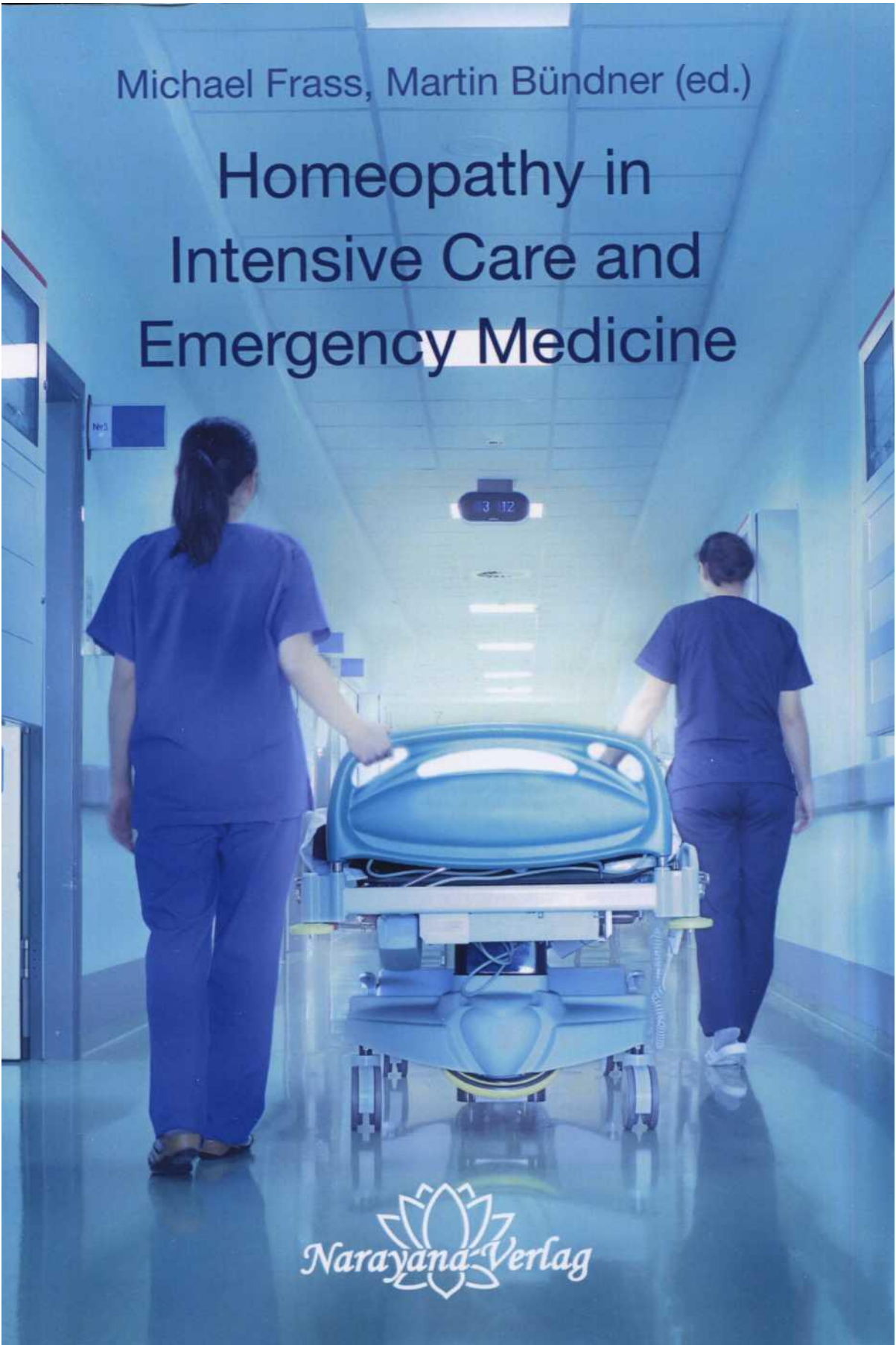


Michael Frass, Martin Bündner (ed.)

Homeopathy in Intensive Care and Emergency Medicine



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Michael Frass, Martin Bündner (ed.)

Homeopathy in Intensive Care and Emergency Medicine

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*For my dear children Albert and Charlotte, my
parents Heinrich and Mariele, who have given
me unfailing support throughout my medical
career. For my teacher Gerhard Resch, for all my
friends and patients who have helped me to gain
knowledge in homeopathy*

Michael Frass

*For my dear wife Peggy, my beloved daughters
Franziska, Johanna, Antonia and Paulina, and
all those of my patients who have been privileged
and grateful to discover the marvellous benefits of
homeopathic remedies.*

Martin Bundner

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Foreword

It seems rather strange for scientifically oriented physicians, especially physicians specialising in intensive care and emergency medicine, to use homeopathy as a complementary weapon in their therapeutic armoury. Specialists in intensive care and emergency medicine are commonly believed to have a more mechanistic outlook on the world than most; they analyse people using physical and chemical principles and take action depending on what they find.

Homeopathy with its doubly empirical approach is not an esoteric healing art, but could by all means be a potential healing science.

Martin Bündner and Michael Frass, not infrequently the targets of criticism from colleagues who work on a strictly scientific basis in compliance with the criteria of evidence-based medicine, have taken the trouble to confront taboos in university circles and break new ground for a healing method which is unfortunately only familiar to a few medical opinion leaders. The fact that they do not do this with the fanaticism of a homeopath uncritically convinced of his healing method but instead constantly seek scientific approaches leading to astonishing publications in renowned scientific journals is not only worthy of respect, but also essential for the development of a healing method which is very much on the fringe of medical science.

As specialists in intensive care medicine, we have experienced numerous failures with paradigm changes and methods which were temporarily recognised by the universities. Many of the strategies we have been using for decades looked promising and could be argued for logically, but did not bring about any positive results. Dopamine for nephroprotection, orciprenaline and sodium bicarbonate for resuscitation, large doses of cortisone and endotoxin antibodies for treating sepsis, the contraindication of beta-blockers for treating cardiac insufficiency - all these are well-known and in some cases costly examples of aberrations of the once "pure teachings" of medicine.

Michael Frass and Martin Bündner are constantly seeking new approaches to intensive care and emergency medicine. Michael Frass, inventor of the Combitude, describes the surprising possibilities of homeopathy in well-prepared case reports and controlled clinical studies. Although one renowned medical journal has foretold the end of homeopathy, the authors show that verifiable medical results can also be achieved in areas beyond the Loschmidt (or Avogadro) constant. Physicists have long been teaching us that the transfer of information via medication does not require the presence of a molecule. Anyone who makes the effort to learn about the astonishing construction of homeopathy will gradually come to realise why homeopathy, probably the only unrecognised form of complementary medicine, has resisted the current of social, political and contemporary opinion right up to the present day. They will also understand why most university-trained medics reject this method: firstly because the data available from controlled studies is not exactly overwhelming, and secondly because it is incredibly time-consuming, difficult and challenging to become familiar with the intricacies of this form of healing and to gain corresponding experience. Numerous positive personal experiences will ultimately bring the conviction of having a healing method at ones disposal which can be used as a complement to the indisputably important progress made in scientifically oriented conventional medicine and which can frequently transform difficult situations for the better. It was an absolutely unexpected, remarkable surprise for me to discover that this is particularly the case in intensive care and emergency medicine, as I had thought the main strength of homeopathy was in treating chronic disease. A scientific approach is essential for maintaining and improving homeopathy as a healing method. However, researchers are confronted with enormous difficulties, even though this research would be possible in methodical terms. Good controlled studies require large budgets which are only made available if the project is backed by sufficient commercial interest.

Foreword

Michael Frass has made many attempts to set up larger homeopathic studies, but has frequently failed due to a shortage of funds and a lack of interest on the part of the pharmaceutical industry. The fact that he has nevertheless been able to publish interesting results testifies to the persistence of a researcher to whom success may come late but who is sure of it in the end. The long history of scientific dogmatism has shown that today's heresy can become tomorrow's truth. If the occasional specialist in intensive care or emergency medicine reads

this book in bed at night and quickly hides it when his colleagues are around, Michael Frass and Martin Bündner will have achieved their aim of arousing interest in additional chances of healing via paths which have yet to be charted.

Prim. Univ.-Prof. Dr. med. Peter Lechleitner
Director of Internal Medicine
Medical Director Lienz
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Editors' foreword

Homeopathy is very popular with large parts of the population, and is now also increasingly being accepted by many doctors. However, the ailments treated are usually chronic. The potential of homeopathy for treating acute disease is less well known. Inspired by the astonishing and rapid success often observed when treating sudden illness, many homeopaths throughout the world have begun using this method of healing for life-threatening or seemingly hopeless cases in the fields of intensive care and emergency medicine, either as an accompaniment to conventional treatment or even on its own. The impulse to use homeopathy in intensive care medicine came from the observation that seriously ill patients often spend days or weeks in intensive care, during which time certain organs stop functioning and are replaced by machinery. During this time, which often seems surprisingly uneventful and monotonous to the non-specialist after the initial spectacular interventions, the patient's condition can only improve if the body's own functions are allowed to regenerate; this process can be accelerated by concomitant treatment with homeopathy. One outstanding strength of homeopathy is that it is known to stimulate the body's powers of self-healing. In contrast, the special attraction of using homeopathy in emergency medicine is the often rapid and almost incredible improvement in the patient's condition which frequently cannot be emulated by conventional measures. In many cases, the patient's state of health undergoes a fundamental improvement by alleviating the symptoms which may cause the patient's condition to deteriorate again at the next opportunity.

One particular aim of this book is to deepen the dialogue between practitioners of conventional medicine and homeopathy. We also aim to have this form of treatment recognised in a medical field which to date has been almost completely and unjustifiably dominated by conventional medicine.

The many successes achieved by classical homeopathy throughout the world, which to outsiders may seem sensational, have inspired us to make these observations and experiences in a generally unfamiliar area accessible to a wider public. We would like to counter the reluctance to treat acute diseases with homeopathy and motivate colleagues working with these seriously ill patients to use classical homeopathy in intensive care and emergency medicine with the skill required. The book provides case studies to assist with repertorisation and remedy choice. The cases presented by no means claim to be perfect, as the remedy was often chosen under immense time pressure. However, we would be delighted to receive comments, reactions and further case studies to help us pursue this project further.

Each chapter of this book starts by giving a general overview of the respective disease from a conventional viewpoint before introducing homeopathic cases. Only the information required for the progression and assessment of each case is presented, along with a description of any conventional treatment. In this way, we want to achieve two things: firstly to impart knowledge to homeopaths who are not so experienced in the fields of intensive care and acute medicine, and secondly to awaken the curiosity of colleagues who mainly work with conventional medicine and motivate them to consider using homeopathy with critically ill patients. The value of conventional diagnosis is undisputed; however, homeopathy has proven its efficacy as a sole or concomitant treatment in many cases.

At this point, we would like to express our warmest thanks to Elsevier and its ambitious personnel. We were more than a little surprised to be asked to edit this book: Rolf Lenzen, Stefanie Regensburger and Elisabeth Harth all cordially invited us to pursue this project. Sonja Frankl was the perfect mastermind behind the creation of this book and was invariably ready to offer encouragement.

From the Austrian side, I would specially like to mention Dr. Gerhard Resch, without whose constant support and deep insight into homeopathy the intensive care medicine section of this book would

Editors' foreword

never have been written. I would also like to thank Dr. Beatrix Wulkersdorfer for her patient, unfailing assistance. We would never have been able to carry out our homeopathic treatments without the support of graduate nurse Christoph Dielacher in our intensive care unit and Gabi Ujfalusi in the secretarial office of our clinic. I would also like to say a big thank you to the director of my clinic, Univ.- Prof. Dr. Christoph Zielinski, who along with my colleagues has been supporting my homeopathic work for many years. However, the greatest joy and satisfaction in this work comes from the healed patients - may their stories be an inspiration to all my colleagues!

May this book achieve one thing above all: help improve the situation of seriously ill patients. Aude sapere!¹

Michael Frass
Vienna,
February 2007

Martin Bündner
Tubingen,
February 2007

¹ “Sapere aude” (as translated by Kant): “Have the courage to use your own understanding!” Hahnemann also prefaced his “Organon of the Healing Art”, the manual of homeopathy, with these words.

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IV Materia medica

Abbreviations

A

A./Aa.	Arteria(e)
ACE	Angiotensin Converting Enzyme
agg	aggravated
amel.	ameliorated
AMG	German Drugs Act (Arzneimittelgesetz)
AO ₂	available oxygen
ARDS	Acute Respiratory Distress Syndrome
ARF	acute renal failure
ASS	acetylsalicylic acid
AST	aspartate transaminase (formerly SGOT)
ATP	adenosine triphosphate

B

BC	blood count
BGA	Blood Gas Analysis
BS	blood sugar
BW	body weight

C

caO ₂	arterial oxygen content
CEE	conjugated equine oestrogen
CH	C potency of Hahnemann
CHD	coronary heart disease
CK	creatine kinase
CLIS	Carcinoma lobulare in situ
CMF	Cyclophosphamide + Methotrexate + 5-Fluorouracil
CO	cardiac output
cond.	condition
cont.	continuation
CRH	corticotropin releasing hormone
CRP	C-reactive protein
CT	computed tomography
CTG	cardiotocography
CWH	continuous veno-venous haemofiltration

D

d	day(s)
DHEA	dehydroepiandrosterone

DIC	disseminated intravascular coagulation
Dil.	dilution
DNA	deoxyribonucleic acid
dr.	drops

E

EDTA	ethylene diamine tetraacetic acid
EEG	electroencephalogram
EMG	electromyography
ESR	erythrocyte sedimentation rate
EUG	extrauterine gestation
ext.	external

F

FC	fluxion potency
fet	film-coated tablet(s)

G

glob.	globules
GnRH; GRH	gonadotropin releasing hormone
GOT	glutamic oxaloacetic transaminase (now AST)
GPT	glutamic pyruvate transaminase

H

h	hour(s)
Hb	haemoglobin
HCG	human chorionic gonadotropin
HCT	haematocrit
HDL	high-density lipoproteins
HDR	high dose rate
HELLP	haemolysis, elevated liver enzymes, low platelets
HLA	Human Leucocyte Antigen
HP	Homeopathic Pharmacopoeia
HR	heart rate

I

i.m.	intramuscular
i.v.	intravenous
IgD, IgE,	immunoglobulins D/E/G/M
IgG, IgM	
IGT	impaired glucose tolerance

Abbreviations

IHD int. intermittent haemodialysis internal

K

K centesimal potency of Korsakov

L

LDH lactate dehydrogenase

LD lethal dose

LDL low-density lipoproteins

M

M 1000 potency in the centesimal series

mg milligram

mil. million

min. minute(s)

Mm. muscles

N

N. nerve

neg. negative

Nn. nerves

NSAID non-steroid anti-inflammatory drugs

O

OGTT oral glucose tolerance test

op. operation

P

p.d. daily

p.o. per os (by mouth)

Ph. Eur. European Pharmacopoeia

poss. possibly

post-op. post-operative

PRBC packed red blood cells

pred. predominant(ly)

PVC premature ventricular contraction

R

RR Riva-Rocci (symbol for blood pressure measurements with Riva-Rocci apparatus)

S

s.c. subcutaneous

sec. second(s)

ssp. subspecies

st. p. status post

susp. suspected

T

T₃ triiodothyronine
(levo)thyroxine

tab. tablet

TM mother tincture

TRH thyrotropin releasing hormone

TSH thyroid stimulating hormone

TTP thrombotic thrombocytopenic
purpura

X

10M 10 000 potency in the centesimal series

Symbols

↑ high, raised

↓ low, decreased

> more than, better from

< less than, worse from

«V cf. (reference)

® trade name

0 mother tincture

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1 Homeopathy in intensive care and emergency medicine

Gerhard Resch

1.1 Using homeopathy in a clinical setting

1.2 Principles of classical homeopathy

Carl Friedrich von Weizsacker: "Science is right about the statements it makes but wrong about what it keeps secret."

ORGANON, Samuel Hahnemann

"By nature, the true healing art is a pure science of experience which can and must rest on clear facts and on the sensible phenomena pertaining to their sphere of action, for all the subjects it has to deal with are clearly and satisfactorily cognisable by the senses through experience. Knowledge of the disease to be treated, knowledge of the effects of the medicines and how the ascertained effects of the medicines are to be employed for the eradication of diseases: all this experience alone teaches adequately. Its subjects can only be derived from pure experiences and observations, and it dares not take a single step out of the sphere of pure well-observed experience and experiment if it would avoid becoming a nullity, a farce." (Preface to the Organon of the Healing Art, 1819)

1.1 Using homeopathy in a clinical setting

In a modern scientific context, it may initially seem strange to publish a book devoted to the use of homeopathic remedies in the fields of emergency and intensive medicine. After all, intensive medicine

is based on a logical, unambiguous way of thinking originally founded on the cognitive structures of Descartes and now anchored in our persisting modern understanding of science. From here, there appears to be no bridge to the mindset and world view of homeopathic medicine; ultimately, homeopathy can only be comprehended by analogy.

While practitioners of emergency and intensive medicine focus primarily on the fundamental vital processes essential to existence, and the treatment administered aims to preserve these at all costs, homeopathic medicine invariably focuses on the whole person, the individual and all his expressions of life - even when treating emergency cases and patients receiving intensive care.

From a homeopathic viewpoint, for example, it is not decisive whether or not the individual is aware of these expressions of life, whether they are imparted by the patient himself or observed by relatives, medical staff etc., whether the corresponding indications are established by laboratory tests or other sources, or whether or not they are immediately relevant for the emergency or intensive treatment of the patient.

Interestingly, the nature and power of homeopathic medication is often observed most clearly when it is used for emergency and intensive treatment. In the next section, I would like to give a brief description of my practical experience of homeopathy in everyday life in the clinic.

1 Homeopathy in intensive care and emergency medicine

Right at the beginning of my still very cautious experiments with the use of homeopathic remedies to treat acute and chronic disease, I was frequently confronted with extremely severe, acute and life-threatening diseases and conditions which required immediate medical treatment. Intensive care medicine as we understand it today did not exist in our hospital back in the 1960s. There was no way to keep patients under observation using monitors, no 24-hour laboratory, no specially trained personnel; many of the drugs at our disposal today had not yet been developed; much of the knowledge taken for granted in present-day intensive care medicine was not yet available. The patients were admitted to and cared for on normal wards, and frequently received their initial treatment in the passages - all without the aids available today. In appropriate emergencies, I started giving doses of a homeopathic remedy which seemed to me to fit the case as well as administering the usual treatment. The scope of the healing reaction left me much impressed with the early successes of my homeopathic approach. I was particularly struck by the speed at which the remedy began to work, especially in acute and traumatic cases, and above all in a wide variety of potentially life-threatening conditions. In such instances, it was completely irrelevant whether the person administering the remedy had a positive or negative attitude towards homeopathy, whether the patient was responsive, unconscious, intubated or not intubated, whether or not recovery was to be expected from a conventional viewpoint.

Case study: 60 year old male patient brought to the clinic unconscious after collapsing in the street. The paramedics who transported him to the clinic reported that according to information gathered from passers-by, the patient had collapsed as though struck by lightning and fallen into a state of deep unconsciousness. The patient was immediately connected to an ECG monitor, which indicated that his collapse had been caused by an extensive transmural anterior myocardial infarction. During the initial clinical assessment, it was noted that his eyes were rotated outward, his pupils were rigid,

his pulse and reflexes could not be found and that his breathing was weak and shallow. The patient's condition seemed to show that centres deep in the brain had already ceased to function. This in turn indicated direct involvement of the central nervous system in an acute myocardial infarction. The ECG was dominated by a plateau-like ST segment showing no other differentiation. Thrombolytical treatment was to be started immediately.

- A similar acute condition is described in J. H. Clarke's materia medica in the remedy description for the venom of the monocled cobra (*Naja tripudians*). Here he describes the case of a man who while skinning a rat which had been killed by a cobra bite had himself absorbed the poison through a tiny injury at the base of his fingernail. Frank Buckland described the consequences of this careless action as follows: "I had not walked a hundred yards before all of a sudden I felt just as if somebody had come behind me and struck me a severe blow on the head and neck, and at the same time I experienced a most acute pain and sense of oppression at the chest, as though a hot iron had been run in and a hundredweight put on the top of it." (Clarke 1962).
- Clarke also mentions another interesting indication for *Naja tripudians*. The Indian homeopath Majumdar saved the lives of a number of seemingly hopeless cholera cases who had reached a state of collapse with respiratory difficulties and no pulse by giving them *Naja*.

The patient was given one dose (2 globules) of *Naja tripudians* 30C orally. Within minutes, the ECG became normal, complete with sinus rhythm, P, Q, R, S and T waves; there was no longer any indication of an "acute myocardial infarction". Shortly afterwards, the patient woke up, was responsive and stated that he felt well and had no pain or any other symptoms. The prepared injections were dispensed with and the patient was admitted to a normal ward, where he was kept under observation for eight days. He enjoyed a full recovery without complications, and was discharged with no medication or suggested treatment. *Naja tripudians* has repeatedly proven its efficacy in treating heart

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attacks, and has also prevented heart attacks before they occur.

This case from my early years of working with homeopathy aims to give an insight into the use and effectiveness of homeopathic medicine when treating the most serious cases of acute disease and invites the reader to enter into a critical discussion of how homeopathy works. » Chapter II, III (Case Studies).

1.2 Principles of classical homeopathy

Homeopathic medicine was developed by the German physician Christian Friedrich Samuel Hahnemann, born in Meissen on April 10, 1755, the highly gifted child of poor parents. The award of a scholarship allowed Hahnemann to attend the Princes School of St. Afra in Meissen, which at that time enjoyed great renown. From here, he went to Leipzig to study medicine. As there was no hospital, the faculty at Leipzig University offered no practical tuition whatsoever, which is why Hahnemann moved to Vienna at the end of 1776. Here he became the favourite of Joseph von Quarin (senior physician at the hospital run by the Brothers of Mercy), who invited the talented student to accompany him on visits to private patients, the only one of his pupils allowed to do so. After a short stay in Transylvania (now Romania), where he contracted intermittent fever, Hahnemann completed his studies in Erlangen and opened his own practice shortly afterwards. Disappointed by the prevailing methods of treatment, which according to his observations caused the patient's condition to worsen rather than improve, Hahnemann turned away from the conventional medicine of his day. His great interest in chemistry soon led him to become one of the leading chemists of his time. He also earned his living by translating medical and scientific works from various languages into German.

Discovery of homeopathic medicine

In 1790, Hahnemann began translating a treatise by his famous contemporary William Cullen, which

had just been published in England and contained extensive descriptions of all materia medica known at that time (Cullen 1789). As per his habit of adding his own comments to various aspects of the works he translated, he reacted to an opinion of Cullen's which seemed to him to be nonsensical - i.e. the authors supposition that the specific effect of cinchona bark in cases of intermittent fever was due to the fact that cinchona bark was bitter, astringent and consequently had a tonic effect on the stomach - by performing an experiment on himself, the results of which were to inspire a new way of thinking.

Hahnemann's self-experimentation

Hahnemann took 15 g cinchona bark twice a day to form his own judgement of the direct effects this drug had on the body. In doing so, he found an indication that such a drug proving can cast a whole new light on the drugs spectrum of activity. With regard to Cullen's ideas, he wrote: "I took, for several days, as an experiment, four drams of good china twice daily. My feet and fingertips etc. first became cold; I became languid and drowsy, then my heart began to palpitate, my pulse became hard and quick; an intolerable anxiety and trembling (but without a rigor), a prostration through all the limbs; then pulsation in the head, redness of the cheeks, thirst; briefly, all the symptoms usually associated with intermittent fever appeared in succession, yet without the actual rigor. To sum up: all those symptoms which are typical to me of intermittent fever, as the stupefaction of the senses, a kind of rigidity of all joints, but above all the numb, disagreeable sensation which seems to have its seat in the periosteum over all the bones of the body - all made their appearance. This paroxysm lasted from two to three hours every time, and recurred when I repeated the dose but not otherwise. I discontinued the medicine and was once more in good health." (Cullen 1790)

It was only this observation that the effects of a certain drug and the symptoms of a specific disease which can be healed by this drug are remarkably similar that drew his attention to the possibility of using the law of similars in medicine.

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Law of similars

Hahnemann went on to test other substances on himself, and later also on his friends and members of his family. Again and again, he demonstrated the ability of the substance in question to influence a healthy subject in a certain way unique to that substance. He then began to take a new approach to medical treatment using those substances which had been tested on healthy persons. Over the six years following the year of discovery (1790), he became convinced that the traditional method of “*contraria contrariis*” could not be the best way forward. The law of similars, i.e. like cures like (*similia similibus curentur*), means that a sick person will be healed by the remedy which produces the same symptoms in a healthy person.

All clinical experience gained in his re-opened medical practice confirmed the theory which had been suggested by his experiment with cinchona bark: a medicine can only bring about a complete cure if it creates symptoms in a healthy person similar to those suffered by a diseased person.

Over the next few years, Hahnemann continued to expand his method and became increasingly successful in treating his patients. The theories he developed from his experience and research went against the spirit of the times, were radically new and incomprehensible to contemporary thinkers. An outburst of opposition from the medical establishment was therefore inevitable.

At the end of his life, Hahnemann left behind a largely complete new form of medicine, the most important elements and aspects of which he had been developing from the age of 35 onwards and which can still be applied to patients today.

Hahnemann's writings

In 1810, Hahnemann published the first edition of his “Organon of the Healing Art”, in which he described his theories in depth and presented them to a wider public. The changes made throughout the six editions (Hahnemann compiled the last version in 1842, but it was not published until nearly 80 years after his death) reflected his struggles with the challenges confronting him while developing

the theory of homeopathic medicine. The “Organon” (Greek for “tool”) is structured hierarchically; the basic principles are dealt with first and the work proceeds step by step to expound the practical knowledge required for homeopathic healing. Hahnemann's next major work was the “Materia Medica Pura” (Dresden 1811-1821; Dresden, Leipzig 1822-1827; Dresden, Leipzig 1830-1833; all during Hahnemann's lifetime), which summarised the results of the drug provings on healthy subjects. Hahnemann's third major work, “The Chronic Diseases, their Peculiar Nature and their Homeopathic Cure” (Dresden, Leipzig 1828-1830; supplemented and improved edition 1835-1839) presents a new approach to treating chronic disease. When treating chronically ill patients, Hahnemann discovered that besides considering the totality and peculiarity of the signs and symptoms shown by the patient, it was necessary to take causal considerations and thought concepts into account in order to tackle the various manifestations of the disease in question. By performing extensive studies and conscientiously following the progress of chronic diseases, he came to the realisation that there had to be a causative factor at work, a process responsible for triggering and maintaining the disease. In keeping with his times, Hahnemann distinguished between three basic forms of chronic miasm encompassing the manifestations and the major fundamental characteristics of various chronic diseases; he called these **psora**, **sycosis** and **sypilis**. Hahnemann subsequently incorporated this knowledge into his evaluations, diagnosis and treatment of chronically ill patients and into his assessment and classification of homeopathic remedy profiles. And his therapeutic successes proved him right.

With regard to the large number of other works compiled by Hahnemann, special mention must be made of the “Pharmaceutical Lexicon” (Leipzig 1793-1799), which is still a useful standard tool for pharmacists even today.

The curative successes of homeopathy, which have been constantly observed ever since the life and times of Hahnemann and his first pupils and imitators, have largely been ignored by the field

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of academic medicine and are hardly ever studied. One reason for this may be that Hahnemann's method is difficult or impossible to comprehend from our present-day understanding of medicine, and is therefore dismissed as insignificant. However, for homeopathic doctors, Hahnemann's therapy is a healing art of far-reaching significance constantly confirmed by successful cures which in their scope conform with the requirements made of any medical science.

Elements of homeopathic medicine

The homeopathic method is founded on three major areas; homeopathic practice is based on the correct use of these. The homeopathic healing art is the synthesis of these three areas, with cures depending on them being correctly linked:

- **Materia medica** (with the repertory as an aid in finding one's way through the wealth of information available)
- **Homeopathic diagnostics** (rule of the totality of symptoms; rule of specific individual symptoms peculiar to the subject in question)
- **Establishing the simile and practice.**

Pharmacology

Homeopathy is based on the "materia medica", the homeopathic pharmacopoeia made up of all known drug symptoms induced by proving on a healthy subject. It also formed the historical foundation of Hahnemann's homeopathic teachings. In his "Organon of the Healing Art", he wrote:

Materia medica

"From such a materia medica, everything that is conjectural, all that is mere assertion or imaginary should be strictly excluded; everything should be the pure nature of nature carefully and honestly interrogated." (Organon of the Healing Art, §144)

In the words of the Swiss homeopath and philosophical thinker Rudolf Flury, the materia medica is the heart of homeopathy. Every major homeopathic remedy can have hundreds of effects on the human body. Without this wealth of information,

it would only rarely be possible to find the simile (if at all), as the actual patient usually only shows a few clear symptoms (Flury, unpublished manuscript, undated).

When proving a remedy, the signs and symptoms manifesting in the healthy tester after taking the remedy must be observed precisely. Only the phenomena occurring in a healthy person are valid when exploring the substances specific capacity for change as per the laws of nature. The phenomena observed by the prover when the remedy interacts with a diseased organism are not universally valid; they will only apply to that prover and not to other patients in general. The often very abundant "harvest" of such remedy provings shows not only the range of symptoms which the specific remedy can induce in a healthy subject, but also supplies information about the possible variety of symptoms which may come to light when taking the patient's case history and which may point to the correct remedy. The starting point and foundation of homeopathic medicine is therefore the complete materia medica. Above all, the materia medica makes it possible to allocate a certain remedy to the patient's disease by **finding the similar** (formal equivalent) between the disease and the drug profile (law of similars).

Homeopathic diagnostics recognises two ways of finding the right remedy for each patient.

- The first, which was codified by Hahnemann and which is based almost exclusively on the results of the remedy provings, is a highly experience-based form of diagnostics. However, it was not enough even for Hahnemann and some of his pupils, particularly Clemens von Bonninghausen (1785-1864). This is because medicine, like every other art, needs science to become complete, so that it can be supplemented by an analytical, scientifically deductive form of diagnostics from case to case. There is nothing to add to this remedy-based form of diagnostics; Hahnemann took it to its highest form.

However, we also need to recognise the connections, something that is only possible when employing a scientific approach. The first remedy

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provings were a more or less accurate representation of the results of the provings themselves; the phenomena were documented in the way they had been formulated by each prover, usually in order of appearance. However, the information available on each remedy is now drawn from so many sources (the provers notes, experience gained in the field of toxicology, medical and historical literature, coincidental observations by physicians and laypeople, reports of cures etc.) that it can by no means be structured simply by adding individual elements. This also makes it clear why a poorly structured materia medica is not a solid resource for successful homeopathic treatment; instead, it is more likely to lead to confusion. The earliest *materiae medicae* had no structure whatsoever; the authors contented themselves with listing facts. Later, particularly as knowledge about the effects of the remedies grew, various authors attempted to introduce some form of order according to their personal preferences. This variety of structures has become familiar to us from perusing older and more recent *materiae medicae*. Most experienced homeopaths have one or more authors who appeal to them more than others; beginners are particularly recommended to consult the classical *materiae medicae* of William Boericke (1849-1929), James Tyler Kent (1849-1916), Eugene B. Nash (1838-1917), S. R. Phatak (1896-1982) and Julius Mezger (1891-1976).

Repertory

The wealth of indications established in the remedy provings and by other sources is so great and the records available so extensive that practising homeopathy on the basis of these alone would be extremely complex and time-consuming. Attempts to redress this situation were made at an early stage by grouping the individual indications common to various remedies; these in turn were arranged and organised in various ways. These collections were called repertories. The various repertories were structured according to a wide variety of principles which invariably reflected the philosophical orientation of the respective author. Many homeopaths

consequently concluded that the best repertory was the one they compiled themselves. The need for repertories arose from the difficulty of finding a symptom manifested by a patient among the wealth of indications established. The practising physician starts with the patient and his symptoms with the aim of proceeding to the cure. The repertory cannot replace the drug profiles but can guide the practitioner to possible remedies more quickly.

The first person to attempt to develop a repertory in the modern sense was one of Hahnemanns first and best pupils, **Clemens von Bonninghausen** (1785- 1864), who was not actually a doctor. Hahnemann had compiled a kind of repertory for his own use, as it was becoming increasingly difficult for him to maintain an overview of the knowledge gained from the remedy provings. Bonninghausen was the first person to recognise the possibilities opened up by taking apart each symptom and classifying its individual elements (concomitants, most important analytical contribution to homeopathic pharmacology) in repertory categories in order to make it easier to find the right remedy. In doing so, he added another major “repertorial” facet to the two main cornerstones of Hahnemanns work (finding the simile, potentisation “« 1.4 of remedies), without which it would not have become so easy and straightforward to practise homeopathy on a daily basis. The issue of repertorisation is crucial for doctors working in the fields of emergency or intensive medicine, as they need to be able to act quickly and often have no time for the in-depth study of remedy profiles. Consequently, it is by all means worth trying to compile a personal repertory to meet the special challenges posed by emergency and intensive medicine. However, this is only possible in collaboration with experienced homeopaths and specialists in these fields.

Rudolf Flury discussed the principle of repertorisation in his talk, “Homeopathy and the Principle of Reality”: “The knowledge peculiar to homeopathy is described as repertorisation. The homeopath is indeed above all a healing artist, yet his artistry goes beyond the knowledge of disease and cure. This knowledge should be complete - complete

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or scientific knowledge is analytical or deductive inasmuch as the individual case is recognised by means of a principle. Logic, mathematics, physics etc. have laws as their principles; the principles of homeopathy are unique because our science is purely qualitative and does not recognise generalisations. Therefore we have no general laws; instead we have groups of carriers with similar qualities which function in a manner similar to laws [...]. These typified groups are termed repertory rubrics; the collections of laws make up the repertory. The perfect rubric is complete and drawn from collective experience, it is universal and verifiable. The perfect repertory is objective with regard to the rubrics, but must be applied in compliance with objective rules.” (Flury, undated presentation manuscript).

Flury also writes: “In scientific terms, subjective repertorisation or analysis is as little valid as a subjective rubric; only general, explicable or - even better - demonstrable rules make it perfect and scientific. In the same way as logical sciences puts its principles and laws in order, we too must organise our qualitative framework in such a way that a fixed before and after is the result.

“Subjective order comes from the subject, the observer - objective order from the object. Our object is disease - a tragic object for creating order, as the nature of disease is disorder, chaos. The science of disease is unfounded. It is not the disease itself that is orderly and consequently able to create order; it is the sufferer, insofar as he is directed, predisposed or susceptible to this disease. This predisposition to a disease gives objective order to the repertory, as the predisposition generates the disease without being a disease in itself, i.e. it does not participate in the fundamental lack of order. This predisposition, the signs and symptoms of which are the first and most important part of the phenomena which should interest the physician, produces the actual symptoms of disease. Hahnemann would have said that it confuses or misaligns the vital forces in such a way that it can no longer tolerate the surrounding environmental factors.” (Flury, undated presentation manuscript).

The so-called **modalities**, i.e. the consequences of environmental influences (e.g. temperature, noise, movement) and the changes they bring about in existing symptoms are the second major part of the phenomena which the doctor should be focusing on, as it is these which produce the actual symptoms. Disease in itself has no order - disease is by nature the abeyance of order. In other words: disease is “chaos”.

A disease can only develop whenever there is a “weak point” in the patient's order, his (inherited) “disposition”. The physician's task of tracing this weak point in the patient's constitution is one of the most important prerequisites for the clear identification of the appropriate remedy. The homeopath does not assume that the patient has a “disease” as an independent natural phenomenon; instead, he only ever sees an ailing individual - a person whose constitutional weakness has led to the appearance of numerous symptoms based on a misalignment of the entire organism, primarily the result of the weakness mentioned. As this weakness is always individual even though the symptoms may seem similar, it very often happens that several patients with apparently identical symptoms may each be prescribed different homeopathic remedies.

Homeopathic diagnostics (individualisation through anamnesis)

The second cornerstone of homeopathic medicine is the **“totality of signs and symptoms”** (Organon of the Healing Art, §§ 3,7,83,84,86) obtained from the case history of the respective patient. The aim is invariably to capture the uniqueness of each patient, i.e. not only what characterises him in his healthy state (because every patient is healthy in his own way) (= signs), but also the specific way in which his diseased state manifests = **(symptoms)**. • At first glance, **homeopathic anamnesis** is not so very different from the type of anamnesis customary in modern medicine. However, the difference lies in how the information obtained is used and the way in which the patient's subjective symptoms, his sensations and observations, are assessed. For homeopaths, these are usually

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much more significant than many objective findings.

- Another difference is the scope and detail of the questions asked of the patient and his relatives. In homeopathy, the **“totality of symptoms”** (“Organon of the Healing Art”, §§ 16, 102, 274 etc.) means that medical specialisation is only of secondary importance, as absolutely nothing can be excluded from the anamnesis. This is because homeopathic treatment ultimately aims to cure the patient completely, even though the doctor treating him may initially only be interested in dealing with a concrete situation which may actually be endangering the patient’s life. In his book “Samuel Hahnemanns Philosophical Ideas on the Foundation of Homeopathy”, Joseph M. Schmidt writes: “The homeopathic principle of applying specific drug stimuli to spur metabolic activity and ultimately to facilitate self-healing proscribes medical specialisation just as much as it invariably demands comprehension of *all aspects* of the patient’s suffering.” (Schmidt 1990). A homeopath searching for the right remedy for a specific patient will initially not know which of the many symptoms described while taking the case history will be applicable and useful when identifying the remedy. Therefore he must at first be interested in every piece of information he can obtain from and about the patient and incorporate all of them into his considerations.
- In contrast to conventional medicine, homeopathic “diagnosis” accordingly refers not to the name of a disease, but to the description of a remedy identified while taking the patient’s case history. However, it is by all means important to distinguish between acute and chronic cases, as these entail a number of discrepancies when taking the case history.
 - In cases of **acute disease**, the symptoms are fresh, they are perceived much more intensely by patients and relatives alike, they are less diffuse and much more pronounced compared to the patient’s condition shortly before. They are therefore described spontaneously and with

special emphasis, they are more immediately apparent as main symptoms and are easier for the observer to identify, with the result that fewer questions have to be asked. In the “Organon of the Healing Art”, Hahnemann says:

Acute diseases

"On the whole, the investigation of acute diseases, or of such as have existed for but a short time, is much the easiest for the physician, because all the phenomena and deviations from the health that has been recently lost are still fresh in the memory of the patient and his friends, still continue to be novel and striking. The physician certainly requires to know everything in such cases also, but he has much less to inquire into; they are for the most part spontaneously detailed to him." (Organon of the Healing Art § 99)

- In contrast, a much more detailed anamnesis and examination is usually necessary when treating patients with **chronic diseases**. In such cases, many of the changes may have begun a long time ago and the patient or his relatives may no longer be directly aware of them; the patient may have become accustomed to them over lengthy periods of time. Usually only patient, time-consuming questioning will bring details to the light of day - and these often only in the second or third consultation. The beginnings of the disease, which could be enlightening for a proper understanding of the disease process, he far back and have been masked, changed, distorted or made more complicated by inadequate attempts at treatment (cf. Organon of the Healing Art, § 95).

According to Hahnemann, the prerequisites for a successful anamnesis are “[...] freedom from prejudice and sound senses, attention in observing and fidelity in tracing the picture of the disease [...]” (Organon of the Healing Art, § 83). The information comes from the patient himself; it is better to let him talk without interrupting unless what he

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is saying has nothing to do with the disease or he merely wants to tell us his opinion of his disease or “explain” it. Useful indicators may also come from relatives, nursing staff, chance eyewitnesses and observations made by the attending physician. The doctor “[...] sees, hears and remarks by his other senses what there is of an altered or unusual character about him [...]” (Organon of the Healing Art § 84). Only after concluding this part of the anamnesis should any or all points be clarified by purposeful questioning if necessary, as this is a process which intrudes on the patients subjective sensations. This is when the frequency, intensity, attendant circumstances, location, chronological progress, duration etc. of the symptoms must be identified. It is important to avoid asking questions with the aim of eliciting a certain answer: “leading question -> misleading answer” (Flury, 1979).

- In acute cases, special attention must be paid to information describing the circumstances prevailing at the beginning of the acute disease or condition. It is also important to consider earlier treatments and the use of medication, as it is the symptoms existing before the first dose of medication that show the correct disease profile. In intensive care units, we are frequently confronted with patients who have already been massively medicated and are consequently showing certain symptoms as side-effects. Their original condition may already have changed considerably. In such cases, the patients condition before medication must be established as far as possible; however, the current situation must also be taken into account when choosing the remedy, especially when we are dealing with serious, lifethreatening side-effects (cf. Organon of the Healing Art, § 92).
- When several doctors examine a patient, they all see the same person in front of them. Their evaluation of the patient depends on many different influences or factors which are initially not directly related to their actual sensory perceptions. Attentiveness, receptiveness, interest in what they are seeing, bias, prejudice, prior education, intellectual capacity, experience, sympathy,

antipathy, personal or imposed interests, worries and many other factors influence the way in which the observer processes his sensory impressions and consequently forms his opinion. For a homeopathic doctor, it is extremely important to avoid any form of restraint by being particularly open to the patient.

- The homeopathic doctor initially assumes ignorance of what is worth recognising about the patient. Only after he has obtained the facts available (“totality of signs and symptoms”) does he begin comparing the signs and symptoms with the homeopathic remedy profiles. If he does this during the anamnesis, he may lose his impartiality and openness toward the patient. According to Hahnemann, this impairs the correct individualisation of each case and could lead to unnecessary difficulties when searching for the right remedy.

Question types and techniques

Patient's nature: constitution

Characteristics and normal behaviour on healthy days: social behaviour, interests, preferences, aversions, habits, reactions etc. (these are not symptoms to be considered when choosing a homeopathic remedy).

Deviations caused by the disease

What changes occurred before the disease, what changes have occurred since (with regard to mood, symptoms, modalities), in which period of life, under which internal and external conditions, through which etiological and external causes and influences (e.g. traumas, poisoning, medical measures, changes in lifestyle, social or professional situation, sudden failure in various life situations); worsening and improvement (e.g. from weather conditions, temperature, season, food, music, acoustic impressions, a troubled conscience). What changes have occurred in the organs and physical functions?

Passive and active parts of the anamnesis (on the physician's part):

- **Passive part:** Allow the patient and/or his relatives and carers to tell their story freely. Every

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anamnesis should begin in this way if possible. The physician should only intervene to bring order into the narrative or encourage the speaker. However, be careful if the patient tries to diagnose himself rather than describing his symptoms, wants to make himself sound interesting or obviously tends to exaggerate.

- **Active part:** Where possible, clarify and obtain additional data about the symptoms and other information from the patient and/or his relatives. Pay particular attention to any information given by the patient in unclear language, hesitantly or without emphasis. Take note of his body language, choice of expression, the urgency of his statements and his attitude in the symptom report. Questions which narrow things down or force a certain answer must be avoided at all costs (leading questions -> misleading answers).
- **Purposeful questioning:** if the patient and his relatives do not talk about areas of medical significance and these seem essential to understanding the case.
- These questions are frequently related to sexuality, family and social, moral, guilt or other issues burdening the patient.
- **General:** Attention should always be paid to the patients linguistic ability, education, origins and religion, where appropriate. Take care with the uncritical use of medical expressions (e.g. influenza, chill, shock, psychosomatic).

When taking a homeopathic case history, the priority is to uncover anything unusual, unique to each case (Organon of the Healing Art § 153). The more the physician develops this faculty, the faster and more reliably will he be able to find the right remedy and the greater will be the success of his treatment. This skill, which can of course be trained, is particularly important in the fields of emergency and intensive medicine, as there isn't always time to take an extensive case history when treating acute cases.

Symptom value

The value of a symptom when selecting a homeopathic

- the more individual (with reference to the actual case) and characteristic it is for the patient
- the more clearly and lucidly it is described and explained (possibly with repetitions)
- the longer it has been present
- the more complaints it causes when the patients condition worsens (also applies to new symptoms)
- the more comprehensively the symptom describes the patient's suffering
- the more life-threatening it is.

In contrast, the significance of a symptom diminishes

- the more frequently it occurs among a large number of patients
- the less severe it is
- the less precise the patient's information is.

In the case of emergency and intensive care patients, it must be noted that acute, life-threatening and clinical symptoms are also of prime importance to the homeopathic physician, and that great significance must be attached to them when making a homeopathic diagnosis (identifying the remedy).

The following points are the most important when treating **intensive care** and **emergency patients**:

- Causative factors
- Organotropism
- Clinical aspects

Finding the similar: homeopathic diagnosis and practice

The third pillar on which homeopathic medicine rests is its unique method of recognition. This is essential, because homeopathic medicine is primarily based on the ways in which healthy and diseased people express life. However, every expression of life is first and foremost a quality (form in movement); homeopathic medicine is therefore mainly qualitative in nature. Preference is given to all direct expressions of life, as these can give us an insight into the patients current vital processes at first hand. This insight is essential to fulfilling the actual purpose of any medical procedure, i.e. to cure a diseased person. Medical endeavours therefore focus on doing:

towards this end. Medicine is consequently an art first and foremost. In his book "Homeopathy and the Principle of Reality", Flury writes: "Just as science is directed towards recognition, art is directed towards doing, towards application, effecting, taking action - and in our case towards treatment. The art which defines us as homeopaths is above all the art of finding the correct remedy. This is the actual act of homeopathic art, which gives a purpose and goal to all the knowledge and insights which precede it. [...] An art - in our case a healing art - cannot gain scientific status of itself; it can only rest on a science, participate in it in such a way that the knowledgeable part, the treasury of experience, grows beyond pure classification, acquires true order, submits itself to principles which become the basis of true conclusions. The example of *modern* medicine is very clear and impressive: it is completely based on mathematical science; all its experiments and experiences are subject to statistics; it strives to find the mathematical formula, the law which allows it to make deductions, find proof and develop arguments. [...] This dependency model is exemplary; however, the science on which modern medicine rests does not fit any kind of healing art - least of all homeopathy, which is a *purely qualitative form of healing*. We as artists live on sensations. Similarity is qualitative conformity; we recognise healthy and diseased states as pure qualia, cures result from the meeting of parallel beings, i.e. those of identical quality. [...] *Only from philosophy, the highest qualitative science, can a purely qualitative healing art like ours gain scientific status, never from mathematics.* [...] Teachings on quality constitute homeopathic theory, or in other words, *homeopathy is an illustration of qualitative teaching*" (flury 1979).

So what is the simile, the "similitudo"? Firstly it is a property attributable to all qualities, making it specific to anything which constitutes quality. For the human mind, these qualities can only be expressed by comparison, as they are fleeting, transitory, i.e. only relevant to the current moment. While substance is recognised by identitas and quantity by

aequalitas, qualities depend on similarities for classification within corresponding areas of nature (in medicine the phenomenon of disease and the phenomenon of drug effects). For the homeopathic physician, the simile is therefore above all a **principle of recognition**.

Let us see what Hahnemann says on the subject:

"The third point of the business of a true physician relates to the **judicious employment** of the artificial morbidic agents (**medicines**) that have been proved on healthy individuals to ascertain their true action **in order to effect the homeopathic cure of natural diseases.**" (Organon of the Healing Art, § 146)

"Whichever of these medicines that have been investigated as to their power of altering man's health we find to contain in the symptoms observed from its use the greatest similarity to the totality of the symptoms of a given natural disease, this medicine must and will be the most suitable, the most certain homeopathic remedy for the disease; in it is found the specific remedy in this case of disease" (Organon of the Healing Art, § 147).

However, as a conscientious anamnesis will in many cases reveal a large number of signs and symptoms, not all of which have the same value and significance when choosing the right remedy, it is necessary to identify the symptoms which are crucial to solving the specific case. Hahnemann explained how to recognise these in his famous § 153:

"In the search for a specific homeopathic remedy [...] the more **striking, singular, uncommon and peculiar** (characteristic) signs and symptoms of the case of disease are chiefly and almost solely to be kept in view; for it is more **particularly these to which the very similar ones in the list of symptoms of the selected medicine must correspond** [...]." (Organon of the Healing Art, §153)

1 Homeopathy in intensive care and emergency medicine

Remedy prescription

- s-1.3,1.4

Once the right homeopathic remedy has been found, the question still remains as to how and in what form it should be administered and how dilute it should be. In principle, all remedies used in classical homeopathic medicine as developed by Hahnemann and his best pupils are administered in the form prescribed by Hahnemann himself. These remedies are **potentised**, i.e. they are diluted step by step and processed mechanically (trituration, succussion) to achieve maximum effect. It may seem paradoxical that a substance progressively diluted in a corresponding medium can unfold its unique properties with increasing dilution and retune the human organism even in concentrations beyond the Loschmidt, or Avogadro constants; however, this is the fact on which the decision as to which potency should be used to treat the patient is based. The higher the potency, the less frequently the remedy is administered and the deeper it works. Not only in acute, life-threatening cases does a well-chosen remedy act very quickly and clearly, as can be seen from the cases described in this book ■• chapters II, III. In chronic cases, healing naturally takes longer, as the chronic nature of the disease will already have caused profound changes and restructuring in the organism; the organism consequently needs time to return to a normal, healthy state. Characteristic phenomena can also appear which accompany and characterise the healing process. These are summarised by the four Hering's laws.

According to **Hering's laws**, healing can proceed as follows:

- From the top to the bottom: a rash produced during the healing process may for example appear first on the head, then on the torso and finally on the legs; or headache followed by abdominal pain etc.
- From the inside to the outside: an internal problem improves, an external problem temporarily worsens.
- From vital organs to less vital organs: heart complaints disappear but the right knee swells up.

- In reverse order of appearance: the most recent symptom disappears first, or the various symptoms of a chronic disease appear briefly then disappear in reverse order until finally the symptom with which the chronic disease began briefly reappears. This is a sign that the healing process has ended.

Homeopathy and conventional medicine

The main difference between homeopathy and conventional medicine is the emphasis placed by conventional medicine on all quantitatively measurable phenomena manifested by the patient, while homeopathy focuses on the qualitative phenomena - which cannot be measured but which are by all means recognisable.

Even in emergency and intensive care medicine, the homeopathic physician is concerned with the recognition of qualitative phenomena which can be observed reciprocally (firstly from the effects which a certain remedy has on a healthy organism, as described in the remedy profile, and secondly from the patient's remarks). Rather than adhering to measurable results, the homeopathic physician instead identifies the remedy which meets the requirements of the case most closely. A thorough study of the "Organon" and the homeopathic materia medica, particularly the remedies used in cases of acute disease, is essential for optimum exploitation of the possibilities of homeopathic medicine when treating patients requiring emergency and intensive care. It goes without saying that finding the simillimum needs practice. In emergency situations, an experienced homeopathic diagnostician will be better able to recognise anything unusual and to individualise the case accordingly.

However, do not allow yourself to be discouraged by any initial difficulties when using homeopathic remedies for emergency and intensive treatment. As Hahnemann writes in his "Organon":

° "The worse the acute disease, the greater the S number of striking symptoms of which it is composed, but with so much the more certainty can a suitable remedy for it be found [...]" (Organon of the Healing Art, § 152)

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2 Intensive medicine: development and current status

Ana Reiter

General

Intensive medicine is a specialist area which focuses on the monitoring and treatment of patients whose vital or organ functions have been so far impaired that the patients life is at risk; these functions must be supported or maintained by intensive therapeutic measures. Such high-risk patients must be accommodated in intensive care units with modern technology and treatments and specially trained personnel.

Despite being relatively new, the field of intensive medicine has grown quickly and is progressing steadily. This development is making it possible for us to treat and cure patients with diseases which not so long ago would have been fatal. Nowadays, life can be extended for longer than ever before. As a result, our intensive care units are being filled by an increasing number of gravely ill patients. The ideal outcome for these patients is of course complete recovery, but a course of intensive therapy not infrequently ends in a reduced quality of life or even in death. Every day, specialists in intensive care have to find a balance firstly between the pressure of social expectations concerning life and death and the realistic possibilities of prolonging life, and secondly between the wish to do the best for the patient and the need to bow to financial pressure from the healthcare system.

The historical development of intensive care medicine

Intensive medicine came into being in 1952, when large-scale artificial respiration was used for the first time during one of the major annual poliomyelitis epidemics in Copenhagen. The iron lung was

the first clinical device capable of administering artificial respiration to people with a respiratory insufficiency over longer periods of time.

In 1830, the Scottish physician John Dalziel was the first to recommend negative pressure ventilation, for which he constructed a “body respirator” (Dalziel 1838). The iron lung was built in 1876 by the Frenchman Eugene Woillez. He called it a “spirophore”, and it was never used. The German inventor J. Ketchum had his iron lung patented in 1883; however, this was never used either. Laryngoscopy came into being at around the turn of the century, paving the way for endotracheal intubation. In about 1904, the famous German surgeons Ferdinand Sauerbruch and Ludolf Brauer held animated discussions about the negative and positive pressure ventilation required when operating on tubercular lesions in the lungs. However, no respiratory device was ever actually developed. The Pulmotor developed by Heinrich Dräger was put to use as early as 1907. This was a ventilation device which could blow fresh air or oxygen into the lungs at controlled intervals by means of a modified clock mechanism. However, Dräger's Pulmotor was only meant for short periods of use (Dräger 1917). Back then, the Pulmotor was manufactured and sold well over 20,000 times. In 1929, engineer Philip Drinker from Boston presented the first respiration device for treating the serious bulbar form of poliomyelitis to the public (Drinker & McKahn 1929). In Europe, the German physician Axel Donhardt collaborated with engineers from the Deutsche Werft shipbuilding company in Hamburg to build an iron lung using the tube cover of a torpedo, the gearing from a fishing smack and a bellows from a . forge

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(Lawin et al. 1999). With this, gravely ill patients at risk of respiratory paralysis could be saved from an otherwise certain death (Janssens & Hanrath 1999). The Dräger works later took over the construction of the iron lungs, some of which remained in use until 1968. These were monstrous devices comprising a hollow metal cylinder in which the patient was hermetically sealed up to the neck. The patient's chest was moved by negative pressure so that the surrounding air was sucked in through his mouth. A build-up of positive pressure in the chamber forced the air back out of the patient's lungs. An original iron lung can still be seen today at the Karl Ludwig Institute of Physiology at Leipzig University. In 1955, Carl Gunnar Engström developed a one-phase positive pressure ventilation device and made it available for clinical use, mainly for treating post operative respiratory insufficiency (Engström 1954).

The poliomyelitis epidemic of 1952 became so widespread that the demand for respiratory devices could no longer be met. Out of necessity, the Danes Bjørn Ibsen (anaesthetist) and Henry Lassen (epidemiologist) developed a concept in which patients with respiratory paralysis were tracheotomised, intubated and given manual artificial respiration by medical students working eight-hour shifts using a mixture of oxygen and nitrogen. This event counts as the official beginning of the era of intensive care medicine, and the respiratory centres established during the major poliomyelitis epidemic were the starting point for our modern intensive care units (Lassen 1953). Special departments for treating gravely ill surgical patients and the Scandinavian detoxification centres followed soon afterwards (Beardsley 1954, Clemmesen & Nilsson 1961).

Other predecessors of our present-day intensive care wards included the coronary care units (Brown et al. 1963). These units made it possible for heart attack patients to be monitored by ECG; defibrillation could also be performed in the event of ventricular fibrillation or ventricular tachycardia. They were propagated by the inventor of defibrillation, the American Bernard Lown. In Europe, the first myocardial infarction monitoring units

were opened in 1962. Developments in intensive care medicine subsequently accelerated rapidly.

ICU staff

Intensive care units are characterised not only by advanced instrumental technology but also by a high staffing ratio. According to data published in the EURICUS I study, 10% of the personnel in intensive care units are doctors and 90% are nursing staff.

Every intensive care unit in Europe has a medical director with years of experience in intensive care medicine. The constant presence of doctors with special training in intensive care medicine has proven to be vital (Carson et al. 1996).

An ICU nurse should be responsible for one or two patients, while the ratio of nursing staff to patients on a "normal" ward is 1:10 to 1:20. Nursing staff in intensive care units need extensive technical and medical knowledge. They perform responsible diagnostic and therapeutic measures. They are also responsible for a large part of the extensive documentation required.

Modern technology has not necessarily lessened their workload to date. The complexity of the monitoring processes means that more staff are now required than ever before. In many European countries, there is a distinct shortage of nursing staff. The nurse-patient ratio quite often remains constant at 1:3, a fact which makes this stressful job even less attractive. Moreover, it has been proven that heavy workloads for nursing staff are directly associated with higher patient morbidity (Tarnow-Mordi 2000). 10-20% of beds have been permanently taken out of circulation throughout Europe, firstly because of personnel shortages and secondly due to deliberate understaffing by hospital administrations. ICU personnel are expensive, accounting for 56-85% of all ICU costs (Prien & van Aken 1997). This is why the funding organisations are trying to cut back on staff.

Where nursing education is concerned, there are still significant differences throughout Europe as regards structured additional qualifications for intensive care nursing.

Evidence-based intensive medicine

As in other medical areas, evidence-based medicine (EBM) is also playing an ever-increasing role in intensive care medicine. EBM is a process in which individual patients are treated on the basis of the best available data. This technique encompasses systematic searches, critical evaluation and assessment of the relevant evidence and the transfer of this evidence to the actual patient on the basis of clinical experience (Graf & Janssens 2004). Evidence-based knowledge in the form of large, randomised, controlled studies, registers and meta-analyses is now available for a whole range of intensive care measures and treatment strategies. Some intensive care publications appearing in recent years are highly evidential and can therefore serve as “benchmarks” for the quality of results in intensive care medicine.

An overview of the most important insights revealed by studies performed this century is presented below. Some of them not only influence treatment concepts for critically ill patients, but also bring about a significant improvement in patient mortality rates.

Artificial respiration

Patients requiring artificial respiration make up a large part of the seriously ill patients on intensive care wards. Data from the ASDI Benchmarking project shows that in 2001, approx. 58.3% of all intensive care patients received artificial respiration at least once during their stay in ICU (ASDI Benchmarking Report 2001). Any form of damage to the diseased lung caused by the artificial respiration itself must be avoided. In a multi-centre study carried out by the ARDS network on 861 patients with ARDS and acute pulmonary failure, it was proven that a respiration strategy protecting the lungs by using low tidal volumes of up to 6ml/kg body weight (based on the patients ideal weight) significantly improved patient survival rates while reducing the number of days on which the patient needed artificial respiration (N. Engl. J. Med. 2000). A number of follow-up studies relating to artificial respiration have also broken new ground.

Sepsis

Sepsis is still one of the main reasons for the high mortality rates in intensive care units. The spread of sepsis - the incidence in Germany is estimated at 125,000 to 300,000 cases each year - is reflected by the high treatment costs. Over the last 22 years, the number of sepsis cases per annum has actually risen (Martin et al. 2003). Analyses have shown that 21-46% of all intensive therapy costs in Germany are incurred when treating sepsis. Numerous attempts to reduce the high mortality rates have led to the development of innovative treatment concepts. These include the development of activated protein C, which according to initial information has cut mortality rates by 6.1% (Bernard et al. 2001). A study published in the same year confirmed the tremendous importance of the early, goal-directed optimisation of selected quantifiable parameters such as central venous oxygen saturation, central venous pressure, average arterial pressure and adequate urine production for the survival of septic patients (Early Goal-Directed Therapy, Rivers et al. 2001). The data showed that the 28-day mortality rate in patients suffering from acute sepsis fell from 49.2% to 33.3%.

Administration of low doses of hydrocortisone may also decrease mortality rates in patients with septic shock. Investigations of this patient group have shown that so-called stress doses of hydrocortisone interfere with the organisms immune response by means of highly complex mechanisms, e.g. the inflammatory response is modulated to the patient's benefit and the cellular response to infection is improved (Keh 2003). The administration of hydrocortisone to treat septic shock is now generally recommended (Dellinger et al. 2004). The idea of using low doses of hydrocortisone in intensive care medicine to treat other systemic inflammatory diseases of various origins is currently being researched extensively. The latest studies on pneumonia acquired by outpatients and patients with severe systemic inflammation after cardiac operations look very promising (Confaloniere 2005, Kilger et al. 2003).

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Renal failure

The mortality rate for acute renal failure (ARF) alone is 45%; the combination of ARF and sepsis has a mortality rate of 70% (Schrier & Wang 2004, Weihprecht 2002). Early kidney replacement therapy is indicated, with high ultrafiltration rates (35 ml/kg body weight) leading to an improvement in the survival rate (Ronco et al. 2000). Interestingly, the widespread practice of giving “kidney doses” of dopamine («■ II.5.2, p. 192) to patients at increased risk of renal failure was not found to have any protective effect on the kidneys (Australian and New Zealand Intensive Care Society 2000).

Other measures

The list of recent clinical studies relating to patient survival is of course by no means exhaustive and could be extended even further. It has been shown that intensive insulin therapy administered with the aim of reducing blood sugar levels to < 110 mg/dl reduces morbidity and mortality in surgical patients in intensive care units (Van den Berghe 2001). A daily break in constant sedation for patients on artificial respiration also reduced the time for which artificial respiration was needed and the length of the patient’s stay in intensive care. Another restrictive treatment strategy involving blood transfusions had positive effects on the mortality rate of patients in ICU (Hebert et al. 1999).

After this overview of the most important studies conducted in recent years, we have to ask whether these treatment strategies affect our everyday medical routine. Practising EBM is a special challenge, especially in the field of intensive care medicine. Clinical studies on critically ill patients are problematic because the patient groups are usually small and heterogeneous and the patients are often in an unstable condition. Moreover, the transference of new strategies and insights is made considerably more difficult by the extraordinary complexity of intensive care medicine and the processes it entails (Kenagy et al. 1999). Last but not least, it has been proven that insufficient familiarity with the relevant literature is often an obstacle to the rapid implementation of new medical

knowledge. One example of this is the frequent failure to elevate the patient’s upper body by 45° to reduce the risk of nosocomial pneumonia, a strategy which is frequently recommended in the literature (Cook et al. 2002). The majority of ICU personnel questioned were sufficiently knowledgeable with regard to the positive effects of 45° upper body elevation. However, this was not performed often enough as physicians frequently did not give relevant instructions, there were difficulties in general patient management and individual staff failed to pay attention. A similar example was mentioned by Professor Konrad Reinhart from Jena at the 18th European congress on “Early Goal- Directed Therapy”: although early, parameter- oriented treatment of patients with acute sepsis was clearly able to reduce mortality rates in hospitals, only about 18% of patients actually received it.

Intensive care units - "hot spots" in the hospital budget

The fast deployment of technical possibilities has increased dramatically in medicine in general and in intensive care medicine in particular. The dynamics of this progress is one of the most important reasons for the increasing shortage in medical resources (Presidium of the DGMR 2004). The pharmaceutical industry’s interests also decline in times of economic change.

Intensive care medicine is one of the most complex, cost-intensive areas in any hospital. In maximum care hospitals, approximately 20% of the entire budget devolves on intensive care, although only about 5% of all patients receive treatment in this department. The EURICUS III study completed in 2001 revealed that fixed costs amounted to 51.1% with personnel expenses accounting for the lion’s share (46%); the variable costs consequently amounted to 48.5%. The costs of treating ICU patients vary considerably: a general overview of the literature reveals costs per person ranging from 1000 to 50,000 US dollars, although far greater amounts are mentioned in individual cases. Costs vary from patient to patient, largely depending on the main diagnosis and the concomitant diseases (Martin 1998). This

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leads to a constant increase in pressure on departments and personnel, while results are supposed to improve despite the limited budget and resources. Intensive medicine is subject to considerable pressure to justify itself due to high patient morbidity and mortality rates (Inman 1996). The average mortality rate of ICU patients varies from 9% to 31% (Miranda et al. 1998). About % of deaths among ICU patients do not occur until after they have been moved to normal wards. Compared internationally, re-admissions to intensive care units average 9.5%. Patients suffering from internal diseases are more frequently readmitted to ICU than surgical patients, and in up to 50% of cases, it is the same organ system which leads to readmission. A direct association between patient mortality and the gravity of the disease, the number of failing organs and the patients age has been clearly proven. The number of aged and chronically ill patients in intensive care wards is rising. We must consequently expect funding requirements to similarly increase in future.

The increasing demands on the healthcare system and the decline in financial resources has made the cost-benefit issue a hot topic in intensive care medicine. The use of cost analysis methods has consequently increased dramatically. The intensive care wards profit from these analyses as they lead to the streamlining of processes and structures. Possible consequences include changes in admission policy (which patients would benefit most from ICU treatment?), a reduction in unnecessary interventions, and shorter patient stays in ICU and the hospital. On the other hand, there is an increased risk of cost-cutting leading to a reduction in treatment quality with a correspondingly poorer patient outcome (Chalfin 1996). Therefore, the performance of cost efficiency analyses paying special attention to evidence-based treatments is being recommended with increasing frequency. While the actual availability of highly specialised medical technology as standard equipment ultimately played a role in the drafting of corresponding norms by users, in recent years the shortage of funding has meant that not all technical possibilities can be given the status of

standards. The new medical and technological possibilities in the early years of intensive medicine gave rise to the idea of unlimited potential, but these days, questions relating to treatment limitations and treatment termination arise every day during ward rounds and team discussions (Druml et al. 2004).

The future of intensive medicine

Intensive medicine has developed at an astonishing rate over the last few years and will continue to do so in future. Further cost developments will take place at the same time: the intensification of interventional measures will naturally lead to a rising demand for equipment and therapeutic measures; the percentage of old and chronically ill patients - in Germany, one in two ICU patients is already older than 65 - will increase. Costs are expected to exceed general economic growth, with the result that private investors (private clinic groups, financial and strategic investors) will become ever more important. All these developments will give rise to new medical, ethical and economic demands and challenges for intensive care medicine.

Efficiency testing

The costs and effectiveness of individual measures will have to be investigated more thoroughly in future if intensive medicine is to become more efficient. Along with cost/benefit analyses and organisational measures, transparent costs, service billing and appropriate medical products will all help boost cost efficiency. At present, financial resources are only rarely controlled transparently.

Computer-based management information systems are important tools. Patient data management systems (PDMS) have now been established in many intensive care units. The systems commercially available at present certainly still have their faults, such as large volumes, high prices, personnel requirements, no possibility of adding bed-related modules and the need for professional maintenance (Heinrichs 1998). Important functions such as patient administration, treatment/nursing planning and communication with other data sources (master data, laboratory, x-ray, bacteriology, pharmacy etc.) are to be added in future. The possibilities of research and

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controlling are far from being exhausted. Nevertheless, the PDMS has succeeded in bringing about a paradigmatic change in intensive care medicine. New perspectives such as the integration of voice recognition and output systems and the frequently cited intelligent alarms and decision support functions with context-sensitive additional information are already opening up. While the concept of a “paper-free” ICU is still utopian, these developments are bringing it closer.

Quality assurance

Safeguarding and improving quality in the intensive care sector will probably be one of the most important challenges faced by healthcare politics over the next few years.

Due to the lack of financial support, relatively little is being published about treatment quality as yet. The efficacy of the treatments administered is not often monitored; neither are many investigations made as to whether the available resources are being optimally used. Intensive care treatment is a highly complex process which is influenced by many factors and benefits an extremely heterogeneous patient group. Primary parameters have to be established before the quality of intensive care medicine can actually be assessed. The quality of the results can only be evaluated if treatment results and the structures and processes on which they are based are recorded methodically. Knowledge of the quality of the results obtained is crucial if quality improvement measures are to be put into place. Only the recognition of deviations and the identification of possible causes can put everything on track for the implementation of quality improvement measures (in terms of internal quality assurance). Benchmark testing is indispensable to the future development of intensive care medicine (Graf 2005).

Economisation in intensive medicine

The range of products available is becoming ever larger and more expensive, although the effects may sometimes be questionable or even harmful. Ethical and economic questions are often raised. One example of this is the ongoing discussion

relating to the use of pulmonary artery catheters (Connors 2002). The effectiveness of many techniques used in intensive care medicine has not been proved in prospective randomised studies. The risk of therapy-related damage increases as the treatments become more complex. Here too, there is still a need for careful analysis and answers to the question of how ICU capacities can be utilised most effectively (Van Aken et al. 2001). The general aim should be to promote optimum treatment at reasonable prices and exclude unnecessary or even harmful measures. One positive development is the increasing globalisation of the medical technology market. A change in mindset is already recognisable from the fact that new medical technology will in future be compatible with older devices and devices from other manufacturers (Albrecht 1998).

Using guidelines and scoring systems

Evaluating therapy costs from the cost centre perspective alone - taken out of process-related context - is both medically and economically counterproductive (Christ & Rbssling 2004). The consistent use of guidelines or the realisation of these as internal clinic standards can cut costs. Clear indications, scoring systems and clinical treatment pathways help staff make decisions, not only about therapeutic procedures but also about which cost-efficient therapy would be of maximum benefit to the patient (Vesely & Gregor 1998, Le Gall 2005).

The need for guidelines or standards in the interest of treatment safety for patients and medical staff is now undisputed (Roeder 2003). At first, the concept itself is less critical than the fact that a concept should be consistently employed and the resulting decision and treatment processes should be clear and comprehensively defined (Kong & Payen 1994). Provonost et al. have shown that compliance with and regulation of therapeutic measures alone are enough to improve quality and create an economic advantage (Provonost et al. 2003).

Quality of medical and nursing care

The quality of hospital care depends on factors such as a stable and uninterrupted doctor-patient relationship. The modern shift models required by

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European law pose a significant threat to this basic emotional connection of trust. A study by Brown and Sullivan has shown that the regular presence of a professional intensive care specialist should be viewed as essential and can reduce mortality rates on intensive care wards by 52% (Brown & Sullivan 1998).

As cost pressure increases in the healthcare system, intensive care treatment is becoming ever more difficult for doctors. The new reforms relating to the financing of the healthcare system are forcing doctors to act more and more often as managers. The critical task here is to eliminate the seeming contradiction between cost reduction and quality assurance. If costs are to be cut in the intensive care sector, it must be certain that outcomes will not be negatively influenced. The future of intensive care medicine will still depend on healthcare policy and economic conditions, but should not be allowed to develop into a branch of medicine with restricted medical ethics.

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3 Aspects of adjuvant homeopathic treatment in intensive medicine

Michael Frass

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3.1 General

Intensive medicine is a medical discipline specialising in the treatment of seriously ill patients in need of intensive medical and nursing care and dependent on complex technical devices. This segment of medicine has developed rapidly over the last three decades. ICU patients are usually suffering from cardiac, pulmonary, renal or hepatic insufficiency, i.e. the failure of one or more organs, or from septic conditions. Many patients may also need lengthy post operative treatment in ICU. ICU patients therefore often require treatment via central venous catheters, continuous infusions of catecholamines, artificial respiration, kidney substitution treatment (haemodialysis or continuous

venovenous pump-assisted haemofiltration) and the administration of antibiotics. Complex special techniques and diagnostic procedures such as emergency intubation, also with alternative respiratory devices such as Combitube®, laryngeal mask airways, perilaryngeal airways, percutaneous dilatation tracheostomy, bronchoscopy with lavage, endoscopy, sonographic procedures, computed tomography, magnetic resonance tomography, high-tech monitoring including right heart catheters, kinetic treatment etc. are frequently used. Depending on the patient population, mortality among ICU patients with internal diseases may reach 35%, although new treatments such as the administration of activated protein C and hydrocortisone have been able to reduce mortality rates among patients with sepsis. All

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this constitutes a special challenge for medical and nursing staff on intensive care wards, particularly from a psychological viewpoint.

In many cases, the patient cannot survive without the instrumental treatment described above. The homeopath therefore has to ask himself how far homeopathic treatment is possible and practical for these difficult patients.

What are the prerequisites for the successful homeopathic treatment of ICU patients? As with all other forms of treatment, the homeopath must have undergone thorough training. Even though novice homeopaths may evaluate some situations correctly and treat the patient appropriately, the complexity of the disease processes in ICU patients is an obstacle which is not easily overcome. Firstly there is a prior disease which must be taken into consideration, and secondly there is the acute situation, which may change very quickly. Moreover, the influence of drugs and the variety of ICU measures may falsify the patient's symptoms. Then there is the unnatural immobilisation, which would also change the nature of any healthy person.

3.2 Anamnesis

For the homeopath, matters are made more difficult by the fact that the case history usually cannot be taken in the detail prescribed in §§ 84-90 of Hahnemann's Organon (6th edition) as some patients, particularly those who need artificial respiration, will be in an artificial coma and unable to respond. The homeopath has to rely on information obtained from the attending physicians, the nursing staff and the patient's friends and relatives. Great care naturally has to be taken when assessing the value and usefulness of various symptoms, especially as they are also influenced by conventional treatment. On the other hand, the fact that a stay in ICU is often preceded by an acute, conspicuous event as described in § 153 of the Organon is an advantage. This event is quite often helpful when selecting the correct remedy and should be scrutinised thoroughly. It can be critical for the choice of remedy.

Characteristic symptoms

"...the more **striking, singular, uncommon and peculiar** (characteristic) signs and symptoms of the case of disease are chiefly and most solely to be kept in view; for it is **more particularly these that very similar ones in the list of symptoms of the selected medicine must correspond to** in order to constitute it most suitable for effecting the cure. The more general and undefined symptoms: loss of appetite, headache, debility, restless sleep, discomfort and so forth, demand but little attention that of that vague and indefinite character, if they cannot be more accurately described, as symptoms of such a general nature are observed in almost every disease and from almost every drug." (Organon of the Healing Art, § 153)

3.3 Information

What must the homeopath pay special attention to when administering a course of homeopathic treatment? It is advisable to inform the persons around the patient, particularly relatives and nursing staff, about the planned homeopathic therapy. This is important because any reactions and new symptoms appearing after the remedy has been given (e.g. skin rashes, changes in mucous membranes, increased sputum, unusual bronchial secretions, diarrhoea, leucorrhoea, bleeding, superficial abscess formation) may otherwise be suppressed by potent conventional treatment, thus disrupting the effect of the homeopathic remedy in a manner described by Hahnemann at a very early stage.

3.4 Administering remedies/ choice of potency/repeat administration

- Remedies can be administered by placing globules on the patient's tongue, as when treating patients who are not in intensive care. The globules can also be easily administered to orally intubated

patients and patients on artificial respiration by opening the mouth and pushing them past the tube. However, care must be taken that the globules are not washed back out by salivation. Moreover, no oral hygiene measures may be performed during the 15 minutes following treatment.

- Liquid potencies can be administered, but the authors experience in intensive care has shown that this is logistically and practically far more complicated than administering globules. Moreover, the useful life of some low-potency liquid remedies (e.g. *Kalium bichromicum* 4X: 12 months) is much shorter than that of solid potencies, which makes storage more difficult.
- Due to the gravity of the disease, the remedy can be given more often than usual, also at higher and the highest potencies. This means that 200C or even higher potencies are often used; in some cases (e.g. death cap mushroom poisoning » II. 8.2), they may even be given once an hour. The use and evaluation of the applicability of the higher and highest potencies must be understood as an observation made by various authors. The case studies should by no means be seen as instructions or recommendations. Here too, the homeopaths familiarity with different potencies and the use of potentised remedies is decisive when choosing the remedy. The author has listed a small selection of remedies which he finds important. Any remedy can of course help any disease provided it is indicated by “characteristic symptoms” (Organon of the Healing Art, § 153). This book is not designed to set limits, but to facilitate an exchange of ideas for interested homeopaths.

3.5 Assessment/changing remedies/follow-up

The fact that the patient is usually in a much reduced state of consciousness makes it difficult to assess the effect of the remedy, with the result that clinical signs have to be drawn on to measure the success of the treatment. One particular foible

of acute disease is that a rapid change of remedy may sometimes be necessary. The normal intervals for administering the higher and highest potencies can probably be ignored in such cases, as the energy of the remedy is used up much more quickly than in patients not receiving ICU treatment. The other difficulty is the number of qualified homeopaths. It is often difficult for one homeopath alone to administer and monitor a course of homeopathic treatment correctly in ICU. This is shown in some cases where the remedy is changed just because of one new symptom, as in the case of Ludwigs angina (Quinsy) (■ ■ II. 1.21).

3.6 Indications/contraindications

The intensive care indications particularly responsive to homeopathic treatment include (but are of course not limited to) sepsis (Frass 1990), various types of haemorrhage, abscesses and all kinds of secretions.

Causes of disease

"Now, as in a disease from which no manifest exciting or maintaining cause (CAUSA OCCASIONALIS) has to be removed*, we can perceive nothing but the morbid symptoms, it must [...] be the symptoms alone by which the disease demands and points to the remedy suited to relieve it [...]. *It is not necessary to say that every intelligent physician would first remove this where it exists; the indisposition thereupon generally ceases spontaneously. He will [...] extract from the cornea the foreign body that excites inflammation of the eye, loosen the over-tight bandage on a wounded limb [...] and apply a more suitable one, lay bare and and put a ligature on the wounded artery that produces fainting, endeavour to promote the expulsion by vomiting of belladonna berries etc. [...]. (Organon of the Healing Art, § 7)

Just as when treating chronic cases with homeopathy, there are no restrictions on the use of

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homeopathy in emergency and intensive care medicine except for certain mechanical causes of disease. These must be viewed with great caution. One important aim when training homeopaths is to create awareness of the limits of conventional and homeopathic medicine. Only if we know the limits of homeopathy can we use it responsibly. This is why we are primarily concerned with practising a balanced form of homeopathy with no fanaticism.

Special emphasis must be placed on the fact that mechanical diseases are not the province of homeopathy. What does Hahnemann say in the “Organon”?

Local maladies

"Those so-called local maladies which have been produced a short time previously, solely by an external lesion, still appear at sight to deserve the name of **local** disease. [...In the case of] injuries accruing to the body from without, [...] the whole living organism sympathises; there occurs fever etc.

The treatment of such diseases is relegated to surgery; but this is right only in so far as the affected parts require mechanical aid, whereby the external obstacles to the cure [...] may be removed by mechanical means, e.g. by the reduction of dislocations, [...] by mechanical pressure to still the flow of blood from open arteries, [...] by making an opening into a cavity of the body in order to remove an irritating substance or to procure the evacuation of effusions or collections of fluids, by bringing into apposition the broken extremities of a fractured bone [...]. But when in such injuries the whole living organism requires, as it always does, active **dynamic** aid to put it in a position to accomplish the work of healing, e.g. when the violent fever resulting from extensive contusions, lacerated muscles, tendons and blood vessels requires to be removed by medicine given internally, or when the external pain of scalded or burnt parts needs to be homeopathically subdued, then the services of the dynamic physician and his helpful homeopathy come into requisition." (Organon of the Healing Art, § 186)

§ 7 and § 186 of the Organon make it clear that mechanical problems must first and foremost be treated surgically. Treating injured blood vessels, removing foreign bodies, setting broken bones etc. is clearly the province of conventional medicine. Other conditions treatable by modern medicine also fall into this category, e.g. safeguarding the airways in acute situations, early defibrillation, mechanical ileus, dissecting aneurysm, pneumothorax, particularly tension pneumothorax. If corresponding conventional treatment is not immediately initiated in these acute situations, the patient's life may be at risk. However, homeopathy can be used concomitantly once the acute situation has been brought under control. In other words, perioperative homeopathic treatment by all means makes sense, but should not replace or delay any necessary surgical treatment.

3.7 Combining conventional and homeopathic medications and viewpoints

The question is often asked whether homeopathic remedies lose their effect if allopathic drugs are taken at the same time.

In principle, it is easier for the homeopath to identify “characteristic symptoms” (Organon of the Healing Art, § 153) if the patient is not taking any medication (including complementary medicines). However, conventional medication is often indispensable for intensive care patients. Even so, it has repeatedly been found that the right homeopathic remedy will work even when the patient is receiving conventional medication at the same time. This is explained by the cybernetic model defined by Georg Bayr, which describes different points of action for homeopathic and allopathic medication: the regulator (brain) sets a “desired value” which is communicated to the control path (target organ). The target organ now attempts to reach this desired value (e.g. a body temperature between 35 and 37°C). The value attained is then passed back to the regulator as the “actual value”. While conventional

medicine has an anti-etiological (e.g. antimicrobial) or antagonistic (e.g. antiemetic) effect on the control path, homeopathy has a direct consensual effect on the regulator by sending it information, thus bringing about a cure at the highest level.

In this book, the conventional treatment administered in each ICU case is described first, followed by the homeopathic treatment with repertorisation, remedy differentiation, assessment and critical comments on the case (II, III). This procedure allows the reader to evaluate each case from the viewpoint of conventional medicine and to make a critical scrutiny of the development of the case in the context of the homeopathic treatment administered.

3.8 Continuing homeopathic treatment after periods in ICU

It makes particular sense to continue the homeopathic treatment after the patients stay in ICU as the gravity of the event indicates a weakness in the patients disposition. The full case history can

usually only be taken after the patient has been transferred - here too with the assistance of his relatives. The patients constitution and underlying miasm can often be recognised more clearly during the convalescent phase. Homeopathic therapy administered during this phase aims to keep the patient from future events of this nature by treating him individually and strengthening his disposition. At this stage, it is also possible to deal with any consequences of the acute disease, e.g. wounds which fail to heal, lengthy secretory processes, keloid formation and any complaints arising after the patient is discharged from ICU, e.g. gastrointestinal disorders.

3.9 End-of-life care

This book also contains information on end-of-life care for dying patients and their relatives. This is particularly important in view of the risk and high mortality rates in this patient group. In many cases, an important contribution can be made to help them accept this sad fate.

Case 3.9-1: Parkinson's disease

Michael Frass

Anamnesis

A 91-year-old patient was more or less healthy until three years ago. For three years, he has been suffering from a progressive form of Parkinsons disease.

Acute event

The patient is admitted to hospital due to respiratory insufficiency and bronchitis. His condition worsens, the patient is terminally ill. His fear of death is written all over his face. In view of his advanced age, the physicians decide not to administer intensive treatment.

Diagnoses

Parkinsons disease, bronchitis

Conventional treatment

Homeopathic treatment

The patient seems very weak and fearful and constantly drinks small sips of water. He receives homeopathic treatment for this.

Repertorisation

COMPLETE REPERTORY MILLENIUM

Mind - fear - death, of

Stomach - thirst, small quantities, for

Generalities - debility

Remedy differentiation

Aconitum is indicated for acute fear of death; the same is true of *Calcarea carbonica*, *Cimicifuga*, *Gel- semium*, *Phosphorus*, *Platinum* and other remedies. The symptom "Thirst, small quantities, for" is also found with *Lycopodium*, *China*, *Helleborus*, *Lachesis*, *Rhus toxicodendron*, *Sulphur* and others. This patient is also suffering from extreme weakness. a svmntom which

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Prescription

The patient receives one dose of *Arsenicum album* 200C.

Progress

The patient relaxes, smiles and is able to sleep all night

Assessment

This case shows that no patient is ever too old and no case too far advanced for homeopathic treatment.

3.10 Effects on the climate in ICU wards

Finally, I would like to mention the case of a 23-year-old nurse (Frass 1988) who described all his headache symptoms unbidden during a night shift in terms of a homeopathic anamnesis, with the result that he underwent a successful course of treatment and has had no more problems of this type for more than two decades. The headaches were caused by an infected tooth discovered while receiving homeopathic treatment. A number of nurses also underwent successful homeopathic treatment for allergies to latex gloves; these allergies were quite severe in some cases. These are prime examples that homeopathy can be successfully used not only on patients but also on ICU staff.

With regard to my collaboration with my university colleagues, it must be said that after the initial surprise and amazement at my homeopathic work, many of them have shown a cautiously sympathetic attitude and obtained homeopathic advice not only for their patients, but sometimes also for themselves and/or members of their families. Enlightenment and a clear definition of the boundaries of “nonhomeopathy” is decisive for the acceptance of homeopathy and to avoid confusion with any other methods.

3.11 Suggestion and placebo effects

Intensive care medicine is a special challenge, as the much-cited suggestion and placebo effects are

irrelevant. The assumption that a heavily sedated patient will react to the administration of globules with a placebo effect is untenable, as many other interventions and nursing routines such as intubation, reintubation, bronchoscopic evaluation and suction, oral hygiene and oral decontamination are often performed even more frequently. In several cases, homeopathic treatment was administered after a telephone consultation with the patient’s relatives, and it is impossible to understand how suggestion could work on a sleeping patient when the homeopath does not know the patient, his relatives and the physicians treating him personally. We must also refer to an article published in the “New England Journal of Medicine” in 2001 which investigates the placebo in a major meta-analysis and concludes that it is powerless to do anything more than “absolutely nothing”. The role of placebos must therefore be reconsidered outside the context of clinical studies and moderate pain. The author does not know of any work which describes the effect of placebos on sedated or comatose ICU patients. The cases described may therefore not be considered in the same light as conventional cases; the placebo effect cannot account for the frequently astonishing developments experienced with patients who were clearly critically ill on admission.

3.12 Summary and studies

Summary

To summarise, it is clear that homeopathic treatment may be successful in ICU, even though it can entail many difficulties. The cases described naturally cannot supply unambiguous proof of the

effect of homeopathic treatment, but the often astonishing progress made by patients makes it at least thinkable, and as such should also be treated as a topic for academic discussion.

Studies

To finish, I would like to discuss the frequently mentioned ineffectiveness of homeopathy. As these arguments are often repeated, we feel it would be wise to shed light on one of the most recent studies. In an article published in 2005, Shang and colleagues (Shang et al. 2005) found that it was belief in a healing method which eased or cured certain symptoms, not however the homeopathic remedy itself. The authors insist that physicians should now be honest enough to pass this “insight” on to their patients. The scientists originally planned to analyse 110 studies testing homeopathic remedies and another 110 studies testing conventional drugs to establish the effectiveness of each method. In each study, the substance being investigated was tested against a placebo. The researchers also evaluated the tests according to the number of participants and the quality of the methods used. Particular importance was attached to randomised double-blind studies, i.e. studies in which neither the participants nor the physicians knew which substance was being administered.

The sensational result: in these 220 studies, both homeopathy and conventional medicine were shown to be effective.

Some of these 220 studies, i.e. 8 homeopathic and 6 allopathic studies deemed to be “larger and methodologically better”, were analysed once again. The authors now found that only the allopathic drugs had a specific effect, not however the homeopathic remedies. The researchers accordingly concluded that “These results confirm the assumption that the clinical effects of homeopathy are placebo effects.” They assume that if an improvement can be seen after a course of homeopathic treatment, this effect would also have been achieved with the placebo - the patient merely has to believe in the efficacy of the remedy he receives.

We acknowledge the effort required to conduct such an intensive study; however, we would now like to comment on it from a scientific viewpoint. The exciting news is that homeopathy works, as described in the results. If all 110 studies are taken into account, a beneficial effect is observed in both groups. The authors also acknowledge that the homeopathic studies were less heterogeneous. Moreover, it was confirmed that the quality of the homeopathic studies investigated was higher (19% vs. 8%).

While we agree with the authors about these sensational results, we see greater problems with the authors’ conclusions (Frass et al. 2005). Firstly, even with careful selection, it is difficult to compare homeopathic studies from a pool of 165 with allopathic studies from a pool of more than 200,000. This factor of 1000 alone is imbalanced. Moreover, we feel it is a form of discrimination to rate English language publications (94/110,85% for conventional medicine vs. 58/110,53% for homeopathy) higher than others. We believe that (German and French are international languages recognised by all scientists, even if previous investigations may have shown that the quality of English-language studies is supposedly higher.

Neither the abstract nor the introduction define a clear aim. Moreover, the study structure deviates from the analysis actually performed, and the detailed description of how the works and databases were selected is therefore deceptive: instead of analysing all of the 220 studies selected according to their inclusion and exclusion criteria, the authors reduce the number of studies included to “larger-scale studies of higher quality”. When using these sub-groups, the results achieved by conventional medicine and homeopathy appear to differ. However, some uncertainty remains about the selection of these 8 homeopathic and 6 allopathic studies. The dividing line is chosen arbitrarily: if we observe the plots, quite the opposite result would have been obtained if the choice of plotted studies had been made using another threshold value. From a statistical viewpoint, the power of the tests should be given, especially in view of the

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small sample drawn. Therefore the choice of larger higher-quality studies is a *post festum* hypothesis but not a clear study structure. The question remains whether restricting this project to larger higher-quality studies was part of the original protocol or whether this was only decided later? As we cannot find information about this reduction in the abstract, we doubt that this was planned right from the beginning.

However, the fact that this selection very probably caused a departure from the original structure of matched studies is significant. This means that the results obtained from each group cannot be correlated.

The dramatic reduction from the original 220 studies to 14 was undertaken by the authors because the 220 studies supposedly showed a publication bias due to funnel plots. Although the available literature (Tang 2000, Terrin 2001) states that these funnel plots should be interpreted with great care, the authors do not once mention the existence of publication bias in this very small selection of studies. It is also remarkable that no information relating to odds ratios, matching parameters, literature etc. is given for the 14 studies used.

Along with the concerns relating to the selection of studies, there are also problems with the interpretation. By limiting the project to larger studies of higher methodological quality, the odds ratio for homeopathy was 0.88 (CI 95%: 0.65-1.19) based on just 8 studies. Although this calculation allows scope for the assumption that the results could have been purely coincidental, it does not refute the hypothesis that they may indeed have been achieved by the effect of homeopathy. The odds ratio for the allopathic studies was 0.58 (CI 95%, 0.39-0.85), which indicates with an improbability of 5% that the results were not achieved coincidentally. However, we would like to emphasise that these statistics only facilitate a statement about “evidence” and “no evidence”, not about “weak or strong evidence”.

In addition, the scientific community aims to reach a significance of 1% for controversial hypotheses. The reader would also be interested to know which

probability of error would have made homeopathy significant.

We should also bear in mind that this work does not compare homeopathic studies with allopathic studies (as incorrectly given in the title), but describes the specific effects of each method in separate analyses. No direct comparison can therefore be drawn from it.

What the authors may not be expressly aware of is the fact that the larger studies are rarely “classical” homeopathic interventions - the main principle of homeopathy, i.e. individualisation, can therefore not be applied. The study consequently lacks a profound understanding of what homeopathy actually represents.

On reading the work, we were convinced that the authors were inspired by the desire to give the reader more information and provide the physician with an aid for advising patients. It is therefore a complete surprise to find that this impression is completely blotted out in the editorial: the title alone implies the intention to publish this special article. The last sentence, “Physicians now have to show courage and be honest with their patients...” gives rise to the concern that the Lancet may be hinting that homeopathic physicians are dishonest.

Finally, the motivation behind this study is revealed by Michael McCarthy in the “World Report”: it is clearly planned to attack Ms. Zhang, the team coordinator for traditional medicine at the WHO Department of Essential Drugs and Medicine Policy, who is currently preparing a report on homeopathy.

So much for the work. While several meticulous studies of homeopathy have been planned (e.g. by the gastroenterology department of the Medical University of Vienna for the treatment of Crohns disease), five funding agencies have refused to support them. Is it therefore any surprise that the number of homeopathic studies is so small?

What is perhaps less well known: the acceptance of homeopathic studies is distinctly lower than that of conventional studies. For academic researchers, this is a clear sign of bias with regard to publications:

keeping the number of homeopathic studies small makes it easier to draw conclusions such as “Homeopaths are not interested in research” or “There is no evidence that homeopathy works”. By denying homeopathic physicians space to work, manpower and financial support, the academic world gains a false impression of the scientific value of homeopathy.

This again shows how important it is to treat controversial topics in an academic, unemotional manner. This is why we support the dialogue between conventional medicine and homeopathy, and hope that this book will contribute to it.

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4 Remedy production and quality

Ilse Muchitsch

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4.1 Pharmaceutical aspects of homeopathy in intensive care medicine

The use of potentised remedies in intensive medicine has become a meaningful, practical form of concomitant treatment, as carefully triggered reactions to remedies stimulate the healing process. The criteria relating to the quality, manufacture and application of remedies are extremely

important, as optimum results can only be obtained by using perfectly prepared remedies. However, potentised remedies show quality discrepancies as regards source materials, manufacture and storage.

The following chapters and the remedy kit aim to provide an overview of materials and processing to facilitate a detailed discussion of the pharmacological and toxicological effects of the remedies.

4.2 Source materials used in potentised homeopathic remedies

Definition in the Ph. Eur. (European Pharmacopoeia): Homeopathic remedies are prepared from substances, materials or concentrated preparations using a homeopathic processing technique.

Homeopathy uses potentised remedies prepared from substances found in nature and from biochemical and synthetic materials. Hahnemann knew of about 150 remedies; these days, around 4000 substances are processed using homeopathic rules. About 65% of these remedies come from the plant kingdom, 30% are minerals and metals and 5% come from the animal kingdom. The original substances are potentised in compliance with certain rules. The higher the potency, the more powerful the effect.

Tab. 4.2-1: Medicinal plants		
Homeopathic name	English name	Brief description
Fresh plants		
<i>Aconitum</i>	Aconite, monkshood	Toxic! Whole plant collected when it begins to flower
<i>Belladonna</i>	Deadly nightshade	Toxic! Fresh plant with rootstock
<i>Conium</i>	Poison hemlock	Toxic! Fresh flowering plant
<i>Digitalis</i>	Foxglove	Toxic! Fresh leaves collected before plant flowers
<i>Echinacea</i>	Purple coneflower	Fresh flowering plant including roots
<i>Hyoscyamus</i>	Henbane	Toxic! Fresh flowering plant
<i>Pulsatilla</i>	Wind flower	Fresh plant collected when flowering
<i>Ruta</i>	Rue	Fresh plant harvested when it begins to flower
<i>Thuja</i>	Arbor vitae, white cedar	Toxic! Fresh twigs collected before the plant begins to flower
Plant parts (leaves, flowers, fruits, bark, roots)		
<i>Allium cepa</i>	Common onion	Fresh onion
<i>Arnica</i>	Leopard's bane	Dried powdered roots and rootstock
<i>Bryonia alba</i>	White bryony	Fresh thick tuberous root
<i>Crataegus</i>	Hawthorn	Fresh ripe fruits, fresh leaves and blossoms
<i>Colchicum autumnale</i>	Autumn crocus	Toxic! Fresh bulbs collected in autumn
<i>Hamamelis</i>	Witch hazel	Fresh bark from twigs and tips, fresh flowering twigs
<i>Lycopodium</i>	Club moss	Fresh spores
<i>Rhus toxicodendron</i>	Poison ivy	Toxic! Fresh leaves
Dried plants		
<i>China</i>	Peruvian cinchona bark	Dried bark from twigs
<i>Coffea arabica</i>	Mountain coffee	Dried unroasted beans
<i>Helleborus niger</i>	Black hellebore, Christmas rose	Dried rootstock
<i>Ignatia</i>	St. Ignatius bean	Toxic! Dried ripe seeds
<i>Ipecacuanha</i>	Ipecac plant	Toxic! Dried roots
<i>Ledum</i>	Marsh tea plant	Dried young shoots
<i>Staphisagria</i>	Delphinium	Toxic! Dried ripe seeds
<i>Nux vomica</i>	Strychnine	Toxic! Ripe seeds
<i>Veratrum album</i>	White hellebore	Toxic! Dried rootstock with roots

4.2 Source materials used in potentised homeopathic remedies

For purposes of simplification, the following text uses the term “homeopathic remedies”, although the remedies only actually become “homeopathic” when used by the patient. The term “potentised remedies” is therefore more precise.

The closer the remedy matches the individual symptoms, the more likely it is that a regulatory healing reaction will be stimulated. As the organism is constantly endeavouring to maintain a state of balance, it responds to any remedy stimulus similar to the symptoms by initiating an active regulation process.

The principles of homeopathy go back to its founder Samuel Hahnemann, and are largely summarised in three types of reference work: the **materia medica** of potentised remedies is one of the most extensive medical and pharmaceutical collections of remedy provings and includes toxicological, botanical and pharmaceutical data collated over two centuries.

Repertories list symptoms of remedy provings performed on healthy subjects and document clinical and toxicological observations. The manufacturing regulations are published in constantly updated **pharmacopoeia**.

4.2.1 Plants

About 65% of all remedies come from the plant kingdom. These remedies are made from whole plants, plant parts or dried plants. Botanical and pharmacological considerations must be taken into

account when choosing the plant, e.g. plant origin, plant quality, the substances it contains, shelf-life and the care taken during processing and storage.

* Ph. Eur: Stock materials of plant, animal or human origin can be processed fresh or dried. Fresh stock materials may be deep-frozen for storage purposes if necessary.

In certain justifiable and approved cases, fresh stock materials of plant origin may be stored in ethanol 96% (v/v) or a suitable concentration of ethanol for transport or storage purposes provided the entire stock material including the ethanol in which it is stored is used for further processing.

4.2.2 Fungi and lichens

Homeopathy also uses unusual source materials which only take on the character of a remedy when they are processed.

4.2.3 Minerals and metals

About 30% of all remedies are made using minerals and metals.

4.2.4 Animal kingdom

About 5% of all remedies come from the animal

Tab. 4.2-2: Fungi and lichens		
Homeopathic name	English name	Description
<i>Agaricus muscarius</i> = <i>Amanita muscaria</i>	Fly agaric	Toxic! Fruiting bodies grow above ground.
<i>Spongia tosta</i>	Common sponge (roasted)	Dried roasted skeleton of the common sponge
<i>Sticta pubvonnaria</i>	Lungwort	Thallus which grows on sugar maple

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Tab. 4.2-3: Minerals and metals		
Homeopathic name	English name	Description
Chemical elements		
<i>Cuprum</i>	Metallic copper	Extracted by several purification processes, almost always bonded with sulphur but may also bond with many other elements, rarely metallic, after other parts of ore have been washed out
<i>Iodum</i>	Elementary iodine	Crystal platelets from Chile saltpetre or sea water
<i>Phosphorus</i>	Yellow phosphorus	Toxic! Extracted technically from phosphates
<i>Silicea</i>	Rock crystal	Aqueous polymerised SiO ₂ from rock crystal
<i>Sulphur</i>	Purified flowers of sulphur	Yellow rhombic crystals from volcanic vapours
Chemical bonds		
<i>Antimonium tartaricum</i>	Tartar emetic	Double salts of tartaric acid with potassium and antimony
<i>Arsenicum album</i>	Arsenic acid	Toxic! White arsenic, chemical formula H ₃ AsO ₃ , manufactured by dissolving arsenic(III) oxide in water
<i>Borax</i>	Sodium tetraborate	Na ₂ B ₄ O ₅ (OH) ₄ • 8 H ₂ O, the most important borate mineral and an important boron bond
<i>Ferrum metallicum</i>	Metallic iron	Oxide ore, Fe
<i>Ferrum phosphoricum</i>	Iron phosphate	Common mineral from the class of aqueous phosphates. Fe ₃ ²⁺ (PO ₄) ₂ • 8 H ₂ O, blue-grey powder
<i>Hydrocyanicum acidum</i>	Hydrocyanic acid or prussic acid	Toxic! HCN; extremely toxic. Many foods and natural substances contain minuscule quantities of prussic acid (e.g. almonds, cherries, apricots, manioc).
<i>Kalium bichromicum</i>	Potassium dichromate	Toxic! K ₂ Cr ₂ O ₇ , potassium salt of dichromic acid, unstable in free form, orange crystals
<i>Kalium carbonicum</i>	Potassium carbonate (potash)	K ₂ CO ₃ , potassium salt of carbonic acid, white, hygroscopic powder
<i>Natrium carbonicum</i>	Sodium carbonate (common name: soda)	Na ₂ CO ₃ , salts of carbonic acid
<i>Natrium muriaticum</i>	Sodium chloride (table salt)	Ionic bond of sodium and chloride ions, NaCl
<i>Nitricum acidum</i>	Nitric acid	Toxic! HNO ₃ colourless (pure), light yellow to reddish liquid (depending on nitric oxide dissolved)
<i>Sulphuricum acidum</i>	Sulphuric acid	Toxic! Dihydrogen sulphate, strong inorganic acid. It is a mineral acid and one of the 20 most important chemicals in the chemicals industry H ₂ SO ₄ , colourless, viscous liquid
Compounds		
<i>Carbo vegetabilis</i>	Charcoal	Birchwood cinders
<i>Graphites</i>	Naturally occurring graphite	Along with diamond and fullerene, graphite is a modification of carbon and a naturally occurring (albeit rare) mineral; besides carbon, it contains silica, iron and manganese.
<i>Hepar sulphur calcareum</i>	Calcium sulphide	The white inner part of oyster shells mixed and heated with flowers of sulphur
<i>Kreosotum</i>	Beech tar creosote	Distilled from beech chippings

4.2 Source materials used in potentised homeopathic remedies

Homeopathic name	English name	Description
<i>Mercurius solubilis</i> <i>Hahnemanni</i>	Precipitated black oxide of mercury	Toxic! Mixture of mercury amidonitrate, metallic mercury and mercury (I) oxide
<i>Petroleum</i>	Fossil oil	Fossil oil after removal of light, heavy and residual oils
Synthetic substances		
<i>Camphora</i>	Camphor	Made of the wood of the camphor tree, camphor is a colourless solid, a bicyclic monoterpene ketone.
<i>Carbolicum acidum</i>	Carbolic acid	Toxic! Phenol (also hydroxybenzene), historically known as carbolic acid, is the simplest bond in the phenol group, C ₆ H ₆ O
<i>Nitroglycerinum</i> (<i>Glonoinum</i>)	Nitroglycerine	Glyceryl trinitrate is a well-known explosive with the chemical formula C ₃ H ₅ (ONO ₂) ₃ , used in medicine for its vasodilatory properties

Tab. 4.2-4: Animal kingdom		
Homeopathic name	English name	Description
<i>Ambra grisea</i>	Ambergris from the sperm whale	Yellow, aromatic, sebaceous excretion from the intestines
<i>Apis</i>	Honey bee	Whole worker bee
<i>Bufo</i>	Common toad	Toxic! Toxin secreted by the cutaneous glands
<i>Cantharis</i>	Spanish fly	Toxic! Cantharidin (= monoterpene dicarboxylic acid)
<i>Crotalus cascavella</i>	South American rattlesnake	Toxic! Physiologically effective components of the snake's venom apparatus
<i>Crotalus horridus</i>	Rattlesnake	Toxic! Snake venom comprises more than 90% proteins and polypeptides along with a few enzymes. The toxic proteins (toxins) are usually very large and complex.
<i>Lachesis</i>	Bushmaster snake	Toxic! Venom from the poison glands
<i>Naja tripudians</i>	Cobra	Toxic! Secretion from the venom-conducting salivary glands
<i>Sepia</i>	Cuttlefish	Dried content of ink bag

4.2.5 Products of disease, nosodes

The nosodes were added to the materia medica by Hering in 1852. By nosodes (nosos, Greek = disease), he meant nothing more than pathological emissions.

These are prepared using human or animal disease products, pathological secretions, bodily fluids and organ parts or manufactured from microbe cultures. Mother tinctures prepared from nosodes must be sterilised and tested for the absence of pathogens before potentisation. The identity of the source material must be verified by the findings of a medical specialist or an appropriately specialised

laboratory. The preparation of nosodes is described in regulations 43-44 of the Ph. EUR.

A valid, up-to-date remedy proving should be made before using a nosode to ensure that it is prescribed in keeping with the law of similars. Attention should be paid to the origin of the nosode during repertorisation.

Special care is required when selecting carcinosi- num nosodes, as mixed preparations are also available on the market.

Ph. EUR regulations

Mother tinctures manufactured according to regulation 43 are prepared from pathologically altered

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Tab. 4.2-5: Examples of nosodes

Homeopathic name	English name	Description
<i>Carcinosinum</i>	Cancer nosode	Tissue from human mammary carcinoma extracted during operation and largely separated from surrounding fatty connecting tissue, or cells from a permanent cell line made of it
<i>Diphthehnum</i>	Diphtheria nosode	Made of membranous fibrous coating in the throat of diphtheria sufferers
<i>Influenzinum</i>	Influenza nosode	Inactivated virus from expectorations of influenza patients
<i>Lyssinum</i>	Rabies nosode	Saliva from a rabid dog
<i>Medorrhinum</i>	Gonorrhoea nosode	Purulent discharge from urethra
<i>Psorinum</i>	Scabies nosode	Purulent, serous content of scabies blisters
<i>Pyrogenium</i>	Pyrogen nosode	Fresh, sterilised fluid extracted from decayed beef from healthy, newly slaughtered animals
<i>Syphilinum (Luesinum)</i>	Syphilis nosode	Secretion from syphilitic ulcers
<i>Tuberculinum/Bacillinum</i>	Tuberculosis nosode	Cavity content and adjoining tissue from TB patients

organs or organ parts from humans or animals. The mother tincture is composed of one part comminuted source material to 10 parts 85% glycerol which is allowed to stand for at least five days and then filtered. This filtrate is the mother tincture.

Mother tinctures manufactured according to regulation 44 are prepared using dead microorganism cultures, products from the decay of animal organisms or bodily fluids containing pathogens or disease products. Unless stipulated otherwise in the monograph, cultures of microorganisms are heated to a core temperature of 133 °C before being sterilised in pressurised saturated steam at 3×10^2 kPa for 20 minutes. The remaining steps are the same as in regulation 43.

4.3 Quality criteria

Quality refers to the nature of a remedy and is defined in terms of its identity, content, purity, other chemical, physical and biological properties and/or the manufacturing procedure (German Medicines Act (AMG) § 4 par. 5).

The quality of a potentised remedy depends firstly on the source material **matching** the substance used during the remedy proving, and secondly on the **quality** of the

compliance with the potentisation rules and on the **conditions in which it is stored**.

Homeopathic remedies should not be exposed to direct sunlight, extreme heat or moisture and should not be kept close to computers, microwave ovens, televisions or mobile phones, as these can impair their effect.

In the case of liquid remedies, **shaking during transport** can lead to undesired potentisation effects. Liquid Q potencies are consequently filled right to the top to avoid shaking.

Authenticity of remedies

"The true physician must be provided with genuine medicines of unimpaired strength, so that he may be able to rely upon their therapeutic powers; he must himself be able to judge of their genuineness." (Organon of the Healing Art, § 264)

Even today, it is still extremely important to manufacture the remedies exactly in line with the prescribed methods, as only correctly potentised remedies can have the desired healing effect, even though the processes have changed over time. Potentised remedies are manufactured pharmaceutically in compliance with the currently valid

European Pharmacopoeia and the Homeopathic Pharmacopoeias of each country.

4.4 Potentisation

4.4.1 Source materials

Homeopathy uses an incredibly wide variety of source materials, which means that various methods of preparation are necessary depending on the substance being processed. Easily soluble substances such as salts are prepared differently from plants with high resin contents or metals such as gold which have to be triturated with lactose.

The Homeopathic Pharmacopoeia gives 54 different regulations for manufacturing potentised remedies.

Hahnemann was already aware that many plants have a significantly higher medicinal content when they are freshly plucked. Wherever possible, he pressed the fresh plants and stabilised the juice with alcohol - his way of preparing mother tinctures. Plants are prepared in various alcohol percentages in certain ratios depending on their juice content and the solubility of their ingredients (HP: PS1-3). Precise calculations of ingredient concentrations are necessary for some plants, particularly plants containing substances with toxicological effects (HP PS 4a, 4b).

Bark, seeds, roots, wood or drugs which are only available in dried form are prepared by maceration or percolation (HP PS 2a).

During **maceration**, fresh plants are chopped finely and mixed with a defined quantity of alcohol; the mother tincture is pressed from this mixture after it has been allowed to stand for at least 10 days.

During **percolation**, fresh or dried materials are passed through solvents and extracted to obtain the mother tincture.

Animal toxins and animal secretions are prepared in spirits or glycerine (HP PS 4 b, 5a, 5b, 41a, 41c, 42a and 42b). These must comply with the regulations imposed by the competent authorities and the European Union relating to the spreading of

spongiform encephalopathy pathogens of animal origin.

Soluble chemical compounds and acids are dissolved in water or various percentages of alcohol depending on their solubility (HP PS 5a, 5b).

Metals or minerals with low solubility are prepared by incremental lactose trituration up to 3C or 6X and then potentised further in liquid form (HP PS 6).

Tab. 4.4-1: Ph. Eur. Regulations on the preparation of potentised remedies

Ph. Eur. regulation	Preparation
Regulation 1b	Mother tinctures from pressed juices containing sap
Regulation 2-3	Mother tinctures made from fresh plant material
Regulation 4a	Mother tinctures made from dried plant material
Regulation 4b	Mother tinctures made from animal material
Regulation 5	Mother tinctures made from solutions
Regulation 6-7	Triturations
Regulation 8	Liquid preparations made from triturations
Regulation 9	Tablets
Regulation 10	Globules
Regulation 17	LM potencies
Regulation 42	Mother tinctures (organ preparations)

4.4.2 Potentisation: dilution and succussion

Hahnemann discovered the law of similars as the basic principle of homeopathy during his experiments with cinchona bark. He started by administering a standard dose of the remedy but made the astonishing discovery that doses which were normally well tolerated suddenly caused violent reactions. Some patients reacted extremely strongly before a lasting cure occurred. One of his daughters almost died when proving *Veratrum album*

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The alarming intensity of these initial reactions caused Hahnemann to reduce the dose of homeopathically selected remedies ever more; this is how he discovered the principle of potentisation, i.e. of dilution and succussion.

As Hahnemann knew from experience that toxic remedies in particular should only be administered in very small doses, he dissolved the remedies and diluted them step by step.

Hahnemann first described this process using the example of *Belladonna*, which he prepared from dried juice pressed from deadly nightshade leaves by diluting it in proportions of 1:400, 1:300 and 1:200.

“[...] one grain (1 grain = 0.06 gram) of this powder is dissolved in 100 drops of distilled water, this cloudy solution is shaken in an ounce glass and rinsed with 300 drops of diluted spirits of wine added to the solution and mixed by industrious shaking. The glass is labelled ‘strong belladonna solution. One drop of this solution is combined with 300 drops of diluted wine spirits by shaking for several minutes and labelled ‘medium-strength belladonna solution’. One drop of this second solution is now combined with 200 drops of diluted wine spirits by shaking it for several minutes and labelled ‘weak belladonna solution; each drop of this solution contains 1/24,000,000, one twenty- four millionth of a grain of dried *belladonna* juice.’ (Stapf 1829).

Assuming that the atropine content was 10^{-5} to 10^{-6} mg, Hahnemanns diluted *belladonna* mixture contained less than one hundred thousandth of the pharmacologically effective quantity of atropine but still worked reliably. By now it should be clear that the effect of homeopathic remedies can no longer be attributed to their drug content, and that we have to consider another mode of action. However, Hahnemann was initially unaware of this, as shown in the works which followed. As the remedy “dilutions” he prepared still often affected the patient too violently if administered in compliance with the law of similars and if the patients symptoms matched, he prepared ever weaker dilutions in the belief that this would make his remedies

easier to tolerate. However, instead of a weakening, he noticed an increase in effectiveness, for example when using the remedy Thuja (*Arbor vitae*): “I then found that even the weakest solutions, e.g. the decillion-fold and even the vigesillion- fold dilutions lost nothing of their power, they did not became completely powerless or fall to nothing - no! On the contrary, the effects of the *Arbor vitae* became stronger and stronger.” (Hahnemann 1989).

In this context, it should be mentioned that the Viennese physicist **Josef Loschmidt** first calculated the constant named after him (6×10^{23}) in 1865. This constant describes the number of atoms or molecules of an ideal gas contained in one mole of a substance. Therefore Hahnemann could not have known that he was preparing “non-material” remedies.

Despite these observations, it became clear to the physician and chemist Hahnemann over his decades of homeopathic work that the effect of homeopathic remedies was not merely a question of dilution, as dilution alone reduces the effect of any drug. Consequently he attributed the effect of potentised remedies to their succussion or trituration.

“The change which occurs in the natural bodies, i.e. in the remedies, through sustained trituration with a non-medical powder or though dissolving it and shaking it in a non-medical liquid for lengthy periods is so remarkably great that it is almost miraculous; it is gratifying that the discovery of this wonderful change belongs to homeopathy.” (Hahnemann 1891).

Ultimately he again distanced himself from the previously used term of “dilution” and called his remedies “dynamisations”.

“Every day, we hear that homeopathically potentised remedies are still merely referred to as dilutions, although they are indeed the opposites thereof, i.e. true revelations of the concealed properties specific to natural substances brought to the light of day by means of trituration and succussion, with a non-medical dilution medium being used merely as a auxiliary aid. Dilution alone, e.g. the dissolution of one grain of salt, simply turns

the remedy into pure water... it never becomes the saline remedy which gains admirable strength through our carefully performed dynamisations.” (Hahnemann 1787).

At the beginning of his pharmaceutical activity as a homeopath, Hahnemann used dried plant juices for conservation purposes; these were suspended before use. These suspensions must be shaken intensively to obtain the most homogeneous solution possible. Succussion developed from this as the liquid form of homeopathic potentisation.

The Latin word “potentia” can be translated as strength, ability, capacity and effectiveness. Hahnemann used the term “potency” to describe powers which generated certain effects. As effects are also triggered by medicines, Hahnemann called them “medicinal potencies”, “healing potencies” or simply “potencies”. He observed that the remedies only became effective when developed and strengthened by the techniques of succussion and trituration. “Potentisation” and “dynamisation” are therefore understood to mean the preparation processes which awaken the homeopathic effects of the raw material by stepwise trituration and/or dilution.

Note: potentisation = dilution + dynamisation (succussion).

The liquid preparations obtained from the source materials are called **mother tinctures**. When these liquids are potentised further, they are referred to as **dilutions**. Preparation with lactose (milk sugar) is known as **trituration**. The Homeopathic Pharmacopoeia describes the various concentrations as degrees of dilution created by dilution and subsequent shaking. The remedies are potentised in various polar media (solvents containing oxygen molecules). Various concentrations of alcohol are used as excipients. Lactose is used for triturations, saccharose as a starting product for (cane sugar) globules, distilled water for solutions and glycerine for remedies using animal material.

4.4.3 Types of potency

The potencies originally developed by Hahnemann include the C (centesimal) potencies and the Q (quinguinta-millesimal) potencies, which due to a translation error are incorrectly known as LM potencies yet are still described as such in the HP. The Latin numerals LM mean 950 and not 50,000, yet they were retained on grounds of practicability! When preparing his potencies, Hahnemann used glasses of a size which only became % or % full when filled with approx. 100 drops of alcohol and water mixed. Dynamisation or succussion was carried out by “manually striking [the preparation] powerfully against a hard but elastic body (...) such as a leather-bound book. To this we add 100 drops of good wine spirit, close the bottle and give it 100 hard strokes against a hard but elastic body with the hand” (Hachl, 1921, § 270, note 2:247).

The number of strokes applied by Hahnemann varied between 2 and 100.

The D (decimal) potencies were introduced by the famous homeopath **Constantin Hering** (1800- 1880). Scientifically minded and critically oriented physicians such as the German doctor Bruno Albert Vehsemeyer (1807-1871) aimed to bring about an organotropic effect by mathematically dividing the stages of potentisation.

The K (Korsakov) potencies were prepared using a simplified potentisation process, the single-container method developed by **Korsakov** (lay homeopath, 1789-1853). According to this method, the remedies were potentised in one single vessel. This exploited the fact that after emptying the potentisation container, a certain quantity of liquid was left behind due to adhesion to the glass wall. This quantity can be determined by weighing; afterwards, 99 parts of ethanol/water mixture are added to the container and shaken.

Korsakovs single-container potencies were not adopted by the HP as preparation regulations, which means there is no uniform labelling obligation. Some manufacturers use this method to prepare high potencies, as it saves considerable time and expense.

4 Remedy production and quality

Hahnemanns multiple-container method is more complex and expensive but more precise.

Fluxion methods

Fluxion potentisation is a special method of liquid potentisation without succussion. The various fluxion processes (fluxion = flowing) are based on the pharmaceutical experience that the turbulence caused by flowing water or water sprayed into a potentisation vessel produces a potentisation effect which eliminates the need for succussion. However, the dynamisation effect achieved is relatively low, which means that very high potencies have to be prepared to produce an effective remedy.

No remedy with a potency higher than 30C was found in Hahnemanns estate. Even in Hahnemanns day, Clemens von Boenninghausen (1785- 1864) was potentising remedies up to 200C. As potencies became higher and higher, some homeopaths, especially in America, began exploring the possibility of developing potentisation machines.

In principle, we know of two types of mechanical potentisation (fluxion methods):

- **Continuous fluxion:** The remedy is diluted continuously without emptying the vessel during the process and without succussion.
- **Discontinuous fluxion:** After preparing a centesimal dilution of the remedy, the container is emptied and the residue is diluted without succussion, making it equivalent to a diluted Korsakov potency.

Succussion methods

The succussion methods involve automatic dilution and succussion with a defined number of strokes; these machines also use the single-container method. When employing these techniques, potentisation is mainly carried out in water, with alcohol only being added in the final stages. Remedies produced in this way are particularly popular in America.

As the various machine-based techniques of potentising high potencies are not standardised in the Ph. EUR, there is some doubt concerning the quality of these remedies with regard to the degree of dilution and intensity of the potency.

C potency (centesimal potency, dilution 1:100)

Preparing a C potency: 1 part of the source material is diluted in 99 parts of ethanol at the prescribed concentration in a vessel which must be at least one-third larger than the volume of liquid needed. This is then diluted and struck powerfully against a hard object at least 10 times (potentised).

The empty space in the vessel is necessary so that the liquid can be optimally succussed. It is not possible to potentise remedies in a full bottle.

The dilution obtained by succussing the liquid 10 times is described as IC, i.e. diluted at a ratio of 1:100 and then potentised. When IC is again diluted and succussed with 99 parts of ethanol as described above, the result is the potency 2C. The next (3C, 4C) and all higher centesimal potencies are prepared according to the same principle.

The liquid preparations obtained from the mother tinctures made up in compliance with HP regulations are known as dilutions. These can either be potentised further up to the required level or, at the final stage, be used with at least 60% (m/m) alcohol to prepare globules.

X potency (decimal potency, dilution 1:10)

Preparing an X potency: 1 part of the source material is diluted in 9 parts of ethanol at the prescribed concentration in a vessel which must be at least one-third larger than the volume of liquid needed. This is then diluted and struck powerfully against a hard object at least 10 times (potentised).

The dilution obtained by succussing the liquid 10 times is described as IX, i.e. diluted at a ratio of 1:10 and then potentised. When IX is again diluted and succussed with 9 parts of ethanol as described above, the result is the potency 2X.

Manufacturing globules

HP regulation 10 describes the impregnation of globules made of sucrose (cane sugar).

This is carried out by uniformly moistening 100 parts of globules with 1 part of a dilution at the required potency in a Petri dish or on an industrial scale. The dilution must contain at least 60% (m/m) ethanol. After impregnation in a closed vessel, the globules are allowed to dry in the open air. They are then labelled with the potency of the liquid preparation used to impregnate them.

Various sizes of globules are available. 100 of the globules used by Hahnemann to make Q potencies weighed one grain (0.06 g). These days, LM potencies are usually made with size 1 globules (470-530 weigh 1 g). The globules normally sold are size 3 (110-130 weight 1 g); size 5 (40-50 weigh 1 g) globules are often used for veterinary purposes.

Q potency (quinquaginta-millesimal potency, dilution 1:50,000)

History

For Hahnemann, the Q potencies were a new process which represented the sum of the knowledge he had acquired in decades of research. The instructions for preparation were included in the 6th edition of the *Organon of the Healing Art* (1842), but did not appear until Haehl published them in 1921. For this reason, homeopathic literature and many of the pharmacopoeias did not consider Hahnemann's experiences with these rarefied remedies until after 1921.

In § 270 of the “*Organon*”, Hahnemann describes how the remedy was prepared by trituration with lactose and adds more details in his remarks: “[...] one grain of this powder is dissolved in 500 drops of a mixture of one part of alcohol and four parts of distilled water, of which 1 drop is put in a vial. To this are added 100 drops of pure alcohol and given one hundred strong succussions [...]. This is the medicine in the *first* degree of dynamisation with which small sugar globules may then be moistened, quickly spread on blotting paper to

- Note: 100 of these sugar globules, which Hahnemann had his confectioner make using starch, flour and cane sugar, weighed one grain.
- Note: “A small, cylindrical vessel shaped like a thimble, made of glass, porcelain or silver, with a small opening at the bottom in which the globules are put to be medicated; these are moistened with some of the dynamised medicinal alcohol, stirred and poured out on blotting paper in order to dry them quickly.”
- Note: “...But if only one such globule be taken, of which 100 weigh one grain, and dynamised with 100 drops of alcohol, the proportion of 1 to 50,000 and even greater will be had, for 500 such globules can hardly absorb one drop for their saturation...”

According to the *Organon*, Q potencies are prepared by triturating source material (fresh or dried plants, minerals, metals, liquids or solids) to IC, 2C or 3C with milk sugar (lactose) in a complex process.

According to the trituration instructions in HP rule 7, tinctures of soluble source materials can be used as there are no regulations for triturating fresh plants.

Instead of triturating the source materials to IC - 3C, which would involve considerably more time and expense, the HP prescribes the subsequent trituration of the 2C succussion of the tincture to 3C before continuing the process up to the Q potencies in the usual way. This does not correspond to Hahnemann's intentions as regards trituration, but instead produces a mixture (№ I.7.4.4).

Preparing the Q globules

- **QI:** one grain (0.06 g) of the 3C trituration is dissolved in 20 ml of 15% alcohol (m/m) (corresponds to about 500 drops of 1 part ethanol and 4 parts distilled water).

1 drop of this solution is placed in a 10 g glass vial with 100 drops of ethanol (corresponds to approx. 2.5 ml) of 86% alcohol (m/m) and potentised 100 times (struck against a hard but elastic surface).

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This solution is used to moisten 100 g of size 1 globules (about 50,000 globules) evenly in a Petri dish; they are then dried carefully in a closed container. This ratio produced a dilution of approx. 1:50,000 (Organon of the Healing Art § 248). These globules are labelled QI.

- Q2: one QI globule is dissolved in 1 drop of water and mixed with 100 drops (about 2.5 ml) of 86% ethanol (m/m). This mixture is succussed 100 times and used to moisten 100 g of size 1 globules, which are then dried. These globules are labelled Q2. They are also available as LM globules, sometimes also in size 3.

Preparing the Q dilution: HP

In order to create liquid potencies (HP: liquid LM potencies), one globule of the required potency is dissolved in 10 ml of 15% ethanol. The solution has the same potency as the globule dissolved in it.

History

Organon of the Healing Art § 248: “For this purpose, we potentise anew the medical solution (x) (with perhaps 8, 10, 12 succussions), from which we give the patient one or (increasingly) several coffee or teaspoonful doses, in chronic diseases daily or every second day, in acute diseases every 6, 4, 3, 2 hours and in urgent cases every hour or oftener.”

Note (x): “Made in 40,30,20,15 or 8 tablespoons of water with the addition of some alcohol or a piece of charcoal to preserve it... The globule of the high potency is best crushed in a few grains of sugar of milk which the patient only need put in the vial and dissolve in the requisite quantity of water.”

Practice

According to the physicians prescription, 1 globule is dissolved in distilled water and the vial is filled with the requisite quantity and concentration of alcohol and water to avoid potentisation effects during transportation. The package leaflet instructs the patient to throw away one third of the liquid Q potency to create the space necessary for potentisation and to make it possible to add the required amount of water (e.g. 125 ml). The package

also mentions the number of succussions to be carried out by the patient every day and the number of drops or spoonfuls to be taken.

4.4.4 Triturations

Substances such as metals (e.g. *Aurum metallicum*) and poorly soluble mineral salts (e.g. *Silicea*) which do not dissolve in water or alcohol must be triturated with lactose to make them soluble. Triturations can be used to prepare the following remedies: • Dilutions, which can then be potentised further in liquid form

- Q potencies
- Tablets pressed directly from the triturated substances
- Also usable as a method of administration (taken directly as triturations).

The source materials are intensively triturated with lactose at a ratio of 1:10 or 1:100 in a porcelain dish following a complex procedure. First, lactose is rubbed into the dish to close the pores. The remedy is then triturated in three steps: firstly, the quantity of lactose to be used is divided into three. The remedy is triturated very firmly for 6 minutes in one third of the lactose, scraped out of the dish for 4 minutes, triturated for another 6 minutes then scraped out for another 4 minutes. This process is repeated in the same way using the second and then the third parts of the lactose. One trituration step therefore lasts 60 minutes. It consequently takes 3 hours to prepare a 3C trituration of the type needed to prepare Q potencies.

Hahnemanns intentions when administering “moderate doses”, as he called our present-day Q potencies, were:

- to adjust the effect of the remedy to the patient by individual dosing in order to trigger an artificial illness and “rescind” the disease, i.e. eliminate it completely from the inside out.
- to avoid the initial worsening of symptoms
- easy repeatability, as each dose is potentised further by the patient
- faster healing by repeating administration more frequently

4.4 Potentisation

Fig. 4.4-1: Making
triturations
(Grimm 2005)

100 grains
lactose

2 grains original
substance

Addition of 2nd third lactose



6 mins trituration
4 mins scraping out
6 mins trituration
4 mins scraping out



6 mins trituration
4 mins scraping out
6 mins trituration
4 mins scraping out

Addition of 3rd third of
lactose



6 mins trituration
4 mins scraping out
6 mins trituration
4 mins scraping out



1C

100 grains
lactose

1st third 1 grain of 1C

Addition of 2nd
third lactose



6 mins trituration
4 mins scraping out
6 mins trituration
4 mins scraping out



6 mins trituration
4 mins scraping out
6 mins trituration
4 mins scraping out

etc. up to 3C

- to facilitate repeat treatment without harming the patient.

4.4.5 Labelling

The label of the potentised remedy first states the Latin name of the source material as given in the HP (e.g. *Acidum phosphoricum*), the type of potency (C, X, Q, LM, K) and the potency level (e.g. 12, 30, 200, 1000, 10,000). The label will precisely state *Acidum*

Other abbreviations:

- Ø = mother tincture, from the Latin word “origo”
- TM = “teinture mere” (in the French-speaking countries)
- CH = C potency according to Hahnemann (in the French-speaking countries)
- K = Korsakov potency (centesimal series)
- M = 1000 potency (centesimal series)

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! Ph. EUR: Homeopathic remedies are labelled with the following information:

- The fact that the preparation is a mother tincture used for making homeopathic remedies (marked with the symbol "TM" or Ø).
- Name of the source material, using the Latin title of the monograph in the Ph. EUR or HP, if such an individual monograph exists.
- Preparation process.
- Percentage of ethanol or any other solvent used in the mother tincture.

4.4.6 Prescription

When doctors issue prescriptions for potentised remedies, they must use the nomenclature in the HP. The name of the remedy should be given without abbreviations (to avoid possible misinterpretation) along with the method of administration (glob., dil., unguentum, supp. etc.), the potency, the quantity in grams and instructions on dosage.

- Date
- Patients name and date of birth
- Prescription, e.g. *Phosphorus* 12C-glob.
- 10 g.

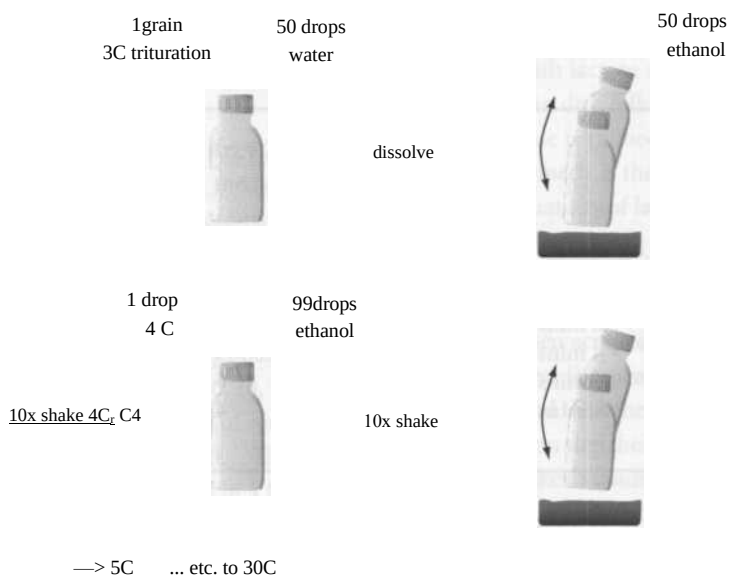
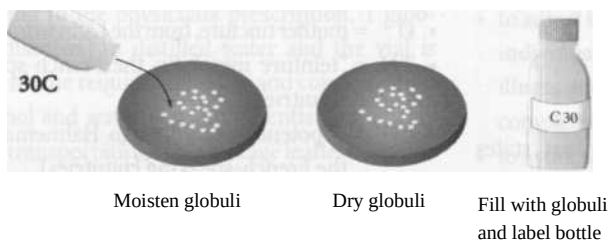


Fig. 4.4-2: Processing dilutions and globules (Grimm 2005)



4.4.7 Shelf-life of homeopathic remedies

1.1.1 10 of the Pharmaceuticals Act (“Labelling finished medicinal products”) stipulates a shelflife of five years with the mark “Use by” (caution: exceptions with shorter shelf lives).

This theoretical period was determined in line with the investigations customary for establishing compliance with pharmaceutical quality assurance standards. However, historical sources record many instances proving that if the remedies are stored carefully, their useful lives will far exceed this limit. Current methods of analysis only allow for limited quantitative and qualitative drug investigations (low potencies), and the remedy’s effect on the sick patient is therefore seen as a parameter of efficacy. Homeopathic remedies should be kept away from direct sunlight, heat and moisture. Direct contact with electrical devices such as microwaves, TVs and mobile phones must be avoided, as this could interfere with the effect of the remedy.

Dilutions should be stored so that there is no risk of them being shaken, as this could give rise to unwanted potentisation effects. This is why Q potency dilutions are filled right to the brim.

4.4.8 Drug legislation

In Germany, the legal basis for the distribution of pharmaceutical drugs is the Pharmaceuticals Act, which also implements regulations standard throughout the EU and contains strict instructions for manufacturing, testing, licensing, prescribing and distributing medication.

Homeopathic remedies are medicines made from substances known as homeopathic stock material in compliance with a homeopathic preparation process described in the European Pharmacopoeia or, in the absence of this, in one of the current pharmacopoeia officially used by members of the European Economic Community. A homeopathic remedy may also contain several substances.

Homeopathic remedies are subject to pharmaceutical legislation. As with all other medicinal products, it regulates their manufacture, quality assurance, monitoring by the competent authorities and import/export regulations. The definition of homeopathic remedies is drawn from the manufacturing process and production techniques described in the Homeopathic Pharmacopoeia.

