Homoeopathic Management Of Malaria

Defining The Problem: Case Taking

Introduction

The astounding discovery of Homoeopathy is closely related to Malaria and the Cinchona bark extract experiments, The "Malaria-like" symptoms greatly facilitated the discovery of the Therapeutic Law of Cure by Hahnemann.

Once the Law was made applicable to treatment of masses, including Malaria or Intermittent Fevers, successes and failures were both aplenty. These, when analyzed judiciously, helped Hahnemann to gradually build up the entire Homoeopathic Theory and elaborate it in the Organon. Allen followed, with his superb 'Therapeutics of Fever'. The more recent experiences however, remained more or less unorganized and hence unavailable in print to the fraternity.

We were forced to grapple much with Malaria over the last few years due to its endemic status in most parts of India.

Our Earliest Encounters With Malaria

Once a physician almost sent a patient of malaria to his death, by administering repeated doses of *Arsenic-alb* 30 (the indicated remedy) during the paroxysm.

The course which followed: patient moved from nervous→restless→anxious→fearful→ delirious: the fever shot upto 107□F with severe anxiety about death. A dose of paracetamol quelled the storm, temporarily. The patient and relatives were then wise enough to switch over to modern medicine. The physician was shocked by the experience and vowed never to treat a case of Malaria again.

But, providence was kind to him and thrust upon him the responsibility of treating another case of Malaria. Reluctantly, the 'Organon' which had been collecting dust on the top shelf was taken down and he meekly took note of Hahnemann's admonishment:

Take total care in taking the case, record it well. Study it thoroughly. Select the right remedy. Administer the (single) remedy after the paroxysm is over.

The second case was taken in detail and very meticulously. A thorough study again revealed *Arsenic-alb* as the similimum. The physician after waiting patiently administered a dose of *Ars-alb* 30. The next paroxysm was due the next day.

Next Day: 3 pm: Telephone rang. Fever 104□F (First paroxysm 102□F) The voice wailed, "Doctor, he is too bad today. Tossing restlessly on bed. I have never seen tears in his eyes. His headache and backache are worse; he has severe nausea. His condition is bad, too bad! He is saying that he is going to die." That is *Arsenic* personified the bewildered physician muttered to himself, looking questioningly at 'Organon' as if to ask what has gone wrong, Dr Hahnemann? He quickly and wisely prescribed a dose of Paracetamol and offered consolation to the desperate wife promising that he would visit late in the evening.

9 pm: The physician was greeted with a pale smile. The temperature was normal but the headache and backache were not relieved at all. The worried physician maintaining his composure, consoled the patient and the anxious relatives: "There is nothing to worry. It is only a question of potency ("Hope you are right, Dr Hahnemann") Once the right potency is administered, he will be all right." He could see that the patient had noticed his feeble voice, so he at once turned to examine the patient (though there was hardly anything to examine) and asked a few questions to confirm his prescription of *Arsenic*. Satisfied he left..At the door the patient timidly asked if he could occasionally take cold water to drink. Yes, yes, why not? The physician assured him

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good humouredly and went away.

The physician was restless. Intuitively he felt something was wrong. He studied *Arsenic* from Allen's Intermittent: "CHILL: If there be thirst during chill except for hot drinks, do not give *Arsenic* - H N Guernsey." Patient was thirsty[3] all right, but whether he desired warm or cold – and that too during chill – had not been inquired at all! His pride began to melt and he immediately dialed the patient. What sort of water does he want? Doctor, we have been giving him warm water only – why?

No, what does he desire? He wants cold water – ice cold water! One cannot give cold water during fever, can one? What sort of water does he want when he is shivering with chill? Doctor he has been demanding ice cold water even when he is shivering from head to toe but that can be very harmful ... And when he is not shivering and removes the covers? He is not very thirsty then but he still wants cold water, but I don't ... How is his headache? Very bad – two Metacins have not given relief... How much did he sweat today? Not much – hardly at all, even after two Metacins ... And backache? Very bad, right from the beginning, it has been going on pretty badly.

