

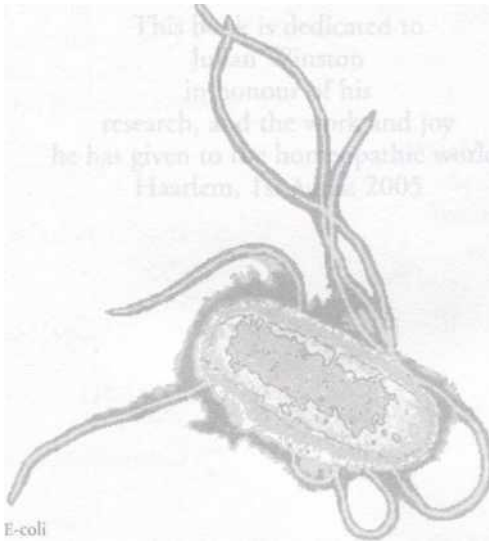
Monera

Kingdom Bacteria & Viruses

Spectrum Materia Medica

Volume 1

Frans Vermeulen



It is like that one bit of evidence.
It's there, it might be the key to the whole case.
You just have to think a little differently to find it.
Jeffery Deaver, The Vanished Man

Emryss Publishers

Dedication

This book is dedicated to
Julian Winston
in honour of his
research, and the work and joy
he has given to the homeopathic world.
Haarlem, 1st August 2005

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NAMING OF PARTS

Orderly systems

Aristotle made in the 4th century BC one of the first attempts to classify living things according to a scientific and orderly system. He made a division into two groups: plants and animals. Depending on their way of locomotion, the animals were placed in three subgroups: flyers, swimmers, and walkers. Fish, sea snake and dolphin consequently fell in the category of swimmers, whilst butterfly, bee, bat and bird were included in the group that flew.

For almost 2000 years Aristotle's division satisfied biologists, until by the 17th century systems were introduced that classified living organisms according to similarities in form and structure, including internal anatomy and external appearance.

Although organisms were now placed in more meaningful groups, the division as either plants or animals was maintained. The 18th-century Swedish scientist Carl von Linné devoted his life to improving the two-tier system taxonomically. He introduced the binominal or Linnaean nomenclature, in which all known living organisms are given a formal scientific *double* name in Latin. First comes the generic and then the specific name.

Flowering plant families vary widely in their contents, as do fungal and other families. Some contain only a single genus and species [monotypic], whereas others contain hundreds of genera and thousands of species [polytypic]. Only recently, around the middle of the 20th century, more consequent divisions of living organisms were proposed and accepted, so that now five kingdoms exist, although some taxonomists have come up with no less than 22 kingdoms.

Homeopathy appears to carry on in the Aristotelean tradition. By and large two groups of living organisms are recognized - plants and animals. Fungi are looked upon as plants without chlorophyll while the Monera kingdom is placed somewhere on the sideline; a few are semi-synthetic antibiotic drugs, the others are disease products called 'nosodes'.

Also regarding drug names and abbreviations homeopathy lives in pre-Linnaean times. It may be argued that homeopathy has its own systematics, namely a classification according to similarities between drug pictures. True, but for this to work, drug pictures must be absolutely reliable and more or less complete. Such an argument moreover tends to ignore or trivialize the connection between the nature [disposition] of [living] organisms and the signs and symptoms associated with them.

Cross-connections between drugs of different origins, eg a plant and an ani

mal, are a good thing, yet become even better when they are supported by more than symptoms only. Substances, animate or inanimate, are the alpha and omega of the homeopathic materia medica and their interconnections therefore define the relationships between symptom pictures. In my opinion, there is no better way to arrange the materia medica than including the nature of the substances/organisms that serve as its sources.

Classification in homeopathy

Homeopathy has adopted some sort of classification system in order to recognize the similarities between the different remedies and to categorize their common characteristics into larger units. With his *Clinical Materia Medica*, Ernest A. Farrington [1847-1885] was the first to arrange drug pictures according to taxonomic groups. Farrington's basic units are what he calls "orders," which actually are families. Currently many homeopaths favour the use of groupings on the level of so-called *families*. Classifications such as "snake family", "spider family", "crustaceans family", etc., are formally inaccurate since these groupings concern a suborder [snakes], an order [spiders] and a class [crustaceans], respectively.

We have to deal with considerable problems, not in the last place because we rely on a materia medica, parts of which are clearly past their expiry dates. Another problem is the frequently obsolete nomenclature and taxonomy. How can we connect with other fields of science when we don't even speak the same language? And what if we want to extend our search for information and use an invalid name?

The kingdoms

Attempts have been made in homeopathy to simplify matters by using three kingdoms: animals, plants, minerals. This system needs revision for the simple reason that today the generally accepted classification system comprises five kingdoms, or six if we regard minerals as living organisms: Monera, Protista, Fungi, Plantae, Animalia, and Mineralia.

Bacteria are placed in the Monera kingdom: unicellular organisms whose hereditary material is not enclosed in a nucleus. The kingdom Protista contains a large group of unicellular nucleated organisms. These organisms are on the borderline between plants and animals, and include unicellular algae, downy moulds, dinoflagellates, amoebae, trichomonads and sporozoans [eg, Plasmodium, which causes malaria]. While some are capable of animal-like movement [protozoans], others have distinctly plant-like characteristics [protophyta or chromista].

Fungi in homeopathy are placed in the kingdom Plantae, a division that not only is outdated but also prevents our perceiving them in their own right, with their specific characteristics, which are fundamentally different from those of other kingdoms.

Systems are artificial and for none of the kingdoms a consistent system of classification exists. Although currently the five kingdom classification stands, revisions are underway to better reflect diversity and evolutionary relationships. The proposed revisions split the Monera into two kingdoms [Archaeobacteria and Eubacteria] and the Protista into three distinct kingdoms.

The necessity of classification and categorisation

Species can be defined as a group of individuals having common characteristics, while a genus consists of a collection of similar and/or closely related species. The basic units of classification, the species, are grouped into higher or more-inclusive units: above the genus comes the family, then the order, then the class and finally the phylum [also called division].

There are many subdivisions: species are subdivided in subspecies or varieties; families in subfamilies, subfamilies in tribes, tribes in subtribes; classes in subclasses; and phylla in subphylla [or subdivisions]. Cultivated [plant] varieties are known as cultivars. The category “superorder” is placed between the taxonomic categories order and subclass or class.

The higher the rank, the larger the number of species contained and consequently the more general and less specific the distinctive features. This can be employed in a similar fashion in case analysis. Starting at the top we first try to decide for the larger unit - snake, spider, fungus, mineral, metal, etc. - and then work our way downward, fine-tuning our choice. Or we begin at the level of the species - a certain remedy - and refine our selection by differentiating *within* the larger unit of which the species is part.

Homeopathic remedy abbreviations

The current abbreviation system in homeopathy doesn't follow clear rules. Its ambiguity lies in the fact that remedy names, and thus their abbreviations, sometimes refer to a genus, eg Hyoscyamus or Conium, and at other times to a species, eg Dulcamara or Abrotanum. A more consistent approach would be to use the Latin binominals of *organisms* instead of drug names. This always gives first the generic and then the specific name, thereby revealing relationships between remedies on the generic level. If the abbreviation for, say, Stramonium would be in line with the binominal system, it would show right away its alliance with other Datura species. It would be good

practice to extend abbreviations now solely indicating the genus, eg Lycopodium or Arnica, with the specific name, thus: Lyc-c. [Lycopodium clavatum] and Arn-m. [Arnica montana], in order to allow future inclusion of other members of such genera. Single names referring to a species, such as Absin. or Bell., can be placed as an extension behind the generic name, preserving the traditional abbreviation: Art-absin. [Artemisia absinthium] and Atro-bell. [Atropa belladonna]. In certain instances the link between a plant and its main alkaloid can then be observed as well: Atropa belladonna and Atropinum. The additional plus-point of such a system, namely the possibility of recognizing themes and patterns of naturally related remedies within repertory rubrics, may serve as a compensation for the trouble of getting accustomed to new names and abbreviations.

Why more remedies?

According to some there is no need for more homeopathic remedies. The polychrests are supposedly good for a 70-80 percentage of cured cases, with a handful of small remedies to fill the gaps. As much self-confirming as self-assuring, this philosophy is in contradiction with the major asset of homeopathy: individualisation. Individualisation works both ways: it is required in each case and it is the cornerstone for self-development of the homeopath. To keep on enlarging established drug pictures works as a self-fulfilling prophesy: the more symptoms are added to a remedy the more often it will be encountered in the repertories, resulting in its being prescribed more frequently, leading to more repertory additions, and so on.

Aside from the concept of polychrests as conflicting with the essence of homeopathy, polychrests derive much of their apparent identity from containing symptoms and indications common to the *larger unit* of which they are a member. For example, a large portion of the Lachesis symptoms are *snake symptoms* rather than individual symptoms typical for the particular species Lachesis muta. The species with the longest use as a homeopathic remedy, or when it is the sole representative of a group, therefore automatically will have most symptoms, due to additions from clinical cases, resulting in its being elevated to polychrest status. Only a proportionally small part of a given number of symptoms will be, by definition, species-related, while the rest is common to the genus, family or an even larger unit.

More remedies, provided their introduction follows some logic, will allow homeopathy to further develop its main contribution to health care: treatment of individuals.

Without going outside, you may know the whole world...

Bacterial benefits

Monera are bacteria. They play a minor role in homeopathy. They have no place as a group and their symptom pictures are often obscure. The current trend of facilitating the selection of remedies on the basis of their place in the natural kingdoms, not only ignores the fungi as a distinct unit, but also the micro-organisms. There are some 80 bacteria listed in the remedy abbreviation list. Some of them are symptomless, whereas a few others have thousands of symptoms.

Bacterial remedies fall into three categories:

- allopathic drugs synthesized from bacterial metabolites;
- normal commensals of the microbial flora;
- species associated with bacterial diseases.

The latter category contains the major nosodes: Medorrhinum, Syphilinum, and Tuberculinum. Psorinum can be included or excluded, depending on one's view. [*See Penicillium, Spectrum Vol. 2*].

A step forward in realising the importance of micro-organisms might be the recent introduction of new "miasms" in addition to the traditional quartet. However, these new miasms mainly serve as categorisation models and hardly pay attention to the micro-organisms associated with them.

The better we learn to know a person, the better we understand him or her. So it is with any other living organism. Learning to know a bacterium, or a virus for that matter, seems less appealing than getting acquainted with animals, plants, or stones. We may feel attracted to flowers, trees, animals, gemstones, metals, but we quickly develop a disliking, or even fear or repulsion for micro-organisms. Bugs bug us; we have bad names for them: germs, creeps, parasites, pathogens, in short: disposable creatures. Flowers have powers, animals have spirits, stones are healers, but bacteria and viruses are "killers." Animals we domesticate, plants we cultivate, bacteria we exterminate. What we cannot see with the naked eye, we tend to discount. With a generous dash of humour, Robert Buckman, a Canadian professor of medicine, succeeds in putting words to what there is to see:

"If the numbers of species on Planet Earth are staggering, the numbers on or in Planet Human are hardly less so. For example, the body space of an average adult human being comprises approximately 100 trillion cells - that is one hundred million separate units of living matter. This is a fairly impressive number. Even more impressive, however, is the fact that of those 100 trillion cells inside the average human frame, only 10 trillion are human

cells. The other 90 trillion cells are bacteria [with a few other parasites, fungi, and miscellaneous riff-raff thrown in for good measure]. Inside our own bodies we are outnumbered by other species nine to one. Fortunately, the human body is not a democracy, so even though our bodily bacteria do influence our workings in many ways, they don't have a vote. They therefore cannot decide - on their own - to throw us out entirely [although on occasions they can cause a variety of expulsions and upsets and ultimately, if one cares to think of it that way, they can cause revolution, dissolution, and redistribution]. Yet, even accepting that some species have the potential for doing us considerable harm, we can perhaps afford to be a little fairer to many of the other less threatening species with whom we share our body [and, in some cases, our planet].

Not everything that is non-human is necessarily bad for us. The mood of recent times has been to regard every non-human species in or on our bodies as untrustworthy and threatening. This is undoubtedly true of some species: there is no such thing as a friendly smallpox virus, and you cannot domesticate a malarial parasite and have it come when you call it."

Hubris versus humus

Bacteria are of major importance to Mother Earth. "An uncharted world of bacteria and other micro-organisms exists in and on the bodies of larger organisms," Edward Wilson has written. Some of the species are neutral guests, neither harming nor helping their hosts; others assist their hosts in digestion, excretion, and even the production of light. Although the vast majority of bacterial types remain unknown, bacteria are perceived as relatively well known because they are so important in medicine and ecology. When in the 1920s the idea was proposed that cell components, eg, mitochondria, originated as symbiotic bacteria, it was roundly rejected and ridiculed. Bacteria were agents of disease, dangerous pests, troublemakers, lying in wait to inflict harm on us. Spirochetes were transmitters of venereal disease, not the originators of motility and as such of the sperm tails of men. Bacteria had no place in the context of life's evolution.

In his Foreword to *Microcosmos*, an intriguing tale of microbial evolution by Lynn Margulis and Dorion Sagan, Lewis Thomas brings the entire affair into the open. He writes: "The biosphere is all of a piece, an immense, integrated living system, an organism. ... We used to believe that we arrived *de novo*, set in place by the Management, maybe not yet dressed but ready anyway to name all the animals. ... Most of us would prefer, given the choice, to track our species back to pure lines of kings and queens, stopping there and look

ing no further. But now look at our dilemma. The first of us, the very first of our line, appeared sometime around 3.5 billion years ago, a single bacterial cell, the Ur-ancestor of all the life to come. We go back to *it*, of all things. Moreover, for all our elegance and eloquence as a species, for all our massive frontal lobes, for all our music, we have not progressed all that far from our microbial forebears. They are still with us, part of us. Or, put it another way, we are part of them. ... [Over a] 2.5 billion year stretch of time... our microbial ancestors, all by themselves, laid out most of the rules and regulations for interliving, habits we humans should be studying now for clues to our own survival. ... Perhaps we have had a shared hunch about our real origin longer than we think. It is there like a linguistic fossil, buried in the ancient root from which we take our species' name. The word for earth, at the beginning of the Indoeuropean language thousands of years ago was *dhghem*. From this word, meaning simply *earth* came our word *humus*, the handiwork of soil bacteria. Also, to teach us the lesson, *humble*, *human*, and *humane*. There is the outline of a philological parable here. ...”

Nosodes and vaccines

Regarding nosodes and vaccines, invaluable work was done by the late French homeopathic physician O.A. Julian. Why French homeopathy in general appears to be favourably disposed towards the use of nosodes is an interesting question. To a lesser extent the same holds true for German homeopathy. Here is a little history.

The French, with Louis Pasteur as their champion, have done much to promote the germ theory of disease. [A role played in Germany by Koch, amongst others.] Convinced that micro-organisms are responsible for disease, Pasteur succeeded in persuading the medical community that only particular organisms can produce specific conditions and that once those organisms were known, prevention would be possible by developing vaccines. To understand how influential the French have been, we only have to look at the number of micro-organisms or vaccines named after French researchers working at one time at the Pasteur Institute in Paris, eg, Bordet, Yersin, Calmette, Borrel, and Pasteur himself. It should therefore not come as a surprise that French homeopaths, eg, Cartier, Vannier, Fortier-Bernoville, Sevaux, and particularly Julian, have introduced into homeopathy a fair amount of remedies derived from either micro-organisms or vaccines. Contrary to Pasteur's coming through in scientific circles with flying colours, the homeopathic community has barely taken notice of the French contributions.

Germs as the cause of trouble might not agree with Hahnemann's concept of an invisible spiritual [dynamic] force capable of affecting and being affected by similar forces, making microbes the result instead of the cause. It nevertheless doesn't take away practical considerations as to the employment of such remedies. Disregarding such established ones as Psorinum, Medorrhinum and Syphilinum, the use of any other nosode in homeopathy is more or less tantamount to being a last resort. If used at all, their use seems to be confined to desperate cases, blocked cases, relapsing cases; no or insufficient activity of apparently well-selected remedies, or malignancies. Might this not just be a reflection of the difficulties in giving "microbial" remedies a place? Accepting remedies from the microbial kingdom would seem to amount to accepting the germ theory as the cause of disease. Yet, irrespective of whether we believe microbes to be cause or result, homeopathy is based on similarity of phenomena.

Over time the established nosodes have grown into recognisable drug pictures for the simple reason that they have been used. Successful cases have been passed on and have helped to flesh out a better picture. Creativity and courage constitute homeopathy's essential requisites. To be able to prescribe we need something on which to base the prescription. Some of the presented microbial remedies are, admittedly, still in their infancy, perhaps never to mature, whilst others have enough individual elements to enable recognition, provided we study them closely. As with photographs, drug pictures also may be enlarged and refined. The sharpness or completeness of a picture depends as much on our focus as on the object.

The dose makes the poison

Paracelsus argued that the right dose differentiates a poison and a remedy, which is now known as the dose-response relationship, the Arndt-Schulz Law, a major concept of toxicology. To this Paracelsian axiom homeopathy has added its two main concepts: susceptibility and analogy. Assuming that the difference between a virulent poison and a great remedy also lies in the combination of dose, susceptibility and similarity, it would seem unfortunate that certain biological agents have such a minor place in homeopathy. For example, the deep impact of the Black Death, with *Yersinia pestis* as its biological agent, has "thrust this dread disease into the collective memory of western civilisation," as one author aptly put it. Terror-stricken societies sought to diffuse the threat by either trying to appease the God who perceivedly had brought the plague upon them or by attempting to create a common bond of union among human beings. It would be a mistake to dis

regard plague because it occurred in medieval times and evoked what we now would consider superstitious reactions, if not mass hysteria. On the basis of analogy, plague represents as much as it causes. Being derived from 'plaga', Latin for 'strike' or 'blow,' plague stands for being stricken, terror-stricken, panic-stricken, stricken by a wrathful God, by war, by famine, by terrorists. It has played a role in many military campaigns: it befell armies of antiquity [Frederick the Great's as well as Napoleon's troops] and military traffic through Asia brought plague in its trail. The possible use of biological agents as vehicles for terrorism has recently induced considerable fear and alertness in western societies. Amongst such agents are plague, anthrax, brucellosis, smallpox and botulism. Aside from bringing up traumatic memories, and while not suggesting that terror is unique to plague, plague lives in the human collective subconsciousness as a miasmatic stain, which in remedy form, it might help to allay.

Many questions, different answers

Harry van der Zee wrote in the Editorial to *Homeopathic Links* 4/01: "Let us suppose that our appreciation of what we and our patients experience in life is indeed, most of the time, determined by a limited perception. Suppose that all those influences that we label as bad are indeed part of a perfect harmony. What then should our attitude be towards them? In general as a method of healing, homeopathy already provides an answer to this question. We are not out there killing the microbes, but rather helping our patients to live in better harmony, both with themselves and also with their surroundings, including the world of micro-organisms. ...

In daily homeopathic practice, there are nevertheless still a lot of issues concerning infectious disease that deserve thought, experiment and discussion. ... How to deal with vaccinations, and with their effects? Do we have an alternative to them? What is the role of nosodes in homeopathic practice? What is there to know about lesser-known nosodes? Is there room for isopathy in classical homeopathy? How to understand and deal with the miasms? ... Considering the rich diversity of our profession I'm sure many have come to different answers. Let's share them, put them together, and see whether there is music in the totality of all these individual notes."

Building blocks

Will there ever come a time that we speak of a Staphylococcus-type, a Pestinum-personality, Salmonella-cravings, or Dysentery-characteristics? Realising our attitude towards micro-organisms helps us to understand our

vision of them as potential remedies.

By a great deal of collecting, some connecting and a little bit of correcting I have attempted to bring together building blocks in order to start constructing a materia medica worthwhile focussing upon. I have followed H.C. Allens advice that “to a proving of Anthracinum must be added all the symptoms of uncomplicated splenic fever; to those of Hydrophobinum [Lyssinum], the symptoms of every case of pure hydrophobia [rabies]; to those of Syphilinum all those of pure syphilis, etc., etc.”

If, as Hering says, “the symptoms of the snake-bite and from the bee-sting have been proved to be useful in numerous cases,” why not also the symptoms induced by Streptococcus, Clostridium, Brucella, Leptospira, etc.?

And if, as Wills has it, “cholera [is] an involuntary experiment on a very large scale,” would then the numerous other “involuntary experiments” not at least furnish outlines of symptom pictures, in a similar fashion, albeit more crude, as provings do?

The first to manufacture and prove Medorrhinum and Syphilinum, Swan was of the same opinion as Wills: “Morbillinum, Scarlatinum, Variolinum” [and the rest] “are the fullest proved poisons in existence; they have been proven for hundreds of years by tens of thousands of persons, old and young, male and female. Here we have the provings ready made by nature for us on healthy persons. Collate the symptoms ... and you have the pathogenetic effect of that poison, and when you have such in the sick, administer the potentized and you will cure the effects of that poison.”

In the Preface to his book *Rats, Lice and History*, Zinsser makes the striking observation that, “In following infectious diseases about the world, one ends by regarding them as biological individuals which have lived through centuries, ... having existences which, in their developments and wanderings, can be treated biographically.”

Humans have their personal histories, so have biological individuals. Hopefully both educative and entertaining, the following is an attempt to unravel parts of such biographies.

Bacterial nomenclature

The naming of bacteria is controlled by the International Code of Nomenclature of Bacteria. Since 1 January 1980, priority of bacterial names is based upon the *Approved Lists of Bacterial Names* [Skerman et al., 1980], The names of the bacteria in Spectrum are in accordance with the Approved List, with the exception of the species without author citations. The latter names, often old synonyms, are without valid publications and therefore have no official standing in bacterial nomenclature.

Acknowledgements

I have included clinical cases, old and new, from homeopathic literature, for which Reference Works and Encyclopaedia Homeopathica have been indispensable and for which I am indebted to colleagues granting me permission to use their cases.

The reasons for including cases are manifold: they are illustrative, show various approaches in case analysis and remedy selection, demonstrate the value of locals and disease history, reveal that everyone struggles, prove that dedication and determination go a long way, clarify that polychrests are no panaceas, and above all, highlight the wonders of homeopathy.

Many thanks to everyone for helping collecting data, for proof-reading, correcting and translating, for being patient, for making difficult subjects lighter to digest and easy ones more complicated, for offering opinions, for explaining national or local customs, for reading the introduction, to Maud and Claire for being Maud and Claire.

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Frans Vermeulen, Molkom, Sweden, 24 April, 2005.

CLASSIFICATION KINGDOM: MONERA
[BACTERIA]

SUBKINGDOM EUBACTERIA

DIVISION GRACILICUTES
[Gram-negative bacteria]

PHYLUM PROTEOBACTERIA

Group Alpha Proteobacteria

ORDER Rhizobiales
FAMILY Brucellaceae
GENUS *Brucella*
SPECIES: *B. melitensis*

ORDER Rhodospirillales
FAMILY Acetobacteriaceae
GENUS *Acetobacter*
SPECIES: *A. xylinus* [Kombucha]

ORDER Rickettsiales
FAMILY Rickettsiaceae
GENUS *Rickettsia*
SPECIES: *R. prowazekii* [Typhus nosode]

Group Beta Proteobacteria

ORDER Burkholderiales
FAMILY Alcaligenaceae
GENUS *Alcaligenes*
SPECIES: *A. faecalis* [bowel nosode Faecalis]

GENUS *Bordetella*
SPECIES: *B. pertussis* [Pertussinum]

FAMILY Burkholderiaceae

GENUS *Burkholderia*

SPECIES: *B. mallei* [Hippozaeninum]

ORDER Neisseriales

FAMILY Neisseriaceae

GENUS *Neisseria*

SPECIES: *N. gonorrhoeae* [Medorrhinum]

N. meningitidis [Meningococcinum]

N. subflava [Flavus]

N. mucosa [bowel nosode Sycotic Co.]

Group Gamma Proteobacteria

ORDER Enterobacteriales

FAMILY Enterobacteriaceae

GENUS *Citrobacter*

SPECIES: *C. freundii* [bowel nosode Bacillus No. 7]

GENUS *Enterobacter*

SPECIES: *E. cloacae*, [bowel nosode Bacillus No. 7]

GENUS *Escherichia*

SPECIES: *E. coli* [Colibacillinum]

E. coli mutabile [bowel nosode Mutabile]

GENUS *Hafria*

SPECIES: *H. alvei*, [bowel nosode Bacillus No. 7]

GENUS *Klebsiella*

SPECIES: *K. pneumoniae*

GENUS *Morganella*

SPECIES: *M. morganii* [bowel nosode Morgan pure]

GENUS *Proteus*

SPECIES: *P. mirabilis* [bowel nosode Proteus]

P. vulgaris [bowel nosode Proteus]

GENUS *Salmonella*

SPECIES: *S. paratyphi* [Paratyphoidinum]

S. typhi [Eberthinum; Typhoidinum]

S. enteritidis [bowel nosode Gaertner]

GENUS *Shigella*

SPECIES: *S. dysenteriae* [bowel nosode Dysenteriae Co.]

GENUS *Yersinia*

SPECIES: *Y. pestis* [Pestinum]

ORDER Pasteurellales

FAMILY Pasteurellaceae

GENUS *Haemophilus*

SPECIES: *H. influenzae* [Hib vaccine]

ORDER Pseudomonadales

FAMILY Pseudomonadaceae

GENUS *Pseudomonas*

SPECIES: ? *aeruginosa*

ORDER Vibrionales

FAMILY Vibrionaceae

GENUS *Vibrio*

SPECIES: *V. cholerae* [Cholera nosode]

Group Epsilon Proteobacteria

ORDER Campylobacterales

FAMILY Campylobacteraceae

GENUS *Campylobacter*

SPECIES: *C. jejuni*.

FAMILY Helicobacteraceae

GENUS *Helicobacter*

SPECIES: *H. pylori*.

PHYLUM SPIROCHAETAE

ORDER Spirochaetales

FAMILY Leptospiraceae

GENUS *Leptospira*

SPECIES: *L. interrogans* [Weil's disease]

FAMILY Spirochaetaceae

GENUS *Borrelia*

SPECIES: *B. burgdorferi* [Lyme nosode]

GENUS *Treponema*

SPECIES *T. pallidum* [Syphilinum]

T. pallidum pertenue [Framboesinum]

PHYLUM CYANOBACTERIA

ORDER Chroococcales

FAMILY Chroococcaceae

GENUS *Microcystis*

SPECIES: *M. aeruginosa*

ORDER Nostocales

FAMILY Nostocaceae

GENUS *Anabaena*

SPECIES: *A. flos-aqua* [Saxitoxinum]

ORDER Oscillatoriales

FAMILY Phormidiaceae

GENUS *Arthrospira*

SPECIES: *A. maxima* [Spirulina]

FAMILY Pseudanabaenaceae

GENUS *Spirulina*

SPECIES: *S. maxima* [Spirulina]

PHYLUM SAPROSPIRAE (no representatives in homeopathy)

PHYLUM CHLOROFLEXA (no representatives in homeopathy)

DIVISION TENERICUTES

[wall-less eubacteria]

PHYLUM MYCOPLASMA (no representatives in homeopathy)

DIVISION FIRMICUTES

[Gram-positive and protein-walled bacteria]

PHYLUM ENDOSPORA

Class Bacilli

ORDER Bacillales

FAMILY Bacillaceae

GENUS *Bacillus*

SPECIES: *B. anthracis* [Anthracinum]

B. brevis [Tyrothricinum]

FAMILY Listeriaceae

GENUS *Listeria*

SPECIES: *L. monocytogenes* [Listeriosis nosode]

FAMILY Staphylococcaceae

GENUS *Staphylococcus*

SPECIES: *S. aureus* [Staphylococcinum]

ORDER Lactobacillales

FAMILY Enterococcaceae

GENUS *Enterococcus*

SPECIES: *E. faecalis* [Enterococcinum]

Enterococcus spp. [Strepto-enterococcinum]

FAMILY Lactobacillaceae

GENUS *Lactobacillus*

SPECIES: *L. acidophilus* [Lactobacillus]

FAMILY Streptococcaceae

GENUS *Streptococcus*

SPECIES: *S. pneumoniae* [Pneumococcinum]

S. pyogenes [Scarlatinum. Streptococcinum]

Class Clostridia

ORDER Clostridiales

FAMILY Clostridiaceae

GENUS *Clostridium*

SPECIES: *C. botulinum* [Botulinum]

C. difficile

C. perfringens

C. tetani [Tetanotoxinum]

PHYLUM PIRELLULAE

ORDER Chlamydiales

FAMILY Chlamydiaceae

GENUS *Chlamydia*

SPECIES: *C. trachomatis* [Chlamydinum]

PHYLUM ACTINOBACTERIA

ORDER Actinomycetales

FAMILY Actinomycetaceae

GENUS *Actinomyces*

SPECIES: *A. albus* [Streptomyces albus]

A. citreus [Streptomyces citreus]

A. griseus [Streptomyces griseus]

A. israelii

A. luteus [Nocardia lutea]??

FAMILY Corynebacteriaceae

GENUS *Corynebacterium diphtheriae*

SPECIES: *C. diphtheriae* [Diphtherinum]

FAMILY Micromonosporaceae

GENUS *Micromonospora*

SPECIES: *M. purpurea* [Gentamicinum]

FAMILY Mycobacteriaceae

GENUS *Mycobacterium*

SPECIES: *M. avium* [Aviaire]??

M. avium subsp. paratuberculosis [Johneinum]

M. bovis [Tuberculinum bovinum Kent]

M. leprae [Leprominium]
M. tuberculosis [Tuberculinum]

FAMILY Nocardiaceae

GENUS *Nocardia*

SPECIES: *N. asteroides*

?? nocardia lutea??

FAMILY Streptomycetaceae

GENUS *Streptomyces*

SPECIES: *S. albus* [Salinomycin]

S. ambofaciens [Spiramycin]

S. aureofaciens [Chlortetracycline; Aureomycin]

S. caespitosus [Mitomycin]

S. erythreus [Erythromycin]

S. fradiae [Neomycin]

S. garyphalus [Cycloserine]

S. griseus [Streptomycin]

S. nodosus [Amphotericin B]

S. noursei [Nystatin]

S. peuceetius var. *caesi* [Doxorubicin]

S. rimosus [Oxytetracycline]

S. venezuelae [Chloramphenicol]

Books like this - materia medicae - depend on the availability of pertinent material. Homeopaths who are willing to share the results and details of their cured cases are generously adding to our database all the time. I was disappointed not to receive more "bacteria" cases, having asked about four hundred homeopaths to share their work. I am sure this does not mean that nobody uses nosodes! I should like to encourage homeopaths to write up, publish, teach, share their cases.

A plea for bacterial behaviour!

Well-documented cases increase our understanding of remedies. I should like to encourage ALL homeopaths to take the time to share their work, [write, publish, teach, talk about, question] and thereby increase our general knowledge.

When we work communally, like the bacteria, our work becomes more than the sum of its parts. To be human is to battle between selfishness and altruism. Strive for the latter, and serve humanity with homeopathy!

info@emrysspublishers.com

BIOLOGY OF BACTERIA

That without substance can enter where there is no room.

Monera are tiny organisms consisting of a single cell. All monerans are considered to be bacteria. With the first species appearing about 3.5 billion years ago, bacteria are the oldest form of life on earth. For about 2 billion years there were no life forms other than bacteria. Some 1.5 billion years ago, bacterial activity increased the percentage of oxygen gas from less than 1 % to about 20%, which made it possible for oxygen-using organisms such as protists, plants, animals, and fungi to evolve.

Bacteria are among the most numerous organisms on earth; eg a gram of garden soil contains an estimated 2.5 billion bacteria. There is some variety in shape: rods [bacillus], spirals [spirochete], chains [strepto], spheres [coccus], or complete shapelessness. Colours range from reds and yellows to blues and violets. Some bacteria live alone like single cells, others live in groups of cells attached to one another. Bacteria live almost everywhere, including places where other living organisms cannot survive. Inhospitable environments are made suitable by them for other organisms to live in.

Bacterial cells are different from all other cells in lacking a nucleus and membrane enclosed organelles. The genetic material, DNA, is free floating in bacteria. Almost all bacteria have a cell wall, a tough, rigid structure surrounding, supporting, shaping and protecting the cell.

Cell walls come in two types, which can be microscopically distinguished with the staining procedure developed in 1884 by

the Danish physician Hans Christian Gram. Bacteria whose cell walls have a thick outer layer of peptidoglycan appear blue to purple after staining and are called Gram-positive; while those with a thin peptidoglycan layer and an extra membrane appear pink to red and are called Gram-negative. Cell walls are favourite targets in medical combat against disease-causing bacteria.

Many bacteria cannot move on their own, but need to be transported by air and water currents, animals, etc. Others have special thin, whiplike structures,

BACTERIAL SHAPES

*rods - bacillus spirals -
spirochete chains -
strepto spheres - coccus
shapeless*

CELL WALLS

*tough rigid
surrounding
supporting
shaping
protecting
targetted*

HANS CHRISTIAN GRAM

*Grams: thick blue-purple
wall
Gram-: thin layer, pink-
red, extra membrane*

termed flagella, to help them move through watery surroundings.

The range of metabolic capabilities of bacteria is far greater than that of all the other kingdoms combined. Because their differences lie in their metabolism rather than in their structure, many kinds of bacteria can be distinguished only by the chemical transformation that they cause. They may

*CELL METABOLISM
AND OXYGEN* Obligate
aerobes need oxygen
Facultative anaerobes
switch metabolism.
Obligate anaerobes cannot
use oxygen

require oxygen to get energy from food [obligate aerobes]; others can switch their metabolism between aerobic and anaerobic modes [facultative anaerobes]; and again others are killed by oxygen [obligate anaerobes].

Many bacteria are heterotrophs deriving nourishment and carbon requirements from organic substances, as are most animals and fungi. Unable to make their own food, heterotrophs are immediately or ultimately dependent upon pre-formed organic compounds from either live or dead sources.

*BACTERIAL
FOOD SOURCES*
Parasites - living matter
Saprobies - decaying
matter
Symbionts - mutualists -
form partnerships

Parasitic bacteria feed on living organisms, others are saprobies [decomposers feeding on dead or decaying matter]; still others are mutualists [symbionts], forming partnerships with other organisms. Intestinal bacteria break down plant cell walls, thus enabling their hosts to digest plant materials such as vegetables, fruit, grass, etc. Cyanobacteria enter into alliances with fungi to create lichens. Nitrogen-fixing [nitrifying] bacteria turn atmospheric nitrogen gas into nitrogen compounds that can be used by other organisms to make proteins and nucleic acids. In turn, denitrifying species of the genera *Bacillus* and *Pseudomonas* keep the nitrogen cycle going by returning nitrogen to the atmosphere as nitrogen gas. Other bacteria carry out a similar cycle for sulphur.

USES OF BACTERIA
Food production -dairy
Fuel - methane
Antibiotics
Vitamins
Pigments & colouring for
foods, textiles, cosmetics.
Stain removal.
Paper I cloth production.
Metal extraction.
Leather tanning.
Chemical conversions
Chemical breakdown.

Some bacteria are autotrophs and make their own food by means of photosynthesis or chemosynthesis, i.e. food is synthesized and energy derived exclusively from inorganic sources. Other bacteria use sulphur or iron-containing substances to make food.

Reproduction occurs very rapidly through budding or dividing. One of the fastest multipliers is *Escherichia coli*, which every 20 minutes doubles its numbers.

Bacteria are involved in the production of food [especially dairy products], fuel [methane gas], antibiotics, vitamins, pigments and colouring matters

[food, cosmetics, textiles]. In addition, bacteria play a role in metal extraction from ores, tanning of leather, conversion of chemicals, removing stains, processing paper and cloth, etc. Pollutants and harmful chemicals are broken down by bacteria [and microfungi]. A recent discovery is that the bulk of modern day petroleum deposits have originated from decaying cyanobacteria.

Harmful bacteria, on the other hand, cause food spoilage, poisoning of water supplies, damage to properties, and plant, animal and human diseases.

Of the about 50,000 species of bacteria, only a small minority is pathogenic. To establish a successful grip on hosts, pathogenic bacteria must overcome several hurdles: they must gain entrance to the host and once inside must multiply [invasiveness]; they must produce toxins harmful to the host's tissues [toxigenicity], and find a way to spread to the next host. These factors may vary. For example, *Corynebacterium diphtheriae*, causative agent of diphtheria, has low invasiveness because it multiplies only in the throat, but its toxigenicity is so great that the host's entire body is affected. *Bacillus anthracis*, by contrast, has low toxigenicity but an invasiveness so great that the entire bloodstream ultimately teems with anthrax-causing bacteria. New hosts are actively enlisted or passively awaited. Active bacterial strategies to broadcast offspring include the production of disease symptoms such as diarrhoea, coughing, skin lesions, genital sores, and discharges.

BACTERIAL QUALITIES
Invasiveness Toxigenicity
Fast reproduction
Contagion -
Communication
Colonization Strategy

Evolutionary Symbiotic
Co-operative Genetically
flexible Socialised
Democratic

Victims!Aggressors

Madeline Drexler thinks that, "Micro-organisms play the survival game exceedingly well. For one thing, they adapt far more quickly than do humans to the scene shifts around them. Humans crank out a new generation every 20 years or so; bacteria do it every 20 to 30 minutes, and viruses even after. Richard Krause, former director of the National Institute of Allergy and Infectious Diseases [NIAID], calls this microbial pace 'a millennium in a fortnight.'

Because they assemble in enormous numbers, viruses and bacteria can support considerable variety in their communities, including the mutated oddballs that may shine when circumstances change. A billion bacteria inhabiting a thimble can be virtually wiped out on Monday and be back in full force by Tuesday."

When we look at the relationship between microbes and humans, epidemiologist David Morens believes that the microbe is the more important thing to look at. “When an enterovirus like polio goes through the human gastrointestinal tract in three days, its genome mutates about two percent. That level of mutation - two percent of the genome - has taken the human species eight million years to accomplish. So who’s going to adapt to whom?” Pitted against such nimble competition, the human capacity to evolve “may be dismissed as almost totally inconsequential.”

It has been argued that the concept of “species” is inappropriate for bacteria because “bacteria that differ in nearly every measurable trait can receive and permanently incorporate any number of genes from each other or from the environment.” To conclude, some quotes from Lynn Margulis and Dorion Sagan’s book *Microcosmos* in order to “magnify the microcosmos to find our origins”:

- “The descendants of the bacteria that swam in primeval seas breathing oxygen three billion years ago exist now in our bodies as mitochondria.”
- “We coexist with present-day microbes and harbour remnants of others, symbiotically subsumed within our cells. In this way the microcosmos lives on in us and we in it.”
- “Because bacteria may mix genes at any time and are not doing so during reproduction, they are far more genetically promiscuous than animals.”
- “Different strains of bacteria in nature are constantly exchanging bits and pieces of their genetic material among one another in a more or less random fashion. ... it makes the bacterial world incredibly more flexible than our world of nucleated cells in terms of adaptation. A bacterium possesses only a streamlined, bare-bones minimum of instructions for replication and maintenance. ... Paradoxically from our standpoint in the human world, prokaryotes [bacteria] have sex more often with more

*BACTERIA -
A worldwide de-
centralized democracy.*

*SHELDRAKE:
Morphogenetic fields.*

*HAHNEMANN:
Genus Epidemicus*

partners yet they remain more faithful in terms of the degree of similarity shown between parents and offspring. ... People and other eukaryotes are like solids frozen in a specific genetic mould, whereas the mobile, interchanging suite of bacterial genes is akin to a liquid or gas. ... **For if, indeed, all strains of bacteria can potentially share all bacterial genes, then strictly speaking there are no true species in the bacterial world. All bacteria are one organism, one entity capable of genetic**

engineering on a planetary or global scale.”

- “Its minimal number of genes leaving it deficient in metabolic abilities, a bacterium is necessarily a team player. A bacterium never functions as a single individual in nature..... In huge and changing numbers, they perform tasks of which individually they are incapable. ... Bacterial teams are to the Earth what our internal organs are to us.”
- [Bacteria] “are not only highly social beings, but behave as a sort of worldwide decentralized democracy.”
- “In the microcosmos guests and prisoners can be the same thing, and the deadliest enemies can become indispensable for survival.”

PHYLUM PROTEOBACTERIA

In terms of numbers of species this is by far the largest phylum of bacteria. The phylum consists of dramatically diverse groups.

Thiopneutes live in sulphur-rich environments, taking in sulphur instead of oxygen and releasing the acrid-smelling 'rotten-egg' gas, hydrogen sulphide. They feed on organic matter and are Gram negative, comma-shaped bacteria. The *Desulfovibrio* is one such Thiopneute.

Anaerobic phototrophic bacteria live on sunlight and carbon dioxide, using the sulphur in hydrogen sulphide gas to reduce carbon dioxide into food. They can be green or purple, motile or not; living alone or in large groups. The slime of pond scum is the bonding they produce when living in large sheets.

Pseudomonads are the rod-shaped motile bacteria with the ability to break down organic ring compounds such as those in petroleum. They also bring swift death to many food plants. The *Bdellovibrio* is particularly cunning in that it uses its host bacterium's cell material to reproduce itself, bursting triumphantly out once the host is exhausted, to find new hosts.

So far, the above groups are not represented in the homeopathic materia medica, although similar behaviour may be found in other kingdoms.

Nitrogen-fixing Aerobic Bacteria, such as *Rhizobium*, contain iron and molybdenum-rich protein ions. They live symbiotically in the root-hairs of the Leguminosae family, aiding in protein formation.

Myxobacteria - complex slime organisms - digest proteins and fatty-acid esters as well as the debris from other bacteria.

Omnibacteria, all Gram negative and heterotrophic, take in Nitrate ions [expensively spread on the soil as fertilizer] and, in the presence of hydrogen, produce nitrous oxide - laughing gas, or ammonia. They are known as de-nitrifiers. *Escherichia coli*, whose speciality is to help convert exhausted food into faeces, along with many other omnibacteria, inhabit intestines and have long been associated with human and other animal diseases. These species are distinguished from each other by the carbohydrates they can attack. Other bacteria in this phylum include the cholera *Vibrio*, and *Neisseria*, found in patients with meningitis or gonorrhoea.

Chemoautotrophic Bacteria need neither light or food, and live on inorganic compounds in water. Their job is to cycle inorganic nitrogen and carbon

compounds which are critical for the growth of living organisms. Although they are important in planetary terms, they do not yet provide us with homeopathic remedies.

Proteobacteria: Group Alpha

| Phylum | Order | Family | Genus | Species | Remedy |
|------------------------------|------------------|---------------------|---------------|------------------------|------------------------|
| PROTEOBACTERIA └ Gp Alpha | Rhizobiales | — Brucellaceae | — Brucella | — <i>B. melitensis</i> | — <i>B. melitensis</i> |
| | Rhodospirillales | — Acetobacteriaceae | — Acetobacter | — <i>A. xylinus</i> | — <i>Kombucha</i> |
| | Rickettsiales | — Rickettsiaceae | — Rickettsia | — <i>R. prowazekii</i> | — <i>Typhus nosode</i> |

“Various proteobacteria form close associations with eukaryotes [organisms with nucleated cells, including us and all organisms except bacteria]. Thus Rhizobium forms nodules within the roots of leguminous plants; the related Agrobacterium is a pathogen of plants, while the Rickettsias are intracellular pathogens of animals. All in all, then, says Carl Woese, we need not be surprised that the mitochondria typical of eukaryotic cells probably arose also from proteobacteria; they, too, after all, dwell intimately within the eukaryotic cell.”

[Tudge]

I. ORDER RHIZOBIALES

IA. FAMILY BRUCELLACEAE

Brucella melitensis

BRUCELLA MELITENSIS

Scientific name *Brucella melitensis* (Hughes 1893) Meyer and Shaw 1920
emend. Verger et al. 1985

Family Brucellaceae

Homeopathy *Brucella melitensis* - Brucel.

FEATURES

- Small, remarkably slow-growing, Gram-negative, non-motile, aerobic coccobacilli occurring singly, in pairs, or in short chains.
- Of the five heterotypes of *Brucella melitensis*, four have moderate-to-significant human pathogenicity: *B. melitensis* [from sheep, goats and camels; highest pathogenicity]; *Brucella suis* [from pigs, hares, rabbits, and reindeer; high pathogenicity]; *B. abortus* [from cattle; moderate pathogenicity]; and *B. canis* [from dogs; moderate pathogenicity].
- In Scandinavia and Alaska, reindeer are an especially important source of brucellosis.
- All four species are parasitic and invade animal tissues, causing infection of the genital organs, the mammary gland, and the respiratory and intestinal tracts.
- Cause abortion in their animal hosts. [Brucella seeks out cells that provide the carbohydrate erythritol — animal foetal tissues and placenta, other than those in humans, are rich in erythritol and, therefore, the organisms often cause abortions in these animals.]
- When infection is first introduced into a flock or herd, there may be an “abortion storm.” Fever, depression, mastitis, arthritis, synovitis, orchitis or nervous signs may accompany acute infection in

HUMAN

PATHOGENICITY

B. Melitensis [Highest]
sheep, goats, camels.

B. Suis [High]

reindeer, pigs, hares,
rabbits.

B. Abortus [Moderate]
cattle

B. Canis [Moderate]
dogs

BRUCELLA INVADES:
genitals, breasts,
respiratory tract,
intestinal tract.

BRUCELLOSIS Alias
Undulant fever

Malta fever

Mediterranean fever

Gibraltar fever

VECTOR

Unpasteurised milk

Milk products - goat <

Animal carcasses

Abortion materials

both sheep and goats.

- *Brucella* [formerly *Micrococcus*] *melitensis* was first isolated by the British Army physician Sir David Bruce [1855-1931] in 1887 on the Island of Malta from spleens of fatal cases of Malta fever amongst British soldiers.
- *B. melitensis* remain viable in damp soil for 72 days, but when exposed to the sun it dies in a few hours.

BRUCELLOSIS

Prevalence

Known as Undulant, Malta, Mediterranean, or Gibraltar Fever, brucellosis is transmitted through contaminated and untreated milk and milk products and by direct contact with infected animals, animal carcasses, and abortion materials. Goats milk and fresh goat's cheese [cow's milk and cheese less so] are the main sources of human brucellosis, although there is a declining incidence in countries where livestock is vaccinated and infected animals are slaughtered. Pasteurisation of milk eliminates the potential reservoir of brucellosis through infected milk.

Careful modern studies have demonstrated that the prevalence of the disease in non-human mammals subject to brucellosis increases with herd density. It is therefore likely that domestication of animals and the rise of herd husbandry led to the increase in prevalence of the organism. Human contact with domesticated cows, goats, camels, sheep, pigs, and dogs introduced the pathogen to humans. Brucellosis also may be found in wild animals that are naturally gregarious and exist in herds, such as bison or elk.

Human disease prevalence in any given area of the world closely parallels animal prevalence, although the likelihood of disease in any given human is further greatly influenced by degree of contact with animals or their excreta, and especially by ingestion of unpasteurised milk or inadequately cooked meat from infected animals. Incidence of brucellosis is likely to peak during summer.

[R.S. Rust, Jr, *Brucellosis*; article at: www.emedicine.com/neuro/topic42.htm]

Clinical manifestations

Most prevalent in rural areas, brucellosis is an occupational disease of abattoir workers, animal handlers, meat-packers, veterinarians, farmers, and livestock producers.

Males of working age are affected at least twice as frequently as females.

The incubation period varies from five days to several months [average, two weeks]. Symptoms vary, especially in the early stages. Onset may be sudden and acute, with chills and fever, severe headache, pains, malaise, and occasionally diarrhoea; or it may be insidious, with mild prodromal malaise, muscular pain, headache, and pain in the nape of the neck, followed by a rise in evening temperature. ... As the disease progresses, the temperature increases to 40° or 41° C, then subsides gradually to normal or near-normal in the morning, when profuse sweating occurs.

Typically, the intermittent fever persists for 1 to 5 weeks, followed by a 2- to 14-day remission with symptoms gradually diminished or absent; the febrile phase then recurs. Sometimes this pattern occurs only once; occasionally, however, subacute or chronic brucellosis ensues, with repeated febrile waves [undulations] and remissions recurring over months or years. In some patients, fever may be only transient.

After the initial phase, constipation usually is pronounced; anorexia, weight loss, abdominal pain, joint pain, headache, backache, weakness, irritability, insomnia, mental depression, and emotional instability occur. Splenomegaly occurs, and lymph nodes may be slightly or moderately enlarged; hepatomegaly may be present in up to 50% of patients.

Complications are rare but include SBE [subacute bacterial endocarditis], meningitis, encephalitis, neuritis, orchitis, cholecystitis, hepatic suppuration, and bone lesions.

[Merck Manual]

Fever and other constitutional manifestations of acute brucellosis tend to be more severe and persistent in patients who attempt to remain active. Severity and duration typically are reduced by enforced bed-rest.

The fever of acute brucellosis caused by *B. melitensis* usually lasts for 10-30 days, undulates irregularly, and is not associated with rash. ... Some very severe cases are termed malariform

because the undulating fever spikes reach very high temperatures and are associated with chills, drenching sweats, and prostration from the very onset of illness. The irregular undulation of fever spikes distinguishes malariform

KEYNOTES

Irregularly spiking fever

Remission

Fever returns and undulates [for years]

PAIN in spine, buttocks, L3-L4. Sacro-iliac.

Joints.

Sciatica

Anorexia

Weakness

Irritability

Depression

Emotional instability

Brucellosis sufferers are

infamous for their bad temper!

brucellosis

acute brucellosis from malaria, which produces quite regular fever spikes.

The most common focal manifestation of acute brucellosis is pain, usually localised to the lower spine, paraspinous muscles, or upper buttocks. In some cases, neuralgic pain is distributed along lumbosacral peripheral nerves, especially the sciatic. The region of the lumbosacral vertebrae may be tender to percussion, as may the course of the sciatic nerve. Thus, these clinical features may closely resemble sciatica.

Non-focal neurological manifestations of acute brucellosis include headache, irritability, lethargy, depression, disturbed consciousness and concentration, anorexia, and disturbed sleep.

Headache, waxing and waning over a considerable period, may be the only sign of acute brucellosis, with symptoms suggesting migraine.

When an encephalopathic syndrome arises during acute brucellosis, it may evolve gradually over weeks to months. During this period, findings may wax and wane. This evolution tends to blur the distinction between acute and chronic brucellosis. In some patients with an encephalopathic form of acute brucellosis, the evolution may suggest development of MS or other chronic inflammatory diseases of the CNS.

Some patients with acute brucellosis have mild or more marked problems with language or memory.

The long duration of fever and malaise, which may persist for three months or more, usually distinguishes brucellosis from influenza and many other febrile viral illnesses.

Relapses in many cases consist solely of typical features of acute brucellosis, such as undulant fever, aches, sweats, and generalized weakness. The recurrence of such bouts is thus highly suggestive of malarial recurrences.

[R.S. Rust]

Key symptoms

Certain symptoms are more prevalent. Case reviews have shown fever to be present in 90-95% of patients, malaise in 80-95%, myalgias in 40-70%, drenching sweats in 40-90%, and arthralgias in 20-40%. The diurnal variation in temperature is characteristic - normal or slightly elevated in the morning, rising in the late afternoon or evening. Musculoskeletal symptoms show a preference for bone ends and the sacroiliac joint or may present as generalised aches. In contrast to adults, in whom sacroiliitis predominates, childhood brucellosis most often affects large peripheral

joints, usually with mono-articular involvement [hips, knees, and ankles]. More common in elderly patients, *Brucella* spondylitis affects the lumbosacral and lower dorsal regions [L3-L4] most frequently. Diagnostic confusion with lumbar disc protrusion is not uncommon.

Although an enteric fever, the systemic symptoms of brucellosis generally predominate over gastrointestinal complaints. The same holds true for typhoid fever. Raue's description of *abortive typhoid fever* probably refers to brucellosis.

The *Abortive typhoid fever* is, in every respect, much lighter, and corresponds to the "*gastric fever, or nervous fever*" of older writers. Although it shows all the symptoms of a regular typhoid fever, yet they are all much milder; the temperature of the body never reaches such an intensity, and already on the eighth or ninth day there is a considerable morning remission, which sinks at the end of the second and during the third week to a normal state, with only slight aggravations in the evening. Still the patients gain their usual strength quite slowly.

Prolonged brucellosis cases often exhibits the typical combination of undulant fever, perspiration, weight loss, anorexia, and fatigue. Dyspepsia is common. Considered an "incapacitating illness," weakness and disability often persist for a period of years. Other long-lasting sequelae include recurrent fevers and joint pain. The chronic phase of illness may persist for as long as 25 years, but such cases are quite rare. Although mortality is low, the loss in productive capacity of the afflicted is tremendous.

A common constellation in young children is refusal to eat, lassitude, joint pains with refusal to bear weight on an extremity, anorexia and failure to thrive.

Tuberculosis

Brucella distinctly resembles *Mycobacterium tuberculosis*: both microorganisms are localised intracellularly, both grow slowly, both are transmitted by droplets or are milk-borne. The key symptoms of intermittent fever, anorexia, weight loss, and sweat are similar, and commonly used antibiotics for brucellosis treatment [i.e. Rifampin and Streptomycin] are also first line drugs for the treatment of tuberculosis.

Worldwide burden of brucellosis

Involved in brucellosis work since its establishment, the World Health Organisation is working on a number of programmes to reduce the incidence of human and animal brucellosis.

Although human brucellosis is a notifiable disease in many countries, official figures do not fully reflect the number of people infected each year and the true incidence has been estimated to be between 10 and 25 times higher than what reported figures indicate. Cases very often remain unrecognized because of inaccurate diagnosis, and are thus treated as other diseases or as “fever of unknown origin.” Animal brucellosis also poses a barrier to trade of animals and animal products and could seriously impair socio-economic development, especially of livestock owners, a most vulnerable sector in many rural populations. As an indication of the importance of this disease, plans to eliminate ovine, caprine and bovine brucellosis from the European Union were expected to receive over half of the total European Commission funding for animal diseases control measures in 1997.

Brucellosis in humans and animals is increasing in certain parts of the world, especially in developing areas of the Mediterranean region, Middle East, western Asia and parts of Africa and Latin America. *Brucella melitensis* especially, being very pathogenic for human beings, constitutes a public health priority. Its recent emergence as a bovine pathogen in intensive dairy farms causes particular concern. A similar problem has also been reported where *Brucella suis* has become established in cattle.

In Mediterranean and Middle East countries, where the annual incidence of brucellosis in people varies from less than 1 up to 78 cases per 100,000; however, over 550 cases have been reported from confined endemic areas where no animal control measures are applied. Up to 77 cases per 100,000 people have been reported from certain communities of south European countries in which animal control measures are mandatory. Reported cases largely underestimate the size of the problem. From a recent survey in a randomly selected human population of a country of the Arabic Peninsula, serological evidence of exposure to *Brucella* has been found to be close to 20%, with more than 2% of these having active disease. Similar figures may be expected from most countries in which the disease is endemic in the animal population. Higher seroprevalence of brucellosis should also be expected in occupationally exposed groups.

[Division of Emerging and other Communicable Diseases Surveillance and Control, WHO, Geneva, 1998]

Biological warfare

Brucellosis was in the 1940s and 1950s a prototype in offensive biological warfare research designed for the mass production of disease. Its potential for long-lasting infection that can disable workers in either military or civilian circles made these bacilli an appealing choice for a biological weapon. With the development of “a continuous culture machine capable of producing brucellosis germs by the ton,” *Brucella* was found to be particularly suitable for aerosol transmission because it, due to its minute size, can avoid the natural body defences found in the cilia of the nose and upper respiratory tract. By 1955, the USA was producing *B. suis*-filled cluster bombs for the US Air Force at the Pine Bluff Arsenal in Arkansas. One ounce contained about 25 trillion bacteria, enough to infect more than two billion people. The *Brucella* munitions were never used against human targets and the development of biological weapons was banned by President Nixon in November 1969. Yet, the research performed had shown the extraordinary infectivity of *Brucella* and this has resulted in concern that *Brucella* species someday may be used as a weapon against either military or civilian objectives.

NEUROBRUCELOSIS

Neurobrucellosis is clinically virtually indistinguishable from the neurological manifestations of syphilis and tuberculosis. Most instances of neurobrucellosis [5% of all brucellosis cases] arise during the chronic phase of brucellosis and develop after a latent, fever-free interval. It is usually heralded by return of fever and associated constitutional signs and symptoms [lethargy, irritability, fatigue, etc.].

In advanced cases where meningo-encephalitis is present, complaints may include changes in mental status, neurologic deficit, neck stiffness, or seizures. Other forms of neurological dysfunction that may accompany the acute phase of brucellosis are hearing loss, usually bilateral, and peripheral neuritis. In regions where *B. melitensis* is endemic, brucellosis may be the most common cause of acquired hearing loss, the onset of which may be during the acute, subacute, or chronic phase of disease. Psychiatric disturbances are frequent in neurobrucellosis. Most commonly this involves depression, but confusion and paranoid delusions also occur.

The most common neurobrucellosis syndrome is that which arises in the wake of a preceding bout of acute brucellosis due to *B. melitensis*. In these cases, the

relapse of illness is characterized a few days of irregular intermittent fever, headache, lethargy, achiness, and drowsiness, followed by the development of waxing and waning headache that resembles migraine owing to the throbbing; anorexic manifestations, and periods of intense pain and photophobia. Headache may lateralise. Meningismus is common and, in some instances, seizures occur. In other instances, higher cortical function abnormalities develop that range from varied degrees of difficulty with concentration, language, or memory to obtundation [bluntness/death] or coma.

Hemiparesis or aphasia may develop.

In rare instances, abnormalities referable to the basal ganglia and associated systems develop, including parkinsonism, chorea, athetosis [a recurring series of slow writhing movements of the hands, usually due to a cerebral lesion], narcolepsy, or cataplexy.

Brucellar inflammatory demyelinating syndromes may wax and wane in a manner that is so similar to that of MS as to have suggested to some authorities that *Brucella* organisms might be the infectious aetiology of MS.

Cranial nerve nucleus signs may include abnormalities of pupils, eye movements, or facial movements or sensation, diplopia, dysphagia, dysarthria, and other abnormalities.

[R.S. Rust]

MATERIA MEDICA BRUCELLA MELITENSIS

Brucel.

Sources

- [1] Proving by Souk-Aloun; *Brucella melitensis* 30c; 10 provers [5 males, 5 females]; 1983-1988.
- [2] Symptoms from 30 clinical cases by Souk-Aloun, who has, as a physician in the Cevennes in France, studied this disease since 1977. [The Cevennes has a high incidence of brucellosis; from 1970 to 1980 several outbreaks were due to contaminated goats cheese.] He concludes: "Physiopathologically, brucellosis is a disease that always becomes chronic, even in cases of apparent and clinical recovery, by the persistence of few germs in the reticulo-endothelial system. Due to its chronicity and its specificity, brucellosis looks like tuberculosis but stands out by its rural and pastoral nature."
- [3] Pathogenesis by Julian.

Clinical characteristics

= Psychological symptoms [depression; irritability, sometimes anger; anxiety and despair].

= Debility and fatigue, typically with seasonal aggravations [often winterspring, sometimes also summer].

= Malaise.

= Vertigo.

= Disturbances of body temperature.

* Tendency to sweat.

[The local population of the Cevennes recognises the disease by the “profuse sweat that smells of decayed straw.”]

= Joint pains [wandering]; headache; low back pain [lumbar region]; pain in lower arms [dorsal side] and hands [pain and swelling of extensors of fingers].

«> Disposition to ear-nose-throat infections [tonsillitis and pharyngitis; one side, extending to other side], recurrent respiratory tract infections, and digestive problems, notably painful bloatedness after eating and soft or liquid stools.

= A curious sensation sometimes present is the sensation as if a body part [eyes, hands] is enlarged, swollen or bloated.

[P. Souk-Aloun, *Brucella et Melitine dans le traitement de la fièvre de Malte-*, at: www.homeoint.org/]

= Profuse perspiration from least exertion and at night.

- Muscular and joint pains, esp. of the lower limbs.

= Emotional instability; insomnia.

~ Constipation; dry and hard stools.

=> Vesicular eruptions.

- *Better* from warmth and sun.

«• *Worse* from prolonged exertion; hot room; sea breeze; humidity; during storm.

[Julian, *Materia Medica of Nosodes*]

SYMPTOMS

Proving symptoms not clinically verified are unmarked; proving symptom clinically verified or cured symptoms are followed by °.

Symptoms from: P. Souk-Aloun & C. Peppey, *Pathogenesis of Brucella*

melitensis and *Melitococcinum*, RefWorks.

Brucella is prepared from killed bacteria; *Melitococcinum* from filtrate of cultured bacteria.

MIND

- ~ Sadness and depression; irresolution.^c
- = Inability to undertake anything.^c
- = Unpleasant sensation of being flabby, slow, as if in cotton.
- Apprehension, irresolution and doubt about everything; doesn't want to see anybody yet dreads being alone; > company or occupation.⁰ Depreciation of self.
- <> Apathy; slowness of comprehension; bad mood, < morning, > occupation.⁰
- Weeping when someone raises voice against her; weeping about trifles.⁰
- ~ Forgetfulness and distraction.⁰
- ~ Lack of emotional control; weeps easily^c; feels confused and worried, persistent thoughts.
- => Irritability, nervousness, emotional instability.⁰

The irritability of patients with chronic brucellosis may come up very suddenly, so that a usually courteous patient suddenly and unexpectedly behaves like a boor or insults you right out; such an outburst is very short, after which the patient behaves as if nothing has happened; this emotional explosion can be compared with the acute appearance of alarming symptoms which disappear as quickly again. [S-A]

<= Dreams of having vertigo.

[Sil., also listed in this rubric, is a remedy for goats, according to Souk-Aloun. Stubborn as an old goat? Playing the giddy goat?]

GENERALS

- <■ No thirst.
- « Loss of appetite and thirstlessness.
- = Appetite wanting, yet thirsty, esp. in evening after 10 p.m.
- « Desire for stimulants [coffee; tobacco; spicy food].
- « Intolerance of alcohol; nausea from beer.

-
- Sleep restless and unrefreshing, & perspiration; & nightmares of bloody accidents and injured persons.
 - <• Frequent waking at night, but falling asleep immediately again.
 - = Great desire for sleep.
 - => Sudden weakness⁰.
 - « Great weariness in morning on rising.⁰
 - Some cases of chronic brucellosis have an alternation of episodes of bronchitis and rheumatism.
 - = Increased sexual desire at night [in females].

Aggravations

- => Periodical; winter, spring, summer [every 2 to 4 weeks].⁰
- = Prolonged exertion.⁰
- = Change of temperature [entering warm room; going into cold air].⁰ Some patients have faintness when going from cold air into a warm room, or vice versa. [S-A]

- Warm room; very hot summer.⁰
- = Change of weather.
- = Dampness.
- = Storm.
- « Alcohol.
- = Morning.
- « After eating.
- = Motion [joints].

Ameliorations

- Being busy / occupation.
- ® Company.
- = Motion.
- ~ Warmth. [Warm open air]
- = Lying.
- ~ Perspiration.

Morning on waking / rising <

- = Frontal headache in morning; dull, pressing sensation, in morning on waking, disappearing about half an hour after rising and moving about.⁰

-
- > rubbing eyes.
 - ~ Pain in liver region in morning on rising.^c
 - = Pain in dorsal region, between spine and inferior edge of scapula, in morning on rising.
 - » Pain right shoulder on waking in morning, < motion.
 - «• Pain and swelling right wrist, < grasping something, in morning on rising.⁰
 - == Numbness right thumb and base of thumb [dorsal side] in morning on waking.

Distension

- = Distension abdomen & slight nausea.^c
- = Abdomen tensed and bloated, with some pain^c; esp. right hypochondrium, as if menses would appear.^c
- = Abdomen bloated and painful.⁰
- In a cured case of R. Schmidt this was accompanied by constipation. In the many cases of brucellosis and Brucella I have seen there was usually diarrhoea or soft stools rather than constipation. [S-A]

Itching, irritation, burning

- = Itching of tip of nose whole day.
- = Itching of anus / perineum.
- = Itching and burning in anus, beginning around 10 p.m. after going to bed.
- == Irritation of anus, sensation of swelling and burning; before and during menses [& spotting during 3 or 4 days before menses].
- = Irritation of terminal part of urethra.
- => Burning during micturition.

SENSATIONS

SENSATIONS **Heaviness**

- The Mental 'flabbiness' and apathy become generalised as a sensation of heaviness, swelling and tiredness: as if carrying a heavy weight*
- = Heavy sensation in liver region, whole day, sometimes as from a blow;
- = < palpation and pressure.
- = Heaviness abdomen with stitching pains.
- = Sensation of an aching band across shoulders, as if carrying a weight.
- » Upper limbs feel heavy and are easily tired.
- « Sensation of heaviness in thighs.

« Feeling of heaviness and pricking sensation in lower limbs, esp. right side, & venous congestion.

« Sleep deep and heavy.

Enlargement, swelling

= Eyes as if enlarged; during dinner.

- Sensation as if liver were swollen; distension and rumbling after evening meal and on going to bed.^c

= Sensation as if hands were swollen or as if hands were larger and very heavy.^c

Coldness

<= Sensation of coldness and chills in the back, descending down the arms to the fingertips and down the thighs, & feeling of heat in the cheeks.

LOCALS

« Vertigo⁶, short-lasting, & loss of vision and sensation of descending coldness; must lean against something for a few seconds.

- Vertigo at the slightest motion.⁶

« Headache, gradually getting worse, from afternoon till bedtime, < motion and strong light; seems connected with eye problems.⁶

= Hair greasy.

« Photophobia.

- Frequent and violent sneezing between 10 and 11 p.m.

<= Feeling of dryness nostrils; left side completely obstructed.

= Much salivation and continuous need to swallow saliva [unconfirmed symptoms].

• Aphthae on inside of left cheek, & swelling around left tonsil, painless, although sensitive to pressure.⁶

«= Throat ache on swallowing and drinking.⁶

- Tight sensation external throat.

- Right hypochondrium and epigastrium so sensitive that palpation nearly causes nausea.

® Diffuse pain [right hypochondrium] on deep inspiration.

» Wandering pains⁶ - epigastrium, below liver, above umbilicus - after eating, while sitting; then appearing in ovarian region, esp. left side, while standing.

== Acute pain whole day in left side of abdomen, < walking.

= Abdominal pain during coition.

-
- ~ Stool soft and sticky.^c
 - = Stool watery and frequent.^c
 - = Frequent urging; much urine although he drinks little.
 - « Profuse menses with prolonged pain [pain usually one day only].
 - Cough as from dust in throat pit, about 9 p.m.

Back

- Aching in dorsal region, as of a painful band across points of scapulae,
 - < sitting, > standing, walking or lying.
- Diffuse, wandering pains, esp. in lumbar region, thighs and hips,
 - > motion.^c
- ~ Pain in lumbar region when sitting, disappearing when standing, in evening.
- = Pain in lumbar region, right side, < sitting, > standing; extending to right scapula, between 3 and 4 p.m.
- Violent pain in lumbar region, when rising after sitting long; lasting some 10 minutes and completely disappearing after about 1 hour.
- = Chronic lumbago < exertion.

Extremities

- = Pain left shoulder, followed the next days by pain left elbow.
- <■ Swelling and stiffness left hand [dorsal side], especially metacarpophalangeal joint of middle finger [seems to follow the extensor tendon],
 - < motion, clenching fist, cold water, damp weather, change of weather.
- = Pain in left hip, beginning in left groin, extending to knee; appearing suddenly in afternoon when driving car and lasting about 30 minutes;
 - < flexion and extension of thigh, > rest.
- ® Pain in knees when rising from sitting, > standing.
- > Pain in feet when walking and putting pressure on the heels.^c

CASES

(1) D.F., age 36, farmer; acquired the disease when 16 years old in the form of a prolonged “flu” with pain in the heels extending to the knees; clinically cured with antibiotics; since then for four years in succession prolonged episodes of fever during winter. Since the acute “flu” progressive development of the following complaints:

- = Digestive problems [burning sensation in stomach; bloatedness in after-

noon; colicky pains; frequent stool; sudden urge to throw up during meals, disappearing after provoked vomiting].

« Bladder inflammations.

« Frequent tonsillitis for two years, worse in winter [often at right side].

= Pain in shoulders and nape of neck or the past year.

«He is depressed, forgetful, hypersensitive to alcohol, sweats easily and copiously, has haemorrhoids, and a mild form of diabetes.

After *Brucella*, 10 drops of the one-millionth dilution, he had the following reactions:

- In the afternoon of the same day: copious perspiration at the lower back; right foot and leg sore, as if broken.

« The next days the pain increases and radiates to the right knee; headache and throat ache, which disappear unusually quickly; confusion [looks for a spoon that he holds in his hand]; fatigue.

«About ten days later: violent abdominal pain around noon lasting two hours [normally persisting for two or three days]; urinary symptoms; afraid that urine or stool will escape involuntarily.

After repeating the *Brucella melitensis* twice, one-millionth dil., [once every two months] a distinct improvement sets in.

[Reviewed in 1995: malaise has disappeared, he feels very good, which is why he hasn't consulted me anymore since 1993.]

[P. Souk-Aloun, *Brucella et Melitine dans le traitement de la fièvre de Malte*]

(2) Mme. H.B.... of San Diego, married, age 69, came to see me in September 1950, and complained of some gastric troubles from which she had suffered for several months; she was also suffering from flatulence, vomiting, regurgitations, as well as from a stubborn constipation.

Constantly depressed and weak, she became nervous, restless and had shiverings. She felt sudden weakness, had vertigo on the least movement. She had been under the care of another doctor for many months. Unfortunately there was no improvement. When she was young she had suffered from a perforated appendix. Physical examination negative, except a distended abdomen, arterial tension 160/75, hyperkinetic pulse, and a marked secondary anaemia. Weight 141 pounds, height 5'1".

After her return to San Diego she asked me to prescribe by correspondence. Arsenicum, Sulphur, Nux vomica, Carb-v., Kali phos., Carboneum sulph. did her some good but this variety of remedies shows that the case was jumbled, making it difficult to get a simillimum. Finally in July, 1951, I had the idea

that this might be a case of brucellosis; the sudden attack of fever and sweats, weight loss [7 pounds], the persistence of some symptoms supported the diagnosis. I gave her *Brucella melitensis* 10 M.

Without any delay the patient informed me that this was the first remedy that gave her result almost instantaneously. This is the typical response of a homeopathic remedy. She soon gained weight, but after six weeks she complained anew of severe vertigo and obstinate constipation. She got *Brucella melitensis* 30 and for 3 months her condition was satisfactory.

On December 6, 1951, she had again fever with profuse sweat and complained of abdominal pains. I gave her *Brucella* 10M which caused a moderate aggravation during two weeks, with a maximum temperature of 100° F during the day, after which a long period of amelioration followed which lasted for 3 years.

[O.A. Julian, *Materia Medica of Nosodes*]

II. ORDER RHODOSPIRILLALES

IIA. FAMILY ACETOBACTERIACEAE

Acetobacter xylinus

ACETOBACTER XYLINUS

Scientific name *Acetobacter xylinus* subsp. *xylinus* (Brown 1886) Yamada 1984

Synonym *Gluconacetobacter xylinus*

Family Acetobacteriaceae

Homeopathy Kombucha [komb.]

FEATURES

- Gram-negative, strictly aerobic acetic acid bacterium.
- Acetic acid bacteria grow after a phase of activity by yeasts, converting the fermentation end products to more oxidised forms, eg oxidise ethanol to acetic acid.
- Occurs naturally on the surfaces of fruits and flowers.
- Important in the commercial production of vinegar, along with *Acetobacter aceti* and *A. ascendens*.
- Generates large amounts of cellulose when growing on sugar sources.
- The genus has been divided into the subgenera *Acetobacter* and *Gluconacetobacter*.

KOMBUCHA

Where to place Kombucha? It is not a single organism but a symbiotic community of a number of bacteria and yeasts. There is no consensus about the exact nature of the culture and it seems easier to establish what it is not than what it is. Popular names as Manchurian Mushroom, *Fungus japonicus*, Tea Fungus, and Champignon de longue vie ['longevity mushroom'] are misnomers because no mushroom species are involved. At least four micro-organisms have been identified in the culture, among them *Zygosaccharomyces rouxii*, *Saccharomyces cerevisiae*, *Candida* sp. and some

others, and above all, the acetic acid bacteria *Acetobacter xylinum*. The latter is responsible for the floating meshwork of cellulose fibres with embedded bacterial cells and some yeasts, which make up the so-called fungus. It is similar in composition to “mother of vinegar,” the jelly-like mass composed of both *Acetobacter* and yeasts growing at the top of the substrate used for making vinegar. It looks like a beige or white rubbery pancake. During incubation, the mother network floats in the tea and duplicates itself by producing a new layer, a “baby”, on the surface of the liquid. These offspring are then given to other persons for starting their own batch of Kombucha.

Traditionally grown on black tea with sucrose for seven days, the symbiotic culture produces a range of organic acids, including lactic, gluconic, glucuronic, malic, citric, tartaric, oxalic, and butyric acids, and, particularly, acetic acid as well as a trace of alcohol [ethanol] and B vitamins. The types and proportions of these compounds vary with time and culture conditions. Ideally, the acids and alcohol combine to create a refreshingly sour and sparkling beverage. Incubations for longer than 7 days, however, result in an increasing production of acetic acid and in the formation of vinegar. Since in the end phase mainly acetic acid is produced, partly due to conversion of ethanol, it appears reasonable to associate Kombucha with the genus *Acetobacter*.

Kombucha has been used in Eastern Europe, Russia and Japan for several centuries. Its recorded use in China goes back to 200 BC, when it was known as “The Tea of Immortality.” The name Kombucha is said to have come from Japan. Around 415 AD, a Korean physician called Kombu or Kambu cured Emperor Inkyo’s digestive troubles with the tea and it took his name, “Kombu” and “cha” meaning tea. The brew is still popular in the Far East. Over a million Japanese people are said to drink the brew daily.

The classification of Kombucha vinegar according to Traditional Chinese Medicine is Sour, Bitter and Warm, and milder than alcohol which is Hot [alcohol contributes to phlegm and stagnation]. TCM uses vinegar [Kombucha] to break stagnation and to move the blood and Qi, thus improving circulation and contributing to the general feeling of well-being.

FIRST ENCOUNTER

Spreading during waves of popularity, the compound is passed on from person to person, from generation to generation, crossing borders, connecting past and present. Its survival seems solely dependent upon human

care as no natural colonies have yet been reported. One day anyone might be introduced to it, as happened to esteemed mushroomer Paul Stamets around 1980 when a friend brought him a Mason jar filled with what Stamets describes as a “close relative of the Blob featuring in that corny Sci-fi thriller from the 1950s.”

But this Blob seemed a bit more cohesive and since the lid was tightly screwed on, I felt secure from immediate attack. He passed it on to me with some ceremony, even reverence, in a ritual that had been repeated for centuries. He called it a miracle cure that could fight cancer, slow or reverse the ageing process, i.e. a panacea. People in Tibet lived into their 100’s because of it, he said. The cardinal rule was that it was a gift, never to be sold, but to be cared for and passed on freely to anyone willing to accept it. Anyone who profited from selling it would reap personal disaster and be doomed to a life of ill-fate. Naturally skeptical, I looked at this gelatinised rubbery goop submerged in water and was completely baffled. What was it? “The Manchurian Mushroom,” he replied, smiling enigmatically.

First off, I thought this Blob does not look like any mushroom I had seen - in culture or otherwise. I wondered if he was playing a practical joke. But his sincerity seemed real and he urged me to keep the Kombucha alive by giving it sugar, tea and water. “It came from Tibet” where “monks have used it for hundreds of years.”

The story seemed to be getting better. My curiosity now piqued, he drew some of the liquid between puckered lips and passed the Mason jar to me. The Blob was in my court. Reluctantly, I sipped some of the amber fluid surrounding the Blob and swallowed. The flavour was refreshing, reminiscent of apple cider. I felt suddenly paranoid. I had ingested the Blob. The Blob and I were one.

Soon, my friend departed. Out of the blue, without request, I had been forced to adopt this strange organism of unknown identity, from an untraceable lineage, of questionable use, with vague instructions and claims too extraordinary to believe. Moreover, the admonitions about the need to keep this thing alive suggested the worst should you be derelict in your duties.

A gelatinous sheath was peeling off from the mother colony. Using a fork I tore off fragments, placing them into their new Mason jar homes. As I discarded the extraneous debris into my sink, I envisioned a monster Blob growing in my septic tank, only to escape at some point to wreak havoc and unimaginable

Blobophobia.

One week later, the Blobettes showed significant new growth in all of the Mason jars. I was actually disappointed. I had secretly hoped the things would have died and that would have been the end of it. Now, I had several pet Blobs which surely would consume more time than I could spare. What to do with them? Unwittingly, I had been drawn into servitude to the Blob.

[Paul Stamets, *Kombucha: The Manchurian Mushroom, My Adventures with 'The Blob'* at: www.fungi.com/info/articles/blob.html]

PRESERVATION

Much of Kombucha's touted reputation as 'longevity mushroom' and 'elixir of immortality' comes from its ability to incessantly regenerate itself. An age-old custom, passed on over centuries, everlasting, invigorating and healthgiving, it renews itself in perpetuity rather than deteriorating with age. Supporters, who recommend the concoction without reservation, claim that Kombucha "protects itself through the production of organic acids and a low alcohol content." And: "All these substances in combination provide a powerful antibiotic effect, which shields the symbiotic colony from unwanted foreign micro-organisms that are not part of its inherent makeup." Due to its vigorous growth and sturdy structure it has successfully survived for ages.

In essence, its self-preservation is due to fermentation, which designates all processes whereby a substance, or even a thing, is transformed into a sour-tasting and effervescent state, which enables it to obtain an ascendancy over anyone who partakes of it.

Man has always utilised fermentation as a means to make foodstuff last longer. Acidic foods are less susceptible to spoilage than neutral or alkaline foods and hence the acid helps to preserve the product. Such products have been traditionally associated with a prolongation of life. The late 19th-century scientist Elias Metchnikoff, for example, was convinced that disease-causing intestinal microbes shorten man's lifespan and could be counteracted by the lactic acid bacteria in fermented or 'sour' milk, better known to us as yoghurt. The title of the book in which he propounded his theory says it all: *The Prolongation of Life*. Yoghurt has been used for centuries by many of the long-living ethnic societies, it reads in the book.

The concept of 'forever young' obviously will be reflected in the materia medica of *Laeticum acidum*. According to Jan Scholten, patients needing

this remedy are childish and immature. “They would like to stay a child, a girl all their life.” Difficulties are perceived as increasing with age, so that “every change in life to more independence and responsibility is a possible problem [college, job].”

Organic acids may depict the qualities of preservation and prolongation, they also stand for acidification, for turning sour, going sour, growing acid, and similar negative designations. A sour-tempered person is called a sour- puss; a morose-looking individual is sour-eyed; wine loses its noble qualities when it has turned to vinegar; sour is linked with such words as disagreeable, inharmonious, bad, and unsuccessful. Depending on their degree of acidity, acids bite, destroy, dissolve.

BENEFITS AND RISKS

Based on anecdotal data it's been claimed that Kombucha:

- » Increases longevity.
- <= Inhibits tumour development.
- <= Is effective against arthritis and gout; increases mobility in extremities.
- = Alleviates symptoms of anxiety, irritability, and dizziness.
- Clears facial skin rashes and smoothes wrinkles.
- ~ Improves vision.
- = Enhances the sense of smell.
- => Prolongs sexual appetite and performance.
- = Cures bronchitis and asthma.
- Cures cataracts.
- = Cures nervous headaches.
- = Cures cardiac illnesses.
- == Cures diabetes.
- = Cures diarrhoea.
- = Replaces white hair by black hair; makes hair grow back on bald spots.
- <• Effective against herpes.
- = Reduces hot flashes during menopause.
- = Useful in the treatment of kidney stones.
- = Increases appetite and helps digestion.
- = Cures insomnia.
- = Lowers high blood pressure.
- ~ Has antibiotic, antiviral and antifungal properties.

-
- Clears up Candida yeast infections.
 - = Improves liver function.
 - = Detoxifies; stimulates excretion of cesium, mercury, lead, and benzol.
 - = Improves allergies.
 - = Strengthens fingernails.
 - = Promotes weight loss.
 - = Stimulates the immune system.
 - = Alleviates arteriosclerosis by regenerating cellular walls.
 - = Diminishes sudden drops of blood sugar.
 - « Helps reduce the alcoholic's craving for alcohol.
 - = Reverses the symptoms of AIDS.

Opponents of the “toxic mixture” hesitate just as little to use hyperboles:

- This thing is recommended by New Agers, so please keep away from it if you value your health.
- People have died of heart failure or ended up in coma and then dying because of it. [Refers to a 59-year-old woman in Iowa, USA, on medication for hypertension, anaemia, and mild renal insufficiency, whose “unexplained severe illness” was “possibly associated with consumption of Kombucha tea”; *Jama Journal*, 1996, Jan. 10]
- Many dangerous viruses may reside in the mix including *Aspergillus* [sic], [Exaggeration mixed with ignorance makes a dangerous combination indeed]
- People may be in danger because of the alcohol produced in the fermentation.
- Kombucha is a New Age fad combining the surrogate-child appeal of the pet-rock craze with chain-letter superstitions and miraculous health claims.
- Making Kombucha under non-sterile conditions becomes, in a sense, a biological form of Russian Roulette.

Weighing the possible pros and cons against each other results in a more balanced assessment:

During the past couple of years, as I've tracked and reviewed the Kombucha literature, I've observed some interesting patterns. The vast majority of “experimenters” find Kombucha agreeable to drink but admit that it takes time to adapt to its vinegary taste. Many say they feel more energetic and sleep better. Yet, such subjective feelings are difficult to assess because they are commonly

cited with many new “natural” products. Of greater interest are medical reports from foreign countries. Topping the list of such Kombucha accolades are claims for remedying gastrointestinal problems [Crohn’s disease, gastritis, *Candida albicans*, dysbiosis, and irritable bowel syndrome] as well as arthritic conditions. Some German literature claims that the drink “detoxifies” the intestines. In Brazil, biotechnologists report using the kombucha “mushroom” to make an artificial skin for grafting and burns. The list goes on and on.

... I’ve found that many of the claims made for Kombucha are similar to those made by advocates of apple cider vinegar drink. Because vinegar has often been cited in medical histories as an antiseptic, it comes as no real surprise that Kombucha is often cited as working as an “antibiotic” in the intestines. But is drinking Kombucha any more powerful than drinking apple cider vinegar? Dr. Keith Steinkraus, a Cornell University microbiologist, studied the activity of Kombucha against several bacteria: *Helicobacter pylori*, *E. coli*, and *Staphylococcus aureus*.

He concluded that the vinegar portion [acetic acid] of the Kombucha drink carried all the true antibiotic potential. However, my own research done in cooperation with Dr. John Babish of Paracelsian, Inc. revealed that the Kombucha elixir does have a modest ability to inhibit tumour development [likely due to chemicals found in the green tea base].

One characteristic often mentioned by Kombucha aficionados is that it contains glucuronic acid, a chemical that’s found in the human liver where it serves as a “police escort” for “shipping out” toxins. Recently, Dr. Philippe Blanc, of France’s National Institute of Applied Sciences, confirmed that Kombucha does in fact produce this unusual compound [approximately 5 grams of glucuronic acid per liter of drink].

A 1960s Japanese study demonstrated that a form of glucuronic acid [called glucuronolactone] was effective in helping rid the body of toxins. This same glucuronic acid, according to Dr. Tamura of Tokyo, can also reduce fatigue due to physical exercise. Is there some merit then to claims that Kombucha acts as an energy booster? Perhaps. What’s not clear is whether the glucuronic acid in Kombucha is absorbed by the body in sufficient amounts to make any real difference.*

Despite the seemingly good news, the bad news about Kombucha may be that Brazilian scientists have discovered that it also makes small amounts of other acids [orsellinic, orcinol, salazinic, and evermic] that could feasibly cause an allergic reaction. Moreover, additional research from West Africa found Kombucha tea reduced appetites in mice and rats, and blood pressure in cats,

but it destroyed liver, intestinal, and kidney tissues in some species of rodents. Based on these experiments, the researchers concluded that consuming Kombucha tea for long periods may be hazardous to humans. Just because Kombucha has been used in various parts of the world for centuries without major clinical problems does not mean that it's without problems; it could simply mean that its effects are too subtle to be linked so far to a particular medical disorder. On the other hand, it may be perfectly safe. We already have sufficient anecdotal evidence to suggest that Kombucha should be seriously investigated by the medical community.

[Jeffrey Gates; //newcentury.vegsource.com/public_html/webzine/archives/kobucha.shtml]

* Glucuronic acid plays a role in connective tissue, cartilage, stomach lining, vitreous humour of the eye, and heparin. Widely distributed in the plant and animal kingdoms. Usually occurs in "paired" form, i.e. as a glycosidic combination with phenols, alcohols, etc. Such glucuronides form in the liver to detoxify poisonous hydroxyl-containing substances. The glucuronides present in normal urine are those of phenol, cresol, and indoxyl. After the ingestion of poisons such as morphine, chloral hydrate, camphor, or turpentine, glucuronides formed with the poison or its hydroxylated derivatives appear in the urine.

[Merck Index, 1996]

"Because of the increasing use of this tea [even in groups that usually do not use alternative therapies]," the CDC advice that "health-care professionals should consider consumption of Kombucha tea in the differential diagnosis of persons with unexplained lactic acidosis."

[Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, December 8, 1995]

COMPARISON WITH ACETICUM ACIDUM

Since no provings have been conducted with Kombucha and dynamic effects are thus unknown, we have to settle for physiological effects as reported by Kombucha drinkers^K.

If regarded as vinegar with attitude, Kombucha should be compared with acetic acid. The homeopathic drug picture of *Aceticum acidum*, although unproven and far from complete, gives an idea of the downside of acidity. Clarke states that "the leading features of acetic acid are excessive wasting and

debility; anaemia with waxy pallor of face; intense thirst; burning in throat; nausea; retching, and sour rising as met with in cases of cancer and debility.” The symptoms of Aceticum acidum stem from cases of overdosing and/or susceptibility to vinegarA

Chronic acetic acid poisoning may be observed in workers engaged in the manufacture of vinegar or from its continued use for the purpose of losing weight. It is characterised by pallor, cachexia, corrosion of the teeth, fetid breath, hoarseness, bronchitis, emphysema, gastrointestinal disturbances, and anaemia.

^KDecreased susceptibility to colds and flu 82%.

^ALiable to frequent catarrhal attacks.

^KFeeling of well-being 81%.

^ASense of oppression and heaviness. Dull and low-spirited.

^KImprovement of constipation 81%.

^ADiarrhoea; watery; liquid; bloody.

^KIncreased energy 44%.

^AGreat debility. Prostration of strength. Fainting fits.

^KRelief from painful arthritis-type symptoms 42%.

^KSensation of lameness in wrists and hands. Diminished muscular power of arms and hands. Impaired muscular power of legs.

■Weight loss 30%.

^ALeanness. Wasting away; great emaciation. Prevents corpulence, but may superinduce fatal marasmus.

^KBetter sleep patterns 27%.

^ASleep broken without known cause. Cannot fall asleep because of distress and agony. Sleepless, with other sufferings.

^ARelief of ulcer pain, heartburn, excessive gas, and digestive problems 27%.

^AVomiting soon after eating. Violent pain and sensation of burning in region of chest and stomach. Severe burning pain in stomach and abdomen. Heat in stomach. Hot eructations. Fetid belching. Sensation as

if stomach contents were in a state of ferment !. Pain as of ulcerative gnawing at a spot in stomach. Fancies there is an ulcer in the stomach, which seems sore in one spot, with gnawing. Abdomen distended. Rumbling in abdomen.

improved condition of skin 21%, liver spots 17%, moles 10%, hair and nails 8%.
^Tetter-like eruptions. Diseased cuticle separates in flakes. Skin pale and waxen.

^KRelief from PMS symptoms 19%, menstrual cramps 13%, menopause symptoms 7%.

^AMetrorrhagia. Breasts greatly and painfully distended with milk [in nursing women]. Flushes of heat in external parts, with increased perspiration.

^KReduced craving for sugar 17%, coffee/caffeine 13%, alcohol/beer.

^AHeadache from abuse of tobacco, opium, coffee, or alcohol.

Compare detoxifying functions glucuronic acid.

^KBetter concentration 12%.

^ADiminished intellectual power. Confusion of ideas. Disinclination to exert the mind. Intellect clouded; hardly able to express herself.

^KBronchitis, asthma, and coughs [6%].

^ARespiration difficult from laryngeal obstruction; hurried and laborious; loses breath on ascending stairs; laboured when lying on back; difficult with attacks of anxiety. Cough: croupy; dry, then moist.

^KBetter alcohol [wine] tolerance.

^AHeadache from abuse of alcohol.

^KImprovement of high blood pressure with headaches and dizzy spells.

^AGiddiness. Indications of vascular excitement in brain. Distension of temporal blood vessels, with increased heat of head.

^K“Incredibly vivid dreaming.”

^ANo dream symptoms reported.

^Offensive foot sweat [cured],

^Not mentioned for Acet-ac., but is characteristic for Butyricum acidum!

^K Hepatitis with “horrible fatigue and nausea” [cured],

^A Liver complaint with great irritability, diminished eyesight, vomiting after every kind of food, difficult breathing with attacks of anxiety, and sleeplessness. [case Hering]

^K Haemorrhoids [cured],

^A Profuse haemorrhoidal bleeding.

^K Improved circulation [including Raynaud’s syndrome].

^A Coldness and prickling in hands. Coldness of the feet. Skin cold; bodily warmth decreased.

[Statistics from Kombucha questionnaire by Ariana Estelle-Symons, 1996; Anecdotal evidence from Health Benefit Reports From Kombucha Drinkers; at:

http://home.mweb.co.za/pe/pedropwd/SI_Kom_02.html]

III. ORDER RICKETTSIALES

III.A. FAMILY RICKETTSIACEAE

Rickettsia prowazekii

RICKETTSIA PROWAZEKII

Scientific name *Rickettsia prowazekii* de Rocha-Lima 1916

Family Rickettsiaceae

Homeopathy Typhus nosode

RICKETTSIA

- Gram-negative, very small, motile, rod-shaped, coccoid and often pleomorphic [occurring in more than one distinct form] bacteria.
- Named after the American pathologist H.T. Ricketts [1871-1910] and the Austrian Stanislaus von Prowazek [1875-1915], who both lost their lives to typhus contracted during their work.
- Considered a separate group because they have the common factor of being spread by arthropod vectors [lice, fleas, mites and ticks].
- Obligate intracellular parasites.
- Resistant to humidity and to dryness.
- In mammalian hosts mainly found in endothelium of small blood vessels, particularly in those of the brain, skin, and heart.
- The genus contains about 11 species; the type species is *Rickettsia prowazekii*.
- *Rickettsia* has many similarities to *Chlamydia*.
- Many *Rickettsia* species are localised to certain geographic areas; hence the naming of typhus fevers by the area in which they occur.

RICKETTSIOSIS

Several forms of rickettsiosis are distinguished.

- Vesicular rickettsiosis, Kew Gardens fever or rickettsialpox. Associated with *R. akari*; transmission by a mite parasitic on the house mouse.

Symptoms: papule developing into a deep-seated vesicle, which dries into a black eschar [scab]; fever, chills; headache, backache; profuse perspiration;

local adenitis. Early in the febrile course, a generalised maculopapular rash with intra-epidermal vesicles appears, sparing the palms and soles [may be confused with chickenpox].

- Mite typhus, scrub typhus, tropical typhus, island fever or tsutsugamushi disease. Associated with *R. tsutsugamushi*; transmitted by larvae of mites.

Symptoms: fever; painful swelling of lymphatic glands; headache; conjunctival injection; small blackish scab on genitals, neck, or axilla; macular rash on trunk, extending to arms and legs.

VECTORS

Lice, body lice, fleas; mice and rat mites, fleas and ticks

RICKETTSIOSIS alias

Kew Gardens fever

Rickettsialpox

Tsutsugamushi disease

Mite typhus, scrub typhus

Island fever / tropical

typhus

Murine typhus / endemic

typhus

Red / Congolian red typhus

Rocky Mountain spotted

fever

Black fever / black measles

Blue fever

Mexican spotted fever

Sao Paolo fever

N. Queensland tick typhus

Siberian IN. Asian tick

typhus

Mediterranean spotted fever

Fievre boutonneuse

Qfever

Brill-Zinsser disease

Epidemic / louse-borne

typhus

Jail/Camp/Ship/Road fever

Irish fever

- Murine [mouse-like] typhus, endemic typhus, red or Congolian red fever, or flea-borne typhus. Associated with *R. typhi* [*R. mooseri*]; transmitted by rat or mouse fleas.

Symptoms: similar to those of epidemic typhus but milder. Onset with shaking chill, followed by headache and fever; fever lasts about 12 days. Rash sparse, discrete, non-confluent and less extensive; renal and vascular complications uncommon.

- Rocky Mountain spotted fever, black fever, blue fever, Mexican spotted fever, black measles, Sao Paulo fever, or tick fever. Associated with *R. rickettsii*; transmitted by wood ticks or dog ticks.

Symptoms: Abrupt onset, with severe frontal and occipital headache, chills, prostration, and muscular pains; oedema of the face; intense lumbar pain; malaise; macular rash - initially pink, later darker - spreading from the palms/wrists and soles/ankles over body; high fever; unproductive, annoying cough. Neurologic symptoms include headache, restlessness, insomnia, delirium, and coma, all indicative of encephalitis.

- North Queensland tick typhus. Associated with *R. australis*.

Siberian or North Asian tick typhus. Associated with *R. sibirica*.

Mediterranean spotted fever or fievre boutonneuse.

Associated with *R. conori*.

All three are transmitted by ticks.

The symptoms and signs are similar for all; they are milder than spotted fever. After an incubation period of 5 to 7 days, fever, malaise, headache, and conjunctival injection develop. With the onset of fever, a small buttonlike ulcer 2 to 5 mm in diameter with a black centre appears [an eschar, or, in *fievre boutonneuse*, *tache noire*]. Usually the regional or satellite lymph nodes are enlarged. On about the 4th day of fever, a red maculopapular rash appears on the forearms and extends to most of the body, including the palms and soles. Fever lasts into the 2nd wk.

[Merck Manual]

- Q fever. Associated with *Coxiella* [*Rickettsia*] *burnetii*.

Sheep, cattle, and goats are the principal reservoirs for human infection. *C. burnetii* persists in faeces, urine, milk, and tissues [especially the placenta]. Onset is abrupt, with fever, severe headache, chills, severe malaise, myalgia, and, often, chest pains. Fever may rise to 40° C. [104° F.] and persist for one to more than three weeks. Unlike other rickettsial diseases, Q fever is not associated with a cutaneous exanthem. A nonproductive cough and x-ray evidence of pneumonitis often develop during the 2nd wk of illness. About one-third of patients with protracted Q fever develop hepatitis, characterised by fever, malaise, hepatomegaly with right upper abdominal pain, and possibly jaundice. [Merck Manual]

- Brill-Zinsser disease or recrudescent typhus. Mild form resembling murine typhus with similar circulatory disturbances and including hepatic, renal, and CNS changes; associated with the “carrier state” in persons who previously had epidemic typhus fever.

- Epidemic typhus, louse-borne typhus, jail fever, camp fever, ship fever, classic typhus, or European typhus. Associated with *R. prowazekii*; transmitted by body lice.

Symptoms: high fever; physical prostration; mental depression; macular eruption - initially pinkish, later darker - spreading from the axillae and upper trunk peripherally, sparing face, palms, and soles; cyanosis; ecchymotic skin necrosis; digital gangrene; renal failure; delirium; coma.

Generally fatal among people over 60, epidemics of typhus fever usually kill about 10-15% of victims around 40, but seldom kill more than 5%

under 20.

Since *R. prowazekii* has more potent effects on malnourished and/or physically exhausted individuals, these factors have no doubt contributed to the predations of typhus during periods of military conflict over the centuries.

EPIDEMIC TYPHUS

Contributing to the epidemic dissemination of infections are the four C's: civilization, colonisation, conquest, and commerce. Guns in the hands of conquerors, and germs in their trail, make a deadly couple.

Like plague, epidemic typhus, at various times raging through Europe, is a typical example of a mass enervating occurrence arising from mass emotional stress due to overcrowding, poor sanitation, war, famine, etc. Conversely, mass overeating may result in epidemics of food-poisoning. Pandemics often follow in the aftermath of war, such as the great flu epidemic after World War I, which actually killed more people than died as a result of the War itself. Or, in the days of Hahnemann, the epidemic from "a kind of war typhus," which had been rapidly spreading upon the return of the remnants of Napoleon's defeated army from Russia, dragging with them the typhus scourge from the inhospitable plains of Asia Minor. During the Great Famine of 1845-47, typhus, called 'Irish fever' by the landlords, worked its way through Ireland.

"Soldiers have rarely won wars. Typhus and other infectious diseases have decided the outcome of more military campaigns than Caesar, Hannibal, Napoleon and all generals in history. Depending on the outcome for each warring faction, either the epidemics were blamed for defeat, or the generals were credited with victory." This wrote the American bacteriologist and immunologist Hans Zinsser [1878-1940] in his classic book, *Rats, Lice and History*.

Typhus is believed to have arrived in Europe from the Near East during the Crusades. First decimating armies in the 16th century, typhus ravaged Europe during the Thirty Years War [1618-1648], and remained widespread, "devastating armies as 'camp fever', dogging beggars [road fever], depleting jails [jail fever] and ships [ship fever]." [Porter]

EPIDEMICS

CIRCULATE BY:

civilization

colonization

conquest

commerce

Disease decides more

wars than military

strategy.

SYMPTOMS OF TYPHUS FEVER

- = Rapid spread where many persons are confined to a limited space.
 - = Continuous high fever.
 - = Sense of great weakness and debility, coming suddenly. "Feels lousy."
 - = Apathy or excitement.
 - Lies apathetic on his back, talks deliriously while awake, or mutters in his sleep. Lies flat on his back, with his eyes half closed, and his hands on his genitals.
 - Mutters single, unintelligible words; gesticulates; catches at something in the air, picks the bedclothes; tries to rise or to put his feet out of bed; draws faces according to the nature of his ever-working imagination; his mind seems to be constantly busy at something, although entirely disconnected from the world around him.
 - Intense excitement, wildness almost, can scarcely be held in bed. Constant attempts to jump out of bed and run away.
 - = Inability to think; answers slowly and incoherently.
 - = Heaviness or pain in head, may be somewhat > by epistaxis.
 - = Vertigo & flickering before the eyes and ringing in the ears.
 - = Hearing impaired.
 - = Tongue dry, parched, coated brownish, trembling; swallowing difficult.
 - = Teeth and gums covered with sordes; nostrils appear blacked as by soot; bad breath.
 - => Constipation & involuntary loss of urine.
 - « Enlargement of spleen.
 - ®> Muscles sore and aching; trembling < motion.
 - = Catarrhal affections of eyes, nose, throat, and chest.
 - =» Harassing, coarse cough, unproductive: sputum scanty, viscid, sometimes bloody.
 - ~ Measles-like rash first on the trunk and gradually spreading over the entire body.
 - = Amnesia; entirely without remembrance of what has passed.
 - = Recovery delayed or complicated by return of "slow fever," or by parotiditis, pneumonia, numerous furuncles, abscesses, or thrombi in the veins of the legs.
- [Extracted from Raue]

MATERIA MEDICA TYPHUS NOSODE

Sources

There are neither provings nor clinical cases. Hering is known, according to David Little, to have bound bags of milk sugar in contact with the skin of typhus patients in an obvious attempt to capture some effluvium for making a typhus nosode. However, the results of such experiments are shrouded in mystery.

To avoid confounding typhus with typhoid, a better name for the nosode might be Rickettsianum.

An emerging picture

The Belgian physician Cecile Jadin, working in South Africa, has advanced the theory that chronic fatigue syndrome is a form of rickettsiosis, caused by rickettsial organisms. One of her arguments is that “the symptoms displayed by CFS, fibromyalgia, rheumatoid arthritis, and even neurological patients as MS, same diversity of symptoms as rickettsial patients. How many blamed the diversity of symptoms for misleading unprepared practitioners in the diagnosis of chronic rickettsial infection? That same diversity could have contributed to the delay in recognising CFS. French authors [Giroud, Jadin, Legag] attribute those multiple aspects to a generalised micro-vascular invasion. They widely demonstrated the persistence of Rickettsiae in the vessels. The suggestion here is that the well-known, well-documented entity of rickettsial disease, showing the same symptoms as the newly arrived CFS, might simply, partially or totally be caused by the same agent.”

Jadin finds support for her view in an article in the Lancet of April 1996, which proposes Post Q Fever Syndrome as a more appropriate name for chronic fatigue syndrome.

Stress or other factors would activate dormant rickettsial infection, altering the asymptomatic stage into a symptomatic one. This idea closely matches Hahnemann’s idea of chronic miasms as arising from infections “driven away from the skin or disappearing of themselves, through causes which are not noticed.” Chronic diseases never pass away of themselves; “they must therefore all have for their origin and foundation in constant chronic miasms, whereby their parasitical existence in the human organism is enabled to continually rise and grow.” [Chronic Diseases, Vol. I, p. 9] Another head of the hydra-headed psora has cropped up.

CONNECT

Chronic Fatigue

Syndrome [CFS] with

Typhus I Rickettsial

infection [CFI]

show the
scientists

Rodents, bird migrations and global air traffic are held responsible by Jadin for the explosion of rickettsial diseases. To demonstrate the reality of “chronic rickettsial infection [CRI]” Jadin reviewed 3,400 patient cases presenting with chronic fatigue syndrome, fibromyalgia, rheumatoid arthritis, depression and/or multiple sclerosis which could be diagnosed as suffering from CRI. Prior to the development of these chronic conditions, the majority of the patients reported “a flu-like condition, with often an elevated temperature and severe headaches” lasting for a few days and then disappearing or reoccurring.

More important than the aetiology, however, are the symptoms most commonly exhibited by the patients since these furnish an emerging drug picture.

Memory and concentration deficit.

Tiredness.

Myalgia.

Loss of balance.

Perspiration, low grade fever.

Migrating joint pains.

Bruising.

Raynaud’s syndrome.

Multiple adenopathies.

Headaches - behind the eyes and in the temples, worse after prolonged horizontal position or mental effort.

Vision abnormalities.

Recurrent sore throat.

Chest pain, palpitations.

Psychological and neurological disorders [predominantly endogenic depression, aggressive behaviour, and seizures].

Aside from treatment with tetracycline as the drug of choice, plus adjuvants such as vitamin B complex and acidophilus, exercise is recommended because:

“Rickettsia is a vascular disease and exercise, properly done, will improve the smooth peri-vascular muscle function, as well as develop the most important muscle, the heart. The fact that strains of Rickettsiae grow better in vitro when maintained in a CO₂ enriched atmosphere suggests that Rickettsiae grow best when the metabolism of the host cell is low.”

[Data from: C. Jadin, *The Rickettsial Approach and treatment of patients presenting with CFS, Fibromyalgia, Rheumatoid Arthritis and Neurological Dysfunction*, Febr. 1999; at: www.cfsresearch.org/rickettsia/]

It should be noted that symptoms commonly regarded as characteristic of chronic fatigue syndrome - alcohol intolerance, irritable bowel, chocolate craving, paroxysmal sweating, loss of sensation on one side of the body, light-headedness, and faintness - are lacking or not reported.

Proteo bacteria: Group Beta

| Phylum | Order | Family | Genus | Species | Remedy |
|----------------|--------------|-----------------|------------------|----------------------------------|-------------------|
| PROTEOBACTERIA | Gp Beta | Burkholderiales | Alcaligenaceae | Alcaligenes — <i>A. faecalis</i> | — BN Faecalis |
| | | Burkholderiales | Burkholderiaceae | Bordetella — <i>B. pertussis</i> | — Pertussinum |
| | | | | Burkholderia — <i>B. mallei</i> | — Hippozaeninum |
| | Neisseriales | Neisseriaceae | Neisseria | <i>N. gonorrhoea</i> | — Medorrhinum |
| | | | | <i>N. meningitides</i> | — Meningococcinum |
| | | | | <i>N. subflava</i> | — Flavus |
| | | | | <i>N. mucosa</i> | — BN Sycotic Co. |

“The beta proteobacteria include a mixture of well-established and newly defined genera. The betas also include photosynthesizers and non-photosynthesizers; some that metabolise sulphur and some that do not; the soil bacterium *Nitrosomas*, which oxidises ammonium to nitrite within the soil.” [Tudge]

I. ORDER BURKHOLDERIALES

IA. Family ALCALIGENACEAE

IB. Family BURKHOLDERIACEAE

IA. FAMILY ALCALIGENACEAE

Alcaligenes faecalis

Bordetella pertussis

ALCALIGENES FAECALIS

Scientific name *Alcaligenes faecalis* subsp. *faecalis* Castellani and Chalmers 1919

Family Alcaligenaceae.

Homeopathy Faecalis [bowel nosode] - Faec.

FEATURES

- Unpigmented, rod-shaped, Gram-negative, motile, obligate aerobic bacterium.
- Does not assimilate glucose or any other carbohydrate; does not produce acid or gas from carbohydrates.
- Found in the intestinal canal, decaying materials, dairy products, and soil.
- Produces fatty acids and putrescine.
- Non-pathogenic.

In homeopathic literature its name is reversed as “Faecalis alkaligenes.”

Gaier lists *Streptococcus faecalis* [= *Enterococcus faecalis*] as its synonym. This appears to be incorrect because *E. faecalis* ferments carbohydrates whereas *Alcaligenes faecalis* can not, which is consistent with the definition of bowel nosodes as obtained from “non-lactose fermenting bacteria”

MATERIA MEDICA FAECALIS

Faec.

One of the originators of the bowel nosode concept, J. Paterson, says about Faecalis: “I have never found this nosode made from the *B. Faecalis* of much value in treatment, but where I have found the organism in the stool, the

clinical symptoms have led me to choose *Sepia*, as the indicated remedy.”

“The bacillus faecalis alkaligenes represents states of alkaline over acidic conditions within the bowel system, with one of the seats of disturbance being the liver. This nosode mirrors mostly the tendencies of the *Sepia officinalis* state, characterized by heightened irritability and impatience, coupled with emotional retreat from loved ones. Typically, physical symptoms centre around a bearing-down or dragging sensation throughout psyche and body, nausea, craving for acids, coldness, and liver troubles. The cuttlefish *Sepia officinalis* symbolizes this emotional retreat by its tendency to pull the body into its shell and exude dark ink when irritated. In contrast to *Proteus* and *Morgan*, *Faecalis alkaligenes* more openly expresses grief, as the *Sepia officinalis* patient weeps when telling symptoms and the emotional retreating is not as solidly entrenched.” [Boedler’s *Psychic Causes*; RefWorks]

The drug has one symptom in the repertory: Urine, albuminous.

BORDETELLA PERTUSSIS

Scientific name *Bordetella pertussis* (Bergey et al. 1923) Moreno-Lopez 1952

Old names *Haemophilus pertussis*
Bordet-Gengou bacillus

Family *Alcaligenaceae*

Homeopathy *Pertussinum* - Pert.
Pertussis vaccinus - Pert-vc.

FEATURES

- Gram-negative, non-motile, obligate aerobic coccobacillus.
- Parasite and pathogen of mammalian respiratory tract, found solely on epithelial cilia. Virulent strains are encapsulated.
- Respiratory metabolism; non-fermentative; use glucose and lactose oxidatively.
- Optimum growth at 35°-37° C.
- Grows best on media [substrates] that contain activated charcoal. *WHOOPING COUGH*
Interestingly, *Carbo vegetabilis* provides “routine protection” against *Progression- Timescale*
whooping cough, according to Grimmer.] *Incubation 1-2 wks*
- Haemolytic. Produces exotoxin. *Infectious 5 wks*
- Type species of the genus *Bordetella*, which at one time was *Increase - catarrh - low*
classified in the genus *Haemophilus*, but has been re-classi- *fever - cough 2 wks*
fied. *Leukocytosis*
- Aetiological agent of whooping cough [pertussis]; transmitted *Whooping cough 2-4*
from person to person by bacteria-bearing respiratory *wks. Vomiting food*
droplets. *and phlegm.*
- First isolated in pure culture in 1906 by Bordet and Gengou. *Symptoms subside.*
Convalescence -

CLINICAL FEATURES

Attaches to ciliated cells of the respiratory tract, where it, during *far patient and nurse.* an incubation period of 1-2 weeks, starts multiplying rapidly and liberating its toxins which inhibit host cell phagocytic responses and natural killer cell activity.

This is followed by a catarrhal stage with low-grade fever, rhinorrhoea, sneezing and mild but progressive cough that lasts for about 2 weeks. At the

end of the catarrhal phase, a leukocytosis with an absolute and relative lymphocytosis frequently begins, reaching its peak at the height of the paroxysmal stage. At this time, the total blood leukocyte levels may resemble those of leukemia with 60 to 80% being lymphocytes.

Next is the paroxysmal stage, lasting 2-4 weeks and characterized by rapid, consecutive, spasmodic cough episodes with a long, crowing inspiration between the coughs [has a whooping sound]. The spasmodic cough most frequently ends with vomiting of ingesta and large masses of tough, gelatinous phlegm from the bronchi. The ciliary action of the respiratory tract has been compromised, mucous has accumulated, and the patient is trying to cough up the mucous accumulations. Hard paroxysms, by their violent convulsive straining, not unfrequently cause bleeding from mouth, nose, and even ears.

Patients are most infectious during the early, catarrhal phase and remain infectious for about 5 weeks.

Finally there is a convalescent stage during which symptoms gradually subside. This can take months.

Antibiotics, with erythromycin as the drug of choice, have no influence on the course of the disease, but will reduce the infectious period to 5 - 10 days.

BACTERIAL Secretory IgA antibodies sit in mucous membranes, forming the
LANGUAGE first line of attack on foreign organisms, and are passed on to
crowd children through the placenta and breast milk. Secretory IgA
overpopulation antibodies in nasopharyngeal secretions usually appear during
mass the second or third week of whooping cough and are indicative
herd of natural infection. Because infants do not regularly produce
The majority of IgA antibodies before 6 months of age, they are considered most
bacteria live at risk and thus subjected to routine immunisation from the age
symbiotically. of 2 months. However, secretory IgA antibodies are not stimu-
What turns bacteria lated by vaccines [other than oral polio]!

into pathogens?

Overcrowding? Stress.

Domestication =

Subjugation by

Adaptation.

CROWD VERSUS INDIVIDUAL

“Whooping cough killed 1400 children out of every million in

1850, but one hundred years later whooping deaths were less than 10 per million. Scarlet fever behaved in the same way.

Measles, typhus, pneumonia, dysentery and polio all share similar histo-

1900 civilization had lost its biological population check: infectious disease. After centuries of hostile encounters, humans and microbes found a new adjustment with little interference from drug or vaccines. In some cases the microbes became less virulent [measles and diphtheria] or the human host more resistant [tuberculosis].”
[Porter]

Infectious diseases, including childhood diseases, are commonly known as crowd diseases or crowd epidemics. Crowd diseases arose with the buildup of large, dense human populations and are believed to have begun with the rise of agriculture some 10,000 years ago. Accelerating with the rise of cities, the first attested dates for many crowd diseases are surprisingly recent: around 1600 BC for smallpox, 400 BC for mumps, 200 BC for leprosy, and AD 1840 for epidemic polio. [Diamond]

Crowd diseases have been the reason for *mass* immunisations to induce *herd* immunity. For the sake of public health, aside from economic motives, individual health may be sacrificed, as Samantha McCormick points out in *Vaccine Skepticism: Adverse Effects and Alternatives*:

Vaccines are designed to protect populations, not just individuals, from diseases. Every individual who is vaccinated will not necessarily develop immunity. However, if enough individuals do respond to the vaccine in a given population, the organism, whose natural host is humans, will not be able to sustain itself in that population and outbreaks will not occur or will be limited. This concept is referred to as “herd immunity”. It protects both immune and non-immune members of a community. If non-immune persons fall below a certain percentage, generally around 70-90%, outbreaks of the disease will occur. This is the reason that the state claims an interest in mandating vaccines, so that the unvaccinated do not pose a threat to the vaccinated. If vaccines truly conferred individual immunity, it would be no one’s business if any individual chose not to vaccinate. The risk we ask some individuals to take on, when some vaccines have dangerous adverse effects, is that a few individuals are, in effect, sacrificed, so that the rest of society may survive disease free. Unlike the virgins sacrificed to the gods in primitive societies, the victims of vaccines are not informed beforehand of their brave duty to their community. Nor are they exalted for their sacrifice.

[article available at: www.gentlebirth.org/archives/immnzal.html]

health subjects, if any, will be so individually challenging as the issue of ination, in particular in countries where herds prevail over individuals

and failure to comply is penalised. Magnifying childhood diseases as potentially fatal is generally effective in reducing individuals to silence. Instead of being harmful by definition, childhood diseases provide potential benefits as well. In the anthroposophical view, for example, childhood diseases are “acute manifestations of the struggle between the ego and the forces of heredity.” Or should we leave one letter out and say, ‘herdity’? Each childhood disease poses special demands and offers characteristic prospects.

The endeavour to rebuild and individualise the physical body gives rise to the predisposition to scarlet fever. At other times the spiritual being is more unstable and tends to give way to the earthly model. The child will then be susceptible to measles. This condition gives one the impression of a watery illness: the eyes water and the eyelids swell, and there is a somewhat puffy appearance of the whole body. ... In contrast, scarlet fever, with its more dramatic character, makes one think of a conflagration. The dryness of the skin and the sandy feel of the rash recall the mineralising action of the ego whose fire leaves ashes. This mineralising action is found also in the complications of scarlet fever, which are nephritis and rheumatism.

If scarlet fever makes us think of the element fire and measles of the element water, whooping cough unquestionably corresponds to the element air and the astral body. It is characterised particularly by the fits of coughing ... which represent a desperate attempt of the organism to get rid of the air contained in the lungs. In normal respiration the union between the astral body and the physical organism varies in a rhythmic manner, but in whooping cough, as a result of the irritation of the bronchi, the astral forces remain fixed firmly to the body, causing spasm of the glottis and retention of air. The trapped air then acts as a foreign body which the organism tries to expel, but this is impossible because of the closure of the glottis.

Finally the increasing carbon dioxide content of the blood gives rise to a tendency to syncope and therefore to a detachment of the astral body. The spasm gives way and the air enters the lung again with a whistling sound. It may seem a paradox that a desperate attempt to expel air ends in an inspiration. In reality it is the residual air which acts as a foreign body which the body tries to expel.

The part played by the astral body makes us understand the importance of the emotional factor in whooping cough. Children of anxious mothers suffer from this condition more severely and dramatically than those whose mothers keep calm. The following is a typical example of this. I had been treating a child

with whooping cough shortly before going on a journey and had handed him over to the care of a colleague the evening before my departure. Everything went off very well up to the moment when the mother learnt of my departure. Her anxiety had immediate repercussions on the child whose fits of coughing increased considerably in frequency and intensity, although the treatment had in no way changed.

Therefore in order to treat a case of whooping cough one should start off by reassuring those in contact with the child and insist on a discipline which is in certain respects very strict. Above all the food intake must be considerably reduced. It is not always easy to achieve this, for a mother is always afraid of her child dying of hunger but never of dying from overeating! When there is vomiting a light meal is given after a fit of coughing. If vomiting is frequent, one should think of compensating for the loss of chlorides by giving salt. ... Setbacks are frequently due to overloading of the stomach. One must not be afraid to see a child lose weight, for when the illness is over the child will show an excellent appetite and quickly regain his weight [unless the fits of coughing have been suppressed with codeine or its derivatives].... [Treated this way] ... one will be surprised at the progress the child will have made. This progress shows itself even in his speech. On the other hand a child in whom the illness has been repressed progresses very slowly for months and sometimes for years. Accordingly a child should never be vaccinated against whooping cough for this would deprive him of the possibility of development which is given to him by the illness.

[Victor Bott, *Anthroposophical Medicine*-, London, 1978]

MATERIA MEDICA PERTUSSIS VACCINUS

Pert-vc.

Sources

The materia medica of Pertussis vaccine is based on reports of adverse effects following pertussis, DPT or DTP vaccination. [See under DPT vaccine for the symptom picture.]

Effects associated with the activity of released toxins include:

Release upon cell lysis [cell death] of a toxin with strong vasoconstrictive effects.

Increased capillary permeability and increased susceptibility to histamine and serotonin.

Metabolic alteration, eg increased insulin release and hypoglycaemia as a consequence.

Secondary infections such as otitis media and pneumonia are common.

CNS dysfunction, eg acute encephalopathy characterized primarily by convulsions, occurs in approximately 10% of cases. The convulsions can result in brain damage.

Bacteraemia does not occur

Hypoglycaemia

Pertussis toxin stimulates the pancreas to secrete more insulin, a causal relationship on which Coulter and Fisher have this to say:

Another name for the LPF, or pertussis toxin, is islet-activating protein, or IAP, so called because it has been shown in laboratory animals to provoke excess production of insulin by the pancreas. Researchers have also detected increased insulin production in infants injected with the pertussis vaccine. Some physicians have suggested that parents give their children sweetened fruit juices before DPT vaccination to prevent hypoglycaemic shock, because of the vaccine's ability to increase insulin production.

In 1970, Pittman stated, "The infant whose blood sugar level is influenced by

food intake may be especially vulnerable to vaccine-induced hypoglycaemia

PERTUSSIS should a feeding be missed because of a feverish reaction following

VACCINE vaccination ... the vaccine induces hypoglycaemia in mice and

REACTIONS rabbits." Stewart observed in 1977 that "*more than any other vaccine in common use, pertussis vaccine is known pharmacologically to provoke*

increased insulin production may link with diabetes. ... hypoglycaemia due to increased production of insulin. "

CNS effects - ... Hennessen and Quast in West Germany found that 59 out of

convulsions, 149 cases of adverse reactions to the pertussis vaccine developed

brain fever, symptoms corresponding to the hypoglycaemic syndrome. An

Allergic reactions - equally serious issue, about which less information has been developed, is the relationship between the vaccine and diabetes. Diabetes

milk, dairy products, has been reported to be a complication of a very serious case of whooping cough, [my italics]

consider also fish, beans, carbohydrates, nuts!

Allergies

Called "histamine sensitizing factor," pertussis toxin induces

gastrointestinal mucosa, increased histamine release results in allergic rhinitis, conjunctivitis, asthma, urticaria or other skin reactions, and gastrointestinal food reactions. In particular allergy to milk and milk products have been demonstrated to be exacerbated by pertussis vaccine, or a personal or family history of allergies are a predisposing factor to more severe reactions to the vaccine, including systemic anaphylaxis and various other types of shock.

Enhanced as well by pertussis vaccine is sensitivity to serotonin, which manifests itself by a host of symptoms such as confusion, mood changes, altered sleep patterns or somnolence, altered pain perception, vomiting, abdominal cramps, diarrhoea, and striking colour changes ranging from pallor to cyanosis. Serotonin induces sleep at night and relaxation during the day; it helps to deal with stress and to control hyperactivity.

Although virtually nothing is known about food issues in relation to both Pertussis vaccine and Pertussinum, except for milk, these may be expected to be associated with foods rich in serotonin, such as pasta, starchy vegetables, potatoes, cereals, bread, bananas, etc., or in its precursor, tryptophan, such as milk, dairy products, fish, nuts, and beans. Carbohydrate based food raises insulin levels which, in turn, raise the levels of tryptophan, which is converted into serotonin in the body.

This puts Pertussinum and Pertussis vaccine on the homeopathic map in the treatment of patients with multiple food allergies, especially when these were activated or aggravated by pertussis vaccination or a severe attack of whooping cough. It should also be noted that reduction of food intake plays an important role in the anthroposophical approach of whooping cough.

SYMPTOMS REPERTORY

Synthesis 9.1 lists 190 symptoms for Pertussis vaccinus that were gathered by Prakash Vakil, India. The following symptoms occur in rubrics of 60 remedies or smaller.

Mind

“Abusive, insulting.

“ Confident.

“ Courageous.

“ Delusion, clouds, head were confused by a cloud, after exposure to sun.

“ Excitement amel.

Irritability from slightest contradiction.

Head - pain

- ~ Occupation amel.
- = While talking.
- ~ Thinking of pain.
- = Temples, from exposure to sun.

Face

- = Wrinkled, after exposure to sun.

Abdomen

- <= Distension, tympanitic, Hypochondria, right.
- = Pain, Umbilical region, afternoon, 15h. - eating does not > - pressure >.
- = Sensitive skin.

Chest

- == Pain, Intercostal muscles, in spots.
- = Pain, stitching, appearing and disappearing suddenly.

Back

- «■» Pain, riding on a moped.
- = Pain, sitting erect amel.
- = Pain, warm bath amel.
- = Pain, Lumbar region, support amel.

Dreams

- = Cats, running.
- = Coition, without pollution; without waking up.
- = Examinations, missing an exam due to oversleeping.
- = Father.
- = Hiccough, constant.
- = Snakes, biting him.

Skin

- « Eruptions, eczema, open air amel.

Generals

- = Food and Drinks, bland food, desire.
- « Pain, appear suddenly and disappear suddenly.
- = Pain, in small spots.
- « Restlessness after exposure to sun.
- « Trembling, internally, after exposure to sun.

MATERIA MEDICA PERTUSSINUM

Pert.

Sources

An unproven remedy, the symptom picture of Pertussinum derives from the clinical picture of whooping cough. The remedy was introduced by Clarke around 1900 for the treatment of whooping cough and other spasmodic coughs. Clarke adopted the French name for the nosode, Coqueluchinum, because the name Pertussin was already taken by the time he published a booklet dealing with the nosode in 1908.

The nosode is also given in cases where there is a distinct element of “never well since whooping cough.” This includes Raskova’s statement that *Bordetella pertussis*, contained in the stringy mucus from which the remedy is made, is thought “to be a precursor of bronchiectasis and the cause of mental deficiency or behaviour disorders in those children that survived the initial disease.”

Symptoms

Clarke noted “a few special symptoms removed by Pertussinum,” such as:

Cough

provoked by intense tickling in throat, fauces or trachea;

accompanied by coryza; dyspnoea; strangling sensation on waking; spasmodic choking;

causing intense flushing of face; stinging pain in or on the chest;

appearing in frequently repeated paroxysms;

sounding deep and croupy;

ending with vomiting or nausea; sobbing or sighing respiration.

Itching of the palate on lying down at night.

CLINICAL PATHOGENESIS

Clarke asserts that, “It is self-evident that every case of an infectious disease is, in effect, a proving of the infective principle. This being evident, it follows that a symptom list compiled from the signs or symptoms of a large number of cases of any infectious disease supplies a solid basis on which the homeopathic physician may prescribe its nosode. It also follows that the nosode must be more or less homeopathic to every case of the disease.

But the homeopath can never lose sight of the necessity of individualising his cases. Individual cases of the same diseases differ enormously, and it not infrequently happens that some consideration apart from the ordinary manifestation of the infection at work will indicate the remedy. The homeopath must be prepared to meet this, and, therefore, can never be a slave to routine.” Despite this statement, Clarke does not elaborate any further on it than presenting cough symptoms. Julian, on the other hand, enlists some mental and general symptoms observed during or following pertussis.

Mind

= Confusion and somnolence.

= Clouding of consciousness. Disturbed state of awareness.

The “Troubles of conscience,” as one abominable English translation of Julian’s book has it, are misinterpreted in one repertory as “Anxiety of conscience.”

= Mental retardation.

Generals

~ Restlessness.

= Anorexia.

~ Asthenia. Weakness. Sweating.

= Predisposition to tuberculosis.

= Paralysis. Paresis.

= Convulsions.

« Muscular jerking [esp. of the extensors and flexors of the wrists].

Respiratory

~ Dry cough, spasmodic of variable intensity, coming suddenly.

= Increasing spasmodic cough with cyanosis, leading to apnoea followed by a noisy inspiratory stridor.

Recurrent bouts which terminate in vomiting of mucus.

Locals

» Epistaxis.

= Chemosis [swelling around the cornea].

« Ulceration of the tongue.

= Tachycardia. Tachyarrhythmia.

Modalities

= Worse: laughing; emotions; exertion; rest; nervous shock.

CASES

(1) Female, 7 years old; May 29, 1951: Very thin, skin muddy all over. Features small. Tires easily. Well until 4 years; then severe whooping cough; tendency to colds ever since with gagging cough. Appendectomy soon after. Never strong since.

Sleep never good. Eyes rather staring. Voice rough.

Congestion head; now nose stopped all the time. Mouth breathing since whooping cough.

Appetite small. No thirst. Desire sour foods.

Skin dry. Perspiration axillae. Chilly easily; also easily heated.

Nervous, excitable. Sensitive. Bright mentally. Rx. Pertussin IM.

July 7: Has gained weight, now up to 52 lbs., in the last 10 days; hungry at last. Looks happy and stouter. Pain head gone; some in back between scapulae. Rx. Pertussin IM.

July 16: Very much better but not quite strong yet. Good colour. Slight head cold.

July 30: Continues to feel fine; going away soon.

Sept. 20: Weight up to 61 lbs. Much better in general. Still has stuffy nose, much discharge from it; some pains head. Rx. Pertussin IM.

Oct. 23: Well except for old congestion over eyes and in sinuses. Chronic discharge nose thick, generally colourless, worse mornings. Postnasal drip stopped frequently but scabby condition gone. Rx. Kali-bi. 10M.

Nov. 23: Still some symptoms of the last cold; cough and thick mucus every day. Rx. Kali-bi. 10M.

Dec. 3: Lost 7 lbs. in the last 2 weeks or so. Sits bent forward in her chair or leans on something, languid. Appetite gone again. Mouth open good deal of the time. School work hard for her. Growing tall fast. Dark circles under the eyes. Features small, mouth small. Chilly; feet and hands cold in bed. Desire sour things. Cough dry, hacking. Yellow thick mucus from nose. Head

congested all over, voice thick. Quantities very thick yellow mucus which gets up with difficulty and comes out in thick chunks; hard to blow nose. Rx. Kali-bi. 50M.

Jan. 29, 1952: Been fairly well until the last week or so when most of the stuffed nose, thick yellow mucus from it has returned; hard to sleep with this. Rx. Kali-bi. 50M.

Aug. 27: Been very well until now starting out with what may be hay-fever. Rx. Kali-bi. CM.

May, 1953: No report since to date.

[J.M. Green, *Two "Chronics"*, Hom. Recorder, May 1954; EncHom.]

(2) Master R., aged 6, a very delicate, nervous boy, with a bad family history behind him, including lupus and cancer in his paternal grandparents, was under me for constitutional treatment, and was brought to me periodically when each prescribed course of treatment was finished. His mother brought him in the usual way on December 18, 1905. This time there was something new. He had had what his mother described as a "fearful cough and cold" for a week. He had also had headache, and had vomited. There was much expectoration with the cough, and I found wheezing all over the boy's chest. He had a suffused and puffy look about the face.

I asked the mother if there had been any cases of whooping cough in her neighbourhood. She did not know of any; but she had her suspicions, and she had always had a dread of whooping cough for her boy, as her husband's only brother had died of it. I told her I believed it was the beginning of whooping cough, but I did not think she need be at all alarmed. I told her to keep the boy quiet. He was to have no fatiguing walks, but he might walk out in the forenoon when the weather was fine. Rx. Coqueluchin 30; a dessert spoonful every four hours.

December 29th. Eleven days later the boy was brought to me again. There was a great change in his condition, and this is what had happened. The characteristic "whoop" appeared after a few days, generally in the early morning. He retched twice in the street after he had had the medicine two days, and he brought up a great quantity of glue-like expectoration. The attacks in the street were so characteristic, that careful mothers of families who happened to be in the street at the same time prudently passed by on the other side, to avoid carrying the infection to their own children.

The whooping only lasted a day or two; the sickness only occurred a few times. The expectoration had ceased three days before his second visit, and

now he hardly coughed at all. I examined his chest, and found that the signs of catarrh had completely cleared up. Repeat, night and morning only.

In this case the remedy had acted by developing at once the crisis of the disease, and then wiping it out. The patient was able to return to school when the holidays came to an end.

[J.H. Clarke, *Whooping cough Cured with Coqueluchin-*, London, 1908]

(3) Miss B., age 63. Indigestion with much pain and rumbling, increases during the afternoon and evening, and goes on half the night; much worse during the menses. Buccal ulcers and B.O. costive all her life, the stool so large it hurts. Headache constant all life till some easing at change of life [menopause], had been so severe she would hit her head on something. Worse during thunder. Is frustrated, suffers from indecision, and has many fears. Menstrual periods had been very heavy, with sickness, faintness, and diarrhoea, sending her to bed for two days. Menses had been irregular and usually late up to six weeks, but would appear if anything special had been arranged. Change of life sudden.

She had had chicken-pox, mumps, and measles, but whooping cough was much the worst - bed for six weeks, and too weak to walk for a further six weeks.

I gave *Pertussin* 200, IM, 10M, and repeated this in six months. A month after the final dose she was very much better in every way. Now has lost her panicky and frustrated feelings, and does not now procrastinate. Perfectly well now for two years.

[J. Fraser Kerr, *Unproven nosodes, their use, and some thoughts thereon-*, BHJ July 1960]

Hippoz.

IB. FAMILY BURKHOLDERIACEAE

Burkholderia mallei

BURKHOLDERIA MALLEI

Scientific name *Burkholderia mallei* (Zopf 1885) Yabuuchi et al. 1993

Old names *Pseudomonas mallei*

Malleomyces mallei

Pfeifferella mallei

Family Burkholderiaceae

Homeopathy Hippozaeninum - Hippoz.

Malleinum

Farcinum

Glanderinum

FEATURES

- Unpigmented, non-motile, non-flagellate, aerobic or facultative anaerobic, rod-shaped bacterium.

VECTOR

Soil, water

Primarily horses,

donkeys, mules.

Destroyed by sunlight

and dessication

Potential for biological

warfare.

- Occurs singly or, rarely, in pairs.
- Grows only between 25° and 42° C.
- Found in water and soil.
- Hardy organism; survives in water at room temperature up to 30 days; also remains viable when kept in a dry state for up to 3 months.
- Parasitic, contrary to related saprophytic *Burkholderia* and *Pseudomonas* species.
- Pathogenic for horses, mules, donkeys. Cattle, swine, rats, and house-mice appear to be immune.

The name of the nosode is a contraction of *hippos*, a horse, and *ozaena*, a foetid, atrophic nasal catarrh with crust formation.

- Human cases mainly occur from contact with nasal secretion of infected horses and occasionally from handling laboratory cultures.
- Human cases occur primarily in veterinarians, horse and donkey caretakers, and abattoir workers.
- Primary affect is in the lungs when the organism is inhaled [glanders] and cutaneous when invasion occurs through abraded skin [farcy]. Both types

disseminate via the bloodstream.

- Occurrence sporadic in Western hemisphere; cases among domestic animals and sporadic human cases continue to occur in Africa, Asia, the Middle East, and Central and South America.
- Discovered in 1882 in the discharges and tissues of a diseased horse.
- Grows characteristically on potato, forming a honey-like, yellowish layer that soon becomes reddish-brown and is surrounded by a greenish-brown irregular halo.
- Destroyed by direct sunlight and sensitive to desiccation.
- Has been considered as a potential agent for biological warfare and of biological terrorism.

CLINICAL FEATURES

Glanders appears in three forms, although these are usually not clearly distinct:

- a) Chronic pulmonary form with cough and mucopurulent discharge.
[Glanders]
- b) Form characterized by multiple abscesses in skin, subcutaneous tissues, and lymph glands. [Farcy].
- c) Acute septicaemic form with fever, chills, prostration, and death in 7- 20 days.

Infection occurs acutely or weeks to months may elapse before manifestations of the disease are apparent.

Ulcers, showing no disposition to heal, slowly spread and persistently discharge a virulent pus. Ulcers have indurated, elevated edges; the surface is often smooth. The disease does not progress to any great extent before the submaxillary lymphatic *glands* begin to enlarge, soften, open, and become discharging ulcers. The lungs may become infected by inhalation of infectious material from nose and throat, and contain small foci of bronchopneumonia not unlike tubercles in their early appearance.

Sources

Unproven remedy. Drug picture based on [1] disease symptoms observed in horses and men, and on [2] clinical cases.

Affinities

Skin and subcutaneous tissue. Mucosa. Glands. Joints and bones.

Melting away

Hippozaeninum reflects a destructive process of *liquefaction [colliquation]*, a process of dissolution, of wasting away, of being digested, of *melting*. Liquefactive necrosis is classically observed in abscesses and frequently in infarcts of the brain. By contrast, tuberculous necrosis turns tissues into “cheese”, i.e. affected tissues preserve a certain friable and crumbly consistency.

Diarrhoea in Hippozaeninum is colliquative [= excessive discharge of fluid] and accompanied by *excessive thirst* to make up for the losses.

Destruction

= “Probably no nosode brings with it such death dealing, or has such destructive properties as this one.” [Allen]

= “This powerful nosode covers symptoms which suggest integral parts of consumption, cancer, syphilis, etc., and promises useful service in the treatment of ozaena, scrofulous swellings, pyaemia, erysipelas, and chronic rhinitis with bloody secretion.” [Boericke]

= Weakness; fatigue; general prostration with considerable emaciation; “they give up their business.” [Hering]

— Bronchitis in the aged where suffocation from excessive secretion is imminent.

= Putrescence, destruction and decomposition of tissues.

= Act of speaking difficult due to ulcers, tenacious mucus, swollen tonsils, and glandular swelling.

Nasal catarrh

Checks the liability to catarrhal affection.

“I have used it with excellent effects in cases of inveterate nasal catarrh and of glandular enlargement. The nasal affection may go on to ozaena,

ulceration of nasal cartilages and bones. Swelling and redness of nose and adjacent parts, with severe pain. Discharge: often one-sided, albuminous, tough, viscous, discoloured, grey, greenish, even bloody and offensive, acrid, corroding.” [Clarke]

ADDITIONAL SYMPTOMS

Berridge collected from medical journals published between 1830 and 1877 more than 50 case reports of glanders, “in order to make Dr. Hering’s forthcoming monographs as complete as possible.” In view of Hering’s introductory note to Hippozaeninum - “Cases by Berridge not found” - these symptoms have not been included in the *Guiding Symptoms*. The cases, the majority of them ending in death, resulted from contact with infected horses and show clear signs of septic metastasis to the brain, eg in the low muttering delirium, the persistent headaches, and the loss of consciousness.

Initially similar to mononucleosis, but more destructive wasting, melting, being digested, liquefactive necrosis

The picture shows a remarkable similarity with *Ailanthus* and *Baptisia*, as well as clinically with *infectious mononucleosis*. It has the typical tetrad of infectious mononucleosis - fatigue, fever, pharyngitis, and lymphadenopathy - as well as the splenomegaly [observed in 50% of mononucleosis cases] and hepatomegaly. In particular the so-called *typhoidal form* of mononucleosis bears a close resemblance to the drug picture. CNS complications such as encephalitis, seizures and headache, are present in both mononucleosis and the nosode. Differences are the limb pains and the general tenderness, pronounced in Hippozaeninum, less so or absent in mononucleosis, as are boils, abscesses, and necrosis.

The following symptoms are extracted from Berridge’s collection.

Common [occurring in most cases]

Onset

» First signs of disease: Fatigue, weakness, prostration.

= Joint pains or lower back pain [at onset and during disease].

Mind

Restlessness at night or lying motionless or in bed [on the back], muttering to himself.

~ Day and night he remains in much the same position on his back, and mutters incessantly.

Constantly talking during sleep or delirium about horses! [5 cases]

=> He made no attempts to get out of bed or resist his attendants, but lay talking about his horses and other home matters.

<•> In his mutterings he made frequent reference to horses.

~ and today he has been talking a great deal about horses.

= In the evening he became more irrational; kept calling out about the black horse, which he had previously told us, when rational, had glanders.

=> A coachman opened a blister in the knee with a lancet which he had used for a glandered horse, and not cleaned. He became delirious; roared, raved, blustered and swore in the most boisterous manner, and all for his horses. If incoherent on many things, he was more connected when speaking of horses or coaches. At last, to prevent his getting up the attendants put ropes to the bedposts and gave them to him as reins, and in this manner he continued driving till he died.

Low “typhoid” state may alternate with excitement and rebellious resistance.

= He became quite maniacal at times, jumping about and biting like a mad dog, and hawking up immense quantities of clear, viscid, glairy, tenacious fluid, of which strings could be drawn out and carried in unbroken tenuity quite round the room. He died in ten days, and was said to have the “features of a donkey.”

At times rational and approachable, at other times irrational and unapproachable.

= He becomes suddenly delirious and as rapidly rational.

=> Could answer questions rationally, but seemed to care but little for what was going on around him.

Facial expression anxious, distressed, indifferent or depressed. Vacant stare.

Generals

= Fetor [breath; sweat; discharges].

=> The nasal discharge is so exceedingly offensive that he said he could scarcely endure himself, and everyone who came near him was quite disgusted.

« His breath had a mercurial foetor.

» The odour of the breath was peculiar and very nauseous.

« A very offensive odour arises from her body, and from the bed impregnated with the discharges.

» The sweat seemed in some degree to partake of the disagreeable smell of the breath.

« The foetor from the diseased surface was intolerable.

~ A remarkable stench pervaded the room.

Lymphadenopathy, particularly submaxillary, axillary and inguinal glands.

Sepsis after injury [prick or splinter in finger].

» Next day the finger became painful and inflamed, the pain extending up the forearm and arm as high as the shoulder.

“The punctures, at first insensible, soon became inflamed, the inflammation spread to the lymphatic vessels of the forearm; dull, aching pains shooting up the forearm and arm.

“Finger inflamed and very painful, with red streaks running up forearm.

Dark red [dusky] discolouration of greatly swollen surfaces.

“ The face looks as if affected with erysipelas.

« Eyelids so swollen that they cannot be opened.

Tenderness *I* pain from slightest touch or pressure. [Mostly right hypochondrium; joints; swellings; abscesses.]

» The skin seemed generally tender and he complained whenever touched.

Food & Drink

Excessive thirst.

= Calls for cold drink every second. Has incessantly called for cold water for the last 48 hours without a moment's rest.

“Loss of appetite or inability to eat from weakness and/or difficulty in swallowing.

Heat

Local sensation of heat.

“ Hot, burning sensation, like fire in the throat and nostrils.

== Patient complains of much heat about the nasal organ and windpipe.

⁰⁰ The sensation of heat was so intense that it seemed to him as if the foot was being broiled.

Locals

Erysipelas beginning on forehead and spreading all over scalp and face. Nasal discharge tenacious, glutinous, offensive. Stringy sputum, profuse. Tongue dry, furred, brown.

Respiration superficial, hurried.

Hoarseness.

Less common

Mind

Does not complain of any pain. Does not seem to suffer any pain.

Great aversion to his friends sitting round his bed.

Generals

Night sweats.

Frequent convulsive twitchings of the whole body; "and for a few seconds after is in a constant state of tremor."

Frequent muscular twitching during sleep or while dozing.

Sleeplessness from pain in limbs.

Sleeplessness from severe headache.

Scarcely any thirst except in the night.

Locals

Illness begins with pain in back of head and neck.

Darting pains in back of head and nape of neck.

Photophobia.

The nostrils swelled out literally "like a horses."

Intense garlicky odour of breath.

Phlegm in throat that cannot be expectorated.

Tightness across the chest; cannot take a deep inspiration.

Pain between shoulders [spine] < pressure.

Wandering pain in the extremities.

Limbs feel almost paralysed; quite unable to stand.

[E.W. Berridge, Pathogenetic Record; Monthly Homeopathic Review, 1880; RefWorks]

CASE

1) August 17, 1951. Dr. M.B.S. of middle life was stricken with breast cancer about seven years ago. After biopsy, an early operation was performed. Two years later a severe and painful ulceration appeared in the surgical scar of the amputated breast. X-ray, radium and various old-school remedies administered hypodermically were tried with a constantly increasing painful destruction of tissue and a progressive weakness and anaemia and marked mental depression. Later on many homeopathic prescriptions were made with some degree of relief, but no definite improvement in the general state of the patient. About August 9, 1951, this patient received a dose of Hippoz. 10M. This remedy repeated about six weeks apart in the 10M and 50M produced most unusual and spectacular results in the condition of the patient. Healing began in the injured parts, and the general strength and well being of the patient improved. On January 14, 1952, another remedy was required over the blood viz, Streptomyces IM. This was taken several days later. The latter part of March, I had the privilege of seeing this unusual patient and found her well and cheerful, doing her household duties; and the ulceration on the ulcerated area was almost entirely healed with only a slight scab remaining.

[Grimmer, *Collected Wirks*]

IL ORDER NEISSERIALES

IIA. FAMILY NEISSERIACEAE

Neisseria gonorrhoeae

Neisseria meningitidis

Neisseria subflava

Neisseria catarrhalis

GENUS NEISSERIA

- Gram-negative, oxidase-positive, aerobic or facultative anaerobic cocci characteristically coffee bean-shaped and paired.
- Part of the normal flora of oropharynx, nasopharynx, and genitourinary tract.
- The genus includes saprophytic as well as pathogenic species.
- Many species in the genus have been isolated from animals:
 - Neisseria animalis*
 - Neisseria canis*
 - Neisseria caviae* - found in the pharyngeal region of apparently healthy guinea pigs.
 - Neisseria cuniculi* - rabbits.
 - Neisseria dentiae* - found in the dental plaque of domestic cows.
 - Neisseria iguanae* - iguanid lizards.
 - Neisseria macacae* - from the oropharynges of rhesus monkeys.
 - Neisseria ovis* - associated with infectious keratoconjunctivitis of sheep.
 - Neisseria weaveri* - commensals in the mouth and nasopharynx of cats and dogs; human infection may occur from a cat or dog bite.

NEISSERIA GONORRHOEAE

| | |
|-----------------|---|
| Scientific name | <i>Neisseria gonorrhoeae</i> (Zopf 1885) Trevisan 1885 |
| Old names | <i>Micrococcus der gonorrhoe</i> Neisser 1879 <i>Merismopedia gonorrhoeae</i> Zopf 1885 <i>Micrococcus gonorrhoeae</i> (Zopf 1885) Fliigge 1886 <i>Micrococcus gonococcus</i> Schroeter 1886 <i>Diplococcus gonorrhoeae</i> (Zopf 1885) Lehmann and Neumann 1896 <i>Gonococcus neisseri</i> Lindau 1898 <i>Gonococcus</i> |
| Common name | <i>Neisseriaceae</i> |
| Family | <i>Medorrhinum</i> - Med. |
| Homeopathy | <i>Medorrhinum Americana</i> - Med-am. [not in repertory] |

FEATURES

- Occurs typically as non-motile pairs of flattened cells.
- First observed in urethral and conjunctival secretions of gonorrhoea and purulent ophthalmia by the German dermatologist Albert Neisser in 1876.
- Found primarily in purulent venereal discharges. “Can be found in the urethral discharges of gonorrhoea from the beginning till the end of the disease, and often for many months and even years after recovery from it.” [McFarland]
- Considered a pathogen of human origin.
- Requires 5-10% carbon dioxide and a humid atmosphere. Does not survive dehydration and cool conditions.
- Ferments glucose but not maltose [“sugar and sex, but no beer”].
- Leading cause of septic arthritis in adults.
- Gonococcal infections are 1.5 times as common in men than in women, although serious sequelae are much more common in women.
- Small quantities of “gonotoxin” introduced into the urethra cause suppuration at the point of application, fever, swelling of the adjacent lymphatic nodes, and muscular and articular pains. [McFarland]

DISSEMINATED GONOCOCCAL INFECTION

Disseminated gonococcal infection [DGI] occurs following approximately 1% of genital infections. It is seen more frequently in women, especially during

menstruation and pregnancy. Patients with DGI may present with symptoms of rash, fever, arthralgias, migratory polyarthritis, septic arthritis, endocarditis, or meningitis. Joint or tendon pain is the most common presenting complaint. About 25% of patients with DGI complain of pain in a single joint, while up to 2/3 describe polyarthralgia, which often is migratory. Severe pain, swelling, and decreased mobility in a single joint suggest a purulent arthritis with effusion. The knee is the most common site of purulent gonococcal arthritis. Tenosynovitis also is common, usually affecting the small joints of the hands. Skin rash is a presenting complaint in approximately 25% of patients, but a careful examination will reveal a rash in the majority of patients with DGI, including maculopapular, pustular, necrotic, or vesicular rash, typically occurring on the torso, limbs, palms, and soles. The rash usually spares the face,

Graffiti on the London Underground: Life is a sexually transmitted disease.

scalp, and mouth. Haemorrhagic lesions, erythema nodosum, urticaria, and erythema multiforme occur less frequently. Headache, neck pain and stiffness, fever, and decreased sensorium may indicate gonococcal meningitis. This disease may be clinically indistinguishable from meningococcal meningitis on presentation, although the course of gonococcal meningitis usually is less rapid than that of meningococcal meningitis. Gonococcal endocarditis is

more common in men than women. Patients with collagen vascular disease [especially those with systemic lupus erythematosus] also may be more prone to this complication. DGI can cause abscess formation within the soft tissues, presenting as localized tenderness, oedema, and pain with motion.

[Behrman, *Gonococcal infection*; website University of Pennsylvania Medical Center]

MATERIA MEDICA MEDORRHINUM

Med.

Sources

Proved by Swan & Berridge [collection of provings] - 45-50 provers [about 50% females, and 50% males], **C.** 1888; method: various high potencies, such as IM, 10M, 20M, 40M, 60M, and MM; manner not stated; contains also cured symptoms.

SYMPTOMS

Mind

Time and space.

Times passes too slowly.

Hurry; always in a rush and anticipating, yet lacking the desire for realisation.

Lacks clear-set goals; chases shadows.

Hurry, everybody seems to move too slowly.

Anxiety if a time is set.

Everything feels *far off*. Objects seem small.

Dazed dreaminess, as if 'stoned'.

Fulfilment - emptiness.

Everything seems *unreal*.

Sensation of unbearable inner *emptiness*.

Vacant staring.

Easily bored. 'Attention junkies; party animals.'

Forgetful; confused - common things escape him.

Seems to herself to make wrong statements because she does not know what to say next; begins all right but does not know how to finish

[Grimmer]

Extremes; exceeding all limits.

No bounds; lack of orientation points.

Chasing shadows or chased by shadows.

Bouts of hopelessness alternating with episodes of hopeful optimism.

Strokes of genius or inexplicable blackouts.

Extroversion - introversion.

Wild feeling in head or vacant feeling in head.

Clair-obscure: lucid after sunset, obscure after sunrise.

Arrhythmia.

Shuns responsibilities.

Generals

= Craves fresh air.

VECTOR

Human

Found in mouth, nose,
throat, genital and
urinary tracts.

-
- = Feels better in evening/night. Night person.
 - = Seaside >.
 - = Lying on abdomen or in knee-elbow position >. Desire to cross the ankles when lying on the back.
 - = Great thirst.
 - = Desire for sweets, green fruits, ice, acid foods, salt.
 - = Craves beer; alcohol; tobacco.
 - = Walks on sides of feet [due to extreme sensitivity of soles of feet].

Local heat - coldness

- Boiling sensation in head.
- Burning hands and feet; wants them uncovered.
- = Heat in eyelids.
- = Hot flashes cervical region.
- Severe burning in the base of the tongue, extending down the bronchi as if he had inhaled hot steam
- = Sensation of coldness in eyes, as if cold air blew on them.
- = Coldness of tip of nose; breasts, esp. nipples; abdomen; liver region; right lumbar region.
- = Chilliness on urging to urination; before urination.

Discharges

- » Discharges >.
- = Discharges mucopurulent or purulent; yellowish-green or yellowish-white.
- <■ Fishy odours.
- = Yellowish staining sweat. Greasy face.
- => Pungent body odour; penetrating pungent odour to stool.

Affinities

Since the drug picture of Medorrhinum is partly based on cured cases of gonorrhoea, the classic complications of gonococcal infections may be expected to present themselves in the drug picture. Above all this concerns Pelvic Inflammatory Disease [PID], characterised in women by infertility, PMS, purulent vaginal discharge, uterine tenderness, intermenstrual bleeding, menorrhagia, enlarged tubes, elevated temperature, urinary tract infections, dysuria, and especially bilateral lower abdominal pain with nausea and vomiting. Due to painful genital swelling difficulty in walking may develop. Intrauterine devices [IUDs] significantly aggravate PID; hence intolerance of

IUDs may be an indication for Medorrhinum, if symptoms agree. There is an increased risk of ectopic pregnancy. Epididymitis-orchitis is the male equivalent of PID.

Acute infectious arthritis occurs somewhat more often in women, with menstrual periods and pregnancy as the most common triggers. Most have joint pains or tenosynovitis involving wrists, knees, ankles and small joints of hands and feet, in combination with skin eruptions, which consist of petechial-pustular lesions on an erythematous base. After a migratory stage the pain/inflammation usually settles in a "hot joint," commonly the knee. Pharyngitis is also frequently observed, as are proctitis and conjunctivitis. Proctitis may present with minor symptoms such as pruritus, pain, pressure, fulness, mild diarrhoea or discharge, or mucus on stools. Less frequently more severe symptoms are present, such as tenesmus, purulent discharge, and bleeding. Conjunctivitis presents with pain, chemosis, oedema of lids, and purulent yellow discharge.

Medorrhinum symptoms such as "sensation of a tumour in the right side of abdomen," "grasping pain in liver," and "pain extending from liver to right shoulder," show a similarity with gonococcal perihepatitis [Fitz-Hugh-Curtis syndrome] observed in women with a history of gonorrhoeal salpingitis. The syndrome consists of acute upper right-quadrant abdominal pain and tenderness aggravated by breathing, coughing, or movement, with pain extending to the right shoulder.

Children

Based on 37 case histories, Jutta Gnaiger-Rathmanner and Mirjam Bohle provide a summary of indications for the treatment of "allergic and nervous children" with Medorrhinum.

All of these children, mostly boys, love to move, happy whenever they can ramble outdoors. They love practical things, and feel extremely bored by the requirements at school. Often the intensity on the one hand and the flightiness and contrariness on the other hand lead to the selection of the remedy. Often having a sensation of heat they like to undress and sleep uncovered.

In early childhood striking or hitting seems to be an important form of expression when other ways to express themselves are not accessible. In school the aggression seems to be reactive - they are followers, ready to join every nonsense. If there is a storm centre, they follow without hesitation. Mostly the leaders are other children. One often hears the mother say, 'I don't understand

his behaviour at school. If he is alone with me, he is obedient and a good boy.’ Medorrhinum-boys charm their mothers - possibly in competition with their fathers?

Medorrhinum-boys feel attracted to girls in a premature and excessive way?

Prematurity manifests itself as:

- = Vigorous denial of all kinds of conformity and book learning, long before puberty.
- « Great interest in all kinds of technology.
- « Precocious curiosity for fashion, trends and eroticism.

The clairvoyance of these children is revealed by their ability to detect every weakness and tension in their surroundings. They are the children who unerringly expose adults to ridicule. The negative and disharmonious moments of life inevitably attract them.

Regarding early infantile development, many remarkable deviations are found. Also these children present very particular disabilities, such as attention deficit disorder. A whole string of symptoms in the Medorrhinum picture corresponds with this:

- = Sleep position genupectoral.
- = Opisthotonus.
- = Motions of head - rolling head.
- ~ Awkwardness.
- <= Lack of perseverance.
- == Concentration difficult.
- = Makes mistakes - in writing; speaking; spelling; in time.

Regarding symptoms such as ‘ailments from reproaches,’ ‘sensitive to reprimands,’ and ‘despair from the slightest criticism,’ it should be noted that these children need encouragement and real help, not criticism.

Jealousy of siblings; quarrels in the family; overcharge at school; heavy competition at school, are mentioned as causations observed by the authors.

The main symptom ‘restlessness’ culminates in symptoms such as biting nails, masturbation, facial twitching, and various sleep disorders. Furthermore there is a tendency to dyslexia. Left-handedness as well as refusal to go to school are

litis, putrid otitis, gastro-enteritis, or dry spasms including laryngitis and asthmatic bronchitis. There is high fever during infections or no fever at all. Food intolerances, in particular to milk, may lead to fussiness about food and a bias towards monotonous nutrition. Cravings change frequently, but always with the same intensity to exclude/refuse everything else.

[Adapted from: Jutta Gnaiger-Rathmanner and Mirjam Bohler, *Medorrhinum - a remedy for modern children*; Hom. Links 2/03]

CASES

(1) Mrs. C.EA at 32; married ten years, one child three years old; one miscarriage. Irritable and nervous; hurried, restless, especially after lying in bed or sitting for a long time - feels as if she would scream if she could not move; queer "nervous feeling in the abdomen." Fear of the dark [as a child would go anywhere in the dark].

Memory failing; leaves work unfinished and starts on something else. Although thin and scrawny, her appetite is unusual; craves salads, salt things, fruit; very little thirst; constipated since early childhood; absolute inactivity of the rectum, but bowels are normal during menses. Going too long without action of the bowels results in an attack of tonsillitis; has had many attacks during the past few years. Heavy, full feeling in the stomach after eating; much belching, especially after fat and rich foods.

Menses every twenty-six days, lasting four or five days; uterus falls so low as to protrude from the vagina, worse during, better after stool. Rheumatic pains here and there, < damp weather. Varicose veins. Excruciating pains in the cervical and dorsal spine, extending to the shoulders, for many years, soreness of the coccyx since the birth of her child, < lying on the back, at night, while sitting and especially when rising from a seat.

Excessive desire to yawn.

The treatment was carried on entirely by mail so that the record may not be complete, especially as to the possibility of infection. A dose of Med. DMM was sent April 22, 1919.

On May 10th she reported improvement in all symptoms, even the bowels showing some signs of renewed activity. A repetition was required, August 27th. On October 21st, she wrote that her neighbours and friends had remarked about the wonderful change that had taken place in her general health and especially in her face, which had rounded out and lost its pale, sickly look. The "dreadful pain" in the spine had almost entirely disappeared.

The remedy was repeated January 26, 1920, April 21st, June 15th, October 28th, and February 28, 1921, with constant benefit. She gained in weight and what was especially gratifying to her, her former good memory and clearness of intellect were reinstated.

[H. Farrington, *Clinical confirmations of Medorrhinum*; Hom. Rec., vol. 36, 1921]

(2) Marshall. S. 24 years of age, the son of wealthy parents, somewhat spoiled and pampered. Though always nervous, he seemed in fairly good health until he returned from overseas. During the greater part of his stay in France he was stretcher-bearer and assistant in one of the base hospitals. He was never at the firing line, although he witnessed many horrible sights among the wounded. On arriving home he seemed utterly unnerved. He was restless, fidgety, hurried in all his actions and speech, stuttered, and showed the peculiar, wild-eyed look of some of the men who served in the trenches, but to a marked degree. The most persistent symptom he now exhibits is fear in the dark and feeling as though someone were behind him. In the text we find this symptom in the case of a woman who thought that someone was behind her, heard whisperings and voices and imagined that faces peered at her from behind various objects. Apparently it has never been elicited in a male prover or clinical case. But the case was clearly one for the nosode, which acted like magic showing that as with Sepia and other remedies, we are quite safe in prescribing regardless of sex, provided the other symptoms agree. Mr. S. never had any venereal disease. [Farrington]

(3) Tommy P., aged 5. As an infant he was frail and under-nourished, although seldom ill until he was 2 years old. He then became peevish, his appetite failed; he complained of frontal headache; pain in the small of the back; had spells of vomiting followed by sleep, sometimes lasting for hours; prickling all over the body but no eruption. Since he lived in a distant city and his mother was too poor to bring him to Chicago, I was obliged to depend upon her letters, and doubtless the record is very incomplete. Possibly he should have had Aethusa at that time. A child specialist diagnosed the ailment as cystitis and under his treatment the boy improved as to the renal symptoms, but the bilious attacks continued to recur. In her first letter dated August 10th 1925, the mother related the following symptoms: "Frequent attacks of headache and vomiting of food and bile. No appetite; craves sweets and highly seasoned food. Nausea if forced to eat. Teeth chalky and easily decay. Enlarged tonsils and adenoids. Frequently recurring styes.

Wets the bed at night and frequently loses some urine on the way to the toilet during the day. Redness and irritation of the foreskin [the specialist recommended circumcision which was not done]. Is sullen, pouting and forgetful. Takes the knee-chest position in sleep.”

Improvement commenced almost from the first day taking the remedy [Medorrhinum]. Repetitions at long intervals and in ascending potencies over a period of two years transformed the puny, peevish youngster into a cheerful, husky one.

[H. Farrington, *Backward and Ailing Children and Medorrhinum*-, Hom. Rec. 1934; ReWorks]

(4) This child weighed four pounds and a quarter at birth and during her first week lost a quarter pound. As you see her today she weighs seventeen pounds in her first summer. Last year she required constant care as a marasmus child. Feeding was a problem for, deprived of her natural food through lack of quality and quantity in the supply, she very cheerfully but persistently refused cow's milk prepared in the usual way for infants. When she was starving apparently, she refused to permit the nipple to be placed in her mouth to take milk. She was always satisfied for a while after taking one of her sugar powders and found water comfortable.

One day, after a period of more than an hour spent in persistent, continued crying, with the most appealing look of hunger in her eyes and refusal of everything offered in the way of food: pap, milk, water, salt, a taste of ordinary sugar was given. This supplied the craving and instantly her crying ceased and did not resume for an hour. Bovinine was then received with pleasure and this with Eskay's food milk served her for months. Although restless and uneasy, she was disposed to be cheerful and playful when in the least comfortable. She was a mental precocity, alert and active. Constipation was her constant ailment and source of sorrow to the household, who considered that feature the cause of all her troubles. After two or three days without an evacuation, there would be one of hard, green mass or mushy, watery, with flatus of offensive odour. Such flatus also was passed without other evacuation. Study of the leading features through many changes resulted in her having many remedies, one after another. Improvement was temporary and she gained very slowly, her interest in feeding being very variable.

From time to time symptoms of brain disturbance were present, rubbing head, rolling it, crying out in sleep and jerking in sleep. Perspiration was



copious in sleep. Disposition sensitive, changeable, easily offended, usually gay and playful in evening, late beginning sleep. When not gay, very irritable and appealing in her cries. During January of this year she survived a siege of capillary bronchitis, measles and on the last day of the month, in the midst of play, surprised her mother with a convulsion. This was repeated next day at intervals of from one to two hours, finally yielding to Cicuta. Five weeks later, on the day she was one year old, convulsions began again and after a night's cessation continued the next day every hour or less almost without variation. Careful study, this time revealed the image of Opium in the spasms.

This remedy appeared so similar and yet so slow to bring results that it was decided, with Doctor Gladwin in consultation, that something underlying the apparent condition was interfering with the apparent homeopathic remedy.

Tuberculinum was administered after further study, though one interval was extended beyond the useful time of the spasm's return. Since that remedy no spasms have appeared. For a week everything progressed beautifully, then the old constipation returned. Large masses just within the anus slipped back instead of being evacuated, in the efforts of hard straining.

At this time attention was directed to the posture in sleep, which was on the back with arms above the head and feet in the air, the legs flexed only at the hips. Use of *Medorrhinum* in this case ended the story of terrible straining with hard faecal masses, which had been heard not only of this child but of her mother and grandmother. Continued improvement has followed. Cina, for nervous manifestation, and Cham, for earache once, have been beneficial. Her first tooth was erupted after she was thirteen months old. Her creeping began after her fifteenth month and only last month did she walk with any certainty and confidence. In her humorous antics she is a constant circus performance to her family, but she does not talk in our language.

The parents of this child and a brother of her mother were marasmic babies. Careful inquiry reveals no suspicion of infection in her parents, but family history leads to suspicion that it occurred three generations ago. Both parents are excessively nervous and anxious and disposed to fret and were particularly solicitous, because the first child born two years before this, weighing over eight pounds, had died at four months after beginning life similarly to this one.

[Julia C. Loos, *Medorrhinum in Childrens Disorders*-, Indian Hom. Review, 1897; RefWorks]

(5) A 40 year old woman enters the room. She sees the chair standing in front of my desk, takes it and turns it around. She sits sideways in the chair. She has to turn her head around in order to speak to me. I wait to find out why she is doing this.

“I was the black sheep of the family. I rebelled against everything. I never wanted to conform. I took part in the hippie scene. I had to live it up when I was young; I took Cannabis, LSD and so on. I wanted to drop out of high school, but my father put pressure on me and sent me to boarding school. This lasted only 3 months, then I rebelled again. I took LSD and got caught doing it. I deliberately got into trouble with the headmistress of the school and was thrown out. I didn’t care.

Today, I think I did this on purpose in order to be free, to do what I wanted to do and not what my father wanted me to do. That was always the case with me; I was always contrary. I always wanted to do what I liked to do. When I got thrown out of school, my father refused to give me money. He said, ‘You wanted it like this.’ I was 18 and I had a hard time.

Later, I started training as a physiotherapist. My father, a doctor, agreed because he thought I would work in his clinic. But I was thinking in a totally different direction. ... As soon as my soul gets out of balance, my lower abdomen is like a ‘battlefield’. My ovaries become inflamed, I get cysts and have other problems.” When patients talk about their childhood or adolescence and I observe that their psychological make-up has not changed since that time, this means to me that their emotional issues also have not changed. So I take their childhood situation into consideration when selecting the remedy, or at least I note it as an interesting symptom for the case.

Most of our problems have their source in childhood, but later on in life we compensate for these problems with the power of our intellect. But even when we think we have totally changed or covered these problems, our body, our posture, gestures, hairstyle, our social surroundings, dreams, emotions, etc. will still speak the truth. She said in her childhood she wanted to do what she liked to do. And during the interview she also did what she wanted to do.

Observation: Disposition to contradict.

And the earrings she was wearing? They looked like weapons. And she talked about the ‘battlefield’ in her abdomen. At the beginning of the interview, she clenched her fist while speaking. She is still fighting against everything, even though it is no longer necessary. Now how does one translate ‘battle field’

into rubrics? What is ‘war’ in a human body? Inflammation!! Her battlefield is the urinary tract or utero-ovarian region: Female, genitalia, Inflammation, ANNE SCHADDE or Abdomen, Inflammation.

SUMS UP

MEDORRHINUM War The chronic nasal catarrh, the extreme desire for tobacco and
or battle inflammation fish led me, together with the whole story, to the remedy:
revolutionary erotic Medorrhinum. I must admit, there is something in
sexual artistic defiant Medorrhinum you get without asking: they enter the room and
extravagant they have a particular kind of energy that is sexual. But there is
contradictory something more in their behaviour: along with the erotic,
artistic characteristics; there is the defiance, the extravagance,
the contradictory, revolutionary attitude that is all part of the
Medorrhinum story as well.

1st follow-up, 1 month later: She sat in a normal fashion, straight in front of me. The first thing she said was, “I couldn’t stick to the promise of avoiding coffee; I needed to drink half a litre a day. I always drink coffee and I couldn’t help it.” I had told her no coffee; her reaction was part of her ‘Gestalt’.

2nd follow-up, 4 months later: She didn’t show up. Instead she phoned and told me her life had completely changed. She said, “I’m full of energy.” She experienced amelioration of her main problems. I have not seen her since.

[Anne Schadde, *The Importance of Body Posture and Gestures in Understanding the Patient*, Hom. Links 4/94]

MATERIA MEDICA MEDORRHINUM AMERICANA

Sources

[1] Combination of classical and meditative proving; two separate groups of 12 provers each; all the provers took a 30th potency daily for 7 days and then either held or took a 10M at the beginning of the meditation.

‘The symptoms recorded included those of the more conventional proving of the 30th potency [which produced very little compared to the meditative proving], those produced in a meditative state and those which continued after the medication, in some cases for weeks. Several of the provers acted as channels, others being sensitive and intuiting the nature of the remedy. Some symptoms were emotionally or physically experienced by the provers, particularly during the 30c proving.’
[Madeline Evans, *Medorrhinum Americana*,

Prometheus Unbound, Vol. 2, No 2, Spring 1996]

[2] Medorrhinum Americana; article in Reference Works. [RW]

New Medorrhinum

Many of the symptoms produced by the proving confirm the already well-known picture of Medorrhinum, such as extremes in terms of behaviour, emotions and energy, as well as extreme irritability with shouting and swearing to the point of violence. 'Some of these have been included, as they are part of the complete proving and perhaps may make this type of proving more credible to those who have no experience of it and are sceptical of its validity. ... The new Medorrhinum is a remedy which encompasses but goes much deeper than the old; it goes deeply into the past, present and future. ... This new Medorrhinum is new and different from the old one we have been using because there are many generations who have carried this bacteria through to the form we have now with this remedy.

Be aware that its [American male] donor has a strong syphilitic miasm. This new remedy contains all the symptoms of the one you are currently using, but goes far, far deeper.' [Evans]

[Remedy available from Helios Pharmacy, UK, under the name of Medorrhinum Americana, in honour of its American donor.]

SYMPTOMS

Mind

Urge to clear out oneself or one's possessions.

Obsessive need for tidiness; sorting and taking bags of clothes and clutter to charity shop. Waking in the night planning next area to sort.

Cleared out half the clothes in my wardrobe that I realised didn't fit me or suit me anymore. Went shopping for new clothes with unusual zeal, in an obsessive almost monomaniacal way.

Comment- This remedy has a profound effect in terms of peeling away these - the corrupting influence which changes the wondrous naivete with which we may experience the physical world into a corrupt over-indulgence - and other delusions and exposing reality, on whatever level. ... Some provers experienced the remedy as having a deep cleansing effect, with water often the typical symbol of cleansing. [Evans]

Conversely, for nine of the provers the remedy brought a sensation of feeling

stuck or trapped - another way of expressing a need for cleansing or shifting. The following were typical descriptions:

Feeling very stuck.

I am stuck.

Felt as if I am stuck somewhere.

When I first took the remedy I thought I was actually going out but I think that as soon as I felt pleased about that I realised I was just being shut away somewhere.

Delusions of time.

= Slowness / hurry / distortion of time.

As if time were passing really slowly.

I would like to hurry all this up and get on with it.

I get the feeling of hurry and the desire to pack as much in as possible. Like the 20th century obsession with production.

Trying to do lots of jobs at once. Very rushed and disorganised.

Feels physically hurried but mentally slow. [RW]

Poor memory and concentration.

Had a very muzzy head and could not memorise.

Lots of things going on but memory so bad I've forgotten them.

Sensation of cluttering rubbish in the head. Generally a cluttered, confused feeling about the remedy.

Blankness is the word for me today. Confusion, blankness and a complete inability to try to sort anything out. I cannot be bothered.

Difficulty thinking straight or keeping the mind on one track.

Sense of isolation.

[One of the less well known aspects of the remedy that was experienced, was the sense of isolation:]

It is a remedy which can make a person feel very alone and separated from their fellow beings and from the world. In feeling separate and alone, it tries to connect and join with others; it has the common characteristic of bringing repulsion from others.

They have problems operating alone. When alone they get confused, more confused than ever and feel they need someone to help them make decisions, to help them through life, so they tend to lean on people, to almost bind other

people to them.

They feel very separate from others, this is because they are so misunderstood, so they withdraw.

Feel separate from themselves and from others. Feel they are out of touch. The fears of being ungrounded, separate or out of touch = need for and reliance on material things but can also fear the lack of spiritual connection: if they move into the spiritual sphere then they are likely to indulge in spiritualism and seances - they show no restraint in their search for esoteric knowledge. In their feelings of being alone they can either be repulsed by others or they can tend to become manipulative and/or smothering towards others: they need to bind people to them. Often join and then attempt to dominate a group or a society. These conditions arise from a lack of sense of self or from an extreme ego- centrality. They feel frustrated even when in a controlling situation because whatever they achieve it is never enough. [RW]

Profound insecurity, expressed as a profound lack of confidence and a fear of making mistakes.

A remedy for situations where you feel you cannot do what is expected of you.

Fear of what other people think, yet often drawing attention to oneself in an extravagant way to cover up one's shortcomings.

Acute fear of failure.

I felt enormous embarrassment as if I'd done something very wrong - great heat [esp. to face] and sweat. Felt useless as if I shouldn't be there, as if I'd never recover from the mortification. Full of negative emotions, especially guilt, self-doubt, worthlessness - an emotional wreck, dominated by negative feelings about myself not being good enough.

Self consciousness. Not wanting to be noticed or feeling that you are being noticed.

Uncontrollable.

Intolerant: irritable: impatient. Inclined to show anger by shouting. Becomes irate and shows no fear of confrontation. Can become violent or feel a compulsion to strike out with either the fist or a weapon. Parent feels the urge to smack their child when they have been driven to the limit - though they feel that their tolerance is on a short fuse.

Frustration leading to uncontrollable anger - shouts and screams: rants and raves.

Gesticulates in their fury or frustration.

Unreasonable behaviour: impossible to get any sense out of the person: the

patient avoids the issue when asked why they are angry. Fear and anxiety. Fearful of a number of things and unable to let go of any of them so that the mind is cluttered. Fear of falling: of being late: of being alone: of being powerless: of what they might do and how they might react. With anxiety comes confusion and tension: feels jittery and nervy. More likely to be angered when fearful esp. if they fear the worst: very great sense of anticipation.

[RW]

Generals

- Four provers felt particularly hot, three experienced hot flushes, one with dizziness, extreme heat, cold sweat, desire for cold water, and faint feeling.
- » Another felt warm, sensitive to heat, needing fresh air.
- Great thirst.
- =» Craving for alcohol [or drugs or stimulation of any sort].
- = Desire chocolate.
- = Likes snow. [2 provers].

Modalities - worse [RW]

- Cold, damp.
- => Mushrooms.
- = Addictions. [‘Very easily lead into addictive behaviour.’]
- = Strenuous exercise. Stress.
- = Excessive sexual activity and/or promiscuity.
- = Celibacy.

Modalities - better [RW]

- = Fresh air.
- = Company.
- =» Dry atmosphere.
- = Gentle exercise.

Clinical indications

- = ‘Key remedy for AIDS. Sexually transmitted and particularly for children who are born with AIDS or acquired it very early on. Of manifest importance in all cases of AIDS.’ [Evans]
- Down’s syndrome, down through the generations.
Fertility problems [both sexes]. Tendency to abortion at 3-4 months.
- Asthma and eczema.

« Diseases of pollution, esp. asthma.

« Breathing < smoke and smoking [but addicted to cigarettes]. Sensation as if breathing in smoke = need to clear throat. [RW]

= Headaches; chronic headaches; head injuries after accidents.

As if great weight on vertex pressing me down so my head and neck felt collapsed and 'concertina d'. Pain in left temple, left shoulder and left occiput; neck stiff, wanted to keep stretching it. Increasing tension in the head as of a band. Felt very ill and spaced out.

Peculiar headache, quite severe, starts in the forehead and moves around to behind the ears. Debilitating with nausea and vomiting associated with it.

Head pain forehead and behind or above the ears. [3 provers]

Left-sided headache.

Brain damage from accidents or vaccination.

For people who have had accidents and are left in a coma or left severely brain damaged.

«< Hay fever symptoms with runny nose and sneezing; > by the sea. [RW]

= Sensation of fullness at root of nose. Thick, yellow, green catarrh which is foul and chronic. [RW]

NEISSERIA MENINGITIDIS

| | |
|------------------------|--|
| Scientific name | Neisseria meningitidis (Albrecht & Ghon 1901) Murray 1929 |
| Old names | Diplococcus intracellularis meningitidis Weichselbaum 1887 Neisseria weichselbaumii Trevisan 1889 Micrococcus intracellularis (Jaeger) Migula 1900 Micrococcus meningitidis cerebrospinalis Albrecht & Ghon 1901 Micrococcus meningitidis Albrecht & Ghon 1903 |
| Common name | Meningococcus |
| Family | Neisseriaceae |
| Homeopathy | Meningococcinum - Meningoc. |

FEATURES

- First isolated from nasal discharges in six cases of cerebrospinal meningitis by Weichselbaum in 1887.

MENINGITIS

SYMPTOMS

Sudden onset

Headache, fever,

vomiting,

< light convulsions

irritability

hallucination

delirium

coma

stiff neck

abnormal reflexes and

eye movement

blotchy rash

SEQUELAE

Depression, OCD.

- Forms minute, rounded, greyish colonies.
- Considered a pathogen of human origin, although strains may be carried as normal flora in the throat.
- Requires 5-10% carbon dioxide and a humid atmosphere.
- Differentiated into four serological groups: A, B, C, D; group C is the most important pathogen.
- Associated with meningococcal meningitis [esp. in children of three months to one year old, and among young adults] and bacterial pneumonia.
- It has been suggested that N. meningitidis may occur more frequently in adults with gonorrhoea and in homosexual men.

MENINGITIS

Meningococcal meningitis among adults is apt to occur in epidemics in closed populations such as military barracks, boarding schools, etc. Headache is usually the presenting feature, with fever and rapidly increasing evidence of general ill-health. Adults may

phobia being common from an early stage. Seizures are rare in adults but frequent in children. Mental disturbance manifests as drowsiness extending to coma and sometimes hallucinations, excitement and other features of delirium. Important confirmatory features are neck stiffness and a positive Kernig's sign [strong passive resistance to attempts to extend the knee when the patient lies upon the back and the thigh is flexed to a right angle with the axis of the trunk].

Abnormal pupils and paralysis of eye movement are common, slight incoordination or tremor may appear in the limbs, and the tendon reflexes are sluggish. The plantar reflexes [contraction of the toes on stroking the sole of the foot] are sometimes up-going. The presence of a petechial or purpuric rash with meningeal signs indicates meningococcal meningitis.

Formerly the mortality rate was high and neurological complications were seen in a large proportion of survivors - hydrocephalus, spastic paralysis, mental defect, blindness, deafness, and epilepsy. ... Change of personality was also reported in children with moroseness, irritability, or moral deterioration, similar to that seen after encephalitis lethargica.

In adults mild but prolonged depression is common during convalescence, no doubt partly as a reaction to the threat of the illness. A period of fatigue and inefficiency may precede full recovery, and loss of libido may last for several months. Pai [1945] investigated 51 adults after meningococcal meningitis, all of whom were seen in a neuropsychiatric unit.

Sulphonamides had been used in the treatment of some but not all cases. Psychogenic reactions outnumbered syndromes of organic defect. Sixteen patients showed intellectual deterioration or organic change of personality, and these were the ones who had had severe meningitis with marked delirium. In the other 35 psychogenic factors seemed to predominate. Disorders of gait and hysterical paresis had often set in after complete recovery and could be related to external stress.

Depression was almost universal. Four patients had developed obsessional disorders for the first time. Other symptoms such as headache, black-outs and temporary loss of memory were occasionally hard to apportion to psychogenic or physiogenic causes.

[Lishman]

Indications

No provings have been conducted with Meningococcinum nor have any clinical observations been made from the use of the nosode. Julian cites Lefors de Tours who found the nosode highly effective in cases of meningitis and severe hypersomnia [condition characterised by excessively long sleep periods with normal responses in the intervals]. Capable of evoking “real resurrection,” Lefors regards Meningococcinum as superior to Helleborus, Nux moschata and Opium in cases of severe meningitis.

Prophylaxis with Meningococcinum 10c, single dose, has proven to be successful during an epidemic of meningitis cerebrospinalis in 1974 in Guarantigueta, Brazil, and has been repeated in 1988 in Blumenau, situated in Santa Catarina State, Brazil, where meningococcal meningitis is endemic. With the use of Meningococcinum 30c, the results in Blumenau were statistically significant, offering “a protection against meningococcal disease of 95% in six months and 91% in a year.” Nine cases had “observable side effects from the nosode. The majority presented with symptoms like chronic headache, fever and nausea.”

[C.R.L. Mroninski et al., *Meningococcinum: Its protective effect against meningococcal disease*-, Hom. Links 4/01]

NEISSERIA SUBFLAVA

Scientific name *Neisseria subflava* (Fliigge 1886) Trevisan 1889

Family *Neisseriaceae*

Homeopathy *Flavus* - Flav.

NOTE: Possible other candidates are *Neisseria flava* Bergey et al. 1923 and *Neisseria flavescens* Branham 1930. The latter species is regarded as a meningococcus-like organism from epidemic meningitis observed in the USA in the 1920-30s. Julian states that the remedy *Flavus* is made from *Neisseria pharyngis* var. *flava*, although this name has no standing in current bacterial nomenclature.

FEATURES

- Gram-negative, aerobic, saprophytic diplococcus fermenting glucose, maltose, and sucrose.
- Natural inhabitant of the mucous membranes of the upper respiratory tract, occurring in saliva and sputum.
- Characterised by the production of greenish-yellow pigmented colonies.

