The Bowel Nosodes In Homeopathic Practice

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Abstract: Serious homeopathic practitioners have all had to face the fact that sometimes their most carefully chosen prescriptions mysteriously fail to improve their patient. When this happens, it is all too easy for practitioners to assume that they are simply failing to identify the best remedy for the case. Often this is not the case, however, and for the sake of patient and practitioner alike, it is vital that homeopaths have a detailed knowledge concerning acquired intrinsic blocks to cure.One major intrinsic source of illness (and prescribing failure) is bowel dysbiosis. Patients who have acquired a deranged bacterial flora (either in their bowel or their airways) will often fail to respond fully to standard homeopathic prescribing. This paper is largely concerned with the often insidious and diffuse clinical presentation of bowel dysbiosis. It is hoped that this account will raise awareness of the problem and help practitioners identify which patients require to be 'unblocked' with a bowel nosode at an early stage in their treatment process.
Keywords: bowel nosodes, bowel dysbiosis, intrinsic blocks to cure, iatrogenic illness, leaky gut and bowel nosodes, probiotics, antibiotics and bowel dysbiosis, chronic illness and the use of bowel nosodes

Bridging Homeopathic Empiricism and Medical Science

There are areas of knowledge that bridge the gap between diagnostic and phenomenological medicine. One of the best examples in homeopathy concerns the Bowel Nosodes of Bach and Paterson. This is a group of materials originally derived from the bowel flora of ill people.

The leading symptoms for most nosodes in the homeopathic materia medica are a collation of the acute and chronic sequelae of infection, together with a mind picture variously derived from provings and cases. The data for the Bowel Nosodes extends beyond empirical observation to encompass bacteriological investigation and collated clinical experience.

For long periods between 1920 and 1959 the bacteriologist Edward Bach, and clinicians John and Elizabeth Paterson, Charles Wheeler and Thomas Dishington were investigating the relationship between chronic illness and the composition of the bowel flora. In the course of their working lives, Bach and Paterson investigated the bacteriology of more than 20,000 stool specimens.

Historical Precedents

Today clinicians are increasingly aware of the important relationship between the bowel microflora and health. Studies are increasingly showing that immunological health is influenced by the presence or absence of a heathy gut microflora. However, it is still not generally appreciated that different kinds of dysbiotic state exist, which generate specific illness tendencies and characteristic symptom pictures.

> The main clinical value of the bowel nosodes is in subacute, chronic and relapsing states. Bowel symptoms are often present in the patients for whom these remedies are required, but in some cases these symptoms may be quite a minor part of the overall presentation, particularly when dysbiosis is predominantly in the respiratory tree, perhaps following inappropriate antibiotic treatments for catarrh or minor infections.

Clinical Awareness

It is also still not widely appreciated within the homeopathic community that an unhealthy gut microflora is not only a contributory aetiology in chronic illness, but is also an intrinsic block to cure. In other words, patients whose illness and/or drug therapies predispose them to altered bowel flora may fail to respond to homeopathic remedies that appear to have been 'correctly' selected on the basis of the symptomatology. These remedies seem to be ineffective while GI toxicity and secondary immunological disturbances trap the dysbiotic patient in a kind of persistent 'systems-chaos.'

Current Boundaries of Knowledge

The gut microflora is extremely complex and only partly understood. Only a small minority of subspecies can be cultured in vitro, due to the highly selective niche environments they occupy in the living bowel. In the live bowel these organisms are inextricably bound together in symbiotic relationships that cannot be replicated in vitro. These symbiotic relationships are partly determined by the availability of particular substrates, synthesized or competitively utilized, by partner species.

It is generally accepted that the dominant flora in the healthy gut comprises more than 90% obligate anaerobes, which are predominantly lactose-fermenting, non spore-forming organisms and are devoid of endotoxins in the structures of their cell walls. Less than 1% of the bowel flora should constitute yeasts, Clostridia, Proteus species and other members of the Enterobacteriacea.

Discrete clinical syndromes are associated with the overgrowth of specific organisms like Clostidium difficil e and these are widely recognized in medicine. Correspondingly many of the Enterobacteriacea are acknowledged bowel pathogens which are responsible for salmonellosis , shigellosis and pathogenic E. coli infections, for example.

However, the illness role of many bowel organisms is unclear, and there are a number of diffuse clinical syndromes associated with the overgrowth of poor lactose fermenters. The diffuse nature of the symptomatology (bloating, discomfort, indigestion, flatulence, alternating or variable bowel habits, etc.) is a problem for many orthodox physicians. These cases are often treated symptomatically, after investigations have failed to identify diagnostic endoscopic features, specific pathologies or significant histopathological change in the bowel mucosa.