Backache was the first symptom at 9 am on the first day. Bitter taste and mild nausea at 11 am. There was no restlessness or weakness till 5 pm when the fever was 102□F at the time the case had been taken. The patient said he was feeling very weak because he was feeling 'terrible' – headache and backache were so severe that he could hardly sit! Wife added that he had a tendency to exaggerate during sickness. At 2 pm (on the 1st day) he started feeling thirsty – quite unusual – and as soon as he had taken a glass full of cold water (he still wanted more, but the sudden chill with rigor prevented him to do so) the chill had set in vigorously. He had once or twice asked for cold water but the wife had prevented it saying that he would get Pneumonia. The patient did not have the courage to offend his caring wife, and obliged by sipping a little warm water that she offered him from time to time. On the first visit: as the physician entered the room he saw the patient sip a little water. On inquiry the wife, who had been eagerly waiting to report everything, had said that the patient was feeling thirsty, and she had been giving warm water every few minutes. Everyone had become very nervous and anxious on seeing the Blood-Report – Plasmodium Falciparum positive. The wife remarked he always becomes nervous, impatient and irritable during sickness. He was very nervous today. When did the paroxysm start? In the afternoon between 2-3 pm. Chill and nausea increased with sips of water which was more because of disgust for warm water. Now what more do you require to prescribe *Arsenic-alb*? The physician had not taken into account the Anamnesis and the Evolutionary Totality- his case-taking was far from adequate. Fortunately, the patient had not taken the dose of *Arsenic-alb* 200 at night (the second paroxysm). *Eupatorium-perf* 200 single dose was prescribed. There were no paroxysms thereafter.

Physician had become wiser. His remorsefulness much alleviated, he went through Allen's Intermittent Fevers and Organon. Retrospection was inevitable. Why had he so thoughtlessly ignored Hahnemann's exhortations despite the fact that he had read his aphorisms 235 to 244 a number of times?

Retrospectively, when the physician had his first encounter, he had obviously set aside the implications of Malaria being an emerging acute phase of a chronic disease. The concept of Deep Acting Anti-Psoric as mentioned by Dr Hahnemann could not be taken lightly.

Third case: A regular patient of mine, contracted P Vivax and was treated with the Phase Remedy *Nux-vom* 200. The paroxysms subsided with a single dose. Thereafter she did not report. After 2 days she had a recurrence at Delhi, a little modified picture yet *Nux-vom* emerged strongly.. One single dose in 200 potency, and one single dose of the constitutional remedy (*Nat-mur* 1M) 36 to 48 hrs after the paroxysm was over. She was all right and has not had a relapse till today.

It is a general experience that we often discover what 'we will do', by finding out what 'we will not do'; and probably he who never made a mistake, never made a discovery that Hahnemann as a True Experimenter had followed this painstaking path.

Fortunately, Hahnemann had brilliant followers like Boenninghausen, Boger, Allen and others to justify his discovery of these 'therapeutic laws' by verification. An enthusiastic reader can easily verify this by going through Allen's Introduction to his Intermittent Fevers – a classic in Homoeopathic Literature. (Allen is the greatest known authority in Malaria.) We can never 'feel' to the full what Hahnemann and Allen have written with total conviction until we have traversed the same path. Now some important facts:

THE ICR FEVER FORMAT:

Learning accrues to the teacher from experiences based on Organon. The teacher shares his learning with the learners. Analysis inevitably occurs. This is the way concepts evolve. To make these concepts useful at an operational level, standardization of concepts/ methods/ techniques is indispensable.

