

Characteristics to the Rescue

Mrs S, 37yrs, B.Com, House Wife, Hindu, Vegetarian. Fa Expired in 1966, Mo-79 Yrs, Bro-5, Si-5, Son-13
Spouse- Mr A, 45yrs, Civil Contractor. Yrs

CHIEF COMPLAINTS

LOCATION	SENSATION	MODALITIES	ACCOMPANIMENTS
GIT Retrosternal Onset age: 18 Yrs Freq: 2times/month	Burning Vomiting- bilious eructations. Gases	< Chillies < Sour < Sun < Night watching < Hungry and food not taken in time > Cold drinks-milk > Ice cream < Lying down < Dinner after > Sitting > Pressure ² > Warmth	Headache Temporal, aching > Vomiting
Sternum / Epigastric Onset: Since 6 Mths Freq: Once/3 Days	Heaviness: Feeling as if something stuck in the throat Gases. Eructations		
Musculo- Skeletal System Lt Elbow Onset since: 3 yrs	Aching No Swelling		

ASSOCIATED COMPLAINTS

LOCATION	SENSA	MODALITIES	ACCOMPANIMENTS
Musculo- skeletal system Lt. knee till sole, Leg (Posterior more than ant aspect) Palms and fingers, Lt and Rt Frequency: 1/2-3dys Duration: 1 1/2 hrs.	Aching Shifting pains Pain No Swelling	> Sitting cross-legged < Fan < Early morning > Pressure > Movement	

PATIENT AS A PERSON

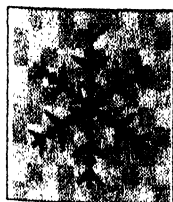
C3H2.

Heat Soles > Cold water

PERSPIRATION: General increased since 1 year partial face,
neck

HUNGER: Normal. GIT complaint, nausea

CRAVING: Sour, sweets



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MENSTRUAL FUNCTION

FMP: 13 yr, regular, 4/ 30

Flow: Moderate. Colour: Red

Clots: 2-3 months back now stopped

Stains: Colour brown, fast, but washable

Menses before: Sleepiness 8-10 days prior, lumbo-sacral
back pain, left calf pain

Beginning within 1-2 hrs: Pain in abdomen > vomiting

During: After 2 days sleepiness reduces

LEUCORRHOEA: Onset after menses; duration 4-5 days.

Character-acrid, bloody, Colour-yellowish

Effects: Irritation-local. pain-back +

OBSTETRIC HISTORY

Abortions- one induced.

Morning sickness, vomiting all through 9 months. Pyrosis.

Foetal movements-normal, pedal oedema after 7 mth.

Delivery-caesarean.

LIFE SPACE

Mrs S, 37 yrs old female came with a red saree worn gujrati style, long Mangalsutra, and a very simple hairstyle. Facial expression: simple and relaxed. Seemed to hail from a well to do family.

At a age of four years, her father died due to diabetic complications. She is youngest of 9 siblings. After the death of her father, the atmosphere in their home was good till a strain relating to money matters appeared between eldest brother and remaining 3. Eldest one kept the estate all to himself and did not share with the rest. So all of them, including the patient, do not talk with him. Her mother is mild by nature and did not take any firm stand about this issue. Her attitude was that he has done this, so we need not do the same. But this clashes between brothers did not make any specific impact on patient.

Academically, she was good upto seventh and always came first. After that her rank went down to 7th -8th because of partiality. There were no ill feelings regarding the same. After 10th, she left school as family felt she should learn household work. She accepted it wholeheartedly without any adverse impact.

After her marriage, they did not stay with in-laws. FIL died two year back, so they got MIL home and now look after her. MIL never interferes.

Patient described nature of husband as perfect, a person who would behave according to the situation. He is the most educated person in the family and wants everyone together.

While describing her nature she said that if anything happens against her wish, then it disturbs her for the time being (without any prolonged / significant impact). She gave example that if she asks her son to do some work and if he does not do it, then she will only once ask why he has not done it and will leave the matter after sometime.

Overall she appeared to be mild , with calm, serene exterior.

FAMILY HISTORY: DM: Br 1, 2, 3, Sister 1, 2, Fa and Mo. HT: Mo.

PHYSICAL EXAMINATION

Weight: 46 Kg. BP: 140/ 100 mm of Hg.

Elbow: Lateral malleolus - tenderness, no swelling, no warmth. Knee: No Crepitus.

CASE UNDERSTANDING

DIAGNOSIS: Hyperacidity.