Homeopathic physicians, however, are trained to seek the subtle differentiating features in the wider clinical presentations of their patients. With awareness, a good holistic history can help us to avoid the travesty of mislabelling dysbiotic patients as sufferers of 'IBS,' 'idiopathic,' or 'functional bowel syndromes.'

Careful differentiation of the GI and systemic symptoms is vital to the homeopath engaged in the process of identifying the most appropriate homeopathic treatment or whatever corollary changes are required in the diet, lifestyle and drug treatment of these patients.

Source and Nature of the Bowel Nosodes

The bowel nosodes of Bach and Paterson are largely derived from non-lactose fermenting isolates. They were subjected to bacteriological examination, including rudimentary typing on the basis of their morphology and sugar fermentation profiles. The remedies themselves are polyvalent, being derived from the stool specimens of many patients. The potencies were collated into groups according to their bacteriology. The presence of 'co' in their nomenclature denotes a 'compound' or polyvalent preparation.

Bacillus 7
Bacillus 10
Dysenteria co.
Faecalis
Gaertner
Morgan gaertner
Morgan pure
Mutabile
Proteus
Sycotic co.

Bacteriology of the Constituent Organisms

This nomenclature is now archaic in the taxonomy of microorganisms, but the names are retained to denote the remedies created from Bach and Paterson's original isolates.

From the available data we can be fairly confident that *Dysenteria co* is predominantly derived from Shigella species, that *Gaertner* is predonimantly Salmonella species, and that *Proteus* is derived from the typical swarming colonies on Edward Bach's agar dishes.

However, it is unlikely that *Morgan pure*, and *Morgan gaertner* are exclusively Morganella species. Modern bacteriological techniques indicate a number of other species that are consistent with the rudimentary fermentation profiles available to Bach and Paterson.

However, recent study evidence has emerged which indicates that Morganella morganii is the strongest bacteriological synthesizer of histamine.

This suggests that the long established clinical association between *Morgan pure* and itchy skin eruptions has a credible biological basis. It also suggests that the symptom picture of the nosode was strongly influenced by the presence of Morganella morganii in those patients from whose stools the remedy was isolated and potentized. Proteus species are also synthesisers of histamine and are similarly linked clinically to itching.

Sycotic co is a gram positive diplococcus which was morphologically compared by Bach & Paterson to Neisseria gonorrhoea, not least because it was often isolated from catarrhal patients who were deemed to typify the classical Sycotic miasm. Most texts identify *Sycotic co* as Streptococcus faecalis. Closer study, both of its materia medica description and Paterson's published papers, suggest that this is not a pure nosode. It is highly likely that the nosode is a composite of Streptococcus faecalis and Brahamalis catarrhalis, with possibly other coccal species typically found in the respiratory microflora.

The bacterial taxonomy of the other bowel nosodes is a subject of some speculation. *Bacillus no. 7* probably contains Citrobacter and Bacillus no. 10 probably contains Gardnerella. In spite of the lack of certainty surrounding the constituent organisms, these nosodes have high clinical value in modern practice because detailed accounts of both their associated symptomatology and their clinical remedy relationships have been refined through clinical experience.

Nature and Origin of the Materia medica Data for the Bowel Nosodes

In chronically ill patients, who have suffered from infection or post infective sequelae, there is a significant divergence between symptoms reported by sufferers and those that emerge from proving experiments on healthy volunteers. The time-frames in which provings were undertaken tends to favor the development of acute treatment, rather than post-acute similia.

In contrast the bowel nosodes were employed for many years in the treatment of subacute or chonic cases. We can now distinguish three broad categories of data within their 'symptom pictures'. Unfortunately a detailed account of the materia medica of the bowel nosodes is beyond the scope of this paper, but the main sources of the known prescribing data for these remedies is outlined below.

Firstly, case data, which alludes to predisposed constitutions; i.e., the kinds of people who are more likely to develop a dysfunctional relationship (dysbiosis) with a particular class of organism, or who are predisposed to chronic illness after exposure. These vulnerable types, and their behavior, correspond loosely to some of the known constitutional pictures. Consequently, a number of important clinical relationships between polychrest remedies and bowel nosodes have been established through experience and observation.

