

Microdoses Megaresults

Clinical Cases

Prof. Dr. Diwan Harish Chand

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*A selection from
50 years of Homoeopathic Practice*

Prof. Dr. Diwan Harish Chand

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Megaresults**

Clinical Cases

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*This work is dedicated to my patients
to whom I have dedicated my life's work
and
presented to the profession in the hope
that it will be absorbed into the growing
body of knowledge that constitutes the
tradition of the Medical System of Homoeopathy
not only for the Homoeopathic doctors of the
present time but also for the generations
yet unborn who will continue to embody
the teachings of Hahnemann in
the service of Humanity.*

Preface

The physician's high and only mission is the rapid, gentle and permanent restoration of health, to cure as it is termed.

— Extract of Aphorism 1 and 2 of *Organon of Medicine* by Samuel Hahnemann.

I always pray that this lofty therapeutic ideal of the Master be the motto in my work. A random selection of clinical cases from a practice of half a century is being presented in this book, "*Microdoses Megaresults*".

During this long period there has been opportunity of long follow up and of observing two, three and sometimes even four generations of a family. As the records have been kept meticulously, this gives an excellent feedback to observing the evolution of ailments, the effect of treatment, particularly in regard to a long term miasmatic study. This also applies to inherited tendencies when many members of a family and many generations in that family have been treated.

Case taking and the consequent methods of prescribing differ not only from person to person, but I have come to realise that they can also differ from country to country. The general level of education, social customs and the general national characteristics may also to a varying extent modify this. We are all taught and fully realise the great importance of what are loosely termed 'Mental Symptoms' but are more appropriately termed 'Symptoms of the Mind'. However, early in my practice I found difficulty in getting many such symptoitis from patients in India as compared to those of Europe and America. There is also a difference between the urban and rural folks, and between the highly educated and

those with very little or no education at all. Also between the affluent and the poor. If I may use one of my old expressions it is those that are highly educated, more likely urbanites, that are 'fed more on poetry than on porridge' that will have more symptoms of the mind. But in India, and iii general in all Asian societies, there has to be a considerable guess-work because by and large these societies lay great stress on puritan behaviour, ethics and high moral values. Therefore, the patients open up far less and do not disclose their satanic thoughts and behaviour, their history of STD and other misdeeds — past or present. This would be so even for young males but certainly far more for women, especially in the younger age group. Many of them hesitate even to give out some of the physical symptoms connected with menstruation and leucorrheal discharges. To ask them about their emotions, their moments of grief, disappointments of love etc. is almost impossible. These histories are thus in sharp contrast to the histories I get from American and most European patients.

Perhaps because of such variation in the problems and the life style in the developed countries, the histories have a plethora of symptoms of the mind. I sometimes get an impression that the homoeopaths in those countries are carried away too much by the symptoms of the "Upper Storey" as it were, and maybe rely excessively on the symptoms of the mind. It is to be remembered that particulars with well-marked modalities that conform to the definition of a complete symptom, i.e., location, sensation, modalities and what are termed accompanying symptoms, may rule out a number of poorly marked and weak generals.

Watching the practice of other senior homoeopaths and from my own experience I can confirm that the use

of such well qualified 'particulars' often leads to equally successful cures.

Many of the masters have expressed similar views and some of these are quoted below:

Boenninghausen, a favourite and most intimate disciple of Hahnemann, asserts that so much emphasis should not be given on mental symptoms as patients sometimes are not able to interpret their mental symptoms precisely, e.g. anxiety can be mistaken for fear or palpitation and so on. Also in a case of an unconscious patient or an infant it is not possible to collect mental symptoms associated with the particular complaint.

Of course, I think, in the case of an infant the observations of the mother and the physician can give some or many mental symptoms.

Also Dr. Constantine Hering advocated that three things should form the basis of prescribing, i.e., location, sensation and modalities, which is popularly known as Hering's three legged stool.

And more recently Dr. Elizabeth Wright Hubbard wrote that, "It behoves us, therefore, even the strictest Hahnemannians among us, to give the pathological symptoms their due".

My teacher Sir John Weir has written, "... later one appreciated the value of symptoms — the mentals and generals first, then the particulars, especially the peculiar and striking. If these latter are marked, they are almost of equal value to generals." (Brit. Horn. Jour. 1950, p. 223)

I have also some comments on important physical generals. In my early training at the London Homoeopathic Hospital I was told that Dr. Gibson Miller would use the temperature modality as an eliminating rubric.

In fact we were handed his own chart of "Hot and Cold Remedies". During the years of practice it was often felt that this modality was not as important as it was made out to be and if the other symptoms corresponded then this modality could be ignored. In fact, a feeling has grown that since as many of the provings have been done in colder countries, the chilly remedies are far too many and the hot remedies are comparatively much less. There is a preponderance of hot patients in the extra warm tropical and equatorial regions. Using this method becomes a handicap as it cuts out the remedy/remedies covering very well the rest of the symptoms including mentals.

It has always been held that medicine, specially homoeopathy, is both a science and an art and the success of the physician depends on a blend of the two. This is certainly very true of the holistic systems of treatment. As such, within the classical mould of the practice of homoeopathy some different methods may be used in evaluating the symptoms for prescribing. The cases presented portray some of these methods.

Some prescriptions have been based entirely on mentals and yet again sometimes only on particulars or even single peculiar symptoms; and rarely even on the background pathology. Some are based on the experience of my teachers, and on my own experience on partially proved and rarely used medicines.

This variance comes not because the teaching of the masters is unclear about the Evaluation and Grading of symptoms, it comes from contact with patients from all continents and many countries and similar contacts with colleagues from all over the world.

Success has been attained by the use of high potencies, medium potencies and even, on occasion, mother tinctures.

There are two ways of reporting clinical work — the statistical and the anecdotal. The holistic systems of treatment that have an individualistic approach obviously do not ideally render themselves to statistical analysis. When each patient is treated as an individual even though having the same nosological diagnosis, it can't be subjected to statistics in the usual way. At best it can be said that so many patients of such and such a disease were successfully - treated by a certain system of medicine. In keeping "with that background, the reporting in this compilation is of the anecdotal type.

I may herein also mention that the records have not been initially maintained separately for different disease conditions and not fully indexed in that manner. Therefore, barring some exceptions, no long series of a particular ailment has been attempted. Very often a case history has been dug up only when the patient or a relation or a friend of the patient has come subsequently and mentioned about the case who had been successfully treated sometimes 20, 30 or 40 years earlier and has been well since then. At times, the patient is suffering from a condition which was successfully treated in one of his relatives and that is the reason for his referral and the reason that prompts him to seek my treatment.

It is said that many homoeopaths have not left records of cases considering that one such example may not be applicable to another case of the same disease. This applies to Hahnemann himself and we have account of very few cases treated by him. However, during my travels through many countries where I lectured I found the audiences particularly receptive and even

enthusiastic to a detailed account of clinical cases that I had treated. Of course, in some of the international congresses this was taken as one of the themes of the Congress. I have even seen accusations in a college magazine that "... senior homoeopaths hide their experiences". Keeping that in view I have been encouraged to write on this subject. I think that such reporting has its great utility. It is inspiring to new entrants and gives them confidence and it also shows one's methodology.

I am also reminded of what Dr. Jacques Imberechts of Belgium once mentioned. He had made a special trip to Geneva to scan the clinical files of our old teacher, Dr. Pierre Schmidt with a view to see if he could retrieve his records and know his method of treatment which could inspire other homoeopaths. In his own words, he felt so disappointed and disgusted that he felt like "throwing all that junk into a waste paper basket". The reason is that Dr. Schmidt used small strips of paper to write the history as he recorded them in a kind of shorthand, which only he could decipher.

I find that many of the clinical cases reported in literature give only the outstanding features and the prescription. This is probably meant to save space and also the time of the reader. However, the cases in this book have been reported in great detail and exactly in the form in which histories were originally recorded and further follow up notes as and when the patient reported or communicated. This would thus give a precise sequential idea of how exactly the case was conducted and followed up.

The only thing which is not mentioned on every occasion is the use of the Placebo. The way the patients have been accustomed in this country, at least the very

vast majority of them, is to consider that they are having treatment only as long as they are using medicine. In the words of Norman Cousins, "It is the psychological umbilical cord that provides a nourishing and continuing connection between physician and patient." Surprisingly, even most of the homoeopathic doctors, when they are taking treatment for themselves, do not comprehend that they are under treatment unless they are taking something or the other on a regular basis. Perhaps the only differences may be that they may need Placebo less frequently. Most of them at the beginning say that: "Please don't give me Placebo. I only need the indicated remedy." This is also the main reason for the homoeopaths not making an open prescription. People have bypassed this problem in many ways. Some of them have a code, others have a number, some indicate by using an odd intervening potency, some use a remedial name that does not exist, etc. Of course, in India most of the homoeopaths have their own dispensing arrangement and so their dispenser understands the indication. Dr. P. Schmidt was using the last of the above-mentioned methods. I saw him writing names like Arsenine, Phosphorine, etc. The outside chemist would not have these medicines, so they will send for it from the pharmacy of his wife Mme. Dora Schmidt. She knew that where the name is ending with ine, there is no such medicine, and that Placebo was required to be dispensed. The homoeopaths are fully familiar about the use of placebo, it being an integral part of their prescribing. All through the text what has been repeatedly mentioned is *Saccharum lactis*. I must clarify that this is not the potentised *Saccharum lactis* mentioned in our materia medica. It is the plain unmedicated milk sugar in the form of powder or cane-sugar in the form of

globules or tablets. It has been designated differently by different homoeopaths or at different times. The terms Rubrum or Phytum or the abbreviation Sac-lac. all mean the same. When an open prescription has to be made and the dispensing pharmacy is also to be kept in the dark then special terms have been devised. Sometimes it is an odd potency mentioned against a remedy e.g., 35th potency.

Wherever I have not mentioned the full prescription in a chronic case, it would be the selected remedy in medium or high potency to be followed by Sac-lac. for 2 to 4 weeks or longer.

Many of the details of my pattern of practice are outlined in my comprehensive article on "Follow up of the Case" and part of it enlarged in another article "Different Clinical Strategies and Bases for Prescription" both of which appear in my book *"A Compendium of Lectures on Homoeopathy"*.

The clinical cases have been arranged in the standard homoeopathic schema of Hahnemann and as in Kent's *Final General Repertory*, starting with those where the predominant symptoms were connected with the Mind and ending with those conditions which figure in the Generalities or are of a miscellaneous nature, e.g. AIDS.

A homoeopath takes a composite multi-dimensional holistic psychosomatic view of every patient and as such the cases cannot be strictly compartmentalised either according to the section of the schema in the repertory or according to the diagnosis. In taking a total psychosomatic view, the patient can exhibit symptoms from different systems, so the cases have been classified arbitrarily in the section from which most of the symptoms were complained of or on the basis of the diagnosis.

Even though the listed headings are 148, the cases reported are well over 200. Those with the same diagnosis are grouped together under one heading.

Many of the clinical cases appear elsewhere in my writings, and to avoid duplication, are not being repeated here. In my book on *Homoeopathy in Geriatrics*, there are cases of C.V.A. and Stroke and Bell's Palsy in the section 'Neurological Disorders'; of Pulmonary Infarction; of Proclivitas; and cases of digestive disorders.

In my book '*Compendium of Lectures on Homoeopathy*', there are many clinical cases specially in the Therapeutic section, e.g. in papers on Warts, Jaundice, Heart, Rheumatism, Vaccinosis, Surgery, Peptic Ulcer and Value of Diagnosis to name some.

I like to draw attention to some infrequently used or rarely indicated remedies. Particular attention to these was drawn at the two congresses held at Athens, in 1976 and 1988. Some of the remedies are: Aethiops antimonialis (pp. 483, 501, 504, 505); Aurum muriaticum natronatum (p. 134); Serum Anguillar Ichthyotoxin (pp. 280, 297); Terebinthina (pp. 237, 246); Streptococin (p. 422); Histaminum (p. 346); Sulphurous acid (p. 337); Gambogia (p. 227); Paeonia (p. 230); Trillium pendulum (p. 318); Ornithogalum umbellatum (p. 164); Solar Eclipse Ray (pp. 482, 487).

At some places a reference page number is mentioned. Unless specifically clarified, it refers to Kent's Final General Repertory.

Practice in India is different from the practice in the occident. Not infrequently, the prescriptions are made on scanty information on the telephone or by a written note. Since everybody is not on telephone, therefore, it is not even possible to get clarifications directly from the

patient when a written short note is received. Yet, Homoeopathy can render very useful service. A perusal of the following will bear out this statement: Cases of Fever on pages 479-481 (3 cases); of Infantile Diarrhoea on pages 223-227 (3 cases); Postmenopausal Bleeding on page 320. There would certainly be many more as it is almost a daily routine to make a number of prescriptions on telephone, especially for acute ailments in patients already undergoing treatment for some chronic disease and for the numerous outstation patients.

The Oath of Hippocrates says:

"Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse), that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets."

According to Medical ethics a physician is honour-bound to keep the history of a patient secret and not reveal it even to those closest to him or her. It is customary therefore that when in the interest of science a clinical case has to be reported, only the initials are given. However in this text as where even that may be objectionable in certain cases, there the initials of the patient have been changed to fictitious ones to protect their identity. If in spite of all this precaution, somebody still discovers the patient, it may be appreciated that it is quite unintentional and the reason for publication is in the larger interest of science.

I am reminded of a monograph on breast cancer which traced the history through 3 generations to show that there was a hereditary effect. While a medical student was studying the subject he found the description tallied with the family of his fiancé and because of this knowledge he broke off the relationship.

In a few cases, a mention has been made that a certain remedy was noted in the margin. It is my usual practice that in the initial analysis, the remedy/remedies that appear fairly close to the one prescribed are noted in the margin for future consideration in case the one prescribed does not show the expected results.

Many abbreviations that are commonly used and some that have been coined by me appear in the text. These have been given in the List of Abbreviations which may be referred to in case of difficulty.

In most of the cases the month has been mentioned to avoid any confusion and the dates have been given in the American pattern. However, most people in India follow the English pattern with the date first, then the month. As the laboratory reports have been shown exactly as received, this has to be kept in mind. I particularly refer to the consolidated reports in the cases pertaining to the urinary system and some hospital reports.

I will conclude in the words of Hippocrates "*Life is short, art is long, the occasion fleeting, experience deceitful and judgement difficult*". Complete pictures are difficult to make, but a smattering from a random selection from my clinical work is humbly presented to the profession and to posterity.

February 7, 1995

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List of Abbreviations

±	Symptom slightly marked
+	Symptom definitely present
+ +	Symptom strongly marked
A.C.	Before meal (ante ci'bum)
A.I.I.M.S.	All India Institute of Medical Sciences, New Delhi
Adv.	Advised
Agg. or Aggrav. or <	'Aggravation
Alt. day	Alternate day
Amel. or >	Amelioration
B	Basophils
B.D.	Twice daily
B.H.	Background History
B.O.R.	Bowels open regularly
B.P.	Blood Pressure
B.P.H. or B.H.P.	Benign Prostate Hypertrophy
B.R.B.	Bright red blood
S.O.M.	Suppurative otitis media
B/L	Bilateral
C.C.F. or C.H.F.	Congestive Cardiac (Heart) Failure
C.S.	Caesarean Section
C.V.A.	Cerebro-vascular accident
C.V.S.	Cardio-vascular system
C/S	Culture & Sensitivity
D&C	Dilatation and curretage
D.M.	Diabetes mellitus
D.T.R.	Deep Tendon Reflexes
D/D	Differential Diagnosis
DHL	Name of a Courier Service

Diag.	Diagnosis
A	Diagnosis
D.L.C.	Differential Leucocyte Count
E	Eosinophils
E.C.G. or EKG	Electrocardiogram
E.H. or E. Hist.	Entamoeba histolytica
E.N.T.	Ear, Nose, Throat
E.R.C.P.	Endoscopic Retrograde Cholangiopancreatography
Exam.	Examination
F.H.	Family History
F.N.A.C.	Fine Needle Aspiration Cytology
F.T.	Full Term
F.W.	Family Welfare
G.I.	Gastro-intestinal
Gran.	Granular casts in urine
HIV	Human immuno-deficiency syndrome
H.P.	Histopathology
H.P.F.	High Power Field
H/O	History of
I.H.D.	Ischaemic Heart Disease
I.M.	Intramuscular (injection)
I.S.Q.	No change (in statu quo): in the former state
IV.	Intra-venous
L	Lymphocytes
L.I.F.	Left Iliac Fossa
L.L.	Lower limbs
M	Monocytes
M.B.	Much better
M.I.	Myocardial Infarction

M.M.B.	Much much better
M.P.	Menstrual or Monthly Period
M.R.I.	Magnetic resonance imaging
M.V.A.	Motor Vehicle Accident
N.	Normal or Neutrophils
N.A.D.	Nothing Abnormal Detected
N.D.	Normal Delivery
N.M.R.	Nuclear magnetic resonance
O.A.	Osteoarthritis
O.A.N.	Osteo arthritic nosode
O.D.	Once daily
O.D.H.	Oro-dental Hygiene
O.E.	On Examination
P	Pulse or Polymorphs
P & N	Polymorphonuclear neutrophils
P.C.	After meals (post ci'bum)
P.G.I.	Post-Graduate Institute, Chandigarh & Lucknow
P.I.	Past Illnesses
P.O.P.	Plaster of Paris
P.R.	Per Rectum
P/C	Present Complaints
PMT	Pre-menstrual Tension
Prot.	Protein
Q.	Mother tincture
Q.i.d.	Four times daily
R.B.C.	Red Blood Cells (Erythrocytes)
R.I.F.	Right Iliac Fossa
R/O	Rule Out
R U Q	Right upper quadrant of abdomen
R.V.	Retroverted uterus

S.O.L.	Space Occupying Lesion
Sac-lac or S.L. or Phytum or Rubrum	Saccharum Lactis (Placebo)
SWD	Short wave diathermy
T & D.L.C.	Total & Differential Leucocyte Count
T.B.	Tuberculosis
T.I.D. or t.d.s.	Three times daily
T.U.R.	Trans-Urethral Resection
U.D.C.	Upper division clerk
U.E.	Urine examination
U.G.I.	Upper Gastro-intestinal
U.T.I.	Urinary Tract Infection
V.E.R.	Visual evoked responses
V.M.B.	Very much better
W.N.L.	Within Normal Limits

OBSESSIVE COMPULSIVE NEUROSIS*

Dr. B.B., age 22 years, not married, a medical doctor doing his Internship, consulted me on June 18, 1986. His father is an Allopathic (Orthodox) doctor but has considerable interest in Homoeopathy. He has an elder brother, who is an Associate Professor in a medical college. So it is a family of doctors. It is an unusual case and he mostly presented symptoms of the mind.

The case needs to be viewed in the ethos of the cultural background of India, which carries a tradition of emphasis on maintaining celibacy and virginity before marriage and poor meeting facilities between adult boys and girls especially in rural areas. Marriages are mostly arranged by the elders of the family.

Dr. B.B. had cherished a silent love affair with a family acquaintance, Miss. K., which he never expressed to her or the family and as no one was aware this girl happened to have got married to his elder brother. Thereafter he developed a tendency to collect pieces of paper, paper chits, even wrappers of soap, paper or plastic bags and other odds and ends that he saw lying here and there. The papers were collected mostly with the thought that the girl may have written something on it for him. Similarly he would read letters 2-3 times to see if she wrote something for him.

Later parents introduced him to another girl Miss M. who also studies in the same town. He is permitted to go and see her in her hostel. He would collect those entry chits. Keeps checking his pockets so that no letter or chit connected with her may be lost. Collects all things con-

* Paper presented at the 46th Congress of L.M.H.I. held at Cologne (Germany), May, 1991.

nected with the girl. Seems to have got over his first silent love affair after meeting the second girl. On reading one of her letters which had mention of names of some boys connected with her elder sister he has started doubting that she may also be having affairs — become *suspicious*. Is very possessive. Wants to reconfirm so asks again and again about those boys. However all his acts and thoughts revolve around that girl.

In addition he has a great fear of infection for the previous one year. One consequence of this fear is frequent washing of hands. When it was bad it was 20 to 22 times a day. At present about 10 times. In order to remain clean avoids going to hospital and examining patients. More worried about transfer of infection to those that are dear to him — parents, girl friend or fiancé. Keeps debating in his mind frequently whether to wash hands or not.

Anger + +, from any contradiction or any delay in carrying out his wishes. Fears spiders. No other fears.

Previously liked company. Now avoids as they may not notice his abnormality. > consolation. > By being explained by parents.

Hides his condition from others.

Allergy to dust — 5 years — sneezings.

Appetite has been more for previous 6 months. Vegetarian but takes eggs. Teetotaller. Likes sweets, takes extra salt, which is added at times without tasting food. B.O.R.

Sleep has increased. It is like an escapism. He talks in his sleep regarding his studies. Covers ears on going to sleep. Dreams are of all types and mostly not remembered.

Had been vaccinated for small pox 4-5 times in childhood.

He is a hpt patient.

Had been given much Calcium in childhood. For his frequent diarrhoea he received Tetracycline often and as a result has stained teeth. Probably desires some movement of air because even in winter (minimum room temp, at night under 10°C) would like a slow fan even though would cover himself with a quilt.

Past Illnesses: P.U.O. for a few months. Temperature 99 to 99.5°F (37.2 to 37.5°C) This was 4 years earlier. Three years ago he got Urinary Tract Infection. It cleared with *Pulsatilla*. As an infant he had urticaria from ?mosquito bites.

Family History: No diabetes, T.B., Asthma. Father has allergic rhinitis. Mother has Neurosis with washing mania. Grand-mothers (paternal and maternal) had Cancer.

As he was from another city, all further treatment was by way of reports in letters that I received. To give a detailed account I may also here mention that at the time of consultation his father brought his case notes and an account of some homoeopathic treatment which had been given to him.

These are put in the annexure.

1986

My first prescription on **June 19, 1986** was *Lueticum* 200/3 powders at 15 minutes interval.

I received a letter from the father dated **July 30, 1986**: "My son intimates improvement." Then I got a letter dated **August 8, 1986** directly from the patient "I am feeling definitely better." Then he detailed the different symptoms.

1. "Acts of hand washing have considerably decreased. At present it is 5 times a day which I think is normal." The fear of infection and the

anxiety he would have when h& saw anybody urinating, coughing or spitting reduced.

2. "Checking pieces of papers etc. it has also decreased. . . . previously I avoided sweeper sweeping my room thinking something important would be lost in this way, now-a-days I let him sweep the room ..."
"Previously I avoided the opening of the window thinking some papers etc. might get lost (though the window has a wire net still I used to avoid to open it). Now-a-days I keep it open."
3. Doubting my girl friend: "The thought that I must trust her is definitely coming with more force now..."
4. My relation with my girl friend: "It has definitely improved."
5. General condition: "I am more confident now, I am happier and enjoy things more . . . I think there is about 50% improvement." He was sent *Placebo* for one month. Letter dated September 8: "Feeling better. Washing almost normal. Overall 60-70% improvement."

Next report was by letter dated October 16: "For last one month the condition seems stationary and-there is no further improvement. Total improvement still about 70% as it was one month back."

He repeated all the symptoms mentioned above in a detailed report. It seems that the two outstanding features were "suspicious" and "fear of infection." These appear in Kent's Final General Repertory on Page 85 and 45 respectively. He mentioned of a "Fear of transferring other's semen to my girl friend." This was repeated in detail in letter dated February 5, 1987 vide infra.

1986

On **October 20** keeping these in mind he was prescribed *Lachesis* 200/3 powders at 15 minutes interval.

Letter dated **December 10:**

1. Checking — less frequency.
2. Washing — no abnormal washing, fear of contamination decreased.
3. "Relations with my girl friend: I trust her slightly more."
4. Fear of getting infection when examining patients is almost the same.
5. Fear of transferring others semen/sperms to my girl friend — this fear has decreased.

He was sent Placebo for one month on December 18, 1986.

1987

Letter dated **January 4** from the father whom he visited. ". . . he has improvement almost to normal, the only thing to note that he takes too much time in deciding and often he is not able to decide . . . he says absurd ideas of suspicions and illusions of chits of papers and letters do come in his mind, but he can control now, there is no compulsion. Apparently he is normal."

Letter dated **February 5** from the patient. This was a long letter of 7 pages. Although he wrote that the condition is same or slightly better, going through the letter left an impression that there was atleast no further improvement. One of his fears he explained in detail and I repeat in his own words:

"Fear of transferring someone's sperms to my girl friend: This fear has decreased. But I still feel that there is a possibility that this can happen. Suppose I touch someone's undergarments and then I touch my girl

friend and then she touches her pelvic parts then there is some possibility of her becoming pregnant, because there is a possibility that live sperms were present on the undergarments.

There is no fear that I will transfer my sperms to her (because I shall marry her in future). The fear of transferring someone's sperms to her disturbs me."

1987

February 9: Prescription *Lachesis* 200/3 powders at 15 minutes interval.

Letter dated **March 10:** "The symptoms are almost the same."

Prescription: *Lachesis* 10M/3 powders at 15 minutes interval.

Letter dated **April 20:** This was again a detailed letter extending to 9 pages. In brief all the symptoms were reduced and he was feeling better.

Prescription: *Placebo*.

At the end of June he wrote "I cannot say whether or not there is any further improvement, if there is improvement, it is slight."

On **July 3:** He was again sent *Lachesis* 10M/3 powders at 15 minutes interval.

In **August** he was sent *Placebo*.

Lachesis 10M was repeated on **October 6.**

In **November** he wrote that "there have been some fluctuations in my conditions. The condition is almost the same." I was considering to give him *Lachesis* 50M. However, since that was not available and the condition was fluctuating so we decided to wait for another month and sent him more *Placebo*.

1988

Letter dated **January 6:** "The main problem that worries me now-a-days is doubting my girl friend. Other symptoms are within control and don't disturb much . .. overall the condition is almost the same as when I wrote last."

January 9: *Lachesis* 10M/3 powders at 15 minutes interval.?

Letter dated **February 28:** "This month has been very nice. The frequency and intensity of doubts have been very much less and I am happy."

Sent *Placebo* through March and April.

Letter dated **April 18:** He again repeated that "this period has been very nice . .. We are happy now-a-days and seriously considering marriage within a few months. We are so indebted to you that we cannot express in words. Without your help, we would h[^]ve separated by now. Words fail me to express my gratitude for all you have done for us."

His last report as regards his ailments is dated **June 5.** For some doubts and lingering suspicion, the last medication sent was on **June 11,** again *Lachesis* 10M/3 powders at 15 minutes interval. Thereafter I received some communications from him and greeting cards for festivals and he always mentions of being quite normal, pursuing his work actively, having harmonious relations with his fiance and repeatedly expressing gratitude for the treatment he had received.

ANNEXURE
PREVIOUS CASE NOTES AND TREATMENT

From summer 1984: Symptoms

1. Collects letters, papers, chits, covers of soaps, containers of tooth paste, paper bags, waste fruits etc. and keeps them carefully so that something may not be lost.
2. Thinks that the girl he loved, Miss K. might have written him letter. So he searches- letters very carefully. Does not allow sweeping.
3. Anxiety and nervousness.
4. Change of mood rapidly (Depressed, Anger — cheerful).
5. Amative — likes to be tip top and to talk to girls.
6. Frowning of forehead.

Symptoms selected for Repertorisation in Kent and Phatak.

1. Thought persisting
2. Impulses (compulsion) does crazy foolish, childish silly action.
3. Illusion of something important (chits).
4. Trifles seem important (Phatak)
5. Fear
6. Frowning of forehead
7. > Sympathy (consolation)
8. Changing mood
9. Amative
10. Imagines he is sick

Result of Repertorisation

Stramonium — 17

Ignatiaamara — 15

Hyoscyamus niger — 14

Prescription — *Stramonium* 200

Stramonium IM
Stramonium CM

Result: much relieved.

Summer 1986: Symptoms

1. Thinks that his hands and body have become dirty by touch of patients, other persons' hands, droplets from coughing etc. So he washes with soap and water repeatedly and carefully.
2. Thinks that his girl friend, Miss M. might have written him letter, chit etc.
3. Miss M. may be friendly with other males.
4. Contradiction intolerant — Irritability, quarrels, cursing.
5. Rags seem important — collects chits, letters, papers.
6. Avoids company so that they may not know his weakness.
7. Suicidal talk (a few times).
8. Averse to work, study
9. > sleep
10. Weeps by sympathy, consolation.
11. > consolation
12. Despair
13. Anxiety
14. Fears
15. Pride
16. Cautious to hide his habit of washing.

Symptoms selected for Repertorisation

Suspicion
Pride (haughty)
Fear
Weeping
Contradiction intolerant

Despair
Trifles seem important
Love disappointment
Thought persisting
Anxiety
Suicidal
Talks in sleep
Wife unfaithful
> Sleep
Rags seem important
Averse to work

Result of Repertorisation

Ignatia amara 30
Pulsatilla nigricans 32
Sulphur 26

April-June 1986

No response to —
Stramonium IM, CM
Ignatia amara 200
Natrum muriaticum 200
Nux vomica 200
Sulphur 200
Carcinosin (3 doses)
Curare IM (3 doses)

My comment is that in the anamnesis an attempt was made to cover a large number of symptoms, many of them possibly not marked or of no importance, leading to many hours of laborious repertorisation. What is needed is a deeper perception and interpretation of symptoms and their evaluation. In the words of my teacher, *Sir John Weir*: "What you need is **minimum symptoms of maximum importance.**"

OBSESSION

In July 1980, I received a letter from someone, who had witnessed a remarkable cure through Homoeopathy in her family. The relevant part is reproduced.

". . . Friend, C.N., 50 years; her own notes included in which (like Emmy) she mentions nothing of the source of an almost lifelong torment, at least since the age of puberty, a lack of breasts. She is flat chested. I know that you will understand when I tell you that I have seldom encountered such a tortured person. She constantly dreams of losing her padded bra and cries bitterly in her dreams, (underlining mine) You will also get an idea of the subterfuges to which she has to resort if I tell you that she thinks her husband probably doesn't know that she wears a padded bra, though this boggles the imagination.

However what I want to know is do you consider this inside the realm of your competence? You must have met with innumerable and various vagaries of the human psyche and know that they can be worse and more constant than an occasional migraine, and cause more suffering. Do you want to send her anything? If you can do nothing without speaking to her will you keep her address and contact her before you go to Calcutta. She's never spoken to a man about her problem and as far as I can make out not to more than two women. Even speaking would help her ..."

Enclosed with this letter was a history written by the patient herself. This is reproduced. It would be noticed that she makes no mention of the complaint which is her biggest torture.

Mother of 3 children: Girl — 29 years; Boy — 26 years; Boy — 17 years.

Father died of heart attack aged 88 years. Mother alive. 5 sisters. 2 brothers.

Childhood and early years of marriage: Rheumatic pains all limbs, acute. Continued till after marriage (age 20 years). After first child's birth had an attack of Sciatica in right leg.

Spongy, soft gums.

First pregnancy time acute constipation.

Second child's birth put on lot of weight. Lost it after a year or so — Backache started from then onwards, continued for many years.

Digestive system: Hyperacidity, belching and wind for many years.

Spondylitis: Affecting neck, shoulders, arms, hands and fingers — more on the right side.

Change of life: Menopause at the age of 36/37 — very sudden due to a family shock resulting in deep pigmentation over arms and neck.

Always a Homoeopathic patient since the age of 14 or so.

Like sweets. Winter coldness. Covering feet and legs during sleep.

Varicose veins — since the age of 8 years.

In my reply I wrote:

"As for Mrs. C.N., she has given in her history more the background rather than the present problems. As such a detailed history is needed and of course, the best is to see her once at the beginning of the treatment. This even more so to study about what we loosely call 'symptoms of the mind'

Mrs. C.N., of whom I had received some details earlier, was seen on September 21, 1980. I was visiting Calcutta for a meeting and took the opportunity of talking to her personally. She repeated the background history:

- (i) Sciatica: After first child 30 years ago. Was confined to bed for one month. Later occasional strain on that side — right.
- (ii) Varicose Veins for past 9 years. Ascribes it to being in a very large house and much standing.
- (iii) Backache: Small of back — 26 years ago, after the second child. It got better by physiotherapy. Is keeping up the exercises.
- (iv) Cervical spondylitis: Now it is mild, but had much trouble for 10-12 years and had all kinds of treatment including acupuncture. Finally only exercise helped.
- (v) Pyorrhoea: Gums spongy from childhood. With care the pyorrhoea is under reasonable control.
- (vi) Vision affected: Using glasses for last 3 years (Presbyopia).

M.P.: Menopause early 36-37 years age, after sudden shock. Did not divulge the nature of the shock. Had flushes for 2-3 years. Before the menopause, menses were regular. Initially had dysmenorrhoea, but it gradually got better after she had children. Never suffered from leucorrhoea.

She feels that her complexion has gone darker after menopause — face, arms and nape of neck (Mostly exposed parts).

Appetite: Good. Non-vegetarian. Very fond of sweets. Previously much gas and acidity. Now takes small frequent meals and is feeling better. Cold things disagree — lead to* more gas. Also aerated drinks.
B.O.R.

Sleep: Good. Though now needs only a few hours sleep. Dreams about people and about activity. Did not mention about her tormenting dreams and as I had been warned, I did **ootpitss on that point.**

Vaccination: Not for last 12-15 years. Previously yearly. No strong reactions to heat and cold — stands both well. Only feels cold on feet and covers feet and legs. Swelling feet by the evening, if much standing or exertion. Prone to palpitations. Been told she has small tumours in uterus. Falling hair.

Mentals: Irritable + +. Quick and short tempered. No patience. Fear dark. No fear thunder. Not fond of company. Prefers alone. Keeps worries to herself. Says she is not a big worrier.

P.I.: Typhoid at age 14 years. Operated for R.V. Uterus between second and third child.

F.H.: Father Diabetes. Sister Epilepsy.

1980

October 2: Sent *Natrum muriaticum* 6x,30,200/1 powder of each to be taken on 3 consecutive days at bedtime.

1981

January 10: Reported "Breasts — little stirring at times but no difference in dimensions".

Natrum muriaticum 200/1 powder at bedtime.

I got no further report from her but on **September 6**, 1981 I had a chance meeting with her friend who had referred her to me and she very excitedly informed me that Mrs. C.N., had ceased to have those dreams which had been tormenting her all her life.

SENILE DEMENTIA/ ALZHEIMER'S DISEASE

Mrs. R.T., age about 88 years was seen on July 25, 1987. She had been confined to the room for the previous four years and confined to bed for the previous two years because of pain in the knees and because she was generally immobile. She had Parkinson's Disease for 8 years but had not had any medication for this, 10 days earlier she had fever following an I.V. drip. This became necessary because she was very agitated and not taking any water and, therefore, had passed no urine for 20 hours. For the fever she had been administered Crocin. There was a history of a very bad constipation for one year. Bowels would move once in 7 to 8 days and the stool was very hard. She wished to go to the toilet but when sat on commode she would become agitated and restless and wanted to be taken back to bed. She had stopped eating for the previous 4 months and that made constipation worse. Her vision and hearing was alright but she was completely confused. She did not recognise her daughter or son. When her daughter came to visit her she said "Who are you?" The daughter answered "I am Meera." And then the patient said "Who is Meera?" Mistook her son for a brother who had died some years ago. Most of the time she is shouting loudly (heard in the neighbourhood) "Where am I?; Where should I go?; someone is coming to meet me; many people are coming to meet; have mercy." Would often say, "I have discomfort" (in Hindi 'Paresani'). Shrieks in sleep also. The shouting goes on throughout day and night. Mild tranquillisers don't work and stronger ones keep her completely drugged, so stopped. The extent of disorientation can be seen from the fact

that at times touches one hand with the other and asks "What is this?" Very occasionally asks for water but never asks for food. Altogether the sleep is fair as she sleeps every two hours or so for sometime. Desires company all the time, mostly asked for her attendant maid who has been there for the previous 15 years. Wants someone to talk to her constantly.

Hot patient; perspiration more than average.

Past Illnesses: Typhoid in 1958, H/O skin eruption on waist line, where she was tying the petticoat, ?fungus. Some 10 years ago she had been accidentally knocked down by a car. Although she had only some bruises but thereafter she stopped going for walks. Six months earlier she had been given *Kali phosphoricum* and *Natrum phosphoricum* and it calmed her for sometime but was now ineffective.

1987

July 25: Prescription: *Baryta carbonica* 200/9 powders t.i.d.

The report a few days later was that it had calmed her slightly for some days but on **August 3, 1987** was again quite agitated and shouting. Repeated *Baryta carbonica* 200/3 powders every four hours. The result was unexpected. She became more quite and even somewhat rational and showed better recognition of her children.

She continued on *Saccharum lactis* till there was a tendency to slip-back and *Baryta carbonica* was repeated on **September 18**. The note that I received mentioned that she is taking reasonable amount of nourishment. She responded again and needed a repeat only on **January 4, 1988*** after 3½ months. During this period she had an occasional relapse of shouting but only for a few minutes when she was unattended and there was no one in that room. Her mental state continued to be

normal or fair right till the end but because of her other problems and difficult nursing she developed bedsores. For this she got *Lachesis* 30/9 powders t.i.d. on **February 5, 1988**. Subsequently there was some sepsis and fever and she received *Pyrogenium* 30/10 powders every 4 to 6 hours.

1988

The last report on February 20 was that she is feeling better and the temperature was normal.

I learnt later that for some other complications, possibly a chest congestion an Allopath was consulted and she passed away in March 1988.

FEARS - ANTICIPATION ETC.

Mr. M.G. was first seen on June 14, 1960. It is a long history as he consulted from time to time for apparently different complaints and there is thus a follow up for 32 years.

At first consultation in June 1960, he was aged 35 years. He had been married for 17 years with 3 living children, eldest 11 and youngest about 2 years. One child had died at 15 months age due to cholera infantum and dehydration; one M.T.P. He was having a flourishing business but was so greatly interested in Homoeopathy that he even attended lectures and had a fair number of books.

Complaints: He started his history from 1952 when he had a 'crick' or sprain in the back. He was lifting something and there was sudden pain and he was fixed in that position. He received Irgapyrin injections. There

formed a lump at the site of the injection for which he was given Infrared exposures and did much fomentation. It took six months to "melt". Ever since then the pain has not been completely wiped out or at least the area has retained some tendency to pain and the slightest provocation like cold breeze or a little extra exertion causes a recurrence. " < coition, specially if frequency is more than once a week."

Lethargy, no desire to work, no go, no energy, procrastination and postponing tendency for 6 months. Previously very active.

Asthmatic tendency — cough, wheezing and dyspnoea. First attack in 1956. In 1958 he feels an attack was precipitated by some trouble in business which he felt very much. He had been investigated at Patel Chest Institute, 1958-59 and found to be allergic to many things. He had suffered from allergic rhinitis since childhood. Would get "Hundreds of sneezes, iliese would be initially in the morning but some days when severe, it may continue for the day or even for a number of days. Tendency to < rainy season < sea-side. Allergy to peanuts — feels a pin pricking on eating it,*

Skin eruption on right leg for previous 4 years. Itching < evening. Slight scales fall off on scratching, no oozing any time. Sometimes scratches to bleeding. In winter scaling of skin of palms. Then sometimes itchy feeling and small reddish areas. Prickling sensation standing in sun in winter. Itching in ears. Numbness right heel on lying where the heel touches the bed — 3 weeks. Crusts in nostrils, so in the habit of boring nose.

Hair falling and got a little thin on top. Tendency to baldness in the family.

Was over-weight, exercise did not help, then took a popular antiobesity proprietary preparation, Formode,

four times the usual dose in order to reduce quickly. This did not help and in fact created new troubles. He started to have frequent stools though not loose.

Appetite — Good. Non-vegetarian, likes sweets and meat. Earlier liked eggs, now has aversion.

B.O.R. — 4 or 5 times daily but normal character.

Vaccination — 6 or 7 times.

Chilly patient.

Mind — Lethargy has been mentioned above. In morning wakes up feeling very tired. No aptitude to do anything and feels restless. Can't even lie down. Sometimes very irritable in the morning, flares up at the slightest provocation. He felt it is possible that because he is at home at that time. On holiday it may be throughout the day. Unless appeased his outburst will be followed by silence and sort of sulking which weighs on his mind and tires him. "Four months ago on a trifle, it was so much anger that I repeatedly had suicidal thoughts."

P.I. — In childhood Pneumonia and Typhoid. Discharge both ears. 1941-42 severe urticaria. Had allopathic treatment which relieved. 1944 appendectomy. Itching especially genitals without eruption 1951.1952 Ringworm in groins and buttocks. Used some ointments. 1956 Renal colic right side. Took Homoeopathic treatment and passed 3 or 4 calculi. Pulse intermittent and palpitation in winter of 1959-60.

F.H. — Father, one sister and one brother asthmatic. One brother diabetes and fistula.

1960

June: Few doses of *Nux vomica* 30 and after some days *Dioscorea villosa* 30 relieved him of his backache.

July 4: On this date he gave a very good new symptom — fear looking down even from moderate

heights. Also giddiness looking at running water but no fear.

Argentum nitricum 200/1 powder.

1960

July 14: Feels depressed in the evening — feels useless and also tired. (? due to fatigue). In morning lethargic. Hungry after lunch within half an hour and craving for sweets and spicy things.

Feels in two minds — one wants to take revenge from persons who have cheated him and wants them to be harmed by some calamity and the second voice says to forgive them and God is great and will take account. A tussle goes on for some time and ultimately feels guilty as to why such bad intentions arose in his mind. The slightest physical trouble as slight heaviness, etc. make him depressed and feeling useless and when he is well he is quite cheerful and at peace with circumstances.

At the end of July he had an asthmatic attack which cleared in one day with a single dose of *Natrum sulphuricum* 200.

August 10: Last evening felt "as if semi-mad." First of all he missed his way while coming to my clinic. Said he had been using wrong words — if wanted a glass of water said, "give me a cup", then said "give me my shoe."

August 11: Yesterday while driving thought came to his mind that his son has died and he must go home immediately. Today during afternoon siesta dreamt of falling from mountain. However, such a dream is not repeated. On lying down slow pulse with anxiety heart, so got up and moved about. Great weakness and low feeling. Can't stand. Frequent urination.

Gelkemia sempervirens 200/1 powder.

1960

August 14: After last medicine no dreams and pulse has been normal.

1961

May 23: Called me up in the night and again early morning. Fearfulness —. "I am going to Simla, I may get some trouble there." It seemed all an anticipation fear.

Gelsemium sempervirens 200/3 powders on the same day.

b} July he was noticed to have some extrasystoles for which I gave him much assurance that it may have no significance.

Gelsemium sempervirens 200 was repeated again on **August 8.**

1967

June 29: He reported again after 6 years. Now his main complaint was frequent attacks of migraine. Mostly right sided hemicrania, rarely right to left < after long sitting in air-conditioned room. This may bring on the attack or aggravate it < jar. Pain throbbing. Hands and feet get cold. Nausea. Vomit tends to aggravate the pain in an hour or so. Previously a visual vertigo ("shaking of vision") for 8-24 hours before attack/This vertigo would be completely relieved if he has a complete diversion of mind. Later blurring vision during attack. Has vertigo with feeling he will fall to the right. Sometimes numb feeling right side face, at times formication, at times foul smell right nostril.

Flatulence. Can't stand rich food. Has been diagnosed as Chronic Amoebiasis. Stool report showed Cysts of E.H. and Giardia. Load on stomach or distention feeling after eating for one or two hours. > lying on abdomen. Rumbling and flatus + +. Gases give a sense

of something jumping in the abdomen. Pessimistic thinking. Can't go in a closed lift. The idea that a door is closed from outside will immediately give a sense of suffocation. Therefore, is avoiding air travel also. Fear of disease, especially heart disease. Fond of relating symptoms. Emotional factors upset — any quarrel with anybody.

A peculiar unsteadiness at times. Mostly felt in walking but even if he continues to walk it can clear, up. Lasts upto 5 minutes. Sitting for a while >. Blowing nose >. Occasionally feels nodes under the skin with fever, the onset of which is with chills and rigor. They may be anywhere on the body "and mostly occur in spring. Rheumatic pains in muscles in change of weather, especially in legs and the heels.

Stiffness in neck. Allergic tendency in August — September. Indiscretion in eating (chillies, black pepper and cloves) especially leads to sneezing. Going out of an air-conditioned room after long sitting gives a slight wheeze, also from packing grass. Allergy to dust + +. *Aralia racemosa* always helps him in this condition. Sometimes migraine the day after coition, especially if indulgence is frequent. Desires sweets but they disagree. Likes everything cold in all seasons — chapati (fresh leavened bread), tea, etc., everything cool or lukewarm.

Lethargy after eating and drowsiness for 1 or 2 hours. Sinking when hungry.

His complaints are mostly morning to evening. Is usually okay in the night. Has palpable glands in right supraclavicular region. Occasional tenderness. At one time his E.S.R. was 125 mm. Three days prior to this test he had taken *Tuberculinum* 200. Then had temperature 99-100°F. Was advised Streptomycin injections but he did not take. After one month E.S.R. dropped to 12 mm.

B.P. 124/88.

1967

July 1: *Argentum nitricum* 200/2 powders at 15 minutes interval.

July 22: Vertigo like intoxication. Funny notions about the body — the eye has got smaller, etc. Numb feeling in head. General uneasiness and feeling of anxiety and slight nausea. Sensation of water trickling on face Any emotional disturbance (controversy, anger, any contradiction) immediately affects the head — a hollowness and wavy feeling on the right side. Dejected, sad, self-pity to the extent of getting fearful. Hopelessness of recovery.

Tuberculinum 200/1 powder.

August 9: Some days after receiving *Tuberculinum* he took on his own *Nux vomica* 200.1 have no notes of this date except that he was prescribed *Gelsemium semper-virens* 200/2 powders at 1 hour interval.

1972

Mr. M.G., now age 45 years again comes for consultation on June 20, 1972. Migraine has been his old complaint. It has been more troublesome in the previous two years. In the interim period before consulting me he had done some self-medication. For low grade pyrexia with occasional shivering and high fever he used *Pyrogenium* and was relieved of it. Then he started to have pain in the abdomen which would start on waking and last whole day and disappear before bedtime. There had been history of Amoebiasis. Took repeated doses of *Morgan* 30 for 4 days. There was no immediate effect but was relieved after 2-3 weeks.

The headaches are right sided. Start in the neck and settle in the right eye. Start soon after waking and

remain till evening, rarely till bedtime. Start suddenly or gradually. There is nausea and giddiness. At one time it was daily, then took *Kali bichromicum* 200 and it became less frequent. Only occasionally it occurs on the left side. The physicians have given different opinions regarding its cause — Cervical Spondylosis, Sinusitis and Allergy. X-Ray P.N.S. showed thickened and hazy mucosa of maxillary sinuses. Has used *Sanguinaria canadensis* 200 and 30 and *Iris versicolor*. These helped very briefly. Also used *Lycopodium*, *Belladonna*, *Glonoinum* and *Kali carbonicum*. *Silica* 30 in repeated doses gave no relief. All this medication he had done on his own or on someone's advice but were not my prescriptions.

?

His other new complaint was pain in knees in ascending and descending stairs. Pain in neck on turning head to right, less on turning to left.

The sneezes have stopped. Now he gets crusts in nose. Any excitement gives congestion in the head leading to anxiety. Claustrophobia in a lift (elevator) because it is closed and he can't go out. Not the same fear in a small room because he knows he can escape by breaking glass. Previously had this fear in cinema hall also. Fear high places on looking down. During headache fear even in crossing the street.

>

1972

August 2: *Ranunculus bulbosus* 200/3 powders at 10 minutes interval.

1979

Consulted again on June 19, 1979. Now age 52 years. Two years ago noticed sudden swelling of right knee. No appreciable pain. Orthopedist put it as Synovitis and advised exercises. Had slight stiffness in the morning. Took *Rhus toxicodendron*. No amelioration. Exercises made

?

no difference. Four months ago pain and swelling increased. Had two courses of S.W.D. Used Tenderil for 5 days and also analgesics as Novalgin and Proxyvon.

Can't lie straight in bed. By full extension of knee feels a stiffness after a while and some pull posteriorly as in the sciatic nerve. Specialist has given the opinion that it is a thickened ligament and the only thing possible now is an operation.

1979

June 19: *Ruta graveolens* 6, 30, 200/1 powder of each on 3 consecutive nights at bed time.

July 3: Better. The stiffness and pull of stretching leg is now after longer period. However, the swelling is still there.

Ruta graveolens 200/3 powders at half hourly interval.

That settled the knee problem. Operation was avoided. No further medication was needed. No recurrence till February, 1992 when he was last seen.

1989

On June, 1989 I was suddenly awakened from a short siesta and I found my friend and previous patient at my door. He seemed very anxious. He had been avoiding air travel for very many years because of claustrophobia, as the doors of the plane are closed. Now the whole family was going on a holiday to the far-east and had already bought his ticket and insisted that he accompany them. He had no excuse not to go and could not disclose them about his fear. The departure date was just a few days ahead. I advised him to take a dose of *Argentum nitricum* 10m and go ahead with the preparations for travel. He came back after 15 days with a number of presents and told me that he had most thoroughly enjoyed the trip and taken many flights, because he went to Bangkok,

Singapore, Hong Kong etc. without any problem or any fear. In fact he said he would like to accompany me the next time I went abroad for an International Homoeopathic Congress.

FEAR OF INSANITY

Mr. K.P., age 48 years consulted on **June 7, 1982**, a businessman and head of a sales organisation. He married in 1962 and has three children. The very first thing he mentioned in the history was a fear of going insane. He had been of superstitious nature from childhood. In 1975, he saw a movie which depicted a mad person and he started fearing that what might be the situation if he became like that. However he was able to brush away the thought and would become normal. In 1977, his son dropped milk on the table for which he gave him a very tight slap so much so that the son showed marks on the face for the next three days. He subsequently regretted it and started feeling that if he gets fits of anger like this he may not hurt or throw his child. However, subsequently he did not beat or even scold his children. In March 1982, his son then aged about 11 years slept in his room, then a fear arose in his mind that he may not hurt or beat his son or if there was a knife he may not stab him. After this incident again he started to have fears that he may not go insane. Then he started recalling of some fears that other people had told him. One patient with obsession had mentioned that he had fear someone

is walking behind him. Then Mr. K.P. also started imagining that someone is standing behind him.

A mad relative visited their house and was there for a few hours and this upset him greatly. A Swami (religious leader) mentioned to him of someone who would see ghosts. Thereafter he would wake up at night and thoughts of seeing ghosts would arise in his mind. Because of these thoughts his sleep was getting disturbed and he would wake up around 4 A.M.

At this stage he consulted a Psychiatrist who dismissed his condition as only a superstition and advised him to do Yoga etc.

Once he had a dog-bite for which he asked the doctor for antirabic injections. The doctor told him that since the dog is alive after 10 days it was not necessary to have the injections. However, for years he felt the fear of rabies and would imagine fear of water.

From all these symptoms I concluded that he was highly impressionable in the direction of illnesses and hearing or seeing anything gives him the fears of that same type.

He had no cravings in food. Was smoking 4 to 5 cigarettes a day and taking alcohol in moderation one or two times a week. He was a hot patient.

Then I asked him about some of his other mentals and discovered that he had a fear of looking down from even moderately high places. "I may not fall". Had many fears as a child. Had fear of dark, storm, lightning etc. but he did not have them after he grew up. He liked company. He had a fear of travelling alone. This had always been so. He was of an unusually passionate nature and sexually very easily aroused. If he went for a movie which had a "Hot scene" he would masturbate there itself. He had no sex weakness. He was prescribed

Phosphorus 200/3 powders to be taken on the same day. This was on **June 7, 1982**. He reported after a week although he had been asked to come after 15 days. He said that some days he felt very well but on other days he had the same fear. Sleep was a bit disturbed.

1982

June 28. Felt good the last two days and felt more confident.

July 7. He reiterated his fear of high places "may not fall, may not jump." Prescribed *Argentum nitricum* 200/2 powders, evening and bedtime.

July 17. "This medicine has helped, less fear and more self confidence." Sleep had also improved.

In August and September he reported that some fears do arise in his mind from time to time and so *Argentum nitricum* 200/1 powder was given on **September 17**. This did not show any remarkable effect. So on **October 16**, I prescribed *Argentum nitricum* 10 M/1 powder. The result was not a remarkable and outright improvement as he said from time to time. He did get the previous disturbing thoughts. On **November 12**, prescribed *Kali phosphoricum* 200/3 powders.

1983-1987

Thereafter he was not seen regularly and in-between for some digestive and other complaints took Allopathic treatment. He had an occasional repeat of *Kali phosphoricum* 200/3 powders. This was on July 4, August 24 and December 22, 1983; April 11, July 3, September 26 and December 28, 1984 and lastly on July 7, 1985.

In May **1983**, he reported that confidence had been more and mostly he does not get the disturbing fears. In July 1984 he said that, "usually I remain all right and the medicine has helped a tremendous lot." Only when he

hears of some bad news then he may have trouble briefly.

He came for a digestive upset in **February 1986**, and said "I have no fears as I reported originally your medicine was very effective, please keep a note of it in case I ever need it in future." The same thing he reiterated in **September 1986**, saying that he was planning a long trip to Europe and he would take that medicine with him as it has been so very effective.

MENTAL DISORDER

Mr. R.P. age 24 years, a University Graduate; been married for one year; was seen by me in a middle of the night on **September 12, 1979**. He had flown to Delhi from a neighbouring country and was accompanied by his Homoeopathic doctor. They had come directly from the airport and woken me up because of his mental condition and the difficulty of keeping him in control. He behaved like a mad person he went talking irrelevantly and loudly and was not in a fit condition to give a proper history. Therefore, it was partly observation and partly what I gathered from the attendants and also partly from what he spoke. He was very ambitious, wanted to be a V.I.P., a great man and a business magnate. Was intolerant, had no self-confidence, easily frustrated by any failure, very egoistic, quick and hurried in everything; voracious appetite and he would eat very quickly, in fact gulp his food. He was a smoker. Would keep cleaning articles repeatedly. During these attacks he would have

no sleep. There would also be insomnia when he was worried. Suspicious nature. He had two brothers. They were both Graduates in Commerce and he has an inferiority complex that they are more qualified. He felt a lot of competition with his elder brother, whose attitude he felt was humiliating.

1979

September 12: He was prescribed *Stramonium* 10 M/3 powders at 1/2 hourly interval followed by *Saccharum lactis*. The response was quick. He had better sleep, that night and was not so violent or irrelevant on waking the following day. He reported on **September 15, 17 and 21** and as the improvement was maintained he continued on *Saccharum lactis*. On **September 21st**, he was quite rational and I asked him about his dreams. He mentioned that he would dream of dead people, dead relations (of mother and others) and even unrelated people one of which was the late Prime Minister of Pakistan, Z.A. Bhutto. He was not from Pakistan. He showed very suspicious nature especially regarding his wife.

Anger + + Aggressive at times. Sleeping very well. On **September 24**, *Stramonium* 10 M was repeated as he was showing some tendencies to slip-back, be irrelevant and more aggressive. This once again restored him to normalcy to such an extent that now he asked me if I could treat him or his wife as they had not had a child. At my suggestion he had a seminal fluid examination after 7 days abstaining. The report was clearly normal, therefore investigations were suggested for his wife. He was last seen on **October 8, 1979** and as he had been away from his country for a whole month, he decided to go back. He was feeling normal and was behaving normally. To assure himself that there is no recurrence he

took a supply of medicine for *IV2* months which naturally was *Saccharum lactis*.

m m m

Observing the change in him many members of his family and circle of friends came to consult me. So I kept getting news about his continued normal condition.

1982-89

Then I had an opportunity to see him again from time to time in the years 1982 to 1985. This time it was for his periodic attacks of Asthma. But his mental state continued to be normal. He was actively engaged in his business and when he came in 1982 he voluntarily made a remark "you have changed my life."

He had also been anxious to have a child as mentioned above. He came with his father-in-law, who sought consultation for himself, on March 8, 1989. He was quite normal, actively engaged in his work and happily informed me, "we now have one child and another is on the way!"

CANCER PHOBIA - IRRITATION THROAT

On February 7, 1990, Mr. G.C. comes to consult for his wife and reminds me that he had been treated 10 years earlier and has been well ever-since. He consulted on May 1, 1980, age 47 years, married 20 years, one child — 17 years. This child was his second. First died a day after birth. There after his wife had two abortions — natural. By training an Electrical Engineer and he was in

Railway Service. His only complaint was an irritation in the throat for the previous three months. Had had allopathic (orthodox) treatment during which he was given some caustic touch in the throat as also other medication, which included antibiotics and anti-allergic medicines. There was only partial relief. Some trouble persisted particularly in the right side of the throat. As he has to control labour, he has got into the habit of talking loudly. Now he hesitates to talk for long or loudly because it gives him discomfort in right side of the throat. There is a feeling of heaviness also in that area. A considerable fear "It may not later become cancer." Earlier was using extra salt in his food but not much now. Had been vaccinated 7 years earlier but otherwise not very frequently. Anger ++.

O.E. O.D.H. — Poor. Has Pyorrhoea. Tonsils unhealthy.

On the basis of his considerable fear of cancer he was given on May 1, 1980 *Carcinosin* 200/3 powders, every half hour. Perhaps I owe an explanation for this prescription. In 1947 while a R.M.O. at the London Homoeopathic Hospital, an indoor patient of Diabetes mellitus would ask every time I went to see her, "Do I have or could I be having Syphilis?" After trying the indicated remedies one day the visiting Physician, Dr. J.D. Kenyon decided to give her a dose of *Syphilinum* (*Lueticum*) 200 with considerable improvement. In fact he reported this case in a paper presented at the meeting of the Faculty of Homoeopathy and has appeared in the British Homoeopathic Journal (Vol. XXXVII No. 3 — October 1947, p. 182). I used the same analogy.

1980

May 17: Reported better but not hundred percent alright.

June 3: If speaks loudly then gets irritation in the right side of the throat and also cough.

Aggravation from cold drinks or direct cold breeze as when he is before a desert cooler or a full speed fan.

I used the Rubric in the Section of THROAT-INTERNAL; PAIN, speaking, on — on page 459, the only remedy in 1st grade (Bold Type) **Kali-i**. I prescribed *Kali iodatum* 200/3 powders to be taken on the same day.

July 7: Reported better.

September 8: Further improvement.

Thereafter I did not see him and he must have felt so much better as to keep getting repeats from my Dispenser for the next six months. Of course, these were *Saccharum lactis*.

Kali iodatum also appears in the rubric THROAT — INTERNAL; IRRITATION, in 2nd grade (italics) on p.454. |

Besides it is an Anti-Syphilitic remedy (1st grade on p. 1406) and the history of two abortions is a pointer to that miasm.

FITS

Mr. C.N., age **24** years, bachelor, University Graduate in Psychology, consulted on August 7, 1978. He had a sedentary office job.

Complaints: His only complaint was that he gets fits for the last 8 years. This had been put as hysteria but he has had them while going in the bazaar and has also hurt himself during a fit. The fists are clenched and he be

comes unconscious. There is no frothiness at the mouth and no clonic convulsions. The first time fit occurred when he was mentally upset. He was in the class and was reprimanded by the teacher and he kept crying for an hour. Now also he cries at times. Can get number of fits in a day. Staggering legs prior to fit.

Memory become weaker, tending to forget things. Errors in work. Slightly impaired hearing.

Urination is with interruptions — jerky discharge of urine.

History of masturbation. Discharge of prostatic fluid with romantic thoughts. "Erection is deficient and early discharge "Organ is bent " or curved."

Appetite — Desire to eat all the while and yet not a good proper meal. Salt + +. As a child would carry bits of rock salt in his pocket "like other children carry gram." Likes fried. B.O.R. But not satisfying.

Sleep — Late falling off to sleep. Dreams — previously + +. Very frightening. Not now.

Vaccination — Not after the age of 10 years.

Feels both extremes. Averse to bath.

Fears looking into a well, looking from height and to bathe in river. Fear dark. Feels inferior. Sensitive. Obstinate. Anger + +. If can't lose temper then beats himself. > full moon.

1978

August 7: *Natrum muriaticum* 6x, 30, 200/1 powder of each on the same day followed by Sac-lac.

August 21: Fits are less frequent.

Saccharum lactis continued.

September 18: Fits again been more frequent. On questioning was told that a close friend had been transferred to another place 12 days ago and it is after that that the number of fits increased. Has also reduced food

intake for the same cause. Has no other friends in that place. Now mentioned that initially fits had started after the death of a close friend.

Ignatia amara 200/3 powders-morning, noon and evening.

November 22: There are no detailed notes but apparently the fits were not totally abolished.

Phosphorus 10M/3 powders at half hourly interval.

1981

Mr. C.N. was not seen after November, 1978 but after more than 2 years on January 8, 1981 a friend of his came for consultation and informed that there had been no further fits and he was keeping quite well.

VERTIGO

Mrs. B.S., age 35 years, consulted on November 23, 1989. A Korean by birth she had been married to an American for 11 years with two children aged 10 and 4. She had had Dengue fever one month earlier followed by great weakness. Would feel dizzy when standing and walking, also turning in bed or looking sideways. Would feel very dizzy when going in car. Had always been prone to motion sickness. Would feel alright only when she remained in one position.

She had been examined by doctors in the Embassy, where her husband was working and was told that there is viral effect on the ear for which there was no treatment.

After the Dengue she had had an itching on the body and a rash but that cleared by itself in a few days. Could have been due to the effect of medicines used for fever.

Her only other complaint was that she would get headaches when tired, mostly the left temple and occiput. With the headache there was vomiting.

O.E.: B.P. 106/66. No abnormality was found in the examination of external ears.

1989

November 23: *Bryonia alba* 200/10 powders q.i.d.

1990

March 3: She reported again after four months and informed me that she had got well with the earlier treatment. In fact in her own words, "I made very quick recovery with the earlier treatment and prior to that I had been in bed for the whole month inspite of the treatment received from the Embassy doctors."

Now her complaint was that she would have a dizzy feeling at times when standing for long. This was frequent because of the official parties at the Embassy. Also when rushed or over-worked.

During these four months she had headaches twice but it was much milder and there was no vomiting.

Sulphur 200/3 powders at 15 minutes interval in the morning followed by *Saccharum lactis* for 2 weeks.

I did not see her again for many months and as there is nothing very spectacular to report in this case nor a promise of symptoms to evaluate and choose from, the case had been filed as a routine. The interesting part arose when she came with a Korean friend seeking help about the treatment of a Korean doctor who had a history of inflammation in the ear and was subsequently feeling dizzy. But as no other details of the history were known and the doctor was in Korea, I expressed my inability to prescribe. It only shows that how much confidence she had developed in the Homoeopathic treatment.

HEADACHE ? MIGRAINE

Case No. 1

Mr. S.A., age 35 years> consulted on **August 30, 1974**. He had been married 7 years and had two children aged 5 and 2. His was a sedentary occupation with long working hours.

Complaints — His only complaint was headaches from which he had suffered for few years. Some years ago when he go up in the morning if there was sudden exposure to light, then felt heavy in the head through the day and pain by evening. Later he felt that exposure to cold, as an air-conditioned room would give him headache. In March 1973 started getting unbearable headaches and he noticed that there was periodicity. He would get the headache every 14 days on alternate weekends. He felt pain in one eyeball, mostly right, and then as if a rope was pulling it backwards into the head. Later it would "explode" into the whole head. *Sanguinaria canadensis* 30 would relieve it and he kept fairly well for a year. But a month ago he had two severe attacks. Pain would be very bad and throbbing in character^ Mostly no nausea or vomiting. 10 years ago he had an accident in which there had been blood from the nose.

Mentioned that he had flickering in the eye in 1971-72.

Mouth — Very foul in the morning. That time saliva thick liquid, ropy, yellowish. Doesn't want to speak till he rinses well. Earlier drooling of saliva in sleep.

Appetite — Can overeat. Does not know when to stop, or even when stomach is full yet can eat. This is only at dinner. Mostly vegetarian. Very rarely meat.

Salt + sweets +. B.O.R.

Sleep — Good. Dreams related to work.

Vaccination — Three times in last 10 years. Previously less often. For yellow fever also.

Stands both seasons well, but prefers hot water bath even in the hot summer of Delhi, especially morning bath.

Cool. Calm temperament. Not a worrier. Mentioned that he had a peculiar habit that in writing may start by firsts writing the second or even third letter so also in dates he will first put the year and then the prefix of the month and then before that the date.

Premature ejaculation.

P.I. — Nil of note except an accident in October, 1965 as mentioned above.

1974

August 30: *Natrum muriaticum* 6x, 30, 200/1 powder of each through the evening and bed-time of the same day.

* * *

1975

June 12: He reports again after a gap of 10 months "Very grateful. No headaches. Not even heaviness of head, let alone migraines." The reason for the second visit was that for the previous week slight heaviness in temples which could be due to extra tension of work that had to be finished by a deadline. Continues to take extra salt and sugar also on high side. Feels better massaging neck muscles. Heavy feeling by sleeping under a fan. Aversion to drafts. No H/O wetting or cold or cough recently.

Repeated the prescription of August 30, 1974 that is *Natrum muriaticum*.

* * *

He did not report again but on January 17, 1982, after seven years, met me in the queue at the security check at the airport and said, "Haven't you recognised me. You cured me of my migraines which have never recurred since and I am so immensely obliged to you."

Case No. 2 (Migraine)

Mrs. K.R. telephones in September 1989 from Turkey seeking help for a lump in the breast and tells me that I have her previous history.

/ She had consulted on February 11, 1980. Age 28 years, been married 5 years, one child three years by Caesarean section. Prior to that she had had two miscarriages. Her main complaint was Migraine headaches for the previous one and half years. No relation to menses. During attacks must have no noise and no light. Is rather tense as her son, the only child, is weak and according to her has poor appetite.

Vaccinated for Smallpox in childhood and revaccinated a few times but not after she left school. Chilly patient +. Previous winter had frequent colds and sinusitis.

Mostly a blocked nose and not so much discharge. Has a Meibomian cyst for three years. Face is greasy otherwise skin dry; gets cuts on soles of feet in winter.

Secondary sterility.

P.I. Much Acne before marriage. Now occasional. At age 16 had a lump in breast. Removed by operation.

1980

February 11: *Sepia 200/3* powders at half hourly interval.

February 27: Headache from ?loss of sleep for two days as child is ill. This was not like the severe migraine variety. *Cocculus indicus*. 30/6 powders every 4 hours.

March 26: Headache for last three days.

Sepia 200/3 powders at 14 minutes interval.

June 14: No Migraine. Meibomian cyst gone.

Feet dry for previous three years, cracks at heels < winter, then there is pain and bleeding from the cracks/fissures. Nails of big toes getting thick and brittle.

Petroleum 200/3 powders on the same day.

1989

September 15: Seen from time to time for some other odd complaints till 1984 when she went abroad and then contacted in 1989 as mentioned at the beginning for altogether different complaints. On enquiry I learnt that there had been no recurrence of Migraine or the cyst in the eye after the treatment she had had in 1980.

Comments: It is to be noted that *Sepia* which does not appear in the Rubric Tumors on lids or the sub-rubric meibomian glands on p.268 but was prescribed on general considerations and it cured this also.

Case No. 3 (Migraine)

Mrs. P.P., age 34 years consulted on **December 23**, 1989. She had come from Calcutta and the subsequent reporting which was mostly by telephone was irregular. She had been married for 13 years; had 2 children aged 12 and 10 and no abortions.

She said she had been diagnosed as a case of 'migraine' for the previous 4 years. The pain used to be in vertex and left paraorbital region. Would have vomits with the pain. It occurred on an average once a month but not related to M.P. Also not related to exposure to sun or cold air or eating. Over-exertion and mental tension could result in attack. For this a year earlier she had

been prescribed Tegretol (Mazetol) which she used for 3 months. With this she felt drowsy, so discontinued.

Bouts of sneezings in the morning "on putting foot on ground in morning or putting hands in cold water". Occasional breathing problem "once a year and very mild".

(H/O Bronchial Asthma in childhood). Itching under eyes and sides of nose in the upper part, between the eyes for previous few months. For some time low B.P. — usual reading is 90/50.

Appetite: Good. Non-vegetarian. Likes sour.

B.O.R. "However, 'heating things' (like garlic, dry fruits, mutton (not fish)-black pepper in excess, garam masala (spices)) result in piles with hard stool and bleeding." Also has a general allergy to garlic — by eating or cutting garlic gets itchiness in fingers and cuts or fissures.

Sleep: Poor. Frequently uses Calmpose, otherwise lies awake till 2 a.m.

Dreams: Clairvoyant. Of the dead — close relations, "because I was much attached". Occasionally of being afraid of water. As a child dreams of falling.

Vaccination for Small Pox a few times in childhood.

Neither markedly hot nor chilly.

Anger — at times. "Have been tense since the time of marriage, there being a joint family with business and other disputes. Now separating. For 6-7 years forgotten to smile or laugh because of the tense atmosphere". Sensitive. Sympathetic. Cries for any emotional scene. No fears. Not keen on company.

M.P.: Regular and normal, no pain. No leucorrhoea.

P.I.: Very bad eczema at age 7-8 years, mostly on head with discharge. Now itching legs from use of nylon and on the area of watch strap in summer. Serious

pneumonia at age 8 years, after that asthma for 3-4 years. Measles at age 31 and Chicken Pox at age 32 years.

F.H.: Mother died at the age of 54 years. Had hypertension and C.H.F. Father has some heart complaint. Has no brothers or sisters.

O.E.: Lean. 109 lbs. Height 5'4". B.P. 120/82. Slight bleeding from gums. In rest of the physical examination N.A.D.

1989

December 23: *Phosphorus* 200/3 powders during evening and bedtime on first day. Made a note in the margin *Natrum muriaticum* for future consideration.

1990

March 16: Sneezing has been less. Still gets headaches. Itching below eyes. Insomnia on some days when tense.

Phosphorus 200/3 powders at 15 minutes interval.

June 6: "Strong aggravation after medicine" - Migraine attack for which used 'strong' allopathic medicines. Later had eczema hands. She has a tendency to get this when she uses detergents for washing. So normally uses gloves. At present has eczema on the hands. Pain in right knee. Father feels that she is by nature a tense person.

Natrum muriaticum 6x,30,200/1 powder of each in morning, evening and bedtime of the same day in that order.

August 31: During the previous 3 months had headache twice and according to her father it was due to unusual tension.

Natrum muriaticum 200/3 powders at 15 minutes interval.

Letter dated **December 26:** Headache on October 6, when she was on fast (Karvachauth). Skin of upper eyelid dry — like dandruff.

1991

January 2: *Natrum muriaticum* 200/3 powders at 15 minutes interval.

February 12: "Much better in this period, please repeat". *Saccharum lactis*.

She had progressive improvement and needed a repeat of the medicine three times during a year whenever there was a tendency to recur. The last occasion when it was given was February 10, 1992.

* * *

1993

January 9: Telephoned after a long gap. Was very happy as she was now completely free of headache. The only complaint was sneezings immediately on rising.

Nux vomica 200/3 powders at bedtime on 3 consecutive nights.

Case No. 4 (Headaches)

Mrs. B.S. age 34 years. Came from Varanasi and consulted on July 5, 1990. She had been married for 15 years and had 3 children, aged 13, 7 and 5, all by caesarean section. No abortions.

She complained of headache for the previous 10 years. Initially, it was occasional, that is once in 2-6 months, progressively, it became more frequent from February, 1990. With headache nausea and at times vomiting. From May 21st, the headache had been a daily feature. It starts in one temple then extends to the other side and then involves the whole head upto occiput. There is no regular alternation of sides and it does not

start more frequently on left or right. There is no visual disturbance. In the previous two weeks she never felt totally normal. There is always some heaviness of the head but the pain is not so intense. During this period whenever pain increases, then there is some difficulty in breathing.

She had anxiety problem for the previous two and a half years. Her father-in-law died in December, '87 and mother-in-law died around beginning of 1989. She gets anxiety, restlessness and has tears. This may be due to some tension or even without any cause. Had some depression tendency even before father-in-law died. Cannot think of any factors that provoke or bring on the headache.

Another symptom she complained of was acidity for more than 8 years. Initially there had been burning and later pain in epigastrium. Endoscopy, Barium Meal, X-Ray examination, etc. were all normal. These symptoms had been relieved for the previous one year.

She had been fond of sour things and chillies but given up after she developed acidity. Thirstless. Dreams: pleasant. Meeting people. Hot patient.

B.P. ? Labile. At present low 105/90. At one time when she was worried it was 160/100.

Anger ++; worrier, likes company.

M.P. Regular for the last 3 months. Before that it had always been irregular. Mild pain in abdomen before menses.

P.I. Tonsillectomy. Some abdominal tumour removed at the time of first C.S. 3C.S.

Family history: Grandfather Asthma, Father Diabetes. No T.B.

O.E. Obese. 5'2", 151 lbs. 108/76. Halitosis, bleeding gums. Using glasses.

1990

July 5: Prescribed *Pulsatilla* 10m/3 powders at 15 minutes interval.

July 13: M.B.; had some trouble on July 9 — after shopping. Subsequent reports were by letter or by telephone from Varanasi and she showed a consistent improvement. So continued on sac lac.

August 24: She had had no headache or depression in spite of viral fever for a few days in interim period.

September 22: Generally better but reported headache four times in the period August 17 to September 18 — thrice with tension and once by exertion. Husband has been ill in the last month and has been tense. Amenorrhoea for two months. L.M.P. July 23. Decided to watch. So continued *Saccharum lactis*.

October 16: No complaints but in previous two days short fits of depression. Gets dull and feels like crying and no appetite but there was no headache.

November 3: No headache. At times a sense of extreme weakness which may last only some 15 minutes or may go on even upto 2 days. It is felt that it is mostly related to over-exertion.

December 15: Had headache for 3-4 hours on 7th. No special reason.

December 24: Came personally. No headache after the 7th. Depression persists-comes on suddenly. There is anxiety and choking feeling. It lasts 20-25 minutes. Can occur any time. In that state crying and desire to hold somebody tightly. Hair falling. Dandruff.

Repeated her prescription — *Pulsatilla* 10M/3 powders at 15 minutes interval.

December 28: On 26th night anxiety + +, flight perspiration, suffocation feeling after watching a movie on video. This was at 10.20 p.m. Got o.k. by 12.30 a.m.

No ascribable reason. She was taking *Saccharum lactis* in pills now added a *Saccharum lactis* powder also at bed time.

1991

January 4: "Been well after starting the powder".

June 14: No headaches. Depression on some days. Gets anxious, then feels weepy, followed by weakness and dullness. The cause may be very minor. During the previous 3 months been much better and had mild depression only on 3 days.

August 19: Headache much much better, practically nil. Now the problem is of depression off and on and suddenly gets serious and leaves company or starts crying. Gives no reason nor any can be deduced from circumstances. *Pulsatilla* 10M/3 powders at 15 minutes interval.

September 24: Headache twice in this period. Lasts 60-90 minutes. Gets phases of irritability and depression. This may or may not be accompanied by headache. With depression much crying and followed by great weakness. Acidity symptoms again, relieved by vomiting *Pulsatilla* 10M/3 powders at 15 minutes interval.

November 25: There was a wedding in the family. She had over-exerted doing all the shopping. The day following the wedding very severe headache. Repeated *Pulsatilla* 10M/3 powders at 15 minutes interval.

December 12: Better in headache and depression.

1992

February 21: "Keep well when using medicine otherwise very occasional and mild headache". And of course what she was using was *Saccharum lactis*.

May 18: Came to see personally "I feel quite well in every way. In the month of March, there was consider-

able strain because of the examination of children, but no trouble. I feel confident that now I will remain well even without medicine as I have already been without it for the previous 6 weeks".

Discussion:

It was a very interesting case fairly typical of the stress headache variety in a somewhat neurotic individual. It will be noticed that only one remedy, that is, *Pulsatilla* was needed all along in the same potency. It is also to be emphasised that altogether she needed it five times during the entire period of little less than 2 years while she was under treatment. The repetition was only when there was a recurrence of symptoms.

CHRONIC HEADACHE

Case No. 1

Mr. N.T. age 36 years consulted on April 13, 1990. He had been married for 13 years and had two children. He was an exporter in textiles. He was very upset because of a prolonged and very frequent complaint of severe headache for 14 years or longer. Analgesics do not help. The pain is mostly right sided and there is also pain in right eye. Often with the headache he has nausea and burping. Even recognised migraine remedies — migril, etc. give no relief. Therefore, he has to leave it alone for it to clear by itself. It may last a few hours or continue even after sleep to the following day. Sometimes the pain is midvertex. First time this occurred in January in New York where it was snowing heavily and there was great tension of catching a flight. The pain was

so severe that he was forced to cancel his journey. This was in 1988. He had stopped taking all medicines for headache as they did not help and in fact made it worse. At times headache is very very severe and he cannot even sleep. Some relief from pressing. No effect of hot or cold; coition or alcohol. Some of the possible provocative factors may be less sleep, delay in eating or after a flight. It has been occurring almost every second day and the severer attack in 7-10 days. ~ •

Appetite — Good. Non-vegetarian. Stopped smoking one month earlier after 12 years. Occasionally takes beer. No cravings in food. Very thirsty. B.O.R.

Sleep good. Dreams more negative than positive, mostly connected with his work or the family.

Vaccination for small pox 3 or 4 times in recent years and yearly while in school.

Hot patient.

P.I. — Jaundice at 14 years; Typhoid at 17 years, put on weight after this. In answer to a question said that headaches may have started after typhoid.

F.H. - Mother-diabetes; father - High B.P. and prone to headaches. Has 3 sisters and one brother — no particular illness. No F.H. of T.B. Whole family tends to have early grey hair.

O.E. - N.A.D. - B.P. Normal.

1990

April 13: *Thuja occidentalis* 200/3 powders to be taken through the evening and at bedtime of the same day. This was to be followed by *Saccharum lactis* for six weeks. He was separately given *Sanguinaria canadensis* 30/20 powders to be taken at intervals of 2-4 hours in case he has an attack of headache.

He was not seen for more than 2 years till he reported again on July 22, 1992. This time he said,

"Medicines were very effective, it was like a miracle. I have had no headaches since my previous visit except occasionally as a hangover from excessive alcohol intake." Now he had sought consultation for a different condition.

Comments: The basis of the prescription was almost entirely on the history of repeated vaccination and bears put the truth of the assertions made by Burnett in his book Vaccinosis. Therein one of the special conditions he mentions is Neuralgic pains and he describes some cases of intractable headaches. The case also clearly demonstrates the efficacy of the potentised remedy in single dose.

. Case No. 2 (Chronic Headache)

Mr. N.P., age 34 years consulted on March 13, 1974. He was an engineer working for W.H.O. His complaint had been headache for sometime. It used to be occasional but in the previous two months the frequency had increased. In fact, he would have a headache every two or three days. It will usually start in the morning mildly but aggravate by afternoon. Then he will have nausea but no vomits. Analgesics did not help. With headache likes cold things and fresh air. Otherwise head is sensitive to cold air and he' feels better keeping it covered. Vision had not been tested but he had no difficulty in reading and so it was presumed it is normal. His other complaint was nausea going in car or bus. Nothing significant with regard to appetite, digestion, sleep and dreams. Only some flatulence.

He was not so happy and cheerful because of a general tired feeling. Sentimental nature, very sensitive, prefers company.

P.I.: Epilepsy diagnosed 8 years earlier by a well known neurologist (Dr. Victor Rao). He put him on Garoin tablets which he used for 3 months. E.E.G. Two years earlier "Definite Lesion". But he took no further treatment.

1974

March **13:** *Pulsatilla* 200/3 powders morning, noon and bedtime of the same day. *Saccharum lactis* for two weeks.

April 19: M.B. for two weeks or more when used medicine. Now have a weak feeling in the afternoon. Repeated *Pulsatilla* 200.

May 7: No headache in this period. Always gets giddiness and nausea by car travel, even when no petrol smell. So it can be ascribed to motion only. However, he also feels uneasy in a dry-cleaning shop where there is petrol smell. Drooling saliva on lying down. Weakness and tiredness is mostly when he gets headache so it is not felt now. Consulted the rubrics on p.509 and 534. The choice was between *Cocculus indicus* and *Petroleum*. Prescribed *Petroleum* 200/1 powder with *Saccharum lactis* to follow.

•

The interesting part of this case, is that I did not see him again for 18 years. In July 1992, he came to return one of my lecture papers which I had lent to his daughter, a new graduate from the Homoeopathic college. He told me that he never got the headache again and it was this good experience that prompted him to send his daughter to the Homoeopathic college.

RECURRENT TONSILLITIS. CHRONIC HEADACHE

Master A.C. age 8 years consulted on July 4, 1979. He was grandson of a homoeopath who had died. The history was frequent sore throat with fever which was always diagnosed as tonsillitis. This problem he had had for the previous four years and he had had frequent courses of antibiotics for the same. The attacks were more frequent in winter.

Another problem was headache for the previous four months and he insisted that he had it daily. It starts in the morning in occiput and later extends to vertex.

< exposure to sun < reading — he puts it to bending the head. Been to an eye specialist who finds nothing wrong after examination.

Appetite: Good. Non-vegetarian. No special cravings but likes mutton and icecream, also fried food and bananas. Lies down p.c.

B.O.R.: Some tendency to diarrhoea but not very frequent.

Sleep: Good. Late riser. No significant dreams.

Vaccinated for small pox two times. Second time in 1976. Has not had B.C.G. Chilly patient but likes winter. Averse to bath "unclean habits" — won't brush teeth or bathe till told.

Cool temperament. Docile; very intelligent.

Lab reports: T and D.L.C.-9400; P69L27E4.E.S.R.-45.

Stool Examination: Cysts-E.H.; Gva-A. lumbricoids

X-ray chest: "increase in Peribronchial striations in both lungs ?Bronchitis."

P.I.: Typhoid at the age of 5 years. Patchy pneumonitis — 1978.

O.E.: Wt. 60 lbs. Heart, lungs, abdomen - N.A.D.

1979

July 4: *Silica* 6x, 30,200/1 powder of each to be taken at noontime, evening and bedtime.

July 20: M.B. Headache had been much less but tendency to recur in the last 2 days.

Silica 200/1 powder at bedtime.

1980

April 30: Reported again after this long interval. Had been free of headache during all this time but recurrence last 2 days. Pain in nape of neck on walking.

< morning and gets less through the day. But this may be due to the analgesic that he used. Not been to school because of headache. Last few days he was blinking much and the father had given him' *Belladonna* 30. Seems to be tense. On enquiry I learn that he had his examination result a month earlier and the result had been not as good as in the previous year.

Nux vomica 200/3 powders at bedtime on 3 consecutive nights.

May 9: Only slight relief so he was again prescribed *Silica* 200/3 powders during the evening and bedtime of same day.

May 20: "50% relief."

May 29: "85% relief" till yesterday. Had headache today, also vomited. < movement of head.

Bryonia alba 30.

June 6: previous improvement maintained but still 15-20% headache remains. It is there all the time. > cold bath or washing head. Nape of neck and vertex. Blinking now practically normal.

Sulphur 200/3 powders at 15 mts. interval to be taken in the morning.

June **21,1980:** Asks for repeat. Feeling very well and goes about in the sun without any discomfort. *Saccharum lactis*.

July **21:** Only occasional slight headache. Prone to sore throat when he takes anything cold. *Silica* 200/1 powder at bedtime.

November **11:** Reported that he had been well even though he did not use any medicine after the one prescribed to him in July.

December **13:** Has had sore throat and cough a few times.

Silica 200/3 powders at 15 minutes interval.
* * *

1988

October **28:** Comes after 8 years. Had been very well all this time and now insists that I give time for consultation for his sister.

1989

Reported again on January 13 with the complaint of pain in the cervical region after continuous study. He was now in the final year of school and working very hard for his examination. There is temporary relief with the pain killers. Tried Brufen and Paracetamol. He feels no problem when holds the book straight in front of eyes so that he does not have to bend his head. The father is very pleased at the way he has progressed physically and mentally. He is now 18 years, 6 feet tall and has exceptionally good results in school. Devoting much time to study but very little exercise or sports. In fact the father remarked "after your previous treatment for headache, he jumped from mediocrity to become a brilliant student."

Calacarea phosphorica 200/3 powders at 15 minutes interval.

1989

February 7: Better. However, after bending neck for 3-4 hours while reading does feel pain in the neck.

Repeated *Calacarea phosphorica*.

February 17: Reported that there had been some initial improvement but not sustained and still has a pain.

Tellurium 200/3 powders at 15 minutes interval.

February 27: Much better.

March 28: Been well.

July 28: Tending to have pain again.

Tellurium 200/3 powders at 15 minutes interval.

1990

October 6: Learnt that he had been quite well after the treatment he received a year before.

Comments: In his initial treatment 1979-80, the only remedy needed was *Silica*. It helped to a great extent, but when it was not getting cured, an inter-current dose of *Sulphur* was given.

You will find reference to this in Clarke's Dictionary of Materia Medica on page 1179 in the section of relations. Also in Clarke's clinical Repertory at page 302 against *Silica* in the section, "Remedy is followed well by". It reads, "If improvement ceases under *Silica*, a dose or two of *Sulphur* will set up reaction and *Silica* will then complete the cure."

In 1989 treatment was considered more as if it was a case of cervical spondylosis. Although the patient is very young, it is to be noted that he was devoting much time studying bending his neck and had neglected exercise

thus giving poor muscular support to the cervical vertebrae. The remedy was chosen accordingly.

1994

Accidently met his father in March 1994. He again expressed much gratitude for the treatment given to his son. He secured one of the top positions in the university exams and so was able to join a prestigious engineering college. There also he was doing extremely well. He was also enjoying excellent health and had no complaints whatsoever.

PERSISTENT HEADACHE ? BRAIN TUMOUR

Mrs. L.B. I was called to see this lady at Sonapat (a place about 30 km. from Delhi) on December 7, 1966. Her age was 54. She was married and had three living children. Two of her children had died in childhood. For previous 2 years one of her sons was missing. The history given to me was that two months earlier she had gone on a pilgrimage to Vaishno Devi Shrine, which involves a steep climb. It had been very cold there and as expected there was lot of exertion. On return she had started to have headaches for which she took Codopyrine and carried on her usual household duties. I was told that headache had been an old complaint. However, for the previous three weeks she had been confined to bed with lot of pain in head and for the previous 10 days she was also having vomitings. The Allopathic doctors were suspecting it to be a case of brain tumour. She was being given Largactil and A.P.C. (a standard combination of Aspirin, Phenacitin and Codeine) with temporary relief

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in the sense that it would put her to sleep. The pain was continuous, varying in intensity only. Pain was mostly in vertex. She wanted the head pressed, prefers warmth and keeping the head warmly wrapped. Additionally for the previous two weeks she had been having Hiccough from time to time. Mostly she was better in the morning and would go through her usual routine of cleaning teeth, bath etc.

She was constipated, did not have stool for 8 days. Then she passed one after being given glycerine syringe (enema) and thereafter again no stool for the previous 4 days.

Occasionally misses words in talking or even the thread of conversation, at times slightly irrelevant talk but this is very rare. For the last 2 years she had been crying very frequently, for most of the time, for her lost son. She felt this very much.

Past Illnesses: She had been operated for Glaucoma in right eye 5 years earlier. Been tested now and tension found normal.

On examination: Reflexes normal, B.P. 120/80, tongue clean and moist.

1966

December 7: Chiefly on the basis of the history of shock and prolonged grief she was prescribed *Natrum muriaticum* 3, 30, 200/1 powdet of each to be taken in that order.

December 13: Reported much better. In the initial period headache one day but to a lesser extent. Now mostly no headache. Was more communicative and mentioned **that** the tendency of the headache was to be on the **right** side. It is to be noted that she had been operated earlier for Glaucoma in the^ right eye. She was having **much** weakness. Still constipated. Desires warm

drinks: milk and tea but no soup. At times forgetful — whether she has eaten or not but at other times remembers everything.

Prescription: *Saccharum lactis* 21 powders t.i.d.

December 18: It was reported that she was very drowsy. Prescribed: *Opium* 200/1 powder.

December 19: Very much better.

Drowsiness almost gone, she is more active.

December 26: Right sided hemiparesis mostly affecting the right lower limb. Understanding and action is deficient — lapses into stupor immediately after. Involuntary passage of urine at times. Weakness ++. Even if the stools are soft they are not evacuated. Sighing is frequent. Does not answer. You ask 10 times before she will reply. Asks for nothing.

Prescribed: *Arnica montana* 200/3 powders every 4 hours.

1967

Subsequent reports were "M.B." till **January 4, 1967** when she showed a set-back and was given *Arnica montana* 200/1 powder. Finding no significant progress on **January 7** she was given *Hyoscyamus niger* 30/9 powders t.i.d. She would recognise a person but forget and could not recall soon after whom she had met. Started improving from January 8, and made rapid progress.

Report on **January 10, V.M.B.** Freely moving the right (paretic) side. Fully conscious and taking interest in the surroundings and family. No headache and vomiting. On occasion had again passed urine involuntarily.

She herself asked for medicine for this condition showing her consciousness. The improvement was maintained.

February 2: Feels alright except for some weakness. Has itching all over her body. Headache on some days

but very mild. When it does occur, it is mostly on right side — vertex, temple, forehead, eye and even right side of face. Reflexes are normal and equal on both sides. No paresis on right side. Forgetfulness is there. Aphasia of recent events. Urination is frequent but not involuntary. Today had a vomit during car journey. *Saccharum lactis* continued.

February 23: Memory alright — no aphasia and no forgetfulness. No itching. Weakness persists, it is improving but not fast enough. Eating well and passing stools regularly.

March 8: Absolutely alright, walking about, even cooking food. Complaint of slight pain in joints of right hand when she uses it. Also pain in thighs and calves on getting up and sitting down.

March 24: Came to report personally, walking around and feeling fit. Occasional headache in temples. The only complaint now was some pains which were worse in the morning on first starting to move.

Prescribed: *Rhus toxicodendron* 200/1 powder.

1968

Thereafter she kept well as I learnt from some of her relations and friends and I did not see her again till end of March 1968 when she came for a sciatica type pain but no recurrence of her old complaints.

* * *

1988

I had forgotten about this case but in August 1988 a gentleman from the same town who felt that she had been saved from a serious condition by my treatment reminded me, "of the remarkable cure of the lady whom you had visited more than 20 years earlier and revived her from a semi-conscious state."

PITUITARY TUMOUR

Mr. S.C.J., age 54 years, consulted on **December 21, 1977 with a** provisional diagnosis of Pituitary Tumour. He **was** married at the age of **18** years. Has **7** children. Eldest **35** and youngest **18** and his occupation is transport business, in which his work is mostly in the office (sedentary).

Background and past illnesses: He gave a history of fever a number of times lasting for as long as six weeks at a time and although according to him it had been diagnosed as Typhoid but from what he remembered he was given Quinine mixture so it may have been recurrent Malaria. In any case this was in childhood. At the age of 25 he had Meningitis. This was treated by Homoeopathy by my father, Dr. Diwan Jai Chand, and he got well.

At 34 years age he got Eczema for which he had Allopathic treatment. According to him he had repeated courses of antibiotic Mysteclin with intervals and altogether may have taken as many as 500 capsules. It was an oozing eruption and eventually an antihistaminic (Incidal) helped clear it. There were some recurrences and the last attack was only six months earlier which he controlled again with Incidal. He complained of pain abdomen off and on when he took water after meals. Taking water alone or solids alone would not give pain. There were no vomits and pain would last 30 to 35 minutes. Relieved by lying down for a while.

1977

On November 25: He had fever with chill. No blood test was done but it was considered as Malaria and he used *chloroquin*. There was a recurrence 5 days later and

the same medicine was repeated. On December 2: He had a convulsive seizure in which he bit his tongue. A doctor examined him immediately after and diagnosed it as Grandmal Epilepsy and gave an injection of Eskazine. On December 8: Again fever with chill and the same *prescription*^*Chloroquin*).

Present Complaints: His main and persistent complaint was headache. He had this even prior to the Meningitis mentioned above and he continued to suffer from it subsequently also and once it occurred it would last two to four weeks. The headaches ceased at the age of 34 and he remained well for 14 years.