Directive 2004/27 has now been implemented in all EU

Fig. 4.4-3: Formula for preparing 50,000 potencies (Grimm 2005)

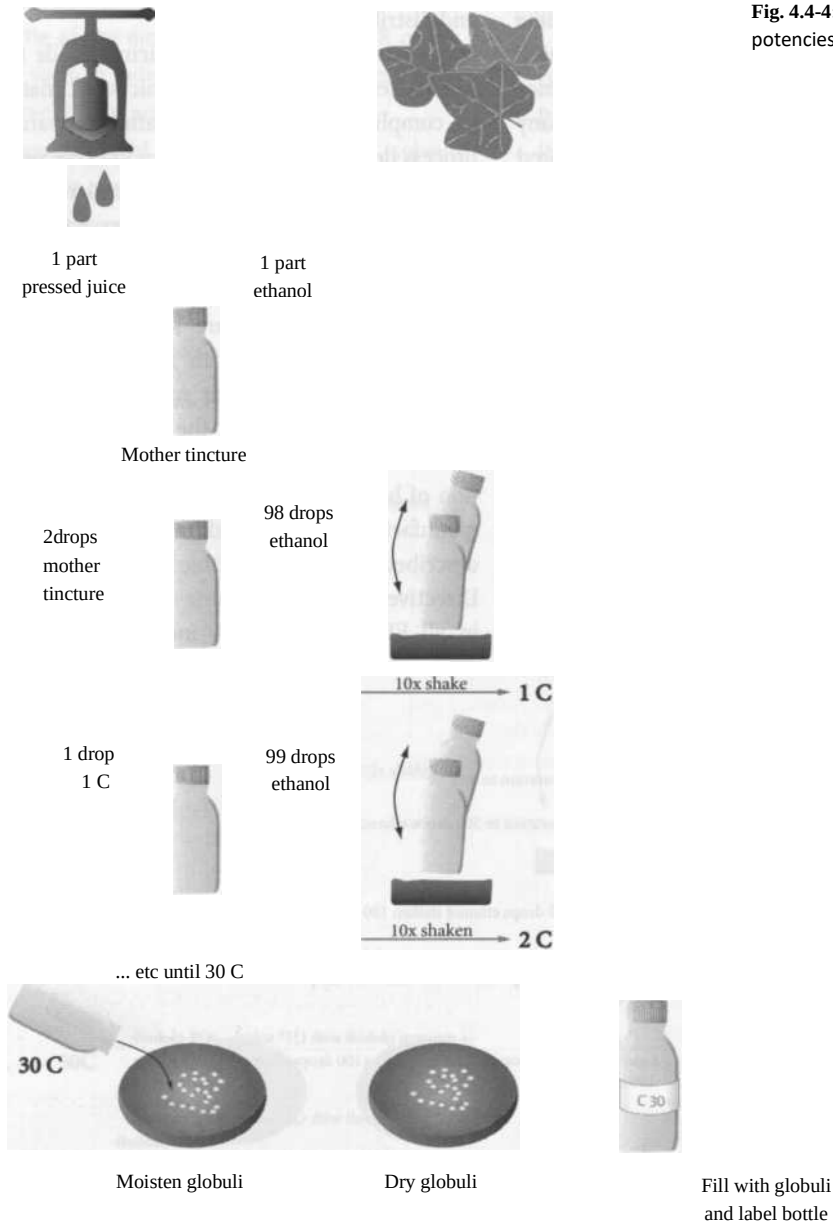
Three-hour trituration to 3 C ↓ 1 grain 3 C trituration in 500 drops ethanol ↓ Q0
 ↓ 1 drop Q0 +100 drops ethanol shaken 100 times ↓
 Qi) dilution → moisten globuli with Q0* soluti → Q1 globuli 1 globule
 Q1 +1 drop water (dissolved) +100 drops ethanol s 100 times ↓
 Q1* dilution → moisten globuli with Q1* soluti* → Q2-globuli 1
 globulus Q2 +1 drop water (dissolved) +100 drops ethanol 100 times
 ↓
 Q2* dilution → moisten globuli with Q2* soluti* → Q3-Globuli
 etc. until → Q30-Globuli
 The notation * is used to better differentiate intermediate stages.

4 Remedy production and quality

registration procedure for homeopathic remedies. However, products registered using this procedure (§ 11 Pharmaceuticals Act) are subject to several restrictions. For example, potencies may not be lower than 4X and no indications may be given.

Moreover, these remedies may only be used orally or externally.

However, both Germany and Austria have taken the opportunity to introduce or uphold extended licensing procedures for homeopathic remedies.



During this licensing procedure (§ 9b Pharmaceuticals Act), the same documentation must be presented (with the exception of clinical and pre-clinical data) as for conventional medicinal products. Moreover, homeopathic remedies licensed via this route are also subject to all other regulations such as pharmacovigilance, the “sunset clause” etc. However, there are no restrictions relating to the potencies and methods of administration used. Indications may also be given for remedies licensed using this procedure.

Extemporaneous remedies are prepared in pharmacies in compliance with the regulations in the relevant pharmacopoeias.

*** Important:** In compliance with the Pharmaceuticals Act, homeopathic remedies may only be obtained over the counter. Physicians may only prepare medicines for a patient directly under their care. Pharmaceuticals legislation sees filling remedies (e.g. crushing remedies in lactose and placing the mixture in powder envelopes) as drug manufacture.

i Note: Physicians may only administer homeopathic remedies in emergencies and for short periods.

In the EU, foreign remedies may be ordered via pharmacies and from private persons. Remedies may only be imported from non-EU countries by presenting a valid prescription to a pharmacist. Physicians may not import medicinal products needed for their practice on their own account.

4.4.9 Taking potentised remedies

Potentised remedies should be taken on an empty stomach or 15 minutes before or after meals, beverages and oral hygiene. Remedies are best absorbed via the oral mucosa. For that reason, globules should be allowed to dissolve under the tongue.

Globules may be administered to artificially respiration patients by pushing them straight past the tube and under the tongue. If this is impossible, they should be placed behind the patient's lips.

4.4.10 Methods of administration

Homeopathic remedies can be administered in many ways. Globules are probably the most familiar.

- **Globules:** small pellets made of sucrose (cane sugar) available in various sizes. These are impregnated with the freshly potentised remedy in a petri dish in compliance with HP regulations and then dried.
- **Dilutions:** these are used for liquid potentisation, administration as drops and as liquid Q potencies, in this case with low concentrations of alcohol.
- **Tablets:** these are produced by triturating the remedy, mixing it with excipients and pressing.
- The HP also describes **other forms of administration:**
 - Liquid potencies for injection
 - Liquid embrocations
 - Ointments
 - Suppositories
 - Eye drops
 - Mixtures potentised together.

However, these methods of administration are not normally used by traditional homeopaths.

4.5 Homeopathic Pharmacopoeia

Remedy catalogues

Pharmacopoeia

A pharmacopoeia (from the ancient Greek words *Pharmakon* - poison, remedy, and *poiein* - make, form, bring forth) is an official book of regulations for the preparation, quality, testing, labelling, storage and dispensing of a certain selection of medical products, the so-called officinal medicines. Almost all countries have their own pharmacopoeias.

Germany

The 10th edition of the Deutsche Arzneibuch (German Pharmacopoeia, DAB 10) appeared in 1992 as a collection of loose sheets containing the 19 volumes and

4 Remedy production and quality

Pharmacopoea Europaea (Ph. Eur.) and the collected regulations of the DAB in one edition. When the 5th amendment to the German Pharmaceuticals Act (AMG) came into force on April 4, 1992, the DAB acquired a different legal character. It is no longer implemented by ordinance; instead, according to § 55 AMG it is a collection of recognised pharmaceutical rules published by the competent federal ministry in the Federal Gazette. In the public notice on the DAB released on November 23, 1995, DAB 10 was renamed DAB 1996. Each version of the amendments and annual addenda drawn up by the pharmacopoeia commission is designated DAB with the year in question. A commentary on the DAB is published as a collection of loose sheets and is updated by addenda.

The regulations in the pharmacopoeia are passed by the Deutsche Arzneibuch-Kommission (German Pharmacopoeia Commission) or the Deutsche Homöopathische-Arzneibuch-Kommission (German Homeopathic Pharmacopoeia Commission) formed by the Federal Institute for Drugs and Medical Devices (BfArM) and by the European Directorate for the Quality of Medicines (EDQM).

Austria

The Austrian pharmacopoeia is known as the Pharmacopoea Austriaca. The pharmacopoeia prescribed by the Pharmacopoeia Act (ABG) of 1980 came into force on January 1, 1982. It consisted of the Ph. Eur., which was declared binding, and the regulations in OAB9 which were not replaced by Ph. Eur. 1. The official edition of the Pharmacopoea Austriaca (OAB) is now available on CD-ROM taking the German version of addendum 5.2 to Ph. Eur. 2005, vol. 1: General Chapters Monographs A-Z and the Homeopathic Pharmacopoeia 2005 (HP) into account.

Switzerland

In Switzerland, the pharmacopoeia consists of the European Pharmacopoeia (Ph. Eur.) and its amendments together with the Swiss Pharmacopoeia (Pharmacopoea Helvetica, Ph. Helv.) and its supplements. In compliance with the Pharmacopoeia

Ordinance (PhV) Sr 812.211, the Ph. Helv. is published in German, French and Italian.

Homeopathic Pharmacopoeia

The necessity of a homeopathic pharmacopoeia (most recent edition HP 2005) and consequently for a special HP commission is due to the methods of use peculiar to homeopathic remedies. The rules and regulations involved don't always have a scientific basis. They are in part based on conventional methods or on historical manufacturing processes in the interest of keeping the preparations consistent.

Historical origins of the Homeopathic Pharmacopoeia

Hahnemann's notes on preparing remedies were preserved in numerous medical texts. The most important works are "The Organon of the Healing Art", "Materia Medica Пирга" and "The Chronic Diseases". The prescriptions in these works are still valid today, as many remedy provings are based on this collected data.

They were followed by numerous pharmacopoeias by a variety of authors, the most important of which were those by Hartmann, Caspari and above all Schwabe. Schwabe's homeopathic pharmacopoeias formed the basis of the HP and only became binding when a professional code was drawn up for pharmacists (ABO). In 1976, legislators requested a HP commission to draft a new, modern homeopathic pharmacopoeia complying with the principles of contemporary analysis and manufacturing methods. The first part of HP 1 appeared in 1978; as part of the German Pharmacopoeia, this was legally binding.

The regulations in the Homeopathic Pharmacopoeia for Germany and Austria largely draws on Hahnemann's preparation procedures, although interpretational modifications were made due to the changes in the legal situation as regards drug manufacture. The HP is divided into a general part containing rules, methods and reagents, and a special part with monographs of homeopathic, anthroposophical and spagyric remedies.

4.6 ICU remedy kit

HP

A pharmacopoeia is a collection of recognised pharmaceutical rules published by the legislative authorities and regulating the quality, testing, storage, dispensation and labelling of pharmaceuticals and the substances used to manufacture them.

- In compliance with § 55 par. 2 and 6 of the German Pharmaceuticals Act, the rules in the pharmacopoeia are passed by the German Pharmacopoeia Commission, the European Directorate for the Quality of Medicines or the German Homeopathic Pharmacopoeia Commission.
- The texts and monographs incorporated into the Homeopathic Pharmacopoeia by the German Homeopathic Pharmacopoeia Commission in 2004 were published in compliance with § 55 par. 7 of the Pharmaceuticals Act.

The legislative instruments include various new monographs, revised texts, amended monographs with reference to the European Pharmacopoeia, corrections and deletions.

- Amendments to the new version of the Homeopathic Pharmacopoeia are made every year to accommodate any changes in the law. The currently valid version is the **“Homeopathic Pharmacopoeia 2005”** (HP 2005).

European Pharmacopoeia

The European Pharmacopoeia Commission is convened by the Council of Europe's European Directorate for the Quality of Medicines. The European Pharmacopoeia (Pharmacopoeia Europaea; Ph.Eur.) is published in English and French and is jointly translated into German by the competent authorities in Germany, Austria and Switzerland.

The European Pharmacopoeia (Ph. Eur.), 5th edition 2005, is binding in all member countries which have signed the Convention on the Elaboration of a European Pharmacopoeia (Ph. Eur. 5.0/1038, page 1261). Source materials, excipients, concentrated preparations, potentisation, methods of administration, plant substances for homeopathic preparations,

legally regulated in the Ph. Eur. The regulations in the Pharmaceuticals Act and the methods of analysis and manufacture in the Ph. Eur./HP are standard for the manufacture of pharmaceuticals and homeopathic remedies; any deviations must be marked.

Homeopathic preparations

Ph.Eur/HP

Definition: “Homeopathic remedies are manufactured using substances, materials or concentrated preparations subjected to homeopathic preparation techniques. A homeopathic remedy is usually labelled with the Latin description of the concentrated preparation and the degree of dilution” (European Pharmacopoeia 2005, 5.0/1038, Homeopathic Preparations). Special attention is paid to the manufacture of remedies using **agents which were originally infectious**, whereby the monographs of stock materials of animal origin must correspond to those for animal products entailing the risk of transferring spongiform encephalopathy pathogens. Animals and tissue used for the extraction of stock materials must also comply with food law regulations, just as if they were meant for human consumption.

Except in substantiated and approved cases, donors of materials of human origin must also conform with the recommendations for blood donors and donated blood (cf. human plasma for fractionation, plasma ad humanum ad separandum).

4.6 ICU remedy kit

The remedy kit («■ tab. 4.6-1) aims to clarify the connection between allopathic medicine and homeopathy by showing the direct relationship between the remedy, the ingredients and the symptoms which manifest during proving. Remedies are traditionally tested on a healthy subject using a 30C potency, in which the concentration of active substance is outside the Loschmidt (or Avogadro) constant. Although the remedy (theoretically) no longer contains any molecules of the original substance, it is interesting to observe that symptoms

4 Remedy production and quality

occur which match those familiar from pharmacological and toxicological observations. We hope this kit will inspire the user to apply his pharmacological knowledge homeopathically, i.e. to think about which substance could create the proving symptoms which match your patients and choose the most appropriate remedy from the homeopathic materia medica accordingly. This choice should then be fine-tuned by selecting the most suitable potency and variation (e.g. C, X, Q). In practice, potentised remedies often create a much wider range of proving symptoms than pharmacological tests; this could be due to the various potentisation techniques and the precision of the prover's observations.

When proving symptoms occur with remedies which according to the current state of scientific knowledge can no longer contain any of the original substance, we should open up to a new way of thinking, as these “information transmission” parameters are still at the stage of interdisciplinary research.

Homeopathy is an interesting challenge particularly in intensive care, as the cutting edge of medical knowledge and technology can be enhanced by methods which may help change the patients responsiveness by precisely applying the finest stimuli. Homeopathy consequently requires powers of accurate observation, thorough knowledge of

repertories and materiae medicae to enable the homeopath to choose the right remedy, and the profound insight of Samuel Hahnemann formulated in his “Organon of the Healing Art”: “The physicians highest and **only** mission is to restore the sick to health, to cure, as it is termed” (Organon of the Healing Art, § 1).

The remedy kit is meant to serve as an inspiration and can be adapted in line with the user's own experience. As far as possible, it should be used in line with the rules of classical homeopathy. The indications given are to be taken as suggestions.

There are no generally valid rules for the choice of potency. According to some of the observations described, the frequent repetition of higher and the highest potencies is by all means possible with ICU patients and has a curative effect in many cases. In general, low (1C-5C) and medium potencies (6C- 12C) can be given several times a day. When treating chronic diseases, higher potencies should be administered once only and the patient observed in the weeks, even months following. However, high potencies do not work for such long periods on gravely ill patients, so it is certainly possible to repeat the dose frequently within a short time. Hopefully the book will motivate users to send their own observations to the authors in order to facilitate an exchange of knowledge in this still relatively new area of homeopathy.

Tab. 4.6-1: Remedy kit					
Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Aconitum</i> , <i>Aconitum napellus</i>	Monkshood, blue rocket, wolfsbane, fam. Ranunculaceae; flowering plant including tuber	0.2-3% readily hydrolysable ester alkaloids: aconitine is one of the most powerful plant toxins. LD 1-5 mg, aconitines (mesaconitine,	When taken p.o.: symptoms of poisoning such as tingling, first in the mouth, then in the fingers and toes, then all over the skin, with	Traditional: particularly tubers (<i>Aconiti tuber</i>) used as a tincture to treat nerve pain, trigeminus	Acute fever with anxiety, CNS, cardiac disorders, pneumonia

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Aconitum</i> , <i>Aconitum napellus</i> (Cont.)		hyaconitine), neopelline, aporphine alkaloids, aconitic acids	outbreaks of sweating, feeling of "furriness", insensitivity to pain and icy coldness after 5-15 min., increased peristalsis, nausea, vomiting, colicky diarrhoea, pain in the head, neck and back, ringing in the ears, yellow-green vision, initial increase in respiratory frequency then irregular heart activity, respiratory and cardiac paralysis, diastolic cardiac arrest after approx. 6 h	neuralgia, tonsillitis, laryngitis, gout, rheumatism (as a liniment, compresses), migraine, today obsolete	
<i>Apis</i> , <i>Apis mellifica</i>	Honey bee, fam. Apidae. Preparation: worker bees are killed in 60% ethanol, further potencies are made using this mother tincture	Apisinum (bee venom from the honey bee's poison sac); most important contents: approx. 50% melittin, approx. 12% phospholipase A2, other peptides, e.g. apamin (2%, neurotoxin consisting of 18 acids with a stimulant effect on the CNS), enzymes, histamine, amino acids	The toxic effect comes from the melittin-phospholipase system. Melittin is a "natural invert soap" (detergent): it changes the cell membrane so that the tissue is destroyed by the formation of lysolecithin; it can also be converted into prostaglandins or leucotrienes.	External: unspecific stimulant therapy for rheumatic diseases, sciatica, neuralgia	Skin inflammation with heat and swelling, better with cold; joints, internal organs with swelling, redness, pain, cerebral fever, oedema.

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Arnica, Arnica montana</i>	Mountain arnica, leopard's bane, wolfs bane, fam. Aster- aceae; dried rhizome	Fresh plant: approx. 0.04-0.4% essential oils comprising approx, various fatty acids (50%), 12% terpene hydrocarbons (e.g. azulene), paraffins, thymol and derivatives, approx. 0.2-0.7% bitter-tasting sesquiterpenoid lactones with azulene structure (pseudoguaianolides) with effect on heart and circulatory system, arnifolin also responsible for contact allergies, 0.5% flavonoids such as astragalin, polyynes, coumarins, caffeic acid, phytomelan and triterpenes (arnidiol and faradiol)	"Emergency remedy", bacteriostatic, anti-inflammatory, analgesic, promotes wound healing, strengthens the heart, stimulates the circulation, vasodilatory, boosts circulation. Allergic reactions may be observed, as with many Aster- aceae (when applied externally in material doses). The ingestion of larger quantities of tincture may produce symptoms of poisoning: nausea, vomiting, gastroenteritis, pulmonary and cardiac symptoms, cramps	Traditional: abortifacient. External: contusions, bruises, promotes wound healing, rheumatic complaints (compresses)	"First aid remedy", trauma remedy, injuries, physical and psychological shock, muscles, connective tissue, atherosclerosis, hypertension, boils, increased bleeding tendency
<i>Arsenicum album, Acidum arsenicosum</i>	Arsenic (III) oxide, arsenic trioxide, arsenic acid, white arsenic. Occurs naturally in mineral form as arsenopyrite, realgar	Arsenic occurs everywhere in mineral compounds and in biochemical bonds in the vegetable and animal kingdoms.	Arsenic poisoning: mainly with arsenic trioxide, which is highly toxic. Acute poisoning: gastrointestinal symptoms; vomiting, cholera-like diarrhoea, leg cramps, circulatory problems; death from dehydration or cerebral manifestations.	Traditional: arsenic was formerly used as a tonic and aphrodisiac. The toxic dose varies because the body builds up a degree of tolerance; used externally for psoriasis, eczema, ulcers, warts	Respiratory insufficiency, terminal conditions, severe diarrhoea, hypotension, (food) poisoning, allergic reactions, weakness

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Arsenicum album, Acidum arsenicosum</i> (Cont.)			Toxic and lethal doses vary between individuals; fatal dose approx. 0.1 g. Chronic poisoning: arsenic melanosis (dark grey pigmentation, especially on the torso), hyperkeratosis on hands and feet, acnelike facial efflorescence, liver changes, disorders of the nervous system, polyneuritis. Arsenic works by paralysing the capillaries.		
<i>Aurum, Aurum metallicum</i>	Metallic gold, Au	Gold naturally occurs in crystalline rocks and river sand, often together with silver and other metals	Gold competes with copper in the organism and appears to play a role in inhibiting inflammation due to its effects on phagocytes and humoral antibodies. Lymphatic tissue has a special storage capacity for gold.	Organic gold preparations are used to treat rheumatic diseases; they work by inhibiting mesenchymal reactions. Toxic reactions are observed in approx. 20-30% of cases (skin alterations, liver and kidney damage, bronchitis), allergic reactions with thrombocytopenia	Hypotension, myocardial degeneration, depression, dizziness, headaches, rheumatic diseases

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Baptisia, Baptista tinctoria</i>	Wild indigo, fam. Fabaceae; fresh roots collected in autumn	Blue indigo dye; isoflavone glycosides: baptisin, baptin. quinolizidine alkaloids: cystine, methylcytosine, sparteine, also isoflavones, flavonoids, coumarins and polysaccharides with immunostimulatory, detoxifying and anti-inflammatory properties	Indigo has a laxative effect in small doses; in larger doses, it causes nausea, diarrhoea and severe gastroenteritis	Traditional: infections of the upper respiratory tract, colds, septic processes, antipyretic, used for scarlet fever, tonsillitis, diphtheria, enteritis, gastritis. Laxative. External: ulcers (ointment)	Typhoid fever, acute respiratory distress syndrome (ARDS)
<i>Belladonna, Atropa belladonna</i>	Belladonna, deadly nightshade, bane- wort, fam. Solanaceae; fresh whole plant excluding woody stem parts collected at the end of the flowering period	Approx. 0.5% tropane alkaloids, mainly L-hyoscyamine, atropine, apoatropine, belladonnine, scopolamine (hyoscyne), N-methylpyrrolidine, N-methylpyrrolidine, pyridine, choline, tannins, flavonyl glycosides	Three of these black berries can be fatal for children. Atropine: has an anticholinergic effect, increases heart rate and reduces atrioventricular conduction, dilates blood vessels in skin and causes a feeling of warmth. Obstructs smooth muscle function in the gastrointestinal tract, bladder, bile ducts and bronchi. Inhibits the production of saliva, sweat, stomach acid and bronchial secretions. As regard the eye, atropine causes widening of the pupils (mydriasis) by relaxing the musculus sphincter pupillae.	Internal: spasmodic, asthma, constipation, whooping cough, vascular cramps, bladder tenesmus. Antidote in cases of digitalis, muscarine (mushroom), pilocarpine, physostigmine, barium and lead poisoning. External: mydriatic	Acute fever with hot face and cold extremities, fever from infections, aggressiveness, scarlet fever, tonsillitis, otitis, spasmodic coughs, sudden severe pain

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Belladonna, Atropa belladonna</i> (Cont.)			Its effects on the CNS manifest as increased or diminished motor activity, also as delirium and hallucinations.		
<i>Bellis perennis</i>	Common daisy, lawn daisy, fam. Asteraceae; fresh flowering plant	Saponin, tannins, acids, wax, fatty and essential oils, inulin, bitter substances	Wound healing, used in phytotherapy as herb tea, fresh plant drops or pressed juice	Traditional: catarrh in the respiratory passages, gastritis, enteritis, slow-healing rashes; as compresses for injuries, sprains, contusions, bruises	Muscle pain, blunt injuries, after operations, abdominal injuries
<i>Bovista lycoperdon</i>	Puffball, fam. Basidiomycetes; powdered spores	Active substances: tyrosine, lycoperdin, enzymes	Haemostatic; if taken internally, the spore powder can cause symptoms of poisoning such as paralysis and bleeding	Traditional: the spore powder was used to stop bleeding and heal wounds, e.g. nosebleeds and eczema	Allergic reactions to conventional drugs (antibiotics)
<i>Bryonia, Bryonia alba</i>	Bryony, white bryony, fam. Cucurbitaceae; fresh roots harvested before shooting	Bryony is a poisonous climbing plant containing toxic glycosides. Bryonin (bitter substance), bryonicine (alkaloid), 0.01-0.4% glycosidically bound cucurbitacins, various sterols	Bryonin is cytotoxic and irritates the skin. Bryonia alba: white bryony, black fruits. The majority of remedy provings were performed using this plant. Bryonia cretica ssp. dioica: red bryony, red fruits. Touching the plant, especially the root, can lead to inflammatory allergic skin reactions with redness and blistering.	Traditional: laxative and diuretic, gout, rheumatic diseases	Rheumatic diseases which worsen with movement and improve with rest, cold and pressure, pneumonia, pleurisy with dry cough, inflamed mucosa, hyperuricaemia, lumbago, biliary colic

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Bryonia, Bryonia alba</i> (Cont.)			The fruits are particularly toxic: the lethal dose is 15 berries for children and 40 for adults. Symptoms of poisoning: vomiting, cramps, bloody diarrhoea, impaired consciousness, respiratory paralysis		
<i>Cactus grandiflorus, Selenicereus grandiflorus</i>	Queen of the night, cactus, fam. Cactaceae; fresh young stems and flowers	Cardioactive substances: with glycosides, alkaloids and resins similar to digitalis, tyramine, N-methyltyramine, flavonol glycosides	This still partly unresearched combination of active substances increases blood flow in the coronary blood vessels, influences inflammatory processes and prevents arrhythmia, PVC	Traditional: a tincture of the fresh plant is used to treat nervous heart complaints, cardiac arrhythmia, PVC, heart spasms, angina pectoris, myocarditis	Heart, vascular muscles, angina pectoris, intermittent claudication
<i>Calendula officinalis</i>	Marigold, fam. Asteraceae; whole fresh flowering plant	0.2% essential oils, triterpene glycosides, alcohols and triols, carotenoids, sesquiterpene glycosides, flavonoids	Anti-inflammatory, antimicrobial, promotes wound healing and granulation	Internal: inflammatory changes in the oral and pharyngeal mucosa. External: poorly healing wounds and ulcers (ointment)	Heals wounds: inhibits inflammation, stops bleeding, promotes granulation
<i>Cantharis, Lytta vesicatoria</i>	Spanish fly, blister beetle, fam. Meloidae; desiccated body of beetle	0.5-1% cantharidin, resin, fat, dyes	Cantharidin: eye irritant, has a corrosive effect on the gastrointestinal tract and causes severe irritation and inflammation throughout the urogenital tract.	Internal: stimulant, aphrodisiac, pleuritis, oedema, epilepsy, lupus, leprosy. External: vesicant plaster, tincture for neuralgia.	Burns, painful cystitis, kidney diseases

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Cantharis, Lytta vesicatoria</i> (Cont.)			Poisonous if taken internally: LD 25 - 30 mg, extremely severe kidney damage possible from just 5 mg. Cantharides camphor causes severe inflammation and blistering of the skin. Unlike mustard oils, the effect is only superficial and the blisters heal without leaving scars.	Veterinary: oestrogenic remedy; treatment for mange	
<i>Carbo vegetabilis</i>	Charcoal from beech or birch wood	Medical charcoal is made of animal or vegetable materials using carbonisation processes	The special carbonisation technique creates a large outer surface and an active inner surface, thus improving adsorption capacities.	Internal: diarrhoea, flatulence, antiseptic, adsorbs bacteria; external: wound powder	Gastritis, bronchial catarrh, circulatory collapse with sweating, cold forehead, respiratory insufficiency, venous stasis, need for fresh air
<i>Chelidonium</i>	Greater celandine, fam. Papaveraceae; fresh root stock with roots attached	The chyle mainly contains alkaloids in the form of chelidonic and meconic acid salts; benzylisochinoline alkaloids, chelidonine, berberine (yellow), chelerythrine (powerful irritant, toxic). Chelidoxanthine, sanguinarine, proteolytic enzymes	Spasmolytic effect on gastrointestinal tract, mild sedative and analgesic (chelidonine), cholekinetic (berberine)	Traditional: liver and gallbladder problems, spasmolytic; external: warts treated with fresh chyle	Hepatopathy, biliary colic

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>China, Cinchona pubescens</i>	Red cinchona, quinine, fam. Rubiaceae; dried bark of young trunks and older branches	More than 30 cinchona alkaloids have been analysed, particularly quinine, quinidine, cinchonine, cinchonidine. In the bark as salts of quinic acid, cinchonannic acid, quinovic acid. China red, quinine, a bitter substance which along with quinine is responsible for the bark's bitter taste. Saponins	Quinine has toxic properties; the consumption of 10-15 mg of quinine can have fatal consequences. Quinine inhibits the formation of glycogen in the liver and destroys red blood cells, leading to thrombi and anaemia. In contrast, overdoses of natural cinchona bark extract are less harmful; they cause noises in the ear, so-called "quinine deafness", gastrointestinal disorders, nausea, vomiting, diarrhoea, intermittent fever, cardiac insufficiency.	Traditional: formerly used as a malaria remedy, replaced by pure alkaloids and modern malaria medication. Stomachic, tonic, fortified wine, tonic bitters	Consequences of blood and fluid loss, weakness, bleeding into the muscles, all bodily cavities and intestines
<i>Cicuta virosa</i>	Cowbane, fam. Apiaceae; fresh root stock and roots collected when the plant begins to flower	The substances in this plant are extremely toxic and were also used to poison arrows; cicutoxin, cicutine	Signs of poisoning: nausea, vomiting, colic, mydriasis, intoxication, somnolence, paralysis of the tongue, severe epileptic and finally respiratory paralysis.	Traditional: cramps and rheumatic diseases. External: analgesic	Cerebral cramps, epilepsy
<i>Colchicum autumnale</i>	Autumn crocus, fam. Colchicaceae; fresh corms collected in spring	0.2-1% colchicine and secondary alkaloids, chelidonic acid, proteins, sugar, hemicellulose	Colchicine is a powerful cellular, capillary and mitotic toxin, LD 20 mg.	Traditional: gout, rheumatic diseases, asthma, kidney stones; external: cancerous growths	Acute gastroenteritis, collapse, rheumatic disorders, hyperuricaemia

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Colchicum autumnale</i> (Cont.)			Signs of intoxication appear 2.5 h after intake and include gastrointestinal bleeding, sore throat, swelling of the mucous membranes, burning in the stomach, colic, vomiting, increased cardiac activity, bladder cramps, joint pain, dizziness, collapse and central paralysis; victims remain conscious until death.		
<i>Conium, Conium maculatum</i>	Poison hemlock, fam. Apiaceae; fresh aerial parts of flowering plant before fruiting	D-coniine, piperidine alkaloids, N-methylconiine, pseudoconhydrine, conhydrine, essential oils	Signs of intoxication include feelings of numbness and paralysis creeping up the body. Problems speaking and swallowing, respiratory paralysis and death from respiratory arrest while fully conscious	Traditional: tranquilliser, neuralgia, asthma, whooping cough. External: whooping cough (poultices, ointments)	Paralysis creeping upwards, hardening of the glands (breast, prostate, paraesthesia, carcinomas)
<i>Comallaria majalis</i>	Lily of the valley, fam. Liliaceae; fresh aerial parts of flowering herb	Approx. 0.3-0.4% cardiac glycosides, e.g. k-strophanthidin, rhamnoside, convallatoxin and convallatoside. Convallatoxin and convallatoside, lokundjoside, convallarin and convallarinic acid, asparagines, malic and citric acids, sugar, resin, essential oils	Convallaria glycosides work in the same way as digitalis glycosides or strophanthine but are usually eliminated more quickly and have no cumulative effect. Intoxication leads to cardiac arrhythmias, muscle cramps, hypertension, tachycardia, respiratory paralysis and cardiac arrest.	For mild cardiac insufficiency, e.g. when digitalis can't be given, in the form of lily of the valley powder, age-related heart weakness, cor pulmonale	Cardiac insufficiency

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Crotalus cascavella</i>	South American rattlesnake, tropical rattlesnake	Crotoxin (poison in the venom sacs in the snake's maxilla), consists of: neurotoxins crota-min and crotacin, phospholipase A, anticoagulant enzymes	Crotalus cascavella causes cardiac symptoms, hypertension, dark passive bleeding and symptoms on the left side	All types of Crotallus containing crotoxin can be used as ointments to treat pain associated with rheumatic diseases	Gangrene, sepsis, haemorrhage
<i>Crotalus horridus</i>	North American timber rattlesnake, fam. Crotalidae	Crotoxin, the main component of the venom, is a viscous light yellow fluid when fresh and dries to a hornlike, translucent, crumbly mass	Most snake venoms have no or only a minor effect if ingested orally. Only when the venom directly reaches the bloodstream can the various components take hold. It mainly attacks the cardiovascular system. Like other snake venoms, it affects the cerebrospinal nerve centres with haemolysis as a secondary effect, causing bleeding and ecchymosis	Internal: circulatory disorders, increases capillary resistance. External: rheumatic diseases, sciatica, inflamed joints (ointments)	Gangrene, sepsis, coronary insufficiency, liver and gallbladder diseases, dark haemorrhages
<i>Cuprum metallicum, Cu</i>	Metallic copper, Cu; manufactured by reducing pure pulverised copper	Occurrence: native pure red copper ore or compounds, chalcocite, copper pyrites, azurite. Univalent and divalent heavy metal.	Cu is an essential trace element required for the formation of blood and chlorophyll. Cu is a component of numerous enzymes, e.g. catalase, peroxidase, cytochromoxy-dase, tyrosinase, monoaminoxidase, lysyloxidase, ascorbic acid oxidase	Copper was formerly used externally as a caustic and astringent for treating wounds.	Consequences of hypoxia, protracted intubation, cramping tendencies in smooth, striated muscles, epilepsy, bronchial asthma

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Digitalis purpurea</i>	Foxglove, fam. Scrophulariaceae; fresh leaves of one or two-year- old plants	The whole plant contains up to 40 digitalis glycosides, the content of which fluctuates naturally. Treatment with pure glycosides therefore now takes precedence, as the dosage can be measured precisely. Glycoside: gital- oxin, stropeside, ca. 1% steroid saponins (digitonin, gitonin, tigonin, natigin), digitofla- vone, flavonoids, vegetable tannins, enzymes, mucilages, organic acids. Cardiac glycosides such as genuine purpurea glycoside A, which are transformed into digitoxin and gitoxin by enzymatic action involving glucose bond splitting; these are then hydrolysed into the aglycones digitoxigenin and gitoxi- genin, the deoxysugar digi- toxose and glucose.	Incorrect dosage can lead to gas- trointestinal symptoms such as nausea and vomiting and to central nervous symptoms such as headaches, oscillopsia, cloudy vision and neuralgia followed by cardiac problems such as dizziness, extreme bradycardia with elevated blood pressure, atrial fibrillation, cyanosis, collapse, cardiac arrest.	Traditional: internally as tincture for treating cardiac insufficiency, strengthening the heart muscle, alleviating symptoms of heart congestion, increasing urine output, regulating cardiac arrhythmias.	Cardiac diseases, enlarged prostate
<i>Echinacea angustifolia</i>	Purple cone- flower, fam. Asteraceae; fresh flowering herb	Caffeic acid deriva- tives, flavonoids, essential oils, pol- yacetylene alkyla- mides, inulin and polysaccharides	Promoting wound healing, increasing granulocyte phagocytosis. Suitable peroral and parenteral preparations	Internal: increases resistance to acute and chronic infections.	Sepsis, proneness to infection

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Echinacea angustifolia</i>		(pressed juices, tinctures) are said to increase the number of leucocytes and splenic cells in the body, thus boosting phagocytosis. Increases resistance to infectious diseases, fever, colds and flu, bronchial diseases, tonsillitis, chronic inflammation, inflammation of the lower abdomen around the ovaries, fallopian tubes and uterus, prostatitis, glandular swelling, suppurative tendencies, abscess formation, furuncles, gangrene	Recurring infections in the respiratory system and efferent urinary tract. External: poorly healing superficial wounds; antiseptic		
<i>Elaps corallinus</i>	Coral snake, fam. Elapidae	The coral snake is a venomous snake about 70 cm long with coral red and black stripes. Adenosine triphosphatase, L-amino acid dehydrolase	Affects the circulation and nervous system	The venom of elapid snakes is primarily neurotoxic and only becomes effective when it has undergone pharmaceutical preparation and potentisation	Lung diseases, blood coagulation disorders
<i>Helleborus, Helleborus niger</i>	Hellebore, Christmas rose, fam. Ranunculaceae; dried root stock with roots attached	Saponin mixture (helleborin and protoanemonin), aconitic acid, essential oils	The glycosides helleborein and hellebrin and the saponin helleborin are responsible for the toxic effect. They have an irritant effect on	Traditional: emetic, cardiac insufficiency, laxative, anthelmintic, abortifacient, anti-aging, sneezing powder	Coma, encephalitis, nephritis following infectious diseases (scarlet fever, measles)

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Helleborus</i> , <i>Helleborus niger</i> (Cont.)			the mucous membranes, leading to nausea, vomiting, colic and diarrhoea. Pulse changes, respiratory distress, loss of consciousness and cardiac arrest may occur in extreme cases		
<i>Hepar sulphur</i> , <i>Calcium sulphuratum</i> <i>Hahnemanni</i>	Calcium sulphide	Hepar sulphur is a remedy used only in homeopathy. It is a yellowish brown, crystalline mixture of calcium sulphides and calcium sulphate. Preparation: equal parts of flowers of sulphur and the finely powdered white interior of oyster shells are kept for a lengthy period in a closed crucible subjected to white heat; after cooling, it is stored in closed jars.	Has a particularly powerful effect on the lymph glands, skin and bronchial mucosa. The glands are enlarged and suppurating; ulcers and eczematous rashes are found on the skin. Catarrhal conditions of the mucous membranes, may resemble croup	Hepar sulphur (kalinum) refers to calcium sulphide created by melting sulphur with calcium carbonate; it was used in medicinal baths by people suffering from skin diseases (eczema, psoriasis)	Suppuration of the skin, mucous membranes with cheesy smell, otitis media, bronchitis, digestive disorders
<i>Hirudo medicinalis</i> , <i>San-guisuga medicinalis</i>	German medicinal leech, fam. Hirudinidae	Hermaphrodite ringworm, up to approx. 20 cm long, with suckers at both ends of its body. The med. leech sucks up to 15 g blood from mammals, can go without nourishment for more than a year and has a lifespan of about 25 years	While the leech is sucking, it discharges hirudin (contained in its saliva) into the host's body to prevent blood coagulation.	External: ointments containing hirudin used to treat inflammation, blood stagnation, haemorrhoids; living leeches are used to suck and thin the blood.	Thromboses in the extremities

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeo-pathic indications
<i>Hyoscyamus,</i> <i>Hyoscyamus niger</i>	Henbane, fam. Solanaceae; whole fresh flowering plant	0.03-0.2% alkaloids: L-hyoscyamine, atropine, L-scopolamine, atroscine, cuscohygrine, choline, traces of essential oil, tannins. Henbane leaves contain high levels of scopolamine.	Henbane leaves have a parasympatholytic effect, cause mydriasis, inhibit secretions, cause paralysis via the central nervous system and have a spasmolytic effect. Symptoms of henbane poisoning are similar to those of deadly nightshade and thorn apple; they include physical restlessness, agitation, euphoria, hallucinations, palpitations, increased respiratory rate, visual and speech disturbances. The skin is hot, red and dry, the body temperature elevated.	Traditional: spasmolytic, narcotic (like Atropa belladonna, Datura stramonium). Asthma (inhalant)	Extreme agitation with hallucinations, mania, hysteria, paralysis of sphincter muscles (bladder, intestines), post-operative confusion.
<i>Hypericum,</i> <i>Hypericum perforatum</i>	St. John's wort, fam. Hypericaceae; fresh flowering aerial parts	Red dyes hypericin and pseudohypericin, flavonoids such as hyperoside and quercetin, phloroglucinols, procyanidins and catechine tannins, pectin, choline, fat, phlobaphenes, essential oils with terpenoids and sesquiterpenoids	Hypericin activates the metabolism; together with its other constituents, this plant remedy is said to have analgesic, calming, wound-healing, spasmolytic and astringent properties. Hypericin and pseudohypericin are responsible for the plant's photosensitising properties.	Traditional: dyspeptic complaints, poor appetite, anthelmintic. Internal: mild to moderate depression. Nervous exhaustion, mental strain, menopausal anxiety	Painful injuries to brain and nerves; depression

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Hypericum</i> , <i>Hypericum perforatum</i> (Cont.)			If taken internally for long periods, fair-skinned people (also animals) can become photosensitised and develop inflammatory conditions similar to sunburn.		
<i>Ignatia</i> , <i>Strychnos ignatii</i>	St. Ignatius bean, fam. Loganiaceae; dried ripe seeds	Strychnine is a poison which triggers reflex spasms. The St. Ignatius bean contains toxic alkaloids such as strychnine and brucine which cause symptoms of strychnine poisoning if an overdose is taken.	Strychnine works by paralysing inhibitory synapses. It antagonises the effect of glycine in the CNS. Painful muscle cramps, agitation, irritability, respiratory paralysis, death occurs while fully conscious.	Traditional: stimulant in cases of vasomotor collapse originating in the CNS, bitter tonic, Today obsolete, abused as doping substance	Physical and mental instability, migraine, gastritis, dysmenorrhoea, consequences of shock and disappointment
<i>Ipecacuanha</i> , <i>Cephaelis ipecacuanha</i>	Ipecacuanha root, fam. Rubiaceae; dried underground plant parts	1.8-4% alkaloids (in the bark), particularly emetine, cephalin, psyllotrine and O-methylpsyllotrine. Secondary alkaloids emetamine, protoemetamine; starch, saponins, sugar, plant acids	Secretolytic, secretomotoric, as expectorant. Overdose leads to nausea, vomiting, salivation, colicky diarrhoea, muscle weakness, cramps and loss of consciousness	Internal: Sirupus ipecacuanhae, Extractum ipecacuanhae, Ipecacuanhae extractum fluidum. Expectorant with secretolytic and secretomotoric effect. The alkaloid concentration is defined in the pharmacopoeias. Emetic (powder, tincture): a predefined amount of ipecacuanha powder is prescribed,	Vomiting, enteritis, migraine, bronchitis, diarrhoea

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Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Ipecacuanha</i> , <i>Cephaelis</i> <i>ipecacuanha</i> (Cont.)				i.e. a total alkaloid content of 1.9-2.1% is fixed and the ipecacuanha is mixed with lactose until this figure is reached.	
<i>Kalium bichromicum</i>	Potassium dichromate ($K_2Cr_2O_7$), dipotassium salts, bichromate of potash; large, dark red crystals soluble in 8 parts water.	Preparation: from chromite ($FeCr_2O_4$) or by reacting sodium dichromate solution with KCl solution. Soluble in water, insoluble in alcohol	Toxic! Toxic reactions familiar from occupational medicine. From ulcers in the nose to perforation of the nasal septum; skin eczema	Traditional: condylomas, syphilitic ulcers (externally as a caustic)	Chronic sinusitis, profuse, stringy, yellowish tracheal secretions
<i>Kreosotum</i>	Beech tar creosote; produced by distilling beech tar	The wood smoke contains cresols and other phenolics. Mixture of guaiacol, cresol, methylated phenols. Clear, slightly yellowish oily liquid, soluble in ether, ethanol, thiol, very difficult to dissolve in water	Cresols and other phenolics are responsible for inhibiting putrefactive bacteria during the smoking process. Caution: carcinogenic	Traditional: Pillulae creosoti (internal): creosote pills prepared by prescription in the pharmacies at the time of prescribed pill production. Antiseptic in cases of pulmonary tuberculosis (internal)	Consequences of diabetes (pruritus, gangrene), tooth decay, ulcerated, bleeding mucous membranes, hyperemesis
<i>Lachesis</i> , <i>Lachesis muta</i>	Bushmaster, surucucu, fam. Crotalidae; carefully dried snake venom	Venomous snake, haemagglutinins and haemolysins; snake venoms in general: ophiotox- ins, the poisonous secretions from venomous snakes, are clear, transparent, yellowish or milky fluids, odourless and slightly	Bite is deadly, toxic effect from haemagglutinins and haemolysins. Oral ingestion has little effect; effect only occurs when poison reaches the bloodstream.	Traditional: non-specific stimulation therapy, e.g. when treating rheumatic diseases	Infectious diseases, serious septic processes, abscesses, phlebitis, pulmonary embolism, rheumatism affecting the joints, dysmenorrhoea, dark bleeding

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Lachesis</i> , <i>Lachesis muta</i> (Cont.)		bitter in taste, mostly easily soluble in water. A snake usually injects several toxins simultaneously. Strongly alkaline peptides, e.g. neurotoxins with effects similar to curare; numerous enzymes, e.g. hyaluronidases (accelerate resorption), phospholipases (formation of lysolecithin; as haemolysins, they cause the disintegration of erythrocytes); proteases: e.g. haemorrhagins (harmful to capillaries), proteases which influence blood coagulation (haemagglutinins, prevent coagulation)			
<i>Laurocerasus</i> , <i>Prunus laurocerasus</i>	Cherry laurel, fam. Rosaceae; fresh leaves	Approx. 1.5% cyanogenic glycosides (bark, buds, seeds), prunasin, emulsin, sugar, tannins	The cyanogenic glycosides are responsible for symptoms of poisoning	Traditional: the essential oils were extracted by steam distillation and used for spasmodic coughs, asthma and colic. Cherry laurel water was used as a spasmolytic.	Right heart failure

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Lycopodium</i> , <i>Lycopodium clavatum</i>	Wolfs foot clubmoss, stag's horn clubmoss, ground pine, fam. Lycopodiaceae	Fatty oil (up to 50%); palmitic oil, stearic oil, arachidic oil, linoleic acid, myristic acid, sporonin (polymeric terpene), hydrocaffeic acid, traces of alkaloids (clavatin, clavatoxin and lycodin) and silicon	The substances in lycopodium are responsible for its diuretic, spasmolytic and analgesic effects and for its ability to strengthen the liver. Incorrect dosage can cause inflammation of the mucous membranes, vomiting and diarrhoea, cramps and coma.	Traditional: as a tea for kidney, prostate and bladder disorders, for diarrhoea (internal), exudative eczema, pruritus (external), as wound powder. Lycopodium spores were formerly used in pharmacies as separation agents during pill production to prevent the pills from sticking together.	Chronic liver diseases with digestive disorders, kidney and gallstones, gout, skin diseases
<i>Mercurios solubilis</i> , <i>Mercuris solubilis</i> <i>Hahnemanni</i>	Soluble mercury as per Hahnemann, Hydrargyrum oxydulatum nitricum ammoniatum	Mixture of dimercurous ammonium nitrate, metallic mercury and mercury(I) oxide $\text{NH}_2\text{Hg}_2\text{NO}_3$	Mercury boosts the reticuloendothelial system's ability to fight inflammatory processes. Most mercury is ingested with food and is primarily stored in the liver, kidneys and brain. Metallic mercury passes through the gastrointestinal tract unchanged. Absorbable compounds and mercury vapours are toxic. Mercury compounds are some of the most powerful inorganic poisons (plasma toxins) in existence.	Mercury compounds were used to treat syphilis. Today obsolete, in amalgams. Ointments: Unguentum Hydrargyri cinereum, Emplastrum Hydrargyri	Chronic inflammation of the skin, mucous membranes and lymph nodes with suppurative tendencies, tonsillitis, slimy diarrhoea, extreme night sweats

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Mercurius solubilis</i> , <i>Mercuris solubilis</i> <i>Hahnemanni</i> (Cont.)			Acute poisoning: salivation, stomatitis, gastroenteritis, colitis, colic, bloody diarrhoea, nephritis. Chronic poisoning: fatigue, headache and aching limbs, salivation, stomatitis, diarrhoea, later central nervous symptoms such as anxiety, agitation, muscle twitching, speech impediments, personality breakdown		
<i>Myristica sebifera</i> , <i>Virola sebifera</i>	Red ucuuba, fam. Myristicaceae; red juice extracted by scratching the bark	Myristin, olein, free fatty acids	<i>Myristica sebifera</i> has an antiseptic effect on the skin, cell tissue and periosteum.	Traditional: rheumatic diseases (Brazil), wounds (tea made from bark decoction)	Suppuration, abscesses, "homeopathic knife". Inflammation of traumatic origin, whitlows, phlegmons
<i>Naja naja</i> , <i>Naja tripudians</i>	Indian cobra, spectacled cobra, fam. Elapidae; carefully dried venom	Cobra toxin, strongly alkaline polypeptides (neurotoxins)	Directly affects the CNS, where it paralyzes the respiratory centre and causes systolic cardiac arrest. Cobra venom is important in medical research, as the enzyme lecithinase can be effectively used against viruses.	External: rheumatic diseases, analgesic (ointments)	Acute coronary ischaemia, heart diseases, acute and chronic myocarditis, endocarditis, conduction disorders, septic processes

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Nux vomica</i> , <i>Strychnos nux vomica</i>	Strychnine tree, poison nut, fam. Log-aniaceae; dried ripe seeds	Monoterpenoid indole alkaloids strychnine, brucine, pseudostrychnine, vomicine, colubrine, chlorogenic acid, fatty oil, phytosterol	One of the main ingredients - strychnine - irritates the spinal cord and its nerves, which is why the plant was earlier seen as an important cure for paralysis, particularly of the lower extremities. The poison nut was also used to treat whooping cough, malaria and asthma. Just 20 mg of the powdered seeds will produce signs of acute strychnine poisoning shortly after ingestion; these include contraction of the skeletal muscles and hyperextension of the spine. Death results from paralysis of the respiratory centre.	Internal: tonic and bitter substance used as a stimulant in cases of debilitation. Extractum Strychni, Tinctura strychni. Semen strychni pulvis Today obsolete	Intoxication caused by medication, muscle stiffness, dyspepsia with constipation, gastritis, undesirable sideeffects of medication, detoxification from poisons and medication, draining the gastrointestinal tract.
<i>Phosphorus</i>	Phosphorus, yellow (white) phosphorus, P	Greek "light bearer"; this description applies to the toxic yellow form which shines in the dark on oxidising. Yellow (white) phosphorus: yellowish-white waxlike mass (mostly in sticks), smokes in contact with air, glows in the dark. Must be stored under water and protected from	Phosphorus is one of the most important elements in the body, as it is a building block for DNA and RNA and is also responsible for metabolising energy. The most important targets are the organs and functional systems of the bodily and cellular metabolism.	Yellow phosphorus is not used in medicine because of its toxicity and reactivity. Only after galenic homeopathic preparation can this substance be used as a remedy.	Pneumonia, epistaxis, exhaustion, liver diseases (liver dystrophy), eye diseases, hyperactivity in children, light-coloured bleeding

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
Phosphorus (Cont.)		light. Ignites easily, burns with bright flame, converting into phosphorus pentoxide Only occurs naturally in salts (orthophosphoric acid, phosphates, calcium, iron and aluminium compounds), animal organisms (blood, protein, cytoplasm, lecithin, nucleoproteins, phosphoproteins, brain substance, muscle fibres, teeth, bones, mussel and crustacean shells). Toxicology: dissolved phosphorus is resorbed in the gastrointestinal tract (not however large pieces of solid phosphorus). After 2 or 3 days with symptoms, metabolic disorders manifest with jaundice, liver swelling, diarrhoea, internal bleeding. LD for adults: 60 - 100 mg (dissolved)			

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Plumbum</i>	Lead, Pb	In nature, lead occurs most frequently as galena (PbS).	Pb and all Pb compounds are highly toxic. Acute lead poisoning after intake of large quantities of inorganic lead compounds: intestinal colic, anaemia (from damage to erythrocytes), damage to liver, kidneys and CNS. Ongoing intake of inorganic lead compounds: anaemia, dark discoloration of the gum line, intestinal spasms, paralysed extremities, pale grey skin	External: lead (II) acetate as anti-inflammatory remedy in eyewashes and compresses. Internal: 1% solution as astringent and haemostatic remedy for bleeding from the stomach and intestines	Gastrointestinal colic, neuritis, muscle atrophy, paralysis, anaemia, sclerosis
<i>Podophyllum peltatum</i>	May apple, hogapple, fam. Berberidaceae; fresh root stock harvested when the fruit is completely ripe	4-6% resin, min. 3.5% podophyllin, lignans, podophyllotoxin, a and p-peltatin. Podophyllin: yellow amorphous powder. Effect: mitotic toxin, teratogenic, contraindicated during pregnancy	Podophyllin stimulates intestinal peristalsis, leading to explosive defecation. In cases of overdose, the substances podophyllin, podophyllotoxin and peltatin stimulate intestinal movement and create inflammation in the gastrointestinal tract with irritation of the rectum and haemorrhoids.	Internal: cytostatic (etoposide, itoposide, teniposide). External: condylomas (10% solution)	Liver diseases, gallstones, severe diarrhoea, haemorrhoids

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Pulsatilla</i> , <i>Pulsatilla pratensis</i>	Pasque flower, fam. Ranunculaceae; fresh whole plant collected while flowering	Ranunculin breaks down into protoanemonin and anemonin, bitter substances, tannins	Highly irritant to the mucous membranes. The plant loses its toxicity when dried as the toxins break down during the drying process.	Traditional: kidney and bladder disorders, gout, rheumatic diseases, general agitation, diseases in the genital area.	Diseases during or following pregnancy, gastrointestinal disorders, venous congestion, menstrual and cyclical disorders, depression
<i>Pyrogenium</i>	Pyrogenium nosode	Extracted from autolysed bullock meat	Pyrogenium is a powerful antiseptic and causes restlessness	Only used in homeopathy	Septic fever with shivering, fever with foulsmelling diarrhoea. Threat of cardiac arrest from infectious diseases and sepsis
<i>Rhus toxicodendron</i> , <i>Toxicodendron quercifolium</i>	Poison ivy, fam. Anacardiaceae; fresh leaves	The entire plant contains a milky sap which turns black when exposed to air and is responsible for the toxic effect. The white sap contains urushiol, a mixture of catechols, tannins, gallic acid, flavonoids	Urushiol, a phenol derivative, is one of the most powerful contact allergens. Even the most fleeting contact can cause severe inflammation (known as rhus dermatitis). Itchy skin, blistering and hives which can become infected when they burst. Swelling, fever and pain in the joints and muscles have been observed. Contact with the eyes can lead to conjunctivitis and keratitis. Severe symptoms of poisoning such as gastroenteritis and bloody diarrhoea occur if taken orally.	This drug is not used in allopathic medicine because of its extreme toxicity.	Rheumatic complaints before falling ill, better with continued movement and warmth, worse in warm bed, restlessness

4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Solidago virgaureo</i>	Goldenrod, fam. Asteraceae; fresh inflorescences	Flavonoids: ruto- side, quercitrin, astragalín, triterpenoid saponins, polygalacic acid as sapogenin	Diuretic, antiphlogistic, slightly spasmolytic	Traditional: gout, rheumatic diseases. Internal: inflammatory disorders of the efferent urinary tract, kidney stones and gravel. External: inflammation in the throat and oral cavity	Renal inflammation, reduced kidney function, enlarged prostate, gout, kidney drainage
<i>Staphisagria Delphinium staphisagria</i>	Larkspur, delphinium, fam. Ranunculaceae; dried ripe seeds	Alkaloids similar to aconite: delphinine (ester alkaloid), staphisagrín, delphisine, delphinoidine	The toxic effect is mainly caused by delphinine, staphisagrín, delphisine, delphinoidine	Traditional: worms, laxative. Today obsolete	Consequences of psychological suppression and insult, itchy eczema, styes, stab wounds, problems with surgical wounds, prostatitis, vegetative dystonia
<i>Stramonium, Datura stramonium</i>	Datura, fam. Solanaceae; fresh herb collected while blossoming	0.2-0.5% tropane alkaloids, mainly L-hyoscyamine, some atropine, L-scopolamine (quantity depends on age of plant), belladonnine, apoatropine, tannins, flavonoid glycosides, umbelliferone, scopoline	The most striking symptoms of datura poisoning are meaningless actions, fits of laughter, bizarre behaviour, frenzy. The first signs of poisoning are restlessness, general agitation succeeded by crying fits, accelerated breathing, palpitations, increased blood pressure, fixed pupils, visual and speech disturbances, hot, dry skin and fever.	Traditional: asthma cigars. Internal: hypnotic, antispasmodic (atropine), asthma, paroxysmal coughing, biliary colic, mental disorders such as mania, hallucinations, delirium, hysteria. Today obsolete	Mental disorders, violent agitation, sleep disorders in small children

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Strophanthus gratus</i>	Strophanthus seeds, fam. Apocynaceae; ripe dried seeds with the awn removed	G-strophanthin (ouabain), cardenolides, fatty oil, saponins, trigonelline, resin	G-strophanthine works like digitalis. Overdosing on strophanthin causes nausea, vomiting, diarrhoea, flushing, tinnitus, oscillopsia and cardiac anxiety. Initially an acceleration of the pulse becomes noticeable; this may progress through bradycardia to a barely perceptible pulse and loss of consciousness. The skin becomes cyanotic, the pupils narrow with no reflexes, the face and feet become oedematous.	Historical: coronary sclerosis, myocarditis, arrhythmia, cardiac insufficiency, angina pectoris	Heart diseases
<i>Sulphur</i>	Sulphur, Sulphur sublimatum	Occurs naturally in the form of sulphur flowers which precipitate out of volcanic steam in yellow rhombic crystals. The typical odour of sulphur is characteristic. Sulphur is one of the most important organic elements and occurs everywhere in nature. Organically bound (component of proteins). Sulphur bacteria (thiobacteria) are able	Irritates the mucous membranes in the intestines; H ₂ S produced by bacteria stimulates peristalsis. Chronic intoxication leads to disorders of the fat metabolism and CNS.	Traditional: laxative. External: acne, eczema (powder, ointments made with sulphur depuratum = purified sulphur)	Acute and chronic skin diseases, reactive remedy when homeopathic treatment does not take effect, skin diseases, skin drainage, intoxication with medication

I 4 Remedy production and quality

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Sulphur</i> (Cont.)		to oxidise the H ₂ S formed when proteins decay and to store the sulphur formed in their organisms. Occurs freely (Sicily, North America, Japan) and as part of compounds: in the form of sulphides (iron, chalcopyrite, galena) and sulphates (gypsum, Epsom salts, Glauber salts)			
<i>Tabacum</i> , <i>Nicotiana tabacum</i>	(Virginia) tobacco, fam. Solanaceae; dried unfermented leaves	The most important active substances are nicotine, other alkaloids: L-nornicotine, DL-nornicotine, nicotyrine, nicotine; pyrrolidine, asparagine, allantoin, coffee tannins, gallic acid, enzymes, nitrates. Nicotine quantities vary (0.08-9%); the leaf tips contain the most nicotine.	Nicotine affects the vegetative ganglia, initially as a stimulant by depolarising the post-synaptic membrane; if taken for longer, the sustained depolarisation leads to paralysis. The secretion of vasopressin also causes blood pressure to rise. Symptoms of poisoning: circulatory collapse, vomiting, diarrhoea, cramps, respiratory paralysis	Traditional: stubborn constipation, colic, worms (enema). Tobacco, snuff.	Cardiovascular diseases, dizziness, circulatory collapse particularly after nicotine poisoning.
<i>Tarentula hispanica</i> , <i>Lycosa tarentula</i>	Wolf spider, fam. Lycosidae, whole spider killed and macerated in alcohol	The poison contains a proteolytic enzyme. The body fluids, particularly of fertilised females, contain arachnolysine,	<i>Tarentula hispanica</i> overstimulates the nervous system, leading to hyperactivity and exceptional industriousness.	There is no known allopathic use for this toxin.	Sexual overexcitability, involuntary muscle twitches, restless legs syndrome, better from music

4.6 ICU remedy kit

Homeopathic name Title of HP monograph	English description of homeopathic source material	Contents	Effect	Allopathic indications	Frequent homeopathic indications
<i>Tarentula hispanica</i> , <i>Lycosa tarentula</i> (Cont.)		a haemolytic toxin containing thrombokinase. Lycosatoxins are cytotoxic			
<i>Veratrum album</i>	White hellebore, fam. Melianthaceae; dried root stock with roots	The main active ingredients are the extremely toxic veratrum alkaloids such as protoveratrine A and B, germarine	<i>Veratrum album</i> works via the cerebrospinal nervous system, particularly on the entire vegetative nervous system.	Traditional: tinctura veratri for cardiac arrhythmia, emetic, neuralgia, rheumatic diseases	Collapse, diarrhoea, vomiting, dysmenorrhoea, psychosis, post-operative shock with cold perspiration on the forehead and pale face, weak, rapid pulse
<i>Vipera berus</i>	Adder, fam. Viperidae; dried venom	The toxin mainly consists of proteolytic proteins and proteides	Cytolytic, haemolytic	No allopathic indications known	Poor circulation, thromboses, paralysis, worse if limbs are allowed to hang
<i>Viscum album</i>	Mistletoe, fam. Viscaceae; fruits and sprouts with leaves freshly harvested in autumn	Evergreen hemiparasitic shrub which grows on various conifers and deciduous trees. The various subspecies are differentiated according to the tree on which they grow. Active substances: viscotoxin, lectins, polysaccharides, choline, viscine, inositol, ursolic acid, quercetin, magnesium	The cytotoxic effect is under discussion; immunomodulation (mistletoe lectins), counteracts tumour growth by triggering apoptosis (viscotoxins), reduces blood pressure. If an overdose is taken, the concentration of viscotoxins can cause gastrointestinal symptoms, vomiting and diarrhoea with bloody stools.	Traditional: hypertension, heart remedy, vasodilatory, strengthens the heart, styptic, spasmolytic. Internal: inflammatory joint diseases, malignant tumours	Hypertension, peripheral circulatory disorders, arteriosclerosis

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Intensive care medicine

Michael Frass

1 Infectious diseases

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- 1.1 Sepsis
- 1.2 Serious local infections
 - 1.2.1 Ludwig's angina (Quinsy)
 - 1.2.2 Hip joint abscess

1.1 Sepsis

Conventional medicine

Definition

Roger C. Bone's definition of sepsis (1998) is the most commonly accepted version: sepsis is an infection defined as a microbial phenomenon and characterised by an inflammatory response to the presence of microorganisms or the invasion of normally sterile tissue by such organisms. At least two of the following criteria must be positive:

- Body temperature $< 36^{\circ}\text{C}$ or $> 38^{\circ}\text{C}$.
- Pulse > 90 beats/min.
- Respiratory frequency > 20 breaths/min. or $\text{PaCO}_2 < 32$ mmHg.
- Leucocytes < 4 or > 12 g/l or more than 10% immature granulocytes.

If the patient has arterial hypotension which cannot be controlled by volume expansion and is causing organ dysfunction or hypoperfusion abnormalities, he is said to be suffering from septic shock (ACCP-SCCM criteria: American College of Chest Physicians, Society of Critical Care Medicine Consensus Conference).

Clinical information

Incidence and mortality

In the USA, sepsis affects 70,000 to 750,000 patients each year. Septic shock is associated with mortality rates of 40-90%. Despite a wide variety of therapeutic

strategies, mortality rates have remained virtually unchanged over the last few decades. The latest guidelines recommend "early goal-directed therapy" (cf. emergency measures below): artificial respiration with low tidal volumes, treatment with recombinant protein C (aPC), intensive blood sugar monitoring with a target measurement of 80-110 mg/dl (4.4-6.6 mm/L) and the administration of hydrocortisone. Despite the increased efforts made by intensive care units, the mortality rates for severe sepsis and septic shock are still very high. Guidelines have therefore been developed for clinicians with the aim of improving survival rates in such cases.

Symptoms

The initial symptoms of sepsis are often atypical; symptoms of organ dysfunction may be the first to appear. It may take some time to find evidence of bacterial, viral or mycotic pathogens. It is therefore advisable to have laboratory tests performed as soon as possible as well as carrying out clinical examinations. Sepsis mostly begins with clinical symptoms which must be recognised quickly by the attending physician and nursing staff. These include the symptoms listed in the definition such as fever or hypothermia, leucopenia or leucocytosis, tachycardia and tachypnoea.

Mental changes, reduced urine output, hypotension and elevated liver enzymes are signs of organ dysfunction and can be classified as late symptoms.

1 Infectious diseases

Diagnosis

Inflammatory markers

The new inflammatory markers are more specific for diagnosing sepsis than conventional parameters (clinical signs, lactate, C-reactive protein, leucocyte numbers). The modern sepsis markers include **procalcitonin (PCT)**, cytokines such as **interleukin-6 (IL-6)** and others, e.g. **LBP (lipoproteinbinding protein)**. IL-6 correlates well with the degree of sepsis and reacts to inflammatory stimuli within a few hours. IL-6 is therefore frequently used to diagnose sepsis in newborns, although it is relatively unstable and not specific to sepsis. C-reactive protein (CRP) is stable and indicates infections very quickly; however, these figures rapidly reach a maximum in ICU patients and correlate only moderately with the severity of the disease, particularly in view of the lengthy reaction time (induction period 6-48 hours). The normalisation of CRP and LBP can lag several days behind, even after the inflammatory focus has been eliminated.

In summary, it can be said that the use of new inflammatory markers can be clinically meaningful in certain patients and can enhance the diagnostic possibilities available. However, it is important always to interpret laboratory figures in connection with the clinical data.

Imaging techniques

In addition, diagnostic tests should be performed as early as possible in order to find the focus of the infection and the organisms responsible. These specifically encompass imaging techniques such as x-rays (e.g. orthopantogram), ultrasounds of the heart and abdomen, computed tomography and magnetic resonance imaging. Other tests can be performed using methods employed by nuclear medicine. Endoscopic tests can also help find the focus.

Blood cultures

It is advisable to set up corresponding blood cultures before commencing any antimicrobial therapy. At least two blood cultures should be set up, one sample being obtained percutaneously and one from each artificial vascular access (except for catheters inserted within the

Therapy

Therapeutic crisis

Sepsis is acknowledged to be the leading cause of death in intensive care units (Machiedo et al. 1981). This is especially true when the patient is admitted with an infection as the primary diagnosis or if an intercurrent complication such as shock or trauma is the reason for admission. Postoperative patients are particularly susceptible to infection; it often also turns out to be very difficult to identify these postoperative infections.

In recent decades, the direct cause of death in sepsis patients being treated in intensive care units has changed. Earlier, the majority of patients died of septic shock as a result of infections, the most prominent clinical signs of which were **haemodynamic changes**. Improvements in monitoring and a better understanding of these changes mean that **multiple organ failure** has now taken over as the primary cause of death in septic patients receiving treatment in ICU (Fry et al. 1980).

Despite intensive allopathic treatment, the prognosis for sepsis has not significantly improved. The additional administration of homeopathic treatment is therefore justifiable in these patients.

Homeopathic treatment

The beneficial effect of homeopathic treatment on ICU patients has been observed on several occasions; the concurrent administration of homeopathic remedies therefore seems appropriate.

Study

Additional homeopathic treatment of patients with severe sepsis. A randomised, double-blind, placebo-controlled study in an intensive care unit (Frass et al. 2005):

Despite modern therapeutic strategies, the incidence of severe sepsis is very high. The idea was therefore to administer additional homeopathic treatment and investigate the effects on the survival of critically ill patients. The aim of this prospective, randomised, double-blind, placebo-controlled study was to examine the influence of homeopathy on the survival of patients suffering from severe sepsis at two points in time (30 and 180 days).

1.1 Sepsis

The study comprised 67 patients who had been admitted to an internal intensive care unit. Bone's criteria for diagnosing severe sepsis were applied. The patients included had a known or suspected infection, fulfilled at least three of the four criteria for sepsis and were suffering from failure of at least two organs. The homeopathic treatment began within 48 hours of ascertaining fulfilment of the criteria for inclusion.

Within 24 hours, the patients were randomised into two groups and received either homeopathic treatment (n=33) or a placebo (n=34). The patients were given this treatment until they were transferred to the general ward; the choice of remedy was free and the potency limited to 200C globules administered twice a day. The patients were examined again 180 days after beginning treatment.

No side-effects from homeopathic medication were observed at any point during the study. There was no discrepancy in patient characteristics and intensive medical intervention between the groups. On day 30, an insignificant survival trend was observed in favour of the homeopathy group (Verum 81.8%, placebo 67.7%, $p = 0.19$). On day 180, survival in the Verum group was statistically significantly higher (Verum 75.8%, placebo 50.0%, $p=0.043$). The most frequently prescribed remedies were *Apis mellifica*, *Arsenicum album*, *Baptisia*, *Bryonia alba*, *Carbo vegetabilis*, *Crotalus horridus*, *Lachesis muta*, *Lycopodium clavatum*, *Phosphorus* and *Pyrogenium*. This data indicates that additional homeopathic treatment may have a positive long-term effect on patients with severe sepsis. Further application of this method therefore seems to be meaningful.

Symptom selection

The fact that most of the patients were unable to communicate meant that the choice of symptoms frequently had to be based on clinical observations. Remarks by relatives and nursing staff were also taken into consideration. Relatives were able to provide important information about the patients temperament. This is why the remedy descriptions include mood and other symptoms which cannot be communicated directly

The following points were given special consideration:

- Triggers (e.g. inflammatory focus, trauma, physical or psychological shock, joint inflammation, pregnancy)
- Fever (temporal modalities)
- Agitation
- Respiratory effort
- Secretions: nose, mouth, stomach, intestines, drains
- Changes in blood coagulation with modalities
- Embolic processes, thrombotic incidents
- Skin changes

COMPLETE REPERTORY MILLENNIUM

Blood - septicaemia, blood poisoning, pyaemia

Achy., *Aeon.*, *Agar.*, *Ail.*, *Am-c.*, *Ant-t.*, *Anthr.*, *Apis*, *Apisin.*, *Aq-mar.*, *Arg.*, *Arg-n.*, *Arist-cl.*, *Arn.*, *Ars.*, *Ars-i.*, *Arum-t.*, *Asaf.*, *Atro.*, *Aur.*, *Bapt.*, *Bar-c.*, *Bell.*, *Bor-ac.*, *Both-1.*, *Bry.*, *Bufo.*, *Calc.*, *Calc ar.*, *Calen.*, *Carb-ac.*, *Carb-v.*, *Cench.*, *Cham.*, *Chin.*, *Chin-ar.*, *Chin s.*, *Chlorpr.*, *Colch.*, *Con.*, *Conch.*, *Crot-c.*, *Crot-h.*, *Dor.*, *Echi-a.*, *Elaps.*, *Eucal.*, *Ferr.*, *Ferr-p.*, *Gels.*, *Graph.*, *Gunp.*, *Hell.*, *Hep.*, *Hippos.*, *Hydro-c.*, *Hyos.*, *Iod.*, *Ip.*, *Irid.*, *Kali-bi.*, *Kali-br.*, *Kali-c.*, *Kali-chl.*, *Kali-ma.*, *Kali-p.*, *Kreos.*, *Lach.*, *Lat-h.*, *Laue.*, *Led.*, *Lob-p.*, *Lyc.*, *Mag-c.*, *Maland.*, *Mang.*, *Merc.*, *Merc-cy.*, *Methyl.*, *Mur-ac.*, *Naja.*, *Nat-m.*, *Nat-s-c.*, *Nit-ac.*, *Nux-v.*, *Op.*, *Paro-i.*, *Ph-ac.*, *Phos.*, *Phyt.*, *Pub.*, *Pyrog.*, *Rad-br.*, *Raja-s.*, *Rhus-t.*, *Ruta.*, *Sal-ac.*, *Sarr.*, *Sec.*, *Sep.*, *Septi.*, *Sieg.*, *Sil.*, *Staph.*, *Staphycoc.*, *Stram.*, *Strept.*, *Sul-ac.*, *Sulfonam.*, *Sulph.*, *Tarax.*, *Tarent.*, *Tarent-c.*, *Fer.*, *Trach.*, *Vario.*, *Verat.*, *Verat-v.*, *Vip.*, *Zinc.*

- Adynamia

Elaps, Pyrog.

- Delivery, parturition, after

Arn., *Ars.*, *Echi-a.*, *Lach.*, *Lyc.*, *Op.*, *Phos.*, *Puls.*, *Pyrog.*, *Rhus-t.*, *Sec.*, *Sulph.*

- Delivery, parturition, after - lochia, from suppressed

Lyc., *Sulph.*

Chill, sepsis, in

Pyrog., *Tarent-c*

Fever, heat - septic fevers

Acet-ac., *Ail.*, *Am-c.*, *Anthr.*, *Apis*, *Arg-n.*, *Arn.*, *Ars.*, *Bapt.*, *Bell.*, *Berb.*, *Bry.*, *Bufo.*, *Cadm-s.*, *Carb-ac.*, *Carb-v.*, *Carbn-s.*, *Chin-ar.*, *Crot-c.*, *Crot-h.*, *Cur.*, *Echi-a.*, *Elaps.*, *Ferr.*, *Ferr-p.*, *Kali-bi.*, *Kali-p.*, *Kreos.*, *Lach.*, *Lyc.*, *Merc.*, *Merc-cy.*, *Mur-ac.*, *Naja.*, *Nit-ac.*, *Op.*, *Ph-ac.*, *Phos.*, *Puls.*, *Pyrog.*, *Rhus-t.*, *Rhus-v.*, *Sul-ac.*, *Sulph.*, *Tarent.*, *Tarent-c.*, *Verat.*, *Verat-v.*, *Vip.*

- Miscarriage, after

1 Infectious diseases

Differentiation between important homeopathic remedies Critical commentary

Important remedies: *Arsenicum album*, *Belladonna*, *Lachesis*, *Phosphorus*, *Pyrogenium*.

Arsenicum album is characterised by severe cardiovascular failure; these patients are extremely anxious.

Belladonna patients are agitated and restless; their heads are hot and they perspire profusely.

Lachesis patients have problems on the left side of the body, are prone to thromboembolic incidents and tend to have bleeding problems, particularly at points where catheters have been inserted.

Phosphorus patients are generally prone to bleeding, particularly bright red (arterial) blood.

Pyrogenium is particularly indicated for septic processes caused by blood poisoning (red linear markings of lymphangitis and cellulitis); changes in position make the condition worse. *Lachesis* is mentioned as a follow-up remedy.

Despite the advanced technology now available in the field of intensive medicine, sepsis is still a very serious disease. Intensive treatment facilitates the survival of patients who just a few decades ago would have been viewed as terminal cases. During the phase of limited organ functioning, the main task of intensive medicine is to compensate for the malfunctioning or non-functioning organs. Intensive care and extensive monitoring of vital functions facilitate precise observation of the patient's progress after receiving homeopathic treatment, which can be particularly helpful when evaluating his initial response.

Homeopathic treatment in cases of sepsis may be successful despite the many associated difficulties. The following case studies do not provide any clear or direct proof of the effectiveness of homeopathy, but in view of the patients progress in each case, the results of the homeopathic treatment is certainly open to informed discussion (Master 2002).

Case 1.1-1: Sepsis from perforated duodenal ulcer

Marcus Zulian Teixeira

Anamnesis

74-year-old female patient with eructation and abdominal colic in the epigastric area, normal stool.

Acute event

On arrival at Accident and Emergency, the patient is alert, oriented and has no neurological abnormalities. The examination reveals normal respiration, normal pulmonary auscultation, no cyanosis, rhythmic pulse with normal pulse rate and rhythm, blood pressure 150/80 mmHg. The abdomen is soft; pain on palpation of the epigastric area, loud borborygmi were heard during auscultation.

(e.g. Buscopan); she receives tramadol (e.g. Tramal), cimetidine (e.g. Tagamet) and further analgesia and is admitted as an inpatient.

22 hours later: the pain is worse despite the administration of analgesics. The patient has dyspnoea, hypotension (blood pressure 100/60 mmHg), tachycardia and abdominal rebound pain. An abdominal x-ray reveals the suspected pneumoperitoneum; an exploratory laparotomy is therefore performed. During the operation, a perforated duodenal ulcer is discovered with severe peritonitis and extensive secretions in the abdominal cavity. The edges of the ulcer are resected and the duodenum closed. The patient suffers hypotension (blood pressure 60/40 mmHg), tachycardia and metabolic acidosis during the operation.

32 hours later: after the operation, the patient is intubated and artificially ventilated with 70% FiO₂

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at a saturation of 96% and is admitted to intensive care. She is somnolent, only opens her eyes on stimulation, is pale, has hypothermia (35°C) and is dehydrated with a thin, rapid pulse.

The interesting thing is that she still has a moist tongue despite suffering from shock. Heart rate 130/min, mean arterial pressure 45-50 mmHg with dopamine 10 µg/kg/min. An arterial blood gas analysis shows a state of compensated metabolic acidosis. BUN 82, creatinine 1.2, leucocytes 4700 with shift to metamyelocytes, 1NR 1.8, GOT, GPT and erythrocytes normal.

38 hours later: after a visit from relatives, whom she recognises and with whom she communicates by signs, the patient suffers an attack of rapid atrial fibrillation with a heart rate of 200/min. A sinus rhythm is restored on administering amiodarone (e.g. Cordarex®). 900 ml secretions aspirated via the nasal tube.

40 hours later: homeopathic treatment begins.

Diagnoses

Perforated duodenal ulcer with acute peritonitis, septic shock.

Conventional treatment

Sonography, abdominal x-ray, exploratory laparotomy, intubation and artificial respiration.

Medication

Buscopan® as infusion, tramadol (e.g. Tramal®), cimetidine (e.g. Tagamet®). Antimicrobial treatment with imipenem (e.g. Zienam®) and vancomycin (e.g. Vancocin®). Dopamine 10 µg/kg/min.

Homeopathic treatment

Ranking of homeopathic symptoms in serious acute cases (Teixeira 2001):

- Etiological, clinical, pathoanatomical diagnosis: - Generalities - septicaemia
- Normal and pathognomonic symptoms of the disease with its typical modalities:
 - Generalities - pulse abnormally rapid, out of proportion to temperature
- Localised mental and general symptoms which occur

- Mouth - smooth, shining, glazed, glistening, glossy tongue
- Mouth - discolouration - tongue - red
- Symptoms or conditions arising from the acute disease (pathological symptoms):
 - Abdomen - inflammation
 - General - wounds, dissecting

Repertorisation

REPERTORIUM	HOMEOPATHICUM	DIGITAL	II	-
		ELECTRONIC	EDITION	

Generalities - septicaemia

Generalities - pulse abnormally rapid, out of proportion to temperature

Mouth - smooth, shining, glazed, glistening, glossy tongue

Mouth - discolouration - tongue - red

Abdomen - inflammation

Generalities - wounds, dissecting

Differentiation between remedies

While there are numerous potential remedies for sepsis, the symptom "Generalities - pulse abnormally rapid, out of proportion to temperature" indicates *Pyrogenium*. Wound dissection is also found with *Lachesis*.

Prescription

Single dose of 5 drops *Pyrogenium* 30C. Continuation of conventional treatment and additional administration of noradrenaline (0.6 mg/h).

Progress

Six hours after administration of remedy: temperature 37.5 °C, heart rate 120/min., mean arterial pressure 68 mmHg, diuresis 2 ml/kg/min. (880 ml/6 h). Full pulse with increased blood flow. Twelve hours after administration of remedy: temperature 37 °C, heart rate 82/min., mean arterial pressure 89 mmHg. Dopamine dosage changed (8 µg/kg/min.) and noradrenaline administered (1 mg/h). Diuresis 2.3 ml/kg/min. (980 ml/6 h). The nasal tube drained 100 ml in twelve hours.

18 hours after administration of remedy: temperature 36 °C, heart rate 85/min and mean arterial pressure 96

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(700 ml/6 h), the nasal tube drains 20 ml/h, FiO₂ reduced to 30%.

24 hours after administration of remedy: temperature 36.9 °C, heart rate 80/min. and mean arterial pressure 99 mmHg with the same medication. Diuresis 3.3 ml/kg/min. Another episode of arrhythmia with acute atrial fibrillation during a visit from relatives.

48 hours after administration of remedy: temperature 36.8 °C, heart rate 77/min. and mean arterial pressure 97 mmHg with the same medication. Diuresis 2.6 ml/kg/min.

96 hours after administration of remedy: extubated ten hours previously with normal temperature, heart rate and mean arterial pressure; no vasoactive medication. Diuresis 3.3 ml/kg/min. (5680 ml in 24 h). The patient is receiving infusions (3000 ml/24 h) and a liquid diet.

Seven days after administration of remedy: discharged from ICU with a light oral diet.

Ten days after administration of remedy: antibiotics with imipenem and vancomycin ends. Twelve days after administration of remedy: discharged from hospital.

Evaluation

The organ systems affected, the cardiovascular system and the lungs, recovered after 48 hours. Such a rapid recovery in patients with acute abdomen and peritonitis is not commonly observed, particularly not in older patients. The gastrointestinal tract healed without complications after the operation. One interesting observation was the extended period of polyuria without dehydration, which continued even after the patient's serum creatinine levels had returned to normal.

Critical commentary

This case study shows the patient's rapid response to the correct potentised remedy, even in the presence of lung and cardiovascular failure caused by sepsis.

Case 1.1-2: Sepsis from bilateral interstitial pneumonia

Marcus Zulian Teixeira

Anamnesis

53-year-old patient with hypertension who has been receiving treatment with beta blockers (e.g. Atenol[®]) and ACE inhibitors (e.g. Capoten) for four years. Known diabetes mellitus II treated with diet; obesity (113 kg at 1.53 m). He complains of colicky pain in the lumbar area radiating to his right side. The pain is accompanied by nausea and does not improve with Buscopan. Physical findings normal except for blood pressure of 230/130 mmHg. The urologists diagnose suspected acute pyelonephritis, treatable in the outpatient clinic, and discharge the patient.

Acute event

Two days later, the patient is admitted as an inpatient and transferred to the intensive care unit the next day with acute respiratory insufficiency and suspected myocardial infarction with pulmonary oedema.

Four days later: no improvement in the patient's condition; he is responsive and oriented. For eight days, the patient has been feeling generally ill as with flu but without typical influenza symptoms. For four days, he has had progressive dyspnoea and thoracic pain which worsens on inhalation. He has no symptoms of cardiac or gastrointestinal disease. The patient has hypoxia despite a breathing mask with 50% FiO₂. Tendency towards hypotension, hypothermia, oliguria. Crepitation in the mid-section of both lungs. The patient is very agitated; he wants to leave ICU and go home. He refuses to stay in the room alone and is afraid of dying. The chest x-ray shows a shadow in the mid-section of the right lung, and the interstitium of the other sections is diffusely infiltrated on both sides. Leucocytosis with marked left shift, increased BUN (129 mg/dl) and creatinine (2.1 mg/dl).

Five days later: little improvement, ventilated with 80% FiO₂. Homeopathic treatment commences.

Diagnoses

Bilateral interstitial pneumonia, acute respiratory

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inflammatory response syndrome (SIRS), metabolic syndrome.

Conventional treatment

Chest x-ray: interstitial pneumonia on both sides.

Breathing mask.

Medication

The patient receives antimicrobial treatment, the antihypertensive medication is discontinued because of the patients hypotensive tendencies.

Homeopathic treatment

Ranking of homeopathic symptoms in serious acute cases (Teixeira 2001):

- Etiological, clinical, pathoanatomical diagnosis: - Generalities - septicaemia
- Normal and pathognomonic symptoms of the disease with its typical modalities:
 - Not applicable
- Localised mental and general symptoms which occur at the same time as the acute disease or change it:
 - Mind - restlessness - bed - tossing about in
 - Mind - restlessness - bed - driving out of
 - Mind - death - presentiment of
 - Mind - company - desire for - alone, while, aggravated
 - Generalities - weakness - nervous
- Symptoms or conditions arising from the acute disease:
 - Chest - inflammation - lungs

Repertorisation

REPERTORIUM	HOMEOPATHICUM	DIGITAL	II
ELECTRONIC EDITION			

Generalities - septicaemia

Mind - restlessness - bed - tossing about in

Differentiation between remedies

This condition is reminiscent of *Phosphorus*; these patients have a lot of fears and don't like being alone. However, the restlessness is a clear indication for the remedy *Arsenicum album*.

Prescription

1 dose of 5 drops *Arsenicum album* 30C.

Progress

24 hours after administration of remedy: the patient is calmer and feels better. Normal temperature, heart rate 85/min., blood pressure 170/100 mmHg without antihypertensive medication, respiratory frequency 30/min. FiO₂ reduced to 50% with peripheral saturation of 94%. Diuresis 900 ml in 6 hours, renal function still poor.

Prescription

Repeat dose of 5 dr. *Arsenicum album* 30C.

Progress

48 hours after the first dose of the remedy: calm patient with normal temperature, heart rate 80/ min., blood pressure 190/100 mmHg, respiratory frequency 23/min., saturation 95%. Polyuria (2000 ml in 6 h), renal function restored.

72 hours after the first dose of the remedy: calm patient with normal temperature, heart rate 80/min., blood pressure 140/70 mmHg without allopathic medication, respiratory frequency 16/min., saturation 97% with nasal oxygen insufflation. Polyuria (> 2000 ml/h) with normal renal function. Transferred to normal ward.

Six days after the first dose of the remedy: after the antibiotic treatment ends and the patients test results return to normal (normal echocardiogram, chest x-ray, blood count, renal function, liver function, saturation etc.), he is discharged from hospital.

24 days after the first dose of the remedy: the patient comes to the outpatient clinic without symptoms and in good general condition. Blood pressure 160/100 mmHg with beta blockers (e.g. Atenolol®, 100 mg/day). Normal

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Evaluation

During the first two days in ICU, before receiving homeopathic treatment, the patients recovery dragged on slowly. After receiving homeopathic treatment, the hypoxaemia was brought under control within 48 hours with normal breathing and circulation, as a result of which the patient was transferred to a general ward. It was interesting to note that the patients hypertension

was controllable without allopathic medication while he was in ICU, and that the polyuria continued even after his serum creatinine levels returned to normal.

Critical commentary

This case shows that *Arsenicum album* is the very first remedy of choice for agitated patients with existing symptoms. The remedy was able to bring this symptom

Case 1.1-3: Meningococcal sepsis

Marcus Zulian Teixeira

Anamnesis

6-year-old female patient with frontal headache, 39 °C temperature and repeated vomiting. On being admitted to the clinic, she is alert and active with no fever or meningism. Hyperaemia of the right eardrum and oropharynx are found along with a petechial rash all over her body.

Acute event

Three hours after admission: diarrhoea with dehydration and somnolence. The patients peripheral circulation declines, petechiae and regions of capillary bleeding with marbled skin appear all over her body. She is therefore admitted to ICU on the same day (day 0). The small patient is unconscious with septic shock, diuresis reduced. Her pulses cannot be felt except for a very weak carotid pulse. Disseminated petechiae are visible all over her body, also in the conjunctivae. No meningism. Severe cyanosis with blue lips, hypoxaemia, tachycardia (heart rate 170/min.) with hyperaemia in the face. Meningococcal bacteria are found in both the blood culture and the petechiae.

Diagnoses

Severe meningococcal sepsis, septic shock

Conventional treatment

Diagnostics from cerebrospinal fluid: one white cell, no erythrocytes, no proteins, no bacteria. X-ray: sinuses, chest normal. Intubation with 100% FiO₂,

albumen). Because of the weak pulse, the arteries cannot be punctured to measure the patients arterial blood pressure. The PTT is prolonged.

Medication

After 21 hours: dopamine (20 pg/kg/min.), ceftriaxone (e.g. Rocephin") Ig, Flebocortid* 300 mg, Fentanyl*.

Homeopathic treatment

Ranking of homeopathic symptoms in serious acute cases (Teixeira 2001):

- Etiological, clinical, pathoanatomical diagnosis:
 - Fever - cerebrospinal
 - Generalities - septicaemia
- Normal and pathognomonic symptoms of the disease with its typical modalities:
 - Head - congestion, hyperaemia
 - Skin - discolouration - mottled
 - Generalities - cyanosis
 - Skin - purpura - idiopathic
- Localised mental and general symptoms which occur at the same time as the acute disease or change it:
 - Generalities - pulse - weak
 - Face - dryness - lips
- Symptoms or conditions arising from the acute disease (pathological symptoms):
 - Ear - inflammation - inside.

Repertorisation

REPERTORIUM	HOMEOPATHICUM	DIGITAL	II	-
ELECTRONIC EDITION				

1.1 Sepsis

Skin - discolouration - mottled

Generalities - cyanosis

Generalities - pulse - weak

Face - dryness - lips

Ear - inflammation - inside

Skin - purpura - idiopathic

Differentiation between remedies

Veratrum viride is characterised by high fever and congestion.

Phosphorus mentions petechiae but is less well represented for cyanosis.

Lachesis, however, is well represented in the “sepsis” and “cyanosis” rubrics, also in purpura, but is not found in “cerebrospinal fever”.

Prescription

1 dose of 5 drops *Veratrum viride* 30C.

Progress

After one hour: temperature 37 °C, heart rate 142/min., marbled skin and diuresis improved.

Prescription

Repeat single dose of 5 drops *Veratrum viride* 30C.

Progress

After two hours: temperature 37.6 °C, heart rate 170/min., diuresis 500 ml/h. The skin circulation has improved, pulses can be easily felt.

After four hours: temperature 37.8 °C, heart rate 130/min., diuresis 200 ml/h. The skin circulation has continued to improve and the pulses feel normal. Hypotension after attempt to reduce dopamine.

Prescription

Repeat single dose of 5 drops *Veratrum viride* 30C.

Progress

37 °C, heart rate 133/min., diuresis 400 ml/h, blood pressure 100/55 mmHg. The skin circulation and pulses are normal. Dopamine dose reduced. After ten hours: temperature 37.2 °C, heart rate 123/min., diuresis 140 ml/h, blood pressure 94/47 mmHg. Normal pulse and circulation. FiO₂ is reduced to 21% with a constant saturation of 98%.

Prescription

Repeat single dose of 5 drops *Veratrum viride* 30C.

Progress

After 32 hours: temperature 37 °C, heart rate 99/min., diuresis 150 ml/h, blood pressure 130/80 mmHg. Normal respiratory parameters. The patient is alert, oriented, cooperative and calm. She asks for a full glass of water. A little diarrhoea. After 36 hours: mild bronchospasm after extubation; this disappears after inhaling bronchodilators. Dopamine discontinued. Diarrhoea four times. Stomatitis without treatment. After 60 hours: negative blood cultures, patient transferred from ICU to normal ward. After nine days: patient discharged from hospital after completing ceftriaxone treatment. She has no more symptoms except for skin marks in localised bleeding. Further treatment is received from an allopathic paediatrician. She remains healthy and there are no more incidents.

Evaluation

This case describes septic shock caused by meningococcal bacteria; this begins to regress after 24 hours of treatment and normal respiratory parameters and renal function are quickly re-established. After the patients creatinine levels return to normal, polyuria is observed with no other cause. During the convalescent phase, she has episodes of diarrhoea with no clinical effects; there is therefore no need for special treatment.

Critical commentary

Veratrum viride obtained good results in this case, although other remedies would certainly also have come into question. Consistent administration of one and the same remedy ultimately led to success.

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Case 1.1-4: Glomerulonephritis, sepsis

Michael Frass

Anamnesis

40-year-old patient with clinical signs of sepsis. Arterial hypertension for 15 years (max. 190/100 mmHg) and chronic glomerulonephritis for which the patient has been receiving haemodialysis for ten years. Uraemic pericarditis seven years ago. Kidney transplant six years ago leaving the patients own kidneys in place; followed by immunosuppression with ciclosporin A (e.g. Sandimmune®) and azathioprine (e.g. Imuran®).

Over the last year, urea nitrogen has increased to 64.8 mg/dl, serum creatinine to 3.3 mg/dl, urine quantity 1 l/day with no subjective complaints. Biopsy of transplanted kidney reveals segmental, focally marked, proliferating sclerosing glomerulonephritis (recurrence of disease), signs of chronic ciclosporin toxicity, i.e. diffuse, linear interstitial fibrosis, arteriolar disease, fibrosing intima in the arteries and a herpes infection of the kidneys. The colour-coded Doppler sonography shows a morphologically normal transplanted kidney with a marginal increase in resistance in the peripheral blood vessels in accordance with the vascular changes described above. After studying all the findings and weighing up the benefits and risks, the treatment with ciclosporin A, prednisolone and azathioprine is continued despite the early signs of ciclosporin A damage.

About one year later, the patients serum creatinine rose to 5.2 mg/dl; treated with three-day bolus of 100 mg dexamethasone (e.g. Fortecortin®) per dose. Suffered a flu-like infection at about the same time. Childhood diseases; measles, mumps, German measles, chicken pox, tonsillectomy twelve years ago. The patient is known for his loquacity.

Acute event

Two weeks after the dexamethasone bolus therapy, the patient is admitted to the clinic (day 0) with massive dyspnoea; an abscess in the region of the epiglottis is diagnosed. The patient becomes acutely cyanotic during the examination and an

emergency cricothyrotomy has to be performed. A tracheotomy is performed under regular conditions. Despite initially good condition with spontaneous breathing, cyanosis suddenly sets in and makes admission to ICU necessary. The patient has tachycardia and hypothermia (35.2 °C). Pulmonary artery occlusion pressure (PAOP 14 mmHg).

Diagnoses

Chronic glomerulonephritis requiring dialysis, uraemic pericarditis, hypertension, post kidney transplant, immunosuppression. Segmental, focally marked, proliferating sclerosing glomerulonephritis in the transplanted kidney with signs of ciclosporin toxicity, herpes infection, arteriolar disease and fibrosis of the intima in the arteries. Cricothyrotomy and tracheotomy due to epiglottal abscess. Sepsis with ARDS (adult respiratory distress syndrome), acute kidney failure, paralytic ileus.

Conventional treatment

Respiration

Artificial respiration was immediately commenced with controlled tidal volume (e.g. Evita®). The chest x-ray shows a butterfly-shaped infiltrate which is diagnosed by radiologists as ARDS. Until day 13, the patient is sedated with midazolam (e.g. Dormicum®) and sufentanil (e.g. Sufenta®) and maintained on artificial respiration with a controlled tidal volume, as several attempts at weaning failed due to hyperventilation and agitation on the patients part. On day 13 the patient can breathe spontaneously by BIPAP (e.g. Evita®), although his respiratory frequency is between 40 and 45/min. and he becomes exhausted.

Haemofiltration

Acute kidney failure has developed as a result of the sepsis; the patient therefore receives continuous pump-assisted haemodiafiltration (CVVHDF).

Medication

A paralytic ileus has also developed, which does not improve on the administration of pyridostigmine (e.g.

1.1 Sepsis

The patient receives the following medication as antimicrobial treatment:

- Ticarcillin (z. B. Ticarpen*) and cefotaxime (e.g. Claforan®) until day 6.
- Vancomycin (e.g. Vancomycin “Lilly”*) because of Staphylococcus aureus in throat swab from day 7 to day 31.
- Imipenem (e.g. Zienam*) from day 10 to day 13.
- Aztreonam (e.g. Azactam*) from day 14 to day 24.
- Fluconazole (e.g. Diflucan*) from day 22.

Results of microbiological pathogen sensitivities: catheter tip on day 15: Pseudomonas aeruginosa, day 21: Staphylococcus hominis, day 23: Staphylococcus epidermidis, Candida titre: 1:64 on day 22, 1:128 on day 25.

Homeopathic treatment

Repertorisation

_____ **COMPLETE REPERTORY MILLENNIUM**

General - septicaemia - blood poisoning - pyaemia

Throat - suppuration

Abdomen - ileus - obstruction of bowels

Differentiation between remedies

Capsicum, *Causticum* and *Opium* are all indicated for ileus, but none of these remedies is appropriate for severe sepsis.

Lachesis, on the other hand, appears frequently under “Sepsis”.

Prescription

One dose of *Lachesis* 200C on day 13 and *Lachesis* 10M on day 15. Prescribed under the clinical aspect of sepsis as the antimicrobial treatment fails to work.

Progress

Day 13: one dose of *Lachesis* 200C. No signs of change over the next two days, therefore one dose of *Lachesis* 10M on day 15.

Day 15: six hours after administering the remedy, the

the same day; normal thrombocyte numbers and normal plasma coagulation. In the evening, the patients respiratory frequency falls below 40/min. for the first time; BIPAP maintained. During the night from day 15 to day 16, peristalsis is restored after four days of paralytic ileus and the patient has a bowel movement. On day 16, the patients respiratory frequency reduces to 22-27/min. He seems much calmer.

Prescription

Day 17: repeat dose of 3 glob. *Lachesis* 10M, as no further progress has been made and the previous dose of *Lachesis* seems to have worn off.

Progress

That same evening, the patient is very restless and moves his mouth continually as if he wanted to talk, which is impossible because of the tracheostomy. Nurse’s entry in nursing report: “Talking to himself non-stop”. The patients face is bright red and he develops a temperature of 38.8 °C after the CVVH had to be stopped in the evening due to massive bleeding near the site where the double-lumen catheter was inserted. The bleeding stops at about midnight. On day 18, the patient is more responsive and can move independently for the first time. On day 19, the patient is responsive but still has high fever. From this day on, the patient breathes spontaneously without the assistance of machinery.

Prescription

Repetition: as the symptoms are no longer changing, the patient receives another dose of *Lachesis* 10M on day 22. As he does not react to the remedy, he receives another dose of *Lachesis* 10M on day 24.

Progress

The patients improvement is only moderate and the homeopathic treatment has to be re-evaluated as he is still septic. He has burning pain in the remains of the abscess in the epiglottal area.

Repertorisation II

_____ **COMPLETE REPERTORY MILLENNIUM**
General - septicaemia - blood poisoning - pyaemia

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Differentiation between remedies

Pyrogenium is indicated by the patients septic condition and latent tendencies to suppuration. Burning pain can also occur with abscesses; this is typical for *Arsenicum album* and *Anthracinum*. However, the patients restlessness had ceased by this time (*Arsenicum album*) and the content of the abscess was no longer dirty brown (*Anthracinum*). *Myristicum sebifera* is justified by the burning pain in the patients throat and the suspected residual abscess in the epiglottal area. *Myristicum sebifera* has repeatedly been used with success as a so- called “homeopathic knife” for abscesses, and in this case could supplement the effect of *Pyrogenium* on the abscess.

Prescription

Day 26:1 dose of 3 glob. *Pyrogenium* 10M, one hour later 1 dose of 3 glob. *Myristicum sebifera* 200C.

*** Double prescription:** the simultaneous administration of two remedies, unusual in classical homeopathy, seems justified by the acute situation, in which getting the sepsis under control and emptying the life-threatening epiglottal abscess are equally important.

While double prescriptions should be largely avoided in chronic situations, they helped cure the sepsis and abscess in this acute case.

Progress

The patient requests solid food that same day (day 26). Transplant biopsy with histopathology report of fibrous transformation of the organ on day 27. The patient still has a high temperature, red face and profuse sweating on the days on which he receives no CVVH (continuous haemodiafiltration).

Repertorisation III

_____ **COMPLETE REPERTORY MILLENNIUM** Fever
- burning heat

Face - redness - fever

Differentiation between remedies

The choice of *Belladonna* is based on the attacks of high

Eupatorium perfoliatum patients also have red faces when they are feverish, but the burning heat is less pronounced.

Prescription

Day 27 and day 28: 1 dose of 3 glob. *Belladonna* 30C.

Progress

On the day on which the remedy is administered, the patient is able to speak clearly and walk a few metres with support for the first time. As the patient still has fever, shivering and unusual restlessness, another remedy is prescribed on day 32.

Repertorisation IV

_____ **COMPLETE REPERTORY MILLENNIUM**
Mind - restlessness - nervousness, with heat

Differentiation between remedies

The most striking symptoms indicative of *Arsenicum album* are the shivering and restlessness, which cause the patient to change his position continually.

Prescription

Day 32:1 dose of 3 glob. *Arsenicum album* 10M.

Progress

On day 33, the patient can walk longer distances and receives a dose of *Tuberculinum Koch* 10M. His relatives report his melancholic, depressive tendencies and fear of animals. On day 34, the patient is transferred to a normal ward and from day 40 on his temperature is normal. He receives dialysis three times a week; the tracheal tube can be removed. On day 61, after just under three weeks in the general ward, the patient is transferred to his former dialysis centre for further treatment.

Evaluation

This case shows that homeopathic treatment can be advisable and successful even in the presence of only a few symptoms strongly influenced by complex allopathic treatment. The sudden turnaround on day 15 (responsiveness, bleeding, reduced

1.1 Sepsis

respiratory frequency) was particularly impressive, as up to this time the physicians and nurses had believed the patient was a terminal case. Despite the suppression of symptoms, the applicability of the homeopathic law of similars was still recognisable (bleeding, loquacity, restlessness). The author has observed that the highest potencies work for a considerably shorter period in acute situations than in chronic cases.

The homeopathic law of similars also explains why symptoms of the original disease (such as

loquacity) appeared briefly in this case then disappeared again when the remedy was administered. The need for high potencies seems remarkable in this context. This should be examined in further cases. The histopathology evidence that the disease in the patient's own kidney reappeared in the transplanted kidney is also interesting from a homeopathic viewpoint: in this case, prompt treatment could perhaps save both the transplanted kidney and the patient's own kidney from irreversible damage.

ORGANON,

Law of similars (similarity of symptoms)

"[...] when a homeopathic cure of the vital force deranged by natural disease is accomplished by the administration of a medicinal agent selected on account of similarity of symptoms, a somewhat stronger, similar, artificial morbid affection is brought into contact with and, as it were, pushed into the place of the weaker, similar, natural morbid irritation, against which the instinctive vital force now merely (though in a stronger degree) medicinally diseased, is then compelled to direct an increased amount of energy, but, on account of the shorter duration of the action of the medicinal agent that now morbidly affects it

the vital force soon overcomes this, and as it was in the first instance relieved from the natural morbid affection, so it is now at last freed from the substituted (artificial) medicinal one, and hence is again able to carry on healthily the vital operations of the organism."

The subsequent remark gives the following explanation: "The short duration of the action of the morbid forces which we term medicines makes it possible that, although they are stronger than the natural diseases, they can much more easily be overcome by the vital force than can the natural weaker diseases..." (Organon of the Healing Art, § 29)

Case 1.1-5: Multiple organ failure, sepsis

Michael Frass

Anamnesis

67-year-old male patient with bladder carcinoma, post cystectomy, prostatectomy, pelvic lymphadenectomy, ileal conduit for urine drainage on day 0. 4th day following the operation: dehiscence of the abdominal sutures with revision. This is followed by a dramatic decline in the patient's condition and the development of temperatures suggestive of sepsis. Percutaneous nephrostomy on day 14 because of a massively enlarged renal pelvis on the right.

Acute event

diagnosis of peritonitis. The septic temperatures persist; the patient's serum bilirubin increases to 11 mg/dl. The patient's skin is livid.

Diagnoses

Bladder carcinoma, status post cystectomy, status post prostatectomy, status post pelvic lymphadenectomy, post ileal conduit for urine drainage. Septic shock with peritonitis, multiple organ failure, kidney failure, necrosis of the left ureter, post bilateral nephrostomy, left nephrectomy. Psoas abscess.

Conventional treatment

As the left renal pelvis is not filling properly, a nephrostomy is performed on the left side. The intravenous pyelography shows necrosis of the

1 Infectious diseases

left ureter. A laparotomy on day 24 reveals a psoas abscess which is then drained. The blood cultures show mycotic sepsis; the patient, who is receiving catecholamines, commences antimycotic treatment in combination with antibiotics. On account of his kidney failure, continuous pump-driven haemodiafiltration is performed for 31 days. The nephrostomy on the right is removed on day 48. Due to continuing dysfunction of the left kidney, a nephrectomy is performed on the left side. 67 days after the first operation, the patient can finally be weaned off the respirator.

Homeopathic treatment

Repertorisation I

_____ **COMPLETE REPERTORY MILLENNIUM**

General - septicaemia - blood poisoning - pyaemia

Skin - bluish

...

Differentiation between remedies

Arsenicum album, *Lycopodium* and *Veratrum album* are just a few of the remedies which should be considered for impaired kidney function. However, *Lachesis* stands out because of the patients livid skin colour.

Prescription

In view of the signs of septic shock, the patient receives one dose of *Lachesis* DM (= 500.000C) on day 23.

Progress

Temperature rises from 38 °C to 41 °C despite continuous pump-assisted haemodiafiltration, which normally cools the body temperature by an average of 2 °C. As the patient still has to be given catecholamines, *Arsenicum album* CM (= C 100 000) is administered on day 27 to improve his circulation.

Repertorisation II

_____ **COMPLETE REPERTORY MILLENNIUM**

Generalities - pulse weak

Generalities - weakness

Differentiation between remedies

Arsenicum album patients often show great exhaustion and significant weakness in the circulatory system. This remedy features prominently for septic infections and low vital energy. The relatively short interval between the two remedies is justified in view of the acuteness and gravity of the patients disease.

Prescription

Day 27: 1 dose of 3 globules *Arsenicum album* CM.

Progress

On day 28, the patients temperature drops to 38.5 °C, the catecholamines can be reduced and the patient is increasingly responsive.

Repeat prescription: another dose of *Arsenicum album* CM is administered on day 29. Urine output increases on the following day, as a result of which the haemodiafiltration can be stopped on day 31. The homeopathic treatment cannot be continued as the patient is transferred to another intensive care unit. The patients condition continues to improve steadily, as a result of which he is successfully weaned off the respirator and transferred to a normal ward on day 74.

Evaluation

The case study does not claim to demonstrate a perfectly performed homeopathic treatment. However, it shows that homeopathic treatment can be successful even if intensive allopathic treatment is being administered at the same time, particularly in cases where allopathic medicine is having little effect. This case emphasises that homeopathy can be used even if only a few physical symptoms and clinical signs are present as per the law of similars, even in the most serious cases of sepsis with multi-organ failure (cardiac, respiratory, renal and hepatic insufficiency).

Critical commentary

The small number of symptoms left a number of options open. Nevertheless, astonishing progress was made with *Lachesis* and *Arsenicum album*.

1.1 Sepsis

Case 1.1-6: Rejected kidney transplant, sepsis

Michael Frass

Anamnesis

40-year-old female patient with chronic glomerulonephritis; chronic renal insufficiency requiring dialysis since the previous year.

Kidney transplant on day 0; transplant initially functions exceptionally well. Signs of transplant rejection on day 11; a biopsy of the transplant reveals vascular rejection. Repeat haemodialysis and increased immunosuppression with ciclosporin A (e.g. Cyclosporin®), prednisolone (e.g. Aprednisolon®), Azathioprin®, OKT3® and ATG®.

Acute event

Fever and poor respiratory situation since day 36, consequently admitted to ICU on day 39. Development of ARDS (adult or acute respiratory distress syndrome), probably due to interstitial pneumonia and sepsis, therefore sedation and artificial ventilation.

Diagnoses

Chronic glomerulonephritis requiring dialysis, renal insufficiency, status post kidney transplant with transplant rejection. Sepsis with ARDS, pneumonia, suspected pulmonary embolism, haemorrhagic-erosive colitis, haematuria, stomach ulcers.

Conventional treatment

An attempt to wean the patient from the respirator on day 46 has to be broken off as her respiratory condition worsens (suspected pulmonary embolism). The immunosuppressive treatment is reduced and subsequently ended. Due to massive haemorrhagic-erosive colitis, the patient is treated with sulfasalazine and antibiotics, which cause the intestinal bleeding to cease. The patient's urine output is initially moderate, but the transplanted kidney ceases to function, as a result of which the patient again has to receive haemofiltration and haemodialysis.

Homeopathic treatment

Repertorisation I

COMPLETE REPERTORY MILLENNIUM

General - septicaemia - blood poisoning - pyaemia

Fever - heat - high, 30-40 °C

Blood - orifices, from

Heart & circulation - embolism

Differentiation between remedies

This constellation is reminiscent of *Phosphorus* and *Lachesis*. Along with the sepsis, the suspected pulmonary embolism is decisive for the choice of *Lachesis*. *Lachesis* is also indicated by the following symptoms: fever up to 38 °C over two days, profuse bleeding from the rectum and the points at which the arterial catheter was inserted.

Prescription

One dose of *Lachesis* DM (= 500,0000) administered orally on day 53.

Progress

A few hours after the administration of *Lachesis*, bronchial bleeding sets in and the blood is aspirated by

* Bleeding propensity: bleeding can occur as an initial healing crisis after administering the correct remedy; the pre-existing bleeding tendencies indicate that this seems quite likely in this case. Bleeding and discharges can also occur as a form of relief in line with the healing principles of homeopathy.

The patient's temperature drops on day 54. Despite a massive shadow on the lungs (right more than left) in the chest x-ray, the oxygen percentage of the respiratory gas can be reduced. Recurrent pulmonary bleeding with a good gas exchange is also observed on the following days. On day 57, the patient's pulmonary situation deteriorates, as a result of which the oxygen percentage in the

1 Infectious diseases

respiratory gas has to be increased from 30% to 60%. At this point, the patients condition appears to be terminal; she is deathly pale with a mean arterial pressure of 40 mmHg, indicating that the remedy has to be changed.

Repertorisation II

	COMPLEIE	REPERTORY	MILLENNIUM
Generalities - pulse - weak			
Face - pale			

Differentiation between remedies

Arsenicum album is a remedy which can be particularly useful in the terminal phase (» 1.3.9).

Prescription

Day 58:1 dose of 3 glob. *Arsenicum album* DM.

Progress

Surprisingly, the patients respiratory condition improves on the following day. A yellowish vaginal discharge is observed from day 59 onwards. On day 63, the site of the arterial puncture begins to bleed and has to be sutured. The patient also brings up vomit with the appearance of coffee grounds and has bright, bloody faeces. The bleeding tendency increases.

Repertorisation III

	COMPLETE REPERTORY	MILLENNIUM
Generalities - wounds - bleeding, freely		

Differentiation between remedies

Phosphorus had already been considered during the initial repertorisation. The choice of *Phosphorus* is now justified by the severe bleeding from several bodily openings.

In contrast, *Crotalus horridus* is more appropriate to dark blood and bluish body parts.

Lachesis is also indicated for freely bleeding wounds, but less so for bloody vomiting.

Prescription

Day 64:1 dose of 3 glob. *Phosphorus* DM. Day 65:1 dose of 3 glob. *Phosphorus* DM.

Progress

On day 65, the artificial respiration is switched from controlled to pressure-assisted. From midnight on, the patient becomes increasingly restless with vigorous movements of the lower extremities. **Repeat prescription:** one dose of *Arsenicum album* DM to ease the patient's agitation while being weaned from the respirator. The gastroscopy performed on day 67 shows two ulcers which are not bleeding; the colonoscopy reveals massive haemorrhagic erosive colitis. The patient is extubated on day 68. The chest x-ray taken on day 69 shows that her lung condition has worsened with an alveolar picture on both sides; small quantities of blood are again present in the sputum. The patient is transferred back to the normal ward on day 73.

Repeat prescription: on day 94, the patient receives a dose of *Lachesis* DM as further treatment following the therapy with multiple antibiotics. *Lachesis* is one of the remedies that has proven itself as a stabiliser after intensive antibiotic treatment. *Nux vomica* is also often indicated after a patient has received massive doses of allopathic medication.

The patient recovers rapidly and is allowed to go home in relatively good condition.

Evaluation

The positive progress made by this patient may be attributed to the homeopathic treatment. The deterioration in her pulmonary condition after administering sulfasalazine is most likely due to vicarious bleeding through suppression of the intestinal haemorrhage. The blockage of the intestinal drain may have caused the patient to relapse during the convalescent period.

Critical commentary

This case shows a decline in the patients condition after a repeat dose of sulfasalazine. We should always bear in mind that suppressive treatment may produce other, vicarious symptoms.

1.1 Sepsis

Case 1.1-7: Sepsis following Caesarean

Michael Frass

Anamnesis

20-year-old patient who is found to be in the seventh month of pregnancy just one month after graduating from high school. Vaginal bleeding up to this point; the patients menstrual cycles have always been irregular.

Acute event

An amniotic fluid embolism is discovered when the patients right thigh swells up. A Caesarean is therefore performed on day 0. On day 4, the patients left arm turns red and swells up; her temperature rises to 39 °C. Day 12: pulmonary embolism, pleurisy on the left side and pleural effusion. Also thrombosis in the vena cava inferior and the right ovarian vein. The enlarged spleen is accompanied by splenic infarctions and/or thromboses. No changes in the subclavian and axillary veins at this time.

Diagnoses

Amniotic fluid embolism, status post Caesarean. Therapy-resistant sepsis. Pulmonary embolism, pleurisy, pleural effusion.

Thrombosis in the vena cava inferior, the right ovarian vein and the right atrium, thrombotic stenosis of the left internal jugular vein, cavernous sinus thrombosis, thrombosis in the left subclavian vein, thromboses in the pelvis and thighs. Spleen enlarged from infarctions, splenic thromboses. Superior vena cava filter, abscesses in chest and gluteal area, suppuration in the intercostal area. Acute kidney failure, cardiac arrest: post resuscitation. Ascites, impaired liver function and coagulation. Oedema in the face and legs, dermatosis.

Conventional treatment

Administration of heparin i.v. with therapeutic doubling of the partial thromboplastin time (PTT). The patient develops treatment-resistant sepsis with a consistently high temperature (38-39.5°C), leucocytosis (>16 g/l), tachypnoea (30/min.) and tachycardia (105/min.). Due

insufficiency, she is transferred to ICU, intubated and respirated artificially.

On day 36, a thrombosis in the right atrium and thrombotic stenosis of the left internal jugular vein despite continuous anticoagulant treatment. The patient develops visual disturbances caused by massive cavernous sinus. The inflammation markers rise (CRP 40 mg/dl, leucocytes 20 g/l). On day 42, the thrombosis in the right atrium is removed and a significant patent foramen ovale is closed. At this time, the patient needs intensive artificial respiration and high doses of catecholamines. On day 43, an operation is performed on a closed suppurating area in the intercostal space. Pump-assisted venovenous haemofiltration due to acute kidney failure. The patient suffers a cardiac arrest and is successfully resuscitated. She later suffers from ascites, impaired coagulation and impaired liver function. A vena cava filter is implanted on day 68 due to thromboses in the pelvis and upper thighs. Numerous abscesses in the chest and gluteal area are likewise incised and drained. The bacteriological tests are negative. The patient is extubated on day 73. A thrombosis in the left vena subclavia is diagnosed on day 84; on day 92, another abscess is drained in the gluteal area.

The patients C-reactive protein levels have been consistently high over a period of three months; her temperature has varied between 37.5 °C and 39 °C for three months. The cause of the thromboses is unclear: there is no evidence of antithrombin III, protein S or protein C deficiency, no APC resistance and no signs of heparin-induced thrombocytopenia. A heterozygous prothrombin polymorphism is not believed to be the cause of the disease.

Homeopathic treatment

Repertorisation I

_____COMPLETE REPERTORY MILLENNIUM

Generalities - septicaemia - blood poisoning - pyaemia

Generalities - septicaemia - blood poisoning - pyaemia - delivery, parturition, after

Female - pregnancy

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_____ COMPLETE REPERTORY MILLENNIUM

Female - delivery, partition, after - puerperal

Heart & circulation - inflammation - blood vessels

Generalities - thrombosis

Stomach - appetite - diminished - fever - during

Face - swelling - oedematous

Extremities - swelling - oedematous - legs

Differentiation between remedies

Pulsatilla comes into question as an important postpartum remedy.

Lachesis is another possible choice. *Lachesis* is chosen because of the patient's thrombotic tendencies; it has also proven itself to be especially effective in cases of severe sepsis.

Prescription

5 glob. *Lachesis* LM 18 orally once a day until day 100.

Progress

The patient receives her first homeopathic treatment on day 95; the case history is taken with her parents' assistance. After careful repertorisation, *Lachesis* LM 18 is administered.

On day 96, the patient's temperature falls to 37 °C and her appetite improves. Until this time, the patient had no appetite whatsoever and was fed enterally and parenterally. On the same day, the patient sits in a reclining chair for the first time in three months. The facial oedema disappears on day 97, while the oedema in her legs increases in accordance with Herings law (I.1). CRP falls from 20 mg/dl on day 95 to 11 mg/dl on day 97. The antibiotic treatment is stopped on day 100, the stomach tube is removed on day 101. The signs of ascites have disappeared.

On days 101 and 102, the patient receives *Lachesis* 200C as the effect of *Lachesis* LM 18 appears to be declining. The patient has severe mood swings, and a change of remedy appears to be necessary as she has suddenly become very tearful.

Differentiation between remedies

Pulsatilla is gentle, shy and tearful, while *Lachesis* is more likely to be nervous, talkative and suspicious. The patient's mood symptoms clearly push *Pulsatilla* to the forefront. She also has the catarrh typical of *Pulsatilla* with a mild yellow discharge.

Prescription

1 dose of 3 glob. *Pulsatilla* 200C on days 103 and 107.

Progress

A second dose of *Pulsatilla* is given on day 107, as the patient is particularly tearful on this day. Another attack of fever occurs on days 108 and 109 and another bout of sepsis is feared. This new, acute situation makes it necessary to repeat the dose of *Lachesis*.

Prescription

Repetition: 1 dose of 3 glob. *Lachesis* 200C.

Progress

Return to former habits: the patient is interested in her surroundings and receives visits from friends. She is again able to perform daily activities such as washing, cleaning her teeth and reading; the visual disturbances disappear and she makes her first attempts at walking. A patch of eczema appears on her right thigh. From a homeopathic viewpoint, this local symptom indicates that the patient is recovering and is therefore not treated. The patient is transferred to a normal ward on day 112.

Local symptom: from a homeopathic perspective, new symptoms can indicate that a different remedy is required. The eczema can be seen as an old symptom which had previously been suppressed or as a symptom which has not yet been cured. It should by no means be suppressed: "... the change [the remedy] produces is most salutary, being the restoration to health of the entire body along with the disappearance of the external affection (without the aid of any external remedy), provided the internal remedy directed towards the whole state was suitably chosen in a homeopathic sense." (Organon of the Healing Art, § 191)

By day 116, the oedema and eczema have disappeared. The CT on day 117 shows no signs of pleural effusions, ascites or abscesses. The patient is discharged on day 131. The child is doing well; the patient has been free of symptoms for more than eight years, is now married and from a conventional viewpoint no longer requires anticoagulant medication.

Evaluation

The most remarkable thing about this case was the sudden change in the patients condition on the day on which *Lachesis* was administered (day 96) after three months of sepsis with a raised temperature and inflammation markers and recurrent thrombotic incidents, abscesses, empyema etc. Even the most advanced antimicrobial treatment was unable to get the sepsis under control. After the administration of *Lachesis*, the sepsis improved steadily,

a process supported at times by other treatments, and an improvement in the patients general condition was observed along with the appearance of phenomena typical of homeopathic treatment: recovery progressing from top to bottom and from the inside to the outside (appearance of rash, cf. I.I., Herings law). It would be interesting to know whether the patients condition would have improved more quickly if the homeopathic treatment had been administered earlier.

Critical commentary

In retrospect, some homeopathic treatments may appear to be superfluous or given too frequently. However, it should not be forgotten that acute situations constitute a special challenge and that the therapist may be tempted to change the remedy frequently when confronted with such a serious condition.

Case 1.1-8: Sepsis following snakebite

Peter Konig

Anamnesis

The 5-year-old patient, who has been receiving homeopathic treatment since he was three months old, was bitten on the right foot by a snake when out for a walk with his family. He was admitted to the nearest hospital as an inpatient and is very unwell. The little patient is hallucinating, sees children who aren't there and who want to grab hold of him; he wants them to go away, screaming and hitting out during the first examination. He vomited bile immediately after the snakebite. He is cold and pale; his face feels cool. Very thirsty. His mother gives him a dose of *Arsenicum album* 30C. However, the patient is no better on the following day. His right leg is three times as thick as usual, soft to the touch with dark blue marbling. The child is frightened by the appearance of his leg but doesn't want a bandage. His tongue is dark blue. His forehead is still cool. He wants to get undressed, be naked. The boy is very sensitive to touch. In the night he screams and raves; he wants to go home

at once. He is tremendously thirsty and drinks in huge gulps. His temperature rises to over 38 °C and his leucocytes to 14 g/l, both signs of sepsis.

Diagnosis

Sepsis following snakebite

Conventional treatment

The patient receives intensive conventional treatment with high doses of cortisone and antimicrobial infusions.

Homeopathic treatment

Repertorisation I

_____ **MACREPERTORY PRO 6.1.5. 4.5** Mind - bed - get out of - wants to

Differentiation between remedies

Arsenicum album, *Agaricus* and *Opium* appear in both rubrics. Because of the general context of the symptoms, the choice falls on *Arsenicum*.

Prescription

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Progress

There is no improvement. The boy is transferred to the intensive care unit of a renowned childrens hospital. However, they too are unable to control the worrying symptoms which are now developing: large bruises rising from above the inguinal area, drop in serum protein concentration. Only now is an antiserum administered. When the boy rouses from his semiconscious state, he curses, raves and screams. Three days later, the bruises have risen to his throat, which irrespective of the clinical evaluation should set the alarm bells ringing for any homeopathic doctor, particularly as the process is going against Herings law (I.1). The swelling has continued to grow. It is now assumed that that patient may not have tolerated the antiserum. The attending physicians believe that no comparable case has ever been documented anywhere in Europe.

Next day, the boys condition continues to deteriorate. For the therapists, the time has finally come when the child's symptoms ought to be clear enough to make a correct homeopathic prescription. The boy was extremely restless during the night. Extreme feelings of heat! The bruises, blue, dark blue, marbled, are continuing to spread and are now moving up his back. However, he is no longer quite as sensitive to touch. His thirst has decreased. Mentally the child is becoming increasingly difficult: he vehemently refuses all treatment ("I'm not doing that!"), doesn't need a sheet, doesn't want pyjamas, absolutely refuses to be covered, screams, hits out and flings obscene words at the doctors and nurses. He needs a double dose of sedative to become somewhat calmer. Only watching TV quietens him a little, as he is not accustomed to such a thing at home.

Repertorisation II

_____ **MACREPERTORY PRO 6.1.5. VERS. 4.5** Mind - naked, wants to be

Mind - restlessness - nervousness - heat

Skin - purpura haemorrhagica

Mind - fight, wants to

Differentiation between remedies

Phosphorus is indicated with purpura, but patients who need this remedy have fewer problems with being covered.

There is a strong emphasis on *Rhus toxicodendron* for restlessness with heat, but like *Phosphorus* it does not appear under the rubric "Mood - wants to fight".

Secale cornutum covers all symptoms.

Prescription

Secale cornutum D30 (30X), 5 globules every four hours, dose to be decreased on improvement.

Progress

Three days later, the patient's mother phones and - much to the author's surprise - joyfully announces that her son can be discharged from hospital. He also calmed down very quickly after the administration of *Secale cornutum*. No other complications arose. The little patient is still rather weak but otherwise healthy.

Evaluation

The positive effect of *Secale cornutum* was astonishing in this case, particularly as certain symptoms spoke against *Secale*, for example the paradoxical fact that it is normally indicated for patients who are freezing cold but cannot tolerate being covered. However, a second glance at the materia medica confirmed a number of symptoms matching *Secale cornutum* which the author had previously not really been aware of:

- General - injuries - fall, with extravasation
- General - wounds - bites
- General - wounds, with extravasation

Critical commentary

This case study shows that the first repertorisation was not complete and the anamnesis was not sufficiently extensive. Only the second prescription covered the important symptoms and led to success. This again shows the importance of precise case-taking.

1.1 Sepsis

Case 1.1-9: Sepsis with cardiovascular shock and cerebrovascular insult with subsequent hypoxic brain damage *Farokh Master, Jayesh*

Dhingreja

Anamnesis

66-year-old female patient Sepsis with cardiovascular shock and cerebrovascular insult with subsequent hypoxic brain damage. The patient has severe hypotension and kidney failure, as a result of which she has to be transferred to ICU.

Acute event

The patient was comatose with staring eyes (coma vigile) and contracted pupils; her lips were swollen. Paralysis of the right side with involuntary movement of one arm. Pulse: rapid and irregular. The mucous discharge from the upper and lower respiratory tract was foamy and bloody. Clinical signs of paralytic ileus. The chest x-ray shows pulmonary oedema, the CT scan indicates a cerebrovascular insult on the left side.

Once these findings have been made, the patient's case history is taken from her relatives. It turned out that the patient has been falsely charged by the inland revenue and is supposed to pay them a large sum of money.

Diagnoses

Sepsis with cardiovascular shock and cerebrovascular insult with subsequent hypoxic brain damage, pulmonary oedema.

Conventional treatment

The patient is intubated and receives controlled artificial respiration. She is given antimicrobial treatment, catecholamines, steroids and other supporting

Case 1.1-10: Sepsis caused by methicillin-resistant staphylococcus aureus (MRSA) *Farokh*

Master, Jayesh Dhingreja

Anamnesis

A lobectomy of the upper right lung lobe was per-

Homeopathic treatment

Repertorisation **SYNTHESIS REPERTORY. VERSION**

8.1 Mind - complaints - reproaches Mind - complaints - anger, annoyance Mind - unconsciousness - coma Eyes - pupils - contracted

Differentiation between remedies

Opium and *Staphisagria* feature strongly in all rubrics.

However, *Opium* has a greater affinity with coma. *Natrium muriaticum* is also found in all rubrics. *Opium* accords the contracted pupils greater significance.

Prescription

The patient receives one dose of *Opium* 50M.

Progress

The patient recovers consciousness on the fourth day; her metabolism and blood pressure also stabilise. The pulmonary oedema dissipates; the patient is weaned from the respirator after ten days of homeopathic treatment. She is discharged with hemiplegia after a hospital stay lasting 45 days.

Evaluation

The patient's disease was obviously triggered by her unjust treatment by the authorities. As homeopathy pays particular attention to triggers, it was possible to help her quickly and efficiently.

Critical commentary

It is worth asking about the patient's social anamnesis even in cases of acute disease, as this may often reveal

from pulmonary bronchiectasis with fibrosis and aspergilloma. After the operation, he developed sepsis caused by methicillin-resistant staphylococcus aureus (MRSA) and pneumonia in the right basal lobe. The patient developed febrile convulsions and lost an increasing amount of weight; this was followed by symptoms of sepsis including

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amoebic dysentery. His general condition worsened and he had to be transferred to ICU. The patient did not respond to various antimicrobial treatments.

Acute event

The following symptoms were observed: the patients facial expression was nervous, discouraged, despairing because any improvement of his current condition seemed impossible. Shivering with goose bumps and cramps starting from the feet and rising to affect the whole body, lasting about half an hour, usually in the morning after food and at night. Thirsty for small quantities taken at short intervals during these chills. Occasional coughing. The patient feels somewhat better on being covered with two blankets. One to three attacks of shivering and cramps every day. The heat comes ten minutes after the chills. His highest temperature was 40.6°C, his lowest 38.3 °C. The right half of his body feels warmer. He asks for blankets and doesn't want a draught or air-conditioning. Headache on the right side. The patient despaired of his recovery every time his fever reached a peak. No appetite. Dry mouth with thirst - drinks water in small sips. Gripping abdominal pains, the patient has to run to the toilet, urge to defecate temporarily relieved by passing stool. The patient weeps when talking about his symptoms. His leucocytes are raised (16 g/l).

Diagnoses

MRSA sepsis.

Conventional treatment

The patient receives medication to strengthen his circulation via a central venous catheter. A stomach tube is also inserted to administer enteral nourishment. Swabs are repeatedly taken from the following areas: nose (swabs from left and right nasal atria (pooled), back of throat, left and right-hand inguinal creases (pooled), perineum.

Homeopathic treatment

Repertorisation

SYNTHESIS REPERTORY. VERSION 9.1

Shivering - lower part of body

Shivering - rising

Stomach - thirst - during chills

Stomach - thirst - small quantities - often

Fever - side - one side - right

Head - pain - heat - during

Skin - goose bumps

Mood - despair - when heated

Fever - septic fever

Differentiation between remedies

Arnica appears quite often in the rubrics but is not mentioned for the symptom "Skin - goose bumps". More restlessness would be expected with *Arsenicum album*.

Sulphur is listed under one-sided febrile symptoms but is not mentioned for the right side.

Prescription

Pulsatilla 200C, 5 globules every six hours.

Progress

Over the next four days, the intensity of the chills and febrile convulsions decreased markedly.

The patient was afebrile just six days after administering the remedy; the medication to strengthen his circulation was discontinued. The intensity of his headaches had decreased by 75%; the gripping abdominal pains were 50% better. The coughing had become less, sputum whitish. The patients appetite had increased and he also felt much better mentally. All symptoms vanished over the next four days and the patient was discharged from the hospital.

Evaluation

The patient responded quickly to the treatment and was

Bibliography

Case 1.1-11: Gram-negative sepsis in a case of cerebral malaria

Farokh Master, Jayesh Dhingreja

Anamnesis

32-year-old man with gram-negative sepsis and cerebral malaria caused by *Plasmodium falciparum*; coma, serious hepatorenal failure and convulsions.

Acute event

The patient was in a coma with high fever and signs of septic shock. A rattle was audible when he breathed and he was intubated to prevent inhalation of gastric contents. His lungs had to be aspirated every 30-45 minutes owing to profuse mucous secretion. His pulse was rapid and faint, his body felt ice-cold yet he involuntarily threw off all covers. He also had epistaxis and a dry cough. His head was pulled to one side.

Diagnosis

Gram-negative sepsis from cerebral malaria.

Conventional treatment

Regular checks for *Plasmodium falciparum* were performed. The patient was ventilated and received antimalarial medication, antibiotics and steroids.

Homeopathic treatment

Repertorisation

SYNTHESIS REPERTORY. VERSION 9.1

Breathing - rattling

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Differentiation between remedies

Camphora appears in all three rubrics. *Opium* has to be considered in terms of differential diagnosis. *Arsenicum album* is also a possibility, but these patients are usually more restless and love warmth.

Prescription

Camphora 1M is given every four hours over one day.

Progress

The volume of the tracheal secretions decreases rapidly within 24 hours. The patient recovers consciousness after 48 hours. The epistaxis stops after 4 days. By the fourth day, the patient's temperature has dropped to 37.2 °C and remains in this area for 10 days. His hepatorenal functions improve on the 6th day; he is weaned from the respirator on the 7th day.

Evaluation

Even in this case of severe cerebral malaria, the progress of the disease was decisively influenced by the concomitant homeopathic treatment.

Critical commentary

This case vividly illustrates the value of precise observation of the acutely ill patient in the context of classical homeopathic anamnesis.

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1.2 Serious local infections

Conventional medicine

Serious local infections are widely varying entities which can only be viewed universally to a limited extent. For this reason, the conventional approach is described for each individual case rather than being expounded at the beginning of the chapter.

Homeopathy

Symptom selection

Only an inadequate selection of symptoms can be given because of their immense diversity. Each case must be treated individually.

COMPLETE REPERTORY MILLENIUM

Generalities - abscesses, suppurations

abrot., aeon., agar-cps., ail., *all-c.*, ambr., am-c., anac., *anan.*, ang., ant-c., Anthr., ant-t., *apis*, aran., arg., arg-n., arist-cl., Arn., ars., *ars-i.*, *ars-s-f.*, *asaf.*, aur., aur-m-n., bac., bad., bapt., *bar-c.*, bar m., batn., *bell.*, *bell-p.*, berb., bor., both-l., bov., brom., *bry.*, bufo, calc., calc-f., *calc-hp.*, Calc-i., calc-m., calc-p., calc-pic., Calc-s., calc-sil., Calen., *canth.*, caps., *carb- ac.*, carb-an., *carb-v.*, care., *caust.*, *cench.*, *cham.*, chel., *chin.*, chin-ar., chin s., cic., cinnb., *cist.*, clem., cocc., coc-c., coloc., con., conch., *croc.*, crot-h., cupr., cycl., digox., dros., *dulc.*, *echi-a.*, elat., euph., euphr., ferr., *fl-ac.*, form., gels., graph., *guai.*, guare., *gunp.*, hecla., hell., Hep., *hippoz.*, hydr., hydrog., hyos., ign., iod., iodof., jug-r., kali-bi., kali-c., kali-chl., kali-i., kali-n., kali-ox., kali-p., kali-s., kalm., *kreos.*, Lach., *lap-a.*, laur., *led.*, lob., lyc., lycps., mag-c., mag-f., *mang.*, matth., Merc., merc-aur., merc-c., merc-d., merc-i-r., methyl., mez., morg., mur-ac., *myris.*, nat-c., nat-m., nat-sal., nat-sil., *nit-ac.*, nux-m., nux-v., *ol-j.*, open, paeon., petr., ph-ac., Phos., *phyt.*, plat., plb., psil., psor., ptel., puls., *pyrog.*, raja-s., ran-b., ran-s., rhod., *rhus-t.*, ruta, sabad., sabin., salx-m., sank., saroth., sars., scol., *sec.*, sei., sep., sieg., Sil., sil-mar., skook., spig., spong., squil., stann., staph., staphycoc., *stram.*, stront-c., *sul- ac.*, sul-i., *sulph.*, symph., syph., tarent., *tarent-c.*, ter., teucr., teucr-s., thuj., thyr., tub., vesp., viol-t., *vip.*, vip-r., wies., zinc.

