Advantage of Homoeopathic IPD

CASE 1

Smt TR, 48 yrs Housewife Married since 32 yrs, Illiterate, Bengali, H 50 yrs, working in Pvt Co, Mo Expired 10 yrs back, Br 5, Sis 1 (all younger to patient), Sons 2, Daughter 1

Patient was seen in the Diabetic OPD on 16th July 04 with UTI. H/o DM since 4 yrs . She has gradual weight loss since 4 yrs and complained of burning soles since 4 yr. This indicates peripheral neuritis.

On 10/7/04 FBS:225, PPBS 362.8mg/dl

She was irregular in treatment. She was given *Puls* 30 on 2/4/04 and *Merc-cor* on 9/9/04. Apart from this; patient was taking oral hypoglycemic agents for 2 yrs, which she had discontinued on her own since 2 months. Patient had consulted MD physician who is attached to our hospital, for fever, off and on since one month. On evaluation she had:

FBS: 307.5 with urine sugar ++++

PPBS: 371.8 with urine sugar ++++ and traces of acetone

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Looking at the high blood sugar levels and presence of acetone in urine, which indicates patient's compromised metabolism and indicates that she can go into Ketoacidosis. Advised hospitalization.

Patients Status on Admission 21/9/04

1. Fever on and off since 3 months. Chills +. Fever < 5 am 5-6 pm. Accompanied by headaches.
2. Month ago, she had fever with chilliness without rigors. Subsided by itself.
3. Since 3 days fever with chills and rigors 1/day.
4. Rigors start at 10-11 am and continue for 30 min.
5. Rigor is followed by chill, which starts from the back and then spreads to the abdomen and chest. Patient feels sleepy with chills. Dryness of mouth and thirst increases, large quantity 2-3 glasses at frequent intervals.
6. Chill is followed by heat sensation all over the body; lasting for 30 min. Thirst is normal and patient experiences mild headaches.
7. This is followed by profuse perspiration, drenching her. She experiences intense weakness during and after perspiration. In apyrexia, patient has reduced appetite and a bitter taste in mouth.
8. Patient also complained of burning soles.

O/E: Looks Weak. GC: Fair. Temp: 99.2 F. Pulse: 80/min regular, good volume, BP: 130/70, R: 20/

min, Bowel Sounds: Sluggish. Per Abdomen: Liver 0, Spleen 0, K0. Tenderness over abdomen.

INVESTIGATIONS

CBC: Hb: 14.2, TC: 6,800, N: 58, L: 35, E: 4, M: 3.
URINE: Alb: ++, Sugar +++, Acetone: ab, RBC: Occ, Pus cell: 4-5, Ep cell: Occ Bacteria: +
LIPID PROFILE: S Chol: 160,, STrig: 114.7, HDL Chol: 42.4, LDL Chol: 95, VLDL: 23, Chol/HDL ratio-3.8.
Sr Creat: 0.6, BUN: 7.9.

TREATMENT

21-9-04:
Diabetic Diet. TPR BP 2 hourly. I/O Chart.

Inj Human Actrapid SC (Insulin)	10 (BBF)-14 (BL)-14 (BD)
Tab: Aciloc RD - 150	1-0-1
Tab: Amitryn -25	1-0-1
Syp: Lasiplex 2 TSF	1-1-1 (before meals)

Inj: Aknil 2cc IM SOS if temp touch 102 F
IVF 1 RL with Multivitamins Inj over 8 hours.
W/F/S/O hyperglycemia ie palpitations, sweating etc.