However, with more and more encounters with Malaria cases and learners, the fever totality section proved to be too inadequate and incomplete for further analyses: Research ←→ Philosophy of treatment and management of Malaria ←→ Learning. Hence, the ICR (Intermittent) fever format is an organized arrangement of Hahnemannian concepts (as elaborated in the ICR symposium volumes) to facilitate case-taking, case-study, analysis, synthesis, repertory study, Homoeopathic Materia Medica study and planning and programming of treatment. This now brings us to a brief discussion on the various sections in the ICR fever format.

1. The 1st Section in the Fever Format is for recording THE TOTAL ANAMNESIS AND THE EVOLUTIONARY TOTALITY. The narration by the patient as guided actively by the physician is 'committed to writing' verbatim. The important Time Axis, serving to check the alert and sensitive physician, is provided to guide the physician. **Caution**: The patient almost always begins with the chill or fever. It is always safe to help the patient recollect his symptoms that might have developed 24 hours before the onset of chill or fever. Sometimes, it is necessary to go back even beyond this. The physician should not try to separate or distinguish between different stages in this section. This, of course, should not prevent him from procuring the characteristic/ peculiar/ individualizing symptoms with the available modalities etc.

2. In the next section, **"STAGES"**: The physician will put down all the characteristic details pertaining to each stage – Prodrome, Chill, Heat, Sweat & Apyrexia. Of these, the prodrome and apyrexia are the most important of all 'hunt' for the remedy. Here the physician's alertness will yield. He can take help of the Allen's Intermittent / H M M/ Repertories to write down more characteristics/ modalities, if available, in this section.

3. 'PATTERNS' is the immediate heading that follows. Refer Kent's repertory - fever, Succession of Stages; Boger-Boenninghausen's repertory – compound fevers. The types of pattern the patient is manifesting will correspond to one of the descriptions in these sections of the repertories. This offers valuable clue for the selection of the remedy.

4. EVALUATION will necessarily be practiced as per principles laid down in the text-book by Dr M L Dhawale.

5. PRESENCE OF CHRONIC DISEASE will necessarily have its bearing on the sensitivity / susceptibility of the patient. The miasmatic background gets more accurately defined. The effect will be felt at the level of posology, the study of which is still incomplete and inadequate. It can be considered as the 'Foresight' of future posology.

6. DRUGS: Which the patient has been taking will be listed here and in what way they are tampering with the patient's susceptibility will be assessed. This will naturally include the anti-malarial drugs also.

7. REMEDY SELECTION: Is the most important aspect and will be considered seriously with reference to the

Symposium Volume D: pages 10 to 14. The phase of disease expression will be mentioned with reasons. Similarly, pre-disposition and disposition will be clearly defined. The significance of these aspects need not be discussed here.

8. In the TYPE OF RELATIONSHIP, it would be wise to note down all the remedies which are closely related to the constitutional remedy or the phase remedy. This helps the physician in going through each and every likely remedy for selecting the first Prescription. This way the chances of making mistakes are minimized to a great extent.

Symptoms not recorded in the H M M or Repertories: Experience soon teaches an alert/sensitive/enthusiastic physician that our greatly adored H M M and Repertories are still incomplete (An unpleasant surprise?) Therefore, all symptoms were not traceable to the Source Books should be listed here. In future, this will enable us collectively to make necessary changes in the H M M and Repertories. (Example: A patient of bronchitis–constitutional remedy: *Nat-mur.* Acute: *Kali-carb*–developed malaria. During the prodrome, he had moderate pain in teeth. However, the rest of the picture – Anamnesis and the evolutionary totality – pointed to *Arsenic-alb* as the phase remedy. *Arsenic-alb* cleared the case, relieving the pain in teeth. It is now possible to enter *Arsenic-alb* in the appropriate rubrics in Repertory and H M M as a clinical symptom.

9. Some 'heads' like physical examination/ investigations etc, are self-explanatory and not discussed here.

Now, the usefulness of the Discipline of the Fever format in organizing a learner's thought process, is seen. It is of great help in improving one's case taking, when it is used with intellectual integrity and sincerity.