- chronic

arg., am., *asaf.*, aur., calc., *calc-f.*, calc-i., calc-p., calc-s., *carb-v.*, cham., chin., con., fl-ac., graph., *hep.*, *iod.*, iodof., kali- bi., kali-i., laur., lyc., mag-f., mang., *mere.*, merc-c., merc-i-r., *nit-ac.*, ol-j., phos., sars., sep., Sil., stram., *sulph.*

- gangrenous

COMPLETE REPERTORY MILLENIUM Generalities - inflammation

abies-c., abrot., achy., Aeon., acon-f., acon-l., act-sp., adlu., adon., adren., aesc., aethi-a., agar., agn., agro., ail., alf., all-c., aln., aloë., alum., alumn., alum-sil., am-be., ambr., am-c., am- caust., am-m., ammc., am-p., anac., anan., ang., ant-ar., ant-c., anthr., ant-t., apis., apoc., aq-mar., aran., aran-ix., arbu., arg., arg-n., arist-cl., am., Ars., ars-br., ars-i., ars-s-f., arum-d., arum-L., asaf., asar., astac., aur., aur-ar., aur-i., aur-m., aur- m-n., aur-s., bac., bad., bapt., bar-c., bar-i., bar-m., bar s., Bell., bell-p., benz-ac., benz-d., berb., bism., bor., both-l., bov., brach., brom., Bry., bufo, but-ac., buth-aust., cact., cael., calad., calc., calc ar., calc-f., calc-hp., calc-i., calc-p., calc-s., calc-sil., calcul-r., calen., camph., cann-i., cann-s., canth., caps., carb-ac., carb-an., carb-n-s., carb-v., care., card-m., caul., caust., cedr., cham., chef, chelo., chin., chin-ar., chin-s., chlorpr., cic., cemic., cina, cist., cit-ac., clem., coca, cocc., coc-c., coch., cod., coff., colch., colchin., coloc., con., conch., cop., cori-r., com., cor-r., cortiso., cory., crat., croc., crot-h., croto-t., cub., cupr., cupr-acet., cupr-m., cycl., des-ac., dig., dros., dulc., echi-a., elat., eos., equis., eucal., euph., euph-pi., euphr., eup-per., fab., ferr., ferr-ar., ferr-i., ferr-p., ferr-pic., fd., fl-ac., flor-p., form., form-ac., frag., franc., frax-e., fuc., gad., gaul., Gels., gins., glon., glyc., gnaph., gran., graph., guai., gunp., ham., hecla., hed., hell., hep., hippoz., hir., hist., hydr., hydr-ac., hydre., hydro-c., Hyos., hyper., ichth., ign., indg., *iod.*, iodof., ip., iris-t., jac., kali-ar., kali-bi., kali-br., kali-c., kali-chl., kali-i., kali-m., kali-n., kali-p., kali-s., kali-sil., kalm., kreos., lac-ac., lac-c., lacer., *lach.*, lact., lap-a., lat-k., laur., lec., led., lil-t., lith-be., lith-c., lith-sal., lob-s., luf-op., lyc., lycpr., lycps., mag-c., mag-f., mag-m., mag-p., mand., mang., m-arct., m-aust., med., menthol., meny., Merc., merc-c., merc- cy., merc-d., merc-i-f., merc-i-r., merc-s., mez., morg., morg-g., morph., mosch., mur-ac., mygal., myric., myris., myrt-c., naja, nat-ar., nat-br., nat-c., nat-i., nat-m., nat-p., nat-s., nat-sal., nat-sil., nicc-s., nit-ac., nux-m., Nux-v., olnd., onop., op., open, ozone, pall., par., pareir., petr., ph-ac., *phos.*, phyt., pin-s., pipe., pip-m., pip-n., pitu-a., plan., plat., plb., plb-p., podo., prim-v., prot., psor., ptel., Puls., pyrog., rad-br., ran-b., ran-s., raph., rheum, rhod., Rhus-t., rumx., ruta, sabad., sabaL., sabin., sal-ac., sal-mar., samb., sang., sanguin-n., sank., sars., scirr., scroph-n., sec., sei., senec., seneg., sep., sieg., Sil., sil-mar., slag, solid., spig., spira., spong., squil., stann., *staph.*, staphycoc., stel., stict., still., stram., stront-br., stront-c., stroph., stry., sul-ac., sulfa., sul-i., sulph., sui ter., syc-co., symph., syph., tab., tarax., tarent., tarent-c., tax., tell., ter., teucr., thal., thiop., thiosin., thuj., thym-gl., thyr., trib., tub., tub-k., urea, urt-u., uv-a., v-a-b., valer., ven-m., Verat., *verat-v.*, verb., vesp., vine., viol-t., vip., vip-a., vise., zinc., zinc-p., zirc.

1 Infectious diseases

Differentiation between important homeopathic remedies

Important remedies: *Hepar sulphur*, *Mercurius solubilis*, *Silicea*.

The most important remedies for local infections are *Hepar sulphur*, *Mercurius solubilis* and *Silicea*. They are distinguished by the following characteristics:

Hepar sulphur: strong suppurative tendencies, particularly starting from papules. The suppurating areas can be painful and blood is commonly mixed with the pus. They can smell intensively of old cheese. Every injury suppurates, no matter how small.

Mercurius solubilis: profuse discharges and sup-puration, sharp and burning. The pus is thin, green and is tinged with bloody stripes.

Silicea: abscesses tend to come to a head. Propensity to whitlows, fistulae. *Silicea* can transport foreign bodies to the surface of the skin and help eliminate them. Every injury suppurates, no matter how minor; the sup-puration lasts for a long time.

1.2.1 Ludwig's angina (Quinsy)

Definition

Infections in the submandibular area are illustrated by a case of Ludwig's angina (Quinsy), a form of cellulitis appearing on both sides which spreads along soft tissue planes, rather than via the lymphatic system. It is defined as a bacterial infection of the floor of the mouth including the tissue under the tongue. The disease causes swelling which may obstruct the airways and prevent the patient from swallowing his saliva. Glandular structures are obstructed and gangrene sets in with a putrid, serous/bloody infiltration, little or no pus and no abscess formation.

Clinical information

Incidence and mortality

Most patients are young, healthy adults; men are affected two or three times as frequently as women. In adults, about 52% of cases are caused by dental caries; the

generalisation of the infection, which can cause sepsis. The transition to septic shock is very rare but potentially fatal. Ludwig's angina (Quinsy) is life-threatening but responsive to treatment provided the airways are carefully protected and the patient receives adequate antimicrobial therapy. It usually occurs after tooth extractions or abscesses in the oral cavity when the bacteria multiply and spread.

Symptoms

Patients notice a sudden, painful swelling and reddening in the parotid area. This is accompanied by high fever and difficulty swallowing. The tongue may be swollen, as a result of which its movement is restricted.

The predominant symptoms are neck pain and swelling, toothache or recent extraction and dysphagia. Respiratory problems such as dyspnoea, tachypnoea and stridor have been noted in 27% of cases. General symptoms such as fever, weakness, nausea, vomiting and severe fatigue are very common. The patient rarely complains of earache. Other symptoms include a muffled voice, saliva loss and tongue swelling.

Diagnosis

When making a diagnosis, it is extremely important to distinguish between abscesses and gingivitis, as the initial treatment options vary in each case. While an abscess requires a surgical incision, gingivitis will respond well to antimicrobial treatment alone.

Inspection/physical examination

Examinations of the throat and head reveal marked reddening and swelling around the mouth and chin. The tongue is also red, and the swelling and inflammation pushes it upwards and backwards. Submandibular abscesses are primarily a clinical diagnosis. Physical examinations show a hard submandibular swelling and deformity of the mouth secondary to enlargement of the tongue, which is raised and often protruding. Obstruction of the airways is a common and feared complication of submandibular abscesses. The restricted breathing is a consequence of obstruction by the swollen,

displaced tongue, oedema in the neck and larynx (the oedema can also include the epiglottis) and poor control of pharyngeal secretions.

Inflammation markers

Procalcitonin (PCT) is a marker of systemic infections which is not usually increased in cases of local infection; however, it may be increased in patients suffering from this dramatic disease. Lipopolysaccharide-binding protein (LBP), an acute-phase protein produced by the liver, is under discussion as a possible indicator for serious local infections. C-reactive protein (CRP) is a good marker for local infections.

Imaging techniques

CT: with a sensitivity of 55%, a CT of the throat can be particularly helpful in assessing how far the inflammation has spread. When combined with clinical examinations, a diagnostic accuracy of 89% can be achieved with a sensitivity rate of 95%.

Blood cultures

Blood cultures are usually negative, particularly in the early stages; tissue cultures are therefore preferable.

Tissue cultures

Tissue cultures usually provide information about the bacteria causing the infection. Inflammation in the oral

or anaerobic bacteria. Although fungi and mycobacteria may occasionally be found, it is the bacteria which occur naturally in the mouth which are mainly responsible for deep infections in the throat area. They become pathogenic when the barrier created by the mucous membranes is breached, as for example with pharyngitis, allowing them to penetrate the deeper regions. These infections are caused by mixtures of aerobic and anaerobic bacteria, with the anaerobic bacteria exceeding the aerobic bacteria at a ratio of 3:1 to 6:1. If the culture does not provide evidence of an anaerobic infection, the following clinical signs may strengthen the suspicion that anaerobic pathogens are present: a putrid-smelling discharge is a diagnostic sign but is not present in half of confirmed cases. Gas production, tissue necrosis and abscess formation are also indicative.

Treatment

Standard treatments for all deep infections in the throat area comprise management of the respiratory tract, the intravenous administration of antibiotics and prompt surgical exploration.

Therapeutic crisis

A therapeutic crisis occurs when the patient's condition fails to improve despite appropriate antimicrobial treatment and it is feared that the infection will penetrate the surrounding tissue.

Case 1.2-1: Ludwig's angina - an atypical form of treatment

Michael Frass

Anamnesis

23-year-old, obstinate male patient with sudden swelling in the left sublingual and submandibular areas. On being admitted to hospital (day 0), his temperature is 39.5 °C. Radiological tests on his jaw show four impacted wisdom teeth but no clear dental cause of the swelling. The ultrasound shows numerous cystic masses in the submandibular area, confirming the clinical diagnosis of Ludwig's angina (Quinsy).

His mother suffers from depression; his sister became

Acute event

After the patient's temperature fails to fall as a result of being given antimicrobial treatment and he develops an antibiotic-induced allergic skin reaction, the patient demands to be discharged from hospital on day 2. Despite being given a detailed explanation of the disease and the potentially life-threatening complications, the patient decides to undergo homeopathic treatment. On day 2, his axillary temperature is 39.7 °C. One striking symptom is a massive, hard, board-like swelling in the submandibular area, mainly on the left side. The patient's face is swollen (he is otherwise very slim) and his mouth is deformed by his enlarged, displaced tongue. Swallowing is painful; the patient can only tolerate soft, mushy food.

1 Infectious diseases

Diagnoses

Ludwig's angina (Quinsy), submandibular abscess.

Conventional treatment

The left submandibular area is incised on day 1; no pus is found and the culture taken is negative.

Medication

The patient receives amoxicillin, oxacillin, diclofenac and sucralfate from day 0 to day 2.

Homeopathic treatment

Repertorisation I

COMPLETE REPERTORY MILLENNIUM

Fever, heat - septic fevers

Face - swelling - left

Face - swelling - jaws - lower

Mouth - swelling - tongue

Mouth - protruding - tongue

Throat - pain - stitching - swallowing aggravated

Differentiation between remedies

The clinical symptoms of septic fever, pressure in the submandibular region, problems on the left side and the swollen, protruding tongue guide the therapist to *Lachesis*.

Echinacea boosts the patients immune system while he is in a septic condition. *Myristica sebifera* has a highly antiseptic effect; it is the so-called "homeopathic knife" which accelerates abscess cleansing and shortens the duration of the disease; it often works more powerfully than *Hepar sulphur* or *Silicea*. *Myristica sebifera*: phlegmons, accelerates pus formation and the bursting of abscesses without surgical intervention; powerful antiseptic.

Anthraxinum (anthrax toxin) is a nosode and has proven itself in treating septic inflammation, carbuncles and malignant ulcers. It is indicated for furuncles and suppurating skin manifestations, abscess formation, bumps and all kinds of inflammation of the connective

Prescription

On day 2: 1 dose of 2 globules *Lachesis muta* CM. One hour later: one dose of 2 globules *Echinacea* 30C; one hour after that: two globules of *Myristica sebifera* 200C.

Progress

In the evening of day 2, the patient notices that the swelling in the left submandibular area is increasing; his temperature falls to 37.8 °C. He sweats profusely during the night. The submandibular swelling on the left moves downwards (fig. 1.2-1). On day 3, the tongue swelling subsides and the patient's temperature has dropped to 37.0 °C.



Fig. 1.2-1: Downward movement of the submandibular swelling, principally affecting the left lower jaw (day 2).

Repertorisation II COMPLETE REPERTORY MILLENNIUM

Abscesses, suppuration - lymphatic tissue

Differentiation between remedies

A repeat dose of *Myristica sebifera* and a dose of *Hepar sulphur* is administered to speed up the rate at which the swelling is subsiding and to help the abscess come to a head. The clinical indication for *Hepar sulphur* is the suppurating tendency.

Prescription

Another dose of two globules *Myristica sebifera* 200C; two globules *Hepar sulphur* 30C administered one hour later.

Progress

Day 4: no more difficulties with swallowing. Pus is flowing out of an opening which formed spontaneously

1.2 Serious local infections



Fig. 1.2-2:D Hemispherical protrusion with a diameter of 5 cm on the left lower jaw (day 4).

is now hemispherical in shape with a diameter of about 5 cm (fig. 1.2-2).

Repertorisation III

COMPLETE REPERTORY MILLENNIUM

General - abscesses, suppurations - pus - stinking

Differentiation between remedies

Anthracinum is well known as a remedy for septic inflammation, carbuncles and particularly for black and blue furuncles as well as for gangrenous parotitis and putrefying secretions.

Prescription

One dose of two globules *Anthracinum* 30C administered on day 5.

Progress

Anthracinum promotes the drainage of the swelling, which is discharging a putrid, bloody, serous, grey-



Fig. 1.2-3: Drainage of the swelling with discharge of a putrid, bloody, serous fluid without surgical intervention.

shows no bacterial contamination. The discharge lasts about ten days; afterwards the submandibular swelling disappears leaving a small scar. An ultrasound check-up six months after the acute disease shows hyper-dense structures with a diameter of 1.3 cm in the left submandibular area corresponding to the fibrotic remains of an enlarged lymph node with no other pathological changes.

The patient recovers completely and has no recurrence of the disease during the follow-up observation period of more than 15 years.

Evaluation

The standard conventional treatment for all deep infections in the throat area is hospitalisation with respiratory tract management, intravenous antimicrobial treatment and prompt surgical exploration. About half of all cases of Ludwig's angina heal without surgical drainage; up to 43% require tooth extraction. There have been reports of complications following the surgical drainage of submandibular abscesses.

This case study deals with a patient with Ludwig's angina (Quinsy). The patient refused all further antimicrobial treatment due to an allergic skin reaction to antibiotics. He requests homeopathic treatment as an alternative. Within 24 hours, his temperature returns to normal while bloody serous fluid flows from a drainage hole in the transformed submandibular swelling over a period of ten days without surgical intervention.

Critical commentary

This case draws attention to the dangers of homeopathic treatment: the patient's life is at risk, as the abscesses could be exacerbated at any time. The case study shows that homeopathic treatment in compliance with the law of similars can be successful in treating Ludwig's angina (Quinsy) when antibiotics cannot be administered for any reason. The almost simultaneous administration of several remedies is subject to criticism from a homeopathic viewpoint. However, the author would like to point out that this is an extremely dangerous disease which can be life-threatening for the patient if he does not respond to treatment.

1 Infectious diseases

1.2.2 Hip joint abscess

Definition

A hip joint abscess is an inflammation of the hip joint caused by the penetration of pathogens. This results in a destructive infection of the joint.

Clinical information

Symptoms

The main symptoms of an infected hip joint abscess are fever and severe pain around the hip joint. This grows worse when moving and putting weight on the joint, making it necessary to relieve the strain on the leg and hip. The muscles in the thigh and lower leg atrophy relatively quickly as a result.

If these symptoms occur after the implantation of a total endoprosthesis, revision of the artificial hip joint is unavoidable in most cases; this is an enormous physical and psychological strain, particularly for older patients.

Diagnosis

Inflammation markers

The primary symptoms of a hip joint abscess are the

swelling and heat. The patients leucocytes, erythrocyte sedimentation rate, C-reactive protein (CRP) and LBP (rarely measured) are also significantly raised in most cases.

Imaging techniques

Suitable imaging techniques include conventional radiography, MRI and particularly CT, which is distinguished by its high levels of sensitivity. Others include nuclear procedures such as bone and gallium scans or arthrography.

Blood cultures

Blood cultures are only of secondary importance when diagnosing hip joint inflammation.

Treatment

Therapeutic crisis

The main problem is protracted exudative inflammation

Case 1.2-2: Abscess close to an artificial hip joint

Michael Frass

Anamnesis

62-year-old miner who has had joint problems for more than 15 years; he is being treated with antirheumatic drugs and corticosteroid injections. Total hip joint replacement on the right one year ago.

Five years ago: supraventricular tachyarrhythmia with indications for a pacemaker. Operation on prolapsed lumbar disc five years ago. Aortocoronary bypass operation three years ago, followed shortly afterwards by pneumonia in the right-hand basal lobe. Cardiac arrest two years ago. Closed perforation of the bowel six months ago due to diverticulosis.

The patient is sensitive and painstakingly precise. He meticulously notes all health changes and many events which occur in his daily life. He is very well organised

to neatness. He is rather choleric by nature, but also very lovable and devoted to his family. He does not like fish or sweet foods. He is sensitive to cold and does not feel well when it is raining.

Acute event

Acute abscess near the artificial hip joint on the right. Simultaneously pneumonia in the basal lobe of the right lung with respiratory insufficiency.

Diagnoses

Rheumatoid arthritis, total hip replacement, hip joint abscess, pneumonia, haemorrhagic tendencies, colon diverticulosis, supraventricular tachyarrhythmia, prolapsed disc.

Conventional treatment

Ultrasound examinations and magnet resonance imaging confirm the clinical suspicion of abscess formation near the artificial hip joint. The abscess is

1.2 Serious local infections

is drained. After the abscess has been opened, the patient suffers recurrent bleeding in the operation site and the bronchi, skin and gastrointestinal tract, especially when defecating. The patient has to be intubated and ventilated. The respirator pressure is high; the patient needs 80% FiO₂.

Medication

Ciprofloxacin, meropenem. Enteral nutrition via stomach tube, pantoprazole to protect the stomach, fluid replacements and noradrenaline as a catecholamine.

Homeopathic treatment

Repertorisation I

_____ **COMPLETE REPERTORY MILLENNIUM**

Chest - bleeding

Mind - fear - alone, of being

Mind - conscientious about trifles

Chest - inflammation - lungs, pneumonia - lower - right

Generalities - food and drinks - fish - aversion

Extremities - abscess - joints

Extremities - suppuration - hips

Extremities, inflammation, hips

Generalities - wounds - bleeding - freely

Rectum - haemorrhage - anus - stool, during

Differentiation between remedies

Phosphorus is extremely important, while *Arsenicum album* has no direct relevance to the local inflammation. The main symptoms are less important in *Silicea* and *Mercurius*. The repertorisation process leads to *Phosphorus*.

Prescription

1 dose of 3 globules *Phosphorus* 200C.

Progress

A few days after the administration of *Phosphorus*, the patient's condition improves considerably. The

after seven days and extubated on the ninth day. The tendency to abscess formation in the operated hip still remains. The patient wakes up in the night with vague anxiety; he would like to escape from the bed.

Repertorisation II

_____ **COMPLETE REPERTORY MILLENNIUM**

Mind - fear - night - aggravated

Mind - fear - nights - aggravated - lie in bed - cannot

Differentiation between remedies

In this situation, *Arsenicum album* is the leading remedy; although *Rhus toxicodendron* seems to be equivalent, the patient does not have the characteristic compulsive restlessness.

Prescription

5 globules *Arsenicum album* 12C twice a day for 20 days.

Progress

Increased sterile secretions are discharged from the wound area; this diminishes after 13 days. After 16 days, a complication arises in the form of a pulmonary embolism, confirmed by spiral computed tomography; thrombolytic treatment and intensive anticoagulation are out of the question because of the earlier haemorrhaging.

Repertorisation III

_____ **COMPLETE REPERTORY MILLENNIUM** Chest - embolism

Differentiation between remedies

The main remedies for pulmonary embolisms are *Crotalus horridus*, *Lachesis* and *Naja*. Differentiating the remedies turns out to be difficult; in view of the localised septic focus, preference is given to *Lachesis*.

Prescription

One dose of *Lachesis* 200C.

Progress

The patient perspires profusely for three days and nights; his general condition then improves. The spiral CT on

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of which the patient is transferred to a normal ward and discharged after 28 days in hospital.

Evaluation

The remarkable thing about this case is that the artificial hip joint did not have to be replaced. Where abscesses form around artificial hip joints, the joint may have to be removed, meaning protracted suffering for the patient. The bleeding problems and pneumonia were brought

surprisingly quickly (even considering the fact that antibiotics were administered simultaneously).

Critical commentary

Pulmonary embolisms are quite common complications in ICU patients. The prompt administration of *Lachesis*, as in this case, may shorten the treatment duration. The profuse sweating indicates disordered elimination via the skin and can be viewed as a positive sign.

1.2.3 Cricoid perichondritis

Definition

Cricoid perichondritis is a purulent or necrotising inflammation of the cartilage or perichondrium of the larynx. The trachea is often also involved, posing a significant threat to the stability of these structures. Inflammation in this area can lead to laryngeal and tracheal stenosis.

Clinical information

Incidence and mortality

Cricoid perichondritis heals in most cases, although the vocal function may be lost and the patient may have difficulty swallowing.

Pathogenesis and aetiology

The laryngeal skeleton consists of epiglottic, thyroid, cricoid and two arytenoid cartilages and can suffer severe damage if it becomes inflamed. Perichondritis in the cartilaginous structures can be caused by long-term intubation, where the surrounding mucous membranes are damaged during respiration, or by incorrect tube positioning and a weak immune system. The radiological treatment of laryngeal carcinomas frequently also leads to secondary infections, particularly with *Pseudomonas* and anaerobic bacteria. Infectious diseases such as tuberculosis or Wegeners granulomatosis can also damage the cartilage.

Symptoms

Cricoid perichondritis manifests clinically with hoarseness and pain, aggravated when swallowing or touching the larynx. The patient commonly reports pain

swelling is a feared complication, as this can lead to dyspnoea.

Diagnosis

When the larynx is examined more closely, the skin of the throat is seen to be reddened with a greasy shine. Laryngoscopy reveals oedematous swelling and reddening of the mucous membranes. The movement of the vocal folds is usually also restricted. If an abscess forms, this may ripen and ultimately discharge onto the skin.

Inflammation markers

In view of the rarity of this disease, no systematic evaluation of the inflammation markers is known to have been made.

Imaging techniques

Computed tomography is the optimum diagnostic procedure.

Blood cultures

Positive blood cultures are found only rarely.

Treatment

The inflammation of cricoid perichondritis is treated with high doses of antibiotics. It often becomes necessary to open and drain the abscess. Laryngectomy may be necessary in patients with difficulties swallowing, aspiration and voice loss. This is usually a palliative measure for tumour patients.

Therapeutic crisis

Problems may occur if it becomes difficult or impossible

Case 1.2-3: Dyspnoea in a case of severe cricoid perichondritis

Michael Frass

Anamnesis

83-year-old male patient with severe abdominal colic, flatulence and constipation. He has had a cough and mild breathlessness for some time, which stops him from singing. Emergency operation 25 years ago due to recurrent abdominal colic with bowel obstruction, construction of ileostomy and reversal 6 months later. Previous cholecystectomy due to cholecystolithiasis 13 years ago. Diabetes mellitus type II diagnosed 6 years ago; treated with diet and medication. Prolapsed disc nine months ago; treated surgically in L4/5 area.

Acute event

Severe abdominal colic with flatulence for four days, worse on passing wind, also constipation and severe halitosis. An abdominal ultrasound and CT reveal a massively dilated, fluid-filled stomach and widened, fluid-filled loops in the small intestine, indicative of ileus caused by adhesions. After surgery performed on the same day to remove the adhesions (no complications), the patient's condition worsens; confusion, abdominal pain and oliguria set in on the second day following the operation. No indication of recurrent ileus in repeat abdominal x-ray.

Due to respiratory decline with conspicuous stridor and poor general condition, the patient is admitted to ICU on day 0 and immediately intubated. Patient extubated on day 2; at this time he is alert and his neurological status is normal. Diuresis restored by administering furosemide and fluids. Although the patient recovers somewhat over the next few days, the stridor in the laryngeal area again increases, the patient becomes more restless and has to be intubated again. Swelling of the vocal cords and cricoid cartilage is noted when intubating the patient on day 7. These findings are confirmed by a laryngeal examination; a laryngoscopy reveals perichondritis of the cricoid cartilage. Blood tests show moderate leucopenia.

Treatment with clindamycin and high doses of cortisone starts on day 7, but there is little improvement in the local situation over the following days.

Diagnoses

Adhesive ileus, oliguria, acute dyspnoea with cricoid perichondritis, diabetes mellitus type II, previous cholecystectomy, previous disc prolapse.

Conventional treatment

Tracheotomy and respiration

Due to a life-threatening increase in dyspnoea showing no tendency to improvement, a tracheotomy is performed surgically on day 12. The patient initially receives controlled respiration, and after a short time is switched to BIPAP (bilevel intermittent positive airway pressure, Evita®).

Imaging techniques

An x-ray of the lungs is normal. A computed tomography of the larynx performed on day 13 confirms the diagnosis of cricoid perichondritis.

Medication

The patient now receives antimicrobial treatment with meropenem (e.g. Meronem®). The blood culture indicates the presence of *Candida glabrata*. The patient is therefore treated with the antimycotic fluconazole (e.g. Diflucan®). The infectious diseases specialists assume that the patient will be ill for a lengthy period.

Homeopathic treatment

Repertorisation

————— **COMPLETE REPERTORY MILLENNIUM**

Larynx & trachea - swelling - vocal cords

Larynx & trachea - inflammation - larynx

Inflammation of the intestines with adhesive ileus:
abdomen - inflammation, peritonitis, enteritis Intestinal
inflammation in the pelvic area

Differentiation between remedies

The patient receives *Belladonna* for the clinical aspect of inflammation. This decision was made

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due to the acuteness of the symptoms and the patients local and abdominal condition.

Apis is also a possible choice. Extreme sensitivity to touch are found along with burning, stabbing pain. However, the patient does not have intermittent fever and shivering.

Prescription

5 globules *Belladonna* 12C 3 times a day from day 13.

Progress

The swelling in the vocal cords subsides after three days (a finding confirmed by laryngoscopy); the tracheotomy tube is removed after another 3 days. There are no

Evaluation

This case study again shows (» 1.2.1, Ludwigs angina Quinsy) that inflammation in the otorhinolaryngeal area can respond very well to homeopathic treatment. After a relatively long period with no improvement, the signs of inflammation disappeared surprisingly quickly after the patient was given *Belladonna*.

Critical commentary

This example shows that older patients can also respond well to homeopathic treatment. Contrary to the doctors' expectations, the patients stay in ICU was shortened significantly and the duration of the intubation reduced to the patients benefit.

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2 Disorders of Haemostasis

Michael Frass, Beatrix Wulkersdorfer (Conventional Medicine) Michael Frass (Homeopathy)

- 2.1 Thrombotic-thrombocytopenic purpura (TTP)
- 2.2 Bleeding after therapeutic puncture wound
- 2.3 Pulmonary embolism

Conventional medicine

All reactions which effectively stop bleeding are summarised by the term haemostasis. The tasks of the haemostatic system are firstly to stop bleeding and secondly to prevent thrombosis. This balance is maintained by the interaction of numerous activators and inhibitors. Disruptions in this system lead to haemorrhagic diatheses and thrombophilia.

Homeopathy

There are several potentised remedies capable of regulating blood coagulation. *Arnica montana* and *Phosphorus* have both been used successfully to treat bleeding complications from surgery. *China officinalis* is often used with great success to treat the consequences of severe blood loss. *Ipecacuanha* is often indicated for postpartum bleeding. *Crotalus cascavella*, *Crotalus horridus* and *Lachesis* can be used concomitantly to treat disorders caused by embolisms.

Symptom selection

The location and severity of the bleeding, the blood colour and if possible also the trigger of the bleeding disorder should be considered when choosing the symptoms.

COMPLETE REPERTORY MILLENIUM

Generalities - bleeding - tendency or actual

abies-n., abrot., acai., acet-ac., aeon., adren., agar., ail., alet., aln., aloe, alum., alum-acet., alumn., ambr., am-c., am-caust., am-m., ammc., amyg-am., anac., androc., ant-c., anthr., ant-t, apis, apoc., aran., arg., arg-n., Arn., ars., ars-h., ars-i., ars-s-f., arum-t, asaf., asar., aur., aur-m., bac., bad., bapt, bar-c., bar-i., bar-m., Bell., bell-p., benz-d., benz-n., berb., bism., bor., Both-1., bov., brom., bry., bufo, cact., Calc., calc-f., calc-i., calc-1., calc-p., Calc-s., calc-sil., cann-s., Canth., caps., carb-ac., carb-an., carbn-h., carbn-o., carbn-s., Carb-v., care., card-m., case., caust, cham., Chin., chin-ar., chin-s., chlöl., chloram., cic., cina, cinnam., cinnb., cit-ac., cit-l., clem., cob., cocc., coc-c., coff., coff-t, colch., coll., coloc., con., cori-r., cortico., crat, croc., crot-c., Crot-h., cupr., cycl., des-ac., dig., dor., dros., dulc., elaps, equis., erech., ergot, Erig., erod., eucal., euph., euph-pi., euphr., eupi., Ferr., ferr-ar., ferr-i., ferr-m., ferr-p., ferr-py., ferr-s., fie., fic-v., fl-ac., gall-ac., gelin., ger., glon., graph., Ham., Hell., helon., hep., hit, hydr., hydrin-m., hydrin s., hyos., hyper., ign., iod., Ip., jug-c., juni-c., kali-c., kali-chl., kali-i., kali-n., kali-p., kreos., Lach., lachn., lat-m., laur., led., leon., lept, lyc., lycps., mag-c., mag-m., mag-s., mang., mangi., m-arct., m-aust., Meli., Merc., Merc-c., merc-cy., mez., Mill., mosch., mur-ac., Murx., naja, nat-acet., nat-c., Nat-m., nat-n., nat-s., nat-sil., nit-ac., nux-m., Nux-v., ol-an., op., par., petr., ph-ac., Phos., pitu-gl., plat., plb., prun., psor., Puls., pyrog., rad- br., rat, rheum, rhod., rhus-a., rhus-g., rhus-t, rhus-v., ruta, sabad., Sabin., sal-ac., sang., sanguis., sars., scirr., Sec., sed-t, sei., senec., Sep., sil., squil., stann., staph., stict, stram., stront-c., Sul-ac., sulfa., sul-h., sui t, Sulph., syph., tab., tarax., tarent., ter., thlaspi, thuj., til., tril., urt-u., ust, valer., verat., vib., vine., vip., vip-a., vise., wies., xan., xanth., x-ray, zinc.

Generalities - wounds bleeding freely

aeon., adren., ail., am-c., ant-t., aran., am., ars., asaf., bell-p., bor., both-L, bov., calc-1., carb-an., carb-v., care., caust, cench., chin., clem., con., cop., croc., crot-h., dor., eug., euphr., ferr., ferr-p., gall-ac., ham., hep., Hir., hydr., kali-n., kreos., Lach., Lat-m., led., mere., mez., mill., m-p-a., nat-c., nat-m., nat-s.

2 Disorders of Haemostasis

COMPLETE REPERTORY MILLENIUM

Generalities - wounds bleeding freely

Nit-ac., *nux-m.*, *nux-v.*, *ph-ac.*, Phos., plb., puls., rhus-t., ruta, sec., sep., sil., *staph.*, sul-ac., *sulph.*, ter., thlaspi, vip., vise., *zinc.*

Generalities - wounds - bites - animals, of poisonous animals

acet-ac., *am-c.*, anthr., *apis*, am., *ars.*, aur., bell., calad., *caust.*, *cedr.*, cist., *echi-a.*, grin., helo., hep., hyper., *lach.*, Led., *lob-p.*, *lyss.*, mosch., nat-m., puls., pyrog., *seneg.*, stram., sul-ac., thuj., vip.

Chest - embolism

crot-h., *lach.*, *naja*

Differentiation between important homeopathic remedies

| **Important remedies:** *China officinalis*, *Crotalus cascavella*, *Crotalus horridus*, *Hamamelis*, *Ipecacuanha*, *Lachesis*, *Phosphorus*.

China is preferred in cases of fluid loss, e.g. major blood loss after operations. In such cases, it can bring about rapid improvement in the patients condition during the convalescent phase.

Crotalus cascavella patients are noted for dark, passive bleeding. If the patient is conscious, he has hallucinations about ghosts, spirits and voices; a burning urticaria-like rash appears on the skin.

Crotalus horridus patients feel worse when lying on their right side, as can be observed for example by drops in blood pressure in ICU patients. Like *Crotalus cascavella*, dark, non-coagulated, thin blood flows slowly out of the body. However, in this case the blood may flow out of every bodily orifice or cavity (retina, tears, sweat).

Hamamelis is characterised by passive venous bleeding from various body parts, including epistaxis, bleeding gums, haematemesis, haemorrhoidal bleeding, haematuria, uterine bleeding (bright red), haemoptysis and varicose veins.

Ipecacuanha is particularly important for bleeding from the uterus; this blood is bright red, profuse and lumpy. *Ipecacuanha* is one of the first remedies for postpartum

Lachesis is indicated when the symptoms set in quickly; the left half of the body is worse affected. The bleeding is dark and mainly appears after puncture-like injuries, e.g. catheter insertions. Wounds bleed freely. It is also indicated for high fever and sepsis when the cardiovascular system is affected. *Lachesis* is closely related to thromboembolic incidents. Varicose veins are also typical of *Lachesis* patients.

Phosphorus has a strong propensity to bright red bleeding, typically epistaxis or bleeding after tooth extractions. Purpura is another diagnosis which points to *Phosphorus*.

2.1 Thrombotic thrombocytopenic purpura (TTP)

Definition

Thrombotic thrombocytopenic purpura (TTP), also known as Moschcowitz syndrome, is characterised by microangiopathic haemolytic anaemia, thrombocytopenia, abnormalities in the central nervous system (e.g. epileptic fits), fever and renal dysfunction. The thrombotic events quite often lead to cerebral insults and myocardial infarctions.

Clinical information

Incidence and mortality

Thrombotic microangiopathy with HUS (haemolytic-uraemic syndrome) and TTP are very rare acute diseases (prevalence 1:1 000 000). If left untreated, these diseases have a high mortality rate of 90%. This can be reduced to 10-30% with plasmapheresis (Rock 1991).

More than 10% of all TTP occurs in pregnant women. Pregnancy is also seen as a predisposing factor for this disease. Thrombocytopenia occurs in about 10% of all pregnant women and can be triggered by all kinds of obstetric circumstances. Although not all of these diseases are directly connected with unfavourable effects on the pregnancy, some may be associated with serious morbidity and mortality for the mother and foetus/newborn.

2.1 Thrombotic thrombocytopenic purpura (TTP)

HELLP syndrome (haemolysis, elevated liver enzymes, low platelet count syndrome), a special form of pre-eclampsia associated with haemolysis, increased transaminase activity and a decreased number of thrombocytes, is an important differential diagnosis. This disease must be expected in about one in every 150-300 births. It usually manifests in the 3rd trimester, in young mothers expecting their first child in around the 34th week of pregnancy, more rarely during the first six days following childbirth. The mortality rate in mothers is about 3%, the perinatal mortality rate in newborns about 25%. Recurrences in subsequent pregnancies are rare.

Symptoms

The most striking symptom in patients with TTP is their altered mental status. Clinical findings include haemolytic anaemia, thrombocytopenia, restricted kidney function with a rise in creatinine levels, icterus and fever. Hypertension is also observed. As the disease progresses, cerebral insults and myocardial infarctions may occur, triggered by thrombotic events.

Diagnosis

These diseases are often difficult to diagnose, as their beginning and clinical manifestation often

overlap. Along with the clinical findings, the results of the laboratory tests are important for diagnosis.

Laboratory

Laboratory tests reveal acute thrombocytopenia (very commonly a rapid fall in thrombocytes < 30 g/l), anaemia, evidence of more than 2% fragmentocytes, Coombs-negative haemolysis (LDH at least 2 to 3 times higher than usual, no evidence of haptoglobin, GOT/GPT unchanged).

Intrinsic and extrinsic coagulation tests are normal (INR, PTT). The kidneys are also affected, with creatinine figures rising to a point where dialysis may become necessary; neurological symptoms are also present and the patient may even become comatose.

Treatment

Therapeutic crisis

Complications may arise if the TTP becomes chronic and the patients thrombocyte numbers do not improve despite intensive treatment. Treating bleeding complications is also made more complicated as the patient does not respond to thrombocyte concentrates.

Case 2.1-1: HELLP syndrome

Michael Frass

Anamnesis

A 33-year-old patient with HELLP syndrome (haemolysis, elevated liver enzymes, low platelet count) is admitted as an inpatient during the 22nd week of her first pregnancy. The patient is a smoker (10 cigarettes a day), an editor by profession and lives with her partner. She rarely drinks alcohol. Hospital stay 13 years ago due to skin bleeding of unknown origin. Glandular fever 7 years ago. Childhood diseases: measles, mumps, chicken pox. Previous tonsillectomy, appendectomy in childhood.

Acute event

The gynaecological ultrasound examinations of the first

underdeveloped. Severe abdominal pain in the 5th month of pregnancy, arterial blood pressure of 160/100 mmHg and antihypertensive treatment. Visual disturbances first occur in the 22nd week of pregnancy followed by a drop in thrombocytes within a few hours on the next day (28 to 18 g/l), a drop in haemoglobin (to 6.4 mg/dl) and an increase in transaminases to 300 U/l accompanied by tension and pain in the Glisson capsule. On being diagnosed with HELLP syndrome, the patient, who is conscious on admission, is given a termination (day 0); the child is already dead. Extubation on day 1 with satisfactory blood gas values. Transaminases fall over the following days, increase in LDH, drop in haemoglobin (haemolysis) and low thrombocyte figures despite substitution. After a negative direct Coombs test, the diagnosis of thrombotic

2 Disorders of Haemostasis

thrombocytopenic purpura (TTP) (Moschowitz syndrome) is made and plasmapheresis is performed from day 5. The patient's general condition declines drastically after the plasmapheresis and she is transferred to ICU. On day 8, the patient is intubated, respired and positioned intermittently on her stomach; she has pulmonary oedema and marked pleural effusions on both sides.

Conventional treatment

Due to the marked thrombopenia characteristic of the TTP, plasmapheresis is performed repeatedly with exchange volumes of approx. 3 l; the patient also receives fresh plasma conserves. From day 29, the daily differential blood counts show a gradual increase in thrombocytes to over 100 g/l accompanied by a decline in fragmentocytes (less than 45%). The patient receives intermittent haemodialysis due to marginal retention parameters and marked overhydration. The thorax CT shows evident consolidation in both lungs with negative microbiological findings. The patient still needs increased controlled respiration; on day 33 she is briefly extubated and transferred to a normal ward, but has to be reintubated and returned to ICU due to hypertensive pulmonary oedema (day 41). The patient still needs transfusions although her LDH and haptoglobin levels are normal. As the thrombocytopenia does not improve despite plasmapheresis, the patient's spleen is removed on day 49 after the administration of vaccinations against *Haemophilus influenzae*, pneumococci and meningococci. After being successfully treated for sepsis and pneumonia, the patient is weaned from the respirator on day 66 and extubated on day 70. The patient is transferred to a general ward to clarify the cardiac symptoms and continue the plasmapheresis; her circulation is unstable, thrombocytes 138 g/l, LDH 288 U/l. The patient receives the 57th and 58th plasma exchange treatments on days 52 and 53 due to falling thrombocyte numbers and increasing LDH.

Medication

The patient receives cortisone after every plasmapheresis. Her increased pulmonary pressure (50 mmHg) and an echocardiography reveal

tricuspid insufficiency and diminished functioning of the left and right ventricles. Due to continuing hypertension and sinus tachycardia, antihypertensive treatment with beta blockers is administered and stabilises her heart rate at 100-120/minute. On day 62, the patient develops a temperature and her C-reactive protein (CRP) rises, as a result of which antimicrobial treatment is prescribed with 4.5 g piperacillin/tazobactam three times a day. *Candida albicans* is isolated in the blood cultures; both the Urin and two central lines are infected with candida, as a result of which treatment with fluconazole commences on day 63. The chest x-ray shows a decline and the chest CT shows a strong likelihood of invasive aspergillosis; the fluconazole treatment is therefore replaced with voriconazole from day 65. This brings about a marked improvement in the chest x-ray and a drop in the inflammation markers.

Homeopathic treatment

After the splenectomy, the patient's thrombocyte numbers initially rose (day 49: 282 g/l); however, on day 56, after an attempt to leave off the plasmapheresis, they again fell dramatically to 69 g/l in the morning and 24 g/l in the evening.

Repertorisation I

COMPLETE REPERTORY MILLENIUM

Female - pregnancy - complaints during

Generalities - bleeding

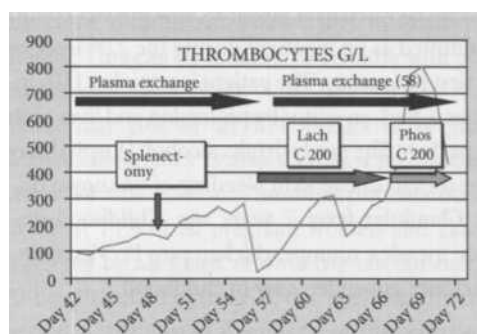


Fig. 2.1-1. Verlauf der Thrombozytenzahl mit Plasma-austausch und Milzexstirpation unter konventioneller und homöopathischer Therapie

2.1 Thrombotic thrombocytopenic purpura (TTP)

Differentiation between remedies

Lachesis was chosen due to the problems during pregnancy, the anamnesis and acute thrombocytopenia and the sepsis-like multiple organ failure. *Phosphorus* does not have such a marked association with sepsis and pregnancy-related complaints. The symptoms of *Pulsatilla* are usually less dramatic, although it is frequently indicated during pregnancy.

Prescription

Lachesis 200C, 5 globules twice a day sublingually from day 57.

Progress

Over the next few days, the patients thrombocytes gradually rise to 109 g/l (day 58) and 181 g/l (day 59). In the days following, her thrombocytes leap to more than 200 and 300 g/l while the plasmapheresis continues. Thrombocytes reach 426 g/l on day 67 and the plasmapheresis is stopped. From day 67,5 globules of *Phosphorus* 200C are administered twice a day as the patient develops marked anxiety after being extubated and *Phosphorus* is also indicated when bleeding threatens. 802 g/l thrombocytes are measured on day 70.

Repertorisation II

COMPLETE REPERTORY MILLENIUM

Mind - ailments, anxiety about

Mind - anxiety, silent

Differentiation between remedies

Natrium chloratum is administered from days 75-85 while the patient is on the general ward, as her mood is very bleak at this time. This is due to the years of conflict with her partner, who is unable to accept her tolerant attitude to homosexuality in others. *Ignatia* would also be a possible choice in terms of differential diagnosis, but this is more suited to acute past events. Neither does the patient have any particular need for warmth.

Prescription

From days 75-85 *Natrium muriaticum* 12C, 5 globules once a day.

Progress

On day 85, the patients thrombocytes measure 511 g/l, she begins to shower with assistance and can be taken into the garden by wheelchair. As her recovery progresses, her thrombocytes rise to over 600 g/l. On day 94, the patient is discharged for home nursing.

Repertorisation III

COMPLETE REPERTORY MILLENIUM

Generalities - pulse, irregular

Chest - pain - clavicle, below, left

Differentiation between remedies

Because of her pre-existing heart weakness, the patient is given *Crataegus* from day 95. Even though it covers all the symptoms described above, *Conium* does not seem appropriate because of the chronic nature of the heart problem.

Prescription

From day 95 *Crataegus* 12C, 5 globules twice a day

Progress

The patient has been well for three years; she has returned to work in her original job.

Diagnoses

HELLP syndrome, previous termination, TTP, pleural effusion, pulmonary oedema, post splenectomy, tricuspid insufficiency, hypertension, sinus tachycardia, sepsis, suspected invasive aspergillosis.

Evaluation

Thrombocytopenia occurs in about 10% of all pregnant women and can be triggered by all kinds of obstetric circumstances (Kam 2004, Sainio 2000). Pregnancy is also seen as a predisposing factor for this disease (Esplin 1999). Although not all of these diseases are directly connected with unfavourable effects on the pregnancy, some may be associated with serious morbidity and mortality for the mother and foetus/newborn. A multidisciplinary team including obstetricians, haematologists, paediatricians and anaesthetists is essential to guarantee

2 Disorders of Haemostasis

thrombocytopenia during pregnancy range from benign diseases such as the comparatively rare pregnancy thrombocytopenia to life-threatening syndromes such as HELLP (McCrae et al. 1992). Thrombotic thrombocytopenic purpura is characterised by microangiopathic haemolytic anaemia, thrombocytopenia, abnormalities in the central nervous system, fever and renal dysfunction. As the disease progresses, the patients creatinine levels rise slightly and her LDH levels dramatically, while her GOT/GPT remain unchanged. More than 10% of all TTP occurs in pregnant patients, particularly during the 2nd trimester. Pregnancy is seen as a predisposing factor for this disease (Esplin 1999). A deficiency in ADAMTS 13 (von Willebrand factor-cleaving protease) has been identified as a causative factor in the pathogenesis of TTP (Furlan 1998, Tsai 1998) along with antibodies against the protease. With HELLP syndrome, patients complain about upper abdominal pain on the right side and epigastrium owing to liver capsule tension, nausea, vomiting, headaches and visual disturbances caused by constriction of the arterioles, possibly with retinal bleeding, exudate and papilloedema. The microangiopathic anaemia, icterus and other signs of haemolysis are noticed very quickly as the haemolysis is so acute. The patients blood pressure rises to over 160/110 mmHg. She develops proteinuria (> 3 g/24 hours) and oliguria with a urine output of less than 400 ml/ 24 hours. Serum tests show elevated uric acid,

creatinine, transaminases, LDH, CK and lactate, while coagulation factors are reduced and thrombocytes fall below 100 g/l. This condition can easily lead to complications: in the mother to cerebral bleeding, liver rupture, brain oedema, pulmonary oedema, renal insufficiency, left heart failure and shock, in the foetus to pathological CTG changes and retarded growth. As soon as the foetal movements decline or stop and the quantity of amniotic fluid diminishes, the pregnancy should be terminated immediately because of the direct threat to the foetus. Recurrences in subsequent pregnancies are rare.

Differential diagnoses which should also be considered are acute fatty liver disease of pregnancy (incidence 1:13 000 pregnancies; main symptoms icterus, fever, leucocytosis, hypoglycaemia, impaired protein synthesis), acute viral hepatitis (most common cause of icterus during pregnancy), intrahepatic cholestasis during pregnancy (incidence 1:500-5 000 pregnancies, the second most common cause of icterus during pregnancy, main symptom itching) and thrombotic microangiopathies (haemolytic-uraemic syndrome, thrombotic thrombocytopenic purpura).

Critical commentary

The progress of this case leads one to assume that the early administration of homeopathic treatment would have shortened the duration of the patient's illness.

2.2 Bleeding after therapeutic puncture wound

Definition

Clinically significant bleeding after therapeutic puncture is defined as blood loss with a measurable effect on the patients red blood cell count and a drop in haemoglobin of more than 0.5 g/dl.

Clinical information

Incidence and mortality

Very little literature exists on bleeding after therapeutic

found. Tryba estimates the risk of spinal epidural haematoma at 1:150 000 after epidural anaesthesia and 1:220 000 after spinal anaesthesia (Tryba 1993). This means that local anaesthetics administered close to the spinal cord are comparatively safe provided they are combined with thromboembolic prevention measures. Back in 1995, the scientific working group for local anaesthesia at the German Association of Anaesthesiology and Intensive Medicine (DGAI) made a statement to the effect that thromboembolic prophylaxis with low molecular weight (LMWH) or unfractionated heparin does not increase the risk of spinal haematoma after local anaesthesia.

2.2 Bleeding after therapeutic puncture wound

After comparatively large doses of low molecular weight heparins (e.g. enoxaparin, 30 mg twice a day) were also introduced in the USA as a form of postoperative thromboembolic prophylaxis, reports came from there concerning the increased incidence of spinal epidural haematomas which led almost without exception to lasting paraplegia and which resulted in the American Food and Drug Administration issuing a warning. The risk of spinal epidural haematomas with the simultaneous administration of low molecular weight heparins was accordingly recalculated in the USA in 1998; these calculations indicated a risk of 1: 40 800 for spinal anaesthesia, 1:6600 for single-shot epidurals and 1: 3100 for catheter epidurals.

Symptoms

The main symptom is blood loss, which may lead to shock. Depending on the puncture site, internal

bleeding must be expected, the full extent of which cannot always be ascertained within the first few hours, even with imaging technology.

Diagnosis

Cardiovascular markers are the first criteria for diagnosis, as bleeding causes fluid loss and compensatory tachycardia. “Swinging” ECG curves are observed in such cases. Laboratory tests reveal a drop in haemoglobin.

Imaging techniques

Both ultrasound and CT can be used; however, it may take some time for positive findings to appear.

Treatment

Therapeutic crisis

Problems can occur if the puncture injured an artery and

Case 2.2-1: Bleeding after puncture

Michael Frass

Anamnesis

A 59-year-old female patient has been suffering from stabbing generalised headaches radiating bifrontally from the occiput since her youth; no pulsating pain, it feels as if a helmet is pressing on her head. She also suffers from nausea and occasional vomiting when the pain is severe. The patient also developed a duodenal ulcer as a result of Parkemed (mefenamic acid) abuse. Over the last few weeks, the pain has intensified and the patient now has a permanent headache with brief intervals of relief. These violent headaches usually start on waking up in the morning.

2.3 months before the acute event, the patient fell down the stairs and suffered a minor trauma in the lumbar area with persistent pain. Paravertebral infiltration was performed one month later. Therapeutic intervention has been unsuccessful and the pain is still present.

Acute event

The patient is admitted on day 0 with fever and

confirm the suspicion of an injection abscess in the local back muscles. A drainage performed on the same day shows that the content is merely serous, no pus. Between day 0 and day 5, the patients thrombocyte count drops dramatically from 460 to 3 g/l with an acute rise in creatinine to 9.2 mg/dl without anuria, epistaxis in the morning and a tension headache. A possible diagnosis of idiopathic epistaxis purpura (ITP) is discussed. There are no signs of haemolysis, no clear rise in LDH and no fragmentocytes in the differential blood count. Between day 3 and day 4, the patients haemoglobin drops from 12.6 to 8.2 g/dl. On day 4, her haemoglobin drops further to 6.5 g/dl within a few hours. Her reticulocytes are massively reduced and a haematoma is observed on the right side. The drain siphons off more than a litre of serous fluid which contains clear traces of dark blood.

Diagnoses

Suspected idiopathic thrombocytopenia (ITP).

Conventional treatment

On day 4, the patient receives 65 g endoglobulin; her thrombocyte levels are now 3 g/l. Cortisone treatment commences (prednisolone 100 mg p.o.).

2 Disorders of Haemostasis

Homeopathic treatment

Repertorisation COMPLETE REPERTORY MILLENIUM

Generalities - haemorrhage - dark

Generalities - haemorrhage - tendency

Generalities - wounds - bleeding, freely

Generalities - wounds - stab wounds Head - pain -

Differentiation between remedies

Lachesis has a propensity to dark bleeding, *Phosphorus* to bright bleeding. *Phosphorus* is not listed under “Wounds - stab wounds”.

Prescription

On day 4, the patient receives one dose of *Lachesis* (5

Progress

The bleeding stops within the hour. On day 5, more bloody, serous fluid is drained. Another dose of *Lachesis* 200C on day 5 again stops the bleeding immediately. On day 9, the patients thrombocyte count increases markedly and her creatinine levels drop significantly with hydration and normal urine output. On day 10, her thrombocyte count rises to 154 g/l. The drain is removed on day 6. The patient feels subjectively well, is fully mobile and can eat and drink.

Evaluation

The most striking feature of this case is the immediate response to *Lachesis*. This remedy stopped the bleeding directly and rapidly re-established a normal thrombocyte count.

2.3 Pulmonary embolism

Definition

Pulmonary embolism is one of the most frequent causes of sudden death. It refers to a thromboembolic obstruction of the pulmonary vessels, although the blood clots mainly come from the venous system. Pulmonary embolisms are very often the result of an undiagnosed deep vein thrombosis in the leg or pelvis.

Clinical information

Incidence and mortality

Pulmonary embolism is one of the most common complications in hospitalised patients. It is estimated that about 50 000-100 000 die of pulmonary embolism every year in Germany alone.

Pathogenesis

The main cause of pulmonary embolism is undiagnosed deep-vein thrombosis (DVT) in the legs. There are numerous factors which contribute to the formation of DVT:

- Operations: knee, hip, tumours
- Trauma to the lower extremities or spinal cord

- Carcinomas
- Immobility
- Obesity
- Pregnancy
- Oral contraceptives in combination with smoking
- Antithrombin III deficiency, protein C deficiency, protein S deficiency

Pulmonary emboli can block the large, medium and smaller branches of the pulmonary artery. Such a blockage creates excess pressure and distends the right heart, which means that patients with coronary heart disease (CHD) are at acute risk of a heart attack. The main symptoms of sudden pulmonary embolism are hypotension, tachycardia, dyspnoea, cyanosis and shock.

According to Grosser, pulmonary embolism can be divided into four stages («? table 2.3-1).

The accompanying circumstances and the extent of the pulmonary vessel obstruction are decisive for the outcome of pulmonary embolism. If the patient already had cardiopulmonary disease, even a minor embolic obstruction will place extra strain on the right heart.

2.3 Pulmonary embolism

Tab. 2.3-1: Stages in Pulmonary Embolism according to Grosser (1980)					
Stage	Clinical Picture	paO ₂ (mmHg)	Arterial RR	Affected Vessels	Pulmonary Mean Arterial Pressure (mmHg)
Stage I	Thoracic pain, mild dyspnoea	80	Normal	Peripheral branches	Normal
Stage II	Thoracic pain, tachycardia, tachypnoea, acute dyspnoea	70		Segment arteries	16-25
Stage III	Thoracic pain, cyanosis, restlessness, syncope, acute severe dyspnoea	60		1 branch of pulmonary artery	25-30
Stage IV	Above-mentioned symptoms plus symptoms of shock, cardiac arrest	< 60	Shock	Main pulmonary artery or several lobar arteries	> 30

Symptoms

About 77% of patients have dyspnoea and 70% tachypnoea. 55% complain of sudden, severe chest pain, especially on inhaling. Coughing, outbreaks of sweating and quite often tachycardia may be observed. Cyanosis, haemoptysis, syncope, hypotension and even cardiovascular shock are seen in about 10% of cases.

Diagnosis

Physical examination

Besides the symptoms mentioned above, a marked second heart sound (best heard in the pulmonary auscultatory region) may be evident and congested neck veins observed. ECG changes are often merely temporary and unspecific. Anomalies may include the occurrence of a right bundle branch block, right axis deviation, S₁-Q_{III}-signs, T inversion in V₁ - V₂ S₁Q₃T₃ signs, sinus tachycardia, tachyarrhythmia and P pulmonale.

Blood tests

Blood gas tests show alveolar hyperventilation with a decrease in O₂ blood gas tension (paO₂) and CO₂ blood gas tension (paCO₂). It is important to be aware that in cases of fulminant pulmonary embolism, the paO₂ may still be normal while the paCO₂ is low.

Evidence of the presence of d-dimers, which represent the circulating degradation products of fibrin, plays an important role in the exclusion of both PE and deep-vein thrombosis.

Imaging techniques

- Spiral computed tomography (CT) mainly shows pulmonary emboli in the major central pulmonary

the outcome of the disease, CT scans are therefore not particularly helpful. Nevertheless, they have the advantage of being non-invasive and able to depict the entire lung and thromboses in the inferior vena cava and pelvic veins.

- Echocardiography has become an indispensable diagnostic tool in recent years. Typical findings with pulmonary embolism include enlargement of the right atrium and ventricle. Dyskinetic or paradox movement of the septum is also observed.
- A right heart catheter may be inserted as an alternative to echocardiography. However, even this is unable to exclude the existence of a pulmonary embolism.
- The value of ventilation or perfusion scintigraphy is highly disputed, not least because it is only rarely available. However, a normal finding safely excludes a pulmonary embolism. Vein diagnostics are extremely important, as thromboses in the deep leg and pelvic veins frequently occur in connection with PE. However, negative findings do not exclude PE.
- The most important radiological tests are the chest x-ray and the angiography. The latter is one of the safest methods of verifying the presence of PE. It is usually performed as a subtraction angiography.
- Chest x-rays are very valuable particularly for excluding other diseases.

Treatment

Therapeutic crisis

Problems are most likely to arise if the patients cardiovascular system is affected. It is also important that the measures described above are implemented as quickly as possible

2 Disorders of Haemostasis

Case 2.3-1: Pulmonary embolism

Michael Frass

Anamnesis

61-year-old male patient treated in ICU for serious acute interstitial pneumonia necessitating artificial respiration. The patient nearly died from this life-threatening disease when sepsis set in. After two weeks of respiration, his condition is slowly improving. The patient received anticoagulant treatment with Fraxiparine but stopped it himself. Previous tonsillectomy at the age of 6 after recurring bouts of tonsillitis. Status post perforated appendix aged 13. "Blood poisoning" (early sepsis?) after a wasp sting and status following surgery on an inguinal hernia on the right, both when he was 35.

Acute event

2 months after being discharged following the attack of interstitial pneumonia, the patient is readmitted to ICU with acute shortness of breath; his temperature is 38.9 °C (day 0). Severe pain on inhaling. Crepitation heard in the upper right lobe on auscultation.

Diagnoses

Pulmonary, respiratory distress post pneumonia.

Conventional treatment

The patient is ventilated non-invasively using an oxygen mask. The chest x-ray shows a clearly demarcated, extensive shadow in the right upper lobe, which supports the diagnosis of pulmonary embolism.

Medication

The patient is given anticoagulant treatment with 1000 U heparin/h and antimicrobial treatment with imipenem/cilastatin (e.g. Primaxin®).

Homeopathic treatment

Repertorisation

COMPLETE REPERTORY MILLENIUM

Chest - embolism

Abdomen - inflammation, peritonitis, enteritis - perforated appendix

Differentiation between remedies

The patient is given *Lachesis muta*, taking the clinical aspect of the pulmonary embolism into account. The remedy was determined firstly by the acute pulmonary embolism and secondly by the sepsis and blood poisoning in the patient's medical history. In terms of differential diagnosis, *Crotalus horridus* and *Crotalus cascavella* could also be considered, along with *Apis*. However, *Crotalus* is not indicated for animal bites or stings.

Prescription

Progress

The patient sweats profusely over the next three days and nights. His respiratory condition and the lung x-ray improve surprisingly quickly, as a result of which the patient can dispense with the oxygen mask. He notices a painful area on the skin of his left lower arm. He remembers that this is where he was bitten by a wasp and subsequently suffered from "blood poisoning". His condition continues to improve and he can return to work. After 11 years in good health, he dies following a cardiac arrest.

Evaluation

The most striking thing about this case is the patient's rapid improvement. Sweating is a typical symptom of *Lachesis* and shows that the pulmonary embolism is healing. The reappearance of the painful area on the skin is in keeping with Hering's law (I.1).

Critical commentary

The homeopathic therapy administered in conjunction with the conventional treatment rapidly restored the patient to health. Hahnemann explains his views on the "ideal of cure" in § 2 of his "Organon":

The ideal of cure

"The highest ideal of cure is rapid, gentle, permanent restoration of health or the removal and annihilation of disease to its whole extent in the shortest, most harmless and most reliable way on easily comprehensible principles." (Organon of the Healing Art, § 2)

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3 Heart, circulation and blood vessels

Michael Frass, Beatrix Wulkersdotfer, Sergio Zajac (Conventional Medicine) Brigitte Bunzel, Michael Frass, Walter Gliick, Gerhard Resch, Irene Schwarz, Sergio Zajac (Homeopathy)

- 3.1 Angina pectoris
- 3.2 Myocardial infarction
- 3.3 Aortic dissection
- 3.4 Cardiomyopathy, heart transplant
- 3.4.1 Cardiomyopathy
- 3.4.2 Heart transplant
- 3.5 Pulmonary oedema

Conventional medicine

The circulatory system comprises the heart and blood vessels. The heart is the “motor” which drives the circulatory system. It acts as a pump to keep our blood flowing constantly, which is critical for supplying oxygen to our bodily organs. The blood is transported through the body’s vascular system (arteries, capillaries, veins and lymph vessels). The arterial part of the vascular system transports oxygenated blood from the heart to the periphery of the body, while the venous part transports deoxygenated blood back to the heart. The cardiovascular system is not only responsible for transporting oxygen, but also for distributing nutrients.

Homeopathy

Homeopathy takes all the existing symptoms into account.

Choice of symptoms

The main symptoms considered with cardiovascular disorders are oedema, pulse changes, hypertension and hypotension.

COMPLETE REPERTORY

Generalities - pulse - weak

acet-ac., *aeon.*, acon-f., *adon.*, adren., aesc., aeth., aether, agar, agar-cps., agar-em., *agarin.*, Agn., ail., aid., aloë, alum-p., am-caust, am-m., ampe-qu., amyg-am., ant-ar., ant-c, anth., ant-m., ant-s., Ant-t., apis, apoc., apom., *arg-n.*, *am.*, Ars., ars-h., *ars-i.*, ars-s-f., arum-d., asaf., asc-c., *aspar.*, aster, *atro.*, Aur., aur-ar., aur-m., *aur-s.*, aza., bapt., Bar-c., bar-m., bar s., bell., benz-ac., Berb., bism., bry., buth-aust, *cact.*, caj., calad., Camph., cann-i., Cann-s., *canth.*, carb-ac., carb-an., carbn-chl., carbn-o., Carb-v., cass., catal., cedr., cench., cham., chen-a., *chin.*, *chin-ar.*, chin-s., chlf., chlöl., chlor., Cic., cimic., *cimx.*, cinch., coca, *cocc.*, cod., coif., coff-t., colch., coll., *coloc.*, con., conin., *com.*, crat, Crot-h., croto-t., cub., *cupr.*, *cupr-acet.*, cupr-ar., cycl., cyt-l., *dig.*, digin., digox., dios., diph., dire., dor., erio., fagu., *ferr.*, *ferr-m.*, gast., Gels., *glon.*, glyc-g., guai., ham., hell., *hydr-ac.*, hydre., hyos., hyosin., iber., *ign.*, *iod.*, *ip.*, iris, jasm., jatr., juni-c., kali-ar., *kali-bi.*, *kali-br.*, *kali-c.*, kali-chl., kali-fcy., *kali-n.*, kali-ox., kali-p., kali-t., *kalm.*, keroso., kreos., lac-ac., *lac-c.*, Lach., lact., lat-k., Lat-m., Laur., lil-t, lob., lyc., *lycps.*, lyss., *mane.*, mang., *mere.*, *mere-c.*, *merc-cy.*, merc-i-f., merc-n., merc-pr-r., merc-s., meth-ae-ae., mez., mom-b., morph., *mosch.*, *mur-ac.*, Naja, narcot., nat-f, nat-m., nit-ac., nit-s-d., *nux-m.*, nux-v., oena., olnd., op., ox-ac., past, peti., Ph-ac., *phase.*, *phos.*, phys., phyt., Plat., plb., plumbg., podo., polyp-p., prop., prun-c., psor., *puls.*, pyre-p., pyrog., raja-s., rhod., *rhus-t.*, rhus-v., ric., rumx-a., sabin., sac-alb., sal-ac., salx-p., *sang.*, santin., sabin., *sapo.*, *saroth.*, sec., seneg., sep., ser-ang., sil., silphu., solin., sol-t-ae., *spig.*, spira., spong., *staph.*, *still.*, *stram.*, stront-c., stry., sul-ac., sul-h., sulo-ac., *sulph.*, *tab.*, tanac., *tarent.*, tart-ac., tax., ter., terech., thea, *thuj.*, thymol., *thyr.*, trif-p., upa., *ust.*, uva., *valer.*, *vario.*, *verat.*, *verat-v.*, verb., vesp., vip., vip-a., vise., xan., zinc., *zinc-m.*, zinc-p., zinc-s., zing.

3 Heart, circulation and blood vessels

COMPLETE REPERTORY

Heart & circulation - pain - heart region

aeon., aeth., agar., am-caust., aml-n., apis, arg., arg-n., ars., ars-met., ars-s-f., Arum-t., asaf., asc-t., aur., bac., *benz-ac.*, both-1., bov., brach., bry., cact., calc., calc-ar., calc-p., cann-i., cann-s., carbn-o., carb-v., caust., cic., *cimic.*, coloc., crot-h., cycl., dig., dios., fago., ferr-p., fl-ac., glon., *graph.*, guat., hydr- ac., iod., jab., kali-bi., kali-c., kalm., kreos., lac-ac., Lat-m., laur., led., lob-s., merc-c., merc-i-f., mez., *naja*, nat-c., *nat-m.*, nux-v., onos., phos., phyt., pitu-a., plb., pyrog., rhus-t., rumx., sang., sec., seneg., sin-n., sol-n., sol-t-ae., spig., *spong.*, stann., stry., sul-ac., sulph., tab., tarent., tell., thea, ther., thuj., verat, vesp., xan., zinc., zinc-m.

Heart & circulation - weakness - sensation of, heart

aeon., alum-p., am-c., ant-c., ant-t., apoc., aran., arg-n., am., ars., *ars-i.*, *aur.*, *aur-m.*, benz-ac., brom., calc., calc-ar., camph., carb-v., cic., colch., croc., crot-h., dig., gels., glon., hell., helo., *kali-bi.*, kali-c., lach., III-t, lob., lycps., *mere.*, *Naja*, nat-m., nux-v., olnd., op., petr., *ph-ac.*, *phyt.*, pyrog., *rhus-t.*, sang., stroph., sulph., sumb., tab., thuj., verat., vip., zinc-i.

Chest - pain - heart

abies-n., *abrot.*, Aeon., aconin., *adon.*, adren., aesc., aeth., *agar.*, ad., aloë, alum., alumn., ambr., am-c., am-caust, *aml-n.*, am-m., am-n., amylam., anac., ant-c., ant-t, Apis, arg., Arg-n., *am.*, Ars., *ars-i.*, ars-met., ars-s-f., arum-t, *asaf.*, asc-t, aspar., aster., Aur., aur-ar., aur-i., *aur-m.*, aur-m-n., bac., bad., bar-c., bell., bell-p., *benz-ac.*, bism., bor., both-1., bov., brach., *brom.*, bry., bufo, Cact., *calc.*, *calc-ar.*, calc-f, calc-i., calc-p., *camph.*, *cann-i.*, cann-s., canth., carb-an., carbn-o., carbn-s., *carb-v.*, card-m., caust, Cenchr., Cereb., cere-s., *cham.*, chen-a., chin., chin-ar., chin-s., chlor., cic., *cimic.*, *cina*, cinnb., clem., cocc., coc-c., coff, *colch.*, coll., coloc., com., con., conv., com., crat, *crot-h.*, croto-t, *cupr.*, cur., cycl., *daph.*, *dig.*, dios., dros., erech., euphr., eupi., fago., ferr., ferr-L, ferr-m., ferr-p., ferr-s., *ferr-t.*, fl-ac., gels., *glon.*, *graph.*, guai., guat., *haem.*, ham., hell., helo., hist, hydr., *hydr- ac.*, hyosin., iber., ind., *iod.*, ip., jab., Kali-ar., *kali-bi.*, *kali-c.*, *kali-chl.*, kali-i., kali-n., kali-p., kali-s., Kalm., kreos., lac-ac., lac-c., lac-d., Lach., lachn., *lat-m.*, *laur.*, led., lepi., *lil-t.*, Lith-c., *lob.*, lob-s., lyc., *lycps.*, lyss., mag-m., magn-gr., mag-p., mane., mand., med., *mere.*, mere-c., merc-i-f, merc- i-r., mez., mosch., myric., *naja*, nat-ar., nat-c., *nat-m.*, nat-p., nit-ac., nux-m., nux-v., oena., olnd., onos., ovi-g-p., ox-ac., *paeon.*, ph-ac., *phos.*, phys., phyt., pip-n., pitu-a., plat., plb., polyg., prun., *psor.*, ptel., Puls., pyrog., ran-b., ran-s., raph., rauw., rhod., Rhus-t., rub-t, rumx., ruta, sac-alb., *samb.*, *sang.*, Sec., seneg., sep., sif, sin-n., sol-n., sol-t-ae., Spig., spirae., *spong.*, squil., stann., *staph.*, stict., stront-c., stront-n., *stroph.*, stry., sul-ac., sul-i., sulph., sumb., syph., *tab.*, tarax., *tarent.*, tell., thea, then, thuj., thyr., trom., verat, verat-v., vesp., viol-o., vip., vise., xan., zinc., zinc-i., zinc-m., zinc-p., zinc-val.

COMPLETE REPERTORY

Extremities - swelling - ankles

acetan., agn., ambr., ant-s., Apis, apoc., arg., *arg-n.*, arist-cl., arist-m., am., ars., ars-s-f, *asaf.*, aur-m., bamb-a., bell., benz- ac., bov., *cact.*, *calc.*, *calc-sil.*, carbn-s., *cenchr.*, *chel.*, *cimic.*, *coloc.*, *cop.*, cupr., cupr-ar., *dig.*, *eup-per.ferr.*, ferr-ar., *graph.*, ham., *hep.*, *hydr.*, hyos., kali-c., kali-chl., kalm., *lac-c.*, lac-d., *lach.*, laur., *led.*, III-t, lyc., mane., mang., Med., Merc., merc-s., mim-p., nat-c., *ol-j.*, onos., ox-ac., *phos.*, *phyt.*, plat, plb., podo., prun., *psor.*, *puls.*, rhod., *rhus-t.*, rhus-v., *ruta*, sal-ac., samb., sars., sep., sd., stann., *staph.*, stict., stront-c., sulph., *syc-co.*, thal., verat-v., xan., zinc., ziz.

Differentiation between important homeopathic remedies

I Important remedies: *Apis mellifica*, *Lachesis muta*, *Latrodectus mactans*, *Naja*, *Strophanthus*.

Naja is frequently used for heart pain and heart attacks.

Latrodectus mactans is indicated for pain which radiates into the right arm.

Apis mellifica can be helpful with peripheral oedema caused by heart disorders, while *Lachesis* is indicated for cyanosis and palpitations with anxiety and fainting.

Strophanthus, which in earlier times was also used in conventional medicine, is prescribed for fast, irregular heart activity caused by myocardial weakness and cardiac insufficiency.

3.1 Angina pectoris

Definition

Angina pectoris is a form of coronary heart disease (CHD/IHD) comprising attacks of chest pain caused by poor circulation and the resulting oxygen deficit. These are known as angina attacks and are usually the consequence of narrowed or blocked coronary blood vessels.

There are two types of angina pectoris:

- **Stable angina pectoris:** occurs at times of physical and/or psychological stress and improves quickly when the patient rests.
- **Unstable angina pectoris:** this is a very serious form which can occur frequently or appear as a

3.1 Angina pectoris

fresh symptom (“new-onset angina”). There are two subtypes of unstable angina pectoris known as “**crescendo**” angina and **resting angina**; one thing they have in common is that they barely respond to the sublingual administration of nitrates. Resting angina occurs spontaneously without any visible stress. Crescendo angina increases in frequency, intensity or duration.

Clinical information

Incidence and mortality

Angina pectoris and myocardial infarction are both coronary heart diseases, the incidence of which rises particularly sharply in women after the menopause. They occur most frequently in people aged 50 and over, and are some of the most common causes of death in the civilised countries.

Pathogenesis

Angina attacks occur when at least 75% of the blood vessel is narrowed by stenosis and there is no longer enough blood flowing to part of the cardiac muscle to supply it with enough oxygen.

Stable angina pectoris is characterised by the fact that the ischaemia of the heart muscle increases under stress, as the blood flowing through the coronary arteries does not guarantee adequate oxygen supply. A critical role is played by the quantity of oxygen consumed by the heart

the ventricle. Tachycardia, hypertension and hypotension can also provoke angina attacks.

Non-cardiac causes such as fever, thyrotoxicosis, anaemia, physical and psychological stress and climatic influences (heat, cold, high humidity) should not be ignored. See table 3.1-1 for risk factors for angina pectoris.

Thrombus formation plays a central role in the aetiology of angina pectoris. If a plaque ruptures, thrombogenic substances are released into the blood stream, activating

Tab. 3.1-2: Differential Diagnosis Angina Pectoris

Cardiac Disease	
Heart	Cardiac valve disease Cardiomyopathy Myocardial infarction Hypertensive crisis Subaortic stenosis Perimyocarditis
Non-Cardiac Disease	
Gastro- intestinal tract	Pancreatitis Cholecystitis, cholangitis Splenic infarction Peptic / duodenal ulcer Gastroesophageal reflux disease Oesophageal spasm Oesophageal perforation Oesophageal rupture Hiatus hernia Subdiaphragmatic abscess
Respiratory tract	Pulmonary embolism Pneumothorax Pleuritis, pleural effusion, pleural empyema Pneumonia
Mediastinum	Mediastinitis Mediastinal tumour ~~Aortic dissection~~
Other	Panic attacks Intercostal neuralgia zoster Cervical / thoracic spine disorder HWS-BWS-Syndrom

Tab. 3.1-1: Risk Factors for Angina

1st Order Risk factors	2nd Order Risk Factors
Smoking	Psychosocial stress
Arterial hypertonia	Obesity
Diabetes mellitus	Lack of exercise
Male gender	
Menopausal women	
Disorders of lipid metabolism	
Fibrinogen ↑	
Homocysteine serum ↑	
Genetic predisposition	
Advanced age	

3 Heart, circulation and blood vessels

causing a thrombus to form. This is transported to the periphery of the coronary arteries and can either dissolve or reform there. Unstable angina pectoris can therefore become stable; alternatively, a coronary blood vessel may become blocked, causing an intramural or transmural myocardial infarction.

Symptoms

Angina pectoris attacks are characterised by crushing pain in the chest accompanied by feelings of anxiety and constriction. These symptoms usually last for seconds to minutes. The pain can quite often radiate into the left arm, back, upper abdomen, throat or jaw.

In cases of stable angina pectoris, the symptoms ease when the patient rests. However, if they remain even when the patient rests and relaxes, they may be precursors of unstable angina pectoris or a myocardial infarction.

Diagnosis

Diagnosis is based mainly on an exact record of the **symptoms** and a **resting ECG**.

Laboratory tests are performed to determine levels of substances specific to the heart muscle such as creatine kinase and troponin T. Other diagnostic

methods such as **coronary angiography** are used to exclude the possibility of other diseases.

Differential diagnoses include both cardiac and non-cardiac diseases. » Table 3.1-2 provides more information about these.

Treatment

When treating **stable angina pectoris**, the main aim is to improve oxygen supply and/or reduce oxygen consumption. Nitroglycerine is administered during an attack with this aim in view. Beta blockers and nitrates are particularly suitable for long-term treatment. However, the patient must be told to leave approx. 10-12 h between doses of nitrates to prevent any tolerance from developing. Should the patient develop nitrate headache, hypotension or various skin reactions, it is advisable to treat him with molsidomine. One benefit of treatment with beta blockers is that they make a critical contribution to reducing oxygen consumption.

Therapeutic crisis

A therapeutic crisis is deemed to exist in cases of persistent angina-type pain, making invasive diagnostics

3.1 Angina pectoris

Case 3.1-1: Angina pectoris

Michael Frass

Anamnesis

A 53-year-old male patient has always been healthy except for colds. He is a smoker (20 cigarettes/day), and other risk factors include obesity, hypercholesterolaemia and lack of exercise.

Acute event

The patient is brought to A&E by the emergency services at around midnight due to burning retrocardial pain radiating into the left arm. The pain began shortly before he was brought in. ST segment elevation is evident in the area of the anterior wall. A heart catheter examination performed three months previously revealed the early stages of coronary heart disease (CHD /IHD) but no need for intervention. The patient is sweating profusely and short of breath. He is unable to lie on his right side; he prefers to lie on his left side or on his back and is so weak that he slides down the bed.

Diagnosis

Vasospastic angina pectoris.

Conventional treatment

The patient is given oxygen, acetylsalicylic acid and beta blockers. Nitroglycerine is not administered because of his low arterial pressure.

Homeopathic treatment

The homeopathic treatment takes the patients extreme weakness into account together with his retrosternal pain and the position in which he prefers to lie.

Repertorisation

COMPLETE REPERTORY

Chest - pain - burning, smarting - sternum

Generalities - weakness - paralytic - sliding down in bed

Differentiation between remedies

The main remedies which might be indicated here include *Phosphorus* and *Acidum muriaticum*. However, *Phosphorus* is prescribed when the patient feels worse lying on his left side.

Acidum muriaticum was chosen on the basis of the symptom "General - weakness - paralytic - sliding down in bed".

Prescription

The patient is given *Acidum muriaticum* 200C, one dose of 5 globules before the heart catheter examination.

Progress

The ST segment elevation disappears within half a minute of the remedy being given; the patient begins to recover within the next half-hour. The creatine kinase and troponin T tests are negative. A heart catheter examination is performed immediately afterwards, but no intervention is necessary. The patient recovers rapidly over the next few days.

Evaluation

This case shows an extremely fast reaction to the remedy administered. However, it also shows that symptoms such as sliding down in bed which are so insignificant from a conventional viewpoint can be decisive for selecting the correct remedy.

Critical commentary

Patients with retrocardial pain and ST segment elevation must of course undergo thorough cardiological testing. Observations made by the author in the cardiology outpatient clinic indicate that in many patients, cardiac symptoms appear at a time at which no organic symptoms can yet be found. It is worth considering whether administering homeopathic treatment at this

3.2 Myocardial infarction

Definition

Myocardial infarctions cause irreversible destruction of the heart muscle. This necrosis is the result of reduced blood flow through the heart muscle when the coronary arteries are blocked for longer periods.

Clinical information

Incidence and mortality

These days, myocardial infarction is one of the most common diseases in the Western world. The typical age for this disease is 55 years. The risk of suffering a heart attack increases dramatically in women after the menopause, as the oestrogen which protects the blood vessels drops markedly.

Studies have shown that about 60% of patients die before they reach the hospital. Thanks to the rapid therapeutic and diagnostic measures available to us today, mortality rates during the hospital phase have dropped to 5-20%.

Pathogenesis

Heart attacks are caused by reduced blood flow to the heart muscle resulting from a blockage of the coronary blood vessels. In 90% of cases, the blockages are caused by thrombi, which can occlude the blood vessels leading to ischaemia in the area they supply. Ruptured atheromatous plaques or bleeding under these plaques can also block blood vessels if the patient already has coronary sclerosis.

Rarer causes of myocardial infarction include severe vasospasm or inflammation in the coronary blood vessels. As mentioned above, myocardial infarction begins with ischaemia of the heart muscle, which in the early stages is still reversible. If this lasts longer than 4-6 h, the heart muscle loses its ability to function efficiently and starts to become necrotic. The extent of the area affected depends firstly on the ability of the coronary blood vessels to form a collateral blood supply and secondly on the relationship between oxygen demand and supply. The heart rate, preload, afterload and the contractility of the heart muscle consequently

Tab. 3.2-1: Typical Clinical Test Values for Cardiac Infarction		
Parameter	Normal Value	Comments
CK	M: 25-90 U/l F: 10-70 U/l	Increase after 4-8h, >150mU/ml for 2-4d
CK-MB	< 10 U/l (3-6% % of total CK)	Increase after 4-8h, >6-10% of total CK, specific to cardiac muscle
CardiotroponinT	< 0,2 pg/l	Increase after 3-8h, specific to cardiac muscle
HBDH	55-140 U/l	Increase after 6-12h, cardiac-specific LDH, ratio LDH/HBDH < 1.3 -> infarction, haemolysis Myoglobin
AST	0-19 U/l	Increase after 4-8h, caution: not specific to cardiac muscle
LDH	120-240 U/l	Increase after 6-12h, caution: not specific to cardiac muscle
Myoglobin	< 70 pg/l	Increase after 2-6h, not specific to cardiac muscle
CRP	< 5 mg/l	Prognostic parameter: poor prognosis if elevated on admission
Leucocytes	4,3-10 G/l	Increase after several hours to 12-15G/l, non-specific signs of inflammation
ESR	M: 0-9 mm/h F: 0-20 mm/h	-

3.2 Myocardial infarction

all play a critical role in the outcome of myocardial infarction.

In contrast to infarctions without ST segment elevation, transmural infarctions are caused by a complete blockage of the coronary blood vessel affected, while non-transmural infarctions are merely the result of extreme stenosis which however is enough to prevent adequate oxygen supplies from reaching the heart muscle. The areas mainly affected are the subendocardial layers of the heart muscle.

Besides the direct causes of myocardial infarction, there are a number of risk factors which increase the probability of it occurring:

- Genetic predisposition
- Years of smoking
- Arterial hypertension
- Disorders of the lipid metabolism: high LDL levels and low HDL levels
- Lack of exercise
- Obesity
- Diabetes mellitus
- Congenitally elevated homocysteine levels in the blood
- Chlamydia and cytomegalovirus infections
- Oral contraceptives in combination with smoking.

Symptoms

Well over half of patients complain of sudden, stabbing retrosternal pain which may radiate into the arms, throat or upper abdomen, more commonly on the left side. Outbreaks of sweating, nausea, vomiting and diarrhoea occur along with terror, agitation and feelings of constriction.

Note: diabetics require special care and attention. They may suffer from "silent" heart attacks as

Heart attacks do not respond to the administration of nitroglycerine. Neither are the symptoms improved by rest. These two facts are important for differentiating between heart attacks and attacks of angina pectoris, as about 60% of patients were already suffering from angina pectoris before they had a heart attack.

Diagnosis

The diagnosis of myocardial infarction is based on three cornerstones. Firstly, it is important to recognise the **symptoms** as quickly as possible to facilitate the immediate performance of an **ECG**. The third cornerstone is to test the levels of **heart muscle enzymes**, which will be elevated if the patient has had a heart attack.

When diagnosing a heart attack, it is important to consider the symptoms and test results together rather than individually. A safe diagnosis can be obtained by ECG in most cases. ST segment depression is typical of inner layer infarctions, while in the case of ischaemia or reciprocal ST elevation, the area affected manifests in the opposite lead. ST segment elevation is usually initially observed in the case of transmural infarctions. If a scar remains, this is depicted by a wide Q wave and R loss. AV blocks are typical of posterior wall or septal infarctions.

Other important diagnostic tools include **echocardiography** and **chest x-rays** for excluding lung congestion and pneumonia. Echocardiography is particularly useful for diagnosing pericardial effusions, hypertrophy, wall dyskinesia, aneurysms and defects of the mitral and aortic valves.

Treatment

Therapeutic crisis

A therapeutic crisis occurs if the patients condition does not improve despite appropriate treatment

3 Heart, circulation and blood vessels

Case 3.2-1: Acute myocardial infarction requiring resuscitation

Gerhard Resch

Anamnesis

A 58-year-old male patient who had already suffered three severe heart attacks with burning pain suffered another acute cardiac arrest in the night. This case dates back about 30 years, and not all details were documented.

Acute event

The patient is resuscitated and his heart begins beating again. He regains consciousness and speaks a few words over a period of 20-30 seconds before losing consciousness and suffering another cardiac arrest. This happens 10 times in all. The ECG between the cardiac arrest shows sufficient indications for a fresh heart attack; ST elevations are clearly recognisable. The patient reports that he feels burning pain as with his previous heart attacks and is aware that his chances of survival are low. He also shows sympathy for the doctor having to work so hard around midnight. The patient is lying largely uncovered at his own request; his skin is waxy and ice cold with blue and white marbling. He resists attempts to cover him. The patient is not cold despite his icy cold sweat.

Diagnoses

Acute myocardial infarction requiring resuscitation, three previous heart attacks.

Conventional treatment

ECG with indications of acute heart attack Resuscitation.

Homeopathic treatment

Repertorisation

COMPLETE REPERTORY

Chest - pain - burning, smarting

Chest - pain - burning, smarting - sternum

Differentiation between remedies

Carbo vegetabilis: it is remarkable that the dying patient is concerned about the doctor treating him. He is composed, calm, and despite his hopeless fight with death, he is willing to approach people and show an interest. The combination of a cold body and circulatory cyanosis with the modalities “Worse when warm” and “Needs fresh air” in a person with burning pain fighting for his life is reminiscent of the remedy profile for *Carbo vegetabilis*. These symptoms were observed when proving the remedy on healthy subjects and in clinical use; only with this remedy do they occur in this intensity and this constellation.

In contrast, the *Arsenicum album* patient would toss and turn restlessly in such a situation; he would be driven by fear and foresee his impending death.

Prescription

One dose of 3 globules *Carbo vegetabilis* 30C.

Progress

Before the *Carbo vegetabilis* is administered, the patient's pupils dilate, his breathing ceases and his heart stops beating. Heart massage is to begin after the remedy has been given. Immediately after the remedy is administered, two small red spots appear on the patient's cheeks and feel warm to the touch. His body begins to return to life, and the heart massage is suspended for the time being. The patient begins to breathe deeply by himself, his heart starts beating of its own accord, his whole body becomes warm, the cold sweat disappears and all his vital functions return. The angina-type pain which the patient is familiar with from his previous heart attacks has disappeared; he feels well and wants to sleep.

He has no more symptoms during the eight days for which he remains in hospital for observation, and no conventional medication is required. Two years later, he has had no recurrences. He feels well.

Evaluation

Before this incident, the author did not believe that a homeopathic remedy could be used so successfully in a life-threatening situation. However, the patient's

3.2 Myocardial infarction

homeopathic remedy was able to cure the patient in compliance with the law of similars (I.1).

Critical commentary

This incident occurred many years ago. From a modern viewpoint, a heart catheter examination would have had to be performed, and current guidelines would present class IA indications for the implantation of a

effect of homeopathic medicine in treating serious acute disease is open to many questions and objections. The difficulty in the case described above is to take both conventional and homeopathic viewpoints into account at almost the same time. Exceptional sensitivity is required to apply both methods correctly at the right time to the patients benefit.

Case 3.2-2: Cardiogenic shock after a myocardial infarction

Walter Gluck

This case dates back about 25 years, and not all details were documented.

Anamnesis

The heart of an 82-year-old female patient was monitored for 4 days after a myocardial infarction. Her condition, particularly her blood pressure, deteriorated from day to day. Despite infusion treatment (dopamine, dobutrex), she developed hypotension and cardiogenic shock.

Acute event

The patient is somnolent and has the following symptoms:

- Ashen facial colour
- Pulse cannot be found
- Tachypnoea
- Cold skin

ECG: atrial fibrillation and tachycardic, arrhythmic QRS complex.

Diagnoses

Cardiogenic shock following myocardial infarction.

Conventional treatment

The patient receives oxygen via a mask along with infusion therapy

Homeopathic treatment

The patient recovers consciousness at irregular intervals, becomes restless and moans. She does not want to eat or drink. The patient demands an electric fan despite the cool room temperature; she requests the fan to be directed onto her.

Repertorisation

KENT'S REPERTORIUM GENERALE Generalities - fanning - requires

Generalities - being fanned, ameliorated

Generalities - cold

Generalities - air - draught, ameliorated

Generalities - worse when covered

Generalities - warmth - aggravated

Mind - unconsciousness - coma

Differentiation between remedies

The patients need for "cold air" points to *Carbo vegetabilis*. *Carbo vegetabilis* is the only remedy with the unusual modalities "draught, ameliorated, being fanned, ameliorated" even though the body is objectively cold.

Other remedies such as *Pulsatilla*, *Argentum nitr- cum* or *China* also feature improvement in cold air or on being fanned, but not to the same extent as *Carbo vegetabilis*.

Prescription

One dose of 5 globules *Carbo vegetabilis* 30C.

Progress

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breakfast. She was alert, had low but measurable blood pressure and no particular complaints. She was discharged one week later.

Evaluation

The change in temperature behaviour and the deep sleep

homeopathic remedy. The patient's rapid recovery can be attributed to the concomitant homeopathic treatment.

Comments

The patient lived for many more years following this acute incident.

3.3 Aortic dissection

Definition

Acute aortic dissection, also known as aneurysma dissecans, is a surgical emergency which mainly affects the ascending aorta. It refers to tearing of the aortic wall. The similarity of the symptoms means that this condition can very easily be confused with myocardial infarction.

The DeBakey and Stanford classifications divide aortic dissections into different categories taking their location into account (table 3.3-1, table 3.3-2).

Clinical information

Incidence and mortality

Acute aortic dissection occurs in about 2% of people in their 60s. In many cases, they were already suffering from arterial hypertension. More than 75% of these patients are men, although older women with thoracic aneurysms generally have a higher risk of rupture. About 60% of all aortic dissections are located in the ascending aorta. Mortality rates in hospital are less than 30%, although this figure is far higher in cases of type A aortic dissection.

After leaving hospital, the five-year survival rate is about 80%, but the ten-year survival rate is only 40%. For

risk of a rupture after 5 years is 0%, for aneurysms with a diameter of 4-6.9 cm 16% and for aneurysms over 6 cm 31%.

Pathogenesis and aetiology

Aortic dissection is usually a consequence of degenerative vascular disease. The main causes are arteriosclerosis and arterial hypertension. Patients with Marfan syndrome (hereditary weakness of the connective tissue) are at high risk of suffering an aortic dissection in their younger years. Rarer causes are trauma, tertiary syphilis and bacterial aortitis. The intima thickens and the vasa vasorum narrow as a result of sclerotic changes. Ruptures in the intima of the aorta cause bleeding into the media. The resulting lesion in the aortic wall can form a false channel through the media, blocking the blood flow to the arteries branching off from the aorta. Such a dissection causes the aortic wall to rupture, leading to bleeding into the mediastinal organs, pleura, pericardium and retroperitoneal space.

Symptoms

The main symptom of aortic dissection is sudden, severe pain in the chest, abdomen and lumbar region. The chest pain usually persists, while

Tab. 3.3-1: Types of Aortic Dissection according to DeBakey

Type I	Type II	Type III
Aortaascendens up to bifurcation; the aortic valves are often also involved; in 70% of cases	Aortaascendens up to proximal to left A. sub-clavia	Distal to left A. sub-clavia up to aorta descendens and Aa. iliaca

Tab. 3.3-2: Types of Aortic Dissection according to Stanford

Type A	Type B
Dissection of aorta ascendens; in 70% of cases; corresponds to DeBakey's types I and II	Dissection of aorta descendens; in 30% of cases; corresponds to DeBakey's type III

the pain in the other areas may subside over the following hours and days; however, this does not indicate that the pathological process has stopped. If the pain recurs, it must be assumed that the pathological situation has been aggravated. Tachycardia, hypertension and differences in blood pressure between the upper and lower extremities are also frequently observed. Local symptoms such as dyspnoea, stridor and dysphagia can also help secure the diagnosis.

Possible clinical signs:

- Shock
- Apoplexy
- Peripheral ischaemia
- Aortic valve insufficiency
- Cardiac insufficiency
- Intestinal necrosis
- Paraplegia

Diagnosis

The normal procedure for the certain diagnosis of aortic dissection is the performance of an angiography, which has a sensitivity of 90% and a specificity of 95%.

Ultra-fast **chest** and **abdominal CT** scans with contrast agent now also have a sensitivity of 90% and a specificity of 95%.

MRI scans are generally recommended for all haemodynamically stable patients, while **transoesophageal echocardiography** is especially suitable for all unstable patients.

Chest x-rays show widening of the mediastinum in more than 80% of cases. More rarely, a double contour, pleural effusion, pericardial effusion and/or a fracture of

Treatment

Operation

Proximal aortic dissection (type A) must be operated on as quickly as possible to replace the aorta and aortic valves with prostheses and reinsert the coronary arteries. The implantation of endoluminal stent grafts appears to be very safe for most patients. In some cases, the separated layers are sutured back together.

Possible complications: acute myocardial infarction and impaired lung function, particularly if the lungs are already damaged by COPD or years of smoking. Patients with manifest kidney disease are also at high risk.

Medication

Aim of treatment with medication: to prevent pain and hypertensive crises during the preoperative diagnostic procedures.

Procedure:

- Analgesia with piritramide.
- Sedation with promethazine.
- Blood pressure reduction with beta blockers such as esmolol or metoprolol combined with urapidil.

These are particularly effective when treating type B aortic dissections, as surgery is not indicated in these cases. However, when reducing the patients blood pressure, care must be taken that the antihypertensive treatment does not cause the patients cardiac output to increase. Propanolol and nitroprusside are particularly suitable in this respect.

Therapeutic crisis

In cases of dissection, the role of homeopathy is to treat and prevent complications. It is therefore important that cardiac and pulmonary problems are taken into consideration

3 Heart, circulation and blood vessels

Case 3.3-1: Multiple organ failure following replacement of ascending aorta and aortic valve implantation

Michael Frass

Anamnesis

After an extensive intrathoracic operation, the patient spent more than 10 weeks in an external intensive care unit. He was transferred to our intensive care unit with severe multiple organ failure. His family medical history and history of childhood disease contained nothing unusual. The patient is self-employed and works approx. 16-20 hours a day in his business. Approx. 8 months before the acute event, the patient had a one-off attack with precordial pain.

Acute event

On the day of his admission to the other hospital (day 0), the patient, who up until then had been healthy, complained of severe angina pectoris and abdominal symptoms. He was also close to collapse. An ultrasound was immediately performed and showed a dissection in an aortic aneurysm. The patient was transferred to a cardiac surgery department where his ascending aorta was replaced and an aortic valve replacement performed. Suspected paraplegia was addressed during the surgery. The patient had to be resuscitated more than 30 times during the operation. A fasciotomy was performed to treat the compartment syndrome which developed in the left leg after the surgery. No complications arose after the surgery, but it was unusual that the patient could not be weaned from the respirator. On the day he was transferred back to the hospital (day 5 after the operation), the patient developed ventricular tachycardia and cardioversion had to be performed. He received noradrenalin for haemodynamic insufficiency and haemofiltration when his kidneys began to fail.

Diagnoses

Septic multiple organ failure following replacement of the aorta ascendens and aortic valve implantation, paraplegia, ventricular tachycardia.

Conventional treatment

The patient initially receives pressure-assisted respiration. The patient again develops ventricular tachycardia; 13 cardioversions and the administration of antiarrhythmic drugs are unsuccessful. His temperature is 39 °C and he is still receiving antimicrobial treatment. His heart rate finally stabilises after the administration of sedacurone; sinus rhythm is restored on the 8th day following the acute event. The ultrasound shows a double lumen which reaches the bifurcation. However, the patient still cannot be weaned from the respirator. He now develops “adult respiratory distress syndrome” (ARDS: severely impaired lung function) and has to be given pressure-controlled artificial respiration. The patient is placed on his stomach and spends several days in a rotating bed. He also commences treatment with prostaglandins. *Staphylococcus aureus* is found in all blood cultures. This is a highly resistant microbe which is only sensitive to a few antibiotics.

The full symptoms of *staphylococcus* sepsis develop with a clear reduction in peripheral resistance. A chest drain is inserted to treat a recurrent pleural effusion on the left side.

Weaning from the respirator is practically impossible, as the patient repeatedly becomes exhausted and his mental recovery is not yet sufficient. He is particularly prone to apnoea when he is not fully conscious. Moreover, the diagnosis of suspected paraplegic syndrome below TH III/IV is now confirmed. On day 50 following the operation, the patient is transferred to the intensive care unit of a teaching hospital for further treatment. The experienced medical teams in the external and teaching hospitals believe that the case is terminal.

Imaging techniques: the results lead to a suspected diagnosis of bilateral paresis of the phrenic nerve. Measurements of the phrenic nerve conduction time show that no stimuli are passing along either side. It must therefore be assumed that the patient has bilateral phrenic nerve paresis, most likely due to cold-related traction damage.

3.3 Aortic dissection

Medication

The patient is treated with vancomycin (e.g. Vancomycin") for 35 days. It is assumed that the infection is still persisting as staphylococcus is present in the thrombotic material in the second lumen and around the prosthesis. The patients treatment is changed to teico- planin (e.g.Targocid*). The patient needs noradrenalin until day 31; he is also more tranquil for a few days.

Homeopathic treatment

Rubrics applicable to patients with aortic dissection include:

- Arteriosclerosis
- Chest, aorta, dilation
- Chest, inflammation, aorta (acute, chronic)
- Breathing, difficult
- Chest - pain - heart

Repertorisation I

COMPLETE REPERTORY

Generalities - sepsis

Respiration - difficult - inspiring, aggravated

Fever - heat - septic fevers

Respiration - stopped

Generalities - pulse - rapid

Differentiation between remedies

All sepsis remedies such as *Pyrogenium*, *Lachesis*, *Belladonna*, *Phosphorus* etc. come under consideration (II.1.1). *Crotalus cascavella* is chosen rather than *Crotalus horridus* because of the patient s extreme breathing difficulties.

Prescription

From day 52, the patient is given *Crotalus cascavella* 200C, 5 globules twice a day administered sublingually over a period of 7 days.

Progress

The sepsis is quickly brought under control. The patient's temperature returns to normal, he requires fewer

Repertorisation II

COMPLETE REPERTORY

Mind - fear - disease, of

Larynx & trachea - pain - burning

Larynx & trachea - pain - larynx

Chest - inflammation - lungs - right - lower

Differentiation between remedies

Phosphorus could be considered, as it is indicated throughout the repertorisation process.

Night sweats would indicate *Mercurius*; patients in need of *Kalium carbonicum* would find their symptoms worsening at around 3 am.

Prescription

The patient is given *Phosphorus* 200C twice a day for 7 days beginning on day 72.

Progress

The infiltration vanished after 4 days while the patient was receiving antimicrobial treatment. The pain in the laryngeal area was now bearable. However, the patient was still terrified of being extubated. His mental condition points the way to the final remedy.

Repertorisation III

COMPLETE REPERTORY

Mind - fear - choking, of

Differentiation between remedies

The rubric "Mind - fear, choking, of" lists two remedies: *Hepar sulphur* and *Lyssinum*. *Hepar sulphur* was chosen because this remedy emphasises the symptom "choking cough".

Prescription

From day 85, the patient received *Hepar sulphur* Q6 twice a day for one month.

Progress

The patient was extubated on day 87 and discharged on day 99.

3 Heart, circulation and blood vessels

experts in their field saw the patients chances of survival as non-existent.

We were all the more delighted when the patient started making slow but constant progress. By the time he was discharged, he was active and had a positive attitude to life. The paraplegia means that he has to get about in a wheelchair. Nevertheless, he still works as a restaurateur and even copes easily with long car journeys. It should also be noted that the patient has helped found 13 residential communities by making suggestions and giving talks in his restaurant. His courteous nature and neurological

skills are very helpful in this respect. Despite the worst possible prognosis, the patient survived and still pursues his original profession today.

Critical commentary

One striking feature of this case was the patient's fear of extubation, caused by his fear of choking. Perhaps this problem should have been tackled more intensively at an earlier stage. Hospital routine does not always allow enough time to provide classical homeopathic treatment following Hahnemann's rules.

1 .4 Cardiomyopathy, heart transplant

3 .4.1 Cardiomyopathy

Definition

According to the World Health Organisation (WHO), cardiomyopathy is a disease of the heart muscle resulting in heart dysfunction.

The World Heart Federation (1996) distinguishes between four types of cardiomyopathy:

1. Hypertrophic cardiomyopathy (HCM)
 - Hypertrophic-obstructive cardiomyopathy (HOCM)
 - Hypertrophic non-obstructive cardiomyopathy (HNCM)
2. Dilated cardiomyopathy (DCM)
 - Idiopathic DCM (special form)
 - Hereditary (genetic) DCM (special form)
3. Restrictive cardiomyopathy (RCM)
4. Arrhythmogenic right ventricular cardiomyopathy (ARVC).

Unclassifiable cardiomyopathy can be allocated to several of the categories mentioned above or none at all, while **specific cardiomyopathy** is a form of heart muscle disease associated with a specific heart-related or systemic disease.

- Ischaemic
- Hypertensive: left ventricular hypertrophy, dilation, restriction
- Valvular: heart valve diseases with ventricular dysfunction
- Toxic: alcohol, catecholamines, radiotherapy
- Metabolic: amyloidosis, storage diseases
- Endocrine: hyperthyroidism, diabetes mellitus
- Inflammatory: myocarditis
- Peripartum: pregnancy-related cardiomyopathy
- Systemic diseases: systemic lupus erythematosus, scleroderma
- Neuromuscular diseases: muscular dystrophies

Clinical information

Incidence and mortality

The incidence of hypertrophic cardiomyopathy (HCM) is 2-3 per 100 000 people and the prevalence 15-20 per 100 000 people. Patients with HCM usually die suddenly from heart-related causes triggered by atrial fibrillation, ventricular tachyarrhythmia and in some cases asystole or bradycardia arrhythmia.

5-8 of every 100 000 people fall ill with dilated cardiomyopathy (DCM) every year. In the USA, it causes 10,000 deaths a year. The five-year mortality rate is about 20%. Patients usually die sudden heart-related deaths or from constantly aggravated cardiac insufficiency.

3.4 Cardiomyopathy, heart transplant

control group comprising people of the same age and sex ($P < 0.001$). The five-year survival rate was 64% compared to the expected 85%, and the ten-year survival rate was 37% versus the expected 70%. The survival rates, which were calculated by multivariate analysis, were inversely proportional for the male sex, the over-70s age group and for each increase in NYHA category and left atrial diameter (Ammasch et al. 2000).

In patients aged from their 20s to their 50s, arrhythmogenic right ventricular cardiomyopathy (ARVC) is not associated with palpitations, syncope, ventricular tachycardia or sudden heart-related death. Mortality rates are low provided the disease is correspondingly diagnosed and treated. The heterogeneity of the disease means that the symptoms manifested can vary considerably (Dalal et al 2005).

Pathogenesis and aetiology

Hypertrophic cardiomyopathy (HCM) HCM is 50% acquired and 50% hereditary.

- Acquired HCM mainly occurs in connection with hypertension, aortic stenosis and hypertrophy of the left ventricle. Acquired left ventricular hypertrophy typically does not involve concentric hypertrophy.
- In contrast, concentric hypertrophy must be present in the **hereditary** form. With regard to the genetic background of HCM, it is known that there are nine gene loci and more than

130 mutations responsible for the development of hereditary HCM. The most common is the mutation of the gene for P-myosin, followed by genes for cardiac troponin T, troponin I and α -tropomyosin. Pathological hypertrophy is concentric. The muscle fibres thicken as a response to pathological growth stimuli, hypertension or genetic mutation. The wall hypertrophy in HCM leads via increasing fibrosis to increased rigidity of the myocardium. The diastolic filling of the ventricles is impeded as a result. The intima also becomes thicker, leading to a narrowing of the lumen in the coronary blood vessels.

Dilated cardiomyopathy (DCM)

- **Ischaemia** is one of the most common causes of DCM. It mainly occurs after heart attacks due to the loss of functional heart muscle fibres; diseases of the coronary arteries are another cause. Years of excessive alcohol consumption can also cause cardiomyopathy.
- **Dilated** cardiomyopathy quite often occurs after viral (e.g. parvovirus B19, Herpes simplex, Coxsackie B, HIV, echoviruses and adenoviruses), bacterial (e.g. mycobacteria), parasitic (e.g. toxoplasmosis, trichinosis, Chagas disease) and fungal infections. Certain **inflammatory** and **autoimmune** diseases (e.g. systemic lupus erythematosus, scleroderma, dermatomyositis) are also associated with cardiomyopathy.
- **Toxins** (e.g. alcohol, heavy metals, phenothiazines, cocaine), **medication** (e.g. chemotherapy drugs such as mitoxantrone, ifosfamide, trastuzumab), **antiretroviral agents** (e.g. alpha-interferon, zidovudine, zalcitabine) and **anthracyclines**, which are primarily used to treat heart disease, can also accelerate the development of DCM.
- **Metabolic abnormalities** are very often also responsible for the development of cardiomyopathy.
- Approx. 35% of all cases of DCM are inherited via autosomal and x-chromosomal genes. Multiple autosomal gene mutations such as A/C lamin, 8-sarcoglycan, P-myosin, troponin T, dystrophin and actin mutations are frequently associated with cardiomyopathy.

Tab. 3.4-1: Classification of RCM by Cardiac Localisation	
Endomyocardial	• Leffler's fibroplastic endocarditis • Hypereosinophilic syndrome • Endomyocardial fibrosis • Carcinoid, tumour metastases, effects of radiation, chemotherapy
Myocardial	• Gaucher's disease, Eabry's disease, Hurler syndrome • Sarcoidosis, amyloidosis, scleroderma, haemochromatosis, haemosiderosis, glycogen storage disease, pseudoxanthoma elasticum

3 Heart, circulation and blood vessels

- **Chronic heart valve diseases** involving increased volume in the left ventricle with normal ejection pressure lead to dilation of the heart.

Causes of dilated cardiomyopathy:

- Alcohol abuse
- Post-infection
- Idiopathic/inflammatory
- Mitral regurgitation
- Hereditary
- Haemochromatosis
- Heavy metals (e.g. cobalt)
- Atrial fibrillation, pacemaker
- Drug consumption
- Muscular dystrophies
- Selenium, thiamine and carnitine deficiencies
- Physiological in athletes

The mechanism which causes dilated cardiomyopathy can be explained as an increased workload leading to muscular weakness, which can make the muscle fibres hypertrophic or long and thin. However, the latter are not sufficiently competent to maintain adequate contractility of the heart muscle. Apoptosis and dysfunctions in the muscle fibre bundles increase. This process results in progressive dysfunction and restriction of the contractility of the heart muscle fibres. An increase in preload becomes necessary to facilitate sufficient ejection, thus placing even more strain on the heart.

Restrictive cardiomyopathy (RCM)

RCM can be **infiltrative** or **non-infiltrative** in origin and occur idiopathically or in connection with storage diseases. The main infiltrative causes are amyloidosis, sarcoidosis, mucopolysaccharidosis and Gauchers disease, while haemochromatosis, Fabry's disease and glycogen storage disease are all cell storage diseases. With regard to location, RCM can be classified as **myocardial** or **endomyocardial** (table 3.4-1).

RCM refers to diastolic dysfunction caused by impaired relaxation of the heart muscle. This leads to impaired diastolic expansion caused by stiffening of the

Arrhythmogenic right ventricular cardiomyopathy (ARVC).

30% of patients have more than one case of ARVC in the **family**; in such cases, it is usually an **autosomal dominant** genetic disorder. The gene loci most commonly affected are those on chromosomes 1, 2, 10 and 14. Mutated desmoglobin and plakoglobin have been found in *autosomal recessive* forms. These were identified in adherent and desmosomal junctions. This type of cardiomyopathy refers to progressive replacement of the myocardium with fatty and connective tissue. This initially occurs most strongly in the right ventricle, but later increasingly affects the left ventricle and the septum. ARVC is generally rare, but when it occurs, it is frequently responsible for ventricular tachycardia and sudden heart-related deaths in young people and athletes.

Symptoms

- Hypertrophic cardiomyopathy (HCM): the patient commonly reports dyspnoea and dizziness when under strain. Chest pain, syncope, palpitations and rhythmic pain are the main symptoms which initially disturb patients the most.
- Dilated cardiomyopathy (DCM): DCM usually presents with chest pain and/or dyspnoea and symptoms of systolic dysfunction.
- Restrictive cardiomyopathy (RCM): the patient particularly notices dyspnoea, orthopnoea, peripheral oedema and ascites. Thromboembolic complications and atrial fibrillation may occur with the idiopathic form.
- Arrhythmogenic right ventricular cardiomyopathy (ARVC): this makes itself noticeable with palpitations, tachycardia, ventricular arrhythmia and syncope. Otherwise the patient is completely fit.

Diagnosis

Hypertrophic cardiomyopathy (HCM)

During **auscultation**, the physician notices a medium-frequency systolic heart murmur caused by an obstruction, best heard at the left lower sternal. It increases during exercise and when performing

3.4 Cardiomyopathy, heart transplant

the Valsalva manoeuvre. High-frequency systolic heart murmurs best heard at the cardiac apex are heard with mitral valve insufficiency.

ECG tests frequently show a left anterior fascicular block, ST depressions, signs of hypertrophy and terminal negative T waves. A long-term ECG is recommended to record the action of the heart. Atrial fibrillation, temporary second or third-degree AV blocks, bursts and tachycardia may be diagnosed. An **echocardiography** can provide evidence of a systolic forwards movement of the anterior mitral cusp, known as SAM (systolic anterior movement) and left ventricular hypertrophy. Intraventricular obstructions and pressure gradients, small volumes in the left ventricle and normal or hyperkinetic contractions may be diagnosed by **heart catheter**.

Dilated cardiomyopathy (DCM)

A third heart sound is heard at the end of the diastole due to contraction of the atrium; in such cases a gallop rhythm is then heard during **auscultation**. The pulse pressure is low. **ECG** tests frequently reveal a left bundle branch block or signs of hypertrophy in the left ventricle. **Echocardiography** tests show significant enlargement of the ventricles by definition. If a **biopsy of the heart muscle** is taken, it is possible to differentiate between fibrosing, non-fibrosing and focally fibrosing cardiomyopathies; narrow heart muscle cells with large nuclei are also observed.

Restrictive cardiomyopathy (RCM)

In **echocardiography** tests, RCM manifests with normal-sized ventricles and normal systolic function. However, less blood flows into the heart during the relaxation phase. The atria are usually significantly enlarged.

Arrhythmogenic right ventricular cardiomyopathy (ARVC).

Typical ECG findings include right precordial negative T waves and an extended QRS complex. Heart echocardiography tests can prove the existence of dysfunctional contractions in the right ventricle. MRI (magnetic resonance tomography) can be helpful to

enhancement in the myocardium of the right ventricle is found in such cases.

Treatment

Hypertrophic cardiomyopathy (HCM)

Conservative treatment aims to keep the patients heart rate low; this is mainly achieved by refraining from excessively intensive physical exercise.

Verapamil, beta blockers and disopyramide can be viewed functionally as muscle relaxants and prescribed for symptomatic treatment. Medication which reduces the preload, causes hypovolaemia and positive inotropic substances should all be avoided as far as possible.

Treatment options also include surgery, although individual risks must be taken into account. One possibility is transcatheter ablation of the septum hypertrophy. AV blocks are the most important complications in such cases.

Transaortic myectomy is recommended if the cardiomyopathy is refractory to medication and the pressure gradient in the ventricle is particularly high.

The implantation of an automatic implantable cardioverter - defibrillator plays a central role in treating the hereditary form of HCM and is also appropriate in cases involving ventricular arrhythmia.

Dilated cardiomyopathy (DCM)

In cases of secondary DCM, the main objective is to attempt to treat the underlying disease. Absolute abstinence from alcohol and avoidance of myocardiotoxic substances are both recommended.

The cardiac insufficiency is treated conservatively with beta blockers (e.g. metoprolol, carvedilol, bisoprolol), ACE inhibitors, vasodilators, diuretics and digitalis.

In exceptionally severe cases, surgical treatment consists of a heart transplant.

If left ventricular functional disorders and/or atrial fibrillation occur, anticoagulation treatment (e.g. warfarin) with a target value of 2.5 to 3.5 INR (international normalised ratio) is essential.

Beta blockers are most suitable for preventing

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beta blockers have a decisive influence on how long the patient will survive.

If the arrhythmia is symptomatic and refractory to conservative treatment, the implantation of a cardioverter - defibrillator or in certain circumstances a heart transplant will be necessary after beta blockers have a decisive influence on how long the patient will survive.

If the arrhythmia is symptomatic and refractory to conservative treatment, the implantation of a cardioverter - defibrillator or in certain circumstances a heart transplant will be necessary after resuscitation. Major complications include cardiac cardioverter - defibrillator or in certain circumstances a heart transplant will be necessary after resuscitation. Major complications include cardiac insufficiency, cardiac arrhythmia and thrombus formation in the enlarged heart cavities.

Restrictive cardiomyopathy (RCM)

The main treatment for RCM aims to prevent complications. Pacemaker implantation is therefore

(e.g. warfarin) prevent the formation of thrombi and embolisms. It is important to maintain a sinus rhythm; amiodarone is often particularly successful in this respect. The administration of digitalis and diuretics can be attempted provided due care is taken. A heart transplant may have to be considered in some cases.

Arrhythmogenic right ventricular cardiomyopathy (ARVC)

Beta blockers and class I or II antiarrhythmic drugs are the best options for preventing arrhythmia. Catheter ablation can be attempted on patients with an arrhythmogenic focus. The implantation of a cardioverter - defibrillator is recommended for life-threatening arrhythmia (sustained ventricular tachycardia)

Therapeutic crisis

A therapeutic crisis occurs if the patient's condition does not improve despite appropriate treatment and it is feared that the disease will progress.

Case 3.4-1: Heart transplant in a case of dilated cardiomyopathy

Michael Frass, Brigitte Bunzel

Anamnesis

Male patient, 40, single, soldier, suffering from cardiomyopathy. Nothing unusual in his family and childhood medical history. The patient was healthy until he recently fell ill. The patient performs his duties as an officer very conscientiously. He suffered shortness of breath for the first time during a hiking holiday. He wanted to enjoy a holiday without stress, a lot of rest and mountain hikes.

Acute event

The patient experiences coughing and shortness of breath during lengthy walks. He becomes breathless when climbing stairs. The ECG shows irregularities. His family doctor prescribed bromazepam (e.g. Lexotanil)

goes back to his family doctor. The doctor diagnoses hypotension. A chest x-ray reveals that the patient's heart is enlarged. He is therefore admitted to hospital.

Diagnosis

Dilated cardiomyopathy.

Conventional treatment

An echocardiography confirmed the diagnosis of dilated cardiomyopathy caused by myocarditis. A thrombus of the cardiac apex and a third degree mitral valve insufficiency were also found. A first-time occurrence of vitiligo and a penicillin allergy were likewise noted. On the third day of his hospital stay, the patient suffered a stroke with paresis of the left hand and temporary aphasia. The patient was particularly upset by this event, as he had initially believed the heart muscle inflammation to be innocuous ("I've never had anything like this before, only blisters on my feet from hiking") and

3.4 Cardiomyopathy, heart transplant

refused medication; he had now been struck down by this serious disease completely out of the blue. The patient felt that the doctors took hardly any notice of the hand paresis, which he himself felt to be drastic. His condition and fine motor skills improved slightly over the two following weeks. The patient was very upset by his increasing hair loss, which made a wig necessary. He was discharged after about three weeks. The circulatory problems and attacks of dizziness continued. However, he immediately went back to work.

A short time later, the patient was again readmitted as an inpatient to the hospital he had rejected, this time with increasing dyspnoea and massive peripheral oedema. He was extremely anxious about the further course of his treatment. A psychological consultation revealed that he was suffering from reactive depression as a result of his condition. One week after being readmitted to hospital, the patient suffered a second stroke which impaired his speech: "I wasn't able to speak, nonsensical letters came out of my mouth. I wanted to say something to the nurse but couldn't". The patient felt humiliated by his helplessness and as if he was being ignored. He distrusted all medication and stopped taking it because he was afraid it would trigger another stroke. He began to collect and hide the drugs.

At Christmas, the patient spent five days with his sister. He was readmitted to hospital with violent coughing and haemoptysis. The patient was terrified: "If you take me to hospital it'll be fatal, you'll kill me!" In hospital, he was afraid of choking in his sleep and said he kept himself awake for nearly two weeks. He was transferred to a central hospital at his sister's instigation. During the days which passed until then, he felt that the doctors practically ignored him on their rounds.

The patient was in poor condition on admission. During the examinations in the run-up to his heart transplant, it was found that he had abscesses around the roots of his teeth and the teeth would have to be extracted. The patient only received the dentures he needed four months later. He did not like eating pureed food. During this period, he lost

15 kg in weight. The patient felt compelled to tell everyone about his previous hospital stay, where he felt that he had not been adequately looked after.

Medication

The patient received diuretics and digitalis.

Homeopathic treatment

Repertorisation

COMPLETE REPERTORY

Mind - humiliation

Mind - anxiety

Mind - anxiety, ailments

Differentiation between remedies

The remedy *Staphisagria* was chosen because of the many preceding humiliations (loss of hair and teeth, cachexia, loss of energy, not being taken seriously, paralysis), the insults, the suppressed anger expressed in the wrong way, the subjectively experienced injustice, oversensitivity and injured pride. The loss of his identity as a soldier also pointed to this remedy, as rank and uniform are important means of identification, and rank in particular enables him to enforce commands and requires him to be treated with respect.

Other remedies such as *Natrium muriaticum*, *Ignatia* and *Nux vomica* do not match this type of patient.

Prescription

The patient received two doses of 5 globules *Staphisagria* 12C, the second dose 16 hours after the first.

Progress

The day after the first dose, the patient was able to express himself without complaining and lamenting. He was also able to explain his situation in talks with the transplant doctors, and his changed, cooperative attitude caused the doctors to take him seriously. The patient was placed on the transplant list, and received a successful heart transplant five days later.

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The patient was discharged and sent to a rehabilitation centre. Four months later, he again took part in a physically tough army training program. He is in good health considering the circumstances, and is very grateful to the psychologist. The vitiligo has almost disappeared.

Critical commentary

This case clearly illustrates how homeopathy and conventional medicine can work hand in hand. It can be assumed that the remedy was able to stabilise the patients emotional condition. The patients newly gained trust ultimately led to improved communication between himself and the doctors.

3.4.2 Heart transplant

Definition

Transplantation is defined as the transfer of viable cells, tissues and organs. The ensuing immunological problems are caused by the various tissue antigens.

We differentiate between various types of transplant (table 3.4-2).

Heart transplants are therefore allogeneic.

The aim is to improve the limited or suspended yet essential functioning of the heart to such a degree that the patient will survive.

Clinical information

Incidence and mortality

Around 3500 heart transplants are performed around the world every year. 2500 of these transplant patients receive surgery in the USA and around 500 in Germany. The reason behind this relatively low number of interventions is the difficulty of finding suitable donor organs. Moreover, ABO-incompatible transplants are only possible in small children.

The 1-year survival rate following this complex surgery is about 85%, while the 5-year survival rate is about 70%. It has been found that patients with one or more HLA-DR (human leucocyte antigen) compatibilities have a better prognosis.

Symptoms

Transplant complications: the main problem is caused by the genetic differences between the donor and the recipient, which provoke an immunological defence reaction which may lead to rejection, the so-called graft-versus-host (GVH) reaction. To counteract this, it is

the donor and recipient have as many histocompatibility antigens (MHC, major histocompatibility complex) in common as possible.

The major antigens are consequently the histocompatibility antigens. These are surface molecules characteristic of the immunological identity of the individual. They facilitate the recognition of foreign structures with the aid of cells in the immune system. They are encoded by the so-called major histocompatibility complex (MHC), also referred to as the HLA complex. While MHC class II antigens are found on antigen-presenting cells, MHC class I antigens are expressed on all cells with nuclei. The latter are viewed as transplant antigens, as it is those that cause rejection.

The fewer the histocompatibility antigens the donor and recipient have in common, the quicker the transplant will be rejected. As total compatibility is unlikely (with the sole exception of identical twins), the rejection reaction has to be suppressed with anti-inflammatory and immunosuppressive drugs. In general, it has been found that heart, kidney and liver transplant patients are less likely to suffer a rejection reaction than recipients of skin and bone marrow transplants.

There are three types of rejection reaction:

- **Hyperacute transplant reaction:** caused by cytotoxic antibodies. It manifests within a few hours and is most likely to occur after multiple pregnancies, multiple transfusions and also after transplants. In such cases, transfusions from related donors must be dispensed with and as few blood transfusions given as possible.
- **Acute transplant rejection:** occurs in cases of HLA incompatibility when the

3.4 Cardiomyopathy, heart transplant

immunosuppressive treatment is inadequate. It appears after a few days. Tachycardia and arrhythmia occur in both forms.

- **Chronic transplant rejection:** this is associated with a progressive loss of organ function and manifests after weeks or months, meaning that the transplant is initially deemed successful. A repeat transplant is usually the treatment of choice in such cases. One typical manifestation is transplant vasculopathy of the coronary blood vessels, most commonly involving the final section. The denervation performed during the operation means that no angina pectoris pain is felt.

Tab. 3.4-2: Transplantation Types	
Classification by Donor and Recipient	
Autogenic	Donor corresponds to recipient
Syngenic	Genetically identical individuals
Allogenic	Same species but genetically different
Xenogenic	Different species
Classification by Function	
Allovidual	Complete maintenance of function by transplantation
Allostatic	Function is limited temporally and mechanically
Auxiliary	Lack of organ function is supported
Substitutive	Functional organ failure is substituted
Classification by Location	
Isotopic	Identical location and tissue
Orthotopic	Identical location
Heterotopic	Different location

Diagnosis

ECG

In cases of acute and hyperacute rejection, ECG tests will show a decrease in QRS amplitude, a change in QRS

Echocardiography

Echocardiography tests will reveal a rapid increase in the thickness of the septum and the posterior wall of the left ventricle along with reduced systolic and diastolic flexibility of the posterior wall and the septum. In some cases, AV valve insufficiency with reflux may be identified by colour Doppler.

Immune scintigraphy

Immune scintigraphy tests are performed with marked antimyosin antibodies. In the event of a rejection reaction, numerous activated lymphocytes and lymphoblasts will be found in the laboratory tests together with an increase in CK-MB (creatin kinase isoenzyme).

Myocardial biopsy

Mild, moderate and severe rejection reactions can be identified by myocardial biopsy. A mild reaction will show lymphocytic cell infiltrations without necrosis of the heart muscle cells; a moderate reaction will show the early stages of heart muscle necrosis; in a severe reaction, the lymphocytic cell infiltration is extreme and accompanied by necrosis of the heart muscle cells and severe oedema.

Intravascular ultrasound

Intravascular ultrasound is the most sensitive diagnostic method in cases of chronic rejection.

Treatment

Transplant indications

The indications for performing a heart transplant must be assessed very carefully; the transplant must of course be planned precisely (table 3.4-3).

Further treatment

The patient must be given appropriate medication after receiving a heart transplant.

Immunosuppressive treatment

Immunosuppressive treatment constitutes a combination

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Tab. 3.4-3: Indications for Transplantation	
Cardio- myo- pathy	• Idiopathic dilated cardiomyopathy • Hypertrophic cardiomyopathy • Infiltrative and restrictive disease
Severe con- gestive cardiac failure	• Myocardial infarction • Myocarditis • Idiopathic • Severe valvular heart disease
Congenital heart abnor- malities	e.g. Tetralogy of Fallot

About 60% of all patients can be weaned off the glucocorticoids in the long term. Further treatment therefore consists of the administration of ciclosporin and azathioprine. Anti-lymphocyte antibodies are used in cases of glucocorticoid-resistant rejection reactions.

Side-effects

This intensive immunosuppressive treatment can however trigger a host of side-effects. The risk of lymphoma increases, particularly in the first year of ciclosporin treatment, as does the risk of prostate carcinoma.

The immunosuppressive drugs naturally weaken the body's own defence mechanisms, making the patient particularly susceptible to opportunistic infections. The main problem here is infection with cytomegalovirus (CMV). Preventive treatment with gancyclovir is helpful for some patients. Foscarnet is a proven alternative.

Infections such as herpes zoster, pneumocystis, fungal infections and bacteraemia are particularly common. After taking the medication for longer periods, the patient may suffer from nausea, vomiting, fever, painful limbs, tremor, paraesthesia, burning hands and feet, fatigue and visual disturbances. The nephrotoxicity and hepatotoxicity of these drugs may cause liver and kidney insufficiency. Arterial hypertension and metabolic disorders are also frequently observed.

Photophoresis

Photophoresis is mainly used to suppress donorspecific T cell clones. This process involves the removal of peripheral blood; the recipient receives leucocyte-depleted fractions in return. The leucocyte-rich blood is exposed to UV light in the presence of methoxalene. Methoxalene forms covalent bonds with pyrimidine and other molecules. Mitotic cells treated with methoxalene are exposed to UV light, thus causing their death. The treated leucocyte fractions are then returned to the patient. The treated leucocytes induce an autologous suppressor response communicated by T cells, which is able to suppress the rejection process.

Therapeutic crisis

Problems can arise particularly in the period preceding the heart transplant, when the patient's heart function is declining and the conditions for the planned transplant are less than ideal. The patient's heart function and above all his circulation can be improved by giving prostaglandin E₁ intravenously. Problems can also arise with the immunosuppressive therapy after the operation.

3.5 Pulmonary oedema

Sergio Zajac

Acute pulmonary oedema is one of the most common medical emergencies. Because of its gravity and life-threatening nature, a diagnosis of the cause (if possible) and knowledge of the diseases previously suffered by the patient can contribute to the success of the treatment.

As soon as acute pulmonary oedema is diagnosed, the patient must be assessed rapidly and begin intensive treatment as soon as possible.

Definition

Pulmonary oedema is defined as an abnormal collection of fluid in the extravascular area of the lung tissue, the interstitium and the alveolae.

3.5 Pulmonary oedema

Pulmonary oedema leads to acute respiratory insufficiency.

Clinical information

Incidence and mortality

In 1998, 978 000 patients in the United States were successfully treated in hospital for cardiac decompensation. In a study titled “Outcomes of a Prospective Trial of Intravenous Milrinone for Exacerbations of Chronic Heart Failure (OPTIME CHF)”, the 60-day mortality rate was 9.6% and the combined 60-day mortality and rehospitalisation rate was 35.2%.

Pathogenesis

Acute pulmonary oedema begins when the balance of Starling forces (which maintain the continuous filtration of fluid from the capillaries into the interstitium of the lungs and onwards into the lymphatic system) is disrupted (decrease in plasma proteins or increase in venous pressure in the lungs) or there is a functional and/or anatomical anomaly in the alveo-capillary membranes.

In healthy people, the pressure on the capillary walls remains below 18-25 mmHg. Any increase in pressure above this range initially causes fluid to collect in the interstitial area and increases lymphatic discharge (phase 1). If the condition progresses and the amount of fluid collected increases, the drainage capacity of the lymphatic vessels is exhausted (phase 2) and the alveoli become inundated (phase 3). The system described above shows the mechanism of cardiogenic pulmonary oedema, the most common cause of acute pulmonary oedema (Miserocchi et al. 2001, Glueker et al. 1999).

Aetiology

In didactic terms, the aetiology of pulmonary oedema can be described as follows:

- Changes in capillary permeability: acute respiratory distress syndrome (ARDS), infectious causes, inhalation of toxins, exogenous toxins in the air, vasoactive substances, disseminated intravascular

immunological processes, uraemia, acute risk of drowning and other forms of aspiration.

- Increased lung capillary pressure: cardiogenic and non-cardiogenic causes including venous pulmonary thrombosis, stenosis or venous occlusion and hypervolaemia.
- Reduced oncotic pressure: hypoalbuminaemia
- Lymphatic insufficiency.
- Strongly negative pleural pressure with end-expiratory volume.
- Mixed or unknown mechanisms: high altitude pulmonary oedema (HAPE), neurogenic pulmonary oedema, overdoses of heroin or other drugs, pulmonary embolism, eclampsia, after cardioversion, after anaesthetics, after extubation and after cardiopulmonary bypass.

It must be noted that cardiogenic pulmonary oedema is the most common form but that there may be more than one cause and the choice of therapy can therefore be a clinical challenge.

Symptoms

The patient may suffer from fear, agitation, a feeling of pressure in the chest, breathlessness, respiratory difficulties, coughing, orthopnoea and nonspecific symptoms depending on the progress and severity of his case. Pulmonary oedema can be an initial manifestation of a specific pathology or a further development of an existing disease.

Diagnosis

Firstly it should be established whether the pulmonary oedema is cardiogenic or non-cardiogenic. A clinical profile should then be compiled with a **history** of previous heart and/or lung diseases, infections, poisonings and chest pain; this is then followed by a **physical examination**. Even the “first impression” of a patient should enable the physician to make a quick choice of suitable treatment.

The **clinical examination** may reveal the following symptoms: fine, low-pitched crackles in both lungs, initially basal and later generalised. Dullness to percussion. Tachypnoea, tachycardia, raised jugular venous pressure, arterial hypertension, coughing with

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auscultation of the heart may reveal anomalies of the aortic or mitral valves, S₃ or S₄; cold extremities with or without cyanosis and sweating. Blood pressure changeable, quite often elevated at the onset.

Laboratory

B-type natriuretic peptide (BNP) in the serum can diagnose decompensated congestive heart failure (CHF) as a cause of acute dyspnoea. Serum counts of BNP <100 pg/ml indicate that CHF is less likely to be the cause. BNP > 500 pg/ml most commonly indicates CHF. Together with the anamnesis and the results of the physical examination, the BNP count can be helpful in identifying or rejecting CHF as a cause of acute dyspnoea (McCullough et al. 2002, Maisel et al. 2002).

- Cardiac enzymes and other serum markers to establish the presence of ischaemia and infarction.
- Electrolytes, creatinine and azotaemia.
- Arterial blood gases for establishing hypoxaemia, ventilation/perfusion (V/Q) ratio, imbalances, hypercapnia and acidosis.
- Complete blood count with differential.
- Urine analysis: proteinuria.
- Toxin and drug levels in serum if indicated by the anamnesis.

Imaging techniques

Chest x-ray: signs of lung congestion or image of “fluid on the lungs”.

- Simple congestion of the pulmonary veins: blood circulation in the upper lobes (pulmonary capillary pressure 10-18 mmHg).
- Interstitial pulmonary oedema: Kerley B lines, blurred hilar image, thickening of the bronchial walls (pulmonary capillary pressure > 18 mmHg).

- Intra-alveolar oedema: confluent shadows, “fluid on the lungs” (pulmonary capillary pressure > 24 mmHg).

Transthoracic echocardiography: can be helpful in diagnosing impaired function of the left ventricle, cardiac tamponade, pericardial constriction, pulmonary embolism, (heart) valve diseases, pulmonary hypertension, myocardial hypertrophy, intracardial thrombus etc.

Electrocardiogram: cardiac ischaemia, arrhythmia, atrial and ventricular strain and right deviation of the QRS axis may show up here.

Continuous pulse oximetry: a major factor for evaluating the oxygen content in the blood and the results of respiration treatment.

Invasive monitoring such as right heart catheterisation (Swan-Ganz catheter - SGC) can help provide the best treatment, especially when initial treatments turn out to be ineffective. However, there is a lot of controversy with regard to cost/benefit and performance/complication ratios.

Studies: a multicentric, randomised study presented at the International Conference of the American Thoracic Society showed the same mortality rates in the treatment group given an SGC and the control group, whose treatment was based on clinical evaluation (Fein et al. 1984). In the Connors study (1996), the mortality rate in the group with SGC was even higher, as were the complications.

Treatment

Therapeutic crisis

If the patient does not respond to medication or mechanical treatment methods, the only remaining

Case 3.5-1: Acute pulmonary oedema following self-medication with a sympathomimetic drug

Sergio Zajac

Anamnesis

A 74-year-old woman came to A&E at around midnight (day 0). She had persistent acute dyspnoea which started 15 minutes after taking a selfprescribed sympathomimetic drug (terbutaline). The family reported that she had previously had a flu-type infection for two days without fever or phlegm.

Acute event

Congestive heart failure (CHF) caused by coronary heart disease, hypothyroidism and anaemia of autoimmune origin. Medication: digoxin and thyroid hormone.

The physical examination revealed agitation, unclear speech, arterial hypertension (170/90 mmHg), cyanosis, heart rate 105/min, tachypnoea, a cough with foamy pink sputum, marked use of respiratory accessory muscles, crackles and whistling; auscultation of the heart revealed an irregular heartbeat with a tendency to atrial fibrillation and sweating. The result of the pulse oximetry was 38%; the ECG showed a left bundle branch block. The chest x-ray showed oedema in the alveolar space with perihilar congestion and Kerley lines. Cardiomegaly was later excluded.

Diagnoses

Acute pulmonary oedema.

