# An Approach to a patient with Anaemia

In evaluating patients, the physician should proceed to diagnose anaemia correctly with minimum laboratory tests and procedures. The presence of symptoms related to anaemia depends on severity and more importantly, on rapidity of onset. In the latter, due to lack of adequate time for compensatory adjustment, the patient tends to have more marked symptoms, than in those of equivalent severity but developed insidiously[1].
To evaluate the etiology, keep in mind the following three processes:
a) Haemorrhage either acute or chronic
b) Hypoplasia or aplasia or red cell production and
c) Haemolysis.

In **Anaemia due to blood loss:**
The patient will have hypotension and tachycardia proportionate to the degree of hemorrhage. Acute hemorrhage usually presents with signs and symptoms secondary to hypoxia and hypovolumia.
If Acute, ie blood loss >100ml, give prompt replacement by whole blood otherwise it will lead to cardiovascular collapse.[2]
Blood loss below 100ml can be corrected by oral supplement of iron (in ferrous form) and protein. Among these *Carbo-veg, Chin, Phos-ac* play a valuable role[3]. These drugs probably correct the hypovolumia by reducing the vascular bed by vasoconstriction. *Stron-c* is the drug for chronic sequalae of hemorrhage[4].

**Iron Deficiency** is by far the most common cause of anaemia worldwide. The possible factors are iron deficient diet, impaired absorption (mainly seen in peptic ulcer, mal-absorption syndrome), increased requirement (eg pregnancy) and loss of blood. Excessive menstruation (average loss 30 mg of iron in each month) and occult bleeding from the gastrointestinal tract (eg peptic ulcer, neoplasm, hookworm infestation, hemorrhoid, etc) are causes of loss of blood[5]. Iron is absorbed in duodenum in ferrous form, but can also be absorbed as haem-form from red meat. Much of the iron in food is un-absorbable because it is irreversibly bonded with phytate and phosphate, eg spinach has high quantity of iron but almost total is unabsorbable[6]. Red meat is a good source of iron. In rural area there is a belief that Kulekhara (Hindi-Tal-makhana or Hygrophilia spinosa) is a good source of iron and used as haematinic. But studies show that its iron content is very negligible. Other than food supplementation, synthetic iron compounds like *Ferrous-sulphate, Ferrous-fumerate, Ferrous-gluconate and Ferrous-succinate*[8] can be used in acute deficiency along with collateral homoeopathic treatment of the aetiological background (ie miasm). There is no reason to administer haematinic such as iron, vitamin B12 or folic acid unless there is a specific deficiency of these substances. In contrast, the inappropriate use of iron preparations over a prolonged period of time leads to a state of iron overload, which is harmful to body.

Most authors claim *Fer-met* as the chief drug for anaemia. The indication for homoeopathic prescription should be the symptom-complex that is due to excess of iron intake in prolonged time[10] ie a picture of increased erythrocytosis, iron overload and iron toxicity. Dr Hahnemann in Materia Medica Pura in *Fer-met* chapter described the symptoms of the effect of iron on persons who habitually drink chalybeate waters; those are very similar to symptoms of high haematocrit. Keep in mind that some symptoms of increased erythropoiesis are very similar to iron

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deficiency anaemia but the cause is totally opposite. Careful study of drug picture of *Fer-met* shows that there are signs & symptoms of iron deficiency anaemia, but these may be due to alternating action of drug. It should be the drug for polycythaemia and anaemia with iron overload only in high potency but we often use it in iron deficiency anaemia when symptomatology corresponds. Readers are requested to go through the "*Ferrum*" chapter of Clarke's Dictionary of Practical Materia Medica and clinical features of polycythaemia from any textbook of Medicine. At the time of Dr Hahnemann the term polycythaemia was not known, and so this type of symptomatology was also classed as "anaemia"[11]. It may also be the drug for chronic iron overload, eg haemosiderosis, haemolytic anaemia, thalassaemia with transfusional iron overload (isopathic use). The laws of Arndt-Schultz states that micro-doses of substances stimulate the physiological function but large doses depress it, supports this contention[12]. So, what is the right answer? Further Trials and Proving of *Fer-met* is needed to search out the real answer.