II. CASE-TAKING

Case Two is an excellent example to demonstrate the importance of case-taking in Malaria and of selecting right prescription straightaway. The wrong/ partially similar remedy will distort the totality and so confuse the prescriber that he will believe the 'wrong-remedy-image' is the right one. There ONLY saviour is Alertness. **DUNHAM** (quoted by Allen) rightly writes "The first duty of the physician is thorough examination of all the elements of the case. This cannot be stressed enough and most so in Malaria.. *(I can personally vouch for that, having had Malaria twice in the last 1yr and both times had to finally resort to Allopathy- an anathema to a staunch Homoeopath like me!- Editor)*

Having honestly ascertained all the elements, let him consider them well and carefully before deciding the first prescription, then make double sure before administering the first dose: no subsequent effort in the case is of of so much import. A confusion at this level has again and again been ascertained as uncorrectable. After this there is only vexation, difficulty and anxiety ... Let it never be forgotten that time here is of no account; here accuracy wins hands down. It is better to do nothing than to do wrong."

Allen writes on this issue: "After the totality of symptoms has been committed to writing, the most difficult part is done. The more time and care devoted to a careful and thoughtful examination of the patient, the less guessing and alternating and changing of remedies, afterwards; case well-taken is already half cured." Allen's Intermittent Fevers is a testimony of his acquired competence in treating Malaria cases; the arrangement of symptomatology speaks volumes about his Sherlock Holmes methods and procedures in case-taking. A homoeopathic physician is but a 'detective at work' his aim to 'detect' the right remedy sensitively and sensibly. Therefore, 'Selection of the Right Remedy or Remedial Forces", a topic, which will be discussed later cannot and must not be separated from the topic of 'Case-Taking In fact, it is an inseparable part of case-taking. Reasons will become clear as one reads further.

Why is Case-taking of Malaria so tricky and trying? Because the ailing patient is constantly taken up for his awful headache or backache or weakness or his

overpowering chill or heat, thus tending to ignore or nor give thought to questions put up by the physician nor co-operative in narrating the experience in a meaningful way. Even the most experienced physician would be moved by the patient's anxious moaning and suffering. Relatives, too are rendered tremendously anxious by P Falciparum, with its potential fatality and this puts a physician under stress resulting in a far from careful Anamnesis and evolutionary totality-all ingredients of a disaster in the making!