Conventional treatment

NIPSV (non-invasive pressure support ventilation) was avoided because of the patient's severe hypoxia and breathlessness. After endotracheal intubation, she received controlled artificial respiration. She was given amiodarone to treat the arrhythmia. Morphine and a loop diuretic were administered intravenously, and the patient began to show some improvement. Treatment with dobutamine began after she was admitted to ICU. Her blood pressure dropped to within the physiological range;

the pulse oximetry rose to 99%. Due to the rapid improvement in her lungs, the artificial respiration was reduced. She was extubated after 20 hours, with oxygen supplies continuing through a mask. The laboratory parameters showed neither an increase in cardiac enzymes nor a disruption in the electrolyte counts. Her serum creatinine was minimally elevated (1.4 mg%, normal count: 0.4-1.3 mg%). Her leucocyte count was normal with a left shift (31%). TSH and free T₄ were also normal. Blood cultures were taken.

On the second day, the patient had to be reintubated and respired because of psychomotor agitation and a drop in arterial oxygen content. She remained conscious and retained her sense of orientation. An echocardiography showed myocardial dilation, a slight reduction in the capacity of the left ventricle (ejection fraction 50%), a slight mitral valve insufficiency and a slight tricuspid valve insufficiency. No thrombi or growths on the valves were found. At this time, the patient was very thirsty and requested cold water. The laboratory parameters showed an increase in serum creatinine and BUN to 1.7 mg% and 80 mg% respectively (normal BUN count: 30 - 50 mg%). There was no change in cardiac enzymes.

On the third day, the patient was extubated and given a CPAP mask. Examination of the lungs revealed some fine, moist, distant crackling at the base of the lungs; the pulse oximetry result was 95% with 40% FiO₂. The patient suddenly developed severe bronchospasm with hypersecretion and the pharmacological treatment turned out to be ineffective. The patient again had to be intubated and given CPAP. Her SaO₂ immediately rose to 99%. Her creatinine/BUN counts remained high (1.9 and 89 mg%). The blood cultures turned out to be positive and antibiotic treatment was prescribed. The patient currently has profuse, sustained, dough-like bronchial secretions.

Medication

The patient received antibiotics, sympathomimetic drugs and secretolytic agents.

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Homeopathic treatment

On the fourth day, the patient's family consented to the administration of homeopathic treatment.

Repertorisation I

COMPLETE REPERTORY Respiration - accelerated, quick

Respiration - asphyxia

Respiration - dyspnoea

Respiration - difficult - oedema of lungs

Respiration - breathlessness - extreme (orthopnoea)

Respiration - breathlessness - lying down aggravated

Respiration - breathlessness - lying down - impossible

Respiration - breathlessness - with sweating

Respiration - gasping - air

Respiration - obstruction

COMPLETE REPERTORY

Respiration - gasping

Respiration - rattling

Respiration - wheezing

Respiration - whistling

Discharges - foamy, frothy

Differentiation between remedies

Ammonium carbonicum: burning eyes, avoids light. Coughing at around 3 am with dyspnoea, palpitations, burning in the chest; worse when sitting up. Chest feels tired. A lot of pressure when breathing; worse after exercise, entering warm rooms or climbing stairs. Slow, laboured, stertorous breathing; bubbling noise. Winter catarrh with slimy sputum and clumps of blood. Pulmonary oedema. Weak heart. Worse: in the evening, in cold, damp weather, with wet compresses, when washing, between 3 am and 4 am, during menstruation. Better: when lying on the painful side and on the front; in dry weather.

Antimonium tartaricum: great despondency. Fear of being alone. Face cold, blue, pale, covered in cold sweat. Nausea and vomiting. Thirsty for cold water, little and often; wants apples, fruit and sour foods. Loud rattling from mucus but little expectoration. Fast, short, difficult

with wheezing. Large accumulation of mucus in the bronchi. Cough worse when eating, with pain in the chest and larynx. Oedema and threat of lung paralysis. Severe palpitations with unpleasant feeling of heat. Fast pulse, weak, trembling. Dizziness with attacks of coughing. Dyspnoea relieved by eructation. Coughing and dyspnoea better when lying on the right side. Severe pain in sacrolumbar area. Rash with pustule formation. Extreme sleepiness. Worse: evening; when lying down at night; warmth; in cold, damp weather; from all acidic foods and milk. Better: sitting up, eructation, expectoration; < 3 am.

Apis mellifica: complains. Tearful. Swollen eyelids, red, oedematous, turned outwards, inflamed; burning and stinging. Tongue fiery red, swollen, rough and sore, with blisters. Tongue feels inflamed, red, hot and trembly. Swollen palate. Swollen lips, especially upper lip. Very tender. Hoarseness; dyspnoea, fast, difficult breathing. Feeling of being unable to draw another breath. Very sleepy. Sudden screams and starting up during sleep. Chills in the afternoon with thirst; < with movement and warmth. Worse: all kinds of heat; touch; pressure; late afternoon; after sleep; in closed, heated rooms. Right side. Better: outdoors, when uncovered, cold baths. *Arsenicum album*: lying down impossible; fear of choking. Obstructed airways. Asthma, < around midnight. Catarrh with risk of choking (croup-like attacks). Coughing < after midnight and lying on back. Scanty sputum, foamy. Wheezing. Haemoptysis with pain between the shoulders. Dry cough, as if from sulphur fumes.

Kalium carbonicum: very sleepy. Sudden screams and starting up during sleep. Sour eructations. Nausea. Feeling of fear in stomach. Dry, hard cough around 3 am with stabbing pain and dry airways. Bronchitis, the entire chest is very sensitive. Scanty sputum, stringy, more in the morning and after eating, < on the lower right side of the chest and when lying on the painful side, > bending forward. Wheezing. Strong propensity for catching cold; > in warm climate. Palpitations and burning in the heart area. Weak, rapid pulse: intermittent, caused by gastrointestinal disturbances. Great exhaustion.

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Worse: in cold weather; from soup and coffee; around 3 am; lying on the left and on the painful side. Better: in warm, humid weather; during the day, when moving.

Lachesis muta: chronic sore throat with a lot of throat-clearing; sticky mucus which cannot be forced upwards or downwards. Very painful; < on slightest pressure, touch is even worse. < when swallowing sputum or fluids. Collars and waistbands must be kept loose. The upper part of the trachea is very sensitive to touch. Feeling of choking and strangling on lying down, especially if there is something around the neck; forces the patient to jump out of bed and run to the open window. Laryngospasm; feeling as if something is running up from the neck to the larynx. Feeling of having to draw a deep breath. Cramp-like pain in the precordial area. Dry cough with tickling and attacks of choking. Scanty secretions and great sensitivity. < from pressure on larynx, left side, after sleep, outdoors. Near-apnoea on falling asleep. Larynx is sensitive to touch.

Naja tripudians: madness with suicidal tendencies. Fear of rain. Depression. Unclear speech. Feeling of strangulation at throat with choking. Dry cough, with heart lesions. Irregular pulse. Sticky sputum and mucus. Feeling of asthmatic constriction in the evening. Asthma begins with coryza. Violent rush of blood upwards, severe dyspnoea, lying on the left side is impossible. Hypertrophy and valve defects. Worse: when using stimulants. Better: walking or riding outdoors.

Phosphorus: lung congestion. Burning pain, heat and pressure on the chest. Feeling of constriction in the chest; heavy weight on the chest. Sharp stabbing in the thorax; breathing fast and difficult. Great heat in the chest; > lying on the left side. The whole body shakes when coughing. Sputum rust-coloured, bloody or purulent. Recurrent haemoptysis. Pain in the chest when coughing.

Spongia tosta: exhaustion and feeling of heaviness after the slightest exertion. Anxiety and difficulty breathing. Copious thirst, intense hunger. Croup-like cough; < on breathing in and before midnight. Breathing short, wheezing, difficult; cough > after

meals or drink, especially warm drinks. Bronchial catarrh with whistling, asthmatic cough, < in cold air, with profuse sputum and feeling of choking; < in heated rooms and when lying with the head low. Feeling of pressure and heat on the chest with sudden weakness. Fast, violent palpitations with dyspnoea; lying down is impossible but patient feels better in a horizontal position. Wakes suddenly after midnight with pain and feeling of choking; redness, heat and fear of death. Cold sweat and feeling of helplessness. Wakes in fright with a feeling of choking. Worse: when sitting up, in wind, before midnight. Better: downwards, head kept low.

Veratrum viride: aggression and delirium. Extreme exhaustion. Severe congestion, almost apoplectic. Hot head, bloodshot eyes. Bloated, livid face. Insincere expression. Head drawn backwards, dilated pupils. Double vision. Rush of blood to the face. Cramp-like twitching of the facial muscles. Lung congestion. Difficulty breathing. Feeling of a heavy weight on the chest. Slow, soft, weak, irregular pulse, intermittent. Fast pulse with little pressure. Continuous dull, burning pain around the heart. Throbbing bodily pulses, especially in the right thigh. Hot sweat.

Prescription

1 dose of 3 drops *Arsenicum album* 30(1)

Progress

Before the homeopathic remedy was administered, the lab tests showed a creatinine count of 2.7 mg% and a BUN of 112 mg%. A few hours later, the patient developed severe diarrhoea (I.1, Herings law). ABP normal, heart rate 78/min. and pulse oximetry 99%. The artificial respiration was reduced. The dobutamine dose was decreased due to the diuresis and the fact that the ABP was stable.

On the fifth day, the patient's creatinine count fell to 2.4 mg% and her BUN rose to 130 mg%. She was given another dose of *Arsenicum album* 30C. On that day, she kept the T tube and was given CPAP at intervals; there was no change in the lung parameters. Only a crackling was audible at the base of

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both lungs. The dobutamine dose was decreased; the patient remained haemodynamically stable.

On day 6, her creatinine count fell to 1.9 mg% and her BUN to 1.14 mg%. APB remained unchanged. No fever. The pulse oximetry was 99% with T tube/ CPAP.

On day 7, the patient was cheerful. There was a brief period of hypersecretion but she was unable to cough up the sputum.

The repertorisation process pointed to *Antimonium tartaricum*.

Repertorisation II

COMPLETE REPERTORY

Respiration - rattling

Respiration - rattling, expectoration, without

Differentiation between remedies

Pulsatilla and *Phosphorus* are alternatives for crackling breathing noises.

Pulsatilla does not usually have a problem with expectoration; with *Phosphorus*, the larynx is often involved and the patient feels as if a heavy weight is lying on his chest.

Prescription

1 dose of 3 drops *Antimonium tartaricum* 30C.

Progress

Further observations showed reduction of the bronchial and tracheal sputum. No crackling was audible on auscultation; only a slight whistle could be heard. The patient was extubated. The pulse oximetry remained at 94% with an oxygen mask administering 5 l/min. Her creatinine and BUN fell to 1.0 mg% and 109 mg% respectively. Another dose of *Arsenicum album* was administered on day 8 when a whistling noise was diagnosed.

Prescription

Single dose repeated on day 8: 3 drops *Arsenicum album* 30C.

Progress

The dobutamine treatment was stopped. The patient

asked for her daughter. Asked about her family and home. Apologised and asked others to forgive her. Read magazines, listened to music, watched TV, took a shower and rested. She had no more complaints. She drank a soup in the evening. Pulse oximetry remained stable at 94% without administration of oxygen. Her cardiac rhythm was back to normal. Her arterial blood gas figures showed neither an acid-base imbalance nor hypoxia or hypercapnia. The electrolyte counts were unchanged.

At 2.40 am on day 9, the patient suffered a sudden cardiac arrest (SCA). Previously she had been mentally confused, although no anomalies were observed. Attempts at cardiopulmonary resuscitation incorporating the brain were unsuccessful. Her death was confirmed at 3.20 am. No post mortem was performed.

Evaluation

The clinical improvement which set in on day 4 could at first glance be attributed to the antibiotic treatment. However, if it is considered that the patient developed diarrhoea just a few hours after receiving *Arsenicum album* and that this was followed by an improvement in all the organs involved (in compliance with Hering's law), not to mention the fact that the time was too short to ascribe the improvement solely to the antibiotics, the benefit of concomitant homeopathic treatment is clear in this case. The weaning off catecholamines and artificial respiration both show a constantly stable pattern; the acute renal insufficiency improved without invasive intervention.

From the patients prior medical history, we concluded that the patient suffered a sudden heart attack caused by coronary insufficiency.

The patients daughter reported that her mother had changed a few months previously and had been complaining about everything since then. However, on the last day something very positive happened. Her mother had been mentally healed despite the fatal heart attack.

Critical commentary

In recent years, the administration of homeopathic remedies parallel to conventional treatment has

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gained acceptance in intensive care units and emergency departments. It is known that many physicians use homeopathy in ICU and for emergencies. However, only a few feel moved to publish their results in scientific publications. This is probably because of the uncompromising attitude towards complementary medicine (formerly known as “alternative

treatment”) in scientific circles. What’s more, the current scientific model does not welcome homeopathic assumptions, which makes the use of the homeopathic model for these conditions more difficult. Nevertheless, publications of well-prepared studies can still be found (Erbel et al. 1998).

Case 3.5-2: Cardiac decompensation after quadruple coronary bypass operation

Irene Schwarz

Anamnesis

60-year-old male patient, doctor by profession. After a walk on a cold winters day, the patient was admitted to a heart clinic with pain on the left side of his chest. This pain had been familiar to him for some time. Posterior wall infarction two years earlier, followed by myocardial necrosis. An ECG is performed in the clinic, immediately followed by a heart catheter examination with the finding that a quadruple aortocoronary bypass operation is urgently required.

Acute event

The bypass operation was successful but the patient’s progress after the operation fluctuated. At times he received large doses of dopamine to treat extreme hypotension (53-70 mmHg). X-ray checks of the chest on the 1st and 2nd days following the operation showed pleural effusions initially on the left, then on both sides. Xipamide (e.g. Aquaphor) administered from the 2nd day following the operation, 40 mg twice a day.

The patient’s recovery is very slow. Marked weakness and increasing depression. On the 7th day following the operation, his wife asks for a psychiatric consultation.

Laboratory: the patient’s serum creatinine was initially normal but rose to 2.02 mg/dl on day 13 following the operation. At the same time, his haemoglobin fell to around 8.5 g/dl within two days; his haematocrit count was 25.2%. The patient rejected the suggestion of a homologous blood transfusion.

Along with the bilateral pleural effusions, the patient developed a pericardial effusion; from day 10 following the operation he was therefore given spironolactone (e.g. Aldactone) 50 mg/d in addition to the xipamide. 3 days after that, he also began treatment with furosemide, 10-40 mg/d. An echocardiography performed four days later showed that the pericardial effusion had remained unchanged despite this forced diuretic medication. The patient’s request for transferral to another hospital closer to his home was refused because of the unchanged pericardial effusion.

Meanwhile the patient had become increasingly depressed and sensitive. Minor aggravations including problems with the patients in the other beds led to violent outbursts of tears. He had hardly any will to live. For three days, he had to be treated with morphine for recurrent heart pain.

His thoughts led to insomnia at night, leaving him tired during the day; he was also tormented by abdominal rumbling and flatulence, for which he was given simethicone (SAB Simplex®).

Diagnoses

Cardiac decompensation following quadruple coronary bypass, bilateral pleural effusions, pericardial effusion, marked hypotension, biapical pneumothorax, bilateral atelectasis, impaired renal functions at the stage of compensated retention.

Conventional treatment

Heart catheter, quadruple coronary bypass operation.

Medication

The most important medication in this case (post-operative):

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Dopamine (3 pg/kg/min. via perfusor), xipamide (Aquaphor) 40 mg/d twice a day from day 2, spironolactone (Aldactone[®]) 50 mg/d from day 10, furosemide (Lasix[®]) 10-40 mg/d from day 13, SAB Simplex[®] 3 times a day from day 15.

As the patient, himself a doctor, feels that the diuretics are weakening him, he gradually weans himself off the oral medication from day 10 onwards.

Homeopathic treatment

A few days after coming off the oral diuretics, the patient requests concomitant homeopathic treatment as his condition has not really improved.

By this time, his serum creatinine has risen constantly from 0.92 mg/dl to 2.02 mg/dl within 8 days.

Repertorisation I

____ SYNTHESIS, COMPUTER VERSION RADAR 8.1

Mind - tired of life

Mind - cries easily

Mind - terrible, sad stories - badly affected by

Generalities - loss - fluid loss

Generalities - weakness - from fluid loss

Generalities - injuries - operation - complaints following

Generalities - injuries - from bones, fractured

Sleep - insomnia - thoughts - compulsive

Abdomen - rumbling

Generalities - medication - allopathic - abuse

Differentiation between remedies

The computer repertorisation puts *China* first followed by *Phosphoricum acidum*, both when simply counting up the symptoms with their weighting and when using the Vithoulkas expert system. Both remedies occur in all rubrics; however, only *China* is found under the mood symptoms "Cries easily" and "Terrible stories...", which are particularly prominent in this case.

Nux vomica is listed in many of the rubrics (ranked higher under "Complaints from abuse of medication" and "Fluid loss"); however, the tearfulness is not mentioned.

medication". This symptom is extremely important from a homeopathic viewpoint, particularly as the patient is being treated with other medication (e.g. antibiotics, heart and blood pressure medication, analgesics, sleeping pills, antithrombosis drugs).

Arnica montana is frequently indicated after operations. According to the weighting of the repertorised symptoms, it only appears in 25th place in this case. However, from day 14 following the operation, this patient's main symptom is great weakness, presumably caused by fluid loss from the pleural effusions, pericardial effusion (15-18 mm lateral wall) and the drug-induced diuresis.

Prescription

On day 14 following the operation: 3 globules *China* 30C dissolved in 250 ml water. One sip every 20 minutes until improvement is observed.

Progress

Day 14: wife's report a few hours after homeopathic treatment commences: the patient's eyes are again clear, he looks much more vital. Creatinine: 1.92 mg/dl.

Day 15, evening: wife's report: today clearly stronger, sleep and appetite improved, the patient has lost his hopelessness and now has the courage to face life. No sleepiness during the day, dazed feelings or dry mouth. The nursing records, which until the day on which the *China* was administered constantly mentioned the patient's fatigue, note that the patient is mobile and "frequently out and about on the ward" from that day. His creatinine begins to fall (1.79 mg/dl). The remedy is changed as he still has problems around the operation site.

Repertorisation II

SYNTHESIS, COMPUTER VERSION RADAR 8.1

Generalities - wounds - incisions

Generalities - injuries - soft tissue

Generalities - injuries - from bones, fractured

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Differentiation between remedies

The *China* had a positive effect on the patient's fluid loss. The pain caused by the operation requires *Arnica montana*. Injuries to bones and soft tissues (caused by sawing open the chest).

Prescription

3 globules *Arnica montana* 200C dissolved in 250 ml, taken several times.

Progress

Day 17: slight improvement in the pericardial effusion (13-14 mm lateral wall), almost no evidence of pleural effusions, general condition so good that the patients transfer is discussed.

Day 18: cystitis with stabbing pain before urinating, sudden imperative urge to urinate; pain in the urethra, particularly after cold drinks and acidic foods. Dry mouth with intense thirst. The operation wounds are inflamed. The patient is annoyed about his delayed recovery and unwilling to enter into discussion.

Repertorisation III

____ **SYNTHESIS. COMPUTER VERSION RADAR 8.1** Bladder - stabbing pain - before urinating

Bladder - urge to urinate - painful

Bladder - sudden urge to urinate - has to hurry to urinate otherwise urine is passed

Generalities - food and drink - cold drinks - cold water, aggravated

Generalities - food and drink - acidic foods - acids aggravated

Mouth - dryness with thirst

Generalities - painful wounds

Generalities - wounds - healing tendency - slow

Generalities - inflammation - of wounds

Mind - answers - disinclination to reply

Mind - dissatisfied

patients other complaints, as the bladder pain was worse before urinating and stopped afterwards, as if the urine and the substances in it were themselves painful. Acidic foods and drinks, for example, also caused dysuria. *Sulphur* and *Pulsatilla* came out top during the repertorisation process. The patients dry mouth and intense thirst indicated *Sulphur*, *Pulsatilla* is typically not thirsty. The slow wound healing (this was day 18 following the operation) also points to *Sulphur* (*Sulphur quadruple* weighting, *Pulsatilla* single weighting).

Prescription

1 dose of 2 globules *Sulphur* 30C.

Progress

The symptoms, particularly the cystitis, improved rapidly after the administration of *Sulphur*.

Day 20: chest x-ray: dorsal diaphragmatic recess not visible as with small effusions or adhesions, bilateral atelectasis, increased infiltrative streaking in the lower lobes on both sides.

Echocardiography: pericardial effusion again 15-17 mm, lateral wall.

Creatinine continues to fall (now 1.46 mg/dl); haemoglobin 10 mg/dl with haematocrit 29%.

Day 21: the patient's satisfactory condition means that he can be transferred to a general hospital with a request for close monitoring of the pericardial effusion.

Day 24: pneumonia on the right side. The patient believes that this was caused by the time he spent waiting in the cold hall after being transferred to the general hospital. The patient is annoyed and despondent about the pneumonia and poor wound healing. Although he feels chilly out of bed, he is hot in bed and wants to "stretch his feet out from under the covers". Despite feeling hungry, he has no appetite and reacts sensitively to odours and light. The patient is again given antibiotic infusions and requests further concomitant treatment with homeopathy on day 28.

Repertorisation IV

____ **SYNTHESIS. COMPUTER VERSION RADAR 8.1** Chest - inflammation - lungs - acute

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Chest - inflammation - lungs - right
Chest - inflammation - lungs - neglected
Chest - stabbing pain - when coughing
Chest - pain - stabbing - when moving
Generalities - cold - from cooling, getting cold
Cough - cold - cooling - from getting cold
Chills - shivering
Extremities - feet hot - in bed
Extremities - feet hot - uncovers feet
Stomach - no appetite - hunger, with
Mind - despair - recovery, about
Mind - blames others
Generalities - inflammation - of wounds
Generalities - wounds - incisions
Generalities - medication - allopathic - abuse
Mind - sensitive - to odours
Mind - sensitive - to light
Differentiation between remedies

Sulphur and *Sanguinaria canadensis* were the leading remedies proposed by the Vithoulkas expert system.

Bryonia covers the cough and pneumonia but is not mentioned at all with the unusual symptom of chilliness with the need to stretch the feet out of bed because they are too hot. The impaired wound healing which is worrying the patient is not found here either, nor with *Sanguinaria canadensis*. *Sulphur* is also the only remedy which mentioned the new symptom of sensitivity to odours. From a homeopathic viewpoint, the antibiotic infusions are encumbering the body with medication, another indication for *Sulphur*.

Prescription

2 globules *Sulphur* 12X once a day for a week, starting on day 28.

spends a lot of time walking on the beach; his legs have regained their strength.

Evaluation

As this case makes clear, recovery is often significantly hindered or even endangered by the frequently considerable loss of bodily fluids during operations (e.g. blood, drained fluids, effusions, oedema, increased sweating); these cannot simply be replaced by infusions. Concomitant homeopathic treatment can have a positive effect on perioperative fluid loss or fluid seepage into the interstitium, as we have seen in this case.

Here too, the essential criterion for evaluating the positive course of healing is Herings law (1.1), according to which healing progresses from top to bottom and from the inside to the outside. In this case, the patient's mood changed from despair and weariness of life to hope and optimism within a few hours of receiving *China*. The patient, who preferred to stay in bed, now walked around the ward and his sleep and appetite improved. His morphine treatment was stopped and his creatinine count began to return to normal. According to Herings law, "from top to bottom" means mood is at the top of the hierarchy while sleep and appetite follow as symptoms of the vegetative nerve system. Wound pain is below and/or outside.

The "cystitis", i.e. pain before urination, could also mean that the homeopathic treatment enabled the organism to mobilise and eliminate the large quantities of medication stored in the body; the process of reversal can certainly be painful. The fact that *Sulphur*, which is the elimination remedy par excellence and was also indicated by the patient's general symptoms, helped so quickly (as with the pneumonia) may imply that the cystitis and pneumonia were in part caused by the impaired excretion of the medication and its metabolites.

Critical commentary

The sooner homeopathic treatment is given, the faster the results will appear. This case seems to show that additional homeopathic treatment in the

Bibliography

perioperative area can make a critical contribution to solving acute problems. Faster consolidation and the associated reduction of allopathic medication to the absolute essentials with the aim of minimising

side-effects (which themselves should not be underestimated) could presumably improve and accelerate the patients recovery - a benefit for patients and health insurance companies alike.

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4 Lungs

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- 4.1 Lung diseases
- 4.1.1 Acute Respiratory Distress Syndrome (ARDS)
- 4.1.2 Pneumonia
- 4.2 Withdrawal from respirator and extubation
- 4.2.1 Withdrawal from respiration devices (weaning)

4.1 Lung diseases

Conventional medicine

This chapter explores the lung diseases relevant to intensive care patients. These include acute respiratory distress syndrome and pneumonia, which are far and away the most common pulmonary diseases. Acute respiratory distress syndrome is one of the most frequent reasons for admission to ICU. The controlled respiration required is associated with a high risk of ventilator-associated pneumonia (VAP).

Homeopathy

As the lungs can be a particularly problematic organ in ICU patients, extra attention should be paid to the possibilities of concomitant homeopathic treatment.

Symptom selection

The location of the inflammation is often critically important when selecting the symptoms.

COMPLETE REPERTORY MILLENNIUM

Respiration - stopped

acet-ac., aeon., alum., alum-p., alum-sil., am-c., am-m., anac., ang., ant-t., apis, aral., arg-n., am., ars., bac., bad., bapt., bar-c., bell., bor., bov., brom., Bry., *cact.*, cadm-s., cahin., calad., *calc.*, calc-p., *camph.*, cann-s., canth., caps., carb-an., carbn-s., carb-v.,

COMPLETE REPERTORY MILLENNIUM

Respiration - stopped

cast., *caust.*, cench., *cham.*, chin., *cic.*, cimx., *cina*, cinnb., dem., coca, cocc., coc-c., coff., con., cop., cor-r., crot-c., Cupr., cur., dig., dios., dot, dros., euph., euphr., ferr., ferr-ar., gels., graph., grin., guai., hell., helon., hep., hydr-ac., hyos., *ign.*, iod., iodof., ip., kali-bi., kali-c., kali-chl., kali-cy., kali-i., kali-n., kalm., kreos., lac-c., *lach.*, lact, *lat-m.*, *laur.*, *led.*, lob., lyc., lyss., mag-c., mere., merc-c., merc-i-r., merc-pr-r., mez., *mosch.*, mur-ac., naja, naphtin., nat-c., nat-m., nat-s., nice., nit-ac., *nux-m.*, nux-v., oena., Op., petr., phel., *phos.*, plan., plat., plb., prun., psor., *puls.*, ran-b., ran-s., rhus-t, rumx., *ruta*, Samb., sang., santin., sarr., sars., sep., *sil.*, spig., spong., squil., stann., staph., stram., stry., sul-ac., *sulph.*, tab., tanac., tarax., ter., thea, ther., thuj., upa., *verat.*, verb., zinc., ziz.

Breathing - difficult - inspiration

aeon., ant-s., *arg-n.*, *urn.*, *ars.*, *brom.*, bry., cact, calad., *calc.*, camph., caps., Caust., chef, chin., chlor., *cina*, cocc., con., crot-h., croto-L, euphr., /ivr., hep., hydrog., *ign.*, *iod.*, Ip., kali-c., kali-n., Lob., meph., mez., mosch., nicot, *nux-m.*, *ox-ac.*, *phos.*, ran-b., rhus-t, sabin., Samb., spig., Spong., squil., staph., sumb., verat, viol-o., zinc.

Respiration - difficult - head low, with

ant-t., Apis, Cact., cann-i., caps., *carb-v.*, *chin.*, colch., cop., eup-per., *hep.*, Kali-c., kali-n., puls., rumx., *spig.*, *spong.*

Chest - inflammation - lungs

Aeon., aesc., *agar.*, *all-c.*, am-c., am-i., ant-ar., *ant-c.*, ant i., ant-s., Ant-t, *apis*, apom., *arg-n.*, *am.*, Ars., *ars-i.*, ars-s-f., arum-t., asaf., asc-t, aur., aur-m., bac., *bad.*, bar-c, bar-i., ba-tn., *bell.*, *benz-ac.*, beryl., both-1., *brom.*, Bry., *cact.*, cadm., *calc.*, calc-s., calc-sil., camph., *cann-s.*, canth., caps., carb-ac, *carban.*, *carbn-s.*, Carb-v., care., cham., Chel., *chin.*, *chlor.*, *cina*, coff., coffin., *con.*, cop., com., crot-h., *cupr.*, dig., dros., dulc., *elaps*, *eup-per.*, ferr., ferr-ar.,

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COMPLETE REPERTORY MILLENIUM Chest
- inflammation - lungs

hippoz., hyos., hyper., ign., iod., ip., kali-ar., kali-bi., kali-br., kali-c., kali-chl., kali-hp., kali-i., kali-m., kali-n., kali-p., kali-s., kreos., lach., lachn., laur., led., Lob., Lyc., lycps., Merc., merc- cy., mill., mur-ac., myos., myrt-c., nat-ar., nat-m., nat-s., nit- ac., nux-v., op., ox-ac., ph-ac., Phos., phys., plb., pneu., podo., psor., Puls., pyrog., ran-b., Rhus-t, rumx., sabad., samb., sang., sec., senec., Seneg., Sep., sil., solin., spig., spong., squil., stann., stann-i., stram., stroph., stry., sul-ac., sul-i., Sulph., syc-co., ter., tub., tub-a., tub-κ., urt-u., verat., Verat-v., x-ray

Chest - inflammation - lungs', lower, right

kali-c., mere., phos., brom., iod.

Differentiating between important
homeopathic remedies

Important remedies: *Bryonia alba*, *Cauticum*, *Phosphorus*

Bryonia alba is specifically indicated for pneumonia, especially when the patient also has the other keynotes of *Bryonia alba*.

Causticum has the symptom “worse when inhaling” and is indicated when lung problems run in the family. Unlike the other remedies, **Phosphorus** is characterised by pneumonia in the right basal lobe, burning pain and a strong propensity to bleeding.

4.1.1 Acute Respiratory Distress Syndrome (ARDS)

This chapter deals with a number of diseases and pulmonary problems caused by artificial respiration for which homeopathic treatment has proved to be beneficial.

Definition

Acute (adult) respiratory distress syndrome is a life-threatening reaction with disseminated changes in the pulmonary interstitium. The clinical criteria of ARDS were defined by the American European Consensus Conference (Benotti 1989).

Clinical criteria of ARDS

- Predisposing diseases as part of the initial situation

- Pulmonary artery occlusion pressures 18 mmHg
- Bilateral infiltration on chest x-ray

Clinical information

Incidence and mortality

ARDS is most likely to occur in connection with certain risk factors such as sepsis, aspiration and pneumonia. 150 000 patients fall victim to this syndrome every year in the USA alone. The mortality rate is approx. 50%.

Pathogenesis

The first twelve documented case histories (Ashbaugh 1967) report diffuse infiltration in the chest x-rays together with hypoxia which was not improved by administering oxygen.

ARDS is caused by a diffuse inflammatory process which manifests in both lungs. The alveolar space contains large amounts of erythrocytes, leucocytes and protein-rich material.

It is assumed that the activation of neutrophil granulocytes plays a central part in the damage to the lungs. In their activated form, they are deposited on the endothelium of the pulmonary capillaries and discharge the content of their granular cytoplasm. The proteolytic enzymes and toxic oxygen metabolites thus released damage the endothelium and cause a capillary leak leading to exudation in the lung parenchyma. Neutrophils and other inflammation mediators subsequently migrate to the site and uphold the inflammation process, which is the ultimate cause of the lung damage.

Important: ARDS is an inflammatory process and not a collection of watery oedematous fluid.

Predisposing factors

All predisposing factors have one thing in common: the activation of neutrophil granulocytes in the lungs and systemic circulation. There are similarities with the development of systemic inflammatory response syndrome (SIRS).

Sepsis (II.1.1), a systemic inflammatory response to infection, is the most common cause of ARDS. As ARDS is not caused by infection, a clear distinction must

4.1 Lung diseases

In principle, ARDS may be caused by any serious disease which facilitates inflammation:

- Shock
- Infections: sepsis (II. 1.1), pneumonia («11.4.2).
- Disseminated intravascular coagulation (DIC), massive transfusions
- Aspiration: stomach contents, fresh or salt water (after drowning)
- Trauma: polytrauma, burns, fat embolism, craniocerebral trauma, lung contusion
- Intoxication: heroin, barbiturates, paraquat
- Inhalation: smoke, oxygen overdose
- Uraemia, coma diabeticum

ARDS can also develop from a large number of other diseases, particularly:

- Increase in intracranial pressure
- Pancreatitis
- Endotoxinaemia
- Urosepsis, catheter sepsis
- Amniotic fluid embolism
- Cardiopulmonary bypass.

Symptoms

Clinical stages

The syndrome is divided into clinical stages based mainly on the severity of the hypoxia.

The **interstitial pulmonary oedema** in stage III is caused by the increase in capillary permeability for protein.

As the condition progresses, severe **hypoxia** and **pulmonary hypertension** develop as the result of capillary thrombosis. Although artificial respiration under high pressure is indispensable, the hypoxia is only very rarely the cause of death. The greatest threat is from multiple organ failure.

Clinical signs

- Trigger events in the last 24-72 h.
- Beginning: acute.

- Positive air bronchogram

- Tachypnoea as the result of a decline in FRC (functional residual capacity).
- $pO_2 < 50$ mmHg, no significant increase after O₂ administration.
- $PaO_2/FiO_2 < 200$ mmHg, PEEP is not taken into account.
- Beginning: $pCO_2 \downarrow$; later: $pCO_2 \uparrow$.
- High protein content in BAL

Tab. 4.1-1: Clinical Stages of ARDS	
Stage	Symptom
Stage I	Triggering event without clinical symptoms
Stage II	• Hyperventilation, $pO_2 \downarrow$, $pCO_2 \uparrow$, pH $\downarrow$ • No recognisable pathology in thoracic X-ray
Stage III	• Tachypnoea ($>25/\text{min}$) • $pCO_2 \uparrow$, $pO_2 \downarrow \downarrow$ • Thoracic X-ray: interstitial pulmonary oedema
Stage IV	therapeutic-resistant hypoxia through: • Coma with respiratory failure • Oedema • Re-li-Shunt $\rightarrow$ cardiogenic shock

Diagnosis

The criteria in the definition must be fulfilled before ARDS can be diagnosed (table 4.1-1).

Physical examination

Percussion and auscultation unspecific.

Blood gas analysis (BGA)

The Horovitz quotient (ratio of arterial oxygen partial pressure in the inhaled air; PaO_2/FiO_2) should be less than 200 mmHg.

Imaging techniques

Chest x-rays show a typical “butterfly shape” and later a diffuse reduction in transparency. Confluent infiltrations (“white lungs”) are characteristic. Measurements of the **pulmonary arterial occlusion pressure** (PAOP) by Swan-Ganz catheter are

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ARDS and cardiogenic pulmonary oedema. In cases of ARDS this figure is < 18 mmHg, in cardiogenic pulmonary oedema > 18 mmHg.

When performing a bronchoalveolar lavage (BAL), the percentage of neutrophil granulocytes in the cells obtained is examined together with the total protein concentration. If ARDS is present, the cells in the lavage fluid from the lower respiratory tract will comprise from $< 5\%$ to as much as 80% neutrophils. Measurements of the protein concentration in the blood and oedema fluid can be very helpful for differentiating between watery hydrostatic oedema with a low specific weight and inflammatory oedema which is rich in cells. If the protein concentration (oedema/serum) is < 0.5 , the oedema is hydrostatic; if it is > 0.07 , the oedema is inflammatory.

Lung function tests show limited vital capacity and a decline in functional residual capacity (FRC) and effective compliance.

An increase in extravascular lung fluid, mainly bound in the interstitium, is also noted.

Treatment

Main focuses of treatment

(during the disease which triggered the ARDS)

Case 4.1-1: Adult respiratory distress syndrome (ARDS)

Michael Frass

Anamnesis

36-year-old patient who underwent a varicose vein operation on both legs seven years ago now has a flu-like infection. She initially complains of fever and moderate earache on the right; eardrum and ear canal normal. One day later, she has no more fever but is weak, tired and photophobic. On the seventh day following the outbreak of the infection (= day of admission), the patient collapses when she tries to get up.

- Reducing the pulmonary oedema
- Protecting the lungs from iatrogenic damage caused by excessively high tidal volumes (a tidal of 6 ml/kg body weight is ideal, based on the patient's ideal body weight).

The oxygen supply is not enough if the systemic oxygen uptake < 100 ml/min $\times$ m², the venous lactate concentration > 4 mmol/l or the pH value of the stomach lining < 7.32 . Besides increasing arterial oxygen saturation, the oxygen transport must be optimised by increasing the haemoglobin content in the blood and raising the cardiac output.

Therapeutic crisis

Problems arise from the difficulty of oxygenating the patient sufficiently. High respirator pressure can damage the lungs.

- Protecting the lungs from iatrogenic damage caused by excessively high tidal volumes (a tidal of 6 ml/kg body weight is ideal, based on the patient's ideal body weight).

The oxygen supply is not enough if the systemic oxygen uptake < 100 ml/min $\times$ m², the venous lactate concentration > 4 mmol/l or the pH value of the stomach lining < 7.32 . Besides increasing arterial oxygen saturation, the oxygen transport must be optimised by increasing the haemoglobin content in the blood and

Acute event

On the day of admission (day 0), there are no indications as to the cause of the disease. Because of the unclear clinical picture, a CT of the patient's head is performed. The CT reveals a well-encapsulated abscess the size of an egg in the right temporal area. Immediately after the CT, the patient falls into a coma. She defecates involuntarily. The abscess is immediately drained following a skull trepanation avoiding the risk of encephalitis or meningitis. After the operation, the patient is admitted to ICU. Three days after the abscess was drained, an operation is performed on the temporal bone; chronic otitis media is found with perforation into the brain. The middle ear is reconstructed. Two days

4.1 Lung diseases

after the operation on the middle ear, the patient suddenly develops acute respiratory distress syndrome (ARDS).

Diagnoses

Adult respiratory distress syndrome, post drainage of a brain abscess in the temporal area on the right, post chronic otitis media with perforation into the brain.

Conventional treatment

The patient receives controlled respiration with a PEEP of 10 cm H₂O. Purulent, stinking secretions are observed when suctioning.

Medication

The patient is given a bolus consisting of 250 mg cortisone (Solu-Dacortin*) and a prostaglandin aerosol. She is fed intravenously.

Homeopathic treatment

Homeopathic treatment is administered in these difficult circumstances.

Repertorisation I

_____ COMPLETE REPERTORY MILLENNIUM

Respiration - difficult - lying down

Mind - unconsciousness, coma

Eyes - photophobia

Rectum - involuntary stool

Face - redness

Differentiation between remedies

Baptisia has already proven itself several times when treating ARDS patients. Involuntary defecation is found with many remedies; the other rubrics also encompass a wide variety of remedies. *Baptisia* should perhaps have its own rubric for ARDS, maybe under “Breathing - difficult - ARDS”.

Apis and *Arsenicum album* have the symptoms “Respiration - difficult - lying down - aggravated”, as do various other remedies. *Apis* is characterised by swelling

Prescription

1 dose of 5 globules *Baptisia* 200C on day 5.

Progress

The chest x-ray improves within one day; the artificial respiration is significantly decreased. One day later, the patient is extubated and transferred to a general ward. Here she is treated with the antibiotic Optinem® (meropenem) and suffers a severe allergic reaction with oedema all over her body, red skin discolouration and intense itching.

Repertorisation II

_____ COMPLETE REPERTORY MILLENNIUM

Skin - redness

Generalities - swelling

Generalities - intoxication, after

Differentiation between remedies

Bovista is one of the main remedies for drug eruptions. It has a marked effect on the skin, where it produces an eczema-like rash. A feeling of growing larger is seen in the mental sphere. Abdominal colic is also typical of *Bovista*. *Arsenicum album* is the main remedy for allergies, particularly for food allergies. *Nux vomica* is indicated for drug intoxication. *Apis* should be considered for generalised swelling.

Prescription

2 dose of 5 globules *Bovista* 200C on day 7.

Progress

The drug eruption and swelling subside within a few hours. The patient is discharged 5 days later and remains in good health over an observation period of nine years.

Evaluation

This severe case shows a rapid reaction to *Baptisia* and *Bovista*. Despite a life-threatening ARDS (acute respiratory distress syndrome) and a physically stressful situation (drug eruption), it was possible to transfer the

4 Lungs

Critical commentary

This case shows that homeopaths need not balk at treating diseases such as ARDS in ICU patients but should progressively tackle difficult cases.

Case 4.1-2: Postoperative ARDS

Peter Konig

Anamnesis

The patient suffers from hypertension and has been taking an ACE inhibitor for some time.

Acute event

Day 0: call from the patient's wife. ARDS has developed after an operation on his aortic valve and an aortic aneurysm on the aorta ascendens. Atelectasis and pleural effusions are both present. More information cannot be obtained in the limited time.

Diagnosis

Postoperative ARDS

Conventional treatment

The patient is connected to the heart-lung machine and is deeply sedated; his body has stored 30 kg in water and he looks pale and bloated. Excretion via the kidneys is functioning well; there is a risk of sepsis. A life-threatening drop in pressure occurred when he was anaesthetised.

Homeopathic treatment

Repertorisation

MACREPERTORY PRO 6.1.5. VERS. 4.5 Heart & circulation - aortic aneurysm

Generalities - dropsy, external

Generalities - shocks, of injury

Differentiation between remedies

The following nine remedies cover all three of the symptoms chosen: *Aconitum*. *Arsenicum album*.

aneurysm" and "Generalities - dropsy, external" and double weighting in "General - shocks, of injury". *Carbo vegetabilis* also has a special relationship with the lungs.

Prescription

5 globules *Carbo vegetabilis* MK (= 1M manufactured using the Korsakoff method) once a day from day 0.

Progress

Day 3: since the homeopathic treatment began, it has been possible to reduce the inspiratory oxygen concentration every day (currently 45%, before treatment 86%). At this point, the patient no longer needed haemofiltration and required fewer fluids; he even reached a state of negative balance.

Day 10: from day 0 the patient received *Carbo vegetabilis* every day; the dose is now reduced to every second day. His circulation is stable, he is responsive and breathing spontaneously with pressure support.

On day 13 the patient is extubated and breathes spontaneously with an oxygen mask. He has symptomatic transitory psychotic syndrome, is responsive but confused, moves very little, is exhausted and limp. The peripheral oedema has subsided.

Six months later, the patient is well except for a weakness in his left hand and foot. He is trying to resume normal everyday life and is once again able to drive.

Evaluation

Carbo vegetabilis (potentised carbonised birch or beech wood) is well known and proven in the treatment of critical (cardiovascular), "inert", extremely weak, slow and non-reactive vital functions and consequently preterminal conditions.

4.1 Lung diseases

Critical commentary

The frequent administration of high potencies did not trigger any violent initial reaction in this ICU

patient. In such borderline situations, the organism can process higher energies more quickly than in cases of chronic disease.

Case 4.1-3: Laryngeal carcinoma with pulmonary metastases and compression of the trachea with breathlessness

~~English Medical Journal, 1998, 12, 12~~

The following example is not a case of ARDS but shows the importance of homeopathy when treating extreme breathlessness.

Anamnesis

A 63-year-old man had a laryngeal carcinoma with pulmonary metastases and compression of the trachea

Acute event

The patient was admitted to ICU with extreme breathlessness. A homeopath was consulted on the second day. He found a patient with a high respiratory frequency, especially when falling asleep. His breathing was deep and laboured. The patient moaned and held his throat when coughing; his hands were icy cold and his pulse slow.

Diagnoses

Laryngeal carcinoma with pulmonary metastases and compression of the trachea with breathlessness.

Conventional treatment

The patient was advised to undergo a tracheotomy,

Homeopathic treatment

Repertorisation I

COMPLETE REPERTORY MILLENNIUM

Respiration - accelerated, quick

Respiration - accelerated, quick - sleep, going to

Respiration - moaning

Cough - throat, holds

Differentiation between remedies

The rubric “Respiration - accelerated, quick - sleep, going to” has *Hydrocyanicum acidum* weighted doubly as the sole remedy.

Numerous remedies are listed under the rubric “Respiration - moaning”; *Arsenicum album* would be possible but these patients are much more restless.

Hydrocyanicum acidum is not mentioned under the rubric “Cough - throat, holds”; however, *Aconitum napellus*, *Allium cepa* and *Hepar sulphur* are all given triple weighting here.

Prescription

In line with the symptoms described above, the patient is given the remedy *Hydrocyanicum acidum* 30C every six hours.

Progress

The breathlessness was under control within 48 hours and the patient was able to breathe freely. The patient lived another 3 months without a tracheotomy.

Evaluation

This case shows the remedy’s palliative effect when the patient is in a terminal condition.

Critical commentary

The following symptoms of *Hydrocyanicum acidum* have repeatedly been confirmed in my practice:

Respiration - accelerated, quick

Respiration - accelerated, quick - sleep, going to

Respiration - accelerated, quick - lying down, aggravated

Respiration - asphyxia - children, newborns

Respiration - deep - impossible

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Respiration - impeded

Respiration - blocked

Respiration - imperceptible

Respiration - irregular

Respiration - moaning

Respiration - crackling

Respiration - rattling

Respiration - cold breath

Cough - holds throat when coughing

Cough - mucus, trachea

Chest - lung paralysis

Chest - paralysed diaphragm

Generalities - Cheyne-Stokes respiration

Generalities - collapse

Generalities - cramps and epileptic attacks

Generalities - unconsciousness - extended

Generalities - tearing, of muscles - when falling
asleep

Generalities - bulbar paralysis

Generalities - pulse - rapid

Generalities - pulse - hard

Generalities - pulse - imperceptible

Generalities - pulse - almost imperceptible

Generalities - pulse - slow

Generalities - pulse - low

Generalities - shock

Generalities - trembling

Generalities - cerebrovascular insult or cerebral
hypoxia

Generalities - very light coma - sudden coma

Generalities - coma vigilie

Eyes - rolled and half open

Eyes - eyeballs fixed

Face - pale or bluish

Face - spasm in masseter muscles

Face - lips pale or bluish

Face - face ashen and the mouth

4.1.2 Pneumonia

Definition

Pneumonia is an inflammation of the lung parenchyma caused by infections, allergies, physical or chemical influences.

Clinical information

Incidence and mortality

Nosocomial pneumonia is contrasted with pneumonia acquired outside hospital. A recent study noted a 128% increase in nosocomial pneumonia, although the increase in admissions to ICU for this reason only amounted to 24%. 85% of admissions came from the same hospital (Woodhead 2006).

Nosocomial infection is the form which most frequently leads to death. High mortality in cases of severe preceding disease (approx. 20%), ventilation pneumonia (approx. 40-50%) and ARDS (approx. 80-90%, 4.1).

Pathogenesis

Viruses, bacteria, in rare cases also fungi and protozoa can all cause pulmonary infections. Pneumonia can also develop after inhaling blood and stomach contents.

Quantities of more than 0.4 ml/kg per kg body weight of stomach acid with a pH value of less than 2.5 can provoke aspiration pneumonia with ARDS (II.4.1) and increase mortality rates (Mendelson syndrome). Those mainly affected are accident victims who are not fully conscious and whose swallowing reflex is impaired.

People at risk of aspiration include children, elderly patients, ICU patients, immunocompromised (transplant) patients, and HIV-positive patients.

Symptoms

The clinical picture of pneumonia is unspecific. It is not possible to draw conclusions about the pathogen. The patient mainly develops general symptoms such as headaches and fatigue.

Shivering, tachypnoea, tachycardia, coughing with expectoration and fever over 39 °C are characteristic

of “typical” primary pneumonia caused by bacteria (pneumococci). The symptoms of “atypical” pneumonias caused by viruses or mycoplasma are less marked. Patients with HIV frequently develop *Pneumocystis carinii* pneumonia which usually manifests with a dry cough and dyspnoea on exertion.

Diagnosis

General diagnostics

A dullness is heard when percussing the diseased section of the lung. Pathological auscultation findings, particularly in cases of “typical” pneumonia, with moist, fine, resonant rattles on inspiration and bronchial breathing.

Chest x-ray

Segmental or lobar shadows in cases of “typical” pneumonia, diffuse interstitial shadows in atypical cases.

Pathogen detection

Microbiological culture of sputum or pleural fluid. The presence of antibodies can usually only be detected a few days after the first symptoms have appeared. Antigen detection in the urine and immunofluorescence colouring in the sputum or bronchoalveolar lavage are particularly useful for detecting pathogens, especially when dealing with “atypical” pneumonias. Immunological antigen detection and pathogen DNA detection are newer laboratory procedures.

Around 85% of *Pneumocystis carinii* pneumonias and 95% of *Mycobacterium tuberculosis* pneumonias can be diagnosed by bronchial lavage.

Open surgical lung biopsies are performed by opening the thorax under anaesthetic and removing a piece of tissue from the diseased lung for histological examination.

Treatment

Therapeutic crisis

Problems can occur with long-lasting respiratory insufficiency and when the causative pathogens are

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Case 4.1-4: Acute pneumonia with pleural effusion

Michael Frass

Anamnesis

60-year-old obese male patient who has been suffering from recurrent erysipelas for 20 years. The last attack, which occurred five months ago, was successfully treated with one dose of *Lachesis muta* 30C and healed within a few days. Several accidents in his medical history with transverse processes broken off in the lower thoracic and lumbar spine. Dog bite on the left side of his face at the age of five with scars still present over the eyebrows and under the chin.

Father died in war, mother died of heart failure five years previously, sister died of lung carcinoma eleven years previously.

Acute event

Sudden dyspnoea with 39 °C fever, the patient can breathe better after eructation. Headache at the top of the head which gets worse when lying down. He had diarrhoea the previous week. Moist, fine, resonant crackling is heard in the left basal lobe on auscultation.

Diagnoses

Pneumonia, pleural effusion.

Conventional treatment

The chest x-ray performed on the following day confirmed the diagnosis of pneumonia. Shadow on the left basal lobe with a small pleural effusion on the right. Evidence of older pneumonic infiltration. The patient refuses antimicrobial treatment.

Homeopathic treatment

Repertorisation

————— COMPLETE REPERTORY MILLENIUM

Chest - inflammation - lungs, pneumonia - lower - left

Differentiation between remedies

Remedy chosen according to the clinical aspect of pneumonia in the left basal lobe: besides *Chelidonium*, *Natrium sulphuricum* and *Sulphur* could also be considered in terms of differential diagnosis. Neither remedy is listed under the rubrics “Breathing - difficult - better after eructation” and “Headache - localisation - crown of head - lying down - aggravates”.

Prescription

The patient is given *Chelidonium* 12C, 5 globules twice a day.

Progress

Within one day, the crackles subside so far as to be almost inaudible. No fever blisters have appeared, although the patient normally develops these whenever he has an infectious disease. A new symptom has manifested: pain in pressure-sensitive points on the right temple which only lasts for a few seconds, which improves when the patient lies down quietly. The pain is piercing, stabbing and burning. The patient remembers suffering similar pain symptoms five years ago when he had shingles. The crackles disappear within four days; the chest x-ray taken on the same day shows no sign of infiltration in the left basal lobe.

Evaluation

The patient was unwilling to undergo antimicrobial treatment. His response to homeopathic treatment and the recurrence of old symptoms (Herings reaction) shows that potentised remedies work at a very deep level.

Critical commentary

This treatment was only possible under close monitoring. Homeopathic treatment should be avoided if the therapist lacks experience and diagnostic facilities.

Case 4.1-5: Nosocomial pneumonia with coronary heart disease

Michael Frass

Anamnesis

A 74-year-old man had mostly been in good health until now. Previously he had only suffered from chronic hepatitis C and bursitis in the right elbow 25 years ago. He had also had a transurethral resection due to benign prostate hypertrophy. The patient likes drinking wine, smokes, enjoys being with friends, talks a lot, is a good entertainer, has a lot of Viennese charm and likes to be the centre of attention. At the time of his admission, the inactive patient is 170 cm tall and weighs 83 kg.

Acute event

The patient suffered a posterior wall infarction with an elevated troponin T count and persistent angina pectoris. The heart catheter test showed advanced three-vessel disease with severe multiple stenosis of the RCA, subtotal stenosis of the LAD in the passing region and CX occlusion after the passing region of the marginal branch. The patient also had moderate mitral valve insufficiency and ischaemic cardiomyopathy with inferior and apical hypokinesia to akinesia. The quadruple aortocoronary bypass was therefore performed with LIMA (left internal mammary graft) to LAD, VV to RCA, RCX and RD. The patient then spent an extended period in ICU due to pump failure, nosocomial pneumonia and the need for long-term artificial respiration. After the operation, he also developed a pericardial effusion and a postoperative neurological transitory syndrome. A diabetic metabolic state was also discovered. The patient was transferred to another hospital on day 5 following the operation.

Diagnoses

Nosocomial pneumonia, coronary heart disease, post quadruple autologous aortocoronary bypass graft.

Conventional treatment

In the intensive care unit, it was difficult to wean the patient off the respirator; the patient extubated

himself but had to be reintubated shortly afterwards. The patient also needed a bilateral chest drain due to persistent pneumothorax. He also developed a systemic infection of the lower and middle lobes of the right lung, followed by systemic inflammatory response syndrome (SIRS) which required treatment with catecholamines. At this time, his CRP was 130 mg/dl, his antithrombin III was low, his thrombocytes normal. He then developed acute kidney failure which had to be treated with venovenous pump-assisted haemofiltration. This added up to multiple organ failure with a very poor prognosis. The patients circulation worsened when lying on his left side, a fact which was taken into account during the kinetic therapy. His faeces stank.

Homeopathic treatment

Repertorisation I

_____ **COMPLETE REPERTORY MILLENIUM** Chest - inflammation - lungs - right - lower

Generalities - lying, during - left, on the, aggravated Stool - odour - offensive

Differentiation between remedies

The patients condition is reminiscent of *Pulsatilla*, but the signs of pneumonia are not mentioned.

Pneumonia localised in the right basal lobe is listed under *Kalium carbonicum* and *Mercurius solubilis*. Neither remedy makes any frequent mention of aggravation when lying on the left side, either in the provings or in the clinical confirmations.

Prescription

After an initial phone consultation with the patients wife and a consultation with the attending physician, the patient was given 5 globules *Phosphorus* 200C via the oral mucosa every four hours starting on the 10th day following the operation.

Progress

The patient's respiratory condition improved dramatically within three days. On day 15, the *Phosphorus* treatment was reduced to twice a day. By this time, the

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to 10 g/l. The signs of SIRS subsided completely over time. The chest drains were removed; the patient woke up and showed signs of postoperative organic transitory psychotic syndrome characterised by crude behaviour towards his wife. He no longer required sedation except when being given nursing care. He was successfully weaned off the respirator and was extubated on day 18. The patient expressed a desire to go home. His kidney function improved and the haemofiltration was stopped.

The patient found it difficult to concentrate. The homeopathic remedy was changed with an eye to his history of alcohol abuse and the transitory psychotic syndrome caused by the sedatives.

Repertorisation II

COMPLETE REPERTORY MILLENNIUM

Generalities - food and drinks - wine

Mind - concentration - difficult

Differentiation between remedies

Sulphur patients suffer from the consequences of excess alcohol but have fewer difficulties concentrating.

Lycopodium is another possible choice, particularly when patients behave strangely as a result of transitory psychotic syndrome.

Prescription

Nux vomica LM, 10 globules 3 times a day

Progress

The multiple organ failure was resolved satisfactorily; the patient was transferred to a general ward. On day 25, the patient developed a violent cough with a red face. The sputum was tinged with bright red blood.

Repertorisation III

COMPLETE REPERTORY MILLENNIUM

Face - redness - coughing

Differentiation between remedies

Unlike *Sanguinaria*, *Belladonna* is indicated for coughs and sputum tinged with bright red blood.

Prescription

The patient was given *Belladonna* LM 12 once a day for 5 days.

Progress

The cough improved within a day. During a telephone call on day 37, it was reported that the patient's condition was largely stable and that he had begun rehabilitative physiotherapy.

Additional prescription: The patient was given *Borax* 6C twice a day when methicillin-resistant staphylococcus aureus (MRSA) was detected in his mouth and nose.

Two weeks later, the patient was discharged for external rehabilitation. We were told that no evidence of MRSA was found three weeks later.

Evaluation

The patient only ever received treatment from the homeopath via the phone, with the necessary information being obtained from his wife and the doctors administering conventional treatment. In my opinion, this largely excludes the frequently postulated placebo or suggestive effect theory, as I am not aware that such a thing is possible over the phone. The patient is still doing well; however, when it came to settling the invoice, another constitutional symptom was discovered: although he is well-off, and despite receiving several reminders, it was more than six months before he paid. He never sent his thanks, and according to his wife showed signs of a miserly nature which had already been present before. As I never saw him even after his stay in ICU and he never came to my practice, it was unfortunately impossible to give him constitutional treatment. According to his wife, the patient was still very well one year later.

Critical commentary

This case shows a rapid response to homeopathic treatment in a case of multiple organ failure. Expe-



4.2 Withdrawal from respirator and extubation

4.2.1 Withdrawal from respiration devices (weaning)

Definition

Weaning is the term used when a patient is to be taken off the respirator and recommence spontaneous breathing. This process accounts for about 40% of the respiration time.

Implementation

General

Weaning aims to strengthen the respiratory muscles weakened while being immobilised by the respirator through a gradual process of slow training. The diaphragm is frequently excluded as it continues to contract independently even when the patient is being respirated. It is controlled by impulses from the brain stem neurones. If the diaphragmatic contraction coincides with a breath, it continues until no more impulses are received from the brain stem. This means that even if the patient is receiving artificial respiration, the diaphragm need not atrophy from inactivity.

Requirements

For the weaning to be performed successfully, the following conditions must be fulfilled. The parameters listed must also be taken into consideration as weaning criteria.

Requirements for successful weaning: it must be ensured that the patient's respiratory muscles are working sufficiently well to cope with the increased requirements of spontaneous breathing. Optimum oxygen transport capacity is indispensable when weaning a patient off the respirator. For this, his haemoglobin count, haemodynamics and neurological situation must be normalised. His body temperature, acid-base, water and electrolyte balances must also be physiological. The last but by no means least important requirement for weaning is the patient's willingness to cooperate. His reflexes

particularly his swallowing and cough reflexes, must be 100% intact.

Target figures as weaning criteria

- . PEEP: < 10 cm H₂O
- RSB (rapid shallow breathing) index AF/V_t (V_t in litres): < 100
- Intrapulmonary right-to-left shunt: < 20%
- Vital capacity: > 10 ml/kg body weight
- Maximum inspiratory force: > 20 cm H₂O
- Artificial respiratory minute volume: < 10 l/min.
- Discrepancy in alveolar oxygen partial pressure: < 350 mmHg at 100% O₂.

Methods

Weaning is initiated by stopping or reducing the drugs (e.g. Dormicum®, ketamine, propofol) which have a sedative or hypnotic effect on the organism; this is necessary to guarantee sufficient respiratory control. The artificial respiration should be adapted in such a way that the pCO₂ is at the upper end of the normal range and respiratory alkalosis is avoided.

There are two weaning methods, both of which have proven themselves:

- **T piece weaning:** this method is named after the shape of the tube attachment used. This type of respirator weaning alternates between artificial respiration and spontaneous breathing. The respiration gas flows through the horizontal arm of the T-shaped tube system at a high rate while the patient breathes the gas from the vertical part. The gas flow is kept very high to prevent him from breathing the air in the room (rebreathing). In T- piece weaning, the periods of time in which the patient is respirated on the T piece are increased until he can tolerate a spontaneous breathing phase of 24 h. If the patient's conditions worsens, he is connected back to the respirator. This process is repeated until he can breathe spontaneously all the time.
- **Pressure support:** this method is used for patients who have received artificial respiration for a long time. It facilitates subsequent CPAP (continuous

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the patient tolerates lengthy CPAP phases should extubation be considered.

The patient may not be left alone at any time during the weaning phase, as anxiety may provoke tachypnoea and exhaustion. The patient should also be raised to a half-sitting position so that he can use his accessory respiratory muscles properly. As pain has a negative effect on breathing, appropriate pain treatment should be administered during the weaning process. The patient should also be given low-glucose nourishment during this period as excessive glucose consumption can increase CO₂ and make breathing harder.

Complications

A variety of complications may occur during the weaning process and make it necessary to break it off. Anxiety and dyspnoea, both of which cause the respiratory rate to increase, usually make it impossible to continue the weaning process. The patient can be sedated to alleviate this condition. Paradoxical abdominal breathing with intercostal and suprasternal retraction is a sign of dyspnoea. If the oxygen saturation falls below 90% and the pCO₂ rises by more than 5 mmHg, the weaning process must be broken off immediately.

Another problem is reduced cardiac output caused by an increase in the afterload on the left ventricle. This can be explained by the negative airway pressure created when breathing spontaneously. Moreover, declines in cardiac output can reduce the contractility of the diaphragm, as pulmonary congestion can occur during the weaning process.

A diet which is too high in energy can increase CO₂ production. The patient's daily calorie intake must therefore not be allowed to exceed his needs.

It must also be considered that the contractility of the respiratory muscles can also be affected if the magnesium and phosphate concentration in the patient's body is too low. These electrolytes must therefore be balanced.

Considerable difficulties are likely with patients who have lung fibrosis, high paraplegia, impaired respiratory muscles and advanced COPD, as the reduced gas exchange and impaired muscle condition will both reduce their lung function.

Therapeutic crisis

A therapeutic crisis occurs if the patient cannot be weaned despite intensive effort.

Case 4.2-1: Weaning problem after heart operation

Michael Frass

After an extensive heart operation, it turned out to be impossible to wean a 57-year-old male patient from the respirator due to severe respiratory insufficiency with no clinically recognisable cause.

Anamnesis

The patient first developed cardiac arrhythmia seven years before the acute event. At that time, an aortic valve insufficiency was diagnosed but did not require surgery. However, his dyspnoea had worsened to the extent that an operation was now necessary. His wife had noticed that he suffered from phases of apnoea when falling

that he liked drinking wine, was very dominant when with other people and enjoyed philosophising. She also mentioned that the patient is particularly sensitive to unpleasant odours.

Acute event

During the heart operation, an inspection of the opened aorta revealed that the leaflets of the aortic valve were delicate but that the right coronary leaflet was clearly restricted and the left and noncoronary leaflets were quite severely prolapsed. There was also an associated aneurysm in the ascending aorta with a diameter of 5.5 cm accompanied by chronic atrial fibrillation. The aortic valve was replaced without complications using a biological aortic valve prosthesis (Magna 27 mm); after supracoronary resection of the aorta, the

4.2 Withdrawal from respirator and extubation

supracoronary aorta ascendens was replaced with a 32 mm Vascutek prosthesis and an epicardial bipolar MAZE procedure was performed. The transoesophageal echocardiography performed during the operation showed that the aortic valve prosthesis functioned excellently with no indication of a paravalvular leak. After the operation, the patient was transferred to intensive care for further treatment.

Diagnoses

Replacement aortic valve and replacement ascendens to treat ascendens aneurysm, MAZE procedure.

Conventional treatment

The patient was extubated on the day of the operation; however, he had to be reintubated and respirated two days later due to respiratory insufficiency. During his stay in ICU, he repeatedly suffered episodes of tachycardic atrial fibrillation. Significant blood loss (950 ml) and pleural effusions (right more than left) were noted through the chest drains inserted; the patients respiratory mechanism was also poor. Moreover, the catecholamine treatment had to be increased markedly due to a sharp decline in peripheral resistance; the pressure in the patients pulmonary artery was also elevated, as a result of which inhalation treatment with nitrogen oxide was commenced on the 3rd day following the operation. On the 8th day after the operation, the catecholamine treatment was stopped and the sedation reduced. Afterwards, the patients lung function deteriorated dramatically; a massive shadow was found on the left basal lobe, the fraction of inspired oxygen (FiO₂) was 70%, the patients temperature rose to more than 40 °C and his CRP was extremely high (> 20 mg/dl, normal count: < 0.5 mg/dl). It was possible to reduce the oxygen fraction to 50% if the patient was placed on his front.

Medication

The patient was sedated and given noradrenaline throughout his stay in ICU. He received parenteral nutrition.

Homeopathic treatment

The following symptoms were selected:

Repertorisation I

COMPLETE REPERTORY MILLENNIUM Mind - philosophy - ability for

Respiration - stopped - when falling asleep

Respiration - stopped - when asleep

Chest - aneurysm - aorta

Sleep - position - on front, ameliorated

Generalities - food - wine - desire

Odour - sensitive - to unpleasant (offensive) odours

Generalities - sepsis

Chest - inflammation - lungs - left - lower

Differentiation between remedies

Lachesis could be considered as well as *Sulphur*. With *Lachesis*, the symptoms appear on the left side of the body then move to the right. However, the location of the shadow speaks against *Lachesis*. *Sulphur* is indicated by the patients constitution (he likes drinking wine, feels at home with other people and tends to philosophise) and his sensitivity to odours.

Prescription

One dose of 3 globules *Sulphur* 200C on days 13 and 14.

Progress

On day 14, the patients lung function increases so markedly (CRP and fever down, FiO₂ 45%, NO stopped, pulmonary shadow smaller) that he extubates himself that day. His breathing is sustained by CPAP mask and helmet for approx. 24 hours; however, on day 16 he has to be reintubated. His airway resistance is significantly elevated. His temperature rises again. His wife now explains his major emotional problems: he is very attached to his children from his first marriage but there is considerable friction with his ex-wife; his mother also died the year before. He also feels as if a lot of his friends

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Repertorisation II

COMPLETE REPERTORY MILLENNIUM

Mind - anxiety

Mind - ailments - anxiety - suffering, sorrow

Mind - ailments - emotional and mental symptoms, from

Respiration - inspiration - aggr.

Differentiation between remedies

Here too, the first thought is of *Lachesis*.

Causticum is indicated particularly when the patient suddenly suffers a cold shock on a warm day and/or is exposed to a cold wind. *Causticum* is useful when there are family problems.

Sulphur can usually cope better with worry than *Causticum*, *Natrium muriaticum* or *Ignatia*.

Lachesis also has difficulties with emotional problems but an extremely domineering, frenzied element is also present.

Prescription

On day 16, the patient is given 4 doses of 3 globules *Causticum* 12C. On the following day, the remedy is administered 9 times.

Progress

On day 17, the patient's temperature drops to 37.2 °C; his breathing and general condition improve to the extent that he is again extubated. The patient remains in good condition; however, on day 18 he becomes increasingly agitated and aggressive, leading to a psychiatrist being called in the evening. The psychiatrist administers 10 mg lorazepam (e.g. Ativan®). On day 19, the patient is extremely restless, weak, exhausted and unmotivated; he doesn't want to eat or speak and barely manages to sit up for quarter of an hour with the physiotherapists help. This weakness is particularly marked in the afternoon.

Repertorisation III

COMPLETE REPERTORY MILLENNIUM

Differentiation between remedies

Symptoms worsening between 4 pm and 8 pm is an important indicator for *Lycopodium*.

Apis, *Pulsatilla*, *Sepia* and other remedies also address symptoms which worsen at a similar time.

Prescription

2 doses of 3 globules *Lycopodium* 200C in the evening on day 19; 2 doses of 3 globules *Lycopodium* 200C in the morning on day 20.

Progress

The lorazepam treatment was halved on day 21 and stopped completely on day 22. An improvement in the patient's general condition was observed. On day 22, the patient's mood and condition have improved dramatically; he sits up for 40 minutes, eats well, talks, makes jokes and is cheerful. He is transferred to the intermediate care ward on the same day and to a general ward the day after. On day 23, he develops transitory psychotic syndrome; his speech is confused, he doesn't recognise people and his memory is poor. He is also tired and wants to sleep a lot.

Repertorisation IV

COMPLETE REPERTORY MILLENNIUM

Mood - confusion, as if poisoned

Differentiation between remedies

Hyoscyamus brings forth deep-seated mental and emotional problems. Insomnia and nervous irritation are typical of this remedy. It is also one of the most important remedies for confusion following surgery.

Like *Belladonna* and *Stramonium*, *Hyoscyamus* is one of the remedies that helps aggressive people. However, *Hyoscyamus* patients are the most confused. *Belladonna* suffers due to humiliation, *Hyoscyamus* more from worry and jealousy.

While *Hyoscyamus* has an active memory, the memory of *Stramonium* patients tends to be weak. *Stramonium* patients suffer from the consequences of bad news.

4.2 Withdrawal from respirator and extubation

Prescription

3 globules *Hyoscyamus* 12X once a day from days 23 to 25.

Progress

Hyoscyamus improves this patient's condition within 2 days. On day 26, the patient commences anticoagulation treatment (e.g. Marcumar*); on day 28 he is discharged for home nursing.

Evaluation

This case shows how a patient who had difficulties being weaned from the respirator was helped by concomitant homeopathic treatment. However, it also shows that the homeopathic treatment often

has to be adjusted very quickly to deal with the respective situation. It also proves that both measurable (respiratory parameters) and non-measurable parameters (such as great agitation) can be influenced by homeopathy.

Critical commentary

This case clearly shows the positive influence of homeopathic treatment, firstly in a dramatic situation in ICU and secondly when weaning a patient from the respirator. The patient reacted very promptly to all remedies and recovered all his mental faculties within a

Case 4.2-2: Severe hypoxic cerebral insult while under general anaesthetic

Farokh Master and Jayesh Dhingreja

Anamnesis

A 62-year-old dentist underwent a hernia operation. While under the general anaesthetic, he suffered a severe hypoxic cerebral insult which led to coma, respiratory insufficiency, hypotension and kidney failure.

Acute event

On the 18th day following the operation, a homeopath was consulted and the following observations made: the patient had constant hiccoughs, was in a deep coma vigile, his lower extremities jerked and his creatinine and BUN were elevated. The secretions removed by tracheal suction contained clumps of blood. His feet were cold and damp. When attempts were made to wean him from the respirator, he developed cyanosis within 2-3 minutes.

Diagnoses

Conventional treatment

The patient was given steroids, antibiotics and enteral nutrition; he received controlled artificial respiration.

Homeopathic treatment

Repertorisation I

COMPLETE REPERTORY MILLENNIUM

Chest - cyanosis

Generalities - cyanosis

Mind - unconsciousness - coma

Stomach - hiccough

Discharges, secretions - bloody

Extremities - jerking - lower limbs

Extremities - coldness - feet - clammy

Differentiation between remedies

Only *Lachesis* and *Laurocerasus* are given triple weighting in the rubric "Chest - cyanosis". *Opium*, *Hyoscyamus* and *Helleborus niger* should also be considered in coma cases. *Hyoscyamus* has triple weighting for hiccoughs. *Laurocerasus* is given triple weighting for bloody tracheal secretions, as is *Aconitum*; *Hyoscyamus* is given double weighting.

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Progress

6 days later, the patient is reacting to painful stimuli, 10 days later to verbal stimuli. After 15 days, he was weaned off the respirator; after 21 days he was fully conscious. After 30 days, the patient was discharged from hospital, albeit with neurological deficits and aphasia.

Evaluation

The patient was in a difficult situation in which there seemed to be no hope of weaning him from the respirator.

Critical commentary

Laurocerasus has repeatedly proven its efficacy in treating the following **symptoms**:

- BUN and creatinine elevated
- Extreme sphincter weakness with involuntary urination and defecation
- Cold, damp feet up to the knees
- Constant involuntary movement of certain body parts, e.g. nystagmus, hiccoughs, jerks, trembling.
- Liver enlargement or hardening
- Patient easily falls into coma
- Sudden memory loss
- Tracheal secretions contain clumps of blood
- Cerebrovascular insults with loss of speech. Rubrics which indicate *Laurocerasus*:

Generalities - apoplexy, impending

Generalities - bleeding - blood thick

Generalities - bleeding - internal bleeding

Generalities - collapse

Generalities - convulsions

Generalities - cyanosis

Generalities - cyanosis - in children

Generalities - death - asphyxia

Generalities - dropsy

Generalities - pulse - slow

Generalities - pulse - faint

Generalities - unconsciousness with nausea

Respiration - accelerated

Respiration - anxious

Respiration - asphyxia - in children - newborns

Respiration - Cheyne-Stokes breathing

Respiration - deep, impossible

Respiration - gasping for air

Respiration - gasping for air - heart complaints

Respiration - gasping for air - better when lying down

Respiration - loud exhalation

Respiration - moaning

Respiration - obstructed

Respiration - rattling

Chest - constriction - heart

Chest - constriction - heart - better when lying down

Chest - constriction - lying down, ameliorated

Chest - cyanosis

Chest - difficult breathing

Chest - heart complaints, accompanied by

Chest - inflammation - lungs, accompanied by

Chest - paralysis - lungs

Face - blue - twitching facial muscles, with

Cough - better sitting up

Cough - constant

Cough - hacking

Cough - hard

Cough - lying down aggravated

Cough - mucus - chest, in

Stomach - hiccoughs

4.2 Withdrawal from respirator and extubation

4.2.2 Extubation

Definition

Extubation is defined as removal of the tracheal tube. It is indicated when the patient no longer needs artificial respiration and his protective reflexes are adequate.

Implementation

Requirements

The requirements for extubation comprise the presence of protective reflexes such as swallowing and expectoration, normal blood gas parameters ($pO_2 > 70$ mmHg when $FIO_2 < 0.3$, $pCO_2 < 45$ mmHg) and strong muscles. The muscles may be weakened after treatment with muscle relaxants or in patients who have received long-term treatment. The patient's muscle strength is checked by having him raise his head or press the examiner's hand. Another important criterion is the patient's ability to breathe spontaneously at a normal rate (< 25 /min.) and respiratory time volume (> 400 ml exhalation volume). The patient may therefore not be in a coma; it must also be ensured that he has no infection and his metabolism is balanced before extubating him.

Application

In order to perform an extubation, a **preparation phase** in which the physician starts by assembling all the materials he needs is essential. He needs sterile and non-sterile disposable gloves, a mask, a bag valve mask or anaesthetic apparatus, a suction device, suction catheters in various sizes and a disposable syringe for releasing the cuff.

After **explaining** the procedure and the associated risks to the patient (this is very important for the patient's cooperation), the patient is brought into a sitting position. Methylprednisolone can be given

one hour before the procedure starts. The aim is to minimise the risk of glottal oedema, which can occur as a result of mechanical irritation.

Next, the mouth and throat are suctioned. If the patient has a stomach tube, the stomach contents must also be aspirated. Before removing the tube, have the patient breathe in as deeply as he can. This is where the bag valve may help. Meanwhile, the tube is released and finally removed. The deep inspiration means that the patient breathes out immediately after extubation and the glottis is opened.

The patient must be kept under observation for the minutes following the successful extubation. Blood gas checks after 10 minutes are absolutely essential. 2-6l oxygen must also be administered in the hours following.

Complications

The most serious complications of extubation are subglottal oedema and laryngospasm.

Glottal oedema is most likely to occur in children. It is characterised by a barking cough and inspiratory stridor. This condition is treated with corticosteroids.

Laryngospasm refers to cramp around the glottis. As extubation involves irritation of the larynx by blood or secretions, the mouth and throat must be suctioned thoroughly before extubation. This can largely prevent this undesirable side-effect from occurring.

Therapeutic crisis

An acute problem arises if the patient again develops respiratory insufficiency after extubation; he may need to be reintubated if this occurs. When extubating risk patients, it is therefore advisable to place a tube exchanger (Cook Critical Care) over the tube to facilitate rapid reintubation.

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Case 4.2-3: Difficult extubation

Michael Frass

Anamnesis

A 62-year-old male patient has been suffering from coronary heart disease for years. Otherwise he is not known to be suffering from any significant illnesses.

Acute event

The patient receives an aortocoronary bypass due to increasing problems with angina pectoris. After the operation, the patient is transferred to the intensive care unit. It is possible to wean him from the respirator, but he cannot be extubated as he is at risk of choking on the profuse, tough tracheal secretions. These secretions are stringy. The greatest volume of secretions has to be suctioned in the mornings. On day 32 following the operation, the patient is transferred to our ICU for organisational reasons.

Diagnoses

Post aortocoronary bypass, tracheal hypersecretion.

Conventional treatment

The patient is tracheotomised and breathes spontaneously with continuous positive end-expiratory pressure.

Medication

The patient is given acetylcysteine (e.g. Mucosol- van*) and glycopyrronium bromide (e.g. Robinul*) as secretolytics; he also receives enteral nutrition via a stomach tube.

Homeopathic treatment

Repertorisation

COMPLETE REPERTORY

Discharges, secretions - yellow - morning

Discharges, secretions - hardened

Discharges, secretions - stringy

Differentiation between remedies

Kalium bichromicum patients typically have tough,

The accompanying symptoms typical of *Lachesis* are not present.

Prescription

The patient is given *Kalium bichromicum* 30C twice a day for three days.

Progress

The quantity of the tracheal secretions declines dramatically; the patient is extubated on the third day following commencement of the treatment.

Evaluation

The patients rapid response to *Kalium bichromicum* made it possible to perform a safe extubation after weeks of problems.

Critical commentary

The excellent effect of *Kalium bichromicum* has frequently been observed outside ICU, and the remedy should therefore be considered early and more often in intensive care units.

Study on the influence of *Kalium bichromicum* on tracheal secretions in difficult phase III patients (Frass 2005, Chest):

Chronic obstructive pulmonary disease (COPD) is the fourth most common cause of death in the USA and is responsible for around 500 000 hospital stays every year. Weaning from the respirator is often a major problem for COPD patients who are receiving controlled artificial respiration in ICU. Weaning from the respirator can be made easier by various new modes of ventilation. Besides weaning, extubation often also turns out to be difficult. Tough, stringy tracheal secretions can prevent patients who have already been weaned off the respirator from being extubated. This prospective, randomised, double-blind, placebo-controlled study was performed to investigate the influence of sublingually administered *Kalium bichromicum* 30C on the quantity of tough, stringy tracheal secretions in ICU patients with COPD and nicotine abuse.

The study consisted of 50 patients with at least ten years of nicotine abuse or a history of COPD who had been artificially respired for between three and seven days

Bibliography

tracheal secretions. These patients were breathing spontaneously with continuous positive airway pressure (CPAP). They randomly received either *Kalium bichromicum* 30C (group 1, German Homeopathy Union, Karlsruhe, Germany) or a placebo (group 2). 5 globules were administered twice a day at 12-hour intervals. The quantity of tracheal secretion on day 2 of the study was recorded along with the time until successful extubation and the time spent in ICU.

On day 2, a significant reduction in tracheal secretion was observed in the homeopathy group ($p < 0.0001$). It was also possible to extubate the patients in group 1 much earlier ($p < 0.0001$). The length of time spent by group 1 patients in ICU was also shorter (4.20 ± 1.61 vs. 7.68 ± 3.60 days, $p < 0.0001$).

This data allows us to conclude that potentised (diluted and succussed) *Kalium bichromicum* can help reduce the quantity of tough, stringy tracheal secretions produced by COPD patients

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5 Kidneys

Michael Frass, Beatrix Wulkersdorfer (Conventional Medicine) Michael Frass (Homeopathy)

- 5.1 Homeopathy in cases of kidney disease
- 5.2 Acute renal failure (ARF)

Conventional medicine

The tasks of the kidneys are to produce urine and excrete water containing metabolic end products and toxic substances (urea, medication etc.). The kidneys consequently make a highly significant contribution to regulating the internal milieu of the bodily tissue. They are also responsible for maintaining electrolyte concentrations, the body's water and acid-base balances and the osmotic pressure in the bodily fluids. They also make an essential contribution to maintaining the circulation and promoting blood formation. They do this by producing hormone-like substances such as renin and erythropoietin.

5.1 Homeopathy in cases of kidney disease

Homeopathic treatment

The materia medica has little to offer in terms of the kidneys and renal function. This is not least because impaired kidney function manifests with many other symptoms. Patients with inflammation of the kidneys and urinary tract can be treated effectively with homeopathy; there are also remedies which promote kidney drainage such as *Solidago*, *Berberis* and *Lespedeza sieboldii*.

Symptom selection

The homeopathic repertory largely refers to the symptoms caused by changes in kidney function.

COMPLETE REPERTORY

Kidneys - inactivity

acetan., alf., benz-ac., helon., kali-n., sac-1., solid., ter.

Kidneys - degeneration

alco., ant-c., ant-t., arg-n., ars., ars-h., aur., carb-ac., crot-h., cupr., eucal., ferr., fuch., iodof., kali-bi., kali-chl., kali-i., mere., merc-c., petr., *ph-ac.*, phos., pic-ac., plb., sul-ac., ter.

Kidneys - suppression of urine

achy-a., Aeon., *aeth.*, agar-ph., *ail.*, alf., allox., am-caust., *anthr.*, Apis, apoc., araJ-h., aran., Arn., Ars., *ars-h.*, *ars-i.*, ars- s-f., *arum-t.*, aur., aur-ar., aur-m-n., aur-s., *bell.*, bism., bry., bufo, *cact.*, calc., calc-i., *camph.*, Canth., *carb-ac.*, carbn-s., Carb-v., caust., chim., *cic.*, coff., *colch.*, con., *crot-h.*, *cupr.*, *cupr-acet.*, *cupr-s.*, cycl., *dig.*, dulc., elaps, *elat.*, *erig.*, *eup-pur.*, form., goss., *hell.*, hep., *hydr.*, *hyos.*, iod., juni-v., *kali-bi.*, kali- chl., *lac-c.*, Lach., Laur., lil-t., lob., Lyc., medus., mere., *merc-c.*, *merc-cy.*, *morph.*, nit-ac., nux-v., *op.*, osm., oxyd., petr., *phos.*, phyt., pic-ac., pitu-p., *plb.*, *podo.*, puls., pyrog., rhus-t., *rob.*, *Sec.*, sep., ser-ang., *sil.*, *solid.*, *stigm.*, Stram., stront-c., sul-ac., *sulpha.*, *sulph.*, tab., tarax., *tarent.*, *ter.*, thymol., *urt-u.*, Verat., vip., x-ray, zinc., zinc-p., zing.

Differentiating between important homeopathic remedies

Important remedies: *Solidago*, *Berberis*, *Lespedeza sieboldii*.

Solidago is characterised by scanty, reddish-brown urine with thick sediment. The urine may also be malodorous. Other symptoms include problems

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with micturition and kidney pain radiating to the abdomen and bladder.

Berberis is indicated by pain in the kidney area, bladder problems, bladder catarrh and nephritis with haematuria. Radiating pain which does not improve with pressure or when standing and moving is typical of *Berberis*, as are burning pain and the feeling that urine is retained by the bladder after urination. Pain may appear in the thighs and loins when urinating.

Lespedeza sieboldii (Thunbergii) has proven itself to be a valuable drainage remedy for the kidneys. Mezger mentions a diuretic effect and nocturia in patients with severe chronic nephritis when treated with a IX potency.

5.2 Acute renal failure (ARF)

Definition

Acute renal failure is defined as a sudden and rapidly increasing decline in kidney function. In ICU patients, this is usually caused by insufficient perfusion of the glomeruli or ischaemic/toxic damage to the tubule cells. ARF is normally reversible. The main symptom is the cessation of urine production with oliguria or anuria (oliguria < 500 ml/d, anuria 100 ml/d) and an increase in urea and creatinine retention values. Kidney failure can also progress to a phase of polyuria.

Clinical information

Incidence and mortality

A prospective study performed between September 2000 and December 2001 at 54 hospitals in 23 countries investigated the incidence of ICU patients who were either treated using a kidney replacement procedure or who fulfilled the criteria for ARF. 1738 of 29, 269 intensive care patients suffered from ARF during their stay in ICU; 1260 of these were treated using a kidney replacement procedure.

The most common cause of ARF was septic shock (47.5%). 30% of these patients already had renal dysfunction before being admitted. 13.8% of them were dependent on dialysis on being discharged. Independent risk factors for mortality

in hospital were the administration of vasopressors, artificial respiration, septic and cardiogenic shock and hepatorenal syndrome (Uchino 2005).

Pathogenesis

Acute prerenal kidney failure

This is caused by **hypoperfusion** as a result of:

- Hypovolaemia.
- Drops in blood pressure, reduced cardiac output in cases of cardiac tamponade, cardiac arrhythmia or pulmonary embolism.
- Increased intrarenal capillary resistance in cases of sepsis (II. 1.1), catecholamine treatment, taking ACE or cyclooxygenase inhibitors, liver cirrhosis.

Acute intrinsic kidney failure

Acute intrinsic kidney failure is caused by damage to the tubule cells or glomeruli. The cells are destroyed by apoptosis. This can be caused for example by primary renal diseases such as interstitial nephritis, Goodpastures syndrome, acute glomerulonephritis, thrombotic thrombocytopenic purpura, disseminated intravascular coagulation, haemolytic-uraemic syndrome or malignant hypertension. Renovascular diseases (thrombosis of the renal arteries, embolism, aortic aneurysm) or preexisting chronic kidney diseases can also lead to intrinsic ARE

A differentiation is made between ischaemic and toxic pathophysiologicals.

Tab. 5.2-1: Classification of Acute Renal Failure (ARF) by Localisation

Prerenal ARF	Disturbance of Renal Perfusion
Renal (intrinsic) ARF	• Persistent renal hypoperfusion resulting in functional disturbance of kidney parenchyma (e.g. acute glomerulonephritis) • Damage to tubular cells, usually of toxic or ischaemic genesis (e.g. interstitial nephritis)
Post-renal ARF	Acute obstruction of efferent urinary tract

5.2 Acute renal failure (ARF)

Tab. 5.2-2: Stages of Acute Renal Failure		
Stage		Clinical Picture and Symptoms
I	Damage phase	• Duration: hours to days • Oliguria to normuria • Ability to concentrate maintained
II	Oliguria and anuria	• Duration: 7 days to 10 weeks • Oliguria and anuria • Isosthenuria • Metabolic acidosis • Hyperkalaemia (cardiac arrhythmia) • Hyperhydration (pulmonary oedema) • Uraemia
III	Polyuria	• Duration: days to weeks • Diuresis ↑↑ • Decrease in uraemia symptoms • Loss of Na⁺ and K⁺ • Dehydration • Fever, apathy, tachycardia, hypo-
IV	Restitution	Duration: up to 12 months (average 3 months)

- **Ischaemic ARF:** ischaemic ARF is caused by impaired renal perfusion. The anatomical structure of the blood vessels and the metabolism of the tubule cells cause the kidney to react highly sensitively to fluctuating oxygen supplies. If too much energy is consumed, the oxygen supplies fall too low. Even if the blood supply is still normal, oxygen supplies to the proximal tubule and ascending loop of Henle may be insufficient as too much energy is consumed and additional energy must be obtained anaerobically.
- **Toxic ARF:** a critical role is played by nephrotoxic substances such as chemotherapy drugs, virostatic drugs, immunosuppressants, aminoglycoside antibiotics, inflammatory mediators, x-ray contrast agents, paracetamol, myoglobin and oxalate (leads to stone formation if not sufficiently washed out).

Acute postrenal kidney failure

This form of ARF is caused by obstruction of the efferent urinary tract, e.g. by:

- Obstruction: in cases of prostate disease, neurogenic micturition problems and after taking anticholinergic drugs
- Ureter obstructions: by tumours or ureter stones
- Bleeding into the bladder in catheterised patients.

Symptoms

The main symptom of acute kidney failure is usually **oliguria** or anuria with an increase in substances excreted in the urine. The following clinical signs may appear depending on the stage of the disease and the nature of the damage (table 5.2-2):

- Metabolic acidosis, hyperkalaemia, hyperhydration, hyperphosphataemia, hypocalcaemia.
- Symptoms of uraemia: restricted creatinine clearance, hypertension, oedema, cardiac insufficiency, uraemic gastroenteropathy, pruritus, halitosis, encephalopathy, pericarditis, bleeding tendency caused by thrombopenia.
- Elevated creatinine.

Diagnosis

Physical clinical signs: dry mucous membranes, reduced skin elasticity with raised skin creases, dehydration, oedema. Lung congestion and pericardial rub may be heard on auscultation. Palpation does not usually provide any further information. Clinical symptoms and pathological laboratory findings only manifest when the disease has already reached an advanced stage. ECG, sonography and laboratory tests are all helpful for further diagnosis. **Important:** confirming the diagnosis and differentiating between prerenal and intrinsic ARF (table 5.2-3) are essential for making decisions relating to conventional treatment.

Treatment

Treating the underlying disease

- Re-establishing perfusion by removing the obstruction.
- Eliminating the toxins responsible.
- Compensating for the existing fluid deficit and

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Advantages of CWH in terms of patient survival:

continuous pump-supported venovenous haemofiltration (CWH) is theoretically more beneficial to ICU patients than intermittent haemodialysis (IHD).

An analysis of the effects of each type of kidney replacement treatment (CWH vs. IHD) on the mortality of ARF patients was performed at the University of Michigan between 2000 and 2001. The mortality rates before this study were 52%. By restricting the analysis to patients who had spent more than five days in hospital and had had kidney replacement treatment for at least 48 hours, it was found that the nosocomial mortality rate in

- Dose: "renal dose" of 1-3 mcg/kg body weight per min.
- Side-effects: affects the mesenteric circulation, oxygen consumption and respiratory drive (individual and therefore not predictable).

Several studies doubt the value of dopamine treatment on the basis of the serum creatinine counts; however, more recent studies indicate that it can improve creatinine clearance. A recent meta-analysis confirms that low doses of dopamine promote urination but can not prevent renal dysfunction or death (Friedrich 2005).

Loop diuretics:

- Mechanism: increase sodium and water excretion via the kidneys.
- Active substances: furosemide (e.g. Lasix'), Na/K/2Cl co-transporter bumetanide (e.g. Bumex'), piretanide (e.g. Arelix') and torasemide (e.g. Demadex').
- Dose: maximum daily dose of 1 g due to ototoxic side-effects.

The diuretics work by reducing the reabsorption of water and sodium from the tubule lumen. In many patients, this may provoke non-oliguric kidney failure.

CWH patients was almost 45% lower than in those who received IHD. The analysis of the 100-day mortality rate also revealed a potential survival advantage with CWH.

The main advantage of CWH is that the body is detoxified more gently and consistently than with IHD; the patient's blood pressure also remains more stable.

Parameter	Prerenal ARF	Intrinsic ARF
Sodium(urine)	< 20 mmol/l	> 40 mmol/l
Osmolality(urine)	> 500 mosmol/kg H ₂ O	< 350 mosmol/kg H ₂ O
Osmolality(urine)/Osmolality(plasma)	> 1,3	< 1,1
Creatinine(urine)/Creatinine(plasma)	>40	<20
Fractional sodium excretion [Sodium(urine) x Creatinine(plasma)] / [Sodium(plasma) x Sodium(urine)] x 100	< 1	> 1

Medication

Medication is administered with the aim of promoting diuresis and renal blood flow. However, the dose given must be adjusted in consideration of the patient's impaired kidney function. Although this medication is frequently used, the effect is not always satisfactory.

Dopamine:

- Mechanism: increases kidney perfusion, promotes diuresis.
- Active substance: dopamine

Therapeutic crisis

Problems arise when kidney replacement therapy is necessary to treat long-standing kidney failure, as circulation or coagulation problems may hinder effective treatment.

5.2 Acute renal failure (ARF)

Case 5.2-1: Acute kidney failure

Michael Frass

Anamnesis

A 68-year-old male patient develops acute kidney failure after suffering severe respiratory insufficiency. The patient's case history includes a tonsillectomy in his childhood and a cholecystectomy performed at the age of 42 due to cholelithiasis. The patient also has recurring bouts of Crohn's disease, which first manifested at the age of 47. The patient was operated on for fistulae and underwent several partial resections. However, at the time of the acute event he had no symptoms and was not taking any medication. The patient was diagnosed with diabetes mellitus type II three years previously. This is being treated with metformin (e.g. Glucophage®).

Acute event

The patient was admitted to hospital with pneumonia. In the general chest x-ray, a shadow was observed at the apex of the right lung. On the general ward, the patient suddenly developed dyspnoea and was transferred to ICU with acute respiratory failure (day 0). An endotracheal tube was inserted, he was sedated and controlled artificial respiration was given (BIPAP, FiO₂ of 75%, pressures: 30 and 10 cmH₂O). He also showed signs of sepsis with a focus suspected in the lung. His temperature was 39.2°C, he had tachycardia (heart rate 95/min.), his leucocyte count was 15.6 g/l. One striking symptom was profuse sweating of the head at night.

Diagnoses

Acute kidney failure, Crohn's disease, pneumonia.

Conventional treatment

It was found that the patient had anaemia, elevated beta 2 microglobulin and elevated C-reactive protein (CRP); a computed tomography of the abdomen was consequently performed, raising the suspicion that he had an abdominal tumour. Histological examination of the biopsy revealed that he had abdominal non-Hodgkin lymphoma (NHL).

Homeopathic treatment

Repertorisation I

COMPLETE REPERTORY

Chest - inflammation - lungs - right - upper

Generalities - fistulas

Rectum - fistulas

Head - sweating - night

Generalities - carcinoma

Differentiation between remedies

Silicea could be considered in terms of differential diagnosis; however, the location of the shadow does not indicate this remedy. *Calcareo carbonica* is the main remedy indicated on repertorisation; this also includes nocturnal sweating of the head as a symptom.

Prescription

On day 3, the patient is given 1 dose of 5 globules *Calcareo carbonica* 200C.

Progress

The shadow in the upper lobe of the right lung subsides rapidly over the next four days; the sedatives are stopped. On day 5, the respiratory pressure is adjusted to pressure support with a FiO₂ of 40%. The signs of sepsis subside at the same time. Surprisingly, acute renal failure (ARF) sets in on day 6. The plasma concentration of creatinine and BUN increase dramatically over the next few days. A cloudy sediment is observed in the patient's urine. Continuous venovenous haemofiltration seems inevitable in view of his declining kidney function. As the homeopath was temporarily absent, the patient was not able to begin homeopathic treatment until day 16. The patient reported pain in the kidney area radiating into the thighs.

Repertorisation II

COMPLETE REPERTORY

Kidneys - pain - extending to - thigh

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Differentiation between remedies

Drainage remedies such as *Solidago* and *Lespedeza sieboldii* could be considered. However, the radiating pain indicates *Berberis*.

Prescription

Berberis 12C three times a day on day 16.

Progress

On day 17, the patients plasma creatinine and BUN counts decrease and his urine output increases. He does not require kidney replacement therapy.

On day 25, he is transferred to a general ward. There are no further complications, the patient is discharged for

Evaluation

This case shows how homeopathy can be used to treat organ failure, firstly of the lungs and secondly of the kidneys. Fortunately, the patient had one important symptom, i.e. the pain radiating into the upper thighs. This case clearly shows the importance of taking a thorough case history for choosing the correct remedy.

Critical commentary

It must be observed that the patient's recovery may also have taken the same course if left to nature. Once the creatinine plateau had been reached, the kidney failure may have resolved spontaneously, meaning that the influence of the homeopathic treatment must be called into question.

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6 Gastrointestinal tract

Michael Frass, Beatrix Wulkersdorfer (Conventional Medicine) Michael Frass (Homeopathy)

6.1 Homeopathy for diseases of the gastrointestinal tract

6.2 Acute abdomen

Conventional medicine

The human body obtains its energy from the intake of nutrients (proteins, carbohydrates, fats, minerals, vitamins and trace elements). These nutrients are reabsorbed in various parts of the gastrointestinal tract through the action of enzymes and pass through the mucous membranes in the stomach and intestines to the blood stream. The gastrointestinal tract is a vital part of the body and plays a central role as a major source of energy production.

6.1 Homeopathy for diseases of the gastrointestinal tract

Homeopathic treatment

The gastrointestinal tract is often very responsive to homeopathic treatment. This treatment option should therefore not be neglected.

Symptom selection

The symptoms selected may include pain, vomiting and bleeding.

COMPLETE REPERTORY MILLENNIUM

Abdomen - pain - crushing

aeon., aesc., agar., agn., alet., all-s., *aloe*, alum., am-c., am-m., androc., ango., ant-c., *apis*, aq-pet., arg., *arg-n.*, arund., asaf., Bell., bol., bor., bov., brom., *bry.*, cact., calc., calc-p., calc-s., calen., canth., carb-ac., carb-an., carb-n-o., carb-n-s., *carb-v.*, card-m., caul., caust., cham., chef, chin., chin-ar., chin-s., cina, clem., coc-c., colch., con., corn., *croto-t.*, cub., cycl., diet., dig., dire., elaps., erig., eug., eupi., *ferr.*, *ferr-i.*, ferr-p., gast., *gels.*, gent-c., gran., *graph.*, ham., *hedeo.*, helon., hipp., hydr., hyos.,

COMPLETE REPERTORY MILLENNIUM

hyper., iod., ip., *kali-c.*, kali-i., kali-n., kali-p., kreos., lac-ac., *lac-c.*, lac-d., lach., lact., Lil-t., lyc., lycps., lyss., mag-c., mag-m., mag-s., mang., med., *mere.*, merl., mosch., mur-ac., *murx.*, *nat-c.*, Nat-h., *nat-m.*, nat-s., *nice.*, *nit-ac.*, *nux-m.*, Nux-v., *op.*, ox-ac., *pall.*, ph-ac., phos., phys., *phyt.*, plan., *plat.*, plb., podo., polyp-p., psor., ptel., Puls., rat, rheum, rhus-t, sabad., sabin., sanic., sars., sec., Sep., spig., stann., Stry., sul-ac., Sulph., sumb., tarent., ter., teucr., thuj., til., trif-p., *tril.*, ust, vib., wies., xan., zinc., zinc-p.

Abdomen - inflammation - peritonitis - enteritis

abrot., *acet-ac.*, Aeon., act-sp., adlu., aesc., aethi-a., agar., agn., ail., alco., alf., all-s., aloe, alum., alumn., ambr., am- c., am-caust., ammc., anag., anan., ant-c., Ant-t., Apis, aran., aran-ix., arg., arg-n., arist-ck, *am.*, Ars., ars-i., asaf., asar., asc-t, astac., atro., aur., aur-m., bac., *bapt.*, bar-c., bar-m., Bell., bell-p., berb., beryl, bism., bol, bold., Bry., bufo, but-ac., *cact.*, cadm-s., cael, calad., *calc.*, calc-f., calc-i., calc-s., calc-sil., camph., cann-i., cann-s., *canth.*, caps., carb-an., *carb-v.*, care., card-m., cean., *cham.*, chef, chelo., chim., chin., chin-s., chion., chloram., chlorpr., cic., cimid., cit-l, clem., cob-n., cocc., coch., coff., Colch., coli., *coll.*, *coloc.*, con., cop., corn., cortiso., *crot-c.*, *crot-h.*, cub., cupr., cupr-acet., cupr-ar., cupr-s., cur., cyn-d., cyt-l, dig., dios., diosm., dol., dros., dulc., dys-co., eberth., *echi-a.*, eucal, euph-c., eup-per., *ferr.*, ferr-ar., ferr-m., ferr-p., fl-ac., flor-p., gamb., *gels.*, gins., graph., grat., grin., guat., ham., hed., hep., hip-ac., hippoz., hist., hoit., hydr., hydro-c., Hyos., ign., iod., iodof., ip., ipom., Iris, iris-t., jal, jug-c., junc., kali-ar., kali-bi., *kali-c.*, *kali-chl.*, kali-i., kali-m., *kali-n.*, kali-p., lac-d., Lach., lap-a., Laur., *lept.*, Lyc., lycps., mag-c., mag-m., mag-s., malar., mand., mang., mang-m., mang-s., med., menis., *mere.*, *mere-c.*, merc-d., merc-i-f., merc-i-r., merc-s., *mez.*, mim-p., morg., morg-g., morph., mosch., mur-ac., myric., nat-ar., nat-c., nat-m., nat-s., nit-ac., nit-m-ac., *nuph.*, nux-m., *nux-v.*, nym., ocl., *op.*, osm., ost., *ox-ac.*, pall, parat., petr., ph-ac., Phos., phys.,

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COMPLETE REPERTORY MILLENIUM
Abdomen - inflammation - peritonitis - enteritis

phyt., pin-s., pitu-a., pitu-p., plb., plb-i., podo., polym., prot., psor., ptel., *puls.*, Pyrog., rad-br., raja-s., ran-b., ran-s., rauw., rham-cath., Rhus-t., rhus-v., ric., rob., sabal., sabin., samb., sang., sanguin-n., santin., saroth., sarr., scroph-n., *sec.*, sei., senec., *sep.*, *sil.*, *sin-n.*, solin., sol-n., spig., spong., squil., stann., staph., stel., *stram.*, stroph-s., succ., sul-ac., sulfa., sul-i., *sulph.*, syc-co., tab., tarax., tell., Ter., tere-ch., thlaspi., thuj., thymol., til., trio., tub., tub-k., tub-r., *uran-n.*, urt-u., ven-m., *verat.*, *verat-v.*, vip., vip-a., wies., *wye.*, xero., zinc-s., zinc-val.

Stomach - vomiting - blood

acet-ac., *aeon.*, aeth., agar., aloe., alum., alumn., alum-p., alum-sil., *am-c.*, anan., ant-c., ant-t., arg-n., Arn., *ars.*, ars-h., ars-i., asar., aur-m., bapt., bar-m., bell., bor., both-1., brom., *bry.*, bufo., Cact., cadm-br., cadm-s., *calc.*, calc-i., calc-s., calc-sil., camph., cann-s., *canth.*, caps., carb-ac., carb-n-s., Carb-v., card-m., *caust.*, cham., Chin., *chin-ar.*, *cic.*, *cocain.*, colch., coloc., con., croc., Crot-h., *cupr.*, *cycl.*, dig., dros., erech., *erig.*, ery-a., Ferr., *ferr-ar.*, ferr-i., *ferr-p.*, fie., gall-ac., *ger.*, guai., Ham., hep., *hyos.*, ign., iod., Ip., iris, kali-bi., kali-c., kali-chl., kali-i., kali-m., kali-n., kali-p., *kreos.*, *lach.*, lath., lat-m., led., lob., lyc., mangi., mere., *merc-c.*, mez., *mill.*, morg., mosch., mut., *nat-ar.*, nat-f., nat-m., nat-s., *nit-ac.*, *nux-v.*, olnd., op., ox-ac., *petr.*, Phos., *phyt.*, *plb.*, *podo.*, prot., psor., *puls.*, pyrog., rat., rhus-t., ruta., Sabin., samb., *sang.*, *sec.*, *sep.*, *sil.*, *stann.*, *stram.*, sul-ac., sul-i., *sulph.*, tab., *ter.*, thuj., tril., *uran-n.*, ust., *verat.*, *verat-v.*, vip., *zinc.*

Differentiating between important
homeopathic remedies

! Important remedies: *Arsenicum album*, *China*, *Nux vomica*.

Arsenicum album is an important remedy not only in cases of stomach carcinoma but also when treating inflammation. **China** is indicated in cases of blood loss. Like *Arsenicum album*, **Nux vomica** is prescribed for severe pain in the gastrointestinal tract.

6.2 Acute abdomen

Definition

Acute abdomen is a pathological state characterised by sudden severe abdominal pain and pressure, muscular defence reflex in the abdominal muscles and impaired intestinal peristalsis. There is a wide variety of causes.

Clinical information

Symptoms

Besides the symptoms mentioned in the definition, the patient frequently shows other signs of illness such as nausea, vomiting, fever, tachycardia, tachypnoea, drops in blood pressure and physical weakness.

Diagnosis

Besides taking a precise case history, the diagnostic procedures include a clinical examination, particularly a rectal examination. The clinical findings can be supplemented by specific laboratory tests and imaging procedures. Acute abdomen requires rapid treatment, as it is a life-threatening condition.

Treatment

The treatment depends on the underlying disease. Surgical intervention, for example, is unavoidable in cases of bowel obstruction or stomach/bowel perforation.

Therapeutic crisis

A therapeutic crisis exists if the patients condition does not improve despite antimicrobial treatment and penetration of the surrounding tissue is feared. This applies in particular to patients receiving antibiotics.

Homeopathic treatment

As always, the homeopathic treatment must take the patients personality into account. Besides the local symptoms, enquiries must be made into the patients mood symptoms and any secondary diseases.

6.2 Acute abdomen

Cause 6.2-1: Acute abdomen during a long-haul flight

Michael Frass

Anamnesis

31-year-old Latin American male with abdominal pain is examined in hospital and discharged with diet recommendations. There are no severe diseases in his medical history.

Acute event

Two days later, the patient is on a long-haul flight and again develops severe abdominal pain. The pain makes him scream loudly and uninterruptedly; he also points to his painful abdomen. He is very restless, moves continually, has sunken eyes and a dry tongue. His whole abdomen is painfully tense but not hard. The pain worsens on palpation. No pain in the epigastrium or McBurney point, Blumbergs sign negative. The patients abdomen cannot be auscultated because of the noise of the plane. The patient regularly passes stool every day; appearance, colour, consistency and odour are all normal. Percussion does not indicate any bladder involvement; the patient has no problem urinating. Normal axillorrectal temperature discrepancy with an axillary temperature of 36.3 °C. These findings indicate that acute appendicitis is unlikely.

Diagnosis

Acute abdomen.

Conventional treatment

In this dramatic situation, there is no other option but to land at the nearest airport and have the patient transported to hospital.

Medication

As the patient continues to scream loudly, he is given one tramadol tablet (e.g. Tramal); however, the pain persists.

possible, homeopathic treatment is given in consideration of the urgency of the case.

Repertorisation

_____ **COMPLETE REPERTORY MILLENNIUM**

Abdomen - pain - severe

Abdomen - inflammation, peritonitis, enteritis

Mind - excitement - nervous

Eyes - sunken

Differentiation between remedies

Arsenicum album is administered taking the clinical aspect of intestinal inflammation into account.

Prescription

1 dose of 5 globules *Arsenicum album* 200C.

Progress

30 sec. after taking the remedy, the patient stops screaming, calms down and is able to lie down. His condition remains relatively stable; he complains of mild pain during the rest of the flight. The plane is therefore able to continue to its destination without stopping. The patient is advised to go to hospital when the plane reaches its destination.

Evaluation

Both the cockpit crew and the flight attendants were relieved by the success of the treatment, as the time and expense of an extra stop were avoided. In this case, the urgent need for medical treatment and the impossibility of having the patient immediately transferred to hospital justified the use of all available remedies. Even the author was surprised that the homeopathic remedy given was so effective. This case can be seen as confirmation of the effectiveness of homeopathy according to the law of similars described in Hahnemanns Organon.

Critical commentary

Although the patient was not treated in intensive care, this case has been included in the intensive care part of

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7 Perioperative care

Michael Frass, Irene Schwarz, Beatrix Wulkersdorfer (Conventional Medicine) Michael Frass, Peter Kdnig, Heidrun Pokorny, Irene Schwarz (Homeopathy)

- 7.1 Intraoperative blood loss
- 7.2 Postoperative transitory psychotic syndrome

Conventional medicine

Perioperative care has become an important aspect of anaesthesiology. It is primarily concerned with monitoring and stabilising the patients haemodynamic and respiratory parameters with special attention to blood loss. The recovery of cerebral function is a special concern - particularly in patients who were attached to a heart-lung machine during surgery, were in a state of cardiac arrest during the operation and/or were treated with artificial hypothermia. These patients frequently suffer from transitory psychotic syndrome which can last for days or even weeks. The delusions which occur in this state are extremely stressful not only for the patient but also for the nursing staff and relatives. The main side-effects of conventional pharmacotherapy are tiredness, apathy and clouded consciousness. In extreme cases, the patient may suffer from impaired blood pressure regulation, leading to hypotension. This can delay mobilisation and lengthen the patients hospital stay.

Homeopathic treatment

Homeopathy can take the following areas into consideration: blood loss, postoperative transitory psychotic syndrome, effects of narcotics and medication. It should be remembered that treatment with *China* can be very successful, e.g. in the postoperative convalescent phase.

Symptom selection

The symptoms chosen mainly refer to the consequences of blood loss, to postoperative delusions and to poorly healing wounds and abscesses.

COMPLETE REPERTORY MILLENNIUM

Generalities - bleeding, after

Chin., ferr., ip., nat-m., ph-ac., senec., sep., squil., stict, stront-c., sul-ac.

Generalities - weakness, blood loss

alum., bry., carb-an., carb-v., Chin., chin-s., ferr., ham., hydr., hyper., ign., ph-ac., rat., stront-c.

Mind - delusions - imaginations

absin., aeon., alum., ambr., anac., anh., apis, arg-n., am., ars., atm., bar-c., Bell., berb., brom., bry., calc., calc-ar., calc-s., calc- sil., camph., cann-i., cann-s., canth., carb-an., carbn-o., carb-v., caust, cham., chin., chin-ar., cic., cimic., cina, coca, con., croc., crot-h., cupr., cur., cycl., dros., dulc., fl-ac., gels., graph., hell., hep., hydrog., hyos., ign., kali-ar., kali-br., kali-c., kali-p., kali- sil., lac-c., Lach., lachn., lap-c-b., lap-mar-c., laur., led., lyc., mag-m., mang., mere., mur-ac., nat-c., nat-m., nat-p., nit-ac., nux-m., nux-v., op., ozone, petr., ph-ac., phos., plat, puls., pyrog., rhod., rhus-t, ruta, samb., sars., sec., sep., sil., spong., stram., sulph., tab., tarent., thuj., valer., verat, zinc., zinc-p.

Mind - restlessness - night

abies-c., abies-n., abrot, aeon., acon-c., adel., alum., alum-sil., ambr., am-caust, am-m., ammc., anac., androc., ang., anh., anil., anth., anthr., ant-o., ant-t, apis, apoc., aran., arg., arg-n., Ars., ars-i., ars-s-f, arum-d., asaf., asc-t, aster., atro., aur., aur- ar., aur-s., bac., bad., bamb-a., bapt., bell., bism., bol., bor., bov., brach., bry., cact., cahin., calc., calc-ar., calc-sil., calen., calo., camph., canth., carb-ac., carb-an., carbn., carbn-s., carb-v., card-m., cast, cast-v., caul., Caust., cedr., cench., cham., chef, chin., chin-ar., cblol., chr-ac., cic., cimic., cina, cinnb., cist., cit-a., clem., coca, coc-c., coff., colch., coloc., colocin., com., cop., com., cor-r., croto-t, cupr., cupr-s., cycl., cypr., dig., digin.,

7 Perioperative care

COMPLETE REPERTORY MILLENNIUM

Mind - restlessness - at night

digox., dios., dire., dor., dulc., erig., euph-a., euphr., eupi., fago., ferr., ferr-ar., ferr-i., ferr-p., ferul., fl-ac., form., franz., gall-ac., gels., gent-l., get., glon., gnaph., graph., guai., hall., hell., hell-v., hep., hura., hydr., Hyos., hyper., iber., ign., ind., indg., iod., iodof., iris., jac., jal., jatr., jug-c., Kali-ar., kali-bi., kali-br., kali-c., kali-i., kali-n., kali-sil., kiss., Kreos., lac-c., lach., lachn., led., lil-s., lil-t., lith-c., lob., Lyc., lycps., lyss., mag-c., mag-m., mang., med., menis., menth-pu., Merc., merc-c., merc-cy., merc-meth., merc-s., morph., mosch., mur-ac., mygal., myric., nat-ar., nat-c., nat-m., nat-p., nat-s., nat-sil., nice., nicot., nit-ac., nux-m., nux-v., nym., op., opun-a., osm., ost., ox-ac., par., ped., petr., ph-ac., phos., phys., phyt., pic-ac., pip-m., plan., plb., podo., polyp-p., psor., ptel., Puls., puls-n., rad-br., ran-b., ran-s., rauw., rheum, Rhus-t., rhus-v., rumx., ruta., sabad., sang., santin., sapin., sars., scut., senec., senn., sep., sil., sol-t-ae., spig., spira., spirae., spong., stann., staph., stram., stront-c., stry., sul-ac., sul-i., Sulph., syph., tab., tanac., tarax., teucr., thea., thuj., tub., uran-n., ust., valer., verat., verat-v., verb., vesp., viol-o., vip., vise., yuc., zinc., zinc-p., zirc.

Mind - delusions - poisoned

care., hyos., kali-br., lach., plb., rhus-t., verat-v.

Generalities - abuse - narcotics

acet-ac., aeon., agar., am-c., apom., ars., aur., aven., Bell., bry., calc., camph., cann-i., canth., carb-v., caust., Cham., chin., cic., cimic., Coff., colch., coloc., croc., cupr., dig., dulc., euph., ferr., graph., hep., hyos., ign., ip., kali-ma., Lach., lob., lyc., macrin., mag-s., mere., mosch., mur-ac., nat-c., nat-m., nat-p., nit-ac., nux-m., Nux-v., op., ox-ac., oxyg., passi., ph-ac., phenob., phos., plat., plb., puls., rhus-t., seneg., sep., staph., sulph., thuj., valer., verat., zinc.

Generalities - wounds - heal, slow

all-c., alum., alum-p., alum-sil., am-c., arist-cl., am., ars., bar-c., bar-s., bell-p., bor., both-1., calc., calc-s., carb-v., care., caust., cham., chef., clem., con., cortiso., croc., crot-h., graph., gunp., hell., Hep., hydrog., hyper., kali-bi., kali-c., kali-sil., kreos., Lach., lyc., lyss., mag-c., mang., mere., merc-c., mill., mur-ac., nat-c., nat-n., Nit-ac., nux-v., Petr., ph-ac., phos., plb., puls., rhus-t., ruta., sars., sep., Sil., squil., staph., Sulph., tub., x-ray

Differentiating between important homeopathic remedies

Important remedies: *Aceticum acidum*, *Arnica*, *Arsenicum album*, *Carbo vegetabilis*, *China*, *Ferrum metallicum*, *Hepar sulphur*, *Hyoscyamus*, *Mercurius solubilis*, *Myristica sebifera*, *Silicea*, *Staphisagria*.

Major remedies for treating the consequences of blood loss include *China*, *Ferrum metallicum* and *Carbo vegetabilis*.

Hyoscyamus is particularly effective in treating postoperative confusion, as is *Arsenicum album*. *Arnica*, *Staphisagria*, the “pus remedies” *Hepar sulphur*, *Mercurius solubilis* and *Silicea* and the “homeopathic knife” *Myristica sebifera* can all be considered for wound healing.

China is characterised by extreme weakness, *Ferrum metallicum* by jumpiness and *Carbo vegetabilis* by an urgent need for air and improvement of the symptoms with air, whether from an open window or from a fan.

Hyoscyamus patients suffer from delusions and restlessness; *Hyoscyamus*, *Belladonna* and *Stramonium* are therefore found among the “aggressive” remedies. *Aceticum acidum* has often proven itself in treating the consequences of inhalational anaesthetics. *Arnica* is helpful for problems relating to surgery.

Myristica sebifera helps with abscesses which cannot be opened with the “pus remedies”.

Abscesses with no opening to the outside should not be treated with *Hepar sulphur*, as this may lead to problems.

7.1 Intraoperative blood Loss

Irene Schwarz

Definition

Until about 20 years ago, intraoperative or postoperative blood loss was treated with allogeneic blood transfusions. Since the early 1980s, there has been an increasing risk of transferring AIDS or hepatitis in homologous blood transfusions (from outside donors) and possibly causing even greater damage (even though the probability is only 1-3 to one million); this has motivated a search for alternatives. Donating autologous blood before scheduled surgery has long been established as a routine procedure and should be performed when circumstances allow (i.e. the patient does not have anaemia, a malignant disease or other problem making the donation of autologous blood impossible). Moreover,

7.1 Intraoperative blood loss

the procedures for recovering blood lost during and after surgery are constantly being refined to minimise the necessity of homologous blood transfusions. This has the advantage of critically reducing transfusion-related immunosuppression, which can otherwise lead to a significantly higher risk of postoperative infection and have unfavourable effects, e.g. on tumours (Deutsches Arzteblatt (96) 1999).

Clinical information

Incidence and mortality

Depending on the scope and complexity of the operation, the patient may lose a considerable amount of blood during or after surgery. The additional loss of other bodily fluids (e.g. gastric juices, secretions from draining wounds, fistulas, sweat, oedema around the operation site, pleural and pericardial effusions) can massively disrupt the balance of intracellular, extracellular, intravascular and interstitial fluids with their electrolytes, trace elements and other substances. Although modern infusion therapy means that most people have a good chance of surviving even major surgery with many complications, the recovery process and consequently the length of the patients hospital stay may be unnecessarily extended by the

perioperative loss of blood and bodily fluids with the associated shift of intravascular fluids into the interstitium (e.g. oedema formation, exsiccosis, reduced glomerular filtration rate and even kidney failure); this naturally also raises costs.

Symptoms

The most frequent symptoms of blood loss are weakness, sleep disorders, hypotension, depression, digestive disorders, impaired wound healing, decreased urine output and ultimately kidney failure.

Diagnosis

Haemoglobin, haematocrit, serum electrolytes (Na, K, C) and urine, urea, creatinine.

Imaging procedures

Sonography, x-ray.

Treatment

Emergency measures

Therapeutic crisis

A therapeutic crisis may occur if there is insufficient donor blood to substitute extended postoperative bleeding, especially if the patient has a rare blood group. Problems may also occur with Jehovah's Witnesses,

Case 7.1-1: St. p. intraoperative blood loss

Irene Schwarz

Anamnesis

After being diagnosed with an extensive benign tumour in the cauda equina, which would require an operation lasting several hours and certainly also blood transfusions, a 47-year-old doctor decided to donate her own blood before the surgery for fear of AIDS and particularly in consideration of her child. As the tumour filled almost the entire spinal canal and there was a corresponding risk of paraplegia, there were no more than two weeks available, in which time she twice donated 250 ml of her blood autologously.

In order to be able to remove the tumour, the back muscles were to be opened along the length of several vertebrae and two vertebral arches were to be removed.

After a previous Caesarean, the patient had had a general feeling of fatigue and weakness lasting more than a week as well as pain in the operation site. This had made it difficult for her to look after her child. The attending physicians had been cautious with the administration of analgesics in consideration of the fact that the patient was breastfeeding. To avoid the problem, the patient this time took *Arnica* 30C immediately after the operation.

7 Perioperative care

Acute event

Extreme feeling of exhaustion on waking up after the four-hour operation; this normally occurs after operations or other traumas, usually because of the accumulation of cell disintegration products.

Diagnosis

Significant tissue trauma (back muscles, connective tissue, bone = hemilaminectomy of 2 vertebral arches) from four-hour operation; significant intraoperative blood loss.

Laboratory

Laboratory results before operation: Hb 11.2 g/ dl, HC 33%, erythrocytes 3.95, Na 138 mmol/l, K 4.2 mmol/l.

Laboratory results after operation: Hb 8.4 g/ dl, HC 25%, erythrocytes 2.96, Na 132 mmol/l, K 3.7 mmol/l, creatinine 0.8 mg/dl.

Conventional treatment

Reinfusion of both autologous blood donations, 2 autologous FFP transfusions on the day of the operation and the day after, hydroxyethyl starch (e.g. HAES 6%) 500 and 200 ml, 2 1000 ml Peri- amin infusions (amino acid/glucose solution with electrolytes).

Haemoglobin 8.9 g/dl on the 3rd day following the operation.

Homeopathic treatment

Repertorisation I

COMPLETE REPERTORY

Generalities - injuries - soft parts

Generalities - injuries - extravasations, with

Generalities - injuries - fractures - bones

Generalities - injuries - surgical

Generalities - pain - soreness - bruised

Generalities - wounds, inflamed

Extremities - thrombosis - lower limbs

remedy for blunt tissue injury with blood seeping into the tissue. With this operation, significant soft tissue injury was to be expected from opening and compressing the muscles over many hours in order to reach the actual operation site, the spinal canal. Moreover, at least two vertebral arches had to be sawn off. *Arnica montana* is also an important remedy for preventing wound inflammation and deep vein thrombosis.

Staphisagria is indicated for injuries/operations with long, smooth cuts, particularly in the abdominal area; *Ledum palustre* may be indicated if the abdominal wall is perforated (microinvasive surgery, laparoscopy).

Prescription

1 dose of 2 globules *Arnica montana* 30C taken immediately after coming round from the anaesthetic.

Progress

Marked reduction in pain and exhaustion less than one hour after taking the remedy. The first days following the operation went remarkably well, as noted in the nursing record. Then increasing flatulence with considerable rumbling in the stomach and intestines, particularly after eating; sleepiness during the day, problems falling asleep before 3 am despite great tiredness. Churning thoughts and depression. Extremities become numb when lying on them.

Medication

Diazepam (e.g. Valium®) 10 mg, promethazine (e.g. Atosil), valerian drops for the insomnia. Chewable Ceolat tablets and caraway tea were given to treat the stomach pain and digestive problems. However, the success of all these measures was very limited. A gastroscopy was even performed to seek the cause of the sustained gastric pain, but the findings were normal.

More blood tests were performed on the 10th day following the operation, leading to the diagnosis of severe anaemia from blood loss.

Repertorisation II

COMPLETE REPERTORY

Sleep - sleeplessness - blood - after loss of

Sleep - sleeplessness - in the night, until morning Sleep - sleeplessness - thoughts, from

Sleep - sleeplessness, night - sleepiness, with, daytime

Mind - sadness

Generalities - bleeding, after

Generalities - weakness - from loss of, blood

Stomach - fluids, from loss of vital

Abdomen - flatulence

Abdomen - rumbling noise - food, after

Extremities - numbness, insensibility - lying, while - parts, on

Differentiation between remedies

The Complete Repertory lists only two remedies in the rubric "Sleeplessness, blood, after loss of": *China* with double weighting and *Phosphorus* with single weighting. The weightings are reversed in the rubric "Sleepless, night - sleepiness, with daytime". Only *China* mentions massive insomnia until the morning. *China*: weakness, despondency after extensive blood or fluid loss. Extreme flatulence, as with *Carbo vegetabilis* and *Lycopodium*. Bloating and rumbling in stomach and intestines after taking only a very little food; ringing in the ears or numbness in the extremities when lying down, particularly in the extremity the patient is lying on and especially after blood or fluid loss.

Phosphorus: weakness after fluid loss, less so after blood loss; nervous weakness, pronounced tendency to bleed from all bodily openings (nosebleeds, particularly with bright red blood, sputum, urine etc.), propensity to ecchymosis; burning pain, great thirst with desire for ice-cold drinks despite being chilly; mental torpor to agitation, desire for company.

The most important difference between the two remedies is in the gastrointestinal area, as the patients gastrointestinal disorders are typical of *China* and she does not have certain symptoms typical of *Phosphorus*.

Prescription

China 30C, one dose of 2 globules on day 10.

Progress

Two days after taking *China* 30C, the patients general condition is much improved, she is mentally stable and has no problems sleeping at night. The digestive disturbances and numbness have disappeared. A few days later, the patient is discharged and goes home in good condition.

Evaluation

China is frequently indicated for loss of blood and other bodily fluids after surgery. The risk of transferring HIV, hepatitis etc. via homologous blood transfusions means that they are given less frequently nowadays, which however can delay convalescence considerably (in this case a lengthy postoperative hospital stay although the patient had no other complications); in such cases, intensive perioperative homeopathic treatment seems to be a good therapeutic strategy. The patients general condition improved after taking *Arnica montana* immediately after the operation and *China* some time later. It can be assumed that the adjuvant homeopathic treatment shortened the patients hospital stay.

Critical commentary

Both *Arnica montana* and *China* would probably have worked better if higher potencies had been administered (200C) and the doses had been more frequent. In cases of hyperacute disease or after major operations, for example, the remedy can be made to work more quickly by dissolving it in water and stirring. Procedure: dissolve 2 globules in a glass of water and stir vigorously with a non-metallic object such as a plastic spoon or wooden spatula. Swallow one mouthful. 10-20 minutes later, add more water (non-carbonated!), stir vigorously and swallow another mouthful. The remedy must be stirred vigorously every time it is diluted. When the patients condition starts to improve, the intervals between taking the remedy should be lengthened and the remedy should only be taken when the patients condition starts to deteriorate again.

If the typical symptoms had been observed more attentively, the remedy *China* could have been given at an earlier stage.

7.2 Postoperative transitory psychotic syndrome

Definition

The term “postoperative transitory psychotic syndrome” (occasionally also known as “functional psychosis”) is used to describe a milder form of an acute organic brain syndrome.

Clinical information

Incidence and mortality

About 10% of all people with physical diseases being treated as hospital inpatients (outside psychiatric clinics) are found on precise assessment to have accompanying or secondary mental disorders in the sense of transitory psychotic syndromes. In a study in Ulm (1974), 7.3% of 123 patients on a general internal ward were found to have transitory psychotic syndrome or functional psychosis. As early as 1980, Gotze observed that 30-50% of patients developed psychological symptoms after heart operations; the first day following the operation was largely normal but their condition started to deteriorate on the second or third day.

Pathogenesis

Transitory psychotic syndromes occur particularly frequently after surgery. They may be caused by general physical factors, e.g. fluid loss, electrolyte fluctuations, infections and fever, pharmacological influences such as painkillers and situational aspects such as insomnia, postoperative pain and unspecific stress factors. Medication without a primary psychotropic effect such as beta blockers, diuretics, cortisone, antiarrhythmic drugs and gyrase inhibitors (e.g. ciprofloxacin) can also increase the risk of transitory psychotic syndrome.

Symptoms

The consciousness of patients with organic transitory psychotic syndrome is impaired (somnolence, coma). Vegetative disorders, elevated blood pressure, tachycardia, fever and profuse sweating are also clear indications of organic transitory psychotic syndrome. Other symptoms include

akathisia, insomnia, disruptions in the patient’s formal train of thought with disorientation of time and place, mania, depression, emotional instability and hallucinations. Perception disorders (false illusions, delusions or hallucinatory experiences). Cognitive disorders affecting attention and comprehension. Psychomotor symptoms include undirected, increased or decreased activity.

Diagnosis

The diagnosis is made clinically on the basis of the symptoms mentioned above. No other diagnostic procedures are necessary if the patient is fully conscious and still able to move.

Treatment

The condition is treated with sedatives, neuroleptics and beta blockers.

Therapeutic crisis

Patients who have been on the heart-lung machine frequently suffer reperfusion damage. This combined with the anaesthetics means that transitory psychotic syndrome is not a rare occurrence after a successful operation. This syndrome is characterised by disorientation of time and place. These patients do not know that they have just had surgery and want to go home right away. Their personalities temporarily undergo such radical changes that previously unknown character aspects may appear. For the relatives, the appearance of transitory psychotic syndrome is very disturbing and stressful. In some cases, their father/mother/partner may appear almost unrecognisable. The patients usually hallucinate, although the severity of the hallucinations may vary. If he can no longer distinguish between illusion and reality, nursing a freshly operated patient who is initially naturally dependent on the help of the nursing staff becomes a tremendous strain for both sides.

Patients who become aggressive as a result of transitory psychotic syndrome frequently develop a type of paranoia. Once the syndrome has subsided, patients often say that they had felt as if the nursing staff/relatives were trying to poison them with medication. Other patients

7.2 Postoperative transitory psychotic syndrome

because of the risk of endangering themselves or others. Such a patient may for example be convinced that he has been abducted by the nursing staff. Nursing staff from other countries can trigger complete confusion (disorientation of place) in the patient. Some patients hallucinate. It is also

astonishing to see how even very delicate patients can suddenly develop incredible, almost “superhuman” strength. These patients may remove all drains, central venous access or even blocked indwelling catheters without feeling much pain.

Case 7.2-1: Postoperative transitory psychotic syndrome after aortic valve replacement

Heidrun Pokorny

Anamnesis

74-year-old male patient who was admitted for selective aortic valve replacement to treat advanced aortic valve stenosis.

This patient had diabetes mellitus which did not require insulin treatment, and had suffered a cerebral insult 14 years previously. A WI pacemaker also had to be implanted before the operation to correct the patients bradycardic atrial fibrillation. The patient was independent and mobile at the time of his admission. He came with his wife, appeared to look after himself well and was in general perfectly normal. Owing to the admission of several emergency cases, the patient had to wait a few days for his operation, during which time he was allowed to leave the hospital during the day. The surgery was performed with no major complications. The patient was extubated on the second day following the operation. During his 4th day in ICU, he temporarily developed a positive Babinski reflex. However, a CT brain only revealed leucoen- cephalopathy; everything else was normal except for the ischaemic lesion already known to exist in the left temporal lobe. The patient had therefore not suffered a cerebral insult in the classical sense. The clinical examination and findings led to the conclusion that the patient was suffering a reaction after the operation with the heart-lung machine. The patient was haemodynamically stabilised and transferred to a general ward on the 6th day following the operation. According to the transfer report from ICU, he was suffering from marked transitory

psychotic syndrome. He was disoriented in both time and place.

The intensive care unit initially treated the transitory psychotic syndrome with medication: olanzapine (e.g. Zyprexa*), haloperidol (e.g. Haldol®) and midazolam (e.g. Dormicum®). Doctors, nursing staff and the patients wife all found it very difficult to get through to him. During the period following, his wife visited him every day on the ward. Experience has shown that this is highly recommended in cases of transitory psychotic syndrome. On making his first attempt to stand up with the physiotherapists help, the patient felt dazed and unusually dizzy. His meals had to be fed to him.

Acute event

Late one evening, the patient became very aggressive and talkative. He wanted to see his wife immediately. When the nursing staff refused to call his wife in the middle of the night, the patient talked about fantasies of death. The nursing staff were unable to calm him; he began to thrash around. Because of the risk of harming himself and others, he had to be secured to the bed, and finally fell asleep after being given Haldol intravenously. The following day, his fatigue lasted until midday. He was put into a reclining chair in the corridor facing the nurses' base. His wife had not yet been to the nurses' base at this time. One of the nursing staff tried to get him to drink, but the patient suddenly and unexpectedly hit her; luckily, he was not yet able to get up by himself. The nurse summoned assistance.

Diagnosis

Transitory psychotic syndrome following aortic valve replacement.

7 Perioperative care

Conventional treatment

Medication

The patient was finally calmed with Gewacalm' (diazepam) administered intravenously. During the day, his oral treatment was changed to Miltown*. Gewacalm' administered intravenously meprobamate was effective in helping him sleep. The medication used to treat the transitory psychotic syndrome was changed to meprobamate (e.g. Miltown') and olanzapine (e.g. Zyprexa'); the hypertension which manifested after the operation was treated with clo- nidine (e.g. Nexiclon').

Homeopathic treatment

Once it was observed that the patients postoperative recovery would be protracted, a homeopathic remedy was administered to accelerate the process.

Repertorisation

SYNTHESIS VERSION 9.1

Generalities - weakness

Mind - restlessness - at night

Mind - delusions - talkativeness

Mind - delusions - is being poisoned

Differentiation between remedies

Lachesis typically triggers talkativeness, but is not recommended as often as *Hyoscyamus* for the delusion of being poisoned.

Rhus toxicodendrum is a strong contender after *Hyoscyamus* and could be considered as the next remedy if *Hyoscyamus* fails. *Hyoscyamus* is known to be effective after operations.

Prescription

Day 8 after the operation: 1 dose of 5 globules *Hyoscyamus* 200X. Dose of 5 globules *Hyoscyamus* 200X repeated on day 11 after the operation.

Progress

The patient was again put into the reclining chair on day 8 and tried to remove his indwelling catheter by constant

had to be secured. He slept well during the night despite being fixed to the bed.

Day 11 after the operation: as the patient was too strongly sedated, the Zyprexa was stopped and the Miltown' reduced to 2 tablets in the evening. As before, he could only be moved in a reclining chair; however, he was no longer as restless and aggressive. His appetite also began to improve. Nevertheless, an attempt to leave him unsecured in the evening was unsuccessful. The patient no longer plucked at his bed cover. Together with the psychiatrist, his medication was changed as follows: lorazepam (e.g. Ativan*) 1 mg, risperidone (e.g. Risperdal*) 2 mg, clonidine (e.g. Nexiclon®) continued, Miltown' and Zyprexa stopped. From this point, he no longer had to be secured at night or during the day.

Day 15 after the operation: as the patient was sleepy during the day, the lorazepam dose was reduced. During the day, the patient was still confused and did not want to eat much. There were no problems during the night.

Day 16 after the operation: the patient was very sleepy throughout the morning until the early afternoon; he slept through lunch. By the time his wife came to visit in the afternoon, he had regained his orientation for the first time. There were no problems during the night.