He started to suffer from them again for the previous six years. The report of the Ophthalmologist was a gross contraction of the field of vision and fundus examination showed early optic atrophy ("? could be due to meningitis"). X-ray of the skull showed enlarged sella turcica and erosion of petrous apex. No evidence of raised intracranial tension. Other points to note in his lab. reports was Eosinophil count 8%, E.S.R. 26mm, blood sugar P.P. 135 mgm%, V.D.R.L. — negative and urine showed albumen one plus.

He had been vaccinated for Small Pox twice before the age of 12 years. He had piles bleeding a few times but had been free of it for nearly two years.

He had no marked reactions to heat and cold and no particular cravings and aversions. In the **family history** the only significant feature was Pleurisy in one brother.

December 21: He was prescribed *Nux vomica* 30/3 powders to be used on the first day; *Sulphur* 200/3 powders to be taken at half hourly interval on second day in the morning and *Saccharum lactis* from 3rd day.

1978

January 11: He reported that he had had fever on January 1, for one day or rather a few hours only. He took some homoeopathic medicines locally (he was from Meerut, a city 65 Km. from Delhi). He had had headache on January 2 and 3. There were no vomits and he felt better by wearing woollen cap. As of today, "No trouble". *Saccharum lactis* continued.

February 15: Reported headache two or three times in one month. Again had fever one day some 10 days earlier. Constipation off and on — that day B.O. but does not get a proper stool. *Saccharum lactis* continued.

March 16: Nothing special to report. *Saccharum lactis* continued.

June 20: Reported that a week earlier he had fever 105°F with chill. It was clinically considered as Malaria and was prescribed by a local physician (Allopath) Resochin. It was noticed that he was getting Malaria frequently and the first seizure had been after Malaria. After Malaria headache for 3 to 4 days and vision seems weaker for some days. Other than that he had been free of headaches. At times restless and disinterested in everything.

Prescription: *Nux vomica* 30/2 powders, evening and bed time on first day and *Natrum muriaticum* 6x, 30, 200/1 powder of each taken in that order on the second day and *Saccharum lactis* from third day.

July 20: Reported much better.

October 21: Again reported much better.

1980

As he was having no troubles now he discontinued treatment and was seen again on May 3, 1980. He reported headache twice in the previous 10 days. And he was wondering if it was because of the extreme summer

heat. After installation of a desert cooler in his office he did not get any headache.

Prescription: *Pulsatilla* 200/3 powders on the first day and *Saccharum lactis* from second day.

1981

February 14: Sent a messenger asking for repeat of medicine. Did not send any report. Given *Saccharum lactis*.

Not heard of again till **November 21, 1981**, Headache for the previous 4 days. Is alright in the morning. Starts later and then gradually increases. Repeated the last prescription i.e., *Pulsatilla* 200/3 powders.

1982-83-84

Next reported after one year' gap on **October 7, 1982** with complaint of headache for the previous 5 days. Repeated *Pulsatilla* 200. Thereafter got well and reported after 7 months on **April 27, 1983** with different symptoms. He feels breathless on exertion, gets tired easily and some anxiety. The E.C.G. showed Anterolateral ischaemia. X-ray chest was normal except for slight cardiomegaly. His S. Cholesterol was slightly raised (264 mg%). Blood Sugar — normal. Blood Pressure — 150/90. For the previous 10 days he had been taking *Lanoxin*. He felt that with this he had started to have headache and pain in the neck. He had some unused medicine taken from me in October 1982 (*Saccharum lactis*). He took this on his own and says he immediately felt better in these pains and restlessness was also less. **O.E.** the heart sounds were not proper; **O.D.H.** poor and some teeth shaky. He was asked to stop *Lanoxin* and given *Saccharum lactis*. Clinically no problems for the next few months and he continued on *Saccharum lactis* till April 1984.

1984-85

April 3: Reported with much headache from the previous day — whole head but especially bad in the nape of neck.

O.E.: N.A.D., B.P. 150/90.

Prescription: *Pulsatilla* 200/3 powders followed by *Saccharum lactis*. Kept well and got repeats from my office (*Saccharum lactis*).

July 6: Recurrence of bad headache for the previous two days. Tends to get it after long distance car travel even though not otherwise tired. Inbetween one day he felt low and restless and saw a local doctor who found his B.P. 180/110 and gave some antihypertensive tabs (Allopathic) which he used for two days.

October 15: He had continued fairly well from April 1984 when he had been prescribed *Pulsatilla* 200. Thereafter time to time sent for repeats (*Saccharum lactis*).

Now reported that he had headache for 24 hours but it was suddenly relieved on 14th afternoon when he skipped his usual lunch and instead took only milk and some bread. Rarely felt a blackout without giddiness. He complained of piles with occasional bleeding, bright red blood.

B.P. 160/90.

Prescription: *Phosphorus* 200/3 powders at 15 minutes intervals.

1986

January 21: Frequent headaches every 4-5 days.

Phosphorus 200/3 powders.

March 22: Headaches been less frequent. Feels it comes as an attack every 6-8 weeks and then lasts for a few days. Still bleeding from piles time to time. Repeated *Phosphorus* 200.

1987

February 9: Came to consult again with the complaint that he still suffers from headaches at two to four weeks intervals but now it gets alright in about 2 hours. Pain in his whole head and there is no vomit and it is better for cool breeze. Getting a rash on his hands which subsides in a few days leaving dark spots.

Pain in knees. Felt on rising and in sitting on the ground. Feels worse in winter and less in summer or rainy season.

Had earlier had some boils on the face for which he was given antibiotic injections and at that time coincidentally felt much benefit to the skin rash.

Prescription: *Phosphorus* 200/3 powders.

1988

After continuing for a while on *Saccharum lactis* there was a break till he was seen again on January 16, 1988.

Complaints of headaches for the previous few days. He feels the sound of a bell in the ear (tinnitus) followed by giddiness. The vertigo is felt for just about 15 seconds. It has never been felt while lying. Itching in the ears. Piles problem persists. Has seen an Orthopodist and the pain in the knees has been put as due to Osteoarthritis.

In the Winter months if he does not protect his head with a cap at night he is likely to get a cold.

Prescription: *Phosphorus* 200/3 powders.

February 16: Giddiness and tinnitus have been relieved. Headache is only occasionally. The problems he has now are the pain in the knees and the piles. The pain in the knee felt especially in using the Indian style W.C. i.e. in squatting when he sits down or rises from that position.

Prescription: *Calcareo carbonica* 200/3 powders to be taken in morning, afternoon and bed time.

March 9: Started feeling better. "Send same medicine." Was the short telephone message. Sent *Saccharum lactis*.

March 30: No bleeding from piles but has slight pain. Pain knees persists.

Prescription: *Calcareo phosphorica* 6x, 30, 20ft'1 powder of each.

Comments: This patient has been observed over a long period of more than 10 years. He had come with signs of a serious ailment — a Pituitary Tumour. He had very quick relief from his clinical complaints and having lived through all these years is also proof of his recovery from whatever was the problem. It is also to be noted that medication was of a minimal nature and no repetition as long as improvement lasted which has been for many months at a time or even for a year after a single dose. There was also no arbitrary raise of the potency as long as the potency previously used (in this case 200) showed long enough effect.

The treatment had been concluded. In any case, there had been gaps of many months or seven years during the period of nearly 11 years that he had been under observation and treatment. As already mentioned in the comments that no recurrence of the main complaint with which he initially sought my treatment but he had developed so much faith that for any complaint he would come or send a note asking for help. Mostly we had been lucky to provide him with quick and lasting reliefs. As mentioned in the report on March 30, 1988, he had pain in the knees which was ascribed to Osteoarthritic changes in the knees. For this he received on May 30, *Calcareo carbonica* 200. On June 25, *Calcareo*

fluoricum 6x, 30, 200. On July 30, *Calcarea carbonica* 1000 and on August 20 O.A.N. 200. With all these he had a variable result and no sustained relief.

September 13: Reported with a skin eruption on hands and feet. It appeared suddenly from the previous day. Burning and itching. Has had eruption off and on during last 35 years as mentioned at beginning of the history. "Since the appearance of eruption, pain in knees is less."

O.E.: Patches of eruption are reddish and warm to touch. Circumscribed.

Rhus toxicodendron 200/3 powders in afternoon, evening and bed time of the same day.

September 26: Burning and itching was relieved within a few hours. Only scars remain.

Thereafter seen off and on for urinary frequency, specially Nocturia (Been diagnosed B.P.H.)

1989

April 4: Recurrence of eruption. "Medicine in September 1988 cleared the eruption like magic, you can give me the same again."

Rhus toxicodendron 200/3 powders through the evening and bed time.

April 15: On April 8 had nausea and took allopathic medicine locally for 4 days. The eruption had persisted. There was itching and pustules have formed. Perhaps the Allopathic medication may have interrupted the action of the remedy.

Rhus toxicodendron 30/24 powders q.i.d.

April 20: Over the past 5 days, there was 50% relief and the same medicine was continued for another 5 days. In July he got medicine for the pain knee.

Continued well till February 13, 1990. Then, he again reported with eruption on head, back and arm pits with

itching. Pustules had formed. "Medication taken for pimples one year ago helped very fast, even before I reached Meerut it was much better."

Rhus toxicodendron 30/28 powders q.i.d.

This helped very considerably. For some recurrences, he received *Rhus toxicodendron* 200 in April and December 1990. I saw him occasionally after that. Once it was for recurrent epistaxis and another time for hiccoughs. The hiccoughs started after use of antibiotic given for sore throat and fever. It was very persistent and it continued through all the waking time. If he tried to control the hiccoughs, he would have a feeling of choking. This was very quickly controlled with *Magnesia phosphorica* 6x/20 powders at 2-4 hours interval.

Was last seen on April **14,1993**. Therefore by now he had been observed for a period of nearly 16 years and he was having no headache, no vomiting, no visual disturbance, i.e., no signs of pituitary tumour or any other S.O.L.

7EFFECTS OF HEAD INJURY

Mrs. S.N., age 45 years, housewife, consulted on December 30, 1988. History of fall from stairs 10 years earlier and got unconscious and had a hurt near right eye. No fracture and no stitches needed but there was much bruising and swelling. No immediate after-effects were noticed. Some three years later she started to have pain in the region of right eye, nape of neck and a general pain in the whole head, not a hemicrania. Usually with the pain gets two to three vomits and then gets better. Medicines used in the attacks are Analgin,

Suganril and Stemetil. Most of the severer attacks occurred on waking and it is possible that she may be awakened earlier than usual because of the pain. During attack she keeps eyes closed, says she just can't open her eyes — even goes to bathroom holding on to objects without opening her eyes. Frequency of attacks is quite variable, anything from one to five weeks. The headache is very intense and during attacks can't touch her head. Repeatedly mentions of the fall and the headache thereafter. Additionally for the previous one year she has pain in upper back and an occasional pain in the chest.

There is nothing else significant in the rest of the history except that she had a very early menopause, menses ceased at the age of 30 years. No particular postmenopausal symptoms. X-ray of the skull showed Hyperostosis frontalis interna X-ray P.N.S. showed no abnormality.

1988

December 30: Prescription *Arnica* 200/3 powders during evening and at bedtime.

1989

January 23: Reported with a severe headache and three vomits on that day.

Prescribed: *Natrum sulphuricum* 200/3 powders at 15 minutes interval.

February 18: Reported that she had pain one day but not severe. For three days initially after taking *Natrum sulphuricum* had some rash which subsided later. Given *Saccharum lactis*.

March 6: Pain is less than before. Has had no severe headache or vomiting. Two days earlier had pain in right eye and occiput. *Natrum sulphuricum* 200/1 powder at bedtime.

March 31: For 2 weeks had no pain in the neck, now feeling it again though milder. Pain right eye in less.

Natrum sulphuricum 200/1 powder at bed-time.

This was repeated by my Assistant in my absence on April 26.

May 15: Was better for 2 weeks and then recurrence.

Natrum sulphuricum 1000/3 powders at 15 minutes interval.

June 7: No headache in this period. Pain neck still there — a drawing feeling < in morning. Pain mid-chest — this has been there for a long time.

Saccharum lactis.

July 11: Headache 1 week ago with vomiting.

Natrum sulphuricum 1000/3 powders at 15 minutes interval.

August 7: Weakness, anxiety, a feeling of lethargy, has to drag herself to get up and do her duties. No appetite. Extra sleepy, desired to keep lying and sleep. Pain in chest is less. Has taken vitamin B Complex capsules and injections of Neurobion (Vitamin Bi, B6, **B12**).

Kali phosphoricum 200/3 powders during the evening and bed time.

September 19: Pain upper back and chest and pain in the neck. All pains are < morning "The stiffness and pain ease as I get busy in work".

Rhus toxicodendron 200/3 powders during evening and bed-time.

October 21: Headache is less, pain neck is less. Has pain in the back and chest.

Kali bichromicum 6, 30, 200/1 powder of each during evening and bed time in that sequence.

November 15: All symptoms better. *Saccharum lactis*.

1990

April 3: Has been generally well. Now having pain in right eye and right side of head. It is a pricking pain. Comes from exposure to sun, even looking at sunshine, herself being in the shade — as when going in a car.

Natrum sulphuricum 1000/3 powders at 15 minutes interval.

September 11: No pain head, no vomiting. Much pain in the neck, mostly right side. Pain in right eye, pain in back.

Natrum sulphuricum 10M/3 powders at 15 minutes inter/al.

October 3: On October 2, had much pain, this was in whole head and there was vomiting. Analgesics did not help. The reason could have been overwork and not enough sleep as the previous day she had about 60 guests for dinner.

Natrum sulphuricum 10M/3 powders at 15 minutes interval.

Thereafter she kept well and was mostly on *Saccharum lactis* right till **November 12, 1991** when she was last seen. Only remedy inbetween was on **March 8, 1991** when she complained that the glare of on-coming car light is very disagreeable and gives pain in the eyes but mostly in the right or the affected eye. This also occurs when the sun is low and so the bright sun is felt directly in the eyes. All along there had been no headaches. For this symptom now, she had been given *Hepar sulphuris* 200/2 powders in evening and bed-time.

ACUTE HYDROCEPHALUS

Case No. 1

Baby Kaka, age 2½ months (born May 26, 1967) consulted on August 14, 1967. F.T., N.D., but mother had been given two injections and medicine twice to promote labour pains. Birthwt. 10 lbs (first child was 9.5 lbs and other two 7.5 lbs). Breastfed. Jaundice at 5 days with fever. Looked normal and healthy at birth. However, when three weeks old, it was noticed that the eyes are turned down (sun-set sign) and the diagnosis of Acute Hydrocephalus was made in the hospital. Takes feeds normally. Diarrhoea off and on. Perspiration average and nothing unusual noticed. B.C.G. when 5 days old. Still not completely healed. Small pox vaccination at 2 months. There was no reaction. Head measurement increased rapidly. When initially taken at 3 weeks, it was 15 inches. In 15 days it increased by 1 inch and one and half month later when brought to me it was 19 inches (equal to 48.6 cms).

1967

August 14: *Sulphur* 30/1 dose first day.

Calcareo carbonica 200/1 dose second day.

August 21: Head measurement remains at 19 inches. Has diarrhoea today. Six motions — forceful, frothy stool with lot of flatus.

Calcareo phosphorica 6x/12 powders q.i.d.

August 30: Diarrhoea continues. Measurement approx. same. Previously eyes always turned down, now sometimes straight also.

Calcareo carbonica 200/1 dose.

September 6: Cough for 3 days. Fever one day. Vomited twice yesterday. Head size increased from 48.6 cms to 49 cms.

Ipecacuanha 30/16 doses at 4 to 6 hours interval.

September 9: Temperature normal. No vomiting. Still has cough-rattly.

Ipecacuanha 30/16 doses t.i.d.

September 23: No cough etc. Measurement of head seems a little reduced. The anterior fontanelle which was full and bulging is lower. B.O. alternate days. Wt. 19 lbs. *Calcareo carbonica* 200/1 dose.

October 13: Head 49 cms., i.e., no increase in the previous 5 weeks. Constipation. B.O. after 3 or 4 days. Offensive flatus. Sun-set sign in eyes much less. Holding head up. Fontanelle has now got depressed and is closing up. The B.C.G. sore has still not healed. Developed a bad-cough which did not respond to *Ipecacuanha* and after 2 weeks looked like whooping cough for which he received *Drosera rotundifolia*, then *Belladonna* (cough and sneezing together), then *Carbo vegetabilis*, later *Bryonia alba* over the next 6 weeks.

On November 4 the mother mentioned another symptom that he had much sweating on head during sleep and after taking milk. On November 29 the head size was very slightly increased (by 3/8 inches). In early December he had diarrhoea which responded to *Calcareo phosphorica* 6x q.i.d.

December 30: Mother reported "Much sweating during sleep inspite of cold winter, sour smelling. I feel bad picking him up as the smell is so strong." *Calcareo carbonica* 1000/1 dose.

1968

January 16: B.C. alternate days. Sweating same. Speaks few words. Ias cut four teeth. Posterior fon-

tanelle closed. Anterior fontanelle approx. 1 inch wide. Head 20 inches, wt. 21 lbs.

March 13: Head 20.5 inches. *Calcareo carbonica* 1000/1 dose. In April she reported that the sweating on the head was probably less and in May inspite of very hot summer it was hardly noticed. The head size continues to remain stable with a very marginal increase to 20 6/8 inches on August 12, 1968. In **November 1968** he got an eruption on the face which was oozing and crusting and spreading like impetigo. This I ascribed to Ijis using nylon pullover and was quickly cleared by *Rhus toxicodendron* 30/16 powders q.i.d. and later one powder of *Pyrogenium* 200. I continued to see him for minor complaints like an occasional cough, diarrhoea or fever, prickly heat, etc. till **October 26, 1970**. He continued to be quite normal and with his general growth, the head did not look at all out of proportion. There was no deficiency — mental or physical.

Case No. 2 (Hydrocephalus)

Baby S.S., age 3*Vi* months (born May 9, 1971) consulted on August 28, 1971. F.T., N.D., but had to be rotated under G.A. and brought out feet first. Birth weight 9 lbs. (previous children IVz and 8 lbs.) Mixed feeding, i.e., breast and bottle. Head was slightly larger at birth. Was normal till August 9, 1971, then started to cry very much and also vomit. At this stage the diagnosis of Hydrocephalus was made. She was operated on August 19 and shunt was inserted. The other end of the tube put in the chest. The operation was done at A.I.I.M.S. The parents were told that on fundus examination some damage was found in the eyes which may or may not recover. Head size on August 10-19V2

inches, August 14-20 inches (50.8 cms), August 19-51 cms.

Felt much better after the C.S.F. was drawn from fontanelle and spine. She is restless when the fontanelle is bulging.

Appetite has reduced. B.O.R.

Sleep varies according to state of intracranial tension. Nothing unusual about perspiration.

F.H. — Mother had no special ailment during pregnancy. Took the usual multi-vitamin and calcium tablets. Has two other children, age 5 and 4, both normal.

1971

August 28: *Calcareo carbonica* 200/1 dose.

She had been brought from another city (Kota, Rajasthan). Subsequently, reports were by letters and as she was doing well, she continued to receive *Saccharum lactis*. In a letter dated September 10, it was mentioned that she had been vaccinated for small pox on that day.

1972

January 12: The patient was brought again. Head size which had remained constant at 47.5 cms. for some months showed a rapid increase to 50 cms. I told them that it appeared that the tube is blocked. The parents also noticed that she was not eating properly for the previous 2 weeks.

Calcareo carbonica 200/3 doses at 4 hourly interval.

February 14: Got her examined in the hospital and was told that the tube is blocked and the whole process has to be repeated and a new tube inserted. This, the parents refused. During the previous month, the head size had increased by 1 inch (2.5 cms).

Lycopodium clavatum 30/1 dose.

February 17: *Sulphur* 200/3 doses at 10 minutes interval.

March 12: Head size 21.5 inches — an increase of V2 inch in one month.

Calcarea carbonica 1000/3 powders at 10 minutes interval.

April 10: Size 22 inches.

Saccharum lactis.

April 30: 22V_A inches.

May 2: *Calcarea carbonica* 1000/3 powders at 10 minutes interval.

June 20: 22V2 inches. Always thirsty. Urine is less than normal for past few months. I ascribed it to the fact that it is normally less in the hot summer months. Had a fracture of the arm and was put in plaster.

Calcarea carbonica 10M/3 powders at 10 mts. interval.

July 5: The head size continues to increase though very slowly. Now 23 inches. The process of closing of the fontanelle seems to have been slowed or arrested.

Apis mellifica 3/21 powders t.i.d.

August 26: 23 inches.

1973

April 20: Size 23% inches. This slight increase could be considered as an increase with age.

Apis mellifica 3/9 powders t.i.d.

July 10: Head size stationary. No unusual perspiration. Normal intelligence. Talking well. The only problem is in walking, possibly due to the larger size of the head. All functions, like digestion, sleep, etc. normal.

September 24: Head size same. Only slight difficulty in walking. "Allopathic doctors who had been seeing her all along considered it a miracle."

Calcarea carbonica 10M/1 dose at bedtime.

1974

January 17: Reported personally. Head size nearly 24 inches. Is talking well and engaging in all activities. Is only hesitant in walking for which she used a roller type support. Has multiple caries in teeth and some broken, possibly flat feet. Eyes slightly open in sleep.

Calcareo carbonica 10M/3 powders on the same day.

May 7: Size stationary. Sleeps in knee-head position. Seems to have good strength in the legs. Maybe not confident in walking because of poor balance.

Medorrhinum 1000/3 powders at 10 minutes interval.

August 24: Head size stationary for many months. Is now walking short distances without any trouble. General development is good.

November 8: Particular liking for milk and asks for it frequently. Appetite more than average. Walking for the previous 6 weeks. Memory and intelligence good. Remembers poems. Talks quite a lot. General condition satisfactory.

1975

May 22: Was last seen on this day. Head size stabilised there being no further increase. Walking much better and also runs.

» * *

1984

October 6: Seen again after 9 years. Now age 13 years. In the intervening period the father had been posted abroad and she had been schooling there normally. It was a good opportunity for follow-up of the case. She had been quite normal through the years and in fact now came for advice about obesity and some lack of concentration in the previous two years.

M.P. — Menarche a few months earlier. Regular.

She was again prescribed *Calcarea carbonica*.

Comments: There are a few notable features in this history:

With Homoeopathic treatment, it was possible to avoid the second operation after the tube got blocked. It was also possible to reverse the damage in the eye found on the initial fundus examination.

She needed practically only one remedy (*Calcarea carbonica*) all through her treatment or certainly most part of it. The potency was gradually raised as per standard rules.

The same remedy (*Calcarea carbonica*) was indicated even after 13 years, even though she now consulted for a different condition.

Case No. 3 (Hydrocephalus)

On October 20, 1987 I am consulted by Mr. A.N.V. The first thing that he tells me as he sits down, "I like to express my profound gratitude for the treatment of my son A.V. for Hydrocephalus 3½ years ago. He is now 4½ years old and is absolutely normal and going to school." At this I took out the history of A.V. for whom I had been consulted on **May 9, 1984**. The child had been born on August 27, 1983, F.T., N.D., Birth Wt. 3 kg., breast fed to date. Only recently occasionally given the bottle also. No inoculations as yet. At birth he was seen to have a meningomyelocele which was operated the same day. 4 to 5 days later when he was taken to the operation theatre to have the stitches cut it was found that the size of the head was 35 cms whereas at birth it was 32.5 cms. Thereafter there was an increase of 1 cm every week for some weeks. Shunt was advised but not agreed to by the parents. He had had some Homoeopathic treatment from 9 lay Homoeopath who

had prescribed *Apis mellifica* 30 and after sometime additionally *Aconitum napellus* 30. This had not made any difference and the size of the head had continued to increase. The child was prone to cold and cough which he would get for any slight exposure. Appetite, bowels and sleep normal. The child would not turn in bed and was late sitting up. In fact it was only a few days prior to consultation that he started to sit. The child had more perspiration than normal in summer. This tends to be more in sleep and possibly on the whole body. The pillow gets wet but to an extent also the clothes.

Family history: No diabetes or T.B. The mother had hypertension during the last pregnancy from 7th. month and also swelling of lower limbs. She had used Lasix (Furosemide) Tabs for the swelling. She had also used Iron and Calcium tablets during the pregnancy. Her first child was premature and the rear part of the head had not developed. This was a still birth. Second was a normal child and is 4 years of age. The patient is the third para.

On examination: Heart, lungs and abdomen — N.A.D. Wt. 21 lbs. Head circumference 46 cms.

Prescription: *Calcareo carbonica* 200/1 powder.

1984

Next reported June 23, i.e., after *IV*2 months. Head measurement same — 46 cms. Growing well, started to crawl a little and stands up by holding a support, is cheerful. Given *Saccharum lactis*.

June 30: Reported again because of diarrhoea and vomiting. Probably due to dietary indiscretion. Had taken spicy food — (Warriaan — a preparation of pulses with spices and chillies).

Prescribed: *Arsenicum album* 30/8 powders every 4-6 hours. Instructed to continue the medicine of **June 23**, if the diarrhoea got alright otherwise to report.

August 4: Head size about the same. Perspiration offensive. *Calcareo carbonica* 200/3 powders at 15 minutes interval.

September 15: Head **47Vi cms.** Otherwise feels alright. *Calcareo carbonica* 200. This prescription was repeated on **October 20**, when it was noticed that he had a V4 cm increase in size of his head and was getting cough frequently in the change of season.

December 8: Head size now 48 cms., otherwise progressing well and general health good.

Calcareo carbonica 1000/1 powder.

1985

On **January 12** and **February 25**, the size of the head remains the same. In February he started to eat lime which he scratched from the walls. Also noticed to have perspiration in the feet.

Repeated *Calcareo carbonica* 1000/1 powder.

May 4: "Much better, started walking, some talking also". Pica is now occasional, head 48 Vi cms. Still has perspiration feet. Again repeated *Calcareo carbonica* 1000/1 powder.

Last seen on **June 12**. Pica continues. Head size approximately the same but with the general growth it does not look so odd. Keeps his right foot at an angle in walking and it seems slightly narrower i.e., a little less in width compared to the left.

Repeated *Calcareo carbonica* 1000.

Was not seen thereafter. On **March 14, 1986** I received a note from his father, "Last time, I came with my son in June 85, and discontinued the treatment on

your advice. Since then, he has been keeping well and grown normally.

For last 4 days, he is down with fever..."

Case No. 4 (Congenital Hydrocephalus)

Master P.C. born September 9, 1984 consulted on March 21, 1986 i.e. at the age of 1 *Vi* years with the diagnosed condition of Congenital Hydrocephalus. This was noticed by the Paediatrician at birth and *Ultrasonography* examination was done within a few days. It showed symmetrical dilatation of lateral and third ventricles, IV ventricle not seen. Thalami normal. Suggestive of *aqueductal stenosis*. The head circumference in October '84 was 40.5 cm and by August '85 it had increased to 56 cm. The child also had unilateral congenital talipes equinovarus of right foot for which he had been put in a P.O.P. Cast. In April '85 this had, however, to be removed after a short while because the patient developed blisters on the skin. The parents mentioned that in early infancy he was diagnosed to have septicæmia and was treated with antibiotics (Ampicillin and Gentamycin). Details of this were not available. For the Hydrocephalus the patient had used Diamox 1/2 tab B.D. and syrup Phenargan. In March '85 the fundus was examined and reported to be normal in both eyes. The obstetric and paediatric notes were F.T., N.D., breast fed for one year, teething at 8 months. Child was having extra sweating of the head in all seasons. More marked during sleep which drenches the pillow.

On examination it was seen that the child responds to sound, moves all limbs, holds the head, can sit for a few seconds before falling but is not able to stand even with support though does put both feet flat on the ground. Makes babbling sounds. The child has a conver-

gent squint. Presently sun set sign is negative but the history shows that it was positive in the past. The left parietal area is disproportionately enlarged. At birth also it was noticed that he had cephalhaematoma in this area. The fontanelles are open. Reflexes in lower limbs absent or very sluggish.

1986

March 21: *Calcareo carbonica* 200/3 powders to be taken at 15 minutes interval.

April 23: Reported with fever for the previous three days. No cold or cough or other symptoms. Prescribed *Belladonna* 30/12 powders q.i.d. and thereafter to take *Calcareo carbonica* 200/3 powders again.

Next reported **May 5th.** Again had fever for the previous six days. The fever reported on April 23 had got alright with Bell. *Belladonna* 30/18 powders q.i.d.

June 26: Fever got alright. Sleeping better. Mentally more alert. Greeted me by folding hands when asked by the mother. Head now 59 cms i.e. an increase of 3 cm. Weight 21 lbs. Repeated *Calcareo carbonica* 200/3 powders to be taken at 15 minutes interval.

August 22: General progress is there. Now there is not so much perspiration in head. Has hair falling from lateral sides of the occiput and some pimples. These are not uncommon in children in the tropics in the rainy season. Repeated *Calcareo carbonica* 200.

October 20: Head circumference increased by another centimetre and now measure 60 cms. *Calcareo carbonica* 1000/3 powders.

November 11: Fever, cold and cough, vomits mildly dyspnoeic-four days. On examination: no rhonchi, medium crepitations. *Ipecacuanha* 30/24 powders q.i.d.

1987

Thereafter was not seen for some months and reported again on July 14, '87. Again sweating from head, stool stony hard with straining, may pass a little blood. Can support head but unable to stand. Talking normal.

Calcareo carbonica 1000.

September 10: Can stand on his own and can keep standing by holding to some support. No sweating head. Appetite good. B.O.R. sleep good. Had cold, fever and cough two weeks earlier for a few days.

Calcareo carbonica 1000.

October 12: Has an abscess on the head and a gland in the neck ?due to the abscess. Stools are big and very smelly. *Silica* 30/18 powders t.i.d.

October 24: The big abscess burst on October 13. At present has some small pimples in that area. Fever for last two days. Temperature not recorded. *Calcareo carbonica* 1000/3 powders.

He was seen from time to time subsequently till early 1991. He remained generally well, the only major complaint was that he did not stand or walk even, though over 4 years of age. Therefore, he had to be carried all the time. The parents thought that he had no strength in his legs. He had started to crawl by March 1989. In September 1989, the parents reported that he had become very irritable and actually beats his younger sister.

Calcareo carbonica 10 M given on September 2 and December 26, 1989 and April 21, 1990 did not make much difference.

In August, 1990 his father reported that he (the father) had got T.B. and had just completed about one and a half year of A.T.T. So Master P.C. was given a dose of *Tuberculinum* 200.

Early in 1991, because of the deformity of his feet, an Orthopedist was consulted and he advised operation on both feet. Learnt that his head size remained nearly stable and he was also walking about.

Case No. 4 (Hydrocephalus)

Baby S.P., a male child was born in February, 1972 and came for consultation at the age of 10 months on **December 29, 1972**. It was a diagnosed case of Hydrocephalus. Nothing was detected at birth. It was F.T., N.D., still breast fed, teething at 10 months, just a few days earlier. No vaccination and no inoculation. He had actually come from a village near Jaipur with poor medical facilities. Two months earlier, he had pus discharge from the ear. The doctor who examined remarked that the head is large and advised an operation and inserting a shunt for drainage. The measurements were taken. The family postponed the operation and instead tried Diamox. But inspite of this in the two months period, the circumference increased by 2 cms. Besides Diamox resulted in loss of appetite and also reduced his sleep. The baby had sweating on head during sleep and when nursing.

P.I.: Perhaps bronchitis or 'flu a few times.

F.H.: Was one of five brothers and sisters. All the rest were normal.

X-ray skull: "It shows silver beaten appearances throughout the skull — suggestive of increased intracranial tension or hydrocephalus". Recent report of E.N.T. specialist — ear n.a.d.

Had been advised:

- (i) Ventriculography and measurement of pressure^
- (ii) Atrio-ventricular shunt (Halter's valve)

O.E.: Head circumference 52 cms. Anterior fontanelle open about 5 cms. across. Eyes slightly turned down (partial sunset sign).

1972

December 29: *Calcareo carbonica* 200/3 doses in water, every 4 hours.

1973

January 31: Eyes look more normal, i.e., not turned down. Is more active. Tending to support head better. Hearing better. Head circumference remains at 52 cms.

Saccharum lactis continued.

March 1: Head circumference maintained at 52 cms. so the progressive enlargement has been stopped. Gradual increase of activity.

April 12: Last reported on this day. Progress maintained and no increase in size of head.

Comments: This child was thus saved complex investigation and an operation and needed only two doses of *Calcareo carbonica* only once (three doses on same day considered as a single divided dose).

ALOPECIA TOTALIS

Mrs. F.A., age 32 years, a case of Alopecia totalis. She consulted me on August 16, 1984. She had been married 5V2 years. Had two children aged AVi and 2Vi years. No abortion. She gave a history of rapid hair falling for the previous four months. In March 1984 she found she had a small hairless patch Alopecia areata. Her mother said this could be an enlargement of a tiny patch where she had a boil in childhood. An Allopathic

doctor prescribed K-5 tincture with no oral medicine. Later she used Pragmater ointment even though she had no dandruff. Had itching on the head especially in areas with less hair.

Menstrual period: Regular. Become scantier for last six months. She felt it was more normal flow now because previously it was copious. She mentioned of pain "in vagina" on first and second day for the previous three months.

Appetite, bowel movement and sleep were all normal. On enquiry I learnt that she had deliberately lost 10 kg in the previous 2½ years by dieting and exercise.

There was a history of frequent vaccination, often yearly till seven years ago. Three years earlier she had received an injection of "Gamma globulin" during pregnancy because elder child had chicken pox.

She is a hot patient. She has extra perspiration specially on the head. As an infant she used to have much perspiration on head in sleep wetting the pillow.

P.I.: Had a congenital hole in the heart which was successfully operated in 1966. Had jaundice in 1963 and Malaria in 1978.

Clinical Tests: HB. 11.9 gm., E.S.R. 45 mm., Thyroid Profile: W.N.L.

O.E.: Heart, Lung, Abdomen — N.A.D. Practically no hair on scalp (completely bald) only a slight rim of hair along the edge especially over the lower occiput and nape of neck.

1984

August 16: Prescription: *Calcarea carbonica* 200/3 powders on the same day.

September 11: Hair fall is less "but as so many have fallen and very few remain so falling rate is less. No new ones growing yet."

Urine examination: N.A.D. X-ray chest — No abnormality found. Stool examination: *Blastocystis hominis* +. *Acid Fluoric* 200/3 powders on the same day.

September 28: Some hair growing but some hair still fall. Altogether better.

Prescription: *Saccharum lactis*.

October 23: Still only a few hair on the scalp. None grown.

Prescription: *Acid Fluoric* 200/3 powders.

December 7: Worse. Practically no hair.

Prescription: *Selenium* 200/3 powders in same day.

1985

January 7: Not many hairs, some new ones have grown and these are white.

Prescription: *Selenium* 1000/3 powders every 15 minutes.

February 11: Fair number of new hairs are growing, mostly white, perhaps a few black ones. Repeated *Selenium* 1000/3 powders every 15 minutes.

March 14: Some white hair are turning black, not many hair growing in this period. Previous ones probably grown longer. Has a "Hollow" feeling in stomach even half an hour after eating, for the previous three days.

Prescription: *Sulphur* 200/3 powders every 15 minutes.

April 8: More hair growing, mostly white.

May 4: Some further growth of hair and also some black ones. Pain in feet and legs for the previous few days.

Prescription: *Calcarea iodata* 200/3 powders.

July 11: Good progress, hair have grown longer, new hair have appeared, some are turning black but still majority is white. Prescription: *Saccharum lactis*.

August 10: Much better. Hair longer and some are turning black. By now the scalp has got covered with hair.

September 14: Complained of anorexia and had lost some weight. No pain in legs, hair growing longer and more are turning black. Earlier had cold, sore throat and fever for which she received *Rhus toxicodendron* 30 and later *Phosphorus* 30.

Prescription: *Selenium* 1000/3 powders every 15 minutes.

October 7: Cold and sinus Okay. Not much change in the hair.

Prescription: *Saccharum lactis*.

1986

January 20: Further improvement in hair growth. In density and length and also some have turned black. (60% black)

March 13: Complained of pain in the legs "as I had earlier in May 1985 and which was quickly relieved with the medicine". "I am quite satisfied with the hair growth, so if medicine for pain interferes with the hair give me medicine for the hair as that is really doing well. Growth is now thick and majority are black" Passed a roundworm in stool.

Prescription: *Calcarea iodata* 200/3 powders every 15 minutes.

April 4: Pain legs practically okay "90% relief". But hardly any difference to hair growth during this period i.e., no further growth. *Selenium* 1000/3 powders at 15 minutes interval.

June 27: M.M.B. Most of the hair turned black "In fact the growth of hair is thicker than my original".

August 16: V.V.M.B. Has now discarded her scarf with which she would tie her head for the previous two

years. She felt so embarrassed to be without it that even as her medical attendant, I saw her scalp only on the first visit and then today. Feels very confident now with her hair re-grown. Everybody marvels at the re-growth of her hair and feel it is a miracle.

On this date I hesitatingly asked her if I could take a photograph from the side without showing her face as she still has some white hair which, according to previous experience, might turn black in a few months. She felt so confident that she said that you can photograph from any angle.

Saccharum lactis continued.

September 3: More of white hair have turned black, only a few remain. Developed a small nodule at the base of right thumb. It is quite hard, looks like an exostosis. It is tender.

October 1: The white hair are gradually turning black. "But the initial speed was much greater — in 3 weeks a lot of them had turned black." Hair are now curly. Previously, they were very straight inspite of using curlers. So planning to stop medication but husband insists that she continue, fearing that discontinuing further treatment may not stop the process of growth of hair and of their turning black.

Saccharum lactis continued.

1987

February 4: No hair fall in combing, "not even one". Hair are growing longer. Exostosis right thumb is smaller and less tender.

March 4: Most of the white hair have turned black. Very few remain white. "Everything satisfactory in general."

Saccharum lactis continued.

July 27: No problem of hair. Now all the hair are black. "No white hair at all — not a single one".

1988

February 2: Noticed a hairless patch (alopecia areata) on nape of neck in last few days. Is much scared because of past experience.

Acidfluoric 200/3 powders on the same day.

April 1: Hair growing and patch fitting up.

June 8: Hair grown fully and the bald patch can no longer be made out.

* * *

Her family and friends were so impressed that many patients were referred, so I have had occasion to see her from time to time. Last visited for her son who had jaundice at the end of **August 1994**. She is carrying on well and continues to have a good growth of hair.

ALOPECIA AREATA

v

Mr. T.R.K. age 54 years, Government servant, concerned with education planning, consulted on September 5, 1987. Hair loss in a patch of 5 cm. diameter in the right occipito-parietal region, around that a circle of grey hair. This condition appeared during the previous 8 months. He felt that it is possible that for sometime in this period he had some puffiness of the scalp at this location. No complaint of pain and no burning or itching. For this had had treatment from a very noted Dermatologist who gave him some oral medication and an ointment as also Beclomethasone Dipropionate lotion.

>

This medication made no difference in more than two months of treatment.

Additionally he had cracks in creases (flexor surface) of finger joints but only in winter months, for the previous several years. There is no bleeding from the cracks and they heal spontaneously as the weather gets warmer.

During the previous one year he had noticed some prominence of bone or exostosis on the medial aspect of right big toe as also in the middle of the wrist on flexor surface. He had a history of sneezing bouts every autumn (September and October). Tendency to wheezing and dyspnoea at seaside during the previous 5 years. Hot patient.

Nothing else to note in his generals and mentals except the past history of a "fear of unknown" at dusk. He would avoid taking up any task at that time. This had occurred some three years earlier and had been relieved by Homoeopathic treatment in about six weeks.

1987

September 5: Prescription: *Petroleum* 200/3 powders during evening and bed time of same day.

September 26: Reported "much better".

October 17: Further improvement.

November 10: "Better. Hair appearing in the patches, though they are white."

On examination I found that the patch was practically covered.

December 12: No itching/cracks in fingers despite cold weather.

1988

April 6: Alopecia patch completely covered and the hair are turning black. After the *Petroleum* given on September 5 he had been only on Placebo during these seven months.

Reports an eruption on genitals. Gives a history of having had it previously in 1975 which had cleared by the allopathic treatment from a skin specialist. Could it be a return of old symptoms according to Hering's Law? However, since it persisted for sometime *Petroleum* 200 was repeated.

Subsequently this also cleared but he was left with a slight Phimosis.

By beginning June 1988 the bald patch had got so well covered with hair which were now totally black that it was not possible to locate where the patch had been. No recurrence of this till March 1989.

ERUPTION SCALP - HAIR FALLING

Miss P.G., age 7 years consulted on August 3, 1983. Even though young in years the main complaint that the parents made was of hair falling for the previous 4 months. The sequence of events was something of this nature — initially there had been dandruff (dry), itching and hair falling. Consulted an Allopath G.P. who prescribed Betnovate and some other medicines. After two weeks consulted a Skin specialist. He prescribed some application for local use which contained, besides some other medicaments Sulphur and Camphor in coconut oil. The next day there were pimples on the whole head. Thereafter they consulted some other Homoeopath and had his treatment for 2 1/2 months. With this treatment there was some relief but not completely cured. There was still much itching on the head and some pimples kept appearing from time to time. There was no discharge. She had many bald patches.

Her other complaint was pain in the legs at night and she wanted them tied hard. There was caries in the teeth.

S.O.M.: She would get earache at least once a month and thereafter discharge.

She had been very fond of sweets and sugar. Would take Chapati (leavened bread) with sugar or brown sugar. Licks salt also. She dreamt rarely but dreams were mostly frightening. Had no fears otherwise. She is peevish and obstinate child and cries much. Has always been so.

As for earlier background her mile-stones have been normal except late talking. She did not speak till age of 4 years and even at present speech is a bit childish and not clear. She can't utter 'Sa\

Hot patient.

1983

August 3: Prescription: *Calcareo carbonica* 200/3 powders.

In the margin of my sheet I wrote *Calcareo sulphurica* for future consideration.

August 18: Reported with eruption on scalp, also pimples and itching. Hair falling is less. It was felt that it was too early to make a full observation or a change, therefore *Saccharum lactis* was continued.

September 3: Hair are growing. Some pimples on head. Circinate eruption on nose.

Calcareo sulphurica 200/3 powders at 15 minutes interval.

October 1: Hair growing, still some pimples on head, itching in ears and pain legs.

Repeated *Calcareo sulphurica* 200/3 powders at 15 minutes interval.

October 25: Much better in every symptom and occasional eruption spot. Dandruff. To continue *Saccharum lactis*.

December 12: Not so well the previous 15 days ?because of winter season. Some dandruff. More boils. Itching.

Repeated *Calcaria sulphurica* 200.

1984

January 21: Only a few eruption spots on the head. Dandruff is less. Given *Saccharum lactis*.

Reported again on **April 14** and **May 5**. On both these occasions I was not in town. Apparently she was better as my Assistant gave *Saccharum lactis* on both these occasions. Possibly for a recurrence he repeated *Calcaria sulphurica* 200 on **July 19** when again I was not available.

No report was received thereafter and it would have remained in our files if it had not been for the fact that her sister came for consultation on **March 11, 1985** and informed that Miss P.G. had fully recovered with the treatment she had had and now had been quite well for many months.

PREMATURE GRAY HAIR

On December 19, 1988 I am approached by the father of M.S. seeking an appointment for some other patient. He then reminds me that I had treated his son for premature graying and he has now no gray hair and a very good lustrous growth on his head. Then I look up through my old notes. I was consulted for Master M.S. on November 8, 1969 and his age then was only 3 years

7 months. For the previous six months he had been already getting some gray hair. He had one sister aged **8V2** years. She and the parents gave no history of early graying. During pregnancy the mother had taken some hormone injections to prevent an abortion as she had had it twice prior to this pregnancy. The notes are F.T., N.D., birth weight 6 pounds, breast fed but supplemented with bottle from beginning. Had whooping cough at age three weeks. Small Pox vaccination twice. Has had D.P.T. and Polio by oral drops.

Appetite: Poor, likes cold things, salt + -I-, licks salt also. Also takes sugar but not as keen as on salt. Threadworms seen on rare occasions. Probably hot patient. Gets cold frequently. Irritable. He was prescribed *Natrum muriaticum* 6x, 30, 200/1 powder of each.

The patient was from out station (from Himachal Pradesh) and for some acute condition took local allopathic treatment. When he reported to me again on **January 6, 1970** he was given *Nux vomica* 30/1 powder to be taken at bed time on the first day and *Natrum muriaticum* 200/1 powder to be taken the next morning. *Natrum muriaticum* 200 was repeated on **February 18**, and one powder of *Natrum muriaticum* 1000 was given on **April 22, 1970**. Thereafter he reported in **May** and **August** but since the letters are lost I have no notes on my history sheet. Apparently he reported progress as I have given only *Saccharum lactis* on both these occasions. There was no further contact till **December 19, 1988** (i.e., 18 years later) as mentioned above.

Comments: The constitutional remedy was prescribed at infrequent intervals and although it does not appear in the Rubric: HAIR, gray, becomes, on page 120 of Kent's Repertory it cured this patient.

UNILATERAL EXOPHTHALMOS (PSEUDOTUMOUR)

Mrs. V.S., age 30 years consulted on May 4, 1992. She had been married in 1988, Had no children and no abortion (primary sterility). Seminal fluid of the husband had been examined and found normal.

She came with a diagnosis of Pseudotumour right eye. The diagnosis had been made by a specialist in May 1991.

BackgroundHistory: In October 1974, at the age of 13 years she had pain, redness, inflammation in right eye. She received antibiotics and steroids, both orally and as eye drops. The condition kept recurring. It was then diagnosed *Retrobulbar Neuritis and Orbital Cellulitis*. Vision continued to be normal. In May 1975, A.T.T. was proposed but not taken. Then she took some treatment from an amateur Homoeopath. She was given *Sulphur* 200 at bed time of one day and it showed remarkable result because the acute pain subsided by next morning though some bulging of the eye and redness remained. He gave 3 more doses of *Sulphur* 200 over the next few days upto May 22, 1975, on May 25, 1975 *Silica* 500, on June 17, 1975 *Silica* 1000 and on July 8, 1975 *Sulphur* 1000.

She kept fairly well for the next 15 years. In July 1990, she had viral fever for which she received much antibiotics. After that low grade pyrexia persisted. Subsequently, she had two or three attacks of viral fever at an interval of some months. In April 1991, she received *Psorinum* 200. This cleared the low grade pyrexia. After 10 days she was given *Calcarea carbonica*. Thereafter she had a recurrence of her eye trouble.

Much investigation was done. The results of some of .
which are given below:

X-ray chest - Normal

C.T. Scan of brain - Normal Study

Ultrasonography right orbit - Impression Endocrine
Exophthalmos

Abdomen scan - N.A.D.

X-ray P.N.S. - Normal

Six weeks ago she had fever 102.6°F. After treatment
low grade pyrexia (99-99.4 F) has persisted. Slight tired
feeling.

In recent months had used Prednisolone for her eye
condition but discontinued two months ago.

Appetite: Good. Non-vegetarian. Likes sweets.
B.O.R.

Sleep — Good. But in last 4 months not so refresh-
ing. Dreams — Is in difficulty: lost her way, does not
know where to go, etc.

Chilly patient, possibly feels both heat and cold but
cold more.

Irritable but keeps it to herself and does not lose
temper. Worrier. Not keen on company.

M.P.: Regular. Mild pain for 1 or 2 hours before and
for short while after onset.

P.I.: Frequent colds. Less for last 2 years ?after use
of steroids. Eczema at the age of 20 years. Suffered for 3
months. Cured by *Croton tiglium*. Had mostly been on
Homoeopathic treatment. Fracture at 3 years — Good
union and no after effects. Arthritis of one knee at 7
years was diagnosed as Rheumatic fever and had
Penidure L.A. injections for one year.

F.H.: Grandfather — asthma. Father had T.B. glands
in childhood. An uncle has Diabetes.

O.E.: Wt. 97 lbs. Ht. 5'3". No abnormality found in general examination. Exophthalmos right eye.

As mentioned earlier during the early phase of eye trouble, the vision had remained normal. However, now it had been affected in the right eye. Even with correction (0.5 D) it is 6/9 on right side. Vision is poorer in bright light which has been considered as due to the development of a cataract as a result of eye drops containing steroids. She also had some pain in the right eye.

In Kent's Final General Repertory on page 262 EYE-PROTRUSION, right eye more than left: Com. This is the only remedy mentioned and in first grade. Boericke Materia Medica page 229: "Eyes — Ciliary neuralgia with eyes feeling large and protruded, especially right... feels as if pressed outward... eyeball feels too large"

1992

May 4: *Comocladia dentata* 200/3 powders on the same day — morning, afternoon and bedtime followed by *Saccharum lactis* for 3 weeks.

May 12: Came to report that she had fever one day. Pain in eye off and on. Asked to continue the medicine (*Saccharum lactis*).

May **26**: Pain became more frequent, i.e., a daily feature in last 2 weeks. However, there has been no pain in the last 3 days.

Saccharum lactis continued.

June 8: "Much better" practically no pain in eye. Has a cold from the previous day and temperature 100°F. Feeling slight chill.

Rhus toxicodendron 30/16 powders q.i.d. and *Saccharum lactis* to follow.

July 22: The cold and fever got okay with *Rhus toxicodendron*. During those days had slight pain. Sub-

sequently, has had trouble in the eye on two occasions. In the last 5 months she feels she had proper M.P. one month and the next month has blackish spotting for one to two days and then proper flow. On such occasions also has pain eye.

Comocladia dentata 200/3 powders at 15 minutes interval.

August 15: L.M.P. on August 12 — spotting for 2 days and then free flow from August 14. For last 2-3 days feeling pain in right eye and right malar bone. Had cold for one week. Now has slight cough and partial nose block.

Sanguinaria canadensis 30/16 powders q.i.d. and after that to take *Comocladia dentata* 200/3 powders at 15 minutes interval.

November 10: In October had a cold and at that time felt very cold especially in the feet. For this *Nux vomica* 30 was used with quick relief. During the last nearly 3 months had pain 4 times — initially there is pain in the right side of the head and then mild pain in right eye.

Comocladia dentata 200 repeated for the last time. ,

November 16: From the previous day has pain in right knee. There is difficulty or pain in bending. It is to be recalled that she had rheumatism in childhood and the same knee was affected. I have put a question mark, could it be return of old symptoms.

Saccharum lactis for 5 days.

November 30: Knee pain disappeared. Eye feels okay.

She has been seen subsequently from time to time as she is now anxious to have treatment for sterility. There has been no recurrence of pain in the eye and the exophthalmos had been much reduced and the two eyes looked practically the same. Last seen on **April 10, 1993.**

TUMOUR ON EYEBALL

On September 16, 1989 we are approached by a patient with a serious ophthalmological problem. He says that he has been referred by Mr. RKG who was successfully treated for similar problems and therefore has referred me here.

Mr. RKG, age 38 years consulted on February 5, 1979 with peculiar and serious visual problems. He gave a history that the lenses in both the eyes were displaced from the beginning. High Myopia from the age of five years. Subtotal retinal detachment left eye in July 1978 after a mild hit from someone's elbow. 3/4 of Retina Detached. Operated in Mid-July 1978. Unfortunately there was an infection and pus, which lasted a long time. Finally a Homoeopath gave him *Hepar sulphuris calcareum* 200 which cleared the pus. The vision was considerably reduced. One month prior to his coming for consultation he was found to have a conjunctival tear and "a clot" in the upper part of eye. The Eye Specialist advised removal of clot by operation and grafting of conjunctiva. The 'clot' later turned out be a growth on eyeball covered with blood. There was nothing significant in the rest of the history and no good mentals or generals. He gave history of revaccination six years earlier.

1979

February 5: Prescription *Arnica* 200/3 powders, to be taken within 12 hours.

February 19: No change.

Prescribed *Thuja occidentalis* 1000/1 powder.

March 3: Much better — hardly any sign of the growth. Given *Saccharum lactis*.

April 3: No sign of growth. Whatever vision he has is from the left eye (right eye has a cataract), and perhaps because of that he gets tired after reading for sometime. Has been seen by the Eye Specialist who is surprised to see that the growth or 'clot' is no longer there and said, "have you had it operated?" He also said that the retinal detachment in left eye is now well settled. The conjunctival tear is still there. Prescribed *Calendula officinalis* 200/2 powders, evening and bedtime.

May 8: Other conditions having improved now he wanted to know if something could be done for the cataract. He was prescribed an unusual remedy *Cataractin* 200/3 powders at bedtime on three consecutive nights. Also the usual eye drops — *Succuss Cineraria maritima*.

June 20: Prescribed *Calcareo carbonica* 200/2 powders evening and bedtime.

Treatment was continued till **April 1981** but the rest of the treatment history may not be of interest. For the eye strain that he used to feel, he was given *Ruta graveolens* 200 on a few occasions with relief. Once for pain and heaviness in the eye after an accidental hit by his child's hand he got *Symphytum* 200 and in **September 1980** when he had surgery for his cataract *Arnica* was given pre and post-operatively.

From February 18 to **April 1981** he actually consulted for some accidental injuries and also because of congestion in the eyes by use of contact lens. He was seen again in April and May of **1982** but this time also for accidental injuries and no problem with the eye.

TINNITUS AUREUM

Mrs. A.D. age 62 years, been married for 36 years, two children, consulted on February 23, 1988. Her **complaints** were (1) Tinnitus — a "buzzing sound" in the right ear and "knocking sound" in the left ear. < at night (possibly because it is more quiet). Duration one and a half month.

(2) Pain right knee, duration one year. Walking with a limp < cold weather.

(3) Dryness of skin, duration four years. Occasional itching in some areas.

(4) Mild hypertension, 10 years.

Been very fond of sour things and chillies. But now avoids both.

Hot patient. Loves cloudy, rainy weather, feels better in open.

Sensitive. If hurt does not express but broods about it. Better in company but also enjoys being alone. One of her hobbies is painting.

Past Illnesses: Intestinal amoebiasis — 15 years ago. Duodenal ulcer — 12 years ago. Still occasional pain if takes chillies. Bronchitis (wheezing) in January 1986 and February 1987.

Family History: Two elder sisters died of tuberculosis, one of Pulmonary and one of Intestinal.

1988

February 28: Prescription: *Graphites* 200/3 powders at 15 minutes interval.

March 11: Tinnitus much less, not continuous as before, now it occurs intermittently. No pain knee. Skin patches slightly better.

Prescription: *Saccharum lactis*.

April 4: Tinnitus practically gone. Skin also better. Says she used to get occasional gas and acidity, this had also reduced. Continued *Saccharum lactis*.

April 26: No Tinnitus, skin better, itching is less, acidity — better. *Saccharum lactis* continued.

June 17: Tinnitus completely gone. No acidity. Even outside food with chillies did not disturb. Skin eruption still there.

Prescription: *Graphites* 200/3 powders at 15 minutes interval.

July 13: Itching more. Some recurrence of arthritis pain in right knee "possibly by taking bath with cold water."

Prescription: *Graphites* 1000/3 powders at 15 minutes interval.

August 19: Continues to be free of Tinnitus "remarkably gone", eruption better, itching reduced, still pain in right knee.

September 13: Much better both with regard to the skin as also the pain.

October 7: Last seen on this date, completely free of Tinnitus and no recurrence. The knee is much much better and now goes for walks. Had been on *Saccharum lactis* after *Graphites* 1000 on July 13, 1988.

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ACOUSTIC NERVE TUMOUR

In August 1989 I am consulted by a patient diagnosed as Brain Tumour and he says he has been referred by Mr. B.D.J., who had been treated some years earlier, and according to him for a similar condition.

Mr. B.D.J. age 54 years consulted on **August 22, 1975** with a complaint of Vertigo. He had been diagnosed at the AIIMS as *Right Acoustic Nerve Tumour (?Neuroma)* and for this he had been advised surgery.

He owned a sweets shop but was no longer attending to his business because of his illness. The first incidence of vertigo was in the winter of 1974 when during urination he fell down. The Vertigo had recurred off and on and he had similar falls a few times. Falls backward. Four months prior to my consultation the vertigo had got much worse which he ascribed to use of some Ayurvedic medicine. At the hospital they found that there was a reduced sensation in the area of the fifth cranial (Trigeminal) nerve. It was also discovered that he has no hearing from right ear. Two years earlier he had a discharge from the right ear. There was an accident with head injuries three years earlier and ever since he was not been able to stand or walk easily. Complained of heaviness in the head and giddiness. Sleep is reduced and sometimes talks in sleep. Hot patient. Giddiness worse in heat. Has been through a period of anxiety and worry. Brooding.

P.I.: Skin eruption feet. Smallpox in childhood.

O.E.: B.P. 110/70. Reflexes: Normal. Heart, Lungs, Abdomen: N.A.D.

1975

August 22: Prescribed *Calcareo carbonica* 200/3 powders.

August 25: Numbness right leg while sitting. Pain right side teeth after eating. Pain lasts for an hour on so. Vertigo > cold washing. This symptom appears on page 98 of the Repertory. The remedy *Natrum muriaticum* may have also suited his mentals but it was too early to review or to change.

September 1: Vertigo better. Head as if in a vice. Can't walk because of the pain in the knees and not because of vertigo.

September 3: Fever. Thirst average. Slight chill and bodyaches. *Rhus toxicodendron* 30/10 powders every 4 hours. The fever later turned out to be ?Tertian Malaria.

Had vomiting and was given *Ipecacuanha* 30. For some subsequent weakness he used *Kali phosphoricum* 6x t.i.d. for 10 days.

Subsequent notes are: "Generally much better, occasional giddiness. Pain — knees also much better" and he was on *Saccharum lactis* for the subsequent 4 months. In the meantime he was completely rid of giddiness and could very well stand the strain of a daughter's wedding with no problem. For sometime in January and **February 76** he had an eruption in which there was more burning than itching. This was eventually relieved by *Apis mellifica* 3/16 powders q.i.d.

1976

March 16: Complained of more pain in the knees. There was crepitus on movement and it was felt that he has osteoarthritic changes. Now *Calcareo carbonica* 200 was repeated. It is to be recalled that it was given at the time of first consultation on August 22, 1975 and now after a period of 7 months. He was seen for different conditions from time to time. It was mostly for the pain in the knee which was helped to a degree but in view of the advanced osteoarthritic changes could not be totally relieved. Then he wanted to be helped for odd complaints from time to time: his developing cataract, at one time for tinnitus, then urinary frequency (?Prostate), an eczema foot, chilblains and even a monkey bite.

1985

Was last seen on **September 17, 1985**. There had been no symptoms pertaining to the tumour and no recurrence of his vertigo.

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As mentioned above **I** learnt in **August 1989** that he was carrying on well and it may also be mentioned that after the initial few weeks of treatment he started going to the shop and attending to all his work. In fact on the occasion of festivals he will bring sweets specially prepared by him.

POSTNASAL DISCHARGE

Case No. 1

Miss V.C., age 23 years, consulted on October 7, 1985. The main complaints recorded were ?postnasal drip. She expressed it as mucus from right nostril moving down pharynx to right side of throat. Duration 5 years. Aggravated for last 10 months. Had Homoeopathic treatment with partial improvement. No significant expectoration. Whitish mucus, no blood.

Throat feels fatigued from talking, as if voice would fail her — "have to strain to speak"

When sitting unoccupied right arm feels weak.

Right side of back has "pins and needles off and on".

Low back pain on right side.

Pain legs, below knees, mainly right, occasional both. Said it felt as a severe ache. Could give no modalities.

Vague right sided headache, ?heaviness. If bends head backwards, occasionally associated sensation of a ball rolling backward in head.

Some burning sensation with increased lachrymation in right eye from time to time.

Pain in right ear from exposure to cold draft. Sensation of a discharge from the ear whereas actually it is not so.

It may be pointed out here that almost all the symptoms that she mentioned of different parts of the body were on the right side.

Hair falling.

She was a vegetarian. Had desire sweets.

Hot patient. Excessive perspiration from hands only in winter. It can drip and things slip from hands. Hands and feet are cold in winter and there is burning in sum-

mer and these are both subjective and objective. Burning specially in the feet and she wants to keep them soaked in water. Lips crack in winter.

M.P.: 5/28-32, regular. Has dysmenorrhoea — an intense heaviness in the hypogastrium. Starts one or two hours prior to flow and continues for three to five hours after onset with cold sweat and associated nausea.

Breast sensitive/painful to touch 4 to 5 days prior to M.P. Leucorrhoea off and on, variable consistency, bland, associated with low back discomfort.

Light sleeper. Dreams — routine matters of the day, mostly of things talked about just prior to falling off to sleep.

Mentals: Irritable, must express it otherwise feels restless or sort of suffocated. If expressed then feels fine very soon. Fear of lizards and to some extent of dogs. No fear dark or thunder. When sad she does not express it but cries at night. This is not very frequent.

At this point mentioned a symptom which could be considered peculiar in adults. She had a strong pica tendency — a craving for eating mud (Multani mitti only) and of eating raw rice.

P.I.: Pneumonia frequently till age 4. Worms in childhood. Typhoid at 14 years. U.T.I, in January 1985.

F.H.: Father-asthmatic.

1985

October 7: *Calcareo carbonica* 200/3 powders through the evening and at bedtime.

October 28: Hemicrania headaches better, other symptoms same. Repeated *Calcareo carbonica* 200/3 powders at 15 minutes interval.

December 18: Pain breast before M.P. is less but not much change in other symptoms including pica. As the

symptoms still pointed to *Calcareo carbonica*, the same was repeated.

1986

January 21: A feeling of coldness in lower half of legs and feet though objectively not so. Hands and upper limbs generally get tired soon, much headache in the previous month. Postnasal discharge and pica continue.

Calcareo carbonica 1000/3 powders at 15 minutes interval. This was repeated by my Assistant on April 2, as I was not then in town.

April 30: Reported *low grade pyrexia* — upto **99.5**, occasionally 100°F. No cough. *Calcareo carbonica* 10M — I powder at bedtime.

June 2: Low grade pyrexia persists. No special symptoms with the fever. *Tuberculinum bovinum* 200/3 powders at 15 minutes interval.

July 18: Pyrexia continued as also pica.

Alumina 200/3 powders on the same day.

October 20: Now temperature remains normal. Pica is less but not totally gone.

Repeated *Alumina* 200/3 powders at 15 minutes interval.

1987

Was seen in January and February 1987 and was doing well and no particular complaints.

On **December 9, 1990**, another relation came for treatment and mentioned about her having been well through all these years after the treatment that she had had from me.

Case No. 2 (Postnasal Discharge)

Mr. **P.K.**, age **44** years. Consulted on **September 9, 1968**. He had been married 21 years and had 3 children.

He was in business, his duties being in the office (Sedentary).

Complaints: His main complaint was "Phlegm chest".-This had been there off and on from boyhood. Initially from nose, now postnasal drip — thick yellow, sweetish at times. Sometimes felt bad smell also. This he felt himself. There can be long remission also. Ears get blocked with cold. Green chillies result in stuffy nose or irritation in throat almost immediately, "I am allergic to it". Use of beer, betel or even slight exposure gives a cold. In fact, anything very cold and very hot upsets. His other complaints were piles — "Feel generally congested in that region". Flatulence — has been using Becozyme two tabs, for a long time. Stopped two months ago. Isabgol amel. Had been investigated in U.S.A. and diagnosed as "Nervous Stomach".

Sudden pain in vertex and then cannot talk — then pain in chest and gets nervous about heart.

Having a cold for the previous three weeks.

Appetite: Good. Non-vegetarian, likes sweets, sour, likes his drinks cold and his food warm. B.O.R.

Sleep: Good, except when he drinks or there is over-eating.

Vaccination for small pox: Every three years. No other inoculations.

Nervous temperament generally, feels afraid when hears of the death of any friend. Fear going in aircraft, fear dark, fear thunderstorm, gets upset if there is delay in receiving an expected letter, would feel insulted excessively. The fears are less when in company and lot of people around. With a cold sex urge goes down considerably. If any one encourages him, he feels elated and Okay. Says, "When I am healthy, I am very bold."

P.I.: Herpes in 1967, Appendicectomy 1964, Syphilis in 1945 for which he received the standard treatment then available — Arsenic Injections.

F.H.: Father had Asthma. One daughter similarly suffers from colds.

Reports: T.L.C. 9250. D.L.C. P65L24M3E8

X-ray — P.N.S. — "Right maxillary sinus opaque, thickened mucosa or fluid."

O.E.: B.P. - 110/70. Pulse 64-68/mt. Heart, Lungs, Abdomen — N.A.D.

1968

September 9: *Pulsatilla* 30/28 powders q.i.d.

This was for the cold was having at the time.

September 21: Reported better. Cold practically cleared. *Phosphorus* 200/1 powder followed by *Saccharum lactis*.

October 29: Reported progress "Phlegm is M.B. Flatus passed very easily with your medicine". Feeling of flatulence is more after lunch and in the evening around 6-7 pm. During this time had piles bleeding once. B.R.B.

Phosphorus 200/3 powders at 4 hrly. interval.

December 11: No piles bleeding after last visit, tendency to be hasty and hurried, for sex weakness took Oligoplex No. 1 on his own. This contains *Acidum phosphoricum* and six other remedies. The sex urge is less otherwise normal. At times pain in left shoulder region with palpitation. He ascribes it to indigestion, "My digestion has never been good".

Kali phosphoricum 3x/24 powders t.i.d.

1969

This was repeated on **February** 19, 1969.

August 2: Reported again. Has been generally much better-*Kali phosphoricum* helps considerably. Nervous-

ness-gone, sleep-normal, sex-normal. Piles — If used toilet paper for a few days instead of the usual Indian custom of washing after stool. Colds have also improved.

His present complaints were pain in right thigh, knee joint and leg from mid June. This started while he was coming down on a mountain side on slippery ground (Gulmarg to Tanmarg). It had rained but he was well protected and did not get drenched but it was strenuous to walk as the wet ground was slippery.

Rhus toxicodendron 200/3 powders t.i.d. followed by *Saccharum lactis*.

The pain was relieved in a few days and I did not see him except in some social gatherings till December 1993, when he came for an entirely different problem (Tinnitus aureum). He had remained well through the intervening twenty four years.

ALLERGIC RHINITIS

Case No. 1

Mrs. P.D., consulted on July 9, 1983, age 40 years, married for 25 years with three children. Came from a farming community and as is customary would work in the fields and also handle grain and thus exposed to pollen and dust. Her complaints were colds for 20 years, not much discharge but nose block and post nasal catarrh. History of having been operated for Nasal Polypi twice. Polyps removed and nostrils cauterised.

A significant point in the history was a craving for clay, even though she controls and does not take it.

P.I.: History of threadworms which were last seen a year earlier. For a dog-bite she had received 14 antirabic injections.

July 9,1983: *Teucrium marum verum* 200/3 powders during evening and bed time.

She came from another place requiring more than 12 hours train journey. The reporting by letters was not very detailed even though her son was a student in a Homoeopathic college.

She also had an occasional fever for which she would take local medical aid and at times recurrence would occur because she could not avoid being exposed to grain dust.

Teucrium was repeated on **8th** and **19th August, 29th** September and **7th** November.

December 16,1987: As there had not been much difference she was now prescribed *Calcarea carbonica* 200/3 powders to be taken on the same day. This was repeated on February 29,1984 and April 9,1984 by my office as on both occasions I was not in town.

April 21,1984: Reported personally. Condition much better: "Approximately 2/3rd cleared." Pica — desire is still there. Mostly controls but occasionally can't resist and is forced to eat clay.

Subsequent reports only show of some weakness but nasal condition continued to be good.

, July 30: Reported that she no longer has a desire to eat clay.

Has been subsequently seen off and on till March 1989. Now for pain in knees due to Osteoarthritis but no recurrence of the nose problems.

Case No. 2 (Allergic Rhinitis)

Master N.A., age 12 years, consulted on November 4, 1987. His complaints were frequent colds for the previous two years. Starts with sneezing and rhinorrhoea, then nose block ?because of thickish discharge. It lasts 7-10 days and average frequency is 5-6 times a year. In-between he gets what may be termed "the allergic type of colds". There are bouts of sneezing and some thin, discharge and this lasts for 1-4 hours. He is prone to get this while reading or for any exposure, after bath, etc. With the cold, there is throat irritation.

Appetite — Moderate. Non-vegetarian. Likes 'Sambhar'. Sour. Averse to many green vegetables. B.O.R.

Sleep — Good. Sleeps late — is very fond of study. Dreams — Nil or nothing significant. Earlier frightening - "of Dracula".

Vaccination — Once for small pox. Has had no other inoculations as he was often ill when those were due.

Hot patient.

Mentals: No fears now, earlier fear dark. Nervous in watching horror movies. Anger + +, then won't have his meal. Obstinate. Won't accept defeat.

P.I. — Much diarrhoea in infancy and this used to be for prolonged periods. Once dysentery with blood.

F.H. — Nil of colds, asthma, T.B., Diabetes.

O.E. - Wt. 72 lbs. Tonsils enlarged + +. Palpable cervical glands — discrete, nontender.

1987

November 4: *Tuberculinum bovinum* 200/3 powders at 15 minutes interval.

December 2: Mild cold one or two times. Once had turbid urine after a long time, previously this was frequent — probably phosphates.

Placebo.

December 21: Feeling well. No cold. Urine been clear.

Placebo.

1988

March 19: Been quite well. No problem now. There is no sneezing while reading or by exposure, even though these were winter months. Urine been clear. As he kept well he did not report regularly.

*

#

1992

He reports again after 4 years on **March 25, 1992**. He had kept well and his present problem was Epistaxis which he initially had after injury and presently for previous 2-3 years.

Now his weight had increased to 108 lbs.

HISTAMINUM

For introductory remarks about remedy and one case of Asthma treated by it see page 346.

Case No. 3 (Allergic Rhinitis: Paroxysmal Sneezing)

Mr. B.K. age 21 years a medical student consulted me on **February 19, 1985**.

Complaints: Blocked nose for seven and a half years. Sneezings and rhinorrhoea. Initially this was in the morning after bath for 2 to 3 hours. However, later there

was no particular time modality. Partially colour blind. Sense of smell is much reduced. This may be due to his having a blocked nose for long. At the time of admission to the medical college a blood pressure of 150/104 was recorded. This was in mid August 1984. It seems that it was only due to tension because by November all examinations and tests were normal.

Has had sinus puncture once with temporary relief.

During the next 8 months he received *Nwc vomica* 200, *Sulphur* 200, *Silica* 200 and *Natrum sulphuricum* 200. The last one because he showed considerable aggravation of his condition with the onset of the monsoon rains and humid weather. None of these seemed to have a satisfactory or long lasting effect. Therefore I decided to try the new remedy *Histaminum*.

1985

October 11: Prescription: *Histaminum* 7CH/12 powders q.i.d.

This showed a remarkable effect and he was much better in subsequent reports. In fact he reported on **November** 29, that there is "sneezings as in a normal person" i.e. a very occasional one. A similar report was received on January 4, 1986. The obstruction in nose was also much less.

In January he had a few bad days, it is possible that this was due to mental tension as he failed in his examination. Therefore, when he reported on **January 25**, 1986 he was given *Histaminum* 7CH/3 powders to be taken every 15 minutes.

He did have sneezings more frequently after the onset of rainy season in July 1986 at which time *Histaminum* did not help him to the same extent. Till **February** 1, 1988, when he was last seen, he has had this prescribed only 5 times in a period of 2 years and

4 months. The last two being on January 28 and August 1, 1987.

He is keeping so well that now he does not come personally to report but only sends one of the parents for repeat which is *Saccharum lactis*.

Comments: This opens up the possibility of useful application of potencies of certain hormones, chemicals and enzymes in the body on the basis of experimental data other than a classical proving.

NASAL POLYPUS

Case No. 1

Mrs. S.K., age 53 years, consulted me on **June 20, 1977**. She had a nasal polypus on right side. She was operated for this in 1975. Soon after had a recurrence and operated again in 1976. There has been a third recurrence on the same side for which she came to me. She had been advised operation and had been hospitalised, but it was found that her B.P. was very high, so the operation was not done.

She consulted a homoeopath, who prescribed *Sanguinaria canadensis* 200 weekly dose and *Teucrium marum verum* 30 three times a day the other days of the week. This kind of prescription I call medicines prepared according to the homoeopathic pharmacopoeia but prescribed allopathically. X-ray picture of P.N.S. showed right sinus hazy and right nostril blocked.

On examination I was a little frightened as I had never seen such a big mass not only blocking the nostril but clearly hanging out in the throat and occupying

major part of it. That part was also ulcerated. Considering the age factor, it looked suspicious and in my notes, I have put down ??cancer. The mass in the throat was so big that it completely altered her speech and made it difficult. Swallowing was also troublesome. She was prescribed on **June 20**, *Calcarea carbonica* 200/3 powders to be taken on the first day followed by *Saccharum lactis*.

July 9: She reported that she felt better and can speak with less discomfort. She said that once she hawked out a small piece ?A part of the polypus. On examination, my notes are "the mass (polypus) in throat seems somewhat shrunk."

August 23: She said "**I** am amazed at the progress." On examination, I found nothing visible in the throat — no hanging polypus or lump and nothing visible in the nostril either. She can breathe normally as the nasal passage is free, voice normal, swallowing normal.

Case No. 2 (Nasal Polypus)

Mrs. B.T., age 38 years consulted on April 20, 1989. Married 14 years, two children.

This was a short out-patient consultation at the President Estate Dispensary. As such the history is brief. Complaint of a blockage of the left nostril. Been operated for nasal polypus in June 1986 and this has recurred. At night if lies on the right side then that also gets blocked additionally and has to breathe from the mouth. Aggravated at changes of season and also by every change of weather. No **H/O** paroxysmal sneezing. X-Ray — PNS — "left maxillary sinus opaque and left •nostril blocked."

Nothing significant in desires and aversions in food or in dreams. Chilly patient. Not been vaccinated after school.

P.I.: Eczema in childhood.

O.E.: Polypus in left nostril.

1989

April 20: Prescription: *Teucrium marum verum* 200/3 powders at 15 minutes intervals.

June 15: Reported much better.

O.E. No polypus visible now.

June 29: No complaints. One day had slight cold.

July 27: Generally been well. In dusty weather, which is quite common at that time of the year in Delhi, had some feeling of blockage of the nose.

Repeated: *Teucrium marum verum* 200/3 powders at 15 minutes intervals.

September 14: Sore throat — *Rhus toxicodendron* 30/12 powders t.i.d.

October 12: Feeling of obstruction nose again ?from change of season.

Repeated: *Teucrium marum verum* 200/3 powders at 15 minutes intervals.

December 7: Had been better after last visit but during the last one week there has been intermittent blockage of nostril.

Again repeated: *Teucrium marum verum* 200/3 powders at 15 minutes intervals.

Has continued well since even through the intensely cold and foggy days of Delhi winter.

Last seen on February 8, 1990. Wants to know if she can continue treatment till April so that she has the assurance that the change of season will not cause any recurrence. She and her husband as also the E.N.T.

Specialist in hospital can hardly believe that the Polypus has disappeared with homoeopathic medicine.

Earlier when she had made some visits to the hospital she was curtly told by the Specialist "Please do not waste our time because it is absolutely necessary to have an operation even though we cannot assure you that there will be no recurrence."

During the period from April to December she used only one remedy and this was given four times.

EPISTAXIS

Case No. 1

B.P.M., age 28 years consulted on April 27, 1979. He belonged to a monastic order and they learn to control most of their emotions and desires and as such the history is extremely brief.

His only complaint was Nosebleeds. The special features were that it occurred only in summer. It is to be noted that he was born in the hills where he spent first 20 years of his life and trouble started ever since he came to Delhi where the summer temperatures range between 38 and 44°C at the maximum. The blood is dark in colour. X-ray — P.N.S. had been done. Left Maxillary and Frontal Sinuses were found hazy and the doctor had told him that he has allergic rhinitis with which diagnosis I did not agree. On page 337 of Kent's Final General Repertory there is only one remedy under EPISTAXIS, hot weather Croc Boericke's Materia Medica (page 239) mentions "Epistaxis. *Dark, Stringy, clotted...*".

1979

April 27: *Crocus sativus* 200/3 powders in morning, afternoon and bedtime of the same day.

May 5: No bleeding after starting treatment, although he had been having it 2 to 3 times daily before that.

As there was no other troubles he was given *Saccharum lactis* for another week and then treatment concluded.

1980

April 14: After the previous treatment I had the opportunity to see him from time to time at the Ashram and there was no recurrence through the rest of the summer months. However, with the onset of summer of 1980 he had a mild recurrence with Epistaxis on a few occasions.

Crocus sativus 200/3 powders were repeated.

1981

I treated him for some pains and at one time Sciatica on right side. He received *Rhus toxicodendron* 10M on March **31**, October **30** and November **21** but throughout the summer of 1981 no Epistaxis.

1982

April 13: He again reported a mild bleeding tendency since **April 4, 1982**. *Crocus sativus* 200 was repeated. Thereafter for the next 7 or 8 years that I had contact with him, there was no Epistaxis inspite of the same environment and work.

Case No. 2 (Epistaxis)

A tall bright teenager walks into my clinic bringing his grand-mother on January 7, 1992 and reminds me that I had treated him many years earlier and he had kept very well and no recurrence of his symptoms.

Master B.K. age seven and half years, consulted on September 24, 1984 with a general complaint of the parents that he was "not thriving" because he was lean in his build and also had palpable glands in the neck.

Appetite slightly less than average; avoids milk; takes slightly extra salt. He used to dream of ghosts. Hot patient.

P.I. H/O epistaxis and skin eruption for which he had allopathic treatment.

O.E. Wt. 49.5 lbs. Rest of the physical examination - N.A.D.

1984

September 24: *Sulphur* 200/3 powders at 15 minutes interval to be taken in the morning.

October 22: Appetite same. Lethargic.

Repeated *Sulphur* 200.

December 8: "Looking better". Wt. 52 lbs.

1985

February 12: Looking better, more active. Appetite better.

March 12: Epistaxis again. In fact it is usual in summers. On page 337 of the Repertory two rubrics could be used. Crocus is the only remedy mentioned for epistaxis in hot weather but as the type of haemorrhage was not "black and stringy" the other rubric was preferred: epistaxis in children. He was prescribed *Ferrum metallicum* 200/3 powders at 15 minutes interval.

May 11: Not much benefit as he had epistaxis a few times. Complained of pain forehead by taking milk. Repeated *Ferrum metallicum* 200.

1986

March 24: Seen again after 10 months. Had been quite well in this period. No epistaxis, no pain forehead with milk. Wt. 58.5 lbs.

April 29: With the onset of summer had epistaxis once. Had taken X-ray P.N.S. and Chest and both were normal. *Ferrum metallicum* 200/3 powders.

May 23: No recurrence of epistaxis. Had itching and some skin eruption put as allergy.

Apis mellifica 3/20 powders q.i.d.

June 25: No epistaxis, occasional rash.

Apis mellifica 3/16 powders q.i.d.

August 19: No epistaxis. In the previous month his father died suddenly and he greatly feels the loss.

Natrum muriaticum 200/1 powder at bedtime.

1992

January 7: As mentioned at the beginning there had been no recurrence of epistaxis after April 1986.

Comments: In India it is a common belief that nose-bleed is due to heat in the body and heating things in diet tend to increase all bleedings. In any case epistaxis is more common in the hot summer months with the maximum temperature ranging between 43°C and 45°C in the drier parts of the country.

This case highlights that prescribing continues to be an art and at times different parameters can be used. In this particular case the remedy chosen did not cover the generals — the desires and aversions or dreams or weather reactions. **Ferr.** is in black letters on page 1367 in lack of vital heat whereas he was a hot patient. It is by no means intended to belittle the importance of the generals but to emphasise that marked particulars can over-rule weak or common generals.

TICS

Mr. S.K.A., age 40 years, consulted on April 16, 1990 for a fistula-in-ano and reminded me of his treatment 12 years earlier. That history is interesting and now there was also a possibility of the long follow-up. He had first consulted on July 17, 1978, age 27 years, married 6 months, is in hardware business. His complaint was that he had jerky movements different parts of the face on either side for the previous one month. Not a daily phenomenon and the frequency had been about twice a week. Can be controlled by pressure locally. The night prior to the first attack he had had severe headache and his observation had been that headaches tend to occur the evening before the attack. < mental exertion.

His second complaint was shifting pains for the previous 15 days. He would be alright in the morning after rest and the pain would occur later in the day.

There was no H/O S.O.M. and his hearing was not impaired.

Other functions as appetite, bowels, sleep etc. all normal.

P.I. Operated for renal calculus in 1956 and again in 1973.

O.E. Heart, Lungs, Abdomen — N.A.D.

The only unusual feature in the examination was B.P. 140/110. Also there appeared a slight drooping on right side of face.

He had received *Neurobion* (Vitamin B1, B6, B12) orally and parenterally with no relief.

1978

July 17: Prescription: *Agaricus muscarius* 200/3 powders on the same day,

July 29: Better. Previously the jerks would be for 10 to 15 minutes, now just single jerks.

August 17: Better. No jerks. Pains M.B.

Having goose-skin like eruption on the nose which is spreading to right cheek. "Started after Neurobion injection course" — from early July 1978. Pin-prick type pain — feels slight itch when there is pin-prick sensation.

August 30: Pain from August 1st to 29th in upper limbs — shifting in nature. When this got less then pin-prick type pain on the nose. These two conditions usually alternate and do not occur together. He squeezed the protuberances on his nose — A little white solid matter could be extruded ? white heads.

Pulsatilla 200/3 powders on the same day. ^

September 26: He had been free from the pains but these have recurred in the last few days. Continues to be free of jerks and headaches.

Pulsatilla 200/3 powders at 15 minutes interval.

November 22: Had twitching or jerky movement and later pain in upper arm. No twitching in face now. Had been free of jerks for more than 3 months.

Agaricus muscarius 200/2 powders in the evening and < bedtime.

December 19: No twitching or jerks.

1979

January 17: No jerks at all.

February 28: Shifting pains. Pain in one place for 30 to 45 minutes then shifts. No twitching.

Pulsatilla 200/3 powders on the same day.

April 6: Carrying on well. Wants a repeat "Please give the same strength of medicine." He, of course, received *Saccharum lactis*.

1982

June 3, 1982: He reports again after three years for a recurrence of his old symptoms for which my Assistant repeats *Agaricus muscarius* 200/3 powders through the evening and bedtime.

1983

Not seen thereafter till May 3, 1983 and from time to time at intervals of three to six months upto June 1985 and then again in April 1990 as mentioned above. On these occasions it was for different complaints and there had been no recurrence of his jerks or twitchings or of the shifting pains.

PIGMENTATION PATCHES FACE

Mrs. P.T., age **21** years, consulted on **January 31, 1989**. She had been married for one year. No child and no abortion. Her complaints were that she had patchy brown hyper-pigmentation on upper lip and along the inferior border of right eyebrow. It was first noticed after she had had electrolysis done on upper lip for unwanted hair. She had also had upper lip hair bleached at the time she was getting married i.e., a year ago. Some three to four months later i.e., about 8 months ago she noticed that the pigmentation was getting darker. There is no discomfort, no associated itching, no burning. Patient is very conscious of her problem from a cosmetic point of view. Has tried different local applications for short periods with no effect. Some months earlier had taken some tablets with resultant gain in weight so I surmised that it was probably steroids. This also did not help. There was nothing much in the rest of the history.

In **Past Illnesses** she gave a history of U.T.I. 8 months earlier. Had a recurrent problem of burning urethra during and after micturition. This had been treated with antibiotics. She had been vaccinated for Smallpox in infancy and revaccinated a' few times in school, the last one being 8 years earlier. On careful examination, in which I also used a magnifying glass, it was seen that some of the spots are raised. ?Scarring from electrolysis. The appearance was like multiple, small, sessile, brownish warts.

1989

January 31: *Thuja occidentals* 200/3 powders to be taken at noon, evening and bed-time of the same day.

On **April 7,1** received a letter dated March 31, 1989 from Surat, about 1000 km. from Delhi, "The medicine given by you is just finished. But it is a matter of disappointment that pigmentation is increasing on right cheek and under my left eyebrow. But a bit faded on my upper lips. And the spots are getting more black".

On **April 7,1** sent *Sepia* **200/3** powders to be taken at 15 minutes interval. Thereafter there was no further communication till she came personally on **September 18, 1989**, "I am quite O.K. and very happy. Now my entire face is free from all the blemishes and I have my original complexion. It is marvellous".

On enquiry I was told that she had started to improve within about 10 days of taking *Sepia* and was quite O.K. by the time the medicine finished. The rest of the medicine was, of course, *Rubrum* for two months.

This time she had come for quite different complaints. She had been travelling and possibly as a result of irregular eating had pain epigastrium for the previous one month. The pain would occur about one hour p.c. and would last 1/2 to 2 hours. For this she was given

Pulsatilla 200/3 powders followed by *Rubrum*. I received the next report on **October 13, 1989**, that the pain was relieved immediately and in any case she dropped medicine bottle after 4 days and has been quite well.

NODULE ON LIP

Miss M.T., age 19 years, consulted on **December 26, 1977** with the complaint of a Nodule inside the mouth, on lower lip on left side. It appeared four months earlier and had been removed surgically two months prior to consultation. After one month it recurred at the same place. She had had some homoeopathic treatment elsewhere. One of the remedies used was Cundurango. It is not known what other remedies were given because they bore some code numbers. At that time Small Pox Vaccination and revaccination was quite prevalent. She was specifically asked on this point. She had not had any revaccination in recent years and had not been revaccinated very frequently. One of the Rubrics considered from Kent's Repertory was on page 415 **PROUD** flesh, **Gums** and the only remedy against this is Alum. This did not seem to cover the case and she was given *Calcarea carbonica* 200/3 powders to be taken on the same day.

She reported again on **January 9, 1978**. There was no change in the condition. She was prescribed *Thuja occidentalis* 30,200,1000/1 powder of each to be taken in one day in that order — morning, afternoon and bedtime.

January 27: Much better, no nodule visible in the mouth. Feels a slight hardness in that region.

Last reported on March 4, 1978. No recurrence of Nodule and is completely alright. Medication stopped and told to report if there was any recurrence. In any case after the doses of *Thuja occidentalis* she had been only on *Saccharum lactis*.

ACNE AND WARTS

Mr. S.S. age 20 years, single, engineering student at Bombay consulted on February 15, 1990. It was a very bad case of Acne. He was a hot patient. Had slight dandruff. There was nothing else in the history nor any marked mentals.

P.I. Malaria in 1989, two or three times.

F.H. Father had H/O Thyrotoxicosis and was successfully treated by me. An uncle has diabetes. He has one brother 16 years and one sister 10 years. Brother has no acne.

1990

February 15: *Sulphur* 200/3 powders at 15 minutes interval in the morning on empty stomach.

August 29: Had felt considerably improved for some months. But now again acne is quite bad. Has observed that use of onions makes it worse. Repeated *Sulphur* 200.

October 22: M.B.

1991

August 7: Improvement maintained and he is satisfied. The number of pimples is less but it is not totally clear. Again repeated *Sulphur* 200 after one year. I was

wondering if it aggravates a little in the warm and humid climate (The monsoon season).

November 4: Acne M.B. Recently developed warts on right hand and forearm. Sessile and small. One linear wart is about one inch (25 cms) long. At Page 1223 of Repertory - WARTS, **Hand**, flat: Berb., Dulc., lach., ruta, *Sep*.

Sepia officinalis 200/3 powders at 15 minutes interval.

1992

January 28: No change in warts.

Sepia officinalis 10M/3 powders at 15 minutes interval.

April 29: All warts, including the linear one nearly cleared. Face free of acne.

August 19: No acne and reminded me that his hands were completely cleared and no sign of any wart.

MOUTH ULCERS

Mrs. G.U., aged 27 years was referred by a colleague as a very intractable case of Ulcers in the mouth — on tongue, gums, throat, etc. for a long period of 8 years. She consulted on July 14, 1970. She had been married 4 years and had one child aged 3 years. She had had lot of allopathic treatment with injections of Vitamin B Complex, Vitamin B₁₂. Had taken lots and lots of calcium tablets and used Boroglycerine and other mouth paints besides some other medicines. These had not been of any benefit. Then in the previous six months she had had Homoeopathic treatment, the precise details of which were not available. All that was known was that she had used — Merc-s, Ac-nit 30, Acon-nap., Hepar-S, Nat-m, Kali m. 6x and Puls. As the ulcers looked so extensive and frightening that two years earlier a doctor suspected it to be Diphtheria but the swab was negative. There was burning in the Ulcers. Cold things hurt more, not the warm things. When she has Ulcers badly, there is a tendency to vomiting even if she slightly overeats. There is Dribbling of saliva when she has many Ulcers. Ulcers from use of any rich diet, sour things, spices and chillies and dry fruits. A peculiar symptom was that the Ulcers aggrav. before M.P., 10 to 12 days before. Amel. after flow sets in. Frequent colds and coughs, sneezes with rhinorrhoea and lachrymation.

General weakness.

A general depression.

Appetite — Reduced. Non-vegetarian. Aversion to rich diet and fried stuff. Likes cold things, including cold drinks. Heaviness and distention after eating.

B.O.R.

Sleep good. Dreams nothing significant.

Vaccination for small pox not frequent, a few times in childhood.

Very Chilly patient. Can't stand air-conditioned room. Besides in a cool place lower limbs start to pain. Perspiration average.

O.E. Extensive ulceration in mouth. Wt. 102 lbs.

P.I. Typhoid three years ago during pregnancy. Nil else of note.

M.P. Regular. Has some pain in waist during menses.

1970

July 15: *Acidum nitricum* 3, 30, 200/1 powder of each.

August 6: Ulcers are healing. Pain in heels.

August 28: V.M.B. Ulcers are very few now and they disappear soon. Pain in heels is also M.B.

September 10: Progress maintained.

September 29: Tendency to recurrence of ulcers.

Acidum nitricum 200/1 powder.

October 19: No relief for the last two weeks. Many ulcers in mouth. Much salivation. In morning on waking feeling of great weakness. **Body aches.**

O.E. — Ulcers in the mouth. Few small white spots in left tonsil region.

Mercurius solubilis 6,30,200/1 powder each.

November 20: Ulcers keep appearing on the tongue.

Mercurius solubilis 200/1 powder.

1971

January 14: At the end of December had cold and cough for which used Homoeopathic medicines. After that ulcers reappeared which had been much better.

Mercurius solubilis 200/1 powder was repeated.

As *Mercurius solubilis* was only giving temporary relief, she was given Acid Nitric in higher potency. She

was given *Acidum nitricum* 1000 on February 6 and March 2, one powder each time.

April 7: M.B.

April 10: Had a mental shock because of some domestic mishap and there were many vomitings.

Ignatia amara 200/3 powders on the same day.

April 13: Feeling well. No problems.

May 3: Again visited and had vomiting after breakfast and after lunch.

Ignatia amara 200/1 powder.

June 14: No ulcers. Poor appetite. Poor sleep. Likes cold things.

Kali phosphoricum 6x/120 tablets, 4 tablets t.i.d.

This was repeated on June 24. Sleep normal, appetite normal, weight 105.5 pound.

September 10: Much weakness. Polyuria since an attack of influenza in August (after the influenza she was given *Influenzinum* 200/1 powder. This did not give any significant relief). Much depression during M.P. with emotional upset. No inclination to talk to anyone and wants to be alone.

Natrum muriaticum 6x, 30, 200/1 powder each.

October 6: *Lueticum* 200/3 powders at 10 minutes interval.

December 3: Lost her father on November 23, 1971. Been having vomiting since, though not much ulceration mouth. Vomiting mostly after food.

Ignatia amara 200/6 powders at 4 to 8 hours interval.

December 15: No relief. Vomitings continue. Tendency to vomit frequently when depressed. *Natrum muriaticum* 6x (3 powders), 30 (2 powders), 200 (1 powder) on 3 consecutive days in that order.