SUMMARY OF TREATMENT from 21-9-04 to 24-9-04
Blood sugar on 22/9/04 showed FBS: 367.8
US: +++, PPBS: 388. Acetone: Ab. RBC (is it RBS): 23/9 was 387
Inj Insulin Human Actrapid SC 16-20-20
Inj Monocef 1 gm IV 12 hrly.
Patient had almost continuous fever for 5 days: ranging from 99.4 to 104. Spikes of 103 -104 were recorded at 10-11 pm (more pronounced) and at 10-11 am. Till 24th patient had fever with rigors.
The generals and particulars used to fluctuate. Patient looked very weak and depressed.
BP spiked180-160 mm of Hg (Systolic) and 110-120 mm of Hg (Diastolic) twice then settled down.
24-9-04: Inj Insulin 20-24-24. Tb Zifi 200 1-0-1 x 5 days
Looking at this state, we thought of starting homoeopathic medicines after consulting physician and orienting the patient. He had suggested Lariago Inj 5CC IM 6 hrly 6 doses to be added to the treatment. But agreed to wait.
On 24-9-04 the case was redefined.

UNDERSTANDING OF THE CASE

Patient was born in a middle class, agricultural family in West Bengal. Agriculture as the main source of income. Patient was eldest and pampered by all. They had a big joint family and patient was not allowed to work. Patient did not go to school as it was far and there were incidences of 2-3 dog bites Patient had tremendous fear of dark in childhood which still persists. Patient got married at a young age. FIL expired early and MIL was a very irritable lady who used to taunt and even beat her, as she did not know anything about household and kitchen work. But this did not affect her. Patient from beginning was jovial and used to make everyone laugh. The only feeling was that her mother did not teach her anything. Patient looked after her MIL in her last days when she was bed-ridden. Her death affected her. Pt said that she was like my mother and every mother has the right to scold her children.
Patient lost her mother 15 yrs back and could not be with her during her last moments. She grieves about it and weeps occasionally. She often sees mother in her dreams. Patient gets along well with her only DIL. Sometimes DIL scolds her, saying that she is very child-ish. This has no effect on the patient. Patient has financial anxiety.
Patient was child-like during interview, laughing most of the time, although she was weak and in distress.

PHYSICAL GENERALS

PERSIPIRATION: Profuse, Scalp[3].
CRAVING: Sweets[3], Spicy[3], Fasting <2.
MENSES: Menopause since 5-6 yr.
O/H: G3P3L3, Morning sickness: 3-4 month in all pregnancies.
STOOL: Hard, has to use laxative occasionally. Patient

had < Before Menses.
THERMAL: Chilly[3] < Sun (General uneasiness).
SLEEP: Disturbed due to thoughts.
DREAMS: Mother. MIL.
F/H: Mo: HT, IHD. Fa: CVA.
DIAGNOSIS: UTI and Malaria / ? mixed infection with D M.

INVESTIATIONS: X-ray Chest: N. Widal: Not positive. Urine R: N.
THE CASE WAS REVIEWED
H/O: Essential HT in parents followed by CVA - IHD in parents revealed a strong tubercular base. (Fundamental Miasm)
FEVER TOTALITY
1. Fever aggravated 10-11 am.
2. Chills beginning in the back.
3. Thirst increased during chill.
4. Heat - Headaches with.
5. Perspiration profuse - Weakness with.

REMEDIES: *Tub, Sep, Calc, Nat-m, Nux-v, Verat, Rhus-t*
In the case we find a very strong tubercular activity in terms of fundamental as well as dominant load.
Long standing infection with high swinging fevers.
Intense weakness.
If uncontrolled, underlying diabetic state with its affect on general metabolism, could go into Diabetic Ketoacidosis.
Tub-bov also covers the fever totality, except the time. Other remedies like *Sep, Calc, Nat* were kept in mind, but with the above mentioned understanding and past experiences *Tub-bov* 1M, was given on 25/9 at 1 am and temp came down to 98.8 F
SYNPOPSIS OF FOLLOW-UP FROM 25/9/04 TO 26/9/04.
Patient on her own said that she felt much better and all symptoms appetite, weakness, sleep, generals and burning soles, abdominal pains were better. Resident physicians and consultants, could see a definite change on the patient's face and said that she looked much better in terms of weakness and general well-being. Restlessness/Depressed look also better.
There were no chills or rigors and the maximum fever spike was 100.6 F. This was expected of *Tub-b* but the improvement did not progress. *Tub* dealt with the miasmatic load in this case. We had to find out another force which would carry on the good work initiated by *Tub*. The current state of susceptibility did not throw any form suggesting an acute remedy and so this indicated that the susceptibility needed a deep acting force ie constitutional remedy.
TOTALITY OF THE CONSITUTIONAL REMEDY
1. Grief
2. Fearful
3. Timid
4. Mirth
5. Sentimental
6. Dreams: dead relatives
7. Anxiety: financial future.
8. < Before menses
9. Fasting <
10. Morning Sickness (< Pregnancy)
11. Perspiration profuse - scalp
12. Cr Sweets
13. Hard Stools