Day 17 after the operation: the patient was oriented during the day, and his appetite had progressed so far that the parenteral nutrition was stopped. AU psychotropic drugs were stopped as of day 17 following the operation. Until day 17, the patient was extremely weak with a pronounced need for sleep. The mobilisation process now progressed more rapidly thanks to the patients cooperation, as far as his weakness allowed. On day 20 following the operation, he was transferred to an internal department after receiving his medication.

Evaluation

After the unsatisfactory progress made by this patient, a discussion was held with experienced homeopaths and the dose administered to patients with transitory psychotic syndrome was changed. From this time on, they were given *Hyoscyamus* in

7.2 Postoperative transitory psychotic syndrome

200C potency. This was astonishingly effective in reducing the length of time for which the patients were disoriented. Patients with transitory psychotic syndrome, who due to paranoia became aggressive towards nursing staff and/or relatives, were often treated successfully with *Hyoscyamus* 200C. The plucking at the bed covers, a typical *Hyoscyamus* symptom, disappeared after 2 days.

Only rarely did the remedy have to be administered a second time 2 days later. After giving the homeopathic remedy, a few days of concomitant treatment with Miltown* to calm the patient were quite sufficient. The patients recovered their orientation more quickly and were more cooperative, they were mobilised more rapidly and spent less time in hospital.

Case 7.2-2: Postoperative transitory psychotic syndrome

Heidrun Pokorny

Anamnesis

The 64-year-old female patient was admitted as an inpatient via A&E with a suspected acute aortic dissection. At the time, the diagnosis of acute aortic dissection was excluded. However, the suspicion grew that she was suffering from aortitis of unknown origin. Except for autoantibodies to smooth muscles cells (a finding which was already known), all parameters tested (e.g. syphilis and rheumatoid factors) were negative. After optimising her blood pressure treatment, the patient was discharged and requested to attend the outpatient clinic for monitoring. Because the ascending aorta was found to have increased significantly in diameter, the decision was made to perform a surgical reconstruction.

The patient came to the heart/thorax surgery department for the scheduled aneurysm operation in the company of her two daughters. She had no history of neurological or psychological problems.

Acute event

The ascending aortic aneurysm, 5.5 cm in diameter, was treated without difficulty at the heart-lung machine using a 30 mm Vascutek prosthesis.

Diagnosis

Transitory psychotic syndrome following surgery on

Conventional treatment

After the operation, the patient spent seven days in ICU to optimise her antihypertensive medication. She was extubated on the day of the operation. Extract from the records kept in ICU:

Day 1 after the operation: patient is becoming increasingly alert. Treatment: Diprivan" (propofol). Day 2 after the operation: patient removes the stomach tube herself. Treatment: clonidine (e.g. Nexiclon*); patient then becomes tired and sleepy. Day 3 after the operation: patient screams loudly for help and cannot be soothed. Treatment: Diprivan*. Day 4 after the operation: The patients orientation improves during the day; in the evening, she becomes disoriented, leaves her bed and screams loudly. Treatment: clonidine, Xanor* (alprazolam). Day 5 after the operation: good communication, fully oriented; not oriented at night but still compliant.

The transfer report from ICU mentioned that the patient was suffering from transitory psychotic syndrome, but did not make any treatment suggestion for the general ward.

Transfer to general ward: on being transferred to the general ward, the patient seemed normal and oriented in both time and place. At 9 pm on the day of the transfer, the nursing staff made the evening round and made the patient ready to sleep. At midnight, she suddenly became completely disoriented, both chronologically and in terms of location. She removed the ECG electrodes from the monitor and triggered an alarm. When the nurses on the night shift went into the room, they found the patient vainly trying to get up by herself. Bars

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were attached to both sides of the bed; the nurses and the doctor on duty tried to calm the patient. Her elevated blood pressure (190/107 mmHg) was also successfully reduced with 1 spray of Buconif® (nifedipine). Half an hour later, her blood pressure had dropped back to 123/60 mmHg. At 4 am, the patient lay awake and told the nurse on night duty (who started a round at this time) that she was at home, not in hospital. At 5.50 am, loud cries were heard from the patients room. When the nursing staff went to her, she told them in the hearing of the mobile patients nearby that she insisted on going home and that they were crazy. The patient was calmed with Psychopax* (diazepam) drops and a talk with the doctor.

At 8.30 am, she was oriented but slow. Her daughter complained that her mother had been “unrecognisable” since the surgery. She had hallucinations and talked about things that did not exist.

Medication

The patient received antihypertensive treatment with Acemin® (Lisinopril) and the Psychopax* drops mentioned above.

Homeopathic treatment

The patient was given concomitant homeopathic treatment with the daughters agreement.

Repertorisation

SYNTHESIS VERSION 9.1

Generalities - weakness

Mind - restlessness - at night

Mind - delusions - hallucinations

Mind - delusions - screaming

Mind - restlessness - drives out of bed, jumps out of bed

Differentiation between remedies

The nocturnal restlessness is a keynote of *Phus*

China is indicated for weakness, especially when it occurs after surgery. However, the repertory only mentions the nocturnal restlessness as a first- degree symptom with *China*.

Prescription

At 9.30 am on day 0, the patient was given 5 globules *Hyoscyamus* 200C.

Progress

The patient was moved to the scales with the help of two nursing staff, then had to be persuaded to perform her morning bathroom routine with her daughters help. When she was back in the room, she removed the indwelling catheter herself (11.30 am). Because of her poor mobility and a skin problem in the genital area, another indwelling catheter was inserted. In the afternoon and evening, the patient was very tired and even slept through the nursing staffs evening round. At 10 pm, she was taken to the toilet by a member of the nursing staff after asking for help herself. The following morning, the patient was independent and able to go to the bathroom without help; her daughter helped her wash. The patient was weak but had no more mental problems from this time on. Once all the necessary laboratory tests and x-rays had been completed, she was discharged 2 days later, i.e. on the third day following the homeopathic treatment.

Evaluation

The patient responded very positively and was discharged quickly thanks to the remedy *Hyoscyamus*, which matched her condition.

Critical commentary

This case shows the effect of homeopathy in a difficult situation; the constructive cooperation with the ward team made this success possible.

7.2 Postoperative transitory psychotic syndrome

Case 7.2-3: Postoperative transitory psychotic syndrome in a case of aortic dissection and aortic valve insufficiency *Heidrun Pokorny*

Anamnesis

A 34-year-old patient with a 10-year history of hypertension developed sudden, violent thoracic pain and goes to the nearest hospital, where a type A aortic dissection was diagnosed. The patient was immediately taken to A&E in a haemodynamically stable condition. The heart ultrasound also showed a haemopericardium and a severe aortic valve insufficiency. The patient is already aware of having cystic kidneys; he undergoes regular checks in the nephrology department.

Acute event

The patient was taken to surgery on the day of his admission; the aorta ascendens and aortic arch were replaced and the aortic valve was reconstructed.

Diagnoses

Transitory psychotic syndrome, acute Type A dissection of the ascending aorta, aortic valve insufficiency, arterial hypertension known for 10 years, cystic kidneys.

Conventional treatment

After the operation, the patient spent six days in intensive care. A tension pneumothorax on the left side, which was eased by inserting a chest drain, meant that the patient could not be extubated until day 2 following the operation. On the 7th day following the operation, he was transferred to the surgical surveillance ward. The patient was alert, oriented and his condition during the day was normal. Neither did the ICU transfer report mention any psychological anomalies. At about 10 pm, the patient started trying to remove the monitor cables. He was also disoriented in time and place, but still slept most of the night without soporifics. On waking up in the night, he plucked at the central venous catheter and also tried to get up without help. The night nurses calmed him by talking to him and fixed protective bars to both sides of the bed.

Medication

During the shift change at 7.20 am the following day, the situation began to escalate. The nursing staff found the patient standing next to his bed. He had managed to disconnect one of the chest drains. He was still disoriented and wanted to leave the ward immediately. Because of the risk of harming himself and others, the patient had to be secured in bed against his will. This made him even more agitated; he could only be calmed by administering Dormicum* intravenously. All the chest drains were removed without difficulty while he was under sedation. About one hour later, the patient became more responsive. He did not know that he had just had an operation; he said that there were a lot of cars around him and he had to get up because there was no “autopilot” and something terrible would happen if he didn’t. He also said the police were already there.

Homeopathic treatment

Repertorisation

_____ SYNTHESIS VERSION 9.1 Mind - delusion - hallucination

Mind - delusion of being healthy

Mind - delusion - figures, sees absurd characters

Mind - delusion - police, sees a police officer coming into the house

Mind - restlessness

Mind - restlessness - bed - thrashing around in bed
Mind - restlessness - bed - drives out of bed, jumps out of bed

Differentiation between remedies

Hyoscyamus and *Stramonium* are both important in terms of differential diagnosis because of the patient’s aggression. *Stramonium* does not appear in the rubric “Mind - delusion - police, sees a police officer coming into the house”, nor in “Mind - delusion of being healthy”.

Lachesis has severe delusions and logorrhoea. *Hyoscyamus* is mentioned in all rubrics; it is given triple weighting for the symptom “Mind - delusion - hal-

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Prescription

On the 8th day following the operation, the patient was given one dose of 5 globules *Hyoscyamus* 200X.

Progress

After taking the globules, the patient fell asleep. Later that morning (about 1.5 hours after giving the remedy), the bonds fastening the patient to the bed were released; around midday, he was placed in a reclining chair. At about 7 pm that evening, the night nurses found a fully oriented patient who expressed a need to apologise for his behaviour during the day. The patient was given lorazepam (e.g. Ativan*) to help him sleep. From midnight, the patient became increasingly restless and wanted to get up again. He was secured for his own protection, but this time fell asleep again

Case 7.2-4: Transitory psychotic syndrome with st. p. polytrauma and aspiration pneumonia

Peter Kdnig

Anamnesis

At the beginning of July 1989, the author received a call from the wife of a patient in ICU who was previously unknown to him. Two weeks before, her husband had been run over by a car in a head-on collision. He suffered multiple fractures with major bruising and a ruptured spleen. He was currently feverish and had aspiration pneumonia. 5 days previously, he had received a dose of *Arnica* MK (*Arnica* IM prepared using the Korsakoff method) from another doctor. The injured man was suffering from phases of manic depression and had been “stabilised” with lithium. The advice given was initially to continue with the *Arnica* and to give the high potency more frequently, depending on how the patient's condition deteriorated.

Acute event

At the end of July, the patient's condition initially improved markedly and the infusions were stopped. However, he then took a dramatic turn for

without resistance. Next day, the patient could barely remember these incidents and remained fully oriented from this time on. He was transferred to a general ward the same day (9th day after the operation). Fortunately the patient continued to progress so well that he was discharged on day 13 following the operation.

Evaluation

Remedy administered acted well and promptly. To the astonishment of the staff, an excellent response to the remedy was observed within just a few hours.

Critical commentary

Hyoscyamus 200X was administered by mistake instead of the 200C potency we normally use. It seems that in some acute cases, prompt homeopathic treatment with a carefully selected remedy is more important than the choice of potency.

the worse: he was confused, disoriented in time and space, did not recognise acquaintances, ranted, was aggressive and also fooled around on occasion. For example, he answered in English even when he was spoken to in German. Other languages such as Italian and French, which he was normally unable to speak fluently, flowed from his lips. It was also said that the patient now had a “healthy colour”.

Diagnosis

Postoperative transitory psychotic syndrome.

Conventional treatment

The patient was prescribed meprobamate (e.g. Miltown*); however, his relatives requested homeopathic treatment before it was administered.

Homeopathic treatment

The remedy *Stramonium* immediately came to mind without referring to the repertory or other books. One couldn't help but think of the following bizarre rubrics:

Repertorisation I

_____ **MACREPERTORY PRO 6.1.5. VERS. 4.5** Mind - talk
- foreign language, in

Bibliography

Differentiation between remedies

While *Stramonium* is the only remedy listed in the rubric “Mind - delirium - talks in a foreign language”, where it is given double weighting, the rubric “Mind - speech - talks in a foreign language” mentions six remedies.

Stramonium is chosen instead of *Lachesis* because of the specific nature of the delusion and the aggressive behaviour.

Prescription

1 dose of 5 globules *Stramonium* 200C.

Progress

The patient quickly calmed down after being given the *Stramonium*. He was alert, calm and held perfectly normal conversations. He subsequently received *Nux vomica* and *Hypericum* (for pressure- related peroneus paralysis) to treat various other symptoms as they appeared. The following year, we heard that the patient had returned to the teaching profession and was

Evaluation

The patient, who had recovered his lucid state by the administration of a homeopathic dose of *Datura stramonium*, a member of the nightshade family, unfortunately died approx. 2 years later, shortly after an operation to remove a stomach carcinoma.

Critical commentary

This case is reminiscent of the medical history of Klockenbring, the privy secretary of the chancery from Hanover, who suffered from madness and was probably cured by *Stramonium* (1792). This account was published by Samuel Hahnemann in 1796: “[...] or he would mutter a form of exorcism for evil spirits in the Vandal tongue [...] The most wonderful thing was the correctness with which he delivered all the passages from writings in all languages that occurred to his memory, especially all that he had learnt in his youth [...] spoke in Hungarian, then again in the Wallachian tongue [...]” (Hahnemann 1796).

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8 Toxicology

Michael Frass, Beatrix Wulkersdorfer (Conventional Medicine) Michael Frass (Homeopathy)

- 8.1 Homeopathy in case of poisoning
- 8.2 Death cap mushroom poisoning

Conventional medicine

Acute poisoning causes direct damage to the organism. The degree of severity depends on the chemical properties, dose and period of exposure to the substance and the way in which it is absorbed.

Every year, 300 000 people receive hospital treatment for poisoning in Germany alone. Two thirds of such cases are the result of suicide attempts by drug overdose. One third of all cases of poisoning are caused by industrial and household chemicals. Many cases of poisoning in young people are caused by alcohol and drugs. Medication, fungi and foods can also be toxic, although the treatment for these types of poisoning varies dramatically; further details cannot be given in this book.

8.1 Homeopathy in case of poisoning

Homeopathy

There is plenty of literature about rescue experiments with cells and potentised substances. This knowledge should obviously be incorporated into human medicine.

Symptom selection

The symptoms should be selected not only according to the type of poison, but also according to the causative agent, insofar as this has been researched to date.

COMPLETE REPERTORY MILLENIUM

Generalities - intoxication*

abies-c., absin., acet-ac., aeon., aether, agar., agav-a., agn., aml-n., am-m., amyg-am., ant-t., arg., ars., atro., bart., bell., berb., bov., bry., camph., cann-s., caps., carb-an., carb-v., chel., chin., chin-s., cic., coca, cocc., coff., coff-t., con., conin., cop., cori-r., dat-m., eucal., euph., fagu., ferr., gels., grat., hyos., ign., indol., ip., kali-bi., kali-c., kali-i., kali-n., kiss., kreos., lach., lact., laur., led., lol., lyc., mere., mez., mill., morph., nabal., naja, nat-m., nux-m., Nux-v., Okou., Op., ph-ac., phel., pip-m., puls., pyrog., ran-b., rheum, rhod., rhus-t., sabad., samb., sec., skat., spong., squil., stram., tab., tax., ter., teucr., thea, til., tus-f., urea, valer., verat., vip., zinc.

Generalities - intoxication after, fish

ars., Berb., carb-v., Cop., euph., lach., lyc., pyrog., rhus-t.

Generalities - intoxication, after - mushrooms

agar., atro., bell., camph., pyrog.

Generalities - abuse* - medicaments

aloe, ars., bapt., camph., carb-v., cham., coff., coloc., hep., hydr., kali-i., lob., mag-s., nat-m., nit-ac., Nux-v., paeon., puls., sec., sulph., teucr., thuj.

Generalities - abuse - narcotics

acet-ac., aeon., agar., am-c., apom., ars., aur., aven., Bell., bry., calc., camph., cann-i., canth., carb-v., caust., Cham., chin., cic., cimi., Coff., colch., coloc., croc., cupr., dig., dulc., euph., ferr., graph., hep., hyos., ign., ip., kali-ma., Lach., lob., lyc., macrin., mag-s., mere., mosch., mur-ac., nat-c., nat-m., nat-p., nit-ac., nux-m., Nux-v., op., ox-ac., oxyg., passi., ph-ac., phenob., phos., plat., plb., puls., rhus-t., seneg., sep., staph., sulph., thuj., valer., verat., zinc.

*numerous rubrics

8 Toxicology

Differentiating between important homeopathic remedies

Important remedies: *Aceticum acidum*, *Arsenicum album*, *Lachesis*, *Nux vomica*, *Sulphur*.

Arsenicum album is a proven remedy for poisoning and allergic reactions. It can also be used when the patient is in a terminal condition.

Nux vomica is known as the homeopathic “hangover cure”; it has helped many people after alcohol abuse (13.1-2).

Berberis and **Copaiva** are also indicated for fish poisoning.

Aceticum acidum and **Lachesis** are useful after inhalation anaesthetics.

Sulphur is a well-known cleansing and detoxification remedy.

Lachesis, *Nux vomica* and *Sulphur* help eliminate the metabolites of various types of medication, e.g. antibiotics.

8.2 Death cap mushroom poisoning

Definition

Death cap mushroom poisoning is a type of fungal poisoning caused by the toxin of the *Amanita phalloides* fungus, i.e. the death cap mushroom. This fungus is most frequently found in deciduous forests under oaks and occasionally under beech trees, very rarely also under coniferous trees. There are various types of death cap mushroom:

- *Amanita phalloides* (death cap mushroom)
- *Amanita virosa* (destroying angel)
- *Amanitaphalloides* var. *verna* (fools mushroom)
- *Amanita citrina* = *mappa* (false death cap mushroom)

Death cap mushrooms grow to about 15 cm high; the cap can grow up to 12 cm wide and may vary in colour from

is bulbous. At the base there is a long, rounded cuplike structure (volva) which is the remnant of a universal veil. The bulb and the volva are frequently buried in the earth. The fruiting body appears from July until into October.

Clinical information

Incidence and mortality

The most common cases of mushroom poisoning in central Europe, most of which are fatal, are almost without exception caused by death cap mushrooms. *A. phalloides* contains three main groups of toxins: amatoxins, phallotoxins and phallolysin. Most cases of death cap mushroom poisoning occur in late summer and autumn. 90% of all deaths from mushroom poisoning in North America are caused by the death cap mushroom (Paydas). In Switzerland, more than 205 cases of poisoning by this mushroom were recorded between 1971 and 1980. 22.4% of them were fatal. The victims age and the latency period between consuming the mushroom and the first clinical symptoms were significant for the prognosis. The mortality rate in children under 10 was 51.3%, falling to 16.5% in patients over 10 years. The average latency period was 10.3 hours in exceptionally serious cases and 12.6 hours in patients who survived.

Pathogenesis and aetiology

Amanitin poisoning (amanitin is the poison in the death cap mushroom) usually occurs after consuming this fungus when it has been mistaken for an edible variety such as the common white mushroom.

With regard to toxicity, death cap mushrooms are the most feared poisonous fungus in our latitudes. The risk of mistaking it for an edible mushroom is unlikely, e.g. because edible mushrooms never have pure white gills. Even in the very early stages of their growth, common white mushrooms always have a light pink tinge.

It is the amanitins which are mainly responsible for the toxic effects of the death cap mushroom. These are bicyclic octapeptides. The amanitin content in dried fungi is up to 5 mg per gram. These fungi

8.2 Death cap mushroom poisoning

contain other toxins, e.g. phalloidin, but these only play a minor role in terms of toxicity. This is because of their instability in heat, which naturally means that they are destroyed during cooking. It is typical of death cap mushroom poisoning that the signs of poisoning only appear after a latency period of 6-10 hours; in milder cases, they may not appear until 36 hours after consumption. In severe cases, death occurs after about 15 hours, caused mainly by destruction of the liver by the amanitins.

Symptoms

The symptoms develop in two phases:

- After a symptom-free latency period of about 8-24 hours, the patient develops severe diarrhoea, bloody vomiting, abdominal pain and nausea. These cause him to become dehydrated
- This is followed by a phase with fewer symptoms; however, the patients liver counts worsen dramatically. An increase in transaminases and a decrease in coagulation factors is observed. After another 3-5 days, he may suffer multiple organ failure with cardiac and renal insufficiency and acute liver

Diagnosis

» **Note:** when making a diagnosis, it is important to be aware that the first symptoms appear approx. six to ten hours after consuming the fungus.

A so-called newspaper test can be used to find out whether the fungus eaten was toxic. For this, the fungus is pressed on a piece of newspaper and 6-8 ml 20% hydrochloric acid poured over it. If the fungus turns blue, the diagnosis of fungus poisoning can be confirmed.

The presence of amanita toxin in the patients urine and serum can be confirmed by radioimmunoassay (RIA).

The delayed onset of symptoms, the similarity of the initial symptoms to influenza and other gastrointestinal viruses and the improvement observed in most patients two or three days after consuming the fungi constitute a problem for immediate diagnosis and treatment. Increased transaminase and serum bilirubin counts are the first and most reliable signs of impaired liver function and should therefore be observed closely.

Treatment

Case 8.2-1: Death cap mushroom poisoning

Michael Frass

Anamnesis

A 69-year-old patient was admitted to ICU with *Amanita phalloides* poisoning. Nothing unusual in her family and childhood medical history. The patient was known to have arterial hypertension and had also survived a myocardial infarction. She was not suffering from angina pectoris at that time. It was known that her kidney function was impaired (serum creatinine 1.5 mg/100 ml, BUN 40 mg/100 ml); she also showed signs of dyspnoea when under stress.

Acute event

On day 0, the patient, two other women and one man ate

a latency period of 8 to 9 hours, the patient developed massive vomiting and diarrhoea and severe abdominal pain. For this reason, she was admitted to the nearest hospital at 7.30 am the following day (day 1). At this point, her blood count revealed leucocytosis (17 g/l) and a slight increase in transaminases (GOT 98 u/l, GPT 195 u/l). Fungi saved from the meal were sent to the Botanical Institute, where they were identified as "death cap mushrooms" (*Amanita phalloides*). 5 mg/kg body weight of Silibinin C (= milk thistle extract, Legalon*) was therefore administered intravenously as a single bolus and followed by a continuous infusion of 24/mg/kg body weight over 24 hours. At 6 pm the same day, the patient was transferred to the General Hospital in Vienna (30 h after admission). At the time of admission, the patient was 162 cm in height and weighed 70 kg.

8 Toxicology

Diagnoses

Poisoning with *Amanita phalloides*, infection with *Pseudomonas aeruginosa*.

Medication

The treatment with Silibinin C (= milk thistle extract, e.g. Legalon®) was continued. The patient was also given acetylcysteine (e.g. Fluimocil'), pan- toprazole (e.g. Pantoloc'), carbo animalis (e.g. Carbomix') and lactulose concentrates (e.g. Laevolac*). She also received intravenous antibiotics and potassium infusions.

Conventional treatment

At 1.30 am on day 2 (37 h after eating the mushrooms), the patient developed ventricular fibrillation. After being defibrillated twice, a sinus rhythm was restored. Afterwards, she needed a higher dose of adrenalin (Suprarenin') with a peak figure of 0.42 pg/kg body weight per min. at 6 am. The patient fell into a coma from the time she was defibrillated and was therefore intubated and given controlled respiration to avoid aspiration; she was also treated with sufentanil (e.g. Sufenta') and midazolam (e.g. Dormicum') as analgesics. At the same time, her arterial pH value fell to 7.16 and she was therefore given substitution with sodium bicarbonate. Her serum lactate rose to 16 mmol/l; her transaminases also rose: SGOT to 167 u/l and SGPT to 413 u/l. Her fluid balance was 41, and her Na²⁺ and Cl²⁻ rose dramatically, reaching a peak at about 7 am; she was therefore given 2.5% glucose. Continuous venovenous pump-assisted haemofiltration was initiated to support her failing kidneys; insulin was substituted intravenously to treat hyperglycaemia. The adrenalin was replaced with noradrenalin because of the tachycardia. The patient was stable for the rest of the day; however, her transaminases continued to rise rapidly while the Quicktest fell: SGOT 450 u/l, SGPT 1070 u/l, Quick test 40% at 6 pm.

The liver transplant coordinator rejected the possibility of a liver transplant because the patient was in such poor condition. Liver replacement therapy was not considered. All experienced colleagues

believed the patients condition was terminal and her relatives were notified of her imminent demise. Despite the hopelessness of this situation, it was decided that homeopathic treatment should be administered.

Homeopathic treatment

Despite the difficult conditions, homeopathic treatment was administered in agreement with the patient's doctors.

Repertorisation I

COMPLETE REPERTORY MILLENNIUM

Rectum - diarrhoea - food, aggravated

Generalities - intoxication, after - mushrooms

Abdomen - inflammation - peritonitis - enteritis - liver

Differentiation between remedies

Although it is not listed for mushroom poisoning, the patient was given *Arsenicum album*. The indication for *Arsenicum album* was its effect on liver inflammation. *Arsenicum album* is also an important remedy for all kinds of poisoning and allergic reaction.

The repertory also lists *Agaricus*, *Atropinum*, *Belladonna*, *Camphora* and *Pyrogenium* for mushroom poisoning.

With *Agaricus*, the intoxication stage (Boericke's 2nd stage) brings great agitation and disconnected speech. Boisterous cheerfulness alternates with melancholy. The patient is physically stronger than usual. This patient did not have these symptoms. Sudden deterioration is typical of both *Atropinum* and *Belladonna*.

Belladonna patients have a red face and violent headache.

Camphora patients are icy cold (from their breath to the tip of the nose and the extremities).

Pyrogenium features sepsis and stinking secretions. These patients may feel that the bed is too hard.

Prescription

Treatment with *Arsenicum album* 200C begins on day 2, 5 globules every hour for 2 days.

8.2 Death cap mushroom poisoning

Progress

On day 3, the patients haemodynamic and respiratory condition was stable. Her transaminases continued to rise: SGOT 1090 u/l, SGPT 2950 u/l, Quick test 20% at 6 pm, elevated LDH 2500 u/l.

The transaminases reached their peak on day 4 (SGOT 2240 u/l, SGPT 6170 u/l at 6 pm, LDH 4800 u/l at 8 pm, Quick test 15%). Her bilirubin had also risen to over 6 mg/dl.

Diagnosis

Liver dystrophy, icterus after death cap mushroom poisoning.

Repertorisation II

COMPLETE REPERTORY MILLENNIUM

Abdomen - liver, region of

Abdomen - atrophy - liver

Skin - yellow - jaundice, icterus

Differentiation between remedies

In view of the developing liver dystrophy, the remedy was switched to *Phosphorus*. *Phosphorus* produces catabolic symptoms; it causes yellow atrophy of the liver and subacute hepatitis with severe jaundice (Boericke 1996). *Phosphorus* is characterised by the sudden onset of symptoms.

Prescription

From day 4: *Phosphorus* 200C, 5 globules once an hour for 3 days.

Progress

Shortly afterwards, the patient spontaneously opened her eyes and reacted to verbal stimuli.

The following day, her transaminases began to fall. On day 6, the patient still needed noradrenalin dosed at 0.45 pg/kg body weight per minute; she was respirated in BIPAP (bi-level positive airway pressure) mode with a FiO₂ of 35%. Despite stopping the sedoanalgesia, the patient showed no signs of regaining consciousness; her bilirubin rose further to 12.4 mg/dl and this was accompanied by leucopenia (2.4 g/l). The patient now commenced antibiotic treatment with netilmicin (e.g. Netromycin*) and amoxicillin/clavulanic acid (e.g.

Augmentin*). Her anaemia was treated with two blood transfusions.

On day 7, the noradrenalin was reduced to 0.06 pg/ kg body weight per min. and the transaminases continued to fall (SGOT: 660 u/l, SGPT: 1530 u/l). Although the patient did not respond to pain stimuli, she opened her eyes spontaneously, and after being given 1 mg flumazenil (e.g. Anexate*), she also responded to verbal stimuli. Neurologically she showed signs of encephalopathy. The examination led to a suspected diagnosis of brain stem syndrome, although the cerebral computed tomography (CT) was negative.

As the liver was clearly recovering and the main cause of concern was now the patient's cerebral condition, the treatment with *Phosphorus* was stopped.

Repertorisation III

COMPLETE REPERTORY MILLENNIUM

Mind - unconsciousness - coma

Mind - answers, answering - stupor returns quickly after

Differentiation between remedies

Helleborus niger is one of the most important coma remedies along with *Hyoscyamus niger*, *Belladonna* and *Opium*.

Helleborus is characterised by great muscular weakness and is used for conditions with low vitality and serious disease. These patients tend to pick at their lips and at the bed clothes.

Hyoscyamus also features this symptom, but these patients are characterised by vulgar actions, thoughts and expressions.

Belladonna patients bury their heads in the pillow and their complaints usually feature heat, redness, throbbing and burning.

Opium is characterised by a complete loss of consciousness similar to apoplexy. *Opium* patients breathe stertorously and feel absolutely no pain.

Prescription

8 Toxicology

Progress

At first, the patient's neurological progress was very slow. On day 3, her haemodynamic and respiratory condition was stable. Her transaminases continued to rise: SGOT 1090 u/l, SGPT 2950 u/l, Quick test 20% at 6 pm, elevated LDH 2500 u/l.

On day 8, the noradrenalin was reduced to 0.06 gg/kg body weight/min. The patient was switched from BIPAP to pressure-supported respiration. Her thrombocyte count dropped to a low of 50 g/l and her C-reactive protein peaked at 15.9 mg/dl.

The noradrenalin treatment was stopped on day 11 in the morning. The patient's CRP fell to 7.6 mg/dl; her transaminases, bilirubin and Quick test were approaching normal. On day 15, the patient was sedated for a tracheotomy as the process of weaning her from the respirator was taking some time. Over the next few days, she breathed spontaneously with continuous positive airway pressure (CPAP). Profuse milky, yellowish secretions indicated an infection with *Pseudomonas aeruginosa*, making a change of antibiotic necessary.

On day 19, the tracheotomy tube and the central venous catheter were both removed. She sat up in bed, was fully conscious and able to eat with help. The treatment with *Helleborus niger* was now stopped. The patient's condition continued to improve. On

day 20, her liver parameters had returned to normal (SGOT 10 u/l, SGPT 32 u/l, LDH 209 u/l).

On day 21, she had to be reintubated for another day and required antihypertensive treatment due to a sudden rise in blood pressure.

She was transferred to the general ward on day 26 and discharged on day 42. Meanwhile, two other people who had eaten the mushrooms had died.

Evaluation

This case shows that the patient could be saved even though her life was clearly at risk. All specialists agreed that her case was terminal.

Critical commentary

It would be interesting to give homeopathic treatment to other patients with mushroom poisoning. This could possibly increase the number of remedies indicated. One critical point is that *Arsenicum album* is not listed as a major remedy for mushroom poisoning. On the other hand, we know that it is an important remedy for allergies and intoxication. *Phosphorus* is weighted doubly for liver inflammation, and its strong relationship to the liver is well known. Further

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III

Emergency Medicine

Martin Bundner

9 Traumatology

Martin Bündner (Conventional Medicine) Martin Bijndner, Michael Frass, Farokh Master (Homeopathy)

9.1 Trauma to the extremities

9.2 Spinal trauma

9.3 Thoracic trauma

9.4 Craniocerebral trauma (CCT)

9.5 Abdominal trauma

Conventional treatment

Traumatology deals with an abundance of different types of injury, most of which cannot be compared with one another. For purposes of clarity, the different types of trauma are listed according to the part of the anatomy affected, with the most important types of injury being discussed in each case.

Homeopathic treatment

Symptom selection

Treating complications is usually the province of the homeopathic specialist, as such a process is frequently very complicated and often has to be integrated into a long-term course of therapy.

Repertorisation - general consequences of injury irrespective of the body part

SYNTHETIC. REPERTORY

Apparent death

- haemorrhage, after chin.
- injuries, after am.

Convulsions, spasms - injuries, from

ang., am., art-v., cic., con., cupr., cupr-act., HYPER., meli., nat-s., op., oena., puls., rhus-t., sil., sulph., valer.
 Generalities - catheterisation, after
 am., mag-p., nux-v.

SYNTHETIC REPERTORY

Generalities - wounds, inflamed

aeon., arist-cl., am., calc-f., calen., cham., con., hyper., kali-bi., lach., led., mez., nat-m., plb., puls., rhus-t., sul-ac., sulph., vip.

Intoxication, after - narcotics

acet-ac., aeon., agar., am-c., apom., ars., aur., aven., Bell., bry., calc., camph., cann-i., canth., carb-v., caust., CHAM., chin., cic., cemic., COFF., colch., croc., cupr., dig., dulc., euph., ferr., graph., hep., hyos., ign., ip., kali-perm., LACH., lob., lyc., macro., mag-s., mere., mosch., mur-ac., nat-c., nat-m., nat-p., nit-ac., nux-m., NUX-V., op., ox-ac., oxyg., passi., ph-ac., phenob., phos., plat., plb., puls., rhus-t., seneg., sep., stram., sulph., thuj., valer., verat., zinc.

Mind - anguish - shock from injury, in

OP-

Sadness - injuries, from

hyper.

Shocks - injury, of

acet-ac., ACON., am-c., ARN., ars., bell., calc., calen., CAMPH., caps., carb-v., cham., chin., chlf., cic., cocc., coff., cupr., cupr-ar., DIG., gels., hell., hep., hydr-ac., hyos., HYPER., ip., LACH., laur., lyc., mere., nat-m., nit-ac., nux-m., nux-v., OP., phos., psor., ran-b., sec., sep., staph., stront-c., stry-p., sulph., tab., VERAT.

Sighing - injuries, after

Lach.

Unconsciousness, coma

- shock of injury, in
- am., atro., camph., cham., dig., hyper.

9 Traumatology

SYNTHETIC REPERTORY

- wounds, with flesh
verat.
Venesection - ailments from
senec., Squil.
Weakness - operations, after
acet-ac., carb-v., hyper.

Repertorisation - trauma to the extremities

SYNTHETIC REPERTORY

Injuries (including consequences of blows, falls and bruises)

- ailments from

aeon., all-c., am., bell-p., con., dulc., ferr-p., glon., ham., hell., hep., ip., kali-m., kali-p., kali-s., lac-c., lac-d., lach., led., lith-c., mag-c., mill., nat-s., nux-v., oena., paeon., par., ph-ac., phys., plan., psor., ran-b., ruta, sec., sep., sil., staph., stict., sul-ac., sulph., symph., tarent., tell., ter., teucr., urt-u., valer., vario

- ailments, from

am-c., am., hyper., valer.

- bones, fractures

aeon., ang., arn., asaf., bell-p., calc., calc-f., calc-p., calen., CARB-AC., con., cortico., cortiso., croc., eup-per., ferr., hep., iod., kali-i., lyc., nit-ac., petr., ph-ac., phos., puls., rhus-t., RUTA, sil., staph., stront-c., sul-ac., sulph., symph., valer.

- concussion

aeon., anac., ARN., aur., BAD., bell., bry., calc., calen., camph., cann-s., caust., chin., cic., cina, cocc., con., cupr., euphr., glon., hell., hyos., HYPER., iod., kali-p., kreos., lach., laur., led., lyc., m-arct., mag-m., mang., mez., nat-m., NAT-S., nux-m., nux-v., ph-ac., puls., rhus-t., seneg., sep., sil., spig., staph., stry., sul-ac., sulph., valer., verat., viol-t.

- dislocation, luxation

aeon., agar., AGN., alum., am-c., am-m., ambr., anac., ang., ant-c., ant-t., ARN., ars., asar., aur., bar-c., bell., bov., bry., calad., CALC., calc-f., calc-p., camph., cann-s., caps., carban., carb-v., carl., caust., cham., chel., chin., cina, cocc., coloc., con., croc., cycl., dig., dros., dulc., eup., ferr-s., form., graph., hell., hep., IGN., ip., kali-c., kali-n., kreos., lach., led., LYC., m-arct., m-aust., mag-c., mag-m., mang., meny., mere., mez., mosch., mur-ac., NAT-C., NAT-M., nit-ac., nux-m., nux-v., par., PETR., ph-ac., PHOS., plat., plb., prun., psor., PULS., ran-b., rhod., RHUS-T., ruta, sabin., sars., seneg., sep., sil., spig., spong., stann., staph., stront-c., sulph., thuj., valer., verat., verb., zinc.

- fractures, compound

ang., ARN., calc., calen., con., crot-h., hen., hvner., iod., lach., petr.,

SYNTHETIC REPERTORY

glands

arn., aster., cann-s., cic., CON., dulc., hep., iod., kali-c., kalm., mere., petr., phos., puls., rhus-t., sil., sul-ac., sulph.

- haemorrhage

acet-ac., agar., ARN., bad., bell-p., both., bry., calen., cham., chin., cic., con., crot-h., dulc., euphr., ferr., ham., hep., hyper., iod., lach., laur., led., mill., nux-v., par., plb., puls., rhus-t., ruta, sec., staph., SUL-AC., sul-i., sulph., symph.

- Injuries

absin., acet-ac., aeon., agn., all-c., aloe, alum., am-c., am-m., ang., ant e., apis, arg-m., arg-n., ARN., aur-m., bad., bell., bell-p., bor., bry., bufo, calc., calc-p., calc-s., CALEN., CAMPH., CANN-I., cann-s., canth., carb-v., caust., cham., chin., chion., chin-s., cic., CON., croc., crot-t., dig., dros., dulc., echi-a., erig., eug., euph., euph-pi., euphr., ferr-p., form., gamb., glon., ham., hell., HEP., hyos., HYPER., iod., ip., kali-c., kali-i., kali-m., kali-p., kali-s., kalm., kreos., lac-c., lac-d., lach., laur., led., lith-c., lyc., mag-c., mere., mez., mill., mosch., naja, nat-c., nat-m., nat-s., nit-ac., nux-m., nux-v., oena., olnd., par., pareir., petr., ph-ac., phos., phys., plan., plat., plb., polyg., psor., PULS., pyrog., ran-b., rhod., RHUS-T., ruta, samb., sec., seneg., sep., sil., spig., staph., stict., stront-c., SUL-AC., sul-i., sulph., symph., tab., tarent., tell., ter., teucr., urt-u., valer., vario., verat., verb., zinc.

- muscles, of

arn., calc., nat-c., nat-m., phos., RHUS-T.

- muscles, rupture of calen.

- nerves, severe pain

bell-p., cur., glon., HYPER., led., mag-p., meny., phos., tarent., ther., xan.

- operations, after

acet-ac., aeon., all-c., apis, arn., bell-p., berb., calc-f., calc-p., calen., camph., carb-v., chin., croc., ferr-p., hyper., kali-s., led., mere., mill., naja, nit-ac., nux-v., op., ph-ac., pop., raph., rhus-t., ruta, STAPH., stront-c., sul-ac., verat., zinc.

- overexertion, after

arn., ars., CALC., calc-f., carb-an., carb-v., cocc., con., ham., lyc., mill., nat-c., ovi-g-p., rhus-t., sanic., sil., ter.

- periosteum

calc., ruta, symph.

- ruptures, blood vessels

mill.

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SYNTHETIC REPERTORY. -
sprains, distortions

acet-ac., aeon., agar., AGN., all-s., am-c., am-m., am-p., ambr., amygd-p., ang., ARN., ars., asaf., asar., bar-c., bell., bell-p., benz-ac., bov., bry., CALC., calc-f., calc-p., calc-sil., calen., cann-s., canth., caps., carb-an., carb-v., carl., caust., chin., cic., coloc., con., cupr., ferr-p., ferr-s., form., graph., guai., hep., hyos., hyper., ign., kali-i., kali-n., kreos., led., lith-c., LYC., m-aust., mag-c., mere., mez., MILL., mosch., NAT-C., NAT-M., nit-ac., nux-v., onos., PETR., PHOS., plat., polyg., polyg-pe., prun., psor., puls., rad., rhod., RHUS-T., RUTA., sabin., sep., sil., sol-n., spig., stann., staph., stram., stront-c., sulph., sumb., symph., tarent., thuj., zinc.

- straining

staph.

- tendons

anac., calen., rhus-t., ruta.

- tendons, ligaments

rhus-t.

- traumatic fever

aeon., apis, ARN., ars., bry, cact., calen., carb-v., chin., coff., croc., euphr., hep., iod., lach., lyss., mere., nat-c., nit-ac., ph-ac., phos., puls., rhus-t., staph., sulph.

- vaccination, tetanus

ARN., HYPER., LED., tetox., thuj.

Paui - amputation, after

aeon., all-c., am-m., am., asaf., bell., cupr., hell., hyper., ign., kalm., ph-ac., rauw., spig., staph., symph., verat.

Shocks of injury - fracture, after

aeon., am.

Wounds

anag., apis, arist-cl., am., ars., bell-p., bor., bor-ac., bov., bry., bufo, calc-p., calen., carb-ac., carb-v., cham., cic., cist., con., croc., echi-a., erig., ery-a., eup-per., ferr-p., ham., helia., hell., hep., hyper., iod., kali-p., kreos., lach., lappa., LED., mere., mez., mill., nat-c., nat-m., nit-ac., ph-ac., phos., phys., plan., plb., puls., rhus-t., ruta, sec., senec., seneg., sil., staph., stront-c., sul-ac., sulph., symph., zinc., zinc-m.

- ailments from

am., bry., calen., ferr-p., hyper., kali-p., led., phos., plan., senec.

- bites

acet-ac., all-s., am., grind., hyper., led., plan., sul-ac.

SYNTHETIC REPERTORY

- bites - dogs, of

hyper., lach., led., lyss., ter.

- bites - dogs, of - rabid

arist-cl., ars., bell., canth., CHR-AC., echi-a., hyos., LYSS.

- bites - snakes

anag., apis, arist-cl., am., ars., aur., bell., calad., camph., cedr., echi-a., guai., gymne., hyper., LACH., LED., Lob-p., lycps., plan., seneg., stram., sul-ac., thuj., vip.

- bites - spiders, of

lycps.

- leaden colour

lach., vip.

- bleeding profusely

aeon., am-c., ant-t., aran., am., ars., asaf., bell-p., bor., both., carb-v., caust., cench., chin., clem., con., cop., croc., crot-h., dor., eug., euphr., ferr., ferr-p., ham., hep., HIR., kreos., LACH., LAT-M., led., mere., mez., mill., nat-c., nat-m., NIT- AC., nux-m., nux-v., ph-ac., PHOS., plb., puls., rhus-t., ruta, sec., sep., sil., staph., sul-ac., sulph., vip., zinc.

- bleeding profusely - blood, black

vip.

- bleeding profusely - small wounds

am-c., carb-v., hydr., kreos., lach., ph-ac., phos., sul-ac., zinc.

- bluish

apis, lach., lyss., vip.

- burning

aeon., am., ars., bry., carb-v., caust., hyper., mere., mez., nat-m., rhus-t., sul-ac., sulph., zinc.

- cold, become

led.

- fingers, tips, crushed, cut

arist-cl., carb-ac., HYPER., led., ruta.

- foreign bodies, from

am., hep., lob., SIL.

- granulations

alum., alumn., anac., ant-t., ARS., calc., calen., carb-v., cund., hep., hydr., kali-m., kreos., lach., mere., nit-ac., sabin., SIL., suloh., thui.

9 Traumatology

SYNTHETIC REPERTORY

- heal, slow

all-c., alum., alum-p., alum-sil., am-c., ars., bar-c., bor., both., calc., carb-v., caust., cham., chel., clem., con., cortiso., croc., crot-h., graph., hell., HEP., hyper., kali-c., LACH., lyc., lyss., mag-c., mang., mere., merc-c., mur-ac., nat-c., NIT-AC., nux-v., PETR., ph-ac., phos., plb., puls., rhus-t., sars., sep., SIL., squil., staph., SULPH., tub.

- injection, from painful

crot-h., led.

- no reaction

ars., camph., carb-v., con., laur., op., ph-ac., sulph.

- plants, from poisonous

echi-a.

- pulsating, throbbing

bell., cham., clem., hep., mere., mez., puls., sulph.

- purulent

arn., asaf., bell., bor., bufo., calc., calc-f., calc-s., calen., caust., cham., chin., croc., echi-a., hep., lach., led., mere., nat-m., plb., puls., sil., sulph., vip-a.

- ailments from

calen.

- black

chin., lach., trach., vip.

- cuts

arn., calen., carb-v., cic., con., dig., ham., hep., hyper., kali-m., lach., led., mere., nat-c., nit-ac., ph-ac., plan., plb., sil., STAPH., sul-ac., sulph.

- dissecting

anthr., apis., ars., crot-h., echi-a-a., ham., kreos., lach., led., pyrog., ter.

- gangrenous

aeon., am-c., anthr., ARS., bell., brom., calen., carb-v., chin., eucal., euph., LACH., sal-ac., sec., sil., sul-ac., trach., vip., vip-a.

- gunshot, punctured

ARN., calen., euphr., hyper., nit-ac., plb., puls., ruta., sul-ac., sulph., symph.

- painful

all-c., am-c., apis., arist-cl., bell., calc., calc-f., calen., cham., con., croc., crot-h., eug., hep., HYPER., led., nat-c., nat-m., nit-ac., nux-v., nh-ac., STAPH., sulph.

SYNTHETIC REPERTORY

- scurfiness, with

calen., carb-ac., hyper.

- septic

ars.

- splinters

con., anag., apis., am., carb-v., CIC., colch., hep., HYPER., lach., led., lob., nit-ac., petr., plat., ran-b., sil., staph., sulph.

- stab wounds

acet-ac., all-c., apis., am., carb-v., cic., con., eug., hep., HYPER., lach., LED., nat-m., nit-ac., phase., phos., plb., puls., rhus-t., sep., sil., staph., sul-ac., sulph.

- stinging

aeon., apis., am., bar-c., bell., bry., caust., chin., clem., led., mere., mez., nat-c., nit-ac., sep., sil., staph., sulph.

- swelling of

aeon., am., bell., bry., kali-m., nux-v., puls., rhus-t., sul-ac., sulph., vip.

Repertorisation - spinal trauma

KENT S REPERTORY

Back pain/general and modalities

- lifting, from

Anag., Bor., CALC., GRAPH., LYC., Nux-v., Ph-ac., RHUS-T., Sang., Sep., Sulph.

- injury, after

Calc., Con., HYPER., Kali-c., Nat-s., Rhus-t., Thuja.

- s Repertorisation - trauma to the extremities (p. 239)

Repertorisation - thoracic trauma

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Pneumothorax

Ars., Colch., Dig., Lyc.

- No Repertorisation - trauma to the extremities (p.239)

Repertorisation - craniocerebral trauma

SYNTHETIC REPERTORY

Confusion of mind - injuries, after - head, to

NAT-S.

9 Traumatology

SYNTHETIC REPERTORY

Dullness - injuries of head, after am., cic., hyper., mere., rhus-t.

Indifference, apathy - concussion of brain, after

ARN., cic.

Insanity, madness - injuries to head, after alco., nat-s.

Memory, loss of - concussion of brain hyper.

- injuries, after am-c., chin-ar.

- injuries, after - head, to

am-c., ARN., cic., hyper., mere., rhus-t.

Prostration of mind - injuries, from acet-ac., camph., hyper., sulph-ac., verat.

Stupefaction, as if intoxicated - injuries of head, after am., cic., con., hell., puls., rhus-t.

Unconsciousness, coma - concussion of brain, after

arn.

- shock from injury, in am., chl.

KENT'S REPERTORY

Cephalohaematoma

Calc-f., Merc., Sil.

Cerebral haemorrhage

Aeon., Arn., Aur., Bar-c., Bell., Camph., Carb-v., Chin., Cocc., Coff., Con., Crot-h., Cupr., Ferr., Gels., Hyos., Ip., Lach., Laur., Lyc., Merc., Nat-m., Nit-ac., Nux-m., Nux-v., Op., Phos., Plb., Puls., Stram.

Concussion of brain

Arn., Bell., Cic., Hell., Hep., Hyos., Hyper., Kali-p., Led., Merc., Nat-s., Ph-ac., Rhus-t., Sep., Sulph-ac., Zinc.

- painless

Caust.

Softening of brain

Ambr., Caust., Fl-ac., Kali-p., Lach., Nux-m., Phos., Sulph.

Paralysis of brain, incipient

Am-c. Ars. Carb-v. Hyos. Lyc. Op. Phos. Plb. Zinc

KENT'S REPERTORY

Head, pain, concussion, from

Arn., Bell., Calc-s., Cocc., Ferr-p., Hep., Lac-c., Merc., Phos.

Head, pain, blows, from

Arn., Calc-s., Hyper., Nat-m., Nat-s.

Head, pain, injuries, mechanical, after

Arn., Bell., Calc., Cic., Con., Dulc., Hep., Hyper., Lach., Merc., Nat-m., Nat-s., Nit-ac., Petr., Phos., Puls., Rhus-t., Staph., Sulph., Sulf-ac.

Head - injuries of the head, after

Arn., Cic., Hyper., Nat-m., Nat-s.

Head - injuries of the scalp, after calen.

Vertigo, concussion of brain, from

aeon., Arn.

Teeth. pain. concussion. from

Repertorisation - abdominal trauma

KENT'S REPERTORY!

Abdomen

- abdomen, hard

Alum., Anac., Arn., Ars., Ars-i., Bar-c., Bar-m., Bell., Calad., Calc., Caps., Carbn-s., Cause, Cham., Chel., Chin., Cina, Clem., Coff., Colch., Con., Cupr., Cupr-ar., Dig., Dire., Dulc., Eup-pur., Ferr., Ferr-ar., Ferr-p., Gels., Graph., Grat., Hyper., Ign., Jug-r., Kali-ar., Kali-c., Kali-p., Kali s., Lac-c., Lach., Laur., Mag-m., Mag-s., Merc., Merc-c., Merc-j-f., Merc-j-r., Mez., Nat-ar., Nat-c., Nat-m., Nat-p., Nit-ac., Nux-m., Nux-v., Op., Paeon., Phos., Plb., Puls., Raph., Sars., Sec., Sep., Sil., Sol- t-ae., Spig., Spong., Stram., Sulph., Sumb., Tab., Valer.

Abdomen, clothing, sensitive to

Apis, Arg-n., Benz-ac., Bov., Calc., Carb-v., Caust., Chin., Coff., Crot-c., Crot-h., Eup-per., Graph., Hep., Kreos., Lac-c., Lach., Lyc., Merc-c., Nat-s., Nux-v., Puls., Raph., Sars. Sep., Spong., Stann., Sulph.

Analgesia (= no pain with complaints which are normally painful)

Bell., Chel., Cic., Cocc., Con., Hell., Hyos., Ign., Kali-br., Laur., Lyc., Merc., Mosch., Olnd., Op., Phos., Ph-ac., Pic-ac., Plb., Puls., Rhus-t., Sec., Stram., Sulph.

Abdomen, pain, flexing limbs ameliorated

Bell. Bar. Chel. Calad. Crot. Nit-ac. Phos. Poda. Puls. Rhous

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KENT'S REPERTORY

Abdomen, pain, pressure aggravated

Aeon., Aloe, Anac., Ant-t., Bell., Carb-v., *Carbn-s.*, Chin-s., Cic., Cina, *Coff.*, Con., Cycl., Eup-per., Jac-c., Kali-bi., *Lac-c.*, *Lach.*, *Mez.*, *Nit-ac.*, *Nux-v.*, Puls., *Ran-b.*, Samb., Sars., *Sulph.*, Zinc.

Abdomen, pain, violent

Aloe, Ant-t., *Apis*, Ars., Bell., Cact, Canth., Cast., Cham., *Colch.*, *Coloc.*, *Cupr.*, Cycl., Dig., Euph., *Kali-ar.*, Kali-c., Kali-n., *Mag-c.*, Merc-c., *Nux-v.*, *Phos.*, Plb., Sil., Sulph-ac.

Abdomen, pain, bend double, must

Ars., Aur-m., Bell., Bor., Bov., Bry., Calad., Calc., *Caps.*, *Caust.*, *Cham.*, Chel., Coloc., Crot-t., Eupi., Grat., *Iris*, Kali-p., *Mag-p.*, Merc., Nit-ac., Plb., Puls., *Rheum*, *Rhus-t.*, Sabad., Sep., Sulph., Ter., Thuj.

Abdomen, pain, bending double, ameliorated

Aloe, Ars-h., Ars-i., Bell., Bor., Cast, *Caust.*, Chin., *Colch.*, Coloc., Cop., Cupr., Euph., Eupi., *Iris*, Kali-c., *Lach.*, Lyc., Mag-c., *Mag-p.*, Mang., Merc-c., *Nux-v.*, Petr., Phos., Podo., Prun., Puls., *Rheum*, Senec., Sep., *Stann.*, Staph., Stram., Sulph., tarent., Verb., Zinc.

® Chapter 12 (p. 315): Acute abdomen.

Differentiation between important homeopathic remedies

*** Important remedies:** *Aconitum*, *Arnica*, *Belladonna*, *Bryonia alba*, *Calendula*, *Cicuta*, *Coccu- lus*, *Cuprum metallicum*, *Gelsemium*, *Glonoinum*, *Hypericum*, *Ipecacuanha*, *Kalium phosphoricum*, *Lachesis*, *Ledum*, *Millefolium*, *Natrium sulphuri- cum*, *Nux vomica*, *Opium*, *Phosphorus*, *Rhus toxicodendron*, *Ruta*, *Staphisagria*, *Symphytum*.

Aconitum: first stage of inflammatory fever before any local focus, rash or exudate appears; characterised by great anxiety and restlessness; often when the patient is suffering from chills before the fever appears. Initial remedy for inflammation and inflammatory fevers. Heat with thirst; full, hard pulse, anxious impatience, cannot be placated; beside himself, rolls back and forth with pain. Cannot bear pain, touch or being uncovered. Sudden and marked loss of strength. <: in warm rooms, in the evening, at night, lying on the affected side, from music, tobacco smoke and dry, cold winds. >: Outdoors. Feeling of

fullness in the head. Severe, throbbing, hot, bursting, burning, surging sensations. Intracranial pressure.

Arnica: main remedy for bruises, contusions, shock, bleeding, concussion, luxations. All the body parts on which the patient is lying feel sore. Severe consequences of mechanical injuries, blows and falls. Concussion and all other mechanical injuries. Bruises and contusions. Problems arising from impact, falls and contusions. Contusions without lacerations. Wrenches. Joint sprains and strains. Bee and wasp stings. Splinter wounds. Open fractures with profuse suppuration. Pain after overexertion. <: from the slightest touch, movement, rest, wine and damp cold. >: lying down or lying flat. Hot head, cold body. Confusion. Brain sensitivity with severe twinges of pain. Cold spot on the forehead. Dizziness: objects appear to whirl around, especially when walking.

Belladonna: this remedy has a marked effect on the vascular system, skin and glands. The patients skin is frequently red and hot, his face red with shining eyes; throbbing carotid arteries, agitation, sensory hypersensitivity, delirium, restless sleep, convulsive movements, dry mouth and throat but aversion to water. Pain appears suddenly, is violent for a shorter or longer time and disappears as suddenly as it came. <: from touch and impact, noise, draughts, in the afternoon and when lying down. >: half sitting. The head is sensitive to the slightest touch. Violent throbbing and heat. Feeling of congestion, particularly in the forehead but also in the temples and the back of the head. Cries out suddenly. Headache: <: from light, noise, jarring, lying down, in the afternoon, lying on the right side, when going to lie down. >: pressure, semi-reclining position. Presses the head into the pillow. The head is pulled back and rolls from one side to the other. Constant groaning. Dizziness: falls backwards or to the left.

Bryonia alba: main remedy for strains. Stabbing, tearing pain. <: with movement, warmth, in the morning, from food, hot weather, exertion, touch. >: when resting, lying on the painful side, from pressure, with cold things. Dizziness, nausea, weariness when getting up, confusion. Bursting, raging headache as if everything is being pressed out. Headache feels like the head was hit with a hammer from the

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inside. The headache sits in the back of the head. Felt in the bones as far as the cheekbone. Headache: < movement, even when moving the eyes. Frontal headache, frontal sinuses also affected.

Calendula: main remedy for infected wounds. A remarkable remedy which is frequently also applied topically. It is useful for open wounds, wounds which are not healing etc.; it promotes healthy granulation and rapid primary healing. Superficial burns and scalds. Cuts and tears. Ecchymosis. Bloody and serous infiltration of cell tissue, open wounds. It reduces suppuration and promotes healing of the injured areas. It encourages benign scar formation with minimum suppuration. In all cases where soft tissue has been lost, where the separated parts cannot be made to join together with dressings. <: in damp, oppressive and cloudy weather. **Cicuta:** consequences of impact to the brain (commotio cerebri) and spine. Concussion. Red face with headache and restless sleep, face later turns cold and pale. Jaw spasm (trismus). Firmly gritted teeth. Tetanus following by weakness, fatigue and sleepiness. Opisthotonus: head, neck and spine bent backwards. The head is turned or pulled to one side. The neck muscles are contracted. Sudden, violent blows with the head. Convulsions after concussion. Headache > from passing wind. Dizziness with stomach ache and muscle spasms. <: being touched, draught, jarring, tobacco smoke.

Cocculus: severe nausea and other symptoms when the bed is moved. Intolerance of warm or cold fresh air. Empty feeling in the head. Pain in the neck and the back of the head, < when lying on the back of the head. Headache: < going by car. Pain in neck and back of head, feeling as if a door is being opened and shut. Contracted pupils. (Convulsive) head shaking. Dizziness, nausea, especially when driving or sitting upright. <: eating, after insufficient sleep, outdoors, smoking, driving, swimming, touch, noise, jarring, in the afternoon.

Cuprum metallicum: Bruised pain in the brain, also when moving the eyes (eye sockets). Many symptoms are accompanied by dizziness, the head falls forward onto the chest. <: touch, movement, vomiting. >: when sweating, drinking cold water.

Gelsemium: congestion in the head or face, chills, sluggish speech, the brain feels squashed. Dull, heavy headache with heavy eyelids. Feeling of exhaustion (in the brain). Headache > pressure and lying down with the head raised. Pain in the temples radiating to the ears, nostrils and chin. Wants to have the head raised on a pillow. Dizziness spreads from the back of the head. < damp weather, fog, before storms, excitement, smoking tobacco, thinking about the symptoms, at 10 am. >: bending forwards, copious urination, outdoors, continued movement, stimulants.

Glonoium: pain and other unusual sensations which occur some time after local injuries; the parts affected feel painful and sore. Mechanical contusions and their delayed consequences. Throbbing pain. Head feels heavy but the patient cannot rest it on the pillow. Cannot bear heat around the head. Throbbing headache. Feeling that the head is enormous, or too small for the brain. Headaches worsen or improve with the sun. Throbbing in the head synchronous with the pulse. Headache > uncovering the head, effects of sun. Confusion, with dizziness. Dizziness when assuming an erect posture. <: in the sun, effect of sunshine, gas, open fire, jarring, bending, peaches, stimulants, lying down, between 6 am and midday. >: brandy.

Hypericum: main remedy for nerve injuries, fingertip injuries. Convulsions after every minor injury or impact. Wounds caused by squashing, e.g. squashed fingers, especially fingertips. Exceptionally painful puncture wounds. Injuries to body parts which are plentifully supplied with sensory nerves, especially fingers, toes and nail beds. Open, painful wounds with general exhaustion from blood loss and severe nervous exhaustion. Lacerations. Stab wounds. Lacerations with unbearable pain, showing that the nerve tissue has been badly affected. Mechanical injuries, wounds inflicted by nails or splinters in the feet, nails in the fingernails, through crushing, blows. Injuries and wounds to the toes and fingers, especially the fingertips. **Hypericum** is particularly appropriate when the nerves have been lacerated, injured or torn, resulting in agonising pain. Nerve injuries from animal

9 Traumatology

bites. Hair loss due to injury. Wounds with ragged edges, blood loss causes great weakness. <: in cold and damp, in fog, in confined spaces, on uncovering any body part and on being touched. Neck pain. Pressure over the sacrum. Trauma to the spinal cord. Injuries to the coccyx caused by falls, with pain which radiates up the spine and down the limbs. Muscle jerks and twitches. <: in cold conditions, when uncovering any part of the body, on being touched. >: bending the head backwards.

Ipecacuanha: persistent nausea and vomiting. The skull feels bruised or squashed. The pain radiates to the teeth and the root of the tongue (with nausea). <: veal, damp, warm winds, lying down.

Kalium phosphoricum: pain at the back of the head > after getting up. Headache, > gentle movement. Headache with a feeling of exhaustion, emptiness and weakness in the stomach. Dizziness from lying down, getting up, sitting and looking upwards. <: excitement, eating, mental exertion, cold, early in the morning. >: warmth, rest, food. **Lachesis:** small wounds with unusually severe bleeding. Bleeding, dark blood, does not coagulate. Can bear absolutely nothing tight. Bluish, purplish skin. Bluish-black swelling. Dissecting wounds. <: on waking up, from pressure or constriction, from hot drinks and when closing the eyes. >: with warm applications. Pain throughout the head on waking up. Pressure and burning at the top of the head. Surges of pain. Headache < after movement. Headache caused by the sun. Headache with flickering in front of the eyes, dim vision, very pale face. Dizziness, > when secretion begins.

Ledum: main remedy for puncture wounds. Insect bites, especially mosquito bites. Skin discolouration which remains in parts affected after the pain and inflammation have disappeared. Stab wounds from sharp instruments such as awls, nails, etc. Rat bites. This remedy is particularly suitable when the patient feels that the injured part is cold and when it also feels cold to the touch. Sprained ankles and feet. Ecchymosis.

Millefolium: main remedy for major internal injuries. An invaluable remedy for various types of bleeding; the blood is bright red. After (bladder)

stone operations. Serious consequences of falls from a height.

Natrium sulphuricum: Head symptoms and mental disorders caused by head injuries. Pain at the back of the head. Head seems to burst when coughing. Serious consequences of falls and head injuries; mental disorders caused by these. Dizziness, > with sweat on the forehead. <: music (preferably sad), lying on the left side, damp weather. >: dry weather, pressure, changing position.

Nux vomica: pain in the lumbar region. Burning in the spine. Has to sit up in order to turn over in bed. Bruised pain below the shoulder blades. <: sitting, touch, in the morning, cold. >: in the evening, rest, strong pressure. Headache at the back of the head or over the eyes, with dizziness. Heavy pain at the top of the head, as if a nail is being driven into it. Frontal headache with the urge to press the head against something. Headache when exposed to sunlight. Head feels enlarged with pain on the inside. (Violent) jerks in the (left half of the brain towards the) eye socket, radiating towards the (temples and the) back of the head. Dazed feeling. <: in the morning, mental exertion, tobacco, alcohol, coffee, outdoors. The brain feels like it is turning in circles. Dizziness with momentary loss of consciousness. Dizziness in the morning and after eating.

Opium: sopor. Deep, drugged sleep and stertorous breathing. Sweaty skin. Dizziness, head feels light. Head feels dull, heavy, stupefied. Pain in the back of the head, feeling of a heavy weight. Bursting feeling. Complete insensitivity, understands nothing. < heat, during and after sleep. >: cold things, constant walking.

Phosphorus: small wounds bleed severely. The blood coagulates after it has left the body. Ecchymosis. <: from touch, physical or mental exertion, at dusk, from warm food or drink, changes in the weather, in the evening, lying on the painful side, during storms. >: in the dark, with cold food, outdoors, sleeping, washing with cold water. Burning headache. Dizziness, after getting up. Dizziness with weakness bordering on unconsciousness.

Rhus toxicodendron: Main remedy for torn muscles and ligaments, distorsions, luxations. Erysipelas

after wounds. Traumatic lesions affecting the cell, fibrous or joint tissue. Problems from wrenches and sprains. Pain in distal body parts as if from being wrenched or sprained. Tendency to strain body parts through lifting heavy things or stretching the arms to reach things located high up. Serious consequences of forced overextension of membrane tissue, especially the joint ligaments. Postoperative complications. Tearing pain in the tendons, ligaments and fascia. <: when asleep, from wet, cold, rainy weather and after rain, at night, when resting, from getting wet through and when lying on the back or right side. >: in warm, dry weather, from movement, walking, changing position, rubbing, warm applications and stretching the limbs. Pain between the shoulders when swallowing. Pain and stiffness in the lumbar region. Stiff neck. <: sitting. >: movement, continuing to move after initial worsening has passed, walking, changing position, warm applications, stretching the limbs. *Ruta*: main remedy for injuries to the periosteum. Dislocations, pain worse at rest or from movement. Severe sprains or torn tendons. Wounded joints with inflammatory processes. Synovitis caused by injury. *Ruta* accelerates the healing process in sprained joints once the inflammation is completely under control (Herings personal experience). Injuries of the periosteum and fibrous tissue. Periostitis. Contusions and other mechanical injuries to the bones and periosteum. Bone lesions and fractures. *Ruta* promotes callus formation after fractures in cases where the area around the injury is extremely painful. Erysipelas. Mechanical injuries to the wrists and ankles, rheumatic paralysis of these parts. Paralysis after sprains, particularly of the wrists and ankles. <: from lying down, in cold, wet weather.

Staphisagria: main remedy for cuts. Mechanical injuries with sharp cutting tools. After surgical operations, lithotomy or ovariectomy. Clean cuts. Wounds with greenish secretions. <: from anger, outrage, worry, humiliation, masturbation, sexual excesses, tobacco and the lightest touch of the affected body part. >: after breakfast, in warmth and when resting at night. **Symphitum**: main remedy for complex fractures. Contusions, sprains. Serious consequences of

severe sprains. Affects the joints in general. Injuries to the tendons and periosteum. Bone pressure, contusions and fractures. This remedy makes it easier for broken bones to knit and reduces the idiosyncratic stabbing pain; also promotes callus formation. Bone irritation at the fracture site. Stabbing pain and sore periosteum. Very useful for wounds which penetrate to the periosteum and the bones.

9.1 Trauma to the extremities

Definition

Accidents involving the extremities frequently lead to complex injuries with various focuses and degrees of severity.

Open and closed fractures

With **open fractures**, the break comes into contact with the surface of the body when the bone breaks through the skin or the object which caused the injury penetrates down to the bone.

The severity of the open fracture depends on the

Tab. 9.1-1: Classification of open fractures (Gustilo 1976)	
First-degree open fracture	• Skin wound < 1 cm • Pierced from the inside • Minimal muscle contusion • Simple transverse or short oblique
Second-degree open fracture	• Wound > 1 cm • Extensive soft tissue damage • Moderate muscle compression • Small fracture surface
Third-degree open fracture	• Extended soft tissue damage • Additional nerve and blood vessel damage

Closed fractures are not directly connected to the surface of the body; the soft tissue covering them is intact. Nevertheless, serious soft tissue damage may result in some cases («? table 9.1-2).

Compartment syndrome

Painful muscular condition with numbness and tingling which restricts the patient's mobility and occurs as a complication of fractures (particularly of the lower leg).

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microcirculatory disruptions caused by increased tissue pressure inside an anatomical compartment (muscle compartment enclosed by fascia).

Tab. 9.1-2: Classification of closed fractures (Tscherne 1982)	
First- degree closed fracture	• No or minor soft tissue injury or superficial abrasion or contusion caused by fragment pressure from inside. • Simple or moderately severe fracture types
Second- degree closed fracture	• Imminent compartment syndrome (see below) • Moderately severe to severe fracture types
Third- degree closed fracture	• Manifest compartment syndrome (see below) • Extensive soft tissue damage and injuries to the main blood vessels • Severe and comminuted fractures

*** Important: compartment syndrome can be made worse by tight plaster casts.**

Subluxations

Traumatic subluxations and dislocations occur when the ends of two bones in a joint are displaced out of their functional position.

Wounds

Wounds are defined as any break in connecting tissue (with or without loss of substance) on the outside or inside of the body in which the blood and lymph vessels are opened.

Imminent or existing loss of extremities

Injuries may cause complete or incomplete separation through (imminent) breaks in the continuity of the major nerves and blood vessels in a terminal part of the extremity; in cases of traumatic amputation, some tissue connections may still remain.

Incarceration trauma (tourniquet syndrome)

One of the patients extremities is trapped. This

Clinical information

Incidence and mortality

The incidence of each type of injury depends on the body part affected and the type of accident. A more precise analysis is therefore not possible here. Unlike complications arising from injuries, isolated solitary extremity fractures are not associated with higher general mortality rates.

Symptoms

Open and closed fractures

Certain signs

- Abnormal mobility
- Grinding noises or palpable sensation when moved (crepitation)
- Axis misalignment
- Initial muscle stupor
- Bone visible in open wounds

Uncertain signs

- Haematoma
- Pain
- Functional impairment

Subluxations and dislocations

Pain causes patient to adopt a relief posture (fixed in a specific position to avoid jarring); the outer contour of the joint is usually misshapen.

Wounds

Wounds are mainly differentiated according to their appearance. They may take many different forms, each of which indicate the origin of the wound. Examples include lacerations, cuts, tears, burns, abrasions, punctures, decollements etc.

Imminent or existing loss of extremities

Compartment syndrome and neurovascular lesions in fractures and luxations can endanger the injured extremity. The symptoms include non-existent peripheral pulses or failed recapillarisation.

Traumatic amputations interrupt the continuity of the

limb is passively extended. The peripheral pulses can still be felt. Neurological deficits are evidence of full-fledged compartment syndrome with irreversible muscle necrosis.

Incarceration trauma (tourniquet syndrome)

The patient is still trapped or buried. He is frequently suffering from multiple injuries.

Diagnosis

Preclinical diagnosis

Open and closed fractures

The preclinical diagnosis is largely based on the existing symptoms; the nature of the accident may give additional information about the extent of the bone injury.

Incarceration trauma (tourniquet syndrome)

As far as possible, the patient should be examined in the situation in which he is found. The emergency doctor will decide on the treatment plan and monitor the measures implemented by the rescue services.

Wounds

External wounds are diagnosed by **inspecting** the surface of the body. The edges of the wound (wound type: abrasion, tear, laceration, cut, puncture), its size and depth, the type of bleeding and the dirt in the wound are also significant.

Imminent or existing loss of extremities

The peripheral pulses cannot be felt either directly after the injury or after recapillarisation; in cases of traumatic amputation, there is a visible loss of continuity in the nerves and blood vessels.

Clinical diagnosis

Open and closed fractures

X-ray, CT, MRI after the patient has been taken to hospital.

Luxations

Pain causes the patient to adopt a relief posture (fixed in a specific position to avoid jarring); the outer contour of

be performed for logistic reasons, even after primary repositioning. Shoulder luxations only rarely undergo primary repositioning (x-ray in the hospital outpatient clinic). X-rays are taken to document the result of the repositioning manoeuvre and to exclude any possible fractures.

Compartment syndrome

Sonography to clarify the differential diagnosis of phlebothrombosis.

Incarceration trauma (tourniquet syndrome) Subfascial pressure measurement.

Compartment syndrome

Along with the uncertain clinical signs “local swelling with reddening of the skin” and “appearance of tension cavities followed by livid discolouration”, **measuring the subfascial pressure** will point the way to the correct diagnosis. EMG tests.

Compartment syndrome

EMG tests are primarily performed to evaluate the prognosis.

Homeopathic treatment

Symptom selection

When treating new injuries, the symptoms should be selected according to the **actual pattern of injury**. The **morphology of the wound** often indicates the remedy

Choice of remedy: if the injuries are so complex that several remedies have to be administered, the most threatening, urgent symptom should be treated first.

Repertorisation

Repertorisation - trauma to the extremities (p. 222)

Differentiation between important remedies

Differentiation between important remedies (p. 226)

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Case 9.1-1: Threat of gangrene following a cut

Martin Bündner

Anamnesis

Several days previously, the 51-year-old patient suffered a cut wound approx. 2 cm long on the middle phalanx of the right-hand middle finger. The wound was not attended to by a doctor; instead, the patient ignored it. However, he went to the doctor on noticing that the wound was getting progressively worse.

The whole middle phalanx of the right-hand middle finger is massively swollen and a livid dark blue in colour, the finger can be moved; there is no peripheral loss of sensitivity. The phalanx is cool.

Diagnosis

Impending gangrene in the middle phalanx of the right-hand middle finger following a cut.

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY

Wounds - bluish

Differentiation between remedies

The only remedy mentioned in both rubrics is *Vipera berus*. This is also the only remedy in the rubric “Wounds - black” (because of the deep discolouration).

The external appearance of the wound also indicates *Arsenicum album* or *Lachesis*; however the influence of *Vipera* on such wounds is already known.

Prescription

10 drops *Vipera berus* Q6 with the instruction to take the remedy several times a day.

Progress

Within a few days, the wound heals completely, the skin colour returns to normal and the circulation is the same as in the other fingers.

Evaluation

The impending loss of the finger was prevented by homeopathic treatment.

Critical commentary

The rubric “Wounds - cuts” was not used, as the condition of the wound had nothing to do with the nature

Case 9.1-2: Distorsion of the left shoulder

Martin Bündner

Anamnesis

The 73-year-old patient falls off his bicycle and severely dislocates his left shoulder when he tries to break his fall with his left arm. He complains of chest pain when coughing. The pain radiates from the left armpit to the chest and shoulder. It worsens on getting out of bed (sitting up), taking deep breaths, lifting the arm and raising the shoulders.

Diagnosis

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Arms, raising, aggravated

Breathing, deeply, aggravated

Bed, rising from, aggravated

Shoulders

Coughing aggravated

Differentiation between remedies

The remedies in question are *Aconitum*, *Bryonia alba*, *Rhus toxicodendron* and *Sulphur*. The Kent repertory contains a rubric very similar to the pain symptoms

9.1 Trauma to the extremities

to treat the patient with *Sulphur*, particularly as the modalities typical of the “injury remedies” *Bryonia* and *Rhus toxicodendron* are not present.

Prescription

10 drops *Sulphur* Q3 three times a day.

Progress

At the next consultation 21 days later (the remedy was used up in just over a week), the patient reports that his symptoms improved considerably while he was taking the remedy. He mentions that the improvement ceased when he stopped taking the *Sulphur*. He is therefore prescribed *Sulphur* in increasing potencies (ultimately

the shoulder injury completely and stabilise the result of the treatment.

Evaluation

The patient's condition improved rapidly after taking the homeopathic remedy but stagnated when he stopped. It then continued to improve until the injury was completely healed and even the smallest functional impairments disappeared.

Critical commentary

The fact that the healing process stagnated when the patient stopped taking the *Sulphur* speaks for the healing

Case 9.1-3: Distorsion of the left knee, lower leg and ankle

Martin Bündner

Anamnesis

The 36-year-old patient falls down some stairs and injures her left leg. Her left knee, lower leg and ankle are all painful. The pain gets worse when climbing stairs, walking for longer periods, stretching the left leg and particularly when sitting down. The pain eases when standing and walking short distances. The left knee and ankle are clearly swollen. The entire area is bruised. The varicose vein already present in the lower leg is swollen. The joints affected are still mobile, albeit painful; there is no compression pain. Radiological diagnostic procedures are therefore dispensed with.

Diagnoses

Sprain of the left knee, lower leg and ankle.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Sprained, as if

Differentiation between remedies

The choice is between *Phosphorus*, *Pulsatilla* and *Sepia*. The unusual modality of improvement when standing up speaks for *Phosphorus* and against the other two remedies.

Prescription

1 drop *Phosphorus* Q3 three times a day.

Progress

When taking the *Phosphorus*, the pain rapidly eases and the swelling slowly subsides. The patient does not take the remedy regularly as prescribed, as a result of which the same dose of *Phosphorus* Q6 is not administered until day 13. A few days later, the patient has almost no symptoms and the swelling is only slight, but the varicose vein is still clearly swollen when she is standing or sitting. For this reason, *Phosphorus* Q9 is prescribed at the next consultation on day 65. The swelling in the varicose vein also subsides with this treatment.

Evaluation

A serious combined leg injury reacts rapidly to the homeopathic remedy administered.

Critical commentary

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Case 9.1-4: Distorsion of the right ankle

Martin Bündner

Anamnesis

The 32-year-old patient comes for homeopathic treatment for an injury to the right ankle. Three days previously, she fell down the stairs and twisted her right ankle. A fracture was ruled out in A&E. However, since then the pain has been increasing; there is a stabbing pain on the inside of the ankle, the pain radiates upwards and becomes more severe when walking. The calf feels cramped. There is also a stabbing pain on the outside of the ankle which also gets worse when walking; this area is also more painful when pressed. There is a dragging pain in the sole of the foot, as if it has been overextended; this too gets worse when walking. She feels as if something is exerting pressure inside the foot and pulling up her toes.

Diagnosis

Distorsion of the right ankle

Diagnosis

Imaging procedures.

X-ray of the upper ankle in two planes: a fracture is ruled out.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Extremities - pain - ankle - extending upwards

Generalities - injuries (including blows, falls and bruises)

Extremities - pain - stitching - ankle

Differentiation between remedies

The choice is between *Phosphorus* and *Pulsatilla*. In this case, the decision is easy: the patient is already receiving long-term treatment with *Pulsatilla*, which has brought no improvement so far; she is therefore treated with *Phosphorus*.

Prescription

1 drop *Phosphorus* Q3 three times a day.

Progress

The pain eases somewhat as soon as the first dose of *Phosphorus* is taken. Three days later, the patient has no pain whatsoever.

Evaluation

The homeopathic treatment administered concomitantly with the measures taken by A&E accelerated the healing process considerably.

Case 9.1-5: Fracture of the left metacarpals

Martin Bündner

Anamnesis

A 65-year-old male patient tries to break a fall with his left hand. Afterwards he notices a dull pain in the middle of his hand which gets worse when he lets his arm hang down, when lying down and when turning his wrist. The area affected is swollen and hot. First aid is administered in A&E.

Diagnosis

Fracture of the left metacarpals

Diagnostic procedures

Imaging procedures.

X-ray of hand in two planes: fracture of the left metacarpals

Conventional treatment

Treated concomitantly with homeopathic treatment for

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Extremities - pain - wrist - motion, on - aggravated

Extremities - hang down - letting limbs - aggravated

Generalities - lying - aggravated

Generalities - injuries - bone

Differentiation between remedies

The repertorisation process leads to *Ruta graveolens*. If we leave out the extremely restrictive bone injury rubric, we also have *Carbo vegetabilis*, *Hepar sulphur*, *Plumbum* and *Sulphur*. However, in this case it seems appropriate to use *Ruta*, a remedy which has already

Prescription

1 drop *Ruta graveolens* Q3 three times a day.

Progress

Three days after taking *Ruta*, the swelling has completely gone and the pain is only mild. The patient continues with the remedy in the same way until the bottle is empty. The fracture heals rapidly without complications.

Evaluation

Gratifying progress with remarkably fast bone healing.

Critical commentary

Small rubrics (here: bone injuries) should only be used for exclusion purposes, even if they match the case

Case 9.1-6: Closed distal intraarticular comminuted fracture of the lower left leg, II°

Martin Bündner

Anamnesis

The 44-year-old motorcyclist has an accident and suffers a severe distal fracture of the lower leg involving the ankle. The patient will have to undergo surgery twice. Initially, an external fixator is attached in the trauma clinic and a minimally invasive osteosynthesis procedure is performed with restructuring of the cancellous bone. The definitive operation is to be performed when the severe soft tissue damage has healed.

The burning, stabbing pain around the fracture gets worse from around 9 pm. The patient needs to take conventional analgesics on a regular basis. He senses a kind of disturbance in the fracture site, as if something were moving around. He feels the urge to move his leg. He has slept badly since the accident; he has particular difficulty falling asleep, also if he wakes up in the night. The feeling of heat in the area affected gets worse at night; he feels a kind of muscle cramp around the fracture site. He notices that he is irritable, which is not usually

the case. Until recently, he felt cramps at the site where the cancellous bone was removed from the iliac crest. Two weeks after the first operation, the patient asks for a homeopathic remedy to optimise the healing process, as radiological examinations have not detected any sign of bone healing.

Diagnosis

Closed distal intraarticular comminuted fracture of the lower left leg, II°

Conventional treatment

Attachment of an external fixator, minimally invasive osteosynthesis with restructuring of the cancellous bone.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - injuries - bone

Differentiation between remedies

These rubrics have no remedies in common. As the soft tissue is healing well, it is decided that the symptoms caused by the bone condition are predominant. The rubric "Injuries - soft parts" is

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therefore relegated to second place for the time being.

The therapist has to differentiate between *Calcarea carbonica*, *Calcarea phosphorica*, *Ruta*, *Sulphuricum acidum* and *Symphytum*.

Symphytum is a major remedy for serious fractures which are not healing; however, it is not often mentioned in the repertory, making a glance at the materia medica necessary. In his foreword to the proving symptoms, Clarke describes the outstanding effects of this remedy on extremely serious fractures and mentions a leg injury with which the patient could feel “how the rough ends of the broken bones tore into the flesh” (Clarke 1995). These movements are deemed similar to the feeling of movement which the patient senses in the fracture site.

Prescription

10 drops *Symphytum* Q6 once a day.

Case 9.1-7: Fracture of the left lateral malleolus

Martin Bündner

Anamnesis

The 16-year-old patient broke the lateral malleolus of her left foot in a fall. The fracture was treated conservatively in a plaster cast. The foot is severely swollen and pitting oedema is evident at all accessible locations near the. The foot turns livid (particularly the toes) when she lets her foot hang. The pain initially increases when the blood rushes into her foot. She reports “terrible burning” on the outside of her ankle. The pain also gets worse when getting up from a lying position and even more when sitting. The pain also radiates upwards from the ankle.

Diagnosis

Fracture of the left lateral malleolus

Diagnosis

X-ray of the upper ankle in two planes: fracture of the left lateral malleolus

Progress

After just three days, the patient has no more pain; the bones subsequently heal without complications. Some time later, the patient still has no pain, can walk without restrictions and is fully able to work.

Evaluation

This kind of fracture is one of the most serious injuries imaginable. The healing process is characterised by complications during the course of treatment. *Symphytum* produced outstanding results considering the severity of the bone and soft tissue injury.

Critical commentary

If the soft tissue damage had been more severe, *Symphytum* might not have been the right remedy. Instead, a remedy which better encompassed all of these symptoms may have been chosen.

Conventional treatment

Plaster cast.

Homeopathic treatment

Repertorisation

_____ **CARD INDEX REPERTORY**

Rising, from sitting, aggravated

Limb, hanging down, aggravated

Bed, rising from, aggravated

Rising

Differentiation between remedies

The repertorisation procedure comes up with *Bel-ladonna*, *Calcarea carbonica* and *Pulsatilla*. The oedematous swelling of the foot speaks for *Calcarea carbonica* and *Pulsatilla*. The pain radiating upwards from the foot is a *Pulsatilla* symptom listed in Kents repertory (“Extremities - pain - ankle - extending - upward”).

Prescription

1 drop *Pulsatilla* Q3 diluted in water and taken once a

9.2 Spinal trauma

Progress

Just two days after the first dose of *Pulsatilla*, there is no more burning and the pain does not radiate upwards as strongly as before. The swelling has subsided somewhat. These symptoms also disappear over the days following; the plaster cast has to be readjusted several times.

Case 9.1-8: Bad fall downstairs

Martin Bündner

Anamnesis

One morning, the 23-year-old patient falls down a staircase with 14 steps because she is not paying attention. She is still able to get up to go and lie down in bed, but by the time of the examination two hours later, she is almost unable to move. There is no indication of a fracture, as a result of which the patient initially refuses the proposed x-ray. Multiple haematomas are visible all over her body. Touch and movement make the pain worse. There are no other symptoms which could indicate a specific remedy.

Diagnosis

Multiple contusions.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - injuries (including blows, falls and bruises)

Generalities - injuries - extravasations, with Generalities - touch aggravated

Differentiation between remedies

The repertorisation process ends with *Arnica*, *Chamomilla*, *Conium*, *Lachesis*, *Pulsatilla*, *Sulphur* and *Sulphuricum acidum*.

9.2 Spinal trauma

Evaluation

Nothing is known about the speed at which the bone healed. Homeopathy can be seen as a helpful form of pain treatment.

Critical commentary

The patient is known to be very sensitive to homeopathic

However, as this is a fresh, blunt, generalised soft tissue injury, remedies with local effects are rejected in favour of *Arnica*, the remedy of choice in such cases.

Prescription

1 dose of 2 globules *Arnica* 30C.

Progress

Two and half hours later, the patient is already showing signs of improvement and the dose is repeated. Further improvement is reported during the evening; the following morning, the patients movements are no longer restricted, she has no pain and no bruising.

Evaluation

Significant improvements in mobility and pain are to be expected under the influence of homeopathic remedies. The use of homeopathic remedies for multiple blunt injuries is strongly advocated.

Critical commentary

In cases of this type, it is possible to quickly administer a typical injury remedy without having to perform a complicated repertorisation procedure every time

Ligaments and disc injuries

Traumas and their consequences only rarely cause disc injuries. Deformities and poor posture may increase the risk. Such symptoms are mainly caused by compression of the nerve roots in the spinal cord (compression syndrome) and vary according to the location.

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Traumatic damage to the spinal cord

- Corresponding injuries (open or closed) frequently lead to lesions in the spinal cord
- Spinal concussion (commotio spinalis) is defined as traumatic damage to the spinal cord with reversible signs of paraplegia
- Spinal contusions (contusio spinalis) refers to mechanical damage to the spinal cord caused by contusions, in some cases with haematomyelia (bleeding into the spinal cord)

Fractures of the vertebrae

Open or closed fractures of the vertebrae can occur in various places:

- Fractures of the vertebral body
- Fractures of the vertebral arch and articular processes
- Fractures of the transverse process and spinous process
- Vertebral luxations (rare, almost solely in the cervical spine)

These fractures are also described as stable or unstable. Spinal fractures are potentially unstable in cases where fractures of the vertebral body involve the posterior edge and when the vertebral arch and the posterior edge of the vertebral body are both fractured. If all three parts of the vertebrae are broken, the fracture is extremely unstable and the medulla is at risk. Fractures of the vertebral body which do not involve the posterior edge are usually stable.

Combined injuries/luxation fractures

Spinal injuries are usually combined.

Clinical information

Incidence and mortality

The incidence of severe **spinal traumas** is estimated at about 1/100 000 per annum. Emergency doctors are relatively infrequently confronted with primary therapy-relevant lesions (i.e. in the bone or ligaments) (approx. 2-3% of all injuries encountered). In cases of **polytrauma**, the proportion of spinal lesions rises to 10-

Traumatic spinal cord damage and vertebral fractures

Tab. 9.2-1: Criteria of complete spinal paraplegia

Location of deficit	Nature of deficit
General	• Inability to move independently/innervation • Flaccid skeletal muscles during the acute phase • Loss of feeling • Absent monosynaptic and polysynaptic reflexes • Possibly priapism in the case of lesions
High lesions in the cervical medulla	Spastic tetraparesis with faecal incontinence
Lesions in the thoracic medulla	Spastic paraparesis with faecal incontinence
Lesions above C4/ C5	• Danger of respiratory insufficiency due to paresis of the respiratory muscles • Clinical signs of spasticity may be absent during the acute phase (hyperactive monosynaptic reflexes, pyramidal tract signs)
Incomplete spinal cord lesions	Partial functional impairments depending on the tract affected by the lesion (e.g. Brown-Segard syndrome caused by lateral hemisection)
Conus/ cauda lesions	• Flaccid paraparesis with absent reflexes • Saddle anaesthesia with faecal incontinence

Symptoms

Ligaments and disc injuries

The clinical signs of isolated traumatic ligament and disc injuries are the same as those caused by degenerative processes. Depending on the location of the compressed spinal nerve roots, the lesion may manifest as:

- Sciatica

- Possibly as conus medullaris or cauda equina syndrome
- Cervicobrachial syndrome

General symptoms include numbness, tingling, pain and impaired sensitivity in the dermatomes affected, weakened reflexes in the reference muscles, possibly paralysis and muscle atrophy, impaired spinal movement and pain-related relief postures. Depending on the severity of the spinal cord compression, the patient may even develop paraplegia.

Diagnosis

Ligaments and disc injuries

The existence of traumatic lumbar disc lesions is confirmed by CT.

* Warning: in view of the trauma aspect, physical examinations may only be performed with the greatest care. The typical signs (Lasague and Schober signs, Valleix points locally tender on pressure) can only be assessed to a limited extent, or in some cases not at all.

Traumatic spinal cord damage and vertebral fractures

In the case of paraplegic lesions caused by fractures of the vertebral body, the location of the fracture can be most safely identified by finding the segmental

limits of the paraesthesia, provided the patient is fully conscious. Clouded consciousness or polytrauma often render acute differential diagnosis impossible, which means that the diagnosis must be confirmed by additional imaging procedures; these are in any case essential for making decisions about the conventional treatment to be given. **Plain radiographs** provide oriented proof of fractures and dislocated vertebral bodies (beware: fractures of the odontoid process). **Spinal CT** imaging (where appropriate with intrathecal administration of contrast agent) is used to find myelocompression when the location of the lesion is known. **Spinal MRI** imaging has diagnostic advantages when the location of the lesion is unclear and when confirming the presence of intramedullary lesions.

Homeopathic treatment

Symptom selection

Particularly in the acute phase, the cause of the trauma is important when choosing the right remedy. If the therapist is already aware of differentiated symptoms, the homeopathic remedy is selected on the basis of these.

Repertorisation

9 (p. 224): Repertorisation - spinal trauma.

Differentiation between important remedies

9 (p. 226): Differentiation between important remedies.

Case 9.2-1: Whiplash injury in a patient with cervical syndrome

Martin Bündner

Anamnesis

The 58-year-old patient fell down some steps and suffered a blunt trauma to the cervical spine. The trauma surgery department ruled out the possibility of a bone injury and diagnosed a whiplash injury of the cervical spine. The patient was already suffering from whiplash symptoms.

Three days later, the patient requested homeopathic treatment for the severe pain. The following were

- The muscles in her shoulders, neck and head are cramped. She does not know how to rest her head; the pain is much worse at night. The pain worsens when she is lying on her side, more on the left than on the right
- She has no difficulties falling asleep but wakes up in pain
- The pain is mainly located on the right side
- She can only turn her head to the left; turning it to the

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Diagnosis

Whiplash injury of the cervical spine. History of cervical syndrome.

Diagnosis

X-ray of cervical bones in two planes: bone injury ruled out. Signs of degeneration in all vertebrae.

Homeopathic treatment

The symptom “Waking up in pain” cannot be repertorised using the Kent Repertory; it is found in the Synthetic Repertory, which however is not at hand at the time the case history is taken. There is also no direct reference to the specific type of injury. The therapist therefore has to consider whether the result of the repertorisation is adequate, which however seems to be the case.

Repertorisation I

KENT'S REPERTORY

Generalities - injuries (including blows, falls and bruises)

Back - pain - night

Back - pain - cervical region - turning head Generalities - lying - side, on, aggravated

Differentiation between remedies

The remedies *Bryonia*, *Calcarea carbonica*. *Natrium muriaticum* and *Natrium sulphuricum* remain.

All of the repertorised remedies are known as injury remedies, although *Natrium sulphuricum* is more suited to contusions and is therefore relegated to the background. The pain of this injury is particularly typical of *Calcarea carbonica*, although *Natrium muriaticum* is also listed. For this reason, *Bryonia* is left out of further considerations.

Deciding between *Calcarea carbonica* and *Natrium muriaticum* turns out to be difficult. The fact that the pain worsens at night speaks more for *Natrium muriaticum*; however, the restricted mobility of the cervical spine seems more significant in this case, and this is more closely matched by *Calcarea carbonica*.

Progress

The next consultation takes place 20 days later. The symptoms have not improved; however, the patient has observed them more closely in the meantime and can now describe them more precisely.

- The neck pain is severe on waking up
- She does not know where to put her head for sheer pain
- Turning her head, even slightly, makes the pain worse
- She cannot turn her head to the right at all
- The neck pain gets worse when lying on her side, raising her head, lying down, turning over in bed and bending her head backwards
- The pain gets much worse when she bends her head forwards

Repertorisation II

BOGER: BOENNINGHAUSEN'S CHARACTERISTICS AND REPERTORY

Sensations and complaints in general - wrenches
Conditions of aggravation and amelioration in general - lying, with head low, ameliorated

Conditions of aggravation and amelioration in general - head, turning, aggravated

Conditions of aggravation and amelioration in general - bending or turning - affected part, aggravated

Conditions of aggravation and amelioration in general - lying - on side, aggravated

Conditions of aggravation and amelioration in general - turning over, in bed, aggravated

Differentiation between remedies

Calcarea carbonica, *Causticum* and *Natrium muriaticum* are mentioned in all of these rubrics, although *Calcarea carbonica* is excluded because it had already failed to take effect.

When considering the weighting of the repertorised symptoms, it is noticed that *Causticum* scores much lower than *Natrium muriaticum*.

Known *Natrium muriaticum* symptoms include the consequences of wrenches, complaints which worsen

9.2 Spinal trauma

Prescription

5 drops *Natrium muriaticum* Q3 once a day.

Progress

After taking the *Natrium muriaticum*, the symptoms caused by the whiplash injury subside; at the next check-up 21 days later, only the symptoms of the pre-existing cervical syndrome remain. The chronic symptoms are also treated with homeopathy.

Evaluation

The treatment and recovery were made more difficult by the fact that the organs affected were already damaged. The patient was initially unable to observe her

was only successful after the ideal remedy was found.

Critical commentary

The case study shows the importance of choosing the right repertory for the case. If the Synthetic Repertory had been chosen and the five rubrics “Generalities - injuries - sprains, distortions”, “Turning, aggravated - head, of”, “Generalities - night (9 pm - 5 am)”, “Generalities - lying - side, aggravated”, “Sleep - waking - pain, from” used, the remedies *Arsenicum album*, *China* and *Natrium muriaticum* would have been found and the chance of immediately administering the right homeopathic remedy increased.

Case 9.2-2: Bruised coccyx

Michael Frass

Anamnesis

52-year-old patient slips on ice and falls on his coccyx; he can neither sit nor lie down. He is already being treated for morbid obesity and its sequelae diabetes mellitus type II with polyneuropathy, hypertension and hypertriglyceridaemia (metabolic syndrome). The patient only contacts the homeopath two days later when the symptoms fail to subside.

Diagnosis

Bruised coccyx. Metabolic syndrome. Osteomyelitis in the big toe of the right foot one year previously.

Homeopathic treatment

Repertorisation

KENT'S REPERTORIUM GENERALE

Back - pain - coccyx - fall, after a

Back - injuries of the spine - coccyx

Differentiation between remedies

The remedy *Hypericum* is chosen because of its strong, clinically proven affinity with bruises of the spinal cord; there is an equally strong relationship with *Silicea* but less so with *Mezereum*. These two remedies could be used as alternatives if the patient does not respond to

Progress

The first dose of *Hypericum* initially shows no effect, and so it is repeated. The patient feels as if “something is happening in the coccyx and then a piece creaks, groans, breaks off and flies away, taking the pain with it”. This feeling comes in waves every five minutes over a period of about two hours. Once this time is up, the patient is more or less able to sit down and lie down again; next day, the symptoms have vanished almost completely.

Evaluation

The severe coccygeal bruising suffered by this patient healed rapidly after two days of pain.

Critical commentary

The vivid and detailed description of the feeling “as if something is happening in the coccyx and then a piece creaks, groans, breaks off and flies away, taking the pain with it” (“as if” symptom) is unusual, as the patient is very much a realist. This symptom is not found in the literature available; however, similar symptoms are found in Allen and Clarke's descriptions of the *Hypericum* provings.

- Neck, back - paralytic pain in the coccyx (Allen 1982)
- Neck, back - severe pain and inability to walk or bend down after falling on the coccyx (Clarke 1987)

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9.3 Thoracic trauma

Definition

A thoracic trauma is an injury to the chest and the organs inside it. This kind of injury can be open or closed.

Closed injuries

These are the result of blunt trauma.

- **Pneumothorax:** when the pleura visceralis is injured, air enters the pleural cavity and influences the normally negative intrapleural pressure, leading to a partial or complete collapse of the lung
- **Tension pneumothorax:** the valve mechanism which causes spontaneous pneumothorax (see below for definition) develops in cases of closed thoracic injury when the pleura visceralis becomes involved
- **Haemothorax:** blood collects in the pleural cavity (between the pleural layers); frequently a component of haemopneumothorax (blood and air collect in the pleural cavity)
- **(Serial) fractures of the ribs:** rib fractures are described as serial when at least two neighbouring ribs or more than three ribs are broken. Compound fractures of the ribs involve several breaks in one rib. Particularly after serial rib fractures, the abnormal mobility of the (bones in the) thorax may cause the thorax to become unstable; this can lead to paradoxical breathing with respiratory insufficiency
- **Lung contusion:** lung injury caused by blunt trauma with bleeding into the lung parenchyma and bronchial system
- **Myocardial contusion:** bruising of the heart caused by brief, blunt trauma. Most common form of traumatic heart damage. Other heart traumas (e.g. ruptured ventricles) can only be survived with the protection of a pericardial tamponade
- **Ruptured aorta:** tearing of the aorta, which usually leads to potentially fatal internal bleeding. Common consequence of deceleration trauma, associated with serial rib fractures on the left side, haemothorax and possibly a fractured

sternum. The part of the aorta most prone to rupture is the isthmus

Open injuries

These are commonly the result of stabbing, impalement and gunshot wounds.

- **Pneumothorax** (see above): injury of the pleura parietalis
- **Tension pneumothorax:** the visceral wound acts as a one-way valve, i.e. air penetrates the pleural cavity every time the patient breathes in and the wound is closed every time he breathes out. The mediastinum and diaphragm are forced to the contralateral side, obstructing the flow of blood in the major thoracic veins and causing the patient to develop increasing respiratory distress, cyanosis, chest pain and shock symptoms. This mechanism is a common consequence of stab and gunshot wounds
- Ruptures in major blood vessels as a result of serious injury and penetrative injuries involving the heart are comparatively rare

Clinical information

Incidence and mortality

Thoracic trauma often constitutes part of a polytrauma. Combinations of cranial (9.4) with thoracic lesions (75%) and abdominal (9.5) with thoracic lesions (40%) are common. 20% of polytraumatised children have serious thoracic injuries.

- 0% of patients with isolated thoracic trauma do not survive the accident; combined with certain other injuries (e.g. abdominal trauma/CCT), this figure may rise to 50%.

Symptoms

Closed injuries

- **Pneumothorax:** grazes, bruises, sudden breathlessness, often pain, limited diaphragmatic excursion with careful breathing and cyanosis. Weakened respiratory sounds are heard over the lung during auscultation
- **Tension pneumothorax:** see below
- **Haemothorax:** leads to respiratory and haemo-

9.3 Thoracic trauma

- **(Serial) fractures of the ribs:** rib fractures are comparatively rare in children and young people as the rib structure is still elastic

The ribs in the middle of the rib cage are most likely to fracture (6-9). In general, ribs 1-3 are not prone to fracturing because they are anatomically protected; ribs 11 and 12 rarely fracture because of their flexibility. However, when they do fracture, complications in the form of injuries to the neighbouring blood vessels and nerves and penetration of the neighbouring organs are highly likely

The clinical symptoms are breathlessness, fracture pain, especially when breathing and coughing, thoracic compression pain, local pressure pain, possibly also a palpable step. Paradoxical breathing, crepitation, tachypnoea and cyanosis all indicate serial fractures. Skin emphysema, pneumothorax, haemothorax and lung contusions may develop in consequence. The thoracic wall may be unstable in cases of serial or compound rib fracture. Air trapping and accompanying lung contusions (possibly haemothorax) quickly lead to respiratory insufficiency with consecutive hypoxia. Where the thorax is unstable, there will be paradoxical breathing with respiratory insufficiency

- **Lung contusion:** bruises may indicate lung contusions
- **Myocardial contusion:** myocardial contusions may produce symptoms such as rhythmic disturbances (arrhythmia, blocks) and ECG anomalies (ST segment changes). Ventricular function may be disrupted and valves may be torn
- **Ruptured aorta:** if there is a difference in the blood pressure measurements from each of the patients arms, his aorta may have ruptured as a result of a blunt thoracic trauma
- **Severe contusions** without fractures are common due to the great elasticity particularly of the juvenile thorax, as it can absorb considerable deformation particularly in a sagittal direction

Open injuries

- **Tension pneumothorax:** increasing respiratory distress, cyanosis, chest pain and progressive shock symptoms, displacement of the trachea
- **Ruptured blood vessels:** may cause haemothorax and progressive shock symptoms

Diagnosis

- **Pneumothorax and tension pneumothorax:** are diagnosed in hospital using imaging techniques (chest x-ray); a preclinical diagnosis is made by evaluating the symptoms
- **Haemothorax:** preclinical diagnosis is difficult, as hyporesonant percussion notes and weak respiratory noises cannot always be used to establish a diagnosis. A diagnosis is frequently only made when progressive hypovolaemic shock sets in due to massive intrathoracic bleeding
- **(Serial) rib fractures** rib fractures are diagnosed using imaging techniques (chest x-ray). Other intrathoracic injuries can be ruled out at the same time. However, negative x-ray findings do not rule out the possibility of a fractured rib
- **Lung contusion:** x-rays will show diffuse shadows in the lungs; a bronchoscopy will find blood in the bronchial system and a blood gas analysis will reveal arterial hypoxia
- **Myocardial contusion:** the diagnosis is made by electrocardiography, which will show cardiac arrhythmia and ST segment changes
- **Ruptured aorta:** diagnosed with chest x-rays (may show shadows and expansion of the mediastinum) and retrograde aortography using the Seidinger method (retrograde catheterisation). Preclinically, a ruptured aorta must be feared if there is a difference in the blood pressure measurements obtained from each arm

Homeopathic treatment

Symptom selection

Therapy is difficult, not least because only very little experience has been gained in the homeopathic treatment of this serious type of injury. It is therefore advisable to give special consideration to the remedies described in this chapter. As with any standard homeopathic

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patients objective and subjective symptoms; however, years of specific homeopathic experience are frequently necessary to treat such cases effectively.

Repertorisation

chapter 9 (p. 224) Repertorisation - thoracic trauma.

Case 9.3-1: Severe thoracic bruising

Martin Bündner

Anamnesis

The patient is sent to hospital by her family doctor. Two days earlier, she fell and landed heavily on her ribcage. The pain is still getting worse. It is located on the left side and gets worse on touch and when moving, breathing deeply and coughing. The thoracic excursion is almost completely absent because of the pain.

Diagnosis

Thoracic bruising.

Diagnostic procedures

X-ray of bones in left hemithorax in 2 planes: rib fracture ruled out.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Chest - pain - sore - motion, on (aggravated)

Chest - pain - sore - touch

Differentiation between important remedies

chapter 9 (p. 226) Differentiation between important remedies.

Differentiation between remedies

Repertorisation of the symptoms leads to *Ranunculus bulbosus*. *Arnica* and *Senega* should also be considered. *Senega* has the chest pain which gets worse when breathing in, but not when breathing (in) deeply, and is therefore not the first choice. *Arnica* is not listed in all of these rubrics. The remedy *Ranunculus bulbosus* is chosen.

Prescription

1 dose of 2 globules *Ranunculus bulbosus* 30(1)

Progress

The patient reports that the pain subsided considerably about three hours after taking the remedy. The thoracic excursion is fully restored. The pain disappears almost completely over the next two days. The patient is discharged from hospital.

Evaluation

The right homeopathic remedy can not only ease pain effectively, it can also significantly accelerate the healing process.

Critical commentary

Arnica is the main remedy for bruises. but is relegated to

9.4 Craniocerebral trauma (CCT)

Definition

Craniocerebral trauma is a collective term for closed or open skull injuries (with perforation of the dura mater, and when the skull is fractured) involving the brain

It is classified according to the severity of the head injury, which in turn is evaluated according to the length of time for which the patient was unconscious following the accident; this allows conclusions to be drawn concerning the prognosis of the CCT. The mildest form of CCT is bruising with no loss of consciousness. More severe types of CCT are classified according to how long the patient was unconscious (table 9.4-1).

9.4 Craniocerebral trauma (CCT)

Tab. 9.4-1: Classification of craniocerebral trauma	
Degree	Symptoms involving consciousness
1 st degree CCT	Loss of consciousness for up to 30 min. (Comotio cerebri)
2 nd degree CCT	Loss of consciousness for up to 1 h
3 rd degree CCT	Longer period of unconsciousness (contusio cerebri)

- **Comotio cerebri (concussion)** in the sense of a functional disorder with no morphologically comprehensible correlate is generally viewed as reversible brain damage of traumatic origin
- **Contusio cerebri (cerebral contusion)** is a form of closed craniocerebral trauma without perforation of the dura mater. Petechiae, torn intracerebral blood vessels and (multiple) tissue damage (so-called cortical contusions, particularly in the frontal brain, temporal and occipital lobes) may appear at the site of the trauma
- **Compressio cerebri (cerebral compression)** is caused by pressure on the brain, mainly when the intracranial pressure rises, less often as a direct consequence of trauma

Cerebral bleeding

- **Subdural bleeding:** venous bleeding between two meninges, the dura mater and the arachnoid mater. It mainly occurs as a result of skull injuries (particularly contusio cerebri) or when the tentorium is torn during birth (birth trauma). If the bleeding is more severe, the pressure in the brain increases, leading to unconsciousness (or foetal asphyxia) after a symptom-free period. If the bleeding is milder, it becomes a “chronic subdural haematoma” with symptoms of pachymeningitis haemorrhagica interna
- **Epidural bleeding:** arterial haematoma between the dura mater and skull, usually in the temples; caused by bleeding from the arteria meningea media as a result of damage to the skull. Usually leads to compressio cerebri within 12 hours, with or without a symptom-free interval

- **Subarachnoid bleeding:** bleeding into the subarachnoid space, usually from a ruptured aneurysm, also from angiomas or as the result of cerebral arteriosclerosis caused by high blood pressure. Also associated with anticoagulant treatment, blood diseases, haemorrhagic leu- coencephalitis, subacute bacterial endocarditis, septicaemia, various tumours and skull injuries. Commonly leads to the formation of an intracerebral haematoma. The symptoms almost always manifest without warning

Babies and toddlers have a soft, elastic skull. **Craniocerebral traumas in children** are therefore different from those suffered by adults, as blows can be cushioned by skull deformation. However, the pressure and shearing force exerted on the child’s brain are correspondingly greater. Children are most likely to suffer from generalised brain swelling and subarachnoid bleeding as a direct consequence of trauma; intracerebral, subdural and epidural bleeding are comparatively rare, as are contusions.

Clinical information

Incidence and mortality

It is estimated that there are 200 000-1 000 000 CCT cases each year in Germany alone; most of these are first-degree CCT. 50% of patients with first-degree CCT are intoxicated, mostly with alcohol. About 30 000 people suffer severe CCT every year. One in three of these patients dies; another 15% survive with extremely severe disabilities and become dependent on nursing care. In small children, CCT is most commonly caused by falls (e.g. from the nappy-changing table), in older children by traffic accidents.

Symptoms

The general symptoms and indicators of craniocerebral trauma are:

- Headache, nausea, vomiting
- Bruises, haematomas or fractures of the skull
- Taut fontanelles in babies
- Blood and/or liquid flowing from the nose, ear or mouth

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- Difference in pupil sizes
- Irregular breathing or breathlessness
- Bradycardia
- Convulsions, neurological deficits
- Somnolence, unconsciousness

Symptoms of each clinical category:

- **Commotio cerebri (concussion):** retrograde and possibly anterograde amnesia, loss of consciousness lasting for minutes or hours, transitory psychotic syndrome, headaches, dizziness, nausea and vomiting, in some cases temporarily impaired brain function
- **Contusio cerebri (cerebral contusion):** loss of consciousness (coma), focal disorders of the brain, rigid pupils, impaired breathing and temperature regulation ("central" fever), brain oedema with signs of rising intracranial pressure; severe contusio cerebri may lead to a persistent vegetative state (apallic syndrome). Subdural haematoma, hydrocephalus, post-traumatic impairment of the brain function or epilepsy may occur at a later stage

Diagnostic procedures

- **Commotio cerebri (concussion):** general changes depicted in EEG; x-rays to rule out the possibility of skull fracture; a cranial computed tomography may be performed in severe cases
- **Contusio cerebri (cerebral contusion):** the following measures are taken: EEG to depict general changes and retardation of the basic rhythm, lumbar puncture to establish the presence of erythrocytes in the cerebrospinal liquor; cranial computed tomography to find bleeding and brain oedema

Therapeutic crisis

Contrary to conventional teachings, it has repeatedly been shown in practice that even severe cerebral contusions can cause major, sustained damage and impaired function.

The high mortality rates and the large number of patients who suffer (severe) disabilities after the injury show that permanent brain damage from

Tab. 9.4-2: Glasgow Coma Scale		
Reactions and motor symptoms		Points
Eye movements		
Opens eyes	Spontaneously	4
	In response to voice	3
	In response to painful stimuli	2
	Does not open eyes	1
Motor response		
In response to voice	Obeys commands	6
In response to painful stimuli	Localises painful stimuli	5
	Flexion/withdrawal from painful stimuli	4
	Abnormal flexion in response to painful stimuli (decorticate response)	3
	Extension (decerebrate response)	2
	Does not move	1
Verbal responses		
Verbal stimuli	Oriented and answers questions	5
	Disoriented and answers questions	4
	Inappropriate verbal response	3
	Incomprehensible sounds	2
	No verbal response	1
Points total		3-15
Severe CCT		3-8
Moderately severe CCT		9-12
Mild CCT		13-15

CCT must still be feared today, despite intensive clinical and experimental research.

The numerous potential complications (post-traumatic brain oedema, cerebral hyperperfusion syndrome, cerebral compression; high risk of intracranial bleeding in cases of closed CCT, particularly epidural haematoma with the typical symptom-free interval; high risk of infection with open CCT, particularly meningoencephalitis or brain abscess, liquor fistulae, post-traumatic epilepsy or headache.

9.4 Craniocerebral trauma (CCT)

brain function impaired by trauma) show that CCT is still a severe injury which is difficult to control with conventional methods; adjuvant homeopathic treatment can therefore only be beneficial. Experience has shown that homeopathic treatment effectively promotes healing of the direct damage and reduces injury-related mortality rates as well as reducing or curing complications.

Homeopathic treatment

Symptom selection

All objective symptoms such as the state of the pupils, unconsciousness, vomiting etc. caused by the accident are considered when choosing the right homeopathic remedy for treating head injuries.

The modalities and frequent subjective symptoms (e.g. nausea, headache) are often decisive in selecting the remedy.

Repertorisation

chapter 9 (p. 224) Repertorisation - craniocerebral trauma.

Differentiation between important remedies

chapter 9 (p. 226) Differentiation between important remedies

Tab. 9.4-3: Indications for computed tomography	
<i>High risk -> CT essential</i>	• Points lost on the Glasgow Coma Scale (>® tab.9.4-2) • Existing or developing focal neurological deficit • Perforated skull injury or impression fracture
<i>Moderate risk CT recommended</i>	• Temporary loss of points on the Glasgow Coma Scale during or after the accident • Suspected perforated skull injury or impression fracture • Polytrauma • Severe facial injuries • Clinical signs of basal skull fracture • Post-traumatic convulsions • Increasing headache • Alcohol or drug intoxication • Vomiting • Post-traumatic amnesia • Unclear or implausible anamnesia • Age < 2 years
<i>Low risk CT unnecessary</i>	• Patient has no symptoms • Moderate headache, dizziness, scalp haematoma, lacerations and tears/compression wounds of the head

Case 9.4-1: Severe craniocerebral trauma

Farokh Master

Anamnesis

The 22-year-old patient suffers a severe craniocerebral trauma in a traffic accident, leading to a subdural haematoma with severe brain oedema. The patient initially suffers from breathlessness, then agonal gasps requiring controlled respiration; he is cramped and unconscious. The homeopathic case history is taken on the tenth day.

Diagnosis

Diagnostic procedures

Findings on admission

Day 10: intubated patient receiving artificial respiration. Significant hypertension; staring eyes; intermittent, irregular pulse; grinding of the teeth. The patient constantly tries to move the respiration mask.

Cerebral computed tomography: subdural haematoma with signs of severe brain oedema.

Conventional treatment

Treatment in ICU with controlled respiration. Anticonvulsants, antihypertensives, diuretics and

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Homeopathic treatment

Repertorisation

KENT'S REPERTORY Generalities - convulsions - consciousness - without

Face - jaw, clenched

Eyes - staring

Head - cerebral haemorrhage

Generalities - pulse - irregular

Respiration - gasping

Differentiation between remedies

The choice lies between *Aconitum*, *Cuprum metallicum*, *Laurocerasus*, *Mercurius solubilis*, *Opium*, *Phosphorus* and *Stramonium*. The patient's current convulsive condition is best covered by *Cuprum metallicum*, which is why this remedy is selected.

Prescription

3 globules *Cuprum metallicum* CM every 4 hours.

Case 9.4-2: Periorbital haematoma

Michael Frass

Anamnesis

The 60-year-old patient hears strange noises and goes into his garden, where he is suddenly hit in the face several times by a burglar. He has severe pain in the face. A periorbital haematoma forms with swelling. The somewhat stubborn patient refuses further diagnostic procedures.

Diagnosis

Periorbital haematoma.

Homeopathic treatment

Repertorisation

COMPLETE REPERTORY MILLENNIUM

Progress

The patient regains consciousness seven days after commencing the homeopathic treatment; the clinical signs of brain oedema also improve significantly during the first week. After 15 days, he is weaned from the respirator. One week later, the patient is discharged with minor residual symptoms (headache).

Evaluation

Although the prognosis was poor, the patient makes unexpectedly positive progress after being given the homeopathic remedy.

Critical commentary

The result would presumably have been even better if the homeopathic treatment had commenced earlier

double-weighted remedies listed are *Arnica*, *Calcarea carbonica*, *Euphrasia*, *Ledum*, *Rhus toxicodendron*, *Silicea*, *Staphisagria* and *Zincum metallicum*. The choice therefore falls on *Symphytum*.

Prescription

1 dose of 3 globules *Symphytum* 10M.

Progress

Symphytum heals the periorbital haematoma within two days; the swelling and blue discolouration are no longer visible.

Evaluation

Bearing in mind the average time normally required for a periorbital haematoma to heal (about three weeks), the healing process was appreciably accelerated, showing what a profound effect a potentised remedy can have.

Critical commentary

Possible injuries to the bone could not be ruled out

9.5 Abdominal trauma

Case 9.4-3: Commotio cerebri

Martin Bündner

Anamnesis

A six-month-old baby falls down some steep steps when his parents aren't paying attention and hits his head several times. Immediately after the accident, the child is pale, screams and begins to vomit violently.

The parents request homeopathic treatment. Closer observation and queries about further symptoms yield only unsatisfactory results; no other usable symptoms can be established to help choose the remedy.

Diagnosis

Commotio cerebri.

Diagnostic procedures

Apart from the symptoms described, the baby's neurological status is normal.

Conventional treatment

Monitoring

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Differentiation between remedies

The repertorisation process ends with *Arnica*, *Beladonna*, *Hyoscyamus*, *Mercurius solubilis*, *Phosphoricum acidum*, *Rhus toxicodendron*, *Sepia*, *Zincum metallicum*.

Arnica and *Hyoscyamus* have both proven their efficacy in treating concussion. The symptom situation makes further differentiation between these two remedies difficult, as a result of which *Arnica* is chosen as the main remedy for injuries of this type.

Prescription

1 dose of 2 globules *Arnica* 30C.

Progress

Shortly after taking the *Arnica*, the baby calms down and falls asleep. He sleeps deeply and peacefully. When he wakes up, he is fine; he plays and is cheerful as if nothing had ever happened.

Evaluation

Excellent results can also be obtained with the main remedy in cases where a lack of symptoms makes differentiated repertorisation and remedy selection impossible.

Critical commentary

9.5 Abdominal trauma

Definition

An abdominal trauma is an injury to the abdomen which may be **blunt (closed abdominal trauma)** or **perforated (open abdominal trauma)**. Children are particularly prone to abdominal trauma, as the comparatively large parenchymatous abdominal organs are only slightly protected by the thin abdominal wall and are therefore relatively vulnerable to injury. Extreme acceleration/deceleration is the mechanism which most commonly leads to blunt abdominal trauma. It is frequently the result of impact, car seat-belt injuries

Open abdominal trauma is most commonly caused by stab and gunshot wounds.

Clinical information

Incidence and mortality

Most intra-abdominal injuries are caused by blunt trauma. Perforated abdominal trauma is relatively rare in central Europe compared to the USA. 20% of multiple injury patients suffer abdominal injuries; 95% of these are caused by blunt trauma. Additional injuries are present in more than 90% of cases; 60% of patients also suffer thoracic trauma. This may also be a reason why the rate of organ failure is almost twice as high as with

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of trauma, with a correspondingly high mortality rate. Along with craniocerebral trauma, abdominal trauma is a major cause of death in multiple injury patients in the 24 hours following the accident. Nearly half of these fatalities are caused by massive bleeding as a result of abdominal injury, often in combination with pelvic trauma. The solid upper abdominal organs are most frequently affected, the spleen more often than the liver.

Symptoms

Depending on the extent of the injury, the clinical symptoms range from abdominal pain to profound shock in cases of extensive intra-abdominal bleeding.

The main symptoms of abdominal trauma are:

- Hard abdomen
- Bruising
- Grazes
- Circulatory centralisation (shock)
- Pain
- Nausea and vomiting

Diagnosis

The **physical examination** alone (accident mechanism, bruises) can lead to conclusions about the pattern of injury, even if the patient is still compensating for his condition. The critical question of massive, life-threatening abdominal bleeding usually has to remain unanswered at the site of the accident, as diagnosis is usually only possible if the bleeding is extreme. Some rescue helicopters are therefore equipped with mobile sonography devices, allowing them to perform further diagnostic procedures to clarify the issue of intra-abdominal bleeding on site.

Serum amylase must be measured in all patients with epigastric trauma to establish the presence of a pancreatic lesion, although only 70% of patients with blunt pancreatic trauma actually show an increase in amylases and such an increase does not automatically mean that the pancreas has been injured.

Despite being simple, safe and cheap, **diagnostic peritoneal lavage** has not established itself as a diagnostic method, as its specificity is low. However,

lavage is particularly recommended when injury to an abdominal organ seems very likely in view of the nature of the accident and the results of the clinical examination, in cases where ultrasound or CT are inconclusive or unavailable, or when the need for surgery must be clarified quickly in a haemodynamically unstable patient (Broos 2003).

Haematuria is ruled out microscopically in cases of blunt abdominal trauma. An **intravenous pyelo-gram (IVP)** is indicated in cases of microhaematuria following high-speed trauma, falls from great heights or suspected urological lesions (e.g. flank pain, absent spontaneous micturition, accompanying pelvic or spinal injury) or in cases of macrohaematuria irrespective of the clinical signs. If the kidney cannot be depicted, an **angiography** and possibly **duplex sonography** may be required.

Routine diagnostic procedures include a **chest x-ray** to establish the presence of freely circulating air (perforated hollow organs or rib fractures; the spleen may be involved if the fracture is on the left). A shadow only becomes visible in an abdominal x-ray if more than 800 ml of blood has already collected in this area.

However, the most essential diagnostic procedure for closed or open abdominal trauma is **sonography** of the abdomen. **Pregnant women** undergo additional gynaecological testing. If the findings are unclear, the procedure must be repeated six hours later - if the patient's condition allows.

If fluid is found in the abdominal cavity and the patient's circulation is unstable, an emergency laparotomy must be performed immediately without further diagnostic procedures. If the patient is morbidly obese or has skin emphysema, a **computed tomography** of the abdomen can be performed if his circulation is stable; if not, a lavage or an immediate operation should be performed.

Therapeutic crisis

If the patient has massive intra-abdominal bleeding, his life is in danger and he may not reach the clinic alive. If he survives the emergency laparotomy, he may be at risk of further life-threatening complications (e.g. ileus or sepsis, especially in the

9.5 Abdominal trauma

event of perforation) besides the general consequences of the injury (anaemia, weakness etc.). Homeopathic treatment should therefore aim firstly to complement the emergency treatment with the objective of stopping the bleeding if possible, and secondly to minimise the risk of complications and possible consequences of the injury.

Homeopathic treatment

Symptom selection

In cases of abdominal injury, the following symptoms should be considered when choosing the remedy:

Case 9.5-1: Blunt abdominal trauma during pregnancy

Martin Bündner

Anamnesis

The 27-year-old patient is in the 34th week of pregnancy. Until now, the pregnancy had been uneventful except for the baby being in breech position.

After going shopping in the supermarket, the pregnant woman trips over the kerb. She falls hard on her abdomen without being able to break her fall. This is a terrible shock for her.

On consulting the homeopathic doctor one hour later, the child, which had previously moved regularly and often in her womb, is completely still; the mother can still feel no movement. She has no contractions.

Diagnosis

Blunt abdominal trauma during pregnancy. Breech position. Threat of premature birth.

Diagnosis:

Abdominal sonography (in the gynaecological outpatient clinic): breech position. The foetus is still alive. Check-up one hour later: occipito-posterior presentation.

Homeopathic treatment

Repertorisation

- Mechanism of injury
- Findings of clinical examination
- Modalities of abdominal pain (only some of which can be given in the repertory rubrics in this book)

Repertorisation

Chapter 9: Repertorisation - abdominal trauma.

Differentiation between important remedies

Chapter 9: Differentiation between important remedies.

Differentiation between remedies

The combination of rubrics indicates *Aconitum*, *Chamomilla*, *Cimicifuga*, *Gelsemium*, *Ignatia* and *Opium* are also possible choices. However, *Aconitum* is the most important remedy for treating the consequences of shock and has also proven itself in correcting abnormal presentations.

Prescription

1 dose of 2 globules *Aconitum* 200C.

Progress

After taking *Aconitum*, the patient again feels the child move. Nevertheless, she is sent to the gynaecological outpatient clinic of the nearest hospital. She waits for her husband to return, as a result of which the clinical consultation does not take place until six hours after she took the remedy. The child turns while she is still in the clinic.

Evaluation

The progress of this case shows the profound effect of *Aconitum*, which not only prevented a premature birth, but also (to the surprise of all present) caused the child to assume an occipito-posterior position.

Critical commentary

9 Traumatology

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10 Cardiovascular emergencies

Martin Bündner (Conventional Medicine) Martin Bündner, Susanne Holtz-Joos, Susan Waag (Homeopathy)

10.1 Cardiac arrhythmias

10.2 Hypertensive crisis

10.3 Pulmonary embolism

10.4 Acute venous occlusion

10.5 Angina pectoris and myocardial infarction

10.6 Cardiac arrest (resuscitation)

10.1 Cardiac arrhythmias

Definition

Cardiac arrhythmias are defined as deviations in the normal chronological sequence and/or regularity of the heart's activity, mostly caused by excitation disturbances (normotropic or heterotropic) or conduction disorders of the heart; these may also be vegetative in origin.

Cardiac arrhythmias can be acute or chronic.

Clinical information

Cardiac arrhythmias can be classified in different ways. They may for example be defined as supraventricular or ventricular, affecting the circulation or not affecting the circulation, tachycardic or bradycardic.

Symptoms

Supraventricular arrhythmias

- Sinus tachycardia: the heart rate is frequently 100-160/min. Each P wave is followed by a narrow QRS complex
- Supraventricular extrasystoles: the QRS complexes are normal. The supraventricular extrasystoles are followed by post-extrasystolic pauses.

The extrasystoles themselves have deformed P waves

- Paroxysmal supraventricular tachycardia: the heart rate is 160-200/min, the P waves are barely distinguishable
- Atrial tachycardia with atrioventricular 2:1 conduction: only every other QRS complex is conducted
- Pre-excitation syndrome: the PQ interval is short, there may be delta waves and a broad QRS complex
- Atrial flutter: the ECG shows regular, "sawtoothlike" oscillations (P waves which rise rapidly, fall slowly and have no clear isoelectric intervals), 3:1, rarely 1:1 conduction to the ventricles (at a regular frequency of 70-150/min); only 1:5 (1:7) conduction in cases of severe or total blocks, irregular ventricular contractions with changeable blocks
- Atrial fibrillation: "F waves" (instead of P waves) which constantly change in sign, shape and frequency and may barely be distinguishable from the isoelectric baseline. The ventricular excitation is usually irregular, manifesting as absolute tachyarrhythmia or bradyarrhythmia

10 Cardiovascular emergencies

Ventricular arrhythmias

These patients frequently complain of a racing heart, palpitations, hypotension, angina pectoris, in some cases near-syncope.

Cardiac arrhythmias affecting the circulation

- Ventricular tachycardia: characterised by wide QRS complexes lasting more than 0.14 sec., bundle branch block, AV dissociation and combination systoles
- Torsades-de-pointes tachycardia: In this form of ventricular tachycardia, the QRS axis changes constantly
- Ventricular flutter and fibrillation: the ventricular frequency is 250/min. (ventricular flutter) to 400/min. (ventricular fibrillation); the ventricular complexes can no longer be clearly separated

Cardiac arrhythmias not affecting the circulation

Ventricular extrasystoles (VES): the ECG shows a configuration of the QRS complexes similar to that of bundle branch blocks with a compensatory pause.

Bradycardic arrhythmias

- Sinus bradycardia: heart rate < 60/min
- Sick sinus syndrome (sinus node syndrome) is a group of complex, non-ventricular cardiac arrhythmias caused by impaired sinus node functioning, primarily as the result of coronary heart disease

Diagnosis:

ECG

The diagnosis of cardiac arrhythmia is confirmed by ECG. This shows exactly whether the problem is in the atria or the ventricles and how the arrhythmia affects the hearts activity. The ECG constitutes the basis for further treatment and is also used to check progress.

Certain cardiac arrhythmias, e.g. extrasystoles, occur only occasionally and may not be recorded in one single ECG. In such cases, it is advisable to perform a prolonged ECG using a Holter monitor. An exercise ECG may be helpful in classifying certain cardiac arrhythmias (e.g. sinus bradycardia) more precisely.

Echocardiography

Additional information can be obtained from an echocardiography. This facilitates precise observation of the atria, ventricles and valves.

Therapeutic crisis

Along with the subjectively extremely stressful complaints associated with many forms of cardiac arrhythmia, patients with ventricular arrhythmias affecting the circulation are particularly susceptible to ventricular fibrillation, which entails a particularly high risk of sudden death.

Patients with bradycardia are at risk from falls in cardiac output; these reduce blood supplies to the heart, brain and other organs.

Despite the high-quality chemical medication available, these risks cannot be completely eliminated. Deaths from malignant cardiac arrhythmias are still common. Adjuvant homeopathic treatment can help reduce the risk even further.

Homeopathic treatment

Symptom selection

The differential diagnosis obtained from the ECG is not primarily relevant when choosing the correct homeopathic remedy; it only makes statements about the prognosis.

Besides the information gained from palpating the pulse, loss of consciousness, dizziness, chest pain, breathlessness and other subjective complaints are more important in terms of remedy selection.

Repertorisation

KENT'S REPERTORY

Generalities - pulse

- abnormal

Aeon., Agar., Agn., Ambr., Am-c., Am-m., Ant-c., *Ant-t.*, Arg-m., *Arg-n.*, Arn., Ars., Ars-i., Asaf., Asar., Aur., Bar-c., Bell., Bism., Bor., Bov., Bry., Calad., Calc., *Camph.*, Cann-s., Canth., Caps., Carb-an., *Carb-v.*, Carbn-s., Caust., Cham., Chef., *Chin.*, Cic., Cina, Cocc., Colch., Coloc., *Con.*, Croc., Cupr., Dig., Dulc., Ferr., *Gels.*, Glon., Graph., Guai., Hell., *Hep.*, Hyos., Ign., Ip., Iod., *Kali-c.*, Kali-n., Kreos., Lach., *Laur.*, Led., Lyc., Mang., Meny., *Merc.*, *Mez.*, Mosch., Mur-ac., Nat-m., Nit-ac., Nux-m., Nux-v., Olnd., Op., Par., Petr., Phos., Ph-ac., Plat., Plb., Puls., Ran-b., Ran-s., Rheum, Rhod., Rhus-

10.1 Cardiac arrhythmias

KENT'S REPERTORY -

agitated

Ant-t., Iod., *Nux-v.*, Petr.

- audible

Ant-t.

- barely perceptible

Aeon., Am-c., Ant-t, *Apis*, *Ars.*, Bell., Camph., Chin., Crot-h., Dig., Ferr., Gels., Glon., Ham., Hell., *Ip.*, Kali-bi., *Lach.*, *Laur.*, Mang., *Merc.*, *Naja*, Olnd., Op., *Ox-ac.*, Phos., Ph-ac., Plb., *Podo.*, *Puls.*, *Rhus-t.*, Seneg., *Spong.*, *Stram.*, Tab., Then, *Verat.*, Zinc.

- bigeminy

Aeon., Agar., Aml-n., *Apis*, Apoc., Bell., Cycl., Ferr., Gels., Glon., Iber., *Phos.*, Plb., *Stram.*, Zinc.

- bounding

Ars., Benz-ac., Camph., Cann-i., Canth., Chin-s., Eup-per., Glon., Iod., Kali-chl., Lil-t., *Naja*, Plan., Raph.

- contracted (small and hard)

Acet-ac., Aeon., Agar., Ant-t., Arn., *Ars.*, *Asaf.*, Aster., Bell., Bism., Calc., Cann-i., Canth., Cina, Colch., Crot-t., Hyos., Iod., *Kali-bi.*, *Laur.*, Merc-cy., Nit-ac., Op., Ox-ac., Petr., Phos., Plb., Sec., Stann., Sulph-ac., Zinc.

- febrile

Aeon., Alum., *Ars.*, Bell., Bov., Lac-ac., Merc-c., Mez., Plb., Sars., Sec., *Stram.*, Thuj.

- tTuttering

Apis, *Arn.*, *Ars.*, Colch., Crot-h., Gels., Kali-bi., Kali-n., *Nux-v.*, Op., *Phos.*, Ph-ac., Pyrog., Sec., Stann., *Stram.*, Zinc.

- frequent, accelerated, elevated, exalted, fast, innumerable, rapid

Aeon., Aesc., *Aeth.*, *Agar.*, *Ail.*, All-c., Aloe, Alum., Ambr., Am-c., Am-m., Anac., Ant-c., *Ant-t.*, *Apis*, Arg-m., *Arg-n.*, Arn., *Ars.*, *Ars-i.*, *Asaf.*, Asar., Aster., Aur., *Aur-m.*, *Bapt.*, Bar-c., Bar-m., Bell., *Benz-ac.*, Berb., Bism., Bor., Bov., Brom., Bry., Calad., Calc., *Camph.*, Cann-i., *Canth.*, Carb-v., Caust., Cedr., *Cham.*, Chel., Chin., Chin-ar., *Chin-s.*, Chin., Clem., Cocc., Coc-c., Coff., *Colch.*, Coll., Coloc., Con., Crot-c., Crot-t, Cupr., Cycl., Dig., *Echi-a.*, Euph., *Eerr.*, Ferr-i., Ferr-p., Fl-ac., Gels., Glon., Grat., Guai., Ham., *Hell.*, Hep., Hipp., *Hyos.*, *Hyper.*, *Ign.*, Ip., Iod., Kali-bi., Kali-c., Kall-i., Kali-n., Kreos., *Lach.*, *Laur.*, Lob., Lyc., *Lycps.*, *Mane.*, Mang., Merc., Merc-c., Merc-cy., *Mez.*, Mill., *Mosch.*, Mur-ac., *Naja*, Nat-a., *Nat-c.*, Nat-m., *Nat-s.*, Nice., *Nit-ac.*, *Nux-m.*, *Nux-v.*, Olnd., Onos., Op., Osm., Ox-ac., Par., Petr., PheL, Phos., Ph- ac., *Phys.*, Phyt., Pic-ac., *Plat.*, Plb., *Podo.*, *Puls.*, Pyrog., Ran-b., *Ran-s.*, Rheum, Rhod., *Rhus-t.*, *Rhus-v.*, Sabad.,

KENT'S REPERTORY -

full

Aeon., Aloe, Am-c., Ant-t., *Apis*, Arn., Asar., *Bell.*, Cann-L, Chin., Con., Crot-t, Gels., Hyos., Merc-c., Merc-cy., Mill., Op., *Phys.*, Raph., Sabad., Sang., Seneg., *Stram.*

-full

Acet-ac., Aeon., Aesc., *All-c.*, Aloe, Ant-t., *Apis*, Apoc., *Arn.*, *Ars.*, *Ars-i.*, *Asaf.*, Asar., *Bapt.*, Bar-c., Bar-m., Bell., Benz-ac., Berb., Bism., Brom., Bry., Camph., *Canth.*, Cedr., Cham., Chel., *Chin.*, Chin-s., Cimic., Coff., Colch., Coloc., Con., Cor-r., Crot-h., Crot-t., *Cupr.*, Cycl., Daph., Dig., *Dulc.*, *Eup- per.*, Ferr., Ferr-p., Gels., Glon., Ham., Hell., *Hep.*, Hyos., Ign., Iod., Kali-bi., *Kali-c.*, Kali-chl., Kali-i., Kali-n., *Lach.*, *Laur.*, *Led.*, Lyc., *Merc.*, Merc-c., Merc-cy., *Mez.*, Mill., *Mosch.*, Mur- ac., *Naja*, Nat-m., Nit-ac., *Nux-v.*, Olnd., *Op.*, Ox-ac., Par., *Petr.*, PheL, *Phos.*, *Ph-ac.*, Phyt., Plan., Plb., Ran-b., Ran-s., *Rhus-t.*, Sabad., *Sabin.*, Samb., Sang., Sarr., Sars., Seneg., *Sep.*, *Sil.*, *Spig.*, Spong., *Stram.*, Stront., *Sulph.*, Sulph-ac., *Tab.*, Tarent., Tell., Thuj., Valer., *Verat.*, *Verat-v.*, Viol-o., Zinc.