1972

Generally she kept well thereafter and free from mouth ulcers but in the month of April, 1992 she had a pilgrimage and ate the available food which had lot of chillies. Thereafter some ulcers appeared. Therefore repeated *Lueticum* 200 on April 8. I saw her from time to time for minor or some odd complaints but no recurrence of ulcers. In June, 1972 she got pregnant and the last visit to my clinic was on July 28, 1972.

* * *

1986

In mid 80s a patient came to consult me from Singapore and said he had been referred by Mrs. G.U. During these years her husband had been posted there. I went to deliver lectures in Malaysia in 1987. I visited Singapore where I received much hospitality from this grateful patient who had remained well all these years and put on weight and was looking very healthy. No recurrence of mouth ulcers. Subsequently, on his reposting in India I met her husband last in August, 1992 and learnt of her continued welfare.

TUMOUR IN TONGUE

Mrs. M.S., age 52 years, consulted on September 30, 1988. She had been married 32 years with four children and no abortions. Her history was that in April 1986, she developed a nodule or a lump on the tongue. This was cauterised at the hospital altogether three times, twice in 1986 and then in May 1987. "After this it has become more protuberant i.e. bigger". Has had bleeding from it

off and on. Now in the hospital it is proposed to operate. As her husband is a senior officer in the Ministry of Health, Government of India, she has surely had the best of attention from the staff of the hospital. On enquiry I am told that she uses no Paan (betel) or Paan Masala. Takes a little extra salt in her food.

Vaccination for Small Pox only in childhood and not frequent. She feels both the heat and cold.

She had her menopause in 1986 with no subsequent symptoms.

P.I.: Diverticulum operation in 1985. Earlier was very anaemic. HB. 5-6 gm. In May 1988 HB. 11 gm. Had Tubectomy for family planning in 1969.

O.E.: Pea size, fleshy, hard lump on tongue, semi-pedunculated. Consulted the rubric of Warts, Tongue on p.430 as there was no rubric that would exactly cover the condition and there was nothing in the rest of the history to give any pointer to the remedy.

1988

September 30: Prescribed *Aurum muriaticum* 200/3 powders at 15 minutes interval.

October 15: Reported better. "Previously felt something heavy put on the tongue and also touching the palate. Now these sensations are less."

October 31: No change.

Repeated *Aurum muriaticum* 200.

November 15: No change in size. Today burning in the nodule. Gets it off and on.

Carbo animalis 200/3 powders during the evening and bedtime.

November 30: Feels it is smaller. Burning occasional.

December 20: Feels it is lighter. Burning is rare so generally more comfortable.

Repeated *Carbo animalis* 200/3 powders at 15 minutes interval.

1989

January 6: Feels it is slightly further reduced.

January 21: Inbetween had a cold. Has had bleeding from growth on tongue on two occasions.

Repeated *Carbo animalis* 200.

February 8: Occasional irritation or burning. As the condition seemed to be static with no further reduction in size I decided to use a remedy not so well proved but which has considerable reputation for growths, specially uterine fibroids.

Aurum muriaticum natronatum 6x/42 powders t.i.d.

February 27: Feels the growth is a bit less.

Repeated *Aurum muriaticum natronatum*.

March 17: Slight further reduction.

Saccharum lactis.

March 31: ?More flat. No burning. *Aurum muriaticum natronatum* 6x/42 powders t.i.d.

April 17: No significant change.

Thuja occidentalis 10 M/3 powders at 15 minutes interval.

May 31: Much smaller in size but feels that for some-time now it is stagnant i.e. not reducing further.

Repeated *Thuja occidentalis* 10 M.

July 4: Not finding much further progress decided to again try *Aurum muriaticum natronatum* 6x/42 powders t.i.d. which was repeated on July 25.

September 2: Much smaller. Continues on *Saccharum lactis*.

November 3: It is much smaller than original but seems to be not finally completely clearing.

Repeated *Aurum muriaticum natronatum* and since the available potency was only 3x that was given for four weeks.

December 8: Further reduced in this period.

December 27: Very much reduced. Only the edge remains.

1990

January 19: Seems stable.

Aurum muriaticum natronatum t.i.d. continued till March 10. By then it was further reduced. She continued to make further progress thereafter on *Saccharum lactis*. But since a slight sign remained it was decided to try *Aurum muriaticum natronatum* 3x again which was given for 20 days each time on **June 9** and **August 28**.

November 8: Last seen on this date with practically nothing visible or felt in that area of the tongue and no discomfort whatsoever i.e. no irritation or burning that she had earlier and, of course no bleeding after January 1989.

RANULA

Miss M.C. was first seen at the age of 10 years on July 24, 1982. The only child of her parents. Her main complaint was ulcers in the mouth. She had had these for many years. Earlier they occurred from time to time, but for the previous two years she was practically never free of it. When an ulcer is forming, there is low grade pyrexia. When she has the ulcers then there is dribbling of saliva in sleep which wets the pillow.

Rubbing eyes — Always had this tendency. Put as allergy. Also keeps rubbing the nose. Sneeziings.

Epistaxis three days ago from left nostril. Had it three years earlier also from the same side but this is not a frequent complaint.

Appetite: Poor. Non-vegetarian, likes meat, desires sour + and Chillies. Salt — average.

B.O.R. Tendency to diarrhoea for any indiscretion.

Sleep: Good. Dreams good ones — fantasies.

Vaccination: Twice. Second at the age of 3 years.

No strong reactions to heat and cold or marginally hot patient.

No fears. Very tense — gets worried over small matters.

In the winter months, she would have complaint of blockage of the nose and mouth breathing in sleep. This was a fairly old complaint. X-ray P.N.S. — slight haziness of maxillary sinuses and a soft tissue view of neck gave a report of enlarged Adenoid.

P.I.: Tonsillectomy at 3 years. Adenoids not removed. Roundworms at 4 years.

O.E.: Heart, lungs, abdomen — N.A.D. Has an ulcer at tip of tongue. One Paediatrician diagnosed as 'Aphthous Stomatitis' and another put it as 'Herpetic Stomatitis'.

Wt.: 54 lbs.

She received *Mercurius* 200 with a relief for some months but would then tend to recur.

Miss M.V. sought a very urgent consultation immediately on my return from abroad on **March 22, 1983**. The reason for the parents anxiety was the appearance of a bluish mass under the tongue on the right side — the size inbetween a big cherry and walnut. She had already been seen by a surgeon who as expected had advised an early operation. He had diagnosed it as a case of Ranula. My opinion was sought as to whether Homoeopathy

could with certainly cure this condition or they may go by the advice of the surgeon. My reply was that it is within the purview of homoeopathy but obviously it depends on the reaction of the patient and as such no absolute assurance can be given before-hand. They agreed to wait and give a trial to homoeopathic treatment.

O.E.: There was a fairly big bluish swelling under the right side of the tongue, the size between a big cherry and a walnut. There were no ulcers at present. Kent's Repertory (page 416) and Therapeutic Index in Boericke's Materia Medica (page 1009) were consulted.

1983

March 22: *Calcareo carbonica* 200/3 powders on the same day followed by *Saccharum lactis*.

March 31: "The lump is 50% reduced." Now, she developed measles for which she was prescribed *Bryonia alba* 30/16 powders q.i.d.

April 7: Been well, last few days there is no fever. "Ranula at least 80% gone." Much to the satisfaction and some amazement of the parents. The surgeon said "I just can't understand it but as the homoeopathic treatment is proving so effective it may be continued."

April 13: Reported personally — Ranula neither visible nor palpable. Has also seen the Surgeon who had advised operation. He just cannot believe it. He says, "How could it vanish and so quickly? It has been a miracle."

Miss M.V. has been seen off and on for other complaints and was last seen on **October 2, 1993**. No recurrence of Ranula and has got rid of the tendency to frequent ulcer in the mouth.

RECURRENT TONSILLITIS

Mr. T.S. consulted on July 21, 1992. He had just undergone Orchidectomy operation for cancer of testis. He reminded me of his earlier treatment.

I had seen him on **May 27, 1977** at the age of 7 years. The parents said that he is a case of 'Tonsils' and has been advised an operation. For the previous one year he had fever frequently with sore throat. There was also halitosis even without fever. "Growth poor". Another complaint was that he has 3-5 stools daily.

Appetite: Poor. Non-vegetarian. Likes spices and chillies.

Sleep — Good. Dreams — events of the day — what he has seen in movies. No nightmares.

Vaccination for small pox — twice — second time in 1975.

Hot patient.

Mentals — No fears and nothing else significant.

P.I.: Had warts which cleared with my treatment two years earlier.

O.E.: Weight 48 lbs. Heart, lungs, abdomen — N.A.D. Tonsils 3+ (grossly enlarged).

1977

May 27: *Silica* 6x,30,200/1 powder of each to be taken in that sequence on the first day followed by *Saccharum lactis*.

August 2: Continues to suffer from frequent sore throat and fever. Has been given Crocin and Septran.

Nux vomica 30/2 powders evening and bedtime of the first day.

Sulphur 200/3 powders at 15 minutes interval on second morning followed by *Saccharum lactis*.

Reported on **August 23** and **December 8, 1977** and **April 24, 1978**. There had been no trouble, so every time he got a repeat of *Saccharum lactis*.

1978

May 5: Had attack of Tonsillitis and fever in this period.

O.E.: Weight 55 lbs. (increase of 7 lbs in one year). Repeated *Silica* 200. Was seen off and on during the next 3 months with no recurrence of his trouble, improved appetite and general well-being.

Had not been seen again till **July 1992**, and he reported that he had remained free of sore throat.

Discussion: It would be noticed that *Silica* was selected even though he was a hot patient. It seems that unlike the dictum of Dr. Gibson Miller this physical general has to be ignored at times. *Nux vomica* was given to antidote the effect of the allopathic medicines used and followed by its complementary remedy *Sulphur* which is specially recommended as an inter-current to enhance the effect of *Silica* which subsequently completed the cure.

You find reference to this in Clarke's dictionary of Materia Medica on page 1179 in the section of relations. Also in Clarke's Clinical Repertory at page 302 against *Silica* in the section, "Remedy is followed well by". It reads, "If improvement ceases under *Silica*, a dose or two of *Sulphur* will set up reaction, and *Silica* will then complete the cure".

PAINLESS SEPTIC TONSILLITIS

Case No. 1

Mr. N.B. I have had an opportunity to observe him from 1968 (then four and half years old) till the date of writing late in 1991. The initial successful treatment was for Bronchial Asthma. Thereafter during childhood he would come occasionally for fever and sore throat. The symptoms would be such that he would invariably and quickly respond to *Bryonia alba* 30 q.i.d. In course of time his father discovered that we are more concerned with the details of symptoms rather than with the examination so he would report on telephone and collect the medicine on his way home from office. On occasion it even happened that I was not in town or not available in the clinic and he would take the repeat from my dispenser. On **October 1st, 1972** it was the same story that the patient had fever, headache, aching all over and was thirsty. As usual he took *Bryonia alba* 30. The boy had not been brought for examination. The next morning he telephoned and desired that I visit the patient at house as he had not responded as on earlier occasions and had had a bad night. After the routine questions and examining his chest I asked him if he had any pain in the throat. On his emphatic denial no need was felt to examine it especially as the boy was reluctant. However, the father brought a spoon and persuaded his son to let me examine his throat as I had come a long distance. In doing so I was absolutely taken aback as both the tonsils were studded with pus in the crypts. I asked him again about pain while eating or otherwise and he again emphatically denied. On page 454 of Kent's Final General Repertory there is only one remedy and that is *Baptisia* in Black

letters. He was given doses of *Baptisia* 30 at 4-5 hours interval with speedy recovery over the next two days.

October 4, 1972: O.E. No pus in the tonsils.

Comments: This case highlights the absolute need for physical examination. In this case it brought out the strange and peculiar symptom of a septic sore throat with no pain.

It also highlights the rapidity of action of a well selected remedy especially in acute conditions. Could antibiotics have done any better!

Case No. 2 (Painless Septic Tonsillitis)

S.N., the son of a Homoeopathic lady doctor was first seen in 1971, when a few months old for diarrhoea. The mother consulted me from time to time even though after a few years she had shifted to Bombay. It was her practice to carry the Kent's Final General Repertory and Boericke's Materia Medica alongwith a box of Homoeopathic medicines whenever she travelled. During one such visit to Delhi in 1982 she requested me to see the child in the hotel as he was having high fever. She had already tried one or two remedies without success. S.N. now 11 years old, had fever and cough for the previous two days.

O.E. Chest was clear, tonsils were inflamed and the left tonsil showed many pus points. He was quite emphatic that there was no pain in swallowing or otherwise. I showed this to mother and asked her to look into the repertory and then check with the Materia Medica that she had with her. In her box of medicine she had *Baptisia tinctoria* only in 200 potency. Doses were made in water there and then and asked to be given a tea-spoonful every 4-6 hours while awake. The response was very

quick. The temperature was near normal by next day so that he could comfortably go back to Bombay.

CANCER OESOPHAGUS

Mr. M.D.N., age 42 years, consulted on July 2, 1983, married 15 years, two children, occupation Brassware shop, also used to polish brass with the appropriate polish liquid. It was a diagnosed case of Cancer of the Oesophagus. The history was that he had difficulty swallowing three years earlier. Initially the difficulty was only with the first morsel which he will push down with water, thereafter there was no problem. This was relieved within two weeks and he kept well for two and half years but there was a recurrence six months prior to the consultation. Once again it was with the first morsel and not through the entire meal. He had some homoeopathic treatment elsewhere without benefit then allopathic treatment again with no relief. X-ray with Barium Swallow was suspicious so Biopsy was done which turned out to be negative. The attending surgeon did not agree with the report so the patient went to the special Tata Memorial Cancer Hospital in Bombay. Another Biopsy was done and cancer was confirmed involving the mid 1/3 of Oesophagus. He was given Cobalt Radiation-16 in all, over a period of three months which finished in April 1983. Two symptoms had arisen as a result of the irradiation and he had had these for the previous four months. One was pain in the ribs and the other was much salivation so that he was spitting through the day and had a dribbling of saliva in sleep. Later he had Chemotherapy courses. He reacted adversely to the second course. He

had diarrhoea, fever, ulcers in the mouth and some other symptoms. As for personal history he was a vegetarian but took eggs. For four years he had been using betel with tobacco 7 to 8 times a day. This was stopped only after the Biopsy. He often used to dream of his dead parents. Feels both heat and cold but the cold more. Had been vaccinated in childhood only. Anger ++, worrier ++.

F.H.: Family history was significant. Both parents and two brothers all died of cancer. They all had cancer of the Oesophagus. One brother had T.B. and Cancer together.

1983

July 2: For the presenting symptoms of fever and diarrhoea at the time of consultation he was given *Natrum sulphuricum* 6x/14 powders every 3 to 4 hours.

July 4: Temperature is less. Now upto 101°F (previously 103°F to 104°F). Diarrhoea completely controlled, in fact no stool for last two days. Considerable pain in the ribs and slight cough.

Arsenicum album 30/16 powders q.i.d.

July 7: Temperature normal. Ulcers mouth healed. Has great discomfort in swallowing anything. Feels burning. In swallowing pain is felt not only in the chest but also extends to the head. Repertory p.461, Column 2, PAIN; burning; oesophagus; swallowing, when: *Ars.*, *Carb-s*, *Ox-ac*.

Oxalicum acidum 30/20 powders t or q.i.d.

July 18: General pains in the whole body continue. *Hydrastis canadensis* Q/42 powders (42 drops) t.i.d.

August 3: Better. Swallowing is easier and without pain or burning, is eating semi-solid as rice and dal (pulses). Repeated *Hydrastis canadensis*.

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August 3: Better. Swallowing is easier and without pain or burning, is eating semi-solid as rice and dal (pulses). Repeated *Hydrastis canadensis*.

August 31: Had been without medicine for about two weeks. Again feeling discomfort in swallowing. Earlier had been to Bombay and been examined by the Specialist who was quite satisfied and advised no more Chemotherapy.

Repeated *Hydrastis canadensis Q.*

September 19: Better. Can swallow liquids and semi-solids easily and soft cereals. *Saccharum lactis.*

October 11: Feeling very good and feels no need of more medicines. Asks if he can use bicycle or scooter. *Saccharum lactis* continued.

Last seen on **November 14, 1983**. In **October 1990**, a patient of same disease is referred by him and he informs me that Mr. M.D.N. is quite hale and hearty.

THYROMEGALY

Mrs. B.P., age 28 years consulted on November 12, 1980. She had been married for 8 years. Had 3 children, eldest 7 and youngest 2 years. Was pregnant, L.M.P. September 1, 1980.

Complaints: Fullness of the neck for more than 1 year. Had been told that it was due to an enlarged thyroid. There was a change in voice — “slight heaviness.” Expectoration for 2 months — greenish or yellowish. Headache. Pain in chest. Anxiety (ghabrahat) and palpitation from exertion. Vomits were frequent, mostly daily (pregnancy vomiting).

Appetite: Reduced for one month (?due to pregnancy). Non-vegetarian. Likes sweets and fried. B.O.R.

Sleep — Good. Dreams of death of people that are living, of missing trains, of being chased.

Vaccination — Two or three times. Last at age 12.

Chilly patient now. Was not so before. Perspiration less than average.

M.P. — Before pregnancy was regular, no pain, no leucorrhoea.

Irritable. Worrier. Fear dark, fear thunder. In dark feels as if someone following her.

P.I. — Probably Chicken pox (she said small pox) at 11 years. Typhoid at 17 years. Pain in waist for one year at age 19 — “Was having leucorrhoeal discharge at that time.” Jaundice 8 months earlier.

O.E. — Tall, lean build. Heart, lungs, abdomen — N.A.D. No noticeable tremors fingers. Wt. 104 lbs. Pulse 105/mt.

1980

November 12: *Phosphorus* 6, 30, 200/1 powder of each at noon, evening and bedtime of the same day.

December 8: Headache, swelling neck and voice had all improved. But two days earlier she again felt an increased fullness of the neck and also the headache. According to her the headache and the enlargement of the Thyroid go together. Apparently, it had been amenorrhoea and not a case of pregnancy. She had normal M.P. on December 1 and it was not a case of abortion. Vomits have stopped.

O.E. Wt. 107 lbs. Pulse 88/mt.

Phosphorus 200/3 powders at 15 minutes interval.

1993

April 5: Mrs. B.P. was not seen after the last visit in 1980. Today her husband came for his own treatment and mentioned that his wife has been quite well through these years and fullness of neck had reduced.

THYROID NODULE ?ADENOMA

Mrs. S.T., age 37 years, consulted on July 15, 1978. She had been married 18 years and had 4 children, eldest 16 years and youngest 9 years. History of one abortion — first para.

Complaints: Her only complaint was that in April, 1978 she noticed a swelling at the base of the neck on left side. On pressing it felt like a firm nodule like goitre. There was no pain or discomfort and it was noticed only accidentally.

She had been investigated including a Thyroid Scan which showed a "Mild Thyromegaly. Cold Nodule Left

Lobe. Clinical presentation — Euthyroid, Solitary nodule left lobe. ?Adenoma.”

Appetite: Good. Non-vegetarian. No craving. Digestion — Good.

B.O.R.

Sleep: Good. Dreams — Nothing significant.

Vaccination: last 7 years ago, before that in school.

No marked reactions to seasons.

No fears and no other marked mentals.

M.P. — Regular. No pain. Quantity reduced somewhat. No leucorrhoea.

P.I.: Nil of note. Had an accident 6 weeks ago with fracture of lower jaw.

O.E.: Two biggish red brown moles on face. Lungs, abdomen — N.A.D. Heart -?Slight systolic murmur mitral area.

No particular tremors fingers. Pulse 104/mt. Nodule felt in left lobe of thyroid. Size of a cherry.

1978

July 15: *Spongia tosta* 6,30,200/1 powder of each to be taken in that order, morning, afternoon and bedtime of the same day.

August 5: Nodule size same. Pulse 88/mt.

Spongia tosta 200/1 powder at bedtime.

The same was repeated on **August 29.**

October 6: “Nodule is smaller. I have been feeling generally weak.” Pulse 96/mt. Wt. 114 lbs.

Saccharum lactis continued.

November 22: “Nodule is definitely smaller — not visible now.” Can still be felt slightly. Wt. 117 lbs.

1979

January 5: No nodule visible or palpable in my examination but she says she can still feel it slightly.

Spongia tosta 200/1 powder.

March 8: Feeling of weakness though eating well.
O.E.: Pulse 72/mt. Wt. 119 lbs.

May 9: Weakness, constipation and insisted that a tiny bit of the nodule is still there.

Spongia tosta 200/1 powder.

1980

February 6: I did not see her for some months. During this time she had itching genitals and had taken Allopathic treatment, local and oral. Though the physicians don't feel any nodule but she insisted that a little bit is still there and desires one more course. Weight is maintained — 120 lbs. (with 1 sweater)

Spongia tosta 200/3 powders at half hourly interval.

June 14: "Nodule has completely dissolved. I did not feel it during the last 6 weeks even by digging in my fingers".

ADENOMA THYROID

Mrs. S.M., age 27 years, consulted on April 28, 1967. She was married with two children. She had a nodule in the neck on the left side. There was no pain and no discomfort. She had been seen by a specialist and already diagnosed as Adenoma Thyroid. Much itching in the ears. Has dandruff and falling hair.

Appetite — Good. Non-vegetarian (was a vegetarian as a child). Aversion to fish and pork. Takes only chicken, mutton and eggs. Very fond of sweets. B.O.R.

Sleep — Good. No dreams but if thinking of something, it may continue in sleep.

No strong reactions to hot and cold season.

M.P. — $\frac{4-5}{26-30}$. Dysmenorrhoea 7-10 days before

M.P. — back, lower abdomen and legs. Pain gets worse during M.P. and subsides by 3rd day. She mentioned that she had pain during the first two months of pregnancy and at the due time of menses throughout pregnancy. Leucorrhoea yellowish, medium consistency, bland. When excessive, then there is pain also.

1967

April 28: *Calcareo carbonica* 200/3 powders at 4 hourly interval.

June 1: Feels the nodule smaller.

July 14: Nodule (Adenoma) definitely smaller. She can feel the marked change herself and the family doctor also says so and is rather surprised at the rapid decrease. Lot of pain at the time of last menses. This was for at least 10 days before and gave the feeling that it is going to start but it did not till the regular date. Pain also continued quite severely during the menses. Slight pain has continued even after. Pain specially in the waist region on both sides, also lower abdomen and legs.

Caulophyllum thalictroides 30/15 powders t.i.d.

July 19: Still having pain.

Cimicifuga racemosa 3/21 powders t.i.d.

July 31: Much better. Pain completely relieved. Adenoma completely gone.

Comments:

This is the most rapid dissolution of a Thyroid Adenoma that I have seen but the observation in this case is slightly vitiated by the fact that in mid-May she had used *Anacardium orientale* and it is not clear as to what that was prescribed for. She has been seen from time to time subsequently, occasionally for other

ailments but mostly socially and always reminds me with much satisfaction about her treatment of Thyroid Adenoma. Met her last in April, 1994. There had been no recurrence during the last 27 years.

TUBERCULAR LYMPHADENITIS

Mr. S.C., age 37 years consulted on September 4, 1984. He had been married 13 years and has two children 12 and 10 years. He was a Government servant with a sedentary desk job.

His complaints were that in February 1984, there was noticed a gland in the left supraclavicular region. There was a past history of a submental gland in 1973 which was excised and he received A.T.T., about 40 injections presumably Streptomycin. He took the oral medicines for about three months but not regularly because it resulted in anorexia and nausea and gave him a general ill-feeling.

In February 1984, the gland was noticed incidentally as there was no pain. Was once again put on A.T.T. But he reacted to it. He took 10 injections. It gave him diplopia and giddiness in driving so he stopped. The oral medicines Rifampycin and Ethambutal gave him nausea and a feeling of fullness of abdomen.

He has had an examination of the Nodal aspirate and it has been put as Tubercular Lymphadenitis.

T.L.C. 15, 400; P60 L36 M3E1 ESR 75 mm.

He was a vegetarian and teetotaler with no cravings.

Dreams at times of water.

Last vaccinated 1971, in school almost yearly.

Hot patient. Likes open air and open places.

F.H.: Father died at age 58 years, probably had tuberculosis. Mother living. No history of Diabetes or Heart.

O.E.: 5'-11". Wt. 189 lbs. The gland was approximately the size of an almond.

1984

September 4: *Tubculinum bovinum* 200/3 powders at 15 minutes interval.

October 6: Gland size appears same, slight oedema ankles. Wt. 191 lbs.

Calcareo iodato 200/2 powders, evening and bedtime.

October 31: Oedema ankles in evening on some days. Gland size seems same with no pain and no significant tenderness.

T.L.C. 9500 P53 L40 M4E3 ESR 32 mm, HB 13.5 gm.

Calcareo iodato 200/3 powders at 15 minutes interval.

The prescription was repeated by my Assistant on **December 21.**

1985

September 6: Came after a gap of 9 months. In February 1985, had fever. Told it is Pneumonia, took 20 days to get well. Informs that in February 1985, ESR was 5 mm.

Report of August 1:

T.L.C. 8600 P60 L35 M2E3 ESR 25 mm. Hb. 14 gm.

Calcareo iodato 200/3 powders at 15 minutes interval.

1990

August 22: Reported again after a gap of 5 years. Says he had got well with the previous treatment and remained well till two months earlier, then there was a

recurrence with a gland in the left side of the neck growing in size. No pain, no significant tenderness till the biopsy 12 days earlier.

Hospital Notes:

Submandibular Lymph Node — Excision and Biopsy on March 10, 1990. H.P. Report — *Caseating Tubercular Lymphadenitis*. Has been prescribed A.T.T. 9 months. X-ray Chest: Normal, ESR 20 mm.

O.E. 207 lbs. One supraclavicular gland on left side. A small lemon size swelling left side of neck.

August 22: *Calcareo iodato* 200/3 powders every 15 minutes.

August 29: The swelling burst and there was pus discharge a few days earlier, still discharging. Feels relieved and the pain is reduced.

September 7: Pus discharge continues even after two weeks but quantity reduced, one or two drops in morning when pressed. No pain, no discomfort, no fever. Wt. 209 lbs.

September 26: The pus discharge stopped around September 10 and it remains closed. Swelling has reduced.

October 17: Much better; only slight feeling i.e. a very mild pain while shaving otherwise no trouble. Size has reduced. Wt. 211 lbs.

November 7: Doing well. Wt 213 lbs.

December 10: Much better.

1991

January 7: Generally well, slight cough, a small lump still palpable. All this while he had been on *Saccharum lactis*.

On January 7, repeated *Calcareo iodato* 200/3 powders at 15 minutes interval.

March 19: Better, the improvement had continued all along. No inflammation. Gland smaller.

June 12: No complaints.

O.E.: 218 lbs, no palpable gland. There is only the scar. Had been on *Saccharum lactis* from January onwards. Asked to discontinue the treatment and watch if there is any recurrence.

Comes to get medicines for his wife and is continuing well. Last seen **September 1991**.

?LYMPHADENITIS

Mrs. S.S., age 81 years, consulted on June 14, 1986. She had been married for 63 years and had six children. Two years earlier she had Vertigo. On investigation it was found that she is suffering from Diabetes mellitus. This was controlled by use of Chlorformin. In the recent past there was also a H/O throat discomfort diagnosed as acute tonsillitis, for which she was treated with Ledermycin.

The immediate complaint was a swelling on the left side of the neck for the previous 10 days. No pain in the swelling but she has some dysphagia for solids since the swelling appeared.

She had been to see the Specialist in AIIMS:- Diagnosis: ? Enlarged Lymph Node; ? Submandibular gland.

Aspiration was attempted twice. Cytology Report: "Aspiration shows only blood".

X-ray chest: Aortic unfolding and calcification. Mild cardiomegaly.

Craving sweets, fresh milk cream (Malai). Likes fried + but stopped lately. Desires cold +. Likes cold milk.

However, off and on some hoarseness from cold drinks. Aversion eggs. Sleep: good. Hot patient.

Loquacity ++. Humorous. Conscientious about cleanliness +. "Spends all day cleaning".

Dreams: "Never".

P.I.: Lost vision in left eye after septicaemia following delivery at age 20.

F.H.: Father, Diabetes. One son, Asthma. Brother, Cancer stomach.

O.E.: Swelling under angle of jaw, left side, approximately 1.6 cm diameter. Smooth surface. Not tender except where the aspiration needle was passed.

Has a small nodule or wart like growth on the tongue on left side near the tip.

1986

June 14: *Calcarea iodata* 200/3 powders, noon, evening and bedtime of the same day.

June 21: Felt extremely well, then started taking cold drinks ++ (very hot summer). Got slight cough and slight pain in a submandibular gland on the left side. On her own had stopped Chlorformin. Asked to continue that to control Diabetes. *Saccharum lactis*.

July 1: No cough, no pain. Size of swelling about the same. *Calcarea iodata* 200/3 powders at 15 minutes interval.

At beginning of **August** she got fever for which her local attendant gave antibiotic. Subsequently for about one month she received *Calcarea fluorata* 6x, three tablets t.i.d. Not finding enough reduction in the swelling on **September 18**, she was given *Carbo animalis* 200/3

powders on the same day. This was repeated on **October 6** and **November 13, 1986**.

From October onwards the swelling started to reduce and on **January 9, 1987**, it was completely gone.

She was seen again on **April 6, 1990** after a gap of more than three years. There had been no recurrence of the nodule and this time she had some blurring of vision and wanted it cured "the same way as you cured my nodule which all other doctors wanted to remove by operation".

ANOREXIA

Master R.C. age 12 years. Consulted on December 18, 1992. The anxious mother mentioned of two main complaints — (1) Poor appetite; (2) Poor growth and short stature, i.e., less in height and weight than other children of his age and in his class in school. He used to have frequent sore throat and fever till the age of 9 years and was suggested Tonsil operation which the parents refused. Now, he is only prone to frequent sore throat but no fever. Another complaint that the mother mentioned was white spots on face during winters.

Appetite: Poor (of course, in my 47 years of practice I came across only a rare mother who said that her child was over-eating. Even when he eats normal, the mothers usually say, "the child is a poor eater", and this notwithstanding the fact that the person may be overweight). Been a vegetarian for 3 years, previously non-vegetarian. Fairly strong craving for sweets.

B.O.R.

Sleep: Good. Dreams — Till two years earlier, he used to have nightmares — dreaming of ghosts. Now, no such dreams.

Vaccinated for small pox once.

Hot patient. Perspiration average.

Some fear dark. A nervous child, while watching a movie cannot see scenes where there is fighting and especially frightening ones with ghosts etc. No fear thunder. Very little anger and not obstinate. Fond of cricket.

P.I.: F.T., N.D., birth weight — 9 lbs. Breast fed for two months. At age of 3 weeks high fever, after that diarrhoea tendency. H/O Worms — both round and thread worms.

F.H.: No diabetes, T.B., Asthma or heart disease.

O.E.: Heart, lungs, abdomen — N.A.D. Tonsils moderately enlarged. Small, discrete non tender glands palpable on both sides of the neck. Weight: 70.5 lbs. (with shoes and woollens). Height: 56½" (with shoes).

1992

December 18: *Sulphur* 200/one powder.

1993

January 23: Telephone message — Very slight improvement in appetite. *Sulphur* 200 repeated.

March 10: Better.

May 8 and 31: Sent a peon asking for repeat of the medicine.

Saccharum lactis was sent.

June 22: Reported personally. Mother said appetite is better, "he is asking for food now, previously he had to be persuaded, coaxed and even forced". Has been generally well with no cold, cough or fever since the beginning of treatment, i.e., in the previous 6 months.

Tuberculinum bovinum 200/3 powders at 15 minutes interval.

September 11: Good progress, appetite — good. Mother is satisfied, weight increased by 4 or 5 lbs.

1994

April 26: His mother came to get medicine for his sister and informed that R.C. is doing very well — he is eating well, active in games etc., gained height and weight and that was the reason why they did not report about him all these months or request for further supply of medicine.

PAIN EPIGASTRIUM

Mr. S.P.N. comes with another patient on February 11, 1989 and reminds me that he had been treated many years earlier and has been well ever since. His notes show that he consulted me on **January 5, 1971**, age 43 years, married with two children. Occupation: Principal of a school.

His complaint was pain in the epigastric region of three months duration < after eating, more or less immediately after eating. Feels practically normal on empty stomach as in the morning. No history of vomits. Not much flatulence and no sour eructations. Regular motion but stools are not well formed in the last few months. Earlier he used to have strong urge immediately on waking with some pain abdomen which was > by passing stool.

Appetite: Good, non-vegetarian. Was smoking earlier which he has stopped. Occasional use of alcohol which also he has now stopped. Liking for sour things and chillies. B.O.R. as detailed above.

Sleep: Good. No special dreams.

Vaccination infrequent, last one was in 1968.

Reaction to heat and cold of seasons is average and not marked.

Laboratory tests T&DLC: Normal. Occult blood in stool: Negative. Serum amylase 30 s.units.

Has had allopathic treatment. Spasmindon, Mag-trisilicate, Mexaform and later (from December 23, 1970) Intestopan. No significant relief with this medication.

1971

January 5: Prescription: *Nux vomica* 30/18 powders, 3 daily (morning, afternoon and bedtime).

January 9: Reported better.

January 16: Continues to be better.

January 25: Has had Barium Meal X-ray study.

The report is "Oesophagus, stomach and duodenum appear normal. No ulcer seen. Stomach — hypertrophic mucosal folds. Duodenal bulb: Margins irregular suggestive of hyper-acidity."

For last two days he felt a heaviness in epigastrium and tenderness. "Gives a feeling of pain as in an inflamed area".

Prescription: *Nux vomica* 30/21 powders, three daily (morning, afternoon and bedtime).

February 1: Feeling normal.

Prescription: *Saccharum lactis* which he had also used between **January 9** and **25**. Not seen after **February 1, 1971** till **February 1989** as mentioned above.

Comments:

1. This is a case where only a medium potency of the medicine was used in repeated doses but for a few days at a time.
2. Second course was given only when there was a recurrence of symptoms.
3. A single medicine sufficed to completely eradicate the condition.

?DUODENAL ULCER

Mrs. S.P., age 35 years, consulted on March 24, 1975. She had been married in 1959 and had four children, eldest 13 and youngest 6 yrs. She had two natural abortions.

Complaints: Pain in epigastrium for the previous two and a half years. The pain was there all the time > P.C. > lying down < by exertion. By eating, relief is only for 15-20 minutes. Relief can occur even by taking water, < taking warm > cold things < savouries < sour > sweets. Nausea but no vomiting < empty stomach, eructations — “offensive”. Pain is also felt at corresponding spot on back. By talking, laughing and crying, gets pain. If there is no disturbance and no one talking and she lies quietly in a dark room then she feels alright.

Chronic pain in waist region; considers it to be “due to Leucorrhoea”.

Hemicrania, right side, for six years; started in pregnancy with it nausea but no vomit > crying.

Appetite: Good. Non-vegetarian, used to like chillies but stopped as it hurts. B.O.R.

Sleep: Good unless disturbed by pain which is frequent then drink some water and goes back to sleep. Dreams: Frightening, of thieves, sometimes of water.

Vaccination: In childhood only.

Feels both extremes of hot and cold.

M.P.: Irregular and early, even thrice a month, very scanty — spottings for one day only. Sometimes the spottings may continue for two to three days. Pain in breasts and tense and tender before M.P. > by onset of bleeding. Leucorrhoea copious, white, thick, at times thin and flows upto the knees. Mostly no itching, when excessive then burning in urination.

Bearing down while walking. No stress incontinence.

Had cervical erosion which was cauterised Has pain in coition, "So presumably, there is an erosion again".

Slight fear thunder. No fear dark. While I was examining her away from the other family members, she whispered that the domestic atmosphere was not very pleasant and it was a joint family and "it is the elder brother-in-law who gives me the pain."

O.E.: Heart, lungs — N.A.D. Pulse — 76/mt. Seems hypersensitives, feels tender all over abdomen, especially right lower abdomen and epigastrium. Barium Meal X-ray (April 1974) "Deformed Duodenal cap ?Ulcer". T & D.L.C. — 12,400; P73L24E3.

1975

March 24: *Phosphorus* 6,30,200/1 powder of each, in the morning, afternoon and bedtime of the same day in that order.

April 8: No relief either to pain or insomnia.

Phosphorus 1000/1 powder at bedtime.

May 22: Condition same.

Ignatia amara 200/3 powders at 10 minutes interval to be taken in the morning.

May 24: Reported that she had relief for some hours after the 3 powders, thereafter, as before. My notes are that she seems to exaggerate and the family atmosphere is very tense. She complained of tenderness practically all over the abdomen. Also mentioned that she has burning in the feet for many years. Even in winters pushes them out of covers.

Pulsatilla 200/3 powders on the same day.

May 31: She had come from other town but presently was in Delhi for some days and so would report frequently. Reported that pain in abdomen is less. Pain in breasts from time to time unrelated to M.P. No nodules.

Saccharum lactis continued.

June 19: Sent a letter reporting better.

August 3: Reported not so well.

Pulsatilla 200 was repeated.

* * *

1994 (Follow up 19 years later)

February 27: During a visit to another town where I had been invited by a Homoeopathic College to give a special lecture, I met the family again. The husband had since retired and was practising as a homoeopath and the daughter had qualified from the Homoeopathic College and was also in practice. They reminded me of the treatment of Mrs. S.M. in 1975. She also mentioned that during the course of the previous treatment, she had whispered to me in low tone that the root cause of her problem was the elder brother-in-law. She had been quite well in the 19 years that had passed. She had no pain in the abdomen ever since. no migraine attacks. In fact, she had feeling very well and had no complaints at all.

**CANCER OF THE STOMACH AND
HEAD OF THE PANCREAS WITH
GASTRO-ILEAL FISTULA**

Mr. J.K.J., age 60 years, seen on **November 8, 1977** with a history of hiccuph from mid-August, i.e. for the previous three months. From July 1977, or earlier he had had fever of an irregular nature which had lasted for two months or more. There had been cough and expec-

toration + + . A history of eruption on both feet for the previous 20 years which had been diagnosed as allergic contact dermatitis. He also suffered from bronchial asthma and there was some suggestion of the skin eruption and asthma alternating in intensity. Prior to July, there was some flare-up of the eruption with pus discharge and may have possibly been the cause for fever. For this he used steroids locally (Betnovate N) and an anti-allergic (Incidal) orally. According to his observation, when the eruption cleared, hiccough started.

He had been fully investigated in hospital and was given the Final Diagnosis: "Cancer of the Stomach and Head of the Pancreas with Gastro-ileal Fistula."

Chest X-Ray showed some shadows, initially thought to be Koch's but later suspected to be secondaries.

O.E. nodular masses felt in the right side of the abdomen. These were irregular and not tender.

1977

November 8: *Nux vomica* 30/12 powders q.i.d.

November 11: Appetite increased. Intake of water and quantity of urine increased. Hiccoughs continue as before — no change.

Magnesia phosphorica 6x/20 powders at 4-6 hours interval.

November 14: Hiccough continues unabated.

Ornithogalum umbellatum Q/12 powders (one drop of tincture in each powder) t.i.d.

November 18: No hiccough at all. The effect was immediate and remarkable and there was no hiccough from the time *Ornithogalum umbellatum* started. *Saccharum lactis*.

November 23: No hiccough, except for a short time on November 22, and so he was continued on *Saccharum lactis* and this was more or less continued right

till March 1978. Hiccough did occur at times, but less intense and with fairly long trouble-free intervals. It was felt that it was so mild that it did not call for a repetition of the remedy.

The patient picked up strength and in about two weeks after starting *Ornithogalum* was no longer confined to bed, even though he avoided much exertion.

1978

January 31: O.E. The masses (nodules) in the abdomen have cleared. Liver margin can now be felt and it was found to be enlarged by one finger. Previously the liver could not be felt separately because of the nodular masses in that area.

March 14: Attack of asthma to which he was particularly prone at the change of seasons. *Arsenicum album* 30/12 powders q.i.d. This relieved him of his attack and he continued to be free of hiccough and the treatment was concluded at the end of April 1978, with the patient quite hale and hearty.

His weight had steadily increased from 92 lbs on December 24, 1977 to 101 lbs on March 5, 1978.

He reported again on May 8, 1978. He had carried on well and everything was normal except that there was a recurrence of eruption on feet for previous two weeks. This complaint, as mentioned above, he had had for twenty years only in summers and rainy season with relief in winter months.

May 8: *Ledum palustre* 200/3 powders through the same day.

May 18: >.

Placebo/42 powders t.i.d.

No report thereafter so it is presumed the eruption cleared.

Comments: I was prompted to use *Ornithogalum* by the encouraging results Dr. R.M. Le Hunte Cooper had reported in his comprehensive article on Cancer in the Transactions of the Ninth Quinquennial International Homoeopathic Congress held at London in 1927. This remedy had been first introduced by his father, Dr. Robert T. Cooper. He considered its "action on the stomach as undoubtedly specific". The only variation I made was in giving 12 doses instead of the single dose of mother tincture as suggested by him and mentioned in Boericke's Materia Medica. But then Dr. Cooper was using unit "Aborivital" doses of tinctures prepared in a special way.

The result was certainly spectacular and beyond my expectation as one is not likely to give credit to mother tincture prescriptions with that much depth of action. The recurrence of skin eruption may have been in accordance with Hering's Law of Direction of Cure.

* * * *

1980 (Follow up after 2 years)

June 27: I met him again in June 1980. There had been no recurrence of Cancer and no abnormality detected on palpation of abdomen.

He was having fever for 1 week and hiccough for 1 day. *Arsenicum album* 30 was given for the fever but even when that reduced the hiccough persisted. An unusual feature was that it would continue during sleep (Ref. Kent's Repertory p.502). He also had a coated tongue and sore mouth which could be a reaction to the allopathic medicines used for fever before he consulted me.

July 2: *Mercurius corrosivus* 30/20 powders q.i.d. This progressively reduced the hiccough and he did not have it at all after using it for 3 days.

This consultation gave an opportunity to observe the patient again. There had been *no recurrence of cancer after 30 months.*

MALIGNANT LYMPHOMA

Master P.G., age 10 years consulted on August 29, 1975.

Background History — He had been operated on June 6, 1974. He had mobile tender lump in abdomen which had been clinically diagnosed to be floating kidney. However, after laparotomy on exploration the diagnosis was proved to be wrong and he was found to have a tumour. The relevant notes of the history are attached. A Right Hemicolectomy was done and the biopsy report showed "*Malignant Lymphoma of Caecum and Terminal Ileum. Mesenteric lymph nodes and muscles were also infiltrated.*" No radio-therapy was done. Prior to operation he used to have colic pains on right side of abdomen. These ceased after the operation.

The family was naturally scared from the diagnosis and to prevent a recurrence, they started treatment from a senior homoeopath and continued from July, 1974 till April, 1975. During this time, the patient had frequent attacks of diarrhoea. Besides from beginning August, 1975 he started to have pain in abdomen again. These were the complaints when I was consulted. During pain he presses the abdomen.

Appetite: Always been poor. Vegetarian. Likes rice. Marked craving for sweets but after operation it disappeared, now developed the taste again for last one month.

B.O.R. No diarrhoea at present.

Sleep: poor since the operation. Late falling off to sleep. **Dreams:** What he reads. Occasionally talking in sleep.

Vaccination for Small Pox: At least 4 times including one this year and last year (1975 and 1974)

Feels heat + +. Can't bear to be covered.

Obstinate. Fear dark, thunder, cats and dogs. Sobs when he cries. Cries if reprimanded

P.I. — Typhoid 2-3 years ago. S.O.M. at 3 years for about 2 weeks. Used antibiotic. The ear dried up and there has been no recurrence.

O.E. — Wt. 51 lbs. Small palpable glands R.I.F. Tenderness R.I.F. and L.I.F. Did not pass his stool today. Myopia. Initially — 5.0 D. After operation it reduced and present number is — 2.25D. Surgeon feels this may be due to tumour.

1975

August 29 — *Calcarea carbonica* 200/3 powders on the same day.

October 7 — Hair falling since the operation. Generally carrying on well. However, obstinacy remains marked. Whatever he wants it must be immediately complied with, otherwise starts to weep in a peculiar way — the sobbing type.

Nux vomica 30/2 powders in evening and bedtime of first day.

Sulphur 200/3 powders every 10 minutes the next morning, followed by *Sac-lac* from third day.

December 4 — Repeated *Sulphur* 200/3 powders, every 10 minutes.

1976

January 6 — Hair falling. Cracks in heels. Obstinate as before. *Phosphorus* 200/1 powder at bedtime.

February 9 — No cracks in heels and no hair falling. Pain in eyes. C/O itching and rash on body for 4 days.

O.E. — No rash seen, only a very few spots in axillae. *Sac-lac*. continued.

April 23 — Sleep poor. Keeps biting his lips or pressing with fingers. Occasionally talks in sleep. Obstinate. Injuries fester.

Saccharum lactis.

August 13 — Pain abdomen off and on, cries with it. In pain lies on belly with pillows pressing the abdomen. The pain lasts 15 minutes or so, then subsides but might recur after a short interval. The pain is in the lower abdomen.

O.E. few nodules are palpable in right lower abdomen and these are tender. Wt. 56 lbs.

Plumbum metallicum 6, 30, 200/1 powder of each taken at noon, evening and bedtime of the same day in that sequence.

November 10 — Carrying on well. No pain.

1977

February 15 — A general itching p.c. Referred to repertory p. 1328. Only remedy mentioned for this symptom is *Calcarea phosphorica*

Calcarea phosphorica 6x, 30, 200/1 powder of each on the same day.

March 15 — No itching. Getting more obstinate. Mostly in angry mood, cannot tolerate any contradiction. No biting lips. No hair falling. Wt. 63 lbs.

July 9 — Recurrence of pain abdomen. Wt. 66 lbs.

Plumbum metallicum 200/3 powders through evening and at bedtime.

December 14 — Had fever in previous month with sore throat. The doctor who examined him ascribed it to tonsils. Had pain abdomen during the fever. Sleep poor. Dryness throat and although the fever subsided in six days, he still has some soreness. Wt. 71 lbs.

Plumbum metallicum 200/3 powders at half hourly interval.

1978

February 23 — Last seen on this date. Has had no trouble after his visit in December, 1977 and had continued on *Saccharum lactis*.

O.E. No lumps or nodules could be found on palpation of abdomen.

* * *

December 5 — Reported again with fever for the previous three days and a cold. Aches at night and when he sits down, though feels nothing when he is moving about. Wt. 80 lbs.

Rhus toxicodendron 30/12 powders q.i.d.

* * *

1985

Had an opportunity to see him again on **June 25** after 7 years. Is now 20 years of age and conducting a successful business in readymade garments. He had come for quite different complaints and not of any serious nature. I took the opportunity to examine him. He had no palpable glands any where and no lumps in the abdomen.

* * *

EXTRACTS FROM HOSPITAL NOTES

Patient admitted on 28.5.74 with complaints of colic pain in right abdomen with vomiting off and on for 15 days. On examination of the abdomen a mobile tender lump was found in the right side of the abdomen, clinically diagnosed to be floating kidney.

Investigations:

Hb.	12 gms%
TLC	5500/ cmm
DLC	P 62 L 33 M 1 E 4
Urine -	NAD
BSR	4 mm 1st hr. (Westergren)

B. Urea. 30 mg%
Stool. Cyst of E. Histolytica.
I.V.P. Showed right kidney normal in
position and functions.

Exploration Lump performed on 6.6.1974. Lump found to be a tumour in the Caecum, which had mesentery and was therefore mobile. Terminal Ileum thickened and dilated. Another small tumour, size of an almond, palpated in the terminal ileum about 6" from the Ileo-caecal junction. The mesentery of the terminal ileum as well as the ascending mesocolon had enlarged and firm lymph-nodes, both distal as well as proximal.

Right Hemi-colectomy performed.

On coming upon the caecum in the specimen, the tumour was found to be a mass arising out of the posterior wall with inferior and side walls free. The ileo-caecal valve was patent, but partially obstructed by the size of the tumour. The small tumour in the ileum was also of similar nature.

Microscopically, the tumour has been shown to be a malignant lymphoma.

REPORT OF EXAMINATION

Specimen consists of Part of ileum, caecum and ascending colon with a few lymph-nodes.

HISTOLOGICAL EXAMINATION

Malignant lymphoma, undifferentiated, in ileo-caecal region, infiltrating upto the muscle and mesenteric lymph-nodes. Resected margin of the ileum also shows the infiltration by lymphoma.

* * *

Four slides were sent for examination to **Grasslands Hospital, Valhalla, NY (USA)**

PATHOLOGIST'S REPORT: Date 8.23.74
(August 23, 1974)

Microscopic Examination: Microscopy disclose intestinal mucosa, extensively infiltrated by poorly differentiated lymphocytic cells. Almost entire thickness of intestinal wall is infiltrated by the same type of cells. The mucosa shows ulceration.

PATHOLOGICAL DIAGNOSIS:

Tissue (said to be small Intestine): Malignant lymphoma, lymphocytic type, poorly differentiated.

Sd.

William L. Thelmo, M.D.
Pathologist

? CANCER PANCREAS

Mr. P.C.B., age 82 years, consulted on **November 5, 1985**. He was a suspected case of Cancer of the Head of the Pancreas and was referred to me by his allopathic family doctor. The rest of the history was Hypertension for the previous 20 years and Diabetes mellitus for the previous 10 years. For these he had been taking Allopathic treatment. He was on M-Dopa and a dietary restriction of salt and protein. For the Diabetes he was taking oral anti-Diabetes tablets but had not been very strict with his diet and also not regularly checked whether it was in control. In April of 1985 he had a Syncopal attack and was admitted to hospital. He was

given Norpace for one week. While he was there he had a chest X-ray and because of some suspicion started on antitubercular treatment which was, however, discontinued after sometime as there was a general aggravation in his condition and another opinion was taken and tuberculosis was ruled out. Around this time he was noted to have Jaundice and this was felt due to extra-hepatic obstruction on the basis of Sonography report. As he did not submit to more drastic investigative procedures including an exploratory laparotomy, therefore a definite diagnosis had not been made but the history and investigation to-date in the Allopathic Hospital made them diagnose the condition as Cancer of the Head of Pancreas.

He had had fluctuating Jaundice since April 1985. The highest Bilirubin reading was 16 mgm (conjugated 10, unconjugated 6). There had been a general worsening of the condition in October and he was admitted to hospital. His wife got him discharged from there because she was not agreeable to the heroic investigative measures as mentioned above.

He was having hiccough which was relieved by drinking water. He had a burning sensation of the skin and also there was much itching and the patient kept scratching himself. There was pain in the rectum and a constant urge so all the time he was saying he wants to pass stool. When he made an attempt he passed small quantity off and on. The stools were black and at times slightly greenish. There was anorexia. He was thirsty and the attendant said "Water is the only thing he asked for" and takes few tea-spoonfuls at a time. The desire was for cold water. He had incontinence of urine. He was restless at night and in general felt worse at that time. He was fairly calm during the day. In delirium he talked

about old incidents of 40 years ago. He recognised his children only when repeatedly asked. At times, recent events are forgotten. Some of his talk was irrelevant. Perhaps he had some visions because at times he would call for people not present.

Past Illnesses: He gave a history of Sciatica in 1948 and was confined to bed for six months. He had cataract operation right eye in 1978.

On Examination: Emaciated. Sclera deep yellow. Eyelids drooping. Arcus Senilis. Somnolent to a slight degree but can be roused and responds to commands like "show your tongue". Tongue coated white. There was a mass upper abdomen to left of midline which moved with pulsation of the aorta. Marginal hepatomegaly. No oedema.

1985

November 6: Prescription: *Arsenicum album* 30/21 powders t.d.s.

November 13: Colour of stool "improved, semi-formed, soft". Patient indicated urge for urine and stool since starting medicine. Earlier there had been a tendency to incontinence. "Generally much better." Keeps his eyes closed but points out that he is fully conscious and carried out relevant conversation. There was decrease in his irritability which was previously specially noticeable at night. Complains that he has feeling that some person is calling him away like pre-sentiment of death. Appetite had improved in the previous two days. *Arsenicum album* 200/1 powder followed by *Saccharum lactis*.

November 28: Jaundice apparently the same or slightly better, itching is less but persists on exposed parts, had developed a desire for fried food, perhaps because of the restriction.

December 31: No itching, urine examination showed a trace of Bile Salts and Bile pigments. Urobilinogen slightly increased.

It was reported that he was quiet hungry in-between the morning and evening meals and wanted to know if he could take a cocoa drink. He still had restlessness — after mid-night although it is not in the violent form as before. Can now get up with minor help and sit for a while.

Saccharum lactis continued.

1986

January 17: Occasional memory lapses. Now has sound sleep at night. Natural appetite is restored. Bowel movement at interval of 2 to 3 days.

February 21: Urine examination: No abnormality. Bile salts and Bile pigments Nil. Urobilinogen not increased. Having a daily stool, sound sleep at night and two hours sleep in the day time. Appetite is now normal and there is no longer acute type of hunger. Can undertake a bit of walking without any help or support. Memory seems alright.

March 24: Says he is alright and nothing to report. His general condition is good and he looks "Bright."

Urine report — normal.

April 28: Quite well. Urine report — normal.

June 4: Quite normal. Urine report — normal.

B.P. remains around 160/100.

July 4: Generally well. More active. Writes letters. Watching T.V. B.P. 180/90. Urine examination shows a trace of sugar (green reduction). It may be noted that there was a history of diabetes for the previous 10 years and he had been on oral antidiabetic tablets.

August 22: Quite normal. Adding to his activity. Reads more and does a little gardening. Urine report normal as before.

October 17: He sent a very pleasant note "I am feeling perfect, better than normal." He very enthusiastically celebrated the special religious festival of Durga Pooja.

1986-87

The urine report of November 28, showed no sugar in fasting and P.P. samples but it had a trace of Albumin. Clinically he was feeling absolutely normal and carrying on all usual activities. Nothing eventful in the next two months except an occasional increase in B.P. and Albumin in some samples and not in others and in March 1987 Glycosuria was increased in Fasting samples 1% and P.P. 1-2% Spec. grav. 1028. Also trace of Bile salts and Bile pigments and urobilinogen slightly increased. This was probably a mistake by the lab. because a re-examination of urine after 9 days on **March 18, 1987**, showed only Albumin and sugar but no Bile Salts or Bile Pigments.

He continues to feel absolutely normal. He is now 84 years of age but feels buoyant and a great change from his earlier state.

ACUTE PANCREATITIS (PSEUDOCYST PANCREAS)

Mr. D.P., age 35 years, consulted on March 17, 1989. He had been married 10 years and had three children. He was running a tailoring establishment with some export of garments.

Complaints: Recurrent attacks of severe pain R.U.Q. for the previous seven years. Would be given Baralgan and some other medicines and often needed Fortwin. During most of the attacks had to be hospitalised and was given I.V. Drip. Five years earlier Pancreatitis was suspected. C.T. Scan done.

Report: "? Swelling Pancreas."

S. Amylase used to be raised during attacks.

In 1986 there was a fire in his shop and he was under much tension. At that time he developed polydipsia and pain in the legs. After investigation he was declared to be having Diabetes Mellitus. This must have been a recent occurrence because in 1984 his blood sugar was found to be normal. For this he had been prescribed Daonil but as it did not help so he was put on Insulin injections which he was taking twice daily.

From 1986 his attacks of pain had been not so severe and there was a slight change in location. Now he would have pain epigastrium extending to back. Applying hot water bottle to back would give some relief to the pain.

Six months earlier he started to have vomits — would vomit everything even water. Ultrasound examination revealed a Pseudocyst Pancreas — Body and Tail with ?Infection.

For the previous 15 days vomiting had been persisting, two hours p.c.

Has greatly reduced in weight in previous two years, from his previous 80 kg now he is 58 kg.

Appetite: presently poor but the usual was hunger +, would have need to eat at short intervals and once at night also. Non-smoker but uses a tobacco toothpaste to clean his teeth. Likings — meat, fried things, slightly extra salt. When diabetes developed he had for some-time much craving for sweets. Had started alcohol 10

years earlier but stopped completely one year before. It was two to three times a week and two to four pegs of whisky. The night he had alcohol he would be restless and couldn't sleep so would deliberately vomit and then feel normal. Thirst + +.

Became chilly, previously markedly hot patient. Now he does not feel the heat but feels the cold.

Mentals: Worrier +; Irritable + +; anger has increased; likes company. Fear dark is marked. Sleeps with a fairly bright light in the room. Also fear thunder-storm.

P.I. Previous reports from hospitals and investigations:

1983

Duodenitis, Amoebic Hepatitis, Sore Throat.

Abdomen — Tender. Liver — just palpable, tender.

S. Amylase 235 (N 60-180). Endoscopy — Duodenitis. Oral Cholecystogram, Ultrasound abdomen and X-Ray Chest-N.A.D.

1984

S. Amylase 310. Diag. ? Chronic Pancreatitis

? Neurotic Depression

(G.B. Pant Hospital)

C.T. Scan — suggestive of phlegmonous pancreatitis with fatty infiltration of liver.

August: S. Amylase 897.

1986

Ultrasound — Pancreas large.

1987

Malaria.

B. Sugar — Fasting 274, P.P. 322 E.S.R. 40
Eosino. 9%

1989

March 17: O.E. 128 lbs, Heart, lungs — N.A.D. Abdomen — Tender. Was having mild pain.

Main complaint at present was persistent vomiting. Was using Ranitin, Penkreon, Perinorm and Insulin. These were discontinued except Insulin.

March 17: *Phosphorus* 30/14 powders q.i.d.

March 27: Had pain and vomited only once in the last 10 days (March 25) and took Baralgan inj.

“Felt very well right from the moment of first powder and in the next six days. Today feeling stronger and no distention after eating.” O.E. 136.5 lbs.

Prescribed: *Saccharum lactis*.

April 5: Carrying on well, eating normal.

O.E. 140 lbs.

Similar good report on April 18.

May 1: Reported that he had an attack on April 30 and took analgesic injection again. O.E. 145 lbs.

Repeated *Phosphorus* 30/12 powders q.i.d.

Reports on June 5 and 15 — No complaints.

July 6: Vomited again as on initial consultation but this time no pain as on May 1.

Phosphorus 30/16 powders q.i.d.

Remained well thereafter and was seen occasionally and continued to receive *Saccharum lactis*.

September 25: Wt. 150 lbs.

1990

February 27: Freed from his more troublesome complaint he turned his attention to something for which he had not bothered earlier. On an off for the previous two years he would have some frequency of stools (3 to 4) with mucus before stool and tendency to pass stools with flatus.

Aloe socotrina 6, 30, 200/1 powder of each on the same day.

June 14: Last seen on this date, feeling very fit and active. No recurrence of pain and vomiting and stools normal. Very jubilant and brought some present of readymade clothes.

Weight: 160.5 lbs. (an increase of 32.5 lbs. in the 15 months of treatment).

1992

September: His wife came seeking appointment for another patient and informed that Mr. D.P. was quite well and had no recurrence of his attack.

MASS ABDOMEN: CYST ?MESENTERIC

Mr. S.S.P., age 38 years working as a Power House Technician consulted me on August 9, 1982 with a mass or lump on the right side of the abdomen for the previous two months. The lump was freely mobile and there was no pain, no bowel symptoms and no Haematuria. He had had an I.V.P. and Barium meal X-Ray studies which were reported to be normal. Later he was investigated at the AIIMS by Ultra sonography the report of which is as follows:

"The mass in the right iliac fossa is cystic in nature. The scan demonstrated one large cyst anterior to the kidney and a small one behind the large cyst. Liver parenchyma and right kidney are normal."

The diagnosis made was "Cyst ?Mesenteric." As there was history of contact with animals the possibility of Hydatid cyst was also considered. The advice given was to undergo surgery.

1982

He was prescribed on August 9, *Calcarea carbonica* 200/3 powders to be taken at approximately two hourly interval and starting from the time of reporting in the evening and the last powder at bed time.

September 18: Report through a messenger: "Feeling much better." Prescription: *Saccharum lactis*.

October 3: Next report by letter "Lump is dissolving." Prescribed: *Saccharum lactis*.

November 6: Report "How long shall I use medicine. The lump is no longer felt." Prescribed: *Saccharum lactis*.

December 6: Asked for repeat. Prescribed: *Saccharum lactis*.

As the patient was from a village in Bihar, some 1200 km from my place (New Delhi), all the above reports were through letters or by his other friends visiting Delhi.

1983

On **January 8**, he reported for personal examination. No lump could be felt in his abdomen. He also reported that the weakness from which he had been suffering was also much improved.

The noteworthy thing is the use of:

1. single remedy
2. single divided dose
3. No repetition as long as improvement lasts.

And in this particular case, the improvement was rapid and uneventful, therefore it was not repeated at all.

JAUNDICE

Case No. 1: Mr. R.K., age 28 years, asked me to see him in hospital on **February 4, 1988**. He had been married for three years, had one child age two years. He was a contractor for construction. The **background** history was that he had an attack of **Appendicitis** in **September 1987**. It settled by conservative treatment. **Second** attack in **November '87** for which he was operated on **November 10**. It healed normally. No blood transfusion had been given. Beginning **January '88** he had anorexia and vomiting, no fever. Few days later the eyes looked yellow. Tests were done and diagnosis of **Jaundice** was made. He was hospitalised on **January 12, '88**. Then serum bilirubin was **10.9 mg. %** but it showed a progressive increase and on **January 25**, it rose to **30.8 mg. %**

When I saw him on **February 4**, he was having no vomits. His appetite was poor. Earlier he was smoking 20 cigarettes a day but he had not smoked for previously three weeks, in fact there was no inclination. Never taken alcohol and he was a vegetarian. His taste was bitter. He did not have much thirst but this may be because he was on constant I.V. drip.

B.O.R. ?with the medicine being given it was semi-solid. Previously it was loose and frequent. He had no pain in abdomen and no headache. Prefers lying on right side but can lie on either. Discomfort turning sides.

Lab Reports

Stool Examination:	Cyst E.H. + Cyst Giardia +
Total S. Bilirubin:	30.8 mg. % (conjugated 18)
S.G.O.T.	290

S.G.P.T.	350
Hb.	12 gm.
Australia antigen	negative on Feb. 3 (it was positive on January 3).

O.E. Pulse 68/mt. Heart & Lungs: NAD. Abdomen: Swollen — Distended. ? Slight Ascitis. Slight puffiness — Feet & Ankles. Tongue coated and eyes deep yellow.

1988

February 4: *Nux vomica* 30/8 powders q.i.d.

February 6: His S. Bilirubin was checked on February 5 and found to have dropped to 18.6 so he asked to be released the following day.

Nux vomica 30/16 powders q.i.d.

February 10: Feels better. Appetite better. *Saccharum lactis*.

1989

January 2: There had been no further report after February 10, 1988. However, today his Uncle brought another patient and mentioned "because your medicine helped so dramatically my nephew — Rajesh, so we want your help for this serious patient diagnosed as Osteosarcoma."

Note:

I cannot mention of any clear indications for *Nux vomica* in this patient. Probably the considerations were initially to antidote the effect of the medicines he would have used in the hospital. Besides in an epidemic in Bombay the maximum number of patients had responded to this remedy so it was considered the genus epidemicus at that time.

Case No. 2 (Jaundice)

Master A.D., age 9½ years.

Fever from **June 12, 1984**. 102°F. Received *Ferrum phosphoricum* 6x.

On **June 13**, number of vomits. Received *Ipecacuanha* 30/8 powders q.i.d.

During this time I was out of the country. Consulted me on **June 15**. The fever was continuing. Patient was very drowsy, thirst ++ for large quantities. Was prescribed *Bryonia alba* 30 every four hours.

June 16: Temperature slightly less but he was tending to vomit even water and was not taking any food, partly for fear of the vomits.

June 17: Examined him again. Vomits were somewhat reduced. Retaining some fresh lemonade. Feeling weak. Slightly yellow discoloration of the sclera. On enquiry was told that the urine was deep yellow which was ascribed to poor fluid intake. Asked for his urine examination report. Prescribed *Phosphorus* 6 q.i.d.

June 18: Urine examination report: Dark yellow; specific gravity 1018; Bile Pigment +; Bile Salts ++.

June 20: Reported improvement. Temperature had been normal. Vomitings practically nil. Taking fluids. Appetite still poor. *Phosphorus* 6 continued.

June 25: Urine report: Pale yellow; Bile Pigment and Bile Salts both negative. No complaints. Very hungry. Asking for all kinds of food. Wants to go out to play and the parents are restricting his activity with difficulty.

Case No. 3 (Recurrent Jaundice)

Mrs. R.P. age 32 years. Consulted on **July 20, 1992**. She had been married 12 years and has two children aged 11 and 8. Both normal deliveries. No abortion.

She had Jaundice 4 times in 7 years. Initially, 3 times in two years and thereafter at a gap of 4 years. The last attack was in December 1991. Ever since then, some pain in abdomen is continuing. Rich diet upsets and increases the pain in upper abdomen. Also any extra eating or heavy food gives her more weakness. In the morning, has nausea and also sinking which is relieved on taking something. Itching persists. It occurred every time she had Jaundice but after the last attack, it has persisted. There is no eruption. < night and especially on the side that touches the bed. If it is bad then slight rash. In the earlier attacks had some urticaria. Presently, using anti-allergic medicine for the itching – Forestal.

All investigations including ERCP were normal. Though ERCP could not be done satisfactorily any calculi in the duct or Gall Bladder were ruled out.

Her other complaint was hair falling.

Appetite: Very poor for 6 months. Slightly better for the previous 3 weeks. Non-vegetarian but taking only vegetarian diet since last attack of Jaundice in December 1991. No strong cravings. Now having a tendency to Hiccough if eats well.

B.O.R. But since the Jaundice a little extra diet or milk or milk products (other than curd) give extra stools. Prior to Jaundice, she had chronic constipation and bowels moved only on alternate days.

Sleeps well. Dreams about whatever is on her mind. No nightmares.

Chilly patient. Perspiration is less than average.

M.P.: Regular. For last 6 months (after Jaundice) bleeding only for 3 days, previously it was for 7 days. Has dysmenorrhoea only on first day of menses. Sometimes needs an analgesic.

P.I.: Fracture right arm 13 years earlier after an accident. History of Threadworms and Roundworms in childhood. No h/o blood transfusion.

F.H.: Father had diabetes and died of Renal failure. Nil of T.B., Cancer, etc.

O.E.: Heart, lungs — N.A.D. Liver margin palpable on deep inspiration. Weight: 52.5 kg. Says, before Jaundice it used to be around 60 kg.

1992

July 20: *Phosphorus* 200/3 powders at 15 minutes interval.

August 11: Better no itching; no longer has the frequent gripe with urge for stool; gets discomfort if eats out in parties where there is rich diet. Generally M.B. — occasional mild pain.

Saccharum lactis continued.

September 1: Slightly worse, cannot stand any exertion.

Phosphorus 200/3 powders at 15 minutes interval.

November 17: M.B. Felt so well that she did not report for two and a half months. Eating everything without restriction, even bazar food. Continued to be free from any itching. Also no weakness feeling. "Feel my normal self and engaging in all activity." She is now back to her normal bowel habit of having a stool on alternate days.

Now complains of having boils on head. Dandruff and hair falling persists.

O.E. looks like a skin eruption with moist crusty eruption on scalp and also behind right ear.

Graphites 200/3 powders at 15 minutes intervals.

December 24: Eruption better. Cleared behind the ear. Hair falling still there.

Saccharum lactis continued.

1993

February 9: Hair falling stopped. Eruption had cleared. Feeling very grateful – “You have saved me”.

* * *

Case No. 4

Details of the most serious case of Jaundice that I ever treated appear in the article on Jaundice presented at the International Homeopathic Congress at Hamburg (Germany) in 1979 and published in my book, “Compendium of Lectures on Homoeopathy”.

ASCITES ?HEPATIC CIRRHOSIS

Mr. S.K., comes for consultation from his village some distance away on July 23, 1991 and reminds me of how tremendously he had been helped when he was treated earlier. So we take out his old notes and find it very interesting. He had first consulted on **October 31, 1983**. Age 23 years, not married, occupation farming. He had fever two months earlier which had been diagnosed as Malaria at the District Hospital and he took Chloroquin. He had had a blood test but being semi-literate he had not seen the report nor was it available. He was relieved in three days but there was a recurrence after four days. There was no chill and he consulted an Ayurvedic Physician who told him he has Typhoid and he was not given solid food for 15 days, all he was allowed was a little milk. After 15 days he was allowed Khichri (well cooked soft rice with some lentil). Thereafter he developed a swelling of the abdomen which progressively increased. At this stage he went to hospital where

it was diagnosed as Ascites ?Tubercular; ?Malignancy. He was put on anti-tubercular treatment and Lasix (Fursemide). Ascitic Fluid Examination showed W.B.C. 68/c.mm. with 80% Lymphos, R.B.C. 84/c.mm., Protein 3.2. He gave a history of Jaundice two years earlier. The final hospital diagnosis was *Ascites – ?Posthepatic. Advanced Cirrhosis, Postnecrotic.*

His appetite was good, vegetarian, prefers sweets. Constipated for two weeks. B.O. alternate days that also with laxative. It was normal prior to two weeks.

P.I.: Jaundice two years earlier. Was treated in the village by mantaras (religious incantation) etc. with rapid recovery. 11 years earlier he had Phthisis and was treated for six months and then declared to be normal.

He was debilitated; had moderate ascites and so liver could not be properly palpated.

1983

October 31: *Phosphorus* 30/15 powders t.i.d.

November 8: For last two days abdomen is **bigger**. Urine is interrupted and oliguria.

Apis mellifica 3/28 powders q or t.i.d.

November 16: Feeling better.

December 2: Appetite voracious, mentioned that he feels better with powders but when he uses pills (which is *Saccharum lactis*) the ascites increases.

Placebo/30 powders t.i.d.

December 12: M.B., appetite normal, urine and stool normal, swelling abdomen less “looks normal to others”

Placebo repeated.

December 21: M.B., no symptoms “there was no hope you have saved him”.

O.E.: Slight Ascites only.

Tuberculinum bovinum 200/1 powder at bedtime.

1984

January 21: Has been to his village. Kept well, an occasional slight pain abdomen.

O.E.: Ascites nil or very slight.

Placebo continued.

February 22: No ascites. Generally very well. Appetite, bowels, sleep — all normal. All along veins on the chest were somewhat prominent. ?some obstruction.

March 21: Feeling quite well. During the previous month had fever on alternate days for three times. But for the previous four days had been normal without any medication.

O.E.: Spleen enlarged 1" below the costal margin.

As the fever had already subsided he was continued on *Placebo* and asked to report if there was any development.

April 16: M.B. Started to take more or less normal salt in food, which he has been restricting earlier and is also engaging in his usual activities and work with no ill-effects.

In August 1985, I received a letter from his brother, who is more literate and a Teacher in the village school. It states, "my brother is quite alright and leading a normal life. I am always at your service. For us you are like God."

During his visit in July 1991, for some trivial complaint I took the opportunity to examine his abdomen. It was normal in every way and what was interesting was that the veins were also far less prominent now showing better circulation.

Comments: It is to be noted that he only received *Phosphorus* 30 for 5 days and *Apis mellifica* 3 for one week and one dose of *Tuberculinum bovinum* 200.

FLATULENCE

Mrs. L.N., age 70 years, consulted on July 12, 1990. She has five living children, one died at the age of 46 years of Cardiac arrest in September 1989. Her son had brought a written history which is reproduced below:

- “1. Acute gastric problem since 25 to 30 years. (People in this country use the word ‘gastric’ when they actually mean gas, wind, flatulence, bloating or distention in abdomen).
2. Earlier low blood pressure.
3. For past two to three years starting to have high blood pressure.
4. Now gets palpitation and sinking feeling with each gastric attack.
5. She is taking Calmpose to get sleep.
6. Very loud wind belching. Almost turn into shrieks during gastric attacks.
7. Complains of pain in chest (both left and right region).
8. Is remaining depressed since demise of her son in September 1989.
9. Complains of acute weakness, headache.
10. ECGs show some abnormality.
11. Tongue remains stiff. Dry.
12. Feels more cold than others.
13. Latest Blood Sugar: Fasting 99.9; P.P. 124.9. Cholesterol 226.9. Urea 32 mg. %
14. Blood pressure 160 to 170/90 to 100 m.m.”

I supplemented this history in that she had very loud eructations and this may result in giddiness and recently occasional blackouts. Trouble possibly more after eating. < tea < fried.

Perspiration head and face with eructations. Palpitation for one and a half year. Mild suffocative feeling. Sinking. Weakness. Lack of energy.

Appetite: Poor. Is an eggetarian, earlier liked rich food and fried things. Dryness and stiffness of tongue. Thirst +.

B.O.R.

Sleep was good till September 1989. After the shock of her son's death, she mostly uses Calmpose. No significant dreams. Chilly + +.

Depression from the time of son's death.

E.C.G.: I.H.D. (Inferior wall ischaemia) Echo and Doppler show heart in fair condition. One of the ECG shows indeterminate transient arrhythmia.

O.E.: C.V.S. — slight irregularity in force of beats as apparent in checking B.P. Edentulous and not using dentures. Lungs, Abdomen: N.A.D.

She was taking the following medicines:

Aldomet $\frac{1}{2} - \frac{1}{2}$; Isoptin $\frac{1}{2} - \frac{1}{2}$;

Sorbitrate $\frac{1}{2} - \frac{1}{2} - \frac{1}{2}$; Calmpose 1; Diovol/Digene

1990

July 12: *Asafoetida* 200/3 powders on the first day followed by *Saccharum lactis*.

July 21: M.B. Generally felt improved. Appetite better. Less eructations. "This relief is after a long time."

August 25: Better.

December 26: The son reported that the medicine is suiting her and although in the previous week had a belching attack but it settled down. B.P. now is not always high and has been put as labile.

1991

January 12: Feeling cold very much and with it pain in knees. Has earlier history of O.A. > fomentation and keeping knees warm. *Asafoetida* 200/3 powders at 15 minutes interval.

February 26: Reported better. Pains are also better.

March 25: I received a note from the son: "My mother is responding to the medicine given earlier. Her medicine has finished, so I request for more medicine". Obviously *Saccharum lactis*.

August 22: In my absence got a repeat from my dispensary. Also *Saccharum lactis*.

Comments: This is the case of an old person who responded to a comparatively lesser used drug prescribed mostly on particulars, rather one very persistent and marked particular. It showed a response in every direction including symptoms dependent on organic changes. Besides, it well demonstrates the effectiveness of high potencies given infrequently. *Asafoetida* was given only twice during the entire treatment (on July 12, 1990 and January 12, 1991) and the rest of the time she carried on with *Saccharum lactis*.

INTESTINAL OBSTRUCTION

Master K.P. consulted in an emergency on September 2, 1983. Approximately 3 years age (born October 2, 1980). The emergency was Intestinal Obstruction and this was already his third episode. The first time one might have occurred at birth itself because apparently it was considered fairly serious and he was operated when he was only 1 day old. He subsequently had a recurrence

which was treated conservatively and the operation could be avoided. Now he had the problem for the previous 3 days. The abdomen was getting enlarged, nothing passed p.r. — no stool, no flatus and he started to vomit whatever little liquid he took. No appetite.

1983

September 2: *Plumbum metallicum* 200/8 doses at 4 to 8 hourly interval according to intensity of complaints.

September 3: Soon after starting treatment the child passed stool, abdomen became smaller. Is hungry and taking feeds. No further medicine needed.

Case No. 2 (Intestinal Obstruction)*

Mr. T.C., age 33 years

Early in the morning of July 8th, 1983, I was rushed in my night clothes to see a patient in a Nursing Home. He had been there for the previous two days with incessant vomiting and no passage of stool or flatus.

Considered to be a case of *Intestinal Obstruction* and the reasons for the hasty summons was because it was proposed to operate some four hours later. Other specialists had been consulted. One of the possibilities was put as "Acute Pancreatitis with Gastritis". Another possibility considered was "? Paralytic Ileus due to perforation clinically". His notes showed "bowel sounds absent; guarding ++; rigidity +." A surgeon was also summoned for opinion and to assess operation risks.

The relevant parts of X-Ray and Ultrasound examination reports are reproduced below:

Paper presented at the 42nd Congress of International Homoeopathic Medical League held at Arlington, Virginia (U.S.A.) March-April, 1987.

July 7, 1983:

Abdomen: Erect and Supine Views

Report: No free air is seen under the diaphragm.

Multiple gas distended bowel loops are seen in central abdomen with a large number of well-defined fluid-air levels. The colon shows minimal gases only. These roentgen changes are compatible with the clinical impression of paralytic ileus. Kindly correlate.

No straight X-Ray evidence of urinary, biliary, pancreatic or appendicular lithiasis is seen.

July 8, 1983:

Plain skiagram of abdomen in erect and supine position

There is no free air in the peritoneal cavity.

There are dilated loops in small intestines with air fluid levels. No air is seen in the colon. The appearances are compatible with low small intestines obstruction.

Ultrasound of the upper abdomen

The sonogram shows normal echo texture of the liver. There is no evidence of any space occupying lesion.

The gall bladder, the common bile duct do not show abnormality.

* * *

Lab reports did not give any significant findings (copy of consolidated reports annexed).

Treatment and Progress Reports

July 8, 1983

He was prescribed *Plumbum metallicum* 200/8 doses. To be administered every 2-4 hours (interval between doses to be according to intensity of symptoms and discomfort). Within about 2 hours he passed some flatus

with a little fluid and in the next six hours passed a number of motions with much relief to the greatly bloated abdomen and discomfort signifying that the obstruction had been relieved and intestinal passage restored.

He had a comfortable night and the whole picture changed. For obvious reasons the operation was cancelled.

On **July 9, 1983** he only complained of some flatulence and weakness for which he was prescribed *China officinalis* 6/10 powders. One powder to be taken every 4 hours.

On **July 12, 1983**, the notes are "Been well. But today stool very little and some bloating. Bitter taste". He was prescribed one dose of *Plumbum metallicum* 200 followed by *Sac-lac*.

On **July 16** he reported that he was feeling quite alright and taking usual food. *Sac-lac* for another 4 days and that concluded the treatment.

At the time that I first saw him the condition was so grave that no other history was taken. Of course, I had known him from childhood and generally known his medical history. Subsequent to his recovery, I asked him to tell me more about his present illness. Then he mentioned that one evening he had consumed 3 or 4 mangoes just before going to bed. Mango is a delicious, sweet and succulent fruit widely grown and consumed in India. Next morning he did not move his bowels. Thereafter, he felt pain in epigastric region and started vomiting. Pancreatic trouble was doubted for which he received some medicine from an allopath without relief and soon thereafter was admitted to a nursing home because of rapidly deteriorating condition. He had not passed stool for three days. He had also not passed urine for two days.

I have had occasion to see this patient from time to time as I happen to be their family doctor. I last met him in November, 1986. He has continued to be well and no recurrence of his trouble.

This case shows the rapidity with which Homoeopathic remedies act in acute and even very serious conditions. It saved the patient from an imminent operation, greatly surprised the entire hospital staff and brought laurels to Homoeopathy. The total treatment was for 12 days out of which the last 7 days was only Placebo.

Mr. T.C.

Laboratory Reports

Date	July 6, 1983	July 7, 1983	July 8, 1983
White Cells count	11,000	8,600	10,000
Polymorphs	79	63	65
Lymphocytes	18	35	32
Monocytes	0	0	1
Eosinophils	3	2	2
Haemoglobin (gms. per 100 ml.)		11.0 (76%)	11.5 (80%)
Serum Amylase (Normal 70 to 300 Somygi Units per lit.)	280	250	153
Urine Amylase per lit.		379	
Blood Sugar (Random)	128	123	
Blood Urea		28	
Serum Creatinine		0.83	
Serum Sodium			132
Serum Potassium			3.6
Serum Chloride			98
Urine Report		Light green Reduction in Sugar Test.	

ULCERATIVE COLITIS

Case No. 1

Mr. G.N., age 22 years consulted on April 1, 1993. He was a bachelor and worked in a cement concrete factory owned by the family.

Complaints — It was a diagnosed case of Ulcerative Colitis. He started his history from 1988 when he came to Delhi from a nearby town for college admission. On return he had loose motions, few days later noticed blood. Stool was not tested but clinically diagnosed as Amoebiasis. Had Allopathic treatment and recovered in a week. There was a recurrence every 6-8 months but would get similarly controlled. At times he was depressed for which he was using tranquillizer-Alprax. The last attack in January, 1993 was not controlled by the usual Allopathic treatment then he tried Homoeopathy and then Ayurveda but neither helped. In March, 1993 he was hospitalised and put on steroids, etc. but not enough relief.

He had sudden urge for stool, tendency for stool p.c. Much rumbling in the abdomen. Before the stool wind gushes out with sputtering sounds. At times nothing is passed or only flatus or only mucus or only blood. Presently 14 to 16 stools (8 to 9 in day and 5 to 6 at night) < evening, i.e., more frequent.

Appetite — Good. Vegetarian. Likes sour and spicy “Chaat Pakori”.

Sleep — Not so good, also disturbed because of stools. **Dreams** — rare and nothing significant.

Hot patient. Hands always warm. Body also warm. Earlier sweaty palms. Evening temperature around

100°F. Was always lean but has lost weight. Before this disease was 45-46 kg. now 38-40 kg.

Mentals — Always been sensitive, nervous and depressed. Irritable. Reacts to anything against his wish.

P.I. — Enteric Fever — 1992. At that time was having Ulcerative Colitis symptoms. With the medication (Allopathic) for typhoid, the Colitis also improved. Fracture both bones, left forearm.

F.H. — Father — Borderline or potential diabetes. Nil of T.B., Asthma, Cancer, Colitis, etc.

O.E. — Asthenic, narrow chested. Tachycardia. Heart, lungs, abdomen, throat: N.A.D. Weight — 79 pounds (approx. 35.5 kg.).

Investigations — Mantoux test — negative. E.C.G. — Sinus tachycardia. X-Ray Chest — Normal. Widal Test — Negative. Hb. 12.4 gms. E.S.R. 49 mm. Sigmoidoscopic examination: ulcerated lesions, which are bleeding, seen. Barium Enema — Active Ulcerative Colitis.

He had been so frightened by the Allopathic physicians about his illness that he wanted to continue with the Allopathic medicines, fearing a big set-back if he stops. I told him I have no such fears but I am agreeable to his progressively reducing the Allopathic medicines if he finds good relief with the additional Homoeopathic treatment.

1993

April 1: *Natrum sulphuricum* 6x/28 powders q.i.d.

April 7: Better. Number of stools is less. The Allopathic medicines have been reduced.

Natrum sulphuricum 200/3 powders at 15 minutes interval.

May 1: One stool daily. Further reduced Allopathic medicine from 4 tabs. to 2 tabs. Complained of Urinary

symptoms. Frequent urge and feeling that it was not fully passed. Occasional burning.

O.E. — Weight 95 lbs.

Saccharum lactis continued.

May 24: Carrying on well. Allopathic medicine now reduced to 1 tab. Has 1 or 2 stools. No gripe, no pain abdomen. Appetite — Good. Eating everything, that is more liberal in his food.

O.E. Weight 100 lbs.

June 19: Feeling very well. He had stopped all Allopathic medicine in the last week of May, a few days after his last visit as he now felt quite confident that the Homoeopathic medicine had really worked. **O.E.:** 102 lbs. (46 kg. was the maximum weight he ever had before this illness).

Saccharum lactis continued.

June 26: Fever 103°F from yesterday. Has Urticaria. Not sure whether he feels better with covering and warmth or by cold. Only new thing that he has eaten is 250 gms of Jamun fruit. (*Syzygium jambolanum* fruit)

Apis mellifica 6/18 powders every 4 to 6 hours.

July 28: Urticaria was cleared in 3 days and temperature became normal in a week. Stools continue to be normal. Once daily, occasionally two. At times distention and feels the gas moving and “as if a ball bounces”. He is going to factory and putting in 7-9 hours of work. Flatulence still there.

Saccharum lactis continued.

August 21: Carrying on well. One or two stools in the day but not fully formed. According to mother takes liberty in diet and at times is indiscrete.

Natrum sulphuricum 200/3 powders at 15 minutes interval.

September 25: Stools one or two daily. Mostly formed. Actively engaged in work. Mother feels that taking extra sweets over many days gives an occasional loosish stool. Wind passed up or down "tickles in abdomen". *Saccharum lactis*.

November 15: Doing well. Usually one stool. Sometimes two. *Saccharum lactis*.

1994

February 17: No eruption legs. Two days ago looked at metal welding without protective glasses. Since then slight discomfort in eyes. Has only one stool but at times it is forceful and noisy.

Hepar sulphuris calcareum 30/12 powders t.i.d.

(I was guided to this prescription by the reference in Hering's Guiding Symptoms – For Effects of Looking at Solar Eclipse) This cleared his eye symptoms and for his digestive complaints *Natrum sulphuricum* 200/3 powders at 15 minutes interval was prescribed. Thereafter he continued to report after every 4 to 6 weeks. There has been no trouble even though he went on a fairly strenuous journey to a number of places where he could not take the usual dietary precautions. He has continued on *Saccharum lactis* ever since. Was last seen on **July 26, 1994**.

Case No. 2 (Ulcerative Colitis)

Mr. M.L.J., age 26 years, consulted on June 9, 1969. He had been married two years, had one child. He had a retail shop for electrical goods. He gave a history of loose motions with blood and mucus or pus during the previous 5 years. It has not been a continuous problem and he had intermittent attacks. At the time of consultation he had been suffering for the previous two months.

During the attacks he was also prone to vomits. He was having 9 to 12 stools with griping pain which was quite severe. Stools were forceful and gushing, quite loose and offensive. He was passing considerable flatus with stool. Blood is mostly passed at the end of the stool while mucus is mixed. He would have a stool invariably after eating and other times additionally. Tendency to attacks is more in summer, in winter months it was getting controlled sooner. Pain in abdomen disappears soon after stool. While lying at times there is gurgling and/or pain while changing sides. Earlier he had been under Allopathic (Orthodox) treatment and had been diagnosed as a case of Ulcerative Colitis. He had been also hospitalised for sometime. Had received heavy doses of steroids (Prednisolone tablets). While in hospital he was having Efcorlin retention enema twice daily. The medication had resulted in a swelling of his face.

He was a non-vegetarian but had stopped meat one year earlier. He had also stopped chillies in his diet which he earlier used in considerable quantity. He was teetotaler. Had liking for meat and used extra salt in his diet. He had not been vaccinated frequently and it was only in childhood and revaccinated in school.

It is interesting to note that in the initial stages he had had Barium meal and Barium enema X-Ray examinations as also sigmoidoscopy. All these investigations had turned out to be normal so a renowned Allopathic physician who was treating him diagnosed it as a case of piles. However, sometime later the same test bore out the true diagnosis of Ulcerative Colitis which was completely confirmed by a repeat sigmoidoscopy.

There were no mentals and generals of significance.

O.E. Tenderness whole abdomen, sigmoid colon area palpable. Pulse 108/mt. Weight 115 lbs.

1969

June 9: It was felt that the first task was to possibly antidote the ill-effects of the medication that he had been receiving so he was prescribed *Nux vomica* 30/12 powders q.i.d.

June 12: Stools are less, blood is less, no griping pain. Vomits continue and possibly more. The vomits are mostly when he is defaecating. There is such a rubric on p.534 of the repertory. Covering this symptom and the rest of the history prescribed *Mercurius solubilis* 30/15 powders t.i.d.

June 17: Blood stopped immediately but the other symptoms (loose stools and vomits) continued till June 14. From 15th there was a definite change for the better: stools more solid and less frequent and no vomits. Had a cold for which he was given a few powders of *Allium cepa* 3 followed by *Saccharum lactis*.

June 25: Cold cleared. Now stools are formed, about 4 in the day, no blood, no vomits.

July 1: Gets repeated hiccough and again some vomits. *Arsenicum album* 30/12 powders at interval of 3 to 6 hours.

July 2: No hiccough. Vomits reduced. A general tenderness in the abdomen. Temperature 99.5°F. There was no stool for two days which is very unusual with him.

Given *Saccharum lactis*.

July 17: I cannot give precise details as that part of the paper has got torn in storage but apparently there was a slight relapse because he has again been prescribed *Mercurius solubilis* 30/15 powders t.i.d.

July 29: This time there was not the dramatic effect as when *Mercurius solubilis* was given on June 12.

He is relieved only to the extent that there was no griping and no blood in stool. But he still has 5-6 stools.

The morning stool is formed, the latter ones are looser. < P.C. < sitting in one place. Stools are less, if he is going about. Gets a stool before going out as he has a fear that he may not get on the way so makes it a point to try before going out. Wt. has increased to 122 lbs. (On June 9 it was 115 lbs.)

Sulphur 200/1 powder.

August 14: Now three stools daily, formed or semi-formed and generally alright. Wt. 133 lbs.

September 6: When he has to go out then wind forms in abdomen and forces a stool. This and the symptoms he mentioned on July 29 gave an impression of "stool by fear or anticipation." *Gelsemium sempervirens* 200/3 powders t.i.d.

He was seen from time to time with very minor digestive complaints and only when he was quite indiscrete in his eating particularly when he went out of town on his business tours. For this he would invariably respond to *Nux vomica* 30, taken over one or two days. In fact he started to rely on this so much that when he will go on tours he will have some of these powders with him. But it is to be noted that this was not needed frequently but only three or four times in a year.

In fact he fully regained health and vigour and this would also be apparent from his weight which on **December 18, 1969** had already increased to 139 lbs. and on **September 28, 1971**, it has been recorded as 159 lbs. (at start of treatment he was emaciated with a weight of only 115 lbs.)

* * *

He has been seen from time to time for himself and when he would accompany other family members whom he brought for treatment. However, right till the end of

1990 there was no recurrence of his Ulcerative Colitis and most of the time he would be consulting for some ear problem. There was a history of chronic S.O.M. left ear from childhood and there was complete hearing loss on that side. He would consult for a feeling of blockage in the ears especially when exposed to cold or an occasional tinnitus. He also had treatment for dandruff and hair falling. In 1982 he suffered considerably when he was given an injection elsewhere for fever and this developed into an abscess.

The idea of mentioning about the period covering 21 years (1969 to 1990) is only to show that there was opportunity to follow-up the case over this long period and the cure had been not a temporary remission but of a lasting nature.

It would also be observed that disease often starts with a general disequilibrium and expressed as functional symptoms without organic changes. If not cured at that stage then organic or structural changes can follow. Systems of medicine that depend on a nosological diagnosis to determine the course of treatment cannot offer proper treatment in the initial and more curable stages because at that time the disease has not advanced far enough to enable a diagnosis. In this particular patient although he had all the symptoms but thorough investigation did not show the Ulcerative Colitis in the initial period.

Case No. 3 (Ulcerative Colitis)

Mr. P.K.J., age 22 years, bachelor, business-fertilizer distribution, consulted another homoeopath on November 10, 1987. Elsewhere he had been diagnosed as ?Piles; ?Ulcerative Colitis and before coming to me had been prescribed *Phosphorus* 200.

Complaints: (1) Pain abdomen, mainly in two locations in the lateral areas of the abdomen for 7 months. Pain burning in nature. It waxes and wanes spontaneously without any clear modalities. No complaint of flatulence. (2) Blood in stool for three months, daily in significant quantity. Occasionally some mucus also. Blood bright red. Has three to four stools daily which is his old habit. At first there is blood and it is followed by stool which is formed. Non-vegetarian, teetotaller, some liking for sweets but not a marked craving. Not tense or worrying. Reserved nature.

December 12, 1987: I saw him on this date. He was feeling worse. Number of stools increased to 6-7 and he was also getting one or two stools at night. There was little pain before stool and he said that the blood was mixed with the stool. With these features my diagnosis was Ulcerative Colitis.

Prescribed: *Mercurius corrosivus* 200/2 powders, evening and bedtime.

Patient was from outstation and was to return so he was also given *Saccharum lactis* for one month. However, he reported again on December 16. Already there was some improvement. Number of stools reduced to his usual three to four, no stool at night. However, blood continued as before. He also said that there was a slight pain in abdomen for 5 to 7 mts. after stool and it gradually gets relieved.

He was told that no change in medication is needed.

1988

February 3: He sent a message, "Please send more medicines." On enquiry I learnt that there was only one stool which was formed and there was no blood.

