Miasm & its Therapeutic Implication

(Editor: Miasm is all pervasive. Whether studying a remedy or disese or patient, the greater the clarity on the subject, the greater will be our efficacy in Homeopathic Practice.)

The Hahnemannian classification of diseases based on theory of chronic miasms is a major breakthrough towards the rational therapeutics.

Introduction of miasmatic classification of disease became the most important milestone not only for the Homoeopathic world but the entire medical fraternity. Unfortunately this unique contribution has become THE most controversial in the Homoeopathic history. It has polarized the Homoeopathic profession. We have Allen, Kent & Robert on one side while Hughes, Hering & others stand on other side who have ignored, misunderstood or misinterpreted this doctrine.

Allen is quite right in saying "the character of miasm yields the character of the disease or the form of the illness. Thus miasm "the residual poison in fact permeates into the cell, tissues & spirit of the individual and you see a distinct pattern in the evolution of disease".

Masters have taught us that miasmatic concepts give an unique perspective to understand man in his totality Each human being, right from the moment of conception, is characterized by a miasmatic modulation through which his individuality is constantly trying to emerge. Greater the miasmatic obstacles, deeper and extensive is its manifestations in health and disease.

It is our day to day experiences of integration of miasmatic totality in handling of chronic illnesses. At the same time clinical experiences taught us immense value of using miasmatic force at a right time in ACUTE EMERGENCY CASES to prevent catastrophe.

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ROLE OF MIASMATIC REMEDY IN ACUTE CASES.

BRONCHIOLITIS is known to be a paediatric emergency as it leads to complication rapidly.

Definition: It is an acute inflammation of the small airways resulting in a clinical syndrome characterized by inspiratory and expiratory wheezing and hyperinflation. More then 70 % cases are due to respiratory syncital virus (RSV)

Age: 2 to 9 months. Later occurrences fall under heading of Hypersensitive Airway Disorders.

Incidences: Mostly in winter & early spring, Males>Females, common in chubby children.

Risk Factors: babies not well breastfed. Crowded localities.H/O viral illnesses in family. Infants of smoking mothers

Clinical presentation: Patient presents with:

a) Abrupt respiratory distress with paroxysmal wheezy cough-a)dyspnoea, irritability & restlessness.
b) Non-acceptance of feeds-difficulty in sucking & swallowing.
c) Excessive crankiness.
d) Moaning.

On inquiry

a) H/o URTI in family with appetite diminished or mild fever.
b) Systemic manifestations like diarrhoea or vomiting may or may not be present.

Complications

Biochemical Changes.

a) Respiratory Failure
b) Pneumonia & its allied complications as it traverses from parenchyma to pleura to multiple organs, brain, blood kidney etc.

PHYSICAL EXAMINATION:

a) Look (sick/ill/active/playful)
b) Alae nasi/use of accessory muscles.
c) Moaning/grunting
d) Cyanosis – central/peripheral.
e) Temperature/resp rate.
f) On Auscultation – Fine crackles at the end of inspiration & early expiration. Prolonged expiration with Audible wheezes. Liver and spleen palpable

INVESTIGATIONS:

a) CBC- Normal.
b) Chest X-Ray 1) Hyperluscent lung shadow.2) increase A.P. diameter of chest.3) flattening of ribs.- – all signs of inflation

MANAGEMENT:

On the strength of respiratory distress and generals, Bronchiolitis is divided into mild, moderate & severe types. Mild to moderate can be managed at home. In severe Bronchiolitis, hospitalization will be required.

MIASM: TUBERCULAR :

1) Sudden evolution & pace
2) Acute inflammatory response – oedema of bronchiolar wall, Hypersecretion of mucus, round cell infiltration, necrosis of cell wall & collection of cellular debris – Pathology of spasm more than exudate.
3) Low reactivity
4) Lingering infection.

The above understanding help us to handle serious disorder without many problems.

CASE 1

Name: Master D Birth date: 23.8.99 (8 months)

D.O.C: 4.4.00.

Fa: 34. MO: 30. Add. Vadodara.