- hard

Aeon., Aesc., *All-c.*, Am-c., Am-m., Ant-c., *Ant-t.*, *Arn.*, *Ars.*, *Ars-i.*, *Asaf.*, Asar., Aster., *Bar-c.*, Bar-m., Bell., *Benz-ac.*, Berb., Bism., Brom., Bry., *Cact.*, Calad., Camph., *Canth.*, Cham., Chel., *Chin.*, Cimic., *Cina*, Cocc., Coff., Colch., Coloc., Con., Cor-r., Cupr., Cycl., Daph., Dig., *Dulc.*, *Ferr.*, Gels., Glon., Ham., Hell., *Hep.*, Hyos., *Ign.*, Iod., Kali-bi., *Kali-c.*, Kali-i., *Kali-n.*, Kreos., Lach., Led., Lyc., *Merc.*, Merc-c., Merc-cy., *Mez.*, *Mosch.*, Mur-ac., Nat-m., *Nit-ac.*, *Nux-v.*, Olnd., Op., Ox-ac., Par., Petr., PheL, *Phos.*, Ph-ac., Phyt., Plb., Ran-b., Ran-s., Sabin., Samb., Squil., Sec., Seneg., *Sep.*, *Sil.*, *Spig.*, Spong., *Stram.*, *Sulph.*, Tab., Tarent., *Ter.*, Valer., *Verat.*, *Verat-v.*, Viol-o., Zinc.

- heavy

Phos., *Stram.*

- imperceptible

Aeon., Agn., Ant-t, *Ars.*, Bell., Benz-ac., Cact, Cann-i., Cann-s., *Canth.*, Carb-v., *Carb-ac.*, Chel., Chin., Cic., Cocc., Colch., Coloc., Crot-h., Cupr., Dulc., Ferr., Guat, Hell., Hyos., *Ip.*, Kalm., Kreos., Lach., *Laur.*, *Merc.*, Merc-c., *Naja*, *Nux-v.*, Op., Ox-ac., Phos., Ph-ac., Plat., Plb., Puls., *Rhus-t.*, Sec., Sil., Stann., *Stram.*, Sulph., Sulph-ac., Tab., *Verat.*, Zinc.

- intermittent

Acet-ac., Aeon., Aeth., *Agar.*, Aloe, Alum., Am-c., Am-m., Ang., *Apis*, *Arg-n.*, *Ars.*, *Asaf.*, *Aur.*, Bell., Benz-ac., Bism., Brom., *Bry.*, *Camph.*, *Canth.*, *Caps.*, *Carb-v.*, Carb-ac., *Cedr.*, Chin., Chin-s., *Cimx.*, Coff., *Colch.*, Con., Conv., *Crot-h.*, Cupr., Daph., Dig., Ferr., Gels., Glon., Grat, *Hep.*, Hyos., Ign., *Iod.*, Kali-bi., Kali-c., Kali-chl., *Kali-i.*, Kali-p., Kalm., Lach., *Laur.*, *Lil-t.*, Lob., *Lycps.*, Merc., Merc-c., Mez., Mur-ac., *Naja*, Nat-ar., Nat-m., *Nit-ac.*, *Nux-m.*, *Nux-v.*, Olnd., Op., Ox-ac., Phos., Ph- ac., Phyt., Plb., *Rhus-t.*, Sabin., *Samb.*, Sec., *Sep.*, *Spig.*, *Stram.*, *Sulph.*, Sulph-ac., *Tab.*, Thea. Thui., *Verat.*, *Verat-v.*, Zinc.

10 Cardiovascular emergencies

KENT'S REPERTORY -

irregular

Aeon., *Agar.*, Agn., Aloe, Alum., Aml-n., Ant-c., Ant-t., Apoc., Arg-m., *Arg-n.*, Arn., Ars., *Ars-i.*, *Asaf.*, *Aspar.*, *Aur.*, Bapt., Bell., Benz-ac., Bism., *Bry.*, *Cact.*, Calc., Camph., Cann-i., Canth., *Caps.*, Carb-an., Carb-v., Carb-ac., Cham., Chel., Chin., *Chin-ar.*, Cimx., *Cimic.*, Coff., *Colch.*, *Con.*, Cor-r., *Crot-h.*, Cupr., Dig., Gels., Glon., Ham., Hell., *Hep.*, Hyos., Ign., Iod., *Kali-bi.*, *Kali-c.*, Kali-chl., *Kali-i.*, Kali-p., *Kalm.*, Lach., Laur., Lob., *Lycps.*, Mang., Meny., *Merc.*, *Merc-c.*, Merc-c., Mez., *Naja.*, Nat-a., Nat-m., Nit-ac., Nux-v., *Olnd.*, *Op.*, Ox-ac., *Phos.*, Ph-ac., Phys., *Phyt.*, *Plan.*, Plb., Pyrog., *Rhus-t.*, Sabad., Sabin., *Samb.*, *Sang.*, Sec., Seneg., *Sep.*, *Sil.*, *Spig.*, *Still.*, Stram., *Sulph.*, Sulph-ac., *Tab.*, Thea, Thuj., Valer., *Verat.*, *Verat.v.*, Zinc

- jerking

Aeon., Aur., Bare., Dulc., Plb.

- nervous

Arg-m., Ars., Colch., Dig., Iod., Kali-bi., Kali-br., Meny., Ox-ac., Stram., Tab.

- slow

Acet-ac., Aeon., Acon-f., Aeth., *Agar.*, Agn., *Amyg.*, Ant-c., *Ant-t.*, Apoc., Arn., Ars., *Asaf.*, *Aspar.*, Bapt., Bell., Benz-ac., Berb., Brom., *Camph.*, Cann-i., *Cann-s.*, Canth., Caps., Caust., Chel., Chin., *Chin-s.*, Cic., Cimic., Colch., Coloc., Con., Crot-h., Cupr., Dig., Dulc., Ferr., Gels., *Glon.*, Ham., Hell., *Hep.*, Hydrac., Hyos., Ign., Iris, Iod., Kali-bi., Kali-c., Kali-chl., Kali-n., *Kalm.*, Kreos., Lach., Lachn., *Laur.*, *Lob.*, *Lycps.*, *Mane.*, Meny., Merc., *Merc-c.*, Merc-cy., Mez., Mosch., Mur-ac., Myric., *Naja.*, Nit-ac., Nux-m., Nux-v., Olnd., Op., Ox-ac., Par., Petr., Phos., Ph-ac., Phys., Phyt., Pic-ac., Plb., Podo., Puls., Rhod., *Rhus-t.*, Ruta, Samb., Sang., Sars., *Squil.*, Sec., Sep., Sil., *Spig.*, Spong., Stram., *Tab.*, Thuj., Valer., *Verat.*, *Verat-v.*, Zinc. - small

Aeon., *Agar.*, Alum., Ant-c., *Ant-t.*, Apis, Arn., Ars., *Ars-i.*, *Asaf.*, *Aur.*, *Aur-m.*, Bar-c., Bar-m., *Bell.*, Benz-ac., Bism., *Bry.*, Calad., Calc., Camph., Cann-i., Cann-s., Canth., Carb-v., Carb-ac., *Cham.*, *Chin.*, Cic., *Cocc.*, *Colch.*, Cond., *Con.*, Cupr., Dig., *Dulc.*, Ferr., Gels., Grat., Guai., *Hell.*, Hyos., Ign., Ip., *Iod.*, Kali-bi., *Kali-c.*, Kali-chl., Kali-i., Kali-n., *Kreos.*, *Lach.*, Lac-ac., Laur., Led., *Lob.*, Lyc., Mang., Meny., *Merc.*, Mere-c., Merc-cy.

- soft

Acet-ac., Aeon., Aesc., Aeth., Agar., Agn., Am-c., Ant-t., Apis, Apoc., Arn., Ars., Aster., *Aur.*, Bapt., Bar-c., Bar-m., Bell., Bism., *Bry.*, Camph., Cann-i., Cann-s., Canth., Carb-v., Carb-ac., Cham., Chin., Cic., Cocc., *Colch.*, Con., Conv., Crot-h., Cupr., Dig., Dulc., Euph., Ferr., Ferr-m., Gels., Guai., Ham., Hell., *Hep.*, Hydr-ac., Hyos., Iod., Ip., Jal., Kali-bi., Kali-br., Kali-c., Kali-chl., Kali-n., *Kalm.*, Kreos., Lach., Lac-ac., Laur., *Lob.*, Lyc., Mang., *Merc.*, Merc-cy., Mez., Mur-ac., *Naja.*, Nat-ar., Nat-m., Nux-v., Olnd., Op., *Ox-ae.*, *Phos.*, Ph-ac., Phys., Phyt., *Plat.*, Plb., Puls., Ran-s., *Rhus-t.*, *Sang.*, Sec., Seneg., Sil., *Spig.*, Stram., Sulph-ac., *Tab.*, Ter.,

KENT'S REPERTORY -

tense

AU-c., Am-c., *Am-m.*, Ant-t., Ars., Bell., Bism., Camph., Cann-i., Canth., Cham., Chin., Clem., Colch., Con., Ferr., Hyos., Kali-i., Mez., Nat-c., Nit-ac., Ox-ac., Petr., Plb., Sabad., Sang., Sec., Verat-v.

- thready

Aeon., Alum., Arn., Ars., Bell., Camph., Canth., Carb-v., Colch., Cupr., Dig., Hell., Hyos., Iod., Kali-bi., *Naja.*, Olnd., Op., Ox-ac., Petr., Phos., Phyt., Plb., *Rhus-t.*, Sulph.

- tremulous

. Aeon., Ambr., Ant-t., Ars., *Bell.*, Calc., Camph., Cann-i., Canth., Carb-ac., *Cic.*, Cina, Cocc., Coc-c., Crot-h., Dig., Gels., Hell., Iod., Kali-c., *Kreos.*, Lach., Merc., *Merc-c.*, Nat-m., Nux-m., Op., Ox-ac., Phos., Plb., *Rhus-t.*, Ruta, *Sabin.*, *Sep.*, *Spig.*, *Staph.*, Stram., Sulph-ac., Valer.

- undulating

Ars., Camph., Crot-h., Dig., Op., Plb.

- weak

Acet-ac., Aeon., Aesc., Aeth., Aloe, Am-m., Ant-t., Apis, Arn., Ars., *Asaf.*, *Aspar.*, Aur., Bapt., Bell., Berb., *Bry.*, Camph., Cann-i., Canth., Carb-an., Carb-v., Cedr., *Chin.*, *Chin-ar.*, Cimx., Cimic., Colch., Crot-h., Crot-t., Cupr., Cycl., Dig., Ferr-m., Gels., *Glon.*, Ham., Hell., Hyos., *Ign.*, Ip., Iris, Iod., *Kali-bi.*, *Kali-br.*, *Kalm.*, Kreos., Lach., Lac-ac., Laur., Lil-t., Lob., *Lycps.*, Mane., Mang., *Merc.*, *Merc-c.*, Merc-cy., Mez., *Mur-ac.*, *Naja.*, Nat-m., Nux-v., Olnd., Op., Ox-ac., *Phos.*, Ph-ac., Phys., Phyt., Plb., Podo., *Puls.*, Rhod., *Rhus-t.*, *Rhus-v.*, *Sang.*, Sec., Seneg., Sep., *Spig.*, Staph., Stram., Sulph-ac., *Tab.*, Verat, *Verat-v.*, Zinc.

- wiry

Ars., Cupr., Dig., Gels., Ham., Kreos., Ox-ac., Phos., Phys., Sec., Zinc

Differentiation between important homeopathic remedies

» **Important remedies:** *Aconitum*, *Arsenicum album*, *Belladonna*, *Digitalis*, *Lachesis*.

Aconitum: palpitations in young, growing and plethoric

Arsenicum album: tense heartbeat. Trembling, irregular cardiac activity. Intermittent heartbeat; somewhat irregular and intermittent pulse in combination with a whistling noise. Palpitations, patient tormented by fear and unable to lie on his back; worse when climbing stairs. Violent palpitations, mostly at night, visible and audible. Palpitations after suppressing herpes or sweat from feet. Heart valve diseases with intermittent pulse, dyspnoea, anasarca (generalised oedema), symptoms worsen in the evening or at night, when climbing stairs, after taking deep breaths or when the patient is angry. Pulse occasionally suppressed with severe palpitations.

Belladonna: violent palpitations with vibration felt up to the throat and head. Severe palpitations which resound in the head.

Digitalis: Subacute heart inflammation with convulsive but incomplete contractions and weak, irregular pulse. Organic heart disease; patient feels as if the heart stops when he moves. Heart is so weak that even changing position or being raised in bed can be fatal. Heart activity accelerates with the slightest movement; better with absolute rest. Strange feeling in the chest, as if the

heart had stopped; isolated, strong, slow heartbeats with sudden, violent heat in the back of the head and temporary loss of consciousness (lasting just a moment). Very weak, irregular heart activity with small, weak and intermittent pulse. Great fatigue, the slightest exertion or movement (even raising the arms) causes the patient to faint; palpitations, cold limbs and body and feeling of threatening weakness in the pit of the stomach, with or without convulsions or loss of consciousness. Sustained pain or distress in the heart area with more or less severe palpitations; pain and palpitations sometimes much worse, especially on exertion or with mood swings; sometimes worse with no recognisable cause when the patient is sitting completely still; attacks accompanied by sinking feeling and purple face; fainting, patient feels like he is going to die; dizziness, ringing in the ears; sharp pain in the left shoulder and arm, tingling in the arm and finger; creeps over the whole skin; sometimes attacks at night, with choking, patient wakes up in terrible fear; terrible dreams.

Lachesis: attacks of choking and fainting, especially when moving; weak, intermittent pulse.

Case 10.1-1: Right ventricular conduction disorder

Martin Bündner

Anamnesis

A mother visits the therapist with her 9-year-old son, who is in very poor condition. He was recently given antibiotics to treat an attack of scarlet fever, and he is now very ill indeed. He breathes in gasps and is frightened of travelling by car and dying. He feels as if his heart would stop.

Diagnoses

Diagnosis

Findings on admission

Lungs clear on auscultation. Urine test normal.

Imaging procedures

Resting ECG: heart rate 69/min., sinus arrhythmia, right ventricular conduction disorder in VI-V3.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Chest - weakness - heart - sensation of - about the

Mind - fear - driving and riding, when*

10 Cardiovascular emergencies

Differentiation between remedies

The remedies *Aurum metallicum* and *Nux mos- chata* remain. In contrast with *Nux moschata*, *Aurum metallicum* is more commonly used for treating complications of scarlet fever and is therefore chosen.

Prescription

1 drop *Aurum metallicum* Q6 diluted in water and taken once a day.

Progress

The next consultation takes place five days after the first dose of *Aurum metallicum*. The boy feels as if he had “bees in his heart which are all stinging [him] at the same time” or as if “a tree trunk is lying on [his] heart”. Sometimes he feels a tickling in his heart, at other times it burns like fire. He thinks he is going to die, then he collapses. He is very weak. His fear of travelling by car has abated to some degree. From this time, the remedy is administered in two dilutions.

At the next consultation one month later, the boy reports that the feelings in his heart subsided quickly after the change of dose; they only come back occasionally in the evening when he is in bed. He is calmer and has no more fears. The treatment with *Aurum metallicum* continues (Q9 and Q12); finally, the remedy is only administered every third day. The ECG performed at this time is back to normal.

Evaluation

The anomalies shown in the ECG quickly return to normal with homeopathic treatment. The symptoms subside quickly.

Critical commentary

Strictly speaking, this is not a complication of scarlet fever (this is why the corresponding rubric is not chosen during the repertorisation process), but the consequence of suppressed scarlet fever, as merely eradicating the bacteria which cause it does not constitute a cure from a homeopathic viewpoint.

Case 10.1-2: Bradycardia

Martin Bündner

Anamnesis

The 42-year-old patient fainted during a car journey one year ago, whereupon she was diagnosed with AV nodal reentrant tachycardia. A slow pathway ablation was performed. Coronary heart disease was ruled out. The patient sought homeopathic treatment for her chronic symptoms. Ten months after the treatment commenced, the patients condition worsens dramatically. Her pulse is 40/min., her blood pressure 90/50 mmHg. She feels very weak and afraid of what is going to happen.

She still has occasional skipped heartbeats despite the homeopathic treatment she has received to date. The patient is once again afraid of driving, fearful that something could happen to her in the car. Her menstrual cycle is shorter than usual

Diagnosis

Bradycardia of unclear origin. Syncope caused by AV nodal reentrant tachycardia, followed by electrophysiological tests without inducing ventricular arrhythmia and a successful slow pathway ablation. CHC ruled out.

Diagnostic procedures

Physical examination.

Conventional treatment

L-thyroxine (e.g. Euthyrox’).

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Differentiation between remedies

The repertorisation procedure finishes with *Digitalis*, *Gelsemium* and *Veratrum album*. *Veratrum album* mentions the short menstrual cycle and is therefore chosen.

Prescription

1 drop *Veratrum album* Q6 once a day.

Progress

The patient quickly feels better after taking *Veratrum album*. Her blood pressure returns to normal, the anxiety disappears, the weakness subsides. When the first bottle is empty, she is prescribed the same dose of *Veratrum album* Q9. A degree of weakness and anxiety reappears

before being taken. When her condition again improves, the patient is given the same dose of *Veratrum album* Q12. Afterwards, the chronic treatment is also concluded as the patient feels well and has no more symptoms.

Evaluation

Veratrum album also had a positive effect on the patients chronic symptoms.

Critical commentary

The menstrual disorder is a chronic symptom which was exacerbated and became acute, which is why this rubric was incorporated into the repertorisation process.

1 0.2 Hypertensive crisis

Definition

A hypertensive crisis (also known as malignant hypertension) is a sudden, sharp rise in systolic and diastolic blood pressure; the patients blood pressure may be normal or elevated in ordinary circumstances. This can be caused by primary (essential) or renovascular/renoparenchymatous hypertension, pre-eclampsia, pheochromocytoma, suddenly stopping antihypertensive medication, hyperthyroidism, neurogenic causes (e.g. paraplegia, tabes dorsalis, intracerebral bleeding) and infections.

Clinical information

Symptoms

- Cerebral symptoms:
 - Headaches
 - Confusion
 - Visual disturbances
 - Somnolence
 - Coma

- Breathlessness.
- Pulmonary oedema
- Cardiac arrhythmias
- Renal symptoms:
 - Oliguria
 - Anuria.

Diagnosis

Hypertensive crises are diagnosed from the patients extremely high blood pressure and other symptoms.

Therapeutic crisis

In rare cases, the hypertensive crisis cannot be brought under control with medication. Homeopathy is another therapeutic option in such cases and can prevent the complications caused by the rise in blood pressure. The extreme rise in blood pressure may affect organ function, particularly in the central nervous system and heart, consequently endangering the patients vital functions. Neurological complications may include brain oedema and papilloedema, intracerebral and subarachnoid bleeding; cardiac symptoms may include pulmonary oedema, cardiac arrhythmias, angina pectoris and even

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formation and/or dissection of an aortic aneurysm has also been observed.

Homeopathic treatment

Symptom selection

The actual blood pressure measurements are not critical for the choice of remedy; instead, the choice should focus on the acute symptoms caused by the hypertensive crisis.

The rubric “high blood pressure” should not be used as the basis for choosing the remedy. The subjective symptoms are a much more reliable basis for selecting the homeopathic remedy; these can vary considerably and are therefore not listed here.

Repertorisation

KENT'S REPERTORY

Generalities - congestion of blood

Aeon., Aesc., *Aloe*, *Alum.*, Ambr., Am-c., Am-m., Ant-c., *Apis*, Arn., Asaf., Aur., Bar-c., Bell., Bor., Bov., Bry., Cact., Calc., Camph., Cann-s., Canth., Carb-an., Carb-v., Carbn-s., Caust., Cham., Chel., Chin., Clem., Cocc., Coff., Colch., Coloc., Con., Conv., Croc., Cupr., Cycl., Dig., Dulc., Ferr., *Ferr-i.*, Ferr-p., Glon., *Graph.*, Guai., Ham., Hell., Hep., Hyos., Ign., Iod., Kali-c., Kali-p., Lach., Laur., Led., Lyc., Mag-c., Mag-m., Mang., Meli., Merc., Mez., Mosch., Nat-c., Nat-m., Nit-ac., Nux-m., Nux-v., Op., Petr., Phos., Ph-ac., Plat., Plb., Psor., Puls., *Ran-b.*, Rhod., *Rhus-t.*, Sabin., Samb., Squil., Sec., Seneg., Sep., Sil., Spig., Spong., Staph., Stram., Sulph., Sulph-ac., Tarax., Thuj., Valer., Verat., Verat-v., Viol-o.

Generalities - heat - flushes of

Acet-ac., Aeon., Aesc., Agn., Ail., *Alumn.*, Alum., Ambr., Am-c., Am-m., Aml-n., Ang., Ant-t., *Apis*, Arn., Ars., *Ars-i.*, Arum-t., Asar., Aur., Bapt., Bar-c., Bell., Berb., Bism., Bor., Bov., Brom., Bry., Bufo, Cact., Calc., Calc-s., Carb-an., Carb-v., Carbn-s., Caust., Cham., Chel., Chin., Chin-s., Cimx., Cocc., Coff., Colch., Coloc., Corn., Croc., Crot-h., Crot-t., Cupr., Dig., *Elaps*, Eup-per., Ferr., Ferr-ar., Ferr-i., Ferr-p., Gamb., Glon., *Graph.*, Helon., Hep., Hura., Hyos., Ign., Ip., Iod., Kali-ac., Kali-bi., Kali-c., Kali-i., Kali-p., Kali-s., Kreos., Lach., Lac-ac., Lob., Lyc., Lyss., Mag-m., Mang., Meny., Merc., Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nit-ac., Nux-v., Olnd., Op., Ox-ac., Petr., Phos., Ph-ac., Plat., Podo., Psor., Puls., Raph., *Rhus-t.*, Rumx., Ruta, Sabad., Sabin., Sang., Seneg., Sep., Sil., Spig., Spong., Stann., Sulph., Sulph-ac., Sumb., Teucr., Thuj., Tub., Valer.,

Generalities - orgasm of blood

Aeon., Aloe, *Alumn.*, Alum., Ambr., Am-c., Am-m., Aml-n., Ant-c., Ant-t., Arg-m., Arg-n., Arn., Ars-i., Asar., Aur., Bar-c., Bell., Berb., Bov., Bry., Calc-ar., Calc., Calc-s., Cann-i., Cann-s., Carb-an., Carb-v., Carbn-s., Caust., Cham., Chin., Cina, Cocc., Coff., Con., Croc., Cupr., Dig., Dulc., Ferr., Ferr-ar., *Ferr-i.*, Ferr-p., Gels., Glon., *Graph.*, Guai., Hep., Hyos., Ign., Iod., Kali-c., Kali-p., Kali-s., Kiss., Kreos., Lach., Lil-t., Lyc., Mag-m., Mang., Meli., Meri., Merc., Mosch., Nat-c., Nat-m., Nat-p., Nit-ac., Nux-m., Nux-v., Op., Petr., Phos., Plb., Puls., Rhod., *Rhus-t.*, Sabad., Sabin., Samb., Sang., Sars., Seneg., Sep., Sil., Spong., Stann., Staph., Stram., Sulph., Tab., Tell., Thuj., Verat

Generalities - plethora

Aeon., Alum., Ambr., Am-c., Arn., Ars., Aur., Bar-c., Bell., Bov., Bry., Calc., Canth., Carb-an., Carb-v., Carbn-s., Caust., Cham., Chel., Chin., Clem., Cocc., Coloc., Con., Croc., Cupr., Dig., Dulc., Ferr., Ferr-ar., Ferr-p., *Graph.*, Guai., Hep., Hyos., Ign., Ip., Iod., Kali-bi., Kali-c., Kali-n., Lach., Led., Lyc., Mag-m., Merc., Mosch., Nat-c., Nat-m., Nit-ac., Nux-v., Op., Petr., Phos., Ph-ac., Puls., Rhod., *Rhus-t.*, Sabin., Sars., Sec., Sei., Seneg., Sep., Sil., Spig., Spong., Stann., Staph., Stram., Stront., Sulph., Thuj., Valer., Verat., Zing.

Differentiation between important homeopathic remedies

Important remedies: *Aconitum*, *Belladonna*, *Calcarea carbonica*, *Dulcamara*, *Glonoinum*, *Nux vomica*, *Sulphur*.

Aconitum: palpitations and fear. Full, strong pulse, more than 100/min., violent symptoms.

Belladonna: rush of blood to the head with pulsating arteries in the head and feeling that the heart is beating inside the head. Extremely violent headache. Headache aggravated by noise, movement, moving the eyes, jarring and touch. Red face.

Calcarea carbonica: rush of blood to the head with heat and stupefying headache; red, swollen face; with toothache.

Dulcamara: congestion up to the head with continuous roaring in the ears and resulting hardness of hearing; from cold feet.

Glonoinum: violent palpitations with pulsating carotid arteries and throbbing headache in the forehead and between the temples. The blood seems to rush to the

10.2 Hypertensive crisis

Nux vomica: dilated head veins with violent pulse in the head; this pulse can be felt throughout the body. Hot, red, swollen face with attacks of dizziness; violent headache particularly in the forehead and above the eyes; aggravated above all by bending and coughing.

Case 10.2-1: Hypertensive crisis with diabetes mellitus

Martin Bündner

Anamnesis

The 37-year-old patient has been an insulindependent diabetic since childhood. Over the last few years, he has developed mild arterial hypertension which is being treated with enalapril (e.g. Enaladex™) and is now well under control. He contacted the therapist in an emergency situation involving acute epistaxis and severe headaches.

On being questioned, he mentioned the following symptoms:

He was aware of throbbing and pulsation in his temples. This had been present in milder form for three days. However, it had now increased dramatically. The headache gets worse when he walks. However, this modality is not very marked. On blowing his nose, he finds that his nose is bleeding. His blood pressure is 170/110 mmHg. His nose is running on both sides; this symptom manifested at the same time.

On being asked several times about unusual occurrences three or four days ago, he finally admits that he had been really angry. Despite being forbidden to play with it, his son had thrown a laptop on the floor and the device was now broken; moreover, his insurance company had refused to reimburse the costs of his wife's surgery.

Diagnoses

Hypertensive crisis, diabetes mellitus type 1.

Diagnosis

Sulphur: heat at the top of the head, cold feet, queasy feeling in the epigastric area.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - anger - ailments after anger, vexation etc.

Head - pain - pulsating

Nose - epistaxis - blowing the nose, from

Coryza - discharge, with (fluent)

Differentiation between remedies

If only the remedies with double or triple weighting are considered, the repertorisation process ends up with *Lachesis*, *Natrium muriaticum*, *Nux vomica* and *Pulsatilla*. All of these remedies help with complaints caused by anger.

The patient's mood indicates *Nux vomica*, which corresponds most closely to this state of irritability and annoyance. *Nux vomica* is famed for its effect in such situations. This remedy is also associated with many different kinds of headache. The other remedies are no more specific with regard to the other symptoms.

Prescription

Nux vomica 6X every quarter of an hour until the patient's condition improves, then once an hour.

Progress

Coincidentally, the patient's wife has a homeopathic home remedy kit containing *Nux vomica* (although only in 6X potency). The patient is therefore advised to take *Nux vomica* 6X every quarter of an hour until he feels better, and then to take it once an hour. The patient's blood pressure falls to 150/90 mmHg within the first hour and he starts to feel better. Over the next two days, his

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Evaluation

Even a low potency is able to treat an acute, threatening condition. However, higher or high potencies should be chosen if there is no doubt about the remedy chosen.

Critical commentary

In cases like this with few symptoms, it is advisable only to use the more heavily weighted remedies listed in the relevant rubrics to limit the choice available.

Case 10.2-2: Allergic reaction to hornet sting - hypertensive crisis

Martin Bündner

Anamnesis

The 56-year-old patient is taken to hospital by ambulance with respiratory distress and blood pressure of 190/100 mmHg after a hornet sting.

His face is dark red and he has a severe headache; his temples throb and pulsate. His general condition is very poor. Discrete bronchospasm heard on auscultation. On closer observation, he is also seen to have dilated pupils and red conjunctiva in both eyes.

Diagnoses

Allergic reaction to hornet sting, bronchospasm. Hypertensive crisis.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Skin - stings of insects

Differentiation between remedies

The repertorisation process ends with *Belladonna* and *Sulphur*. The externally perceptible symptoms are typical of *Belladonna*, as is the congestive element of the headache.

Prescription

One dose of 2 globules *Belladonna* 30C.

Progress

Two hours later, the patient's blood pressure, lungs, facial colour and pupil size are back to normal and his headache has subsided. The patient is monitored for one more night to be on the safe side, but is discharged next day after no further complications occur.

Evaluation

The remedy obviously did the patient good.

Critical commentary

Case 10.2-3: Severe hypertensive crisis - imminent apoplexy

Martin Bündner

Anamnesis

The 74-year-old patient requests a house call at 10.30 pm. She has had severe dizziness and a violent headache since 4.30 am; her ears feel "blocked". She is nauseous and has vomited several times. No fever. At times she is so cold that she feels as if she is freezing. The patient is diabetic and also has a history of arterial hypertension:

glimepiride (e.g. Amaryl*), glyceryl trinitrate (e.g. Nitrolingual N-Spray*), irbesartan + HCT (e.g. CoAprovel®) and bisoprolol (e.g. Concor*) for these diseases. Until now, she had coped well with this medication. However, a short time ago she was admitted to hospital with severe angina pectoris. Her blood sugar is currently 43 mg/dl, her blood pressure 260/130 mmHg. Normally her blood pressure is no more than 140/85 mmHg.

It turns out that the patient had already used the Nitrolingual spray several times that morning, but

without improvement. Her usual daily medication also had no effect. She is now given another six sprays, but these do not ease the pain. Her blood pressure falls briefly in response to the Nitrolingual spray, but then immediately rises again.

Considering the duration and intensity of the symptoms and the lack of response to chemical medication, it must be assumed that the patient is about to have a stroke.

The patient objects violently to the ambulance services being alerted; she does not want to go back into hospital. Homeopathic treatment is offered as an alternative.

Queries about the symptoms give the following picture.

- Dizziness: her head is “going round”; it feels as if something is turning round inside her head. The dizziness gets worse when she walks or turns her head back and forth
- The headache feels as if something is rising, particularly when she gets up after sitting down. Her head feels empty
- It feels as if a stone is pressing on the front of her head
- She suffers stabbing pain in the forehead when she breathes deeply. She feels as if her head will burst whenever she takes a deep breath
- It seems as if her head is being squashed from behind and in front
- There is a sensation of heaviness in her ears, as if something were exerting pressure inside them
- Her lower arms feel numb
- Slight breathlessness
- Everything is trembling and fluttering, as if she were cold
- She complains about her poor state of health (her condition is indeed poor)

Diagnoses

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY* _____ KENT'S REPERTORY**

Generalities - breathing, aggravated - deep *

Head - pain - rising from sitting aggravates**

Vertigo - turning - or moving the head**

Vertigo - walking - while, aggravated**

Mind (mood) - lamenting, bemoaning, bewailing**

Differentiation between remedies

Belladonna is the only remedy present in all rubrics; it even has double weighting in each case.

The repertory does not mention *Pulsatilla* or *SUP cea* in the rubric “Vertigo - turning - moving the head”. The cerebral congestion and violence of the symptoms also speak for *Belladonna*.

Prescription

Initially 10 drops *Belladonna* Q6 every 5 minutes.

Progress

The first blood pressure measurement is taken about five minutes after the first dose of *Belladonna*. Her blood pressure has fallen to 180/120 mmHg. The subjective symptoms are unchanged. Immediately after the second dose of *Belladonna*, her blood pressure sinks to 170/110 mmHg. She is given repeat doses of *Belladonna*, which however do not reduce her blood pressure any further. The dizziness improved quickly and has now disappeared, and the headache is slowly subsiding.

As the immediate threat is now removed and the patient is progressing well, the following procedure is decided upon: the patient is to take *Belladonna* regularly every 15 minutes for as long as she is awake. Her sleep should not be disrupted by the remedy. If she gets worse, she should contact the therapist again. Another house visit is

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Next morning, the patient still has no dizziness. The headache is generally better; the feeling of a “stone pressing on the forehead” is still present but milder.

She took the *Belladonna* until 3 am. Against her expectations, the patient was able to sleep a little. In normal circumstances, she sometimes falls asleep at 6 am; otherwise she lies awake. The patient had to vomit in the night when she had to exert herself. The nausea is unchanged.

After the break at 3 am, her blood pressure rose to 200/100 mmHg, which is still moderate compared to the measurements on previous days.

Because her blood pressure is still too high and the subjective symptoms have not yet disappeared, the patient is requested to take *Belladonna* once an hour.

The patient sleeps from 12 noon until 3 pm. Afterwards, the headache is almost gone, her blood pressure has fallen (165/90 mmHg) and the nausea has subsided. She continues taking the *Belladonna* once an hour. By evening, the patient has no more subjective symptoms. The patient's blood

pressure has fallen to the values which are normal for her.

Evaluation

Conventionally, the patient would have been monitored in ICU and her blood pressure “regulated” with antihypertensives.

Critical commentary

The slow progress made by the patient despite the administration of the matching remedy indicates that her condition would have worsened. Besides evaluating the correct remedy, great patience was required from the patient and physician to allow her condition to improve in its own time.

The Kent repertory does not contain any adequate rubric for symptoms which worsen when breathing deeply, either in the chapter “Head, pain” or in the general chapter on generalities. The Complete Zandvoort gives *Belladonna* double weighting under the rubric “Generalities - breathing, aggravated - deep” besides mentioning many other remedies.

10.3 Pulmonary embolism

Definition

Pulmonary embolism is a thromboembolic occlusion of the pulmonary blood vessels caused by a thrombus (in rare cases also by air, pieces of parenchyma or fats) washed in from the periphery, usually from the veins which flow into the inferior vena cava. The aetiology of pulmonary embolism also includes phlebothrombosis.

*** Note: pulmonary embolism is one of the most dangerous complications which can arise after surgery or childbirth.**

Clinical information

Incidence and mortality

The mortality rate immediately after a pulmonary embolism is high - between 45% and 90% in the two

Symptoms

The clinical picture largely depends on the size of the displaced thrombus. Massive pulmonary embolism (occluding more than half of the lung's circulatory system, occurs in 5-10% of all cases) usually manifests with all the symptoms including a feeling of being in danger, mortal fear, sudden breathlessness, tachypnoea, hypoxaemia, cyanosis, thoracic pain (related to breathing), congested jugular veins in cases of right heart insufficiency and dilation, tachycardia, hypotension, syncope and possibly shock. Pre-existing pulmonary and cardiac diseases modify the clinical picture. Sudden dyspnoea is often one of the earliest symptoms. Breathing-related thoracic pain and coughing (possibly with haemoptysis) are primarily symptoms of pulmonary infarction and are therefore more likely to occur at a later stage.

Diagnosis

Physical examinations do not normally reveal any pathological findings in the lungs.

A split second heart sound is often heard on auscultation together with an accentuated pulmonic sound and a gallop rhythm; congested jugular veins and an enlarged liver may also be found.

ECG tests frequently show S_1Q_{III} changes indicating excess strain on the right heart (acute cor pulmonale); however, the variability of these means they cannot be used as confirmation.

Chest x-rays may show diaphragmatic elevation and flat atelectasis; in cases of massive pulmonary embolism, the pulmonary arteries may be dilated and increased transparency may indicate non-perfused areas in the perfused blood vessels.

Pulmonary scintigraphy and in certain cases pulmonary arteriography are particularly valuable for diagnostic purposes.

In terms of differential diagnosis, it is important to rule out diseases with similar symptoms such as angina pectoris, acute myocardial infarction, pleuritis, pneumothorax and dissecting aortic aneurysm.

Therapeutic crisis

Even today, the high mortality rates in the early stages of fulminant pulmonary embolism are a problem which cannot be satisfactorily solved by therapy. Adjuvant homeopathic treatment is an option for improving the results of allopathic therapy.

Homeopathic treatment

Symptom selection

Phlebothrombosis as the cause of pulmonary embolism is not the primary focus when treating acute pulmonary embolism with homeopathy. This must be treated once the crisis is overcome.

The symptoms of the disease and the modalities of the pathognomonic symptoms are particularly important for selecting the remedy.

Repertorisation

KENT'S REPERTORY

Chest - embolism

Crot-h., Lach., Naja.

Respiration - deep - desire to breathe deeply

Acet-ac., Aeon., Agar., Alumn., Alum., Am-br., Aur., Bapt., Bor., Brom., Bry., Cact., Calc., *Calc-p.*, Caps., Carb-v., Carb-ac., Card-m., Caust., Cedr., Chin., Cimx., Coca, Cocc., Crot-t. Cupr., Dig., Euon., Eup-per., Glon., Hydr., *Hydr-ac.*, Ign., Ind., Kali-c., Kreos., Lach., Lact, Lil-t., Lyc, Merc., Mez., Mosch., Nat-s., Nux-m., Op., Par., Phos., Plan., Podo., Poth., Prun., Ran-b., Samb., Sang., SeL, Seneg., Sep., Stann., Stram., Sulph., Ther., Verb., Xan.

Respiration - deep - impossible

Alumn., Ant-c., Ars., Aur., Bry., Calc-p., Cocc., Crot-t., Dig., Euphr., Ferr., Lach., Lob., Morph., Plat., Stann., Sulph.

Respiration - difficult

. Abies-n., Abrot., Absin., Acet-ac., Aeon., Aesc., Aeth., Agar., Agn., Ail., All-s., Aloe, Alumn., Alum., Ambr., Am-c., Am-m., Anac., Ant-a., Ant-c., Ant-t., Apis, Apoc., Aral., Arg-m., Arg-n., Arn., Ars., Ars-i., Arum-t., Arund., Asaf., Asar., Asc-t., Aspar., Astac., Aur., Aur-m., Aur-m-n., Aur-s., Bad., Bar-c., Bar-m., Bell., Benz-ac., Bism., Blatta, Bor., Bov., Brom., Bry., Bufo, Cact., Cain., Calad., Calc-ar., Calc., Calc-f, Calc-p., Calc-s., Camph., Cann-i., Cann-s., Canth., Caps., Carb-an., Carb-v., Carb-ac., Carb-o., Carbn-s., Carl., Cast, Caust., Cedr., Cench., Cham., Chel., Chen-a., Chin., Chin-ar., Chin-s., Chlol., Chlor., Cic., Cimx., Cimic., Cina, Cist., Coca, Cocc., Coc-c., Coff., Colch., Coll., Coloc., Con., Cop., Cor-r., Croc., Crot-c., Crot-h., Crot-t., Cub., Cupr., Cupr-ar., Cupr-s., Cur., Cycl., Dig., Dire., Dros., Dulc., Equis., Ery-a., Eup-per., Euph., Euphr., Ferr., Ferr-ar., Ferr-i., Ferr-p., Fl-ac., Gels., Gins., Glon., Graph., Grin., Guai., Ham., Hell., Hep., Hippoz., Hura, Hydr., Hydr-c., Hydr-ac., Hyos., Hyper., Ign., Indg., Ip., Iris, Jab., Jatr., Iod., Jug-c., Kali-ar., Kali-bi., Kali-c., Kali-chl., Kali-i., Kali-n., Kali-p., Kali-s., Kalm., Kreos., Lac-c., Lach., Lact., Lat-m., Laur., Led., Lil-t., Lith., Lob., Lyc., Lycps., Lyss., Mag-c., Mag-m., Mag-s., Mane., Mang., Med., Meli., Meny, Meph., Meri., Merc., Mere-c., Merc-s., Mez., Morph., Mosch., Murx., Mur-ac., Mygal., Naja, Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nice., Nux-m., Nux-v., Oena., Ol-j., Osm., Ox-ac., Par., Petr., PheL, Ph-ac., Phys., Phyt., Plat., Plb., Prun., Psor., Ptel., Puls., Ran-b., Raph., Rat., Rheum, Rhod., Rumx., Ruta, Sabad., Sabin., Sang., Sarr., Sars., Squil., Sec., SeL, Sep., Sil., Spig., Spong., Stann., Stram., Stry., Sulph., Sulph-ac., Tarent., Tax., Ter., Thuji., Tub., Verat., Verat-v., Vesp., Viol-o., Zinc., Zing.

Respiration - gasping

Acet-ac., Aeon., Am-c., Ant-t., Apis, Apoc., Arg-n., Ars., Ars-h., Brom., Camph., Canth., Carb-an., Cast, Chlor., Cic., Coff., Colch., Coloc., Cub., Cupr., Dig., Dros., Gels., Hell., Hydr-c., Hydr-ac., Hyper., Ip., Lat-m., Laur., Lyc., Med., Merc., Mosch., Naja, Op., Phos., Phyt., Puls., Samb., Spong., Stram., Stry., Tab., Tarent., Thuji.

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KENT'S REPERTORY

Skin - discolouration - bluish

Aeon., Aeth., Ail., Am-c., Ant-t., Apis, Arg-n., Arn., Ars., Aur., Bapt., Bell., Bism., Brom., Bry., Bufo, Cadm., Calc., Camph., Carb-an., Carb-v., Carbn-s., Chin., Chin-ar., Coca, Cocc., Con., Cop., Crot-c, Crot-h., Cupr., Cur., Dig., Gels., Hydr-ac., Kali-br., Lach., Laur., Led., Merc., Mur-ac., Naja, Nat-m., Nux-m., Nux-v., Op., Ox-ac., Phos., Ph-ac., Phyt., Plb., Puls., Rhus-t., Samb., Sec., Sil., Spong., Stram., Syph., Parent., Thuj., Verat., Verat-v., Vip.

Cough - breathing - deep, aggravated

Aeon., Aesc., Am-c., Am-m., Apis, Arn., Ars., Asar., Bell., Bism., Brom., Bry., Carb-an., Chin., Chin-ar., Cina, Coc-c., Con., Cor-r., Crot-h., Cupr., Dig., Dros., Dulc., Euphr., Ferr., Ferr-ar., Ferr-p., Graph., Hep., Ip., Iod., Kali-ar., Kali-bi., Kali-c., Kali-p., Lac-c., Lach., Lee., Lyc., Mag-m., Mang., Meny., Merc., Mez., Mur-ac., Naja, Nat-ar., Nat-m., Nit-ac., Phos., Ph-ac., Plb., Puls., Rhus-t., Rumx., Sabad., Samb., Squil., Seneg., Sep., Serp., Sil., Stann., Stram., Sulph., Zinc., Ziz.

Cough - inspiration

Aeon., Apis, Asaf., Asar., Bell., Benz-ac., Brom., Calc., Camph., Chlor., Cina, Coff., Con., Cor-r., Croc., Dig., Dulc., Graph., Hep., Ip., Kali-bi., Lach., Mag-m., Ment-pip., Meny., Meph., Merc-i-f., Nat-s., Olnd., Op., Plb., Prun., Puls., Rumx., Squil., Stict., Ter., Verb.

Differentiation between important homeopathic remedies

Important remedies: *Arsenicum album*, *Calcarea carbonica*, *Echinacea*, *Kalium iodatum*, *Lachesis*, *Secale cornutum*.

Arsenicum album: unable to lie down, afraid of choking. The airways feel tight. Breathlessness > around midnight. Burning in the chest. Cough < after midnight. < lying on the back. Stabbing pain throughout the upper third of the right lung. Wheezing.

Calcarea carbonica: extreme breathlessness. Attacks of choking. Constriction, burning and soreness in the chest, < climbing stairs or the slightest incline, has to sit down. Stabbing pain in the chest from the front to the back. The chest is extremely sensitive to touch, percussion or pressure. Desire for fresh air.

Echinacea: pain as if from a lump in the chest and below the sternum. Pain in the chest muscles.

Kalium iodatum: violent cough < in the mornings. Wakes up choking. Stabbing pain through the lungs to the back. Breathlessness when climbing, with heart pain.

Lachesis: sensation of choking and strangling when lying down, particularly when the patient has something around his throat. Feeling of needing to take a deep breath. Agonising cramp in the precordial area. Dry, tickly cough; attacks of choking.

Secale cornutum: breathlessness and constriction with cramp in the diaphragm. Boring pain in the chest. Precordial sensitivity. Palpitations and contracted, irregular pulse.

Case 10.3-1: Exclusion of pulmonary embolism

Martin Bündner

Anamnesis

While urinating, the 34-year-old patient feels sudden pain under both costal arches; she breaks into a sweat, is chilly and feels as if she is about to faint. Her family doctor sends her to hospital due to a suspected pulmonary embolism and a severe flu- like infection. The patient is a smoker and takes the contraceptive pill. On the way into hospital, she becomes nauseous. On being admitted as an

inpatient at 4.20 am on day 1, she is suffering from constant, breathing-related pain in the right costal arch.

She has had a flu-like infection for several days and has been taking antimicrobial medication to treat it for two days. Over the last few days, she has been taking paracetamol (e.g. Panadol®) and acetylsalicylic acid (e.g. Aspirin*) to treat severe headaches. She has been sweating in the night for two nights. The patient has been feeling tired in the mornings for years; she also frequently suffers from nausea. She often has pain on the right side of her chest and upper abdomen, but never as severe as now. She is

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no longer able to differentiate these earlier pains with any precision.

Further symptoms:

- When taking the case history, she complains of a feeling of inner restlessness
 - The symptoms began with severe headaches directly above the eyes which began when moving her eyes
 - She also had a sore throat, which made it extremely difficult for her to swallow. This was the case with everything she swallowed (saliva, food, drink). These symptoms have since disappeared
 - She has severe, stabbing pain in the right hypochondrium which began while she was urinating. However, she can now urinate without pain. The pain then spread throughout the patients abdomen and into her back; she now feels a stabbing pain in the abdomen. She keeps placing her hand over her ribs on the right side. When asked, she says she feels better if she puts her hand on this area. The light touch eases the pain
 - She also has a feeling of heaviness in the area of the right hypochondrium
 - The pain nearly made her faint
 - She feels chills and trembling all over her body
 - She feels dizzy, but this is nothing new
- » She feels tired and lacking in energy
- She has pains everywhere, in her legs, back and hands; they feel as if they had been battered
 - She is very thirsty for water; her mouth is dry
 - She cannot lie on her left side because of her heart; this makes breathing more difficult. However, this symptom is not new
 - She is not hungry; her food seems to have no taste

Diagnosis

Exclusion of pulmonary embolism.

Diagnostic procedures

Findings on admission

Overweight patient in debilitated condition. Seems to be suffering greatly. Blood pressure 90/60 mmHg. Extensive intestinal sounds, the entire abdomen is

Laboratory

Day 1: leucocytes 3700/pl. LDH 275 u/l. CRP 9 mg/l. The blood gas analysis shows signs of partial respiratory insufficiency. D dimers normal. Day 2: leucocytes 3000/pl. Blood gas analysis normal.

Imaging procedures

Resting ECG on day 1: heart rate 81/min., sinus rhythm, left axis deviation leading to assumption of left anterior fascicular block, incomplete right bundle branch block No ST segment changes. Day 2; no significant changes from findings on date of admission.

Schellong test (for orthostatic hypotension): normal.

Conventional treatment

Aspirin, paracetamol, antimicrobial treatment before admission, heparin in the clinic.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Touch ameliorated

Sensitivity, painful, sore, pain as if bruised or compressed

Stomach and abdomen, heavy, weight, constriction

Forehead, above the eyes

Differentiation between remedies

Spigelia is the only remedy mentioned in all rubrics, even if only the first three are taken into consideration. These symptoms were not previously known to belong to *Spigelia*. If the right cards have been selected (genius symptoms), and particularly when repertorising a minor remedy, it can however be assumed that the remedy in question will have good results. The decision is therefore made to administer *Spigelia*.

Prescription

- globules *Spigelia* 30C, one dose in the afternoon on day 1.

Progress

Shortly after taking the remedy, the patient reports that

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pain in her abdomen increases, particularly on the left; she is unable to breathe deeply.

On day 2, the patient's current symptoms practically disappear. However, she complains of a throbbing headache on the left side which radiates downwards over her ear. The patient is familiar with this pain from earlier; however, it has never been as strong as now. Drinking coffee always helped. There is also a recurrence of the throat pain on swallowing (irrespective of what is being swallowed) which manifested as an early symptom. On day 3, she is discharged with no symptoms (with regard to all the symptoms which had previously appeared). As the symptoms improve so rapidly, it is no longer deemed necessary to perform an echocardiography or spiral CT.

Evaluation

The patient's progress and reaction to *Spigelia* (recurrence of earlier symptoms and reaction as per Hering's law) shows that the remedy worked deeply and thoroughly; the initial worsening of the symptoms confirmed that the remedy chosen was correct but also indicated that the potency or dose was less than ideal.

Critical commentary

The increase in abdominal pain which appeared after taking the remedy should be considered as an

initial aggravation (even though the pain was now greater on the left side). The feeling of the nose being blocked and the burning pain in the legs were also reactions associated with the initial worsening of the symptoms. In § 157 of the *Organon*, Hahnemann remarks: "[...] yet [the homeopathic remedy] usually, immediately after ingestion - for the first hour, or for the first few hours - causes a kind of slight aggravation (where the dose has been somewhat too large, however, for a considerable number of hours), which has so much resemblance to the original disease that it seems to the patient to be an aggravation of his own disease. But it is, in reality, nothing more than an extremely similar medicinal disease, somewhat exceeding in strength the original affection." There was also a recurrence of the neuralgia familiar to the patient from earlier times. If earlier symptoms reappear and persist although the patient is generally making good progress, this can be seen as an indication that a follow-up remedy may be required. However, the therapist should first wait and see whether these symptoms subside by themselves.

The reappearance of the sore throat suffered by the patient in the early stages of her illness is also a good sign, as it reflects the chronological reversal of the symptoms as per Hering's law.

Case 10.3-2: Suspected pulmonary embolism

Martin Bündner

Anamnesis

At around midday (1 pm), the 18-year-old patient has a sudden attack of chest pain, which persists and seems to be associated with his breathing. As this severe pain does not go away, he goes to the hospital at about 6 pm, where he is admitted as an inpatient with a suspected pulmonary embolism.

The patient describes the chest pain as follows:

- The pain is pulling and stabbing

- The pain started suddenly at around 1 pm while he was resting
- The pain gets worse when bending forward (in a sitting position)
- It also increases when he lies on his back
- He feels worse when he pulls back his shoulders and arms, i.e. when he pushes his chest out

Diagnosis

Suspected pulmonary embolism.

Diagnostic procedures

Findings on admission

10.3 Pulmonary embolism

or percussion. Legs are identical in circumference; there is no direct indication of thrombosis. His temperature is 36.9 °C.

Laboratory findings on admission

Pathological findings: D dimers 0.81 mg/l (normal range < 0.2 mg/l).

Resting ECG on admission

Heart rate 69/min., sinus rhythm, normal axis. Incomplete right bundle branch block.

Conventional treatment

Administration of heparin.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Extending, stretching the limbs aggravated, bending backwards aggravated

Bending forwards aggravated

Lying, on back, aggravated

Time 1 pm

Chest and lungs

Arsenicum album is another possibility. However, the result of the repertorisation process clearly indicates the remedy genius of *Pulsatilla*.

Prescription

1 dose of 2 globules *Pulsatilla* 30C.

Progress

Shortly after taking the remedy, the patient feels much better. He leaves the clinic that same evening against medical advice. He says that he has no more symptoms.

The ECG check-up on the following day shows a normofrequent sinus rhythm and no significant changes from the initial findings. The patient still has no complaints. Nevertheless, he is advised to undergo an echocardiography, an exercise ECG and a Doppler sonography of the leg veins.

Evaluation

The nature of the patient's condition is unclear. Because of the elevated D dimers and the subjective symptoms, it is assumed that he had developed a (small) pulmonary embolism. *Pulsatilla* was able to remedy this situation.

Critical commentary

Unfortunately, nothing is known about the patient's progress or the other test results.

Case 10.3-3: Pulmonary embolism with deep vein thrombosis in the right leg *Martin Bündner*

Anamnesis

The 76-year-old patient is taken to hospital by ambulance and admitted to ICU with massive dyspnoea, anxiety, palpitations and outbreaks of sweating; it is suspected that she has developed a pulmonary embolism.

For two days, she has been complaining of breathlessness on the slightest exertion; however, she has no angina pectoris. She has been suffering from pain in the right thigh for several days. The right leg has been swollen for the last month; it was not possible to confirm the presence of phlebothrombosis.

Because of the tachycardia, she is connected to an intravenous infusion line and treated with metoprolol (e.g. Betaloe*). The patient's anxiety is treated with diazepam (e.g. Valium*), which eases this condition to some degree. She is also given a heparin infusion (e.g. Liquemin").

Questioning and observation of the patient reveal the following symptoms:

- The patient is talkative despite severe breathlessness. This breathlessness became extreme at about 5.30 pm on the day of admission
- Over the last few days, she has also suffered from breathlessness when climbing the stairs
- The lateral region of the right knee is painful when she

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- For one week, she has had no appetite and mild nausea but no vomiting and no other abdominal symptoms
- She generally feels worse when bending over
- Physical exertion also affects her condition adversely
- Her speech is distorted
- It is not completely clear whether she is somewhat confused or whether she has problems with her memory
- She now needs a lot of sleep, which was not the case before

Diagnoses

Pulmonary embolism. Deep vein thrombosis in the right leg. Arterial hypertension. Depression. Osteoporosis. Vertigo. Previous knee replacement surgery due to (presumed) osteoarthritis. Previous hysterectomy. Previous subtotal thyroidectomy. Previous unsuccessful cataract operation in both eyes.

Diagnostic procedures

Findings on admission

Febrile 76-year-old patient in debilitated condition with agitation and general feeling of weakness. Dyspnoea at rest, mild cyanosis of the lips. The skin all over the patients body is warm and damp. Putrid halitosis. Very faint respiratory sounds. No rattling. Tachycardia 120/min; blood pressure 140/80 mmHg. Bloated abdomen, morbid obesity. Extensive intestinal noises. Oedema in both lower legs. Cold extremities.

Laboratory

D dimers 4.40 mg/l (normal range < 0.20 mg/l). Leucocytes 14 000/pl. CRP 36 mg/l. LDH 295 u/l.

Imaging procedures

Resting ECG

Heart rate 121/min., sinus rhythm, left axis deviation. S_{JQ_m} type. S declines then disappears. T wave inversion in V1-V6, later no longer evident.

Echocardiography (day 5)

Mild global dyskinesia and hypokinetic left ventricle. No paradoxical septum movement. No tricuspid valve

Doppler sonography normal. Acute cor pulmonale cannot be confirmed with certainty.

Chest x-ray in recumbent position

Normal.

Doppler sonography of the deep leg veins (day 5)

Thrombosis in the distal third of the femoral and popliteals and the group of veins in the dorsal lower leg. No floating thrombus head. Fresh thrombosis in the right thigh.

Conventional treatment

Diazepam (e.g. Valium*). Heparin (e.g. Liquemin'). Metoprolol (e.g. Betaloe*).

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Respiratory disorders, attacks of choking

Exertion, physical, aggravated

Speech, affected

Agitation

Bending forwards, aggravated

Differentiation between remedies

Bryonia and *Lycopodium* are mentioned on all cards. *Laurocerasus* covers some aspects of this case, but not enough of the symptoms as a whole. Tachycardia is not as characteristic of *Lycopodium* as it is of *Bryonia*. On the other hand, *Lycopodium* has the cyanosis of the lips; however, as this symptom was not apparent on admission and was also not so pronounced at the time the remedy was prescribed, this symptom should not necessarily be decisive for the choice of remedy.

The very warm sweat only features with *Bryonia*. In general, the patient would be expected to be suffering from cold sweats, which means this symptom is indeed unusual. Taking the patients general condition into account, the decision is made to administer *Bryonia*.

Prescription

1 dose of 2 globules *Bryonia* 30C on day 2.

10.4 Acute venous occlusion

clearly and comprehensibly. The rest of the day proceeds well. The patient becomes short of breath on exertion.

On day 3, the patient subjectively feels much worse; she develops dyspnoea on the slightest exertion.

On day 4, the situation changes radically. The patient has recovered so far that she is transferred to a general ward. She no longer has dyspnoea, not even on exertion.

From day 5 on, she receives anticoagulant treatment with phenprocoumon (e.g. Marcumar[®]); this overlaps with the heparin (e.g. Liquemin[®]) treatment given via the IV drip until day 6. She is mobilised from day 10 on, after the Quick test results return to the therapeutic range. On this day, the patient, who lives alone, is transferred to the geriatric department for further treatment, mobilisation and rehabilitation. Her recovery proceeds with no complications.

1 0.4 Acute venous occlusion

Definition

Acute venous occlusion is caused by intravital, intravascular blood coagulation leading to thrombus formation. In pathoanatomical terms, it is a disease involving inflammation of the vein wall linked with thrombosis formation in the area affected, irrespective of whether the thrombus was formed locally as a result of the phlebitis or whether it formed in another way. Physicians differentiate strictly between thrombophlebitis (thrombosis superficialis), inflammation of the superficial veins, and phlebothrombosis (thrombosis profunda), inflammation of the deep veins. Superficial venous thrombosis occurs almost exclusively with varicose veins and hardly ever causes embolism, while deep venous thrombosis is associated with a higher risk of embolism and the prognosis is less favourable. Thrombosis can be caused by:

- Damage to the vein wall
- Hypercoagulability

Evaluation

The patient responds well to *Bryonia*, as shown by the rapid improvement in her speech. The progress of this case leads to the assumption that the worsening of the dyspnoea on day 3 is not a relapse, but rather an aggravation caused by the homeopathic remedy.

One striking feature of this case is the rapid change between extreme dyspnoea and good general condition, which is not usually observed with this disease and despite the heparin treatment is mainly attributed to the effect of the homeopathic remedy.

Critical commentary

The patient's flow of speech is also unusual in view of the acute dyspnoea. However, as it was initially unclear whether this is a chronic symptom (confirmed retrospectively by the result of the treatment), it was not taken into consideration when choosing the remedy.

Clinical information

Symptoms

Thromboses frequently form when the patient is confined to bed for longer periods. It is a feared complication with a high risk of (pulmonary) embolism. Thromboses often form in the lower extremities. Deep venous thrombosis has fewer symptoms but is associated with a much greater risk of embolism than thrombosis of the superficial veins (* table 10.4-1).

Tab. 10.4-1: Stages of thrombosis	
Day	Development and symptoms
Days 1-3 (5)	Thrombosis starts; stage with the greatest risk of embolism; maximum thrombus mobility
Days 3 (5)-14	Appearance of first clinical symptoms; thrombus mobility reduced.
From day 14	Complete thrombus organisation; no more risk of embolism

Diagnosing thrombosis is often difficult, and not only during the initial phase. About 25% of all thromboses only become manifest when the patient

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develops a fulminant pulmonary embolism, and only about 10% of all pulmonary embolisms found during autopsy are diagnosed clinically.

Local symptoms, painful pressure points, pain and signs of congestion are only uncertain indicators of a thrombosis in the area affected («? table 10.4-2).

General symptoms:

- Elevated heart rate, temperature initially normal or subfebrile
- Signs of inflammation (fever, leucocytosis, accelerated ESR) in cases of thrombophlebitis

The diagnosis can be confirmed by:

- Phlebography
- Fibrinogen uptake test
- Ultrasound

Therapeutic crisis

of complications. Substitutes for heparins (e.g. Refludan") have specific indications and also have disadvantages such as the risk of bleeding and anaphylactic reactions.

The risk of fulminant pulmonary embolism is problematic, as this is a life-threatening complication. Thrombosis patients must be treated in hospital in cases where the leg is massively swollen and the patient has severe concomitant diseases, especially as further diagnostic procedures may be necessary. Outpatient treatment is not possible with unreliable patients or patients who cannot be nursed at home and have no access to medical care.

After five to eight years, 30% of patients will develop varicose veins, their legs will swell, and in the long term they may develop leg ulcers.

Compression treatment is usually necessary for the rest of the patients life, although this is met with only little

Tab. 10.4-2: Indicators of thrombosis	
Signs	Clinical manifestations
Homans' sign	Heaviness and tingling in the legs. Calf pain, particularly on dorsal flexion of the foot
Rossie's sign	Pain on pressing the vein (leg must be relaxed; test performed on both legs for comparison): hypersensitivity of the plantar region
Payds sign	Pain in the sole of the foot in response to pressure and plantar flexion
Deneke's sign	Spontaneous pain in the sole of the foot, without pressure
Bisgaard's sign	Pain on pressure behind the malleolus
Pratt's sign - dilated pretibial veins	Dilated superficial veins on the front of the lower leg, or on the thigh and in the groin if the thrombosis is located high up.
Rieler's sign	Inguinal pain
Louvel's sign	Pain in the leg when coughing
Tschmarke's sign	Pain in the calf and the back of the knee
Ducuing's sign	Ballotement, calf pain
Mayefs pressure points	Pain along the affected vein and the anterior tibial edge
Lowenberg's sign	Pain elicited when pumping up a blood pressure cuff to more than 100 mmHg indicates thrombosis of the lower leg veins; pressure pain in the back of the knee indicates thrombosis of the V. poplitea; pressure pain in the groin indicates thrombosis of the V. femoralis.
Oedema (late symptom)	The circumference of the calves and thighs is measured; any difference between the legs indicates the presence of oedema. The oedema is initially only endofascial; spreading around the lower leg indicates a thrombosis in the lower leg, throughout the leg a femoralis thrombosis, through the buttocks to the iliac crest a pelvic vein thrombosis.
General sign	The leg turns blue when the patient is standing.

The homeopathic treatment of (acute) venous occlusion can help minimise these problems.

Homeopathic treatment

Symptom selection

Acute venous occlusion only rarely manifests with absolutely unambiguous signs, which is why special importance must be attached to the accompanying symptoms when selecting the remedy.

Insofar as they exist at all, possible clinical indicators are poorly represented in the repertories and materiae medicae, which means that attempts to select the right remedy using these criteria are usually unsuccessful.

Repertorisation

_____ KENT'S REPERTORY

Generalities - inflammation - blood vessels

Aeon., *Ant-t.*, Am., Ars., Ars-i., Bar-c., Calc., Cham., *Cupr.*, *Ham.*, *Kali-c.*, Kreos., Lach., Lyc., *Puls.*, Sil., Spig., Sulph., Thuj., Zinc.

_____ SYNTHETIC REPERTORY

Heart & circulation - inflammation - blood vessels - phlebitis

ACON., agar., all-c., ant-c., ant-t., apis, arist-cl., am., ars., bell., both., BRY., bufo, CALC., calc-ar., calc-f, carb-v., carbn-s., cham., chin., chlorpr., crot-h., ferr-p., graph., ham., hecla., hir., hep., iod., kali-c., kali-m., kreos., LACH., led., lyc., lycps., mag-c., mag-f, mere., merc-cy., merc-i-r., nat-s., nux-v., phos., puls., rhod., RHUS-T., ruta, sep., sil., spig., stront-br., stront-c., sulfa., sulph., thiop., thuj., verat., VIP., vip-a., zinc.

Generalities - thrombosis

acetan., ars., apis, both., calc-ar., carb-v., cortico., kali-m., kres., lach., nat-s., sec., vip.

- albuminuria, in calc-ar.
- damp, aggravated nat-s.
- pneumonia, in

Differentiation between important remedies

• **Important remedies:** *Aconitum*, *Allium cepa*, *Apis mellifica*, *Arnica*, *Arsenicum album*, *Belladonna*, *Bryonia*, *Calcarea carbonica*, *Crotalus horridus*, *Hamamelis virginiana*, *Kalium carbonicum*, *Lycopodium*, *Pulsatilla*, *Rhus toxicodendron*, *Sepia*, *Sulphur*.

Aconitum: fever, agitation, patient tosses and turns with no improvement. Hot skin, dry tongue, parchment-like lips, thirst.

Allium cepa: whole leg swells after forceps birth, extremely painful, worse in the thigh. Panaritium of the skin around the fingernails, inflamed and suppurating; the pain extends up the entire arm. Suppuration after stabbing the area under the left thumbnail with a needle; red stripe up to the elbow, where a hazelnut-sized lump forms. The pain drives the patient to despair.

Apis mellifica: restlessness, tossing and turning. Fever without thirst. Scanty, strongly coloured urine. White, transparent swelling with sharp, stabbing pain.

Arnica: early stage, after long, intense contractions, caused by pressure on nerves and blood vessels. The patient feels sore and battered.

Arsenicum album: anxiety and restlessness. Every movement triggers a feeling of exhaustion. Burning thirst for cold water. Constant longing for drinks; drinks often but amounts get smaller. Cold and chilly, wants to be covered. Burning pain; pale, oedematous swelling.

Belladonna: stabbing in the mid thigh as if with a knife, moving more to the back. Pulling pain in the limbs, tearing pain in the joints; cannot bear the slightest jarring or touch. Pulling in the legs, especially the knees. Pain gets better in the night and in the afternoon at about 3 pm or 4pm; worse for the slightest touch and often also movement; some symptoms worsen when the patient is asleep and also appear when he wakes up. Sensation of heaviness in the thighs, pubic region and genitals. Fever with burning thirst and sensory hyperaesthesia. Groaning

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Bryonia: stabbing pain in the thigh, from buttock to ankle, touch and movement unbearable, generalised sweating which does not ameliorate the patients condition. Dragging in the abdomen and down the legs as if the patient is about to start menstruating. Pale pink swelling in the leg. Painful, tense stiffness but no reddening. Dry lips. Thirst with infrequent drinking of large quantities.

Calcarea carbonica: white swelling in the foot and leg with a sensation of coldness, as if the leg were covered with a cold, damp cloth. Milk secretion suppressed with a feeling of coldness throughout the body. Strumous cachexia.

Crotalus horridus: phlegmasia alba dolens; left leg swells to twice its usual circumference; grinding pain in the legs, aggravated by the slightest movement. Weak pulse, sluggish circulation, bluish skin, fainting, general weakness.

Hamamelis virginiana: great pain and swelling in the right leg from the knee to the hip, very sensitive to touch; the superficial veins are hard, swollen, knotted and painful; the abdominal veins become involved at a later stage; erysipelas; pulse 120/min., small and wiry; great thirst; no appetite; constipation; red, scanty urine, later suppressed; kidney pain, worse when moving; great weakness. Tympanitic bloating of the abdomen.

Kalium carbonicum: swollen foot and leg with shooting, stabbing pains. Shooting, stabbing pain in the abdomen, which is bloated with wind. Stitch in the abdomen, upper and lower. Extremely bloated abdomen, particularly after eating. Flatulence with stomach ache. Stabbing or shooting pain in the back, spreading to the buttocks or hips. Agitation, tossing and turning, thirst.

Lycopodium: swelling in the foot and leg, the saphenous vein is very swollen and sensitive; its

path can be precisely traced all the way up. Flatulence with release of small quantities of gas and pressure around the navel; inability to release gas. Severe pain in the back before urinating. Restless tossing and turning, particularly in the evening. **Pulsatilla:** pale swelling in the foot and leg. Suppressed lochia. The milk flow suddenly stops; the lochia appear milky white. Worse in warm rooms, better on moving the leg; patient desires fresh air. Phlegmasia alba dolens; swollen, pale white leg, hard, knotted veins extremely painful to the touch, movement impossible. Stinking, putrid taste in the mouth, particularly after sleep.

Rhus toxicodendron: weakness in the leg from the time the condition begins; the patient cannot raise her leg. A red line following the course of the saphenous vein appears on the leg. Cannot sit still due to inner restlessness; has to rock in all directions and move all limbs while sitting. Symptoms improve when moving the body part affected (i.e. better for sustained movement or changing position but improvement only lasts for a short time). Worse after midnight, from water or wetting the body part affected; patient wants to be covered and kept warm.

Sepia: the disease is associated with chronic metritis. Weakness in the sacroiliac region. Eructation ameliorates the backache; slow walking also improves. Swollen legs and feet, worse when sitting or standing, better when walking.

Sulphur: often flushes of great heat which pass quickly. Strength in arms and legs disappears as if the patient is about to faint; patient is close to losing consciousness. Wakes up often in the night and suddenly becomes wide awake. Mild papular rash on legs and other body parts.

Case 10.4-1: Deep vein thrombosis in the left leg

Martin Bündner

Anamnesis

On day 1, the 73-year-old patient is admitted to hospital as an emergency with a painful swelling in the left thigh. She first noticed this swelling 14 days previously, and was also short of breath.

This breathlessness is clinically interpreted as a small pulmonary embolism.

On day 2, she complains of the following symptoms:

- The right (!) leg is red and patchy
- She has severe pain in the left thigh
- The pain is tearing and stabbing, and extends downwards to the left knee
- The pain in the left leg gets worse when sitting, lying on the left side and particularly on pressure. Cold compresses did not help. The pain also worsens when putting weight on the left leg, letting it hang and even more when raising it
- The pain and swelling improve when lying down and particularly when applying heat to the area
- The left foot is cold, the pulse in the left foot also feels somewhat weaker than the right

Diagnoses

Deep vein thrombosis in the left thigh. Suspected pulmonary embolism prior to admission.

Diagnostic procedures

Findings on admission

73-year-old patient with limited mobility particularly of the left leg caused by pain. The left thigh is extremely swollen, the right red and patchy.

Laboratory

Significantly elevated D dimers.

Imaging procedures

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Becoming cold aggravated, uncovering, aggravated, warm bed, wrapping up ameliorated

Pressure aggravated, lying on painful side, aggravated

Lying, ameliorated

Motion, aggravated, walking aggravated

Downwards, descending

Differentiation between remedies

The only remedy left is *Bryonia*. *Nux vomica*, *Psorinum* and *Silicea* are also possible, but do not have the keynote of pain radiating downwards. The decision is made to treat the patient with *Bryonia alba*.

Prescription

1 dose of 3 globules *Bryonia alba* 30C on day 2.

Progress

During the day, the patient manages to raise her leg with no pain. On day 3, she again has some pain when raising her left leg. She is therefore given another 3 globules of *Bryonia* 30C. Ten minutes after taking the remedy, the leg pain temporarily becomes significantly worse, particularly when the patient raises her leg. Both feet are warm and the pulses feel the same in each foot. The patient has the impression that the circumference of her left thigh has shrunk to some extent, although this is not confirmed when her legs are measured. She is given the customary conventional treatment with phenprocoumon (e.g. Marcumar[®]). There is no indication of another pulmonary embolism. No further homeopathic treatment is necessary in this case.

Evaluation

Bryonia clearly proved its efficacy as a painkiller in this case of phlebothrombosis. However, because of the anticoagulant treatment administered at the same time, it cannot be proved with any certainty that the homeopathic remedy had a direct influence on the clinical picture.

Critical commentary

The situation where the pain worsened after the patient took the remedy on day 3 should be interpreted as an initial aggravation in response to the remedy. The repetition of the dose seemed clearly

justified by the recurrence of the thigh pain when the patient raised her left leg. However, the subsequent reaction may indicate that the first dose had not yet ceased to work and it would have been more beneficial to give the repeat dose at a later time.

1 0.5 Angina pectoris and myocardial infarction

The definition, clinical information, incidence and mortality, symptoms and diagnosis of angina pectoris and myocardial infarction are all discussed in chapters II.3.1 and II.3.2.

Case 10.5-1: Unstable angina pectoris

Martin Bündner

Anamnesis

For the last six days, the 46-year-old patient has been suffering from increasing retrosternal pain which gets dramatically worse as he breathes. He has been unusually tired all week. Since the symptoms began, he has also lost his physical stamina. The chest pain gets worse on turning and particularly when stretching backwards. The pain also increases when he takes a deep breath. He feels as if there is a foreign body, a kind of lump, in his chest. The patient is admitted to hospital at around midday.

He had already suffered a myocardial infarction some years previously, but it was no longer possible to establish the exact date. He is also a heavy smoker (two packets of cigarettes a day) and drinks large amounts of coffee. Ten years previously, the patient suffered a disc prolapse at L5/S1.

Diagnoses

Unstable angina pectoris, cardiovascular risk profile: former myocardial infarction, nicotine abuse, positive family history. Former disc prolapse at L5/S1.

Diagnostic procedures

Findings on admission

Therapeutic crisis

Although a wide range of differentiated conventional treatment is available nowadays, mortality rates in the acute stage are still very high. The rate of recurrence is also very high. Lysis and surgical intervention do not change this fact.

otherwise normal. The thoracic pain is not influenced by pressure on the thorax.

Laboratory

Pathological laboratory findings: Cholesterol 224 mg/dl (5.8 mm/L), D dimers 0.63 mg/l.

Imaging procedures

ECG: heart rate 55/min., sinus rhythm, normotype. No indication of acute myocardial infarction, poor R-wave progression in chest leads VI-V4.

Chest x-ray: emphysematous thorax

Exercise ECG (day 3): heart rate rose from 51-123/min., blood pressure rose from 100/60 mmHg to 160/70 mmHg, duration 90 minutes from 50 to 150 watt, adjustment every 2 minutes. Findings: normal.

Echocardiography (day 3): normal, no newly infarcted area, area of previous infarction cannot be clearly demarcated, no strain on right heart. Colour Doppler sonography also normal.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Stretching, extending limbs aggravated, bending backwards aggravated

Breathing, deeply, aggravated

Weak, dull, lack of strength

10.5 Angina pectoris and myocardial infarction

Differentiation between remedies

The repertorisation process ends with *Kalium carbonicum* and *Sulphur*. The fact that the complaints worsen when the patient turns his upper body is significant for the choice of remedy, as only *Kalium carbonicum* appears in this constellation.

Prescription

1 dose of 2 globules *Kalium carbonicum* 30C (day 1).

Progress

The patient is given *Kalium carbonicum* immediately after being admitted as an inpatient. The thoracic pain subsides to some degree within the first half an hour while the diagnostic procedures are being performed; it is therefore decided that no conventional treatment need be given for the time being. The pain continues to subside during the afternoon. The patient has no more pain after just three hours despite no conventional treatment being given; by evening, he only feels as if there is something in his chest.

Because of the positive progress made by the patient so far, he is given no conventional treatment but an appointment is made for a coronary angiography in another clinic. After taking his medical history, this hospital also evaluates his cardiac situation as unstable.

An elective coronary angiography is performed without complications on day 14. No advanced, circumscribed, haemodynamically significant coronary stenosis was found. The echocardiograph shows that the left ventricle is functioning normally. The ECG shows a normofrequent sinus rhythm, vertical type, no extrasystoles, no repolarisation disorders,

no changes over time. The patient is advised to take acetylsalicylic acid (e.g. ASS 100), but he refuses. The patient is also given an explanation of his individual risk profile and informed of the atherogenic consequences of nicotine consumption.

Evaluation

The patient had formerly been diagnosed with a myocardial infarction. It was not possible to confirm the diagnosis of acute myocardial infarction, so it must be assumed that the patient was suffering from unstable angina pectoris. The heart catheter findings could indicate a vasospastic incident, for example. However, a misdiagnosis is generally held to be relatively unlikely (Remarks). A third alternative could be that with regard to the earlier myocardial infarction, the homeopathic remedy may have triggered “spontaneous thrombolysis” or a correspondingly rapid reversal of any stenosis of the coronary arteries within 14 days; this possibility cannot be ruled out with any certainty.

Critical commentary

In view of the spinal lesion and the modalities (the fact that the chest pain becomes worse when stretching and bending over backwards), the diagnosis of unstable angina pectoris could by all means be queried. However, these modalities repeatedly occur in patients with acute myocardial infarction, which means that pain which worsens when performing certain movements may not necessarily be orthopaedic in origin. The movement modalities could also be caused by muscular tension resulting from the heart problem.

Case 10.5-2: Unstable angina pectoris after myocardial infarction

Martin Bündner

Anamnesis

The 76-year-old patient comes for homeopathic treatment nine days after suffering an acute myocardial infarction of the posterior wall (day 9). She is trembling

is coming up into her throat, which makes it difficult for her to fall asleep. Talking is an extreme effort.

Diagnoses

Unstable angina pectoris after myocardial infarction of the posterior wall and successful recanalisation and stent implantation to treat coronary heart disease with occlusion of the RCA. Arterial hypertension.

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Conventional treatment

Acetylsalicylic acid (e.g. ASS*), bisoprolol (e.g. Concor*), ramipril (e.g. Delix*), clopidogrel (e.g. Plavix*), simvastatin (e.g. Zocor*) and hydrochlorothiazide (e.g. Esidrix').

Homeopathic treatment

Repertorisation _____ KENT'S REPERTORY
Generalities - weakness - tremulous

Generalities - weakness - talking, from

Stomach - pain - extending - throat

Differentiation between remedies

The only remedy left at the conclusion of the repertorisation process is *Alumina*. If the location (the stomach pain extending to the throat) were left out, there would also be *Cocculus*, *Sepia* and *Stannum metallicum*. However, the extreme weakness is an indication for *Alumina*, and the decision is therefore made to administer this remedy.

Prescription

Progress

The weakness and breathlessness subside within a week of taking the *Alumina*. On day 25, the patient undergoes ergometric testing; she has to stop at 25 watt as she develops angina-type symptoms with breathlessness and pressure on the throat. *Alumina* Q9 and Q12 are prescribed. Almost three months after commencing homeopathic treatment, the patient is able to undergo an exercise ECG rising to 50 watt, which is then broken off due to peripheral exhaustion. She no longer has chest pain or breathlessness. *Alumina* is then prescribed in Q18 and Q21 potencies as no other remedy is indicated.

Evaluation

Despite the successful recanalisation and PTCA with stent implantation, the patient only really starts to get better after taking the homeopathic remedy.

Critical commentary

No change was made to the chemical medication. The treatment was not yet finished at the time of going to print

Case 10.5-3: Recurrent angina pectoris with myocardial ischaemia

Martin Bündner

Anamnesis

61-year-old patient with arterial hypertension and recurrent angina pectoris. He complains of burning heart pain and a feeling of constriction in the left side of his chest. His chest feels compressed when lying on the left side and he feels as if he can't get any air. He also has burning pain in his left shoulder; this pain sometimes moves to his back. The patient blames the angina pectoris on the considerable stress he has been subjected to at work for the last six years.

Since developing angina pectoris, the patient falls asleep at his desk and has become bad-tempered, silent and withdrawn.

The angina pectoris is quite severe and recurs often;

admitted to hospital. The patient is in such poor condition that an imminent myocardial infarction is feared. The severity of the symptoms makes it necessary to focus on his heart condition when choosing the remedy.

He had already taken antihypertensive medication while undergoing an earlier course of conventional treatment; however, he refuses this and other chemical medication because of problems with tolerance.

Diagnoses

Unstable angina pectoris, arterial hypertension.

Homeopathic treatment

Repertorisation I _____ KENT'S REPERTORY
Chest - pain - lying - side - left, aggravated Respiration - difficult - lying, on - left side, aggravated

Mind - nervous, weakness, exhaustion

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Differentiation between remedies

The only remedy present in all rubrics is *Phosphorus*. *Naja tripudians* and *Spigelia* should also be considered, but unlike *Phosphorus*, these remedies do not feature the taciturn mood or the falling asleep in a sitting position.

Prescription

1 0 drops *Phosphorus* Q6 once a day rising to *Phosphorus* Q42 over the next 12 months.

Progress

Over the days following the administration of the remedy, the patients symptoms improve steadily: his blood pressure stabilises at 150/80 mmHg and he also becomes calmer, more relaxed and less difficult. At a check-up four weeks later, he reports that he has no more chest pain; neither does it recur in the period following. The sleepiness is also decreasing, although nine months later it has still not completely disappeared. The neck pain, knee swelling, unusual sleeping position and sensitivity to opposition have also improved or are subsiding. 19 months later: the patient stopped taking *Phosphorus* seven months ago and contacts the therapist urgently after a lengthy break. He is again in very poor condition. He complains of feeling unwell when the weather changes, regularly wakes up at 4 am, is again prone to falling asleep while sitting up and has a marked craving for sweet foods. However, the actual reason for the consultation is his evident fear of heart disease, as he is again aware of a burning sensation on the left side of his chest. He also has palpitations when sitting or lying down. The situation and possible forms of conventional treatment are discussed with the patient; he vehemently refuses treatment with chemical medication, further diagnostic procedures except for an ECG (see below) and admission to hospital, and insists on being treated homeopathically. His blood pressure is again significantly elevated (up to 190/105 mmHg).

This time, the heart disease is not easy to repertorise, and it is also affecting the entire organism rather than being restricted to one location; the

existing general symptoms are therefore used for repertorisation purposes.

Imaging procedures

Resting ECG (7 months after finishing the *Phosphorus* treatment): sinus rhythm, heart rate 80/ min., occasional ventricular extrasystoles, mild ST segment depression in II, III, aVE

Repertorisation II

SYNTHETIC REPERTORY

Sleep - waking - 4 am

Sleep - falling asleep - sitting

Mind - anxiety - health, about*

Mind - fear - disease, of*

Generalities - weather - change of, aggravated

Generalities - food and drinks - sweets - desires

*rubrics condensed

Differentiation between remedies

The repertorisation process ends with *Arsenicum album*, *Kalium carbonicum*, *Mercurius solubilis*, *Natrium muriaticum*, *Nux vomica*, *Sepia* and *Sulphur*. Even the inclusion of the palpitations and chest pain on the left side does not create a uniform picture.

The palpitations are considered to be important. Of the remedies mentioned, they are covered by *Nux vomica* and *Sulphur*.

Nux vomica patients are more likely to wake up at 3 am; the palpitations typically occur when lying down after the main meal. Pressure and burning chest pain are characteristic of *Sulphur*. It works more deeply than *Nux vomica*. Moreover, *Sulphur* is well known as a follow-up to *Phosphorus*.

Prescription

2 0 drops *Sulphur* Q6 once a day, potencies gradually increasing.

Progress

After commencing treatment, the patient's blood pressure shows a tendency to fall but is still changeable

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sleeping through the night more often. The chest pain is subsiding, and the ST segment depression is no longer evident in the ECG performed at the next consultation. He has almost stopped eating sweets.

The next emergency consultation takes place six weeks later. The patient's blood pressure rises on exertion but falls quickly when he is at rest. However, his condition has changed dramatically. The patient now has the feeling of a stone on his chest when inhaling and taking deep breaths; he again has burning pain on the left side of his chest, his blood pressure is 150/100 mmHg and he can feel his heartbeat all over his body, especially when sitting or standing.

Sulphur is no longer helping; a follow-up remedy is urgently needed. The patient again refuses conventional diagnostic procedures and treatment.

Repertorisation III

KENT'S REPERTORY

Chest - palpitation heart - standing, while

Chest - palpitation heart - sitting, while, aggravated Chest - palpitation heart - tumultuous, violent

Chest - pain - pressing

Chest - pain - burning

Differentiation between remedies

The superordinate rubric is used for the burning chest pain, as the more appropriate rubric "Chest - pain - burning - sides - left" does not contain any of the remedies repertorised so far.

The two remedies remaining are *Agaricus muscarius* and *Lachesis*, although *Lachesis* is weighted more heavily (second degree) in each rubric. Unlike *Agaricus muscarius*, *Lachesis* has already proven itself many times in treating angina pectoris and organic heart disease. In contrast with *Agaricus muscarius*, it is also well known as a follow-up remedy to *Sulphur*. The

materia medica (Hering) does not list any symptoms resembling the patient's condition under *Agaricus muscarius*.

Prescription

1 0 drops *Lachesis* Q6 once a day, potencies gradually increasing.

Progress

Just two hours after taking the remedy, the chest pain and palpitations improve perceptibly. The pain continues to subside; the patient becomes more relaxed and affable. Seven days later, he has almost no pain; at the check-up seven days after that, he reports that the pain has completely disappeared. The blood pressure peaks in the mornings have also ceased; the patient's blood pressure is becoming increasingly stable and consistent. After another six days, he reports that about one hour after taking the remedy, his heart feels as if something is changing; afterwards, his blood pressure drops markedly. 28 days after starting the treatment with *Lachesis*, the chest pain has not recurred at all. Nine months after beginning treatment with *Lachesis*, the patient goes for an easy walk but develops shortness of breath despite his blood pressure being stable. Three weeks later, his condition has improved so far that he can even mow the grass. Seven days after this, he returns to his full-time job as a mechanic for the first time since the incident. There have been no further developments over the last one and a half years.

Evaluation

The patient suffers three attacks of unstable angina pectoris; the ECG also shows signs of myocardial ischaemia. His complaints all subside with homeopathic treatment.

Critical commentary

The patient was informed of the risks and potential problems associated with his disease.

10.5 Angina pectoris and myocardial infarction

Case 10.5-4: Post-infarction angina following acute posterior wall infarction *Martin Bündner*

Anamnesis

At around 12.50 am on the day of admission, the patient suddenly develops pain throughout the thorax radiating into the throat and the left arm. He also breaks into a cold sweat. The patient is taken to intensive care by ambulance with the diagnosis of myocardial infarction. Despite appropriate preliminary treatment (nitrates, beta blockers, morphine, acetylsalicylic acid, Heparin), it was not possible to ease the patients pain before admission. He is still suffering from retrosternal pain and describes a feeling of pressure in the chest. He is extremely agitated and restless.

The resting ECG taken on admission to ICU (2.44 am) shows changes indicating an acute posterior wall infarction. The patient is then given thrombolytic treatment with streptokinase. Moderate arrhythmias appear temporarily as a typical sideeffect of this treatment.

The laboratory tests performed on the morning of the same day confirm the myocardial infarction. The patient is connected to a heparin infusion. Otherwise, he has no symptoms.

The ECG tests performed on the same day (7.35 am) and the following days show that the signs of infarction are subsiding as expected.

On the following day (day 2), the patient still has no complaints. As he remains symptom-free, he is transferred to a general ward on day 3.

At 3 am during the night from day 5 to day 6, the patient reports chest pain and a feeling of constriction, and is given glyceryl trinitrate (e.g. Nitrolingual N-Spray[®]) and diazepam (e.g. Valiquid 0.3* drops). By 3.30 am, he is whimpering with pain. He is transferred back to ICU and is given further doses of Nitrolingual N-Spray, which bring about an improvement. He is again connected to a heparin infusion.

The symptoms are the same as those the patient suffered at the time of the acute posterior wall

infarction. He explains that he also had the same symptoms at midday on day 5.

The ECG performed at 3.30 am shows no direct signs of infarction; the cardiac enzymes are also continuing to fall.

As his cardiac situation seems to be stable, the patient is transferred back to the general ward on the morning of day 6.

Because the patient is suffering recurrent pain and ultimately severe angina pectoris despite receiving thrombolytic treatment after the acute posterior wall infarction, the decision is made to treat him homeopathically.

The angina pectoris symptoms are identical to those associated with the acute infarction. It must be assumed that the existing problem could not be adequately solved by the thrombolytic treatment; the progressive symptoms are extremely likely to recur and will ultimately lead to another infarction. The patients individual symptoms are therefore recorded late in the morning on day 6:

- There is a feeling of discomfort in the chest, exactly the same as during the infarction and attacks of post-infarction angina
- The pain in the chest is constrictive
- The pain extends to the inside and outside of the throat
- The left arm is weak and “limp” (no strength); the patient is therefore unable to move his hand properly
- The pain radiates from the chest into the upper arm
- The patient is sweating; his forehead and face are covered in cold sweat
- Lying down is very uncomfortable
- He generally feels better in the fresh air
- The patient is agitated and fearful; he tosses and turns in bed
- The patient has a constant cough (smokers cough)

Diagnoses

Post-infarction angina following acute posterior wall infarction with thrombolytic treatment.

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nicotine abuse, arterial hypertension, hyperlipoproteinaemia, obesity, lumbar syndrome.

Findings on admission 63-year-old patient, adipose abdomen.

Laboratory

Day 1: y GT 28 u/l. Cholesterol 239 mg/dl (6.2 mm/L). Triglycerides 257 mg/dl. BGA with global respiratory insufficiency. SGOT 22 u/l. LDH 177 u/l. CK 104 u/l. Day 2: SGOT 27 u/l. LDH 222 u/l. CK 83 u/l. Day 6: SGOT 20 u/l. LDH 192 u/l. CK 13 u/l.

Imaging procedures

Resting ECG (day 1) at 2.44 am: heart rate 63/min., sinus rhythm, left axis deviation. ST segment elevation in III, aVF, ST segment depression in aVL. Acute posterior wall infarction; at 7.35 am: Normo- frequent sinus rhythm, left axis deviation. ST segment depression in II, III, aVF, V 4 to V 6. Signs of infarction in the ECG diminish over the days following.

Resting ECG (day 6) at 3.30 am: T wave inversion in II, III and aVF. Preterminal negative T wave in V5 and V6; 9.40 am. Findings as at 3.30 am on day 6. ECG tests progress as normal following a myocardial infarction.

Echocardiography (day 5): Echocardiogram performed under difficult conditions. Small hypokinetic and dyskinetic area suspected in latero-pos- terobasal region. Ejection fraction > 60%. Mitral valve insufficiency I°.

Coronary angiography (day 13): coronary artery disease (RCA and LAD), slightly reduced function in left ventricle with diaphragmatic akinesia, previous posterior wall infarction with systemic thrombolysis on day 1.

Cardiac risk profile: nicotine abuse, arterial hypertension, hyperlipoproteinaemia.

Measures planned: aortocoronary bypass operation (elective).

Conventional treatment

Thrombolytic treatment with streptokinase, intensive monitoring, heparin perfusor.

Homeopathic treatment

Repertorisation _____ **KENT'S REPERTORY**

Mind - restlessness - anxious, etc.

Mind - restlessness - bed, driving out of

Face - perspiration - cold*

Head - perspiration - forehead - cold*

Chest pain - heart - extending to hand, left

Extremities - weakness - arms

Generalities - air - open, ameliorated *rubrics condensed

Differentiation between remedies

The main remedies left after repertorisation are *Arsenicum album* and *Rhus toxicodendron*.

In the authors experience, *Arsenicum album* is more frequently indicated for heart conditions than *Rhus toxicodendron*. Both remedies feature restlessness, but *Rhus toxicodendron* patients normally have a brief sense of relief before they have to move again. This is not the case with this patient, so the decision is made to administer *Arsenicum album*. The choice of remedy is confirmed by a retrospective glance at the materia medica (Trinks 1847): "Constriction of the chest, [...] tightness and pressure in the chest [...]. Diminished contractility of the heart [...]. Trembling hands and feet, all strength lost in these [...]. Remarkable weakness and paralysis of the extremities. [...] Perspiration on body parts. [...] Full, extremely slow pulse (38 beats) [...]. Remarkable smallness of the pulse. [...] Worsening of the pain, rendering it unbearable and driving the patient to despair. [...] Worsening of the pain [...] when lying on the diseased parts."

Prescription

1 dose of 2 globules *Arsenicum album* 30C.

Progress

After administering *Arsenicum album*, the discomfort in the patients chest subsides (day 6). Next day, the patient reports that he slept better than usual and that the chest pain has disappeared. Only the pain in the lumbar region is still present. The angina pectoris does not recur. On

10.5 Angina pectoris and myocardial infarction

patient reports that since taking the remedy, he has been sleeping much better than he had done for a long time, despite the fact that the hospital surroundings are not as quiet as at home.

The patient continues to make steady progress. On day 13, a coronary angiography is performed and reveals coronary artery disease in 2 arteries (RCA and LAD), slightly impaired left ventricular function and diaphragmatic akinesia. An elective aortocoronary bypass operation is indicated.

Evaluation

Despite systemic thrombolytic treatment, it is not possible to keep the patient symptom-free in the long term. Instead, the infarction symptoms reappear in the

although no new infarction occurs. The patients condition worsens and he is at risk of suffering another infarction.

He is given homeopathic treatment when his heart condition fails to stabilise. He suffers no other symptoms during the hospital observation period; his left ventricular function improves markedly.

Critical commentary

It can be assumed that the homeopathic treatment stabilised the patients condition. *Arsenicum album* works at a deep level: the long-standing sleep problems also disappeared.

The acute indication for coronary angiography was

Case 10.5-5: Acute posterior wall infarction

Susan Waag

Anamnesis

The 69-year-old patient is a member of a group cruising on the Nile from Cairo to Aswan. Three days earlier, he had visited St. Catherines monastery in Sinai and made the arduous climb up the steep side of Mount Sinai during a night walk, both of which required tremendous effort. After visiting a temple in the morning, he has lunch on the ship and then retires to his cabin feeling unwell. Against his expectations, his condition worsens and he gets up to seek help. He collapses halfway up the stairs. His wife and son take him back to his cabin. The next port is two hours away; an ambulance with intensive care facilities is called by radio to take him to the nearest hospital in Aswan. No conventional treatment can be given on the ship.

Diagnosis

Acute heart attack suspected and confirmed by ECG.

Diagnostic procedures

Physical examination

69-year-old obese patient, sitting upright in bed wearing a vest, back supported by several pillows. Uncovered, upper body leaning slightly to the right, slumped. His face is a livid bluish colour, his lips pale. His eyes are closed; he opens them with an effort when he is spoken to. Face and extremities sweating and icy cold. Profuse cold sweat on his forehead. The room has been darkened and the cabin window opened wide at the patient's request. The outside temperature is about 25 °C with a slight breeze. The patients breathing is shallow, his pulse barely perceptible, bradycardic at 42/min., soft, irregular, extrasystoles and occasional skipped beats. Extreme weakness; he is initially unable to respond to questions, indicates the heart area with his right hand. Small graze on the left side of his forehead which has since stopped bleeding; there is also a small split in the upper lip and dried blood under his nose from the fall on the stairs.

Laboratory

Impossible during the acute stage; two hours later in hospital: elevated CK and CK-MB.

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Conventional treatment

Later in the clinic: 4 tablets acetylsalicylic acid (e.g. Aspirin*) 75 mg, thrombolysis with streptokinase. Heparin and nitroglycerin by infusion, diazepam (e.g. Valium*) 1.5 mg.

Homeopathic treatment

Repertorisation I

The remedy is given on the spot on the basis of the therapists knowledge, as no repertory is available. The case is repertorised retrospectively.

_____ COMPLETE MILLENIUM D REPERTORY
Generalities - collapse

Generalities - cyanosis

Generalities - air - open - desires

Generalities - weakness - faint-like

Generalities - pulse - weak

Generalities - pulse, intermittent

Generalities - pulse - weak

Generalities - pulse - slow - bradycardia

Differentiation between remedies

In this acute emergency situation, in which no repertorisation can be performed, the general cyanosis and desire for fresh air, the cold extremities, general weakness and extremely poor condition of the patient all point to *Carbo vegetabilis*.

Prescription

1 dose of 3 globules *Carbo vegetabilis* 30C dissolved in a glass of water, administered by teaspoon over the first few minutes.

Progress

After about 15 minutes, the patient opens his eyes and responds to questions. He reports pain in the heart region, "as if someone were forcibly crushing his chest". The pain extends to the left shoulder. He is still dizzy. He sits up in bed and wants to be turned onto his right

being given a fresh pair of pyjamas because of the blood spots and dampness of his vest. He refuses to enter into discussion with his wife or son about this. The frequent administration of the remedy, teaspoon by teaspoon, is obviously doing him good; his gaze is clearer and more alert. There is no doubt about the heart problem, but the port is still one hour away. The patients life-threatening condition has been improved by *Carbo vegetabilis*; however, the patient is now complaining of a frontal headache, dizziness and nausea.

In this extremely critical and desperate situation on board, the patient is now given *Strophanthus hispidus* 6X with the idea of improving his heart activity and maintaining his circulation. His circulation continues to stabilise but the headache gets worse (the patient indicates his forehead with his hand); the nausea becomes more severe.

Repertorisation II

_____ COMPLETE MILLENIUM D REPERTORY
_____ SYNTHESIS VERSION 7*

Mind - contradiction - tolerates no

Generalities - pulse - slow - bradycardia

Vertigo - headache, during

Vertigo - nausea, with

Head - pain - forehead, in the*

Differentiation between remedies

The number of potential remedies is large, but the decision is made to administer *Nux vomica*, as the patient does not tolerate contradiction despite his poor condition. This is an unusual symptom, particularly in such an acute state of disease. Moreover, *Nux vomica* is especially effective in treating headaches, dizziness and nausea.

Prescription

1 dose of 5 globules *Nux vomica* 6X given directly on the tongue.

Progress

Barely five minutes after taking the *Nux vomica*, the patient goes to the toilet with his son and vomits

10.6 Cardiac arrest (resuscitation)

face is pale but no longer livid and he has no cold sweat. He now participates in the discussion about his condition and further proceedings actively and with a steady voice.

As the paramedics at the port are unable to take the stretcher directly into the cabin, the patient meets them on the stairs, leaning on his sons arm. His condition is stable, as confirmed by the tests performed in the ambulance: pulse regular, 55/min., blood pressure 120/80 mmHg.

The patient is able to fly home after just three days in hospital.

Evaluation

The case described here illustrates the effectiveness of homeopathic remedies even in the extreme situation of an acute myocardial infarction.

Critical commentary

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two or even three remedies may have to be administered in quick succession. *Carbo vegetabilis* initially dealt with the most threatening symptoms but not with the bradycardia, the patients dictatorial nature, the headache or the nausea. It is not clear what effect *Strophanthus* had. It remains to be seen whether another remedy would have matched the symptoms better. *Carbo vegetabilis* also has triple weighting in the corresponding rubric. In this unusual situation, it was only possible to choose from the limited range of remedies available in the therapists travel kit. Nevertheless, the marked stabilisation of the patients condition within the first two hours of administering nothing other than homeopathic treatment is undisputed and impressive.

10.6 Cardiac arrest (resuscitation)

Definition

In cases of cardiac arrest, the heart stops functioning efficiently and the circulation comes to a standstill. This may be caused by a large number of respiratory, cardiac, circulatory and metabolic factors. Clinical death is characterised by cardiac arrest with unconsciousness, respiratory failure, cyanosis, non-existent pulse and dilated, non-reactive pupils. The organ damage is reversible, which is why resuscitation is given.

Cardiac arrest leads to tissue anoxia with the threat of brain death. Biological death usually occurs after another 3-5 minutes; by this time, the damage to the essential organs is irreversible. Certain signs of death are lividity, rigor mortis, cooling and a smell of decay. Resuscitation measures are no longer performed once this stage has been reached.

Clinical information

Incidence and mortality

Cardiac arrest in adults is most commonly caused by heart problems; the prognosis can be good if the emergency service chain is functioning optimally. The success of cardiopulmonary resuscitation depends directly on the time at which it began and the correct performance of basic resuscitation measures.

Symptoms

The signs of cardiac arrest are sudden loss of consciousness (no response when spoken to, no reaction to tactile stimuli), circulatory failure (no pulse perceptible even in the major blood vessels such as the carotid artery, no signs of circulation), pale, grey or cyanotic skin discolouration, respiratory failure (no breathing movements, no air flow, no breathing noises), agonal respiration (a certain indication: final diaphragmatic contractions with insufficient ventilation, i.e. only the dead space is ventilated) and dilated, non-reactive pupils in both eyes.

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Diagnosis

The following steps are recommended for diagnosing cardiac arrest.

The patient's **state of consciousness** should be checked first. The patient is unconscious if he does not respond when spoken to or shaken by the shoulder. His state of consciousness should therefore be checked by speaking to him loudly and clearly and, if he does not react, by shaking him by the shoulder. If he still does not react, it must be assumed that his vital functions are at risk of shutting down.

The **breathing is checked** by palpating and observing the movements of the chest and abdomen. The flow of air from the mouth and nose can also be checked by listening and feeling; for this, the person performing the examination places his cheek in front of the patients mouth and nose.

As palpation of the carotid artery is not sufficiently reliable even if carried out for a long time, this is no longer recommended in the new guidelines for basic resuscitation published by the General Medical Council for training laypeople. However, professional helpers such as doctors, paramedics and nurses should continue measuring the carotid pulse for no more than 10 sec. while paying attention to other signs of cardiac arrest.

The degree of pupil dilation is also insufficient for diagnostic purposes and is therefore no longer seen as a criterion.

Respiratory failure may not necessarily be associated with cardiac arrest in the early stages. Nevertheless, people administering first aid should not start by giving the patient mouth-to-mouth respiration as taught earlier; instead, they should begin with 30 compressions as soon as the circulation stops. If there are no clear signs of circulation, external heart massage must begin right away. One new recommendation is that the decision to resuscitate the patient should be made as soon as he no longer responds when spoken to and stops breathing normally.

Therapeutic crisis

Despite extensive training in first aid, the prompt administration of basic resuscitation techniques, treatment with medication and the use of technical measures, mortality rates in cases of cardiac arrest are still very high in clinics and even more so on the street. Even if the resuscitation phase is successful, the prognosis is still unfavourable regardless of the intensive care available. The degree of damage to the brain caused by lack of oxygen seems to be critical; however, the length of time before such damage occurs may vary, depending in particular on the external circumstances. Rapid clearing of the airways and adequate respiration, if possible with an alternative respiration device, are therefore priorities. However, as the success rate of resuscitation measures varies considerably even in “favourable” conditions, other factors also appear to play a part in the result of the treatment. It may therefore be assumed that the success of the resuscitation measures may be improved by homeopathic treatment.

Homeopathic treatment

Symptom selection

Two major aspects must be taken into consideration when choosing the correct homeopathic remedy: firstly, the external appearance of the clinically dead patient may give crucial indications for selecting the right remedy, and secondly, the causes and symptoms preceding clinical death may also be considered.

Even in the early days of homeopathy, clinically dead patients (then described as “seemingly dead”) were treated successfully irrespective of the cause of the cardiac arrest. “Here I must only think of a case of asphyxiation by carbon monoxide which occurred in a thirteen-year-old child who had been living in a windowless room next to a burning brazier and who, when I saw him, lay there completely rigid. Washes with dilute vinegar caused signs of life, gentle respiratory movements and a perceptible pulse to return, whereupon I had him smell *Opium* 6 [6C] every five minutes to improve his lethargic state. I saw this condition yield within 15 minutes; however, convulsions then occurred which were like rapidly banished by *Bellad.* [*Belladonna*]” (Jahr 1869).

10.6 Cardiac arrest (resuscitation)

Hering also observed the successful treatment of people who had been struck by lightning: "Persons rendered insensible by a stroke of lightning are placed in a half-recumbent, half-sitting posture, with the face turned toward the sun, and covered entirely (except the face) with newly dug earth. The face is shaded as soon as movement of the eyes is observed. Internally, a few pellets of nux vom. (*Nux vomica*) should be administered by placing them on the tongue, and the dose repeated in half an hour if there are no signs of returning consciousness. After quarter of an hour, nux vom. is mixed with a little water and rubbed into the neck; after another quarter of an hour, the posterior is uncovered and an

enema administered with 10-20 pellets nux vom. in half a spoonful of water, cotton wool inserted into the anus to prevent it from flowing out, everything again covered with earth and the apparently dead patient allowed to lie there until he begins to breathe, whereupon the chest is uncovered and the patient taken into a bright, sunny room" (Hering 1864).

These historical case studies obviously do not come up to today's scientific standards of emergency and intensive medicine, but show the remarkable efficacy of homeopathic remedies when administered without major external influences (10.6-1: Cardiac arrest in newborn).

Repertorisation

SYNTHETIC REPERTORY

WITH ADDITIONS BY G.H.G. JAHR

Death, apparent - asphyxia

acet-ac., aeon., ant-t., arn., ars. (Jahr), bar-m. (Jahr), bell., bry. (Jahr), camph., carb-v., carbn-s., chin., chlor., cochl., coff., coloc., crot-h., hydr-ac., LACH. (Jahr), laur., mere., mosch. (Jahr), nit-ac., NUX-V. (Jahr), op., ph-ac., phos., rhus-t., sin-n., stram., sul-h., tab., upa.

- carbon monoxide or coal gas poisoning aeon., bell., op.
- drowned persons, of lach.

- fall, blow, other mechanical injuries, from

arn., chin. (Jahr)

- from loss of blood

chin.

- frozen persons, of aeon., ars., bry., carb-v. - hanged, strangled persons, of

op. - lightning strike, after

lach., nux-v.

- newborns

aeon., am-c., ANT-T., am., bell., CAMPH., chin., crot-h., hydr-ac., hyos., laur., op., vip.

- suffocation, from aeon., bell., op.

KENT'S REPERTORY

Respiration - asphyxia

Ant-t., Camph., Carb-v., Carbn-s., Chin., Chlor., Coch., Op., Rhus-t., Sin-n., Tab.

Respiration - asphyxia - cholera

Hydr-ac., Laur.

Respiration - asphyxia - coal gas

Carb-v., Carbn-s.

Respiration - asphyxia - newborns

Cupr.

Differentiation between important homeopathic remedies

Important remedies: *Aconitum*, *Antimonium tartaricum*, *Apis*, *Arnica*, *Arsenicum album*, *Belladonna*, *Camphora*, *Carbo vegetabilis*, *Lachesis*, *Laurocerasus*,

Aconitum: once the patients breathing restarts, he shivers, feels hot and is anxious. Suitable for ailments following successful resuscitation after asphyxiation in toxic air. Patients with hypothermia have stabbing pain or heat in the head after warming up. Death occurs after shock with violent upset. When newborns are resuscitated and the face is red and blue. Apoplectic appearance; the baby is hot, purple, not breathing and has no pulse, or is nearly in this condition.

10 Cardiovascular emergencies

Antimonium tartaricum: pale face, patient looks as if he is sleeping peacefully. In cases of asphyxia in newborns, repeat treatment after 10-15 minutes, then administer as an enema (Hering). Choking; mucus rattling in the throat; the child is pale and not breathing although the umbilical cord is still pulsating.

Apis: death after violent emotion, when the face is deathly pale. When death occurs after fainting and such extreme weakness that the patient has to sit or lie down on the spot, or is about to collapse, sometimes with vomiting, sometimes asking for water, particularly when this occurs after extreme physical or mental suffering.

Arnica: pupils of different sizes, small in one eye and large in the other.

Arsenicum album: suitable for ailments following successful reanimation after asphyxiation by ether or chloroform. In patients with hypothermia: pain after warming up.

Belladonna: patient lies there without moving, as if dead. No reaction, as if in stupor. After respiration restarts, the patient feels a sensation of dizziness or heaviness and heat in the head. Suitable for ailments following successful resuscitation after asphyxiation in toxic air. Apoplectic appearance; the face is very red, the eyes bloodshot, the pupils dilated.

Camphora: a piece of camphor or camphor spirit (not a potentised remedy!) should be shaken with water and administered rectally every 15 minutes. **Carbo vegetabilis:** the breath remains cold after restarting. Suitable for ailments following successful reanimation after asphyxiation by ether or chloroform. In patients with hypothermia: pain after warming up.

Lachesis: face distorted, lips drawn back and teeth bared, tongue in between. Death occurs after love troubles and violent pain in the heart. Pale face; when newborns do not react to *Antimonium tartaricum* or *China*.

Laurocerasus: patient lying down as if dead or paralysed, pulse 30/min. and barely perceptible, flexible limbs and persistence in the given position. Blue or pale face, especially when the eyes are shining brightly. Blue face, gasping for air and almost imperceptible breathing; twitching facial muscles. **Opium:** for newborns. Blue or pale face, especially when the pupils have become very large or very small. Suitable for ailments following successful resuscitation after asphyxiation in toxic air. Blue face; when newborns do not react to *Antimonium tartaricum* by beginning to breathe. Purple, swollen face; no breathing, the umbilical cord is still pulsating.

Case 10.6-1: Cardiac arrest in newborn

Susanne Holtz-Joas

Anamnesis

During a brief period of medical service in Kenya, the author and her husband are called to an emergency, a completely exhausted nomadic woman in labour, who had already had a stillborn baby two years ago following a Caesarean. During the initial examination, it is found that the child is too large to pass through the mothers pelvis and that the mother had been infibulated (been given pharaonic circumcision).

The labour had also come to a standstill after more than 24 hours of contractions; the mothers condition is poor. As there are no transport possibilities and the child's

50/min. after waiting in vain for the Flying Doctors service for an hour, an emergency Caesarean is performed at night in the most primitive conditions. The child is wedged into the mothers pelvis. After freeing the head with considerable effort, the child appears grey, hypotonic and asphyctic with no pulse or reflexes. The eyes are open but appear glassy and fixed. The newborn is given naso-gastric suction and wrapped in a blanket. Cardiopulmonary resuscitation begins immediately. No perceptible heart activity, reflexes or breathing after approx. 5 minutes.

Diagnosis

Asphyxia in newborn (APGAR 0-0-1).

Diagnostic procedures

External appearance and auscultation.

10.6 Cardiac arrest (resuscitation)

Conventional treatment

Cardiopulmonary resuscitation of newborn.

Homeopathic treatment

The repertorisation process is performed retrospectively when reviewing the case.

Repertorisation I

KENT'S REPERTORY

Respiration - arrested - asphyxia - in newborn infant
Generalities - shocks from injury

Eye - open - unconsciousness, during

Differentiation between remedies

The repertorisation process confirms *Opium*. Other possibilities are *Aconitum*, *Arnica*, *Belladonna*, *Camphora* and *Cuprum metallicum*. The open eyes in a state of unconsciousness speak for *Opium*, as this symptom is unique to this remedy. The choice of *Opium* is therefore confirmed.

Prescription

1 dose of 5 globules *Opium* MK.

Progress

The reaction to *Opium* is almost immediate: the previously lifeless child moves her eyes and whimpers softly. Less than one minute after administering the remedy, a gentle heartbeat is felt. The small body acquires muscle tone. One deep breath, and her breathing becomes almost regular; her sucking reflex and heart activity increase markedly. Five minutes after giving the remedy, the child's condition seems to be almost stable. After the mother and child have been washed and put into another bed, it is noticed that the newborn's skin is cold and her expression fearful.

Repertorisation II

KENT'S REPERTORY

Respiration - arrested - asphyxia - in newborn infant
Generalities - shocks from injury

Face - expression - anxious

Aconitum is indicated after emergency surgery (Caesarean), hypothermia, consequences of shock and as a follow-up to *Opium* if the patient's condition improves after administering *Opium* (Rehman). The alert, fearful expression in the infant's eyes speaks against *Camphora*, as patients who require this remedy have a fixed gaze. The cool head contraindicates *Belladonna*.

Prescription

2 dose of 3 globules *Aconitum* 200C.

Progress

After administering *Aconitum*, the child's breathing again stops briefly. She now closes her eyes, although she had previously been looking around. Resuscitation repeated. The child again reacts immediately, and from this time, she is completely stable, rosy, alert, calm and drinks glucose solution from a syringe. Her expression is normal and her skin no longer cold. She passes meconium and urinates. The child's reflexes and movements on the first and second days following the birth are completely normal. The child develops well. The mother and child are both well. The little girl is named Susanne.

Evaluation

The reaction to *Opium* was astonishing. In the absence of the usual emergency medication, this remedy succeeded in bringing the child back to life. Her reaction to the subsequent administration of *Aconitum* must be seen as an initial aggravation of the symptoms in this critical situation. The renewed initiation of resuscitation measures was understandable and in keeping with the prescribed guidelines, but it can be assumed that in essence it was not really necessary. The pulse was still present. A moment's patience would presumably have had the same results.

Critical commentary

Practising homeopathy in emergency situations in the so-called Third World is a completely different challenge to practicing here, where all alternatives are available and

10 Cardiovascular emergencies

Case 10.6-2: St. p. myocardial infarction with subsequent cardiac arrest

Martin Bündner

Anamnesis

The 47-year-old patient needs to be resuscitated after a myocardial infarction. After passing through the acute phase and regaining consciousness, he complains of severe, stabbing chest pain, which was obviously induced by the resuscitation measures. Worse from pressure, tapping and coughing.

Diagnosis

Post myocardial infarction with subsequent cardiac arrest and successful resuscitation.

Homeopathic treatment

Repertorisation I

CARD INDEX REPERTORY

Jarring, violent blow, treading heavily, riding aggravated

Coughing aggravated

Pressure aggravated, lying on painful side aggravated

Chest, external

Differentiation between remedies

The repertorisation process ends with *Bryonia*, *Calcarea carbonica*, *China*, *Nux vomica* and *Phosphorus*. Stabbing pain and aggravation of the symptoms when moving or coughing are characteristic of *Bryonia*.

Prescription

1 dose of 3 globules *Bryonia* 30C.

Progress

A short time after taking *Bryonia*, the pain subsides considerably, as a result of which the next remedy is

indistinctly and has memory problems. After being resuscitated, he initially suffered tonic seizures and rigidity in his whole body.

Repertorisation II

KENT'S REPERTORY

Mind - answers - reflects long

Mouth - speech - indistinct

Mind - memory, weakness of

Generalities - convulsions - consciousness - without

Generalities - convulsions - tetanic rigidity

Generalities - convulsions - tonic

Differentiation between remedies

The optimum remedy is *Cocculus*. The patient's mental state is also reminiscent of *Phosphoricum acidum*, but this remedy is eliminated as it does not precisely match the convulsive symptoms.

Prescription

1 dose of 3 globules *Cocculus* 30C.

Progress

Over the days following the administration of *Cocculus*, the patient's mental function improves but is still not as good as it was before the infarction. He has no more convulsions and is transferred to another clinic for rehabilitation.

Evaluation

The progress of this case shows that brain damage caused by lack of oxygen is not static but can be reversed, at least to some degree.

Critical commentary

It is possible that the patient's mental function improved

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II Lungs

Martin Bündner (Conventional Medicine)

Martin Bündner, Edacheril Scaria Rajendran (Homeopathy)

11.1 Asthma bronchiale

11.2 Pulmonary oedema

11.1 Asthma bronchiale

Definition

Bronchial asthma (from the Greek “panting”) is a disease involving sudden, violent attacks of breathlessness. This breathlessness is caused by a generalised, obstructive impairment of the ventilation in the lower airways; the constriction of the airways is caused by spasms, oedema and excess mucus secretion.

Bronchial asthma can be triggered by numerous endogenous and exogenous factors (allergens, infections, gases, irritants), often by several at the same time.

Status asthmaticus describes a condition when the patient does not respond to medication; instead, the severity of the bronchospasms increases and may last for hours or days.

Clinical manifestations

Symptoms

The main symptoms are:

- Dyspnoea, especially on expiration
- Cyanosis
- Sitting position to facilitate use of the auxiliary respiratory muscles, often at an open window
- Feeling of suffocation and chest constriction
- Anxiety
- Prolonged expiration
- Hyperresonant sounds on percussion of the lungs
- Expiratory wheezing

- Weak respiratory sounds
- Dry cough
- Attacks of breathlessness
- Attacks ends with expectoration
- Cold sweat

Diagnosis

Asthma attacks are diagnosed on the basis of the main symptoms. Mechanical tests of the patients lung function also point the way to the correct diagnosis.

Other lung diseases must be excluded before a diagnosis of asthma bronchiale can be confirmed (tables 11.1-1 to 11.1-5).

Tab. 11.1-1: Differential diagnosis - asthma bronchiale and bronchitis	
Asthma bronchiale	Bronchitis
Brief physical symptoms	Lasting physical symptoms
Attacks of breathlessness	Constant breathlessness
Scanty expectoration	Copious expectoration
Slow, wheezing, prolonged breaths	Rapid breathing

Tab. 11.1-2: Differential diagnosis - asthma bronchiale and pseudocroup	
Bronchial asthma	Pseudocroup
More common in older children/adults	Babies and children
Breathlessness mainly on exhalation	Breathlessness on inhalation

11 Lungs

Tab. 11.1-3: Differential diagnosis - asthma bronchiale and laryngospasm or breathlessness caused by laryngeal diseases	
Bronchial asthma	Laryngospasm/breathlessness caused by laryngeal diseases
Breathlessness mainly on exhalation	Breathlessness on inhalation

Tab. 11.1-4: Differential diagnosis - asthma bronchiale and pulmonary emphysema	
Bronchial asthma	Pulmonary emphysema
Severity of dyspnoea	Dyspnoea not so severe in milder forms (can progress to severe dyspnoea)
Attacks of breathlessness	Constant breathlessness
No symptoms between attacks	Symptoms cannot be eliminated completely

Tab. 11.1-5: Differential diagnosis - asthma bronchiale and dyspnoea with renal/cardiac causes	
Bronchial asthma	Dyspnoea with renal/cardiac causes
Brief physical symptoms	Continuous, sustained breathlessness
Attacks of breathlessness	Attacks of breathlessness possible
Bronchospasm	Usually pulmonary oedema

Aortic aneurysms and other mediastinal tumours frequently produce symptoms similar to asthma bronchiale by pressing on the vagus nerve and its branches. The characteristic stridor is caused by laryngeal spasm.

When diagnosing a child, it must be considered that he or she may have inhaled a foreign body. Asthma attacks in children can also be mistaken for epileptic attacks, as spontaneous emptying of the bowel and bladder may occur.

Therapeutic crisis

Influence on cardiac function: the fluid which collects during asthma attacks may trigger a pericardial

The clinical picture of coronary insufficiency is most likely to occur in older patients with a lengthy history of chronic obstructive lung disease requiring treatment; they may have prior myocardial damage caused by increasing pulmonary hypertension and long-term treatment with β_1 sympathomimetic drugs. Other long-term complications in chronic cases are the development of **pulmonary emphysema** and **chronic bronchitis**.

Status asthmaticus is a life-threatening condition which can only be stopped conventionally by anaesthetising the patient. Weaning from the respirator also poses particular problems.

Adjuvant homeopathic treatment can help prevent the problems associated with acute attacks; chronic complications can only be prevented by long-term homeopathic therapy.

Homeopathic treatment

Symptom selection

When treating acute asthma attacks with homeopathy, it is important to record the modalities, particularly the triggers and any accompanying symptoms, if appropriate also with their modalities.

Repertorisation

KENT'S REPERTORY

Respiration - asthma*

Aeon., Agar., AU-c., Aloe, Alum., Ambr., Am-c., Anac., Ant-c., Ant-t., Apis, Arg-n., Arn., Ars., Ars-i., Arum-t., Asaf., Asar., Aur., Bar-c., Bar-m., Bell., Bov., Blatta, Brom., Bry., Cact., Calad., Calc., Camph., Cann-s., Caps., Carb-an., Carb-v., Carbn-s., Card-m., Caust., Cham., Chel., Chin., Chin-ar., Chlol., Cic., Cina, Cist., Cocc., Coc-c., Coff., Colch., Coloc., Con., Croc., Crot-h., Crot-t., Cupr., Daph., Dig., Dros., Dulc., Eup-per., Euph., Ferr., Ferr-ar., Ferr-i., Ferr-p., Gels., Graph., Grat., Grin., Hep., Hippoz., Hydr-ac., Hyos., Ign., Ip., Iod., Kali-ar., Kali-br., Kali-c., Kali-chl., Kali-i., Kali-n., Kali-p., Kali-s., Lac-d., Lach., Lact., Laur., Led., Lob., Lyc., Mane., Med., Meny, Meph., Merc., Mez., Mosch., Naja, Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nit-ac, Nux-m., Nux-v., Ol-an., Op., Par., Petr., Phel., Phos., Phyt., Plat., Plb., Podo., Psor, Puls., Ran-s., Raph., Rhod., Rumx., Ruta, Sabin., Samb., Sang, Sars., Squil., Sec., SeL, Seneg., Sep., Sil., Sin-n., Spig., Spong., Stann., Still., Stram., Stront., Sulph., Sul-ac., Thuji., Verat., Verat-v., Viol-o., Viol-t., Zinc.

* numerous subcategories

11.1 Asthma bronchiale

Differentiation between important homeopathic remedies

* **Important remedies:** *Arsenicum album*, *Kalium carbonicum*, *Pulsatilla*, *Sambuccus nigra*, *Silicea*, *Sulphur*.

Arsenicum album: periodic asthma attacks; asthma in the elderly after suppressed cold and in association with emphysema and heart complaints. Asthma in elderly people who occasionally suffer from attacks of diarrhoea in the morning; rheumatism, scanty urine and excessively loud heart sounds. When lying down at night, the patient has a sensation of tightness in his chest and becomes short of breath; he is obliged to sit up in bed; < after midnight (2 am); drinking coffee or sugared water > a little; symptoms < when climbing stairs. Rapid breathing and feeling of constriction, feeling of tiredness and exhaustion in the chest; pulmonary hyperaemia, thin mucus, foamy, spotted with blood; the chest is still clear on percussion but sounds of crepitation can be clearly heard.

Kalium carbonicum: patient anxious and despondent during the attack; more or less severe outbreaks of sweating on the upper body, < on movement; increased salivation, scanty urine; facial pallor. Asthma; patient has to bend forward with his head on his knee, < at around 2-3 am. Terrifying asthma attacks; < around 3 am. < when walking, as if there is no air in the chest. Breathlessness in the morning. Inability to breathe deeply wakes the patient at night.

Pulsatilla: asthma: in children after suppressed skin rash; in cases of hysteria or when menstruation

is suppressed; in the evening, particularly after meals; at night, as if from sulphur fumes; from menstrual disorders or suppressed urticaria. Attacks of choking; with hiccoughs; as if from cramping in the throat and chest, with anxiety. Feeling of constriction in the lower part of the chest, as if it is too full and tight, in the morning.

Sambuccus nigra: rapid, whistling, wheezing breaths; loud, anxious. Constriction and pressure under the sternum and pressure in the epigastrium and stomach area with nausea and feeling of imminent collapse (fainting, weakness). Nightly attacks of spasmodic choking with crying, agitation and hand waving. Deep, hollow, choking cough caused by cramps in the chest with expectoration of small quantities of tough mucus during the daytime only. Choking cough with screaming in children. Cough < around or shortly after midnight, at rest, when lying in bed or when the head is kept low; from dry, cold air. **Silicea:** breathlessness and wheezing from fast walking or physical exertion. Dyspnoea when lying on the back, bending over, running, also when coughing after running. Nervous asthma; dry, spasmodic cough; the constriction in the patient's chest prevents him from bending over or lying down. Tightness in the chest; the patient is unable to take a deep breath. Asthma < when lying down, spasmodic cough; laryngospasm.

Sulphur: when other remedies do not work properly. Breathlessness. Frequent retching, bronchospasm, breathlessness and attacks of choking, especially when lying down at night or asleep, sometimes also when speaking or walking outdoors. Worse when bending the arms backwards. Chest feels constricted when trying to take a deep breath.

Case 11.1-1: Asthma attack

Edacheril Scaria Rajendran

Anamnesis

Anxious 47-year-old male patient comes to the clinic with severely constricted expiratory breathing which

hours. Mild asthma treated with *Arsenicum album* 30C over the last three days. He has had continual difficulty breathing for the last six hours and is very fearful. His tongue is moist and his thirst normal. His forehead is covered with cold sweat, he is coughing and expectorating thin, white mucus and has a moderate frontal headache.

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Diagnoses

Attack of bronchial asthma, headache.

Diagnostic procedures

Findings on admission

Respiratory frequency 26/min., pulse regular, 90/min.

Laboratory

Routine blood tests normal except for erythrocyte sedimentation rate of 34 mm/h and Hb 10 g/dl.

Imaging techniques

Chest x-ray in supine position

Normal except for prominent vascular hili.

Homeopathic treatment

The main symptom is asthma. The cold sweat on the patients forehead and the excessive weakness are characteristic in this case.

Repertorisation

KENT'S REPERTORY

Respiration - asthmatic

Head - perspiration - forehead - cold

“Laboured respiration and shortness of breath, while walking. [...] Wheezing and rattling of mucus in the chest. [...] Compression and cramplike constriction in the chest [...]” (Clarke 1995) Face: “Puffy, cyanotic. Pale, Hippocratic, cold with cold sweat; [...]” (Boericke 1996)

Prescription

10 drops *Carbo vegetabilis* 30C diluted in water every 30 minutes.

Progress

Two hours later, the patients respiratory frequency has fallen to 20/min., the cough and whistling noises have subsided. He continues to take the remedy every 30 minutes for another four hours. After six hours in all, the patient is auscultated and the whistling noise is heard to have improved remarkably; the patient has no more acute symptoms and can lie down comfortably. Remedy administered 4 times a day for another three days.

Evaluation

The early stages of status asthmaticus are cured using only homeopathic treatment.

Critical commentary

Case 11.1-2: Asthma attack with psychological decompensation *Martin Bündner*

Anamnesis

The 63-year-old patient is known to suffer from asthma and depression. Just under three weeks ago, she developed an infection with a high temperature, and has still not completely recovered. Her mental condition is also deteriorating because of the delayed convalescence. The patient was prescribed (the mucolytic) acetylcysteine (e.g. ACC), which made her cough worse. In order to strengthen her voice, which was weakened by the infection, she drank a ginger tea the evening before the homeopathic consultation for

just the second time in her life. A few hours later, she developed severe dyspnoea and coughing, presumably as an allergic reaction to the ginger tea. She took the medication previously prescribed by her family doctor - terbutaline (e.g. Terbutin') and beclometasone (e.g. Junik DA) - which stabilised her breathing enough for her to be able to fall asleep.

During the homeopathic consultation, the patient complains that despite using the aerosol medication, she is still very short of breath and has a “barking tracheal cough” caused by a tickle in the throat. Bronchitic rhonchi are heard in both lungs on auscultation; there are no longer any signs of bronchospasm, probably due to her use of the aerosols. Her

11.1 Asthma bronchiale

heart rate is 100/min., her blood pressure 120/70 mmHg and her body temperature 37 °C.

More thorough investigation of the cough and accompanying symptoms reveal the following: the cough is caused by a tickle at the base of the throat. It gets worse when lying down and breathing in. The patient feels as if her throat is being constricted. She is breathless and can't take a deep breath.

She has a "feeling of fear" in her belly which is made worse by the breathlessness. The patient feels her heart racing. She is chilly and trembling inside; she also feels a kind of weakness in the chest and abdomen. She feels as if her abdomen is pressing upwards onto her lungs. Her abdomen is massively bloated with wind. She still feels so weak after the infection that she can hardly walk or move. Her voice is still somewhat hoarse.

The patient seems very depressed. When the therapist mentions this, she begins to cry. She says she has reached a point where her self-confidence has completely gone. Her life is pointless; she is only living for her diseases. This theme is also reflected in her dreams. She dreams that nothing goes right for her and that she is unable to accomplish anything. She had been very much looking forward to a concert taking place that evening. Now she is worried that she won't be able to attend. While she is talking about her feelings, her condition worsens and she starts to wheeze so loudly that it can be heard by the therapist sitting opposite.

Diagnoses

Asthma attack, mental decompensation.

Diagnostic procedures

Physical examination.

Conventional treatment

Aerodur, Junik DA (both without the desired success).

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Cough - inspiration

Cough - lying aggravated

Larynx and trachea - tickling - throat pit, in, from

Throat - choking - constricting

Cough - sleep - preventing

Differentiation between remedies

Apis and *Pulsatilla* are listed in all of these rubrics. Both remedies have a decidedly positive influence on patients who seem discouraged. The patient had already taken *Pulsatilla* on the day of the consultation, but it did not improve her symptoms. *Apis* is therefore the remedy of choice.

Prescription

1 dose of 3 drops *Apis* Q6 as needed.

Progress

After the very first dose of *Apis*, the breathlessness improves so markedly that the patient is able to attend the concert. Two more doses taken during the evening stabilise her condition even further. She has no difficulties sleeping and feels well the following morning. No lung sounds are heard on auscultation. As her abdomen is still found to be bloated on palpation (albeit not as severely as on the previous day), the patient is instructed to continue taking *Apis*. At the check-up on the following day, the patient has no more breathing problems and her abdomen is normal. Her mood is good and the depression has subsided.

Evaluation

The cause of the asthma attack (e.g. psychological decompensation) is not important for the remedy to work provided the correct one is administered.

Critical commentary

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Case 11.1-3: Asthma attack and indeterminate abdominal problems

Martin Bündner

Anamnesis

The 4-year-old patient has bronchial asthma. He is brought to the clinic with an acute asthma attack. The mother requests homeopathic treatment. The symptoms found are as follows:

- Abdominal pain in the right hypochondrium and epigastrium since the previous evening
- The abdominal pain increases markedly shortly after 6 am; it is now so severe that the boy cries during the consultation
- Coughing and lying on his front make the abdominal pain worse
- The cough is worse at night and wakes him up
- Vomiting: clear with mucus
- No appetite, listless
- Pain at the top of the head which gets worse outdoors and when bending over
- Nose is running on both sides
- Severe asthmatic symptoms since the morning
- Ubiquitous rhonchi audible in both lungs
- The boy finds it easier to catch his breath outside
- The breathlessness eases when he lies curled up on his right side

Diagnoses

Acute asthma attack, unclear abdominal symptoms.

Homeopathic treatment

It is unusual for asthma to improve when the patient is lying on his side. However, no repertorisation rubric exists for this symptom, and the remedy is selected by combining the symptoms as described by Boenninghausen.

Repertorisation

Differentiation between remedies

Aconitum, *Kalium carbonicum* and *Sulphur* are listed on each card. None of the major symptoms should go against the essence of the chosen remedy. It is unusual that the headache gets worse in the fresh air and the abdominal pain gets worse with coughing.

It is known that *Kalium carbonicum* can have an appropriate effect, but the two modalities (“Cough aggravated” and “Air, cold, aggravated, outdoors, aggravated”) are not part of the essence of this remedy.

The essence of *Aconitum* incorporates these two symptoms, but the character of the remedy does not match the nature of this disease. The remedy *Sulphur* is selected.

Prescription

1 dose of 3 globules *Sulphur* 30C.

Progress

After taking the remedy, the patient's breathing rapidly returns to normal; all his acute symptoms subside within an hour. His mother is advised to give him a long-term course of homeopathic treatment.

Evaluation

The most unusual symptom, i.e. lying doubled up on the right side improving the asthma, leads to the correct remedy.

Critical commentary

To some degree, combining symptoms makes it possible to generate symptoms not mentioned in the repertory.

At the time of repertorisation, only the Card Index Repertory was available. However, the Complete Repertory contains the rubric “Respiration - difficult - lying - ameliorated - side, on”. This rubric (which unfortunately doesn't specify the right side) contains *Sulphur*. It would by all means have been applicable in this case, apart from the lack of reference to which side is affected.

11.1 Asthma bronchiale

Case 11.1-4: Allergic reaction with breathlessness

Martin Bündner

Anamnesis

The 4-year-old boy comes home from kindergarten with hives and breathlessness when outdoors (cool air). The rash is located in the crooks of his arms and backs of his knees; it worsens when scratched and when the patient is outdoors. The child has scratched himself until his skin is raw.

He tosses and turns in his sleep and can hardly sleep because of the itching. No clear bronchospasm on auscultation.

Diagnosis

Allergic reaction with breathlessness. Previously diagnosed with neurodermatitis and multiple allergies.

Diagnostic procedures

Physical examination.