Soft tissue rheumatism (non-articular rheumatism) describes the multitude of painful conditions affecting the extra articular soft tissues resulting from the trauma of everyday life, characterized by a self-limiting inflammation in the soft tissues, be it muscles, ligaments or tendons. Their incidence and chronicity increases with age. Many are well recognized and have a definite anatomical basis.

DD: Two such common conditions are tennis elbow and also golfer's elbow on lateral and medial epicondylitis respectively. These conditions arise from inflammation around the tendinous origin of the extensors (at lateral epicondyle) and flexors (at medial epicondyle). They are often precipitated by the use of these muscles and patients experience severe pain and tenderness over the medial or the lateral aspect of elbow radiating into the forearm and occasionally into the upper arm. Pain can be made worse on resisted extension (tennis elbow) or flexion (golfer's elbow) of the wrist. Tenderness is usually elicited in a point distribution over the affected epicondyle. This patient had tennis elbow.

Other clinical conditions in the case are easily referable.

CLASSIFICATION

Some of the issues needing explanation are

1. Amelioration vomiting: is raised to a general level. It is present as a modality of an accompaniment of a chief complaint as well as of another concomitant (Menses During).
2. Menses concomitant during: here vomiting amelioration is classified rather than abdominal pain.

Hence it is classified as modality.

3. Left elbow: All through the case we will find that the left side is a prominent feature. So in the classification, left side affection is taken as characteristic and affection of elbow is considered as diagnostic.
4. Menses staining: Menstruation process is taken as general. But few characteristics related with the discharge since they are related with the part are taken particular. (Ref: Commentary on Organon by Dr Sarkar; Kent philosophy; Dr HA Robert; Gibson Miller)
5. Vomiting pregnancy during: since this belongs to one of the strong epochs in females it is classified as a characteristic symptom.

APPROACH

Looking into this case, we find that major characteristic expressions are present at the body level where the modalities and the concomitant are very important and characteristic.

When one looks critically, vomiting amelioration becomes a very important characteristic since it is a modality which comes in accompaniment column in chief complaint as well as it is present in concomitant – menstrual complaints – pain in abdomen.

When we take this point in view, then we can appreciate the importance of Boenninghausen's phenomenon of GRAND GENERALISATION. Along with this modality, there are various other modalities which would depict the whole person and that is how we can take a classical Boenninghausen approach.

When we go one step ahead of this, then we find that amelioration vomiting acquires a status of eliminating rubric and thus we will not think of remedy at all if it doesn't cover this aspect of the case.

BBCR: Cond aggr and amel: vomiting after amel: *acon*², *colch*², *dig*⁵, *eup-per*⁴, *hell*², *hyos*³, *kali-bich*², *nux-v*³, *puls*³, *secale*⁴, *tab*⁴

The remedies coming after classical approach are two: *Nux-vom* and *Puls*.

The repertorization will take us this far. Beyond this, the quantitative logic will come to a standstill and qualitative aspects of the totality would have to be studied. Now we can take help of the mental state of the patient.

She appears to be a very mild lady. There was serenity in her demeanour, which was experienced throughout the interview. She has faced difficulties in the relationship with her brother, but there are no grudges kept at all. This whole appreciation of the mental state directly fits into *Pulsatilla*. On the other hand *Nux-vomica* with its irritability and ardent character does not stand after studying the whole anamnesis of the case.

Some physicians may consider the chilly thermal state as a point going against *Pulsatilla*, which is known to be hot during chronic phase and can be chilly during acute phase. Some would also doubt if *Pulsatilla* has the depth to be a constitutional remedy. Some of the clinical experiences (my own and of my colleagues) have shown that *Pulsatilla* can be chilly even though not very chilly. The issue of depth of action of *Pulsatilla* is an open issue.

PLANNING AND PROGRAMMING

Considering moderate susceptibility and sensitivity, *Pulsatilla* 30 was selected and tennis elbow pathology made me opt for daily repetition. Retrospectively I think that *Pulsatilla* 200 weekly dose could have sufficed, though it did not cause any aggression.

FOLLOW UP SUMMARY

Pulsatilla 30 was given in daily doses (7P HS) on 08-06-99. Patient reported back on 22-06-99. All the complaints were better ++ including aggravation before menses and no vomiting. She was again given *Pulsatilla* 30 7P HS and then she came on 06-07-99 with amelioration. Placebo was given as menses were due on 13-07-99 and *Pulsatilla* 30 was given as stock to be taken only if she got any problems during menses (Since the pt was >++ during previous menses).

Patient came directly after 4 months, but this time not for herself. She had brought a relative for treatment and she has been totally free of all symptoms.