This totality points to *Calc-carb* as the constitutional remedy.
ACTION: *Calc-carb* 200 1P given on 26-9-04 at 10.30 am temp was 99.2 F.
The plan was to give a single dose and assess response after 12 hrs and then plan the repetition schedule. This is one of the advantages that we have in a IPD set up
The FU after 12 hrs showed no significant improvement- Fever range remained 99-100 F and *Calc-c* TDS.
27/09/04 Evening: Generals much better. Fever touched Normal twice in 24 hrs.
FBS: 210.7 US: +PPBS: 254.8. UR: N
Due to insulin doses and antibiotics.
After this there was a gradual improvement in general and specific symptoms. Fever range was 99^0. On 29th it remained normal for more than 6-8 hrs, for the 1st time in 8 days!! Patient was discharged on 30th. She followed up after 4 days. She had only one spike of 99 at home, that too she did not feel it. Patient has been reporting regularly and is much better. Her diabetes is being taken care of by insulin injection, diet and exercises.

LEARNING

1) Scope of homoeopathy in fever case where diagnosis is not very clear.
2) Adantage of treating complex fever cases in a Homoeopathic IPD set up.
3) Role of homoeopathic management in co ordination with allopathic consultants in fevers.

CASE 2

Mr NP, 30 yr. Occupation: Service MIDC Contract, Married since 7 yrs. Br: 2 younger. No sister.
Children: (3): 6 yrs, 4 yrs, 6 mo.
Date of screening 6/10/04 at 10 am. COMPLAINTS:

1. Fever high grade since 21 days. Usually associated with chilliness and 3-4 episodes of rigors. Fever < 4-6 pm[2].
2. Vomiting since 21 days F: 2-3 times / day. Vomiting <[2] immediately after eating and drinking warm water, can retain cold water for sometime.
3. Pain + in Right Iliac Fossa, continuous mild pain
4. Along with fever: App, Thirst large quantity frequently 1 glass ½ hrly Cr. For cold water[2], (His last symptom but during acute), Weakness[3].
5. Stool N. Urine N.

Patient has pain in Rt Iliac fossa since 1 yr. Always associated with vomiting & fever. Frequency: 1/month, 3 days, >3 allopathic treatment.
O/E: GC OK, T: 104, P 116/min, Wt: 46 kg, BP 112/60, RS: Clear, CVS: S1S2-N, P/A: Liver 1 FP, non tender. Spleen 0. Tongue: Thick coated white[2].
Mc' Burney's tenderness
No Guarding No rigidity
No Rebound tenderness

PREVIOUS INVESTIGATIONS

21/2/04: Hb: 16.6, PCV: 47.4, RBC: 5.84, WBC: 6,800, N58, L31 E4, M7.
S. Creat: 0.7 U. R: E/C 5-6 P/C: 2-3
3/4/04: Barium Meal follow through: Appendix not filled. liver echopattern

RECENT INVESTIGATION

6-10-04: USG Abd: Parenchymal inflammation of liver with subacute on chronic appendicular mass? Inflammatory iliocecal mass with minimal fluid collection.
X-ray Chest: Prominent Bronchovascular markings.
Widal: Typhi 0 1:120
Paratyphi A: 1:120

Thus we see in this case, the patient has contracted an acute infection (typhoid) and at the same time has a sub-acute on chronic infection. Initially this presentation possesses a problem of clinical diagnosis. But careful history taking along with investigations makes our task easier.