LOCATION	SENSATION & PATHOLOGY	MODALITIES	ACCOMPANIMENTS.
RESP.SYSTEM. SINCE Jan.00. Every 15 days. Developed within 2 – 3 hrs. Feb :00	RATTLING3, DYSPONEA3. Cough bouts2 Temp.100 – 101. Diag: Pneumonitis.	<3change of atmos.<3 4 am. <3 lying down.. <Cold air, >3 admission in Hospital for 4 – 8 days.treated with Steroids, nebuliser, antibiotics & bronchodilaters. >Warm appl.	Weepy3 Clings to Mother. Appetite Decreased.

Thermal State: Chilly.
Since last attack Pt.is on Beclate & Asthalin Inhaler twice a day.
O/E Chest: NAD.

FOLLOW UP: (next Page)

Treatment was started with *Bacillinum* 200 every 15 days & inhaler was withdrawn within a week

Date	sleep	weeping	appetite	N.D/ Rattling.	Wheezing	Dysponea	RR/Chest Temp.	Int/Exp	Action
13/5	N	-+	G	++	-	-	N	acute	*Puls* 200 bd.
14/5	N	S		>/++	+		26/Ronchi +		*Puls* 200 4 hrly.
15/5 am	Dis.	+++	Dis.	+++ 10 Min	++	++	42/Ronchi ++	Thirst ++ Few , Freq.	*Antim-ars* 200 3 hrly.
15/5 PM	>	>	S	>?	S	>?	Same	Once Inhaler	Ct all 2 hrly.
16/5 am	S	s	s	s	s	S >inhaler	same	> then SQ >	*Bacillinum* 200 Stat. *Antim-ars* 200 ct all
16/5 PM	>2	>	>	>2	>	>2	32/ronchi +		*Antim-ars* 200 4 hrly
17/5 PM	>2	>3	>	>80 %	>2	>80	24/ronchi +		*Antim-ars* 200 8 hrly.
18/5	N	N	>2	Occ	Occ	N	20/Faint ronchi		

Later the patient stabilised with weekly doses of the Intercurrent & Constitutional. Later on he had 3 more attacks in 2000 & one in 2001, which responded promptly to *Bacillinum* & *Antim-ars* 200 – 1M

CASE- 2:

Master P: B.D.29.9.00 (6 months) Fa: 30 yr. Mo: 26 yr. D.O.C: 16.3.01.
Add: Vadodara.

LOCATION	SENSATION/PATHOLOGY	MODALITIES.	ACCOMPANIMENTS.
Nose —— chest 2 to 3 days. Since 1st month of life. Every month/remain for 5 to 6 days. Since 14 Th c/o started	Running nose – watery – yellowish, greenish. Noseblock2 Coughbouts2 Rattling3 – vomiting of curd like sticky profuse material Breathlessness3 Temp 100 – 101 Diag :bronchiolitis	< 3 C.O.W.<2 Dust < 2 evening <2 Lying down, <3 2 – 4 am. >2 vomiting >2 Vicks >3 Nebuliser with Steroids & bronchodilaters. Antibiotics & bronchodilaters for 4 to 6 days.	Appetite 0. could not suck milk. Thirst Decreased. Weepy^2.Desire Mother at all times. Carried desires to be Eyes lachry : bland (Initially)

Thermal: C2H2 – C3H2.
F/H Fa: allergic bronchitis, Gr. Asthma. O/E Temp 100. Chest: Few creps with ronchi +. R.R 30 /min:
Treatment Started with *Pulsatilla* 200 4 hourly.