Saccharum lactis continued.

March 8: Now again blood and number of stools increased to three. There was also pain abdomen with cough. Mentioned that he had been helped much by medicine of December 12, 1987. Repeated *Mercurius corrosivus* 200/2 powders, evening and bedtime.

April 14: Digestion better. No abdominal discomfort. No blood in stool. Only one stool in day. However, appetite is not so good.

July 2: Doing well. Appetite also improved. Normal stool.

August 3: Number of stools increased and also has blood.

Mercurius corrosivus 200 repeated.

September 9: Not well in last two months, 8 to 10 stools, stools at night also. Gripe and tenesmus. Blood and Mucus.

Mercurius corrosivus 1000/3 powders at 15 minutes intervals.

September 13: No change. *Aloe socotrina* 6/12 powders q.i.d.

September 16: Better. Four to five stools. Blood still there. No gripe. Given him *Saccharum lactis* but as he was leaving he was also give *Aloe socotrina* 6/16 powders q.i.d. These he was asked to keep with him and use only in case of recurrence.

October 25: Further improvement. Two stools. Blood is only occasional. Did not need the medicine "for attack." (Aloes)

1989

January 3: Digestion been well. Stools normal and no blood. This time came for different complaint. Three weeks earlier had colicky pain. Investigations revealed urinary calculus.

March 31: Stool — once daily. Normal formed.

July 24: Last seen on this date. Stools continue to be normal. Gets occasional pain right side abdomen due to the calculus.

Case No. 4 (Ulcerative Colitis)

Mrs. P.S. This is a case which has been followed up over a long period of time. She first consulted on March 17, 1975. Age 30 years, been married six years; two children; ages 5 and 4, no abortion, natural or induced.

Her complaint was passing blood p.r. for the previous 10 years. The bleeding had been intermittent and variously considered to be dysentery or piles. It started while still a student. She had been living in Srinagar till she got married and had passed roundworms a few times. Helminthiasis is endemic to that region. Three years earlier had passed threadworms also. In 1973 there was a lot of pain in the anus. It was diagnosed as fissures ani and operated on December 19, 1973. Had been having bleeding for five months prior to consultation. Before that she had been well for 7 months after allopathic treatment. Now getting blood, mucus and shreds. Has had Barium enema X-ray pictures and sigmoidoscopy and a provisional diagnosis of ulcerative colitis had been made. The allopaths had given her the usual remedy Salazopyrin. This would reduce the bleeding but she would get side-effects and swelling of the face. Stool examination at times has shown E.H.

At present having 15 to 20 stools, many times only blood and mucus, urging for stool is there all the time and an unsatisfied feeling and tenesmus after stool.

After the treatment that she has had she also has frequency of urination with difficulty in passing, has to strain.

Appetite: Fair. Vegetarian. Likes warm things, excess salt and fried things. Eructations +, flatulance

Sleep: Good. Dreams ++, frightening and anxious.

Vaccinations: Nil after school years.

Chilly patient (said before marriage she felt the heat much i.e. hot patient).

M.P.: Regular. Got scantier one year ago, then with treatment improved. Pain before and during, lower abdomen, both sides. Leucorrhoea sticky, burning and itching if not regularly washed and oil or greasy preparation applied.

Mentals: At times inclined to go on crying without cause. Likes an absolutely quiet place to get peace. Affectionate but now feels disturbed from the activity of her children. Says she became weak-hearted and prone to nervous tension after she had children. Weak, tired feeling even from talking.

O.E.: Obese, Wt. 157 lbs. Weight has increased, as is usual, after marriage and having children. Says I am "Bloated up or Swollen", which is not an uncommon expression by women in India when, it is actually an increase in weight.

Heart, Lungs, Abdomen — N.A.D.

P.I.: Legs were put in plaster as a child. Was told she has less calcium. Exact diagnosis not known.

1975

March 17: Prescription: *Nux vomica* 6/20 powders q.i.d. This was partly covering the symptoms but mostly to take away the effect of considerable previous medication that she had had.

March 21: Only minor change: less blood in stools, tenesmus is less but there. No pain abdomen.

Mercurius solubilis 6/20 powders q.i.d.

March 28: *Mercurius corrosivus* 6/16 powders q.i.d.

April 1: Gets nervous and anxious and then starts crying while talking. Relates her troubles with tears in her eyes. Urge for stool all the time. Any time she squats some blood and pus ooze out from anus. Sits long in latrine. When has urge must go quickly and yet when she goes stool does not pass quickly.

Pulsatilla 200/3 powders on the same day.

April 8: Better for the previous two days. One day had itching hands — urticarial. Every few days has a break-down then behaves abnormally or cries and feels relieved. Takes a pessimistic line of thinking and imagines the worst. Cannot bear any wrong.

“Three persons I was attached to, God took away — father, sister and a guru”.

Prescribed *Saccharum lactis*.

Reasonable improvement continued with the same prescription. *Pulsatilla* 200 was repeated on **May 15th**.

July 25: Husband had an accident and with the shock and worry conditions of stools got worse.

Appetite excessive, feels sinking and then wants to eat quickly.

Saccharum lactis continued as I wanted to watch for sometime.

August 6: H/O fits.

August 16: C/O hazy vision, which I interpret as a nervous symptom. She also cries telling her symptoms.

September 2: Distention of abdomen in the morning which gets alright only after two or three stools and passing considerable flatus and urine. Shifting pains.

Pulsatilla 200/3 powders - morning, noon and bed-time.

September 24: After a considerable period of relief from the main symptoms again has blood and mucus in stools for the previous two days. Has a changeable state

of mind and consequently physical strength also varies even within a short time.

Pulsatilla 200/3 powders — morning, noon and bedtime.

October 15: Had been M.B. till four days ago when she was indiscrete in eating at a wedding party. Thereafter more stools and more blood.

Anger ++, especially when has less sleep and headache.

December 1: Digestion generally M.B., headache frequent — from any tension. Then likes head pressed and absolutely quiet place to rest and desire to sleep. With headache an anxiety (ghabarahat in Hindi). With it at times feeling of chill while other times would like the fan.

I noticed that as she is describing her condition she has tears in her eyes.

Having given *Pulsatilla* a number of times I now decide to give her the other remedy covering her mentals.

Sepia 200/3 powders, during evening and bedtime, on the same day.

After three weeks she developed fever and cough for which she needed some acute remedies. After that settled, there was a recurrence of her colitis complaints.

1976

February 9: She again received *Pulsatilla* 200/3 powders at 15 minutes interval.

February 25: No change, 7 to 8 stools, all contain mucus and blood and most of them just that and no faecal matter. Much flatus. Gripe. Sputtering stools. Flatus passed with lot of force.

Podophyllum peltatum 30/24 powders q.i.d.

March 2: Better than before. Blood is less. Sputtering stool, forceful flatus.

Aloe socotrina 3, 30, 200 — one powder of each on the same day.

March 16: "Very bad, distended feeling abdomen, pain all the time as from distension, pain + + during stool." Pain > passing flatus. Urge sudden. Can't wait. Has soiled clothes at times. When goes for stool some thin matter is passed forcefully thereafter ?prolapsus ani. On pushing this in, passes blood — liquid and clots. Faecal matter only in one or two stools in the morning, other times only blood etc. Same happens when goes for urine. Goes 8 to 9 times. Passing urine relieves suprapubic pain. Takes deep breath for relief "I keep sighing".

General weakness, can't eat because of distended feeling. Can't bear pressure on abdomen or tie petticoat. Bearing down feeling, can't bend. I have put my comments: "full of complaints, talkative."

Nux vomica 200/3 powders during evening and at bedtime.

March 23: I have no notes on this date but apparently no relief or worse as I have prescribed *Pulsatilla* 1000/3 powders.

March 31: Better but stool very offensive. Sac-lac.

April 30: M.B. one to two stools. No mucus, no blood. Stool normal consistency. Only it is offensive and also has lot of flatus.

July 19: Continues to have normal stools. Now complains that for the previous three months menses have not been proper, scanty and brownish spotting off and on.

Pulsatilla 1000/3 powders at 10 minutes interval.

1976-94

I have continued to see her from time to time right till 1994 for different complaints. During her numerous visits she revealed some more of her mental trends. Would have tension over slight matters; can't stand any contradiction. Argument over whether a movie is good or bad give her headache and delayed sleep. ?occasional sleep walking. In 1964 when her father died, she had her first fit. Hysterical nature. Was married in 1969. Feels that she does not get the attention from the husband that she should. Always been sentimental, emotional, hospitable. Concerned for others. Even if a neighbour or anyone else is sick, gives her anxiety and she can get a fit. At times is violent. Great fear of insects, a phobia even when the insect has been swept away. Fear at night, sees faces — dead persons. Fear of any bang.

For an acute mental upset in February, 1977 she was given *Ignatia amara* 10 M/1 powder with very rapid relief.

In August her husband had been ill. She had fits and feeling of ball in throat. *Ignatia amara* 10 M/I powder again helped rapidly.

Because of her temperament and as a chronic of *Ignatia* she was also given one powder of *Natrum muriaticum* 200.

In March, 1978 she had a skin eruption in which itching was > for cold and was given *Ledum palustre* 200. This cleared the skin and no recurrence.

Over the years she became grossly obese, developed diabetes mellitus. Partly because of obesity and partly by nature she was quite lethargic and would not undertake more than the minimum physical activity. It is important to note that over all these years, there was no recurrence of ulcerative colitis. Most of the time, her symptoms

appear to be of a superficial nature even though she would make out that she is very ill and would be on the verge of tears. The reasons for the neurotic behaviour could also be some domestic problems as on occasions she accused and quarrelled with her husband in my presence.

However, the purpose of relating this case is not how those situations were helped by Homoeopathic treatment but only to emphasise that there was no recurrence of ulcerative colitis inspite of many mental shocks and an occasional digestive upset during a long period of about eighteen years.

Case No. 5 (?Hysteria. Ulcerative Colitis)

Mrs. A.R. In January 1990 she refers a patient who reports about continued good health of Mrs. A.R. prompting us to dig out her history.

Mrs. A.R. consulted on February 20, 1978. Age 24 years; been married four years; one child — age two years. No abortion. She reported that on November 30, 1977 she had an attack in which there was a drawing feeling lower jaw, dryness of throat, difficult breathing (no panting but only an internal feeling), coldness of body. This lasted for one and half hour and thereafter to a lesser extent for another four hours. It had been a cold rainy day and she had washed a few clothes. At this point I have mentioned my assessment ?Hysterical. On enquiry she did not recall any cause for anger or upset or worry prior to the attack. After the attack there was weakness and anxiety ('Ghabrahat'). This was so even before but got worse after the attack. Had been having anxiety from time to time. Has had on occasion the premonition of an attack by way of dryness in the throat but it got O.K.

Appetite: Moderate. If over-eaten and it is not digested it leads to burning and sour eructations. B.O.R.

Sleep: Good if not anxious. Dreams of snakes; of water — fear of falling in water; of religious places.

Hot patient. Earlier had burning of hands and feet but after the attack they feel cold.

On enquiry she said that the domestic atmosphere is good but she is very sensitive and feels much even small matters. Has fear dark and thunder (this started after lightning struck their house the previous year).

M.P. — irregular and early after child-birth. Dysmenorrhoea after marriage which continued after child-birth but she got relieved of it after some months of treatment. Leucorrhoea: White, thick. No abnormality on physical examination except that she was noticed to have a Meibomian cyst in right eye.

1978

February 20: Prescription: *Pulsatilla* 30, 200, 1000/1 powder of each in the morning, afternoon and bedtime of the same day.

She was from another place (a small town in Himachal Pradesh) and unfortunately subsequent reports through messengers were probably so sketchy that they have not been noted on the history sheet.

Pulsatilla 1000 was repeated on April 21 and again on November 12. Apparently she kept well and asked for medication at long intervals for some tendency to recurrence. A significant feature in the history is to be noted, which is already mentioned in the Homoeopathic literature. I refer to the Dysmenorrhoea which started after marriage. The reason would be clear from what follows.

* * *

1982

November 3: I see her again after a gap of four years. This time for a different condition. Has had no further pregnancy, "we planned like this". Her present complaints were: Blood in stool, duration one and half years. "When there is tension or anger then suddenly the appearance of blood. The sequence of events is, gets very angry, anxiety ('Ghabrahat') then blood P.R. Then pain left upper limb and pain waist. Breathless. With the bleeding no stool (faecal matter) or slight. Followed by three or four loosish motions. No pain in passing blood, neither in the rectum nor in abdomen."

The child, now six years of age, is obstinate and adamant and is the usual cause of anger. First time bleeding occurred after she slapped the child. Since 1975 husband serves a shipping company and is away for long periods. Has got over her fear in dark. Still has fear thunder. Now not many dreams. Menses are regular and no leucorrhoea. Has been examined by a lady doctor and told she has no haemorrhoids. (in India most often this examination in ladies cannot be conducted by male doctors).

Family history: A very interesting and significant feature came up while interrogating during this consultation. It was revealed that the husband suffered from Gonorrhoea in 1967, about 7 years before his marriage. Was adequately treated by Allopathy and later also had Homoeopathic treatment from a senior Homoeopath in Bombay.

Prescription: *Phosphorus* 200/3 powders on the same day (November 3, '82).

There is no written record but apparently she did not send a satisfactory report because on December 20, '82

she has been prescribed *Arsenicum album* 6, 30, 200/1 powder of each.

1983

June 16: Reported again personally. Much better. Has had no further blood with stools. Has put on weight and improved in general health. Weight increase more than 5 kgs. in the previous eight months. Had now come for some trivial odd complaints. Keeping in view her previous mental background she was prescribed *Kali phosphoricum* 200.

Case No. 6 (Ulcerative Colitis)

Mrs. R.N. aged 47 years consulted on **June 24, 1980**. She had been married 23½ years and had three children, eldest 22 and youngest 17, with one abortion in 1971. Occupation: Teacher in a school. She is the sister-in-law of a very well known surgeon of Delhi and had been fully investigated for her complaints. She gave a history of passing blood with stool and at times only blood which had been diagnosed as Ulcerative Colitis. She had had this condition for 18 years but with remissions in-between. The present attack was for the previous one month.

She was passing 3-4 stools and took considerable time for every stool. The urge was sudden so that she had to rush and there was sputtering in the beginning with passage of flatus and blood. Thereafter some stool or blood only and usually towards the end a clot "looks like a piece of liver." She had griping pain at times. Gets tired after stools and would like to lie down and rest for a while. Has previously had allopathic treatment and used Salazopyrin.

Appetite is reduced. She is a vegetarian and has a liking for fruit. Sleep — good; dreams — rare and

nothing significant. Vaccinations for Small Pox: last in 1974, before that it was frequent every one to two years. Neither markedly chilly nor hot. Menopause two years ago without any symptoms. Past illnesses: Nil of note.

1980

June 24: Prescription: *Natrum sulphuricum* 6x/28 powders q.i.d.

July 1: Reported better, had had only one stool the previous day.

Prescription: *Saccharum lactis*.

July 8: Tending to recur.

Prescription: *Natrum sulphuricum* 6x/28 powders t or q.i.d.

July 16: "10% better, feeling weak." Repeated prescription of July 8th. i.e., *Natrum sulphuricum* 6x.

July 25: Feeling better. Prescribed *Saccharum lactis*.

July 29: Improvement continues. But still there is blood in stool. Having fever and sore throat for which given *Rhus toxicodendron* 30/16 powders q.i.d.

September 9: Much better "I feel 90% cured."

Would like to avoid relapses that she had had in the past. *Saccharum lactis* continued.

September 17: Became more careless with diet and after taking rich food is having diarrhoea for the previous days. Given *Pulsatilla* 30/12 powders q.i.d.

September 27: Reported well and received *Saccharum lactis*.

October 8: Again slight blood in stool and they are noisy and sputtering as originally. Also some showed a little blood. *Natrum sulphuricum* 6x/12 powders q.i.d. Thereafter continued on *Saccharum lactis* and treatment concluded after her last visit on **November 4, 1980.**

* * *

Next seen for a slight recurrence on **September 7, 1981**. Repeated *Natrum sulphuricum* 6x/12 powders q.i.d. with no further medication till **April 1983** when she had another relapse. No particular reason could be ascertained for the relapse after having been well for two years. *Natrum sulphuricum* 6x q.i.d. given for two weeks. Did not help this time. On **May 13**, prescribed *Mercurius corrosivus* 6/14 powders q.i.d. Not much response.

1983

June 10: reported the same type of sputtering stools with darkish blood. Prescribed: *Podophyllum peltatum* 30/9 powders t.i.d.

August 1: "Definite improvement." Usually one stool, occasionally two; formed, may have some darkish coloured matter which she thinks may have a trace of blood. There is no longer any sputtering with the stool.

Now that the main complaint is better, mentions about some blotchy, darkish spots on both ankles which have the appearances of freckles. Also a spot on upper back, which feels itchy and has become dark. Has been using a hair dye for the previous three years.

Prescription: *Natrum muriaticum* 6x, 30, 200/1 powder of each on three successive days.

October 12: One stool daily. No blood. The spots on the ankles are the same or increased. As these were not causing any trouble no further medication was given.

* * *

1986

December 12: Reported again after more than three years with a relapse of her colitis.

In view of the previous experience she was once again prescribed *Natrum sulphuricum* 6x/24 powders q.i.d. This reduced the number of stools. In fact she had

only one stool in the day and felt somewhat constipated so that she had to take something in the morning before having a motion. She continued to pass darkish blood and was prescribed *Hamamelis virginica* 6/21 powders t.i.d.

December 27: Felt worse in the previous week. The number of motions increased. Also gas, blood in most of the stools which were sputtering and with gripe. A repeat of *Natrum sulphuricum* 6x did not help. On January 5, 1987 given *Podophyllum peltatum* 30/9 powders t.i.d. which had helped in June 1983.

1987

January 31: No significant change. Urge is sudden. In fact stool escapes if cannot reach quickly. Flatus with stool — (sputtering stool) blood in most of the motions and sometimes only blood. *Podophyllum peltatum* 200/3 powders on the same day.

February 18: Better, number of stools less. Some of them without blood. Sputtering etc. all decreased. In her own words "25 to 30% relief." Started to feel better the very next day after starting the last course.

Saccharum lactis continued.

March 9: "80% better".

May 9: "100% O.K. and feeling quite well". Only one stool.

Appetite is good. Digestion normal. Not much wind.

* * *

I had concluded her treatment and drawn up this report but I did see her from time to time later for other conditions. Also in view of the remarkable and impressive recovery she brought her husband and son so I had occasion to follow up. She remained completely free of her colitis symptoms for more than 15 months and

reported again on **September 20, 1988**. For the previous two days she **had been** very indiscrete in her eating taking highly spiced and improper food from the roadside sellers (chhola bhatura). This resulted in loosish stools and slight blood. She was prescribed *Pulsatilla* 200/3 powders, taken at short intervals, through the evening and bedtime.

October 15: Two to three motions, blood continues.

Natrum sulphuricum 6x/28 powders q.i.d.

November 2: No significant relief. *Podophyllum peltatum* 200/3 powders, during evening and bedtime.

November 21: Number of stool same. Blood is reduced but still there. Stools passed with flatus and sputtering sound.

Podophyllum peltatum 200/3 powders at 15 minutes intervals.

December 5: Much better, mostly one stool, very little blood.

January 3, 1989: Improvement maintained. Stools normal and no blood.

July 10, 1990: Has remained free of colitis symptoms even though there has been considerable travelling and some irregularity and indiscretion in eating.

ACUTE INFANTILE DIARRHOEA

Case No. 1

Baby N.C. a case of Infantile Diarrhoea. The child was born on February 18, 1982. The parents approached me on September 25, 1982 and gave the following history:

It was a full term normal delivery. Birth weight: 7 lbs. Breast fed entirely for six weeks thereafter supplemented with diluted buffalo milk. Received BCG on April 29, 1982 and triple vaccine and Polio drops on April 29, 1982, June 3, 1982 and July 8, 1982. At age of 5 months, on July 27 to be more precise she had diarrhoea and in a few hours stools became dysenteric with blood and mucus and were greenish in colour. It resulted in dehydration and she was hospitalised. Given glucose drip and also dialysis. For the previous month or more prior to consulting me she had not been given milk and had been put on Amisoy. Condition had been very bad and she had been given blood transfusion six times. When the parents consulted me the patient was still in Hospital and the diarrhoea was still not controlled. I was told that the weight is 5.4 kg. She was then having 6 or more stools and practically everytime she was fed. Some of these stools had mucus and few showed blood streak. There was a history of excessive perspiration on the head before she got ill. Presently this symptom was not there but "Head remains hot." Teething had been unusually very early at two and half months.

1982

September 25: Prescription: *Calcarea phosphorica* 6x/20 powders every 4-8 hours. The response was immediate. Report on 28 September "in last two stools no blood and no mucus either, but stools still loose."

September 30: Stools loose and 4-5 in number, continue to be free of blood and mucus.

Prescription: *Natrum sulphuricum* 6x/8 powders every 6-8 hours. The number of stools gradually reduced. On October 19, she developed cold and cough for which she was given *Ipecacuanha* 6/12 powders q.i.d. Reported better on October 22, but still having

some cough. By now stools OK. Repeated *Ipecacuanha* 6/12 powders q.i.d.

October 26: Again noticed perspiration on the head. Has a tendency to cold and cough and there appeared a skin eruption on the head.

Prescription: *Calcareo phosphorica* 200/1 powder.

At the end of December there was a recurrence of diarrhoea for which *Calcareo phosphorica* 6x/20 powders were given followed by *Calcareo phosphorica* 200/1 powder on January 1, 1983. Has been seen from time to time for some other ailments including an attack of chicken pox and one time some allergic rash. Generally been well. Last seen on August 5, 1985.

The interesting feature of the case was that since she was admitted in an Allopathic Hospital I had not the opportunity to see the patient initially. When there was a very good response in the first few days of treatment the parents informed the treating Paediatrician that they wanted her discharged from the hospital. When he learnt the real reason he personally requested me to see some more of the serious patients in the Hospital that were not responding to their treatment.

Case No. 2 (Infantile Diarrhoea)

Baby G.K., consulted on **November 10, 1990** and the mother reminded me as to how 11 years earlier I had saved the boy from an extremely serious situation while he was admitted in the hospital. I have hardly many notes of the time but on the old history sheet I have a few sketchy remarks and the prescription. This supplemented with the account of the mother is now reproduced.

The boy was born on August 7, 1979 and when a few months old had a very severe diarrhoea that could not be controlled during a whole month of treatment initially at home and then in hospital. He had had diarrhoea for more than a month and in hospital he had already received 60 bottles of I.V. Glucose and Lipids and different medicines without any relief. In fact he was having much blood and mucus in the stools and the parents were told that there is an ulcer in the intestine for which they wanted to carry out an emergency operation. This frightened the parents and it was at this stage that I was called. I was reminded of a number of such serious sick infants saved by my father, Dr. Diwan Jai Chand, and I decided to try the same remedy and also the same potency so as to get an immediate response if possible which was necessary under the circumstances.

Prescription: *Podophyllum peltatum* 1000/8 doses in 1 oz. water. One dose to be given every 4 to 6 hours.

The result was both immediate and absolutely dramatic. In fact I am not sure if all the 8 doses were needed. I followed my father's practice that after the first or second dose if there is a response increase the interval between the doses or instruct the parents to administer a dose if there is a stool.

Now he is in robust health and was brought for quite a different condition.

Comments: Apart from showing the great efficacy of Homoeopathy even in a very serious condition it also shows how quick can be the response and is an effective answer to those who say that Homoeopathic treatment is slow acting. The dictum is that in very acute conditions the action is very quick while in very chronic conditions the action will be slow because it is curative and not suppressive of one or the other symptom.

Case No. 3 (Acute Infantile Diarrhoea)

Baby A.S. I received a telephone call on **September 26, 1990** asking me to see this 9 months old baby in Jaipur. It was reported that the child is in desperate condition and unless something could be done immediately they feared the worst and as such there was great panic in the whole family. He was suffering from a very intractable diarrhoea for nearly two weeks which had not responded to the treatment from a local homoeopath (*Calcarea phosphorica* 200/1 powder and *Chamomilla vulgaris* 30 every 2 hours). Thereafter he had allopathic treatment which had also failed. So far he had not cut any teeth. It was not possible to see the child immediately and only a few symptoms could be ascertained on the telephone. On the basis of that and partly on previous remarkable experiences in cases of severe infantile diarrhoea (sometimes described as Cholera infantum in our books) he was prescribed *Podophyllum peltatum* 30 q.i.d.

Six days later on **October 2**, I got a very gratifying report from the jubilant family. "It was a miracle. The child started improving as soon as he was put on your medicine (*Podophyllum peltatum*) and now only one normal looking stool. The child is active. Normal appetite and eating everything."

GAMBOGIA — GARCINIA MORELLA (GUMMI GUTTI) IN ACUTE DIARRHOEA

Gambogia is not as commonly prescribed a remedy although listed in the Kent's Repertory and a reasonable description from provings appears in Clarke's Dictionary

of *Materia Medica*. I have used it with considerable success and very quick results in cases of diarrhoea.

Clinical Cases:

(1) A patient age 65 years after some indiscretion in eating for a number of days by way of spicy and possibly rich diet had bout of diarrhoea. Initially considering that it was the improper diet he was given *Nux vomica* 30/4 powders q.i.d. Finding no change and possibly slight worsening the symptoms were gone into in further detail. It was found that the stools were very forceful, some of them completely watery "they pass almost like urine." At times the urge was so great and sudden that they had passed before he could get to the toilet. Stools were offensive. Slight bits of mucus. He volunteered the description that it was like mucous colitis. There was a slight discomfort in the abdomen all the time making him conscious of the digestive upset. The number of motions 5 to 6 in a day. With all these symptoms *Gambogia* 30 was prescribed of which 8 powders were dispensed to be taken four times a day or at longer intervals if he was better. He noticed improvement with the very first powder which he took in the evening, a second powder was taken at bed time. Next morning the stool was normal formed and the lingering uneasiness in the abdomen was much relieved. Further medication was not needed.

Looking in the books one finds that the symptoms are given rather cryptically as "profuse watery diarrhoea in hot weather, particularly with old people. Rumbling and rolling. Sudden and forcible ejection of stools."

(2) I have used it in a teenager also with these symptoms and he, a medical student, was also amazed at the immediate relief from an acute diarrhoea.

BLEEDING POLYPI COLON

Miss S.N. age 9 years.

Consulted on **March 4, 1984**. History of blood with stools for the previous six weeks. Was having 2-3 stools semi-formed and softish. The normal habit was one stool. Had colonoscopy done in which polypi were visualised. Appetite, sleep etc. were all normal and the only mental that could be elicited was fear in the dark. In Kent's Repertory at Page 631, there is a rubric Rectum, Polypi. The only remedy in black letters is Phos. This also covered the tendency to bleed as also the mental symptom. Prescription: *Phosphorus* 6,30,200/1 powder of each. (Morning, afternoon, bedtime)

1984

March 19: Reported that number of stools is less and quantity of blood is less but it still occurs with every stool.

Prescription: *Phosphorus* 200/1 powder.

April 7: No blood or very slight quantity of blood if she has a second stool in day which is only occasional. Stool is now formed.

Prescription: *Saccharum lactis*.

May 19: Reported that there had been no blood after April 25. It occurred for a few days before that when she was out of station and had possibly been indiscrete in eating. Was having occasional pain in abdomen and anorexia.

Prescription: *Phosphorus* 200/1 powder.

There had been no blood with stool ever since, i.e., 25th April 1984. the patient has been seen from time to time for some other complaints of cold, sorethroat, noseblock etc. Last seen in 1991. There has been no recurrence of blood with stools.

PAEONIA FOR INFLAMMED PILES

Mr. R.S., was in such agony that he cut short his trip and returned to his home in Delhi and sought an urgent consultation on **October 17, 1975**. He had already had some Homoeopathic treatment at the place he fell ill but this was a prescription of multiple remedies to which I do not give any importance. In any case it had not helped. He was virtually carried by attendants and laid on my examination table. He was found to have a rectal prolapse and acutely inflamed prolapsed piles. He was prescribed *Paeonia officinalis* 30/16 powders to be taken at 4 hourly interval. The report received three days later on **October 20** was that he was feeling better and the pain was reducing. The prescription was repeated over the next two weeks. By **November 8**, inflammation had completely subsided and so the piles and the prolapsed rectum could go in.

I kept seeing him for some other ailments till **1982** and he also came along with other members of the family for their treatment so I could observe him right till the time of his passing away in **1988** when he was in mid 70's. He died suddenly of a massive coronary infarction. There was no recurrence of the piles problem.

ANAL FISSURE

Case No. 1

Mrs. K.T. age 29 years, had been married 8 years and has one son age 6 years. She was in such acute trouble and was so desperate that she was frantically trying

through my assistants that I visit her. She had been initially told that because of pre-occupations it is usually not possible for some weeks. I went to see her on **October 27, 1992**. She had been practically confined to bed and complained of acute pain in the anal region for the previous six weeks. She had known her father to have piles and she thought it was the same and on her own used Pilex tablets. This is an Ayurvedic preparation from Himalaya Drug Company. There was slight relief initially but it recurred. The stool showed a streak of blood always on the left side. For the previous 8 days, the pain had been very acute, but there was no blood streaking. There is excruciating pain at the time of stool, then eases a little, after half hour again increases and is at its peak by 1 p.m., thereafter reduces gradually, but is never completely free of pain. Prior to this had used much Flaxon and Proxyvon (analgesics) as the pain was very great but had not used these in the previous 8 days while she had some Homeopathic treatment elsewhere with marginal relief.

No strong cravings in food but generally fond of chillies.

B.O.R. — Only rarely constipated.

Prefers the cold weather.

P.I. — The only significant illness was Pleurisy with effusion 9 years earlier.

F.H. — Father had piles. Mother diabetes. No history of T.B. in the family.

1992

October 27: *Acidum nitricum* 30/20 powders at 3 to 6 hours interval according to intensity of complaints.

November 4: "Much much better, no pain, very occasional blood spotting, slight burning which is relieved

in 10-15 minutes after taking medicine. Relief started from the moment I started taking the powders."

Sac-lac/28 powders at 3-6 hours interval.

December 1: "I am completely alright. You are a miracle man. I cannot believe that it has been cured. I keep medicine like a talisman and take a powder if I am indiscrete which results in slight constipation." Used many other adjectives in praise of the medicine which I need not repeat. Now sought help for another condition and that was secondary sterility. A more detailed history was now taken including her mentals.

December 28: She did report a slight recurrence of the fissure pain which was again relieved very quickly by a few powders of *Acidum nitricum* 30. Relief started with the very first powder.

Case No. 2 (Chronic Anal Fissure)

Dr. (Mrs.) S.N., age 46 years consulted me on October 26, 1979. She is a medical doctor; married for 19 years with two children; the younger one aged 16.

Complaints: Difficulty in passing stools for the previous six months, bowels have been regular and stools are normal formed. She had pain while passing stool and more so after passing for the previous four weeks. This pain would last five to six hours. Also for a fortnight had been having considerable burning in the anal region. She had been examined by a surgeon and the notes showed "a non-bleeding sentinal pile and chronic anal fissure". In the previous few days there had been itching at times, felt both outside and inside the rectum. The pain was of a pricking type. Nothing worthy of note in the rest of the history.

1979

October 26: *Acidum nitricum* 30/10 powders q.i.d.

October 30: No pain or discomfort while passing stools or thereafter but, itching was more.

Sulphur 30/9 powders t.i.d.

November 6: *Ratanhia* 6/21 powders t.i.d.

November 13: Pain much less. Itching also less.

Repeated *Ratanhia* 6 on November 13 and again on November 21.

December 15: No pain. No burning. Mild itching. Stool not clear, has to strain considerably.

Saccharum lactis.

December 31: Pain recurred 10 days ago but duration and intensity are less. Pain is now dull and bearable at the site of fissure and sentinal pile.

Acidum nitricum 6/11 powders q.i.d.

1980

Thereafter she continued quite well and no complaints till **April 1, 1980**. Then for a slight recurrence *Acidum nitricum* 6 was repeated.

May 21: Of late again difficulty passing stool and recurrence of pain and also itching. She feels she has a stricture.

Acidum nitricum 6,30,200/1 powder of each on 3 consecutive days at bed-time.

1981

February 7: She had been quite well after the medicine given on May 12, 1980 and had continued on *Saccharum lactis* for the previous 9 months. In fact, she had been so well that she would only send a messenger for repeat of the medicine because she said, "It helps me a lot in every way." However, I requested that she come personally so that we could review.

There was now no pain, no itching, no problem in passing stool, no feeling of stricture. She also mentioned that she used to have much flatulence. This was also now very much better.

I suggested that she discontinue further medication and watch. My personal feeling was that there had been no stricture but only a spasm. An organic stricture would have been far more difficult to eradicate with medicine.

ENURESIS NOCTURNA (BEDWETTING)

Miss D.C., age 11 years consulted on October 10, 1988. The main complaint was bedwetting for the previous three years. It was likely to be worse with cool breeze or when the weather was colder. There was some halitosis.

She had been vaccinated for small pox only once.

She said she did not get any dream and on direct enquiry about any dreams of urinating I got a reply in the negative.

She had fear dark, no fear thunder, would have fear when there were frightening scenes in a movie or on T.V. Anger +. She was social and liked company.

P.I. Tonsilectomy one and half years ago. Jaundice one year ago. ? Malaria off and on.

O.E. N.A.D. Weight 87 lbs.

Urine had not been examined.

She had used Depsonil for few days without relief.

1988

October 10: *Pulsatilla* 200/3 powders on the same day.

1989

January 3: Urine examination on November 19, 1988 — N.A.D. Stool examination — N.A.D.

Reported that she still bedwets two-three times a month, which is less frequent than when treatment was started.

Causticum 200/3 powders during evening and bed-time.

February 20: Not yet completely cured. Bedwets on an average every 15 to 20 days. Repeated *Causticum* 200/3 powders at 15 minutes interval.

The patient was not seen thereafter. However, another relation came for consultation in October 1990 and mentioned that Miss D.C. has been completely cured after the last prescription.

ACUTE GLOMERULONEPHRITIS

Case No. 1

Master D.T., age 6 years — consulted me on **October 28, 1976** with complaints of low grade pyrexia ever since he had tonsillectomy one month earlier.

Cough duration 10 days.

Epistaxis thrice in the previous week, twice in sleep and once in waking hours.

There had been slight puffiness of the face, so two days earlier, he had his urine examination which showed Albumen ++ Pus Cells 8-10/H.P.F. Erythrocytes 1-2/H.P.F. spec. grav. 1010. Subsequently the urine had been reported "coffee colour". Blood urea 39 mgm. % Haemoglobin 10.1 gm. %

There was a history of Acute Glomerulonephritis in 1974 for which he had allopathic treatment and was later reported as cured. However, some time earlier, in the follow up, it was found that B.P. is high and puffiness of the face as also some albumen in urine. It had been then felt by the attending physician that his tonsils are giving trouble and on his advice the operation had been done.

With the subsequent condition and the urine report, it was now labelled as a recurrence of his acute Glomerulonephritis.

1976

October 28: Prescription: *Terebinthina* 3x/20 powders q.i.d.

November 3: The report today amazed the parents as much as it amazed me. There had been such a remarkable change in the whole condition. No further nosebleed and temperature quite normal.

The patient was not seen thereafter. However, another relation came for consultation in October 1990 and mentioned that Miss D.C. has been completely cured after the last prescription.

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Urine examination:

Spec. grav. 1011
Albumen: Nil
Erythrocytes: Nil
Pus Cells: 2-3/H.P.F.
Casts: Nil
Cylindroids +

1977

Thereafter he has been seen from time to time — for an attack of measles, subsequently for an attack of diarrhoea and a general check up off and on, mostly to allay the fear of the parents, who had been through a nightmarish time because of the serious renal condition during the previous two years and the difficulty of believing that these tiny powders could have completely cured him in such a short time. The urine had also been examined frequently and the appended chart would show the variations. The treatment was concluded after his visit on **March 21, 1977**. At that time his physical examination showed no abnormality and he had no oedema anywhere. His B.P. was now 84/56. As mentioned before, in the past many months he had been taking normal food without any restriction on salt. The parents mentioned that for the previous 10 days he was having much perspiration on his head in sleep.

Silica 6x, 30, 200/1 powder of each to be taken on the same day in that order.

December 3: Feeling quite normal and is now taking whatever is cooked in the house, i.e., with normal quantity of salt. His urine report showed R.B.C. — 1 per 4-5 H.P.F. and Calcium oxalate 3+. As there was no albumin, I wonder whether the R.B.C. was the result of any crystaluria.

Saccharum lactis/27 powders t.i.d.

December 13: Cold, thick yellow nasal discharge. Nose block. Dry cough. Temperature 100°F. Urine showed a faint trace of albumin.

Pulsatilla 30/16 powders q.i.d.

1977-1991

He reported again after 2 months on **May 16, 1977** for cough and cold. Opportunity was taken to ask him about any puffiness of face in the morning and the headsweats. The answer to both of these was negative. It is to be noted that the profuse sweating of head had stopped inspite of the season being much warmer. He was similarly seen for some odd complaints from time to time till 1982 and then after a long gap of 5 years he reported in 1987. This time it was for different complaints (slight stammer and a low back pain). Opportunity was taken to have a fresh urine examination which again was satisfactory. Has been followed up till September 1991 with no recurrence of Nephritis.

Comments: What is of unusual interest in the case is that a comparatively lesser used medicine was tried and even though given in low potency, the effect was very rapid and at the same time lasting.

Master D.T.

Date: 1976-77	Oct. 28	Nov. 3	Nov. 12	Dec. 3	Dec. 13	Feb. 15	Mar. 21	May 31	Jul. 11	1987 May 12
Urine Examination										
Colour	Coffee	Yellow	Pale	Pale	Yellow	Pale Yellow	Pale			
Specific gravity	1010	1011	1016	Q.N.S.	-	1011	-		1016	1012
Albumin	+	Nil	Nil	F. Trace	Nil	Nil	Nil			
Pus Cells/H.P.F.	8-10	2-3	2-3	1-2	1-2	Nil	Nil		1-2	0-1
R.B.C./H.P.F.	1-2	Nil	Nil	1 per 4-5	Nil	Nil	Nil		1 per 4-5	Nil
Casts	Nil	Nil	Nil	Nil	Nil	Nil	Nil		Nil	Nil
Cylindroids	-		Nil	Nil	Nil	Nil				
Calcium Oxalate			small no.	++		Nil	Nil			
Blood										
Haemoglobin	10.1 gm.									
Urea	39 mgm. %									

Case No. 2 (Acute Glomerulonephritis)

Master A.P., age 6-1/2 years, was seen from time to time over the previous three years, mostly for ordinary complaints of Colds and Coughs. Inbetween there were bedwettings for which he received *Causticum* 200 on December 12, 1985 and later *Calcarea carbonica* 200 on March 8, 1986. That stopped his bedwettings. In July '86 he got Jaundice and in June '88 a mild attack of Measles.

1988

On November 4 it was reported that he has a Cold, Sore-throat and slight fever. The patient was not brought. For this he was prescribed *Rhus toxicodendron* 30, four times a day for four or five days.

November 14: The boy was brought to my Clinic. He looked quite ill and as he was brought into my room I noticed that his face was swollen. He had a temperature of 103°F. He had vomited repeatedly and it was reported that the urine was "Deep colour". He was very thirsty. He was prescribed *Phosphorus* 30/16 powders to be taken every 4 to 6 hours. He was asked to get the urine examined as also blood for T and DLC and MP and Serum Bilirubin. After a few hours the reports were brought and they confirmed the provisional diagnosis of Acute Glomerulo-Nephritis. Then on further probing I was told that there had been oliguria and what was put as "deep colour urine was in fact the colour of coca-cola". The relevant parts of the reports are reproduced below:-

1. Urine Examination;

Colour - smoky; Albumen - + +; Blood - + +. In Microscopic examination: P.C. 2-3/H.P.F. R.B.C. Over hundred/H.P.F.

2. Blood Report:

TLC - 10,500. DLC - P 72, L 28. No MP. Hb - 12 gm. Bilirubin - 0.4 mg. %

In addition to the medicine he was asked to take low protein and salt free diet.

1988

November 15: Much better. Temperature normal through the day and as he felt normal he could not be restrained from activity and for a short while in the evening the temperature rose to 101°F. Progressively the urine colour started to be lighter and he started to pass urine freely.

November 16: Temperature normal and feeling normal in every way. Swelling much reduced or nil. Urine examination - colour yellow, Albumen +, P.C. 15-20/H.P.F., R.B.C. - 6-8/H.P.F.

November 18: Improvement maintained, now thirst is normal, no swelling. U.E. - colour yellow, Albumen +, P.C. 10-15/H.P.F., R.B.C. - 6-8/H.P.F. Permitted more protein and a low salt diet. Prescription: Placebo

November 22: Urine Examination: Pale Yellow; Albumin - Trace; P.C. 8-10/H.P.F. RBC 20-25/H.P.F.

Came personally.

O.E.: B.P. 110/68, Heart, lungs, abdomen-NAD. No swelling on face. No pitting ankles. Temperature has been normal after November 17th. Usual buoyant, restless and aggressive self. Has mild cough and still vomits a few times in a day.

Thirst-less than average.

Phosphorus 30/16 powders q.i.d.

November 24: U.E.: Pale yellow, Clear, Albumin-Trace; P.C 4-6/H.P.F. R.B.C. 8-10/H.P.F.

November 29: U.E.: Pale yellow; Clear; Albumin - nil; P.C. 1-3/H.P.F. RBC 2-3/H.P.F.

No swelling at any time. Urine passed in good quantity. O.E. face normal, no pitting at ankles. Given *Saccharum lactis*.

December 6: As he had been anxious to attend his school and in fact had gone for the previous few days I had suggested that he also get a blood urea estimation done before he could be given up a clean chit.

His reports were:-

Blood urea - 34 mgm

U.E.: Albumin - nil

Now the family expressed very special gratitude and told me that some 12 years earlier a cousin of Master A.P. had had the same disease and was under allopathic treatment. She was hospitalised. Had to have glucose drip and took many many months to recover. Had become extremely weak, and had one complication or the other. By contrast they felt that this seemed a very simple treatment. This patient "recovered so quickly without any complication or after affects and without resorting to any invasive measures and in a gentle manner".

Follow-up

As far as the nephritis is concerned, he had now had a clean chit. However, as I was almost their family doctor, I have continued to see him from time to time and he had had an occasional urine examination also. These reports are invariably normal and are shown in the appended chart. At one time, the mother did say that he overeats and is getting obese. She felt that in consequence he was also slightly lethargic. He had had thyroid function tests and these are within normal limits. He was last seen on **June 8, 1994**. He had grown quite tall, approximately 5'9" but was overweight, more stout than obese.

: 1 :

Master A.P.

Date	1988	Nov. 14	Nov. 16	Nov. 18	Nov. 22	Nov. 24	Nov. 29
Urine Report							
Colour		Smoky	Yellow	Yellow	Pale Yellow	Pale Yellow	Pale Yellow
Turbidity		Present	Present	Present	Slight	Nil	Nil
Transparency		Hazy	-	-	-	Clear	Clear
Albumin		++	+	+	Trace	Trace	Nil
Blood		++	Nil	Nil	-	Nil	Nil
Pus Cells/H.P.F.		2-3	15-20	10-15	8-10	4-6	1-3
R.B. Cs/H.P.F.		over hundred	6-8	6-8	20-25	8-10	2-3
Blood Report							
T.L.C./c.mm		10,500					
Polymorphs		72%					
Lymphocytes		28%					
Haemoglobin		12 gms.					
Bilirubin		0.4 mgm.					
Urea							

Master A.P.

: 2 :

	Dec. 5, 1988	1989 Jan. 20	March 9	April 12	March 3, 1994
Urine Report					
Colour	Pale Yellow	Pale Yellow	Pale Yellow	Pale Yellow	Yellow
Turbidity	Nil	Nil	Nil	Nil	-
Transparency	Clear	Clear	Clear	Clear	Clear
Albumin	Nil	Nil	Nil	Nil	Nil
Blood	Nil	Nil	Nil	Nil	Nil
Pus Cells/H.P.F.	1-2	0-1	0-1	0-1	0-1
R.B. Cs/H.P.F.	2-4	2-3	Nil	Nil	Nil
Blood Report					
T.L.C./c.mm					
Polymorphs					
Lymphocytes					
Haemoglobin					
Bilirubin					
Urea	34 mgm.				

Case No. 3 (*Te. ebintina* in Acute Nephritis)*

S.S., age 15 years — consulted me on September 14, 1956 with the complaint that for the previous 4 days, there had been noticed a puffiness on the face and the urine was scanty. On Sept. 7 and Sept. 8, he had been for a National Cadet Corps parade for 2 days running and this had been quite strenuous. On Sept. 8 and Sept. 9 he had fever which dropped without any medicine. He had also been drowsy for a few days.

History of past illness: He had suffered from intermittent fever off and on during previous two years for which he had allopathic treatment. This had been diagnosed and treated as Malaria. After the last attack low grade pyrexia of 99°F continued till he took Esanofele (a proprietary anti-malarial preparation) — 45 tabs. between August 18 and August 30, 1956.

Threadworms (*Enterobius vermicularis*): For these he had been treated with two courses of anthelmintics in 1955.

Or. examination: B.P. 175/90, pulse 66/mt., swelling face, oedema legs.

I asked that a specimen of urine be brought for examination. Next morning, he brought some and as I removed the paper wrapping from the bottle, I was taken aback as it was a Coca-Cola bottle he had used for the purpose. But what struck me was that the contents were of Coca-Cola colour. On enquiry, the father said the bottle had been carefully cleaned and this was indeed the urine. It was only about 50 c.c. so I said, "Why did you bring so little"? "He passed only this much with

* Presented at the XXXI International Homeopathic Congress of L.M.H.I. held at Athens (Greece) May, 1976. (Theme: Rarely indicated remedies).

difficulty after about 18 hours". Urine examination showed Albumen + + + Erythrocytes + + + + and various casts including blood cast. (Complete report in attached sheet).

1956

September 15: Prescription: *Terebinthina* 3x/xvi doses in two ounces of distilled water to be taken every 6 hours.

Put on salt free diet.

The response was remarkable. Heamaturia vanished quickly and colour of urine changed to normal and the quantity of urine increased with the clearing away of oedema.

September 21: Prescription: *Saccharum lactis* t.d.s.

My notes are as follows:

September 28: 'Feeling very much better. No oedema. B.P. 124/55". Urine Examination — Albumen present + chemical test for blood-negative.

October 10: "B.P. 122/60. No complaints. Feeling quite fit". Went to watch a religious procession and to get a better view climbed up an electric pole and stayed there some hours. Felt slightly unwell after this exertion. The blood pressure went up to 136 mm. systolic and temperature rose to 99°F.

October 15: Prescription: *Terebinthina* 3x/viii doses in one ounce of distilled water to be taken every 6 hours.

The slight setback in his condition due to overexertion settled down quickly.

1957

May 22 (about 6 months later): Reported for routine check up. Has been engaging in normal activity since Nov. 1956 and been on normal diet including salt for past many months. No complaints. B.P. 120/54. Urine report now nearly normal.

He kept absolutely well thereafter. I had an occasion to see him from time to time as he would accompany a

brother being treated by me. Nine years later around 1964, I received an invitation for his wedding!

If I was to end the account like so many childhood stories. I would say "they lived happily ever after", or at least "he has lived healthily thereafter"!

Comments:

What may interest you is the fact that although clinically alright with no complaints or symptoms, his urine examination report was not normal simultaneously. This is a point worth stressing as typical of homeopathic pathology and true understanding of disease. A clinical improvement comes first i.e. the symptoms are gone and the patient feels better while the pathological or morbid (using the words 'pathological' and 'morbid' in their ordinary sense) changes last longer and are likely to disappear in time even without further medication.

This is exactly what happened in this case as would be clear from a comparison of the urine examination reports tabulated in attached sheet. No medicine had been given after October 1956 and *Placebo (Saccharum lactis)* had also been discontinued after November 1956.

The patients and the attending allopaths always feel concerned about the laboratory reports. I tell them, "I am treating you as an individual for your complaints or symptoms that brought you to me and not treating the laboratory". If the patient is better clinically while the laboratory report is worse, I have no anxiety as I am confident that that will also improve in time. However, if the patient feels worse and the laboratory report is better. I am not pleased as there may be danger ahead.

It is the Clinician who sees the whole person while the laboratory sees a tiny or microscopic part of him, so let it have only that much importance.

EXTRACTS FROM THE URINE EXAMINATION REPORTS

S.S.

	Sept 15, 1956	Sept 28, 1956 (Partial Exam.)	Sept 29, 1956	Oct 26, 1956	Nov 21, 1956	May 21, 1957
Physical Examinations:						
Colour	Smoky	Pale Yellow	Pale Yellow	Pale Yellow	Pale Yellow	Pale Yellow
Transparency	Hazy & Sediment.	Hazy	Slightly Hazy	Clear	Slightly Hazy	Clear
Specific grav.	1020		1012	1012	1015	1010
Chemical Examinations:						
Albumen	++ +		Present	Present	Fine Trace	Nil
Blood	Present	Nil	Nil	Present	Nil	Nil
Microscopic Examinations:		Not Done				
Pus cells	6-8/H.P.F.		15-20/H.P.F.	2-5/H.P.F.	0-4/H.P.F.	Rare
Erythrocytes	+++ +		Rare	Present +	Very Rare	Nil
Casts:						
Hyaline	Present		Present	Present	Rare	Rarely One
Granular	Present		Present	Present	Very few.	Rarely One
Blood	Present		Nil	Nil	Nil	Nil
Pus (leucocytic)	Nil		Present	Very Rare	Nil	Nil
Epithelial	Nil		Rare	Nil	Nil	Nil

NEPHROTIC SYNDROME

Case No. 1

Miss L.C. age 20 years, consulted on September 1, 1979. Occupation: Student. She came with a confirmed diagnosis of Nephrotic Syndrome which had been diagnosed 5 years earlier i.e. 1974. The illness began as a cold, sore throat and fever. Two days later, she had breathlessness and two weeks later she was noticed to have swelling below lower eyelids. There had been no history of Haematuria, Oliguria, burning in urination etc. Kidney biopsy had been done and the report was "*Membranoproliferative Glomerulonephritis with minimal scarring.*" All through these years of illness she had been on Prednisolone. At one stage this was tapered down to one tablet (5 mg.) on alternate days then urine examination showed Albumen ++ and on that basis the dosage was again pushed up.

There had been no significant points in the rest of the history. Her appetite, cravings and aversions, bowel action, sleep and weather reactions, mentals as also past illnesses and family history gave no special indications for classical prescribing.

The dreams were mostly about the things that she thought about in the day. Would dream about examinations when these were near. Occasionally had frightening dreams.

Vaccinations for Small Pox had not been frequent.

She mentioned that her perspiration leaves white powdery or salt like deposits on the skin.

On examination the B.P. was 136/90 and the pulse rate 112-120/mt. I noticed some tremors in the fingers. I

was told that this is not constant and occurred sometimes only.

Looking at other symptoms or rather the lack of it, the prescription was mostly on the pathology of Chronic Kidney Inflammation with raised Blood Pressure.

1979

September 1: She was given *Plumbum metallicum* 6, 30, 200/1 powder of each to be taken on three successive days at bed time followed by *Saccharum lactis* in the form of globules.

September 29: Reported with a cold for the previous few days. Presently thick, yellow, bland discharge. Prescribed: *Pulsatilla* 6/9 powders t.i.d.

October 23: Reported feeling well. Pathological tests all normal (see annexed chart). There was no albumin in the urine and B.P. 120/80. At this stage Prednisolone was reduced from 3 to 2 tablets daily.

December 7: Generally carrying on well. In November Prednisolone had been reduced to 1-1/2 tablets on alternate days. Again having a cold, which is usual for her in winters. Thick yellowish discharge. *Pulsatilla* 30/15 powders t.i.d. was prescribed for the immediate condition and because of recurring tendency was given *Silica* 6x, 30, 200/1 powder of each to be taken morning, noon and bedtime on the same day, after the course of *Pulsatilla*.

1980

January 12: From 2nd week of December 1979 had been on one tablet of Prednisolone on alternate days, later further reduced to 1/2 tablet on alternate days. From January 11 it has been stopped completely. 24 hours urine sample has been tested and albumin is nil.

March 3: Has a cold, sneezing, thin discharge, irritation in throat and slight pain and also developed cough.

Prescribed: *Arsenicum album* 30/12 powders q.i.d.

March 15: Cold and cough persisting for two weeks now. No fever. Dry cough which is mostly at night.

Prescribed: *Arsenicum album* 30/20 powders, six hourly. Urine remains free from albumin.

March 29: Cough persisting. > taking warm water, < after eating. Referred to Kent's Repertory P.810 and 790.

Prescription: *Nux vomica* 200/3 powders at bed time on three consecutive nights.

April 24: Reported well. Results of laboratory reports satisfactory (details in attached chart).

July 2: 24 hours urine sample showed traces of Albumin. However, it was decided to watch for some more time to see if there was a recurrence.

July 26: 24 hours urine sample showed no albumin. She was feeling normal in every way.

All through the intervening period as also at this stage *Saccharum lactis* was continued.

1981

February 27: Had continued well through intervening months. Only once she needed *Arsenicum album* 30 for a cold and once *Sanguinaria canadensis* 30 for a residual cough.

On examination today B.P. 120/70, Pulse 108-112/mt. slight tremor fingers.

Prescription: *Natrum muriaticum* 6x, 30, 200/1 powder of each to be taken morning, noon and bedtime on the same day.

August 11: Had fever last week for four days. Feeling of weakness in general, lost stamina. Appetite decreased after fever, has also pain in the abdomen.

Prescribed: *Kali phosphoricum* 6x/126 tablets, 3 tablets t.i.d.

This was repeated for 10 days on August 28.

September 10: She was seen last time on this date. Has been quite well. No weakness and all tests normal as would be seen from the reports in the attached chart.

* * *

1987 (Six years later)

May 2: I was informed by her aunt that she had remained quite well after my treatment and was married in 1983. At present she is pregnant four months. There are no complications but the family wanted to know if any special measures are necessary.

Note: It would be observed that in this case Prednisolone was continued alongwith Homoeopathic treatment and gradually as the patient recovered it was possible to do away with Prednisolone. It would also be noticed that when such a trial was made prior to Homoeopathic treatment it was unsuccessful because even the reduction of Prednisolone doses resulted in a recurrence of Albuminuria. This procedure could be a matter of debate. The high-brow Homoeopaths may frown for permitting any medication from the orthodox school. However, experience has shown that in drug dependent patients such latitude at times becomes necessary to avoid the risk of complications or suffering as a withdrawal effect of that drug.

Miss L.C.

. 1 :

Year	Sept. 79	Oct. 79	Nov. 79	Dec. 79	Jan. 80	Mar. 80
Urine Examination						
Albumen		Nil	Nil	Nil	Nil	Nil
Microscopic		NAD	NAD	NAD		
Urine Culture		Sterile	Sterile	Sterile		
Blood Serum						
Urea		22 mgm. %	28		24	
Creatinine					1.0	
Uric Acid					5.2	
Cholesterol					192	190
E.S.R.		14	3			
B.P.	136/90	120/80				
Homoco. Medicine	Plumb-met. 6,30,200		Silic 6x,30,200			Nux-Vom 200/3P
Prednisolone	15 mgm	10 mgm	5 mgm	5 mgm alt. day later 2.5 mgm alt. day	Stopped Jan. 11, 1980	Nil

Miss L.C.

: 2 :

Year	Apr. 80	Jul. 80	Jul. 26, 80	Nov. 80	Feb. 81	Sep. 81
Urine Examination						
Albumen	Nil	Traces (24 Hour Samples)	Nil	Nil	Nil	Nil
Microscopic						
Urine Culture		Sterile			NAD Sterile	NAD
Blood Serum						
Urea	28	26		38		26
Creatinine	0.9	1.2		1.2		
Uric Acid	4.5			4.5		
Cholesterol						210
E.S.R.	15					19
B.P.					120/70	
Homoeco. Medicine						
Prednisolone	Nil	Nil	Nil	Nil	Nat.m 6x,30,200 Nil	Nil

NEPHROTIC SYNDROME WITH RENAL FAILURE

Mr. S.H.N., age 60 years, married for the previous 27 years, an academician — Head of an Academy. Consulted on October 30, 1987. He gave a history of swelling of the feet first time in 1965 after travelling and hectic activity. He stopped salt and took some medicines (allopathic) and was alright for a few days. 1966 he had been in England and he had no swelling. He felt that urine was scantier at times. On return to India again he had swelling and then he noticed that he was having it every summer. Swelling now would occur right upto the knee. The medical Specialist consulted then ascribed it to the heart and prescribed diuretic Lasix (Furosemide) and some tonics. In March of '87 for the first time some swelling was noticed on the face in the morning and then he was told that the kidney is affected. This symptom has persisted. He also feels some swelling in hands. The blood urea was found to be high. The highest reading was 102 mgm%. E.S.R. 110, Hb 10 gm. For the previous 2-3 weeks he had had much itching, possibly uraemic. He had had allopathic treatment for three months without relief, possibly some worsening. In the previous two-three weeks he had had homeopathic treatment with variable results. Fever had persisted for some months upto 99.4 to 99.6°F. According to him this became normal by use of *Carduus marianus* and *Chelidonium majus*. Was feeling much weakness. Was having cough for one week with grayish expectoration.

His appetite was good. A Teetotaller, liking for meat, salty food, chillies, spices and cold things. Much gas, noisy flatus. B.O.R.

Sleep good but lethargic feeling.

Vaccinated for small-pox a few times. Last was in 1966 when he went abroad.

Previously a hot patient, now chilly or feeling both heat and cold. Earlier perspiration ++. Last summer no perspiration or very little.

Cramps ++.

Mentals: anger moderate, not a worrier. Not fond of company, averse to bright light.

On examination: heart, lungs, abdomen clinically N.A.D. Fair amount of oedema legs with pitting upto the knee. No skin eruption. Wt. 152.5 pounds. Ht. 6'. B.P. 160/96.

U.E. Albumin + + + +

He had been diagnosed in the hospital as a patient of Nephrotic syndrome with Renal Failure. He had been given a life of 4 months only and asked to get ready for dialysis.

1987

October 30: Prescription: *Arsenicum album* 6, 30, 200/1 powder of each to be taken in the morning, afternoon and bed time of the same day in that sequence.

November 13: He reported in two weeks and said that he felt better. He feels no swelling on hands and much less or nil on the face, also reduced on the feet but not completely gone. Complained of a very slight numb feeling in left hand with desire to move it.

Given *Placebo*.

December 2: Brought reports of tests done on November 24: Urea 72 mg. %; Creatinine 2.0 mg. %; Cholesterol 210 mg. %; Hb. 10.6 gm. %; ESR 65 mm (wintrobe)

Urine Exam.: Albumin +; Granular casts; P.C. 5-6

His report was that he felt more swelling with the second course of medicine prescribed on November 13

(this was *Saccharum lactis*). The first course had helped to the extent of 40-50%. Because of the increase in swelling he cannot wear shoes.

Prescription: *Arsenicum album* 200/3 powders at 15 minutes intervals.

December 18: He did not have the exact readings but had been told by the laboratory that urea and creatinine both had decreased but albumen had increased from + to + + + and Hb. decreased.

Clinically he was better. As the swelling was much less and in fact it enabled him to reduce the lasix from 2 tablets to 1 tablet daily. He had continued this alongwith homeopathic medication because he had been so greatly frightened by the allopathic doctors and warned with dire consequences if he stops lasix. He had been prone to colds which also he now felt was much better.

1988

From here onwards except for report of urine examination, when significant, the rest of the reports appear in the annexed charts.

January 8: Urine exam: Albumin +

Swelling on legs was a bit more. During the preceding three days he had cramps again but much less intense than earlier.

January 27: Swelling is less and took the courage to further reduce his lasix to one tablet on alternate days.

Complained of giddiness on rising in morning and at times on turning in bed before going to sleep.

Prescribed: *Conium maculatum* 200/3 powders to be taken in the morning, afternoon and bedtime on first day and followed by sac-lac from the second day.

February 23: Urine exam: Albumin + +; P.C. — occasional; Cast-Granular 2-3/H.P.F.

No giddiness, feels that the weight is bit less "look more lean". My comment is that this may be due to the reduction in the swelling. There is no accompanying weakness.

March 21: Not so well, slight swelling again. In between had a cold. His allopathic Attendant whom he would see occasionally now told that he can now stop lasix and take Fruselac instead.

Prescription: *Arsenicum album* 200/3 powders every 15 minutes.

April 13: Urine exam: Albumin — Trace; P.C. 5-7/H.P.F.

Feeling of swelling on the face in the morning and slight swelling on ankles. It may be noted that weather is now quite warm and in previous years he was having more swelling in summers.

April 27: Urine culture: Sterile. Generally feeling better. Swellings are less on face, hands and ankles. Weakness still. Himself suggests that I repeat the last course and naturally he was given *Saccharum lactis* again.

June 3: "I have been well. In fact in my life I have never been better." No swelling anywhere. In the previous 10 days a papular eruption of hands. Slight itching, worse after bath. Gives no previous history of skin eruption.

Urine exam: Albumin + + + +; P.C.-occasional

Surprisingly his lab. reports do not show much improvement even though he again repeated "this medicine helped most."

June 24: He has been off Lasix for sometime and yet no swelling. Skin eruption is the same, occasional mild itching.

B.P.: 150/90. Repeated *Arsenicum album* 200.

ing to a lecture or otherwise. These are not unusual features at that age.

April 1: Slight swelling feet with change of season as it is getting warmer. Sneezings M.B. for 7 to 10 days then reappear for a few days "This is not a significant trouble".

April 22: "Very nominal swelling. Previously in this weather it would be difficult to walk." Sneezings are more in the morning and rhinorrhoea continues longer, till 9 or 10 a.m. *Arsenicum album* 200/3 powders at 15 minutes interval.

June 6: Sneezings are less and not daily.

Appetite good; sleep good; no particular complaints.

July 10: Urine examination: Albumin + + +; Pus cells: Very occasional; Amorphous Urates; Casts: Fine Granular — few.

Repeated *Arsenicum album* 200.

August 22: Had a trip to the mountains (Nainital). Was taking hotel food — more spicy and extra salt. Felt well in every way except that in those days swelling of legs increased.

September 30: Urine exam. (See annexed chart).

Sneezings persist.

Repeated *Arsenicum album* 200.

November 25: Sneezings M.B. No complaints except slight swelling on ankles.

1990

February 10: No complaints. All laboratory reports normal. Only urine report still not normal.

Urea: 28; Creatinine: 1.0

Developed a pain in the left upper arm for the previous three weeks ? muscle pull.

Rhus toxicodendron 200/3 powders on the same day.

April 7: Pain in one spot left upper arm still felt in certain position. No swelling.

Calcarea fluorata 6x, 30, 200/1 powder of each on the same day taken in that sequence.

April 20: Month of Ramzan (Muslim month of fasting)

Urine examination: Albumin: Trace; Urates (? dietary reasons)

Having sneezes since change of season.

Feels he has lost some weight O.E. 151 lbs.

Arsenicum album 200/3 powders at 15 minutes intervals.

June 12: Cold — 2 weeks ago. From previous day hoarseness and slight pain larynx when he speaks. Started after eating a not so good item in a restaurant. "Generally very well and no swelling feet".

Phosphorus 30/18 powders q.i.d.

August 10: "I feel most fit in this period."

Lab reports in annexed chart.

It is to be noted that although he had been well for a long time but this is the first occasion when the albumin has completely disappeared. Was very jubilant for another reason. He said, "After 1965 it was the first time that there is no swelling (oedema) legs through the summer months."

September 11: In August I had told Mr. S.H.N. that he may need no further medicine and had recorded his follow up for 20 months. However, he reported again on September 11. He had a slight eruption on the dorsum of left hand. Gets echhymosis spots time to time. No sneezings and no swelling at ankles. In every other way feels well.

Sulphur 30/9 powders t.i.d.

October 9: The eruption hands in dry. There is itching when he is free.

Arsenicum album 200/3 powders at 15 minutes interval.

1991

January 28: Has slight swelling ankles. Ascribes it to being indiscrete in eating and taken more salt. Urine showed a trace of albumin. Remaining reports are shown in the appendix. O.E. Wt. 146 lbs.

Arsenicum album 200/3 powders at 15 minutes interval.

March 8: No swelling. Echinymosis again.

Phosphorus 6, 30, 200/1 powder of each in the course of the day in that order. Wt. 149 lbs.

April 19: Full reports in appended chart. It shows Albumin + Wt. 149 lbs.

Arsenicum album 200/3 powders at 15 minutes interval.

June 10: The eruption right hand persists. No Oedema: "For first time this summer I am perspiring like a normal person. Previously I had no perspiration".

Arsenicum album 1000/3 powders.

July 26: Eruption persists. Very itchy. Enjoys scratching. < when not occupied.

Sulphur 30/9 powders t.i.d.

September 10: Reports in appendix. Albumin in trace. No relief in skin. Sneezing for one week with much watery discharge < morning < warm room.

Pulsatilla 200/3 powders during the evening and bedtime.

November 11: Slight softening of skin patch and reduction in itching after use of a non-medicated cream. Feels some heaviness in the chest if he goes for a walk after dinner. > rest.

November 21: Had a heart attack around 4 a.m. and a neighbouring doctor immediately moved him to I.C.U. of a Government hospital (Allopathic). Even though he took some immediate medication, but he was so much taken by the improvement he had had in his serious renal condition that he insisted on the attending doctors that they get in touch with me and take my approval about the proposed Allopathic medication. Such a procedure is very unusual, at least in India. However, at his insistence, the doctor did telephone me to discuss about proposed Allopathic medicine in hospital, "so that it does not harm the kidney and as Mr. S.H.N. insists."

1992

January 14: Came to see me as soon as he was in a position to do so after his heart attack. He was still on hospital medication. He had an occasional feeling of tremor in the lips and sometimes was conscious of his heart beat.

Kali phosphoricum 6x, 30, 200/1 powder of each on the same day in that sequence.

April 7: "Feel 100 per cent fit. Even the slight pinches in chest are gone. Stopped Larpose and yet sleep is perfect. Only the trousers have gone loose." (lost weight by dieting).

Reports of test in March can be seen in the chart.

The weight loss was only initial and while in hospital thereafter it is maintained around 138 lbs (62 kg).

As he met a number of doctors during his heart ailment and while he was hospitalised, he said that all of them felt surprised at his earlier recovery. All those doctors feel that "Nephrotic Syndrome is normally progressive. At most, it may remain stationery for 6 months or so but for the pathology to reverse is a miracle."

He continues to report from time to time, for some odd complaints and to show me reports of periodical tests, the test reports can be seen in the appended charts.

1993

As he was planning the Haj Pilgrimage, he consulted a Urologist in April 1993 to get his opinion about the condition of the kidneys. He was told, "You are 100 per cent okay."

June 15: He stood very well the strain of the Haj Pilgrimage. Urine report on return was normal and no Albumin.

1994

Last seen on **May 16, 1994** with no major complaints, inspite of many months of mental stress and depression due to some domestic circumstances. Continues to have a full and active day.

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ANNEXED CHART OF LAB. REPORTS
No. 1 (November 24, 1987 to June 3, 1988)
S.H.N.

Date	Before treatment	24.11.87	?	8.1.88	23.2.88	13.4.88	3.6.88
Urine							
Albumin			+	+	+	Trace	+
Pus cells/H.P.F.		5-6			Occas.	5-7	+
Casts/H.P.F.					Granular 2-3		+
Others							+
Urea	102	72		64	46	56	56
Creatinine		2.0		2.0	1.5	1.9	1.5
Haemoglobin	10	10.6		13		9	12
R.B.C./C. mm						3 million	
E.S.R. (Wintrobe)	110	65		40	48	50	62
	(Westergren)						
Cholesterol		210		190	220	190	

No. 2 (June 24, 1988 to July 10, 1989)
S.H.N.

Date	24.6.88	24.9.88	8.10.88	23.12.88	22.2.89	10.7.89
Urine						
Albumin	++	++	+	Trace	+	+
Pus cells/H.P.F.				6-8		Very Occasional
Casts/H.P.F.						Fine granular-few
Others						Amorphous Urates
Urea		54	46	40	40	52
Creatinine		2.2	1.5	1.2	1.4	1.0
Haemoglobin	12					
R.B.C./C. mm						
E.S.R. (Wintrobe)			50	25		16
Cholesterol			210	210	200	170

No. 3 (September 30, 1989 to April 19, 1991)
S.H.N.

Date	30.9.89	10.2.90	20.4.90	10.8.90	28.1.91	19.4.91
Urine						
Albumin	Trace		Trace	Nil	Trace	+
Pus cells/H.P.F.					Occasional	2-3
Casts/H.P.F.	Hyaline	Fine granular -few				Hyaline very-few
Others						
	Amorphous Urates	Amorphous Urates	Urates	Uric acid-few		
Urea	46	28	40	32	34	30
Creatinine	1.0	1.0	1.2	1.2	0.9	1.0
Haemoglobin	14.5	13	12	13.5	12.6	14.2
R.B.C./C. mm						
E.S.R. (Wintrobe)	24	18	38*			16
Cholesterol	165	165	168			160
Eosinophil percentage	2	6	17	10		2

*? Due to Fasting (Ramzan - Muslim month of fasting)

No. 4 (September 10, 1991 to March 22, 1994)
S.H.N.

Date	10.9.91	14.2.92	17.10.92	15.6.93 (After Haj)	27.8.93	22.3.94
Urine						
Albumin	Trace	Nil	Nil	Nil		Nil
Pus cells/H.P.F.	3-4	Occasional		Occasional		
Casts/H.P.F.	Hyaline very-few		Occasional			
Others	Present					
Urea	30	35	38	48	54	35
Creatinine	1.0	1.1	1.2	1.4	1.2	1.3
Haemoglobin	13		10.8	13.4		13
R.B.C./C. mm						
E.S.R. (Wintrobe)	10					10
Cholesterol		181	195			
Eosinophil percentage	5		4			

CHRONIC RENAL FAILURE*

Case No. 1

Mr. T.U.H., age 50 years, consulted me on **September 11, 1985**. It was a diagnosed case of Chronic Renal Failure and was already on Dialysis since March 1985. The background history that he gave me was that apparently he had been well till January 1985 when he developed dry cough followed by constant nausea and vomiting at sight of food or water. At this time he also developed swelling of feet and to a lesser extent on the face and oliguria with haematuria. As mentioned above in March he was started on Dialysis, initially twice a week and subsequently gradually reduced to three times a month. He had also been given the diuretic Lasix (Furosemide) which was stopped sometime in June. Prior to the Dialysis the Blood Urea was 202 mgm./100 ml. and Serum Creatinine was 15 mgm/100 ml. Post-dialysis readings were 130 and 7.5 respectively. In Ultrasound examination "right kidney measured 11.3x4.8 cms. with some degree of dilatation of pelvicalyceal system. The left kidney measured 11.6x5.5 cms. Medullary pyramids prominent." There was nothing significant in the rest of the history. He liked very cold water and thirst was average. At the time he came for treatment he was having nausea only on looking at garbage and not at food or water.

* Cases presented at the 42nd Congress of International Homoeopathic Medical League held at Arlington, Virginia (U.S.A.) March-April, 1987.

1985

September 11: Prescription: *Arsenicum album* 6,30,200/one powder of each administered on 1st day followed by *Placebo*.

As per schedule he had the last Dialysis on September 12, and was advised by the Urologist to have the next one after 10 or 12 days. In the meantime he generally felt somewhat better and did not feel the need and so did not go for Dialysis. In fact he never needed another one. Blood Urea on **October 14**, was 68 mgm./100 ml. which was lower than the previous readings. On **November 30**, it dropped further to 48 mgm.% when Creatinine was also done and it was 1.8 mgm.%. He continued on *Placebo*.

On **December 27**, he complained that he got headaches often, mostly in the afternoon which got alright after sometime without any medication. He also had an aching pain in upper arms and felt difficulty in raising arms to remove his clothes. No particular modalities of time, motion, heat or cold.

Prescription: *Calcarea carbonica* 200/3 powders.

1986

January 20: He reported 8-9 vomits the previous night and was still having nausea. According to him the vomiting resulted after he had eaten meat (mutton). As this was at a marriage party it is possible he may have been indiscrete in the rest of his eating also.

Prescription: *Arsenicum album* 30/18 powders, every 4 to 6 hours.

He reported again on **March 3**, once again with nausea feeling for the previous one week and also frequent headache in previous two months. He was given a repeat of the prescription of January 20, and asked to

get the Blood Urea done again. His urea continued to be stable and the report on **March 10**, was 49 mgm./100 ml.

Report on **October 1**. Time to time he would feel a pain in the left thumb and some burning in the region where the shunt had been fixed so went to hospital to have it taken out. The Urologist and the Surgeon could not recognise him and were surprised that he was still alive and without Dialysis for the previous 13 months. They advised him against the removal of the shunt on the plea that Dialysis may be needed again.

To make sure he got another test done on **October 6, 1986** and the Blood Urea was 48 mgm./100 ml. and Serum Creatinine 2.4 mgm./100 ml., E.S.R. (Westergen) 15 mm. T. and D.L.C. had normal figures.

On the basis of this report and on his great insistence the Urologist reluctantly got the shunt removed on **November 14, 1986**.

He was last seen on **November 27, 1986** and his only complaint is some frequency of urine at night. This is likely to be due to Benign Hypertrophy of Prostate. He has been prone to such frequency in winters for the past few years.

It is significant to note the uneventful recovery with very little medication from a fairly serious condition and the fact that he could almost immediately do away with the irksome and expensive procedure of Dialysis.

In fact he later told me that he has spent more than Rs. 200,000/- (Approximately US \$17,000) in the 8 months of allopathic treatment and it would have been a continuing drain on his purse apart from the discomfort and risk but for the Homeopathic treatment which had been "life saving" and had cost him practically nothing in comparison.

Case No. 2 (Chronic Renal Failure)

Mr. J.L.T., age 54 years

I was asked to visit this patient on **March 17, 1985** as he was lying practically in an unconscious condition. He had been diagnosed as Chronic Renal Failure. History given to me was that in July, 1984 he had fever, temperature 101-102°F, with vomiting. This lasted for few days. At the end of August, 1984 B.P. 190/120; urine examination: Albumin trace; Pus cells 20-22/H.P.F. and Casts.

Hospital report dated **September 4, 1984**: Blood Urea 160 mgm/100 ml., Serum Creatinine 8.7/100 ml. He had slight puffiness of face. A week later Blood Urea shot up to 200 mgm/100 ml.

Ultra-sound examination of abdomen gave the report "Right Renal Cyst, small left kidney with normal echo pattern".

He was diagnosed as *Chronic Renal Failure with Hypertension and Anaemia. ? Chronic Glomerulonephritis.*

On **September 14, 1984** he had had Peritoneal dialysis for 30 hours and that brought down the Urea level to 60 mgm/100 ml.

Incidentally his earlier report of August 1982 which included examination of Urine, Stool, B.P., E.C.G., were all normal.

In January 1985 his symptoms were anorexia, vomiting, general weakness and facial puffiness. He was on anti-hypertensive drugs, restricted diet with 40 gms. protein and low salt. Occasionally the diuretic Lasix (Furosemide) was also given. He was also taking Autrin (Iron preparation) for Anaemia.

In January 1985 he also developed Cervical Adenitis. Biopsy showed Chronic inflammatory granulation tissue only. Aspirate was suggestive of Tuberculosis. X-ray

chest was normal. He had been put on antitubercular treatment by way of Rifampycin and Ethambutol.

His condition deteriorated from February 1985. He gave a history of general weakness specially in the month prior to my consultation with a very poor appetite. Earlier in March 1985, Blood Urea again shot up to 190 mgm/100 ml. and Serum Creatinine was 14.9 mgm/100 ml. He again had Peritoneal dialysis. This brought down the urea to 70. However, next day it again rose to 120. He had progressive drowsiness and was labelled as *Grade-I Encephalopathy*. It was at this stage that I was called to see the patient. During the entire period that I was in the room getting the history from the attendants he was in a condition of stupor and not disturbed at all by the conversation and the noise by numerous people in the room. Even when he was jolted and told, "relate your condition to the doctor," he opened his eyes but remained blank and non-communicative.

1985

March 18: Prescription: *Opium* 30/16 powders to be given every 4-6 hours.

March 20: He was reported to be fully conscious. Had been sitting in the sun for sometime. Itching was reduced. He had had this symptom earlier (possibly because of uraemic condition) but because of his very grave condition the attendants forgot to mention at first consultation.

Prescription: *Placebo*/24 powders q.i.d.

March 27: Had been quite conscious, generally better. In his own words, "I feel 100 times better." Complained of back-ache, which was felt more at night. Appetite increased; urine quantity increased upto 1500

ml. Slight itching, occasional mistake in speech. Behaves like a normal person. *Placebo* continued.

April 3: Appetite like a normal person. Urine flow good. Feeling of weakness. Mild itching. Slight discharge from the Biopsy Scar (Biopsy done on **February 5, 1985**), temperature normal.

Prescription: *Placebo*/45 pills, 3 pills t.d.s.

April 5: Came personally. Fully oriented and logical in his conversation. Except weakness no other complaint. Good sleep. Good appetite. He continued on *Placebo*.

May 1: Carrying on very well. Very good appetite. Demands food which the family restricts and that makes him angry. His only complaint is weakness. He was feeling so normal that he climbed one flight of steps to my temporary clinic on first floor. Over the next few months he was seen not for any problem of decreased urine or of drowsiness but for glands in the neck, some of which formed abscesses and burst. For these he received *Drosera rotundifolia* 200 on **July 24** and **August 10** and *Tuberculinum* 200 on **August 20**. *Drosera rotundifolia* 200 was also repeated on **October 4**. This took care of the glands.

I may also mention that when he was first seen he was scheduled to go to the hospital the following day for another dialysis. This the family was dreading because it seemed not easy even to take him to the hospital and in any case he looked as if he was on his death bed. Subsequently he always resisted having his blood urea done because he said he felt quite well and, therefore, did not want to get into any worry or superstition in case the urea was above normal. Clinically, of course, there was no sign of uraemia.

Comments: The dramatic and rapid improvement with homeopathic remedy in a serious condition is to be noted and I like to emphasise the fact that the medication for the uraemia and encephalopathy was with a medium potency given for 2 days only.

SERUM ANGUILLAR ICHTHYOTOXIN (EEL SERUM) AND BLOOD UREA*

I owe my introduction to this not so frequently used remedy to Dr. J.D. Kenyon, who was the visiting Physician to my Ward while I was a Resident Medical Officer at the London Homeopathic Hospital in 1947.

Case No. 1

J.M., age 12½ years. Admitted to London Homeopathic Hospital on April 29, 1947 with a temperature of 103.8°F. He had been taken ill on April 16, 1947 with diarrhoea, fever and cough. On April 28, there was painless haematuria. Urine examination showed blood and acetone. The acetone was ascribed as possibly due to starvation because it disappeared after two days. The rest of the case does not concern the discussion here.

1947

May 1: Blood urea 126 mgm. %

Prescriptions:

May 4: *Eel Serum* 6/xii doses hourly.

May 6: *Eel Serum* 6/xii t.d.s.

* Paper presented at the XXXI International Congress of L.M.H.I. held at Athens in May, 1976.

May 12: *Eel Serum* 6/xii t.d.s.

This medicine was thus administered from May 4 to May 15 (inclusive) with a day's break on May 11 when no medicine was given.

May 16: Blood urea 52 mgm.%

Case No. 2 (Serum Anguillar Ichthyotoxin [*Eel Serum*] and Blood Urea)

J.S., age 64 years. Case of Cardiac Failure. Admitted to the hospital on **December 27, 1946** with the usual symptoms of this condition. The rest of the history is not significant to what I wish to point out.

Blood urea on **December 31, 1946** was 68 mgm.% and on **February 1, 1947**, it was 50 mgm.%

He came under my care, when I joined the hospital in April 1947.

Notes on **April 22, 1947**: "He has been in a state of collapse in the last two days, unconscious most of the time, only occasionally regains consciousness for a short while. Intermittent delirium."

Because no signs in the heart could account for his collapse and it was assumed that it might be more a renal failure, *Eel Serum* 6 was prescribed. xii doses at half-hourly interval (The last blood urea report available was of February 1 when it was 50 mgm.%). *Eel Serum* was continued next day at 2 hourly intervals and from April 24 to April 28, it was t.d.s. (altogether xxx doses).

However, the observation is slightly confused by the fact that during this period, he also used the following prescriptions:

1947

April 26: *Opium* 30/iv, 3 doses hourly, then 2 hourly. (10, 11, 12, 14 hours).

April 26: *Bryonia alba* 30/ii 2 hourly (22 & MN).

April 26: Inj. *Morphia* gr. $\frac{1}{4}$ at 23.15 hours given by the M.O. in-charge in my absence.

On **April 29**, blood urea 45 mgm.%.

By **May 9**, the blood urea had risen to 62 mgm.%. Once again, he was put on *Eel Serum* 6, t.d.s. from May 12. In all ten doses given till May 15.

On **May 16**, Blood urea report was 34 mgm.%.

As not unexpected, he did not have any marked symptoms with a blood urea of 62 mgm. and *Eel Serum* was chiefly given as it was considered an excellent opportunity to test the relationship of *Eel Serum* to a pathological report of high blood urea.

As a concluding note, I am happy to say that he was discharged from the hospital on **July 4** in a fairly fit condition and I have never forgotten the tears of joy which rolled down on his wife's cheeks when she thanked me for tiding him over many difficult periods during his stay in the hospital.

* * *

Case No. 3 (Serum Anguillar Ichthyotoxin [*Eel Serum*] and Blood Urea) comes as a recent confirmation.

R.A., age 11 years — consulted me on **January 8, 1976**. History of severe abdominal pain intermittently over previous two years that defied diagnosis. Recently Retrograde Pyelography put it as "single pelvic kidney on right side." Blood urea high — minimum in recent tests is 85 mgm.% and maximum touched is 320 mgm.%

January 14, 1976: 88 mgm.%

January 29, 1976: 85 mgm.%

March 11, 1976: 183 mgm.%

March 15, 1976: Prescription — *Eel Serum* 30/xv powders t.d.s.

March 20, 1976: Blood urea 50 mgm.%

Comments: I can see that many Homeopaths would criticise and frown at this approach. It is certainly not traditional or classical Homeopathy. But then, there is so much laboratory investigations being done to-day and my idea in presenting this paper is to stimulate research on these lines and that may have its own rewards.

URAEMIA

Mrs. K.D.D. age 63 years consulted on November 27, 1982. She had many medical problems: Diabetes mellitus for which she was on Insulin alongwith DBITD; Hypertension; Glaucoma; commencing Renal failure and most recently Hemiparesis on right side. Also obesity. She had come with the diagnosis of Diabetic Nephropathy. She also had some other symptoms including the frozen shoulder (periarthritis) for which she was being treated with some benefit. The important happenings are from July of 1984 which I give in some detail.

On July 29, 1984 she had a C.V.A. with Hemiplegia on left side. Earlier she had suffered from Hemiparesis on the right side. On July 30th she had a C.T. scan and the report is "CT findings reveal old infarcts in the right internal capsule and left putamen region, associated with mild cerebral atrophy."

She was hospitalised but her condition worsened very fast and the anxiety was only because of *Renal failure* and rapidly rising Blood Urea. On August 8, it was 240 mg/100 ml. and on August 9th, it touched its maximum of 250. She became semicomatose and it was at this stage that I was approached for help. As the

patient was in an Allopathic hospital I had no opportunity to see but was only given a description of some of the symptoms and shown the reports.

1984

August 9: She was prescribed *Opium* 200/8 doses in 1 oz. of distilled water to be given every 4 to 6 hours.

August 14: Reported better. The reports were that on August 11, the Urea dropped to 120 and by 14th it was down to 60. Blood sugar (Random) 123 mgm/100 ml.

Prescription: *Saccharum lactis*.

August 18: Much better. Fully conscious. Urea 50 mgm. Her only complaint was constipation.

August 25: Much better in general. Urea 39. *Sac-lac* continued.

September 1: Complained of constipation. In fact she had suffered from this for very many years and even in her initial history had mentioned of chronic constipation in which she misses days and even when bowels move it is not satisfactory. In view of the paralysis, hypertension, renal condition and constipation, she was given a single powder of *Plumbum metallicum* 200.

September 17: Better, walks with support, partial recovery in hand.

October 1: B.P. reading higher. Repeated *Plumbum metallicum* 200.

She carried on well and continued on *Saccharum lactis*.

1985

February 20: Urea 43, Creatinine 1.6. Urine examination: Albumin + + +.

In March: Urine culture was done and found to be sterile.

1985 to 1989

April 27: Reading were a little higher with urea at 60 and creatinine 2.6. She was prescribed *Opium* 200 four doses in water every three hours.

June 12: Even though the lab. reports were same she became more drowsy and she was again given *Opium* 200/1 powder.

She carried on fairly well with occasional problems and has mostly been helped by *Plumbum metallicum* 200 which has been given on September 2nd, October 26, 1985, February 19 and April 26, 1986.

May 19, 1986: Not well, speech not understood, heaviness limbs, appetite reduced, urine C/S — sterile.

Prescription: *Causticum* 200/3 powders at 15 minutes intervals. This was repeated on August 4 when it was reported that she was dragging her feet.

On **May 22nd** the urea had increased to 100 and creatinine to 3. At that time she was given *Eel serum* 30/20 powders q.i.d.

The next report on **June 9** showed a drop in urea to 73 even though creatinine remains at the same level.

After April '86 she received doses of *Plumbum metallicum* 200 on August 12, '87, October 10 and December 11. In 1988 she got it altogether four times.

January 7, 1989: No particular complaints.

Comments

- (1) Very rapid effect of well chosen Homoeopathic medicines in serious acute conditions.
- (2) Effectiveness of Homoeopathic remedies alongside of some Allopathic drugs and substitution or replacement therapy as Insulin.

KOCH'S INFECTION, DIABETES MELITUS, URAEMIA

Mr. J.R.G., age 69 years, sought an emergency appointment because of a number of serious complaints. He was seen on **October 2, 1993**. Had been married with 4 children. Had been in Railway service where he had active outdoor duties. Retired from there 11 years earlier and got employment in a shop where it was a sedentary job.

Complaints: Diabetes mellitus (D.M.) — 10 years.

Pulmonary Tuberculosis — First time 10 years ago. He had low grade pyrexia, X-ray chest showed Koch's infection and in routine investigation the diabetes was discovered. He received 90 Streptomycin injections and also Oral A.T.T. for 6 months. For the Diabetes, he took Daonil tabs. One or two tabs daily, but he was not careful with his diet. One year earlier he developed cataract and he was successfully operated on one eye.

One month earlier he had fever. This was initially treated as viral but he did not respond to treatment so an X-ray of the chest was taken and they discovered that he had a recurrence of Koch's infection. He received 3 Streptomycin injections and all the 3 usual A.T.T. drugs.

Around September 20, he got a wound in the right foot, especially on the big toe. Gangrene was being feared. The wound was ascribed to the use of a new sandal but he had no sensation in his feet for the previous 6 months and to a degree also numbness in his hands. Most likely Diabetic Neuropathy. On September 24, he started to have a persistant hiccough and was hospitalised the same night. The hospital diagnosis was "D.M. with Infected Wound; Koch's with left Pleural Effusion; Hiccoughs with Uraemia".

Lab Reports: Urea — 105 mgm./100 ml. Creatinine 2.0 mgm. %. Urine C/S — Sterile.

Appetite: Poor for one month. Vegetarian for last 15 years. Used to smoke and drink but stopped both 10 years earlier when he fell ill. Likes sour — pickles and lemon. Salt +. Likes warm drinks and food. Mouth dry but no thirst.

B.O.: Erratic, constipation and diarrhoea often alternate. Earlier was constipated.

Sleep: Disturbed by hiccough. Previously good. (Hiccough had been persisting for the previous 8 days and had not stopped with hospital treatment). Dreams: "Bad" — of the dead.

Feels both heat and cold.

1993

October 2: *Arsenicum album* 30/20 powders at 4-6 hours interval.

October 5: Better. Hiccough much less and shorter duration. Sleep okay.

Arsenicum album 30/20 powders at 6-8 hours interval.

October 13: No hiccough. Anorexia, Weakness. On October 8 he had the tests done. Urea — 45 mgm./100 ml. Blood sugar — Fasting — 57 mgm./100 ml. Therefore Daonil had been stopped.

Tuberculinum bovinum 200/3 powders at 15 minutes interval.

October 29: Appetite better and now taking some food. No hiccough. Delirious talking at times. *Saccharum lactis*.

November 17: Much better. Is eating lot better "Overall well". Have stopped A.T.T. as that reacts and takes away his appetite. Is now only taking Homoeopathic medicine and temperature has reduced.

Cough also reduced. No delirious talking, only weakness. Tests one week earlier. Urea 45 mgm. Blood sugar — Fasting — 204 mgm. thereafter started Daonil again.

December 15: "Much better". Had vomits on November 18. No recurrence and is carrying on well and walking about.

December 22: Was doing well till 21st morning. He went for a blood test and walked half a kilometre. On return had cauliflower stuffed paranthas*, thereafter he vomited. By evening he had some kind of C.V.A. As the reporting was by his son, it was not clear whether it was Hemiparesis or Hemiplegia on left side.

Phosphorus 30/11 powders q.i.d.

December 27: Much better. Can raise hand. Constipated. Some disorientation and irrelevant talk. *Saccharum lactis*.

1994

January 14: M.B. Movements have returned to considerable extent. Can himself walk upto bathroom and in the house. Chest condition also better. No fever. Still quite weak.

February 4: Is well in every way. Eating very well, in fact very hungry but still feels quite weak.

Tuberculinum bovinum 200/3 powders at 15 minutes interval.

March 2: Generally well. Walking is tiresome. Takes short steps.

August 5: Has been well. Walking around. Practically no effect of the stroke. Temperature normal all along. No cough of any significance. Walks to the temple daily, though feels a bit tired on return. His only complaints

* Cauliflower stuffed paranthas are leavened bread with a filling of grated cauliflower and fried.

are weakness and Hyperglycaemia. Blood sugar — Fasting — 220. Appetite excessive, but no increase in weight.

Iodium 200/3 powders at 15 minutes interval.

Treatment is continued.

Comments: The patient had come personally only the first time and maybe one more time in the initial period of treatment, otherwise all reporting was by his son. It is a usual experience that when a patient improves, then the reporting becomes erratic and infrequent. In this case, initially the whole family appeared so nervous and anxious that they would telephone sometimes a number of times on the same day and yet there was no report for 5 months after March 1994.

U.T.I. & FITS

Miss S.S., was seen from time to time between February 1982 and November 1984 so it is a long narration. I am tempted to write about this case as on February 14, 1990 when the parents came to consult me for her brother they informed me that Miss S.S. had been quite well over the years and is now studying in the 12th class and is physically and mentally well.

When first seen on **February 23, 1982**, she was 9 years of age and the complaints were recurrent U.T.I. (Urinary Tract Infection) from 1978. She would complain of burning micturition and there would be redness of the parts. In 1979 urine examination was carried out and it showed infection for which she was treated by an Allopath with Furadantin. She recovered but there was recurrence after few months and she continued to have trouble from time to time ever since. Additionally for

about the same period of four years she also had bed-wetting. For six months she was having pain abdomen, near navel and lower abdomen. The pain had no relation to eating or stools and no other modalities. This is, of course, not uncommon in children. She had only had primary vaccination. She had frightening dreams, mostly of being strangled. There was fear in the dark and of thunder-storms.

P.I. Nil of note.

O.E.: Weight 60 lbs. Heart, Lungs, Abdomen — N.A.D. Throat showed cheesy pus in the tonsil.

February 23, 1982: *Sulphur* 200/3 powders to be taken at 15 minutes interval in the morning on an empty stomach.

* * *

1983

April 8: Reported again after a gap of about 14 months. Urinary symptoms had got O.K. i.e. no burning thereafter and lab. examination of urine was normal. Bedwetting was still there.