**Megaloblastic Anaemia** is caused either by deficiency or impaired absorption of vitamin B12 and folic acid. Impaired absorption due to cessatation of intrinsic factor secretion, owing to atrophy of the gastric mucosa, is termed as pernicious anaemia. Here features of vitamin B12 deficiencies are prominent along with features of anaemia. Current studies show that pernicious anaemia is an autoimmune disorder. The neurological manifestations are most worrisome and many times irreversible. It is due to degeneration of spinal cord featuring numbness and paresthesia in the extremities than weakness, ataxia, and poor finger coordination[13], simulating the drug picture of *Phosphorous*[14]. In Boericke's Repertory *Arsenic* and *Phosphorous* both are in Italics[15]. However both are useful also in aplastic anaemia, which is discussed below.

**Aplastic Anaemia** happens due to severe hypoplasia (Miasmatically syphilitic in nature) of the erythroid, myeloid, thromopoietic cell lines in bone marrow leading to ecchymosis, petechiae or hameorrhage due to thrombocytopenia along with classical features of anaemia. Patient becomes susceptible to infection due to leucopenia. Chemicals, which can cause aplastic anaemia in toxic doses or prolonged use, are the drugs in potentised form[12]. A number of cases of aplastic anaemia have been reported following infectious hepatitis[19]. *Phos* is a very effective drug in this condition as it causes fatty degeneration of blood vessels, bone marrow, atrophy of liver leading to petechiae, hemorrhage and hematogenous jaundice[16]. Aplastic anaemia is also from toxic effects of *Arsenic, Chloramphenicol* and *Benzene* and others[17, 18]. Besides *Ars* and *Phos, Chloramphenicol* and *Benzene* can be used in potentised form in aplastic anaemia, if totality corresponds. Can irreversible condition of bone marrow be cured homoeopathically besides palliation? Management of aplastic anaemia has become one of the most challenging aspects of modern medicine[19]. It has already been proven that homoeopathic medicine can repair chromosomes even in the irreversible condition[20]. So the homoeopathic drug can do better in aplastic anaemia besides supportive therapy of modern medicine. Clinical trials can confirm.

In **Haemolytic Anaemia** (syphilitic in nature), red blood cells undergo premature destruction by intravascular or extravascular haemolysis. Haemolysis is seen in a variety of diseases like thalassaemia, spur cell amenia, hereditary spherocytosis, certain infections (eg clostridium welchi) sickle cell anaemia, auto-immune haemolytic anaemia, etc. Substances, which have haemolytic property in crude form, can be used in potentised form if symptomatology corresponds (eg *Crot-h, Phos,* etc)

Most times, anaemia is secondary to chronic inflammatory disorders, as for example, rheumatoid arthritis, liver disorders, chronic infections, neoplastic disorders, regional enteritis, systemic lupus erythmatous etc. anaemia may also be found in endocrine failure,

uraemic syndrome. Treatment by Homoeopathy is not disease specific rather aetiology and stage specific, which Dr Hahnemann called miasm. Criteria for selection of homoeopathic drugs, depends upon symptom similarly in miasmatic background.

Apart from the above, there are many more drugs, which can manage anaemia, popular ones being *Calc-p, Cyclamen, Puls, Nat-m,* etc. However readers are requested to treat their cases miasmatically by single drug at a time [21] along with collateral management if needed.

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# Anaemia: Different Types

Anaemia represents a clinical syndrome of an inadequate number of circulating red blood cells and an insufficient amount of hemoglobin to deliver oxygen to tissues, resulting in pallor, fatigue, shortness of breath and predisposition to cardiac complications.

Various types of Anaemia and their manifestations are discussed below.

**IRON DEFICIENCY ANAEMIA (Covered)**
**HAEMOLYTIC ANAEMIA (Tackled)**

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**APLASTIC ANAEMIA:**

A reduction in the number of circulating RBCs resulting from bone marrow failure, accompanied by agranulocytosis and/ or thrombocytopenia.

**Causes and Incidence:** Etiology is unknown in half the cases; other half being induced by chemicals, drugs, viruses or radiation. It has a low incidence in the population.

**Disease Process:** Exposure to known or unknown toxins depresses production of erythrocytes, platelets and granulocytes in the bone marrow. Common toxins include ionizing radiation, chemical agents (eg Benzene, DDT, carbon tetrachloride), and drugs (eg anti-tumor or anti-microbial agents).

**Symptoms:** Onset usually insidious, occurring weeks