Secondly, and more objectively, dysbiotic patients have been shown to externalize specific organisms after they have been treated with an appropriate polychrest remedy (e.g., *Morgan pure* has been isolated in increased numbers from the stool of dysbiotic *Sulphur*-sensitive patients following administration of homeopathic *Sulphur* potencies.)

Thirdly, regional indicators have also been recognized for each nosode. Different nosodes have affinities for different regions, organs or body orifices. Correspondingly there tend to be different inflammatory problems that emerge with different kinds of dysbiosis. Dysbiosis at different levels of the gastrointestinal tract often indicates a regional vulnerability to over-colonization with a specific group of organisms.

In the same way that Helicobacter pylorii adversely colonizes the stomach, the gastroesophageal area and pylorus, Shigella species (*Dys-co*) appears to have an association with the pylorus, duodenum and small bowel. The nosode *Morgan gaertner* has several regional affinities, but has a particularly strong associated with the caecum. *Bacillus 10* is associated with the vagina and genital tract.

Fourthly, corollary symptoms: In the same way that there are regional dysbiotic states, there are also differences in the systemic symptoms associated with different kinds of dysbiosis. Fatigue often dominates the picture for *Bacillus-7* (Citrobacter dysbiosis), whereas bloating, gas and flatus is a common feature of *Morgan gaertner*; muscle cramps and itch are commonly found when Proteus is present; and skin eruptions are often evident when Morganella morganii (*Morgan pure, Morgan co.*) is over-represented in the large bowel.

This has some relevance to the known regional and organ affinities of certain classical remedies and contributes to awareness of clinical remedy relationships for the bowel nosodes. There are also mind-body models for the different dysbiotic states, which appear to emerge in patients with specific emotional and psychological problems.

Headline Indications for the Bowel Nosodes

The main clinical value of the bowel nosodes is in sub-acute, chronic and relapsing states. Bowel

symptoms are often present in the patients for whom these remedies are required, but in some cases these symptoms may be quite a minor part of the overall presentation, particularly when dysbiosis is predominantly in the respiratory tree, perhaps following inappropriate antibiotic treatments for catarrh or minor infections.

Most patients who require treatment with bowel nosodes have signs and symptoms of altered surface immunity: e,.g. skin eruptions, vaginitis, anal pruritis, recurrent urinary infections, balanitis, halitosis, gingivitis, mouth ulcers, coated tongue, blepharitis. Unsurprisingly, the body orifices are frequently sites of low-grade inflammation in dysbiotic patients, these sites of primary immune exposure being among the most vulnerable areas in patients who are immunologically challenged.

Identifying Dysbiosis as an Intrinsic Block to Cure

Homeopathic physicians who are engaged in the treatment of chronic cases are well advised to determine whether there is clinical evidence of dysbiosis at the first consultation. Failure to identify the key features of dysbiosis may lead to disappointing treatment responses as well-chosen remedies are often blocked in their action when dysbiosis is present.

Any combination of the following features should raise suspicion of bowel dysbiosis.

1. Recent history of infection
2. Recent history of antibiotic use (especially when there have been two or more consecutive courses of treatment using antibiotics with different antibacterial spectra).
3. "Never well since . . ." Especially when etiological events have converged with periods of stress, infection, or dietary modification. Ironically, the bowel clearance required for endoscopic examination often complicates or compounds a pre-existing dysbiosis.
4. Systemic disturbance, often of a diffuse nature. Patients complain of 'fatigue,' 'feeling unwell' or may describe feeling toxic or poisoned.
5. Gastrointestinal symptoms: particularly bloating, flatulence, discomfort and alternating or variable bowel habit.
6. Symptoms referable to body orifices, usually characterized by low-grade inflammation.
7. Failure to respond to well-chosen homeopathic stimuli, or incomplete, poorly maintained responses.
8. Insidious progression of symptoms, where investigation usually yields inconclusive results.

The Role of the GI Tract in Systemic Immunity

The bowel contains numerous patches of lymphoid tissue where monocytes continuously sample the immune status of the endothelium and its microflora. This is known as the Gut Activated Lymphatic System (GALT). When the microecology of the bowel has been damaged by stress, drugs, surgery, radiotherapy, antibiotics, or xenobiotic agents in processed food, there are negative consequences reflected in the wider immunity of the host.