For the previous six months was having Paraumbilical pain when she would study or when reprimanded. Parents complain that she has become very lazy and lethargic. Once she had pain in the left upper limb and chest and said she could not move her hand. It was clenched and could not be opened, and then she was seen at the AIIMS where it was opened under anaesthesia.

They told the parents that she is a psychological case and should get less attention. When she is made to study, she says, "I cannot see." At AIIMS she had been prescribed Tryptanol.

April 8: *Phosphorus* 200/2 powders, evening and bed-time.

May 4: Came with sore throat and fever. Having dreams of ghosts. *Ferrum phosphoricum* 6x/16 powders q.i.d. followed by *Silica* 6x, 30, 200/1 powder of each to be taken on the same day.

* * *

November 29: Reported again after a gap.

No longer having the dreams of ghosts.

Bedwetting still. Does not have dreams of urinating. Lazy, numbness hands, pain in the waist.

Lazy, nervous, cries even if someone else is reprimanded. *Sepia officinalis* 200/1 powder at bedtime.

1984

January 10: Bedwetting now rare, provided she has urinated at bedtime.

Lazy — desire to keep lying and over-sleep.

c/o: Numbness hands when there is a pressure of work as during examinations. Pain in the waist is there but less. *Sepia officinalis* 200 repeated.

Reported again twice in January, more or less with the same complaints continuing.

February 13: Had Chickenpox. The complaints were now different. There was no bedwetting and no pain in the hands. She would have fits of anger. Has unexplained fears on going to sleep and at times 'starts'. In my notes I have put a remark "? seems hysterical to a degree." This assumption proved correct when next reported on February 18 with fits — which would fit in with the description of hysteria. On February 13, I had given her *Pulsatilla* 200/3 powders to be taken the same day. On February 24 she was given *Varicella* 200/3 powders at 15 minutes interval.

She was shown in hospital where they took X-Ray of the skull. It was reported normal but the report of

E.E.G. was a bit of surprise to me. The report was "Abnormal EEG record suggestive of seizure disorder." They labelled it a case of Epilepsy and prescribed Dilantin.

Looking at her different symptoms through "Pointers to Common Remedies" by Tyler page 139 and 150 I considered two remedies *Belladonna* and *Cuprum metallicum* and gave her *Cuprum metallicum* 200/3 powders at 15 minutes interval.

March 21: Abnormal behaviour is less. However, gets fits of blankness for one to two seconds, a kind of unconsciousness. It is less if she is in company or watching T.V. I gathered that there had been tense atmosphere in the house in the previous two-three years and that her attacks were much less by change of place as when she shifted to her grandmother's house.

Has some funny fears: Fears a cat will come even when the door is closed; may have fear on seeing a truck. Anger + +, very obstinate — must have her way. Had used some allopathic medicines *Mazetol* and *Sodium valproate*.

I was told that they had a repeat EEG and it was suggestive of Epilepsy originating in the right and becoming generalised. I must say I was not somehow satisfied with the diagnosis keeping in view all the symptoms and the circumstances.

Repeated *Pulsatilla* 200.

April 7: Reported better, still very irritable and if not listened to then loses temper and gets a fit.

Consulted the rubric on page 1352 — CONVULSIONS; anger, after. Selected **Nux vomica** which appears in bold letters (1st Grade). She was given *Nux vomica* 10 M/1 powder at bedtime.

April 21: Has had no fits. Gets jerks in upper limbs one or two times on falling asleep. Talks in her sleep, "Cat has come, will bite me etc." Some pain in hands. The impression of the parents was that in general she is M.B. in fact more than 80% normal.

May 12: Quite normal. No fits. No talking in sleep. Still irritable. In the previous three days some burning in urine but only morning and evening. Continued *Saccharum lactis*.

June 26: I have no notes but possibly there was some set-back as I have repeated *Nux vomica* 10 M.

August 26: V.M.B. If awakened out of her sleep then slightly disoriented. Makes odd complaints which I thought were for seeking attention e.g. she said, "My hands and feet are blue." But in reality were not so. Now and again complains of mild pain near umbilicus which lasts only for a short time. She had been given a few powders of *Magnesia phosphorica* 6x to use S.O.S.

November 16: Last seen on this day. Generally well. Not so obstinate. No bedwetting which had recurred in the interim period. Still not interested in studies as per the desire of the parents. Thereafter lost touch till **February 1990** when her most grateful parents gave news of her welfare and thanked me profusely as a saviour of their family.

RECURRENT URINARY INFECTION

Ms. A.P., age ten and a half years, consulted on February 23, 1985. She was the daughter of a senior Allopathic doctor — a Paediatrician. She had come from outstation and the subsequent reports were by post.

Complaints — She came with a diagnosis of Recurrent Urinary Infection for the previous six years. The first time she had fever, pain in passing urine and frequency. Urine examination showed infection and C/S showed a growth of E.Coli. The appropriate antibiotic relieved her of the symptoms but thereafter the condition kept recurring at intervals of 1 to 4 months. In the attacks subsequent to the first one, there was no fever but only dysuria and frequency.

Redness genitals and burning. Occasional leucorrhoea — yellowish.

Nose block in winters.

Appetite: Good. Non-vegetarian but meat rarely. So practically a vegetarian. Fond of sweets. B.O.R.

Sleep: Good. Dreams of thieves.

Vaccination once.

No particular reactions to heat and cold.

I.V.P. Micturating Cystogram: N.A.D.

P.I. — Jaundice 6 years ago. Malaria every year.

Other than the urinary symptoms the rubric "leucorrhoea; girls, little," on page 722 was also considered and she was prescribed:

1985

February 23: *Pulsatilla* 200/3 powders at 15 minutes interval followed by *Saccharum lactis* for a month.

Letter dated **March 15:** ".... feeling better. Urine examination done repeatedly and is clear...."

Saccharum lactis continued.

Letter dated **May 3:** "... no symptoms complained by her since she started medicine except itching over the hands for the last 10 days... fine rash limited to dorsum of hands and inbetween fingers... Urine Examinations-N.A.D. except 3 weeks earlier few pus cells recorded only once..."

Saccharum lactis continued.

June 14: Continues well. Sent sac-lac for a month.

June 26: Received a communication "No trouble since treatment was started. Shall we now stop medicine".

URINARY TRACT INFECTION

Mr. O.C.D. age 69 years consulted on February 27, 1994 under unusual circumstances. I had gone to another town to deliver a special lecture but in addition got loaded with patients. When I was leaving for the airport, Mr. O.C.D. emphatically pleaded with me that I must give him a few minutes. Fearing that I will miss my flight, I offered to see him at the airport after checking in.

He had been married for 51 years (married at the age of 18 years). Had two children, age 40 and 36. He had a manufacturing concern — agricultural implements and sawing tools. His work had involved a great deal of travelling as he looked after the sales side and for 9 months in the year was travelling. However, he had to stop all this after his illness.

His present history starts with an attack of *Herpes Zoster* which he had on October 15, 1993. He had no local post-herpetic neuralgia symptoms but during that time he got anuria. This was diagnosed as B.P.H. and he had indwelling catheter for 4 weeks. Thereafter he had T.U.R. operation. His tale of woes starts now because ever since he has tremendous burning in the urethra. Some reports show U.T.I. but even when this is controlled with the appropriate antibiotics, burning continues. The operating surgeon says that everything is normal

and the operation has been successful. He has consulted many urologists but they are unable to find any cause for his condition.

Burning is constant, only varying in degree. < after urination. There is frequency and at times it is so bad that he literally goes within minutes. Of late he has found some difficulty to urinate at night and has to exert some pressure.

He had always been prone to colds. Much itching in ears for 10 to 15 years. Has a perforation in left ear. For the previous two months his B.P. was raised: 160/90-100. Earlier he always had low B.P.

Appetite — Good. Non-vegetarian. Likes sweets . stopped smoking in 1961. Never took alcohol. B.O.R.

Sleep has always been good earlier but now much disturbed. Since December 1993 doctors have put him on Calmpose because of his complaints. Dreams — Nil.

Chilly patient. Equivocal regarding open air and indoors.

Anger + + Flares up quickly but also calms down soon.

Likes company.

P.I. — Cholecystectomy in 1987 for calculi. Jaundice 3 times before the operation. Malaria in childhood. Diabetes from 1963 to 1972. Took Ayurvedic treatment and used neem (*Azadirachta indica*) leaves and got cured.

F.H. — Mother diabetic.

1994

February 28: Sent him *Cantharis* 30/28 powders q or t.i.d. followed by *Saccharum lactis*.

March 15: (Telephone report) Relieved of constant burning but sharp pain after urination for 10-15 minutes.

Pulsatilla 200/12 powders q.i.d. to be followed by *Saccharum lactis*.

Somehow these medicines got delayed in the post and he sent a letter dated March 19 that he had passed the week with great agony.

Letter dated March 22:

"I had received your medicines on Saturday 2.30 p.m. (19.3.94) and started it the same day. First 3 days, i.e., 19th, 20th and 21st March, 1994: I felt great improvement: (i) Time of urination was reduced from 25-40 times to 10-12 times. (ii) Sensation and burning was reduced." By sensation he probably meant pain.

Letter dated March 23 (Received on March 26):

"... Your first medicine started on March 19 has effected much but the new medicine started March 22 is not that effective and the old symptoms are coming again. Pain in the end while passing urine. It is pressing, pinching, deep pressure. Cannot quite describe. After urination sensation like burning continues". The first medicine was *Pulsatilla* and the new medicine was *Sac lac*.

He was sent *sac-lac* for 10 days and *Pulsatilla* 200/3 powders at 4 hourly interval and he was instructed to keep these in case there was a recurrence of the symptoms after use of *Saccharum lactis* for a few days.

Letter dated April 27:

"I feel that 60 percent of my agony has been removed" (he underlined this). "The extreme burning is not there. Urination has also been reduced". During the day he went only 5 or 6 times but he still had some nocturia. "The burning is reappearing every now and then, practically every day for short period of one to two hours, though intensity is reduced".

Pulsatilla 200/3 powders at 15 minutes interval.

Letter dated June 15:

"I have no words to thank you. I am cured (There is no burning now)". He only had to get up for urine a number of times at night. "I hope with your blessings I will be able to lead a normal life."

Now that his agony is over, he reminds me of his other complaints of the itching in the ears, the discharge from left ear and some impairment of hearing. Itching on the back, on the right nipple and at the root of the penis. He also mentions of an old trachoma and the fact that he has been getting diarrhoea off and on.

Sulphur 200/3 powders at 15 minutes interval to be taken in the morning.

The treatment is continuing but it is to be noted that he has been relieved of his very distressing undiagnosed or untreatable condition. The relief would also be apparent from the fact that whereas initially he was telephoning or writing every few days (once he wrote two letters in one day), now even after his medicine (*Saccharum lactis*) is finished in 4 weeks he reports after a gap of 6 weeks. This I always take as a good sign because it shows that the patient is comfortable.

Pus cells per H.P.F. in Urine Reports

Dec 14, 1993	0-2
Feb 14, 1994	50-100
Feb 15, 1994	15-25
Mar 16, 1994	120-130
Mar 23, 1994	30-50 and in groups.

It would be noticed that there is hardly any correlation between his lab reports and clinical condition. This is not an uncommon experience and hence the Homoeopath's emphasis on the feeling of the patient more than on his investigation report.

BENIGN HYPERTROPHY OF PROSTATE

In January 1989 I am approached by a patient diagnosed as Benign Hypertrophy of Prostate and seeking Homoeopathic treatment so as to avoid an operation. He reminds me that many years ago I successfully treated two of his relations.

Case No. 1

Mr. D.M.A. consulted me on March 10, 1964, age 75 years. His complaint was Dribbling of urine and from mid February '64 this had been diagnosed as *retention with over-flow*. On two occasions at interval of 5 days he was unable to pass urine at all and catheter was passed. He would soil his clothes with dribbling urine at night. Blood urea checked four days earlier was 180 mgm. He had been having high B.P. for a long time. At its maximum it touched 190/95. For this he had used Serpasil. 15 days earlier he had a bath in the open and thereafter got sore throat and fever. Ever since he had loss of appetite. He had occasional vomiting. He had much constipation since he was operated for Cataract in January '64. He also had some degree of insomnia.

1964

March 10: Prescription: *Solidago virgaurea* 3x/16 powders every 2 to 4 hours.

March 12: Reported better, urine flow upto 3 ozs or so at a time $\frac{D}{N} = \frac{4}{2}$. No vomiting, now dribbling is rare and bedwetting not frequent, more cheerful.

Solidago virgaurea 3x/12 powders every 3 to 5 hours.

March 18: Continues to have free urination. Now 4 to 6 ozs. at a time "general condition is improved". In

addition to voluntary urination, some intermittent dribbling.

"Ever since the catheterisation, there is pain in urine". In the beginning he was dazed and drowsy, now quite conscious B.P. 150/90.

Prescribed: *Staphysagria* 30/12 powders q.i.d.

March 21: Urine control better, burning urethra less. Blood urea done on March 18: 24 mgm.

Repeated *Staphysagria*.

March 23: Not so well last two days. Some nausea and vomiting. Dribbling urine has been more though still passes urine voluntarily also.

Solidago virgaurea 3x/12 powders every 3 to 5 hours.

In the subsequent few weeks he received *Ipecacuanha*, *Baryta carbonica*, *Berberis vulgaris* Q.

He was last seen on May 12, 1964 and was doing fairly well.

1967

He reported again after a gap of three years on February 8, 1967 with slight recurrence and was again given *Solidago virgaurea* 3x/8 powders every 2 to 4 hours.

His attendants reported in a few days that he was passing urine freely but he developed Hemiplegia on right side.

He was prescribed: *Causticum* 200/2 powders at 10 minutes interval.

On **3rd March** he was given *Causticum* 1000/1 powder which was repeated on 1st April.

On **4th May** *Causticum* 10 M. He made considerable progress and could sit and walk hesitatingly. But his condition had come to a stand-still so on **May 31st** he was given *Plumbum metallicum* 200/1 powder.

He was last seen on **June 19, 1967** when his general condition was quite good and he had no problem passing urine.

Case No.2 (Benign Hypertrophy of Prostate)

Mr. B.D.A., consulted on April 14, 1965 for some pigmentation patches, mild diabetes "sluggish liver and mild hypertension". In 1966 he came for bleeding piles.

Then he came on August 17th, 1970 and brought a long written history from age 5 to age 58 which is of no consequence and his complaints at this time were:-

1. Cataract developing over the previous three years wants preventive
2. Frequent urination $\frac{D}{N} = \frac{8-10}{2-3}$

At night: around mid-night, then 2 a.m., then 4 a.m. "This trouble is noticed as gradually increasing for two years". Urge sudden but can hold if busy. Never involuntarily.

Surgeon's opinion "I.V.P. shows chronic pyelonephritis and residual urine. Would require cystoscopy".

Later "Cystoscope was passed. Obstruction was felt at the Bladder neck. There was median bar seen with a small median lobe of the prostate and narrowing of the bladder neck".

Diagnosis: Median bar bladder neck obstruction.

Was advised T.U.R.

Urine examination: normal

B.P. 140-150/84-90

1970

August 17: *Calcareo carbonica* 200/3 powders, every four hours.

September 5: Not much change.

Prescribed: *Thuja occidentalis* 1000/1 powder

September 18:

$\frac{D}{N} = \frac{\text{Same frequency}}{\text{Generally twice, sometimes once}}$

Solidago virgaurea 3x/21 powders t.i.d.

September 22: Urine has been measured for the previous four days: 66 to 85 ozs in 24 hours in 10 to 11 times. Giving an average of 7.5 ozs at a time.

September 25: "Much better 75% relief". Repeated *Solidago virgaurea* 3x/24 powders t.i.d.

Was not seen thereafter and had no further information till January '89 when his relation informed that he had not suffered any Urinary problems after the treatment in 1970.

URETHRAL STRICTURE

Mr. C.L.S., age 50 years consulted on July 10, 1987. He had been married 30 years and had 3 children. He was in Government service as an Engineer with mostly outdoor work. It was a diagnosed case of Urethral Stricture.

History — Three years earlier he had pain in the left loin. After investigation it was diagnosed as urinary calculi. An initial attempt was made to remove the same by cystoscopy and ureterotomy. This was not successful and it resulted in infection. Then the standard operation was performed and at that time two lobes of prostate were also resected as that had got infected and formed an abscess. The operation was on February 16, 1987. Postoperatively or some time later he got high fever 104°F. The reports showed *Pseudomonas* infection. All antibiotics were tried without success, finally a vaccine was given and the fever subsided but he was left with urinary obstruction at the neck of the bladder. Ultrasonography showed 70% retention of urine in the bladder. His symptoms were a thinner stream and pain at tip of penis in urination. For this new problem, he underwent a T.U.R. operation on May 16, 1987. Six days later he had an attack of Hepatitis. This was ascribed to the blood transfusion he had during his earlier operation in February, 1987. Test was positive for Australia antigen. However, he made a reasonably quick recovery in 15 days.

Two weeks prior to consultation, i.e., from last week of June, he again felt obstruction in urinary flow. He had to strain to pass urine and again started feeling pain in tip of penis. Now it was opined that he had developed a urethral stricture. There was nocturnal frequency

$$\frac{D}{N} = \frac{3-4}{\text{Every } 1\frac{1}{2} \text{ hr.}}$$

In fact the nocturnal frequency was there even after T.U.R., though for sometime the flow was more free. He also noticed that if he passes urine sitting then some drops dribble after urination which is not so if he passes standing.

1987

Urine examination on **June 24** — Albumin-Trace; R.B.C. 1-2; Pus cells 30-40/H.P.F. Urine culture: *Pseudomonas aeruginosa* isolated in large number of colonies.

Appetite — Poor since T.U.R. Vegetarian. Teetotaller. No cravings. Can take vegetables and also porridge. However, taking a piece of roti (leavened bread), immediately gives retching and is vomited.

B.O. — Three in day and 4 at night, in fact has urge for stool every time he goes for urine. Passes lot of flatus and then stool. Earlier normal habit was 2 stools daily and he was often constipated to the extent that he would use laxatives.

Sleep — Fair. Dreams-yes, but not remembered.

Vaccination — Not for at least 30 years.

No strong weather reactions but gets pain in legs if sleeps under a fan in summer.

Mental: Anger — Average; worrier — average; not fond of company.

P.I. — Nil of note.

F.H. — Two brothers — both diabetic. No family history of T.B.

July 10 — *Silica* 200/3 powders on the same day.

July 28 — Urine passes without much trouble "only when I go for stool and sit longer then extra urine, after the main quantity has been passed, is in drops and

causes some burning or discomfort near the tip of penis as long as I keep sitting". Number of stools now reduced to 4, 2 in day and 2 at night. Placebo continued.

August 12 — No pain in left loin. Urine passes in drops at the end of urination when he urinates sitting. Pain across the waist while sitting. Stools now 2 in day and one at night. Appetite better.

Sarsaparilla 6,30,200/one powder of each in morning, afternoon and bedtime of same day.

September 1 — Urine culture done on August 12: Sterile. Urine now passes freely, no difficulty. Pain right loin in morning on waking, partially relieved after one hour or so. Previously, it was across the waist on both sides.

October 5 — Pain loin better by 25%. Pain neck after sleep. It gets very stiff. Urine is passed normally without discomfort or pain.

Rhus toxicodendron 200/3 powders on the same day.

October 28 — Pain loin practically gone. Pain neck 50% better. Now complained that he had pain twice like a cramp in the lower part of buttock. Once it lasted for one hour and once for about 3 hours.

Cuprum metallicum 6,30,200/one powder of each in morning, afternoon and bedtime of the same day followed by *Placebo* for 3 weeks.

* * *

He was not seen after his visit on October 28, 1987. However, on **February 15, 1993** his son came to consult for his wife and he informed me that his father Mr. C.L.S. has been quite well after the treatment he had received in 1987.

Comments:

In this case the indicated Homoeopathic remedy not only cleared an intractable urinary infection which was refractory to all antibiotics but also helped in the organic condition of Urethral Stricture which normally means a life-long dependence on regular urethral dilatation.

IMPOTENCE

Mr. S.N., age 40 years consulted on June 28, 1982. He had been married 16 years and had two children, age 14 and 7. He was a lecturer in a college. He had come from out-station (Aligarh), so further reports were by letters.

History: He had been having bleeding from rectum off and on for the previous 3 years and this had become continuous from June 28, 1981 till he was operated on February 10, 1982. He had had *Colostomy* operation and was provided with a bag for stools. Biopsy report confirmed *Cancer Rectum (Adenocarcinoma)*. Even after the operation, the hospital notes of April 8, 1982 showed that Inguinal lymph nodes were palpable. Most of his problems had been left-sided — at 13 years, a black mole on left finger; a boil on left thigh; an abscess on left forearm which had to be operated; and for 3 months prior to start of bleeding rectum, he had pain in the left foot ascending to the left hip.

Teeth sensitive to hot and cold but not to sweets.

Dandruff — Itching scalp.

Skin dry in winter.

Appetite — good. Non-vegetarian but mostly vegetarian and eggs, meat only rarely. Teetotaler. Till 12 years earlier was taking extra salt. Fond of sugar in raw-form (Gur). Averse to tea, feels it causes dryness. Takes things of 'cooling nature'. Dreams of falling from roof quite often. In other dreams he finds that he cannot walk.

Vaccination only in childhood.

Hot patient and likes open air.

Sensitive and angry but bottles up. Averse to noise, likes it quiet and peaceful. Man of literary taste. Worry-

ing and anxious nature. Conscentious. Sympathatic. Has had a life of considerable struggle.

P.I. — Eosinophilia — 40%. This reduced after passing worms. Had a history of passing roundworms. No other illness of note.

1982

June 28: *Carcinocin* 200/3 powders at 15 minutes interval.

August 1: Letter mentioned, "... pain left heel and sole of foot on resting after walking and at night. Have sensation of passing urine during urination which was not there earlier. During the operation for cancer of the rectum, the surgeon had removed the semen bag, hence I have sexual weakness with practically no erection. I have been advised to take Aquaviron B12 injections but I will await your instructions." I wrote to him that there is no need of injections and to let me have a report of the blood as he mentioned in his initial letter that he had been anaemic.

Natrum muriaticum 200/3 powders at 15 minutes interval.

1983

January 13: His report showed HB. 14.8 gms. On some nights he is very thirsty. Waterbrash often. Pain hip joint in walking.

Natrum muriaticum 200 was repeated.

May 8: *Sepia officinalis* 200/3 powders at 15 minutes interval.

November 1: In his letter he mentioned that he has been feeling occasional stiffness (erection) of penis.

Saccharum lactis continued.

1984

January 13: Feeling better. *Saccharum lactis*.

May 15: Erection is better but not as original. Can have successful coition at times.

July 31: "Much better. Having coition often."

Saccharum lactis.

1985

March 21: *Natrum muriaticum* 200/3 powders at 15 minutes interval.

July 18: Itching feet.

Natrum muriaticum 200/3 powders at 15 minutes interval.

November 11: "Sex continues normal. Dryness of skin which is usual in winter."

1986

July 1: He had continued on *Saccharum lactis* all these months as his general condition had been well. The only complaint was slight itching which could be ascribed to the dry skin in the winter months. However, now he developed itchy eruption on the feet.

Natrum muriaticum 200 repeated.

Eruption cleared rapidly. I continued to receive occasional communication. The last letter being in November 1989. He remained well and did not have any major complaint. The only thing that he would occasionally mention during the winter months would be the dryness of the skin as also dandruff. He received a repeat of *Natrum muriaticum* 200 on August 10, 1987 when he had urticaria following on indigestion and loose motions and again on February 31, 1988 and July 12, 1988. The last dose he received was of *Natrum muriaticum* 1000 on March 12, 1989.

Comments: *Natrum muriaticum* had been chosen mostly on his mentals — bottled up feelings, sympathetic, worrying nature, on his cravings as also the

physical generals. Of course, it was also indicated for the particulars as dandruff. It is note-worthy that only one remedy was needed all through and relieved him of a very depressing situation of losing his virility at the young age of 40 years.

SEMINAL EMISSIONS

Mr. J.C., age 21 years, consulted on October 22, 1982, a bachelor; works for a newspaper, has night duty. His main complaint was "night fall", i.e., seminal emissions for the previous 5-6 years. This, unfortunately is a cause for considerable anxiety for ill-informed young men at that age, especially because of the kind of advertisements they are exposed to. In fact this is not unusual. Some of his other complaints could be linked with this one. He would have these emissions 8-10 times a month. There was a history of masturbation but no history of coition. "Semen thin." His other complaints were stabbing pain chest on bending the day he has emission.

Weakness — On sudden rising "black out." (Vaso-vagal)

"Weak heart" — Feel nervous from any quarrel in the house, etc. even if it did not involve him.

Memory poor.

Anorexia for the last 2 months eversince he was on night duty.

Vegetarian. Teetotaler. No cravings.

Nothing significant in the rest of the history.

O.E. — Heart, lungs, abdomen — NAD — wt. 132 lbs. Ht. 5'9".

1982

October 22: *Kali phosphoricum* 200/3 powders at 4 hourly interval.

November 9: During this time had coition. There was bleeding due to injury to prepuce.

Arnica montana 200/2 powders follows by *Saccharum lactis* q.i.d. Calendula Ointment locally.

November 22: M.B. — Bleeding got controlled, the wound healed, emissions not so frequent.

December 20: Well for nearly three weeks. Thereafter had 3-4 emissions in 5 days for no special reason. *Kali phosphoricum* 200/3 powders at 15 mts. interval.

1983

January 29: "Emissions in phases. Remains free for 8-10 days then may have 2-3 times on consecutive nights." "Heart weak" — tachycardia for slightest reason, as when he is to meet an important person (anticipation).

Acidum phosphoricum 3, 30, 200/1 powder of each on same day.

February 21: 3-4 emissions in a month. Quickly excited by any sex talk or picture. *Acidum phosphoricum* 200/3 powders at 15 mts. interval followed by *Saccharum lactis* for 5 weeks.

April 14: "While using medicine (Sac-lac) emission after 1 or 2 weeks but without medicine it is frequent." Repeated *Acidum phosphoricum* 200/3 powders at 15 mts. interval.

May 24: Much better. *Saccharum lactis*.

There was no further contact and I would have forgotten about this patient but he came again after 6 years on January 4, 1989 to consult me for his sister and he reminded me of his own happy experience with my treatment as he had felt very well thereafter.

MENORRHAGIA

On July 14th, 1991 at the get together of a medical society I am approached by a distinguished elderly couple and the gentleman asked me if I recognise them. Looking at my blank face he introduced himself as Dr. Lt. General (Retd.) S.P. He had been a noted Surgeon of the Army Medical Corps. He told me how very well his wife had been since my treatment 14 years earlier.

Mrs. S.P., consulted me on April 12, 1977; age at that time 52 years, had been married 30 years, two children aged 24 and 14. Her main complaint was Menorrhagia which had been particularly profuse and prolonged for the previous one and half years. When it was copious there were also clots. She also had Leucorrhoea for many years. Discharge white, watery and bland.

Dry eczema on the legs for 9 years. Itching. Has been using Betnovate. Varicose veins. She is vaccinated every three years.

For Menorrhagia she had been given Primolut and she remained well for one year. Six months earlier she had been examined and found to have Polyp and small fibroid. For the recurrence of Menorrhagia she was given Sistometril with relief but only as long as it was used.

1977

April 12: *Phosphorus* 30/16 powders every 4 to 6 hours.

April 15: Bleeding much reduced, only spotting. Sac-lac.

April 22: Bleeding stopped completely.

Phosphorus 200/1 powder at bedtime.

May 21: L.M.P. for 5 days only; fairly normal bleeding. Vagina feels raw and sore. Possibly as a result of itching ? from acrid leucorrhoea.

Sepia 200/1 powder at bedtime.

1978

July 21: Saw me again after more than a year. In end of 1977 there had been much exertion from pilgrimages in South India. This resulted in a recurrence of the prolonged bleeding which had been quite regular and normal after the previous treatment. She had kept with her some powders of *Phosphorus* 30 which she took on January 14 and that again controlled the prolonged bleeding. It continued regular and normal after January but again there was a period of over-exertion and menses got prolonged when she came to see me. She was repeated *Phosphorus* 30/24 powders q.i.d. and even though I saw her from time to time till the end of the year and occasionally in 1979 but as she kept well there had been no need to repeat the *Phosphorus* and she was taking only *Saccharum lactis*.

1982

January 2: She was last seen on this date. She had been quite well but as she was going abroad and had developed so much confidence in this medicine she wanted to keep a supply with her just in case there was any problem.

* * *

1991

As mentioned above, when I met the couple in 1991 I was told that she had been quite well ever since.

MENORRHAGIA AND ALLERGIC RHINITIS

Mrs. P.S., age 52 years consulted on November 22, 1984. She married at the age of 18 years and had 2 children, age 33 and 25 years.

Complaints:

1. Menstrual trouble since the birth of her second child. It was irregular and early $\frac{6-7}{15-20}$ Very copious. She said she passes 'big pieces'. Whether it was clots or shreds or both was not very clear. Has pain in the spine at that time. No leucorrhoea. To reduce bleeding uses C.V.P. six capsules in a day as also calcium tablets. Ten years earlier after D and C had continuously used C.V.P. for 3 months then she started to have joint pains, so now only uses it during M.P.
2. Cold — sneezings in morning and rhinorrhoea, which is so copious as to wet a whole towel. Once in 2-3 weeks it becomes like 'flu with fever. These symptoms she has had from the age of 17 years.
3. High blood pressure for 23 years. Is using anti-hypertensive tabs.

Appetite — Good. Non-vegetarian. No cravings.
B.O.R.

Sleep — Using a sleeping tablet for more than 20 years soon after she was found to have high B.P. Dreams about events of the day, also of the dead.

Vaccination in childhood.

Feels both the extremes of heat and cold. Says she is prone to get fever after bath.

F.H. — Parents died young, both from heart conditions. They were rather depressed as they had six

daughters and their only son died at the age of 3 years, probably of nephritis.

O.E. — Heart, lungs, abdomen — N.A.D. B.P. — 174/110. Weight — 146 lbs.

1984

November 22: *Sabina*, 6, 30, 200/1 powder of each at noon, evening and bed-time of the same day.

December 17: *Sabina* 6, 30, 200/3 powders at 15 minutes interval.

1985

February 13: M.B. *Saccharum lactis* continued.

April 8: Improvement maintained. *Saccharum lactis* continued.

September 14: Reported again after 5 months. In May 1985 she had cataract operation. It got infected "mind is disturbed. There is no peace though I have everything." During operation kept thinking "I should die, I should die." Since the eye operation because of complications she felt greatly shocked.

Sleep bad in spite of the use of tablet.

Had been relieved of the sneezings and continues to be well.

M.P. had been much better. Recently has been again tending to be frequent.

Kali phosphoricum 200/3 powders on the same day.

Kali phosphoricum was repeated on October 5.

October 26: M.P. better. Mind still wandering and disturbed. Palpitation, then weak feeling in legs, then ghabrahat (nervousness) "I desire to go out but no peace outside or in the house. Someone should make me unconscious!" Worse when alone.

Pulsatilla 200/3 powders during evening and bedtime of same day. This was repeated at her request on **June 4, 1986** and **May 20, 1987**.

* * *

1992

On October 11, 1992 her son came to consult and informed me that his mother Mrs. P.S. was doing very well and it was that happy experience with my treatment that prompted him to come to me.

MALPOSITION OF FOETUS

Mrs. C.P., age 29 years. I was approached by the husband of this lady on **August 10, 1985** seeking assistance in correcting the malposition of the foetus in utero. The patient could not be seen and the few facts given here were gathered from the husband. They had been married for 5 years (marriage date: November 30, 1980). First delivery was normal on December 4, 1981. Thereafter she had an M.T.P. in Feb., '83. When I was consulted she was 8 months pregnant, to be more precise last menses date was November 29, 1984 and the expected date of delivery was September 5, 1985. She had had Ultrasound examination at different periods of gestation and the latest report was the cause of her anxiety. Ultrasonography reports:

1. 3rd month — Confirmed the pregnancy
2. 7th month — Transverse lie
3. At the beginning of 8 month — normal position
4. At the beginning of 9 month (July 30, 1985) — Breach presentation.

She was complaining of difficulty in breathing at times especially while lying for the previous 15 days.

1985

August 10: *Pulsatilla* 200/2 powders, evening and bed time.

Ultrasound examination was done again on **August 21st** and the report is "*Single foetus with vertex presentation.*"

Having heard that Homeopathy has something for easy delivery they now desired that I prescribe that medicine. She was sent *Caulophyllum thalictroides* 3/42 powders t.i.d.

* * *

No further report till I was consulted again 2 years later on **July 8, 1988** for other conditions. I was informed that though initially they had been preparing her for a Caesarean Section but with the use of the Homeopathic medicine she had had absolutely normal delivery.

ACNE. DISCHARGING SINUS

In the first week of December 1990 at a large dinner party I am approached by a young and charming lady who showers embarrassing praises at the treatment she had received from me and how she had been saved from an imminent operation. The next day I dug out her old history.

Mrs. N.M. was first seen when she was Miss N.R. on February 1, 1977. 20 years of age, her main complaints were a chronic constipation for the previous 5 years in the sense that she would have no stools for many days at

a stretch. There had been no change in diet or the residence 5 years earlier to account for this. Her other complaint was Acne for the previous one and half years. She mentioned that at that time for four months there had been a slight change in the menses as she got it earlier — at 20 days interval. For the Acne she had taken *Acne vaccine* which gave some relief for two months but on recurrence the same vaccine did not help on a second trial.

She said she had a dry skin and was using cold cream three or four times a day.

She was a vegetarian. Was averse to green vegetables, used much salt in her food, often adding even without first tasting the food. She had started adding salt for the previous one year.

She had been vaccinated for small pox frequently, almost yearly over many years.

No particular reaction to heat or cold.

M.P. Menarche at 15 years (my observation was that it could have coincided with the onset of constipation). Regular 6/26-28. No dysmenorrhoea, Leucorrhoea — white, medium consistency, bland.

P.I. Typhoid 1974. Skin eruption off and on. Used Betnovate ointment (Steroid) ?Scabies four months earlier.

F.H. She is the 3rd out of four brothers and sisters. None else had Acne. No special ailments in the family.

1977

February 1: *Natrum muriaticum* 6x, 30, 200. One powder of each to be taken in that order on the same day.

February 19: Better. *Saccharum lactis*.

March 15: "Not as well as after first course of medicine" — More constipation and more Acne. Has reduced salt.

Natrum muriaticum 200/3 powders at 10 minutes interval.

Even though treatment continued till October '77 but thereafter I have no notes as possibly she reported only on telephone and sent for the medicine. She was given Sac-lac on March 30 and April 21. Apparently her constipation continued to bother her as she has been prescribed *Lac vaccinum defloratum* 200 on **June 24** and **September 1**. Thereafter she kept well and asked for a repeat of the dose after one year on **September 15, 1978**. In the intervening period she had not taken any medication and not even Sac-lac.

* * *

Now I relate about the other treatment about which she was being so very grateful.

Mrs. N.M. consulted me again on **July 20, 1984**. She had been married in November '81 and had one child born in November '82 by caesarean section. After that one abortion.

As for the old complaint, the acne had cleared and the constipation was much better. Her present complaint was that she got a lump near the genitals in February '84. This would increase in size in midcycle (probably ovulation time). From April '84 it inflamed like a boil and there was slight pus discharge. She consulted a Gynae who punctured the boil. She got pregnant in April '84 but had a miscarriage on June 23. After that the boil/abscess got bigger. It was incised on July 13. However, it filled up again and was painful. There was no fever at any stage.

She was still using salt + + in her food. Now she had become a chilly patient and complained of cold hands and feet.

O.E. A discharging sinus on right side of vulva.

July 20: *Calcareo carbonica* 200/2 powders in evening and bedtime.

August 22: M.B. The lump has decreased, discharge stopped. Now only feels a little hard spot "where it had been incised" (probably the fibrosed scar tissue).

Now complains of itching in axillae for about three weeks. Usually does not have much perspiration in the armpits. Her husband was now working in a small township. She felt the change much and was very tense and would have phases of uncontrolled crying for 5 to 6 days.

Natrum muriaticum 200/3 powders on the same day.

* * *

1987 (T.B. Glands)

After that she had been seen from time to time for various other complaints (frozen shoulder, fibroadenosis breasts, placenta praevia) but no recurrence of the sinus near the genitals. 1987 she consulted for glands in the axillae. A histopathology report had put it as due to koch's.

However, this also cleared without recourse to surgery or allopathic treatment by use of *Calcareo carbonica* 200 in August 1987 and *Calcareo carbonica* 10 M on October 16, 1987 and lastly *Tuberculinum bovinum* 200 on November 13, 1987.

POSTMENOPAUSAL BLEEDING

Case No. 1

Mrs. B.T., age 52 years, consulted on November 16, 1989. She was descendent of a famous Homoeopathic family of Calcutta. She had consulted me from time to time since 1975.

She had menopause at age 48 years. After 2 years, there was bleeding off and on mostly connected with extra exertion. With rest and 'cooling food' it would get alright. Presently, it has been going on for a month, initially slight but later the bleeding has increased. She feels that she has not had enough rest. Has not had any gynae examination. Has had no stool for the last 7 days; had made changes in her diet and is eating very little.

Mild pain lower back and abdomen. Backache < sitting.

1989

November 16: *Trillium pendulum* 6x/20 powders at 4-6 hours interval.

November 20: Bleeding reduced but not stopped fully. *Calcarea carbonica* 200/3 powders — at noon, evening, bedtime.

November 21: I receive a note from her husband, "... feels better today and continues the medicines you gave yesterday. She took some food by sitting. In other words, she is able to get up and take food. . ." Previously, she was unable to do this, partly due to the prolonged bleeding and weakness and I think partly by her temperament.

November 23: Bleeding stopped on 20th, then started exerting. From 22nd, some yellowish discharge but no

blood. With rest it is reducing. Has increased her food intake including porridge, etc. as suggested by me.

Trillium pendulum 30/16 powders q.i.d.

* * *

1994

I had no further news till I was asked to see her again in April, 1994 for viral fever. On specific enquiry, I was informed that there had been no bleeding or discharge since she had the treatment in November 1989.

Case No. 2 (Postmenopausal Bleeding)

Mrs. H.L., age 64 years, long past the menopause consulted me on **April 15, 1961** for vaginal bleeding. As per the rubric **MENSES**; return after having ceased; old woman, in an (p.728), I prescribed *Calcarea carbonica* 200. There was only partial response and considering that it was still indicated and something in the regimen may have interfered, the dose was repeated on **April 18, 1961**. This had an immediate effect. There were occasional recurrences upto 1972, i.e., till the age of 75 years. Everytime she responded to the same medicine of which she received a total of 15 doses in a period of 11 years. The potency was gradually increased and the last dose was *Calcarea carbonica* 10 M on **June 27, 1972**. At the end of 1961, when there was a recurrence, at my insistence, she had the expert opinion of a Gynaecologist who put it to Fungus and some local inflammation. She ruled out malignancy. However, the treatment that she suggested did not help and produced some reactions in the patient.

This lady was seen from time to time for other problems. At the age of 83 years she got much benefit from *Conium maculatum* for progressive weakness in the legs and vertigo.

She passed away around 1987-88 over 90 years of age and had no recurrence of bleeding after 1972. The last 2 years she spent with her grandson at a farm and was not in Delhi. I was informed that she had no specific trouble, just old age weakness.

Case No. 3 (Postmenopausal Bleeding)

Mrs. C.C., born around 1928, had been known to me since her childhood. Professionally, she had consulted me off and on for some minor complaints from the early 1950s. For the more chronic complaints for which I recorded her history, it was on March 8, 1972 at the age of 44.

The main purpose of reporting this case is not regarding her treatment of Tropical Eosinophilia or Vertigo or pain in knees etc.

In August 1989, at age 61 years she wrote a letter to me (as she was not in Delhi) that she has had bleeding as in menses although she has had the menopause 14 years earlier in 1975. Obviously, I felt alarmed and the usual suspicion of Uterine Cancer was there. Accordingly, I advised her to go for a Gynae check up but she resisted that advice and insisted on homoeopathic treatment.

At page 728, there is a rubric "MENSES; return after having ceased, the periods" and a sub-rubric — "Old women, in an". In my repertory, I have a cross reference for p.729 where under 'Metrorrhagia' there is a rubric, "Aged women, in". This I do not think as precisely applicable as the rubric at p.728. In any case, *Calcarea carbonica* and some other remedies are common. Having had very good experience in another old lady, I sent her on August 27, 1989 *Calcarea carbonica* 200/3 powders at 15 minutes interval.

She reported in one month that she had some bleeding, every 10 to 15 days, mostly spotting, sometimes a little more. She also complained of leucorrhoeal discharge — watery, white or yellow, with itching off and on.

1989

September 27: *Calcareo carbonica* was repeated.

Subsequent reports, “No bleeding but some discharge still there, feeling much better.” Clinically, no trouble. So, she continued on *Saccharum lactis* till end of July 1990.

1990

Letter dated **July 30:** Felt 90% better but of late, some increase in discharge. Otherwise I am well. “She made no mention of the colour of discharge or if there was any blood and about any smell.”

Calcareo carbonica 200/3 powders at 15 minutes interval.

From the very beginning I had insisted that she be thoroughly examined. She had reluctantly seen a Gynaec first time in September 1989 but as a number of tests were advised she neither went to her again nor got the tests done. I kept requesting her for this examination in every letter in spite of the clinical improvement that she was showing.

She wrote in her letter in July “I will only take your medicine as only you can cure me and no one else”. However she agreed to make a visit to Delhi to see me for a more detailed history which was the alternative I had suggested. *Calcareo carbonica* 1000/3 powders at 15 minutes interval.

October 15: “After 3 or 4 days of taking the medicine, discharge got 99.9 per cent cleared as if it

never occurred. Discharge is watery and colorless. From October 13 there is discharge again but less than before."

Calcarea carbonica 1000/3 powders at 15 minutes interval.

November 28: No complaints. *Saccharum lactis*.

1991

Letter dated **October 16:** "Medicine helped considerably. I am alright and have no trouble. There is occasional discharge. I had a fracture 6 months ago and can't walk so I could not come to see you nor did I feel the need. I have resolved to take your medicine only and undergo no tests"

Calcarea carbonica 1000/3 powders at 15 minutes interval.

1993

Letter dated **July 6:** "... slight discharge but no blood. For last 2 months much itching in genital region disturbing my sleep. I got an ultrasound done and report shows no abnormality. I will only take your medicine even if you give me milk sugar. Please don't tell my family about my illness. . ."

Calcarea carbonica 1000/3 powders at 15 minutes interval.

Letter dated **August 30:** "Much itching. Also burning. Blood with discharge off and on. Blood is slight, just spotting. Suffering from arthritis also, first in left knee and now on right side also. White discharge is much."

Carcinosin 200/3 powders at 15 minutes interval.

Letter dated **November 5:** "Itching M.B. 90% relief. Slight blood again. Just spotting. Leucorrhoea is always there."

Calcareo carbonica 1000/3 powders at 15 minutes interval.

1994

Letter dated **February 15:** Had been M.B. but discharge again last 10 days. More at night. White in colour, occasionally pale yellow, pain in knees.

“Please don’t ask me for gynae check. I feel afraid. I only want your medicine.”

Calcareo carbonica 1000/3 powders at 15 minutes interval.

Comments: It is to be noted that in this entire span of 5 years I had no opportunity to see the patient personally even once and had no proper gynae examination report to guide. In any case it is gratifying to see that she passed this period of 5 years without an operation and got rid of her horrifying symptom.

MENOPAUSAL FLUSHES

Mrs. L.L., a French lady, age 51 years, consulted on October 17, 1979. She had been married for 23 years and had one child in 1958 which died in June, 1979.

Complaints: Uncomfortable in abdomen — feeling of heaviness when very tired and depressed. Depressed at times especially after the death of her only daughter in June 1979. Feels very tired and low.

The most troublesome complaint was very bad hot flushes for the previous two years or more. She was using a homoeopathic combination “Vanocomplex (contains *Sepia*, *Sang.*, *Sulp-ac.*, *Lach.* etc.)”

Appetite: Good, non-vegetarian. Non-smoker. Stopped whisky some months ealier, would use beer with meals.

B.O.R.

Sleep: Good. Earlier had been using sleeping pills. No significant dreams.

Vaccination: Every 3 years for international travel (Husband, an airline official), last in October 1977. Antitetanus Serum given in 1975 gave a very bad reaction.

Sometimes itching after bath with no eruption and no urticaria.

No strong reactions to heat and cold.

M.P.: Menopause two-three years earlier.

Irritable: Flares up suddenly but then calms down quickly.

P.I.: Jaundice (infective hepatitis) 20 years ago, very bad attack was quite ill for 4 months and took 8 months to fully recover. Even now, S.G.O.T. and S.G.P.T. slightly raised.

1979

October 17: *Natrum muriaticum* 200/2 powders evening and bedtime on same day.

November 17: Hot flushes + +, very frequent, nearly all the time, makes her nervous when she gets the flush. Discomfort in abdomen is less.

Lachesis 200/3 powders noon, evening and bedtime on the same day.

December 8: After two and a half years had menses bleeding two days ago. Normal bleeding — copious on first day. Generally better and less tired.

Saccharum lactis.

December 28: Some recurrence of flushes.

Lachesis 200 repeated.

1980

January 23: No relief in flushes, headache most of the time, wakes up with it. No itching after bath.

Sulphuric acid 200/3 powders during evening and bedtime on the same day.

February 23: Flushes had been very bad — heat and perspiration.

Flushes especially felt on waking in morning.

Lachesis 1000/3 powders at half hourly interval.

April 9: Flushes continued for about 2 weeks but then suddenly stopped and has felt very comfortable for the last one month. Nausea feeling many times in day or night for the previous two weeks, at times actually vomited, can have in middle of night or on waking in the morning. One episode lasts 10-15 minutes.

Ipecacuanha 200/3 powders at bedtime on 3 consecutive nights.

Thereafter she left for Paris. I was sent information on **May 29** that nausea was relieved on reaching Paris and she asked for medicine for flushes.

Lachesis 1000/3 powders at half hourly interval.

Thereafter I received a letter dated **August 26, 1980** some extracts of which are reproduced:

“I would like to ask you whether you know of a good doctor in Libredille (Gabon) and also would it be possible for you to have prepared some of the very good medicine which helped me so well: Menopausal flushes which I took from December 28, 1979 to February 1980. Would it be possible to have such medicine in enough quantity for six months.”

I vividly remember her mentioning during the earlier period of treatment that she had many embarrassing moments when in the midst of formal parties by diplomats she would suddenly get the flush and with it anxiety and palpitation and then break out into a sweat.

CANCER CERVIX

Mrs. C.A. sends me a letter in March, 1993 reminding me of the successful treatment of her cancer many years ago and of her continuing good health. In fact she asked me if I was still in practice so that she could refer another patient from London. She herself had come to see me from South Africa.

Case History — Mrs. C.A. consulted on October 3, 1980. Age 52 years. She had been married for 31 years and had two children, aged 29 and 25. She had not had any abortion. She was having periodical Pap smear as a routine. Till 9 months earlier the report was always satisfactory. Later there was a slight change and so she had been suggested to have hysterectomy operation. For these 9 months she had tried Homoeopathic treatment locally and had received Galium. Three weeks earlier Pap smear showed that “the cells are multiplying more.” Now the doctors were more insistent for the operation.

M.P. — She had been on family planning pills for about 15 years. Prior to that M.P. was regular and normal and there was no dysmenorrhoea. When changes appeared in the Pap Smear, the pill was discontinued, i.e., 9 months earlier. There was no M.P. thereafter. In these 9 months slight leucorrhoeal discharge — pale lemon colour, medium consistency, no itching or burning.

Appetite — Good. Vegetarian for the last 9 months on the advice of the Homoeopath. Likes spicy food — “Food with some taste”. No extra salt.

B.O.R. — Been taking some herbs which make the stool softer but was not constipated even before that.

Sleep — good. Dreams occasional and nothing significant.

Vaccination-last was 3 weeks earlier but otherwise not frequent. Previous to this it was in 1947.

Not markedly hot or chilly but prefers the summer.

P.I. — Tonsil operation in childhood. Appendicectomy 29 years ago. Gout, "she ascribed it to emotional upset" 4 years ago, lasted about six weeks. Had pain all over the body and fever. It was diagnosed as Gout and treated accordingly. (I have my doubts if it was Gout).

1980

October 3: *Carcinosin* 200/3 powders morning, afternoon and bedtime of the same day followed by *Saccharum lactis* for 5 weeks.

Thereafter I received a letter dated November 27, 1980, part of which is reproduced below:

"Dear Dr. Chand, I feel you must be the first person to tell the good news to! On Monday 24th I had another test done and today my doctor phoned me in great excitement to say that the pathologist had just phoned him, in great excitement to ask what had Mrs. C.A. been doing since her last test — what treatment? For the slides are now completely clear and entirely different picture has emerged. Isn't that wonderful?! ..even the slight discharge has stopped".

Comments:

This is a remarkable cure from a potentially dreadful condition. Only a single divided dose of *Carcinosin* was needed. No further treatment was required.

NODULES — PAPILLOMAS LARYNX

Master G.B., age 5 years, consulted on **October 9, 1982** with the complaint that his voice got progressively reduced from the age of 1-1/2 years. One specialist opined that there was a small nodule which was likely to be alright by the age of 8 years. However, by June, '82 he had a breathing problem and cough without fever. He was operated. The parents were informed that there were a large number of nodules but only half of these could be removed. On August 29, he had suffocation at night and was operated in emergency. There were multiple papillomas above and below the vocal cords. Post-operatively the breathing was normal but not his voice. On September 6, he had again suffocation and the Throat Specialist said that now there are many more papillomas than before. A Tracheostomy was proposed.

He also had a nodule in left upper arm. This was tender. It had been noticed two years earlier. The child used to have cold and coughs frequently. He had been vaccinated for Small Pox only once after birth and had also received the 3 shots of Triple Vaccine and B.C.G.

The child had tendency to constipation. There was nothing significant in the rest of the history. No strong mentals or generals and no cravings and aversions.

In the **family history** a significant point was that both father and mother had warts which were cauterised. Grandmother suffers from Diabetes. No T.B. in the family.

On page 755 of Kent's Repertory two remedies are mentioned for **POLYPI**, vocal cords; Berb., *Thuja*. A reference to Boericke's Materia Medica P-121 (*Berberis vulgaris*): "Hoarseness; Polypus of Larynx."

He had been prescribed Thuja elsewhere. So I decided to try *Berberis vulgaris* to which I had no previous experience in this condition.

1982

October 9: He was given *Berberis vulgaris* 6/16 powders q.i.d.

October 12: Reported much better. The rattling and difficulty in breathing which was there even after operation is much reduced. He reported a general itching all over without eruption. This had been occurring on and off. It also occurred after Thuja. Repeated *Berberis vulgaris* 6/24 powders q.i.d.

October 18: Voice much better. No problem in breathing. In fact no symptoms and feeling quite normal and active. Sound sleep. Slight cough. Given *Saccharum lactis*.

* * *

On **January 26, 1994** I accidentally met his father, now a member of Delhi Legislative Assembly, at Republic Day party at Rashtrapati Bhawan. He again expressed gratitude for the recovery of Master G.B. who had continued well.

CHRONIC HOARSENESS — NODE ON VOCAL CORD

Mrs. D.K., age 32 years, consulted on September 4, 1982. She had been married 9 years with two children aged 8 and 5 and one M.T.P. on January 15, 1982.

Her complaints were Chronic Hoarseness for one year. In fact, she dated it precisely to September, 1981 and she felt it resulted after she was angry and shouted

on her children for 20 minutes or more. There was no sore throat or pain larynx, only a strain in talking. That same day she had also been exposed to dust in removing the curtains and washing them. In any case she had an old complaint of allergy to dust, perfumes, kerosene oil, etc. for 15 years. An exposure would result in bouts of sneezing, itching palate, root of nose and ears. In fact she used an antihistaminic (Incidal) almost continuously, at least once daily. This condition was better when she was at a hill-station, in winter months and when she stayed for some-time at Bangalore.

Appetite — Good. Non-vegetarian. No marked cravings. Sour $\pm$. B.O.R.

Sleep — Good. Using Incidal anyway. Dreams — Events of the day and sad and frightening dreams.

Vaccination — Only in childhood.

Hot patient — but hands and feet very cold in winter.

M.P. — Amenorrhoea. L.M.P. July 13, 1982. Before that regular. Pain before M.P., lower abdomen or lower back. No leucorrhoea.

P.I. — Typhoid at 5 years. C.S. for both deliveries.

F.H. — No diabetes, T.B., Asthma or any other significant ailment.

Report of ENT specialist “thickening of left Vocal Cord and a node.”

She had had Homoeopathic treatment elsewhere and received Arundo, Caust., Ambrosia, Spongia, Thuja etc. But they were all multiple prescriptions to which I give no importance.

Page 755 Polypi, vocal cords: Berb., Thuja.

1982

September 4: *Thuja occidentalis* 30, 200, 1000/1 powder of each on 3 consecutive days at bed-time in that order followed by *Saccharum lactis* for 20 days.

1983

January 12: She did not report in 3 weeks after the previous course was finished and came after 4 months. She had felt very much better in her voice and even in her allergy. Then she got malaria and as she was coming from another town could not contact me and took Allopathic treatment. After that there has been some recurrence of her symptoms.

If she washes face with warm water it gives headache and burning in eyes.

Thuja occidentalis 1000/3 powders at 15 minutes interval.

March 23: "Medicine of September 4, 1982 gave more relief than of January 12." Voice is better but gets much itching and irritation in palate, also in throat and ears and then nose, so uses anti-allergic tabs. < air-conditioned room. Anger increases allergy for 3-4 days. *Nux vomica* 200/3 powders at bed-time on 3 consecutive nights.

On **April 15** she was given *Nux vomica* 1000/1 powder at bed-time.

September 23: Had kept well for some months. Trouble again from end-August — sneezing, rhinorrhoea, watering eyes, feeling of much heat. These symptoms start in the morning and she takes Incidal tabs. Says that if she does not take the tab. then troubles continue through the day.

Hoarseness is much better "This is definite." ENT specialist is reluctant to admit that the node may have disappeared but he feels that since there is so much clinical improvement, no operation is now called for.

* * *

1987

May 4: After 4 years she comes again and we have a chance of follow-up. Her husband had been posted out of the country and that was the reason for no contact. Her voice continued to be normal. For her allergy she had had the allergy tests in U.S.A. where she had been these last 4 years and taken appropriate vaccine injections. These have not made any significant difference. That forms another long narration as the treatment continued till July, 1988 in which she got great relief. Almost the only remedy needed at intervals was *Pulsatilla* 200.

BILATERAL NODULES VOCAL CORDS

On July 4, 1987 I am consulted by a patient and the father of the patient, who accompanies her, pleads for very quick results and reminds me of his own immediate recovery so I took out his history. Mr. F.C.A. age 67 years consulted on **March 6, 1967**. His chief complaint was a hoarseness of voice for the previous 4 months. There was no pain, no cough and no expectoration. He had got into the habit of frequent hawking before being able to talk. For this complaint he had been to three noted E.N.T. specialists and the findings were "Both vocal cords thickened and also nodules in both vocal cords." He had been in the habit of always speaking somewhat loudly and in angry tone.

His other complaint was piles which he had had for 20 years. Occasional bleeding, bright red blood and fairly profuse quantity and as if "ejected from a syringe". He had a moderate craving for salt, thirst was average, he

wanted water very cold "almost frozen water or melting ice." For his weather reactions he felt both heat and cold excessively, earlier he had been hot patient. The only significant mental was sympathetic + + . He had not been vaccinated for the previous 20 years but had had it a number of times in childhood, in school and a few times subsequently.

As far as the local condition is concerned the Rubric that could be used is POLYPI, Vocal Cords on page 755 but considering his total history he was prescribed *Phosphorus* 200/3 powders to be taken at 15 minutes interval. The local remedy *Thuja occidentalis* was only noted in the margin of the history sheet. *Phosphorus* was given on **March 6, 1967**. He reported again on **March 18**, "no trouble in throat, voice better." He was given S.L. for a month and I never saw him again till he came with his daughter in **July 1987**, i.e. 20 years later. He said that he had completely recovered his normal voice and therefore did not report.

ASTHMA

Case No. 1 (A Patient with Parapsychology)

July 4, 1989, a lady brings her husband for treatment and mentions that she has been treated by me 12 years earlier for the same condition and has remained well since. I take out her old notes. Mrs. R.T. consulted on **September 13, 1977**. Then her age was 35 years, married for 12 years with four children. She gave a history of asthmatic attacks particularly in the last four years although she did have them occasionally even before. < winter > taking hot tea. There is no fever. She had been mostly prescribed the antibiotic Tetracycline. Attacks occurred around 2 A.M. and she has to sit-up during attacks.

Her other complaint was headaches to which she was particularly prone before and after menses. May be a hemicrania or pain in the vertex. When bad then in the whole head. No accompanying nausea. In food the only liking she mentions was for rice which does not appear in the Repertory. If she ate to repletion then she felt difficulty in digesting and a sense of heaviness. The dreams were mostly of her dead parents. Vaccinations had been infrequent and the last one was 16 years earlier. She feels both extremes — heat and cold. Perspiration + + for any exertion. Gets tired quickly.

A very unusual thing that she mentions was that she remembered her previous life and she remembered having died at the age of 17 years with breathing difficulty.

1977

September 9: Prescription: *Arsenicum album* 6, 30, 200/1 powder of each. Take in the morning, afternoon and bed-time of the same day.

September 26: Prescription: *Thuja occidentalis* 200/3 powders in evening and bed-time.

October 27: Reported better. Slight cough at night, easy expectoration — thick phlegm.

November 14: Cold — thick yellow discharge, Cough — phlegmy. No dyspnoea.

Pulsatilla 6/21 powders t.i.d.

December 7: Recurrence of cold and cough with same features as on November 14.

O.E.: No rhonchi (no wheezing)

Pulsatilla 6/24 powders q or t.i.d.

1978

January 6: Cough with much expectoration — purulent, feels bad smell from it — for previous 10 days, slight dyspnoea today morning “first time since starting treatment in September 1977.”

Prescribed: *Pulsatilla* 6/24 powders q or t.i.d.

March 27: Reported after a long gap. Said that the medicine helped the dyspnoea but the cough had persisted for which she used some antibiotic. At present gets some wheezing only at night around 3.30 A.M.

Natrum sulphuricum 6x/28 powders q.i.d.

April 5: Symptoms persist.

Arsenicum album 6/28 powders q.i.d.

April 12: Much better. Completely free of any trouble for the previous few days.

Gave her a stock of *Saccharum lactis* and as a standby some powders of *Arsenicum album* 6 to be used in case of an attack.

She found that the attack powders would invariably help and control the spasm.

June 9: She observed that there is aggravation for one or two days before menses. She also had headache before menses. In the Repertory the only remedy

mentioned on page 765 in the rubric, Asthmatic, menses, before is Sulphur in the III grade.

Sulphur 200/3 powders at half hourly interval to be taken on empty stomach.

June 28: Feeling well.

September 15: Been well, no asthma. But for the last few days again has sneezings. Also a patch of eruption on the upper back for the previous two weeks which on examination seems to be circinate.

Bacillinum 200/1 powder at bed time.

November 22: Complained of cough morning and evening and dyspnea at times.

Thuja occidentalis 200/3 powders every 4 hours and was also given a supply of *Arsenicum album* 30 to be used if she had any attack.

Was not seen thereafter till she appeared again after 11 years and as mentioned at the beginning, completely free of her ailments.

Apart from the clinical case those interested in metaphysical sciences and believe in rebirth may be interested in details of what is mentioned in para 3 of her history. I questioned her a little more and was informed that at the age of 4 she revealed the facts of her previous life to her parents informing them the village where she previously lived which was not very far from where she was at that time as also the identity of her parents in previous life and some other details. She was taken to that village and she recognised everything. Met her parents who were still alive and who corroborated her story. They had two daughters and one of them died at the age of 17 years as mentioned by the patient (then aged 4 years) of some respiratory condition. On enquiry I elicited that there was a difference of one year between her death and rebirth. It is also to be noted that in both

lives she had a respiratory problem. Are diseases inherited or rather carried over to future lives also?!

Case No. 2: (Use of Sulphurous Acid in Asthma)

Mr. V.S.A., age 34 years, consulted on **September 25, 1987**. He had breathing problem as also urticaria, both of which are recognised allergic conditions. He had suffered from these for the previous five years and his treatment had included steroids. To be brief I will not give the details of the rest of the history and treatment but would mention something of interest that came out at the time of his third visit on **October 27, 1987**. He reported that his condition was worse which I was wondering as a possible result of the change of season. When he himself mentioned that may be it is due to diesel fumes and dust. I was immediately reminded of the remedy *Sulphurous acid* which was administered in repeated doses in the 30th potency. Altogether 28 powders were dispensed and he was asked to stop as soon as he felt better. His next report on **November 9th** was one of great relief. On **November 23**, he mentioned of having had some attacks in the previous fortnight then he was given *Sulphurous acid* 200 and he remained free of attacks till **June 1988** when the remedy was repeated.

Attention was particularly drawn to this remedy by Dr. Wm. Gutman, Chairman, Homoeopathic Research Council of LMHI. He did research on this remedy and presented a very interesting paper at the International Homoeopathic Congress held at New Delhi in October 1967. The full paper can be seen in its transactions.

Case No. 3: (Asthma)

Baby M.R., age 2 years consulted on November 14, 1977. He was getting attacks of dyspnoea (asthma). The

first attack occurred at the of age of 7 months when the baby got exposed and had fever. Had had a particularly bad attack three months earlier. Tends to get vomiting in attacks. < changes of season < cold things < Nocte-after 2-3 A.M. Sits up in attack. For the previous three days was suffering from a phlegmy cough. His other complaints were that he was bedwetting many times every night. He was fond of cold things — cold drinks, ice cream etc. Very fond of tea. He had had small pox vaccination once, also B.C.G., D.P.T. and Polio. No special reaction to heat and cold, nothing special about perspiration, no history of Pica. Prone to insect bites.

P.I. S.O.M. — two months earlier. No recurrence. No H/O skin disease and no other significant ailment.

F.H. Mother used to suffer from frequent sore throat and had had tonsillectomy operation. No history of Asthma or other allergies. Has a brother and sister who are healthy. No T.B. in the family.

Investigations: He had already had an X-ray of the Chest which showed no abnormality. Mantoux test had been done and was reported as positive (15 mm). Eosinophil count was 10%.

1977

November 14: Prescribed *Ipecacuanha* 6/16 powders t. or q.i.d. to be followed by *Nux vomica* 200/1 powder at bedtime.

November 28: Breathing alright, has slight cold and cough. *Saccharum lactis* continued.

For a mild attack *Ipecacuanha* 6/18 powders were given on **December 21**, and this was repeated on **January 18, 1978** for a lingering cough.

1978

March 18: Reported with a cold and cough but no dyspnoea and no wheeze. Additionally he was having diarrhoea for the previous two days. He was then prescribed *Pulsatilla* 30/18 powders t. or q.i.d. He had diarrhoea again in April and on **April 11**, had a repeat of the same prescription. The parents felt that since there had been practically no trouble or very little through the winter months as also during spring change they did not come for further advice.

August 23: I see him again with the complaint of cough, occasional vomiting but no breathing trouble. Is given a repeat of *Ipecacuanha* 6 for 4 days.

September 2: Reports again, now he has skin eruption with itching. The eruption has scabs and crusts and in some areas there is oozing of pus. The eruption had appeared a week earlier.

Prescribed: *Rhus toxicodendron* 200/3 powders to be taken on the same day.

September 7: Reported with fever 100°F. Cough and wheezing.

Ipecacuanha 6/12 powders q.i.d.

This was repeated on **October 30**. This is the time of the change of season and apparently he showed some tendency to have cough off and on and occasional vomiting. The bedwetting continued and the father additionally mentioned that injuries tend to fester. In my notes there is no mention of the skin but there may have been a slight recurrence as *Rhus toxicodendron* has been repeated on **November 22**. He was last seen on **December 15** when he was given *Ipecacuanha* 30/24 powders t. or q.i.d.

* * *

1982-1985

After more than three years on **November 16, 1982** his father brought his niece for consultation and said "because I have very good experience in the treatment of my son I have brought another patient. My son is growing well and has none of the troubles for which he was treated in 1977-78." It so happens that I saw M.R. again on **October 16, 1985**, now aged 10 years. There was nothing much that he needed treatment for. He mentioned only two things:

(1) Obesity and (2) Some pityriasis like spots which were nonitchy.

It is noteworthy that they reiterated that ever since his treatment for asthma in 1979 he had been completely alright: "not even cough for a day since."

Case No. 4: (Asthma)

March 19, 1990 a patient tells me "please cure me as you cured my relation R.G.J., who is quite well after your treatment." Mr. R.G.J. age 41 years, consulted on **May 15, 1984**. Married 10 years, has four children, working as a Supervisor in a thermal power plant with some exposure to ammonia. His complaint was breathing difficulty for 7 months. Mostly felt in the evening after dinner. It does not occur after lunch and it does not occur or occurs very mildly if he does not take dinner. There is a feeling of heaviness and distension abdomen and then some discomfort in throat and some choking feeling which is felt as secondary to abdominal distension. There is no cough and no expectoration. < By taking cold things < after 2 a.m. Has to be leaning forward for relief, sitting or standing against a wall. Vaccinations for Small pox — last in 1976, yearly before that. Had similar trouble in 1977-78. After treatment was well for two and

half years. Thereafter mild and occasional trouble. But more so in the previous 7 months.

P.I.: Stray expiratory rhonchi. Is presently using allopathic medicine — Bronchodilators, mostly Selbutol.

1984

May 15: Prescribed: *Arsenicum album* 30/18 powders, every four to six hours.

May 19: Been able to discontinue the allopathic medicine, and generally well. Had dyspnoea only one night.

Thuja occidentalis 30,200,1000/1 powder of each at bedtime on three consecutive days. So that he may not need the Bronchodilators he was given *Arsenicum album* 30 to keep and use only in case he had an attack.

June 30: In the previous six weeks had attack only once at 3.00 a.m. Took *Arsenicum album* at that time and again in the morning and was relieved. *Thuja occidentalis* 1000/1 powder at bedtime.

August 11: Had trouble two weeks ago and it continued for one week. Repeated *Thuja occidentalis* 1000/3 powders at 15 minutes interval. For recurrences the same was repeated twice on November 24 and December 29. Thereafter he was seen from time to time till July 1988 but no recurrence and no medication.

Case No. 5: (Asthma)

On September 11, 1991 I am consulted by a patient of Asthma and he says he has been referred by his uncle and father of Miss M.S., who had been treated for a similar complaint many years ago and got cured and is completely well since.

Miss M.S. consulted on **June 23, 1973**, age 4 years and a diagnosed case of Allergic Bronchitis (Bronchial Asthma). She had suffered from it for the previous one

year. < change of weather. The change results in cold and cough and later dyspnoea and wheezing. At times controlled by use of Bronchodilator tablets but other times it is so severe that she has to have injections. Cough is mostly dry, during attack tendency to vomit. She is prone to vomiting even otherwise, as by a little over-eating. She keeps lying in attack but does not eat anything as long as the attack lasts. Her only other complaint was a frequent pain in the abdomen which is only relieved by passing the stool and may last two to three hours. She bends double with pain. Pain in the legs by exertion and according to parents "since she got weak in the last one year." They feel that "she had reduced by 33%."

Appetite is poor; likes sweets and ice-creams.

B.O.R. but not a good stool, either loose and copious or very hard.

Talks in her sleep mostly not intelligible, occasionally gets up and says there was a snake; my brother beat me; my aunt beat me.

Has been vaccinated for Smallpox twice. Second time 4 months earlier.

Chilly patient.

P.I.: Measles recently. Nil else. In fact had been very normal in her health and development till the age of 3 years.

T. & D.L.C. 13050. P 35 L59 MI E5. Stool examination — N.A.D.

Weight 27 lbs.

1973

June 23: *Magnesia phosphorica* 6x, 30, 200/1 powder of each on same day.

July 5: Had slight cough two or three times. Pain abdomen three to four times; gets tired easily.

Sulphur 200/1 powder in morning on empty stomach.

July 9: Had cough for two days and breathing trouble from the 8th. Has had vomiting number of times.

Ipecacuanha 30/16 powders every 3 to 5 hours.

July 25: Another attack one week earlier. Had again been given *Ipecacuanha* and attack had subsided in a day. Gets easily chilled, as after a bath especially head wash, gets sneezes and cough. Also feels cold when given a bath. She felt better in most symptoms.

August 12: No attack of Asthma. Appetite variable. Now some days it is excessive. Headache is much better. It used to be very frequent, now rare. No longer talks in sleep.

September 4: No attack. Appetite improved.

September 28: Had attack on September 7. Took *Ipecacuanha* 30 and it controlled quickly. Has a skin eruption like a rash (papular). Itching. *Sulphur* 200/1 powder.

October 12: Had an attack few days ago but very mild. Rattly cough, vomiting. Skin is much better but not yet completely normal.

November 14: Much grinding of teeth, anorexia, at times pain abdomen.

Scirrhinum 200/1 powder at bedtime.

December 19: Stool examination N.A.D. Pain abdomen, grinding teeth, anal itching. No asthma attack as was usual in the season.

Cina 200/1 powder at bedtime.

1974

February 1: Feeling well, no pain abdomen, appetite increased, no attack, no grinding teeth, no anal itching. Used *Ipecacuanha* for occasional cough.

March 9: Had an attack at the end of February. Used *Ipecacuanha* and got well. "The attack was very mild — 25%."

O.E. No wheeze (rhonchi)

Weight: 31 lbs.

March 15: Feeling well.

April 19: Sneezings from April 1, invariably in the morning. Sleeps much. Aching limbs towards evening. General sluggishness and tired feeling.

Calcarea carbonica 200/3 powders at 4 hourly interval.

June 25: Much better.

July 12: Sneezings with a certain brand of soap, not otherwise. No attack for many months. Grinding teeth again. *Tuberculinum* 200/1 powder at bedtime.

August 13: Appetite increased, may be more than normal. Hunger after stool. *Petroleum* 200/1 powder at bedtime.

September 20: Complained of a persisting dry cough for some weeks without any asthma.

Spongia tosta 30/12 powders q.i.d.

October 8: Much better but cough keeps recurring and in sleep or while laughing there is slight wheeze.

O.E. No rhonchi.

November 18: I felt that she should have received earlier a dose of *Thuja occidentalis* having been vaccinated twice and the second time soon before the start of asthma so it was given now.

Thuja occidentalis 200/1 powder at bedtime.

1975

January 11: No attack. Appetite + + . Goes for stool two-three times — sometimes loose and big.

Weight 35 lbs. (an increase of 8 lbs. in 18 months).

Sulphur 200/3 powders at 10 minutes interval in the morning.

Kept well thereafter. Last seen on **June 9, 1975**, having no complaints. O.E. Chest N.A.D.

Consulted again, at age 15 years. No recurrence of Asthma. Conscious of her looks and came for many prominent white-heads on the face. Explained to her that this was usual during adolescence and she was lucky that she did not have Acne.

Case No. 6: (Bronchial Asthma)

Mr. A.S.B., age 37 years, consults on **March 16, 1990** with a history of having suffered from Bronchial Asthma from childhood. In giving the history to my Assistant he mentioned that he had been treated by me in 1982 with what seemed to him a complete and permanent cure and for 7 years thereafter he had lived absolutely normal life without observing any restrictions in diet or otherwise. He mentioned this with much gratitude. In fact also reminded that when he came the first time he had to be brought supported by some attendants. A year earlier he had visited a Chemist shop to get medicines for someone else. At this place he was exposed to the smell/smoke of burning incense. That night he again had a recurrence of his Asthma. Also during the previous winter months on one or two occasions he had a very mild trouble but that would clear by morning. The remedy that had helped him for attacks in 1982 was *Arsenicum album*. The same was repeated by the Assistant but he came a week later saying that it did not help and he used a Bronchodilator. I asked him the time of aggravation and he put it as between 2 and 3 A.M.

Prescribed: *Kali arsenicosum* 30/24 powders q or t.i.d.

Next reported on April 13. Feeling alright. No trouble at all. He was given *Saccharum lactis* and separately *Kali arsenicosum* 30 to keep in case there was a recurrence.

EXPERIENCES WITH SOME RARELY USED REMEDIES* (HISTAMINUM AND AETHIOPS ANTIMONIALIS)

All remedies in the Homoeopathic Materia Medica have not had their introduction or usage in the classical and ideal way of "*Provings on the healthy*". There are many remedies which have been introduced on the basis of "*Provings on the sick (clinical provings)*". And there are others that have been introduced on the basis of "*toxological data.*" The latter two approaches have also served a useful purpose. Besides it is to be remembered that the basis for prescription even for the most Hahnemannian — Kentian prescribers, can be other than symptomatic totality. Just to give a few examples it may be miasmatic, etiological, tautopathic, isopathic (nosodes), organopathic etc. It is against this background that some unproved remedies that I have tried are presented.

* Paper presented at the 43rd Congress of the International Homoeopathic Medical League, Athens, May 1988 (Theme: Rarely used Remedies).

HISTAMINUM

Histaminum has had no proving. It has been much studied in research labs. in recent decades because of its association with allergic conditions and the increasing incidence of such conditions. There has been some experimental work with a Homoeopathic potency (7CH) of *Histaminum*.

In *in vitro* experiments with *Histaminum* 7CH it was noted that a blocking of the degranulation of Basophils was observed. This was so for haptens as well as for multivalent antigens. Double blind trials were carried out on two ordinary batches, one of which was distilled water. The blockage was systematically observed with the same batch (*Histaminum* 7C) whereas the other one (Distilled water 7C) showed no activity whatsoever. The allergens selected for the *Histaminum* trials were both proteins (molds, mites, dremoskeleton, retinal antigens) and drugs. Certain of these allergens were haptens.

I received this preparation from the *Homoeopathic Pharmacopoeia Laboratory of the Government of India* in 1985 and since then have tried it in about half a dozen cases of allergy (allergic rhinitis and asthma) on an experimental basis, chiefly where indicated remedies were not succeeding. Some of the case showed a remarkable response. While in a few it did not seem to have much effect. This would also indicate that further work needs to be done to find out its range of action and any special indications. I have not tried it in urticaria or allergic dermatoses.

Case No. 7 (Use of *Histaminum* in Asthma)

Mrs. I.R.N., age 38 years first consulted me on October 31, 1983. She had been married 14 years and had two children aged 13 and 7 years. Her complaint was

Asthma from which she had suffered for the previous 13 years, in fact had started within one month of the birth of her first child. Six months earlier she had changed residence as her husband had been posted to Bangkok (Thailand). The attacks were seasonal starting in the Spring and occurring more frequently through the Summer months (March to October).

< Rains and humidity < dust < exertion < in closed rooms. Wants fresh air, feels suffocated in closed rooms which brings on attacks.

> cold things. She is also very fond of cold drinks and these ameliorate. She had been vaccinated for Small Pox a number of times while at school, later in 1969 and 1975.

The medication and response and other conditions that she had later could make it too long for the purpose of this paper. She was seen from time to time during the next two years. I would describe from the autumn of 1985. She was seen on **September 20, 1985** with an Asthma attack for the previous 4 days. < 1-1.30 A.M.; has to sit-up, no vomiting, no expectoration, dry cough. Prescribed *Arsenicum album* 30/28 powders q.i.d. Although there was no relief but she repeated the prescription on her own on September 27.

1985

October 5: She reported to me again. By then she had had persistent trouble through the previous 25 days. As the indicated remedy had not helped, I decided to try the new remedy *Histaminum* 7CH of which she was given 24 powders q.i.d.

October 11: Reported better, "At least I can sleep but have some choking feeling in the morning." Still has cough. *Histaminum* 7CH was repeated and in my absence on October 18, the same prescription was

repeated a third time. So altogether it was used for about 18 days.

I saw her again on **November 22**. She had been much better and had no attack for the previous six weeks since she had used *Histaminum*.

1986

I did not see her again for 10 months till the end of **September 1986** when she sent for medicine only as a precaution fearing an attack at the change of season. To watch the condition she was given only *Saccharum lactis* and no remedy till **January 14, 1987** when she was again going in for an attack and she was given *Histaminum* 7CH/24 powders q.i.d.

1987

January 23: Breathing better. Still has cough. Repeated *Histaminum*.

February 6: Much better. Cough also practically cleared. She mentioned that if she misses a powder specially at night then she has slight premonition of trouble at night. Given *Saccharum lactis*. She needed only one repeat of *Histaminum* on April 6, and she continued well till July 31. At that time the atmosphere was very dusty in Delhi and she felt a recurrence. *Histaminum* 7CH/28 powders q.i.d. cleared the condition.

Comments: *Histaminum* may not have fully cured this case of Asthma but it very definitely helped to control the attacks and most likely made them less frequent.

A case of *Allergic Rhinitis* where *Histaminum* was used is described on page 115.

Aethiops antimonialis is dealt with later with cases of skin eruption.

BRONCHIECTASIS/ASTHMA

Mr. R.S., age 22 years, son of a doctor, consulted on August 9, 1978. He came from a city about 1200 kms from Delhi, so after the first consultation and the report in two weeks, which time he stayed in Delhi to watch the effect, the subsequent reports were by letter.

Complaints — He had cold, cough, fever, acute chest pain and breathing difficulty 7 years ago. The trouble has recurred frequently since and it takes long to get well by use of antibiotics. He uses these for 2-3 weeks in every episode. In addition, he also uses Tedral — a bronchodilator. Even without an attack he gets pain in the left chest off and on which lasts for a few hours. < deep inspiration. < wet weather — this may give him an attack. Has always had a tendency to frequent colds.

Appetite — Good. Non-vegetarian. Sweets ±.

B.O.R. Some tendency to diarrhoea.

Sleep — Late falling off to sleep. Dreams-at times frightening — of snakes, of getting stabbed, etc.

Vaccination — Frequent — yearly — last in 1977.

No strong weather reactions. Perspiration + +.

P.I. — Measles, January 1978. Jaundice, 1972.

F.H. — Maternal Grandmother and father diabetic.

Investigations — X-ray Chest-Bronchiectasis left side with secondary infection in posterior basal region.

E.S.R. — 22 mm T. and D.L.C. — 11,200; P72L26E2
No A.F.B. in sputum.

1978

August 9: *Thuja occidentalis* 30, 200, 1000/1 powder of each at bed time on 3 consecutive nights in that order.

August 24: He had slight fever after getting wet in rain (it is the rainy season in Delhi). The fever was for one day only. Sleeping better. No cough.

Sac-lac continued.

Letter dated **September 18** — "... am in fairly good health except for two troubles:

- (i) I am having cough more frequently than last time when I was in Delhi and after cycling the cough increases and when I am bit overstrained by cycling (3-4 kms. of cycling), the colour of cough becomes rusty (dull red) and there is a pain in left chest at the middle. (By cough he means expectoration)
- (ii) I am feeling a sort of indigestion every now and then and there is belching and sometimes acidity."

Thuja occidentalis 1000/3 powders at half hourly interval.

Letter dated **October 23:** "This month I have been quite well except for an occasional cold. I had no fever and not much chest pain, but cough remains though it is much less frequent than previous days." Much better.

Saccharum lactis continued.

December 15: There are no notes but probably a telephone report about his continuing complaint of flatulence and eructations.

Carbo vegetabilis 6x, 30, 200/1 powder of each at bed time on 3 consecutive nights.

1979

February 15: The last report of a slight tendency to recurrence of cough through the winter months.

Thuja occidentalis 1000/3 powders at half hourly interval.

1980

I did not hear from Mr. R.S. after February, 1979 but on June 12, 1980 his uncle came to consult for someone else and said that R.S. is "totally cured and has no complaints whatsoever and is vigorously pursuing higher education."

Comments:

It would be noticed that the same remedy carried him through to a complete cure. It was mainly prescribed on the history of frequent vaccinations and since it is an antisycotic remedy it also covered the catarrhal condition and a hydrogenoid constitution.

CANCER LUNG

Mrs. J.K., age 50 years consulted on June 5, 1976. She had been married 30 years and had 3 children, eldest 28 and youngest 22. One had died at the age of 2 years which she alleged was "due to black magic." She came from another city and the family members informed me of the frightening diagnosis of cancer lung. She was a rustic woman with a rural background and apparently seemed quite composed and oblivious to her dangerous disease.

Complaints — Cough for the previous few months, was very bad in the month of March. Cough is dry.

Breathing difficulty.

Distention upper abdomen. Sharp pains right hypochondrium specially for the last 3 months but had some discomfort in the area even earlier.

Burning soles and palms — 10 years. Feels if she has enough rest, the burning is less and vice versa.

Appetite — Fair, but heaviness p.c.

B.O.R. though not satisfactory.

Sleep — Poor. Dreams of the dead in March, 1976.

Vaccination — In childhood.

Weather reaction not clear. Probably stands both heat and cold well.

P.I. — Difficulty passing urine, passed in drops, burning and unsatisfied feeling 10 years ago. Renal Colic 3 years ago.

O.E. — Heart and abdomen normal. No hepatomegaly. Bronchial breathing and crepitations right mid chest. *X-ray report* (April, 1976): "Lung fields appear emphysematous. *Mass in right hilum*. Costophrenic angles clear. *Right dome of diaphragm raised*." "*Right hilar lymphadenopathy, possibility of Bronchogenic Carcinoma*." X-Ray pictures were taken twice (on April 5 and April 12, 1976). The second radiograph was taken in order to confirm the findings before pronouncing the diagnosis.

Biopsy (specimen taken through Bronchoscope) showed *malignancy ?Bronchogenic Carcinoma*.

1976

June 5: *Carcinosin* 200/3 powders at 10 minutes interval.

June 30: Had fever on June 12 for 2-3 days. Cough p.c.

Arsenicum album 30/15 powders t.i.d. followed by sac-lac.

July 23: Cough is less. Says she used to have bad odour from mouth and also burning abdomen. Now both of these symptoms are relieved. Now main trouble is pain right chest, right hypochondrium and back, on right side. Had this pain 12 days ago and recurred 4 days earlier at which time she was given Baralgan injection.

O.E. — Very feeble breath sound right upper chest.
Chelidonium majus 6/20 powders q.i.d.

July 24: As *Chelidonium* did not give any quick relief and she reported again the next day she was given *Magnesia phosphorica* 6x/10 powders every 4 hours in warm water.

August 3: "Pain was relieved. No burning abdomen. No bad smell mouth." Having much cough — dry. Burning palms and soles. Leucorrhoea-yellow like turmeric, stiffens the clothes.

Spongia tosta 6/21 powders t.i.d. followed by *Saccharum lactis*.

Saccharum lactis was repeated on Sept. 11 as she was feeling better.

November 2: M.B. — General Health better. Cough after eating and not severe. Dry cough > drinking "It is from very dry throat." Breathless on exertion. Burning palms and soles okay.

Spongia tosta 30/9 powders t.i.d.

December 11: Had been better in interim but now cough is again troublesome and involuntary urine with cough.

Phosphorus 30/9 powders t.i.d.

December 18: "I felt very well for the last 2-3 months as if no trouble at all. However, for the last 2 weeks cough is bothering me."

Spongia tosta 30/16 powders q.i.d.

December 21: Still coughing. Cough spasmodic. Metallic sound in cough > if can expectorate.

Sanguinaria canadensis 30/16 powders q.i.d.

December 25: Much relief in cough. *Saccharum lactis*/30 powders t.i.d.

1977

January 4: Improvement maintained. C/o pain in calves. She carried on well through rest of the year and will only keep some *Sanguinaria canadensis* powders in case she got cough but these were used only 3 or 4 times during the next 18 months. There was no regular treatment. She would write from time to time informing about her welfare and asking for repeat of medicines. The last communication was on **October 18, 1978** when as usual she was sent *Saccharum lactis* for three weeks and cough medicine (*Sanguinaria canadensis* 30/16 powders).

1979

November 23: After a gap of one year of the last communication and nearly 3 years after her previous visit, she came personally. She said that she gets cough from time to time. There is heaviness right hypochondrium, occasionally a momentary pain — a stab. At times difficulty swallowing, then it goes down only by taking some sips of water. The feeling is in throat and not midchest. No expectoration, dry cough. Pain legs on exertion. Burning palms and soles and at times heat in head, eyes, temples, nose also. Urine quantity reduced by exposure to heat then feels some burning.

O.E. — Heart, lungs and abdomen N.A.D. Liver not palpable. In my notes in the margin I have put Puls. and Sulph but in view of past experience I prescribed *Sanguinaria canadensis* 30/16 powders q.i.d.

December 4: Much better.

1980

February 20: Weakness. Dyspnoea even on very moderate exertion. Leucorrhoea greenish, thick. She

had a very early menopause. Possibly soon after her last child, that is in her early 30s.

Sepia 200/3 powders on the same day.

1981

There was no contact for 16 months till she reported again on June 22, 1981. She had carried on well till mid-January, 1981. On 15 January she was indiscrete in her eating at a wedding party. Since then cough has persisted. Feels a sense of strangling of throat, "Can't bear even light cloth to touch the neck on lying — as if being pressed or strangled." Cough lying. No expectoration. Tongue slightly cyanotic.

Lachesis 30/12 powders q.i.d. followed by *Saccharum lactis*.

There have been no subsequent contacts but what is significant is that she not only lived for 5 years after the initial diagnosis but in fact kept reasonably well. Whether eventually she passed away from cancer or any other ailment or hopefully is still living, it is not possible to ascertain.

The report of the X-Ray picture taken on June 15, 1981 is as follows: "Dense opacity right hilum region with fibrotic band like shadows extending from it through the right lung mainly in the right upper zone. Rest of lung fields show prominent bronchial markings and suspicious miliary shadows marked on right side. Malignancy to be kept in consideration."

CHRONIC COUGH

Mrs. C.V., I relate her case for two reasons, firstly, the tremendous benefit she had from simple homoeopathic treatment, which is of course not unusual. Secondly, how mistakes are made in diagnosis and a system of therapy where treatment is based on diagnosis would obviously be completely on the wrong track because of such a mistake.

Mrs. C.V., consulted me on April 27, 1985, age 60 years, she had been a widow since 1973. Had six children, eldest 38 and youngest 22. Her trouble started with a fever in 1979. The duration of the fever was only 10 days. However, the tests showed an E.S.R. of 120, and the interpretation of the signs in the Chest X-ray by the radiologist and medical specialist was that she is suffering from T.B. Accordingly, she was put on anti-tuberculosis treatment (A.T.T.). With this she lost all appetite and sleep. Then she consulted another specialist who declared "No T.B." and A.T.T. was stopped. She was examined in a teaching hospital (Rohtak Medical College Hospital) where the diagnosis was simply put as P.U.O. Their notes show "Systemic examination — NAD, X-ray chest and abdomen — normal. Lungs — clear."

Thereafter she remained well for three years and then had a recurrence of fever which was again diagnosed as T.B. and put on A.T.T. However, the following day an X-ray of the chest was taken on the basis of which the opinion on the diagnosis was changed and A.T.T. stopped. The opinion expressed was:

- "A. Pulmonary Tuberculosis unlikely
- B. ? Bronchial Cancer;
? Lymphoma;
? Other causes."

Bronchoscopy was done and it was declared as Cancer and they were so sure of the diagnosis that without waiting for the biopsy report she was given a sitting of Radiotherapy. The Biopsy Report was negative for Cancer. The examination was repeated and again the report was negative. Thereafter she went in for Ayurvedic treatment which she carried on for six months without any change in her condition. By now the temperature was normal but she was having cough which started after the Bronchoscopy. For this the Allopaths again put her on A.T.T. which was carried on for six months. Thereafter a follow-up X-ray of the Chest showed increase of patch in lungs but she was otherwise maintaining normal health and there had been no loss of weight. However, she could not exert much.

The cough was erratic in that there were no particular modalities except a peculiar one mentioned later. Dry cough with no expectoration at all. Her own feeling was that it was due to gas accumulation as she felt better if she kept passing flatus. Two months earlier she had had blood with the morning spit for three to four days. My own feeling is that it is very often from the gums and not necessarily a haemoptysis from the lungs. Burning in chest. Pain in chest "from gas". Also pain back with eructations. I could not get anything significant in rest of her history and any marked generals.

A major complaint in the past had been excessive uterine bleeding for which they doubted cancer and carried out hysterectomy 10 years earlier. Biopsy report ruled out malignancy.

Her general health was good and there was no adenitis.

1985

April 27: She was prescribed *Spongia tosta* 6,30,200/1 powder of each.

May 3: Reported after one week complaining of "much gas". Says if she uses an antacid (Gelusil) it helps both in the gas as well as the cough. Because of her persistently harping about gas and the relief from passing it, prescribed *Carbo vegetabilis* 200/3 powders to be taken on the same day.

She was from an another town and subsequently I only received messages on **June 13** and **August 31**, and the usual message would be that "she is much better." The obvious prescription therefore continued to be Placebo. Thereafter I received a letter dated **November 16, 1985** and she continued to report of feeling better and asking for medicine to be sent by post.

Her daughter came to consult me in **December 1989**, and reminded me of the benefit of the treatment that her mother Mrs. C.V. had received.

CARDIAC NEUROSES

Mr. K.K.C., age 28 years, bachelor, consulted on January 23, 1960. He complained of pain in the region of the heart and the corresponding spot on the back is tender. Also when he sits pressing his back against the chair then feels pain in the praecordial region in front. < mental disturbance or stress. He mentioned of a peculiar sensation — sensation as if blood drips from heart to left lateral region of abdomen. Afterwards the region feels cold. The prescription was based on this very peculiar symptom. On page 832 of Kent's Repertory there is only one remedy against FALLING, sensation, drops were falling from the heart: Cann-s. This is confirmed in Boericke's Materia Medica on page 163 under Heart.

1960

January 23: Prescription: *Cannabis sativa* 200/1 powder followed by *Saccharum lactis*.

February 3: Reported that he had immediate improvement and was alright for one week. Then he took a heavy meal which was followed by a recurrence of slight pain and thereafter again the sensation of drops falling.

Saccharum lactis was continued.

March 3: Had been well the entire month but in the previous two days had a bad cold and he did not have his breakfast. On those evenings he did not have the drip sensation but as if a cold fluid is spreading outwards in a circular manner from the praecordium. Also slight pain. He is prone to these colds at changes of season in March and September. Lots of sneezings and watery flow.

Prescribed: *Sabadilla officinarum* 3/16 powders at 3 to 5 hours interval.

April 4: Whenever there is anything depressing or he is anxious then he is conscious of some discomfort in praecordium of various types and also dropping sensation as mentioned earlier. A fluttering sensation in the chest also. At the time of these sensations in the chest he gets quite disturbed and gets a sweat on the forehead, the body feels cold as also the hands — a sort of feeling of exhaustion. If flatus keeps passing he feels comfortable. Usually no eructation but when he gets this praecordial discomfort then has eructations next morning or next day.

Repeated *Cannabis sativa* 200/1 powder. Thereafter he kept well and needed repeat of this medicine on July 8 and October 22, when there was tendency to recurrence of symptoms.

* * *

He was seen in April 1969, for a totally different complaint and on enquiry he said that there had been absolutely no recurrence of his old heart symptoms.

I had news of him from some other family members even in 1980s and was told that he is well with no recurrence of symptoms.

PAIN CHEST

Mr. A.M. age 19 years consulted on June 20, 1980. Not married. Degree student.

Complaints: (1) The first complaint he made that he has got lines on his chest near shoulder, back and lower abdomen for the previous two and a half years. On examination these looked like lineae atrophicae. Seen on the abdomen of women that have borne children. He

CARDIAC NEUROSES

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Saccharum lactis was continued.

March 3: Had been well the entire month but in the previous two days had a bad cold and he did not have his breakfast. On those evenings he did not have the drip sensation but as if a cold fluid is spreading outwards in a circular manner from the praecordium. Also slight pain. He is prone to these colds at changes of season in March and September. Lots of sneezings and watery flow.