An Example of Case-taking

A 35 yrs old woman (from a slum area) complained of fever with chill (now afebrile) and severe bodyache. While she was describing all this, she yawned twice or thrice. 'Are you feeling sleepy?" Yes, she said with embarrassment. 'Since how long have you been feeling sleepy?' She looked a little confused, smiled and hid her face in embarrassment. 'When did the fever start?' – Last night. 'Night is a long period', the physician said firmly but gently. – About 8 or 9 pm. And how do you know it was 8 or 9? She had gone to see Hindi news on TV. What did you feel at that time? She felt 'cold' and started shivering. (She coughed once.) Have you got cough? Yes. You did not report about it, why? You must report everything. She said that it was quite mild. When did it start? Two days back she had got wet in the rain and since then very mild cough, one or two at a time, twice or thrice in a day. It is nothing much, but this fever was very high yesterday... and bodyache was very acute... 'You answer the questions correctly. I am going to treat your fever,' the physician said firmly 'When did you sit to watch TV?' She usually goes there at 8 pm. Was the fan on? Yes, she did not like it (unusual). Were you yawning there? Yes, yes, very much. The mistress of the house remarked that she looked sleepy and tired. What did you say? She said that she hadn't slept well for 2 days. Why? Bodyache and tired. Have you been working too hard? But the bodyache, whole body aches so much after getting wet. Sleep? Poor, because of bodyache. Dreams? She laughed. Have you been getting dreams? She always gets dreams. What type of dreams since two days? Yesterday, she did not see any. Day before yesterday? She had been toiling at some work – hard manual work. And previous to that? She had been helping her mother on a field. How were you feeling yesterday at 6 pm? She was fine except the bodyache which was mild. 7 pm? Same 8 pm? Bodyache had increased – Cough? That was severe at 8 o'clock. 'Wait, wait,' the physician said quickly, "You said at 8 o'clock" – Does it mean that the cough was not present at 9 pm?' She thought with keen interest, now and then throwing glances at the physician's pen. After a while, she remembered it correctly – At nine o'clock, when the shivering started, the cough had almost disappeared for a while, but it had again started when she reached home. Dry or wet? Wet cough. The mistress of the house gave her a clove to chew. Do you want to stretch your legs and arms? Yes, she liked it. (Her eyes showed surprise.) Was she doing that frequently yesterday evening? Yes, very much (The physicians all knowing–look appeared on her face.) Headache? No. Colds? No. Nausea? No. Appetite? Not bad. Any Desires/ Aversions? She wants cold water. And during the chill? She drank matka (earthen pot) water. No, you did not answer my question – What you desire is one thing and what you drink is another. What did you desire to drink, cold water or matka water? She said that she was poor... No, the physician said firmly, what would you have preferred? Yes, she would have loved to have cold water. How is your back? Bad. Which is the most painful part in the body? Arms and legs – whole body. Back? Better than the body. What relieves your bodyache? Tablet. No, apart from the tablet? Who would press the body, she moaned? Cold bath or warm bath? She is poor. How do you feel when you sit outside in the sun? Normally, she does not like sun, but since 2-3 days, she likes it because she feels better. Stools? No problem. Urine? No problem. Tongue? White. What makes the bodyache worse? Bath. Any other time? Night. Daytime? Not so much. During daytime, you must be

working? Naturally! Does it mean that when you are moving around, you feel better? Exactly. In the morning, when she tries to get up from bed, the body is very painful – after wards, the pain wears off. Now think very carefully and answer the questions which I ask you – (the patient nodded her head) – Earlier, you said that you started feeling cold at about 9 pm, and then you started shivering, am I right? Yes. Does it mean that there was no fever at that time or was there fever with it? No, no, the fever was there since evening! What time? Must be around 7 pm. The physician was quite perplexed. Look here, the physician said, ready to make the necessary changes on his Fever Format, this is something quite new you are saying, so please be careful in giving these details – How did you know there was fever? My body was warm. Did you measure the temperature? How can I? But the nieghbours had said that my body was warm! And you had gone to see TV with fever? Yes, she laughed. The mistress there had also felt her body and said that she appeared warm, and had given her a *chadar* (sheet to cover) for covering her body. So you are sure the shivering etc. started much later? Yes, she said emphatically. OK, then when did the shivering and 'cold feeling' subside? After about half an hour or so. Then what happened? I fed my children? Does it mean you were not feeling cold then? No, I had removed all my covers. Sweat? No. You mean you did not sweat at all? No, no there was profuse sweat at night. What time? Must be after mid-night. Are you sure? Yes I got up wipe it. Now, let us revise the sequence again – You had fever (feeling warm) at about 7 pm, then you shivered at 9 pm and the sweat came on after midnight? High fever! She said simply. How did you know? Feeling very very warm. Fan? Off. Covers? None. The physician opened his repertory and studied it closely for a few minutes, and then wrote down on his Fever Format, under the heading – **Patterns**: Heat, then Chill, then Heat, then Sweat. He verified it again and again from the patient. He quickly took the family history and past history to determine the predisposition and disposition. Family history/past history – not contributory.

Constitutional Remedy was obvious – *Calcarea-carb*, which is closely related to *Rhus-tox*. The patient was given one dose of *Rhus-tox* 200, one dose during apyrexia, and then a dose of the constitutional remedy. Thereafter, there have been no paroxysms till today. Besides the methodology of case-taking, this 5th Case has been cited to demonstrate the indispensable importance and significance of the total anamnesis and the evolutionary totality of the case.