ACUTE TOTALITY

Fever <[2] 4-6 pm
Desire Cold drink[2] with fever
Thirst large qty and frequent with fever.
Vomiting <[2] immediately after eating and drinking
Can retain cold water for some time

SUSCEPTIBILITY / SENSITIVITY: Moderate-200
Case was defined in detail on 6-10-04 evening.
Totality after going through lifespace ie

CHRONIC TOTALITY

1. Fear of dark+
2. Atatchment[2] with parents
3. Anxiety[2] anticipatory about daughter
4. Sleeplessness anxiety from
5. Dreams of dead bodies
6. Dreams of snakes
7. Dreams of water
8. <+ Riding - Vomiting
9. <[2] Fasting - Weakness, Backache
10. <+ Sun - weakness, occ headaches
11. Cr. Spicy[3]
12. Perspiration profuse[3]
13. Chilly

CORRESPONDENCE- *Kali-carb*

TREATMENT / FOLLOW UP SUMMARY

1. Patient admitted on 6-10-04
2. All investigations were done and in spite of totality available we waited for reports and a study the temperature range. It is always better to wait for 12 - 24 hrs to observe the temperature chart and confirm what patient says. It is also important to observe pt and ask them about their subjective symptoms. Eg one patient with rigors in a malarial fever (P Vivax) assumed a knee chest position during chill and rigors and on being asked said she always does it and feels better (she never gave this in the history).
3. Temperature range 100° to 102.4° F *Phos* 200 QDS was started on 27-9 at 11 am. Patient gradually improved in all his symptoms. First there was no subjective feeling of fever/Chills. His appetite, nausea, weakness gradually improved. Patient had dry cough which was better within 2 days.
4. By day 2 his concomitants of increased thirst was better. His temperature range (Highest fever) fell by 1° F every day and on day 2, ie 9-10-04 it was 100° F. *Phos* was continued. Patient also reported that the pain in rt iliac fossa was much better.
5. Then on 9/10 there was one spike of 101 and the general distress again increased. This indicated that *Phos* 200 QDS was not holding. At this point of time there were 2 options. To go to *Phos* 1M or go to the constitutional. As the form of *Phos* had disappeared, *Kali-carb* 200 1P was given on 9/10 at 10 pm. After introduction of the constitutional, patient made a very rapid progress and temperature touched normal within 24 hrs and remained so for the next 24 hrs. On 11am there was one spike of 100 after which *Kali-c* 200 3 powders were given. Patient was kept under observation for 24 hrs after the fever touched normal. Patient was discharge on 12 and all his reports came normal.

LEARNING

1. *Phos* 200 QDS was fairly slow in its action. Probably going to 1M on day 2 or day 3 would have cut short the duration of acute disease.
2. *Phos*200 was continued even after the susceptibility stopped throwing indications for *Phos*- (Totality of signs and symptoms). The demand of the susceptibility was fulfilled by *Kali-carb*. If this force would have been given on 7th or 8th, it would have sped up the recovery process. ❑

The Evolving Totality

Mrs SS, 40 yrs, Muslim, came with her husband complaining of

1) Itching all over the body since last 2–3 years
Frequency: 2–3 episodes / day. Duration: 1-2 hrs

2) Fever since yesterday. Acute Fever Totality taken:
24/9/04: Fever with chills at 6 pm the previous evening.
Bodyache [2], Headache [2], Weakness [2]

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Mild, thin, white, watery coryza with sneezing. Had taken cold drinks the previous day.
THIRST: Decreased, APPETITE: Decreased.
SLEEP: Disturbed.
O/E T: 101.2 F. P: 100/min. BP: 110/80. RS/CVS: Clear. PA: NAD.