Prescribed: *Sabadilla officinarum* 3/16 powders at 3 to 5 hours interval.

April 4: Whenever there is anything depressing or he is anxious then he is conscious of some discomfort in praecordium of various types and also dropping sensation as mentioned earlier. A fluttering sensation in the chest also. At the time of these sensations in the chest he gets quite disturbed and gets a sweat on the forehead, the body feels cold as also the hands — a sort of feeling of exhaustion. If flatus keeps passing he feels comfortable. Usually no eructation but when he gets this praecordial discomfort then has eructations next morning or next day.

Repeated *Cannabis sativa* 200/1 powder. Thereafter he kept well and needed repeat of this medicine on July 8 and October 22, when there was tendency to recurrence of symptoms.

* * *

He was seen in April 1969, for a totally different complaint and on enquiry he said that there had been absolutely no recurrence of his old heart symptoms.

I had news of him from some other family members even in 1980s and was told that he is well with no recurrence of symptoms.

PAIN CHEST

Mr. A.M. age 19 years consulted on June 20, 1980. Not married. Degree student.

Complaints: (1) The first complaint he made that he has got lines on his chest near shoulder, back and lower abdomen for the previous two and a half years. On examination these looked like lineae atrophicae. Seen on the abdomen of women that have borne children. He

has had it for the previous two and a half years even though there had been no remarkable change, increase or decrease in his weight. (2) Pain chest also for two and a half years. No special time and no relation to exertion. Possibly more ascending stairs. (3) Weak vision. Using glass for two and a half years. Number 0.75 D. (4) Hair falling one year. Slight dandruff. No itching. (5) Acne off and on.

Appetite — Good. Likes meat. B.O.R.

Sleep good. Talks in sleep from childhood.

Vaccination — Yearly in school, last three years ago.

Hot patient.

P.I. — Nil of note.

O.E. — Heart, lungs, abdomen — N.A.D. Wt. 164 lbs.

1980

June 20: *Sulphur* 200/3 powders at 15 minutes interval.

July 18: No pain in the chest. Symptom number 1 same. *Saccharum lactis*.

* * *

1983

Seen again on **August 2, 1983** after a gap of three years. Now finished his education and in transport business. Apparently, he had stopped the previous treatment too soon as he now again complained of pain chest < winters. Occurs occasionally at night and less often in day. Can last 5-30 minutes. The pain is over lower sternum. < eating unhygienic food from the market.

2. Glasses number — 1.5 D

3. Hair falling — 2 years. Felt better after using *Arnica* hair oil. There is sweating with hunger > p.c. Started to smoke one cigarette a day. Feels tired and

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PYROGEN IN A CASE OF SUBACUTE BACTERIAL ENDOCARDITIS*

Mrs. P.W.J., age 67 years. Late in the evening of February 20, 1964, I was approached to see this lady, whose condition was described as very serious. I was also shown the diagnosis slip of a medical specialist who attended on her till then. It read "*Rheumatic Heart Disease, Mitral Stenosis, Congestive Heart Failure, Subacute Bacterial Endocarditis, Anaemia*".

On the way while driving to her place, I was given a brief history that she had been having fever for more than five months, 100°F. In addition to cardiac medicines and injections of Mersalyl (a Mercurial diuretic), she had already received heavy doses of Penicillin by injections, eight million units to be precise. Now, it was proposed to give her more than twelve million units of Penicillin through Intravenous drip and the Cardiologist had also made it clear that it was not without risk. Panbretin had been specially imported from U.K. as it was not available in India then. I am not sure whether it was used or not. A classical history from the homoeopathic point of view was hardly possible in that low state of the patient.

Her urine output was low unless she received the diuretic injections. She was having nausea and night sweats.

After seeing the patient, on the way back to my place, I kept thinking hard on what lines to treat this serious patient, even though I confess to my state of

* Presented at XXXI International Congress for Homoeopathic Medicine held at Athens (Greece) May, 1976 under the theme "Rarely Indicated Remedies"

sleepiness at that late hour. Lacking any special symptoms and on the basis of a longstanding bacterial infection I decided to start with *Pyrogenium*. This was given in a single dose of 200th on **February 20, 1964**. The report after forty-eight hours was: "No night sweats and no nausea." An added symptom was a feeling of prickling on tongue (?a return of old symptoms, as she had this one month earlier). The heart specialist who had been constantly looking after this patient, examined her that day and said "No deterioration, look is better". The obvious prescription *Saccharum lactis*/ix powders t.d.s.

Thereafter, I received a report from her every three to four days and each time, my amazement grew at the salutary effect of this single dose of medicine as my prescription thereafter continued to be *Saccharum lactis*.

I was called in to see her again on **March 3** and my notes are "No complaints, clinically alright in every way, urine passed freely but more at night than in day." On examination, very slight oedema on lower parts of the legs.

On **March 13**, 3 days later the temperature rose a little, started to be 99°F for sometime in the evening. She does not normally feel it. Only one day she felt slightly unwell. I decided to watch for another 3-4 days before deciding on any repetition. Her own remark was "My appetite is good and I am not useless as I had become." So it was clear that the patient is better regardless of the slight rise in temperature. *Saccharum lactis* continued.

March 18, after almost 1 month "Feeling stronger, temperature now only up to 98.4°F. Complained of slight pain and discomfort in an area where she had Herpes

Zoster two year earlier (Post-Herpetic Neuralgia). This was not a new complaint". It had been there ever since she had the Herpes but in view of her serious condition received no attention from her. In my notes, I find my remark "Now that she feels quite well in other ways, she asked for medicine for this complaint."

March 25, 5 weeks later my notes in her own words "General improvement very great, temperature quite normal, feel hungry and relish my food better."

Comments: This is an excellent proof, if any is needed, on the long action of a single dose, even in a serious condition provided there is non-interference with vital reaction.

I repeat so as to re-emphasise that the medication was a single dose of *Pyrogen* 200 followed by *Saccharum lactis* for 6 weeks till the treatment for this condition was concluded.

A.S.D. & TUBERCULOID IN BRAIN

Master M.G., age 10 years, was referred by a colleague from another city. He consulted on **November 10, 1989**. His symptoms as given-out by the parents were rather vague. A general irritability — anger over little things from June, 1989. Easy fatiguability, bodyache, mild headache off and on. He was having a low grade fever from July 25, 1989. Although the temperature was not high but he had a convulsion on July 28. The sequence of events was like this. He had some itching or burning at the left angle of mouth then some jerky movements of left hand and then a distortion of position of head, the patient says he recalls everything but in fact

at that time eyes had been rolled up, he was lying down and was unable to speak. Left side of the body felt weak for about an hour after. Speech restored about half hour after the fit. Following this for two to three days had some itching or burning near left angle of mouth sporadically and some numbness finger tips of left hand. Another confusing matter regarding the convulsion was that two days before its occurrence he had a cut from some metal implement for which he did not receive any anti-tetanus injection. Other children scared him that something serious would happen to him.

During this period he also had a bout of diarrhoea/dysentery. This was from August 24, and he suffered for nearly one month. He had 20 to 30 stools per day and mostly mucus, no blood.

Some fear in the dark.

P.I.: The parents said that in 1985 he had "Primary complex" for which he had Homoeopathic treatment for one and half years with some fluctuations in fever and general health. However, chest X-ray was either not done or it was clear so diagnosis remains a little doubtful. However, in 1984 he had cough for three months and some palpable cervical glands and fever also. This was relieved by Homoeopathic treatment.

F.H.: Paternal grandmother – Diabetes.

Paternal great grandfather – TB of bone

Maternal great grandmother – Intestinal Koch's.

O.E.: Heart murmurs. White spots nails + +. These have been reported there from the age of three years.

His investigation reports were rather disturbing. C.V.S. Exam. report was "fixed splitting S2 ?A.S.D." Cardiac Echo study "Secundum Type ASD (I.I Cu)."

X-ray of skull — N.A.D. but NMR report indicated Tuberculoid in the brain. X-ray chest — N.A.D.

Hospital Notes are appended.

1989

November 10: Prescription: *Tuberculinum bovinum* 200/3 powders at 15 minutes interval.

December 5: Appetite variable. Tired feeling on return from school. Temperature remains normal.

Greatly attached to his belongings — if loses anything then remains upset for long.

O.E.: Weight: 61 pounds

November 10: *Silica* 6x, 30, 200/1 powder of each on the same day taken in that order.

1990

January 2: M.B. Has a cold for the previous 5 days and phlegmy cough. Yellowish expectoration. Appetite — better.

Pulsatilla 30/15 powders t.i.d. followed by *Saccharum lactis*.

February 12: Pain right chest on playing.

Weight: 64 1/2 pounds.

Silica 200/3 powders at 15 minutes interval. The same was repeated on **March 17**, and **April 21** when he again complained of poor appetite. Pain in calves and head.

It was also repeated on **June 20**, after he received *Hepar sulphuris calcareum* 30 for a few days for some summer boils and fever.

August 4: For a recurrence of his symptoms of poor appetite and pain in calves and headache from mental strain he was again given *Silica* 200. Also because in the intervening period he took some medicines locally for minor complaints.

September 29: The family came very jubilant and had reason to be so. The boy had been examined and told that even though it is unbelievable but "the hole in the heart is closed and also the tuberculoma in the brain cleared."

As he had been examined by many leading Cardiologists which includes specialist from the famous centre at Vellore, who because of a good introduction had offered to operate personally and they had all confirmed the A.S.D. They are now surprised. Doubting the present study, the Cardiac Echo was repeated twice at separate centres and both declared "No A.S.D. and a normal study."

Notes of the Hospital **(GB Pant Hospital, New Delhi)**

- 1.8.89
1. C/O Unipolar convulsions on July 28.
One episode only and then again on July 30
On C.V.S. examination — Fixed splitting of S₂
? ASD.
 2. ?Epilepsy — Focal seizures.
ASD
X-ray skull — N.A.D.
 3. C.T. Scan: Axial scans without and with contrast were made as indicated in the scanogram. These reveal a normal ventricular system. There is a hypodense area in Right fronto-parietal region which does not show any change on contrast administration.
Affect of ?Post ictal oedema.

4. Echocardiography: The inferences are secundum type of ASD (1.1 Cm.) No pulmonary stenosis/PAH. Intact IVS.
- 3.8.89 5. E.C.G.
- 7.8.89 6. Diagnosis: Left partial seizures with Todds.
Rt. sided ring lesions surrounded by oedema.
Advised MRI Scan from INMAS (Institute of Nuclear Medicine and Allied Sciences).
Treatment: Mazetol 200 mg.
1/2 twice daily x 7 days
1/2-1 at night x 7 days
1 tab. twice daily onwards.
Glycerol I ounce three times a day.
In Top Right corner of Page mentioned T.B.
- 26.8.89 7. Rifampicin 300 mg. OD
Isonex forte 1 OD
Pyrazinamide 750 mg. OD
B Complex 1 BD
Mazetol (200) 1/2 BD x 3 months.
- 26.5.90 8. Echo repeated
No ASD
Normal study
- 27.9.90 9. 2 D echo
Normal study
- 28.9.90 10. As the Heart surgeon was sure of the presence of the ASD and there was a delay in the receipt of the report of 27.9.90 already they got the permission from the parents authorising the operation.

TUMOUR IN THE MALE BREAST

Case No. 1

C.K.B., — A young boy of 13 years — first consulted me in 1970 at the age of 13 years. Thereafter, I saw him from time to time for different complaints. On **July 10, 1972**, for the first time, he complained of a small lump under the right nipple which was tender. For this, four remedies were considered *Calcarea phosphorica*, *Phellandrium aquaticum*, *Phytolacca decandra* and *Conium maculatum*. Rest of the history was of no consequence. In the previous two years, it was initially that “he is not thriving and there is a tendency to frequent sore-throat with fever.” He often complained of chest pain but not every time in the same area. He has been vaccinated every two to three years. Hot patient. For this, he had at different times received *Thuja occidentalis* 1000, 10M., *Pulsatilla* 200 and *Spigelia* 200.

1972

July 10: *Calcarea phosphorica* 200 (Kent Repertory, p.882 Tumours — Mammae, like a walnut in left male mamma: Calc-p). Although this patient had it on the right side, which is not mentioned in the Repertory, but it was still selected.

July 25: Tenderness is a bit less. O.E.: Probably the nodule is smaller.

August 4: Size of the nodule increased and tenderness possibly a little more. *Calcarea phosphorica* 200 repeated.

August 19: Size smaller, hardness less.

It continued to decrease in size. In the second week of September 1972, he had ear-ache for which he took some allopathic medicines from a nearby doctor. There-

fore, on next visit, *Calcarea phosphorica* 200 was repeated. The last dose was given on **December 9, 1972**. When seen on **January 12, 1973**, the tumour had completely vanished.

1973

Seen again on **March 3, 1973**, when he noticed a similar lump. This time under the left nipple. *Calcarea phosphorica* 200 repeated. Another dose given on **April 14, 1973** as he had not shown much response. On **April 25, 1973**, the nodule was still the same size and slightly tender. Given *Conium maculatum* 200.

May 15: Condition same. Prescribed *Calcarea phosphorica* 10M.

June 2: There was a very good response. Much better.

June 22: "Nodule reduced — much smaller". Asked for repeat of medicine. *Placebo* continued.

July 21: Nodule practically gone.

* * *

1974-78

November 15, 1974: Reported for recurrent tonsillitis. Two attacks recently and been advised operation which he naturally wishes to avoid.

O.E. Tonsils + +, pitted. 5'8". 114 lbs. No sign of any lump in breasts on either side.

Seen off and on thereafter. On **September 3, 1976** again noticed a lump under right nipple which was tender. This also cleared quickly with a dose of *Calcarea phosphorica* 200.

Last seen on **December 20, 1978**. Now a healthy, tall and handsome young man of 21 years. No recurrence of nodules in breast.

Case No. 2 (Tumour in the Male Breast)

A.C. — A boy aged 16 years, consulted me on **March 12, 1980** with a nodule in his left breast for the previous three years. In the last three months, it had started to give him pain. It had become fairly tender. He was greatly concerned and upset over the fact that when riding a cycle or motor-cycle, there would be pain with every jerk. His only other symptoms were a grating sound in the joints, especially in the ankles, by movement. This would occur even in sleep when he happens to move. He had acne and recently started to have some grey hair.

Had tendency to frequent colds which would have a prolonged course.

He was well built and on examination, the nodule under the left nipple was about the size of walnut (approximately 3½ cm. diameter). It was firm to hard and tender (Kent Repertory, p.882, **Tumors** — *Mammae*, like a walnut in left male mamma: *Calcarea phosphorica*).

Prescription on **March 12, 1980**: *Calcarea phosphorica* 6x at noon time, 30 in the evening and 200 at bed-time i.e. one powder of each potency given on the same day in ascending series.

1980

April 15: Much better, nodule at least 50 p.c. reduced.

May 10: Nodule further reduced and no pain in cycling either. On examination, nodule practically gone. No tenderness.

May 30: Sent report through a messenger. Nodule completely disappeared and no pain etc.

After the doses of *Calcarea phosphorica* administered on March 12, 1980, he had continued all the while on S.L. No repetition was necessary.

CERVICAL SPONDYLOSIS

Case No. 1

Mr. K.R., age 56 years, consulted on December 12, 1989. He had been married in 1959 and had two sons. He was in the Police Service and had a very taxing assignment.

Complaints: Pain in the neck on left side which extends to left shoulder and scapular region for 10 days. > day time, can move neck also < night after going to sleep. Wakes up because of pain after two hours, applies some ointment and lotion and after tossing around for about half an hour, sleeps again and the story is repeated every two hours. There is slight relief by fomentation which in any case is welcome in this cold weather. X-ray picture has not been taken but has consulted an Orthopedist who says it is most certainly Cervical Spondylosis and on his advice has been using a collar. He is not sure if this has made any difference at all because in any case there is not that much discomfort in the day and use of the collar is irksome.

Had been having general body massage for the previous two months, is wondering whether it may have been too vigorous and caused this pain.

Appetite: Good, has become a small eater after heart attack. Non-smoker, likes fresh juices and vegetables.

B.O.R. but not fully satisfied.

Sleep: Disturbed in last 10 days because of pain. Is using Larpose 2 tablets at bed time and even then keeps waking up. No significant dreams.

Earlier stood both heat and cold well, now slightly chilly.

Has lost weight by dieting after heart attack.

Sensitive, conscientious, has been through a lot of stress because of domestic problems of partition in a joint family.

P.I.: Massive heart attack in Jan. '88 and minor in April, '88 operated May, '88 — triple coronary bypass.

1989

December 12: *Rhus toxicodendron* 200/3 powders through the evening and at bed-time.

December 19: Feeling very well, sleeping soundly even without larpose. Sleep not disturbed with pain.

He felt so impressed with the instant relief that he asked me to give the same course of medicine for his brother-in-law, a medical doctor. Of course, I could not agree to this because in Homoeopathy, the treatment has to be individualised and the symptoms can vary even though the diagnosis may be the same.

1994

February 22: I had a chance meeting after more than 4 years at a wedding party and he especially came to express his gratitude because he has never had a recurrence of his pain and he told me that he recommends all his friends who complain of Spondylosis to have homoeopathic treatment.

Case No. 2 (Cervical Spondylosis)

Mr. G.N., age 42 years, consulted on August 3, 1984. He had been married 20 years, 4 children (three daughters, one son) then had vasectomy operation. In Government service — clerical (UDC). His complaints: he had pain in the left scapular region and left upper limb — 8 months earlier. In addition to some usual analgesics he had S.W.D. and continuous bed traction twice,

5 days each time. This relieved his pain on the left side. Three months later while turning in bed felt sudden pain in the right side of the neck. Since then movement of head to right side is restricted. No effect of season or rain. > by rest. Can't sit for two hours at a stretch because of the pain in the neck, then needs rest. When very cold then has stabbing pain in right upper limb extending down to medial 2 fingers. Numb feeling in these fingers in all seasons. He also had pain in the waist region for the previous six months. Liking for sweets. Gases (flatulence) + + "since vasectomy." Eructations lead to tachycardia. Dreams: "Snakes or water." Feels both heat and cold "since vasectomy."

1984

August 3: *Argentum nitricum* 200/3 powders on the same day.

August 24: "I am better." Still has mild pain in the neck by moving it on either side. *Saccharum lactis*.

September 14: Better.

October 27: Not so well. Repeated *Argentum nitricum* 200.

December 8: Generally alright and no special complaints "Give me some tonics to give quick strength."

1985

January 5: Feeling pain in the back from lumbar region upto upper back — interscapular area. Is happier using a collar while sitting long hours in office or travelling in the bus.

Argentum nitricum 10M/3 powders at 15 minutes interval.

1990

Was not seen thereafter till he referred a friend 5 years later in 1990 and informed that he had been well through all these years after his last visit.

Comments: It is to be noted that in this particular case the prescription was based mostly on generals as there were hardly any modalities. Recurrent dreams gave a very important clue supplemented by his craving and to a minor extent the flatulence.

The usual rules of follow-up were kept in mind and repetition was needed only at long intervals and when the symptoms tended to return.

Case No. 3 (Cervical Spondylosis, ?Disc Prolapse)

J.A. male, age 51 years, consulted on **October 4, 1985** with the diagnosis of Cervical Spondylosis after investigations that had already been carried out. The history he gave was that on September 23, 1985 he woke up in the morning with acute pain. The X-ray picture of Cervical Spine gave a report of "Spondylosis with ? Prolapsed Disc. I.V. space has been reduced C5-6." He had received traction of 16 kg. and cervical collar and even had been given injection of Cortisone and massive doses of analgesics. The pain was felt in the neck and was extending to both upper extremities. The Neurologist also found a numbness in the C6, C7 area.

He gave a history of similar attack in 1982 which had subsided after the use of collar, rest and some medicine not known to him. There was also history of an injury to the back of the head as a result of fall onto the factory floor from a height of 30 ft. There had been no bleeding but he was unconscious for about 10 minutes. History of a fall down the stair-case at the age of 5 years with some injuries.

“Lung Congestion” in 1956. X-ray showed thickening of Pleura, had allopathic treatment.

As for other tests he had had his GTT which showed a maximum blood sugar level of 152 mgm/100 ml. ESR was 5mm.

In his written notes he mentioned of “acute constipation; tension, nervousness, loss of self-confidence and bouts of depression.”

“Feeling quite unwell as a reaction to medicines.”

He also mentioned of fear of high altitudes and he suffered from an unwell feeling suddenly during night and feels that he is going to collapse.

He had been prone to hypertension for the previous 20 years. Without anti-hypertensives the readings were 156/116.

The noteworthy symptom was considerable restlessness — keeps stretching, also tossing in bed.

1985

October 4: Prescription: *Arsenicum album* 30/20 powders q.i.d.

Report received on October 7, “pain is somewhat better although he is getting bouts of pain, specially in the latter part of the day and in the evenings. Heat application relieves to some extent.”

In the meantime on October 5, 1985 he was seen by a Neurosurgeon with whom he had a prior appointment. The Neurosurgeon labelled it as “A case of Spondylotic radiculopathy C5/6. Clinical impression: Disc prolapse C5/6. Advised Myelogram to be followed by Anterior discectomy operation.”

His (Neurosurgeon's) notes mention of neurologic pain in left upper limb, of parascapular pain, and dull pain upper forearm. His examination revealed minimal

weakness, left grip. D.T.R. upper limb diminished, more on left side.

October 9: "There is improvement and the severity of the pain is reduced. Pain and numbness in left arm persists. The pain in the arm increases in evening and night.

Improvement in B.P. the reading now is 148/92. Constipation is much better."

Prescription: *Arsenicum album* 30/12 powders q.i.d.

October 12: Feeling better. Has shifting pain in different parts — small areas in left upper limb and left scapular region.

Prescription: *Rhus toxicodendron* 200/12 powders q.i.d.

Report on **October 15:** "He was feeling better when your treatment was started as the pain was slowly getting reduced in intensity and also in its duration. His mental condition was better too. These last two days and specially since last night he is again depressed and upset. His left hand fingers and left toes are feeling numb and this is troubling him a great deal."

He was then leaving for his home town and there was no possibility of an early report.

Prescription: *Arsenicum album* 30/56 powders q.i.d.

November 2: There had been some relief initially but pain had increased 4 days ago and this increase lasted for 2 days. He mentioned of some additional fears which he had always had but had forgotten to mention at the time of first consultation. He had fear going in a lift. He was afraid of taking a flight and was generally very nervous.

Prescription: *Saccharum lactis*/84 pills, three pills q.i.d.

Report dated **November 9**, "Arms pain is making me quite uncomfortable at times but it is not severe. Sleep is disturbed since 2nd night. Had no problem of sleep ever since I started your medicine. Restlessness at night makes me tired in the morning and also adds to my pain. I feel I was feeling better with the medicines you gave me in the middle of October when I left for Hardwar."

Prescription: *Arsenicum album* 200/3 powders, at 15 minutes interval followed by *Saccharum lactis*/240 pills, 3 pills q.i.d.

December 7: Has been seen by the head of Orthopaedic department of the All India Institute of Medical Sciences and fresh X-ray pictures taken for follow-up. He was told "three is much improvement — the X-ray shows that the slipped disc is much reduced so now he needs to use collar only in travelling." Initially the left thumb and the adjoining two fingers were numb. Now only a very slight numbness in the index finger.

Prescription: *Saccharum lactis* continued and as improvement was maintained this was continued right till April 1986.

He was seen on March 3, April 28 and last on **July 15, 1986**. During his last visit he said "The problem of cervical spondylosis is 100% OK. I am very actively engaged in my work, the medicine has done wonders and saved me from possible surgery."

PROLAPSED INTERVERTEBRAL DISC

Case No. 1

Mr. H.R. age 52 years consulted on **October 11, 1967**. He had been a milk seller but because of his disability he had not been able to carry on that or any other work for the previous 1½ years. He had a pain in the back during that period. For this he had received Irgapyrin injection and tablets and other allopathic drugs but the relief from pain was not lasting. Then he had Ayurvedic and Unani treatment without any special benefit. He had also had vitamin injections and S.W.D. In his profession there was heavy physical work as it involved pushing the cycle loaded with milk cans. The pain had started in the back but later it was also in the lower limbs. In the hospital they felt that there was a slight shifting of a vertebra and they put it as ?Prolapsed Disc.

He was put in plaster of paris with slight relief by immobilisation. His urine examination showed the presence of sugar 0.25%. He did complain of frequency of micturition. As the different treatments did not help him he had a myelogram done and it showed a disc prolapse L3 L4. He also had a tenderness at L2. The reflexes in the lower limbs were increased. There was no sensory loss. In his past illnesses the one significant illness was syphilis at age of 22 for which he did not take any proper treatment. On **October 11**, when he came he was administered *Arnica montana* 200/3 powders at 1/2 hourly interval.

1967

October 18: No significant change.

Prescribed: *Kali phosphoricum* 3x-4 tabs q.i.d. for 12 days.

November 2: He was given *Hypericum perforatum* 200/2 powders at half hour interval.

Thereafter he felt better but after some 10 days he travelled and also over-exerted and on **November 17**, reported that as a result thereof the position is the same as originally. He also mentioned that the exertion always aggravates. Repeated *Hypericum perforatum* 200/1 powder. Thereafter he again felt better but few days later was bitten by a street dog and thereafter received 14 antirabic injections. Once again he felt the improvement was "washed off" after the injections.

December 7: *Hypericum perforatum* 1000/1 powder.

Thereafter I did not see him for three months. Next report **March 8, 1968:** stronger than before and can walk longer distances. Now he mentioned about his other usual complaint which is cough. Has some Asthma tendency (like chronic bronchitis). As he was smoking 20 to 30 cigarettes, such symptoms were not totally unexpected.

* * *

March 22, 1971: He reported again after three years saying that the earlier treatment had brought about great transformation, from being a near cripple confined to bed he had been engaging in full activity. Now he felt a slight recurrence of the old pain in lower limbs mostly left side. On the basis of the previous experience he was again given *Hypericum perforatum* 200.

I did not see him again but in **October 1988**, his son brought some other patient for consultation and mentioned that his father often spoke of the great benefit he had had from my treatment. He had died some years earlier but had kept free from pain.

Comments:

(1) *Arnica montana* was given on the basis of excess muscle strain as the possible reason for his complaint and as he reported back within one week, which was too early to know the full effects, *Kali phosphoricum* 3x was given for a few days. However, once the Similimum was found, it remained effective throughout the treatment of this patient.

(2) Whether the structural change of a Prolapsed Intervertebral Disc was corrected or not, clinically he was relieved of all symptoms including symptoms of pressure on the spinal cord. One can only surmise that the prolapsed disc got corrected.

Case No. 2 (Prolapsed Intervertebral Disc)

Mr. B.G., age 48 years consulted on July 10, 1986 with the complaint of feeling of weakness in lower back and pain in the right hip. The complaints had been there since December '85 and had been diagnosed as P.I.D. (Prolapsed Intervertebral Disc). A Mechanical Engineer by profession and a senior officer in Government service he had all the facilities of investigation in the hospital. There was a history of a sharp pain in that region while lifting a heavy weight some 12 years earlier. He had then been confined to bed for some days. He felt that he had a weak back ever since. There would be an aggravation of pain with general physical strain and with stooping. There is no pain on waking in the morning. It starts about an hour after sitting/standing/walking. He feels a stab in the lower back whenever he has a sneeze or when he coughs. Mild formication (pins and needles feeling) mainly in the right foot laterally. X-Ray of Lumbosacral

spine shows Osteophyte formation in vertebral bodies and ? narrowing L4-L5.

Tendency to sore throat at changes of season. In food he tended to take a little extra salt and also had some fondness for sweets, pickles and chillies. He would eat the ice in cold drinks. He was a hot patient. He enjoyed rainy weather and thunder and lightning. Worrying nature, selective about company. Dreams occasional and ridiculous or funny. Had had no major illness in the past. In **family history** — Father had diabetes. He also suffered from Bone T.B. and eventually died of Cancer in abdomen — probably in the Liver. Mother is asthmatic and perhaps due to prolonged use of steroids having marked osteoporosis which had at one time even been diagnosed as ?T.B. Bone.

1986

July 10: He was prescribed *Gnaphalium* 200/3 powders on the first day followed by Sac lac. He reported 8 days later feeling better. In his own words, "Distinct improvement noticed after the first 2 powders. However, that night was disturbed with many dreams and next day was not so good, subsequently progressive improvement. Have been walking considerably, for about 1/2 hour at a stretch without any pain".

August 6 (i.e. about one month later): "Much better than before. Walking upto 2 k.m. but with a belt on. No formication."

His subsequent reports continued to be encouraging and so he continued to receive *Saccharum lactis*. In one report he said "occasional slight discomfort because I mostly forget the problem and so tend to overexert". In September he was doing normal duties and started on some exercises also. There would be some pain when he over-exerted or remained without belt. He spontaneous-

ly remarked that, "you made me normal and I am very grateful. At one time I was much depressed."

1987

May 9: Pain mostly alright. Occasionally occurs and settles with medication given to him. This was of course *Saccharum lactis*. "slipped disc is under control." He was having constipation in the sense that although there was a daily motion but it was unsatisfactory. He was prescribed *Calcarea carbonica* 200/3 powders, morning, afternoon and bed time.

September 16: Came with his mother, who is under treatment. He said, "I have been half way round the world, to different places in Europe and U.S.A., with a hectic programme and carrying my baggage and inspite of all the strain, no trouble at all".

November 11: Further travelling. Occasionally feels pain in left hip < descending stairs.

Calcarea carbonica 200/3 powders at 15 minutes interval.

* * *

1990

March 27: Had kept well all this while, for nearly 3 years. Having pain from this morning. Started on waking. A slight pain yesterday by long sitting on thickly caushioned seats in which one sinks. Pain is in a spot on right S.I. joint and extends along the sciatic. No numbness. Mold diabetes, blood sugar, fasting 105 and P.P. 176 mgm %.

Rhus toxicodendron 30/24 powders q or t.i.d.

Seen from time to time till end of 1993, as he would come to collect his mother's medicine. He kept well and there was no recurrence of pain in his back or the lower limbs.

spine shows Osteophyte formation in vertebral bodies and ? narrowing L4-L5.

Tendency to sore throat at changes of season. In food he tended to take a little extra salt and also had some fondness for sweets, pickles and chillies. He would eat the ice in cold drinks. He was a hot patient. He enjoyed rainy weather and thunder and lightning. Worrying nature, selective about company. Dreams occasional and ridiculous or funny. Had had no major illness in the past. In **family history** — Father had diabetes. He also suffered from Bone T.B. and eventually died of Cancer in abdomen — probably in the Liver. Mother is asthmatic and perhaps due to prolonged use of steroids having marked osteoporosis which had at one time even been diagnosed as ?T.B. Bone.

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Case No. 3: (Backache ?Slipped Disc)

Mr. S.H., age 53 years consulted on January 2, 1967. He was a retired Colonel from the British Army, now serving as Executive Head of an important company.

His complaints were pain in the back. It occurred suddenly one morning in Rangoon in 1954 as he got out of bed. It persisted for a few weeks. There was a recurrence in 1960 in Karachi after a slip though he managed to balance and did not fall. It was diagnosed as slipped disc. He was given Homeopathic treatment with complete relief after a severe initial aggravation. For a recurrence in 1963 in Calcutta he again had Homeopathic treatment with gradual relief. Thereafter sporadic attacks continued to occur but were milder. In U.K. 18 months ago he had a very bad attack. Pain always comes suddenly. Lasts 3 to 4 days and then leaves a stiffness.

Modalities: < Sitting upright. > With a reclining back. > After rest except the first few steps after waking in morning.

Appetite — Good. Digestion — very good. Vegetarian. Smokes moderately. Alcohol — A peg of whisky in the evening.

Sleep — Good “because feel better lying down.”

P.I. — Malaria (B.T. and M.T.). Dysentery (Bacillary and Amoebic), Jaundice. All these illnesses occurred in the Burma jungles during the Second World War. (Burma now changed to Myanmar)

1967

January 2: *Bellis perennis* 3/9 powders t.i.d.

January 5: Reported better. *Saccharum lactis* t.i.d.

January 9: No complaints. As he was going abroad he was given sac-lac for a longer period and asked to

reduce the dosage. Also in case of attack he was separately given powders of *Bellis per.* 3.

May 30: He had been without any medication and practically well. I met him socially on a few occasions and he mentioned that he had a very mild pain on one or two occasions but did not need any medicine. He did need a repeat of *Bellis per.* 3 on **January 30, 1968** for just 4 days. Earlier in **June, 1967** for a sharp pain like a crick in the back, he received *Cimicifuga racemosa* 3, 30, 200/1 powder of each to be taken on the same day in that order with very good relief and in fact he made a note of the medicine so that he could use it if there was any recurrence and he was away from Delhi. I had contact with him till **September, 1974** when he retired and moved to South India. He kept practically free of this trouble and for some unknown reason considered me specialist in backache and referred other patients of the same complaint. Only once on **August 23, 1969** after recovering from acute dysentery, he had a Sciatic type pain felt on moving. Had to turn in bed to well side before getting up. For this he was given *Kali carbonicum* 30/10 powders q.i.d. with complete relief. (See Repertory p.1065 col.2)

Case No. 4 (Spondylitis [Cervical & Lumbar] with Disc Degeneration)

Mr. P.G., an Englishman, was referred by a countryman of his, who had been confined with backache and sciatica. He was cured by my treatment and thought I was a specialist for that condition.

Mr. P.G. age 50 years consulted on **November 14, 1974**. He had been married in 1956, had two children

aged 15 and 13. He was the manager of a bank and had been serving in India for 10 years.

The history as he related was that in July, 1972 he had a tingling feeling in right foot and a slight pain in the back. An X-Ray taken at that time showed no abnormality. At that time he also had severe pain in right groin and swelling of the right testis. The tingling got less in course of time without any treatment.

In February, 1973 he had pain in right leg < morning on getting up from bed. Used some ordinary analgesics.

In December, 1973 recurrence in a severer form. At that time pain was in hip and leg on the right side. With treatment this gradually got better.

In May-June, 1974 pain shifted to left side.

In July, 1974 he was on home leave in U.K. On July 12, 1974 he woke up in the middle of the night with severe pain. After Allopathic treatment he tried Osteopathy and Acupuncture with a gradual relief. By end-August there was slight recurrence in right hip. By end-September pain in left side was completely relieved but re-appeared on right side and progressively got worse. Tried S.W.D. and Traction but that made it worse. X-Rays showed Spondylitis in Cervical and Lumbar region. Intervertebral spaces intact in Cervical region. Reduced space between L4 and L5.

When pain is bad he is most comfortable in knee-elbow position. Tingling is felt on stretching. Season, time and hot fomentation have no effect.

Pain in hip with cough. Feels very sensitive while sitting.

He is a non-smoker. Drinks very moderately and only in social gatherings.

P.I. Sprue in 1958. E.H. in Bangladesh for 3-4 years. Been okay thereafter.

1974

November 14: *Gnaphalium polycephalum* 200/3 powders noon, evening and bedtime of the same day.

November 21: Definite progress in pain in right lower limb but in the last 48 hours it has shifted to left hip. More comfortable lying on side opposite to pain (painless side). Right foot, specially toes still have some numbness.

Saccharum lactis continued.

November 29: Feels the condition has stagnated. In the last 3 days not so good possibly because he had to stand much in the course of his work.

Gnaphalium polycephalum 200/3 powders during evening and at bed time.

December 6: M.B. after November 30. Pain keeps shifting but mainly concentrated in left hip. Amel. continued till December 5. Then pain lower part of left leg. There was a feeling that it was swollen and heated "pain in hip feels less neuralgic and more stiffness of muscles." Numbness is less though not gone. Pain lower left leg is more today. "All told pain is 5-10% of what it was before starting treatment." Best position is lying in bed with the limb flexed.

Saccharum lactis continued.

1975

January 10: The formication and numbness gone by 90%. Pain is mainly in left hip. < standing. During a recent visit to U.K. he was investigated and told "Disc Degeneration and you have to live with it."

Feels heartbeat has increased and it gives a tinnitus more noticeable at night when it is quiet. B.P. is normal. Pulse 64-68/mt.

Saccharum lactis continued.

January 29: M.B. Feels pain only in standing, in standing still. No pain in walking unless it is for very long. Now it is relieved much quicker on sitting down after the walk. No pain while lying down. Can lie on both sides. Occasional pounding heart and at that time hearing also affected. More at night in bed.

Spigelia anthelmia 200/3 powders during evening and at bed time.

February 15: Carrying on well. Pain V.M.B. Goes for fast walk and feels quite normal. In the initial period pounding heart continued but later eased off both in frequency and violence. Not completely gone yet. E.C.G. — W.N.L.

Saccharum lactis.

February 25: Pounding heart less frequent. A new symptom has developed — noticed hair loss in some spots in the beard region. For this he received *Baryta carbonica* 6 t.i.d. for 2 weeks. Then *Calcarea carbonica* 200 but eventually responded to *Selenium*. which was given in the 200 on **April 7** and in 1000 on **May 26**. Hair reappeared in those spots.

In **June, 1975** he got posted to Madras from where he telephoned that as a result of a jolt in the car because of a pothole on the road, he felt some pain in the back left hip and thigh. The modalities now clearly pointed to *Rhus toxicodendron* which he needed on 2 or 3 occasions during the two years he was there.

In **November, 1979** he sent for medicine from U.K. and then he was posted to Qatar but by now he had so much faith in this medicine that I received a letter from

him in **June, 1980** saying that there was a recurrence of the problem and asking me to send him medicines.

SPONDYLITIS ANKYLOPOETICA

Mr. C.R., age 30 years, consulted on **October 9, 1967**. He was a bachelor, in service as a Research Asstt. in the Chemical Section of a Government establishment. Eight years ago, he had been diagnosed to be suffering from Spondylitis Ankylopoetica and all the treatments that he had so far had been of no avail. He started his history by saying that his father had the same trouble from the age of 35 years and he died at the age of 60 completely immobilised. For the rest of the family history he had one brother, age 39 years and one sister, age 35 years. Both healthy and free from this trouble. Mother was in good health.

Stiffness had been progressive and by now there was considerable disability. This leads him to lot of disappointment and frustration. He feels that in 1960-61, he was much better, i.e., had only slight stiffness of the back with fair degree of mobility and bending possibility. Then a doctor gave him half a dozen calcium injections. Thereafter the disease went on increasing and he had never been well since.

His other complaint was twitching of muscles in various parts of the body.

His modalities were: < after rest < in morning > walking about, "the part warms up." < cold exposure and cold drinks < winter. No effect of wet weather.

He was sleeping on hard bed as advised by the physician for the previous 3 years.

Appetite and Digestion: Good. Non-vegetarian. Likes curd and cauliflower but given up. B.O.R.

Sleep — Not sound and disturbed.

P.I. — Typhoid 2 months ago resulting in further weakness.

O.E. — He was of Asthenic build. Ht. 5'10". Wt. 102 lbs.

1967

October 9: *Rhus toxicodendron* 10m/1 powder.

October 30: I.S.Q. *Calcareo carbonica* 200/1 powder.

December 8: Pains are ameliorated. In fact, he has no pain now. However, stiffness is as before.

Repeated *Calcareo carbonica* 200/1 powder and on January 2, 1968 *Calcareo carbonica* 1000/1 powder.

* * *

1969

He reported again after a lapse of more than a year. He had been carrying on fairly well, had been free from pain, though only marginally and not substantially relieved from stiffness.

Twitching had continued. From January, 1969 he started to feel pain in the waist region which had not occurred before. Earlier it was in the cervical and dorsal region. Modalities were the same as in the initial history. So I decided to try *Rhus toxicodendron* again in a different potency.

January 23: *Rhus toxicodendron* 200/3 powders on the same day.

February 24: No significant change. *Rhus toxicodendron* 1000/1 powder.

March 8: He sent a letter as he had assumed his duties in another city. He reiterated that he had been well for 8-9 months (March to mid-December, 1968).

Thereafter has had intermittent trouble. Now mentions that he feels better in the morning after having slept on hard bed. "Hard bed helps a lot." Wants to know if his disease will be inherited.

Much dandruff.

Calcarea carbonica 1000/2 powders at half hourly interval.

This was repeated on April 10.

May 27: *Calcarea carbonica* 10M/1 powder.

Few reports were received subsequently. In general he continued to remain free of pain but there was only partial relief in his stiffness.

* * *

1993 (A report 24 years later)

On May 24, 1993 his cousin who had initially brought him to me in 1967 came to consult me for his son having the same complaints. He pleaded with me to help his son just as I had helped his cousin brother Mr. C.R. in 1967-69. He informed me that Mr. C.R. got married around 1970 and has two children, aged about 22 and 18. He had carried on fairly well after the treatment.

CASTOR EQUI FOR PAIN COCCYX

This is another of the lesser known drugs and therefore, infrequently used. Even though proved and introduced into Homoeopathy by the great Hering but the proving is not extensive. Therefore it is prescribed mostly for two or three conditions i.e. only for 'particulars' and not on the basis of a classical history.

I used it for a patient Mr. A.K. age 26 years who had bleeding piles, frequent headaches and premature grey

hair. He mentioned of "pain in the tail bone" which he mostly felt by long sitting. He was benefitted in the rest of his symptoms by the constitutional remedy prescribed but this pain persisted. He again emphasised that it would occur after sitting for sometime and was being felt especially after travelling which could be interpreted as sitting for an extended period. In Kent's repertory on page 912 column 2 one of the lesser known drugs mentioned under PAIN; Coccyx; sitting, while, is *Castor equi*. This symptom is briefly mentioned in Boericke's Materia Medica (p. 180) But in Clarke's Dictionary of Materia Medica page 427 it appears as "Pain in Coccyx aggravated every evening while sitting." The patient was first seen on October 20, 1982 but *Castor equi* 200/3 powders at a few hours interval on the same day was prescribed for the first time on **September 24, 1984**. Over the next five years it has been repeated ten times as and when he reported recurrence of that pain. It has given relief every time.

PAIN WRISTS

IMPORTANCE OF POTENCY SELECTION

It has often been expressed that the potency does not matter if the remedy chosen is the correct one. It goes without saying that if the correct remedy is not chosen no variation in potency is going to help. But a case is being presented where the potency made the difference.

Mrs. I.R., age 26 years, consulted on July 13, 1985. She had been married 5 years. Had one son age 5 months, born by caesarean section. No abortion — natural or induced.

Her complaints were:

1. Pain wrists for three months — they started two months after delivery. She stopped nursing the baby one month earlier and it was her impression that the pain has increased after weaning. Pain started in both the wrists at the same time though sometimes it is more in the left and other times more in the right. Pain is worse in the morning for an hour or so. It is worse by sleeping in a room with a desert cooler. On the advice of an Orthopedist she had tried S.W.D. and some sittings with ultrasonic applications. These had no effect.
2. Falling of hair: For the previous one month after weaning. Has dandruff, no itching.

She preferred a little extra salt in her food. Menses were irregular and late.

Past Illnesses: Chicken Pox 1972 (at age 13 years); Measles 1982 (at age 23 years); Malaria 1982.

O.E.: No sign of active inflammation could be made out in the wrist joints.

1985

July 13: Prescription: *Rhus toxicodendron* 200/3 powders, afternoon, evening and bed time.

August 5: No change in pain, hair falling a bit less. The complementary remedy of *Rhus toxicodendron* was chosen *Calcarea fluorata* 6x,30,200/1 powder of each to be taken at bed time on three consecutive days in that order.

August 31: No change. Pain by touch also. If there is a jerk then much pain.

In the Repertory on Page 1058 Col. I there is a short sub-rubric PAIN; wrist; jerking; Anac., rhus-t.

Considering that the new modalities as also the ones in the initial history were well covered by *Rhus toxicodendron* it was decided to try a higher potency before thinking of any change. As such on **August 31**, she was given *Rhus toxicodendron* 10M/3 powders at 15 minutes interval.

October 19: Wrists much better. Hair falling much better.

November 9: Further relief in pain in wrists and hair falling has stopped. Thereafter I lost touch with the patient till I received a letter dated **May 20, 1986** from France, "I am sorry I could not personally come and thank you for curing my wrists before coming to France but it happened very suddenly . . . My wrists have healed completely (touch wood) and I have no pain for the last 2-3 months. Thank you very very much."

What prompted me to take out the history and examine it again was that on **July 4, 1989** her husband comes to consult me and gives her reference and also the news that she continues to be free of her symptoms and enjoying good health.

MYELONEUROPATHY ?ADRENOLEUCODYSTROPHY

Mr. P.R., age 36 years, consulted as a desperate emergency on November 12, 1993. He was from another city. Had been married in 1980. Had two children aged 11 and 4 years. He was a building contractor.

Complaints: Difficulty in walking for one month. Initially, the difficulty was in starting to walk and there was some pain in the knee, will get better after walking a short distance. At this stage, he was given analgesics by the doctor. He fell on one or two occasions as he lost balance.

Later he started to have a numbness of the feet and formication. If he used slippers or chappal, it could come off without any sensation.

Gradually, he developed a heaviness in the lower limbs and he had to make an effort to raise his foot in walking.

There is much problem in the morning and in the evening he feels exhausted. The symptoms ease in about half an hour after walking and by a little exercise < after rest > hot water bath. Has not tried fomentation.

Face has got darker and this is especially noticeable in the last 6 months. Also some increased pigmentation near the ankles.

Perspiration face + + while eating < spicy food < hot drinks, i.e., warm food or quite warm tea.

Sex desire reduced in the last 4-5 months.

Appetite: Good. Non-vegetarian but not particularly keen on meat, fond of sweets, smokes about 10 cigarettes daily, likes alcohol and takes it twice a week or more often.

Constipation: One month. Had slight tendency even before; now using one laxative or the other.

Sleep: Good. Dreams nothing significant.

Hot patient. Perspiration +.

Irritable.

He had consulted many physicians and finally been investigated at AIIMS. The hospital note showed that on admission his B.P. was 170/110 but later it settled to 130/80.

“**Sensation:** 25% loss of touch and temperature. Has pain over stocking region.

Impression: Myeloneuropathy ?Cause; to rule out Adrenoleucodystrophy.”

Cortisol 12.6 (Normal 4 to 26)

1993

November 12: *Rhus toxicodendron* 200/7 powders to be taken morning, afternoon and bedtime followed by *Saccharum lactis* for a month. After taking the medicine, he went back to his home town and subsequent reports were mostly by telephone.

December 10: “Much better. Walk is 40% better but not yet the previous speed. By evening he gets tired feeling. Also in morning has stiffness. Even complexion has improved. Slight itching on legs. Appetite – increased, still constipated.”

Saccharum lactis.

1994

January 11: Telephone by wife. “Quite normal in the day but some stiffness in the morning and an occasional limp is noticed when extra exertion is done. Carrying on his full activity. We really do not know how to thank you enough.”

Now he felt so well that he asked for a supply of two months' medicine.

Rhus toxicodendron 200/3 powders at 15 minutes interval.

March 28: Not a very significant further improvement although generally feeling quite well.

Rhus toxicodendron 1000/3 powders at 15 minutes interval.

May 17: Pain and swelling in ankles B/L < morning. Cramps in calves. Tiredness in the evening. Has gained much weight. Originally, was between 80-85 kgs. In illness, reduced to 75 kgs. Now 87 kgs. He repeated the symptoms mentioned earlier about sex desire being very little even though in other directions he had improved.

Sepia was selected using this symptom as also the relief from walking, the pigmentation and perspiration taking warm food.

Sepia 200/3 powders at 15 minutes interval.

July 2: Reported personally. Has no problem in carrying out routine duties — in going around, in driving his car, scooter and cycle. No numbness at all, pigmentation getting progressively reduced.

Appetite — Good, says, "somewhat voracious." He is trying to control because his weight has increased. He puts it partly to the good appetite and rich diet and mostly to the fact that during his illness, the activity was much reduced or nil. Digestion — good. B.O.R. No constipation. The problems he has now are that for the last 2 months when lying if he extends lower limbs then feels a drawing in the calves, no difficulty in flexing the limbs. This he feels especially at night when he wants to straighten the legs. In rising from sitting position, there is some drawing in the hips so he has to rise cautiously. This is also for the last 2 months. In front of the ankle a

slight stiffness in the morning "as if a crepe bandage has been tied on it" and the movement is slightly restricted. This lasts for 5 to 10 minutes. Has swelling feet off and on. Sex is quite normal, both desire and performance.

O.E.: Weight 208 lbs. (approx. 88 kgs.). D.T.R.: Brisk
Rhus toxicodendron 1000/3 powders at 15 minutes interval.

The treatment is still continuing but it is to be noted that he is practically cured from the serious condition with which he came and is back on his job. It is also to be noted that the prescription had no relation to the diagnosis but only to the symptoms with their modalities.

I felt greatly touched when his young children were brought to meet me by his wife. She said they had been insisting all these months that they want to see the doctor who has saved their father and brought about a transformation in his condition.

Letter dated **July 29, 1994**: "With your blessings I am feeling much better and trying my best to lose weight as advised. I have no words to thank you for all you have done for me and my family. As required by you, I am sending you my prescription of AIIMS. I will talk to you on phone in a week or two for the medicine."

Mr. P.R.

HOSPITAL NOTES
Cardio-Thoracic and Neuro Sciences
All India Institute of Medical Sciences
New Delhi-110 029

Discharge Summary

O.P.D.O.
N.S. VI/Neuro I

D.O.A.: 05.11.93 (5th November)
D.O.D.: 11.11.93 (11th November)

P/C - Difficulty in walking - 1 month.
Tingling sensation over soles
H/o. - HT - ?PIVD 8 years back.
O/E. - Hyperpigmentation over face, feet.
Pulse - 80/Mt. B.P. - 170/110
Higher Functions - Speech: N
Motor - LL - B/L Hip 4/5; Knee 4/5; Ankle 3/5.
Sensory - 25% loss of touch, temp. Pain over
stocking region. No meningeal/Cerebeller Sign.
Imp. - Myeloneuropathy. Cause? R/O Adreno-
leucodystrophy.

Investigations:

Hb-11.2, B.urea - 24, B.Sugar 78.
S.elec.: Na. 143; K. 5.1.
S. cortisol - Report awaited.

CT Head
Abdomen

) Normal

S. Bilirubin 0.9
S. PP 177

SGOT/SGPT — 27/36

S. Creatinine — 1.2

V.E.R. — 3.6.93 (3rd June) (R) 108.0 m-sec. 3.6 ub
(L) 111.0 m-sec. 3.2 ub

EPS — S/o. Sensori-motor peripheral neuropathy affecting LL predominantly.

Adv — Readmission for further evaluation on 16.11.93 (16th November)

Treatment — Inj. Vit. B₁₂ 1000 mg. IM weekly x 4 weeks then once a month.
Cap. Becosule 1 o.d.

PAIN LEGS

Case No. 1

Mr. V.K.J., brought a patient in September 19⁹⁹, and reminded me that he had been treated some years earlier and had remained well ever since. The notes in our files are that he consulted on **September 6, 1980**, age 33 years, married 6 years with one child two years of age. In Government service as a Junior Engineer. His only complaint was pain in the legs and feet for the previous six months. He had been transferred to a new station which was more humid but that was one year prior to my consultation while the pain was for six months. No effect of seasons. Worse in the morning on first rising. > Motion. There was nothing much in the rest of the history. He was a hot patient. Perspiration +. Irritable temperament and a worrier. Was smoking 10 to 12 cigarettes and taking Paan (Betel) without tobacco, two to four in a day.

In Past Illnesses he gave a history of enteric fever in 1966 and Malaria a month earlier.

No abnormality was found on examination — general and of the lower limbs and calf muscles.

Laboratory reports:

Urine examination — N.A.D.

HB 16 gm. ESR 3 mm. T & D.L.C. 7000

P47 L48 M3 E2

Stool examination: Had shown ova of *Ascaris lumbricoides*.

For this he had taken Vermifuges a number of times: Helmacid once, Antepar twice and Wormin. He had himself not seen any worms passed in the stool after taking these medicines.

1980

September 6: *Calcareo fluorata* 6x,30,200/1 powder of each to be taken in the course of the first day and thereafter *Saccharum lactis*.

September 13: Reported better. But still at times pain can be quite bad. Had a cold in the last few days. *Saccharum lactis* continued.

October 7: No further progress. *Calcareo fluorata* 200/3 powders to be taken at half hourly interval. This was repeated on **December 26**.

1981

January 24: Was last seen on this date. Was complaining that he had more pain in the last few weeks and a possible reason for that would have been extra exertion in view of wife's delivery. He also mentioned that the "pain is more the day I eat rice".

Calcareo fluorata 10M/3 powders at 15 minutes interval.

* * *

He was not seen thereafter and if it had not been for the chance meeting in **September 1989** I would not have known of the relief that he obtained.

Case No. 2 (Pain Legs)

Mrs. M.T., consulted on **June 5, 1986**, age 24 years, married two years, one child ten months (still breast feeding), one M.T.P. December 6, 1985. Her complaints were that for the previous two months she was having pain in the legs more especially the calves. Could not ascribe it to any special reason (like overexertion, getting wet, injury etc.) Initially there was also low grade fever for a week (99 to 100°F) also vomiting. She took Unani treatment. The temperature became normal but pain persisted. Vomiting still occurs but instead of being a daily feature as when she had fever now it is occasional. With regard to vomiting it turned out that it has been there for about two years. It started one month before marriage and she has had it off and on since.

Pain in the legs is after 3 P.M. and it lasts for three to four hours. If she has had a siesta or rested then it is less. < walking. No effect of heat and cold. She has not tried fomentation.

When the pain in the legs is bad then she can get headache.

As regards history of vaccination, it had been frequent in school. The last one had been around the age of 14.

Menses normal.

Irritable temperament.

P.I.: Malaria 1974. No other illness of note.

F.H.: Father had Diabetes and High B.P. and died after operation for Carbuncle. No T.B. in family.

1986

June 5: Prescribed: *Natrum muriaticum* 6x, 30, 200/1 powder of each to be taken in that order morning, afternoon and bedtime.

June 14: Temperature normal. No vomit. However, pain had been more from June 9, possibly due to having been out whole day, the previous day.

Prescribed: *Calcarea carbonica* 200/3 powders to be taken on the same day.

June 28: Pain in the legs is better. It does occur but is less intense. It gets worse if does not rest or over-exerts. Vomited on two occasions after taking rich diet.

Gave her *Saccharum lactis* but in the margin noted *Pulsatilla* for future consideration.

July 15: Pain legs better. Feels alright if has a short rest in the afternoon. Vomiting still occurs for no known reasons.

Prescribed: *Pulsatilla* 200/3 powders to be taken on the same day.

August 5: Occasional vomit. If she tries she can prevent it also but somehow feels compelled to do it. Pain legs no longer a daily feature and only felt after over-exertion.

Calcarea phosphorica 200/3 powders in the evening and bedtime.

August 29: Much much better. Practically no pain. Vomited only once.

September 24: Hemicrania which lasted for six days. Two days later got news of a death in the family and had it again. She came up with a peculiar symptom of nausea after stool, also a sinking feeling and generally feels weak. Now there is no vomiting. Sinking after stool appears on page 526 of Kent's Repertory. At this stage she

was given *Acidum phosphoricum* 3,30,200/1 powder of each to be taken on the same day.

1987

Thereafter she kept well and reported again after 11 months on **August 28, 1987**. For the previous two weeks there had been a recurrence of pain in the legs and hemicrania. In this period there had been no vomiting tendency. She received *Calcareo phosphorica* 200/3 powders.

October 19: Reported better.

* * *

After three years in **March 1990**, her husband came for treatment and informed me that Mrs. M.T. had remained quite well after her last visit.

* * *

1990-94

Has been seen again off & on between July 21, 1990 and February 1, 1994 for different complaints: Alopecia areata which responded quickly to *Calcareo carbonica* 200. Later she came for Acne, which she considered was a reaction to some allopathic medicine given for a hair-line fracture after a fall. It is to be particularly noted that she remained free of her old symptoms. There was no recurrence of pain legs or knees and no headache.

PAIN FEET

Miss A.R., age 30 years, working in an office — clerical duties, consulted on **December 21, 1990**. She and her mother had desperately sought an appointment as her

condition was incapacitating her in her activity. She had much pain in mid-portion of the feet (instep) for nearly three months. She initially had orthodox (allopathic) treatment and received a variety of analgesics which did not give any lasting relief. For a while, using shoes without heel gave slight relief. The only other complaint she had was a tendency to colds at changes of season. The modalities were marked and immediately and easily indicated the remedy. The pain was aggravated on starting to move whether in the morning or after a period of rest and was ameliorated after a few steps and then she would have no trouble in walking. The rest of the history had nothing significant. In the family history the mother was suffering from a very chronic Psoriasis.

December 21, 1990: She was prescribed *Rhus toxicodendron* 200/3 powders, given on the same day — noon, evening and bedtime.

1991

January 19: Much better. The mother remarked, “she had used so many medicines prior to your treatment and none had helped.”

February 12: Quite normal. Even using high heeled shoes without any problem at all “The whole family is so thankful”.

SCIATICA

Case No. 1

Mr. V.R.R., age 47 consulted on **November 22, 1984** with complaint of pain in right thigh on posterior surface. This pain started after he had driven some

300 kms., part of it was hill driving (Simla to Delhi). Recalls that even earlier from time to time he had pain in the back ever since he had a catch while playing squash. Had taken Neurobion (Vitamin B₁, B₆, B₁₂) orally and by injection. In May 1984, he had again made a trip to Simla where it is colder. There he noticed that the pain was "< morning, < starting to walk > after walking a few steps. Also < driving a car." X-ray of back revealed no abnormality. He had lukewarm Sitz bath and was given Hydrocortisone infiltration in the back, three injections altogether. He experienced a shooting pain on rising from sitting. A well known Orthopedist told him that the muscles have become shortened and advised only exercise and no medication. In the sitting posture he could not cough because it will give him a sharp pain in the thigh. He had tried *Calcarea fluorata* 6x for two months. On examination the sign for sciatica was positive on the right side, that is he would feel pain on flexing the lower limb on the abdomen with the knee extended.

1984

November 22: *Rhus toxicodendron* 200/3 powders on, the same day followed by *Saccharum lactis*.

December 3: With the initial three powders very much better "as if never any pain. It was absolutely like magic." Gradually some reappearance of pain specially in the previous three days. Repeated *Rhus toxicodendron* 200.

December 12: No particular relief. *Rhus toxicodendron* 10M/1 powder. Next reported on **January 10, 1985**. Had been to Simla in the bitter cold of early January but no increase of pain. Feels better walking about and also while standing, is worse after sleep and very much worse on sitting.

Prescription: *Rhus toxicodendron* 10M/3 powders every 15 minutes.

1985

January 29: In his own words "good news after a long time. On **January 26** I had sat in the open on hard chair for 5 hours without any trouble." Can now sit longer hours and can change posture comfortably.

February 6: Again reported some recurrence of pain. Repeated *Rhus toxicodendron* 10M/3 powders every 15 minutes. Thereafter he continued generally well and so received only *Saccharum lactis* till on **May 9**, after a possibly strenuous tour, in which for some days he had been in Bombay (Coastal town), he felt not as well and so again had a repeat of the prescription *Rhus toxicodendron* 10M/3 powders, every 15 minutes. Once again there was an improvement but in July possibly due to the heavy monsoon some recurrence and the medicine was repeated on **July 22, 1985**.

Last reported on **September 6, 1985**. "Very much better — 90 percent OK. I am really grateful. I was in great agony and you have saved me."

Prescription: *Saccharum lactis*.

After some months he came to see me for treatment of his son and reported that he had been quite well. He confessed that he had been so bad that he anticipated he would be crippled and told his wife to take interest in his business and handle his accounts as he may not be able to carry on much longer. Last seen on **March 15, 1986**. Feeling quite fit and no trouble at all.

Case No. 2 (Sciatica)

Mr. M.K.B., age 42 years, consulted on March 15, 1986. Had been married 11 years and had two daughters. He was serving in a foreign firm as an Engineer.

Complaints: Pain in the right lower limb. Has had a number of attacks since 1973. The pain is from the right buttock to heel along the posterior side. In 1974 he was successfully treated with Homoeopathy. In April 1985, it recurred then it was relieved by five injections of Neurobion (Vitamin B1, B6, B12). He had it a third time in July 1985, after lifting a heavy weight. It was relieved again with Neurobion injections. The fourth attack was in December 1985, after playing football. This time the pain was very severe and he was bedridden for 38 days. After that he was using a lumbar belt but the usual allopathic treatment gave only partial relief. No significant modalities with regard to weather, time and position. No backache. No paraesthesia. Pain, burning in character
> fomentation > pressure (lying on the affected side)
> walking a short distance.

Nothing significant with regard to appetite, cravings and aversions, weather reactions and past illnesses. Was taking 4-5 paan (betel) to chew with tobacco.

Active habits, cool temperament. Very social and fond of company < alone (I cannot be alone for long).

X-ray: L.S. Spine — early osteophytes. Disc spaces W.N.L.

F.H.: Nothing significant except elder brother has a slipped disc.

1986

March 15: *Arsenicum album* 6, 30, 200/1 powder of each on same day.

April 5: Pain less, more comfortable "M.B.". *Placebo* continued.

May 5. Again M.B. No pain, walking and sitting in office. However, cannot extend leg easily when sitting on bed. "From previous condition M.B."

May 30: Had a recurrence of pain on 28th. ?After some house work. *Arsenicum album* 200/1 powder.

August 9: Continues to be better. Has none of the symptoms. However, the right leg is not the same as left. Cannot move it as freely. *Placebo* continued.

* * *

1992

September 1: Came again after six years and reported that he had been completely well with regard to his Sciatica in right lower limb — "Was 100 per cent normal", but in last fortnight the same type of pain on the left side. He had been so happy with the previous treatment that now he decided not to go anywhere else and came here rightaway. *Arsenicum album* 200/3 powders at 15 minutes interval was repeated again with gratifying results.

Case No. 3 (Sciatica)

Mr. D.K.G., age 30 years, unmarried, in service (sedentary job), consulted on September 27, 1988.

Two months earlier he felt pain in the right hip extending to the right lower limb posteriorly and had been diagnosed as Sciatica. After a few days he started to feel pain in the left side also. He had interesting modalities. The pain was < lying, better standing. Could stand even for hours. In rising he would feel a jerk like pain which would be > continued motion. There was no pain while walking. At night would get up and walk or stand for relief. No H/O getting wet in the rain. He had this pain

8 months ago. At that time he received Neurobion (Vitamin B1 B6 B12) injections and some other allopathic medicines. He also had some homoeopathic treatment but as that was a coded prescription one does not know what was given. One week prior to the consultation he had a sore throat for which he had allopathic treatment. There was copious thick yellow expectoration. No other significant features except in P.I. he mentioned of colds from childhood.

1988

September 27: Prescribed: *Rhus toxicodendron* 200/3 powders to be taken on the same day. The relief was very rapid. He reported on **December 16**, and again on **January 11, 1989** and was prescribed only *Saccharum lactis*.

1989

He reported again on **May 15** with some recurrence and *Rhus toxicodendron* was repeated — three powders at intervals of 15 minutes.

He was not seen again till **September 8**. For the previous four days he had been feeling some pain in the right hip and right lower limb.

Rhus toxicodendron 200 was given for the third time.

In **April 1990**, he referred a friend who informed that Mr. D.K.G. had been quite well after the last prescription on September 8, 1989.

Case No. 4 (Sciatica)

Mrs. V.C., age 41 years, consulted me on November 20, 1990. She had been brought by her brother, who is a doctor and has established a nursing home and had seen me cure a number of Sciatica patients including himself. Mrs. V.C. had been married for the previous 18 years,

had one child, 16 years age. Thereafter pregnancy was deliberately avoided.

She gave a history of Lumbago that occurred suddenly in January 1990. She stayed in bed for 40 days and received analgesics and gradually recovered. Thereafter she had an occasional pain by exertion. Rest would ameliorate.

Present problem started from November 10, and the pain was so acute that she was moaning and groaning all the time and sitting in an odd posture. On that day she had felt a sudden jerk in the waist region and acute pain, thereafter there was pain and numbness in right lower limb. Numbness is increased by exertion. Pain > lying especially on right (painful) side. There was much pain in standing and walking. With the pain a sense of heat and sweating. An area below the knee has pricking sensation. Desire to keep pressing the foot.

Only pertinent points in the rest of the history were she had frightening dreams — always of snakes and water. Huge snakes. Not biting her. Dreams of danger from water as if it was coming over her.

She was a chilly patient, feet cold, can't get them warm. Lacking the generals the following rubrics were chosen:

P-1065 Sciatica, lying on painful side, amel.: *Bry.*, *Coloc.*

P-1065 Sciatica, numbness, with: *Coloc.*, *Gnaph.*, *Nux-v.*, *Phyt.*, *Rhus-t.*

1990

November 20: *Colocynthis* 6/28 powders q.i.d.

November 27: Lot of improvement. *Saccharum lactis*.

December 3: I received a letter from Dr. (her brother) which reads "So grateful to you I am, for accommodating me out of the way every time when I step

in. I wonder as to how Homoeopathy works in such acute problems. Some how I have started feeling and believing that Homoeopathy works in many hopeless cases. Before your treatment, Vijay was so much in trouble that she fainted in bathroom. She has almost recovered." "Can lie on either side. Generally much better but pain in heel is more persistent though dull. Pain < sitting. Pricking pain below knee is OK. Some stiffness in leg. No sense of heat or sweating, that she had before. From 3rd day she has been moving about in the house." She was from out-station and now she decided to go home so I decided to give medicine to act for longer duration.

Colocynthis 200/3 powders at 15 minutes interval followed by *Saccharum lactis* for a month.

1991

January 22: Stiffness in back if she sits for some time — for about 2 hours. Is alright in the morning. Cold may possibly increase it (lives in the mountains — Solan). Stiffness right leg and cramps. Symptoms better by rest.

Sepia 200/3 powders at 15 minutes interval.

February 4: Stiffness in back better, stiffness right leg and cramps better. Can't walk for long. Seems like dragging right leg. In last week some sense of pinching again. Ten days ago urticaria, had it one year ago. ?Return of old symptoms. Relieved of it in a few days without any treatment.

Colocynthis 200/3 powders at 15 minutes interval.

March 3: She is feeling well generally. Occasionally stiffness in the back. *Saccharum lactis*.

March 30: Received a telephone message. Had been well all these days but feeling some recurrence for the previous two days. The medicine was repeated.

Colocynthis 200/3 powders at 15 minutes interval.

May 31: Telephone call received. "99% O.K."

July 15: Telephone call received. "I am quite well. Shall I stop medicine or take for one month more." Of course after the *Colocynthis* on March 30 she had all along been on *Saccharum lactis*.

August 27: Came personally to collect medicine for her mother-in-law. She was quite normal and engaged in all the activities. Very happy and grateful at the result of treatment which was concluded.

Case No. 5 (Sciatica)

Dr. D.K., age 39 years, married for 10 years with three children; a practising physician consulted on July 13, 1990. He came as an emergency from outstation without appointment and brought by a doctor colleague who had been treated by me for a similar trouble some years earlier and been well ever since.

He stood near the chair for a few minutes which I thought was out of politeness or respect as is customary in this country so I asked him to kindly sit down. At this he replied that he preferred to stand because the pain in his leg increases very much by sitting. He had pain in the left lower limb for the previous 10 days with extension typically along the course of the sciatic nerve. Sometimes he felt some formication in the area of the pain. He had had two previous attacks — in 1981 and 1987 but this was the most severe. As it was the rainy season I asked him if he had got wet in the rain but this he denied. His modalities were marked > > lying back > lying on right (painless side) > standing < < sitting. < bending. > Fomentation. Feels alright in walking. X-Ray picture of Lumbosacral spine showed no abnormality. Is moderately obese. Because of the great pain in sitting he was not attending his clinic. The repertory in-

licated a remedy which I had never used for this condition before. I used the two rubrics on page 1065, pain; lowerlimbs; sciatica; sitting agg. and lying amel. Both of them had Am-m. in bold letters. Prescribed: *Ammonium muriaticum* 200/10 powders q.i.d.

July 23: I received a telephone call, 'much better', attending to his patients i.e. sitting in the clinic for two hours at a stretch. Thereafter starts to feel slight discomfort which is quickly relieved by rest. Pain is now only in the Lumbar region of back and no extension along the left sciatic nerve. Sent *Saccharum lactis*.

August 13: I received the following note:

"I am feeling much better than earlier. But I am having more pain in lumbosacral region and left sacroiliac joint. I have radiation numbness in my leg on the anterior side. For how long medicine to be taken?"

Now I repeated *Ammonium muriaticum* 200/3 powders at 15 minutes interval.

That relieved him quickly and whatever further news I had till the end of September 1990 was that he continues to be well and there has been no recurrence, and he is actively engaged in his medical practice.

Case No. 6 (Sciatica)

Dr. A.C., age 40 years consulted on **November 27, 1981**. He was married and had children. He was running a nursing home and his own role there was as a surgeon. He came in desperation, the reason for which I mention later.

Complaints: He had been having pain in right lower limb for the previous 2½ months. The pain was from the hip to the heel and foot. It started after a bout of sneezing during which he got a sudden pain in the back. There had been a history of such a pain on previous occasions

but that was not so intense or so prolonged. With the pain there was also some numbness. X-ray pictures had shown a reduced I.V. disc space L4L5 with local osteophytosis.

Modalities: > Warmth — in bed > hot water bath > pressing the limb < walking < sneezing < coughing < straining at stool > lying on painful side < starting to move > after a few steps. However, as mentioned above in general he was worse by walking.

Appetite: Good. Non-vegetarian. Salt ++. Smokes 1-2 cigarettes. Alcohol in socials, average one or two times a week.

B.O.: But not quite satisfied (tendency to be constipated).

Sleep good. No significant dreams. Weather reaction not marked.

P.I.: Bronchial Asthma as a teenager. This was cured by Ayurvedic treatment. During a later visit mentioned that he had a weeping eczema at the age of 14 years.

F.H.: Mother — Asthma. Father — T.B.

1981

November 27: *Colocynthis* 200/3 powders in the evening and bedtime of the same day followed by *Saccharum lactis* t.i.d. for 11 days.

December 10: Sent a messenger and asked for repeat from my assistant and got *Saccharum lactis*.

December 21: Reported that the pain had gone within one week of the first prescription. Slight numbness was still there. *Saccharum lactis* for 3 weeks. Been free of Sciatica and no further medicine for this complaint till date of reporting, i.e. 1993 (12 years later).

* * *

1993

On **February 21**, he took me to see a cousin of his, a famous surgeon who was bed-ridden with severe pain in the back extending to both lower limbs. He now recounted to me with great satisfaction his experience from the treatment he had had from me in 1981. He told me that before coming to me he went to see Prof. Dr. Dave, the senior-most Orthopaedist of AIIMS. Dr. Dave, in a way, rebuked him for having neglected his condition for so long as already he was showing signs of neurological deficit in the right lower limb which was ascribed to the pressure on the nerves in the lumbar region. Prof. Dave insisted on immediate admission and operation and brushed aside the hesitancy on the part of Dr. A.C., who suggested trial with conservative treatment for some time. Fearful of the possible consequences of any complication at the operation which may leave him lame or paraplegic for life, he virtually ran away from the ward against medical advice. He now confessed to me that he had earlier had no faith in Homoeopathy and had been persuaded to come to me by his father, who, though an Allopathic physician, had seen some remarkable cures with Homoeopathy. Now, since he had been saved from an imminent delicate operation on his spine he even bought some books on Homoeopathy and would use it from time to time. After he felt relieved, he called on Prof. Dave again and asked him, "Do I still need an operation?" After careful examination he answered, "Though there is a very slight neurological deficit still, but considering the great relief and the fact that you are carrying on all activities without any discomfort, it is better we do not take the risk of an operation".

* * *

Hypertension

1983

In 1981, the Sciatica treatment was concluded and Dr. A.C. was not seen again for 15 months. He was seen again in March 1983, but this time it was for Hypertension — B.P. 160/100.

Natrum muriaticum 200/1 dose improved him generally and B.P. reading reduced to 130/90.

* * *

Hyperchlorhydria

1985

Thereafter he (Dr. A.C.) reported again in November, 1985. This time with hyperacidity symptoms. A year earlier he had Acid Peptic symptoms which was diagnosed as Duodenal ulcer and I think he hastily went in for surgery — truncal vagotomy with gastrojejunostomy. His present symptoms have been put to a reflux acidity which will awaken him at 3.00 a.m. with some choking sensation. He will wake up with cough with a feeling “as though some fluid were going down larynx and he must cough it out”. Off and on he will have sour bitter greenish vomit. Postoperative endoscopy (3 months after the operation) showed: “Area of hyperaemia high up on lesser curvature and mild duodenitis. Stoma not seen”. Lateral view endoscopy: “Stoma high up on posterior wall; afferent and efferent loops normal.”

His smoking had increased to 5-6 cigarettes daily; had stopped alcohol after surgery; still a craving for salt which he added even without tasting. Had a desire for spicy food with chillies and fried food though he was trying to avoid in view of his condition.

< closed > open air (windows open even in winter nights).

Mentals: Irritable at work. Feels upset for any injustice/foul play. Fastidious about cleanliness.

1985

November 2: *Phosphorus* 200/3 powders during evening and bedtime of the same day.

November 19: Remarkable relief. No problem at all after starting treatment. Slight heartburn after being indiscrete in eating on a festival night. This was however very mild and he had no waterbrash or vomiting. He was so impressed that he remarked "I think I will have to put away my scalpel and surgical instruments." As mentioned above, he met me after 8 years on February 21, 1993 and informed me of his having been well since the previous treatment.

Case No. 7 (Sciatica [Use of Low Potency])

Mr. P.R. age 65 years, a businessman, consulted on March 17, 1989. He had been diagnosed as a case of Sciatica on the left side from which he had suffered for the previous two years. He complained of pain in the left hip extending down on the posterior aspect of the limb, right upto the foot. At times he felt some sensation of heat in the sole of left foot. This was likely to be aggravated in the months of June and July. There was no seasonal modality for the sciatica pain. He had had S.W.D. and used analgesic tabs. (Diclogesic). This gave some relief initially in October 1987 and helped again when it recurred in May 1988. In fact he was free of pain in 1987-88 winter. In November 1988 he had S.W.D. as well as Traction and used different tablets because it was his feeling that Diclogesic which he used earlier caused flatulence. However, the new tablets resulted in ulcers in the mouth.

When he had another recurrence in February 1989 S.W.D. was tried again but this time no relief.

Pains start after he gets up and has walked a few steps and it increases with continued motion.

> By rest (sitting or lying, especially on back). Twice noticed that his sciatica would aggravate when he had an upset digestion with semi-formed stools. Chilly patient. Nothing significant in the mentals or cravings and aversions in food.

X-ray picture of the Lumbosacral spine showed Osteoarthritic changes with marginal lipping. No spondylosis.

P.I.: Urolithiasis 1975 — passed calculi by use of Ayurvedic medicine and no surgery was necessary.

1989

March 17: Prescription: *Colocynthis* 6/24 powders q. or t.i.d.

April 7: Much better. Can walk. Goes to market. No pain at all. Sleep is not very good.

Prescription: *Placebo*.

April 12: Continues to be free of pain. Reports better, appetite and digestion better. Sleep is alright but not refreshing. *Placebo* continued.

April 19: Sleep good. No pain. *Placebo* continued.

May 13: In this period had a nasal catarrh and since I was abroad he used antibiotic (Bactrim). Now nasal catarrh is better but has sensation as if something has stuck in throat. Thirstless.

He was prescribed by my Assistant *Pulsatilla* 30/20 powders q.i.d.

June 5: Continues well. Now driving his car which he had not done for a long time. He continued well thereafter and so everytime received *Placebo*. In the month of August he went to his home town (Ahmedabad) and

there for diarrhoea he had allopathic treatment (Lopomide etc). Reported again on **September 2**. There had been no recurrence of sciatica but in the previous few weeks felt a pull in lower half of left leg during sleep, mostly in the early hours of the morning and when he turns to right side. Even though his diarrhoea had been controlled but he still felt discomfort in the abdomen, particularly in R.I.F. He had used the allopathic medicines till August 31 and to neutralise this effect he was given *Nux vomica* 30 morning, afternoon and bedtime for four days.

September 11: Reported better. No pain R.I.F. and no discomfort abdomen. The sensation of pull in the leg also much better.

Comments:

1. This is a case where a remedy in low potency helped a patient with history of fairly long illness.
2. Very little medication was necessary and the golden rule of "No repetition as long as improvement lasts" was observed with gratifying results. In fact no repetition was needed at all after the initial stimulus to the system.

STREPTOCOCCIN IN A CASE OF POLYARTHRITIS

Mr. V.P., age 35 years, consulted on **December 6, 1977**. He had been married 6 years and had two children. He was an officer in the Army.

Complaints: His problem started with cold and cough on **November 11, 1977**. Initially, there was also

fever with lot of aching in the body. In the military hospital he received Antibiotic Ledermycin for 3 days. The temperature dropped from 101-102 range to 99.5°F. Then he was given Antimalarial medicine plus Erythromycin. On November 19 he had severe pain in the left lower limb and back. Pain was especially acute behind the knee and in the big toe. There was slight swelling of the big toe. Next day the right big toe and right hip also got affected. As the right got affected, the pain eased on the left side. The next day the bony cage (ribs) started to pain and the lower limbs felt comparatively much better. Thereafter this kind of shifting pain continued. The Rheumatologist in the military hospital put it as Polyarthrititis and put him on Aspirin 10 tabs. daily. Throat never really cured fully. So from November 28 to December 4 (7 days) he received additionally Septran. This reduced the pain in the throat and the cough but did not clear it completely. It still hurt slightly on swallowing. Expectoration — thick, yellow, small quantity after much coughing.

Lost about 8 lbs in weight.

Appetite — Good. Non-vegetarian. No cravings.
B.O.R.

Sleep — Good. Dreams — Nothing significant.

Vaccination — 3 years ago. Earlier every 2-3 years.

Neither significantly chilly or hot patient.

Has been a patient of "Allergic colds" — bouts of sneezing, rhinorrhoea and redness eyes, lasting one to three hours for the previous 10 years. More likely in winters and from change of temperature, especially change from warm to cold.

F.H. — All members of family suffer from colds but no asthma or urticaria history.

P.I. — Typhoid at 5 years, with that had swelling of foot. Fungus in groins in summers. Has been using antifungal applications. Has occasionally had bald patches in beard region. They appear and disappear and reappear. At one time took Pix liquida 30.

O.E. — Heart, lungs, abdomen: N.A.D. Joints show no signs of active inflammation or swelling. Throat — slight congestion.

1977

December 6: *Pulsatilla* 200/3 powders on the same day.

December 13: No change. Lost 2 lbs. more.

Rhus toxicodendron 30/21 powders t.i.d.

December 21: "Definite relief." Is better but not completely relieved.

Rhus toxicodendron 30/18 powders t.i.d.

December 27: Pain got alright in all other places — the slight pain he had in all the joints and now it is concentrated in right hip from December 26. "As I had a month ago and it may shift in a day or so." Dry cough has persisted.

Rhus toxicodendron 200/3 powders in the same day.

1978

January 7: Better. Cough >; Pains >; Pain hip >; Clarified that the pain that is there is not so much in the joint but at the end of the bone.

Saccharum lactis continued.

January 27: I have no notes but apparently there was a slight recurrence as I have repeated *Rhus toxicodendron* 200.

February 8: Better but not totally free. "I feel there is more relief with the initial powders than with the pills that follow." (The pills are *Saccharum lactis*).

Rhus toxicodendron 10M/3 powders on the same day.

February 22: Better than before. Has throat irritation with slight soreness and cough. Repeated *Rhus toxicodendron* 10M.

March 24: A very slight feeling of discomfort in feet in the morning. Most of the other joints normal. By and large feeling okay. Throat irritation time to time.

Streptococcin 200/1 powder.

April 21: Pain sole of foot in the region of heel and adjoining part of the foot.

Calcarea fluorata 6x/168 tabs. 4 tabs t.i.d.

* * *

1979

I did not see him for 11 months till he reported again on February 6, 1979. In the meantime he had been transferred to another town. Had kept very well after his last visit, so regularly playing golf. In January 1979 he played a golf tournament and having played for more than 4 hours that day he felt slight stiffness in muscles that evening. Three weeks earlier he had bad throat and slight fever for which he had local Homoeopathic treatment. From last night there is concentration of pain and stiffness above the left knee. < morning.

February 6: *Rhus toxicodendron* 10M/3 powders.

February 9: No change. Has a low grade fever — upto 100°F. There was no feverish feeling and it was just recorded accidentally. So it is possible that he may have had it even earlier.

Saccharum lactis continued.

March 15: He made a long distance telephone call and reported generally well but occasional sore throat and sometimes mild pain.

Streptococcin 200/1 powder.

April 2: Much better. Has no complaints.

Saccharum lactis.

April 28: Continues well and asks for a repeat.

Saccharum lactis.

Comments: Homoeopathy teaches us not to theorise. However, an understanding of the pathology and possible interlinks between some conditions can at times help in the treatment. Inflammation of the tonsils has been widely considered as linked with certain systemic ailments and one of these is the joint inflammation and rheumatism. In this case because of a lingering problem with the throat Streptococci was prescribed with very good effect. This and some other nosodes were especially promoted by Dr. Margaret Tyler of England.

RHEUMATOID ARTHRITIS

In July 1993, I received a telephone call from a well-known and very important person in Delhi, who had benefitted from my treatment earlier, to give medicine for her cousin brother who was in another city and was in a desperate condition. The patient had been fully investigated in a hospital in Bombay and consulted well-known physicians and rheumatologists. A voluminous file containing copies of all the investigations and treatment was sent to me under the impression that that will give all the information. Some of the papers are annexed. I told her that having carefully scanned through all those papers, I have known only 3 things: (i) name of the patient, (ii) his age, and (iii) the diagnosis of Rheumatoid Arthritis. Beyond that the rest was all a heap of junk for me and it was quite impossible to make

a proper Homoeopathic prescription and I insisted that I see the patient at least once personally. At her great reluctance, I told her if he can go to Bombay, he can surely come to Delhi which is nearer to his home town. She made a long distance call to him and I agreed to give them an urgent early appointment. However, on that day instead of the patient, his wife came at the appointed time. She said that they tried their best but the pain was so great that he just could not undertake the journey and she would give all this history. I learnt much later that in fact she was a doctor (allopath) which fact she did not tell me initially. So we managed the following history:

Mr. S.N., age 40 years, married in 1977, has one child 15 years of age. Subsequently, the wife had two abortions. She was found to have fibroids and had a Hysterectomy operation in 1987. He was working for a company and as he was Incharge Sales it involved much driving and outdoor work and also touring.

Complaints: It started with pain in the right shoulder 5 or 6 years ago. After 2 months as pain used to be quite severe, R.A. Factor was checked and found positive. He had been a good cricketer and is right hander but there is no history of injury or any other obvious cause. Later as other joints got affected, he felt that the pains are < winter < rain (slight increase) > fomentation. Pains are shifting always been a chilly patient and never felt comfortable sleeping with a cooler in summer. Had been < morning for about an hour, then he takes analgesic tablets (Brufen, later Voveran, recently Indocap). Time to time has used steroids (Betnesol) in the last one year. It would give dramatic relief. Therefore he would take it quite frequently. In fact there were periods when he took it on alternate days. Then as a side effect of steroids he started to have swelling with puffiness face (moon

face) neck etc., so stopped one month ago and thereafter is practically locked up and immobile.

Appetite: Good. Non-vegetarian, smokes 8-10 cigarettes, alcohol occasionally, only a social drinker. Fond of eggs, in any form but specially fried. Fond of bananas. B.O.R.

Sleep: Always been short and wakes up unrefreshed.

Skin is dry < winter. Is tall and lean, approximately 5'11" and weight around 68 kg.

Very irritable, hurried, pessimistic in all matters, looks at darker side of things, depressed, sympathetic, helpful. Averse company. Opens up with difficulty and has few friends. In his work it is the opposite.

P.I.: Piles, bleeding in 1988 for about 1 year, got relieved without any treatment and has been free of it for the last 4 years. Jaundice in 1987. Malaria 2 weeks ago. Suffered for 10 days and was followed by diarrhoea. Has had no operation and no major injury.

F.H.: Nil of R.A., D.M., T.B., Asthma. Mother died during operation for thyrotoxicosis when he was 4 years of age.

1993

July 30: *Nux vomica* 200/3 powders at bedtime on 3 consecutive nights with *Saccharum lactis* in pills to follow.

August 13: (Telephone message) Pains relieved by 60 per cent or more. Further supply of *Saccharum lactis* sent.

August 24: (Telephone message) Recurrence of symptoms. Has fever, vomiting and pains.

Repeated prescription of **July 30** (*Nux vomica* 200).

September 3: (Telephone message) Before receiving medicine of **August 24**, had already started to improve,

so he continued with medicine of **August 14** (*Saccharum lactis*).

September 17: (Telephone message) Much better. Pain gone, swelling gone. However, HB. is low at 8.4 gm. The doctors opine that this is due to the earlier use of Indocap.

September 24: Came personally. As the entered the clinic he said, "I feel quite normal and I have only come to offer obeisance and to see you personally because I worship you. I was cripple before your treatment and now I am quite normal and even going round and attending to my official duties". Pains are tremendously better. Temperature normal for the last few weeks. On one day it was 99.4°F.

It was a slow amelioration from **August 25**. For the first time asked for food. Now for last few days felt he is eating a normal meal. Still have some pain mostly in right shoulder and usually in the evening 6.30 to 9.30 p.m. Has reduced cigarettes. The desire to smoke itself has reduced.

O.E.: Restricted movement of right shoulder and slight discomfort right elbow. All the other joints normal. Heart, lung, abdomen and throat N.A.D. Thereafter had telephone reports on **October 22**, **November 20** and **December 21** and since every report was "doing well" he continued to receive *Saccharum lactis*.

1994

I got an occasional report from other relations that he is actively engaged in his work and no health problems. On **May 14**, a cousin of his consulted me and I enquired about Mr. S.N. and was given a good report. Even though initially I had prescribed *Nux vomica* 200, but I had in the margin noted for consideration two remedies: *Natrum muriaticum* and *Aurum*. However, since the response was unexpectedly good, the need for any of these did not arise.

Annexure

Letter dated July 20, 1993 from wife of the patient to his cousin in Delhi: "I am writing this letter in real desperation. As you know, Salim is suffering from Rheumatoid Arthritis since the last four to five years. Initially when the disease started, only the right shoulder was involved. Pain was occasional, and relieved by mild pain killers. Gradually, other joints were involved — knee, ankle and finger joints.

He feels run down and very weak specially towards the evening. We had been giving him various combination of drugs, Brufen, Voveran, Paracetamol, Aspirin and Betnesol occasionally.

During the last fortnight, his condition worsened and he was taken to Bombay. Dr. S.N. Amin, a famous Rheumatologist has prescribed *methotrexate*.

Methotrexate had been prescribed in very small doses but nevertheless it is a very toxic drug. Toxicity is manifested in the lungs, liver and bone marrow. I am not keen to start him on that. The second line of treatment is to give him Golder (Gold tablets). Golder though not so toxic, damages the kidneys after a long time.

At present, though there is lot of pain and immobility, yet there is no deformity. It is difficult for him to reach for a glass of water, and dial the telephone, and is not in a fit condition to travel.

Please take this letter and the attached reports to the best Homoeopath known to you and ask for his opinion.

Please send me the medicines urgently through courier. Also please note, that Allopathic pain killers will have to be given simultaneously for some time, and they cannot be stopped immediately. Also *Betnesol* has been totally stopped since the last 15-20 days.

Please treat this letter as very urgent."

* * *

Notes of Dr. S.N. Amin, Rheumatologist, Bombay.

Diagnosis — *Rheumatoid Arthritis: Secondary Sjogren's Syndrome.*

Treatment:

A. Inj. *Mexate-5* : 1.5 ml. I.M. once a week for 3 months

or

Tab. *Neotigexate (Methotrexate)* 2.5 mg. : 3 tablets at once on every Sunday at 11.00 a.m. (1-2 hours before lunch) for 3 months.

B. Tab. *Voveran* 50 mg. : Thrice daily or s.o.s.

C. Physical exercises.

CBC, SGOT, SGPT — To be checked once in four weeks regularly and to send the report.

Laboratory Reports:

— E.S.R. (Westergren) 127 mms.; (Wintrobe) 52 mms.

— Latex slide test for Rheumatoid Arthritis
... Positive

— T. and DLC : 13,000 P 63 L 34 M 1 E 1 B 1

— HB. : 12.80 gms (81 per cent) Rest of the Haemogram normal.

— Urea, Blood Sugar and detailed blood chemistry (S.M.A. 12 profile) : W.N.L.

— X-ray — Both hands and wrists. "Early Inflammatory Arthritis ?Rheumatoid Disease should be considered."

The above papers were sent to me alongwith letter dated July 22, 1993 by the cousin of the patient, who resides in Delhi. This short letter reads as follows:

"My cousin (who is in Bhopal) is seriously ill. He has sent me his medical reports. I shall be very grateful if you kindly go through the papers and advise me as he is in real agony. I shall anxiously wait for your reply."

OSTEO- ARTHRITIS

On April 21, 1992, I am consulted by Mr. S.C.C. suffering from Osteo-arthritis and he requests me to cure him in the same manner as I cured his brother Mr. K.C.C. suffering from the same condition.

Mr. K.C.J., consulted me on **February 12, 1972**. Age 42 years, got married in 1955, has four children aged between 11 and 6. An Advocate by profession.

His history was that there had been over-exertion in 1968 while he was constructing a house. He started feeling a pain in the left knee when there was a slight jerk. Also a swelling appeared which the Orthopoedist put as due to fluid in the joint. He remained fairly comfortable with the Indocid that was prescribed for him: and later Butacort helped to dry up the fluid and reduced the swelling. However, in the previous two months he had had considerable discomfort and pain and X-ray pictures of the left knee showed Osteoarthritic changes (osteophytes). He had been using a knee cap and possibly due to that or reduced use of the limb there was thinning of the left thigh.

His other complaint was a chronic history of digestive trouble. He was bothered with much flatulence for which he will walk and that would promote the passage of flatus with some relief. He also felt constipated. The only outstanding feature in his mentals was that he was intensely sympathetic. Could be upset on hearing anyone's trouble or accident or even news of someone's death on the radio. Generally of nervous temperament. Used to keep wringing his hands till a friend of his rid him of the habit.

F.H.: Diabetes in both parents. Father died of heart attack at age 54.

1972

February 12: *Causticum* 200/3 powders at 10 minutes interval.

February 23: Reported better. Can stand longer without discomfort and walk is easier. Digestion is also better.

March 15: Better.

April 3: Improvement continued. No trouble in walking.

April 18: Slight pain in knee after squatting. Swelling much less but not totally gone.

Repeated *Causticum* 200/3 powders at 10 minutes interval.

June 26: "Feel better by 80 to 90%"

July 6: Improvement had continued in the previous two and half months. Had been involved in a relation's wedding and had considerably over-exerted. Thereafter more pain.

Causticum 200/3 powders at 10 minutes interval.

July 29: "90% O.K. in pain and nervousness."

* * *

1974

March 29: There had been no report for nearly two years as he was located in a township about 30 Km. from Delhi. He had been feeling quite normal and carrying on his work in the court which involved considerable walking and standing. Therefore he felt no need to report. In his own words, "it has been a marvel that I did not expect". Recently he had been through considerable physical strain again and felt a very slight recurrence and desired a repeat of the old prescription so that trouble may not increase. So he was again given the

Causticum 200/3 powders and I had no further news till his brother came 22 years later as mentioned above.

Comments: There are not many many symptoms in this history and there could be many remedies for pain in the knee. On the basis of the pathology one might lean more to the Calcareas. Therefore the additional symptom that brought about such a remarkable cure was in the mentals. The symptom was marked and it was considered necessary to choose the remedy from within the rubric "Sympathetic" on page 86.

CHRONIC OSTEOMYELITIS

Case No. 1

In April 1987 a lady in her late 50s came to Delhi from outside searching for me for her treatment. As an introduction she said that I had saved her daughter Miss D.D., 23 years ago and also informed me that she had subsequently been well, is married and has a family of her own. I dug out the notes of Miss D.D. but was disappointed to see that these were sketchy as I had made a house call.