CLINICAL PICTURE

Usually considered non-pathogenic, although it has been associated occasionally with serious infections including bacteraemia, meningitis, endocarditis, septic arthritis and septicaemia with petechia. The clinical picture of *N. subflava* infection may resemble that of *N. meningitidis* including petechial haemorrhage, purpura, and septic shock.

A clinical review of 67 patients - age range 16-84, mean age 62.7 - with sputum samples notable for the presence of *N. subflava* revealed the following:

- Recent/current intubation - 63% of patients.
- Recent surgery - 53% [of which 65% received cardiac thoracic surgery and 28% trauma service].
- Co-morbid conditions: coronary artery disease [33%]; chronic obstructive pulmonary disease [19%]; diabetes mellitus [18%]; congestive heart failure [18%]; hypertension [16%]; recent/current head trauma/brain injury [15%]; cancer [15%]; valvular disease [10%]; renal insufficiency

[7%]; arrhythmias [7%]; sleep apnoea [4%]; alcoholism [3%].

- Data concerning smoking were available on 42 patients: 64% were current or recent smokers, 36% had never smoked.
- Prior antibiotic exposure data were available on 47 patients: 66% had antibiotics administered within 24 hours of sputum sample.

[J.R Manzella et al., *Neisseria subflava* as a Respiratory Pathogen at York Hospital, at: www.wellspan.org/EducationResearch/resdayO1_mcdonnell.pdf]

MATERIA MEDICA FLAVUS

Flav.

Sources

No provings. Clinical pathogenesis by Julian.

SYMPTOMS

Mind

= Low morale, exaggerates difficulties.

» *Sensitive to emotions to and being contradicted.*

Generals

~ Aggravation: cold; heat; at night; morning on waking.

= Amelioration: hot bath; spring and autumn.

= Wine < [digestive upsets; palpitation of heart].

Bruises easily, from slightest impact.

Digestive

= Bad digestion.

= Frequent nausea after meals.

= *Digestive complaints* < wine. [Zinc.; Nux-v.]

Cardiovascular

— Palpitation at night, & sensation of having fever, < after drinking wine.

Female

= Hot flushes at night.

— Menses irregular; of varying quantities, with pale blood.

= Menses late, & PMS.

<= *Loss of blood at ovulation.*

Respiratory tract

« Pain in frontal and maxillary sinuses.

= Discharge from nose and eyes.

«• Takes cold easily, coughs and expectorates. Wakes between 1 and 1:30 a.m. from cough.

<= Sensation of a feather in the throat. [Kali-bi.]

= Throat pain after having had wet feet.

= Dryness of throat, < at night.

■> Pharyngitis with sensation as if palate is touching the tongue.

= Sensation of heaviness in larynx after talking for a long time.

= Frequent loss of voice.

= Dyspnoea < at night around 2 a.m.; suffocating feeling on waking.

Nose

* Dry with dry crusts.

= Epistaxis in morning.

~ Discharge of greenish pus. [Kali-bi.]

“*Nasal congestion at night*, one nostril becomes blocked, the other opens; > in morning after sneezing.

« Sneezes easily.

Other locals

“ Peri-orbital headache, right-sided. [Sang.]

Eyes swollen in morning on waking; heavy eyelids.

- Red eyes, tired in evening.

~ Frequent otitis [one patient had otitis 25 times]; right-sided earache.

= Pain dorsal region radiating to both arms.

= Arthrosis of the cervical region, with cracking.

« Slight tremor, particularly in fingers.

= Sweaty palms of hands.

= Left-sided sciatica.

= Pain in knee joints, with cracking.

MORAXELLA CATARRHALIS & NEISSERIA MUCOSA

Sources

John Paterson described the bowel nosode Sycotic Compound as Gram-negative non-lactose fermenting diplococci. Julian thinks it is *Streptococcus* [= *Enterococcus*] *faecalis*, whilst according to Gaier it concerns *Diplococcus* [= *Streptococcus*] *pneumoniae*, *Neisseria gonorrhoeae*, and/or *Neisseria meningitidis*.

Julian's and Gaier's conceptions conflict with the bacteriological characteristics of the organisms. Both *Enterococcus* and *Streptococcus* are Gram-positive and lactose positive [i.e. they ferment lactose], whilst *Neisseria* spp. are Gram-negative and part of the normal flora of the oropharynx, nasopharynx, and genitourinary tract rather than being intestinal bacteria. What does fit with Gaier's suggestion, on the other hand, is that gonococci and meningococci are positive for glucose and/or maltose, but negative for lactose [non-lactose fermenting]. They also have been isolated from the stools of patients with proctitis.

However, both the gonococcus and the meningococcus can be excluded given Paterson's remark that "this nosode is prepared from an organism closely related to the meningococcus." And: "It will be evident that this coccal organism of the intestinal tract is related morphologically and clinically to the Gonococcus. Hahnemann related what he called 'The Sycotic Miasm' to the disease, Gonorrhoea, but this disease is only one form of catarrhal infection of the mucous membrane of the urinary tract. There are many other non-gonorrhoeal organisms associated with the symptom picture of 'catarrh' and I suggest that the miasm 'Sycosis' may be considered synonymous with 'Catarrh'. Gonorrhoea is an infection of mucous membrane [i. e. it is a sycotic manifestation] but catarrhal manifestations [Sycotic] are not all due to gonorrhoeal infection."

Two other species are suggested by their very names: *Neisseria mucosa* Veron et al. 1959 [synonym: *Diplococcus mucosus* von Lingelsheim 1906] and *Moraxella catarrhalis* (Frosch & Kolle 1896) Bovre 1979. The former is a normally saprophytic diplococcus, the latter is a member of a separate genus of cocci in the family Neisseriaceae. The dimorphic *Moraxella* appears as either rods or cocci. These organisms are normal inhabitants of the human nasal cavity and nasopharynx, occasionally associated with meningitis,

conjunctivitis, otitis media, sinusitis, bronchitis, and pneumonia.

Speculative by definition, attempts to accurately determine the origins of Sycotic co. are bound to fail since bacterial cultures in the 1920-30s were performed with non-selective media, which neither inhibited the growth of other bacterial species nor permitted differentiation between colonies of Neisseria and related species. MacConkey agar, as used by Paterson, is employed to detect Salmonella and Shigella from stool specimens, but is less selective for the recovery of enterococci. The division into cocci and rods appears to agree with Paterson's observation that the diplococcal organism isolated from stool cultures of 22 cases, together forming the basis of the nosode Sycotic co., is pleomorphic. In the words of Paterson: "By variation of media it was found possible to change the morphological appearance under the microscope from diplococcus to bacillus [rod] and vice versa." However, Paterson's finding that "each agar plate yielded a bacillus and each MacConkey culture yielded a diplococcus" is more likely to have its explanation in the change of media - each allowing the growth of different organisms - rather than demonstrating the pleomorphism of the "sycoccus."

Any doubts about the involvement of Neisseria spp. in Sycotic Co. will be taken away by the following:

His [Paterson] success in gonorrhoea, using his own bowel nosode *Sycotic Co.*, caused him some embarrassment. He remarked that during the war, No. 923, where he lived, was not so much a bacteriologist's consulting room, as a V.D. [venereal disease] clinic. At all hours of the day people, usually from the Foreign Forces he added, would present at the door, and Mrs. Paterson would show them in. He used to tell ruefully how on one occasion he lost his temper and sent one away, amid the reproaches of Mrs. Paterson, who said, characteristically, you could not treat suffering humanity so. Half an hour later there was a telephone call from a senior Medical Officer of one of the Foreign Forces Contingents, asking for an appointment, and along he came with precisely the man who had been turned away. We recall him saying, "He had all the pain an acute epididymitis can give, and all the inflammation."

When Dr. John still refused to treat, the Medical Officer stated they did not know what Dr. Paterson gave, but his cases were *cured* and gave no more trouble, whereas their practice merely suppressed. Dr. John gave him a supply of *Sycotic Co.* [one would assume in high potency because it was an acute attack], and information as to where he could get as much more as he wanted.

Thereafter, he told us, his house was no longer a V.D. clinic.

He did not use *Sycotic Co.* for this purpose alone. He regarded it as an all purpose remedy where there was a background of catarrh, whether of the respiratory, intestinal or sexual systems. It has been remarked that he appeared to pay more attention to sycosis and psora than to the third miasm. He certainly used *Sycotic Co.* a great deal, and two of his rather surprising prescriptions were of its near relative *Medorrhinum*. Both came from his days in the Childrens Department, where he used it in the infantile diarrhoea that runs through such places. He regarded it as specific for both this disease and Pink disease. [Kneechest posture and the pink colouring, and the foot symptoms.]

...In human diseases where the subject was Grauvogl's Hydrogenoid type, *Sycotic Co.*, *Thuja* and *Natrum sulphuricum* were the foremost in mind. ... He frequently used the nosode high, and the related everyday remedy low. He would give *Sycotic Co.* IM, a single dose, and *Natrum sulphuricum* 6, twice daily.

[Geoffrey Brown, *Drs. John and Elizabeth Paterson*-, British Hom. Journal, Oct. 1967]

MATERIA MEDICA SYCOTIC COMPOUND

Syc.

Sources

- [1] The drug picture of Sycotic Co. is based on clinical observations. The symptoms come from John Patersons *The Bowel Nosodes* and Elizabeth Paterson's summary of 53 cases [43 females, 10 males] in *A Survey of the Nosodes*. [EP]
- [2] Louis Klein, *Clinical Focus Guide to Homeopathic Remedies*, Vol. 1. [LK]

SYMPTOMS

Keynote

= Irritability & irritation of mucous and synovial membranes.

Mind [EP]

- = Nervous irritability. Bad-tempered. Blinking of eyelids; twitching of facial muscles. Bites nails.
- = Excitement = loose stools.
- = Fear of dark; of being left alone; of animals and dogs.

<• Dreams of dead people.
= Cannot sleep till 3 a.m. Insomnia.

Fear of obscurity [LK]

= “One of the key rubrics is ‘fear of obscurity.’ In understanding this remedy it is important to make some subtle distinctions concerning *Sycotic-co.* individuals. They have a nature driven by the desire to be in the limelight and to create a distinct and conspicuous personage. Inversely, you could describe this, as some authors have, as a ‘fear of obscurity.’ This fear drives the child or adult to be a ‘star’ or to stand out.

It is not so much a question of ego as in *Platinum*, but they have a great fear they’re going to be obscured by other people around them. Their conspicuous presence is not necessarily related to how they look but more through their actions.

As older children and young adults, they may choose to participate and perform in competitive sports such as tennis, swimming, gymnastics or in the entertainment field with activities such as singing or playing a musical instrument. The key is that the activity requires individual excellence and the ability to attain distinction. It is not so much the competition that drives them, but the need to be the best and excel in order to maintain attention and distinction.

This desire to be in the limelight and be distinct can start at a young age, particularly if they have a great deal of sibling rivalry similar to *Hyoscyamus*. Children feel that their sibling ‘obscures’ them and then they desire attention. They are frequently, but not always, the first-born and desire to maintain a leadership role. It comes more from not wanting to be obscure than a fear of loss of social position as in *Veratrum*. It may be more subtle in some individuals, even to the extent that they are not into sports or entertainment. In any case, they will feel that they are not ‘seen’ and will therefore take pride in and protect something that makes them distinct. If they lose this, they are devastated.

On the surface and in the interview, they appear and maintain a subdued and polite element. They may even seem to want to please. Underlying this can be some contemptuousness and irritable touchiness along with being very demanding. They can be tense and nervous perfectionists like *Nux vomica*, but there is the ‘sycotic’ changeability and extremes. They weep when irritable [which is much of the time] and they can have quite a wild side like *Medorrhinum*.”

Irritation/catarrh [EP]

- = Meninges, subacute or chronic.
- = Sinuses; sinusitis headache.
- = Nasopharynx [nasal catarrh (50% of cases); enlarged tonsils; cheesy masses from tonsils; adenoids]. Profuse mucus from throat in morning.
- = Alimentary tract; catarrhal conditions; acute or chronic gastroenteritis [in children];
- = Loose, offensive stool, excoriating; urgent call to stool as soon as rising out of bed.
- = Bronchi; acute, subacute or chronic bronchial catarrh. Asthma and bronchitis, < damp and frost; > seaside. Wheezing and cough 2-3 a.m. or on waking. Gasping < waking. Bronchitis in winter. Hard, spasmodic cough - 2 a.m., 4 a.m., or 6 a.m.; cough till sick. Descending colds.
- = Genitourinary system, from the "kidney to the urethral tract"; albuminuria; pyelitis; cystitis; urethritis; vulvo-vaginitis; balanitis.

Cracks [EP]

- « Cracks in angles of nose.
- = Cracks in angles of mouth.
- == Lips dry and cracked.
- = Tongue sore, scalded; dry, fissured; furred. Pins and needles on tongue.
- ~ Splinter pain in rectum.
- » Cracks on fingertips.
- == Cracks on heels.

Generals [EP]

- = Mostly cold sensitive.
- = Anaemia; hydraemia [dilution anaemia]. [Patient always anaemic looking, without much colour in the face.]
- = Perspiration, worse head and body, during sleep.

Appetite & Food [EP]

- = Finicky; pernickety [exacting minute care]; fastidious; fussy.
- = *Eggs* - aversion eggs in 50% of cases.
- Upset by eggs - nausea, vomiting, bilious attack, hay fever. Even thought of eggs in morning produces nausea.
- == Upset by fat, onion, oranges.
- = Aversion to: fat; milk; milk pudding; cream; salt; sugar; tea; vegetables;

vinegar; cheese; meat; bread; potato; tomato.
« Craves: butter; fat; cheese; sweets; milk; salt.
« Nausea from smell of cooking.
= Averse and worse *oranges* [unlike *Med.*]. [LK]

Gastrointestinal [EP]

= Pain and distension in epigastrium. Flatulence.
« Acidosis attacks.
« Distended colon. [Hirschsprung's disease - congenital megacolon.]
« Nocturnal vomiting - must empty stomach.
« Abdomen distended.
= Rectal prolapse.
= Liquid stool after every meal. Frothy loose stool. Stool pale, crumbly; bad odour.
« History of antibiotic use [common to bowel nosode remedies as a group] and subsequent bowel problems - diarrhoea [particularly right after eating], constipation or alternations of the two with excessive gas, bowel distension and intestinal yeast problems]. [LK]

Respiratory [LK]

« Asthma < frosty air and humid weather, > seaside.
« Old cases of asthma; patient has been asthmatic for years and is moving into emphysema.
« Asthma in children, < 2 a.m.; or mucousy cough < 2 a.m.
« Asthma/bronchitis & digestive problems.

Neuromuscular [EP]

« General rheumatic fibrositis, < dampness and after a period of rest.
« Pain neck and back; stiffness; lumbo-sacral; ileo-sacral joints; hips stiff; generally < after sitting, at night, on beginning to move, > motion and heat.
« *Arthritis fingers-*, pain > dry weather, hot water.
Arthritis metacarpo-phalangeal joints.
= Fingers go dead, numb; with spasm of the fingers. Prickly feeling in hands.
= Ankles swollen and stiff.
« Feet painful when walking, as if walking on loose cobble stones.
« Pain in metatarsal bones.
« Fidgety feet at night in bed.

= Big toe joint painful.

Genitourinary [EP]

= Pain in left ovary at menstrual period.

— Profuse leucorrhoea. Leucorrhoea yellowish; white; dark brown; offensive; corrosive.

= Uterine polyps.

~ Amenorrhoea up to 6 months.

Dermatologic [EP]

= Sallow complexion; oily, greasy skin.

= Prematurely grey hair. Alopecia. Painful dry scale spots. Hairs on face and upper lip.

— Vesicular or varicellar type of eruption on face or body. [According to Paterson, a rash varicellar in type, resembling, and often mistaken for chickenpox may appear after administration of this drug to children.]

= Warts on mucocutaneous surfaces; hands [large, flat, ragged]; feet; body.

= Circinate eruption both arms; thighs and shins.

= Herpes - face, neck, chest, groin.

«= Palmar dermatitis - vesicles itch at night, & heat, < excitement, flour, detergents.

— Varicella eruption of limbs since immunisation.

Locals [EP]

= Headache - weekly; every Sunday morning, worse on left side; throbbing;
> heat and rest; < noise.

= Headache - frontal, congestive.

= Migraine before or after menses.

=> Face puffy in morning, especially under eyes.

== Tarsal cysts. Conjunctivitis. Photophobia. Hemipopia.

= Excessive formation of ear wax.

=» Nose dry; formation of crusts; burning.

= Epistaxis.

=> Sense of smell lost. Sense of taste lost.

<- Hayfever.

<■» Persistent herpes labialis.

~ Tongue dry, sticks to roof of mouth.

=* Salivation increased.

= Swallowing difficult; chokes easily.

«• Peri-anal warts.

= Brittle nails.

Associated remedies

Thuja. Antimonium tartaricum. Calcarea carbonica. Ferrum. Natrum sulphuricum. Nitricum acidum. Rhus toxicodendron.

Remedies mistaken for [LK]

Streptococcinum. Medorrhinum. Thuja. Lycopodium. Natrum sulphuricum. Nux vomica.

Remedies that follow well [LK]

Natrum sulphuricum. Thyroidinum. Tuberculinum. Sulphur.

CASE

(1) Mrs. J.C., aged 57. Her complaint is rapid heart action [pulse rate about 100], This state is punctuated by more acute spells of tachycardia attended by shaking of hands and feet. She also suffers from intense headaches localized on top of the head, pressing or penetrating pains. She is very apprehensive, nervous and impatient and very sensitive emotionally. There is a fine tremor of hands and fingers, globus sensation in throat, easy perspiration. Her basal metabolism rate was above +15 when taken several times in the past. Tendency to constipation and flatulent distension from sweets and fats. Clinically, this is a definite case of hyperthyroidism [in the past she had had treatments with Lugol's solution* without any effect]. Generals: lack of vital heat, better from warmth but worse in closed rooms; worse night, after eating, in damp weather, approaching storm; she is of fine, thinly built, narrow-chested, phthisical habitus. The obvious prescription was Sulphur, which over 2 years improved her condition but never succeeded in bringing about a really decisive change. In spite of giving it as high as 50M, she still was in need of monthly repetitions and, though in a milder form, retained her tachycardia, as well as the acute cardiac syndrome and the migraine. Arsenicum iod., Tuberculinum, Psorinum, Thyroidinum proved of no avail. Iodum is evidently not indicated by the modalities.

Sycotic Co. [Paterson], a single dose of the 200, proved the most effective prescription she had ever received. A progressive improvement of all symptoms

still continues after four months without any repetition of the dose, thus showing that this remedy affects her more deeply and lastingly than Sulphur, which by her symptoms seemed indicated.

[E. Whitmont, *When the Well Selected Remedy Fails to Act*, Hom. Rec., June 1952; EncHom.]

* Lugol's iodine solution, an iodine-potassium iodide, introduced by the French physician Jean G.A. Lugol [1786-1851] for the treatment of thyroid problems.

Proteobacteria: Group Gamma

| Phylum | Order | Family | Genus | Species | Remedy | | | |
|----------------|----------|-------------------|--------------------|-----------------|-------------------------|----------------------|----------------------|----------------|
| PROTEOBACTERIA | Gp Gamma | Enterobacteriales | Enterobacteriaceae | Citrobacter | <i>C. freundii</i> | BN Bacis-7 | | |
| | | | | Enterobacter | <i>E. cloacae</i> | BN Bacis-7 | | |
| | | | | Escherichia | <i>E. coli</i> | Colibacillinum | | |
| | | | | Escherichia | <i>E. coli mutabile</i> | Mutabile | | |
| | | | | Hafnia | <i>H. alvei</i> | BN Bacis-7 | | |
| | | | | Klebsiella | <i>K. pneumoniae</i> | | | |
| | | | | Morganella | <i>M. morganii</i> | BN Morgan pure | | |
| | | | | Proteus | <i>P. mirabilis</i> | BN Proteus | | |
| | | | | Proteus | <i>P. vulgare</i> | BN Proteus | | |
| | | | | Salmonella | <i>S. paratyphi</i> | Paratyphoidinum | | |
| | | | | Salmonella | <i>S. typhi</i> | Eberthinum Typhoidin | | |
| | | | | Salmonella | <i>S. enteritidis</i> | BN Gaertner | | |
| | | | | Shigella | <i>S. dysenteriae</i> | BN Dysenteriae Co. | | |
| | | | | Yersinia | <i>Y. pestis</i> | Pestinum | | |
| | | | | Pasteurellales | Pasteurellaceae | Haemophilus | <i>H. influenza</i> | Hib vaccine |
| | | | | Pseudomonadales | Pseudomonadaceae | Pseudomonas | <i>P. aeruginosa</i> | |
| | | | | Vibrionales | Vibrionaceae | Vibrio | <i>V. cholerae</i> | Cholera nosode |

“The gamma proteobacteria include three distinct feeding types: photosynthesizers, many of which find their closest relatives among non-photosynthesizers; plus heterotrophs [dependency upon organic compounds for carbon and energy] and chemolithotrophs [dependency upon hydrogen-rich chemicals for energy and upon carbon dioxide for carbon], which again may be closely related phylogenetically despite their great difference in lifestyle. Non-photosynthetic gammas include *Legionella*, the cause of legionnaires’ disease; the enterics such as *Escherichia coli*, *Salmonella* and their kind; *Vibrio*, which includes *Vibrio cholerae*, the agent of cholera; *Oceanospirilla*, fluorescent pseudomonads, and so on.” [Tudge]

I. ORDER ENTEROBACTERIALES

IA. FAMILY ENTEROBACTERIACEAE

Citrobacter freundii.
Enterobacter cloacae
Escherichia coli.
Escherichia coli-mutabile.
Hafnia alvei.
Klebsiella pneumoniae.
Morganella morganii [syn. *Proteus morganii*],
Proteus mirabilis.
Proteus vulgaris.
Salmonella enteritidis.
Salmonella paratyphi.
Salmonella typhi.
Shigella dysenteriae.
Yersinia pestis.

FAMILY FEATURES

The family Enterobacteriaceae contains more than 120 species in over 30 genera. All are found in the gastrointestinal tract of animals or humans, but many are also free living in soil and water. All are small Gram-negative, nonsporeforming bacilli which ferment glucose with acid production, reduce nitrates to nitrite or nitrogen, and are oxidase negative. All are aerobic but can be facultatively anaerobic; all are motile [except *Shigella* and *Klebsiella*, which are non-motile], and are encapsulated or covered by a slime layer or neither.

The colonial morphology of enterobacteria is quite similar; colonies are usually dome-shaped, grey, and smooth.

Most species are opportunistic or cause secondary infections of wounds, the urinary and respiratory tracts, and the circulatory system.

The original classification of the Enterobacteriaceae, devised by Edwards and Ewing, was based upon the different metabolic profiles of the organisms. Edwards and Ewing chose traits that were easy to test, such as lactose fermentation and the production of hydrogen sulfide.

BOWEL NOSODES

Bacteriologists and homeopathic physicians, Dr. John Paterson and his wife Dr. Elizabeth Paterson applied in the 1920-1960s the Law of Similars to bacteriology, building on the work of Dr. Edward Bach, who used this approach in the cure of disease. [Dr. Bach, incidentally, later exchanged stool samples for flower essences.]

Paterson regarded bacteria in their context instead of alone, emphasising the interaction of the bacterium and the host. He saw bacteria as the **scavengers** of disease, rather than the cause, and he considered Pasteur's exclusive emphasis on the bacteria as a distortion, unscientific and harmful. [Paterson actually saw Pasteur as both a showman and a social flir.]

... Louis Pasteur will forever be remembered as the founder of the science of bacteriology. It was he who first isolated and identified a specific germ and related it to a definite clinical entity [disease]. Following upon his discoveries, medical science concentrated on the laboratory technique for the isolation and identification of a specific germ for each known disease, and the Koch postulates were accepted as the standard for declaring any germ capable of pathogenesis - of having power to cause disease. The motto of the medical profession is still *Tolle Causam*, find the cause, and today there are many who consider that germs are the only cause of disease and are working to discover the specific germ or virus for well known clinical entities.

It must now be accepted as scientific fact that specific germs, in many cases of disease, can be isolated and identified, but is it a true conclusion that the specific germ is always the cause of the disease?

... Is the "specific germ" the actual cause of disease, or is it the result of the action of the vital force [Dynamis] which characterises all living cells, in their resistance to z/h-ease.

The Paterson work on the bowel nosodes was primarily concerned with chronic disease. The basic idea was that the patient's condition is reflected by the intestinal flora.

In nature, where there is balance, there is no zfc-ease and the germ, in this case the *B. Coli* in the intestinal tract, performs a useful function. Where the intestinal mucosa is healthy the *B. Coli* is non-pathogenic. Any change in the host which affects the intestinal mucosa will upset the balance and will be

followed by a change in the habit and the bio-chemistry and the *B. Coli*, which may then be said to become pathogenic, but it should be noted that the primary change, the «/«-ease originated in the host, which compelled the bacillus to modify its habit in order to survive.

The clinical and bacteriological observations on 12,000 cases brought Paterson to the following conclusions:

[A] Non-lactose fermenting bacilli were isolated in 25% of the stool specimens examined.

[B] The appearance of non-lactose fermenting bacilli often *followed* and seemed to bear relationship to the previously administered homeopathic remedy - the choice of the remedy being made according to “the law of similars” and prepared by “potentisation.”

In the laboratory one observed an unexpected phenomenon, that from a patient who had previously yielded only *B. Coli*, there suddenly appeared a large percentage of non-lactose fermenting bacilli of a type which one associated with the pathogenic group of typhoid and paratyphoid.

... The patients stool yielded a large percentage of presumably pathogenic organisms, and according to the accepted Pasteur and Koch theory, the patient was suffering from disease. Clinical investigations, however, revealed that the patient did not feel ill, but had experienced a sense of well being which he had attributed to the last medicine he had received. Since the non- lactose fermenting bacilli had appeared after a definite latent period of 10 to 14 days, following the administration of the remedy, it would seem that the *homeopathic remedy* had changed the bowel flora, and had caused the *dis-ease*.. The pathogenic germ in this case was the *result* of the vital action set up in the patient by the potentised remedy. The germ was *not* the *cause* of the disease.

Translated into the practice of medicine this comes down to:

[A] The specific organism is related to the disease.

[B] The specific organism is *related to the homeopathic remedy*.

[C] The homeopathic remedy is related to the disease.

... The practice of Homeopathy is founded on the hypothesis that the true *simillimum* [the homeopathic remedy] is related to the disturbed metabolism [the disease] and now it can be demonstrated that the non-lactose fermenting

organism of the bowel is biochemically related to the disease and the homeopathic remedy.

Paterson used to take a stool specimen for examination and prescribe as an “autogenous vaccine” the prevailing bacterium found. A swab gave him a bird’s-eye view of the constitution of the patient; he was convinced that “the nature of the person is imprinted on the bowel flora” and that a stool specimen allowed him “to see all he wanted to.” He argued that these intestinal bacilli had a *constitutional* significance.

In due time, Paterson, in collaboration with Drs. Wheeler, Dishington and Bach, worked out clinical indications that made it possible to prescribe the bowel nosodes without any bacteriological knowledge.

Paterson formulated a series of working rules for the use of the nosodes and their associated remedies:

1- *New Case*. A patient who has *not received homeopathic treatment*. Where there is a definite symptom picture which points to a remedy, this should be given, and not a nosode. In many cases, however, the choice may lie within a number of possible remedies and it is in this difficulty that one may use the list of remedies and the associated bowel nosodes.

2, - *Old Case*. A patient who has been under homeopathic treatment but who may not be responding to the treatment given. These are difficult cases, even from the nosode point of view; when there is no evidence available from stool culture to give a clue to the group of remedies likely to be useful, or as to the phase in which the patient is at the moment. The choice of a nosode for any case can be determined by a study of the clinical history and noting the remedies which have given the greatest, although not sustained, effect. Tabulate this list of remedies and compare it with the Nosode list and the associated remedies and choose the nosode which has the greatest number within its group. In many cases there may not be much apparent effect from the nosode, but it would seem that the giving of the nosode had in some manner readjusted the case, because thereafter considerable benefit follows the remedy previously given without much effect. If there seems no apparent benefit from the nosode, do not be disappointed but repeat the remedy which has given the evidence of partial reaction before, and this time you can expect more permanent action.

One last remark, and that of warning, do not repeat a bowel nosode within three months; but if it is necessary to prescribe, select a remedy within the

group, and give the remedy in high or low potency as you find indicated from the symptoms present.

Lactose fermenters are part of the normal bowel flora, colonising the intestine soon after birth. Since the first nutrient for human or animal newborns is lactose, most normal enteric bacteria are capable of fermenting it. Lactose fermenters are rarely pathogenic, eg, commensal *E. coli*, *Citrobacter*, *Klebsiella*, and *Enterobacter*.

Non-lactose fermenters [lactose negative], on the other hand, include bacteria associated with virulent illness, such as *Salmonella*, *Shigella*, *Pseudomonas*, *Yersinia*, and *Proteus*.

Paterson postulates the idea that constitutional changes result in shifts in the intestinal flora, changing the ratio of lactose fermenters to non-lactose fermenters. Interpreting the term virulence as indicative of the patient's vital reaction rather than of the disease-causing nature of the bacterium itself, he regards "the loss of power to ferment lactose" as being "related to virulence in the typhoid coli group of organisms." Shedding these non-lactose organisms in the faeces can thus be taken as a measure of the patients vitality: "the larger the output the less the internal miasm, and *vice versa*." As a rule it was found that when there was a large output of organisms in the faeces it was much easier to find a homeopathic remedy than when the output was small; the cases that were fighting the disease as a rule threw out good symptoms. This change to non-lactose organisms in the stool, as Paterson found, coincided with the first definite clinical signs of improvement in chronic disease.

Citations from: John Paterson, *The Bowel Nosodes*, British Hom. Journal, July 1950.

Background information from: Geoffrey Brown, *Drs. John and Elizabeth Paterson*-, British Hom. Journal, October 1967.

MATERIA MEDICA BACILLUS No. 10

Back-10

Sources

No information is available about the identity of the bacteria from which this nosode was prepared. The nosode is so named as it was the tenth non- lactose fermenting type of bacillus observed in the laboratory.

The symptoms were collected from five cases [four females, one male] and

described by Elizabeth Paterson in *A Survey of the Nosodes*, British Hom. Journal, July 1960.

SYMPTOMS

Mind

» *Anxious; active; irritable; depressed.*

Generals - Food

-*Aversion* to eggs; bread; tomato; tea.
= Aversion to breakfast.
= *Craving for sweets; chocolate; fried fish.*
~ Aggravation from eggs and fat.

Female

« *Pruritus vulvae.*
= *Leucorrhoea* fishy odour; greenish; corrosive.
« Skin groin raw; dry and cracked.
=> Pain left iliac fossa and right iliac fossa.

Locals

= Headache forehead, [above] left eye.
= Nasal catarrh.
= Gums spongy.
« Bad breath.
= Occasional pain in gall bladder.
= Bowel motion first thing in the morning or bowel motion sluggish.
« Frequent micturition.
~ Axillary perspiration.
« *Asthma.*
<• Cough < mornings; sputum difficult.
<• Tenderness coccyx.
= Rheumatoid arthritis left knee.
« *Warts hands* - numerous, flat or pointed [after working with pickled hams].
= *Ringworm.*

Associated remedies

Thuja. Natrum sulph. Aralia. Sepia. Calcarea phosphorica. Kali bichromicum.

BACILLUS No. 7

Origins and names

The lactose-negative organisms isolated by John Paterson from stool samples of patients in the 1920s were named 'Bacillus No. 7' because they were the 7th non-lactose fermenting type of bacillus to be observed in the laboratory, which did not conform to any of the previously known groups.

Bacillus No. 7 has been identified by Julian as consisting of three species: *Bacillus asiaticus*, *Bacillus cloacae*, and *Bacillus freundii*.

Over time all three species have undergone a series of name alterations and reclassifications, so that *Bacillus asiaticus* is now known as *Hafnia alvei*, *B. cloacae* as *Enterobacter cloacae*, and *B. freundii* as *Citrobacter freundii*.

Of these three, *Enterobacter cloacae* does not entirely match Paterson's definition of bowel nosodes as non-lactose fermenting bacteria. Most strains of it do ferment lactose but so slowly that they likely will be regarded as lactose-negative.

Citrobacter freundii

- *Citrobacter freundii* (Braak 1928) Werkman and Gillen 1932.
- Gram-negative, motile, rod-shaped bacterium occurring in pairs.
- Belongs to the normal gut flora and is found in the faeces of man, mammals, birds, reptiles, and amphibians.
- Ubiquitous in soil, water, sewage; commonly present in foodstuffs.
- Survives well in water, but survives only for a few hours on dry surfaces.
- Colonies strongly resemble *E. coli* colonies. [*C. freundii* was previously classified as *Escherichia freundii*.]
- Biochemically more closely resembles the *Salmonella* group. [The former Bethesda-Ballerup group of *Salmonella* is presently classified in *Citrobacter freundii*.]
- Produces hydrogen sulfide.
- Able to use citrate as its sole carbon source; hence its generic name.
- *Citrobacter* spp. have the ability to accumulate cadmium [from the environment]
-
- Associated with fatal infections in salmon and trout [anorexia; skin erosions; superficial haemorrhages; enteritis; erratic movements].
- Opportunistic pathogen in humans, associated with nosocomial infections; causes diarrhoea and secondary infections in immuno-compromised

patients and occasionally severe primary septicaemia. Frequently associated with brain abscess formation.

Enterobacter cloacae

- Enterobacter cloacae (Jordan 1890) Hormaeche and Edwards 1960.
- Gram-negative, motile, rod-shaped bacterium.
- Normal inhabitant of the intestinal tract.
- Biochemically similar to Klebsiella.
- Implicated in mild forms of gastroenteritis, and in urinary tract and respiratory tract infections.

Hafnia alvei

- Hafnia alvei Moller 1954.
- Single species in the genus, which some taxonomists believe should be classified in Enterobacter.
- Resembles Salmonella [but doesn't produce hydrogen sulfide].
- Found in soil, water, and foodstuffs [of animal origin],
- Normal intestinal commensal.
- Associated with fatal infections in trout [weakness; dark discolouration; protrusion of eyeballs; bleeding in eyes; petechiae].

MATERIA MEDICA BACILLUS No. 7

Bads-7.

Sources

No provings.

Symptoms collected from nine cases [eight females, one male] and described by Elizabeth Paterson in *A Survey of the Nosodes*, Br. Hom. Journal, July 1960.

Also included is the summarised drug picture by John Paterson in *The Bowel Nosodes* [1],

SYMPTOMS

Mind

= The outstanding symptom is mental fatigue, a feeling of unfitness for any mental effort, which produces a sense of extreme physical exhaustion.¹

~ Becomes fatigued at the idea of effort. [Julian]

Generals

- => Sensitive to cold, to draughts and cold damp air.¹
- Excessive perspiration.
- > Light sleep; wakes 2 or 3 a.m.; difficult to fall asleep [takes 2 hours].
- « Aversion to fat.

Digestive

- = All the symptoms can be related to general lack of nerve and muscle tone; a sense of fullness after food; flatulence and distension of the stomach; enteroptosis.¹

Urogenital

- <■ Feeble urinary flow; loss of sexual function; premature senility.¹

Respiratory

- <> Asthma; bronchial catarrh; tough sticky mucus, difficult to raise.¹

Cardiovascular

- " Slow pulse rate, often with lowered blood pressure; myocardial weakness.¹
- = Angioneurotic oedema face.
- «• Thrombosis central retinal vein.
- = Blood vessels burst in fingers.

Musculoskeletal

- = Relaxed fibrous tissue, with tendency to the formation of "rheumatic nodules"; backache, cannot stand long without feeling of faintness; tendency to syncope after sudden exertion.¹
- = Stiffness neck - "cracks like a nut."
- => *Fibrous rheumatism neck and back.*
- = Backache < damp and cold; < beginning motion; > heat and rest.
- => Joints lower limbs swollen and painful.
- = Cramps in legs at night.
- » Pains shooting up and down leg.
- => *Rheumatoid arthritis; shoulders; elbows; wrists; knees and ankles.*

Dermatologic

- = Cracks knuckles - palms - fingertips
- = Circinate eruption palms of hands - hot, nippy and scaly.

= Paronychia fingers.

Associated remedies

Kali carbonicum. Calcarea fluorica. Calcarea carbonica. Rhus toxicodendron.

Causticum.

“The ‘proving’ of Bacillus No. 7 is not unlike that of Proteus [Bach] as it has similar relationship; Proteus is related to Chlorine whereas Bacillus No. 7 seems to have a closer relationship to the two halogens, Bromine and Iodine, often in combination with Potassium.” [JP]

ESCHERICHIA COLI

| | |
|------------------------|--|
| Scientific name | Escherichia coli (Migula 1895) Castellani & Chalmers 1919 |
| Old name | Bacillus coli commune |
| Family | Enterobacteriaceae |
| Homeopathy | Colibacillinum - Coli. Serum anti-colibacillum - Ser-a-c. |

FEATURES

- First isolated and characterised in 1885 by the Austrian paediatrician Theodor Escherich from faeces of newborns.
- Gram-negative, rod-shaped, motile, aerobic, facultative anaerobic, saprobic bacterium.
- Peritrichous flagella [flagella distributed all around cell].
- Commensal of the intestinal flora of virtually all warm-blooded animals.
- Most abundant of the bacteria making up the bulk of the faeces.
- Normally serves a useful function in the human body by suppressing the growth of harmful bacterial species and by synthesising appreciable amounts of vitamin K and the B-vitamins from undigested material in the large intestine.
- Habitually present in faeces of humans and animals, and in water and soil contaminated with them.
- Ferments lactose/glucose; reduces nitrate to nitrite.
- Produces acetic, lactic, and formic acids in sugar-containing cultures.
- Rapidly coagulates and acidulates milk, with the evolution of gas of a faecal odour.
- One of the fastest multipliers; doubles its numbers every 20 minutes .
- Common cause of sepsis and urinary tract infections [eg “honeymoon cystitis”].
- Common cause of traveller’s diarrhoea.
- Not infrequently found in pus in suppurations connected with the intestines, eg appendicitis.
- Many strains produce haemolysins.

CLINICAL FEATURES

Certain strains of *E. coli* can cause intestinal infections that produce bloody, watery, or inflammatory diarrhoea [traveller's diarrhoea]. In children, diarrhoea caused by certain strains of *E. coli* may lead to destruction of red blood cells and kidney failure [haemolytic-uraemic syndrome] or haemorrhagic colitis. *E. coli* can also cause urinary tract infections [particularly in women] and bacteraemia and meningitis in newborns [particularly premature newborns]. There are hundreds of serotypes of *E. coli*. The disease-causing types are placed in four groups:

Enterotoxigenic *E. coli* [ETEC];
Enteropathogenic *E. coli* [EPEC];
Enteroinvasive *E. coli* [EIEC];
Enterohaemorrhagic *E. coli* [EHEC].

EPEC is associated with infantile diarrhoea; ETEC with gastro-enteritis and traveller's diarrhoea, EIEC with bacillary dysentery, and EHEC with haemorrhagic colitis, haemolytic uraemic syndrome [HUS], or thrombocytopenic purpura.

EHEC is also known as verotoxin or *Shiga* toxin-producing *E. coli* [VTEC or STEC]. These toxins are closely related or identical to the toxin produced by the closely related species *Shigella dysenteriae*. It is postulated that bacteria transferred the gene for the *Shiga* toxin from *Shigella* to *E. coli* during a pandemic in Central America in the 1970s.

HUS develops when 0157 enters the bloodstream through the bowel wall and begins to release *Shiga* toxin. *Shiga* toxin is effective against small blood vessels, such as found in the digestive tract, the kidney, and lungs, but not against large vessels such as the arteries or major veins. A specific target for the toxin appears to be the vascular endothelium of the glomerulus. *Shiga* toxin [ST] is considered the third most deadly bacterial toxin in the world. Red blood cell haemolysis leads to brain haemorrhaging, uncontrolled bleeding, and the formation of clots in the bloodstream. Complications caused by ST eventually lead to epilepsy, strokes, blindness, paralysis, and/or heart failure. [Data at: www.nal.usda.gov/fsrio/]

Food poisoning with Shiga toxin often also has effects on lungs, brain, and pancreas. The commonest sources are the bacteria *Shigella dysenteriae* and enterohaemorrhagic *Escherichia coli* [EHEC] of which the strain O157:H7 has become the best known.

E. coli O157:H7 is the classical serotype that was first associated with enterohaemorrhagic diseases in the early 1980s as a cause of serious outbreaks and sporadic cases of illness. Over 100 different STEC serotypes, other than O157:H7 have now been associated with human illness. As with O157 STEC, human infection with non-O157 strains may be associated with serious complications such as haemolytic uraemic syndrome.

Non-O157 STEC infections are found in 20 to 70% of patients with STEC-associated disease, depending on geographical location. The clinical course and outcome with non-O157 STEC appears to be similar to that of infection with serotype O157:H7, although the latter may more frequently cause haemorrhagic colitis [HC], STEC infections are seen most frequently in infants, children and elderly patients. No gender differences have been observed.

Non-O157 associated intestinal disease includes watery diarrhoea, usually with painful cramps, and HC. Extraintestinal manifestations include HUS, or incomplete forms of the syndrome that consist of only one or two of the three features associated with it, namely thrombocytopenia, haemolytic anaemia and acute renal failure. About 75% of patients with HUS caused by non-O157 STEC require peritoneal or haemodialysis. Uncommon complications of STEC infections include urinary tract infection and, particularly in women after pregnancy and in elderly patients, thrombotic thrombocytopenic purpura.

... Overall, in studies of persons with diarrhoea, non-O157 STEC are isolated more frequently than O157, with a median of a 4-fold higher isolation rate, but with wide variation among studies. The only area where non-O157 STEC have been isolated less frequently than O157 in recent studies of diarrhoea is North America, where they are isolated about half as frequently as O157.

STEC have been isolated from a variety of animals, particularly ruminants. ... As with O157 STEC, the intestinal tracts of bovines and other ruminants, as well as foods originating from these animals, are likely the major sources for human infection with non-O157 STEC.

[*Zoonotic Non-O157 Shiga Toxin-Producing E. Coli (STEC)*. Report of a WHO Scientific Working Group Meeting; Berlin, Germany, 23-26 June 1998]

For reasons unknown serotype O157:H7 occurs more frequently in North

America than non-O157 types.

Escherichia coli O157:H7 is an emerging cause of foodborne illness, the leading cause of post-diarrhoeal haemolytic-uraemic syndrome, and the leading cause of acute renal failure in infancy and childhood. According to the Centers for Disease Control and Prevention [CDC], E. coli O157:H7 infects close to 20,000 people each year. Of those 20,000 infected, approximately 250 will die, mostly from HUS and other complications. A third of those who develop HUS will be left with varying degrees of permanent kidney damage, and another 8% will have other life-long complications such as hypertension. HUS following E. coli colitis has become the leading cause of paediatric renal failure requiring kidney transplantation in North America.

... Infection with E. coli O157:H7 may cause non-bloody diarrhoea or no symptoms, with the illness resolving in 5 to 10 days. However, clinically illness is commonly heralded by severe abdominal pain* and watery diarrhoea, followed within 24

hours by grossly bloody stools. This complex of symptoms constitutes the clinical picture, "haemorrhagic colitis." Unlike with other bacteria-associated diarrhoea, patients may be afebrile and inflammatory cells are seldom present in the stool. Robson et al. [1993] reported that fever is present in only 5% - 20% of cases. With the exception of the individuals who develop HUS, the illness is generally self-limiting. ... HUS tends to occur predominantly between the ages of 6 months and 4 years of age. HUS commonly develops 7 days after the onset of diarrhoea. ... Antibiotic therapy is contraindicated. Antibiotic therapy has been targeted as increasing the subsequent risk for HUS and has been associated with a higher case fatality rate in the more severe cases. A retrospective study showed that children treated with antibiotics had a higher risk of developing HUS compared with children who did not. This may be because antibiotic treatment causes the release of the Shiga toxin from injured bacteria in the intestine. Antibiotic therapy also kills normal bowel flora allowing E. Coli to flourish.

[E. Peacock et al. *Escherichia coli O157:H7: Etiology, Clinical Features, Complications, and Treatment*; Nephrology Nursing Journal, October 2001, Vol. 28, No. 5]

* Many victims say it's the worst pain they ever suffered, comparing it to a hot poker searing their insides.

*SYMPTOMS OF
E-COLI 0157:H7
Abdominal pain
watery diarrhoea
Bloody stool
No fever
Babes and children at
highest risk as Anti-
biotics contra-indicated.
Use may lead to HUS -
acute renal failure*

E. coli 0157 is found regularly in the faeces of healthy cattle [bovine reservoir] and is transmitted to humans through contaminated food, water, and direct contact with infected people or animals. Transmissions in outbreaks reported to the CDC in 1998-1999 have mainly been through drinking water [including well], fresh produce [fruits, vegetables, juice], seafood and meat [crab meat, scallops, roast beef, game sausage, and ground beef such as undercooked fast food hamburgers]. Transmission also can occur directly from person-to-person through the oral-faecal route in families, child care centres and custodial institutions.

Enterotoxigenic *E. coli* produces toxins which stimulate the lining of the intestines causing them to secrete excessive fluid, thus producing diarrhoea. Associated with gastro-enteritis and travellers disease, the list of symptoms mentioned for Enterotoxigenic *Escherichia coli* includes profuse watery diarrhoea, abdominal cramping, abdominal bloating, nausea, vomiting [rare], chills, loss of appetite, headache, muscle aches, and low-grade fever. Illness develops 1-3 days after exposure and usually lasts 3-4 days, but occasionally up to 3 weeks. ETEC is frequently resistant to common antibiotics. Since ETEC is a foodborne and waterborne pathogen, high-risk foods are raw fruits and vegetables [salads], raw seafood or undercooked meat or poultry, unpasteurised dairy products, food from street vendors, and untreated water [including ice] in areas lacking adequate chlorination. [Campylobacter and Salmonella infections, the two most common causes of bacterial foodborne illnesses, are characterised by fever in addition to abdominal cramps and diarrhoea, and bloody stools are possible but not common.]

Human volunteer studies performed with some of the enteropathogenic *E. coli*. resulted in the following symptoms [recorded by Riemann]:

Abdominal discomfort; cramps.

Nausea and/or vomiting.

Diarrhoea.

Fever; chills.

Pains in limbs and head.

Lack of appetite.

Rapid weight loss.

Approximately 5-10% of endogenous bacterial endophthalmitis in the U.S. is due to E. coli.

E coli rarely is found in the normal flora of the conjunctiva. It most commonly is seen as a source of infection in ophthalmia neonatorum. E coli endophthalmitis is a rare complication of E coli septicaemia. Also, endophthalmitis may occur in neonates following meningitis. However, almost all cases of E coli endophthalmitis have been in adults with an immunocompromised state or with diabetes, or in corneas with an underlying pathologic condition. Exogenous endophthalmitis usually is associated with trauma or intraocular surgery. In endogenous endophthalmitis, urinary track infection was the most common primary site of infection and nearly all patients are diabetic.

Visual complaints include decreased vision, upper eyelid oedema, diplopia red eye, mild to severe ocular pain, photophobia, and mucopurulent discharge from the eye.

[D.W. Suh, MD, *Escherichia coli*; at: www.emedicine.com/oph/topic496.htm]

MATERIA MEDICA COLIBACILLINUM

Coli.

Sources

- [1] David Riley; *proving* 12c, 3 times daily until symptoms developed or for three days; 17 provers [12 females, 5 males], 2 of whom received placebo; duration; 8 weeks; 1995.
- [2] Michael Neagu; short dream proving with 4 provers and clinical observations; in: *Colibacillinum*, Homdopathische Einblicke, 15/93.
- [3] Julian; pathogenesis based on the clinical works and clinical experiences of various French authors.

SYMPTOMS

Mind

= Irresolution: *empty feeling in the head, great timidity, irresolution*. Always hesitating, cannot decide on anything.³

= *Loss of memory*. Forgets recent occurrences; great difficulties in expressing oneself [to find the right words]. Constant mental *confusion* due to memory loss. Forgets proper names. *Mistakes in speaking*; uses wrong words.³

The patient complains of loss of memory. Sometimes it is due to an old urinary or intestinal trouble. Everything has started since that time.³

~ “Schizophrenic states”; loss of contact with surroundings and with own reality.³

In ordinary psychosis, when accompanied by chronic urogenital complaints it is certainly useful.³

=• *Dulness*. Confusion, < mornings. Lack of self confidence.¹

= Fear, particularly in narrow places.¹

Synthesis 9.1 has in addition:

Anxiety driving from place to place.

Censorious.

Complaining of others.

Confusion of mind, of surroundings.

Delusions: he was threatened with an accident.

Delusions: he is poor.

Fear of undertaking anything.

Forsaken feeling; feeling of isolation.

Giggling-

Irritability, to her family.

Laughing; evening; at trifles; uncontrollable.

Loquacity.

Thoughts persistent, haunted by unpleasant subjects.

Objects seem nearer.

Energy - sleep

= General fatigue and depression getting worse with aggravation of digestive and urinary complaints.³

= Permanently worn-out condition.³

= Asthenia with physical and mental weakness.³

= Hypotension, tendency to weakness, even collapse.³

= Great weakness during fever.³

= Catatonic condition with somnolence and nightmares.³

=> Great somnolence; hypersomnia.³

Temperature

= Chilliness; esp. in the night or after dinner.³

« Sensation of intense coldness with chill immediately after meals.³

Alimentary canal

- « Tongue flabby, coated yellowish-white; red, clear stripe down centre from root to tip.³
- « White tongue.³
- « Bloating after dinner.³
- « Flatulence; intestinal cramps.³
- « Heavy and drawing sensation in the intestines.³
- = Rumbling in caecal region.³
- « Liver *enlarged* and *sensitive*. Gallbladder painful.³
- « Discharge of putrid gas.³
- « Constipation.³
- Digestive troubles < milk.³
- » Nausea < afternoon and evening; < after eating.¹
- « Nausea & heart palpitations.¹
- « Burning stomach pain > lying down.¹
- « Spots of blood in the stools.¹
- « Orange colour to the stools.¹
- « Stools in hard pieces.¹

Digestion - Food & Drink

- « Very slow digestion, with long-lasting heavy sensation in the stomach after eating.³
- <= Capricious appetite or anorexia.³
- « Appetite diminished.¹
- « Milk < digestive troubles.³
- « Dairy products <. [Synthesis]
- « Cheese [aversion]; coffee [aversion or desire]; eggs [<]; fish [desire]; fruit [desire]; meat [aversion]; sweets [desire]. [Synthesis]

Urinary

- « Urine cloudy, offensive.³
- « *Frequent micturition; small amount each time-*, painful, burning sensation at close of urination.³
- « Heat and burning after urination.³
- « *Urging returns immediately after urination?*
Renal region painful.³
- « Pain along the urethra; pain in lumbar region [right side], < pressure.³
- « Urinary complaints < damp cold.³

-
- » Bloody urine.³
 - = Urine smells mouldy.¹

Genital

- =» Erection and ejaculation sometimes painful, with burning sensation in urethra after coition.³
- > Heavy sensation in hypogastrium with pain in both ovaries.³
- = Painful menstruation.³
- = Yellow leucorrhoea, slightly irritating.³
- » Coition difficult due to burning sensation in vulva and vagina.³
- = Bloody vaginal discharge that initially appeared to be the onset of menses but was not.¹
- = Increased sexual desire [in females].¹
- = Frequent menstruation.¹

Locals

- » Headache - frontal and suborbital - < damp cold, < after contradiction and strong emotions.³
- = *One-sided swelling of the upper eyelids*, sometimes left, sometimes right.
[Keynote symptom according to Vannier and Bernoville.]
- <• Polyarticular pains; swelling of small joints of hands and feet.³
- <•» Vertigo & nausea; vertigo > closing eyes.¹
- = *Eyes*: Discharge of mucus from the eye. Itching. Lachrymation.
Photophobia. Changes in colour vision [yellow colour before the eyes].¹
- = *Ears*: Aching pain in left ear. Stopped and clogged sensation in the ear, > blowing nose. Impaired hearing with confusion of sounds.¹
- «■ *Nose*: Burning pain in nose, < inhalation. Boils in the nose. Discharge of green mucus. Bloody mucus.¹
- » *Face*: Pimples on nose, chin, and lower jaw. Dryness of the face.¹
- = *Mouth*: Dry sensation in mouth. Bitter, chalky taste in mouth. Metallic taste.¹
- ~ *Teeth*: Teeth very sensitive to cold.¹
- = *Throat*-. Scraping pain in throat, < talking. Mucus in throat. Swelling of cervical glands.¹
- = *Heart*: Palpitations & nausea. Palpitations in morning on waking.¹
- « *Limbs*: Itching of the lower limbs, particularly the right foot. Swelling of the foot.
Pain and soreness of the right hip.¹
- ~ Dreams adventurous; coloured; vivid. [Synthesis]

Modalities

= Damp cold c.³

« Sea-side c.³

= After rest c.³

= Warmth >.³

= Antibiotics < [= allergic reactions]. [Synthesis]

Clinical indications

Julian refers to good results in salpingitis, cystitis, renal calculi, cholangitis and in depressive psychoses. May also be used intercurrently in chronic pelvic inflammation. According to Reckeweg, it is especially indicated after antibiotics and in damage caused by antibiotics.

“I used potentised B. coli clinically on various types of cases but its effectiveness can be summarised in the following three conditions:

[1] The best utility of the medicine in the 30th and 200th potency was obtained in cases of low puerperal sepsis where after delivery offensive lochia with or without blood continuing for a long period with slow rise of temperature. Pyrogenium in low and high dilutions have failed to produce desired effect in these cases. Pyrogenium works well in cases where the temperature comes with chill and rises high and then subsides with perspiration. The cases covered with B. coli have not got such acute phase in them. They are slow lingering persistent febrile condition. In these cases I have never met with failure with B. coli 30th or 200th.

[2] In cases of chronic diarrhoea after delivery where fever is present and important remedies fail.

[3] Its isopathic use in coli infections or in cases of typhoid with loose stools and tympanites and pain in the abdomen. In these cases sometimes temperature tends to be very obtuse and does not come down properly.”

[Ghosh, *Rare Nosodes*-, RefWorks]

Observations

“My father, who was the chief physician of the Urological Uni-hospital in Bukarest and who had much confidence in homeopathy, referred in the period 1983-1988 over 20 patients to me who suffered from colibacillosis and were resistant to all antibiotics and other antimicrobial drugs. Very often it concerned an acute or subacute colibacillosis accompanied by pus in the urine and fever. All these cases were treated successfully with Colibacillum

6c one dose daily for 2-3 days, then 1 -3 times every second day Colibacillum 9c and finally one dose of 15c or 30c. Most cases were promptly cured and what was very important, there were no relapses. These patients normally had 6 to 8 attacks of colibacillosis from beginning October to April, i.e. during the cold season. ... To my surprise the patients had no fear that the disease would return, as they had when treated with antibiotics. After three or four attacks of colibacillosis they knew exactly when a new attack was imminent. But now they all had the feeling that the cure was permanent. In regard to the frequency of symptoms I want to emphasize that urinary [bladder] complaints were in each case the reason for prescribing Colibacillinum - the gastrointestinal symptoms invariably accompanied them. The red stripe down the centre of the tongue I have observed in about 50% of the cases, just as the swelling of one of the eyelids. A few patients who didn't have this symptom at the time of the treatment said that they had had it with other attacks or at the onset of the last one. All patients suffered from headache and exhaustion. The exhaustion resulted in a complete lack of self-confidence rather than in irresolution and timidity, both of which were not clearly present."

And: "Colibacillinum markedly affects the mental-emotional level. I have seen an unexpected cure of bulimia with the remedy, whilst two other [Colibacillinum-] patients had a history of bulimia cured with psychotherapy." [Michael Neagu, *Colibacillinum*]

MATERIA MEDICA SERUM ANTI-COLIBACCILUM Ser-a-c.

Sources

No provings.

Clinical pathogenesis of E. coli antiserum of caprine [goat] or equine [horse] origin. [Julian]

SYMPTOMS

Mind

- = Loss of will power. Doubt [insecurity; lack of self-confidence] leads to extreme conscientiousness or exactness, and this leads to phobias.
- = Phobia of crowds, of spaces.
- « Nocturnal anxiety.
- = Prostration; passivity; confusion with difficult ideation and dulness.

Alimentary canal

- Pasty tongue; bad breath, esp. in the morning.
- » Dry, pasty mouth, desire for cold drinks, which >.
- = Intestinal gurgling & spasmodic pain in large intestine.
- « Gallbladder swollen and painful, sometimes & subfebrile temperature and chills.
- = Atonic constipation.

Urogenital

- = Frequent micturition, great urgency.
- ~ Burning in the urethra.
- » Urine turbid, alkaline.
- => Slow, difficult erection; libido markedly diminished; pain in urethra after ejaculation.
- = Yellow, corrosive leucorrhoea; libido markedly diminished.

Cardiovascular

- = Hypotension and tendency to collapse.
- => Moderate blueness of ankles, which are swollen during the day.

Locals

- = Eyeballs painful; sensation of coldness in eyeballs.
- » Pain at root of nose. Sinusitis ethmoidales. Purulent nasal discharge when bending head forward; < damp cold.
- = Throat pain when breathing deeply, & spasmodic cough.

ESCHERICHIA COLI MUTABILE

| | |
|------------------------|--------------------------------|
| Scientific name | Escherichia coli mutabile |
| Family | Enterobacteriaceae |
| Homeopathy | Mutabile [bowel nosode] - Mut. |

Mutations

Mutants of the rod-shaped *E. coli* can make spherical cocci or long filaments. In the 1930s it was observed that *E. coli* mutates very fast, for which reason it was named *E. coli mutabile*. This element of mutation has been described by Nobel Prize winner Jacques Monod, who at some time in 1940 sought to discover the appearance and selection of ‘spontaneous’ mutants:

Using a strain of *Escherichia coli mutabile* [to which we had given the initials ML because it had been isolated from Andre Lwoff’s intestinal tract], we showed that an apparently spontaneous mutation was allowing these originally ‘lactose-negative’ bacteria to become ‘lactose-positive.’ However, we proved that the original strain [Lac-] and the mutant strain [Lac+] did not differ from each other by the presence of a specific enzyme system, but rather by the ability to produce this system in the presence of lactose. In other words, the mutation affected a truly genetic property that became evident only in the presence of lactose.

There was nothing new about this; geneticists had known for a long time that certain genotypes are not always expressed. However, this mutation involved the selective control of an enzyme by a gene, and the conditions necessary for its expression seemed directly linked to the chemical activity of the system.

[J. Monod, *From enzymatic adaptation to allosteric transitions*-, Nobel Lecture, Dec. 11, 1965]

Unravelling the question of bacterial adaptation to their environment, Monod’s work demonstrated that many genes were only expressed after an appropriate environmental trigger started their synthesis. In this sense the mutability of *E. coli* must just as well be interpreted as adaptability.

Monod’s discoveries triggered worldwide interest. *E. coli*, the “best known living organism,” is at present widely employed as a genetically modified organism to produce foreign substances [even human ones, such as the Human growth Hormone] or metabolites. Thousands of laboratories work on *E. coli* and the major rules of gene expression have been discovered by

scientists working with this bacillus. Genetic screening and engineering are making great headway and it won't be long until gene replacement therapy is introduced into medicine.

MATERIA MEDICA MUTABILE

Mut.

Sources

This bacillus is so named because it mutates almost as soon as it is sub-cultured from a non-lactose to a lactose fermenter and is of interest mainly from a bacteriological point of view as the *Bacillus Mutabile* as an intermediary form between the *B. Coli* and the true non-lactose fermenting type.

Symptoms

Its associated remedy is *Pulsatilla* and the nosode *Mutabile* [Bach] is likely to be of value in treatment where there is alteration of symptoms, eg, where skin eruption alternates with asthmatic symptoms.

It fits "patient with ever-changing symptoms; pains which move about; somewhat of the *Pulsatilla* mentality; flushing or congested puffiness and blueness." [Wyne]

Associated remedies

Ferrum phosphoricum. *Kali sulphuricum*. *Pulsatilla*.

CASES

(1) G.G., aged 20, printer, told me in August, 1925, that he had had a constant short cough and yellowish-white spit since being gassed in France. Cough did not interfere with sleep; it was worse in a warm room or if he himself became heated. He had no night sweats. On examination I found dulness at both apices and the outer third of the first interspace on the right side, but no other physical signs. Other symptoms were nasopharyngeal discharge all his life; offensive foot sweat; and during Army service he had had scabies and boils. I gave Puls 10M [1] on August 14, which effected some improvement up to December, when he caught a chill and was in bed for ten days. After it I repeated the Puls. 10M [1], which kept him going for another three months. Two doses of Puls. 5 IM at six months' interval took him through 1926 with one cold in September. In 1927 his symptoms were still *Pulsatilla* so I started double doses, working gradually up from the 30th

and 200th in July to the IM and 10M in July, 1928, during which period his colds became much less frequent and less severe. In October, 1928, however, the cough returned and it seemed to me that a change of remedy was indicated. I gave Mutabile 12[1], He had colds in November, January and April but was not off work. On April 13, 1929, as he was not so well in himself, I gave Mutabile 13[1], and did not see him again till about a fortnight ago when he required treatment for sore throat. He reported that the cough and spit had ceased and that he was feeling perfectly fit.

[C. Gordon, *Auto-intoxication from the bowel and psora-*, RefWorks]

(2) Mr. J.L., aged 56. This man was tall and thin and stooped much from asthma and chronic bronchitis. The asthma began 21 years ago, and was very severe. About six years ago the nose was operated on with some relief. For many years he had suffered from frequent attacks of bronchitis; had been getting gradually worse; he was suffering from an attack of bronchitis when seen. Symptoms ran out to Sanguinaria, which was given with great relief, but the Sang, did not seem to be striking rock bottom, and he still had a good deal of tightness and asthma. His bowels had been constipated for many years, and his stool revealed a Mutabile. On July 13, 1926, his vaccine was administered in the 12c, a daily dose plus for three days.

The report on July 27 was that he had no asthma; the cough was very much less but the bowels were not quite right. Another three doses of the 12c were given eight-hourly. On September 8 it was quite obvious that a deep vital reaction had set in; his chest was clear, he felt very much better in himself but the bowels latterly had become irregular again, and he said that he had not felt the same response from the last doses of the 12c. He got the vaccine 30, daily doses for three days. On October 6 he was all over better and more vital, all functions were good, and the chest was clear, with very little cough and very little phlegm.

Since then up to date he has had infrequent doses of the vaccine 30 in the plus - that is to say, no dose has ever been repeated twice, but has been plussed slightly by succession and dilution. He has put on a considerable amount of weight and is very much stronger in every way, all functions are good, and his chest is quite clear. He has straightened up, his face has lost its gauntness and its muddy grey pallor and as he says himself, he feels like a young 'un! The remarkable thing about this case is that his son, a young man of 20, suffered from attacks of asthma. When he was a year old his face and head were covered with eczema; this went and asthma held the field from

seven years of age till eleven. The eczema came back when he was eleven, and has alternated with asthma ever since. Calves of both legs, the right thigh, and both arms were broken out with a chronic eczema with a good deal of thickening of the skin. He suffered from headaches; his stomach was poor, and he was inclined to be weakly and to take fainting turns. He had no very diagnostic symptoms, but he was given his fathers vaccine, 12c plus, daily doses for seven days. Immediately after the vaccine he had slight asthma, the skin got very itchy and hot and erupted more for fully a week. The asthma went away and the skin died down again; he had only one head ache and was very much better in himself. No further doses were given, as with this increase of vitality peculiar symptoms came out that were diagnostic of Lyc. Since then up to date he had had infrequent doses of Lyc. 30. and latterly one dose of the 200 on April 14, 1927. I may say that his improvement was so very marked that by January he had straightened up, his chest had expanded, he had put on weight, his skin gave him very little trouble and he was able to play rugby. His improvement has been continuous and emphatic and is still going on.

(3) A.R., a girl of 13 years of age, had a history of eczema since three years old and alternating since with asthma. Asthma attacks came with frequency: her case ran out to Sulph. and she got Sulph. in infrequent single doses, starting with the 200, going up to the IM. Though it did great good it did not clear. Definite symptoms came out of Kali-carb, and that gave her great relief, but there was not the vital response that one wished. On September 16, 1926. I gave her three doses of the vaccine Mutabile 12c.

After this she was very much better - no asthma and the skin became much better, though at first there was short aggravation. On December 23 she got another three doses of the Mutabile, and since then she has had no medicine as there has been no need. She is perfectly well. I do not wish to suggest that Mutabile is a nosode for asthma, but her symptoms were so similar on all points both in her generals and particulars, to Mr. L's. son, that I felt that it would produce a good vital response.

[T.M. Dishington, *The Autogenous Vaccines and their Relations to Chronic Disease*-, RefWorks]

KLEBSIELLA PNEUMONIAE

Scientific name *Klebsiella pneumoniae* subsp. *pneumoniae* (Schroeter 1886)

Trevisan 1887

Old names *Pneumococcus* Friedlander

Bacterium pneumoniae

Bacillus capsulatus mucosus

Family Enterobacteriaceae

Homeopathy *Bacillus* Friedlander [*Mucotoxinum*] - *Mucot.*

FEATURES

- Large, non-motile rod-shaped bacterium producing large sticky colonies.
- Surrounded by a distinct transparent capsule, hence its old name ‘capsule bacillus’.
- Produces a heat-stable enterotoxin which contributes to its toxicity.
- Common in hospitals.
- Typically infects the urinary tract [esp. in catheterised patients] or the respiratory tract.
- Second only to *Escherichia coli* as a urinary tract pathogen.
- Causes pneumonia characterised by emission of sticky, dark brown or dark red sputum; pneumonia possibly followed by formation of abscesses in the lung or in the lining of the lung [empyema].
- Predisposing factors for pneumonia: alcoholism; diabetes; old age.

FRIEDLANDER

Friedlander linked in 1883 lobar pneumonia with pneumococcus. He recovered the organism from the pulmonary exudate from a case of croupous pneumonia and named it ‘pneumococcus’ in the belief that it was the cause of pneumonia in general. What Friedlander in reality found was the enteric *Klebsiella*, an organism that due to its variable form has been described as a coccus, a bacterium, and a bacillus.

The name Friedlander’s pneumonia is presently used to describe a necrotic upper lobe pneumonia with currant jelly-like sputum, a fulminant course and high mortality, caused by Gram-negative enterobacteria, with *Klebsiella pneumoniae*, or *Bacillus* Friedlander, as the most common agents.

Despite its reputation as a respiratory pathogen causing severe community-

acquired pneumonia, *K. pneumoniae* is most commonly found in nosocomial extrapulmonary infections, including septicaemia.

MATERIA MEDICA MUCOTOXINUM

Mucot.

Sources

I have placed Mucotoxinum under *Klebsiella* despite some doubts about the origins of the nosode. Boericke writes that it is “Cahis’ preparation from *Micrococcus catarrhalis*, Friedlander *Bacillus of Pneumonia*, and *Micrococcus tetragenus*,” indicating that it is a mixture of three different species, whose current names are *Neisseria* [*Moraxella*] *catarrhalis*, *Klebsiella pneumoniae*, and *Peptostreptococcus tetradius*, respectively.

Wichmann & Bolte think it is *Micrococcus* [= *Moraxella*] *catarrhalis*; Schroyens [*Synthesis 9.1*] and Reckeweg take it to be *Klebsiella pneumonia* [*Bacillus Friedlander*].

There are neither provings nor clinical cases.

SYMPTOMS

Mucosa

« Sinusitis.

Gastrointestinal

= Indigestion after sour food.

= Pancreatitis.

Respiratory

» Bronchiectasis.

= Chronic bronchitis.

= Pleuritis.

“ Stone-cutters’ lung [*silicosis*].

As indications Boericke mentions “acute and chronic mucous catarrhs in children and old people,” and Reckeweg: “*Silicosis. Pneumoconiosis. Bronchiectasis. Bronchial asthma. Iatrogenic damage from treatment for influenza. Also in acute influenza, pleurisy and pneumonia, especially in obese patients.*”

MORGANELLA MORGANII

| | |
|------------------------|---|
| Scientific name | <i>Morganella morganii</i> subsp. <i>morganii</i> (Winslow et al. 1919) Fulton 1943 |
| Old names | <i>Proteus morganii</i> [homotypic synonym] <i>Bacillus morganii</i> |
| Family | Enterobacteriaceae |
| Homeopathy | Morgan pure - Morg. and Morg-p. |

FEATURES

- The monotypic genus *Morganella* belongs to the tribe Proteae of the family Enterobacteriaceae, along with the genera *Proteus* and *Providencia*.
- Formerly classified under the genus *Proteus* as *Proteus morganii*, named for the British physician Harry de Reimer Morgan [1863-1931], who discovered the organism in 1906 in the diarrhoeal stool of infants.
- Resembles *Proteus*, except that *Morganella* does not produce hydrogen sulfide or liquefy gelatin.
- Commonly found in the environment and in the intestinal tract of humans, mammals, and reptiles as normal flora.
- Usually isolated from the urine; identified as a cause of urinary tract infections.
- Frequently colonizes burn wounds as an airborne micro-organism.
- May cause infections similar to *Proteus*, but is an uncommon cause of community-acquired infection and is most often encountered in postoperative and other nosocomial settings, in particular postoperative wound infection in patients who have been treated with beta-lactam antibiotics.
- Has a natural resistance to many beta-lactam antibiotics.

FISH POISONING

Consumption of dark-meated scombroid [relating to the mackerel family] fishes, including tuna, mackerel, albacore, sardine, mahi-mahi and swordfish, may cause a severe allergic reaction known as scombrototoxicism or scombroid poisoning. Many reported cases of “fish sensitivity” are more correctly instances of scombroid poisoning following the ingestion of spoiled mackerel-like fishes. Scombroid poisoning is generally caused by the improper preservation of such fish, which results in the proliferation of

certain bacteria acting on histidine in the muscle of the fish, converting it to a histamine-like substance called saurine. It is presently believed that scombromo-toxin is a complex of substances containing saurine, histamine, and possibly other unidentified toxic products.

Morganella morganii is the most prevalent and prolific saurine/histamine former, followed by *Proteus vulgaris* and *Klebsiella pneumoniae*. Histamine formation by *M. morganii* is controlled only by frozen storage of the fish, but accumulates rapidly in the previously frozen fish stored at 25.8° C or exposed to the sun, resulting in histamine formation above the FDA guideline for histamine of 5 mg/100g in fish and fishery products. Bacterial counts rapidly increase when mackerel is exposed to 25° C, with histamine reaching levels of over 200 mg/100g in 2 days of storage.

Saurine/histamine is not detectable by the usual smell of decomposition, although the flesh reportedly has a “peppery” or sharp taste. Within a few minutes to several hours after ingestion, symptoms develop that clinically resemble a severe histamine reaction. The symptoms consist of mouth dryness, flushing of the face, swelling of the lips, burning of the throat with difficulty in swallowing, intense headache, dizziness, throbbing of the carotid and temporal vessels, epigastric pain, nausea, vomiting, abdominal pain, diarrhoea, heart palpitation, thirst, and intensely itching red massive welts or generalized urticaria. In severe cases, there may be muscular weakness.

MATERIA MEDICA MORGAN [PURE]

Morg.

Sources

In an article entitled *Indications for the use of the intestinal nosodes in diseases of children*, Paterson writes that “Morgan co. [Paterson] is the nosode prepared from cultures of *B. morgan* [pure],” suggesting the pure culture of *Morganella morganii*. In the article *The Bowel Nosodes* [BHJ, July 1950] he writes that “it was found possible to isolate two subtypes of *Bacillus Morgan*,” i.e. Morgan pure [Paterson] and Morgan-Gaertner [Paterson], From this it can be concluded that Morgan co. and Morgan pure are identical and should not have the separate entries in the repertory they have now, respectively as *Morg.* [bacillus Morgan (Bach)] and *Morg-p.* [bacillus Morgan pure (Paterson)].

According to Paterson, Morgan pure is indicated “where there is a marked symptom of skin eruption or disturbance of the liver; bilious headache, or

actual presence of gallstones.” Morgan-Gaertner is “also indicated in skin and liver conditions, but it is likely to be more useful where there is evidence of acute inflammatory attack, such as that found in cholecystitis.”

From a bacteriological point of view, Morgan-Gaertner cannot be considered a subtype of *Bacillus Morgan*, although the Gaertner-component does belong to the large group of Gram-negative enteric microbes that inhabit intestines. The organism was first cultivated in 1888 by the German bacteriologist A. Gaertner from the flesh of an emergency-slaughtered cow and from the spleen of a man poisoned by eating meat obtained from it. Gaertner named it *Bacillus enteritidis* [Gaertner]; the organism has later been reclassified as *Salmonella enteritidis*. Hence this nosode appears to be a mixed bag of enterics.

Puzzling is Paterson’s remark that “Morgan Co. [pure] is a much more complex Sulphur compound with a greater width of action.” He probably wanted to indicate that the nosode shares many characteristics with the group prototype remedy, *Sulphur*, since the bacillus itself, *Morganella morganii*, does not produce hydrogen sulfide, in contrast to the closely related *Proteus* spp., and thus cannot be regarded a “Sulphur compound”.

No provings in the usual sense have been made with the nosode.

The synopsis below is extracted from Paterson’s description of *Morgan* [Bach] in *The Bowel Nosodes*. It can be regarded as a review of the central issues of the nosode. The rest of the symptoms come from the 156 cases [116 females, 40 males] collected and described by Elizabeth Paterson in *A Survey of the Nosodes*, British Hom. Journal, July 1960.

SYNOPSIS

Congestion

John Paterson suggested that the keynote for the *Morgan* group is “contained in the word ‘*Congestion* and if this is used in the study of the various parts of the body affected it will afford a good symptom picture of the pathogenesis of the *B. Morgan*.” As proof he provides the following examples of congestion:

Congestive headaches, & flushed face.

- < Hot atmosphere; thundery weather; excitement; travelling in bus or train.
- < Before/at onset of menses; & ovarian pain [congestive dysmenorrhoea].
- & Congestive flushings of the menopausal period.

There are two important things with migraine symptoms. The first one is

periodicity, usually weekly, but not always at the same time - not always a weekend migraine as it might be in *Iris versicolor* or *Nux vomica*, but usually once a week, related to some other rhythm which we have not discovered.

Usually has a concomitant of acid eructation, water brash or some other stomach disorder, i.e. headaches with stomach problems. The headaches are worse for any form of travelling and in the extreme case, they can be worse from moving from one side to the other, though mostly from place to place. If you have a headache in your office, you are actually worse for going home; if you stay at the office until it has gone, however, then you will be okay It's not just motion; it is going from one point to another, i.e. travel over a period of time. ... These headaches are also worse for any excitement or change, or for raised barometric pressure.

[Anthony Bickley, *The Bowel Nosodes*, The American Homeopath, Vol. 9 - 2003]

High blood pressure resulting in vertigo.

Congestion of gastric mucosa; heartburn, pyrosis, dirty tongue, bitter taste in mouth in the morning with accumulation of mucus causing gagging as soon as rises from bed.

Congestion of liver; "bilious attacks" with severe headache which is finally relieved by vomiting large quantities of bile-stained mucus.

A history of "bilious attacks," especially occurring at the menopause in women should lead one to consider the use of this nosode.

Congestion of nasal and bronchial membrane, especially in children, broncho- and lobar pneumonia.

A history of repeated attacks of "congestion of the lungs" or bronchopneumonia, in children, is indicative for the use of the nosode *Morgan* [Bach] or one of the subtypes *Morgan pure* [Paterson] or *Morgan-Gaertner* [Paterson].

Congestion and sluggish [circulatory] action is seen by the tendency to haemorrhoids and varicose veins and the condition known as "erythro-

MORGAN PURE

KEYNOTES

Congestion

Introspection

Head

<menses

< menopause

Ovaries

Liver [gallstones, easy bruising]

Circulation [hbp]

Lungs [mucus]

Skin [eczema < heat, teething; thickened, cracks]

Constipation

cyanosis puellorum”, a blueness of the lower extremities, often in female adolescents and marked by chilblains of feet and toes.

Chronic congestion around the joints causes arthritic conditions, usually affecting the phalangeal or knee joint regions.

It is in the *skin* that the “outstanding action of the *Bacillus Morgan* group of organisms is to be found. *Morgan* [Bach] is the nosode indicated where there is congestion of the skin with itching eruption, worse from heat. ... There are few eczemas of the infant at the teething stage or later life, which do not require a dose of this nosode *Morgan* [Bach].”

SYMPTOMS

Mind

« Introspective, anxious and apprehensive about state of health. [JP] = Avoids company but often shows mental anxiety if left alone. [JP] « Mental depression, often with suicidal tendency. [JP]

= *Tense; active; irritable.*

** *Weepy; depressed.*

= Fears crowds; unknown; ill-health.

They have puffy, florid faces like someone who has been on steroids, and also seem congested in their figures, with a tendency to obesity. In terms of mental symptoms you find depression with introspection and gloom. These individuals are not very stable people; it's quite easy to push them into this gloom. They have difficulty communicating in words, though they let you know that things are not right. ... This is someone who lets you know that things are going badly, and that you need to suffer as much as they do. They are anxious and want you to know about it - anxiety mostly about their health, about dread diseases.

I had an insurance broker as a patient to whom I gave *Morgan* because he had a new type of policy, a dread disease policy. Once his company had introduced this policy and he had to go out and sell it, he could not stop thinking about dread diseases, and this made him ill. That is a typical example of a *Morgan* state: once you think of disease, you can't stop. Individuals who need *Morgan* have fear of crowds [congestion again!] and are tense when in company, but

anxious if left alone.

They are claustrophobic and may get suicidal if left to their own worries too long.

[Bickley]

Modalities

- < Storms and stormy atmospheres.

~ < At night [sleeping into aggravations] and first thing in the morning.

=> Insomnia at the least light; they have to have everything dark around them, sometimes even to the extent of wearing blindfolds to bed. [Bickley]

Sensory

=> Spots before eyes.

« *Catarrhal deafness.*

~ Sense of smell lost.

«• Taste deficient or lost.

= Sense of touch lost; limbs cold in patches.

Alimentary canal

= Burning tongue; *tongue raw and dry, burning*, coated; slimy; swollen.

- Tongue / lips stiff in morning [from dryness].

= Bad taste in mouth; halitosis; salivation.

~ *Throat dry and burning.*

= Apple core sensation in throat; easy choking.

=> *Heartburn*; sour, acid; bitter, mouthfuls.

<• *Burning in throat and stomach.*

=> Pain and acid > with food.

= Duodenal and peptic ulcer.

=> *Constipation* [95% of cases],

~ Bowel motion without help; loose; urgent in the morning; immediately after food.

=> Stool may be pasty, foul and contain blood and mucus.

Hepatic

=> *Bilious attacks.*

<= Epigastrium: pain, discomfort, or tenderness.

= *Pain/tenderness liver and gallbladder.*

~ *Gall stones*-, confirmed by X-ray or operation.

= *Attacks of jaundice.*

Food

Fond of fats; sweets; eggs and butter, more than averse.

- = Fats and eggs upset; or avoids fats and eggs.
- = Nausea after eating eggs; after fat.
- = Vomiting after eating eggs.

Skin and mucosa

«• Hair falling out; alopecia totalis.

= Scalp sensitive.

« Hirsutism [hairy face].

— *Granular lids.*

= Tarsal cysts; stytes.

= Boils meatus.

= *Catarrh and post-nasal catarrh* [30% of cases].

<= *Cracks angle nose.*

Cracks angle mouth; lips very red.

= Redness and moisture at umbilicus; bad odour.

= *Pruritus ani.*

= Thick skin soles of feet with *cracks heels.*

Herpes zoster [both axillary regions; right hypochondrium; chest pain since shingles].

~ Eruptions:

pustular, weeping [face; scalp; neck];

scaling and very itchy [brow];

hot, red, dry and fissured [face];

eczema [chin and forehead];

cracks and eruption behind ears - weepy, itchy, scaly and fissured;

eczema [ear passages];

erysipelas [face];

acne [face and scalp];

acne rosacea;

intertrigo [breasts];

acne [shoulders and back];

boils and carbuncles [neck];

dry, cracked, fissured, itching [flexures arms];

prickly heat [dorsum arms and elbows];

dry, cracked, fissured, weepy, itchy and burning [backs and palms of hands and between fingers!];

cracks [knuckles, fingers and thumbs];
flat warts [hands];
vesicular, *scaling, weepy, red, raw, itching* [eruption *scrotum*]-, *itchy, red, raw*
and *burning* [eruption *perineum and groins*];
circinate eruption [both legs inner side];
erythema nodosum [legs];
athlete's foot;
eruptions generally < heat, washing, and at night-, cannot wear wool next
skin;
skin sensitive to sun - prickly heat.

Circulatory

~ *Varicose veins; varicose ulcer.*
<= High blood pressure.
= Sluggish circulation.
<= Easy bruising.
- Cerebral thrombosis.
= Hands too hot at night.
<= *Feet too hot at night-*, offensive foot sweat.

Joints - limbs

« History of rheumatic fever.
~ Pain [neck and back] generally < at night; heat; beginning to move; > moving.
= Arthritis spine; sacro-iliac joints.
~ *Pains shoulder*, rheumatism shoulders.
~ Numbness and tingling arms.
~ Hands puffy; stiff; grip poor.
=> Fingers stiff in morning.
=> *Rheumatoid arthritis wrists.*
Finger joints swollen and painful.
Metacarpophalangeal joints swollen and painful, esp. middle finger.
= *Nodules on fingers.*
<= Lack power legs; limbs stiff; limbs numb.
= Knee swollen and painful [grating]; peri-arthritis knee; *osteo-arthritis knee.*
~ *Pain soles of feet.*
<= Pain heels.
« Metatarsal-phalangeal joints painful, swollen.
= Pes planus [flatfoot].

Female

- = *Pruritus vulva, and vagina.*
- = *Menorrhagia* and *metrorrhagia* - polypi and fibroids of uterus.
- = *Leucorrhoea - corrosive*, offensive; brown; green; yellow.
- = Coition painful.
- = Boils vulva.

Urinary

- = Urine of strong smell and corrosive.
- = Urine contains sugar.

Inflammations

- = Conjunctivitis; iritis; keratitis.
- = Sinusitis [frontalis and maxillaris].
- « Periostitis [jaw],
- = Adenitis [neck].
- » Tonsillitis [recurrent]; cheesy pieces come out.
- Pharyngitis; laryngitis; tracheitis.
- «■ Cystitis; with frequency and pain.
- ® Bartholinitis [inflammation of a vulvovaginal gland].
- = Fibrositis [chest wall; neck; shoulders; dorsal; lumbar].
- = Bronchitis [each winter].
- = History of pneumonia or bronchopneumonia; never well since.
- = Neuritis arms; pain keeps awake at night.

Associated remedies

Alumina. Baryta carbonica. Calcarea carbonica. Calcarea sulphurica. Carbo vegetabilis. Carboneum sulphuratum. Digitalis. Ferrum. Graphites. Kali carbonicum. Magnesia carbonica. Medorrhinum. Natrum carbonicum. Petroleum. Psorinum. Sepia. *Sulphur*. Tuberculinum bovinum.

CASES

(1) A young man, Mr. C., aged 22, was seen on June 30, 1926. He had suffered all his life since he was five months old from a chronic eczema all over the body. At the time he was seen there were large patches on the body and back, and both arms and legs were affected. There was tremendous thickening and congestion of the skin with deep cracks, which gave a good

deal of pain. Heat caused great irritation and itch. He had no symptoms except considerable constipation with a lot of offensive flatus, and a hard stool. He had had a great deal of treatment, and every effort had been made by the skin specialist to heal the skin, but well for him, the efforts failed. I was in a quandary what to give him, but I gave him Sulphur, and it did not work. Immediately I decided to have his stools cultured and a Morgan was discovered. He got his own autovaccine on July 28, 1926, the 12c potency plus a daily dose for three days. The 12c carried him in infrequent doses of the plus to December 1. Improvement set in at once and was continuous; all functions became active. The skin gradually cleared up and by December 1 there were only a few small patches.

As the bowels were tending to be sluggish the 30th potency plus a daily dose for three days was given and was not repeated until February 3, 1927. During February the skin cleared, and in every way he had become a robust, active young man. On April 6 the vaccine was again repeated in the 30th potency plus daily doses for seven day, because of a slight irritation in the skin and a tendency to a less free evacuation of the bowels. At present he is perfectly well.

[T.M. Dishington, *The Autogenous Vaccines and their Relations to Chronic Disease-*, RefWorks]

(2) Miss R., aged 58, a case of rheumatoid arthritis. For the last eight years her knee-joints were very large, like bags of nuts, with considerable pain and stiffness; could not straighten them; pains were constant; seemed to be worse in cold east or north-east dry winds. All her joints were affected, and her hands were twisted and deformed, and she had great difficulty in moving about. Indigestion came just prior to the rheumatoid condition. Her bowels had always been constipated. She had no definite symptoms at the time she was seen, but when the rheumatism first appeared she had what she called a "nervous breakdown" with very definite mental symptoms calling for Sepia. I put her on Sepia 12c plus a daily dose for a week.

There was a marked reaction and she continued to do well generally on the Sepia in infrequent doses until December, when the pains became much worse. Re-examination of her symptoms and her history brought out that she had had prolonged suppuration at the root of the nails, and eighteen months ago there had been a callosity on her right foot which suppurated, and last year a toe of her left foot suppurated. I put her on Hepar, which helped her all over, producing a good vital response, and helped all the functions,

but it did not hold her, and as her rheumatic pains had become much worse by May 21 I gave her some Guaiacum 30 plus a daily dose for seven days. Though better in herself her rheumatic pains continued to be bad. I got her stools examined, and the Morgan type was found, but the vaccine was not given as Sepia came out prominently. She got Sepia 200 in single dose, but by July 30 it was obvious that though Sepia helped her mentally, her pains were so very much worse and she was so sleepless from the pains, that I determined to give her the auto-vaccine of Morgan in the 12c plus, a daily dose for three days.

On September 15 her report was that the bowels from the very beginning became much more active, and she felt very much brisker in herself. She felt that a load had been taken from her, had got relief from pain, and slept well at night. There had been some swelling of the joints with relief of pain. A week afterwards the pains returned, and she took one single dose of the vaccine in the plus with relief.

This carried her for ten days; pain again returned and she took another single dose with immediate relief. Her progress for the next six weeks was, to say the least of it, remarkable on every point. The good effect of Sepia was not antidoted but augmented by the auto-vaccine. At very infrequent intervals the vaccine 30 was given in plus dosage, not more than three at a time, and her improvement went on with an increase of freedom in the joints with no pain. Stiffness began to disappear; she was able to straighten both knees and to walk very well, and the feet that had given so very much trouble, though swollen, were very much easier.

On February 3, 1927, there was some return of the mental symptoms that had preceded the rheumatoid condition. As the bowels had become a little constipated I determined to give her Sepia again, in the 200th potency plus for seven days, and since then she has had no medicine, and has not needed it. Her vitality has been gradually increasing, and on all points there is a vast improvement; she is able to take quite decent walks; sleeps well at night; eats well, and all functions are good. Apart from the swelling in the knuckles, her fingers and hands are fairly mobile, and she is able to do quite a lot. In June she was bright and active with no symptoms except some stiffness. [T.M. Dishington]

Sources

No provings.

Symptoms collected from 69 cases [31 females, 38 males] and described by Elizabeth Paterson in *A Survey of the Nosodes*, Brit. Hom. Journal, July 1960.

SYMPTOMS**Mind**

= Irritable [< before menses]; quick tempered; impatient; easily offended; restless.
=> Tense; nervous; bites nails; nervous breakdown; particular; apprehensive. =
Fears crowds; excitement; company; narrow places; heights.

Someone who has a bilious temperament, i.e. tends to be critical, censorious, always picking holes in things and people, very acerbic in their responses. Irritability with a quick response into temper, impatience, jealousy, and apprehension. These patients have a fear of crowds, but they are claustrophobic for both lack of space and for a surfeit of people. They are worse for excitement and in company and have night terrors that make them scream out in their sleep. [Anthony Bickley, *The Bowel Nosodes*-, The American Homeopath, Vol. 9 - 2003]

Alimentary canal

= *Bitter* or bad taste in mouth.

= Tongue burning; pins and needles tongue; tongue gluey in morning.

= *Flatulent indigestion; eructation excessive.*

<= Eructation of bad odour.

« Sour mouthfuls [pyrosis]; acid burns throat.

« *Fulness epigastrium*, unrelated to food or sensation of fulness after eating ever so little.

= Pain in epigastrium after food.

- Vomiting after food - afternoon or night.

<= History of duodenal ulcer.

~ *Flatulence excessive* in bowel.

= *Distended* feeling.

« *Constipation* more common than looseness [ratio of 2 to 1].

& Haemorrhoids - painful, itchy, bleeding.

— Mucus per rectum, even if motion [stool] is not stiff.

~ Stool hard, dry with mucus.

Hepatic

— Pain/tenderness gallbladder.

— Pain to right or left scapula.

Food

« Craves *sweets*; salt; prefers food hot.

=> Fond of fat; eggs; meat.

— Averse fat; eggs; meat.

Skin and mucosa

= Alopecia areata.

= Styes; cysts on lids.

~ Boils in ear.

= *Nasal* and/or *post-nasal catarrh*.

Cracked corners of mouth.

— Psoriasis - elbows; knees and ankles, legs or body, toe nails.

« Eruption thighs; eruption wrist, metal dermatitis.

= Eruptions: herpetic on sole of foot; vesicles hands; papulo-pustular on face, brow, scalp; herpetic left side of face; urticaria arms - large wheals; warts hands - large, flat or jagged; warty condition of nipples.

Circulatory

=> Tightness chest, pain extending to left arm.

=>> Discomfort cardiac area.

= Myocardial enlargement.

= Palpitation at night, awakening patient; > eructation, flatus, moving about.

= Right foot warmer than left.

— Feet too hot at night.

Joints

~ Rheumatism neck; back.

= Rheumatism right shoulder; right deltoid muscle, elbow; right arm; right wrist.



-
- = Rheumatoid arthritis wrist.
 - “ Fibrous rheumatism wrist.
 - <= Pain fingers and thumb; thumb swollen.
 - « Arthritis knee-joints; knees stiff and painful.

Female

- » Dysmenorrhoea.
- ~ Warty condition of nipples.
- ® Pruritus vulvae.
- = Leucorrhoea - heavy; brown; bad odour; corrosive.

Urinary

- Frequency micturition.

=> Enuresis.

=> *Renal colic - renal stone.*

The subtype *Morgan Gaertner* has often been found in the stool of patients suffering from renal colic and where X-ray has demonstrated the presence of renal calculus. This nosode should therefore be considered as a possible remedy in cases of renal colic. It is also likely to be of value in treatment in any case which has a 4-8 p.m. modality, which is also a characteristic of the group prototype remedy - *Lycopodium*. [John Paterson]

Inflammations

- Blepharitis.

<• Otitis; mastoiditis.

«• Sinusitis [frontalis; maxillaris].

= Gingivitis; pyorrhoea.

=> Tonsillitis [recurrent].

<• Gastritis.

= Cholecystitis.

=> Cystitis.

<• Nephritis; pyelitis.

- Fibrositis [neck].

-Neuritis [arms].

Associated remedies

Chelidonium. Chenopodium. Helleborus. Hepar sulphuris. Lachesis.
Lycopodium. Mercurius sulphuricus. Sanguinaria. Taraxacum.

PROTEUS

| | |
|-------------------------|---|
| Scientific names | Proteus vulgaris Hauser 1885 Proteus mirabilis Hauser 1885 |
| Family | Enterobacteriaceae |
| Homeopathy | Bacillus Proteus - Prot. |

NOTE: Of the four Proteus species mentioned in homeopathic literature, two have been renamed and reclassified. Proteus morganii is now Morganella morganii and Proteus rettgeri is Providencia rettgeri.

FEATURES

- The genus Proteus belongs to the tribe Proteae of the family Enterobacteriaceae, along with the genera Morganella and Providencia.
- Gram-negative, aerobic to facultative anaerobic, glucose-fermenting bacteria.
- Hypermotile [dubbed “swarmers” or “wanderers”], to the extent that a single colony can grow to swarm over the entire surface of a Petri dish after overnight incubation. On agar media “entire groups of bacilli or single threads, by gradual extension and circular movement, detach themselves from the colony and wander about upon the plate.” [Kruse]
- Most commonly found in the human intestinal tract as part of normal human intestinal flora, along with Escherichia coli and Klebsiella species, of which E coli is the predominant resident. Produce infections after leaving normal habitat in intestinal tract.
- Also found in soil, water, sewage, manure, decaying meat and decaying matter. Survives well out of host, especially in areas where animal protein is decomposing [sewage, soil, water].
- Common cause of malodorous decomposition. Typically produce putrefaction odours. Also produce a very disagreeable odour in most culture media not containing sugar. So bad is the odour that the effluvium from a flourishing colony of Proteus vulgaris allegedly “would drive a dog into a tanyard.”
- A characteristic of Proteus spp. is the abundant production of urease, the enzyme that splits urea into carbon dioxide and ammonia. Proteus is “capable of developing severe cystitis with ammoniacal urine.” [Anshutz]
- Produces hydrogen sulfide.

-
- First found by Hauser in 1885 in decomposing animal infusions and have been secured in cultures from wound and puerperal infections, purulent peritonitis, endometritis, and pleurisy.
 - *Proteus mirabilis* causes 90% of *Proteus* infections, in particular urinary tract infections, and can be considered a community-acquired infection.
 - Pathogenicity includes bacteraemia, pneumonia and focal lesions in debilitated patients or those receiving intravenous infusions, neonatal meningoenophalitis, empyema, osteomyelitis, cystitis, pyelonephritis, prostatitis.
 - Important cause of nosocomial infections acquired after antimicrobial therapy.
 - Inactivated by moist heat [121° C for at least 15 min.] and dry heat [160 -170° C for at least 1 hour],

PROTEUS - the SHAPE-SHIFTER

Variable in size and shape and of erratic morphology, the bacterium is named from this peculiarity after the mythological sea-god Proteus who was capable of assuming any form that pleased him. The phrase *As many shapes as Proteus* refers to people who are full of shifts, aliases, disguises, etc., whose *protean nature* enables them to readily take on different aspects, ever-changing, versatile.

Hysteria is essentially of a protean nature. Hysterical persons involuntarily counterfeit the symptoms of physical illness as a means of attracting attention to themselves, of attaining sympathy, and of avoiding disagreeable situations. Persons with hysteria may become deaf, mute or blind instantly; they may believe themselves suffering from a certain disease and show all the signs of that condition; and they, after being bitten by an animal, may develop the symptoms of rabies without having the disease, exaggerating the symptoms and going into a frenzy, barking and snapping like a dog. Pills and elixirs, diet and physical hygiene are of no benefit. Interestingly, “emotional hysteria, suggestive of the remedy *Ignatia* is also found in the proving of *Bacillus Proteus*”, as Paterson has it.

There are more parallels to be found between the micro-organism, the seagod and the symptom picture of *Bacillus Proteus*. Proteus is the herdsman in charge of Neptune’s pod of seals, the so-called *Old Man of the Sea*, with a *stench* as rank as the animals he tends. Proteus’ element is the sea; the sea, formless, limitless, inexhaustible, and full of possibility; the sea, in which two chemical elements abound: chlorine and sodium. Paterson gives *Natrum*

muraticum [sodium chloride] “as the outstanding member of the list of remedies I associate with the *Proteus* nosode.” All other chlorides [muri- aticums] fall also in this category of associated remedies. Peculiarly, *Proteus* organisms are very susceptible to disinfectants with 1% sodium hypochlorite.

Proteus possesses the gift of prophecy, but refuses to enlighten those mortals who question him. There is no way of catching him but by stealing upon him and holding him fast at the time that he falls asleep after telling over his herds of seals at noon. The timing is critical because *Proteus* only assumes the human shape when he first falls asleep and he can only be questioned when he is constrained to stay in the same reality as the mortal questioning him.

When Menelaus, king of Sparta, becalmed on his way home from Troy, seeks the advice of *Proteus*, he follows the instructions of Eidothea, *Proteus*'s daughter, how to get the old man to tell him how “to make his way home over the fishy deeps.” To succeed, Melaneus and three of his men have to obey the law of similars: they must become like *Proteus* by disguising themselves in the repugnant sealskins provided by Eidothea and by masquerading as animals in his herd until the unsuspecting Old Man comes and sleeps amongst them. Then Melaneus had to grasp him, “keeping hold of him firmly with steadfast spirit” through the whole repertory of elusive, cunning metamorphoses displayed by the Old Man.

Eidothea's instructions are in Homer's *Odysey*:

As soon as you see him asleep, then is the moment for all your courage and strength: you must hold him there all the time he frenziedly struggles, trying to escape.

He will try your strength by changing to all kinds of shapes, all things that move on the earth, and water, and furious fire, while you must hold him fast and squeeze him the harder. But then when he questions you, looking the same as when you saw him sleeping, then you must stay your strength, hero, and set the Old Man free, and ask him which of the gods makes life so hard for you, and how to make your way home over the fishy deeps.

The Old Man of the Sea possesses the gift of prophecy, as does his daughter Eidothea, whose name means “Godly Vision”. In this context the renaming

of the enterobacterium *Proteus rettgeri*, formerly placed in the *Proteus* group, as *Providencia rettgeri* appears to be a synchronistic whim of fate because the name comes from the Latin word *providere*, “to foresee.” As *Providentia* it was the personification of female prophetic or mantic concerning divination or prophesy] talents.

Other synchronicities are two modalities of *Bacillus Proteus* given by Julian: aggravation in stormy weather and aggravation by exposure to sun. According to the *Odyssey*, “When the sun has climbed up to bestride the middle of the sky, the trusty Old Man of the Sea comes out of the water, under the west wind blowing, with the dark sea rippling over him.

By using disguise to intimidate and to instil fear *Proteus* escapes unwanted attention, as did two Polish physicians during World War II by using the microbe *Proteus vulgaris*.

The Microbe that Saved Villagers from the Nazis

During World War II, millions of people were forced into labour camps run by the Nazis. Two Polish physicians discovered a microbe that saved their village from this fate.

Dr. Eugeniusz Lazowski and Dr. Stanislaw Matulewicz learned about a microbe, *Proteus vulgaris* 0X19, a soil microbe. *Proteus* is a Gram negative, rod-shaped bacterium. It is classified as enteric bacteria, and is a facultative anaerobe. *Proteus* 0X19 has the same o-polysaccharides as the pathogenic bacteria *Rickettsia prowazekii*. These o-polysaccharides are thought to be the antigens responsible for antibody production in humans. There, infection by *Proteus* 0X19, a non-pathogenic bacteria, causes the same immune response as infection by *Rickettsia*, a highly pathogenic and contagious bacteria that causes typhus.

The physicians had the residents of Rozawadow, Poland inoculated with *Proteus* 0X19. Blood samples from the inoculated individuals then became positive for antibodies indicating typhus infection. As more and more tests came up positive for typhus, German officials became convinced that there was a typhus epidemic in the town. They were particularly fearful of typhus because the disease had not occurred in Germany for over 25 years, and so their native population would have been very susceptible.

A team of German doctors sent to investigate the “typhus epidemic” was shown a man dying of pneumonia as proof of the effects of typhus. As typhus carriers, the townspeople were not conscripted into forced labour, and the Nazis avoided that area of Poland. So the little bacterium, *Proteus vulgaris*

OX19 saved possibly hundreds of lives, and is further proof that “Microbes Rule!”
[Valerie Soledad, web.umr.edu/-microbio/BI0221_2001/teus_vulgaris_ox19.html]

MATERIA MEDICA PROTEUS

Prot.

Sources

- [1] Summarised drug picture by John Paterson in *The Bowel Nosodes*.
- [2] Symptoms collected from 13 cases [5 females, 8 males] and described by Elizabeth Paterson in *A Survey of the Nosodes*, British Hom. Journal, July 1960.
- [3] Clinical pathogenesis by Sevaux, 1965; symptoms recorded by Julian in *Materia Medica of the New Homoeopathic Remedies*.
- [4] Proving British School of Homoeopathy [Anthony Bickley], 2003; 11 provers [10 females, 1 male], 30c [5 provers], 200c [3 provers], and IM [3 provers]; three doses. Extracts/summaries of symptoms by Lisa Mansell and Debbie Schofield.
- [5] Massimo Mangialavori, Repertory Additions.

SYMPTOMS

Mind

Brain Storm [keynote to indicate “the sudden and violent upset of the nervous system”].

Outbursts of violent temper, especially if opposed in any way; will throw any missile which is at hand; kick or strike; the child objecting to parental control will lie on the floor and kick and scream.¹

Could commit a murder if crossed.²

There is considerable want of mental balance, great irritability and fits of violent outbursts of temper; very quarrelsome, hypersensitive both mentally and physically, with definite solar plexus symptoms. Anxiety and agitation and excitement felt in the stomach. There is metastasis and great changeableness in the symptoms. [Dishington]

Anger.

It is said that “Nux vomica on a bad day is Proteus on a good day.”

Several provers reported feeling in a Nux vomica state.⁴

Anger, which feels uncomfortable because I have not been angry for years.

The things I want to say involve swearing and are very aggressive.

Exceedingly bad tempered, very angry. Flipped over something I was furious about.

Reaction was over the top.

Had a customer who seemed to be trying to make me hit her.

Need a discharge of anger. At any time feel I could blow my top.⁴

Destructiveness. Children like to play making accidents, destroying their toys.⁵

Aversion to company. Wants to be left alone, but wants to be taken notice of.

Inflexibility, both of body and mind.

The patients are mentally stubborn and unresponsive, and amongst the most difficult to treat, not only because of their mental attitude but also because of the intractable nature of their ailments. Often *fixed ideas*. [Schmidt]

If you think of *Nux vomica* on a bad day, then you have a mild *Proteus* fit. They throw things harder and more often. Easily irritable, averse to company, can't bear difficulties or confrontations or contradictions.

These individuals lose control. You might say that in *Proteus* their level of control is minimal: it doesn't require much to tip them over the edge. ... *Proteus* people are very definitely capable of murder; these are not nice people! They tend to be unyielding, stubborn, and unable to see someone else's point of view. They often have fixed ideas, usually relating to their own abilities and importance. You might even call this a delusion of importance. They tend to keep to themselves, but like to be respected from a distance. They are not social creatures since they consider most people not worth the trouble.

... Unlike *Phosphorus*, where you get the thunderstorm but the sky clears quickly, with *Proteus*, you get the sudden storm, which doesn't abate and lingers on for days - like a volcanic explosion, rather than a thunderstorm. The best thing to do with a *Proteus* when they are ready to explode is to feed them. They usually stop to eat - it's tiring having temper tantrums, so if they lose their tempers, the best thing you can do is to put some food in front of them. [Anthony Bickley, *The Bowel Nosodes*-, The American Homeopath, Vol. 9 - 2003]

Inflation of ego.

The original picture [by Paterson] has large ego, superiority and self-importance and there were elements of this recorded by the provers. They mentioned feeling aloof and detached and felt that others could not do things properly or as well as them.⁴

No longer care about others. Own desires more important, want to take things for myself.

Felt very frustrated at work - as if everyone was doing things wrongly, or too slowly.

Felt distant and separated from others ... very tall.

Felt separated and much taller than others and older - as if I was their parent.

I feel very tall and looking out of my bedroom window I thought, "I'm on top of the world here. I seem to be higher than everywhere."⁴

Stress

An important place in the Proteus picture is occupied by what Paterson calls "nerve strain" and what now would be termed "stress". Julian speaks of "a feeling of extreme nervous tension and over-exertion." Based on the case of a salesman with migraine attacks, the "Proteus personality" is typified by Mount as follows: "He works under moderate pressure and in his own words 'has to conceal aggression in his work.' He feels generally apprehensive and most significantly of all he volunteers that he never feels better than when 'tearing an audience apart.' He is an amateur entertainer, it unwinds him and gives vent to his explosive temperament. His headaches are a safety valve and an important release factor."³

Stress can be defined as a challenging event that requires physiological, cognitive, or behavioural adaptation. Traumatic stress is caused by exposure to an event that involves actual or threatened death or serious injury to oneself or others and induces intense fear, helplessness, or horror. Richard Lazarus, in 1966, offered the leading definition of stress as the combination of a difficult event plus the appraisal of the event as being potentially harmful and exceeding the individual's coping resources. The American physiologist Walter Cannon [1871-1945] viewed stress in terms of evolutionary psychology as the activation of the *fight or flight response*. Cannon related this response to the adrenals, calling them "the glands of emergency." The glands of emergency energy, the Glands of Combat, the glands of preparedness, such are the adrenal glands when viewed from the evolutionary

scheme of struggle and survival. Cannon suggested, however, that the evolution of stress in the human environment has outpaced the evolution of our biologically based reactions to a threat, resulting in maladaptive reaction to much stress.^b

John Paterson has pointed out that increased [traumatic] stress leads to an increase of *Proteus* in the intestinal flora: "It may be of interest to know that in Great Britain since the war years, there has been a marked increase in the frequency with which one has been able to isolate *B. Proteus*, and this I associate with long continued "nerve strain" - a factor of considerable importance of the pathogenesis of this type of bowel organism."

Stress activates the hypothalamic-pituitary-adrenal axis, leading to the secretion of a variety of hormones, of which two are particularly influential: *adrenalin*, secreted by the adrenal medulla, and the steroid hormone *cortisol*, secreted by the adrenal cortex. In particular fear and rage will trigger the adrenal secretions which, by their entry into the blood, cause a tremendous heightening of the tone, a tensing of the nervous system. A greatly increased supply of energy is released immediately, which, if not fully utilised for its emergency purpose, produces after-effects known as "nervous shock" or, alternatively, as "shell shock" or "neurasthenia". *Outlets for frustration, whether directed at the stressor itself or indirectly in the form of physical activity, have direct physical benefits.* For example, rats secrete less cortisol if they can attack another rat or run on a running wheel after exposure to great stress. Attempts to release frustration in the *Proteus* fashion result in the keynote symptoms "brain storm" and "suddenness".

The size of the adrenal cortex has been demonstrated to vary directly with the sexuality and pugnacity of the animal. The charging bull possesses a most generous supply of cortical substance, the timid deer but a trace. Wild animals, for example, have more cortex than the domesticated.

Excess adrenalin in the blood displays all the classic manifestations of fear, whereas with an overwhelming amount of cortisol secreted from the first in the blood there will be no fear, but anger immediately. Excess of the cortical response in humans will lead to a liability to go off the handle at the slightest provocation.¹

Proteus infections have a marked propensity to affect the urinary tract and the kidneys. Twentyman takes this one step further with the suggestion that "*Proteus* and its remedies, including *Nat-mur*, find the basis of their action in the kidney and suprarenal system." He writes:

I think the empirical findings of modern research justify taking kidney and suprarenal as parts of a common function. Their closely interrelated actions in the renin-angiotensin mechanisms of hypertension, the peculiar kidney phenomena in the adaptation syndrome, the role of the kidney in maintaining electrolyte balance and homeostasis, and the suprarenal influence on sodium and potassium do, I think, give a basis for thinking of these organs together. ... Embryologically, both the kidney and the suprarenal gland are formed by a combination of polar forces and systems. The kidney originates in the pronephros at the cephalic pole which, as it were, calls forth the metanephros from the sacral pole. The adrenal gland also combines a nervous medullary with a metabolic cortical portion.

From this inner tension of origin and function arise the rhythmic phenomena of the kidney and suprarenal function. I would draw attention particularly to the rhythmic changes in cortisol level. This level rises during the morning and there is a corresponding fall in the number of eosinophils in the peripheral blood. By 10 to 11 a.m. these have reached a minimum, the cortisol a maximum, and this is maintained over noon-tide. In the afternoon reversal begins, and by 10 p.m. eosinophils are nearing a maximum, cortisol a minimum. Now *Natrum mur.* is characterised homeopathically by a 10 a.m. aggravation and *Chamomilla* by a 10 p.m. aggravation.

I suggest that the depressed, often hypotensive, fatigued, wasting picture of *Natrum mur.* lies in the direction of hypoadrenalism, as has often been suggested before, but also I suggest that the strong, angry, flushed, screaming *Chamomilla* who by contrast wants to be held, points rather to the hyperadrenal side of the balance.

[L.R. Twentyman, *Natrum muriaticum and our convulsive age* \ Br. Hom. Journal, July 1973]

Suddenness [keynote]

= Sudden outbursts of temper.

= Sudden vertigo.

« Sudden onset of headache.

= Sudden [cardiovascular] spasms; sudden cardiac attacks - at rest or walking.² =

Duodenal ulcer caused by prolonged nerve strain; no prodromal symptoms, hence

“sudden perforation and sudden haemorrhage resulting in a sudden crisis.”

[Kennedy]

Sun and light

« Marked sensitivity to exposure to ultra-violet light.¹

« Sensitivity to the sun.

The internal secretion of the adrenal cortex acts upon the pigment cells of the skin, blunting their sensitiveness to light. In hypofunction of the cortex the sensitivity of the pigment cells in the skin to light is increased, which results in darkening of the skin, i.e. in Addison's disease. [Berman]

Aggravation³

« In morning on waking.

« Wine.

« Stormy weather.

« Heat.

« Winter; cold.

« At night.

= Lying down.

Amelioration³

« Moderate temperature.

« Lying down.

= Stretching.

<• Eating.

« One hour after rising. [Cortisol levels are maximum by 10 to 11 a.m.]

« In the mountains.

Digestion & Food

~ *Acidity; heartburn; sourness.*²

=> *Hunger pain* not better with eating.²

= *Craves* fat; sweets; salt; butter; eggs.²

- *Aversion* to butter; pork; butcher meat; eggs [esp. boiled].²

« *Aversion* to green beans; salads; cucumber; garlic; onions; chocolate [which he cannot digest] ?

- Cystitis after eating pork.³

They have a very high metabolic rate - you don't see many fat 'proteans'. These are the people who wake up at 2 a.m., go downstairs and raid the fridge; they eat a meal and go back upstairs to bed. Then they have a full cooked breakfast

the next morning. They eat phenomenal amounts of food, but use it up. They are also known for food fads so can be averse to almost anything, but most commonly to greens and beans. [Bickley]

Energy from food

“Someone in a Proteus state is using up a huge amount of energy which needs replacing. Nearly all provers felt hungry immediately after taking the substance, and several noted a huge increase in appetite during the proving, but not an increase in weight. A Proteus keynote is getting up in the middle of the night to eat and some provers experienced this. Others ate breakfast when they normally wouldn’t, because they were ravenous. Some got up early so they could eat. One prover who had been a vegetarian for most of her life suddenly craved some sausages that were at the family’s house. The craving went on for a couple of hours until she finally ate them.

Eggs — craving/aversion/aggravation — keynote of Proteus. Other provers were craving boiled eggs, egg and bacon etc.

Food and its effect on blood sugar was an important factor. Provers “had” to eat, were > or < for eating and one prover with diagnosed hypoglycaemia felt the substance had acted curatively for the duration of the proving.

Alcohol: Several provers had severe cravings for beer, wine, spirits, but they paid for it. Alcohol effects and hangover symptoms were out of proportion to the amount of alcohol drunk. This was a symptom experienced by most of the provers.”⁴

Feminine

“One of the reasons for choosing Proteus as the proving substance was because the known picture was a very masculine one and we felt that it would be interesting to see if the remedy could be found to have a more female side. Something that has been particularly interesting for us is that the remedy has a strong hormonal connection and is capable of producing very striking symptoms relating to The Feminine.

With the anger we saw that there was a very confrontational aspect and this sense of confrontation can also be seen here. Proteus seems to make women confront their femininity — both on the emotional and on the physical levels. These are not subtle, mild symptoms, but symptoms that make you take notice of them - they cannot be ignored. There is a constant reminder of the feminine.

On the physical side, this gave symptoms such as protracted, more notice

able ovulation, ovulation pain, strong ovulation symptoms such as spotting and increased leucorrhoea. Menses were heavy, clotted and flooding or in contrast, one prover's periods stopped for the entire duration of the proving, previously she had had very heavy intermittent flow, when her periods did return they were entirely normal. A cured symptom.

On the emotional side there were some very powerful experiences relating to "the feminine". One prover, for example, found herself confronting the issue of wanting to have children - obviously the most fundamental aspect of The Feminine. In a relationship where she wanted children but her partner did not, she found herself thinking about it all over again, having thought that the issue had been resolved. She described experiencing during the proving feelings of "inadequacy as a woman", "a discomfort with being female". She described having difficulty in "coming to terms with the feminine as a part of me because I don't have children. I married someone who didn't and I squashed my desire down. These feelings led to her wanting to withdraw from her partner, not wanting to be touched. This same prover also described getting angry "in an hysterical, womanly way".

Another prover who said that she had been thinking more about pregnancy and feeling "gushy" about it during the proving found herself experiencing breakthrough bleeding at mid-cycle although she was on the pill - as if her body was drawing her attention to the possibility or the need to have a child and not wanting to have that suppressed by the pill.

In both these examples, the provers appear to have experienced a strong reaction against the suppression of The Feminine - in the first prover, against the suppression of her natural feminine instinct to have children and in the second, against the physical suppression through the use of the pill.

Proteus had a marked effect on libido. Some experienced a much higher libido than usual. They described wanting sex all the time, thinking about it all day. They referred to having a "heightened desire" and being "more passionate" and "more playful". The polarity to this was a reduced libido with some provers not wanting sex at all or describing feeling unsexual. Some took longer than usual to reach orgasm or were unable to reach orgasm at all. For some provers, this lack of desire could be put down to the physical symptoms. Sex felt uncomfortable because of symptoms such as vaginal soreness and itching or the sensation of the vagina being bruised. The sexual theme continued in the dreams. There were several sexual and erotic dreams and interestingly, provers made the comment that it felt strange to have such strongly sexual dreams when physically they felt unsexual.

The provers likened some of their symptoms to those of puberty, pregnancy, lactation and PMT. There was nausea on waking - similar to morning sickness and also some urinary symptoms which brought pregnancy to mind. Some provers - and also supervisors - experienced the “let down” reflex sensation of breastfeeding.”⁴

Circulatory

Spasm of the peripheral circulation.

Further indication for the use of this nosode is disturbance of the peripheral nervous system, evidenced by *spasm* of the peripheral circulation, e.g. “dead fingers”; intermittent claudication in the circulation of the lower limbs; anginal attacks due to spasm of the coronary capillaries. There are two well known diseases associated with capillary spasm where the nosode *Proteus* has been found useful in treatment - Raynaud’s Disease, where there is spasm of the capillary circulation of the extremities, and Meniere’s Disease where spasm of the brain circulation results in vertigo attacks.¹

= Numbness of hands in morning; hands dead at night.²

=> Cramps leg, calf; icy cold feet, as if frozen, < cold atmosphere.²

» Angioneurotic oedema.¹

= Bruised appearance leg.²

= Palpitation when lying down; from the slightest emotion.³

= *Proteus* is used therapeutically as a specific for Raynaud’s Syndrome,

« Repetitive Strain Injury, Intermittent Claudication. Our results confirmed these symptoms. There were icy and numb hands and feet, writer’s cramp and inability to type, cramps in calves < cycling and running.⁴

LOCALS

*Headache.*¹

Frontal with sense of weight.

< Before menstrual period for one week.

Coming on in morning.

& Visual disturbances [with migraine].

& Diarrhoea and furred tongue.³

= Much clearer and brighter in head, and more efficient, after urination.⁴

« Head [brain] feels dry, dehydrated.⁴

«Vertigo with feeling that the ground is coming up to meet him.³

«Vertigo after breakfast, & nausea, < standing.⁴

« Pains in eyes > pressure.³

« Stopped nose - worse indoors.²

« Feeling of numbness around face and left ear.⁴

= Face feels more congested on the right side.⁴

«Pain right side face in sinus cavity, from right eye to just above teeth < moving head, sudden movement, pressure, stooping down, lying on left side; sore, shooting electric nerve pain.⁴

' Constant feeling of puffiness below the right eye.⁴

■ Salty taste in mouth.²

' Cracks corners of mouth - resistant.²

- Vomits at the slightest exertion.³

- Urine *turbid and fetid. Violent burning pain in urethra?*

Fibrous blood clots at end of menses.³

Vagina and inner thighs suddenly ice cold, almost painful, as if ice had been placed on it, numbness.⁴

Sensation as if heart were doing summersaults.⁴

Sensation of heaviness around the heart.⁴

Copious perspiration axillae, *falling in large drops*-, clammy hands.³

Slipped disc.²

Nails split; hair falls out.³

Functional or professional contracture. Writers cramp, pianist's cramp, dancer's cramp. Flexor contraction of the little finger. Cannot close the hand. [Murphy]

“Herpetic eruptions were already in the existing picture. Several provers developed cold sores or felt as if one were developing. This was also one of the cured symptoms of the proving. Very interestingly, one prover who had been seriously ill with chickenpox in recent years and had “Never been well since” had the experience of the old chickenpox scars itching and spots then forming again in those places. At the end of the proving she felt that she had regained her “Pre-chickenpox state”.

Notably, in view of the “re-activation” of the chickenpox scars, other provers noticed changes in surgical scars, eg caesarian and episiotomy scars and scars from the removal of varicose veins.

Provers experienced severe itching - in all parts of the body, but particular in and around the genitals.”⁴

Associated remedies

Ammonium muriaticum. Aurum muriaticum. Apis. Baryta muriatica. Borax. Conium. Cuprum. Calcareo muriatica. Ferrum muriaticum. Ignatia. Kali muriaticum. Magnesia muriatica. Muriaticum acidum. *Natrum muriaticum*. Secale.

- a. S.J.L. Mount, *On the genesis, nature and control of migraine-*, Br. Hom. Journal, July 1973.
- b. T.E Oltmanns & R.E. Emery, *Abnormal Psychology*, Upper Saddle River, New Jersey, 2004.
- c. Louis Berman, *The Glands Regulating Personality*, Garden City, New York, 1928.

CASES

Rheumatism

Researchers have long postulated that some forms of arthritis, especially rheumatoid arthritis, may be related to bacterial Streptococcus infection. New evidence suggests that several other bacteria may also be implicated, two of which are *Proteus vulgaris* and *Klebsiella pneumoniae*. It is thought that antibodies are produced to neutralize antigens produced by bacteria. These antibody-antigen complexes may be absorbed through the intestinal lining and thus enter the bloodstream. Normally, these complexes are eliminated by the liver, kidneys, and lymphatic systems, but in some individuals these filters function insufficiently.

With *Klebsiella pneumoniae*, this reaction usually occurs in the spinal column, causing a condition known as ankylosing spondylitis, resulting in immobilization of segments of the spinal column, and subsequently in drastic loss of flexibility and consequent problems.

In the case of *Proteus vulgaris* complexes, inflammatory responses can occur in any joint. Left unchecked, this can produce the swelling, pain, deformity, and other signs of rheumatoid arthritis.

The bowel nosode *Proteus* has been found curative in cases of chronic arthritis, fibrositis, rheumatoid arthritis and osteo-arthritis. The three cases below, by Roger A. Schmidt*, of “chronic, advanced, incurable spinal arthritis” demonstrate “the typical - almost miraculous - response to the nosode

Proteus.” The cases moreover seem to exemplify an affinity of Proteus for the spinal column, an affinity it shares with the closely related enterobacterium Klebsiella.

* R. A. Schmidt, *Proteus - A Bach Nosode*; Journal of the American Institute of Homeopathy, September-October 1965.

(1) Mrs. S.B., a 70-year-old married woman, no children, came to see me on July 21, 1964, complaining of her back ever since a fall on her bottom in 1942. She was treated for *coccycodynia* for two years ... could not sit... later, low back pains so severe that only cortisone, first in shots, then orally, for many months controlled them, but it had to be stopped for the last four years because of serious side effects. Between 1950-60, she had three rectal operations for bleeding haemorrhoids requiring several blood transfusions. Meanwhile the back was getting steadily worse to the point of not being able to walk without assistance and needing a wheelchair. ...

She was unable to get out of bed alone in the morning because of severe pains and stiffness of her back, sometimes lightning-type, sometimes like a hot poker on the sacral area. X-rays demonstrated degenerative arthritis of the lumbar spine and the sacro-iliac joints. Her husband, a lawyer, added that she was failing markedly in the last year and was often confused, apathetic, very depressed with laborious mentation and increasing senility; a pathetic contrast to her usual keen intelligence. Physical examination revealed a 123-lb., 5' 2", white-haired, well nourished female with a besotted, rigid and depressed expression, hardly able to stand and make a few hesitant steps without assistance. Blood pressure 170/90, pulse 90, not too regular. The lower extremities appeared wasted with flabby muscles, but exaggerated reflexes. Marked bilateral arcus senilis.

Because of the difficulty of the patient to express herself, due mostly to the abuse of sedatives, I gave her *Nux-vom.* 6x, b.i.d., and asked her to stop as much as possible, all the other drugs as to give her homeopathic medication a chance to act. *Nux* definitely helped her for about three days so that she could sit without special cushions ... then the pains came back. July 28, 1964, *Sulphur* 200, two doses, six hours apart, then continue *Nux-v.*

August 4, 1964. Steadier. Weight, 122 lbs., blood pressure 142/88, pulse 78. Was much better until the day before, but the bottom hurt so much that night that she “had to walk the floor.” Lightning-like pains in lower back extending down the legs. I gave her that day *Proteus* 200. That dose worked

like a miracle, she said, when she reported on August 14. She had gone these ten days without any of her pain or sleeping pills. Her appetite and digestion were much improved. She was now able to walk alone with a cane and rest more comfortably at night. August 31, 1964. Weight, 124 lbs., blood pressure 160/88. Swollen legs - because of the hot weather, she said. Pains seemed to return the last few days, but not to the point of requiring her former pain pills. *Proteus M*, one dose.

September 17, 1964. Looks like a new woman, ten years younger, smiles and jokes. Has been on a little trip with her husband - for the first time in many years. Pain like a hot poker at the base of the spine lately. *Phos.* 30, b.i.d., six doses, relieved promptly. October 8, 1964. Weight, 125 lbs., blood pressure 140/90. Up and around daily. Restless, aching, low back pains, extending to the heels, worse in bed. Can sleep only on the right side. *Rhus-t.* 6x, p.r.n. October 29, 1964. Better, but not as well as a month ago. *Proteus* 30x, b.i.d., for four days helped at once; eats better, sleeps better, walks better without cane or help, does household chores, cooks for herself and husband - which she was unable to do for years ... thanks to *Proteus*, which needed to be repeated every three months or less since.

(2) Mrs. M.R.J., a 48-year-old mother of four children, waddled into my office with great difficulty from her wheelchair on February 4, 1963, saying that she had been crippled with arthritis of the neck, back, and extremities for over two years. Presently, she can hardly stand without falling. She had a course of cortisone a year ago because she could not get out of her bed. She is now taking from 15-20 aspirin tablets a day. She has suffered a long time with her lungs: cough, expectoration of yellow sputum. X-ray demonstrates a fibrous scarring in the right lower lung field with an elevated diaphragm and pleuro-diaphragmatic adhesions antero-laterally. The hands are typically deformed by rheumatoid arthritis so that she is unable to make a fist.

Physical examination discloses further, an overweight - 155 lbs. - brunette, 5ft.5 ins., with a blood pressure of 130/90, a good regular pulse, a 2+ oedema of the ankles. Feet and legs are icy cold and bluish.

Any motion aggravates, better by rest. February 4, 1963, *Bryonia* 6x, b.i.d. February 11, 1963. Better, has been able to cut down her aspirin intake to three tablets a day. Digestion much improved. *Bry.* 6x, b.i.d. February 21, 1963. Lost eight lbs. Much improved, can move her head and neck easier. Pains in the legs and calves worse in bed. *Bry.* 30x, a.m. only. March 4, 1963. Lost another 2.5 lbs. Can manage now with one or two aspirins a day. Feet

burn and throb at night, has to stick them out of the covers. Poor sleep, very tired, ribs sore. *Pub.* 30x, b.i.d., six doses. March 14, 1963. 144 lbs. Diplopia looking up, due to strabismus divergence. Pain along the right sternocleidomastoid muscle. Feet very swollen, still burning at night. *Sulph.* 6x,

b. i.d.

Except for the loss of weight until the end of July [131 lbs.] which enables her to walk better, the basic condition seems to have settled without lasting response, to the apparently indicated remedy, so on July 23, I gave her *Proteus* 30x, at bedtime for a week, then every two or three days. August 22, 1963. 133 lbs. "Is this last medicine a sleeping one?" she asks. "From that very day I saw you last, I have slept wonderfully." She has such ambition and stamina now that she is doing a lot of housework.

Diplopia has almost disappeared. Better in every way than in years. *Proteus* 30x, twice a week, leads to further improvement and enables her to take a trip to Arizona. January 9, 1964. Patient got very tired from Christmas shopping and New Year festivities, regained 14 lbs., now 147 lbs. ... *Proteus* 10M, one dose brought prompt relief. She has taken NO aspirin for over six months. *Proteus* 10M was repeated October 16, 1964, and maintained her remarkable progress until the present time.

(3) Mr. R.A.N., a pimply, stoop-shouldered, married engineer, consulted me in April, 1954, for a backache in the right lumbar region, better by walking and local warm applications, worse lying down. *Rhus-t.* 200, four doses relieved the symptoms promptly for over a month but recurred with the pains extending down to the left limb. He went to an osteopath who treated him for sciatica during the whole summer of 1954. By September, 1954, he had *wandering* pains, bouts of fever, backache and pains in the limbs, especially the left ankle which is swollen. *Kali-bi.* 10M, one dose relieved the back at once, but the left ankle is unchanged after ten days. The end of October, 1954, the ankle is better but the left big toe is now swollen and painful, worse from heat of the bed, worse standing, moving, pressure. *Led.* 6 helped fairly well.

November 5, 1954. X-ray of the spine disclosed a definite rheumatoid spondylitis, involving the cervical and lumbar spine with a right scoliosis and sacro-iliac involvement. The *Rhus-t.* modalities are again to the fore so that the 200, M and 10M potencies are prescribed with fairly good results for the next six months. Then I did not see this patient for the next five and a half years. He came back in February, 1961. Weight unchanged, 177 lbs., blood

pressure 112/70, pulse 55, regular. His main complaint is his neck, which is stiff and painful, worse on the left side. Pains in the right shoulder extending down the arm. Low back pains, worse on the right, worse sitting, evening, on waking at night and in the morning. His father died of cancer of the stomach, but had been treated for tuberculosis for a long time. X-ray of the spine: Rheumatoid spondylitis much worse since 1954. *Bacillinum* M, one dose followed by occasional doses of *Ruta* 30x, *Rhus-t. 12*, *Lyc.*, *CheL*, *Puls.*, depending on the symptomatic variations and modalities, gave decided but momentary relief during 1961 and 1962.

Back from the A.I.H. Convention at Atlantic City, where I heard Dr. Benjamin Goldberg's impressive paper on Bach's nosodes, I thought that this unyielding, progressive, inexorable disease of at least ten years' duration required a nosode with similar features, so on July 31, 1963, I prescribed *Proteus* 30x, 200, then M, one dose daily ... The patient was most gratified, stating that the improvement was definitely noticeable in 48 hours, not only for the pains but also for the stiffness; he can move his head, neck and back much easier now.

These three doses controlled the condition for six weeks. September 6, 1963. *Proteus* 30x, b.i.d., for five days promptly relieved a recent aggravation. Early in December, 1963, he suffered a bad cold with a temperature of 102° F which brought back the former miseries. *Rhus-t. 12* improved the acute symptoms but *Proteus* 30x, 200, M and 10M was a great boon for two months and needed repetition at the end of April, 1964, followed by a good period until August, 1964. The sedimentation rate was then up to 36mm/h showing a definite reactivation. *Proteus* 30x failed and other medicines had to be prescribed, but it had given this patient a most welcome relief for over a year.

MORE CASES

(4) I have never seen such a bag of nerves as the man R.B., aged 31, plumber, who walked into my consulting room on May 18, 1928. During the War he had been torpedoed more than once, had gone through several bombardments and finally been shell-shocked. He had also had nine months in hospital with dysentery. Of course he had had a lot of nerve tonics. He took alcohol but not to excess, and smoked fifteen to twenty cigarettes a day. I stopped his alcohol and reduced his smoking to six cigarettes a day. He was trembling and could not sit still and said he could not face either people or

things. He got Proteus co. 12, that day, Proteus co. 13, on July 30, Proteus co. 14, on August 21, and Proteus co. 30, on October 9, improving all the time. After that he needed no more medicine till April, 9, when Proteus co. 35, was prescribed, and on August 16, Proteus co. 40. He is a different man now. A few months ago he applied for and obtained a better job and is doing well at it. All prescriptions were single doses. [C. Gordon]

(5) Mrs. S., aged 26, complained in May, 1925, of wandering rheumatic pains and stiffness, cold hands and feet, headaches. For two and a half years she was under treatment but never obtained anything more than temporary benefit. Silica and Natrum mur. were the remedies most used. At last, in December, 1927, I gave Proteus co. 12, with very definite success. In March, 1928, Proteus co. 13, was given, after which I saw no more of the patient until July of this year, when she sought treatment for bursitis of the right knee. The rheumatism had practically disappeared. All prescriptions were single doses.

[C. Gordon, *Auto-intoxication from the bowel and psora*-, RefWorks]

(6) A woman of 32 years of age; epileptic fits for seven years. She has had as many as twenty to thirty epileptic fits in a month. Always was nervous; throat gets dry with excitement and diarrhoea comes on; extremely sensitive to the sight of anything unpleasant, or to horrible stories. Weeps very readily, especially when talking of her complaints; very sensitive to the opinion of others; averse to meeting people, as she says herself, because they might know of her trouble; great depression and wants to be left alone; easily startled by noise and touch, and easily scared.

Great fear that something was going to happen; convulsions brought on if she became agitated, startled, or frightened in any way. Feels her head wooden; cannot think; gets dazed; loses the thread of what she is saying; great mental confusion; suddenly forgets what she was going to say. Drops things; twitchings of the hands.

Frequent sudden mental blanks while speaking. Memory is very poor; could not retain anything she had just heard; she had a great fear of insanity. While talking she branches off on to other subjects. Excitement felt very acutely in the epigastrium. Very irritable; very easily annoyed; takes offence readily. Dreams of dying and of dead people; great fear of the dark. Quarrelsome; the least little thing upsets; fancies slights; misinterprets what is said; vertigo is very frequent, especially so if she is in a car or in a train, or at the sight of

any quickly moving object. *All these mental symptoms have entirely disappeared under Proteus*, and the number of epileptic fits are greatly reduced and seem only to take place at night while asleep; she has become placid and confident and reasonable and is in no sense so easily startled or excited. In this case the interval of repetition of the Proteus was three and a half months. Apart from the mentals of Proteus I have observed that Proteus cases tend to fibrosis, hardening and piling up of inflamed tissues, and that they are liable to spasms and constrictions.

I have a case of a lady who has a pre-systolic murmur at apex. She had frequent attacks of great exhaustion, with pains across the left chest with constriction. If excited got palpitation and a gripping sensation and the fingers became dead and white. At times left dazed and did things mechanically. Left arm and left leg at times felt numb and contracted. Several times over a number of years she had what she called “dead” turns in which she would lie in a perfectly conscious condition, but faint and unable to do anything. She is a woman of high intellectual attainments, brilliant, but very easily exhausted. She reacted at once and profoundly to Proteus, with mitigation of all her symptoms and a very marked increase of vitality.

[T.M. Dishington, *The Autogenous Vaccines and their Relations to Chronic Disease*, RefWorks]

(7) First visit on 8 July 1992

A mother brought her seven year old son to see me. His presenting complaint had been diagnosed as asthma, consisting of explosive sneezing fits, chronic nasal obstruction and nosebleeds. When the boy was two the family had moved from London to the country and the boy had developed hayfever symptoms, confined to the summer months, which appeared to be an allergic reaction to pollen and grass. When the boy was four the family moved to Hong Kong and the more humid climate aggravated the symptoms which then became continuous rather than seasonal and remained so when they moved back to England a year later. At this stage they consulted a doctor who diagnosed asthma and prescribed Bricanyl, Triludan and Rynacrom. The boy had been given these medications on a daily basis for the last two years with no effect.

At the first visit I made two observations about the boy: firstly, his complexion was a shiny yellow-green; secondly, he seemed very angry. He punched and shoved his mother and was generally belligerent throughout the session although I felt that the anger was in some way directed at me. On

his appearance and behaviour and the respiratory symptoms I prescribed Medorrhinum 200, single dose, and advised his mother to leave the other medication unaltered for the time being.

Follow up on 3 August 1992

They came back four weeks later. Good and bad, the mother said. The good news was that within twenty four hours of the remedy the respiratory symptoms had completely cleared and that for the last four weeks there had been no sneezing fits, no nosebleeds and a noticeable improvement in the nasal obstruction. Indeed, in the last few days she had noticed that her son had started to breathe through his nose again during his sleep, something which he had been unable to do for several years. The improvement had been so dramatic that his mother had stopped the other medications on the second day and last week she had thrown them away.

The bad news was that his temper had attained unmanageable proportions over the last few weeks. At the first consultation the mother had seemed concerned to concentrate our discussion on the respiratory symptoms and it had been difficult to explore the emotional picture much beyond simple observation. Now she was keen to talk about his behaviour.

The mother explained that her son was prone to sudden violent tantrums where he would throw himself on the floor, kick, shout and scream and become abusive to his sister, his parents, his friends and even his friends' parents. I asked what appeared to provoke the tantrums, expecting the standard response of 'not getting his own way'. The reply was rather different. He has a tantrum, she explained, when he sees somebody doing something the wrong way. What is the right way, I asked.

The way that he was first shown how to do it, she replied. I asked for examples. Almost anything, she said. If she showed her son how to make a cup of tea, putting the milk in the cup then the tea, and the next time reversed the procedure, there would be a tantrum. If she used a particular route to go to school and then, a week later, changed the route to avoid a jam, there would be a tantrum. It seemed that the boy had a great need for routine and I asked how long this had been apparent. Since he was a baby, she said, when he was perfectly happy as long as he was fed every four hours precisely, otherwise there would be a tantrum. I asked if he was organised and she replied that every object in his bedroom had its place - every book, every toy, every record - and that there would be a tantrum if something was borrowed and not returned to its allotted place. I asked whether he was conscientious and she told me how, when they

returned from Hong Kong, they had employed a personal tutor for a few months as their son's education was out of step with the English system. If the tutor was even five minutes late, the five year old boy would be sitting at his desk and studying. I now understood why he had been so furious at the first consultation. We had started five minutes late.

I wondered what could make a young boy so fastidious and I suspected that it must be fear. I asked the mother what her son was afraid of and she mentioned several things of which the most prominent element seemed to be a fear of danger. "He is always telling me to slow down when I'm driving," she said, and then recalled how, at a recent fair, he had gone up to the other children and tried to persuade them not to go on the rides which he felt were too dangerous.

I felt that the Medorrhinum had done good work in allowing us to get to the core of the problem, but I felt that this more complete symptom picture was no longer adequately covered by Medorrhinum. I had the sense of being faced with a picture of great clarity but one which I did not immediately recognise. I decided on Anacardium - the two very opposite natures, the fastidiousness and the violence - and gave Anacardium 200, single dose.

Analysis

Some days later I found myself mulling over this case and feeling unconvinced about Anacardium. To me, Anacardium violence has an air of revenge, a retaliation against an imposed and unwelcome straitjacket. In the boy, the violence seemed to be the release of a tremendous pent-up nervous tension that the least provocation was sufficient to unleash. I began to consider the bowel nosode *Proteus, the brainstorm remedy, the explosive flipside of the conscientious Natrum muriaticum*, the remedy where the nervous tension builds and builds until it erupts in the most violent tantrums, migraines, spasms and cramps. The mother had described the boy's sneezing fits as explosive and I was intrigued to find that Julian made special mention of the other nasal symptoms, the nasal obstruction and the chronic rhinitis.

Follow up on 28 August 1992

Four weeks later the boy was unchanged. The respiratory symptoms were still lying low but the temper was, if anything, more explosive, more Protean than ever before.

Rx: Proteus [Bach] 10M, single dose

Follow up on 25 September 1992

Four weeks later the boy came back. He was different, there was a serenity that I had not seen before, he had been unplugged from the mains. "He

doesn't criticise my driving any more," said his mother with delight and went on to say that within a day of the Proteus there had been no more tantrums, that her son had become altogether much calmer. Two weeks after the Proteus he had gone back to school where, typically, the respiratory symptoms were more pronounced. For two days he had sneezing fits and nosebleeds of an unprecedented fervour and then it all calmed down.

Follow up on 20 November 1992

There have been no nosebleeds, no sneezing fits and the nasal obstruction has gone. He is altogether much happier. He is well.

Discussion

So, on one level, this is a well-defined Proteus case, where Medorrhinum clarified the picture and Proteus did the rest with a passing aggravation of the original physical symptoms as befitted the deeper prescription. But there is more.

Two things continued to puzzle me about this case. Firstly why should a boy of seven adopt a Proteus stance and indeed apparently adopt this stance from birth. This would suggest something of significance in the pregnancy and, at an early stage of the case-taking, I had tried to confirm this. The mother had replied that the pregnancy had been uncomplicated. Only sometime later, when the mother herself came for treatment, did I realise that this had been a somewhat literal answer.

The classic environment for the development of a Proteus picture is the tension of war, where fear becomes the emotional norm, where nothing is certain and where there will be a corresponding desperation to maintain some facade of normality and routine. During her own case-taking the mother had explained that although her son had been born in this country [which I already knew], he had been conceived in South Africa [which I did not know] and that the family had moved to England when she was seven months pregnant. I asked why. She replied that the political tension had become unbearable, that she and her husband had realised that this was no place to bring up a family and that in Johannesburg, where they were living at this time, there were bombs going off all around them in the street.

The final puzzle concerned a bizarre and enigmatic symptom which I have omitted from the case-notes so far and I am grateful to a fellow homoeopath, Colin Griffith, for alerting me to the mythological resonances that would seem to be at play.

What led Bach and Paterson to ascribe the name Proteus to the third bowel flora they isolated is not clear. The word protean has come into the language

to describe someone or something that can assume many shapes or guises. Perhaps this particular bacillus appeared in a variety of forms and thus suggested the name. In Greek legend the god Proteus possessed the ability to assume many shapes and guises as by this means he could evade capture. However the legend also explains that he was vulnerable whilst he slept for then his would-be captors could steal upon him and trap him before he could assume his disguise.

When the boy's mother had described his liking for routines she had recounted a peculiar nocturnal ritual. Unlike his sister who threw her clothes in an untidy heap on the floor, the boy was most meticulous about undressing for bed. He would remove each piece of clothing in turn and lay it on the bed so that it retained the selfsame shape as when he had been wearing it - the pullover placed flat with the arms at the side, the shirt placed flat on top of it, then underneath the shorts and below that his socks - so that his clothes assumed his own shape and form beside him on the bed. Then, and only then, would he feel comfortable to don his pyjamas and go to sleep.

Each night, before this boy goes to bed, he lays out his disguise, his mantle, ready, in case they should come whilst he sleeps...

[Robert Bridge, *'In Case They Should Come Whilst He Sleeps'*, The Homoeopath, Vol. 13 No. 1, 1994]

SALMONELLA

GENUS

- Gram-negative, aerobic to facultative anaerobic, motile, flagellated rods.
- Unlike the rest of the family Enterobacteriaceae, Salmonella spp. live in the gastrointestinal tracts of animals, but are not part of the normal intestinal flora of humans.
- About 2,200 serotypes are known, each of which is named as if they were separate species.
- Named after the American veterinary pathologist Daniel E. Salmon [1850-1914], who in 1885 described the species *S. choleraesuis* ["hog-cholera-bacillus"] in a strain isolated from pigs with hog cholera.
- Divided into 7 distinct subgroups or grouped into those [1] highly adapted to human hosts and then invariably considered pathogenic instead of being part of the normal human bowel flora; [2] adapted to non-human hosts, or [3] unadapted to specific hosts. The third group contains some 2,000 serotypes that are ubiquitous in nature.
- Worldwide distribution, although salmonellosis seems to be more common where livestock are intensively farmed.
- Symptomatic salmonella infections in livestock are often precipitated by stressors such as transport, drought, malnutrition or food deprivation, and crowding. Clinical disease is common in horses after major surgery.
- Some Salmonella can persist for months or years in the environment, particularly in wet, warm environments.
- Ferment glucose but neither lactose nor sucrose.
- With few exceptions, produce abundant hydrogen sulfide.
- Cause of salmonellosis, with in the USA an estimated 3 million new cases of gastroenteritis annually.
- AIDS patients suffer salmonellosis frequently [estimated 20-fold more than general population] and suffer from recurrent episodes.
- Transmission is via ingestion of contaminated materials, particularly raw fruits and vegetables, oysters and other shellfish, eggs, poultry, dairy products, ground beef, and contaminated water.
- Outbreaks occur most commonly in summer months. [Summer diarrhoea]. Cold weather seems to slow the growth of Salmonella.
- Infants and people older than 60 years are most susceptible and tend to have more severe infections.

-
- Outbreaks have also been associated with pets, reptiles [lizards, snakes, turtles, and especially iguanas], and [contaminated] marijuana. [Salmonella is found in the intestinal tracts of many animals, specifically reptiles and birds.]
 - Salmonella infection may present clinically as gastroenteritis, enteric fever [typhoid fever], a bacteraemic syndrome, or focal disease.
 - Subtotal gastrectomy, achlorhydria or ingestion of antacids [gastric acid decreases the viable bacterial inoculum], sickle cell anaemia, splenectomy, louse-borne relapsing fever, malaria, bartonellosis, cirrhosis, leukaemia, lymphoma, and HIV infection predispose to Salmonella infection.

[Merck Manual]

SALMONELLA ENTERITIDIS

Scientific name *Salmonella enteritidis* (Gaertner 1888) Castellani & Chalmers 1919

Family Enterobacteriaceae

Homeopathy Gaertner. *Bacillus* Gaertner [Bach] - Gaert.

FEATURES

- First isolated as *Bacillus enteritidis* in 1888 by the German bacteriologist A. Gaertner from the flesh of an emergency-slaughtered cow and from the spleen of a man poisoned by eating meat obtained from it.
- Specific reservoir in poultry; less common reservoir in horses.
- Transmission typically *egg-borne* [notably in the yolk].
- Causes gastroenteritis [non-typhoidal salmonellosis] of usually short duration [12-48 hours]; onset 6 to 48 hours after ingestion of contaminated food.
- Common cause of restaurant/hospital/nursing home outbreaks of gastroenteritis.
- The first symptoms are nausea and cramping abdominal pain, soon followed by non-bloody loose stool or watery diarrhoea, fever, and sometimes vomiting.
- Antibiotics prolong shedding without shortening the illness.

MATERIA MEDICA BACILLUS GAERTNER

Gaert.

Sources

- [1] Summarised drug picture by John Paterson in *Indications for the Use of the Intestinal Nosodes in Diseases of Children*.
- [2] Symptoms collected from 11 cases [3 females, 8 males] and described by Elizabeth Paterson in *A Survey of the Nosodes*, Br. Hom. Journal, July 1960.

VECTOR

GI tracts - animals, birds, reptiles.

Pathogenic in humans.

[S. typhi has no animal reservoir being a purely human pathogen.]

TRANSMISSION

through contaminated material - raw fruit and vegetables, oysters, shellfish, eggs, poultry, dairy, ground beef contaminated water contaminated marijuana

SYMPTOMS

*Violent diarrhoea
Abdominal cramps
Nausea, vomiting,
Fever.*

Rarely fatal

AVOID

uncooked or raw foods

SYMPTOMS

Keynotes

Nutrition/assimilation

All brain/no muscle

Ketosis

Tendency to malignancy

Nutrition - malassimilation.

The keynote of Gaertner co. is “nutrition,” and this nosode might suitably be named “The Children’s Nosode,” because in the clinical picture you will find something of practically all the nutritional disorders so common in the child. It is significant that this organism was first isolated from a case of food poisoning, and when identified by Gaertner was given the title *B. enteritidis* - the bacillus of the intestine. It is therefore in keeping with that title that in the clinical picture very marked nutritional disturbances should occur. In the child, the first point I would call your attention to is the very poorly developed musculature of the body and limbs. It strikes you the moment you commence your physical examination. You need never think of Gaertner co. as a remedy where you find a well nourished physical frame.

Remember the keynote “nutrition,” and associate with that two chemical substances, silica and phosphorus. Silica will remind you of the underdeveloped musculature system, and phosphorus of the overactive nervous system.¹

All brain and no muscle.

The second point of note is the hypersensitive state of the child’s cerebro-nervous system, which is in contrast to the undeveloped physical body. This child is all brain and no muscle, and it would seem as if the cranium had enlarged proportionately. Mental development is advanced - the child is precocious in many ways, and many symptoms are prominent. He is hypersensitive to all impressions, psychical and physical and shows marked fear of the dark or of being alone. Such a condition recalls to mind the clinical picture of Phosphorus, and my observations have shown that this chemical substance has a specific relationship to the *B. gaertner* and its metabolic disturbances.

It may be helpful to make a comparison and to remember the “Dys. co.” child, whose nervous tension expressed itself by an uneasiness of the muscular system.

Although fidgety and uneasy, the shyness of his temperament would prevent him from leaving his chair while you are taking the preliminary notes in your consulting room.

The Gaertner child has a mental uneasiness. He must know the reason for everything you do and for what purpose you use this or that article lying on your desk or somewhere in the room. Furthermore, he will proceed to make close inspection of it, but you will notice that his attention is not held long on any one object.

This symptom complex of overactive brain and under nourished body is characteristic of the Gaertner child, and you will recognize it also as that found in some well known but variously named diseases of children.¹

Ketosis.

[Ketosis is enhanced production of ketone bodies, as in diabetes or starvation, resulting in a metabolic acidosis, with symptoms such as nausea, vomiting, and, in children, abdominal pain. Produced by the liver as a result of the metabolism of body fat deposits, ketone bodies are normally used as energy sources by peripheral tissues. Deficient insulin modulation of glucose and lipid metabolism results in diabetic ketoacidosis. Glucose and other sugars are necessary for the generation of ATP, the phosphor-carrier of energy. The underlying factor for the malnutrition in Gaertner therefore appears to be a disturbance in sugar and fat metabolism.]

With a basic nutritional error, a shortage of available glycogen in a poorly developed muscular system, a tendency to over-exertion, mental and physical, it is easy to understand how these ketone by-products are produced and result in attacks of vomiting. The effect is cumulative so that the attacks occur in cycles at varying points of time.

A more chronic condition, beginning very early in infancy and often prolonged over many years, is that associated with the inability to absorb fats - a condition sometimes called "intestinal infantilism."¹

[Salmonella bacteria have a predilection for the gallbladder..]

Tendency to malignancy.

I should like to point out that malignant disease in the adult takes a very prominent place under Gaertner, and I cannot free my mind from the thought



that many of these nutritional errors in the child, apparently overcome by dieting alone, find expression in the malignant tumours of later life.¹ [Paterson wasn't far off the spot: Epidemiologic data indicate that typhoid carriers are more likely than the general population to develop hepatobiliary cancer.]

Mind

« Nervous; anxious - alone; noise; crossing street.

= Fidgety hands and feet. Bites nails.

<■ *Intelligent.*

~ Wants company; wont sleep alone; wants to be beside mother.

As well as finding it difficult to absorb things through the gut, these individuals find it difficult to absorb and dispel emotional trauma. In other words, they are like an open book. If you say something that wounds them, you can see it. Very satisfying if you are of that evil taint. They are hypersensitive to insults and changes in atmosphere, both emotional and physical. Because of their difficulty adapting, they are nervous, anxious and aware of their own sensitivity. They find it difficult to let go of emotional trauma, are made miserable by it and become pessimistic. “Whafs the point of doing something if somebody is always going to put me down for it?” Still, because of this difficulty in absorption, which we may interpret as a failure to adjust, they are also afraid of the dark, the unknown, and new things. This also goes for their diet, because they are afraid to try new things in case the new food upsets them. They like routine, physically and emotionally, and are uneasy and restless, in case something should go wrong. ... You put a *Calcarea carbonica* child in front of a puzzle, and it will play quite happily for hours even if it has only used a few pieces. *Gaertner* children don't have that ability to concentrate: they are restless mentally, inquisitive, but lack the concentration. As attention span is an issue here, I have used *Gaertner* in Attention Deficit Disorder with good effect.

These children are disruptive, don't do what they are told and you can't rely on them. ADD is typical *Gaertner*, and very often these are children who exhibit allergic responses as part of their ADD or Attention Deficit Hyperactivity Disorder [ADHD].

[Anthony Bickley, *The Bowel Nosodes*-, The American Homeopath, Vol. 9 - 2003]

Food

® Craves oatmeal [porridge and oatcakes]; cheese, eggs; milk pudding; sugar

-
- and sweets.
 - = Averse - bread; butter; butcher meat; fish.
 - = Intolerance for fats.
 - = Vomiting < after sweets.

Sleep

- « Restless sleep; night terrors.
- « Late in falling asleep.
- «• Sleepwalking.
- «• Not afraid dark or alone.

Night

- « Rheumatism shoulders <.
- ~ Soles of feet covered with blisters which itch and are < at night.
- « Perspiration c.

Locals

- White sclerotics.
- « Styes.
- « Nasal polypi; nasal catarrh.
- « Dry scaly eruption round mouth.
- « Deep fissures in tongue.
- Teeth black.
- » *Vomits* everything.
- = Blood and mucus in stool; blood and mucus with urine.
- = Profuse, offensive leucorrhoea; pruritus vulvae.
- > Severe pain hip and back.
- ® Fibrositis shoulders.
- = Rheumatism hands; feet.
- « Chilblains hands in winter.
- ® Urticaria; heat rash.
- = Circinate eruption sternum.

Associated remedies

Calcarea fluorica. Calcarea hypophosphorica. Calcarea phosphorica. Calcarea silicata. Kali phosphoricum. *Mercurius vivus*. Natrum phosphoricum. Natrum silicofluoricum. *Phosphorus*. Phytolacca. Pulsatilla. *Silicea*. Syphilinum. Zincum phosphoricum.

Antibiotics

Whenever I see recurrent courses of antibiotics, the file opens at *Gaertner*. *Gaertner* works therapeutically for allergies, that is, where there is strong and compelling evidence that the patient is actually worse from some foods, particularly carbohydrates and grains. Therefore, it is a remedy for bowel problems like Crohn's disease, colitis, Irritable Bowel Syndrome, and a very good remedy after surgical interventions to the gut or even to the stomach. *Gaertner* is a major remedy for ear discharges, ear infections, and throat infections. Of course, those are problems that very often get treated by antibiotics.

Actually, a lot of the conditions for which a child might be given antibiotics fit the symptom picture of *Gaertner*, the infection link breaker. I am keen to point out that it's not just because we know *Gaertner* has this effect on antibiotics, but because it often matches the conditions the antibiotics were prescribed for in the first place. Slow recovery is a general indication for *Gaertner*, also another reason why patients are given antibiotics. ... Adults tend to need this remedy after antibiotic treatment or as a result of allergies and failure to recover from a debilitating disease. [Anthony Bickley]

CASES

(1) Mrs. R. tearfully proclaimed that she could not accompany her husband on a trip to Europe two months hence because she had so much bladder distress. She had increased desire, especially when lying, and a burning externally before and after micturition with crampy pain in bladder after each urination. She was chilly in the afternoon but could not stand heat, felt better in the open air.

The mentals, the contradictions, indicated Puls. CM and she was told to report in two weeks. In her report, she was improved in every way but had some of her bladder trouble at night. Now it was time to get at cause and cure. She has always abhorred fats, rich food, hot food, never was above normal weight, so we gave her *Gaertner* 200 and the admonition to avoid milk, sweets and white flour. Within a week she reported improvement of all symptoms and the improvement held. Just before she left for Europe we gave her two powders of *Gaertner* 15 in case of a relapse. On her return from the trip she was exuberant over the good health she had enjoyed without recourse to the powders. In over a year she has needed no medication.

[Wm.A. Boyson, *Time and the Nosodes*-, RefWorks]

(2) G.M., aged 38, came under my care in May, 1928. He complained of itching at knees and elbows for the last five months < if heated or sweating, < undressing, < during night: it rarely troubled him in the daytime. Other symptoms were rheumatic pains of knees and elbows for many years; arms go to sleep if lain on; he had sick headaches formerly, and still had migraine occasionally from worry or overwork; bowels regular as a rule; axillary perspiration copious; he also had tenesmus at night, relieved by warmth of gas-fire. Before coming to me he had had Sulphur, Psorinum and Polyvalent, but none of these had relieved the intolerable itching which spoils his sleep at night. As Sulphur had been given in his student days by Dr. Patrick with marked success in clearing up an eczematous outbreak, I started him on Morgan co. 12[1].

For four weeks there was no change; then a decided improvement for three weeks; then symptoms returned as severe as ever. I then advised examination of stools by Dr. Bach, the result being a 40% Gaertner. On December 13 I gave Gaertner 30[1], but in three months there was no improvement, so on March 25 I gave Gaertner 30 + 1 .d. [7]. I heard casually in April or May that he was a good deal better, and then silence. Wishing to know last month if his was a suitable case for inclusion in this paper, I wrote to him and will give you his reply in his own words: "I am delighted to report that the vaccine did me a world of good.

The tormenting itch disappeared in about a month and my rheumatic condition has been improved although I do get some trouble with my knees and elbows yet. I have not taken medicine of any kind since my plus doses. Occasionally I get some itch when undressing but nothing really to grieve about in comparison to what I had."

I have reported this case at length because I consider it will well repay study. To mention a single point, it demonstrates clearly the invaluable aid - maybe the absolute necessity - of plus dosage when the single dose fails, and yet there is no possible doubt of the correctness of the remedy.

[C. Gordon, *Auto-intoxication from the bowel and psora*, RefWorks]

(3) My first case is an interesting one as she has had homeopathic treatment since June, 1912. Miss M., a maiden lady of about 50, complained of constipation all her life; no power to expel the motion and a very loaded sensation in the rectum, and for some time she had had backache with bleeding piles. Examination revealed an induration in the sigmoid region, but at the time that was put down to impacted faeces. She said that since her teens she had



never been anything else but tired, and she looked it. Her face was expressionless and soft, with a muddy complexion. She was a woman without initiative, unable, from mental tiredness, to take an interest in anything that called for any exertion. Inertia was the one word to cover her condition. She had vertigo on looking down from a height, a lifelong symptom. Careful treatment relieved her symptoms, and remedies like Sulph., Calc., Sepia, and Silicea, in single dose up to the highest potencies, kept her going, but with no real, lasting, fundamental change. Latterly attacks of cystitis from March, 1919, to September, 1924, complicated and interfered with progress. Examination then revealed that her induration in the sigmoid was still present, and that it was affecting the bladder.

Over all these years of careful prescribing no real progress had been made. I came to the conclusion that the induration was malignant. It was then that I determined to use a single dose of Gaertner, and I gave her Gaertner 30 on October 2, 1924, and from that date to June, 1925, when she had a slight cold, she had no medicine. Her improvement was so striking on all points, both mentally and physically, that her friends could not help but remark. I can not describe it otherwise than to say that she bloomed. The muddiness of her skin cleared up completely. She became very much more vigorous, and was able to take an interest in things and did not feel tired. She said herself, "I have not felt so well since I was a girl." Her bowels acted regularly, her appetite was very much better, sleep was good, and there was no bladder trouble. Examination revealed no induration. For this slight cold in June she got Puls, with good effect.

There was no recurrence of the slightest tiredness until July, 1926, when she felt she was not quite so brisk and she got another dose of Gaertner 30. Since then she has gone straight ahead without interruption. This woman, who was always greatly disturbed by any little extra exertion, was able in July to consider a visit to Canada with enthusiasm, and the bustle of departure did not seem to tire, but rather to stimulate. She has kept up improvement and all reports are that "she never was better."

[T.M. Dishington, *The Autogenous Vaccines and their Relations to Chronic Disease*, RefWorks]

(4) Miss T., another maiden lady over 50, has had careful homeopathic prescribing since September 1919. For many years she had suffered from stomach disturbance with periods of pain coming on two to three hours after eating and with at times haematemesis. There was great weakness and

all her symptoms called for Phos. She got considerable comfort from Phos. which held her until December, 1920. Then during May, 1920, she was in hospital; the note of physical examination of the abdomen is recorded: "Tenderness on pressure to the right and at mid - line in region of umbilicus, where there is a feeling of induration on palpation." In June X-ray plates were taken and the report was: "Plates show band obstruction or tumour on right side outside the bowel near the flexure of the colon." Several attacks of bronchitis have complicated the difficulties. In July, 1921, she had a very bad left-sided pleurisy. In her acute illnesses, both pleurisy and bronchitis, she responded well to the remedies given, but the stomach condition was not improved. All the remedies that have been prescribed have acted well and held her for, in some cases quite long periods, but no remedy had any permanent effect.

There was a period of six months when she was not seen, but when she was seen again in September, 1924, her condition was very much worse. She had been having a very trying time with an invalid mother and her general condition was extremely poor. Her stomach was very bad; there was a good deal of pain and swelling of the epigastrium; great loss of appetite, and nausea after food; weakness was extreme; attacks of giddiness; good deal of retching and vomiting of bile and blood. Constant dull occipital headache, with pain above the right eye. Owing to her extreme weakness and emaciation she was put to bed, and remained in bed for nine months. Examination of the abdomen revealed a very large, irregular, nodular tumour in the epigastrium towards the right side. Her extreme emaciation made examination easy and the tumour visible. There was no doubt in my mind about malignancy; the prognosis was bad. Careful observations were made, but no remedy did more than relieve.

From November until February she had infrequent doses of Phos. in the plus up to the IM with great comfort, but no deep vital response. Between February and June her weakness was so great that at times I felt recovery to be impossible.

On June 7, 1925, Gaertner was given in the 30th potency, a daily dose to be taken plussed each time for seven days. Before the end of the month she was much better all over; much stronger, and for the first time she had been able to get up. She had no headaches and the bowels were moving daily; the stomach was very much better; her appetite had returned. In July she was up and going about and was able to go on holiday. She was very much stronger; the bowels continued to act well, and the stomach was good, and any discom-

fort that she had was slight. In September her improvement was still marked; she was having a stool every day, and there was very little discomfort: there was some return of giddiness and her old nervous symptoms. A dose of Gaertner 30 was repeated in the plus, a daily dose for seven days. On October 8, 1925, the note was that she was growing very much stronger; the bowels were acting very well; she was mentally stronger and able to sustain a good talk; able to be out, but not able to go far. At times there was tenderness of the stomach, with heat and burning no medicine was given. On November 6, 1925, she was feeling stronger and mentally had more grip; the bowels were still good; the mass in the epigastrium was tender to touch, but did not give any trouble. It was less irregular and less hard. Gaertner 30 plus a daily dose for three days was given.

By the end of the month her symptoms were Phos., and Phos. was given in the 30th potency plus a daily dose for seven days. Phos. was given in infrequent doses by the plus method until March 18, 1926, but then her case was retaken as symptoms had changed.

Mag. mur. 30 carried her till May 15, when Nat-c. was given with relief till November. In November the stomach was behaving well and the bowels were regular but she had gone back vitally. I then determined to go back to Gaertner, and gave her the 30th potency plus a daily dose for seven days. Her improvement was immediate and progressive, but was interrupted in December by a severe attack of tonsillitis, for which Arnica was given with very prompt effect.

In January, 1927, her case was retaken. Ever since June, 1925, when she got her Gaertner, all her symptoms had become much modified. Her nutrition was good; she had put on a good deal of weight, become much stronger, but symptoms still remained and some old symptoms that she had had in her early days had returned, all pointing unquestionably to Kali-c. She got Kali-

c. 30 plus a daily dose for seven days; this was repeated on February 25, 1927, for a recurrence of tenderness and discomfort in the stomach. She got immediate relief from Kali-c.

On March 29 she was examined all over. The tumour had practically disappeared; the mass was small and of a soft pulpiness; the nodular, irregular hardness had entirely gone. All her functions were good and any symptoms that she had were really of a rheumatic nature. She was well nourished. At the end of April she reported that she was getting on very well, and said, "Never since you have known me have I improved so fast; any little symptoms that I have trouble me but don't master me as they used to do." I am more than

satisfied that without the Gaertner she would not have recovered. Since April up to date her progress on all points has been constant. There is now no ill feeling when tired. On June, 20, 1927, examination disclosed no tumour, but some tenderness to pressure in pyloric region.

In this case I have used the plus method of giving the remedy; no potency has ever been repeated unchanged. Each dose has had a plus added to its potency by dilution and succussion - all according to my interpretation of Hahnemann's precept in the 6th edition of the "Organon." [T.M. Dishington]

(5) Mrs. E, aged 46, was seen on January 6, 1926, with scirrhus carcinoma of both breasts. For the last four years in the left breast there had been a knotted lump with a good deal of puckering involving the skin. Recently in the right breast there had appeared a large lump in the upper segment attached to the muscle with glands in the axilla, and a slight involvement of the skin. It was hard and nodular.

She was thin and lost a good deal of weight over the last few years. She had no symptoms, but any symptoms she had had in the last seemed to indicate Arsenic. I gave her a single dose of the 19m of Ars. After six weeks and no reaction I went carefully into her history and decided to give Graphites. A daily dose for seven days of the 30th of Graph, in the plus was given. There seemed to be a general good reaction from this - better in herself and had put on a little weight.

The bowels were more active. The effect on the tumours was slight, but if anything they seemed softer. Graph, was again administered in the 30 plus on April 14, and again another dose was taken on May 2 as she had gone off and her bowels were inactive. Graphites 200 single dose, was given on May 26 and again on July 14. Under Graph, she had altogether put on one pound and seven ounces in weight and looked better.

Her stools were examined and Gaertner was found. She got the vaccine 12c plus a daily dose for three days on July 23. On August 18 things were very much the same. There did not seem to be any reaction after the dose. The bowels had gone off a little and then she had had two severe headaches. The vaccine 30 plus, a daily dose, for three days was given with a very marked and immediate response. By September 8 she had put on 5 3/4 lbs. weight, was generally very well, the bowels very much more active, and had had no headaches.

A very tragic bereavement in October put her back for a time, but in six

weeks she lost only half a pound of the increase in weight. The vaccine plus a daily dose for seven days was given on October 26. On November 3, 1926, she was very well. The right tumour was decidedly softer, and the gland in the axilla had disappeared. The left was also softer; all functions were good. This case had been under the observation of the surgeon since the beginning of treatment, and in his remarks he notes "glands have disappeared from the axilla. The left tumour is very much the same, but is softer. She is undoubtedly very much better in her general health, and should an operation be ultimately decided upon, she will certainly stand it better than she would have done at the beginning."

When asked if he were satisfied that the tumours were both carcinomatous, he replied, "There is no doubt at all." "And are you quite sure about the improvement?" He said, "There is also no doubt."

By December 1, 1926, she had gained another pound and a half, and was generally very much better. Stools had been infrequent, but had become better again. On December 27 she had put on another pound weight. The right breast was less hard and not so defined at the edge. On January 26, 1927, symptoms of Graph, came out and she was given the IM, a single dose. Since that date she has gone on improving, putting on weight steadily, and is very much more vital. Both tumours are softer and much reduced. In June the bloom of health was obvious in a much clearer skin and a well-nourished body. The right tumour has reduced to quite half its original size and is much softer.

[T.M. Dishington]

(6) Miss M.L., aged 51, was first seen and treated homeopathically in 1918. From that date until December, 1926, she was under constant homeopathic treatment for chronic ulceration of the stomach with attacks of great pain with haematemesis. The pain was of a gnawing character, coming on before a meal, with relief from eating, and the bowels very constipated. She was thin and weakly, and there was a definite tenderness to the left side of the epigastrium with induration.

No remedy gave her more than temporary relief. On December 7, 1926, she was examined carefully and there was found an induration in the left hypochondrium stretching from under the ribs right down to the umbilicus, very markedly tender to pressure and irregular in outline. On December 24, 1926, she was given Gaertner 30 plus one dose daily for three days. On January 21, 1927, she still had pain in her stomach relieved from resting and

eating; the bowels were still inclined to be constipated. Her stools were examined and Gaertner was found. As her condition on March 23, 1927, was I.S.Q., [in status quo] the auto - vaccine of Gaertner was administered in the 12c potency plus, a daily dose for seven days. On May 5, 1927, she felt very much better and looked it, and the bowel action had been free and normal. Her vitality was obviously very much increased, and she said herself. "This is the best month I have had since the beginning of treatment. I am free of pain, and I am very much astonished at the regular action of my bowels." Up to date improvement continues, nutrition is much better, stomach is comfortable, and bowels continue active.

I have had a large number of Gaertner cases and in every one there was a definite vital reaction. In some no remedy was required, and in others clearcut symptoms with cancer, but the Gaertner bacillus is associated with the specific constitutional nidus that breeds malignancy. Proteus is also found in certain cancer cases. The constitutional factors are all important to the homeopathist.

[T.M. Dishington]

SALMONELLA PARATYPHI

| | |
|-----------------|---|
| Scientific name | Salmonella paratyphi (Kaiser 1902) Ezaki et al. 2000 |
| Old names | Bacterium paratyphi Kaiser 1902 Bacterium paratyphi typhus A Brion and Kaiser 1902 |
| Family | Enterobacteriaceae |
| Homeopathy | Paratyphoidinum A - Parat. Paratyphoidinum B - Parat-b. |

FEATURES

- Three serotypes: S. paratyphi A, B [= S. schottmuelleri] and C [= S. hirschfeldii]. Serotype B is most common, C is extremely rare.
- Causes enteric [paratyphoid] fever, identical to typhoid fever caused by S. typhi, though often less severe. Onset is abrupt.
- Continued fever, malaise, headache, anorexia, enlargement of spleen, bradycardia, rose spots on trunk [in approximately 25% of Caucasians], constipation is more common than diarrhoea in adults.
- Transmission by contaminated food, especially milk, milk products, and shellfish.
- Enteric fever should be considered in travellers returning from tropical and subtropical areas.

MATERIA MEDICA PARATYPHOIDINUM B

Parat-b.

Sources

Nosode prepared from cultures of Salmonella schottmuelleri [= S. paratyphi B]. No provings. Clinical pathogenesis by Julian.

SYMPTOMS

Mind

= Depressed state; pessimistic; sees the dark side of everything; the future is dark; fears a catastrophe.

== Intolerance noise.

Generals

a Recent or old history of a salmonella infection.

«Emaciation due to malassimilation [malnutrition]. Chronic state of marasmus following an old salmonella infection [typhoid or paratyphoid]. Dehydration.

« Evolution towards cancer [mesenchymoma].

= Intense fatigue & general perspiration. [But prolonged fever without perspiration.]

<= Frequent insomnia & loss of appetite and nausea.

= Shellfish poisoning.

<= Persistent low-grade fever.

Locals

= Intense, persistent headache, with or without vertigo, with or without epistaxis.

■> Stomatitis; aphthae; foul tongue.

- Herpes labialis.

«< Inflammation of salivary glands.

<= Pancreatitis.

= Enterocolitis. Summer enteritis. Haemorrhagic coloproctitis.

= Gastroenteritis after eating ice-cream and from shellfish.

= Gallbladder: colic or burning pain. Acute or chronic cholecystitis.

~ Obstinate constipation. Or diarrhoea in morning or after breakfast.

= Enlargement of liver and spleen.

= Cystitis and pyelocystitis & recurrent colibacillosis [diarrhoea caused by *E. coli*].

= Non-productive cough.

= Pulmonary congestion and bronchopneumonia appear and disappear rapidly.

= Phlebitis, insidious onset; especially of the lower limbs, of the left side.

= Hydrarthrosis [effusion of serous fluid into joint cavity] of the knees.

= Purulent arthritis of the knee.

= Spondylitis; discopathy.

= Articular rheumatism, wandering from joint to joint.

SALMONELLA TYPHI

| | |
|------------------------|---|
| Scientific name | Salmonella typhi (Schroeter 1886) Warren and Scott 1930 |
| Family | Enterobacteriaceae |
| Homeopathy | Eberthinum - Eberth. |

FEATURES

- Prototype *TYPHUS* - of Salmonella infections causing typhoid [enteric] fever. [Not to be confused with typhus. The latter group of diseases is caused by rickettsiae, obligate intracellular bacteria which require living cells for growth and which are transmitted by bites of infected arthropods, eg. ticks, lice, mites, fleas.]
 - [Typhus nosode]* -
 - Rickettsia* - transmitted in flea, lice, mites and tick bites.
 - Affinity: Brain*
- More frequently transmitted by water than by food in endemic areas where sanitary measures are generally inadequate.
- An estimated 16 million cases of typhoid fever and 600,000 deaths occur worldwide. The disease is endemic in many developing countries of the Indian subcontinent, South and Centri America, and Africa.
- Salmonella typhi, as opposed to other types of Salmonella, has no animal reservoir. It is strictly a human pathogen.
- Affinity: Small intestines,*

TYPHOID FEVER

DYSENTERY- [Dys Co] - In contrast to the abrupt onset of dysentery, typhoid fever begins usually gradually or insidiously, with chills, malaise and headache, followed by fever, abdominal pain, prostration, muscle weakness, joint pains, faintness, bouts of sweating, pharyngitis, anorexia, constipation, and/or thirst. Less common symptoms include restlessness, muscle twitching, drowsiness, herpes labialis, epistaxis, non-productive cough, and dysuria. A characteristic rash may appear during the second week of illness, consisting of crops of pink, slightly raised maculopapular lesions called "rose spots" that blanch with pressure, usually on the chest and abdomen. The spots resolve in 2 to 5 days.

The temperature rises in steps over 2 to 3 days, remains elevated [usually to 39.4 to 40° C] for another 10 to 14 days, begins to fall gradually at the end of the third week, and reaches normal levels during the fourth week.

Sustained fever is often accompanied by relative bradycardia and prostration.

CNS symptoms such as delirium, stupor, or coma occur in severe cases. Splenomegaly, leukopaenia, anaemia, liver function abnormalities, proteinuria, and a mild consumption coagulopathy are common. [Merck Manual]

Late in the disease, when intestinal lesions such as necrosis and haemorrhage are most prominent, and Salmonella spreads from the liver through the gallbladder and eventually back into the intestines, severe gastrointestinal symptoms including pea-soup-like diarrhoea occur. The stool may contain blood. Occasionally, localised infections such as arthritis, septic arthritis or Reiter's syndrome develop. Osteomyelitis affecting the long bones typically occurs in patients with sickle cell disease.

Following infection up to 5% of patients shed the bacteria in their stool for over 1 year. Such patients are termed chronic carriers and are asymptomatic; some have no history of clinical illness. Millions of viable bacteria are present in the biliary tree and are excreted into the bile and into the faeces. Most of the estimated 2000 carriers in the USA are elderly women with chronic biliary disease [“gallbladder carriers”]. Epidemiologic data indicate that typhoid carriers are more likely than the general population to acquire hepatobiliary cancer. The chronic carrier state is less important for other Salmonella species, where the carriage rate is less than 1%.

An accurate description of the course of typhoid fever is given by Raue:

The patient has generally several days previous to the attack a sense of general indisposition, weakness and debility, with headache, dizziness, soreness of the limbs, and sometimes repeated attacks of bleeding from the nose, or none at all. The attack itself begins almost always with a more or less violent chill, or repeated chilly sensations, but sometimes without a chill.

[From day 3 or 4 to day 10 or 11] the patient complains of great weakness and prostration, severe headache, dizziness, flickering before the eyes, and ringing in the ears; his sleep is restless and disturbed by tiresome dreams, sometimes of the same thing over and over again; he calls out in sleep or talks incoherently. When awake he is fully conscious but indifferent, answers questions slowly and reluctantly. His thirst is great, his appetite gone, and his taste pappy, disagreeable. The bowels are during the first days frequently constipated, but change towards the end of the first week to diarrhoea. There is in many cases repeated bleeding from the nose, and already at this time a catarrhal irritation of the chest. The face is flushed, especially the cheeks look dark red as long as the patient lies quietly on his back, but it turns pale and sunken when he sits up a while.

.....The abdomen at this time appears somewhat bloated and is sensitive to strong pressure. A deep pressure upon the ileo-caecal region may cause a gurgling noise in that region, especially if there be already diarrhoea present. The spleen is swollen. Finally, there appear toward the end of the first week, single, pale, reddish, lentil-sized roseola spots upon the epigastrium and adjacent parts of the chest and abdomen.

In the second week the temperature of the body ranges between 104° F and more. ... The dizziness increases, the ringing in the ears changes to hardness of hearing, which is generally dependent upon a catarrhal affection of the Eustachian tubes and tympanum. The expression of the face becomes more and more stupid, and the indifference of mind increases.

By and by the consciousness of the patient becomes clouded and he sinks gradually in a state of somnolence and stupor. Although the tongue is a dry as “chip,” yet he utters no desire for drink; takes it, however, when offered, very greedily. ... The patient lies always on his back, and having lost consciousness of all muscular power, the body follows its own weight and the patient slides gradually down in bed, without any effort of his own to change this position. The mental operations are still going on; we see it on the now and then trembling lips, as efforts to speak, and in the low murmuring of unintelligible words now and then. This is *febris nervosa stupida*.

Other patients, although likewise mentally disconnected with the exterior world, neither knowing nor understanding what is going on about them, manifest a vivid, dreamful perturbation of the mind. They are in constant agitation, throw off the covers, try to get out of bed and to escape, talk loud or lisp some unintelligible words, gesticulate and become angry when interfered with. ... This agitation of the mind is generally greatest during the night. This is *febris nervosa versatilis*.

During this week the bowels are almost always loose; the cheeks have a brownish-red or bluish colour; the eyelids are half closed; the conjunctiva is injected; the nose is thoroughly dry, and the nostrils are blackened as by soot. On the gums and teeth we observe sordes; the tongue is covered with a brownish crust, which gradually grows black from the mixture of blood; it is stiff, making swallowing quite difficult.

The third week does not bring any amelioration as yet. The prostration reaches, in this week, its climax; the patient slides down in bed; there is a constant jerking of the tendons; somnolence and stupor are complete, and stools and urine are passed unconsciously. This is, indeed, the week when the mortality of typhoid patients is the greatest, while in favourable cases its latter part is the turning point.

MATERIA MEDICA EBERTHINUM

Eberth.

Sources

Nosode prepared from cultured *Salmonella typhi*.

No provings.

Clinical pathogenesis by Julian.

The nosode gets its name from the German bacteriologist Karl Joseph Eberth [1835-1926], who in 1880 isolated the bacillus of typhoid fever. The organism was termed *Bacillus typhosus* or *Eberthella typhi*, until it was found to belong to the *Salmonella* group. [In English speaking countries the nosode may be referred to as *Typhoidinum* or *Typhinum* - in the second case below misspelled as *Typhlinum*. The latter name suggests a relationship with typhus instead of typhoid fever.]

SYMPTOMS

Generals

- Fever up to 40° C; dicrotic and dissociated pulse [pulse out of proportion to temperature].
- = Prostration; passivity; indifference to persons around him.
- = Collapse [cardiovascular].
- « Restlessness; burning thirst; deep-coloured urine.

Locals

- = Egg-shaped ulceration, superficial, painless, on the tonsil.
- = Spleen enlarged.
- => Rumbling in right iliac fossa.
- => Intestinal haemorrhage.
- = Ochre-coloured diarrhoea, abundant, fetid.
- ~ Suppuration of gallbladder; liver; pancreas.
- » Respiration adynamic.
- ~ Spondylitis. Periostitis.

Julian suggests as an indication for Eberthinum “all psychosomatic affections that date back to an old typhoid”

CASES

(1) Mme R. age 55 y, had always been in good health up to the age of 20 years, at which time she got typhoid fever. Since then she has never felt well again. She has intestinal problems and all the symptoms she relates lead me to the diagnosis of muco-membranous colitis, which was confirmed by other physicians. The least error in her diet or the least fatigue causes great aggravation, resulting in burning pains in the stomach, stomach cramps, and vomiting. The patient is emaciated, depressed, and has ptosis. All classical treatments have been tried.

All her complaints go without any doubt back to the typhoid fever. I prescribe *Eberthinum* IM.

Initially she has an aggravation, followed by an improvement of the general and local symptoms. Gradually she can tolerate all the foods that since years had to be abandoned. The stomach pains disappeared after three months. A second dose of *Eberthinum* IM was prescribed.

Improvement has gradually continued over the last six months. Perhaps the cure can be completed with remedies selected from the materia medica, although the indicated nosode has greatly shortened the time of cure.