6TH CASE: One remembers the case of a young girl *Kali-carb*) who came one late evening with mild fever and a few rhonchi. She had developed fever since morning. Her usual acute remedy (to which she has been responding very well), *Arsenic-alb* 1000 – 1 dose was given at 8 pm. Thereafter, the fever shot up to 104°F (Metacin was given at night.) Next morning, there was fever - 102°F to 103°F – it appeared to be a continuous type of fever. The blood-report was available at 11 am. (She had been on placebo ever since the dose of *Arsenic-alb* 1000). It was P. Vivax. There was a lot of confusion: Was this an aggravation because *Arsenic-alb* was prescribed during the paroxysm? If so, then, one had to wait. The physician waited almost for 36 hours. There were no clues available during 3-4 visits that he made. Finally, it was the anamnesis and evolutionary totality + absence of a balanced image of any phase remedy which solved the problem: 1st day – fever without chill at 9 am. Pricking pain in throat in the morning: *Kali-carb* 10M, 1 dose was needed. (At the moment of this crucial decision, the fever was 104°F. One dose of Metacin given to bring fever to manageable level. *Kali-carb* 10M was prescribed when the temperature came down to 102°F). There is good agreement to what Dr A Charge (quoted by Allen) says: "Study the patient during apyrexia to form an exact idea of the functional action, regular or otherwise, of all the organs" Sometimes, one is urgently called upon to see a patient with continuous fever (most commonly, the much dreaded Falciparum). If cold

sponging is not enough, it would not be unwise to prescribe a dose of Paracetamol to alleviate the fever and suffering of the patient, and also the anxiety of the relatives so that proper justice is done to case-taking (till we have a better alternative) Greatest care should be taken in inquiring about symptoms that a patient is likely to ignore, eg thirst, urination, stools, cough, coryza, appetite, cravings and aversions, sleep, dreams, temperament etc. Sometimes, symptoms tend to appear or disappear, or get worse or better during a particular stage or stages – a careful note of this/ these should be made e.g. prolonged heat/chill, absence of heat/ chill/ sweat etc. A great many variations have been recorded in the repertories by Kent and Boger in his Boenninghausen's characteristics (succession of stages; compound fevers). An excellent example is available in case 5.

Chill, then heat with sweat; chill alternating with sweat; Chill alternating with heat; heat, then sweat then chill; heat with coldness of single parts; sweat, then chill; sweat, then heat. Equal importance should be given to the nature of heat/chill/sweat – partial/general; leftside / right side / upper parts/ lower part; ascending / descending etc. Both the repertories give an exhaustive study of this.

One of the most useful studies of these stages has been supplied to us by Boger Boenninghausen's characteristics – concomitants, an addendum after each stage. This wisdom of Boger is as indispensable as Allen's intermittent fevers. Kent has given these Concomitants in different sections. For example, cough as concomitant of chill in Boger in his Boenninghausen's repertory will be found in Kent repertory under cough, chill during. Thus, it will be quite obvious to a homoeopathic physician that an exhaustive study of the invaluable fever sections in these repertories and Allen's intermittent fever is but an integral aspect of case-taking. Cases cited above are enough to exemplify this point. To put it more explicitly, case-taking study of Repertories + Allen's fevers. Allen writes – "This is a mental process, so expeditious sometimes that we are hardly aware how we engage in it. But it shows how difficult it is to take a case unless we have some knowledge of the Materia Medica, and how much an extensive knowledge of the Materia Medica aids us in taking the case."