Miss D.D. age 16 years, was seen on May 4, 1964.

This was a case of Chronic Osteomyelitis of left Femur. At the beginning of this condition she had also a lung affection ?T.B. She had had some other treatment before seeing me and the lung trouble had already cleared. Remembering the recommendation of Dr. M.L. Tyler and the possibility of the Tubercular miasm I prescribed on May 4, 1964 a single powder of *Drosera rotundifolia* 200. This was repeated on August 8, and September 25. Possibly there was some improvement

but the condition was not cured. On **October 27**, she was given *Calcareo carbonica* 200/2 powders at 1/2 hourly interval.

The next report was on **December 1, 1964**. My notes read as follows:

"5 days after taking medicine very extensive discharge of pus and blood the like of which had not occurred for years. This continued for about 5 days. Thereafter it reduced rapidly and then ceased and now the wound is quite healed. The pus discharge which had never entirely stopped all these years is now absolutely ceased."

January 9, 1965: "Absolutely alright. No discharge and the wound fully healed."

Case No. 2 (Chronic Osteomyelitis)

On August 28, 1990 I am consulted by Mr. B.D., now aged 26 years, with the complaint of premature grey hair and wishing to be cured as fast and effectively as he was from a serious condition for which he had been treated 10 years earlier "I had been suffering 8 years and you cured me in a few months." His previous notes show that he consulted me on October 20, 1980. The history was that he had pain and swelling in right thigh for which he had been operated some six years earlier i.e. around the age of 10. The pus was drained, the wound closed and he was normal for 5 to 6 months. Then an abscess formed and burst itself from the same place. This kept repeating from time to time. In 1978 was operated again and in the pus discharge there was also a small piece of bone. The wound closed but some pain persisted. One month prior to my consultation he again had an abscess and was operated. Every time there was inflammation he would

also have fever. There was nothing pertinent in the rest of the history. There were no illnesses of note in the past nor anything important in the family history. He was a hot patient.

Reports: 1976 — X-Ray shows sequestrum. Pus culture at that time gave a growth of staphylococcus aureus.

1980

X-Ray shows Periosteal calcification and expansion of shaft of femur. "Suggestive of Chronic Osteomyelitis."

October 20: Prescribed *Drosera rotundifolia* 200/3 powders to be taken during evening and bedtime.

November 12: Condition unchanged. Discharging pus. Also complains of pain below the knee — upper end of tibia. Pain and swelling increases by over-exertion. Passed a small piece of bone.

Boericke's Repertory page 954:

BONES, Inflammation (osteo-myelitis): Acon.; Chin-s.; Gun-powder; Phos.

Prescribed: *Phosphorus* 200/3 powders at 15 minutes interval.

November 22: Passed two more tiny pieces of bone. Pus discharge persists. Has a sore throat and cold for which he was advised saline gargles and no other medicines.

December 16: "One week ago passed a biggish piece of bone. Thereafter all discharge stopped and the opening closed." No pain, no inflammation signs. The sinus on lateral side remains closed and shows no tenderness but from the previous day has inflammation, pain and tenderness over the operation scar on medial side of thigh.

Repeated *Phosphorus* 200.

1981

January 2: Not finding any spectacular relief, I prescribed *Hekla lava* 6x t.i.d. and this was continued for three weeks.

January 28: Reported that some days earlier openings, both on medial and lateral sides, had closed but after a few days started to have pain in stretching the leg and in walking. There was inflammation.

Prescribed: *Silica* 6x, 30, 200/1 powder of each to be taken on the same day.

February 21: Reported that at beginning of February it opened on both sides, then inflammation and pain subsided. One week earlier a small piece of bone passed from medial opening which is still discharging. It had protuberant granulations. But is now getting better. Lateral opening has closed.

March 31: A week earlier the spot on medial side got a boil. This burst and discharged pus. No further sequestra. *Silica* 200/3 powders at 15 minutes interval.

June 10: No complaints. Feels quite well.

August 11: A boil is forming in the scar for the previous 4 days.

Silica 200/3 powders at 15 minutes interval. He did not report again till 9 years later in **August 1990** and now informs that he had been well all the while. Has grown quite tall. General health very good.

Case No. 3 (Chronic Osteomyelitis)

Mr. A.V. had been looked after me over long period of nearly 2 years. He first consulted me on **October 20, 1986** then aged 18 years. He had developed pain and swelling in the right upper arm on December 24, 1985. He also had fever and cough and chest X-ray showed

Bilateral Pneumonitis. Koch's was suspected but subsequently felt that it was not so. X-ray of the right shoulder and of the upper arm did not reveal any abnormality. He had allopathic treatment and it was felt that as a consequence of this he later developed Jaundice. After sometime he developed an abscess on medical aspect upper part of right upper arm which was operated (incised and drained) under General Anaesthesia on January 16, 1986.

The wound did not heal fully and a sinus remained at distal end of incision. This continued to discharge pus, at times with blood staining. Some bone particles/spicules also appeared in the discharge. Now it was diagnosed to be a case of Chronic osteomyelitis. X-ray picture taken in April 1986 showed the Chronic osteomyelitis involving the whole shaft of right humerus. The periosteum was lifted in two locations and there were irregularities in the bone pattern in different parts of the upper half of the shaft. Thereafter he had Homoeopathic treatment elsewhere for six months. Initially the sinus closed but he developed a swelling on the lateral aspect at about the same level which burst later and discharged pus. After sometime this closed but still later another opening formed with similar pus discharge. The patient had swelling, redness and pain which was relieved by discharge of pus. He had had C/S (Culture/Sensitivity) of the pus and on the basis of that report was given repeated courses of Gentamycin. His appetite was somewhat reduced but there has been no appreciable loss of weight. He had craving for salt and moderate liking for spicy and sour food. The thirst was average and he preferred very cold water. Perspiration somewhat more than average. He was a hot patient and generally felt better in the open. Vaccination has been very infrequent

(certainly had it twice). Sleep was good. He said he sleeps a lot. He was irritable but anger is not long lasting. Stubborn. Likes being alone or meet only selected people and keeps problems to himself.

P.I.: He gave a history of Typhoid 5 years earlier.

Family history: A grand-father suffers from Diabetes.

1986

October 20: *Drosera rotundifolia* 200/3 powders every 15 minutes. **November 8** reported better. The discharge is less and pain is not increased and possibly somewhat decreased. Mentioned that previously if the discharge got less the pain would increase. A fresh X-ray showed considerable damage to the right humerus.

November 24: Discharge is less, pain slightly less. Some increase in movement. All told better.

December 20: Not as well as when last reported.

Prescribed: *Phosphorus* 200/3 powders every 15 minutes.

1987

January 8: Nothing special to report, condition keeps varying.

February 7: The pain increases after writing for sometime. He had more occasion to observe this as he was preparing for an University exam. Repeated *Phosphorus* 200.

March 6: Occasional cough after exposure, dry.

Now gave an additional symptom that he has fear looking down. During these months no sequestrum was passed.

Prescribed: *Silica* 200/3 powders every 15 minutes.

April 18: Inbetween he had taken the examination and to reduce pain and write his papers he had been

taking analgesics. Elbow feels stiff and cannot be extended.

May 16: "Last medicine has helped". Felt generally better. There was a swelling just above the elbow joint and the area felt slightly warm and tender. Elbow can be fully extended now.

At beginning of **June** he had much pain, was prescribed *Hepar sulphuris* 200/3 powders. Thereafter the abscess burst and a small piece of bone was passed.

July 23: The sinus near elbow is nearly closed whereas the original sinus persists.

August 18: *Silica* 200 repeated. In the previous six weeks he had had an abscess on the foot which burst and healed in due course.

September 12: *Tuberculinum bovinum* 200/3 powders, every 15 minutes. By **October 1987** pain was much less, movement better. He could write more freely. Feels heat much. Likes cold things.

October 10: *Sulphur* 200.

November 21: Reported that he had 'flu in the intervening period for which he used some antibiotics.

Repeated *Sulphur* 200.

December 28: Had passed a small bone particle but the sinus is still discharging.

1988

January 30: Reported that he passed another thin but fairly long bone particle. Report of X-ray a "multiple radiolucent areas with periosteal thickening, sclerosis and sequestration . . ."

Prescribed: *Gun-powder* 2x/21 powders t.i.d.

March 3: *Gun-powder* 2x/42 powders t.i.d.

During the subsequent months an uncertain condition prevailed. Sometimes the sinus discharged more and sometimes less — till he reported on **June 10**. Ear-

lier on **April 4**, he had been given *Silica* 200/3 powders every 15 minutes.

In June he complained more pain and more discharge. On examination it was noticed that a sequestrum is slightly protruding out of the wound. There was no fever. Repeated *Silica* 200/3 powders. Four days later a 6" long sequestrum extruded out of this wound.

On June 28, another X-ray picture was taken on my advice. The report was brief "Chronic osteomyelitis with sequestration". But it showed much disorganisation and a huge piece of bone having separated from the shaft of humerus.

Not being certain whether that this big piece would come out of its own or need surgery he was advised to take the Orthopoeidist opinion. The advise he received was to continue the medicine as the sequestrum is being extruded. It is separated from the main bone and will come out. The patient became very confident with the powders that were given to him and wanted a repeat.

He felt that the three powders given to him on **June 10**, brought about the rapid expulsion of the sequestrum. Therefore he was given three powders again but for obvious reasons these were not of *Silica* but *Saccharum lactis*. This was on **July 4th**.

July 12: the big piece of bone "long and thicker than a pen, approximately 1 cm. diameter came out. Thereafter the pus discharge ceased and the wound is healing."

August 13: No pain, no pus, considerably healed, very slight remains.

September 10: Wound completely healed. Stopped bandage by **August 27**, by then it had got completely covered with skin. In fact wound had practically healed by mid-August, only remained to be covered. No pain.

Shoulder has restricted movement, possibly due to long disuse. Acne for last 3-4 years. Recently a little more.

Pulsatilla 200/3 powders in the same day.

1988

October 21: Remains well. Weight 128 lbs. (On August 18, 1987 it was 113 lbs.).

November 28: Pain right upper arm, Shoulder and lower part near the elbow since **November 4**. ?due to a friendly blow on the shoulder one or two days prior to it, also extra cycling. Pain is considerable and disturbs sleep. Report of X-ray taken on **November 27**, "Multiple radiolucent and sclerotic areas are seen in the humerus with periosteal reaction due to chronic osteomyelitis". The Orthopaedist who had seen him before was amazed at the recovery and in such a short time.

Mercurius 6, 30, 200/1 powder of each on the same day.

December 5: Had fever for 4 days. 101-102°F. Pain is quite severe. The abscess that formed on the upper arm has burst in one place.

Hepar sulphuris 30/24 powders q or t.i.d.

December 19: Much discharge of pus from **December 15** and the swelling has reduced, the pain reduced immediately after that. Fever also subsided. The swelling has actually burst at the site of one the earlier incisions.

Silica 200/3 powders at 15 minutes interval.

He continued to make progress thereafter and the sinuses gradually closed with only a slight discharge from one sinus by **April 3, 1989** when he was last seen.

Silica 200 was repeated with *Saccharum lactis* to follow for a month.

This was his last visit and it is presumed that there was no further trouble.

GANGRENE

Mrs. S.K., age 61 years. Around 10 AM on August 14, 1991, I received a very urgent telephone call from someone who introduced himself as an old acquaintance having briefly met me in London in 1970. He wanted me to immediately visit his wife at the Escorts Hospital as it was proposed to amputate her right leg at 2 PM, the same day. I was extremely busy in my own clinic and in any case felt it useless to give a remedy which had to be effective in two to three hours and I conveyed this to him. Besides, it is not very congenial to visit patients in an allopathic hospital unless the attending doctors themselves invite and offer to cooperate. So, I suggested that he immediately come to my clinic and take the remedy which would depend more on the symptoms rather than the examination.

I was informed that the lady had I.H.D. with narrowing of the Coronary arteries for which Ballooning had been done 6 days earlier. Subsequent to this, she had pain in the right leg and progressive swelling. Then, she developed Gangrene of the right foot with bluishness extending to above the ankle. All this complication was considered as due to embolism in the artery (embolus coming from the heart). As a desperate measure, to reduce compression from the massive swelling, a long incision was made in the leg. This, however, did not make any difference to the Gangrene.

Some three days earlier, she had anuria for many hours and therefore, catheter was put in. The urination was normal now but the catheter was still in place.

Other features of her history were that she was mildly diabetic for 12 years which was controlled with oral tablets. She also had very high B.P. At one time, the

diastolic had touched 150 mm Hg. This was also being controlled with antihypertensives.

1991

August 14: *Lachesis* 30/8 doses in 1 oz. of water. A dose to be taken every 2-4 hours.

August 15: Partly at slight signs of relief and may be more from the persuasion of the husband, the Surgeon who examined her decided to postpone the operation till the evening. In the evening, he felt it could be postponed till next morning.

Lachesis 30 was repeated.

August 16: Slightly better. *Lachesis* repeated.

August 17: There has been some progressive relief and therefore the operation is being constantly postponed.

August 19: No significant further amelioration in last two days. The mauvish (bluish) patches are clearing and getting more normal colour. Foot is less cold but still no sensation. Much pain. Big toe still deep blue and not changing colour.

Lachesis 200/8 doses in 1 oz. of water. A dose to be taken every 2-4 hours.

August 20: As the patient had improved so much the idea of operation had been practically given up and all this only on a description by the husband. They now felt a personal examination may give much greater relief. On my visit, I reconfirmed the above features and was rather surprised at the extent of the long and wide wound on the leg as I had not expected it to be that massive an operation. The main problem was pain and the gangrenous condition of the big toe and two-three other toes which appeared to be recovering from the Gangrene. In any case, the foot though swollen was now

gradually assuming normal colour. In general, she reported much better.

Saccharum lactis.

August 23: No change. *Secale cornutum* 30/20 powders every 3-4 hours.

August 27: Slow further progress. Developed some vesicles on toes. Still no sensation. Considerable pain also on passively moving toes. Except the toes, rest of the foot now has normal colour and has no bluish/red-dish blotches. She was giving contradictory reports about aggrav. or amel. from heat or cold. So, it was decided to try *Arsenicum album* even though the modalities are quite different from *Secale cornutum*.

Arsenicum album 30/16 doses at 4-6 hours interval.

August 29: Same was repeated.

September 2: *Acidum sulphuricum* 30/12 powders q.i.d.

September 5: Repeated

September 7: Repeated

September 13: *Euphorbium officinarum* 30/20 powders q.i.d.

September 20: *Carbo vegetabilis* 30/24 powders q.i.d.

October 1: Has shown progress. Now 4 toes can be moved (all except the big toe). With the progress in the position of the foot, and the wound on the leg being wide, skin grafting has been done.

Carbo vegetabilis 30/24 powders q.i.d.

October 7: Graft has healed well and is using no bandage now. Skin on foot peeling, comes off fairly thick from the heel. Big toe still black.

October 14: *Kali phosphoricum* 6x/42 powders t.i.d.

November 1: *Hypericum perforatum* 30/21 powders t.i.d.

November 25: Started to walk with the help of walker but has lot of pain. The foot turns blue if she is in upright position for long. Feels the circulation is incomplete. Sensation of heat in sole but dorsal surface, neither hot nor cold.

Saccharum lactis.

November 26: Took me by surprise as she came personally and walked into my clinic.

O.E. — Foot is warm to touch. Says, at times, it is cold. Hard, black, parchment-like dead skin on big toe, middle toe and little toe — All on ventral surface. Can move the foot and toes. There is no sensation to touch on dorsum of foot but even slight pressure gives pain. Nail of big toe has fallen off but no bleeding from there. Slight oedema lower third of right leg and foot.

December 9: Telephoned, "Other than big toe, other toes have become normal, much pain."

Saccharum lactis continued.

1992

January 3: Only big toe remains gangrenous — dry and hard on the ventral surface. Has started to feel hot and cold. Has pain and tenderness.

Hypericum perforatum 200/3 powders on the same day.

January 17: Started to recover sense of touch even though it is less. Developed a dry cough for which she was given *Spongia tosta* 6 q or t.i.d. for a few days.

February 4: The black spots on toes have fallen off and skin underneath is quite normal. Only the spot on big toe remains and is hard like a button. On pressing it a little pus oozed out. It is clearly demarcated and may fall off as from other toes after some time.

Hepar sulphuris calcareum 30/21 powders t.i.d.

February 26: Had this last report on telephone, "it seems the gangrenous part on big toe will fall off. Pain of foot still persists."

Kali phosphoricum 6x tabs. t.i.d. for 15 days.

1993

Thereafter, she suddenly decided to join her husband who had earlier gone back to his work in England, considering that she was doing fairly well. I got no further report till January 23, 1993 when she consulted me again. While in England, she had an attack of Bronchitis or Pneumonia and was hospitalised. The Cardiologist felt that the heart condition was not very satisfactory and as the gangrenous scab had not yet fallen off and there was slight pus oozing, for reasons best known to the Surgeon there, the right big toe was amputated. I feel the decision was rather hasty and if she had waited longer even without treatment it would have come off like in the other toes.

Her present problems were more related to the heart and symptoms of atypical angina.

Comments: The patient and the family were particularly grateful for saving her from an imminent operation and losing a leg when it was a race against time. The operation was being postponed only by some hours every time and being closely monitored by the Surgeon and the C.M.O. of the hospital and the other staff who were greatly surprised to see the remarkable change that homoeopathic treatment brought about. Thereafter, they readily cooperated with me when I visited this patient twice in hospital and subsequently even some other serious patients.

INSOMNIA

Mrs. U.S., age 44 years consulted on **March 4, 1993**. She had been married 21 years with 3 children aged 20, 17 and 9. The second child was a C.S. while the first and third were forceps. She had had two premature deliveries and one abortion in the third month.

Complaints: Her main complaint that had been tormenting her for 8-9 years was severe Insomnia for which she had had all kinds of conceivable treatments. It started slightly during the second pregnancy, i.e., 17 years ago but in the last 8 years it has got so bad that she does not sleep at all for 3-4 nights at a stretch. Thereafter either she uses tranquilliser (at present Alprax) or sleeps out of sheer exhaustion. Then she sleeps for about 6 hours but is not at all refreshed after that. She had never been in the habit of a siesta or sleeping in the day time. When she sleeps, she has dreams of being strangulated, of snakes, of water — getting submerged and drowning. She complained of a heavy head in which she felt better the day she sleeps.

The other complaint she made was “anxiety”. I asked her about what and her answer was “about sleep”. However, her father-in-law told me that may be she was anxious about her only son aged 9 years who was suffering from Epilepsy. Besides, her mother also has some mental trouble.

She was never relaxed. Hurried from one occupation to another in an agitated manner. Though there may be no logic but she said the hurry was, “to finish the work quickly and then sleep”. Very irritable. Would have outbursts of anger. Pessimistic, negative thinking — a sense of incapability.

Palpitation off and on.

Appetite: Normal or a little reduced. Vegetarian. "Not relaxed enough to sit down and eat." Complained of gas.

B.O.R. but not satisfactory. Uses mild laxative (Isabgol) 2-3 times a week.

Earlier chilly, now feels both heat and cold. Much heat in upper part of body, keeps washing face to cool for the previous 2 years. < when angry.

M.P.: Irregular last 8 months. Has it every 2-3 months. No pain. No leucorrhoea. PMT — more anger, less sleep, etc. — 8-10 days before M.P., for last 3-4 years.

P.I.: High B.P. during pregnancy and then oedema ankles. Second delivery was a C.S. as mentioned above. No other significant illness.

F.H.: Mother: diabetes and mental trouble.

O.E.: Heart, lungs, abdomen — N.A.D. Ht. 4'9" Wt. 123.5 lbs. B.P. 132/80.

1993

March 4: *Silica* 200/3 powders at 15 minutes interval.

March 30: "There was no effect in first week, then normal sleep which I never expected. Normal sleep for 2 weeks or longer. For last 2 days again poor sleep possibly because of days of fasting (Navratrya fast)". Previously also there would be no sleep if she fasted.

Saccharum lactis continued.

April 10: Better. Some feeling of heat in face (the weather was also getting warmer). Still needs a laxative every 2-3 days for a clear stool.

May 8: Took a repeat (*Saccharum lactis*) from my Assistant saying that she was carrying on well.

June 18: Feeling very well. Has been consistently sleeping well for the last few months. Feeling of heat is less. Anxiety, agitated hurriedness and tormented feel-

ing all gone. "I feel normal, relaxed and tremendously better." Some feeling of constipation still remains.

Comments: *Silica* was given only on the first day and it resulted not only in complete relief of symptoms but a total transformation of the individual. No repetition was done during the next 4 months because the improvement was sustained. For a brief setback as reported on 2nd consultation on March 30, an effort was made to find a cause in the life style of the individual and since that was temporary, it was decided to continue with *Saccharum lactis* rather than repeat *Silica* or prescribe another remedy.

I may be asked as to how *Silica* was chosen in this case out of the very long list of remedies for sleeplessness on page 1251. The answer is that it was chosen mainly on the basis of her dreams — "of being strangled", "of snakes" (both on page 1243) and "of water" (on page 1244). Of course it appears in bold letters in the Rubric of Sleeplessness and Irritability and in italics in Impatience.

SYMPTOMS STUDY — DREAMS*

CASE OF OSTEOPOROSIS

When a Homoeopath asks a patient suffering from a gross pathological physical condition about his dreams, the patient often asks the Doctor, "What have my dreams got to do with my Fistula?" or he says, "Doctor, do you also interpret dreams?" Of course, the

* Presented at International Congress for Homoeopathic Medicine held at Acapulco (Mexico), May 1980.

Homoeopath has neither any pretensions to astrology, or to any psychological analysis of the dreams. Since, they have been brought out in the 'provings' he looks for them, as indeed for the other symptoms, in order to find a matching remedy.

However, dreams are of importance only if they occur repeatedly about the same subject. They are important because during sleep a man is off his guard, and his subconscious, freed from the restraining and modifying influence of his conscious self, can assert itself and so we get a little glimpse into the deep and hidden mysteries of that disordered life we call disease.

They pertain to the whole man and not to any of his parts and according to the classical formula are predicated by 'I' and not by 'My'. Therefore, within our classification dreams rank as strong 'Generals'.

There is the famous case of Aortic aneurysm treated with relief by Dr. Gibson Miller on the basis of the patient dreaming night after night of pools and seas of blood. He was given *Solanum tuberosum aegrotans* which completely removed his dreams and relieved the chest pain he had.

I now give in detail a very interesting recent case of mine which has brought considerable publicity to Homoeopathy through an article published in the famous Italian Fashion Magazine "Esquire and Derby", the patient herself being a journalist.

The case of Miss E.H.

I was asked in the summer of 1978 if Homoeopathy can treat **Osteoporosis**. My obvious answer was that Homoeopathy treats sick individuals and not disease names. It would, therefore, be necessary to get a detailed history from the homoeopathic view point. Thereafter, I received a request to see this patient in

Milan during a forthcoming trip of Europe.

I suggested that the patient may come to Vienna, where I was attending a Seminar. At this, the request was repeated to go to Milan, as the patient was practically in wheel chair. The person who was acting on behalf of the patient concluded the letter with the remark "If you can keep her out of the wheel chair, that would be wonderful."

I confess to considerable anxiety not unmixed with some nervousness at being called to a far off country to undertake the treatment of a condition where the chances of recovery were minimal. The reason for the anxiety was of course, the keenness to be able to help such a patient. Therefore, while in Europe, this matter had been on my mind before I actually went to see the patient. As such, I took every opportunity to ask colleagues there as to what they do for Osteoporosis. In London, I was told "Of course, Calcarea." In Austria, I was told by a learned colleague, who is stout and somewhat obese, "for me, Calc-carb." and pointing to some other colleagues, "for so and so, Calc-phos. and for that tall and thin doctor Calc-flour." The advice, therefore, all along revolved around the Calcareas.

I saw Miss E.H., age 70 years on 29th October 1978. A reputed photo journalist, she had led a very active life in the past and had travelled extensively to most parts of the world. Thus, she had been used to a hard and vigorous life and felt extremely depressed at her present state. "All my life is changed. It is awful to be disabled like this."

Present Complaints:

Her complaints were pains in lower limbs generally but especially the knees which greatly restricted her movements particularly after 1975.

Swelling on knees.

In mornings a general stiffness of body and especially felt in the lumbar region.

> Motion < Rains

Her condition had been diagnosed as **Osteoporosis** in 1975 and **Osteoarthritis** in the knees and lumbosacral spine. For Osteoarthritic condition, she had received intra-articular steroid injections — altogether six times in the right knee joint. Had also been given Calcium.

In October, 1977, she fell down in the kitchen and sustained a fracture of the neck of left femur. For this, she was in the hospital for three months and needed to have the broken ends fixed by a steel plate and screws. On 27th August, 1978, she fell down again and had some injuries which took a month to heal, but no fracture.

Personal History (only the pertinent part is reproduced):

Chilly patient for last five years. Previously enjoyed the cold.

Anger + + “I feel more angry than depressed at my condition.” Sensitive + +.

Says she feels the vibrations of persons she meets. “All suffering has a limit and then indifference. Now I am indifferent.”

Vaccinations and inoculations had been frequent (for international travel) but none after 1973 as that was the last time she could go abroad. She could not travel after that.

A part of the questioning I give in actual sequence:

(Q) “How is your sleep?”

(A) “Good.”

(Q) “Do you have any dreams?”

(A) “Yes.”

(Q) “Dreams of what?”

(A) “Of falling.”

(Q) “How often?”

(A) “Every night.”

(Q) "From where?"

(A) "From the balcony of my house (her apartment is on the 7th floor of the building)."

(Q) "You never considered marriage?"

(A) "I like meeting people but afterwards like to be alone so I never married. Besides, I did not wish to go to bed with a man."

Past Illnesses (prior to 1975):

1941	:	Jaundice
—	:	Dysentery
1971	:	Migraine attacks. Was under considerable mental tension that year.
1972	:	Pericarditis
1973	:	Bronchitis or Pneumonia (Bronchopulmonito in Italian) three times.

In routine investigations while at the hospital for Pneumonia a staghorn calculus in right kidney was found. She was operated for it in the same year, i.e., 1973.

1974	:	Cholesterolaemia
	:	Sustained a fracture of the left wrist.

She also had an operation on the right knee. It is not clear whether that was for Osteoarthritis or removal of cartilage.

Investigation (X-Ray Pictures):

- (1) Knees-bilateral osteoarthritis with osteophytes tibial margins etc.
- (2) Lumbosacral spine — osteoporosis diffuse. Modest manifestation of spondylosis. Marginal osteophytes. I.V. spaces normal.
- (3) Barium enema — Multiple Diverticulosis

- (4) Oral Cholecystogram — poor contraction of G.B. after fatty meal: Hypofunction Gall Bladder.

Treatment & Follow Up:

After my return to India, I kept thinking for a whole week whether I should prescribe one of the Calcareae, or not follow the common practice and stick to the standard principles. Finally, I felt that although the Calcarea might help, but if she was to have a real cure. I should prescribe on the very unusual symptom of the dream which she was having with such persistence. (Kent's Repertory p.1239 Sleep: Dreams: falling, of; from high places). Accordingly, I sent *Thuja occidentalis* 10M, three powders to be taken at half-hourly interval. This was to be followed by S.L., one powder morning and evening. She started the treatment around **15th November 1978**.

Not expecting anything dramatic, in the covering letter, I wrote, "I hope and pray I can help you improve to the extent of being more mobile. I am sure we both fully realise that it cannot be a complete recovery, both for reasons of age as well as the operations and the steel plate fixed in the hip."

However, the medicine did more than anticipated. I received a letter dated **29th November 1978**. She wrote, "I am happy to inform you that after about two weeks of taking your medicine, I can see a good progress: my knees are now quite back to normal size and I can walk much better. So I think to come to India at the beginning of January and want to stay three to five days at New Delhi and some days at Benaras before going to Pondicherry. I have arranged different reportages (assignments) on these places."

She must have felt really well to have dared plan such a strenuous trip.

She was able to undertake the journey, and when she came to see me on **22nd January, 1979**, she was completely transformed, feeling very bright and cheerful. Her first remark was "see I can walk well, and even though I have a stick, I do not need it and therefore, sometimes I forget it at the houses of friends I visit." I checked up with her regarding her 'dreams of falling'. To this she replied, "Did I tell you about them? Now that you ask me I realise I don't get those dreams anymore."

In addition to the above places, she went to Mathura and roughed it out by sleeping on the cold ground in January and made pictures for an article to cover W.H.O. International Year of the Child. Incidentally, Mathura is a place of pilgrimage and the arrangements there are austere.

Letter dated **27th April 1979**: "I feel quite perfect, thanks to your care."

Prescription naturally continued to be S.L., till I received letters dated **6th and 8th May, 1980** from Tunis (Tunisia) where she went on a week's assignment. This was to prepare an article for the tourism department and incidentally shows her continued fitness for work and her activity. She wrote, "Now it is two months that I have finished the medicine and I begin to feel some trouble at the knees. Also, for some time I have not been able to sleep undisturbed, in the night as I did during the time I used your medicine. I think it should be better to continue with the medicine." This was the time that I repeated *Thuja occidentalis* 10M/1 powder (May 1979). There has been no trouble ever since and no medicine i.e. not even S.L. has been sent after September, 1979. Letter dated **August 21, 1979**: "Re: myself, I feel very good. I can say always better. I have finished the

medicines and I ask you, if I must stop for some time, or to continue? Perhaps, it could be useful if you send me some, to have it when it should be necessary." Treatment concluded.

* * *

Letter dated **October 6, 1979**: "I sent you the article on Homoeopathy with photos by airmail. They are five pages. My health is very good, thanks to your cure, and I think there should be no recurrences."

She continues to be well as would be seen from her letter dated **June 10, 1980**: "Last month I was 72 years — very old. But when I am in good health — like I am now, and when I am able to work — as I do, I forget completely my age ..."

* * *

December 1988 I was in Rome for a conference and made a long distance call. She was carrying on well. Her only remark was "I am getting old." She was over 80 years of age!

Comments: This case highlights (1) The place of dreams in our anamnesis and also how an unusual well marked 'mental general' may overrule the 'particulars'. (2) The long action of potentised remedies and (3) The rules of follow up in 'no repetition as long as improvement lasts.'

* * *

Miss E.H. described her recovery in an article, "It Happened One Autumn Sunday" which appeared in the well known and widely read Italian magazine 'Esquire & Derby' of September 1979. It is reproduced in my book, "A Compendium of Homoeopathic Lectures."

CHRONIC FEVER

Master S.S.B., age 7 years. Consulted on September 26, 1980. His complaints were that he had been having fever for the previous four years. It was not a daily feature but would occur at variable intervals of three to thirty days. The attack would last two to three days. It starts with 100°F, but later rises to touch 104°F. There is lot of chill and shivering. As fever rises he vomits some frothy stuff. During these years they tried many things but no particular medicine helps. So they depend on the use of cold packs. He has small cervical glands. I am told that in fever these swell up and get more prominent. His appetite was good. Fond of milk. Must have milk with his meal, which is unusual in India. Likes strong tasting things (chat patta — golgappa, chola bhatura) Averse to fruit. At times "fear during sleep" but on questioning it turned out that he only starts in sleep and does not wake up. No dreams.

Vaccination for small pox: twice, second at three years.

Fever started a month or so thereafter.

Motion sickness — car, scooter, bus, train.

No fears. Anger + Obstinate + +

F.H.: One sister 4 years age, healthy, parents healthy, mother had no special trouble in pregnancy.

P.I.: H/O roundworms 2 years earlier.

Investigations: He brought a number of reports of previous blood tests carried out on different dates.

	T.L.C.	D.L.C.	
1.	6,950	P39 L54 M4 E3	Hb. 11.6 gm.
2.	10,200	P71 L19 M9 E1	Negative for M.P.
3.	5,000	P42 L55 M3 E0	

4. 7,400 P32 L50 M18 E0 ESR 5mm

5. *Brucella abortus*: < 1:20

Tests at No. 3, 4 & 5 done at A.I.I.M.S.

Urine examination: Albumen — Faint trace.

One report (March 27, 1979) showed occasional Trophozoites of *P. Vivax*.

Throat swab: No Beta haemolyticus streptococci.

Chest X-ray of all family members — N.A.D.

Mantoux Test: OXO mm. (Negative)

O.E.: Lean. Weight: 46 pounds. Heart and Lungs: N.A.D. Liver margin — palpable. Cervical glands palpable. Tonsils — nothing significant.

1980

September 26: He was prescribed *Tuberculinum* 200/3 powders, at half hourly intervals followed by *Saccharum lactis*.

November 8: Temperature normal from the time he started treatment on September 26, i.e., he had no fever any time. He was from outstation, a distance of 40 miles. Today in travel he did not have car sickness. Now that the temperature is normal he mentioned of some other symptoms. Some pityriasis like spots on face. No itching. Phimosis is an old complaint. Has crusts in the nose which have blood when detached. Weight has increased.

Phosphorus 30/9 powders t.i.d.

1981

January 23: Continues to be free of fever. Spots on face cleared rapidly. For the previous 10 days has eruption on head with pussy discharge. Itching. Prescribed *Graphites* 200/3 powders, at half hourly intervals.

July 14: I did not have notes on his condition but apparently he had some recurrence of fever as I have

repeated *Tuberculinum* 200/3 powders, at half hourly intervals.

December 28: Has had no fever, weight 63 lbs. (An increase of 17 lbs.)

In 1982 I saw him twice, in the month of February and again in November. He had carried on well and had been free of fever. In February he only came for treatment to ensure that there was no recurrence. In November also it was some trivial complaint and on both occasions he received *Saccharum lactis*.

1984

September 1: He reports again after a gap of two years. He had been having fever since August 3. On that date the temperature shot upto 107°F and he possibly had a convulsion. He had treatment locally without sustained relief. The temperature would rise suddenly and also drop suddenly but it is possible that this was because of the medicine (?some febrifuge) being given. He had vomits; was thirsty, took small quantity (3 to 4 sips) every 10 minutes or so. After taking water he tends to vomit. Appetite poor. Constipation, no stool for many days. If he eats he has a motion.

He was prescribed *Arsenicum album* 30/20 powders at 4 to 8 hours interval.

September 6: Much better. No fever. Given *Saccharum lactis*.

* * *

1985

August 17: Reported again after one year complaint of fever for the previous 4 days. Temperature from 101°F to 103°F. Had cold and cough. Vomits; headache. Very thirsty, moderate to large quantities at a time and taken water 4 times in the night and thrice in the two

hours that he was in my clinic. *Bryonia alba* 30/20 powders at 4 to 6 hours interval.

August 21: Temperature normal from August 19. Has dry cough. No vomit.

Spongia tosta 6/20 powders q or t.i.d.

* * *

1989

March 13: I see him again after many years. Now 16 years of age. Grown tall and healthy. Came with complaint of fever for the previous 6 days. Sore throat. Blocked nose is usual and remains through the year. Nocturnal emission for previous 7 months, at an interval of one to four weeks. Eruption abdomen for 8 months. Itching, no modalities.

O.E.: Eruption circinate on lower abdomen. Tonsils ++. Gray hair. Weight 137 lbs. Height 5'10".

Silica 6x, 30, 200/1 powder of each on the same day.

April 1: He had recovered from the fever reported on March 13, but now has fever again from the previous day: 102°F to 103°F. Diarrhoea and vomiting. It followed some indiscretion in eating.

Arsenicum album 30/16 powders q.i.d.

April 4: Temperature normal. *Saccharum lactis*.

1990

July 25: Reported again. By now he considers me almost a specialist for fever and travels all the way whenever he has this problem. Fever from July 24. The previous night had slept in the open and it drizzled. Maximum temperature 102°F.

Has a skin eruption for previous one year. Uses Quadriderm Ointment which clears it for a time but it keeps recurring.

Again has tendency to blockage of nostrils.

Rhus toxicodendron 30/16 powders at 4 to 6 hour intervals for the fever and after that has subsided to use *Bacillinum* 200/3 powders at 15 minutes intervals.

September 1: In July he took one powder of the medicine in my clinic and "even before I reached home in Meerut (about 65 km. distance) the temperature became normal." Gets tired very soon. Desire to lie down and to sleep. Thirst + + for large quantities frequently. Desires it very cold.

Phosphorus 200/3 powders at 15 minutes interval.

September 29: Feeling better.

PROLONGED FEVER

Mr. K.T., age 53 years, consulted on October 31, 1991. He gave a history that in July he had a slight pain in right testis for which he had an Ultrasound examination. It was diagnosed as Torsion right testis with testicular haemorrhage. There was fever. He had allopathic treatment but there was no relief. After 10 days he had blood tests done. T. & D.L.C. gave normal figures; Widal was positive.

The medication was changed and he was given the newest antibiotic, again without effect. Then he had a series of tests at the Holy Family Hospital. These did not show any particular abnormality. The doctor there put him on Chloromycetin plus Chloroquin. The temperature still persisted at 99.2°F. By now he had been in bed for two months. The tests were repeated in September. Most of them were still normal. Mantoux was doubtful and E.S.R. 124 mm. In July this had been 55 mm. and in August 110 mm. He was put on A.T.T. but after 15 days

of use there was no effect so given up. To rule out the unusual conditions he had more tests.

T3-175 (Normal 80-160); T4-8.6 (Normal 5-12.5). Serum Protein Electrophoresis — W.N.L. X-ray Chest and Lumbo-Sacral spine as also Ultrasound examination of abdomen were all normal.

He had very few symptoms. He complained of dull pain in the lower back, hips and lower limbs. Also from July there had been frequency of urination especially at night. $\frac{D}{N} = \frac{3-4}{3-4}$

He was also not sleeping well; no dreams of significance. Appetite was poor. Taste was bad. When he ate something it tasted as if he was eating clay. Had been fond of eggs, meat and parantha (fried leavened bread). These he had stopped because in earlier examination his Cholesterol had been 240 and with dietary change he had brought it down to 170.

There was no family history of Tuberculosis and no special illnesses in the past except that he had Typhoid twice.

1991

October 31: *Tuberculinum bovinum* 200/3 powders at 15 minutes interval.

November 8: He reported that he felt much better for two-three days initially, was eating better though taste still not proper. For the previous four days he felt slight chill in late afternoon and then temperature would rise to 99.2°F. This would be normal for most part of the day. In the meantime he had had blood culture which showed no growth and the test for Antinuclear factor was negative.

Arsenicum album 30/15 powders t.i.d.

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Arsenicum album 30/15 powders t.i.d.

November 13: Temperature been normal. Backache much better. Taste clay like is improved by 80%. As he had urgent work he had even made a train journey without any ill-effect.

Wt. 166 lbs.

He continued to be well thereafter and in fact would contact me from Ambala where he had much construction work to do and wanted to catch-up with lost time. He felt quite normal and very active. As expected he continued to receive *Saccharum lactis*. He still felt his taste was not quite normal and a slight feeling of clay in his mouth was there.

December 31: He came to see personally. No complaints. Now he is quite normal. Wt. 180 lbs. — an increase of 14 lbs. in six weeks.

1992-1994

Has been seen from time to time as he comes to collect medicines for his wife. His weight increased further to 202 lbs. (Height approx. 6'2") There was no recurrence of fever till his last visit in September, 1994.

FEVER ?ENTERIC

Master M.D., age 10 years, consulted on **August 21, 1990**. He gave a history of having had fever from August 1 to 4. Then he had a remission of four days and a recurrence of fever from August 8. It was probably a continued type of fever but this observation was vitiated by the fact that he was frequently being administered Crocin. There were not very many symptoms. He had earlier mild cough but that had cleared before he came to me. There was no headache, taste was normal. He

complained of slight pain in the chest on eating. He was thirsty, was drinking water frequently, at times in small and other times larger quantities.

His physical examination also did not reveal anything significant.

Pathological Reports:

August 13 – T. and D.L.C. – 5000; P50 L44 M2 E4
M.P. – Negative

August 16 – Widal Test – Negative

August 20 – Widal Test – Typhi O – Positive 1 in 100; Typhi H – Positive 1 in 200 (The test was done while using Enteromycetin)

Treatment: Prior to my consultation he had been having allopathic treatment. It had been considered to be a case of Typhoid and from August 16 he was using Enteromycetin + Betonin + Solubet. From August 19, Amoxycillin had been added to the previous medicines. This medication had not given any significant improvement and in fact his temperature was very high – above 104°F at its peak and that was the reason the family thought of a homoeopathic consultation.

1990

August 21: *Baptisia tinctoria* 6/16 powders every 4 to 6 hours.

August 24: Not much change.

Baptisia tinctoria 30 every three hours.

On **25th**, the temperature showed sign of decrease so *Baptisia tinctoria* continued but interval between dosage increased. By **29th**, the temperature rose to maximum of 99.8°F and on **30th** not beyond 99°F.

August 31: *Saccharum lactis*, every 4 to 6 hours.

September 4: For some unexplained reason temperature again rose to 99.5°F.

Tuberculinum bovinum 200/3 powders at 15 minutes interval.

September 8: Low grade pyrexia continued. However, no aches and pains and the only symptom is slight heart-burn. Again put on *Baptisia tinctoria* 30/16 powders q.i.d.

September 12: Better. Temperature normal. Has a small boil in nose. Wt. 64 lbs.

September 17: There are no notes but probably the boil persisted and he was prescribed *Sulphur* 200/1 powder.

September 29: Feeling quite normal. Temperature range 97.6°F to 98.2°F.

October 8: No complaints. Feels very hungry. Wt. 69 lbs. (An increase of 5 lbs in one month)

Treatment concluded.

P.U.O.

Case No. 1

On April 28, 1988 I received the following letter:

"Respected Doctor Uncle,

I owe my sincere thanks and regards for the miraculous healing touch of your medicines. I have no words for appreciation as the favours you have conferred upon us are so immense that I really feel incapable of doing so.

I still cannot forget the day 9th March, 1986 when I had given up all hopes of getting well, all our family members were so worried and upset, they had left no stone unturned, in that hour of need it was your kind self like an angel who took out the time from your precious

schedule and made it to our place. Inspite of being Sunday you went to the clinic, prepared the medicine and handed over to my brother and Uncle.

This reveals your kindness, love, patience and dedication towards your patients and serves as an example for us.

Well, sir I had come on April 1, 1988 regarding the pain in my knee joins, calf muscles and knuckle bones etc. The pain is much better than before but it's not fully cured. I am still having pain in my knee joints but the intensity is comparatively less. In other joints I have pain only due to over exertion. In case I rest for 2-3 hrs. it's much better. In morning time, I don't feel any pain except when I have to bend my knee joint. Regarding weather conditions — it does not have any effect on my pain. In calf muscles also there is slight pain.

I have tried to write down as many details as possible, hope they are sufficient.

It would be very kind of you if the medicines are sent by post . . .”

This letter prompts me to go over her previous history. I was consulted for Miss P.B. age 24 years on March 9, 1986. A teacher by profession, she was suffering from fever for more than a month, from February 6 to be precise. She had been exposed to cold that morning, by afternoon she had headache in the left temple and then fever. Temperature in the evening 102°F. She had in any case been prone to frequent fever, every three months or so, mostly this would last for about a week. Also prone to ulcers in the mouth. Had always been anaemic and always had poor appetite.

During the present illness she had been under Allopathic treatment. She had been prescribed different antibiotics as also antimalarial drugs without effect.

Temperature of continued type and fairly high. It drops only when she is given Crocin (Paracetamol). A feeling of chill when temperature is rising. In fever had headache and burning hands and feet, heaviness abdomen. Appetite nil but off and on an uneasiness and inclination to take milk. When she takes something she needs someone to keep rubbing her back so that she can belch and feel comfortable.

Thirst increases in fever. Takes only sips frequently, though would like a glass of cold water. Nausea quite badly throughout the period of present illness i.e. one month. Stools are loose for the previous 25 days and for last 10 days usually three times a day. Much flatus with stool. Uneasiness in abdomen before the stool – like something bursting, feels easy after stool. No mucous. Sleep – only when temperature reduces by Crocin.

O.E. Pulse found to be very rapid. Lab investigations:

February 10: Urine exam.: Albumin – Trace

February 13: Urine exam.: P.C. 50-60.

Culture – E.Coli isolated, count not made.

February 22, Urine exam.: P.C. I-2

February 22, Blood, T.L.C. 9000 P 70 L27E3 ESR 15

March 5, Blood: T.L.C. 11,900 P 72 L28 ESR 75.

Hb. 6.5 gm.

1986

March 9: *Nux vomica* 200/1 powder stat. Followed by *Arsenicum album* 30/8 powders every four hours. In the margin of my sheet I made a note of *Pyrogenium* for future consideration.

With the withdrawal of Crocin the temperature on March 11, touched a maximum of 105.4°F. *Arsenicum album* 30 continued.

March 12: Brought a written report. Minimum temperature 101.2°F maximum 103.2°F. General feeling

better. Only one stool, still loose. Complained of some photophobia.

On March 13 temperature minimum 99.5°F maximum 103°F.

March 14: As fever persisted prescribed *Baptisia tinctoria* 30/20 powders, every four hours.

March 17: Finding that the temperature range still about the same prescribed *Pyrogenium* 200/4 doses, every six hours.

March 18: Now says that she has a sinking feeling when has empty stomach, and this feeling occurs almost every two hours. Then must have something quickly.

Repertory page 477: **APPETITE**; increased; fever, during: **Phos.**, *Chin.*, *Cina.China officinalis* 6, every 4 to 6 hours and this was continued till March 25.

On **March 25** reported much better. Temperature normal. More active. Sleep normal. No irrelevant talk. Stool more normal and no flatus. Given *Saccharum lactis*.

March 31: Temperature continues normal. Heaviness p.c. and eructations. Sinking if does not eat, weakness, which would be expected after this long illness.

Repeated *China officinalis* 6/16 powders q.i.d.

April 7: Blood report T.L.C. 12000 P80 L16E4 ESR 60 mm. PCV — 33% Hb. 11 gm.

April 8: Felt so well and strong enough to be able to come personally to my clinic. (Initially I had visited at the residence and subsequent reports were brought by family members).

O.E. N.A.D. Tongue clean and moist. Taste normal. Appetite fair, no sinking. Occasional headache but nothing significant, slight aching in legs — a tiredness.

In view of the history of recurrent fevers she was now prescribed *Tuberculinum* 200/3 powders at 15 minutes interval.

Continued well thereafter. Got engaged at the end of June and was seen from time to time till October 1986 with no recurrence of fever.

Came under treatment again on April 1, 1988 with complaint of pain in joints for which she received *Pulsatilla* 200/3 powders to be taken on the same day. This helped her as is apparent from the letter reproduced above and in response to that report she was sent *Saccharum lactis* on May 2, 1988.

Case No. 2 (P.U.O.)

Mr. R.N. Age — Nearly 80. Consulted on **September 9, 1993**. This senior citizen had been through so many problems, I think, partly iatrogenic, that he insisted on an urgent visit. There I was confronted with a voluminous file of papers about the reports/investigations running into some 80 pages. Apart from routine investigations (like T. and D.L.C.; Haemograms; Blood Sugar; E.S.R.; Urea; Creatinine; Urine and Stool examination) done a no. of times there were reports of Blood culture and sensitivity; Urine culture and sensitivity; Widal Test; Throat swab; Clinical Chemistry (CPK, CPK MB, L.D.H., S.G.O.T.); Hepatic Profile; Perfusion lung scintigraphy; Serum Protein Electrophoresis; IgA; Anti Nuclear Antibodies; Prostatic Specific Antigen; IgG to A60 Mycobacterium; IgA Antibodies to Kp-90 ImCRAC (the last five by Elisa); X-Ray examinations of routine as well as special types; Ultrasonography (three reports); CT Scans; Colour Doppler Echocardiography etc. etc.

And inspite of all this extensive investigation no definite diagnosis was arrived at or the diagnosis varied from time to time by the different specialists. In consequence much medication, mostly one or the other antibiotic was used, without any consistent benefit. At one stage the culture and sensitivity test showed him to be resistant to 26 antibiotics. This could even be the result of extensive use, or what could be more appropriately called abuse, of these drugs.

His history begins with what appears to have been a simple fever on July 8, 1993. With some routine treatment the temperature was normal after few days. Then one night he felt breathless so he was immediately hospitalised. After much investigation, any heart ailment was ruled out and it was considered as some sort of pneumonia. With the treatment, he was normal for 7 to 10 days (August 3 to 13) and was even going to office. On August 12, he again felt feverish after his habitual evening walk. The temperature was found to be 100°F.

In the background history he was a known diabetic and this was controlled by use of Dimicron. Off and on, he had been lax in dietary restrictions.

For the previous six months there had been some burning in micturition. This had now increased. It had been considered as due to B.P.H.

Occasional shifting pains which lasted minutes to hours.

Prone to cold and coughs especially in winter and it takes long to get well. Sneezings after bath.

Appetite: Normal. Chronic constipation, would miss a day. Recently started to use Isabgol.

Sleep: Good. Now wakes up five or six times for urine. Not many dreams but recently dreaming of the dead.

No strong reactions to heat and cold.

P.I.: Heart attack — 1974. Angina 3 years ago, was in hospital for one day.

1993

September 9: *Nux vomica* 30/10 powders q.i.d.

September 13: *Tuberculinum bovinum* 200/3 powders at 15 minutes interval.

September 25: Temperature — Maximum 99-99.4°F.

Constipation — B.O.R. but has to strain. Slight burning in urination and nocturia.

Sweating after waking in morning, feels weakness after.

E.S.R. — 30mm

O.E. — Wt. 152 lbs.

Tongue — Clean

Sulphur 200/3 powders at 15 minutes interval.

October 16: Temperature range now 97-98.8°F, often not beyond 98°F. "Burning in urination 30-40% relief." Nocturia reduced from 5-6 times to 3-4.

Saccharum lactis continued.

October 18: Sore throat and cold. Slight rise in temperature.

Rhus toxicodendron 30/24 powders q.i.d.

November 3: Telephoned "Temperature normal, no sore throat, burning urination less. Feeling well."

November 6: Reported personally — Temperature been completely normal after October 27, (97-98.4°F), urine frequency reduced by 50%, now only once at night and no frequent urge. In day, earlier at times, used to have an urge soon after passing. This has been completely relieved. Occasionally, slight burning in urination, at times, half hour after.

Constipation as usual which is his very old complaint.

Tendency to cold and dry cough in winters.

Tuberculinum bovinum 200/3 powders at 15 minutes interval.

November 18: Slight cold, not much of a discharge but crust formation with slight expectoration.

Temperature — Normal.

Burning in Urethra much better — “Only 25% remains.”

Saccharum lactis continued. Was going for his regular walks, attending office and feeling very good, sought my permission to travel for meetings. I suggested not to strain too much.

December 18: Has been to attend meetings in Bombay and Hyderabad. Travelled alone and had no trouble of any type.

“Burning urine only 10-20% remains. In spite of the winter urine only one or two times at night. Feel urinary stream is better and no residue left, no feverish feeling any time. So, I have stopped taking temperature.” Few days earlier blood sugar was, Fasting — 80 and P.P. — 140, therefore, reduced Daonil to half tablet. Cold is frequent, if there is exposure sneezings and some discharge, gets alright in one or two days. Keeping head covered at night helps.

Baryta carbonica 200/3 powders — Morning, afternoon and bed-time of the same day.

1994

January 22: Burning in urination is M.B. and only occasional; urination at night only once in spite of this cold season and also rains (cold and wet weather). Sleep-good; No sweating in or after sleep, a symptom he complained of on September 25, 1993. Less costive, stools better. On January 20: Blood sugar Fasting 98.6 mg/dl and P.P. 110 mg/dl so Dimicron totally stopped.

Mr. R.N. has been seen from time to time thereafter till November, 1994. Mostly he comes to persuade me to give early appointment for some relation or close friend, as they are all greatly impressed by his quick recovery and without any troublesome or expensive investigation. He has himself not needed any further medicine and is actively engaged in his work, including some travelling for meetings and a strenuous trip abroad to U.S.A. and other countries in September.

LOW GRADE PYREXIA

Case No. 1

Ms. R.K., age 36 years, comes to consult me on October 21, 1992. Her mother reminds me that I had successfully treated her for prolonged low grade pyrexia when she was a child. Her old notes show that she consulted me on **August 2, 1962** when she was less than 6 years of age (born on October 16, 1956). She gave a history that on July 13, 1962 she got a sore throat with ?Bronchitis and fever 100°F. She had allopathic treatment. After a few days the temperature dropped to 99°F. Then she accidentally got an injury from a nail which pierced her thigh. She again had fever — 101°F. Was given Elkosin for four days. The temperature continued even though the wound had healed. The attending doctor said that now the child had chest congestion and he gave injections of Dicrysticin for four days. The temperature gradually reduced but only to 99°F.

Appetite is poor. Likes sour things, also toffees, chocolates and snacks rather than proper meals. Likes to take milk and prefers it cold. Averse to butter and fats,

prefers dry toast. Always had costive tendency. B.O.R. but in small quantity and hard like sheep dung. Light coloured.

1962

August 2: *Sulphur* 200/1 powder.

Stool report (**August 6**): Vegetable fibres ++, Starch granules +, Fatty soaps +, Pus & Leucocytes +, Erythrocytes few. No ova, amoeba or cysts.

August 7: M.B. Temperature completely normal. No cough, no trouble at all. Insists on going to school as she feels normal. Stool report shows few R.B.C. and W.B.C. in fair number but no ova, amoeba or cyst. *Saccharum lactis*.

August 15: Feeling normal. Weight 31 lbs. *Saccharum lactis* continued.

August 25: M.B. Normal in every way. Appetite better. However, stools still in balls, like sheep dung as always. But B.O.R. and satisfying.

September 6: Not so well.

Sulphur 200 was repeated.

September 7: Cough and fever. *Ferrum phosphoricum* 6x/12 powders, every 3 hours.

Recovered quickly and *Saccharum lactis* continued till her last visit on November 9, 1962. The weight also showed an increase.

She kept well thereafter and came to consult me after 30 years on October 21, 1992, as mentioned above, for Uterine Fibroids.

Case No. 2 (Low Grade Pyrexia)

Miss S.V., age 11 years, consulted on April 23, 1990. Her complaints were frequent fevers from September 1989, mostly no other symptoms and the attending physician would put it as Viral. With the last attack had

sore throat also. Her other complaint was frequent pain in abdomen. The pain would last a short time. This she had for the previous 6 to 7 years. It would be aggravated by car journey. She also had a tendency to motion sickness. "Growth poor".

Appetite: poor. Non-vegetarian. Not keen on milk and C/O pain abdomen after milk. Likes sour and spicy things. Pizza, Hamburger, Idli (a preparation from steamed ground rice and pulses). Cold drinks, ice cream, chocolate, very fond of butter. Chronic constipation tendency but B.O.R. for the last few months.

Sleep good. No bad or frightening dreams.

No special reaction to heat and cold. Perspiration average.

P.I. Chickenpox at four years, no complications. Earache. There had been much wax and after cleaning she had been alright.

F.H. Father Asthma, grand-mother T.B.

O.E. Weight 61 Lbs. Heart, Lungs, Abdomen, Throat — all normal. Few small discrete glands neck — not significant.

1990

April 23: Prescribed *Mercurius solubilis* 6,30,200/1 powder of each on the same day.

June 16: For last one week sore throat and slight fever. Also pain abdomen especially after milk.

Mercurius solubilis 200/3 powders at 15 minutes interval.

June 25: Low grade pyrexia persists, 99 to 99.8°F. Even in morning it is 99. Feels a slight headache. On waking in the morning complains of slight breathing problem and not fresh. Not thirsty.

O.E. Lungs clear, tongue clean and moist.

Tuberculinum bovinum 200/1 powder at bedtime.

July 12: Morning temperature 98°F. Rises to 99.4°F by afternoon or evening. Headache through the day but < on waking. Giddiness only in morning.

Prescribed: *Lachesis* 30/3 powders, morning, afternoon, bedtime on the same day.

July 14: No headache, no giddiness. Now maximum temperature upto 99°F.

August 1: Dry cough for previous three days. No vomiting. *Spongia tosta* 6/20 powders q.i.d.

August 6: Relieved of the cough.

August 11: Again slight rise of temperature. Now gave the information that in June 1990 had an Anti-Typhoid inoculation (T.A.B.). The low grade pyrexia has persisted since.

Typhoidinum 200/3 powders at 15 minutes interval.

August 25: Now temperature does not exceed 98.4°F. *Saccharum lactis* continued.

September 7: Temperature continues normal. Pain abdomen M.B. Headaches are frequent. *Tuberculinum bovinum* 200/1 powder at bedtime.

September 12: Fever from September 11. *Rhus toxicodendron* 30/16 powders at 4 to 6 hours interval.

September 14: Fever persists. Much pain abdomen and vomiting. *Ipecacuanha* 30/14 powders at 4 to 6 hours interval.

October 1: As the parents had been very anxious they got all the tests done and the reports are:

W.B.C. 8,400; P5IL46MIE2

ESR 15 mm HB 13.2 Gm

Urine Exam - Normal, Culture - sterile

Blood culture - No growth after 72 hrs.

Mantoux Test - 3 mm

As there was nothing positive in the tests and in the meantime temperature had been normal now they felt complacent.

November 10: Feels quite normal. No headaches. No pain in the abdomen. Temperature normal. Asks her mother "why do I need more medicine". On examination weight 66 lbs. The mother was feeling relieved but having gone through months of anxiety wanted that she take medicines for sometime more to avoid any recurrences. So she was given *Saccharum lactis*.

1991

January 8: The mother came for her medicine and had brought the child along. She had been quite normal and I assured the mother that no further medication was necessary.

My own comments are that ever since it was mentioned that her complaints started after T.A.B. inoculation and she received the corresponding nosode, *Typhoidinum* since then she had been alright. It is also possible that *Tuberculinum bovinum* which did not show such a good effect earlier now completed the cure after the block was removed.

* * *

1994

I have seen her from time to time. Last report on **August 8, 1994** — Dandruff and Acne. There was no recurrence of Low Grade Pyrexia. Only significant illness in this period of 3½ years was a cold in August 1992 with slight pain in knees and elbows. The over anxious parents got a throat swab done and the report was "Strepto B-haemolyticus positive". She was administered one dose of *Streptococcin* 200 and that cleared everything.

ACUTE CASE – FEVER

Case No. 1

June 16, 1989: I received telephone call from a family where many members are under my treatment and the patient Miss M.D., a girl in her teens had also had treatment some time earlier for obstruction nose and other symptoms. On the telephone I am told she has fever from the previous day and the temperature today is ranging between 103°F and 104°F. She is complaining of much pain in the right side of the chest extending to the back. On enquiry I am told the pain is not related to breathing. Has felt some chill in the initial phase of the fever.

I asked the following three questions:-

(1) Which side she prefers to lie?

Ans. On the right (painful) side.

(2) What is state of bowels?

Ans. Constipation.

(3a) How is her thirst?

Ans. She is very thirsty.

(3b) How much at a time?

Ans. Glass-full.

Prescription: *Bryonia alba* 30/10 powders to be taken at intervals of 4 to 6 hours.

1989

June 17: Temperature is as follows:-

7 AM: 101°F

9 AM: 100.4°F

2 PM: 98.8°F

6 PM: 99°F

Pain chest reduced. Feeling better. More comfortable.

Repeated *Bryonia alba* 30 to be taken at 6 to 8 hours interval for two days. This may not have been necessary but June 18, being a Sunday one could not take a chance.

The parents were anxious and on their own got a blood test (T and DLC). TLC 10,800/cmm. P60 L38 E2. Urine Examination showed a trace of albumin. Pus cells 2-3/HPF. No RBC. These tests were done on June 17th.

Report on **June 19, 1989**: Temperature normal on June 18 & 19. No pain chest. Patient quite normal. No further medication.

Case No. 2 (Acute Case — Fever ?Viral)

Mrs. P.B., now aged 32. First consulted in 1980 and has been seen from time to time as I have been like their family doctor ever since. Now lives in Nagpur (about 1200 km from my place) and consults on telephone for acute conditions. Was visiting Delhi and had been seen for some chronic complaints on **January 5, 1990** and then I received a call on **January 9**, that on arrival in Nagpur she was having fever — temperature 100°F with great pain in the whole body and specially joints. Not having more details I asked her to take *Eupatorium perfoliatum* 30/16 powders q.i.d. She rings up again on January 17 “the medicine was marvellous. It did wonders. I got quick relief and I am quite well. Please send me more medicine.” Of course, she was sent more medicine in the form of *Rubrum*/30 powders t.i.d.

Case No. 3 (Acute Case — Fever)

Master A.N., age 8½ years under treatment since October 17, 1989 with a history of frequent colds and other catarrhal complaints. This report is about an acute

fever for which the father detailed the symptoms. This was on December 27, he had high fever, much headache and nausea. I was told that the temperature is 103°F and the Pulse 140/mt. On enquiry I was told that he is thirsty but he is taking only a few sips though very often. I prescribed *Arsenicum album* 30/16 powders to be taken at intervals of three to six hours according to intensity of condition. There was no further report till he called again on January 13, 1990.

In the words of the parents, "It was absolutely remarkable. Fever got normal within about 16 hours and we have never seen such fast relief even with antibiotics. He started to improve and felt more comfortable soon after taking the first powder." Has been well since and came for his routine examination and the chronic complaints.

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SKIN ERUPTION

Case No. 1: Mrs. M.M., age 27 years consulted on September 10, 1980. She had been married for 9 years and had two children, age 6 and 4; no abortion (natural or induced). She had come from Moradabad, a place about 160 kms from Delhi. Therefore, the reporting was sometimes in person and other times by letter or telephone. The treatment often got interrupted and she came off and on for different complaints during the subsequent 4 years.

At the time of the first consultation, her main complaint was skin eruption for 3 weeks. It started on the face. There was much itching < warmth. Initially the eruption was dry, later oozing. Previously, at times there had been slight eruption on the chin. Even normally scratching anywhere gives a wheal. Gets itching by putting hands in water or when she is near a fire. Pain in abdomen on lifting heavy weight.

Appetite, digestion and sleep all normal. No significant dreams.

M.P.: Regular. Scanty and only for one day for the previous 8 months. Vaccination for small pox — quite frequent and last 3 years earlier. Took an antimalarial prophylactic injection 4 months earlier.

Hot patient. No significant mentals.

She had been under allopathic treatment which included use of steroids. Had been applying Betnovate-N and later Quadriderm. Orally took Betnatone tablets.

1980

September 10: *Nux vomica* 30/1 powder at bedtime.

Sulphur 200/3 powders at 15 mts. interval next morning.

October 18: Consulted a gynae. Her report was: "P.V.: Cx ↑, Ut. R.V. Fx-Parametritis both sides. P.S.: Slight erosion Cx." L.M.P.: Very scanty and bleeding for only half a day.

Itching etc. persists — slight exposure to warmth or a little work in the kitchen gives itching (page 1329 — itching; warm, on becoming).

Ledum palustre 200/3 powders given on the same day.

November 13: Touch of wool: blanket, shawl, etc. gives irritation on face. M.P. improved from half to one day.

Seems to have allergy to wool — (page 1329 — itching; wool agg.).

Psorinum 200/3 powders at 15 minutes interval.

December 8: Got better. But few days ago sat near the fire and there is recurrence.

Pulsatilla 200/3 powders on the same day.

1981

November 9: Reported again after 11 months. She had remained completely well for 8 months. Got pregnant, L.M.P. July 18, 1981. In August 1981, after she travelled by car and there was much exposure to sun and heat, there was a recurrence. She took allopathic treatment locally. Was prescribed Avil-2 tabs. daily for 10 days and locally Crotex ointt. These gave only temporary relief. In the previous 2 weeks, she used a bio-chemic mixture with 4 medicines. During sleep, there is oozing from the eruption and pus discharge in some places. There is itching and burning and sleep has been very disturbed for a week. For the previous 3 days also slight fever.

Aethiops antimonialis 6x/30 powders t.i.d.

November 17: M.B. *Saccharum lactis*.

December 22: 10 days ago washed a few clothes with a washing soap (containing detergent). There was an immediate reaction by way of miliary rash, then much swelling on forearm which lasted 5 to 6 days. Contact with woollens also gives itching. Can't sit long in sun. Especially cannot bear sun on the face.

S.E.R. 3x/3 powders on the same day. (*S.E.R.* stands for a new remedy made by triturating milk sugar exposed to solar eclipse rays. It subsequently had a short proving).

1982

March 9: Been well. Got better in January and has continued well. No eruption now.

June 11: Normal delivery on May 1. Has been keeping well but sensitivity to sun persists, as also to application of some antiseptic medicines to the skin, e.g., Furacin applied for an injury to the foot resulted in a rash and similarly from methylated spirit used for giving her I.V. glucose at the time of delivery. Calendula ointt. helps. "I am generally better".

S.E.R. 3x/3 powders on the same day.

December 31: Reported again after 6 months. She had fever on November 26 ?Dengue. Took half tablet Crocin and it resulted in rash and much itching. Besides, still gets itching by sitting in the sun and by direct touch of wool.

S.E.R. 3x/3 powders on the same day.

1983

November 7: During the period of 11 months I had an occasional report. She continued well even through the summer months and had a repeat of *Saccharum lactis* a few times. Now she consulted for entirely different symptoms. She had pain in abdomen for the previous 15

days. Gynae report said: "Swelling and inflammation and ulcer inside". I had considerable doubts about these findings. The pain was greatly aggravated after eating, she also had a tendency to stool p.c.. She had ulcers on the tongue, and according to her headache all the time. She had lost weight.

Nux vomica 6,30,200/1 powder of each to be taken at noon, evening and bedtime of the same day.

1984

February 3: She reported well and got a repeat of *Saccharum lactis*.

August 13: Reported that a month earlier, she had loose motions. It resulted in dehydration and she was on drip. She had diarrhoea again twice in this period and used Lomotil to control. Pain in abdomen. Has been there throughout, after eating, and before and after stool. She has allergy to many allopathic medicines which resulted in urticaria and swelling around eyes. There is much weakness — legs tremble on descending stairs. If she greatly controls her eating, she gets constipated, otherwise tendency to diarrhoea. A medical specialist has diagnosed it as Koch's Abdomen. Many dreams — all bad. Someone coming, holding her, carrying her away and she is shrieking.

O.E.: General tenderness of abdomen.

Nux vomica 6,30,200/1 powder of each in the morning, afternoon and bedtime of the same day in that sequence.

October 26: Had been well since her last visit till ten days ago when after a day of fast with no food or water (Karvachauth), she had pain in abdomen which was mild but continued for a few days. However digestion normal and during this pain, no diarrhoea nor constipation.

Nux vomica 200/1 powder at bedtime.

As mentioned earlier, she was from another town and I received occasional reports of her welfare from her friends. It is to be noted that two unusual remedies had been tried in this case. *Aethiops antimonialis* I find very useful for septic, skin eruption or eczema and acts like antibiotic. *S.E.R.* is a little known remedy and does not appear in our literature. It is for skin eruptions that show much sensitivity to the sun.

Case No. 2 (Skin Eruption)

Miss V.N. age 4½ years consulted me on April 4, 1983 with the complaint of skin eruption — rash since 1981. The eruption occurs only in summers while in winter only the spots can be made out but otherwise the eruption gets alright. There is considerable itching. In the summer of 1982, it got septic.

Has had the best of allopathic treatment including skin specialist and the best hospital in the country. Has used many anti-allergic medicines and steroids (oral and local). At the hospital it was diagnosed as “Sun-Allergy” and was given some kind of radiation also.

I personally have some doubt regarding the Sun-Allergy because she could sit in the sun in winters and the aggravation was really from the month of July whereas the hottest months are from April to June prior to the monsoon rains.

She had a craving for salt which she used to lick and also for sour things. She was a hot patient.

1983

April 4: She was prescribed *Natrum muriaticum* 6x, 30, 200/1 powder of each followed by *Saccharum lactis*.

Next reported on April 19: As the weather was getting warmer, itching increased i.e. there was no relief. Prescribed *Ledum Palustre* 200/2 powders to be taken in

the evening and bed-time. Reported on **May 3**: Had itching on return from school. ?Exposure to sun, also complained of Anorexia. Prescribed S.E.R. 3x/9 powders T.D.S. (S.E.R. is a potency from milk sugar exposed during the total eclipse of the Sun in 1981. It is the abbreviation for *Solar Eclipse Ray*).

Reported on **May 16**: No special relief. Prescribed *Sulphur* 200. Reports on May 31 and June 18 were better, better — only an occasional spot.

Report on **July 13**: much better and having no trouble in spite of that being generally the worst period.

After May 16, 1983 obviously the prescription remained *Saccharum lactis*.

On **August 20, 1983**, the mother came to see me and spontaneously said: "We had been to so many doctors and tried so many medicines to no avail. So we have had a very trying time but your treatment was remarkable in giving quick relief and finally riding her of this uncomfortable ailment and we are most thankful."

Case No. 3 (Skin Eruption)

Mr. R.C., age 36 years consulted on April 28, 1983. He had been married for 10 years with two children. His business establishment had been closed for some time due to litigation between partners.

Complaints: Skin eruption since December, 1982. It started after a scooter accident in which he sustained a fracture of right forearm and was in P.O.P. and was given antibiotic ampicillin. He started to feel itchy inside the plaster, so that was removed and underneath they discovered the skin eruption. Later it spread to other areas also. The eruption was moist and oozing. There was a history of similar skin eruption in 1972 for which he had Homoeopathic treatment elsewhere and again in

1979 when it was treated by a well known allopathic dermatologist. Itching < winters and possibly by contact with woollens < standing in the sun < touch of cloth. His other complaint was a pain in the waist for some years. An odd complaint was that time to time he would have a feeling as if a hand is pushed in at navel drawing in the abdomen upto rectum. It can occur any time. Each spasm lasts only a few seconds. Usually gets a few spasms in succession. Has had it even while driving his scooter.

Appetite — Good. Non-vegetarian. Smokes 5-6 cigarettes. Used to take paan (betel) with tobacco, 5-6 doubles in the day but stopped this six months earlier. Stopped alcohol one year before. Recently started to take a little extra salt.

B.O.R. — Two to three in day, loosish, with slight gripe, occasional mucus.

Sleep — very good. Dreams — Whatever is on his mind, i.e., about his problems.

Vaccination — In childhood.

Hot patient.

Mentals — Nothing marked or significant.

P.I. and F.H. — Nil of note.

1983

April 28: *Natrum muriaticum* 6x, 30, 200/1 powder of each on the same day.

June 1: M.B. Many spots cleared. Itching reduced.

1984

January 31: The eruption had completely cleared after the previous treatment but had a recurrence in the previous six weeks. General feeling of weakness. Again taking tobacco in paan (betel). Now mentioned that the pain in the abdomen is after coition.

Natrum muriaticum 200/2 powders evening and bedtime of the same day.

Reported on March 21 and April 21. Eruption is much better and generally well. Was given *Saccharum lactis* only on both of these dates.

May 19: Mild diarrhoea for previous one week. Inflammation in groins. I felt this may be due to the extra heat and perspiration.

Natrum muriaticum 200/1 powder at bedtime.

November 16: Was last seen on this date with a slight recurrence of the skin eruption. ?winter aggravation. Felt that his appetite was voracious but digestion slow.

Natrum muriaticum 200/3 powders at 15 minutes interval.

1986

September 24: Reported again. The skin problem had remained well. Now he had a number of other complaints which for brevity are not mentioned in detail. The main complaint was frequent stools. He would go at least 3 times in the morning and subsequently had a tendency to go immediately after eating. For this he received *Nux vomica* 200.

He was not seen again but his brother-in-law consulted in June 1988 and reported that Mr. R.C. continues well. The brother-in-law was suffering from Psoriasis and not realising that the remedy must be individualised he asked for the same remedy as the one which cured Mr. R.C.

Case No. 4 (Skin Eruption)

Mrs. S.A., age 29 years, consulted me on July 27, 1981. She had been married three and a half years with one child aged one year, born by Caesarean Section. There had been no abortion. She was a teacher.

Complaints: Her only complaint was skin eruption which she had had from the age of 5 years with some remissions. There was itching. No relation to time or season. Has been using cortisone ointment which clears the eruption and may remain well for some months. Has had oozing but now mostly uses the ointment in the dry stage and it does not get so bad.

Appetite: Good. Vegetarian. Likes sweets, but controls. "I do yoga and digestion is good." B.O.R.

Sleep: Good. No significant dreams. Vaccination for small pox not frequent and not for a long time.

Says she is neither chilly nor hot but feels cold in the hands and pushes feet out of covers except when very cold.

M.P.: Regular. No pain. No leucorrhoea.

P.I.: Diphtheria in childhood. Malaria 2-3 times, last attack in 1979. Had very bad acne earlier. Now the face is clear, but there is a fair amount of pitting from the previous ones.

F.H.: Father has skin eruption.

1981

July 27: *Sulphur* 200/3 powders at 15 minutes interval in the morning on empty stomach.

October 29: Reported after three months. She had been better but there was a flare up during the previous week after she used a nylon watch strap. An eruption started there and then spread all over. Repeated the prescription of July 27 (*Sulphur* 200)

November 4: As the eruption was bad and started to ooze she reported in one week. *Graphites* 30/15 powders t.i.d.

November 10: Eruption on joints. Oozing pus. Feeling very chilly. *Hepar sulphuris calcareum* 30/16 powders q.i.d.

November 17: Pussy (Purulent) discharge. Feeling quite bad. Unable to work. *Aethiops antimonalis* 6x/24 powders q or t.i.d.

Gentian violet lotion for local application, if much oozing.

November 24: *Aethiops antimonalis* 6x/21 powders t.i.d.

December 12: Better. Progressively got better. *Saccharum lactis* in pills No. 40/3 pills t.i.d.

December 23: M.B.

1982

January 29: Better. An occasional spot (dry) on hands or feet. *Saccharum lactis* continued.

March 5: Last seen on this day and was feeling quite well and the skin was absolutely clear.

* * *

1992

August 27: Seen on this date after a lapse of more than 10 years. Came to consult me for her daughter and told me that she had been quite well after the previous treatment and remained free from eczema that had bothered her for 24 years prior to my treatment.

Case No. 5 (Skin Eruption)

The longest overseas telephone call I ever had was from Mr. L.P. who sought my help for a skin eruption that had baffled specialists in USA and India. He happened to have seen my Press Report on "What Homoeopathy can offer for AIDS" in India News issued by the Indian Embassy in USA. He telephoned me from New York on January 12, 1991 and then insisted that I immediately send him medicine and in spite of my protests that it is highly desirable, if not necessary, to

have a detailed history and a personal examination at least once at the beginning of the treatment he insisted that I take his history on the telephone regardless of the expense and this call lasted a whole hour. It only shows how desperate he was.

Mr. L.P., age 42 years, migrated from India to USA in September 1969. He had been married 14 years with two children age 5 and 1. He was importing frozen food but his work involved only office routine. He gave me the details of his skin disease from which he had suffered for previous one year. It had baffled diagnosis and the skin biopsy done by a specialist in Delhi and another one in New York had differed. One of them mentioned "Psoriasis may be considered in D/D" while the other had ruled out this condition. He gave the details of his report as also the treatment as a lay person. He had a very dry skin, ?allergy and that scratching gives bleeding. Over the telephone, of course, it was difficult to ask the personal history or to watch his reactions to the different questions. I asked him to put down all he had told me in writing which he sent me by courier service. He was due to visit India a month following. But was very keen that some medicine may be tried meanwhile so that he can report the result during his short stay in Delhi. The relevant portion of the history sent is annexed.

1991

January 23: *Arsenicum iodatum* 30/20 powders t.i.d. followed by Sac-lac for two weeks.

February 19: Came personally and reported that itching had reduced and bleeding was much less. As for itching he said that it was not affected by season or humidity. It could occur anytime of the day but some increased tendency on changing clothes and had more

itching on the head on waking in the morning. Enjoys scratching.

Appetite: good, non-vegetarian but meat is taken occasionally. Non-smoker. Alcohol only in parties and mostly beer. No special cravings. He is a "Nibbler." B.O.R.

Sleep: good, no special dreams, but has woken-up shouting on occasions and found himself lying on the back and clutching the heart. Vaccination for Smallpox: Regular after 1969 for international travel i.e. every three years. Hot patient.

Found him rather verbose — talkative. Noticed the eyebrows joined in the middle. Noticed that his hair were not in natural colour; asked if he was using a hair dye which he confirmed. He started with Revlon Hair Dye three years earlier. As he got a rash on the neck after one and half years he was told he is allergic to it so he changed to Loving Care Dye which does not contain Peroxide and Ammonia.

P.I. As regards past illnesses there was history of Duodenal ulcer. He had never had any symptom of pain and it was discovered only when there was sudden bleeding in 1972 and again in 1982. The first time in 1972 he had been under great stress.

As he had reported relief he was continued on *Sac-lac*.

March 11: Had been in South India the previous two weeks. The climate was more warm and humid and he was at sea-side place. There was aggravation of itching for one day after taking Prawns. Had noticed that he would get itching from one type of Prawns even before he got the skin eruption. Eruption is maximum on lower limbs especially right, then on head, slight on back and buttocks. In the previous three weeks the eruption spots

have become a little bigger and some new tiny ones have appeared. Eruption also in the navel.

Thuja occidentalis 30, 200, 1000/1 powder of each to be taken in morning, afternoon and bedtime of same day.

April 16: Telephone report from New York. New eruptions subsided, previous dried up or drying. Itching is better except on the skull. But there also no new eruption. On rest of body "very soothing effect" so the spread is controlled "this is the first time that there is no new eruption at all. Very positive result."

August 26: Telephone report. Arms and back 100% Okay. Buttocks 99% Okay, Right Calf 95% Okay, has a localised area on the calf. So only area left is the skull where it is 70% Okay and 30% remains. It is hardly an eruption on the skull but scaling like dandruff. "Remarkable amelioration all around except the skull. First time I have had so much relief."

1992

February 14: Reported personally. No visible sign anywhere. Last to disappear was on legs. The skin is totally clear. The only area left is the skull where small patches form. They scale or flake off by scratching leaving a skin which only shows slight sign. The scales reform in same areas in about a week. All the patches are within the hairy region.

Thuja occidentalis 1000/3 powders at 15 minutes interval.

Subsequent reports on telephone and through his family were that he is quite well.

Annexure

Letter dated January 12, 1991 received by courier mail

“Respected Diwanjee:

First of all I would like to thank you for giving me an extensive audience over the phone despite the fact that you must have had patients waiting for you. THANKS VERY MUCH.

I will attempt to put into writing all that I told you over the phone so that you can review the same & diagnose accordingly.

Family Background: Born, April 23, 1945. Married for last 14 years. Have two healthy children . . . Boy, age 5 years and daughter, age 1 year. All in the family including myself, wife and children generally healthy without any serious ailments of any kind. Myself had Duodenal Ulcer. Come from a family of 5 brothers and 3 sisters. All married and healthy. Father died premature death at age 46 because of Colon Cancer. Mother alive, approx. age 81 years. Generally healthy but suffering from engina condition. Both mother's side and father's side uncles have warts but more of a cosmetic nature rather than grape bunches.

Personal Medical Background: Had Typhoid at approx. age 15. Have had Tonsils removed at approx. age 14. Twice suffered from Duodenal Bleeding Ulcer. Once in 1972 and then in 1982. On both occasions it bled and went away by itself without any surgery. Had “Tegemet” 2nd time. Had only milk the first time. Presently don't feel a thing about my Ulcer. No diet restrictions and eat normal diet-everything.

Height 5 ft 11½ ins. Weight approx. 185 lbs and steady. Approx. 3½ years back got some warts removed from left side of forehead by electric burns and a few by

sucking. All of these were of a cosmetic nature. The ones removed by electric were just dots on the forehead. The ones cut by suction method were slightly raised from the skin.

Have a large mole on the right cheek. This is a birth mark and the size and appearance of it has been the same since birth. Have had Malaria atleast 2 times both in the last 10 to 12 years.

About a year back noticed a skin eruption on the back of my skull, below the hair approx. 3 ins. above the neck line. This skin eruption was like a little mound with a White Layer of skin. It was very Itchy and when I itched and scratched the area it scaled off into white flakes and subsequently the eruption became worse and larger. I applied "Tenovate" ointment locally on the area and the eruption dissolved overnight. I noticed white flakes in the comb after I took a shower and the skin became absolutely even.

Around May, 1990 I started noticing a few Red Rashes on my forearms and thighs. Just about that time I had contact with Poison Ivy. Poison Ivy gave me other rashes which then got mixed in with my existing rashes and aggravated the old rashes. Eventually, the Poison Ivy went away by local applications of Calamine Lotions etc. However, my other rashes remained.

There were 3 prominent areas of these rashes. (A) On my forearms. (B) On my thighs and (C) On my lower left back.

In addition I started having Skin Eruptions of the earlier kind in my scalp area at random places below the hair. These skin eruptions were very itchy and when I scratched them they would shed white scales like dandruff but only bigger than dandruff scales.

The Red Rashes on my thighs, arms and back were of the size of a pimple. They were very itchy and when I scratched them I found that white scales would shed from them and then they would bleed.

A typical rash would be as follows:

Once a rash would appear it would be of Bright Red Colour. At this stage it would be very itchy.

After about 3-4 days the intensity and the ferocity of the rash would calm down and the colour would then start changing into a maroonish shade.

At this stage it would be less itchy.

If scratched it would shed off white flakes and bleed.

After a few days the colour would be brownish maroon like a cut or bruise which shows signs of healing. Again, if scratched it would shed flakes and bleed.

The first appearance of rashes in May last year lasted about 2 months and then they disappeared just as quickly as they had begun. Although I had used some local ointment and taken some oral pills I don't believe that any of them had any effect because I did not notice any correlation between their administration and the disappearance of the rashes.

Skin Biopsy, Urine Test and Blood Test were done by the "Skin Institute" in Delhi in July of last year when the rashes were significant.

Skin Biopsy of the rash area was also done in New York. That result is not available at present but their findings were a little different than the "Skin Institute" because they ruled out Psoriasis. As a matter of fact the doctors here have not been able to diagnose these rashes as yet.

About 2 months back I started noticing the reappearance of Red Rashes on other parts of my body. This time they are more prevalent on the right Calf between

the knee and the ankle. Few lesions are noticed on the left calf, thigh, right thigh and back.

This time the rash is not in a cluster form. It is very random. (The pimples are indiscriminately scattered in the above mentioned areas.)

In addition, the eruptions on the scalp below the hair have increased and are more itchy than ever. After I scratch the scalp I notice white flakes from the eruptions. If I scratch deeper then they bleed and also leave a red lesion below the hair.

The rashes are following their usual pattern starting from bright red in colour to maroon and then brownish. In some areas they have healed and there is a layer of brownish tissue where the rash was. However, if I scratch those tissues they would have a tendency to flake but not bleed.

Where the rash shows signs of healing it will only flake upon scratching. However, if the rash is still tender then it will flake and bleed upon scratching.

Medications used:

1. Cephalexin	Taken orally for about 2 weeks in June 1990. (No effect)
2. Nystatin	Taken Orally in June 1990. (No effect)
3. Celestamine	Taken Orally for about 3 weeks in July 1990. (Had some relief but not too much)
4. Zovate-GN	Applied locally July 1990. (No effect)
5. Tenovate	Applied locally on Scalp, June 1990. (Had limited effect/symptoms recurred after stoppage of use)
6. Betnovate-n	Applied locally on rashes. (Had some Degree of healing effect)

Presently using Olive Oil on body and scalp. Olive Oil seems to relieve itching, soothe the rash and also seems to have a slight healing effect.

Am totally confused about diagnosis since no one has accurately diagnosed so far. In the meantime I continue to suffer from indiscriminate rashes at random parts of my body and scalp. They are itchy, scaly, irritative and ugly looking.

I hope you will be able to put a finger on the pulse of these rashes and prescribe a "Magic Formula" to relieve me of this discomfort.

I briefly read an article in one of the Indian Weekly here about AIDS. You are quoted as saying "Homoeopathic Treatment Can Cure AIDS" Well, if you can cure that deadly disease I'm hopeful that you will be able to get rid of my rashes ... whatever they are!!!

As I mentioned to you over the phone, I plan to be in India in middle of February. I will be in Delhi for 2 days prior to leaving for Bombay/Madras etc. Thereupon I will be back in Delhi by end of February and will then stay in Delhi for about a week. I shall inform you and Sonia my exact date of arrival in Delhi.

If you permit me I would like to drive straight from the airport to your clinic or home so that I don't waste even a single minute to have myself physically examined by yourself. You can understand my state of mind when I express my sentiment!!

Would appreciate your sending me via DHL some medicine to hold me for a month prior to my seeing you personally.

Kindly keep a tab on all expenses and I shall settle my accounts when I see you.

Warm personal regards.

Sd.

THE SKIN INSTITUTE & SCHOOL OF
DERMATOLOGY, NEW DELHI 110 048

HISTOPATHOLOGY EXAM

7/7/90

Section shows laminated hyperkeratosis with follicular plugging. There is confluent parakeratosis and aggregates of neutrophils within the parakeratotic layers. There is hypogranulosis and acanthosis with elongated rete pegs. Small foci of spongiosis are present in the epidermis. Dermal papillomatosis is seen with a number of tortuous thin walled capillaries in the papillae. At places rupture of these capillaries has led to extravasation of R.B.Cs. A perivascular lympho-histiocytic infiltration is present in the superficial dermis. Psoriasis may be considered in D/D.

MISCELLANEOUS TESTS

7/7/90

Smear Gram's stain shows few epithelial cells. No micro organism seen. KOH — No fungus seen. Saline — NAD.

AETHIOPS ANTIMONIALIS (HYDRAGYRUM STIBIATO SULFURATUM)*

Boericke's Materia Medica mentions it on page 17 only under Relationship with *Aethiops mercurialis-mineralis* and all that is mentioned is "often more effective than the above in scrofulous eruptions, glandular swellings, otorrhoea and scrofulous eye affections, corneal ulcers. Third trituration". This does not catch the eye and the description is rather vague and as such the remedy has not been much used. *Clarke's Dictionary of Materia Medica* gives a few extra lines about its use but mentions right at the beginning that the remedy has not been proved. It does not appear in *Hering's Guiding Symptoms* or *Allen's Encyclopedia of Pure Materia Medica*. I was taught its great utility by my father, late *Dr. Diwan Jai Chand*, who demonstrated its good effects in a number of frightening eczema cases with much oozing and pus formation. I have used it in numerous cases when there is pustular eczema or an oozing eczema gets infected and pus is formed and found it extremely effective. So great is my reliance on it that I may be accused of using it even routinely, when there are no clear indications for any other remedy. It has been used in situations which would prompt dermatologists to immediately prescribe an antibiotic. *Aethiops antimonialis* has saved the situation. Once the septic process has been cleared it has been possible to revert to the constitutional or a deeper acting remedy. I have used it exclusively in the 6x in repeated doses: three or four times a day.

* Paper presented at the 43rd Congress of the International Homoeopathic Medical League, Athens, May, 1988 (Theme: Rarely used Remedies).

Mostly it has been needed from 3 to 7 days, rarely for two weeks. As illustration I give the details from the following cases:

Case No. 1

Mr. R.K.A., age 58 years, owns a factory where copper and aluminium are used. He consulted on **August 19, 1985** and gave a history of eczema for the previous 30 years. He had had Homoeopathic treatment earlier which would clear the eruptions for sometime but then some slight injury or other factor would cause a recurrence. He had lot of itching and the eruptions were oozing. Sleep was disturbed by itching around 2.30 A.M. < winter < rain.

Additionally he had pain in the waist for the previous 8 years and pain and restricted movement in the right shoulder for the previous three months.

He was obese and on examining eruption was seen mostly on the feet and ankles and it was oozing in some areas.

1985

August 19: Prescription: *Aethiops antimonialis* 6x/21 powders, t.i.d. followed by *Saccharum lactis*.

September 3: Reported much better in his eruptions. From the previous day had developed a boil on the left side of the neck and the whole of the area was paining. For this he was given *Belladonna* 30/12 powders q.i.d.

September 20: Reported much better. Right foot cleared, left foot much better but still had some eruptions. *Saccharum lactis* continued.

October 8: Getting better in left foot also. Some itching on removing socks in evening.

October 24: Reported worse. He had travelled for the previous few days and since this was for a wedding

party had had indiscretion in eating. The food being more spicy and richer (more fried items). Thereafter the eruption had got worse and there was more itching and again oozing.

Prescribed: *Aethiops antimonialis* 6x/9 powders t.i.d. followed by *Saccharum lactis*.

November 1: No relief. Prescribed: *Graphites* 200/3 powders to be taken on the same day and followed by *Saccharum lactis*.

November 22: Reported better. Oozing from eruptions nil or much less. *Saccharum lactis* continued.

1986

January 27: Itching more but otherwise continues to be dry. He spontaneously said "gives a feeling it will get well."

He continued to receive occasional doses of *Graphites*. Inbetween for some incidental conditions of a road accident and 'flu he got other medicaitons.

1987

April 15: The potency was increased and he got *Graphites* 1000. After this itching increased and the skin condition was worse.

April 25: *Aethiops antimonialis* 6x/21 powders t.i.d.

May 2: Much better. Most of the region dry. Repeated the prescription.

May 9: Further improvement. Given *Saccharum lactis*.

The improvement was maintained over the subsequent many months and he remained on *Saccharum lactis*.

Case No. 2 (*Aethiops Antimonialis* in Purulent Skin Eruption)

Mrs. K.K. age 33 years consulted on November 8, 1984. She gave a history of skin eruption from the age of 3 years. Initially it was on buttocks and legs and was mostly dry. It had cleared from there but she always had it somewhere or the other. On the toes she had weeping eczema. Eruption is very itchy. It burns by scratching and then there is oozing. The year she consulted me it had also appeared in the armpits. Two weeks prior to consulting me she had a rash all over her body which cleared in a week by use of antihistamine drugs — Avil and Dilosyn. There was a definite < winter. Starts getting worse from autumn when the skin is very dry and it persists through the winter months. However, she had been quite well during a two years stay in London. She received *Psorinum* and later *Graphites* with variable result.

1984

December 5: She presented with a frightening picture: there had been much oozing and pus formation.

Prescription: *Aethiops antimonialis* 6x/20 powders q.i.d.

December 10: Steady improvement after starting *Aethiops antimonialis* 6x. Much much better today. Oozing stopped. Itching reduced.

Prescription: *Aethiops antimonialis* 6x/16 powders q.i.d.

December 14: Very marked improvement.

Prescribed: *Saccharum lactis* 28 powders q.i.d.

Thereafter reverted to the deeper acting constitutional remedies.

Case No. 3 (*Aethiops Antimonialis* in Pustular Skin Eruption)

Mrs. D.M., age 36 years, consulted on **May 8, 1985**. She had a history of skin eruption from the previous 7 years. When she came to me the condition was very bad as her hands and feet were full of pustules which she had had for the previous one week. The rest of the history is not significant. On the basis of what I have mentioned above I prescribed *Aethiops antimonialis* 6x/30 powders t.i.d.

1985

May 18: Reported much better. Most of the pustules had dried and scabs fallen off, even though some new spots had appeared.

Prescribed: *Saccharum lactis* for 25 days. However, she tended to relapse and reported again on **May 25** with pustules.

Prescribed: *Aethiops antimonialis* 6x/30 powders t.i.d.

June 22: Much better. She said that she had been very much helped by the prescription of **May 25** and after using that had reverted to the remaining medicine of **May 18**.

July 16: For the previous few days again the eruption has increased with pustules on palms. *Aethiops antimonialis* 6x/21 powders t.i.d. followed by *Saccharum lactis*.

Reported again on **August 12** and her condition was better. Some itching persisted and on the basis of the rest of the history now she was prescribed *Psorinum* 200.

Comments: These cases highlight the quick response in oozing septic eczemas. Once the septic process has been cleared one can revert to a deeper acting or constitutional remedy. It has not been usual that *Aethiops antimonialis* has completely cured these cases.

PEMPHIGUS ERYTHEMATOSIS

Mrs. K.P. aged 45 years came for consultation from Lucknow on February 16, 1990. She had been married 14 years and had one son aged 10 years. No abortions.