[O.A. Julian, case published in Revue Beige d'Homoeopathie, 1953, No. 2]

(2) A married man, seventy years of age, came to my office April 22, 1949. He was tall, chilly, thin [weight 137], looked anaemic. Forty odd years before he had had attacks of what was then called "acute indigestion." Otherwise health was good until 38 years ago when he had typhoid fever. This attack was severe and he was long recovering; a sister died with it at that time.

Since then he has presented the following indefinite but deep-seated symptoms: Stomach tender to touch, pressure, jar of riding, etc.

After walking a short distance he must suddenly sit down wherever he is, cannot wait. There is no faintness or pain, just weakness, no staggering.

Time of almost blindness walking on the street, once so bad could hardly walk at all, no headache.

Spells of abnormal hunger, would eat heartily and in less than half an hour rush to the refrigerator and grab whatever he could reach.

Tendency to constipation; stomach attacks when constipated.

Desire for sweets, cheese. Aversion to meat.

Times when tongue coated and breath foul.

Typhoidinum IM given on that April 22^{n<^}.

May 3 - Reported feeling all right, symptoms gone, stools regular.

June 3 - Wouldn't be without those powders; stool every day, wonderful.

June 27 and July 19 - Same report.

Aug. 9 - Not so well, constipation returning, making him weak. *Typhlinum* IM.

No more direct reports but his daughter says he continues to feel fine, thinks homeopathy is marvellous. He has been made over like a new man.

[J.M. Green, *Results to Date in Using Dr. Tyler's Method with Nosoder*, Hom. Rec., Feb. 1951;

Encl.Hom. This same case has been reprinted in slightly different form in J.M. Green, *More Cases*, Hom. Rec., March 1954.]

SHIGELLA DYSENTERIAE

Scientific name *Shigella dysenteriae* (Shiga 1898) Castellani & Chalmers 1919

Old name *Bacillus dysenteriae* Shiga

Family Enterobacteriaceae

Homeopathy *Bacillus dysenteriae*. Dys-co. [bowel nosode] - Dys.

FEATURES

- Non-motile, facultative anaerobic, Gram-negative, rod-shaped bacterium.
- Closely related to *Escherichia coli*.
- By some scientists considered to be a strain of *E. coli*, but does not produce gas from carbohydrates [*E. coli* is aerogenic] and does not ferment lactose.
- Produces diarrhoea [bacillary dysentery or shigellosis] accompanied by fever [*E. coli* usually causes afebrile diarrhoea].
- Common cause of traveller's diarrhoea.
- Rarely causes extra-intestinal infections.
- Invasive.
- Some strains produce Shiga toxin.

SHIGELLOSIS

Named after the Japanese researcher Shiga, who isolated the organism in 1897, the genus *Shigella* is divided into 4 major species or subgroups, which are subdivided into serologically determined types. The members of this genus are pathogens and not part of the normal flora of humans or animals. *S. flexneri* [subgroup B] and *S. sonnei* [D] are more frequently isolated, accounting for about 90% of all isolations, than *S. boydii* [C] and the particularly virulent *S. dysenteriae* [A].

All of the species cause shigellosis, the incidence of which may show an increase beginning in May or June and a peak in September or October. The disease is less common in the winter.

Shigella accounts for 10-20% of all cases of diarrhoea worldwide, in any given year infecting over 140 million persons, with an estimated 600,000 fatalities, particularly among children and elderly people.

Shigellae are transmitted by means of personal contact, fomites, flies, and water, as well as by food. Epidemics occur most frequently in overcrowded

populations with poor hygiene and improper storage of food or whenever war or natural calamities [earthquakes, floods] result in overcrowding and poor sanitation. Only primates, no other animals, appear able to get bacillary dysentery and then apparently only in association with humans, not in the wild.

Shigellae may survive in alkaline faeces, but will perish - often in a few hours - when faeces becomes *acid* through growth of other bacteria. Longer survival often occurs at lower temperatures, even at 20° C below zero.

Shigellosis [bacillary or epidemic dysentery] differs from amoebic dysentery in rarely producing the extensive undermined ulcerations so characteristic of amoebic dysentery. Also very uncommon in the former are abscess of the liver and perforation of the bowel wall, both common in amoebic dysentery.

The incubation period is 1 to 4 days. In young children, onset is sudden, with fever, irritability or drowsiness, anorexia, nausea or vomiting, diarrhoea, abdominal pain and distension, and tenesmus. Within 3 days, blood, pus, and mucus appear in the stools. The number of stools generally increases rapidly to about 20/day, and weight loss and dehydration become severe. If untreated, a child may die in the first 12 days; if the child survives, acute symptoms subside by the second week.

Though adults may present without fever, with non-bloody and non-mucoid diarrhoea, and with little or no tenesmus, the onset of illness may be characterised by episodes of gripping abdominal pain, urgency to defecate, and passage of formed faeces initially, which temporarily relieves the pain. These episodes recur with increasing severity and frequency. Diarrhoea becomes marked, with soft or liquid stools containing mucus, pus, and often blood. Rectal prolapse and consequent faecal incontinence may result from severe tenesmus. The disease usually resolves spontaneously in adults; mild cases in 4 to 8 days, severe cases in 3 to 4 weeks. Significant dehydration and electrolyte loss with circulatory collapse and death is limited mainly to infants under 2 years of age and to debilitated adults.

S. dysenteriae infection may present with delirium, convulsions, and coma but little or no diarrhoea; it may be fatal in 12 to 24 hours.

Secondary bacterial infections may occur, especially in debilitated and dehydrated patients. Severe mucosal ulcerations may cause significant blood loss. Other complications are uncommon but include toxic neuritis, arthritis, myocarditis, and rarely, intestinal perforation. The haemolytic-uraemic syn-

DIFFERENTIATION:

Bacillary Dysentery:

Primates only.

overcrowding

poor hygiene

improper food storage

[war, earthquake, flood, refugee camps]

Less ulceration than

Amoebic dysentery which

has liver abscess and

perforation of bowel wall

drome may complicate shigellosis in children. Bacillary dysentery does not become chronic and is not an aetiologic factor in ulcerative colitis. However, patients with the HLA-B27 genotype probably have a significant association with arthritis or even full-blown Reiter's syndrome following shigellosis.

[Merck Manual]

Reiter's syndrome involves the triad of conjunctivitis [eye pain and redness] arthritis, and urethritis, for which Medorrhinum is thought to be a specific remedy homeopathically. The syndrome occurs most commonly in men aged 20-40 years and appears 2-4 weeks after the *Shigella* infection [in particular *S. flexneri*]. The arthritis is asymmetrical and can be chronic and relapsing.

Bennish et al. have reviewed the total number of admissions and deaths of patients with shigellosis in Bangladesh over the period 1974-1988. They conclude:

Of 9780 *Shigella*-infected inpatients, 889 [9.1%] died; 32.3% of deaths occurred in children less than 1 year of age. Fatality rates were highest [10.3%] in *Shigella sonnei*-infected patients and lowest [6.7%] in *Shigella dysenteriae* type 1-infected patients. Age less than 1 year, lack of breast feeding in patients 1-2 years of age, hypothermia, severe malnutrition, severe dehydration, altered consciousness, abdominal distension, thrombocytopenia, hypoproteinemia, hyponatremia, hypoglycaemia, renal failure, and bacteraemia were all significantly more common in case patients. In a multivariate analysis, younger age, decreased serum protein, altered consciousness, and thrombocytopenia were predictive of death.

[Bennish et al. *Death in Shigellosis: incidence and risk factors in hospitalized patients*-, Journal Infect. Diseases, March 1990]

Cats injected with shiga toxin show behavioural changes which resemble those produced by intraventricular administration of 5-hydroxytryptamine [serotonin]. After a latency period of several hours, cats become quiet and hesitant, they stay within an opened cage, and invariably return to it when taken out. Even after a dose of 1 mcg, a gradual impairment of co-ordination, rapid respiration, trembling, perseverance in bizarre positions, convulsions, and death were observed. In laboratory animals, glycogen depletion in the liver and hyperglycaemia occurs as early as one hour after shiga toxin administration. [Raskova]

MATERIA MEDICA BACILLUS DYSENTERIAE

Dys.

Sources

“Proving in the usual sense, that is experiment on the healthy human, had not been made, so the symptom picture was not available. In order to obtain a picture of each nosode, notes were kept of symptoms appearing or cured when the corresponding organism was found in the stool.” [Paterson]

- 1) R.E.S. Hayes, *Dysentery Compound-*, observations based on 88 cured cases; Hom. Rec., Oct. 1940.
- 2) T.M. Dishington, *Pathogenesis of Dysentery Co.*; RefWbrks.

SYMPTOMS

MIND

Fears

- » Strangers [= shyness and uneasiness].
- «Going out, public places, new doctors, meeting unknown persons [yet desire to wander].
- = Being alone.
- «= Dark.
- = Thunderstorm.
- = Claustrophobia [church; lift; office; theatre; train; aeroplane; bus; tram],
- = Future.
- «»Anxiety felt in epigastrium; extends from stomach to head; = palpitations.
- « Fear = gastrointestinal problems / urging to urinate or to stool.
- = Excitement/emotions = congestion of head; headache; nausea; diarrhoea; stammering; urticaria; trembling; perspiration; exhaustion.

Keynotes

- « Nervous tension
- « Apprehensive
- = Blushing
- = Nervous embarrassment
- Twitching, restlessness
- = Fear/Anxiety if anything is asked or expected of them
- ~ Sinking/electric shock sensations
- ~ Stomach/abdomen/heart

Nervous tension

Paterson suggests “nervous tension” as a keynote for Dys. co. Searching for this identifying factor all through the clinical provings “will help you to understand the pathogenesis of the symptoms.”

The Dys. co. child is of hypersensitive nature, which expresses itself as shyness or timidity, and you cannot fail to note this in the typical facies of the child. In the presence of strangers the whole attitude of the child expresses the nerve tension felt within, and you will observe the tenseness of the facial expression, which is not altogether an expression of fear, but more an expression of an alertness - a tuning up of the nerve centres to full pitch of expectancy to enable an immediate response to be made on the reception of the slightest external stimulus.

Headache, frontal over the eyes, or in vertex, brought on by excitement; often occurs at regular time periods of 7 or 14 days' cycle. Duodenal ulcer often calls for the use of the nosode *Dysentery co.*

For example, if you address the child or make a complimentary remark there will appear almost immediately a blushing of the skin - which is the more noticeable because of the peculiarly white background of the rest of the skin area. The instability of the capillary circulation under the influence of the sympathetic nervous system is a characteristic you must remember in the clinical proving of Dys. co.

If you continue your observation - that is keep the child under tension - you may note the fibrillary muscular twitchings of the face or limbs which would suggest to your mind the symptom complex so common in the child, namely St. Vitus dance [chorea].

[W.B. Griggs, *Thirty Years of Clinical Research and Confirmation of the Intestinal Nosode Dysentery Co.*, Journal of the American Institute of Homeopathy, Vol. 59, Nos. 7-8, July-August 1966]

The dysentery patients are in a highly strung, tense state of mind and body, and very sensitive to all impressions. They are easily excited and flustered, lack self-confidence and are full of worries about little things and the anticipating fear of difficulties that might arise. The facial expression depicts the anxiety. Later, the pallor and flabbiness tell their weakness and the lines are the record of the strain that life has become. Fear of the future is their bugbear. They carry a load that they need not carry, and those likely to develop Dys. co. symptoms are the hypersensitive souls that are burdened with over-conscien-

tiousness. They are shy and lack initiative; feeble in effort, cannot sustain a course, are easily deflected and have little power of concentration. In children this diffuse mentality is frequent. 'Feels miserable from the fear that she cannot accomplish what she has to do,' is the reason for the impatience and hurry that is so frequently seen in *Dys. co.* patients. This leads to constant tension and they lose the power to relax, and even in their recreation there is bustle and feverishness. The restless desire to go from place to place, to go out, and then when out to get back home again, is a mental found in Tuberculinum.

It has several times occurred in dysentery patients, and been removed by *Dys. co.* Fear has come out in both children and adults. Fear of the future, fear of the dark, fear of thunder and storms, and fear of being alone. A patient expressed himself thus: 'I desire to be left to my self but have a fear of being alone.' It is not surprising that brain fag comes on. 'Loses train of ideas from interruption.' 'Forgets what he was going to say.' 'Forgets what she went for.'²

Nervousness manifested by physical restlessness, fidgets, facial tics, restless hands, twitching, or choreic movements of limbs.

The keynote for *Dysentery co* is apprehension, but that understates the case, as it is actually stronger than apprehension, more like terror. Apprehension is what the textbooks say, but this is almost a certainty that something is going to go wrong.

... *Dysentery co* patients feel as if everything they do is wrong and is going to go even more wrong. They are hypersensitive to all criticism. It can come from really small things. When you are dealing with someone who needs *Dysentery co* you have to walk on eggshells the whole time because everything that you say is taken as an indication of how awful they are.

... They have to plan ahead to try and cover all eventualities. They are easily flustered: if you ask them to do two things at once, it's totally impossible. ... They get flustered if someone interrupts them and then they can't possibly get back to what they were saying before you interrupted the stream and they don't have any reference point to get back to where they were, so they lose it. They feel aversion to strangers, and worry in case they might be murderers or rapists, but also fear the stranger might talk to them or that they will say something wrong in talking to the stranger! ... Very modest, these patients blush easily and use baby words to denote bodily functions. They blush if they see someone breast-feeding; have to walk out of the room if they see a couple on TV having sex. There are so many challenges; they can't relax, because so many

things are asked of them during the day.

... When they do produce something it is usually good because they are quite creative; they are talented, but they can't bear to be interrupted. ... There is a tubercular desire to move or travel, maybe a way to escape creditors and challenges. The individual can't cope with things that are demanded of

*DYSCO Nervous
tension. Anxiety:
anticipatory, nervous,
restless, apprehensive.
Nausea I Diarrhoea
from anxieties;
excitement Fears:
something will go
wrong; dark; storms;
alone. Loses train of
thought from
interruption. 'Heart
nosode'*

them, so they move on. If they stay in one place, people get used to them and ask them things. If you keep moving, you stay hidden. That's the lesser of the two evils. The physical restlessness goes with that, too. ... They are easily thrown into weariness and depression.

If they actually give off some energy, they have to sleep a lot to get it back. You will usually find that *Dysentery co* patients spend lots of time in bed resting or sleeping. ... *Dysentery co* is a very good remedy for postnatal depression. These women are in state of change, not getting the sleep they were used to, and their energy is depleted, so it's not surprising that they are depressed. This applies to everybody but doubly so to *Dysentery co*, because they have so few resources to spare. Of course they are also worried that they are going to do harm to the baby by not being able to do everything right. You have never seen so many baby books as a *Dysentery co* patient will

have. Then of course they read all these baby books which don't all say the same thing, so they panic wondering which advice to follow. ... Anything is an ordeal; anything that the rest of us could smile at may be a worry for them. ... They panic about what they have done and they panic about what they have got to do tomorrow. The sign on the door says, "If all else fails, panic."

[Anthony Bickley, *The Bowel Nosodes*-, The American Homeopath, Vol. 9 - 2003]

Depression & Anxiety

Depression comes on from tiredness from the constant tension and from a sense of failure to accomplish; when spirits are low there is a desire to be left alone and indulge in tears. Consolation aggravates the weeping and brings out the irritability. They feel unsociable and have an aversion to meeting strangers, not only because of the depression, but because of the strain that talking to people involves. Patients have expressed that the least excitement exhausts them and brings on their worst symptoms.

A constant symptom is anxiety and excitement felt in epigastrium and in a great number of cases 'nausea from excitement' and 'diarrhoea from excitement.' Excitement, anxiety, or any agitation causes palpitation, flushings and

perspiration and at times breathlessness and even pain in cardiac region. Sleeplessness, trembling weakness and in some cases a 'sinking dying-like sensation.' Late in falling asleep from crowding of thoughts and from excitement and from palpitation are frequent symptoms. Sudden shocks through the body on falling asleep and awakening with fear and palpitation and breathlessness have repeatedly occurred.

The general aggravation period that has come out is from 3 a.m. to 6 a.m. Altogether like Kali carb., yet Dys. co has completely removed where Kali carb. has only palliated. When Kali carb. is the simillimum there is no need for Dys. co. Dys. co has a nature of its own and peculiar symptoms not found in Kali carb.²

Weeping¹

<> Weeping before menstruation.

= Weeping easily.

= Tries to weep because it relieves.

= Has to "weep it out" after any bad news.

= Weeping even when looked at, doesn't know why.

GENERALS

~ Chilliness; desire for warmth, yet easily heated up by exertion and in warm rooms.²

= Perspires easily but chills down rapidly.²

« Better in general in open air.¹

= Feels < during hot weather but the evening air chills.¹

«• Wants air and space.²

= Desire for cheese; sweets; cold, tasty things.¹

= Sleeplessness after eating hurriedly or too much.¹

« Faint spells [frequent with this remedy]. Faint spells after dinner. Faintness with darkened vision. Faintness from hot weather. Weak spells from any extra [home] work.¹

» Restless; wants to travel or keep going.¹

GASTROINTESTINAL

“More often than otherwise the Dysentery patient will complain about abdominal or stomach symptoms and next probably, heart sensations.”¹

Dys. co. is rich in gastrointestinal symptoms. Appetite as a rule is poor in the morning. The stomach symptoms are those associated with hypotonic stomach and conditions that lead to duodenal ulceration. Delayed digestion with ‘pain > eating,’ ‘heartburn some hours after food.’ Acrid vomiting burning up throat. ‘Bilious vomitings.’ There is a ‘thirst and desire for cold drink but stomach worse afterwards.’ ‘Sinking emptiness during day with relief from rest and food.’ ‘Pain as a rule relieved by lying down.’

Any mental strain reacts on stomach and aggravates the stomach stasis. ‘Excited feeling in stomach when acidity is at its worst.’ There is both constipation and diarrhoea, loose morning diarrhoeic stools forcibly expelled and ‘acid and burning.’ Diarrhoea may alternate with constipation. When constipation is present there is a weight and fulness in the hypogastrium. Piles and anal fissures are common and the piles come down when walking. There is weak expulsion of hard knotted stools with mucous.²

CIRCULATORY

<■ Dys. co. has a selective action on the cardiac muscle.

Functional disturbance of heart action, associated with nerve tension.

In the adult many symptoms of cardiac disorder.

The characteristic mental tensions are present.

= Tachycardia, palpitations, extra systoles.

= Palpitations before important events.

= Anticipatory discomfort in the cardiac area.

= The heart rate is fast and may be irregular.

= The limbs get cold and bluish and perspire.

= Feels heart skip and flutter when ascending stairs, turning in bed or walking fast; with desire to sigh.¹

« Palpitation on waking in the morning.¹

= Palpitation like a dull tapping on centre of sternum.¹

= Weak sensation at heart.¹

= Pain and soreness inside as of the heart and a smarting through left chest extending to the arm, > belching gas, with a band sensation hindering

respiration.¹

= Palpitation & heat of face and choking in throat < excitement; with slight cardiac pains.¹

» Heart pounds in ears during weak spells.¹

~ *Nervous tension / anxiety / fear* “hits” the stomach [and heart] area.

The mental aberrations and nervous symptoms are distinct and are frequently found in this age of strenuous living, and are just those symptoms that precede and are associated with myocardial and circulatory disease. Dys. co. might be termed *the heart nosode*, not indicated because of the presence of valvular disease, but for those symptoms of distress [mental and physical], the predicate failure of the heart to respond to normal efforts.

Many cases of heart inefficiency have been cured by Dys. co. when the history and peculiar mental and physical symptoms have agreed with the symptoms found in the pathogenesis of the dysentery group. It is not debated that disturbed function precedes organic changes in the organs, and therefore the symptoms of disordered metabolism which are first most clearly seen in the change from the normal mental disposition are the essential symptoms not only of the early beginnings of disease process, which eventuate in gross pathological lesions, but are in themselves the essential guides to the curative remedy.

... Dys. co. affects the venous circulation. Walls of veins get thin and veins dilated. There is a stasis of abdominal circulation and varicose veins of the leg are frequent. A very constant symptom is ‘bruises very easily’ and ‘bleeds easily.’

... Very early in our observations, dysentery was associated with the disturbance of the circulation and the distress most commonly found in myocardial disease. The failure of the heart to stand up to effort with the usual symptoms of tightness across the chest, pain in the chest going down arm - mostly the left - breathlessness and palpitation and oedema of the feet and legs was a frequent observation. Dys. co. in many cases has given amazing relief, and has led to normal functioning in all the organs. Tachycardia and arrhythmia and the sinking death-like sensation, so commonly associated with the proving of *Digitalis* have yielded to Dys. co. Knowledge and confidence are begotten of experience. When the symptoms agree, the symptoms of heart failure are among the first to be relieved, provided pathological changes are not so gross as to obstruct the recuperative effort induced by the remedy.²

LOCALS

= Vertigo felt in the eyes, < opening them.¹

= Vertigo at menstruation time.¹

= Acne [face] from eating candy.¹

= Puffy over lids before menses.¹

« Respiration smothered, catching of breath, on falling asleep, < after 4 a.m.¹ «
Dreams she cannot breathe, wakes suffocated.¹

Associated remedies

Anacardium. Argentum nitricum. *Arsenicum album*. Cadmium. Kalmia. Veratrum album. Veratrum viride.

CASES

(1) E W. H., aged 35, came last November and said that he had had postnasal catarrh for many years, and that for the last two years it had been causing dyspnoea. There was evidence of gastrointestinal disturbance in the following symptoms: Digestion failed unless he was working hard [he is a market-gardener]. He had a craving for sweets, and formerly had been, as he expressed it, a glutton for sugar. He had marked aversion to fat, vinegar, rich things, pastry and eggs. I gave Natrum mur. but without success; in April he reported nervous exhaustion, irritability from slight causes, depression and aggravation from cold or wet weather. I then gave Dys. co. 12, which caused a severe aggravation for the first ten days, followed by four months' steady improvement. His September report was not so good, so I gave Dys, co. 18.

[C. Gordon, *Auto-intoxication from the bowel and Psora-*, RefWorks]

(2) When an eczema comes that appears like the Graphites condition, yellow, scaly, powdery, sticky yellow discharge, deep painful cracks, compare Dysentery comp. Here is an instance: man, dorsa of hands; had been rayed and had had other topical attentions, four years duration, no occupational causation. Graphites, Tuberculinum, Manganum aceticum and Graphites again helped temporarily but Dysentery comp. 1000, d.u., cured not only the hands but also radically improved the vitality.

The symptoms upon which I selected it were the appearance of the eruption, pain in the hands preventing sleep; if a finger is hit a little, the pain "hits the

heart”; the whole condition worse in damp weather, especially snow air and winter dampness; and rapid weakness after the second reaction from Graphites. He gets a bad taste four of five hours after eating; sluggish, lazy gait, so unlike him, feels all run down, drowsy and dazed. Suddenly tired while working. Rapid onset of weakness following the Graphites amelioration and his phrase “hits the heart” were what turned my attention to Dysentery. Sudden faintness or weakness is often observed with Dysentery conditions; and an apparent Sulphur syndrome often needs comparison with Dysentery. [R.E.S. Hayes, *Outside the Routine*-, Homoeopathic Recorder, April 1939; Enc.Hom.]

(3) Roger C. - Age 12-1 was called to see this young chap who was suffering rheumatic pains in the joints of his upper extremities. His temperature was 103° F. and he had pain on the least movement of the limbs. I gave him *Bryonia*, which brought temporary relief. Then the pains all descended down through the lower extremities with some pain in the chest. I then prescribed *Kalmia lat.* In 48 hours all pain in the extremities was completely dissipated, but he complained of pain over the cardiac region. Upon careful examination, I diagnosed a soft systolic murmur over the mitral area; we were dealing with an acute rheumatic endocarditis.

Observing the child’s anxiety and nerve tension about himself, I prescribed *Dysentery co.* Under the influence of this nosode, his temperature came down, the cardiac pain was relieved, and the murmur completely disappeared at the end of two weeks. This demonstrated the curative effect of this particular nosode in rheumatic endocarditis. This boy continued to improve physically and was pronounced by a prominent cardiologist fit to go into athletics.

[W.B. Griggs, *Thirty Years of Clinical Research and Confirmation of the Intestinal Nosode Dysentery Co.*-, Journal of the American Institute of Homeopathy, Vol. 59, Nos. 7-8, July- August 1966]

YERSINIA

GENUS

- Gram-negative, rod-shaped, anaerobic, facultative anaerobic bacteria.
- Pleomorphous: may appear as elongated rods or as diplococci.
- Motile when isolated from the environment, become non-motile in mammalian host.
- Some of the 11 species now comprised in the genus were formerly placed in the related genus *Pasteurella*, named after the French bacteriologist Louis Pasteur [1822-1895].
- The genus received its name in honour of Alexandre Yersin, a Swiss student of Pasteur, who discovered the plague bacterium [*Y. pestis*] in the summer of 1894 during an epidemic then raging in Hong Kong. The discovery of the bacterium has also been credited to the Japanese bacteriologist Shibasaburo Kitasato [1852-1931], a student of Robert Koch. Having arrived shortly before Yersin, Kitasato soon found a bacillus, a discovery published in *The Lancet* of August 13, 1894. Kitasato's bacillus turned out to be a Gram-positive coccus, so that it is now agreed that Yersin and not Kitasato was the discoverer of the plague bacillus. Postulated by Yersin in 1894, the connection of plague with rats and fleas was demonstrated by Haffkine some twenty years later.
- Three species are deemed potentially pathogenic to humans. *Y. enterocolitica* and *Y. pseudotuberculosis* are both associated with foodborne gastro-enteritis, whilst *Y. pestis* causes the plague, entering humans by routes other than food.

YERSINIOSIS

A collective term for yersinia infections, yersiniosis is usually associated with one species, *Y. enterocolitica*, a ubiquitous species isolated frequently from soil, water, animals, and a variety of foods.

Yersinia enterocolitica

Y. enterocolitica is the fourth most common bacterium isolated from patients' faecal specimens, trailing *Salmonella* [the most frequently isolated], *Campylobacter*, and *Shigella* species.

Common symptoms in young children include fever, anorexia, abdominal

pain, vomiting, and watery diarrhoea, which is often bloody. Symptoms may last for 1 to 3 weeks or longer, although chronic cases may persist for up to a year. During the illness the bacteria are excreted in the faeces; excretion of bacteria can continue for 2 to 3 months.

Older children and adults may present with right-sided abdominal pain [right lower quadrant] and fever [which may be confused with appendicitis] and/or mesenteric lymphadenitis. Occasionally complications occur including skin rash, erythema nodosum, cutaneous ulceration, arthritis, hepato-splenic abscesses, osteomyelitis, or bacteraemia. Those with iron overload [eg, haemochromatosis] or the immunocompromised are predisposed to the septicæmic form of disease.

Yersiniosis has been misdiagnosed as Crohn's disease as well as appendicitis, resulting in the performance of unnecessary appendectomies as a "major complication." The Centers for Disease Control and Prevention [CDC] estimates that about 17,000 cases occur annually in the USA. It is a far more common disease in Northern Europe, Scandinavia, and Japan. In Europe, yersiniosis is more common in the cooler months than in warmer weather. The major reservoir for *Y. enterocolitica* is pigs, in which the bacteria are most likely to be found on the tonsils. *Y. enterocolitica* infection is an occupational risk of pork butchers in Europe. Strains of the organism can also be found in other meats [beef, lamb], oysters, fish, and raw milk. Some strains of *Y. enterocolitica* produce an in vitro heat-stable enterotoxin that is very similar to the enterotoxin produced by *Escherichia coli*. In vivo, however, the compound is only produced at temperatures below 30° C. Its role in yersiniosis remains uncertain.

Both species are motile at 25°C and non-motile at 37°C.

Although *Y. enterocolitica* is often isolated from clinical specimens such as wounds, faeces, sputum and mesenteric lymph nodes, it is thought not to be part of the normal human flora.

In Scandinavia, the incidence of reactive arthritis following *Y. enterocolitica* infection among adults is estimated to be at least 10%. About 80% of these patients have preceding symptoms such as fever, diarrhoea, or abdominal pain. Typically, these symptoms precede the arthritis by 1 week and are of short duration. The most commonly affected joints are the knees and ankles, but other joints can be involved. Typically, multiple [two to eight] joints become involved sequentially and asymmetrically over a period of a few days to 2 weeks, after which no additional joints are affected. Monoarticular arthritis occurs less

commonly. In two-thirds of cases, the acute arthritis remits spontaneously within 1 to 3 months. Chronic joint disease is documented in a minority of cases. A few HLA-B27-positive patients with *Y. enterocolitica*-induced arthritis have subsequent ankylosing spondylitis, but this development is best explained by the fact that HLA-B27 is a major risk factor for each of these diseases. Mild, self-limited myocarditis accompanies about 10% of cases of *Yersinia*-induced arthritis and can occur independently. Typical manifestations include cardiac murmurs and transient electrocardiographic abnormalities, such as prolongation of the PR interval and non-specific ST-segment and T-wave changes. The syndrome of *Yersinia*-induced arthritis and carditis can be confused with acute rheumatic fever. In Scandinavia, erythema nodosum occurs in 15 to 20% of patients with yersiniosis, usually within a few days to 3 weeks after the onset of intestinal illness. Lesions typically are located on the lower extremities and resolve within 1 month. Less commonly reported non-suppurative sequelae of *Y. enterocolitica* infections include reactive uveitis, iritis, conjunctivitis, urethritis, and glomerulonephritis. The complete triad of Reiter's syndrome [arthritis, conjunctivitis, and urethritis] is seen in 5 to 10% of patients with *Yersinia*-induced arthritis.

[G.L. Campbell & D.T. Dennis, *Plague and other Yersinia Infections*-, McGraw-Hill Companies, 2001]

***Yersinia pseudotuberculosis* (Pfeiffer 1889) Smith & Thai 1965**

First described in 1889 by Pfeiffer, who reported cases of so-called pseudo-tuberculosis occurring in guinea pigs, and characterised by the formation of cellular nodules in the liver and kidneys much resembling miliary tubercles.

*YERSINIA PSEUDO-
TUBERCULOSIS*
VECTOR *birds rodents*
small mammals

The organism is widely spread among many species of avian and mammalian hosts, particularly rodents and other small mammals. Most cases of infection occur in the winter season because of the enhanced growth characteristics in cold temperatures. Both *Y. enterocolitica* and *Y. pseudotuberculosis* can

survive and even grow at refrigeration temperature, hence may be present in contaminated refrigerated food.

The Far East scarlatinoid fever was first described in the context of *Y. pseudotuberculosis* infection. A scarlatinoid-appearing rash involving the head and neck, upper and lower extremity erythema, mucous membrane enanthem, and strawberry tongue characterise this syndrome.

Y. pseudotuberculosis shows a predilection for males, although the post-infectious complications of erythema nodosum and arthritis are more common in females.

The most common clinical presentation of *Y. pseudotuberculosis* infection is fever and abdominal pain caused by mesenteric adenitis; diarrhoeal illness is less common than in *Y. enterocolitica* infection. Systemic manifestations, including septicaemia, focal infections, reactive arthritis, and erythema nodosum, are generally similar to those associated with *Y. enterocolitica* infection. In addition, *Y. pseudotuberculosis* has been associated with a scarlet fever-like syndrome, acute interstitial nephritis, and haemolytic-uremic syndrome. [Campbell & Dennis]

Physical findings may be grouped into three main categories, systemic, enteric, and rheumatological. The predominant and often self-limited presentation is that of a febrile gastroenteritis with right lower quadrant abdominal pain.

Systemic findings may include fever, skin rash, strawberry tongue, hypotension, and lymphadenopathy.

Enteric findings include abdominal tenderness with or without rebound indicative of peritoneal involvement. Tenderness may be exquisite over McBurney point [point where pressure elicits tenderness in appendicitis].

Rheumatologic involvement may include joint effusion, tenderness, or decreased range of movement and may be asymmetric in distribution.

Erythema nodosum lesions [often erythematous indurated tender areas on the anterior surface of the lower extremities] also may be found.

Ophthalmic findings including uveitis and conjunctivitis also have been reported.

[[^]sim]ani,*Pseudotuberculosis*[*Yersinia*]; at: www.emedicine.com/med/topic1947.htm]

YERSINIA PESTIS

| | |
|------------------------|---|
| Scientific name | <i>Yersinia pestis</i> (Lehmann & Neumann 1896) van Loghem 1944 |
| Old name | <i>Bacillus pestis bubonicae</i> |
| Family | Enterobacteriaceae |
| Homeopathy | Pestinum - Pest. Serum yersiniaie - Yers. |

FEATURES

- Gram-negative bacillus, quite variable in appearance, but usually short and thick [“cocco-bacillus”], and not infrequently occurring in chains of four or six or even more.
- Called “bipolar” because it doesn’t stain uniformly, being darker at the ends than at the centre.
- Has its primary reservoir among rodent populations, such as rats, mice and squirrels, and transmitted by infected fleas.
- The death of its natural host pressures the flea to seek other mammals. It begins a blood-sucking rampage to overcome starvation, inoculating into the human victim’s skin up to 24,000 bacilli, which have proliferated in the flea’s foregut and are regurgitated into the bite wound.
- The bacilli are not virulent in their alternate host, the flea, because fleas have a body temperature near 25° C, which is too low to trigger production by the bacterium of two anti-phagocytic compounds required for virulence. These compounds are only produced when *Y. pestis* grows at 37° C.
- Dogs and cats may carry the rodent flea. Dogs are generally resistant to plague, in contrast to cats, which can develop any of the three forms of plague and have a mortality rate of 50%.

BLACK DEATH

Clinical manifestations

In human populations three forms of plague occur:

bubonic plague, which is principally mediated by fleas;

primary pneumonic plague, airborne by contaminated respiratory droplets;

septicaemic plague, primary blood-borne plague, characterised by ‘blood poisoning’.

All forms develop very rapidly and have a high mortality. In reference to the virulence of the disease, Boccaccio [1313-1375] wrote in his *Decameron* that “many valiant men and many fair ladies breakfasted with their kinsfolk and the same night supped with their ancestors in the other world.” [The *Decameron* is a collection of 100 tales related in 10 days by a group of 10 young men and women who had fled Florence to escape the plague.]

The bubonic form was named after buboes [inflamed, necrotic, and haemorrhagic lymph nodes] which first become visible during, or shortly after, the fever. Spread occurs along the lymphatic channels toward the thoracic duct, with eventual seeding of the vasculature. Bacteraemia and septicaemia ensue. The bacillus potentially seeds every organ, including the lungs, liver, spleen, kidneys, and, in 6-7% of cases, the meninges. Spots appear on the skin which are red at first and then turn black; hence the name Black Death. Restlessness, delirium, and finally coma and death generally follow.

The plague throughout history

The probably oldest reference to bubonic plague, originating from circa 1320 BC, is recorded in the biblical book of I Samuel: “The Lord’s hand was heavy upon the people of Ashdod and its vicinity; he brought devastation upon them and afflicted them with tumours. And rats appeared in their land, and death and destruction were throughout the city. ... The Lord’s hand was against that city, throwing it into a great panic. He afflicted the people of the city, both young and old, with an outbreak of tumours in the groin.”

In the year 68 AD endemic bubonic plague occurred in Rome, eleven years later followed by a second episode. In 125 AD and again in 164 AD the disease raged, and after the latter date continued without interruption for sixteen years, threatening to exterminate the Roman army. After appearing as the Plague of Justinian in 542-43 AD, plague ravaged the known world over a 50-year period causing an estimated 100 million deaths. The Black Death or Great Pestilence hit Europe with full force some eight centuries later. When in 1346 a new route for overland trade with China had provided rapid transit for flea-infested furs from plague-ridden areas of Central Asia, the disease wiped out one-third of the European population in a 5-year period, with death tolls ranging up to 70% in some cities. The pestilence returned

YERSINIA PESTIS

RESERVOIR

Rodents: rats, mice, squirrels.

Dogs and cats.

VECTOR

Flea living on the animal. The bacillus lives in the flea’s gut and is regurgitated when the flea bites its host. Whereas the rodent and the dog are resistant, the cat and the human are not.

at least once every 8 years over the next three-quarters of a century, in all wiping out some 75% of the population. In winter the disease seemed to disappear, because fleas are dormant then. Relatively humid and warm weather provided ideal conditions for them to breed and flourish, so that the months between May and October normally nurtured optimum infestation.

In general plague spread by routes where trade and traffic were most active. After 1352 smaller outbreaks kept on appearing until 1720, with a final foray into Marseilles. In London the plague had existed from 1349. It reached its height in the great epidemic of 1665. Tens of thousands of cats and dogs, allegedly the carriers of the disease, were killed. With their natural enemies away the rats could play, spreading the germs more rapidly. What men unknowingly had encouraged, the great fire of London corrected in 1666: it destroyed the infected rats and brought a definite end to the already declining Black Death in England.

The last pandemic arose in 1894 in China and spread throughout the world via modern transportation. It arrived in Bombay in 1898, and during the next 50 years, more than 13 million Indians died of plague. Plague entered Vietnam in 1898 and several pneumonic epidemics have occurred since, the last one in 1941. During the Vietnam War, plague was endemic among the native population, but U.S. soldiers escaped relatively unaffected owing to the use of plague vaccine and antibiotics. On the islands of Hawaii and Maui endemic plague became established since December 1899. In

Extract from Psalm 38:

*My wounds stink
and are corrupt,*

*My loins are filled with
burning and there is no
soundness in my flesh.*

I am faint and

sore and bruised.

*My lovers and my
friends stand aloof from
my plague..*

And my kinsmen stand

far off.

the north-east Chinese region of Manchuria a pneumonic plague epidemic caused 50,000 deaths in 1910-1911.

The disease officially arrived in the United States [San Francisco] in March 1900, to appear the same year in New York and Washington D.C. Epidemics occurred in San Francisco during the years 1900-1904 [118 deaths] and 1907-1908 [78 deaths], and in Los Angeles in 1924-1925.

After 1920 the spread of plague has been largely halted by international regulations that mandate control of rats in harbours and inspection and rat-proofing of ships. Because of its pandemic history, plague is one of three quarantinable diseases subject to international health regulations [the other two being cholera and yellow fever],

Pestis minor, a benign form of bubonic plague, has been identified as occurring alongside bubonic plague in past epidemic areas; in modern times it usually only occurs in endemic areas. Lymphadenitis, fever, headache, and prostration subside within a week.

Social breakdown

Social breakdown followed. Preaching, processions and feast-day assemblies were banned, measures of exclusion adopted, persons or goods banned from entering or leaving. Communities shattered, the healthy rejected the sick. "One citizen avoided another, everybody neglected their neighbours and rarely or never visited their parents and relatives unless from a distance; the ordeal had so withered the hearts of men and women that brother abandoned brother, and the uncle abandoned his nephew and the sister her brother and many times, wives abandoned their husbands, and, what is even more incredible and cruel, mothers and fathers abandoned their children and would refuse to visit them," Boccaccio wrote. [Hence the saying "Avoiding someone like the plague."]

Essential services, law and order, collapsed, panic pervaded Europe. Properties stood empty, cattle wandered untended, deserted by desperate owners. Fires were burned to purify the air, as were aromatic substances. Perfumed water was sprinkled in rooms and on clothing. Eau de Cologne is a survival of one of these plague waters or essences.

The sick died alone by the hundreds, their corpses dumped in the street or thrown in ditches and covered with earth.

The customs that held men together in commerce, law, and order fell apart before the approach of the plague and left raw human nature to follow its own dictates. Some men gave way to the wildest panic; others to the deepest despair. Some rose to heights of heroism in their self-sacrifice, others indulged in unbridled revelry. This last, wild festivity in the face of death, always appears when life is in great uncertainty. The Bible tells us that Jerusalem, when threatened by the attack of Sennacherib, gave itself over to revelry: "and in that day did the Lord God of Hosts call to weeping and to mourning, and to baldness, and to girding with sackcloth: but behold joy and gladness, slaying oxen, and killing sheep, eating flesh and drinking wine: let us eat and drink, for tomorrow we die." [Haggard]

The whip of God

Such frantic reactions obviously hold true for any great pestilence, yet all other scourges seem feeble before the Black Death. For centuries human populations could not increase, for any increase predisposed for pestilences. The Black Death eroded the veneer of civilisation, blackening body, soul, and spirit in equal measure, yet it permitted society to reconstruct and

rejuvenate because its attacks were intermittent, bringing a new fluidity to the hitherto rigid stratification of society. [Malaria, by contrast, is continuous and slowly saps the strength of a society.] The deep impact of the Black Death has “thrust this dread disease into the collective memory of western civilisation,” as one author put it aptly, with abandonment as its psychological aftermath, one might add. It is hopeless to try to shake off excommunication by saying that we are damned by blacker things than ourselves.

The devastation and despair spurred the pious activity of flagellantism: bands of men trudging from town to town hoping to propitiate divine wrath by denouncing sinners and lashing themselves. The belief that sickness was the whip of God for the sins of man gave rise to this curious form of similia. [The word plague’ derives from *plaga*, Latin for blow or strike.] Self-punishment would stave off divine punishment, holding the plague in check.

While all countries were filled with lamentations and woe, there first arose in Hungary, and afterwards in Germany, the Brotherhood of the Flagellants, called also the Brethren of the Cross, or Cross-bearers, who took upon themselves the repentance of the people for the sins they had committed, and offered prayers and supplications for the averting of this plague. This Order consisted chiefly of persons of the lower class, who were either actuated by sincere contrition, or who joyfully availed themselves of this pretext for idleness, and were hurried along with the tide of distracting frenzy.

But as these brotherhoods gained in repute, and were welcomed by the people with veneration and enthusiasm, many nobles and ecclesiastics ranged themselves under their standard; and their bands were not unfrequently augmented by children, honourable women, and nuns; so powerfully were minds of the most opposite temperaments enslaved by this infatuation. They marched through the cities, in well-organised processions, with leaders and singers; their heads covered as far as the eyes; their look fixed on the ground, accompanied by every token of the deepest contrition and mourning.

They were robed in sombre garments, with red crosses on the breast, back, and cap, and bore triple scourges, tied in three or four knots, in which points of iron were fixed. Tapers and magnificent banners of velvet and cloth of gold were carried before them; wherever they made their appearance, they were welcomed by the ringing bells, and the people flocked from all quarters to listen to their hymns and to witness their penance with devotion and tears. ... The influence of this fanaticism was great and threatening ... but at length the priests resisted this dangerous fanaticism, without being able to extirpate the

illusion. ... Penance was performed twice every day: in the morning and evening they went abroad in pairs, singing psalms amid the ringing of the bells; and when they arrived at the place of flagellation, they stripped the upper part of their bodies and put off their shoes, keeping on only a linen dress, reaching from the waist to the ankles.

They then lay down in a large circle, in different positions, according to the nature of the crime: the adulterer with his face to the ground; the perjurer on one side, holding up three of his fingers, etc., and were then castigated, some more and some less, by the Master, who ordered them to rise in the words of a prescribed form. Upon this they scourged themselves, amid the singing of psalms and loud supplications for the averting of the plague, with genuflexions and other ceremonies, of which contemporary writers give various accounts; and at the same time constantly boasted of their penance, that the blood of their wounds was mingled with that of the Saviour. [Hecker]

Absolution and abandonment

Since the Flagellants gained more credit than the priests, the Church could not allow its position as God's representative challenged, which resulted in the prohibition of flagellantism by Pope Clement VI under the guise of it posing a threat to public order by creating panic. Instead, Clement VI offered absolution from all sins to all Christians who should die on a journey to Rome, where, in spite of the plague, a Holy Year was being celebrated.

Not only was absolution given, but the souls of those who died were to be carried straight to heaven without first passing through purgatory. By Easter 1.2 million people from all parts of Europe had gathered in Rome. Some of these pilgrims brought the plague with them; it spread rapidly through the crowded people. Scarcely 10% lived to return to their homes. But the offerings that the pilgrims made to the Church amounted to an enormous sum. The pope did not contract the plague.

He was in Avignon, which he had just purchased from Queen Jane of Naples, and when the plague reached that city he isolated himself in one room for the duration of the epidemic. This excellent advice was given him by the famous physician Guy de Chauliac, who himself died of the plague. The mortality at Avignon reached such heights that Clement consecrated the river Rhone so that corpses could be sunk in it instead of being buried. Among the victims of this epidemic at Avignon was Petrarch's Laura. [Haggard]

The medical profession had little more to offer than the advice to “flee early, flee far, and return late,” and to “take plenty of purgatives,” if indeed these two activities could be combined. Abandonment and desertion were common reactions to the threat.

Nobility, lawyers, merchants, surgeons, all fled, as did most of the clergy, as if they could best minister to their flocks from far away. During the Great Plague in London, any officials in contact with plague victims were compelled to carry coloured staffs outdoors so that they could be easily identified and avoided. When anyone in a house caught the plague the house was sealed until 40 days [quarantine, from Italian ‘quaranta giorni’, forty days] after the victim either recovered or expired. [Recent research suggests that the bacterium operates similarly: It ‘seals off’ cell signalling, i.e. it cuts off the cell’s ability to communicate with other immune system cells.]

A red cross was painted on the door, a guard posted in front of it. Others were [re]moved to special “pesthouses.”

Dance of Death

A Europe which had been relatively epidemic-free turned, in the words of Roy Porter “into a crucible of pestilences, spawning the obsessions haunting late medieval imaginations: death, decay and the Devil, the dance macabre and the Gothic symbols of the skull and crossbones, the Grim Reaper and the Horsemen of the Apocalypse.

The Dance of Death [Danse Macabre or Todentanz] began as a response to the plague. It was expressed in poetry, performing arts, music, and visual arts and spread as a contagion all over Europe. The dance was described as a wild leaping dance in which people screamed and convulsed with a fury to sweat the disease out of the body. A contemporary author wrote that the dancers went around half-naked with wreaths in their hair, “and they engaged without shame in their dances, both sexes as if possessed, in churches and in houses, and while dancing they sang and invoked the names of unheard-of devils. When the dance was over the devils tormented them with violent pains in their chests, so that with terrible voices they shouted that they were dying if they were not tightly wrapped up round their bodies.”

The iconographic version most probably arose in France, in 1424, with the dance of death of Cimetiere des Innocents in Paris, followed by the creation of the frescoes of London, Basel, and Lubeck. Manuscripts or books with painted verses began to appear at the end of the 15th century.

Death, depicted as an emaciated corpse or skeleton, lead everyone into the

dance, usually charming them with music. The major motif was not the fear of death but a great levelling of classes by death, regardless of rank, age, sex or fortune. Dancers represented bishops, kings, burghers, peasants, and beggars - showing that all are equal in the end. Hans Holbeins Totentanz [Wurzburg, Germany] has Death demonstrating the vanity of wealth and rank.

Where the Church had used its symbolism to emphasise the futility of human vanity in the face of mortal destiny, for the common people it was an opportunity to dispense with the usual social constraints and enjoy some licentiousness.

Unable or unwilling to suppress his disgust, the German physician Hecker [1795-1850], wrote in his account of "The Black Death" published in 1832, of a "strange delusion ... which took possession of the minds of men, and in spite of the divinity of our nature, hurried away body and soul into the magic circle of hellish superstition."

The "demoniacal disease" spread like wildfire and, in Hecker's view, completely disrupted social and religious life, fostering mental disturbances:

Peasants left their ploughs, mechanics their workshops, housewives their domestic duties, to join the wild revels, and this rich commercial city became the scene of the most ruinous disorder. Secret desires were excited, and but too often found opportunities for wild enjoyment; and numerous beggars, stimulated by vice and misery, availed themselves of this new complaint to gain a temporary livelihood. Girls and boys quitted their parents, and servants their masters, to amuse themselves at the dances of those possessed, and greedily imbibed the poison of mental infection. [Hecker]

Hecker deemed the Dance of Death as due to "morbid sympathy" resulting from widespread pessimism and despair. As a "half-heathen, half-Christian festival," commencing as early as the year 1374

... assemblages of men and women were seen at Aix-la-Chapelle, who had come out of Germany, and who, united by one common delusion, exhibited to the public both in the streets and in the churches the following strange spectacle. They formed circles hand in hand, and appearing to have lost all control over their senses, continued dancing, regardless of the bystanders, for hours together, in wild delirium, until at length they fell to the ground in a state of exhaustion. They then complained of extreme oppression, and groaned as if in the agonies of death, until they were swathed in cloths bound tightly round

their waists, upon which they again recovered, and remained free from complaint until the next attack. This practice of swathing was resorted to on account of the tympanites which followed these spasmodic ravings, but the bystanders frequently relieved patients in a less artificial manner, by thumping and trampling upon the parts affected. While dancing they neither saw nor heard, being insensible to external impressions through the senses, but were haunted by visions, their fancies conjuring up spirits whose names they shrieked out; and some of them afterwards asserted that they felt as if they had been immersed in a stream of blood, which obliged them to leap so high. Others, during the paroxysm, saw the heavens open and the Saviour enthroned with the Virgin Mary, according as the religious notions of the age were strangely and variously reflected in their imaginations.

Where the disease was completely developed, the attack commenced with epileptic convulsions. Those affected fell to the ground senseless, panting and labouring for breath. They foamed at the mouth, and suddenly springing up began their dance amidst strange contortions. Yet the malady doubtless made its appearance very variously, and was modified by temporary or local circumstances, whereof non-medical contemporaries but imperfectly noted the essential particulars, accustomed as they were to confound their observation of natural events with their notions of the world of spirits.

... these fanatics had manifested a morbid dislike to the pointed shoes which had come into fashion immediately after the "Great Mortality" in 1350. They were still more irritated at the sight of red colours*, the influence of which on the disordered nerves might lead us to imagine an extraordinary accordance between this spasmodic malady and the condition of infuriated animals; but in the St. John's dancers this excitement was probably connected with apparitions consequent upon their convulsions. There were likewise some of them who were unable to endure the sight of persons weeping.

[Hecker]

However, the basic ideas of the Dance of Death are timeless: to recall the shortness of life as well as to affirm life in reflecting the happiness to be alive in the face of death and desperation. The very nature of dance is language and fusion. Its aim is "to throw off every vestige of the dual nature of temporal things to rediscover at a bound the primeval Oneness," as Chevalier and Gheerbrant put it. Stripped from its excesses, the ultimate social function of the Dance of Death, as Hecker admits, is to create "a common bond of union among human beings" based on "an instinct which connects individ

uals with the general body, which embraces with equal force reason and folly, good and evil, and diminishes the praise of virtue as well as the criminality of vice.

Changing times

The historian and cleric Francis Gasquet showed in his book *The Great Pestilence*, published in 1893, how the Black Death helped to intensify the religious and political upheavals that began during the 14th century and thus marked the end of the Middle Ages and the advent of the modern world.

Later researchers have endorsed this view - but with an important twist. It's now clear that the ravages of *Y. pestis* created a European society in which there was much less competition for food, shelter and work. Even at the lower levels of the social scale people were able to prosper as never before, while the wealthy quickly became more wealthy as they inherited the fortunes amassed by their deceased relatives. Thus were created conditions favourable to the Renaissance, which in turn presaged the shape and character of Europe as we know it today. [Dixon 1996]

* Hecker refers here to tarantism, the southern Italian variant of the European 'dancing manias'. While the more phlegmatic Germans detested red colours, the excitable Italians generally liked them. Colours played a predominant role in southern Italy: "... a patient was seldom seen who did not carry a red handkerchief for his gratification, or greedily feast his eyes on any articles of red clothing worn by the bystanders. Some preferred yellow, others black colours, of which an explanation was sought, according to the prevailing notions of the times, in the difference of temperaments.

Others, again, were enraptured with green; and eye-witnesses describe this rage for colours as so extraordinary, that they can scarcely find words with which to express their astonishment. No sooner did the patients obtain a sight of the favourite colour than, new as the impression was, they rushed like infuriated animals towards the object, devoured it with their eager looks, kissed and caressed it in every possible way, and gradually resigning themselves to softer sensations, adopted the languishing expression of enamoured lovers, and embraced the handkerchief, or whatever other article it might be, which was presented to them, with the most intense ardour, while the tears streamed from their eyes as if they were completely overwhelmed by the inebriating impression on their senses."

Although the attribution of tarantism to the bite of *Lycosa tarentula* is dubious, there is a peculiar correlation between this spider having its habitat in uncultivated coastal areas and the “ardent longing for the sea” evinced by tarantists. Those who were suffering under the bite of the tarantula feel themselves attracted to the boundless expanse of the blue ocean, and lost themselves in its contemplation. Some songs, which are still preserved, marked this peculiar longing, which was more over expressed by significant music, and was excited even by the bare mention of the sea. Some, in whom this susceptibility was carried to the greatest pitch, cast themselves with blind fury into the blue waves ...”

**Year of Wonders: A Novel of the Plague* by Geraldine Brooks, published by Fourth Estate, London 2001, is a very convincing novel that works out all of the threads and themes of the plague. It is based on the true story of the ‘plague village’ of Eyam in Derbyshire, England in 1665.

MATERIA MEDICA PESTINUM

Pest.

Sources

Pestinum is virtually non-existent in the homeopathic literature: no provings, no clinical pathogenesis, no clinical cases. Aside from giving such obvious indications as “bubo, plague, typhus,” for its use, Clarke remarks that “the prophylaxis and treatment of plague with injections of more or less modified virus of plague by old-school practitioners affords evidence that the nosode of plague is available, like other nosodes, for the treatment of cases of the disease from which it is derived.” The nosode might prove valuable in the treatment of sequelae of plague or in its own right, based on symptom similarity, irrespective of the name of the disease. Plague is far from rare and will never be eradicated. It lives in millions of wild rodents and in the myriad fleas that reside on them. Various countries are foci of plague, including India, Zaire, Tanzania, Madagascar, and Vietnam. In developed countries the disease may be endemic. For example, plague is now permanently established from the eastern slopes of the Rocky Mountains westward; between 60% to 90% of human plague infections occur in the southwestern states of the USA, particularly New Mexico, Arizona, California, and Colorado. The majority of these cases occur between April and November, with a peak in July. Contributing to the rising number of cases is the “increasing encroachment of humans on previously

wild areas, which brings people closer to infected animals and their fleas.” Hikers, campers, and hunters in natural areas are at a small but finite risk of exposure to plague, especially in the summer months.

International health regulations require that national health authorities immediately report plague cases to the World Health Organization. From 1982 through 1996, 23,904 human plague cases and 2105 deaths [mortality, 9%] were reported by 24 countries. In the same 15-year period, the United States reported 212 plague cases [mean, 14 cases per year] and 27 deaths [mortality, 13%].

SYMPTOMS

[Extracted from medical texts and historical accounts]

Onset

- » Sudden onset with high fever, chills, and headache.
- > Followed [several hours later] by nausea and vomiting.
- = Vomiting of bloody matter.

Mind

- = Resignation.
- » Anxiety. Fright. Fear of being abandoned.
There were many who pleaded with their relatives not to abandon them when night fell.

- <• Apathy. Confusion.
- «< Transience of all aspects of life.

In common with other disasters, like famine or war, plague undermined any assurance one might normally find in family, friends, business and property, or even in government and nation.

Generals

- « Carbuncles.
- ~ Prostration or severe malaise.
- =» Hypotension.
- = Cyanosis of peripheral parts [ears; nose; fingers; toes; nates; penis],
- = Necrosis/gangrene of peripheral parts.
- = Petechiae; ecchymoses; purpura.
- == Bleeding from orifices or cavities; small wounds bleed profusely.

=> Fetid, “overpowering” smell of breath, sputum, faeces, and sweat.

Locals

— Epistaxis.

=> White coating on tongue.

~ Pharyngitis/tonsillitis & cervical lymphadenopathy.

~ Peritonsillar abscesses.

«« Slurred speech.

~ Burning thirst, unquenchable.

= Pain in abdomen.

= Enlargement of spleen.

~ Constipation or diarrhoea; black or tarry stools.

« Urine turbid, thick, black, or red.

||| Pain in chest. Tachycardia.

||| Productive cough; blood-tinged sputum.

||| Haemoptysis; blood bright red, often foamy.

||| Distension of bladder.

||| Oliguria or anuria.

Neck stiffness.

Myalgias. Diffuse muscle and joint tenderness.

Staggering gait.

Buboes, heralded by severe pain, in groin, axillary, or cervical lymph nodes.

Buboes so intensely painful that even nearly comatose patients will attempt to shield them from trauma and will abduct their extremities to decrease pressure.

References:

- T.W. McGovern & A.M. Friedlander, *Medical Aspects of Chemical and Biological Warfare*, chapter 23, Plague; website nbc-med.org.
- D. Velenzas, *Plague*, article at: www.emedicine.com/EMERG/topic428.htm.
- J.F.K. Hecker, *The Great Epidemics of the Middle Ages*, London, 1844.
- Ian Jessiman, *A General Study of the Plague in England 1539-1640*, article at: www.loughborough.co.uk/plague/.
- *Plague and Public Health in Renaissance Europe*, hypertext archive of narratives, medical consilia, governmental records, religious and spiritual writings and images documenting epidemic disease occurring in Western Europe between 1348 and 1530; at: <http://iefferson.village.virginia.edu/osheim/intro.html>.

. Susan Scott and Christopher Duncan in *Return of the Black Death: The World's Greatest Serial Killer* (published by John Wiley, 2004) maintain that the Black Death was not Bubonic Plague but an unknown virus possibly related to the Ebola or Marburg viruses which is “lying in wait ready to strike again.”

TUBERCULINIC MIASM

It is not just the name ‘pseudotuberculosis’ that suggests a link between *Yersinia* and the tuberculinic miasm or with Tuberculinum as its prototype. If we regard the features of all three pathogenic *Yersinia* species as belonging to a totality, and compare this totality with the tuberculinic miasm, we find the following similarities:

- Predilection for lymphatic system and respiratory tract [including haemoptysis].
- Pork [including bacon and ham].*
- Milk.
- Dogs and, especially, cats.
- Travel.
- Febrile conditions.
- Erythema nodosum [Tuberculinum is listed in this rubric]. •Appendicitis [Tuberculinum-Koch is under ‘chronic appendicitis’]. •Abscesses and boils. [Tuberculinum has ‘succession of boils’].

A difference might be the stronger tendency to haemorrhages in *Yersinia* [Pestinum].

* Derived from *L. scrofa*, a sow, *scrofula* [“litde sow”], an old name for tuberculosis of the cervical lymph nodes, is linked to swine. Sows were supposed to be prone to it, or, alternatively, scrofulous patients were perceived to resemble them in having a tendency to obesity, a red swollen nose, a swollen upper lip, a large belly, and coarse hair.

MATERIA MEDICA SERUM YERSINIAE

Yers.

Sources

In 1896, the Swiss bacteriologist Alexandre Yersin [1862-1943], in collaboration with Calmette and Borrel, obtained an anti-plague serum from horses which had been immunised by means of killed or living cultures of plague bacilli. The bacilli were killed by heating them at 50° C for one hour. Yersin

perfected the serum in 1906, reducing with it the death rate of bubonic plague in Vietnam. However, the serum confers short-lasting immunity only and has been replaced by Haffkine's plague vaccine.

In 1897, during an outbreak of epidemic plague in Bombay, Waldemar Haffkine [born Vladimir Khavkin in Odessa, Russia] prepared a plague vaccine using a broth culture of the organisms heated at 70° C and phenolised. Haffkine [1860-1930] tested the vaccine by injecting himself and several hundred volunteers recruited among the Byculla prison population. This "plague prophylactic fluid," as Haffkine called it, was in 1942 replaced by a whole-cell, formaldehyde-killed, phenol-preserved modification of the original Haffkine vaccine because an inordinately high rate of adverse reactions caused recipients and scientists to reject the original preparation.

The protection provided by killed plague vaccine is of brief duration and only effective for preventing or ameliorating bubonic but *not* pneumonic plague. Booster doses are necessary every 6 months for one and a half year, and then every 1 to 2 years thereafter when danger of infection continues to exist.

Its use is recommended for health personnel who may come into contact with *Y. pestis*. Soldiers and naval personnel are routinely vaccinated with PV in war situations.

According to CDC-reports, primary vaccination may result in general malaise, headache, fever, with mild lymphadenopathy, and erythema and induration at the injection site in about 10% of recipients. These reactions occur more commonly with repeated injections. Sterile abscesses occur rarely. Rare cases of sensitivity reactions manifested by urticaria and asthmatic phenomena have been reported.

Indications

Julian suggests the use of Serum *Yersinia*, in homeopathic potency, for the following clinical conditions. [They probably may be taken as indicative for the nosode *Pestinum* as well.]

- = Severe forms of influenza, of pulmonary type, with high fever, difficulty in breathing, and soft, thick, rosy-red sputum.
- = Acute enterocolitis.
- == Summer gastroenteritis.
- = Terminal ileitis [regional enteritis or Crohn's disease] & involvement of regional lymph nodes. [This condition is commonly associated with *Yersinia enterocolitica* and/or *Y. pseudotuberculosis*.]

= Gastrointestinal form of influenza.

“ “Pseudo-typho meningitis of milkmen.”

“ Meningitic syndromes of influenzal origin.

= Parkinson’s disease [?].

» Encephalitis lethargica [Economo’s disease or ‘epidemic encephalitis’].*

* “Encephalitis lethargica was first reported by von Economo in 1917, after a small local epidemic had led to numerous patients being seen in the Vienna Psychiatric Clinic with a strange variety of symptoms that did not fit into any known diagnostic category. The shared features were slight influenza-like prodromata followed by a variety of nervous manifestations, marked lethargy, disturbance of sleep and disturbance of ocular movement. ... Complete recognition followed in the great pandemic which started in London in 1918 and spread throughout

Europe during the next two years, approximately coincident with the influenza pandemic of that time. ... There was a seasonal pattern, most epidemics beginning in early winter. The peak incidence was in early adult life from age 15-45, though no age group was spared. ... Parkinsonism sometimes developed gradually out of the acute stage, or could set in unexpectedly after full recovery.” [Lishman]

* Read the book *Awakenings* by Oliver Sacks, and see the film with the same title starring Robin Williams and Robert de Niro..

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IL ORDER PASTEURELLALES

HA. FAMILY PASTEURELLACEAE

Haemophilus influenzae

HAEMOPHILUS INFLUENZAE

| | |
|------------------------|---|
| Scientific name | <i>Haemophilus influenzae</i> type B (Lehmann & Neumann 1896) Winslow et al. 1917 |
| Old name | <i>Bacillus influenzae</i> |
| Family | Pasteurellaceae |
| Homeopathy | <i>Haemophilus influenzae</i> B vaccinus - Haem-i-b-vc. |

FEATURES

- Small, non-motile, Gram-negative bacterium which may appear Grampositive.
- Encapsulated strains of *H. influenzae* isolated from cerebrospinal fluid are coccobacilli, similar in morphology to *Bordetella pertussis*, the agent of whooping cough. Non-encapsulated organisms from sputum are pleomorphic and often exhibit long threads and filaments.
- Present in the nasopharynx of approximately 75-90% of healthy children and adults, usually in its non-encapsulated form, while 5% of these organisms will be type B [the commonest type of the six capsulated types known].
- Has humans as its only known hosts; has not been detected in any animal species.
- Its name a misnomer, *H. influenzae* is not related in any way to influenza. First isolated by Pfeiffer during the influenza pandemic of 1890, it was mistakenly thought to be the cause of influenza.
- *Haemophilus*, meaning “blood loving,” requires growth factors present in blood.
- Disease usually begins in the upper respiratory tract as nasopharyngitis and may be followed by sinusitis and otitis, possibly leading to pneumonia. Severe infections may result in peri-orbital cellulitis, facial cellulitis, septic arthritis, meningitis and, rarely, epiglottitis.
- Possible neurologic sequelae of Hib meningitis include learning disabilities, epilepsy, hearing loss, or partial blindness.

HIB VACCINATION

- Several Hib conjugate vaccines derived from *H. influenzae* type B polysaccharide are part of routine vaccination schedules since 1985.
- As with other vaccines, adverse effects of Hib vaccination may involve allergic reactions: difficulty in breathing or swallowing; urticaria; itching [esp. of hands or feet]; reddening of ears [esp. around ears]; swelling of eyes, face, or inside of nose; unusual, sudden and severe tiredness or weakness.
- Other side effects include vomiting, diarrhoea, fever, irritability, lack of interest, anorexia, fatigue, joint pains, trouble in sleeping, and convulsions.
- The vaccine has been linked with an increased susceptibility to Hib meningitis in the first weeks following vaccination.
- While Hib vaccination has diminished the incidence of Hib-meningitis, it appears to have caused a shift in the flora of nasopharynx and upper respiratory tract, allowing *Neisseria* and *Streptococcus* species to proliferate. This might explain the higher relative frequency of pneumococcal [*Streptococcus*] and meningococcal [*Neisseria*] infections in children since the introduction of mass Hib vaccination. A Finnish study found that “following the disappearance of invasive Hib disease in children, bacteraemic pneumococcal infections have increased,” suggesting “that the increase in invasive pneumococcal infections is causally related to the disappearance of Hib disease. It is known that Hib vaccinations have reduced the carriage of *H. influenzae*, and pneumococci may have found a new niche in colonising children.”

The proclaimed success of Hib vaccination “is not measured by how much disease it prevents. It is only measured by how much Hib bacteria are found in laboratory tests. It was primarily introduced to combat meningitis, but we are yet to see any reports of a reduction in meningitis.” [An attempt to address this problem involves the use of conjugated vaccines combining *H. influenzae* type B and meningococcal proteins.]

= A steep rise in the annual incidence of insulin-dependent diabetes in young children has been reported in Finland, the U.S. and Great Britain after the Hib vaccine became widely utilised.

MAT. MED. HAEMOPHILUS INFLUENZAE B VACCINUS

Sources

[1] [Fragmentary] proving by Klaus Lbbisch; 200c; 7 provers [6 females, 1 male], 1995.

[Remedy made from vaccine - PedvaxHIB - which consists of H. influenzae type B polysaccharide conjugated to Neisseria meningitidis outer membrane protein complex, with thiomersal as a preservative.]

Symptoms

Headache [6 provers].

= Pressing in temples [disappearing suddenly].

= Stitching pain behind the eyes.

= Tension at base of skull and above the eyes, in morning on waking.

= Headache starting in nape of neck, extending to occiput or to forehead/cheekbones [with painful eyes], < bending head backward, > keeping head erect, open air, lying, evening. [This prover had had a meningitis two years earlier.]

~ Headache as if drawn together into one spot. Backward pulling sensation as from a heavy ponytail.

— Headache as from a knot [lump] above right eye.

Pruritus [6 provers].

= Eczema in armpits [aggravation of existing condition], accompanied by copious perspiration.

=> Itching all over. Broad band of eczema-like eruption around mouth. Itching of scalp > open air.

= Burning sensation *under* skin of head, hands and arms; had to restrain himself not to scratch. In evening red spots on dorsum of hands, biting and itching sensation; must scratch until it bleeds.

= Itching of left lower leg [tibia]; scratches until it bleeds.

= Itching all over, esp. back and legs, without eruption, > evening, rest.

= Itching of external throat and legs during daytime, > at night.

Evening > [4 provers].

4 to 8p.m. < [2 provers].

Peculiaris [each symptom in 1 prover only],

- Euphoria, uninhibited [talking, laughing].

- Dreams of childhood, of school years [“as if going back in time”].

- » Desire for paprika crisps.

- « Desire for chocolate.

- Great chilliness; had to go to bed in afternoon from coldness, > evening.

- » Forehead hot, hands cold [with headache].

- » Taste of chlorine in mouth.

- Pressing sensation in plexus solaris & nervous feeling [internal and external trembling], restlessness, feverish sensation [heat], and weakness.

- « Sensation of heat in external chest.

- = Fear heart has ceased to beat; puts hand on heart region; 5.30-6.30 p.m.

- « Sensation as from an iron rod between 2nd and 3rd dorsal vertebrae.

- « Numbness right hand.

III. ORDER PSEUDOMONADALES

IIIA. FAMILY PSEUDOMONADACEAE

Pseudomonas aeruginosa
Pseudomonas mallei [see *Burkholderia mallei*]

PSEUDOMONAS AERUGINOSA

Pseud.

| | |
|------------------------|--|
| Scientific name | <i>Pseudomonas aeruginosa</i> (Schroeter 1872) Migula 1900 |
| Old names | <i>Pseudomonas pyocyanea</i> <i>Bacillus pyocyaneus</i> |
| Common name | Blue pus bacillus |
| Family | Pseudomonadaceae |
| Homeopathy | <i>Pseudomonas aeruginosa</i> - Pseud. |

FEATURES

- Obligate aerobic, liquefying, Gram-negative, actively motile bacterium with polar flagella.
- Straight or curved rod occurring singly.
- Non-fermentative; derives its energy from oxidation rather than fermentation of carbohydrates.
- Ubiquitous; found in soil, water, plants, and animals; predilection for moist environments.
- Common saprophyte in humans; can be isolated from throat, skin, and stool. Has been found in saliva, sputum, and sweat.
- Colonization reportedly occurs in more than 50% of humans.
- Optimum growth at 25° to 37° C; tolerates higher temperatures up to 42° C.
- Common cause of nosocomial infections.
- Resistant to high concentrations of salt, dyes, weak antiseptics, and many commonly used antibiotics.
- Type species of the genus *Pseudomonas*. The genus further includes *Pseudomonas cepacia*, a species causing bacterial rot of onions and found with increasing frequency as the cause of pneumonia and septicaemia in children with cystic fibrosis.
- Produces a bluish-green pigment [pyocyanin] and a yellowish-green pigment

[fluorescein or pyoverdin].

- Fluorescent; colonies have a metallic lustre and a characteristic aromatic smell [aminoacetophenon].
- Produces toxin A, an exotoxin similar to diphtheria toxin.

CLINICAL FEATURES

Pathogenic when physical barriers to bacterial invasion are disrupted, eg. burn lesions, urinary catheters, IV lines, dialysis catheters, or in immunocompromised hosts, eg. cystic fibrosis, neutropenia, neonates, and AIDS.

Infection occurs in three stages: [1] bacterial attachment and colonization; [2] local invasion; [3] dissemination and systemic disease.

Disease usually is limited to the first two stages, as in otitis externa, urinary tract infections, dermatitis, and cellulitis. The disseminated form manifests as pneumonia, endocarditis, peritonitis, meningitis, ecthyma gangrenosum, and overwhelming septicemia.

Localized infection following surgery or burns commonly results in a generalized and frequently fatal bacteremia. Urinary tract infections following introduction of *P. aeruginosa* on catheters or in irrigating solutions are common. Furthermore, most cystic fibrosis patients are chronically colonized with *P. aeruginosa*. Interestingly, cystic fibrosis patients rarely have *P. aeruginosa* bacteraemia, probably because of high levels of circulating *P. aeruginosa* antibodies. However, most cystic fibrosis patients ultimately die of localized *P. aeruginosa* infections. Necrotizing *P. aeruginosa* pneumonia may occur in other patients following the use of contaminated respirators. *Pseudomonas aeruginosa* can cause severe corneal infections following eye surgery or injury. It is found in pure culture, especially in children with middle ear infections. It occasionally causes meningitis following lumbar puncture and endocarditis following cardiac surgery. It has been associated with some diarrhoeal disease episodes.

Since the first reported case of *P. aeruginosa* infection in 1890, the organism has been increasingly associated with bacteraemia and currently accounts for 15 percent of cases of Gram-negative bacteraemia. The overall mortality associated with *P. aeruginosa* bacteraemia is about 50 percent. Some infections [eg. eye and ear infections] remain localized; others, such as wound and burn infections and infections in leukaemia and lymphoma patients, result in sepsis. The difference is most probably due to altered host defences.

[Barbara H. Iglewski, *Pseudomonas*; at: www.gsbs.utmb.edu/microbook/ch027.htm]

Has been occasionally involved in foodborne cases of acute enteritis, which were more severe among children, leading in newborn infants to such symptoms as “extreme prostration, explosive diarrhoea with 10 to 20 thin watery stools per day, rapid dehydration, and cyanosis.” [Riemann]

IV. ORDER VIBRIONALES

IVA. FAMILY VIBRIONACEAE

Vibrio cholerae

VIBRIO CHOLERAEE

Scientific name

Old names *Vibrio cholerae* Pacini 1854
 Comma bacillus [Koch] *Vibrio*
 comma Spirillum cholerae

Family *Vibrionaceae*

Homeopathy *Cholera nosode*
 Choleratoxin

FEATURES

- Short, comma-shaped or curved, actively motile, aerobic or facultative anaerobic, Gram-negative rods.
- Belonging to the most common organisms in surface waters of the world, *Vibrio* species occur in both marine and freshwater habitats and in associations with aquatic animals. Some species are bioluminescent and live in mutualistic associations with fish and other marine life. Other species are pathogenic for fish, eels, and frogs, as well as for other vertebrates and invertebrates.
- Most *Vibrio* species require 2-3% sodium chloride or a seawater base for optimal growth.
- Capable of both respiratory [oxidation] and fermentative metabolism. Ferment carbohydrates into mixed products, including acids, but do not give off carbon dioxide and hydrogen.
- Quickly destroyed by acidity and desiccation.
- Two species are associated with cholera and food-borne or water-borne watery diarrhoea.
- *Vibrio cholerae* has its reservoir in humans, but may persist for some time in marine and estuarine coastal areas. [According to the WHO, it is part of the normal flora of brackish water and estuaries, and often associated with algal blooms, plankton, which are influenced by the temperature of the water.]

- *Vibrio parahaemolyticus* is part of the normal flora of coastal and estuarine waters throughout the world. It is associated with wound infections [from exposure to warm seawater] and food-borne self-limiting gastrointestinal illness, primarily affecting the colon. Foodstuffs linked with it include sushi and raw or undercooked shellfish [particularly oysters].
- *Vibrio*-related outbreaks of gastroenteritis occur most frequently in the summer season or in tropical regions.
- Robert Koch isolated *V. cholerae* in 1883 and 1884 from the intestinal discharges of cholera patients in Egypt and India.
- In 1905 a new haemolytic biotype was isolated from pilgrims headed for Mecca. Considered non-virulent, it was named “El Tor” after the quarantine station in the Sinai Peninsula where it had been discovered.

CHOLERA

CHOLERA VIBRIO Formerly a non-specific name for a variety of suddenly occurring gastrointestinal “summer” disturbances, eg, cholera morbus and cholera infantum, the term ‘cholera’ [supposedly from *chole*, bile] is now reserved to indicate Asiatic or endemic cholera. First reported in 1629 in Calcutta, it remained confined to the Ganges delta where it had been endemic, for a further two hundred years whence it spread to China, across Asia, through Russia and into Europe, favouring shipping routes and ports. Between 1817 and 1923 six pandemics of cholera swept the world. In 1961, the 7th cholera pandemic wave [biotype El Tor] began in Indonesia and spread rapidly to other countries in Asia, Europe, and Africa. In 1991 El Tor broke out explosively in Peru and spread rapidly over Central and South America. A new biotype, designated 0139 or Bengal, emerged in late 1992 in India and Bangladesh, and has since been detected in eleven countries in South-East Asia.

VECTOR Human
Reservoir Fresh water
Seawater Brackish water
Estuaries

TRANSMISSION Human
faecal-oral route Poor sanitation
Contaminated water Floods, disasters, refugee camps
Shellfish, raw fish, oysters
Exposure of wounds to infected waters.

DESTROYED by acidity and dryness.

Outbreaks continue to be of major public health concern, causing considerable socio-economic disruption as well as loss of life. In 2001, WHO and its partners in the Global Outbreak Alert and Response Network participated in the verification of 41 cholera outbreaks in 28 countries.

Generally spread by poor sanitation., resulting in contaminated water supplies, cholera is transmitted to humans by water or food through the faecal-

oral route. Man-made and natural disasters - complex emergencies and floods - can intensify the risk of epidemics considerably, as can conditions in crowded refugee camps. Epidemics typically have the tendency to spread with explosive speed. In its extreme manifestation, cholera is one of the most rapidly fatal illnesses known. Progression from the first liquid stool to shock may take no longer than 4 to 12 hours.

Persons with damaged or undeveloped immunity, reduced gastric acidity, or malnutrition are likely to suffer more severe forms of the illness. Antacid consumption, lowering the pH of the stomach, markedly lowers the infective dose because vibrios grow best in an alkaline environment. The acid-sensitive organism quickly disappears from acid foods, but survives for at least a couple of days in salt solutions as well as on sugar, sweets, and other carbohydrates. Gastric acid, mucus secretion, and intestinal motility are the prime non-specific defences against *V. cholerae*. Breastfeeding in endemic areas is very important as a means of increasing immunity of infants to cholera and other diarrhoeal diseases.

The organism multiplies to reach enormous numbers on epithelial cells lining the intestinal mucosa, primarily affecting the small intestine by secreting an enterotoxin [choleragen], which in mode of action is very similar to the *Campylobacter jejuni* enterotoxin and the heat labile toxin produced by *Escherichia coli*. The enterotoxin causes a reaction leading in the worst case to hypersecretion of electrolytes and water into the intestinal space. The torrential watery discharges will largely flush out the vibrios, but not before they have secured their supply of nutrients necessary for survival - salts and glucose - so that the therapy of cholera essentially consists of refilling the losses.

The gastrointestinal upset ranges from mild to severe. In its severest form the symptoms include:

= Sudden onset.

« Purging, massive, non-offensive diarrhoea [the initial stool may exceed 1 litre].

<• Continuous discharge of large amounts of watery fluid mixed with flakes of mucus, epithelial cells, and large numbers of vibrios [“rice-water stool”].

“ Nausea, bilious vomiting and abdominal cramps.

= Vomiting after drinking. [Raue]

=> Distressing hiccough.

<• Oppression in the pit of the stomach. [Raue]

-
- = “When touched in the stomach he screams out.” [Hahnemann]
 - Sudden profound prostration.
 - = Insatiable thirst. [Raue]
 - = No thirst. [Hahnemann]
 - == Dehydration and subsequent cramps [typically of calves and in bowels],
 - ~ Anuria. Uraemia and metabolic acidosis.
 - Weak pulse; scaphoid [boat-shaped] abdomen; loss of skin turgor [state of being swollen or distended]; eyes sunken back into the skull; wrinkled hands [“washerwoman’s hands”]; noise pointed; cheeks fallen in.
 - ~ Lips, extremities, and genitals assume a bluish, cyanotic colour. [Raue]
 - = Body surface icy cold.
 - = Cold breath [characteristic]. [Raue]
 - = Deep inspiration and short moaning expiration. [Raue]
 - => The voice changes into “the peculiar cholera voice, which is rough and coarse, with perfect articulation.” [Raue]
 - = Cardiac complications and circulatory failure [from loss of potassium].
 - = Shock, collapse and death may occur from severe fluid and electrolyte loss.

CHOLERA

KEYNOTES

Studies indicate that recovery from cholera results in immunity for a number of years.

Sudden onset

Massive purging of

watery diarrhoea

Non-offensive.

Dehydration

Nausea, vomiting

Cramps

Hiccough

Cold body & breath

Blue lips, limbs

Sunken withered

features

Shock, collapse, death.

Most symptoms are

concomitant to

electrolyte loss.

Camphor, Cuprum

and Veratrum are the

tried and tested

remedies.

PATTERNS AND CARRIERS

Cholera appears to exhibit three major epidemiological patterns: heavily endemic, neo-epidemic [newly invaded, cholera-receptive areas], and, in developed countries with good sanitation, occasional limited outbreaks. These patterns probably depend largely on environmental factors [including sanitary and cultural aspects], the prior immune status or antigenic experience of the population at risk, and the inherent properties of the vibrios themselves, such as their resistance to gastric acidity, ability to colonise, and toxicogenicity. In the heavily endemic region of the Indian subcontinent, cholera exhibits some periodicity; this may vary from year to year and seasonally, depending partly on the amount of rain and degree of flooding.

Because humans are the only reservoirs, the survival of the cholera vibrios during inter-epidemic periods probably depends

on a relatively constant availability of low-level undiagnosed cases and transiently infected, asymptomatic individuals.

Long-term carriers have been reported but are extremely rare. The classic case occurred in the Philippines, where “cholera Dolores” harboured cholera vibrios in her gallbladder for 12 years after her initial attack in 1962. Her carrier state resolved spontaneously in 1973; no secondary cases had been associated with her well-marked strain. Recent studies, however, have suggested that cholera vibrios can persist for some time in shellfish, algae or plankton in coastal regions of infected areas and it has been claimed that they can exist in “a viable but non-culturable state.”

... Infection with cholera vibrios results in a spectrum of responses. These range from no observed manifestations except perhaps a serologic response [the most common] to acute purging, which must be treated by hospitalisation and fluid replacement therapy; this is the classic response. The reasons for these differences are not entirely clear, although it is known that individuals differ in gastric acidity and that hypochlorhydric individuals are most prone to cholera. ... Prior immunologic experience of subjects at risk is certainly a major factor. For example, in heavily endemic regions such as Bangladesh, the attack rate is relatively low among adults in comparison with children. In neoepidemic areas, cholera is more frequent among the working adult population. [R.A. Finkelstein, *Cholera and Vibrio cholerae*-, <http://gsbs.utmb.edu/microbooks/ch024.ht>

Approximately one case of cholera per week is being reported in the United States. Most of these cases have been acquired during international travel and involve persons who return to their homelands to visit family or foreign nationals visiting relatives in the United States.

MIASMATIC THEORIES

In a paper on the aetiology of infectious diseases [1879], the German bacteriologist Robert Koch formulated what came to be known as Koch’s Postulates. Confirmation of his theory seemed to come when Koch isolated *Vibrio cholerae* from cholera victims in 1883. [One year earlier Koch had seeded the question of the aetiology of tuberculosis by discovering its causative agent, *Mycobacterium tuberculosis*.]

Some 30 years before Koch’s discovery of the cholera vibrio, a distinguished English physician, John Snow, had tracked down a public pump as the source of a serious cholera outbreak in an area of London called Soho. He

demonstrated that contaminated water was the cause of cholera and incidentally recounted the story of a nurse who accidentally drank some of the 'rice water' [undoubtedly teeming with vibrios] that had been evacuated from the bowels of a cholera victim. Nothing happened - the nurse remained unaffected. In spite of Snow's findings, it was officially announced during the third International Sanitary Conference, held in Constantinople in 1866, that air and not water was the medium through which cholera spread. The announcement maintained the ancient opinion that miasmas [poisons in the air, exuded from rotting animal and vegetable material, the soil, and standing water] were the origins of diseases.

The Munich professor of hygiene Max von Pettenkofer [1818-1901] refuted Koch's claim of cholera being caused by vibrios. Upholding a version of the miasmatic theory, he was convinced that ground water from porous soils resting on a layer of closely packed alluvial clay were the very breeding beds for the spread of cholera. He got Koch to send him a culture of cholera vibrios and conducted his famous experiment by drinking the culture, after first neutralising the acid of his stomach. "Herr Doctor Pettenkofer," he wrote in a letter to Koch, "presents his compliments to Herr Doctor Professor Koch and thanks him for the flask containing the so-called cholera vibrios, which he was kind enough to send. Herr Doctor Pettenkofer has now drunk the entire contents and is happy to be able to inform Herr Doctor Professor Koch that he remains in his usual good health."

The slight swelling of Pettenkofer's stomach and the mild diarrhoea following the ingestion of the culture were nothing compared to the violent diarrhoea and leg cramps that occurred in his co-worker, Rudolf Emmerich, who faithfully had repeated the experiment. Pettenkofer insisted nevertheless to the end of his life that the vibrio was only one of an unknown number of causes that had to operate in concert. He was certainly right in thinking that many factors are involved since exposure to an infectious agent alone in most cases is not sufficient to cause disease.

KOCH'S POSTULATES

The following is taken from the website: www.medterms.com

- * the bacteria must be present in every case of the disease
- * the bacteria must be isolated from the host with the disease and grown in pure culture.
- * the specific disease must be reproduced when a pure culture of the bacteria

is inoculated into a healthy susceptible host.

* the bacteria must be recoverable from the experimentally infected host.

However, Koch's Postulates have their limitation so may not always be the last word. They may not hold if:

* The particular bacteria [such as the one that causes leprosy] cannot be 'grown in pure culture' in the laboratory.

* there is no animal model of infection with that particular bacteria.

A harmless bacteria may cause disease if it:

* it has acquired extra virulence factors making it pathogenic

* it gains access to deep tissues via trauma, surgery, an IV line etc.

* it infects an immunocompromised patient

* not all people infected by a bacteria may develop disease - subclinical infection is usually more common than clinically obvious infection.

Despite such limitations, Koch's Postulates are still a useful benchmark in judging whether there is a cause-and-effect relationship between a bacteria [or any other type of micro-organism] and a clinical disease

CHOLERAIC PARANOIA

Mass diseases run parallel with mass developments, or vice versa. Bubonic plague brought up certain aspects of human nature as selfishness, sin, and penance. Instead of being simply dismissed as the superstitious and delusional ranting of primitive, medieval minds, they appeal to a deeply rooted human tendency to see illness as punishment. As during other pandemics, cholera sparked theories of oppressive conspiracy and provoked fury and riots. The disease is "one of the great social and political forces in human history," according to Biddle, setting up alarming outbreaks of upheaval which left little time for something so contradictory as Gabriel Garcia Marquez describes in his *Love in the Time of Cholera*.

In England, cholera assaulted not only bodies but some people's pride in race, class, and nation. The disease seemed a product of colonial backwardness. Its symptoms, to say nothing of its stench, were a humiliating fate for Victorian gentlemen. They saw that cholera afflicted them less than it did the poor, ill fed, ill housed, dirty, and drunk. To chronically moralising Victorian minds, the lower classes' weak resistance to disease proved their physical and moral inferiority. By falling prey to cholera, they showed that some of the "sceptered race" lacked industry, self-control, and godliness - sad testimony to their fitness

to dominate the world's wogs. Cholera's early visitations to the United States provoked equally intense fits of moral ague; there were similar preachings and days of prayer, though with less stress on class distinction. ... Cholera also humbled the medical and civil establishments. ... Cholera had some respect for class lines, but not for the moral reasons recited from pulpits and in editorials. ... As the epidemic worsened throughout Europe, the mood of the poor turned ugly. ... Protests and riots followed.

The greater disease resistance of the rich seemed proof first of unfairness, then of oppression, and finally of conspiracy. Rumours spread that cholera was not a disease but poisoning by agents of the rich, who wanted to dispose of the troublesome poor. ... A sense of helplessness before cholera unleashed similar fury and fantasies. In Russia, cordons sanitaires provoked disorder, then violence; peasants massacred doctors and magistrates who were trying to enforce health edicts. In Hungary, where cholera killed more than 100,000 in the summer of 1831, peasants who thought they were being poisoned sacked castles and killed doctors, army officers, and nobles.

In Prussia, tales spread that doctors were receiving three thalers from the king for every cholera death; mobs beat and killed physicians and government officials. Paris saw riots and the stoning of doctors. In some places, cholera was deemed a British fiction meant to mask the poisoning of restive Indian subjects. ... In England, ... doctors were accused of using the disease as a cover for murdering patients in order to dissect them. [Karlen 1995]

MATERIA MEDICA CHOLERATOXINUM

Except for the occasional advice to take the Cholera nosode as a prophylactic when travelling to endemic areas, the homeopathic literature contains no information on this nosode.

Because no long-term sequelae from cholera have been recorded there seems no reason for prescribing it on aetiological indications. The disease is acute, tumultuous, but self-limiting and can usually be managed with proper homeopathic treatment, as Hahnemann demonstrated in 1831 when a cholera epidemic swept through Europe.

Yet, there are some grounds to link Cholera toximum to the bowel nosode Proteus: storm, sea, suddenness, cramps, and chlorine [muriaticum]. [See Proteus.]

Due to its appalling rapidity and its victims becoming corpse-like even

before death, cholera is associated in India with Kali, the Hindu goddess of death, disease, and destruction. The connection with the goddess, known as the Black One, is an apparent one since cholera victims often turn black as the blood congeals and the skin collapses. As an agent of sudden death, cholera was depicted in Europe in a likewise manner:

Cholera is perhaps the most famous of that large number of diseases, some distressingly little-known, which can kill by violent vomiting and diarrhoea. Cartoonists of the 19th century depicted cholera as a death's head, with outstretched black skeletal arms representing the blackened blood beneath the skin of its victims. Its swiftness was commemorated as well - it was often drawn as a death's head or as a giant vulture plucking up its victims with a single sweep of its grim talons. [Wills 1996]

The main homeopathic remedies in the treatment of cholera are in line with these characteristics: Camphora [coldness all over], Cuprum [violent cramps], Veratrum [excessive watery discharges, also craving for salt and fruit juices], Carbo vegetabilis [cold breath and death-like state; dubbed the "corpse reviver"], Aconitum [suddenness and fear of death], and Arsenicum [sudden sinking of strength and fear of death]. This suggests that homeopathic employment of the Cholera nosode might come in when the apparently indicated remedies mentioned above fail to act in acute or chronic ailments with cholera-like symptoms.

Group Epsilon Proteobacteria

| Phylum | Order | Family | Genus | Species |
|----------------|------------|-------------------|---------------|------------------|
| PROTEOBACTERIA | | | | |
| | Gp Epsilon | Campylobacterales | Campylobacter | <i>C. jejuni</i> |
| | | Helicobacteraceae | Helicobacter | <i>H. pylori</i> |

The epsilon proteobacteria emerge as a deep division of the delta proteobacteria, which include three disparate phenotypes: reducers of sulphur and sulphate; the colourful myxobacteria, which are remarkably reminiscent of the cellular slime moulds [belonging to the kingdom Fungi]; and the predatory parasites of other Gram-negative bacteria. [Tudge]

I. ORDER CAMPYLOBACTERALES

IA. Family CAMPYLOBACTERACEAE

IB. Family HELICOBACTERACEAE

IA. FAMILY CAMPYLOBACTERACEAE

Campylobacter jejuni

CAMPYLOBACTER JEJUNI

| | | |
|-----------------|----------------------|---|
| Scientific name | Campylobacter jejuni | subsp. jejuni (Jones et al. 1931) Veron & Chatelain 1973 |
| Family | Campylobacteraceae | |
| Homeopathy | Campylobacter jejuni | |

FEATURES

- Small, Gram-negative, curved and highly motile rods, often flagellated.
- Found in natural water sources throughout the year, particularly during the cold season in temperate regions.
- Animal reservoir particularly in rodents, domestic chickens, migratory birds [cranes, ducks, geese, and seagulls], cattle [intestinal commensal], and on exoskeleton of beetles and flies.
- Colonises intestines of poultry; highest levels of contamination in skin and giblets of retail chicken [Salmonella harbours mainly in eggs].
- First isolated in Belgium in 1972 from stool samples of patients with diarrhoea.
- Maximum growth at 37° C to 42° C, the approximate body temperature of wild birds and poultry [41° C to 42° C],
- Prefers low oxygen environments.
- Favours relatively high concentrations of carbon dioxide.
- Sensitive to freezing, drying, acidic conditions [pH below 5], and salinity.
- Most commonly reported bacterial cause of foodborne infection in the USA.
- Chronic sequelae associated with *C. jejuni* infection include Guillain- Barre syndrome and reactive arthritis.

CAMPYLOBACTERIOSIS

Consumption of undercooked poultry or of raw milk are the major risk factors for human campylobacteriosis. Less frequent ways of transmission accounting for a smaller proportion of sporadic illnesses include drinking untreated water; travelling abroad; eating barbequed pork or sausage; and contact with dogs and cats, particularly juvenile pets or pets with diarrhoea. In the United States only, an estimated 2 to 4 million cases of human campylobacteriosis [ranging from loose stools to dysentery] occur each year. Outbreaks occur mostly during the spring and autumn. A notable feature of the epidemiology of campylobacteriosis is the high isolation rate among infants and young adults [predominantly males]. Older children as well as middle-aged and older adults are less susceptible.

Headache, muscle pain, abdominal cramping, [bloody] diarrhoea, nausea, vomiting, and fever are the most common symptoms. Relapses are not uncommon, occurring in about 25% of cases. Fever that follows a relapsing or intermittent course is a constant feature of systemic *Campylobacter* infection. Swelling of liver and spleen are also frequent presentations. Less frequently, *C. jejuni* infections produce bacteraemia, reactive arthritis, Reiter's syndrome, and other extra-intestinal symptoms. The knee is the most commonly involved joint in reactive arthritis.

The incidence of campylobacteriosis in HIV-infected patients is higher than in the general population.

As with cholera, supportive measures, particularly fluid and electrolyte replacement, are the principal therapies for most patients with acute campylobacteriosis.

GUILLAIN-BARRE SYNDROME

Guillain-Barre syndrome [GBS], a demyelating disorder resulting in acute neuromuscular ascending paralysis, is a serious sequela of *Campylobacter* infection. An estimated one case of GBS occurs for every 1,000 cases of campylobacteriosis. Up to 40 [western countries] to 65% [Japan] of patients with the syndrome have evidence of recent *Campylobacter* infection, although various other infectious agents [eg, Epstein-Barr virus, and cytomegalovirus] as well as immunisations have been implicated. Studies demonstrate that a high proportion of GBS patients have *C. jejuni* in their stools at the time of onset of neurologic symptoms. Studies have found that

preceding infection with *C. jejuni* is associated with neurological degeneration, slow recovery and severe residual disability compared to GBS patients without prior infection. The frequency of *C. jejuni* infection as the predominant antecedent infection in GBS is especially high in Japan.

Since the decline in the number of polio cases, GBS represents the leading cause of acute flaccid paralysis. Symmetric weakness and/or paraesthesias beginning in the legs and spreading to the arms and upper body characterise the progressive course of GBS, which may develop over hours to days to weeks. Weakness is more prominent than sensory deficits.

Deep tendon reflexes are lost. Sphincters usually are spared. Recovery may be without or with only minor long-term effects, whereas mechanical ventilation may be required in severe cases due to respiratory paralysis. Autonomic dysfunction develops in severe cases, including manifestations such as orthostatic hypotension [low blood pressure caused by standing up], weakness of facial and oropharyngeal muscles [which aid swallowing], pupillary changes, sweating abnormalities, and cardiac arrhythmias. Approximately 15% of GBS victims remain bedridden or wheelchair bound at the end of one year.

The development of GBS is rare in children less than 2 years of age despite their susceptibility to *Campylobacter*.

HOMEOPATHY

The distinct link between *C. jejuni*-induced gastroenteritis and GBS appears to justify the introduction of *Campylobacter jejuni* into homeopathy. Initially prescribed as a nosode on a clinical-aetiological basis, exact homeopathic examinations eventually will lead to an established drug picture in its own right.

To date no individual symptom picture of *C. jejuni* is known, except for a few clinical indications provided by Ptok, which relate to the digestive system only:

Gastrointestinal disorders, particularly involving the stomach, accompanied by loud eructations after eating and stomach pain aggravated by pressure, flatulence with discharge of odourless flatus, especially in the afternoon; rumbling in abdomen beginning around 3-4 p.m.; urging to stool thirty minutes after eating.

[M. Ptok, *Der Wert der Nosoden-*, Allgemeine Homdopathische Zeitung, 5/1999]

IB. FAMILY HELICOBACTERACEAE

Helicobacter pylori

HELICOBACTER PYLORI

Scientific name

Helicobacter pylori (Marshall et al. 1986) Goodwin et al. 1989

Old names

Campylobacter pylori Helicobacter nemestrinae

Family

Helicobacteraceae

Homeopathy

Helicobacter pylori - Helic-p.

FEATURES

- Gram-negative, highly motile, curved or spiral rod with four to seven unipolar flagellae.
- Worldwide distribution; estimated to be present in the stomach of one-third of the world's population. In Western countries, about 50% of people over 60 years of age are carriers of the organism, while 20% below the age of 40 have them. Its presence is uncommon in young children.
- Survives the acid environment of the human stomach by residing in the mucus layer overlaying the gastric mucosa, a niche protected against gastric acid, and by generating ammonia and bicarbonate, which buffer acidity. Ammonia damages gastric epithelial cells.
- Has also been isolated from faeces and dental plaque.
- Linked with chronic superficial gastritis and peptic ulcer, yet also frequently isolated from asymptomatic persons who have no dyspeptic or ulcer-related symptoms, suggesting that *H. pylori* is a fortuitous and non-pathogenic agent.
- Acute infection may cause vomiting and upper gastrointestinal pain; hypochlorhydria and intense gastritis develop.
- Essentially all patients with duodenal ulcers harbour *H. pylori* in the duodenum. Ulcer patients without *H. pylori* infection are typically those who have taken non-steroid anti-inflammatory drugs such as aspirin and ibuprofen, which make the stomach vulnerable to the harmful effects of acid and pepsin.

-
- In the current vaccination craze, development of vaccines against *H. pylori* is underway, for which *Helicobacter felis*, inhabiting the stomach of cats, is used as an animal model.

HOMEOPATHY

Helicobacter pylori, listed as “Helic-p.” has seven symptoms in Synthesis 9.1:

Stomach, Acidity.

Stomach, Eructations acrid, after eating.

Stomach, Heartburn.

Stomach, Hyperchlorhydria.

Stomach, Pain, burning, after eating.

Abdomen, Pain, burning, after eating.

Abdomen, Ulcers, duodenum.

Like with other small nosodes, there is hardly any way to predict its value as a homeopathic remedy until a drug picture has been established on the basis of provings and/or clinical experience.

Individual indications are lacking, unless one would accept as valid such diagnostic terms as gastritis, peptic ulcer, duodenal ulcer and the like. Some clues may be derived from the observation that duodenal ulcers usually occur for the first time between the ages of 30 and 50, while stomach ulcers are more likely to develop in people over age 60. Duodenal ulcers occur more frequently in men than women, with the reverse for stomach ulcers.

Orthodox medicine regards the rising prevalence of the organism in age-related hypochlorhydria and associated gastric carcinoma as sufficient evidence for a causal relationship, contending that eradication of the bacterium from patients greatly reduces the recurrence of ulcers. Homeopathy holds that proper constitutional treatment improves the general condition, which will result in a less agreeable environment for *Helicobacter*.

At any rate, Dr. Barry Marshall, the Australian microbiologist who discovered the bacterium in 1983 in biopsies of gastric ulcers, “did something that only a very few physicians have done before him: he gave himself a stomach ulcer by swallowing some *Helicobacter* bacteria,” as Buckman has it. Except for audible nocturnal intestinal gurgling, he had no symptoms for a week. On the 7th day, he had a feeling of epigastric fullness after the evening meal, and

on the 8th day, he vomited on waking up at 5 a.m. The vomitus “had no acidic taste.” He became irritable and was accused of having “putrid” breath. Endoscopic gastric biopsies on the 10th day showed histologic evidence of gastritis with spiral bacteria adherent to the glandular epithelium. Culture of the biopsy material grew *H. pylori*. Morris in 1987 conducted a similar experiment on himself and noted on day 2 cramping and vomiting increasing in severity to day 4; on day 5 gastric pH was 1.2 and biopsies showed acute antral gastritis.

On homeopathic level, Ptok claims success with this nosode in 30x, single dose, in “gastrointestinal affections, esp. gastric, consisting of loud eructations after eating, stomach pains aggravated by pressure, flatulence with discharge of odourless gases, in particular in the late afternoon, abdominal rumbling from 3-4 p.m., and urging to stool half an hour after eating.” [M. Ptok, *Der Wert der Nosoden*, Allgemeine Homöopathische Zeitung, 5/1999]

My experience is that the helicobacter flourished in one patient despite good constitutional homeopathic treatment of twenty years. Although the patient herself was asymptomatic, her husband complained that before a period her breath smelled so badly that it filled the room. As nobody else could detect this change, the husband submitted himself to treatment on the basis of Delusions of odours! However, he still maintained that his wife’s breath smelled terrible.

So she went for medical biopsy, and sure enough *H. pylori* was cultured and ulcers discovered. She accepted one course of antibiotics, after which her breath improved and also her already good response to homeopathic remedies. Her father had a history of ulcers, but she had never shown any symptoms. Her constitutional remedy was Arsenicum. A subsequent biopsy showed no ulcers.

[Jenni Tree]

PHYLUM SPIROCHAETAE

Phylum Order

Family Genus Species Remedy

| | | |
|--------------------------------|-----------------------------|--|
| SPIROCHAETAE — Spirochaetales^ | Leptospiraceae — Leptospira | — <i>L. interrogans</i> — Weil's disease |
| | Borrelia | — <i>B. burgdorferi</i> — Lyme nosode |
| | | <i>T. pallidum</i> — Syphilinum |
| | Treponema | <i>T. pertenu</i> — Framboesinum |

Looking like tightly coiled snakes, spirochaetes are characterized by unique structures in the cell wall called *axial filaments*, composed of flagella and responsible for the motility of these organisms. Spirochaetes are able to move flexibly through thick, viscous liquids with great speed and ease. In other respects the spirochaete cell is similar to that of other gram-negative bacteria. The cell body is a long cylinder coiled into a spiral. Many spirochaetes live in humans and animals as internal parasites. Others live free in mud or water.

All spirochaetes are chemo-heterotrophs, i.e. they depend on organic chemicals for their energy and carbon.

Leptospira spp. differ from other members of the phylum in requiring gaseous oxygen, the slightest trace of which kills most other spirochaetes.

I. ORDER SPIROCHAETALES

IA. Family LEPTOSPIRACEAE

IB. Family SPIROCHAETACEAE

IA. FAMILY LEPTOSPIRACEAE

Leptospira interrogans

LEPTOSPIRA INTERROGANS

| | |
|------------------------|--|
| Scientific name | <i>Leptospira interrogans</i> (Stimson 1907) Wenyon 1926 emend. Faine and Stallman 1982 |
| Old name | <i>Leptospira interrogans</i> serovar <i>Icterohaemorrhagiae</i> |
| Family | Spirochaetaceae |
| Homeopathy | <i>Leptospira ictero-haemorrhagica</i> - Leptos-ih. |

FEATURES

- Obligate aerobic, flexible, spiral-shaped, Gram-negative spirochaete with internal flagella.
- Normally found in rodents [rats] but can infect humans, dogs, cattle, horses, and swine. Field mice, voles, shrews, and hedgehogs are common reservoirs.
- Can establish a commensal relationship with animal hosts, persisting in the renal tubules without producing disease or causing pathologic changes in the kidney.
- Enters human host through mucosa [eyes, nose, mouth, pharynx, oesophagus] and broken skin. Multiplies in organs, most commonly the central nervous system, kidneys, and liver. Infective bacteria are shed in the urine.
- Survives outside the host best in fresh water, damp alkaline soil, vegetation, and mud with temperatures higher than 22° C.
- Cannot survive in an acidic environment.
- Requires vitamins B1 and B2 as the only organic compounds necessary for its growth.

LEPTOSPIROSIS

Acquired by contact with animals [infected urine] or from contact with fresh water, damp soil, or mud, leptospirosis is known under a variety of names: Weil's disease, Canicola fever, Hemorrhagic jaundice, Mud fever, Swamp fever, and Swineherd's disease. It is an occupational hazard to rice and sugar cane field workers, farmers, veterinarians, coal miners, sewer workers, pet shop owners, military troops, abattoir workers, laboratory workers handling infected rodents or dogs. Outbreaks occur also among those exposed to rivers or lakes contaminated by animal urine. Leptospirosis is a problem in deteriorating inner cities that are infested by rats.

The condition prevails in male adults and is biphasic, i.e. periods of intense exacerbations are followed by periods of remission.

The disease has a seasonal incidence. Most cases occur during the rainy season in the tropics and, in Western countries, during the late summer or early fall, when the soil is moist and alkaline.

The main clinical manifestations include a combination of fever, renal involvement and/or jaundice or hepatic involvement, haemorrhages, eye symptoms, meningism, and neurological signs.

Clinical manifestations of leptospirosis are associated with a general febrile disease and are not sufficiently characteristic for diagnosis. As a result, leptospirosis often is initially misdiagnosed as meningitis or hepatitis. Typically, the disease is biphasic (an acute leptospiremic phase followed by the immune lepto-spiruric phase.) The three organ systems most frequently involved are the central nervous system, kidneys, and liver. After an average incubation period of 7 to 14 days, the leptospiremic acute phase is evidenced by abrupt onset of fever, severe [frontal] headache, muscle pain, and nausea; these symptoms persist for approximately 7 days. Jaundice occurs during this phase in more severe infections. With the appearance of anti-leptospiral antibodies, the acute phase of the disease subsides and leptospire can no longer be isolated from the blood. The immune leptospiruric phase occurs after an asymptomatic period of several days. It is manifested by a fever of shorter duration and central nervous system involvement [meningitis]. Leptospire appear in the urine during this phase and are shed for various periods depending on the host. The more severe form of leptospirosis is frequently associated with infections having the serotype icterohaemorrhagiae and is often referred to as Weil's disease.

... The most notable feature of severe leptospirosis is the progressive impairment of hepatic and renal function. Renal failure is the most common cause of death. The lack of substantial cell destruction in leptospirosis is reflected in the complete recovery of hepatic and renal function in survivors. Although spontaneous abortion is common in infected cattle and swine, only recently has a human case of fatal congenital leptospirosis been documented.

[<http://gsbs.utmb.edu/microbook/ch035.htm>]

CLINICAL FEATURES

- LEPTOSPIROSIS* => Mental confusion.
- HOSTS* == Mild delirium.
- Rodents, dogs, cattle,* = Psychosis.
- horses, pigs.* = Fever. Chills.
- Survives in damp, wet,* = General malaise.
- alkaline, mud.* « Generalised enlargement of lymphatic glands, resembling infectious mononucleosis.
- Inhabits organs, liver,* = Hypotension.
- kidneys, CNS in* « Muscle pains or cramps, primarily affecting calves and thighs.
- humans.* ~ Joint pains.
- Bacteria are shed in* = Haemorrhages; petechiae; purpura; ecchymosis; epistaxis.
- urine.* = Anorexia.
- Also known as:* = Severe frontal headache, & pain behind eyes; “intense and poorly controlled by analgesics; this often heralds the onset of meningitis.”
- Weil's disease* = • Photophobia.
- Canicola fever* = Conjunctival suffusion.
- Mud fever* «■ Subconjunctival haemorrhage. [Keynote]
- Swamp fever* = Iridocyclitis; chorioretinitis [may persist for years].
- Swineherd's disease* = Nausea and vomiting.
- Haemorrhagic* = Renal symptoms: oliguria; anuria; pyuria; haematuria; proteinuria; jaundice
- jaundice* = Pulmonary symptoms: cough; dyspnoea; chest pain; blood-stained sputum; haemoptysis.
- = Cardiac arrhythmia.
- = Skin rash.
- = Jaundice.

[Data collated from WHO & International Leptospirosis Society, *Human Leptospirosis*’, and J. Green-McKenzie, *Leptospirosis*, at: www.emedicine.com/emerg/topic856.htm]

MATERIA MEDICA LEPTOSPIRA

Leptos-ih.

Sources

Clinical pathogenesis by Julian.

[Although having a worldwide distribution, with incidence varying from sporadic in temperate zones to endemic in a few tropical countries, leptospirosis has a relatively high prevalence in continental France plus French overseas territories, with 5104 reported cases in the period 1996-2002. In the USA, where leptospirosis has been removed from the list of notifiable diseases, 43-93 cases are reported annually. The actual numbers are probably much higher and in particular seem to be rising among urban children. However, many cases are asymptomatic or mildly symptomatic, self-limited, and non-fatal. Little is known about long-term sequelae.]

With one entry in the repertory - Eye, Inflammation, Conjunctiva - the chance of coming across this remedy through repertorisation are nil.

SYMPTOMS

= Flu-like condition with chill, headache, diffuse pains, and asthenia.

“ Meningeal syndrome with headache, vomiting, muscle pains, pain in spine, and fever.

= Relapsing infections.

= Jaundice; stool normal, urine very dark-coloured.

= Conjunctivitis & photophobia.

= Epistaxis.

~ Pain in muscles and joints.

= Herpes nose and lips; petechiae.

“Leptospira seems to be of great therapeutic value in acute or subacute hepato-biliary affections. It closely resembles *Phosphorus*.” [Julian]

IB. FAMILY SPIROCHAETACEAE

Borrelia burgdorferi

Treponema pallidum

Treponema pertenuis

BORRELIA BURGDORFERI

Scientific name *Borrelia burgdorferi* Johnson et al. 1984

Family Spirochaetaceae

Homeopathy *Borrelia burgdorferi*

Borrelia nosode

Lyme nosode

FEATURES

- Named after W. Burgdorfer, the physician who isolated the spirochaete from a deer tick in 1981.

BORRELIA is also known as: LYME DISEASE

HOST Parasitic in animal mucosa VECTOR

Ixodes scapularis - a tick [found on deer]

Can camouflage itself in humans; can exist in suspended animation until conditions are favourable for it.

Hence it is a relapsing condition.

- Flexible, spiral-shaped, Gram-negative spirochaete propelled by an internal arrangement of flagella, bundled together, that runs the length of the bacteria from tip to tip.
- Microaerophilic, i.e. requires oxygen but less than is present in the air.
- Parasitic on many forms of animal life; found on mucous membranes.
- Transmitted by tick bites.
- The lipid components of *Borrelia* are unusual in that they include cholesterol, a substance found in only one other bacterial genus, *Mycoplasma*.
- Also one of the very few bacterial species having linear DNA [typical of organisms with nucleated cells] instead of circular DNA.
- *B. burgdorferi* is a slow growing [division time is estimated to be 12-24 hours], fastidious organism that requires a complex liquid medium and an optimal temperature of 33-35° C for growth, due to which it is extremely difficult to culture *in vitro*.
- Glucose provides its major energy source and lactic acid is the predominant metabolic end product.

* Readily adapts to various hosts and “can enter the tissue that is optimal for its survival, and it may evade the immune system and antibiotics by hiding inside certain types of cells. ... It is for certain that its ability to kill B-lymphocytes evolved as part of a defence mechanism to evade its own destruction. The observation that it can use the B-cell’s own membrane as camouflage indicates that it may be able to go undetected by our immune system. The way our immune system is supposed to work is that it recognizes foreign invaders as being different from self, and attacks the infection. ... The most intriguing fact about *Borrelia spirochaetes* is their well documented ability to change the shape of their surface antigens when they are attacked by the human immune system. When this occurs, it takes several weeks for the immune system to produce new antibodies. During this time the infection continues to divide and hide.” [Grier]

- “Like other spirochaetes, such as those that cause syphilis, the Lyme spirochaete can remain in the human body for years in a non-metabolic state. It is essentially in suspended animation, and since it does not metabolise in this state, antibiotics are not absorbed or effective. When the conditions are right, those bacteria that survive can seed back into the blood stream and initiate a relapse.” [Grier]

NOTE: While it was first thought that *B. burgdorferi* was the only species causing Lyme disease, it has since been determined that any number of the different species in the genus *Borrelia* might be capable of this feat.

The different manifestations of Lyme Borreliosis do not show an even geographical distribution. This is partly due to the uneven distribution of the different genospecies of *B. burgdorferi* sensu lato, some of which seem to be associated with particular symptoms. Only one of them, *B. burgdorferi* sensu stricto, has been implicated as the cause of disease in North America, mainly causing arthritis [60%], but in Europe three genospecies, *B. afzelii*, *B. garinii* and *B. burgdorferi* sensu stricto, are known to be pathogenic. ... *B. afzelii* seems to be associated with a degenerative skin condition, acrodermatitis chronica atrophicans, and *B. garinii* with neurological symptoms. However, these associations are not clear-cut and there

LYME DISEASE

SYMPTOMS

STAGE ONE

Rash, large red splotches,

maybe bull’s-eye,

wandering.

Flu symptoms

Glands involved

STAGE TWO

[may last a year]

Less rash

Fatigue

Hypoglycaemia

Glands

Headache

Joint pains

Facialpalsy/cranial nerves

Carditis

STAGE THREE

Arthritis - large joints

Carditis

CNS problems -

numbness, delusions

Brain fog.

Dementia

is considerable overlap. *B. garinii* seems to predominate in western Europe and *B. afzelii* becomes more prevalent in northern, central and eastern regions, while there is some evidence that *B. burgdorferi* s.s. has been introduced from the west. [European Union Concerted Action on Lyme Borreliosis, 1997-2003]

LYME BORRELIOSIS

Borreliosis or Lyme disease occurs in the north temperate zone. It is the most commonly reported tick-borne infection in Europe and North America. A multi-system disorder, borreliosis can affect a complex range of tissues including the skin, nervous and musculoskeletal systems, and to a lesser extent the eyes, kidneys, and liver. [Predilection for the latter three organ systems is more specific for *Leptospira*.]

The term Lyme disease was first used following investigation into a geographical cluster of juvenile rheumatoid arthritis in the town of Old Lyme, Connecticut, USA, in the mid 1970s. Subsequent studies led to the isolation from the deer tick, *Ixodes scapularis* [*dammini*] of a gram-negative spirochaete, which was named *Borrelia burgdorferi*. The disease has, however, been known in Europe under a variety of names [including erythema migrans, acrodermatitis chronica atrophicans, Bannwarth syndrome*] since the 1880s. In 1909, Afzelius had associated a red rash [erythema migrans] with the tick, *Ixodes ricinus*.??36

In 1948, spirochaetes were observed in erythema migrans [EM] biopsies and in 1951 a Swedish clinician, Hollstrom, successfully treated EM infected patients with penicillin. Also in 1951, it was suggested that EM, with associated meningitis, was probably the result of an infection by a tick- or other insect-borne bacterium. ... However, EM was considered a relatively harmless condition with no connection made between the lesion and subsequent symptoms caused by the same bacterium. [European Union Concerted Action on Lyme Borreliosis, 1997-2003]

The clinical presentation of borreliosis can be divided according to its progress. Borreliosis runs its course in three stages. The early stage presents in up to 70% of cases with erythema migrans, an expanding red maculopapular rash that can reach a large size in diameter and typically clears from the central area [“bull’s-eye rash”]. The rash can be circular, triangular, and

cover large portions of the body. Vague or pronounced flu-like symptoms and sometimes glandular swelling accompany the rash.

During the second or disseminated stage, which may last for over a year, the spirochaete spreads gradually to other tissues via the bloodstream and lymphatics. Manifestations of this stage may include erythematous patches [usually smaller than the initial lesion], fatigue, headache, muscle and joint pains, facial palsy or other cranial nerve lesions, and, rarely, carditis. Progression to the third stage, late borreliosis, involves Lyme arthritis, commonly restricted to the large joints, acrodermatitis chronica atrophicans, and neuroborreliosis.

Erythema migrans, the characteristic rash which may appear some days to weeks following infection, is the most common manifestation, next comes arthritis, then neuroborreliosis, while carditis is rare. Some studies report higher disease incidence rates for males, although a recent Swedish study on recurrence of erythema migrans showed the majority of cases to occur in middle-aged women.

In addition, acrodermatitis chronica atrophicans [indurated, erythematous plaques, bluish-red, commencing on feet, hands, elbows, or knees, and gradually progressing to epidermal atrophy with thin, shiny, papery appearance of the involved sites] reportedly occurs mainly in elderly women, whereas bilateral facial palsy is a frequent manifestation in children. The number of cases of Lyme disease reported in the United States is about 17,000 per year, but the actual incidence is estimated to be some 10 times higher. According to a WHO report, the number of European cases approaches 60,000 annually.

* Bannwarth syndrome or Garin-Bujadoux syndrome [“paralysie par les tiques,” tick-induced paralysis] is characterised by intense pain, mostly in the lumbar and cervical regions, and radiating to the extremities, accompanied by migrating sensory and motor disorders of the peripheral nerves, including such symptoms as facial paralysis, abducens palsy, paraesthesias, anorexia, fatigue, headache, diplopia, and erythema migrans.

THE IMITATOR’S NEW CLOTHES

Syphilis was known as the “great imitator” because its multiple manifestations mimicked other known diseases. Lyme borreliosis, likewise, has now entered the stage as “the new great imitator.” P.H. Duray concedes: “Initially thought to be a disorder beginning in the skin and progressing to involve the

joints, Lyme disease is now ranked as one of the great mimickers of other diseases, in a manner similar to that once ascribed to syphilis.” Sir William

Lyme Disease has been Osler remarked that “to know syphilis is to know all of medicine.”
misdiagnosed as:

Arthritis Homeopathy knows the major syphilitic remedy, Mercurius, as the “great masquerader.” Judging by the close family connection
Rheumatoid arthritis between both spirochaetes, it does not come as a surprise that
Juvenile arthritis one of very first cases of borreliosis, in 1922 in France, had a
Fibromyalgia weakly positive syphilis test and thus was treated with arsenicals, the then current treatment for syphilis. Making another
Chronic Fatigue connection with Mercurius, it is interesting that the writer Amy
Multiple sclerosis Tan, a *Borrelia* sufferer, refers to the disease as “the terrorist in
Lupus my body”. She has trained her dogs to “sniff out bin Laden” -
Amyotrophic lateral using them to tell her whether the enemy she sees is real or one
sclerosis of her many violent hallucinations.
Alzheimer’s disease

Crohn’s disease There are great differences in how borreliosis manifests in
Irritable bowel Europe versus in the USA. The major presentation of early
syndrome neuro-borreliosis in the USA is facial palsy, whereas it is
Post traumatic Stress encephalomyelitis in Europe. In Europe, the erythema migrans
Disorder lesion is quite indolent and sometimes hardly noticeable, while
Dementia US patients have intense inflammatory cutaneous reactions
with early dissemination. Acrodermatitis chronica atrophicans

is only seen in Europe. Conversely, arthritis is uncommon in Europe, but extremely common in the USA in untreated patients. Neuroborreliosis overall seems to prevail in Europe. These differences are attributed to the distribution of the various *Borrelia* species.

There is a wide range of symptoms associated with Lyme borreliosis. Symptoms vary greatly, one or more systems may be involved, and new manifestations continue to be described. Like syphilis, Lyme borreliosis may remain latent and asymptomatic for a long period of time; progress for many years through successive stages; or fluctuate dramatically and unpredictably.

Many Lyme patients were first diagnosed with other illnesses such as arthritis, juvenile arthritis, rheumatoid arthritis, fibromyalgia, chronic fatigue syndrome, multiple sclerosis, lupus, early ALS [amyotrophic lateral sclerosis], early Alzheimer’s disease, Crohn’s disease, irritable bowel syndrome and various other more nondescript illnesses.

So bewildering is the range of symptoms that a borreliosis patient conceded that “while one misguided doctor writes in his book on Lyme that the more

widespread and peculiar the symptoms are, the more likely the complaint is psychosomatic, I'd have to say that the more widespread and peculiar the symptoms are, the more likely that the problem is Lyme disease."

Diagnosis is controversial; some believe the disorder to be "over-diagnosed," others think it is "under-diagnosed" and again others speak of frequent "mis-diagnosis." The virulence of the spirochaete is equally poorly understood. Involvement of immunological host factors have been proposed, whereas the remission of even psychiatric disorders after antimicrobial treatment is deemed proof that it concerns merely a bacterial infection.

Tracking the culprit, the new elusive spirochaete, is riddled with problems, considering that there are asymptomatic seropositive patients, seronegative patients with intractable symptoms, patients with persisting symptoms despite the standard two-to-four-week IV antibiotic treatment regimen, seropositivity despite antibiotics, and so on.

Patients may have one or all of the stages, or the illness may not become symptomatic until stage 2 or 3. What initially was held for "Lyme Hysteria" turns out to be linked with long-term, chronic problems. Yet, there is, as one author put it, "chronic persistent denial of chronic persistent infection in Lyme Disease."

TICK-STRICKEN

Borrelia is transmitted by ticks belonging to the genus *Ixodes*. The two-year life cycle of the tick consists of four stages: egg, larva, nymph, and adult. Between each stage the tick needs a blood meal in order to mature. It usually becomes the host for the *Borrelia* spirochaetes during its larval stage, when it feeds on small animals such as rodents or birds. After its blood meal the tick drops off the host to transform over a period of months into the next instar. Because off-host ticks are vulnerable to desiccation, an environment with high humidity is required to maintain a stable water balance.

Temperate deciduous woodland with patches of dense vegetation and little air movement coupled with high humidity constitute ideal conditions. Here *Ixodes* will be encountered, usually in the spring, the season that warrants sufficient humidity. Animals or humans brushing through the vegetation may pick up ticks, then commonly in their nymphal stage, involuntarily assisting in the completion of their life-cycle.

While gorging, ticks increase salivation and with the saliva the spirochaetes which resided in the tick's digestive tract pour out. Ticks are slow feeders, so

that spirochetal transmission usually happens after the tick has been feeding for 24 hours. Prompt removal of the attached tick is therefore believed to prevent infection. Given time, the tick needs to strike only once. That such a relatively short, though unwelcome visit has such devastating long-term effects seems incredible. Although a history of exposure to a tick-endemic area is essential to support the diagnosis of Lyme borreliosis, about one-third of patients do not recall a rash or tick bite “because the nymphal stage of the tick is so tiny and many rashes in body hair and in discrete areas go undetected.”

The dazzling array of borreliosis symptoms has prompted disbelief. One explanation is that the tick simultaneously delivers other parasites such as Ehrlichia canis [ehrlichiosis], Coxiella [Rickettsia] burnetii [Q fever], other rickettsias, Staphylococcus aureus, and Babesia species [babesiosis]. Rather than using the broad spectrum of symptoms as the main guideline, a medical system that so strictly bases its treatment on diagnosis and identification of causative agents is likely to fail. Psychiatrist Robert Bransfield writes: “There has been a recent trend to incorrectly view so called ‘objective’ signs and symptoms as more valid than those which are ‘subjective.’ Often a machine or laboratory test is perceived as giving validity to these ‘objective’ signs. Many of these ‘objective’ tests are far less valid and are based on questionable techniques, faulty assumptions, and flawed logic. On the other hand, ‘subjective’ complaints are sometimes viewed with excessive suspicion. ... In an effort to create predictability, reliance upon cookbook medicine has given us a recipe for disaster.”

The commonly used ELISA test [enzyme linked immunoassay], although having a 90% specificity, delivers an unacceptable amount of false negatives as its sensitivity level is only 65%. The Western blot test is more sensitive. Allopathic treatment by ten days of anti-biotics is insufficient in long term sufferers when the spirochaete is already comfortably ensconced in the brain. And Thomas Grier says: “Too often, I have seen the word *cured* used in Lyme Disease Studies, only to find that the researchers have redefined the word cure to mean seronegative. Seronegativity is not synonymous with cure. The numerous culture positive cases in recent years should have negated that kind of logic years ago, and yet, in 1997, researchers are still publishing studies that use antibodies and PGR as the end point for cure. It’s time to ask the patients one simple question: How are you feeling?”

SYPHILITIC MIASM

We cannot fail to see the close resemblance between Lyme borreliosis and the syphilitic miasm with *Syphilinum* as its prototype. The correlations even go beyond the symptomatology, encompassing such elements as controversy, denial, stigmatisation, blame, and banishment. Hardly any other subject creates as much alienation as the syphilitic miasm in all its disguises.

With the exception of a few symptoms, borreliosis appears to be a spitting image of the syphilitic miasm in general and *Syphilinum* in particular, as is evidenced by Boericke's and Clarke's summary of the latter:

- « Utter prostration and debility in the morning.
- = Fears the night, and the suffering from exhaustion on awakening.
- = Shifting rheumatic pains.
- = Chronic eruptions and rheumatism.
- ~ Alcohol.
- = Loss of memory [names, dates, etc.]; remembers everything previous to his illness [i.e. short-term memory deficit].
- == Hopeless; despair of recovery, does not think will ever get better.
- = Cross, irritable, peevish.
- = Violent on being opposed.
- » Feels as if going insane or being paralysed.

The theme of insanity pervades the borreliosis picture. Pains are described as maddening; patients are labelled as crazy by medical practitioners; patients go out of their minds from their complaints falling on deaf ears.

Descriptions of the mental state induced by *Borrelia* depict the despair and darkness, the forceful removal of hopes and dreams:

- ~ "In this darkness that surrounded me, there was no room left to turn or to run. Only to survive. Days passed like an insect caught in tree sap. Enveloping. A strangely warm, amber struggle in slow motion - a quiet resignation to a world that was filled with nightmare images. Trapped in a mind that knew it had gone insane."
- = "I thought I was slowly going crazy, never knowing what the next day would bring."
- "Some days I haven't a clue what I did two days ago or even that morning. This continues to drive me crazy."
- = "After years of being told that I was crazy and then suddenly that I had

yme ORDER: *Spirochaetale*:

some type of auto-immune connective tissue disease ...
 = “I was trying to make sense of it myself, I was grasping at straws for an explanation of what was happening to me. ... I felt as if the self knew was dissolving.”
 « “Sometimes one can’t hope *for* better. One can only hope for differe .
 Death is definitely different.”
 „ “When I looked in the mirror I saw someone I didnt recognise.
 => “In essence, I was dropping out of life.
 [Citations extracted from the Personal Stories collected on the website Lymealnhance.org!

MATERIA MEDICA BORRELIA

Non-existent in homeopathy to date, the extensive literature on Lyme borreliosis provides a fine opportunity for the creation of a provisional yet ThTnumbenbehind the symptoms refer to the sources below from which the symptoms were collated.

SYMPTOMS

MIND

General picture

- „ “In one U.S. study of 27 patients with late neuroborreosis, 33 /0 were depressed based on their scores on the Minnesota Multiphasic Personality Inventory. 89% of these 27 patients also had evidence of a mild encephalopathy, characterised by memory loss [81%], excessive daytime sleepiness [30%], extreme irritability [26%], and word finding difficulties [19%]. Controlled studies indicate significantly more depression among patients with late Lyme borreliosis than among normal controls and other chronically ill patients.’²
- “A diagnostic tip in favour of Lyme disease as the cause of the depression and irritability might be concomitant memory loss, word finding problems, or a concomitant polyneuropathy.”²

Hypersensitivity.

Light.

=Photophobia [keynote]; must wear sunglasses or glacier glasses, even indoors, even at night.³

[Massimo Mangialavori lists this as one of the features of the Parasites group of remedies.]

a Feeling of faintness or dizziness from exposure to fluorescent lights, making it difficult to go to supermarkets or other public places.³

[DD: Bird remedies]

= Panic attacks triggered by light stimulation, esp. flickering bright lights.³

- Nausea from flickering bright lights, fluorescent lights, TV or computer screens, strobe lights during EEG testing or the headlights of cars moving in the opposite line of traffic.³

Sound.

= Ordinary conversation perceived as deafening; wears head phones and puts pillows over his head to block out the sound.³

a “To one woman even the sound of another persons breathing seemed unbearably loud. In her case, the sound sensitivity also included vertigo, nausea and nystagmus in response to sounds. Any sudden sound, like the phone ringing, and certain household sounds, like the running of tap water, could cause her to fall or retch. This peculiar short-circuiting of the inner ear’s auditory and vestibular functions is known as the Tullio phenomenon. This phenomenon has been deemed pathognomonic for syphilis but, as it appears, can occur in Lyme disease as well, and thus provides one more example of the ‘new great imitator,’ Lyme disease, imitating the old ‘great imitator,’ syphilis.”³

Smells.

» Smells seem overly intense and noxious.³

Taste.

» Foods taste abnormally sour or bitter.³

a Or the reverse: loss of taste *on left side of tongue*.¹

Touch

» Regional or generalised hyperaesthesia of skin to touch or temperature.¹

= Sensitivity to touch; “the bed sheet resting lightly on my toe would make

the toe ache, like a toothache.”¹¹

- “Even the thinness of a sheet was too painful for my legs.”¹¹

Vibrations.

~ Abnormally heightened vibration sense, eg, thinks car was vibrating with unusual violence.³

Emotional lability / mood changes / irritability.

<■ Accompanied by headache and neck stiffness.³

= Sudden, intense irritability from sensory stimulation [sound, touch, light] or occurring unprovoked and inexplicably.³

= Sudden, unprecedented fits of violence.³

- Uncontrollable outbursts. “A woman, typically reserved and eager to please, became uncontrollably irritable one day at work and found herself yelling at her boss in a most uncharacteristic fashion.”³

= Sudden bursting into tears from trifles.³

= Fluctuations from marked agitation to severe depression with suicidal threats.⁸

•» Rapid mood swings [from grandiosity to sudden tearfulness].⁸

« Violence; striking children and breaking furniture.⁸

- Homicidal ideation, urges, and behaviour occur in some of these patients. Some adult patients describe struggling to not act on these urges. When these patients act on a homicidal urge, more commonly it is a child becoming assaultive to a sibling. Dissociative episodes sometimes occur with these patients, occasionally accompanied by aggressive behaviour and loss of memory.⁹

Cognitive impairment - Lyme Fog

~ Short-term memory problems, word-finding difficulties, dyslexia, problems with calculations or inability to concentrate.¹

Many Lyme patients state “I feel like I have become dyslexic.” Impairment of reading comprehension is an earlier sign with the later addition of auditory comprehension difficulties. Acquired left/right confusion is seen with some of these patients displaying what appears to be an acquired Gerstmann’s syndrome or some variant of this syndrome.* They have problems with calculations and often complain of errors when trying to calculate their checkbooks. Fluency of speech is a very significant problem. When interviewing these patients, this is a

clearly evident symptom. Stuttering is seen in many of these patients.⁹
[Boy aet. 5] “I would mix up stories and get cranky. I tried to tell Mom that my brain was ‘sticky’, but she didn’t know what I meant. It didn’t hurt, it just wouldn’t work. I would climb up on the sink and put a wet washcloth on my head. On those days, my behaviour was hyperactive and I would stutter.”¹¹

“The kicker, though, was the virtually unexplainable difficulty in writing, typing, speaking, and thinking. I’d use the wrong letters, hit the wrong keys, stutter, reverse things, and find myself unable to say the right word. Everyone does this occasionally, but this was consistent and unrelenting. I felt like something poisonous had taken over my brain.”¹¹

On interview, patients with Lyme encephalopathy tend to be vague and disorganized in the presentation of the history of their illness. This is despite their close attention to their symptoms and having recounted them many times before. Although in most cases memory of discreet events - tests, dates, diagnoses, responses to medications — is intact, the patient is unable to recall them spontaneously or organize them in temporal order. They may be unclear as to their chief complaint. They may completely lose track of what they were saying, sometimes repeatedly, or of what the question was. They may get off on a tangent and have trouble re-orienting themselves. Frequent prompting and refocusing will be necessary. Beginning the interview with an open-ended question like “Tell me what the problem is” will allow these qualities to become clear.

However their experience is different from that of ADD, in that rather than having the experience that there are many thoughts competing for attention, the Lyme patient has difficulty bringing any thought into clear focus. They experience difficulty thinking. One patient described it as the universe ending six inches from his face. He can’t process information that is not immediately apparent, immediately experienced. Another said that when he tries to think about something, or figure something out, all he can do is repeat the question - he can’t get to the meaning. One patient, a physician, described it as a “mental intention tremor” — the more she tries to focus on something the more out of focus it becomes.¹⁴

= Brain fog. Problems with facial recognition.¹

» Spaced out, as if in a fog.³

= Difficulty remembering details such as names or appointment times.

- Engaged in new compensatory behaviour, such as daily list-making,³
- = Compensatory compulsions are common in an effort to compensate for the memory deficits.⁹
- = These [Lyme disease] patients generally come to the office disorganised [despite a supreme effort to be organized], unable to give a coherent history. They will bring copious notes, which are invariably in the wrong order.⁷
- « I used to have a quick mind and a good memory, now I was dependent on notes plastered everywhere so I could remember things.¹⁰

Mistakes in speaking and/or writing

- = “Patients with no prior history of dyslexia have found themselves writing letters backwards, reversing numbers or routinely reversing the first and second letters of a word.”³
- = Mistakes in time: says “tomorrow” instead of “yesterday” and vice versa.³ « Garbled speech, substituting like-sounding but nonsensical words.¹⁵

Spatial disorientation - sense of position [“spatial dyslexia”]

- = Loses his way in well known streets.³
- » Difficulty with spatial awareness of where front and back doors are in one’s own house.⁹
- « Disturbed sense of position. “Repeatedly bumps into things on the left side of her body, drops things from her left hand despite having no weakness in that hand and occasionally places objects several inches short of a table edge with the result that they fall to the floor.”³
- = Disturbed sense of position, esp. in hands; grasps the air when reaching for objects.⁶
- = “Everything around me looked strange. The people sounded like cackling geese. Everyone looked like they were in fast motion, like someone had sped up the projector. Every time I turned, I was dizzy and disoriented. I was sweating, and completely lost.”¹¹
- = “I was getting lost driving to places that I had been to hundreds of times.”¹¹
- = “I was getting lost in my own neighbourhood when I tried to drive.”¹¹
- = “I forgot where I was on my way home.”¹¹
- = “Difficulty ‘recognizing’ things when driving - familiar landmarks lost their meaning; I stopped at green lights, made wrong turns or drove past my destination, even in territory close to home.”¹¹

~ “In New York once, I wandered aimlessly for an hour in a snowstorm, just two blocks from home, because the blanketing of white rendered the terrain unfamiliar.”¹⁵

Hallucinations

- => Musical hallucinations with a sudden onset and taking the form of patriotic or operatic music.¹
- = “I was hallucinating both visually and auditorily. I heard phones ring when there were none. I saw shadows twist into menacing shapes. I heard voices talking. At night, I saw flashing lights fill my vision, and my ears were constantly buzzing with static and ringing. I felt for the first time that I might be truly going mad.”¹¹
- = [Upon awakening in the night] “A skeleton hallucination in black and white, looking at me, grinning a very toothy smile, head cocked, propped up by one arm.”¹¹
- = “The hallucinations always occurred when I had just awakened from sleep. Before me would spring the embodiment of my nightmares, the incarnation of my imagination ...a corpse lying next to me, or a pudgy poodle dangling from the ceiling, or a woman in a white dressing gown standing in a garden, a carnival barker playing a circus organ.”¹⁵

Intrusive thoughts/images

- « Intrusive obsessional thoughts with checking; horrific images of killing others; excessive bathing.⁸
- « Intrusive images which are more commonly of an aggressive nature but sometimes can be of a sexual or other nature. Occasionally these images are of a homicidal nature.⁹
- == “My mind was a hopeless jumble of uncontrolled thoughts - images and sounds that haunted me. It was as if several minds had been merged into one, and there was no way to sort the images.”¹¹

Fears

- » Chronic morbid dread of vomiting [without actual emesis]⁶.
- = Panic attacks in sleep.¹¹
- = “I woke up several times in pain and experiencing panic attacks.”¹¹

* Gerstmann's syndrome: inability to perceive a stimulus applied to the fingers, impairment of the ability to write, inability to do simple mathematical problems, and confusion of laterality of body.

CHILDREN

The majority, over ninety percent, of the children that we have treated complain of headache. The headache, in a few cases, has been very acute accompanied by papilloedema [oedema of optic disc] but in the majority of cases the headache comes on gradually, becomes quite persistent and does not respond to over-the-counter analgesics. In addition to the headache, the children complain of photophobia, dizziness, a stiff neck, backache, somnolence and, those that are in school, have problems with memory and difficulty concentrating. Some patients have developed progressive weakness.

The parents complain that pre-schoolers develop mood swings and become very irritable and they see a personality change. Among school age children and those who are in adolescence, chest pain is a very frequent complaint. At least seventy percent have complained of chest pain. About fifty percent have complained of abdominal pain. More than half the children have arthralgia usually involving the knee and sometimes also the wrist. Other complaints include palpitations, tingling, numbness, rashes that come and go, usually malar [cheek] rashes, and sore throats that are excruciatingly painful.

It is easy to see how this long list can be very non-specific and many of these children are thought to have functional problems.¹³

GENERALS

Typical combination of features

— Joint pain + major cognitive dysfunction [esp. short-range memory] + major sleep disturbances + terrible fatigue + sensory hyper-acuity.

Alternating states

— Perplexing fluctuation in symptoms. Spry and energetic one day, drained and confused the next day. May be brought on by exertion, stress, or exposure to sensory stimuli, or come without apparent cause. Cannot make plans due to the unpredictable nature of the fluctuations.³

= Days of near normality alternate with days of profound debility.¹

— The symptoms shift in kaleidoscope fashion from one hour to the next in the same patient and seldom present identically in two different individuals.⁶

<= “Days of hope and black despair coupled together.”¹¹

=> “I thought I was slowly going crazy, never knowing what the next day would bring.”¹¹

Suddenness

= These patients can become suddenly suicidal.¹

~ Sudden worsening of symptoms.²

« Sudden inability to remember how to transfer calls [in a woman who had been a telephone switchboard operator for 20 years] .²

=>> Worse by any sudden sound.³

= Sudden intense irritability.³

= Sudden soreness of sinuses and throat, then disappearing, then sore again in a seemingly rhythmic way.⁶

≡ Sudden, complete inability to swallow.⁶

≡≡ Awakened in the middle of the night by severe arthritic pains over entire body. Pain sudden, dramatic, and excruciating. Pain gone when waking the next morning.⁶

Sudden changes in stool consistency from normal to putty-like, to constipation [stools have to be removed mechanically], etc.⁶

Sudden arrhythmia.¹¹

Sudden falling to the ground.¹

Sudden paralysis. “As I stood in front of the bathroom sink brushing my teeth, I suddenly lost the use of my right arm and hand. A quivery, ticklish feeling travelled like lightning from the shoulder to the fingertips; paralysed, the arm dropped down into the sink, hit the enamel hard and broke the skin.”¹¹

Neurological

= Left-sided hemiparesis when waking up.¹

« « “The left side of my face was paralysed with the numbness extending to the left side of my tongue and down my throat. Also, my left side felt weaker and my left lung felt somehow affected - cold and heavy.”¹¹

« Intermittent paraesthesias.¹

» Nerve pains severe, *burning*, tearing, migrating, with characteristic exacerbations at night.³

« Clumsiness; “ataxia is common in these patients who are often clumsy, which leads to frequent accidents.”⁹

= The close resemblance between neuroborreliosis and certain neurological

conditions has been explained thus: “When the human brain becomes inflamed, cells called macrophages respond by releasing a neurotoxin called quinolinic acid. This toxin is also elevated in Parkinson’s Disease, MS, ALS, and is responsible for the dementia that occurs in AIDS patients. Quinolinic acid stimulates neurons to repeatedly depolarise. This eventually causes the neurons to demyelinate and die. People with elevated quinolinic acid have short-term memory problems.”⁴

Energy

- = “Too fatigued and sore to even think about moving around.”¹⁰
- = “The best description I can think of for the misery of acute Lyme disease is a combination of debilitating mononucleosis and severe arthritis in the knees and elbow.”¹⁰
- = Debilitating fatigue & periodic attacks of left-sided paralysis.¹⁰

Sleep - Night aggravation

- > Excessive daytime sleepiness.¹
- = Falling asleep while talking with others.⁶
- Falling asleep at work.¹¹
- = Narcolepsy. “At first, I would fall asleep spontaneously and unpredictably a few times a week, but over the next three months it climbed to four hundred times a day. I would fall when this happened.”¹¹
- = Can not sleep at night, can not wake up during the day.¹¹
- = Apnoea - a sudden ‘gasping’ for air just before falling asleep.¹¹
- == Sleeping disorder. “He [13 year old boy] would thrash around at night disrupting his bedding, knocking over lamps and rearranging things during the night. I never actually saw any of these episodes but saw the result of them in the morning.”¹²
- = “When I did sleep, it was a tortured sleep where I would toss and turn and tear at my covers. I despised warmth and craved cold. My bed in the morning would look like a war zone.”¹¹
- = “In the beginning, I was horrified to awaken knowing that I was still alive and had not died in my sleep. What a great cop-out, I would think, except the nightmares were actually worse than reality.”¹¹
- » “Woke up angry in the night that I hadn’t just died.”¹¹
- « “I experienced night terrors, where friends that had died in the last twenty years gathered around my bed nightly, smiling and waving for me to come with them. ... I hated to go to sleep at night because of my dead friends

appearing.”¹¹

= Early morning insomnia with nightmares.¹¹

= Sleeplessness due to pain in kidneys.¹¹

= Sleeplessness from stabbing pain in feet.¹¹

~ “I could sleep for only two or three hours before being wakened by a sensation I described as “Dolby-Digital syndrome,” a constant vibration within my body, which felt as though someone had installed in me a souped-up megabass system for stadium-strength rap music.”¹⁵

Pains

= Burning [pain] seems quite specific [to neuroborreliosis]; the patient describes a sensation that a blowtorch is burning the skin.⁹

= Feeling as if muscles and nervous system were on fire.⁶

= “The burning pain in my spine was so bad that I broke out in sweats day and night.”¹¹

•» Sharp shooting or stabbing pains.¹

= “My left arm, which had been numb down to my forefinger, now developed an icy-burning sensation. I’d had a similar problem with my right arm two years before.”¹⁵

Food & Drink

= Anorexia.¹

= “Eating disorders are common. Invariably these patients either gain or lose weight. Sometimes massive weight gain is also seen.”⁹

= Increased thirst.¹

= Intolerance for alcohol. “Most patients state, ‘I don’t drink any more’.”⁹

= Exaggerated symptoms or worse hangover from alcohol.³

Temperature

«= Great chilliness.¹

~ Low body temperature [slightly below normal],⁵

~ Profuse sweating.¹

® Unexplained sweats. Night sweats. Sweating even in cool temperatures.⁵

Weather

“ Symptoms worse in low pressure weather systems.”⁵

Miscellaneous

- = Lymphocytoma [small solitary bluish-red plaque or nodule], particularly at ear lobes or nipples.¹
- = Delayed development, failure to thrive in infants.⁵

LOCALS

Vertigo

- = Sensation of whirling motion of oneself or of external objects.¹
- = Meniere's disease.¹
- = Vertigo with drop attacks of the Tumarkin type.¹ *
- = Motion sickness.⁵
- = Balance severely off; would fall when closing eyes.¹¹
- = Vertigo from even slightly turning head; "the world would swim if I just moved my eyeballs."¹¹
- « Floor feels as it were rolling beneath the feet, or as if one were on an elevator or a boat, going up and down in waves.¹¹

Head

- <= Headache frontal or occipital; intermittent [duration] and fluctuating [intensity].¹
- ~ Feeling of pressure behind eyes, pain < moving eyes.¹
- Sore/tender areas on skull/scalp area.⁵
- = Pressure migrating from vertex to occiput when turning head.¹¹
- "When I would move my head, there was a disturbing gurgle as I heard bubbles move around inside my head."¹¹
- = Daily excessive hair fall in clumps.¹⁵

Eyes & Vision

- « Conjunctivitis.¹
- <- Intermittent diplopia and visual blurring.⁸
- <•» Diplopia & vertigo and nystagmus.¹
- = Tripplopia in right eye.¹¹
- = Sparks, spots, waves, floaters before eyes.⁵
- = Sensation of a foreign body in eye[s] [keratitis].¹
- = Twitching.⁵
- = Bloodshot eyes.⁵
- = Vision reduced to a circle directly in front of eyes; peripheral vision just a

blurry swirling mess of lights and images.¹¹

« “Seeing ‘trails’ of objects, i.e. my own moving limbs or doorways I walked through.”¹¹

Hearing

≈ Impaired hearing [bilateral] & fatigue, headache, or arthritis.¹

≈ Hearing loss & tinnitus.¹

Face

» Bilateral facial nerve palsy.¹

«= Muscle twitches in face.⁴

= Pain in face, teeth, articulation of jaw, and masticatory muscle.¹

= Swelling around eyes.¹

« Facial redness.⁵

= “My chin hurt, and felt ‘ticklish’ - as if something were blowing on it.”¹¹

~ Audible clicking of jaw when speaking or eating.¹¹

« “Around my mouth, all around the lips and down into the chin, a vibrating, biting, humming itch, as though there were a thousand bees swarming over my lips and the majority of them were stinging.”¹¹

Mouth

«• Numbness/tingling of face or tongue.¹

~ Weakness tongue.¹

« Sore spots on tongue.⁵

« Speech; slow and laboured; slurred; poorly articulated.¹

Throat

= Must drink in order to swallow food.¹¹

Urogenital

«Irritable bladder; trouble starting/stopping; frequent urination; voiding dysfunction.¹

<=> Urinary retention followed by paralysis of lower limbs.¹

= Numbness genitals.⁵

Chest

= Short stabbing pains in chest lasting only seconds.¹

« Dry, non-productive cough.¹

-
- ~ Awakening in middle of night with chest pains and pain and tingling down my left arm.¹¹
 - = Sensation as of hot water were being poured into lungs.¹¹

Back

- = Stiffness of nape of neck & headache, pain in joints and/or muscles, or fatigue.¹
- Weakness nape of neck.¹
- = Tired feeling between shoulder blades, as if neck wouldn't support weight of head.¹¹
- = Jabbing pain in the back as if being kicked in the kidneys.¹¹

Extremities

- Wandering joint/muscle pains [without swelling]; lasting only hours or days in a given location.¹
- = Pain in joints only on motion.¹
- = Joints sensitive to pressure.¹
- ~ Localised joint pains/swelling involving mostly the knee[s], and to a far lesser extent the ankles, shoulders, and elbows.¹
- = "I kept looking down at my upper arms to brush off the hair or cobwebs on them, and realised there was nothing there."¹¹
- <= Sensation as of a band pulled tightly around [right] lower arm halfway between wrist and elbow.¹¹
- = Tendon problems - hands/fingers temporarily lock into unusual position.⁵
- = Carpal tunnel syndrome; & numbness of fingers < during sleep or using hands.¹
- => Intention tremor hands.¹¹
- = Fingers on both hands fumble and cannot pick up small objects.⁶
- ~ White spots on fingernails; ridges; brittle nails.⁵
- Deep, aching, burning pains in the hamstring muscles when sitting; sits on the very edge of a seat; cannot bear touch or slightest pressure on hamstrings.⁶
- = Leg joints give out or wobbly, rubbery legs. Unable to walk.⁵
- <= Sensation of a tourniquet wrapped around right leg.¹¹
- = Restless legs at night in bed, resulting in sleeplessness.⁶
- » Throbbing pain in ankles and in long bones in calves and shins; "not an ache, but a feeling that someone had scraped the skin away, thrown salt into the raw tissue, then set it on fire."¹¹

~ Severe pain in balls of feet; painful to put any weight on feet.¹¹

Skin

=> Warm, wet or cold sensations on skin.⁵

= Regional or generalised hyperaesthesia of skin to touch or temperature.¹

~ Excessively itchy skin. Urticaria.⁵

* During Tumarkins episodes or Tumarkins otolithic crisis patients suddenly fall to the ground without prior warning and without losing consciousness. Thought to be caused by a sudden change of the otolithic organs in the ear, the condition is not uncommon in the later stages of Meniere's disease.

Sources:

- 1) Joanne Rubel, *Lyme Disease, Symptoms & Characteristics; A compilation of peer-reviewed literature reports*. Website Canlyme.com.
- 2) B.A. Fallon et al., *The Neuropsychiatric Manifestations of Lyme Borreliosis*. Website LymeNet.org.
- 3) Jenifer A. Nields, *The Clinical Experience of Lyme Disease: Patient Perspectives and the Psychiatrist's Role*. Website LymeNet.org.
- 4) T.M. Grier, *The Complexities of Lyme Disease*. Website Canlyme.com.
- 5) Lyme Disease Symptom List. Website Lymedisease.org.
- 6) Virginia T. Sherr, *The Physician as a Patient: Lyme Disease, Ehrlichiosis, and Babesiosis; A Recounting of a Personal Experience with Tick-Borne Diseases*. Website llads.org.
- 7) Audrey Stein Goldings, *Controversies in Neuroborreliosis*. Website llads.org.
- 8) B.A. Fallon, *Late-Stage Neuropsychiatric Lyme Borreliosis, Differential Diagnosis and Treatment*. Website Wadhurst.demon.co.uk.
- 9) R. Bransfield, *The Neuropsychiatric Assessment of Lyme Disease*. Website Mentalhealthandillness.com.
- 10) Lyme Disease: A Diagnostic and Treatment Dilemma; Witness List, Oversight Hearing for the Senate Committee on Labor and Human Resources, August 5, 1993.
- 11) Personal Stories. Lymealliance.org.
- 12) Faces of Lyme Disease. Lyme Disease Foundation.
- 13) Dorothy M. Pietrucha, *Neurological Manifestations of Lyme Disease in Children*. Lymealliance.org.
- 14) Marian Rissenberg & Susan Chambers, *Distinct pattern of cognitive impairment noted in study of Lyme patients*. Lyme Times, Vol. 20, January-March 1998.
- 15) Amy Tan, *The Opposite of Fate*, Harper Perennial 2004.

TREPONEMA PALLIDUM

| | |
|------------------------|--|
| Scientific name | Treponema pallidum (Schaudinn & Hoffmann 1905) Schaudinn 1905 Treponema pallidum subspecies pallidum |
| Synonym | Syphilis spirochaete |
| Common name | Spirochaetaceae |
| Family | Syphilinum - Syph. |
| Homeopathy | Luesinum Lueticum |

FEATURES

- Discovered in 1905 by the German zoologist Fritz Schaudinn, who gave it the name Spirochaeta pallida.
- The anaerobic genus Treponema contains one of the few spirochaetes to be pathogenic to humans, T. pallidum which causes syphilis in humans. T. denticola, T. macrodentium and T. oralis all live in the human mouth where teeth and gums meet.
- Treponema, like Mycobacterium spp., have a very high lipid content, which is unusual for most bacteria.
- Gains access to the body by way of minute abrasions of the skin or mucous membranes.
- Readily destroyed by soap and water, drying, or temperatures greater than 42° C.
- Cannot be cultivated in vitro.
- Diagnosis of syphilis is obtained by serology, darkfield microscopy, immunofluorescent staining, and clinical assessment.
- False-positive [test] results can be found in persons with non-venereal treponemal infections, those who have received certain immunisations [eg, smallpox], pregnant women, and patients with malignancy, acute or chronic infections [eg, infectious mononucleosis, malaria], or certain chronic conditions [eg, ageing, intravenous drug usage, auto-immune disorders, malignancy].

[R.P. Knudsen, Neurosyphilis; www.emedicine.com/neuro/topic684.htm]

THE GOOD ...

The biblical Job might have been afflicted with a syphilitic condition. Deprived of both family and wealth, he was covered from head to toe in loathsome sores. The night racked his bones and the pain that gnawed him took no rest, it reads in the *Book of Job*. He is supposed to understand that suffering is a humbling and a purification of the mind rather than punishment, but, knowing himself blameless, he revolts against the injustice.

Carl Gustav Jung called the malady “the poison of the darkness.” Yet, to some, darkness seems nurturing, as is suggested by Deborah Hayden in her book *Pox: Genius, Madness, and the Mysteries of Syphilis*. By what Hayden calls “creative euphoria” ... “the syphilitic was often rewarded, in a kind of Faustian bargain* for enduring pain and despair, by episodes of creative euphoria, electrified, joyous energy when grandiosity led to new vision.” It was believed that syphilis, in rare instances, could produce genius: “The heightened perception, dazzling insights, and almost mystical knowledge experienced during this time were expressed while precision of form of expression was still possible.”

The French novelist Guy de Maupassant [1850-1893] was exalted at having acquired syphilis in 1877, exclaiming: “Eve got the pox! At last! Not the contemptible clap ... no-no - the great pox, the one Francis I died of. The majestic pox ... and I’m proud of it, by thunder, and to hell with the bourgeoisie.” Hard as it is to draw the line between good and bad, a clear distinction between madness and genius is even more difficult to make. Hayden has it that “Maupassant’s literary leap from mediocrity in 1876 to the supreme mastery of the short story in 1880 might have been the result of a tremendous stimulation of the brain cells.”

Fyodor Dostojewski [1821-1881] suffered from epilepsy and syphilis. He wrote: “What do I care if it is a disease? What do I care whether it is normal or not normal, if in retrospect and in a healthy state, I still feel that moment as one of perfect harmony and beauty, and if it arouses in me hitherto unsuspected emotions, gives me feelings of magnificence, abundance and eternity, and reconciles me to everyone; if it is like a glorious, heavenly merging with the highest synthesis of life.” In a general sense all art might be created to preserve the artist’s sanity, Lawrence Block claims in his novel *Small Town* [Orion, London, 2003].

Didn’t they all make art the way oysters made pearls? A grain of sand got into

the oyster's shell, which was to say under his skin, and it irritated him, it chafed him. So the oyster secreted something, squeezed out some essence of its own self, and coated the offending grain of sand with it, just to stop the pain. Layer after layer of this mystical substance the oyster brought forth, until the grain of sand and the pain it had occasioned were not even a memory. The by-product of the oyster's relief was the shimmering beauty of the pearl. And every pearl, every single luminous gem, had at the core of its being a grain of irritation.

Hans Zinsser, in the 1930s, thought it conceivable that the interaction of spirochaetes and humans has done much to shape our own species and that, if left undisturbed, "finally a stage may be reached in which mutual adjustment is so nearly perfect that the host may show no signs of injury whatever."

If mankind could be kept as thoroughly syphilised in the future as it has been in the past, another thousand years might produce a condition not unlike the present spirochaetosis of mice, in which a peritoneal puncture of almost any *bon vivant* would reveal the presence of a *treponema pallidum* infection of which the host is all but unconscious.

To his apparent regret the treatment of syphilis with arsenicals "probably ruined the prospect" of the syphilization of mankind.

This might be a loss to civilisation: it has often been claimed that since so many brilliant men have had syphilis, much of the world's greatest achievement was evidently formulated in brains stimulated by the cerebral irritation of an early general paresis. [Zinsser 1960]

* Featuring in Goethe's *Faust* and Thomas Mann's *Doctor Faustus*, Faust exemplifies the readiness to make a bargain with the devil to gain creativity and limitless knowledge in exchange for one's soul.

... AND THE BAD

Neurosyphilis was first clearly described in the early 19th century by physicians working in the mental hospitals of Paris. Soon after the Napoleonic wars 'madness' was on the rise. It became known as the "disease of the century." Where syphilis by the *avant garde* was held to provide drive and restless energy, thus fostering genius, for the great majority of syphilitics the disease

was something to conceal. It turned sex into shame, pleasure into guilt, painful life into an often early death. Consistent with the belief that syphilis resulted from sin and depravity, physicians saw their neurosyphilitic patients as hopeless, immoral, and stupid paralytics.

Concealment lies in the nature of syphilis. After the initial sores have disappeared, the disease goes into hiding throughout the body to reveal itself again after decades of latency or to remain dormant for its host's lifetime.

In its appearance, or rather disappearance, as a disease it probably behaves in a similar fashion. Medical historians accept that syphilis originated in the army of Charles VIII of France during his invasion of Italy in 1494-95. Among the mercenaries in this army were Spanish soldiers who had accompanied Columbus on his journey to the New World and had brought syphilis back to Europe. Speaking of the "surprising evolution of syphilis," Jared Diamond writes:

Today, our two immediate associations to syphilis are genital sores and a very slowly developing disease, leading to the death of many untreated victims only after many years. However, when syphilis was first definitely recorded in Europe in 1495, its pustules often covered the body from the head to the knees, caused flesh to fall off people's faces, and led to death within a few months. By 1546, syphilis had evolved into the disease with the symptoms so well known to us today. Apparently, just as with myxomatosis, those syphilis spirochaetes that evolved so as to keep their victims alive for longer were thereby able to transmit their spirochaete offspring into more victims.

[Diamond 1998]

It remains unsettled whether syphilis has newly arrived on the human stage or whether it has been around since ancient times. Ancient texts seem to testify to the latter, as do discoveries in Africa of skeletal remains dating back some 1.5 million years with deposits of new bone on arm and leg bones. The location and the amount of deposits are held to be indicative of yaws. Similar bone deposits were found in southern Italy on a *Homo erectus* femur dated ca. half a million years ago, suggesting that when early humans spread out from Africa they took the non-venereal syphilitic disease yaws with them.

Can it be that syphilis has only relatively recently evolved into a venereal form? "We must begin," says biologist Christopher Wills, "by realising that syphilis is one extreme of a continuum of diseases, most of them surprisingly

little understood, which have afflicted humans and their relatives for a very long time. Syphilis is simply the most extreme manifestation of the attempts of a parasite to spread from host to host.”

Instead of regarding yaws, pinta, and bejel as mere varieties of treponema diseases, Arno Karlen puts them in a broad and evolutionary perspective, reflecting *Treponema*'s response to changing human culture. The quartet might be actually one disease, which takes different forms with changes in transmission and human lifestyle.

The treponemes common ancestor first probably lived on decaying matter and then became a non-venereal parasite of African primates. About 20,000 years ago, it created a zoonosis [an animal disease that is transmissible to humans]. This was pinta ... transmitted [in tropical climates] by children's bare, perspiring skin ... through casual body contact. Some 10,000 years ago, a mutation of the germ gave rise to yaws, probably in Africa. Like pinta, yaws usually affects the skin of the young; however, it is more severe and can erode the bones. It persists today in the rural tropics of Africa and Latin America. A few thousand years later, the germ spread to Neolithic villages in dry, cool environments, where people were fully clothed.

Because clothes interfered with the germ's passage to new hosts, it retreated to the warm, moist refuges of the mouth and, secondarily, to the genitals. Transmitted chiefly by common eating utensils and sometimes by kissing, it led to a new disease variously called bejel, endemic syphilis, or non-venereal syphilis. More severe than pinta and yaws, bejel can damage the bones and the heart. It once flourished in European slums from Russia to Scotland [where it was known as sabbens], but it faded as hygiene improved. It is still common in villages in arid and semi-arid parts of Africa and Asia.

Venereal syphilis emerged some 6,000 years ago, in the Middle East, once the bejel germ had adapted to urban life there. More sexual partners were available to everyone, and coitus became the usual means of transmission. Venereal syphilis was not limited by climatic conditions, and eventually it spread worldwide. Opportunities for transmission were less frequent than for pinta, yaws, or even bejel; the germ survived by lingering in the body for long periods, wreaking slow havoc on the heart, nervous system, and other organs. Thus treponemal sickness was transformed from a mild disease of village children to a serious one of urban adults. ... Only a single kind of treponeme infection is common in any region; each gives immunity to the others. This confirms that

the germs are, if not identical, very closely related. Furthermore, one treponemal disease can replace another as conditions change. Syphilis has ousted yaws in Venezuela, New Guinea, and parts of Africa as people moved from villages to cities. And when people with yaws move from tropical lowlands to cool mountain areas, they lose the sores of yaws and develop bejel. Bejel and venereal syphilis have each been reported to change into the other.

The germs tendency to change in transmission, symptoms, and virulence makes the complexity of its disease manifestations less puzzling. ... When syphilis first struck during the 1495 outbreak in Europe, its florid symptoms resembled acute yaws almost as much as syphilis. ... Syphilis and typhus were typical new plagues of the first age of global exploration and conquest. They came from the new machinery and tactics of war; the hunger and dirt of bigger, denser populations; altered clothing and sex behaviour; changing agriculture; the movements of soldiers, traders, and uprooted peasants.

[Karlen 1995]

PSORA ... OR SYPHILIS?

Considering the multitude of syphilitic manifestations mimicking other diseases, I cannot help but wonder if syphilis, in terms of symptomatology, would not be a more likely candidate for psora than “the Itch disease” [generally held to have been scabies]. Hahnemann sees psora as the “most ancient, most universal, most destructive, and yet most misapprehended chronic miasmatic disease which for many thousands of years has disfigured and tortured mankind, and which during the last centuries has become the mother of all the thousands of incredibly various [acute and] chronic [non- venereal] diseases, by which the whole civilised human race on the inhabited globe is being more and more afflicted.” Such a definition seems to rule out syphilis, unless we regard syphilis as “one extreme of a continuum of diseases,” syphilis-like in nature.

Due to its recent appearance as a venereal disease, syphilis obviously didn't qualify as the most ancient miasmatic disease. However, the syphilitic miasm should not be equated with syphilis, although the latter mirrors the former. The syphilitic miasm is a basic constitutional tendency, syphilis one of its manifestations, as are a host of other potentially malignant afflictions.

The British surgeon and pathologist Sir Jonathan Hutchinson [1828-1913], who coined the term “Great Imitator” to describe the puzzling multiformity of syphilis, spent most of his professional life gathering clues and indications

to identify the disease, which he published in *Syphilis* in 1887. The American physician John Stokes followed his example and produced in 1926 his exhaustive *Modern Clinical Syphilology* [revised editions appearing 1934 and 1944], Comparing these two symptom collections with Hahnemann's enumeration of psora symptoms [Chronic Diseases, pp. 52-79] will demonstrate a distinct resemblance. Detailing the similarities will go beyond the scope of *Spectrum*, but a few examples, taken from Hayden's book *Pox*, might arouse the interested to undertake such a comparison.

Hahnemann mentions for psora: "Quick change of moods; often very merry and exuberantly so, often again and, indeed, very suddenly, dejection. Sudden transition from cheerfulness to sadness." And: "Mania of selfdestruction. ... They are impelled, urged, yea, compelled by a certain feeling of necessity, to self-destruction."

Hayden: "In the final period ... mood shifts become more extreme as euphoria, electric excitement, bursts of creative energy ... alternate with severe, often suicidal depression."

Hahnemann: "Attacks of passion, resembling frenzy." "Melancholy by itself, or with insanity, also at times alternating with frenzy and hours of rationality."

Hayden: "... periods of extreme clarity ... alternating with episodes of bizarre, uninhibited acts ..." "Delusions of grandeur, paranoia, exaltation, irritability, rages, and irrational, antisocial behaviour ..."

Hahnemann: "Disinclination to work, in persons who otherwise are most industrious; no impulse to occupy himself, but rather the most decided repugnance thereto." "She became suddenly so weary, she had to lie down." "They often weep for hours without knowing a cause for it." Hayden: "A calm person becomes emotional, a neat person sloppy, a timid one aggressive." "Exercise at this time causes exhaustion and the patient becomes inactive, often declining to walk even a short distance." Hahnemann exemplifies the nature of psora as "a thousand-headed monster, pregnant with disease," by recounting more than 100 disorders "erroneously designated [by the old school] as well-defined, constant and peculiar diseases." Stokes asserts that syphilis "apes every disease in any field of medicine" and will never yield to one diagnostic key.

It should be noted that Hahnemann believed that "the internal augmentation of the venereal disorder" only takes place when the primary local manifes-

tation, the chancre, is destroyed. He was clearly mistaken in stating that the chancre “never passes away of itself.” This belief paved the way for his conception that the secondary stage, following weeks to months after disappearance of the chancre, results from suppression instead of its being the natural course of the disease. The latter reflects the failure of the organism to prevent dissemination, which in Hahnemann’s view depends on “complication of syphilis with developed psora.” Psora, then, appears to stand more for the basic pattern underlying all development, the fundamental challenge to assimilate, than to arise solely from suppressed “Itch.” The challenge prompts reaction, which entails balance [health], overcompensation [sycotic], or destruction [syphilitic]. The latter may be absolute or part of an evolution towards construction.

Finally, although Hahnemann proclaims that “the general venereal disease dwells in the body from the first moment of infection,” i.e. is a constitutional affliction, his proposed treatment of its first stage with “one little internal dose of the best mercurial remedy,” conflicts, to my idea, with the golden rule of individualisation. It gives the impression that he underestimated the extent of the syphilitic miasm, limiting it too much to syphilis as a disease. While syphilis may be almost prototypical for the miasm, it is not its only manifestation. The miasm precedes the disease rather than being caused by it, which is in accordance with the law of similars.

TRACING THE SYPHILITIC MIASM

Recognising the syphilitic miasm is not easy. In comparison to other major miasms - psora, sycosis, tubercular - it is more difficult to trace due to its inherent element of concealment. It can be safely assumed that the extent of the syphilitic miasm, according to Hahnemann, is underestimated. Having been “a diligent observer during a long series of years of all that concerns syphilis in the living subject,” it will be to our advantage to take to heart what Hutchinson had to say about its detection. It shows that while a clear aetiology often cannot be ensured, the signs and symptoms will be a sure guide.

Prior to the observations as to the value of the teeth and physiognomy as enabling us to recognise the subjects of inherited taint in adult life, it was not possible to maintain respecting any syphilitic infant that one or other of its parents had incurred a like inheritance. ... Without being discourteous to the

statements published by others, I may perhaps be allowed to hint that, in all, much of what I would call good-hearted credulity in the reception of evidence is displayed. When a surgeon undertakes to guarantee for his patient that no exposure to the risk of contracting syphilis has ever occurred, I can but suspect that his experience of life has been but small, or that he is habitually not prone to attempt to look below the surface. If it is attempted to strengthen the guarantee by saying that the parties have been well known to him, my suspicions are strengthened, for it is precisely under such circumstances that sexual follies would be concealed. I have no reason to think that my own experience has been worse than the average, but I have known enough of what is possible in reference to the acquisition of syphilis, in all ranks of life and under apparently the most unlikely circumstances, to induce me to disregard almost absolutely the denials of patients and to allow my opinions to rest not upon what I am told, but upon what seems probably true.

[Hutchinson 1913]

A well-known characteristic of [hereditary] syphilis is that it leaves behind a physical signature in physiognomy, bones, and skin. The inherited venereal taint can be recognised thus:

Skull presents a somewhat square appearance and is somewhat larger than normal.

Hair dry and thin.

Forehead large and protuberant in regions of frontal eminences.

Often well-marked transverse depressions a little above the eyebrows.

Tendency to frowning, consequent on prolonged intolerance of light [due to keratitis].

Cornea hazy; peculiar, leaden [steel-grey], lustreless appearance of the irises.

Facial skin often thick, pasty, and opaque, although not infrequently remarkably soft and silky. [Soft, pale, earthy-tinted in adults.]

Facial skin often shows pits and scars, the relics of a former eruption.

Bridge of nose usually broad and low, often remarkably sunken and expanded.

Radiating linear scars at the corners of the mouth, running out into the cheeks.

Central upper incisors [permanent teeth] short and narrow, with a broad vertical notch in their edges, and their corners rounded off. "If the upper central incisors are dwarfed, too short, and too narrow, and if they display a single central cleft in their free edge, then the diagnosis of syphilis is almost certain. ... In most cases the conditions are symmetrical, but now and then

they are notably one-sided.”
[Hutchinson 1913]

Several of Hutchinson’s observations on syphilitic patients are incorporated in medical terminology.

Hutchinsons facies: Facial expression produced by the combination of drooping eyelids and motionless eyes [in syphilitic paralysis of eye muscles].

Hutchinsons mask: Sensation as if the face were covered with a mask or with cobwebs [in tabes dorsalis]. [The mask-like sensation is comparable with the repertory rubric Face, Tension, as if egg white were dried on the face.]

Hutchinsons crescentic notch: Semilunar notch on the incisal edge of Hutchinson’s teeth.

Hutchinson’s pupil: Dilation of one pupil [on side of meningeal haemorrhage], contraction of the other.

Hutchinson’s triad: Combination of parenchymatous keratitis [inflammation of the cornea], labyrinthine [inner ear] disease, and Hutchinson’s teeth [in congenital syphilis].

A method that utilises physiognomy in homeopathy has recently been developed by Australian homeopath Grant Bentley. Understanding that every individual is dominated by one of the miasms, he has identified facial features and matched them to each group, so that the dominant miasm of the patient can be determined on the combination of themes and facial features. [See Case 4 below.]

LOCOMOTION

Spirochaetes have made a major contribution to the evolution of species, according to Margulis and Sagan, by introducing the element of locomotion. Sperm tails of men, propelling sperm to the eggs of women, as well as oviduct undulipodia [flexible whip-like intracellular extension of cells] derived from spirochaete bacteria that became ancestral cell “whips.”

The origin of rapid motion in bacteria seems to be connected to a rotary device that is unknown in cells with nuclei. A flagellum, or whip-like strand, is attached to the disk-shaped base of the bacterium. ... In some bacteria, such as the spirochaetes, the flagellum is internalised. ... The first spirochaetes were

a form of fermenting bacteria and probably evolved very early in the history of life. ... Bacterial mergers ... seem to have conferred on life the capacity of motility. By joining the big, new cells, rapidly moving bacteria gave them the basic advantages of locomotion - avoiding danger and seeking food and shelter. Other benefits of travel - a greater selection of habitats, more opportunities for genetic exchange - came within reach. Mobility, however, was only the most obvious benefit of these partnerships. ... In sharp contrast to a bacterial cell whose contents are motionless or drift passively about, the interior of eukaryotic cells is swarming like a city. ... We believe that the nucleated cell's ability to move both without and within is the contribution of another symbiotic merger with bacteria, this time with rapid, whiplashing spirochaetes. ... Our candidate for this common ancestor [of undulipodia] is the spiralling, motile, hairlike spirochaete, the fastest bacterium in the microcosm. In the sticky regions of their microworld of gelatinous muds and viscous fluids, spirochaetes are often the only bacteria capable of passing through a certain region. The spirochaetes *metier* is motion. ... To us the evidence strongly suggests that ancient pacts were made between the early bacterial confederacies that became cells with nuclei and spirochaetes or spirochaete-like bacteria. Spirochaetes hovered both inside and outside their non-spirochaete neighbours, and in the end they provided efficient movement for those who had never even requested it. ... Free-living, scavenging spirochaetes are still well known today, as are many varieties engaged in symbiotic or parasitic lifestyles with other organisms, such as insects, molluscs, and mammals, humans included. ... Spirochaetes tend to attach to things, living or not.

When they swim next to each other, they also tend to undulate in unison simply due to their proximity in a liquid medium. As scavenger spirochaetes feed on the surface of their host, particularly if they are amassed together on one side, they can propel it through its medium with their coordinated undulations. Those spirochaetes and protists that co-evolved elegant attachments swam well. Consequently they found more food and reproduced more often - a clear advantage. Natural selection would undoubtedly have favoured these alliances until the two partners gradually became one. ... The advance of spirochaete alliances 2,000 million years ago must have altered the microcosm. The new motile eukaryotes must have revolutionised the bacterial world by their sudden boost to microbial transportation and communication. ... Modern-day spirochaetes still readily enter symbioses for the purpose of mobility.

[Margulis & Sagan 1997]

Elaborating on the symbiotic origins of locomotion, Margulis and Sagan come up with another intriguing thought: “Did the spirochaete motility system of the microcosm evolve within the ordered environment of larger organisms to become the basis of their nervous systems?”

Proof of spirochaete identity in the cells of the brain, beyond the rich presence in them of microtubules [neurotubules], is slowly accruing. ... After maturity, brain cells never divide, nor do they move about. Yet we know mammal brain cells - the richest source of tubulin protein anywhere - do not waste their rich microtubular heritage. Rather, the sole function of mature brain cells, once reproduced or deployed, is to send signals and receive them, as if the microtubules once used for cell-whip and chromosomal movement had been usurped for the function of thought. ... If spirochaetes are truly ancestral to brain cells or neurons, then the concepts and signals of thought are based on chemical and physical abilities already latent in bacteria. ... Could the true language of the nervous system then be spirochaetal remnants, a combination of autocatalysing RNA and tubulin proteins symbiotically integrated in the network of hormones, neurohormones, cells, and their wastes we call the human body? Is individual thought itself superorganismic, a collective phenomenon? ... All our favourite inventions were anticipated by our planetmates; why not thought? ... In a sense we are “above” bacteria, because, though composed of them, our power of thought seems to represent more than the sum of its microbial parts. Yet in a sense we are also “below” them. As tiny parts of a huge biosphere whose essence is basically bacterial, we - with other life forms - must add up to a sort of symbiotic brain which is beyond our capacity to comprehend or truly represent.

[Margulis & Sagan 1997]

With spirochaetes seeking out sex cells and brain cells history seems to repeat itself. *“Out of all the species, ”says Fracastoro, syphilis infects “the one that is great through its mind, the human race. ”*

THE FINE LINE BETWEEN SURVIVAL AND DESTRUCTION

Treponema pallidum, whose name means “pale twisted thread,” weaves a fragile thread between survival and destruction. Some of its many free-living spirochetal relatives inhabit various places in the human body - skin, mucosa, intestines, and the gum-line around the teeth - and can be grown

outside of the human body in artificial media. *T. pallidum* refuses to do so and if it can be brought to begin multiplying in carefully selected media, it invariably dies or stops growing after only a few divisions. It appears to require human beings as its exclusive hosts.

T. pallidum seems only able to survive under the narrow and highly specific set of conditions found in the human body. A small rise in temperature will kill it, as [Austrian psychiatrist] Julius Wagner von Juaregg found when he introduced the successful malaria therapy for syphilis in the 1920s. [Fascinatingly, the fact that sufferers from high fever could be cured of syphilis had been noted by Ruy Diaz de Isla in 1539, which shows what remarkably keen observers the great doctors of the past could be.] And cold is fatal to it as well - when blood contaminated with *Treponema* is placed in the refrigerator, the bacteria die off so completely that after two or three days the blood is actually safe to use for transfusions. A bit of soap will kill it, too.

One might think that there is nothing to fear from such a nebbish of a parasite. Paradoxically, its very feebleness seems to enable it to survive in the hostile environment of its host. It is skilled at making do with very little, and its sheer doggedness makes it one of the most infectious organisms known.

Some of this feebleness can be traced to the fact that *T. pallidum* has very few genes. ... The paucity of genes in its genome may help to explain two odd facts about it, one that contributes to its destruction and the other to its survival. First, and most unusually, mutant strains of *T. pallidum* that are resistant to penicillin have never arisen. Because it is unable to exchange genetic information with other bacteria, it cannot acquire genes from them that would enable it to destroy penicillin, and it does not seem to have the genetic resources to make an enzyme on its own that can break down the antibiotic.

Second, because *T. pallidum* has so few genes, it manufactures only the merest excuse for an outer cell membrane. This threadbare coat is easily breached by even small changes in the bacterium's environment, which is an obvious disadvantage. But at the same time it contains few proteins that can alert the host's immune system. Flimsy though it is, its membrane none the less has the capacity to attract and bind proteins found in the host's blood. These proteins form an additional protective layer, and because they are invisible to the host's immune system they also help to conceal the bacterium from host antibodies and patrolling white cells. Such relative invisibility undoubtedly helps to explain why the bacterium can survive its host's body for years.

The bacterium seems to be adapted to life in humans, and only in humans -

most other animals may break out with early lesions when deliberately infected, but the disease progresses no further. Surely then, this fragile web of adaptations implies that *Treponema* has had a long history of association with humans. Indeed, this association appears to be real - but not, it appears, as the agent of syphilis. [Wills 1996]

As “team players” bacteria readily exchange genetic information among each other, which will contribute to the virulence of some species and their acquired resistance to antibiotics. Since *T. pallidum* cannot borrow genetic information from other bacteria for its survival it appears likely that it can neither do so for its virulence. Yaws, bejel, pinta, and syphilis are caused by spirochaetes that because of their similarity are all designated *Treponema pallidum* or have been demoted to subspecies of *T pallidum*, although they cannot be distinguished by immunological tests. If there is no difference in the “causative agents,” the differences in the symptomatology can only be produced by the interplay between spirochaete and host.

Emerging during the Age of Exploration, more specifically after the ruthless invasion of the New World, resulting in dreadful traffic in human cargo, venereal syphilis and neurosyphilis can just as well be regarded manifestations of the syphilitic miasm instead of its cause. Adapted to life in humans, and having contributed to it symbiotically, spirochetel development probably runs parallel with human evolution, with its fine line between survival and destruction.

STAGES OF SYPHILIS

Spirochetel diseases typically progress in stages. Syphilis has four stages, which may overlap one another and also do not always follow in the same sequence.

Primary syphilis

- Appearance of one or more indurated, round, small, and painless sores or ulcers [chancres] at the site of inoculation. The chancre secretes clear, serous fluid and disappears by itself in one to five weeks. [Highly infectious.]
- Regional adenopathy.

Secondary syphilis

- Dissemination of the bacteria through the blood.
- Skin rashes, often generalised and bilateral, consisting of crops of macular, papular, follicular, papulosquamous or pustular lesions. [This translates as splotchy, pimply, with little sacs, scaly and pus-filled - so covering a wide range of rashes!] Often involvement of the palms and soles. Copper- coloured spots the size of a penny are typical. All of the skin lesions are highly infectious.
- Condylomata lata [syphilis warts] in the genital tract.
- Circular mucous patches of mouth, pharynx, genitals, anus. Patches often greyish white with a red areola.
- Generalised lymphadenopathy [painless]. [Any disease of the lymph glands.]
- Enlargement of spleen.
- Alopecia areata [syphilitica] [typical “moth-eaten spotty baldness].
- Iritis.
- Periostitis; aching pains in bones.
- Systemic symptoms: fever; malaise; weight loss; tiredness; anorexia.
- Symptoms remit spontaneously after two to six weeks, although they may recur later.

Tertiary syphilis

- After a latency period of indefinite duration, in up to 30% of cases, tertiary syphilis develops with a broad range of characteristic signs and symptoms involving the cardiovascular system, bone, skin, eyes, and/or brain and nervous system.
- Tertiary stage symptoms include:
 - Muscular inco-ordination.
 - Paralysis.
 - Anaesthesia.
 - Blindness.
 - Glossitis.
 - Impotency.
 - Shooting pains.
 - Aneurysm.
 - Tumours or gummas. [Soft degenerating tumours.]
 - Severe abdominal pain.
 - Repeated vomiting.