Distal Fermentation and Leaky Gut Syndrome

Often the bowel becomes diffusely inflamed distally as a result of delayed fermentation by inefficient lactose-fermenting bacilli. These organisms utilize residual substrate, which is available to them due to a failure of uptake proximally by healthy lactose fermenters. The poor fermenters produce alcohols and long-chain toxins. When the bowel becomes toxically inflamed, it becomes 'leaky' and this results in systemic uptake of these substances into the portal circulation. Dysbiotic patients therefore often show derangement in their liver biochemistry and feel tired, headachy, and 'muzzy-headed' or confused as a result. The permeability of the gut can be investigated by means of a PEG-400 challenge test.

Risk-Benefit Aspects of Drug Intervention

Patients with recurrent respiratory infections, who are subjected to sequential courses of antibiotics with different spectra of activity, are very vulnerable to dysbiosis, which itself predisposes to further infections. Recent studies indicate negative consequences from the use of prophyllactic antibiotics in urinary tract infections. Conversely, other studies have shown that the use of probiotics reduces the incidence of post-operative wound infection. Recent studies have demonstrated clinical improvements in atopic eczema in children routinely using probiotics.

Probiotics help to competitively increase the proportion of healthy lactose-fermenting organisms in the stool. They do not, however, change the immune relationships that determine which adherent populations grow on the mucosa. These symbiotic communities (biofilms) can be remarkably stable and resistant to treatment, even when their constituent microflora is damaging to the host organism.

A Model for the Action of Bowel Nosodes

It is postulated that a well-chosen bowel nosode will act to alter the host's surface recognition of

unhealthy microbial communities. Bach and Paterson observed an increase in the number of non-lactose fermenting organisms in the stool following successful treatment. It is possible that the nosode somehow changes the surface adherency of the unhealthy groups and effectively stimulates the host to eliminate them from biofilms, which line the lumen of the bowel. This may help to explain the observed paradox that treated patients start to feel better despite an observed increase in the relative proportion of illness-associated organisms in the biomass of their stools in the early weeks of treatment.

The Systems Nature of Subacute Infective Sequelae

The bowel nosode *Sycotic-co* can be particularly helpful in cycles of respiratory re-infection; typically associated with constant residual catarrh. Troublesome catarrh is often reported by patients between acute infective episodes. Some cases of secretory otitis media also respond beautifully to *Sycotic-co*. Improved responses to more traditional polychrest remedies (e.g., *Calcarea silicata, Pulsatilla, Kali muriatica*, etc). are also observed after the use of the nosode.

Dysbiosis and Allergy

Some ENT patients who are particularly refractory to treatment have evidence both of respiratory dysbiosis and an incipient sensitivity to an inhaled allergen. Carefully timed prescriptions, where isopathic treatment is alternated with *Sycotic-co*, can sometimes lead to a break-through in the treatment of these patients.

It is possible that secondary immunological disturbances arising from bowel/respiratory dysbiosis is a contributory factor in the onset of allergies in adulthood. The bowel nosodes *Dys-co* and *Sycotic-co* are both useful in some cases of hayfever and dust mite sensitivity.

Timing and Sequencing

In homœopathic teaching and practice there is a great deal of time dedicated to the identification of an appropriate remedy. There are many more texts in our homeopathic libraries which discuss the issue of remedy selection, than texts which address the methodological issues of remedy timing and sequence. Even less is written about the blocks to cure or perpetuating causes for illness. Perhaps it is assumed, by practitioners and teachers, that these elements are self-evident from the case history. These methodological aspects are best discussed in the context of clinical case studies. The optimal timing for treatment is discussed at length in the 'Systems and Symbiosis' seminar (see the full page announcement at the beginning of the Journal).

Bowel Nosodes and the Repertory

The leading symptoms associated with bowel dysbiosis can rarely be classed as 'strange' or 'peculiar.' So bowel nosodes are not usually 'jumped to' on the basis of a single strong feature in the case. A variety of inductive methods (based on the context) are required. It may also be necessary to undertake more than one form of analysis using the available clinical data.

The data for the remedies themselves is largely derived from clinical case studies. The priorities of Bach and Paterson were, as far as possible, to establish a scientific basis for the selection of bowel nosodes. Whether it was this priority or a general lack of keynotes in what was a chronic and often debilitated patient sub-population, we find that 'leading symptoms' for the bowel nosodes are in short supply. The remedies themselves cannot all be said to have undergone a standard proving, although careful clinical observation and stool culture data lends some objectivity to Paterson's case series.

Most modern repertories have imported the bowel nosodes into their rubrics, but no one appears to have marked up the rubric entries as they are clinically verified, in spite of the considerable number of cases that have appeared in the journal literature over the last fifty years. As a result, these medicines have almost never been elevated above 'normal type' in the standard repertories of the present day.