FOLLOW UP

Date	Mind	Appetite	Cough	Dysponea	vomiting	RR/Temp/ Chest	Int/Exp Other	Action
17.3.01	>	S	>	>	++ sticky	30/99 –100 Chest :s	Registration	*Puls* 200
18.3.01	S	S	~	S	Once	28/~/Chest :Increased	SQ	*Puls* 200 3 hrly
19.3.01 9.am	S	S	~~ Mild >	> then <	++ of sticky	35/99/ Chest: S	At Night : Nebulisation Disease ~ Inadequate Response	*Bacillinum* 200 Stat. *Puls* 200 3 hrly ct.all
!9/3.PM	S	>	>	>	Once	32/99/ Chest: > Creps, Ronchi S	>	*Puls* 200 3 hrly
20/3/01	>2	>	>2	>2	0	28/N/>2	>2	*Puls* 200 6 hrly
22/3/01	>3	>2	>80%	>3	0	N.Chest :occ.ronchi	>	*Puls*.200 8 hrly.

Later on Pt. stabilized with weekly doses of *Calc-phos* & *Bacillinum* 200 (infrequently).

CASE 3: Name: Master M B D – 15.1.98. D.O.C. 6.11.98. **Address: Vadodara.**

Location	Sensation & Pathology	Modalities	Accompaniments
Resp.system. Since 3 months of age.once/15 days. Remain 5 – 6 days. Sudden within few hours. Chest – Nose. 2nd day------	Rattling3,Cough Bouts3 Dysponea3 Vomiting Thick3,White2 Sticky,Stringy2 Remove mechanically Temp.101 –103. Diag :Bronchiolitis —	<3C.O.W., <3Cold, <2Banana, <3 Evening, <2 1am. >3 Hospitalized Treated with steroids,antibiotics & bronchodilaters(inj.)	Irritable2, Thirst Increased 2 few sips frequent. Weakness2.

Thermal: Hot pt. F/H: Gf – Asthma, Pgmo: Eczema.
O/e Chest: Nad.
4th & 5th Month developed Pneumonitis because of Bronchiolitis.
Treatment started with *Calc-iod 200* wkly. In Nov – Last attack: pt. was serious, admitted & treated heavily with Inj.Steroid & Deriphyllin with Nebuliser QDS. For 3 days.

FOLLOW UP

6.12.98. _ Cold + Rattling 3 since Morning. Temp.100.Vomiting of food, was not able to sleep because of Cough.
O/E: Temp.100, Chest Ronchi +. Paed.consulted, who started Bronchodilaters + Steroids + Antibiotics. *Ars-iod* 200 6 hrly.

Date	Sleep	Mind	Appetite	Cough/ Rattling	Dysponea	Vomiting	RR/Temp. Chest	Int/Exp.	Action
7.12.98	Disturbed	Irritable	~~	+++	+	Twice	30/101 Chest - S	<	*Ars-iod* 200 4 hrly.
8.12.98	S	S	S	>	++	4 - 5	34/100/S	Weakness	Ct.all
8.12.pm	> Nap.	s	s	s	>?	>	38/100/s	Neb Once	*Ars-iod* 200 3 hrly.
9.12.98.	Dist.	S	S	S	S	>2	42/100/ Chest.Crep Ronchi++	Xray: Hyper Inflation. Tc.11000	*Bacillinum* 200 stat. *Ars-iod* 200 ct.all
PM	S	>2	>	>?	>2	S	36/100. Chest >?		*Ars-iod* ct.all
10.12.	>	S	>2	>2	>	0	26/N/ chest >		*Ars-iod*.200 4 Hrly.
12.12.98	N	N	S	>80 %	>3	0	N		8 .hrly

Later on Pt.settled with *Calc-iod* 200 with infrequent Intercurrent. He did develop attacks later on but responded promptly to *Ars-iod* 200 & *Bacillinum*.

CONCLUSION

All these cases beautifully demonstrate of need of Miasmatic remedy during Handling of acute serious disorder. Allen has mentioned "until you do not resolve miasmatic dyscrasia, you may not able to achieve rapid cure". Clarke in his introduction of *Bacillinum* write "Bad cases of asthma, Chronic respiratory disease, COPD, often helped by *Bacillinum* instead of other forces. Dr Cartier has written maximum on *Bacillinum* and has labeled *Bacillinum* a Syco- Tubercular remedy.

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"The tragedy of life is not that it ends so soon, but that we wait so long to begin it."

- Author Unknown