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- Damage to knee joints.
 - Bone changes.
 - Deep sores on the soles of feet or toes.
 - Condylomata all over genitals and rectum.

Tremor is one of the commonest early signs, occurring in about two-thirds of patients. It is typically coarse and irregular, involving the face and hands particularly. Close attention may be required to detect it in the lips and the facial musculature around the mouth, often increased when the patient is given difficult tasks of verbal articulation. The facies may be characteristic when the typical tremor is associated with a dull and mask-like expression. Tremor of the hands and fingers contributes to the clumsiness which is seen on manual tasks. The tongue may be involved and show characteristic back and forth jerking movements when protruded.

Dysarthria, partly due to the tremor of lips and tongue, occurs in 80% of patients. Speech becomes slurred, hesitant, jerky, irregular, and ultimately incoherent. Tremor may appear in the voice, which is also feeble and lacking in intonation.

Reflex abnormalities are seen in approximately 50% of cases. The knee jerks and ankle jerks are usually exaggerated, with clonus and spasticity in the lower limbs. With progression of the disease the plantar responses become extensor, and there is increasing weakness of the limbs leading eventually to severe spastic paralysis. By contrast tendon reflexes may be absent when *tabes dorsalis* is combined with general paresis.

Ataxia is seen in the clumsy incoordinated movements of the hands, and in the characteristic slouching, unsteady gait.

[Lishman]

Neurosyphilis

- A minority of tertiary stage patients develops neurosyphilis, up to 30 years after initial infection.

Three types of tertiary neurosyphilis are distinguished; these types may occur alone or in combination.

1) Meningovascular neurosyphilis.

- Low grade meningitis and/or stroke-like symptoms.
- Poor concentration.

- Mental confusion.
- Lassitude.
- Insomnia.
- Dizziness.
- Headache [often sharply localised and accompanied by tenderness of overlying skull].
- Hearing loss.
- Blurred vision.
- Paresis of external ocular movements.
- Papilloedema.
- Optic atrophy.
- Hemianopia.
- Photophobia.
- Reduced colour perception.
- Aphasia.
- Weakness and atrophy of shoulder and arm muscles.
- Neck stiffness.
- Hemiplegia.
- Polyuria, obesity and somnolence [due to hypothalamic involvement],
- Pseudobulbar palsy [speech and swallowing difficulties due to paralysis of lips and tongue, accompanied by emotional instability and spasmodic, mirthless laughter; sometimes called laughing sickness],

2) Parenchymatous neurosyphilis [general paresis or dementia paralytica].

- Insidious onset.
- Headache.
- Lethargy.
- Tremor, convulsions.
- Aphasia.
- Disorientation.
- Loss of concentration.
- Loss of memory.
- Slow process of losing one's personality.
- Male to female ratio: 3 to 1; peak age of onset between 30 and 50.
- Congenital general paresis may declare itself in early childhood. It presents as backwardness at school, symptoms of mental deficiency, and epileptic fits.

[3] Tabes dorsalis [locomotor ataxia].

- Sensory deficits including loss of pain sensation, loss of position sense, loss of vibration sense, and loss of temperature sensations.
- Characteristic sites of sensory loss, involving both touch and pain, are the side of the nose, the ulnar aspect of the arms, patchy loss over the trunk and the dorsum of the feet. [Numbness of the top of the foot also found in Borreliosis.]
- Pupils react to accommodation [focus] but not to light.
- Pupils contracted and irregular, or one may be contracted while the other is dilated.
- Episodic pain in viscera, commonly attacks of epigastric pain and vomiting lasting for hours or days.
- Rectal crises consisting of tenesmus.
- Urinary symptoms: incontinence; retention; infections.
- Impotence.
- Laryngeal crises consisting of dyspnoea, cough, and stridor.
- Lightning-like [stabbing] pains in legs [degeneration of spinal nerve roots].
- Burning and tearing pains in legs.
- Lancinating pain extending to chest and abdomen.
- These pains appear suddenly, spread rapidly, and disappear.
- Girdle pains of neuritic distribution around the trunk.
- Paraesthesias in legs and feet; skin may be hyperaesthetic to touch or patient may have a feeling of walking on cotton wool, [also Borreliosis]
- Ataxia < dark.
- Walks with feet wide apart or with a typical 'high stepping gait'.
- Painless disorganisation of joints may result in gross deformity, most frequently at the knee or the hip.
- Perforating ulcers and other trophic skin changes.
- Males are affected much more frequently than females with a peak age of onset in the fifth decade.

GENERAL PARESIS

General paresis, also known as 'dementia paralytica' and 'general paralysis of the insane', refers to neurosyphilis combined with personality changes which can be divided into three major forms: [1] grandiose or expansive form; [2]

dementing form; [3] depressive form.

The latter two forms can be clearly distinguished in the symptom picture of Syphilinum [and other syphilitic remedies], whilst the expansive form occupies a minor place, in spite of it formerly being the most common manifestation of general paresis, in particular in patients from the higher social groups. Over time this form has been gradually replaced by the dementing and depressive forms, both of which are now a great deal more common. The manic form nevertheless has tended to remain the prototype of the disorder in medical teaching,

The dementing and depressive forms have overlapping features.

Symptoms below extracted from Hutchinson, 1913; Stokes, 1944; Coleman, 1980; Lishman, 1987; Merck Manual, 1992; Hayden, 2003

Dementing Form and Depressive Form

- Onset: insidious change of temperament - moodiness, apathy, outbursts of temper, lessened emotional control with ready tears or laughter, or loss of ambition at work.
- Egocentricity and general loss of refinement.
- Behaviour unmannerly, tactless, unethical.
- Unconcerned with appearance.
- Evading people or important problems or reacting with smug indifference.
- Blunting of affect: ceases to share in the joys, sorrows, or anxieties of loved ones.
- Careless, inattentive, making mistakes at work.
- Deterioration of personal habits, such as hygiene.
- Sentimentality.
- Promiscuity.
- Fleeting delusions, mostly of a persecutory nature.
- Slow, silent, suicidally inclined, delusions melancholic, nihilistic or hypochondriacal [depressive form of general paresis].
- Difficulty with calculation [stressed as an early feature].
- Disturbance of writing, with tremulous lines and omission or transposition of syllables.
- Vacant, dissipated expression with a silly grin.
- Memory deficits, esp. short-term memory impairment.
- Compensatory compulsions or fabrications in an effort to compensate for the memory deficits.

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- Intellectual deterioration, inability to comprehend the simplest problems.
 - Mental deterioration alternates with episodes of excited overactivity.
 - Periods of clouding of consciousness alternate with periods of relative normality.
 - Paranoid delusions, ideas of influence, passivity phenomena, and auditory hallucinations of an abusing or threatening nature [paranoid form of general paresis].
 - Hand-writing shows tremor quite early, as well as characteristic changes: erasures, writing over, leaving out words and letters, piling up words at the end of a line, and change in the size of letters.

Their demeanour and movements are either altogether inexpressive, or are expressive only of very weak emotions; and here also are presented many childish and capricious habits, such as collecting rubbish, remaining always in bed, pleasure in toys, and dressing fantastically. Sometimes they manifest a wayward refusal of food, and other symptoms of childish obstinacy; more frequently we observe the love of eating - they frequently swallow the most loathsome things.

Very many of these patients who have been long confined in the asylum are addicted to onanism, and we may frequently gather from their conversation indications of considerable disorder of the sexual functions. The physiognomy is generally old and stupid, the expression vacant, and the countenance obscured by neglect and dirt. Not infrequently there is a great tendency to become corpulent.

An accurate description of the dementing form is given by Griesinger, who calls the condition *apathetic dementia*'.

The inability to comprehend several ideas and to compare them always increases, and instead of the numerous abrupt disconnected ideas seen in other forms, there gradually ensues almost a total absence of images and thoughts. The sensorial impressions are no longer elaborated, nothing comes out of them; memory is so completely effaced, that not merely what happens in one moment is forgotten in the next, but all reminiscences of bygone times are almost entirely lost.

Language even is to a great extent forgotten, so that patients even in the most favourable cases can employ only a few current, very limited, and little applicable expressions; more frequently the few words themselves are not

entire, but are merely ejaculations of accustomed sounds. This very high degree of dullness of the imagination and loss of the intelligence is accompanied by extreme weakness of the will. The patient can no longer actuate himself to do anything, even by the force of former habits; he must rather passively submit to be directed by some extraneous impulse. He is frequently unable to supply his simplest wants, and requires to be fed; he loses himself every moment in his own room, and his ignorance of danger renders it necessary that others should protect him against accidents.

His conduct is uniform, and always the same; sometimes apparently concentrated in self - shy, dull, silent, and inert; sometimes automatic movements are gone through - swaying to and fro of the body, rubbing the hands, murmuring, making unmeaning noises, etc. The gestures are lifeless - the countenance is relaxed or amazed, or apparently attentive without motive, and the vacant look and bursts of laughter show that there exist no ideas which the patient can express.

[Wilhelm Griesinger, *Mental Pathology and Therapeutics*, 1869]

Grandiose or expansive form

- Lapses of social conduct: squandering money; involvement in antisocial acts; law-breaking; outbursts of violence; indecent exposure.
- Euphoria, electric excitement, bursts of creative energy and grandiose self-reflections alternate with severe, often suicidal depression.
- The patient may suddenly begin to gamble, go on absurd spending sprees, or imagine owning vast riches.

The hallmark is the patient's bombastic and expansive demeanour, with delusions of power, wealth or social position. The patient boasts of fantastic riches, exploits in battle, or tells of his athletic and sexual prowess. He may believe he is some eminent person from the past or present, yet at the same time accepts his stay in hospital without complaint.

The mood is euphoric, good humoured and frequently condescending. Typically the patient enjoys an audience for his display. His recital may be amusing but his jocularly is rarely infectious. Usually the underlying dementia imparts a shallowness and a naive quality to the prevailing affect. If his beliefs are questioned or his wishes thwarted, the mood may readily turn to petulance or anger. In some cases there may be extreme irritability with outbursts of violent behaviour, but this is rare.

[Lishman]

-
- Foolish, eccentric or reckless behaviour.

In one case the first whim was the purchase of a quantity of old silver for which payment could not be made; another patient rose in his stall at the theatre and threw sovereigns at a comedienne on the stage; a third ordered 700 hymn books for a hospital ward of 16 beds, and a ton of guano for the ward plants. Another wrote to the War Office demanding three Victoria crosses which he considered he had won in fighting some 10 years before. At the outbreak of hostilities in August 1914, an incipient paralytic sent telegrams to all the crowned heads and rulers, proffering his services as peacemaker.

[Wilson, 1940, cited in Lishman]

- Delusions of grandeur [termed *monomanie des grandeurs* by 19th century French psychiatrists].

These patients are active, busy, speak a great deal, are constantly in movement, buy and sell, plan great schemes; their manner is, indeed, odd, peculiar, and extravagant, but they are only recognised as mentally diseased by the initiated. Soon they allow themselves greater freedom, become more and more restless; manifest in everything their satisfied, exalted frame of mind; spend lavishly and make magnificent presents; recount imaginary histories, in which they frequently contradict themselves; now and then they give offence by their habits of drunkenness and gross indecencies; in short, they make themselves unbearable. ... In the great majority of cases there are developed the specially characteristic ideas of greatness, in which all what relates to the person of the patient assumes in his eyes colossal dimensions, and is expressed by him in the most superlative language and highest numbers. At the same time, however, the intellect, character, and emotions, all assume the character of weakness.

In their delirious ideas they often contradict themselves; they do not persist in them, but soon forget and pass on to others; the circle of the ideas is, in spite of their apparently active production, very limited; incoherence soon becomes [particularly in writing] marked; and it is in the highest degree remarkable how all things, even the most absurd, are at once accepted as realities without the least internal opposition; the *ego* becomes quite incapable of resistance, and is entirely taken possession of and subdued by them. Their will is weak; they appear violent, but are pliable as children, easily subdued, and they are also somewhat mobile and lachrymose in their nature.

The weakness of the mental faculties becomes more and more pronounced in proportion as the paralytic appearances becomes more marked; the patient loses his memory, the capability of mental association, all sense of duty; he becomes completely indifferent, dirty in his habits, etc. From this time the dementia progresses step by step with the paralysis: still, in certain patients the course of the disease is varied, sometimes by increased restlessness - sometimes even by attacks of mania, vociferation, and desire to destroy.

Certain patients continue for a long time to manifest, but without any actual sense of what they say, those extravagant ideas of possession of provinces, riches, worlds, millions, etc., variously modified according to the degree of education. The one possesses millions of billions - all the world belongs to him, all things were made by him, etc.

Another has built the most splendid castle, bought all Italy, plundered Asia, destroyed the bridge from the earth to the moon, transferred the Chinese to Paris, is himself 800 feet high, etc. Others walk 100 leagues in a day, write 100 tragedies and 1000 poems in the same space of time - have heads made of diamonds set in gold, horses and palaces made of gold, etc.

In the latter periods of this affliction these ideas completely disappear: the patient is in the extreme stage of mental decay; he is as little capable of having a complete idea as he is of pronouncing a proper word; he is void of any conception of his whereabouts. It is not generally until the advanced period that the patients become emaciated; gangrenous spots appear in various parts of the skin, especially of the back; large abscesses form; extensive suppurations and infiltrations of the extremities occur, and the patients sink under hectic fever, which in many cases is connected with pyaemia - in others with acute or chronic intestinal catarrh, accompanied by profuse diarrhoea and ulceration of the intestines; at other times it is connected with general tuberculosis.

[Wilhelm Griesinger, *Mental Pathology and Therapeutics*, 1869]

MATERIA MEDICA SYPHILINUM

Syph.

Sources

- [1] Proving Swan with 12 provers, 1890; higher potencies; method unknown.
- [2] Proving Carr with 3 provers [2 females, 1 male]; method unknown.

The quality of these provings is dubious, in my opinion. H.C. Allens presentation of the symptomatology comes across as somewhat deceptive in giving the

impression that the recorded symptoms were the result of provings. Yet, study of Syphilinum in Herings Guiding Symptoms, reveals that the majority of the symptoms come from clinical cases of patients suffering from secondary or, mostly, tertiary syphilis. If such data can be accepted as the foundation of the homeopathic Syphilinum picture, it seems obvious, at least to me, that accurate and reliable descriptions of neurosyphilis will give additional keys to its essence.

Jeremy Sherr proclaims that, "When pure provings are deficient or insufficiently studied, clinical information and idle theories take on lives of their own." True enough. Yet we must also be aware of the possible unreliability, deficiency or insufficiency of the 'pure proving' too. If clinical information prevails, as it does with Syphilinum, we should ensure that it is sound and solid and proceed from there.

SYMPTOMS

MIND

Vile indignity

= Delusion he is dirty.

=» Delusion he is stinking.

= Delusion of being neglected by members of family.

<= Delusion he will become insane.

What imagery comes to our minds when the word syphilis is spoken? ... Is it not DISGUST? Syphilis has a special connotation. There is almost an objective impression felt by all people in the collective unconscious. We often think of it as something dirty and disgusting to have, something of a low order which corrodes the organism and cripples it. Even the word phonetically seems to produce such a reaction.

The word syphilis was taken from a poem written by Fracastoro circa 1530 and was the name of a swine herd who contracted the disease. There is some discrepancy as to the correct origin of the word. The word *sys* in Greek means pig and *philos*, lover; pig lover. Others claim *syph* means 'along with' and *phi-los*, 'loving'. In other words a disease that comes along with loving. And finally the word *siphlos* again in Greek means crippled. And yes, syphilis cripples. ... All translations capture the essence of syphilis very well. From 'pig lover' we get the imagery of an unclean sex which we often associate with syphilis, a

licentious sex fuelled by extreme lasciviousness and lust.

The image of disgust and dirt come into my mind and is borne in the feelings of the prover and the person whose disease state is similar to the state wrought by the remedy on the human organism. Syphilinum feels dirty in himself; fears dirt, infection, contamination; feels loathsome; she finds her physical complaints dirty; she feels full of poison, consequently she was always washing her hands. ... This is one of the most striking and central features of the mental state of Syphilinum. The patient feels horrid, a hopeless mass of filth; often they feel good for nothing. Loathing of oneself. I feel that it can be added under delusions, dirty everything is and delusions, dirty he is and under dreams of dirt.

The organism which is encompassed and overwhelmed by the feeling of disgust and dirt seeks to remedy the state by attempting to wash, hoping that this will ease the feeling of being dirty. This is a compensation and survival mechanism for the organism.

[Roberto Bianchini, *Syphilinum, the remedy*. The Homoeopath, Dec. 1992]

This is interesting particularly in view of the fact that the spirochaete cannot survive soap!

Obsessional behaviour; thoughts; anxiety.

= Obsessive checking.

~ Obsession with cleanliness.

= Ritualistic.

= Superstitious.

~ Compulsive neurosis.

» “Expresses an artistic talent, though tainted with morbidity and obsession.”
[Sonawala]

= Relentless self-reproach.

- Self-chastisement [self-mutilation].

Loss of sense of self

= Indifferent to friends and feels no delight in anything; he always says he is not himself and cannot feel like himself. [Margaret Burgess-Webster]

= Stranger; loner; hider.

= Estranged. Strangers <.

= Evasiveness [avoids others, confrontation, challenges, consequences].

Let us think of what could occur in someone who has contracted syphilis. Their contact with people would be limited as they would be considered

unclean. They would be isolated, a kind of outcast, somewhat like a leper and feel degraded. This in essence is what Syphilinum can feel like. Syphilinum will often say they feel like a stranger, separate from the world, separate from people and society and even from themselves. It is not in the rubric estranged from society but I have heard several Syphilinum patients relate this.

There is an expression in the materia medica which states 'a far away feeling'. This feeling is felt on many levels; far away from themselves, from their feelings, from the world. Because of this distance they feel that they have to hide themselves from society and from people. Thus Syphilinum becomes markedly secretive; they feel they have to keep things hidden from others. This is so deeply ingrained in the psyche it is often involuntary and unconscious. This is one of the most frequent characteristics that I have observed so far in cases requiring Syphilinum. [Bianchini]

Grandiosity - needs an audience

- = Boasting; reckless; heedless; unrestrained.
- » Expansive; eccentric; bouts of euphoria; elevation of self.
- = Loss of judgement; impulsive.

Cognitive impairment

- ~ Short-term memory loss; cannot remember faces, names, dates, events, books, places.
- ~ Difficulty in finding words, in expressing oneself.
- <■ Difficulty with calculation.

See also section 'General Paresis'.

GENERALS

Modalities - Aggravation

Time

| | |
|----------|--|
| Night. | Pains. Mental state. Sensation of hot water boil in veins. Headache. Pain in eyes. Obstruction nose. Salivati Urging to urnate. Ovarian pain. Leucorrhoea. Asthma. Cou; Cardiac pain. Pain in limbs. Rheumatic neuralgic pains in all the muse Swelling legs. Soreness soles of feet. Sleepless™ Biting sensation in different parts of body, as if I ten by bugs. Itching.* |
| Morning. | Prostration. Swelling upper eyelids. Intense itchi waking/rising, vulva. Urethra as if clogged. |

Seasons / weather Winter.

| | |
|--------------------|--|
| Damp weather. | Bronchial cough. Pain in legs. [Aggravation get rally due to the long nights in winter time.] |
| Frosty weather. | Rheumatic neuralgic pains in all the muscles. |
| Warm weather. | Rheumatic neuralgic pains in all the muscles. Asthma. |
| Warm damp weather. | Asthma. |
| Summer | Asthma. |
| Thunderstorm | Asthma. |

Temperature

| | |
|-------------------------|--|
| Coldness. | Copper-coloured spots become blue. Severe bone pains. |
| Cold drinks. | Pain in throat. |
| Draft of air. | Chilliness. |
| Extremes of heat & cold | “Often bring out the symptoms.” |
| Hot or cold things. | Toothache. |
| Heat. | Varicose veins. |
| Heat of sun. | Headache. |

Position / activity

| | |
|-------------------------|-------------------------------------|
| Exertion. | Pulsating in vertex. |
| Lying on affected side. | Pain in face. |
| Lying on right side. | Cough. |
| Micturition, after. | Pain in renal region/lumbar region. |
| Motion. | Chilliness up the back. |
| Protruding tongue. | Pain above right eye. |
| Raising arm laterally. | Pain in shoulder/deltoid. |
| Sitting. | Pain in coccyx/sacrum. |
| Standing. | Pain in soles of feet. |
| Touch. | Pain in tibia. |

Environment Seaside.

Profound depression. Bilious diarrhoea.

Sensory Light.

Headache. Pain in eyes [lamplight].

* Such a litany of complaints will drive the syphilitic patient most likely out of bed at night and into the arms of a poor sleep during daytime. Both in its extreme forms reversing the day-night rhythm, there is no other way out for the syphilitic, contrary to the sycotic [eg. Medorrhinum], for whom the night opens up new horizons. The shadowy, transparently pale spirochaete favours darkness, so much twisting and distorting 'normal' life that, for example, Oswald Alving, a victim of congenital syphilis in Henrik Ibsen's 1881 play *Ghosts*, cannot tell the difference between night and day. Having a screw loose and being screwed up, so to speak, gain additional meaning in view of the spirochaetes cork-screw shape.

Modalities - Amelioration

Time Daytime. Evening.

General.
Anxiety.

Temperature

Cold bathing/applications. Pain in eyes. Pain in limbs.

Warmth.

Temporal headache extending into or from eyes.
Cramping pain umbilical region.

Warm applications. Headache. Pain in limbs.

Position / activity Bending

| | |
|-------------------------------|---|
| head back. Changing position. | Pain in neck. |
| Continued / slow motion. | Nocturnal pains [temporary]. |
| Lying on abdomen. | Headache. Sciatica. |
| Pressure. | Cough. |
| Pressing teeth together. | Pain in face. Cramping pain umbilical region. |
| | Toothache. |

Environment

Mountains. Bilious diarrhoea. Asthma.

Succession of boils; abscesses; suppurations.

Foul secretions; fetid discharges.
Peculiar disagreeable odour to body.

Accumulation of adversities and linear progression

Syphilinum diseases can have an onset overnight. One goes to bed as a healthy man and wakes in the morning with a chronic disease. For example, rheumatoid arthritis in a Syphilinum patient sets in overnight with strong and persistent pains in various joints already on the first morning.

In Syphilinum patients you often see a ‘worst case scenario,’ i.e. they suffer from all adversities that possibly can accompany their main complaint. Examples are the symptoms “discharge from ear with pains” [a discharging ear usually does not hurt any more] or “fissure in anus and in rectum.” A vaginal discharge will not only be massive, but also excoriating and accompanied by intense itching. Another patient suffered from sneezing and coughing at the same time.

Another important trait of Syphilinum is linearity. The patient is faced with a linear progression from health to destruction. The course of his disease is usually a continuous progression and not a story characterised by ups and downs of recoveries and relapses [otosclerosis, rheumatoid arthritis, multiple sclerosis, etc.]. One often finds linearity in physical Syphilinum symptoms. If any physical phenomenon occurs in two parallel lines [eg, pain, cracks in tongue, eruptions, inflammation, etc.] you definitely know what remedy to prescribe.

[W. Springer & H. Wittwer, *Syphilinum: Past and Present-*, Hom. Links 2/00]

LOCALS

[Some peculiar locals extracted from Margaret Burgess-Webster, *Syphilinum*-, Hom. Rec., No. 3, 3rd quarter, 1934; RefWorks]

= Terrible *vertigo*, under any conditions, but particularly worse rising up suddenly from bed; turning over in bed; or going into the prone position on lying down; on stooping; on looking up, seems to be caused by heat. Vertigo accompanied by easy fatigue, great weariness in limbs. Much vertigo; tendency to fall forward.

~ *Headache* begins in occiput or back of neck, extending through to eyes or works over the head and settles over one eye or the other, with soreness of eyeball, or may change sides. Pains start at 4 p.m. and continue all night, cold sweat on back, arms and feet.

= Violent pain in whole *head* as if head would be crushed in, with red face, enlarged veins of face, restlessness and sleepless nights.

as *Headache*.

Preceded by sensation of choking, as if throat were closing, on stooping. Pain bursting, violent, maddening; as if head would be crushed in or as if top of head would come off.

Worse light, must lie down in dark room; worse effort of speaking or being spoken to.

Better by walking and better wrapping head up.

Hungry during headache.

Much urine as headache is relieved.

After headache neck and between shoulders stiff; subjective trembling; hungry.

= *Nose* and sinuses painful to inhaled air.

CASES

(1) Congenital Malformation of Intestines.

Is interesting because of its pathological aspects, said to be congenital and also because of the unexpected response to the homeopathic remedy which was selected chiefly on one unusual symptom. This case was referred to me by Dr. W. J. Gier of San Diego, California. It is that of a young college student

Of abdominal pain and bowel dysfunction, occurring about every week to ten days since early life, but the attacks are gradually becoming more severe and more frequent.

The patient is fond of meat and it agrees; coffee aggravates. Desires sweets, no thirst for water. No serious disease in his lifetime. Father is living at fifty- one, but has a stomach ulcer. Mother living at forty-seven is anaemic. X-ray of intestines shows a congenital malformation of intestinal tract. Not much affected by temperature changes; sleeps well and is rested after sleep.

Any prescription based on the symptoms, findings and history of this case would insure little change to find a curative remedy. On taking the patient's blood for testing the patient fainted and fell to the floor. When he regained his composure, he said that the sight of even a little blood always made him faint; this was the key to the remedy. Syph. 10M was given, and the blood was tested only to confirm the correctness of the prescription which was proved to be the case. The remedy was given on July 11, 1955.

July 26, 1955. The patient reported improvement, and the remedy was continued.

September 15, 1955. Syph. 10M.

October 13, 1955. Better until recently. Syph. 50M.

December 15, 1955. Better except for a great deal of gas. Syph. CM.

February 10, 1956. Syph. CM.

April 24, 1956. Continued on Sacch-L

June 19, 1956. Always perspired profusely in hot weather. Lyc. 10M.

At times even while eating he fills up and is satiated. Specific indications like gas and distension and easy satiety with sensitiveness to hot weather mark Lyc., a sure winner in intestinal and nutritional troubles. Syph. in ascending potencies helped and strengthened the patient in a wonderful way, but finally there was needed the deep anti-psoric *Lycopodium* to complete the cure of an apparently surgical case without the need for surgery.

Many of our master prescribers have observed that a nosode rarely completes a cure of a chronic case; but, on the other hand, I believe we would fail to cure some cases without the searching and unfolding power of these subtle specifics.

[Grimmer, *Collected Works*]

(2) Female: age 25; PC dysmenorrhoea.

First visit 2 May 1990. Severe cramps during menstruation, copious flooding, wakes her 10 times every night. Periods every 6 weeks. One heavy followed by

one normal. Menstruation up to six days long. Takes BCP one cycle on and one cycle off. Soreness in breasts before period. Has had herbal treatment to no effect. Constipation for 5 days before menses. Feels in a constant state of stress. Great irritability towards husband. Her main occupation is sculptor, keeps another part time job on the side. Nervous flushing < round neck, bright red, comes about during stress or when in company.

Memory poor. Lack of confidence. Feels insecure. Low sense of self-esteem. When criticised gets angry. Strikes self - self-torture. Three years ago she would strike herself, esp. punching herself in the head. When young would not feel like seeing anyone, feels distant from people and world. Remember as a child sitting on a tree and feeling distant from everyone and everything. Averse company. Ill at ease, anxious in company. Heightened feeling of what people are thinking of me. Feels alone. Often in a rage destroys her pieces of sculpture. Fear swimming. Dreams: boyfriend doesn't want to see her; of toilets; dirt. Doesn't show grief. H/o anorexia.

Observation: very quiet, distant and difficult to get information from. Sensitive nature, anxious and flushing around people, but strong character. Rubrics chosen: Company, aversion to. Secretive. Delusions, people talking about her. Delusions of dirt [dreams]. Strikes with fists. Symptoms not in repertory but confirmative: A feeling of distance from the world and people [far away feeling]. Strikes self; self mutilation. Low sense of self-esteem. Destructive.

Rx Syphilinum 1M

15 June 1990. Feeling better all round. Does not feel so stressed, general feeling of well being. For three days after Remedy there was aggravation felt distressed. Menses >, should have had a bad cycle but was not so severe. More open, responsive, less depressed. Feels better in her work, happier in self. Better in company. Flushing >. Constipation >. Only one toilet dream - she was happily sitting on toilet, and thought that the toilet problem was in her homeopath's imagination.

August 1990. Feels well in general, still improving, happier in self. Periods good, no flooding. General all round improvement. Advised her to return sometime in six months.

[Roberto Bianchini]

(3) In May, 1894, Dr. B., an allopathic physician, age seventy years, consulted me. Has had for seven or eight years a number of sores on his face, which have been pronounced by several allopathic dermatologists to be

cancerous in their nature. They came first as raw places on the face, and then covered with perfectly black scabs, which either do not come off or, if they do, leave raw sore places, which will not heal, but become again covered with the black scabs. Under each eye, and especially at the outer canthus of the right eye, the spots or sores look decidedly like epithelioma. The one under the corner of the right eye is threatening to involve the lower lid and the internal structure of the eye. On this eye, a few years since, there was an ulcer on the cornea, which nearly destroyed the sight. He can only distinguish daylight from darkness.

The conjunctiva of this eye is very red and inflamed, and there is ectropion of the lower lid. He is in bad health, and drinks a good deal of whisky. He had been treated by himself and all the “eminent” dermatologists and general practitioners in this part of the country and in New Orleans, and they had given the comforting assurance “that he might live several years, but that it would finally kill him.” I put him on Syphilinum CM [Swan]. To make a long story short, he has gradually improved with occasional relapses, until today he appears to be entirely well. He says for the first time in ten years there are not sores or scabs on his face.

Where the worst ones were there are now cicatrices, but they look perfectly healthy and are gradually becoming smaller. The inflammation is entirely gone from his right eye, the ectropion is nearly removed, and he can see small objects six feet distant with his lame eye.

What perhaps is the most remarkable of all, he has stopped drinking whisky, thus verifying Dr. Thomas Wildes’ observation, made some years since, upon the great efficacy of Syphilinum in alcoholism, although I am not prepared to agree with his second observation, that all chronic drunkards are syphilitics. My patient’s skin troubles were always worse from the light and heat of the sun. There was but little local discomfort, but from the inroads the sore spot at the corner of his right eye was making on that structure, I have no doubt it was epithelioma.

There can be no question of the great value of this remedy for cancer. I believe every case of cancer to be the direct offspring of either syphilis or sycosis, or perhaps both, either acquired or inherited, and no case should be allowed to die or pass under the surgeon’s knife, which alternative is about equivalent to death, without being given the benefit of a trial of Syphilinum. [H.C. Morrow, *Syphilinum in Cancerous Ulceration*-, Hom. Physician, May 1896; RefWorks]

(4) Ms T.L. presents with eczema and stress symptoms. She is an engineering student and the pressure of impending exams is difficult for her. Her mother had previously contacted me concerned about the degree to which she will study as she forgets to eat and drink unless meals are placed in front of her and she is made to stop. Sometimes she will not leave her room for two days. It is as if the rest of the world is forgotten.

The eczema has developed slowly over the last eighteen months and is copper coloured and concentrated in both armpits, the legs and around the genitals. Many natural substances have been tried without result. Further discussion around her study habits reveals that when she concentrates she unknowingly pulls the hair from her arms, legs and head. She is later surprised to find blood on her arms, legs and face.

The rubrics chosen for her case were: Mutilate his body, inclination to. Aversion to society. Compulsive disorders. Eruptions, coppery.

Ms T.L. displays classic destructive blue tendencies and her facial features also show the dominance of blue. [Note: Blue is the colour coding for the syphilitic miasm.] Syphilinum IM single dose resulted in a complete clearing of the eczema and a less obsessive attitude towards studying. She no longer pulls the hair from her body. No further dose was required. Three months later on seeing her mother as a patient she reports that her daughter is still doing well.

[Grant Bentley, *Appearance and Circumstance*]

(5) Miss B.P. Only glimpses of the history can be given. She belongs to a family full of mixed miasmas, very difficult to treat. Her father had epilepsy. Temperamentally she is the odd one of the family, inclined to withdraw, to be silent, to make blunt, offending remarks, misunderstanding and misunderstood.

Difficult concentration. Memory poor. Cannot recite in school, mind goes blank. Irritable. Self-centred. Feeling as if nothing is worth while. Depression, marked before menses. Menses late, scanty. Face flushed and then very pale. Hands and feet icy cold. Piles bedclothes on all year around. Dreams much, busy, tiring dreams, often when half awake. Worse in morning, very hard to get up, slow, fussy. Constipation chronic. Haemorrhoids which bleed. Vision blurred occasionally. Eyeballs burn after using eyes. Numbness of the fingertips. Skin very scaly, dry. Styes, abscesses, pustules. Cracks behind ears.

This patient went stumbling on, not succeeding at anything, until she fell

madly in love with a soldier who went to France. She married him on his return, only to find later that he became insane at times, when he would desert her. She discovered a fresh infection of syphilis. 1921-22 found her in Reno seeking a divorce, and while there she became infected at least once more, having the initial lesion and the eruption. Mentally she grew gradually worse. Her mind would go blank for a moment. She became more indicative and mean, saying horrid things. Her nights were terrible, sleepless, and filled with thoughts which frightened her. Her head was full of distressing confusion with areas of pressure; she complained that she could not think, could decide nothing.

August 1924 she began to notice slight dragging in left leg. June 1925 there was a left-sided paralysis which cleared gradually. The left arm has been heavy ever since and muscles of hand somewhat wasted. This experience made her bitter against all the world and she retired more than ever from people, spending most of her time in bed, not caring to try to take any place in the home.

For remedies, I began way back with Sulphur, followed by Calc-carb, and much later Ferrum. In 1914 Dr. Kent advised Calc-phos. as long as it would hold and then Tub. Tub. was finally followed by Med. When paralysis came, Lachesis was chosen by Dr. Dienst and myself working independently. The mind and head grew worse.

In 1926 I first gave her Syphilinum and have kept her on it. She was sure for a long time it did no good but her family began to see a change. Very gradually mental characteristics dating back to girlhood have become softened and lessened. She has ceased to complain of her head all the time, has left her room, efforts to be helpful, has ventured out alone, and has welcomed guests in the home. She has a better colour and expression than of many years. She will not admit much of this but actions speak louder than words.

[J.M. Green, *Syphilinum*-, Hom. Recorder, Aug. 1930; Enc.Hom.]

(6) In March 1938, M.D. came to consult me asking for any medicine that might cure his epilepsy. He was a young man [30] whose family antecedents and personal antecedents gave me no information. His present affliction began when he was 15 years of age.

The patient had a swollen face, full of acne, and he seemed depressed. He responded hesitantly to my questions, which appeared to bring back his thoughts from far away. Rather than his pathology this condition seemed more likely a result of the 40mg Luminal [phenobarbital] he took daily since

4 to 5 years; even such a high dose had been without any result, instead he had become severely intoxicated by it. He had great weakness of memory and copious salivation particularly at night. Besides that there were hardly any symptoms. Regarding the epilepsy, for the last 15 years he had every night, without exception, 4 to 6 epileptic attacks; violent attacks during sleep, without any aura noticed by his environment [the patient is married]; congested face, trismus, terrible jerkings. Of all this he does not remember anything on waking up in the morning. His whole body hurts and he often

Based on the symptom aggravation at night and a few others mentioned above, I prescribed *Syphilinum* 200, with the advice to stop all sedatives.

After one month the patient comes back. No change. Stopping the Luminal didn't make it worse. I prescribed *Syphilinum* 30 followed after 8 days by *Syphilinum* 1M. No improvement after one month.

I abandoned *Syphilinum* and replaced it with *Bufo* 30. No result. I then prescribed a single dose of *Ignatia* 1M because of the changeable temperament he had started to show since some time. That dose was taken in the morning and in the evening I received an urgent call. He had become furiously mad, breaking everything, beating his wife and his father and causing some injuries. He recognised me. I managed to calm him down and told the family to send him to a psychiatric hospital.

He was in the hospital for eight months, without having a single epileptic attack during this period. His nights were perfectly calm. Finally one night the attack reoccurred and the next morning he woke up in a perfectly healthy state of mind. The attacks became again regular, 4 to 6 each night. I didn't feel much for repeating the experience, but he insisted.

Since I could not find any other remedy than *Syphilinum*, I prescribed this in 10M. It was taken at 7 p.m. The night was worse than ever. The attacks came with 30 minutes intervals and for the first time instead of ceasing in the morning the attacks increased to the point of becoming proleptic [recurrence of attacks at regularly shortening intervals]. Between the attacks the

Treponema Diseases

T. pallidum - Syphilis

T. carateum - Pinta

T. endemicum -

Bejel/endemic syphilis

T. pertenue - Yaws

HOST

Human

TRANSMISSION

Direct contact to

abraded skin from

infected skin lesion of

carrier

patient was unconscious. This condition lasted for 21 hours.

Finally, after an entire day, the attacks stopped. The patient slept for 3 days an almost comatose sleep and woke up cured, completely cured, to have never an attack again.

[Adapted from: R. Paturiaux, *Luesinum in epilepsy*, cited in Julian, *Materia Medica of Nosodes*]

TREPONEMA PERTENUE

| | |
|------------------------|--|
| Scientific name | Treponema pertenu (Castellani 1905) Castellani & Chalmers 1910 |
| Synonym | Treponema pallidum subspecies pertenu |
| Family | Spirochaetaceae |
| Homeopathy | Framboesinum - Fram. |

FEATURES

- Spiral-shaped, motile, pale bacterium.
- Requires a pH in the range of 7.2 to 7.4 and grows at temperatures in the range of 30 to 37° C.
- Endemic in rural, tropical areas; associated with high humidity and rainfall.
- Isolated by Castellani in 1905 and named Spirochaeta pertenuis, Spironema pertenu, or Spirillum pertenu.
- Serologically and morphologically indistinguishable from Treponema pallidum, the spirochaete associated with syphilis, as are Treponema carateum [pinta] and Treponema endemicum [bejel or endemic syphilis].
- Transmitted by direct contact to abraded skin with skin lesions of infected people.
- Primarily present in the epidermis.
- Differs from T. pallidum in its geographic distribution, in its non-venereal transmission, and in its clinical manifestations [does not produce central nervous system or cardiovascular pathology].

YAWS

Analysis of Homo erectus skeletal remains suggests that yaws had its origins in Africa 1.5 million years ago. An estimated 50-100 million persons were infected before mass antibiotic treatment campaigns in the 1950s. In 1997, the World Health Organization estimated that 460,000 new cases of endemic treponematoses [yaws, bejel, pinta] occurred worldwide.

Yaws currently presents mainly in children younger than 15 years in Latin America, West Africa, India, Southeast Asia, and the Caribbean Islands in areas where conditions of overcrowding and poor sanitation prevail.

Its name derives from *yaw*, an African word for raspberry, in allusion to the

raspberry-like appearance of the initial sore at the site of infection. Its alternative name “frambesia tropica” has the same origin; it comes from ‘framboise’, French for raspberry.

Around the world yaws is known by many different names that include pian, patek, parangi, bouba, granuloma tropicum, polypapilloma tropicum, Breda’s disease, and Charlouis’ disease.

Contrary to syphilis, which seemingly required the social conditions of urbanisation, yaws was considered a “village disease.” In order to retain its spread in North America, yaws-infected African slaves were isolated in specially constructed “yaw houses.”

Yaws has three or four stages.

- Stage 1 symptoms typically occur in childhood [peak incidence in children aged 6-10 years] and consist of a papillomatous lesion, termed mother yaw, at the site where the organism entered the body, usually on the foot, leg or buttock. The sore commonly enlarges and becomes crusted. It may coalesce with satellite lesions to form a plaque. Lesions are considered highly infectious. Lymphadenopathy, fever, and joint/muscle pain may accompany this stage. The mother yaw leaves an atrophic scar with central hypopigmentation. Hairs at the seat of a yaw turn white. This is probably the “lepra” described in the Bible in Leviticus.
- Stage 2 follows several weeks or months after the initial symptoms, involving the appearance of similar reddish skin sores, daughter yaws. These lesions are frequently located near body orifices, particularly the mouth and nose, but may also appear on forehead, legs, arms, groin, genitals, perineum, and buttocks. The daughter yaws do not all arise in one crop: some are found mature while others are only starting. They expand, ulcerate, and exude a fibrinous fluid, which dries into a crust and attracts flies. They heal slowly and are usually painless when rubbed or irritated. A traditional diagnostic tool involved the opening of a yaw and dropping a little Capsicum juice in it. Where the acrid juice normally would lead to flinching, no smarting would be felt in case of a yaw.
Sores on the soles of the feet may produce painful ulcerations and result in an awkward crab-like gait or “crab yaws.”
Other symptoms include inflammation of the bones and fingers, hyperkeratosis of palms and soles, generalised lymphadenopathy, malaise, and

anorexia. Climate influences the morphology and the number of lesions. In the dry season, lesions are fewer in number and macular in appearance. Papillomas are found in moist areas of axilla, skin folds, and mucosal surfaces.

The skin lesions, especially those around the mouth, anus and axilla, may relapse for as long as 5 years after the initial infection.

The disease then enters a non-infectious latent period, and patients do not exhibit any signs or symptoms.

- Stage 3 occurs in one-tenth of affected individuals. It appears after 5-15 years of latency [typically around the time of puberty] and includes deformities of bone, joint, and soft tissue. Most patients, however, remain in a non-infectious latent stage for their lifetime.

Deformities and disability are typical of stage 3. Granular nodules [gummatous lesions] in subcutaneous tissue of the face lead to disfigurement, whereas destructive lesions of bone and cartilage reduce function and mobility. There may also be shortening of the ligaments in the joints.

An hypertrophic osteitis known as Goundou syndrome or “dog nose” may develop in this stage. On both sides of the nose painless exostoses develop that overgrow the maxillary bones, producing a symmetrical swelling of the middle section of the face. The syndrome may be accompanied by headache and excessive nasal discharge.

Another stage 3 manifestation is Gangosa syndrome or rhinopharyngitis mutilans. It is characterised by degenerative ulcerations beginning on the soft palate and extending thence to the hard palate, nasopharynx, and nose. The destruction of nasal cartilage and the scarring of tissue results in obstructed nasal respiration, as in congenital syphilis, to which the name refers, ‘gangoso’ being Spanish for ‘snuffling’.

Due to chronic osteoperiostitis of the tibia a third characteristic deformity may arise, which is known as saber shins, sharp-edged anteriorly convex tibia. Other lesions observed in patients with late yaws are monodactylitis [inflammation of one finger] and juxta-articular nodules.

MATERIA MEDICA FRAMBOESINUM

Fram.

Sources

No provings, no clinical cases, no materia medica except for Julian's remark that "as homeopathic indication it has some common points with *Psorinum*- chilliness often accompanied by lowering of body temperature."

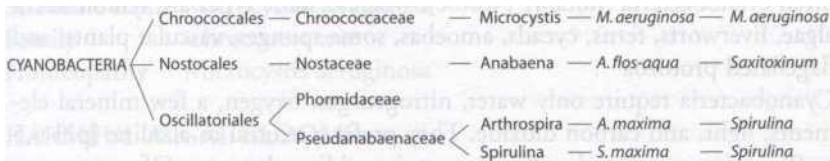
In addition, the clinical differential diagnosis of yaws may deserve consideration:

- = Atopic dermatitis.
- <•» Plaque psoriasis.
- = Rhinoscleroma.
- = Sarcoidosis.
- = Scabies.
- Impetigo.
- =» Molluscum contagiosum.
- = Tinea versicolor.

PHYLUM CYANOBACTERIA

Phylum Order Family

Genus Species Remedy



Until some twenty years ago referred to as blue-green algae or cyanophyta and considered to be plants, cyanobacteria are now classified in the Monera Kingdom. Physiologically, cyanobacteria are somewhat of a hybrid between algae and bacteria. Their photosynthetic ability and the presence of pigments links them to algae, while their cell structure and lack of a nucleus relates them to bacteria.

They come in various colours including light gold, yellow, brown, red, emerald green, violet, blue, and blue-black. Despite their name, only about half of the species are actually blue-green [cyan] in colour. [The Red Sea gets its name from occasional dense concentrations of a reddish species of Oscillatoria and African flamingos get their pink colour from the carotene pigments in Spirulina.]

They are among the oldest form of organisms found on earth. Traces of cyanobacteria have been found in fossils dating from the early Precambrian period, some 3 billion years ago, when they appeared in a time of intense competition among heterotrophic prokaryotes, and prospered on the basis of autotrophy [i.e. manufacturing their own food]. They most probably contributed significantly to the presence of oxygen in the earth's atmosphere.

Believed to be the forerunners of modern-day plant and algal chloroplasts, cyanobacteria are very independent nutritionally. The chloroplast with which plants make food for themselves is actually a cyanobacterium living within the plant's cells. Sometime in the late Proterozoic, or in the early

Cambrian, cyanobacteria began to take up residence within certain eukaryote cells, making food for the eukaryote host in return for a home. This event is known as endosymbiosis, and is also the origin of the eukaryotic mitochondrion.

Cyanobacteria photosynthesize by using chlorophyll *a* and liberating oxygen gas, and many species also fix nitrogen. The blue pigment, phycocyanin, enables them to absorb wavelengths of light for photosynthesis that are missed by chlorophyll in plants. The photosynthetic partners of lichens are often cyanobacteria [notably *Nostoc*], whereas some types are symbionts of algae, liverworts, ferns, cycads, amoebas, some sponges, vascular plants, and flagellated protozoa

Cyanobacteria require only water, nitrogen gas, oxygen, a few mineral elements, light, and carbon dioxide. They prefer a neutral to alkaline [pH 6.5 to 9] environment and will not grow in acidic substrates. Often growing under inhospitable environmental conditions such as high temperature and salinity, they also appear to prefer waters that have higher levels of phosphorus than ammonia.

Associating in colonies or living free as single cells, cyanobacteria are extremely common and are found in fresh, brackish, and salt water. At times they agglomerate and form masses and patches, known as 'scum' on ponds or 'algal blooms'.

Certain cyanobacteria, in particular *Anabaena* spp., produce potent neurotoxins termed saxitoxins and anatoxins.

Other cyanobacteria are grown and harvested for the commercial production of a food supplement with miraculous properties known as 'spirulina'.

I. ORDER CHROOCOCCALES

IA. Family Chroococcaceae

IA. FAMILY CHROOCOCCACEAE

Microcystis aeruginosa.

MICROCYSTIS AERUGINOSA

Scientific name *Microcystis aeruginosa*

Family Chroococcaceae

Homeopathy *Microcystis aeruginosa*

HARMFUL ALGAL BLOOMS

Everyone is familiar with cyanobacteria. Fossil records show that they are one of the earth's most ancient life forms, dating back to some 3.5 billion years. They are often found on greenhouse glass, shower curtains, around sinks and drains, as layers on rocks or trees, as bluish-black patches on lawns if growth of the grass is poor, and so on. Their ability to occupy habitats with extreme environmental conditions is unsurpassed, a specific quality utilised by certain species for participation in lichens, another typically 'extreme' life form.

In any habitat, massive amounts of cyanobacteria are termed *blooms* because masses suddenly appear - almost overnight in shallow surface water. In general, cyanobacteria prefer warm conditions, while low temperatures are one of the major factors that ends cyanobacteria! blooms. Actually, the sudden explosion in numbers is caused by bacteria moving upward nearer to the water surface, in response to increased light and warmth. Gas-filled spaces in their cells enable these organisms to regulate their buoyancy and thus to actively seek water depths with optimal growth conditions. As suddenly as the agglomerations arise, they disappear when the weather changes, or they may remain unchanged for weeks during quiescent conditions.

Harmful algal blooms [HABs] are increasing in severity and frequency on a global scale. Although algal blooms historically have been considered a natural phenomenon, i.e. occurring long before significant pollution by human population, agricultural runoff and other pollutants of freshwater and marine wetlands and water bodies have resulted in increased nutrient loading of phosphorus and nitrogen, thus providing conditions favourable to the growth of potentially toxic cyanobacteria and algae.

MICROCYSTIN

Toxic freshwater algae are largely limited to a few species of cyanobacteria, particularly *Microcystis aeruginosa* [microcystin and cyanoginosin, mono- cyclic heptapeptide hepatotoxins], *Anabaena flos-aquae* [anatoxins and microcystins], and *Aphanizomenon flos-aquae* [anatoxins].

All three are scum-forming species.

Microcystis aeruginosa is the most common toxic cyanobacterium in eutrophic freshwater producing microcystins. Microcystins are the most common of the cyanobacteria! toxins found in freshwater, as well as being the ones most often responsible for poisoning animals and humans who come into contact with toxic blooms. More than 65 structural analogues of microcystin have been identified. Extremely stable in both cold and warm water and able to survive radical changes in water chemistry, microcystins cause in severe cases enlargement and congestion of the liver followed by necrosis and haemorrhage, and may also exhibit neurotoxic activity.

In addition, the compounds can accumulate in the tissues of fish, particularly in the viscera [liver, kidney, etc.] and in shellfish. In relation to cyanobacterial blooms, microcystins are the most significant drinking water quality issue in various countries. Clinical signs following exposure to these compounds include lethargy, vomiting, diarrhoea [often bloody], weakness, pallor, shock and death from massive hepatic failure. Symptoms develop less rapidly as with anatoxins. In China, a high incidence of primary liver cancer in populations drinking water from ditches or rivers has been ascribed to the presence of microcystin-producing cyanobacteria in these water supplies.

The toxins were in the news in 1996 as they caused liver failure in 131 Brazilian dialysis patients who were exposed to microcystins from the water used for dialysis. Within 7 months 56 patients died of the typical hepato- toxic effects associated with microcystin, a constellation of symptoms now referred to as 'Caruaru Syndrome'. The syndrome is characterised by headache, nausea, vomiting, eye pain, blurred vision, painful hepatomegaly, jaundice, and a bleeding diathesis manifested by ecchymosis, epistaxis and metrorrhagia.

MATERIA MEDICA MICROCYSTIS AERUGINOSA Micro-a.

Sources

[1] Proving Melanie Grimes, 9 female provers, 12c and 30c; 2003.

Substance was sourced during an algal bloom in Green Lake, Seattle, Washington on August 8, 2002. Labs showed toxin levels of 1.3 microns/liter, above the WHO levels of 1 micron/liter.

SYMPTOMS

[Numbers indicate number of provers experiencing the symptom.]

Synopsis of proving

Main area of action in the proving was aching pain in head, back, shoulders, felt by most of the provers and described by some as 'miserable' pain. Two found that coffee antidoted but only temporarily.

At the same time, the mental state included a feeling of benevolence, grace, and sympathy and compassion for others.

There was fear of disease, including sensation of something foreign in the body, in the stomach area that needs to be taken out, fear of fainting, and fear of drinking hot fluids. Dreams included: water, being kidnapped, of being pursued, detective investigations, theatre, animals [dog, mussels, crocodile, green parrot, fish], money, and the colours blue and green.

Itching occurred on eyes, shoulders, back, and chin.

The proving was curative for the following symptoms:

Dull neck/back pain; tension headaches; *molar ache*-, insomnia; itch from bug bites healed immediately; back and hip not sore while driving long distances.

As the proving also created the same pathology in other provers, we can be quite sure of these symptoms as integral to the proving picture. [MG]

Mind

« Benevolence, sensation of grace. [3]

» Impatience. [2]

= Laziness; avoiding work to play instead. [2]

= Detached. [3]

» Nervous. [2]

<= Defiant. [2]

= Anxiety about health. [3]

Generals

- = Aching pain [2]; aching all over [3].
- = Fatigue, low energy, weariness, exhaustion. [4]
- = No appetite [2] or increased appetite [2].
- = Desire soft food [1]; salt [1]; garlic [1].
- = Chilliness [4] - freezing cold after eating [1]; cold at night [1]; cold on waking

[1],

- = Hard work amel. [4]
- = Motion amel. [5]
- = Open air amel. [2]

Locals

- = Headache - dull ache across eyebrows [4] - dull ache over entire head [4].
- = Headache around head, with throbbing pain over eyes. [4]
- ~ Headache extending to vertex. [4]
- => Headache above eyebrows in occiput. [4]
- = Headache, pressure in temples. [4]
- = Headache > coffee. [2]

- = Backache, & headache, > standing. [4]
- = Backache > lying on firm surface, stretching. [4]
- = Backache & restlessness. [4]
- « Low backache & aching pain in hips. [4]
- = Backache [neck area] > coffee. [2]
- = Shoulder pain, aching [5], > motion [2], > heat [2]; & nausea [2].
- = Pain right arm. [2]
- = Hip pain, ache. [4]
- ~ Aching in bones and joints. [5]

Sensations

- = Feeling of falling apart.
- =>> Eyes as if hollow.
- « Of cold needles pricking in right ear.
- ~ As if being cut in two pieces right through the abdomen by a huge knife [during menses].
- = Weight of world on shoulders.

Resolutions

-
- » Sulphur taste in mouth when burping, frequent and smelly.
 - = Metallic-bitter taste in mouth.
 - « Explosive vomiting; explosive diarrhoea, as if a tornado went through.
 - > Menses very heavy; dark red; < at night.

IL ORDER NOSTOCALES

IIA. Family Nostocaceae

IIA. FAMILY NOSTOCACEAE

Anabaena spp.

ANABAENA FLOS-AQUA

| | |
|------------------------|-----------------------------------|
| Scientific name | Anabaena flos-aqua (Lyngb.) Breb. |
| Family | Nostocaceae |
| Homeopathy | Saxitoxinum [?] |

CYANO-HABS

Blooms produced by cyanobacteria are referred to as 'cyano-HABs'. Toxic cyanobacteria include freshwater species like *Anabaena flos-aqua*, which yields both potent neurotoxins and liver toxins [microcystins]. Genera of cyanobacteria reported to cause neurotoxic symptoms include *Anabaena*, *Aphanizomenon*, *Oscillatoria*, *Trichodesmium*, *Cylindrospermum*, *Lyngbya* and *Nostoc*, but *Anabaena flos-aqua* is the species implicated in most neurotoxic outbreaks.

Neurotoxins synthesized by *A. flos-aqua* include saxitoxins, anatoxin-a and anatoxin-a[s], the latter having a toxicity approximately 10 times higher than anatoxin-a. It was named anatoxin-a[s] because it induced much the same symptoms as anatoxin-a but caused vertebrates to salivate excessively - the [s] standing for salivation.

The more toxic species of Cyanobacteria are of the filamentous variety, i.e. they form long, stringy masses. Like other filamentous forms, they develop in late spring or early summer. A common component of pond scum throughout the world, *A. flos-aqua* is usually found as a bright green layer on stagnant water which may later turn blue. [No doubt an interesting substance for a homeopathic proving!] A late 19th-century report of algal bloom in the estuary of the Murray River, in Australia, described the organisms as forming "a thick scum-like green oil paint, some two to six inches thick." However, anatoxins have been identified in freshwater cyanobacteria from Europe, North America and Japan but not in Australian cyanobacteria.

The toxins in water supplies, particularly released by thick blooms occurring in summer, have caused mass mortalities of wild [migratory birds, deer, wild sheep and even bears] and domestic animals [cows, horses, sheep, pigs, ducks, geese and family pets], farmed fish and shellfish [salmon, trout, shrimp] as well as human intoxications and death from exposure and consumption of contaminated drinking water supplies. Depending on the quantity consumed, anatoxin can be fatal within four minutes, so that the compound has been dubbed ‘Very Fast Death Factor’.

Toxin levels are greater in older cultures and in cultures supplemented with phosphorus. The bacteria bioaccumulate phosphorus. Anatoxin-a[s] is a natural organophosphate with a toxicity similar, but more potent than the known synthetic organophosphate pesticides. It inhibits enzymatic breakdown of acetylcholine [anticholinesterase], resulting in overstimulation of muscle cells and in manifestations as excessive salivation, lachrymation, diarrhoea, and urination.

Death occurs when the muscles of the chest responsible for breathing are affected. The effects are similar to those of other cholinesterase inhibitors, eg, muscarine, cytisine, nicotine, physostigmine, warfare nerve agents sarin and soman, and the insecticides parathion and malathion. The anatoxins seem unique to cyanobacteria. Cyanobacteria may cause other problems as well; a species of *Lyngbya* is responsible for one of the skin irritations commonly known as “swimmer’s itch.”

SAXITOXIN AND BREVETOXIN

Both freshwater cyanobacteria and marine dinoflagellates produce saxitoxins. Saxitoxin and neosaxitoxin have been shown to be produced by the freshwater - brackish water cyanobacteria *Aphanizomenon flos-aqua* and *Anabaena circinalis*. Little evidence exists for their involvement in poisonings in freshwater environments. A few animal deaths have been linked to saxitoxins in U.S. freshwaters. However, in temperate parts of Australia, blooms of saxitoxin producing cyanobacteria are very prevalent. The first reported neurotoxic bloom of *Anabaena* in Australia occurred in 1972.

The most publicised bloom occurred in late 1991 and extended over 1,000 km of the Darling-Barwon River system in New South Wales. A state of emergency was declared with a focus on providing safe drinking water to

towns, communities and landholders. Thousands of stock deaths were associated with the occurrence of the bloom but there was little evidence of human health impacts.

Despite its presence in freshwater cyanobacteria, most saxitoxin poisonings arise from exposures to marine dinoflagellates - flagellated, nucleated, aquatic micro-organisms classified in the Kingdom Protista. Due to their occurrence and association with seafood, saxitoxins are commonly referred to as paralytic shellfish poisons.

Under good conditions [warm climate, warm water], dinoflagellates may reach 60 million organisms per litre of water. The most common of these toxic dinoflagellates contain a red pigment causing with their rapid growth the “red tide” characterised by patches of discoloured water, dead or dying fish, and respiratory irritants in the air. Toxic red tides, which vary in potency, generally occur in calm coastal waters during the summer months, and can be so invasive that countless fish and birds are killed. Fish kills associated with these red tides have been estimated up to 100 tons of fish per day.

Shellfish [mussels, clams, and oysters] can filter dinoflagellates from water and accumulate the toxins. Human consumption of shellfish that have been feeding on the toxic protists may lead to a syndrome termed ‘paralytic shellfish poisoning [PSP] or a milder variety, ‘neurotoxic shellfish poisoning’ [NSP], which presents as a milder gastroenteritis with neurologic symptoms compared with PSP. NSP is associated with the neurotoxic compound brevetoxin, found in the marine dinoflagellate *Ptychodiscus* [previously *Gymnodinium*] breve.

Not uncommon in the past in coastal areas, shellfish poisoning outbreaks are rare today due to prohibition against eating certain shellfish during the summer months.* The toxicity of mussels and oysters show definitely seasonal variation; the concentration of toxins increases during the spawning season.

Saxitoxin acts in a similar manner to Botulinum toxin because it is a cholinergic agonist that inhibits the release of acetylcholine at synapses in the peripheral nervous system. PSP develops extremely fast [within 10 minutes], beginning with tingling and burning sensation and numbness of lips, tongue, and face, spreading elsewhere to the body, and followed by headache, dizziness, weakness, joint pain, ataxia, intense thirst, anuria, difficulty in swallowing, and incoherent speech or complete loss of speech. Pupillary changes are variable, and there may be impairment of vision, diplopia, or even temporary blindness. Breathing problems and muscular

paralysis occur in severe cases and death is caused by respiratory paralysis within two to 12 hours. The manifestations are consistent with pufferfish poisoning, with the absence of significant hypotension in shellfish poisoning as the main difference. Saxitoxin is a member of the CDC Select Agent List for its potential use as bioweapon.

Saxitoxin and brevetoxin are odourless, tasteless, heat- and acid-stable, and cannot be easily detected nor removed by food preparation procedures.

In contrast to saxitoxin, brevetoxin can be aerosolised both in the droplets of salt spray and attached to salt particles. Waves hitting the shore during a red tide break the fragile diatoms open, thereby generating high concentrations of airborne brevetoxin. Red tide-associated clinical manifestations were first reported from Florida. Symptoms consist of conjunctival irritation, copious catarrhal discharges, rhinorrhoea, non-productive cough, bronchoconstriction, and, less commonly, dizziness, tunnel vision, and skin rashes. Asthmatics seem particularly susceptible. The condition is usually rapidly reversible by leaving the beach.

* Kent refers to this when writing: "Diarrhoeic from eating oysters out of season. You might be disposed to give Lyc., because in the text books poisoning from oysters is laid down under Lyc. I do not know that you would be justified in saying poisoning from oysters in season is Lyc., and out of season is Aloe, but there is a tremendous poisoning effect about oysters in the hot weather and in the breeding season that is not found at any other time. A great many people become nauseated, bloat up, purge tremendously, vomit everything for several days after eating oysters.

Now, when that group of symptoms is present Lyc. will cure it and will remove the tendency to get sick from oysters. But if you notice those who get sick have a cholera-like trouble from eating oysters in the hot season, you will find that is where Aloe is the remedy."

MUSSEL POISONING

Prior to the identification of the causative agents, shellfish poisoning was usually described as 'mussel poisoning' in older toxicological literature. A relative harmless and self-limited form is known as gastrointestinal, choleric or diarrhetic shellfish poisoning [DSP]. The causative organisms are marine dinoflagellates in the genus *Dinophysis*. Diarrhoea is the most commonly reported symptom, closely followed by nausea and vomiting, with onset thirty minutes to twelve hours from ingestion. One case in homeo-

pathic literature is almost certainly a case of DSP. It was reported in 1880 and is listed under *Mytilus edulis*, the common mussel.

Miss H. ate some boiled *Mussels*, which for the first time disagreed with her. In half an hour afterwards, she had sickness and retching, vomited a white, oily, frothy substance; this lasted two hours, followed by severe pain in abdomen, which lasted about 7 weeks; this pain came in paroxysms; at first there was burning pain, then whitish diarrhoea running like water; then, after the stool, pain as if bowels were screwed up; after an interval of about a fortnight, the burning in the abdomen returned, in paroxysms, followed by natural stool every time, with pain as if bowels were screwed up after the stool; these symptoms lasted fourteen days, then ceased, then again returned in about three weeks.

[Berridge, *Involuntary Provings: Mytilus edulis*: The Organon, Vol. 3, 1880, p. 283]

The paralytic variety of mussel poisoning [*see also Saxitoxin*] played a noteworthy role in the early explorations of the Pacific Northwest by Captain George Vancouver. In June 1793, while he was surveying the area near Fitzhugh Sound, some of the crew members landed in one of the coves and collected “muscles” [sic] which were promptly cooked for breakfast.

Mr. Johnstone was now informed by Mr. Barrie, that soon after they had quitted the cove, where they had breakfasted, several of the crew who had eaten of the muscles were seized with a numbness about their faces and extremities; their whole bodies were very shortly affected in the same manner, attended with sickness and giddiness. Mr. Barrie had, when in England, experienced a similar disaster, from the same cause, and was himself indisposed on the present occasion. Recollecting that he had received great relief by violent perspiration, he took an oar, and earnestly advised those who were unwell, viz, John Carter, John M’Alpin, and John Thomas, to use their utmost exertions in pulling, in order to throw themselves into a violent perspiration.*

This Mr. Barrie effected in himself, and found considerable relief; but the instant the boat landed, and their exertions at the oar ceased, the three seamen were obliged to be carried on shore. Mr. Johnstone entertained no doubt of the cause from which this evil had arisen, and having no medical assistance within his reach ordered warm water to be immediately got ready, in the hope, that by copiously drinking, the offending matter might have been removed. Carter attracted nearly the whole of their attention, in devising every means to

afford him relief, by rubbing his temples and body, and applying warm cloths to his stomach; but all their efforts at length proved ineffectual, and being unable to swallow the warm water, the poor fellow expired about half an hour after he was landed. His death was so tranquil, that it was some little time before they could be perfectly certain of his dissolution.

There was no doubt that this was occasioned by a poison contained in the muscles he had eaten about eight o'clock in the morning; at nine he first found himself unwell, and died at half past one; he pulled his oar until the boat landed, but when he arose to go on shore he fell down, and never more got up, but by the assistance of his companion. From his first being taken his pulse was regular, though it gradually grew fainter and weaker until he expired, when his lips turned black, and his hands, face, and neck were much swelled. Such was the foolish obstinacy of the others who were affected, that it was not until this poor unfortunate fellow resigned his life, that they could be prevailed upon to drink the hot water; his fate however induced them to follow the advise of their officers, and the desired effect being produced, they all obtained great relief; and though they were not immediately restored to their former state of health, yet, in all probability, it preserved their lives.

...

This very unexpected and unfortunate circumstance detained the boats about three hours; when, having taken the corpse on board, and refreshed the three men, who still remained incapable of assisting themselves, with some warm tea, and having covered them up warm in the boat, they continued their route, in very rainy, unpleasant weather down the south-west channel, until they stopped in a bay for the night, where they buried the dead body. To this bay I gave the name of Carter's Bay, after this poor unfortunate fellow; and to distinguish the fatal spot where the muscles were eaten, I called it Poison Cove, and the branch leading to it Muscle Channel.

[G. Vancouver, *A voyage of discovery to the North Pacific Ocean and round the world*, London, 1801; cited in: Halstead, *Poisonous and Venomous Marine Animals of the World*, Vol. 1, 1965]

* The popular belief that illness could be 'sweated out' is also evidenced by the dancing frenzy, to induce profuse perspiration, following the real or perceived bite by a tarantula.

ALZHEIMER'S DISEASE AND ALGAL BLOOMS

The mode of action of anatoxin makes it an attractive agent as a starting point for the development of drugs for use in the treatment of a number of neurological diseases, including Alzheimer's disease. Because of its ability to

mimic the behaviour of the neurotransmitter acetylcholine, pharmaceutical companies hope to develop less toxic, modified analogues of anatoxin-a to help counter the depletion of acetylcholine in Alzheimer's disease patients. A cure for Alzheimer's disease derived from the scum of ponds!? Although the cause of Alzheimer's disease is unknown it is thought to be due to a chemical defect after it was found, in 1976, that the brains of patients who had died with Alzheimer's disease contained far less acetylcholine than those of normal individuals. Stone and Darlington offer an explanation: "Cells in some parts of the brain seem to be more susceptible than others to damage in Alzheimer's disease. These include cells in those areas involved in learning and memory, especially cells in the basal nucleus, which secrete acetylcholine as their neurotransmitter.

Cells in this region also have branches which travel to the cerebral cortex, the area of brain which is important for the ability to think and reason clearly and logically. Whenever we learn something new, a change occurs in a nerve cell or group of cells which lasts for some time. Acetylcholine is involved in producing those changes. If animals or people are given drugs which block the effects of acetylcholine in the brain, they have difficulty in learning, and may forget recently-learned facts or tasks. These are often the earliest symptoms of Alzheimer's disease: people forget simple, everyday things and eventually, after several years of this progressive disease, may not even remember the names, or recognise the faces of their husband, wife, or children. ...

Most of the drugs being developed are intended to replace or restore the functions of specific groups of cells which appear to be damaged in Alzheimer's disease, most emphasis being placed on those cells releasing acetylcholine. ... One approach to treatment is to increase the amounts of acetylcholine in the brain by inhibiting the enzyme that breaks it down. By stopping the breakdown of acetylcholine, these compounds increase the amount of this transmitter in the brain, and can slow down the progressive development of Alzheimer's disease.

Two of the drugs being used are tacrine and eserine [also called physostigmine], but they are far from ideal. Both tacrine and eserine inhibit cholinesterase throughout the body, not just in the brain, so that there are many side-effects. These include increases in the flow of saliva, sweating, activity of the intestine [leading to diarrhoea], and acid secretion in the stomach, together with difficulty focusing the eyes and muscle cramps." [Pills, Potions and Poisons; Oxford University Press, 2000]

There is more than only a biochemical mode of action to link algal blooms

with Alzheimer's disease. Amnesic shellfish poisoning [ASP] is particularly serious in elderly people and includes symptoms reminiscent of Alzheimer's disease. First reported from Canada and later identified as a continuing problem in Washington State and Oregon, the toxicosis is characterised by the onset of gastrointestinal symptoms within 24 hours of the consumption of toxic shellfish [nausea, vomiting, diarrhoea, abdominal pain]; neurological symptoms occur within 48 hours [dizziness, headache, confusion, shortterm memory loss, disorientation, seizures, coma]. Permanent neurologic sequelae, especially cognitive dysfunction, are prevalent in patients above 60 years of age. The culprit is an excitatory amino acid, domoic acid, which has been isolated from blue mussels, fish, and crab viscera. Associated with blooms of the marine diatom *Pseudonitschia pungens*, domoic acid is similar to its biochemical analogue glutamic acid. When rats are exposed experimentally to domoic acid and its analogues, they get limbic seizures, memory and gait abnormalities, and degeneration of the hippocampus. In animals, domoic acid is 30-100 times more potent than glutamic acid. Both are excitatory amino acids [neurotransmitters] and bind at the same receptor site in CNS. For the treatment of Alzheimer's disease drugs have been developed that act on these glutamate receptors.

MATERIA MEDICA SAXITOXINUM

Saxitox.

Sources

No proving nor clinical cases.

Symptoms from intoxication cases from the consumption of contaminated mussels; symptoms collected by Kate Birch or extracted from Christison's description in *A Treatise on Poisons* of an outbreak of mussel poisoning in Scotland, 1828, involving 30 persons [c].

SYMPTOMS

Peculiar lightness

<- Patient takes his condition *lightly* despite the severity of the symptoms. The patients often feel exhilarated and are not aware of the seriousness of their condition.

~ General motor incoordination and ataxia are accompanied by a peculiar feeling of *lightness*, "as though one were floating in air."

Mind

- = Lucid. Alert. Calm and conscious of ones condition. Mentally clear up to death.
- Joking mood and not considering his intoxication to be serious.
- = Disorientation. Incoherence and drowsiness.
- = Lightness as if floating in air. Sensation of rising in the air. Feeling he could fly. Heavy objects feel as if they were light.

Generals

- = Comatose appearance with flaccid, unresponsive paralysis with fixed dilated pupils. Yet patient actually fully conscious.
- = General weakness and feeling of lightness. Dizzy and weak on waking & general numbness.
- = Body temperature slightly subnormal. Chilly sensation felt in extremities.
- = Increased perspiration. Cold perspiration.
- = Intense thirst.
- = Sleeps well but dizzy and weak on waking. Restless sleep interrupted by many dreams.
- ~ Numbness [in and around mouth; of lips of tongue; in hands and feet; in fingertips and toes, spreading to arms, legs and neck].
 - Marked ataxia. Ataxic gait, as if wading in deep water.
 - Muscular debility. “In some it merely prevented them from walking firmly, but in most of them it amounted to perfect inability to stand. While lying in bed they could move their limbs with tolerable freedom; but on being raised to the perpendicular posture, they felt their limbs sink under them.” [c]

Locals

- = Impaired vision or temporary blindness. Fixed dilated pupils.
- = Irritation of mucous membranes. Sneezing.
- = Generalised muscle weakness in facial muscles. Flaccid expression.
- = Face pale and rather cold, [c]
- = Numbness of cheeks and of chin.
- = Tingling sensation in lips.
 - Tingling around lips, gums and tongue gradually spreading to face and neck
- = Burning sensation of lips, gums, and tongue.
- = Coppery taste in mouth, [c]

-
- = Increased salivation.
 - = Teeth feel loose or set on edge.
 - = Choking, constrictive sensation in throat.
Dysphagia. Aphonia.
 - = Diarrhoea. Or tendency to constipation that can last for several days after ingestion of the toxin.
 - >> Slight pain in abdomen, < pressure [particularly in hypogastrical region]⁰-
 - = Urinary symptoms: “In some the secretion of urine was suspended, in others it was free, but passed with pain and great effort.” [c]

III. ORDER OSCILLATORIALES

IIIA. Family Phormidiaceae

IIIB. Family Pseudanabaenaceae

SPIRULINA

Scientific name Arthrospira maxima Setchell & Gardner

Family Phormidiaceae

Homeopathy Spirulina - Spirul.

Microbial mats

A large portion of early life forms was concentrated in thin scummy sheets called microbial mats. Some mats built up thick columns under them, distinctive rock formations called stromatolites, but most formed thin, unsupported sheets in marginal habitats where physical conditions were severe and predators and competing organisms scarce, such as hot springs, salty lagoons, Antarctic lakes, deep-sea sediments, and damp rock surfaces on land.

Three billion years ago all available space in the shallow seas was probably covered by a variety of such microbial formations, each kind specialised for a particular niche of light, temperature, and acidity.

Since the beginning of life, the denizens of microbial mats have gathered into communities of considerable complexity. The plain appearance of the outer coat viewed with the naked eye is misleading. When a mat is sliced vertically and examined under the microscope, it is seen to be packed with photosynthetic organisms from the surface to a depth of a millimetre. Across that short distance, sunlight attenuates to 1 percent of the intensity it has in the water above. That is about the same amount of energy lost by sunlight in travelling from tree crown to floor in a dense forest. And the analogy runs deeper: the mat community is even organised somewhat like a forest.

Cyanobacteria, which capture solar energy, are distributed in succession from top to bottom like different kinds of trees, with least shade-tolerant species near the surface and most shade-tolerant species towards the bottom. They use the energy to combine water and carbon dioxide into organic molecules, giving off oxygen in the process. ... Swimming and drifting in open water around the ancient microbial mats were almost certainly populations of cyanobacteria and

other prokaryotic forms different from the mat organisms.
[Edward O. Wilson, *The Diversity of Life*]

In this living mat, microscopic unicellular algae with flinty shells in two halves called diatoms live in the uppermost layer, with underneath layers of cyanobacteria of the order Oscillatoriales such as Spirulina, Oscillatoria, and Microcoleus.

Food supplement

Used as a staple food by the ancient Aztecs of Mexico and to this day in certain parts of Africa, cyanobacteria of the genus Spirulina* are now commercially processed as high-protein food supplements rich in vitamins and minerals. The spiral-shaped bacteria [hence their name] thrive in warm alkaline lakes in Mexico and on the African continent [Ethiopia and Chad] as floating green scum, which is harvested, dried and sold.

Popularly designated as “blue-green algae” or erroneously as “aquatic plants,” consuming cyanobacteria from natural lakes and cultured algae farms is increasingly popular among health food devotees. That confusion may become ignorance bordering on the ludicrous is demonstrated by microbiologist Robert Young [2001] who contends that, “Algae supplements do contain vitamin B12, not found in veggies, but the algae can’t make the vitamin; it’s made by bacteria which experts believe get into the algae via bird feathers and droppings.” To bolster his claim that over-acidification of the body is the cause of nearly all misery afflicting humankind, Young manages to reverse the growth conditions of “algae” [= cyanobacteria] from alkaline to acid and to make them moreover responsible for the production of fungal toxins: “As far as algae are concerned, and specifically Klamath Lake blue-green algae ... they are a negative because they thrive in acid conditions ... The fact that algae appear and grow freely in a stagnant and acid terrain gives rise to concern of mycotoxicity.”

Non-spirulina products, such as dried Aphanizomenon flos-aquae or even Anabaena or Microcystis species, are also on the market. Spirulina species are most often grown under controlled conditions and are subject to less contamination than non-spirulina species that may be harvested in nature. Spirulina, by one company advertised as “Our Immortal Ancestor,” is not known to produce anatoxins or microcystins. There is comfort in knowing that “the oldest organisms - the ones who gave us life - are back to revitalise us.” The real benefits of Spirulina will be difficult to separate from the sales

arguments, but may lie for susceptible individuals somewhere between the extremes presented in a Reuters dispatch of 29 October 1996 as: "Its fans call it 'brain food,' claiming it has powers to boost energy, stimulate the immune system, heighten mental clarity and increase sexual stamina. Its detractors say it is nothing more than pricey pond scum and the latest bit of nutrition quackery. Eating it can cause nausea and vomiting. Some strains have been found to cause paralysis in laboratory animals."

Falquet has reviewed the literature on the nutritional aspects of Spirulina. A brief extract follows:

Protein content of spirulina varies by 10-15% according to the time of harvesting, the highest values being obtained at early daylight.

High biological value of proteins, including all the essential amino acids, except for the sulphur-containing amino acids methionine and cysteine, which are relatively poorly represented.

Can be considered as one of the best known sources of gamma-linolenic acid, after human milk and some little used vegetable oils [evening primrose, borage, blackcurrant seed, and particularly hemp oil].

Spirulina polysaccharides are believed to have a stimulating effect on DNA repair mechanisms, which might explain the radio-protective effect mentioned several times in relation to spirulina. Other explanations have been put forward to account for this effect, including the neutralisation of the free radicals generated by irradiation. This rapid neutralisation is thought to be primarily due to beta-carotene. Moreover, the abundant metallothioneins in spirulina may be involved in the accelerated excretion of certain radioisotopes as observed during a nutritional study on a group of Belo-Russian children seriously contaminated following the Chernobyl disaster. Certain polysaccharides are also thought to have immune-stimulating and immune-regulating properties.

A study conducted on 5000 Indian pre-school children showed that a single daily dose of one gram of spirulina was surprisingly effective against chronic Vitamin A deficiency.

Inhibition by spirulina of mother-child transmission of HIV is suggested by the fact that it has been shown that the transmission of HIV from an infected mother to her child is strongly dependent on Vitamin A deficiency.

Less rich than yeast in the B vitamins, except for vitamin B12, but nevertheless a good source. The bioavailability of the B12 is disputed.

Calcium, phosphorus and magnesium occur in quantities comparable to those found in milk.

High potassium content.

The high carotenoid content of spirulina [mainly beta-carotene or pro-vitamin A] may be correlated with its effectiveness in the treatment of skin conditions such as psoriasis, acne, and even herpes.

Spirulina is high in phenylalanine, the amino acid suppressing the appetite centre of the brain, thus assisting in weight loss.

[Jacques Falquet, *The Nutritional Aspects of Spirulina*-, www.antenna.ch/UK/Aspect_UK.htm]

Therapeutically, Spirulina has been used in the treatment of anaemia, weakness, malnutrition, hepatitis, inflammations, diabetes, hypoglycaemia, and poor skin tone.

Few side effects have been reported with spirulina use in people. The most frequently reported adverse effects are headache, muscle pain, flushing of the face, sweating, and difficulty concentrating.

* According to Antenna Technology and the University of Geneva, Switzerland, the eatable cyanobacteria sold under the name of spirulina are actually members of the genus *Arthrospira*. "What distinguishes the *Arthrospira* genus from the rest of the cyanobacteria is its ecological niche: this micro-organism proliferates in very mineralised, alkaline and warm waters. Hardly any other living organism can survive in such conditions. The *Arthrospira* development in such an environment excludes other organisms due to three phenomena: [1] By feeding on the carbonates and bicarbonates of its environment the *Arthrospira* increases the alkalinity of the water - up to a pH of 12.5! [2]

As the *Arthrospira* filaments are very pigmented and often float they form a very effective shield against sunlight, which would otherwise enable algae to grow [as *Chlorella*, an eatable microalgae that sometimes proliferates in low concentration spirulina cultures]. [3] It was demonstrated that the *Arthrospira* is capable to discharge defence molecules. Amongst these molecules one is very active against a range of waste bacteria. This could explain the traditional use of 'spirulina' plasters on gangrene wounds."

[www.antenna.ch/UK/BkSpi_UK.htm.]

DIVISION FIRMICUTES

[Gram-positive and protein-walled bacteria]

PHYLUM ENDOSPORA

| Phylum | Order | Family | Genus | Species | Remedy | |
|-----------|------------|-------------------|------------------|---|--|--|
| ENDOSPORA | BACILLALES | Bacillaceae | Bacillus | <i>B. anthracis</i> <i>B. brevis</i> | — Anthracinum — Tyrothricinum | |
| | | Listeriaceae | Listeria | <i>L. monocytogenes</i> | — Listeriosis nosode | |
| | | Staphylococcaceae | Staphylococcus | <i>S. aureus</i> | — Staphylococcinum | |
| | | LACTOBACILLALES | Enterococcaceae | Enterococcus | <i>E. faecalis</i> Enterococcus spp. | — Enterococcinum — Streptoenterococcinum |
| | | | Lactobacillaceae | Lactobacillus | <i>L. acidophilus</i> | — Lactobacillus |
| | | | Streptococcaceae | Streptococcus | <i>S. pneumoniae</i> <i>S. pyogenes</i> | — Pneumococcinum Scarlatinum — Streptococcinum |

PHYLUM ENDOSPORA

In periods of food shortage or other adverse conditions many species in this phylum form resting cells called endospores. Endospores, formed within the mother cell, can survive long periods of harsh environmental conditions - drought, freezing cold, blazing heat, boiling water, radiation - to develop into active bacteria again when the conditions improve. Extreme examples are known of endospore germination after as many as 1,000 years of dormancy! Members of the endospore-forming group include the many species of *Bacillus* and *Clostridium*.

Staphylococci are abundant on the human body surface and are responsible for boils and a variety of other skin problems. Staphylococci also produce toxins that are linked with food poisoning.

Lactic acid bacteria, such as *Lactobacillus* and *Streptococcus*, ferment sugars, in particular lactose in milk, and produce lactic acid, succinate, acetate, carbon

dioxide, and ethanol. Dietary sugars are important in tooth decay because lactic acid bacteria [esp. *Streptococcus* spp.] ferment the sugars to lactic acid which removes calcium phosphate from teeth, making them softer and less resistant to the dental plaque-causing action of the bacterium *Leptotricha buccalis*.

CLASS BACILLI

I. ORDER BACILLALES

IA. Family BACILLACEAE

IB. Family LISTERIACEAE

IC. Family STAPHYLOCOCCACEAE

IA. FAMILY BACILLACEAE

Bacillus anthracis

Bacillus brevis

BACILLUS ANTHRACIS

Scientific name Bacillus anthracis Cohn 1872

Common name Anthrax bacillus

Family Bacillaceae

Homeopathy Anthracinum - Anthraci.

GENUS BACILLUS

- Gram-positive, obligate or facultative aerobic, motile, rod-shaped bacteria.
- Ubiquitous soil bacteria.
- Form endospores, the most durable type of cells found in nature, which can remain viable for extremely long periods of time, perhaps hundreds of years.
- Endospore formation is a mechanism of survival; it is normally not part of active growth and cell division, but a result of nutrient depletion.
- Mature spores remain in a dormant state termed cryptobiosis [“hidden way of life”] and are highly resistant to high and low temperature, irradiation, strong acids, disinfectants, and desiccation. Under appropriate environmental conditions they germinate and become vegetative cells.

This is a strategy used by other microbes in the soil habitat, including the filamentous fungi and the actinomycetes, which also predominate in the aerobic soil habitat. It is probably not a coincidence, rather an example of

convergent evolution, that these three dissimilar groups of microbes live in the soil, form resting structures [spores], and produce antibiotics in association with their sporulation process.

Since most *Bacillus* species can effectively degrade a series of biopolymers [proteins, starch, pectin, etc.], they are assumed to play a significant role in the biological cycles of carbon and nitrogen.

As in the case of the actinomycetes, antibiotic production in the bacilli is accompanied by cessation of vegetative growth and spore formation. This has led to the idea that the ecological role of antibiotics may not rest with competition between species, but with the regulation of sporulation and/or the maintenance of dormancy.

[Kenneth Todar, University of Wisconsin-Madison Department of Bacteriology]

Several *Bacillus* spp. are antibiotic producers. *Bacillus licheniformis* yields bacitracin, active against Gram-positive bacteria. Cerexin is obtained from *Bacillus cereus*, an organism also associated with a variety of disease states including food poisoning, ocular infections, bacteraemia, and septicaemia. *Bacillus subtilis* produces the antifungal drug mycobacillin. Tyrothricin [gramicidin, tyrocidin] is obtained from *Bacillus brevis*. Finally, *Bacillus polymyxa* yields various closely related antibiotic substances termed polymyxins. Other *Bacillus* spp. are pathogens of insects, eg, *B. larvae* causes foulbrood of honeybees.

Bacillus brevis [syn. *Brevibacillus brevis*] is found in soil, air, dust, milk, and cheese. Discovered in 1939 by the French-American microbiologist Dubos, *B. brevis* is of historical interest because it yielded the first antibiotic to be produced on a commercial scale. [Penicillin had been discovered some ten years before, but couldn't be produced in vast quantities for another 15 years.] Dubos named the substance extracted from the bacterium "tyrothricin." Containing two polypeptide components, gramicidin and tyrocidine, the drug Tyrothricin, however, quickly turned out to be more toxic to humans than to the invading organisms it was supposed to combat. Dangerously toxic when administered intravenously, it causes haemolysis, erythema multiforme, and liver and kidney damage.

Application of the drug as a nasal spray resulted in destruction of the nasal epithelium with prolonged loss of smell. Irrigation of paranasal sinuses with it entails the danger of potentially fatal chemical meningitis. Its use as an agent for systemic treatment has been abandoned, so that it today is

employed for the topical treatment of ulcers, abscesses, and wound infections caused by Gram-positive bacteria such as staphylococci and streptococci. In the form of tyrothricin-containing lozenges it is also used to treat strep throat infections.

Homeopathically, no symptoms are listed for *Tyrothricinum* in spite of it having a repertory entry, abbreviation *Tyrothr.*

ANTHRAX-3 TYPES

| | |
|--|--|
| <i>Skin:</i> | <ul style="list-style-type: none"> • Of the polymyxins elaborated by Bacillus polymyxa [syn. B. aerosporus] the antibiotics polymyxin B [repertory abbreviation: Polymix.] and colistin [Polymyxin E] are most commonly used. The use of these drugs is limited by their toxicity and is confined largely to topical treatment of ear, eye or skin infections. It is interesting to compare the adverse effects of polymyxin B with the symptoms associated with anthrax, and even more so with those of <i>Clostridium botulinum</i>, its close relative. |
| <i>Black-centred ulcer with severe oedema</i> | |
| <i>Chills. Glands.</i> | |
| <i>Ulcer necroses deeper into tissues, to bloodstream.</i> | |
| <i>Lungs - Brain:</i> | |
| <i>Fluey aches dr fever</i> | |
| <i>Cough - cyanosis</i> | |
| <i>Meningitis.</i> | |
| <i>Subarachnoid haemorrhage. Coma.</i> | |
| <i>Intestines:</i> | |
| <i>Fever. Headache.</i> | <= * Meningeal irritation; headache; fever. |
| <i>Vomiting blood and bile.</i> | = Restlessness [preceding respiratory paralysis]. |
| <i>Dizziness.</i> | = Dizziness progressing to ataxia. |
| <i>Diarrhoea. Very high mortality rate.</i> | « Paraesthesia hands and feet. |
| | = Diplopia. Ptosis. Blurred vision. |
| | = Facial flushing. |
| | = Dysphagia. |
| | == Difficulty speaking. Slurred speech. |
| | = Dyspnoea. |
| | <= Tubular necrosis. Interstitial nephritis. |
| | == Punctate, macular, or urticarial rashes. |
| | = Generalised weakness; generalised areflexia. |
| | = Myasthenia gravis [increased weakness]. |
| | [Goodman & Gilman 1970] |

BACILLUS ANTHRACIS

- Gram-positive, aerobic or facultative anaerobic, spore-forming, encapsulated, non-motile, rod-shaped soil organism.
- Grows between the extremes of 20° and 45° C, best at 37° C.
- Pronounced tendency to form long threads, somewhat resembling bamboo rods.

-
- Very similar to *Bacillus cereus* and to *Bacillus thuringiensis*, a pathogen for certain caterpillars and moths. [The latter is sold as “Bt” insecticide for the biological control of garden and crop pests.]
 - Feared as an agent for biological warfare and bioterrorism.
 - Anthrax spores are virtually indestructible. “Researchers have tried to burn them in fires, freeze them, even blow them up. The spores endured. They’ve been sprayed from nozzles and hoses and disseminated via explosions from missiles and bombs. They survived. Steam under pressure [autoclaving] and irradiation seem to be the best ways to kill them.” [Holmes]

ANTHRAX

While primarily a disease of domesticated and wild animals, particularly herbivorous animals, such as cattle, sheep, horses, mules, and goats, humans can contract anthrax from contact with infected animals, which includes their flesh, bones, hides, hair and excrement. Anthrax cannot be transmitted from person to person. The swelling and subsequent breakdown of the spleen, induced by release of anthrax toxin, gave rise to the common name for the disease in cattle: “splenic fever”

[“Milzbrand” in German], Another name for anthrax is Black Blood, which refers to the very dark colour of the blood of animals or humans with overwhelming septicaemic anthrax. Blood may fail to clot because of a toxin released by *B. anthracis*. Anthrax may take one of three forms:

Cutaneous anthrax, acquired by inoculation by spores via injured skin or mucous membranes. This form accounts for about 95% of all natural infections. The spores germinate, vegetative cells multiply, and a characteristic subcutaneous gelatinous oedema develops at the site, mostly on the hands, arms, face or neck. This develops into red-brown papule within 12-36 hours after infection. The papule changes rapidly to

a large vesicle, then to a painless malignant pustule with a characteristic coal-black necrotic area in the centre [hence the name anthrax, after the Greek word for coal], and finally into a necrotic ulcer. A rim of vesicles filled with bloody or clear fluid surrounds the black eschar. Surrounding oedema is severe and can lead to airway occlusion if present in the neck.

ANTHRAX HOST

Wild and domesticated animals:

cattle, sheep, horses, camels, mules, goats.

Humans infected by animal contact.

ANTHRAX

also known as:

Splenic fever

Milzbrand

Black Blood

Woolsorters disease

In 9 out of 10 cases the infection remains limited to the skin sore, with considerable swelling around the lesions and bouts of shivering and chills. When bacilli escape from the sore the infection may disseminate, giving rise to septicaemia. Lymphatic swelling also occurs within seven days. In severe cases, where the blood stream is eventually invaded, the disease is frequently fatal.

Pulmonary or inhalation anthrax [woolsorters' disease], from inhalation of spore-containing dust where animal hair or hides are being processed. Initial symptoms are flu-like: sore throat, mild fever, muscle ache, and tiredness. After a few days of apparent recovery the disease can progress rapidly to severe respiratory distress, weakness, dry hacking cough, cyanosis, perspiration, and chest pain. Meningeal involvement may be present in up to 50% of cases; it usually is bloody and may be associated with subarachnoid haemorrhage. Decreased level of consciousness, meningismus, and coma may be present. Systemic haemorrhagic pathology may develop, which is virtually always fatal if treatment cannot stop the invasive aspect of the infection.

Intestinal anthrax is analogous to cutaneous anthrax but occurs on the intestinal mucosa. It results from the ingestion of poorly cooked meat from infected animals and is characterised by an acute inflammation of the intestinal tract, high fever, headache, dizziness, general weakness, severe abdominal pain, vomiting of bile and blood, diarrhoea [tarry blood] or constipation, and insomnia. Intestinal anthrax, although extremely rare in developed countries, has an extremely high mortality rate. [Note: Intestinal anthrax is termed 'inner anthrax' in the old homeopathic literature.]

THE FIFTH AND SIXTH PLAGUES

Anthrax has been recognised since antiquity, being common in essentially all areas where livestock were raised. The fifth and sixth plagues of Egypt described in Exodus are believed to have been anthrax. Virgil wrote about the disease in 25 BC and in medieval times it was known as the Black Bane. Holmes reviewed the evidence:

The 5^{1*}1 [plague] affected primarily livestock: cattle, horses, asses, camels, and sheep. In a short time, all Egyptian animals were dead [Exodus 9:3]. It must

have been a catastrophic event to have caused such widespread loss, an epizootic of truly biblical proportions! Later writers refer to the disease as a “murrain,” an archaic term for a pestilence of animals. ... While the Exodus author does not specifically mention that *people* were affected by this plague, the later Jewish historian Flavius Josephus does. Working from Talmudic sources, he refers to the disease as a “distemper” and clearly states that it affected man as well as beast. ... The 6th Plague was one of boils. In modern medical terms, a boil is a skin infection around a hair follicle. Its technical name is *furuncle* or, if it invades the skin deeper, a *carbuncle*. In ancient times, any pustular infection of the skin was called a boil, including the malignant pustule of anthrax. ... The 6th Plague began, according to the Bible [Exodus 8:11], with ashes. These turned to dust and settled over the land, now dry and parched. The boils soon followed.

They turned to sores in both men and beasts. Josephus calls them “blaines,” an old name for skin inflammations. He also states that Egyptians who developed these boils were “inwardly corrupted,” and many perished. That description of the 6th Plague fits the course of cutaneous anthrax perfectly. It began as a skin infection - a boil - then clawed its way deep into the skin, where it gained access to the blood stream. It was now *sepsis*, or blood poisoning, a generalised, fatal infection. The term *sepsis* is Greek. It translates into “corruption” or “decay within the body.”

There is another piece of evidence pointing the finger of guilt at anthrax for the 5th and 6th Plagues of Egypt. Veterinarians will tell you that anthrax epizootics typically occur after both floods and droughts. In the former, sick animals are drowned, die, and release their anthrax bacteria into streams, lakes and ponds. The bacteria quickly turn into spores. As the standing water evaporates, the concentration of spores increases, also increasing the risk of an animal ingesting them when it drinks. Conversely, during droughts like the one which accompanied the 6th Plague of Egypt, the grasses are stunted from lack of water. Animals have to forage closer to the ground, where they are more likely to pick up anthrax spores from the soil.

[Holmes 2003]

MATERIA MEDICA ANTHRACINUM

Anthraci.

Sources

[1] No provings; symptoms from anthrax cases and from cases cured with Anthracinum [10 cases in Hering’s Guiding Symptoms]. [Cured symptoms

indicated with C.]

[2] New aspects derived from 3-4 cured cases; Jeff Baker, *A remedy prescribed by a keynote reveals its totality & essence-*, 1990 IFH Professional Case Conference.

SYMPTOMS

MIND

« Similar to Natrum muriaticum, but chillier and liking the sun.

[The four patients] ... are basically happy people; they said so themselves. Yet, something is awry inside. They probably won't spontaneously complain or volunteer any information on their emotional states unless they are asked. And then you may get a story about a big grief, from which they have effectively disconnected themselves. It's as if their emotional fabric has an invisible wall in itself. In a way, this wall serves them well in that they are happy, but it fails to put them in touch with dormant emotional issues that are clearly unresolved. It is as if on some unconscious level each person has made the decision to be selfless, rather than to confront their wounded self and attempt to heal it. In all three cases they have been forsaken at some point in their lives.

In case no. 1, the husband left; in case no. 2, the father died; and in case no. 3, the sister died and, later, she lost a child. But, curiously, she didn't even think to mention the loss of her sister until after Anthracinum had been given. So, again, the idea of disconnecting from a painful experience is present.

[One patient] ... in the second week after the remedy, ... wept almost continuously, ... the weeping was centred on a grief she had experienced 18 years earlier, when her marriage with her first husband broke up. It was a tremendous purging of emotion that had never before emerged. This woman had been given Natrum muriaticum six years earlier, and, although it had acted, the effect was minimal.²

Fear of being alone.

Anxiety about others, esp. husband.

These patients are very family-oriented people. The anxiety they experience concerning their husbands relates to the unresolved grief and abandonment in their pasts. The husband represents a pillar of support, so the mere thought

that his safety is threatened in any way poses a threat to their entire world. Having known the families of all three women, I can also say that these patients are strongly bothered by disharmony in their environment, especially the noise of shouting.

They are fast-moving people, not impatient, but quick to grasp [Ignatia]. They seem to be quite refined, with rather delicate features [Silicea]. They may be sweet, unassertive, very sensitive, and proper. They may not have a very strong sense of themselves. They lack self-confidence, can be hard on themselves [self-reproach], and need to be in control.²

GENERALS

•» Abscesses; boils; carbuncles; felon; whitlow; ulcers; erysipelas; cysts; pustules.

== Darkness; blackness; blueness. Discolouration; in spots; bluish; bluish red; bluish black.

Prostration. “Completely exhausted, she thinks she feels death approaching.”⁰

Marked prostration with subnormal temperature. [H.C. Allen]

Great restlessness. Bouts of trembling. Single muscles twitch or tremble.

Sleep restless, short, disturbed by twitching and jerking of muscles.

Intense *burning* pain, like “a coal of fire.”

≡ Oedema of affected parts, more or less reddened, sometimes cool, sometimes hot.

≡ Excessive thirst, little appetite.

≡ Horribly smelling discharges. Offensive odours [breath; sweat].

≡ Perspiration all over body, debilitating, sticky; in severe cases, copious and cold. [H.C. Allen]

= Discharges >.

In fact, every type of discharge - eg, appearance of menstruation or an abscess that bursts - signifies an enormous improvement in the constitutional symptoms. [Vithoukias]

Based on at least two cured cases, Jeff Baker considers the following symptoms characteristic:

== Allergies: hay fever, petroleum products, insect bites [3 cases],

= Premenstrual syndrome with irritability [2 cases].

-
- = Love of the sun; skin problems may be ameliorated by the sun [3 cases].
 - = Photophobia [2 cases].
 - = Craving for sweets [3 cases].

LOCALS

- = Headache with sensation as if smoke and hot pain were passing through it. [Cured symptom in two shepherds who contracted anthrax from their sheep.]
- = Dulness in head as from narcotics. [H.C. Allen]
- = Pale yellowish or greenish swelling; if in eyelids, of a half-translucent aspect.
- « Pale redness above brows along forehead.
- = Can open mouth only far enough to put point of tongue out; case of quinsy & increased salivation⁶⁻¹
- = Sweetish taste in mouth, or loss of taste. [H.C. Allen]
- ~ Sensation as if diaphragm were pushed forward⁶⁻²
- ~ Enlargement of spleen.
- = Dry, cracking dermatitis.
- = Inflammatory skin reactions, with involvement of subcutaneous tissue, to wool, goats hair, cow hide.
- ~ Carbuncles etc. < cold application, > hot application. [Lippe]

1. Called ‘anthrax quinsy’ by Hering and Allen, oropharyngeal anthrax is a proximal manifestation of intestinal anthrax, characterised by local, often unilateral ulceration and oedema, throat pain, swelling of cervical lymph nodes, and difficulty swallowing. The condition resembles peritonsillar abscess or quinsy [a corruption of L. *cynanche*, sore throat, a peculiar name derived from Gr. *kynos*, a dog, and *anchein*, to throttle.]

2. This symptom was observed in two cases suggestive of streptococcal septicaemia. The first concerned a case of erysipelas; the second is given as a case of “poisoning by foul breath” [streptococcal infection] in a “weakly, hysteric woman, aet. 43, after great fatigue and mental suffering, bedridden since years, after losing two children with putrid diseases.” Where enlargement of the mediastinum, through swelling of the local lymph node, thus putting pressure on the diaphragm, is a telltale sign of inhalation anthrax, this becomes an indication for Anthracinum in any condition other than anthrax.

CASES

(1) Woman, aged 44. Terrible headaches, more on the right side, with feeling as if she had a hole in her head; so terrible that she thought of doing crazy things now and then. ... Burning pain at the front of the legs [worst in right leg], starting in the knees and extending downwards to the dorsum of the feet. ... “I am completely chilly, but I have the feeling as if my legs are burning. It seems as if I stand up to my knees in a fire.” ... Burning in lower legs, day and night. ... Feet very warm, but feel cold when touched. ... Spots on legs, differing in colour, sometimes green, other times blue; spots so big “as if I have knocked against something”. Big spots, like bruises, but turning green immediately. Spots very sensitive to touch; can’t bear anything on them, not even a sheet over legs at night; slight rubbing >. ... Very tired in legs; cannot stand on them for longer than half an hour. ... Lying down > tiredness in legs, but not the burning pain in them. Must lie down completely flat, not even a pillow under the head, otherwise the tiredness doesn’t go away. Yet, gets headache from lying flat on the back; headache starts in neck, scapulae and extends to head, just above the eyes, mostly on the right side. ... Sometimes an itchy feeling on legs, as if from mosquito bites. ... Allergic to mosquito bites ... gets yellow blisters discharging yellow moisture. “When I have been bitten by a mosquito, I suffer from it for one month.

But only when I have been bitten on my lower legs, not on my arm, or thigh.” ... Small wounds bleed freely ... “must put it under cold water, until it has completely cooled off, otherwise it won’t stop bleeding.” ... Cannot keep legs still and cannot sit long; tries “to be in motion as much as possible.” *Anthracinum 200c*, single dose, then placebo.

Follow-ups every 4 weeks. Situation after 4 months: Spots and burning are gone; energy very good; no more restless legs; sleeps well.

[Summarized from: Kris Gaublomme, *Headache, Burning Legs*-, case in Small Remedies Seminar, Hechtel 1990, February 5].

(2) Young man in his early 30s - tall, thin, *Silicea*-like in appearance. Somewhat shy, artistic, refined, and articulate. Presented with severe cystic acne and dermatitis; entire back “looked like a battle zone, it was covered with large, angry pustules, involving deeper skin layers, and with scars, craters, birthmarks, and moles.” Some lesions on buttocks and thighs. Skin problem had begun around puberty; suffered with it for about 20 years, despite numerous courses of antibiotics and other conventional treatments.

Had many immunisations, which may have been a factor in his condition. On an emotional plane, had never felt very supported by family; felt he was on the outside looking in, forsaken by his family. Consequently, as an adult, “he was desperately looking for a love relationship that would give meaning to his life. Being independent was difficult, despite much psychotherapy.” History of orchitis.

First gets Aurum metallicum, without effect. Natrum muriaticum was considered, but this patient “loved the sun.” After Anthracinum 200c “a gradual yet remarkable improvement has taken place” [over a period of three years, during which the remedy had been repeated about three times]. Skin approximately 90% better; skin has become softer, more flexible, and less indurated; remaining lesions more superficial. Very positive emotional changes: has become more independent and more able to stand on his own; no longer driven by a desperate need to be in a relationship.

[summarized from a case presented by Stephen King, in 1990 IFH Prof. Case Conference]

(3) I remember with pride how on these symptoms after Arsenic and Lachesis had failed, I saved a man’s arm from amputation. His troubles started with an ordinary felon. Alarming symptoms very soon made their appearance and his whole hand from the elbow joint to the finger tip became one huge mass of swelling. Amputation was the only thing they thought that might possibly save the man’s life. Under the action of Anthracinum within an incredibly short time the swelling got dispersed, the pains vanished, the sloughing stopped and he became his old self minus the loss of half of his big finger which had sloughed off before he came to the homeopath.

[Choudhuri; RefWbrks]

IB. FAMILY LISTERIACEAE

Listeria monocytogenes

LISTERIA MONOCYTOGENES

| | |
|------------------------|--|
| Scientific name | <i>Listeria monocytogenes</i> (Murray et al. 1926) Pirie 1940 |
| Old names | <i>Bacterium monocytogenes</i> <i>Corynebacterium infantisepticum</i> |
| Family | Listeriaceae |
| Homeopathy | Listeriosis nosode - Lister. |

FEATURES

- Small, Gram-positive, motile [at 25° C.], aerobic, non-sporeforming, rodshaped bacterium.
- Widely distributed in nature; found in soil, leaf litter, sewage, silage, dust, and water; recovered from mammals, fowl species, trout, ticks, and crustaceans.
- Very hardy: Survives salting processes used in meat processing, withstands repeated freezing and thawing, withstands direct sunlight and ultraviolet light; survives in dry straw, animal faeces, manure, and soil for several weeks or even for years.
- A particular property of *L. monocytogenes* is the ability to multiply at low temperatures.
- Slightly more heat resistant than many other bacteria such as salmonella and *E. coli*, and will grow at temperatures as high as 60° to 65° C.
- Multiplies both extracellularly and intracellularly.

LISTERIOSIS

Most cases of listeriosis are either mild or severe. The incubation period ranges from 4 days to 8 weeks, the duration from a few days to several weeks. Milder cases are characterised by a sudden onset of fever, severe headache, vomiting, diarrhoea, muscle aches, photophobia, sore throat with swollen glands, and other influenza-type symptoms. Severe cases may include septicaemia, meningoenzephalitis, disseminated abscesses, confusion, stiff neck, loss of balance, movement disorders such as ataxia and/or tremor, convulsions, delirium, and coma. Meningitis is often complicated by enzephalitis,

which is exceptional among bacterial infections. Death occurs in 20% of severe cases. Listeriosis may cause premature death in foetuses or newborns. In severe cases developmental complications, hydrocephalus, and

LISTERIOSIS mental retardation have been observed, while the mothers themselves
SYMPTOMS IN SEQUENCE might have shown hardly any signs of infection during the pregnancy.
Fever Early-onset neonatal infections, often in newborns of low birth
Severe headache weight, begin at the mean age of 1.5 days; late-onset neonatal
Vomiting infections begin at the mean age of 14 days. Meconium-stained
Diarrhoea [murky] amniotic fluid is common in newborns with early-
Muscles ache onset listeriosis. Respiratory difficulty is common, including a
Photophobia history of cyanotic episodes, rapid breathing, and grunting.
Sore throat Also, irritability, refusal to drink, fever, and vomiting.
Swollen glands Neither the presence of nor the exposure to *Listeria monocytogenes* determines whether one develops listeriosis. Research has
Septicaemia shown that humans can be exposed to high doses by consuming
Meningo-encephalitis contaminated food, such as hot dogs, soft cheeses, or pate, with-
Confusion out getting sick. Moreover, a large percentage of all people will
Stiff neck at any given time have *Listeria* organisms in their bodies with-
Loss of balance out becoming ill. The organism appears to move through
Ataxia/tremor humans and animals without causing problems.
Convulsions The majority of cases occur in infants younger than 3 weeks old
Delirium or in immuno-compromised older adults. An underlying factor
Coma is immaturity of the immune system [foetuses/newborns] or
AT RISK: deficiency of the immune system due to cancer, diabetes, renal
Pregnant women disease, heart disease, AIDS, organ transplants, or treatment
Newborn, babies with glucocorticosteroids. The third well-defined risk group
Elderly concerns pregnant women, in whom listeriosis, however, has a
Transplant patients relatively mild course and may be manifested as a flu-like syn-
Immunocompromised. drome or placental infection. Infected pregnant women can
transmit the disease to their foetuses/newborns either before or

gestation, it is most commonly seen during the third trimester, with premature labour as a possible complication.

Of all listeriosis cases, an estimated 85-95% are attributed to food. *Listeria* has been isolated from foods such as raw milk products, soft cheeses, ice cream, leafy vegetables, seafood, poultry, red meat, raw and smoked fish, and liquid whole egg.

[Adapted from: Bacterial Foodborne Disease: Medical Costs and Productivity Losses / AER - 741; Economic Research Service/USDA]

MATERIA MEDICA LISTERIOSIS NOSODE

Lister.

Sources

Listeriosis nosode has merely one entry in the repertory: Eye, Inflammation, keratoconjunctivitis. It seems one of those remedies destined to remain obscure and unused. However, studying its context and the clinical manifestations associated with *Listeria* might reveal some useful clues as to its applications, irrespective whether the symptoms are due to the presence of *Listeria* or based on similarity. We might detect reluctance in having to dissociate the symptoms from their associated bacterial disease. Listeriosis nosode is a drug and not a disease. As long as there are no provings or cured cases to guide us, its initial symptom picture must come from what is characteristic for the disease. In this way a starting point will be created, similar to making a genus epidemicus into an individual picture.

Ultimately, the use of nosodes is not limited to the morbid conditions from which they are derived, as we have seen with the development of such major nosodes as *Medorrhinum*, *Tuberculinum*, etc.

The Listeriosis nosode thus might warrant consideration in premature babies and neonates who have developed septicaemia after birth, or in women with habitual miscarriages or stillbirths. Likewise in mental retardation or infectious mononucleosis as other conditions with which *Listeria* has been linked. Theoretically, it should match the combination food-poisoning with flu-like symptoms during the last trimester, premature birth, low birth weight, and circulatory or respiratory insufficiency.

IC. FAMILY STAPHYLOCOCCACEAE

STAPHYLOCOCCUS AUREUS

| | |
|------------------------|---|
| Scientific name | Staphylococcus aureus subsp. aureus Rosenbach 1884 |
| Old name | Staphylococcus pyogenes aureus |
| Common name | Golden Staph |
| Family | Staphylococcaceae |
| Homeopathy | Staphylococcinum - Staphycoc. Staphylotoxinum - Staphytox. |

FEATURES

- Gram-positive, non-motile, aerobic or facultative anaerobic, non-sporulating coccus.

STAPHYLOCOCCUS • Appears in grape-like clusters [Gr. *staphyle* = a bunch of grapes].

HOST: Produces a yellow to orange pigment [golden staph.].

Commensal with humans and their environment • Many strains produce staphylokinase, which dissolves fibrin clots; the mechanism is identical to streptokinase, used in medicine to treat patient suffering from coronary thrombosis.

*Nose, throat, skin. **

Dairy foods, air,

dust, water, faeces,

*sewage. **

ASSOCIATED

CONDITIONS

Food poisoning

Abscesses, ulcers, boils,

impetigo, styes, acne

Meningitis

Mastitis after labour

Endocarditis Phlebitis

Wound infections

Toxic shock syndrome.

Sudden onset,

rapid development ,

Observed in pus and cultivated by Koch and Pasteur independently in 1878 and 1880. First obtained in pure cultures by Rosenbach in 1884.

Ubiquitous in the environment of humans, particularly in milk [dairy products] and food, but also in varying numbers in air and dust, water, faeces, and sewage. The commensal relationship between man and Staphylococcus has been attributed to the inability of staphylococci to compete effectively in complex ecological systems. Due to this biologically operative restraining mechanism Staphylococcus appears to have resorted to humans.

“Lives in close association with man, and, although every strain is potentially capable of causing disease, the host-parasite relationships is relatively stable, with infection occurring only on the disruption of man’s systemic defence mechanisms.”

[Angelotti]

Primary habitats are the nasopharyngeal mucosa and the skin

[skin glands and hair follicles] of man and animals.

Colonisation by *S. aureus* of the nasal passages of man is common, and a large proportion of normal persons carry these organisms in the nose. Williams [1963], in his review of the healthy carriage of *S. aureus*, tabulated the nasal carrier rates in different population groups as reported by numerous investigators. These data reveal that the carrier rates in normal adults not associated with hospitals are between 30 and 50%. The incidence of nasal carriage increases to approximately 60 to 80% in patients and working personnel associated with hospitals.

Staphylococci are isolated most frequently from the nose, but the throat and skin are also important sources. The percentage of skin carriage in adults varies from 4 to 44%, depending on the skin site examined. Carriage on the nose is consistently high [4 to 44%], whereas hand carriage varies [14 to 40%] and only 4 to 16% of individuals examined harboured staphylococci on the leg. [Angelotti, in Riemann]

- Requires calcium, magnesium, potassium, and sulphur for growth. Grows well in the presence of high concentrations of sodium chloride [media containing 10% sodium chloride stimulates luxuriant growth].
- Withstand desiccation and frozen storage in foods for long periods.
- Produces an alpha toxin with skin-necrosing and haemolytic properties. [Rupture of red blood cells gives rise to loss of haemoglobin.]

FOOD POISONING

Incubation varies from less than one hour to several hours. Rapid onset of symptoms such as nausea, vomiting, retching, abdominal cramps, and diarrhoea. Acute symptoms often accompanied by headache and muscular cramps, and in severe cases by prostration. Temperature changes are not common; fever is common, but temperature sometimes drops. Complete recovery within 24 to 72 hours is the rule.

Reported to be the major identified cause of food poisoning in the United States, in contrast to the prevalence of salmonellosis in, for example, England. According to Angelotti, this may be correlated to the “enormous number of commercially prepared, served, and catered meals consumed by the American people in public establishments.”

Dolman and co-workers did in 1943 a proving-like experiment by swallowing

toxic *Staphylococcus aureus* filtrates as human volunteers. Not without humour, Dolman wrote:

The vomiting is accompanied, and sometimes replaced, by considerable retching. At first, one is astonished to note from what depths and after what strivings it is possible to recall portions of meals long forgotten; but as the stomach empties of food, bile-stained, and even blood-flecked mucus becomes the chief return. Abdominal cramps and diarrhoea are often very marked and may precede the vomiting but more usually begin after the vomiting has started and may continue after it has ceased. The first evacuation may be merely a loose stool, but this is apt to be followed by frequent and remarkably profuse discharges of watery fluid.

The resulting dehydration no doubt accounts largely for the pinched, shocked appearance of the subjects and to some extent also for the marked lassitude and depression which sets in after the first glamour of a positive reaction has given way to disenchantment. The ordeal can perhaps be compared to pregnancy, in that it may have been light-heartedly enough embarked upon the first time but is not so willingly repeated, and in its being bearable as the situation moves to a climax, only by the reflection that deliverance is bound to come. Once begun, recovery was usually rapid, the only after-effects being a larger appetite, and a sense as of calm after a storm.

[C.E. Dolman, *Bacterial Food Poisoning*, cited in: L.B. Jensen, *Poisoning Misadventures*, Springfield, 1970]

Food poisoning caused by bacterial poisons, mostly due to staphylococci, were formerly erroneously believed to be the result of ptomaine ingestion. Derived from the Gr. 'ptoma', corpse, the word 'ptomaine' was coined by the Italian chemist and toxicologist Francesco Selmi in 1870 to denote certain nitrogenous compounds produced in the putrid decomposition of animal or vegetable matter. End products of protein decomposition, ptomaines impart such an extremely bad smell to meat that "even a starved alley cat wouldn't be interested." Although the unappetising smell would seem to safeguard against consumption of spoiled foods, Selmi nevertheless believed these compounds to be the primary cause of food poisoning. A few such compounds have been isolated from spoiled foods, but only a very small percentage of them is physiologically active. Food decomposed by putrefactive organisms is not as toxic as hitherto has been supposed which explains the apparent paradox of the harmless custom of eating 'ripened'

cheeses or game well on the road to putrefaction. The term 'ptomaine poisoning' therefore has come to have an indefinite meaning and should be discarded as obsolete. The majority of cases of acute food poisoning are now known to be caused by toxins produced by bacteria such as *Staphylococcus aureus* [predominantly], *Salmonella*, *Shigella*, *E. coli*, and *Clostridium botulinum* ['sausage poisoning'].

CLINICAL MANIFESTATIONS

Notoriously resistant to antimicrobials, *S. aureus* has a high carriage rate in hospitals, where it colonises surgical wounds, sutures, and indwelling medical devices. The organism is estimated to account for 10 to 15% of hospital-acquired pneumonias, especially among patients with severe debility, surgery, tracheostomy, endotracheal intubation, and immunosuppression.

Staphylococcal pneumonia differs in its tendency to recurrent rigors, tissue necrosis with abscess formation [rare with streptococcal pneumonia] and a fulminant [sudden onset and rapid development] course. "Although often fulminant, staphylococci may account for pneumonia in some patients who do not appear critically ill; occasional individuals have a rather indolent course, sometimes with chronic pneumonia or chronic lung abscess." [Merck Manual]

Staphylococcal scalded skin syndrome [SSSS] prevails in infants, young children, or immunosuppressed patients. It is characterised by an erythematous process in which large areas of the epidermis peel off, resembling a second-degree burn, as a result of upper respiratory staphylococcal infections. The skin may be sterile, i.e. is free from staphylococci.

Illness begins with a localised crusted infection [often impetigo-like], most often at the umbilical stump or in the diaper area during the first few days of life. When it occurs sporadically in children aged 1 to 6 yr, it starts with a superficial crusted lesion, frequently around the nose or ear. Within 24 hours, tender scarlet areas appear around the crusted area.

The red areas may become painful and generalised and may progress rapidly to large, flaccid blisters that are easily broken to produce erosions. The epidermis peels off easily, often in large sheets, when the red areas are touched inadvertently or pushed by the examiner's finger. The disease progresses rapidly to widespread desquamation of the skin within 36 to 72 hours and patients may

become very ill with systemic manifestations [eg, malaise, chills, and fever].
Loss of the protective skin barrier exposes the patient to sepsis and to fluid and electrolyte imbalance.

... Corticosteroids are contraindicated and topical therapy and patient handling must be minimised. If the disease is widespread and the lesions are weeping, the skin should be treated as if it were burned.

[Merck Manual]

Other conditions associated with *Staphylococcus aureus*:

- = [Recurring] boils, abscesses, styes; infected acne.
- = Impetigo contagiosa [“school sores”].
- = Meningitis.
- = Endocarditis.
- = Septic phlebitis.
- = Osteomyelitis.
- = Mastitis, esp. after labour.
- = Bacteraemia; associated factors: diabetes, leukaemia.
 - «• Wound infections; associated factors: age, corticosteroids, obesity, diabetes, malnutrition.
- = Toxic shock syndrome.

[Syndrome mainly associated with menstruation and the use of vaginal tampons, but also seen in postoperative and postpartum women. Symptoms consist of sudden high fever, headache, sore throat, non-purulent conjunctivitis, profound lethargy, confusion, vomiting, profuse watery diarrhoea and diffuse sunburn-like erythema.

Diminished urine output and increased creatinine levels are almost universal. Between the 3rd and 7th days desquamation of the skin occurs that may lead to epidermal sloughing, particularly of the palms and soles.]

MATERIA MEDICA STAPHYLOCOCCINUM

Staphylococ.

Sources

[1] Proving by David Riley; 16 provers [11 females, 5 males]; 1995; 12c, 3 times daily until symptoms developed or for seven days.

SYMPTOMS

Affinities

Gastrointestinal tract. Skin. Head.

Mind

Disorientation and confusion. [3 proverbs]

After third dose while at baseball park, lost all sense of direction.

I seem to be forgetful where the houses are I am driving to.

Was slightly disoriented at one point. Forgetting my train of thought while writing. Forgetting where I placed my glasses. This is very unusual for me.

Or the opposite:

Smiling and almost laughing at times. Felt clear and focused. Noticing details.

Trapped and victimised. [2 proverbs]

Emotionally feeling trapped and shut in and stifled.

Felt victimised, irritable and bitter. "Why is this happening to me?"

Shakiness. [2 proverbs]

Feeling nervous, "hyper." Also at 4 p.m. Like a caffeine buzz, with slight hand trembling.

I am shaking badly. I can literally see my hands shaking. [Felt like an increased heart rate.]

Generals - Sleep and dreams

Restless sleep. [3 proverbs]

Didn't sleep well at all. Kept waking up and dreaming of bugs and cockroaches.

Slept badly. Would drift off several times and then wake up with a sudden start.

Restless night sleep; awoke at 4 a.m.

Dream of dying. ["Had a dream that I died. I never thought you could dream of dying."]

Bizarre dream that she was a man.

Generals - Food

Craving for peanut butter [2 proverbs]; cookies [1 pr.]; spicy food [1 pr.].

Ate 12 peanut butter crisps.

Ate a small jar of crunchy peanut butter.

Craving Oreo cookies. It is all I end up eating today.

Spicy foods at lunch that were good at time but gave me diarrhoea two hours

later. Also November 19 and 20 craving spicy food - Mexican, garlic bread, pizza.

Head

Headache. [5 provers]

Pulsating pain first in left temple [for a few seconds], then in right temple.

Pounding pain in back of head; after midnight, until early morning; & sour taste in mouth.

Pounding headache about 4 p.m., as if entire head would explode with the pressure.

Headache & dull pain in back of head.

Headache on left side behind eye and extending to ear; pain in sharp and constant.

Gastrointestinal

Cramps, gas & looseness. [6 provers]

Abdominal pain, crampy, with loose diarrhoea. Flatulence [before and during stool]. Sometimes uncontrollable diarrhoea. Other times urgency but without stool.

Diarrhoea early in the morning.

Extremely loose diarrhoea. Felt like water. Needed to go about 8 different times.

Cramping in lower abdomen throughout the day.

Had some cramping in my lower abdomen. Lasted till mid afternoon.

I have had gas all day. It has been really bad. I could not stop farting. I didn't eat anything unusual.

One small bowel movement in afternoon comes out explosively.

Skin

Eruptions & itch. [2 provers]

Red rash with small bumps on abdomen, lasting one day.

Skin felt itchy all over. [Mainly chest and abdomen.]

Slight smooth pink rash around waist; little, tiny bumps that do not itch.

Raised red rash on both sides of external throat and across chest below throat.

Sensations

» Eyelids feel very heavy and sore.

= Feeling of a blemish forming on tip of tongue.

= Chest feels contracted and tight, making it hard to breathe.

-
- = Tingling in lungs; lungs feel as if they are clearing.
 - = Feeling of swelling in hands and feet.
 - = Elbows feel stiff, “as if they need to be loosened up somehow.”

COCCAL CO.

Boericke advises the use of Staphylococcinum ‘in diseases where the staphylococcus is the chief bacterial factor, as acne, abscess, furuncle, empyema, endocarditis, etc.’ The nosode “Coccal co.” was employed by Paterson in the treatment of boils. Considering its name and its application it seems likely that the nosode was derived from staphylococci, in spite of them not belonging to the intestinal flora nor being lactose-negative.

... the writer had a nasty series of carbuncles spaced at six months, the last of which appeared just about the time of his final visit to Glasgow during Dr. John’s lifetime. The impairment of his own health had caused no decline in his mental activities. Antibiotics, of course, he never used. He gave me one of his searching looks, handed over a little bottle of *Coccal Co.* 30 and said: “Three doses and no more, and we must test to see there is no sugar.” The thing softened and liquified and aborted. He added the warning too, “It is dangerous stuff unless handled carefully.” It rarely appears in his “Tables” [of remedies associated with the bowel nosodes] but the related remedy was *Tuberculinum*. Hence, presumably, the care with which he used it.

[Geoffrey Brown, *Drs. John and Elizabeth Paterson-*, British Hom. Journal, Oct. 1967]

STAPHYLOTOXINUM

Staphylococcus aureus produces an alpha toxin with skin-necrosing and haemolytic properties. There are 5 symptoms listed for Staphylotoxinum in Synthesis 9.1:

- » Mind, Contradiction, disposition to contradict.
- = Skin, Purpura.
- = Generals, Convulsions.
- = Generals, Haemorrhage, blood, non-coagulable.
- = Generals, Intoxication, after.

II. ORDER LACTOBACILLALES

IIA. Family ENTEROCOCCACEAE

IIB. Family LACTOBACILLACEAE

IIC. Family STREPTOCOCCACEAE

| Phylum | Order | Family | Genus | Species | Remedy | |
|-----------|------------------|-------------------|--------------------|-------------------------|--------------------------|-------------------------|
| ENDOSPORA | BACILLALES | Bacillaceae | Bacillus | <i>B. anthracis</i> | — Anthracinum | |
| | | | | <i>B. brevis</i> | — Tyrothricinum | |
| | | Listeriaceae | Listeria | <i>L. monocytogenes</i> | — Listeriosis nosode | |
| | | Staphylococcaceae | Staphylococcus | <i>S. aureus</i> | — Staphylococcinum | |
| | | LACTOBACILLALES | Enterococcaceae | Enterococcus | <i>E. faecalis</i> | — Enterococcinum |
| | | | | | <i>Enterococcus spp.</i> | — Streptoenterococcinum |
| | Lactobacillaceae | | Lactobacillus | <i>L. acidophilus</i> | — Lactobacillus | |
| | | | | <i>S. pneumoniae</i> | — Pneumococcinum | |
| | Streptococcaceae | Streptococcus | <i>S. pyogenes</i> | — Scarlatinum | | |
| | | | | — Streptococcinum | | |

IIA. FAMILY ENTEROCOCCACEAE

Enterococcus faecalis

ENTEROCOCCUS FAECALIS

| | |
|------------------------|---|
| Scientific name | Enterococcus faecalis Andrewes & Horder 1906, Schleifer & Kilpper-Balz 1984 |
| Old names | Streptococcus faecalis Streptococcus zymogenes |
| Family | Enterococcaceae |
| Homeopathy | Strepto-enterococcinum - Strept-ent. Enterococcinum - Enteroc. Enterotoxinum - Enteroc. |

FEATURES

- Formerly classified in the genus *Streptococcus* as group D streptococci, *Enterococcus* was given formal genus status in 1984.
- Non-motile, Gram-positive, facultatively anaerobic, spherical bacterium, occurring singly, in pairs or short chains. Non-haemolytic.
- Early descriptions of the organism noted that it was “hardy and tenacious of life”. It can survive for extended periods of time on environmental surfaces; cheese - 180 days; soil up to 77 days; soiled linen up to 90 days; cultures at *minus* 70° C for several years.* It is resistant to detergents and antiseptics, including carbolic acid and chloroform, can adapt to high [lethal] levels of bile salts, and is able to grow in 6.5% sodium chloride.
- Inhabits many different ecological niches, including humans, and is disseminated in animal excrement. As a benign commensal organism it inhabits the female genital tract and is part of the normal intestinal flora of humans and animals, where it ferments lactose for energy production. *E. faecalis* and other enterococci are found in relative abundance in human faeces.
- May become pathogenic outside of its normal habitat and cause many of the same problems as other members of the intestinal flora, including urinary tract infections, wound infections [eg, colonization of open wounds and ulcers], and dental plaque formation.

-
- Bacteraemia, leading to endocarditis or colonization of previously damaged or prosthetic heart valves, however, is more commonly associated with this species than with other members of the family Enterococcaceae. In addition, *E. faecalis* is among the most destructive causative agents of endophthalmitis following cataract surgery.
 - Most notably caused by *E. faecalis*, which accounts for 80% of all infections, enterococcal infections include urinary tract infections, bacteraemia [presence of viable bacteria in the bloodstream], intra-abdominal infections, and endocarditis.
 - After *Escherichia coli*, *E. faecalis* is the second most common organism recovered from nosocomial [hospital-acquired] infections.
 - Enterococci are intrinsically resistant to many antibiotics.
 - Enterococci have been used as indicators of faecal pollution for many years and have been especially valuable in the marine environment and recreational waters as indicators of potential health risks and swimming-related gastroenteritis.

[Sources: Health Canada, Material Safety Data Sheet, 2001, and Human Enterococcus 1DTM service.]

AETIOLOGICAL FACTORS

= Hospitals.

~ Biliary tract, genitourinary or rectal procedures.

=> Ulcers; intra-abdominal abscesses; blood, faeces, urine.

- Antibiotic therapy.

CLINICAL FEATURES

Symptoms associated with *endocarditis*:

*= Malaise and weakness.

~ Fatigue and anorexia. Weight loss.

~ Fever. Night sweats.

- Splinter haemorrhages [petechiae].

- Pain and swelling of joints.

~ Chills.

- Swelling of spleen.

= Heart murmur. Systemic emboli.

Symptoms of *cystitis* are atypical: Pain on urination; dysuria; frequent urination; haematuria; chills.

MATERIA MEDICA

There are two homeopathic drugs made from or containing *Enterococcus faecalis*.

- 1) The first is *Strepto-enterococcinum*, abbreviation *Strept-ent.* for *Bacillus strepto-enterococcus*. It was introduced into homeopathy in 1950 by the French physician Pommier de Santi, who obtained it from diseased human gums. Its name *Strepto-enterococcus* or *Enterococcus proteiformis* reflects the situation before the nomenclatural revision, *E. proteiformis* being an old French synonym [Thiercelin and Jouhaud, 1903] for *E. faecalis*. According to Pommier de Santi the gingival origin is very important because “this germ which loses nine-tenth of its virulence in the intestine, has all its virulence the very moment it passes into the blood or comes in contact with the gums.” A normal inhabitant of the intestinal tract, *E. faecalis* becomes an opportunistic pathogen outside its habitat. One of the places it travels to is the human mouth, where it can be frequently isolated from dental plaques.
- 2) The second, *Enterococcinum*, is made from “a mixture of many stocks of *Enterococcus*.” The mixture corresponds, according to Julian, “with Group D of which three different biochemical varieties are distinguished, [*Enterococcus*] *faecium*, *durans*, and *faecalis*.” The classification of enterococci as group D streptococci dates back to the scheme established by Lancefield in the early 1930s. Three members of this group were assigned a new genus in 1984: *E. faecalis*, *E. faecium* (Orla-Jensen 1919) Schleifer & Kilpper-Balz 1984, and *E. durans* Collins et al. 1984. *Enterococcinum*, therefore, represents the genus rather than an individual species.

MATERIA MEDICA ENTEROCOCCINUM

Enteroc.

Sources

No provings have been conducted with this drug. The drug picture is based on a clinical pathogenesis, presented by Julian.

SYMPTOMS

Gastrointestinal

- = Diarrhoea & loss of appetite and coated tongue.
- = Diarrhoea during dentition.
- = Stools like 'cowdung'.
- ~ Morning diarrhoea between 4 and 9 a.m.; great urgency; many stools.
- = Diarrhoea related to emotions.
- = Diarrhoea related to menstrual period.
- ~ Stools contain glairy mucus or blood.

Concomitants

- = Loss of appetite.
- = Coated tongue or tongue *milky white*.
- ~ Nausea, flatulence and eructations.
- = Low blood pressure; slow pulse.
- = Fatigue and irritability.
- <= Loss of minerals from mucous stools.

Enterococcinum has 34 symptoms in Synthesis 9.1:

- Mind, Anorexia nervosa.
- Mind, Irritability.
- Mouth, Discolouration, Tongue, white.
- ~ Stomach, Appetite, wanting.
- = Stomach, Eructations.
- » Stomach, Nausea.
- ~ Abdomen, Flatulence.
- = Abdomen, Inflammation, Colon.
- = Abdomen, Inflammation, Colon, recurrent.
- = Abdomen, Pain, Colon.
- = Abdomen, Pain, Colon, right.
- = Abdomen, Pain, Colon, left.
- <= Abdomen, Pain, Colon, descendens.
- <= Abdomen, Pain, Colon, transverse colon.
- = Rectum, Diarrhoea.
- = Rectum, Diarrhoea, morning.
- Rectum, Diarrhoea, morning, waking with urging.
- = Rectum, Diarrhoea, excitement, emotional.

-
- Rectum, Diarrhoea, menses, during.
 - Rectum, Dysentery.
 - « Rectum, Inflammation.
 - Rectum, Pain, tenesmus.
 - Rectum, Urging, diarrhoea, with.
 - Stool, Bloody.
 - Stool, Cow-dung, like.
 - « Stool, Frequent, night, after midnight, 4-9 a.m.
 - Stool, Mucous, slimy.
 - Generals, Allergic constitution.
 - Generals, Hypotension.
 - Generals, Mucous secretions, albuminoid.
 - Generals, Pulse, slow.
 - Generals, Weariness.

MATERIA MEDICA STREPTO-ENTEROCOCCINUM Strept-ent.

Sources

No provings have been conducted with this drug. The drug picture is based on a clinical pathogenesis, presented in Julian's *Materia Medica of Nosodes*.

SYMPTOMS

Generals

=> *Asthenia; anaemia; emaciation.*

- Insomnia.
- *Pain in muscles I joints.*
- Purulent discharges.

Mucosa

- Chronic sinusitis; chronic purulent rhinitis; ozaena.
- « Acute and chronic otitis.
- Gums swollen and red; painful, especially during dentition.
- Coated tongue.
- = Redness of pharynx.
- Chronic lacunar tonsillitis [inflammation of the mucosa lining the tonsillar crypts].
- ~ Pseudo-membranous tonsillitis.

-
- ~ Acute angina accompanied by marked influenza symptoms.
 - = Vincent's angina [ulcerative infection of tonsils and pharynx, usually associated with necrotizing ulcerative gingivitis; may cause suffocative attacks].
 - Chronic aphonia < tobacco and humidity.

Skin

- Eczema of newborns.
 - = Boils.
 - Recurrent erysipelas.
- = *Dental symptoms* accompanied by hyperaesthesia, redness, adenopathy, hyperthermia, and lymphangitis.
Convulsions during dentition.

Repertory

The drug has 48 symptoms in Synthesis 9.1, of which the following are in rubrics containing less than 50 remedies:

- = Ear, Inflammation, acute.
- = Ear, Inflammation, chronic.
- Nose, Inflammation, chronic.
- = Nose, Inflammation, purulent.
- = Nose, Sinuses, complaints of.
- « Mouth, Boils at gums.
- <= Mouth, Congestion of gums.
- ~ Mouth, Pain, Gums, during dentition.
- = Throat, Inflammation, accompanied by influenza.
- = Throat, Inflammation, Tonsils, chronic.
- « Throat, Membrane, Tonsils.
- External throat, Complaints, Thyroid gland.
- ~ Larynx and Trachea - Discolouration, red, Larynx.
- = Larynx and Trachea, Voice, lost, chronic.
- = Larynx and Trachea, Voice, lost, by tobacco.
- = Larynx and Trachea, Voice, lost, wet weather.
- = Chest, Complaints, Bronchial tubes, chronic.
- = Skin, Eruptions, eczema, in children, infants.
- = Generals, Convulsions, during dentition.
- = Generals. Convulsions. during dentition. in newborns.

-
- « Generals, History, personal - erysipelas, of recurrent.
 - « Generals, Inflammation, Sinuses, chronic.
 - Generals, Tetanus.

IIB. FAMILY LACTOBACILLACEAE

Lactobacillus acidophilus

LACTOBACILLUS ACIDOPHILUS

Scientific name Lactobacillus acidophilus (Moro 1900) Hansen & Møcquot 1970

Family Lactobacillaceae

Homeopathy Lactobacillus - Lactob.
Bacillus acidophilus - Lactob.

FEATURES GENUS LACTOBACILLUS

- Gram-positive bacilli varying in shape from long, slender rods to short coccobacilli, which frequently form chains.
- Non-motile, non-sporulating.
- Optimum growth at pH 5.5-5.8.
- Some species are part of the normal flora of mouth, intestinal tract, and vagina.
- Intestinal activities consist of the breaking down of proteins and fats, making them more easily digestible for the host; hence the great value of lactobacilli in dietetic formulations for infants, geriatrics and convalescents.
- Lactobacilli produce metabolites that exert antagonistic action against putrefactive micro-organisms in the gut, which elaborate chemicals as hydrogen sulphide, phenol, and skatole.
- Convert glucose and lactose into lactic acid. [Lactose is a disaccharide made up of the monosaccharides glucose and galactose.]
- Some lactobacilli synthesize B-vitamins in symbiosis with other intestinal micro-organisms.
- Grown and delivered in buttermilk, yoghurt, bioyoghurt, sauerkraut, sourdough bread, and certain sausages.

LACTIC ACID

There are eight main genera of lactic acid bacteria: Streptococcus, Enterococcus, Bifidobacterium, and Lactobacillus, amongst others. Of these, members of the genus Lactobacillus are able to live in acidic environments

well below the pH other lactic acid bacteria can live in. Consequently, *Lactobacillus* spp. are responsible for the final stages of fermentation in products. *Lactobacilli* produce lactic acid from lactose or glucose. Lactic acid is reported to have some physiological benefits such as:

- Production of digestive enzymes which enhance the digestibility of milk proteins by splitting them into fine curd particles.
- Improving the utilisation of calcium, phosphorus, and iron.
- Stimulating the secretion of gastric juices.
- Accelerating the onward movement of stomach contents.
- Increasing peristaltic action of the gastrointestinal tract.
- Serving as an energy source in the process of respiration.
- Controlling the pH balance of the colon.
- Lowering the pH of the intestinal environment to 4-5, which inhibits the growth of harmful organisms: *Salmonella typhi* die, *E. coli* are unable to develop, and *Salmonella paratyphi* and *Corynebacterium diphtheriae* lose their pathogenic properties.

Lactic acid is metabolised in glycogen synthesis by the liver. Unmetabolised acid is excreted in the urine. When oxygen supply is limited or exhausted, additional energy is generated by anaerobic metabolism of glycogen stored in the muscles and liver. This results in the formation of lactic acid, which, when the rate of production exceeds the rate of removal, accumulates and leads to acidification resulting in “tying up” of muscles. Excessive buildup of lactic acid results in lactic acidosis, signs of which include deep and rapid breathing, vomiting, muscle cramps, and abdominal pain.

The ability of *lactobacilli* to convert lactose to lactic acid is used in the successful treatment of lactose intolerance, a condition characterised by abdominal pain, bloating and diarrhoea in response to drinking even small amounts of milk. [Milk of mammals contains between 4 to 7% lactose.]

Interestingly, lactic acid is not found in the tissues of people with cancer, and its lack has been established as indicating susceptibility to cancer.

BENEFITS OF LACTOBACILLI

Species used for therapeutic purposes include *Lactobacillus acidophilus*, *L. plantarum*, *L. casei* [used to make Yakult], *L. bulgaricus* [now *L. delbrueckii*

subsp. *bulgaricus*], and *L. lactis*. An enormous amount of substantiated and unsubstantiated health claims associated with ingestion of lactobacilli in the form of dietary supplements or food ingredients has been forwarded:

- Treatment of diarrhoea [eg, traveller's diarrhoea; acute infectious diarrhoea; rotavirus-induced diarrhoea in children; prevention of diarrhoea in undernourished children; antibiotic-related diarrhoea; reduction of diarrhoea and other gastrointestinal side effects caused by chemotherapy or radiation in cancer treatment; Crohn's disease; ulcerative colitis].
- Enhancement of immune system functions [increase of number of white blood cells; stimulation of T-lymphocyte production].
- Lowering of serum cholesterol levels and reduction of incidence of coronary heart disease.
- Prevention or treatment of peptic ulcer disease. [By inhibiting the growth of *Helicobacter pylori*, a primary 'cause' of ulcers in stomach and duodenum.]
- Management of food allergy [lactose intolerance] in infants.
- Treatment of vaginal yeast infections.

HOMEOPATHY

Two sour lacs

No provings have been done with *L. acidophilus* or any other lactic acid bacterium. Although *Lactobacillus acidophilus* may not exist as a remedy up to now, it seems a reasonable assumption that it will resemble the 'sour milk' remedies *Lac vaccinum coagulatum* and *Lac vaccinum butyricum*. The former is made from curd, the latter from buttermilk. As cow's milk thickened or coagulated by lactic acid producing bacteria, curd comes closest to yoghurt, while buttermilk is produced by fermentation of cow's milk. Yoghurt is made by adding live cultures of *Lactobacillus bulgaricus*, *Streptococcus thermophilus* and/or *L. acidophilus* to milk; buttermilk results from the metabolic activities of *Lactobacillus* [*Streptococcus*] *lactis*, *S. cremoris* and/or *Leuconostoc citrovorum*.

"The only use that I know as having been made of *Lac coagulatum*," writes Clarke, "is in the nausea of pregnancy, the indication being 'Nausea of pregnancy with desire for food and > by drinking milk.'" An additional symptom of this remedy is "Lump sensation in larynx."

[Note: Lac defloratum, skimmed cow's milk, is worse by milk. Lacticum acidum has nausea of pregnancy on waking/rising, > breakfast.]

Lac vaccinum butyricum received a one-man proving in 1871 by Bender, who took two doses of the 30c, after 19 days one dose of 200c, and 24 days later one dose of 1M. He observed the following effects [in order of appearance]:

- = Pain in bone beneath right eye, pressive as with the point of a finger.
- <= Dryness of skin of hands, requiring constant wetting of the fingers in order to hold anything or turn leaves of paper.
- => Loose lumpy stool, painless, sometimes very offensive, & pressure on anus as if rectum would protrude.
- ~ Scanty urination, extremely slow in passing.
- Great heat and dryness in nostrils, mucus becomes hardened and difficult to remove.
- «= Great restlessness at night.
- « Musty smell from body with moisture of skin, but no sweat.
- « Great depression of spirits, the future looks dark and hopeless. [He records this on New Year's Day.]
- Dreams of the bodily appearance of the devil. [One day after taking the 200c.]
- « Heat in head, with dull pain in vertex with fulness; a creaking sound as the head is turned, with throbbing in base of occiput.
- « Pain in and around right eye, the ball is sensitive to pressure.
- Great dryness of larynx at night, esp. at region of glottis, causing irritation and coughing.
- Both shoulders pain as if dislocated.
- Water running from nose while eating; for several days. [Six days after taking 1M.]
- « [After touching his tongue to the 16¹*¹ potency] In a short time great drowsiness, could scarcely keep eyes open.
- « Dulness of hearing as if right ear were filled with water, or as if there was a thin film of wax on membrana tympani.
- = Similar symptoms appeared when he later repeated the 200c and after 6 months the 30c.
- = Mrs. B., suffering from flatus from the uterus, reacts on one dose of 10M with "a great increase of flatus which could be felt passing into uterus and down through it and vagina, like marbles; the discharge was with a puff instead of a report as before the remedy."

= Bender states to have cured a throbbing beating in right ear with 1M and to have verified with cures the symptom ‘dulness in ear as if filled with water’.

[Provings of *Lac vaccinum butyricum*; Hom. Rec., June, 1931; Enc.Hom.]

Lactose and Lactic acid

Hypothetically *Lactobacillus acidophilus* is linked with both *Saccharum lactis* and *Laeticum acidum*, the first being the principal nutrient of the bacterium, lactose, the second its main product, lactic acid.

Swan, who introduced and proved the remedy, dubbed *Saccharum lactis* his “Fatigue powder.”

To use the words of Berridge: “When a man, woman or child is completely fagged out by muscular work of any kind too tired to eat or sleep, *Sac-lac.* in a high potency will very quickly and permanently remove the fatigue, the patient will fell rested. *Sac-lac.* is to muscular fatigue what *Tela araneae* [web of cross-spider] is to nervous fatigue or depression.”

Sight fails; eyes tire very easily. It has cold pains as a feature. Swan considers cold pains as a keynote. Cold, neuralgic pains in lobes or cartilages of either ear, and in other places. These pains were icy cold like needles. Symptoms worse before a storm, in a damp room or basement. Better by warmth of a fire. Sensation as if it is only by a great effort one is kept together [yet would be much relieved if she could fall to pieces]. Loses way in well known streets. Imagines there is a large hole in back just above sacrum; that her mother wants to kill her; that someone is behind her. Very nervous, jumps from her seat at least noise. Great fear of death during paroxysms of pain in heart. Faecal odour of body, or only hands, before stool, passing away after stool. Great soreness around anus, passing up rectum three inches. It has a number of important rectal symptoms; also urinary. Heart symptoms are marked and peculiar. Sensitive in every part of body. Restless at night caused by itching all over body as soon as covered in bed. It has symptoms all over the body.

[Berridge, *Saccharum-*, The Homeopathic Physician, Aug., 1889; RefWorks]

Lactose maldigestion or intolerance, with gastrointestinal upset and fatigue, is an indication for *Saccharum lactis*. With *Laeticum acidum* the emphasis lies more on problems with sugar in general instead of with lactose alone, eg, hypoglycaemia. There is a sore or burning pain in the muscles that is out of proportion to the work done. [Lactic acid is a by-product from exercise. It is

ated with fatigue. An Australian study found that patients with ic fatigue syndrome release more lactic acid in their blood.]

also Acetobacter.]

IIC. FAMILY STREPTOCOCCACEAE

Streptococcus pneumoniae

Streptococcus pyogenes

STREPTOCOCCUS PNEUMONIAE

| | |
|------------------------|---|
| Scientific name | <i>Streptococcus pneumoniae</i> (Klein 1884) Chester 1901 |
| Common name | Pneumococcus |
| Family | Streptococcaceae |
| Homeopathy | Pneumococcinum - Pneu. Vaccinum pneumococcale - Pneu-vc. |

FEATURES

- Gram-positive, lancet-shaped, facultative anaerobic organism typically observed in pairs [diplococci], although it may occur singularly or in short chains.
- Non-motile; alpha-haemolytic.
- Soaks up DNA that has spilled out of dead or dying brethren - inheritance by cannibalism that has imparted, among other things, antibiotics resistance. [Drexler]
- Common inhabitant of the respiratory tract; isolated from nasopharynx of healthy adults.
- Subdivided in encapsulated and non-encapsulated strains. Encapsulated organisms are pathogenic for humans, the capsule being an essential virulence. The capsule, a compound of polysaccharides, protects the bacterium against phagocytosis.
- Ten of the 90 known serotypes produce the majority of pneumococcal infections. Serotype prevalence differs by age group and country.
- Incidence peaks in the winter and early spring in temperate regions.
- First identified by Pasteur in 1881 from the saliva of a patient with rabies.

CLINICAL MANIFESTATIONS

Pneumonia, febrile bacteraemia and meningitis are the most common manifestations of invasive pneumococcal disease, whereas bacterial spread within

the respiratory tract may result in middle-ear infection, sinusitis or recurrent bronchitis. Compared with invasive disease, the non-invasive manifestations are usually less severe, but considerably more common.

Transient nasopharyngeal colonization rather than disease is the normal outcome of exposure to pneumococci. In persons susceptible to the involved serotype, however, bacterial spread to the sinuses or the middle ear, or bacteraemia following penetration of the mucosal layer may occur. In the United States alone, 7 million cases of otitis media are attributed to pneumococci each year. Pneumonia is by far the most common cause of pneumococcal death worldwide.

In young children, fever, vomiting and fits may be the only signs initially. Adults with pneumococcal pneumonia develop fever, chills, sharp chest pain, breathlessness and cough productive of brownish sputum.

Pneumococcal meningitis may occur as a direct extension of infection from the middle ear or sinuses, or without evidence of local infection. Previous skull fractures or congenital bony defects predispose to pneumococcal meningitis. Especially at risk, according to the Merck manual, are alcoholics and persons with chronic otitis, sinusitis, mastoiditis, closed head injury, recurrent meningitis, pneumococcal pneumonia, sickle cell disease, or asplenisim.

Pneumococci may be isolated from the nasopharynx of 5% to 70% of normal adults. Rates of asymptomatic carriage vary with age, environment, and the presence of upper respiratory infections. Only 5%-10% of adults without children are carriers. In schools and orphanages, 27% to 58% of students and residents may be carriers. On military installations, as many as 50% to 60% of service personnel may be carriers. The duration of carriage varies and is generally longer in children than adults.

Pneumococcal pneumonia is the most common clinical presentation of invasive pneumococcal disease among adults. The incubation period is short, about 1 to 3 days. Symptoms generally include an abrupt onset of fever and shaking chills or rigors. Typically there is a single rigor; repeated shaking chills are uncommon. Other common symptoms include pleuritic chest pain, cough productive of mucopurulent, rusty sputum, dyspnoea, rapid breathing, hypoxia, tachycardia, malaise, and weakness. Nausea, vomiting, and headache occur less frequently.

An estimated 150,000 - 570,000 cases of pneumococcal pneumonia occur annually in the United States. Pneumococci account for up to 36% of adult

community-acquired pneumonia and 50% of hospital-acquired pneumonia. It is a common bacterial complication of influenza and measles. The case-fatality rate is 5%-7%, and may be much higher in elderly persons. Complications of pneumococcal pneumonia include empyema [infection of the pleural space], pericarditis, and endobronchial obstruction, with atelectasis and lung abscess formation.

An estimated 16,000 to 55,000 cases of *pneumococcal bacteraemia* occur each year. Bacteraemia occurs in about 25%-30% of patient with pneumococcal pneumonia. The overall mortality rate for bacteraemia is about 20%, but may be as high as 60% in elderly patients.

Pneumococci cause 13%-19% of all cases of *bacterial meningitis* in the United States. An estimated 3,000 to 6,000 cases of pneumococcal meningitis occur each year. One-quarter of patients with pneumococcal meningitis also have pneumonia. The clinical symptoms, spinal fluid profile and neurologic complications are similar to other forms of purulent bacterial meningitis. Symptoms may include headache, lethargy, vomiting, irritability, fever, nuchal [nape of neck] rigidity, cranial nerve signs, seizures and coma. The mortality rate of pneumococcal meningitis is about 30%, but may be as high as 80% in elderly persons. Neurologic sequelae are common among survivors. [Most commonly deafness on one or both sides; less frequently, mental impairment and seizures]

Bacteraemia without a known site of infection is the most common clinical presentation among children under age 2, accounting for approximately 70% of invasive disease in this age group. With the decline of invasive Hib disease [Haemophilus influenzae type B], *S. pneumoniae* has become the leading cause of bacterial meningitis among children younger than 5 years of age in the United States. [Can we perceive the effects of mass vaccination here? Just what is the effect of introducing 29 diseases directly into the bloodstream of a child under the age of 5? Ed.]

Pneumococci are a common cause of acute otitis media, and are detected in 28%-55% of all middle ear aspirates. By age 12 months, 62% of children have had at least one episode of acute otitis media.

[US Centers for Disease Control and Prevention, *Pneumococcal Disease-*, at: www.cdc.gov/NIP/publications/pink/pneumo]

Called *lobar pneumonia*, *croupous pneumonia* or *lung fever* in traditional homeopathic literature, Raue describes the course of pneumococcal pneumonia thus:

This is an acute infectious disease characterized by a fibrinous inflammation of the lung parenchyma, with infiltration and consolidation of the same.

The exciting causative micro-organism is now generally conceded to be Frankel's *diplococcus pneumoniae*, some bacteriologists, however, particularly Weichselbaum, think that other bacteria may also excite pneumonia, such as the streptococcus, staphylococcus pyogenes aureus and the pneumococcus of Friedlander.*

The chief predisposing cause is unquestionably exposure to cold. It is a frequent sequela to other acute infectious diseases.

It attacks in preference the inferior *lobes* of the lungs, especially on the right side; very rarely both lungs at the same time. It very rarely pervades one whole lung, being much oftener confined to limited portions, which may even be too small to be detected by percussion. In aged persons and cachectic individuals the posterior part of the lungs are most frequently attacked. When normally progressing, pneumonia offers three distinct stages for consideration: 1. The inflammatory stage. 2. Hepatisation, or infiltration of the lung tissue with coagulable lymph. 3. Its resolution, or purulent infiltration.

The characteristic signs of these different stages are as follows:

First stage. As a general thing the disease sets in with a violent chill, often attended with vomiting and followed by an intense fever, with a temperature of 104° to 105° in the evening and from 0.9° to 2.7° less in the morning; the pulse rises to 100 or 110 and the respiration to 40 or 50 per minute. In other cases the disease sets in with several light chills or chilliness, or the chill is entirely absent and the scene opens with convulsions and complete loss of consciousness. The skin is at first very dry, but becomes moist usually about the third day, though only temporarily.

The face is purplish-red, and frequently only on that side which corresponds to the diseased side of the lungs. The lips become covered with *hydroa* [fever blisters] and also very often only on the affected side, or, at least, more marked on that side. The alae nasi make corresponding movements with respiration; the voice of the patient is low and he speaks in broken sentences. *Cough* is, in almost all cases, present, although in some less marked than in others; the patient generally tries to suppress it, on account of the pain which it gives. At first it is dry, but after a time it yields a tough, jelly-like, viscid sputum, difficult to expectorate, and adhering to the lips, from which it has to be wiped off; it soon changes to the characteristic colour of *rust*, from an admixture of blood.

When the patient complains during the coughing spells of *stitch-pain* in the chest, it is more or less a sign that the pleura participates in the morbid process;

when he complains of *dull, heavy pains*, they probably originate in the bronchial tubes.

PNEUMONIA

SYMPTOMS

THREE STAGES:

1. *Violent chill, vomiting*

Fever in evenings.

Dry skin

Purple-red face - unilateral

Fever blisters - lips

Painful dry cough

Rusty sputum

Delirium/ stupor

2. *As above plus less*

movement in chest.

3. *Crisis. Sudden resolution*

temperature, colour,

urination normalised.

Sputum frothy, yellow.

Lasts 25 days without

treatment.

In consequence of the disturbed circulation through the lungs, the blood being either not sufficiently oxygenized, or being prevented or retarded in its return from the brain, different *brain symptoms* originate, such as *delirium, stupor*, etc., so that the case may take the appearance of typhoid fever, from which, however, it is easily distinguished by the *hydroa* on the lips, which are scarcely ever found in typhoid fever.

Second stage, hepatization. The above-mentioned symptoms, fever heat, dyspnoea, cough, pain, and brain symptoms, continue. The thorax appears, on inspection, still less movable during respiration; the vocal fremitus [speech induced vibration felt in chest on palpation] is strong, provided there does not intervene a pleuritic effusion between the hepatized lung and the thoracic wall.

Third stage, resolution. This sets in sometimes with a sudden relaxation of all the violent symptoms - the temperature falls in from twelve to thirty-six hours to the normal, and at times even below the normal; the congested, even purplish face becomes pale, the skin moist, the dyspnoea ceases, the sputa becomes copious, frothy, yellowish, easily expectorated; the urine increases and becomes again normal.

The disease may take a debilitating form when the symptoms of the central nervous system assume great prominence from the beginning, so that the whole process might be mistaken for meningitis or typhus; still the infiltration of the lung progresses slowly, and in severe cases is often attended with pleuritis, jaundice, albuminuria, and considerable enlargement of the spleen. This form is called *typhoid pneumonia*.

The mean or average time which it takes for pneumonia to run its course, if it is not interfered with by medicines, is twenty-five days. But this average may, by judicious treatment, be considerably shortened, for pneumonia can be arrested in each of its stages.

The most interesting data in this respect have been brought forth by Dr. Eidherr, of Vienna, who has collected all cases of pneumonia out of a large hospital practice, which had been recorded there for ten years. From these data it appears that under the application of the sixth decimal attenuation of the appropriate remedies the average comes down to nineteen, under the application of the fifteenth potency to fourteen, and under the application of the

thirtieth potency to eleven days. [Raue]

* The organism historically known as 'pneumococcus of Friedlander' is now known not to have been a pneumococcus [= streptococcus] but *Klebsiella pneumoniae*. [See *Klebsiella*].

MENINGITIS

Course of pneumococcal meningitis:

- It generally occurs during winter and spring, and especially when there is great moisture of the air and wide variations of temperature. Childhood is the age most severely attacked, yet no age is spared. The disease-germ seems best to thrive where it finds a soil prepared by insufficient nourishment, damp, overcrowded, badly ventilated houses with unclean ground floors.

- *Sudden onset*, commencing with a chill, followed by fever; violent headache; extraordinary prostration of strength and great restlessness.

Headache is usually severe, sometimes in the front, sometimes in the back part of the head.

Vomiting is especially excited by rising and is rarely absent.

Irregular fever, varying from 100.4- 104° E [38 - 40° C.], with very irregular variations above and below these points, often interrupted by long-continued normal temperatures, while the other symptoms continue unabated.

Pulse likewise irregular, and not always corresponding to the height of the temperature.

In severe cases there occur at the start loss of consciousness, coma or delirium, or at least somnolence, out of which the patient may be roused by being spoken to, answering correctly, but soon relapsing into the same state again.

Some cases commence with convulsions, and that characteristic stiffness of the neck which, in a few hours, may develop into a tonic contraction of all the extensors of the spinal column; orthotonos [tetany-like spasm in which the neck, limbs, and body are held fixed in a straight line]; opisthotonos is rare. Great aching in all the limbs, esp. in the spine; oversensitiveness of the skin; great pain from every touch and motion.

Cutaneous stage. Now appear also cutaneous eruptions, herpes on the face, or

*PNEUMOCOCCAL
MENINGITIS*

SYMPTOMS

Humid/wet seasons.

Sudden onset

Chill - Fever

Violent headache

Prostration

Restlessness

Vomiting < rising

Irregular fever, pulse

Stupor

Herpes - face

Rash purplish

Coated tongue

Depression

Convulsions

Paralysis

Coma

on the extremities; then erythema, roseola, urticaria and petechiae. [Skin rash is presently considered to indicate meningococcal meningitis “until proved otherwise.”] Irregular purplish, ecchymosed spots, from the size of a pin’s head to larger patches, appear generally on the second day of the disease, usually first on the upper eyelids, gradually extending to other parts; they do not get white under pressure.

Third to fifth day: Tongue dry and cracked in comatose cases; tongue moist but heavily coated in other cases. Diarrhoea or constipation. Symptoms of depression may ensue in severe cases: complete unconsciousness, involuntary loss of stool and urine, convulsive movements, half-sided paresis, general convulsions, profound coma, and death. In favourable cases these symptoms of depression do not set in at all, or are not so marked nor lasting. Headache, pain in limbs and spine continue, but gradually grow milder.

Convalescence begins in from one to two weeks.

Possible *sequelae* include deafness, derangement of vision, chronic hydrocephalus and chronic meningitis, with the consequent impairment of intelligence, and lesions of motility in the form of paralysis or paresis.

[Raue]

PNEUMOCOCCAL VACCINES

Pneumococcal diseases are a major public health problem all over the world, according to a 1999 WHO position paper on Pneumococcal vaccines. The position paper continues: “At least one million children die of pneumococcal disease every year, most of these being young children in developing countries. In the developed world, elderly persons carry the major disease burden. Conditions associated with increased risk of serious pneumococcal disease include HIV infection, sickle-cell anaemia and a variety of chronic organ failures. Vaccination is the only available tool to prevent pneumococcal disease. Pneumococcal resistance to essential antimicrobials such as penicillins, cephalosporins and macrolides is a serious and rapidly increasing problem worldwide ... underlining the urgent need for more efficient pneumococcal vaccines. The currently licensed pneumococcal vaccine is based on the 23 most common serotypes, against which the vaccine has an overall protective efficacy of about 60%-70%. ... Due to reduced immunogenicity and unclear efficacy in children under two years of age, the current polysaccharide vaccine is not recommended for routine immunisation of children in this age group. ... The duration of protection in elderly and immunocompromised target

groups is relatively short. Infants respond poorly to this vaccine. Also, the vaccine has no significant effect on nasopharyngeal carriage, and hence induces no herd effect. These important shortcomings underline the need for developing improved pneumococcal vaccines.”

This vaccine, named PPV23 in the U.S., has been recently followed by a new generation of pneumococcal vaccines, believed to “overcome most of the problems inherent in the polysaccharide vaccine.” The first licensed version in the U.S. is pneumococcal conjugate vaccine [PCV7 or Prevnar], a combination of 7 serotypes of *S. pneumoniae* with a nontoxic variant of diphtheria toxin.

The most common adverse effects of Prevnar include injection site reactions, fever, irritability, drowsiness, restless sleep, decreased appetite, vomiting, diarrhoea, and rash or hives.

MATERIA MEDICA PNEUMOCOCCINUM

Pneu.

Sources

No provings.

Drug picture based on a clinical pathogenesis by Sevaux, presented by Julian.

Aetiological factors

“Never well since ...” is an important indication for the use of nosodes. An unresolved, suppressed [with antibiotics] or recurrent bacterial illness in the patient’s disease history may lead to long-term constitutional sequelae or complications and/or blocks the response to well-selected remedies.

Borland held this opinion regarding Pneumococcinum: “I use all the nosodes of that type much more for the after-effects than during the acute illness. I have been awfully disappointed by them during the acute attack, but they are simply marvellous in clearing up the effects of pneumonia. For instance, if you have a patient who has never been well since a pneumonia, a dose of Pneumococcinum simply makes a new man of him.” Pneumococcinum should be considered in cases where a [pneumococcal] pneumonia over time has evolved into a picture of [persistent] headaches and/or altered mental status [eg confusion]. The same is probably true for constitutional neurological complications following meningitis or recurrent otitis media or sinusitis.

Boericke mentions “pneumonia and paralytic phenomena; pleuritic pain and pain in ilio-coecal region.”

SYMPTOMS

Mind

~ Depressed, anguished condition.

Associated with pain all over cervical and dorsal regions.

Accompanied by fears:

Of impending disease; of death; of going out [wants to stay home].

Accompanied by:

Weakness of memory. Weary of life.

Gastrointestinal

= Indigestion. Nausea after eating. Stomach cramps with burning sensation.

= Stomach pains, *especially when hungry*, > *eating*

=> Constipation; with ineffectual urging; when travelling.

Or alternating with foetid stools & flatulence.

=> Distension and pain in left hypochondrium, > discharge of flatus.

Respiratory tract

= Tickling; feeling of having a *feather* in the throat.

«• Cough in morning after breakfast, causing nausea, > after 9 a.m.

- *Dry cough* in cold or hot air; < *entering a warm room*, and when clearing the throat.

- *Incessant* cough, unproductive, < at night; & nausea.

= Must *stoop* to be able to cough.

= Coughing = headache; loss of urine.

Cardiovascular

~ Palpitations related to emotions; frequent, at any time of the day.

= Palpitations at times so violent that he has *to stop when walking rapidly or ascending stairs*.

- Reddening of face when entering a warm room.

Female

- Short menstrual cycle [every 22 or 24 days]; menses stop on 2nd day.

- Menses late and scanty.

• Worse before menses [migraine; vertigo; legs heavy and swollen; restless legs].

= *Bearing-down sensation*.

-
- Burning sensation during coition [in fatigued patients]; *no orgasm*.

Musculoskeletal

- ~ Pain in *cervical region* with frontal headache; with pain in dorsal region.
- = Pain in dorsal region, preventing standing.
- « Pains in arms; in legs.
- = Legs: painful; trembling; restless, < before menses; *heavy, in morning on waking*.

Sleep

- Sleepiness in afternoon, around 3 p.m.

Modalities - worse

- = Entering a warm room [cough; redness of face].
- = Inactivity; rest; at night [headache].
- = Humidity.
- = Before menses [migraine; vertigo; legs heavy and swollen; restless legs].

Modalities - better

- ~ Open air.
- <• In countryside.
- Movement [headache].
- Short nap after meals.
- = Hot foot-bath.
- ~ Eating [stomach pain].

Sensations

- Of liquid in head when stooping.

Head

- = Pain in *left frontal sinus* or in forehead above the eyes.
- = Headache lasting 3 to 4 days.
- <= *Migraine*, left or right sided, < walking [= throbbing pain].
- « Frequent headaches, localized at nape of neck, < noise.
- ~ Headache on coughing or bending the head forwards.
- = Acute pains, suddenly appearing and short-lasting; pain stitching or cramping.
- = Constricting pains, *as if in a vice*.

= Headache < *rest and at night*, > *movement*.

Locals

= Tired eyes from neon light.

~ Aphthae in mouth.

CASES

(1) X. Y. Z, age 66, brought by a keen homeopath to know if he must have the [threatened] operation for glaucoma on his left eye.

The ball did not appear very hard, but the patient was nearly blind with both eyes. The eye troubles dated from 1938. He had been treated by an oculist; but now he was suffering much pain and loss of sight with the right eye also.

We took him to an ophthalmic surgeon [not feeling qualified to advise in such a serious case]. The verdict was, "No need for immediate operation," and we were left to treat medicinally for a month, when he was to be seen again. He groped his way diffidently with help; a physical wreck. The eye surgeons shook their heads over him. "Too old for his years; arteries hard and tortuous."

He had few symptoms, but he had had pleurisy and double pneumonia in 1915, some 22 years before the eyes began to suffer; so he was given on August 1st Pneumococcin 200, a few doses.

He reappeared on August 25th, having seen the eye surgeon. His sight had improved so amazingly as to wring an exclamation from the surgeon, whose report was: "Haemorrhage nearly gone from left eye. No haemorrhage right eye. Pulse better, much more compressible and regular."

Patient was jubilant. He volunteered: "He had lost the pressure in head and pain at back of neck. Heart much better; feels altogether better; breathing better and deeper." He looks ten years younger: moves better; walks easily and alertly. Better colour.... Is ten years younger: - actually, if it be true, that "a man is as old as his arteries."

[*An Amazing Nosode Case*-. Homoeopathy 1941; RefWorks]

(2) Mr. D., a congress man of Delhi [1936] came to my office with coryza and fever. At first I took it for an ordinary attack of influenza and so treated him with Aeon., Bry., Nux-v., Sulph., etc. Nearly two weeks and he was not better. He was then examined by an allopathic doctor and he said that it was

a case of typhoid fever. His treatment failed to cure him. Another doctor was consulted and he treated him for malaria. He again asked me to prescribe for his ailments. I was not very willing to do it and I asked him to consult Dr. K.N. Bose. He went to Dr. Bose with the following symptoms:

On the left side of the back, below the left scapular region, he experienced a pain, stitching in character and the pain was felt only in a small spot which could be covered by a silver rupee. The pain was worse on coughing, breathing, and also on motion. Temperature 101-102 F; dry, short cough, almost constant. The cough was extremely troublesome. No expectoration.

The doctor gave him no medicine but advised an X-ray examination. On the same day towards the evening I was called urgently to see him in his house. On entering the room I found him in great distress. His cough was severe and constant. The expectoration was a mixture of blood and pus. He was frightened to look at it. He received a dose of Pneumococcin 200. In the morning I found him quite well. He had no cough, no pain, no fever and no anxiety. The symptoms never returned.

[Wonders of homoeopathy, The Homeopathic Herald, Jan. 1949; EncHom]

(3) J.W.K., age 41. Pneumococcin.

At 21 years had sinuses washed out because of findings of neurologist. At 30 had crop of boils, ended with carbuncle. Penicillin. Off work 8 weeks. At 32 abscess in right groin - lanced, heat treatment - off work three months. At 34 growth under right axilla; thought to be a fatty tumour, removal advised. Removed 14 months later, believed to be malignant. Deep X-ray with much pain after each regular dose. Age 40 lump under left axilla; hospital, more radiation. December 1958, sudden headache, right side; < after each sinus wash-out, < head down, must sit up in bed. March, 1959, right eye bloodshot and very dark under; said to be acute iritis, with even more severe headache. Cortisone eased and he got back to his work as a very expert teaching laboratory technician for one week only.

In April, 1959, his wife came for my help, because headache was continuous day and night. He is going downhill, wants to be alone, and hates noise. He is chilly, craves fresh air. His chest has always been a weak spot with a fair amount of phlegm. Coughing makes him hold his head, even though touching the hair of the right side hurts. His sleep used to be very good, now gets hardly any. Fogs and mist or fumes cause cough. Sense of smell very acute. Aversion to fats. Has had some eczema for over 20 years, wool irritates. Shy, averse company, has always been very quiet, almost morose. Lacks self

confidence though a most brilliant technician. Recently a pain in the throat, a tickle causes him to swallow all the time. Out of all this we would normally take the symptoms: Averse company; lacks self-confidence; sensitive to noise; indisposed to talk; aversion to fat; desires fresh air. There are also: Chilly; smell very acute; scalp and hair tender to touch; cough < fog, mist or fumes; skin irritated by wool. Repertorisation gives Nat-c. 8, Phos. 9, Carb-an. and Carb-v. 11 each, Bry. and Nat-m. 12, and Pulsatilla 15.

But I have kept you in the dark; when I dug deeper into his history I found that he had had pneumonia at age 5, so badly was not expected to live, and again 18 months ago when he was 39 or 40. This attack came after Asian influenza, when he was very ill, and since this illness has rapidly gone downhill. These two illnesses had not been told me by his intelligent and very cooperative wife as they had [to her] no obvious relation to this illness which is regarded as a probable cerebral tumour by the hospital authorities. He has no relish for further use of X-rays.

I prescribed Pneumococcin 30, 200, 500, IM, in daily doses. In six days he was fit to travel, in eight days he began to have a little energy, though he was so wise to lie down for an hour every afternoon. Within a fortnight the headache had gone. Up to April 1960 he has required no further treatment. This is a case where from the time of reoccurrence of an illness the patient's health declines, with many, from the diagnostic angle, apparently unconnected symptoms.

[J. Fraser Kerr, *Unproven nosodes, their use, and some thoughts thereon*-, BHJ, July 1960]

STREPTOCOCCUS PYOGENES

| | |
|------------------------|---|
| Scientific name | Streptococcus pyogenes Rosenbach 1884 |
| Common name | Strep |
| Family | Streptococcaceae |
| Homeopathy | Scarlatinum - Scarl. Streptococcinum - Streptoc. |

FEATURES

- Gram-positive, non-motile coccus, occurring in pairs or chains.
- Microaerophilic: requires an oxygen concentration less than normal, i.e. less than 20% by volume.
- Type species of Group A beta-haemolytic streptococci and the most virulent species in man, which cause pharyngitis [“strep throat”], tonsillitis, wound and skin infections, septicaemia, high fever, headache, scarlet fever, pneumonia, rheumatic fever, myalgia, and glomerulonephritis.
- Pyogenesis, suppuration, is a key factor of this organism, as its name indicates.
- Part of the normal nasopharyngeal flora in 5-15% of humans and also found frequently on the skin. Disruption of the normal bacterial flora may turn *S. pyogenes* into a pathogenic colonizer.
- Common cause of mastitis in dairy cattle, outbreaks of scarlet fever, rheumatic fever and septic sore throat transmitted by milk were numerous prior to the advent of milk pasteurization. That “scarlatinous angina is often complicated with diphtheria,” as Raue states, may have an explanation in the fact that diphtheria epidemics have been frequently associated with consumption of unpasteurized milk as well.
- Outbreaks of scarlet fever or septic sore throat transmitted by food agents other than milk have been attributed to consumption of ham, ice cream, custard, and, most commonly, eggs or egg salad. In almost all cases, the foodstuffs were allowed to stand at room temperature for several hours between preparation and consumption. [Riemann]
- Salad bars have been suggested as possible sources of infection. Most current outbreaks have involved complex foods [i.e., salads] which were infected by a food handler with septic sore throat. *S. pyogenes* has caused chronic

PATHOGENIC STREP

CAUSES:

- Pharyngitis*
- Strep throat*
- Tonsillitis*
- Scarlet fever*
- Pneumonia*
- Rheumatic fever*
- Kidney inflammation*
- Wound/skin infections,*
- Impetigo*
- Septicaemia*
- High fever*
- Headache*
- Myalgia*
- Mastitis in cattle*

impetiginous lesions on the hands of workers in meat-packing plants.

- Large clusterings of cases with short incubation periods and symptoms such as sore throat, exudative pharyngitis, myalgia, cervical adenopathy, and fever can be suspected to be caused by foodborne transmission of *Streptococcus pyogenes*.
- Homeopathically, *Streptococcinum* should be considered in cases of rheumatic fever and/or glomerulonephritis following food-poisoning accompanied by these symptoms.

CLINICAL MANIFESTATIONS

S. pyogenes infection remains commonly limited to mild, uncomplicated pharyngitis/tonsillitis or pyodermic infections such as impetigo. In more severe cases extension of the infection may result in sinusitis, otitis, mastoiditis, pneumonia with empyema, arthritis or osteomyelitis, erysipelas, and, rarely, meningitis or endocarditis.

The most common type of streptococcal disease is *primary pharyngeal infection with Group A beta-haemolytic streptococci*. Typically, the infection is manifested by sore throat, fever, a beefy red pharynx, and tonsillar exudate. About 20% of patients with Group A infections have this type of illness. The remainder are asymptomatic; have fever or mild sore throat alone, resembling viral pharyngitis; or have nonspecific symptoms such as headache, malaise, nausea, vomiting, or tachycardia. Convulsions may occur in children. The cervical and submaxillary nodes may enlarge and become tender. In children under age 4, rhinorrhoea is common and sometimes the sole manifestation. None of these symptoms [including sore throat] and none of the signs [including pharyngeal exudate or occasional palatal petechiae] are specific for streptococcal infection; any or all of these clinical features can occur in viral infections, particularly

bullae - large fluid filled

blisters

crepitus - discharge of

flatus

violaceous - turning

violet

obtund - to blunt or

deaden a faculty

with the adenoviruses and in infectious mononucleosis. The only sign or symptom statistically associated with serologically confirmed streptococcal disease is cervical adenitis.

[Merck Manual]

The severe but rare invasive disease *necrotizing fasciitis* destroys muscles, fat, and skin tissue. While *S. pyogenes* alone may produce it, this infection, according to the Merck Manual, is usually caused by a mixture of aerobic and anaerobic bacteria,

coined by the news media as “the flesh-eating bacteria.” The Merck Manual describes the condition thus: “The involved site is usually very painful, and the overlying skin is red, hot, and swollen. With progression, violaceous discoloration, bullae, crepitus, and dermal gangrene may develop. Fever, nearly always present, typically is accompanied by systemic toxicity, including tachycardia and altered mental status ranging from confusion to obtundation. Evidence of intravascular volume depletion, including hypotension, is frequent. ... Patients with diabetes mellitus seem predisposed to these infections. ... When the male genitalia are involved, this infection is called *Fournier’s disease*.”

SEQUELAE

Serious non-suppurative sequelae - acute rheumatic fever [fever, polyarthritis, carditis] and acute glomerulonephritis [fever, haematuria, oedema] - may develop 1-3 weeks after the acute illness. Acute rheumatic fever is a sequela only of pharyngeal infections, but acute glomerulonephritis can follow infections of the pharynx or the skin. Acute rheumatic fever can result in damage to the heart valves. Patients with hyperthyroidism are reported to have a high susceptibility to rheumatic fever. [Raskova]

Chorea

General agreement exists about the relationship between streptococcal infections and Sydenham’s chorea, also known as chorea minor or St. Vitus’ Dance. The disorder appears after a much longer time interval, up to 6 months, than does rheumatic fever and thus may appear to be an isolated, unrelated event. Incidence is higher in girls, in the summer and early fall [in temperate climates], and in the period of bodily development. Typical manifestations include:

Rapid, purposeless, involuntary movements without interruption, except during sleep, which is generally restless and unrefreshing. The movements may involve all muscles except the eyes.

Voluntary movements abrupt, with impaired co-ordination.

Incoordinate twitchings and jerkings of groups of muscles.

Facial grimacing.

Clumsiness, complicating dressing and feeding.

Exertions to overcome the difficulty have the opposite effect - increase of

spasmodic action.

Reflex motions are undisturbed; sneezing, coughing, evacuation of bladder and bowels, etc., gives no problems.

Sensibility, muscle strength, and sensory perception are normal.

At length: Loss of memory, weakness of mental capacity; fretful, irritable, and peevish.

Relapses frequent after mental excitement. [Raue]

THOUGHTLINKS

History of Strep infections

with Attention Deficit

disorder! [ADHD/ADD]

"Naughty child syndrome"

History of Rheumatic

fevers with chorea and

schizophrenia.

Chorea has sometimes been regarded as a form of "rheumatic encephalitis." Rheumatic fever and rheumatic chorea may occur together, or the latter may be seen in the absence of joint, skin or heart manifestations. Both rheumatic fever and chorea may occasionally be associated with psychotic illnesses, and behaviour disorder is recognised as extremely common in rheumatic chorea in children. It has been suggested that chorea is more prone to occur in families with nervous disorder.

Kraus [1946] described how experience of encephalitis lethargica led observers to turn attention to the sequelae of other infectious 'encephalopathies', chorea being one of the first to be examined. His own investigation of 24 patients showed that hyperkinesis in some degree was almost universal, in the form of restlessness, fidgetiness and inability to sit still. Compulsive utterances might appear, or localised tics such as blinking, stammering or shrugging. Neurasthenic symptoms were common in the form of headache, insomnia, fatigue and diminished perseverance. The patients often lacked vitality or colour in the personality. Intellect was rarely affected, but peculiarities of temperament were frequently marked - patients became sensitive, suspicious and seclusive while retaining awareness of the changes in themselves.

Guttmann [1936] similarly stressed the persistence of personality disturbances and emotional instability after the acute effects of chorea had subsided. But against the implication of a particular cerebral pathology to account for these changes, he reported an equally strong impression that a particular type of person was prone to the disease. Constitutional factors seemed to be important, with a high incidence of mental and nervous disease among the relatives of patients. A 'choreopathic personality' had been described as typical of those who were susceptible to chorea. Bender [1942] found that rheumatic chorea was by far the most common form of 'encephalopathy' among child psychiatric referrals to the Bellevue

Hospital. Many were sent because they were thought to have primary behaviour disorders, the chorea being either overlooked or considered coincidental. Such children were restless, irritable, emotionally unstable, inattentive and awkward in motility. They often displayed the classical 'naughty child syndrome'. They were unresponsive to discipline or psychotherapy, yet could improve spontaneously as the rheumatic process went on to recovery.

Finally the affinities between acute rheumatic diseases and schizophrenia have attracted a good deal of attention. It has often been noted that schizophrenia is unusually common in the family history of choreics. Guttman [1936] found in addition that a history of chorea was twice as common in patients with schizophrenia as in patients with manic-depressive psychosis. ... Among one hundred consecutive autopsies on schizophrenic patients, rheumatic valvular disease of the heart was discovered in 9%, always in association with possible rheumatic changes in the brain.

[Lishman 1987]

EPIDEMIOLOGY

The incidence of respiratory disease attributed to *S pyogenes* peaks at about 6 years of age, and then again at 13 years of age, and is most common during late winter and early spring in temperate climates. Skin infections are more common among preschool-age children, and are most prevalent in late summer and early fall in temperate climates [when hot, humid weather prevails], and at all times in tropical climates. Skin infections often follow minor skin irritation, such as insect bites. There are occasional reports of streptococcal disease traced to rectal carriers, and of foodborne and vector-borne outbreaks. In children, invasive disease with *S pyogenes* may follow varicella, or be associated with burns or malignancy; in adults with surgical or non-surgical wounds or underlying medical problems, i.e., diabetes, cirrhosis, underlying peripheral vascular disease, or malignancy.