Complaints: She had skin eruption from April, 1985, i.e., for five years. It started from neck and shoulder region and spread to face and some other areas of the body. There was mild itching and some burning on the face. In 1985, she had vesicles on the body which would burst and ooze fluid. For this, she had treatment from a noted dermatologist and the vesicles cleared. This treatment could relieve only temporarily and it kept recurring. There are variations in her condition. At times it is nearly clear though not totally and then suddenly flares up again. Aggravation at change of seasons: October-November and March-April.

In April, 1985 skin Biopsy was done and the Histopathology report declared it as "compatible with Pemphigus Erythematosis." In July, 1985 Urine examination showed Albumen ++; ESR (Westergren) 30 mm.

The trouble started at Jodhpur where the climate is dry and hot and the area is sandy and like a desert. In 1987, she had moved to Guwahati which is milder in summer and cold in winter and is more humid. She had been on steroids for a considerable time. This resulted in swelling ("puffiness") and weight increased to 75 kg. After discontinuing it, the weight reduced to 61 kg. The steroid use also resulted in high B.P. and diabetes which have cleared after it was stopped. *Imuran* was used but she could not tolerate it so it was stopped. Then she was put on *Endoxan* which she is still using.

Her appetite is good. She is non-vegetarian. Earlier liked sweets, now no craving.

She was using *pan bahar* (consists of betel leaf, arecanut, lime and essences, catechu, all dessicated and in granular form) but no tobacco chewing.

Hot patient — Was born and brought up in the mountains, so not used to heat.

Menopause 4 years earlier, was then using steroid. No flushes or other menopausal symptoms.

Does not give any significant mentals.

She was using Dexona, Endoxan and some Vitamins. Also some unorthodox pulse therapy.

P.I. — Jaundice at 14 years.

O.E. — Dry eruption, patches on face, neck, upper back and abdomen, weight 131 lbs.

1990

February 16: *Arsenicum iodatum* 6x, 30, 200/1 powder of each in the morning, afternoon and bedtime of same day followed by Sac-lac for a month.

March 16, letter: No appreciable change. Dryness more pronounced.

March 23: Sent *Arsenicum iodatum* 200/3 powders.

June 25, letter: "After the second course, there was a complete flare-up of all the old rashes in third week of April, but no new lesions had appeared. We had come over for consultation in third week of May but you had not returned from abroad. Now, the rashes are completely dry and approximately 45% of them have cleared also."

September 26, letter: "No relapse since the last one in April. The rashes are completely dry and clearing up slowly."

December 1, letter: Improvement continued.

December 28: Came personally. "Progress maintained and no relapse which she had at every season

change. The areas of eruption progressively getting smooth."

1991

February 22, letter: "Very satisfactory improvement. Most areas are now smooth. No aggravation at the last two changes of season."

April 15: "Skin condition very satisfactory, nearly clear."

O.E. — Few patches — Dry, rough and some scales behind right ear and scalp. Most of the patches have cleared.

Prescription — *Arsenicum iodatum* 200/3 powders at 15 minutes interval.

All subsequent reports mentioned, "Progress is very satisfactory." In October 1991 whatever little allopathic medication she had continued from the AIIMS, partly because of the tremendous fear from this very serious disease, was also discontinued completely.

December 30, letter: "... has been progressing very satisfactorily, in fact her face and body are absolutely clear now. Only her scalp now remains to be clear."

1992

June 2, letter: This was the last communication I received and it mentioned that, "She is quite well now, there are no rashes/scales on any part of her body . . . both myself and Mrs. K.P. are very grateful and thankful for curing Mrs. K.P. of the dreadful disease."

1993

February 17: Was visiting Delhi and specially came to see me and to say that she was quite well and again expressed a very profound gratitude for the treatment.

DERMATITIS

Mrs. C.S. age 42 years consulted on June 11, 1988. She had been married 19 years with two children age 18 and 15. She was a teacher.

Her problems really start from the time she had an operation in February, 1987. She was having excess bleeding and on investigation was found to have Fibroids for which she had Hysterectomy and Bilateral Oophorectomy in February, 1987. Post-operatively there was some infection and fever. This was controlled with appropriate treatment. Later she had menopausal symptoms of intense and frequent flushes. For this she was given injection of Mixogen once a month for 3 months and felt comfortable. However, on stopping the injection, there was a recurrence of flushes and she would get soaking wet with sweat at that time. Geriatone one tab. every night made the flushes milder but only as long as she used the medicine.

Face appears somewhat swollen in the morning. In the previous 3 to 4 months she started getting patches on the skin where there would be discoloration and itching. There would be burning in those areas with perspiration. No urticarial wheals. The dermatologist had diagnosed it as *Autosensitisation Dermatitis with Acne Rosacae*. Was prescribed Polarmine and Allergen tabs., Flucort oint. and Lactocalamine for local application. This treatment for 3 months has not helped and the patches have extended to other areas. Itching has no time modality and not affected by any particular diet. After scratching there is some burning. No oozing anywhere. Earlier had oily skin, now skin is dry. Dryness < after bath.

Appetite: Good. Non-vegetarian but takes meat occasionally. Was brought up as a vegetarian. Salt, perhaps

a little more but now avoiding the extra. Sweets $\pm$. B.O.R. Sleep good unless disturbed by flushes.

Not significantly chilly or hot but possibly feels the heat slightly more than the cold. In winter feels better as the flushes are not so bothersome.

Put on 5 kg in weight after the operation.

P.I. — Mumps at 30 years.

1988

June 11: *Lachesis* 200/3 powders during the evening and bedtime.

June 21: Feeling better. Was asked to discontinue the Hormone tab. on June 11. After 3 days felt slight trouble, so decided to withdraw gradually, now using on alternate day instead of daily. Sac-lac.

June 27: Improvement maintained. Sac-lac continued. As the patient was from another city, she had gone back to her home. I received the following message.

July 20: Itching scalp. Dryness of the body with itching.

Lachesis 200/3 powders at 15 minutes interval.

Letter dated **August 18:** "I am feeling much better than what I was when I first came to see you . . . I was progressing quite well slowly but steadily. However, since the last one week I find that the blotches on my skin have reappeared."

Lachesis 200/3 powders at 15 minutes interval.

Letter dated **September 30:** "The medicines have done me a lot of good . . . The skin has improved a lot and except for some patches on my legs and feet, the rest of the body is clear. Hot flushes are also less frequent and less severe." (?According to Hering's Law . . . From above down).

Saccharum lactis.

Letter dated **November 15**: "I am feeling much better in fact, the blotches on my skin are almost cured."

1989

Letter dated **July 13**: I received a communication after nearly 9 months. "I had fully recovered so medication was discontinued but now since the last week, I can feel the same symptoms coming back, swelling and puffiness on the face, irritation of the skin, and generally I feel low and sluggish. The skin on my face is rough, dry and sallow."

Lachesis 200/3 powders at 15 minutes interval.

1993

Letter received on **May 10**: "I had been to you for consultation for a skin problem I was suffering from some four years ago. With your medicines I was fully cured and was okay all this time. But since the last few weeks the same skin problem has come up again." I repeated the prescription of *Lachesis* 200 but suggested that as considerable time has passed, she may try and make another trip to see me in Delhi.

Comments: In this case the prescription was based more on the basis of causation (stoppage of a natural discharge) and the flushes rather than the skin symptoms. The subsequent recurrences of the skin eruption were helped with the same remedy repeated in the same potency.

It indirectly highlights the great importance and utility for a Homoeopath to meticulously maintain records.

SKIN ERUPTION (ATOPIC DERMATITIS)

Case No. 1

Master A.S., was brought by the parents on July 29, 1989. He was then 8 months of age (born November 29, 1988).

Notes of earlier period; F.T.; N.D.; B.W. 2.8 kg; breast fed for three months. Thereafter totally weaned. Had had B.C.G., D.P.T. and polio (oral) drops. Weight at 7 months over 8 kg. Teething during 8th month — erupted one week earlier. All milestones normal.

Complaints: Skin eruption from the age of 1 week. Started on scalp then on face. Oozing. Initially had allopathic treatment with a preparation that contained steroids. The eruption cleared very soon but recurred. Thereafter seen by some other Homoeopath who gave *Rhus toxicodendron*, *Graphites* and *Viola tricolor*. These were given together for one month. There was an aggravation initially. For the previous one week, he was using *Sulphur* and some other medicine and was M.B. Presently eruption is on face, folds of elbows, behind the knees and on ears. He scratches himself to bleeding.

Appetite: Good. No food allergy discovered.

B.O.R.

Sleep: good.

Sweats on head, wets the pillow.

Generally a happy child.

P.I.: Nil of note. Had jaundice when 5 days old. It was mild and considered physiological.

F.H.: Nil of allergy, diabetes, T.B. Great grandmother had Eczema. Mother had uneventful preg-

nancy and used the usual tonics — iron, M.V. capsules, etc.

As he had been using Sulphur and was better, he was given Placebo for one week and asked to stop the medicines he was using.

1989

October 31: Did not report after the first visit on July 29, as he had gone to his grandparents in Indore. He took Homoeopathic treatment there. He had been prescribed *Psorinum*, *Sulphur*, *Hepar sulphuris calcareum* and *Rhus toxicodendron*. The exact dates, the order in which they were used and the strength were not known. The amelioration that had started in July continued in the initial period, but later same medicines were of no use and in the previous one month there has been almost a complete recurrence. There was oozing on scratching and again blood. < evening. Itching on face after meals. ? Contact of vegetable, etc., is fed with a spoon. In last 2 weeks appetite reduced and weight decreased by 500 gms. Also tending to throw up.

Viola tricolor 6/21 powders t.i.d.

November 7: Slight aggravation 8 p.m. onwards.

Graphites 200/1 powder.

November 18: Amel. on face in first week. Itching was also less, almost stopped. For last 4 days again worse — itching increased as also eruption, oozing on upper limbs.

Repeated *Graphites* 200/1 powder.

December 25: By the end of November rash cleared completely for about 72 hours, then recurred. Had then started applying coconut oil. Later got chest infection with temperature 102°F. Had used antibiotics for 9 days. When he had the chest problem, the skin cleared again for three days but then recurred. Some breathing prob-

lem and wheeze at that time. ?I wonder if it was an alternation between the skin and the chest. Now eruption mostly on cheeks.

Graphites 200/1 powder.

1990

January 17: M.B. Had progressively improved and completely cleared two days ago. Some recurrence now. Earlier also twice it had cleared and recurred. *Saccharum lactis*.

February 19: Had again been to Indore (January 18-31). It got worse. There was itching and even blood. It started clearing 2-3 days after return and, "was so clear and normal that no one could make out he ever had a skin problem. At present is alright on legs and folds of joints and is there mostly on right hand." *Graphites* 200/1 powder.

March 28: Eruption improved progressively and completely cleared one week ago then went to Bombay (coastal city) and it has recurred. There is no oozing. Has itching on hand. *Graphites* 200/1 powder.

April 14: No relief, has been deteriorating. Much scratching. Oozing and blood spots. Looked up the Rubric Agg. Sea shore (Page 1344) *Arsenicum album*, *Magnesia muriatica*, *Sepia*. *Sepia* 200/1 powder.

April 20: Worse. Increased in area and extent of itching. *Saccharum lactis* for one week.

April 28: A little better.

April 30: M.B. on face, still has on hand. *Saccharum lactis* continued.

June 1: M.B. during this period.

July 11: V.M.B. all clear. Has a tiny spot on the right cheek for the previous three days. This looks like an insect bite.

August 22: Skin been clear and no problem on that score. Has fever today. *Rhus toxicodendron* 30/16 powders q.i.d.

September 21: "Medicine was very effective. Temp. got normal." Slight itching and a little roughness. Considering that the fever might have interrupted the effect of the remedy, repeated *Sepia* 200/1 powder.

November 10: Been well.

1991

April 13: Reported after 5 months. It remained well all this time till he started going to school and from the very first day some itching and eruption started and is increasing. Except that the school is not air-conditioned, it is very clean and he has not been playing in the garden. His father is the General Manager of a five star hotel and lives on the premises which is totally air-conditioned. *Sepia* 200/1 powder.

1992

August: During this time of 15 months has had a baby sister who was brought for consultation for a similar eruption and I learnt that Master A.S. has remained completely well after his visit on April 13, 1991.

Case No. 2 (Skin Eruption ?Atopic Dermatitis)

Master V.S., age two and half years, consulted on January 21, 1975.

Complaints: Skin eruption — duration four months, itching + +, itching worse at night, scratches hard. Initially oozing. Now dry but bleeds on scratching. Had allopathic treatment — used antibiotics and anti-allergic medicines. These could only partially relieve and it keeps recurring.

Appetite: reduced of late. Likes to eat raw leaves. Also aniseed (saunf) + +. No other cravings.

B.O.R. Stools are hard.

Sleep: recently restless. Gets up three-four times for urine. No bed-wetting. No nightmares, no talking in sleep.

Vaccinations for smallpox ?Twice, second in 1974.

Reaction to heat and cold not marked. Perspiration average but as an infant had profuse perspiration on head in sleep.

P.I. Prolonged fever at age of three months. At times even as high as 106°F. It was put as due to excessive heat and hot winds in the hot summer. No H/O worms.

1975

Prescription: **Jan 21:** *Nux vomica* 30/2 powders evening and bedtime first day. *Sulphur* 200/3 powders at 10 minutes interval on second day in morning.

February 8: Eruption cleared on the abdomen. Still has on legs. Itching reduced in previous three days. C/O: Pain abdomen. He used to make this complaint before he got eczema. *Saccharum lactis* continued.

February 17: Itching I.S.Q. Eczema patches bigger. Reappearing on abdomen. No pain abdomen for the previous two weeks.

Sulphur 200/3 powders at 10 minutes interval

March 3: Itching + + and does not sleep well. However, itching is less than before.

March 18: Eruption had practically disappeared and very slight remained. Itching had also reduced but in the last few days tending to reappear. Repeated *Sulphur* 200.

March 24: Developed fever, cold and cough.

Ipecacuanha 30/16 powders every four hours.

April 4: V.M.B. Skin nearly clear.

May 22: Few glands in the neck. Pain abdomen at times. Flatus — passed with noise. *Calcarea carbonica* 200/3 powders at noon, evening and bedtime.

June 13: Glands still palpable. Repeated *Calcarea carbonica* 200/3 powders.

June 24: M.B.

Not seen thereafter as he was from another town. Some years later another family member consulted me and I learnt that he had been quite well after the treatment he had had in 1975.

Comments: 1. The description is like that of an Atopic or Allergic Dermatitis which at times is very difficult to completely eradicate.

2. Although *Sulphur* is not mentioned for perspiration on the head in sleep in Kent's repertory but it is mentioned in some of the standard *Materia Medica*s.

3. The report on February 8, 1975 in some ways conformed to Hering's Law of Direction of Cure and as such was encouraging. Pain abdomen was like "recurrence of old symptom" and clearing of eruption from abdomen was like "from above downwards."

4. *Calcarea carbonica* follows *Sulphur* well and completed the cure.

ALLERGY — DERMOGRAPHIA

Mrs. B.K. comes for consultation on February 15, 1989 and mentions of her happy experience with the treatment 10 years earlier and of having kept well during this time. So I take out her earlier notes. She had consulted on February 27, 1979 and had been referred by a colleague from Rome. Her husband was posted there

and was on a short visit to Delhi. Her complaints were of such nature that would ordinarily be described as allergy. She was having itching and wherever she would scratch raised lines would appear. This had started six years earlier after the use of antibiotics. When she used those (antibiotics) the lips had swelled-up and later there were swelling in different places of face. This would occur suddenly and sometimes at night during sleep. She also developed an allergy to milk and milk products but she got over this gradually in six months. Presently it was the sudden itching and the appearance of raised lines as she scratched. On one occasion someone casually slapped her and there was a sign of all the fingers as the area showed up in the raised markings.

She was having plenty of dreams. At times happenings of the day or anything worrying her. Other times she had frightening dreams of thieves. On occasion she will shout out in sleep 'Chor chor' (Trans: thief, thief). She had been vaccinated every three years as per the requirements for international travel. Hot patient. Fear in dark. Anger +. Had been using hair dye for three years. This did not give any reaction and she had not made any change in the brand. She had an allergy to pineapple, oranges, melon and a very great allergy to strawberries. When she got the eruption she felt more comfortable by applying cold.

1979

February 27: Prescribed: *Natrum muriaticum* 10 M/1 powder at bed time.

March 12: As she was returning to Rome she reported again. My notes are brief. She additionally mentioned that if she uses nylon material and it is warm then she has trouble but not when the weather is cold. Can get itching from woollens also. She was given a

month's supply of Placebo and I had not any further report till she came in February 1989 after 10 years.

* * *

1989

Her present complaints were that in the summer months when she sweats there is itching on back and raised lines appear. She no longer gets the swelling reported in 1979. Can take oranges, melons and strawberries without any problem. Pineapple she had not tried, out of fear. Has allergy to aspirin and penicillin. Has developed many warts — mostly face and neck. Dreams: All kinds. Now not the frightening ones.

February 15: Prescription: *Natrum muriaticum* 10 M.

?ALLERGIC RASH

S.K.A. came to the National Homoeopathic Centre on July 28, 1990 and mentioned that he had been very successfully treated earlier for a different condition. His old notes show that he consulted on **September 7, 1973**. A short history was taken as he came without appointment but wanted an urgent consultation. He had a rash all over his body, in many places circinate, of short duration. He had used Paradeca, antibiotics and some other medicines without much relief. There had been itching only on the first day of the rash. There was some swelling over the eyes. Low grade fever. No thirst. He mentioned that he had been eating out and mixing drinks (different kinds of alcoholic drinks) which he felt may have been the causative factors. There was no digestive upset.

He was prescribed *Apis mellifica* 3/16 powders at 4 hourly interval.

September 1, 1974: He comes back after one year and gives a report that the rash he complained of at the first consultation in September 1973 was relieved by the use of two powders only and he has remained well all this time. Now he had a recurrence over the last few days. Since it was the same month, in my notes I have put it ?seasonal.

I repeated the same medicine that is *Apis mellifica* 3/16 powders q.i.d.

September 16: The rash cleared rapidly but has recurred on September 15 ?after taking beer.

The prescription of *Apis* was repeated and continued for about 10 days.

Had no recurrence of this trouble till July 1990 when as mentioned above he consulted for some other complaints.

Comments: In this case the prescription is based only on local symptoms with modalities and the medicine has been prescribed in a low potency, repeated doses.

It also highlights the advantage of keeping records as on a second visit a year later with the same condition one did not have to spend time going over details and finding a remedy.

URTICARIA

Case No. 1

Mr. A.R., age 28 years — consulted me on April 18, 1954 with the complaint of urticaria for the previous two months. Had been using anti-allergic medicines which

gave only temporary relief. A symptom that he mentioned has remained very vivid in my memory. He said that when he goes out for a walk in the evening, he starts feeling the tingling and wheals come up on his hands. He would wrap his handkerchief on the hand and then, there will be no urticaria. Another time, he would get the trouble is when he will go to office in the morning and take off his shoes and sit under the fan (his work involved sitting on the ground, so he would take off the shoes. Switching off the fan would prevent the urticaria < use of cold drinks > warm drinks. A cup of hot coffee would help. The rubric in Kent's Repertory, page 1321, **Eruptions**; urticaria; warmth and exercise amel., *Hep., Sep.* A single dose of *Sepia officinalis* 200 was administered on April 18, 1954.

Next report on May 10, 1954: much better. No urticaria under the fan or any cool air, while going for a walk, can also take cold drinks. It occurred once after taking ice-cream. Prescription S.L.

Thereafter, went to a hill-station, received a letter dated May 21, 1954. I quote "During my stay at Ooty, I suffered a lot. So far I remained in the bed it was alright but no sooner that I would go out for a walk, the trouble starts."

As soon as he shifted to a warmer climate, Madurai, he felt better. He, therefore, put his observations as "From my experience at Ooty, it seems I have not been cured. Still I am allergic to cold breeze and cold drinks." *Sepia officinalis* was repeated.

Next report "I am going out for a walk every day and when I come back, there is slight sensation in both my hands, though nothing comes out."

I did not see him again till May 20, 1955 when he reported signs of recurrence.

Sepia officinalis repeated.

Next report in the second week of June 1955, "No sign of any trouble so far. I am taking everything including iced water, coca cola etc."

Case No. 2 (Urticaria)

Mr. U.C. comes to consult me in February 1994, and mentions that he had been treated by me in 1970s for Urticaria and the treatment had been so successful that there has been no recurrence of that to date. Now, he seeks consultation for an entirely different condition, which has not responded to the treatment he has had in USA, where he now resides.

His old history shows that U.C. consulted on May 22, 1971 at the age of 23 years. He was then single and was an engineering student.

He had been having spots on the body for the previous two months which itch. First, there is a red wheal and subsequently that area feels itchy. It is warm to touch. It can be anywhere on the body, i.e., both covered and uncovered parts < morning < after bath. One morning on waking he found the lips swollen.

Appetite: Good. Non-vegetarian, fond of non-vegetarian dishes. Salt +. Some tendency to flatulence. B.O.R.

Sleep: Light sleeper and takes time to fall off to sleep. No dreams.

Vaccination: Every three years. The last was 18 months ago. Feels extremes of both heat and cold, likes it moderate.

P.I.: Typhoid in childhood. Some years ago had eczema confined to the feet and it was ascribed to the use of nylon socks.

1971

May 22: *Urtica urens* 3/20 powders q.i.d.

May 28: M.B. Though still gets urticaria at times but frequency much reduced.

Urtica urens 3/30 powders t. or q.i.d.

June 8: Worse last two days. ?After taking fish < night after dinner.

Caladium seguinum 30/16 powder q.i.d.

June 14: Was okay till last night when it occurred again after dinner which consisted of potato, *dal* (pulses) and a bit of pickle and of course *chappati* (leavened bread). "I get it by use of potato, rice and raw onion." Now, it occurs mostly at night.

Pulsatilla 200/3 powders at 4 hourly interval.

1971-94

Thereafter no urticaria at all. He reported a few times for a minor cold or sinus and was last seen on **October 5, 1971** but after June no urticaria and had been free of it even when he reported in 1994.

URTICARIA (DERMOGRAPHIA)

Mr. R.J., age 18 years, first seen on November 19, 1979 with history of having had scabies at a camp in May 1978. Allopathic treatment. The scabies cleared and there was no itching, but he started to get wheals like dermographia. For this, used an anti-allergic tablet (Incidal) which makes him doopey. There is itching and wherever he scratches, raised lines appear. If he gets into bed or covers up, it gets better. He is a chilly patient, has been vaccinated every two to three years, fond of raw-onions and spicy food. Nothing else of note

in his history. He received *Sepia officinalis* 200 on November 19, 1979 and December 17, 1979 with only partial relief.

On January 15, 1980 he was back to his original condition and also reported falling of hair and dandruff. Prescription: *Sepia officinalis* 10M single powder.

Report on January 30, 1980 "better in last fortnight, now no itching or eruption on back but gets it to a lesser extent on lower limbs (could it be according to Hering's Law of Direction of Cure — from Above Down?"

SCLERODERMA

Mrs. U.T. age 28 years consulted on June 22, 1977 and it has been possible to observe her over a long period of 15 years. She had been married for 9 years with 2 children aged 7 and 2 and no abortions.

Her ailment started during the latter months of second pregnancy, i.e., two and a half years ago. She felt a hardness of skin on upper and lower limbs as also upper chest. On the chest and upper limbs perhaps more markedly on uncovered parts. The only symptoms she had at that time was a discomfort in walking. During the ante-natal check up it was found that the B.P. was raised and weight was much increased so she was put on an appropriate diet and asked to reduce weight.

After the child was born, she started with allopathic treatment for her ailment and she was put on Butacortil F and Endoxan. She admits that this improved her condition by 75% but she had many side effects and therefore, had to stop the treatment. Immediately on discontinuing, the symptoms returned and she was as

before. With the medicines she had lost much hair on the head, got dark patches on skin and depigmentation on chest alongwith itching. The specialist had diagnosed her as suffering from *Scleroderma* with puckering of skin. However, the subsequent history gave one the feeling that the symptoms were like *Progressive Systemic Sclerosis*.

Her appetite, bowel function and sleep were all normal and no significant dreams. She was adding extra salt in her food.

Small pox vaccinations from time to time in school and once thereafter.

Become markedly chilly after the onset of this illness.

No mentals of consequence.

M.P. L.M.P. January 1977, amenorrhoea since. For many months before they have been irregular and late and scantier. This was ascribed to the medicines that were being given.

P.I. Typhoid and Small pox in childhood. But she has no pock marks and has scars of successful vaccination. During second pregnancy, she had slight bleeding in the fourth month and was given some medicine for one month.

1977

June 22: *Nux vomica* 30/2 powders evening and bedtime 1st day. *Thyroidinum* 200/3 powders at half hourly interval on 2nd day. *Saccharum lactis* from 3rd day onwards.

July 4: Feels difficulty in walking due to tightness of skin, being felt more after stopping the allopathic medicines. Also gets tired quickly by exertion.

July 21: Right forearm skin a little softer. In other places same.

August 16: Leucoderma patches in the dark affected areas. These are in small spots and in some areas like a tiny-tiny spray of white dots.

Itching in the dark patches — whether indurated or not.

Thyroidinum 200/3 powders at half hourly interval.

September 6: Started to have slight perspiration. Previously it was nil. Skin hardness perhaps a bit less. Itching same. *Causticum* 200/3 powders noon, evening and bedtime of the same day.

October 22: *Thyroidinum* 1000/3 powders at half hourly interval.

November 12: *Natrum muriaticum* 6x, 30, 200/1 powder of each, noon, evening and bedtime of same day.

December 9: “Maybe a little worse, hands get blue in cold water” (temperatures in Delhi about that time are around 10° C min. and 22° C max.) *Thyroidinum* 1000/3 powders at half hourly interval.

1978

January 6: *Proteus* 30/3 powders at bedtime on three consecutive nights.

January 30: *Natrum muriaticum* 6x, 30, 200/1 powder of each noon, evening and bedtime of same day.

February 20: Feels much drawing and hardness in legs, below knees “probably because of cold. It makes walking difficult.” By now amenorrhoea for 13 months. *Tuberculinum bovinum* 200/3 powders at half hourly interval.

March 14: Painful corns. Walking is difficult partly because of the original disease and partly because of the corns.

Antimonium crudum 6, 30, 200/1 powder of each noon, evening and bedtime of the same day.

April 3: Corns M.B. Skin slightly softer. "This may be due to the summer season." Getting slight perspiration also. Palms moist and cold. *Saccharum lactis* continued.

May 1: *Proteus* 30/3 powders at bedtime on 3 consecutive nights.

May 26: Flexibility of knee is there but due to weakness feels unstable. Feeling very weak.

June 20: Weakness better. Appetite is increased. Skin softer. Itchy feeling on white patches. "Generally somewhat better than before."

July 15: Fingers cannot be extended yet but in other places skin is definitely softer and more pliable or elastic. Palms no longer moist and cold.

August 4: "Better in walking and flexibility of fingers."

September 23: Gradual relaxation and increased flexibility. "I am beginning to be hopeful."

October 14: Progressive improvement in flexibility.

November 11: When it is cold, then fingers get blue as by washing. Lower limbs more free and walking is easier.

Proteus 30/3 powders at bedtime on 3 consecutive nights.

December 6: With the weather getting colder fingers get blue more often and some stiffness.

Natrum muriaticum 200/3 powders at half hourly interval.

1979

January 20: Difficulty in walking chiefly because of pain in the right foot which has corns in the heel, possibly because of that she puts weight on the forepart of the foot. With the pain in the corn there is also a general pain in the right lower limb. "Corns had earlier cleared and have now recurred."

Antimonium crudum 6, 30, 200/1 powder of each at noon, evening and bedtime.

March 5: Pain in corn is less but not gone. *Antimonium crudum* 200/3 powders at half hourly interval.

April 4: *Proteus* 30/7 powders at bedtime on 7 consecutive nights.

May 12: Corns still painful. Selected Sulphur after checking in the repertory (see p.969). *Sulphur* 200/3 powders at half hourly interval.

There was no dramatic response and this was repeated on June 23, August 7 and October 25. During this period a corn may disappear and another one appear. However, from September onwards, the pain in the foot was much better. The skin on the forearms got much softer and the remedy was repeated in October not for the corns which were by then completely cleared, but for the general improvement and to ward off the possible increase in the winter months.

November 26: Again tendency of fingers to get blue by exposure to cold or by washing. *Proteus* 30/3 powders at bedtime on 3 consecutive nights.

1980

January 28: In spite of the winter, the skin all over is better — softer and more pliable. Fingers however remain stiff and flexed and the skin is hard. It seems now that having remained immobile and in that position for the previous few years they have become partially ankylosed.

September 10: Maintaining progress. The one disability she feels is that she cannot sit on the ground for prayers or otherwise.

I will cut out other details as she continued to make good progress. She received *Thuja occidentalis* 1000/3 powders at 15 minutes interval on April 21 and June 19,

1980. Also through that winter considering that capillary circulation may be poor giving her the blue fingers she was given *Carbo vegetabilis* 200/3 powders at 15 minutes interval on December 2nd and repeated in 1981 on May 5, October 5 and December 19.

On January 10, 1981 she reported an improvement also in the white patches which she noticed were getting less in some places. By March 24, many of the white patches had got completely covered and others were reducing.

By 1983 she felt very well and remarked, "Only problem now is some stiffness of fingers, otherwise, I feel quite okay" Even during the winter months no significant discomfort. By now she was doing all the household work including kneading dough for bread. Later reports are that she could even sit on the ground but had slight difficulty in rising. Can do normal activity so feels happy and satisfied. Skin colour practically normal. There was improvement in the movement of the fingers but right middle finger remains flexed at 90° due to ankylosis and some other fingers were partly flexed.

She had been so much frightened by her condition and the outlook as given to her by the hospital doctors that out of sheer fear of recurrence she kept visiting me for check ups or for any minor incidental complaints or for treatment of other family members. So, it gave me an opportunity to see her over all these years. Other than the medicines mentioned above, she had been in the intervening periods on *Saccharum lactis* and in fact for months together she would take a repeat of this from my dispensary without even seeing me.

VITILIGO (LEUCODERMA)

Case No. 1

Miss K.S., age 4 years, was brought all the way from Jordan to consult me on the recommendation of an old patient on **July 4, 1988**. She was suffering from Vitiligo (leucoderma) for the previous three months and the parents naturally were greatly worried about the looks of their daughter.

She had had a rash on the face under lower lip and the chin for which she used some ointment. The application of the ointment caused itching. In about 10 days the rash cleared but depigmented (leucoderma) spots appeared. Besides there were a few spots on other areas of the face which had appeared after minor injuries.

She was still drinking milk from the bottle and earlier was in the habit of biting the lower lip and the rash had been ascribed to these factors.

There were no strong cravings, had a general liking for fried potatoes, candy and chocolates. Stool — irregular. Some tendency to constipation. Stool — hard. Occasional grinding teeth in sleep. Had had all the inoculations. Perspiration more than average. Tendency to perspire in sleep especially on the head. Prone to sore throat with fever. She would get 4 to 5 times a year and use antibiotics. Allergy to egg which she would either vomit or get a rash ?urticarial. Fear — dark, no fear thunder, obstinate, anger + +. Earlier used to hit the wall with her fist when she was angry.

Past Illnesses: Jaundice at birth, skin rash as an infant. Was told it is some allergy and no medication was used. Was told to avoid nylon and change her pillow.

Chicken Pox March 1982, Measles May 1987. No history of worms and no history of pica.

Family History: Mother had vomiting all through pregnancy. Paternal great grand-father had vitiligo. Father has a small patch on the leg. Uncles and aunts (10 in number) and grand-father — no vitiligo. No TB in the family. Grand-father has Asthma and grand-mother has diabetes mellitus.

Her general health was good and weight normal. On **July 24, 1988** she was prescribed *Calcareo carbonica* 200/3 powders at 15 minutes interval followed by Placebo in pills No. 30 three pills three times daily for 1½ month.

Reported on **September 27** "spots below lip have got pigmented. Still has spots below the eyes. Repeated the prescription i.e. *Calcareo carbonica* 200."

I received the next report through a letter dated **February 8, 1989**. It stated "My daughter Miss, has fully recovered from her spots since last three months. We discontinued her medicine since two months. Kindly confirm if this is in order." Of course no further medication was necessary.

Case No. 2 (Vitiligo)

Mrs. G.J. age 34 years consulted me on **May 12, 1969**. She had been married for 15 years and had four children ranging in age from 14 to 5½. She gave a history of white spot diagnosed as Vitiligo (leucoderma) for a period of 2½ months. The spot had progressively increased. Initially there had been itching and also some roughness but that was only for a short time but not when she came for consultation. She had a single spot on the nape of the neck. It measured roughly 2cm x 2.6cm.

She had small-pox vaccination twice — in infancy and at the age of 31. She had a tendency to colds and also nose block. Nothing significant could be had in the rest of the history and in her mentals and physical generals. She was therefore prescribed on the basis of the diagnosis *Arsenicum sulphuratum flavum* 6x/42 powders t.d.s. She next reported on May 27. Already there was a sign of improvement by way of some dots appearing in the white patch. The medicine was repeated.

She next reported on **June 12, 1969**. Much better; dots all over the area. The medicine was repeated once again. Thereafter she was only on S.L. and there was progressive improvement.

On **August 4**, the spot was hardly visible and now she told me that she had had one other spot in the left armpit which possibly of its awkward location she had not shown me earlier. This also got pigmented along with the one on the neck. At this time she was more particular for her treatment towards the tendency of colds and sneezings.

I last saw her at the end of **October, 1969** when there was no trace of leucoderma.

I was simultaneously treating her elder sister who had very extensive vitiligo and made good progress but all the spots did not get pigmented. Then I did not see her sister for 17 years till she reported again in **June 1987** and I was reminded about the above patient, being one of the most rapid recoveries from this condition in my practice. Her sister told me there had been no recurrence. I have not had such quick, rather immediate results in other vitiligo patients with *Arsenicum sulphuratum flavum* or with constitutional remedies.

Case No. 3 (Vitiligo)

On October 29, 1988 a young lady, a medical doctor brings a Swedish colleague for consultation and reminds me of her own happy experience with Homoeopathy when she was treated for Vitiligo (Leucoderma) some 16 years earlier.

Miss T.S., age 8 years, daughter of a Professor in the medical college consulted on June 30, 1972. The white spots had been noticed a year earlier while she was in USA. They started on the left ankle. Thereafter appeared on the knees and have been spreading in that area and also appeared on the elbows and the eyebrows. She had used Manaderm (Psoralen) internally and locally without any help. It did not even prevent the spread.

Of late she had become very irritable. Was emotional, fearful and anxious. Had fear in dark, and fear of water. According to the parents she was crying a lot since she had been on the above-mentioned medication.

Her vaccination history is important. The first three vaccinations for Small Pox did not take and only the fourth time there was a successful take. Thereafter she had been revaccinated another two times. The last occasion was in 1970. She had also received the other usual inoculations: B.C.G., D.P.T. and Polio and boosters.

In Past Illnesses: She had had Chicken Pox and some months earlier in 1972, Mumps.

Family History: She had a brother and a sister younger than her. There was no family history of Vitiligo. Her mother was French and father Indian.

1972

June 30: Prescription: *Nux vomica* 30/3 powders, noon, evening and bedtime of first day. *Thuja occiden-*

*tal*s 200/3 powders at 10 minutes interval on second day. *Thuja occidentalis* was repeated on **August 17, 1972**. Report on **September 4**, "improving but pigmentation process is very slow".

On **September 30**, *Thuja occidentalis* 1000/3 powders.

December 19: A new spot appeared at the ankle. Old spots were better with many pigmentary islands.

Prescribed: *Sulphur* 200/3 powders at 10 minutes interval.

1973

January 27: Reported better. Spots on knees filling up. Spots on eye-brows completely gone as also a spot on the face. "Anger not better. A difficult child. Cries for very small things."

May 16: No further progress. Repeated *Sulphur* 200.

August 21: Spot on knee is much better but one on left ankle is as before. *Sulphur* 1000/3 powders.

1974

Then I lost touch and I saw her again after nine months on **May 6**.

The spot on right knee had shown further improvement but left ankle was the same. *Sulphur* 1000/3 powders.

July 20: Some new spots were seen. She had in the preceding months an inoculation for Typhoid (T.A.B.) and was vaccinated again for Small Pox.

Thuja occidentalis 1000/3 powders during the evening and at bed time. This was repeated on **October 15**.

1975-1978

Next reported on **February 26, 1975**. Spot on right ankle much better. The one on left ankle is persisting and this is the spot that had appeared first of all.

Thereafter I did not see her for a long period in which time she would take preventive inoculations from time to time inspite of her experience that these would tend to increase the Vitiligo. So when there will be an increase she would come to see me and she received *Thuja occidentalis* 1000/1 powder on **June 16, 1976** and *Thuja occidentalis* 10 M/1 powder each time on **May 3, 1977, July 29, 1977, April 24, 1978 and July 5, 1978.**

* * *

Then I saw her after six years in **September 1984** but she had been completely rid of Vitiligo and now she had come for the problem of sore throat during the previous one year and very recently in one such attack had S.O.M. *Pulsatilla* 30 in repeated doses for a few days followed by *Silica* 200/3 powders on the same day cured her of this condition.

KELOID

Mr. A.B., age 19 years, a college student consulted on **April 4, 1988**. He brought with him a list of his symptoms and these were further illustrated at the consultation. Nine months earlier he developed Upper Respiratory Catarrhal symptoms and since then was having symptoms generally described as Allergic Rhinitis. He used to have sneezings in bouts irrespective of season or time of day. Associated with it was itching eyes and ears. During this period he had also had two attacks of Asthma in November 1987 and March 1988. Both these attacks occurred at night, around mid-night. During the attacks he was worse lying down and better sitting.

His other complaint was with regard to the eyes for which there was not much that I needed to do. He had Myopia since 1980. Developed haziness in vision since July 1987, diagnosed as Keratoconus and operated on November 8, 1987 with a left corneal transplant.

He had a mild craving for salt, a liking for meat and was averse to sweets except ice-cream. Hot patient.

F.H.: Mother: Diabetic, Father: Asthmatic.

On April 4, 1988 he was prescribed *Arsenicum iodatum* 6,30,200/1 powder of each to be taken at noon, evening and bedtime of the same day. He generally carried on well after that and was on *Saccharum lactis*.

1988

July 16: It was noticed that he has a Keloid type of scar between little and ring finger of right hand. He felt slightly itchy and there was mild tenderness. No reason could be found as he denied any injury or boil in that spot and felt that it came on spontaneously.

Prescription: *Acidum fluoricum* 200/3 powders to be taken during the evening and bedtime of same day.

August 16: When he reported after a month the Keloid was much better. On enquiry he said that it probably got scaled or crusted and then peeled off.

September 27: Keloid practically gone and skin is smooth. During the previous six weeks he had had cough and then sneezings off and on but no shortness of breath (i.e. no asthmatic attack).

Prescription: *Arsenicum iodatum* 200/3 powders E. 15 minutes.

He was not seen thereafter and it can only be presumed that he remained well.

WARTS & ASTHMA

Master A.G., age 13 years, student of 8th class, consulted on March 19, 1981.

Complaints: Difficulty in breathing for two years. Started in the spring of 1979. Insidious onset, progression unclear because of Allopathic and Homoeopathic medicines used. Mainly a feeling of having to make an effort to breath. Wheezy sound; sometimes feeling of suffocation. Noisy breathing < night — timing unclear; ?11 p.m. ?1 a.m. May sometimes also wake up from this. But also in daytime. > if able to expectorate. < winter. < both weather changes. < cold drinks. < fried food. < lying down. During attacks sits up slightly bending forward. Dyspnoea Grade I.

Cough: "Because of breathing problem, not much at other times." Expectoration-scanty, yellow, no blood.

Warts face — soft, sessile, around the eyes; has one on right thumb — for 5 months. Only one of these is painful where it is pressed by the spectacles.

Myopia — 2.0D B.E.

Appetite — "Not much." Vegetarian. Likes fried things and chaat (sour). Thirst-less than average. Has lost some weight recently which could be because he had been in boarding school for the last 2 years. But the breathing problem started before going there. B.O.R.

Sleep — Good except when he has cough and breathing problem. Dreams — All types. No significant pattern.

Vaccination in infancy.

Not markedly hot or chilly patient but likes winter and rainy season.

Tendency to be irritable.

P.I. — Used to have some low grade fever in the evenings. No night sweats.

F.H. — Grandmother asthmatic. Diabetes on father's side. No T.B. or cancer.

O.E. — Weight 65 lbs. One lymph node palpable behind left ear, firm, nontender. Chest — inspiration and expiration prolonged. Low pitched expiratory rhonchi.

1981

March 19: *Thuja occidentalis* 30, 200, 1000/1 powder of each at bed time on 3 consecutive nights in that order. He was also given *Arsenicum album* 30/20 powders q.i.d. to be used in case of an attack.

May 13: There are no notes as I was abroad. Perhaps no improvement as my assistant has repeated the prescription.

June 8: He had been having cough for previous 10 days. No expectoration. Wart on thumb gone. Others on the face either gone or reduced to such an extent that hardly anything is visible.

O.E. — Mild rhonchi in chest. Noticed that he was using considerable talcum powder. Directed him to stop its use.

Arsenicum album 30/24 powders q.i.d. followed by *Saccharum lactis*.

June 26: No cough. Chest clear. No trace of warts.

He reported thereafter in August and was having cough with thick yellow expectoration but was not seen again so it is not sure whether in the subsequent winter he remained free of Asthma or not.

IDIOPATHIC THROMBOCYTOPOENIC PURPURA

Case No. 1

On August 3, 1994 there barges into my room, bypassing my staff, a middle aged lady seeking a very urgent appointment for her 22 year old son and as an extra recommendation mentions that she had been one of my old patients having consulted me 22 years earlier in 1972. She said that she had benefitted so remarkably that she cannot take her son to any other doctor.

Mrs. P.S., age 25 years, consulted on March 13, 1972. She had been married for one year and had one child age 2 months. It was a diagnosed case of Idiopathic Thrombocytopenic Purpura.

Her history was that when her menses started at the age of 12 years, the very first time it continued for 20 days, then suddenly very heavy bleeding. She was taken to hospital and given a blood transfusion. This reduced the bleeding but took a whole month to stop. Thereafter it had been normal for one year, then menses were progressively earlier and in a few months started to appear every 20 days. At about 14 years age, the story of the first appearance was repeated and it could not be controlled and once again she had to have a blood transfusion. Thereafter she was put on some hormone treatment for one year. At age 17 years, the hormones did not fully control so again transfusion became necessary. During these years the *Platelet Count* had been low, around 60,000/c.mm. and at one time touched the lowest figure of 10,000. Cortisone was given and it helped. Splenectomy was being considered. In 1971 she had been pregnant and a child was born in the first week of

January 1972. Bleeding had not stopped since and that was the reason for my consultation. Blood bright red. There had been no history of epistaxis or jaundice. Lump in left breast near the nipple for last 4 years, no pain. Eruption on head. Oozes blood, no pus, tender to touch but no pain as such.

Appetite — Good. Vegetarian. Likes sweets, eats raw rice, salt average.

Constipated — Does not have a daily motion.

Sleep — Good.

Vaccinated for small pox 3 times, last one was 6 years earlier. Had the problem of bleeding even before by way of prolonged menses and had to resort to Cortisone but possibly it coincided with an increase after the last vaccination.

Hot patient.

Changeable moods.

Had consulted Dr. Wm. Gutman of New York when he was in Delhi for the International Congress of 1967. On his advice had tried *Sanguisuga* in low as well as higher potency with no benefit. This is made from leech and is a very rarely used remedy.

1972

March 13: *Phosphorus* 200/3 powders at 10 minutes interval.

March 18: Bleeding stopped on March 15, restarted the following day and is continuing.

Sabina 6/16 powder q.i.d.

March 23: Bleeding stopped for 3 days, then started again.

China officinalis 6/20 powders q.i.d.

April 3: M.P. on March 28 lasted for 5 days, normal flow.

Crotalus horridus 200/3 powders at 10 minutes interval.

April 12: From April 9 has slight bleeding — just spotting, also ecchymosis. For the previous 2 days cold, fever (100°F) and aching in body.

Rhus toxicodendron 30/16 powders q.i.d.

May 12: Did not get M.P. in April and pregnancy was feared. After use of *Pulsatilla* 30/12 powders q.i.d. given on May 2, M.P. commenced on May 5 and lasted for 4 days.

Crotalus horridus 200/3 powders at 10 minutes interval.

* * *

1974

Seen again after a gap of 2½ years on **December 28, 1974**. She had felt quite well after the previous treatment and in February 1974 got pregnant again. She had been delivered of a healthy child in mid-November and as before the bleeding was persisting, though not as badly.

Crotalus horridus 30/16 powders q.i.d.

1975

January 11: Bleeding had stopped but getting blue spots on the lower limbs (ecchymosis). *Saccharum lactis*.

January 20: Copious bleeding from yesterday — probably M.P., the first after her delivery.

China officinalis 6/20 powders q.i.d.

For a generally low feeling after the bleeding she was prescribed the same medicine t.i.d. on February 4 and February 22.

* * *

1976

Reported again after one year on **January 20**. Had been well through the year and the present problem was

that she had missed her periods and did not wish to go through another pregnancy.

Apis mellifica 3/16 powders q.i.d.

* * *

1977

February 2: Reports again after one year. Had been well and again the problem was a missed period. This time *Apis mellifica* did not work, so she had D and C on February 6. Bleeding persisted after this and she reported on **February 19**, when she was given *Arnica montana* 30/16 powders q.i.d.

* * *

1981

November 6: Remained well for the intervening period of more than 4 years. Three months before reporting, the M.P. had been prolonged. It had continued for 3 weeks. The following month had been normal. At present, it had not only been prolonged but she had very profuse bleeding for the previous 2 days.

Crotalus horridus 30/12 powders q.i.d.

November 9: Bleeding reduced in quantity but is still continuing.

Phosphorus 200/3 powders at 10 minutes interval.

* * *

That was the last time she took medicine. When she saw me on **August 3, 1994** I asked her if she had got a blood test done in the intervening period as I was very anxious to know that although clinically completely normal what was the present Platelet count. Her reply was, "I have felt quite normal, thanks to your treatment, so why should I get a test done."

Case No. 2 (Idiopathic Thrombocytopenic Purpura)

H.K., age 10 years, consulted on May 12, 1984. The case had been investigated and diagnosed as I.T.P. — *Idiopathic Thrombocytopenic Purpura*. The history was that he had a haemorrhagic spot in the eye and later bluish spots (ecchymosis) on the legs. This was in October 1983. On October 17, 1983 he had a blood test. T & D.L.C. — W.N.L. but the Platelet Count was down to 23,000/c.mm. E.S.R. — 40 mm. 1st Hour. He had received Streptobion and later for 4 weeks was on Prednisolone. In subsequent tests the Platelet count kept fluctuating but constantly much below normal and he continued to have ecchymosis and that is why he sought my consultation.

It is to be noted that prior to October 1983 he had fever two or three times in quick succession for which he received Orthodox (Allopathic) treatment. Prior to the blood spot in the eye he had taken these medicines, he did not know the names, for only one day — one capsule and two tablets. The following day he noticed the spot in the eye. Could it be a reaction to the drugs used and not I.T.P.?

Appetite: Poor or variable. Very fond of cold drinks, also of pickles and meat.

Hot patient.

P.I.: Bronchitis at six months. Jaundice at 2½ years. Been prone to colds. Complaint of frequent pain in the abdomen.

O.E.: General physique good. Heart and Lungs — N.A.D. Liver — only the margin was palpable. A wart on neck.

1984

May 12: *Phosphorus* 200/2 powders, evening and bedtime.

July 10: Platelet Count: 190,000. If he exerts much then there are more ecchymosis spots. Gets ill frequently with cold or fever. Poor appetite. Anger + + . Breaks things.

Phosphorus 200/1 powder — bedtime.

October 1: Had fever one month ago. The nearby doctor diagnosed as Viral Fever. After that reappearance of ecchymosis spots.

Phosphorus 200/1 powder at bedtime.

October 23: No ecchymosis, not even when he got hurt.

December 22: No ecchymosis.

1985

March 22: Ecchymosis again.

Phosphorus 200/3 powders at 15 minutes interval.

Thereafter seen from time to time for other conditions but no recurrence of ecchymosis.

Last seen on **February 20, 1991** and there has been no recurrence during these 6 years.

ECCHYMOSIS

Dr. G.G.J., age 72 years, male, a Canadian national who had been living in India for very many years, consulted on **December 9, 1986** with a complaint of Ecchymosis on forearms for the previous three years. All the tests that had been conducted were found to be normal so no reason could be ascertained. He had a history of Hypertension for 20 years. With the use of Ismelin it

was stabilised at 150-160/90. He also had a history of Chronic Asthma which tended to be worse in cold weather. For this he was using inhaler with Beclet or Asthalin. In his Past Illnesses he gave a history of two operations: Appendicectomy in his youth and cholecystectomy 25 years ago. He had had urinary calculi but these passed naturally. In the rest of the history there was nothing significant by way of weather reactions, desires and aversions, mental symptoms etc.

In addition to the medicines for Hypertension and Asthma he was also taking vitamins. For the Ecchymosis Allopathic treatment had been of no avail. He was prescribed 3 powders of *Phosphorus* 200 to be taken on the first day followed by *Saccharum lactis* for a month.

He reported by letter dated **January 3, 1987**, the relevant part is reproduced, "The medicine you gave me has been wonderfully successful. Since I started taking it only one or two small spots have appeared on the skin and they also faded very rapidly. At present my skin is clear. The tablets are almost finished. Please let me know whether I should continue to take them." He was sent another supply of *Saccharum lactis* for 1½ months. The next report is dated **February 17, 1987**. "The medicine is almost finished so I am writing to you again. Progress has been maintained — a few spots have appeared during the past month, but they have been small and have disappeared fairly quickly. I forgot to tell you that I used to get occasional blood blister in the mucous membrane of the mouth. These have also cleared up completely..."

ACUTE EMERGENCY — FAINTING

Mrs. H.R., not sure of her exact age but said it is certainly more than 65 years. This lady, a very severe case of Psoriasis, had been under my treatment over the past few years. On the morning of **December 6, 1988** she is carried wrapped-up in blankets and quilts by her sons, who come rushing to my clinic while I am in the midst of another consultation. They said it is an acute emergency as their mother is dying. The story narrated to me is that she had over-exerted the previous day by way of doing a lot of washing and went without her lunch. In the afternoon she took simple food — black gram soup and chapati (fresh leavened bread). She woke up around 2.30 a.m., with pain in the abdomen and had two vomits. Soon thereafter she felt the urge for urination but when she went to the bathroom she had nausea, but no vomit, giddiness and then fell unconscious and had involuntary urination in that state. She had considerable sweating and hands and feet were cold, that is why the frightened children rushed to my clinic in the morning. She was very restless, anxious and still feeling very cold and shivery. She complained of dryness mouth and took sips of water.

On examination she was still shivery and cold but conscious. The blood pressure 120/80. The pulse was regular but arteries felt hardened, somewhat like pipe-stem arteries. The heart showed no abnormality clinically.

Prescription: *Arsenicum album* 30/12 powders to be given at intervals of 2 to 6 hours according to intensity of symptoms. One powder was administered in the clinic and some relief was perceptible almost immediately. In the next few hours she recovered completely.

As a precaution she was also examined by a Cardiologist and an E.C.G. was taken. It showed only the expected Ischaemic Heart Disease. She ignored the precautions regarding exertion etc. mentioned by the Cardiologist as she felt quite well.

1988

December 7: As there was no problem she was given only *Saccharum lactis* for a period of 10 days as I was to go abroad.

Comments: In acute emergencies the results of Homoeopathic treatment are dramatically quick and convincing.

NEONATAL CONVULSIONS

Baby M.G., a male child, age 7 months, consulted on November 27, 1989. It had been a full term baby, normal delivery, birth weight 6.5 lbs, breast fed for three months, did not cry immediately after birth and the cord was tightly around the neck. Had convulsions immediately or soon after birth. Diagnosed as Neonatal Convulsions. Recurrence at age 12 days. Investigations including C.T. Scan of head showed nothing abnormal. However, baby was put on Luminal which he was still taking when he came for consultation. From the age of three months had had diarrhoea frequently. Is teething i.e. first tooth a few days ago. Stools loose, offensive, pale or whitish colour. The mother volunteered the statement "has much sweating on the head in sleep". On enquiry learnt to an extent even when awake and even in an air-conditioned or air-cooled room in summer.

1989

November 27: Prescribed: *Calcareo carbonica* 200 single dose.

November 29: Still having diarrhoea 10 to 12 stools.

Tends to have a motion p.c. Stool forceful as from a syringe. *Calcareo phosphorica* 6x/14 powders, every 4 to 6 hours.

December 5: Number of stools reduced and no longer loose. Has a cold for the previous two days.

Arsenicum album 30/3 powders on the same day.

December 13: M.B., cold M.B., stools normal.

"Would like medicine for trouble-free teething and to stop Luminal."

I asked them to reduce Luminal gradually and start by cutting out one dose.

Prescribed: *Calcareo carbonica* 200/1 dose.

December 27: Again has cold and cough as he now crawls on the cold cement floor in this weather. Still having head sweats. Had Polio drops on 15th.

Arsenicum album 30/12 powders q.i.d.

1990

January 9: Generally well. Feels more hungry. Slight looseness of bowels from the previous day.

Prescribed: *Calcareo phosphorica* 6x/16 powders q.i.d.

February 12: No complaints. Has cut teeth un-noticed and without any diarrhoea. Sweat on the head is negligible. No further medicine. Stopped even *Saccharum lactis* which he had been using earlier.

March 2: Mother came for her own treatment and informed that he was growing well. No recurrence of convulsions although the Luminal had been discontinued completely from end December. On enquiry was told that now he does not have any sweating on the head inspite of the weather being warmer.

CONVULSIONS

Miss P.G. born on December 27, 1981. Consulted on February 9, 1982. H/O convulsions on left side. First attack on December 31, 1981 and second attack on February 9, 1982. Both times convulsions were at night 2 A.M. to 3 A.M. The description was like jerks or clonic convulsions. There was nothing to note in the rest of the history. It had been an uneventful pregnancy and a normal delivery.

1982

February 9: Prescription: *Cuprum metallicum* 200/1 dose.

February 17: Jerks left or right or both. Could not get proper information. Had had a cold from the previous day for which the parents had used Vicks. Was instructed to avoid this as it contains camphor. and is likely to antidote Homoeopathic remedies. Repeated *Cuprum metallicum* 200/1 dose.

March 3: Better. Had jerks once — transitory and not a series of them as on previous occasions.

Prescription: *Cuprum metallicum* 200/1 dose.

March 16: Had cold and fever and ? slight jerk.

Prescription: *Gelsemium sempervirens* 30/16 powders 4-6 hours interval.

Seen from time to time for other incidental complaints like cold, cough, urticaria and occasional fever but no convulsion reported.

1983

July 20: Slight jerk on falling asleep noticed occasionally. I felt it was more like a start but because of the background the overanxious parents thought it may be a

convulsion. Would be quite alright when fast asleep or during waking hours.

Routinely prescribed: *Thuja occidentalis* 200/1 powder as in the previous few months had been receiving all the inoculations.

October 17: Slight movement of hand or leg which occur only on falling asleep. Quite OK when fast asleep.

Prescription: *Cuprum metallicum* 200/1 powder.

This was repeated on March 27, 1984, June 21, 1984, July 18, 1984 and May 18, 1985.

1986-93

Last seen on March 4, 1986. No recurrence of convulsions or even of jerks while going to sleep or at any other time. Have had contact with other members of the family till 1993. Miss P.G. had been thriving and kept free of convulsions.

SEIZURE DISORDER

Master I.K. age 3½ years consulted on December 12, 1983 with complaint of seizures. The first attack occurred six months earlier in daytime. He fell down while standing. Thereafter the seizures had been frequent, as many as four a day. He took medicine from some Sadhu (Monk) whereafter the attacks were milder. However, after sometime they got severer for which an Allopath was consulted. He prescribed *Luminal* 30 mgm. B.D. but it was not administered.

He had deformity in the feet from birth ?Telepis. One foot had been corrected by operation, the other was proposed to be operated. At birth perhaps he cried late

and had a degree of birth asphyxia. However, he had been declared to have no neurological deficit.

He is obstinate. May have a minor attack sometimes if his wishes are not acceded to. On rare occasion has been seen eating earth.

Has had B.C.G. and D.P.T. inoculations and Polio oral drops.

Recently noticed perspiration on head in sleep (even though it is winter) otherwise no particular reaction to heat and cold.

P.I.: Measles one year ago.

F.H.: Mother — no significant illness during pregnancy. Grandmother has Asthma.

1983

December 20: Prescription: *Calcareo carbonica* 200/3 powders through the evening and at bedtime.

1984

January 4: Convulsions are less. Now not much in day but gets at night in sleep. Grinding teeth in sleep and kicks away covers. No fresh medication.

January 12: May not have attacks for three-four days and then gets three-four in one evening. Repeated *Calcareo carbonica* 200/3 powders at 15 minutes intervals.

February 16: Had many fits on January 26 but none thereafter.

March 7: Much better. No fit. Still obstinate. Anger +.

March 27: General sense of fear. Says I am afraid. Has had EEG but result not available. Repeated again *Calcareo carbonica* 200/3 powders at 15 minutes interval.

May 1: Has no problems.

May 17: Doing well and father feels that he can do without medicine.

* * *

Thereafter I had no further contact till **August 7, 1989** when his sister was brought for treatment also with Seizure Disorder. Then I was informed that I.K. has had no further seizures after the treatment that was concluded in 1984.

It was a surprising coincidence that after I had taken the history of the sister, also having seizures, and incidentally prescribed the appropriate remedy I subsequently saw the history of Master I.K. and found that his sister's history had also led me to prescribe *Calcarea carbonica* to her.

CONVULSIVE SEIZURES

On June 2nd, 1991 in the lobby of a hotel I was greeted by a couple and on noticing my blank face they introduced themselves and reminded me that I had treated their young child, who is quite well since and now studying at Harvard in U.S.A.

Master K.P., age four and half years was brought to me on June 11, 1976. He had been suffering from convulsive seizures from February 19, 1976. He had two seizures, one week apart, both around 7 P.M. Thereafter he was free for six weeks, then a recurrence by a seizure in the afternoon. Thereafter these had been very frequent and at one time he had seizures daily for 7 days. For the previous month there had been no major fit but he had slight jerks after sleep. The remission could also be due to the fact that he was taking treatment

(allopathic) — Luminal and Tegretol. The day he is likely to have a fit he does not look too well from morning of that day.

Appetite reduced from November 1975 when he had a digestive upset. Vegetarian. Likes cold drinks, ice-cream etc. Chronic constipation, will miss three to four days. From November 1975 flatulence, passes much flatus — offensive. Worms had been suspected but in spite of the use of anthelmintic three times none were passed. Earlier used to grind teeth in sleep but not at present.

Vaccination for smallpox once only. Had B.C.G. No D.P.T. because a sister got paralysed after the triple vaccine injection.

Not particularly hot or cold. Perspiration ++ on exertion and then the body feels cold.

Mentals: Generally somewhat dull since November 1975 after a period of digestive upset. Fear dark. Imaginative — sees figures in clouds. Anger +, very obstinate. Has tantrums and hits out. Likes company of children and he is good at studies.

P.I. Had many boils in summer two years ago. Was given 10 injections of some antibiotic and also Betnovate locally. There was no itching. Thread-worms passed in stools two and half years ago.

Stool examination: Cysts of Giardia.

E.E.G. on February 28, 1976 “*grossly abnormal and shows paroxysmal features.*”

1976

June 11: *Causticum* 200/3 powders; noon, evening and bedtime of the same day.

June 24: Initially normal and natural stool but again constipation and needs enema. “In general better.” No flatulence. Previously dull, now alert and active.

July 8: Had 7 to 8 attacks in two weeks but minor ones. Previously minor jerks would occur all the time. Now these are less but there are more attacks of moderate intensity. Anorexia continues with no ascribable reason. He continued on *Saccharum lactis*.

August 16: Had a major attack on July 22nd but more thereafter. Repeat EEG report is better "*suggestive of neural hyperexcitability with some subcortical focus.*"

In addition to the allopathic medication above which had continued he was also receiving ACTH injections. The dosage of this was now increased.

September 13: Quite well. No seizures. ACTH injections stopped. B.O.R.

Saccharum lactis continued.

October 6: No complaints.

1977

January 31: Dog-bite from a pet dog. No fits.

Belladonna 200/3 powders, noon, evening and bedtime of same day.

March 18: No complaints except constipation for the previous two weeks.

Causticum 200/3 powders, noon, evening and bedtime of same day.

April 22 and May 20: Carrying on well. At times complains of aching in legs in the evening. For this minor symptom no change in medication was done and continued on *Saccharum lactis*.

June 6: At times slight tremor in hand on holding a glass. Asked to observe further.

He reported from time to time and was last seen on November 2, 1977. There had been no recurrence of the seizures after the one on July 22, 1976. There was also no other major complaint needing any fresh prescription

so he continued all along on *Saccharum lactis*. As mentioned above, he continued well ever since as reported by the parents on June 2, 1991.

Comments: There was the successful treatment of a comparatively serious and chronic condition wherein the allopathic anticonvulsants were carried on side-by-side for some time. Thus the risk of status epilepticus or greatly increased number of seizures consequent on sudden withdrawal was avoided.

It appears that the homoeopathic remedies did act all the same. And it is to be particularly noted that the major seizures as also jerks were not controlled by the use of allopathic anti-convulsant drugs and he was eventually cured of these only after using homoeopathic medicines.

2. The indicated remedy *Causticum* was given only twice (June 11, 1976 and March 18, 1977) during nearly 15 months of treatment. Even the second dose may not have been needed if inbetween *Belladonna* had not become necessary on January 31, 1977.

3. *Belladonna* was given to ward off any immediate risk of rabies from the dog-bite. Since it was a pet dog it could be observed. If it was a street dog then some other course of action might have been necessary.

CONVULSIONS ?EPILEPTIC

C.C., a baby girl age 1 year 8 months consulted me on June 18, 1983 with a history of convulsions.

The first of these occurred on December 12, 1982 and there were a few repeats during fever i.e. febrile convulsions. However, on June 6, 1983 she had convul-

sions six times in one day and without fever. On earlier occasions the baby would have fever and diarrhoea a day before the convulsion. The convulsion would usually last for a day during which period they would occur a number of times. She would make a sound then become stiff (tonic) and followed by shaking (clonic) convulsion.

Appetite, bowel movement and sleep all normal.

She had been vaccinated for small-pox and received the usual inoculations including B.C.G.

Nothing particular about perspiration, perhaps slightly more on the head. She was a 8-1/2 months baby, delivery was normal, teething at 8 months, other milestones normal.

P.I.: She had had an attack of Measles in March '83 (at that time Anti-measles or MMR inoculation was not current in India).

F.H.: The mother had bleeding in 3rd month of pregnancy. She was on bedrest for one month and received allopathic treatment. One brother age 4 years — healthy. No family history of Diabetes, T.B. or Epilepsy.

On examination: Wt. 19.5 pounds. Liver palpable 1" (2.5 cm), soft. Other systems showed no clinical abnormality.

When she had the first convulsion in December '82 she had been put on Gardenal. This was used for one month but even during its use had convulsions so it was discontinued.

1983

June 18: Prescription: *Cuprum metallicum* 200/1 powder. Seen again on July 15, August 23, September 21, October 21, November 26 and December 26. No recurrence of convulsions during this entire period. In the summer months had boils from time to time for

which no other remedy was given. On August 23 liver was not palpable.

1984

January 28: Nasal discharge for previous 2½ months (during the severe winter months). Had an eruption on right cheek and popliteal areas, dry and itchy. In September 1983 had had some eruption, mostly in the bends of elbows. The eruption is recurrent. It disappears and reappears without any medication. No convulsions.

Prescription: *Sulphur* 30/1 powder.

Last seen April 28, 1984 and reported that she had had continued temperature from March 5 to 11 but no convulsion.

Comments: This is a case of convulsions where even though EEG was not done but the description was like epilepsy or epileptiform and it was cured by a single remedy in unit dose.

EPILEPSY

Case No. 1

Miss S.P., age 14 years, student of 10th class, came to the National Homoeopathic Centre on August 15, 1987 and the following history was recorded. She was suffering from Convulsive Disorder since February 1986. There would be tonic-clonic fit with frothing at mouth. There was no aura. Her other complaint was dizziness with slight nausea. This was a very continuous symptom and she said that she had it even before she had the convulsions. There was no vomiting even if she tried to throw up. Other features of note were thirst above

average and desired cold drinks. Feels both extremes but especially the cold. Fear dark +; Fear ghosts; Fear thunder and lightning $\pm$. As regards company/alone she was non-committal.

Investigations:

C.T. Scan — N.A.D.

E.E.G. — *Electrographic abnormality with maximum involvement in right hemisphere in centro-parieto-temporal region and often becomes generalised to all points on both hemispheres. Conclusion: Epileptiform abnormality; not Petit mal or primary general type of discharge.*

She was taking Sodium Valproate every six hours and also Gardenal 15 mg. Earlier she had used Mazetal with "Partial Seizures" i.e. body would feel numb with drooling of saliva and occasional unconsciousness for a few seconds.

1987

August 15: She was prescribed *Phosphorus* 200/2 powders in evening and bedtime.

For the present the anti-convulsants (Sodium Valproate) were continued.

August 29: General feeling better. No complaint in previous two weeks despite staying up late to study for examination. However, had some dizziness day before and unconsciousness on the day of reporting.

Phosphorus 200/3 powders at 15 minutes interval.

September 18: Been complaining of giddiness and so lies in bed. No modalities. Because of giddiness not able to study which she could after the first course of medicine, i.e. after *Phosphorus* 200 given on August 15.

Costive, B.O., not satisfying.

Phosphorus 1000/3 powders at 15 minutes interval.

October 14: Reported better, less giddiness, less co-sitive.

November 7: Had been much better for about 15 days but in the previous week had much giddiness from 5 p.m. to 8.30 p.m. At 5 p.m. she wakes up from siesta. Thereafter because of giddiness she keeps lying in bed. However, if she goes out to play with friends she is alright.

Repeated *Phosphorus* 1000/3 powders.

December 5: Very much better. "Medicine was very effective, no giddiness, was well all through the month". Thereafter she remained well except for some other complaints as Dandruff, Acne, a consciousness of gaining weight and getting fat etc. Nothing was prescribed for these, only *Saccharum lactis* was continued. Had no problem even when she had much strain during her final examinations. This situation continued for nearly 10 months and it became a routine for the father to come once a month to report that the patient was alright and ask for a repeat.

As she continued well, in May 1988 the dosage of Sodium valproate was reduced from 5 to 3 tablets daily without any adverse effect.

In August, stopped Gardenal completely. Even earlier, in the preceding few months, she had taken it very occasionally.

1988

September 19: Had some symptoms of giddiness four or five times in the previous month.

Repeated *Phosphorus* 1000/3 powders at 15 minutes interval.

October 17: Carrying on well. No complaints.

November 23: In this period once while at school had some odd feeling in the head for a few minutes which

she had not experienced before. Could not describe more precisely. It was not followed by a seizure.

Saccharum lactis continued.

1989

January 3: In the previous month further reduced Sodium valproate from 3 to 2 tablets a day. Is quite alright. Very cheerful and active.

February 10: Father reported "No symptom to mention, has responded very well to this treatment".

June 28: By now Sodium valproate further reduced to one tablet daily. Carrying on well.

July 31: Extra pressure of study and has less time for sleep yet keeping well.

September 2: Headache almost daily for the previous three weeks. It is aggravated by study. Has had her vision checked. Been prescribed for, 0.25 D for left eye.

Previously acne was on and off, now getting more persistent. Has dandruff. Oily face.

Natrum muriaticum 200/1 powder at bedtime.

September 29: No headaches and feeling well.

1990

Continued on *Saccharum lactis*. Gradually the acne also cleared. In March 1990, totally stopped Sodium valproate.

April 18: "No complaints". Feeling quite healthy. No acne also.

September 3: Last seen on this date. No seizures; no jerks; no giddiness; no headache; no acne.

Case No. 2 (Epilepsy)

Miss P.C., age 25 years, unmarried, consulted on March 2, 1988. She had already been diagnosed as suffering from Epilepsy. She gave a history that she had been having mainly during the time of menses during

the previous 8 years. Some crawling sensation in the left arm off and on with or without some associated nausea. This sensation would be for a few seconds and it occurred once in two or three months. The condition worsened from March 1983 at which time she had a 'fit' (Seizure). There was the same Aura in left arm but then she dropped things and there was also a scream and convulsions then the diagnosis was made. She had consulted orthodox (Allopath) doctors and received the usual treatment consisting of Sodium valproate and Mazetol to which more recently was added the Tranquilizer Librium. In addition, during menses she was using a Diamox. This medication had not controlled the seizures. The fits were occurring off and on but it was quite usual during menses. There would be a tonic and clonic convulsion in which she would have incontinence of urine. It would last two to three minutes and she would regain consciousness in 10 to 15 minutes. After the fit heaviness of the head.

She said that she had more than an average of sleep and had lots of dreams but mostly about the routine things of the day. Would not express when angry. There was dryness of feet in winter and a liking for sweets. She had a faint freckle like pigmentation patch on left cheek.

EEG had been done three times but was told they are "abnormal records," reports are not available.

The symptom particularly chosen was the association of fits with menses. On page 1354 of the *Kent's Final General Repertory* we have a number of remedies. The only one in black letters is **Oenanthe crocata**. That was given in the 200 potency three powders during the evening and bed time. This was on **March 22, 1988**.

Reported on April 6th "continuing well, menses on April 3, no fit." Continued on Placebo which she took

erratically upto November 18, 1988 (during nine months took *Placebo* for three months — it was given on April 6, April 27 and July 13). During all this time no fit.

Report of **November 18, 1988** had a slight feeling in beginning September: only the aura in hand and voice changed but not followed by a fit. At this time repeated *Oenanthe crocata* 200/3 powders at 15 minutes intervals.

1988

December 24: No problem. Given *Placebo*.

1989

April 15: Last seen on this date, continues well and free from seizures.

TETANUS

Mr. A.H. age 42 years walks into my clinic on **March 27, 1992** accompanied by his wife, for whom appointment had been sought. As an introduction he tells me that he is the grandson of late Dr. K.G. Noticing a very big scar on the centre of his forehead, my memory immediately flashed back to 40 years earlier when I had saved this child from a desperate, if not mortal condition. The events as far as I recall are that he had been playing in the sun on a hot summer day when he fell unconscious. Whether there was a convulsion or not is not very clear. Even though the incident occurred at his grandfather's place who was a homoeopathic doctor but in that panic the household must have come into some superstition and took the baby to a Maulvi (Muslim priest). It is not clear whether he had done cupping or cautery. It resulted in a big wound on the forehead.

Some days later the child developed lock-jaw (Tetanus) and could not open his mouth. He was taken to the allopathic hospital but when he was showing no signs of response, he was rushed from Moradabad to Delhi. I saw him in the desperate state. I still remember I gave him *Hypericum perforatum*, most likely in the 30th potency. Repeated probably at 2-3 hours interval. Baby A.H. showed progressive improvement and recovered completely in 2-3 days, much to the relief and amazement of everyone, including myself.

? NEUROLOGICAL DISORDER

Mr. A.K., age 18 years, bachelor student, consulted on November 22, 1980. He had peculiar complaints:

Numbness of fingers and hand. It starts as a feeling of weight, a heaviness, then an ascending pulsation, some convulsive movement or vibration and a forcible flexion of fingers which has to be opened with the other hand. It gets normal in a few minutes. There is no pain. First attack occurred in 1977, i.e., 3 years earlier in right hand little finger. There was also a slight numb feeling on right side of face. Attacks have occurred at variable intervals since then. In 1978 it occurred in left hand. Through 1979 no attack and none in 1980 till mid-November. In last week it occurred 3 times out of which twice it was in sleep and he woke up because of it.

His other complaint was general weakness and he wanted medicine "to grow taller."

Appetite — Poor, always been so. Eats because parents want him to. Vegetarian for last one year but eats eggs. Likes sweet especially. Sour +. B.O.R.

Sleep — Good. Dreams — nothing significant, mostly before exams.

Vaccination: last in 1975, before that annually.

No special reactions to heat and cold.

Irritable. Nervous.

P.I. and F.H. — Nil of note.

O.E. — N.A.D.

Had been to A.I.I.M.S. They found no neurological deficit and was referred to the Psychiatric Deptt. X-Ray — Cervical Spine — Normal study.

1980

November 22: *Kali phosphoricum* 200/3 powders during the evening and at bedtime.

December 13: Felt a slight premonition of attack of numbness on one or two occasions but it did not occur.

1981

April 13: Had been well but in last 2-3 days a slight sensation and fear it may not recur. Appetite reduced.

Kali phosphoricum 200/3 powders at 15 minutes interval.

November 19: Reported after 7 months. Kept well all this time. Two weeks ago fell off his motorcycle. Had few scratches and was hit on the right hand as he supported himself on it during the fall. Last night he had a slight numb feeling in right ring finger while driving a car. This was momentary — for a few seconds, but it occurred 2-3 times with intervals. There was no vibration and no convulsion and it did not extend to the rest of the hand as on previous occasions.

Arnica montana 200/3 powders on the same day.

He kept well thereafter and would occasionally come and take a repeat from my office, i.e., *Saccharum lactis*. There are no notes but perhaps there may have been a

slight recurrence because I find that during my absence once *Kali phosphoricum* has been repeated by my Assistant on **October 13, 1983**. He was last seen on **January 5, 1984** and had remained completely well.

NEUROLOGICAL PROBLEM — HYPERAESTHESIA

Mr. B.N., age 48 years, consulted on April 29, 1992. He had been married 20 years and had one daughter aged 11 years. He was a businessman in which his work was mostly in the office.

He made a peculiar complaint that his tongue had become very sensitive for the previous six weeks. "It is psychological or real, I do not know as I have lot of stress and strain." < by evening. From his childhood he had been used to taking very hot milk and also lot of chillies. Now started feeling that it was uncomfortable and hurt his tongue, so stopped. Took *Merc-sol.* and some other Homoeopathic medicines as also *Alfalfa* without any significant or sustained relief. When had a short remission, whether due to medicine or otherwise, there was immediate recurrence if he used anything spicy or took pickles. Does not take paan masala or paan (betel). Vegetarian and teetotaller.

Sleep — "Good, unless there is a problem".

Dreams — Not scary. General scenes.

Weather reactions — Feels both hot and cold if tense. Does not feel either excessively if relaxed.

Mentals — Compulsive worrier from childhood. Agitated if there is much work, otherwise cool. Worries much about future, "I am built that way though it is not

going to help.” Worries about health — thinks of the worst, e.g., “The condition of my tongue may lead to cancer; if I get a scratch, I worry about tetanus. For a minor pain in the chest I worry about the heart. Between 1983 to 1988, it was real bad and I took much medication, then became very spiritual and that has helped greatly to come out of that state and I am better now.” Very conscious about health. Worries for business, family problems and almost everything.

P.I. — Pleurisy with effusion in 1958. Hypertension. Took salt-free diet for 2 years and got okay. Also spiritual practices helped.

F.H. — Father died of heart attack at the age of 41. His age at that time was 17 years and this “had a major impact” on him. Mother has massive splenomegaly and earlier had T.B. One sister Epilepsy. Another sister had Alopecia totalis and was cured by my treatment. A brother has Allergic asthma.

Page 418 of the Repertory was consulted and out of the remedies listed two were particularly looked up in the Materia Medica for final choice. These were *Nitricum acidum* and *Natrum muriaticum*.

1992

April 29: *Acidum nitricum* 6, 30, 200/1 powder of each in morning, afternoon and bedtime of same day in that order.

May 14: M.B. can eat more comfortably. *Saccharum lactis*.

May 23: Came to see me as he was going abroad and desired medicine for a longer period. Was doing very well. Because of the sensitivity of the tongue, the speech had been also slightly affected — a slight stammer. This had also improved now. Is generally more confident. The previous night was dining out and could not resist

Tabasco sauce and it did not cause any special problem. *Saccharum lactis* continued. He was given a dose of *Acidum nitricum* 200 in case there is a recurrence during his 2 months stay abroad, but he did not need to use it.

December 30: I did not see him again till December 30 when he consulted for an entirely different problem — a skin condition. There had been no recurrence of the symptoms of the tongue.

HIV POSITIVE WITH HAEMATEMESIS

Mr. S.N., age 39 years, consulted on May 13, 1992, married for 14 years with 3 children. Occupation — Was manufacturing machine parts and exposed to some dust in the environment.

History — Previously had Chronic Gastritis. There had been much alcohol intake and this would be continuous in spells of several days. On March 18, 1992 he had Haematemesis and Malena. UGI Endoscopy could not reveal the cause of bleeding. While he was investigated in hospital, he was found to be HIV Positive. There was no history of drug abuse, but history of multiple sexual contacts with women of different backgrounds and without use of condom. Four years earlier he had donated blood when his father needed transfusion. It is not sure whether he had been HIV Negative at that time or HIV screening had not been done. Before coming to the National Homoeopathic Centre, he had had some Homoeopathic treatment and had received *Mercurius Solubilis* 1 M (3 doses), *Nitric acid* 30x20 days, *Nitric acid* 200x20 days, *China officinalis*. He had not taken any alcohol or smoked since the Haematemesis.

Appetite — Good. Non-vegetarian. Is a smoker, not smoked after May 18. Takes tea 3 or 4 times a day, though he says he is not particularly habituated to it. At times has heartburn after tea. Likes cold things — cold milk, cold drinks, ice cream, etc. Likes fried “But feel heavy after intake”. Indifferent to sweets. Thirst average, likes it cold.

B.O.R. — Previously 2-3 times, now one to two. Stool tends to be hard.

Sleep — Not Good. “Partly due to worries”. Earlier used to sleep well but since started taking alcohol, about the age of 18 years, has delayed sleep. No significant dreams.

Vaccination — Only in childhood.

Hot patient. Perspiration average. Maybe also some perspiration palms in summers. < closed > open air.

Mentals — Irritable but anger does not last long. Equivocal about company or alone, “become more social after started heavy drinking”.

P.I. — Typhoid in childhood. Other ailments are mentioned above.

F.H. — Mother was diabetic.

1992

May 13: He was initially seen by my partner, Dr. Diwan Vijay Chand, who recorded the history and prescribed for him.

Nux vomica 200/2 powders on first day evening and bed time.

Sulphur 1000/3 powders second day morning at 15 minutes interval.

June 20: Burning epigastrium and some aching upper abdomen — lateral quadrants, off and on. He felt fairly well while eating home food but lately he ate out for a few days in a row and felt the symptoms.

Acidum nitricum 1000/3 powders at 15 minutes interval.

July 22: Reported that he had another blood examination at the same hospital and it was reported negative for HIV. Prescription: *Saccharum lactis*.

August 8: Seen by me. To be certain, another blood sample was now sent to a better laboratory — P.G.I. Chandigarh. He was informed that 2 tests were done and both were found negative.

August 28: Burning abdomen and heaviness after meals off and on.

Phosphorus 200/3 powders during evening and bedtime.

November 13: Elisa test repeated and found negative. Had 2-3 sessions of excess drinking and that upset his digestion, as it always did.

Phosphorus 200/3 powders at 15 minutes interval.

December 25: Tendency to have burning abdomen specially if he takes alcohol but at times even otherwise.

Nux Vomica 200/3 powders at bedtime on 3 consecutive nights.

1993

March 23: Has had Elisa test for HIV done in a private lab. and the result is negative.

June 21: In spite of having been warned, he keeps drinking 4-6 pegs of whisky, then he has irritation in the abdomen, tightness and some eructations.

Nux Vomica 200/3 powders at bedtime on 3 consecutive nights.

August 26: Last seen on this date with no particular complaints. Placebo.

December 11: Had another Elisa Test in September and report is again HIV negative. Last seen on this date. Treatment is continuing for digestive complaints.

ASYMPTOMATIC HIV POSITIVE CASE

Mr. P.A., a bachelor, age 22 years, consulted on March 22, 1993. He had gone to study abroad and as per regulations was routinely tested and told that he is HIV positive and therefore he cannot study or stay in that country. On return he got himself tested at a well known University Hospital. The blood was taken once but tested 3 times. Surprisingly, the first two tests were negative but it showed a positive test the third time.

He gives no history of blood donation or transfusion, no history of use of drugs and no history of sex with any female or male. The only pricks he has had are the ATS injections for injuries or occasional routine blood tests during fever. Occasionally has been shaved by a barber. Tendency to colds from childhood.

Appetite — Good. Non-vegetarian. Teetotaller. Fond of non-vegetarian diet, especially chicken.

B.O.R. For the last 3-4 years, he takes long in latrine as stool is passed in bits. Eventually satisfied. Stool not too hard. On enquiry regarding use of aluminium utensils, he said there were one or two such in the kitchen.

Sleep — Good. Dreams not much — entangled in smugglers group; of snakes, etc.

Vaccination for small pox infrequent. Total one or two times.

Become slightly chilly in the last two years. Perspiration average. Hands and feet slightly moist.

Mentals — Cool. Not a worrier.

P.I. — Chickenpox in January, 1993. Took Homoeopathic treatment and quickly relieved. From March 8, 1993 had fever and loose motions. Temperature 102-103°F. On March 12 he received *Hura* 6 from a colleague who, knowing my interest and study of the

subject, referred him to me. The temperature gradually reduced to normal by March 15. Stools also got normal. Earlier once he had fainted on seeing his mother in hospital and was put on Eptoin as a precaution. C.T. Scan and E.E.G. subsequently gave normal results.

O.E. — Heart, lungs and abdomen — clinically N.A.D. Tonsils + and slightly congested. Ht. 5'10". Wt. 114 lbs. (approximately 52 kgs). Tall, lean, narrow chested and long neck. No significant adenitis.

1993

March 22: *Phosphorus* 200/3 powders at 15 minutes interval.

Placebo pills for 40 days.

He was from outstation, so his subsequent reports were on telephone.

May 5: General feeling very good. Increased 3 kg. in weight. Slight itching sides of scrotum and offensive perspiration. This could be due to extreme summer heat.

Placebo pills for 40 days.

May 15: Reported that with milk he was prone to get flatulence and slightly loosish stool. Told him that no change is needed in the medication.

June 25: Feeling quite well.

July 23: General feeling well. Wt. 61 kg. Starts at sudden noise. Skin eruption around testes. Has been there for the previous two years.

September 16: Reported much better. No problem. I was not in town and on this report my Assistant sent him Placebo for one month.

October 15: Weight increased to 62 kgs. Recently more dreams of appearing for exams. Appetite reduced in last two months. Anger + +. Thereafter giddiness. Can't bear any wrong and that makes him very angry. Had been well all along since the start of treatment.

Only in the last few days cold and cough and a feverish feeling which started during a pilgrimage to Vaishnodevi Shrine (strenuous mountain trek with some cold exposure). Pale yellow discharge.

Pulsatilla 30/28 powders q or t.i.d. to settle the acute condition, thereafter *Bacillinum* 200/3 powders at 15 minutes interval.

December 9: Weight reduced by 1½ kg since return from the pilgrimage. Appetite is less. Feverish, though temperature only upto 99°F. Perspiration if he exerts even though it is winter. Cold, cough, yellow expectoration. 4-5 stools. Small but loosish.

Pulsatilla 200/3 powders on the same day.

1994

January 25: Keeping well. Only if exerts a little more then feverish feeling (face feels warm) but on checking no rise of temperature.

March 9: Feeling very well. Have gained the lost weight.

June 6: Came personally. Appetite reduced from 15th May. Weakness. Perspiration specially on Head. Feverish feeling but temperature normal except last evening 100.2°F. Epigastric pain more after 15th May. Heaviness heart region. In last few days, pain in the joints. Mild pain all the time, < rising from ground.

I noticed that he had some new symptoms and most of his symptoms dated to 15th May. Therefore, I enquired from him if there had been something unusual on that day. He revealed that his grandmother, to whom he had been greatly attached, died on 15th May. The pain abdomen, heaviness heart and reduced appetite could all be due to that. Used the Rubric Grief; ailments, from on page 51.

Ignatia amora 200/3 powders at 15 minutes interval.

Mid-June: He telephoned that he was not feeling well. Had slight fever and the urine was very yellow. Suggested urine examination and blood for Bilirubin. The results were positive for jaundice of moderate severity (Bilirubin around 5). Asked him to procure *Phosphorus* 30 locally and take it thrice daily. There was a good and quick response.

June 27: Bilirubin 1. Feeling quite normal. Appetite normal. Temperature normal.

Phosphorus 200/3 powders at 15 minutes interval.

July 12: Continues to feel well and engaging in all activities including an engineering examination.

Placebo.

HIV POSITIVE CASE

Mr. D.P., age 26 years, consulted on March 19, 1993. Bachelor. Businessman with no exposure to any chemical fumes or dust in his business.

History: He had been donating blood frequently as his father was on dialysis and needed blood time to time. For some reason, the blood that he donated in the hospital for the fifth time in April 1992 was given to a two and a half years old child who developed some symptoms, so he was sent for in September, 1992 and subjected to tests. He turned out to be HIV positive. He was himself completely asymptomatic at that time. He denied use of any drugs or of having had any sexual contact. In January 1993, he developed a slight pain in mid-chest on breathing, then anoxemia. In mid-February breathing difficulty + +. Difficult even to stand, could lie only on back and not on either side.

X-ray Chest: Clear.

From about the same time, i.e., mid-February, he had fever 100°F. He had been put on Septran which he took for 15 days. Temperature became normal after 2 days but while still using the medicine, it recurred, so stopped all medicines. The day before the consultation, it was 102°F, and he had vomits p.c. Chilly + + in fever but head feels hot. Thirst + + generally, a little more in fever. Uses tap water which is only moderately cold in this season. Taste is bitter — everything tastes bitter except sweets which taste normal. Has lost 3 kgs in 6 weeks. Vomitish feeling from smell of vegetables and chapati (leavened bread). At present, the usual diet is milk, fruits and khichri (a preparation of rice and pulses which is well cooked and soft). B.O.R.

Sleep: Is restless in fever. No dreams.

Previously no special reaction to heat and cold of seasons.

P.I.: Jaundice in April 1990. Australia antigen positive.

F.H.: Father died at the age of 55 years. Last illness was jaundice. Earlier had renal failure and was on dialysis. Father also suffered from tuberculosis when he was on immunosuppressor drugs. A grand-aunt died of T.B. long ago.

O.E.: No abnormality found on clinical examination except some small, discrete glands in neck. Wt. 109 lbs.

1993

March 19: *Phosphorus* 30/20 powders q.i.d.

March 24: Temperature is erratic. Some days normal and other days it is upto 100°F, i.e., less then before. When he gets fever, then has cough and with cough pain in chest.

Tuberculinum bovinum 200/3 powders at 15 minutes interval.

March 29: When temperature rises, then has considerable cough and expectoration — white mucoid “transparent jelly like”, after that some perspiration and temperature drops. The episode lasts for about one and a half hour. With cough, pain chest — feels shaken up for some time even afterwards. Weakness ++. Gets breathless even by going to bathroom.

Had an X-ray of the chest on March 27. It shows “Bilateral Paracardiac opacities. Impression — bilateral Pneumonitis (comparing to X-ray of February 21, there is extension (spread) of opacities (infiltration) in lungs)”.

Phosphorus 30/20 powders q.i.d.

April 3: In the meantime, he also consulted the Allopath who again put him on Septran and Dapsone which he had used for the previous 3 days. Fever is continuing. Cough is less. Thirst + + +, 2-3 sips every few minutes.

Arsenicum album 30/16 powders q.i.d.

Mr. D.P. has not been seen thereafter and therefore there is no knowing of subsequent developments and it can only be presumed that the short treatment of 2 weeks that he had, did not help him. The case is reported only to show the development of symptoms which vary from patient to patient.

OPIUM DE-ADDICTION

Mr. H.C.J., age 70 years, consulted on **March 28, 1990.**

Occupation business: Selling cloth.

Complaints: (1) Pain in both knees for the previous 7 years. Season and rain have no effect. < under fan. Stiff starting to move > as he drags along. (2) Some sort of wave sensation or ?twitching in both calves. It can occur at any time and can last for two to three hours. When it occurs the foot moves with it up and down — as if drawn. Prevents sleep if it occurs at night. Most of the night he keeps sitting as lying down brings on pain. Duration three years. (3) Shortness of breath even on slight exertion. Duration three years.

Personal & Background History: He was a heavy smoker, smokes bidi (tobacco wrapped leaf). No alcohol. Been an opium addict for 14 years. He started opium because he used to have pain in legs. The pain would be suppressed as long as there was opium effect. After few years pain stopped but opium habit continued. Consumes about 2 gms. daily. Takes opium three times a day: morning, noon and evening — between 7 and 8 p.m. There was craving for salt which he would add even without tasting. Hot patient. However, for the previous 15 years bathes with warm water throughout the year (lives in Alwar which is quite hot in summer).

Prescription: *Rhus toxicodendron* 200/3 powders on the same day.

1990

April 21: Calf pain better. Prescribed for him *Avena sativa Q* 10 drops in water thrice daily.

June 9: Has been able to stop opium for which he and the family are most grateful “It is a miracle. I had used opium for 14 years and I was able to stop it soon after starting *Avena sativa Q*”. Calf pain better. So now

he does not have to be sitting. In fact the pain or sensation in the calves occurred only two or three times since March 28, when treatment was started. Other days no trouble in calves. For years he had not been able to lie comfortably as he can do now. Sleeps normally i.e. lying down.

Pain in the knees ascribed to advanced osteoarthritis could only be partially relieved by *Rhus toxicodendron* prescribed on March 28 and *Calcarea carbonica* 200 prescribed on June 9.

FRACTURES

Mr. V.P.S., age 45 years, a Colonel in the Army sustained multiple fractures of the femur on **February 27, 1986**. Belonging to a princely family of Rajasthan and being one of the world's best polo players he had worldwide contacts and admirers. As such special equipment was imported and a very skillful American surgeon, specialist in his particular line, guided the complicated surgery of putting in of steel plates and rods. He made good recovery but as soon as he assumed a limited activity he had another unfortunate accident — he slipped in the bath tub and the steel rods and plates could not take the heavy jolt and he again had a fracture. A second surgery was carefully done but now the healing process was not satisfactory.

I was therefore, called to see him in hospital and to give an opinion if Homoeopathy can help.

I saw him on **September 22, 1986** and prescribed *Symphytum officinale* 6/30 powders t.i.d. The prescription was repeated on **October 4**.

On the surmise that that should give enough stimulation for callus formation from October 13, he was prescribed *Calcareo phosphorica* 6x, t.i.d. which he carried on for one month. Thereafter he was on *Saccharum lactis* for two weeks.

I was called to see him again on **November 29**. He had had an X-ray on November 26, which showed good healing. But there was still a slight gap between the fracture segments of the femur. His personal report was "the medicine has definitely helped, it took away the pain and strength in the leg is returning faster."

On **November 29**, he was again prescribed *Calcareo phosphorica* 6x, which he took for 4 weeks t.i.d. followed by *Saccharum lactis* for 4 weeks.

1987

February 6: Called to see again. Recent X-ray showed a very considerable improvement in calcification and the Surgeon assessed his condition as "much better".

To complete the process he again received *Calcareo phosphorica* 6x t.i.d. for 4 weeks. Thereafter he left hospital and joined his Unit outside Delhi. I did not see him again but learnt that he was quite active and even assumed the strenuous game of polo.

I subsequently saw his name in the newspaper as he was leading the Indian Polo team to play abroad.

When I saw him initially he was so depressed about his condition that he said, if he could not recover completely and play polo life was not worth-living. Even though he did not mention the word suicide but it almost amounted to that.

His recovery to complete fitness put him back into 'A' category and he was promoted to the next rank in the Army.