Homeopathic treatment

Repertorisation I

SYNTHETIC KENT'S	REPERTORY*, REPERTORY**
Sleep - sleeplessness - itching, from*	
Skin - eruptions - scratching, after**	
Mind - restless, nervousness - bed - tossing about in**	
Respiration - difficult - air, in cold**	
Skin - itching - scratch, must - bleeds, until it*	

Differentiation between remedies

The repertorisation processes ends with *Alumina*, *Mercurius solubilis*, *Pulsatilla* and *Sulphur*. The fact that the symptoms worsen outdoors contraindicates *Pulsatilla*. The existing literature does not mention hives/urticaria with *Alumina*. The location of the rashes confirms the choice of *Mercurius solubilis* and *Sulphur*. *Mercurius solubilis* is weighted doubly and *Sulphur* singly for the unusual symptom of breathlessness

Progress

After taking the *Mercurius*, the patients breathlessness rapidly subsides and the rash and sleeplessness improve. Over the next few days, the symptoms change: the breathlessness returns from day 4 but is now unspecific; the child now has a constant cough and even coughs in his sleep. He is becoming increasingly hoarse; a cold sore forms to the right of his lips. He also has rings around his eyes.

Day 7: as the symptoms are still developing and the child is not in a serious condition, no other prescription is given at this point so that the symptoms can be observed more closely. However, by the next day, his breathing has deteriorated rapidly. The boy cries non-stop. He is not hungry and tosses and turns in bed.

Repertorisation II

KENT'S REPERTORY

Cough - sleep - during

Cough - persistent

Mind - restless, nervousness - bed - tossing about in

Differentiation between remedies

These three major rubrics contain a large number of remedies; however, only *Belladonna*, *Causticum*, *Lachesis* and *Rhus toxicodendron* have double or triple weighting. The rapid deterioration clearly points to *Belladonna*.

Prescription

1 drop *Belladonna* Q3 diluted in water, three times a day from day 8.

Progress

After taking *Belladonna*, the breathlessness rapidly subsides. The other symptoms decrease over the next ten days.

Evaluation

This child required two remedies administered consecutively for a cure.

Critical commentary

The most notable feature of this case was that *Mercurius*

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Case 11.1-5: Allergic asthma

Martin Bündner

Anamnesis

For the last three days, the 4-year-old boy has been suffering from night-time breathlessness which is eased by cool, fresh air. His eyes are itchy and swollen (the left one more than the right); the whites are bulging. Ubiquitous bronchospasm heard on auscultation.

He has abdominal pain after eating which eases after defecation. His stool is light in colour and soft in consistency. He passes stool 5 to 6 times a day.

He has no appetite. The skin at the back of his knees is rough.

Diagnosis

Allergic asthma. Previously diagnosed with pollinosis.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Eye - swollen - conjunctiva

Eye - conjunctiva and sclera - chemosis

Respiration - asthmatic - night

Differentiation between remedies

The repertorisation process leads to *Arsenicum album*, *Bryonia alba*, *Nux vomica* and *Thuja*. The fact that the patients breathlessness improves outdoors speaks for *Bryonia* and *Nux vomica*-, the skin manifestation in the backs of the knees for *Arsenicum album*, *Bryonia* and *Thuja*.

Nux vomica is eliminated because it does not have the general modality of improvement in the fresh air. *Bryonia* covers all the symptoms, including the stool symptoms.

Prescription

1 drop *Bryonia* Q3 diluted in water twice a day.

Progress

The allergic asthma eases over the two days following the administration of *Bryonia*; the eye problems also subside, as do the abdominal pain and stool symptoms. The skin manifestation at the backs of the knees is most stubborn and lasts for another one to two weeks.

Evaluation

After administering homeopathic treatment, the major symptoms subside first and the minor symptoms later.

Critical commentary

Pollinosis is a chronic disorder; however, if it is exacerbated, it usually has to be treated like an acute disease.

Case 11.1-6: Infectious asthma

Martin Bündner

Anamnesis

3-year-old girl with asthma triggered by recurrent infection is brought in with the following symptoms: after a cold, the child has developed marked shortness of breath; she is breathing quickly (respiration frequency < 60/min.) and has a cough and sniffles. The sniffles presumably started after the cough. Her appetite has decreased; she has rhinitis with redness under the nose

frequently. Her abdomen is bloated. The girl is very clingy and wants to be carried; her mother is not allowed to leave her side. The child feels very ill; she wants nothing other than to lie down. The conventional treatment given to date invariably required the use of 0-sympathomimetic drugs and corticoids; the child's progress was slow.

Diagnosis

Infectious asthma.

11.1 Asthma bronchiale

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - weeping - coughing - during

Respiration - accelerated

Nose - discharge - excoriating

Nose - sneezing - frequent

Mind - carried - desires to be

Differentiation between remedies

The repertorisation process leads to *Arsenicum album*.

Prescription

1 drop *Lycopodium* Q6 given 3 to 5 times a day.

Progress

Just quarter of an hour after the first dose, the child is sitting at the table and talking again. The breathlessness gradually subsides, and the child wakes up next morning completely healthy.

Evaluation

This case illustrates an extremely rapid cure, which is possible albeit not very common with homeopathy.

Critical commentary

The mothers detailed observations were decisive for the

Fall 11.1-7: Spastic bronchitis

Martin Bündner

Anamnesis

Since the previous day, the 3-year-old boy has had a barking, dry, spasmodic cough with severe dyspnoea. His temperature is 40.5-40.8°C. He is not thirsty. He was initially chilly, then turned hot and finally began to sweat. The fever is accompanied by headache and pain in the limbs. The continuous cough makes it difficult for him to fall asleep; when he finally does so, he tosses and turns in bed.

The cough also causes a sore throat and pain in the chest and abdomen. He feels pain all over his body which gets worse when he is touched. He is crying with pain. He can barely draw breath and wants to go outside into the fresh air.

He is also aggressive and irritable, which is unlike him. He hits and insults his mother. His mother explains that this is always the way he behaves when he is ill.

Diagnosis

Severe spastic bronchitis.

Diagnostic procedures

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY*, KENT

S REPERTORY**

Mind - weeping - pain, during*

Stomach - thirstless - heat, during**

Cough - constant**

Cough - asthmatic**

Mind - restless, nervousness - bed - tossing about in**

Fever - succession of stages - heat, alternating with chill - then sweat**

Differentiation between remedies

Kalium carbonicum, *Lycopodium* and *Pulsatilla* are all suggested by the repertorisation process. The desire for fresh air, the generalised pain aggravated by touch and the headache during feverish phases all strongly indicate *Pulsatilla* but do not exclude the other two remedies. The pain in the limbs accompanying the fever speaks against the other two remedies. The tearfulness and lack of thirst are keynotes for *Pulsatilla*, making this is the remedy selected.

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Prescription

1 drop *Pulsatilla* Q3 diluted in water and given 3 times a day.

Progress

The boy shows a clear improvement that same day. He sleeps through the night and eats some food the next day.

Evaluation

The more acute the disease, the more rapidly it responds to the appropriate homeopathic remedy.

Critical commentary

This remedy was administered for another two weeks

Case 11.1-8: Spastic bronchitis

Martin Bündner

Anamnesis

A 4-year-old boy is brought in with severe dyspnoea which has lasted three days. The symptoms began after a carnival parade during which he was frightened by a witch. He is trembling with fear and has had difficulty falling asleep ever since, as he is unable to forget this incident.

The breathlessness wakes him up; a whistling noise is audible from a distance.

Other symptoms since the carnival are yellowish nasal discharge, pain in the abdomen, throat and chest and a cough (the modalities cannot be determined in this case). His anus is itchy inside. The parents have noticed that the boy talks in his sleep. His face is pale with rings under his eyes.

Diagnosis

Spastic bronchitis.

Diagnostic procedures

Auscultation.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY Mind - excitement - emotional - causes ailments

Differentiation between remedies

The two potential remedies are *Calcarea carbonica* and *Phosphorus*. *Calcarea carbonica* is indicated by the sleeplessness caused by churning thoughts.

Prescription

1 drop *Calcarea carbonica* Q3 diluted in water and administered 3 times a day.

Progress

The boys breathing improves rapidly after taking the *Calcarea carbonica*. His recovery proceeds without complications; two days later, the symptoms have disappeared.

Evaluation

As the symptoms had already been present for three days, it was not expected that the dyspnoea would subside immediately.

Critical commentary

The parents had to be told that they should not

11.1 Asthma bronchiale

Case 11.1-9: Bronchiolitis

Martin Bündner

Anamnesis

The 4-year-old boy has had extremely severe dyspnoea since the previous day; he seems to be almost suffocating. The inhalations and corticoid treatment he has been receiving to date have been unsuccessful. Along with the dyspnoea, he has suddenly developed fever. The fever lasts for one to two hours, subsides then comes back. The boy's face is red during the feverish phases and deathly pale between them; he has dark rings around his eyes. He chokes while coughing, and the cough also prevents him from falling asleep. It is almost impossible for him to sleep. The cough causes chest pain. He drinks very little. He feels pain in the epigastrium after eating. Sore throat which gets worse when swallowing or talking. He also has earache, sniffles and urticaria which constantly changes location.

Diagnosis

Bronchiolitis.

Diagnostic procedures

Findings of physical examination

Dyspnoea, primarily on expiration with pallor and indrawn thorax. Tachycardia. Aggravated breathing noises. Tympanic sounds on percussion. Isolated discrete rhonchi.

Conventional treatment

On the previous day: inhalations with cooking salt and

Homeopathic treatment

Repertorisation

KENT'S REPERTORY*, _____ SYNTHETIC REPERTORY**

Face - discolouration - red - fever, during*

Respiration - difficult*

Generalities - complaints - wandering**

Differentiation between remedies

Tuberculinum is the only remedy listed in all of these rubrics. *Belladonna*, *China* and *Sepia* should also be considered. However, only *Tuberculinum* covers the changeable nature of the fever, which means this remedy is chosen.

Prescription

1 drop *Tuberculinum* Q6 diluted in water and given twice a day.

Progress

The dyspnoea begins to subside immediately after the first dose of *Tuberculinum*-, the boy quickly feels better. His condition improves every time he takes the remedy. Three days after starting to take *Tuberculinum*, the boy sleeps like a log, can breathe relatively easily and his condition is much better. *Tuberculinum* Q9 is prescribed on the tenth day; this remedy is diluted as before and taken once a day. This cures the infection completely.

Evaluation

This potentially life-threatening disease subsides remarkably quickly after being treated with the homeopathic remedy *Tuberculinum*.

Critical commentary

The other modalities of this case are not covered by

normally relieved by bronchodilators. This time the breathlessness does not improve with the bronchodilators; instead, it progresses with acute dyspnoea, severe headaches, cough, pain in the limbs and acute exhaustion; the symptoms have worsened dramatically over the last three hours. The

Case 11.1-10: Status asthmaticus

Edacheril Scaria Rajendran

Anamnesis

54-year-old patient with breathing problems for three days. Over the last 20 years, she has had similar attacks

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patient has a dry, coated tongue and no thirst; she fears not being able to draw breath and that she could soon die.

Diagnosis

Status asthmaticus

Diagnostic procedures

Findings on admission

Cyanotic patient. Oedema in the left ankle, can be pressed in. Pulse 90/min., respiratory frequency 26/min., rhonchi heard in all parts of the lungs on auscultation.

Homeopathic treatment

Most of the patients symptoms are typical of status asthmaticus. The most unusual symptom is the lack of thirst in connection with fear of death from this specific cause. The patient thinks that every breath is her last and she will be unable to continue breathing. This is the totality of her symptoms.

Repertorisation

KENT'S REPERTORY

Respiration - asthmatic

Mind - fear - death, of

Stomach - thirstlessness

Differentiation between remedies

“Breathing hurried and difficult (with fever and headache)” (Clarke 1995)

“[...] Dyspnoea. Breathing hurried and difficult [...]. Feels as if he could not draw another breath.” (Boericke 1996)

Prescription

Day 1 from 6 pm: 10 drops *Apis mellifica* Q6 diluted in water and given every 30 mins.

Progress

Around midnight, the patient's severe expiratory constriction eases. She is able to lie down and sleep for the rest of the night. She is given *Apis mellifica* four times a day from days 2 to 8, afterwards twice a day for another three months. The patient has had no more asthmatic symptoms since this time (four years ago).

Evaluation

In conventional terms, the only way of treating this case would have been to intubate the patient and administer artificial respiration.

Critical commentary

The rubric “Mouth - dryness - thirstless” should perhaps have been selected rather than general lack of thirst,

1 1.2 Pulmonary oedema

Definition

Pulmonary oedema is defined as an abnormal accumulation of serous fluid (transudate) in the interstitium of the lung tissue (interstitial oedema) or in the alveolae (alveolar or manifest pulmonary oedema).

Cardiac pulmonary oedema

Pulmonary oedema is usually the result of left heart insufficiency caused by acute myocardial infarction, myocarditis or decompensated heart valve defects; more infrequent causes include a drop in colloid osmotic pressure under capillary pressure

caused by a loss of plasma proteins as the result of nephrotic syndrome, excessive fluid intake (infusions) or starvation. Abnormal vascular permeability caused by toxic, infectious or allergic processes or rapid moves to high altitudes without allowing time for acclimatisation (“high-altitude pulmonary oedema”) can cause a drastic drop in colloid osmotic pressure; it can even lead to death.

Toxic pulmonary oedema

Toxic pulmonary oedema is a special form of pulmonary oedema in which an inhalation trauma to the alveolar epithelium caused by chemical irritation (by aggressive or toxic gases, e.g. fumes from burning plastic, welding or smouldering fire)

causes the permeability of the capillary membrane to increase, leading to an accumulation of transudate in the alveolae and interstitium. This condition progresses to failure of the lymph drainage system with a resulting accumulation of *foamy* fluid in the respiratory tract and subsequently death from suffocation.

Clinical information

Symptoms

Cardiac pulmonary oedema

- Dyspnoea through to orthopnoea
- Cyanosis
- Wet crackles, particularly in the basal lobes, later spreading to all lobes
- Foamy, flesh-coloured sputum
- Occasional bronchospasm (“cardiac asthma”)
- Congested jugular veins
- Pallor
- Cold sweat
- Tachycardia
- Possibly cardiac arrhythmia
- 3rd and/or 4th heart sound may be heard on auscultation

Toxic pulmonary oedema

- Swelling of the upper respiratory tract
- Stridor caused by constriction around the glottis
- Difficult breathing due to increasing resistance in the respiratory tract
- Increasing cyanosis
- General signs of hypoxia (tachypnoea, use of auxiliary respiratory muscles)

Diagnostic procedures

Cardiac pulmonary oedema

- In cases of pulmonary oedema, the sounds heard on **auscultation** are initially normal, followed by the development of fine, wet crackles, initially in the basal lobes then spreading throughout the lungs
- **Chest x-rays** show the image typical of the so-called fluid lung

decrease in pCO₂ is an expression of increased ventilation aimed at compensation. If the patient is not treated, he will become increasingly exhausted and his pCO₂ will increase.

Therapeutic crisis

In some cases, the left heart decompensation associated with cardiac pulmonary oedema cannot be brought under control even with appropriate chemical treatment. Even after recompensation with medication, the left heart insufficiency can only be kept stable with drugs.

Toxic pulmonary oedema is difficult to treat and associated with high mortality rates. Atelectasis is practically unavoidable in cases of severe toxic pulmonary oedema.

Homeopathic treatment can improve the prognosis of both forms of pulmonary oedema.

Homeopathic treatment

Symptom selection

The homeopathic treatment of pulmonary oedema is determined on the basis of the acute dyspnoeic symptoms with their modalities and the current concomitant symptoms.

Repertorisation

KENT'S REPERTORY

Chest - oedema - pulmonary

Am-c., *Ant-t.*, *Apis*, *Apoc.*, *Ars.*, *Aspar*, *Aur-j.*, *Carb-v.*, *Chel.*, *Coch.*, *Colch.*, *Crot-h.*, *Crot-t.*, *Dig.*, *Hyos.*, *Ip.*, *Kali-c.*, *Kali-i.*, *Kali-p.*, *Lach.*, *Lyc.*, *Merc-s.*, *Nat-m.*, *Phos.*, *Puls.*, *Squil.*, *Seneg.*, *Sulph.*, *Verat.*

Chest - dropsy

Acet-ac., *Am-c.*, *Ant-t.*, *Apis*, *Apoc.*, *Ars.*, *Asaf.*, *Aspar.*, *Aur-m.*, *Bry.*, *Calc.*, *Canth.*, *Carb-v.*, *Carbn-s.*, *Chin.*, *Chin-ar.*, *Colch.*, *Crot-h.*, *Dig.*, *Dulc.*, *Ferr-m.*, *Fl-ac.*, *Hell.*, *Iod.*, *Kali-ar.*, *Kali-c.*, *Kali-i.*, *Lach.*, *Lact.*, *Lyc.*, *Merc.*, *Merc-s.*, *Mez.*, *Mur-ac.*, *Nat-m.*, *Op.*, *Psor.*, *Ran-b.*, *Rat.*, *Sang.*, *Squil.*, *Seneg.*, *Sil.*, *Spig.*, *Stann.*, *Sulph.*, *Ter.*, *Uran.*, *Zinc.*

Respiration - difficult

Abies-n., *Abrot.*, *Absin.*, *Acet-ac.*, *Aeon.*, *Aesc.*, *Aeth.*, *Agar.*, *Agn.*, *Ail.*, *All-s.*, *Aloe*, *Alumn.*, *Alum.*, *Ambr.*, *Am-c.*, *Am-m.*, *Anac.*, *Ant-a.*, *Ant-c.*, *Ant-t.*, *Apis*, *Apoc.*, *Aral.*, *Arg-m.*, *Arg-n.*, *Arn.*, *Ars.*, *Ars-i.*, *Arum-t.*, *Arund.*, *Asaf.*, *Asar.*, *Asc-t.*, *Aspar.*, *Astac.*, *Aur.*, *Aur-m.*, *Aur-n.*, *Aur-s.*, *Bad.*, *Bar-c.*, *Bar-m.*, *Bell.*, *Benz-ac.*, *Bism.*, *Blatta.*, *Bor.*, *Bov.*, *Brom.*, *Bry.*, *Bufa.*, *Cast.*, *Coin.*, *Colad.*, *Colag.*, *Colo.*

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KENT'S REPERTORY

Carb-ac., Carb-o., Carb-v., Carbn-s., Carl., Cast., Caust., Cedr., Cench., Cham., Chel., Chen-a., Chin., Chin-ar., Chin-s., Chlol., Chlor., Cic., Cimx., Cmic., Cina, Cist., Coca, Cocc., Coc-c., Coff., Colch., Coll., Coloc., Con., Cop., Cor-r., Croc., Crot-c., Crot-h., Crot-t., Cub., Cupr., Cupr-ar., Cupr-s., Cur., Cycl., Dig., Dire., Dros., Dulc., Equis., Ery-a., Eup-per., Euph., Euphr., Ferr., Ferr-ar., Ferr-i., Ferr-p., Fl-ac., Gels., Gins., Glon., Graph., Grin., Guai., Ham., Hell., Hep., Hippoz., Hura, Hydr., Hydr-c., Hydr-ac., Hyos., Hyper., Ign., Indg., Ip., Iris, Jab., Jatr., Iod., Jug-c., Kali-ar., Kali-bi., Kali-c., Kali-chl., Kali-i., Kali-n., Kali-p., Kali-s., Kalm., Kreos., Lac-c., Lach., Lact., Lat-m., Laur., Led., Lil-t., Lith., Lob., Lyc., Lycps., Lyss., Mag-c., Mag-m., Mag-s., Mane., Mang., Med., Meli., Meny., Meph., Meri., Merc., Merc-c., Merc-s., Mez., Morph., Mosch., Murx., Mur-ac., MygaL, Naja, Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nice., Nux-m., Nux-v., Oena., Ol-j., Osm., Ox-ac., Par., Petr., Phel., Ph-ac., Phys., Phyt., Plat., Plb., Prun., Psor., Ptel., Puls., Ran-b., Raph., Rat., Rheum, Rhod., Rumx., Ruta, Sabad., Sabin., Sang., Sarr., Sars., Squil., Sec., SeL, Sep., Sil., Spig., Spong., Stann., Stram., Stry., Sulph., Sulph-ac., Tarent., Tax., Ter., Thuj., Tub., Verat., Verat-v., Vesp., Viol-o., Zinc., Zing.

Differentiation between important homeopathic remedies

Important remedies: *Antimonium tartari- cum*, *Apis mellifica*, *Arsenicum album*, *Lachesis*, *Lycopodium*, *Mercurius sulphuricus*.

Antimonium tartaricum: crackling breathing. Sleepiness, weakness, sweating. Yawning after coughing.

Apis mellifica: dyspnoea. Feeling of being unable to draw another breath. Difficult, accelerated breathing with headache and sensation of heart. **Arsenicum album:** foamy sputum. Wheezing. Dry cough, as if from sulphur fumes.

Lachesis: need to breathe in deeply. Breathing falters when falling asleep.

Lycopodium: salty-tasting sputum. Crackling in all parts of the lungs.

Mercurius sulphuricus: acute dyspnoea. Has to sit up. Shallow, rapid breathing.

Case 11.2-1: Pneumonia with decompensated cardiac insufficiency

Martin Bündner

Anamnesis

The 86-year-old multimorbid patient is admitted to hospital with breathlessness and swelling in the legs which has been increasing over the last week (day 1). Since the previous day, she can only sleep in a sitting position; on the day of admission, she also develops a dry cough. On day 4, the situation becomes acute: in the morning, the patient is still comparatively well; shortly afterwards, her condition deteriorates without warning. She suddenly develops a temperature of 38.8°C. She does not drink enough and is dehydrated. This acute stage is to be treated with homeopathy. She is also found to have the following symptoms:

- Attacks of coughing
- Breathlessness when coughing
- The patient feels better when lying on her side and worse when lying on her back (from extended periods

- She finds it difficult to speak; everything seems so heavy, especially her tongue
- Her tongue is dry and grooved; she is very thirsty and is being treated with diuretics
- She desires cold drinks
- The patient tosses and turns in bed

Diagnoses

Pneumonia with bronchospasm, early stages of left heart insufficiency, decompensated right heart insufficiency with peripheral oedema and pleural effusions. Previously diagnosed with coronary heart disease. Cardiac pacemaker implanted to treat third-degree AV block. Arterial hypertension.

Diagnostic procedures

Findings on admission

Exhausted 86-year-old patient in poor general condition. Dyspnoea. Oedema in the lower legs and tops of the feet. The lungs can only be auscultated with difficulty while the patient is lying down; a whistling rattle is audible along with loud wheezing and spasticity. Dry tongue.

11.2 Pulmonary oedema

Laboratory

Day 4: CRP 100 mg/l. Signs of partial respiratory insufficiency in the BGA. Day 5: signs of partial respiratory insufficiency in the BGA; tendency to deteriorate observed while monitoring progress. Day 6: CRP 82 mg/l. Signs of partial respiratory insufficiency in the BGA.

Imaging techniques

Resting ECG (day 4): heart rate 141/min., regular cardiac pacemaker action.

Echocardiography (day 3): moderately reduced pump function. No hypertrophy. All heart cavities dilated. Moderate valvular sclerosis. Mild mitral, aortic and tricuspid valve insufficiency established by colour Doppler sonography; PAP approx. 30 mmHg.

Chest x-ray in supine position

Day 4: pleural effusion on the right, DD pneumonia. Central congestion. Pacemaker from the right. Wedge-shaped parahilar thickening on the right with distended right hilus.

Day 8: discrete improvement with slight reduction in the wedge-shaped parahilar thickening. Right hilus still clearly distended; leaking pleural effusion on the right. Bands of atelectasis in the central area of the left lung. No major signs of insufficiency.

Day 14: marked decrease in perihilar infiltration and the accompanying effusion on the right. Certain signs of infiltration no longer present. No major signs of insufficiency. Dystelectasis in the central region of the left lung.

Day 20: almost complete regression of the infiltrative thickening on the right; heart moderately dilated with no major signs of insufficiency. Dystelectasis in both central areas.

Abdominal sonography (day 3): hepatomegaly. Congested liver and abdominal veins.

Pleural sonography (day 3): large pleural effusion on the right, effusion in the costophrenic angle on the left side.

Conventional treatment

medication. Standard antimicrobial treatment administered from day 6; the patient has no fever but her CRP is still elevated.

Homeopathic treatment

The first index card is selected on the basis of the unusual external temperature sensations experienced by the patient. The second card with a desire for cold drinks is chosen as an equivalent to cold ameliorating the symptoms.

Repertorisation

CARD INDEX REPERTORY Crosswise direction, side to side

Food, drink, cold ameliorated, warmth aggravated

Differentiation between remedies

The remedies suggested are *Belladonna* and *Sepia*. The sudden appearance of the symptoms and the whistling found on auscultation both indicate *Belladonna*; *Sepia* patients are more likely to have rattling sounds.

Prescription

1 dose of 2 globules *Belladonna* 30C on day 4.

Progress

Half an hour later, the patient is clearly better and the fever is subsiding. Her speech is normal and her left hand a little warmer. On auscultation, the lungs are found to be less spastic; the patient is much calmer. After one hour, the heat in her right hand has subsided. The patient falls asleep and is not disturbed. On day 5, it is found that the patient has deteriorated despite the treatment with *Belladonna*; she is now in critical condition. The symptoms present on the previous days have returned. The patient has massive dyspnoea. She is again given *Belladonna* 30C and the fever disappears; her condition improves and the dyspnoea subsides. A few hours later, the fever returns and she is given *Belladonna* 200C. Afterwards, the patient's temperature stabilises at normal levels; the symptoms disappear completely during the day. 1.5 l of fluid are drained during a therapeutic pleurocentesis performed to ease the strain on the lungs.

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Evaluation

In acute situations, it may be necessary to repeat the dose of the chosen homeopathic remedy to eliminate the symptoms completely. The antibiotics were administered as the patients CRP was still elevated even though the fever had subsided. The homeopathic remedy had to be given relatively frequently as the patients life-threatening condition caused it to expend its effect correspondingly quickly.

Case 11.2-2: Acute cardiac decompensation and urinary tract infection

Martin Bündner

Anamnesis

The 85-year-old patient is admitted to hospital with severe, rapidly increasing dyspnoea and acute cardiac decompensation. She is also unable to micturate, which is causing severe abdominal pain. The abdominal pain takes the form of a band around the lower abdomen. Vomiting mucus with no nausea. She suffered a heart attack seven months previously and a brainstem infarction six months previously.

Diagnoses

Acute cardiac decompensation, urine retention caused by urinary tract infection. Coronary heart disease, previous myocardial infarction, recurrent angina pectoris, sick sinus syndrome, arterial hypertension, second-degree mitral valve insufficiency, previous brainstem infarction. Depression.

Diagnostic procedures

Findings on admission

85-year-old patient who appears gravely ill; slightly overweight and in poor general condition. Cool skin. Coated tongue. Dyspnoea. Fine wet crackles, particularly in the basal lobes, audible at a distance. Pressure pain in the lower abdomen, particularly in the

Critical commentary

Unfortunately, the cardiac decompensation was not treated consistently with adjuvant homeopathic therapy. Therefore, we can only speculate how far *Belladonna* would have influenced the subsequent recompensation documented in x-ray images on days 14 and 20. As *Belladonna* only worked on this patient for a short time, it must be assumed that it would have had little or no effect on the cardiac recompensation process. A homeopathic remedy with a deeper effect would probably have had to be administered for this purpose.

* Rubrics condensed

Laboratory

Differentiation between remedies
Cholesterol 317 mg/dl (8.2 mmol/L), blood sugar 203 mg/dl (11.3 mmol/L). Hypoxia in the BGA. Urine status: The repertorisation processes ends with *Arsenicum album* and *Lycopodium*. *Belladonna*, *Caprum* in the sediment.

Imaging techniques

Resting ECG: heart rate 60/min., sinus rhythm, total left bundle branch block.

Chest x-ray taken while standing (6 hours after *Lycopodium*): no sign of left heart insufficiency.

Conventional treatment

No change made to the diuretics, nitrates and ACE inhibitors used to treat the patients hypertension and angina pectoris.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY Bladder - retention - painful

Abdomen - constriction

Stomach - vomiting - mucus

metallicum, *Nitricum acidum*, *Nux vomica* and *Sulphuricum acidum* are also possible if the clinical rubrics are excluded. The vomiting without nausea is characteristic and justifies the choice of *Lycopodium*, the only remedy in this rubric.

Prescription

I dose of 3 globules *Lycopodium* 30C on admission.

Progress

The dyspnoea starts to subside shortly after taking the *Lycopodium* and disappears completely during the next two hours. Her temperature also drops to 37 °C. The patient has no more symptoms and insists on being

11.3 Hyperventilation syndrome (tetany)

cardiac symptoms at any point during her stay; the angina pectoris treatment is continued.

Evaluation

The correct homeopathic remedy cures the pulmonary oedema and the clinical signs of urinary tract infection.

Critical commentary

The inclusion of the urinary tract infection which appeared at the same time as the pulmonary oedema is essential for the choice of remedy if the therapist sensibly does not wish to rely on one rubric, however characteristic, with just one single remedy.

II .3 Hyperventilation syndrome (tetany)

Definition

This disorder manifests as tetanic cramps caused by respiratory alkalosis resulting from hyperventilation of psychogenic or organic origin and the associated decrease in serum levels of ionised calcium.

Psychogenic causes include pain and any kind of agitation. There is a wide variety of organic causes: neurological diseases, intoxication, lack of oxygen, elevated body temperature, asthma bronchiale, uraemia, pulmonary embolism, pneumonia, diabetes mellitus, hypotension, hyperparathyroidism, hormonal influences and pregnancy.

Clinical information

Symptoms

There are four different forms of psychogenic

Tab. 11.3-1: Various types of breathing during hyperventilation	
Types	Clinical manifestations
Hyperventilatory sigh respiration	• Rapid, shallow polypnoea • Isolated sighs
Even hyperpnoea at rest	• Corresponds to normal exertion hyperpnoea in healthy people
Restless hyperventilation	• Irregular breathing • Frequent breaths of varying amplitude • Respiratory pattern typical of anxiety
Restrained breathing	• Deep, calm breathing at an even rate

11 Lungs

Hyperventilation tetany manifests with a wide variety of clinical symptoms (^ table 11.3-2):

Tab. 11.3-2: Symptoms of hyperventilation tetany	
Classification	Symptoms
Psyche	• Anxiety • Agitation • Apathy
Respiratory tract	• Dyspnoea • Feeling of constriction or as if a foreign body is present; no physiological explanation
Muscles	• Tremor • Tetany • Myalgia
Cardiovascular system	• Heart complaints such as angina pectoris • Tachycardia • Hypotension • Orthostatic reaction
Neurological symptoms	• Parasthesia • Unconsciousness • Hyperreflexia • Poor concentration
Gastrointestinal tract	• Unspecific abdominal pain • Aerophagia • Meteorism • Flatulence

Diagnostic procedures

The **blood gas analysis** shows respiratory alkalosis; the $\text{HCO}_3/\text{pCO}_2$ quotient and consequently the pH value are elevated. The normalisation of the pH value and the reduction of bicarbonate levels in the blood indicate the metabolic compensation of respiratory alkalosis which has been present for a long time; bicarbonate is eliminated via the kidneys as a result.

Therapeutic crisis

Acute hyperventilation tetany frequently seems to all concerned to be a life-threatening condition. If it is psychological in origin, the causative factors may be so powerful that the patient has to be sedated. Homeopathic treatment is indicated to bring the patient back to a state of equilibrium. This will also cause the hyperventilation tetany to subside.

Homeopathic treatment

Symptom selection

The underlying cause is decisive for the homeopathic treatment of hyperventilation tetany. The other current symptoms establish the framework for the choice of remedy.

Repertorisation

SYNTHETIC REPERTORY

Ailments caused by

- Abstinence

calc., con., lyc., pic-ac., plat.

- Ambition, deceived

bell., mere., nux-v., plat., puls., verat.

- Anger, rage

apis, arn.

- Anxiety

aur., calc., calc-p., cimic., hyos., kali-p., lyc., ph-ac., samb.

- Bad news

alumn., apis, arn., art-v., CALC., calc-p., chin., cinnb., cupr., dros., form., GELS., hist., ign., kali-c., kali-p., lach., lyss., med., mez., nat-m., nat-p., paeon., pall, ph-ac., phos., puls., stram., sulph., tarent.

- Blame

agar., care., coloc., gels., ign., med., OP., ph-ac., staph., stram., tarent.

- Blows of fate

ambr., con., dig., lach., stann., sulph.

- Business failure

ambr., calc., cimic., coloc., kali-br., nat-m., nux-v., ph-ac., puls., rhus-t., sep., sulph., verat.

- Contempt, disdain from others

aeon., alum., aur., bell., BRY., CHAM., coff., coloc., fen., hyos., ip., lyc., nat-m., NUX-V., olnd., par., phos., plat., sep., staph., stront-c., sulph., verat.

- Contradiction

anac., aur., aur-ar., cael., cham., ign., sil.

- Death of a child

calc., caust., gels., IGN., kali-br., lach., nux-v., ph-ac., plat., staph., sulph.

11.3 Hyperventilation syndrome (tetany)

SYNTHETIC REPERTORY -

Disappointment

alum., AUR., IGN., lach., LYC., mere., NAT-M., nux-v., op., PH-AC., plat., PULS., sep., STAPH., verat.

- Drunkenness

agar., ars., calc., lach., nux-v., op., ph-ac., sulph.

- Egotism, self-esteem, desire for recognition

calc., lyc., mere., pall., sil., sulph.

- Emotional excitement

acet-ac., aeon., agar., anac., arg-n., arn., asaf., aster., aur., bell., bry., calc., calc-ar., calc-p., CAPS., caust., cimic., cist., cob., cocc., coch., cod., COFF., coff-t., COLL., con., convo-s., cupr., cypr., epiph., ferr., GELS., glon., goss., hyos., ign., kali-br., kali-c., kali-p., kreos., lach., lyc., lyss., nat-c., nat-m., nit-ac., nux-m., nux-v., pall., PH-AC., phos., phys., plat., psor., PULS., pyrog., sacch., samb., scut., sep., stann., STAPH., tarent., TUB., verat., zinc., zinc-val.

- Excesses

arg-n., carb-v., dig., fl-ac., nux-v., pic-ac., sei., sep.

- Expectation, premonitions, forebodings

aeon., aesc., aeth., agn., alum., am-c., anac., apis, ARG-N., ARS., bar-c., bry., CALC., camph., canth., carb-v., CARC., caust., cench., chin., chlorpr., cic., cocc., coff., crot-h., dig., elaps, fl-ac., GELS., GRAPH., hyos., IGN., kali-br., kali-c., kali-p., lac-c., lach., levo., LYC., lyss., MED., mere., mosch., naja, nat-c., nat-m., nux-v., ox-ac., petr., ph-ac., PHOS., PLB., PSOR., PULS., rhus-t., sep., SIL., spig., staph., still., stram., stront-c., thuj., verat.

- Fear

aeon., arg-m., arg-n., bell., calc., calc-sil., caust., cocc., coff., cupr., gels., glon., graph., ign., kali-p., lyc., op., phos., puls., sil., verat.

- Friendship, deceived

ign., mag-c., mag-m., nux-v., ph-ac., sil., sulph.

- Haste, hurry-

aeon., am-c., arn., bry., nit-ac., nux-v., puls., rhus-t., sulph.

- Homesickness

caps., clem., eup-pur., hell., ign., mag-m., PH-AC., senec.

- Honour, from wounded

cham., ign., nux-v., staph., verat.

- Indignation

aeon., coloc., ip., nux-v., plat., STAPH.

SYNTHETIC REPERTORY

- Joy, excessive

aeon., caust., coff., croc., cycl., helon., mane., nat-c., op., ped., puls., verat.

- Laughter, excessive

coff.

- Literary, scientific failure

calc., ign., lyc., nux-v., puls., sulph.

- Loss of money

aur., arn., calc., ign., rhus-t., verat.

- Love, disappointed

am-c., ant-c., AUR., bell., bufo, cact., calc-p., caust., cimic., coff., com., con., hell., HYOS., IGN., iod., kali-c., lach., NAT-M., nux-m., nux-v., PH-AC., phos., sep., STAPH., sulph., tarent., verat.

- Mortification, humiliation

aeon., alum., anac., arg-n., ars., aur., aur-m., bell., bry., calc., caust., cham., COLOC., con., form., gels., IGN., lach., LYC., lyss., mere., NAT-M., nux-v., op., PALL., PH-AC., plat., puls., rhus-t., seneg., sep., STAPH., stram., sulph., verat., zinc.

- Music

phos.

- Noise

cocc.

- Overexertion, mental

agar., alum-p., alum-sil., ambr., anac., arg-n., arn., ars., ars-i., ars-m., aven., bar-acet, bell., calc., calc-p., calc-sil., chin., coca, cocc., con., CUPR., cupr-act, epig., epiph., fl-ac., gels., graph., ign., iod., iris, kali-br., kali-c., KALI-L, kali-p., lach., lyc., mag-p., med., NAT-C., nat-m., nat-p., nux-m., NUX-V., ph-ac., phos., pic-ac., pip-m., psor., pyrog., rhus-t., sabad., scut., sei., sep., sil., STAPH., TUB., vine.

- Position, loss of

ign., pers., plat., staph.

- Pride of others

orat

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SYNTHETIC REPERTORY -

Rage, fury

ACON., agar., alum., am-c., anac., ant-t., apis, arg-m., arg-n., arn., ars., ars-s-f., aur., aur-ar., aur-m., bar-c., bell., bry., cadm-s., calc., calc-ar., calc-p., calc-s., camph., caust., CHAM., chin., cimic., cina, cist, COCC., coch., coff., COLOC., croc., cupr., ferr., ferr-p., gels., graph., hyos., IGN., iod., IP., kali-br., kali-p., lach., lyc., mag-c., mag-m., mane., mere., mez., nat-ar., nat-c., nat-m., nat-p., nat-s., nux-m., NUX-V., ol-an., olnd., OP., petr., ph-ac., phos., PLAT., puls., ran-b., rhus-t, sacch., samb., scroph-n., sec., sei., sep., sil., stann., STAPH., stram., stront-c., sulph., tarent., verat., vine., zinc.

- Rudeness of others

calc., cocc., colch., nat-m., nux-v., ph-ac., STAPH.

- Sexual excesses

agar., agn., alum., alum-p., APIS., arg-n., arn., ars., asaf., aur., aur-ar., bov., calad., CALC., calc-p., calc-sil., carb-an., carb-v., CHIN., chin-ar., cocc., con., dig., iod., kali-br., kali-c., kali-p., kali-s., kali-sil., lil-t., LYC., mag-m., mere., nat-c., nat-m., nat-p., nit-ac., NUX-V., ol-an., onos., petr., PH-AC., PHOS., plat, plb., puls., sec., sei., SEP., sil., spig., STAPH., sulph., symph., thuj., upa., zinc., zinc-p.

- Shame

ign., OP.

- Schock, seelischem

aeon., ambr., apis, arn., coca, gels., iod., kali-p., op., pic-ac., plat.

Schreck

ACON., act-sp., agar., anac., apis, arg-m., arg-n., am., ars., art-v., aur., aur-m., bell., bry., bufo, calc., calc-sil., camph., carb-n-s., care., caust., cham., cimic., cina, cocc., coff., crot-h., cupr., gels., glon., graph., hyos., hyper., IGN., iod., kali-br., kali-c., lach., laur., LYC., lyss., mag-c., mere., morph., nat-c., NAT-M., nit-ac., nux-m., nux-v., OP., petr., PH-AC., PHOS., plat., PULS., rhus-t, sabad., samb., sec., sep., SIL., stann., stram., sulph., verat., vise., zinc., zinc-p.

- Surprises, pleasant

COFF., mere., op., verat.

- Vehemence

aur., bry., coff.

- Worries

ambr., ars., calc., caust., con., ign., kali-br., kali-p., nat-m., nux-v., ph-ac., phos., pic-ac., staph.

- Worry

alum-p., am-m., ambr., anac., ant-c., apis, arn., ars., art-v., AUR., aur-ar., aur-m., aur-s., bell., bry., calc., cael., calc-p., caps., CAUST., clem., COCC., colch., coloc., con., cycl., cypr., dig., dros., gels., graph., hura, hyos., IGN., ip., kali-br., kali-p., LACH., lob-c., lob-s., lyc., mag-c., naja, NAT-M., nit-ac., nux-v., op., PH-AC., PHOS., phys., pic-ac., plat., puls., samb., sol-o., STAPH.,

KENT'S REPERTORY,

Respiration - anxious

Abrot., Aeon., Aeth., Alumn., *Am-c., Anac.,* Ant-t., *Apis, Arn.,* Ars., Aur-m., Bar-c., Bar-m., *Bell.,* Bov., Bry., Bufo, Calc-ar., Calc., *Camph.,* Cann-s., *Carb-an., Cham.,* Chel., Chin-s., *Chlor.,* Cina, Cocc., *Coff.,* Colch., *Coloc.,* Crot-c., Crot-h., Crot-t, Cupr., Dig., Ferr., Gins., Hell., Hep., Hydr-ac., *Hyos.,* Ign., Ip., Kali-ar., Kali-bi., *Kali-c.,* Kreos., *Lach., Laur.,* Lob., Mang., Nat-m., Nit-ac., Nux-v., Olnd., *Op.,* Phos., *Ph-ac., Plat.,* Plb., Prun., *Psor.,* Puls., Rhus-t., Sabad., *Samb.,* Sars., Squil., Sec., Spig., Spong., Stann., Staph., *Stram.,* Tab., Ter., Thuj., Valer., Verat., *Viol-o.,* Zinc.

Respiration - accelerated

Absin., Acet-ac., Aeon., *Aesc., Agar., Ail.,* Alumn., Am-c., *Aml-n.,* Anthr., Ant-t, *Apis, Apoc., Arg-n.,* Arn., Ars., *Ars-i., Asaf.,* Aspar., Aur., Bar-c., Bar-m., Bell., Bor., *Brom.,* Bry., *Calc., Calc-p.,* *Camph.,* Cann-i., Cann-s., *Canth.,* Carb-v., Carb-ac., Carb-s., Cast., *Cedr., Cham.,* Chel., *Chin.,* Chin-ar., Chin-s., Chlor., Cimic., *Cina,* Clem., *Coca, Cocc., Coc-c.,* Coff., *Colch., Coloc.,* Con., *Cop.,* *Crot-h.,* Cub., Cupr., *Cycl., Dig.,* Dulc., Gels., Glon., Hell., Hep., Hydr., Hydr-ac., Hyos., Ign., Ip., *Iod., Kali-ar., Kali-bi.,* Kali-c., *Kali-L,* Kali-p., *Lact.,* Laur., Led., Lyc., Lyss., *Merc., Merc-c., Merc-s.,* Mez., *Mur-ac.,* Naja, Nat-ar., Nat-c., *Nat-m., Nux-m., Nux-v.,* Op., Ox-ac., Petr., Phos., *Phyt., Plan.,* Plb., *Puls.,* Rhod., Rhus-t., *Samb.,* Sang., Squil., Sei., Seneg., Sep., *Sil.,* Spong., Stann., *Stram.,* Sulph., Sulph-ac., Tab., Tub., *Verat., Verat-v., Vesp.,* Vine., Zinc.

Differentiation between important homeopathic remedies

Important remedies: *Ignatia, Natrium muri-aticum, Nux vomica, Phosphoricum acidum, Pulsatilla, Staphisagria.*

Ignatia: irritable and depressed. Easily offended. Involuntary sighing. Mental and physical exhaustion.

Natrium muriaticum: worse when comforted.

Nux vomica: very irritable. Cannot bear noise, light smells etc. Reproaches others with their mistakes.

Phosphoricum acidum: apathetic, indifferent. Dazed and exhausted with worry.

Pulsatilla: Changeable mood. Very tearful.

Staphisagria: very sensitive. Sad, despairing. Feels like

11.3 Hyperventilation syndrome (tetany)

Case 1.3-1: Hyperventilation tetany with hysterical convulsions

Martin Bündner

Anamnesis

The 35-year-old patient is lying on the bed and has been having severe convulsions for four hours almost without a break. These are recurrent and affect his hands, legs, throat and chest. During the convulsions, his mouth is open and he moves his head and neck. Sometimes his hands tingle and become cramped and cold; at these times he hyperventilates. He is conscious all the time, also during the convulsions; he can talk during the brief periods in between. The cramps do not affect all the body parts involved at the same time; instead, they change in no order. His hands are trembling.

During the anamnesis, it becomes clear that he is an extremely sensitive person. Just recently, a friend who was like a father to him passed away, and he is unable to get over his death. He sheds a few tears when telling this story. On this day, someone also offended him badly. Both of these incidents are obviously oppressing him, as the cramps become markedly more severe while he is telling his story. Before the doctor arrived, he was no longer able to speak. He felt as if the connection between his thoughts and voice had been broken, like a kind of rigor. As if all his strength had gone.

Diagnoses

Hyperventilation tetany. Hysterical cramps.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - convulsions - grief, after

Mind - mortification - ailments after

Generalities - convulsions - hysterical

Differentiation between remedies

The remedies *Ignatia* and *Natrium muriaticum* feature prominently during the repertorisation process. The Synthetic Repertory also suggests *Arsenicum album* and *Nux vomica*. Both *Ignatia* and *Nux vomica* have proven themselves in treating ailments caused by deaths; the hypersensitivity combined with the convulsions and their changeable nature clearly indicates *Ignatia*, which is why this remedy is chosen.

Prescription

1 dose of 5 drops *Ignatia* Q6.

Progress

Immediately after taking the remedy, the patient ridicules it as being a placebo. The therapist tells him that he has been given a homeopathic remedy and not a placebo. Immediately after being told this, the patient begins to suffer terrible convulsions throughout his body while remaining fully conscious. His arms, legs, head and upper body shake and writhe more violently than ever before. This situation continues for more than six minutes. The patient hyperventilates and constantly opens his mouth to groan. He slides almost one metre down in the bed. Suddenly he collapses exhausted and asks, "What on earth was that?" After this, he has no more convulsions and stops hyperventilating.

Evaluation

After an initial aggravation of the symptoms, a single dose of *Ignatia* instantly cured the convulsions which had been going on for four hours.

Critical commentary

Initial aggravations can also occur after Q potencies have been administered. In this case, they could have been prevented by giving the patient a smaller dose.

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12 Gastroenterological emergencies

Martin Bündner (conventional medicine) Martin Bündner, Edacheril Scaria Rajendran (homeopathy)

- 12.1 Acute abdomen
- 12.2 Homeopathic treatment

12.1 Acute abdomen

II.6.2

Definition

Acute abdomen is a painful, acute and potentially life-threatening condition affecting the abdominal area. It requires immediate diagnosis and treatment.

The entire spectrum of intra-abdominal diseases is ultimately based on four different mechanisms:

- Organ rupture or perforation
- Acute ischaemia
- Restriction to or blockage of a hollow organ
- Inflammation

Acute abdomen does not include abdominal trauma or extra-abdominal diseases with pain radiating into the abdomen.

The differential diagnosis of acute abdominal symptoms depends on their location.

- **Upper abdomen, right side:** perforated ulcer, cholecystitis, pancreatitis, appendicitis, subhepatic abscess, liver congestion, ruptured liver
- **Upper abdomen, right or left:** subphrenic abscess, pleuritis, stones in the renal pelvis, pyelitis, perinephritic abscess
- **Upper abdomen, left:** pancreatitis, splenic infarction, myocardial infarction, ruptured spleen
- **Lower abdomen, right:** appendicitis, invagination, perforated, Meckel's diverticuli,

lymphadenitis mesenterica, enteritis regionalis, Crohns disease

- **Lower abdomen, right or left:** mid-cycle pain, tubal pregnancy, ureteric stone, adnexitis, incarcerated hernia, torsion of ovarian cyst, testicular torsion, psoas abscess
- **Lower abdomen, left:** rectosigmoid carcinoma, sigmoid diverticulitis
- **Entire abdomen:** pleuritis, angina pectoris, myocardial infarction, hiatus hernia, perforated oesophagus, perforated ulcer, pancreatitis, bowel obstruction, occlusive mesenteric infarction, gastroenteritis, pseudomembranous enterocolitis, ruptured aneurysm, acute urine retention, metabolic, toxic and bacterial causes

This chapter discusses the following diseases in more detail:

- Stomach perforation
- Ileus
- Gastrointestinal bleeding
- Biliary colic
- Pancreatitis
- Appendicitis

Stomach perforation

Perforation refers to the opening of a closed body cavity, usually a hollow organ, caused by trauma or inflammation and necrosis. Perforation of the

12 Gastroenterological emergencies

stomach wall is usually a serious complication of peptic ulcer, open perforations occurring with ulcers in the stomachs anterior wall and closed perforations in other areas.

Ileus

Ileus is caused by paralysis or obstruction of the intestinal passage. The intestinal tone and peristalsis become paralysed reflexly. This leads to increasing stasis and distension of the intestinal wall, local circulatory problems, oedema in the intestinal wall and loss of intestinal fluid and protein with general symptoms such as hypovolaemia, haemoconcentration, reduced cardiac output and possibly shock. Pathogenetically, ileus is caused by mechanical (occlusion through blockage of the intestinal lumen or strangulation, e.g. of hernias in cases of circulatory disorders of the mesenteric blood vessels) or functional (paralytic or spastic) factors.

Newborn ileus and postoperative ileus are special forms.

Gastrointestinal bleeding

Gastrointestinal bleeding refers to bleeding in any part of the digestive tract and is classified according to its location (upper gastrointestinal tract including the oesophagus, intestines, entire gastrointestinal tract).

Biliary colic

Gallstones (cholecystolithiasis or choledocholithiasis) can become symptomatic and cause colic.

Pancreatitis

Inflammation of the pancreas caused by autolysis, with symptoms ranging from interstitial oedematous changes to haemorrhagic pancreas necrosis according to the degree of severity. This book focuses on acute pancreatitis; chronic pancreatitis only becomes an emergency during acute flare-ups. Acute pancreatitis is commonly found with alcoholism, diseases of the bile ducts (particularly papillary stenosis), after surgery in the abdominal cavity, with hyperparathyroidism, hyperlipoproteinaemia, peptic ulcer, mumps and after taking glucocorticoids.

Appendicitis

Appendicitis refers to inflammation of the appendix vermiformis usually caused by enterogenic (rarely haemogenic) infections. The development of appendicitis is favoured by narrowing or obstruction of the lumen as a result of distortion, scarring, inflammatory swelling of the mucous membranes, coproliths, worms or occasionally by foreign bodies. Acute appendicitis is referred to in this context.

Clinical information

Symptoms

Pain is the main symptom of acute abdominal diseases.

The following symptoms may appear depending on the disease: vomiting, diarrhoea, melaena (tarry faeces), haematochezia (rectal bleeding), ileus, hypovolaemia and shock, fever.

Stomach perforation

The pain begins suddenly and may radiate to the left shoulder. After a symptom-free interval, the abdominal wall becomes tense and the patient develops symptoms of shock.

Ileus

This condition begins suddenly or develops gradually (subileus or incomplete ileus). The patient suffers from nausea and vomiting, meteorism with retained stool and wind, (severe) colicky pain and eructation; in the later stages, he may vomit faeces.

Gastrointestinal bleeding

Depending on the severity of the bleeding, occult blood may be found in the stool or it may be bloody or tarry; the patient may vomit blood. In certain circumstances, the patient's blood pressure may drop and he may develop hypovolaemic shock. Anaemia is frequently a leading symptom in cases of chronic gastrointestinal bleeding.

Biliary colic

The condition is associated with pain caused mainly by the movement of gallstones obstructing bile flow, colic

vomiting. Icterus may be temporarily observed after instances of biliary colic.

Pancreatitis

Acute pancreatitis can occur at any age. The symptoms vary widely, from nausea, vomiting and indeterminate upper abdominal pain in mild cases to the severest abdominal pain radiating into the back, tense abdominal wall, meteorism, subileus, ileus, icterus, ascites, cardiovascular shock followed by oliguria or anuria, palpable swelling in the upper abdomen and fever.

Appendicitis

The symptoms often begin suddenly with nausea and vomiting, in some cases with colicky abdominal pain (frequently beginning in the epigastrium and only moving to the lower right quadrant of the abdomen after several hours), a coated tongue and fever (37.5–39°C). Elderly patients in particular may only have very few symptoms.

Diagnostic procedures

Stomach perforation

Diagnosed by means of abdominal x-rays taken while the patient is standing (free air under the diaphragm).

Ileus

- **Inspection** of the abdomen (surgical scars, hernias), **palpation** (intestinal rigidity, swelling, abdominal defence mechanism, hernias), **rectal examination**, **percussion** and **auscultation** often provide critical information
- The diagnosis is confirmed by abdominal **x-rays** to locate the problem by means of air-fluid levels
- **Laboratory tests** are performed to assess electrolyte and fluid loss and prepare for surgery

Gastrointestinal bleeding

Laboratory tests of haemoglobin and haematocrit levels are performed to confirm the diagnosis. The source of the bleeding can usually be located by **endoscopy** (oesophagogastroduodenoscopy or proctorectosigmoidoscopy/colonoscopy). An **angi-**

Biliary colic

Biliary colic is confirmed by various test results.

- During **palpation**, sensitivity to pressure is found below the right costal arch with a local muscular protective reflex and possibly enlargement of the gallbladder
- These days, **ultrasound** is the apparatus-based diagnostic method of choice with an accuracy rate of 95%; however, the results may be affected by meteorism due to air covering the area
- The presence of calciferous stones is confirmed by plain **x-rays** of the gallbladder area
- **Cholecystocholangiography** is used to confirm the presence of choledocholithiasis and prepare for surgery
- **Endoscopic retrograde cholangiopancreatography** (ERCP) may be performed to remove obstructive papillary stones

Pancreatitis

- **Laboratory tests** may reveal hyperglycaemia, hypocalcaemia, elevated lipase and amylase levels (the most sensitive parameters) in the blood and urine and leucocytosis
- **Abdominal x-rays** may show signs of paralytic ileus with increased gas quantities and air-fluid levels in individual intestinal loops. Chest x-rays may show diaphragmatic elevation on the left, possibly flat atelectasis, pleural effusions and the so-called watering-can sign in the passage from the stomach to the intestine
- The diagnostic procedures may be rounded off by **ultrasound**

Appendicitis

- **Laboratory tests** frequently confirm leucocytosis with relative lymphopenia. The ESR is initially normal and accelerates 12–24 hours later. The physical examination reveals sensitivity when palpating typical points (McBurney point, Morris point, Kiimmell point, Lanz point and Lenzmann point)
- Rebound tenderness (Blumberg's sign): pain increases in the ileocaecal region when pressing and releasing

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- Rovsing's sign: increased pain when pressing the bowel towards the caecum
- Extension pain, Sitkowski's symptom: pain worsens when lying on the right side
- Ten Horn sign: pain worsens during rectal examination and possibly also when exerting traction on the spermatic cord
- Psoas sign: pain in the psoas region when raising the right leg against resistance
- Normally the most reliable symptom during the acute stage, the local defence reflex may not be present in cases of empyema (pressure pain), if the appendix is located in the pelvis minor (pain on rectal examination) or behind the caecum (lumbar tension, psoas contraction)
- Rectal-axillary temperature difference $< 1^{\circ}\text{C}$

*** Warning: the location of the pain may be atypical in pregnant patients.**

Therapeutic crisis

The high mortality rates associated with acute abdomen are shocking, even more so as they increase in cases of perforation and (purulent) peritonitis. In conventional terms, many diseases can only be controlled by surgery; early and late complications (e.g. adhesions) may be a problem. In cases of biliary colic, the therapist must be aware of potentially problematic complications such as gallbladder hydrops in cases when the cystic duct is obstructed by stones, cholecystitis, gallbladder empyema (beware perforation), cholangitis, pancreatitis caused by stones blocking the papillary area or after the passage of stones, obstructive icterus, stone perforation in the intestinal tract and Mirizzi syndrome (obstruction of the common hepatic duct by stones in the neck of the gallbladder or the cystic duct).

Mortality rates in cases of pancreatitis are particularly high, ranging from between 15-20% to up to 80% depending on the severity of the disease. Complications which clearly worsen the prognosis include abscess formation and sequestration of the

pancreas, pancreatic necrosis, bleeding caused by vascular erosion and pancreatic (pseudo) cysts.

Homeopathic treatment can help the acute disease subside and prevent or cure other complications.

12.2 Homeopathic treatment

» II.6

Symptom selection

Besides the causa occasionalis (exciting or maintaining cause/s), the abdominal symptoms and their precise modalities are critical for the choice of homeopathic remedy; these should therefore be established despite the pain symptoms.

Mood symptoms, respiration, sweating and fever should not be forgotten.

Repertorisation

KENT'S REPERTORY

Abdomen - hard

Alum., *Anac.*, Arn., *Ars.*, Ars-i., Bar-c., Bar-m., Bell., Calad., Calc., Caps., *Carbn-s.*, Caust., Cham., *Chel.*, Chin., *Cina*, Clem., Coff., Colch., Con., Cupr., Cupr-ar., Dig., Dire., Dulc., Eup-pur., *Ferr.*, Ferr-ar., Ferr-p., Gels., *Graph.*, Grat., Hyper., Ign., Jug-r., Kali-ar., *Kali-c.*, Kali-p., Kali-s., Lac-c., Lach., Laur., *Mag-m.*, Mag-s., Merc., Merc-c., Merc-j-f., Merc-i-r., *Mez.*, Nat-ar., Nat-c., Nat-m., Nat-p., *Nit-ac.*, Nux-m., Nux-v., *Op.*, Paeon., Phos., Plb., Puls., *Raph.*, Sars., Sec., *Sep.*, Sil., Sol- t-ae., Spig., Spong., Stram., Sulph., Sumb., Tab., Valer.

Abdomen -

- Inflammation - appendicitis

Bell., Bry., Cadm., *Calc-s.*, *Chel.*, *Chin.*, *Cocc.*, Con., *Crot-c.*, Dulc., *Echi-a.*, *Graph.*, *Hep.*, *Lach.*, *Lyc.*, *Merc.*, Merc-c., *Nit-ac.*, Phos., *Plb.*, Sil., Ter.

- Typhlitis

Apis, *Ars.*, Bell., Bry., *Calad.*, *Card-m.*, *Chin.*, *Colch.*, *Crot-h.*, Gins., *Lach.*, *Lyc.*, *Merc.*, *Nat-s.*, *Op.*, *Phos.*, *Plb.*, *Rhus-t.*, *Samb.*, *Sep.*, *Sil.*, *Stram.*, Sulph., Thuj.

Abdomen - intussusception

Aeon., Arn., *Ars.*, *Bell.*, Bry., *Colch.*, *Coloc.*, Cupr., Kali-bi., Kreos., *Lach.*, *Lob.*, *Lyc.*, *Merc.*, *Nux-v.*, *Op.*, *Phos.*, *Plb.*, *Rhus-t.*, *Samb.*, Sulph., Tab., Tarent., Thuj., Verat.

12.2 Homeopathic treatment

KENT'S REPERTORY

Abdomen - peritoneum - inflammation, peritonitis, enteritis etc.

Acet-ac., Aeon., Aloe, Alumn., Ant-t., Apis, Arn., Ars., Ars-i., Atro., Bapt., Bell., Bry., Bufo, *Cact.*, *Calc.*, *Canth.*, *Carb-v.*, Card-m., Cham., Cocc., Coff., Colch., *Coloc.*, *Crot-c.*, *Crot-h.*, Cupr., *Echi-a.*, Ferr., Ferr-ar., Ferr-p., Gamb., Gels., Hyos., Ip., Iod., Kali-c., Kali-chl., Kali-i., Kali-n., Kali-p., Lach., Laur., Lyc., Merc., Merc-c., Mez., Nux-v., Op., Ox-ac., Phos., Plb., Puls., Pyrog., Rhus-t., Sabin., Sec., Sil., Spong., Sulph., Ter., Thuj., Uran., Urt-u., Verat., Verat-v.

Abdomen - pain - aching, dull pain

Acet-ac., Aeon., Aesc., Aeth., Agar., Agn., Ail., *All-c.*, Aloe, Alumn., Alum., Ambr., Am-c., Am-m., Anac., Anthr., Ant-c., Ant-t., Apis, Arg-n. Arn., Ars., Ars-i., Asaf., Asar., Asc-t., Aster., Aur., Aur-m., Bapt., Bar-c., Bar-i., Bar-m., Bell., Berb., Bism., Bol., Bor., Bov., Brom., Bry., Bufo, Cact., Calad., *Calc.*, *Calc-p.*, *Calc-s.*, Camph., Cann-s., Canth., *Caps.*, Carb-an., Carb-v., Carb-ac., Caust., Cedr., Cham., *Chel.*, Chin., Chin-ar., Chin-s., Chlor., Cic., Cimic., Cina, Clem., Cocc., Coe-c., Coff., Colch., Coloc., Con., Cop., Crot-t., Cub., Cupr., Cupr-ar., Cycl., Dig., Dios., Dor., Dros., Dulc., Elaps., Eug., Euon., Eup-pur., *Euph.*, Euphr., Eupi., Fago., Ferr., Ferr-ar., Ferr-i., Ferr-m., Ferr-p., Gels., Gins., Gran., Graph., Grat., Gymn., Hell. Hep., *Hydrc.*, Hyos., Ign., Indg., Ind., Ip., Iris, Jac-c., Jatr., Iod., Jug-r., Kali-ar., Kali-bi., Kali-br., Kali-c., Kali-chl., Kali-i., Kali-n., Kali-p., Kali-s., Kreos., Lach., Laur., Led., Lept., Lil-t., Lith., Lob., Lyc., Lycps., Lyss., *Mag-m.*, Mag-s., Mane., Mang., *Meph.*, Meri., Merc., Merc-c., Merc-j-f., Merc-i-r., Mez., Morph., Mosch., Murx., Mur-ac., Myric., Naja, Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nice., Nit-ac., Nat-m., Nux-v., Olnd., Op., Ox-ac., Paeon., Pall., Par., Petr., Phos., Ph-ac., Phyt., Pic-ac., Plan., Plat., Plb., Podo., Prun., *Psor.*, Ptel., Puls., Ran-b., Ran-s., Raph., Rat., Rheum, Rhus-t., Rhus-v., Rob., Rumx., Ruta, Sabad., Sabin., Sang., Sars., Squil., Sec., Senec., *Seneg.*, Senn., Sep., Sil., Spig., Spong., Stann., Staph., Stram., Stry., Sulph., Sulph-ac., Sumb., Tab., Tarent., Tarax., Ter., Thuj., Til., Urt-u., Ust., Valer., Verat., Verat-v., Zinc., Zing.

Stomach - pain

KENT'S REPERTORY

Abies-n., Abrot., *Acet-ac.*, Aeon., Aesc., Aeth., Agar., Aloe, Alumn., Alum., Ambr., Am-c., *Aml-n.*, Anac., Anat., *Ant-c.*, *Ant-t.*, Apis, Arg-m., Arg-n., Arn., Ars., Ars-h., Ars-i., Arund., Asaf., Asar., Asc-t., Aur., Aur-m-n., Bapt., Bar-c., Bar-j., Bar-m., Bell., Benz-ac., Bism., Bol., Bor., Brach., Brom., Bry., *Cact.*, Cadm., Calad., *Calc.*, *Calc-p.*, *Calc-s.*, Camph., Cann-s., Canth., *Caps.*, Carb-an., Carb-v., Carb-ac., Carbn-s., Card-m., Carl., Caul., Caust., Cham., Chel., Chin., Chin-ar., *Chin-s.*, Cic., Cimic., Cina, Clem., Cob., Cocc., Coc-c., Coff., Colch., Coloc., Con., Cop., Cor-r., Corn., Croc., *Crot-c.*, *Crot-h.*, Crot-t., Cupr., *Cupr-ar.*, Cur., Cycl., Dig., Dios., Dulc., Echi-a., Ferr., Ferr-ar., Ferr-i., Ferr-p., Gels., Glon., Gran., Graph., Grat., Ham., Hell., Hep., Hura, *Hydr.*, *Hydr-ac.*, Hyos., Ign., Ip., Iris, Iod., Kali-ar., Kali-bi., Kali-c., Kali-chl., Kali-i., Kali-n., Kali-p., Kali-s., Kalm., Kreos., Lach., Laur., Led., Lept., Lob., Lyc., *Mag-c.*, *Mag-m.*, *Mag-p.*, Mag-s., Mane., Mang., Med., Merc., Merc-j-f., Mez., Mosch., Mur-ac., Naja, Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nice., Nit-ac., Nux-m., Nux-v., Olnd., Ol-an., Op., Ox-ac., Petr., Phos., Phys., Phyt., Plan., Plb., Podo., Prun., Ptel., Puls., Ran-b., Ran-s., Rhod., Rhus-t., Rob., Rumx., Ruta, Sabin., Sang., Squil., Sec., Senec., Seneg., Sep., Sil., Sol-t-ae., Spig., Stann., Staph., Stram., Stront., Stry., Sulph., *Sulph-ac.*, Sumb., Tab., Tarent., Ter., Teucr., Thuj., Uran., Ust., Valer., Verat., Verat-v., Zinc., Zing.

Differentiation between important homeopathic remedies

| **Important remedies:** *Belladonna*, *Bryonia*, *Colocynthis*, *Lachesis*, *Lycopodium*, *Nux vomica*, *Opium*, *Phosphorus*, *Sulphur*.

Belladonna: urge to vomit and dry heaving. Frequent nausea; spasmodic vomiting. Vomiting: mucus, bile and mucus or undigested food; watery, acidic, bloody mucus. Cerebral vomiting. Vomiting in the evening; with dizziness and hot flashes, followed by profuse sweating. Feeling of fullness and constriction in the stomach; the patient is unable to lie still. Warmth and congestive burning in the stomach with desire for acidic drinks. Nausea following violent hiccoughs. Painless throbbing and pounding in the pit of the stomach, vomiting bright red blood, bile and mucus. Pain appears and disappears suddenly. Congestive delirium and convulsions. Violent, convulsive swallowing; at night (midnight), also with profuse sweating; alternating with convulsions of the head and limbs, followed by nausea and weariness, or thirst with heat and

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redness in the face. Painfully distended abdomen, hot. Abdomen sensitive to the slightest touch. The abdomen is so sensitive that the slightest jarring, even of the bed or chair on which the patient is sitting, worsens the pain; he is forced to take careful steps when walking to avoid jarring. The pain, particularly in the abdomen and pelvis, appears suddenly, remains for a time then disappears just as suddenly; more rarely, the pain may come and go gradually. Complications with enteritis or typhlitis may be accompanied by scratching around the navel (as if from nails), mucous diarrhoea etc. Cramp-like, colicky abdominal pain; contracting, squeezing, tightening, gripping and clawing pain as if the area is being filled with nails or as if a ball is being wound up, particularly around the navel; causes the patient to double up. Severe pain in the ileocaecal region; the patient cannot endure the lightest touch, even the sheet is too much; nausea and vomiting. The patient is forced to lie on his back without moving; high temperature, sharp heat in the abdomen. Heat and burning in the abdomen; with nausea, fear and outbreaks of sweating. Gripping colic. Colic from copper poisoning. Feeling as if a solid object is pressing from the inside to the outside in the right groin; the place affected does not feel hard if the patient bends forward while sitting. Distended abdomen, neither hard nor painful. Intensive local inflammation. Inflammation of the upper part of the duodenum.

Bryonia: vomiting solid, non-liquid foods. Vomiting (initially) bitter water or bile and (then) food, also at night. Bitter vomiting if the patient drinks immediately after a meal. Vomiting bitter substances or yellowish green mucus. The patient wants to lie still; the slightest movement, silting up, walking around, even just moving a hand worsens the nausea or can trigger vomiting; all food is vomited at once. Vomiting blood instead of menstrual bleeding; vomiting bright red blood followed by dry, exhausting cough and insatiable thirst for large quantities of water, with dry mouth and furry white coating on the tongue; < when trying to get up and even on the slightest movement. Complication with diaphragmitis; exudation stage. Stabbing, pressing,

piercing pain in the intestines, with every breath, < on the slightest movement. Localised abdominal pain, dull, with a throbbing feeling. Peritonitis with stabbing, burning pain; the abdomen is very sensitive to touch, with constipation, particularly in rheumatic patients, < on moving and standing up. Sudden, painful, cutting pain in the intestines with the feeling that someone is digging around with their fingers, forcing the patient to double up, > with profuse, paste-like defecation. Abdomen very sensitive, feels sore. The patient has to keep absolutely still during the colic. The patient feels most comfortable if he lies on the affected side or on his front. Colic after a hot day, particularly during a hot summer. Hard swelling around the navel and hypochondria. Painful twisting and turning around the navel; constipation.

Colocynthis: vomiting and diarrhoea from rage and indignation. Vomiting food and drink, also without nausea or nauseous taste; greenish vomit; vomiting with diarrhoea. Vomiting mucus and bile without nausea. Extreme colic with tympanitis. Pain as if abdomen is being cut with knives, cold and tearing pains radiating down the legs. Abdomen sensitive to touch. Colic from lead poisoning. Violent, overwhelming colic with cutting, gripping or constricting pain forcing the patient to double up, restlessness in the whole body and shivering in the face, starting from the lower abdomen. Severe colicky pain, mainly around the navel, every change in position <; great agitation and loud screams when changing position; from eating fruit. The colic is so violent that the patient seeks relief by pressing his abdomen against a bedpost or the edge of a table. Colicky, cramp-like abdominal pain after annoyance or anger. Pain in the groin, as if from a hernia; feeling as if the hernia recedes when pressed. Distended abdomen; swelling, painful. **Lachesis:** violent vomiting of food and drink, with pain in the head and body; convulsive vomiting, also with bile or diarrhoea (at night); green vomit; mucous. Dyspepsia which gets worse as soon as the patient eats; constipation; after taking mercury. Gnawing in the stomach; gnawing pressure in the stomach, > after food but returns after a few hours;

the emptier the stomach, the more severe the pain. Nausea with many other symptoms; in the stomach and abdomen, with feeling of malaise, as if about to faint; forces patient to open his clothing, which ameliorates the symptoms. The pit of the stomach is sensitive to touch. Bloody vomit and stools which look like burnt straw. Vomiting blood instead of menstrual bleeding. Inflammation of the caecum. Sensitivity, swelling and pain around the caecum. Hot abdomen; the patient resists the slightest touch of his abdomen even when he is unconscious. Abdomen hot and sensitive to touch; painful stiffness from the loins down to the thighs. Unable to bear tight clothing around the stomach and hypochondria; even in bed, the patient has to open his pyjama jacket to stop himself from feeling constricted; he can't even rest his arm on his body because of the pressure. Abdomen hot and sensitive to touch; painful stiffness from the loins down to the thighs; has to lie on his back with his knees drawn up to his chest; particularly for complications from typhlitis. Patient lies on his back with knees drawn up to his chest; sensitivity, pain and swelling around the caecum. When turning onto his left side, the patient feels as if a ball is rolling over in his abdomen, particularly if pus has formed. Threat of gangrene in strangulated hernias; the skin covering the hernia turns dark and patchy; abdominal pain; feeling of constriction in the abdomen; cutting, tearing, burning pain; the hernia is extremely sensitive; the patient will not allow treatment (touch).

Lycopodium: round stomach ulcer. Nausea followed by vomiting of coagulated blood or dark green masses, with soreness and tension around the liver and stomach, < when bending over or pressing hands on the area. Regurgitation of sharp, acidic liquid. Vomiting acidic substances. Feeling of fullness in the stomach and abdomen. Severe stomach pain after eating and slight cold, with chills, the fingers turn waxy as if they have died off. Abdominal rumbling, also with tension or gurgling. Stomach pain < when sitting doubled up, better on getting up and walking around; no pain at night in the warmth of the bed. Rumbling in the

splenic flexure. Diaphragmitis with the feeling as if a cord is marking the places where the diaphragm is attached to the ribs. Chills, vomiting, abdominal pain; stabbing pain in the left side of the chest radiating into the abdomen and groin. Stabbing in the shoulders, arms and left armpit; the abdomen feels painful even when touched; when lying on the left side, the patient feels as if a stone-like weight is rolling from his navel into his groin, making this position unbearable; abdominal pressure; stabbing, tearing pain around the epigastrium and abdomen to below the navel; tearing pains in the ribs and the sides of the abdomen radiating into the back; anxiety; burning sensation in the stomach and around the navel; (intestinal) rumbling which makes the pain worse. The abdomen is sensitive to the slightest touch; the patient cannot bear being covered; fever, nausea; desire and vain attempts to yawn. Pressure on the hypochondrium causes pain and sensitivity in the epigastrium and vice versa. Severe biliary colic. The liver area is sensitive to touch; pressure and soreness, as if from a blow. Colicky pain in the right side of the abdomen radiating into the bladder, with urge to urinate frequently. Cutting pain through the abdomen, from right to left. Inguinal hernia on the right. Fullness and distension of the stomach and abdomen, with cold feet. Considerable fermentation in the abdomen; rumbling, squeaking, gurgling; with colic, large amounts of wind passed. Constrictive cramps, tense abdomen. Hernia (on the right); femoral hernia, in women; stabbing and tearing. Hernia on the right side as the result of sagging tissue; caused by chewing tobacco. Pancreas stones. Jaundice. Dyspepsia; ravenous appetite; the more the patient eats, the more she wants to eat; her head aches when she doesn't eat. Alternatively: constant feeling of fullness, patient does not eat, says she wants nothing because she is full; the slightest morsel makes her feel full up to the throat. Frequent eructation without relief.

Nux vomica: severe nausea in the stomach and feeling that vomiting would be a great relief; patient feels as if there are substances in the stomach which have to be brought up before he can feel better.

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Nausea in the early hours. Nausea: constant; in the morning; affecting the body in various places, as if everything is fermenting; after lunch; after anxiety; from smoking; with tendency to lose consciousness. Vomiting: food; drink; bile; oily, fatty or black substances; mucus; acidic mucus; vomiting blood, after suppressed haemorrhoidal bleeding; before breakfast; food which was eaten one or two days ago (pyloric spasm); faecal; morning sickness; greenish substances or undigested food; periodic attacks. Portal hypertension; dyspepsia: vomiting bright red or black blood with nausea, tendency to lose consciousness and dizziness, burning, throbbing pain and feeling of a weight in the stomach. Sudden loss of consciousness without obvious cause, with vomiting of about a pound of black, coagulated blood; stool similar. Tarry faeces. Stools like pitch, with blood. Patient cannot bear tight clothing around the hypochondria. Colic after coffee, spirits or overeating. Colic from suppressed haemorrhoidal bleeding. Tight clothing around the hypochondria is unbearable. Abdominal muscles sore and painful on movement, when pressed, when laughing or coughing. Constipation as if from constriction and contraction of the bowels; as if from intestinal inactivity. Attacks of colic after midnight or in the morning. If the child is already able to walk, the swelling around a hernia may appear blue. Umbilical, inguinal and femoral hernias, also strangulated. Pain in the bowels as if beaten, also in the loins, early while in bed, with nausea. Tension over the stomach (epigastrium) in the afternoon, then pain in the lower abdomen as if everything inside is raw and sore. Inguinal hernia often protrudes, with red or yellowish patches; swelling somewhat sensitive to pressure. Nausea, vomiting, constipation. Feeling of weakness around the waist, as if a hernia were trying to break through. The left side is more severely affected (*Lycopodium*: worse on the right side).

Opium: vomiting from gaslight. Struggles in vain to vomit, in alcoholics. Vomiting: often, with revulsion; after eating; with stomach pain and

convulsions; green; bloody; of faeces, as with strangulated hernias or volvulus (*Colchicum*): with hiccoughs, great thirst, cold limbs and distorted face (ileus, strangulated hernias). Bloody vomiting in alcoholics and elderly people with apathetic, meaningless gestures, tendency to lose consciousness, great thirst, livid face and cold extremities. Hard, distended abdomen. Wind accumulates in the upper part of the abdomen, particularly around the navel, with antiperistaltic movements, eructation and vomiting. Intestinal activity and retained stool. Complete standstill of lower intestines. Cramp-like movements in the bowels, as if a solid object were trying to roll up in the right hypochondrium. Sluggish bowels and retained stool; or involuntary defecation of thin, stinking diarrhoea. Tense, distended, tympanitic, hard, swollen abdomen, sensitive to touch. Putrid vomiting. Pain in the abdomen, as if the intestines are being cut into pieces.

Phosphorus: water vomited. Vomiting blood; vomiting bloody liquid masses. Regurgitation of food and drink and eructation without nausea. Nausea which eases on drinking water. Nausea, late evening, progressing to vomiting and unconsciousness. Amenorrhoea with spitting of blood. Vomiting substance like coffee grounds with burning and feeling of constriction in the stomach. Severe pressure in the stomach after eating with vomiting of food and drink. Stomach bleeding improves on drinking cold water; after dancing. Acidic, stinking fluid is vomited in large quantities, looks like water, ink and coffee grounds, after the patient takes a little food or even just a sip of water. A feeling of emptiness in the stomach area, as if the stomach had been removed. Frequent loss of consciousness, cold extremities. A feeling of great weakness, emptiness or queasiness felt throughout the abdominal cavity; this is a clear indication for this remedy irrespective of whether it occurs alone or as part of a complication, especially if it occurs with a feeling of heat in the back between the shoulder blades.

Peritonitis with tympanitis. Abdomen feels sore when touched, when walking. Burning and pressure in the abdomen. Lightning sensation of being cut from stomach to navel. Sharp pain through the abdomen. Intestinal paralysis. Agonising, burning pain in the middle of the abdominal cavity. Tympanitis, particularly in the caecum and colon transversum. Undigested stools containing fat particles. Pancreatic atrophy with glycosuria.

Sulphur: portal hypertension with enlarged liver. Tense, burning, tearing, stabbing pain. Patient vomits blood and tasteless fluid while feeling as if she is about to faint, when menstruation starts. Peritonitis, particularly in childbirth, asthenic from the beginning. Colic after eating and drinking, makes the patient double up, < after sweets. The intestines feel knotted. Soreness throughout the abdomen with feeling of rawness, especially when taking a deep breath, coughing and exerting oneself.

Case 12.2-1: Acute abdomen with suspected closed stomach perforation *Martin Bündner*

Anamnesis

In the morning of day 1, the 59-year-old patient's family doctor sends him to hospital with acute abdomen; he is taken there by ambulance. He is known to be an alcoholic, both his arms are trembling and he is obviously in the early stages of delirium caused by alcohol withdrawal. When asked when he last drank alcohol, the patient explains that he hasn't been able to drink any today. Unlike earlier hospital stays, the patient is unshaved, his hair is greasy and unwashed and he generally appears unkempt.

He is complaining of severe abdominal pain which began today. This is completely different from usual. He has constant pain in the upper right quadrant, but this time it is much more severe and has spread throughout his abdomen. Until yesterday, the stomach pain was also different from usual. Normally, the severe stomach pain he suffers when sober disappears when he drinks alcohol; however, this pain has increased over the last three weeks. This is why he had to drink alcohol regularly. However, today this was not the case. He also feels as if all his bones are aching.

Diagnosis

Acute abdomen with strongly suspected closed stomach perforation. Severe recurrent pancreatic disease. Liver cirrhosis caused by alcoholism.

Korsakov syndrome. Post BI stomach resection 8 years previously.

Diagnostic procedures

Findings on admission

59-year-old cachectic patient who appears lethargic and seriously ill, and is obviously suffering from severe pain. The patient is unkempt, dehydrated and slow to react. His tongue is covered with a white coating. His heart rate is 100/min. His abdomen is hard and clearly painful on pressure. Discrete swelling in the right side of the epigastrium; scanty intestinal peristalsis. Despite the severe abdominal pain, various positions are tested so that the modalities can be evaluated correctly. The patient explains that lying on the left side makes the pain worse; nevertheless, he is lying on his left side. Doubling up, bending the upper body backwards and percussing the abdomen are all painful. The abdominal pain gets worse when he is sitting or standing up. Lying on his front just makes the nausea worse. The patient has to lie down because he feels dizzy when sitting or standing up. His arms are trembling violently.

Laboratory (day 1)

Hb 12.5 g/dl. SGOT 100 u/l. SGPT 41 u/l. AP 431 u/l. y-GT 400 u/l. Cholesterol 357 mg/dl. Triglycerides 227 mg/dl. Lactate 50.1 mg/dl. The laboratory parameters (lipase and amylase normal) indicate that acute pancreatitis is unlikely. Ferritin 691 ng/ml (normal range 10-265), CEA 7.7 u/ml (normal range < 3.0), CA 19/9 177 u/ml (normal range < 37) ■®" table 12.2-1.

Tab. 12.2-1: Progression of laboratory parameters					
Parameters	Day 1 10.35 am	Day 1 6 pm	Day 2	Day 3	Day 4
Hb (g/dl)	12.5	10.5	11.2	11.4	17.7
SGOT (u/l)	100	81	78	60	-
SGPT (u/l)	41	32	30	27	-
AP (u/l)	431	362	365	341	-
Y-GT (u/l)	400	342	364	355	-
Cholesterol (mg/dl)	357	-	287	278	-
Triglycerides(mg/dl)	227	-	126	153	-
Lactate (mg/dl)	50,1	40,7	13,7	12,2	-

Imaging procedures

Overview of abdomen in standing position (day 1): no certain indication of free air. Obvious meteorism in the small intestine with partial coprostasis in the left hemicolon. No changes clearly indicative of ileus.

Abdominal sonography (day 1, 1 pm): fluid collection (approx. 10-15 ml) clearly visible around the stomach, otherwise no free fluid can be found. In view of the previous BI stomach resection, it must be assumed that the patient has a closed stomach perforation.

Oesophagogastroduodenoscopy (day 7): mild gastritis in the part of the stomach remaining after partial resection, small axial hiatus hernia. The stomach perforation has healed. No ulcer can be found.

Surgical consultation

Day 1 (early afternoon): closed stomach perforation. As the patients condition improves markedly after administering a homeopathic remedy, it is decided that no surgery will be performed at present; the patient is to be monitored intensively.

Conventional treatment

Total fasting.

Homeopathic treatment

The patients unkempt condition should be taken into account as a psychological symptom; this is a new development. When repertorising according to Kent, this symptom is given first place. The modalities have to be considered for further

repertorisation: abdominal pain normally improves when bending over. With this patient, the opposite in the case. This is the most unusual modality with this patient.

The fact that the pain worsens when the abdomen is percussed is more usual, as aggravation of the symptoms on pressure is practically pathognomonic in cases of acute abdomen. Nevertheless, this marked and quasi-pathognomonic symptom is included during repertorisation as it is an important modality for finding the correct remedy in this constellation, and also constitutes an important reference to the dangerous pathology of this disease. The modality of aggravation from percussion is not mentioned as such in Kents Repertory, which means that a similar rubric with related content has to be used corresponding as closely as possible to the process of tapping, i.e. a kind of jarring of the abdomen.

The fact that the dizziness gets worse in a sitting position is an interesting modality of one of the accompanying symptoms, and is particularly important as there seems to be no direct connection with the primary symptom. However, it must also be remembered that dizziness is not so rare in cases of acute abdomen and could be viewed as a cardiovascular reaction, e.g. from blood loss. This symptom is therefore less important when prioritising the symptoms, but can be checked to confirm the choice of remedy.

12.2 Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - indifference, apathy etc. - external things, to
Abdomen - pain - bending double, aggravated Jarring -
stepping, aggravated

Abdomen - pain - pressure, aggravated

Differentiation between remedies

The remaining remedy is *Sulphur*. *Belladonna* is also possible, but is eliminated because the patients mental condition is typical of *Sulphur*. *Sulphur* also mentions dizziness in a sitting position. *Sulphur* is therefore the remedy of choice.

The remedy description in the *Materia Medica Pura* is also interesting (Hahnemann 1830):

“All day an indolent disposition of mind and body, indisposed to all occupation and movement [...] For hours he sits motionless and indolent, without any definite thoughts, although he has many things to attend to. [...] She imagines that she has beautiful clothes, she takes old rags for beautiful clothes, she takes a coat for a jacket, a cap for a hat. [...] He seems dull, cannot remember, is embarrassed and shuns intercourse with others. [...] Vertigo while sitting; staggering while rising. [...] Severe vertigo, in the morning on rising; as soon as he tried to stand, he every time fell over on the bed, this only ceased after half an hour. [...] Vertigo, with tendency to falling forward, when quickly rising from a seat. [...] White tongue. [...] Uncommon thirst for beer. [...] Constant intense thirst for beer, [...]. *The gastric region becomes extremely painful when touched, and even the coverings of the bed cause pain; but there is no pressure from eating.* [...] The hepatic region is painful when touched. [...] Pain in the hepatic region. [...] The liver seems swollen, [...]. The abdomen is painful when touched [...], with [...] pain in it. [...] Trembling of the... hands [...]. Trembling of the right hand, in the morning. [...] Tremulous sensation in both hands. [...]”

Prescription

1. Dose of 2 Globules *Sulphur* 200C

Progress

Within ten minutes of taking the remedy, the abdomen's sensitivity to percussion has almost disappeared. Over the next three hours, the abdominal pain gradually subsides and the patients abdomen slowly becomes softer. The upper and middle right abdominal regions are still painful.

In the upper abdominal ultrasound performed at 1 pm on the same day, about 10-15 ml of fluid is clearly evident around the stomach; otherwise no free fluid can be found. In view of the previous BI stomach resection, it must be assumed that the patient has a closed stomach perforation. As this ultrasound examination was performed some time after the remedy was administered, it cannot be ruled out that the marked clinical improvement was accompanied by a resorption of free fluid.

By around 3 pm, the abdomen is no longer painful on being percussed and has already softened on the left; the patients general condition is still clearly improving. At 9.30 pm, the doctor on duty records: “Patient tenses his abdominal wall against examination but can relax it fairly well on request; the abdominal wall is then soft. Patient reports no change to pressure pain in the upper right abdomen, no guarding. Patient feels better. Abdominal pain and dizziness also much better; patient can sit up.” On the next day (day 2), the right side of the abdomen is almost completely soft; the abdominal image taken in a standing position shows that the meteorism is subsiding. No more free fluid is found in the ultrasound check. However, there is a suspected hyperechoic tumour in the gallbladder, for which reason a computed tomography of the abdomen is performed on day 4 for purposes of differential diagnosis.

In all, no pathological findings are made other than inhomogeneous steatosis of the liver. A surgical check-up now definitely rules out the need for surgery.

By day 3, the patient is already walking around on the ward.

An oesophagogastroduodenoscopy is performed on day 7 to assess his stomach. Mild gastritis is found in the part of the stomach remaining after

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the partial resection along with a small axial hiatus hernia. The stomach perforation has already healed. No ulcer can be found.

On day 8, it turns out that the patient has been eating a normal diet against medical advice.

Evaluation

Rapid healing of a (probably small) stomach perforation, which from experience may in all probability have been brought about by the homeopathic remedy.

Critical commentary

The Kent Repertory encompasses the mind symptom perfectly: “Mind - indifference, anathy etc. - external

this rubric, even though it is given triple weighting. Nevertheless, the therapist should not begin with such a small rubric when eliminating remedies in order to find the right remedy; instead, a rubric similar to the first but somewhat larger should be chosen.

For the third repertorised symptom, the use of the rubric “Jarring - stepping, aggravated” should be reconsidered. Firstly it is a small rubric with only a few remedies; secondly, it is not an optimum description of the symptom, as the entire abdomen is affected. It is therefore better to use the more general rubric for repertorisation purposes, although is only found in the Generalities section.

Case 12.2-2: Acute abdomen

Martin Bündner

Anamnesis

The 17-year-old patient comes for treatment of massive acute abdominal pain. She cries and screams mainly because of the pain, although she is not usually sensitive to it. The epigastrium is tense. The pain here also worsens on pressure, when percussed, when lying down, when leaning the upper body to the side and particularly when walking. The pain eases when she doubles up. She feels absolutely full although she has not eaten anything. The pain feels as if it is tearing her apart. She refuses to be admitted to hospital before an attempt has been made to treat her with homeopathy.

Diagnosis

Acute abdomen.

Diagnostic procedures

Examination of the abdomen.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Mind - shrieking - pain, with

Abdomen - pain - sore - walking, while

Differentiation between remedies

The repertorisation process clearly points to *Belladonna*. However, *Pulsatilla* should also be considered. Ultimately *Belladonna* is chosen to maintain the totality of symptoms, as *Pulsatilla* does not mention the aggravation when turning the upper body to the side.

Prescription

3 drops *Belladonna* Q6 as needed.

Progress

The patient feels better immediately after taking the first dose of *Belladonna*, although the intensity of the pain remains the same. The pain subsides as the patient continues to take *Belladonna*. Next morning, the pain has returned and gets worse when sitting up, which indicates that *Belladonna* is still needed. The patient takes *Belladonna* 6 times a day, also on the third day, although she has no more symptoms. On the fourth day, she develops a temperature of 39.4 °C. The patient feels chilly without a cover, even when stretching her arms outside the bedclothes; however, she feels too warm when covered. Even so, she still needs a hot water bottle. First she is chilly, then she is hot, then she sweats. She also has a headache which gets worse on moving her head, walking and when exposed to light.

12.2 Homeopathic treatment

Repertorisation II

KENT'S REPERTORY

Fever - uncovering - chilliness, from

Fever - succession of stages - chill followed by heat - then sweat

Head - pain - moving head, on, aggravated

Head - pain - light, in general, from

Head - pain - walking, while, aggravated

Differentiation between remedies

The repertorisation process leads to *Belladonna*, *China*, *Nux vomica* and *Sepia*. One striking symptom is the inconsistency of the patients heat sensations; this

Case 12.2-3: Ileus

Martin Bündner

Anamnesis

The 84-year-old patient has been constipated for eight days; he has been unable to pass wind for the last four days. He is admitted to hospital with dyspnoea. Meanwhile, he has developed the following symptoms: his abdomen is taut, distended and full of wind. He feels pressure and tension in the lower abdomen when sitting up. He feels a dragging, tearing pain in the lower abdomen when coughing or getting up (from the bed or chair). The pain gets worse when walking, moving or changing position. He can hardly walk from sheer weakness.

Diagnosis

Ileus.

Diagnostic procedures

Findings on admission

84-year-old patient in very poor general condition. Deathly silence heard on auscultating the tense, distended abdomen. Fine crackles heard in the central lobe of the right lung.

Prescription

1 drop *Sepia* Q6 administered 3 to 5 times a day.

Progress

On the day after taking *Sepia*, the patients fever has gone and the headache has clearly subsided. This symptom also disappears completely over the next four days.

Evaluation

The author believes that the fever was connected with the acute abdomen. The patient was rapidly cured.

Critical commentary

The subjective improvement of the patient s general condition alone is good evidence of the effect of the

Plain x-ray of the abdomen in a standing position:

fluid on the left, Luftsichel sign. Meteorism. Coprostasis on the right.

Abdominal ultrasound: no precise statement possible due to air interference.

Conventional treatment

Antimicrobial treatment. Surgical consultation planned.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Abdomen - intussusception

Abdomen - pain - cough, during

Generalities - rising, aggravated

Abdomen - pain - motion, aggravated

Abdomen - pain - sore - walking, while

Generalities - change of position aggravated

Differentiation between remedies

The repertorisation process leads to *Bryonia*. Other remedies to be considered are *Belladonna*, *Lachesis*, *Lycopodium*, *Nux vomica* and *Sulphur*. Only *Belladonna* and *Bryonia* mention the pneumonia on the right side. *Belladonna* does not cover all the local abdominal

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Prescription

1 dose of 3 globules *Bryonia* 200C.

Progress

The patient empties his bowels two hours after taking *Bryonia*. He continues to receive antimicrobial treatment for the pneumonia.

Evaluation

The homeopathic remedy obviously matched the

Critical commentary

Unfortunately, the author knows nothing about how the case progressed or about the cause of the ileus. A surgical consultation is essential if an intestinal obstruction is suspected.

Ileus was also treated successfully in the early days of homeopathy. Boenninghausen, who was highly esteemed by Hahnemann, suffered from this disease and was ultimately cured with *Thuja* followed by

Case 12.2-4: Acute biliary colic

Martin Bündner

Anamnesis

In the evening of day 3, the obese 28-year-old patient drags herself to the emergency clinic holding her abdomen, her face clearly drawn with pain which is also preventing her from moving freely.

In the evening of day 1, she ate a very fatty sausage which subsequently lay like a stone in her stomach. She developed increasing abdominal pain in the night. An ultrasound examination of her abdomen (day 2) revealed a gallstone; it was therefore assumed that she is suffering from biliary colic.

After taking chemical medication, the pain subsided somewhat and disappeared almost completely during the evening; however, it is now stronger than ever. The patient is breastfeeding and therefore refuses further chemical or surgical treatment.

The following acute symptoms were ascertained: The abdomen is soft, the epigastrium and liver area are clearly sensitive to touch but there is no resistance.

She has stabbing, pressing upper abdominal pain in the gastric area and the right hypochondrium.

- The pain radiates from the gastric area into her back
- The nausea came first, followed by the gastric pain
- The warmth of the bed eased the pain somewhat
- The patient sits stiffly upright. She feels worse when bending her upper body backwards, which

is why she is unable to sit comfortably on the chair. The pain also increases when she stoops or bends forward

- The pain is making her short of breath
- The journey to the clinic was agony because of the potholes
- She also feels worse after eating a little, and is therefore now fasting
- The pain increases whenever she lifts anything
- The pain also prevented her from falling asleep
- The shortness of breath is making her dizzy, as if she is about to pass out
- She is unusually thirsty (unable to describe the quantity)
- She has a feeling of hunger in her stomach, but no appetite
- Her sweat smells so strong that the odour fills the room
- She is crying with agitation (“What’s going to happen now?”)
- She is worried about what is wrong with her, as she doesn’t want to stop breastfeeding

Diagnosis

Acute biliary colic.

Diagnostic procedures

Abdominal ultrasound (day 3): liver homogeneous, no intrahepatic cholestasis, common bile duct 5.3 mm, i.e. not enlarged, gallbladder (GB) contains a lot of small

Homeopathic treatment

Repertorisation

THERAPEUTIC POCKET BOOK

Aggravation - from different kinds of nourishment, food and drink - fat food

Aggravation - from stepping heavily upon the ground or floor

Aggravation - after eating

Aggravation - from lifting too heavy a weight

Aggravation - from turning or twisting the part - backwards

Differentiation between remedies

The repertorised rubrics list *Causticum*, *Kalium carbonicum*, *Natrium muriaticum*, *Acidum nitricum*, *Nux vomica*, *Sepia*, *Sulphur* and *Thuja*. However, only *Sepia* and *Sulphur* have all these rubrics as their essence, and so only these two remedies are included when differentiating further.

The patients stinking body odour filling the entire room and the hunger with lack of appetite both speak for *Sulphur*. The pain radiating from the abdomen to the back is also a *Sulphur* symptom.

Prescription

Acute: 10 drops *Sulphur* Q3 every half an hour.

Case 12.2-5: Unclear abdomen - cholestasis with choledocholithiasis

Martin Bündner

Anamnesis

The 80-year-old patient is admitted to hospital as an emergency by her family doctor because of acute abdominal pain. Since suffering a perforated stomach four years previously, she regularly has gastric pain which becomes worse when she drinks cold beverages. Six months previously, she began developing biliary

significantly; the abdomen is markedly less sensitive to pressure. The smell of sweat in the room has disappeared; the patient's mood is much improved. The patient is advised to keep taking the remedy as described until she falls asleep; she should consult the therapist directly if the pain increases or other problems develop.

Next morning, the pain has almost disappeared; the patient slept well.

She is now told to take *Sulphur* just once an hour. By the second evening, the symptoms have completely disappeared; her abdomen is no longer sensitive to pressure and the modalities present at the onset have vanished.

Nevertheless, the patient is recommended to keep taking *Sulphur* every two hours. Next day, the prescription is changed to 10 drops of *Sulphur* Q6 once a day to consolidate the improvement in the patient's condition after this severe attack of biliary colic.

Evaluation

The biliary colic subsided quickly when treated with the appropriate homeopathic remedy.

Critical commentary

The patient is advised to undergo long-term homeopathic treatment.

The patient is now to receive acute homeopathic treatment. The following symptoms are recorded:

- The abdominal pain has been occurring every eight days for the last four weeks. The periodicity of the pain is uncertain
- The patient has had pain in the right hypochondrium for several weeks; this has now increased dramatically
- She has had increasing pain in the left hypochondrium for eight days
- A heating pad eases the pain
- Eructation occurs when the pain begins

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- She is groaning with pain, feels weak and nauseous
- The entire lower abdomen is painful on pressure; this produces an urge to go to the toilet
- She passes stool four times a day. Stool colour brownish grey
- The right hypochondrium and left quadrant of the lower abdomen are sensitive to pressure
- The patient is shivering all over so severely that the whole bed is shaking
- She feels like she is about to die

Diagnosis

Cholecystitis with cholecystolithiasis, cholestasis with suspected choledocholithiasis. Latent hyperthyroidism.

Diagnostic procedures

Findings on admission

Poor general condition. Right pupil distorted and larger than the left. Machine-like 2/6 systolic murmur with punctum maximum over Erb's point. Blood pressure 140/80 mmHg. Left quadrant of lower abdomen and right quadrant of upper abdomen painful on pressure. Peripheral pulses more palpable on the left than on the right. Forgetful. Stool brownish grey. Temperature 38.5 °C.

Laboratory

ESR 56/76. SGOT 34 u/l. AP 1117 u/l. γ -GT 551 u/l. CHE 1743 u/l. Calcium 2.11 mmol/l. CRP 21 mg/l. TSH

Imaging procedures

Abdominal sonography (day 2): intrahepatic bile ducts congested in ventral direction. Liver parenchyma normal. Several stones in the neck of the gallbladder. Ductus hepatocholedochus (DHC) dilated to 1.8 cm, narrowing to a point at the papilla. No certain evidence of intraductal stones, papillary stenosis is a possibility.

Assessment: intrahepatic and extrahepatic congestion of the bile ducts. Cholecystolithiasis.

ERCP (day 3): "Cholestasis with juxtapapillary diverticulum. As there is insufficient evidence of stones in the DHC, we believe the cause to be the two juxtapapillary diverticula. Moreover, the ERCP shows that the bile is flowing away adequately. Currently still no indication of manifest cholangitis."

Conventional treatment

ERCP.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY Rubbing, stroking ameliorated

Poor memory, memory loss, forgetful

Stool, white, grey

Becoming cold aggravated, uncovering aggravated, warmth of bed, wrapping up ameliorated

Parameter	Day 1	Day 2	Day 3 In the morning before ERCP	Day 3 In the evening after ERCP	Day 4	Day 6	Day 8
SGOT (u/l)	24	23	47	39	30	30	25
SGPT (u/l)	17	16	28	26	22	24	23
AP (u/l)	1117	919	1033	909	909	1143	936
γ -GT (u/l)	551	488	617	546	543	598	535
CHE (u/l)	1743	1420	1503	-	-	1429	1335
Total bilirubin (mg/dl)	1.9	2.5	3.4	3.3	3.4	1.8	1.7
CRP (mg/l)	21	-	39	40	45	21	20

12.2 Homeopathic treatment

Differentiation between remedies

The remedies remaining are *Rhus toxicodendron* and *Sepia*. Of these two remedies, only *Rhus toxicodendron* has the symptoms “thinks he is going to die”.

A glance in the materia medica (Trinks and Muller, 1847) confirms *Rhus toxicodendron*:

“A pushing forwards in the hypochondrium, with anxiety, as if about to die [...] When lying no pain in the abdomen, but when sitting the abdomen is painful as if it were pressed. [...] Violent vertigo [...], with fear that he will die. [...] When walking, reeling, unsteady and staggering in the body [...]. Anxiety, as if he must die. [...] Confusion of the reason: he thinks he is dying. [...] Forgetfulness, he cannot remember what happened quite recently. [...] Shivering, [...] the chilliness went off only in bed, [...] chill, he must lie down in bed and cover himself up, then he got warmer.”

Prescription

1 dose of 2 globules *Rhus toxicodendron* 30C.

Progress

The patient's mental condition stabilises shortly after taking the remedy. That day (day 1), the patient develops a temperature. The abdominal pain is subsiding. On day 2, the abdomen is soft, the upper left quadrant somewhat painful to pressure but otherwise normal. The laboratory results are improving. From the ultrasound, it is suspected that the patient has papillary stenosis but no stones. The ERCP is performed on day

3; no certain cause (e.g. papillary stenosis) is found for the cholestasis, as a result of which it is assumed that the stone was passed spontaneously.

The patient's laboratory test findings worsen in reaction to the ERCP and she develops fever which is treated antimicrobially.

As the patient progresses, the cholestasis parameters initially fall gradually and then more rapidly; the patient subsequently has no more symptoms. She refuses a cholecystectomy.

Evaluation

The progress of this case does not meet normal expectations. The ultrasound of the upper abdomen leads to the suspicion of papillary stenosis with no intraductal stones. However, the ERCP does not confirm the papillary stenosis. Instead, it indicates cholestasis with juxtapapillary diverticula. The bile flow is normal; there is no evidence of manifest cholangitis. In all, it must be assumed that the stone passed spontaneously at the same time as the patient noticed a subjective improvement after taking the homeopathic remedy; this was probably triggered by the remedy.

Critical commentary

In theory, the spontaneous stone passing could be viewed as a coincidence; however, the chronological proximity of this occurrence to the time at which the remedy was taken is a strong indication that this was the effect of the

Case 12.2-6: Cholecystitis followed by laryngitis

Martin Bündner

Anamnesis

The 64-year-old patient hasn't had a temperature in years, even with infections. She is now seriously ill with a temperature of 39°C and requests a house visit for homeopathic treatment. The following symptoms are recorded:

- The patient has been feeling chilly for two days. The chills come in phases (she has been using

- heating pad). She feels as if her whole skin is drawing tight
- She has a headache around her eyes which gets worse when she is lying down or exposed to sunlight. The pain radiates from her neck into the back of her head
- No thirst
- The pain in the lumbar region is familiar, but is now stronger and radiating into her hip. This pain worsens when moving and walking
- Nausea felt in the throat and stomach
- Cough (mucus)

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- Severe abdominal pain in the upper right quadrant
- When asked about her mental condition, the patient says that she has had to write Christmas poems for years; the expectations are now so high that she can hardly meet them. These thoughts are very persistent and she is finding the situation too stressful

Diagnosis

Suspected cholecystitis.

Diagnostic procedures

Findings of physical examination

Upper right abdomen and epigastrium clearly painful on being pressed, although the patient had previously only experienced this in the epigastric area. Lungs clear on auscultation, no rattles. The patient refuses an abdominal ultrasound examination.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Mind - thoughts - persistent

Stomach - thirstless - heat - during

Head - pain - sun, from exposure to

Differentiation between remedies

The repertorisation process leads to *Pulsatilla* and *Sulphur*. The headache radiating upwards from the neck indicates *Pulsatilla*.

Prescription

- 0 drops *Pulsatilla* Q3 administered 3 to 5 times a day on day 1.

Progress

The patient is informed that it is suspected that she has cholecystitis. However, as she does not tolerate antibiotics, she insists on being treated homeopathically.

On day 2 after taking *Pulsatilla*, the patient's temperature early in the morning is 39 °C; however, during the morning it drops to 38 °C. The headache and nausea have

pain in the upper right abdomen is unchanged on palpation.

The slight improvement in the headache and nausea are seen as a positive reaction to the remedy, but the improvement is not sufficient. The patient is therefore advised to take the remedy more often, i.e. 5 to 8 times a day. In the evening, her temperature is 38.5 °C.

Her temperature continues to subside on day 3. The nausea is now only mild, the patient feels very weak. She has developed a tickly cough in the trachea which worsens when lying down and breathing in.

On day 4, the pressure pain in the upper right abdomen subsides markedly. The patient's temperature is showing a tendency to fall; values below 38 °C are measured for the first time. The lungs are still normal. The same dose of *Pulsatilla* Q6 is prescribed.

Next day, the patient reports that she had a bad night. The cough moved upwards and she became hoarse. She has stabbing neck pain extending to her left ear. Although the symptoms are changing and a different remedy is now indicated, *Pulsatilla* is again administered on this day: firstly, the patient's temperature is still somewhat elevated (*Pulsatilla* is still expected to have a positive effect on this); secondly, it is hoped that the symptoms will become still more concrete.

On day 6, the patient's temperature finally falls to 37.1 °C as hoped. The symptoms have now changed: • The upper right abdomen is still somewhat painful on pressure (epigastrium unchanged as expected)

- Her voice is hoarse
- The cough is now "on her chest"
- The patient feels pain in the lumbar region when she coughs. The pain on coughing increases when she lies on her back; it subsides if she lies on her side with her legs drawn up
- The pain on the left side of her neck extends to her left ear. The pain is rhythmic, like a series of electric shocks. This prevented her from falling asleep
- The earache increases when she coughs
- Profuse night sweating

12.2 Homeopathic treatment

Repertorisation II

KENT'S REPERTORY Perspiration - profuse - night

Cough - when coughing

Generalities - shocks, electric-like

Larynx and trachea - voice - hoarseness

Generalities - lying - back, on, aggravated

Generalities - lying - side, on, ameliorated

Differentiation between remedies

The remaining remedies are *Arsenicum album*, *Baryta carbonica*, *Causticum*, *Cuprum metallicum*, *Kalium carbonicum*, *Natrium muriaticum*, *Phosphorus* and *Sulphur*. *Sulphur* is a follow-up remedy to *Pulsatilla*. It covers the complaints on the left side (at least the ear) and the difficulty falling asleep caused by pain; *Sulphur* also mentions the aggravated lumbar pain when coughing. This is the only one of the remedies mentioned above which is listed in this (admittedly small) rubric ("Back - pain - sacral region - coughing, when"). Because of the change in symptoms, the decision is made to administer *Sulphur*.

Prescription

10 drops *Sulphur* Q15 administered 3 to 5 times a day on day 6.

Progress

The next check-up takes place two days after the first dose of *Sulphur*. The right quadrant of the upper abdomen is still normal on palpation. The symptoms prevalent on day 6 have subsided. However, new symptoms have appeared:

- Insomnia caused by laryngeal pain which increases when the patient is lying down. A feeling of pressure in the larynx, as if from a tennis ball, and soreness immediately after swallowing saliva
- The patient wakes up at 2.30 am absolutely drenched in sweat
- Air is unable to pass through the larynx when she is lying down, as a result of which she spends the night sitting up in bed until 4.30 am; this makes her feel

- The cough is situated in the larynx and bronchi
- Her head feels heavy and dazed
- Feeling of weakness and malaise; she has no strength. Her condition worsens on the smallest exertion
- No appetite
- Pain in the temples caused by the cough
- Dizziness when moving from a lying to a sitting position
- The right quadrant of the upper abdomen is still normal

Repertorisation III

CARD INDEX REPERTORY

Voice and speech, lacking, mute, aphony

Larynx and trachea

Lying aggravated

Swallowing, empty, aggravated

Differentiation between remedies

The remedy *Pulsatilla* is most prominent. Another possibility is *Phosphorus*. *Phosphorus* does not mention the aggravation of the pain when swallowing saliva, but does have the marked weakness from the slightest exertion. However, as the symptoms mainly focus on the larynx, the aggravation of the pain when swallowing saliva is considered more important (although it is only a local modality) and *Pulsatilla* is therefore chosen.

Prescription

Pulsatilla Q9 administered 3 to 5 times a day on day 8.

Progress

After taking *Pulsatilla*, the patient's voice is found to have improved markedly by day 11; by the next day, the cough has moved away from the larynx. The other symptoms have subsided.

Evaluation

The slow healing reflects the severity of the disease, which finally (including the laryngitis) subsided within eleven days.

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Case 12.2-7: Acute biliary pancreatitis

Edacheril Scaria Rajendran

Anamnesis

49-year-old man with severe pain in the epigastrium, left hypochondrium and navel region for the last three days; the pain extends into his back; vomiting and acidic eructations after eating. The abdominal pain worsens when lying down and after eating; it comes with nausea and acidic vomiting; the patient feels better when he doubles up. Previous diagnoses of alcohol abuse and diabetes mellitus.

Diagnoses

Acute pancreatitis, diabetes mellitus, alcoholism.

Diagnostic procedures

Findings on admission

The patient's lower abdomen is bloated; a muscular guarding reflex is present all over the abdomen. Normal hepatic dullness, weak peristalsis. Temperature 36.6 °C, pulse 66/min.

Laboratory

Leucocytes 16 g/l (neutrophils 63%, lymphocytes 31%, eosinophils 4%, monocytes 2%), ESR 80 mm/h, haemoglobin 13.4 g/dl. Total bilirubin 1.2 mg/dl, direct bilirubin 0.6 mg/dl, indirect bilirubin 0.6 mg/dl, amylase 280 u/l.

Imaging procedures

Abdominal ultrasound

The ultrasound shows pancreatitis with stones in the pancreatic duct (size 0.9 x 0.4 mm) and cystic duct (0.6 x 0.4 mm).

Conventional treatment

Nil by mouth, liquid diet possible from day 2.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Abdomen - pancreas - inflammation

Stomach - vomiting - sour

Stomach - eructations - sour

Differentiation between remedies

The choice of *Iris versicolor* is confirmed by the materia medica:

“Nausea and vomiting [...] of a watery and very acid substance. [...] Great burning distress in the epigastrium [...]” (Clarke 1995)

“Pain in the region of the liver. < from motion. [...] Awful burning distress, deep in the region of the pancreas, not > by cold water, colic > by bending forward.” (Boericke 1996)

Prescription

On the day of admission (day 1), the patient is given *Iris versicolor* 30C every two hours beginning at 3 pm.

Progress

The patient feels better; the pain and vomiting subside at about 10 pm. Day 2: normal stool, the vomiting and abdominal pain persist. Day 3: the patient's general condition is improved; he is still vomiting but not as frequently. It is now possible to give him a liquid diet. Day 4: continued improvement with no more vomiting; abdominal pain significantly better but the acidic eructations persist.

Prescription

Iris versicolor 30C 4 times a day (days 5 and 6).

Progress

Day 7: the acid eructations have stopped; the patient is discharged with the advice to take *Iris versicolor* 30C twice a day for two weeks.

Evaluation

The stones obviously passed spontaneously.

Case 12.2-8: Acute appendicitis

Edacheril Scaria Rajendran

Anamnesis

The 37-year-old patient is admitted to hospital with acute pain in the right abdomen which has persisted for several hours (day 1). The pain began suddenly and severely in the right groin and was accompanied by dizziness, fever, pain in the limbs and vomiting. Eating and drinking aggravate the vomiting. Appetite good but unable to eat because her mouth and throat are so dry; she is also very thirsty.

Diagnosis

Acute appendicitis with peritonitis, vertigo.

Diagnostic procedures

Findings on admission

Muscular guarding reflex in the right groin and loin; the McBurney point is painful on pressure. Rectal temperature 38.9 °C, axillary temperature 37.5 °C.

Laboratory

Leucocytes 13,200 g/l (neutrophils 69%, lymphocytes 28%, eosinophils 3%), ESR 98 mm/h, Hb 8.4 g/dl.

Imaging procedures

Abdominal ultrasound: positive finding for appendicitis.

Homeopathic treatment

As the main symptom, the appendicitis is the basic pathological element. The other symptoms selected are not necessarily relevant to the appendicitis; instead, they are individual to the patient.

On day 3, the patient is able to consume a liquid diet without difficulty. Her temperature is still normal, the abdominal guarding has almost disappeared and the ultrasound findings are normal. On day 4, the leucocytes fall to 10.2 g/l; the patient is discharged with the advice

Repertorisation

	KENT'S MURPHY'S	REPERTORY* REPERTORY**

Abdomen - appendicitis**

Mouth - dryness*

Mouth - dryness - thirst, with*

Stomach - vomiting - eating, after (aggravated)*

Stomach - vomiting - drinking, after (aggravated)*

Differentiation between remedies

The choice of *Bryonia* is confirmed by the materia medica:

“Around the navel a painful twisting with stitches. [...] Pains in the abdomen as if he had been purged [...]. Horrible cutting in the bowels (in the forenoon) as if she would have dysentery [...]” (Samuel Hahnemann 1992).

Stomach, abdomen: “Vomiting of bile and water immediately after eating. < warm drinks, which are vomited...Tenderness of abdominal walls” (Boericke 1996).

Prescription

Bryonia 1M repeated several times («• Progress).

Progress

After six doses of *Bryonia* 1M administered at hourly intervals, the patient's temperature falls to 37.8 °C, the vomiting stops and the abdominal guarding subsides. The dose is therefore reduced to *Bryonia* 1M every three hours. On day 2, the patient's morning temperature is normal, there is no recurrence of the vomiting and the abdominal guarding is significantly reduced. The dose is therefore reduced to *Bryonia* 1M four times a day.

Evaluation

If she had been treated conventionally, the patient would have had to undergo immediate surgery.

Critical commentary

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Case 12.2-9: Acute appendicitis

Martin Bündner

Anamnesis

The 15-year-old girl comes to the practice without prior notice on day 1 and complains of severe abdominal pain. The abdomen is soft when palpated but the area around the McBurney point is clearly painful on pressure. The patient's body is hot; she is obviously running a temperature and also feels feverish but has not taken her temperature.

The abdominal pain worsens when she is standing or walking; it eases when she is lying on her front and also improves a little when she bends over. The girl also complains of nausea without vomiting; she has no appetite. The last stool that morning was normal.

Emergency laboratory tests are immediately performed and reveal a Hb value of 12.8 g/dl, leucocytes 20.3/nl. The symptoms indicate acute appendicitis.

Diagnosis

Acute appendicitis

Diagnostic procedures

Haemoglobin and leucocyte testing; the difference between the rectal and axillary temperatures is more than 1 °C.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Abdomen - pain - walking, while, aggravated

Abdomen - pain - standing, while, aggravated

Abdomen - pain - lying - on abdomen, ameliorated

Abdomen - pain - bending double, ameliorated

Differentiation between remedies

The repertorisation processes points to *Belladonna*. The aggravating modalities also speak for *Ptelea trifoliata*, *Sulphur* and *Zincum metallicum*. However, these remedies do not mention the typical improvement in the pain when the patient is lying on her stomach. As the

A materia medica comparison is carried out using Hahnemann's *Materia Medica Purga*; this confirms *Belladonna*: "Ineffectual effort to vomit, empty retching [...]. He cannot vomit, want of irritability of the stomach [...]. Bellyache, as from a hard weight, only when walking and standing, always going off when sitting [...]. Contractive pain in the abdomen; she must bend forwards on account of the pain [...]" (Hahnemann 1830).

Prescription

10 drops *Belladonna* Q6 repeated several times (Progress).

Progress

After taking the remedy, the patient is referred for surgery. Despite the diagnosis and her symptoms to date, the girl is unwilling to go. The parents are uncertain and their daughter's behaviour makes them decide to wait for the time being.

A telephone consultation is therefore held with the patient about two hours later. She no longer feels feverish; her temperature is normal and she already feels much better. In agreement with her parents, it is therefore decided that she need not be admitted to hospital for the time being provided her symptoms continue to improve.

Next morning (day 2), the girl reports that the symptoms worsened again at around 8 pm (i.e. 1.5 hours after the phone call); her temperature rose to 37.9 °C. She then took another 10 drops of *Belladonna* according to instructions. By 10 pm, her temperature had fallen to 37.1 °C and she again felt better. This morning (day 2), the symptoms merely worsened a little when getting up from a lying position and when walking longer distances. Today her leucocytes are 5.7/nl, Hb 12.9 g/dl. She is given another 10 drops of *Belladonna*.

The last check-up takes place on day 4. The patient has no more symptoms; she requires neither another dose of the remedy nor a referral for surgery.

Evaluation

A homeopathic remedy can have the power to prevent surgical intervention.

12.2 Homeopathic treatment

Critical commentary

The clinical findings, temperature and leucocyte levels all confirmed the diagnosis. The patient should have undergone ultrasound testing in hospital, but refused to go.

Case 12.2-10: Subacute peritonitis with terminal renal insufficiency

Martin Bündner

Anamnesis

The 49-year-old patient had both kidneys removed after a transplant performed ten years previously was rejected; since then, he has again been undergoing dialysis. For the last 4 1/2 years, he has also been giving himself peritoneal dialysis. The patient developed peritonitis, necessitating admission to hospital and systemic treatment with antibiotics. Although the findings on discharge were initially good, 20 days later (day 1) the patient complains of severe pain due to a recurrence of the peritonitis. He has cramp-like abdominal pains, like contractions, which are constantly increasing in intensity. His stool is becoming increasingly watery. The rinsing fluid from the peritoneal lavage is cloudy. At around 11 am, he feels as if he is about to have diarrhoea. He is vomiting bile, he is shivering and his temperature is 38.2 °C. He becomes nauseous in the car. He develops cramps in his right thigh. His abdomen is tense.

Diagnoses

Subacute peritonitis. Terminal renal insufficiency.

Conventional treatment

Systemic antibiotic treatment previously administered when the patient was in hospital.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY Stomach and abdomen - inflammation

Basing the repertorisation on small rubrics in critical areas can lead to a false result. The symptoms of the case should always be compared with those listed in the materia medica.

Differentiation between remedies

The only remaining remedy is *Sulphur*. As the Card Index Repertory lists the essence symptoms of each remedy, it can be assumed - provided the right symptoms are chosen - that the degree of accuracy is very high.

Arsenicum album does not list colic as an essence symptom. Moreover, these symptoms are congruent with *Sulphur*, as a result of which this remedy is selected.

Prescription

10 drops *Sulphur* Q3 once a day for three days.

Progress

The patients subjective abdominal symptoms initially get worse. On day 3, the patient has several bouts of whistling in his left ear accompanied by temporary difficulty of hearing; the following night, he develops a severe headache when lying down which eases when he stands up. He has an aversion to sour and fried foods. Over the next few days, he has a feeling of warmth in his head and left foot. The abdominal pain has already clearly subsided. The medication is continued.

Over the next three days, the patients symptoms disappear completely and there are no further recurrences.

Evaluation

Patients with terminal conditions such as terminal renal insufficiency are also amenable to homeopathic treatment without the risk of overdose; in contrast, antibiotic treatment is difficult and prone to complications.

Critical commentary

This patient suffered from initial aggravation of his symptoms as well as symptoms caused by the dose being too high. Nevertheless, treatment continued at the same dose, the idea being that an excessively low dose would not control the disease sufficiently.

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Case 12.2-11: Severe abdominal colic

Martin Bündner

Anamnesis

For the last week and a half, the 66-year-old patient has been suffering from increasing abdominal pain with severe, pressing, constrictive stomach pain. Two weeks ago, he was discharged from hospital where he had been receiving treatment for similar symptoms; except for a gastric fold, the findings of the oesophagogastroduodenoscopy were normal. The treatment recommended on discharge was pantoprazole (e.g. Pantozol*). The patient is nauseous with an intense need to vomit. The pain presses up to his chest and gets worse when he is lying down. He also suffers from waves of pressing pain in the lower abdomen. He is only able to pass a small amount of stool; his stools are loose and frothy, stink appallingly and come much more frequently than usual (5 to 6 times a day). He brings up air after eating. His belly rumbles. His mouth and throat are dry and his breath smells unpleasant. The patient also reports stabbing pain in the heart region and pain between his shoulder blades. On enquiry, he says that he was subjected to great psychological stress before the symptoms appeared; however, he cannot or does not wish to explain further. The patient is given homeopathic treatment as an outpatient; the treatment with pantoprazole (e.g. Pantozol*) is stopped.

Diagnosis

Severe abdominal colic.

Diagnostic procedures

Findings on admission

Sweat-soaked patient with tympanitic abdomen. A frontal headache appears when his abdomen is pressed; this gets worse on pressing to defecate, after passing stool, when returning upright from a stooping position, when turning his head and above all when getting out of bed.

Conventional treatment

Homeopathic treatment

The nature of the psychological stress would definitely be informative for the choice of remedy, but unfortunately this is not described in any detail and can therefore not be used. The direct connection between the headache and abdominal pain is particularly unusual. The remedy should cover the general symptom of sweating caused by pain. The tympanitic abdomen is also included in the repertorisation because of its intensity. The frothy consistency of the stool as an elimination product is also worth consideration. Finally, the striking modality of the headache worsening when getting up from lying down is also incorporated.

Repertorisation I

KENT'S REPERTORY

Head - pain - gastric

Head - pain - rising - from lying aggravated Perspiration - pains, from

Abdomen - distension - tympanitic

Stool - frothy

Stomach - eructations, empty - eating, after

Differentiation between remedies

Calcarea carbonica and *Sulphur* are listed in all these rubrics. Unlike *Calcarea carbonica*, *Sulphur* mentions abdominal pain extending upwards as in this case. Nausea with abdominal pain is also typical of *Sulphur*. *Sulphur* is therefore chosen.

Prescription

10 drops *Sulphur* Q6 every day.

Progress

The patient contacts us again on day 2. He is groaning with pain; the pain is still increasing and kept him awake. He is again able to laugh, but laughing causes abdominal pain. His abdomen is still painful on pressure.

The repertorisation process is revised taking the new symptoms into account. As the symptoms cannot all be

12.2 Homeopathic treatment

Repertorisation II

	KENT'S SYNTHETIC	REPERTORY* REPERTORY**
Sleep - sleeplessness - pains, from**		
Generalities - laughing, aggravated**		
Perspiration - pains, from*		
Abdomen - distension - tympanitic*		
Stool - frothy*		

Differentiation between remedies

The repertorisation process clearly indicates *Colocynthis*. *Aconitum* might also be considered, but the character of this remedy does not match this case. The rubric “Mind - moaning, groaning - pain, from” in the Synthetic Repertory is only small (*Chamomilla*, *Coffea*, *Colocynthis*, *Eupatorium perfoliatum*, *Hydrastis*, *Nuxvomica*, *Phosphorus*) but confirms *Colocynthis* with double weighting. This remedy is a good match for the symptoms described. It directly mentions the abdominal pain extending to the chest and the aggravation of the pain when lying down. It covers almost all of the headache modalities.

Prescription

Case 12.2-12: Unclear abdomen - pneumococcal sepsis

Martin Bündner

Anamnesis

On day 1, the 70-year-old patient is sent to hospital as an emergency by his family doctor with a diagnosis of unclear abdomen and suspected myocardial infarction. The patient's poor condition makes it extremely difficult to establish the precise symptoms. However, it is possible to determine the following symptoms which are essential for the choice of remedy: the patient reports that he had already had severe abdominal pain two days previously; this was worse in the morning. On being asked whether he knew of a likely cause, the patient spontaneously replied that the abdominal pain was related to his psychological condition:

Progress

The patient has less pain during the following night. Continued improvement over the next few days. On day 6, his stool is almost normal, the pain has subsided and the condition has almost disappeared. On day 8, the patient feels well but is given *Colocynthis* Q6. More than one year later, no relapse has occurred.

Evaluation

Sulphur only had a moderate effect. It improved the mental symptoms, as a result of which the patient was again able to laugh, but did not have a curative influence on the physical symptoms. The appearance of new symptoms made it possible to repertorise *Colocynthis*, and taking *Colocynthis* cured the patient completely.

Critical commentary

The use of the rubric “Head - pain - gastric” seems justified as the content includes analogous as well as literal content. *Colocynthis* was not chosen after the first repertorisation process as it is not mentioned in the apparently important rubric describing the connection between the headache and abdominal pain.

his son wants to emigrate to America, and this is having a considerable effect on him. He does not want to accept this. When asked what he means, it becomes clear that he is deeply concerned about his sons planned emigration.

There is a feeling of tension in the right hypochondrium and central abdomen. He doesn't want a heating pad, as this makes the abdominal pain worse. The pain continues when he is lying on his back. He feels better lying on his side, as this makes the pain disappear. He also feels restless inside. He last passed stool the day before yesterday, although this normally happens daily. The stool itself was normal. His family doctor gave him several shots of Nitro-lingual pump spray before sending him to hospital. Since then, his head has been feeling “mushy”. He became short of breath at 2.30 am the previous night; he is still finding it difficult to breathe. His

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mouth is dry and he feels thirsty. He also feels very feverish.

When asked about his chest symptoms, the patient remembers having chest pain on the left side five days ago which was caused by worry. However, this symptom has been familiar to him for a long time. During the anamnesis, both the therapist and the patient notice that he is talking very slowly, which is unlike him. He does not know why this is. Otherwise his mental functions are unchanged.

Diagnosis

Pneumococcal sepsis. Myocardial infarction ruled out. Severe chronic spinal syndrome. Dilative cardiomyopathy. Hypertensive heart disease. Renal insufficiency in the compensated retention phase. Arterial hypertension. Latent hyperthyroidism. Absolute arrhythmia with atrial fibrillation.

Diagnostic procedures

Findings on admission

Obese 70-year-old patient, weak and in poor general condition. Appears seriously ill. All movements slow. Dry tongue with a dirty coating. Heart rate 100/min., arrhythmic. Scanty intestinal peristalsis. Thread veins in both feet. The patient speaks slowly. Temperature 40.8 °C.

Laboratory

Pathological laboratory findings (day 1): leucocytes 11.6/nl. ESR 88/104. Left shift in differential blood count. Γ GT 158 u/l. Urea 51.9 mg/dl. Creatinine 1.43 mg/dl. Total bilirubin 2.6 mg/dl. Calcium 2.14 mmol/l. CRP 74 mg/l. Lactate 108.1 mg/dl. Trop-T test normal. The blood gas analysis reveals signs of partial respiratory insufficiency. Blood cultures are also taken.

Imaging procedures

Resting ECG (day 1): HR 106/min., absolute arrhythmia with atrial fibrillation, marked left axis deviation, left anterior hemiblock, right bundle branch block. No signs of ischaemia. Later checkups: normal heart rate, otherwise no significant changes from the initial findings.

Echocardiography (day 2): EF severely restricted at approx. 20%. Left atrium and left ventricle both dilated. Colour Doppler sonography reveals first- degree mitral valve insufficiency.

Conventional treatment

Antimicrobial treatment (once the patients body temperature has returned to normal after *Phosphorus*, cf. Repertorisation).

Homeopathic treatment

This disease is clearly caused by worry. Worry is therefore given top priority when repertorising this acute disease. Interestingly, the cause is also affecting the patients chronic conditions, at least in the chest area.

The slow speech is a striking mental symptom, even more characteristic than the mental symptom of internal restlessness. The modality “Aggravation from applying warmth” is also important, as exactly the opposite is usually the case.

Repertorisation

SYNTHETIC REPERTORY

Mind - anxiety, ailments from

Mind - answer, answering, answers - slowly

Mind - restlessness, nervousness - internal

Generalities - warmth, aggravated

Generalities - lying - ameliorated - side, on

Generalities - morning and evening

Differentiation between remedies

Phosphorus is the leading remedy. *Lycopodium* and *Natrium muriaticum* should also be considered.

However, *Lycopodium* patients feel worse (not better) when lying on their side and *Natrium muriaticum* does not mention the symptoms being worse in the morning and evening; this symptom is found with only a few remedies but is very clear in this case. It is decided that *Phosphorus* is the most suitable remedy.

The patients symptoms are later compared with the materia medica, which shows how similar they are to the

12.2 Homeopathic treatment

awoke with an oppression as from a load on the chest, impeding the respiration; [...]. Mind. - [...] Restlessness: [...] inner, with anxiety; [...]. Mouth. - [...] *Dryness in the mouth*: [...] enormous feeling of dryness in the mouth, sticky, with violent thirst, yet not diminished by drinking. [...]. Abdomen. - [...] "Abdominal pain: "early in the morning, also in bed; [...] violent pain throughout the abdomen. [...]. Chest and respiration. - [...] *Breathlessness*, - also mainly in the evening in bed; [...]. Taste and tongue. Speech: [...] slow; [...]." (Jahr 1848 and Hering)

Prescription

1 dose of 2 globules *Phosphorus* 30C.

Progress

On admission, the patient is given *Phosphorus* in 30C potency. A few minutes after administration of the remedy, he begins to sweat profusely all over his body; there are drops of sweat on his face. The patient is so hot that he has to push the covers off. He had previously felt cold inside. His temperature has dropped to 38.8 °C.

Shortly afterwards, the patient falls into a deep sleep, and by the time his temperature is taken, several hours after administration of the homeopathic remedy, his fever has disappeared without antibiotic treatment. His temperature remains stable over the next few days.

Over the next few days, his total bilirubin and all inflammation parameters return to normal. With additional fluid intake, the renal retention parameters also return to normal. The Γ -GT parameter sinks only slightly. The most striking and important parameter is the patients lactate count, which has dropped from 14.1 mg/dl on day 2 (as with the blood gas analysis) back to normal.

Case 12.2-13: Ruptured ovarian cyst and ectopic pregnancy

Martin Bündner

Anamnesis

The 28-year-old patient had her first child eight-and-a-

He last complained of lower abdominal pain on day 2. On day 3, the abdominal pain has disappeared. However, the patient is unable to sleep because of his chronic backache. A course of physical therapy is prescribed. On day 7, the patient says that he is now quite calm about the problems caused by his sons emigration.

The findings of the blood culture are now available and prove the presence of pneumococci. The diagnostic procedures indicate sepsis (leucocytosis with left shift, erythrocyte sedimentation rate, blood cultures). In retrospect, it is assumed that the patient had septicaemia induced by pneumococci, as the criteria for sepsis (bacteria issuing into the blood stream from a septic focus) are fulfilled. An ENT consultation is then requested to seek the source; however, the findings are normal and no source is found. The x-ray of the sinuses taken in two planes on day 9 also fail to find any evidence of a focus; no fluid found; the sinus aeration is normal. It must be assumed that *Phosphorus* has already eliminated the septic focus.

Evaluation

This case confirms that worry can make people ill. The homeopathic remedy has a curative effect and helps the patient to come to terms with the source of the worry.

Critical commentary

In homeopathy, healing processes occur after diagnosis of the remedy which best suits the individual case; in conventional medicine, treatment is initiated after diagnosis of the disease. However, for people who understand the language of the symptoms, they provide enough information to point the way to the correct remedy.

breastfeeding, her menstrual cycle has been irregular; her last period started three days too early. During her previous cycle, she had light breakthrough bleeding which lasted for ten days. The patient wakes from an afternoon nap at 4.50 pm with abdominal pain and wind; this also happened the previous evening but the pain is now

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clearly increasing. The abdominal pain is stabbing, mainly located in the right side of the lower abdomen and extending to the pubic area. The patient is no longer able to lie down flat without pain.

She can only pass wind with great effort and pain; it is stuck in the lower right quadrant of her abdomen and has congested as far as the upper abdomen. When she passes wind or stool, she feels a sharp pain throughout the lower abdomen as if she were being stabbed with a knife. She feels pressure from the lower abdomen to the anus.

The patient passed stool three times, ranging from soft in consistency to diarrhoea; she sweats when doing so and shivers afterwards. The wind and stool smell like rotten eggs. Passing stool is painful. “Agonising” pain when the stool is passing through her bowel (not in her anus, the stool passes easily at this point). Her lower abdomen hurts whenever she moves. The pain moves with the flatulence and returns to the lower right abdomen after the wind is passed. She feels as if her bowel is about to tear or burst. Stabbing pain in the lower right abdomen when she breathes out.

The patient feels hot flashes in her head. She can no longer lie down quietly and keeps tossing and turning.

She needs to cover herself while she is feeling chilly; she finds it unpleasant to put her arms outside the covers. She has no strength. Even going to the toilet is exhausting. She wants to drink cold beverages. She feels a kind of stitch in her side when lying on her side (both sides).

The physical examination shows that abdominal palpation is unpleasant; tapping, jarring and bending her legs all make the pain worse.

She took a warm bath to ease the abdominal pain, but this made her feel worse.

While the doctor is with her, she has to go to the toilet again; this time she collapses, her eyes are wide open, she begins to snore while breathing, she is leaning against the door and is placed in the recovery position. She regains consciousness after about three minutes.

The patient reports that before the syncope, the noise of the WC ventilator sounded very far away

and the writing appeared blurred. The patient sweats whenever she feels as if the pain is about to make her faint. Thinking about her baby is the only thing which stops her losing consciousness. If she can distract herself, the feeling of faintness subsides (this occurred for the first time after she took a bath). The sweat on her upper body is warm and stinking (although she is freshly bathed); it always breaks out with the feeling of faintness.

The patient urgently requests homeopathic treatment, whereupon her admission to hospital is postponed for the time being.

Diagnoses

Ruptured cyst on the right ovary with intra-abdominal bleeding. Ectopic pregnancy.

Diagnostic procedures

Physical examination (day 1): abdomen soft, pain in the left and right lower abdomen on pressure, no muscular defence reflex. Pain on pressing the cervix; tenderness in the entire lower abdomen.