The world prevalence of the serious late sequelae of *S pyogenes* infections [acute rheumatic fever and acute glomerulonephritis] has shifted from temperate to tropical climates. In particular, acute rheumatic fever had ceased to be a major health concern in the U.S., despite no concomitant decline in group A streptococcal pharyngitis. These diseases previously affected persons with a low standard of living and limited access to medical care. Since 1985, there have been scattered outbreaks of acute rheumatic fever in some regions of the United States. Temporal and geographic clustering provides further

evidence for “rheumatogenic” strains. Whether ethnic or racially determined factors affect this shift is not known.

[Maria Jevitz Patterson, *Streptococcus*-, <http://gsbs.utmb.edu/microbook/ch013.htm>]

OTHER STREPTOCOCCI

Group A

Group A streptococci [GAS], with *Streptococcus pyogenes* as the type species, are beta-haemolytic, i.e. they destroy red blood cells completely, which is indicated by a clear zone around colonies in blood agar cultures. Human disease is most commonly associated with group A streptococci.

Group B

Group B streptococci are part of the normal oral, intestinal and vaginal flora. Initially recognized as animal pathogens, in particular of bovine mastitis, group B beta-haemolytic streptococci [GBS] are now a major cause of severe neonatal septicaemia, pneumonia or meningitis in developed countries. This group accounts for a changing clinical spectrum of diseases in both pregnant women and their infants. Transmission is from mother to child, either in utero or during birth. Nosocomial acquisition probably accounts for a large percentage of adult infections. Risk factors include chorioamnionitis, premature rupture of membrane, fever during labour, maternal diabetes, preterm birth, and previous sibling with invasive GBS disease. Mortality rates in full-term infants range from 2-8% but in pre-term infants are approximately 10% to 20%. Sequelae of meningitis include cerebral palsy, sight and hearing loss, learning disabilities, and developmental problems. GBS also have been associated with pneumonia in elderly patients, and with cellulitis complicating severe peripheral vascular disease in elderly diabetics. The type species is *S. agalactiae*, which may cause meningitis, neonatal sepsis, and pneumonia in neonates, and vaginitis, puerperal fever, urinary tract infection, skin infection, and endocarditis in adults.

Group C - Viridans

Group C streptococci are alpha-haemolytic. Haemolysis is partial, resulting in a green discolouration around colonies in blood agar cultures. The group is collectively called the viridans streptococci [from *L. viridis*, green]. Viridans streptococci are normal commensals of mouth, pharynx, vagina, and skin. Although considered generally non-pathogenic streptococci, some

of them are associated with suppurative infections and as aetiological agents of bacterial endocarditis, in particular when related to dental diseases or dental manipulation and/or when the heart valves have been damaged by previous rheumatic fever or by congenital heart disease. *S. mutans* and *S. sanguis* inhabit the human mouth and are involved in dental caries.

One case in homeopathic literature relates the use of a *Streptococcus* with the species name *viridans*, although this name has no bacteriological equivalent.

Mrs. M.R., aged 42. Recurring paronychia affecting the bases of all her fingernails with tenderness, swelling and seropurulent discharge, always aggravated by hard use of her hands [housework, dishwashing, etc.]. Chronic constipation with enema habit for years of spite of correct eating. Tendency to what she calls "bilious spells" consisting of nausea, vomiting, griping pains in the abdomen and violent headaches. Several times she found pinworms in her rectum. Recurrent violent attacks of trifacial neuralgia. She gives a history of having been a sickly child of thin build with swollen lymph glands; had several attacks of pleurisy, recurring cystitis and an outbreak of boils and carbuncles over the face and upper arm.

She is of small spare posture, easily exhausted, very sensitive and emotional, impatient and irritable, easily worried; feels worse in wet, cold weather and suffers from lack of vital heat; her menses are scanty and she feels worse before them. Easy perspiration and damp feet. The skin is dry, chafes and cracks easily. She craves sweets, starches and fruit. The neuralgia is worse on the right side and worse at night. The first prescription, Silica, did not touch her at all, nor did Tuberculinum. Phosphorus initiated good progress for 5 months, then ceased to act. The next two years saw attempts with Psorinum, Arsenicum, Sulphur, Lycopodium, Nitric acid, Hydrastis, etc, with absolutely no success. A reconsideration of the case started from the premise that, Phosphorus having been the nearest medicine which failed to hold, a fitting antipsoric nosode must be found. The tendency to pus formation lead to the consideration of *Streptococcus viridans cardiacus* [Stearns] 200. The ensuing response was a true homeopathic aggravation which, prior to the improvement, singled out each group of symptoms, rather than the purulent state alone, thus marking as belonging apparently to the pathogenesis of this drug. The first response came from the gastrointestinal tract, then came the trifacial neuralgia and lastly the inflammation of nails and skin.

[When the well-selected remedy fails to act; case in Hom. Herald, January 1943, Vol. V]

TUMOURS AND STREPTOCOCCI

Streptococcal infections may have unexpected beneficial [side] effects.

The early clinical literature contains many reports on total or partial regression of malignant tumours during and after intercurrent streptococcal infections. In the past several investigators tried to explain the mechanism of anti-tumour activity of haemolytical streptococci through released toxins. Koshimura [1955] reported that the take of Ehrlich ascites carcinoma can be prevented by previous incubation of the tumour cells with living haemolytic streptococci, or with an extract of these. Christensen observed that both living haemolytic streptococci and the phage lysate of the cocci were inhibitory against Brown-Pearce carcinoma in rabbits. Ginsburg and Grossowicz examined the effect of various streptococcal haemolysins on Ehrlich ascites tumour cells, and observed swelling and pseudopode-like formation in the treated cells.

[Raskova 1971]

Coley's toxins

The medicinal use of streptococci dates back to the 1890s, when Dr. William B. Coley [1862-1936], a bone surgeon at Memorial Hospital in New York City [now Memorial Sloan-Kettering Cancer Center], introduced his mixed toxins' for the treatment of inoperable sarcoma. Dr. Coley came to his ground-breaking discovery after reviewing the case of a patient suffering from erysipelas accompanied by very high fever lasting for days. After the fever had abated the patient experienced a full regression of a huge malignant round cell sarcoma on the neck for which he had been operated three times to no avail. Attributing the regression to bacterial high fever induction, Coley identified the bacteria, heat-inactivated them and combined their endotoxins into a mixture, which he injected into cancer patients. What he actually did was induce artificial sepsis with high fever. The mixture consisted of the unfiltered toxins from *Streptococcus pyogenes* and the enterobacterium *Serratia marcescens* [group Gamma Proteobacteria in the Order Enterobacteriales].

The clinical observation that occasional accidental erysipelatous infection of malignant tumours is followed by sloughing and the subsequent disappearance of the tumour, suggested the experimental inoculation of such tumours with

Streptococcus erysipelatis [= *S. pyogenes*] as a therapeutic measure. The danger of the remedy, however, caused many to refrain from its use, for when one inoculates the living erysipelas germs into the tissues it is impossible to estimate the exact amount of disturbance that will follow.

To overcome this difficulty Coley [in 1894] has recommended that the toxin instead of the living coccus be used for injection. A virulent culture of the streptococcus is obtained, by preference from a fatal case of erysipelas, inoculated into small flasks of slightly acid bouillon, and allowed to grow for three weeks. The flask is then re-inoculated with *Bacillus prodigiosus* [= *Serratia marcescens*] ... It is claimed that the combined products of the streptococcus of erysipelas and *Bacillus prodigiosus* are much more active than a simple streptococcus culture. The best effects follow the treatment of cases of inoperable spindle-cell sarcoma, where the toxin sometimes causes a rapid necrosis of the tumour tissue, which can be scraped out with an appropriate instrument. Numerous cases are on record in which this treatment has been most efficacious; but, although Coley still recommends it and Czerny upholds it, the majority of surgeons have failed to secure the desired results. [McFarland 1907]

Use and effects

Coley's toxins were administered hypodermically or directly into the tumour, in small doses diluted with normal salt solution. The injections were given daily. The idea was to induce hyperthermia. Daily injections were given, increasing by one-fourth of a minim [0.015ml] until the desired reaction - namely a temperature of 39.5°-40° C - had been obtained. In regard to the duration of treatment, Cory wrote in 1909: "It is very hard to lay down any definite rules as to the duration of treatment that would apply in all cases. My own feeling, based upon my experience up to the present date, is that there is much more danger in stopping the toxins too soon than in giving them too long. That they can be given for very long periods without harm is shown by some of my cases, one in particular having taken the toxins with some intervals of rest for a period of nearly four years. In many of the prominently successful cases the toxins have been given for comparatively short periods - six weeks to three or four months ... In a few cases there have been recurrence of the tumour after it had once disappeared under the toxins treatment, and I feel that had the toxins been given for a longer time cure might have resulted . . . Can we, then, form any practical rules to guide us as to how long the toxins should be administered? I would

say, give the toxins until the tumours have entirely disappeared, and then continue in smaller doses and greater intervals for three or four months longer. If no improvement is noted at the end of four or five weeks, a successful result is not likely to occur, and retardation of the growth is all that can be expected from a further use of the toxins.”

In the *Boston Medical and Surgical Journal* [March 4, 1915] Dr. T.W. Harmer, of Boston, tabulated 222 cases of sarcoma occurring in his own and Dr. Coley’s practice, with a few from other sources. From these 222 cases he abstracted 134 of microscopically proved sarcoma, all inoperable and free from concurrent treatment [x-ray, radium, arsenic, etc.], the toxin treatment only having been given.

Analysis of the 134 cases according to the type of sarcoma, and as to the tissue of origin or anatomical situation, with apparent cures of the various types, are recorded as follows.

Spindle cell and fibro-sarcoma: 41 cases, with apparent cures in 26.

Round cell, small and large: 56 cases, with apparent cures in 28.

Melanotic: 6 cases, with apparent cure in one.

Giant cell: 14 cases, with apparent cure in 11.

Mixed cell: 13 cases, with apparent cure of 5.

Leiomyoma: 2 cases, with apparent cure in one.

Angiosarcoma: 1 case, with reduction in size of tumour.

Hypernephroma: 1 case, with apparent cure.

[Parke, Davis & Company, *Manual of Therapy*, 1927, p. 100]

Adverse effects

Side effects occurred, most commonly nausea, more rarely headache, backache, chest pain, and shock-like reactions. Shaking chills could be so bad that patients had someone lying on top of them to quell the shakes. Herpes of the lip was not uncommon but it usually disappeared promptly without special treatment. Coley also reported three cases which developed a fatal nephritis which may have been due to the treatment and a fourth who was known to have died 6 years after treatment. [Nephritis is a known complication of erysipelas.] Other uncommon but potentially serious side effects included the possibility of excessive haemorrhage.

About an hour after it [IV containing 0.02 ml of Coley’s] ran in I would start to feel very cold; not just unpleasantly cold but cold to the core, like you are

dead cold. No amount of blankets or heating pads really helped. Then I would start to feel extremely achy, like you have the flu, but worse. Then the shaking chills would start, uncontrollable. Mine weren't as bad as some people's. Lasted about half hour, I guess. You really have no sense of time in there.

What was the worst for me was that I would get really terrible backaches and the worst headaches I ever had. ... The few other people who did Coley's while I was there had worse chills but no severe pains. After the chills stopped then my temperature would go up. Mine never got higher than 38.8° - 39.3° C, most people got higher temps than me. After about 2-3 hours of all this severe discomfort I would ask them to please give me something to stop it. ... I did this twice a week, It was hell.

[Patient Experience with Coley's Toxins;

www.geocities.com/HotSprings/Villa/5443/alts/colegypt.html]

Current use

Coley's discovery was first tolerated, then ridiculed, and finally suppressed. His son, Bradley Coley, MD, continued to use the vaccine at Memorial Sloan-Kettering into the 1950s, but in an increasingly hostile environment. First radiation and then chemotherapy became directly competitive with this more natural approach. Coley's daughter, Helen Coley Nauts, founded the Cancer Research Institute of New York to save and promote his work. She published 18 monographs of treating cancer with Coley's toxins.

At the present time, there are few clinics that use Coley's toxins as part of a comprehensive treatment protocol. Coley's Toxins is also known under the names Mixed Bacterial Vaccines and Vaccineurin [in Germany].

[Ralph Moss, *The Promise of William B. Coley*]

IMMUNOTHERAPY

Tumour necrosis factor

Coley's work was a starting point for all modern immunotherapy. The bacterial endotoxins used by Coley turned out to trigger immune cells to secrete substances with anti-tumour effects. Further research showed that a direct necrosis of tumour cells occurred and this led to the discovery of tumour necrosis factor [TNF] in the 1970s. A group of natural chemicals, TNF occurs in the body in small amounts. TNF regulates both inflammation and immunity and has powerful anticancer properties. TNF can now be manufactured by recombinant DNA technology for the production of anticancer

drugs.

As 'Coley's mixed bacterial vaccine' it is used today in cancer immunotherapy, eg in the Issels Treatment. The vaccine "opens blockades in the body matrix [all solid, semi-solid and fluid connective tissues], stimulates the production of the body's own interferons, interleukins, colony stimulating factors, tumour necrosis factor and other potent disease fighters."

In the context of triggering the immune system into action an intriguing observation by Dr. Charles Starnes at Amgem in California is worth mentioning. A renowned specialist on Coley's toxins, Starnes noticed that the success rate of toxin treatment declined towards the end of Coley's career in the 1920-30s. He found that Coley's treatment worked best in the period of high incidence of tuberculosis, suggesting that the immunological preactivation of large parts of the population with tuberculosis actually enabled the Coley's toxins to work better. Interestingly, TNF was discovered in a mouse activated with BCG! It raises some questions. Are streptococcal infections, and, by extension, Streptococcinum, based on the tubercular miasm? Is immunological pre-activation limited to TB? Doesn't any type of mind-body medicine, eg, homeopathic constitutional treatment, aim to get patients into full action?

Febrile activity, whether occurring as a natural reaction or artificially induced, does more than dissolving tumours. Ancient Greek physicians reported febrile inflammatory events as having beneficial effects on certain psychiatric disorders, including depression. During the past decades research has been conducted into the biochemical mechanisms behind such effects. A German study found the following:

During febrile inflammatory events, mediators of the immune system such as interleukin-1 can be detected in the brain and may act on their respective receptors which have also been demonstrated in the brain. Since cytokines such as interleukin-1 have been shown in animal studies to exert sedative behavioural effects, to be somnogenic, and to induce slow-wave sleep, we performed a pilot study to evaluate scientifically the anecdotally reported beneficial effects of inflammatory states on depressive disorders. Mood and sleep parameters were monitored in seven drug-free, severely depressed patients before, during, and after the administration of a single dose of endotoxin.

All patients responded with a short pulse of increased synthesis of the cytokines tumor necrosis factor, interleukin-1, and interleukin-6 and elevated body temperature for several hours. During the night following endotoxin administration,

rapid eye movement [REM] sleep was significantly suppressed, while changes in slow wave sleep were not significant. During the next day, all patients were in a significantly improved mood; however a rebound of REM sleep was observed in the second night after endotoxin administration and mood worsened again during the next days, indicating an only transient beneficial effect of the treatment.

[J. Bauer et al., *Induction of cytokine synthesis and fever suppresses REM sleep and improves mood in patients with major depression*; *Biological Psychiatry*, 1995, Nov. 1:38 (9):611-21]

Endotoxins and Serratia

Endotoxins form in the cell walls of a variety of relatively avirulent as well as virulent bacteria. These toxins can be released into the environment [body], albeit to a lesser extent than occurs with the more active exotoxins. Coley combined *Streptococcus pyogenes* with *Serratia marcescens*, having noticed that the latter boosted the activity of the mixture. This is reflected in the name of the organism, *Bacillus prodigiosus*, a name derived from the word 'prodigious', astonishing, causing great wonder. It proved to be an inspired choice because in the 1930s endotoxins in the cells walls of *Serratia*, and other Gram-negative bacteria, were discovered to have a marked antitumour effect. These endotoxins, termed lipopolysaccharides [LPS], evoke a strong immune reaction that floods the body with tumour necrosis factor, interferon, and other cytokines. Pain-killing endorphins are also among the released substances.

Formerly considered a harmless saprophyte used widely to track bacterial movement by virtue of its blood-red pigment, *Serratia marcescens* was recognised in the 1960s as an opportunistic human pathogen, causing about 2% of nosocomial infections of the bloodstream, lower respiratory tract, urinary tract, surgical wounds, and skin and soft tissues of adult patients, as well as endocarditis and osteomyelitis in heroin addicts. It causes infections in the same sites as do the closely related enteric species *Klebsiella*, *Enterobacter*, and *Escherichia coli*.

Present in water and soil as a saprophyte, *S. marcescens* is also a normal commensal in the alimentary canal.

Its prodigious nature in causing miraculous bloody discolourations is, on a less serious note, linked with the Miracle of Bolsena, a painting by Raphael on the walls of the Vatican. The painting depicts a German priest, Peter of Prague, who, on breaking the communion bread, sees it has a blood-like

substance on it. One year later, in 1264, Pope Urban honours the Bolsena miracle by instituting the feast of Corpus Christi. Rather than to divine intervention, microbiologist Bernard Dixon attributes this miracle to the preference of the ubiquitous *Serratia marcescens* to grow on starchy foodstuffs, there producing its red pigment that easily can be mistaken for drops of blood.

Bizio, the Italian pharmacist who discovered the organism, which he believed to be a fungus, named it after the Italian physicist Serafino Serrati and added *marcescens* after the Latin ‘to decay’ because the pigment fades quickly, being sensitive to light.

Considerably less awe-inspiring is a *Serratia*-related incident, which took place in the beginning of the 1950s. Carrying out a study called ‘Operation Sea-Spray’ on the effects of wind currents on the transmission of biological weapons, the US Army filled balloons with the presumably harmless *S. marcescens* and burst them over San Francisco. Shortly thereafter, doctors noted a drastic increase in pneumonia and urinary tract infections. The Pentagon, however, announced that it had no convincing evidence that the experiments, also conducted in the New York underground and in Key West in Florida, had led to any infections or deaths.

References:

- Alan M. Dattner et al., *Comprehensive Cancer Care: Integrating Complementary & Alternative Therapies*, 1998; www.cmbm.org/conferences/ccc98/transcripts/105.html.
- Vera Bradova, *Coley's Toxins*, www.geocities.com/HotSprings/Villa/5443/alts/coley.html.
- Bernard Dixon, *Power Unseen: How Microbes Rule the World*, 1996.

THERAPEUTICS

Streptokinase

The dissolving properties of streptococci are still utilized in present medicine, be it for other purposes than tumour regression. An example is streptokinase. Streptokinase is a protein produced during the growth of strains of haemolytic [group A] streptococci. The substance was formerly used in conjunction with streptodornase, a pus-dissolving streptococcal enzyme, as an adjunct to antibiotic therapy and/or surgery in the treatment of haemothorax, haematoma, empyema, and of chronic suppurations involving draining sinuses, osteomyelitis, and infected wounds or ulcers. Contraindications for the use of the compound included cases of active tuberculosis due to the

danger of reopening previously existent bronchopleural fistulas.

Streptokinase alone is employed as a thrombolytic agent in the removal of clotted blood and fibrinous or purulent exudate following trauma or inflammation, such as in deep vein thrombosis, pulmonary emboli, peripheral arterial thrombosis, and myocardial infarction. Active internal bleeding, bleeding diatheses, pregnancy, recent CVA and uncontrolled hypertension are contraindications for its use because the drug may interfere with clotting.

Adverse reactions to streptokinase

| | |
|----------------|--|
| CNS | Hallucinations; depression; headache; chills; fever; hyperthermia. Incidence of streptokinase-induced Guillain-Barre syndrome is 5 cases/30,000-40,000 cases. [Guillain-Barre syndrome or acute idiopathic polyneuritis is marked by paraesthesia of the limbs and muscular weakness or a flaccid paralysis.] |
| Cardiovascular | <i>Hypotension; arrhythmias; chest pain; pericardal effusion /pericarditis; extravasation injury; angina pectoris; local phlebitis.</i> |
| Dermatologic | <i>Angioneurotic oedema; rash/eczema.</i> |
| Haematologic | <i>Haemorrhages [surface and/or internal]; cerebral haemorrhage; haemolytic anaemia; anaemia.</i> |
| Hepatic Ocular | |
| Renal | Liver haemorrhage. <i>Periorbital oedema; ocular haemorrhage.</i> Renal failure from acute tubular necrosis; glomerulonephritis. |
| Respiratory | <i>Bronchospasm; epistaxis; bleeding gums; pulmonary haemorrhage; haemoptysis.</i> |
| Miscellaneous | Diaphoresis. [Leikin & Paloucek 1998] |

TWO nosodes are directly or indirectly obtained from *Streptococcus pyogenes*: *Scarlatinum* and *Streptococcinum*.

SCARLET FEVER

Scarlatina

Scarlet fever is associated with Group A streptococcal [and occasional other] strains that produce an erythrogenic toxin, leading to a diffuse pink-red cutaneous flush that blanches on pressure. The rash, an additional feature of this illness that otherwise resembles streptococcal pharyngitis, is seen best on the abdomen, on the lateral chest, and in cutaneous folds. Among the characteristic manifestations of the rash are *circumoral pallor* surrounded by a flushed face, a *strawberry tongue* [inflamed papillae protruding through a bright red coating], and *Pastia's lines* [dark red lines in the creases of skin folds]. The upper layer of the previously reddened skin often desquamates after the fever subsides.

[Merck Manual]

Scarlet fever, antibiotics, streptococcal resistance and the enforcement of health

Scarlet fever had in the 19th century a high mortality, particularly among children. Streptococci were first isolated from the blood of scarlet fever patients by Edward Klein in 1887, but he was unable to reproduce the disease in animals, so that the bacteria, according to Koch's postulates, could not be regarded as the cause of the disease.

Medical science claims that scarlet fever "because of antibiotic therapy is now little more than streptococcal pharyngitis accompanied by rash," whilst Roy Porter, medical historian, writes that, "as with many other communicable diseases, what brought its decline was not a therapeutic breakthrough but a healthier environment and improving patient resistance."

At any rate, indiscriminate use of antibiotics has resulted in the problematic combination of decreased human resistance and increased bacterial resistance. As flexible team players and part of an all-encompassing group organization, bacteria possess the unsurpassed property of worldwide genetic transfer and exchange. The worldwide spread of resistance to antibiotics is as much a medical nuisance as spectacular proof that "bacteria act as a united entity capable of solving complex problems, and solving them efficiently every time." Bacteria are normal and necessary inhabitants of "Planet Human" and health is not so much a matter of enforcement as it is of re-enforcement, eg, by restoring appropriate microbial communities.

There has been a recent increase in variety, severity and sequelae of *S. pyogenes*

infections. Also other streptococcal strains with increased invasive capacity have started to emerge. The rapid emergence of antimicrobial resistance among enterococci contributes to their emergence as prominent nosocomial pathogens, making them among the most difficult to treat. Group B streptococci are currently the leading cause of neonatal septicaemia. Hostilities are intensified with the development of streptococcal vaccines containing multiple serotypes and with synergistic regimes that combine several types of antibiotics.

Having “disappeared” in its classical form, scarlet fever now manifests itself as chronic disease affecting musculoskeletal system, heart, kidneys, and skin. The applicability of both *Scarlatinum* and *Streptococcinum* is still intact.

MATERIA MEDICA SCARLATINUM

Scarl.

Sources

Clinical observations with the use of *Scarlatinum*, the nosode of scarlet fever. The nosode is prepared from swabs from the pharynx or squamae [epidermic scales] of scarlet fever patients.

Aetiological factors

- Never well since throat inflammations [with or without scarlatina-like rash] or scarlet fever.
- « “Its well-known affinity for the skin, throat and kidneys suggests its applicability for affections of those organs.” [Clarke]
- = It is recommended as an intercurrent remedy in cases that have followed an attack of scarlet fever.
- According to Dorothy Shepherd the “scarlet fever serum [inoculation] is a powerful agent in producing a long lasting urticaria, therefore it should be remembered as a standby in urticaria which will not yield to other means, provided it is given in a high dilution.”

Clinical pathogenesis

- Weakness; headache; vomiting; sometimes abdominal pains; debility.
- Swelling of tonsils; pharynx red.
- Cervical adenopathy. Tachycardia.
- ~ Diffused erythema with small plaques; marbled appearance of skin.
- = Strawberry tongue.

<-> Nephritis with uraemia, haematuria or proteinuria.

- Joint pains. Rheumatism of fingers and hands.

[Julian]

Sequelae of scarlet fever

= Cardiac neurosis.

= Disorders of coronary circulation; angina pectoris.

«• Thrombocytopenic purpura [Werlhof's disease].

“Chronic polyarthritis.

~ General debility from [myo] cardiopathy.

= Scaly, dry skin diseases with a red outline, eg, psoriasis, especially in pasty persons [“whereas Diphtherinum is more effective in slim persons and predominantly in heart conditions”].

“Whilst the Diphtherinum patient has a red coating of the tongue and is lean and heart-orientated, the Scarlatinum patient has a clear, smooth tongue as if varnished, and is pasty and bloated with a tendency towards oedema.” [Reckeweg]

CASES

(1) November 30th, 1939. Patient, sent by an old school doctor with the request for “Massage for her legs and feet, for rheumatism.”

She “had rheumatic pains up legs for two years.” Both legs are seen to be mottled, as if from sitting over the fire: but the mottling is back and front. The pains are aching in character, especially in bed. Best position, sitting with feet up. Symptoms indefinite as regards choice of a remedy; but she had scarlet fever as a child, and “it had left her a bad ear.” R Scarlatinum 200, 3 doses, 6-hourly. No massage.

December 14th, 1939. “Walks better. Pain gone from leg. Better in herself.” Next seen, February 15th, 1940. “Better: but still some pain in knees.” Repeat Scarlatinum.

Next seen April 4th, 1940. “The pills were wonderful!”

Next seen October, 1940. For “some pain, left leg” the nosode was repeated, as before. This was her second “Rep.” in eleven months, in which she had been practically well of two years' rheumatism. She had never needed or been given massage.

November 25th, 1940. Looks very well: but, “Just a little pain on outer side of left leg below the knee when going up and down stairs.” Says she “feels a

different woman for those wonderful pills: is afraid to be without them.” [A Little Nosode Case, *Rheumatism - Scarlatinum*’, Homoeopathy 1940; RefWorks]

(2) Young lady with much discomfort from sinusitis. The sinuses sore and a sensation of a tight band across the forehead. Sensation of pressure there when stooping. The condition had been rather acute some months previous and the discharge which she had had ceased suddenly. Sore throat in the morning. Late falling asleep. Depressed, not her lively self. Sulph. 10M, two doses a month apart together with the hot season helped a while but the trouble returned in the fall and the same prescription did no apparent good. She does, however, now blow much mucus at long intervals.

The band sensation is there again. She has “queer,” disturbing dreams. Yesterday she slept thirteen hours from “exhaustion.” No appetite; no ambition; too restless to study; gets pains in the head which she describes as a tightness; flushed face with the pains. I find that she has not been herself since having scarlet fever a year ago. Scarlatina IM [Fincke] has brought decided improvement, general and local.

• Robert, aet. 7. “Not doing well a long time.” The cervical glands slightly but persistently swollen. His eyes are dull and he is pale. He gets a little evening fever sometimes. He had scarlet fever a year ago and was debilitated for a long time after that, “did not recover as he should.” Since the scarlet fever he has had a strong and persistent craving for salt, never before. Scarlatina IM [Fincke], unit dose. In a few weeks he was a changed boy and his craving for salt entirely gone. The craving was so strong and the cure of it so complete that I added “Scarlet” enclosed in erasable parenthesis in the salt rubrics of my repertories.”

[*Two Scarlatinum Cases*’, Homoeopathy 1941; RefWorks]

(3) ... a woman came along: fat and dirty, waddling like a duck as the result of many pregnancies, lower eyelids loose and relaxed, hanging down over her cheeks like brilliant red coxcombs, extremely deaf as well, she had to be bawled at before she could understand a word. She brought an undersized lad of 10 to me with anaemia and severe conjunctivitis. I was still undaunted in spite of past failures, and on her general make-up gave her Sulphur 30 on March 25th, 1941.

The next week the eyes were definitely improved, not so inflamed; she had not gone to the Eye hospital, as the almoner of the clinic had urged her to. Another dose of Sulphur 30; visited and chivied during the week by a visitor

from the hospital on the report of the officious though well-meaning almoner of the clinic.

Seen again on April 22^{n^}, eyes very much worse, had some green paint applied to her eyelids at the hospital which she disliked intensely and thereafter flatly refused to have any further local treatment. I went further into her case and discovered that the eye condition came on after a severe attack of scarlet fever when she was 37 years old, about 10 years ago. They had steadily grown worse and so had the deafness.

She was “up against it” and bore a grudge against everybody because of this blemish. Nobody could help her. It was evidently a chronic condition, the cartilage of the eyelids were much thickened and hardened. “Since an attack of scarlet fever” now conveyed a lot to me. I was triumphant. I should be able to help her. Scarlatinum 200, unit dose, was given on 21st April; no local treatment advised. A week later another dose of Scarlatinum 200, that was on April 29[^].

The mother was not seen again until June 1^{7*1}, 1941, as she had slipped down some stairs during an air raid and injured her left shoulder, but the eyes were much improved and there was hardly any deafness. Scarlatinum 200. Three weeks later she presented herself again, almost unrecognizable, a completely changed woman, clean and spick and span in the morning, with bright cheeks not owing anything to art - clean white silk blouse, and her eyelids well - they were as normal as anybody else’s.

They had turned round, all the red flesh had gone, the cartilages in the eyelids were smooth and thin, and the mucous membranes barely pink, no inflammation at all! A miracle had happened in a short six weeks; she had been made new almost overnight, after suffering from this disfiguring blight for over ten years. It had not prevented her from catching a second husband though in the interval!

[Dorothy Shepherd, *The Magic of the Minimum Dose*]

(4) I just recall another case of discharging ear in a young child following scarlet fever. She had been 13 weeks or more in a fever hospital with it and her ear was very offensive and running freely. Scarlatinum 200 cleared it up in a fortnight and I have known these cases of ear discharge, dating back to scarlet fever, go on for months and months, and even years.

Another girl of 10 who was suffering from bed - wetting and had a foul smelling discharge from her ears due to scarlet fever, was given weekly doses of Scarlatinum 200 and the ear cleared up effectively in a month. It had gone

on for a year previously, and the bed - wetting disappeared as well in three or four weeks, though she had suffered from it for more than five years.

A girl of 14 some years ago came up with static albuminuria, after scarlet fever. Albuminuria which came on as soon as she got up from her bed in the morning and stayed with her as long as she was up and about; her legs were swollen to her knees. *Scarlatinum 200* in weekly doses soon put her right. [Dorothy Shepherd, *The Magic of the Minimum Dose*]

(5) Jan. 12, 1941. Mrs. P, about 30, gaunt and very slender; TB on mother's side; confined to bed several days with dizziness, tends to fall forward, > closing eyes; the vision blurred.

Coughing two months, daytime only, > while warm in bed, < warm air. Has felt heavy and tired a long time, especially mornings.

Tight sensation about the waist. Craves sweets. Chills easily. Backache > continued motion [lumbar region].

Irritable; timidity about noise at night [husband works out]. Driven in a hurry to urinate. Persistent sleepiness. Bony tumefaction on vertex.

What could one do with this mixture of symptoms? Ask for more!

Dulness lower left lung; diminished respiration right lower. But what is this? Ichthyosis? [Dry, rough, thickened skin.] It looks just like it; all over uncovered parts; worst on extremities and back. Scarlet fever at six. Rash did not appear; was sick almost a year.

The skin has been "desquamating" ever since. Finckes Scarlatina IM. One month later. Steady improvement since but has a dreadful nervous spell; cannot do anything; feels as if something awful would happen. I took this to be a moderate psychosis resulting from the radical change that was going on and gave *Sac lac*. Greatly improved since, no further medication needed. [*Scarlatinum Cases*, Hom. Recorder, May 1944; EncHom]

(6) A fine-looking, tall, rather stout, medium-blond lady, aged 59, with so many troublesome chronic symptoms that she has been a semi-invalid for many years, in bed for weeks, sometimes months at a time. This lady looks well but is far from it. She is not a hysterical patient but a woman of great ambition and good judgement. Inheritance poor: cancer; nervous ailments including convulsions and mental deterioration.

Second summer severe diarrhoea, doctor said she could not live. At five years severe chicken-pox, necessitating shaving the hair.

At 7 years: jaundice; many attacks since of liver symptoms.

At 10 years: scarlet fever severe, long lasting; throat symptoms bothersome at times ever since.

Married at 19, first child at 20, easy births. Nausea of pregnancy very severe, for three months.

Years after last childbirth pains fingers, then arms, legs, all over; in bed for weeks and months for this; severe suffering, never quite free from pain. Soreness all over, so cannot bear least touch, even of bedclothes. Chilliness with such attacks, < least draft. Numbness all over or in parts; once lay for three weeks numb all over. Swelling of parts affected. No fever.

Tired all the time, wants to lie down, endurance low. Drowsy; rarely refreshed in morning.

Appetite large; wants fresh fruits, salads.

Nausea severe on trains or in automobiles, spoils any trip she takes.

Sensitivity to any dust: nostrils burn, ache.

Glasses at an early age; never comfortably fitted. Granulated eyelids in childhood.

Headache frequent from childhood, long-lasting, < fat food. Eruptions face, chest, back. Skin dry. Nails brittle. All teeth extracted at thirty-five years. Varicosis since birth first child.

1938 menopause started, lasted nine years, much flooding; then hysterectomy; fibroid discovered.

This patient came to me March 11, 1949 and I watched the complex picture for more than a month before giving her a dose of Scarlatinum, Apr. 22. Before this it was a disordered grouping of symptoms coming and going. All through May reports come of increasing sense of well-being and absence of any of the most troublesome symptoms, especially pains.

July 12 - The dose was repeated because of return of pains and deep soreness, also the old weariness.

Sept. 2 - Went by auto to Atlantic City and actually had no pain and no nausea; could enjoy every minute of the trip. Before, she would be nauseated all the way, go to bed on arrival and again on getting home.

Sept. 17 - Freedom from pain for several weeks.

Nov. 15 - Soreness returned, in bed again. Another dose.

Febr. 15, 1950 - Soreness all over returned again. Another dose.

May 22 - Last report: well until four weeks ago, more soreness and stiffness, with old exhaustion. Another dose.

I suspect the value of the remedy is running out and another study is due.

However, no complaints have been reported for a month.

[J.M. Green, *Results to date using Dr. Tyler's method with nosodes-*, Hom. Rec., Febr. 1951; EncHom]

MATERIA MEDICA STREPTOCOCCINUM

Streptoc.

Sources

- [1] David Riley; *proving* 12C, 3 times daily until symptoms developed; 16 provers [8 females, 8 males]; duration: 10 weeks; 1995.
- [2] Foubister, clinical observations.
- [3] Julian, clinical pathogenesis.

Aetiological factors

“We may consider the prescription of Streptococcin in chronic disease where there is a history of acute streptococcal infection very probably including severe infection in the mother during pregnancy. Given such a history, there are two kinds of case where consideration of a comparatively unproved remedy seems justifiable.

Firstly, when there is unsatisfactory response to reasonably well-chosen medicines; when there is a tendency to relapse, or when there is only partial improvement. Secondly, where streptococcal infection immediately precedes chronic illness or when it is an outstanding event in the history although separated by a comparatively healthy interval from the illness under consideration. Naturally, cases combining these features more strongly suggest Streptococcin, especially when it is difficult to find a similar proved remedy. These remarks can obviously be applied in consideration of other nosodes of acute infectious diseases.

A frequently verified and common indication is severe or repeated tonsillitis or quinsy. Not infrequently in streptococcal patients artificial teeth are acquired early in life on account of gross dental caries. Acute sinusitis may suggest Streptococcin. Acute rheumatism, acute parenchymatous nephritis, erysipelas, puerperal sepsis or other streptococcal manifestations may be taken as indications. In some cases streptococcal infection may or may not have played the major part as in severe influenza, pneumonia, bronchitis, pleurisy, otitis media, meningitis, peritonitis and cholecystitis. Intestinal toxæmia may be associated with increased growth of intestinal streptococci sometimes secondary to amoebic dysentery or other intestinal infection. Scarlet fever has its own

nosode, but Steptococcin sometimes is effective where Scarlatinum fails.

The relationship between streptococcal infection and chronic rheumatism including fibrositis and rheumatoid arthritis is generally recognized, and clinical experience has confirmed the value of Streptococcin in treatment. In the writer's limited experience of about seventy cases, most successful results were seen in rheumatism, chronic bronchitis, cervical adenitis, gastritis and gastric ulcer.

Three cases of psoriasis were very markedly influenced, and one case of disseminated sclerosis of eighteen years standing has been very much improved after getting Streptococcin 30, and later other remedies and Streptococcin 200 in occasional doses during the past three years. It remains to be seen whether or not this is a coincidence. Before the onset of nervous symptoms this patient had several severe attacks of tonsillitis."²

SYMPTOMS

Mind

Weeping.

Some years ago I made a brief study of Streptococcin from about thirty cases. The most definite symptom which emerged was "Weepy, consolation aggravates and this has been of value in confirming several subsequent prescriptions. The streptococcal patient weeps on being given sympathy. This was present in well over half the cases. When this symptom is marked, the patient gives a practical demonstration on the question of the effect of sympathy being asked. Another symptom which emerged although not quite so definitely was "better in the open air."²

Tormenting thoughts. Anxiety.

Thinks he will become insane.³

Fear of cancer.³

Hopeless of his condition and cure.³

Auditory hallucinations, hears cry for help.

Suspicious; that people are talking about her.^{1,3}

Although she had only a moderate fall of hairs, she does not want to go to her office, believing that she looks ridiculous, that everybody mocks her.³

Was suspicious of the people I work with at the school. Strong urge to "bug" the work area or listen in on conversations. Felt they were talking about me.¹

Fear of being attacked.¹

Dreams of being shot.¹

Homesickness.¹

Feel somewhat homesick for Vancouver and my good friends. A bit lethargic and anxious for green spaces, water, and familiar environment.

Changeable mood.¹

Enraged and revengeful.¹

Livid with rage when my ex-husband asks me to go to the store for him. So furious when I leave his house after screaming at him that my muscles hurt all over my body. I'm so angry that I want to slit his tires and bash in all his windows with a bat.

Hurry, haste.¹

Felt the same anxiety that I experienced yesterday. I was very impatient which is out of the ordinary for me. My hands don't shake. But on the inside I am wanting things to happen more quickly than they do. I was watching a video and during the climax I fast forwarded it because I wanted to get to the climax and was tired of waiting. I have never done this before.

Time passes too slowly, appears longer.¹

I felt the same anxiety but it went away after eating today. The radio in my car made me jittery but a cassette tape relaxed me. I felt this desire to have things happen spontaneously. It seemed that everything was taking too long.

Intolerance to noise and light.³

Sensations

- > Of having salty lips.³
- Of intermittent puffs of wind in right ear.³
- Of weakness of the heart.³
- =■ Of vibrations in spine and in limbs.³
- = Of lump on scapula.¹
- Of muscle weakness in forearms and hands.¹
- Body feels larger; head feels light.¹

-
- Head feels heavy and groggy; eyes feel heavy.¹
 - ~ Of a bowl on top of head.¹
 - = Of mucus on teeth.¹
 - = Feel a build up on teeth. I brushed teeth but still feel like I never brushed them.¹

Pus

- = Alveolodental. Gums painful when chewing.³
- = Nose [mucopurulent discharge]. Sinusitis.³
- ~ Acne on forehead.³
- = ■ Tonsils.³
- Around fingernails.³
- Large painful pimples on back.¹
- ~ Pustular eruptions.³

Food

- = Desire for: bread; cold milk; peanut butter; soup; warm food.¹

Sleep and Dreams

- = Restless; dreams of violence and scuffles.¹
- = Dreams of being shot.¹
- ~ Dreams of old friends.¹
 - Dreams during the proving about friends from high school and university.
 - Being in school, travelling with them, going places with them. Some dreams were disconcerting, [prover I]¹
 - Dreams were about past friends and I stood up for myself against them.
 - [prover 13]

Modalities

- ~ < Consolation.
- ~ < Humid weather.²
- < Draft [least current of air].³
- > Open air. Continued motion [beginning to move <].²⁻³
- > Extending the back or leaning backwards [sore pain lower back].¹

Skin

- Redness.³
- = Erysipeloid patches on the limbs.³
- ~ Cellulitis.³

= Desquamating dry eczema.³

Musculoskeletal

= Joint pains with hydrarthrosis [effusion of serous fluid in joint cavity].³

- Inflammatory muscular pains.³

= Rheumatism of small joints of wrist or hand, with redness, sometimes with swelling.³

= Numbness lower limbs.³

= Chronic oedema of lower limbs.³

= Inco-ordination.¹

~ Sore, bruised pain in extremities during motion; after exertion.¹

- Chorea-like movement.³

= Streptococci has certain rheumatic symptoms indistinguishable from those of Rhus tox. and other remedies which one might expect from its pathological relationship of Pyrogen.

“Worse in wet weather, worse on beginning to move, better for subsequent movement.”²

Throat

=> Tonsils swollen, infected, purulent.³

= Persistent pain and redness of throat.³

- Pain on swallowing, extending to ear.¹

= Swallowing difficult, with choking.¹

- Cervical glands swollen and painful to touch.¹

= Respiration difficult while eating.¹

I felt out of breath today many times, especially when eating.

= Food sticking in throat better with fluids. “Like no lubrication in throat to wash it down. Desiring cold milk.”¹

Locals

= Bursting headache with vomiting of bile.³

• White tongue with red tip.³

= Oedema of the face.³

~ Flushes of heat in face on motion.¹

Felt a mild face flush after eating when I stood up. Also felt a warmness and relaxation spread through my body as soon as I started walking.

= Cramping pain in stomach during menses.¹

- Bloody leucorrhoea before menses.¹

= Cracking of spine; cracks 3 or 4 times when leaning back in chair.¹

CASES

R.E.S. Hayes, *Streptococci Reports*-, Hom. Recorder, Vol. 67 no. 7, July 1952; EncHom.

1) Impetigo.

Boy, aged five, one of the two worst cases of impetigo - in fact I had never seen anything like them. The other worst one was his brother, ill with it at the same time. The lesions began on the membranes of the lips, with yellowish crusts. Sulphur had no effect. Three days later, the lips, nose and chin were covered with black crusts, with bleeding from underneath them. The cervical glands were swollen and tender. Tonsils also swollen which caused snoring, which had never occurred before. He was disturbed by any company and by noise. Sepia relieved only temporarily and Lachesis, with Rhus-t. interposed, did nothing. The temperature remained consistently at 103 F; he was thirsty all the time and had a white coated tongue of the strawberry type. Streptococci was then given. Improvement went on four days when the temperature shot up to 105 F; the left axillary glands were considerably swollen and very sore. He kept his hot feet out of bed; felt full after a bit of food. Incontinence of faeces and urine. Marked pallor despite the high temperature and abject weakness. Improvement was more rapid after another prescription of Streptococci IM and he made a good finish.

2) Impetigo.

The case of the brother, aged 8, was even more difficult. A month was consumed in overcoming the disease with its complications. The lesions began on the inside of the wrist and spread up the extremity in one raw, bloody suppurating mass. The discharge of pus was almost incredible. The chin was covered with red crusts. Of course there was serious glandular involvement as with the other boy. Temperature some of the time reached 105 F. Sulphur did nothing. Sepia modified.

Pyrogenium helped once but not a second time. The most distressing feature was involvement of the nerve branches, causing the boy to shriek day and night during the times when the effect of Hypericum would wear off [and he was thirty miles away]. We had four days of this. Hypericum 200 helped but once and the IM twice. Still the pain would wake him. Lachesis 10M helped twice. Meantime the eruption through all this had improved but then began afresh at the original point on the wrist. Streptococci 10M then finished the case in short order. Had I been a routinist much trouble might have been saved, for Streptococci has been said to cure impetigo!

3) Chronic infections, melancholy.

N.J.W., 22, tonsillectomy at 13; mastoid operation a year later, followed by a succession of lancements and sera. Sulphur in various potencies modified acute attacks for a year and a half. Cupressus semp. 6x and 30[^] was a relief after so much Sulphur. Merc. dulc. and viv. made progress for six months. Then Streptococcin 200, 6 doses during the year and one of 1M did more than all the others. Morbillinum carried on for seven or eight months, when the patient thought no more treatment was needed. The reasons for giving Streptococcin were of course the relapses, history of suppressions, melancholy, general debility and loss of spirit especially. These have never relapsed as before.

4) Concretions causing bad taste in the mouth, vertigo, pain in joints.

Mrs. P., 56, much diabetes in family history, also cancer. Obese, weight 220. Dental abscesses at 10, glycosuria at 18, colitis in twenties, tonsil concretions, pyelitis off and on several years, sunstroke. Was under the care of a homoeopath, so she escaped the customary operations. During the first three years under my observation, Pulsatilla at long intervals seemed to do well most of the time, then it failed. Four months after the last 200[^], she had a persistent debility, the concretions were much in evidence, and the bad taste after one popped open would last four or five days. During that period she would have a little dizziness and pain in the joints. Her head felt thick and dull. Had gas pressure and palpitation. Fears at night, craved air. The joint aches were relieved after a copious defecation, but followed by headache. Streptococcin 1M and 10M brought emphatic appreciation of improvement, then Sulphur became the cue to further progress.

5) Eczema of the hands and wrists, cysts of the neck, uterus and ovaries.

A part of a woman came in 1942 [Mrs.P., 47], that is, she was minus tonsils, some cysts that had formed on the back of the neck, the uterus, one ovary and some adhesions that had formed. History of gastric ulcer, mastitis with lancements, bronchopneumonia and much grippe. She had had eczema since fourteen with repeated suppressions; covering the hands and wrists; raw, cracked, and bleeding. The laboratory diagnosed it as eczema, although the eruption had a distinctly fungoid aspect. Graphites three doses, Sulphur one, Sepia two doses, Petroleum one dose, Psorinum one dose and Kali muriaticum 6 and 12, these at intervals during eight years had pretty well cleared the skin and, of course, the general health was much better. Then the eruption

started all over again acutely, with red vesicles, “it felt good to scratch,” lips also sore, dry and cracked in the corners. Streptococcin 10M and 50M, three months apart, and nine months later Sulphur 200. No symptoms the last seven months.

6) Vaccinosis, arthritis.

Mrs. MacD., 49, had a tight sensation in the head for which she had had a series of inoculations. Then a sudden attack of arthritis, lasting six weeks during which she consumed four hundred aspirin tablets. Present history was that she gets attacks every few days, which come suddenly and severely, lasting two or three days. The foci are wandering, rather worse on the left side, with stiffness and swelling, The character of the pain is soreness, throbbing, piercing like a knife. The attacks always begin in the afternoon, are positively worse in damp weather, by change of weather, approach of storm, relieved by heat. Heat waves accompany the onset of the attacks. She has cold feet. Streptococcin 10M checked the attacks for a month, then the symptoms were so pronounced for Psorinum that I switched to that remedy. The 3M and 10M did good work. Then Sepia 10M. No attacks have appeared during the last year and a half.

7) A case of disseminated sclerosis.

A woman of thirty-three came with a history of transient paralysis since she was eighteen years of age. She had been informed that although her condition would get better and worse, she would never completely recover. At the time of examination, in September, there was loss of sensation for heat and cold in both inferior extremities up to the inguinal region, and the knee jerks were uneven. After working out the case carefully, Causticum was prescribed with little benefit. On going into her previous illnesses, there was a history of having had a series of severe tonsillitis preceding her nervous disorder. Streptococcin 30c, one dose, was given in October. Her symptoms cleared up in a few weeks and she was very well thereafter, except for a transient weakness in one leg the following March, which did not necessitate her staying off her work as a waitress. Streptococcin 30c, 200c, and 1M on three consecutive mornings was given, and there was no further trouble. This of course may be a natural remission, in spite of the fact that both the patient and her sister said she had never been so well since the onset of her troubles fifteen years ago. [Foubister, *Tutorials on Homoeopathy*]

CLASS CLOSTRIDIA

I. ORDER CLOSTRIDIALES

I A. Family CLOSTRIDIACEAE

I A. FAMILY CLOSTRIDIACEAE

Clostridium botulinum

Clostridium difficile

Clostridium perfringens

Clostridium tetani



CLOSTRIDIUM

FEATURES

- Members of the genus Clostridium are Gram-positive, obligate anaerobic, motile, spore-forming rods.
- Ubiquitous saprophytes in nature; especially found in soil.
- Clostridia play a vital role in atmospheric nitrogen fixation and converting it to the ammonia-like side chain of amino acids, nucleotides, and other organic compounds.
- Opportunistic pathogens.
- Form endospores within parent cells that are resistant to heat and desiccation and which may survive for years without water and nutrients.
- Employ butyric [relating to butter] fermentation pathways for energy production.
- Produce end products such as butyric acid, acetic acid, butanol and acetone,

and large amounts of gas during fermentation of sugars. A variety of foulsmelling compounds are formed during the fermentation of amino acids and fatty acids. [Butyric acid is an acid of unpleasant, rancid odour occurring in butter, cold liver oil, sweat, and many other substances. It is also present in the intestines and in gastric juice.]

- Four clinically important species are distinguished:

- * *Clostridium botulinum* - associated with botulism.
- * *Clostridium difficile* - associated with pseudomembranous colitis.
- * *Clostridium perfringens* - associated with gas gangrene [wound infection] and food poisoning.
- * *Clostridium tetani* - associated with tetanus [lockjaw].

CLOSTRIDIUM BOTULINUM

| | |
|------------------------|---|
| Scientific name | <i>Clostridium botulinum</i> (van Ermengem 1896) Bergey et al. 1923 |
| Family | Clostridiaceae |
| Homeopathy | Botulinum - Botul. |

FEATURES

- Worldwide distribution in soil, freshwater and saltwater sediments, household dust, and on the surfaces of many foods.
- Survives harsh conditions due to formation of spores.
- Colonises the gastrointestinal tract of fish, birds and mammals.
- First described in 1895 by Van Ermengem, who isolated the organism from raw salted ham in a food poisoning outbreak in Belgium. Van Emergem likened the outbreak to sausage poisoning and proposed the name *Bacillus botulinus* [from *L. botulus*, sausage] for the causative organism.
- Different strains of botulism-causing organisms produce 7 types of neurotoxins, which are designated A through G. Types A, B, E, and F cause human disease, the first two being most virulent since they are resistant to breakdown by gastrointestinal enzymes.
- Botulinum toxin is a zzw-c-containing endopeptidase that blocks the release of the neurotransmitter acetylcholine, without which muscles are unable to contract, resulting in flaccid muscle paralysis. [The venom of various snakes in the cobra family also inhibits acetylcholine release; hence the similarity between the symptoms of botulism and those of *Naja*.]
- Foodborne outbreaks of botulism are most often caused by type B, followed by type A and type E. [Reverse in the USA: type A most frequent, followed by type B.]
- *C. botulinum* spores are heat-resistant, whereas the toxins are readily destroyed by heat.
- Animals susceptible to botulinum include chickens, ducks, wild birds, mink, cattle, and horses; dogs, cats, and pigs are relatively resistant to it.

CATEGORIES OF BOTULISM

The WHO* recognises five clinical categories of botulism, according to the mode of acquisition:

- Foodborne botulism.

Home-prepared and home-preserved foods [often inadequately pasteurised vegetables] in North America, and fish, uncured ham or sausages in Europe are the most frequent cause of poisoning. Home-preserved foods containing fish, vegetables, or potatoes are often involved in outbreaks of botulism, in particular low-acid [i.e. higher pH] vegetables such as beans, peppers, carrots, spinach, asparagus, and corn. Non-acidic foods need to be pasteurised twice, at 24h intervals, to kill the bacteria generated from the surviving spores.

When *C. botulinum* types A and B grow in low-acid foods of bland taste, a foul and rancid odour [butyric acid, etc.] is generally observed.

The CDC suggests attention to the following cardinal features:

- ~ Patient is afebrile unless another infection is present.
- ~ Patient demonstrates symmetrical [descending] neurological symptomatology.
- ~ Clear mentation; patient remains responsive.
- = Patient has a normal or slow heart rate in the absence of hypotension.
- = Signs typically are not accompanied by sensory deficits, with the exception of blurred vision.

- Wound botulism.

Associated with trauma, surgery, subcutaneous heroin injection [notably “black tar” heroin], and sinusitis from intranasal cocaine abuse.

A review of 40 cases of wound botulism showed that most of these cases involved puncture wounds, open fracture, lacerations, crush injuries, shotgun wounds, drug abuse [abscesses], and surgical incisions. Gastrointestinal manifestations are absent.

- Infant botulism.

This is caused by the absorption of toxin produced by *C. botulinum* that

colonise the intestinal tracts of infants under one year of age. It is in 15% of cases [but unknown in 85%] associated with ingestion of raw honey [may contain *C. botulinum* spores] and the first clinical sign is usually constipation. After a few weeks, progressive weakness and poor feeding are observed. The weakness is symmetrical and descending. It evolves over hours or several days. The infant is afebrile and has a weak cry, has either absent or diminished spontaneous movements, decreased sucking, floppy head and decreased motor response to stimuli. The autonomic nervous system manifestations include dry mucous membranes, urinary retention, diminished gastrointestinal motility, fluctuation of heart rate, and changes in skin colour.

Infant botulism progresses for 1-2 weeks and stabilises for 2-3 weeks before recovery begins. The average length of a hospital stay for infants is approximately 1 month, although excretion of toxin and organisms may continue for more than 3 months following discharge.

Adult intestinal colonisation botulism has been identified recently. Similar in pathogenesis to infant botulism, this form occurs in older children and adults in the presence of colitis, with a recent history of bowel surgery, or in association with other conditions that may create local or widespread disruption in the normal intestinal flora.

Predisposing factors for intestinal botulism: achlorhydria; chronic antibiotics; gastrectomy; intestinal surgery; Crohn's disease.

- Adult infectious botulism.

Occurs as a result of intestinal colonisation with *C. botulinum* and in vivo toxin production in a manner similar to that of infant botulism. These patients often have a history of abdominal surgery, achlorhydria, Crohn's disease or recent antibiotic treatment. The disease may simulate Guillain-Barre syndrome.

This rare disease should be suspected in patients with some abnormality of the gastrointestinal tract who develop cranial nerve autonomic dysfunction, and muscular weakness.

- Inadvertent botulism.

This has been reported in patients who have been treated with intramuscular injections of botulinum toxin. Marked clinical weakness is observed as well as electrophysiologic abnormalities. [*See below.*]

All categories of botulism display basically identical neurological signs and symptoms: an acute, afebrile, symmetrical, descending flaccid paralysis beginning in bulbar musculature and successively affecting the upper extremities, then the respiratory muscles, and finally, the lower extremities in a proximal to distal manner.

- Clinical differentials.

Botulism resembles:

- * Diphtheria.
- * Encephalitis.
- * Guillain-Barre Syndrome.
- * Cerebrovascular Accident.
- * Hypermagnesemia.
- * Hypocalcemia.
- * Lambert-Eaton Myasthenic Syndrome.
- * Myasthenia Gravis.
- * Congenital neuropathy or myopathy.
- * Mushroom [muscarine] poisoning.
- * Atropine poisoning.
- * Shellfish poisoning or puffer fish poisoning.
- * Organophosphate poisoning.
- * Poliomyelitis.
- * Tick paralysis.

* World Health Organisation, International Programme on Chemical Safety, Poisons Information Monograph 858, Bacteria, Clostridium botulinum.

FOODBORNE BOTULISM

Described in the old homeopathic literature as food poisoning from “bad sausages,” the first accounts by Kerner of sausage-poisoning date back to the 1820s. Spoilage was noted in the 230 cases of sausage poisoning described by Kerner; hence the illness became known as “Kerners disease” and warnings were issued against consumption of spoiled sausages.

A lengthy yet first-rate review of case reports from the 19th century is given by Boehm [incidentally disclosing a striking similarity with the Gelsemium drug picture]:

The putrefied sausages, or portions of sausage, when recently cut across, have a dirty, greyish-green colour, and a soft cheesy-like, smeary consistence. They diffuse a very disagreeable smell of putrid cheese; the taste is disgusting, and sometimes causes smarting or soreness in the throat.

... The course of botulismus is, as a rule, subacute and very commonly chronic. Cases running a very sudden course are rare. Under all sorts of circumstances poisoning by sausages is more tedious than most cases of poisoning by other well-known poisons. Even a fatal termination, as a rule, seldom closes the sickness in less than five or six days.

The first symptoms of poisoning occur in the majority of cases in from eighteen to twenty-four hours after taking the injurious food.

... The gastrointestinal symptoms do not invariably precede the nervous symptoms; often enough both occur simultaneously. As a rule, however, the sufferers complain at first of general discomfort and nausea, pain and sense of weight in the region of the stomach, quickly followed by diarrhoea and vomiting. Very often colicky pains, which disappear and then return again after a while, are the first symptoms, the severer symptoms not setting in till some days after. Sometimes also the scene commences with violent vomiting and retching, vertigo, cloudiness of vision, and difficulty in swallowing; lastly, the gastrointestinal symptoms may be entirely absent, and the difficulty in swallowing, disordered vision, muscular weakness, and general prostration constitute the disease.

Dyspnoea and feelings of suffocation [precordial anxiety] have been especially mentioned as being not infrequently some of the early symptoms.

Although this condition is often protracted for several days with indefinite disorders, partly gastric and partly nervous, during which the patient very commonly goes about his usual business or occupations, in the majority of cases there is very soon so much weakness that they cannot long keep out of bed. The vomiting, often so troublesome at first, and sometimes, though rarely, persisting in the form of tormenting feelings of choking and retching, the diarrhoea and the colicky pains all recede into the background, and give place to the nervous symptoms.

These are in part of a general nature, and in part limited to special regions and nervous tracts. Consciousness and thought, and all the special qualities of soul which are called the higher faculties, remain, with but few exceptions, intact all through the whole course of the attack, although giddiness, headache, and an apathetic comatose condition in many cases indicate anomalies in the functions of the brain.

Any definite paralysis of the voluntary muscles or of sensation has never been noted, any more than clonic or tonic spasms. It is rather extreme muscular weakness - which limits to the most minimal degree the exercise of the voluntary muscles, but never till just before death renders it impossible - than an actual paralysis. Any marked disorders of sensation are also absent, although the sensibility of the tips of the fingers is said to be diminished, and sometimes the patients complain of crawling and painful feelings in the extremities and back. Moreover, it is expressly declared that sleep generally occurs in a perfectly normal way.

The visual apparatus suffers in a very extraordinary way in sausage-poisoning. The first complaints of the patients point to diminished visual power, and are sometimes complained of as a cloud or mist before the eyes, sometimes as sparks, and sometimes as mere weakness of sight. Very soon there is double vision, with diminished acuteness of vision; the powers of the ocular muscles are greatly limited, and sometimes quite abolished, and one of the most constant symptoms is paresis of the levator palpebrae superioris [ptosis]. The pupil is dilated, but does not become quite insensible to light; finally, the faculty of accommodation seems considerably lessened. Indeed, in some cases total blindness has been observed.

Whilst, then, all the remaining nerves of sensation preserve their faculties unimpaired, some of the nervous apparatus subservient to respiration appears to undergo very extensive changes. This is indicated by the more or less perfect aphonia of those poisoned, with the varying degrees of general difficulty of breathing, and the frequently noted tormenting, and sometimes croupy cough, which, however, may very seldom really stand in close connection, as to their true cause, with the difficulty of swallowing [dysphagia], so that when nourishment is being taken, whether food or drink, a portion may easily find its way into the air passages.

The disorders in the domain of the glosso-pharyngeal nerve are expressed in the almost pathognomonic symptom of dysphagia, which sometimes culminates in perfect aphagia or complete inability to swallow. The tongue also appears more or less hampered in its movements, and speech becomes stammering and unintelligible.

The remarkable dryness of the mouth and fauces indicates anomalies in the secretion of saliva. The mucous membrane of the mouth and pharynx shows either speckled or diffused redness, sometimes one, sometimes the other; sometimes there are also swelling, and aphthous formations; the tongue has a whitish coat. Lastly, the constipation which is constantly observed in the later stages, and

the less constant retention of urine, must be considered as nervous symptoms.

The signs of need of nourishment are often rather more manifest than is usually the case; some patients complain of hunger, the above-named difficulty of swallowing making it almost or entirely impossible to take nourishment. Thirst is mentioned only in a few cases. The organs of circulation appear greatly weakened in their functions. The pulse, which at first is feeble and slower than usual, vanishes sometimes altogether. Indeed, authors maintain that it is impossible in the later stages to make out the sounds of the heart. Accordingly, we find the skin pale, and the mucous membranes of a livid colour. The failing energy of the circulation is shown by the coldness of the skin. The rapid decrease of the nutrient powers, the great emaciation, are the unavoidable result of the want of power to take food, and the disordered functions of the digestive organs.

The organism, thus condemned to hunger, may, however, last a remarkably long time, unless the introduction of food into the air passages, by causing oedema of the lungs, brings life to a more rapid end. As a rule, notwithstanding the long-continued depression of the circulation, there is not generally any oedema, with the exception of a few cases in which the formation of marasmic thromboses may give rise to it. Death generally occurs without any specially violent symptoms; it is preceded by a comatose or soporific condition, sometimes with slight general convulsions, from one day to three weeks after the poisoning. Those cases which end favourably are often marked by a very slow convalescence, in which the disorders of vision, and the difficulty in swallowing often persist for a long time, and the patients' strength returns to them very slowly and gradually. In some cases desquamation of the epidermis has been noted.

[cited in von Ziemssen 1878]

FROM BIOWEAPON TO BIODRUG TO COSMETIC CRAZE

Because botulinum toxin carries a high morbidity and mortality, it is considered a biological warfare agent. It is classified by the CDC as a category A threat to national security due to its easy dissemination.

Development and use of botulinum toxin as a possible bioweapon began at least 60 years ago. The head of the Japanese biological warfare group [Unit 731] admitted to feeding cultures of *C. botulinum* to prisoners with lethal effect during that country's occupation of Manchuria, which began in the 1930s. The US biological weapons program first produced botulinum toxin during World

War II. Because of concerns that Germany had weaponised botulinum toxin, more than 1 million doses of botulinum toxoid vaccine were made for Allied troops preparing to invade Normandy on D-Day. ... After the 1972 Biological and Toxin Weapons Convention prohibited offensive research and production of biological weapons, signatories Iraq and the Soviet Union subsequently produced botulinum toxin for use as a weapon. ... Four of the countries listed by the US government as “state sponsors of terrorism” [Iran, Iraq, North Korea, and Syria] have developed, or are believed to be developing, botulinum toxin as a weapon. After the 1991 Persian Gulf War, Iraq admitted to the United Nations inspection team to having produced 19,000 L of concentrated botulinum toxin, of which approximately 10,000 L were loaded into military weapons. These 19,000 L of concentrated toxin are not fully accounted for and constitute approximately 3 times the amount needed to kill the entire current human population by inhalation. [Amon et al., Botulinum Toxin as a Biological Weapon; Journal of the American Medical Association, 2001; 285 (8): 1059]

Amon et al. find it “regrettable that botulinum toxin still needs to be considered as a bioweapon at the historic moment when it has become the first biological toxin to become licensed for treatment of human disease.” In the United States, botulinum toxin is currently licensed for treatment of cervical torticollis, strabismus, and blepharospasm associated with dystonia. It is also used ‘off label’ for a variety of conditions that include migraine headache, chronic low back pain, stroke, traumatic brain injury, cerebral palsy, hemifacial spasm, writer’s cramp, spasticity in cerebral palsy in children, stammering, spasmodic dysphonia, voice tremor, urinary retention, as well as excessive sweating.

There are two toxins in use: botulinum toxin type A, brand name Botox, since 1990, and botulinum toxin type B, brand name Myobloc, since 2001. Both are applied by local intramuscular injection, temporarily paralysing the muscle. Improvement is not long lasting, so that treatment is usually repeated every 3 to 4 months.

In April, 2002, the FDA approved the employment of botulinum toxin type A as “Botox Cosmetic” to “temporarily improve the appearance of moderate to severe frown lines between the eyebrows.” In placebo-controlled, randomised clinical trials involving a total of 405 patients with moderate to severe frown lines who were injected with Botox Cosmetic the severity of the

frown lines was reduced somewhat for up to 120 days for those patients who received the toxin. Because “the overall result can be a more symmetrical appearance,” and “furrowed brows become smooth, squinting eyes relax and the years seem to recede,” the cosmetic treatment has caught on to the extent that now in the USA “Botox parties” are thrown, a development frowned upon by the medical establishment. Such parties have the future for wrinkles have a habit of returning. Legions of people line up to restore their fading beauty, desperate to look younger at any cost rather than growing older gracefully. What an irony that an intoxicating social delusion of looks being everything is maintained with a neurotoxin pronounced as “Beau-Tox.”

Repeated treatments may result in atrophy or thinning of muscles, leaving the face expressionless, mask-like, an effect known to appear with botulinum. Attempting to bring the ageing process to a standstill requires that one must turn a blind eye on the possible long-term effects of this “safe and effective treatment.” Chronic sequelae may still be largely unknown, it won’t take much to understand in which direction they will be going.

Adverse effects

Side-effects of the fastest-growing cosmetic procedure in the USA appear to be limited to minor discomfort and short-lived local reactions. Documented and undocumented case reports, however, tell a different story.

Blockade of neurotransmitter release at peripheral cholinergic nerve terminals is permanent; recovery only occurs when the axon sprouts a new terminal to replace the toxin-damaged one. The most common adverse events following injection of botulinum toxin type A were headache, respiratory infection, flu syndrome, droopy eyelids, neck pain, and nausea. Less frequent adverse reactions [less than 3% of patients] included pain in the face, redness at the injection site and muscle weakness. These reactions were generally temporary, but could last several months. [FDA Talk Paper T02-20]

Complications are more common when Botox is used in the lower face, including drooling, an asymmetrical smile, and repeatedly biting the inside of a flaccid cheek. With injections into the platysma muscle, difficulty in swallowing and changes in vocal pitch may occur. [The platysma muscle depresses the lower lip, and wrinkles the skin of neck and upper chest.] Studies of the side effects of botulinum toxin type B in 570 subjects showed that dry mouth and dysphagia were the most frequently reported adverse events.

The following additional effects were reported by at least 5% of patients treated with type B botulinum:

- = Neck pain [17%].
- « Headache [11%].
- = Dyspepsia [10%].
- = Nausea [8%].
- = Flu syndrome [8%].
- = Torticollis [8%].
- = Joint pain [7%].
- = Back pain [7%].
- = Cough increased [7%].
- == Myasthenia [6%].
- «Asthenia [6%].
- = Dizziness [6%].
- == Rhinitis [5%].

In 2% or greater of patients participating in any of the clinical studies these reactions occurred:

- = General: allergic reaction; fever; headache; chest pain; chills; hernia; malaise; abscess; viral infection.
- = Musculoskeletal: arthritis; joint disorder.
- ~ Cardiovascular: migraine; vasodilation.
- = Respiratory: dyspnoea; lung disorder; pneumonia.
- » Neurological: anxiety; tremor; hyperaesthesia; somnolence; confusion; vertigo.
- Digestive: gastrointestinal disorder; vomiting; glossitis; stomatitis.
- « Urogenital: urinary tract infection; cystitis; vaginal moniliasis.
- = Special senses: amblyopia; otitis media; abnormal vision; taste perversion; tinnitus.

[Data from: www.rxlist.com/cgi/generic2/botulinumtoxin_ad.htm]

Allergan Inc., the manufacturer of Botox, states that “there have been rare spontaneous reports of death, sometimes associated with dysphagia, pneumonia, and/or other significant debility, after treatment with botulinum toxin.” And: “There have also been rare reports of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including

cardiovascular disease. The exact relationship of these events to the botulinum toxin injection has not been established. The following events have been reported since the drug has been marketed and a causal relationship to the botulinum toxin injected is unknown: skin rash [including erythema multiforme, urticaria and psoriasiform eruption], pruritus, and allergic reaction. ... Dysphagia and symptomatic general weakness may be attributable to an extension of the pharmacology of Botox resulting from the spread of the toxin outside the injected muscles. ... Inducing paralysis in one or more extraocular muscles [in the treatment of strabismus] may produce spatial disorientation, double vision, or past-pointing. The incidence of ptosis was 0.9% after inferior rectus injection and 37.7% after superior rectus injection.”

MATERIA MEDICA BOTULINUM

Botul.

Sources

- [1] Proving British School of Homoeopathy [Anthony Bickley], 2004; 12 provers, placebo [1 prover, no symptoms], 12c [2 provers], 30c [2 provers], 200c [2 provers], 1M [2 provers], and 10M [3 provers]; single dose. Extracts/summaries of symptoms by Lisa Mansell and Debbie Schofield. [LD]
- [2] Fragmentary description by Boericke, based on a food poisoning from canned spinach. [B]
- [3] Botox intoxications.

Eye symptoms, ptosis, double vision, blurred vision. Difficulty in swallowing and breathing, choking sensation; weakness and uncertainty in walking, “blind staggers,” dizziness, thickening of speech. Cramping pain in stomach. Mask-like expression of face, due to weakness of facial muscles. Severe constipation. [B]

Indications

The classical triad of botulism in combination with the various D’s of cranial nerve palsies can serve as a guideline for Botulinum:

1. Absence of fever.
2. Clear sensorium.
3. Symmetrical, descending flaccid paralysis with prominent cranial nerve palsies.

-
- Dizziness.
 - = Drooping eyelids.
 - <= Diplopia.
 - = Dysarthria.
 - <= Dysphonia.
 - = Dysphagia.
 - = Dryness mouth.
 - = Diminished gag reflex.
 - Dyspnoea.

Clinically, Botulinum can be considered for myasthenia gravis, which is characterised by muscle weakness chiefly in muscles innervated by cranial nerves: drooping eyelids [ptosis], diplopia, dysarthria, dysphagia. Sensory modalities and deep tendon reflexes are normal in both myasthenia gravis and botulism.

Individual symptoms - Botox intoxications

Statistical assessments of adverse reactions give an indication as to affinities and general symptoms, while reports of intoxications can be utilised to obtain individual symptoms. For this purpose I have screened websites* for personal accounts of “botox complications” to get an idea of the drug picture of Botulinum.

- = Sensation as if one is going to die.
- = [After third injection in three years] ... “never had a problem and bam ... insomnia, panic attacks and anxiety big time.”
- <= Itching skin lesions looking like “raised” comedones on forehead and between eyebrows.
- => Eyebrows arched and raised up high; expression of being “overly surprised.
- = Diplopia, appearing suddenly; extreme; inability to drive a car.
- Sensation as if eyes were swollen.
- = Muffled hearing accompanied by tingling of ears and face.
- > Slurred speech.
- = Numbness and stiffness of jaw and external throat; burning at back of tongue, extending down the arms and legs.
- <= Severe chronic contraction of entire nape of neck; atrophy of neck muscles.
- = Nape of neck stiff and painful.
- Weakness of nape of neck; can hardly hold up head.
- = Continuous tremor of arms and hands. making all activity very difficult.

= Hands weak, clumsy and tingling.

-> Numbness, tingling and burning sensation left lower limb.

- Inability to walk.

<= Sleeping problem, “it feels as if I am falling and then I jolt [which wakes me up].”

<= Tremor all over body and dizziness; bedridden.

= Sudden feeling of illness; must lie down for a few hours.

= Numbness left side of body.

« Flu-like symptoms [without fever]; “I was in bed for 4 straight days with horrible body aches, sore throat, nausea, and my lungs feel as though I can’t breath.”

- Urticaria [“itchy welts”], coming up around 9 p.m. or at night, either on stomach region and forearms or on back and legs, disappearing in morning around 10 a.m.

• Intensely burning pains < slightest touch.

* [1] Botox Forum at www.secure-practices.com/forum/; [2][www.botoxusers.com.](http://www.botoxusers.com/); [3] legalnewswatch.com/

Repertory

Synthesis 9.1 lists 36 symptoms for Botulinum, most of them in large, nondescript rubrics, with the following in rubrics containing less than 50 remedies:

⇒» Head, Paralysis of brain, Medulla oblongata [= bulbar paralysis].

- Eye, Complaints of eyes.

= Eye, Paralysis, Lids, upper.

<= Face, Expression, mask, immobile like a.

- Face, Expression, mask, immobile like a - from weakness of facial muscles.

= Face, Stiffness, paralytic.

= Face, Weakness, Muscles.

- Mouth, Speech, thick [= slurred].

= Throat, Choking, sensation of.

= Respiration, Difficult, when talking.

~ Extremities, Awkwardness, Lower limbs.

•> Extremities, Weakness, Lower limbs, while walking.

== Generals, Brucellosis, chronic.

= Generals, Food and Drinks, spinach agg. [Should be canned spinach!]

- Generals, Paralysis, after diphtheria.

= Generals, Uraemia, chronic.

PROVING SYMPTOMS

THEMES

Excitation - Inhibition

“Going back to the biological explanation of the effect of Botulinum resulting in Inhibition or to Excitation. From what we’ve seen so far, this action really sums up the overriding theme of the substance. Disturbances of *inhibition and excitation* were seen throughout the body resulting in unusual sensations, tightening, uncontrollable twitching of some muscles and the release of the muscles of the tongue enabling the prover to roll it. There was an increased tolerance to alcohol - which normally reduces inhibition, whilst appetites were described as being ‘out of control’.

This theme of tightening and release was seen very clearly on the mental level. In particular, many provers experienced a release from control - and very specifically, from the control that their *inhibitions* would normally hold over them and as a result they manifested a far more ‘*excited*’ response than usual. This was experienced in terms of feeling less inhibited in social situations, less inhibited sexually and less inhibited in situations of conflict or confrontation where they lost their normal self-control and said what they really thought. Interestingly, many specifically used the word ‘inhibitions’ or ‘inhibited’ to describe these experiences. For some this was a positive response, in that the reduced inhibition freed them from the control they had exercised before. Others felt less comfortable with being out of control.” [LD]

Substance seemed to remove my inhibitions for a short while.

A layer of veneer has been scraped of my tight control, feels as if inhibitions have been lowered

Happier and have reduced inhibitions, more relaxed, laughing a lot.

Less inhibition, less control and less self suppression.

Far more spontaneous than normal.

Was the opposite of inhibited. It had to come out. I articulated clearly and was very focussed.

Feel more comfortable with emotions and able to express them more, don't bottle them up like usual. Social life very active. Not as negative, selective or shut as usual.

Unable to control emotions regarding the past which had been previously suppressed.

Desire to grope opposite sex.

Libido out of control.

Far too busy indulging excessive libido to notice any other symptoms.

Time sense

“An area where these symptoms of control and release were seen was that of *Time*. Provers’ time management was noticeably affected, with them becoming more organised or more disorganised. Several reported increased efficiency in doing their homework and found that they sat down to do it straight away on the Sunday evening they returned from college. Provers’ perception of time was affected - they lost track of time, misjudged how much time had passed - either underestimating or overestimating. Several overslept - waking up quite a bit later than usual but - to use the words of some of them - they ‘couldn’t give a shit!’” [LD]

No sense of time.

Planned to meet friend after class and felt I’d been waiting for hours but it had only been 5 minutes.

Time felt more normal, but cooking proved it is still slipping. I was watching the grill but left the sausages too long and burnt them.

Time just disappears.

Talked for what seemed like 20 minutes, but when I looked at my watch it had been nearly 2 hours.

Time is out of sync. When I went to fetch my son from school, I couldn’t remember if I had dropped him off in the morning.

Woke very late - 11 a.m. - unusual for me.

Woke up thinking it was an hour later than it was which would have made my son late for school but I didn’t care.

Time-keeping unusually important to me. Very irritable if delayed.

Sense of time different. Time went more quickly because more focussed.

Don’t normally juggle timings well when cooking. However, managed to keep all balls in the air without a second thought.

Looked at clock non-stop.

Constantly aware of time. Want to be ahead of time.

Short memory deficits

“*Memory Power* was severely impaired — especially short term memory. One prover managed unfortunately to lose all recollection of her birthday - her friends had arranged to take her out - she knew that she went out and that she had a nice meal, but had no recollection of it. Something that must surely be an SRP is that a number of provers recorded being totally unable to remember the content of the days’ lectures! A couple noted the sensation of being on autopilot - they knew they got where they did or did what they had done, but were unaware of actually doing it.” [LD]

Made mistakes at work - went to the Post Office but forgot to post the parcel. Only vague memories of the days’ lectures. I don’t remember driving home or cooking the evening meal, but I know I did.

Can’t remember if I’ve eaten or not. Always hungry, but if I ask, I have eaten. Forgot to prepare a report for a meeting. Forgot to prepare copies of accounts. Went back and got them and then when handing them out, realised they were the wrong ones. Couldn’t remember which drawer they’d come from so couldn’t put them away. Couldn’t focus on the substance of the meeting. Wasted time on unimportant things.

Sat through lectures but not really hearing anything. Couldn’t remember.

Forgetful - keep forgetting to take things with me and have to run up and down stairs for forgotten items.

Cannot remember words - can visualise the item but not its name.

Mislaid my eldest son - I forgot he was going to the hairdressers after school.

Parenting

“The theme of *Parenting* was a striking issue. Provers recorded feelings of guilt and inadequacy as parents. There were also overwhelming feelings of love for their children and other family members, plus a readiness to fight if necessary to protect them.” [LD]

Felt I was a terrible parent.

Feeling a lot of guilt around not having properly attended to the children. Have become acutely aware of it since yesterday. Feel neglectful.

I feel very passionate about my children. Want to hold them, reach out. Tears come into my eyes when I think about them. Bursting with love for them. This feeling came on suddenly.

I’m normally stubborn - unusually I relented towards my son and felt better for it.

It's my place to protect my daughter. I'm her mother and it doesn't matter a scrap that she's nearly 25 and can look after herself.

I was going to fight for my husband. This remedy has made a huge difference to my desire to speak.

“This theme of parenting was reflected in some of the dreams. Provers dreamt of their children dying, yet in their dreams were apparently unaffected by their deaths.” [LD]

Cats

“When we were researching Botulinum, we discovered that there are three animals that are relatively resistant to it, one of which is the cat. We don't know whether or not there is any connection, but cats featured quite prominently in the proving.” [LD]

Was accused of stalking like a cat.

My partner commented that I made cat-like sounds in my sleep.

Dream of two cats in boxes on desk, cats were squashed, prover doesn't like cats. My cats have become obsessive about touching me, nuzzling and rubbing my face and hands. They seem particularly fascinated by my mouth, sniffing repeatedly at my lips particularly happens when I am writing up my diary as if to prevent me. Standing on the diary, chewing the pen, getting on my chest between the diary and my face so that I couldn't see. Abnormal behaviour for them.

Dream about a kitten eating marshmallows.

During the proving cats from the neighbourhood started to accompany me on walks with the dog. Sometimes up to 6 cats, number diminished as the proving symptoms abated.

GENERALS

Pains

sss As if *bruised*.

= *Sharp* [as from a sharp piece of glass behind eye; needle-like in right wrist joint; as if with a very fine stiletto (period pain); like a little sharp pinball shooting around and going down little tubes (period pain)].

~ *Sudden*.

Sensations

= *Tightness* [top of head; nose (sinus pain as if tight); throat; abdomen; rectum; legs (as if swollen and tight); skin of finger; skin of back; skin of feet].

=> Other sensations:

As if a worm were burrowing in head.

As if a taut elastic band were pulling on brain, on turning head to right.

As if had been beaten across the back of the head.

As if arms were too long.

Food

- Ravenous hunger [4 proverbs].

= Increased thirst [3 proverbs; one proverb felt thirsty after drinking tea].

- *Cravings*: Bananas; carbohydrates; chocolate; crisps; eggs; ham; pizza [for breakfast]; salt.

= *Aggravation*: Grapes.

Sides

«. There was a tendency for symptoms to move from *left to right*.

Fluid balance

~ *Weight* fluctuations and changes in waist measurement. Abdominal distension and oedema.

Abdomen really bloated, feels like a water filled balloon.

Waist measurement can fluctuate by up to 2 inches through the day.

General feeling of being bloated especially in waist.

Bloated during menses, sensation as if abdominal walls thicker with fluid [not air]. Feel enormous heavy and big weight fluctuations - not normal - increased by 21b in one day.

Weight increased by 61b in one week.

Left leg won't bend because of swelling; sensation as if tingly, swollen and tight.

Left eye swollen mainly underneath and slightly above, fluidy puffy bag under eye.

Left eyelid swollen right up to the eyebrow.

Hands very puffy and swollen.

Urine concentrated and is constipated as if all fluid in the body was in the wrong place, in puffy extremities rather than in the gut.

Menses

“One area in which there was a marked influence was Menses. There were many cured concomitants such as pain, diarrhoea, pmt, headache, menorrhagia, breast tenderness. Six provers had their periods start up to two weeks early and for most of these the flow was different - usually lighter, fewer clots, intermittent, watery. In fact, one of our provers thought that she was unlikely to experience proving symptoms as she felt she wasn't very sensitive - however, the pattern of her menstruation which had been secure for 25 years changed dramatically.” [LD]

LOCALS

Vision difficulties

Strange focus as looked out of window shortly after taking substance, a 3D effect.

Vision is worse today - like everything is in soft focus.

Ongoing visual disturbance. Started with left eye and now right, at the edge of my vision.

Eyesight poorer than normal hard to read printed text.

Seeing small mouse type things out of the corner of the eye.

Odd visual experience as if going to get a monster headache.

Eyes terribly sensitive to light. Feel disorientated by bright light, can't see. Couldn't focus on small print during the day, couldn't adjust eyes to small from large print, feels as if eyes have aged 10 years.

Dry mouth and difficulty swallowing

Throat feels as if closing up within minutes of taking substance, swallowing seems an effort.

Sensation of tightness in throat.

Pain in right side of throat < swallowing.

Sensation of lump in throat.

Sticky lump hard to swallow.

Mouth feels dry all afternoon.

Tongue much drier than usual.

Mouth dry, but not thirsty.

Dry sensation in mouth but dribbling excess saliva all over pillow and in waking too, pools of it coming out. Dribbling in sleep.

Speech and tongue

“The aim in Botox injections is to inhibit facial expressions. In terms of the voice, it was interesting to read that some supervisors noted that their provers’ voices had sounded flat and monotonous.” [LD]

Voice noticeably higher and a little husky.

Voice breaking and clearing throat with a little cough.

Mistakes with words, keep getting tongue tied, words get muddled or I can’t remember the word at all. Total aphasia.

Tongue and brain don’t always seem connected, making mistakes with words.

Strong tingling on the tongue immediately after taking tablet.

Very aware of tongue, can feel it tingling at the tip.

Tongue at back of lower teeth felt tingling like a very mild electric shock.

Noticed tongue trembling, looking much more mobile. Tried to roll my tongue and to my amazement I rolled it into a deep tube with no difficulty

[This affect on the muscles of the tongue was extraordinary as the ability to roll the tongue is genetically determined you can either do it or you can’t. She has since returned to normal.] [LD]

Peculiar particulars

~ Muscle under right eye twitching intermittently then upper lid of left eye twitching, < thinking about it.

= Sudden taste of strawberries in mouth.

= Stomach uncomfortable while in bed; soreness in epigastrium, < lying down, > eating.

= Gastritis-type of gnawing pain as if stomach were digesting itself, < lying on side, > lying on back.

- Nape of neck feels delicate and breakable, > drinking wine.

= Coldness moving up and down extremities while talking.

« Left leg cold, heavy, and as if swollen; very cold behind knee.

= Right hand much colder than left.

= Tingling in shape of bands around ankles then spreading into feet.

«= Feet and lower legs warm inside but cool outside - as if surrounded by cold air.

• Coldness of leg felt internally - not cold to touch.

- Woke with fingers [not thumbs] feeling stiff; felt as if fingers were made of wood with only one hinge where larger joint is.

~ Hands numb on waking - couldn’t turn off alarm clock. Quite extreme - like having sausages for fingers - > hand clapping, rubbing, flexing fingers.

Numbness started in base of thumb and first two fingers then throughout hands and fingers.
Numbness < flexing wrists inwards.

CASE

(1) The drug is to be thought of use in hydrophobia, bulbar paralysis and allied affections, diphtheritic paralyses, and the dyspnoeic attacks and coma of diabetes. Paroxysmal dyspnoeas occurring in various diseases, in so far as they are central in origin, should be aided by Botulinum, and it is interesting to note that it is precisely repeated attacks of dyspnoea that Dr. Schepens [who was the first to record any use of botulinum as a remedy] has found himself able to cure with the drug. His first recorded case is that of a lady of 70, with arterial sclerosis, slight albuminuria, and a small pleural effusion, who suffered from nocturnal dyspnoeic attacks of an alarming kind.

Phos., Ars., Lach., Spong., and Hyos. all did little or nothing. After fifteen days Botulinum 30 was given, one dose. Short aggravation followed by amelioration ensued. The dose was repeated in two days' time, and the same phenomena occurred, but the improvement was more marked. In another two days another dose, and no more, was required. Nine days from the first dose the effusion had disappeared, and albuminuria and attacks of dyspnoea followed suit.

The second patient was a man of over 50. An erysipelatous eruption of the right leg disappeared under Apis, Iodum, and Kali iod., but when the patient returned to work he was at once attacked by paroxysms of dyspnoea, preventing him from lying down and causing great distress. Traces of albumen were found in the urine. Rhus and Lachesis did little. Botulinum 50 - two doses - with an interval of two days, caused amelioration; after two days more, Botul. 30, one dose. The next day the albumen had disappeared. One more dose after four days was all that was required, and the patient returned to work restored fully to health. Dr. Schepens' last case is that of a lady of 50, with tubercular family history, a sufferer from neuralgias and minor nerve troubles. Dr. Schepens was called to her one night, and found her anxious and labouring for breath, somewhat cyanosed, with a dry cough and weak and irregular pulse. No fever, a few moist sounds at the lung bases, a good deal of flatulence, and symptoms relieved by belching. Causticum 12 and 6 relieved a little. Cactus 6 and 3 carried relief further, but dyspnoea on the least exertion confined her still to bed. Finally Botul. 50 was administered, and then Botul. 30 at infrequent intervals. There was a rapid improvement after the first two doses, then after three days without medicine a slight set-back. Great relief followed four doses more of Bot. 30, given during

eight days, and by this time the patient was up and doing her ordinary duties, but with a tendency to slight paroxysms of dyspnoea on exertion. After a dose of Tub. 100, Botul. 20 was given. All tendency to dyspnoea now disappeared, but for a day or two there was great sensation of weakness in all the limbs.

There is little comment to add to Dr. Schepens' brilliant applications of the therapeutic possibilities of this poison. It is obviously a remedy of power, and there should soon be a number of cures to set to its credit that may define its sphere of usefulness, and give it a permanent position in the materia medica. [Wheeler, *Botulism and Botulinum*-, Homeopathic World, 1907; RefWorks]

CLOSTRIDIUM DIFFICILE

Scientific name Clostridium difficile (Hall & O'Toole 1935) Prevot 1938

Family Clostridiaceae

Homeopathy Not used

FEATURES

- Named 'difficile' because of its slow growth and difficulty to culture.
- First described in 1935 as a component of the faecal flora of healthy newborns. The organism is present as a member of the natural intestinal flora in 2-3% of healthy adults and in as many as 70% of healthy infants.
- Forms heat-resistant spores that can persist in the environment for several months to years.
- Associated with diarrhoea and colitis after employment of antibiotics.

CLINICAL MANIFESTATIONS

C. difficile colitis results from disruption of the normal bacterial flora of the colon, colonisation with C. difficile, and release of toxins that cause mucosal inflammation and damage.

C. difficile infection commonly manifests as mild-to-moderate diarrhoea, occasionally with abdominal cramping. Pseudomembranes, adherent yellowish- white plaques on the intestinal mucosa, occasionally are observed. In rare cases, patients with C. difficile infection can present with an acute abdomen and fulminant life-threatening colitis. Approximately 20% of individuals who are hospitalized acquire C. difficile during hospitalisation, and more than 30% of these patients develop diarrhoea. Thus, C. difficile colitis is currently one of the most common nosocomial infections.

... In the US: C. difficile infection primarily occurs in hospitalised patients, causing as many as 3 million cases of diarrhoea and colitis per year.

... Most patients develop diarrhoea during or shortly after starting antibiotics. *However, 25-40% of patients may not become symptomatic for as many as 10 weeks after completing antibiotic therapy.*

Symptoms often include mild-to-moderate watery diarrhoea that is rarely bloody; cramping abdominal pain; lower abdominal tenderness; anorexia; malaise; fever, esp. in more severe cases; dehydration.

[C.A. Gronczewski, *Clostridium Difficile Colitis*-, at: www.emedicine.com/med/topic3412.htm]

CLOSTRIDIUM PERFRINGENS

| | |
|------------------------|---|
| Scientific name | Clostridium perfringens (Veillon & Zuber 1898) Hauduroy et al. 1937 |
| Synonym | Clostridium welchii |
| Common name | Gas bacillus |
| Family | Clostridiaceae |
| Homeopathy | Clostridium welchii - Clostr-we. |

FEATURES

- Widely distributed; spores persist in soil, sediments, sewage, and human or animal excrements.
- Non-motile.
- Found as a commensal in normal intestinal flora, particularly in the colon.
- Becomes pathogenic due to abnormal anaerobic environment within tissues [eg, from arterial insufficiency or after deep penetrating or crushing injuries].

CLINICAL MANIFESTATIONS

Associated with a condition termed ‘gas gangrene’ or myonecrosis. There is

I would usually have history of deep contaminated wound [surgery, trauma], followed by sudden pain at wound site, local swelling and oedema, and thin, bloody exudate. The organism, formerly called “Bacillus aerobaculum”, was first secured by Welch from the body of a man dying suddenly of aortic aneurysm with a peculiar gaseous emphysema of the subcutaneous tissues and internal organs, and a copious formation of gas in the blood vessels. The blood was thin and watery, of a lac colour, and contained many large and small gas bubbles, and many gas bacilli. The pathogenic powers of the bacillus are limited, and while in some infected cases it seems to be the cause of death, its power to do mischief in the body seems to depend entirely upon the pre-existence of depressing and devitalising conditions predisposing to its growth. Being anaerobic, the bacilli are unable to live in the circulating

C. perfringens provides us with an explanation for the death, ‘engendered in the corrupted humours of the vicious body itself’, by Spontaneous Combustion of Krook in Dickens’s novel ‘Bleak House’ “thick yellow liquid..offensive to the touch and sight and more offensive to the smell, and a smouldering suffocating vapour” is all that is left of Krook!

blood, though they grow in old clots and in cavities, such as the uterus, etc., where little oxygen enters, and from which they enter the blood and are distributed.

... After death, when the blood is no longer oxygenated, the bacilli grow rapidly, with marked gas-production, which in some cases is said to cause the body to swell to twice its natural size. Upon palpation a peculiar crepitation can be felt in the subcutaneous tissue nearly everywhere, and the presence of gas in the blood vessels is easy of demonstration. The gas is inflammable, and as the bubbles ignite explosive sounds are heard.

[McFarland]

The wound site may be pale initially, but it becomes red or bronze and finally turns blackish-green. The affected muscle is a lustreless pink, then deep red, and finally grey-green or mottled purple. The patient's condition becomes progressively toxic; shock and renal failure are manifested, though the patient often remains alert until the terminal stage.

[Merck Manual]

Clostridium food poisoning also is usually caused by *Clostridium perfringens*. Meats, poultry, and gravy are the foods most frequently implicated. The foodborne illness, commonly referred to as the "24-hour flu," is self-limited and includes abdominal pain, gas, and sudden, watery diarrhoea. Usually there is no fever [distinguishing it from *Salmonella*] and no vomiting [distinguishing it from *Staphylococcus*].

Dubbed the "food service germ" or "cafeteria cramps," *C. perfringens* is a frequent source of poisoning from food prepared several hours before serving and then held at room temperature or on a steam table. *Clostridium* is a common guest at schools, camps, banquets, and buffets.

CLOSTRIDIUM TETANI

| | |
|------------------------|--|
| Scientific name | Clostridium tetani (Fliigge 1886) Bergey et al. 1923 |
| Old name | Bacillus tetani |
| Family | Clostridiaceae |
| Homeopathy | Tetanotoxinum - Tetox. Tetanus vaccinus - Tetan-vc. |

FEATURES

Motile, flagellated, spore-forming, Gram-positive bacillus.

Its name comes from the Greek tetanos, a word derived from teinein, meaning to stretch.

Typically has an enlargement of one end, giving it the appearance of a squash racket, which contains a large round spore.

Spores resist desiccation and exposure to high temperatures for considerable

periods of time [while the toxin is easily destroyed by heat] and may remain alive in dry earth for many years.

The three most toxic

substances known:

Tetanus toxin

Botulism toxin

Diphtheria toxin

- Strictly anaerobic; will not grow where the slightest amount of free oxygen is present.
- Discovered in 1884 by Nicolaier, who produced tetanus in animals by injecting them with samples of soil, and obtained in pure
- Common saprophyte in soil, dust, and, particularly, manure. Found in the intestinal tracts and faeces of animals including horses, sheep, cattle, dogs, cats, rats, guinea pigs, and chickens.
- Carrier rates in humans vary from 0 to 25% [high rates in agricultural areas] and the organism is thought to be a transient member of the flora whose presence depends upon ingestion. The organism is harmless when entering via the digestive tract, but may turn pathogenic when it gains access to wounds.
- Produces tetanus toxin, one of the three most toxic substances known, the other two being the toxins of botulism and diphtheria.

TETANUS

Clinical forms

The occurrence of tetanus is worldwide, but is most frequently encountered

in densely populated regions in hot, damp climates with soil rich in organic matter.

There are four clinical forms of tetanus:

Localised tetanus, characterised by persistent rigidity and contraction of the muscle group close to the injury site. These contractions may persist for many weeks before gradually subsiding. Local tetanus may precede the onset of generalised tetanus, but is generally milder.

Cephalic tetanus, a rare form, occasionally following chronic otitis media or head trauma. Characterised by cranial nerve palsies, most frequently the 7th [facial]. This form may progress to generalised tetanus.

Neonatal or umbilical tetanus, a form of generalised tetanus occurring in newborn infants, generally through infection of the unhealed umbilical stump. It presents at the end of the first week of life [whence its name “the illness of the seventh day”] with an inability to suck, followed by irritability, excessive crying, grimaces, intense rigidity, and opisthotonos. This form is common in some developing countries.

Generalised tetanus, the commonest form, manifests as generalised muscle rigidity with intermittent reflex spasms in response to stimuli such as noise, light or touch.

Generalised tetanus

The bacterium produces an exotoxin called tetanus toxin or tetanospasmin which blocks the release of glycine and GABA [gamma-amino butyric acid], neurotransmitters inhibiting the contraction of antagonistic muscles. The toxin migrates along lymphatic and vascular paths from the local wound to sites of action in the central nervous system. The shortest peripheral nerves are the first to deliver the toxin to the CNS, which leads to the early symptoms of facial distortion and back and neck stiffness.

In general a descending pattern of muscular rigidity is observed: first stiffness/spasms of the masseter muscle [lockjaw or trismus], then stiffness of the neck, difficulty in swallowing, and rigidity of abdominal muscles. This may be accompanied by other typical signs such as auditory hyperacuity, sweating, opisthotonos, elevated blood pressure, restlessness, and episodic rapid heart rate. There is usually no fever. Sustained contraction of facial musculature

produces a sneering grin expression known as risus sardonicus. Spasms may occur frequently and last for several minutes, consisting of opisthotonos, flexion and abduction of the arms, clenching of the fists on the thorax, and extension of the lower extremities. Spasms continue for 3-4 weeks. Complete recovery may take months. Fatal cases result from interference with the mechanics of respiration or from autonomic dysfunction [extremes in blood pressure, cardiac arrest].

It is seldom that the disease is at once fully developed. Several days before its outbreak, chilly sensations are occasionally felt, even shaking chills, and auralike pains from the injured part of the body. There are at first drawing pains in the neck and stiffness in the nape of the neck, with some difficulty of swallowing. These symptoms increase ... frequently the tonic spasm gradually extends over all the dorsal muscles, down to the sacrum, and over the muscles of the chest and abdomen, so that the whole body becomes as hard and rigid as a piece of wood. The muscles of the extremities are not quite so severely affected, and sometime not at all.

The muscles of the face are likewise less severely involved; but still they participate more or less. There is a peculiar tension and painful expression in them. The eyeballs are rigidly drawn towards the inner canthus, and during the convulsive exacerbations the forehead becomes corrugated; the eyebrows frown, the eyes stare, the lips are drawn asunder, showing the teeth; the tongue is thrust between the teeth, and frequently severely bitten. ... The disease progresses, alternating with rigidity, partial relaxation and convulsive concussions. ... As long as the spasms prevail, the will has not the slightest influence over the muscles. On the contrary, an effort to check the spasm only increases the rigidity of the muscles, and likewise do all reflex irritations, so that, as is well known, even the slightest touch, movement of the bed, or even a draught of air, is sufficient to instantly cause the most violent convulsive concussions. ... There is great pain in the muscles during their contractions, and especially is there a painful sense of pressure in the pit of the stomach, with extreme anxiety and discomfort. There is usually distressing thirst, and in some cases actual hunger, neither of which can be satisfied; the bowels, as a rule, are constipated, and micturition is often impossible. ... Sleep is entirely absent, and if the patient loses himself for a moment in consequence of exhaustion, he is at once roused again by violent concussions. The functions of the brain seem entirely unmolested; the patient has to suffer all these tortures in full consciousness.

[Raue]

However, tetanus remains a clinical diagnosis because confirmatory laboratory tests are not available for routine use. Isolation of the organism from wounds is neither sensitive nor specific.

Tetanus symptoms
Rigidity
Spasm
Stiff muscles

Wounds

There is general consensus that tetanus results from trauma or a puncture wound leading to tissue contamination. The spores need tissue with the proper anaerobic conditions to germinate. Somewhat puzzling in connection with this is that “Clostridium tetani is recovered from the wound in only 30% of cases.” [CDC report on tetanus] The report continues with: “Transmission is primarily by contaminated wounds [apparent and inapparent]. The wound may be major or minor. In recent years, however, a higher proportion of cases had minor wounds, probably because severe wounds are more likely to be properly managed.”

Convulsive spasm
< touch
< light
< noise
< draft
< slightest stimulus
Great thirst - urination impossible.
Sleepless but exhausted and fully conscious.

Other reported risk factors, such as diabetes, chronic wounds, parenteral drug abuse, and recent surgery [4% of US cases], suggest that constitutional factors may play a major role.

That the bacterium “might be grown from wounds in the absence of clinical signs and symptoms of disease” [CDC] provides ample evidence of its ubiquitous presence, which is also evidenced by the fact that the spores normally can be found on skin surfaces. “An interesting fact has been presented by Vaillard and Rouget, who found that if the tetanus spores were introduced into the body freed from their poison, they were unable to produce the disease because of the promptness with which the phagocytes took them up. If, however, the toxin was not removed, or if the *body-cells were injured* by the simultaneous introduction of lactic acid or other chemical agents, the spores would immediately develop into bacilli, begin to manufacture toxin, and produce the disease. This suggests that many wounds may be infected by the tetanus bacillus though the surrounding conditions rarely enable it to develop satisfactorily and produce enough toxin to cause disease.” [McFarland]

Spores gaining entry to the body can persist in normal tissue for months to years, without causing any harm. An organism sufficiently oxygenated will hold them in check. If the conditions change into their favour, however, these spores may germinate and elaborate their toxin. Oxygen supply to tissues decreases with age, which probably explains why tetanus has the highest incidence and mortality in persons aged 60 years or older.

The virulence of *C. tetani* seems related to the constitutional state of the host.

It has been observed that the duration of the initial period, in which the symptoms build up, correlates with the severity of the disease. Goodman and Gilman [1970] cite a study of 114 tetanus patients which showed that slow development of the initial phase [7 days] was followed by mild or moderate tetanus, with symptoms restricted to face and neck spasms, whereas fulminating tetanus had a buildup phase of maximally 72 hours and a high mortality.

From this it can be concluded that the course of tetanus depends, at least partly, on the ability of the organism to mount its defences. The stronger the defences the less chance of being invaded - the initial phase - the milder the outcome. Proper wound management is essential and will eliminate the possibility of tetanus in most cases. "Every wound should be allowed to bleed freely, since this eliminates bacteria and infected matter from the wound and supplies oxygen through the blood stream. It is an inexcusable professional mistake to sew infected wounds. They should be left open to the air until completely clean before being stitched. Application of hydrogen peroxide is another cheap, easy, very efficacious and, thus, essential protection against tetanus infection of open wounds. The only exception is small punctured wounds in which the peroxide will not permeate. Peroxide is the first essential product in every household pharmacy. In order to be effective, it has to be replaced annually." [Gaublomme] *Ledum* is in homeopathy an important remedy to prevent tetanus from developing after sustaining a puncture wound. There are two keynotes: cold sensation [i.e. less blood, thus less oxygen] around the site of the wound and amelioration by cold applications [which as a reaction draws blood to the area].

Fluctuation

Rising and falling appears to be a characteristic phenomenon, as is evidenced by the extremes of spasticity and relaxation, of opisthotonos and emprosthotonos, of hypertension and hypotension, of tachycardia and bradycardia, of flexion and extension.

Biting

A diagnostic test of great specificity, known as the spatula test, involves touching the oropharynx with a spatula, which normally will elicit a gag reflex, but in tetanus patients typically induces a reflex spasm of the masseters resulting in biting the spatula.

Loganiaceae

The medical differential diagnosis of tetanus includes strychnine poisoning and hysteria. Tonic spasms caused by strychnine are referred to as *drug* or toxic tetanus, while *imitative* tetanus is perceived as a form of conversion hysteria that resembles tetanus. [The term “tetanus” stands here for “a sustained muscular contraction caused by a series of stimuli repeated so rapidly that the individual muscle responses are fused.”]

Homeopathically this brings Nux vomica and Ignatia to mind, both strychnine-containing members of the Loganiaceae, a plant family that further contains Gelsemium sempervirens, the symptoms of which markedly resemble those of Clostridium botulinum, the close relative of Clostridium tetani.

MATERIA MEDICA TETANOTOXINUM

Tetox.

Sources

[1] Proving by the Association of Homoeopathic Physicians, Matunga, Bombay; 1965; 30c; 14 provers [10 males, 4 females].

SYMPTOMS

Mind

= Lethargic and dull; perception not clear; weakness of memory.
= Dreams of rivers and water.

Generals

= *Anorexia*.
« Craving for sweets.
- Disturbed night sleep [sleeplessness after 3 a.m.] and sleepiness daytime.
= Modalities: *worse in evening; worse at night*.

Locals

~ Head feels numb or empty and hollow.
= Headache from 7 a.m. to 10 p.m., < between 7 and 10 p.m.
~ *Humming noises in ear*.
= Burning pain in eyes.
= Sour taste in mouth.
= Thick coating on tongue.

-
- = *Dryness throat.*
=■> *Abdomen* distended and *painful*-, severe spasmodic pain < lying down,
< *pressure*. Pain “off and on.”
= *Constipation* with frequent urging.
= Dysuria.
= Menses delayed [for 10 days]; painful.
~ Troublesome violent erections, < 7 to 10 p.m.
« Burning pain in chest.
= Palpitation of heart, frequent.
= Intermittent back pain, extending to hips or lower limbs.
- Stiffness nape of neck.
- *Pain and stiffness upper limbs / lower limbs.*
*= Numbness of hands and feet.
= Perspiration lower limbs, in evening, and soles of feet.
~ Stiffness upper and lower limbs.

All symptoms from P.N. Pai, *A proving of Tetanus toxin*-, Br. Hom. J. 1967, Vol. 56 no. 2.
Symptoms in italics were observed in 3 or more provers.

MATERIA MEDICA TETANUS VACCINUS

Tetan-vc.

Sources

This nosode is prepared from Tetanus toxoid, used in anti-tetanus injections. No provings have been conducted with the toxoid, nor have any cases been reported in literature.

As main indications are given: Anaphylactic states, especially after injections of serum [equine serum]. Spastic illnesses of all kinds. Muscle cramps. Tetany. Disorders of the parathyroid gland and calcium metabolism. May be used experimentally in arthrosis and neuralgias, also in spastic paresis and possibly in multiple sclerosis. Parkinson’s disease. [Reckeweg]

Tetany

Tetany, as defined in Stedman’s Medical Dictionary, closely fits the symptomatology of tetanus. Tetany is “apyretic or benign tetanus; a disorder marked by intermittent tonic muscular contractions, accompanied by fibrillary tremors, paraesthesias, and muscular pains; the hands are usually first affected, followed by spasms in the face, the trunk, and sometimes in the laryngeal muscles, with

increased irritability of the motor and sensory nerves to electrical and mechanical stimuli; results from decreased ionised calcium in the plasma and occurs with gastric and intestinal disorders, alkalosis, or a deficiency of vitamin D and parathyroid function.”

Tetanus is a purely clinical diagnosis; there are no specific confirmatory laboratory tests. The diagnosis is clinically based on the presence of trismus, dysphagia, generalized muscular rigidity, and/or spasm.

As with tetanus, a diagnosis of hysteria or neurosis is suggested by the peculiar and intermittent nature of the symptoms, including paraesthesias and muscular spasms. Common mental manifestations in latent tetany are characterised by Lishman as temper tantrums and night terrors in children and depression, nervousness and irritability with frequent crying spells and marked social withdrawal in adults.

Immunisation

The argument that potential risks associated with tetanus are much greater than the potential risks associated with the tetanus vaccine is usually advanced to promote prophylactic immunisation, which is accomplished with tetanus toxoid, as part of the DPT [DTP] vaccine or the DT [TD] vaccine. Tetanus toxoid consists of a formaldehyde-treated toxin. Five doses of a tetanus toxoid-containing vaccine consisting of a primary series and 2 booster doses starting in infancy and booster doses at 10-year intervals are recommended. .

A second argument to advocate immunisation is the decline in the incidence of tetanus since the introduction of tetanus toxoid into routine childhood immunisation [in the USA] in the late 1940s. To demonstrate the effectiveness of active immunisation, rather than of appropriate wound management, figures are presented of the incidence of tetanus in World War II, when “there were only 12 cases of tetanus among 2 785 819 hospital admissions for wounds and injuries.” No information is offered how many of this huge number of admissions were fully immunised. The addition that of these 12, “6 were not properly immunised and 2 received no booster dose at the time of the injury,” implies that the remaining 4 acquired tetanus in spite of being fully immunised.

Improved sanitation and personal hygiene, better wound care as well as the mechanisation of farming have doubtless contributed significantly to the drop in tetanus cases. This view is supported by medical heretic Robert Mendelsohn, who confessed in 1988:

You have every right to closely question me on the tetanus vaccine, since that was the last vaccine I abandoned. ... As you point out, I gave up belief in this vaccine in stages. For a while, I still held onto the notion that farm families and people who work around stables should continue to take tetanus shots. But in spite of my early indoctrination with fear of “rusty nails,” in recent years, I have developed a greater fear of the hypodermic needle. My reasons are:

- 1) Scientific evidence shows that too frequent tetanus boosters actually may interfere with the immune reaction.
- 2) There has been a gradual retreat of even the most conservative authorities from giving tetanus boosters every one year to every two years to every five years to every 10 years [as now recommended by the American Academy of Pediatrics], and according to some, every 20 years. All these numbers are based on guesses rather than on hard scientific evidence.
- 3) There has been a growing recognition that no controlled scientific study (in which half the patients were given the vaccine and the other half were given injections of sterile water) has ever been carried out to prove the safety and effectiveness of the tetanus vaccine. Evidence for the vaccine comes from epidemiologic studies which are by nature controversial and which do not satisfy the criteria for scientific proof.
- 4) The tetanus vaccine over the decades has been progressively weakened in order to reduce the considerable reaction [fever and swelling] it used to cause. Accompanying this reduction in reactivity has been a concomitant reduction in antigenicity [the ability to confer protection]. Therefore, there is a good chance that today’s tetanus vaccine is about as effective as tap water.
- 5) Until the last few years, government statistics admitted that 40 percent of the child population of the U.S. was not immunised. For all those decades, where were the tetanus cases from all those rusty nails?
- 6) There now exists a growing theoretical concern which links immunisations to the huge increase in recent decades of auto-immune diseases, eg, rheumatoid arthritis, multiple sclerosis, lupus erythematosus, lymphoma, and leukaemia. In one case, Guillain-Barre paralysis from swine flu vaccine, the relationship turned out to be more than just theoretical.

[Robert S. Mendelsohn, *But Doctor, About That Shot... The Risks of Immunisations and How to Avoid Them*-, The People’s Doctor Newsletter, Inc., 1988]

Adverse effects

An article in the Archives of Neurology [1972] described brachial plexus neuropathy from tetanus toxoid. Four patients who received only tetanus

toxoid noticed the onset of limb weakness from six to 21 days after the inoculation. A 1966 article published in the Journal of the American Medical Association reports the first case of “Peripheral Neuropathy following Tetanus Toxoid Administration.” A 23-year-old white medical student received an injection of tetanus toxoid into his right upper arm after an abrasion of the right knee while playing tennis. Several hours later, he developed a wrist drop of his right hand. He later suffered from complete motor and sensory paralysis over the distribution of the right radial nerve. One month later, no residual motor or sensory deficit could be found.

In an article in the Journal of Neurology, entitled “Unusual Neurological Complication following Tetanus Toxoid Administration,” the case is reported of a 36-year-old female who received tetanus toxoid in her left upper arm following a wound to her finger. Five days later, she noticed a weakness first of the right, and then of the left and later of both legs. She complained of dizziness, instability, lethargy, chest discomfort, difficulty in swallowing, and inarticulate speech. She staggered when she walked, and she could take only a few steps. Her EEG showed some abnormalities.

After a month, she was discharged without neurologic disturbance, but she continued to feel weak and anxious. Examinations during the next 11 months showed continued emotional instability and some paraesthesias in the extremities. The medical diagnosis was “a rapidly progressing neuropathy with involvement of cranial nerves, myelopathy, and encephalopathy.” [Robert S. Mendelsohn]

Some 15 cases of anaphylactic reactions were reported before 1941. The reactions were traced to beef proteins in the culture broth. Since the removal of these components from the preparation “only” nine cases of anaphylaxis have been reported. This would seem to be low, but the outcome may have been affected by the selection criterion of including cases only if reactions occurred within 4 hours of vaccine administration. By defining anaphylaxis as “a sudden, potentially life-threatening, systemic condition,” allergic reactions of the delayed type [12 to 48 hours] could be excluded.

The evidence provided by these nine cases, however, favoured acceptance by the Vaccine Safety Committee of the Institute of Medicine of a causal relation between tetanus toxoid and anaphylaxis. The clinical manifestations of the nine cases included pallor followed by diffuse erythema, urticaria, and itching, subcutaneous oedema, oedema and spasm of the larynx, wheezing, tachycardia, hypotension, and hypovolemic shock.

Twenty-five instances of Guillain-Barre syndrome [GBS] or polyneuritis after administration of tetanus toxoid alone [21 cases] or of tetanus toxoid and anti-tetanus toxin serum [4 cases] were for the Committee evidence of a causal relation between tetanus toxoid and GBS. Likewise with a causal relation between tetanus toxoid and brachial neuritis [supraclavicular pain, weakness and diminished reflexes, heralded by deep, steady aching pain in shoulder and upper arm and followed by profound weakness].

[Stratton et al. 1994]

The *New England Journal of Medicine* published in 1984 a study showing that tetanus booster vaccinations cause T-lymphocyte count ratios to temporarily drop below normal. The largest drop occurred between three to fourteen days post vaccine. The report noted that these altered ratios are similar to those found in patients with acquired immune deficiency disorder [AIDS].

[M.M. Eibl et al., *Abnormal T-Lymphocyte Subpopulations in Healthy Subjects after Tetanus Booster Immunisations*, *New England Journal of Medicine*, Jan. 19, 1984, Vol. 310/3]

PHYLUM PIRELLULAE

| Phylum | Order | Family | Genus | Species | Remedy |
|------------|--------------|---------------|-----------|------------------------|--------------------|
| PIRELLULAE | CHLAMYDIALES | Chlamydiaceae | Chlamydia | <i>Ch. trachomatis</i> | <i>Chlamydinum</i> |

Members of this phylum have cell walls that are rich in the amino acids cysteine [contains sulphur] and proline. The phylum includes free-living freshwater bacteria, which often form colonies, either plankton-like or attached by stalks to a variety of substrates. Chlamydia and related forms, obligate parasites of mammals and birds, form desiccation-resistant elementary bodies analogous to the endospores.

Chlamydias are among the smallest bacteria. They can live only as parasites within the cells of other organisms. These tiny spheres are unique because of their complex reproductive cycle, which involves two different types of cells. Small, dense elementary cells invade host cells and develop into larger, thin-walled reticular bodies, which grow and divide and finally reorganise into elementary bodies again, which are liberated by rupture of the host cell. Elementary bodies can exist outside host cells, but can only grow inside cells.

I. ORDER CHLAMYDIALES

I A. Family Chlamydiaceae

I A. FAMILY CHLAMYDIACEAE

Chlamydia trachomatis

CHLAMYDIA TRACHOMATIS

Chlam-tr.

Scientific name *Chlamydia trachomatis* (Busacca 1935) Rake 1957
emend. Everett et al. 1999

Old name Family Bedsonia

Homeopathy Chlamydiaceae
Chlamydinum - Chlam.
Chlamydia trachomatis - Chlam-tr.

FEATURES

- Gram-negative, non-motile, spherical, obligate intracellular parasite forming compact micro-colonies in the cytoplasm of host cells.
- Two stages: an elementary body for dispersal and invasion, a reticulate body for growth and division.
- Produces glycogen within host cells to develop its reticulate body for reproduction.
- Name from Gr. *chlamys*, cloak, in allusion to the bacterium “draping” itself around infected cell nuclei.
- The enigmatic members of the genus *Chlamydia* were formerly included in the order Rickettsiales due to obligate intracellular parasitism as well as being considered to be viruses [PLT virus, Bedsonia or basophilic virus] due to similarity in pathogenesis, pathology and epidemiology of chlamydial infections with viral infections.
- As “energy parasites” and similar to viruses, chlamydias depend for survival on ATP [adenosinetriphosphate] from the cells in which they reside.
- *Chlamydia* has a preference for epithelial tissue, particularly the mucosa of cervix, rectum, urethra, throat, and conjunctiva.

SUBGROUPS

The Chlamydias are divided into two subgroups. Subgroup A includes mammalian parasites, such as *Chlamydia trachomatis*, which synthesize glycogen and folates [salts of folic acid]. Subgroup A organisms primarily infect the mucous membranes of the eye or the genitourinary tract of humans. Linked with outbreaks of pneumonia of varying severity, the species *C. pneumoniae* has recently been identified as a factor in atherosclerotic heart disease. The DNA of *C. pneumoniae* has been found within the plaques of atherosclerosis, demonstrating a correlation and not necessarily a causal relationship. Subgroup B includes bird parasites, such as *Chlamydia psittaci*, which do not produce glycogen and folates.

Chlamydia psittaci [from Gr. *psittakos*, parrot] is primarily a bird parasite, living on 71 species of parrots as well as finches, pigeons, chickens, ducks, turkeys and seabirds. About 100 species of birds are naturally infected with chlamydia, which is communicable to humans as lung infections, ranging from asymptomatic to mild flu-like symptoms or severe broncho-pneumonia, particularly in older persons.

CHLAMYDIA TRACHOMATIS INFECTIONS

• *Trachoma*

Chlamydia trachomatis was originally associated only with trachoma [from *trachys*, rough]¹, a contagious eye disease characterised by hard, greyish or yellowish granules on the conjunctiva/inner eyelids, which may leave a residuum of permanent lesions that can lead to blindness. Flourishing in hot, dry areas, trachoma is a major cause of blindness in Asia and Africa.² The bacteria are transmitted by flies as well as by person-to-person contact. After a latency period of many years trachoma may eventually become manifest. According to WHO estimations, there are 400 million trachoma patients worldwide, of which the disease has blinded some 16 million people, mostly children and women; the latter because of their contact with children.

Chlamydia trachomatis also causes inclusion [follicular] conjunctivitis, an eye disease of children and adults that is milder than trachoma. It presents as a unilateral [or less commonly bilateral] red eye with mucopurulent discharge, marked hyperaemia, and papillary hypertrophy; it heals spontaneously without scarring. Gonorrhoea is the most common co-infection with adult inclusion conjunctivitis. Women often have a concomitant vaginal discharge.

• *Non-Gonococcal Urethritis*

In the late 1970s different serotypes of the organism began to be linked with a common sexually transmitted disease [STD], first called Non-Specific Urethritis, now Non-Gonococcal Urethritis [NGU]. Chlamydia is today the leading STD in industrialised countries, with 3-4 million new cases under the age of 25 occurring each year. The infection is asymptomatic in up to 75% of women and 25-50% of men; hence it is often referred to as the 'silent infection'. However, women are more likely to develop long-term complications.

As well as a young age, infection is associated with a recent change of sexual partner or more than two partners in one year, lack of use of barrier contraception and concurrent gonococcal infection. Prevalence rates in general are highest in sexually active adolescent girls. Prevalence in teenagers attending for termination of pregnancy has been found to be as high as 25% in the UK. Prevalence of chlamydia as high as 27% has been reported in female detention centres in the USA.

Acute or subacute symptoms in women include increased vaginal discharge, burning during urination, irritation of the area around the vagina, pain and bleeding during or after sexual intercourse, intermenstrual bleeding, lower abdominal pain, and abnormal vaginal bleeding. Urethritis is the main symptom in men, with clear, white, or yellow urethral discharge, burning and pain during urination, and tingling or itching sensations.

The infection may remain latent for years, although up to 40% of women with untreated chlamydia may develop Reiter's syndrome or PID [pelvic inflammatory disease], with infertility, chronic pelvic pain, or ectopic pregnancy. *Statistics show that the chances of infertility increase from 12% with the first infection to 80% by the third.*

Antibodies develop during infection, but they do not prevent re-infection. Common among young men, chlamydia typically causes urethritis and subsequent complications including swollen and tender testicles, epididymitis, and/or Reiter's syndrome.

A study of women in Finland, Norway and Sweden found a strong link between three of the 10 serotypes of chlamydia and cervical squamous cell carcinoma [SCC], an increasingly common cancer.

Chlamydial infection is easily confused with gonorrhoea because the symptoms of both diseases are similar, and they often 'travel' together.

Tetracycline and erythromycin are the antibiotics commonly used to treat chlamydial infections in humans. Penicillin is not effective.

- *Lymphogranuloma*

Known as the “fifth venereal disease” or lymphogranuloma venereum, chlamydial infection by other *C. trachomatis* serotypes is associated in men with small, transient genital ulcers or vesicles and prominent swelling and inflammation of the lymph nodes in the groin, accompanied by fever, anorexia, headache, and muscle and joint aches. Inguinal adenopathy may also occur in women, usually with concomitant involvement of perirectal lymph nodes, possibly resulting in rectal stricture. In both sexes, the glands blend together, become full of pus, adhere to the skin, and form fistulae, which discharge pus from the anus, rectum, vagina, or bladder.

- *Neonatal*

Chlamydia may be passed to newborns during delivery, with subsequent neonatal conjunctivitis, otitis media, or pneumonia. Infant Chlamydia [*trachomatis*] pneumonia results in moderate illness or produces rapid, closely spaced staccato coughing - in *Corallium rubrum*-fashion - with brief inspirations resembling whooping cough but without whoops or fever. Approximately 11-20% of infants born to infected mothers develop symptomatic pneumonia before age 8 weeks. A higher-than-normal incidence of obstructive airway disease or asthma occurs in children who had chlamydial pneumonia before the age of 6 months.

1] In the old homeopathic literature trachoma is termed “granular ophthalmia.” A number of repertory rubrics is related to the condition, although not uniquely, including Pannus [proliferation of fibrovascular connective tissue on the superior cornea]; Inversion of [eye]lids; Hair, ingrowing eyelashes [trichiasis]; Injected cornea; Opacity of cornea; and Spots on cornea. As common modalities of trachoma, Raue mentions: “... light, cold air, wind, dust, and smoke; reading, writing, and sewing cause pain in the eyes and an increase of redness,” and as concomitants: “... mistiness of sight and rainbow colours around luminous bodies.”

2] The prevalence of trachoma in Egypt at one time led to the name ‘Egyptian ophthalmia.’ Writing in the 1940s Margaret Tyler had this to say about it in her *Homoeopathic Drug Pictures*: “We all know that one of the plagues of Egypt, in our day, is ophthalmia. Go there, if you want to study the destruction of eyes, and the various causes that contribute. Well, a year ago, a once-missionary [now third-year student of medicine] went back to Egypt in the pause in school-work which occurs in late summer and early autumn. One of her eyes got infected, and to the terror of the medical missionaries developed *trachoma*.”

They scraped the inside of the lids and, with the aid of a competent ophthalmologist 'treated' the condition, and it slowly yielded, leaving the eye undamaged. But she was told to expect recurrences - which duly kept their appointment. When attack No. 3 started, she happened to be in the house of a homeopathic doctor who was not concerned with treatment, but cure; and accordingly the Repertory was asked for the drug that met the symptoms. It worked out to APIS, and she got *Apis CM* that evening.

Next morning she was jubilant; the terror had practically subsided; and by night the eye was well. At that time she was just starting again for Egypt, and was provided with plenty of *Apis CM* for the eyes she might find there. Result? - simple amazement! - and she, the not yet qualified, was allowed to treat all the eyes in one Dispensary - real bad eyes! - because, *after one dose of the Apis, again and again they cleared up in twenty-four hours.*"

OTHER CHLAMYDIAS

- In adults chlamydial pneumonia is transmitted by the respiratory route and attributed to either *Chlamydia psittaci* [from infected birds] or a newly discovered Chlamydia strain, designated *C. pneumoniae* serovar TWAR organism [from Taiwan Acute Respiratory infection]. Chlamydia trachomatis is implicated only occasionally.

Some bacteriologists classify the TWAR serovar as a distinct species, Chlamydomphila pneumoniae. It causes mild to severe pneumonia, prolonged bronchitis, pharyngitis, sinusitis, and febrile illness. The onset is usually gradual and may be biphasic. Symptoms of bronchitis or pneumonia follow upper respiratory symptoms in 1-4 weeks.

A history of hoarseness is more common in *C. pneumoniae* infection than in mycoplasmal infection or other pneumonias. Headache occurs in as many as 58% of cases and may be important as a non-classic pneumonia finding. *C. pneumoniae* is more common in males [60-90%] than in females; this difference is possibly due to cigarette smoking. Although *C. pneumoniae* infections occur every year, epidemiological studies suggest a 4-year cycle in the incidence of pneumonia caused by this organism.

[M. Bashour, *Chlamydia*, at: www.emedicine.com/MED/topic341.htm]

- *C. pneumoniae* kindled renewed interest in the theory that multiple sclerosis might be caused by an infectious agent. After dismissal of an earlier suspect, the measles virus, *C. pneumoniae* was proposed as one of the possible culprits after analysis of epidemiological data suggesting a correlation between outbreaks of MS and *C. pneumoniae* infections in the Faroe Island shortly after World War II. Additional evidence that the bacteria could be involved

came from a research team at the Vanderbilt University Multiple Sclerosis Centre in Nashville, Tennessee, which reported a 64%-incidence of *C. pneumoniae* infection of the central nervous system among MS patients, compared with only 11% in patients with other neurological diseases. Researchers from the University of Heidelberg, Germany, came to similar results: signs of the bacterium were found in 12 of 18 MS patients [66%], versus 21% in patients with other neurological illnesses. *C. pneumoniae* has caused epidemics of respiratory tract infections in Scandinavia and women of Scandinavian descent have a high incidence of MS. Whether the organism triggers MS or takes advantage of the lowered defences of MS patients remains unsolved.

- Pneumonia associated with *C. psittaci*, known as “parrot fever,” occurs mainly in pet shop owners, poultry workers, pigeon fanciers, taxidermists, and zoo attendants. [Control of the disease consists of the addition of tetracycline to bird food.] The severity of disease ranges from asymptomatic to severe pneumonia with systemic illness. Symptoms include dry hacking cough with scanty, sometimes bloody sputum, and systemic manifestations such as fever, shaking chills, lethargy, somnolence, enlarged liver or spleen, severe headache, and/or a maculopapular rash. Less common manifestations are epistaxis, tinnitus, deafness, photophobia, muscle and joint ache. Full recovery is slow; relapses occur.

MATERIA MEDICA CHLAMYDIA TRACHOMATIS Chlam-tr.

Sources

[1] Proving Richard Bocoock, Jan.-April 2000; 4 provers [3 females, 1 male]; 30c [2 provers], 12c, 9c. Method: three doses twice daily for two days, to stop as soon as symptoms appeared.

Of unclear origin, the proving substance was believed to have been prepared from the attenuated *Chlamydia* bacterium. [Hom. Links 1/02]

[2] Clinical experience. Having used the remedy in more than 300 cases, Bulgarian homeopath Mario Boiadjev has found *Chlamydia* particularly important in treating cancer patients and “hopeless cases.” He warns that “the treatment of patients with chlamydial infections takes a long time,” so that “it is often necessary to prescribe other [constitutional] remedies and when their action is exhausted, to return to *Chlamydia*.”

Clinical experience

“I usually use Chlamydia in 10M or CM potency. At first I applied 30c, but I found that in most cases it is impossible to get quick and permanent results without using a CM potency. Very often, Chlamydia has to be prescribed for allergic complaints. I have established that *Histamine* is the complementary remedy to Chlamydia. It often has to be prescribed when the action of Chlamydia is exhausted. For several years I have been trying to write the remedy’s materia medica on the basis of my clinical experience but this proved practically impossible. The remedy covers literally all possible symptoms. I have come to the conclusion that the remedy’s key symptoms are as follows:

Unclear remedy pictures.

- ~ Anti-chlamydial titre higher than 1/0.
- <= Unbearable itching in the genital area.
- Sterility.
- Bone disorders.
- «• History of hormone treatment.
- = Allergies.
- Vascular disorders.
- = Almost all diseases at an advanced stage when the patient is very weakened.
- ~ Patients of advanced age.
- » Conjunctivitis.
- ~ Brittle fingernails.
- ~ Parodontose.
- = Sycosis.
- = Reiter’s syndrome.

[Mario Boiadjiev, *Chlamydial infection*, HL 1/02]

SYMPTOMS

MIND

- Masculine and aggressive behaviour. [3 female provers]
 - = Have found myself doing ‘manly’ things, eg, lifting up my coat to put my keys in my trouser pocket like a man and putting my foot up on a wall to retie my shoelaces - I never do that. I was aware of doing something different and of what other people may think, but it didn’t really worry me. I just

thought, this is strange.

= I noted I was walking along and was aware I was striding out more than I usually do; like a man's walk. This also happened this afternoon in the town. I checked myself and reverted back to my usual walk.

~ Became very aware of my shoulders being broad and aware of the width of the top half of my body.

= I'm being very nasty to my daughters - psychologically bullying them. I just seem to want to be in control and 'better at doing things' than they are. Losing patience quicker. Daughter says that the remedy has stopped her mother from knowing her.

= Irritable, especially with children who are driving me mad.

• Confusion over communication. Secretive; hiding; mistakes. [4 provers]

~ There were numerous problems with communication throughout the proving. This starts with the uncertain provenance of the remedy itself and the confusion for many years over whether Chlamydia was a bacteria or a virus. Provers were often very reluctant to discuss their symptoms with their supervisors, and indeed the full scope of the proving was only identified once the proving notebooks had been returned. Provers reported finding the attention of their supervisor intrusive or unwelcome at certain points in the proving. [Bocock]

- Forgot to phone supervisor yesterday - or was it supposed to be today? Have become forgetful of when I'm supposed to phone - even if it's my turn or hers.

<• Feels as if losing track of communication with supervisor - forgot to phone - could not remember if she was meant to.

= Intended to telephone my supervisor, but dialed another student's number instead.

-> Made silly mistakes — went swimming but took daughter's [age 7] swimming costume instead of my own, even though it's kept in a different place. Took engagement ring off to put on hand cream whilst waiting for traffic light in car and put ring on lap. Forgot about ring, got out of car and lost ring. [Found again later.]

= I have felt a bit dreamy, airy. I did have to try and concentrate a little bit more to push the right buttons at work — and did make mistakes punching in numbers. Had to double-check all the numbers I was punching into the till - I don't know if it is my eyes having trouble focusing on different distances all

the time, but I don't have it with letters. I feel I could easily make a mistake.
« I feel scatty — feels the way it did when I was pregnant.

- Distressing dreams of danger. [3 proverbs]

= Dream: I am walking along on a road, I take a leaf off a tree, I break the leaf and taste the milky fluid on my tongue. Having tasted it I was afraid that it could be poison, so I found myself lying down. I was comforted by a female, who also kissed me on the lips. Feeling of worry when I woke up.

= Dream: I'm standing in a house I use to live in 17-18 years ago with family and family friends. A lorry crashes into the house and I shouted "move out of the way" and immediately woke up. My wife also had a dream the same night: we are inside our house a lorry crashed into our house. We try to run, but we can't run, can't move out of the way.

- Bad dream - son died - dream concentrated on after the event. Trying to be normal and then just bursting into tears and rushing out from wherever I was [public place]. Woke up freaked out by dream.

~ Dream of driving in car with husband, passing very narrow bridge with nasty drop. Husband got out of car and I drove over [with a feeling of "I can do this"]. But then car started tipping over to the left. I woke up shouting with fear and feeling "I do need him after all."

GENERALS

- Temperature. [2 proverbs felt warm; 1 proverb felt cold]

= Feel heavy and very cold.

<= Feel very warm on a cold day; want car window open and desire cold drinks.

= Flush of heat. It started at my neck and was quite intense. I was red in the face and felt hot to touch. Lasted about 1 minute. Passed off quickly. My daughter said 'Mum is boiling'.

- Today I went for a walk without my usual coat and I didn't feel the cold at all. I was also very tired which usually makes me feel the cold even more.

- Energy. [2 proverbs]

~ Feel weak and muscles feel relaxed.

= Sudden onset of extreme tiredness, eyelids heavy and gritty eyes. Had to lie

down and rest for 1 hour. Couldn't sleep - too much on mind.

~ My daughter and husband think the remedy has made me look tired.

- Cravings. [1 prover]

- = Sudden desire to eat lots of cream crackers, butter and cheese.

- = Strong desire for chocolate.

- Sensation of heaviness. [2 provers]

- = Heavy pressing sensation in middle of chest, followed by same sensation in head.

- = Sensation of a heavy weight behind sternum in centre of chest; wants to hunch shoulder over; > rubbing.

Same feeling of weight behind sternum > sitting up right and rubbing. Most uncomfortable sensation, accompanied by palpitations and irregular heartbeat. Sensation like something moving around behind sternum, plus feeling of warmth in my chest at same place. As if something inside pushing forwards to get out. Unpleasant and uncomfortable. > Walking and drinking water.

- Sensation as if menstruation would appear. [2 provers] Menses too early. [1 prover]

- Had a dull ache in my lower abdomen just like the period pains. I really thought I was coming on but I knew I couldn't be. I kept going to the bathroom to check for bleeding if felt so like my period pains. Also notice white [and sticky] leucorrhoea like I have when I'm ovulating but it's too early for that.

- = Bloating tummy, feeling as if period would start - but not yet due for 10 days. Crampy pains in lower tummy.

- <• Appear to have started period [9 days early] - passes small blood clot - but checked again 3 hours later and false alarm - no further bleeding. But 8 hours later bleeding re-started. Period starts. Period seems to be a bit heavier than normal. Extremely bloated before bedtime. I look pregnant.

- = In the shower I noticed that my nipples were tender just like they are before a period, but I have just finished my period.

-
- Sensation as if pregnant. [1 prover]

- ~ Headache went overnight but returned on waking. Headache made her feel like when she was pregnant.
- = When setting down to sleep an old symptom from when I was pregnant and experiencing Braxton-Hicks contractions came back.
- = Daughters keep wanting to pretend that they are breastfeeding from me - games included being pregnant and expecting twins.
- = I feel scatty - feels the way it did when I was pregnant.
- Pain in right buttock - dull ache, constant, > standing, < sitting [previously noted when pregnant].

LOCALS

- Headache.

- = Vague headache on and off all morning, like a pressing pain over the front of head and above eyes. Feels as if it goes to the tip of the nose. < Leaning forward, cold air, thinking about it. > Firm pressure on forehead.

- Eyes. [2 provers]

- => Slight stinging, watering sensation.
- = Sensation as if there were eyelashes in both eyes, & slight lachrymation. [Trichiasis is a symptom of trachoma.]
- ~ Lachrymation [right eye] in cold air.
- = Slight photophobia.

- Extreme sensitivity of teeth to cold water when brushing teeth. [1 prover]

CASE

(1) Patient, aged 36 and 6 months pregnant, with a history of thrush and infertility, cervical erosion, cervical cysts, cervical warts, uterine fibroids, appalling menstrual pains, thyroid tumour, sebaceous cysts, endometriosis, varicose veins and mild eczema of the hands. Her mother died of thyroid cancer at the age of 45 when the patient was only thirteen years old. Since then she has had a fear of early death herself. She also suffered with recurrent sinusitis and eczema on the

hands, but thrush and vaginitis have been the complete bane of her life, starting at age sixteen-seventeen, after the death of her best friend from cancer. She said that after this death, she made a promise to never love anybody else, 'which of course I have'.

Described herself as introspective, creative, independent and self-contained. Likes to read horror and crime stories. Works as an illustrator of children's books, and through this exhibits a kind of dark humour while in her darker states there is a marked morbidity. There are big issues around death, grief and pain. The thrush and vaginitis have inhibited her life to a marked degree, preventing her from taking work outside her home or from travelling, which she loves, and has also deeply affected her sexual expressiveness.

She has leucorrhoea with pains, which are scalding, sore, stabbing upwards, biting or nipping. Irritation of the bladder with bearing down pains. The pains are made worse by intercourse and therefore interfere with a normal sexual relationship with her husband.

Over the course of the years ... she has received both chronic and acute prescriptions including *Nat-mur.*, *Care.*, *Sep.*, *Kreos.*, *Con.*, *Nit-ac.*, *Thuj.*, *Med.*, *Folliculinum*, *Berb.*, *Merc.*, and *Puls.* Invariably the remedies would bring relief but inevitably the condition would deteriorate and the patient returned.

October 1999. Had given up milk and been free of pain, although the discharge continued and she had a recurrence of eczema. Towards the end of September, the symptoms started to recur after intercourse; simultaneously the eczema cleared up. Thick, green, copious discharge, really sore, stinging and burning. Yelling at the kids and wanting to be left alone.

Had started a job working with elderly people, although she didn't really like working with people. Still feeling morbid when unwell. Prescription: *Chlamydia 30c* bd. for 10 days. Symptoms abated after the remedy, but did not go completely. Discharge persisted and at ovulation, the symptoms started to relapse. Earlier on in the week she thought she was getting sinusitis; has been very dizzy in the morning but nothing further materialised. Sleep disrupted by irritability of the bladder, which was better avoiding milk. Plan: Wait.

November 1999. OK for one month. Immediately after menses she felt burning and sore, with viscous mucus, streaked with yellow. Repeated *Chlamydia 30c*, which helped. Discharge went away, but burning continued; however, intercourse was OK. Had some facial cysts and skin felt puffy. Had aches and pains in throat, which cause her anxiety because of her mother's cancer. A lot of issues are coming up for her around her mother's death and she has been feeling a bit glum and neurotic when well. Remedy: *Chlamydia 30c* bd. for 10 days.

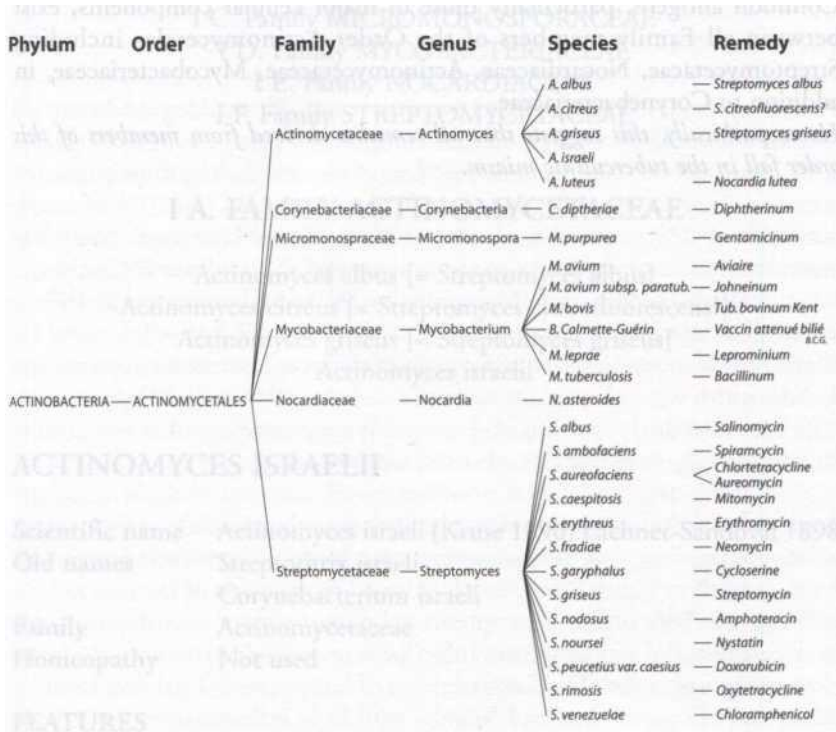
May 2000. Slowly but surely everything ameliorated. For the previous month she was getting sore throats and self prescribed *Nit-ac*. When the sore throats ameliorated she started with sinusitis. Had quite a lot of sore glands around neck and face and eyes have been full of pus. ... Still getting a yellowish, mucous discharge at ovulation and slight irritability in that region. Sleep is brilliant. Had a little eczema on one finger and some skin eruptions before menses. Mood has been fine. Finally begins to get some body confidence and her horizons are starting to open up. Prescription: Chlamydia 10MK.

October 2000. Has had three good months, apart from slight discharge prior to ovulation, whitish, yoghourty. No real discomfort. Very slight recurrence in the last couple of days, burning across abdomen, a bit of increased frequency, slight green discharge; some recurrence of the eczema on her hands. Chlamydia 10MK.

April 2001. Continues to be well. Occasional return of some vaginal symptoms [a slight greenish discharge], usually at the beginning and end of ovulation with 80-100% freedom from symptoms at all other times. ... Continues to increase the amount of work she does outside the home and is now able to enjoy a normal sex life with her husband. Continued the patient on Chlamydia 10M. *September 2001.* Had gone all through the summer 90% symptom free.

[Summarised from: Lynda Kenyon & Mario Boiadjev, *An Introduction to Chlamydia, With a case of Chlamydia trachomatis*-, HL 1/02]

PHYLUM ACTINOBACTERIA



Developing an elaborately branched mycelial system of filaments, these bacteria were long mistaken for fungi. [Actinomyces means 'ray-fungus'.] Some reproduce by forming chains of actinospores at the tips of the filaments; others, eg Nocardia, break their filaments up into cocci or rods. Actinomycetes are typically saprobes [esp. in soil] but a few are pathogenic for humans, animals, and plants, while others form lichen-like associations with green algae. Mycobacterium spp. have short filaments, Streptomyces spp. have long ones. Most antibiotics are derived from actinomycetes, notably Streptomyces spp.

Because the antibiotics are produced at the same time as the spores, it is thought that these compounds inhibit the growth of bacteria and fungi that would otherwise compete for nutrients with the germinating spores.

Common antigens, particularly those of major cellular components, exist between all Family members of the Order Actinomycetales including Streptomycetaceae, Nocardiaceae, Actinomycetaceae, Mycobacteriaceae, in addition to Corynebacteriaceae.

Homeopathically, this suggests that all remedies derived from members of this order fall in the tuberculinic miasm.

I. ORDER ACTINOMYCETALES

- I A. Family ACTINOMYCETACEAE
- I B. Family CORYNEBACTERIACEAE
- I C. Family MICROMONOSPORACEAE
- I D. Family MYCOBACTERIACEAE
- I E. Family NOCARDIACEAE
- I F. Family STREPTOMYCETACEAE

I A. FAMILY ACTINOMYCETACEAE

- Actinomyces albus [= Streptomyces albus]
- Actinomyces citreus [= Streptomyces citreofluorescens?]
- Actinomyces griseus [= Streptomyces griseus]
- Actinomyces israelii

ACTINOMYCES ISRAELII

| | |
|------------------------|--|
| Scientific name | Actinomyces israeli (Kruse 1896) Lachner-Sandoval 1898 |
| Old names | Streptothrix israeli Corynebacterium israeli |
| Family | Actinomycetaceae Not used |
| Homeopathy | |

FEATURES

- Gram-positive, anaerobic, non-motile, facultative aerobic organism that may appear as rods or cocci and can be mistaken for diphtheroids.
- Named after the German bacteriologist Israel, who wrote the first important paper on actinomycosis as a disease of man in 1876.
- Forms spidery colonies with a dense mycelial white to yellowish centre, referred to as “sulphur granules.” [Granules have a sulphur-like colour but do not contain sulphur.]
- Commensal of the normal saprobic oral flora; isolated as normal flora from saliva and tonsillar crypts.
- Grows in dental plaques and at the roots of carious teeth in a morphological

form resembling diphtheroids. The organism has been associated with dental caries.

- Forms in the tonsillar crypts white to yellowish granules of cheesy consistency, always in association with bacteria of many kinds.

ACTINOMYCOSIS

Actinomyces israelii and related organisms are the aetiological agents of actinomycosis. The condition has an endogenous origin, arising from pathogenic changes in the normal anaerobic flora of the mouth. The three important sites of primary lesions of actinomycosis are cervicofacial [50-70% of cases], thoracic [15-20%], and abdominal [10-20%]. These three forms bear close resemblance to cervical, pulmonary, or intestinal tuberculosis, respectively. Actinomycosis occurs more frequently in males and seems to prevail in individuals aged 20-50 years.

Until 1944 the traditional treatment of actinomycosis consisted of potassium iodide, which was only partially successful and after 1944 replaced by penicillin. The basic histologic reaction of *A. israelii* is suppurative, and is very similar to that seen in chronic lesions due to *Staphylococcus*.

Injury of oral mucous membranes, eg, after a tooth extraction, may result in actinomycetic infection of adjacent face and neck areas, producing a swollen, hard, reddish to bluish lump, usually located at the angle of the jaw, known as *lumpy jaw*. Poor oral hygiene appears to be an important contributing factor in the incidence of actinomycosis. Infection is more liable to occur in the lower than in the upper jaw. The first symptom of lumpy jaw is a painless swelling which later becomes firm and 'woody' with little inflammatory tissue reaction. As the disease progresses the abscess breaks through the skin surface to produce draining sinus tracts [fistulas]. Pain is minimal to absent. Lymphadenopathy typically is absent. Trismus is present if the mastication muscles are involved.

Aspiration of the fungus-like bacteria into the lungs, in combination with lowered vitality of the host, produces *thoracic* or *pulmonary* actinomycosis. The initial infection resembles early tuberculosis, but differs from it by being more frequently located in the bases of the lungs. [TB typically favours the apex of one or both lungs.] The condition is characterised by fever, dry or productive cough, mucopurulent sputum [occasionally blood-streaked],

shortness of breath, chest pain, weight loss, fatigue, anorexia and, ultimately, draining lung sinuses, which may contain sulphur-coloured granules.

Abdominal actinomycosis typically occurs in patients with a history of recent or remote bowel surgery or ingestion of foreign bodies [eg, chicken or fish bones], during which actinomycetes is introduced into the deep tissues. The ileocaecal region [right lower quadrant] is involved most frequently, and the disease presents classically as a slowly growing tumour. Symptoms are nonspecific: low-grade fever, weight loss, fatigue, vague abdominal discomfort, nausea, vomiting, diarrhoea or constipation, sensation of a mass.

Pelvic actinomycosis most commonly occurs by the ascending route from the uterus in association with intrauterine contraceptive devices. In such cases, an IUCD has been in place for an average of 8 years. Presenting symptoms are lower abdominal discomfort, sensation of a mass, abnormal vaginal discharge, and/or irregular or excessive bleeding during menstruation and between menstrual periods.

Haematogenous spread of *A. israelii* from the jaw, lungs, or gastrointestinal tract may result in systemic illness involving numerous organ systems. Characteristic of actinomycosis is the healing of sinus tracts with scar formation in one area with appearance of new sinuses in other areas.

I B. FAMILY CORYNEBACTERIACEAE

Corynebacterium diphtheriae

CORYNEBACTERIUM DIPHTHERIAE

Scientific name *Corynebacterium diphtheriae* (Kruse 1886) Lehmann & Neumann 1896

Old names *Microsporon diphthericum*
Mycobacterium diphthericum

Homeopathy Diphtherinum - Diph.
Bacillus diphtheriae - Diph-b.
Diphtherotoxinum - Diphtox.
Diphthero vaccinus - Diph-vc.

FEATURES

- Gram-positive, non-motile, straight or slightly curved bacterium with rounded and usually clubbed ends [Gr. *koryne* = club].
- Aerobic or facultative anaerobic; obligately parasitic, pathogenic organism.
- Fermentative metabolism [converts carbohydrates into lactic acid],
- Does not form chains, but occurs in configurations of two, three or rarely four individuals.
- Typically polymorphic.
- Corynebacteria undergo snapping movements just after cell division which bring them into clumps resembling Chinese letters or in palisade arrangements of cells in short chains ['V' or 'Y' configurations].
- Old bacteria store inorganic polyphosphates [metachromatic granules].
- Aetiological agent of diphtheria known in 17th century Spain as "El garatillo" [the strangler]. Disease name from Gr. *diphthera*, leather, in allusion to the choking tissue produced in the throat.
- A disease of the colder months in temperate zones, seasonal trends are less distinct in the tropics.
- Colonizes the mucous membranes of the respiratory tract.
- Described and isolated by Klebs in 1883; cultivated by Loftier in 1884.
- Part of the CMN group [Corynebacteria, Mycobacteria and Nocardia].
- One of the fastest growing bacteria with an incubation period [1-4 days] and prodromal period [12-24 hours] which are among the shortest in

bacterial diseases.

- Proliferates in milk. Diphtheria epidemics have been associated with raw milk supplies.
- Survives freezing and frozen storage for at least five days, eg in ice cream, but a temperature of 58° C is fatal to it in ten minutes.
- Reyes has demonstrated that “in absolutely dry air diphtheria bacilli die in a few hours. In sand exposed to a dry atmosphere the bacilli die in a five days in the light; in sixteen to eighteen days in the dark. When the sand is exposed to a moist atmosphere, the duration of their vitality is doubled.” [McFarland]

CLINICAL FEATURES

- Diphtheria is more severe for those under 5 and over 40 years of age. Central and South America, Africa, Asia, Russia and Eastern Europe are regions with high rates of endemic diphtheria.

- *Toxigenic* strains produce a virulent exotoxin causing a pseudo-membranous inflammation of the mucous membranes, accompanied by a systemic toxæmia with a high affinity for the heart and kidney, although degenerative changes may occur in other tissues such as muscles, peripheral nerves, adrenals, liver and spleen. The pseudo-membrane occurs particularly upon the fauces but is also not infrequent in the nose, in the mouth, or upon the genital organs. *Diphtheria toxin production is greatest under conditions of iron deficiency.* The bacterium may not produce maximal amounts of toxin until the iron supply in tissues of the upper respiratory tract has become depleted.

Nontoxigenic strains produce symptomatic diphtheria with a milder clinical course. Cutaneous diphtheria occurs when the abraded skin is the primary site. Lesions appear as punched-out ulcers with dirty grey membranes at margins.

- *Streptococcus pyogenes* and *Staphylococcus aureus* are often found in association with diphtheria bacteria, especially when severe lesions of the throat exist.

Initial stage

- Onset sudden with sore throat, malaise, low-grade fever, and headache.
- Nausea, vomiting, chills, headache, and fever are more common in children.

Later stages

- Formation in the tonsillar area of a greyish-blue or white, tough, adherent membrane which may cause bleeding on removal.
- Foul breath.
- Dysphagia.
- Pallor.

Its *mild forms*, which, by some, are designated as *catarrhal diphtheria*, usually commence with fever and soreness in the throat. The temperature may rise from 101° to 105° F. in the first days, showing always evening exacerbations. From the fourth to the sixth day the temperature gradually declines. The fauces look at the beginning only inflamed but show in a short time the characteristic patches first on one tonsil, and then on the other. With this we find the lymphatic glands of the jaw regularly somewhat swollen, a distinctive feature of diphtheria from a mere catarrhal inflammation of the throat. The fever is, in most instances, attended with more or less, sometimes excessive, *languor* and debility from the outset, with *headache*, pain in the *back*, also at times with gastric symptoms, seldom vomiting. [Raue]

- Signs of toxæmia and prostration when the disease progresses.
- Pharyngeal and laryngeal oedema, impeding respiration.
- Swelling of cervical lymph glands.
- Muscle weakness.
- Marked oedema of tonsils, uvula, submandibular region, and anterior neck [bull neck] in severe cases; may be associated with thick speech.
- Bloody or mucopurulent nasal discharge [with nasopharyngeal involvement], often one-sided.
- Haemorrhagic conjunctivitis and dissolution of the cornea may occur.
- Hoarseness, dyspnoea, stridor, and a loud brassy cough [from extension of membrane into larynx and bronchial tree].

It occurs oftener in children than in adults, and much more frequently in severe than in mild cases. Its characteristic signs are the long-drawn respiration, frequent, dry coughs, toneless, hoarse voice, great restlessness, and pain in the throat. [Raue]

Complications/sequelae

- Myocarditis; heart failure.

-
- Arrhythmias.
 - Cranial neuropathy [oculomotor, nasociliary]. Dysphagia and nasal regurgitation.
 - Peripheral neuropathy. Symptoms start in proximal muscle groups of extremities and spread distally. Severe cases spread to the trunk and cause bowel and bladder dysfunction.
 - Paraesthesias, mainly occurring distally, are the most common sensory disturbances.

IMMUNISATION

- Diphtheria antitoxin [toxin-neutralizing antibody] came into general use about 1895; it is prepared from blood of horses challenged with gradually increasing doses of either bacillus or toxin. Antitoxin is administered to neutralize circulating diphtheria toxin. Adverse effects include serum sickness [fever, urticaria, muscle and joint pain]. Diphtheria paralysis is more frequent after the use of antitoxin than in cases treated without it. Henry Lindlahr, in the 20th edition of his book *Nature Cure*, comments that, in the 1920's, "many of the best medical authorities are abandoning its use on account of its doubtful curative results and certain destructive after-effects." And:

In my own practice, I am frequently consulted by chronic patients whose troubles date back to diphtheria "cured" by antitoxin. Among these I have met with several cases of idiocy and insanity, with many cases of partial paralysis, infantile paralysis, and nervous disorders of a most serious nature, also with various other forms of chronic destructive diseases.

In the iris of the eye, the effect of the antitoxin on the system shows as a darkening of the colour. In many instances, the formerly blue or light-brown iris assumes an ashy-grey or brownish-grey hue.

- Passive immunity in utero is acquired transplacentally and lasts at most 1 or 2 years after birth.
- Active [artificial] immunisation is carried out with diphtheria toxoid [vaccine consisting of formaldehyde-inactivated toxin]. In most countries, infants are immunised with a trivalent vaccine containing diphtheria toxoid, pertussis vaccine, and tetanus toxoid [DPT or DTP vaccine].

- Mass immunisation is advocated and denounced with equal zeal. Ardent supporters of the method claim that immunisation programs in Western Europe and the U.S. have decreased the incidence of clinical diphtheria significantly. However, disease and death rates had already fallen dramatically prior to widespread vaccination. Regarding the use of the diphtheria nosode, Diphtherinum, as a prophylactic instead of the immunisation carried out with diphtheria toxoid, Dorothy Shepherd regards the homeopathic prophylactics as “far safer” and “not complicated by any early or late after-effects.”

Dr. Bodman said that at the Bristol Homoeopathic Hospital some thirty to forty nurses were immunised by the orthodox method. It was noticed hereafter that an enormous amount of sickness followed immediately after the immunisation. It temporarily reduced resistance to any infection, and they went down with influenza, German measles, whooping cough, and the sickness rate among the nurses was higher during the six months following diphtheria immunisation than in any period in the history of the hospital.

Personally, as I have stated already on different occasions, I have observed during the last twenty years that immunisation is followed in an appreciable percentage of cases by a general lowering of resistance, and I have seen serious and fatal cases of toxæmia coming on within a week or two after diphtheria inoculation. Dermatitis starting from the point of inoculation and spreading all over the arm and to the chest and cheek developed in three children of one family after the inoculation, and the Loftier bacillus was found in the discharges from the skin. Diphtherinum M in daily doses cleared up the dermatitis in a fortnight, when previously it had gone on spreading for several months, and resisted all sorts of local treatment.

I am chary of advising diphtheria inoculations as a method of prevention of the disease. I was medical officer at a children's clinic which served a crowded area in South London within the reach of eight big schools, with a population of several hundred scholars in each. We had a daily attendance of over a hundred children for treatment. We always knew when there had been an immunisation session at any of the schools nearby, for they flocked in their dozens to us, having their swollen arms, the septic sores, and the dermatitis dressed within a few days. We used to give them as a matter of routine Diphtherinum 30 in daily doses, and got rapid healing and disappearance of the lesions. Later results in many of the children who bore the brunt of the inoculations well in the early days, were crops of multiple warts on hands, arms, and in their hundreds on the cheeks and face, peculiar dark brown, almost black, minute warts,

which went on for months, but cleared up, almost overnight, at any rate in a week or two, with repeated doses of Diphtherinum 30.

[Dorothy Shepherd, *Homoeopathy in Epidemic Diseases*, 1967]

MATERIA MEDICA DIPHThERINUM

Diph.

Sources

Drug picture based on symptoms observed in clinical cases of diphtheria and postdiphtheritic affections treated with Diphtherinum and/or Diphtherotoxinum [potentized antitoxin].

Contrary to the claim that Diphtherinum has been proved by Frash, no “careful and thorough proving of the dynamic potency on the healthy” has been conducted.

The “involuntary proving” by Frash, in 1907, involved the prescription of Diphtherinum IM three times daily for eight days and then twice daily for two days as a prophylactic in a nine-year-old girl who had been exposed to malignant diphtheria. This can hardly be regarded a proving because no symptoms appeared during the ten days of taking the drug. The onset of the disease coincided with the last day of taking the drug. The disease then ran its normal course; hence the symptoms attributed to the drug merely display clinical manifestations of diphtheria.

Several symptoms in the materia medica of Diphtherinum come from this nine-year-old girl:

- Face flushed, with centre of cheeks almost purple. [First day of fever.]
- = Talks in sleep, with open eyes. Also: Sees imaginary objects. [First day of fever: “Monday night talks in sleep, with eyes wide open. Wanted imaginary objects taken from room, and to ‘make those people get away.’ Sat up and picked among bedclothes for strap for her schoolbooks.”]
- ~ Jerking of single parts. [Third day of fever.]
- = Hold; desire to be held; > being held. [“Desired to have mother hold her hand”; fourth day of fever.]
- Fanning of the alae nasi & snoring. [Fifth and last day of fever.]
- = Dry skin. [“Skin seemed dry,” fifth day of fever.]
- => Moisture at margin of hair, when first falling asleep. [Fifth day of fever.]

The proving by Waffensmith in 1921 on Mrs. P., aged 55, appears to have been an attempt at prophylaxis, given the conclusion that “this case one

month later developed a malignant type of diphtheria, on the left side and passed from under my care, and was given antitoxin by another and finally recovered.”
[J.W. Waffensmith, *A Proving of Diphtherinum, 10M-*, Hom. Rec., Vol. 36, 1921]

Applications

- « Especially adapted to the strumous diathesis; scrofulous, psoric or tuberculous persons, prone to catarrhal affections of throat and respiratory mucous membranes.
- = Patients with weak or exhausted vitality hence are extremely susceptible to the diphtheritic virus; when the attack from the onset tends to malignancy.
- = Painless diphtheria; symptoms almost or entirely objective; patient too weak, apathetic or too prostrated to complain; sopor or stupor, but easily aroused when spoken to.
- » When the patient from the first seems doomed, and the most carefully selected remedies fail to relieve or permanently improve. Epistaxis or profound prostration from very onset of attack.
- « “Never well since diphtheria.”
- « Postdiphtheritic paralysis, especially where antitoxin has been used; many cases cured after Caust., Gels., Nux., Secale and the best selected remedies have failed.
- In postdiphtheritic paralysis and spinal affections following diphtheria many brilliant cures have been effected by the potencies.

[H.C. Allen, *The Materia Medica of the Nosodes*]

SYMPTOMS

Waffensmith’s “proving” of Diphtherinum 10M, one powder every three hours, three doses, resulted the next day in:

- Chilliness, followed by heat.
- Restlessness.
- Desire for cold. Desire for cold air to pass down throat.
- « Small, greyish-white patch on left tonsil.
- Faint feeling in stomach, > milk; sipping small quantities of milk [likewise in another case after having taken the remedy for prophylaxis].
- ~ Internal trembling.
- Yellow, thick discharge from nose [also presented in another case].
- Aching, breaking sensation in all joints, > lying.

= Dryness of palms; felt as if withered; hot to touch.

- Drawing of muscles, then a sudden snapping. [This is a peculiar symptom in keeping with the fact that the corynebacterium undergoes snapping movements shortly after cell division.]

[These symptoms were “promptly cleared up” with *Mercurius iodatus ruber* 200.]

CASES

(1) Master P. B. aged 14 years, a young boy, was brought to me for consultation on 28th Oct. 1963, with very severe pain in the hamstring tendons of the right leg, of 15 days duration. The pain was so severe and he was so much aggravated by stretching the leg, that the boy could not stand up or walk. He had to be carried to the bathroom by his father whenever he wanted to attend nature’s calls. On examination, I found tenderness in the right popliteal fossa. The lateral tendon which is normally palpable on flexion could not be felt or seen.

His appetite, thirst, stool, sleep etc., were normal but enquiry revealed that one month previously he had an attack of measles. Further, I learnt that in July ’56, he had suffered from an attack of diphtheria from which he had recovered with the help of A. D. Serum but since then his health had not at all been good. He used to suffer every day some disorder or another, throat trouble or fever or abdominal pain or vomiting and so on.

Though the boy had approached me only for the acute condition of the pain in the hamstring tendons, I thought of treating the background first. After all there was the possibility that he was suffering from ill-effects or sequelae of diphtheria whether it was related to the present illness or not. So I gave him six doses of Diphtherinum 1 M to be taken t.d.s., thinking I would clear up the background first. I was planning to work out the remedy for his acute condition, after two days.

On 31st Oct. ’63, that is three days later, he returned to consult me and you imagine my surprise when I found that the severe pain and tenderness in the legs had completely disappeared! He could extend his legs completely and was able to walk about normally. His mother reported that within the last two days his general health has become much better.

I gave him no further medicine. I saw him again on 11th Nov. 1963. His condition was normal. He got slight pain in the leg only if he walked very long distances. Till 1st August 1966, he has remained normal.

[P. Sankaran, *Some Notes on the Nosodes*]

(2) A woman, 26 years of age, first seen in 1936, had been deaf following a

perforated drum and discharging ears after diphtheria when she was ten years old; very deaf and in consequence appeared stupid; one had to shout at her several times before she was able to take in anything. Her ears had to be cleared every month by her panel doctor, as they got so full of matter and debris. She told me later she had had a very severe attack of diphtheria and had been given up by the hospital doctors; then the ear started discharging in hospital and she had never completely recovered from all this trouble.

She was used to her deafness and believed nothing could be done for it. I saw her off and on when she brought her children, but did nothing for her until August 1940, when she complained of severe noises in the right ear, which made sleep impossible and life almost unbearable. She was given Diphtherinum CM on this history, and at the end of November, 1940, she reported that the noises in the head had been much better for a few weeks after her last visit, but the gun fire and the bombs had made the noises in her head worse again. Diphtherinum CM. 2-1-1941. - Noises much improved. Still deaf, but she fancies she can hear a trifle better. Diphtherinum CM.

21-3-1941. - Noises better, deafness distinctly improved. Diphtherinum CM. 2-4-1941. - No noises, hearing greatly improved. No medicine.

27-10-1941. - Hearing wonderfully better, no noises. Diphtherinum CM.

9-2-1942. - Left ear discharging again - very offensive; no noises in head. Streptococcus 200.

6-7-1942. - The ear discharge cleared after a few days in February. She can hear ordinary conversation, and can hear me, when I speak to her softly six feet behind her back, so that there is no likelihood of lip reading; much more intelligent in consequence. Watch test; can hear watch ticking on contact with drum on both sides. Diphtherinum CM.

Her hearing is now good enough for everyday work and communication with the rest of the world. She rarely misses a word. Deaf for 20 years; had given up all hope, and with a few doses of this nosode, spread over nearly two years, the deafness had ceased to give her trouble; and the noises in the head, which are almost impossible to get rid off by ordinary methods, have also disappeared.

(3) A second similar case turned up in September, 1941; married woman, aged 25. Almost total deafness; used to attend the deaf school as a child. History of deafness since a severe attack of diphtheria at the age of 7.

She was so deaf that she could hear nothing at all, but brought a friend with her as an interpreter. Three months pregnant, really only came to have her milk form signed. She was given a dose of Diphtherinum CM.

Seen five weeks later on October 6[^], 1941, when she came by herself, and was able to hear what was said to her with hardly any difficulty. Diphtherinum CM. 20-10-1941. - Much brighter, more intelligent, deafness hardly noticeable. Diphtherinum CM.

1- 12-1941. - Quite chatty, hearing for the human voice good; hears ordinary conversation without the voice having to be raised. Diphtherinum CM.

2- 2-1942. Deafness greatly improved, can hear my voice even with my back turned and always comes by herself now. Syphilinum 30 given, as besides her deafness following after diphtheria at the age of 7, she looked a typically congenital syphilitic, and had deformed hands and fingers since birth.

23-3-1942. Seen again. Premature child born, weight 4 lbs. 3 ozs. Syphilinum 30. No deafness noticeable.

Deaf for 18 years; almost total blotting out of the human voice for years and then a few doses of the correct nosode, and the hearing, useful hearing, returns. I do not claim that she can hear 100 per cent or the slightest whisper, but ordinary conversation without lip reading is now possible for her, as well as to the other woman mentioned previously.

[*Diphtherinum cases*-, The Homeopathic Herald, Jan. 1943; EncHom]

(4) This is a small, slight, single woman of 55 years whom I first saw in 1939. It has been a history of colds returning at intervals in all the years since. Always starting with a raw throat and with the throat taking part in the whole attack, she has been more nearly prostrated with the attacks than she should have been and longer recovering as time went on. She would have a low fever, creeping chills, ears feeling full, all of it a real prostration. Remedies were palliative but not satisfactory. She began to have dyspnoea climbing stairs.

In March, 1949, she reported that when twenty years old she had had very severe diphtheria and was long recovering; no antitoxin given.

I looked back over the many years of throat symptoms and general health depression and drew a long breath of relief.

Diphtherinum IM, given twice, four months apart, produced improvement which did not last; but given in the CM this remedy has begun good work. It is not time yet for final judgement as her last dose was last February but I have hopes now.

[J.M. Green, *Results to date using Dr. Tyler's method with nosodes*-, Hom. Rec., Feb. 1951; EncHom]

(5) Baby G.A.S., first seen May 5[^] 1951, aged one year and a day. The baby

was born prematurely, estimated at seven and one half months; from birth, his eyes have been useless to him due to paralysis of the extrinsic muscles. He lies quietly, not trying to move very much, appearing not to notice anything of the surroundings, as if unable to see. The eyes roll in their sockets without co-ordination, the predominating position being rolled downward. Mother states his urine is very strong in odour, similar to ammonia. Many red naevi on his body. First prescription, May 5^{1*1}, 1951, Causticum 10M.

May 19, 1951 - Second visit. Some improvement. Plays with his hands. Gets onto his knees, and rocks on knees and elbows a good deal of the time. Focuses his eyes for very short periods on his fingers. His mother has a sore throat and a cold. R.: Diphtherinum 10M.

May 20, 1951 - R.: Causticum 10M.

June 9, 1951 - Neighbours and family enthusiastically affirm improved ability to focus. R.: Causticum CC.

Having been fortunate enough to find the remedy Diphtherinum and its complement, Causticum, for this baby, I now learned the rest of the case history, withheld at the earlier visits. The baby was expected in June. In December, before Christmas, his mother suddenly suffered an inflammation of the eyes, which were very red, and very sensitive to light. This was treated with argyrol drops in the eyes, and soon was under control.

But right after Christmas, she had a very sore throat. This was not yet cured when she began to bleed, and was hospitalized under sedation for about ten days to avert a miscarriage. Her throat continued sore at intervals. She developed a chronic "sinus" condition. The baby was finally born prematurely at seven and a half months about the fourth of May. At first his eye condition was assigned to his prematurity, but remained quite stationary for one year, improving only after the administration of Diphtherinum and its complementary remedy, Causticum, and then rapidly showing signs of disappearing altogether.

[M.B. Rood, *A Case of Prenatal Suppression*-, Hom. Recorder, Dec. 1951; EncHom]

(6) Miss H.M., age 20 years. About three months before admission to hospital patient had attack of diphtheria, which lasted for three weeks. A few days after recovery she suffered from post-diphtheritic paralysis of the throat. About two weeks previous to admission her legs became so stiff that she was unable to walk. Patient complained of loss of sensation in legs and feet. This soon passed, but legs felt heavy and weak. Throat symptoms continued with inability to swallow, etc. Patient told by doctors that nothing could be done for her. January 22. Patient admitted to Flower Hospital. Temperature normal, pulse 100.

Jan. 23. Diphtherinum CM.

Jan. 26. Out of bed in afternoon for three hours. Pulse normal.

Jan. 29. Complained of swelling of feet. No pain.

Febr. 5. Diphtherinum CM.

Febr. 13. Discharged from hospital apparently cured.

The *New England Medical Gazette* says in commenting on this:

Some time last fall there came to Flower Hospital a young woman whom examination showed to be in from diphtheria. Immediate transference of the case to Willard Parker Hospital was made, where diphtheria antitoxin was employed with an uneventful recovery. Shortly after, during her convalescence, this patient noticed a weakness of the knees, as though they might give way, while standing or walking. There now followed much difficulty of swallowing, with regurgitation of solid food and of fluids, through the nose.

The patient returned to Flower Hospital and returned to Dr. Rabe's ward. Examination showed a post-diphtheritic neuritis, with paralysis of the muscles of deglutition and absent patellar reflexes. Eating or drinking were practically impossible, and a loose tracheal cough added to the trouble. In these cases we naturally think of Gelsemium, but no characteristic indications for its use appeared to be present.

Accordingly three doses of the nosode, Diphtherinum in the CM potency, were given at intervals of twelve hours. Immediate improvement began, and within three days the patient was able to eat a hearty meal of solid food. Homesickness now claimed her and in spite of the persuasive gentle eloquence of the intern, Dr. Markham, the patient insisted upon going home. Within three weeks or less she was back, applying for admission to the Women's Medical Ward. This time her legs would not carry her, being altogether paralyzed, so that she had to be carried in and put to bed. But her throat was and had remained entirely well. Diphtherinum CM, a single dose, was again given. In five or six days' time the patient was able to walk unsupported in the ward. At the present writing she continues to improve and has been given another dose of the remedy. There is every promise of a complete restoration to health.

[*High potency in post-diphtheritic paralysis*-, The Homoeopathian, Vol. IV, no. 5-6, 1914; EncHom]

(6) Girl, aged 7. - On October 21st, 1941, treated at first for warts on right hand and thumb following after immunisation in July, 1941.

On December 16th 1941, large ulcer seen on joint of left elbow; second diphtheria

inoculation done three weeks previously. This ulcer spread and spread until the whole of the left arm and forearm was involved. The skin was continuously bleeding and also discharging a clear serum. Various homeopathic remedies were tried, Calendula lotion was applied, but the infection got worse, the bleeding became more troublesome; it might heal here and there, just to break down a few days later; on the whole the tendency was to spread slowly and another patch appeared without rhyme or reason on the front of the right elbow and began to creep up to the right shoulder. Two months passed until on February 17^{*1}, when I was puzzling my brain what to do with her, I remembered the two diphtheria inoculations, and gave her Diphtherinum 30.

February 27^{*1}. - The arms which had looked so angry and red and inflamed, are paler, skin less thickened, a distinct and rapid improvement already in a week. Diphtherinum 30.

3-3-1942. - Elbow and forearm well, except for some roughness and scaling. Diphtherinum 30.

Further doses of Diphtherinum 30 given on March 17^{*1} and April 9^{*1} as the warts for which she originally came the previous October had not disappeared yet. 5-5-1942. - Both arms remain healed; warts gone.

A dermatitis involving both arms, getting worse for two whole months, until Diphtherinum 30 was given, when it just faded out in two weeks, showing the power of the potentized remedy, if it is the correct one, and similar to the complaint.

[*Diphtherinum: Ulcers and warts on arms-*, Hom. Herald, Vol. V, Jan. 1943; EncHom]

MATERIA MEDICA DIPHTHEROTOXINUM

Diphtox.

Toxigenic strains produce a virulent exotoxin causing a pseudo-membranous inflammation of the mucous membranes, accompanied by a systemic toxæmia with a high affinity for the heart and kidney, although degenerative changes may occur in other tissues such as muscles, peripheral nerves, adrenals, liver and spleen. The pseudo-membrane occurs particularly upon the fauces but is also not infrequent in the nose, in the mouth, or upon the genital organs. *Diphtheria toxin production is greatest under conditions of iron deficiency.* The bacterium may not produce maximal amounts of toxin until the iron supply in tissues of the upper respiratory tract has become depleted.

Indications

“This is a useful remedy for some obstructed cases in which there is a history

of recurrent sore throats or laryngitis, diphtheria, or a bad reaction to the diphtheria vaccine [give one or two doses in 15 and 30CH. For children subject to recurrent laryngitis, it is advisable to replace the DTP vaccine with a TP vaccine [without diphtheria].”

[Grandgeorge, *The Spirit of Homeopathic Medicines*]

Symptoms

The 107 symptoms listed for Diphtherotoxinum in Synthesis 9.1 are based on the clinical pathogenesis presented by Julian. It should be noted that Julian includes in his pathogenesis some symptoms of Diphtherinum as recorded by H.C. Allen. Both remedies have different sources, Diphtherinum being prepared from diphtheric pseudo-membrane, while Diphtherotoxinum is made from diluted diphtheria toxin, formerly known as Schick Test Toxin, a sterile filtrate from a culture in nutrient broth of *Corynebacterium diphtheriae* which, after being allowed to mature, is diluted so that 0.2 ml contains the test dose.

The Schick Test was used for the diagnosis of susceptibility to diphtheria and not, as Julian has it, to “create in man a state of immunity from diphtheria.” A 1966 survey among 3205 American children previously vaccinated against diphtheria, found a high incidence of positive reactions to the Schick test, particularly in children who had recently had various infections or who had had other vaccines within two months of being vaccinated for diphtheria.

Clinical experience will teach us whether there is reason to distinguish Diphtherotoxinum and Diphtherinum as separate remedies.

The following symptoms are in rubrics with less than 50 remedies:

- Mind, Insanity, with sadness.
- = Mind, Playing, aversion to play, in children.
- = Mind, Sensitiveness, want of sensitiveness.
- => Mind, Slowness, in motion.
- = Mind, Studying, difficult.
- = Vision, Accommodation, defective.
- Nose, Discharge, cold.
- == Nose, Discharge, offensive, fetid.
- = Nose, Epistaxis, children.
- ~ Mouth, Paralysis, Palate.
- ~ Throat, Diphtheria, malignant.

-
- = Throat, Mucus, black.
 - « Throat, Mucus, like false membrane.
 - = External throat, Complaints, Thyroid gland.
 - ~ Stomach, Eructations, when vomiting.
 - « Stomach, Eructations, through nose.
 - = Stomach, Nausea, deep breathing.
 - ~ Stomach, Nausea, after expectoration.
 - <• Larynx and Trachea, Inflammation, Trachea, in winter.
 - Larynx and Trachea, Voice, bi-tonal.
 - = Expectoration, Difficult, at night.
 - Expectoration, Difficult, children.
 - > Expectoration, Difficult, old people.
 - ~ Expectoration, Odour, fetid.
 - = Chest, Heart complaints, accompanied by Thyroid complaints.
 - = Chill, Chilliness, frequent attacks of.
 - = Generals, History, personal, laryngitis, recurrent.
 - = Generals, History, personal, throat, recurrent inflammation.
 - <• Generals, Multiple sclerosis.
 - ~ Generals, Paralysis, after diphtheria.
 - Generals, Tuberculosis, Glandular, Lymphatic glands.
 - = Generals, Weakness, in diphtheria.
 - > Generals, Weakness, rapid.

DIPHTHERIA, TETANUS, PERTUSSIS [DTP] VACCINE

History

In most countries, infants are immunised with a trivalent vaccine containing diphtheria toxoid, pertussis vaccine, and tetanus toxoid [DPT or DTP vaccine]. The DTP vaccine was introduced in the United States in the 1940's, heralding an era of ever-increasing numbers of targeted vaccines.

The logic of combining the pertussis vaccine with the diphtheria vaccine "became even more compelling when it was found that the pertussis component boosted the efficacy of the diphtheria component when the two were combined: the pertussis vaccine itself acted as an adjuvant. Shortly afterwards, tetanus was added to these other two vaccines for the same reasons." [Coulter]

The pertussis component has been the subject of hot debates concerning its

risk/benefit ratio. The debate has led certain countries to replace the whole cell pertussis vaccine by an acellular variant to improve efficacy and reduce adverse side effects such as febrile seizures and protracted crying. For example, Sweden cancelled whole cell pertussis vaccination in 1979 and has replaced it with acellular pertussis vaccine, which is administered either separately or as part of the DTP cocktail.

In the USA, the DTP vaccine was replaced in 1997 by the DTaP version, which allegedly produces fewer side effects. The vaccine contains thimerosal [ethylmercury sodium salt] as a preservative and aluminum as an adsorbative.

Post-vaccination syndromes

- A study of 209 cases of post-vaccination illness in the Netherlands found the main presenting complaints to be: respiratory problems [56%], skin problems [40%], general complaints including malaise, weakness, sleeplessness and immunological problems [32%], digestive problems [21%], neurological complaints [18%], emotional complaints [21%], and developmental complaints [7%]. [Tinus Smits, *The post-vaccination syndrome*-, Hom. Links 4/01]
- In comparison, based on analysis of 500 cases in Great Britain where DTP 30 had been prescribed, Len Marlow grouped the most commonly occurring symptoms as follows: sleep [70.5%], respiratory complaints [45%], thirst [49%], food issues [43%], bowels [41%], skin [29.5%], stomach [20%], dreams [17.6%], and urinary [10%].

[Len Marlow, *The DPT Picture*-, The Homoeopath, vol. 54, 1994]

MATERIA MEDICA DTP VACCINE

Dtp-vc.

Sources

Unproven remedy. Drug picture derived from adverse effects occurring within 48 hours of DTP shots. The individual descriptions and symptoms are taken from Harris Coulter & Barbara Loe Fisher's book *A Shot in the Dark*. Symptoms indicated with [M] come from Len Marlow's study of "approximately 50 cases where the prescription of DPT 30 had shown a marked reaction." NOTE: Because Coulter and Fisher ascribe all adverse effects of DPT to the pertussis portion of the vaccine, the symptoms should also be included in the materia medica of Pertussis vaccine.

SYMPTOMS

Mind

High-pitched screaming [“thin, eerie, wailing sound” resembling *cri encephalique*-, may go on for hours or days].

Arms drop to his side, he lets out a terrible, blood-curdling scream, and becomes flaccid.

Screamed a shattering scream.

Persistent, inconsolable crying [for 3 hours or longer].

Crying on waking up.

The child would lie on its cot, flushed and irritable, sometimes with the head moving from side to side. No amount of nursing or lifting the child would cause this screaming to abate.

Falling asleep from exhaustion, to reawaken with further bouts of screaming.

Nothing we did would stop her screaming. She acted like she was falling, like she thought she was falling and was screaming as she fell.

Screaming continues off and on for two weeks during day and night. Brief periods of sleep alternating with long bouts of screaming.

Abrupt personality and behaviour changes [*see below*].

Uncontrollable screaming. Turned overnight from “a brave and happy child into a trembling, fearful child who screamed in terror at the sight of balloons or at the thought of leaving the house. ... wouldn’t even enter a room if someone was chewing gum ... wouldn’t leave the doorstep when we went out... would just stand there and scream and shake until we picked him up.”

Disorientation.

When he awoke, he was disoriented and then had violent diarrhoea.

