Hiccoughs and Hering's Law

by Paul Herscu

Seven years ago I had the opportunity to treat an eleven year old girl. She had unceasing hiccoughs for five weeks(3). She had been treated by several doctors, been hospitalized, taken sedatives and antacids and changed her diet, all to no avail. The hiccoughs came in paroxysms (3), were aggravated by laughter (3), eating (2) and especially cold air (3). She would be well at home but on her way to school, when she walked in the cold December air, she would begin to hiccough unendingly (3). The hiccoughs were painful and after several paroxysms would cause burning (2) in her throat. During an hour long interview and careful questioning, no aetiology could be uncovered. A complete history elicited the following. She complained of chronic headaches (2) twice a week, occurring after school. She was nearsighted (2) and wore soft contact lenses. Perhaps her headaches were connected to her vision, her mother offered. She developed recurrent ulcers in her mouth, accompanied by red pimples inside her lips and gums. The tip of the tongue was red. She loved chocolate, cheese, cold pop and bacon. She hated fat and meats. Her stools were normal. She has had frequent bladder infections in the summer (2). It was difficult for her to fall asleep at night, her mind was actively thinking about all sorts of things (2). She preferred to sleep on her back or right side and ground her teeth at night. She awoke refreshed.

The only thing that her parents mentioned about her behavior was she was 'kind of jumpy.' She could not sit still for very long. She had to interrupt her piano lessons by doing other chores before she could finish her practice. She was a very nice, jovial girl who watched me with reserved eyes as if to judge if I approved of her responses.This was a thin, blonde girl with blue eyes and red lips. She had restless legs in the office and sat close to her mother. She had beautiful freckles all over her face. She was very neat in hygiene and choice of clothing.

How should we analyze such a case? Relevant rubrics in Kent's *Repertory* under Stomach; hiccoughs, reveal remedies such as *Hyoscyamus, Zincum*, and other assorted rather small remedies. Clearly, the hiccough section of Kent's *Repertory* is not close to being complete. In my repertory, for instance, I have added many remedies to the main rubrics and have also added a few new rubrics, such as: Stomach; hiccoughs in infants. This is a very common complaint found in paediatric practice and yet there was no rubric for it. So this section of the repertory is not very helpful for analyzing this case. One is supposed to match the symptoms of the illness to the symptoms of the remedy. However, if the case is carefully taken, many symptoms will be elicited. A hundred symptoms may come from the healthiest of us, so the list of symptoms of an unhealthy person can reach unfathomable length. Which of these symptoms do we choose? I have found in order for me to find the remedy, I need to both elicit and analyze the case in a certain fashion. As I receive the case, I divide it mentally into two parts; the chief complaint and everything else.

I try to elicit information to find a remedy for the chief complaint. If it seems as though I will not have enough information upon which to prescribe, I quickly forsake this part of the case as I know there will not be a remedy found there. Instead, I concentrate on the rest of the person. What I ask myself is, 'What would I give this person if they didn't have hic-

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coughs, psoriasis, arthritis, headaches or any other chief complaint?' I decide to abandon prescribing upon the chief complaint for any of the following reasons: there are not enough symptoms, the illness is poorly represented in our texts and repertories, the symptoms are too new, the patient is too unobservant, the symptoms are too erratic, and other similar reasons. What is needed for this leap away from the chief complaint is a good working knowledge of the materia medica and the repertories.

Having made that departure I begin to focus on the rest of the case where a remedy will always make itself known. Now another crucial step. Once I have found a remedy, I go back to the first portion of the case. Can I confirm the remedy with some of the important symptoms of the chief complaint? To reiterate, in the beginning, I ask a small handful of questions about the chief complaint. If nothing glares back at me, I skip this part and find a remedy making believe the chief complaint did not exist. Once the remedy is selected, I go back and see if this remedy covers the chief complaint. Most often it is easy and timesaving to go about it in this order as the remedy found will many times cover the chief complaint. The broadstrokes of the painting are laid down first and only the fine brushstrokes are left. The trunk is painted before the leaves, making my job much easier. This method offers me another advantage. Once I know what the remedy is, I hold it up against the chief complaint. If I find glaring discrepancies in modalities or specific symptoms, which I often do, I try to find a different remedy using those contrasting symptoms as keynotes. I will often give that remedy to open the case. I use this as a routine method, one of several methods, during the interview. As such, it helps me direct the case taking in the direction that will lead to the correct remedy. This type of homœopathy is what the *Organon* and Kent's text on philosophy is all about: follow where the energy of the organism takes you. Sometimes this means treating the whole person, sometimes only a part of the person. The road signs are put up by the patient, not the doctor. Reality first, philosophical teachings second.

For the case in point, the illness is poorly represented in our Repertory. The overall case, sans hiccoughs pointed to *Phosphorus*. If one looked at the symptoms of the hiccoughs in a more general sense, the symptoms of the hiccoughs also fit *Phosphorus*, being aggravated by the cold air, by excitement, by going to school, and the hiccoughs caused burning pain in her throat. That these symptoms are general symptoms of *Phosphorus*, further confirm the remedy.

Now it was my turn to ask direct questions in the case taking. To take a case well is intimately connected with knowledge of materia medica and the repertories. One does not know what one should ask at the beginning of study. As one fills out a personal knowledge of the old texts, case taking becomes straightforward. When asked specifically, it was elicited that she could not lie or sleep on her left side. She walked in her sleep. She hated eggs. She said whenever she watched scary movies she experienced nightmares afterward. She had a fear of spiders, of other insects, of being alone and of thunderstorms. During thunderstorms she would put the covers over her head and try to hide. She also feared monsters. These symptoms were all denied the first time asked. All these symptoms produce a clear *Phosphorus* picture but I first had to go through the process mentioned above to become confident of the remedy before going back and asking again.

Another point that was interesting in this case is that she had developed these intense hiccoughs all of a sudden for no apparent reason. How do we and should we account for that? In my clinical judgement and personal philosophy, I have come to believe that there is no such thing as a sudden onset of illness such as this; onset without cause. Since I could not find a reason, even though I searched for one, I gave *Phosphorus* 6c, four times daily and asked her to return in one month. I did not wish to severely aggravate the cause of this illness and so gave a low potency. I saw the child one month later. The follow-up was quite enlightening. The father said the hiccoughs left very quickly the same day she started taking the *Phosphorus*. He also said,

"The strangest thing happened. Just as soon as the hiccoughs went away, her rash came back."

"What rash?"

said I. Well, it seemed what the whole family forgot to mention at the last visit (even though I pleaded with them to confess a hidden aetiology) is the girl had had an eruption on her arm, back and hips. The lesions were flat patches which did not change for over two months. They itched and discharged a serous fluid. After a few weeks of home treatment, they went to their physician who, thinking it fungal, gave her an antifungal ointment. She tried it without success. They went back to their physician, who gave topical steroids. That worked beautifully!! The patches quickly disappeared but just as soon, the hiccoughs began. So the mystery was finally solved!

This is a clear example of Hering's Law. The illness was expressed on the skin, and was treated. It disappeared only to bring forth an illness on a deeper level, this time the hiccoughing, which is closer to a nervous system illness, totally disrupting her life. Treated properly, the rash came back and the hiccoughs left. The rash continued to grow and then finally started to disappear. The last patch to disappear was the first patch to appear. The girl was quite well in all her other complaints as well.

What was amusing about the case is that, even upon careful questioning, one could not elicit this history. This is quite common in chronic illnesses where after treating someone for months or years they return to say, ***continued on page 73***