Symptoms during prodrome and apyrexia, though grossly incomplete, have been listed only in Allen's Intermittent Fevers. Kent has given too few prodrome and apyrexia symptoms which in Kent have been listed under 'Before Chill' in appropriate sections. Thus, the beloved repertories are far from complete, and as one encounters a growing sense of insecurity while one turns pages of the thick volumes assiduously. It gives rise to fresh enthusiasm to complete the incomplete works of Kent, Boger and Allen. Hence, the Standardised Fever Format. We are reproducing below the Fever Format, as used in a case: to make the enthusiastic reader's learning complete

CASE 7: Fever Format:

Patient reported on 5-8-89:

1-8-89: Headache++ and Bodyache ++ especially arms and legs. Both Temples, + Occiput, Throbbing++. After exposure to Sun (?). Came home and slept, felt better after waking at 7 pm. At night felt chilliness. Took one chaddar and no fan. Bodyache. Bonepain+ Felt weak+ Thirst ↓ed. Did not like anything cold. Temperature not measured. Heaviness of Abdomen.

2-8-89: Bodyache and Headache started at 9 am. Bodyache throughout the day. She felt uneasy. Took one Tab Novalgin. (Note: On 1st and 2nd, she was at Bombay doing shopping. The weather was cloudy and gentle showers whole day. Occasionally sunny for short intervals. She got wet once or twice).

3-8-89: Day 3 At 7.30 am fever started with headache at both temples. Uneasiness ++ at 11am. Fever increased. Heat ++ all over body and head also. Even after taking Crocin there was no sweat. Desired cover and slow fan. At noon 103□F. Bodyache++, weakness+++. Thirst ½ glass cold water every 2 hrs. Took 2 Chaddar and fan on 2 (indirect). She would

ask to slow down fan whenever she felt chilly. Cold compresses on forehead to control the fever.
4-8-89: No fever but headache + and weakness ++ throughout the day. Headache began around 10 am. Headache < Noise[3]. < Light[3]. > Pressure[3].
5-8-89: No complaints till 12 noon. Chill started after noon (sleep disturbed). Before noon, there was pain in hands and legs. Bodyache + Heaviness of head. Internal heat with slight chilliness started around 10-15 am. < 11-30 am. With chill and headache+. Took 4 chaddar. Headache++ Both temples. > pressure[2]. Pain in legs / hands - ↑ ed. Thirst – not much. Preferred Matka water. Chill lasted till 1.30 pm. Then 'Heat' started. Headache > +. No fan and no coverings. Headache > cold application. Weakness ↑ ed and was more than yesterday. Now thirst for cold water – 1 glass every ½ hr, at times every 10 minutes. Burning eyes. Muscular pain all over ++. Sweat around 2.15 pm on face++ and head++. Cough and colds. Sl+ since yesterday. No fixed time for cough. Lacerated feeling in throat. Sneezing+ but no nasal discharges. Pain in sternal region, during cough. Occ pain in abdomen with Sweat. Headache > but +.

(B) Analysis In Stages
(Special stress to be given to the symptoms which change in occurrence in different stages)
Prodrome: Headache++ Bodyache++→ hands and legs, Temples and Occiput < 9/10 am.
Chill/Chill With Heat: Headache < Internal heat with chilliness Bodyache < (hands/legs)
Heat/ Heat With Sweat: Headache Temples. Throbbing. <[3] Noise <[3] Light
Occiput >[3]Pressure > cold application, < Sun (?)
Bodyache <, Thirst ↑ ed. Heat All over body. Weakness++.
Sweat: Headache >++ but + continued on Face++/ Head++
Apyrexia: Headache+, Bodyache+ Weakness++ Headache at 10am
(C) **Anamnemesis: Fever Patterns: (Stages)**
(Write down the different rubrics which corresponds with the case from BB Compound Fevers (Pgs: 1099-1102), Kent's Repertory: Succession of Stage (Pgs: 1290-1292).
Prodrome → Chill → Heat → Sweat.

(D) **Evaluation:** Paroxysm start around 9-11 am. Headache, Prodrome during. < Chill during. Modalities < ++ Heat during. > Sweat during. Headache during Apyrexia. Chill → Heat→ Sweat.