She seemed to be dazed and not know where she was.

He began to see double and would knock over things he reached for and walk into walls or furniture.

Restlessness / Hyperactivity.

Can’t sit still for more than a few minutes at a time.

Started writhing on the floor of the car, screaming that he had a headache; [later] he vomited, ran around the house, and hid in corners as if he was frightened to death.

So hyperactive that she was always full of bruises and cuts due to running aimlessly and crashing into things.

Hypersensitivity.

He became hypersensitive and cried easily without warning.

Learning disabilities.

Dyslexia, with disturbed visual perception, auditory processing deficit, fine motor delay, and attention span deficit.

Indifference.

He no longer played, would not reach out for objects, became indifferent to his surrounding, and slept for long intervals during the day.

We took her to an amusement park, where ordinarily she would be hard to handle. But that day [after fifth DPT shot] she just stared and acted like she was in a daze, like she was sleepwalking.

=> “Although many of these children exhibited a tubercular diathesis and later were prescribed Tuberculinum, temper tantrums do seem to be a symptom of DPT as well. Many of the symptoms associated with hyperactive behaviour were changed by DPT - biting, stamping feet, waving arms about, hyperactivity. Equally, symptoms of the other extreme were represented - thumb sucking, lacking confidence, low energy. DPT in potency often showed a marked change that could be described as taking the lid off”. Hyperactivity turns into an appreciation of music, lack of confidence turns to anger. Symptoms which you would often expect to find in a child but which have not been apparent in the case taking, appear after DPT in potency, eg sibling jealousy starts to be expressed, as does anger. In general, the constitutional picture clears. There were also the signs of better health. They did better at school. They made progress with their reading or writing. They communicated better with their parents. They showed the signs of growth which were usually supported in the physical body as well [better co-ordination, new teeth, new growth, new shoes].” [M]

CNS

Collapse.

Inability to hold head up.

Pupils unresponsive to light.

Suddenly becomes marble white, ‘white as a sheet’ or ‘ashen ; cold and collapsed

and remains so for about 15 to 30 minutes; after recovery, the child often remains pale and listless for a few hours.

Turns blue and seemingly stops breathing.

Face white; very blue around the mouth; head drawn backward.

Gets very silent and turns white with a purple-blue tinge around the mouth.

Convulsions, with or without fever.

“Had a red and swollen leg and was crying a strange cry”; when put in a tepid bath “his eyes rolled back in his head and he quivered all over.” From then on, he continued to have seizures and high-pitched screaming. “Today, he is hyperactive and physically and mentally handicapped.”

Stares straight ahead, eyes dilated, mouth wide open; lips blue, body stiff; trembling of right side of body; at times she makes sucking sounds during the seizure.

Convulsions followed by deep sleep.

He became very pale, stared momentarily at his mother, then his eyes rolled back and he fell into a deep sleep.

Shrill screams, staring, and holding body rigid followed by deep sleep [lasting sixteen hours].

Convulsions just after falling asleep.

Opens her eyes and mouth and gives a brief shout shortly after having fallen asleep [for the night].

Convulsions increasing in frequency during the pollen season or from drinking milk.

Nodding spasm [salaam spasm; epilepsia nutans].

Sudden forward dropping of the head with adduction and flexion of the arms; brief attacks, paroxysmal.

Called “jack-knife seizures” because the child seems to be “bowing” as he violently bends at the waist and throws his head to his knees or brings his knees up to his chest.

He first begins to stare and then suddenly jerks his whole upper body violently forward.

Strange movements.

Her hands go straight up in the air, her feet go straight out, she clenches her fists, holds her breath for some seconds, and then utters a shrill cry.

Twitching.

Twitching of fingers during sleep.

Immunologic

Anaphylactic reaction [hives; swelling of the mouth; difficulty breathing; hypotension; shock].

Allergies.

To pollen.

Seasonal [spring and fall].

To milk and dairy products. [Many cases, eg Diarrhoea from milk and Seizures < milk.]

Sleep

Somnolence.

High-pitched screaming followed by excessive sleepiness.

Lapses into a deep, stuporous sleep from which the child cannot be awakened, no matter how hard one may try.

Falls asleep at strange times, even when playing outside.

Sleep alternating with bouts of screaming.

Drowsiness alternating with irritability.

Drowsiness alternating with restlessness.

“Sleep was the area that was most affected. The symptoms seemed to occupy two extremes, those relating to over-activity and those relating to under-activity. In the first group there was constant waking, overheating and uncovering, night terrors, difficulty getting to sleep, enuresis and somnambulism. In the second group sleeping long, sleeping in the day, unremembered dreams. It might have expected that, at the follow-up visit, the child would just be describing in more detail what had previously been called a nightmare, but this was not the case. The nightmares stopped after DPT in potency and it was the children without dreams who, for the most part, developed dreams [animals and chasing].” [M]

Piles up bedclothes and sleeps on top. [M]

Temperature

Fever [38° - 40.5° C].

Coldness.

Whole body “on the cool side”; cold hands.

Forehead ice cold and clammy.

Gastrointestinal / Appetite & Thirst

Vomiting.

Projectile vomiting and diarrhoea that “got all over everything.” Severe diarrhoea and projectile vomiting.

Anorexia. Weight loss.

Diarrhoea.

Green; curdsh in consistency; sometimes changing colours but mostly green; lasting for four months.

Light brownish with much mucus; odour musty and pungent.

Violent [after deep sleep preceded by convulsion]; dark green, almost black.

Yellow; consistency looking like “attic foam insulation.”

“Again, in this symptom group there were extremes of symptoms - they had great appetite or no appetite. This was more marked than a particular food craving. The food cravings seemed to be those associated with other remedies that are indicated in the treatment. Commonly they were < eggs and desired dairy food. They have extremes of thirst, particularly with extremes of temperature, liking very cold or very hot drinks or having no thirst at all. The extremes of temperatures are often reflected elsewhere, sometimes in the appetite but also in frequent baths, either hot or cold, and the tendency to overheat at night. With the thirst there was often increased urination. After the remedy there were also signs of increased and often yellow urine. Their bowels also suffered - being flatulent, loose and smelly, rather than having diarrhoea or constipation [although these were also recorded]. These symptoms tended to be improved after the remedy, although there was an aggravation first in some cases. They often complained of stomach pains, in particular pain around umbilicus. In most cases this improved after the remedy.” [M]

Respiratory

Cough.

Hard cough, like whooping cough, prolonged [10 minutes at a time]; croupy cough, inducing vomiting; must sit up to prevent choking.
Cough day and night.

Respiration.

Sighing respiration.

Upper respiratory tract infection; wheezing. [M]

Locals

Eyes. Strabismus. Ocular cellulitis. [M]

Ears. Earache. Yellow/green discharge. Glue ear. [M]

Nose. Catarrh, sniffles. [M]

Face. Lacks vital colour; rings under eyes. [M]

Mouth. Grinds teeth [often during sleep]. Talks late; stuttering and stammering.

Disorders of speech [sing-song]. [M]

Throat. History of tonsillitis. [M]

Stomach. Eats refuse. Thirst increased at night. [M]

Female. Vaginitis. History of *Candida albicans*. [M]

Extremities. Numbness and tingling. [M]

Skin. Eczema with or without itching. Diaper rash. Eruptions under skin. Local reaction to vaccination [erythema; oedema; heat; induration]. Purpura. Boils. [M]

BEHAVIOUR AND PERSONALITY CHANGES

Harris Coulter presents more vaccine-induced symptoms in his book *Vaccination, Social Violence and Criminality*. Len Marlow collated them in the form of a materia medica:

Detached and inaccessible. Could not, or would not, smile. Refused to be touched, even by their own parents. Nervously hostile with strangers. Awkward; clumsy in gait. Rhythmic movements.

Fear of everything: dogs and other animals, loud noises, guns, the refrigerator, a furnace, flashing lights, a spot on the wall, the dark, night terrors,

losing control. Loses control. Mental retardation. Cannot accept instructions from teacher. Loquacity or absence of speech. Talks about one single subject, talks in monologue, the 'to and fro' of normal conversation is missing, unaware that people are talking to him, needs several moments to process the words he hears, lost in own thoughts. Loneliness.

Poor handwriting, left handed or ambidextrous, dyslexia, poor visual-motor coordination, difficulty distinguishing left from right [if asked to touch left ear with right finger becomes baffled]. Reads but cannot spell. Gestures with their hands. Ritualistic behaviour. They rock, hum and love to dance. Uncooperative, stubborn, negative, can provoke more or less hostile or violent reactions, avoids answering questions or complying with requests, screams when frustrated, throws things, hateful and sneaky. Impulsive. Loves music, can memorise music and repeat it from memory. Over-activity [lessens with age], walks early, limited attention span.

Loquacity, over emphasis on one subject, poor listener. Curses and calls people names.

Bossiness, bullying, inability to change. Lack of emotion, remorse leading to suicide, remorse, kisses and cuddles nurse. Steals, lies, destroys property, sets fire to things.

Rolls head from side to side, bangs head [before sleep, on floor, into mother's chest], picks at his hair or ears.

Infantile speech, disorders of speech, lack of expressive language, inability to complete sentence because right word cannot be found.

Early masturbation [both sexes].

CASES

(1) One morning in April Tom's mother phoned me because her ten month old son had a fever of 40°C. He'd had a cold since his third shot of DTPerPol [DTP + Poliovirus vaccine] in January. After the first two vaccinations of DTPerPol he hadn't developed problems, but after the third one he had become listless and passive and for almost three months had failed to thrive. He required more sleep and was interested in virtually nothing. Where he once had been a happy child,

he was now irritable. In January he had been able to sit up normally, but after the vaccinations he started to fall to one side. His motor skills had stopped developing. His hair and nails seemed to have stopped growing. In the last two weeks he developed a wet eczema behind his right ear and on the underside of his penis. I advised the mother to give him DTPerPol 200K in water hourly. A day later, the fever was gone. Treatment was continued for another day. When I saw him a week later, Tom was fine. He was happy, crawled on all fours and was able to sit up again without falling. His mother bicycled seven kilometres to my office with Tom sitting happily on a seat in front of her. He was active again his hair and nails were growing normally. The wet eczema was almost gone and after a few months he resumed normal development.

[Tinus Smits, *The Treatment and Prevention of Post Vaccinal Disease*, Hom. Links 4/94]

(2) While I was doing the clinic analysis, I looked for cases that would indicate whether or not the DPT acted as a remedy or just as a catalyst, [opening the door to cure rather than affecting it]. I treated a child who had only the first DPT and Polio vaccination and, subsequently, had no other vaccine or medical treatment [no antibiotics etc.] and had a sugar free healthy diet.

She had glue ear, was deaf in both ears and the doctor referred her to a specialist. Personal history: Nappy rash ++ after vaccine, high temperature once a month for six months, chest infections, no thirst.

Mood swings, temper tantrums, 'drifts off' in company, likes travel, not car sick, happy staying with friends.

Hot person, kicks covers off, sleeps long, screws up sheet and holds on to it. Prescribed DPT 30.

Five weeks later: confidence ++, energy ++, awake more hours, tantrums gone, not confrontational any more. Hearing », writing and learning >. No physical aggravation at all [sister had cold in this period]. Report from cranial osteopath - very good progress. No prescription.

Two months later Tuberculinum IM. No further treatment from specialist.

[Len Marlow, *The DPT Picture*, The Homoeopath, vol. 54,1994]

I C. FAMILY MICROMONOSPORACEAE

Micromonospora purpurea.

MICROMONOSPORA PURPUREA

Scientific name *Micromonospora purpurea* Luedemann & Brodsky 1964 **Synonym**

Micromonospora echinospora

Family Micromonosporaceae

Homeopathy Not used

MATERIA MEDICA GENTAMICINUM

Not in use

The drug

Micromonospora, an ubiquitous soil inhabitant, yields gentamicin, a substance employed in the form of gentamicin sulphate as a broad-spectrum aminoglycoside antibiotic. Brand names include Cidomycin, Garamycin, and Genticin. The antibiotic was introduced into medicine in 1964 to treat bacterial infections. Its mode of action is similar to that of other aminoglycoside antibiotics, such as streptomycin.

The drug, given by injection, is generally reserved for hospital treatment of serious or complicated, usually Gram-negative bacterial infections such as respiratory tract, bone, joint, CNS, wound and urinary tract infections, peritonitis, and septicaemia. It is also used with penicillin for the prevention and treatment of heart valve infections [endocarditis]. Also available as drops and ointment, gentamicin is commonly given for eye and ear infections and ointment may occasionally be prescribed for infected burns or ulcers.

Gentamicin may deplete or interfere with the absorption or function of calcium, magnesium, potassium, and vitamin K.

Gentamicin particularly damages the kidneys and the 8th cranial nerve, the sensory nerve supplying the hair cells of the vestibular organ and the cochlea. The latter impairment includes loss of balance functions, dizziness, loss of hearing, particularly in the higher pitches, and ear noises [ringing, buzzing, roaring, whistling]. The risk of toxicity to the 8th cranial nerve is highest in the presence of renal insufficiency.

The damage occurs to both ears simultaneously and can be irreversible. Because inner ear balance information is needed for clear vision during head movement, vision can be impaired as well, resulting in bouncing and blurring

of vision during head movement. This is known as oscillopsia, subjective sensation of oscillation of objects viewed.

With severe damage to the balance areas of the inner ear, balancing in the dark or with the eyes closed may be impossible. Vision will be bouncy and blurred during head movement. Reading during head movement may be difficult or impossible. Fatigue can make accomplishing tasks much more difficult. Walking will be difficult, with stumbling and staggering. Turning while up and about will be hard, and someone with this kind of damage might need to grab onto furniture and the walls to stay upright while walking. People with severe damage to the balance hair cells may over-reach for objects and bang into things. They may lose words during speech.

Their short-term memory may be poor, and they may be easily distracted. They may have trouble following directions. Even after trying for two or three years to return to normal, they may continue to experience four kinds of symptoms: [1] poor balance, particularly in the dark; [2] bouncing vision during head movement; [3] fatigue, and [4] depression, fear, anxiety, and loss of selfconfidence.

People with this kind of loss to gentamicin have formed a support group, Wobblers Anonymous.

[P.J. Haybach, *Gentamicin: Problem or Solution?*, at: www.vestibular.org/gentamicin.html]

Gentamicin has been put to “good use” for patients with Meniere’s disease, apparently on a crude basis of symptom similarity, by “intentionally killing balance parts of the inner ear” with streptomycin or gentamicin. Because streptomycin ear injections caused deafness in too many people, gentamicin was tried, this time with “far fewer people developing hearing loss.” The therapy caught on and is now in widespread use for severe cases of unilateral Meniere’s disease.

Rare adverse effects

- « [Transient, toxic] psychosis. Anxiety. Hallucinations.
- ~ Headache.
- = Progressive alopecia and loss of eyebrows.
- = Nystagmus.
- Nausea and vomiting.
- Transient proteinuria.

-
- Thrombophlebitis.
 - = Macular skin eruptions.
 - ~ Systemic contact dermatitis.
 - ~ Pustuloderma.
 - = Myasthenia gravis. Lethargy.

I D. FAMILY MYCOBACTERIACEAE

Mycobacterium avium
Mycobacterium avium subsp. paratuberculosis
Mycobacterium bovis
Mycobacterium leprae
Mycobacterium tuberculosis

MYCOBACTERIUM AVIUM

Scientific name *Mycobacterium avium* subsp. *avium* Chester emend. Thorel et al. 1990
Old name Family *Bacillus tuberculosis avium*
Homeopathy *Mycobacteriaceae*
Tuberculinum avis - Tub-a.
Aviaire - Tub-a.

FEATURES

- Free-living, widely distributed mycobacterium found in soil, water, dust, dirt, animals [birds, chickens, pigs, cows, rabbits, dogs], and humans [in gut or lungs]; has been recovered from foods and milk.
- Acidic soil types, notably peat bogs, harbour higher than average numbers of *M. avium*.
- High *M. avium* numbers correlate with warmer temperature, low pH, and high soluble zinc.
- Can inhabit body surfaces or secretions without causing problems.
- As an environmental source of infection potential exposure is associated with “ingestion of raw fish or hard cheese, daily showering, and occupational exposure to water.”
- The occurrence of fowl tuberculosis in chickens, parrots, ducks, and other birds was observed as early as 1868 and was attributed to *Mycobacterium tuberculosis*.
- Grows at higher temperatures than *M. tuberculosis* [birds have a higher body temperature than humans]; hence grows well in the high water temperature of indoor hot tub, to possibly cause in susceptible people by inhalation of contaminated water a type of hypersensitivity pneumonitis known as “hot

-
- tub lung,” a condition previously often misdiagnosed as sarcoidosis.
- Fowl tuberculosis never begins in the lungs but affects chiefly the liver and alimentary tract of birds.
 - *M. avium* consists of two subspecies: *M. avium* subsp. *avium* and *M. avium* subsp. *paratuberculosis*, which are genetically for more than 95% identical. The latter has been linked with Crohn’s disease [see below].

MYCOBACTERIUM AVIUM COMPLEX

Mycobacterium avium complex [MAC] consists of 2 predominant species, *M. avium* and *M. intracellulare*, both classified as non-tuberculous mycobacteria [NTM]. MAC is considered the “most common cause of non-tuberculous pulmonary disease worldwide.” The modes of transmission include inhalation through the respiratory tract and ingestion via the gastrointestinal tract. Localised MAC typically prevails in three groups of patients:

1] Middle-aged or elderly white men, possibly prone to alcoholism and/or smoking, with underlying pulmonary disorders such as chronic bronchitis, chronic obstructive lung disease, lung, emphysema, healed TB, bronchiectasis, silicosis, cystic fibrosis, lung cancer, or pectus excavatum [a hollow at lower part of chest due to backward displacement of xiphoid cartilage; funnel chest]. The apical and posterior segments of the upper lobes and the superior segments of the lower lobes are commonly involved. The disease resembles TB clinically and radiographically, with cough, chest pain, weight loss, upper lung infiltrates, consolidation, and cavitation [thin-walled]. Pleural effusion is rare, in contrast to pulmonary TB. Lesions are indolent and progress slowly, or may be stable for long periods.

2] Middle-aged, postmenopausal or elderly non-smoking white women without prior lung disease. Persistent exposure to indoor hot tubs may be an aetiology. Predisposition in women who have a “narrow anteroposterior chest diameter, pectus excavatum, scoliosis, or mitral valve prolapse.” The condition presents as an isolated lingular [tongue-shaped projection from upper lobe of left lung] or right middle lobe pattern and, according to one hypothesis, is thought to arise from habitual voluntary suppression of cough. Symptoms and signs are variable and non-specific: cough [productive or dry], dyspnoea, chest pain.

The course may be slowly progressive, or it may be stable for long periods. Systemic symptoms - fatigue, malaise, weakness - occur occasionally. Hilar

adenopathy, volume loss, pleural effusion, and cavitation are usually absent, while X-ray changes [bronchiectasis, lung nodules] may be present. The syndrome has been termed 'Lady Windermere syndrome,' named for the main character in Oscar Wilde's play *Lady Windermere's Fan*. [See Aviaire case no. 4 below.]

3] Children 1 to 5 years of age. MAC has surpassed *Mycobacterium scrofti-laceum* as the most common cause of chronic submaxillary and submandibular cervical lymphadenitis in developed countries.

Disseminated [systemic] MAC is common in patients with AIDS and occasionally in other immunocompromised patients. Symptoms are non-specific and include high fever, chills, diarrhoea, weight loss, stomach and abdominal pain, anorexia, night sweat, adenopathy, fatigue, anaemia, swollen abdominal lymph nodes [usually unilateral], and enlarged liver and spleen. Cough and respiratory insufficiency are less common. Organs most commonly affected are the liver [causing liver tests to be high], spleen, bowel and bone marrow. Disseminated disease can lead to bone, brain or skin infections, or cause painful joints. The clinical course of pulmonary MAC in HIV-positive patients is usually indolent.

MATERIA MEDICA TUBERCULINUM AVIS

Tub-a.

Sources

Introduced to homeopathy by Cartier, 1896. No provings, clinical observations only.

SYMPTOMS

General picture

"My experience has led me to select *Tuberculinum bovinum* for patients presenting more pronounced localisations in the meninges, abdomen, skin, glands or joints, but the *Aviaire* for patients who were affected by a more evident depreciation of quality in the entire person at the same time, such as occurs after grippe or similar crises. This observation is purely clinical. The sphere of action of the *Aviaire* is mind, spinal nerves and branches, muscles, joints, bronchi and mucous membranes. Mentally changeable in feeling and purpose; dissatisfied with present conditions and surroundings; desires change;

is depressed; easily frightened; has desperate, wicked feelings. The sense of dissatisfaction is such as to do something wicked and destructive. The moral sense becomes irreverent. Restlessness, the desire for change is physical as well as mental. Muscular or nerve pains are > by motion, but the patient tires easily. Pains and mental symptoms are > in the open air. Relaxed, degraded conditions of tissues and secretion. Dingy, unhealthy, doughy or aged appearance and feeling of the skin and soft tissues and an old catarrhal aspect of mucous excretions. In acute conditions the rapidity of the emaciation is notable. GRIPPE and its SEQUELAE.”

[Hayes; cases below]

Indications

- = Acts most markedly on the apices of the lungs.
- ~ Pulmonary and/or meningeal complications of measles. [Julian]
- = Corresponds most closely to influenzal bronchitis or pulmonary complications of measles characterised by acute dyspnoea, incessant cough and nonspecific but severe general symptoms [fever, malaise, anorexia, fatigue].

In contrast with *Bacillinum* I have noted, in my observations on *Aviaire*, considerable cough and little dyspnoea - an acute inflammatory, extremely irritating cough, such as one meets with in acute diseases or subacute affections in young people; a cough which fatigues, and which leads to enfeeblement and loss of appetite - in a word, a suspicious cough. ...

To conclude my remarks, the utility of *Aviaire* in suspicious bronchitis - an expression on which I again lay stress - I will recall certain indubitable examples of the cure (at the Hospital St. Jacques) of bronchitis or of pulmonary congestion at the top of one of the lungs, or of bronchitis on one side only, or of congestion predominating on one side. These localizations on one side are sufficiently grave symptoms to warrant apprehension of the hatching of tuberculosis.

If I were myself attacked, as the result of influenza of measles, or of some weakening malady, with an incessant tickling and stubborn cough, with certain closely localized pulmonary symptoms; if I lost my strength and appetite; if in a word, I were attacked by bronchitis whose upshot was highly doubtful, and which caused apprehension of tuberculosis, I should not hesitate a single moment, with the examples which I have had before me, to try *Aviaire* 100c upon myself.

[Cartier, cited in Anshutz]

Generals

= Persistent tendency to take cold.

Locals

~ Frontal headache & hot forehead and pain at root of nose. [Julian]

« Continuous sneezing with watery hypersecretion. [J]

- Face pale or red. [J]

= Pain in upper part of lungs. [J]

=> Thoracic wall painful. [J]

~ Rapid breathing & fan-like motion of wings of nose. [J]

»= Itching of palms and ears. [Boericke]

= Circulation problems in extremities; cyanosis. [J]

= Palms hot and sweating. [J]

CASES

(1) Mrs. E.M., age 40, came from England something less than a year previous to the events related. She had not been as strong in this country. She has had what she calls “grippe” for several weeks and does not improve though she is about the house every day. Present symptoms: Cough, worse at night, from tickling in the chest and throat-pit. Soreness inside the upper part of the chest. Hoarseness, worse in the evening.

In a general way she feels better in the open air and from motion; worse after a nap in the daytime, better after a night’s sleep. Although a refined lady and well enough nourished, physically she appears to be of coarse fibre and to lack general physical tone from poor quality of vegetation, evidenced by the coarse hair, skin, complexion, flat chest, stooping shoulders and angular form. This, with the decided lack of reaction following grippe, relief from motion and open air decided positively in favour of *Tuberculinum aviaire*. *Tuberculinum aviaire* IM, S.P.

This not only cured the present illness but proved to be the general restorative needed. *Rhus* and *Lycopodium* also came to mind. *Rhus* was the epidemic remedy for grippe and similar affections that season. All three have marked relief from motion and open air. But *Rhus* could not touch the evident dyscrasia. *Lycopodium* would be more suitable for a finer grade organisation. There was no family history of tuberculosis. No history of previous illness.

(2) Mr. N.S. Age 46, looks 56. La grippe, ill in bed. Chilly yesterday. Has been troubled with sleepiness indoors. Has had much sore throat lately. Subnormal

temperature. The gentleman knew more about drugs than I did as evidenced by the few symptoms presented. He had been successful in curing about all symptoms of previous years except the above. In fact he had cured about everything except himself. He seemed to be in poor general condition.

Quinine was his favourite standby. Nux vomica IM relieved so that there was no report for six weeks. Then: Chilliness, especially out of doors [winter] and on undressing for bed. Ill in bed again today. Nux vomica 40M [Fincke]. Five days later, no result worth mentioning. Rheumatic pain in legs when tired. Has had grippe twice a year for several years. Tuberculinum aviaire CM. Good improvement generally ever since. Four months later slight attack of grippe but better health since. One thing I could not cure notwithstanding his promises, the habit of taking tonics, cathartics, quinine, etc.

I believe this man had a narrow escape from organic involvement. The Nux was able to palliate some of the drug impression, but the vital force was insufficient to prevent a return of the acute attack nor could it even develop symptoms. This fact, together with evidence of deep-seated dyscrasia and the knowledge that the Aviaire has a relation to such cases, was practically my only excuse for the prescription, and a slender chance it was for his fate to rest upon. Sulphur was indicated and made good a few months afterward. But it developed a racking bronchitis and coryza.

(3) Mrs. S. had not been well for one year. She spent much money on physicians, including frequent visits of a specialist [surgeon] from the city. The present illness, which she called grippe, began with marked hydroa on lips two weeks previous. Cough in paroxysms night and day. Soreness in chest and back from coughing. Constant perspiration while in the house. Nervousness and anxiety while in the house, relieved by getting out. Headache in the house, better out doors. Sleepless after midnight until 5-6 AM. Constantly tired and weak, worse from slight exertion. Generally worse from motion [probably exertion], relief from open air. History of grippe every winter with frequent relapses from slight exposures. Has increased in weight during the eleven months' illness "from tonics." Menses have been absent six months [climacteric age]. Tuberculinum aviaire IM S.P. 1 did splendidly. No more need of the specialist. Calcarea came in well four months later.

(4) Deals with Mrs. A.C., a sufferer from spinal irritation for about twenty years. She gave a history of tubercular affection of the chest in young adult life, with spontaneous recovery. A portion of the middle of the right lung, however, remained

solidified until an attack of pneumonia a few years ago, when it cleared up [under homeopathic care].* After that incident the vegetative system became quite improved. The spinal symptoms became worse, however.

When presented to me she had led the life of an invalid for several years, spending much of her time in bed, with practical disability when out of bed. She received single doses of Rhus tox. in various potencies, Arnica, Nux vomica and Bryonia in the order named at long intervals, according to the totality in the mechanical sphere of the difficulty. The pressure and irritation of the spinal nerves were relieved sufficiently for the spinal bones to limber up to some extent, the ligaments, tendons and cartilages to become more flexible and improved in nutrition. There was much relief from the various pains and disturbances of parts supplied by the affected nerves. But most striking of all, it allowed the vital force freedom to express its resistance to the predisposing cause of all this trouble. Some of the following symptoms had been present before but were never able to be presented in an orderly form:

Fear as if some evil would happen, or, as if something [undefined] was wrong. Mentally restless. Irritable; destructive feeling [momentary] [x].

Weary of life's struggle; positive aversion to living; thoughts of suicide from hopelessness; worse late in the afternoon [x].

Tendency to get buried in thought, but not irritable if disturbed [x].

Desire to curse, at times, without provocation - this in a woman of the finest moral sensibilities [x].

Anxiety in the evening, growing worse through the night if sleepless [x]. Depression at twilight [x].

Aversion to conversation; talking an effort. At times when nervous tension is most marked, she "could talk one's head off." [x]

Company aggravates. Aversion to any mental work; "seems to have no mind to work with;" cannot concentrate thoughts [x].

Sometimes difficult to comprehend even very simple things. [Naturally a very intelligent and talented lady.] [x]

Memory has failed, especially for what she has read. Sensitiveness to all surroundings. Aversion to travel [x].

Nervous tension always present, though outwardly she is always calm and self-contained [x].

Nervous, involuntary gestures [x].

Sleepless from nervousness, from persistent, crowding thoughts; mind clear and active from 12 to 2 a.m., or sleeps until 4 a.m.; no more thereafter; from any trifle [x].

Canine appetite; craves meat and sweets [x].

Cold perspiration from any nervous excitement [x].

Craving for fresh air [x].

Generally worse from cool winds or drafts; takes cold but bears still cold very well. Weakness worse in the evening [x].

Feels better generally after a night's rest. Used to have grippe every year for several years. (?) Timid, from fear of jar, touch or jostling; worse lately [x].

Uncertainty in walking; worse lately [x].

These last two symptoms were decidedly worse, in spite of the fact that there was much benefit from the previous prescriptions and that she was stronger. On observation, I decided that they were largely mental. Tuberculinum aviaire IM S.P. 1. This developed severe and long-lasting coryza and bronchial irritation, with great temptation to prescribe on account of the mechanical conditions involved in sneezing and coughing. But everything was withheld except sac lac. Three weeks later: Tuberculinum aviaire 30m S.P. 1. This acted longer and deeper, resulting in great increase of strength and a greatly improved spinal system. Sulphur later became well indicated and is being prescribed at increasingly long intervals. From an almost helpless invalid, the lady has become able to take care of herself and do much for others. The Tuberculinum aviaire prescription was the real turning point in the case. It was only one instructive aspect of this remarkable case, however. The symptoms cured or markedly relieved by Tuberculinum aviaire I have marked [x].

[All 4 cases from: R.E.S. Hayes, *Experiences with Tuberculinum Aviaire*, Med. Advance, Sept. 1908; RefWorks]

(5) Boy, age three years, having asthma for the past year. Family history involved tuberculosis on the mother's side, the grandfather, two brothers and a sister being tuberculous. The mother, one of those washed-out blondes, thin chested and stooped; her face, all eyes. Father's history negative although his work as a meat cutter required his going and coming in iceboxes so that he had many colds and recurring bronchitis. Active TB undemonstrable in either of the immediate parents. Personal history of the small patient included delayed dentition, flabby tissues, pot belly, recurrent eczematous patches and difficult adjustment of diet and considerable diarrhoeal history.

For a period of six months he was treated with Calcarea carb., Sulphur, Calcarea sulph. and Bacillinum without much perceptible result. It was a helter-skelter asthma with no great responses to any irritant although pillows, bedding, room and so forth were carefully checked as well as the diet scrutinised with no deter

mined modality. If he improved one time on a prescription at another time he didn't. Seemingly a true Calcarea patient, he failed of response to it and Sulphur intercurrently didn't improve effects. At this time, influenza led the parents to take him to an allergy clinic some two hundred miles away and he went through the mill for six days and was tested for everything from house dust to pollens and food. He was found sensitive to house dust and Johnson grass. Treatment was outlined and closely followed. They prescribed everything thinkable to secure a result. Adrenaline relieved a little but mostly he wheezed along regardless of effort in his behalf. At the end of their prescribed term he was practically unchanged. During this treatment his asthma had been attended by recurrent showings of the eczema and diarrhoea. Repetition of his Calcarea sulph. over six weeks' time fell flat.

He was then given a dose of Tuberculinum CM [Skinner] and placebo to last a month. His mother reported every four or five days. About the fifth day after the nosode was given he had a furious attack of asthma which lasted all that day. It was not interfered with save for steam inhalations. In ten days following he had two more severe attacks irregularly placed, and the wheezy breathing was evident each day. The next two weeks evidenced only the wheeze and that seemingly was decreasing in amount.

By the end of six weeks that also had vanished and he was free from irritation. Coincidentally the skin cleared and he has had no further eruption nor irritation from it. His general health is excellent, his development of the best. There has been no further scrutiny in his diet, nor is he protected from dust or other things and he even has a cat. Follow-up through a period of six years records no attacks of either the asthma or the eczema and there has been no diarrhoeal disturbance. ... In relation to the type of Tuberculin used, it was the aviaire. It was used presumably at my insistence by a very good doctor.

[R.M. Troup, *Tuberculinum: An Explosive-*, Hom. Recorder, March 1940; RefWorks]

MYCOBACTERIUM AVIUM SUBSP. PARATUBERCULOSIS

| | |
|------------------------|---|
| Scientific name | Mycobacterium avium subsp. paratuberculosis |
| Synonym | Mycobacterium paratuberculosis Bergey et al. 1923 |
| Family | Mycobacteriaceae |
| Homeopathy | Johneinum [nosode] - Johnhein. |

FEATURES

- Robust and phenotypically versatile organism which causes chronic inflammation of the intestine in many species, including primates.
- Evidence conflicting as to its ability to survive outside its hosts; some claim that it is exclusively dependent upon human and animal bodies for survival [like *M. tuberculosis*], others believe that it can survive and probably replicate in the soil, on the surface of plants, and in ground and river waters [like other environmental mycobacteria].
- Opinions regarding its pathogenicity equally conflicting; considered a “strict pathogen” as well as thought to live in a “relatively benign relationship with the cells of the host, existing in tissues without causing disease.” [3]
“With the opportunity to amplify in our efficient but intensive farming for over a hundred years, *M. avium* subsp. paratuberculosis has probably undergone an adaptive radiation and has taken up the intestine of animals and humans as one of its natural habitats, acquiring as it has done so an intermediate status between an environmental organism and a low-grade pathogen.” [5]
- Facultative intracellular organism.
- Widespread in domestic livestock and present in retail pasteurised cow’s milk in the UK and, potentially, elsewhere.
- High thermal tolerance; capable of surviving commercial pasteurisation of milk when there are more than 10 bacteria per millimetre in raw milk. Pasteurisation at 72° C for 15 seconds which was introduced in the first half of the 20th century to ensure the destruction of *Mycobacterium bovis* and *Mycobacterium tuberculosis*, does not ensure the destruction of the tougher *M. paratuberculosis*. [Both *M. avium* subsp. *avium* and *M. avium* subsp. *paratuberculosis* are more resistant to pasteurisation time and temperature criteria than other milk-borne organisms. This is of particular importance when considering that approximately one third of the cheese produced in the USA is derived from unpasteurised milk.]

-
- Requires an exogenic growth factor, mycobactin, extracted from other species of the genus*; requires at least 3-4 months for laboratory growth.
 - Controversial organism; the slowest growing of the culturable mycobacteria.
 - Replicates in intestinal tissues and associated lymph nodes of its host.

- An iron-transport protein unique among mycobacteria, *mycobactin* is produced by mycobacteria as an essential element for growth and survival from the environment. Because *M. avium* subsp. *paratuberculosis* is a mycobacterial species unable to produce mycobactin it is dependent upon animal cells, most often immune cells called macrophages, where it scavenges iron.

Consequently, infected hosts are thought to be the only place in nature where growth and multiplication of *M. avium* subsp. *paratuberculosis* can occur, giving rise to the concept that the species is an obligate parasitic pathogen of mammals.

Hypothetically this does not exclude, however, the possibility of *M. avium* subsp. *paratuberculosis* living in symbiosis with environmental mycobacteria, such as *M. avium* subsp. *avium*, in order to obtain iron, enabling it to survive and probably replicate in the soil, as some researchers assert.

References:

- [1] R.J. Chiodini, *Is Crohn's disease a mycobacterial disease?*
 - [2] R.J. Chiodini, *Crohn's disease and the mycobacterioses; a review and comparison of two disease entities.*
 - [3] J. Hermon-Taylor et al., *Mycobacteria and the eat to logy of Crohn's disease.*
 - [4] J. Hermon-Taylor et al., *Mycobacterium paratuberculosis Cervical Lymphadenitis followed five years later by terminal ileitis similar to Crohn's Disease.*
 - [5] J. Hermon-Taylor, *The Causation of Crohn's Disease and Treatment with Antimicrobial Drugs.*
 - [6] D. Mishima et al., *On the Etiology of Crohn disease.*
- [Articles available at <http://alan.kennedy.name/crohns/reslist.htm>]

CROHN'S DISEASE

Mycobacterium avium subsp. *paratuberculosis* [short: MAP] has since 1984 been implicated as a possible cause of Crohn's disease. Its involvement in humans, nevertheless, is controversial since the organism is very difficult to detect. Some studies found MAP in Crohn's patients, others did not. Since 1996, however, the chances of detection have advanced with the discovery of the IS900 sequence, a genetic 'fingerprint' that is unique to MAP. The appli

cation of molecular biology is today the only way to definitely distinguish this organism from other *M. avium* subspecies.

Researchers at the University of Central Florida are developing a blood test for MAP. Findings from the research show that a majority of patients with Crohn's disease mount a significant immune response to MAP, when compared with control patients. Clinical trials are in progress to treat Crohn's disease with anti-mycobacterial drugs. Some authors believe that no conclusive benefits of such treatments can be expected because data from the treatment of tuberculosis cannot be extrapolated to other mycobacterial infections.

Suggesting a mycobacterial aetiology of Crohn's disease, a distinct similarity was observed as early as 1913 between Crohn's and Johne's disease, which is a MAP-caused inflammatory bowel disease in ruminants and primates. Consequently, a correlation has been proposed between the epidemiology of Crohn's and transmission from milk and other bovine products.

It is unknown when Crohn's disease emerged. Descriptions dating back to the early 1700s probably fell under the heading of the various undefined intestinal disorders of that era. Dr. Chiodini, founder of the International Association for Paratuberculosis, established in 1989, argues that the earliest descriptions probably occurred sometime after the discovery of the tubercle bacillus in 1882 "since Crohn's disease and intestinal tuberculosis were confused for years and such confusion continues to date." He goes on to state:

... sometime after that period, an intestinal disease was recognized that was similar to intestinal tuberculosis, but acid fast bacilli could not be visualised in tissues or isolated in culture and the characteristic caseous nodules of tuberculosis were absent. By 1913, cases of intestinal tuberculosis which did not fit the classical pattern were well recognized, but nevertheless, were classified among the tuberculous lesions and the disease was known as hyperplastic tuberculosis. By the 1920s, these cases of intestinal tuberculosis which did not contain caseous necrosis or acid fast bacilli were reclassified as nonspecific granulomata in an attempt to recognize these cases as distinct from the classical or hypertrophic forms of intestinal tuberculosis. Each description, however, discussed the remarkable resemblance of these cases to intestinal tuberculosis - the only difference being the absence of the pathognomonic lesions of tuberculosis, caseous necrosis and acid fast bacilli.

In 1932, the landmark article of Crohn, Ginsberg, and Oppenheimer brought recognition of a disease to be known as regional ileitis as an distinct entity and

separated these cases from intestinal tuberculosis. Crohn and his colleagues also recognized the “remarkable resemblance” of their regional ileitis and intestinal tuberculosis. For over 50 years, regional ileitis or Crohn’s disease as it is now known, has been regarded as a granulomatous ileocolitis of unknown aetiology, distinct from that of intestinal tuberculosis and other mycobacterioses. Unfortunately, identification of the aetiology and treatment for patients afflicted with this disorder has progressed little over the last 50 years.

... In the last few years, there have been more reports on mycobacteria and Crohn’s disease than in the last 100 years or more. This current worldwide effort and excitement [by at least some] over a mycobacterial aetiology of Crohn’s disease was perhaps generated by 2 unrelated circumstances: 1) the isolation of an organism with a reputation for causing a disease very similar to Crohn’s disease in animals; and 2) after 50 years of getting no where, with all theories including autoimmune, dietary, viral, etc., losing ground, and with medical treatment supportive at best, the time was perhaps right to awaken an old dead horse.

... The data suggesting a role is largely based on cultural isolation or other methods of detection of a well known animal pathogen from the tissues of Crohn’s disease patients, but interpretation of the data has been complicated by the isolation of closely related environmental mycobacteria from both Crohn’s disease patients and controls. Nevertheless, it is now conclusively and irrefutably shown that *M. paratuberculosis* can be found within the tissues of a major proportion of Crohn’s disease patients. With current studies and efforts continuing, this association is likely to become more and more established and the aetiologic role of *M. paratuberculosis* in Crohn’s disease will likely gain momentum. [1]

A host of different mycobacteria can be isolated from Crohn’s disease patients, as well as control populations. Most of these organisms are identified as environmental opportunists. According to Chiodini, “Some laboratory and other strains of *M. paratuberculosis* are actually MAI [*Mycobacterium avium* and *M. intracellulare*]. The lack of any previous suggestion that *M. paratuberculosis* had public health significance has added to its disregard by medical mycobacteriologists. It is interesting to note that all investigators who have been successful in isolating *M. paratuberculosis* from Crohn’s disease patients were trained originally in veterinary mycobacteriology and had years of experience dealing with this peculiar species.” [2]

Whether *M. paratuberculosis* behaves strictly like a pathogen or awaits

favourable conditions, as opportunists tend to do, remains unresolved, as is evidenced by Hermon-Taylor's statement: "An unexpected finding in our carefully performed studies was the presence of *Mycobacterium paratuberculosis* in the colon of about 12% of people without IBD. How are we being exposed to this organism? Milk supplies and waters draining from heavily grazed pastures are obvious places to look. Reliable experimental evidence in relation to pasteurised milk supplies throughout central and southern England, using meticulously applied DNA-based methodologies, is accumulating. ...

Most of us will have at some time been exposed to these agents as benign and possibly transient intestinal or respiratory cohabitants. But in those of us with an inherited susceptibility [well known in Crohn's disease], an intercurrent microbial collaborating coinfection [well known in the initiation of CD] or in whom permissive conditions are created by psychological factors mediated through the neuroendocrine and immune systems in the gut [well known with the emergence of Johne's disease in stressed animals], the benign enteric cohabitation of *Mycobacterium paratuberculosis* converts to parasitism and the development of clinical disease." [3]

CROHN'S DISEASE AND INTESTINAL TUBERCULOSIS

An inherited susceptibility factor for Crohn's disease to develop exists especially amongst Jewish people and possibly also in Celtic races. Crohn's disease occurs with its highest incidence in the United States, the United Kingdom, and Scandinavia. It is less frequent in Central Europe and rarely is reported in Africa, Asia, and South America. The disease is seldom reported in underdeveloped or developing countries.

In women who are of English or northern European descent, the incidence rate of Crohn's disease is 30% greater than in age-matched males. The age incidence of Crohn's disease shows a bimodal distribution. The primary incidence mode occurs at ages 15 to 25, followed by a second mode at ages 55 to 60.

While pulmonary tuberculosis has a greater frequency in males, primary ileocaecal tuberculosis is predominant in females, approximately 70% of cases. The maximum age incidence of intestinal tuberculosis is also 15 to 24 years, with 65-85% of patients being under the age of 40. If we assume that Crohn's disease and human intestinal tuberculosis occur at the prime of life [15-25 years of age], then a similar maturity incidence occurs in animals with paratuberculosis. The maximal age incidence of paratuberculosis in cattle is 3 to 5 years, during their

prime of life and period of maximum productivity.

... There is a known familial association of Crohn's disease, which suggests a genetically-linked increased susceptibility to the disease, or alternatively, a common exposure to an aetiological agent. There is a low incidence of Crohn's disease in married adults, but these rare occurrences have yet to be explained. A genetic link, as assessed by HLA-typing, has not been found, but genetic predisposition is likely. There is a 30 times greater rate of Crohn's disease in siblings and 13 times greater incidence in first degree relatives. [2]

Although Crohn's disease was first described as a segmental disease of the small intestine, in 1960, it was recognized that the same disorder affected the colon and had been confused with ulcerative colitis. In recent years the lesions of Crohn's disease have been recognized in the mouth, larynx, oesophagus, stomach, skin, muscle, synovial tissue, and bone. Crohn's disease and ulcerative colitis continue to be confused clinically and the term inflammatory bowel disease [IBD] was developed to comprise both diseases.

Patients afflicted with this disorder generally suffer with chronic weight loss, abdominal pain, diarrhoea or constipation [obstruction], anorexia, fever, vomiting, generalized malaise, and a right lower quadrant mass or fullness. Other symptoms not involving the intestine may occur, such as sore mouth due to ulcers on tongue or inside of cheeks; painful, inflamed eyes; painful, stiff or swollen joints; erythema nodosum.

Between 70 to 80% of Crohn's disease patients require surgical resection of the diseased intestine. Most patients will suffer recurrences and require further surgical procedures.

Crohn's disease can be distinguished from intestinal tuberculosis by the absence of the pulmonary involvement so highly characteristic for intestinal TB, in particular for the ulcerative type, its most common manifestation.

Every clinical, radiologic, endoscopic, and pathologic feature of Crohn's disease may occur in primary intestinal tuberculosis or some other mycobacterioses, and they are indistinguishable. Both occur most frequently in the ileocaecal region, and both may occur anywhere in the gastrointestinal tract from mouth to anus. In the United States where ileocaecal tuberculosis is rare, such cases are generally diagnosed only after surgical resection for Crohn's disease. When the features of these two diseases are compared, the only distinguishing criteria are the presence of caseating granulomas and acid-fast bacilli in tuberculosis. Thus, the absence of caseation necrosis and failure to isolate or demonstrate

mycobacteria are the chief if not sole criteria for the diagnosis of Crohn's disease. These are not reliable criteria. Taylor, in his study of intestinal tuberculosis and Crohn's disease, concluded that "it is impossible on the basis of clinical features or morbid anatomy to distinguish between these two conditions."

... Crohn's disease and mycobacterioses not only share the features of primary intestinal disease, but of extra-intestinal manifestations as well. In Crohn's disease, arthritis, iritis, erythema nodosum, and amyloidosis are occasionally encountered and are considered to be important extra-intestinal manifestations. Arthritis is a well-known complication of mycobacterial infections, and in recent years, it has been shown that arthritis can be produced by mycobacterial antigens alone. Erythema nodosum has its counterpart in leprosy, a condition known as erythema nodosum leprosum. Amyloidosis may occur in intestinal tuberculosis, leprosy and paratuberculosis [Johne's disease] of animals. Ocular lesions occur in leprosy and are occasionally encountered in paratuberculous animals.

Comparisons of Crohn's disease pathology have been made almost exclusively with tuberculosis, yet *M. tuberculosis* most likely is not the aetiologic agent of Crohn's disease. The major distinguishing feature between Crohn's disease and primary intestinal tuberculosis is the presence of caseation necrosis and pulmonary lesions, features of disease produced by the *M. tuberculosis* complex, but not necessarily other mycobacteria. Therefore, if Crohn's disease is caused by some other *Mycobacterium* spp., caseation necrosis need not be present. In addition, *M. tuberculosis* intestinal infections are not readily produced experimentally, suggesting that this is not a preferred site of the organism. In contrast, *M. paratuberculosis*, a more likely candidate as the aetiologic agent, has a strict preference for the gastrointestinal tract and does not produce caseation necrosis. [2]

CERVICAL LYMPHADENITIS FOLLOWED BY TERMINAL ILEITIS

The English paediatrician Dr. Barnes has reported a case illustrative of the link between paratuberculosis' and chronic enteritis clinically similar to Crohn's. Infection was probably acquired by consumption of milk contaminated with non-tuberculous mycobacteria including *M. paratuberculosis*. The organisms would have entered his cervical lymphatics as well as his terminal ileum, as also occurs in animals with Johne's disease.

In September 1988, JL, a previously healthy boy aged 7 years 10 months living in a small village outside Cambridge U.K., developed enlarged lymph nodes on the right side of his neck. He was asymptomatic, Mantoux negative and had a normal chest x-ray. He had not had BCG. He was referred to the surgical service at Addenbrooke's Hospital and the enlarged lymph nodes were removed. The histology ... suggested a mycobacterial infection. Samples of the diseased lymph nodes were incubated on Lowenstein-Jensen slopes with duplicates including pyruvate, but not mycobactin, for 12 weeks at room temperature, 30° C and 37 ° C.

He was treated with rifampicin 450mg, isoniazid 150mg once daily, and pyrazinamide 250mg 3 times daily for two months but when the cultures were negative drug treatment was stopped. The remaining lymph nodes on the right side of the neck progressively enlarged and were removed by block dissection in November 1989. Mycobacterial culture again proved negative. He remained well until March 1993 when he developed an arthritis affecting both knees, and an anaemia refractory to iron. By the end of 1993, he was an ill child with daily abdominal pain, anorexia, 2-3 loose bowel motions a day, weight loss and lethargy.

His weight was 37kg and his height 153cms. He looked pale and ill and had angular stomatitis. Firm lymph nodes were still palpable on the right side of the neck. There was no clubbing. In the abdomen, an enlarged, tender loop of bowel was easily felt in the right iliac fossa. Radiologically the small gut showed narrowing and distortion of a 10cm segment of terminal ileum and prominent cobblestoning of the mucosa. White cell scan at one hour showed intense uptake of the label over the affected intestine. These findings were considered typical of Crohn's disease.

He was treated with rifabutin 300 mg and clarithromycin 500 mg daily and was advised to have UHT [long-life] milk only. Eight days after the start of treatment, lymph nodes on the left side of the neck and residual nodes on the right, became enlarged and firm with surrounding oedema. At the same time he had a transient episode of subacute intestinal obstruction which subsided on conservative management.

With continued rifabutin and clarithromycin treatment the nodes gradually subsided. By mid 1994 after six months treatment he was virtually asymptomatic and he was completely so by February 1995, when his weight had increased to 49kg and his height to 160cms. White cell scanning then showed a complete resolution of the previously inflamed gut. However, he was beginning to get obstructive symptoms. Barium enema showed no active disease but

there was a tight stricture of the terminal ileum with upstream dilatation. A limited resection was therefore carried out, with removal of the terminal ileum and adjacent ascending colon for a pale fibrotic stricture followed by end-to-end anastomosis. ... There was no other visible evidence of inflammatory disease throughout the gut. Rifabutin and clarithromycin treatment and restriction to UHT milk was continued. The drugs were stopped at the end of October 1996 after a total of 32 months treatment. By January 1997 his weight was 67kg and his height was 170cms. He was asymptomatic and a well developed adolescent on physical examination. [4]

JOHNE'S DISEASE

In 1895 Johne and Frothingham described a chronic inflammatory disease of the intestine in a German cow in Dresden as "ein eigentümlicher Fall von Tuberkulose beim Rind" ['a typical case of tuberculosis in a cow']. At that time, the disease was called pseudotuberculous enteritis, and was thought to be caused by the avian tubercle bacillus [*Mycobacterium avium*]. It received the name pseudotuberculosis in recognition of its remarkable similarity to intestinal tuberculosis, but without caseous necrosis. Between the period of the discovery of the disease in 1895 and the isolation of its aetiological agent in 1910, pseudotuberculous enteritis was reported from around the world. Initially named *Mycobacterium enteritidis chronicae pseudotuberculosis bovis Johne*, or Johne's bacillus, the organism was officially given the name *M. paratuberculosis*, with *M. johnei* as its synonym, in 1932.

Johne's disease in animals occurs in domestic ruminants especially cattle, sheep and goats. Studies have shown that a broad range of animals can be affected, including deer, rabbits, and sub-human primates.

Animals acquire MAP during early life, before 30 days of age, either from exposure to faeces from cattle shedding the organism or from ingestion of mother's milk. Sub-clinically infected dairy cattle shed MAP abundantly in their milk. The gut is the main target organ, and MAP is shed in the faeces, but it can traffic widely throughout the animal in macrophages. After a long latent interval the disease becomes manifested in adult life, during the animal's prime of life and period of maximum productivity. An age-dependent resistance develops such that adult animals not exposed to the agent during early life rarely become infected, even experimentally. MAP can be isolated from the gut or faeces of about two-thirds of sick animals after 2-4 months in conventional in-vitro culture, although in many cases of 'paratuberculosis' in

animals the organism cannot be isolated at all. [2, 4]

The classical picture of “paratuberculosis” of Johne’s disease in animals is characterized by chronic diarrhoea, weight loss, and the visible presence in the diseased intestine of millions of acid-fast bacillary form Mycobacterium paratuberculosis together with macrophages, but little additional inflammatory cell infiltrate.

MATERIA MEDICA JOHNEINUM

Johnein.

Sources

- [1] Introduced and proven by Louis Klein, Canada; 3 female provers, 30c.; 2002. [p]
- [2] Clinical cases Louis Klein.
[Extracted from Louis Klein, Clinical Focus Guide, Vol. 2]

SYMPTOMS

Mind

- Persecution and suffering.
 - Holocaust survivors.
 - Tortured and tormented by others.
 - Persecuted; the scapegoat.
 - Insensitive to suffering - have suffered much.
 - Robbers or those are going to attack them.
 - People are after them to kill them.
 - Dreams of being dead or being murdered.
 - Dream husband is trying to murder her.
 - Dreams of walking with others to their death.
 - Part of large group persecuted.
 - Del. Being held prisoner by someone they know.
 - Suspicious - watching people or feeling of being watched.

I got very despondent this evening. I told my husband and my friend that I believe we will soon be in World War III. [p]

It crossed my mind later that night that this is what it must have been like for Jews during the ‘night of glass’.* [After an incident with a window cleaner wanting to be paid and “pounding on door so much I thought he was going to break it down and attack me.”]

Last night and tonight I have locked the doors earlier and even when I went out. I am making sure I have locked things, including the garage door. Usually I don't pay attention to these things even when R. [husband] has been away before, [p]
When I was walking the dog at lunch and tonight I noticed several unmarked vans slowing down on our street or near our house, and at one time I turned around to see [after he drove by] where he was stopping [near the house?] - but he didn't stop, he just sped up and drove away. I felt like I was being watched, [p]

- Drama - melodrama.

Drama.

Acting.

Irritable.

Hard done by, self-pity, self indulgence.

Cursing.

Swearing like a sailor, especially saying fuck. Very loquacious. Getting excited when speaking. Told M. people have something up their ass tonight. Challenged some guy who was screaming at a cabbie, told why don't you fucking walk down asshole. M. was standing there but I did not see him. He said, hey what's going on? [p]

- Forgetfulness.

Doing many things but in a disorganised fashion. Messy.

House is a mess, have found I am not as interested in keeping things in order.

Stuff lying around doesn't bother me like it used to. [p]

In the past few days I have been full of mental energy and doing many things - but in a very disorganised manner. Often starting tasks but not completing, wanting to move onto the next thing. Leaving a big mess everywhere: piles of papers, laundry to put away, sketches, garden tools. [p2]

- Hurried.

Pressure to finish.

Life is limited time-wise.

I have noticed my hearing and my memory are not as sharp as normal. I have

to keep asking people to repeat themselves, everyone seems to be speaking much softer. Also I keep forgetting to do so simple things I am supposed to do or have promised to do. The biggest things is forgetting names though. I keep saying you know the person that ... It is extremely frustrating, [p] Memory - I looked at a note I made to myself to call J. and I got angry that I could not remember who J. was. Usually that kind of stuff comes to me immediately. [p]

- Miscommunication.

Lots of things not fitting during proving, also lots of miscommunication stuff. We seem to be missing phone calls when we are home and don't hear the phone. Delay in communication. All day my plans kept changing every 15 mins due to other people, [p]

- Why bother?

Need to be with people but inside feel isolated, under attack.

Sensitive to social injustice.

Despair about politics.

Despair and giving up.

Sense of futility. "It seems petty and small."

Decreasing options with increasing age.

Then thought of life as very ephemeral - what's the use - what does it matter anyway? How pointless it is and what a lot of work and you just die in the end. Woke up this morning feeling old. [p3]

I've noticed an attitude in myself - nothing we do matters - not exactly cynical. Ran across husband's father's diary. After we die, who gives a ripp. Not hopelessness, almost reptilian. It's not that I don't care about people, but I ran across my own notes from the past and it doesn't matter. What was significant at one time isn't anymore [typewriters, books, old text books...]. Well that's over... To preserve things because they're old or cool eventually doesn't matter.

Maybe a sense of mortality. I used to gather up things for quilting - gathering up so many things and it's eventually futile. Thinking about the economy and feel we can't go on like this. NM economy is low, people in Africa are starving. Anything we do is a stop gap effort. Where would the money come from? Where do we go from here? Got to look at the bottom line; there's just not enough to go around. [p3]

I feel like discounting everything as unimportant. [p3]

Feel like nothing I do matters very much. I read an obituary. How can a person's life be stated so briefly? It's all rather sad. [p3]

- Money and business matters.

Incredible businessmen.

Loss of money - robbers, people taking it away by force.

Or anything is theirs, anything is possible money-wise.

Money has become a big issue in our household. Cash flow in particular. We are chasing money that is owed to us and juggling accounts, [p]

I noticed today that I am taking an active interest in our finances, watching the dollars so to speak. I have been doing it for about a week. Following bills, our investments, etc., making appointments with new finance people. Regardless of my training as an economist, R. [husband] has always done this. I never had any interest in this. Now I have a keen interest, so tidy up the sloppy stuff [paying high interest on credit cards, etc.], [p]

We can't really afford it [new computer program] but I am finagling and fiddling to figure out a way to have it anyway. [p3]

Dream of stacking and rolling coins. I think my subconscious is telling me about the slow accumulation of wealth. [p3]

- Cats.

Dreams of cats; yet < cats.

Generals

- Waking at 3 or 4 a.m.

- Waking frequently.

- *Morning on waking* <

Very tired; difficulty rising. "Could easily go back to bed." "Kept pushing the snooze button in morning." [2 proverbs]

Stiffness, esp. neck, shoulders and upper back muscles. [2 proverbs]

Slow in moving.

Waking up hungry. [2 proverbs]

- Lying <

Lying in bed both my headache and my menstrual cramps were the worst. As soon as I get out of bed they are much better. The headache almost disappears. I can feel the 'outline' of the headache in the sensitivities of my sinuses and when I breath in cold outside air. [p]

-
- Recurrent infections.
 - Tightness - tightening muscles.

In bed before going to sleep I felt muscles stitching and tightening, not really pain. Tightening - very short, goes all over my body. Tightening on waist area, left side. Both hamstrings very tight > bending legs. Muscles all over tightening slightly. Top of head, right side, tightened. Left side neck, right side lower back radiating down buttock. There seemed to be a sensation of electricity humming in my legs from the tightness of the hamstrings, [p]

Food & Digestion

- Constant eating of small amounts.
- Crave one food and then eat it only.
- Food important - change of diet. Anorexic diet.
- Sensitive to wheat - wheat free, allergen free diets. Cut out wheat, vegetarian, etc.
- Dreams about food; dreams about eating, buying or preparing food, etc.
- Nothing digests right.
- Weight loss. Dwarfish failure to thrive - absorption deficient; lack of nutrition.

Gastrointestinal

- Spasms - 'tightening in body' goes to abdomen.
- Gastrointestinal disorders - bowel disease; Crohn's disease; ulcerative colitis; irritable bowel syndrome, etc.
- Abdominal pain, like gas pains - 'painful fullness'.
- Pain in hypochondrium - sensation there of something hard inside, like a piece of wood, approximately over the transverse colon.
- Cramping pains.
- Sensation as if diarrhoea were coming on.
- Diarrhoea alternating with constipation.
- Diarrhoea with urgency; < after breakfast.
- Frequent soft stools.
- Dreams about toilets.

Other locals

- Headache, mainly forehead, severe pressure with pressure in ear; & twitching; on waking.
- Difficulty swallowing - lump sensation.
Eating dinner, difficulty swallowing as if a bolus in throat after eating noth-

ing particularly big or hard. Painful when I try to swallow water to wash it down and the water doesn't want to go down for a while either; this goes on for several swallows and then clears. [p2]

Difficulty swallowing liquid, again the sensation of a blockage in oesophagus, as if the water gets stuck partway down, with a little clucking noise. [p2]

- Tender spots in upper torso.
- Spasmodic asthma - gagging cough leading to asthma.
- Menstrual cramps - endometriosis.
- Eruptions - pimples.

I have never had many pimples!! - if I get any I usually get them just before my period on my face [lower half] and on the left side of the neck. They disappear before the end of my period. Not this time though; they continued on stubbornly, especially on the left side, just above my chin. It was like a hard bump that wouldn't go away. I also got 5 or 6 pimples on my buttocks both sides, [p]

- Kristalnacht, the night of 9-10 November 1938 during which the Nazis marched through the streets smashing the windows of Jewish businesses, looting them, vandalising Jewish homes, and burning synagogues. More than 7500 Jewish shops across the country were destroyed; the debris of the shattered shop windows gave the pogrom its name 'Night of the Broken Glass'. Of 100,000 Jewish-owned businesses in 1933, 40,000 were left in 1938. After Kristalnacht, the remaining Jewish businesses were closed down.

The government confiscated the insurance money that was due to the Jewish business owners saying that it was a fine imposed on the Jewish people for having started the trouble. More than 30,000 Jews were hauled off to concentration camps, beginning the Holocaust.

MYCOBACTERIUM BOVIS

| | |
|------------------------|---|
| Scientific name | Mycobacterium bovis subsp. bovis Karlson & Lessel 1970 |
| Common name | Bovine tubercle bacillus |
| Family | Mycobacteriaceae |
| Homeopathy | Tuberculinum bovinum Kent - Tub. Bacillus Calmette-Guerin vaccine [BCG] - V-a-b. |

FEATURES

- Gram-positive, non-sporeforming, non-motile, aerobic, slow-growing rods forming strands and cords.
- Facultative intracellular pathogen [M. tuberculosis likewise].
- Hydrophobic with a high lipid content in the cell wall.
- Host range: primarily cattle, primates, rodents, badgers, swine, humans.
- Survives outside host for periods ranging from 6 weeks [eg, in manure or clothing] to several months [eg, in dust, paper book, carpet, but particularly in sputum if kept cool and dark]. Survival is better under cool conditions, eg, survives in cow dung for 5 months in winter and 6-8 weeks in summer.
- In contrast to the urban prevalence of M. tuberculosis infection, bovine tuberculosis infection prevails in rural areas.
- Wild animals infected with M. bovis manifest clinical signs of weakness and a loss of timidity.

MILK-BORNE TRANSMISSION

Arguing for cross-contagiousness of tuberculosis between humans and cattle, the French physician Jean Villemin attempted to confirm this by inoculating rabbits and guinea pigs with blood, sputum, and secretions of TB-patients. He found a powerful opponent in Koch, who insisted that bovine tuberculosis was different from human tuberculosis and was never transmitted. Koch was wrong. M. bovis is no less a hazard to man than is M. tuberculosis, and it soon became apparent that milk and meat were responsible for the transmission of tuberculosis. Tubercle bacilli end up in milk from infected udders, from animal or human respiratory contamination, or from faeces, the latter being a major source of contamination of milk. This has led to measures to purify

Mycobacterium bovis
Hosts:
cattle, primates,
rodents
badgers, pigs, humans
Infected animals lose
their timidity

milk through pasteurisation and tuberculin tests.

It is not possible to clinically differentiate between TB caused by *M. bovis* and that caused by *M. tuberculosis*. The course and extent of the disease is the same. However, milk-borne infection with *M. bovis* has a predilection for the gastrointestinal tract [intestinal or alimentary tuberculosis], which may progress to spinal involvement [Potts disease or tuberculous spondylitis] or lymph node enlargement in the cervical [appearing as scrofula] or the mesenteric region. Tuberculous lesions in children are most frequently localised in the cervical lymph nodes. The angular hump peculiar to Pott's disease has been found in skeletons from Europe's Neolithic and Bronze ages, up to 7,000 years ago. TB of the tonsils, bones, and joints was in the past also commonly caused by ingestion of milk infected with *Af. bovis*.

There is hardly any evidence to associate *M. bovis* infection with pulmonary tuberculosis. According to the 1930 Ministry of Health Statistics, as cited by Dormandy, "28% of all non-pulmonary tuberculosis deaths [and 2% of pulmonary tuberculosis deaths] in Britain were of bovine origin. Over a thousand children under the age of 15 died in England and Wales every year from the bovine strain."

DIFFERENTIATING THE TUBERCULINUMS

The classical Tuberculinum symptom "craving for cold milk originates from milk-borne infections, which obviously have an increased incidence in populations with a high intake of dairy products. The symptom dates back to the time when people drank raw, unpasteurised milk or used products prepared from such milk [eg, ice cream]. Individuals who crave milk will obviously appease that craving by drinking milk, thereby increasing the chances of contracting tuberculosis, dependent upon disposition and susceptibility. One might also argue that TB-susceptible individuals love milk. [It should be noted that the milk craving is only mentioned by Kent under Tuberculinum bovinum.] Finally, a glass of milk every four hours was part of the daily dietary regimen in 19th-century sanatoriums.

A possible way to differentiate Kent's Tuberculinum bovinum from the "pulmonary types" such as Bacillinum, Swans Tuberculinum, and Tuberculinum Koch is to study the clinical pictures associated with the human and the bovine strains.

The bovine organism entered the body by a different portal from that of the dust- and droplet-borne human bacillus; and, though the clinical pictures overlapped, there were also characteristic differences. Pulmonary tuberculosis was almost always associated with the human bacillus. Intestinal tuberculosis associated with tuberculous peritonitis in children was the typical presentation of the bovine strain. It could be an agonisingly painful illness, a succession of episodes of acute or subacute intestinal obstruction often requiring desperate operations. ... The main symptoms were colicky pain, vomiting and constipation [or, occasionally, diarrhoea]. The abdomen was distended and hyperresonant. ... Few forms of tuberculosis were so lacking in Romantic appeal and were yet so heartrending to watch. Death was often due to progressive malnutrition and general debility.

The bovine organism may also have been responsible for nearly half of all cases of tuberculous meningitis, the most rapidly fatal form of the system; and it was probably a frequent cause of tuberculosis of the bones and joints, the genitourinary system, the cervical lymph-nodes and lupus vulgaris. In some parts of the world it was - and still is - the chief killer of babies and young children. It also calls for separate consideration for yet another reason.

In contrast to pulmonary tuberculosis and other infections with the human bacillus, infections with the bovine organism were eminently preventable for at least fifty years before the introduction of specific chemotherapy. They continued only in countries where they were not prevented. Such statements are usually arguable rather than provable, grist to the mill of the 'if only school of history'. Not in this case. With unflinching resolve the United States eliminated bovine tuberculosis within a decade of the scientific evidence and technical means becoming available. [Dormandy 2000]

MATERIA MEDICA TUBERCULINUM BOVINUM KENT Tub.

Sources

- No provings. Drug picture based on observations by Kent, who had the remedy made from tuberculous bovine glands. He derived the mind-picture from "the mental symptoms that I have seen give way while the patient was under treatment, and the mental symptoms that I have seen crop out under the provings, and the mental symptoms that I have so often seen associated when the patient is poisoned by the tubercular toxins are such as belong to many complaints and are cured by Tuberculinum." While Kent's confusing

reference to symptoms “cropping out under the provings” suggests that provings have been done with the drug, this is contradicted by his earlier statement that “it is hoped that provings may be made.” What probably is meant with the so-called ‘provings’ are the symptoms appearing during treatment with *Tuberculinum bovinum*.

TUBERCULAR MENINGITIS

- While temporarily lending wings to the artistic inspiration of some, the majority of TB patients wasted away in silent resignation [reflected in repertory rubrics as apathy, taciturn, indifference, etc.]. Kent also holds it “true that phthisis and insanity are convertible conditions, the one falls into the other. Many cases that are treated, cured and phthisis of the lungs has just been turned aside, finally become insane. Persons who have been cured of insanity go into phthisis and die, showing the deep-seated character of their nature. The intellectual symptoms and the lung symptoms are interchangeable.” Such a course would today be explained as dissemination of tuberculosis to the central nervous system.

The cerebral pathology is characteristic. In areas where TB is common among children, tubercular meningitis usually occurs between age 1 and 5. In the USA, however, this complication is most common in the elderly, occurring as a manifestation of recrudescence of an infection acquired many years earlier. [Merck Manual]

[Note: Since CNS involvement seems as common for *M. bovis* as it is for *M. tuberculosis*, the comparison below between tubercular meningitis and the symptoms of *Tuberculinum* is placed under *Tuberculinum bovinum* because the various *Tuberculinum* preparations are probably interchangeable in regard to their effects on the brain. For a cured case of tubercular meningitis, reported by H.C. Allen, *see* also *Bacillinum.j*

- The yellowish gelatinous exudate that forms mainly at the base of the brain relates to the “basilar meningitis” and “deep brain headaches” [recorded for both *Bacillinum* and *Tuberculinum bovinum*]. The basal exudate obstructs the flow of cerebrospinal fluid. The effect on the central nervous system is illustrated by a case cured by Swan with his ‘*Tuberculinum*’:

Suddenly became unconscious while sewing or talking, began screaming,

tearing her hair, beating her head with her fists, or trying to dash it against wall or floor; attacks daily, for a month, then spasms set in, with rolling of head from side to side and moaning; continuing five weeks, followed by a recurrence of fainting fits, at least twice a week; a few hours before an attack of fainting, a shuddering like a chill seemed to go from brain down spine; when questioned about an attack, she said head would suddenly seem to swell over eyes and pain became “horrid,” and she knew no more; between attacks she was free from all complaints except fatigue and ever-present frontal headache, [case Swan] [Head banging in children, esp. at night, is a reliable indication for Tuberculinum.]

- The obstruction may lead to internal hydrocephalus, which, in combination with the spinal involvement is demonstrated by a case cured by Burnett with Bacillinum:

An author of eminence, with terrible pain in the head, almost absolute sleeplessness and profound adynamia: had phthisis, with blood-spitting for years, with a solid right lung, but who had “grown out” of his consumptiveness. His brothers and sisters had *died of water on the brain*. He was being “shadowed” on advice, as he was thought to be on the verge of insanity. The pain in his head is “as if he had a tight hoop of iron round it”; and he has a distressing *sensation of damp clothes on his spine*. It sounds hardly credible, but in less than a month after beginning with the virus the pain in the head had gone, the sensation of damp clothes had gone, and his sleep was fairly good. He got a few more doses at long intervals, then needed no further treatment. Continued in good health, hard at work finishing his forthcoming publication, [my italics]

- Mental changes form an integral part of the picture of tuberculous meningitis, typically apathy, irritability and insidious change of personality.

MM Tuberculinum: Felt positively ugly; personal aversions became almost a mania. Trifles produced intense irritation and I could not shake them off. Very irritable, want to fight; no hesitancy in throwing anything at anyone, even without cause. Fretful, snappish, morose. Irritable on waking. Naturally of a sweet disposition, now on the borderland of insanity. Ill-mannered, quarrelsome; lies in bed and complains.

- As the disease progresses, the mental abnormalities increase with drowsiness, confusion, disorientation, and inability to sustain a rational conversation.

MM Tuberculinum: Drowsiness during day. Great sleepiness and weariness; entire muscular system relaxed; desire to lie down all the time. Everything in the room seems strange, as though in a strange place. Soporose, dazed condition; unable to find the right way; is confused; surroundings appear strange.

- Characteristically the patient sleeps when alone but becomes disturbed when roused, in contrast to the perpetual 'silent struggling delirium' of purulent meningitis.

MM Tuberculinum: Very restless in evening when aroused. Does not like to be disturbed; trembling of hands and feet.

- Occasionally the patient is hallucinating and wildly delirious. The terror may resemble that of delirium tremens.

Sullen, taciturn, irritable, screams in his sleep, is very restless at night, costive; sister died of tubercular meningitis.

Tubercular meningitis, with effusion; head greatly enlarged; alternately wakeful and delirious at night, talked nonsense by day, at intervals; nocturnal hallucinations and fright; delirium; pyrexia; had eczema which almost disappeared after two unsuccessful vaccinations, and which were soon followed by above condition; after administration of Bacillinum there occurred a severe pustular eruption, then patches of lepra [scaly] and eczema appeared.

[Two cases Burnett]

- “Williams and Smith [1954] have described the picture in detail. It is remarkably constant in kind though varying in degree, consisting essentially

Confabulation is a psychological term meaning the fabrication of imaginary experiences in compensation for loss of memory.

of a disproportionate disturbance of memory in relation to other cognitive defects. The patient may appear reasonably alert, and copes fairly well with intellectual problems, but proves to have a grave defect in retaining new information for more than a few minutes. Confabulation may be much in evidence, and memory for temporal sequences is severely disorganised. Memory is hazy for the events of the illness and those preceding it for several weeks or months, but beyond this is usually intact. ... Throughout the amnesic phase the patient is usually euphoric and shows little concern about his memory difficulties. Some, however, are withdrawn, negativistic, paranoid or acutely depressed.”
[Lishman]

MM Tuberculinum: Comprehension and concentration almost impossible. Memory weak, unable to think. Forgetful; averse to all labour, esp. mental work. Memory weak; unable to think or comprehend. Comprehension difficult; must read a paragraph several times before he can understand it. Weakness of memory for what he has read.

SEQUELAE

“Lorber [1961] followed the long-term results in 100 children who survived the acute illness [tubercular meningitis]. A large variety of sequelae were seen but the number of children seriously affected was surprisingly small. Seventyseven had made a complete recovery, including some with severe neurological abnormalities during the active phase of the illness. Twenty-three showed defects in the form of paresis, fits, deafness or blindness, sometimes with gratifying improvement over time. Fits persisted only in 8 children despite their frequency in the acute stages. Six of the 23 were profoundly mentally retarded; all of these had been under two years of age and severely affected when first seen, and all had major neurological sequelae. In the remainder there was no evidence that intellect had been impaired. Among children of normal intellect there were 6 with disorders of character and behaviour, 4 in association with a physical handicap and 2 without apparent relation to the meningitis.” [Lishman]

Wheeler and Kenyon assert that “Tuberculinum should always be considered in the treatment of mentally deficient children. Where there is arrested development, mental or physical, for example delayed dentition it is a particularly valuable remedy. Many cases are recorded wherein a backward child has been stimulated to normal development following the administration of Tuberculinum.”

Since sixteen months many very remarkable cures have been performed, even several known as incurable, so that from east to west, all through Switzerland, Bacillinum has found an entrance. In a journal, treating on “General Conduciveness,” I asserted that the principal cause of idiotism and cretinism are tubercles in and around the brain, and the only remedy to reach these tubercles, and to re-establish a harmony between moral and physis, are Bacillinum in its different strengths. ...

A case of idiotism and cretinism, which made a great stir. In August, 1891, I

was called by telegram to go to a place near Neuchatel, about 150 miles from Herisau, and found there a 10 year old girl, a perfect idiot and cretin. The history of the child was about this: Until after vaccination at 15 months, she was very well. From that time she began to act as having no sense, growing worse from months to years. ...

I found the girl in the following condition: Long or tall, 2 feet and 5 inches; old, 10 years; the teeth hidden in the gums, could hardly stand on her legs, unable to walk and talk; head, front narrow and large on the back; several smaller and larger elevations on the skull, some soft, others hard; nose, eyelids and lips extremely large; type of an idiot and cretin.

A careful examination, especially of the deformed head, with its elevations, disclosed nests of tubercles. Her eyes without life, no desire for anything; in fact the most ungrateful expression! - now what to do! My thoughts settled soon on one point, to give an antidote to these colonies of tubercles, and decided on Bacillinum, as the only means to bring on a change. She received on the 10¹*1 of August, 1891, 20 pellets, to continue every week the same dose. Visited her in October same year; great change; she began to talk and walk, the teeth sprouting out of the gum, the head a better form, and the general condition of the whole body was changed. Kept on by the same medicines. ...

After this, every month brought some new change. It is just a year since the child came under my attendance, and what a change has Bacillinum 200 made! The child talks, walks, [even runs], has grown three and a half inches, intelligence restored, enjoys extremely her life, being so cheerful and bright. Now am I wrong to assert that the main causes of idiotism and cretinism are tubercles, brought on either by bad virus of vaccination, or inherited from the parents the germ of such a dreadful calamity?

[John Young, Hom. Recorder, November 1892; RefWorks]

CASES

(1) Tubercular History, Love and Mental Ability Revived. Now another strange case I may tell you: A woman had been sick four years, declining steadily, when she came to consult me. She had lost all her loves: had not the ability to exercise that function at all. She was ashamed of it: did not like her husband; did not love her children: and she said: "What shall I do! Don't tell of it. I don't want anybody to know that I do not love my husband; he is a good man.

And my children; I have lost all my love for my children." She had no resolution whatever; was entirely irresolute: was irritable; had no desire to do anything:

it was all lost. Undertaking any mental exertion brought much pain in the occiput; she put her finger directly on the spot: she felt hot right at that spot. Hers was a marked tubercular history. From her recital I recognized that there was a difficulty; it was clear to me that there was some obstruction in the passage between the third and the fourth ventricles; it appeared to me that the cerebrospinal fluid would not flow out of the brain to accommodate her mental exertion, and then she would have congestion.

I could strongly suspect that there were tubercular deposits in the brain; I was convinced of this by her strongly tubercular history. But I did not come to a conclusion until after studying her for more than six months, giving her such remedies as I could. She would pick up slightly; and then within a week would drop right back again; I would select another remedy, and after another slight improvement she would again drop back.

Finally, I thought: Here is a tubercular history and here are the tubercular symptoms; I am going to test her. Putting her under a test with *Tuberculinum bovinum* 10M, she responded to it. She said, "Doctor, I am a new woman." All of her loves came back; her mental ability revived. She had 10M twice at long intervals and: had 50M twice, also at long intervals. She responded and felt better after the first dose; within three or four weeks her symptoms returned and I gave her a second one. She is now on the third or fourth dose; now, after about three or four doses she is a new woman, perfectly natural in everything.

[Kent, *Clinical Cases*-, RefWorks]

(2) P. Sankaran noticed that quite often patients with a family history of tuberculosis [not patients with actual tuberculosis] were found to have glossy or shiny fingernails. He writes: I once had a chance to utilise this observation in practice. I was called to see a lady aged 30 years who was suffering from an attack of acute rheumatic fever. She presented the usual picture of this disease with the swelling of joints, high temperature etc. Her remedy worked out clearly to *Rhus tox*. So we put her on *Rhus tox*. 30 every four hours, but with no result. Being sure of the remedy, we raised the potency to 200 and then to IM, all of which produced not the least change in the condition of the patient. On the contrary, by the fifth or sixth day her condition became very much worse and she also developed and presented signs of a very severe form of conjunctivitis and keratitis. Her vision became blurred and she was not able to see anything. The husband and relatives naturally became panicky and they practically decided to change over to allopathic treatment. I examined her closely and I noticed that

the lady had markedly glossy finger nails. They were shining as if nail polish had been applied. Naturally I enquired if there was any history of tuberculosis in the family. The answer was negative. But still I gave her one dose of Tuberculinum IM and then repeated the Rhus tox. The response was really dramatic. Within a few hours she became much more comfortable, the pains and swelling in the joints and the temperature came down, the condition of the eye and vision improved and she felt very much better. She improved steadily and made an uneventful recovery in a week's time.

Now she has remained well for over two years. The condition of the patient had been so bad and the response to the medicine had been so remarkable that it impressed the whole community. About two weeks after she had recovered, she came and told me that she thought over my question about tuberculosis and had written to her mother who was away. The mother had replied that indeed she [the mother] herself had suffered from tuberculosis in her younger days. This fact, her daughter, that is my patient, had not been aware of. This experience has been repeated numerous times in my practice.

[P. Sankaran, *Some Notes on the Nosodes*]

(3) I will detail a case that shows very poor judgement on my part, but it brings out some interesting facts. A lady of forty, mother of four children, of medium height and build and having brown hair and blue eyes, consulted me some years previously for pain beneath the right breast which was overcome with Phyt. She now gave the following symptoms; Crushing burning pain as if the parts were in a vice, starting beneath right breast and going through to back. Pain always started at 1 a.m. and lasted until 4 a.m. Pain came gradually and left gradually. At the height of the seizure she was in great agony and walked the floor with her body bent forward moaning with the pain. Sometimes when the pain was at its worst she was forced to run. At times external heat relieved somewhat and at other she wanted cold. She could not bear to be touched during the paroxysm and often was very snappy and uncivil. Phyt. relieved for one day only. The Kali bi. Kali carb., Chem., Cina and Ars. were given each as best seemed indicated. Each relieved once and once only some for 24 hours, none for more than 48 hours. Cham, relieved almost at once, the others slowly much as morphine does. Higher and lower potencies were given, but without apparent results. The medicines were used both during and between the attacks, but the results were nil. Cedron and Coloc. were given without changing the general character of the case. Then gradually the pain began to move toward the heart, that is its starting point moved toward the

heart a little nearer each day, until the seizures began at the heart region, but the general character of the pain remained the same, and the time element did not change. The heart itself seemed in no way affected by the paroxysms, but Lach., Naja, Latrodectus mact. and Am. each gave the patient one gasp of relief and then died. What was wrong?

Why did my remedies expire after one effort? Evidently the patient's acute symptoms were blinding me to something of greater import. I retook the case and found besides the symptoms already enumerated, swollen glands under and about left clavicle; changing shifting symptoms; marked periodicity; icy cold feet; scant menses with painful swelling of the breasts during the period; craves the open air though chilly; obstinate constipation for years; as soon as she gets over one illness another takes its place.

After careful study I gave her Tub. bov. 200, about one dose a week, and later the 10M of the same remedy, which not only mitigated the paroxysms of pain, but bettered the general health of the patient. Likewise, before the paroxysms had entirely ceased the location of the pain had reversed itself, travelling back to its original location beneath the right breast.

[Charles M. Olds, *Tuberculinum*-, Hom. Recorder, Nov. 1929; RefWorks]

BACILLUS CALMETTE-GUERIN

V-a-b

History

Bacillus Calmette-Guerin vaccine [BCG]; tuberculosis vaccine.

Suspension of an attenuated live strain of *Mycobacterium bovis*, inoculated into the skin for tuberculosis prophylaxis [particularly miliary TB and tubercular meningitis] in infants and young children. Protection is not permanent or predictable and does not extend to the adult years, so that many people develop active tuberculosis even though they received BCG, even in multiple doses, in earlier years.

Introduced by the French bacteriologist Albert Calmette [1863-1933] and Camille Guerin [1872-1961], French veterinarian.

Name in homeopathy: Vaccin Attenué Bilie.

BCG

In 1904, *Mycobacterium bovis* was first isolated from an infected cow by Nocard. First produced in 1906, Calmette and Guerin eventually created a

non-virulent strain of *Mycobacterium bovis* by growing the tubercle bacilli for hundreds of generations over culture media containing bile for a period of 13 years. They ended up with a strain that received their names, Bacillus of Calmette and Guerin [BCG]. In 1921, the BCG was first used as a vaccine in humans. Since the vaccinations were well tolerated, a worldwide interest in the BCG arose, so that currently an estimated 70% of the world children are given it; more than any other vaccine.

Unfortunately, the vaccine produced using this strain works rather poorly. Some studies have shown a 70% effectiveness rate, others no effect at all, and a good many have fallen somewhere in between. Still, the vaccine turns out to have most surprising properties. A recent study carried out in Malawi in central Africa found no effect of the vaccine against tuberculosis, but an almost 50% effectiveness against the closely allied disease of leprosy.

In First World countries, where the incidence of TB is low, use of this vaccine is rare because its effectiveness is so uncertain, and because after it has been given, the skin test for the presence of tuberculosis no longer works. This means that once somebody has been immunised using BCG, not only is there no guarantee that he or she will be protected, but there is no easy way to determine if a later infection with real tuberculosis bacilli might have taken place. Further, BCG cannot be given to AIDS patients, for their immune systems have been destroyed to the point that even this attenuated bacillus can multiply in their bodies, giving rise to systemic infection.

[Wills 1996]

Complications of BCG administration commonly involve local reactions such as regional lymphadenitis, local abscess, local ulcer, or keloid scar formation. These reactions can persist for as long as 3 months after vaccination. BCG vaccination often results in permanent scarring at the injection site.

A rare but serious complication is disseminated BCG infection. BCG osteitis affecting the epiphyses of the long bones, particularly the epiphyses of the leg, can occur from 4 months to 2 years after vaccination.

The risk for developing osteitis after BCG vaccination varies by country; in one review, this risk ranged from 0.01 cases per million vaccinees in Japan to 32.5 and 43.4 cases per million vaccinees in Sweden and Finland, respectively. Case reports of other severe adverse reactions in adults have included erythema multiforme, pulmonary TB, and meningitis. Fatal disseminated

BCG disease has occurred at a rate of 0.06-1.56 cases per million doses of vaccine administered; these deaths occurred primarily among immuno-compromised persons. [Data CDC]

BCG is no longer recommended for health care workers, school teachers, travellers or other adults who are likely to be exposed to TB.

BCG AND PERTUSSIS

Mycobacterium bacilli, as part of the Corynebacteria and Nocardia group, seem to prevent or cure susceptibilities provoked by whooping cough vaccination. Possible beneficial 'side effects' of BCG were suggested by a study of 274 pupils of British Rudolf Steiner schools:

125 of them had been immunised against whooping cough versus 149 non immunised. Among the 125 pupils vaccinated against whooping cough, 23 [18.4%] were diagnosed as asthmatic, versus 6 [4.02%]. The difference was statistically significant.

The findings of these first two steps have been to a certain extent confirmed by an American study that used the data from the Third National Health and Nutrition Examination Survey on infants aged 2 months through adolescents aged 16 years. It appeared that DTP or tetanus vaccination doubles the risk of allergies and related respiratory symptoms in children and adolescents. Unfortunately this study could not separate children who received DTP and those who received tetanus only.

The third step is represented by an analysis of the medical records of the 210 pupils of the French Steiner school La Mhotte. Pupils of Steiner schools belong to families whose lifestyles are apparently similar, whatever the side of the Channel. However there are differences where vaccinations are concerned. French immunised children usually receive BCG at birth or a very early age. None of the children who had received both whooping cough vaccination and BCG have been diagnosed as having asthma. We came to the conclusion that BCG protects whooping cough immunised children against asthma.

This protective effects of BCG contributes to explain differences between countries. In countries with the highest prevalence of asthma, BCG is not routinely offered [eg, UK, New Zealand, Australia, Republic of Ireland]. Before the fall of the communist system, BCG during infancy was routine practice in Eastern Europe. The rate of asthma in childhood and adolescence in such countries is comparatively low. School children in Leipzig, East Germany, born three years

before unification, still had a comparatively low rate of asthma in 1995-96, whereas the prevalence of atopic sensitisation was already increasing.

[\[www.gentlebirth.org/archives/vaccinesPHRC.html\]](http://www.gentlebirth.org/archives/vaccinesPHRC.html)

CANCER TREATMENT

An interaction between acute bacterial infections, bacterial toxins and malignant tumours had been recognised in the 1920s and 30s when Coley successfully applied bacterial products [streptococci] for cancer therapy. By inciting severe inflammation at the site of injection, these “Coley’s Toxins” could induce local regression of various cancers. Coupled with autopsy observations that patients with tuberculosis had an apparent lower incidence of cancer, Holmgren in 1935 was the first to report the use of BCG inoculations against cancer. After demonstration of anti-tumour effects of BCG in acute leukaemia and bronchial carcinoma, favourable results were reported in the 1970s from direct injection of BCG into melanoma nodules.

[See for the dissolving effect of fever/inflammation on cancerous growths also under Nectrianinum, Vol. 2 of Spectrum, Fungi.]

In 1976, the intravesical instillation of Bacille Calmette-Guerin [BCG] in superficial bladder carcinoma was first performed and since then: “Local therapy of superficial bladder cancer with BCG has become firmly accepted and is accepted as being the gold standard in urology for recurrence prophylaxis and the most effective immunotherapy of solid bladder tumours. Currently BCG is being applied at a rate of approximately 1 million instillations per year worldwide.”

Adverse effects of BCG occur particularly from its use for scarification in the treatment of malignant melanoma. Adverse effects include fatigue, exhaustion, swelling of lymph nodes, influenza-like symptoms, nausea, dizziness, and allergic reactions. One case of Pott’s disease [typical for *M. bovis* infection] following BCG immune therapy for melanoma has been reported.

Adverse effects of intravesical BCG therapy tend to be progressive in frequency and severity with subsequent instillation, and may occur up to six months post-treatment. *M. bovis* infections have been reported in lung, liver, bone, bone marrow, kidney, regional lymph nodes, and prostate in patients who have received intravesical BCG.

Summary of adverse effects seen in 674 patients with superficial bladder cancer, in descending order of prevalence:

-
- Dysuria. Increased urinary frequency.
 - Influenza-like syndrome.
 - => Haematuria.
 - = Fever. Chills.
 - =■ Malaise, fatigue, lethargy.
 - ~ Cystitis. Bladder cramps.
 - = Increased micturition at night.
 - = Arthritis/myalgia.
 - <= Headache and dizziness.
 - = Urinary incontinence.
 - « Anorexia/weight loss. Nausea/vomiting.
 - Diaphoresis.
 - = Allergic reactions.
 - Cardiac complaints.
 - Rash.

PUBERTY

Puberty has been observed to be a factor in the resistance to infection with *M. tuberculosis* as well as with *M. leprae*. Bentley, Grzybowski, and Benjamin [1954] state that chronic pulmonary tuberculosis develops more commonly among those infected at the time of puberty than in those infected earlier. A study on persons living in contact with open TB and followed up for a period of 10 to 14 years, found that 20% developed clinical tuberculosis of those first exposed between 10 and 14 years of age, an incidence twice as high as in those first exposed between birth and 9 years of age and in those with first exposure after the age of 15. Cochrane and Davey [1964] argue that “during the years surrounding puberty the normal child is extending the range of his activities” and that “environmental factors may assume greater significance than in earlier years.”

While the incidence of TB is approximately the same between both sexes in childhood, the mortality from TB rises at an earlier age and is more pronounced among females, who reach puberty at an earlier age than males, a fact suggestive that pubescence rather than environmental factors is the critical factor. The authors observe that “puberty also has a bearing on the hypersensitivity which lies at the heart of acquired resistance. The rising curve of tuberculin sensitivity in a population during the years of childhood tends to slow down or even be depressed in the years around puberty. ... Puberty thus

appears to be associated with a temporary decline in resistance to the infection.” Christina Head [1999] has noticed that many of the problems of teenagers “start or are exacerbated by the BCG vaccination they have at thirteen or fourteen years.” As common side-effects of the BCG at this age she has seen “increased sweating, bad temper, period pains, allergies, lack of concentration, a desire to run away and low grade lung and skin affections, all of which often disappear after a dose of a homeopathic remedy made from TB.”

Since these symptoms are also common characteristics of most teenagers, there might be a relationship, resulting in Head’s advice: “If you clear out the BCG very often their problems disappear, or the case becomes much clearer and easier to treat. This clearing is well worth doing, and my message to homeopaths is to try it. You will see much more effective and quicker cures.”

MATERIA MEDICA VACCIN ATTENUAE BOVICUM

V-a-b.

Sources

Proving by Julian, 1960-61; six provers; 5c, 7c, 9c.
[S] = Additions from Synthesis 9.1.

SYMPTOMS

MIND

- ~ Easily irritated, angry, depressed; *any noise annoys him.*
- ~ Brain as if benumbed, difficult to find words, quickly tired by mental exertion.
- *Anxiety*; feeling that *death is imminent* and *tendency to exaggerate worries.*
- = Excitement while reading in foreign language. [S]
- «> Inconstancy. [S]

GENERALS

Energy

- = *Extreme fatigue*, & heaviness in head and diffuse pain in occiput.
- = Persistent asthenia.

Sleep

- Disturbed; erotic dreams.
- = Prolonged sleeplessness in latter part of night.

Food

- *Anorexia* & nausea; or incessant hunger.
- ~ Slow digestion, & gastric distension and sensation of having to vomit.

Constitution

- ~ Thin types, always tired, with chronic constipation.
- = Tendency to hyperthyroidism.
- Phosphoric types; hypersensitive, nervous, uneasy, restless.

Conditions

- = Insidious infection due to diffusion of BCG in the body after vaccination.
- = Insomnia and headache in school children.
- ~ Scheuermann's disease.
- ~ Besnier-Boeck-Schaumann disease [sarcoidosis]. [S]
- ~ History of recurrent bronchitis. [S]
- <= Aversion to smoking cigarettes, & dulness of head and paleness of face.

LOCALS

- ~ Pain in left temple and maxilla, < chewing.
- = Headache, esp. in late afternoon and evening.
- ~ *Scalp tender*, < brushing hair.
- = Swollen eyelids.
- = *Sneezing* and feeling of having a *severe cold*.
- ~ Nose obstructed, dry when indoors, > fresh, open air.
- = Nose, sensation of coldness. [S]
- = Bitter, pasty taste in mouth.
- = Tongue coated whitish-yellow.
- => Right tonsil slightly painful when swallowing.
- <= *Nausea on waking*, when rising, > eating.
- = Pricking pains in liver > lying down.
- = Cough *hoarse, dry, tiring*.
- *= Swollen cervical glands, with or without suppuration.
- = Cervical pain < turning to the right, > slow, continued movement.

-
- ~ *Polyarticular pains*, esp. in small joints.
 - ~ Cramps in toes of left foot.
 - = Dryness of skin and lips; *cracks* and fissures at anus and corners of mouth.
 - =» *Ichthyosis* [dryness and fish-skin-like scaling of the skin]

MYCOBACTERIUM LEPRAE

Lepr.

| | |
|------------------------|---|
| Scientific name | Mycobacterium leprae (Hansen 1880) Lehmann & Neumann 1896 |
| Common name | Leprosy bacillus |
| Family | Mycobacteriaceae |
| Homeopathy | Leprominium - Lepr. |

FEATURES

- Gram-positive, non-motile, non-sporulating, tiny, rod-shaped bacterium closely resembling the tubercle bacillus.
- Obligate intracellular parasite.
- Excessively slow growth; divides once in 12-14 hours.
- Tends to grow only in cooler parts of the body, such as the feet, nose and ears.
- Discovered in 1873 in Norway by the Norwegian physician Armauer Hansen.
- Has never been cultured in the laboratory.
- *M. leprae* cannot survive outside of host; however, may survive in nasal secretions for more than 36 hours].
- Previously thought to have uniquely adapted to humans and occurring in us alone, leprosy is now known to occur naturally in wild armadillos as well. The core body temperature of the armadillo is low enough to favour the growth of the bacillus.
- Incidence in humans is 2:1 males to females [1:1 in Africa].
- Up to 75% of cases occur in India, Myanmar [Burma], Nepal, Bangladesh, Indonesia, Nigeria. Brazil accounts for over 80% of cases in Latin America.
- Incubation period ranges from several months to 30 years.
- Leprosy tends to have a bimodal age distribution, with peaks at 10-14 and 35-44 years.
- “Although leprosy is caused by *M. leprae*, a host of other mycobacteria have been associated with the lesions. Such mycobacteria, which are termed leprosy-associated mycobacteria [LAM] or armadillo-derived mycobacteria [ADM], can be isolated from leprosy skin lesions of humans and armadillos. It has been suggested that infection with *M. leprae* favours the multiplication of environmental and other culturable mycobacteria within the lesions. In addition to LAM or ADM, leprosy lesions are associated with large numbers of coryneform bacteria, termed leprosy-derived corynebacteria [LDC].

Some investigators believe that the LDC and LAM have a symbiotic relationship with *M. leprae*, while others believe these organisms represent opportunistic superinfection of the leprosy lesion.” [Chiodini]
[*Corynebacterium diphtheriae* is such a coryneform bacterium. It may show a relationship between Diphtherinum, Leprominium, and Tuberculinum.]

CLINICAL MANIFESTATIONS

- While leprosy was once a disease of families, it is now being acquired increasingly from other sources in the community. Despite the terror of contagion aroused by it, leprosy is probably the least contagious of all communicable diseases and seems even so difficult to transmit that “one can share home and bed with a leper for decades and not catch it,” as Karlen puts it.
- Leprosy is not a stable disease; the polar forms described below are rarely diagnosed at Clinical Units. Between these two extremes a continuous clinical and histopathological range, termed borderline leprosy, is more often seen. The two polar forms include:

[1] *Tuberculoid leprosy*; also known as paucibacillary, localised or contained form. Affects 75% of the world’s sufferers. Involves people with strong cell-mediated immune reactions, which help confine the bacillus to a few peripheral nerves and adjacent skin areas. From the onset, small cutaneous nerve fibres are involved. Central nervous system infection does not occur. The typical tuberculoid lesion is a large [3-30 cm] erythematous plaque with sharp outer margins fading centrally to a flattened clear zone of healing that is rough, anhidrotic, hairless, hypopigmented, and anaesthetic. Affected skin areas dry, scaly, thick, rough, puckered [appearance of pigskin, gooseflesh or an orange-peel]; commonly affected parts include extensor surfaces of limbs, face, and buttocks [cooler parts].

Studies have shown that over a period of 20 years, the extent of spontaneous regression [self-healing] among children with tuberculoid leprosy ranges from about 75 to 90%.

[2] *Lepromatous leprosy* [multibacillary, proliferous or aggressive form] arises in patients with little or no cell-mediated immune responses. All tissues affected. Bacteraemia is virtually continuous, yet, there is little systemic reaction; fever, anaemia, leukocytosis, and other manifestations of overwhelming

infection are absent. Tissue destruction occurs mainly in cool, superficial locations: the skin [except in folds]; peripheral nerves in subcutaneous loci, oral and nasopharyngeal mucous membranes [not enteric or vaginal]; the testes [not the ovaries]; and the anterior third of the eye.

Skin.

Symmetrically distributed macules, papules, plaques, and nodules [lepromas]. Macules diffuse, ill-defined, shiny, and greasy. Lepromas shiny, waxy, with an erythematous, cyanotic surface; mainly involving the face, particularly the forehead.

Loss of eyebrows [lateral portion or entirely] and eyelashes; rarely, loss of scalp hair. Leonine facies [accentuation of features due to diffuse facial swelling, peri-orbital oedema; skin thickened and corrugated]. Thickened pendulous ears. Spider telangiectasias. Oedema of extremities [invasion of lymphatics].

Due to atrophy in large areas of sweat and sebaceous glands, along with hair follicles, sweating is impaired and hair ceases to grow, particularly the cooler eyebrow region and eyelashes. To compensate, the body's cooling system makes the sweatable areas sweat excessively.

Erythema nodosum leprosum is an acute reaction consisting of disseminated nodular skin lesions [red, hot, tender] usually involving face, trunk, and extremities; accompanied by fever, joint pains, muscle pains, and redness of eyes.

Eyes.

Pain; photophobia; decreased acuity of vision; glaucoma; blindness.

Upper respiratory tract.

Nasal stuffiness, crust formation, coryza, epistaxis, ulceration; septal perforation, nasal collapse [destruction of cartilaginous septum]; saddle nose deformity. Ulcers of uvula and tonsils. Loss of teeth, in particular upper incisors. Hoarseness [sometimes producing a squeaky, female-type voice], stridor, asphyxia.

Male genitalia.

Testicular invasion and destruction [sterility and impotence], leading to gynae-comastia.[female type breasts] and gynaecotelia [female type nipples].

Peripheral nerve involvement.

Ulnar nerve, elbow [“funny bone”] and several inches above: clawing of 4th and 5th fingers, wasting of intrinsic hand musculature.

Posterior tibial nerve: clawing of toes, plantar anaesthesia.

Superficial peroneal nerve: foot drop.

Median nerve: loss of opposability of thumb; palmar anaesthesia.

Radial nerve: wrist drop [unusual].

Facial nerve: anaesthesia of face, cornea and conjunctiva; lagophthalmia [hare’s eye; inability to close eyes].

- Inability to differentiate heat from cold sensations is the first sensory defect to appear. The next sensation lost is light touch, then pain, and finally deep pressure. Numbness, tingling and/or burning sensation of affected parts of hands, feet, legs and back. Numbness presents in 90% of cases prior to the skin lesions, sometimes years earlier.
- The wide variety of dermatological manifestations, simulating different skin diseases, has given leprosy the nickname “the great imitator.” The lepromatous type may appear as lupus vulgaris, urticaria, mycosis fungoides, cystic acne, erythema; the tuberculoid type mimics drug eruptions, erythema multiforme, erythema nodosum, erythema induratum, tinea, lichen planus, discoid lupus erythematosus; and borderline tuberculoid may look like pityriasis alba, tinea versicolor, seborrhoeic dermatitis, and pellagra.

LEPROSY AND TB

It is unknown where leprosy originated, but enormous numbers of excavated skeletons exhibiting the telltale signs of leprosy leave little doubt that the disease reached its peak in Europe in the 12th and 13th centuries and travelled as far north as Britain and Scandinavia. A century later it had almost vanished there except in the Shetland Islands, Scandinavia and a few other scattered areas. In Scandinavia the disease persisted until in the 1930s, when in Sweden 50 cases of leprosy were registered while the last Norwegian leprosy hospital closed in the 1950s. Leprosy was unknown in the New World prior to the immigration of European settlers and Africans being traded as slaves.

While it faded in Europe, it continued to flourish in Africa and the Orient and afflicts millions of people around the world.

Only recently was it noticed that leprosy in Europe increased as tuberculosis faded, and that a thousand years later, as leprosy faded, tuberculosis returned. This has special significance in the light of the discovery that *M. leprae* and *M. tuberculosis* are so closely related that in laboratory tests, each causes an immune reaction in the presence of the other. The logical conclusion is that within the human body, the germs cross-immunise; each confers resistance to the other. Cross-immunity between leprosy and tuberculosis is not automatic and absolute, but the presence of either disease does greatly lower the odds of catching the other. Of the two germs, *M. tuberculosis* is a more efficient preventive than *M. leprae*, because it is more aggressive.

As Europe's urban population grew in the late Middle Ages, many young children were exposed to *M. tuberculosis*, had mild symptoms or none, and afterward were resistant to *M. leprae*. Thus tuberculosis won an edge over leprosy in the struggle to find a niche in the human body. It is a case of ecological competition, with *M. tuberculosis* winning.

Just as the ruralising Dark Ages gave an edge to *M. leprae*, the urbanising late Middle Ages offered an advantage to *M. tuberculosis*. The changing balance shows that even small differences in a germ, in a host, or in a natural or manmade environment can alter the pattern of human disease.

[Karlen 1995]

HOLY AND SINFUL

The Egyptians believed that leprosy resulted from drinking pig's milk. The position of the pig in ancient Egypt was as ambivalent as the ambiguous attitude of the Jews towards the animal. Generally abhorring the pig as a foul and disgusting creature, the Egyptians at one time appear to have held it sacred. After the pig had fallen from grace, swineherds came to belong to a separate class and were the only men excluded from entering the temples. Puzzled by the Jewish attitude towards pigs, Greek observers could not decide whether the Jews worshipped swine or abominated them. The ban on eating pork suggested uncleanness, while the ban on killing them spoke more strongly for their sanctity.

Analogous views regarding sanctity, sin and leprosy are not limited to these cultures, but are universal. Sir James Frazer's *The Golden Bough* has this to say: "In the island of Wetar [between New Guinea and Celebes] people believe themselves to be variously descended from wild pigs, serpents, crocodiles, turtles, dogs, and eels; a man may not eat an animal of the kind from which

he is descended; if he does so, he will become a leper, and go mad. Amongst the Omaha Indians of North America men whose totem is the elk believe that if they ate the flesh of the male elk they would break out in boils and white spots in different parts of their bodies. The Bush negroes of Surinam, who practise totemism, believe that if they ate the *capiat* [a pig-like animal] it would give them leprosy; perhaps the *capiat* is one of their totems. ... The Chasas of Orissa believe that if they were to injure their totemic animal they would be attacked by leprosy and their line would die out. These examples prove that the eating of a sacred animal is often believed to produce leprosy or other skin diseases. ... For it is common belief that the effect of contact with a sacred object must be removed, by washing or otherwise, before a man is free to mingle with his fellows.... In short, primitive man believes that what is sacred is dangerous. Hence the savage is unwilling to touch or even to see that which he deems peculiarly holy.”

Doing what pigs do might, on the other hand, also serve as a therapy for leprosy, as is evidenced by the story of Bladud, the English king who according to legend founded the City of Bath. Afflicted with leprosy, Bladud escaped in disguise his father’s court, where he was confined, and accepted employment as a swineherd in a nearby village. Noticing how his pigs liked to wallow in a mire and as a result were free from scurfs and scabs, he cured himself of his leprosy by bathing in the warm muddy water. After returning to his fathers court he was restored to his inheritance. He succeeded to the throne on his father’s death, whereupon he founded the City of Bath around the hot springs and built the baths so that others might benefit as he had done.

The dualism of deeming something at the same time both sacred and unclean stems from the undifferentiated feelings of awe and fear, in which, as Frazer states, “reverence and abhorrence are almost equally blended,” with which man often regards his religious symbols.

In this connection the Latin word *sacer* is of interest since it means on the one hand, “sacred,” “devoted to the divinity for destruction,” and “forfeited, while on the other hand it stands for “accursed,” “criminal,” “impious,” and “wicked.” [Simoons, *Eat Not This Flesh.*]

A similar dualistic attitude towards lepers has existed since antiquity. Treatment ranged from good to bad, with bad usually prevailing. The disease was thought by some a gift of God, because He chose lepers to bear one of the heaviest burdens of man.* The poor leper had several gracious blessings beyond others. He alone was favoured with the anointing which was given only to

the Prophet, Priest, and King! He alone had the priestly consecration.

Others saw in leprous skin the brand of spiritual rot. The leper was cut off from a relationship with God, irrespective of his earthly status. King Uzziah, or Azariah, was such a leper, dwelling in a separate house unto the day of his death. A great ruler and a skilled politician, whose “name spread far abroad” [II Chronicles 26:15], Uzziah committed the mortal sin of taking upon himself a duty reserved only for priests. “But when he was strong, his heart was lifted up to his destruction,” it reads in the next verse. As a punishment for his haughtiness God struck the king with leprosy.

Thus lepers were seen as both holy and sinful. God gave them special grace, or punished them for their sins.

* This is reflected in the peculiar notion of the ‘Leper Messiah,’ which alludes to the idea of the Messiah being despised and rejected as a leper. “Surely he has borne our grieves and carried our sorrows, yet we did esteem him a leper, smitten of God and afflicted,” it reads in the Babylonian Talmud. Another story, of a rabbi visiting an old leper deformed by the disease, alludes to the belief that a Messiah will reveal himself if the right conditions are met; if the generation is not worthy, he will remain a leper and depart.

The gradual transformation of a leper into a saviour is the theme of Stephen Donaldson’s double trilogy *The Chronicles of Thomas Covenant the Unbeliever*. A real doubting Thomas, excluded from the covenant of redemption, ostracised in his backward hometown, Thomas Covenant is a leper in the literal sense. He loses two fingers, ends up in a leprosarium, becomes an outcast and finds his wife divorcing him and leaving with their son. Having worked in a leper colony himself, Donaldson gives in the first book a description of leprosy and its corrupting effects on a man’s morality. Taught how to protect himself from injury to prevent any further loss of body parts, Thomas Covenant has nevertheless no way of protecting himself from getting emotionally traumatised. As a result, he is benumbed emotionally and crippled morally, behaving with despicable brutality once he finds himself magically transported to The Land, a place of magic, health, hope, and dedication to the preservation of life, where he is perceived as the incarnation of The Land’s greatest hero, Berek Halfhand. And so begins an intriguing narrative of a journey through a Land he refuses to believe in and yet has to save.

THE STIGMA OF SIN

Although certain diseases can be considered more repulsive and far deadlier, none has inspired the particular horror of leprosy and left behind such a terrifying image in history and human memory of mutilation, rejection, and

exclusion from society. The aim of defining the other as a leper is to cast him out of the order of the normal man who belongs to and constitutes the group. Association of leprosy with sin is not unique to Western culture.* Among Hindus leprosy was commonly believed to be brought on by sin, for example, by telling a lie in a certain sacred grove of trees, such as banyan [Indian fig-tree, *Ficus bengalensis*] or pipal trees [Bo tree, *Ficus religiosa*]. Interestingly, the leaves or barks of these trees were employed in treating leprosy. Similarly, in China, people might seek protection from leprosy by putting a small branch of the banyan tree over their doors. [Simoons, *Plants of Life, Plants of Death.*]

Objects of fear and loathing, lepers have been killed, driven from society, or forced to wear hoods, badges, and bells to warn off the rest of humanity. Attempting to erase the stigma, scientists renamed leprosy Hansen's disease.

Leprosy was the first pestilence to be controlled in Europe. It was a disease easily controllable even by the methods available in medieval times. The method of control, avoidance of contact with the sick, had been developed by the ancient Jews and is set forth in the Bible. Leprosy is transmitted with difficulty; usually it requires intimate contact of long duration. Systematic isolation of those afflicted eventually brings an end to the pestilence. When the medieval Europeans set out to eradicate leprosy they did so with characteristic brutality. In 1313 Philip the Fair ordered that all the lepers in France should be burned. But this radical measure was not fully carried out and instead the monasteries of Saint Lazarus were set aside for the lepers.

These institutions were named lazarettos. Into them were crowded "Christ's poor," as the lepers were called, to be cared for by priests who were themselves lepers. In western Europe alone there 19,000 of these lazarettos. The lepers were the living dead; as they were torn from their friends and families to be entombed in the lazarettos, the burial ritual was read over them; they were dead for all civil affairs and buried so far as their wives and children were concerned.

When they crept out from their filthy quarters they dressed in a manner to show their illness. They wore masks to hide their deformities. In their hands they carried a bell or rattle to mark their coming and to warn the healthy from their path. If they bought at the market they pointed with a stick to the article they wanted and with the stick drew their purchase to them. They were forbidden to speak above a whisper to healthy persons.

[Haggard 1929]

People treated this way are likely to develop a deteriorated self-image with feelings of being unworthy of love or companionship.

Spiritually, leprosy is unlike any other disease. To the fervently religious, AIDS is a punishment for promiscuity, while leprosy is a punishment by God for mortal sin. The difference lies in millennia of tradition.

No one was surprised or doubtful when chimpanzees got AIDS. Devout worshippers were sceptical when armadillos got leprosy. When we claimed leprosy was a natural disease of armadillos, doubt turned into whispers of heresy. Leprosy was a disease peculiar to the human race. It was an integral part of the contract between God and Abraham. Lower animals simply couldn't get it.

Leprosy workers tend to be religious. This is not surprising. Many of their spiritual forebears were medical missionaries. Remnants of this old tradition still persist. Years after the European colonial empires collapsed, many medical evangelists still found their callings in the outbacks of the world still bearing "the white man's burden."

[Eleanor Storrs; <http://pandoras-box.org/my05042.htm>]

With its negative biblical associations the care of leprosy sufferers seems like a Christian altruistic duty and an obvious component of any mission to 'civilise' the uncivilised.

* Thomas Szasz has put it aptly in words: "For centuries, man attributed disease to sin, and endeavoured to rid himself of illness by attending to his moral conduct. Today, he attributes sin to disease, and endeavours to rid himself of evil by attending to his health."

REJECTION FROM NORMALITY

The policy of physical isolation of leprosy patients came to an end with the decline of leprosy in the course of the 15th century, only to be replaced by the exclusion of other people viewed as a threat to the community, according to the French social philosopher Michel Foucault [1926-1984], Since the eradication of leprosy from Europe was thought to have resulted from the policy of isolation, it was believed that other threats to the society could be solved by similar measures.

In *Madness and Civilisation* [1960], Foucault examines the incarceration of the insane into asylums in 17th and 18th century France and England. He asserts that the disappearance of leprosy left the buildings used to confine

lepers empty, which provided places to put 'mad' people. Out of this grew asylums and therefore institutional psychiatrists and over time 'madness' became a medical diagnosis termed 'mental illness'. The category of madness arose as a means to justify the elite status of reason and rationality. Madness, through a series of conceptual shifts, replaced leprosy as the disease of the outcast, which in turn elevated reason to the highest sign of health.

A strange disappearance, which was doubtless not the long-sought effect of obscure medical practices, but the spontaneous result of segregation and also the consequence, after the Crusades, of the break with the Eastern sources of infection. Leprosy withdrew, leaving derelict these low places and these rites which were intended, not to suppress it, but to keep it at a sacred distance, to fix it in an inverse exaltation. What doubtless remained longer than leprosy, and would persist when the leper houses had been empty for years, were the values and images attached to the figure of the leper as well as the meaning of his exclusion, the social importance of that insistent and fearful figure which was not driven off without first being inscribed within a sacred circle.

If the leper was removed from the world, and from the community of the Church visible, his existence was yet a constant manifestation of God, since it was a sign both of His anger and of His grace: "My friend," says the ritual of the Church of Vienne, "it pleaseth Our Lord that thou shouldst be infected with this malady, and thou hast great grace at the hands of Our Lord that he desireth to punish thee for thy iniquities in this world." And at the very moment when the priest and his assistants drag him out of the church with backward step, the leper is assured that he still bears witness for God: "And howsoever thou mayest be apart from the Church and the company of the Sound, yet art thou not apart from the grace of God."

... Abandonment is his salvation; his exclusion offers him another form of communion.

Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals, and "deranged minds" would take the part played by the leper, and we shall see what salvation was expected from this exclusion, for them and for those who excluded them as well. With an altogether new meaning and in a very different culture, the forms would re-main-essentially that major form of a rigorous division which is social exclusion but spiritual reintegration.

The categorisation and stigmatisation of madness as social failure replaced, in Foucault's view, the old stigma of leprosy, leading to the asylum becoming a tool of accusation, judgement and condemnation. The physical and moral rejection from society or home of those perceived as not abiding to the 'norm' allowed 'normal' people to legitimately regard themselves as members of a homogenous social body - the society. A central element for Foucault was the state, a political structure that emerged in the 16th century to look after the interests of the totality - everybody within the community.

The insane were forced into asylums, the poor into workhouses, and criminals in prisons. Foucault elaborates on this theme in *Discipline and Punish: The Birth of the Prison* [1975]. He sees 'surveillance' as a key component of modern societies - "the gaze that sees is the gaze that dominates" - a mode of power used in schools, barracks, factories, hospitals and prisons, and comparable to the omnipresent, 'all-seeing' Christian God. It is interesting to note that these commodities of the welfare state tend to be the places where infectious diseases strike first, a likely reason why tuberculosis out-competed leprosy. These 'disciplinary institutions' collectively produce what society demands: docile, productive, hard-working, loyal conformists - 'normal' people in every way.

Medical science has forced the individual from the private realm to a statistically standardised model [blood pressure, cholesterol levels, mass immunity, etc.]. Rather than emphasise the importance of the individual, it values unity over diversity in order to homogenise society and health. The individual does not gain in power, knowledge, and status, or, to paraphrase Foucault, "he is the object of information, never a subject in communication."

As a human being, man is a particular kind of animal: a social animal. As such, he is always the member of a group, never a solitary individual. The conditions of his membership in the group go far in defining the kind of person he becomes. To remain the member of a group, man must often attack and sacrifice non-members. Wars against external enemies have traditionally propelled individuals into playing this role, thus integrating them further into their own groups. In addition, man also converts members of his own group into nonmembers, so that they may then be attacked and sacrificed. ...

The tendency [perhaps one ought to call it a "reflex"] to sacrifice a scapegoat in order to save the group from disintegration and, hence, the self from dissolution, is clearly basic to man's social nature. It follows that man's *refusal* to sacrifice scapegoats - and his willingness to recognise and bear his own and his

group's situation and responsibility in the world - would be a major step in his moral development, comparable, perhaps, to his rejection of cannibalism. I believe, indeed, that in the rejection or transcending, of the scapegoat principle lies the greatest moral challenge for modern man. On its resolution may hinge the fate of our species.

[Thomas S. Szasz, *The Manufacture of Madness*, 1970]

The theme of the scapegoat is, of course, not confined to leprosy. Similar practices to protect from illness are described for other scourges and plagues.

MATERIA MEDICA LEPROMINIUM

Lepr.

Sources

Introduced by Prakash Vakil in the 1980s, the drug picture comprises:

[A] Collection of signs and symptoms from 100 leprosy patients, including signs and symptoms reported "by other reliable sources, such as physicians working for many years in leprosy hospitals."

[B] Observations of effects of Leprominium 30x, 30c or IM "in the treatment of 26 patients who exhibited some symptoms in common with the leprosy patients studied but who did not have leprosy. Only patients with some actual physical pathology, such as psoriasis or joint pain, were given the nosode."

[3] = Signs and symptoms observed in 25 or more patients.

[2] = Signs and symptoms observed in 15 to 24 patients.

[1] = Signs and symptoms observed in 5 to 14 patients.

[c] = Symptoms disappearing after administration of Leprominium 30x, 30c, or IM, single dose. "Some symptoms, such as religious melancholy, desire for white clothes, or aversion to black clothes, may take time to actually disappear. However, when such symptoms were useful in selecting the prescription, and, when the prescription then relieved the patient in general, these symptoms are also indicated [c]." [Vakil]

[GJ = Colin Griffith, *Leprosy and its Nosode: Leprosinum [Leprominium]*, Prometheus, No. 8, June 1998.

SYMPTOMS

MIND

- ~ Religious melancholy. Attributes his disease to fate. It can make a person mild or irritable. [3] [c]
- ~ Loathing life yet would not like to commit suicide. [3] [c]
- » Hopeful of recovery [1]; feels no one should suffer from such a disease [3] [c] «
- Is sympathetic [2] [c]and desires sympathy [2] [c]yet in the initial stage secludes himself for he does not want others to know about his disease. [1]
- = Likes company. [1] Tends to look for like-minded company to avoid rejection. [G]
- = Meticulous. [2] [c]
- => Fearless. [1]
- «Weeping. [1]
- = Would not like to beg [3]; would rather die than beg. [1]
- Brooding. [1]
- Feels rejected and dejected. [3]
- « Feels others are selfish and therefore turns to God. [1]
- “ Desire to wear white clothes. [3] [c]Aversion to black clothes. [2] [c]
- Frightful dreams. Dreams of dead people, dead relatives. [1]

It is not only deformity that prevents a person from returning to a normal life; it is his mental attitude as well. When a young person with good ability, a happy family life, and good prospects is told that he has leprosy there usually follows a period of absolute despair. He sees his future entirely without hope. He sees his friends avoiding him and he may see deformity beginning in his own hands and face. It is at this stage of acute misery that patients sometimes commit suicide. This stage of acute misery and abject despair cannot last. The human mind is so constituted that it will always develop a method of compensating for extreme misery or extreme happiness, neither of which seems to be continued in an unalloyed form.

The patient will begin to exchange misery for a bitterness against the society that is casting him out. He will blame it for misunderstanding him and maltreating him. He will get a certain satisfaction in looking upon himself as persecuted and may even become a hero in his own eyes. If he is in a sanatorium where he is getting free treatment he may begin by wishing that he could pay for his treatment and repay by his gratitude those who are helping him. Soon,

however, he develops the feeling that he deserves everything that he is getting, and more, because of the debt that society owes him. Many superintendents of leprosy sanatoria know how bitter and ungrateful and demanding their patients can be.

A patient who is not in a sanatorium may have a pride which will not allow him to accept charity. But, before long, he finds that he cannot get work and nobody will employ him. He cannot live at home and he must either starve or become a beggar. He chooses the latter and hates himself for having to stoop so low as to beg for his food. Soon, however, this feeling passes and is replaced by a bravado and a feeling that society owes him more than it is giving him, and that he has every right to accept the best.

Once a person has undergone the mental change that allows him to enjoy his begging, to feel that society is his enemy from whom he must get everything that he can, and gets the feeling of being persecuted, then it becomes difficult to re-waken in him the pride of independence and the satisfaction of cooperation in normal social relationships.

[Cochrane & Davey 1964]

(This state is also recognizable in many people who have lived on welfare benefits, or lived homeless for some time. Ed.)

GENERALS

- «Tendency to suppuration. [2] [c]
- « Megaloblastic and haemolytic anaemia. [1]
- « Tendency to catching cold. [2] [c]
- « Normal sleep; feels refreshed when waking up. [1]
- « No desire for sex in females [1]; in males [2],
- « Appetite normal. [1]
- « Thirst increased or normal [1] but desires ice-cold water [3].
- « Desires spicy [3]; meat [3]; fish [3]; green chillies [2]; sour [2]; sweets [1]
- Aversion to sweets [2]; milk [2].
- « Aggravated by sour [2].
- ~ Modalities: < Radiating heat, sun. > Rest.
- « Family history: Tuberculosis. Leprosy [or no history of leprosy].
- ~ Personal disease history: Worms [1]. Repeated vaccinations [3]. Smallpox [2]. Scabies [2], Tendency to haemorrhages [2]. Pulmonary tuberculosis [[1],
- « Hormonal changes [puberty; pregnancy] <.

Every leprologist is familiar with the teenager in whom the first manifestations of leprosy appeared at the time of puberty or shortly afterwards, or the case of leprosy in childhood in whom puberty was associated with a shift in the form of the disease towards the lepromatous end of the spectrum, frequently with one or more acute phases. If relapse is to occur at all in children discharged from treatment in the pre-pubertal period, it may be expected to manifest itself at the time of puberty.

... Although exacerbation of leprosy does arise during pregnancy it is much more common during the puerperium and the early months of lactation. The young mother with new lesions often associated with acute phases and a shift in disease type towards the lepromatous end of the spectrum is of frequent occurrence among leprosy patients.

... There are a number of examples in the literature of the onset of leprosy being associated with [other] alterations in endocrine balance, and a wide range of hormones may be implicated. Three examples will suffice. Iswariah [1944] reports cases in which lepromatous leprosy first appeared during the treatment of obesity with thyroid extract. Furniss [1962] mentions the rapid development of lepromatous leprosy in a patient after bilateral ovariectomy. Symmers [1951] reported the case of a male aged 84 who first developed leprosy after stilboestrol treatment for carcinoma of the prostate.

[Cochrane & Davey 1964]

LOCALS

« Vertigo & nausea, < opening eyes; < sun. [1]

Head

~ Feeling of weakness in head; blackouts. [1]

= Premature greying of hair. [2]

= Alopecia. [1]

= Hemicrania; headaches usually affect the left side more; < sun. [G]

Eyes

=> Photophobia. [3]

= Lachrymation, bland or acrid, < light [1], < sun [3].

= Redness of eyes without pain. [1]

= Eyes swollen puffy. [1]

~ Dryness of eyes [3] & lachrymation [1].

-
- = Iritis; iridocyclitis, [c]
 - » Cataract formation, first left then right. [1]
 - « Cannot close the eyes completely. [2]
 - ~ Sleeps with eyes half open. [1]
 - = Eyelashes drop off. [1]
 - Baggy swelling under eyes. [1]
 - = Ectropion. [1]
 - ~ Strabismus, [c]
 - <= Glaucoma. [1]
 - Staphyloma. [1]

Nose

- » Nose sunken in. [3]
- = Nose waxy. [3]
- = Tip of nose flattened. [3]
 - Epistaxis, < cold water on head, washing face, sneezing, change of weather [1];
< sun [G].
- = Clinkers and scabs from nose. [1]
- « Atrophic rhinitis. [1]
 - Sense of smell affected. Offensive scabs from the nose, but patient cannot smell. [1]
- = Obstruction of nose. [1]
- = Atrophy of anterior and inferior turbinate. [1]
- ~ Perforation of septum. [1]

Face

- = Waxy or oily. [3]
- = Outer one-third of eyebrows lost. [3]
- « Alopecia areata. [1]
- = Leonine face. [3]
- = Angioneurotic oedema. [1]
- = Anaesthetic patches on face. [1]
- = Nodules on face. [1]
- = Thickening of facial skin with permanent transverse and vertical wrinkling. [1]
- = Premature old look. [1]
- => Nodulation and ulceration *of nose and lips*. [1]
- =>> Facial paralysis. [1]
- Age like face. [1]

-
- Trigeminal neuralgia. [1]
 - «Numbness and cobweb sensation. [1]
 - Anaesthesia of the face. [1]

Mouth

- = Swollen lips. [1]
- Turgid and swollen gums, shiny and purplish in colour. [1]
- « Gums bleed easily. [1]
- « Decreased sensitivity to pain. [1]
- « The upper central and lateral incisors fall out. [2]
- « Deeply fissured tongue. [1]
- « Nodules on the tongue, especially on the anterior part. [1]
- « Oral mucosa becomes tinged with yellow - looks pale. [1]

Throat / larynx

- Laryngeal constriction due to scarring. [1]
- Hoarseness [2]; complete loss of voice. [1]
- Sensation of something stuck in throat, [c]

Rectum

- «Normal bowel movements. Sometimes constipation. [1]
- Three to four semi-solid stools with mucus, without pain in the abdomen. [2]*

Urinary

- « Painful urination after walking in the sun. [1]
- « Intermittent flow [1J; < sun [G].
- = Increased frequency. [1]

Extremities

- «Ascending numbness with icy coldness of hands and feet. [1]
- « Numbness and tingling starts in arms and legs simultaneously [2], < noon,
> continued motion. [1]
- « In some, it starts on right side. [1]
- «Ascending coldness. [1]
- « Sensation of ice in extremities, > warm clothes. [1]
- « Pain in extremities, > massage. [1]
- « Pain in the calf muscles, < exertion. [1]
- « Oedema of feet, < evening, walking, hanging feet down. [1]

- = Anaesthesia of hands and feet. [1]
- Hypopigmented patches [2] [c] - thickened, well-defined, raised patches. [2]
- Non-healing ulcers. [1]
- = Wrists and feet drop. [1]
- = Pain in joints, especially knee joints and back. [2]
- . Pain in joints [esp. knees and back] < first movement, > subsequent movement. [c]
- = Heat of palms and soles, [c]

Skin

- = Scaling of skin resembling psoriasis [c], exfoliative dermatitis [c], pellagra [1], ichthyosis [1].
- = Deep cracks in palms and soles. [1]
- => Skin sticking to bones, giving a shiny appearance like scleroderma. [1]
- ~ Pemphigoid eruptions. [1] Bullous eruptions. [1]
- = Itching all over, [c]
- Ringworm-like lesions. [1]
- = Discharging sinuses. [1]
- «■ Erythema multiforme. [1]
- = Dryness of whole body, [c]
- ~ In many patients, scanty perspiration. [1]
- Lupus vulgaris, [c]
- Small, dark-brown scabs, [c]
- « Urticaria, [c]
- « Dark pigmentation, [c]
- « Neurofibromatosis. [1]

* In most cases where Leprominium acted favourably, the patient got loose stools with mucus after administration of the nosode. [Vakil]

COMPARISONS

Syphilinum and *Leprominium*.

- ~ Depression; *Syph.*: leading to suicidal tendencies; *Lepr.*: leading to accepting one's fate and turning to God and religion.
- « Recovery; *Syph.* despair; *Lepr.* hopeful.
- Fastidious; *Syph.* washing mania; *Lepr.* meticulous, want and keep things in order.

<= Sleep; *Syph.* sleepless; *Lepr.* normal sleep, wakes refreshed.

■= Generals; *Syph.* < at night; *Lepr.* < sun. *Syph.* craves alcohol; *Lepr.* craves spicy food, green chillies, meat, fish. *Syph.* salivation; *Lepr.* no salivation.

Tuberculinum and Leprominium.

- Appearance; *Tub.* beautiful appearance, with long eyelashes, round face, and sparkling eyes; *Lepr.* ugly appearance, with ugly face, oily skin, and waxy nose.
- Religion; *Tub.* not especially religious; *Lepr.* religious.
- Behaviour; *Tub.* kleptomania; *Lepr.* will not steal.
- Mood; *Tub.* very irritable; *Lepr.* usually mild in manner, sometimes irritable.
- Travel; *Tub.* desire to travel; *Lepr.* no particular desire to travel.
- Fears; *Tub.* fear of dogs; *Lepr.* fearless.
- Perspiration; *Tub.* profuse perspiration, esp. on face, nose, and upper lip; *Lepr.* perspiration not prominent, dryness of skin.

Carcinosinum and Leprominium.

- Work; *Care,* industrious; *Lepr.* indolence because of physical incapacity.
- Ailments from; *Care,* anticipation, fright, and reproach; *Lepr.* chronic grief.
- Mood; *Care,* anger over own mistakes; *Lepr.* usually mild in manner.
- Emotions; *Care,* weeping from admonition and music, and while telling symptoms; *Lepr.* weeping not prominent.
- Consolation; *Care,* consolation <; *Lepr.* consolation >.
- Fears; *Care,* fear of animals, dogs, dark, crowds, examinations; *Lepr.* fearless.
- Travel; *Care,* desire to travel; *Lepr.* no particular desire to travel.
- Skin; *Care,* prone to moles; *Lepr.* prone to ichthyosis and psoriasis.
- Eyes; *Care,* blue sclerae; *Lepr.* eyes excessively dry, and lustreless.

MYCOBACTERIUM TUBERCULOSIS

Scientific name Mycobacterium tuberculosis (Zopf 1883) Lehmann & Neumann 1896

Common names

Bacillus tuberculosis [Koch] Tubercle bacillus

Family Mycobacteriaceae

Homeopathy

Bacillinum - Bac.

Tuberculinum Denys - Tub-d.

Tuberculinum Koch - Tub-k.

Tuberculinum Marmorek - Tub-m.

Tuberculinum residuum Koch - Tub-r.

Tuberculinum Rosenbach - Tub-ro.

Tuberculinum Spengler - Tub-sp.

FEATURES

- Obligate aerobic, Gram-positive, non-motile, non-sporulating, tiny bacterium.
 - Discovered in 1881 by the German bacteriologist Robert Koch [1843-1910].
 - Considered an obligate pathogen; has never been found outside its hosts.
 - Sensitive to temperature variations, not growing below 29° C or above 42° C.
 - Requires considerable oxygen.
 - Doesn't develop well in the light; quickly killed by exposure to sunlight.*
 - Notoriously slow-growing with a waxy coat that protects it against immune defences.
 - Hydrophobic with a high lipid content in the cell wall.
 - Acid-fast, i.e. it remains stained after an acid wash, standing out as “little red bandits in a sea of decolourised fluid or tissue.”
- Light increases the ventilation of the lungs and the depth of breathing. Pulmonary tuberculosis is favourably affected by small amounts, yet extremely sensitive to strong light radiation, while the non-pulmonary TB responds favourably to any degree of radiation. Trivial respiratory infections vanish most rapidly in the intense radiation of high altitudes. [Whitmont, *Psyche and Substance*]
- Anthroposophical medicine takes this one step further by asserting that the predilection of tubercle bacilli for the lung is connected with the low content of silica of this organ, a mineral with an affinity for light and as “the light of thought” regarded “as an expression of the form-giving forces of the upper pole

... referring to clear thought reaching to the point of abstraction.” It is this type of abstract thought that is believed to be lacking in tuberculosis, so that the other pole, characterised by a lively imagination and an artistic sense, becomes overemphasised. Tuberculosis, indeed, impedes cognition rather than emotion and it might be this to which Kent alludes when speaking of the “insanity” of Tuberculinum. In keeping with the little concern that TB patients with amnesia show about their memory difficulties, Bott concurs that “one often finds a certain lack of concern in these patients towards their physical condition which can even go so far as to become a flight from material reality, an expression of a real refusal to incarnate.” It sheds light on the homeopathic perception of Phosphorus, the “light-bearer,” and Silicea, the “light of thought,” as major tuberculinic remedies.

TAMING THE BEASTS

Molecular studies of agents of crowd infectious diseases unique to humans indicate that their closest microbial relatives are those confined to various species of our domestic animals and pets. With the domestication of social animals, such as cows, sheep, and pigs, an intimacy going on for the last 9,000 years or so, former animal inhabitants evolved into specialised human pathogens. *M. tuberculosis* is probably a human-specialised form of *M. bovis* developed among milk-drinking Indo-Europeans who then spread the disease during their migration into western Europe and Eurasia. By 1000 BC, *M. tuberculosis* and pulmonary TB had spread throughout the known world.

[*Mycobacterium bovis*] has long lived in wild cattle, causing few symptoms or none. When people domesticated cattle, lived with them, and consumed dairy products, they acquired *M. bovis*. ... *M. bovis* infection was nasty enough, but a worse type of tuberculosis appeared some 4,000 years ago. *M. bovis* gave rise - by quick mutation, slow adaptation, or both - to *M. tuberculosis*. This bacillus thrives in the oxygen-rich tissue of human lungs; it can be transmitted from person to person by coughing or close contact, especially in crowded environments. Humans also gave it to their herds, which reinfected them in turn. *M. tuberculosis* did its worst damage among the crowded urban poor, preying especially on the young, ill fed, and overworked who lived without sunlight and fresh air.

Consumption, or pulmonary tuberculosis, soon became widespread in the cities of Asia and the Near East. It spread to Greece, where Hippocrates



described it in detail. It was so common in late Roman times that it survived for a while even in the sunlight and fresh air of early medieval village life. As the more healthful rural conditions of the Dark Ages continued, consumption waned. ... The Industrial Revolution created ideal conditions for *M. tuberculosis* through malnutrition, crowding, and poorly ventilated homes and factories. During the 20th century, as urban conditions improved, the spread of TB slowed. ... By 1985, ... the disease returned for several reasons.

One was the vulnerability of the immunosuppressed; TB is often the first sign that a person harbours HIV. Another was inadequate health care for the poor and socially marginal. At first, TB increased most visibly among drug addicts, prison inmates, and the homeless. ... In 1984, half of the people with active TB had a strain of the germ that resisted at least one antibiotic. Today many strains resist four to seven drugs for treating TB, and some resist them all. Tuberculosis is even more threatening elsewhere in the world. In the years 1985-1991, when it increased 12% in the US and 30% in Europe, it rose 300% in the parts of Africa where TB and HIV are inseparable. It is skyrocketing in Asia along with AIDS.

[Karlen 1995]

A DISEASE OF CAPTIVITY

Tuberculosis, says McFarland, “is no respecter of persons, but affects alike the young and old, the rich and poor, the male and female, the enlightened and savage, the human being and the lower animals. While “wild animal under natural conditions seem to escape the disease,” animals “when caged and kept in zoological gardens, even the most resistant of them - lions, tigers, etc. - are said at times to succumb to it, while it is the most common cause of death among captive monkeys.” Incidence of TB is higher in males, among poor and in cities.

The differential was reversed in the 19th century, when two-thirds more women than men succumbed to tuberculosis. In low incidence areas, most TB is endogenous, i.e. reactivation of initial latent foci. Three million people succumb to TB every year; an estimated one third of the worlds population is infected with tuberculosis, which in 90% of them will be contained by immune reactions, never producing symptoms of illness.

Hormonal changes [puberty, pregnancy, lactation] and endocrine disorders [diabetes, hypothyroidism] are invariably mentioned by 19th-century authors as predisposing factors for tuberculosis.

CLINICAL MANIFESTATIONS

Nineteenth-century medical textbooks divided pulmonary tuberculosis into separate stages, although “the earliest signs of the disease might easily portend another, much less serious ailment” and “each stage may merge imperceptibly into the next.”

First stage:

Dry, persistent cough.

Irritation in the throat.

Pains in chest and shoulders.

Slightly accelerated pulse.

Some difficulty in breathing, particularly during exercise.

Second stage-

More intense and debilitating symptoms.

Cough increasingly severe, frequent, and harassing.

Expectoration mucous and purulent initially; later becoming thicker, more opaque, greenish, with fine streaks of a yellow colour.

Hectic fever in periods, spiking twice daily and marked by a rapidly accelerating pulse [up to 120 a minute],

“The fever often lent a ruddiness to the complexion of consumptives, giving them a deceptive appearance of good health. ... The red tint often appeared as if it had been laid on with a brush ... Death-like paleness alternating with a glowing hectic flush.”

Ulcers in throat and larynx, causing a continual hoarseness and making it painful to eat or speak above a whisper.

Perspiration from slight exertion.

Third and terminal stage-

Increasing emaciation; “ghostly and cadaverous appearance.”

Hollow cheeks. “The fat of the face being most absorbed ... rendering the expression harsh and painful.”

Eyes sunken in sockets; eyes often “look morbidly bright and *staring*.” The cough, known as the “graveyard cough” or “death rattle,” assumes a peculiar toneless sound.

Haemoptysis.

Sudden profuse haemorrhages “pouring from the mouth and nostrils.”

Constant pain in the joints.

Pulse first accelerated, then weak.

Choking and suffocating sensation.

Anorexia.

Nausea, occasional vomiting, especially after coughing, with pain or oppression in pit of stomach.

Profuse perspiration, esp. at night.

Diarrhoea, sometimes uncontrollable.

Colic pains.

Swelling of the legs.

Nails curved like claws.

Bulbous enlargement of third phalanx of fingers.

“In the majority of instances, the mind maintains its integrity to the last.”

[Adapted from Rothman, 1995]

HOPE AND OPTIMISM

What would become of hope, if it had no dilated breast?

[J.J. Garth Wilkinson]

Thomas Dormandy dedicates two chapters, *Seeking the Sun* and *Going West*, of his superb account of the history of tuberculosis to the “escape from illness by moving to another place - to almost any other place.” The exodus of health-seekers spawned a flood of travel guides larded with pseudo-medical recommendations. Often the driving force behind “the pilgrimage of consumptives from northern fog to southern skies” was what came to be known as *spes phthisica*, the hope of the tuberculous. The rush to embrace change, any change, was the reflection of such an eternal optimism. However irrational the optimism, and despite its tendency to alternate with troughs of deep depression, hope is so characteristically tuberculinic that Dormandy calls it “a thin but seemingly unbreakable thread woven into the history of the White Death.” Hope keeps man alive. The dramatic 19th-century narratives of restored health under more gentle skies eclipsed the failures so that “by the 1880s the migration of the sick began to rival that of those who came to seek their fortune.” Dismissed as a folly and the Great Delusion by medical science, such figments, however, “rarely survive for centuries without reason,” bringing Dormandy to the plausible conclusion that: “Illnesses have their personalities in much the same way as nationalities and historic periods, impossible to define

but, once experienced, instantly recognisable. Nor do they affect only their victims. They imprint themselves on all those with whom they come into contact - families, friends, lovers, doctors, researchers, reformers, administrators, even politicians. The hope of the tuberculous has always been of a particular kind. Without conflicting with a more transcendental faith, it has always inspired a will to live in this world, a will to fight in this world and a will to create in this world.”

Notwithstanding the optimistic belief that resistance could be toughened by adopting a “more natural lifestyle of roughing it,” not all health seekers possessed the resilience for such “a desperate and sometimes heroic gamble,” which consequently “many lost and few won.” Over the course of the 1880s and 1890s, as Sheila Rothman notes, “the entire southern sector of the state [California, dubbed the ‘New Lung’] became a ‘sanatorium belt,’ dotted with communities, resorts, hotels, and boarding houses, some more makeshift than others, but all hoping to attract invalids, especially consumptives. San Diego, Santa Barbara, Los Angeles, and Pasadena were among the most successful recruiters, in part because of their climatic advantages, in part because a considerable number of their promoters were themselves consumptive.”

Wandering through the streets of those places “with a certain aimless unsteadiness which says plainer than words that hope has well nigh died out of their hearts,” less fortunate “lungers” were soon to realise that they would “never experience the miracle of cure.” At least some of them “hastened their own death.” Rothman concludes that, “The high numbers of suicides in the towns popular among health seekers attest to the magnitude of the disappointment. In Santa Barbara, California, the suicide rate in 1893 was thirty per hundred thousand, among the highest in the world. That same year, one of every three deaths in the town was due to tuberculosis.”

Likewise Thomas Mann’s captivating images in *The Magic Mountain* made sanatorium life appear seductive with “every aspect of daily life taking on startling intensity,” owing to both “a fevered sexuality running right beneath the surface calm” and engagement in “lengthy discussions as ethereal as the alpine setting in which they reside.” Painted in a rosy tint similar to the typically tuberculous hectic flush, Mann’s magic mingles fact with fiction in Tuberculinum-like fashion, that is “it at once illuminates and obscures reality.” The first sanatoria were opened in Germany between 1859 and 1876, followed by plenty of others in Switzerland, England and the USA. Set in mountainous regions, sanatoria were closed institutions with rigid

“business of life to live,” not debilitated by the shadow that chronic illness cast over their lives. It was not passivity or resignation but tenacity and resolve that marked their response to consumption.

- Deciding to stake everything on a voyage for health, one such voyager expressed it thus: “A love of the adventurous inclined me to a voyage in preference to any other plan for the recovery of my health.”

- Invalids were generally often in motion, even the most responsible of them were forced to lead, as one phrased it, “a decently restrained vagabond life.” And so he, like his fellow invalids, formulated an invalid’s creed: “We must act as though we expect to live, although we may be taken from this world at any moment.”

- Evangelicalism had a particular appeal for invalids, and its influence in their life histories is marked. ... The experience not only provided personal comfort but enabled some of them to turn a vagabond life and voyage for health into a spiritual odyssey.

- Although the scourge of consumption in both the United States and England declined over the period 1850-90, it still forced those men and women who evinced its symptoms to alter their life patterns in dramatic fashion. ... The term invalid does not capture the essence of their self-definition. They are better understood as health seekers, committed to travel to a salutary climate, where they could follow a health-giving routine, but the search was for a new place to live, not just to take a cure. In ways that are quite remarkable, the biographies of health seekers are integral to the history of the westward movement [in the US]. Beginning slowly in the 1840s and then gathering momentum in the 1870s and 1880s, men and women with the symptoms of consumption moved to the mountains and deserts of the West. By 1900 fully one-quarter of the migrants to California and one-third of the newcomers to Colorado had come in search of health. ... While practically every state west of the Mississippi had communities founded and developed for and by health seekers, Colorado, southern California, Texas, New Mexico, and Arizona, ... received the largest influx.

- Those in search of fortune and those in search of health both saw the West as an “El Dorado,” an “earthly paradise,” where past failure [commercial or constitutional] would be transformed into future success [wealth and health]. At the core of each tale was the discovery of a new life through an encounter with the natural bounty of the new land.

- Curative powers were ascribed to the “pure and bracing air of the Rocky Mountains.” “The greater dryness of mountain air acts beneficially in

phthisis, the air being rarefied, the *sun* which is always more constantly visible in mountainous districts has a *much greater influence* and enables the enfeebled invalid to spend several hours, almost daily, in the sunshine with very great advantage.” Similar claims were made for the Alps.

- In Mark Twain’s *Roughing It*, the anecdotes of rejuvenation achieved their ultimate acknowledgement, becoming the stuff of parody. “Three months of camp life on Lake Tahoe,” recounted Twain, “would restore an Egyptian mummy to his pristine vigour. ... The air up there in the clouds is very pure and fine, bracing and delicious.

And why shouldn’t it be? - it is the same the angels breathe.” Drawing on the anecdotes of others he declared: “I know a man who went there to die but he made a failure of it. He was a skeleton when he came and could barely stand. ... Three months later he was sleeping out of doors regularly, eating all he could hold, three times a day, and chasing game over mountains three thousand feet high for recreation. And he was a skeleton no longer, but weighed part of a ton. This is no fancy but the truth. His disease was consumption. I confidently recommend his experience to other skeletons.”

[Rothman 1995]

* The term ‘invalid’ encompassed in the 19th century all men and women with chronic and debilitating respiratory ailments, carrying the harbingers of consumption or already afflicted with the disease, those who were weakened by disease and lacked the strength to participate fully in daily activities. Robert Louis Stevenson, himself an invalid, labelled the group “the wounded soldiery of mankind,” bringing the new definition together with the older one of invalids being soldiers and sailors unfit for active duty.

SEEKING FORTUNE

Lacking the social upheaval characteristic of cholera and smallpox, migration and immigration have been proposed as a *cause* for the explosive rise of tuberculosis in the second half of the 19th century.

As densely packed human populations, festering under poor sanitation conditions, slum housing, poor diets and lack of fresh air and sunlight, everexpanding cities formed veritable breeding grounds for tuberculosis and other crowd diseases. Not only was the constant immigration of healthy peasants from the countryside necessary to make up for the constant deaths of urban populations from crowd diseases, the rural exodus of young people to big cities was equally sparked by disillusionment with poverty-stricken farm life, fuelling

the hope of finding fortune and opportunity in the big city.

While such “absurd, reprehensible impulses” had to be resisted to escape TB, enforced restriction proved equally hazardous, as is epitomised by tuberculosis ravaging native Americans since the forcefully imposed change from nomad to reservation living.

Reviewing the situation in late 19th-century France, Barnes writes:

[This] was a familiar literary motif, and its element of tragic inevitability lent it considerable evocative power ... [offering] a fairly typical view of the rural exodus and its relation to tuberculosis. The young peasant, healthy and robust, dazzled by what he saw in the big city during his military service, deserts health, home and family, and comes to enlarge the incalculable number of malcontents and have-nots who begin to see that life is not all roses and that health is not always in abundant supply. Poverty, alcohol, and tuberculosis catch up with the stragglers and rip them apart without mercy. ...

Many authorities accepted uncritically [and repeatedly] this notion of peasants seeking to strike it rich in the city. Few mentioned the devastating poverty of some rural regions, or indeed any other type of “push” motive, as possible factors in migration. Thus, even before the full sociomedical aetiology of tuberculosis had been set forth, the soon-to-be-victim of the disease was depicted as at least partially at fault for choosing the conditions that would lead to his own downfall. ... Louis Renault, in a medical thesis on tuberculosis among Bretons, recognised that the attraction of the big city might have something to do with economic conditions at home. ...

Knowing a few examples of fellow villagers who left with nothing and found success, they hope to have the same experience and they abandon their native soil to seek adventure. ... As much as delusions of grandeur, Renault blamed France's mandatory military service for encouraging rural-urban migration. ... Their army comrades boasted of the advantages offered by urban *life* and ridiculed them for being mere peasants. Their envy is sparked: ambition and *pride urge them on*. When they return to their homes, the pastoral *life seems* hard and monotonous to them; at the first opportunity, they permanently desert their native land. ...

In all of the rural exodus literature, the most commonly cited trap awaiting the new urban arrivals - and the most common gateway to tuberculosis - was debauchery. ... Powerless to resist, the newcomer to the city was doomed; as all of the core narratives on this point make clear, opportunities and enticement to debauchery were everywhere. ... The true *dimensions of the problem [how*

ever] could not be accurately understood through urban mortality statistics, because many tuberculosis victims returned to their home village or province, either to die among family or in the hope of a cure in the country air. The result of this reverse migration was the introduction of tuberculosis, the “city disease,” into the countryside.

[Barnes 1995]

Consequently, the decline of tuberculosis and other infectious diseases in the industrial world of the 20th century was largely seen as a result of rising standards of living and sanitary reforms rather than of medical advances or interventions. “By the time vaccination and effective medication were made widely available in the 1950s, most of the historical decline in the industrialised nations had already occurred,” concludes Barnes.

UNLEASHED YEARNINGS

The mind picture of Tuberculinum has been elicited from patients with latent or manifest TB, including children with actual or suspected tubercular parentage. Rather than being characteristic for a particular Tuberculinum, this picture will by and large apply to each of them.

What for the TB patient is a reality - the prospect of a life shortened by tuberculosis - is on the basis of similarity a sensation for Tuberculinum individuals. Consumption, an earlier name for pulmonary TB, makes one realise that there is no time to waste. [The term phthisis comes from Gr. *phthoe*, meaning ‘individual shrivelling up under intense heat’.]

Driven by despair, alternating with hope [eg, when Koch proclaimed his cure for tuberculosis], the TB patient, as Kent puts it, “gradually running down, never finding the right remedy, or relief only momentarily; has a constant desire to change, and travel, and go somewhere, and do something different, or to find a new doctor.” From this restlessness and changefulness arise naturally “the desire to travel, that cosmopolitan condition of the mind belonging so strongly to the ones who need Tuberculinum.”

Barnes points out that romantic novels drawing on the consumptive

TB sufferers
Laennec } TB researchers
Max Lurie /
R. L. Stevenson
Branwell Bronte
Emily Bronte
Anne Bronte
Charlotte Bronte
[also the Bronte parents
and Sisters Elizabeth and
Maria]
Anton Chekov
Albert Camus
Dylan Thomas
George Orwell
Voltaire
Byron
Keats
Chopin
Thoreau
Goethe
Descartes
Spinoza
Kant
Modigliani
Purcell
Paganini
Grieg
Weber
Beethoven
Nelson Mandela
George Washington
Eleanor Roosevelt
Tina Turner
Ringo Starr
Vivienne Leigh
Bishop Desmond Tutu

ideal of female suffering made use of tuberculosis to express an age-old Christian attitude that exalted women's suffering as sublime, spiritual, and potentially redemptive. The Catholic ideology of suffering and bodily renunciation had for centuries associated the wasting away of young female bodies with a heightened state of spirituality [anorexia mirabilis]. The decay of the body signalled the blossoming of the spirit.

The typical rise in temperature that befalls TB patients in the afternoon or evening, accompanied by slight flushing of the face, has its parallel in the feverish condition of the mind and eventually rises to a fever pitch, a state of great excitement or agitation. He has to work with the intensity of a condemned man and to cherish "the preterminal euphoria which makes our last departure easier by spreading a merciful veil over painful reality."

The slight fever livened the associations and filled the thoughts with fantastic, dreamlike pictures. A greater zest for life, which could not be satisfied in reality because of the lassitude produced by the disease, finds an outlet instead in imagination, "the mind's internal heaven," often with an erotic touch. ... In *The Lesson of Love* the lone musician is playing to a pretty girl who is turning away from him. Carl Nordenfalk suggests that this guitar player is a "symbolic self-portrait, the melancholic consumptive to whom it was never given to drain the cup of life's pleasure, which he so brimmingly offers us in his art." ... We find the same feeling of sweet sadness in the poetry of Keats and in Chopin's *Nocturnes* - these tenderly melancholic fever-dreams. Both suffered from consumption and the poor, deserted Chopin worked himself to death during the last stages of disease. ...

[His] famous Funeral March is interrupted for a few moments by a nostalgic remembrance of happier days but soon succeeded by a presto that has been compared to the flutter of the night breeze among tombstones - the concert where no encores are granted. ... [John Keats], in his last years, consumed by a hopeless passion and wasted by disease, inappropriately treated, reflects on the relations between disease and creation: "How astonishing does the chance of leaving the world impress a sense of its natural beauties on us ... I muse with the greatest affection on every flower I have known from my infancy - their shapes and colours are as new to me as if I had just created them with a superhuman fancy. It is because they are connected with the most thoughtless and happiest moments of our Lives."

Seeing her sisters die [of tuberculosis], Charlotte [Bronte] became intimately and tragically acquainted with the symptoms of progressing pulmonary tuber-

culosis; her descriptions in the chapter *The Valley of the Shadow of Death* are more vivid than those of any doctor. There is the ominous loss of appetite: “palatable food was as ashes and sawdust to her,” replaced by increasing thirst. “She felt her brain in strange activity: her spirits were raised; hundreds of busy and broken, but brilliant thoughts engaged her mind. ... Charlotte knew, “one alone reflected how liable is the undermined structure to sink in sudden ruin.” ... In the final stage of her difficult life Charlotte did indeed experience perfect but brief happiness in a late marriage. But in keeping with her misfortunes the token of her happiness - pregnancy - proved fatal, the *nausea gravidarum*, the vomiting and other strains caused her tuberculosis to flare up and end her life.*
[Sandblom 1992]

*I long for the land that never was,
For all that is I am tired desiring.*
[Edith Sodergran]

Despite the hunger for life there is no fulfilment from whatever is taken in, no satiation, no increase, but, instead, “a gradual losing of flesh, a gradually growing weakness, a gradually increasing fatigue,” despite good appetite. Nothing can please him, nothing satisfies.

* Observations in the 1930-50s demonstrate that dramatic alterations in hormone balance, such as with puberty, pregnancy or lactation, tend to [re]activate tubercular lesions or make the disease progress with “greater activity.”

One author put it thus: “Not infrequently, the first symptoms of tuberculosis in married women follow close on the heels of labour.” If true for TB, it most likely applies to the tuberculinic disposition [miasm] as well; hence Tuberculinum should be added to such rubrics as “Puberty,” “Pregnancy,” and “Lactation.”

A PERPLEXING PLETHORA OF PREPARATIONS

Every single symptom related to tuberculosis or tuberculous conditions appears to be lumped together under the heading ‘Tuberculinum’, concealing the past and present disparity in regard to this group of remedies. Probably no other remedy has evoked so much controversy and discord, which holds equally true for the use of tuberculins in orthodox medicine.

Clarke found no “appreciable difference between the action of *Tuberculinum*.

[= Tuberculinum Koch] and that of *Bacillinum*. My own impression is that they are practically identical, and that the one will answer to the indications of the other.” Cartier, on the other hand, pronounces that “to place these products together in the pathogenesis gives an absolutely wrong sense, and the fact that both contain Koch’s bacillus gives no excuse for confounding them. In my opinion there are, from a homeopathic point of view, distinct differences between Bacillinum and the Koch’s lymph.” Moreover, having studied “conscientiously the action of Bacillinum in tuberculosis,” Cartier confessed, at the end of the 19th century, to not have found “an authentic cure by this remedy.” [cited in Anshutz]

Successes in the treatment of active TB with Tuberculinum [s] have been claimed by some and debunked by others because periods of latency, common to certain stages of TB, are difficult to separate from real cures if cases are not followed over a prolonged period of time.

Cowperthwaite gave as his opinion that, “We only have a few unsatisfactory, fragmentary provings made with extremely high potencies, and are obliged to depend entirely upon clinical indications in the use of the remedy. It is therefore quite impossible to individualise each case as is desirable in homeopathic prescribing.

We can only prescribe Tuberculinum when the patient presents a picture of tuberculosis or of the tubercular constitution.”

Pierre Schmidt, of Switzerland, thought that the indications given by the French homeopaths for many of the preparations used by them are fanciful and based on insufficient data. He based this, however, on the mistaken belief that Tuberculinum bovinum “is the only tuberculin, with Avicular tuberculin and Bacillinum, which has been proven on healthy man,” which is only partly true for Bacillinum.

Total confusion arises with his emphatic statement, “I have always given Tub. bov., when indicated, according to Allen and Hering, with excellent results,” only to prove Clarke’s point since the symptoms in Allen and Hering’s compilations come from observations with the use of either Swan’s Tuberculinum or Burnett’s Bacillinum.

Recently, Laren Bays found the established keynote of the remedy often to be missing in Tuberculinum cases, so that “if we used only these symptoms to prescribe on, Tuberculinum would often be missed.”

And so it goes on.

Rather than aiming at playing down the importance of Tuberculinum [s] in homeopathy, quite the contrary, the point I want to make with this is that

general context as well as concomitant circumstances need to be investigated and included in the ‘picture’. Every substance reveals its nature both internally and externally. *Circumstance, context, circumference, content, core, all combine to constitute a characteristic complex.*

In an attempt to clarify matters the introduction of the various types of Tuberculinum can be placed on a time line:

- c. 1874, USA. Swan introduces what he calls ‘Tuberculinum’, a remedy made from “pus expelled from the lung of a man far gone with consumption.” Swan prescribed it primarily in patients with tuberculosis.
- c. 1885, UK. After having used Swan’s sputal tuberculin for a number of years, Burnett comes with his own preparation, made from the tuberculous lung of a person who had died of pulmonary tuberculosis. He named it ‘Bacillinum’ because the portion of lung used for making the potencies contained tubercle bacilli [as well as a load of other micro-organisms]. Burnett suggested that people with a family history of tuberculosis would find Bacillinum useful. He used it in cases of incipient as well as of more chronic tuberculosis, and on indications of tubercular diathesis, i.e. fungal infections such as ringworm and pityriasis.
- 1890, Germany. Koch launches tuberculin for use in general medical practice.
- c. 1891. Introduction of homeopathic potencies prepared from cultured Koch’s tubercle [M. tuberculosis].
- 1893, USA. Introduction of Tuberculinum bovinum by Kent because he found that “the Tuberculinum in vogue [i.e. Swan’s] was not the best form for use as a remedy or to prove, as it was made from sputum which must have been mixed with products from fermentation. It also seemed in many ways repulsive.” [One may wonder about the sterility of tuberculous glands from slaughtered cows or about the appeal of gonorrhoeal pus.]

The above makes clear that all clinical [cured] symptoms reported before 1893 belong to the human type, M. tuberculosis. Hering’s Guiding Symptoms, as said before, consist of a collection of symptoms cured / improved with Burnett’s Bacillinum or Swan’s Tuberculinum, complemented with seven proving symptoms obtained with Swan’s preparation.

Deeming Burnett’s and Swan’s Tuberculinums more or less identical, both comprising a mixed bag of bacteria, *the symptoms from the Guiding Symptoms should be placed under Bacillinum.*

Except for Aviaire, BCG, and the 'standard' Tuberculinum [Tuberculinum bovinum Kent], all other Tuberculinums are from human strains of the tubercle bacillus. They will be discussed in this order.

- Bacillinum.
- Tuberculinum Denys.
- Tuberculinum Koch.
- Tuberculinum Marmorek.
- Tuberculinum residuum Koch.
- Tuberculinum Rosenbach.
- Tuberculinum Spengler.

KEYNOTES

[Apply predominantly to Mycobacterium tuberculosis but are listed for Tuberculinum bovinum in the repertory]

- Wanderlust.
= Optimism.
- Restlessness despite weakness.
- . Hyperactivity and violent outbursts of temper; marked lack of fear of consequence or punishment. [Boedler]
- = Changeability, instability; ever changing complaints.
- Alternation of burning with intensity and feeling burned out.
- „ Recurrent colds and respiratory ailments.
- = Profuse perspiration at night and on [slight] exertion.
- „ Craving for salt; smoked meat; fat; cold milk; sweets.
- = Worse night [3 a.m.] and morning.
- « Worse by changes in temperature and weather.
- = Worse by cold, wet weather.
- = Worse in close room; must have windows/doors open.
- = Strong desire for open air, eg wind blowing in the face.
- Family history of tuberculosis.

- “When I am consulted for infants who take cold frequently and when I find in the eyes of the mother or the father little indications of tuberculosis, I ask three questions: “What are the animals that your child likes or doesn’t like?” “What are his palms like?” “When you scold him what does he do?” Children who need Tuberculinum fear dogs; the palms of the hands are damp.

when you scold diem, even if they are very little, they lift their fists and threaten you back... the naughty things!”
“This is a remedy which I like particularly, and have no need for any Spengler, Marmorek, Denys, etc.... with their purely theoretical and conventional indications.”
[Pierre Schmidt]

MATERIA MEDICA TUBERCULINUMS

BACILLINUM

Bac.

Sources

- [1] Clinical observations by Compton Burnett and others.
- [2] Clarke, c. 1886, self-experimentation with 30c and 100c.
- [3] Boocock, 1892, self-experimentation.
- [4] Rajan Sankaran, 1993, seminar proving with 200c.

Purulence

• “To fully understand its action it is necessary to know with exactness its composition. Dr. J. Compton Burnett has christened it Bacillinum, because he recognized in its lower dilutions the presence of Koch’s bacilli. As a matter of fact Bacillinum contains in its elements everything that a cavity of a tuberculous lung is capable of containing; that is to say, many other things beside Koch’s bacillus. The bacillus of Koch is feebly pyogenic, and the purulent contents of the cavities include pyogenic staphylococci and streptococci, to say nothing of the organic products which play a large part in the production of the hectic fever of tuberculosis.

It is a combination of toxins, then, which constitutes Bacillinum, and especially of toxins of a purulent nature. I lay stress upon this last fact, as it goes to sustain the opinion that I hold on the action of Bacillinum. The infinitesimal dose of homeopathy is in no way inimical to the entrance of all the elements constituting a substance into its materia medica.

The salts of potassium owe their effect to their base as well as to their acid; Graphites is analogous to Carbo and Ferrum, because it contains both carbon and iron; Hepar sulphuris calcareum acts by reason of its sulphur as well as of its lime. Bacillinum, then, combines in its action all its constituent

products, owing its efficacy to its suppurative microbes as well as its inclusion of Koch's bacillus."

[Cartier, cited in Anshutz]

- Particularly useful in cases where there is excessive muco-purulent bronchial secretion threatening to occlude the lungs.
- In the use of Bacillinum, during the three years past, experience has taught me that it should only be employed in cases where the expectoration is very profuse, and usually of a greenish-yellow colour and of the consistency of thick, heavy pus; the cough sounds loose and rattly; there is laboured breathing, because the lungs are filled with loose pus. In many cases the cough is loose and rattling, yet the quantity expectorated is quite small, because the patient has not the strength to raise it; but in most cases the expectoration is very profuse. [Marcy]
- "When Bacillinum acts on tuberculosis the sputum is less abundant, less purulent, less green, and more aerated. It is this which has always struck me most in the action of Bacillinum. ... Far more potent is the part played by Bacillinum in non-tuberculous pulmonary affections. Dyspnoea resulting from bronchial and pulmonary obstruction caused by a superabundant secretion from the mucous membrane is marvellously relieved by Bacillinum. ... Last year I was called to the house of an upholsterer. He preferred not going to bed at all to passing the night in bed without closing his eyes.

He had humid asthma with incessant cough, which ended by causing him to eject thick yellow and purulent mucus. For eight days he took Arsenic and Blatta, and for a whole week he passed the nights without sleeping. From the day he took Bacillinum he was able to sleep. I saw him again this year in good health. Once or twice he was attacked with the same bronchorrhoea, and had my prescription made up at the chemists, with the same success. This year, too, I have given Bacillinum to several patients at the Hospital St. Jacques for the same symptoms, and it never yet failed me. ...

When I am called upon to treat a patient suffering from an obstruction of the bronchial tubes occasioned by mucus, which is frequently thick and opaque and purulent - an obstruction extending to the delicate bronchial ramification, and causing oppression more frequently than cough - I turn my thoughts at once to Bacillinum.

Bacillinum is a drug for old people, or, at any rate, for those whose lungs are old; for those chronically catarrhal, or whose pulmonary circulation is enfeebled without regard to the age of the subject; for those who have dysp-

noea, and who cough with difficulty from inaction of the respiratory ducts; for the humid asthmatic, the bronchorrhoeal, who feel suffocated at night; and, finally, for those who, after taking cold, are straightaway attacked with pulmonary congestion. Here, I believe, is the exact sphere of action of Bacillinum as a homeopathic remedy.” [Cartier]

PROVING CLARKE

I began to use Bacillinum, and at the same time I proved it on my self, in the 30th and afterwards the 100th potency, with the following result.

1. Pain in glands of neck, worse turning head or stretching neck. Right side more affected.
2. Pain deep in head, worse on shaking the head.
3. Aching in teeth, especially lower incisors [all sound].
This was felt at the roots, especially on raising lower lip: the symptoms persisted many months, and I occasionally feel it now. Teeth very sensitive to cold air.
4. Sharp pains of short duration in chest and various parts of body.
5. Pain in left knee whilst walking one evening: passed off after persevering in walking for a short distance.
6. Nasal catarrh. Pricking in throat [larynx] then sudden cough. Single cough on rising from bed in the morning. *Cough waking me in the night*. Easy expectoration. Sharp pain in precordial region, arresting breathing. Very sharp pain in left scapula, worse lying down in bed at night, relieved by warmth.
7. An indolent angry pimple on left cheek. This persisted many weeks and I began to fear it was something worse. After it had healed it broke out several times at long intervals and even still a slight indentation can be felt at the spot.

[J.H. Clarke]

PROVING BOOCOCK

- Flush of heat, some perspiration and a severe headache, deep in.
- Headache mostly in the temples and occiput.
- » Stitching, creeping pain through left lung & tickling cough. Left lung irritated and sore, a creeping, stitch-like feeling passing through from below upwards.

~ Weak feeling in the right lung.

- Feeling of great weakness.

. Very restless feeling, nor able to read with profit went to bed ear y.

- Had to rise co urinate three rimes; urine clear, but of a very bad smell, putrid

-Awoke ar daybreak and could nor sleep, feeling very tired.

. Passed a good deal of flatus, smelling very bad, like rhe urine

. *While* preparing my tub for shower bath, felt very sick; upheaval of stomach,

but could nor vomit
acter, mixed with mucus.

, *Felt* very weak and *sleepy* all forenoon.

, Good deal of tickling in the pharynx, provoking a cough and enabling me to raise a little phlegm, white and frothy like cotton ball.

Weakness continued all the day; did not want to be disturbed. Sought to be quiet; slept a good part of the day, when not attending to my professional duties; passed a great deal of urine; foul-smelling, of a pale colour, with white sediment.

„ Second night very restless; at night slept well, but foil of dreams; in my dream was attending to large numbers of malignant diphtheria cases. Woke many times and slept and dreamed, the same kind of dream; my cases in my dream did not die, but were greatly worse; worried about them. Awoke at five AM, and after lying awake, wondering what these dreams meant. My thought took this form: Intending me to get ready for an epidemic of diphtheria, and this thought I cannot get rid myself of.

= Sweat on the least exertion; very poor appetite; bowels move.

= Slept better, not so restless, but troubled dreams about diphtheria, and yet there is none in the town.

= Am passing more urine, very pale, with strong odour. A good bit of back-ache across kidneys.

<= Very weak and nervous, full of anxiety as of impending trouble.

« Very cross and full of fault-finding, everything is going wrong.

[summarised from: P. Peacock, *A partial review of Bacillium*, *Hom. Rec.* Nov. 1892
RefWorks]

PROVING SANKARAN

Many provers had dreams of intense and quick activity and used the word “hectic” to describe their dreams. Also some provers had dreams having to

do with trains going up and down mountains, which situations were described as being “dangerous, risky, and fast.” Still other dreams, that brought out the theme of risk and danger, included descending into an abyss by a rope with a feeling of “So what if it is deep”; of being in a narrow restaurant with a feeling that this was dangerous for her; of being bitten in the neck by a big dog. Further, dreams of being oppressed by a neighbour in one prover, dreams of concentration camps in a couple of others and symptoms like nausea and oppression, asthma-like symptoms, and a relief in open air, brought out the theme of oppression. Other themes that came up were: a need to help others, especially those in danger, and hopefulness.

The proving of Bacillinum confirmed the picture I had in mind of the tubercular miasm. It made the picture clearer and brought it to life. The main themes of this remedy [and the miasm] are:

= Intense and hectic activity.

= Feeling of danger; risk.

= Need to take a risk.

«■ Fearlessness; does not feel fear to the extent demanded by the situation.

« Sense of oppression.

- Need to help others, especially those in danger, [compare Boocock’s dream of malignant diphtheria]

• Hopefulness.

Some physical reactions:

= First reaction: Physical - heart started to beat heavy as if it had hard work to do.

Temperature went up - I was extremely warm - had to turn the cover many times

- open the windows - feet out of cover, but once out, they got icy cold. Peculiar

feeling in body as if poisoned. Very restless - turned in bed. Kidneys affected -

had to go to toilet to urinate 3 times during night. I could not sleep until 4 a.m.

That is unusual. I normally sleep after two minutes. I had a sudden fear of cancer,

[compare Boocock]

~ Some diarrhoea with liquid stool in evening and once more in the night. In the

night and in morning a sickness like vomiting but I didn’t vomit. In the morning

some chilliness. Diarrhoea very explosive, [compare Boocock]

~ On starting to fall asleep, pulsating sensation in front and back of head, as if something big pulsating is in there and wants to come out.

[Rajan Sankaran, *The Substance of Homeopathy*]

PROVING SWAN

Seven symptoms resulted from Swan's proving of his own 'Tuberculinum' on a male prover with CM and a female prover with CMM.

- = Headache, with frequent sharp, cutting pains passing from above right eye through head to back of left ear.
- = Soreness inside of nose, commencing as watery pimples, which, suppurating, form scabs; nose and lips somewhat swollen; itched slightly.
- ~ Nausea before breakfast with sudden diarrhoea.
- = Lump, size of a walnut, on cord of neck, is movable and occasionally itches. =
- Lame feet for three weeks, would walk or stand on sides of feet to rest them. <=•
- Cramps in calves.
- = Eruption of itching blotches all over body, with exception of face and hands.

SYMPTOMS

Mind

- = Indolence, < mornings.
- Desire for activity. [M]
- = Instability; begins a task and before it is finished takes up another. [W]
- <- Fear, unexplainable; of solitude; < after sleep, in morning and during day. [W]
- Dreams of death, with desire to escape; dreams of intent to violence. [W]
- = Dreams [or delusions] of spiders. [M]
- ~ Dreams of flying. [M] [compare Tuberculinum Koch]

Generals

- = Personal or family history of chest affections.
- = Purulent, offensive discharges; yellow or yellowish-green.
- «= Enlarged glands [esp. cervical].
- ~ Chronic recurrent fever. Disposition to catch cold.
- > Worse cold, wet weather. [Said to work better in damp climates.]
- ~ Perspiration [forehead, armpits, palms of hands], < anxiety and slight exertion.
- = Sleep restless, unrefreshing; frightful dreams.
- = Worse mornings [indolence; unexplainable fear; vertigo; heaviness in occiput; pain in occiput and nape of neck; green nasal discharge; bitter, slimy taste in mouth; urging to stool; anguish in chest; sensation of heat], [W] [compare Tub-k.]
- « Craving for salt; vinegar; beer, during fever; eggs [W]; milk; mustard; pork

-
- [M]; pickles; pungent food.
= Aversion chicken; fat; water.
- Worse: chicken; milk [M],
= Worse in Spring [hay fever]. [M]
« Cannot bear woollen clothing. [M]

Locals

- Vertigo & dimness of vision; < mornings, walking.
- ~ Deep-in headache, < motion; of students, < least exertion, mental exertion, & defective eyesight; & sleeplessness.
- Sneezing and running nose in morning.
- « Pallor; face turns red on excitement.

M = repertory additions Mangialavori.

W = J.W. Waffensmith, Socio-homeopathic problems: Bacillinum - Second Annual Physicians' Conference of the A.F.H., Washington, D.C., 1929.

CASES

(1) By toothlessness I mean that the patient, a little girl of 7 years of age, who was brought to me in the winter of 1893, had only very rudimentary bits of something imbedded in tartar where the teeth ought to have been. Her hair, too, was very, very weak, thin, dry, and she had patches of ringworm, with areas of "diffuse ringworm" [Alder Smith] here and there on her scalp, worse on the left side. Numerous superficial glands, indurated and enlarged. In general aspect the child was puny and very ugly. I put her on the treatment set forth in my little work on "Ringworm"; and a year later [she was on the remedy a full year, and on no other, but at longish intervals between the doses, and all of the 30c] her mouth was full of teeth, her hair and grown, and the little maid looked positively pretty, as one would expect from her young and good-looking parents. Her teeth are not yet white and only poorly covered with dentine, but still she has a mouthful of teeth, and they will certainly go on improving in quality. No trace of ringworm or scrofula left, but the hair is still lacking in gloss. Midsummer 1895. Continues very thriving.

[Compton Burnett, *Delicate, Backward, Puny, and Stunted Children*]

(2) A well-nourished, pleasant-faced woman of 50 is ill with what appears to be Influenza; there is fever, rapid pulse, cough, aching, chilliness; congested feeling

in nose and throat; some nosebleed; thick, yellow, bland discharge from nose; the cough is worse talking and lying on the back. The appetite is poor, there is no thirst although the temperature is 101 1/2. She is not constipated, having two normal stools daily.

She likes summer better than winter and when well has an aversion to fats. Four weeks ago she had a similar attack while in Boston, which was followed by catarrhal, inflammation of the throat and a slight cough, from which she has not recovered. Physical findings were normal. Pulsatilla was prescribed with immediate relief, but in a few days she was ill again, this time with fever of 101, sore throat and headache,. Pulsatilla was prescribed again, but she derived no benefit from this; the tonsils are swollen, she is chilly if she moves about in bed; she has pain in the head worse from cool air; she sweats a little and desires to be covered up.

She is running a slight fever each day - 99 to 101. Silicea 200 is given. Five days later there was discovered localized sibilant rales posteriorly in the upper right lobe. Silicea has given some relief and is repeated. Three days later there is no improvement, the fever continues, the cough is distressing. There is no history of tuberculosis in the family, the sputum is negative for tubercle bacilli; a careful X-ray study is negative for any pulmonary disease. Bacillinum 200 one dose was prescribed with rapid improvement and cure in about three weeks. ... Although the remedies Pulsatilla and Silica were both well indicated, they did not go deeply enough.

[E.W. MacAdam, *The Newer Aspects of Bacillinum-*, Hom. Rec. 1921; RefWorks]

(3) Bacillinum triumphant in rachitis. Early in June, 1892, a lady brought her little five year old girl to be examined and attended, as the girl was very sick. Questioning the lady concerning how long the disease had troubled the child, she answered: "since childhood." Examination revealed a quite advanced state of rachitis; spine curved inward [lordosis], the belly and stomach pressed out, very large and hard, especially the lower part, skin of the face deep yellowish, and of the body brownish color; the front part of the head narrow, pointed out, while the back part was very large and rather square.

No appetite, no sleep and more or less diarrhoea of putrid, strong smelling excrement. As several quite eminent physicians [Allopaths] from different places had attended her, but without avail, the child getting from time to time weaker, unable to stand on her thin legs, I hesitated at undertaking the treatment of such a forlorn and apparently hopeless case. But the clamour of the distressed mother decided me to try Bacillinum 200, 20 pellets every eight days. End of July, the

mother wrote me of the effect of the pellets in the following terms: "My child begins to walk, belly and stomach smaller and less hard, diarrhoea subsiding, appetite and sleep good. Send more medicine!" Continue in the same manner. September 25, child improving, runs and jumps around the rooms. Keep on the same dose of 25 pellets of Bacillinum 200. October 29, child all right; she had grown taller, gained flesh on chest, arms and legs, and to the astonishment of all, her head has become its natural shape, as also the stomach and belly. This peculiar case greatly occupies my mind concerning the possibility of the curative power of Bacillinum on rachitis, and strengthens my assertion that in many so called incurable diseases the main causes are parasites of a peculiar nature.

[J. Young, Hom. Recorder, Feb. 1893; RefWorks]

(4) Baby B., nearly a year old, had suffered for months with an eczema which completely covered the face and at times much of the scalp. Several members of the family of both father and mother have died of tuberculosis, and two children at about the same age after suffering for months with eczema of scalp and face, had died from tubercular affections of the brain, said to have been tubercular meningitis. Was called in consultation with Dr. Waddell, Professor of Diseases of Children in Hering Medical College, and Dr. Woodward of the Chicago Homeopathic College, to see the baby that for 48 hours had been thought to be dying. The eruption was pale and had to a large extent, disappeared, the scalp being nearly free.

Extremities were cold and at times bathed in cold perspiration. Boring of the occiput into the pillow. Heat, in almost constant motion. Complete unconsciousness. Eyes averted or staring and glassy. Pupils contracted and insensible to light. Face white, pale, distorted. Constant twitching of the right arm and leg. Dark, involuntary and offensive discharge from bowels. Pulse thready, scarcely able to count it. Brain symptoms appeared as eruption faded. Marked symptoms of effusion. This formed a very fair picture of diffuse tubercular meningitis. The prognosis was grave. The family history, and the death of two children from similar conditions at about the same age, rendered the outlook very dark and the consensus of opinion was the child could scarcely recover.

The totality of the acute symptoms, after a careful comparison, was found to be covered by Zincum which was given in the cm potency, and within an hour the child was asleep and passed the best night for weeks. The reaction was prompt, but it did not continue. The following day the old symptoms began to return. On the second day Zincum was repeated in the same and in different potencies, but no improvement followed; in fact, the symptoms of effusion were more pronounced.

At my suggestion and as a dernier resort Tuberculinum IM [Fincke]* was given dry on the tongue. Improvement began at once and continued for four days, when a return of the symptoms called for a repetition.

This was followed by further improvement, and the same remedy in various potencies was repeated at every three or four weeks; when the mental irritability marked the onset of an attack it was repeated in the CM potency until complete recovery took place. The eruption returned on the face for a few weeks in a mild form with much itching and then permanently disappeared. The patient suffered at intervals from severe attacks of mental irritability for two or three years, when a dose of Tuberculinum promptly restored the equilibrium and the child is now the picture of a healthy boy.

[H.C. Allen, *Tuberculinum*-, Med. Advance, Jan. 1901; RefWorks]

- The potencies of Fincke and Swan were prepared from a drop of pus obtained from a pulmonary tubercular abscess or sputa. [H.C. Allen]

(5) On April the 17th, I was called to see Adele L., aged about two years; found her in a convulsive condition with twitching and spasmodic contraction of the muscles, great hyperaesthesia of the skin, photophobia, nausea and vomiting; temperature 103 degrees, great cerebral excitation; nervous temperament, prominent roundish forehead, small face and slightly downward look of the eyes. Bowels constipated, attacks of colic, grinding of the teeth, terrible thirst for water; very slightly open fontanels and sutures.

With these symptoms and many others less prominent, my prognosis was, of course, very guarded, the chances of recovery being extremely slight, but with the powerful guns that Homeopathic remedies furnish, I was not willing to announce to her loving parents that their only little one could not live, and I therefore mustered all the courage I possessed, and said that while I considered their little one very dangerously ill, still I had hopes that she might pull through, and went into the fight with a determination to win if possible. To make a long story short, my first prescription, on account of the intense thirst and small, rapid, tremulous and intermittent pulse, sensitiveness to touch about the head, was *Helleborus niger* 30; this remedy seemed to control the eagerness for water and the pulse, but stopped there.