Pulsatilla 200 TDS for 3 days was prescribed on the following totality:

- A/F Cold drinks
- Fever < evening
- Thirstless heat during
- Extremities pain heat during
- Headache heat during

27/9/04: Partial amelioration in the generalities but since the fever was not localizing on any system, routine

investigations were ordered. No medicine was given.
28/9/07: Hb 10.9, TC 7,400, N 61, L 32, E 8, M 2.
MP: Not detected. Widal: O: 1:30, H: 1:60. [It was Day 5 of the fever and Widal may not come positive.]
Urine routine: Albumin: +++, RBC: Occ, Bact: +, Pus cells: 3 – 4.

Life Space

She has 3 sons and 2 daughters. Youngest son and daughter go to school and elder three are married. The eldest DIL stays with her and one grandson.
Basically shy and timid by nature and throughout the interview she insisted that her husband be called in the cabin.
Husband gave the information that she is very dependent on him. Never goes out anywhere alone. At home she will shout on family for small things but outside she would be very quiet. She is fearful and if husband would scold her right now she would faint.
She was very young when her father expired. Even today, cried while talking about him. Whenever anyone talks about her father she is not able to control her tears.
Relations with her brothers and sisters is good.

Physical Generals

Sleep: Good, awakes on slightest noise
Dreams: Does not remember
Cravings: Salty things [3], sour [2].
Aversion: Sweets [2], spicy [2].
Perspiration: Profuse all over the body.
Menstrual History: Early Menopause since 5–6 yrs. PMC: 2 – 4 / 30 regular
Obstretic History: H: G5 P5 L5 A0. (All FTND)
Thermals: C4H
O/E: Temp: 100.2 F. Pulse: 104 / min. BP: 100 / 70. RS / CVS: Clear. PA: NAD.

Chronic Totality

Dependent [3], will never go anywhere anytime, alone
Fearful of being scolded by others
Irritable at home
Thermals: C4H
Perspiration: Profuse all over the body
Craving: Salty things [3], sour [3]
Aversions: Sweets [2], spicy [2].
Has always been weak since beginning.

Remedy: *Calc-carb* 200 I dose given. (D/D *Calc-phos*)

Treatment

4/10/04: Fever with chills daily evening lasting throughout the evening.
Weakness [3], Giddiness [3], Bodyache [3]. Sleep: Disturbed. App: Decreased.
O/E: T: 99.8 F. P: 104 / m. BP: 100 / 64. RS / CVS: Clear. PA: NAD.
Patient did not respond to the constitutional remedy. So *Tuberculinum* 1M I dose was given
Indication: There was no fundamental tubercular miasm in this case. Neither was the totality of fever similar to the fever of *Tuberculinum*. (Ref – Materia Medica of Nosodes by Dr H C Allen. Chapter *Tuberculinum*. Page – 527.)
Then what were the indications on which *Tub-b* was prescribed?

- *Pulsatilla* did not act though it was covering the acute totality.
- The chronic constitutional remedy also did not act.
- Fever was not getting localized to any part or system and fever was persisting inspite of treatment.
- These type of fevers talk of peculiar susceptibility which shows lack of reaction to well indicated remedies and creates a state similar to Typhoid and Malaria which are Chronic fevers.
- *Tuberculinum* is a well indicated remedy in persistent fevers.
- When the best selected remedy fails and the case comes to a halt nosodes are indicated.

7/10/04: Within 24 hrs patient was better; fever dropped. No complaint of fever and chilliness. Weakness [3], No Body ache, No Giddiness. Itching continues.
Slept well last 2 nights. Appetite Improved.
O/E: T: 99 F. P: 96/m. BP: 90/70. RS / CVS: Clear. PA: NAD.
Case Was Reviewed: *Calc-phos* 200 I dose was given as the constitutional.
14/10/04: No fever and chilliness throughout this week. No other complaints.
Itching only 3 episodes, with reduced intensity. Over the next 1 mth this too reduced. Only few further doses required sporadically, of *Calc-phos* and *Tub-b*. ❑