobnail" appearance. This is effective when the liver is engorged or indurated with ascites.

Hepatitis-B pathology has soreness on the liver, while Hepatitis-C has pain. 'B' has syphilitic tubercular type of pathology in form of cirrhosis while 'C' is sycotic in form of tumours. If soreness of a Hep B patient is better lying on abdomen, think *Phosphorus*. If pain of a tumour case > lying on abdomen, *Medhorrinum* would be the remedy. *Phosphorus* & *Flouric-acid* have more ascitis than *Medhorrinum*. In Hepatitis 'B' the history of blood transfusion is common, while in Hepatitis 'C' suppressed gonorrhoea.

Similarly, *Opium* has therapeutic efficacy on persistent fibrosis. *Opium* patients usually do not express their sufferings but their fear of extravagance speaks. It reminds me a case of a lady, of around 50 yr, in an advanced stage of pathology: Abdomen bloated and hard, with colic and vomiting, diagnosed as multi-nodular hyper-texture homogeneocity of liver due to ? possibly Hepatitis-C. She was in a very bad state with poor prognosis but she kept on refusing to take homoeopathic medicines in a state of anticipated fright that "something else would happen". Although struggling with pain & discomfort, she said, "Kaheen kuch aur ho gaya to?" ("What if something else happens?") A dose of *Opium* 1M brought back the fight, and she developed malaria. After few days her malaria disappeared without further medicine and the nodule started disappearing. *Thuja* as an intercurrent helped her recoup completely.

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