My next prescription was *Apis mel.* 30[^] dil. Continued this remedy 48 hours with improvement. I was then taken sick myself, and did not see the patient for four days, but recommended a physician who carried out my line of treatment, and when I again saw my little patient she had lost flesh so rapidly that it sent a

shudder over me, as I viewed her tiny limbs and body. I prescribed at once Calc.carb. 30th dil., and asked for a sample of urine which I received in 24 hours, and to my horror, it seemed to me almost solid albumen. I thought then my little patient was doomed. After thinking over the history of the case, and from what I knew of the family history, and the prodromal symptoms, the irritableness, swollen abdomen and constipation, great and rapid loss of flesh, etc., I concluded to prescribe Boericke & Tafel's 200 dilution of Tuberculinum*, one dose every three days, with placebo every hour.

From this day began rapid and permanent improvement. Oh, what a relief to mother, father, friends, my little patient and myself! I know that under any other treatment, and I might say remedy, this interesting little child could not have survived. Great credit is due to her mother, whose good judgement never forsook her for a moment. She said she believed a thousand people called to inquire after the patient; and of course all kinds of friendly advice was volunteered, both as to remedies and physicians, but the parents stood firm in the belief that it was not good policy or safe to "swap horses while crossing a stream," and today they have their little one well, but weak, and feel well satisfied with their first venture with Homeopathy. Tomorrow they go to Atlantic City with out little patient to enjoy the invigorating breezes of Old Ocean for a time.

[Charles W. Roberts, *Tuberculinum*: Hom. Recorder, 1893, p. 311]

- Preparation from a tubercular abscess of the lung made by Boericke & Tafel on a Skinner potentiser. [The original article was written in June 1891; Kent's Tuberculinum bovinum came in 1893.]

TUBERCULINUM DENYS

Tub-d.

Sources

Made by the Belgian physician Denys in 1896 from filtered peptonised beef broth in which human tubercular bacilli were grown.

No provings; clinical observations only. Rarely used in countries other than France and Germany.

SYMPTOMS

Type

- Fits the "type of individual who, though of tubercular tendency, has good reactions and often does not appear ill. Indeed he may be of a florid, large,

even fat, appearance, though he is easily wearied on exertion which may induce pyrexia. Sudden attacks of weakness and great depression at irregular intervals develop or a sudden anorexia and gastric disturbances with nausea, vomiting and diarrhoea. Pulse tension is persistently low.” [Wheeler & Kenyon]

- Tuberculinum Denys is generally a hydrogenoid having a florid look. He is fat, having a healthy and deep coloured appearance. It is indicated from the age of 15 to 40 and corresponds to pre-tuberculous conditions. If the application of this nosode cause aggravation, it may be replaced by T. R. which is milder. [Bemoville]

Sudden and violent crises

- Sudden illnesses with no obvious cause in subjects apparently in good health are considered to be indications. Sudden crises include, according to Voisin:

<= Depression.

= Fatigue.

= Anorexia.

= Fever [< least exertion].

= Migraine.

Migraine, irregular, intermittent, comes suddenly, variable duration, 2 to 3 days or may last for 15 days, disappearing suddenly to return suddenly at the end of 15 days, even after 2 to 3 months in the same manner. [J] = Coryza.

Copious, watery, non-irritating discharge suddenly appearing and disappearing.

The hoarseness has the same character of suddenness. [Julian]

~ Stomach problems with sudden nausea and vomiting.

= Diarrhoea.

Watery of soft stools, frothy, frequent for 2-4 days then ceasing suddenly.

(J) <= Asthma

<> Eczema.

Oozing vesicular eruptions. [J]

Generals

<<• Craving for fresh air.

- Intense fatigue during pains. [J]

Locals

- Face red, congested.
- Lips fiery red.
- » Chest pains: intercostal or in nipples, esp. right side. [J]
- Precordial pain, < after walking or slight exertion.

TUBERCULINUM KOCH

Tub-k.

Sources

Observations of the effects, curative and pathogenetic, of the use of a 50% - glycerin extract of cultures of killed human tubercle bacilli in the 1890s, compiled by Clarke and including effects reported by Nebel. While Clarke states that Nebel conducted a “proving” with the 30th potency, the symptoms were, according to Julian, observed in TB-patients after the application of Koch’s tuberculin by injection or ‘absorption’. In a later article, Nebel related the results obtained with Tuberculinum Koch 7c.

[This article appeared after the publication of Clarkes Dictionary.]

Koch’s tuberculin

This extract was made by Koch, who called it “tuberculin” and announced its discovery in August 1890 in a speech before the Tenth International Congress of Medicine in Berlin. Although tuberculosis was already declining, Koch’s claim that it could cure the disease attracted worldwide attention, so that when the treatment was first launched, the medical papers, to quote Clarke, “were teeming with reports of cases undergoing the injection for *various* diseases.” [my italics]

... Koch had found a substance which arrested the growth of the tubercle bacillus in the test-tube and in living bodies, referring to this agent, which he called ‘tuberculin’, as a ‘remedy’ and thus leading the world to believe he had a TB cure.

Dazzling publicity followed, and Koch was feted. Before tuberculin’s efficacy and safety had been evaluated, the Kaiser personally conferred upon him the medal of the Grand Cross of the Red Eagle, and he received the freedom of the city of Berlin. Despite Germany’s law prohibiting ‘secret medicines’, Koch avoided disclosing the nature of tuberculin. Sent to Berlin to report for the press, Arthur Conan Doyle [1859-1930] [the creator of Sherlock Holmes] paid a call on Koch’s son-in-law and found his office knee-deep in letters begging for the

miraculous remedy; the whole business was like Lourdes.

Within a year thousands had received tuberculin treatment, without system or controls. It seemed to help some patients in the first stages of lupus [tuberculosis of the skin], but experience quickly showed that tuberculin was useless or even dangerous for patients with pulmonary tuberculosis. The fiasco brought a violent backlash, with denunciations of Koch and his secret remedy. A study prepared for the German government found little evidence to justify the claims made for tuberculin. Koch was rumoured to have sold his secret' to a drug company for a million marks, to help finance his divorce and remarriage.

In a paper published in January 1891, Koch at last revealed the nature of his remedy: tuberculin was nothing but a glycerine extract of tubercle bacilli. He was accused of divulging the great secret only when it had become obvious that tuberculin was financially worthless. He disappeared to Egypt with his young bride, leaving his underlings to cope with the debacle.

[Porter 1999]

The extract produced a striking flare-up of skin lesions, but not a cure, as time and further testing showed. "Instead, Koch had stumbled on what is known as delayed hypersensitivity, a component of cellular immunity. And while tuberculin wasn't a cure, it eventually proved valuable for diagnosing the disease. A version of it, PPD - Purified Protein Derivative - is the standard skin test [Mantoux test] used for TB today. It does not diagnose the disease but detects the presence of infection from prior exposure." [Holmes]

Effects of tuberculin injections

Wheeler and Kenyon, in *A Study of Tuberculinum*, reviewed the gross effects of tuberculin injections on patients suffering from TB and in non-tubercular cases.

- « "Serious mental symptoms, delirium with fever and confusion of mind, hallucinations and illusions followed injections on several occasions."
- = Rise of temperature, fever as high as 41.5° C.
- = Fever & polyuria.
- <= Persistent subnormal temperature [rare].
- = Somnolence or sleeplessness.
- « Anorexia.
- = Violent headache [frequently observed],
- = Disturbances of vision with the subjective experience of seeing colours.

-
- == Glossitis & abscesses of the tongue and suppuration of the gums.
 - = Acute parotitis.
 - = Persistent vomiting and diarrhoea.
 - = Gastric and intestinal pain.
 - = Neuralgic pain in intercostal regions.
 - = Palpitation, rapid pulse, pain in cardiac region, cardiac anxiety. "Death followed in some cases with every sign of an acute cardiac crisis."
 - = "Blood pressure was usually lowered and the haemoglobin content diminished."
 - <= Enlargement of spleen.
 - = Acute nephritis.
 - = Proteinuria, passage of casts; sugar and acetone in urine.
 - «• Swelling of joints with effusion; considerable pain, < at night.
 - = Neuralgic pains in limbs.
 - ~ Skin eruptions: erythema; urticaria; papular and vesicular eruptions.

Feverish dreams and failing strength announce the end.

Oh! I have had a suffering night. This morning I am worse. I have tried to rise.
I cannot. Dreams I am unused to have troubled me.
[Anne Bronte]

SYMPTOMS

[from Nebel, recorded by Clarke]

Morning aggravation

- ~ Vertigo, esp. in morning.
- = Headache.
- ~ Headache & epistaxis.
- Headache & swelling of eyelids.
- = Anorexia, esp. in morning.
- = Burning thirst in morning.
- «• Nausea and sickness & heaviness in stomach region.
- Palpitation early in morning.
- « General fatigue.
- = Inclination to sleep in mornings.

Night aggravation

- ~ Irritating cough.
- = Chest pains.
- ~ Palpitation, < raising himself up.
- ~ Perspiration.
- ~ Much sweat, esp. on head in night.

Sensation of constriction

- Throat.
- ~ Larynx.
- = Abdomen.
- ~ Precordial region.

Peculiarities

- = Doesn't like to be disturbed by people; trembling of hands.
- ~ Vertigo by bending down, esp. by rising after bending down.
- = Headache & rushing in ears and pressure on vertex.
- Sensation as if teeth were all jammed together and too many for his head.
- ~ Salty taste in mouth.
- Abdominal colic & great thirst.
- == Has to urinate very often, esp. during changes of weather.
- Sensation of heat in external genitalia & increased leucorrhoea.
- = Sticking pain in lungs when laughing.
- = Deep inspirations cause severe palpitation of heart.
- Great weakness in lower extremities, esp. from knees down to feet.
- <• Shivering when beginning to sleep.
- >= Dreams of shame.
- Profuse sweat during or after slight exertion.

Four typical dreams

- Enuresis nocturna while dreaming of sitting on toilet and emptying bladder at one's leisure.
- Being devoured by fish or dog.
- = Flying over landscapes.
- Pigs-

fM. Stübler, *Studie über das Arzneimittelbild von Tuberculinum-*, *Allg. Hom. Zeitung*, 1978,

Heft 41

Outstanding indications

[after Wheeler and Kenyon]

= After-effects of influenza, eg, long lasting prostration.

- Patients suggesting potencies of Koch's Tuberculin do not readily put on weight in spite of all efforts that are made with suitable dietary. There is a tendency to digestive disturbances, accompanied by a bad taste in the mouth and bad breath.

There is an aversion to food, especially sweets, and he experiences nausea at the sight or smell of food, even cold milk, which he desires, nauseates him.

Attacks of offensive diarrhoea are usual and the urine may be offensive.

Nebel's whiff

"On the evening before I had prepared Tuberculin 1000c and 500c for my colleague, Schlegel, in Tuebingen, the thought suddenly occurred to me, now I will experiment on that gigantic swindle of Hahnemann, smelling of medicines. So I took in the evening a good whiff from the bottle containing Tuberculin 500c. I could not sleep that night till three a.m., though I was not excited only wide awake; at first I had a slight oppression on the chest which, however, soon disappeared. Besides this there was a peculiar sensation of heat in spots on the skin, so striking that I felt the spots with my hand, but the skin showed no heat in these spots. The sensation was similar to that caused by Sepia; toward morning there was some sour smelling perspiration in the axillae. On the afternoon succeeding this there was some oppression on the chest, with a desire of taking the fresh air, but the evening and night succeeding were undisturbed. From this I concluded that, in my case at least, Tuberculin 500c acts more gently when it is smelled at than in oral ingestion." [A. Nebel, *Tuberculin and Diphtherinum*-, Hom. Rec., April 1901; RefWorks]

DIFFERENCE WITH BACILLINUM

Yingling held the opinion that, "While there is undoubtedly great similarity in the pathogenetic sphere of the various Tuberculinum, yet, in my humble opinion, I feel confident there is a difference and that it would amply repay a most careful and complete research. In the more brilliant results obtained in any of our remedies, the finer distinctions are the basis upon which remedial selection must be made. In a rough way, I find Bacillinum better suited

to acute manifestations of lung troubles, while the Tuberculinum Koch is better suited to the chronic results of pneumonic troubles. In pneumonia the first remedy I think of is Bacillinum, unless there is plain indications for another, and in many cases even where Aconite, Bryonia, Belladonna, or some other remedy leads in the acute turmoil, I find Bacillinum soon comes in to rapidly finish the attack in very many cases. ... Tuberculinum Koch I think of more often in tubercular conditions of the skin.”

[W.A. Yingling, *Tuberculinum*: Hom. Recorder 1905, p. 185]

TUBERCULINUM MARMOREK

Tub-m.

Sources

No provings; clinical observations only. Rarely used in countries other than France and Germany.

History

Made by the French bacteriologist Marmorek in 1903 from serum of horses injected with successive doses of tuberculin obtained from filtrates of young cultures of human tubercle bacilli.

According to Vannier, besides the tuberculin injections, the horses were treated with cultures of streptococci recovered from the sputum of tuberculous patients. If this is true, one would expect, theoretically, a combined picture of Tuberculinum and Streptococcinum.

Fact is that Marmorek in the 1890s had researched extensively the virulence of streptococci and developed in 1895 an anti-streptococcus serum by injecting horses with cultures of living virulent streptococci. The serum was used, allegedly with success, in numerous cases of suppuration, septic infection, puerperal fever, and scarlatina.

Apparently intending to develop a tuberculin with less severe adverse effects than Koch's tuberculin, Marmorek thought that the streptococcal antibodies would neutralise the toxins released by the tubercle bacilli, a toxicity problem which Koch had not been able to solve. Marmorek's tuberculin was declared unsuitable by Calmette, who a few years later started working on his own idea of a safe and effective type of tuberculin, BCG.

Type

= Lean, nervous, anxious, restless, hypersensitive individuals. [Julian]

- Skinny, anorectic children with a lack resistance and disposed to acute otitis.

[Voisin]

-
- Lean, anorectic people with intermittently discharging, chronic fistulas. [Voisin]
 - Lean, chilly, constipated, anorectic individuals with a dry skin and a tendency to wandering rheumatic pains. The rheumatic pains may alternate with asthma and there is a pronounced disposition to contractures.*

* A. Vbeggeli, *Das Asthma und seine Behandlung*, Haug Verlag, 1981.

SYMPTOMS

Indications

- “A potency of this serum may be given with benefit to patients who react badly to other remedies and at the same time show progressive wasting. Not only is it effective as a prophylactic for the common cold but also for the treatment of inexplicable febrile attacks where there are no obvious physical signs to account for them. We recall the cases of a young woman who suffered from intermittent fever and vague joint and bone pains for several months, but after receiving the apparently indicated remedies without result, a rapid improvement was experienced after the administration of this serum in potency. There is some resemblance to Sulphur in its pathogenesis. The skin is rough, especially the skin of the back, the lips red and the tongue dry, red and furrowed.” [Wheeler & Kenyon]

Generals

« Sudden bouts of fever of the inverted type: elevated in morning, abating in afternoon. [Voisin]

« Erratic, wandering pains. [Julian]

Modalities

= Worse: Mental exertion; walking; prolonged exertion; before menses.

= Better: Rest.

Locals

- Axillary pains alternating sides.

<> Pain in apices of lungs.

•= Marbled skin.

Complementary to Calc-phos., Silicea, and Sulphur iodatum [good appetite in Sul-i.]. [Voisin]

History

Confronted with the injurious effects of his original preparation, known as 'old tuberculin', 'concentrated tuberculin' or 'crude tuberculin', Koch endeavoured to produce an improved form of tuberculin, in the hope that this would serve as an immunising agent or cure. Meanwhile, however, many continued to use the 'crude tuberculin', despite that:

Tuberculin does not exert the slightest influence upon the tubercle bacillus, but acts upon the tuberculous tissue, augmenting the poisonous influence upon the cells surrounding the bacilli, destroying their vitality, and removing the conditions favourable to bacillary growth, which for a time is checked. This action is accompanied by marked hyperaemia of the perituberculous tissue, with transudation of serum, softening of the tuberculous mass, and its absorption into the blood, a marked febrile reaction resulting from the intoxication.

Virchow, who well understood the action of the tuberculin, soon showed that as a diagnostic and therapeutic agent in man its use was attended by grave dangers. The destroyed tissue was absorbed, but with it some of the bacilli, which, being transported to new tissue areas, could occasion a widespread metastatic invasion of the disease. Old tuberculous lesions which had been encapsulated were sometimes softened and broken down, and became renewed sources of infection to the individual, so that, a short time after an enthusiastic reception tuberculin was placed upon its proper footing as an agent valuable for diagnosis in veterinary practice, but dangerous in human medicine, except in cases of lupus and other external forms of tuberculosis where the destroyed tissue could be readily discharged from the surface of the body.

[McFarland 1907]

In developing an improved form of tuberculin, Koch used with advantage the directions provided by Klebs, who, in 1892, had made strong claims for his own modifications of tuberculin by means of mechanical fragmentation of bacilli, known as *antiphthisin* or *tuberculo cidin*. Koch proceeded by pulverising living, virulent, dried bacilli in an agate mortar with the intention to liberate the toxic substance from its protecting envelop of fatty acid. After having reduced the bacilli to fragments, he placed them in distilled water, washed them, and collected the fragments by centrifugation, as a muddy residuum at the bottom of an opalescent, clear fluid. To eliminate any toxic remainders,

the residuum then once again was dried, triturated, recollected in fresh distilled water, and recentrifugated.

The resulting sediment constituted Koch's new commercial product named T.R., marketed in 1897. Since Koch had specifically disapproved the addition of any antiseptics or germicides to the preparation, believing that these would cause destructive changes in the T.R., in some instances unpulverised, living, virulent bacilli could be secured from the preparation. The medicinal agent wasn't received favourably; it failed to cure tuberculosis and remained an interesting laboratory product until the possibility of danger could be removed and could inspire the confidence that "attempts to cure patients may not result in their infection be restored."

It is of interest to note that *Tuberculocidin Klebs*, a tuberculin treated with the antiseptic cresol, was promoted in the 1960-70s in Germany by Stiibler as a specific for enuresis nocturna. The remedy was prescribed in the 12x, once daily five drops over a prolonged period of time, when two or more of the following indications were present:

- == The child answers all questions in the negative.
 - = Recurrent colds.
 - = Fear of dogs, either during the day or in dreams at night.
 - ~ Rigorous rejection of meat, usually in combination with a general lack of appetite.
- [M. Stiibler, *Enuresis*; Allgemeine Homdopathische Zeitung, Band 214, 1969, Heft 4]

Sources

[1] Proving by Julian; 1960-61; 4 provers [2 females, 2 males]; 5c, 7c, 9c.

[2] Clinical observations.

Rarely used in countries other than France or Germany.

SYMPTOMS

Mind

= Discouraged; dejected; undefined sadness.

Generals

« Subject weak, tired; complexion greyish, lips bluish.

= Extreme fatigue & desire to sleep.

Modalities

« Worse: After long rest; motion.

<=• Better: Open air; lying down.

Locals

= Heaviness head & desire for open air.

=> Heaviness head & dimness of vision; has to pucker up eyebrows to see clearly.

=> Heaviness and bloating after eating.

- Pyrosis, eructation, and regurgitation of an acid, burning liquid.

~ Dry cough & dyspnoea; sputum scanty, difficult to expel.

= Urine decreased, strong odour.

- Pain in dorsal region < motion.

- Acne on shoulders and back.

Nodular acne on shoulders and back in people prone to fibrosis and articular rheumatism due to insufficient elimination. [Voisin]

=■ Dupuytren's contracture.

« Congestion of veins of legs.

- Slight heaviness and cramps in legs.

= Sensation of stiffness in joints, as if fixed and immobile; < waking up after long sleep.

< Rest and beginning to move; > Continued motion. Not affected by changes in weather or temperature. [Voisin]

- Shoulders painful and stiff; movement limited and difficult.

~ Dryness of skin.

Type

“We are indebted to Dr. Vannier's observations for the record of the special indications for this Tuberculinum. He considers this preparation is of more value than others in the subject who has recovered from an attack of tuberculosis but who is still under the influence of the tubercular toxin in the system. In these patients the reaction of the body to the toxin is usually of an arthritic order and results in the production of fibrous formation: for example, induration round the joints or tendon contractions. In such cases, Dr. Vannier believes, should a potency of the Residual Tuberculinum be given, the body will be stimulated in such a way that symptoms will appear indicating Rhus tox., which can then be given with great benefit. Again, he would think of this remedy for old tubercular patients who later on develop a periodic com

plaint such as migraine, and in general he appears to regard the patient who requires the residual preparation as very much more frail than the average candidate for Tuberculinum. Patients look pale and ill, with pale bluish lips. They are incapable of leading any but the quietest of lives and any slight emotional or physical upset may precipitate some acute attack.” [Wheeler & Kenyon]

TUBERCULINUM ROSENBACH

Tub-ro.

Sources

Prepared from tubercle bacilli grown symbiotically with *Trichophyton* [fungus associated with tinea and favus].

No provings; occasional clinical observations only. Hardly ever used.

“The Tuberculin of Rosenbach has never become well known to practitioners and has received less fame than perhaps it deserves. In lupus particularly it has helped considerably and under it we have seen a case recover from a condition which presented every symptom of acute pulmonary miliary tuberculosis. We hesitate to make the definite claim that it was a case of this disease, as recovery was complete and permanent, but no symptom was lacking in the picture to suggest that diagnosis. There was temporary amelioration from Tuberculin in potency, itself a suggestive sign and when the Rosenbach Tuberculin was given [hypodermically not in potency] response was immediate and recovery thereafter uninterrupted. It is put on record here for further observation and testing on similar cases. The preparation might be worth remembering in tubercular meningitis.” [Wheeler & Kenyon]

TUBERCULINUM SPENGLER

Tub-s.

History

Developed by the Swiss physician Carl Spengler [1870-1937] as a more efficient form of Koch’s tuberculin; released in 1904 as Spengler IK [Immunkorper = immune bodies] and obtained from the serum of rabbits injected with Koch’s tuberculin.

Sources

No provings; occasional clinical observations only. Hardly ever used.

Indications

- ~ Anaemia; pallor; weakness < before menses.
- = Periods of fever; fever more prolonged before menses.
- ~ Especially suits obese women of the Calc-c. type.
- = Wandering rheumatic pains.

I E. FAMILY NOCARDIACEAE

Nocardia asteroides

NOCARDIA ASTEROIDES

Scientific name Nocardia asteroides (Eppinger 1891) Blanchard 1896

Synonym Actinomyces gypsoides

Family Nocardiaceae

Homeopathy Nocardia asteroides - Noc-a.

FEATURES

- Worldwide distributed Gram-positive, fungus-like, spore-forming, aerobic soil organism with branching filaments breaking into pleomorphic cells, varying from cocci to rod shaped or Corynebacterium-like organisms.
- Most of the about 30 species contained in the genus are saprophytic, the remainder, eg Nocardia asteroides, being pathogenic.
- Colonies resemble the dry, brittle colonies formed by mycobacteria. [A difference lies in the colour: Mycobacterium tuberculosis colonies are lustreless and slightly yellowish, those of Nocardia are orange or yellow.]
- Exudes an earthy odour, similar to the muddy smell of Streptomyces spp.
- Has the peculiar ability of utilising paraffin and can be isolated by “baiting,” i.e. by burying glass rods coated with paraffin in soil, removing them after some weeks and subculturing to appropriate media. [Emmons]
- Prefers high temperatures for growth, up to 50° C, eg in fermenting vegetation.
- The genus was named Nocardia for the French veterinarian Etienne Nocard [1850-1903] who, in 1889, described an actinomycete from bovine *farcy*, a lymphatic disease of cattle caused by *N. farcinia*. In homeopathy, Farcinum is the nosode of farcy. It is usually regarded as being identical with *Hippozaeninum* [see], although Clarke makes the distinction between “glanders” when the catarrhal symptoms are pronounced and “farcy, when these are not noticeable, the skin being chiefly affected, with deposits in the lungs.”

NOCARDIOSIS

Nocardia asteroides is associated with nocardiosis, an infection observed with increasing frequency, esp. in patients with cancer or those on corticosteroids.

After inhaling the organism, manifestations are initially pulmonary, resembling tuberculosis or bacterial pneumonia. Purulent sputum contains acid-fast branching filaments. Early spread of the disease: results in scattered subcutaneous draining abscesses involving the brain and skin, and less frequently, the pleura and heart. Granules are usually not observed. Nocardiosis should be considered whenever the physician suspects tuberculosis, since the clinical manifestations may be similar, the ftmgus-like bacteria are acid-fast, and generalised nocardiosis has a high mortality.

[Kern & Blevins 1997]

The pulmonary and abdominal forms of nocardiosis have the same symptoms as tuberculosis, i.e. afternoon fever, chills, cough, haemoptysis, chest pain, weight loss, weakness, night sweat, and anorexia. Pulmonary lesions often involve the lower lobes [TB prefers the apices], beginning as infiltrative lesions and leading to larger areas of consolidation; cavity formation is rare, as are bone lesions. Incidence of nocardiosis is greater in older adults and men. It is rare in patients with AIDS. Another interesting connection with tuberculosis is that nocardiosis is observed in dogs oftener than in other domesticated animals. Economically more important hosts include dairy cows.

While being a bacterial disease of respiratory origin, nocardiosis has a predilection for the central nervous system and is frequently manifested by pyogenic lesions of the brain and meninges. [Tuberculous or basilar meningitis is usually confined to the base of the brain and is accompanied, in children, by acute hydrocephalus.] The typical manifestations of purulent meningitis can probably help to develop a first idea of the symptoms belonging to *Nocardia asteroides*, a remedy with an entry in the repertory but without symptoms. This should be seen as a starting point only since it allows no differentiation with other organisms associated with purulent meningitis, such as *Neisseria* spp., *Staphylococcus*, *Streptococcus*, and *Haemophilus influenzae*.

- ~ Headache, usually with fever.
- = Irritability; moroseness; moral deterioration.
- =• Drowsiness extending to coma.

-
- « Hallucinations; excitement and other features of delirium.
 - ~ Intellectual deterioration; temporary loss of memory.
 - “ Photophobia.
 - « Oculomotor palsies.
 - = Vomiting.
 - « Slight incoordination or tremor in the limbs.
 - Increased plantar reflexes; tendon reflexes sluggish.

To determine the specifics of Nocardia would, of course, necessitate the conduction of provings and/or accurate clinical observations. Yet, on the basis of speculation, it would seem that Nocardia furnishes a Tuberculinum-like picture, possibly with clinical indications in the past or current disease history such as cancer, brain tumour, or use of corticosteroids.

I E FAMILY STREPTOMYCETACEAE

Streptomyces albus
Streptomyces ambofaciens
Streptomyces aureofaciens
Streptomyces caespitosus
Streptomyces erythreus
Streptomyces fradiae
Streptomyces garyphalus
Streptomyces griseus
Streptomyces nodosus
Streptomyces noursei
Streptomyces peucetius var. caesius
Streptomyces rimosus
Streptomyces venezuelae

GENUS STREPTOMYCES

- Ubiquitous soil inhabitants with worldwide distribution, which play an important ecological role in recycling organic matter.
- Gram-positive, aerobic organisms.
- Colonies grown on artificial media exude an *earthy odour*.
- Most species are free-living organisms, only a few are pathogenic.
- Produce branching filaments, similar to fungal hyphae, which do not fragment easily.

ANTIBIOTICS

Streptomyces spp. have yielded about 60% of the naturally derived antibiotics used in clinical medicine today, the remaining 40% coming largely from Bacillus spp. [bacitracin, polymyxin B] and microfungi [penicillins, cephalosporins, griseofulvin, etc.].

Antimicrobial agents obtained from Streptomyces spp. fall into the following categories:

- * Aminoglycosides [streptomycin; kanamycin; neomycin].
- ‘Aminocyclitols [spectinomycin].

-
- * Glycopeptides [vancomycin].
 - * Tetracyclines [chlortetracycline (aureomycin); oxytetracycline (terramycin); doxycycline],
 - * Macrolides [erythromycin].
 - * Lincosamides [clindamycin; lincomycin].
 - * Chloramphenicol.
 - * Antifungals [amphotericin; nystatin].
 - * Anthracyclines [doxorubicin; mitomycin].

Soil organisms have filled man's medicine box, both to his benefit and his detriment. Rain prompts streptomycetes to release a chemical named geosmin [Gr. for "smell of the earth"], just like pharmaceutical plants do which are growing Streptomyces to produce antibiotics. Fashioned from earth and water, Pandora was presented to man in a box as "an evil thing in which they may all be glad of heart while they embrace their own destruction." Filled with both blessings and afflictions, hope lies at the bottom of Pandoras Box; a fleeting hope when the box is opened indiscriminately.

A major consequence of prescribing antibiotics for trivial or viral disorders is microbial adaptation to antibiotics as well as changes in the bacterial environment and human constitution, both frequently containing antibiotics. While it is contentious whether antibiotics in homeopathic potency can be prescribed on such a non-specific indication as aetiology, i.e. never well since antibiotics, there can be no doubt that Streptomyces have a deep and sometimes lasting effect on the constitution of susceptible individuals. A particular disadvantage is that such remedies have not been investigated on their individual characteristics through the conduction of provings or based on clinical experience, with the exception of Chloramphenicol, with which no less than two provings have been done, and possibly Streptomycine sulphate. Hence we are left with the difficult task to derive a picture from the plethora of adverse effects of Streptomyces based antibiotics.

STREPTOMYCES ALBUS

Bacterium: *Streptomyces albus* subsp. *albus* (Rossi Doria 1891) Waksman & Henrici 1943.

Drug: Salinomycin [sodium].

Uses: Additive to feedstuff of poultry, pigs and calves to improve the conversion ratio of feedstuff [growth promotant]. Added to chicken feeds for the

prevention of coccidiosis.

Adverse effects: Skin lesions; gastrointestinal irritation; swelling of joints. Human food safety data, other than tissue residue data, are not required for approval of animal drug applications.

In a paper entitled *The Effects on Human Health of Subtherapeutic Use of Antimicrobials in Animal Feeds* [1980], the Commission on Life Sciences found that tetracyclines and aminoglycosides have far: less allergenic potential than penicillins. "Tetracyclines are excreted fairly rapidly in urine but may require 4 to 5 days to disappear from soft tissues. Moreover, they have a high affinity for bones and teeth. ... In the United States the impact of these tissue residues on human allergy may be mitigated somewhat by the fact that most edible meats are cooked prior to consumption." Therefore: "... it seems highly unlikely that a sizable proportion of those individuals ingesting foodstuffs containing trace quantities of antibiotic residues will become sensitised to a clinically significant degree. ... Of course this does not prove that sensitization does not or cannot occur, but merely that clinically apparent cases are very rare or non-existent." And: "In this age of antibiotics, exposure to penicillin [and other antibiotics] in therapeutic doses is very common, and the prevalence of prior therapeutic exposure to antibiotics among the adult population is appreciable. Thus, an individual is at many orders of magnitude greater risk of becoming sensitised to penicillin after treatment with a prescribed course of antibiotic than after ingestion of antibiotic residues in food." However: "...we know virtually nothing about the immunogenicity of chronic low-dose administration of penicillins and tetracyclines in human populations." In conclusion: "There is little reason to believe that foodstuffs obtained from animals fattened with antibiotic-supplemented feeds impose a significant risk to human health by contributing to antibiotic-induced allergic reactions."

STREPTOMYCES AMBOFACIENS

Bacterium: *Streptomyces ambofaciens* Pinnert-Sindico 1954.

Drug: Spiramycin.

Brand names: Rovamycine. Selectomycin.

Uses: Toxoplasmosis in pregnant women. Streptococcal and staphylococcal infections of the respiratory tract, buccal cavity, skin and soft tissues. Alternate choice of treatment for gonorrhoea in patients allergic to penicillins. Additive to feedstuff of cattle, chickens and pigs.

Adverse effects:

- = Skin rash and itching.
- = Bleeding or bruising.
- ~ Stomach pain; heartburn; nausea; vomiting. Bloody stools.
- => Chest pain; arrhythmia.
- « Jaundice.
- => Recurrent fainting.

STREPTOMYCES AUREOFACIENS

Bacterium: *Streptomyces aureofaciens* Duggar 1948 emend. Groth et al. 2003.

Drug: Chlortetracycline.

Brand names: Aureomycin. Chrysomycine. Orospray.

History: Introduced in 1948 in clinical medicine, chlortetracycline was the first *Streptomyces*-derived antimicrobial of this group, two years later followed by oxytetracycline [from *Streptomyces rimosus* subsp. *rimosus* Sobin et al. 1953]. Tetracycline, the third member of the group, came in 1952. These classical tetracyclines were subsequently followed by families of semisynthetically modified derivatives such as demeclocycline, in 1959, methacycline, in 1961, and doxycycline, in 1966.

Uses: Broad-spectrum antibiotic. Tetracyclines generally have a wide spectrum of antimicrobial activity, including Gram-positive and Gram-negative bacteria, mycoplasma, rickettsia, and chlamydia. May also be used for acne, exacerbations of chronic bronchitis, *Helicobacter pylori*, and treatment of gonorrhoea and syphilis in patients that are allergic to penicillin.

Adverse effects [in varying degree common to all tetracyclines]:

- ~ Alimentary tract: Metallic taste in mouth; nausea, vomiting, diarrhoea; stomach cramps or epigastric burning; anorexia. Discolouration of stool [black; greenish grey; red; white/speckled].
- CNS: Visual hallucinations; diplopia; hyperthermia.
- Dermatologic: Photosensitivity [mild to severe skin reactions from exposure to direct sunlight]. Exfoliative dermatitis. Lichenoid eruptions. Acneform eruptions. Angio-oedema. Loosening and pigmentation of nails.
- « Fatty degeneration of liver [in pregnant women].

- Predilection for bony tissues [reduced bone growth; bone deformation; yellow or brownish discolouration of teeth]. Disturbed calcium/magnesium metabolism.
- « Renal: Uraemia; loss of sodium and nitrogen; acidosis.
- « Myasthenia gravis [exacerbation or provocation].
- Systemic lupus erythematosus [exacerbation],
- = Candidiasis [overgrowth of *Candida albicans*]; oral candidiasis and pruritus ani.

STREPTOMYCES CAESPITOSUS

Bacterium: *Streptomyces arduus* (de Boer et al. 1961) Witt and Stackebrandt; heterotypic synonym of *Streptomyces caespitosus*, according to Hatano et al. 2003. *Streptomyces caespitosus* has no standing in nomenclature.

Drug: Mitomycin.

Brand names: Mutamycin. Ametycine.

Uses: Antineoplastic agent; treatment of solid tumours. Use limited due to its toxicity.

Adverse effects:

- = Bone marrow suppression with leukopenia and thrombocytopenia.
- « Fever, anorexia, nausea, vomiting.
- « Alopecia.
- = Ulceration of mouth.
- = Intestinal perforation.
- Impairment of hepatic and renal function.
- = Fibrosis of lung tissue.
- = Paraesthesia.
- = Pruritus.

STREPTOMYCES ERYTHRAEUS

Bacterium: Streptomyces erythraeus (Waksman 1923) Waksman & Henrici 1948.

Synonym: Saccharopolyspora erythraea.

Drug: Erythromycin.

Brand name: Erythrocin.

Uses: Bacterial infections such as strep throat, pneumonia, Legionnaires' disease, chlamydia, and diphtheria.

Adverse effects:

- <= Hearing loss [esp. in older patients].
- Liver damage, jaundice [in pregnant women].
- <= Gastrointestinal reactions [stomach cramps; nausea; vomiting; abdominal pain; diarrhoea; anorexia].
- Skin reactions [urticaria; erythema multiforme; itching rashes; peeling, dryness, or oiliness of skin].

STREPTOMYCES FRADIAE

Bacterium: Streptomyces fradiae (Waksman & Curtis 1916) Waksman & Henrici 1948.

Drug: Neomycin.

Brand names: Minims. Mycifradin. NeoTab. Nivemycin.

History: Isolated in 1949 from the soil organism *S. fradiae* and found to contain a group of antibacterial substances and an antifungal compound.

Uses: Topical use in antibiotic creams, ointments, eye-drops, and ear-drops. Component [preservative] of MMR vaccine, Rubella virus vaccine, Measles virus vaccine, Mumps virus vaccine, Influenza virus vaccine, Rabies vaccine, Varicella vaccine, and Poliovirus vaccine.

Adverse effects: Interferes with absorption of vitamins A, B6, B12, D, and K as well as of a broad variety of nutrients including carbohydrates, fats, calcium, iron, magnesium, nitrogen, potassium, and sodium.

Too toxic for parenteral administration. Toxic effects include renal damage and ototoxicity [nerve deafness] and are similar to those of gentamicin and streptomycin. Another important toxic reaction is a curare-like paralysis of respiration.

STREPTOMYCES GARYPHALUS

Bacterium: *Streptomyces garyphalus* [no official standing in nomenclature].

Drug: Cycloserine.

Brand names: Seromycin. Pulvules.

History: Produced by certain strains of *S. garyphalus* or *S. orchidaceus*. First isolated from a fermentation brew in 1955, now obtained by synthesis.

Uses: Potentially broad-spectrum but usually limited to adjunctive treatment in pulmonary and extra-pulmonary tuberculosis and treatment of acute urinary tract infections caused by *E. coli*.

Adverse effects: Pronounced and widely varying effects on the central nervous system.

= CNS: Confusion; psychotic states with suicidal tendencies; paranoia; grand mal seizures; petit mal absences; catatonia; extreme irritability; depression; nightmares; drowsiness; dizziness; paresis; delirium; headache; tremor; dysarthria; hyperreflexia; twitching.

<=■ Arrhythmia.

~ Pricking, tingling, numbness, burning pain, or weakness in hands or feet.

= Pellagra.

« Impaired absorption of vitamin B6, B12, and folic acid.

= “Contraindicated in individuals with a history of epilepsy and may be dangerous in persons who are depressed or are experiencing severe anxiety.”
[Goodman & Gilman]

STREPTOMYCES GRISEUS

Bacterium: *Streptomyces griseus* subsp. *griseus* (Krainisky 1914) Waksman & Henrici 1948.

Drug: Streptomycin.

Brand names: Streptocol. Novostrep.

History: In 1943, two strains of *S. griseus* were isolated that soon showed to inhibit the growth of the tubercle bacillus in vitro and in vivo. In 1947, streptomycin was released for general clinical use. Because bacteria rapidly become resistant to streptomycin and due to its toxicity, the drug is now infrequently used.

Uses: “In combination with other agents for treatment of streptococcal or enterococcal endocarditis, mycobacterial infections, plague, tularemia, and

brucellosis. Streptomycin is indicated for persons from endemic areas of drug-resistant *Mycobacterium tuberculosis* or who are HIV infected.” [Leikin & Paloucek]

Component [preservative] of Polio vaccines [both the inactivated and the live oral trivalent forms].

Adverse effects:

- ~ Tinnitus.
- = Impairment of vision. Oscillating vision.
- = Central scotoma.
- = Diminished sense of smell.
- ~ Numbness, tingling, or burning of face or [around] mouth.
- « Nausea; vomiting.
- Paraesthesia; tremor; arthralgia; weakness.
- ~ Renal: Nephrotoxicity; proteinuria, cylindruria, and reduced urine output.
- Cardiovascular: Hypotension; angina pectoris; chest pain; tachycardia; myocarditis.
- => Anaemia.
- = Dermatologic: Rash. Contact dermatitis. Angio-oedema. Exfoliative dermatitis.
 - “Morbilliform, maculopapular, erythematous, and urticarial rashes have been observed. Pruritus, scaling, eosinophilia, lymphadenopathy, and fever may accompany the eruptions.” [Goodman & Gilman]
- = “Skin sensitisation is common among nurses, pharmacists, and other who handle streptomycin, and may lead to dermatitis sometimes associated with periorbital swelling and conjunctivitis.” [Wade]

Vestibular disturbance.

Nearly 75% of patients given 2 g of streptomycin for 60 to 120 days manifest some detectable vestibular disturbance; reduction of the dose to 1 g daily decreases the incidence to approximately 25%. Moderately intense headache lasting 1 to 2 days usually precedes the onset of labyrinthine dysfunction. This is immediately followed by an *acute stage*, in which nausea, vomiting, and equilibrium difficulty develop and persist for 1 to 2 weeks. Vertigo in the upright position, inability to perceive termination of movement [“mental past pointing”], and difficulty in sitting or standing without visual cues are prominent symptoms. Drifting of the eyes at the end of a movement so that focusing and

reading are difficult, positive Romberg test [closing the eyes increases unsteadiness when standing], and, rarely, pendular trunk movement and spontaneous nystagmus are outstanding signs.

The acute stage ends suddenly and is followed by the appearance of manifestations consistent with *chronic labyrinthitis*, in which, although symptomless while in bed, the patient has difficulty when he attempts to walk or make sudden movements; ataxia is the most prominent feature. The chronic phase persists for approximately 2 months; and it is gradually superseded by a *compensatory stage*, in which symptoms are latent and appear only when the eyes are closed.

Adaptation to the impairment of labyrinthine dysfunction is accomplished by the use of visual cues and deep proprioceptive sensation for determining movement and position; it is more adequate in the young than in the old, but may not be sufficient to permit the high degree of coordination required in many special trades. Full recovery may require 12 to 18 months, and some patients have permanent residual damage.

- *Deafness.*

Although the toxic effect of streptomycin is greater upon the vestibular than upon the auditory function of the eighth cranial nerve, disturbances in hearing occur, nevertheless, in an appreciable number of patients. Four to 15% of individuals receiving the drug for more than 1 week can be shown to have a measurable decrease in hearing, and complete deafness may ensue in rare cases. A high-pitched tinnitus is often the first sign of impending difficulty. ... Since perception of sound in the high-frequency range [outside the conversational range] is lost first, the affected individual is not aware of the difficulty, which is not detected unless careful audiometric examination is carried out. If the loss of hearing progresses, the lower sound ranges are affected, and conversation becomes difficult.

[Goodman & Gilman 1970]

Treated in a sanatorium near Glasgow for bilateral apical tuberculosis, George Orwell received in 1948 the then revolutionary new treatment for tuberculosis, streptomycin. It was “evidently doing its stuff ... [since] ... lam much better in every way,” he wrote to a friend, but then a severe hypersensitivity reaction started to appear so that its administration had to be suspended. Orwell wrote an excellent description of the reactions in his notebook because “it might be useful to have a written record as streptomycin is still a new drug.”

A sort of discolouration appeared at the base of my fingers and toenails; then my face became red and the skin began to flake off and a rash appeared all over my body, especially down my back. After about three weeks I got a severe sore throat which did not go away and was not affected by sucking penicillin lozenges. It was very painful to swallow and I had to have a special diet for some weeks. There was now ulceration with blisters in my throat and the inside of my cheeks and the blood kept coming up in little blisters on my lips. At night these burst and bled considerably, so that in the morning my lips were always stuck together and I had to bathe them before I could open my mouth. Meanwhile my nails had disintegrated and my hair began to come out in patches. It was very unpleasant.

[cited in Dormandy 2000]

Orwell was at the time working on the second draft of *Nineteen Eighty-Four*, constantly typing in bed with a hand rolled cigarette between his lips, and managed to finish it. The book, an instant success, came out in 1949, six months before Orwell's death in January 1950.

MAT. MED. STREPTOMYCINUM SULPHATUM Streptom-s.

Sources

Observations for 4 days in 12 patients receiving injections of Streptomycin sulfate. [Vakil 1992]

Markings: [2] symptoms found in 2 patients; [3] symptoms found in 3 or more patients; no marking: symptom found in 1 patient.

SYMPTOMS

Mind

= Slow comprehension.

Generals

~ Great weakness. [2]

« *Increased appetite*. [3]

« Desire for meat. [2]

= Desire for pungent food; sweets.

~ Aversion to spicy food.

= Increased sleep. Drowsiness.

« Patient gave up smoking.

Vertigo

» Everything seems to move around and around & tendency to fall to the right or forward.

“Vertigo < rising from sitting [2]; morning [2]; sun; stooping.

- Vertigo > *closing eyes* [3]; *rest* [3]; *lying down* [3]; sitting down [2]; perspiration; eating; drinking ice-cold water.

= Vertigo accompanied by *nausea and vomiting* [3], followed by drowsiness.

« Vertigo accompanied by perspiration [2]; blurring of vision [2].

- Vertigo accompanied by *sensation as if ears were blocked* [3], < noise, > open air.

« Vertigo accompanied by sensation as if insects were crawling in both ears.

Head

= Headache [8 patients]

... D. // Headache, 8 patients and 11 symptoms [2]

Abdomen

« Flatulence lower abdomen, < morning, rice, > passing flatus.

Chest

« Pain left side. Pain right side & pain in back and shoulder.

Urinary

« Has to strain to pass urine. Urine feels hot.

Extremities

» Burning of dorsal aspect of feet.

= Pain in legs.

« Drawing pain in calf muscles, < rest, at night, > walking, motion.

= Sensation of ants crawling on legs, > fanning.

STREPTOMYCES NODOSUS

Bacterium: Streptomyces nosodus Trejo 1961. **Drug:** Amphotericin B.

Brand names: Fungilin. Fungizone. AmBisome.

History: *S. nodosus* yields two antifungal agents, amphotericins A and B, which are produced together during the fermentation process. The antibiotic used clinically since 1956 is amphotericin B.

Uses: Treatment of severe systemic infections and meningitis caused by fungi [Histoplasma, Cryptococcus, Coccidioides, Blastomyces]; fungal peritonitis; irrigant for bladder fungal infections; topically for cutaneous and muco-cutaneous fungal infections [Candida, Sporothrix],

Adverse effects:

- Cardiovascular: Hypotension; hypertension; tachycardia; flushing; fibrillation; flutter; cardiomegaly; myocarditis.
 - = CNS: *Fever; generalised pain; chills; headache; malaise-*, delirium; seizures; psychosis; dysphoria; dizziness; parkinsonian symptoms; hyperthermia; hemiparesis; gustatory hallucinations; hypothermia; vision changes; diplopia.
 - = Endocrine: Hyperthyroidism.
 - = Gastrointestinal: *Anorexia*; nausea; vomiting; black faeces.
 - « Haematologic: *Anaemia-*, leukocytosis; coagulation defects; thrombocytopenia; leukopenia; bone marrow suppression.
 - = Renal: *Nephrotoxicity* [cortical ischaemia]; renal failure; acidosis.
 - « Loss of potassium and magnesium.
 - =< Pain along distribution of lumbar nerves; paraesthesia; nerve palsies [including foot drop]; difficulty in micturition; impaired vision.
 - Alcohol c.
- [Leikin & Paloucek 1998; Goodman & Gilman 1970]

STREPTOMYCES NOURSEI

Bacterium: *Streptomyces noursei* Brown et al. 1953.

Drug: Nystatin.

Brand names: Mycostatin. Nilstat. Mykinac.

Uses: Treatment of cutaneous, muco-cutaneous, oral cavity, and intestinal tract fungal infections, primarily *Candida*.

Adverse reactions: Remarkably low toxicity.

- = Dermatologic: Contact dermatitis.
- Gastrointestinal: Nausea; vomiting; diarrhoea.
- = Respiratory: Wheezing; cough.

STREPTOMYCES PEUCETIUS var. CAESIUS

Bacterium: *Streptomyces peucetius* Grein et al. 1963.

Drug: Doxorubicin.

Brand names: Adriamycin. Rubex.

Uses: Antineoplastic, cytotoxic antibiotic.

Adverse effects:

- = Alimentary tract: *Stomatitis; oesophagitis; nausea; vomiting; diarrhoea; ulceration and necrosis of colon; anorexia-*, mouth ulceration; taste perversion; dry mouth; glossitis.
 - = Cardiovascular: Congestive heart failure; arrhythmia; facial flushing; pericarditis; cardiomegaly; tachycardia; bruising.
 - = CNS: *Somnolence-*, depression; dizziness; anxiety; headache.
 - = Dermatologic: *Alopecia-*, hyperpigmentation of nail beds; radiation recall dermatitis; increased pigmentation in interphalangeal and palmar creases; soreness of palms and soles; plantar callus formation; oedema [face].
 - = Haematologic: *Leukopenia-*, thrombocytopenia; haemolytic anaemia.
 - = Ocular: *Lachrymation-*, iritis; conjunctivitis.
 - = Urinary: Urine *discolouration* [red].
- [Leikin & Paloucek 1998; Wade 1977]

STREPTOMYCES VENEZUELAE

Bacterium: *Streptomyces venezuelae* Ehrlich et al. 1948.

Drug: Chloramphenicol.

Brand name: Chloromycetin.

History: *S. venezuelae* was first isolated by Burkholder in 1947 from a soil sample collected in Venezuela. By 1948, chloramphenicol was produced synthetically in amounts sufficient for general use, and was then found to be of value in the therapy of a variety of infections. By 1950, however, it became evident that the drug could cause serious and fatal blood dyscrasias. [Goodman & Gilman]

Uses: Wide spectrum of antimicrobial activity against Gram-positive and Gram-negative organisms, and rickettsiae, but due to its toxicity usually reserved for treatment of serious infections due to organisms resistant to other less toxic antibiotics.

Adverse effects:

- = Alimentary tract: Atrophic glossitis; black coating on tongue; bleeding gums; stomatitis; nausea, vomiting; enterocolitis; colitis; faecal discolouration [black, blue, blue-green]; cholera-type syndrome.
- = Cardiovascular: Cardiotoxicity [left ventricular dysfunction]; myocarditis; congestive heart failure.
- = CNS: Nightmares; depression; headache; confusion; hallucinations.
- = Dermatologic: Rash; urticaria; epidermal necrolysis; erythema multiforme bullosum; loosening of nails; scarlatina-like rash; angio-oedema.
- = Haematologic: Bone marrow depression; aplastic anaemia; haemolytic anaemia; leukopenia; coagulopathy; red blood cell aplasia; agranulocytosis; porphyria; ecchymosis; petechial purpura; epistaxis.
- ~ Neuromuscular: Paraesthesia fingers, toes; peripheral neuropathy.
- = Ocular: Optic neuritis and papilloedema [esp. noted in patients with cystic fibrosis]; vision colour changes [yellow tinge]; nystagmus; colour vision abnormalities; central scotoma; retinal haemorrhage; paresis of accommodation.
- = Grey baby syndrome [vomiting, meteorismus, loose green stools, flaccidity, irregular and rapid respiration, low temperature, refusal to suck, and ashen-grey colour].

[Leikin & Paloucek 1998; Julian 1984; Wade 1977]

MATERIA MEDICA CHLORAMPHENICOLUM

Chloram.

Sources

- [1] Proving by Homeopathic Drug Research Department of the Midnapore Homeopathic Medical College Hospital, Midnapore [West Bengal]; April 1959-November 1960; method, potencies used, and number of provers not stated. Symptoms in: B.K. Sarkar, *Up-to-date with Nosodes*, 1971. [s]
- [2] Proving by Julian; 1970; 6 provers [3 males, 3 females]; 30c, 7c, 3x. [J]

SYMPTOMS

Mind

- Depressed and lethargic. Tired, no zeal for work. Desire to lie down, [s]
- «• Apathy, depression, extreme muscular weakness. [J]

-
- Likes solitude. Dislike to speak; taciturn. Indifference, [s]
 - = Easily discouraged. Hopeless, [s]
 - == *Sadness*, despair, > rising. [J]
 - Confused. Cloudy sensorium. Forgetful. Cannot recollect thoughts. Vanishing of thought. Uses wrong words in writing. Loss of concentration. As if ideas become jumbled up. [s]
 - = Religious thoughts, [s]
 - = Irritable with disturbed mind. Dissatisfied about his own performance. Presence of other intolerable. Childish peevishness, [s]
 - = Apprehensive. Anxious about future, [s]
 - <= Oversensitive to sounds, [s]
 - = Somnambulism, [s]
 - = *Restlessness*-, must move, gets out of bed due to sensation of heat, must uncover himself and walk about. [J]
 - « *Agitation with necessity to move a great deal*. [J]
 - <= Euphoria after meals. [J]

GENERALS

Temperature

- = Liking for cold in all forms, [s]
- ~ Worse from heat and sunshine, [s]
- = Heat or sensation of heat all over body. [J]

Food & Drink

- = Thirstless, [s]
- = Thirst for large quantities of water, [s]
- *Thirst for large quantities of liquid* [esp. *beer*]. [J]
- Desire for cold drinks, [s]
- ~ Appetite increased or lost, [s]
- = Morbid hunger, causing pain in morning, esp. between 11 and 12 a.m. [J]
- = *Hunger* with empty sensation in stomach in afternoon and around 5 p.m. [J]
- = Extreme sleepiness after meals. [J]
- « Desire for sour things, [s]
- = Desire for salt and meat, [s]
- == Craving for fruits, [s]
- « *Aversion to sugar and sweets*. [J]
- *Colic and diarrhoea after eating sweet pies*. [J]

Sleep

- = Disturbed by dreams, esp. about business, [s]
- Insomnia from mental restlessness, [s]
- > Sleepy but cannot sleep, [s]
- Sleeplessness first part of night, [s]
- Drowsy in morning. Feeling of weakness after sleep, [s]
- Dreams: past events; various diseases, [s]

Modalities

- ~ > Cold applications [heaviness head; burning sensation in eyes; inflammatory oedema and redness eyes; burning sensation ears; abdominal distress; burning rectum]. [s]
- “ > Cold [vesicular eruptions; itching without eruption], [s]
- » > Drinking cold water [dryness and burning throat]. [s]
- => > Pressure [headache; throbbing sensation head; pinching pain in stomach; cramp around umbilicus; stitching pain in right hypochondrium; menstrual pain in lower abdomen; aching pain in limbs; aching pain in left deltoid; bruised pain in calf muscles, esp. left side], [s]
- > Hard pressure [headache; colicky abdominal pain; pain lumbar region; pain knee and ankle joints], [s]
- > Motion [sensation as if brain were contracted; backache; weakness lower limb], [s]
- => Heat [throbbing sensation ears]. [s]
- > Rubbing [aching pain in left deltoid; backache], [s]
- = < Night [aching pain in limbs; itching scabies-like eruption; circular eruptions in inguinal region], [s]

Sensations

- Tightness in head, [s]
- Contraction of brain, <5-7 p.m., motion, > yawning, [s]
- « Emptiness in head, [s]
- ~ Insects in eyes, [s]
- == Protrusion of eyes, > pressure, [s]
- = Navel being drawn towards spine, [s]
- « Long thread along spine, [s]

Pains

= Burning [eyes; ears; nose; throat; stomach; lower abdomen; rectum; urethra (< micturition)], [s]

Discharges

- Watery and offensive [nose]. Yellowish [nose]. Thin, watery [nose], [s]
- = Profuse lachrymation or dryness eyes, [s]
- Epistaxis, [s]
- = Profuse salivation or dryness mouth, [s]
- = Vomiting of yellowish fluid, [s]
- = Stool: dry, hard, knotty; liquid, yellow; offensive, black, [s]
- = Stool soft with *nauseating fetid smell*. [J]
- > Urine profuse or scanty and high coloured, [s]
- = Profuse perspiration, [s]
- = Considerable *axillary sweating*. [J]

LOCALS

Vertigo

- < Rising; motion; warm room, [s]
- > Open air. [s]

Head

- = Headache: frontal; temporal; occipital [> lying down]; vertex [burning sensation], [s]
- = Modalities headache:
 - < sun heat; afternoon.
 - > pressing over eyeballs; hard pressure; pressure; tight bandaging; open air; rest, [s]
- = Concomitants headache:
 - Nausea. Blurred vision. Stiffness of neck. Stupor, [s]

Eyes

- Photophobia & burning sensation in eyes, > dark room, cold applications, [s]

Nose

- = Tip of nose red and painful. Itching of tip of nose, [s]
- = Sneezing with burning sensation, [s]

Mouth

“ Sore blisters on lips and gums. Ulcers on tongue and inside of cheek, [s]
« Fetid breath. Bitter taste in mouth. Bad taste in mouth, [s]

Throat

- Cannot swallow any solid food, [s]

Stomach

- Nausea < for 3 hours after meals; when eating; morning and evening; when stomach is empty; > eating, [s]

Abdomen

-> Flatulent distension lower abdomen < inspiration, motion, [s]

Rectum

« Insecurity rectum < mornings, [s]
- Sudden urging for stool, [s]

Urinary

- Must hurry to urinate. Cannot retain urine, [s]
» Colicky pain in left kidney. [J]

Female

- Pain and heaviness in lower abdomen before menses, > after flow and from pressure, [s]

Back

- Sharp bouts of lumbar pain. [J]
- Lumbar and sacro-iliac pains, right side, extending to right side of back and to between the scapulae.

Part two

VIRUSES

The connections may be invisible, but they are always there,
just beneath the surface.

[Dan Brown, *The Da Vinci Code*]

'KINGDOM' VIRUSES

Sub-microscopic, obligate intracellular parasites, viruses are considered nonliving organisms since they cannot self-replicate and thus are not placed in a kingdom. Viruses have no membranes, no ribosomes on which to make proteins, no cytoplasm, and no source of energy, but consist of just an envelope for protection and a single type of nucleic acid, either single or double stranded RNA or DNA, to direct the synthesis by the host cell of new virus particles. The normal metabolic activities of the host cell is often stopped. This and other changes within the host cell frequently lead to its destruction. The protective envelope is formed from the lipid membranes of the host cell. Some envelopes also have complex proteins formed by the virus. Viruses which lack envelopes are referred to as naked viruses. Complex viruses have a mix of body styles, such as a head and tail portion.

Viruses are not classified like other living organisms; instead, they are classified according to the type and structure of their nucleic acids, chemical and physical characteristics, replication methods, host range, and disease caused. The taxonomy of viruses is similar to that of all other forms of life. The largest unit is the Class, followed by Order [suffix: *virales*], Family [suffix: *viridae*], Subfamily [suffix: *virinae*], Genus [suffix: *virus*], and Species. To date, only three orders have been named, and many families have not yet been classified into orders. Approximately 80 families and 4000 species of virus are known.

Lynn Margulis, in *Symbiotic Planet*, defines them thus:

We are persuaded that viruses do not belong in any of the five kingdoms. They are not alive since outside living cells they do nothing, ever. Viruses require the metabolism of the live cell because they lack the requisites to generate their own. Metabolism, the incessant chemistry of self-maintenance, is an essential feature of life. Viruses lack this. Through ceaseless metabolism, through chemical and energy flow, life continuously produces, repairs, and perpetuates itself. Only cells, and organisms composed of cells, metabolise. Whether capable of invading plants, animals, fungi, or protocists, any virus outside the membrane of a live cell is inert. Viruses nevertheless are important to the story of life on Earth. Since they depend upon the metabolism of others, the first viruses

started as irradiated portions of bacterial cells living in sunlight. Some viruses, quite complex in structure, may look, under an electron microscope, like miniature robots or hypodermic needles. ... The point that bears mentioning is that viruses are no more “germs” and “enemies” than are bacteria or human cells. Viruses today spread genes among bacteria and human and other cells, as they always have. Like bacterial symbionts, viruses are sources of evolutionary variation. Populations of the virus-infected organisms are honed by natural selection. Viruses, like all forms of cell-based life, produce problems when they overgrow their habitats. The high-profile Ebola and other viruses are blamed for wreaking havoc in certain populations. Overgrowth of resources, viral or other, tends to be due to weakening and disruption of the ecosystem. We can no more be cured of our viruses than we can be relieved of our brains’ frontal lobes: we are our viruses.

CLASSIFICATION AND TAXONOMY VIRUSES

DNA VIRUSES

CLASS I - DOUBLE STRANDED DNA

a. Double stranded DNA; naked; polyhedral capsid

- **Adenoviridae**

 - Mastadenovirinae

 - [1] Mastadenovirus

 - *Human adenovirus A - F*

- **Papillomaviridae**

 - Papillomavirinae

 - [1] Papillomavirus

 - *Human papillomavirus* [HPV]
Verrucinum

b. Double stranded, circular DNA; enveloped; complex

- **Poxviridae**

 - Chordopoxvirinae

 - [1] Molluscipoxvirus

 - *Molluscum contagiosum virus*

 - [2] Orthopoxvirus

 - *Cowpox virus*
Vaccinium
 - *Horsepox virus*
Malandrinum [?]
 - *Vaccinia virus* [vaccination strain]
Malandrinum [?]
 - *Variola virus* [smallpox]
Variolinum

c. Double stranded DNA; enveloped; polyhedral capsid

• **Herpesviridae**

Alphaherpesvirinae

- [1] Simplexvirus
 - *Human herpesvirus 1* [HHV-1]
Herpes simplex nosode
 - *Human herpesvirus 2* [HHV-2]
- [2] Varicellovirus
 - *Human herpesvirus 3* [HHV-3]
Varicellinum
 - *Human herpesvirus 3* [HHV-3]
Herpes zoster nosode

Betaherpesvirinae

- [1] Cytomegalovirus
 - *Human herpesvirus 5* [HHV-5]
Cytomegalie
- [2] Roseolovirus
 - *Human herpesvirus 6* [HHV-6]
Herpes Virus Type 6 nosode

Gammaherpesvirinae

- [1] Lymphocryptovirus
 - *Human herpesvirus 4* [HHV-4]
Epstein-Barr virus [infectious mononucleosis]
- [2] Rhadinovirus
 - *Human herpesvirus 8* [HHV-8]
Kaposi's sarcoma-associated herpesvirus

d. Double stranded DNA with a RNA intermediate in replication

• **Hepadnaviridae**

- [1] Orthohepadnavirus
 - *Hepatitis B virus* [HBV]
Hepatitis B vaccinus

CLASS II - SINGLE STRANDED DNA

Parvoviridae

RNA VIRUSES

CLASS III - DOUBLE STRANDED RNA

Reoviridae

Rotavirus

CLASS IV - POSITIVE SINGLE STRANDED RNA

a. Positive single stranded RNA [+ssRNA]; naked; polyhedral capsid

Picornaviridae

[1] Enterovirus

- *Human enterovirus C*
[Human coxsackievirus] Coxsackie virus nosode
- *Poliovirus* [PV]
Polio

[2] Hepatovirus

- *Hepatitis A virus* [HAV]
Hepatitis A vaccinus

[3] Rhinovirus

- *Human rhinovirus A - B* [common cold]

b. Positive single stranded RNA [+ssRNA]; enveloped; usually a polyhedral capsid

Coronaviridae

[1] Coronavirus

- *Human coronavirus* [common cold]

Flavi viridae

- [1] Flavivirus
 - *Dengue virus* [DENV]
 - *Tick-borne encephalitis virus* [TBEV]
 - *Yellow fever virus* [YFV] Yellow fever vaccinum
- [2] Hepacivirus
 - *Hepatitis C virus*

Togaviridae

- [1] Rubivirus
 - *Rubella virus*
Rubella vaccinum

CLASS V - POSITIVE SINGLE STRANDED RNA [+ssRNA] with a DNA intermediate in replication; enveloped; bullet-shaped or polyhedral capsid

Retroviridae

- [1] Lentivirus
 - *Human immunodeficiency virus* Virionum
AIDS nosode

CLASS VI - NEGATIVE SINGLE STRANDED RNA

a. Negative single stranded RNA; enveloped; pleomorphic

Bornaviridae

- [1] Borna disease virus

Filoviridae

- [1] “Marburg-like viruses”
- [2] “Ebola-like viruses”

Paramyxoviridae

Paramyxovirinae

- [1] Canine Distemper Virus
Distemperinum
- [2] Respirivirus
 - *Human parainfluenza virus 1, 3*
- [3] Rubulavirus
 - *Human parainfluenza virus 2, 4*
 - *Mumps virus*
Parotidinum [syn. Ourlianum]
- [4] Morbillivirus
 - *Measles virus*
Morbillinum

Rhabdoviridae

- [1] Lyssavirus
 - *Rabies virus*
Lyssinum

b. Segmented negative stranded; enveloped

Orthomyxoviridae

- [1] Influenzavirus A
 - *Influenza A virus* [Spanish flu; Asian flu]
Influenzinum
Oscillococcinum [?]
Influenza vaccine 97/98
- [2] Influenzavirus B
 - *Influenza B virus*
Influenzinum
Influenza vaccine 97/98
- [3] Influenzavirus C
 - *Influenza C virus* [common cold infection]
Influenzinum [?]

DNA VIRUSES

CLASS I - DOUBLE STRANDED DNA

a. Double stranded DNA; naked; polyhedral capsid

| Family | Subfamily | Genus | Type Species | Remedies |
|---|-----------|----------------|---------------------------|-------------|
| a: double stranded DNA viruses [ds DNA]; naked; polyhedral; capsid | | | | |
| Adenoviridae | | Mastadenovirus | Human adenovirus A-F | |
| Papillomaviridae | | Papillomavirus | Papillomavirus Verruca | Verruccinum |

ADENOVIRIDAE

General

- Family of 51 viruses, identified by sequential letters and numbers [Human adenovirus A - F].
- Widespread in nature, infecting birds, many mammals and man. There are 2 genera, Aviadenovirus [avian] and Mastadenovirus [mammalian].
- The latter were first isolated in 1953 from adenoidal tissue removed from children during tonsillectomy and from military recruits with febrile illness.
- Transmission by respiratory and faecal-oral route.
- Ubiquitous; most adenovirus infections are asymptomatic.
- Aetiological agents of mild to severe respiratory illnesses, pharyngitis [tonsils and adenoids], conjunctivitis [“pink eye”], gastroenteritis, or genitourinary infections [urethritis; haemorrhagic cystitis; cervicitis],
- Associated with 5% of acute respiratory childhood illness and 10% of infantile gastroenteritis.
- Common cause of acute upper respiratory tract infections in military recruits and at boarding schools.
- Can undergo latent infection in lymphoid tissues, becoming reactivated some time later. Virus can be isolated from the majority of tonsils/adenoids surgically removed, indicating latent infections.

Homeopathy

- Probably present in the [obscure] nosode *Tonsilinum*.
- Staufen-Pharma, Germany, produces a nosode termed *Adeno-12-Virus*, which is recommended for “Infections of the upper respiratory tract, Adenoids, Otorrhoea, Sinusitis with tough secretion and frontal headache, Ophthalmia with redness of conjunctivae.”

PAPILLOMAVIRIDAE

General

- Most of the about seventy known types of human papillomaviruses [HPV] are harmless.
- Most of them have distinct anatomic predilections, infecting only certain epidermal sites, such as skin or genital mucosa, eg, common cutaneous warts [verrucae vulgaris], palmo-plantar warts, flat warts [verrucae plana], and genital warts [condyloma acuminata].
- About thirty types are spread by sexual contact, some of which [particularly HPV types 16 and 18] have been linked with cervical cancer and seem to interact with Human herpes virus 2 and HIV.
- Often occurring in clusters, genital warts can be very tiny or can spread into large masses.
- Two virus-like particle [VLP]-based prophylactic human papillomavirus vaccines are currently in the trial phase.

Homeopathy

- *Verrucinum*, the wart-nosode, appears to belong to the collection of homoeopathic curiosities, although Samuel Swan, pioneer in the use of nosodes and morbidic products, had in his possession a remedy called “Verruca menstruo,” with the annotation: “Menstrual blood from a woman who had warts, and with which many have been cured.” [Source: Julian Winston]

Verr. [short for Verrucinum] stands in the repertory under: Extremities, Warts, Hands.

b. Double stranded, circular DNA; enveloped; complex

| Family | Subfamily | Genus | Type Species | Remedies |
|--|-----------|--------------|--------------|-------------|
| b: double stranded DNA viruses (ds DNA); enveloped; circular; complex | | | | |
| Poxviridae | | Horse-grease | — | Malandrinum |
| | | Cowpox | — | Vaccinum |
| | | Variola | — | Variolinum |
| | | Smallpox | — | |

POXVIRIDAE

Plenty of pox

- The family Poxviridae comprises two subfamilies, Chordopoxvirinae and Entomopoxvirinae, of which the former contains a small zoo of genera, such as avipox ['bird-pox'], sheeppox, camelpox, cowpox, swinepox, monkeypox, raccoonpox, buffalopox, rabbitpox, 'human-pox' [variola] and the now extinct horsepox. The subfamily Entomopoxvirinae includes viruses carried by insects.
- The genus Molluscipoxvirus, classified in the subfamily Chordopoxvirinae, contains the Molluscum contagiosum virus, its name referring to the soft, clam-like lesions [L. molluscus, softish] it specifically causes in humans. Distributed worldwide and most commonly occurring in children, the virus is transmitted by direct bodily contact, through minor abrasions, or indirectly via fomites. Swimming pools are a common vector for transmission. Among young adults, it is usually a sexually transmitted disease.

The incubation period ranges from 14 to 50 days, after which pearly, flesh-coloured, raised, umbilicated, painless nodules appear in the epidermal layer of the skin. A relative lack of inflammation and necrosis distinguishes these proliferative lesions from other poxvirus lesions. Lesions may persist for months to years, to disappear spontaneously or following bacterial infection. There are no known systemic complications, although the disease is often more generalised, severe, and persistent in AIDS patients than in other groups, frequently involving the face and upper body.

Inoculation, scarification, variolation

Named 'small'pox to distinguish it from the great pox, syphilis, the disease has been present from remote times. It is thought to be at least 3000 years old, spreading from Africa to India and China. Pock marks have been found on Egyptian mummies. It came into Europe about the 10th century, although epidemics may have occurred as early as AD 180. In the 1500s, Spanish and Portuguese conquistadors brought smallpox to the New World, where it spread to Aztecs, Incas, and Native Americans.

Smallpox has changed the course of history. It probably heralded in AD 180 the decline of the Roman Empire; it ended in 569 the Ethiopian rule in Arabia; it killed in 735-736 several members of the ruling Fujiwara family in Japan, which led to a religious fervour that facilitated the spread of Buddhism; it ravaged the native inhabitants of Mexico in 1520 and was credited with the victory of Cortes over the Aztec empire at Tenochtitlan [present-day Mexico City] in 1521; it killed the Inca ruler and destroyed the Inca Empire [1525- 27]; it decimated in 1617-1619 the Massachusetts Bay Indians population to 10%, who were consequently unable to resist the landing of the Mayflower settlers at Plymouth in 1620.

It eliminated in 1634 95% of the Indians along the Connecticut River, opening up that area to settlement by the English; between 1666 and 1721 four outbreaks struck Boston, the latter prompting the first use of inoculation against smallpox in the New World.

Rulers died of smallpox: Emperor Gokwomyo of Japan in 1654, Queen Mary II of England in 1694, Emperor Joseph I of Austria in 1711, King Louis XV of France in 1774, , and Emperor Komei of Japan in 1867.

In some ancient cultures, smallpox was such a major killer of infants that custom forbade the naming of a newborn until the infant had caught the disease and proved it would survive.

When smallpox prophylaxis by means of inoculation began is not exactly known; estimations range from 1500 BC to AD 1000. The practice appears to have spread from India to China, Western Asia, and Africa, and finally in the 18th century to Europe and North America. The procedure consisted of inoculating pus taken from the pustules of a variola patient on the 12th or 13th day of the illness into the scratched forearm or hand of the recipient. Known as ingrafting, the method was introduced into England by Lady Mary Montagu, wife of the British ambassador at the Turkish court, who in 1717 explained the process in a letter to a friend and promised to introduce it to the notice of the English physicians.

Through the good offices of Lady Montagu smallpox inoculation came into English practice a few years later, albeit on a limited scale, not in the last place because of fierce public objections. Equally great antagonism aroused the attempt of Cotton Mather, a Puritan minister, to introduce variolation during a horrific epidemic in Boston, Massachusetts, in 1721.

Historical data from: George C. Kohn [ed.], *Encyclopedia of Plague and Pestilence-*, Facts On File, Inc., 1995

Vaccination or equination?

While ingrafting, inoculation, scarification and variolation refer to essentially the same thing, i.e. implanting live variola virus, these should not be confused with vaccination, introduced to the world by Edward Jenner [1749-1823] in *An Inquiry into the Causes and Effects of the Variolae Vaccinae*, published in 1798. An English country doctor, Jenner built on an understanding of prevention garnered from folk culture.

In the countryside where he lived there had long been a tradition that milkmaids who had contracted cowpox from the cows they milked were not susceptible to smallpox. Cowpox produced sores both on the udder of a cow and on the human skin which somewhat resembled the pustules of smallpox. In 1796 Jenner formulated a vaccine derived from a milkmaid's cowpox sores and introduced this into the blood, via two cuts in the arm, of an 8-year-old boy named James Phipps. Two years later Jenner came up with a new vaccine. He postulated that cowpox could be traced to the grease of the horse's hocks, a belief motivated by local folklore holding that infection with the grease protected from smallpox. Horse-grease was known to produce large whitish vesicles and subsequent painful open sores on the hands of men. Conjecturing that horse-grease was transmitted to the udders of cows, where then cowpox developed, Jenner held that all genuine cowpox came from horse-grease.

"There is a disease," he wrote, "to which the horse, from his state of domestication, is frequently subject. The farriers [groomsmen] call it the grease. It is an inflammation and swelling in the heel, from which issues matter possessing properties of very peculiar kind, which seems capable of generating a disease in the human body, which bears so strong a resemblance to the smallpox that I think it highly probable it may be the source of the disease." And: "... I feel no room for hesitation respecting the common origin of the disease, being well convinced that it never appears among the cows ... unless they have

been milked by some one who, at the same time, has the care of a horse affected with diseased heels.” “It is the thin, darkish-looking fluid, oozing from the newly formed cracks in the heels, similar to what sometimes appears from erysipelatous blisters, which gives the disease.”

Jenner accordingly used horse-grease for a few experiments performed in 1798. He vaccinated a 5-year-old boy and six other children with grease, that “true and genuine life-preserving fluid” as he called it, direct from the heel of a horse. The boy died of what was diagnosed as “contagious fever.” Whether it was this disastrous result or the public’s sheer disgust of employing something as filthy as horse-grease, the equine grease vaccine’ had to be discarded. Pearson, one of Jenner’s most influential contemporary supporters, criticised the horse-grease cowpox theory and asked Jenner to take the horse out because “the very name of horse-grease was likely to damn the whole thing.”

And so Jenner had to revert back to the use of human and/or bovine cowpox material, although Jenner’s ‘cowpoxing’ seemed to increase the cow-related disease tuberculosis. James Phipps died of TB at the age of 20, as did Jenner’s eldest son Edward - coincidentally at about the same age - who received his first inoculation at the age of 18 months and a second another 18 months later. Phipps had been re-vaccinated 20 times!

Horse-grease

Caused by the horsepox virus, a member of the family Poxviridae, horsepox manifested as typical eruptions, first papular, then vesicular, in the mouth or on the lips and buccal mucosa. However, almost exclusively, they will erupt and form on the pasterns and fetlocks of the horse.

At one time very common in Europe and now regarded as rare or even extinct, the condition was often confused with so-called grease heel, scratches or pastern dermatitis. Of unknown aetiology but widely evident throughout the horse industry, grease heel is defined thus by The Center for Equine Health: “The disease processes start at an early age, progress throughout the life of the horse and often end in disfigurement and disability. It first appears as small, well-demarcated, multiple ulcerations of the skin at the rear of the pastern in any one or all of the four legs.

These ulcerations are covered with crusty exudative material and often bleed, especially during exercise and work. These small sores may seem to respond initially to treatment with topical medications but often reverse course, only to progress in severity and multiply in number. These multiple lesions often

will coalesce into larger and more intractable areas of skin ulceration. They then become chronically infected, produce copious amounts of foul-smelling exudate and chronic thickening of the affected areas of skin.”

Jenner believed horse-grease to be the same pathological entity as human smallpox, modified, however, by its transmission through the cow. When inoculated into man, as horse-grease derived cowpox matter, it produced a localised skin eruption and a slight “constitutional indisposition” which Jenner called “vaccinia.”

Some researchers are of the opinion that horse-grease should be designated as horsepox and that horsepox virus is vaccinia virus. In the days of Jenner both cowpox virus and vaccinia virus existed as viruses causing bovine cowpox and equine horsepox [“grease”]. Others claim that vaccinia is a manmade virus, an animal/human hybrid, created by the passing back and forth of viruses between humans and animals. Another

theory has it that vaccinia came about as the result of arm-to-arm inoculations, the process of taking pus from one patient and using it in another, thereby transforming the virus into something new, vaccinia. To confuse matters even more, still another theory holds that the smallpox virus [variola], when passed through cattle and horses, becomes weakened. The weakened virus, then called vaccinia, is used for vaccination against smallpox.

Vaccinia’s origins remain an unsolved mystery. The virus has no natural reservoir; it is now a laboratory virus. With the pronounced eradication of smallpox in 1979, the routine use of vaccinia has ceased. However, some researchers see the virus as a potential means of delivery for immunisation against other viruses. On November 12th 2001, vaccinia was put to work in South Africa and Switzerland in trials of an AIDS vaccine by the International AIDS Vaccine Initiative, a New York-based charity.

Smallpox vaccination purportedly offers protection against HIV infection, an idea based on the theory that the rapid spread of HIV in central Africa in the 1980s coincided with the widespread discontinuance of smallpox vaccinations. The theory can be reversed just as easily, as was promoted by the English newspaper *The Times* in 1987. It claimed that long-latent, ancient HIV infections were activated when people were vaccinated against smallpox.

“A variant of the smallpox virus may still be alive and active in the world, causing human disease and deaths. The claim that smallpox has been eliminated is contradicted by numerous reports of pox virus transmission in Africa today. This disease has been named human monkeypox because the virus resembles a pox virus found in captive monkeys in 1958. Human monkeypox

exists in rainforest villages of central and western Africa, where it is readily transferred through person-to-person contact. It causes the same symptoms as smallpox, and differs from smallpox virus only in its protein structure, a difference of a few nucleotide sequences.” [Neustaedter]

The virus in the vaccine today is believed to be the same vaccinia virus Jenner created over 200 years ago or it may have arisen at some time during the 19th century. It is definitely *not* cowpox and this dispels the ad absurdum perpetuated myth that cowpox confers immunity against smallpox.

Malandrinum

Made from horse-grease, Malandrinum has an old-time reputation “both as a prophylactic and therapeutic remedy against smallpox and the bad effects of [smallpox] vaccination.” Following Jenner’s hypothesis, H.C. Allen says: “From Jenner we have it that the origin of cowpox is infection of the udders of cows by contact with grass, on which a horse infected with grease has trodden; while the other historical origin from a similar source of infection, also from Jenner, is that it was from the unwashed hands of the stable neys who milked the cows after grooming the horses infected with grease.

These assertions are to some extent confirmed by the clinical experience of many homeopaths, who have successfully used Malandrinum against infection with smallpox, and for the bad effects of vaccination.”

These bad effects include particularly “cases of unhealthy, dry, rough skin remaining for years after vaccination” as well as “impetigo, ecthyma, fat, greasy-looking pustular eruptions.”*

The combination of skin problems and vaccinosis matches both the pastern dermatitis of the horse, if the remedy was made from grease heel, and the adverse effects of smallpox vaccination, if the source was horsepox/vaccinia virus.

Wesselhoeft describes the chronic skin troubles after vaccination that were cured by Malandrinum as crusts formed on raw patches on the skin, the crusts thickening and rising [by the forming of under layer] in conical form to one- half inch; they were fragile, rims yellow. When removed, they would leave a raw surface and deep fissures, and the crusts would re-form in about 48 hours.

It should be noted that the word vaccination as used by the old masters refers to smallpox vaccination, for the bad effects of which Compton Burnett coined the term ‘vaccinosis’, recommending Thuja as the best antidote. In current homeopathy this advice has erroneously been extended to Thuja as an antidote

to *any* vaccination. Compton Burnett considers the following combination of symptoms as typical for vaccinosis: [1] Habitual influenza. [2] Chronic frontal headache. [3] Skin spotted with pimples. [4] Feeling of general malaise.

- Ecthyma may refer to ecthyma as an ulcerative form of impetigo or to contagious ecthyma, also known as contagious pustular dermatitis or sheep-pox. The condition is associated with a poxvirus [orf virus] of the genus Parapoxvirus, the genus being in the same subfamily, Chordopoxvirinae, as cowpox, horsepox, variola and vaccinia. The disease in humans is similar to the disease in sheep, goats and wild ruminants and consists of a ‘chicken pox’ type of lesion usually developing on fingers, hands, face or forearms.

The lesion starts as a small, firm, red-to-blue papule that grows to form a haemorrhagic, flat-topped pustule or bulla. The bulla may have a crust in its umbilicated centre. It is often tender and may bleed easily. Mild fever and malaise may be associated. It is very common among shepherds, veterinary surgeons, and farmers’ wives who bottle-feed young lambs, as well as in butchers and meat porters from handling infected carcasses. [L.H. Hawayek, *Orfi* emedicine.com]

MATERIA MEDICA MALANDRINUM

Malan.

Sources

Introduced and first used by Boskowitz.

[1] Proving by Straube, 1881; 30c.

[2] Proving by Wesselhoeft, H.C. Allen, Steere, Holcombe, and students of the Hering College; 1900-1905; 30c, 35c, 200c; number of provers not stated.

[3] Clinical observations in ill effects of vaccination.

Clinical manifestations of horse-grease infection

“William Morris, aged thirty-two, servant to Mr. Cox of Almondsbury, in this county, applied to me the 2nd of April, 1798. He told me that, four days before, he found a stiffness and swelling in both his hands, which were so painful it was with difficulty he continued his work; that he had been seized with pain in his head, small of the back, and limbs, and with frequent chilly fits succeeded by fever.

On examination I found him still affected with these symptoms, and that there was a great prostration of strength. Many parts of his hands on the inside

were chapped, and on the middle joint of the thumb of the right hand there was a small phagedenic ulcer, about the size of a large pea, discharging an ichorous fluid. On the middle finger of the same hand there was another ulcer of a similar kind. These sores were of a *circular* form, and he described their first appearance as being somewhat like blisters arising from a burn.

He complained of excessive pain, which extended up his arm into the axilla. These symptoms and appearances of the sores were so exactly like the cowpox that I pronounced he had taken the distemper from milking cows. He assured me he had not milked a cow for more than half a year, and that his master's cows had nothing the matter with them.

I then asked him if his master had a GREASY horse, which he answered in the affirmative, and further said that he had constantly dressed him twice a day for the last three weeks or more, and remarked that the smell of his hands was much like that of the horses's heels. On the 5th of April I again saw him, and found him still complaining of pain in both hands, nor were his febrile symptoms at all relieved.

The ulcers had now spread to the size of a seven-shilling gold coin, and another ulcer, which I had not noticed before, appeared on the first joint of the forefinger of the left hand, equally painful with that on the right. I ordered him to bathe his hands in warm bran and water, applied escharotics to the ulcers, and wrapped his hands up in a soft cataplasm. The next day he was much relieved, and in something more than a fortnight got well. He lost his nails from the thumb and fingers that were ulcerated."

[Edward Jenner, *Further Observations on the Variola Vaccinae, or Cowpox*, 1799]

SYMPTOMS

Lassitude

- Confusion and lassitude of the mental faculties with a dread of any mental exertion and a lack of concentration, an entirely new and unusual experience which continued several weeks after stopping the remedy. [2]

Unightly

= Yellowish honey-comb crust on upper lip, an appearance so unightly that "she had excluded herself largely from contact with society and was consequently mentally much depressed and anxious." [cured case; Maland. CM]

Smallpox had disfiguring effects and was by some feared for this very reason: <•
“In the reign of Charles II it is well known that the court beauties envied the dairy-
maids because having had cowpox, they could not take smallpox which all
women so dreaded. Dr. Corlett tells us that the Duchess of Cleveland, one of the
King’s mistresses, on being told that she might lose her place in the royal favour
if she were disfigured by smallpox, replied that she had nothing to fear as she had
had cowpox. [Harris, *Edward Jenner and Vaccination*] “Smallpox was always present
... leaving on those whose lives were spared the hideous traces of its power,
turning the babe into a changeling at which the mother shuddered, making the
eyes and cheeks of the betrothed maiden objects of horror to the lover.” [Haggard]
« In Charles Dickens’s “Bleak House” Esther survives smallpox, drifting in and
out of consciousness, dreaming of striving to reach the top of colossal stair-
cases, never-ending stairs and “strung together somewhere in great black space,
there was a flaming necklace, or starry circle of some kind, of which I was one
of the beads.” All the mirrors have been removed from her rooms. Months after
the illness she regards herself for the first time. “My hair had not been cut off,
though it had been in danger more than once.” Charles Dicken, *Bleak House*.

Sensations

- <= Sensation of great heaviness of body, bed seems insufficient support. [2] =
Feeling of lightness, yet of pressure on top of head; sensation confined to region
above ears. [2]
- ~ Sensation as if a saw were drawn up and down through left eyeball, very painful.
[2]
- ~ Sensation as if tongue were enlarged. [2]
- Feeling of soreness and lameness under jaw and chin when mouth is opened very
wide. [2]
- « Left tonsil, rough scraping sensation like a corn husk or a foreign body, which
must be removed mechanically. [2]
- ~ Sensation of rawness of skin over chest and shoulders, after bathing, as if skin
had been scraped with burning acid, smarting by covering parts. [2]
- Toes felt as if scalded and itched terribly underneath; was compelled to change
hose twice a day, and bathed with cold water morning, noon and night, which
gave >. [2]
- Sensation of a draft of air blowing on feet at night [cold sweat on soles of feet];
must get up and tuck in the bed clothes which >. [2]

= Creepy sensation like crawling of ants. [2]

Before eleven o'clock began to feel a creepy sensation in my skin, particularly in the face, like the crawling of ants over it, accompanied by itching. It was red, and I had to resist a desire to jerk my fingers and twist my hands; this continued and increased even after I had taken my warm bath. Went to bed about twelve very sleepy, but could not get to sleep because I could not lie still on account of creepy sensation which spread over my arms, shoulders and upper part of my body, with jerking of the limbs. I turned from one side to the other, but could not be quiet long enough to get to sleep. Accompanying this was a ringing in my head, as it once had when years ago I had taken quinine, but it was not of long duration. At half-past one I got up and wrote this. My lower limbs did not seem to be affected by any of these sensations, but I kept scratching my arms and face, head and shoulders, and my hands and fingers felt particularly restless and nervous. Had no internal disturbance other than my head. Finally fell asleep at half-past two and slept soundly until six. [1 prover]

Energy

= Low energy. Movements uncertain. [2]

My movements seemed to be uncertain. I was afraid of falling, or tipping. It was difficult work getting in and out of the cars. I had occasion to go up two flights of stairs, very old, narrow and rickety, and was afraid that I should fall on my way down. ... I felt as if I must get home as soon as possible. [1 prover] After I have been walking a very short distance, my legs pain me and get so heavy and my back and hips drag so that I have to sit down, and when I sit down, all these feelings go away, [ibid.]

That day was without pain or other disturbances, except I felt in a state of collapse nearly all day. Had no strength in my arms or legs, and every little while was obliged to lie down wherever I happened to be. Would almost fall asleep and my breathing was very deep and heavy, like puffing. My body felt heavy, and I had difficulty in lifting my legs and walking. Frequently low sighs would come, [ibid.]

Appetite & Thirst

« Thirstless; water nauseates. [3]

= Entire absence of thirst. [3]

= Very thirsty all day. [2]

~ Very hungry. [2]

«• Empty, faint, all gone' sensation, with faintness and trembling, not > by eating, though desire for food is very marked. [2]

Left side

The left side seems more affected, like in Thuja. [Vaccination administered in left upper arm!]

= Sharp darting pain first in left temple then in right. [2]

« Left ear painful on waking. [2]

= Left ear ached and gums on left side of mouth inflamed and swollen; marked salivation. [2]

~ Dryness of nose and throat on left side. [2]

= Left tonsil swollen. [3]

= Throat symptoms and pains in throat begin on left side, and extend to right. [3]

= Itching on back, neck and shoulders, more marked on left side, < undressing and after going to bed. [2]

- Backache, intense in sacral region; in dorsal region, under scapulae, chiefly the left side. [2]

~ Awakes in the morning with left arm very lame and a peculiar restlessness in the arm. [2]

= Pains especially in left tibia, with petechia-like patches on anterior aspect of left leg from knee to ankle. [3]

= Petechia on both thighs, < on left. [3]

~ Left foot drenched with sweat; right foot dry. [2]

Crusts and cracks

~ Thick, greenish crusts with pale, reddish scabs, itching < in evening. [1]

- Tongue cracked and ulcerated down the centre. [1]

~ Deep rhagades [cracks and fissures], sore and bleeding, on soles of feet and palms of hands < cold weather and washing with any kind of soap. [3]

Discharges

- Profuse, purulent, greenish yellow discharge from ears, mixed with blood. [1]

Odours & Taste

= Salty taste in mouth. [2]

= Taste in mouth like the smell of sour milk. [3]

= Horribly offensive breath. [2]

-
- ~ Dark stools, cadaverous smell. [1]
 - ~ Yellowish or blackish, foul smelling diarrhoea. [1]
 - ~ Profuse foot sweat with carrion-like odour.

Skin

- Burning hot feeling in face [cheeks]; skin looks inflamed and shiny. [2]
- Skin of face and neck chaps and smarts after shaving; must shave on warm moist days. [3]
- <• Toes so sore [from foot sweat] unable to walk, only > when feet were bared and elevated. [2]
- Itching or sweating of feet returns on covering or letting feet hang down. [2] = Skin greasy; oily eruption, and hair excessively oily. [3]
- = Itching or prickling on back, arms and legs; relieved by warmth rather than by scratching. [2]
- = Slow pustulation, never ending, as one heals another appears. [3]
- Itching; sensation as if burned. [3]

Circulation

- Great discomfort on lying down in bed, from heart beating very quickly with occasional skipping of a beat; hissing in ears, weak feeling in arms. More comfortable with head propped high. Heartbeat quickened by slightest movement. [2]

CASE

(1) Mr. H., aged 42, American, youngest of ten children; father died at 45, of pneumonia; a brother died at 20, of pneumonia; mother died in old age. Two sisters complain of rheumatism.

Brunette, black hair, dark blue eyes, healthy and athletic, until 21 years old. Never used tea, coffee, alcoholics or tobacco; lived a chaste life, father and brothers the same.

From birth his skin has been rough, dry, harsh; one brother has the same. Skin of palms and soles thick, cracks in cold weather; deep rhagades, sore at bottom; < dry cold weather; < when using soap or any alkali; skin of face and neck chaps and smarts after shaving. Must choose moist warm days for shaving. At 21 had malaria, and was given very large doses of quinine. Never had another chill; but has been constipated ever since, and sciatic rheumatism then set in, < in cold weather, < before storms. Was nearly crippled from it for ten years.

Had sphincter dilated; papillae removed at two different times, but with no

permanent benefit.

Bowels inactive, no desire for stool. Move after an enema, but leave a sore bruised feeling in rectum; dread of stool. Thirstless; water nauseates. Was vaccinated Feb. 1901. A slight "take."

February, 1902, commenced taking Malandrinum 30; noticed improvement in bowel condition. Skin improved.

March. Malandrinum 200, with continued improvement.

April. Malandrinum 500, repeated; hands and feet nearly well. Skin growing thin and smooth. Bowel movement nearly comfortable, and three or four times a week. Could drink several glasses of water a day. Palms crack some yet when exposed to strong alkali or sharp winds. Rheumatism practically gone. Has not been so well for twenty years. Says he feels like a boy again. Can work without weariness, and is becoming agile once more.

[H.C. Allen, *Malandrinum*-, International Hahnemannian Association, 1902]

MATERIA MEDICA VACCININUM

Vac.

Cowpox

Cowpox virus has been found only in Europe and in adjacent parts of the former Soviet Union. Despite its name, the reservoir hosts of cowpox virus are rodents, from which it can occasionally spread to cats, cows, humans, and zoo animals, including large cats and elephants. Transmission to humans has traditionally occurred via contact with the infected teats of milking cows.

However, currently, infection is seen more commonly among domestic cats, from which it can be transmitted to humans.

After an incubation period of generally 9 to 10 days, localised pustular lesions occur, usually on the hands or face, and occasionally accompanied by fever, conjunctivitis, respiratory difficulties, and myalgia. The lesions differ from those of smallpox [variola] in having greater epithelial thickening and less rapid cell necrosis.

www.stanford.edu/group/virus/pox/2000/cowpox_virus.html

Cowpox

Host: rodents, cats, cows, humans.

Spread by contact.

Symptoms:

Pustules -hands, face

Fever

Conjunctivitis

Muscular pain

Sources

Vaccinum is prepared from [primary] cowpox lymph used for vaccination. The remedy was employed as a prophylactic against, and to modify the course of an attack of smallpox.

Drug picture based on

[1] Clinical effects [s] or initial aggravations [F] of Vaccinum; Swan and Fincke.

[2] Fragmentary proving by Power, 1852, self-experimentation with 3x.

[3] Clinical observations by Erika Scheiwiller-Muralt [EJ. /See Variolinum]

SYMPTOMS

Mind

= Nervous depression, impatience, irritability, disposition to be troubled by things.

[F]

= Confusion, she does not remember things at the time she wants them. [F; this symptom occurred after inoculation with matter derived from a smallpox scab.]

« Morbid fear of taking smallpox.

Case 1. Lucy, age 35, waiting-maid, “had great fear of the smallpox; heard there was a great deal of it in the city; feared to go out of doors lest she should catch it; felt very well; had no pain or unpleasant sensation; had never felt the same fear of the disease before; had been near the disease previously, but had not fear of it.” Gave Vaccin. 30, a powder night and morning. The following night she felt chilly, followed by fever, dull headache, and severe pain in small of the back as if broken; the second day after, was quite well, and all the fear of the smallpox had vanished.

Case 2. Ellen, age 25, a hearty, healthy, rosy-cheeked chambermaid; was afraid to go out for fear she should take the smallpox; saw a great deal about in the papers [the usual five-line paragraph]; knew she should catch it if she went in the street; felt perfectly well. Gave Vaccin. 200, Jenichen, a powder night and morning. Next day she had dull headache in occiput, creeping chills, with very bad pain in back; fever at night. The third day quite well; all fear of the smallpox was gone.

Case 3. In a subsequent case, there was the same dread of the disease, and fear of taking it, which disappeared after one dose of Vaccin. IM, Jenichen, without the symptoms that followed the exhibition of the lower potencies in the previous cases, [s]

Head and face

= Sensation as if forehead would split in two in the median line from the root of nose to top of head. [F]

« Forehead feels as if split horizontally. Both horizontal and vertical pain: ‘The Cross’! [E]

- Sensation as from a tight band around the forehead [rarely with Vario.]. [E] « Swelling of the neck under right ear [parotid gland], with sensation like being cut. [F]

« Puffed red face and red eyes, with small pimples on face and hands. [F]

= Redness and swelling of face, chill running down back. [F]

Alimentary

~ Dry mouth and tongue. [P]

= Coffee tastes sour. [F]

• Appetite gone, and disgust to taste, smell, and appearance of food. [P]

External throat and chest

- Coolness at throat, anteriorly down the breastbone, in and outwardly. [F] «

Stitches in right side under short ribs in front from right to left and then at corresponding place in left side, but from left to right, lasting five minutes. It was felt distinctly, not in the ribs but deeper inward, in liver and spleen. [F]

“ Shortness of breath, with aching in pit of stomach and pressure in region of heart. [F]

Back and extremities

~ Weakness in small of back coming on suddenly when walking; went home and to bed and it then gradually passed off. [F] [Compare Malandrinum]

« Aching pain in back, worse in lumbar region, extending around waist, [s] «

Severe pain in left upper arm at vaccination mark; could not raise arm in morning. [F]

= Severe aching of the lower limbs, amounting to an almost unfitness to get about in the performance of my daily avocation, and which cannot be better described, than by the appellation of a break-bone sensation - i.e., my legs ached immoderately, and to the aching was conjoined a sensation, as if the bones were undergoing the process of comminution [to break into minute fragments]. [P]

~ Soreness of lower limbs, as if heated or overexerted. [P]

Skin

== Tingling burning sensation in the skin, over the whole body, similar to the

sensation of an eruption of fever blisters on the lips, nose, cheeks, etc., the sensation being very and most intense in the skin of the forehead, and of the lower and anterior portion of the hairy scalp, which on examination in a mirror, revealed the fact, that those portions of the skin were “tinged” with a scarlet blush, or efflorescence, precisely similar in appearance to that which I have always seen as the most immediate precursor, and certain sign of an immediate variolous eruption. [P] [“Seriously alarmed now, at the prospect, as I feared, of an eruption on the face, which would interfere with the discharge of my official duties, the further prosecution of the experiment was unfortunately instantly terminated,” resulting in antidoting the action of Vaccinum with Ant-t. 3x.]

Indications

« Neuralgias, inveterate skin eruptions, chilliness, indigestion with great flatulent distension, are leading features of the vaccinal dyscrasia, and therefore indications for the nosode. [Clarke]

= Aggravation time of Vac. is the early morning. [Burnett]

VARIOLA - SMALLPOX

Clinical manifestations of smallpox

Smallpox is spread through respiratory transmission of virus found in the oropharyngeal secretions of infected individuals. There are two clinical forms: variola major and variola minor. The two forms show similar lesions, although the disease follows a milder course in variola minor. The incubation period for both forms is between 10-14 days. The onset is acute, with fever, malaise, headache, prostration, severe backache and, less often, abdominal pain and vomiting. After the initial toxæmia phase, lasting four to five days, the temperature falls and the characteristic rash appears, first on the buccal and pharyngeal mucosa, the face, and the forearms, to spread to the trunk and lower limbs within a day.

The centrifugal distribution of lesions, more prominent on the face and extremities than on the trunk, is a distinctive diagnostic feature of smallpox. [In contrast to the rash from varicella, which progresses from the limbs centrally.] Lesions progress from macules to papules to vesicles to pustules. Lesions favour ventral surfaces and all lesions in a given area progress together through these stages. Unlike in varicella, where lesions in different stages are

present, the exanthema of variola is synchronous, with numerous monomorphic lesions. From 8 to 14 days after the onset of the rash, the lesions dry up and become crusted. By the end of the third week, most crusts have fallen off, with the exception of the palms and the soles, leaving depressed hypo- or depigmented scars upon healing.

The rare haemorrhagic type smallpox ['black pox'], apt to appear in immunocompromised individuals, is associated with bleeding from the conjunctiva and mucous membranes, very severe toxæmia, and early death, usually before the lesions of the skin have developed. Flat-type or malignant smallpox, another clinical type, is characterised by severe toxæmia and delayed appearance of the skin lesions, which are commonly flat and soft or velvety, and do not develop to the pustular stage.

Between 65-80% of survivors were marked with deep-pitted scars [pockmarks], most prominent on the face. Blindness was another complication. In 18th century Europe, a third of all reported cases of blindness was due to smallpox.

Headache, backache, fever, vomiting, and general malaise all are among the initial signs of infection. The headache can be splitting; the backache, excruciating. Lakota [Sioux] Indian representations of smallpox often use a spiral symbol to illustrate intense pain in the midsection. Anxiety is another symptom. Fretful, overwrought patients often die within days, never even developing the distinctive rash identified with the disease. ...

In most cases, the rash turns outward, covering the victim in raised pustules that concentrate in precisely the places where they will cause the most physical pain and psychological anguish: The soles of the feet, the palms of the hands, the face, forearms, neck, and back are focal points of the eruption. Elsewhere, the distribution is lighter. ...

If the pustules remain discrete - if they do not run together - the prognosis is good. But if they converge upon one another in a single oozing mass, it is not. This is called confluent smallpox, and patients who develop it stand at least a 60% chance of dying. For some, as the rash progresses in the mouth and throat, drinking becomes difficult, and dehydration follows. Often, an odour peculiar to smallpox develops. "The smallpox pustules begin to crack run and smell," wrote a Boston physician in 1722. A missionary in Brazil described a "pox so loathsome and evil-smelling that none could stand the great stench" of its victims. Patients at this stage of the disease can be hard to recognise. If damage to the eyes occurs, it begins now.

[Fenn, *Pox Americana*]

Adverse effects of smallpox vaccination

For routine smallpox vaccination the live *vaccinia, virus* has been used. [Routine vaccination has ceased in the 1970-80s in all 158 member countries of the WHO. Currently, U.S. military recruits are vaccinated because of concerns about biologic warfare.] The virus is closely related to the variola virus. Most existing vaccine stocks and the vaccine used in the WHO eradication campaign consist of pulp scraped from vaccinia-infected animal skin, mainly calf or sheep, with phenol added to a concentration sufficient to kill bacteria but not so high as to inactivate the vaccinia virus.

The vaccine is administered by intradermal inoculation by multiple puncture with a bifurcated needle. The primary response consisted of a papule at the site of vaccination which, a few days later, became vesicular and dried on the 9th or 10th day from the centre outward. The brown scab fell off after about three weeks, leaving a scar, a mark, by which previous vaccinees could [and can] be recognised. Complications from the vaccinia virus can be mild, moderate, and severe. Mild adverse reactions include local pain and tenderness, swelling, and erythema at the injection site. Many people report flu-like symptoms and itchiness for three weeks after the vaccination.

Moderate adverse reactions include joint pain, diarrhoea, dizziness, hyperkinesia, drowsiness, pruritis, rash, perspiration, and vasodilation. Back and abdominal pain, nausea, and vomiting can occur within the first 10 minutes of injection. Chills, fever, headache, myalgia, and fatigue can begin at the end of infusion and continue for hours.

Severe adverse reactions include skin eruptions and encephalitis.

- Eczema vaccinatum occurred in vaccinated persons or unvaccinated contacts who were suffering from or had a history of eczema. In these cases, an eruption occurred at sites on the body that were at the time affected by eczema or had previously been so.

These eruptions became intensely inflamed and sometimes spread to healthy skin. Symptoms were severe. The rash is often accompanied by fever and lymphadenopathy, and affected persons are systemically ill.

- Generalised vaccinia [GV] occurred in otherwise healthy individuals and was characterized by the development, from six to nine days after vaccination, of a generalized rash, sometimes covering the whole body. The condition manifests as a disseminated maculopapular or vesicular rash. Pearly vesicles may appear, which resemble smallpox lesions but do not have the centrifugal distribution

characteristic of smallpox. GV rash might be preceded by fever, but usually, there is no systemic involvement. Lesions can be present anywhere on the body, including the palms and soles and can be numerous or limited.

- Progressive vaccinia [vaccinia necrosum] occurred only in persons who suffered from an immune deficiency. In these cases the local lesion at the vaccination site failed to heal [progressive necrosis], secondary lesions sometimes appeared elsewhere on the body [skin, bones, and other viscera], and all lesions spread progressively until - as was likely - the patient died, usually 2-5 months later. The differential diagnosis of PV includes severe bacterial infection, severe chickenpox, other necrotic conditions [eg, gangrene], and disseminated herpes simplex infections.

- Postvaccinal encephalitis, the most serious complication, occurred in two main forms. The first, seen most often in infants under 2 years of age, had a violent onset, characterised by convulsions. Recovery was often incomplete, leaving the patient with cerebral impairment and paralysis.

The second form, seen most often in children older than 2 years, had an abrupt onset, with fever, vomiting, headache, and malaise. Symptoms can progress to loss of consciousness, amnesia, confusion, disorientation, restlessness, delirium, drowsiness, seizures, and coma with incontinence or urinary retention, obstinate constipation, and sometimes meningismus. The fatality rate was about 35%, with death usually occurring within a week.

[WHO Fact Sheet on Smallpox, October 2001; CDC Report on Smallpox Vaccination and Adverse Reactions, Feb. 2003]

Heart pain [angina pectoris] and heart attack [myocardial infarction] also have been reported following smallpox vaccination. Mercola holds the opinion that “this vaccine is no walk in the park. Many whose immune systems are already challenged with high insulin levels and autoimmune diseases will never recover from the damage this vaccine causes.”

Vaccination is contraindicated for certain groups. These include pregnant women, persons with a history of eczema or atopic dermatitis, and persons with weakened immune systems, such as organ transplant recipients, HIV positive individuals, or patients on cancer chemotherapy. Cases of foetal vaccinia infection have been reported, commonly after primary vaccination of the mother in early pregnancy. Foetal vaccinia is manifested by skin lesions and organ involvement, and often results in foetal or neonatal death.

The skin lesions in the newborn infant are similar to those of generalised vaccinia or progressive vaccinia and can be confluent and extensive. Smallpox vaccine is not

MATERIA MEDICA VARIOLINUM

Vario.

Sources

Remedy made from the contents of the ripened pustule of smallpox.

Most of the symptoms in the old materia medica are derived from its use as a prophylactic or to modify the course of smallpox.

[1] Clarke cites a case of Swan, who used to prescribe Variolinum at the onset of the disease:

Miss H., 21, healthy, hearty, complained of the following symptoms: Confusion of head as if going crazy, with a sensation as if it was all in the back of the head and running down spine, followed by intense, heavy, hot headache in back of head and neck and region of medulla, sensation as if head weighed a hundredweight, with a tendency of it to fall backwards, deathly nausea in throatpit during headache.

During headache hands and feet icy cold, particularly the hands, tongue coated yellow in morning, with bad, disgusting taste in mouth, no appetite, knees feel weak as if they would give way, especially on going down stairs, pains in thighs and hips, severe aching, burning pain in small of back, skin hot and dry, pulse not feverish.

Vario. CM [Swan], in water, cured in six hours, the confusion of the head ceased after the pain did.

[2] Swan's 'proving' involved the administration of Variolinum CMM to 200 institution children in New York, "mostly waifs and strays," where he was medical officer. In five days, 160 children were ill, some even bedfast, with the usual preliminary symptoms of smallpox, while 25 of them produced later the characteristic smallpox pustules, some umbilicated, some purulent; "but these passed away, leaving no scars." Before these children had recovered their vitality and without Swan's knowledge 23 of them were vaccinated. All but one took and had terrible ulcers on the arms and had to be remedied by Vac. [CM, Swan].

[3] Nearly all symptoms recorded by Swan, and listed in Hering's Guiding Symptoms, come from *only two* cases.

[1] Terrible pains in back on right side of spine, and over and below shoulder blade; muscles sore to touch, nausea, pains all over especially in legs; tongue clean; pulse 120; Variolinum CM; body completely covered with large pustules,

face one mass of confluent pustules, pulse still high, constant expectoration of viscid mucus, mouth and fauces lined with pustules, even tongue covered with them; bowels constipated, mild delirium at times; eight days later temperature 104 1/2; pulse 120, very weak and stopping at intervals; great fear of death; begging to know if he must die, and before sentence was completed would drop into a heavy sleep with stertorous breathing, jaw dropped on chest, pupils contracted, teeth covered with thick brown slime, centre of tongue perfectly black, mucous membrane of mouth and pharynx of a deep purplish-crimson, with gangrenous appearance and breath horribly offensive; skin of face and neck of a deep dark purple; odour from body like a fetid stream; little control over tongue or jaw, latter hanging down, and tongue protruding like a mass of decayed liver when asleep; an effort to speak when roused up caused violent trembling of jaw and tongue, which was drawn back into mouth with difficulty, was stiff, but looked like a mass of putrid flesh; urine dark coloured, passing freely through whole attack; had continued the CM till now, gave one dose CM dry on tongue; next day almost convalescent; made a good recovery with but few marks.

[2] Severe chill followed by high fever; severe pain in back as if broken; pain all over head, very severe and constant in occiput; frequent bilious vomiting; thick, dirty, yellowish coating on tongue; wild delirium and spasms; night before eruption appeared obstinate constipation; on third day very thick eruption of small-pox pustules, soon assuming confluent form, Variolinum CM.

[4] If symptoms cured by Swan with Variolinum are accepted in the materia medica, then this should also go for those cured by Riickert.

Riickert, a student of Hahnemann, reported the following symptoms as being cured with Variolinum:

Case 1. Symptoms: Some pocks had come out; an immense number was coming out; they appeared afterwards in the mouth, nose and urethra. Pulse hard, irritated. Face hot, glowing, red. Delirium with open eyes, uses wrong words frequently, and sees ghosts. The eyes are red, shining, fiery. All her movements are sudden, animated. Hurried speech. Violent thirst. The second dose produced a general feeling of comfort.

[The second dose was given the day after the first dose on account of delirium having set in. Two more doses were given on the 5th and 16th day. The disease lasted 20 days from the eruption to the complete desiccation.]

Case 2. Child of seven weeks. Symptoms: Violent heat all over the body. The

child is very nervous; weeps all the time. The whole body is covered with small, red, elevated stigmata and blotches; on the back there are some pocks almost fully developed. The fever disappeared the next day; the pocks ceased to grow, and those which had come out dried up very soon.

[Cured with one dose of Variolinum. The disease lasted five days.]

Case 3. Dangerous variolous ophthalmia. Symptoms: Violent ophthalmia with photophobia. Copious lachrymation. Stinging pains in the eyes; has to press something hard against the eyes all the time. In spite of remedies, a pannus came on, hindering sight altogether. *Variolinum* restored the sight completely. Case 4. *Variolinum* removed within ten hours violent burning pains in the feet in a young man of eighteen years, sick with smallpox. The eruption was very thick and of a miliary character, with violent fever and delirium; the whole body swelled up, and the red eruption looked as if it had been pressed down, like herpes. *Variolinum* changed the exanthema to fine large pocks, which dried up soon.

[5] Turner's 'proving of Variolinum' [Hom. Recorder, 1907, p. 71] was conducted during the smallpox epidemic in Boston, in the autumn and winter of 1901. The 'provers' were Mrs. X and her daughter, who "desired to be protected, but not by means of vaccination." Both were given Variolinum 1M [Fincke], two doses dry on the tongue, one Nov. 22^{nc} at night and the other in the morning of Nov. 23^k

[Mrs. X] On Nov. 24^a a vesicle appeared on the left side of her neck, the top being rubbed off, it promptly became sore and itched severely. It gradually enlarged until the areola, which was sharply defined, very red and angry, was at least seven-eighths of an inch in diameter; standing up from this inflamed base were light yellow ray-like scales in general thickness and colour like psoriasis. These rays were discrete and arranged about the clear red centre, which was perhaps three sixteenths of an inch across, radiating from thence toward the periphery like the spokes of a wheel.

The spot gradually improved but did not disappear for over two weeks and it itched a great deal. During this time other spots appeared, one over the left scapula, one on each arm, at about the insertion of the deltoid, and, at the end of the fortnight, another on the left arm near the first one there; also a small one near that on the neck. All the spots were of the same character though less marked than the first which appeared. *There were no systemic symptoms.* [Emphasis added.] [Daughter] On Nov. 24¹¹ spots appeared on the right arm, one above and two

below the elbow, all on the flexor surface to the ulnar side, in character like those on prover 1. Later, about the fourteenth day, another spot came on the left arm above the elbow, also on the flexor surface. All the spots itched severely, as did those on the first prover. *No systemic symptoms* with the second prover. [Emphasis added.]

While both had been vaccinated years before, neither prover ever had any eruption of a similar character except that Miss X when she had varicella had one umbilicated pustule; otherwise the attack of chickenpox, though accompanied by a severe cough, was not extraordinary.

[6] A modern, valuable contribution comes from Switzerland, where homeopathic physician Erika Scheiwiller-Muralt performed a case study with smallpox nosodes. On the basis of some 200 successful cases, she found that “smallpox nosodes such as Variolinum, Vaccinum and Malandrinum are able to cure deeply rooted disorders in cases where well-chosen homeopathic remedies failed,” leading her to propose the existence of a smallpox miasm.

[Erika Scheiwiller-Muralt, *Variolinum, Vaccinum and Malandrinum: The powerfull smallpox nosodes and their therapeutic use-*, Hom. Links 4/02]

SYMPTOMS

[B = Boger. ES = Erika Scheiwiller-Muralt. R = Riickert. S = Swan]

Mind

- Fear of death, wild excitement and begging to know if he was to die, and before the sentence was complete, he drops into a heavy sleep with loud breathing. [s]
- = Fear of death / despair about recovery, esp. at times of illness in the evening before falling asleep. [ES]
- Marked sense of duty. [ES]
- = Very good concentration and memory. [ES]
- Delirium with open eyes, uses wrong words frequently, and sees ghosts. The eyes are red, shining, fiery. All her movements are sudden, animated. Hurried speech. [R]

Generals

- Cures neuralgia left by herpes zoster. [B]
- Very profuse, bad smelling perspiration, [s]
- « Sudden and intolerable fatigue:

-
- Jaw falling when asleep, with trembling when aroused, [s]
 - Before snowfall and thunderstorm. [ES]
 - = First three days of stay in mountains [while fit at the seaside]. [ES]
 - « After emotional shock and fright. [ES]
 - « After pain. [ES]
 - « As a first sign of disease. [ES]
 - Faintness. [ES]
 - Syncope in attempting to rise [from loss of sleep; when hungry; from fright; from pain; in snow-air; before thunderstorm; first three days being in mountains; convalescence].
 - Fainting [from pain; after vaccination; after operation; from strong odours; from nausea; after blood donation].

Variolinum has fainting at the least provocation: when hungry, when thirsty, by loss of sleep, with sudden pain, and so on. *Variolinum* faints suddenly before an attack of vertigo.

Vaccininum faints also, but the trigger has to be stronger: being hungry and overworked and loss of sleep. Sudden pain is the final trigger on top of all, which leads to fainting. *Vaccininum* often has vertigo.

Malandrinum is stronger. Although fainting is rare, it can however be observed immediately following a vaccination and during high fever [as with *Vario*, and *Vac.*].

- « It is a remedy to be considered in cases of Vertigo that do not clear on the indicated remedies - it is common for people to faint when they are immunised; the shock of the trauma *and* introduction of a poison into the system might be enough to mean that indicated remedies do not work until the nosode of the vaccine is given.

[Colin Griffith, *Should We Still Remember Smallpox?* Prometheus, No. 9, Dec. 1998]

Alimentary canal

- ~ Thick dirty yellow coating on tongue, [s]
- = When asleep tongue protruded, black coating, when raised it is with difficulty drawn back; looks like a mass of putrid flesh, [s]
- « Teeth covered with thick brown slime, [s]
- ~ Throat very sore, redness of fauces, [s]
- « Painful deglutition, [s]
- Sensation as if throat were closed, [s]

-
- Sensation as of a lump in right side of throat, [s]
 - = Diphtheria with horrible fetor oris, [s]
 - = Soreness in pit of stomach and across epigastric region, [s]
 - ~ Severe pain in precordial region, frequent nausea and vomiting of bilious and bloody matter, [s]
 - « Frequent bilious vomiting, [s]
 - As soon as he drinks milk he vomits it up. [s]
 - Thin, bloody stools, [s]
 - ® Several brown, green, at last grass-green stools, painless, loose, of intolerable fetid odour, [s]
 - = Dysentery, [s]
 - Constipation, [s]

Sensory

- Green vision on rising. [B]
- = Chronic ophthalmia with loss of sight, [s]
- ~ Violent ophthalmia with photophobia. Copious lachrymation. Stinging pains in the eyes; has to press something hard against the eyes all the time. [R]
- = Pupils contracted, [s]
- Deafness, [s]
- « Food, especially water, taste sickish sweet, [s]
- = Every odour nauseates. [B]

Head

- <= Headache / migraine. Pain rising from nape of neck to top of head and to forehead. [ES]
- = Forehead and all over head,
 - < Cold and dry north wind.
 - < Loss of sleep.
 - < Fever. [ES]
- = As if a band tightly encircling head, [s]
- <= Intolerable pain in occiput, [s]

Urinary

- = Urine: high-coloured, like brandy; turbid and offensive; stains a rose teacolour, [s]

Male

« Enlargement of testicle, [s]

« Hard swelling of left testicle in consequence of a contusion, [s]

Female [ES]

- Easy conception in spite of irregular menstrual cycle, esp. at seaside, in warm and dry weather.

~ Good health during pregnancy.

« Labour pains are only felt in the back [in more than 80% of cases].

= Protracted and painful birth.

- Caesarian section, forceps delivery and Ventouse extraction [method using a vacuum suction cup on the crown of the baby's head] occur in a far higher than average percentage [in Variolinum patients].

Respiratory

= Oppressed respiration, [s]

= Asthma. [s]

« Troublesome cough, with serous and sometimes bloody sputa, [s]

- Hawking up thick, viscid slime, smelling bad. [s]

» Cough, tormenting and persistent, in wet weather and rainy spring. [ES]

Back and limbs

« Stiffness of neck, with tense drawing in muscles, < motion, [s]

= Pains in muscles of back like rheumatism, < motion, [s]

~ Pain in base of brain and neck, [s]

~ Chills like streams of ice-water running down from between scapulae to sacral region, [s]

= Intolerable aching in lumbar and sacral region, [s] Pain as if broken, esp. when rising. [ES]

= Hands icy-cold, [s]

~ Violent burning pains in feet. [R]

Skin

= Acne vulgaris [face; decollete; back]. [ES]

= Cicatrices. Keloid. [ES]

<= Dry skin. [ES]

- Sensation as of bugs crawling under skin. [B]

= Ulcers look scooped out. [B]

= Eczema of palms. [B]

=> Tyler finds that the pitting of the skin due to the scars left behind after smallpox can be mitigated by Variolinum. She writes: "Cases with histories of smallpox forty to fifty years before, treated by Variolinum with marvellous improvement, till friends have asked, 'Why, whatever have you done to your face?'"

Modalities [ES]

Aggravation:

- Wet. Cold damp weather. Humid climate.
- = Snow-air.
- = Before thunderstorm.
- = When hungry or thirsty.
- = Strong odours.
- = Chlorinated water.
- <= Fever.

Amelioration:

- « Dryness.
- = Warmth.
- « At seaside.
- = Motion.
- « Sleep.
- <=> Eating and drinking.
- => Lying down.

Common symptoms of Variolinum, Vaccininum and Malandrinum [ES]

- Sense of duty.
- ~ Fear of death.
- «= Despair about recovery.
- « Fear that something will happen.
- Hypersensitivity to:
 - Chemical elements [esp. chlorine and nickel];
 - Nutritional supplements;
 - Body care products [skin reactions];
 - Drugs and anaesthetics;
 - Vaccinations [in general].
- ~ Sensitive to / ailments from:
 - Injuries of the coccyx.

-
- Injuries in general.
Cold weather; dry north wind; snow-air [sudden fatigue]; thunderstorm [sudden fatigue].
- => Weakness; general malaise; weakness; leaden tiredness.
 - = Fainting.
 - = Restlessness. Restless sleep; insomnia.
 - Chills running down the back.
 - = Aching in all limbs and joints. Knee pain.
 - = Frontal headache; violent headache.
 - ~ Conjunctivitis.
 - = Nausea, vomiting, diarrhoea.
 - = Back pain [lumbar and sacral, as if beaten]; pain in bones; stiffness nape of neck; broken-bone sensation.
 - = Cracked skin. Rough skin in winter.
 - <= Acne.
 - = Felons.
 - ~ Sensitive skin.
 - = Acute illness indications:
 - Smallpox.
 - Measles.
 - Herpes. Herpes zoster.
 - Contagious impetigo.
 - Influenza.
 - Bronchitis.
 - Pneumonia.
 - Whooping cough.
 - Sinusitis.
 - Back pain, as if broken.
 - Adverse effects of vaccinations in general.

CASES

(1) A child of 4 years in our family had a severe attack of smallpox from which she eventually recovered. But though she recovered, she did not regain her original health or vigour. On the contrary, she started weakening and emaciating steadily. She became more and more listless and inactive and soon she ceased to stand up or walk. Later on still, she failed to sit up also; she could only lie down. She even stopped speaking; when she wanted anything she would merely roll her eyes. Her condition was most pathetic but none of the several physicians whom

we consulted could do anything because all investigations that had been done failed to show the presence or nature of any gross disease. However, it was very clear that the child was declining very rapidly in health and perhaps in another fortnight or a month she would be lost to us.

At this stage, a homeopath friend of mine arrived and I consulted him about this child. Without thoroughly examining the child but only on hearing the history that the child had been declining since the attack of smallpox, he prescribed three doses of Variolinum 30, 200, 1000 to be given one dose each on three successive days. I was rather perturbed that this physician instead of taking very active steps, was merely putting his whole faith in three little powders of medicine.

But strange to say, within a week the child's condition was reversed; she started regaining all her original activity and also grew as chubby as before, and in the course of a month or two became perfectly normal. In the words of the father of the child, the child regained her original vivacity and vitality and he considered that homeopathy had justified its greatness by this single case.

I may also mention another interesting case. Once I had gone to Kota for a private visit. I was then casually consulted by a gentleman for his daughter aged 16 years. She was very backward in her studies and had failed in the same class for 3 years. I noticed that the girl had deep smallpox scars on her face. On enquiry, I learnt that indeed she had a severe attack of smallpox and that since then she had become retarded. Without bothering further, I prescribed for her Variolinum IM. Thereafter I heard reports of her excellent progress. She got a double promotion in school and also came first in rank in her new class!!

[P. Sankaran, *Some Notes on the Nosodes*]

c. DOUBLE STRANDED DNA; ENVELOPED; POLYHEDRAL

| Family | Subfamily | Genus | Type Species | Remedies |
|---|--------------------|-----------------------------------|--|-------------------------|
| c: double stranded DNA viruses [ds DNA]; enveloped; polyhedral; capsid | | | | |
| Herpesviridae | Alphaherpesvirinae | Simplex virus (Herpes simplex) | — HHV 1 + 2 | — Herpes Simplex nosode |
| | | Varicellovirus | — HHV 3 Chickenpox | — Varicella nosode |
| | | Herpes zoster | — HHV 3 Shingles | — Herpes zoster nosode |
| | Betaherpesvirinae | Cytomegalovirus | — HHV 5 | — Cytomegaly nosode |
| | | Roseolovirus | — HHV 6 | — Herpes virus 6 nosode |
| | Gammaherpesvirinae | Lymphocryptovirus | — HHV 4 Epstein Barr Infectious mononucleosis | |

HERPESVIRIDAE

General

- Large family of more than 90 members “that harass innumerable species, from us down to the lowliest fungi,” as Biddle maintains. “They have been around for eons and are found in people everywhere, even in isolated primitive tribes. All have the capacity to survive for the entire lifetime of their host, hiding in nerve cells, sometimes producing symptoms of disease, often not. They have been implicated in causing cancer. Nothing can eradicate them from the body once they gain entry.”
- Reactivation from latency is characteristic of herpes viruses. It occurs in immunocompromised hosts, eg, in nearly half of all bone marrow or solid organ transplant recipients two to three weeks following the procedure. Except for the individual’s immune status, other triggers may reactivate the dormant virus as well. These include stress, flu-like infections, sunlight, menstruation, sexual conflict or ambivalence, foods containing high levels of the amino acid arginine [chocolate, peanuts, grains, beans], and deficiencies of vitamin A, B complex, iron, zinc, and folic acid.

ALPHAHERPESVIRINAE

HHV-1 & 2 - Herpes simplex

- Herpes simplex comes in two closely related types. HHV-1 causes cold sores or fever blisters; HHV-2 creates similar spots in the genital area. “The fact,” says Biddle, “that one is a social non-issue and the other a possible scandal is a perfect example of how our reaction to disease reflects cultural values.”
- Recurrent episodes can be brought on by emotional stress, ultraviolet energy in sunlight, physical exertion, other infections, and immune system disorders.

Herpes Simplex Nosode

The Herpes Simplex Nosode [abbreviation: Herp-s.] has no symptoms in the repertory. Reckeweg’s Antihomotoxica states that “it would seem expedient to use the Herpes Simplex and Herpes Zoster Nosodes in cancer of the womb” because “malignant disease of the womb is said to show a close relationship with earlier herpetic infections generally.” In addition, the Herpes Simplex Nosode “is also said to be of use particularly in influenzal illnesses, since herpetic conditions [on the cheeks, around the mouth] frequently appear in these; likewise before, during and after menstruation. The nosode can also be used in cases of postherpetic neuralgia following remission of herpes zoster - alongside the otherwise indicated homeopathic remedies [such as Mezereum, Rhus-tox., Ranunculus bulbosus, Vaccinium, Variolinum, etc.]

HHV-3 - Varicella-zoster virus

- HHV-3, the varicella-zoster virus, has in varicella [chickenpox] “the last holdout of the common childhood diseases.” Having remained dormant within the body, often for decades, the virus is apt to re-emerge past the age of fifty, as the immune system weakens, in the form of herpes zoster [shingles]. Exactly what triggers this reactivation has not yet been determined precisely, but likely candidates include external re-exposure to the virus, acute or chronic disease processes [particularly malignancies and infections], certain medications, radiation therapy, physical trauma, and emotional stress.

[Ed: I noticed during the past twenty years an increasing number of children presenting with shingles, rather than chickenpoxly understood shingles to be the prerogative of the over-40’s.]

Chickenpox symptoms:

Varicella.

Contagious

Malaise

Low grade fever

Rash - scalp, face, trunk, limbs.

Rash - very itchy -blisters - pustular - crusts.

. I previous-

-
- Chickenpox, highly contagious, is usually acquired by the inhalation of airborne respiratory droplets from an infected host, typically occurring in winter and early spring in 3- to 4-year cycles. Countries with tropical and semitropical climates have a higher incidence of adult chickenpox compared with countries with a temperate climate [eg, United States, Europe]. The triad of rash, malaise, and low-grade fever signals the onset of chickenpox. Small, erythematous macules appear on scalp, face, trunk, and proximal limbs, with rapid sequential progression to papules, clear “teardrop” vesicles [accompanied by intense pruritus], and pustules, with subsequent central umbilication and crust formation. The characteristic vesicles are described as “dew drops on rose petals,” the latter representing the erythematous halo surrounding the vesicles. Complications, although rare, include pneumonia, myocarditis, transient arthritis or hepatitis, and haemorrhagic lesions.
 - “Post-chickenpox encephalopathy is unusual, occurring in less than 1/1000 cases. Like the encephalitis following measles, it tends to occur toward the end of the disease or one to two weeks after its termination. One of the most common neurologic complications is acute post-infectious cerebellar ataxia. Transverse myelitis, cranial nerve palsies, and multiple-sclerosis-like clinical manifestations have also occurred. Reye’s syndrome, an unusual but severe complication, may begin three to eight days after onset of the rash.” [Merck Manual]

[Reyes syndrome may follow acute febrile illnesses such as influenza or varicella. Studies have linked the syndrome to aspirin-containing medicine used to treat these illnesses. It consists of recurrent vomiting, with subsequent recovery or, in some cases, coma due to intracranial hypertension.]

Varicella Nosode

The Varicella Nosode, or Varicellinum, has hardly a place in homeopathic literature, except for Reckeweg’s recommendation “for use in skin eruptions, including those which itch at night and are of a pustular nature; it may also be used in herpes simplex [or zoster], and in cervical cancer, possibly in alternation with the Herpes Simplex Nosode, the Herpes Zoster Nosode and Variolinum.”

Herpes Zoster

- In 10-25% of all herpes zoster cases the ophthalmic division of the trigeminal nerve is involved, resulting frequently in such complications as chronic ocular inflammation, visual loss, and debilitating pain. Involvement

of the seventh cranial nerve leads to Ramsay-Hunt syndrome [facial paralysis, otalgia, and herpes zoster], which accounts for as many as 12% of all facial paralyses.

- Postherpetic neuralgia [particularly in elderly persons who are debilitated or arteriosclerotic], encephalitis, myelitis, and cranial- and peripheral-nerve palsies are among the complications of herpes zoster.
- Arsenical medications [now abandoned] predispose to herpes zoster.
- There is substantial evidence that patients with multiple sclerosis “have a unique relationship with the herpes zoster virus.” Young MS patients may have herpes zoster earlier and more often than the general population. Recurrence of herpes zoster is also more common in MS patients. A Canadian study found “a significant geographic correlation between the prevalence of MS and varicella in North America. Both have diminishing occurrence from north to south. In the tropics, varicella is often a disease of late onset [average age 26], low contagion, and is relatively uncommon. In these countries MS is extremely rare.” [Canadian Journal of Neurological Sciences, 1999; 26:29-32]

Herpes Zoster Nosode

The indications for the Herpes Zoster Nosode are as minimal as those for the other herpes-associated nosodes. Aside from obvious clinical indications - “never well since ...” or “herpes zoster itself, and the unpleasant and painful herpetic eruptions, labial, genital or elsewhere, which often occur during menstruation” - Reckeweg speaks of its application in “pre-cancerous states of the uterus, or in outright cancer of the womb or parts of it.”

Shingles symptoms:

Herpes zoster.

Often very itchy, tingling eruptions following nerve pathways on the face and trunk.

Can cause paralysis along these nerves.

Can leave unsightly

scarring akin to bums.

BETAHERPESVIRINAE

HHV-5 - Cytomegalovirus

- The ubiquitous human CMV [salivary gland virus] has the propensity for remaining latent in man, like all members of the herpes group of viruses. Infection ranges in severity from a silent infection without consequences, through disease manifested by fever, hepatitis, pneumonitis, and [in neonates] severe brain damage, to stillbirth or perinatal death. Infected persons may excrete virus in urine or saliva for months; virus can also be found in human cervical secretions, semen, faeces, and milk. High infection rates may occur among children in closed populations, such as orphanages and infant day

care centres, and are the rule in male homosexuals with multiple sexual partners. Many women who become infected with CMV during pregnancy are asymptomatic, but some develop a mononucleosis-like illness. About 10% of infants with congenital CMV infection are symptomatic at birth; manifestations include intrauterine growth retardation, prematurity, microcephaly, jaundice, petechiae, hepatosplenomegaly, periventricular calcifications, chorioretinitis, and pneumonitis. Symptomatic newborns have a mortality rate of up to 30%, and more than 90% of the survivors have neurologic impairments including hearing loss, mental retardation, and visual disturbance. [Merck Manual]

Cytomegalie nosode

Ptok¹ employs the nosode Cytomegalie [in 30x, single dose] for “non-specific swelling of lymph nodes, with solid consistency, particularly in children; fatigue since infectious mononucleosis.”

HHV-6 - Roseolovirus

- A 1997 study involving 102 individuals, 36 of whom had MS, conducted at the National Institute of Neurological Disorders and Stroke in Bethesda,

Maryland, USA, indicated that more than 70% of patients with the relapsing-remitting form of MS had an increased immune response to human herpes virus-6 [HHV-6] and approximately 35% of all MS patients studied had detectable levels of active HHV-6 in their serum.

Roseola symptoms:

“baby measles”

Sudden high fever

Possible fits.

Fever abates as pink rash

appears on trunk, arms

and neck.

Child may be playful or

irritable and restless.

- Associated with a common childhood illness, sixth disease or roseola infantum, HHV-6 is known to be present in 90% of the adult American population as a result of infection between 6 months and 2 years of age. Scientists believe that the reactivation of HHV-6 virus may be linked with the breakdown of myelin, the protective covering of nerves. Reactivation is characteristic of herpes viruses.

Symptomatic infections typically induce roseola infantum, also known as exanthema subitum [meaning ‘sudden rash’] or baby measles, characterised by abrupt onset of high fever, which lasts for 3-5 days with non-specific complaints. With the fever, some children exhibit bilateral periorbital oedema in the prodrome. A febrile seizure occurs in 10-15% of patients. Rapid decrease of feverish symptoms is striking with the onset of a mild, pink, morbilliform [maculopapular] exanthem. The rash blanches on pressure

and mainly is distributed on the trunk, arms, and neck. It fades in 1-2 days. Most children are playful despite high-grade fever; however, anorexia, irritability, and listlessness may be the presenting signs.

- More severe primary infections may include gastroenteritis, hepatitis, meningo-encephalitis, seizures, interstitial pneumonitis, and mononucleosis-like syndrome. In immunosuppressed patients [eg, transplant recipients] HHV-6 primary infection or reactivation may cause marrow suppression, pneumonitis, encephalitis, hepatitis, fever, and an eruption or may induce a rejection of transplanted organs and thereby cause death. HHV-6 was implicated as the cause of 30% of cases of pneumonitis in patients who underwent bone marrow transplantation.
- In the primary infection, replication of the virus occurs in the leukocytes and the salivary glands. It is present in saliva.

Herpes Virus Type 6 Nosode

Ptok¹ finds the nosode useful in cases with “fatigue in morning, even at breakfast time, also in children; difficulties in concentrating when reading; rumbling in abdomen without specific findings on palpation.”

GAMMAHERPESVIRINAE

HHV-4 - Epstein-Barr virus - Infectious Mononucleosis

• HHV-4, or Epstein-Barr virus [EBV], is associated with infectious mononucleosis, also known as glandular fever or “kissing disease.” Referred to as “mono” for short, it derives its name from distorting the white blood cells, causing them to only have one nucleus. One of the most common viruses, EBV occurs worldwide and most people become infected sometime during their lives. When infection with EBV occurs during adolescence or young adulthood, it causes infectious mononucleosis 35% to 50% of the time. When younger children are infected, it causes little or no illness. Although the symptoms of infectious mononucleosis usually resolve in one or two months, EBV remains dormant or latent in cells in the throat and blood for the rest of the persons life.

Periodically, the virus can reactivate and is commonly found in the saliva of both healthy and infected persons. The clinical diagnosis is commonly made from the characteristic triad of fever, pharyngitis, and lymphadenopathy

lasting for one to four weeks. Other symptoms include swelling of the upper eyelids [first days of illness only], photophobia, uvular oedema, nausea, anorexia, extreme fatigue, enlarged and painful spleen, dyspnoea, tachycardia, excessive perspiration, and a maculopapular generalised rash. [Ed: The course of this disease has gradually lengthened as its severity has increased. In the 1930's and 40's Epstein-Barr was characterized by swollen glands and sore throat, often in the autumn, and over in a week. By the 1960's and 70s the disease was less selective in its time of onset, and could last two to three weeks.

Patients were isolated and advised 'no stress or alcohol'. By the 1980's it was evolving as recurrent episodes of swollen glands, pharyngitis, anorexia, extreme fatigue, excessive perspiration, dyspnoea and tachycardia. It often affected students at exam time, even students as young as nine, competitive athletes, and other hard workers. Many of these patients continue to suffer from constant or sporadic bouts of extreme weakness for years after the initial onset. Epstein Barr has become one of a number of diseases included under the name of Chronic Fatigue Syndrome.]

- In addition to infectious mononucleosis the Epstein-Barr virus is thought to be responsible for two rare cancers, nasopharyngeal carcinoma and Burkitt's lymphoma [malignant lymphoma involving facial bones, ovaries, and abdominal lymph nodes]. It has been proposed as a possible cause of Hodgkin's disease. The virus is furthermore associated with 'post-transplant lymphoproliferative disease', a tumour often found in organ transplant patients.

Homeopathy

EBV is not used as a separate homeopathic nosode, whereas Carcinosinum is considered the nosode of choice for the chronic sequelae of mononucleosis ["never well since ..."]. To the small group of other remedies listed for the condition - Calendula, Influenzinum, Muriaticum acidum, Phosphoricum acidum, Ailanthus and Baptisia should be added.

1. M. Ptok, *Der Wert der Nosoden*: Allgemeine Homöopathische Zeitung, 5/99.

d. Double stranded DNA with a RNA intermediate in replication

| Family | Subfamily | Genus | Type Species | Remedies |
|---|-----------|------------------|--------------------------|-------------------------|
| d: double stranded DNA and RNA Reverse Transcribing Virus | | '—Hepadnaviridae | <i>Orthohepadnavirus</i> | — <i>Hepatitis B</i> |

HEPADNAVIRIDAE

Hepatitis B

- The genus Orthohepadnavirus, of which hepatitis B virus is the type species, is associated with hepatitis in humans, ducks, woodchucks, ground squirrels, snow geese, and woolley monkeys.
 - Transmission: person-to-person in blood, saliva, and semen, thus ranking it among venereal diseases.
 - One of the most common human pathogens, HBV has been estimated by the World Health Organization to have infected over two billion people worldwide. Approximately 500 million are chronic carriers. The large reservoir of infected individuals has sustained a satellite virus known as the hepatitis D virus [HDV].
 - The incubation period can be long as six months, versus six weeks for hepatitis A.
- Extremely stable virus, surviving for prolonged periods on needles [drug abuse; body piercing; tattooing], surgical tools, and even thorns or sharp stones.
- Vertical transmission from mother to infant [during birth or in breast milk] occurs in Asian or African regions with high prevalence of hepatitis B.
- Chronic HBV infection may lead to hepatocellular carcinoma, one of the most common cancers afflicting humans.
- HBV symptoms include headache [occasional], anorexia, nausea, abdominal

Hepatitis B

Reservoir: humans, ducks, snowgeese, woodchucks, squirrels, woolley monkeys.

Transmission:

Venereal - blood, saliva, semen, breast milk.

Hepatitis B Symptoms:

Headache.

Loss of appetite.

Abdomen bloated.

Pale faeces.

Jaundice.

Anxiety.

Averse alcohol, tobacco.

Slow recovery.

bloating, malaise, darkening of urine, lightening of faeces, jaundice, rigors, and loss of desire to drink alcohol or smoke.

- Recovery may take from a few weeks to several months, with common features such as anxiety, fatigue, failure to regain weight, anorexia, alcohol intolerance, and right upper abdominal discomfort.

Hepatitis B vaccine

- Available since 1982, hepatitis B [HB] vaccination has been added by approximately 100 countries to their routine childhood immunisation programmes or in programmes targeting risk groups.
- Data from the Vaccine Adverse Event Reporting System [VAERS] show a rate of neurological disorders following hepatitis B vaccination higher than with any other vaccine. The disorders include both demyelinating diseases [multiple sclerosis; optic neuritis; transverse myelitis] and non-demyelinating conditions [vertigo; paraesthesia; vasodilatation]. Yet, “when examined individually in relation to hepatitis B vaccine,” neurological disorders “do not appear to have occurred at a greater than expected frequency,” and thus “the evidence is inadequate to accept or reject a causal relation between hepatitis B vaccine and optic neuritis, multiple sclerosis, or transverse myelitis.” [Stratton 1994]

Homeopathy

One case in homeopathic literature relates to *Hepatitis B vaccinus* [Hepati-b-vc.]. It concerns a 34-year-old mother of two children, in excellent physical condition and sport-loving, who began suffering from chronic fatigue shortly after her first hepatitis B vaccination. Three months later, after the second shot, her concentration became severely impaired, she felt drained, could no longer digest fat and lost weight progressively [20 kg]. She suffered from occipital headaches and contracted all kinds of infections, in particular throat infections.

“She was unable to work and when she tried to work again on a therapeutic basis, three-and-a-half years later, she had to admit that her health was too bad. She felt locked up in herself and her own little world. She finally was treated in a psychiatric hospital, ready to try anything to feel better, but the psychiatrist didn’t understand her case. Something didn’t tally, but it did not seem to be a psychological problem, he said.

Half a year later she became depressed and took Prozac. A year later, she got mononucleosis which made her still weaker. Then she dragged herself along for another five years. She had completely lost confidence in her body. She was unable to do sports and had to be very careful. ... Her treatment was simple.

She got three courses of Hepatitis B in the 30, 200, IM and 10MK. Over five months time she recovered completely. Her headaches were gone and she was able to exercise again. Her immune system is also stronger; she doesn't have infections any more. Her confidence in her body is back and she doesn't need to sleep in the afternoon any more."

[Tinus Smits, *The post-vaccination syndrome*, Case 4; Hom. Links 4/01]

CLASS II - SINGLE STRANDED DNA

Parvoviridae - Not in homeopathy.

RNA VIRUSES

CLASS III - DOUBLE STRANDED RNA

Reoviridae - Not in homeopathy.

Rotavirus - Not in homeopathy.

CLASS IV - POSITIVE SINGLE STRANDED RNA

a. Positive single stranded RNA; naked; polyhedral capsid

| Family | Genus | Type Species | Remedies |
|---|-------------|--|--------------|
| a: positive single stranded RNA [+ssRNA]; naked; polyhedral capsid | | | |
| Picornaviridae | Enterovirus | Poliovirus Coxsackie A & B virus Echoviruses | Polio nosode |
| | Rhinovirus | Human Rhinovirus A [common cold] | |
| | Hepatovirus | Hepatitis A virus | |
| | Aphthovirus | Foot & mouth disease | |
| | | | |

PICORNAVIRIDAE

General

- Picornaviruses are small [pico], naked, single stranded RNA viruses without projections.
- All members of this family lack a lipid envelope and, therefore, are resis-

rant to ether, chloroform, and alcohol, whereas ionizing radiation, phenol, and formaldehyde readily inactivates them.

- They include the rhinoviruses [more than 100 serotypes], hepatitis A virus, aphthovirus [bovine/porcine foot-and-mouth disease virus], and some 63 enteroviruses.

GENUS ENTEROVIRUS

Enteroviruses - General

- The genus Enterovirus contains three poliovirus serotypes, 23 Coxsackie A viruses, six Coxsackie B viruses, 31 echoviruses, and a few others.
- Enteroviruses and rhinoviruses are morphologically identical but differ in their clinical manifestations and the conditions required for replication.
- Replicating best at 37°C, enteroviruses begin in the oropharynx, survive the acidic environment of the stomach and then invade the small intestine.
- Enteroviruses are transmitted via the faecal-oral route.
- Enteroviruses prevail in temperate climates during summer and fall, rhinoviruses in spring and fall.
- Exercise, cold exposure, malnutrition, pregnancy, drug-induced immunosuppression, and radiation can increase the susceptibility to Enterovirus infection and/or its severity.
- Enteroviral infections occur predominantly in children; approximately 95% of infections caused by poliovirus and at least 50% of non-polio entero-viral infections are completely asymptomatic.

Coxsackie viruses

- Syndromes associated with coxsackie viruses include herpangina [palatal and pharyngeal herpes-like lesions], hand-foot-and mouth disease [vesicular stomatitis and cutaneous lesions of distal extremities], aseptic meningitis, myopericarditis, haemorrhagic conjunctivitis, gastroenteritis, exanthema, respiratory affections, and illnesses resembling mild paralytic poliomyelitis.
- Coxsackie virus infections are the most common cause of viral heart disease. Myopericarditis is most prevalent in young adults, especially those who are physically active.
- Coxsackie viruses and other “non-polio viruses” have been recovered from patients who had received one or more doses of Salk vaccine.

Homeopathy

Coxsackie virus nosode [Coxs.] has five symptoms in Synthesis 9.1:

Abdomen, Inflammation, Colon, mucous.

Respiration, Asthmatic.

Chest, Heart, complaints, Myocardium.

Chest, Heart, complaints, Pericardium.

Generals, Circulation, complaints, sluggish, congested.

Reckeweg's Antihomotoxica says, "The attenuations of this nosode are prepared from inactivated Coxsackie viruses groups A9 and B4. The main indications are: Pyelonephritis, acute and chronic cystitis. Chronic sinusitis. Abacterial meningitis and headache. Asthma, circulatory disturbances. Valvular stenosis and heart-pains, damaged or strained myocardium or pericardium, sequelae of mumps. Pancreatitis, hepatitis, nephritis, orchitis, ovaritis, pleurisy, abacterial meningitis or encephalitis, possibly including pareses. Chronic conditions of the large intestine [spastic colon], especially in combination with Coloc. Nux Vomica, Cantharis, etc."

Poliovirus

- Spread by the faecal-oral route, polio infection occurs equally in boys and girls, although paralysis is more common in boys than in girls. Among adults, women are at increased risk of infection and Post-Polio Syndrome compared with men.
- Although in 90-95% of cases accompanied by minor symptoms only [usually a transient, self-limiting summer diarrhoea], polio may affect the central nervous system, destroying motor neurons controlling muscle movement, which results in paralysis of one or more limbs, or death.
- Abortive polio presents with symptoms similar to those of other viral infections, such as 2-3 days of fever, headache, sore throat, listlessness, anorexia, vomiting, and abdominal pain.
- Non-paralytic polio appears clinically as aseptic meningitis. Symptoms are similar to those of abortive polio but are more intense, and patients complain of stiffness of the posterior muscles of the neck, trunk, and limbs.
- Spinal paralytic polio has a biphasic course. The minor illness corresponds to the symptoms of abortive polio and lasts one to three days. This is followed by apparent recovery and a symptom-free interval of two to five days before the abrupt onset of the major illness, heralded by meningitis. Meningismus and accompanying muscle pain generally are present for one

to two days before frank weakness and paralysis ensue. The paralysis is flaccid, asymptomatic in distribution. Exercise increases the severity of paralytic polio, especially during the first three days of major illness. Proximal muscles of the extremities tend to be more involved than distal muscles; the legs are more commonly involved than the arms.

- Bulbar polio affects the muscles of the face, mouth, tongue and throat, with weakness of the muscles supplied by the cranial nerves, and variable “encephalitis” symptoms, including diplopia [uncommon], weakness of mastication, facial weakness, dysphagia, dysphonia, nasal voice, regurgitation of fluids through the nose, weakness of the sternocleidomastoid and trapezius muscles, difficulty in chewing, inability to swallow or expel saliva and respiratory tract secretions.
- Tonsillectomy increases the risk of bulbar polio.
- The virus can be isolated from human faeces and sewage. In areas where raw sewage enters a watershed without treatment, polio can be found in rivers, lakes, and streams.
- At the turn of the century, the disease was termed ‘infantile paralysis’ because it tended to strike young children. Over the years a steady increase in the age of onset occurred, so that the median age of those acquiring polio before 1949 was 8 years compared with a median age of 16 years for those affected in 1949 or later. Older victims manifested more severe symptoms than younger victims did.
- There are two vaccines: inactivated polio vaccine [IPV], the formaldehyde-killed virus, developed by Jonas Salk in 1953 and licensed in 1955; and oral polio vaccine [OPV], the live attenuated virus, developed by Albert Sabin in 1956 and licensed in 1960. The virus used for the production of both vaccines is cultured on monkey kidney cells. Batches of the early vaccines were found to be contaminated with a monkey virus termed SV40. The virus survived the formaldehyde that Salk used to kill his polio viruses and made Salk admit that, “The last thing in the world one would want to do now is to make vaccines out of the tissues of monkeys that come from the jungle.”
- One of the many hypotheses about the origins of HIV/AIDS proposes that the pandemic was sparked by the vaccination of hundreds of thousands inhabitants of central and west African countries between 1957 and 1960 with an experimental oral polio vaccine, known as CHAT, developed by Koprowski and co-workers, who grew the virus in a substrate of monkey kidney tissue culture. The substrate presumably got contaminated with simian [monkey]

viruses and these ended up in some vaccine batches. Many of the places where CHAT was administered in Africa were the very places where HIV-1 and AIDS first appeared, suggesting that the vaccine may have been the vehicle whereby chimp SIVs [simian immunodeficiency viruses] were first transmitted to humans, in whom they recombined with their own normal genes to create a monkey-human hybrid now known as HIV-1. The hypothesis has provoked savage criticism in medical circles.

Polio and carbohydrates

- Paralytic polio was first described in an epidemic in 1887 in Sweden. The first large recorded outbreak of polio in the U.S. began in 1893 in Boston, and spread into New England. Polio turned into a major problem in the U.S. in the period 1907-1916, with about a thousand cases in New York in 1907 and the first widespread outbreak, affecting 26 states, in 1916. The disease swept the U.S. several times between 1942 and 1953, peaking in 1952 with about 60,000 cases.
- In 1994, the WHO declared poliomyelitis to be eradicated from the Western Hemisphere. In the Eastern Hemisphere some 4000 cases are reported annually, mostly in developing countries of Africa and South Asia.
- Sabin observed that polio epidemics “occurred with greatest frequency and severity in the very countries in which sanitation and hygiene have undoubtedly made the greatest advances.” For this apparent paradox the American physician and nutritionist Benjamin P. Sandler offered the explanation that “sugar consumption is by far the greatest in the richer countries where one would also expect to find advanced sanitation and hygiene.

Epidemics have occurred with the greatest frequency and severity in the high sugar consuming countries. In fact, epidemics have never been reported in the natives of the low sugar consuming countries, such as China.” Sandler compiled records showing that in countries such as United States, Britain, Canada and Sweden, which have an extremely high per capita consumption of sugar, there is also a high incidence of polio. He saw the increased incidence of polio during the summer months as resulting from these being “the months of the highest sugar intake in the form of ice cream, bottled drinks, candy, desserts, etc.”

During one of the worst polio epidemics in North Carolina, USA, in 1948, Sandler set up a one-man campaign consisting of “a simple formula for preventing polio: eliminate from the diet sugar and foods containing sugar, and reduce the consumption of foods containing starch.” His conviction

that “such a diet, strictly observed, can build up in 24 hours’ time a resistance in the human body sufficiently strong to combat the disease,” turned out to be correct: within 72 hours polio had declined dramatically and the epidemic was brought under control. By the next year the polio incidence of North Carolina had dropped 90%. [For a further exploration of the link between polio and sugar see the article *The euglycaemic status and infections* by Juan Manuel Martinez Mendez in Homeopathic Links 4/02.]

Susceptibility to polio

Homeopathy considers that man’s susceptibility to any particular disease is more important than his environment or the organism, asserts Stewart, who proceeds thus:

This century-old idea of Hahnemann has had confirmation by modern writers, susceptibility to infantile paralysis [poliomyelitis] appears to depend upon definitely recognisable bodily configuration. At the end of the 18th century even before the idea of infection was known, it had been noted that infantile paralysis appeared to attack strong healthy children. Stature is partly hereditary, so the possibility that immunity might likewise be hereditary was considered and studies in America have shown that poliomyelitis runs in families.

In 1944, after studying 273 cases and 229 children who had not taken the infection, Draper stated that children affected tended to be larger in size during the period before and after puberty, but although there was an overgrowth as regards stature in the susceptible children, there was underdevelopment in other respects, suggesting that some factors in the developing child might be responsible for the susceptibility.

He said that apparently the period when the second teeth begin to come at 6- 7 years, and puberty at 11-15 years are critical ones, and it was noted that the children who did not take infantile paralysis passed through these periods without much change in their rate of growth, whereas the susceptible children had a sudden increase in size following each of these periods, but this growth did not advance their already retarded development in other respects.

Out of a large number of noticeable differences between sick and well groups of children, he selected the following six most common characters as dependable for estimating a child’s susceptibility to infantile paralysis:

- 1] Pigmented spots, larger and more numerous than normal.
- 2] Persistence of long curved eyelashes, which normally grow shorter with advancing age.

-
- 3] Large central incisors.
 - 4] Spaces between central incisors. Both these factors are indicative of irregular development of teeth.
 - 5] Excessive flexibility of hands and fingers. This is normal in infants, gradually disappears with age, until a sharp drop occurs at about thirteen years of age.
 - 6] Internal eyefolds. These mongoloid folds of skin sweeping down almost vertically over the inner angle of the eye are present in the normally developing baby some months before its birth.

It was further noted that 93% of paralysed boys under seven had three or more of these characters, and 88% of paralysed girls under seven had three or more, while 80% of boys or girls who had all six characters took the disease before the age of seven.

[T. Fergus Stewart, *Homeopathy, Virus Disease and Research-*, British Hom. Journal, January 1959]

Homeopathy and Post-Polio Syndrome

- Synthesis 9.1 lists three symptoms for the remedy *Polio*:

Extremities, Pain, during fever.

Generals, Amyotrophic Lateral Sclerosis.*

Generals, Multiple Sclerosis.

* At one time, some researchers thought that the late effects of polio might actually be a form of amyotrophic lateral sclerosis [ALS], which bears a clinical similarity to the post-

*Babinski signs:
on stroking the sole of the
foot, the big toe bends
upwards instead of down-
wards.*

polio syndrome. However, ALS is characterised by new, rapidly progressive, generalised muscle weakness and by the presence of bulbar signs, respiratory difficulties, and upper motor neuron signs such as increased deep tendon reflexes, spasticity, and abnormal Babinski signs. Patients with ALS die within an average of 3 years after the onset of the disease.

The post-polio syndrome progresses slowly, and upper motor neuron signs are rarely present. No evidence, either from clinical or experimental studies, suggests that the two conditions are related. [1]

It goes without saying that such a paucity of symptoms will not earn this remedy a place in the homeopathic materia medica. Even the classical indication for the use of nosodes - “Never well since ...” - is of little help

because the sequelae of polio may take several decades to develop fully. The aetiology is likely to be overlooked, in particular since the original bout of polio may have been mild or even non-paralytic.

PPS support groups report that between 1 and 10% of their members had non-paralytic polio as children and now have fatigue, new muscle weakness and pain. Many non-paralytic cases [and even cases with mild paralysis] were never seen by a physician and may not know that they had polio. [4] Post-Polio Syndrome [PPS] is a name that has been adopted to indicate a constellation of *new* symptoms that occur an average of 31 years - generally ranging from 20 to 40 years - after the onset of the initial polio infection and after a period of “recovery” of at least 10 years. [3] The incidence of PPS in previous acute polio patients in the U.S. ranges from approximately 22-68%. PPS is estimated to occur in 28.5% of persons who had paralytic polio. The current prevalence is approximately 1.6 million cases in the U.S. [2]

Taking the latter figure as accurate, it would mean that the actual number of acute polio cases, including those not developing PPS, lies between 2.3 and 7.2 million cases, which conflicts with the purported reduction of polio by means of vaccination. Since “wild” polio is claimed to be largely under control, mass vaccination with the live-virus vaccine [Sabin] constitutes the dominant cause of polio cases in countries using this vaccine, a risk greater than the risk posed by the disease. Polio vaccination can consequently be assumed to lead to PPS, an assumption more accurately accounting for the high incidence of the syndrome.

Aetiology appears to be a rather unstable basis for prescribing a nosode since it requires both a reliable diagnosis and a reliable memory. In the case of PPS, non-polio enteroviral infections, eg, Coxsackie and other enteroviruses, have been associated with the syndrome as well. At any rate, whether the so-called ‘cause’ can be established or not, selecting the remedy Polio on the basis of the law of similars is no doubt most appropriate, for which the symptom picture of PPS can be used.

- * Anxiety about the future.
- * Self-reliance and resilience. [Considered typical of PPS patients, of whom 80% is still independent of help from others.]
- * Difficulty in concentrating and remembering. Fatigue relating to cognition and alertness [known as “brain fatigue” or “brain fag”].
- * Generalised fatigue; low energy; < morning on waking.
- * In contrast to patients with chronic fatigue syndrome, post-polio fatigue

is prominent in the early hours of the afternoon and decreases after brief periods of rest. PPS-related fatigue usually does not prevent patients from working. [2]

- * Slow, progressive weakening of muscles. [Flaccid paralysis.]
- * Deep aching pain in muscles or soreness, < slight exertion. [6]
- * Muscle cramps.
- * Lower extremities more often affected than the upper extremities.
- * Paralysis may be asymmetrical [one side only] and patchy.
- * Sensation in affected muscles not altered.
- * Shrinking muscle size [atrophy].
- * Twitching, sometimes in atrophic muscles.
- * Joint pain.
- * Headache in morning on waking. [5]
- * Food lodges in throat, making swallowing slow or difficult, often with coughing and choking. [6]
- * Hoarseness. [5]
- * Urinary incontinence. [5]
- * Difficulty breathing [apnoea], worse during sleep.
- * Decreased cough and expiratory flow, and decreased clearing of secretions. [2]
- * Flat back syndrome: inability to stand erect because of forward flexion of the trunk and pain in the low back and legs. [2]
- * Difficulty with gait is caused by progressive weakness, pain, osteoarthritis, or joint instability. [2]
- * Restless legs. [5]
- * Weakness knees, < walking and ascending stairs. [5]
- * Sleep problems.
- * Hypersomnolence. Morning drowsiness. Excessive daytime sleepiness. [5]
- * Snoring in sleep. [5]
- * Exercise/exertion <.
- * Intolerance of cold. Exposure to cold temperatures aggravates local symptoms, generalised fatigue, and weakness. [6]
- * Onset often occurs after a physical or emotional trauma, illness or accident. [3]

* Overcompensation was another helpful mechanism used by polio survivors. It contributed to their assertiveness and brought them to the highest possible level of functioning. The fear of not being as good as others was

a challenge that pushed many polio survivors to become overachievers [type A personality]. However, although these coping strategies worked well in the early stages of the disease, they could be detrimental if used by persons suffering from the late effects of polio. [1]

- The fatigue, a systemic, generalised exhaustion, may be so severe and so out of proportion to the level of activity that such persons feel an overwhelming need to ‘just stop dead in their tracks’. Dr. Lauro Halstead, a polio survivor, describes a phenomenon called the polio wall, which is a sudden onset of symptoms such as intense fatigue, headache, weakness, hot and cold rashes, sweating, or a feeling like ‘hitting a wall’. [1]

Increase in difficulties with activities of daily living. Most frequently reported were difficulties with walking and climbing stairs. Other activities of daily living affected were homemaking, driving, bathing, dressing, eating/swallowing, and bladder/bowel function. [1]

- A “typical” presentation to a physician of a person with a history of non-paralytic polio and current PPS-like symptoms goes something like this. “As a child, I was very ill with a high fever and a headache. I was hospitalised for a few days [or quarantined and not hospitalised]. My mother says I was never paralysed and I was discharged from the hospital with a diagnosis of ‘non-paralytic’ polio. I had cramps and pains in my back and legs and I was very weak for some months afterwards but then I recovered completely and forgot all about polio. I wasn’t very good at sports, but then, neither were lots of other people.

About ten years ago [35 to 45 years after the acute illness], I began tripping on smooth floors and occasionally falling. Now everyday jobs like vacuuming tire me so that I have to lie down for an hour or two before I can do anything else. When I’m this tired, I can’t “think”, can’t focus or remember words. It’s difficult to put in a full day of work.

My legs ache after I walk only a short distance and at night the muscles in them “jump” or twitch. My feet are always cold. I can no longer climb a flight of stairs and the weakness in my legs is frightening. I saw a neurologist who specialises in PPS and he said that he saw no evidence that I ever had polio although he did not give me a thorough examination or order any tests. He says I don’t have PPS and suggested that my problems are caused by arthritis or fibromyalgia.” [4]

Key symptoms

- Cold intolerance; weakness from coldness.
A hallmark symptom of PPS, being present in two-thirds of all PPS patients, this might prove a keynote symptom homeopathically, for which the repertory currently lists three remedies: Arsenicum, Carbo vegetabilis, and Veratrum album.
- Sleep apnoea or snoring.
- Morning aggravation.
- Fatigue > afternoon rest.
- Aching muscle pains, < slightest exertion.
- Motoric impairment; sensation unaltered.

References:

- [1] Grace R. Young, Occupational Therapy and the Post-Polio Syndrome; American Journal of Occupational Therapy, Vol. 43, No. 2, February 1989. [Available at: www.zynet.co.uk/ott/polio/lincolnshire/]
- [2] Flor M Muniz, Postpolio Syndrome; www.emedicine.com/pmr/topic10.htm.
- [3] Lincolnshire Post-Polio Network; at: www.ott.zynet.co.uk/polio/lincolnshire/
- [4] Marcia Falconer & Eddie Bollenbach, Non-Paralytic Polio and PPS; Lincolnshire Post-Polio Library Publication, January 1999.
- [5] Post-Polio Syndrome, A literature search at Indiana University, Bloomington, Indiana [146 abstracts]; www.indiana.edu/~pietsch/postpoliosyndrome.html
- [6] Burk Jubelt & Judy Drucker, Poliomyelitis and Post-Polio Syndrome; www.ott.zynet.co.uk/polio/lincolnshire/library/jubelt/polioandthepps.html

PROVING POLIO NOSODE

Sources

- 1) Proving / clinical cases Ravi Roy & Carola Lage-Roy; potencies, number of provers, and duration of proving not stated.
[R. Roy & C. Lage-Roy, Behandlung von Impffolgen; Lage & Roy Verlag, 2005]

[c] = symptoms from clinical cases.

[p] = proving symptoms.

Italics = clinically confirmed proving symptoms.

SYMPTOMS

Mind

- = *Difficulty understanding*; understands the words, but not the sentence, [p]
- == Cannot find words, thinking slow, [p]
- « Condition of dulness and stupefaction, without being alarmed about it. [p]
- « Prefers to sit and look at others, eg people passing by, TV, cinema, [p]
- ~ Tidy, neat, orderly, [p]
- « Conscientious about trifles, yet doesn't do anything about disorder when passive, [c]
- « Forgetful, [p]
- « Problems with speaking from extreme lack of energy, [p]
- « Indifference towards food / eating, [p]
- « Dreams: of being persecuted; of having leucorrhoea. [p]
- <= Fears: when alone; of future; that something will happen; not to manage; that problems will be insurmountable; of leaving house; anticipation, [c]
- = Irritable and oversensitive before menses, [c]
- « Dulness after fatty, rich food, [c]

Generals

- = Thirsty, but doesn't drink, [p]
- Hungry, but doesn't eat. [p]
- Awakes early, lies in bed as if paralysed, cannot rise, [p]
- <= Aversion to getting up in morning, lame feeling psychologically, [p]
- “Weakness [mostly], sometimes bursts of energy, [p]
- « So weak that he must lie down for half an hour in afternoon, [p]
- Intolerance of fatty, rich foods, [p]

Sensations

- « Dark feeling in head, as from a plug in occiput, [p]
- « Sense of weakness in uterus; sore feeling in external genitals; bearing-down sensation; as if open, as if everything will fall out. [p]

Locals

- Pain in occiput as if pressed together, [c]
- Bad taste in mouth; dry, raw feeling, esp. tongue [as after rhubarb]. [p]
- « Nausea & violent eructations; eructations > nausea, [p]
- Cramps around and under umbilicus, [p]

-
- = Bloating after [Chinese] cabbage, goulash, and meat, [p]
 - Diarrhoea; chronic; before menses; anticipation, eg before travelling, before appointments, [c]
 - Constipation during menses, [c]
 - « Constipation alternating with diarrhoea from anticipation, [c]
 - ~ Very painful menstruation, uterine cramps; must lie down, [p]
 - *Abdominal cramps during menses.*
 - « Profuse, purulent leucorrhoea. [p]
 - = Pain lumbar region and upper part of pelvic area, & exhaustion, after light physical exertion, [p]
 - « Tired legs, esp. lower legs; brief moments as if legs are paralysed, [p]
 - « Itching of lower arms and hands; small, red, water-filled vesicles after scratching, [p]
 - ~ Skin sensitive to sun. [c]
 - <= Rash after taking a hot shower, [c]

GENUS HEPATOVIRUS

Hepatitis A

- Hepatitis A [HAV] infects only humans and a few other primates. It is transmitted via the faecal-oral route, causes acute hepatitis, after which it disappears. Unlike both hepatitis B and C viruses, HAV has no known chronic carrier state and plays no role in the production of chronic active hepatitis or cirrhosis. [Merck Manual]

Homeopathy

While listed as a remedy - *Hepatitis A vaccinus* [Hepati-a-vc.] - no symptoms are presented in repertory or homeopathic literature.

GENUS RHINOVIRUS

Common colds

- Rhinoviruses cause common colds. They need 33°C for replication, don't survive the acidity of the stomach and thus usually remain limited to the cooler nasal passages.

b. Positive single stranded RNA [ssRNA]; enveloped;
usually a polyhedral capsid

| Family | Genus | Type Species | Remedies |
|---|-------------|-----------------------------------|----------|
| b: positive single stranded RNA [+ssRNA]; enveloped; polyhedral capsid | | | |
| Coronaviridae | Coronavirus | Infectious bronchitis virus | |
| Flaviviridae | Flavivirus | Yellow Fever virus | |
| | Hepacivirus | Hepatitis C | |
| Togaviridae | Rubivirus | Rubella virus [German measles] | |

CORONAVIRIDAE

General

- Family of about 15 species, which infect man, cattle, pigs, rodents, cats, dogs, and birds.
- First isolated from chickens in 1937.
- Named for their crown of club-shaped thorns.
- Transmission through respiratory droplets and by faecal-oral route.
- Aetiological agents of common cold, especially during the winter and spring, and gastrointestinal infections [“stomach flu”].
- Second only to rhinoviruses, the “kings of colds,” which favour the late summer and fall.
- Associated with Severe Acute Respiratory Syndrome [SARS], with symptoms including fever, dry cough, dyspnoea, headache, and low blood oxygen concentration.

Homeopathy

Non-existent as a nosode in homeopathy, unless included in *Influenzinum*.

FLAVIVIRIDAE

General

• Large group of about 70 viruses. “Most of them are transmitted in cycles involving animals that serve as reservoirs [such as monkeys, bats, birds, and domestic animals], arthropods that serve as carriers [such as mosquitoes of the genera *Aedes*, *Culex*, or *Haemogogus*], and humans that serve as the final host.” The most well known are yellow fever, dengue, Japanese encephalitis, tick-borne encephalitis, West Nile, Kunjin and St Louis encephalitis virus.

Flaviviridae viruses Designated flaviviruses on the basis of similar molecular and pathological properties as yellow fever virus [flavus = yellow].
Reservoir: animals

Carrier: mosquitoes

Final host: humans

Dengue fever

• Endemic in the Caribbean islands, Central and South America, Africa, and Southeast Asia, dengue fever, or “break-bone fever,” is transmitted by mosquitoes.

• With *Eupatorium perfoliatum* as its specific homeopathic remedy, dengue fever is characterised by acute high fever, nausea, vomiting, violent headache, skin rash, bone and muscular pains, and a long convalescence. Although the disease is usually non-fatal, the virus can cause more severe illnesses characterized by haemorrhage, as with dengue haemorrhagic fever, or shock, as with dengue shock syndrome. Dengue haemorrhagic fever is a leading cause of death in tropical Asia, where it is endemically established.

• TBEV is tick-borne; yellow fever is transmitted by mosquitoes.

Dengue fever symptoms:

Acute high fever

Nausea, vomiting

++Headache

Skin rash

Bone and muscle pain

[Break-bone Fever]

Haemorrhagic fever =

death

Yellow fever

• Yellow fever virus originated in Africa and was brought to the Americas with European colonisation and the introduction of slaves during the 17th and 18th centuries. For many decades following its introduction to the Americas, yellow fever was continuously epidemic in cities at the southern and eastern coasts of the U.S., striking major cities such as Philadelphia, New York, and Boston, and spreading up the Mississippi River from New Orleans, causing large outbreaks in cities along the river. The disease afflicted most urban dwellers and caused death rates of 20% or more of a city’s original population, resulting in panic, leaving cities virtually empty. The virus was also

transported overseas to Europe, where it caused thousands of deaths in Italy, France, Spain, and England in the 18th century. Having observed the impact of an epidemic in Philadelphia in 1793, “where the sinews of society were wrenched apart, with family members abandoning each other,” Thomas Jefferson fearfully predicted that “yellow fever will discourage the growth of great cities in our nation.”

Today, yellow fever can still appear in epidemic form in the tropical and subtropical regions of Africa, Asia, Latin and Central America, Indonesia, and northern Australia. The disease is mainly characterized by haemorrhage and jaundice. The disease begins abruptly with fever, chills, anorexia, nausea, vomiting, constipation, and minor bleeding. After three days, the initial symptoms reach their worst state, and additional symptoms such as jaundice, dehydration, vomiting of black matter [due to presence of blood], and severe haemorrhages begin to appear. Death, which occurs in about 20-50 % of all cases, usually happens during the seventh to tenth day of illness as a result of extensive liver damage. This final stage is generally preceded by deepened jaundice, uncontrolled haemorrhages, rising pulse, agitated delirium and coma - the terminal signs.

Yellow Fever Symptoms:

Sudden onset.

Fever, chills.

Anorexia, nausea, vomiting.

Constipation.

jaundice.

Dehydration

Haemorrhage

Delirium

Coma

*Death in 7-10 days in
20-50% of cases*

Hepatitis C

- Closely related to the flaviviruses, hepatitis C virus [HCV] causes a common chronic blood-borne infection in the U.S. and Europe. It is encountered in the context of intravenous drug abuse and/or spread by exposure to blood and blood products [eg, blood transfusions, long-term haemodialysis]. At risk are also persons with multiple sexual partners and children born to HCV-positive women.

Homeopathy

None of the flaviviruses is employed in homeopathy, except for the nosode *Yellow Fever Vaccinum*, which has one listing in Encyclopaedia Homeopathica in a case of “infectious jaundice” where it is used as an intercurrent remedy [in 30c] based “on the great similarity between infectious jaundice and yellow fever.” The remedy “helped very satisfactorily for six weeks.”

TOGAVIRIDAE

Rubella

- The family Togaviridae owes its name to the toga-like “loose envelope” displayed in electron micrographs.
- Classified as a togavirus in the genus Rubivirus, rubella virus is most closely related to group A arboviruses, such as Eastern and Western Equine Encephalitis viruses. [The word ‘arbovirus’ derives from the phrase ‘zrrthropod-Zwne virus.’]
- Rubella was initially considered to be a variant of measles or scarlet fever and was called “third disease.” Due to early 19th-century German scientists describing it as a separate disease, rubella was dubbed “German measles,” in spite of its being unrelated to true measles.
- In temperate areas, rubella outbreaks were common in the late winter/early spring with a periodicity of six to nine years. It is a human disease and has no known animal reservoir.
- Rubella virus was first isolated in 1962. A live, attenuated vaccine was licensed in 1969, which in 1972 was merged with the measles and mumps vaccine to become the MMR vaccine.
- Rubella virus is spread from person-to-person via airborne transmission or respiratory droplets and thought to replicate in the nasopharynx and regional lymph nodes.
- The virus can be isolated from nasal, blood, throat, urine and cerebrospinal fluid specimens from rubella and CRS cases.
- Symptoms are often mild, and up to 50% of infections may be subclinical or inapparent. In children, rash is usually the first manifestation and a prodrome is rare. In older children and adults, there is often a one to five day prodrome with low-grade fever, malaise, cervical lymphadenopathy, and upper respiratory symptoms preceding the rash.
- The rash spreads from the face downwards, lasts about 3 days and usually is non-pruritic. The rash does not coalesce, in contrast to measles, and may be more prominent after a hot shower or bath.

Complications

- Arthralgia and arthritis [fingers, wrists, knees] are common complications in adults, in particular in adult women; rare in children and adult males. Encephalitis, although rare, occurs more frequently in adults [especially in females] than in children. Haemorrhagic manifestations, on the other hand, are more prevalent in children, with thrombocytopenic purpura being the most common manifestation.

Congenital Rubella Syndrome

- In the 1940s a high incidence of congenital cataracts was noted by Norman Gregg, an Australian ophthalmologist, who discovered the condition to be closely related to a maternal rubella infection in the first trimester of pregnancy.
- Follow-up studies showed that first-trimester maternal infections of rubella were also correlated with other birth defects, such as deafness, glaucoma, blindness, and mental/physical retardation, as well as with miscarriage, premature delivery or stillbirth.
- Congenital defects due to prenatal infection are known under the name ‘congenital rubella syndrome’ [CRS].
- Manifestations of CRS may be delayed from two to four years. Diabetes mellitus appearing in later childhood occurs frequently in children with CRS. In addition, progressive encephalopathy resembling subacute sclerosing panencephalitis (SSPE) has been observed in some older children with CRS.
- Rubella is only moderately contagious; the virus may be shed from seven days before to five to seven days after rash onset. By contrast, infants with CRS shed large quantities of virus from body secretions for up to one year.?
- A “very safe vaccine,” most adverse reactions following MMR vaccination are attributable to the measles component. The most common complaints, particularly in adult females, following rubella vaccination are fever, lymphadenopathy, arthralgia, and transient [or chronic] arthritis. Women who are pregnant or intend to become pregnant within four weeks should not receive rubella vaccine.

[Data from CDC Fact Sheet on Rubella and CRS]

Rubella
German measles
Reservoir: humans
Vector: airborne droplets.
Symptoms:
malaise
slight fever
swollen glands
Rash (may itch < after bathing) spreads from face downwards.
May cause cataracts and birth defects to unborn child if patient is pregnant.

Homeopathy

With one repertory listing - Eye, Cataract - the Rubella Nosode occupies a negligible place in the materia medica. Reckeweg recommends it to be “tried in cataract, likewise in deafness, if no pathogenetic cause can be found.”

- One brief, aetiology-based case can be found in homeopathic literature. It concerns a 9-year-old girl, “a poor wee thing, three inches shorter than her twin brother,” with pustules on her skin and in the nose, the latter causing the nose to swell. “Headaches, eyes inflamed, sleeps lightly, quickly tired. Giant

urticaria makes life a misery occasionally. Always ailing. Had German measles at 4 years of age, very badly for one week, and again at 6 years of age, when she was very ill with a vivid rash and a high fever for a whole week.

Three weeks passed before she was allowed out of bed. Rubella 30 and 200 were given and caused much reaction. Tickling here, there and everywhere [an old symptom], but no rash. Painful sinuses, discharge of scabs from nose, and septic spots on skin. A nettle rash continued to come, and wax and wane. Several pustules appeared during six months of placebo, accompanied by great mental and physical improvement.”

[Indian Journal of Homeopathic Medicine, 1996, Vol. 31 No. 1; Enc.Hom.]

CLASS V - POSITIVE SINGLE STRANDED RNA
 [+ssRNA]; with a DNA intermediate in replication; enveloped;
 bullet-shaped or polyhedral capsid

| Family | Genus | Type Species | Remedies |
|---|------------|--------------|-------------------------|
| c: positive single stranded RNA [+ssRNA]; with a DNA intermediate in replication; enveloped; bullet-shaped or polyhedral capsid | | | |
| Retroviridae | Lentivirus | HIV | AIDS nosode Virionum |

RETROVIRIDAE

HIV and retroviruses

- Human immunodeficiency virus exists in two varieties: HIV-1 and the less virulent HIV-2. Both are classified in a small group of human retroviruses.
- Retroviruses derive their name from proceeding retrograde [= backward]. They reverse the process of DNA transcribing into messenger RNA by using an enzyme, reverse transcriptase, that converts viral RNA into a DNA copy that becomes part of the host cell's DNA.

The discovery revolutionised the hitherto held tenet that the flow of information is strictly one-way from DNA to RNA. It has been suggested that the enzyme occurs in all living matter, which would justify the idea that reverse transcriptase activity is a process inherent to life rather than being unique to retroviruses per se. The model nevertheless has served to postulate retroviruses as the cause of cancer, depicting cancer as a sort of atavism, a reversion to a primitive state. Whether or not viruses are involved, the idea is appealing and poses the intriguing question if AIDS also can be seen as an “untimely regression.”

The body is totalitarian in its regulation of genes. Once a cell becomes a muscle cell, for example, it is so forever. The only exception to this rule of permanent roles within the body is during cancer, when cells seem to revert back to the more primordial condition of reproducing continuously without regard to their place or function in the body. During cancer, chromosomes break apart

and mitochondria reproduce even more rapidly than the cells of which they are a part. Usually once a cell commits itself to growing an undulipodium it is evolutionarily dead: it cannot grow again.

But as if disobeying all authority, some cancer cells in tissue culture even grow undulipodia, which they withdraw just before mitosis. It is as if the uneasy alliances of the symbiotic partnerships that maintain the cells disintegrate. The symbionts fall out of line, once again asserting their independent tendencies, reliving their ancient past. The reasons, of course, are not all that clear, but cancer seems more an untimely regression than a disease.

[Margulis & Sagan 1997]

Conservative views and conspiracy theories

Riddled with a good deal of controversy, the relatively short history of HIV/AIDS has engendered a pandemic of fear and helplessness. It appealed to the public prejudice that all evil comes from without and inevitably led to a cascade of speculations and theories.

Karlen has it that “AIDS has aroused the sort of hate and repugnance that once greeted leprosy. Its deadliness is not the only reason; its frequent association with sex and drugs has elicited indifference or vengefulness towards its victims. They are often treated with more rage or fear than compassion.” Lishman asserts that “widespread alarm within populations at risk has led to a high incidence of psychiatric disorder, even among persons not already affected. Many patients may therefore present to the psychiatrist with no more than a fear of the disease, and in the absence of a fully reliable diagnostic test the anxiety can at times be prolonged.” Neither in this nor in the resulting social upheaval and repercussions and the blame and counter-blame campaigns, does HIV/AIDS differ significantly from such former ordeals as plague, smallpox and tuberculosis. The situation is unresolved and one theory seems as good as any other.

Although HIV is generally held responsible for AIDS, no evidence has been produced of a direct cause and effect relationship according to Koch's Postulates, i.e. recovering the virus from every instance of AIDS, producing it in a pure culture and maintaining it over several viral generations, reproducing with it the disease in another host, and retrieving the virus anew from that host. These *postulates are notably difficult to fulfil for certain viruses, so that the HIV = AIDS hypothesis is accepted without meeting Koch's criteria.* Gary Null points out that “simply finding the two in bed together, as it were, that is finding a disease and a new microbe co-present, is not satisfactory proof. Both

may have been caused by a third pathogen. Or the microbe may be a co-factor, needed but not sufficient by itself to bring on the disease state.”

While the conventional view supports the germ theory, opponents and skeptics have come up with alternative theories of HIV/AIDS as arising from the murky waters of medical and/or sociopolitical manipulation.