(E) **Selection of Rubrics/ References:**
Paroxysm returning at 9 to 11 am (Allen's therapeutics of fever – time, pg 396)
Headache, prodrome during (Allen's: Prodrome – Headache, pg 406)
Chill. Concomitant Head (BB 1038)
Heat Concomitant Head (BB 1065)
Also See Therapeutics of Fever, Allen: *Nat-mur* (Pg 276 Comparison between *Ars-alb* and *Nat-mur*)
Chill – Heat – Sweat (BB 1099)

(F) **Original Unmodified Picture**
Prodrome, Chill, Heat, Sweat, Apyrexia: Not Available
(G) **Presence of Chronic Diseases:** (Refer SCR No 18/89). Acne vulgaris and hair falling.
(H) **Drugs:** (Crocin and Novalgin)
(I) **Physical Examination:** Time: 6-30 pm; Temp: 100.8□F. Pulse: 90/min; BP: 100/60.
Abdomen: Liver and Spleen: Not enlarged. Tongue: White++. Coldness: Partial, General.
Warmth: Partial, General.
(J) **Investigations:** Hb: 9.5 gms; RBC: 4.02 mi/mm; PCV: 30; MCV: 75; MCH: 23.6; MCHC: 31.7; TC: 5,400; P: 74; L: 22; E: 0; M: 4; B: 0; ESR: 55; MP: +VE – Gametocytes of P Vivax.

(K) **Remedy Selection:** (Refer D4, Pg 10-14)
(a) Phases of Disease Expression:
1. Chronic deep acting constitutional.
2. Acute. Short acting, superficial.

3. Constitutional remedies in acute syndromes, including fulminating type.
4. Alternating Disease Expressions.
5. Evolutionary sequence the whole range of miasmatic expressions.
(b) PRE-DISPOSITION: F M: *Tub.* D M: *Tub*
INTER-CURRENT REMEDY: *Tub-bov.* Disposition: Constitutional. Remedy/ Chronic/ Remedy:
(Refer SCR No BR/BPK 18789)
(C) Sectorial Relationships:

Types of Relationship
i. Acute —— Chronic Relationship.
ii. Complementary *Mag-carb* —— *Nat-mur*
iii. Remedies that follows well.
iv. Antidotal Relationship.
v. Cyclical Relationship. (Sequential)
vi. Intercurrent Remedies.

(L) Symptoms not recorded in H M M or repertories: (none in this case).

(M) Planning and Programming of treatment

Define with reasons: The States		Potency Choice	Repetition
1. Susceptibility	Moderate	Medium	Single dose
2. Sensitivity	High	Higher	Single dose
3. Suppressions	High	Higher	Single dose
4. Correspondence (Degree and Level) Const Rx and Phase Rx	Adequate	Higher	Single dose
5. Correspondence:	Inter-current	Higher	Single dose
6. Correspondence: Sector		Higher	Single dose
7. Functional Changes	+	Higher	Single dose
8. Structural Changes	-	Higher	Single dose
9. Variation Time	-	Higher	Single dose
10. Gen. Vitality	Good	Higher	Single dose
11. Confused:	-	Higher	Single dose

(N) Selection of Remedy with Potency: *Nat-mur* 30 (1 P) when Fever drops to 99□F

CONCLUSION: In this article I have tried to delineate, as far as possible, the learning I went through, so as to be able to handle Malaria today, fairly successfully . I have stressed, maybe more than required, what is important and how to arrive at that data. I have demonstrated actual cases. I do hope I have been able to do justice to this kind of an approach and have been able to put down ALL my learning in this brief space of 8 pages. If there are any lacunae or if there are any questions, I will gladly answer them in the NJH to the best of my ability. □

Failure does not mean I'm a failure
It only means that I have not yet succeeded.
Failure does not mean I have accomplished nothing;
It does mean I have learned something.