This low-key representation, together with the small overall number of symptoms, means that these nosodes almost never turn up in a totality analysis. 'Broad sweep' repertorizations, which analyze only large headline rubrics, do not bring them out. Expert systems and family group searches often fail to show them up, even in those patient analyses where they are clearly indicated and ultimately shown to be effective.

Given the poor representation of the nosodes in the general repertory, it may be wise to undertake two separate analyses in those cases where the bowel nosodes are clearly indicated. In one analysis the clinician would use the traditional methodology (whether it be totality, thematic, pathological or synthetic) in order to identify the range of potential 'classical' similia. In the other analysis, one would use a specialized bowel nosode repertory to assess which nosode is most likely to address the systems disturbances relating to the patient's dysbiosis. One might also use the results of the

classical analysis to weight the search in favor of known remedy-nosode relationships.

As one becomes more familiar with the nosodes and their related medicines, these two repertorizations will inform one another. So, for example, if a 'traditional' analysis yields *Phosphorus, Silica* or their salts, one will probably use the nosodes analysis to assess whether *Gaertner* is indicated. With experience these empirical relationships can be employed to good effect, using the remedies sequentially to 'unblock' the case or augment the effect of each other.

quite carefully and read a materia medica account of the remedy.

The table below gives an indication of the case data attributed to each remedy, from the two main sources of clinical data in the CIMT repertory. Note that *Dys-co* was extensively used by Thomas Dishington. Since we have no knowledge of his case numbers, it is not possible to assess their influence on the data finally collated by Elizabeth Paterson. A wider survey of cases by other experienced users, like Griggs, has not yet been carried out or integrated into the data.

Nosode	John & Elizabeth Paterson number of cases	Russell Malcolm number of cases	Totals	Percentage of case literature
Bacillus 7	9	7	16	4 %
Bacillus 10	5	4	9	2 %
Dys-co.	14	12	26	6 %
Faecalis	0	3	3	< 1%
Gaertner	11	5	16	4 %
Morgan-co.	0	3	3	< 1%
Morgan gaertner	69	8	77	18%
Morgan pure	156	10	166	40%
Mutabile	0	4	4	<1%
Proteus	13	5	18	4%
Sycotic co	53	27	80	19%
TOTALS	330	88	418	100%

The repertory prepared by the Centre for Integrative Medical Training conforms to the search-word and chapter conventions of modern clinical repertories (based on *Kent's General Repertory*). Because the listings are short, it takes only a few minutes to do a hand repertorization of the nosodes.

Unless one is very clear that an uncommon symptom is unique to a remedy, one would be wise to keep the analysis general and favor the head rubrics. The more unusual the feature, the more likely that the data is derived from a single case study, and potentially, with experience, the same symptom could arise from time to time in patients who are sensitive to a different nosode. It is therefore inadvisable to use small rubrics to exclude remedies. Use them only to lend support. Nosodes which do not appear in the listing for a common feature are easier to exclude.

Be aware that 'small' nosodes like *Bacillus -10, Faecalis* and *Mutabile* are severely under-represented, even in a specialized bowel nosode repertory. They have been used very rarely and have therefore generated much less data than their counterparts. If an analysis throws up three points of contact with *Bacillus-10*, as opposed to six for Morgan pure, one should consider *Bacillus-10*

Comment

In the absence of holism, diagnostic labels usually lead to protocol-driven treatments. A treatment determined by protocol is usually 'evidence-constrained.' Institutionalized medicine also insulates the practitioner from a certain level of accountability because, in doing 'the right thing' or prescribing 'by the book,' many practitioners can cling to a moral 'high ground,' even when they are faced with therapeutic failure or emergent iatrogenic illness. The case literature strongly suggests that bowel dysbiosis frequently has an iatrogenic component. It is then under-diagnosed in orthodox hospital medicine due to the non-specific nature of its symptomatology and presentation.

Homeopaths may cling to a different comfort zone -- that of the elusive similimum. They can also become institutionalized into rejecting flexible prescribing methods, in favor of a quest for one ideal similimum. Indeed, entire schools have been founded on claims that a new algorhythm, index, or group matrix can provide new levels of certainty in our remedy choices. Patients with organic illness, however, deserve not only an oblique or creative search for a similimum, but also a search for sound rational medical etiologies and the main obstacles to cure in their particular case.

Awareness of bowel dysbiosis can encourage early prescribing of an appropriate nosode. This significantly improves the outcome of more traditional treatments used subsequently.

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