The syndrome was started by abuse of pharmaceuticals;

Mutations turned a harmless virus into a killer;

The virus was engineered by governments for political purposes;

It was the deliberate outcome of biological weaponry experiments;

It arose from genetic recombination in viruses from monkey kidneys used to make polio vaccine for Third World nations;

HIV entered the human population via smallpox vaccines;

The HIV hypothesis ranks with the ‘bad air’ theory for malaria, it is a hoax that became a sham;

The HIV-causes-AIDS dogma represents the grandest and perhaps the most morally destructive fraud that has ever been perpetrated on young men and women;

The medical diagnosis of AIDS equals a sentence of death;

The virus cannot be isolated and therefore doesn’t exist;

AIDS is syphilis in disguise;

Malaria and tuberculosis are misdiagnosed as AIDS;

It is a cover-up for the fundraising necessary to fill the bottomless pit of orthodox medical research.

Reminiscent of medieval beliefs surrounding plague and ergotism, AIDS is even perceived as a divine retribution for homosexuality and prostitution. [An interesting collection of unconventional, thought-provoking ideas can be found on the website [Virusmyth](#).]

According to what would seem a plausible theory HIV/AIDS comes down to a combination of many factors other than HIV in the causation of AIDS.

AIDS is a syndrome, not a distinct disease entity. AIDS patients all die of previously identified diseases, not of HIV infection per se. ... AIDS patients have multiple, well-established causes of immunosuppression prior to, concomitant with, subsequent to, and sometimes in the absence of, HIV infection.

These immunosuppressive agents are of seven basic types: chronic or repeated infectious diseases caused by immunosuppressive micro-organisms; recreational and addictive drugs; anaesthetics; antibiotics; semen components; blood; and malnutrition. While no AIDS patient is likely to encounter all of these agents,

all AIDS patients encounter several. Therefore, the conclusion that HIV is the sole cause of immunosuppression in AIDS, and the sole factor differentiating AIDS patients from non-AIDS patients, cannot be maintained, and alternative hypotheses remain possible. ...

Many gay men, particularly promiscuous ones, also tend to abuse antibiotics, apparently as a prophylactic or remedial measure against repeated sexually transmitted diseases. Chronic treatment with most antibiotics causes T-cell immunosuppression, possibly by depleting trace elements such as zinc, which is an essential cofactor for enzymes controlling lymphocyte cloning. Gay men typically have unusually low zinc and selenium serum levels and abnormally high copper levels as compared with heterosexual men and women and lesbians. ... Another risk factor for AIDS that is common to most patients is the presence of multiple, concurrent infections. Several viral diseases are as highly correlated with AIDS as is HIV: hepatitis B virus, herpes simplex virus [HSV], cytomegalovirus [CMV], and Epstein-Barr virus [EBV].

Herpes simplex virus, CMV, and EBV are all known to reduce the helper T-cell [T4]:suppressor T-cell [T8] ratio that typifies the AIDS patient's immune system, and one type of herpes virus has been shown to act symbiotically to increase the cytotoxic effects of HIV. Both hepatitis and cytomegalovirus were present in unusual proportions of high-risk populations before the recognition of AIDS. ... Epstein-Barr virus, CMV, influenza virus, and various bacterial diseases including chronic syphilis and tuberculosis, are known to adversely affect B-cell and macrophage function, and the World Health Organization lists genital ulcer disease caused by HSV and *Treponema pallidum* as risk factors in AIDS. ... Chronic malnourishment is perhaps the oldest known and most frequent cause of immunosuppression. ...

Also noteworthy is the fact that weight loss and anorexia are frequent concomitants of AIDS in all risk groups, and that AIDS patients in general display nutrient insufficiencies that are manifested in significantly low levels of zinc and selenium. Deficiencies of each are known to cause immunosuppression in man and experimental animals. ... Thus far, every group at high risk for AIDS has been demonstrated to have multiple immunosuppressive risks other than HIV - save for one group: paediatric AIDS cases.

These cases are of particular importance, since they are often cited as some of the best evidence that HIV alone is sufficient to cause AIDS. Anthony Fauci, for example, has disparaged life-style theories of AIDS by asking what possible risky behaviours a newborn infant could indulge in. Also, it is considered significant by many investigators that HIV-infected mothers who show no

clinical symptoms of AIDS nonetheless give birth to children who develop AIDS during the first years of life. The inference that is often drawn from these data is that HIV is the only immunosuppressive risk associated with these infants and thus must be the sole cause of their immunosuppression.

In fact, the mother transfers all of her life-style risks to the foetus and newborn. ... Most AIDS infants not only have HIV infections but also must be treated for one or more of the following: sexually transmitted diseases, CMV, hepatitis, and a variety of other infectious diseases acquired from their mothers. Maternal immunodeficiencies, malnutrition, drug abuse, and infections can all play a role in determining the immune status of the infant: AIDS infants, like all other AIDS patients, therefore have multiple sources of immunosuppression. ... So, it appears that acquired immunosuppression can be acquired in many ways, and that HIV is, at best, only one of many immunosuppressive factors encountered by all AIDS patients. ... A single immunosuppressive agent as HIV cannot explain why AIDS has different manifestations in different individuals.

[Robert S. Root-Bernstein, *Do we know the cause(s) of AIDS?*: Perspective in Biology and Medicine, Summer 1990; www.virusmyth.net/aids/]

Misconceptions

HIV-antibody-positive individuals suffer major health risks from AIDS medications routinely administered by physicians uncritical of drug-company propaganda.. AZT*, an isolate from herring sperm, was first isolated in 1964 ... [and] ... designed to kill cancer cells. ... AZT was the perfect killer of dividing cancer cells. When the compound was tested on cancer-ridden mice, however, it failed to perform as expected and instead revealed its extraordinarily deadly nature. The experimental drug was withdrawn from testing and never approved for human use - until AIDS syndrome.

... I have worked with many HIV-antibody-positive individuals who have for years remained completely free of any AIDS-indicator symptoms or any other significant ones. When treated with medications like AZT, however, people are observed to sicken and die from “wasting disease” in a short period of time. I, as well as other molecular cell biologists, know of no one who has been treated with AZT and lived for more than around one year. Fortunately, it has begun to fall out of favour as the drug of choice. ... “AIDS” death and AZT death are outwardly indistinguishable. Here is a perfect combination: an illness incorrectly billed as universally fatal, treated by a useless, frequently fatal drug. ...

Even if AIDS syndrome does exist as a new phenomenon, perhaps insufficient scrutiny has been paid to the idea that it is not virus-based, but related to an inverted way of living and eating. ...

Disease intensity and statistics must also be considered in terms of the ineffectiveness and iatrogenic influence of the orthodox approach to illness - the equivalent of trying to remove a screw with a hammer. HIV/ET** attempts to divert responsibility for health disaster from an inept, sometimes malfasant, pharmaceutically controlled medical tradition. A century of medical practice and health concepts based on the scientifically erroneous germ theory is as much the cause of AIDS as any single factor - probably more.

AIDS could easily have been predicted epidemiologically as an aspect of the burgeoning crisis in health. It had to be blamed on a virus in order to distract attention from the real problems. Current medical science gives credence to the so-called immune response, where white cells said to be deranged indiscriminately destroy and/or clear out healthy and unhealthy cells. This misconception arises as a consequence of germ theory mentality, which misunderstands the central function of the immune system. It is essentially a sophisticated janitorial service. It operates to keep the place clean and to recycle usable material.

Should "self" cells or tissue become useless or even dangerous to the body, the immune system will clean them out. Thus, it is not deranged, but is doing its job correctly. The host is somehow not doing its job, however, to maintain a balanced internal environment, which is the first line of defence, not immunity, against tissue destruction and infection. This is because infection can come from within. And it bears repeating that the fundamental misconception of the germ theory is that infection must be invasion, rather than an endogenous morbid change in chemistry or microbiology.

[Robert O. Young & Shelley Redford Young 2001]

* Azidothymidine, also known as Zidovudine, Retrovir, or Compound S; drug used in the management of patients with HIV infections.

** HIV/Elastic Theory, or HIV/ET; term used by the authors to indicate that "the HIV/AIDS theory is so elastic [that] it stretches to embrace all reasonable criticism."

CLINICAL MANIFESTATIONS

Disease definition: "HIV infection is a continuously changing and progressive spectrum of immunologic deterioration and associated clinical conditions,

of which the end stage is acquired immunodeficiency syndrome [AIDS].” [Merck Manual]

Primary HIV infection is defined as an acute mononucleosis-like syndrome with fever, malaise, rash, arthralgias, and generalised lymphadenopathy. The rash is similar to the exanthemas of other viral infections and not specific for HIV infection. It may be exanthematous or pityriasis rosea-like, usually does not itch, is distributed over the upper trunk and proximal limbs, and may involve palms and soles.

Neurologic

Neurologic disease is the first manifestation of symptomatic HIV infection in roughly 10-20% of persons, while about 60% of patients with advanced HIV disease will have clinically evident neurologic dysfunction during the course of their illness.

Earliest symptoms of central nervous involvement are frequently non-specific, consisting of lethargy, depression and social withdrawal. More definite signs consist of personality change, memory disorder, confusion, headaches, fits, ataxia or focal neurological signs.

There is a wide range of neurologic disorders. Global cerebral disease can present with altered mental status or generalised seizures, whereas focal disease often produces hemiparesis, hemisensory loss, visual field cuts, or disturbances in language use.

Of the peripheral nervous system disorders distal symmetric polyneuropathy is the most common manifestation. Typical symptoms are tingling, numbness, and burning pain in the toes or over the plantar surface of the feet, often ascending over time. Ankle-tendon reflexes are depressed. There is often decreased appreciation of temperature distally.

Symptoms of cognitive impairment typically occur late in symptomatic HIV disease, usually in the setting of severe immunosuppression.

The AIDS Dementia Complex [ADC] is one of the most common and clinically important CNS complications of late HIV-1 infection. The general character of ADC involves three functional categories: cognition, motor performance, and behaviour.

Cognitive impairment usually underlies patients’ earliest symptoms. Mildly afflicted patients most often have difficulty attending to more complex tasks at work or at home. They need to make lists, sometimes very detailed, of the

day's activities. They lose track of actions [eg, leave the water boiling, get up to go to another room and then forget why they did so] or of conversations in mid-sentence ["What was I saying?"]. Processing unrelated or complex thoughts becomes slower and less facile. While similar lapses can trouble many normal people especially in the face of fatigue or generalized illness, lapses in ADC patients intrude on daily function to a greater degree.

Multi-staged tasks become difficult; eg, the waiter can no longer keep verbal orders straight when he arrives at the kitchen or the avid reader needs to reread paragraphs or pages. ... Because it was constructed for other conditions, the standard Mini-Mental Status may not be sufficiently sensitive at this point; however, when ADC patients do perform abnormally, it is usually on reversals [reversing a five-letter word like "world," or subtracting from 100 by 7's], complex sequential tasks [placing the right thumb on the left ear and sticking out the tongue], or remembering three objects.

Although motor symptoms are far less common during this early phase, individuals relying on rapid or fine co-ordination may note a change. For example, the guitarist may no longer be able to keep up with a difficult piece or the athlete may be slowed to below a competitive level. An inquiring history may discover a change in handwriting or, less commonly, clumsiness in tying shoes or buttoning a shirt.

Moreover, even in those without overt symptoms, motor signs may be detected on examination, including slowing of attempts at rapid opposition of the thumb and forefinger, rotation of the wrist, or tapping of the toe. While the gait may be generally steady, it is often slow, and rapid turns may be interrupted by an extra step or performed hesitantly. Reflexes are also often abnormal. The deep tendon stretch reflexes, including importantly the jaw jerk, are frequently hyperactive, although the ankle jerks may be relatively less active when there is concomitant polyneuropathy.

Thinking and speaking also becomes slower and the content more impoverished. Concomitant behavioural changes may become more evident. Patients appear duller and less vivacious. If left alone, they may sit still without spontaneously offering conversation, but only answering briefly in response to questions. This poverty of output and apathy may be mistaken for depression, but in most of these patients, dysphoria is absent, and disinterest and lack of initiative are the predominating aspects of behaviour without sadness.

[Richard W. Price, *AIDS Dementia Complex*, HIV InSite Knowledge Base, June 1998]

Wasting

The prevalence of “wasting syndrome” as an initial AIDS-defining diagnosis ranges up to 37% in surveys. The condition is defined as a weight loss of at least 10% in the presence of diarrhoea or chronic weakness and documented fever for at least 30 days that is not attributable to a concurrent condition other than HIV infection itself. Weight loss typically consists of both fat and lean tissue.

Dermatologic

Staphylococcus aureus is the most common cutaneous bacterial infection in persons with HIV disease. Approximately 50% of HIV-infected persons are nasal carriers of *S. aureus*. Infection with *S. aureus* may occur before any other signs or symptoms of HIV infection. Morphologic patterns that may occur include: bullous [blister-filled] impetigo, ecthyma [pustular impetigo leaving pigmented scars], folliculitis, abscesses, cellulitis, and pyomyositis [pus-filled inflammation of muscles]. Bullous impetigo is most common in hot, humid weather, presenting as very superficial blisters or erosions, most commonly seen in the groin or axilla.

Folliculitis due to *S. aureus* occurs most commonly in the hairy areas of the trunk, groin, axilla, or face, especially in men who shave. Often the follicular lesions of the trunk are intensely pruritic and may be mistaken for other pruritic dermatoses, such as scabies.

Thrush is the most common form of yeast infection in HIV patients.

As HIV disease progresses, up to 83% of patients develop extensive seborrheic dermatitis, often involving the scalp, face [eyebrows and nasolabial folds], and, less commonly, the peri-auricular region..

Atopic dermatitis may appear in both children and adults infected with HIV. In one series, 50% of infants with advanced HIV disease had atopic dermatitis.

Endocrine

Hypogonadism is relatively common in HIV-infected men. Associated symptoms include weight loss, specific symptoms of hypogonadism [loss of pubic or axillary hair, reduced beard growth, testicular atrophy, sexual dysfunction] or non-specific symptoms [fatigue, loss of libido, loss of energy]. However, many of these symptoms are non-specific and overlap with those of depression or chronic illness.

Gastrointestinal

Gastrointestinal and hepatobiliary disorders are among the most frequent complaints in patients with HIV disease. Manifestations include diarrhoea, difficulty and pain on swallowing, nausea, vomiting, weight loss, abdominal pain, anorectal disease, jaundice and hepatomegaly, GI bleeding, interactions of HIV and hepatotropic viruses, and GI tumors [Kaposi's sarcoma and nonHodgkin's lymphoma].

Head and neck

HIV disease is associated with a variety of problems in the head and neck region including otologic, nasal and paranasal sinus, oral and pharyngeal, and neck manifestations; as many as 70% of HIV-infected patients eventually develop such conditions. Hypertrophic adenoidal tissue can cause recalcitrant nasal obstruction. Serous or recurrent acute otitis media is common. The lymph nodes in HIV lymphadenopathy are soft and symmetrically distributed and can range from one to five cm. Such findings are common in the head and neck locations, especially the posterior triangle.

Sensorineural hearing loss, both unilateral and bilateral, occurs in 21 to 49% of HIV-infected patients. The sensorineural hearing loss may steadily worsen with increasing frequencies, becoming moderate at high frequencies, but speech discrimination is usually near normal.

Hairy leukoplakia is a white, vertically corrugated lesion with a "hairy" surface that appears along the anterior lateral border of the tongue, occurs almost exclusively in HIV-infected patients, and is associated with more rapid progression to the advanced stage of HIV disease [AIDS].

Recurrent giant [several centimetres in diameter] aphthous ulcerations in the oropharyngeal region are also a frequent presentation, as are aggressive gingivitis and periodontal disease, which can progress rapidly to a necrotizing process with severe pain, soft tissue loss and gingival recession, and bone exposure and sequestration.

Dryness of the mouth accompanied by diffuse glandular swelling is fairly common.

AIDS-defining diseases

Kaposi s sarcoma; toxoplasmosis; tuberculous meningitis [Mycobacterium avium/intracellulaire]; fungal diseases such as cryptococcosis, coccidioidomycosis, histoplasmosis, Pneumocystis carinii pneumonia, systemic Candida or Aspergillus infections.

[Data from respective chapters of HIV InSite, a project of the UCSF Center for HIV Information]

MATERIA MEDICA AIDS NOSODE

Aids.

Sources

Nosode prepared from the blood of a man diagnosed as having AIDS who subsequently died of Syndrome related diseases.

- [1] Two group provings amongst students at The School of Homeopathy [Devon, England] in 1994; one group received 30c and the other the 200c.
- [2] The M.R. Vaccine proving. "In order to verify whether the above mentioned proving symptoms gave a clear picture of the essence of the nosode itself, rather than the personal characteristics of the patient whose blood was used, we arranged another proving at the School of Homeopathy. This remedy was made up at Nelsons Homeopathic Pharmacy from the blood of another terminal AIDS patient: Mr M.R."

The proving symptoms were almost identical to those of the first proving, with the following as the most outstanding features:

- ~ Immediate reaction of floating, happiness, playfulness.
- = Able to fit lots of work into a very short space of time.
Or the opposite: extreme heaviness and sluggishness.
- ~ Concern about children, needing protection.
- ~ Dreams of huge houses with many staircases and dark passages.
- ® Dreams of threats of violence.
- = Loss of money, jewellery, possessions.
- = Loss of words, cannot express himself.
- <= Angry with everybody and desire to kill.
- <= Anger at injustice.
- = Great fear of terminal illness.
- <=> Fear of impending disease.
- <= Death is inevitable.

Physical:

- = Feeling as if about to go down with a bad cold or flu.
- => Coryza, fluent.
- <= Itching in eyes, spreading to rest of body.

- ~ Many eye problems.
- > Became short sighted. [Also: short-sightedness cured.]
- Blisters in mouth, on face and lips.
- Left sidedness.

MAJOR THEMES

Loss of protection

Loss of protection/shell/wall. "I felt that I had lost my wall and my shell, and there was a free flow of emotions both in and out. I was exposed, almost naked, with no control." versus "I wanted to do something naked and extravagant. I had no embarrassment with nakedness."

"... uninterrupted flow between self and group." versus

"... does not belong."

felt excluded, lied to."

Estrangement.

= Feeling rejected; outcast.

«= Feeling betrayed.

- Feeling contaminated and fear of contaminating others; always washing.

« Responsibility for others. Responsibility for children.

= Self loathing.

•= Left-sidedness.

Blank

- Continually sensing that I have forgotten something or forgotten to do something.

~ This forgetfulness is not me. Usually very organised. Also finding I lose words. Know what I want to say but the odd word just vanishes.

- Forgetfulness. Forgot any clean pants. Put my top on back to front. Realized that I had put my trousers on back to front as well.

« Mind going completely blank.

= Forget immediately that which I have just done or seen, brushed teeth, poured water for tea, etc.

- I am working very slowly and carefully, otherwise I would be making mistakes because my mind is just not on my work.

Paranoia

- > Its a very closed sensation as if I've been closed out.
- Felt that people were plotting against me.
- ~ Felt lied to, angry, frustrated.
- *< I felt that everyone was watching me and really isolated. And I think 'persecuted' is too strong, but everyone was getting at me. And lots of people came to me and said 'well, look, sorry for offending you'.
- = Felt every one was talking about me in an unkind way.
- ~ Thought people might think I'm a bit strange.
- ~ Feeling like people are looking at me and saying 'she's no good'.
- ~ Felt picked on. Very easily offended. Everyone is watching me; flush very easily.
- > Had this idea that my hayfever is about being under attack, worse when I am not taken seriously. It is about me not identifying correctly external changes in the environment; only having one set of responses to this type of situation. I have to expel it violently, physical, mental, emotional.

Dream themes

[Bracketed numerals refer to number of provers who had these dream themes.]

- ~ Huge houses, vast rooms, small outside, huge within. [8]
- Houses or things richly ornate, jewelled, gold, beautiful interiors, colours stunning and rich. [8]
- ” Big, grand houses, ornate, ramshackle or both. [8]
- Staircases and corridors. [6]
- Wood, metal, water. [5-3-3]
- = Colour: red. [5]
- ~ Violence. Panic. [6]
- « Responsibility. [4]
- ~ Anger - irritability. [3]
- ~ Fear. [6]
- = Teeth. [3]
- = Snow. [3]
- Septic state. [2]
- Children. [5]
- ~ Transport, travelling, buses, cars, trains, airports, bus station, train station. [6]
- = Lots of people - being busy - rushing about. [5]

Main themes of several cases treated successfully with the Aids nosode

= History of sexual abuse.

~ Powerless in the hands of people who are in control, people who can violate your boundaries. Nowhere is safe. The people who should be offering safety and security are the very people who either ignore you, or even worse, betray you.

« Sensation of isolation and estrangement.

» Comfort is found in a bond with a special [innocent or young] friend, dog, kitten etc. who understands the longing for recognition and love.

« Persevering, strong, responsible. There is no time for moping around.

« Restlessness and desire for order. Time is short and there is much to do.

ISSUES

The AIDS nosode is associated in a homeopath's mind with boundary issues. Keeping what is in, in; what is out, out. In health the vital force through the medium of the defence system reacts homeostatically to morbid influences, throwing them off. Keeping what is out, out. Acute manifestations are of this kind, such as fevers, discharges, diarrhoea, pus, and on an emotional level, such as shouting, hitting, moaning, tears. However, should the being become encumbered by disease through a deficiency of acute responses, due to miasmatic predisposition or social suppression or drug use, then chronic disease may begin to settle in. In this aspect we note complimentary aspects to Carcininum and a strongly Psoric colouration.

The relationship with Lac Humanum is also noteworthy - here the central issues revolve around individuality versus group conformity, helping others versus thinking about self first, family obligations versus pleasing oneself with inevitable feelings of isolation and accusations of being uncaring. In Rajan Sankaran's provings of Lac Humanum themes of houses, self loathing and rejection feelings also came prominently into the foreground.

These features are echoed in the AIDS proving. Not unsurprisingly, human blood and milk have features in common. For in Lac Humanum the theme is about what C.G. Jung termed individuation whereby the individual becomes known to Self and therefore is able to integrate egoic drives with social expectations, while in AIDS the boundary between me and you and the outside world is the central issue.

As Carcininum is primarily about the cost of conformity, and Lac Humanum

is about the price of individuality, so AIDS is about the complete breakdown of the defence mechanism. As stated, the key concept is chronic weakness at the boundary.

Sex is about as close as our physical and emotional experience can get to dissolving the boundary. Since the myth of AIDS as well as its 'discovery' is bound up with the gay community in San Francisco we will home into this: casual sex with multiple partners is attempting an impossible union, too much thinning of the boundary, and certainly has resulted in frequent venereal infections and associated allopathic treatments as well as providing the pathway of infection. This hunger for intimacy expressing as its perversion in superficial unions may be associated with a low self opinion [and its compensations in arrogance] and isolation feelings.

Witness the gay community and its exclusion and suppression by heterosexual folk. Gay also stands for, 'Good As You'! With the arrival of AIDS related symptoms, a sense of desperation, breakdown and decay enters the picture. The Syphilitic note. The breakdown of the immune defence system is mirrored in ecology by such phenomena as the ozone hole, monoculture diseases, [combated by agrochemicals in a manner analogous to the multiple drug therapies employed in the conventional treatment of AIDS] and in sociological terms, by abuse. Here the boundary of the self is violated. It is also worthy of note that Chiron, the asteroid associated by astrologers with wounding and healing was discovered at around the time that AIDS became known.

[Misha Norland]

Extract from *Bruce Chatwin* by Nicholas Shakespeare.

Publisher: The Harvill Press in association with Jonathan Cape. ISBN 1 86046 544 7

Bruce Chatwin, writer, storyteller, traveller, died of AIDS in 1989. Always unwilling to believe he was suffering from a "homosexual" disease, he clung to the idea that his body was riddled with a rare fungus, *Penicillium marneffei*, whose host is a South Asian bamboo rat.

He hid his HIV status from relatives and friends.

He suffered a whole gamut of symptoms, including tremendous, catatonic weakness and anaemia, cough, diarrhoea, molluscum contagiosa, Kaposi sarcoma. His mental state was fascinating, and perhaps produced difficulties for his wife and carers:

"Bruce's plans had been getting progressively grander.. ..His mind started

racing again. He wanted to buy the Duchess of Windsors clothes. He wanted to buy Elizabeth [his wife] a Bugatti for £2 million. He wanted to found a city and to develop underwater tourism.. ..He had solutions for ending the Cold War [1989].. "He was going to write to Gorbachev and go and see him and stop all this nonsense, sort it out, and he, Bruce, was going to get the Nobel Peace Prize." [Keith Volans]

Bruce planned a collection of art objects called The Homer Collection. Having been told by his accountant that he could spend £100,000 on it, he started buying. Volans describes "His eye was not out of control. He knew exactly what he wanted; he was immensely precise. 'I want that Japanese lacquer box I saw, the one made for export.' He would write out cheques for £100,000 and no-one would question. The prices were breathtaking.

In brisk succession Bruce bought a Bronze Age arm band for £65,000, an Etruscan head for £150,000, a jade pre-historic English cutting knife, a flint Norwegian hand axe and an Aleutian Islands hat. He could not sit waiting for the objects to be wrapped. They were shoved into plastic bags and attached to the back of his wheelchair." His purchases were often secretly returned to the dealers in the following weeks.

This is a telling extract from his biography, showing the gaiety, brilliance, hurry, bombast, naivety and extravagance of Bruce Chatwin in the very grip of his disease. He recognized few boundaries.

REPERTORY RUBRICS

Mind

- Desire for company; of his family; of close friends; of the group.
- « Delusions: of being above it all; of not being appreciated; of not belonging here; of being a child; of being friendless; of being naked, unprotected and exposed; as if being in a strange land.
- = Dwells on his childhood; on past disagreeable occurrences.
- « Eating in company amel. mental symptoms.
- Fear of high places, as if he might be pushed by someone behind him.
- Fear in narrow places, fear of trains and closed places.
- => Forsaken feeling, of not being beloved by his parents, wife, friends.
- « Helplessness, feeling of.
- = Desire to kill everyone he sees.

-
- Always too late.
 - ~ Slowness [3]; in work.

Locals

- Vertigo: accompanied by heaviness [eyes, head]; with sensation of ascending; when looking at revolving objects.
- Head, Heaviness, < smoking.
- Head, Pain, Forehead, right side, extending to neck, nose, teeth.
- Head, Pulsating, Vertex, on waking.
- =■ Head, Swollen feeling, Vertex.
- Eye, Swelling, morning on waking.
- Nose, Coryza, from change of temperature.
- « Nose, Epistaxis, morning in bed on waking; profuse; when sneezing.
- Nose, Obstruction, morning on waking.
- « Nose, Sneezing, from dust.
- Face, Eruptions, herpes, about lips.
- Face, Eruptions, rash, < warmth.
- Face, Numbness, about mouth.
- Mouth, Numbness.
- Mouth, Ulcers, Gums.
- Teeth, Looseness, sensation of, lower teeth.
- Throat, Hawk, disposition to, from dryness.
- External throat, Sensitive to slightest touch, sensation of rope around neck.
- « External throat, Tight around neck and waist, cannot bear anything.
- Stomach, Fulness, sensation of, morning.
- == Stomach, Pain, morning on waking.
- = Thirst for small quantities, and often.
- « Female genitalis, Menses, copious at night; painful on waking; too short.
- = Respiration, Difficult, during palpitation.
- Chest, Pain, Mammae, during cough.
- Back, Pain, Cervical region, during menses.
- Extremities, Coldness, Foot, right.
- Extremities, Heat, one hand cold the other hot.
- Extremities, Numbness, Foot, toes, morning on waking.
- Extremities, Perspiration, Foot, night on waking.
- « Extremities, Perspiration, Hand, palm, night on waking.
- Extremities, Weakness, Knee, as if knees would knock together.
- Sleep, Position, on back; on back with left arm over head; on back with hands behind head.

Generals

= Coldness of affected parts.

= Food and drinks:

- * alcoholic drinks <. [Hayfever]
- * alcoholic drinks, easily intoxicated.
- * beer <. [Itchy rash on right side of chin]
- * bitter drinks, desire.
- * bread c. [Hayfever]
- * chocolate, desire.
- * coffee <. [Hayfever]
- * fish, desire.
- * ice cream, desire.
- * milk, desire.
- * peaches, desire.
- * sweets, desire.

= Sleep, after sleep, morning on waking <.

MATERIA MEDICA VIRIONUM

Sources

Nosode prepared from the serum of HIV-1 positive woman [who was cured]. Introduced by Dr. Mirza Anwer Baig, of Mumbai, India, who “conducted the conventional proving with studies on HIV positive but healthy individuals and then tested it on patients.”

Indicated for HIV-2 type and cases of full-blown AIDS with a low viral load; also for AIDS-related conditions in HIV-1 negative patients, for resistant TB cases and for treatment of advanced stages of cancerous conditions.

Virionum is contraindicated for HIV-1 positive patients and for children below the age of 15 years.

A second nosode introduced by Baig, termed *Carcinomin* and prepared from the breast milk of a woman suffering from breast cancer [cured], is indicated for HIV-1 patients [to “increase their CD-4 counts, i.e. immunity marker cells” or to “reduce their viral load”], for diabetic patients and to counteract the adverse effects of conventional vaccines.

SYMPTOMS

Mind

- « High-grade anxiety about health with garrulous loquacity and tendency to go from one physician to another.
- = Anticipatory anxiety about every symptom and marked fear of death. “Virionum is the remedy for the anxious youngsters of our society who grope in the dark and who live with the fear that every little symptom would prove fatal.”
- Love for music and dancing.
- Excessively worried; weary of life; weeping, depression, and dwelling on unpleasant occurrences.
- = Lack of confidence “with stimulated lower instincts; desire for violent sex, but decreasing ability, with disposition to masturbation.”
- « Changeable moods: cursing and laughing; fault finding and vivacity.
- « Aversion to being spoken to, aversion to meeting people.
- = *Sympathetic and helpful but indolent and brooding in silence.*
- Guilt feelings.
- = *Anger towards parents or clinging to mother.*
- = Throwing things when angry.
- = Religious affections.
- Sensitive to reprimands.

Generals

- Flushes of heat with soreness of body.
- General weakness, very marked, > motion, much > walking.
- = Feverish with pain in bones.
- « Wandering pains or *numb sensation* all over.
- « High-grade fever [up to 41° C] with delirium and even loss of consciousness.
- Appetite good during fever, otherwise diminished.
- Weight loss despite good appetite.
- Increased thirst & dryness of mouth; desire for juicy things.
- « *Frequent colds with cough, low backache, fatigue and weakness.*
- = Great sensitivity to “grievous physical trauma, psychological or emotional trauma.”

Locals

- Vertigo & weakness of brain.

-
- Fullness of nose, plug sensation, & dizziness.
 - = Urine copious; stool watery and even involuntary.
 - ~ Urticarial eruptions, nodular or in streaks, with intense itching.

Differentiation

Marked loquacity which in Virionum might prove to be boring, unlike the loquacity of Lachesis.

Love for music and dancing like Carcinosinum. Carcinosinum fits better the creative and adventurous, the more bold and happy-go-lucky type, whereas Virionum is inactive, worried, and timid.

[Mirza Anwer Baig, *Homo-Immunization: AIDS versus Cancer*, reviewed and summarised in Rozina A. Zaheer, *Virionum, the nosode ofHFV: As remedy and as vaccine!* Hom. Links 4/01]

CLASS VI - NEGATIVE SINGLE STRANDED RNA

a. Negative single stranded RNA; enveloped; pleomorphic

| Family | Genus | Type Species | Remedies |
|---|----------------------|----------------------------|--------------------------------|
| a: negative single stranded RNA [-ssRNA] | | | |
| Bornaviridae | <i>Bornavirus</i> | <i>Borna disease virus</i> | |
| Filoviridae | Marburg-like viruses | <i>Marburg virus</i> | |
| | Ebola-like viruses | <i>Zaire Ebola virus</i> | |
| Paramyxoviridae | <i>Morbillivirus</i> | Measles | Measles Vaccine Morbillinum |
| | | Canine distemper | |
| | <i>Rubulavirus</i> | Mumps MMR | Parotidinum MMR |
| Rhabdoviridae | <i>Lyssavirus</i> | <i>Rabies virus</i> | Lyssinum |

BORNAVIRIDAE

General

- Newly recognised virus family, with borna [disease] virus as its prototype.
- Non-segmented, negative-strand, enveloped RNA virus with worldwide distribution.
- Infects a broad range of warm-blooded animals; has been found in horses, cats, dogs, foxes, sheep, llamas, alpacas, cattle, donkeys, mules, rabbits, and ostriches. The sources and routes of potential human infection are yet to be established, but assumed to be transmitted via saliva or nasal and conjunctivae secretions.
- Named after the German town Borna, where an outbreak of borna virus- induced encephalomyelitis in cavalry horses crippled the Prussian army in the late 1800s.

- Borna disease in naturally infected horses and sheep is characterised by hyperthermia, anorexia, colic, and constipation, followed by a syndrome including aggressive and passive stages, circular movement into tighter and tighter circles, awkward positioning, disorientation leading to running into stationary objects, and progressing over weeks to ataxia, paralysis and inanition. A peculiar symptom, termed ‘pipe smoking’, consists of the animal holding hay or straw in the mouth without chewing it. The illness lasts one to three weeks and has a high death rate.
- Most outbreaks appear to occur in spring or summer months, although cases are reported year round.
- Referred to as ‘Sad Horse Disease’ in equids.
- In New Zealand, borna virus is thought to be associated with wobbly opossum disease, which causes bizarre behaviour in opossums and has been known to cause BVD-type infections in mammals that have had contact with sick opossums.
- Experimentally infected adult rats initially exhibit hyperactivity and exaggerated startle responses, subsequently followed by stereotyped motor behaviour, dyskinesias, dystonias, decreased activity, and cachexia.
- Rats infected as neonates, on the other hand, display a syndrome characterised by stunted growth, hyperactivity, learning deficits, and altered taste preferences.
- Persists in the nervous system despite vigorous immune responses. Clinical signs may be dramatic, subtle, or inapparent.
- Appears to have a predilection for the limbic area of the brain.

[C.G. Hatalski et al., *Borna Disease-*,

<http://www.cdc.gov/ncidod/EID/vol3no2/hatalski.htm>]

Neuropsychiatric disorders

A virus that makes horses and cats go through episodes of apathy, energy loss and sleepiness, borna virus was recovered in 1996 from two patients with manic depression and another with chronic obsessive-compulsive disorder in Germany. While some researchers attributed the link to accidental contamination, the discovery boosted for others the evidence that the virus may play a role in human neuropsychiatric disorders, eg, it triggers depressive episodes in people predisposed to major depression or bipolar disorder. An earlier German study of 71 psychiatric patients had found that 37% of patients with major depression and 25% with paranoid psychosis were seropositive by day 17 of illness.

Supporters of the hypothesis say that traces of the virus are found in a region of the horse brain that control emotion, suggesting the depressive behaviour comes from interference there rather than as a general reaction to feeling ill. That the viral proteins and genetic material tend to appear during or near episodes of depression has led German investigators to the conclusion that the virus can promote depression when it is activated from a dormant state. The improvement in BVD-positive cases of depression from treatment with the anti-viral drug amantadine appears to substantiate the hypothesis. [Originally developed for the treatment and prophylaxis of influenza, amantadine is used in the treatment of Parkinson's disease, traumatic head injury, dementia, cocaine withdrawal, and apathy in multiple sclerosis.]

Borna virus disease [BVD] has been depicted as "a new human virus infection possibly threatening mental health."

A 1995 study among psychiatric patients from a schizophrenia research clinic in Baltimore, USA, found that 13 of 90 patients [14.4%] had antibodies to BDV antigen. The study concluded that "there is tentative evidence for a schizophrenia - control difference in the prevalence of anti-BVD antibodies" and "it is likely that there are neuro-anatomical/behavioural features that differentiate seropositive from seronegative schizophrenic patients." [Several other viruses have been implicated as an infectious aetiology for schizophrenia, including influenza and tick born viral agents. A 1995 case control study even supported the association of cat ownership with schizophrenia since cats may transmit feline BVD and other neurotropic viruses.]

BVD specific antibodies could furthermore be demonstrated in 4-7% of sera from more than 5000 psychiatric or neurological patients from Germany, Japan and the U.S.A. Nonetheless, BVD remains controversial in the induction of neuropsychiatric manifestations in humans.

- Hanns Ludwig, a German veterinary virologist, performed some early animal experiments with the borna virus in the mid-1970s.

The experiments involved tree shrews - small, long-nosed Asian mammals that superficially resemble squirrels. A friend of Ludwigs happened to be a specialist in tree shrew behaviour. Yet not pretty, ordinarily: they are nasty, aggressive little beasts, not much given to affection and parenting. After pups are born the mother wastes little effort on nurture before chasing them away. Yet tree shrews, while not primates themselves, are considered close to what our earliest primate ancestors must have looked like. Their brains are organised like ours.

One evening in the mid-1970s, Ludwig suggested to his friend that they try injecting borna virus into some of his animals to see what it would do to them. This they eventually did to 19 shrews.

“And lo and behold, they didn’t die, like rabbits!” Ludwig recalls. “Or like horses. Instead they developed a persistent infection. They had antibodies to the virus but no clinical signs - only changed behaviour; they became tame. They had a lot of sex. They got their children, and they reared them differently - they lay with them and licked them all the time. It was a disruption of social behaviour in animals with a primate-like brain. So that was very exciting. But of course we had no proof that it was the virus that did it.”

[cited in: Robert Kunzig, *It kills horses doesn't it? - Borna disease-*, Discover, Oct. 1997]

Homeopathy

Non-existent as a nosode.

FILOVIRIDAE

General

- Family with only two known members: Marburg-like and Ebola-like viruses.
- Named for its threadlike structure, resembling a “woolly bear caterpillar,” enabling the virus to roll up tightly for protection.
- Transmission: direct contact with blood or body fluids; droplet and aerosol infection.
- First isolated in 1967 from workers at vaccine factories in Belgrade, Serbia, and Marburg, Germany, where wild-caught African green monkeys from Uganda were used. Nine years later a morphologically identical but antigenically different virus emerged in remote villages in Zaire and Sudan. It was named *Ebola* after a river near the epidemic’s starting point in northern Zaire.
- Both cause haemorrhagic fever with a high mortality.

Homeopathy

Non-existent as a nosode.

PARAMYXOVIRIDAE

General

- Mixed group of large, enveloped RNA viruses with projections.
- Common to many paramyxoviruses is the fact that they can cause neurological symptoms in their final host.
- Some members of Paramyxoviridae are associated with distemper [viral diseases in animals], such as dolphin distemper, seal distemper, porpoise distemper, and canine distemper.
- Measles [rubeola] and mumps are essentially respiratory illnesses with other, significant manifestations: conjunctivitis, rash, encephalitis [measles], and parotitis and orchitis [mumps].
- Measles tends to prevail in winter/early spring, whereas mumps may occur year-round.
- The various parainfluenza viruses are associated with respiratory symptoms.
- Parainfluenza 1,2, and 3 cause periodic outbreaks of croup, bronchiolitis, and pneumonia in all age groups, while types 4A and 4B cause milder colds.
- Type 3 is apt to cause pneumonia epidemics in children in the spring months at 1,2, or 3-years intervals.

CANINE DISTEMPER VIRUS [CDV]

Features

- CDV belongs to the genus Morbillivirus, as does the rinderpest [cattle plague] virus. Medical historians theorize that measles somewhere after 2500 BC mutated from the canine distemper virus or the rinderpest virus. Eventually the measles virus adapted to humans, in a variant that could no longer survive in dogs or cattle.
- Multiple sclerosis was at one time thought to be associated with exposure to CDV, although further research seems to suggest that actually the human measles virus might be the culprit.
- Canine distemper virus is readily inactivated by heat and sunlight. It is very resistant to cold. A small majority of distemper cases occur in the fall and winter.
- Canine distemper occurs in dogs from four months to four years old. Young puppies between three and six months of age are most susceptible to the disease and are the most likely to die from it. All species of dog-like animals

are affected as well as weasel-like animals such as ferrets, mink skunk, badgers and racoons and red pandas.

- “The onset of the attack is either sudden or gradual, generally the latter. In the earliest stage, the dog is observed to be dull and depressed, and takes no notice of food, or of his owner. In a short time, a scanty, clear, and watery fluid issues from the nose; the eyes are watery and unusually sensitive to light; and the animal has a short, dry, husky cough. ...

As the disease advances, fresh symptoms appear and existing ones become aggravated. There is constant shivering, accompanied by aversion to cold, and preference for warmth; the coat stares [bristles]; the bowels are either relaxed or confined, and the faeces dark; the urine is scanty and high- coloured; the pulse is still more frequent and compressible; the temperature of the surface, and especially of the paws, higher; and frequently an offensive vomit comes up from the stomach.

At the same time the nasal discharge assumes a purulent character, and increases in quantity; it adheres to the nasal orifices and obstructs respiration, much to the patients annoyance; the respiration is quickened; and the cough is short, almost constant and sonorous. At this stage, inflammation of the air-tubes, or of the lungs, may come on. Eye disease is also apt to appear. The discharge becomes mattery, and when abundant runs down the face. The lids stick together, especially in the morning.

General cloudiness gradually comes over the eye, rendering it opaque and white, and, of course, impairing vision. Then in the centre, or towards one side, there appears a circular ulcer, at first minute, but gradually extending in depth and width.

The ulcer at last penetrates the cornea, the aqueous humour escapes, the iris protrudes, and the extreme pain is relieved. When the distemper yields, these affections of the eye gradually subside, and the ulcer heals up, leaving only a small speck, which generally disappears after a little while.”

[J. Moore, *Dog Diseases Treated by Homeopathy*, 1859, reprint Jain Publ, New Delhi, 1994]

- Canine distemper encephalomyelitis manifests itself by gastrointestinal and respiratory disturbances that precede or occur simultaneously with neurological signs. Ruddock, writing in the 1880s, says that the dog, at the onset of the shivering fits, “hides in any hole or corner, and is difficult to persuade to come out.” The neurological symptoms vary greatly and include generalised seizures, depression, aggressiveness, disorientation, inco-ordi- nation, hypermetria [ataxia characterised by overreaching a desired object

or goal], falling, walking in circles, aimless wandering, head tilt, nystagmus, olfactory dysfunction, lack of appetite, and flexor spasms of the muscles of neck, abdomen and/or limbs.

These rhythmic contractions, sometimes also involving the masseteric and periorbital muscles, usually persist during sleep. Seizures classically start with snapping or trembling of the jaws and progress to convulsions of the whole body. An unusual form of seizure occurring with distemper produces a syndrome that looks like the dog is chewing gum frantically.

• Several long-term problems may appear after apparent recovery from CDV infection: seizures [can be lifelong], retinal damage, tear deficiency, corneal discoloration, formation of hard crusts on the nose or the edges of the footpads [one of the old names for distemper was 'hard pad disease'].

• The neurological form of distemper in dogs can be confused with rabies. In wild carnivores, signs of abnormal behaviour and apparent lack of fear, suggestive of rabies, may be the only signs grossly visible

• It has been reported that humans can contract an asymptomatic canine distemper infection. Cats are not susceptible to canine distemper. Distemper of cats refers to a different virus, the feline panleukopenia virus [FPV], which closely resembles the virus causing parvovirus disease in dogs.

• Prevention of infection is considered the best way to deal with canine distemper. Distemper vaccination, available since the 1950s, has made it a rare disease, except in the shelter, rescue, and pet store world. Dogs that are confined, reportedly, are more susceptible than those that are free to roam. Ruddock lists as causes: "Contact with dogs having the disease; too much meat while young; exposure to damp and cold; pampering and confining dogs; too early or suppressed sexual gratification." [The Pocket Manual of Homeopathic Veterinary Medicine, New Delhi, 1972.

• Veterinarians tend to begin vaccination against canine distemper [with modified live virus] at approximately six weeks of age and continue until 12 or even 16 weeks of age at three to four week intervals. The vaccine is repeated due to interference with vaccination from antibodies passed to puppies in the mother's milk. Some puppies develop signs of canine distemper following vaccination even though they do not appear to have the

Canine distemper's

distressing symptoms:

*Dullness, depression -
the dog hides itself.*

Coryza, + photophobia.

Dark urine.

Dry, husky cough.

*Cold, shivering. Averse
cold, desires warmth.*

*Coryza - pus, thick
discharge glues eyes and*

*nose. Lips dry, stuck
together.*

Vision clouded. + Pain

Cornea ulcerates.

*Rhythmic fits with snap-
pingjaws and chewing
motions.*

Crusts on nose and pads.

DD: Rabies

disease. In these puppies encephalitis occurs. The virus is shed in all body secretions from infected animals.

A small percentage of dogs develop neuro-distemper, referred to as 'vaccinal distemper', 10 to 21 days after administration of a modified live distemper vaccine.

In older times puppies were immunised for distemper with vaccine against measles. It has been said that children in the home of a dog vaccinated with live distemper virus vaccine will become exposed to the virus and immunised against the measles.

Homeopathy

There are two remedies related to CDV: Distemperinum nosode [Distemp.] and Distemperinum vaccinum [Distemp-vc.]; the first has zero symptoms in Synthesis 9.1, the second one: Generals, Inflammation of sinuses [sinusitis].

The similarity between rabies and neuro-distemper suggest a similarity between Lyssinum and Distemperinum. Both diseases involve an acute encephalomyelitis, both viruses are neurotropic, and both remedies are made from the saliva of affected dogs. Distemperinum nosode 200x, once a week, has been recommended in Germany in the treatment of multiple sclerosis to help reduce demyelination.

MEASLES

Features

- The word 'measles' appeared in English in the 14th century and, according to Biddle, stems from the word 'miser,' which was used to refer to the wretchedness of lepers. In stark contrast to this stands Viera Scheibner's suggestion that "the name 'measles' itself is an old Sanskrit word meaning 'visitation by a goddess'." The recognition of these benefits has even manifested in a tradition of measles [etc.] parties, to which parents bring their children to deliberately expose them to the infection, in order to gain the benefits of lifelong immunity.
- Measles has a close historical association with smallpox.

Epidemics of measles and smallpox, both viral crowd diseases without animal reservoirs, have often travelled on each other's heels, as is evidenced by measles following smallpox to the New World. The Persian physician al-Rhazes

Measles:

Middle English - meser = leper.

Middle Dutch - Mosel - pustule.

Colloquial English - measly = inferior, contemptible, worthless.

Measles symptoms:

fever, prickling eyes, conjunctivitis < light.

Hacking cough, sneezing, nosebleed.

Koplik's spots in mouth.

Rash starts around ears, neck; spreads to trunk, limbs. Mild itching. Flat spots may leave brown marks and later peel.

Sequelae:

Increased sensitivity

Strep infections.

Catarrh, cough, pneumonia. Fits.

Gradual paralysis.

of Baghdad [850-923] thought that they were two phases of one disease, a view that persisted for many centuries.

- A highly contagious, acute disease, measles is spread mainly by airborne droplets from the nose, throat, and mouth.
- Whereas measles in the past primarily occurred in children, it now has its peak incidence in previously immunised teenagers and young adults. [This must bring into question the efficacy of such a vaccine.] The risk of complications of pneumonia [3%] and liver abnormality [20%] have increased as a result.
- Studies of measles in Old World populations indicate that the disease is much more virulent when transmitted by a consanguineous family member than when transmitted by an unrelated person. Mortality nearly doubles when the measles virus passes between cousins and nearly quadruples when passed between siblings. This occurs because measles and other viruses mutate constantly, adjusting quickly to the immune systems of individual hosts. When the contagion passes from one family member to another, much of the adaptive work is already done. The virus is tailor-made for attacking the unlucky victim. [Fenn, 2001]
- Several studies in areas with severe vitamin A deficiency problems have found that vitamin A treatment of children with measles has resulted in reduction in morbidity and mortality

Clinical manifestations

- Clinical manifestations include prodromal fever, coryza, hacking cough, and conjunctivitis, followed by the appearance of Koplik's spots on the buccal or labial mucosa [typically on the buccal mucosa opposite the first and second upper molars], pharyngitis, laryngitis and/or bronchitis. One to two days after the spots, the characteristic rash appears, first as irregular macules in front of and below the ears and on the side of the neck, to soon become maculopapular and spread rapidly to the trunk and extremities, as they begin to fade on the face. At the peak of the illness, the temperature may exceed 40° C, and headache, peri-orbital oedema, watery eyes, conjunctivitis, photophobia, running nose, sneezing, epistaxis, hoarseness, hacking cough, extensive rash, and mild itching are present.

In three to five days the rash begins to fade rapidly, leaving a coppery-brown discolouration followed by desquamation. Patients with measles are highly susceptible to streptococcal infection. In some cases a haemorrhagic rash [black measles] develops.

-
- The eruption of measles consists of numerous, roundish, lentil-sized red spots, which are a little raised above the level of the surrounding skin and generally contain in their centre a little papule. The measly redness disappears under the pressure of the finger and reappears again after removing the finger, from the middle towards the periphery, contrary to scarlet fever redness, which reappears from the periphery towards the centre. In the eruptive stage there is a peculiar measles-smell, scenting the whole atmosphere of the patient. [Raue]

Sequelae of measles

- Measles causes transient suppression of delayed hypersensitivity, leading to a transient reversal of previously positive tuberculin and histoplasmin skin tests and sometimes to *worsening of active TB or reactivation of latent mycobacterial infection*. [Emphasis added.] [Merck Manual]
- As sequelae of measles are mentioned as quite prominent, chronic catarrhal cough, and chronic pneumonia, which may end in *consumption*. Besides these, a number of scrofulous affections, such as chronic inflammation of the eyes, otorrhoea, glandular swellings, and chronic inflammations of the periosteum and of the joints. [Raue]
- A very rare complication is subacute sclerosing panencephalitis [SSPE], a progressive, usually fatal neurological disorder. SSPE develops one to ten years after measles infection or after receipt of live attenuated measles vaccine. "Onset is usually before age 20. Often the first signs are diminished performance in schoolwork, forgetfulness, temper outbursts, distractibility, sleeplessness, and hallucinations. Seizures follow the mental changes and initially are myoclonic jerks - sudden flexion movements of the extremities, head, and trunk; grand mal seizures may occur. Patients show further intellectual decline; changes in speech, and abnormal involuntary movements and transient periods of opisthotonos are seen. Later, rigidity of the body musculature, difficulty in swallowing, cortical blindness, and optic atrophy may be noted. In the final phases, the patient becomes increasingly rigid, with intermittent signs of hypothalamic involvement [eg, hyperthermia, diaphoresis, and disturbances of pulse and blood pressure]. Those who survive are severely impaired mentally and physically." [Merck Manual]
- The combination of chicken pox and measles dramatically increases the risk for SSPE.
- Guillain-Barre syndrome has been shown to follow both natural measles virus infection and live attenuated measles virus vaccination.
- Disintegrative psychosis is recognized as a sequela of measles encephalitis.

Measles vaccine and adverse reactions

- Live morbillivirus [measles virus] is a component of MMR vaccine.
- According to a study conducted by the World Health Organization, chances are 14 times greater that measles will be contracted by those vaccinated against the disease than those who are left alone.
- It has been determined that the measles vaccine may cause ataxia, learning disability, retardation, aseptic meningitis, seizure disorders, paralysis and death. It has also been investigated as a possible cause of or cofactor for multiple sclerosis, Reye's syndrome, Guillain-Barre syndrome, blood clotting disorders, and juvenile-onset diabetes. [Miller]
- Adverse effects of live attenuated measles vaccines were collected and reviewed by the U.S. Vaccine Safety Committee:

The first report of encephalopathy following vaccination with the live attenuated Edmonston B [Rubeovax] measles vaccine appeared in 1967. A 2-year-old girl developed unsteadiness 7 days following vaccination. This was followed by pronounced generalised ataxia [diagnosed as cerebellar ataxia], fever, vomiting, and an exanthema. The ataxia persisted for at least 8 months.

... Retrospective analyses of populations who have received measles vaccine have been reported from many countries, including the United States. ...

A report of 23 cases of neurological disease following measles vaccination in the U.S. from Jan. 1965 to Feb. 1967 characterises 18 of the 23 cases as "encephalitis" [described as including disturbances of sensorium, seizure, major loss of motor function, and cerebral oedema]. The interval from vaccination to the onset of symptoms ranged between 3 and 24 days. ... There were two cases of aseptic meningitis, two cases of cerebellar ataxia, and one case of extraocular muscle paralysis. ... A review of 84 patients with neurologic disorders occurring within 30 days of vaccination against measles virus reported to the Centers for Disease Control from 1963 to 1971 revealed 59 patients with extensive neurological disorders, which included encephalomyelitis. ...

A 5-year-old received a live measles vaccine and developed fever two weeks later. Three days after the onset of fever, the boy presented with hemiparesis, dysarthria, and a generalised rigid-akinetic syndrome. A spinal tap obtained four days later showed pleocytosis. One month later he was diagnosed with postencephalitic parkinsonism. The parkinsonism persisted for the 2 years between the time of vaccination and publication of the report [in 1992].

A 14-month-old girl received the Wellcome measles vaccine and developed convulsions 12 days later. She became confused, restless, and then unconscious.

She made little progress in the 4 months between hospitalisation and publication of the report. ... A 13-month-old girl was admitted to the hospital with involuntary jerking movements of her limbs 10 days after receiving a further attenuated Enders live measles vaccine. She was afebrile, although she had fever for 2 days prior to admission. The CSF was turbid and showed pleocytosis. She had a convulsion followed by apnoea. She died 13 days after vaccination.

[Stratton et al. 1994]

MATERIA MEDICA MORBILLINUM

Sources

Remedy made from buccopharyngeal exudates from measles patients.

No provings. Clinical observations only.

Indications

“The well-known symptoms which characterise an attack of measles may all be taken as guides for its homeopathic use. Its chief use hitherto has been as a prophylactic against infection, and to clear up after-effects of an attack. ... For an attack of the disease I find nothing better than Morbil. 30, eight or ten globules in six ounces of water, a dessert spoonful every two hours. The effect of this is heightened by giving alternately Bell. 30 in the same way. These two medicines will be sufficient to carry through any uncomplicated case, and in my experience do even better than Pulsatilla.

As the measles poison has a great affinity for the mucous passages, the eyes, the ears and the respiratory mucous membranes, Morbil. *may be used in such cases like any other homeopathic remedy*, when the symptoms correspond.” [Clarke] [Emphasis added.]

“In view of the almost inevitable infection of the whole European population with measles, the measles nosode can be indicated in numerous kinds of illness. These illnesses follow the use of some chemical drug [possibly decades ago] in the treatment of measles, in an attempt to suppress one or other of the various stages in the automatic course of a measles infection [incubation, initial or prodromal stage with catarrhal symptoms, the enanthematous or subsequent exanthematous stage, and finally the desquamatory stage] by medical means. This happens very frequently in the typical measles complication

of bronchopneumonia and also in otitis media and in measles encephalitis [usually 4-5 days after the eruption of the exanthema].

Apart from this. Morbillinum is particularly indicated in iatrogenic exanthemata resembling measles; these may occur after the administration of eg, acetylsalicylic acid [Aspirin], barbiturates and codeine. Additionally, all violent and highly febrile bronchopneumonias are an indication for Morbillinum, according to the Law of Similars, particularly if they are viral pneumonias. Cases of viral encephalitis may find their simile in Morbillinum, likewise acute otitis media and pleurisy, which is the most frequent complication of measles. In a this case, one should also use the indicated homeopathic remedy [Bryonia, Apis, Ranunculus, and where there is suppuration Hepar Sulph. or Mercurius Solubilis].” [Reckeweg]

Dorothy Shepherd emphasises the affinity of measles with the eyes and the tendency for chronic eye troubles. “I wish I had known about Morbillinum before, when I think of the hundreds and hundreds of chronic eye inflammations I have treated during the last two decades, months and months of local treatment, relapse after relapse, the same cases invariably used to attend year in, year out, until they left school.

A pitiful confession of the failure of orthodox treatment: of course conjunctivitis and blepharitis when due to dust and dirt clear up quickly enough with the local antiseptic treatment; but chronic external eye conditions remain with their victims, if they are caused by measles. Of course under-feeding, wrong feeding, has a lot to do with it and the irritation of the eye due to dust and dirt does not improve it; nor does the poor illumination in the working class homes help matters.

But many of these cases had treatment for months at special eye convalescent homes, where particular attention is paid to diet: extra milk, Marmite, cod liver oil and malt, a plentiful supply of butter, cream, eggs and oranges, extra vitamins were supplied there; in spite of this the children stayed for months - 3-6 months’ stay at this home is common - while a few doses of Morbillinum under war conditions - a reduced fat consumption and no cod liver oil and malt - cleared up similar chronic eye conditions in a matter of two to three weeks!”

Symptoms

[From Synthesis 9.0]

- = Mind: Fear of the sea. [Vithoukias]
- Eye: Inflammation Optic nerve.
- = Eye: Paralysis upper lids.
- = Chest: Inflammation Lungs.
- Fever: Typhoid fever.
- = Skin: Eruptions, Measles.
- == Generals: Chronic disease, to begin treatment.
- = Generals: History, personal, of cancer.*
- = Generals: Measles, ailments after.
- = Generals: Measles, ailments after - never well since.
- <-> Generals: Syphilis.

* This addition by Margaret Tyler is based on cases of Burnett, who claimed that tumours often came on after severe measles.

Cases

(1) I had a case of this sort a few years ago, when no remedy seemed clearly indicated from the start. A university student had been unable to concentrate and suffered from attacks of vertigo when walking. He described this as feeling 'as if he had put one foot in a small boat'. This began after an attack of measles two years previously. The cause of the vertigo was obscure, he had been checked over at the ENT department of a teaching school without a definite diagnosis having been made. *Morbillinum* 200c, one dose, was followed by a short aggravation, then complete cure.

(2) One indication of primary importance is where an acute infection marks the onset of chronic disease: 'Never well since measles', for example. My first experience with *Morbillinum* impressed me in that respect. A girl of nine came with a history of having had a cough of two years duration following measles. She had been off school for most of the two years, was losing weight and was generally debilitated. Tuberculosis was suspected and she was thoroughly overhauled at one of the London teaching hospitals, by X-rays, skin tests and sputum examination, with negative results. *Drosera* and *Carbo Veg.* helped her, but *Morbillinum* acted like a charm. She was back at school within a month, and for the next fourteen months was able to attend school regularly. There were two slight recurrences, which did not necessitate her staying at home. *Morbillinum* was repeated once, six months after the first dose. She put on weight and looked extremely fit.

(3) A woman of seventy-eight had suffered from cardiac disease for over twenty years. The pulse showed an irregularity on three occasions when I examined her. The only acute illness she knew about was measles, which she had had very badly. *Morbillinum* 30c, one dose, was given. Within a week the pulse was restored to normal rhythm and she was decidedly benefited in strength and appearance.

[1-3: Foubister, *Tutorials on Homeopathy*]

(4) Mrs. E. G. complained of visual discomfort, particularly on reading or sewing. Her vision would blur after a short time of close application, to be relieved by looking off at a distance. Other symptoms that were brought were: A vague headache around the hairline and the top of the head; generalised easy fatigue, a dull aching pain in the legs, a lack of sexual response. All followed an attack of measles three months prior to her visit. *Morbillinum* 200x was prescribed on discs to be taken four times daily. About two years later she came in with a simple problem and stated that those little pills had made a new person out of her. [Schachterle, cited by P. Sankaran]

(5) ... a lady in the late fifties, who has been an ardent homeopath for years. She was evacuated officially against her wishes and while in the country came in contact with measles. She discussed the prophylaxis of measles with me and I suggested *Morbillinum* 200, 2 doses at monthly intervals. She was rather nervous at the idea of taking a measles nosode, and delayed taking it until after her next visit. When she was seen again, 4 weeks later, there was a great change in her. She had always suffered from a brilliant red nose all her life and had been very conscious of this, and had always tried to camouflage it with creams and face powders, with not too much success. The veins in her cheeks were very noticeable. When she came in through the door this time, her nose was white and of normal colour, and so were her cheeks. I laughingly asked her, had she at last found a special new varnish for covering up the colour of her nose and cheeks, when she replied with great pride that she had not used anything at all, the redness of the nose had just faded away during the last month. She had sought relief for this cosmetic trouble for years, had hoped homeopathy would help her, but though homeopathic medicines had helped her general health greatly, the red beacon of a nose had always stayed with her. Now it was gone. Then she told me, she had a severe attack of measles at the age of 5, and her mother had told her that she became very short-sighted after that and had to wear strong glasses for her myopia since then; her red nose had worried her ever since she began to take

notice of her personal appearance in her teens. Morbillinum 200, the measles nosode, wiped this cosmetic defect out. This may not seem to be very important to most people, but it is an interesting point to remember, that enlarged veins of nose and cheeks come on after measles, and if so, that Morbillinum in a high potency even after half a century, will effect a cure. Still a month later the cure had held good. The nasal beacon had gone. Now one wonders whether the myopia will improve too, or has that condition become too deep-seated? It is early days to make any prophecies, but I have hopes that her sight will improve as well. [Dorothy Shepherd]

(6) This is a small, slight, sallow, hollow-eyed woman of fifty-three years, married but never pregnant, who came to me first in 1944 for help for continuing backache for a few months. She has been a school teacher for a great many years, therefore much on her feet. Uterus was retroflexed, aggravating the sacral pain. She was reported anaemic and looked it. Her symptoms made a Sepia case and this remedy helped her much, but as she improved, the back pain grew worse and other pains in all joints increased until the backache took its place in a general arthritis, first in wrists, then in fingers, knees, shoulders, ankles. Slight deformity increased, to make it difficult to stand straight or walk without limping. To complicate matters two falls produced fractures. Remedies given [and there were several, including Medorrhinum] were palliative only.

Finally, in July, 1947,¹ learned that about eight years before she had had measles, not so bad an attack, but a leucorrhoea began soon after which she never had had before and which preceded the uterine symptoms. Also the arthritis [which is in her family] started then, too. A dose of Morbillinum IM on July 8, 1947, brought out spells of itching followed by patches of eruption scattered over the body, caused an eruption on the feet to return. The arthritis began to improve within a month and she began using her cane only out-of-doors and doing all her housework. She had three more doses in all but I see her now only once in five to seven months. [In the last year she has reported only twice and then to say how well she had been.]

[J.M. Green, *Seeking the Heart of Homeopathic Prescribing*; Hom. Rec., Oct. 1949; same case in slightly extended form in: J.M. Green, *Results to Date in Using Dr. Tyler's Method with Nosodes*: Hom. Rec., Feb. 1951]

MMR

MMR consists of three live attenuated viruses: measles, mumps, and rubella [German measles]. The vaccine has been used in the U.S. since its introduction in 1975 and in the United Kingdom since 1988. In Japan, the MMR vaccine was withdrawn in 1993, because of an unacceptably high level of side-effects [the vaccine was shown to cause meningitis in 1 in 2026 recipients].

Adverse effects of MMR

A 7-year-old girl developed total deafness in the left ear 11 days after an injection of MMR. This was not preceded by any symptoms such as dizziness or earache. There was no recovery of hearing. ... A 3-year-old girl was evaluated because of bilateral deafness. At the age of 15 months she received MMR. Ten days later, she developed high fever, headache, ataxia, and irritability, which lasted several days. Nystagmus was noted. She recovered spontaneously, but soon after she was noted to have hearing impairment..... A 16-month-old girl experienced an acute loss of vision 16 days after an injection of MMR.

Two days earlier she felt warm to the touch and developed a cough, conjunctivitis, and a generalised maculopapular rash. ... Seven months later she improved, but she had macular scarring. Riikonen [1989] described 18 children with optic neuritis following infection, vaccination, or both. Of those 18, 10 went on to develop multiple sclerosis. ... All 18 of the children were reported to have received measles vaccine between 12 and 18 months of age. ... Published reports of passive surveillance systems from several countries provide evidence that MMR is associated with clinically significant thrombocytopenia within two months of vaccination. On the basis of data from Finland and Sweden, the incidence appears to be on the order of 1 per 30,000 to 40,000 vaccinated children.

[Stratton et al. 1994]

MMR and autism

There are links of autism to such vaccines as DTP, polio, and MMR. The Autism Research Institute sees a statistical overlap between the first uses of MMR vaccine in the United States [in 1975] and in the United Kingdom [in 1988] and a sudden spurt in cases of childhood autism. Ever since Dr. Andrew Wakefield and associates, in 1998, cited twelve cases that suggested a link between the MMR vaccine and autism, a flood of opposing articles

has appeared denying such a connection categorically, while the vaccine industry increased its efforts in trumpeting around the safety of the triple vaccine.

The study in the *Lancet* by Wakefield draws attention to a particular subset of vaccine users. He looked at nursing mothers who were re-vaccinated with MMR because rubella protection offered by the original vaccination had worn off or didn't take. He found that these mothers seemed to have a higher than average number of children beset with autistic enterocolitis syndrome, a condition in which autism is paired with bowel disorder.

Wakefield feels the intestinal disease is caused by the measles virus in the MMR. In trying to explain how the measles' component, which is given in a disabled form, can have such a dreadful impact on the child, Wakefield argues that it is not vaccines per se that are to blame, but the unwarranted coupling of one than one weakened pathogen per shot, so that one virus interrupts immune system action against another. He writes: "The ability of mumps virus to interfere with the cellular immune response to certain strains of measles virus and thereby, in particular combinations, reduce viral clearance [that is, the elimination of the virus by the immune system] and increase the risk of persistent [intestinal] infection, is an intriguing hypothesis [which merits consideration]." Wakefield's work centres on explaining the generation of the bowel disorders in this disease, not the autism. However, the findings of another researcher who looked at MMR vaccine, Dr. Vijendra Singh from the Utah State University Biology Department, may have a bearing on this issue. His tests of autistic children "found that a large majority ... had antibodies to brain tissue in the form of antibodies to myelin basic production." ...

What Singh's research implies is that autism can be associated with an auto-immune reaction in which the immune system is attacking its own brain tissue. But here's the frightening finding: Singh noted that "there was strong correlation between myelin basic protein antibodies and antibodies to measles." ... The measles antibodies must have been produced in relation to the MMR vaccine, since none of the children studied had had the measles disease, but almost all had been given the MMR vaccination. [Null 2003]

In the 1980s, one in 2500 children in Britain and America were diagnosed as autistic. Latest figures compiled by researchers revealed a dramatic leap - to one in 146. ... In California the incidence of autism was running at 150-200 a year until 1980, when it dramatically rose to reach nearly 600 in 1990. ...

Most children received the vaccine with no obvious serious side-effects, but some became seriously ill within a few weeks. These children began behaving

strangely, stopped talking and became socially withdrawn, staring into space for hours on end. Many developed a raging thirst, bizarre eating habits, multiple food allergies, hyperactivity and sleep problems. This was usually accompanied by abdominal pain, bloating and bowel disturbances. Some children became incontinent of urine or faeces. Their development deteriorated. Thousands of children now fall into this category of abnormal development only after receiving the vaccine. ...

Professor John O'Leary, Director of Pathology at the Coombe Women's Hospital in Dublin, told the US Congress in April, 2000, that he had produced compelling evidence of an association between autism and the MMR vaccine. Professor O'Leary found the measles virus in the guts of 24 out of 25 children who had developed autism, after an apparently previously healthy infancy. ... While Taylor argued that MMR cannot contribute to autism, and Wakefield argued that it might, both studies may be correct. What Taylor may have missed is the susceptible child argument. He limits himself to the more typical, reductionistic, one variable theory of disease. In this theory, one agent causes a disease.

All individuals exposed to this agent have equal probability of developing the disease. A more accurate theory of disease posits susceptible individuals who succumb to the disease after multiple contributory insults. ... Studies support our view that MMR vaccine may trigger a cascade of events leading to autism in genetically susceptible children, and not affect children who lack susceptibility.

...

Kawashima et al. reported that measles virus could be present in the intestines of patients with Crohn's disease. Responding to Wakefield's data on "autistic enterocolitis," the authors set out to determine if the virus found in Crohn's disease, ulcerative colitis, and autistic enterocolitis came from wild strains of measles or from vaccine strains.

To do this, they found measles RNA from peripheral blood mononuclear leukocytes [PBML] in eight patients with Crohn's disease, three patients with ulcerative colitis, and nine children with autistic enterocolitis. They used healthy children and patients with subacute sclerosing panencephalitis and human immunodeficiency virus 1 as controls [eight patients]. ... One of eight patients with Crohn's disease, one of three patients with ulcerative colitis, and three of nine children with autism, were positive. Controls were all negative. The sequences obtained from the patients with Crohn's disease shared the characteristics with wild-strain virus. The sequences obtained from the patients with ulcerative colitis and children with autism were consistent with being vaccine

strains. The results were concordant with the exposure history of the patients. Persistence of measles virus was confirmed in PBML in some patients with chronic intestinal inflammation.

[Lewis Mehl-Madrona, *The MMR Vaccine and Autism*,
www.healing-arts.org/children/vaccines/vaccines-mmr.htm]

MMR CASES

The measles virus appears to affect assimilation, judging from Dorothy Shepherd's observation that, "Frequently one is told that a child has never been well since an attack of measles, and had to take cod liver oil and malt or an iron tonic for months afterwards, and our convalescent homes are full of cases of weakness and debility after measles or measles plus whooping cough. ... Lately I have come across a number of children who had measles in the late autumn and early winter of last year [1939], and definitely suffered from weakness, loss of weight and anaemia, and in some cases from eye lesions as well." She proceeds by giving eight cases of children who after measles vaccination begin losing weight, to become "under-sized, flabby, thin, and pale." A few doses of Morbillinum restores their health and makes them gain weight rapidly.

Since MMR contains the live measles virus [attenuated] it may be expected that the vaccine evokes similar problems to the illness.

Two of the cases below exemplify the correlation between MMR vaccination and intestinal disorders and bring to mind Viera Scheibner's statement that "it is evident and proven that the MMR causes bowel problems which result in malabsorption and maldigestion of waste products of digestion, which results in brain dysfunction called autism."

Case 1

20-month-old girl. Her problems started one week after the MMR, with diarrhoea and vomiting and double otitis media. She was hospitalised and treated with antibiotics and ORS. After that, her appetite was gone; she had a permanent running nose with green mucus, was very thirsty and had frequent ear infections. The family doctor assured the mother that a link with the MMR could be excluded because MMR does not cause bowel infections. ... Treatment with MMR in increasing potencies from 30K to 10MK over four consecutive days was started. After the MMR 30K, she had a very bad night. She was sad, cried a lot, coughed heavily and was gasping for breath. But after three days the rhinitis

was gone, her appetite was back and she drank much less. She is happy, nice and attentive again. It is another child, says the mother!

Case 2

With Tom, the change occurred the same day as his vaccination with MMR. He lost consciousness for five minutes, and two hours later, urticaria began, which disappeared the next day, but Tom wasn't Tom anymore. Before the MMR he was calm, ate everything and slept until seven in the morning. He became very restless, disobedient and destructive. He could not concentrate and played without interest. He had fits of anger, kicking and striking at others, and was extremely insolent. He was very aggressive towards other children and beat them without any reason. He was sweating profusely during the night and his stools were sour-smelling, offensive and always thin.

He suffered from diarrhoea until the age of three. When first seen for consultation, he was six years old. He woke every morning at 5 a.m. and had become a difficult eater. He tapped on everything with a little stick and threw stones and sand at other children. The official diagnosis was PDD. After four courses of potentised MMR, he was much calmer, his aggressiveness almost disappeared and he was much more affective. He played by himself again and was able to explain what he meant. He became 'my old little boy again, as the mother said. His allergies improved. His stools, however, are still very offensive. He probably needs several courses of MMR more to be cured completely, but he is almost a normal child now. [Both cases adapted from: Tinus Smits, *The post-vaccination syndrome*: Hom. Links 4/01]

Case 3

In November 1992 an 11-year-old boy came for homeopathic treatment of recurrent migraine headaches. According to the mother, the migraines started after a MMR vaccination in May 1990, when he was nine. The doctors he had consulted so far had denied a possible connection. The migraines occur mostly on Wednesday or Saturday. They start in the afternoon, and can be triggered by eating only a little. During the migraine he gets very nauseous and vomits horribly. He gets an intense headache behind the eyes. It feels as if they would be knocked out with a hammer. He is sensitive to noise and light, and prefers a cold, wet towel on his head. Sleeping ameliorates. For painkillers, he uses motilium and paracetamol, both as sups. In the past he had the mumps twice, rubella, whooping cough, chickenpox, possibly the measles, and scarlet fever five times. As a baby he was lactose intolerant, with cramps, screaming, stretching and aversion to touch. Later he had white foamy

diarrhoea. As a baby he was restless and active. He would climb in and on things without ever hurting himself. He is still rather restless and has difficulties with concentration.

Treatment. Based on the history of the onset of the migraine, I gave him one dose of MMR 200K. A week after the remedy he woke up at 11 p.m. with a high fever. That night he had such a horrible headache that he had to move. The headache was worse than ever before. Both the headache and the fever lasted for three days. After that he recovered. Now many years have past and the migraines never returned.

[Harry van der Zee, *Migraine since MMR vaccination*-, Hom. Links 4/01]

MUMPS

Features

- The name “mumps” comes either from “to mump,” meaning to grimace, grin or be sullen, or from “mump,” a dialect word for “munch” since the unilateral parotid gland swelling of mumps suggests the shape of the face when munching.
- There is one serotype of the virus and in an affected patient it can be found in most body fluids including cerebrospinal fluid, saliva, urine, and blood.
- A very contagious illness, mumps is acquired from respiratory secretions and saliva via aerosols or fomites. The virus is secreted in urine.
- Mumps is found equally in males and females. Man is the only known natural host and the disease is found worldwide.
- The mumps vaccine virus is usually given as MMR vaccine that contains three live, attenuated viruses: mumps, measles and rubella. It is also available as a single virus preparation or combined with the rubella vaccine.

Clinical manifestations

- The average time to full manifestation of disease is two to three weeks but there may be fever, anorexia, malaise, myalgia during the prodromal phase. Many mumps infections [up to 20%] result in no symptoms at all and about half of infections result only in the primary respiratory symptoms.
- Pain from parotitis swelling persists for 7-10 days. This is the most common feature of mumps and is seen in about 30-40% of infections.

Complications of mumps

- Aseptic meningitis has a three times higher prevalence in males than in females.

| | |
|--|---|
| <i>Mumps host: human</i> | In 50% of cases the meningitis is asymptomatic. Mumps-related meningitis is more severe in adults. |
| <i>Mumps symptoms:</i> | |
| <i>Fever, malaise, loss of appetite, aching muscles.</i> | Encephalitis may occur up to seven days after parotitis. Usually there is complete recovery; hearing loss is a rare complication. |
| <i>Swollen parotid glands, difficulty and pain on salivation and swallowing.</i> | In adult males orchitis, often unilateral, may occur; the orchitis is not a significant cause of sterility. Females can suffer from unilateral or bilateral ovaritis or mastitis. |
| <i>Maybe asymptomatic, or one-sided swelling.</i> | Pancreatitis, a rare complication, plays a possible role in juvenile diabetes; outbreaks of diabetes have been reported after mumps outbreaks. |
| <i>Possible swelling of mesenteric glands, testes or ovaries with aching</i> | Thyroiditis, myocarditis, arthritis, and joint pain occur occasionally. |

pains. MATERIA MEDICA PAROTIDINUM

Sources

- [1] Clinical observations; prescription based on aetiology.
- [2] Dream proving, Karl-Josef Muller, 1998; 12 proverbs [8 females, 4 males], 30c. [Kontakt-Priifung der Mumps-Nosode Ourlianum]

Indications

The complications of mumps [see above] suggest the use of Parotidinum [French name: Ourlianum] in these conditions. Margaret Tyler highlights the affinity with the pancreas: "Pancreatitis may start in infectious diseases - enteric, pyaemia, septicaemia, also in mumps: which is of interest from the structural resemblance of the pancreas to the salivary glands. Mumps affects the pancreas, and diabetes has followed mumps, indicating that the Islets of Langerhans are affected.

Dr. X., impressed by his results with the nosodes of previous acute diseases in difficult chronic conditions, tells of two cases of diabetes which had not been progressing favourably in spite of careful prescribing. "No. 1 suffered from neuritis and rheumatism of thighs, of several years' duration. After three 6-hourly doses of Parotidinum 30, the rheumatism vanished and has not returned during the past 5 months. The blood sugar has not been tested owing to war conditions. No. 2 had a severe aggravation, and then clinical improvement. These cases are merely suggestive."

SYMPTOMS PROVING

Suggested repertory rubrics

- = Industrious. Cheerful. Irritable. Confused.
- « Copious perspiration on forehead on waking.
- « Diplopia on waking in morning; left and right side of field of vision uneven; one side seems higher than the other side.
- ~ Epistaxis.
- « Toothache, right side, < warm drinks, extending to ear.
- = Appetite increased. Thirst, for large quantities.
- = Menses too late.
- ~ Hoarseness.
- « Cough, dry, at daytime, from tickling in larynx.
- « Pain cervical region extending to occiput and/or shoulders.
- « *Stiffness nape of neck.*
- <= Contraction of muscles and tendons; shoulders; knees [posterior side].
- Pain legs extending downwards.
- Dreams: Abortion; death of children. Blonde women. Buildings; building sites; churches; houses; towers; villas. In colour [red; black; white]. Competition. Deceit. Eggs. Envy/jealousy. Fire. Indifference, apparent. Money. Moon. Music; concert. Prisoners; imprisonment. Rocks. Shameful.

Hypothetical drug picture of Parotidinum (Ourlianum)

The *Ourlianum* patient divides the world into winners and losers. Winners are viewed as people with good looks, property [eg, a nice villa with a swimming pool], resources and savings; people with a university degree, who go to church regularly and are blessed with many children.

Deep inside *Ourlianum* patients consider themselves losers. They have nothing to fall back on, no recognised qualifications and, in addition, the inability to conceive children. *Ourlianum* women have difficulties to get pregnant or a tendency to miscarry. *Ourlianum* may solve relative sterility in men. One testicle is larger than the other.

Ourlianum s dilemma can be counterbalanced in various ways. One possibility is to feign indifference and nonchalance, to give the impression that things are not so bad. “Says he is well,” in combination with great irritability and unilateral facial symptoms may require differentiation with *Chamomilla*. A good remedy for mumps, *Chamomilla* has redness and heat of one half of the

face while the other half is cold and pale.

Behind the facade of indifference lies an intense feeling of shame and embarrassment, as if a crime has been committed. In addition, there is envy of those who are more successful. Envy of people who have been more lucky. Feeling of being excluded: "Private property - no admittance."

The *Ourlianum* patient will attempt to become a winner. He will take an evening course to increase his chances of achieving a better social position. *Ourlianum* is a remedy that can alleviate examination funk. With some sort of diploma in his hands *Ourlianum* feels closer to his goal, believing to stand a better chance to rise on the social ladder.

Ourlianum may be inclined to cheat to reach his goal. An empty wallet and the idea of big bucks justify for *Ourlianum*, for example, tax evasion, shady business, or making much fuss to promote an inferior piece of work.

Due to the feeling of having failed, the shame and also the envy towards happy parents *Ourlianum* goes all out to realise with the help of modern medical technology the wish to have children. *Ourlianum* women have phantom pregnancies, which ultimately reinforce the feeling of being a loser.

Ourlianum resembles *Lycopodium* in trying to hide a feeling of incompetence behind an appearance of success, and *Selenium* in the polarity "all or nothing." Cure in *Ourlianum* cases entails steering a middle course. Shrinking back to normality is in the winner's type the foreboding of cure, similar to what happens in mumps with the swelling of the parotid gland.

The characteristic one-sidedness of mumps has a parallel in the visual disturbance of *Ourlianum*: one side of the field of vision appears to be higher than the other side, and the difference can't be levelled. *Ourlianum* produced in the proving furthermore unilateral toothache extending to the ear.

The *Ourlianum* patient has a tendency to catarrhal complaints of the upper respiratory tract. Recurrence of a cough that seemed to be gone.

Ourlianum has severe tension in the neck area, with extension to the occiput or the shoulders. It is a remedy for torticollis, of either traumatic or rheumatic origin. Feeling of tension and contraction in tendons of arms and legs. Leg pain extending downward. Muscular twitching ranging from quivering to jerking. [Karl-Josef Muller]

RHABDOVIRIDAE

FEATURES

- Viruses classified in the Rhabdoviridae family have a distinct ‘bullet’ shape. The family includes three genera, the genus Lyssavirus rabies virus and several bat viruses.
- The virus replicates in the salivary glands. By modifying its host’s behaviour, i.e. by inducing it to bite, it accelerates its transmission to new hosts.
- During active rabies infection, the virus can be cultured from saliva, respiratory secretions, urine, and, most easily, from brain tissue.
- Rabies is an infectious viral disease that invades the central nervous system of warm-blooded hosts, including humans. A wide variety of mammals can contract the disease, but it is most often noticed in dogs, cats, foxes, racoons, skunks, coyotes, bats, and livestock.
- Louis Pasteur created the first rabies vaccine in 1885 using live rabies virus. The vaccine caused serious, even fatal, reactions.
- U.S. virologists have developed a HIV vaccine using a weakened rabies virus to carry a fragment of the HIV virus. Experiments on laboratory mice with the vaccine showed them to respond with creating immune system antibodies to attack the fragment. Similar work has been done using a smallpox virus.

CLINICAL MANIFESTATIONS OF RABIES

[1] Period of incubation greatly varying in length. [Typically 1 to 3 months.] During all this time the persons bitten feel, for the most part, quite well, only of some it is said, that touching the scar produces peculiar sensations, such as shuddering, feeling of anxiety, and sighing.*

Early symptoms include pain, burning, and numbness at the site of infection.

[2] Precursory stage.

Flu-like symptoms: loss of appetite, headache, chills, malaise, pyrexia.

Erratic behaviour: depression, apprehension, excitability, agitation. Speaks of the bite and its impending fatal results in a quick and sharp manner. Sleeplessness and restlessness.

Ominous symptoms of aversion to fluids, great sensitiveness to a slight breeze and reflection of light.

Other early symptoms involve unusual sensitivity to sounds and changes of temperature.

[Rabies is difficult to distinguish from hysteria when a patient has been bitten by a supposedly rabid dog. However, in hysteria true pharyngeal spasm does not occur, and the mental disturbance is amenable to sedatives and *suggestion*. Positive suggestion acts as a cue to the brain which triggers a series of self-regulatory responses; negative (self)-suggestion reinforces the belief in the inevitably fatal outcome of rabies: "There is no cure for rabies once an animal or human shows symptoms."]

[3] Second stage: hydrophobic spasms.

'Furious' rabies mainly affects the brain [encephalitis].

[a] Spasms involving the oesophagus muscles result in sudden inability to drink, followed by general convulsions, or brought on by an attempt to drink water, by a sudden fright, or by any agitation.

Spasms of the swallowing muscles may be precipitated by blowing on the patient's face [aerophobia].

[b] Spasms involving the respiratory muscles, induced by a sudden draft of air, causing dyspnoea, feeling of suffocation, sighing, groaning respiration, makes sounds like the hoarse bark of a dog.

Crises are characterised by intense fury or profound terror, and in the intervals between the mind is clear.

[Rabid animals display unexplained roaming and viciously attack even inanimate objects.]

Face red, pale or cyanotic; eyes wild, rolling, staring and livid; eyeballs injected; pupils dilated; photophobia.

Mouth full of viscid saliva, much spitting. [The accumulation of saliva, referred to as 'foaming' at the mouth, results from the inability to swallow it.] Excessive thirst with burning in throat, but cannot swallow fluids.

Appetite usually not affected.

Bowels constipated; urine scanty, concentrated, cloudy.

Fever; skin moist. Extremities cold and livid.

[4] Third stage: paralysis.

Paralytic' or 'dumb' rabies mainly affects the spinal cord [myelitis].

Gradual sinking or sudden death during a hydrophobic spasm.

Fury and excitement may be totally absent; patient instead retreats steadily and quietly goes downhill to death.

Muscles continue to twitch; pupils contracted or of unequal size; eyes fixed; strabismus.

Death from asphyxia, exhaustion, or general paralysis.

[Raue]

* This reaction to touching old scars can be transposed to the emotional level as shuddering, anxiety, sighing etc. from touching on painful topics, bringing up painful memories, or receiving bad news such as an unfavourable medical diagnosis. [Lyssinum has ‘Ailments from bad news’.] An underlying predisposing condition is suggested by Hering’s remark that, “Such as were afflicted with grief from any cause were much sooner affected with the disease.” The Italian physician Girolamo Fracastoro [1483-1553] called rabies “an incurable wound.”

Of the five phases following the diagnosis of a fatal disease, as defined by Kiibler-Ross, at least three can be recognised in the Lyssinum-picture:

[a] anger;

[b] denial, of which Hering says that the majority of patients bitten by a dog “have no adequate perception of the real origin of their malady, and affirm in decided terms that the scar is of no significance whatever and causes them no pain.” And: “[They] deny with great obstinacy that they have ever been bitten.” Denial can help block perception of certain threatening information when attending to it will only arouse unnecessary anxiety and contribute little to changing the situation.

[c] bargaining.

[d] depression;

[e] acceptance.

MATERIA MEDICA LYSSINUM

Lyss.

Sources

- [1] Proving: [a] Hering, self-experimentation, 1833; [b] Schmid, self-experimentation, 1835; [c] Behlert, 10-15 [?] proverbs, 1835-38; higher potencies; [d] Coxe, proving, 7 proverbs [6 males, 1 female], 3c, 6c, 30c; 1853.
- [2] Clinical observations. Clinical manifestations rabies.

SYMPTOMS

MIND

- SUGGESTIBILITY. Apprehension. [1 - 2]

- The pity is that since Pasteur’s day there should have been so much scare on the subject, for hydrophobia is a complaint of the nerves and, consequently, *fear is its primary factor*. Various instances have been recorded of cases unquestionably brought on by suggestion. For example, two young Frenchmen were

bitten at Le Havre by the same dog in January, 1853. One died from the effects within a month, but before this the other young man had sailed for America, where he lived for 15 years in total ignorance of the end of his former companion. In September, 1868, he returned to France and heard of the tragedy, and actually then himself developed symptoms and within three weeks was dead of hydrophobia. Again, a patient who threatened to bite his medical attendant, after being told that the correct symptom in a human being was the use of the fists, struck out all round him like a boxer and indulged up to the time of his death in this quite novel form of paroxysms. *The avoidance of fear* is, therefore, the main essential of safety after a dog-bite, and the very slight amount of risk may be realised by the thousands of innocuous bites received by veterinary surgeons and others in the habit of constantly handling animals. [Emphasis added.] [Douglas Hume 1932]

- = “Could not get rid of the indescribable tormenting feeling that something terrible was going to happen to him.” [Hering]
- “The mad dog from which I took the saliva belonged to a baker, here in Philadelphia. I put the saliva in alcohol, potentised it, and at once began the proving. I had to desist when I had become almost crazy with mental forebodings and anxiety.” [Hering]
- ◀• “A man came to my office and said: ‘I am crazy. I know it. I am rich and have no cause for complaint. I walk the floor every night until my wife comes, with tears in her eyes, and implores me to lie down. I fear that I shall die with hydrophobia. I have read all the books on the subject and know I shall die from the disease. It is very clear to me. Why don’t you promise to cure me?’ ‘Well,’ I said: ‘We do cure horses, and they do not imagine things. ‘You *do* cure horses?’ ‘Yes.’ ‘Well, have you had any cases to treat like mine?’ ‘Yes, similar ones. We will try’ He promised to take the medicine and I gave him a single dose in a high potency of *Lyssinum*. Later he returned once more to say that he had not missed a night of sleep, but thought that imagination had made him well. The case brought me one dollar in fees, at fifty cents each, but I would not have missed the cure for a thousand!’” [Hering]

In addition to provings, the drug picture is partly derived from cases of true hydrophobia, all with fatal outcome, and partly from cases of so-called pseudo-hydrophobia. The latter cases demonstrate the effect of fear on the perception of an event as being bitten by a *non-rabid* animal. Rather than the exposure to the assault itself, it is the way how the event is perceived and

appraised in combination with the availability and use of resources to cope with the challenge that decides on its impact. Two *Lyssinum* cases given by Hering show the mismatch between perceived environmental demands and perceived resources to adapt. Both cases involve persons whose mechanisms for adaptation are overwhelmed and blitzed by too much challenge. A major role also plays the fact that the assault cannot be anticipated; it comes from a seemingly harmless animal like the “small pet dog” in case 2, taking the victim entirely by surprise. Its impact may initially not be realised, to become reactivated later by some external event as in case 1.

== Mary M., aet. 17, had been bitten several years previously by a dog, and reading of several cases of hydrophobia as reported in papers, was found in the following condition: crouched in a sofa, dark red bloated face, expression of terror in face, eyes glistening, conjunctiva injected red; was brought into this condition by endeavouring to take a drink of water, and could not hear water mentioned without a shudder of fear, could not swallow, pulse very high, tongue dry and coated red; *Lyssinum* 2c, one dose; she was better next day, but had several slight attacks afterwards, always induced by running of water, but always yielding to remedy; has not had an attack in nearly a year.

= A musician received a bite from a small pet dog in calf of left leg while walking through a dark entry; the bite was very slight, scarcely wounding skin; the animal was in a healthy condition and remained so; a pain in bitten place kept returning from time to time independently of mind dwelling on it, until finally it grew to a burning which extended through entire body, causing an indescribable strange sensation; in night trembling, and a tormenting fear that he would have hydrophobia; was thirsty and drank water freely; it was two years after the bite when these and the following symptoms appeared: frequent spitting of saliva all through day, only ceasing awhile after taking strong tea in evening; disturbed dreams at night; finally could not partake of food or drink, and complained of pricking stitches under tongue; mental excitement now as all his life, affects him badly; hot vapour relieved burning pain in bite, and *Lyssinum* 2c improved all symptoms rapidly; in three weeks he considered himself cured, and started on a journey.

[Hering, *Guiding Symptoms*, Vol. 7, p. 163]

The mechanism to cope with the perceived danger may involve “animalistic” counter-attacks, i.e. putting oneself in the assault mode

« Imagine that they are being abused, and energetically defend themselves against attacks and insults, which in reality are products of their own fancy. [Hering]

Or include the control and denial at all costs of feelings of aggression by taking on a compliant, self-suppressing attitude towards others. Repression thus is the main defensive technique, although it is not complete, as evidenced by the continuing diffuse anxiety.

An interesting *Lyssinum* dream in this context is: “Dreams of influential persons to whom he occupies position of servant or subordinate” [Hering],

« The kind of polarity relationship between spasmodic hyperactivity and paralysis that occurs on the physical level can also occur on the mental and emotional levels. A mental ‘paralysis’ can occur if the intense emotional outbursts are suppressed or if the aetiology is the more modern type associated with refined rabies vaccine. The result is a mental state of compulsive neurosis and deep anxieties and phobias, such as agoraphobia and claustrophobia, similar to *Argentum nitricum* or other syphilitic remedies including *Syphilitinum*. In these cases, therefore, we may not see the violent anger, but rather a kind of routine and repetitive behaviour arising out of tremendous anxiety. It is accompanied by a great fear, especially of closed places. The intensity of *Lyssinum* is still there, but it is expressed on the mental plane.

[Louis Klein, *Xanthium spinosum and the Rabies Miasm-*, IFH 1993 Professional Case Conference]

Repressed impulses and fears may find indirect means of expression. Repressed hostility, for example, may reveal itself in fantasies of killing or injuring other people. [See Strange Impulses]

•FITS

Strange impulses. [1]

« Feels impelled to do reckless things, such as throwing child, which he carries in his arms, through the window, and the like.

- Thought came into his mind to attack others in a mean way; to cut others with a knife he holds; to throw water he has in a tumbler into another’s face. [Hering]

Absent-mindedness. [1]

- = More inclined to reflect than talk. Seems to be influenced by two entirely different trains of thought.
- ~ Does not converse as well as usual, but plays chess better; more inclined to reflect than talk; not at all lively.
- ~ Takes hold of wrong things, often does not know what he wants, says wrong words which have but a remote similarity of sound. [Hering]

Anger; aggression. [2]

- = Outbursts of destructiveness. Impulse to cut, bite, stab, destroy and kill.
- ~ Outbursts followed by quick repentance.
- = Frantic anger, especially if annoyed, obstructed or tormented.
- Very cross, so much so that my children expressed great surprise; took offence at the merest trifles; scolded my wife and children; could not concentrate my mind on anything. [1]

• OVERACUTE SENSES.

[contributing to delusion of being abused, obstructed or tormented]

- Very ill-disposed after meals; every noise irritates him; if others eat apples or hawk, or blow their noses, it brings him beside himself; passes away after siesta and coffee. [1]
- = Cannot bear to hear others sing. [1]
- <• My sense of smell, which is always extremely acute, became painfully so, particularly in reference to unpleasant effluvia. [1]
- = The greatest sensibility to the smell of tobacco; tastes the snuff, while the box is one foot distant. [1]
- He says he can see hands on dial plate of church clock. [2]
- = He could hear what was spoken in next room, and counting coppers in a room below him. [2]

Extrasensory perception. [2]

[Only observed after bites and in people with rabies; not in provings.]

- = He knew exactly where his nurses, his doctors and acquaintances were, if at any distance from him.
- = On a watch held to scrobiculum he sees the hour and minute hands.
- <- He knows every one, and answers questions, also is in mesmeric rapport with his doctors.

- BIRDS. [2]

- = Thinks he is a dog or a bird, and runs up and down, chirping and twittering, until he falls down fainting.
- = After fainting spell he wrote on paper: I am forsaken by all; even the birds of heaven, they do not look at me, do not feed me if hungry; I hunger with the young ones and am thirsty with their she ones; my nest is made out of dirt, not gotten by my own exertions, but by driving them out of their nests and sitting there with the females and the young.
- Showing him a bird, he got frightened and thought it was a mouse.
- Before every spell of somnambulism he crowed like a cock.

GENERALS

- = Cannot bear heat of sun. [1]
- Aversion to and aggravation by draft of air. [2]
- Convulsions and spasms; esp. from glistening objects and reflected light. [2] « Aversion and disgust to everything fat, particularly mutton; leaves a long greasy after-taste. [1]
- = Eating eggs or fat meat = nausea, headache, and giddiness. [1]
- ~ Desire or aversion salt. [1]
- Desires chocolate; meat; raw tomatoes; aerated water. [Mangialavori]
- => Sweets <. [M]

WATER [2]

- = Unable to drink water.
- <- Sight of water = vomiting; must close eyes while bathing.
- ~ Vertigo on crossing running water.
- = Headache from noise of falling water.
- = Noises in ear, rushing like a waterfall. [1]
- = Hearing acute to noise of running water.
- « Choking sensation at sight or sound of water.
- «= Diarrhoea from hearing running water.
- « Urging to stool on hearing running water.
- Sudden urging to urinate at sight of running water.
- = Sudden urging to urinate on hearing running water or putting hands in water.
- Thinking of fluids of any kind, even of blood, brings on convulsions.

Sensation of motion. [1]

- = As if a small leaden ball were rolling about in the brain.
- = Dulness in the middle of the brain where it waves and moves.
- A slow vacillation or wavering of head, from something being loose in upper part of head.
- ~ A sensation in forehead as of something moving. [2]
- == Something moves before the eyes [while sewing], but always at a distance from the place she looks at.
- <= A sense of motion in stomach.
- > A sense of motion, with slight stinging in middle of abdomen. [2]
- => The clavicles feel as if they would slip from their sockets; had to place arms akimbo.

REPERTORY ADDITIONS

- « Desire to attack others.
 - = Biting, in children, to demonstrate their love.
 - Forsaken feeling, feeling rejected by others.
 - Aversion to household duties.
 - = Feels could injure oneself out of rage.
 - « Jealousy, tendency to choose mainly faithless partners.
 - = Love for suffering animals.
 - = Masochism, sexual.
 - Desires music.
 - Inclination to mutilate his body.
 - = Sensitive, oversensitive to sacred music.
 - ~ Sympathetic, compassionate, feels great pain seeing suffering animals.

 - HEAD. Hair, baldness in women.
 - = VISION. Diplopia, in demyelinating disease.
 - EXTREMITIES. Formication, in demyelinating disease.
- [Massimo Mangialavori; RefWorks]

Of Love and Other Demons by Gabriel Garcia Marquez, is the story of a 12 year old girl, bitten by a rabid dog and made to withstand therapies indistinguishable from tortures. Believed to be possessed, she is imprisoned in a convent, to await exorcism. It is a powerful tale of rabies and hysteria, set in a South American port during the colonial era, and makes compulsive reading, with an added perspective for homeopaths with an interest in *Lyssinum*! [Ed.]

b. Segmented negative stranded RNA; enveloped

| Family | Genus | Type Species | Remedies |
|--|----------------|--------------|--|
| b: segmented negative single stranded RNA; enveloped | | | |
| Orthomyxoviridae | Influenzavirus | Influenza | Influenzinum Influenza vaccine 97/98 Oscillococcinum |

ORTHOMYXOVIRIDAE

Influenza

- The term “influenza” was introduced in Italy in the 15th century when colds, coughs and fevers were attributed to the influence (= “influenza”) of the stars. Later Italian writers refer to “influenza di freddo,” the influence of the cold, thinking that exposure to the cold caused influenza. The British physician John Huxham [1692-1768] adopted the name in his *Essay on Fevers* [1739].
- The only members of the Orthomyxovirus family, influenza viruses are divided into three types: A, B, and C. With existing strains mutating all the time, influenza A shows the greatest variation in HA [haemagglutinin] and NA [neuraminidase] antigens.
- Spread via aerial droplets and fomites [inanimate objects by which disease may be conveyed i.e. cups, towels], influenza viruses make their debut in late December or midwinter in the Northern Hemisphere, unlike the tropics, where no specific flu season exists. Major pandemics occur at unpredictable intervals when novel strains appear with antigens to which humans have no immunity, whereas epidemics, linked to minor antigen changes, tend to occur more frequently [every 1-3 years] with varying degrees of severity. Pandemics occur only with influenza A viruses. Essentially of avian origin, type A infects man, swine, horses, birds, and other animals, and is associated with such pandemics as Spanish flu, Asian flu, and Hong Kong flu. Type B doesn't show the variability in antigens and is limited to mild human infections. The very rare type C is infectious to man and swine.

Domestic poultry, including chickens and turkeys, are particularly susceptible to epidemics of rapidly fatal influenza. Direct or indirect contact of domestic flocks with wild migratory waterfowl has been implicated as a frequent cause of epidemics. Live bird markets have also played an important role in the spread of epidemics. More recently pigs have been discovered to be a primary host of influenza A viruses as well or to serve as intermediate hosts which transmit the virus to humans.

Symptoms range from very mild to very severe and consist of fever [abrupt onset and higher than in common colds], headache, eyes painful and red, photophobia, nasal congestion, pharyngitis, non-productive cough, tightness in chest, myalgia, and prostration. Coryza may or may not be present, in contrast to the runny nose of common colds. People particularly susceptible to complications of influenza include the very young and the very old. Others at risk include people with chronic heart or lung disease, diabetes, kidney failure, sickle cell disease, a weakened immune system, or HIV infection.

A special feature of the Spanish flu [1918], one not present in normal influenza, consisted of a purple discolouration extending from the ears that could spread all over the face or remained centred around the lips. The cyanosis could cover other parts of the body and was a sure sign of imminent death.

Secondary bacterial infections during influenza are not uncommon, eg, pneumonia caused by *Staphylococcus aureus*, *Streptococcus pneumoniae*, or *Haemophilus influenzae*. The latter is also associated with influenzal meningitis. The devel-

opment of bronchopneumonia on the fourth or fifth day is followed by death or a long period of convalescence. Pneumonia is the most common complication of influenza, and the influenza-pneumonia combination causes more deaths than influenza alone.

Other complications involve the circulatory and nervous system. Influenza can produce various cardiac complications, ranging from temporary irregular heart beat to inflammation of the heart muscles. Encephalitis and encephalopathy are rare complications usually found only in children.

- After the influenza pandemic of 1889-90, Richard Pfeiffer, a German bacteriologist, discovered that a certain bacterium was present in the blood, throats and sputum of influenza victims. Suspecting it to be the flu pathogen it was named *Bacillus influenzae* or Pfeiffer's bacillus, to be renamed later as

Influenza hosts: birds, poultry, pigs, horses.

Symptoms:

Nov-Feb in Northern Hemisphere.

Abrupt onset -fever.

Headache. Sore throat.

Tight chest.

Painful red eyes < light.

Dry cough. Blocked nose.

Great weakness with aching muscles.

May progress to pneumonia or heart problems.

Haemophilus influenzae. [See]

- Structure changes in influenza viruses, resulting in the appearance of different strains circulating each year, necessitates annual adjustment of the composition of flu vaccines, based on predictions as to which strains will be likely to set the stage for the coming flu season. This unpredictability makes, according to vaccine pressure groups, “the whole influenza vaccination business into a giant poker game.” It also explains the great number of different nosodes termed *Influenzinum*.
- After the 2003 SARS epidemic, linked to a coronavirus, a novel strain [H5N1] of avian influenza [flu type A or “bird flu”] emerged in the Republic of Korea in mid-December 2003 and spread to Thailand and Vietnam, with a total number of 34 “laboratory-confirmed” cases by March 17, 2004, 23 of them fatal.

MATERIA MEDICA INFLUENZINUM

Sources

No provings. Clinical observations with the use of Influenzinum prepared from secretions of influenza patients [probably containing several other organisms besides the virus] or from mixtures of cultured flu strains.

Prophylaxis

Clarke advocated the use of the nosode “as the routine remedy in epidemics. It may be given in the 12th or 30th potency, either in the form of tincture, pilules, or discs. When colds’ appear in a family let all those who are unaffected take Ars. 3 thrice daily, and let the patients take Infl. 30 every hour or two. This generally prevents the spread of the trouble and clears up the ‘colds,’ whether they are of the influenza type or not.” Aware that routine prophylactic prescribing goes at the expense of individualisation, he adds the warning: “Influenza has the property of developing old troubles, and thus it takes an infinite variety of forms in different persons, so that Influenzinum, need not be expected to cure all cases unaided, or indeed, to be appropriate to every case.”

Post-influenzal sequelae

Margaret Tyler preferred to use the nosode [in fact any nosode] on the basis of aetiology. The cause, if clear, overrides in her view the rule of remedy

selection on peculiar individual symptoms: “Some of us are already doing our most brilliant work by following Hahnemann’s lead into the chronic realms of what are called acute diseases. With him we find that, where cure does not hold; where one trouble succeeds another with recurrent, or fresh complaints, that, by harking back to the acute infective sickness of years ago - the first lapse from normality - and by treating that basic ill-health [possibly even communicated in utero] by its analogous remedy, we may experience unimagined delights of healing.” To understand where things are headed it helps to know where they started.

A stern believer in germs, “parasitic micro-organisms,” as the cause of chronic disease, Tyler envisaged “the manner in which some such undreamed-of persistent parasitic diseases may so vitiate health, as to render the host unable to react against blows - adverse circumstances- other diseases, which in a normal healthy person would be so easily outlived or overcome. In the case of tumours and in malignant diseases it were well to enquire about that long-ago illness, since which she had never been the same. Hahnemann tells us that that is a part of the present disease-picture, and must be considered in the prescription.” She then proceeds by briefly recapitulating a few illustrative cases, one of which applies to influenza:

POST INFLUENZAL EPILEPSY. Fits ever since influenza twelve months ago. Severe fits several times a week, with enuresis. Also fits of very violent temper. Had been treated unsuccessfully for six months at a Children’s Hospital. She was given Influenzinum 200, three doses six hours apart. She needed no other medicine. The report was, No more fits, and now she is no more trouble than the other children.

Banerjea regards aetiology/disease history as all-important and has successfully prescribed Influenzinum IM in cases of nervous complaints such as obsessions, delusions, etc. after influenza, flu-like symptoms with malaise, lack of reaction after influenza, cardiac problems with arrhythmias developing after influenza, encephalitis and post-encephalitis cases, eczema of newborns whose mothers had influenza during pregnancy, and anorexia, malaise, headache since flu.

Stearns elevated influenza to miasmatic status: “If we were to add another chronic miasm to those already suggested, influenza should be placed at the head of the list. It is vicious, hydra-headed and ubiquitous. Its ramifications

are so extensive that a full description calls for the rich vocabulary that Hahnemann applied to psora.” He saw it as “the most important of all the nosodes.”

It is often required in patients who give no history of ever having had influenza. This leads us to believe that influenza is the most common of all chronic diseases. It blends in with all other chronic troubles so that it is difficult to determine from the symptoms when this miasm is the major one. In our experience, all patients, when first treated, have more than one chronic miasm and it is essential when making the first prescription, that the dominant miasm have its specific nosode. Frequently, Influenzin is required when there is no history of the patient having had the disease.

However, there may be a history of a severe attack far back in the past or of a series of attacks over a period of years. Where a patient has never been well since an attack of influenza, the nosode will almost certainly be indicated. Patients requiring this nosode may have trouble in any part of the body, although it has a particularly close relationship to diseases of the central nervous system.

Usually a patient with any type of nervous disease will be benefited at the start by Influenzin. Chronic heart conditions, particularly with low blood pressure or with a rapid or arrhythmic pulse often call for this remedy.

One of our patients, a man in the early sixties, who holds a high executive position, had a constant pulse around 100 with frequent extra systoles and shortness of breath. Along with this, his memory was becoming poor, especially for names. We gave him a series of ascending potencies of Influenzin, spaced at long intervals, which greatly improved his condition. After Influenzin, he had a course of constitutional remedies and his pulse and general conditions further improved. Then, as occasionally happens another nosode was required, in his case, Faecalis alkali, followed by another course of constitutional remedies. And now, for more than two years, his pulse has been in the seventies and he has lost all shortness of breath. At the same time, he has regained his memory and looks ten years younger.

[Guy Berckley Stearns, *Influenzins*; RefWorks]

In accordance with the erratic, random and unpredictable nature of influenza, P. Sankaran asserts that “Influenza is the cowbird* of the disease family, ‘depositing its germ in the nest with every other infection.’ Fifty percent of all chronic cases have chronic influenza as one of its complications and often it

is the sole cause of their chronic state. Obsessions, delusions and other anxious states may show their appearances so long after the acute attack of influenza as not to be readily associated with it. While Influenzinum is of no benefit in an acute case of influenza, its use in the chronic case is frequently astonishing. Patients who have been ailing or complaining since an attack of this disease, recent or remote, will also show a marked relief from their symptoms.”

* An American bird (*Molothrus*) of the troupial family, the cowbird or cow blackbird deposits its eggs into other bird's nests, much like the cuckoo [*Cuculus canorus*] does.

Flu shots

The application of Influenzinum can be extended to “never well since flu shots.” Stearns noticed that influenza “has a particularly close relationship to diseases of the central nervous system,” so that “usually a patient with any type of nervous disease will be benefited at the start by Influenzin.” Likewise, influenza vaccines tend to produce neurological complications, albeit infrequently. Influenza vaccines are inactivated vaccines, developed from haemagglutinin extracted from recombinant virus. Live attenuated influenza virus vaccines are currently being developed, which include the administration of a single intranasal inoculation. [Influenza vaccine should not be confused with Haemophilus influenzae type b or Hib vaccine.]

A 1978 German study of 28 cases of neurological affections after influenza inoculation found an incidence significantly higher in autumn [September-November], four times more common in males than in females, and in all age groups [16-73 years old] with an average age of 38.9 years.

A review of 21 reports of adverse effects is presented in the International Vaccination Newsletter:

- * Guillain-Barre syndrome [acute polyneuropathy with muscular weakness, paralysis, and areflexia usually in an ascending pattern].
- * Blood pressure increased or decreased.
- * Paralysis of both upper arms, with severe pain, atrophy of deltoid muscles and hypaesthesia of the right arm [inoculation in the left upper arm],
- * Paralytic symptoms preceded by vomiting.
- * Paralytic symptoms of extremities preceded by paralysis of bladder.
- * Vertigo with tendency to fall to the right side.
- * Vertigo with nystagmus; impossibility to stand up or sit.
- * Protrusion of eyeballs.

-
- * Oedema of retina.
 - * Diminished or blurred vision.
 - * Diplopia.
 - * Paralysis of eye muscles.
 - * Tinnitus or impaired hearing.
 - * Brachial plexus neuropathy.
 - * Trembling of upper limbs.
 - * Automatic motions of fingers and toes.
 - * Transient livid discolouration of the hands.
 - * Paraesthesia of fingertips, followed by bronchopneumonia.
 - * Trigeminal neuralgia.
 - * Aphasia.
 - * Intercostal neuralgia.
 - * Rectal incontinence.
 - * Sexual impotence.
 - * Right-sided sciatica.
 - * Ataxia, worse right side.
 - * Somnolence.
 - * Disorientation about places.
 - * Multiple “drop attacks” [unconsciousness],
 - * Difficulty in thinking.
 - * Loss of initiative.
 - * Confusion and hallucinations.
 - * Depressive tendencies; sadness.

[Adapted from: David L. Hoffmann, International Vaccination Newsletter, 1996]

Cases

(1) We have the following report from a patient - a gentleman aet. 53 - who is very sensitive to the action of homeopathic remedies. Influenzinum - a nosode made from the sputum of an influenza patient - was prescribed for extreme susceptibility to nasal catarrh. The patient making the report has had about 25 attacks of influenza during the last twelve years or so; and during the last three years has at times been subject to brief [usually] but violent attacks of nasal catarrh, provoked by touching anything cold, most on waking, and moving hand or arm ever so little, thus touching a cooler part of the bed, and attended by sneezing and profuse discharge of clear mucus.

November 13 - In afternoon came into contact with a person suffering from influenza. An hour or so after felt ill, eyes ached, larynx felt raw; 7 p.m. took

Camphor gtt. iii. Soon felt better; but feet went cold, eyes pink and smarting, worse inner canthi; skin of forehead felt dry and tight. Phos. 3, one pilule.

November 14 - Much better, but recurrence of inflammation of nose imminent. Merc. sol. 6, one pilule.

November 16 - Much pain [aching] in right sacrum and tendon of thigh; shooting in psoas muscles or sciatic nerve when sitting; rheumatic pain in right calf, right ankle, bend of foot. This has troubled him somewhat last few days, always coming on at 7. 30 or 8 p.m., and a little at other times. Better by holding outer aspect of ankle to the fire. Eyes feel dry and smarting, especially inner canthi, most left. Skin about eyes, especially left upper eyelid, feels chapped.

November 18 - Nux-v. 30, one pilule at bedtime.

November 19 - All the above symptoms practically gone.

November 22 - Evening, much aching in throat, worse right side; nasal catarrh continuous; feel stuffed at supra-eternal fossa. Phos. 3, one pilule.

November 24 - More mental vigour than have felt for some time; but last two evenings have had much smarting about inner canthi, and the sciatic neuralgia (?) returned. Nux vom. 3.

November 27 - Sat for a minute or two on a cold chair without cushion at 4. 30 p.m., which immediately produced sensation of piles and excoriation in anus; 6 p.m. right tonsil inflamed, swollen, painful. Dark redness extending towards uvula. Merc. sol. 6, every twelve hours.

November 29 - The Merc. sol. acted well, but now wakes often during the nights, and feels unable to rise before 10 a.m. Brain weary; mental operations slow; forgetful, especially of names. Occasional tearing pains in fingers and toes, most left; also sciatic neuralgia in evenings, worse stooping and from colds, worse thinking of it. Raw feeling at throat pit. Throat painful, worse talking loudly.

November 30 - Feverish. Aeon. 3x at bedtime.

December 1 - Severe nasal catarrh, worse on moving in morning and when dressing. Influenzinum 30 gl. v. in one-third of a tumbler of water, two teaspoonfuls every eight hours.

December 2 - Feel more vigour, and brain and memory a bit more active. Headache at night, about eyes and occiput. The pain in sacrum and right leg, which had continued from the 24th has gone. [The leg trouble had not returned up to 6th*1 of January, except evening of 26th of December, and patient regards it as cured by Influenzinum.] Influenzinum, one dose on rising.

December 3 - Headache continues, and more in eyes, worse in a close room. Copious nasal discharge on rising [not produced by Influenzinum]. Evening, throat aches, but not so dark red. Last night dreamed he had his father [who died years

ago] in a motor car; also awoke in terror from dream of men trying to enter house to shoot Miss xx. Fear and perplexity in both dreams.

December 4 - Influenzinum on rising. Today and this evening more mental vigour and memory; more vivacious. Throat looks cleaner and brighter red than usual. Still anything cold touching [even a book on knees] causes profuse nasal discharge. Right hand numb on waking last two or three mornings on right side. Cramp in left hand most evenings. Knees cold in bed. Tonight, stool pale and a little blood.

December 5 - Still feel more vigour. Took no medicine this morning. Tonight much hot blood passed at stool.

December 6 - Sleepy till 10 a.m. Improvement maintained, although much below par. Since taking Influenzinum, stools [previously soft stool rather flattened] are round and rather small. No blood at stool tonight. Lachesis 6 at bedtime. December 7 - Feel better; memory better; less catarrh. At night not so well. Tenesmus. Nux-v. 6.

December 8 - On waking, hot flatulence.

December 9 - Better every way. Can now go to London on business. Still, however, subject to attacks of nasal catarrh.

REMARKS. Of the above, the following appear to be effects of the action of Influenzinum: [1] The removal of the leg pains; [2] improved appearance of the throat, which is slightly relaxed and granular, and habitually rather dark red; [3] cramp in left hand, numbness in right; [4] the dreams; [5] the increase of mental vigour, probably. Collinsonia and Nat-mur. have both produced such improvement, and it would be expected of those remedies on their indications. It is, however, noticeable that in this patient [who was cured of prolapsus ani of years' standing by a unit dose of Collinsonia], the use of Collin., Nat-mur., and Influenzinum has been followed by stools becoming paler; and a liver derangement, increasing his somewhat deficient supply of blood to the head, is accompanied by greater brainpower. [*Influenzinum*; Homeopathic World, 1906, p. 131; RefWorks]

(2) On December 20th I was introduced to a lady suffering from arthritis. ... The lady, a Mrs. W., proved to be a willing patient and fortunately for me an extremely intelligent one with whom one could reason, and she proceeded to hand me one perfectly good symptom after another. Her history was the usual sequence of visits to medical men with attendant heat and ray treatment interspersed with X-ray photography of the joints, the last of which confirmed her own fears that there was a definite "leafing" especially around the thumb joints. When I met

her she explained that in addition to her painful joints she could never get warm and especially her feet; even in bed on the hottest summer night her feet would be icy cold. Her heart too was inclined to be unduly irregular, and in the morning she felt as though it would stop. At this time she also had a shortness of breath accompanied by a sense of suffocation which made her want to take deep breaths of air or she would faint.

These extremely clear symptoms seemed to indicate that she might be a Rhus-tox.-patient and so I put the question, "Are your pains better after you have limbered up the joints by movement and are they worse in damp weather?" She promptly replied, "Yes, they are," and so Rhus-tox. seemed to be the first remedy to try.

I was dissatisfied, however, that this was all the assistance her economy needed as she had not always had these troubles.

On eliciting the information that she had suffered a very bad attack of influenza some five years before, which was immediately followed up by a severe attack of gastric "flu" and that her heart symptoms had commenced thereafter, I thought it would be as well to antidote the effects of these illnesses on her system, it is unwise to confuse patients by suggesting more than one or two remedies at one time quite apart from it being an admission of "Hit and miss" prescribing, and so I visited my stock of remedies and fetched Influenzinum 200x and Rhus-tox. lx. ... Continental experts tell us that the 200x potency should be taken three times a day once every three weeks only, and so on December 23rd Mrs. W. took Influenzinum 200x. On December 25th at 11 a.m. she took the first dose of Rhus- tox. lx which I had given her to see how she reacted on this remedy. At 3 p.m. on the same day she reacted to this remedy by producing the following very marked symptoms:

[1] Flu pains in the head. [2] Flu pains in the back and a bruised feeling in the skin. [3] Pain in most joints, especially on right side. [4] Tailbone pain of exceptional severity. [5] Lachrymation. [6] Pain in right side [probably in liver].

This was precisely the sort of reaction I had secretly hoped for when giving her such a low potency of Rhus-tox. and so I promptly gave her Rhus-tox. 12x, one dose every four hours. On January 2nd I rang her up and found she was already very much better than she had been for many months saying,

"I don't know that I have a heart at all nowadays." Apparently she had lost her shortness of breath in the morning and was actually feeling a trifle warmer in spite of the acutely cold weather. ... I have now prescribed Rhus-tox. 60x, one dose every four days taken first thing in the morning when the stomach is nearly empty. She is continuing with Influenzin 200x three times a day every three weeks until

no further effect is felt. Of course no one suggests her cure is assured but all homoeopaths will agree that she is well on the way to being cured, having in two weeks shown a good reaction to the indicated remedy. ... As we leave the patient at present she is still showing favourable reaction to Influenzin 200x within a few hours of dosing. The next step when reaction is absent will be to try Influenzin 100x and then 60x until no further effects of her illness remain in her system. [*Arthritis and the first stages of cure*~, Heal Thyself, March 1940; Encycl.Hom.]

NOTE: The cases and adverse vaccine effects seem to indicate that Influenzinum has a predilection for the *right side*.

MATERIA MEDICA INFLUENZA VACCINE 97/98

Unclear remedy picture

According to Mario Boiadjev, of Sofia, Bulgaria, there are several first prescription options when there is an unclear remedy picture, one of them being:

In a great number of cases, when an influenza vaccine has been administered to the patient, the result is an unclear remedy picture. I have established that no matter which anti-flu vaccine has been applied, the remedy Influenza vaccine 97/98 10M produces a profound therapeutic effect.

This particular vaccine was composed of three main antigenic types of influenza viruses - two strains of type A and one type B strain - then circulating among the world's population. These types are known as A [H1N1], A [H3N2], and B [Beijing/184/93], strain H1N1 being the one of the Spanish flu while H3N2 was linked to the Hong Kong flu pandemic of 1968.

Considering that influenza viruses all have a remarkable capacity to change their antigenic characteristics from year and year, it certainly would save a lot of trouble to regard the 1997-98 vaccine as the prototype of all influenza vaccines, regardless of their composition.

As evidence Boiadjev presents case examples of unclear remedy pictures where a curative response occurred after prescribing Influenza vaccine 97/98.

CASES

Case 1. Male patient, 55, mechanic.

“What are your complaints? What would you like to see cured?”

“Headache and tension in the eyes. I have an awful headache; I take all sorts of pills but nothing helps at all.”

“How long have you been having headaches?”

“Two years maybe. I cant stand it anymore, the pain in the temples and the tension in the eyes, all is dark, not light as day.”

“Have you had any distressing experience before the headache started?”

“Well, we were travelling in a car, my wife and I, three or four years ago, and the guy in the truck hit us and I was injured and since then I feel as if something is pinched in my back.”

“What did you feel when the accident happened?”

“I wasn’t scared, I was just angry that the guy hit us ...”

“Have you had any other distressing experience before the headache?”

“Injustice makes me angry, when I see someone acting mean I get mad inside but I don’t start screaming, it just irritates me because it’s not right.”

“What makes you angry?”

“When I see something being done not as it should have been done, and those who steal also, you know. I have a car and they keep breaking into it to steal something and there is nothing to steal ...”

“Have you been ill before the headache?”

“No.”

“Anything else?”

“I cough a lot in the morning ...”

“Anything else?”

“Sometimes I feel a constricting pain in the region of the heart.”

“Anything else?”

“Nothing, I eat normally ...”

“Is there anything in your life that you have found hard to accept?”

“Can’t think of any.”

“Is there anything you lack in life, anything you need?”

“I want to get rid of this headache.”

“Is there any food you dislike?”

“I’m not too keen on alcohol, I don’t drink much.”

“Is there any food you particularly like?”

“Strawberry and raspberry juice, preserves.”

“Have you ever been given hormone treatment?”

“No, I have never been in hospital.”

“Have you ever had scabies?”

“No.”

“Have you ever had an influenza vaccine?”

“Yes, two years now.”

“Have you ever taken cortisones?”

“No.”

“Have you a headache now?”

“I feel a tension.”

Commentary: In this case it is impossible even to complete the repertorisation because of the lack of clearly defined symptoms. The only clear-cut symptom is “Injustice, cannot support.”

Prescription: Influenza vaccine 97/98 10M.

Ten minutes later: “Less tension in the eyes, I feel more relaxed, the tension is gone.”

Follow-up one month later:

“The fourth and fifth day I had an awful headache, then it was gone. I feel relieved, I can see better, I feel better. In the beginning I was sleepy all the time, I wanted a nap, I needed more sleep. My nerves are better; I get angry but only for a short time and then it passes away quickly.”

“What about tension in the chest?”

“I feel better, I don’t have that tension anymore, it used to hurt inside.”

“How many times have you had headaches?”

“Once since the crisis; before it used to be all the time.”

Since that time, the patient has reported no more headaches or tension in the eyes. He feels much more relaxed and has had no heart-related complaints.

Case 2. Male, 42, depression and atypical psychosis.

At the time of the case taking, the patient was in a mental hospital. Initially, he was treated with Antilepsin, Deanxit and Fluanxol. Two years earlier, sharp cutting pains in the area of the perineum and repeated ineffectual urging for urination before falling asleep had occurred. During the treatment with Antilepsin, he began in the morning to wake up in horror and panic, and suffered from a watery diarrhoea driving him out of bed. Later, he lost his appetite entirely, had numbness in the solar plexus area, numbness of the limbs, muscle cramps, perspiration, weakness, faintness and a desire to commit suicide.

He was admitted to a mental hospital and given treatment with Eglomil, Mianserin, and Chlorprothixen. As a result of the treatment he felt depressed, sleepy, and faint. The treatment then switched to Anafranil, Amitriptylyn and Parkisan. Later, Eglomil and Ripsored were prescribed.

As a result, the patients condition aggravated considerably; he lost his sense of taste and was incapable of any physical or mental activity, had a blank stare, spent all day lying in bed, and his muscles began to atrophy. He felt confused, helpless, and apathetic. He smoked incessantly.

The homeopathic treatment started with Caladium 50M [Korsakoff] three times daily for a month. All psychoactive medication was discontinued.

The follow-up showed that the patient had become much more active both physically and mentally. He started moving and engaging in physical labour. He no longer spent the day in bed. The first ten days, the urinary urging reoccurred and then disappeared. He began to entertain the hope of recovery.

The treatment was continued with Caladium CM twice daily.

A month later, the patient became ill with influenza: pains, constriction and dryness in the throat during swallowing, irritation of the throat and painful skin all over the body. Caladium failed to bring amelioration.

The repertorisation of the acute state did not lead to a clear remedy picture. Several months before his first symptoms of depression, the patient had had a influenza vaccination. Thus, it was the sole indication for a homeopathic remedy.

We started treatment with Influenza vaccine 97/98 10M once daily. The flu was cured in a day. Three months later, the patient was physically and mentally healthy and went back to work.

Case 3. Male, 25.

He came with the following complaints: Constant headache, strong fear of examinations, alopecia, despair of recovery, waking from nightmares, suicidal thoughts, physical weakness, and lack of energy. His general state ameliorated from vigorous physical exercise and hot baths. The headache caused complete inability to study or engage in mental labour. Everything had started with the influenza vaccination.

The repertorisation showed an unclear remedy picture, so the treatment started with Influenza vaccine 97/98.

The patient was completely cured after a year of treatment with Influenza vaccine 97/98 administered once a month; he took all his examinations at the university and found a job.

Case 4. 8-year-old girl.

The girl came with the following complaints: Asthma that had appeared for the first time in the spring when she was three and a half years old. The crisis had started with a watery discharge from the nose; several days later, she had fever, the discharge thickened, a cough with vomiting appeared and asthmatic crises began. The temperature quickly rose to 40° C. The crisis usually continued for about two weeks, during which time she took Novophyllin, Ventoline and antibiotics. At a younger age, the asthmatic attack usually started after rain. When she was younger, she used to knock her head against the bed board. The crises would start about 1 a.m. in the night. Several months before the interview she had been given the influenza vaccination. In the family history there were three cases of tuberculosis, four cases of hay fever and one case of asthma.

She desired smoked meat and chocolate, and had an aversion to fruits and vegetables. She often used to drink vinegar.

At the time of the interview, the child had coryza, fever, an asthmatic attack and headache, and was taking Ventoline every 8 hours and Dimex cough syrup.

In the past, she had been treated unsuccessfully for two years with Tuberculinum and Medorrhinum.

The repertorisation showed a clear remedy picture of Arsenicum album. I administered the remedy but it brought no amelioration; the headache worsened. After two more doses, there was no improvement, which indicated that the remedy would not work.

The only remaining choice was the potentised flu vaccine, Influenza vaccine 97/98 10M. The asthmatic attack passed in a few minutes, the child calmed down and the headache disappeared.

All medication was discontinued and the Influenza vaccine 97/98 10M was repeated only when she fell ill with influenza or suffered an asthmatic attack. Each new dose almost immediately improved her condition. During the rest of the time she didn't need any repetitions because she felt very well both mentally and physically. After that, several doses of Tuberculinum were described and the child was cured.

[All four cases from: Mario Boiadjiev, *Systemic Approach in Homeopathic Theory and Practice*, Sofia, 2000]

MATERIA MEDICA OSCILLOCOCCINUM

HISTORY

The microbe

Rarely encountered in homeopathic materia medicas, Oscillococcinum is a proprietary drug with a great reputation in France as a prophylactic or an acute for influenza or flu-like conditions. It has an interesting, though enigmatic history, initiated by the French physician Joseph Roy who, when working as an army physician during the outbreak of Spanish influenza in 1917-18, discovered in the blood of flu victims a strange microbe. Under the microscope it looked like a diplococoid organism, consisting of two “unequal balls” which could vary in size. It performed quick oscillating movements, which led Roy to call it “oscillococcus.” Although never identified by modern bacteriology, Roy subsequently started to see the mysterious organism almost everywhere: in syphilitic chancres, in gonorrhoeal discharges, in the lungs of TB patients, in the blood of patients suffering from eczema, herpes, and chronic arthritis. Patients with mumps, chickenpox, or measles also turned out to harbour the oscillococcus, as well as cancer patients, the latter having it in their blood and tumours. Roy was able to produce a fatal influenza-like syndrome in laboratory rats by injecting them with blood of flu victims containing oscillococci, while rats and rabbits injected with oscillococci-containing blood or cancerous tissue of cancer patients died of influenza with “thermic shock,” pneumonia, and gastrointestinal haemorrhages. These experiments were conducted in the period 1920-1924.

Cancer treatment

By the time that Roy moved to Paris, where he came in contact with the renowned homeopath Leon Vannier, the idea was borne to make a homeopathic remedy of it. The finding of the micro-organism in cancerous tissues spurred further investigation into its internal employment in cancer treatment. Believing he had made a new discovery in the cure of cancer, Roy published his ideas and findings in 1925 in a book titled “Vers la connaissance et la guerison du cancer” [Towards the knowledge and the cure of cancer].

More or less a homeopathic variation of Coley’s experiments in the 1890s with inoculation of tumours with *Streptococcus pyogenes*, Vannier noted that cancer patients after administration of oscillococci developed febrile reactions, flu-like symptoms, an aggravation of their general state, and progression of

their cancer. This process could be reversed, it was thought, by giving the oscillococci in homeopathic potency. And so Oscillococcinum came in vogue as a cancer remedy, years before Foubister introduced Carcinosinum, despite disagreement whether to use it in active cancer or in pre- or post-cancerous states. For example, Hui Bon Hoa, to whom we owe a few additions to the Carcinosinum drug picture, wrote that there “was a time when we were using *Oscillococcinum* instead of *Carcinosinum*.”

Indeed, in the mind picture of Oscillococcinum we find symptoms reminiscent of Carcinosinum, eg, fastidiousness and the need for control. While its employment as a preventative for colds and flu currently dominates the picture, its application for cancerous conditions has not entirely fallen into oblivion, as is evidenced by the following statements by Degroote [1992]; “Oscillococcinum resembles Carcinosinum in many respects.

Doctor Hui Bon Hua [France] gave us many reports where he used it in place of Care., with good results. The action is less profound than that of Care. Often Care, has to be administered afterwards. Doctor Pladys used it in cases where there was a too violent reaction after the administration of Care.”

The duck

What Roy saw through the eyepiece of his microscope we will never know. We can speculate that he might have been looking at streptococci and/or gonococci, considering some of the samples he studied, but their morphology was at that time common knowledge and, moreover, these cocci are non-motile. Roy first discovered the microbes in the blood of Spanish flu victims, which would suggest influenza viruses, but it would take until the 1930s before the equipment was developed to spot and isolate viruses.

What happened next adds to the mystery because Roy, for reasons unknown, decided around 1925 to take the barbary or muscovy duck as his source for the production of oscillococci.

Roy failed to explain whether this was out of convenience, muscovy ducks being readily available for the French cuisine to prepare duck breast, or whether there was a rationale behind it. Pure luck, intuition, premonition, even genius, it all may be applied to the good doctor Roy, for in the last two decades it has become accepted that migratory waterfowl, particularly wild ducks, are the natural reservoir of avian influenza viruses, and these birds are also the most resistant to infection. In common with such waterfowl as geese, swans, pochards, and teals, muscovy ducks have been demonstrated to host a variety of flu viruses, among others influenza A type H1N1, which happens

to be the one linked with the Spanish flu!

On top of that, muscovy ducks harbour many more viruses: parainfluenza viruses, enteroviruses, adenoviruses, reoviruses, herpesvirus, parvoviruses, and hepatitis B virus. In addition to the influenza viruses, adeno- and parainfluenza viruses in their related human varieties [serotypes] cause respiratory diseases, “colds and flu-like symptoms.” More interesting connections with Roys observations can be made. Parainfluenza viruses are part of the family Paramyxoviridae, to which also belong the viruses causing mumps and measles. Herpesvirus can be linked to both herpes simplex - cold sores *orfever* blisters - and chickenpox [a name indicating its avian origins].

Such viruses normally produce no significant clinical disease or lesions in the ducks, except for Muscovy duck parvovirus, which results in high mortality in young ducks with symptoms of weight loss, pericarditis and perihepatitis. Round hearts are found in ducks that recover from the infection. Muscovy duck heart and liver give another nice twist to the story.

Roy insisted on the specific use of the heart and liver of muscovy ducks, for which he ventured an esoteric explanation: “The Ancients considered the liver as the seat of suffering, even more important than the heart, which is a very profound insight, because it is on the level of the liver that the pathological modifications of the blood happen, and also there the quality of the energy of our heart muscle changes in a durable manner.”

To this curious view refers the official name of the remedy: *Anas Barbariae Hepatis et Cordis Extractum*. It is basically the common name turned into Latin, *Anas* meaning duck and *Barbariae* barbary. In biology, however, this duck is known as *Cairina moschata*.

In conclusion, Roy cannot have hit upon the existence of viruses, yet he succeeded in coming up with a source for a remedy with an indisputable relationship with viruses. By analogy, the remedy might be considered for patients with an increased susceptibility to viral diseases. Finally, it should be borne in mind that more and more voices go up that correlate cancer with viruses.

SYMPTOMS

Sources

No provings. Clinical observations of Chavanon, Hui Bon Hoa, and Julian.

Mind

- = Anxiety, unquietness without clear cause.
- == Impatience, improves when one is busy.
- Tendency to be maniacal. *Busy*, cannot bear disorder.
- ~ Fixed ideas; obsessions.
- == Fear of dirt and pollution [contagion]; urge to often wash hands.
- « Afraid to shake hands for fear of contagion.
- = Fear of thunderstorm.

Generals

- = Sensitivity to cold.
- ~ Need for fresh air despite fear of catching cold.
- ~ Sensitivity to changes in weather and humidity of air.
- ~ Better warmth and rest.
- « Worse from milk and eggs [indigestion].
- = Sleeplessness with agitation during the night.
- Pruritus after antibiotics.

Alimentary

- = Tongue coated white.
- ~ Putrid regurgitations.
- = Vomiting of water or food.
- = Stomach distended.
- Abdominal cramp followed by fetid diarrhoea.
- « Pain in region of appendix.
- Persistent constipation [sometimes].

Respiratory

- Catarrh of nose [and eyes].
- Stuffed nose, nasal obstruction, sneezing.
- = Nasal voice; loss of voice; dry painful cough.
- = Pain in sinuses [frontal and maxillary]. Pulsating frontal headache, > blowing nose.

- = Nasal discharge first serous, then muco-purulent.
- = Muco-purulent expectoration with moist cough.

Other locals

- = Yellow conjunctiva.
- Feeling of a bug running over the face at night.
- = Hearing diminished.
- « Needle-like pains in one or both ears.
- = Pain behind ear [mastoid], spontaneous or felt on pressure.
- ~ Urine turbid, diminished, deep yellow colour. Sometimes painful urination.

BIBLIOGRAPHY

- Allen H.C. 1910. *The Materia Medica of the Nosodes*. New Delhi: Jain Publishing Co. [reprint 1982].
- Barnes D.S. 1995. *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France*. Berkeley: University of California Press.
- Bechamp A. 2002 [reprint of 1911 edition]. *The Blood and its Third Element*. Metropolis Ink.
- Bentley G. 2003. *Appearance and Circumstance: Miasms, Facial Features and Homoeopathy*. Niddrie: Pennon Publishing.
- Biddle W. 2002. *A Field Guide to Germs*. New York: Anchor Books.
- Bott V. 1978. *Anthroposophical Medicine: An extension of the art of healing*. London: Rudolf Steiner Press.
- Buckman R. 2003. *Human Wildlife: The Life That Lives On Us*. Baltimore: John Hopkins University Press.
- Cochrane R.G. & Davey T.F. [eds.] 1964. *Leprosy in Theory and Practice*. Bristol: John Wright & Sons Ltd.
- Coleman J.C, Butcher J.N. & Carson R.C. 1980. *Abnormal Psychology and Modern Life*. Glenview: Scott, Foreman and Company.
- Coulter H.L. & Fisher B.L. 1991. *A Shot in the Dark*. New York: Avery Publishing Group.
- Degroote F. 1992. *Physical examination and observation in Homoeopathy*. Gent: Homeoden Bookservice.
- Diamond J. 1998. *Guns, Germs and Steel: A Short History of Everybody for the Last 13,000 Years*. London: Vintage.
- Dixon B. 1996. *Power Unseen: How Microbes Rule the World*. New York: W.H. Freeman and Company.
- Dormandy J. 2000. *The White Death: A History of Tuberculosis*. New York: New York University Press.
- Douglas Hume E. 1932. *Bechamp or Pasteur: A Lost Chapter in the History of Biology*. Facsimile edition by Kessinger Publishing.
- Drexler M. 2003. *Secret Agents: The Menage of Emerging Infections*. New York: Penguin Books.
- Enby E., Gosch P. & Sheehan M. 1990. *Hidden Killers: The Revolutionary Medical Discoveries of Professor Guenther Enderlein*. Sheehan Communications.
- Fenn E.A. 2001. *Pox Americana: The Great Smallpox Epidemic*. New York: Hill and Wang.
- Foubister D. 2001. *Tutorials on Homoeopathy*. Beaconsfield: Beaconsfield

Publishers Ltd.

- Fraser P. 2002. *The AIDS Miasm: Contemporary Disease & The New Remedies*. West Wickham: Winter Press.
- Garrett L. 1995. *The Coming Plague: Newly Emerging Diseases in a World Out of Balance*. New York: Farrar, Straus and Giroux.
- Garth Wilkinson J.J. 1918 [reprint of 1851 edition]. *The Human Body and Its Connexion With Man*. London: The New Church Press.
- Gascoigne S. 2003. *The Prescribed Drug Guide: A Holistic Perspective*. Clonakilty: Jigme Press.
- Goodman L.S. & Gilman A. 1970. *The Pharmacological Basis of Therapeutics*, 4th ed. New York: Macmillan.
- Griesinger W. 1965 [reprint of English edition of 1867]. *Mental Pathology and Therapeutics*. New York: Hafner Publishing Company.
- Haggard H.W. 1929. *Devils, Drugs, and Doctors*. New York: Harper & Row.
- Hall S.S. 1997. *A Commotion in the Blood: Life, Death, and the Immune System*. New York: Henry Holt and Company.
- Hayden D. 2003. *Pox: Genius, Madness, and the Mysteries of Syphilis*. New York: Basic Books.
- Hays H.R. 1972. *Birds, Beasts, and Man*. New York: G.P. Putnam's Sons.
- Head C.J. 1999. *An Educated Decision: One Approach to the Vaccination Problem Using Homeopathy*. Lavender Hill Publishing Company.
- Holmes C. 2003. *Spores, Plague and History: The Story of Anthrax*. Dallas: Durban House Publ.
- Hutchinson, Sir J. 1913. *Syphilis*. New York: Funk and Wagnails Company.
- James W. 1988. *Immunization: The Reality Behind The Myth*. New York: Bergin & Garvey.
- Julian O.A. 1984. *Materia Medica of New Homoeopathic Remedies*. Beaconsfield: Beaconsfield Publishers.
- Julian O.A. 1988. *Treatise on Dynamised Micro-Immunotherapy*. New Delhi: B. Jain Publishers.
- Karlen A. 1995. *Man and Microbes: Disease and Plagues in History and Modern Times*. New York: G.P. Putnam's Sons.
- Klaassen C.D. [ed.] 1996. *Casarett and Doull's Toxicology* [5th ed.]. New York: McGraw-Hill.
- Klein L. 2003. *Clinical Focus Guide to Homeopathic Remedies, Vol. I*. Canada: Luminos Homeopathy Courses Ltd.
- Leikin J.B. & Paloucek EP. 1998. *Poisoning & Toxicology Compendium with Symptom Index*. Hudson: Lexi-Comp Inc.

- Lindeboom G.A. 1971. *Inleiding tot de Geschiedenis der Geneeskunde*. Haarlem: De Erven F. Bohn.
- Lishman W.A. 1987. *Organic Psychiatry: The Psychological Consequences of Cerebral Disorder*. Oxford: Blackwell Scientific Publications.
- McTaggart L. 2003. *The Field: The Quest for the Secret Force of the Universe*. London: Element.
- Margulis L. & Sagan D. 1997. *Microcosmos: Four Billion Years of Evolution from Our Microbial Ancestors*. Berkeley: University of California Press.
- Margulis L. 1998. *Symbiotic Planet: A New Look at Evolution*. New York: Basic Books.
- Margulis L. & Schwartz K.V. 1998. *Five Kingdoms: An Illustrated Guide to the Phyla of Life on Earth*. New York: Henry Holt and Company.
- Maton A. et al. 1994. *Parade of Life: Monerans, Protists, Fungi, and Plants*. Needham, MA: Prentice Hall.
- McBean E. 1974. *The Poison Needle: Suppressed Facts About Vaccination*. Mokelumne Hill: Health Research.
- McFarland J. 1907. *A Textbook upon the Pathogenic Bacteria* [5th ed.]. Philadelphia: W.B. Saunders.
- Mendelsohn R.S. 1979. *Confessions of a Medical Heretic*. Chicago: Contemporary Books.
- The Merck Manual [1b¹*1 ed.] 1992. Rahway: Merck Research Laboratories.
- Miller J. 1978. *The Body in Question*. London: Jonathan Cape.
- Miller N.Z. 1993. *Vaccines: Are They Really Safe and Effective?* Santa Fe: New Atlantean Press.
- Neustaedter R. 1990. *The Immunization Decision: A Guide for Parents*. Berkeley: North Atlantic Books.
- Null G. & Feast J. 2003. *Germs, Biological Warfare, Vaccinations: What You Need To Know*. New York: Seven Stories Press.
- Ornstein R. & Sobel D. 1987. *The Healing Brain: Breakthrough Discoveries About How The Brain Keeps Us Healthy*. New York: Simon and Schuster.
- Porter R. 1999. *The Greatest Benefit to Mankind*. London: Fontana Press.
- Portmann A. 2000. *Biologie und Geist*. Gottingen: Ulrich Burgdorf Verlag.
- Postgate J. 2003. *Microbes and Man* [4¹*1 ed.]. Cambridge: Cambridge University Press.
- Purves W.K. et al. 1998. *Life: The Science of Biology* [5¹*1 ed.]. Sunderland MA: Sinauer Associates.
- Rang H.P., Dale M.M. & Ritter J.M. 1999. *Pharmacology*. Edinburgh: Churchill Livingstone.

- Raskova H. 1971. *Pharmacology and Toxicology of Naturally Occurring Toxins*, Vol. 1. Oxford: Pergamon Press.
- Raue C.G. 1985 [reprint of 4th ed. 1896]. *Special Pathology and Diagnostics with Therapeutic Hints*. New Delhi: B. Jain Publishers.
- Riemann H. [ed] 1969. *Food-borne Infections and Intoxications*. New York: Academic Press.
- Robbins P. 2002. *Evolving Homoeopathy: Towards a Developmental Approach to Homoeopathy*. Lismore, Australia.
- Rothman S.M. 1995. *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History*. Baltimore: Johns Hopkins University Press.
- Sandblom P. 1992. *Creativity and Disease*. New York: Marion Boyars.
- Sankaran P. 1978. *Some Notes on the Nosodes*. Bombay: The Homoeopathic Medical Publishers.
- Scheibner V. 1993. *Vaccination*. Blackheath, Australia: own publication.
- Sherr J.Y. 2002. *Dynamic Materia Medica - Syphilis*. Great Malvern: Dynamis Books.
- Stedman's Medical Dictionary [25th ed.]. 1990. Baltimore: Williams & Wilkins.
- Stokes J.H., Beerman H. & Ingraham N.R., Jr. 1944. *Modern Clinical Syphilology: Diagnosis, Treatment, Case Study*. Philadelphia: WB. Saunders Company.
- Stone T. & Darlington G. 2000. *Pills, Potions and Poisons*. Oxford: Oxford University Press.
- Stratton K.R., Howe C.J. & Johnston R.B. [eds.] 1994. *Adverse Effects Associated with Childhood Vaccines: Evidence Bearing on Causality*. Washington, D.C.: National Academy Press.
- Tomes N. 1999. *The Gospel of Germs: Men, Women, and the Microbe in American Life*. Boston: Harvard University Press.
- Tompkins P. & Bird C. 2002. *Secrets of the Soil*. Anchorage: Earthpulse Press Incorporated.
- Tudge C. 2000. *The Variety of Life*. Oxford: Oxford University Press.
- Vakil P. 1992. *Proving and Clinical Symptoms of New, Old and Forgotten Remedies*. Bombay: Vakil Homoeopathic Prakashans.
- Wade A. 1977. *Martindale: The Extra Pharmacopoeia*, 27th ed. London: The Pharmaceutical Press.
- Wills C. 1996. *Yellow Fever, Black Goddess: The Coevolution of People and Plagues*. Reading: Addison-Wesley Publishing Company, Inc.
- Wilson E.O. 1992. *The Diversity of Life*. Cambridge, MA: Belknap Press of Harvard University Press.

- Winston J. 1999. *The Faces of Homoeopathy*. Tawa: Great Auk Publishing.
- Young R.O. & Young S.R. 2001. *Sick and Tired? Reclaim Your Inner Terrain*. Pleasant Grove: Woodland Publishing.
- Zimmerman B.E. & Zimmerman DJ. 2003. *Killer Germs: Microbes and Diseases that Threaten Humanity*. Chicago: Contemporary Books [McGraw-Hill books].

GLOSSARY

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| 5 -hydroxytryptamine | Serotonin. |
| Achlorhydria | The absence of free hydrochloric acid in the stomach. May be found in pernicious anaemia, pellagra and gastric cancer. |
| Acrodermatitis chronica atrophicans | Hardening bluish-red patches of skin starting on hands, feet, elbows or knees, which die and dry to a thin shiny papery appearance. |
| Acrodynia | An allergic reaction to mercury in children, causing pain and erythema in the fingers and toes. |
| Aerobes -obligate Aerobes | Organism restricted to living in oxygenated conditions. Organisms that can live and thrive only in the presence of oxygen. Obligiate aerobes are unable to live without oxygen; facultative aerobes can live in oxic or anoxic environments. |
| Anaerobe | An organism that does not require air or free oxygen to live. Obligiate anaerobes are unable to live in even low concentrations of oxygen; aerotolerant organisms can live in the presence of oxygen, but do not use it. |
| Anoxic Archaeobacteria | Devoid of molecular oxygen. Aquatic or terrestrial micro-organisms that exhibit a diversity of shapes, including spiral, spherical and rodshaped forms, They survive in various extreme environments, including very hot or salty ones. Some require oxygen; some do not. Some produce an end-product of methane; others depend on sulphur for their metabolism. Some scientists think that archaeobacteria are the most ancient form of orga-nisms still living. |
| Arrhythmia | Variation from the normal rhythm. |
| Arthrosis | A degenerative disease of a joint. |
| Asthenia | Want of strength. Debility. Loss of tone. |
| Athetosis | A recurring series of slow writhing movements of the hands, usually due to a cerebral lesion. |
| Autopoiesis | The way in which an organism maintains itself. |
| Autotroph | An organism that grows and synthesises organic compounds from inorganic compounds by using energy from |

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| | sunlight or from oxidation of inorganic compounds. |
| Bacillus | Rod-shaped bacterium. |
| Bartholinitis | Inflammation of a vulvo-vaginal gland. |
| Bartonellosis | Rickettsial infection, caused by the bacterium bartonella bacilliformis of the order Rickettsiales. |
| Basal cell | Cell in the lowest layer of stratified tissue [epidermis, epithelia] from which the tissue is renewed. |
| Binomial nomenclature | System of naming and identifying organisms that assigns each organism two names, a genus name and a species name. |
| Blepharitis | Inflammation of the eyelids. |
| Bronchiectasis | Chronic dilatation of the bronchi and bronchioles with secondary infection, usually involving the lower lobes of the lung. Often an acquired disease secondary to partial obstruction of the bronchi with necrotizing infection. |
| Budding | The reproduction by the outgrowth of a protrusion [bud] from a parent cell or body of an animal, plant or fungus. |
| Bulbar paralysis | Labioglossopharyngeal paralysis, due to changes in the motor centre of the medulla oblongata. Affects the muscles in the mouth, tongue and pharynx. |
| Bulbar | Pertaining to the medulla oblongata. |
| Cataplexy | Sudden recurrent loss of muscle power without unconsciousness, often associated with narcolepsy. May be produced by any strong emotion. |
| Chemolithotrophs | Organisms dependent upon hydrogen-rich chemicals for energy and upon carbon dioxide for carbon. |
| Chemosis | oedema of the conjunctiva; swelling around the cornea. |
| Guillain-Barre syndrome | Acute infective polyneuritis. Respiratory or general weakness and paralysis after an infection. |
| Chemosynthesis | Synthesis of organic compounds [as in living cells] by energy derived from chemical reactions. |
| Chitin | Tough, resistant nitrogen-containing polysaccharide that is a component of arthropod skeletons and cell walls of some protocists and fungi. |
| Chlorophyll | Green pigment that absorbs visible light energy and helps convert it to usable chemical energy in photosynthesis. |

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| Chloroplast | Microscopic, ellipsoidal, chlorophyll-containing organelle in a green plant cell. The site of photosynthesis. |
| Cholangitis | Inflammation of the bile ducts. |
| Chromatin | Complex of nucleic acid [DNA] and basic proteins [histones] of which chromosomes are made during mitotic cell division. |
| Chromista | Once considered Fungi, these potato blight organisms are now placed in their own kingdom. |
| Coccoid | Spherical, nearly-spherical, or berry-shaped structure. |
| Coccydynia | Persistent pain in the region of the coccyx. |
| Colonial (adj) | Refers to genetically identical cells or organisms that live in a permanent association. Although each is capable of growth by division, colony members live in stable but loose association. |
| Colibacillosis | Diarrhoea caused by E. coli. |
| Commensalism | Physical association between members of two or more species in which neither species necessarily takes nutrients from the other. Eating at the same table. |
| Conjugation | In prokaryotes, cell-to-cell contact between a donor and a recipient bacterium at which the transmission of genetic material occurs. |
| Cortex | The outer layer of an organ or organism. |
| Cyanobacteria | Bacteria formerly called blue-green algae. |
| Desquamation | Peeling or flaking of the skin. |
| Dikaryotic | Containing two nuclei, each usually from a different parent. |
| Dioecious | Having male and female organs on different individuals of the same species. |
| Diploid | Having two complete sets of chromosomes, one each from the maternal and the paternal parents. |
| Diplopia | double vision |
| DNA | Deoxyribonucleic acid; a long molecule composed of nucleotides in a linear order that constitutes the genetic information of cells and that is capable of replicating itself and of synthesising RNA. |
| Dorsum | 1. The back. 2. The upper or posterior surface. |
| Dysarthria | Difficulty in articulating words due to disease of CNS. [Tremor of lips and tongue.] |

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| Dysphagia | Difficulty in swallowing |
| Ecchymosis | A bruise; an effusion of blood under the skin causing discoloration. |
| Ecthyma | A form of impetigo with an eruption of pustules usually with a hardened base. |
| Emphysema | The abnormal presence of air in tissues or cavities of the body. |
| Empyema | A collection of pus in a cavity, often the pleural cavity. |
| Encephalomyelitis | Inflammation of the brain and spinal cord. |
| Endocarditis | Inflammation of the membrane lining the heart - due to infection by micro-organisms, fungi, Rickettsia or rheumatic fever. |
| Endospore | Desiccation and heat-resistant spore produced inside a bacterium. |
| Enteroptosis | Prolapse of the intestines. |
| Enzyme | Biological catalyst for a specific substrate and product; molecule that accelerates but does not enter metabolic reaction. |
| Epigastrium | The region of the abdomen situated over the stomach. |
| Epizoon | Any external animal parasite. |
| Erythema | Redness of the skin caused by congestion of the capillaries in its lower layers, as with any skin injury or inflammation. |
| Eschar | Scab. |
| Eubacteria | A group consisting of the true bacteria, one of the two major groups of the prokaryotes, the other of which is the archaeobacteria. All bacteria other than the archaeobacteria. |
| Eukaryote | Any organism composed of one or more cells, each of which contains a clearly defined nucleus enclosed by a membrane, along with organelles (such as mitochondria and plastids). All organisms except bacteria are eukaryotes. |
| Exotoxin | A toxin released by a living bacterial cell into its surroundings. |
| Facultative | Having the capacity to live under more than one specific set of environmental conditions, as an animal or a plant that can live a parasitic or a non-parasitic life. |
| Farcy | A disease of horses, communicable to man, through |

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| | abraded skin, caused by the glanders bacillus <i>Burkholderia mallei</i> . It is marked by a purulent inflammation of the mucous membranes and an eruption of nodules on the skin. See glanders. |
| Felon | An abscess near the finger-nail; paronychia or whidow. |
| Fetor or foetor | offensive smell. |
| Fibrin | An insoluble protein formed from fibrinogen during blood-clotting . |
| Finicky | Pernickety, exacting minute care; fastidious; fussy. |
| Flagella | pl. long whiplike appendages serving as organs of locomotion, sensing and feeding. |
| Follicular | With little sacs [rash]. |
| Fomes | See fomites. |
| Fomites | Sing, fomes; inanimate objects or material on which disease-producing agents may be carried, (e.g. clothing, cups, door handles etc.) |
| Fulminant | Sudden in onset and rapid in course. |
| Furuncle | A boil. |
| Gemma | (pl. gemmae) a small mass of cells from body tissue that can be released and develop into a new individual. |
| Gingivitis | Inflammation of the gums. |
| Glanders | A disease of horses, communicable to man, by inhalation, caused by the glanders bacillus <i>Burkholderia mallei</i> . It is marked by a purulent inflammation of the mucous membranes and an eruption of nodules on the skin. See farcy. |
| Gram-negative | Failing to retain the purple stain when subjected to the Gram staining method, used to classify bacteria |
| Gummas | Soft degenerating tumours. |
| Haemolysin | A substance which destroys red blood cells. It may be an antibody, a bacterial toxin or a component of a virus. |
| Haemolytic | Having the power to destroy red blood cells. |
| Hemianopia | Partial blindness in which the patient can see only one half of the normal field of vision. |
| Heterotroph | A micro-organism requiring a complex organic compound such as glucose for its source of energy. |
| Hirsutism | Hairy face. |
| Homologous | Relating to structures or behaviours that have evolved from common ancestors, even if the structures or |

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| | behaviours have diverged in form and function. |
| Host | The animal or plant tissue on which a parasite lives and multiplies. |
| HUS | Haemolytic Uraemic Syndrome. |
| Hydrarthrosis | Effusion of serous fluid into joint cavity. |
| Hyperkinetic | Excessive motor activity. |
| Hypersomnia | Condition characterised by excessively long sleep periods with normal responses in the intervals. |
| Hypochondrium | The upper region of the abdomen on either side of the epigastrium. |
| Hypoglycaemia | A condition in which the blood sugar level is less than normal. Usually arising in diabetic patients due to insulin overdose, delay in eating or a rapid combustion of carbohydrate. |
| Infection | Initiation of a symbiotrophic (usually necrotrophic) relationship between organisms of different species. |
| Keratitis | Inflammation of the cornea, caused by physical trauma or infectious conditions. |
| Kernig's sign | Strong passive resistance to attempts to extend the knee when the patient lies upon the back and the thigh is flexed to a right angle with the axis of the trunk. |
| Kingdom | The most inclusive taxonomic level immediately above the phylum. |
| Lamella | Flat, thin scale or flattened saclike structure. |
| Larva | (p. larvae) immature form of an animal, morphologically distinguishable from the adult form. |
| Lacunar tonsillitis | Inflammation of the mucosa lining the tonsillar crypts. |
| Leukocytosis | An increase in the number of leukocytes in the blood. Often a response to infection. |
| Lysis | Death |
| Macular | Spotchy [rash]. |
| Mantic | Having the power of divination. |
| Mediastinum | |
| | The space in the middle of the thorax, between the two pleurae. |
| Medullafpl. medullae) | Inner portion of a gland or other structure surrounded by the cortex. |
| Medulla oblongata | That portion of the spinal cord which is inside the cranium. In it are the nerve centres governing the respiration |

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| | and heart action etc. |
| Meiosis | One or two successive divisions of a diploid nucleus (with two sets of chromosomes) that will result in the production of haploid nuclei (with one set of chromosomes each). A stage of reduction cell division when the chromosomes of a gamete are halved in number ready for union at fertilisation. |
| Menorrhagia | An excessive discharge of menses. |
| Metacarpophalangeal joint | The joint at the bones of the wrist and the bones of the fingers. |
| Microaerophilic | Requires oxygen but less than is present in the air. |
| Microbe | Organism that requires a microscope to visualise it; microscopic living thing; bacterium, protoctist or small fungus. |
| Monoamine oxidase | An enzyme that breaks down noradrenaline and serotonin in the body. |
| Monoamine oxidase inhibitor - abbreviated MAO I. | A drug that prevents the breakdown of serotonin and leads to an increase in mental and physical activity. |
| Murine | mouse-like. |
| Murrain | An infectious disease of cattle carried by parasites, or a plague such as the nineteenth century Irish potato blight. |
| Mutualists | Organisms living in mutual beneficial association. |
| Mycelium | Mass of hyphae that constitutes the body of a fungus or a funguslike protoctist. |
| Necrotrophy | Nutritional mode in which a symbiotic partner damages or kills the organism in or on which it resides. |
| Nidus | A nest or breeding place [particularly where bacteria or other organisms lodge and multiply.] |
| Nosocomial | An infection acquired or occurring in a hospital. |
| Nucleus (pl. nuclei) | Large membrane-bounded organelle that contains most of the genetic information of a cell in the form of DNA. |
| Obligate | Mandatory; compulsory. |
| Obtundation | Bluntness/death. |
| Oliguria | Scantiness of urine due to diminished secretion. |
| Ophthalmia | Inflammation of the conjunctiva or eyeball. |
| Opsonic index | A measurement of the bactericidal power of the phagocytes |



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| | in the blood of an individual. |
| Organelles | Small, self-contained cellular parts that perform specific functions. |
| Otolith | A calcareous concretion of the inner ear. |
| Ozaena | Foetid, atrophic nasal catarrh with crust formation. |
| Papular | Pimply [rash]. |
| Papulosquamous | Pimply and scaly [rash]. |
| Parasite | Organism that lives on or in an organism of a different species from which it obtains nourishment. |
| Parenchyma | The essential active tissues [cells] of an organ as distinguished from its connective or supporting tissue. |
| Paronychia | An abscess near the finger-nail; a felon or whitlow. |
| Peptidoglycan | Rigid layer of bacterial cell walls. |
| Peritrichous flagella | Flagella distributed all around cell. |
| Pernickety | Exacting minute care; fastidious; finicky; fussy. |
| Pes planus | Flat feet. |
| Petechiae | Minute reddish or purplish spots containing blood appearing in skin or mucous membrane as a result of localised haemorrhage, like bruising. |
| Phlebitis | Inflammation of a vein, usually in a leg. |
| Photosynthesis | The formation of carbohydrates from carbon dioxide and a source of hydrogen [as water] in the chlorophyll-containing tissues of plants exposed to light. |
| Pink disease | Acrodynia: an allergic reaction to mercury in children, causing pain and erythema in the fingers and toes. |
| Plantar reflex | Contraction of the toes on stroking the sole of the foot. |
| Platysma | The platysma muscle depresses the lower lip, and wrinkles the skin of neck and upper chest. |
| Pleomorphic | Occurring in more than one distinct form. |
| Pleomorphism | Occurring in more than one form. The existence of several distinct types of the same species. |
| Pneumoconiosis | An industrial disease of the lung caused by the inhalation of dust particles over a period of time. |
| Proctitis | inflammation of the rectum. |
| Prokaryotes | Bacteria. |
| Protist | Single-celled (or very few celled), and therefore microscopic, protocist. |
| Protista | A group of organisms including all the unicellular plants |

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| | and animals. Microscopic in size. |
| Protoctist | Nucleated organism that contains more than a single bacterially derived genome per cell, but is not plant, animal or fungus. Protoctists include the group of organisms traditionally called protozoans and all fungi with mastigote stages, as well as all algae (including kelps), slime moulds, slime nets and many other obscure eukaryotes. All protoctists are products of coevolved bacterial symbioses, and some, as kelp, are too large to be called protists. |
| Protophyta | First plants. |
| Protozoans | Belonging or pertaining to the phylum Protozoa, comprising single-celled animals, or a colony of like or similar cells. |
| Pseudobulbar palsy | Speech and swallowing difficulties due to paralysis of lips and tongue, accompanied by emotional instability and spasmodic, mirthless laughter; sometimes called laughing sickness. |
| Purpura | Blood in the skin and mucous membranes causing purple patches. |
| Pustular | Pus-filled. |
| Pyorrhoea | A discharge of pus. <i>P. alveolaris</i> pus in the sockets of the teeth. |
| Pyrosis | Heartburn; indigestion. |
| Reiters syndrome | Conjunctivitis, arthritis and urethritis. |
| Reservoir | The host or environment in which an organism lives, i.e. hands, skin, nose, bowels, and from which it is able to infect susceptible individuals. |
| Reticulo-endothelial system | A collection of endothelial cells in the liver, spleen, bone marrow and lymph glands that produce large mono-nuclear cells or macrophages. These are phagocytic; they destroy red blood cells and have the power of making some antibodies. |
| RNA | Ribonucleic acid. |
| Salpingitis | Inflammation of the uterine tubes. |
| Saprobe | An organism living on organic debris. |
| Scombroid | Relating to the mackerel family. |
| Serotonin | An amine present in blood platelets, the intestines and |

the CNS, which acts as a vasoconstrictor. Derived from the amino acid tryptophan, it is inactivated by monoamine oxidase.

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| Spondylitis | Inflammation of the vertebrae. |
| Squamous | Scaly. |
| Stridor | Harsh, vibrating, shrill sounding respiration. |
| Substrate | Foundation to which an organism is attached (e.g. a rock). Also a compound acted upon by an enzyme. |
| Symbionts | Two dissimilar organisms living together in close union or intimate association. |
| Tachycardia | Abnormally rapid action of the heart and consequent increase in pulse. |
| Thrombocytopenia | A reduction in the number of platelets in the blood; bleeding may occur, giving rise to purpura. |
| Tracheotomy | Surgical incision of the trachea. |
| Vector | |
| | An animal that carries organisms or parasites from one host to another, either of the same species or to one of another species. |
| Vermiform | Worm-shaped. |
| Vibrio | Bacterium shaped like a comma. |
| Vincent's angina | Ulcerative infection of tonsils and pharynx, usually associated with necrotising ulcerative gingivitis; may cause suffocative attacks. |
| Virus | Protein-coated genetic material that is capable of growth and replication only within a living cell |
| Whitlow | An abscess near the finger-nail; paronychia or felon. |
| Zoonosis | An animal disease that is transmissible to humans. |

Sources used to prepare Glossary

Webster's Encyclopedic Unabridged Dictionary of the English Language. 1994. Grammercy New York.

Margulis L., Schwartz KV, Dolan M., 1999. *Diversity of Life*. Second Edition.

Jones and Bartlett. Massachusetts.

Weller B., Wells R., *Bailliere's Nurses' Dictionary*. 1990. 21st Edition. Bailliere Tindall Ltd. London.

www.britannica.com. *Encyclopaedia Britannica* online.

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| Zincum phosphoricum | 175 |
| Zoo attendants | 461 |

Frans Vermeulen is Dutch, living in an old Swedish farmhouse with his wife and daughter. He spends his days buried in homeopathic literature, making forays out into the world to lecture, and lecturing in his Swedish School of Homeopathy in Stockholm. His love is to elucidate, categorize and structure huge amounts of homeopathic information, making a strong stable and secure base on which homeopaths may build their understanding of this complex medical art. To do this he chases every symptom to its source. So he himself is now a reliable source and resource for homeopaths.

FUTURE PLANS

Frans is currently working on Spectrum, a set of *Materiae Medica* divided into the Kingdoms. Books on non-vascular Plants, Plants, Minerals and Compounds, Gases, Imponderables and Animals of air, sea and land will follow this first book of the Monera. It is an encyclopaedic work, and of such benefit to Homeopathy.

Frans is also lecturing worldwide about his work.

BOOKS IN PRINT

Concordant Materia Medica [1994] - the practitioner's bible. This contains *Materia Medica* from Hering, T.E Allen, Boericke, Boger, Clarke, Cowperthwaite, Kent, Lippe, Pulford

and Vermeulen. It is a concordance of annotated sources, clearly laid out, starting with the main characteristics of the remedy, and working in sections through from the Mind to the Modalities. Then follows a section on related remedies. This book contains the maximum number of reliable *Materia Medica* facts in the minimum space.

Synoptic Materia Medica [1992] — a handy reference of *Materia Medica* from many modern sources. 195 rxs. Great for learning the basics, the essence and for passing exams. Interesting reading. First published in 1992, and reprinted a dozen times since. Sold over 18.000 copies Now updated as:

The New Synoptic One.

Synoptic Materia Medica 2 [1996] — continues in the vein of *Synoptic Materia Medica* to give valuable information on 'small' and unknown remedies. However SMM2 is expanded to include Signs, Folklore, Comparisons, Botanical and Chemical information, which also bring the remedies to life. A very useful chapter on Botanical relationships starts the book, followed by one devoted to food desires and aversions This book contains remedies made from drug substances [Haloperidol, Amyl nitrate]; hormones [Corticotropinum, Folliculinum]; bac

teria, [Streptococcinum]; the bowel nosodes; little known plants [Ocimum canum, Onopordon] indeed it takes remedies from every conceivable kingdom. This book brings together remedies about which little is written, and which is even more difficult to find. In 1996 it was ahead of its time. In 2004 however, these remedies are in more common usage, and this is the only materia medica in which information about these unusual remedies can be found together.

Prisma: The Arcana of Materia Medica Illuminated is a fully expanded version of *Synoptic One*, containing the same remedies, and also an encyclopaedic amount of information on the source, zoology, chemistry, physics, distribution, folklore, mythology and history of the remedies. This contextual material is absolutely fascinating reading, bringing the medicinal substances vibrantly to life. Whereas *Synoptic One* and *Concordant Materia Medica* are vital books for the student and clinical reference texts, *Prisma* is all this, plus bedtime reading too.

The New Synoptic One, 2004. An updated, re-edited reference based on the 'out-of-print' *Synoptic Materia Medica* of 1992. Contains the fresh ideas of many modern writers and draws on the standards of our basic texts too. Easy to read, fascinating. Also contains material from Jan Scholten and

Sankaran — Sensation and Miasm, and stage in the periodic table. An essential for Essence and Exams!

TRANSLATIONS

Concordant Materia Medica is available in German [Konkordanz MM] *Synoptic Materia Medica* is available in French, German, Russian, Chinese and Japanese.

Synoptic Materia Medica 2 is available in German and French, Russian, Italian 2006

Prisma: The Arcana of Materia Medica Illuminated will be available in German in 2005, Italian 2006, Japanese expected.

ALSO FROM EMRYSS b.v.

A Modern Guide and Index to the Mental Rubrics of Kent's Repertory — David Sault [1990]

Synthetic Bedside Repertory for Gestation, Birth and Childhood - Jan Willem Janssen [1992]

GRACILICUTES
(Gram negative bacteria)

MONERA
Eubacteria

TENERICUTES
(wall less eubacteria)

PHYLUM MYCOPLASMA

| Phylum | Order | Family | Genus | Species | Remedy | |
|----------------|-------------------------|-----------------------------|----------------------|-------------------------|--|-------------------------|
| PROTEOBACTERIA | Gp Alpha | Rhizobiales | — Brucellaceae | — Brucella | — <i>B. melitensis</i> | — <i>B. melitensis</i> |
| | | Rhodospirillales | — Acetobacteriaceae | — Acetobacter | — <i>A. xylinus</i> | — <i>Kombucha</i> |
| | | Rickettsiales | — Rickettsiaceae | — Rickettsia | — <i>R. prowazekii</i> | — <i>Typhus nosode</i> |
| | Gp Beta | Burkholderiales | Alcaligenaceae | Alcaligenes | — <i>A. faecalis</i> | — <i>BN Faecalis</i> |
| | | | Burkholderiaceae | Bordetella | — <i>B. pertussis</i> | — <i>Pertussinum</i> |
| | | | Burkholderiaceae | Burkholderia | — <i>B. mallei</i> | — <i>Hippozaeninum</i> |
| | | Neisseriales | — Neisseriaceae | — Neisseria | <i>N. gonorrhoea</i> — <i>Medorrhinum</i> <i>N. meningitides</i> — <i>Meningococcinum</i> <i>N. subflava</i> — <i>Flavus</i> <i>N. mucosa</i> — <i>BN Sycotic Co.</i> | |
| | Gp Gamma | Enterobacteriales | — Enterobacteriaceae | Citrobacter | — <i>C. freundii</i> | — <i>BN Bacis-7</i> |
| | | | | Enterobacter | — <i>E. cloacae</i> | — <i>BN Bacis-7</i> |
| | | | | Escherichia | — <i>E. coli</i> | — <i>Colibacillinum</i> |
| | | | | Escherichia | — <i>E. coli mutabile</i> | — <i>Mutabile</i> |
| | | | | Hafnia | — <i>H. alvei</i> | — <i>BN Bacis-7</i> |
| | | | | Klebsiella | — <i>K. pneumoniae</i> | |
| | | | | Morganella | — <i>M. morganii</i> | — <i>BN Morgan pure</i> |
| | | | | Proteus | — <i>P. mirabilis</i> | — <i>BN Proteus</i> |
| Proteus | | | | — <i>P. vulgare</i> | — <i>BN Proteus</i> | |
| Salmonella | | | | — <i>S. paratyphi</i> | — <i>Paratyphoidinum</i> | |
| Salmonella | | | | — <i>S. typhi</i> | — <i>Eberthinum Typhoidinum</i> | |
| Salmonella | | | | — <i>S. enteritidis</i> | — <i>BN Gaertner</i> | |
| Shigella | — <i>S. dysenteriae</i> | — <i>BN Dysenteriae Co.</i> | | | | |
| Yersinia | — <i>Y. pestis</i> | — <i>Pestinum</i> | | | | |
| Gp Epsilon | Campylobacteriales | Campylobacteraceae | Campylobacter | — <i>C. jejuni</i> | | |
| | | Helicobacteraceae | Helicobacter | — <i>H. pylori</i> | | |
| | | Pasteurellales | — Pasteurellaceae | Haemophilus | — <i>H. influenza</i> | — <i>Hib vaccine</i> |
| Gp Delta | Pseudomonadales | Pseudomonadaceae | Pseudomonas | — <i>P. aeruginosa</i> | | |
| | | Vibrionales | Vibrionaceae | Vibrio | — <i>V. cholerae</i> | — <i>Cholera nosode</i> |
| SPIROCHAETAE | Spirochaetales | Leptospiraceae | Leptospira | — <i>L. interrogans</i> | — <i>Weil's disease</i> | |
| | | Spirochaetaceae | Borrelia | — <i>B. burgdorferi</i> | — <i>Lyme nosode</i> | |
| | | | Treponema | — <i>T. pallidum</i> | — <i>Syphilinum</i> | |
| | | | Treponema | — <i>T. pertenue</i> | — <i>Framboesinum</i> | |
| CYANOBACTERIA | Chroococcales | Chroococcaceae | Microcystis | — <i>M. aeruginosa</i> | — <i>M. aeruginosa</i> | |
| | | Nostocales | Nostaceae | Anabaena | — <i>A. flos-aqua</i> | — <i>Saxitoxinum</i> |
| | Oscillatoriales | Phormidaceae | | | | |
| | | Pseudanabaenaceae | Arthrospira | — <i>A. maxima</i> | — <i>Spirulina</i> | |
| | | Spirulina | — <i>S. maxima</i> | — <i>Spirulina</i> | | |

FIRMICUTES

(Gram positive protein-walled bacteria)

| Phylum | Order | Family | Genus | Species | Remedy | | | | |
|--------------------|----------------|------------------|-------------------|------------------|---|--|---|---|--|
| ENDOSPORA | Class BACILLI | BACILLALES | Bacillaceae | Bacillus | <i>B. anthracis</i> <i>B. brevis</i> | — Anthracinum — Tyrothricinum | | | |
| | | | Listeriaceae | Listeria | <i>L. monocytogenes</i> | — Listeriosis nosode | | | |
| | | | Staphylococcaceae | Staphylococcus | <i>S. aureus</i> | — Staphylococcinum | | | |
| | | LACTOBACILLALES | Enterococcaceae | Enterococcus | <i>E. faecalis</i> Enterococcus spp. | — Enterococcinum | | | |
| | | | Lactobacillaceae | Lactobacillus | <i>L. acidophilus</i> <i>S. pneumoniae</i> | — Lactobacillus — Pneumococcinum | | | |
| | | | Streptococcaceae | Streptococcus | <i>S. pyogenes</i> | — Scarlatinum | | | |
| | | | | | | — Streptococcinum | | | |
| | | Class CLOSTRIDIA | CLOSTRIDIALES | Clostridiaceae | Clostridium | <i>C. botulinum</i> <i>C. difficile</i> <i>C. perfringens</i> <i>C. tetani</i> | — Botulinum — Tetanotoxinum | | |
| | | | | | | PIRELLULAE | CHLAMYDIALES | Chlamydiaceae | Chlamydia |
| | | ACTINOBACTERIA | ACTINOMYCETALES | Actinomycetaceae | Actinomyces | <i>A. albus</i> <i>A. citreus</i> <i>A. griseus</i> <i>A. israeli</i> <i>A. luteus</i> | — Streptomycetes albus — <i>S. citreofluorescens?</i> — Streptomycetes griseus | | |
| Corynebacteriaceae | Corynebacteria | | | | | <i>C. diphtheriae</i> | — Nocardia lutea — Diphtherinum | | |
| Micromonosporaceae | Micromonospora | | | | | <i>M. purpurea</i> | — Gentamicinum | | |
| Mycobacteriaceae | Mycobacterium | | | | | <i>M. avium</i> <i>M. avium subsp. paratub.</i> <i>M. bovis</i> <i>B. Calmette-Guérin</i> <i>M. leprae</i> <i>M. tuberculosis</i> | — Aviaire — Johneinum — Tub. bovinum Kent — Vaccin attenué bilié <small>B.C.G.</small> — Leprominum | | |
| | | | | | | Nocardiaceae | Nocardia | <i>N. asteroides</i> | — Bacillinum |
| | | | | | | Streptomycetaceae | Streptomyces | <i>S. albus</i> <i>S. ambofaciens</i> <i>S. aureofaciens</i> <i>S. caespitosus</i> <i>S. erythreus</i> <i>S. fradiae</i> <i>S. garyphalus</i> <i>S. griseus</i> <i>S. nodosus</i> <i>S. noursei</i> <i>S. peucetius var. caesius</i> <i>S. rimosis</i> <i>S. venezuelae</i> | — Salinomycin — Spiramycin — Chlorotetracycline — Aureomycin — Mitomycin — Erythromycin — Neomycin — Cycloserine — Streptomycin — Amphotericin — Nystatin — Doxorubicin — Oxytetracycline — Chloramphenicol |

RNA Viruses

| Family | Genus | Type Species | Remedies |
|---|----------------------|-------------------------------------|--------------|
| a: positive single stranded RNA [+ssRNA]; naked; polyhedral capsid | | | |
| Picornaviridae | Enterovirus | Poliovirus | Polio nosode |
| | | Coxsackie A & B virus | |
| | | Echoviruses | |
| | Rhinovirus | Human Rhinovirus A [common cold] | |
| Hepatovirus | Hepatitis A virus | | |
| Aphthovirus | Foot & mouth disease | | |

| | | | |
|---|-------------|-----------------------------------|--|
| b: positive single stranded RNA [+ssRNA]; enveloped; polyhedral capsid | | | |
| Coronaviridae | Coronavirus | Infectious bronchitis virus | |
| Flaviviridae | Flavivirus | Yellow Fever virus | |
| | | Dengue Fever virus | |
| | Hepacivirus | Hepatitis C | |
| Togaviridae | Rubivirus | Rubella virus [German measles] | |

| | | | |
|--|------------|-----|-------------------------|
| c: positive single stranded RNA [+ssRNA]; with a DNA intermediate in replication; enveloped; bullet-shaped or polyhedral capsid | | | |
| Retroviridae | Lentivirus | HIV | AIDS nosode Virionum |

| | | | |
|---|----------------------|---------------------|--------------------------------|
| a: negative single stranded RNA [-ssRNA] | | | |
| Bornaviridae | Bornavirus | Borna disease virus | |
| Filoviridae | Marburg-like viruses | Marburg virus | |
| | | Ebola-like viruses | Zaire Ebola virus |
| Paramyxoviridae | Morbillivirus | Measles | Measles Vaccine Morbillinum |
| | | Canine distemper | |
| | Rubulavirus | Mumps MMR | Parotidinum MMR |
| Rhabdoviridae | Lyssavirus | Rabies virus | Lyssinum |

| | | | |
|---|----------------|-----------|---|
| b: segmented negative single stranded RNA; enveloped | | | |
| Orthomyxoviridae | Influenzavirus | Influenza | Influenzinum Influenza vaccine 97/98 Oscillococinum |

DNA Viruses

| Family | Subfamily | Genus | Type Species | Remedies |
|---|--------------------|---|--|------------------------------|
| a: double stranded DNA viruses [ds DNA]; naked; polyhedral; capsid | | | | |
| Adenoviridae | | <i>Mastadenovirus</i> | Human adenovirus A-F | |
| Papillomaviridae | | <i>Papillomavirus</i> | <i>Papillomavirus</i> <i>Verruca</i> | <i>Verruccinum</i> |
| b: double stranded DNA viruses [ds DNA]; enveloped; circular; complex | | | | |
| Poxviridae | | | <i>Horse-grease</i> | <i>Malandrinum</i> |
| | | | <i>Cowpox</i> | <i>Vaccinum</i> |
| | | <i>Variola</i> | <i>Smallpox</i> | <i>Variolinum</i> |
| c: double stranded DNA viruses [ds DNA]; enveloped; polyhedral; capsid | | | | |
| Herpesviridae | Alphaherpesvirinae | <i>Simplex virus</i> [<i>Herpes simplex</i>] | HHV 1 + 2 | <i>Herpes Simplex nosode</i> |
| | | <i>Varicellovirus</i> | HHV 3 Chickenpox | <i>Varicella nosode</i> |
| | | <i>Herpes zoster</i> | HHV 3 Shingles | <i>Herpes zoster nosode</i> |
| | Betaherpesvirinae | <i>Cytomegalovirus</i> | HHV 5 | <i>Cytomegaly nosode</i> |
| | | <i>Roseolovirus</i> | HHV 6 | <i>Herpes virus 6 nosode</i> |
| | Gammaherpesvirinae | <i>Lymphocryptovirus</i> | HHV 4 Epstein Barr Infectious mononucleosis | |
| d: double stranded DNA and RNA Reverse Transcribing Virus | | | | |
| Hepadnaviridae | | <i>Orthohepadnavirus</i> | <i>Hepatitis B</i> | |