RR constant at 120/80 mmHg. Heart rate initially 96/min., in the clinic 130/min. Blood sugar 121 mg%. SpO₂ 100%.

Abdominal sonography (day 1): free fluid in the upper abdomen and pouch of Douglas. Conglomerate visible.

Vaginal ultrasound (day 1): polycystic ovary.

Histological findings: bleeding into parts of the wall of the right tube and blood clots with no evidence of villi. Clearly exuding endometrium, rich in glands; no evidence of foetal cell elements.

Follow-up report: endometrium in the late secretion phase with a few small pieces of cervical mucous membrane and decidual transformation of the stroma. We believe this was a bleeding ectopic pregnancy.

Conventional treatment

Laparoscopic coagulation of the bleeding area of the right ovary (day 1).

Salpingotomy of the right tube with removal of blood clots and tissue parts, removal of the ectopic pregnancy.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Mind - restlessness - bed - tossing about in

Abdomen - pain - motion, on, aggravated

Abdomen - pain - bend double, must

Abdomen - pain - respiration, on

Abdomen - pain - stool - during

Perspiration - odour - offensive

Stomach - desires - cold drinks

Abdomen - pain - anus, extending to

Differentiation between remedies

Sulphur is the only remedy listed in all the rubrics, except for the last, which is also believed to be important; this is also true of *Belladonna*.

Mercurius solubilis and *Rhus toxicodendron* should be considered. However, these two remedies do not have the worsening with respiration, which should definitely be covered by the remedy as an expression of the diaphragmatic irritation. As no materia medica is available for reference, the decision is made to administer *Sulphur*, which mentions the pain extending to the anus.

Prescription

Two doses of *Sulphur* 200C dissolved in water.

Progress

The abdominal pain eases a little after the first dose of *Sulphur*. Shortly afterwards, it increases again; the diaphragm is also painful, as if cramped, as are the sides of the abdomen and the shoulders, even when the patient

situation is somewhat confused and too dangerous to continue outpatient treatment; an ambulance is called to transport the patient to the women's clinic and she is prepared accordingly. *Belladonna* is therefore not administered for the time being.

In the clinic, an acute abdomen is diagnosed with haemoperitoneum and a suspected ectopic pregnancy. The pregnancy test performed on the patient's urine on admission was positive. Hb 9.3 g/dl on admission, haematocrit 28.7%. A laparoscopy is performed immediately. The diagnosis of haemoperitoneum is confirmed during the surgery; however, this comes from a ruptured, bleeding cyst on the right ovary. An intact haematosalpinx is also found with a suspected ectopic pregnancy. During the operation, the patient's Hb sinks to 7.5 g/dl. The patient's husband, and later the patient herself, refuse a transfusion of erythrocyte concentrate. Laboratory (Table 12.2-3).

Next day, the abdominal pain is extremely severe; the patient now requests homeopathic treatment. The following symptoms are established:

- Major blood loss
- Stabbing pain in both sides of the abdomen extending into both shoulders, also when breathing
- The stabbing pain extends from both sides of the abdomen to the chest, is also very severe in the patient's back, moves from there to the chest and finally to the shoulders
- Breathing is painful
- Turning onto her side (the motion associated with this) and bending her upper body both make the pain worse
- She feels a continuous stabbing pain, sometimes a really strong stitch after 4-5 breaths, like a cramp in the diaphragm

Tab. 12.2-3: Laboratory findings						
Parameters	Day 1 on admission	Day 1 during surgery	Day 2	Day 3	Day 4	Day 5 (discharge)
Haemoglobin (g/dl)	9.3	7.5	7.3	6.9	-	7.5
Haematocrit (%)	28.7	-	22.9	21.5	-	23.2
β-HCG in urine (mIU/ml)	positive	-	-	-	82	41

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- She would like to sit down; this would be no problem for her abdomen but she cannot keep her upper body upright
- Distended abdomen
- The pain keeps her from sleep

Repertorisation II

KENT'S REPERTORY

Abdomen - pain - respiration, on

Abdomen - pain - motion, on, aggravated

Abdomen - pain - bending double, aggravated

Generalities - loss of fluids

Differentiation between remedies

The repertorisation processes finishes with *Belladonna* and *Sulphur*. There is a singly weighted entry for *Belladonna* in the repertory under the rubric “Abdomen - pain - stitching - sides - extending upwards”; this rubric contains just one remedy. In view of the fact that *Sulphur* has already been given without success, the decision is made to administer *Belladonna*.

Prescription

4 globules *Belladonna* 200C dissolved in water and taken as needed.

Progress

The patient takes one dessertspoon of *Belladonna*. Over the next few minutes, the pain subsides rapidly and ultimately disappears completely. The remedy has to be taken another three times when the pain recurs. On day 5, the patient is discharged completely well.

As her recovery progresses, headaches and other symptoms occur as a result of the blood loss; these are treated with *Natrium muriaticum* from day 11 and also subside under the influence of this remedy.

Evaluation

Despite the severity of her condition, the patient recovers

Critical commentary

Homeopathic remedies are strong enough to stop bleeding. In considering the case retrospectively, the author believes that prescribing *Belladonna* at the beginning would have stopped the bleeding and cured the acute abdomen. However, homeopathy could not have prevented surgical treatment of the ectopic pregnancy also found on examination. A subsequent glance at the materia medica (Noack, Trinks 1843) confirms the view that a *Belladonna* condition was already present before surgery: “Blunt stitches in the right side of the body at the lowest ribs; violent stabbing as if from a blunt knife, between the right hip and the navel; [...] violent, tense, pressing throughout the lower abdomen, particularly in the pubic area, [...] appearing in bursts and forcing the sufferer to bend double; [...] Distension of the lower abdomen and hardness thereof; body bloated to bursting. [...] painful pressure in the scrobiculus cordis, [...]. Pressure in the rectum, moving towards the anus. Urge to pass stool, which is thinner than usual yet is passed normally. [...] mostly diarrhoea, stinking stools; [...] stools with [...] simultaneous sweating. Urge to pass stool and abdominal pain [...] penetrating deep into the lower abdomen, preventing the slightest movement of the body. [...] griping, snatching pain in the bowels located deep in the lower abdomen, alternating with blunt stabbing or jerking towards the middle abdomen. Rush of blood to all three major bodily cavities, i.e. to the organs of the skull cavity. Great restlessness, incessant twisting and turning of the body. [...] general chills when the hands are uncovered, [...]. Violent thirst for cold drinks, without heat; insatiable thirst. Rapidly passing stabbing sensation as if from a blunt knife under the last two ribs, next to the sternum and above the false ribs. [...] Attacks of faintness.”

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13 Intoxication

Martin Bündner (Conventional Medicine) Martin Bündner, Walter Gluck (Homeopathy)

- 13.1 Drugs
- 13.2 Intoxication from medication
- 13.3 Poisoning with industrial and household substances

13.1 Drugs

Definition

The term “drugs” was initially used as a description for dried plants or plant parts used directly as healing remedies; alternatively the active ingredients were isolated from them for medical purposes.

These days, the word is also used to describe substances, mostly illegal, which lead to dependency (addictive drugs and alcohol). The presence of drugs in the blood and urine can be proven using comparatively simple procedures (e.g. thin-layer chromatography).

Clinical information

Opiates and narcotics

Strictly speaking, the term “opiates” refers to morphine and opium alkaloids with a morphine-like effect; however, it is also applied to the so-called opioids (semi-synthetic and wholly synthetic drugs or substances with the same effect as morphine). The opiates include morphine, heroin, codeine, papaverine and thebaine. Their specific effects are activated for example by reversible bonding with opiate receptors. They are normally euphoriant, analgesic, sedative, hypnotic, antitussive and antiemetic (late effect); the vegetative nervous symptom is influenced, causing for example respiratory depression, reduced intestinal motility,

nausea and vomiting (as an early effect). Opiates are highly addictive.

Sedatives and anxiolytics

Benzodiazepines are psychotropic drugs classified as minor tranquillisers; they have an anxiolytic, sedative and anticonvulsive effect as well as relaxing the skeletal muscles.

Stimulants and amphetamines

Amphetamine derivatives: Amphetamine was synthesised at the end of the last century and was originally used as a cold remedy. Amphetamine and its derivatives (known as weckamines, e.g. Ecstasy, XTC, Adam, MDE = Eve) are related to adrenaline both chemically and in terms of their pharmacological effect; they have a marked stimulatory effect on the central and peripheral nervous system and carry a correspondingly high risk of addiction. These substances are manufactured illegally by amateur chemists and are only rarely chemically pure.

Phencyclidine: Phencyclidine (PCP) was already being synthesised as early as 1926; however, it was only used as a non-narcotic anaesthetic for a short time because of its side-effects. As an illegal drug, the substance is known as peace pill, angel dust, blue dust, killer weed, rocket fuel or ape tranquillizer. Its chemical structure and effect is similar to that of ketamine. PCP is taken orally as a tablet, smoked or injected intravenously. It is highly addictive.

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Cocaine

Cocaine is the alkaloid of the coca leaf and has been known for centuries as a stimulant. Chronic cocaine abuse with sniffing or inhaling, more rarely with intravenous injection, is known as cocaine addiction. Cocaine increases the quantity of catecholamine available. This leads to physical restlessness, feelings of happiness and hallucinations. Sniffing cocaine leads to inflammation and in some cases to ulcers or perforation of the nasal septum. Psychological dependence develops; withdrawal symptoms may include an extreme need for sleep, anxiety, tremor and depression. This substance is a fashionable drug. It can be smoked, inhaled, sniffed or injected intravenously.

Inhalation drugs

The term “inhalation drugs” is imprecise. It primarily describes a form of use; more strictly, it refers to the substances contained in the cannabis plant which (when smoked) are classified as “soft” drugs, or to the volatile solvents contained for example in glue which induce intoxication when inhaled (“slum cocaine”).

Incidence and mortality

Opiates and narcotics

Over the last few years, an official figure of between 6000 and 7000 drug-related deaths (overdose) has been recorded in the EU every year.

Sedatives and anxiolytics

Benzodiazepines are widespread, and intoxication with these substances is therefore relatively common. If taken alone, benzodiazepines are relatively safe even in cases of extreme overdose; they frequently only become lethal when mixed with other substances (usually alcohol).

Stimulants and amphetamines

Amphetamines and their derivatives are currently the most used drugs. The number of consumers in Western Europe is estimated at about 3 million. The substances are typically taken at techno parties, usually in tablet form. The acute toxicity is relatively low; the chronic toxicity cannot be adequately evaluated at present.

Cocaine

In the USA, about 30 million people (approx. 10% of the population) has tried cocaine; 5 million take it regularly. About 5-10% of drug-related emergencies in the USA are cocaine-related.

Inhalation drugs

Substances in cannabis: marijuana and hashish (identical substances) are widespread. Glue is very popular in the developing countries but its significance in the Western world is relatively minor.

Symptoms

Opiates and narcotics

Opiate addicts are usually treated for the depressive effect which these drugs have on the respiratory system (reduced respiratory frequency/respiratory arrest) or for withdrawal symptoms.

Sedatives and anxiolytics

In cases of acute overdose, the patient develops apathy, sleepiness, anterograde amnesia and other symptoms; chronic overdose causes dysphoria, memory problems and poor reflexes. High doses can cause so-called paradox phenomena such as euphoria, agitation, sleeplessness and excitement. If stopped abruptly, withdrawal symptoms may include vomiting, headaches, restlessness, tremor, occasionally muscle cramps etc.

Stimulants and amphetamines

Amphetamine derivatives: the classic toxic consequence of taking amphetamine and its derivatives is “serotonin syndrome” (hyperthermia, restlessness, tremor, hyperreflexia, myoclonus, trembling, vegetative reactions, convulsions).

Phencyclidine: the symptoms depend on the dose. In low doses, PCP causes a loss of inhibition similar to that induced by ketamine. In high doses, it also causes nystagmus, ptosis, analgesia, ataxia and rigid muscles.

Cocaine

Cocaine is toxic because of the way it increases the quantity of catecholamines. Noradrenaline mainly

stroke, deteriorating renal function and muscle damage. Thromboses and tachyarrhythmia are common. There are similarities with the symptoms of pheochromocytoma. Hyperthermia and muscle rigor have also been observed.

Inhalation drugs

Substances in cannabis: the acute toxicity of both marijuana and hashish is low. It is mostly mixed with other substances, often with alcohol. These substances also cause damage if consumed over a long time.

Inhalation drugs in the glue group cause intoxication. The acute toxicity is low, the chronic toxicity all the higher.

Case 13.1-1: Cannabis intoxication with circulatory dysregulation and hyperventilation tetany

Martin Bundner

Anamnesis

In the evening, the 17-year-old patient allegedly smokes hashish for the first time in the company of his friends. Immediately afterwards, he feels a scratching in his chest. This develops into breathlessness, dizziness and tachycardia. All his fingers turn numb.

Because of the severity of the symptoms, an ambulance is called to take the patient to hospital, arriving at around 10 pm. His parents have already been notified of the incident. The emergency doctor has already given the patient 5 mg metoprolol (e.g. Betaloc®) and 5 mg diazepam (e.g. Valium®), whereupon the tachycardia (heart rate originally 160/min.) and “panic” symptoms present at the scene and documented by the emergency doctor subside a little.

On admission, the patient reports feelings of fear which he cannot define more precisely. He is extremely dizzy. At the scene of the emergency, he had to go outdoors into the fresh air, where he felt better. Fresh air still has a positive effect. The dizziness itself takes various forms and changes according to the situation:

Diagnosis

In drug-related emergencies, the emergency doctor should try to find out the nature and quantity of the toxic substance(s) taken. Unfortunately, it is not always possible to obtain all the necessary information, in which case he could concentrate on his main task - treating the patient.

The physical examination can provide information about the way in which the drug was taken (e.g. puncture marks). A look around the patient's house or in his clothing can give other hints, e.g. drug papers.

A precise diagnosis can be made with drug screening, urine and blood tests supplemented by liver and kidney parameters. Hair analysis is outside the scope of hospitals.

- Initially, the floor seemed to be shaking
- The dizziness gets much worse when he is standing up
- Whenever he looks at an object, it appears to move closer then further away
- He feels better lying down
- The dizziness subsides when he closes his eyes
- The ceiling appears to move when he looks at it
- Looking at the ceiling makes the dizziness worse
- He also has difficulty describing the dizziness precisely, as it takes on so many different forms
- On admission, everything mainly seems to be swinging backwards and forwards

Before the emergency doctor arrives, the patient is unable to speak, as he cannot get enough air and is hyperventilating. He is not yet able to breathe freely during the examination performed on admission to the clinic. His mouth feels so dry (although his tongue is moist) that he can't speak clearly. The patient drinks several times during the anamnesis. He says that his heart is pounding rapidly. His hands feel as if he had put them in snow and they were now warming up. This feeling is still present to some degree; a discrete form of Trousseau's sign is also observed. Parts of the hands are white.

One striking observation is that the patient keeps blowing his nose, which he attributes to the nasal tube inserted in the ambulance for oxygen

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insufflation. He keeps pressing the palm of his hand against the base of his nose; when asked, he says that this makes him feel better. He also sneezes constantly, as if he had something in his nose. This has always been the case. Despite being asked several times, he cannot clearly explain whether the pressure of his hand also makes a difference to the urge to sneeze.

The patient feels very tired and would like to sleep; however, sleep is impossible because his body is too stimulated.

Diagnoses

Cannabis intoxication, circulatory dysregulation, hyperventilation tetany.

Diagnostic procedures

Findings on admission

17-year-old patient, alert, responsive but very tired. Oriented. Pupils moderately dilated on both sides, normal reaction to light. Heart rate 116/min. Blood sugar 108 mg%. Lungs free, no rattling, no bronchospasm. Vitiligo.

Neurological: unclear, somewhat slurred speech. Trousseau's sign still recognisable to some degree.

ECG on admission

Sinus tachycardia 120/min., normal axis.

Conventional treatment

Betaloc®, Valium*.

Homeopathic treatment

Symptom weighting

According to Boenninghausen, the dizziness is a complete symptom and is therefore used for repertorisation purposes. The modalities together with the elements of the complete symptoms most important for the choice of remedy should be sufficient to find the correct remedy.

Repertorisation

KENT'S REPERTORY

Differentiation between remedies

The repertorisation clearly leads to *Pulsatilla*-, there is no reasonable alternative. Other remedies such as *Natrium muriaticum*, *Sepia*, *Staphisagria* and *Thuja*, which also show contradictory states, do not have the necessary modalities and are therefore eliminated from further consideration. *Pulsatilla* is also confirmed by the available keynotes: the vertigo which constantly changes rather than being constant, the contradiction between the marked subjective dryness of the mouth and the moistness of the tongue (the patient even asks for something to drink!). The other symptoms also indicate *Pulsatilla*. As a chronic symptom, the vitiligo is not included in this acute case.

Prescription

1 dose of 2 globules *Pulsatilla* 30C.

Progress

Just quarter of an hour after taking the remedy, the vertigo and anxiety have both disappeared; the dyspnoea and tetany have subsided, as have the nasal symptoms. Another quarter of an hour later, the patient is asleep and is calm and quiet all night. Next day, the patient feels well and is discharged. The patient and his parents are advised to undergo drug counselling when he returns home.

Evaluation

Despite the medication administered in the ambulance, the patient still had quite severe symptoms. *Pulsatilla* eliminated them within a very short time and enabled the patient to sleep peacefully.

It is assumed that the homeopathic remedy would also have helped the patient sufficiently if it had been administered first and the chemical substances had been omitted; it could have been repeated if necessary.

Critical commentary

The rubric "Generalities - contradictory and alternating states" is considerably smaller in the Kent Repertory than it is in the Synthetic Repertory. However, even when the corresponding rubric from the Synthetic Repertory is used, the result is still *Pulsatilla*.

Case 13.1-2: Severe alcohol intoxication

Martin Bündner

Anamnesis

The 27-year-old patient, a smoker, has been reunited with her family after a long time; almost all of her family members have not seen each other for a lengthy period. They get together to eat onion tart and drink new, partly fermented wine. It turns out that the wine is rather more fermented than expected, and the alcohol content is considerably higher than indicated. They also drink asparagus schnapps, and the patient eats the asparagus soused in the schnapps. Everyone is cheerful and drinks much more than they can tolerate.

When she is taken home that night, the patient is almost unable to stand for sheer drunkenness; she is babbling.

A holiday trip by car is planned for the next day. In the morning, the patient's boyfriend tries to wake her. He shakes her and applies a cold flannel for more than two hours. She cannot be woken; even painful stimuli have no effect. Finally, the patient reacts and comes more or less to herself. She needs more than an hour to get dressed and ready to go on holiday. She doesn't want to eat breakfast, complains of a severe headache and feels cold. She staggers and smells extremely strongly of alcohol. She shouts at her partner, reproaches him, is angry, bad-tempered and irritable. During the breaks in the argument, she has nothing to say. The patient's partner consults a homeopathic doctor, as he feels that his holiday is not the only thing at risk.

Diagnosis

Severe alcohol intoxication

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY

Mind - alcoholism, dipsomania - ailments from

Mind - abusive, insulting

Mind - censorious, critical

Generalities - debauch, as after a

Differentiation between remedies

Arsenicum album and *Nux vomica* are present in all rubrics. *Lachesis* should also be considered, but the *Lachesis* patient would be more talkative, jealous and suspicious. Where *Arsenicum album* is concerned, important symptoms such as restlessness, weakness and exhaustion are missing. In contrast, *Nux vomica* perfectly matches this patient's mental condition. The excessive wine drinking, the intake of stimulants such as nicotine, the irritable nerves and fiery temperament all indicate this remedy. There is no better remedy than *Nux vomica* for the symptom "Alcoholism, dipsomania - irritability in".

Prescription

1 dose of 3 globules *Nux vomica* 30C.

Progress

Just five minutes after taking *Nux vomica*, the smell of alcohol on the patient's breath has disappeared. The patient's mood and alertness improve steadily. She is no longer staggering and is able to depart on holiday.

Evaluation

Homeopathic remedies (here: *Nux vomica*) appear to accelerate the enzymatic breakdown of alcohol to a remarkable degree. A blood test documenting the change in the patient's alcohol levels would have been interesting.

Critical commentary

Homeopathy should not be misused to reduce blood alcohol concentration e.g. before driving, or to cope better with alcoholic excess. No tests are known to have been performed to ascertain the measurable influence of homeopathic remedies on blood alcohol concentration, meaning that no certain statement concerning an accelerated decrease in blood alcohol concentration compared to normal conditions (provided the correct remedy is chosen) can be made. Homeopathy is a curative process which makes ill people healthy and should not be used to promote an unhealthy lifestyle.

13.2 Intoxication from medication

Definition

Intoxication from chemical medication is a pathophysiological condition which occurs when the body has received an overdose of these substances.

Clinical information

Psychotropic drugs

Antidepressants: psychotropic drugs which have either a stimulatory, mood-lightening effect or a sedative, anxiolytic one; these are mainly used to treat endogenous and psychogenic depression. The most commonly used depressants are tricyclic and non-tricyclic.

Neuroleptics: neuroleptics are classified according to their potency (their ability to block dopamine receptors). There are weak neuroleptics with a distinctly sedative, anticholinergic effect, and strong neuroleptics (e.g. haloperidol) with a powerful antipsychotic effect and extrapyramidal motor side-effects.

Analgesics: Paracetamol: this substance is an analgesic and antipyretic with relatively mild side-effects.

Salicylates: these medications are used as ointments, antiseptics, anticoagulants and antiphlogistics.

Other medication

P receptor blockers: these drugs selectively or non-selectively inhibit the activity of the sympathomimetic neurotransmitters noradrenaline and adrenaline at the cellular P-receptors of the respective organ.

Theophylline: this substance is a purine derivative which occurs in small quantities in tea and is mainly used to treat acute asthma attacks.

Digitalis: these substances boost the contractility of the heart muscles (positive inotropism).

Isoniazid (INH): isoniazid is an antitubercular drug which has been in use for many years. Intoxication with this drug is usually suicide-related. 2-3 g are toxic for adults.

Incidence and mortality

Psychotropic drugs

The tendency to prescribe psychotropic drugs is rising continually. Cases of intoxication are therefore also increasing; intoxication in adults mostly occurs with suicidal intentions.

Antidepressants: intoxication occurs most frequently with tricyclic compounds (TCA) followed by non-tricyclic, including the new selective serotonin reuptake inhibitors (SSRI) and other drugs which do not inhibit reuptake. Intoxication with TCA in the lower therapeutic range of this substance category are particularly common; their cardiotoxicity (negative inotropism and negative dromotropism) makes them especially hazardous.

Analgesics

Paracetamol: this substance is available without prescription; cases of intoxication are correspondingly common.

Salicylates: suicide-related overdoses with the wide range of medication containing salicylates (e.g. Aspirin) are rare, probably because it is erroneously assumed that these substances are harmless. Accidental intoxication therefore most commonly occurs in small children, and can be life-threatening if taken in larger quantities.

Other medication

Theophylline: chronic intoxication is particularly common with this substance, as its therapeutic margin is narrow and its pharmacokinetic activity is difficult to predict in individual cases. Its breakdown in the liver can also be hindered by numerous substances. Acute intoxication is frequently iatrogenic.

Digitalis: intoxication occurs after acute overdose or, in the case of patients receiving long-term treatment, by taking additional drugs which bring about a massive increase in the amount of digitalis in the bloodstream. Acute deterioration in renal (or more rarely, hepatic) function can also manifest as digitalis toxicity depending on the drug used.

Isoniazid (INH): the metabolism is genetically

13.2 Intoxication from medication

Symptoms

Psychotropic drugs

Antidepressants: in view of the large number of substances available, the symptoms of acute intoxication vary.

Symptoms of intoxication with **tricyclic compounds (TCA)** depend on the dose:

Low doses:

- Dry mouth
- Accommodation disorders through to glaucoma
- Micturition disorders through to urinary retention
- Ileus
- Supraventricular tachycardia
- Sedation

Central cholinergic syndrome occurs when the anticholinergic symptoms are particularly severe.

Moderate dose: additionally

- Ventricular tachyarrhythmia
- Tremor
- Myoclonus
- Convulsions
- Delirium

High doses:

- Conduction disorders (QT prolongation)
- Negative inotropism of the heart
- Respiratory depression
- Seizures
- Coma

Symptoms of SSRI intoxication:

- Sleep disorders
- Motor agitation with myoclonus, tremor, hyper-reflexia, muscular hypertonia
- Nausea and vomiting
- Cerebral seizures

SSRI intoxication is more benign than TCA intoxication. Combined with other substances which increase serotonin concentration (e.g. monoamine oxidase

- Extrapyramidal motor side-effects are rare Strong neuroleptics:

- Extrapyramidal motor symptoms are common
- Early stages of dyskinesia

In rare cases, patients receiving treatment with neuroleptics may develop malignant neuroleptic syndrome, which can be fatal:

- Hyperthermia
- Severe extrapyramidal motor disorders (generalised rigor) with impaired consciousness through to coma

Analgesics

Paracetamol: for adults, 10-15 g are hepatotoxic, higher doses (approx. 25 g) are acutely life-threatening. Children, particularly babies, are much more sensitive than adults. Symptoms of paracetamol intoxication:

- Methaemoglobinaemia
- Cyanosis
- Respiratory depression
- Cardiovascular arrest

The way in which the intoxication manifests depends on the dose. If a hepatotoxic dose is taken, the patient will suffer general symptoms (e.g. vomiting and outbreaks of sweating) on the first day. On the 2nd day, the disrupted liver function can be established by means of laboratory tests. After 4 days, all the signs of liver damage occur with icterus through to encephalopathy.

Salicylates:

- Tinnitus
- Nausea and vomiting
- Abdominal pain
- Hyperventilation
- Respiratory alkalosis
- Later metabolic acidosis
- Increase in body temperature with reddening of the skin and increased sweat production
- Dehydration

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Other medication

p-receptor blockers:

Cardiovascular system:

- Cardiac insufficiency
- Life-threatening bradyarrhythmia, particularly when taken with Ca^{2+} blockers with suicidal intentions
- AV blocks
- Prolonged QT interval through to “torsades de pointes”, only with massive intoxication
- Peripheral vasoconstriction

Lungs:

- Bronchospasm

Metabolism:

- Metabolic disorders, particularly hypoglycaemia
Beware: suppressing the adrenalin-induced warning signs of hypoglycaemia (palpitations, tremor) may “mask” this condition
- Electrolyte imbalances with NaCl retention
- Hyperkalaemia

CNS:

- Tiredness
- Sleep disorders
- Depression
- Hallucinations

Tab. 13.2-1: Degrees of severity of theophylline intoxication according to Sessler (Sessler Severity Score)	
I	Vomiting, abdominal cramps, diarrhoea, tremor, agitation, tachycardia > 120/min.
II	Haematemesis, lethargy, disorientation, mean arterial pressure = 60 mmHg
III	Convulsions, ventricular tachyarrhythmia, mean arterial pressure < 60 mmHg, therapy-resistant
IV	Status epilepticus, ventricular fibrillation, cardiovascular arrest

Tab. 13.2-2 Antidotes	
Physostigmine salicylate (Anticholinium) 2 mg/5 ml	
Indication	Acute intoxication with tricyclic antidepressants, atropine, alcohol
Effect	Central-acting cholinesterase inhibitor
Precautions	Asthma sufferers, nausea, impaired consciousness
Dose	1-2 mg as bolus, then 2 mg/h in infusion

Digitalis:

The symptoms are caused by the pharmacokinetics of this substance category:

- Bradycardia
- AV conduction disorders through to blocks
- Asystole
- Bronchoconstriction
- Hyperkalaemia
- Tachyarrhythmia (sign of impending death)

Isoniazid (INH):

- Dizziness
- Impaired consciousness through to coma
- Generalised cramps, refractory to treatment
- Severe metabolic acidosis
- Hyperglycaemia or hypoglycaemia

Diagnosis

Antidepressants and neuroleptics:

In cases of malignant neuroleptic syndrome and intoxication with SSRI, other diseases with hyperthermia (lethal catatonia, central anticholinergic syndrome, lithium or cocaine intoxication, salicylate intoxication) must also be ruled out.

Paracetamol: the degree of liver damage can be ascertained using laboratory diagnostics.

β-receptor blockers: ECG tests are used to diagnose cardiac arrhythmia.

Theophylline: in cases of acute intoxication, the plasma theophylline count correlates much more

Case 13.2-1: Slow atrial fibrillation from intoxication with amiodarone and digitalis, concomitant organic psychosyndrome

Martin Bündner

Anamnesis

In the morning during a visit to the dentist, the 86-year-old patient suddenly becomes dizzy with nausea and vomiting. She is taken directly from the dental clinic to the hospital by ambulance. She reports that these symptoms had already appeared the previous day, and that she had fainted four days ago. "I lay on the sofa, and it was a long time before I came round. I was also dizzy the day after, that's three days ago. Everything was going round, spinning in front of my eyes. Everything went black in front of my eyes; I had to sit down, then fainted again." Three years ago, the patient had a heart attack and was put on the antiarrhythmic drugs amiodarone (e.g. Cordarex®) and digoxin (e.g. Novo-digar) to treat atrial fibrillation. She had already been treated as an inpatient in another hospital for nausea caused by intoxication with these two substances. She also has arterial hypertension and atrial fibrillation.

Immediately after the initial examination, the patient is transferred to intensive care with suspected amiodarone and digoxin intoxication and given large doses of atropine and orciprenaline (e.g. Orciprenalin) orally. Laboratory tests show that the digoxin, amiodarone and desethylamiodarone levels in the patients blood are massively elevated, thus confirming the clinical diagnosis.

As her blood pressure is stable, it is decided that she will not be given a temporary pacemaker. After a while, the nausea and dizziness subside while she is lying down, meaning that she has no more problems in this respect. The next day in ICU is normal, except that there is no change in the bradyarrhythmia.

The following morning, there is again no change in the slow atrial fibrillation despite the medication; however, the patients circulation is stable. She is neither dizzy nor nauseous. The ECG still shows slow atrial fibrillation with a heart rate of about 40/min. with no significant changes from the findings on

admission. At about 9.50 am, her heart rate drops to 27/min. but recovers spontaneously. At 6.30 pm, another phase of extreme bradyarrhythmia with bigeminy is observed; the patient is now also given atropine intravenously. At 7.30 pm, the symptoms are the same as they were an hour earlier; atropine is again administered intravenously but has no effect. As the bradyarrhythmia persists at this low level, the patient is connected to a dopamine infusion for a day. At 7.50 pm, the heart rate is now being kept "stable" at 35/min. During all of these phases of bradyarrhythmia, the patient is alert and has no subjective complaints. In the night, the bradycardia increases and her heart rate drops to 20/min. It is noted that the patient passes large quantities of urine throughout the night. Her cardiac outlook is uncertain. She is therefore booked in to have a heart pacemaker inserted.

The following morning (day 3), the patient in the neighbouring bed dies; afterwards, the patient has hallucinations and sees a large blood sausage in her bedpan, which does not disappear when she looks again. She is finding it difficult to speak; her diction is unclear. At present, there are no other neurological abnormalities. It is assumed that she has developed toxic psychosis. She is then prescribed haloperidol (e.g. Haldol®). The pacemaker implantation is postponed because of her mental condition. Her heart rate begins to stabilise to some degree as the hallucinations develop.

The patient is to receive adjuvant homeopathic treatment. The following additional information is provided during the anamnesis.

- The continuing bradycardia was diagnosed at least three days ago. The continuing arrhythmia from atrial fibrillation is already known and is assumed to have been present for some time
- She wants to die. During the conversation, it is not absolutely clear whether this is a new symptom or one which she has already experienced before
- She suffers from constipation unless she takes laxatives
- The patient currently has a dry, sticky mouth with normal thirst. This is why she is speaking unclearly

13 Intoxication

Diagnoses

Continuing bradycardia (already known to atrial fibrillation), digitalis and amiodarone intoxication and former digitalis intoxication, previous myocardial infarction; arterial hypertension, toxic psychosis. Hyperthyroidism.

Diagnosis

Findings on admission

Fully conscious, alert and fully oriented 86-year-old patient in poor general condition. Warm skin. Dry tongue. Lips and oral cavity normal on inspection. Slightly congested jugular veins. Vesicular breathing on both sides. Normal heart sounds, heart action arrhythmic. Heart rate approx. 40/min., blood pressure 120/80 mmHg. Soft abdomen, regular intestinal sounds, no pain on pressure or percussion, no muscular guarding, no rigidity of the abdominal wall. Renal area normal on both sides. Extremities can be moved freely, no oedema, no ulcers. Foot pulses can be felt on both sides. Neurological findings generally normal.

Laboratory

Leucocytes 11,700/pl. CRP 8 mg/l. (Cholesterol 246 mg/dl. Creatinine 1.26 mg/dl. TSH basal 0.06 pU/ml (normal range 0.30 - 5.00), fT₄ 2.27 ng/dl (normal range 0.75 - 2.20).

Imaging procedures

Resting ECG (day 1): heart rate approx. 40/min., atrial fibrillation, left axis deviation. Posterolateral repolarisation disturbances (ST depression). Relative QT interval 100%.

Conventional treatment

Atropine, orciprenaline, dopamine, intensive monitoring.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Differentiation between remedies

Aconitum, *Belladonna*, *Nux vomica* and *Opium* are all listed in each of these rubrics.

The tachycardia is typical of *Aconitum*, also with anxiety and unconsciousness. The pulse may sometimes skip a beat. *Belladonna* also has frequent palpitations with a rapid but weak pulse. However, each of these remedies are listed for contrary conditions. Of the remedies mentioned, the hallucinations clearly speak for *Belladonna*. A dry mouth is mentioned with *Aconitum*, *Belladonna* and *Opium*; the last two are also indicated for difficulties speaking. *Aconitum* is eliminated when the patient's presumably acute wish to die is considered. *Aconitum* fears death rather than wishing for it. *Belladonna* also has the sticky saliva. Taking all the symptoms into consideration, the remedy that covers them best is *Belladonna*.

Prescription

1 dose of 2 globules *Belladonna* 30C.

Progress

Belladonna is administered during the morning. The bradyarrhythmia is still present at approx 30/min.; since the hallucinations began, the life-threatening decline in the patient's heart rate has ceased.

The patient becomes feverish at around midday. Her urine smells pungent. A urinary tract infection is diagnosed. The patient is still very confused and disoriented and has hallucinatory phases: she has moments of clarity when she notices that her speech is confused. By 9 pm, the patient is very confused; she calls for the police and leaves her bed, after which her hands are restrained for her own protection. She wets the bed during the night.

On day 4, the patient is still feverish and is given antimicrobial treatment with ampicillin (e.g. Bino-tal'). The patient is fearful and agitated. Early in the afternoon, the patient's heart rate stabilises at 45/min. for the first time (persistent slow atrial fibrillation); the ECG otherwise shows no significant changes from the findings on admission. The protective measures are still necessary as there is no change in the transitory

13.2 Intoxication from medication

At 2.30 pm, the patient pushes her legs through the rails to the floor and tries to lever the rails apart with force. In doing so, the infusion needles are ripped out and blood is spattered everywhere. The patient removes the ECG electrodes, the blood pressure cuff and other utensils herself. She is now given an abdominal belt as an additional protective measure. The patient causes problems all afternoon, as she is difficult to manage, still very confused but very determined.

In the evening, it becomes evident that she is afraid that the nursing staff will poison her with tablets: she pretends to swallow the tablets she is given then secretly takes them out of her mouth. Neither does she want to accept anything to drink, although this changes during the evening. In the night, after an attempt at leaving her unsecured, the patient again leaves her bed and refuses to hear reason, as a result of which she again has to be secured to the bed by her hands and with an abdominal belt. She refuses all measures and suggestions.

Early in the morning of day 5, her heart rate surprisingly stabilises at normal levels within one hour. A pacemaker is obviously no longer necessary.

The patient is still aggressive and restless. She is still feverish. The orciprenaline treatment is stopped. No other changes are made to the conventional treatment she has received to date.

The stabilisation of the patients heart rate means that she appears to be out of danger. From a homeopathic viewpoint, the situation has not yet been adequately clarified. The homeopath therefore considers administering another remedy which optimally covers all the symptoms to date in order to defuse the situation.

Repertorisation II

CARD INDEX REPERTORY

Slow pulse

Fantasies, hallucinations, delusions

Mouth and throat, general dryness

Differentiation between remedies

The remedy *Stramonium* covers all the symptoms characteristic of this case. In contrast, *Belladonna*

is eliminated because its essence does not include all the symptoms.

Prescription

1 dose of 2 globules *Stramonium* 30C.

Progress

At about 10.30 am, after administering *Stramonium*, the patient becomes much calmer and less aggressive. A check-up at about 1 pm shows that she is still confused but has moments of clarity, is much easier to manage than on the previous day and that her aggression has almost gone. Her urine is milky and has a strong smell; however, her urine status is normal. In the evening, the patients condition declines; she becomes restless and disoriented, communication is impossible. Her heart rate is still stable at approx. 60-70/min. The patient is initially watched for further developments. She is restless during the night.

On day 6, the antimicrobial treatment is changed as the fever has not subsided. The patients leucocyte count is 17,000/pl, CRP 215 mg/l. As her heart condition has stabilised, the atropine treatment is now stopped. During the morning, the patient is sleepy but responsive. When she wakes up, the toxic psychosis appears to have vanished and does not recur. She is then transferred to a general ward. The anti-arrhythmic drugs are stopped; the patient is treated with high doses of a beta blocker. In the long-term ECH performed on day 15, no cardiac arrhythmia is evident with this medication; the patients heart rate does not drop below 41 /min., the average is 50/ min. and the maximum 64/min. Thyrostatic treatment of the hyperthyroidism diagnosed is initiated with carbimazole (e.g. Camazol®).

Evaluation

Hahnemann described his observations on how a life-threatening physical condition affects the mind:

“The cases are not rare in which a so-called corporeal disease that threatens to be fatal - a suppuration of the lungs, or the deterioration of some other important viscus, or some other disease of acute character, e.g. in childbed etc. - becomes

13 Intoxication

transformed into insanity, into melancholia or into a kind of mania by a rapid increase of the psychical symptoms that were previously present, whereupon the corporeal symptoms lose all their danger; these latter improve almost to perfect health, or rather they decrease to such a degree that their obscured presence can only be detected by the observation of a physician gifted with perseverance and penetration. In this manner they become transformed into a one-sided and, as it were, a local disease, in which the symptom of the mental disturbance, which was at first but slight, increases so as to be the chief symptom, and in a great measure occupies the place of the other (corporeal) symptoms, whose intensity it subdues in a palliative manner, so that, in short, the affections of the grosser corporeal organs become, as it were, transferred and conducted to the almost spiritual, mental and emotional organs, which the anatomist has never yet and never will reach with his scalpel.” (§ 216 Organon of the Healing Art)

This case illustrates the process described by Hahnemann: only when mental symptoms developed was the patient's life-threatening heart condition “diverted” to some degree: at first rather slowly, then relatively fast with the support of the homeopathic remedy.

Considering the progress of the case and the severity of the intoxication, the rapid stabilisation of the patient's heart rate was more likely due to *Belladonna* than to the orciprenaline and adrenaline treatment. *Belladonna* reinforced the “diversion process” which had already been initiated. The

patient's heart rate stabilised shortly after her mental condition worsened. From a homeopathic viewpoint, this is a bodily “survival strategy”, and the question is how far treatment with chemical medication actually suppresses this reaction. It can be assumed that adjuvant homeopathic treatment would by all means support the healing process in suitable cases.

Critical commentary

The rubric “Mind - bad news - ailments from” was not used, as a causal relationship between the death of the patient in the neighbouring bed and the patient's condition could not be established with any certainty. Neither does it contain any of the remedies from the first repertorisation, although *Stramonium* from the second repertorisation is included.

None of the remedies appear in all the rubrics if the rubric “Mouth and throat - dry, but no thirst” is applied, as a result of which the superordinate card was used. However, a glance at Kents Repertory shows that the chosen remedy *Stramonium* is also mentioned in the rubric “Mouth - dryness - thirstless”, where it is even given double weighting.

Perhaps *Stramonium* would have cured the patient's initial condition completely; this remedy would certainly have covered it, but because it was not listed in the rubric “Generalities - pulse - irregular - irregular and slow”, it was not included in further considerations.

It would be advisable for this patient to undergo follow-up homeopathic treatment.

Case 13.2-2: Medication-induced Lyell syndrome - severe allergic reaction

Martin Bündner

Anamnesis

The 84-year-old patient caught a cold three or four weeks previously, in mid-January; for the last 2 weeks, she has had increasing breathlessness and even dyspnoea at rest with attacks of asphyxiation. Her family doctor

From day 1 to day 5, she is treated there for cardiac insufficiency. At the same time, she is given clarithromycin (e.g. Klacid®) to treat relapsing fever. On day 6, the antimicrobial therapy is changed to ampicillin (e.g. BinotaT) as the fever is not responding. Later it turns out that the patient is known to be allergic to penicillin.

On day 8, a medication-induced rash appears on individual body parts. The patient is therefore given dimetindene (e.g. Fenistil®) and ranitidine

13.2 Intoxication from medication

(e.g. Zantac®). She was initially to be discharged the following day; however, her discharge is postponed for another day when blood is found in her stool. A massive increase in the medication-induced rash is observed on day 10. The rash is now spread all over her body; she is now given 100 mg prednisolone (e.g. Solu-Decortin®) a day in addition to the antiallergic medication. Nevertheless, her condition continues to deteriorate. Her skin, which was previously only red in places, is now red everywhere.

The allergic reaction worsens dramatically until day 12. The reddening of the skin is becoming more intense. As the treatment given to date does not appear to be having a positive effect, advice on further treatment is sought from a consultant at the university skin clinic. However, he confirms that the measures taken to date are correct and suggests the additional application of a cooling lotion. On the next day, the patient's condition has again deteriorated. Her skin is now in such poor condition that it is feared she is developing the full symptoms of Lyell syndrome (toxic epidermal necrolysis). Her skin is turning dark red. It appears that blisters are forming in individual small areas.

As the chemical treatment given to date is not helping and her condition is now becoming life-threatening, the patient consents to homeopathic treatment.

The patient mentions the following symptoms which have manifested since the rash appeared:

- Abdominal pain
- Eyes seem swollen
- The skin of her face looks like a mask and feels like leather
- Physical restlessness with urge to keep moving
- Ears severely swollen and hot
- Rash development: first her back was affected, then her chest and abdomen, then her throat and head and finally her legs; at this time, the rash on her back subsided a little but increased massively everywhere else
- Skin raw and dry all over her body, feeling of tautness
- When touching the skin, she feels as if she is being stabbed by needles from the inside

- Her skin feels hard all over her body; she feels as if she has cardboard in her face
- Itchy eyes
- Her skin itches terribly. Rubbing and tapping the skin briefly eases the itching, but afterwards it feels as if it is burning. Better when cooled. Woollen clothing makes the itching worse
- The itching prevents her from falling asleep
- The patient woke up during the night in a kneeling position

Diagnoses

Medication-induced Lyell syndrome from severe allergic reaction to penicillin derivative. Cardiac insufficiency. Mitral stenosis. Atrial fibrillation.

Diagnosis

Findings on admission

84-year-old patient in poor general condition. Dyspnoea at rest, dry cough. Pretibial and bimalleolar oedema. Fine crackles in both basal areas, left > right. Arrhythmic heart sounds, systolic heart murmur with punctum maximum over Erb's point.

Imaging procedures

Resting ECG: day 1: HR 62/min., sinus rhythm, left axis deviation, left bundle branch block.

Echocardiography: hypertrophy of the left ventricle, more marked on the outside (cardiac apex); no criteria for non-impaction. EF > 60%. Mild mitral stenosis, left atrium significantly enlarged. Calcified aortic valve.

Chest x-ray: cardiomegaly with central congestion.

Conventional treatment

Dimetindene, ranitidine, prednisolone.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY Restlessness

Hardness, hardening

Fine, stabbing pain, as if from needles, splinters, threads

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Differentiation between remedies

The repertorisation process finishes with *Arsenicum album*, *Bryonia*, *Carbo vegetabilis*, *Phosphorus*, *Rhus toxicodendron* and *Sulphur*. The aggravation of the itching is mentioned with *Phosphorus* and *Sulphur*, while the itching of *Sulphur* also causes sleeplessness. *Sulphur* is therefore chosen.

Prescription

1 dose of 2 globules *Sulphur* 30C.

Progress

The patient is given two globules of *Sulphur* 30C on day 14. The check-up on the following day shows that the allergy has already improved considerably. The swelling in her face is also subsiding, as is the restlessness.

From day 30, the cortisone treatment is stopped. The skin is still red or bluish in various parts of her body, but in general her condition is better. Her skin has improved daily ever since she took the *Sulphur*. However, the improvement seems to have stopped over the preceding

Summary

The patient does not think she needs to take *Sulphur* again and refuses to do so. Afterwards, the rash reappears and the chemical treatment with Fenistil", Zantac* and Prednisolone* is recommenced. As before, the rash continues to worsen despite this medication (although not as badly as before) and continues for weeks. Unfortunately, it is not known what happened afterwards.

Evaluation

Only with *Sulphur* is the aggressive allergic reaction stopped and the patient's subjective and objective condition improved. Unfortunately, a cure was not possible because of the patient's refusal to cooperate. The appropriate chemical medication is unable to cure the symptoms; this is also the case after the patient refuses to take another dose of *Sulphur*.

Critical commentary

The 30C potency worked for an unusually long time in this acute case and was able to keep the patient stable

Case 13.2-3: Vaccination complication

Martin Bündner

Anamnesis

The 20-year-old patient is given a combined hepatitis A and B vaccination in the left deltoid muscle under regular conditions. Problems develop in this area shortly after the vaccination and worsen over the next two days.

The young woman requests homeopathic treatment for the following complaints: the area where the vaccination was given is sensitive to pressure and touch. Every movement of the left arm is painful; the scope of movement is clearly restricted in all directions. Stretching her arms to the side, bending them at the elbow, fine work with her fingers and putting her arm behind her back make the pain much worse. The arm pain wakes her up. Close-fitting clothing rubs uncomfortably. There is no fever.

Diagnosis

Vaccination complication.

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY* KENT'S REPERTORY**

Sleep - disturbed - pain, from*

Extremities - pain - shoulders - motion - of arm*

Generalities - sewing, agg*

Generalities - touch - aggravated**

Generalities - pressure, aggravated**

Generalities - clothing - loosening, amel**

Differentiation between remedies

The only remedy left is *Lachesis*. *Kalium carbonicum* and *Mercurius solubilis* could also be considered; they were only eliminated by the last rubric. One striking

13.3 Poisoning with industrial and household substances

background. The side affected speaks for *Lachesis* but is not accorded prime significance because of the external cause.

Prescription

1 drop *Lachesis* Q6 three to five times a day. 1 extra drop *Lachesis* Q6 if the pain increases.

Progress

The pain subsides every time the patient takes a dose of *Lachesis*. Nevertheless, the symptoms continue to get worse. The patient is now almost unable to move her arm. She feels pain all down the left side of her body, “as if it is being stabbed all over”. On the third day, her condition finally begins to improve; the pain subsides markedly. On the fourth day, the patient is given *Lachesis* Q9 with the instruction to take the same dose just once a day. By day 23, the symptoms have almost completely disappeared; she is given *Lachesis* Q12 and another 1.5 months later *Lachesis* Q15 to cure her

Evaluation

Unclear progressive complication after which, despite homeopathic treatment initially, progresses further and is not stopped until the third day. *Lachesis* may have prevented something even worse from happening.

Critical commentary

The possibility of initial aggravation is ruled out, as the symptoms were still developing when *Lachesis* was administered and the remedy always relieved the pain until its effect was exhausted.

The therapist should not rely on the very small number of remedies which have proven their efficacy in treating the consequences of vaccinations (after smallpox); the decision should always be based on the entirety of the current symptoms.

1 3.3 Poisoning with industrial and household substances

Clinical information

Gas poisoning

Carbon monoxide (CO): in its pure state, carbon monoxide is a colourless, odourless, tasteless, flammable and in certain circumstances explosive gas emitted when coal, wood etc. are incompletely burnt. It also occurs in mineral and natural gases and industrially as generator gas, city gas, coke oven gas (illuminating gas) and as exhaust gas from petrol engines. Carbon monoxide is inhaled via the lungs and exhaled unchanged. Because its affinity with haemoglobin is significantly greater than that of oxygen, even relatively low CO concentrations can be fatal. Moreover, CO poisoning is extremely complex due to the mechanisms through which it takes effect.

Dichloromethane (methylene chloride): dichloromethane is a commonly used industrial solvent. Carbon monoxide and hydrochloric acid are released by endogenous metabolism. The result is

endogenous CO poisoning: because the metabolic process is so slow, CO/Hb levels in the blood can keep rising for a long time, while in cases of exogenous poisoning they decline after a while.

Prussic acid (HCN): this substance is a colourless fluid which boils at 26 °C. It is derived from cyanides and in small quantities also from cyanogenic glycosides (e.g. bitter almonds, linseed etc.); it also exists as a combustion gas (along with carbon monoxide). It is used industrially to fight pests and fumigate rooms.

Prussic acid easily penetrates all organic membranes and is reabsorbed via the skin. An endogenous detoxification mechanism exists.

Pesticides (organophosphates)

Pesticides are a group of chemical substances for fighting harmful animals and plants. This category of substances encompasses several thousand compounds, several hundred of which are available commercially as acaricides (against mites), fungicides (against fungi), herbicides (against weeds), insecticides (against insects), molluscicides (against snails), nematicides (against worms)

13 Intoxication

and rodenticides (against rodents). They are also described as respiratory, stomach or contact poisons depending on the method of absorption.

Volatile organic compounds

Solvents: the enormous number of all kinds of solvents makes it necessary to divide them into groups. In chemical terms, they can be classified as halogenated and non-halogenated. These two groups are divided further into aliphatic and aromatic solvents.

Aliphates (non-halogenated alkanes, alcohols, ketones, esters, ethers and halogenated hydrocarbons) are relatively common causes of acute poisoning.

In the aromatics group, non-halogenated benzene is particularly likely to cause chronic intoxication. The numerous compounds in the halogenated aromatic group are mainly used as pesticides rather than solvents.

Cases of poisoning with benzene and tetrachloromethane (CCl₄), for example, occur quite frequently. In earlier times, tetrachloromethane was commonly used as a carpet cleaner; these days, it is only used in the laboratory and for industrial purposes.

Alcohols: alcohols are hydrocarbons in which carbon atoms are replaced by hydroxyl groups. This term is also commonly used to describe ethyl alcohol. Alcohols are used for example in disinfectants, in beverages and as solvents.

Incidence and mortality

Gas poisoning

Carbon monoxide (CO): in the USA, it is assumed that there are around 8600 fatalities each year. Mortality rates in all cases of CO poisoning are assumed to lie between 30-40%.

Pesticides

The global production of organophosphates is estimated at about 500,000 tons per year; their widespread use (particularly in agriculture) and their ready availability are reflected by the numbers of accidental or suicidal poisonings. The WHO

estimates that there are more than 5000 cases of fatal intoxication all over the world each year.

Volatile organic compounds

Solvents: intoxication with benzene and tetrachloromethane (CCl₄) is comparatively common.

Alcohols: acute intoxication can be caused by monohydric (methanol, ethanol and isopropanol) and/or dihydric alcohols (glycols). Poisoning with monohydric alcohols is far more common because of their availability. Where methanol is concerned, spectacular cases of poisoning with contaminated spirits occur again and again, particularly as a result of consuming home-made schnapps.

Symptoms

Gas poisoning

Carbon monoxide (CO): the typical cherry red skin colour caused by CO-Hb covers the cyanosis caused by hypoxia but only occurs in cases where the CO-Hb > 40%. The degree of poisoning depends on the CO concentration and the time it has had to take effect. The symptoms depend on the percentage of CO-Hb in the blood, but do not always correlate (« table 13.3-1).

Dichloromethane (methylene chloride):

- Irritation of the skin, eyes and respiratory tract •

Tab. 13.3-1: Symptoms of carbon monoxide poisoning	
CO-Hb in blood [%]	Symptoms
5-10	Decrease in physical stamina, angina pectoris, tendency to claudication
10-20	Dyspnoea on exertion, headache, impaired CNS function
20-30	Severe headache, irritability, visual disturbances, impaired thinking, nausea, tachypnoea
30-40	Cardiac arrhythmia, muscle weakness, nausea and vomiting, impaired consciousness
40-60	Unconsciousness, cramps, paralysis
60 and over	Coma, death

13.3 Poisoning with industrial and household substances

Tab. 13.3-2 Antidotes

Apomorphine (e.g. Apokyn) 10 mg/1 ml	
Indication	Triggers vomiting in cases of poisoning, e.g. Paraquat, prussic acid, alcohol, mushrooms
Effect	Central emetic
Side-effects	Hypotension
Precautions	Only together with sympathomimetic drugs (due to drop in blood pressure)!
Dose	0.1 mg/kg body weight
Contraindications	Shock, impaired consciousness
Sodium thiosulphate (e.g. Sodium Thiosulphate 10%) 1 g/ 10 ml	
Indication	Cyanide, prussic acid poisoning
Effect	Converts cyanide into rhodanide
Precautions	Only works slowly
Dose	50-100 ml of 10% solution
4-dimethyl-p-aminophenol (e.g. 4-DMAP) 250 mg/5 ml	
Indication	Cyanide, prussic acid
Effect	Forms ferrihaemoglobin cyanide
Precautions	Works immediately
Dose	100 - 200 mg (3.25 mg/kg body weight)

- Burning pain, redness and drying of the skin
- Nausea, vomiting, abdominal pain, headaches, dizziness, weariness, exhaustion, dyspnoea with the risk of aspiration leading to aspiration pneumonia if taken orally
- Damage to the blood (methaemoglobin formation), even if the period of exposure was only short
- Impaired consciousness through to unconsciousness
- Dermatitis from repeated or long-lasting contact
- Damage to the liver (enlargement) and central nervous system (degenerative brain damage)

Tab. 13.3-3 Antidotes	
Atropine (e.g. Atropine) 100 mg/10 ml	
Indication	Alkyl phosphate intoxication, e.g. E 605
Effect	Inhibits the muscarinic effect of acetylcholine
Side-effects	Urinary disorders, overdose causes tachycardia
Precautions	Improvement in hypersecretion and bronchospasm serves as orientation! Beware: atropine intoxication!
Dose	Initially 2-5 mg, then 0.5-2 mg/h depending on the effect

Prussic acid (HCN):

Low doses:

- General symptoms such as headaches
- Irritated mucous membranes (eye, nose)
- Hyperpnoea
- Reddened skin

High doses:

- Massive damage caused by intracellular asphyxiation and in the respiratory centre
- Cyanosis
- Unconsciousness
- Cerebral convulsions
- Death in a very short time (approx. 1 min.)

Pesticides (organophosphates)

The acute symptoms are the same as those caused by “endogenous acetylcholine poisoning” following acetylcholinesterase inhibition.

- Bronchoconstriction
- Bronchospasm
- Increased bronchial secretion
- Pseudo-oedema in the lungs
- Weakness/paralysis of the respiratory muscles
- Respiratory depression

Volatile organic compounds

13 Intoxication

Tab. 13.3-4 Antidotes	
Ethanol (e.g. Alcohol Concentrate 95% Braun®) 20 ml vials = 19 g	
Indication	Methanol intoxication
Effect	Saturation of alcohol dehydrogenase (metabolised the same way as methanol)
Dose	Initially 0.5 g/kg body weight, then min. 0.1 g/kg body weight per hour

The symptoms of acute poisoning primarily affect the CNS:

- Various narcotic effects
- Euphoria
- Cramps
- Vomiting
- Respiratory depression

If the acute phase is survived, the metabolic products often cause tissue damage and even necrosis of the nerve tissue, liver and kidneys.

The symptoms of acute tetrachloromethane poisoning are as follows, depending on the quantity consumed:

- Dizziness
- Headaches
- Agitation
- Cerebral convulsions

Alcohols:

Methanol: methanol is absorbed more slowly than ethanol and is also metabolised more slowly (about 1/7 of the speed). Formic acid (consequence: severe acidosis) and formaldehyde are produced as toxic metabolites. The slow breakdown means that large quantities of methanol can be exhaled via the lungs. A dose of approx. 30 ml (taken orally in adults) causes blindness; the lethal dose is about 100 ml. These doses may be higher if ethanol is consumed at the same time. Individual symptoms:

- Hardly any signs of drunkenness

- Severe toxic damage to the optic nerve (beginning after about 48 hours) with risk of blindness Children are particularly at risk in cases of ethanol intoxication: the lethal dose is 300-400 g, in toddlers less than 30 g! Only a small percentage (2-3%) is eliminated via the lungs; the majority is broken down into acetaldehyde and acetic acid.

The signs of intoxication may be simple or pathological. Simple intoxication:

- Behavioural disturbances with loss of control and inhibition
- Neurological disorders with impaired coordination and articulation, patchy memory loss and loss of protective reflexes
- Impaired consciousness with somnolence, stupor and coma
- Respiratory depression
- Hypothermia
- Urinary incontinence
- Faecal incontinence
- Hypoglycaemia
- Hypovolaemia
- Dehydration
- Convulsions

The boundaries between the various stages of impaired consciousness fluctuate; the therapeutic margin is only narrow. The loss of protective reflexes can cause death

Tab. 13.3-5: Conventional treatment of toxic pulmonary oedema	
Budesonide (e.g. Pulmicort Spray®) 0.2 mg/ spray	
Indication	Inhalation trauma
Effect	Prevents bronchospasm and toxic pulmonary oedema
Side-effects	Practically none
Precautions	Only together with sympathomimetic drugs (due to drop in blood pressure)!
Dose	2 - 5 to 10 sprays
Contraindications	Shock, impaired consciousness

13.3 Poisoning with industrial and household substances

Tab. 13.3-6 Antidotes	
Toluidine blue (e.g. Tolonium) 300 mg/10 ml	
Indication	Forms methaemoglobin, e.g. in cases of nitrate, aniline and nitratine poisoning
Effect	Complex formation
Dose	2 mg/kg body weight

Pathological intoxication:

Unlike simple intoxication, pathological intoxication is very rare and depends on the patient's individual disposition. If the patient is so disposed, the consumption of just a small quantity of alcohol can trigger the following symptoms:

- Behavioural disturbances with increased aggression
- Consciousness impaired to varying degrees
- Patchy memory loss

Glycol poisoning is similar to ethanol and methanol poisoning. The CNS symptoms are similar to those of ethanol poisoning, the tissue damage like that caused by the metabolic products of methanol. The metabolic products of glycol are nephrotoxic and cause acute hypocalcaemia, the symptoms of which are muscle cramps.

Diagnosis

Gas poisoning

Carbon monoxide (CO): tests with the pulse oximeter are not helpful because they are unable to distinguish between CO-Hb and Oxy-Hb and may therefore incorrectly report complete oxygen saturation even in cases of extremely severe CO poisoning. ECG tests will show ST depression and flat T waves as signs of hypoxaemia. The presence of CO-Hb in the blood can be proven by spectroscopy or gas analysis. CO-Hb blood is cherry red to scarlet. A CO-Hb percentage of 10% or more is pathologically significant.

Dichloromethane (methylene chloride): this colourless liquid has a characteristic odour. The fumes are heavier than air.

Prussic acid (HCN): one typical sign is the smell of bitter almonds on exhalation (not registered by 25% of people). Another is the difference between the skin

Tab. 13.3-7 Antidotes	
Dimethyl polysiloxane (Sab-Simplex) 30 ml drops	
Indication	Ingestion of tensides and/or detergents
Effect	Defoaming
Dose	10 - 30 ml per os

condition: the skin colour indicates that the breathing is normal, although exactly the opposite is true. The "healthier" the skin colour, the more severe the intoxication.

Pesticides

Diagnosed by gas chromatography.

Volatile organic compounds

Solvents: precise identification of the solvent (chemical classification) is not relevant in acute cases. Cases of intoxication may involve a mixture of pesticides.

Benzene is inhaled ("sniffing") or - particularly in children - taken orally. The symptoms are similar to those of alcohol intoxication. If consumed orally, the lethal dose is 5-10 ml/kg body weight.

Alcohols: the diagnosis of acute intoxication is confirmed by blood tests.

Therapeutic crisis

The acute survival phase is not the only phase to cause therapeutic problems. There are no antidotes for certain poisons, or it may only be possible to obtain them after some delay (e.g. snake venom). Some toxins are so aggressive that survival may be doubtful even if the treatment is commenced quickly (e.g. pesticides).

If the patient survives the acute phase, chronic damage may occur sooner or later such as late-onset neurological damage in cases of CO poisoning or fatal renal failure caused by the metabolic products of tetrachloromethane, which cause damage particularly to the liver and kidney tissue. Conventional medicine is often only of limited use; chronic damage can frequently not be prevented. Homeopathy provides additional support with the frequently vain attempts to limit the existing damage, assure survival and avoid subsequent problems.

13 Intoxication

The consequences of chronic intoxication, e.g. the formation of neurotoxic metabolites in cases of chronic benzene poisoning can be alleviated with homeopathy. However, this kind of treatment falls outside the scope of this book; instead, it should be treated as a chronic condition by an experienced homeopathic doctor.

Homeopathic treatment

Homeopathic treatment administered alongside conventional treatment is wise to avert the possibility of further damage.

Symptom selection

The intoxication rubrics listed in the repertories often refer to “classical” cases of poisoning; there are no rubrics which cover more “modern” forms. In such cases, the correct homeopathic remedy must be selected with the aid of a standard repertory. Basis for selecting the correct remedy: ♦ Type of poisoning

- Externally perceptible symptoms caused by the poison
- The patients subjective complaints (which cannot be listed fully here in the short repertory)

Repertorisation I

SYNTHETIC REPERTORY

Generalities - china abuse, from - without quinine cachexia

ant-t., aran., arn., ars., bell., calc., carb-v., cham., coff., eup- per., ferr., hell., HEP., iod., ip., lach., led., meny., mere., nat-c., nat-m., nux-v., ph-ac., puls., rhus-t, salv., sei., sep., sulph., thea, verat.

Generalities - convulsions - medicaments, after

aeon., ARN.

Generalities - convulsions - mercury fumes, from

stram.

Generalities - copper fumes, aggravated camph., ip., lyc., mere., nux-v., op., puls.

Generalities - food and drinks - vegetables - decayed carb-an., CARB-V.

Generalities - intoxication, after - aluminium alum., bry., cadm-o., camph., cham., ip., puls. Generalities - intoxication, after -

SYNTHETIC REPERTORY^

Generalities - intoxication, after - bromides

am-c., camph., cham., lach., mag-c., op., phos., zinc-p.

Generalities - intoxication after - carbon monoxide, coal

gas _____ — — — — —

aeon., bell., op.

Generalities - intoxication, after - fish

all-c., ars., bell., BERB., carb-an., carb-v., chin., COP., euph., kali-c., lach., lyc., plb., puls., pyrog., rhus-t., ter.

Generalities - intoxication, after - gas

acet-ac., am-c, am., bell., bor., bov., carbn-s., carb-v., coff., ip., lach., op., phos., sec.

Generalities - intoxication after - iodine

ant-c., ant-t., ars., bell., camph., chin., chin-s., coff., conv., hep., lycps., mere., op, phos., sec, spong., sulph.

Generalities - intoxication, after - lead

alum., alum-sil., alumn., ant-c., ars., bell., carbn-s., CAUST., chin., cocc., coloc., crot-t, cupr., gels., hep., iod., kali-br., kali-i., kreos., lyc., mang., mere., nat-s., nux-v., op., petr., pipe., plat., plb., sul-ac., sulph., zinc.

Generalities - intoxication, after - meat

absin., acet-ac., all-c., ARS., bell., bry., camph., carb-an., carb-v., chin., crot-h., cupr-ar., gunp., kreos., lach., ph-ac., puls., pyrog., rhus-t., urt-u., verat., vip.

Generalities - intoxication, after - nicotine

ign., okou., nux-v., tab.

Generalities - intoxication, from - china

am-c., ant-t., apis, ARN., ars., ars-s-f., asaf., aza., bell., bry., CALC., calc-ar., caps., carb-an., CARB-V., cham., chelo., chin., cina, coloc., cupr., cycl., dig., eucal., FERR., ferr-ar., gels., hell., hep., IP., kali-ar., lach., mang., meny., mere., NAT-M., nat-p., nat-s., nux-v., parth., ph-ac., phos., plb., PULS., ran-s., samb., sei., sep., stann., sul-ac., sulph., verat

Generalities - iron - after abuse of

ars., calc-p., chin., chin-ar., cupr., hep., iod., ip., mere., nat-m., puls., sulph., thea, verat., zinc.

Generalities - medicaments - abuse of

aloe, ars., bapt., camph., carb-v., cham., coff., hep., hydr., kali-i., lob., mag-s., nat-m., nit-ac., NUX-V., puls., sulph., teucr., thuj.

Generalities - mercury - abuse of

aeon., agn., alumn., anan., ang., ant-c., ant-t., arg-m., am., ars., asaf, AUR., aur-m., aur-s., bell., bor., bry, calad., calc., camph., CARB-V., caust., chel., chin., cic., cina, clem., cocc., coff., colch.,

13.3 Poisoning with industrial and household substances

SYNTHETIC REPERTORY

Generalities - mushroom poisoning

absin., agar., ars., atro., bell., camph., pyrog.

Generalities - narcotics, aggravated

acet-ac., aeon., agar., am-c., apom., ars., aur., aven., Bell., bry., calc., camph., cann-i., canth., carb-v., caust., CHAM., chin., cic., cime., COFF., colch., croc., cupr., dig., dulc., euph., ferr., graph., hep., hyos., ign., ip., kali-perm., LACH., lob., lyc., macro., mag-s., mere., mosch., mur-ac., nat-c., nat-m., nat-p., nit-ac., nux-m., NUX-V., op., ox-ac., oxyg., passi., ph-ac., phenob., phos., plat., plb., puls., rhus-t., seneg., sep., staph., sulph., thuj., valer., verat., zinc.

Generalities - paralysis - intoxication, from

apis, ars., bapt., crot-h., gels., lac-c., lach., mur-ac., rhus-t.

Generalities - paralysis - intoxication, from - arsenic, with

chin., ferr., graph., hep., nux-v.

Generalities - paralysis - intoxication, from - lead, with alumn., ars., cupr., kali-i., nux-v., op., pipe., plat., plb., sul-ac. Generalities - paralysis - intoxication, from - mercury, with

HEP., nit-ac., staph., stram., sulph.

Generalities - paralysis - intoxication, from - nicotine, with

nux-v.

Generalities - plant-based medicaments - abuse of

camph., nux-v.

Generalities - ptomaine poisoning - ailments from

ars., pyrog.

Generalities - purgatives - after abuse of

hydr., nux-v., op., sulph

Generalities - salt - abuse of

carb-v., nat-m., nit-s-d., sei.

Generalities - sausage, spoilt, aggravated

acet-ac., ARS., BELL., bry., ph-ac., rhus-t., verat.

Generalities - silica - after abuse of

camph., FL-AC., hep., mere., sulph.

Generalities - sewer gas poisoning

bapt., phyt., pyrog., tub.

Generalities - smoke, aggravated

ars., brom., calc., caust., chin., euphr., kali-bi., lyc., naja, nat-m., nux-v., olnd., puls., sep., SPIG., sulph.

Generalities - sulphur - after abuse of

Repertorisation II

REPERTORY (LILIENTHAL)

Acid poisoning coff., op.

- acetic acid poisoning

aeon., ars., asar., ign., nux-v., puls., sep.

- burns with other acids (particularly crab apple vinegar) aeon.

- hydrochloric acid poisoning bry.

- skin injuries caust. (watery solution) - sulphuric acid poisoning kali-c., nat-c., puls.

Ammonium salt intoxication coff., nit-s-d., nux-v.

Cantharides - intoxication with aeon., camph., kali-n., laur., puls.

Carbonic acid poisoning am-c., am., bov., op.

Carbon monoxide poisoning bell., op.

Autumn crocus (colchicum), intoxication with

bell., camph., cocc., nux-v., puls., spig.

Hepar sulphur - intoxication with alum., bell., cham., graph., hep., ign., sil. Chalk poisoning

bell., canth., caust., rhus-t. (each in a watery solution) Chamomile poisoning

alum., bor., camph., cocc., coff., coloc., ign., nux-v., puls.

Cinchona bark - severe consequences of abuse of am., ars., bell., calc., caps., carb-v., cina, ferr., ip., lach., mere., nat-m., puls., sep., sulph., verat.

Cooking salt poisoning

initially nit-s-d., later ars., carb-v., lyc., mere., nux-v., puls.

Copper poisoning

aur., bell., chin., cocc., dulc., hep., ip., mere., nux-v.

Ergot poisoning

aeon., bell., colch., hyos., op., plat., rhus-t., sol-n., stram. Ergot poisoning - gangrene formation ars., chin., euph., sil.

Hemlock - poisoning with nit-ac., nit-s-d.

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REPERTORY (LILIENTHAL)

Intoxication with anaesthetics and narcotics am-c., ars., bell., carb-v., caust., cham., coff., graph., hyos., ip., kalm., lach., lyc., mere., nat-m., nux-v., op., puls., rhus-t., sep., sulph.

Iodine poisoning ars., bell., chin., coff., grat., hep., phos., spong., sulph.

Iron poisoning

am., ars., bell., chin., hep., ip., mere., puls., verat.

Liquid ammonia - poisoning with hep.

Lobelia inflata - poisoning with aeon., bell., ip., tab., verat.

Magnesium poisoning

ars., cham., coff., coloc., nux-v., puls., rheum.

Mercury poisoning - bone problems, exostoses, caries etc. aur., asaf., calc., dulc., lach., lyc., nit-ac., ph-ac., sil., sulph.

Mercury poisoning - changes in weather - exceptional sensitivity to changes in weather, temperature etc.

carb-v., chin.

Mercury poisoning - dropsy/oedema chin., dulc., hell., sulph.

Mercury poisoning - mercurial cachexia asaf., aur., chin., chion., hep., iod., kali-i., mez.

Mercury poisoning - nervous excitement carb-v., cham., hep., nit-ac., puls.

Mercury poisoning - nervous weakness carb-v., chin., hep., lach., nit-ac.

Mercury poisoning - rheumatic pain am., bell., calc., carb-v., cham., chin., dulc., guai., hep., lach., lyc., ph-ac., puls., sars., sulph.

Mercury poisoning - sore throat arg-m., bell., carb-v., hep., lach., lyc., nit-ac., staph., sulph., thuj. Mercury poisoning - tooth and gum problems, salivation carb-v., chin., dulc., hep., iod., nat-m., nit-ac., staph., sulph.

Mercury poisoning - ulcers

aur., bell., carb-v., graph., hep., lach., nit-ac., sars., sil., sulph., thuj.

Mushroom poisoning aeon., coff., nux-v., puls.

Mushroom poisoning - liver and kidney failure ars., lach., phos.

Nutmeg poisoning camph., gels., laur., nux-v., op., carum carvi

REPERTORY (LILIENTHAL)

Opium or morphine poisoning bell., ip., mere., nux-v.

Organic dust (ODTS: organic dust toxic syndrome) - poisoning with sul-ac.

Poison ivy - poisoning

agar., am-c., anac., am., bry., crot-t., cypr., graph., grind., kali-s., led., lob., nymph., rhus-t., sang., sep.

Poison ivy - poisoning - rash, with ars., bell., bry., grind., mere., puls., sulph. Potash (potassium compound) poisoning carb-v., coff.

Prussic acid poisoning coff., ip., nux-v.

Saffron poisoning bell., op., plat., puls. Sarsaparilla - poisoning with am-c., bell., cham., lyc., mere., sulph. Snake venom ars., nit-s-d.

- chronic consequences mere., ph-ac.

- eye contact aeon.

- wounds with bluish colour ars., bell., seneg.

Solanine poisoning - dulcamara

bell., camph., cupr., ip., kali-c., lach., mere. - secale cornutum sol-n.

Stramonium poisoning bell., hyos., nux-v.

Strychnine poisoning

aeon., bell., camph., cham., cocc., coff., ign., op., puls., stram.

Sulphur poisoning mere., puls., sil., chin., nux-v., sep.

- ailments from wine containing sulphur ars., chin., mere., puls., sep.

- terrible consequences of sulphur fumes puls.

13.3 Poisoning with industrial and household substances

_____REPERTORY (LILIENTHAL)_____

Tobacco poisoning

ars., cic., clem., ign., ip., lyc., nux-v., phos., plan., puls., sep., stram., verat.

- facial neuralgia on the right side, dyspepsia, chronic nervousness

sep.

- gastric complaints the morning after smoking nux-v.
- impotence, dyspepsia, cold sweat

- hiccoughs ign., puls.

- palpitations phos.

- terrible consequences of chewing tobacco ars., carb-v., lyc., nux-v.

- tobacco-related heart complaints, pulse slow, soft and changeable and feeling of constriction in the chest and epigastrium

apoc.

- toothache clem.

- vomiting

ip.

Tea poisoning

chin., coff., ferr., lach., sei., thuj., verat.

Valerian poisoning

cham., coff., nux-v., sulph.

Wound poisoning from pus or decayed animal material ars.

Differentiation between important homeopathic remedies

Important remedies *Aconitum*, *Arnica montana*, *Arsenicum album*, *Belladonna*, *Calcarea carbonica*, *Cedron*, *Chamomilla*, *Cocculus indicus*, *Coffea*, *Colocynthis*, *Eucalyptus globulus*, *Ferrum metallicum*, *Ignatia*, *Ipecacuanha*, *Lachesis*, *Mercurius solubilis*, *Natrium muriaticum*, *Nux vomica*, *Pulsatilla*, *Rheum*, *Veratrum album*.

Aconitum: chamomile poisoning. Fever with heat and

Arnica montana: consequences of using cinchona bark. Rheumatic pain, feeling of heaviness, weariness and fatigue-related pain in the extremities, dragging pain in the bones. Great sensitivity of all sensory organs. Pain aggravated by movement, speaking and noise.

Arsenicum album: consequences of using cinchona bark. Ulcers on the extremities. Dropsy or oedema in the feet. Short cough and breathlessness. Magnesium poisoning. Intense, burning pain, < at night and forcing the sufferer out of bed.

Belladonna: consequences of using cinchona bark. Blood congestion in the head with heat in the face. Pain in the head, face and teeth; for treating icterus when *Mercurius solubilis* fails.

Calcarea carbonica: consequences of using cinchona bark. Headache; earache; toothache; aching limbs; particularly when these symptoms occur through suppressing fever or malaria and treatment with *Pulsatilla* is unsuccessful.

Cedron: consequences of using cinchona bark. Hissing in the ears.

Chamomilla: Magnesium poisoning. Severe colic with or without diarrhoea.

Cocculus indicus: chamomile poisoning. Hysterical abdominal cramps, either new or an exacerbation of old complaints.

Coffea: chamomile poisoning. Severe pain or feverish heat with great nervousness and exceptional sensitivity. Magnesium poisoning. Sleeplessness and nervous excitement.

Colocynthis: Magnesium poisoning. Extreme cramp-like pain, constipation or slow defecation.

Eucalyptus globulus: after abusing cinchona bark with characteristic complaints such as headache, tinnitus, general malaise, as if the sufferer were developing a cold.

Ferrum metallicum: consequences of using cinchona bark. Oedema in the feet.

Ignatia: chamomile poisoning. Severe cramps or convulsions. Soreness in the folds of the skin (intertrigo)

13 Intoxication

Lachesis: Suppression of fever or malaria by large doses of cinchona bark when *Pulsatilla* fails to help.

Mercurius solubilis: consequences of using cinchona bark. Icterus and other liver complaints.

Natrium muriaticum: constant hiccoughs after abuse of cinchona bark.

Nux vomica: chamomile poisoning. Worsening of old complaints; cardialgia (cramp-like stomach pain). When *Coffea* fails to work. Magnesium poisoning. Stubborn constipation or constipation with colic; when treatment with *Colocynthis* fails.

Pulsatilla: consequences of using cinchona bark. Earache; toothache; headache; aching limbs; after suppressing fever and malaria. Chamomile poisoning. Nausea with vomiting or diarrhoea. Sore skin folds in children. Magnesium poisoning. Cramplike colic with leucorrhoea or watery diarrhoea with colic, after *Rheum*

Rheum: magnesium poisoning. Watery acidic diarrhoea, with colic and tenesmus.

Veratrum album: consequences of using cinchona bark. Coldness in the body and limbs with cold sweat, constipation or diarrhoea.

Critical commentary

Generally speaking, conventional detoxification measures should be initiated whenever possible. If necessary, an emergency poison centre should be consulted to determine treatment. Conventional and homeopathic treatments do not impede one another. In the authors experience, the allopathic medication needed to treat poisoning seems to be considerably greater than the homeopathic treatment required. Allopathic medicines seem to be “used up” more

Case 13.3-1: Acetic acid burns

Martin Bündner

Anamnesis

The 22-year-old patient drinks a large quantity of acetic acid from a bottle with the intention of committing suicide; he then vomits it up. He is taken to hospital, where the gastroscopy performed shortly after his arrival shows multiple ulcers in his upper gastrointestinal tract. Despite being given extensive conventional pain therapy, there is little which can be done to help the patient, and it is decided that he should be given homeopathic treatment concomitantly.

The following symptoms are observed:

- Multiple ulcers in the mucous membranes
- The larynx and stomach are particularly painful, as is the oesophagus
- Cutting stomach pain
- Pain in the oesophagus which gets worse when swallowing saliva and even more so when swallow-

- Eructation impossible
- Pain in the pit of the stomach which gets worse when external pressure is applied
- The pain gets worse when the patient changes the position in which he is lying
- Urge to smoke (he is a smoker!)
- Violent trembling all over the body
- Vomiting transparent mucus
- Brown patches all over the lips
- Small white spots on the tongue

Diagnoses

Multiple mucous ulcers in the oesophagus, stomach, mouth and on the lips. Suicide attempt.

Diagnostic procedures

Gastroscopy. Psychiatric consultation: no acute risk of suicide.

Homeopathic treatment

Repertorisation I

	CARD	INDEX	REPERTORY
Swallowing - drinks, aggravated			

Turning over in bed aggravated

Mucous membranes

Stomach and abdomen - inflammation

Differentiation between remedies

Belladonna and *Nux vomica* are mentioned on all four cards. However, *Belladonna* does not seem to match as well as *Nux vomica*, as the patient has no congestive symptoms. Moreover, *Nux vomica* has a positive effect on many gastrointestinal complaints. This remedy also has a great affinity with complaints of the larynx and oesophagus; it seems to be very suitable.

Prescription

1 dose of 2 globules *Nux vomica* 10M.

Progress

The patient is given *Nux vomica* on the day he is admitted. The remedy has no real effect.

A psychiatric consultation rules out the possibility that the patient is at acute risk of committing suicide.

Change of remedy: in the evening of day 3, a dose of *Bryonia* 1M is administered without repertorising the symptoms again. On day 4, the patient reports that his symptoms have changed somewhat. • No change in the intensity of the pain (chemical medication unchanged)

- The pain is now worst below the larynx
- The patient throws his head back somewhat when drinking, so that the water can pass to the stomach more easily
- Feeling as if there is something like a skin around the larynx. This feeling increases when swallowing saliva
- The pain is worse when swallowing saliva than when swallowing water
- The throat feels as if it is being scratched by a nail or by pepper

Repertorisation II

_____ CARD INDEX REPERTORY

Morning, aggravated

Empty swallowing, aggravated

Fold, valve, sheet, skin, as if

Mouth and throat, lumps, sphere, ball, splinter, stick

Mouth and throat, choking, strangling, cramps, as if constricted

Differentiation between remedies

Lachesis and *Sabadilla* are the main remedies. Both of them have a great affinity with inflammation in the area affected. *Sabadilla* is a remedy with a relatively small therapeutic spectrum. If it appears during the repertorisation process, the indications for its use must be examined particularly carefully. However, *Lachesis* covers the symptoms better than *Sabadilla*. In order to differentiate further between these two remedies, the original symptoms in the *Materia Medica* Puga (1848) are consulted: *Sabadilla*: "Sore throat, particularly when swallowing saliva; pain as if from a foreign body in the throat. Scratching in the throat, as if from a sharp object. Feeling of strangulation deep in the throat, as if it is being pulled tight, similar to feeling after swallowing a hot beverage. [...]"

Lachesis: "Sore throat irritates the patient after every period of sleep. Pressure in the throat after consuming acidic foods and drinks. Feeling of thickness in the throat, [...] also with difficulty swallowing fluids. Feeling of rawness everywhere in the throat. Dryness on the right of the throat as if a piece of dry skin were there. Soreness and numbness in the mouth, as if after swallowing strong acids."

Lachesis shows a greater affinity with this case than *Sabadilla*.

Prescription

1 dose of 3 globules *Lachesis* 200C.

Progress

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discharged the same day. Further psychological treatment is recommended.

Evaluation

The patient's condition only begins to improve when he is given the right remedy; despite the hospital treatment, which had already lasted several days, it is highly unlikely that this cure occurred naturally, especially as the improvement set in immediately after taking

Critical commentary

A remedy which does not match the case, e.g. *Nuxvomica*, has no effect; a less than ideal remedy, e.g. *Bryonia*, can change the symptoms but may not necessarily do so. New symptoms make a change of remedy necessary.

Case 13.3-2: Conjunctivitis caused by dye contamination

Martin Bündner

Anamnesis

A 28-year-old patient is painting with Window Colors[®] and accidentally squirts numerous small sprays of the substance over the left upper part of her body, in her hair, in her face and on her clothes, which she washes immediately afterwards (day 1). She does not rinse her eyes or consult an eye doctor as she is unaware of any dye in her eyes.

In the evening of day 2, she gradually develops the feeling of a foreign body in her left eye; she feels as if she has sand in her eye. This gets worse when blinking and closing her eye and better if she keeps her eye open. The complaint causes the patient to wake up several times in the night. A feeling of pressure also develops in the left eye. The eye is only moderately reddened, but there is a circular swelling around the eye with the emphasis on the upper and lower lids. Tears are streaming from the affected eye, which is also extremely painful. The intensity of the pain does not correlate with the redness of the eye, which the patient finds surprising. On day 3, the circular swelling around the eye is extremely marked in the morning but subsides a little by around midday; the swelling is slightly reddened and painful to the touch, as if someone had hit the patient in the eye. The patient is chilly but does not want to cover up; her eyeball feels as if it is burning. The eyes are sensitive to light, and she has to wear sunglasses even in a darkened room. The light causes terrible boring pain in

under the eyebrow; winking makes the pain worse. When she closes her left eye and looks into the light with her right eye, she feels pain on the left side. The pain gradually subsides when she keeps her eye open and applies cold compresses. In the morning, she finds that looking up is easier and looking down is more difficult; at midday, this situation is reversed. There is no change in the comparatively mild reddening of the left eye, which is still streaming with tears.

Diagnosis

Conjunctivitis of the left eye following dye contamination.

Diagnostic procedures

Inspection of the eye.

Homeopathic treatment

The cause of all the symptoms is given top priority. In this case, the cause is obvious, i.e. the contamination of the eye with dye, which must be seen as a type of injury.

At first glance, continuing the search for the right remedy seems very complicated in this case because of the way in which the symptoms change over time. Even though individual symptoms subsided before the remedy was administered, when considering the totality of the ailment, it is remarkable that the central phenomenon of contradiction persists throughout.

The mild redness of the left eye is unusual, especially when considering the extremely severe pain. Here the subjective and objective findings contradict each other just as they do in the next symptom:

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the eye pain worsens when the eye is opened; however, if the patient keeps it open, the pain strangely subsides.

Another contradiction is that the patient is chilly but does not want to be covered.

Unexpected symptoms are highly characteristic. The marked swelling around the eye is very unusual for conjunctivitis and indicates serious complications such as (the early stages of) an eyelid abscess. It is therefore essential that the remedy covers this symptom, which is why it is placed third during the repertorisation process.

Finally, the sensations “As if from a blow to the eye”, “Boring pain” and “Feeling of sand in the eyes” are considered. However, only the boring pain is included in the repertorisation process, as the symptom is striking and very severe in its intensity. Moreover, this symptom is one of those that developed at a later stage. The burning pain in the eyeball is a common occurrence in this constellation and therefore uninteresting for purposes of repertorisation.

The extreme sensitivity to light is also remarkable. However, as photosensitivity is nothing unusual in cases of conjunctivitis, the corresponding rubric need only be used for confirmation of the chosen remedy once the repertorisation process is complete. The side affected is not primarily relevant in this case, as this is an eye disease caused by an external influence and the choice of remedy is clear, as described below. However, if there had been two remedies and no symptoms to differentiate clearly between them, the side affected would have been a final, decisive criterion for the choice of remedy.

Repertorisation

	KENT'S REPERTORY*
_____	SYNTHETIC REPERTORY **
inflammation - injuries, after*	Eye -
Eye - consequences of injury*	
Generalities - contradictory and alternating states**	
Eye - swollen - lids*	
Eye - pain - boring*	

Differentiation between remedies

Pulsatilla is the only remedy listed in all rubrics. Other remedies which mention the contradictory nature of the complaints, e.g. *Nux moschata*, are eliminated, as only *Pulsatilla* covers all the symptoms; it has also proven itself in treating eye injuries.

A materia medica comparison of *Pulsatilla* adds to the certainty:

“There is another condition of *Pulsatilla*, which may be considered characteristic, and which Hering does not mention in his cards, viz. **changeableness of symptoms** (*Ignatia*, *Nux moschata*). All that Hering said, was ‘**Wandering pains shift rapidly from one part to another, also with swelling and redness of the joints.**’ [...] We sometimes have patients come into the office, and find, in trying to take their case, no “head or tail” to it. It is mixed. The suffering and pain is now here, now there. The symptoms are contradictory, as we term them. This condition should always call attention to *Pulsatilla*, and it will often clear up and cure the case.” (Nash 1994)

Hering describes the leading symptoms of *Pulsatilla* as follows: “Oversensitiveness to light. [...] Like a veil before the eyes [...]. Dimness of sight: with lachrymation [...]; like a fog or mist; [...]. Sensation as of a veil before the eyes, especially in a bright light. [...] Soreness of ball to touch and itching or pain in eye, < in evening and > in cool air or by cold applications. [...] Conjunctivitis: [...] feels best in open air and by cold applications [...].[...] with a constant feeling of sand in eye. [...] as if a foreign body were pressing in eye. Inflammation of eyes; severe pain around eye; sclera injected; [...] but slight inflammation of cornea; oedema of upper lid; [...]. Conjunctivitis palpebrarum et oculi; profuse lachrymation during day; [...] as if a grain of sand were between eye and lid. Severe ophthalmia; pain relieved from cold applications. Swelling and redness of eyelids.” (Hering 1988)

Prescription

1 dose of 2 globules *Pulsatilla* 30C.

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Progress

All symptoms begin to improve, slowly at first then more rapidly towards evening. On day 4, the patients condition is continuing to improve but she notices a kind of fog in front of the eye, as if she were looking through a veil. Initially, no further action is taken and further developments awaited. On day 5, the symptoms have again worsened to some degree; the patient is then given *Pulsatilla* 200C. Afterwards, the symptoms subside markedly within about two hours and a whitish mass is discharged from the eye; in retrospect, this is likely to have been the remains of the dye. After this mass is secreted, all the symptoms described, which had persisted up to that point, disappear within another two hours.

Evaluation

Homeopathic remedies are also effective in treating external causes, e.g. when the organism is retaining

foreign bodies; in such cases, they may eliminate them from the body, for example via a purulent discharge.

Critical commentary

It should naturally be considered whether the patient should have been sent to an eye specialist. An ophthalmological consultation would by all means have been advisable, but was rejected by the patient as the symptoms began to improve with homeopathic treatment after the first dose of *Pulsatilla* was given.

Only considering the current and most recently occurring symptoms and overlooking the past ones might perhaps also lead to a successful choice of remedy, but is unnecessarily hazardous and does not do justice to the case.

Case 13.3-3: Anaphylactic shock

Martin Bündner

Anamnesis

The eight-month-old girl suffers from a milk allergy and severe neurodermatitis. The milk allergy manifests as massive vomiting after she eats a little milk pudding. Subsequently, hives form on her face and on the areas which came into contact with the vomit; the child scratches herself in these places. After licking an ice cream, her right eyelid swells and hives form around her mouth and on her cheeks. After eating milk chocolate, hives form on the areas of skin which were smeared with chocolate. They also form on the skin under the chocolate stains on her T-shirt. The parents avoid giving her foods which contain milk. As yet, it is unknown whether she is allergic to egg white, but the parents are currently trying to avoid foods containing egg white equally strictly for fear of another allergy.

One evening, the baby is given a small piece of pasta with home-produced fresh egg. After the meal, the girl suddenly begins to scream uninterruptedly at quite a low pitch, which is completely atypical.

Her cheeks seem to be itching, as she keeps scratching them. She then convulsively stretches her whole body backwards. After a few minutes, she relaxes and appears to return to normal. Half an hour later, she falls asleep at a time which is unusual for her, and wakes up half an hour later. She now appears to be back to her old self. The evening proceeds absolutely normally; she seems to have come through it safely. The homeopathic doctor treating her advises the mother just to breastfeed her for the time being without giving any additional food. At the mothers wish, the child remains at home and is not taken to a clinic for monitoring, contrary to the doctors advice. The parents are then told to contact the doctor immediately if the slightest sign of another reaction appears.

There are no unusual occurrences in the night. However, next morning, the girl is found to be sweating profusely on her back and the back of her head, although she is no more warmly dressed than on the previous nights and there has been no change in room temperature. Her nappy is found to contain greenish-brown stool, which smells fermented and

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extremely sour. The consistency is soft and it contains food remnants, presumably from the pudding. Suddenly, the mother sees large, red, hot hives appear at the lower edge of the nappy; the skin is raised. She is using the same brand of nappy as usual. The homeopathic doctor is notified immediately and he sets off right away to make a house call. Before he arrives, the situation worsens dramatically within a few minutes: the hives spread rapidly upwards over the abdomen, armpits, throat, neck and face. The baby cries shrilly and scratches herself all over, causing the hives to increase in size. Suddenly her face turns ashen, then as white as chalk; even her lips are affected. The girl's eyes roll inwards and she loses consciousness. She collapses, stops crying, no longer responds when spoken to. She appears lifeless; only her shallow breathing shows that she is still alive. The mother panics and is about to call emergency services when the homeopathic doctor arrives. As the baby is still alive, the situation is evaluated quickly. It would take more than ten minutes for emergency services to arrive. However, with these clear symptoms, a homeopathic remedy is quickly found. The emergency services are not ideally equipped to deal with this special case of anaphylactic shock in a baby; transport to the nearest clinic would take about half an hour even if special rights were utilised. There are no corticoids or adrenaline available, as a result of which the doctor decides to administer emergency homeopathic treatment taking all circumstances into consideration.

Diagnosis

Anaphylactic shock. Neurological symptoms. Neurodermatitis. Multiple allergies. Atopic diathesis.

Homeopathic treatment

This case is characterised by the following symptoms: the general symptoms are the comatose sleep, the sudden manifestation (which can be repertorised in parallel using the pain rubric), the specific location of the unusual sweating, the hives moving upwards and the opisthotonos of the previous evening, which is part of the symptom complex and must therefore be incorporated into the

case. The skin manifestation is characterised more specifically by the heat over the rash.

The rolled-in eyes are merely an unusual local symptom. However, this cerebral involvement is unusual for an allergic reaction and therefore very important for finding the right remedy, which is why this symptom along with the opisthotonos and the comatose sleep is given precedence over the other general symptoms during the repertorisation process.

Repertorisation

KENT'S REPERTORY

Perspiration - single parts - lain on

Back - opisthotonos

Sleep - comatose

Eye - turned - inwards

Generalities - pain - appears suddenly

Skin - eruption - urticaria

Skin - heat - without fever

Differentiation between remedies

Belladonna is the only remedy listed in all these rubrics, where it is invariably weighted doubly or triply. The only exception is the heat rubric, in which except for two doubly weighted remedies, the remaining 24 remedies (including *Belladonna*) are weighted singly. *Aconitum* and *Pulsatilla* might also be possible.

However, *Aconitum* does not have the typical rash and *Pulsatilla* is not a perfect match because it does not cover the neurological symptoms sufficiently. The upward movement of the symptoms is typical of *Belladonna*. This is not mentioned in the repertory but can be found in the materia medica, possibly in connection with another symptom, when working up the case.

Prescription

2 doses of 1 drop *Belladonna* Q6.

Progress

Just a few seconds after administering *Belladonna*, some signs of life reappear; the eyes are no longer rolled

13 Intoxication

confirmed by the baby's further progress. The *Belladonna* Q6 is shaken and she is given another drop. Within another 20 to 30 minutes, the rash progressively subsides from top to bottom in accordance with Herings Law and the girls reactions return to normal. The last hives disappear during the day. No more doses are given on this day, as the remedy is taking effect slowly but surely and should not be disrupted by another dose. Afterwards, the girl is given long-term treatment with *Belladonna* (1 drop *Belladonna* Q6 daily after shaking the bottle), which continues to have a positive effect.

Evaluation

The child would presumably have died if an attempt had been made to initiate conventional treatment, as the time available was so short.

Critical commentary

In this extremely dangerous situation, in which there is hardly any time for the customary careful selection of the homeopathic remedy, the repertorisation process must begin with an elimination rubric which should be not too big, nor so small that critical remedies may be omitted.

The materia medica comparison (Hahnemann 1830) performed later confirms the outstanding similarity of the remedy to this case, which ultimately facilitated successful treatment: *Belladonna*: "*Belladonna*, in the small dose just described, is, if the case is homeopathically adapted, capable of curing the most

it acts with a rapidity proportionate to the nature of the disorder) [...]. Paleness of face [...]. Sudden paleness of face for a considerable time [...]. Great dullness of head and sight, [...] with very small, unequal, dark red spots, especially on the forehead, swollen face [...]. Red swollen face [...]. Red swollen face with staring eyes [...]. Swollen face [...]. The eyes [...] roll about in the head [...]. The eyeballs rove about in a circle spasmodically [...]. The eyes are distorted [...]. Spasms of the eyes [...]. The eyes are distorted, with redness and swelling of the face [...]. Curdled [...] stool [...]. Motions of a very sour smell [...]. Green stools [...]. The pain mounts gradually from the ankles to the hips [...]. Head and trunk drawn quite back to the left side, so that he could not walk [...]. Soporose state [...]. Very deep slumber [...]. Deep sleep [...]. Very deep sopor, with [...] pale cold face, cold hands and hard, small, rapid pulse [...]. Heat of the whole body, with violet redness of all the skin [...]. Redness of the whole body [...]. The whole body is swollen, burning hot, and red [...]. Redness and swelling of the affected part [...]. Chest and abdomen are covered with small, red, somewhat elevated, painless spots, that sometimes disappear and reappear, with general redness of the skin [...]. Blood-red spots all over the body, especially on the face, neck, and chest [...]. Night sweat [...]. Night sweat during sleep [...]. Sweat, that rose from the feet up into the face [...].

Case 13.3-4: Food poisoning

Martin Bündner

Anamnesis

The 46-year-old patient comes to the clinic in the evening; she is vomiting, has a feeling of pressure on the chest and her general condition is deteriorating rapidly. The symptoms appeared in the morning and have persisted ever since. As the symptoms cannot be clearly identified, she is admitted as an in-patient to rule out a heart condition. She had no thoracic pain at the time of

first time she has ever felt the pressure on her chest The patient requests homeopathic treatment. The history reveals the following symptoms:

- In the morning on the day of admission, she ate a two-day-old lemon which had been cut open and not carefully stored. Afterwards, she became nauseous and her general condition deteriorated significantly
- The nausea is located in the stomach and improves when she drinks
- Eating triggers nausea
- The patient has an appetite but is not hungry

13.3 Poisoning with industrial and household substances

- At times, she vomits; the vomit is lemon yellow
- She does not want to drink anything cold
- When she is nauseous, a feeling of constriction develops in her chest
- Better on eructation
- Her hands have been trembling since she was told that she was to be admitted as an in-patient. This made her agitated

Diagnosis

Food poisoning.

Diagnostic procedures

Findings on admission

Patient in poor general and physical condition. Abdomen adipose, no resistance, no pain on pressure. No indication of cardiac or pulmonary decompensation.

Laboratory findings

Day 1: ESR 40/50 mm. Hb 11.5 g/dl. Leucocytes 12,900/pl.

Imaging procedures

Resting ECG: Day 1: HR 61/min., sinus rhythm, left axis deviation. No repolarisation disorders. Day 2: normal heart rate, sinus rhythm with no significant changes from the previous day's findings.

Exercise ECG: (day 2): stopped at 125 watt after 9.5 minutes due to physical exhaustion, heart rate 64/min. (RR 100/70 mmHg) to 141/min. (RR 150/80 mmHg)

Echocardiography (day 3): normal, colour Doppler also normal.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - food - sour food and beverages agg*

Generalities - food - fruit aggravated - sour fruit aggravated*

Stomach - nausea - drinking - ameliorated

Differentiation between remedies

Phosphorus is listed under all these rubrics. The rubric "Generalities - food - fruit aggravated - sour fruit aggravated" consists only of the remedies *Antimonium crudum*, *Ipecacuanha*, *Phosphoricum acidum* and *Psorinum*. It accounts for the fact that the symptoms were triggered by the lemon, but its small size makes it problematic for eliminating other remedies. Even when the rubric "Stomach - nausea - drinking - ameliorated" is used instead of the second one, only *Mercurius corrosivus* is left as a theoretical alternative; however, this remedy is not mentioned in the rubric "Stomach - vomiting - yellow".

In contrast, *Phosphorus* optimally covers all the symptoms.

Prescription

1 dose of 2 globules *Phosphorus* 30C.

Progress

One hour after administering the remedy, the patient is already feeling much better; by the time she is examined the following morning, all her symptoms have disappeared. Angina pectoris is ruled out, as a result of which the patient is discharged in good condition.

Evaluation

Phosphorus cured the food poisoning much more quickly than would have been expected under normal conditions.

Critical commentary

The rubric "Stomach - nausea - eructations - ameliorated" does not completely cover the symptoms, but is

13 Intoxication

Case 13.3-5: Acute glottal oedema

Walter Gluck

Anamnesis

The parents consult the doctor with their 12-year-old girl, who has always been healthy except for a few children's diseases. About half an hour previously, the girl felt an insect sting her inside her mouth while she was eating a piece of bread and jam. It was most likely a wasp, but they could not identify the insect precisely when the girl spat out the mouthful of bread. The child complained of intense pain in the centre of the throat, on the palate. By now, she was hardly able to swallow, was restless and suffered subjectively from severe breathlessness and chilliness. She refused anything to drink; she was not thirsty, which is normal for her. Pulse 90/min., RR 90/60 mmHg.

Diagnosis

Acute glottal oedema.

Diagnostic procedures

Heart rate 90/min., blood pressure 90/60 mmHg.

Findings: extreme, livid swelling of the uvula, which hangs far down into the throat. The surrounding tissue and the tonsils are swollen and livid. The insect probably stung her in the soft palate above the uvula, but the sting itself is no longer recognisable.

Homeopathic treatment

Repertorisation

_____ **SYNTHESIS VERSION 9.1** Skin - insect bites

Skin - swelling - stinging

Throat, internal - swelling - oedematous

Differentiation between remedies

Lachesis is a remedy suitable for treating inflammatory, septic consequences of insect bites.

Pulsatilla is also used to treat swelling, but less so in acute situations.

Ledum, like *Apis*, mentions that coldness ameliorates the condition; however, *Apis* is the first remedy which springs to mind for treating severe consequences of insect bites.

As an acute remedy, *Aconitum* also has a certain affinity with this case; however, *Apis* is more suitable.

Prescription

1 dose of 5 globules *Apis* 200C.

Progress

Preparation of conventional emergency treatment (which was not necessary as *Apis* worked so well); emergency services alerted. When they arrived about 10 minutes later, the child's breathing was already easier and she was less agitated. No treatment was given in hospital as the girl's condition had largely returned to normal.

Evaluation

This case shows the rapid effect of a homeopathic remedy on a life-threatening case of acute glottal oedema.

Critical commentary

In such an acute case, it must be possible to intubate the patient immediately. The patient must also be taken to hospital by ambulance as quickly as possible. Homeopathy was used concomitantly, in this case with a curative effect, making a hospital stay unnecessary.

It would be advisable to add the rubric "Mouth - swelling - tongue" to the repertorisation process along with the more specific rubric "Mouth - swelling - tongue -

13.3 Poisoning with industrial and household substances

Case 13.3-6: Infected bee sting - tendency to collapse

Martin Bündner

Anamnesis

The 20-year-old patient is stung by a bee at the distal end of her lower right arm. The area around the site is red and hot, the edges are indistinct. The oedema is soft with hardening in some areas. The patient is unable to bend her hand as far as usual. The area is itchy; the itching worsens when scratching; scratching makes the skin hard.

The patient is nauseous and feels as if she is about to faint. She has to make every effort to pull herself together so that she does not lose consciousness. She feels as if an internal heat is rising from her abdomen.

Diagnosis

Inflamed bee sting at the distal end of the lower right arm.

Diagnostic procedures

Homeopathic treatment

Repertorisation

.....KENT'S REPERTORY

Stomach - nausea - faint-like

Skin - insect bites

Skin - swelling - oedematous

Skin - swelling - hard

Differentiation between remedies

The repertorisation process finishes with *Lachesis* and *Sulphur*. The fact that scratching aggravates the itching speaks for *Sulphur* and against *Lachesis*.

Prescription

2 drops *Sulphur* Q6 three times a day.

Progress

The patients feeling of imminent collapse disappears immediately after taking *Sulphur*. The infection subsides over the next two days; by the third day, the area has returned to normal.

Evaluation

Antibiotic treatment would not have stopped the patients tendency to faint

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14 Neurological emergencies

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- 14.1 Apoplexy and intracranial bleeding
- 14.2 Epilepsy
- 14.3 Meningitis and encephalitis
- 14.4 Disc prolapse

14.1 Apoplexy and intracranial bleeding

Definition

Apoplexy (stroke)

Due to the similarities between the early clinical symptoms, the term “stroke” is used as a collective term for a number of completely different diseases (particularly ischaemic insults, intracerebral bleeding and subarachnoid bleeding). It is often difficult to differentiate between these diseases with any certainty if only clinical diagnostic procedures are used. Depending on the duration of the neurological deficits, clinical medicine differentiates between **transitory ischaemic attacks (TIA)**, **prolonged ischaemic neurological deficits (PRIND)** and **clinically manifest infarctions (STROKE)**. By definition, TIA last < 24 h and PRIND > 24h; the symptoms subside completely in both cases. The symptoms of clinically manifest strokes do not subside completely.

- **Primary ischaemic insults** (ischaemic stroke): ischaemic strokes lead to encephalomalacia (softening of the brain) and are the result of impaired arterial circulation in the brain (stage IV cerebrovascular insufficiency). They are mostly caused by arteriosclerosis, thrombosis or thromboembolism, predominantly in the arteria cerebri media

- **Primary haemorrhagic insult** (massive intracerebral bleeding): this form of bleeding comes from a ruptured intracerebral blood vessel (usually the arteria striatolenticularis) or an intracranial aneurysm. The primary cause is angiopathy resulting from arterial hypertension or arteriosclerosis and a haemorrhagic diathesis or anticoagulant treatment
- **Subarachnoid bleeding (SAB)**: this refers to acute bleeding in the subarachnoid space. The bleeding almost always comes from a basal aneurysm (in the area of the circulus willisii and/or the major cerebral blood vessels nearby), more rarely from an angioma. It can occur spontaneously, while asleep or after physical exertion

Clinical information

Incidence

- Ischaemic insults: 80-85% of “strokes”
- Massive intracerebral bleeding: 15% of all so-called strokes
- Subarachnoid bleeding: 5-10% of all so-called strokes

Symptoms

Ischaemic insults

The main clinical symptoms are largely influenced by the focal neurological deficit, which is usually acute. However, in some patients the neurological deficits develop progressively over the hours

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following the appearance of the first symptoms (progressive stroke).

The nature of the deficits is determined by the localisation of the ischaemic area:

- Area supplied by the carotid arteries: hemiparesis/hemiplegia with or without aphasia
- Area supplied by the basilar arteries: impaired consciousness, impaired cranial nerve function, other oculomotor disorders, central dysfunction of the systems which regulate respiration and circulation, cerebellar symptoms, signs of damage to the pyramidal tract with spastic tetraparesis
- Area supplied by the posterior cerebral arteries: visual disturbances, i.e. homonymous hemianopsia

Other pre-existing internal conditions frequently decompensate at the same time; the patients blood pressure and blood sugar may be disordered.

Massive intracerebral bleeding

In these cases, the main symptoms are again influenced by the acute focal neurological deficit, in some cases combined with impaired consciousness. Patients frequently suffer from acute cephalgia. As the perifocal oedema increases, so do the focal neurological deficits; the patient increasingly loses consciousness. Bleeding into the CSF spaces may also cause meningism. As with cerebral insults, the nature of the neurological deficits depend on the location of the haemorrhage (see above).

Subarachnoid bleeding

Subarachnoid bleeding is not limited to a certain period of life; it can occur at any time. The main symptom is a hyperacute crushing headache, often most painful at the back of the head, together with secondary stiffness of the neck. In about half of cases, the bleeding starts on physical exertion. Besides the acute cephalgia, the patient may often (but not always) have a greater or lesser degree of meningism.

He may suffer focal neurological deficits, disordered autonomous regulation and impaired consciousness which may reach a state of deep coma. The following autonomous functional disorders

may be acutely life-threatening: blood pressure instability, electrolyte imbalance and marked changes in ECG patterns.

Note: The absence of meningism does not necessarily exclude the diagnosis of SAB!

Subarachnoid bleeding is classified according to its degree of clinical severity using the categories developed by Hunt and Hess (1968):

- Stage I: mild cephalgia, mild meningism
- Stage II: severe cephalgia, deficits of individual cranial nerves, marked meningism, no impairment of consciousness or other focal neurological deficits
- Stage III: somnolence, mental changes, discrete focal neurological deficits
- Stage IV: stupor, severe focal neurological deficits, disordered autonomous functions
- Stage V: coma, impaired vital functions

In all cases, the intracerebral bleeding may cause an increase in cranial pressure. The symptoms of this are: headache (as far as this can still be expressed), cranial nerve dysfunction (especially abducens nerve and oculomotor nerve), vomiting on an empty stomach, bradycardia, respiratory disorders, impaired consciousness and possible signs of constriction.

Diagnosis

Neurological tests may reveal pyramidal tract signs; pathological reflexes and sensory disorders may also be evident.

It is usually impossible to differentiate between ischaemic insults and massive intracerebral bleeding using only clinical criteria, which means that diagnostic procedures must be performed as quickly as possible for conventional treatment to begin.

Ischaemic insult

- **Cerebral CT and MRI:** the most important acute diagnostic procedures; Brain CT scans depict intracerebral bleeding directly and reliably, while ischaemic zones only become demarcated several hours after the infarction. CT scans are usually

14.1 Apoplexy and intracranial bleeding

or intracerebral bleeding in the area of carotid circulation, while the higher resolution capacity of MRI makes it more suitable for diagnosing infarctions in the posterior cranial fossa; it can also depict and localise smaller infarcted areas more precisely during the post-acute phase

- **Doppler sonography** of the blood vessels in the neck using CW Doppler and B scan: can be performed rapidly to exclude or diagnose and specify haemodynamically relevant stenoses in the area being examined and to identify local sources of embolism or any pre-existing vessel dissection
- **(Transoesophageal) ECHO:** should also be performed as quickly as possible to exclude any potential source of cardiac embolism
- **Emergency arterial-angiographic vein examination:** only in specific cases (e.g. thrombosis in the basilar artery before possible local thrombolytic treatment)
- An epidural pressure probe can be implanted in patients with clinical signs of an oedema-induced increase in intracranial pressure in corresponding centres to monitor intracranial pressure

Note: as the clinical development of each case cannot be foreseen at the onset, it is usually impossible to differentiate between TIA, PRIND and manifest brain infarctions in the early stages. Every form of cerebral ischaemia should therefore be diagnosed and treated like a manifest insult. (In > 40% of patients with TIA, differentiated diagnostic procedures involving MRI will reveal a morphological substance defect.)

Massive intracerebral bleeding

- **Cerebral CT and MRI:** the cerebral CT is the most important diagnostic tool for depicting intracerebral bleeding shortly after the event. The MRI has no diagnostic advantages but cannot be used in cases of bleeding caused by hypertension where evidence of blood vessel malformation is sought, particularly when cavernous haemangioma is suspected

- **Arterial angiography:** provides evidence of blood vessel malformation; however, such a malformation may be compressed by the haematoma and only found in another angiography after the blood has been completely reabsorbed. In 30% of intracerebral haematoma cases, no cause of bleeding will be found even if the angiography is repeated
- **Doppler sonography:** for diagnosing vascular spasms, particularly if the bleeding has broken through into the CSF spaces
- Intracerebral pressure monitoring by means of an ICP pressure probe is carried out if there are signs of an increase in intracranial pressure or a risk that CSF drainage may be impeded

Subarachnoid bleeding

- **CCT:** fresh subarachnoid bleeding can be reliably diagnosed by cCT (except in cases of microbleeding with minimal blood loss). Emergency diagnostic procedures do not usually have to include a MRI
- **CSF puncture and testing:** if the CT clearly confirms the diagnosis of SAB, a CSF puncture and tests will not be necessary. However, CSF testing is essential if a clinical diagnosis of SAB is suspected but the CT findings are negative. As the circulation of blood as far as the lumbar dural sac takes some time, a false negative may be obtained from the CSF test during the hours immediately following the acute event, which means that check-ups are necessary
- **Cerebral panangiography:** for the reliable localisation and diagnosis of the source of bleeding, particularly to provide evidence of an arterial aneurysm; an emergency diagnostic tool which should be used as soon as possible if early surgery is being considered to stop the source of bleeding
- **Transcranial Doppler sonography:** used to diagnose and monitor any occurrence of vascular spasm
- An epidural pressure probe for monitoring ICP should be inserted in any case of SAB and also if there is any indication that liquor reabsorption is impaired

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Massive intracerebral bleeding

- Medication should only be administered to reduce the patients blood pressure if the systolic value is > 200 mmHg and the diastolic value > 130 mmHg; hypertension should be allowed to persist up to this point to prevent the reduction in cerebral perfusion which may occur if the patients intracranial pressure is raised and his mean systemic blood pressure falls
- Reduction of intracranial pressure (see above)
- Artificial respiration with controlled hyperventilation (paCO₂ approx. 30 mmHg) if there are marked symptoms of intracranial pressure
- Neurosurgical intervention in cases of spaceoccupying infratentorial haematomas and extensive supratentorial lobar bleeding with a risk of constriction
- Emptying the haematoma, either stereotactically or via an open access
- Inserting an external CSF drain if there are signs of CSF congestion caused by blocked CSF channels
- Administration of anticonvulsants if epileptic attacks occur or in general after surgical revision of the bleeding
- Emergency surgery to stop the source of bleeding only if there is evidence of an aneurysm
- Elective surgery on other vascular malformations during the post-acute phase
- Prescription of physiotherapy as an early rehabilitative measure

Subarachnoid bleeding

- Early neurosurgical intervention to eliminate any aneurysms found during angiographic testing, provided they are operable in clinical stages 1-II1 (in some cases also stage IV), and to reduce the risk of recurrent bleeding by 60-70%
- Administration of calcium antagonists (nimodipine 5-10 ml/h i.v. for 2-3 weeks) to prevent arterial vasospasm and thus reduce the incidence of clinically manifest ischaemic complications. Caution: may cause undesirable reductions in blood pressure

- Immobilisation for 3 weeks with low doses of heparin
- Reduction of intracranial pressure (see above)
- Prescription of physiotherapy as an early rehabilitative measure

Therapeutic crisis

Ischaemic insult

Mortality is high at about 20%. Moreover, it is assumed that secondary cell damage occurs in the area around the necrotic centre (the penumbral zone), causing the necrotic area to spread. In cases of extensive insult, there may be massive cerebral displacement leading to constriction above and/ or below, dramatically worsening the prognosis. However, the treatment is unsafe (haemodilution) or entails major risks (thrombolysis).

Massive intracerebral bleeding

At about 50%, the mortality rate is exceptionally high. The destruction of brain tissue, space-occupying processes causing the displacement and compression of surrounding brain structures, the formation of perifocal oedema and the risk of acute, frequently lethal upper or lower constriction (particularly in cases of bleeding in the posterior cranial fossa due to the limited space in this area) all increase the risk.

Subarachnoid bleeding

Spontaneous mortality rates for SAB are high, but largely depend on the severity of the initial symptoms: 10-15% at stages I-II, about 80% at stage V. About 15% of patients are dead on arrival at hospital. In about 50% of cases, the bleeding recurs usually within the first three weeks; ventricle rupture and the formation of an intraparenchymatous haematoma cause the prognosis to worsen dramatically. Vasospasms of major intracranial arteries may also occur 3 to 10 days after the initial event (particularly in cases of severe SAB); in 30-40% of patients, these cause clinically manifest ischaemia with impaired consciousness and/or focal neurological deficits. Impaired CSF reabsorption frequently occurs during the post-acute phase, leading to the development of hydrocephalus.

14.1 Apoplexy and intracranial bleeding

Experience has shown that in many cases, these problems can be successfully countered with homeopathy (which causes the cerebral oedema to subside, thus reducing the risk of constriction as well as minimising subsequent bleeding, easing vasospasm and restoring CSF resorption).

Homeopathic treatment

Symptom selection

Unlike conventional medicine, homeopathy does not treat the insult independently of any other disorders. Instead - as far as the corresponding symptoms allow - it incorporates any other co-existing functional disorders into the choice of remedy.

The patients state of consciousness must be established as the main symptom for all three diseases (ischaemic insult, massive intracerebral bleeding and subarachnoid bleeding. Other functional disturbances (e.g. paresis), the condition of the eyes and other accompanying symptoms (e.g. convulsions) are also important.

Repertorisation

KENT'S REPERTORY

Generalities - apoplexy

Aeon., *Arn.*, *Aur.*, *Bar-c.*, *Bell.*, *Champh.*, *Carb-v.*, *Chin.*, *Cocc.*, *Coff.*, *Con.*, *Crot-h.*, *Cupr.*, *Ferr.*, *Gels.*, *Hyos.*, *Ip.*, *Lach.*, *Laur.*, *Lyc.*, *Merc.*, *Nat-m.*, *Nit-ac.*, *Nux-m.*, *Nux-v.*, *Op.*, *Phos.*, *Plb.*, *Puls.*, *Rhus-t.*, *Sec.*, *Sep.*, *Sil.*, *Stram.*

Head - cerebral haemorrhage

Aeon., *Arn.*, *Aur.*, *Bar-c.*, *Bell.*, *Camph.*, *Carb-v.*, *Chin.*, *Cocc.*, *Coff.*, *Con.*, *Crot-h.*, *Cupr.*, *Ferr.*, *Gels.*, *Hyos.*, *Ip.*, *Lach.*, *Laur.*, *Lyc.*, *Merc.*, *Nat-m.*, *Nit-ac.*, *Nux-m.*, *Nux-v.*, *Op.*, *Phos.*, *Plb.*, *Puls.*, *Stram.*

Mouth - speech, wanting - apoplexy, after

Bar-c., *Crot-c.*, *Crot-h.*, *Ip.*, *Laur.*, *Nux-v.*

Face - distortion

Absin., Aeon., Am-m., Ant-t., Apis, *Ars.*, *Bar-m.*, *Bell.*, *Bism.*, *Bufo*, *Camph.*, *Cann-i.*, *Caust.*, *Cham.*, *Cic.*, *Cina*, *Cocc.*, *Coloc.*, *Crot-c.*, *Crot-h.*, *Cupr.*, *Dulc.*, *Graph.*, *Hell.*, *Hydr-ac.*, *Hyos.*, *Ign.*, *Ip.*, *Kali-i.*, *Kali-s.*, *Lach.*, *Lact.*, *Laur.*, *Lyc.*, *Lyss.*, *Merc-c.*, *Mill.*, *Nux-m.*, *Nux-v.*, *On.*, *Petr.*, *Phos.*, *Phvt.*, *Plat.*, *Plb.*, *Rhus-t.*, *Sauil.*, *Sec.*, *Sil.*

KENT'S REPERTORY.

Face - distortion - mouth

Agar., *Bell.*, *Bry.*, *Camph.*, *Cocc.*, *Con.*, *Cupr.*, *Cur.*, *Dulc.*, *Graph.*, *Ign.*, *Kali-n.*, *Lach.*, *Laur.*, *Lyc.*, *Merc.*, *Nux-v.*, *Op.*, *Ph-ac.*, *Plat.*, *Plb.*, *Puls.*, *Sec.*, *Stram.*, *Stry.*, *Sulph.*, *Tarent.*

Respiration - stertorous (e.g. after apoplexy)

Absin., Aeon., Am-c., Amyg., *Anac.*, *Ant-t.*, *Apis*, *Arn.*, *Ars.*, *Bell.*, *Bufo*, *Camph.*, *Cann-i.*, *Carb-an.*, *Carb-ac.*, *Cham.*, *Chen-a.*, *Chin.*, *Chlol.*, *Cic.*, *Cocc.*, *Cupr.*, *Ferr-m.*, *Gels.*, *Glon.*, *Hydr-ac.*, *Hyos.*, *Kali-bi.*, *Lach.*, *Laur.*, *Lyc.*, *Meri.*, *Nit-ac.*, *Nux-m.*, *Nux-v.*, *Oena.*, *Olnd.*, *Op.*, *Petr.*, *Phos.*, *Plb.*, *Puls.*, *Sabad.*, *Sarr.*, *Spong.*, *Stann.*, *Stram.*, *Sulph-ac.*, *Tab.*, *Ter.*

Extremities - paralysis

Abrot, Aeon., *Agar.*, *All-c.*, *Aloe*, *Alum.*, *Ambr.*, *Anac.*, *Arg-n.*, *Ars.*, *Art-v.*, *Aur.*, *Bapt.*, *Bar-c.*, *Bar-m.*, *Bell.*, *Bry.*, *Bufo*, *Calc.*, *Calc-s.*, *Carb-v.*, *Carb-o.*, *Carbn-s.*, *Caust.*, *Chel.*, *Chin.*, *Cic.*, *Cocc.*, *Coff.*, *Colch.*, *Con.*, *Crot-c.*, *Crot-h.*, *Cupr.*, *Cur.*, *Dros.*, *Dulc.*, *Ferr.*, *Form.*, *Gels.*, *Guare.*, *Hydr-ac.*, *Hyos.*, *Kali-ar.*, *Kali-c.*, *Kali-i.*, *Kali-n.*, *Kali-p.*, *Kalm.*, *Lach.*, *Laur.*, *Lyc.*, *Meph.*, *Merc.*, *Merc-c.*, *Mill.*, *Morph.*, *Naja*, *Nat-m.*, *Nit-ac.*, *Nux-v.*, *Olnd.*, *Op.*, *Phos.*, *Ph-ac.*, *Pic-ac.*, *Plat.*, *Plb.*, *Puls.*, *Rhod.*, *Rhus-t.*, *Ruta*, *Sec.*, *Sep.*, *Sil.*, *Spong.*, *Stann.*, *Stram.*, *Stront.*, *Sulph.*, *Tab.*, *Tarent.*, *Tax.*, *Thuj.*, *Verat.*, *Vip.*, *Zinc.*

- apoplexy, after

Alum., *Anac.*, *Apis*, *Bar-c.*, *Cadm.*, *Caust.*, *Cocc.*, *Crot-c.*, *Crot-h.*, *Cupr.*, *Gels.*, *Lach.*, *Laur.*, *Nux-v.*, *Op.*, *Phos.*, *Plb.*, *Sec.*, *Stann.*, *Stram.*, *Zinc.*

- hemiplegia

Aeon., *Alum.*, *Anac.*, *Apis*, *Arg-n.*, *Ars.*, *Bapt.*, *Bar-m.*, *Both.*, *Cadm.*, *Caust.*, *Cocc.*, *Coc-c.*, *Cop.*, *Elaps*, *Graph.*, *Hyos.*, *Kali-c.*, *Kali-i.*, *Kali-p.*, *Lach.*, *Mur-ac.*, *Nat-c.*, *Phos.*, *Ph-ac.*, *Plb.*, *Rhus-t.*, *Sars.*, *Stann.*, *Staph.*, *Stront.*, *Sulph-ac.*, *Tab.*, *Thuj.*

- upper limbs - left - apoplexy, after

Ars.

- upper limbs - apoplexy

Aesc., *Ars.*, *Bar-c.*, *Op.*, *Phos.*

- lower limbs - apoplexy, after

Nux-v., *Phos.*

Generalities - convulsions - apoplectic

Bell., *Crot-h.*, *Cupr.*, *Lach.*, *Nux-v.*, *Stram.*

Head - softening of brain

Amb., *Caust.*, *Elap.*, *Kali-s.*, *Lach.*, *Nux-m.*, *Phos.*, *Sabad.*

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Differentiation between important homeopathic remedies

Important remedies: *Aconitum*, *Arnica*, *Belladonna*, *Lachesis*, *Nux vomica*, *Opium*.

Aconitum: exceptional heat in the head; strong pulsation of the carotid arteries; skin warm rather than cold; full, strong pulse, hard, sometimes even suppressed, but not intermittent; particularly if the disease was caused by shock or annoyance; in plethoric, apoplectic patients.

Arnica: head or face hot, the rest of the body cold; loss of consciousness with numbness, involuntary emptying of the bladder and bowels, paralysis (left side); full, strong pulse; stertorous breathing; sighing; murmuring; suitable for middle-aged patients, with strong, plethoric constitutions.

Belladonna: during the early stages of the disease with teeth grinding before the attack and severe hyperaemic symptoms; or for later stages when the seepage of blood from the vessels causes severe inflammatory reactions. Numbness with congestion to the head, enlarged pupils; delirium; loss of consciousness; loss of speech; muteness; convulsions of the limbs and facial muscles. Paralysed extremities, particularly on the right; convulsive movements of the face and mouth, which is pulled towards the ear; trembling tongue; paralysis of the

speech organs; cramp-like constriction, painful narrowing and pulling in the throat; also impossible to swallow even the smallest amount; temporary blindness, with headache; shiny, red, sparkling eyes; half-open, protruding, staring eyes; reaches for his genitals with his hands.

Lachesis: numbness with loss of consciousness; blue face and convulsive movements, tremor of the extremities; apoplexy on the left side, particularly after mood swings or alcohol abuse; blowing exhalation.

Nux vomica: apoplexy in sociable people who have an easy life and suffer from dyspepsia. Apoplexy, lies unconscious, drowsy with paralysis of the legs, swallowing organs and jaw; apoplexy: stertorous breathing; with salivation; numbness of the brain.

Opium: before the attack: numbness of the senses, dizziness and heaviness of the head; deafness and buzzing in the ears; staring facial expression, insomnia, fearful dreams or frequent need to sleep. During the attack: tetanic rigidity of the body, redness, bloating and heat in the face; palsy with dizziness, buzzing in the ears; loss of consciousness; red, bloated, hot face; red, half-closed eyes; dilated, insensitive pupils; foam around the mouth; convulsive movements of the limbs and slow respiration with snoring; deep, comatose sleep with snoring and raiding and hanging lower jaw.

Case 14.1-1: Apoplectic insult

Leopold Drexler

Anamnesis

The 60-year-old patient had suffered an ischaemic insult in the area of the artery to the angular gyrus at the age of 34. The patient took early retirement seven years previously because of difficulty forming words and sentences; this has gradually been worsening since then. His physical stamina was excellent and he enjoyed mountain tours in the high Alps. He had suffered no other major diseases. On day 1, the patient was found lying unresponsive on the floor. Admission to the ward.

the acute CT reveals neither fresh bleeding nor an ischaemic area. He is transferred to the neurological intensive care unit of the state hospital as his condition is worsening and he only reacts slightly to severe pain stimuli. Here infusion treatment commences and a stomach tube is inserted.

The next day, his coma deepens; one eye is wide open. The CT on day 3 shows an extensive cerebral insult on the right side with diffuse bleeding and occupying a considerable amount of space. Fulminating cerebral oedema. The chest x-ray shows signs of increasing congestion and the early stages of pneumonia in the left lung

14.1 Apoplexy and intracranial bleeding

The patient is now in a deep coma, is being fed via a stomach tube and receiving antimicrobial treatment. Because of his condition and the hopeless prognosis, the attending physicians and the patient's wife agree to follow his wishes and dispense with the administration of intensive treatment. All medication including the antibiotics is stopped the same day.

Day 4: signs of congestion pneumonia still present on auscultation. Targeted homeopathic treatment now commences: the patient appears red to bluish-red. He is lying in a deep coma, he snores, evinces Cheyne-Stokes respiration which constantly stops and does not react to any stimuli.

The decision is made to administer *Opium* as his appearance and main symptoms - the deep red, bluish red face, the deep coma, the snoring, the interrupted Cheyne-Stokes breathing and the lack of reaction to any stimuli - are typical of this homeopathic remedy.

Diagnosis

Severe apoplectic insult (right middle cerebral artery and right posterior cerebral artery) with fulminant cerebral oedema, post ischaemic insult (artery to the angular gyrus) 26 years previously, pneumonia.

Diagnosis

Computed tomography

Day 1: no fresh bleeding, no ischaemic area.

Day 3: extensive media insult on the right side with diffuse bleeding and occupying a considerable amount of space. Fulminant cerebral oedema. **Chest x-ray in supine position** (day 3): signs of increasing congestion, early stages of pneumonia in the left lung.

Conventional treatment

Infusion therapy, stomach tube. Antibiotics.

Homeopathic treatment

The repertorisation performed after the administration of the remedy confirms the prescription made.

Repertorisation

RADAR 8.1

Sleep - comatose - apoplexy, with

Mind - unconsciousness - Cheyne-Stokes respiration, with

Respiration - irregular

Respiration - snoring - unconsciousness, with

Generalities - analgesia

Face - colour - red - bluish red

Differentiation between remedies

The repertorisation process confirms the choice of *Opium*. Consideration should also be given to the closely related remedies *Belladonna* and *Stramonium*.

While *Stramonium* patients may also have a deep red, bluish red face, this remedy does not mention the Cheyne-Stokes breathing; it is typical for aggressive symptoms such as thrashing around and resistance.

With *Belladonna*, the red is normally brighter and the incident more acute. However, this remedy does not mention snoring while unconscious.

Cicuta is a remedy known for treating cramps when the patient has a pale face and overextends his body and head. In this case, the patient is lying quietly in a coma.

Hyoscyamus patients are paler, more restless and often have bizarre twitches and movements which are totally missing in this case.

In contrast, the patient having one eye open while being unconscious also speaks for *Opium*.

Prescription

Opium repeated several times in various potencies («s' Progress).

Progress

Opium M is administered 5 times at half-hourly intervals. Afterwards, the patient is given *Opium* 200C three times a day until his condition improves. On day 6, the patient is transferred home at his relatives' request. At home, the coma becomes less deep, in response to which *Opium* 200C is now administered once a day. On day 10, the patient's breathing again worsens. He is

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once a day. On day 11, his breathing improves. He shows sensitivity to pain for the first time and briefly raises his shoulders. The further administration of *Opium* is stopped for the time being as a result of the improvement. Passive physiotherapy begins.

On day 13, the neurologist sees a possibility of survival for the first time. On days 14 and 15, the patient is feverish with an axillary temperature of up to 38.8 °C. The neurologist prescribes a preparation for dissolving mucus, which is administered via the stomach tube.

On days 17 and 18, the coma is again deeper and the Cheyne-Stokes breathing has returned. One dose of *Opium* 200C is given on each of these days. The patients breathing improves markedly in the evening of day 18. Over the following days, the coma becomes lighter and the patients breathing more regular.

On day 21, the patient shows signs of anxiety or pain when his head is passively moved. He again receives a dose of *Opium* 200C.

On day 25, the patient wakes up briefly and speaks his first words. On day 27, he can manage to sit on the edge of the bed with support. On day 30, he recognises a visitor for the first time. Each wakeful period lasts no more than 1-2 minutes before the patient falls back into a coma. A repeat dose of *Opium* 200C is given.

Day 33: the wakeful phases are growing longer. The patient asks for his children. Because of the improved controllability, the homeopathic treatment continues with a daily dose of *Opium* Q6. Day 44: the patient raises his knee. He is fed by tube until day 46.

The patient takes his first steps about one month later. *Opium* Q6 is given once a day for another two months. As the treatment of the acute event is largely finished and other symptoms have become more important, the treatment with *Opium* is concluded.

Epicrisis

The patient has survived the acute phase. He is becoming increasingly mobile, begins to walk ever longer distances and finally starts cycling. Five months later, he hikes to an altitude of 1500 m. About one year after his stroke, he suffers an epileptic attack. The neurologist stabilises his condition with anticonvulsants. The patient goes to concerts and on trips but has gradually increasing, often only discrete problems with memory and orientation. Further long-term treatment follows.

Today, ten years after the second insult, the patient is 70 years old, mobile and communicative. He still has difficulty finding words and is unable to form or understand long sentences. Since the incident more than ten years ago, his chronological memory has suffered, he cannot read a clock, only has limited perception on the left side and is always cold. Over the last two or three years, his strength - despite his extremely firm handshake - has subsided considerably; he tires more quickly and cannot walk more than 2 kilometres with breaks.

Evaluation

The homeopathic treatment of the 60-year-old patient after a massive insult followed by pneumonia, which re-established his mobility and reintegrated him into daily life despite the hopeless prognosis given under conventional treatment, shows that even seemingly incurable conditions can be reversed by administering the right homeopathic remedy.

Critical commentary

Because of the terminal prognosis and the deep coma, the patient is initially given 5 doses each consisting of 5 globules of *Opium* M at half-hourly intervals, as necessary and expedient in the homeopathic treatment of acute conditions. Afterwards, *Opium* 200C is given up to 3 times a day due to the severity of his condition. Only when the patients condition begins to stabilise and improve is the dose reduced to once a day, then as needed as the improvement becomes more marked. However, in retrospect it should be considered whether

14.1 Apoplexy and intracranial bleeding

the remedy should have been given even more frequently.

Once the patient's condition became stable and no more neurological or pulmonary fluctuations were observed, the patient was given a Q potency. The Q potency is a very controllable high potency.

Case 14.1-2: Basal ganglia and thalamus infarction, left side

Martin Bündner

Anamnesis

The 70-year-old patient contacted the physician on Saturday afternoon (day 1). She had already received a visit from the doctor on call that morning, who on examination suspected that she was suffering from vegetative complaints. However, as she feels unwell, she requests homeopathic help. The patient is already familiar after having received a course of treatment for Lyme disease. The following symptoms are mentioned: there is a buzzing in her head. She is trembling and has pins and needles in her right arm. Her right arm and leg feel weak, especially her foot. This sensation is now also beginning in the left foot. Her gait is somewhat uncertain, she feels as if she is swaying. She has difficulty grasping objects; this has already caused her to knock over a glass. She is also having difficulty speaking. Her speech is slower than usual, although her thoughts are all there. She feels as if her tongue is heavy; she is unable to speak as clearly as usual. This is obviously a progressive cerebral incident, as shown by the fact that her left foot only becomes affected at a later stage.

She adds that she developed toothache in the right upper jaw at exactly the same time as these symptoms appeared; the tooth is painful and feels loose, although it isn't. The facts of the case are discussed with the patient; however, she initially wishes to receive homeopathic treatment as an outpatient.

Diagnosis

Cerebral infarction in the basal ganglia and thalamus

which can be given in varying quantities at different intervals.

Even though the choice of remedy was clear, novice homeopaths in particular are advised to refrain from prescribing a remedy without careful, well-considered repertorization due to the risk of failure.

Diagnosis

Findings on admission

Day 2: cranial nerve status normal except for paralysis of the buccal branch of the facial nerve. Evidence of hemiparesis in the right-hand extremities, limb sinks on attempting to hold it up. Positive Babinski sign on the right. Mild fine motor and coordination disturbances in the right hand. Able to stand and walk with assistance. Numbness in the left thumb and index finger when testing blunt/ sharp discrimination on both sides.

Laboratory findings

Total cholesterol 309 mg/dl. LDL cholesterol 228 mg/dl.

Resting ECG (day 2): normal-frequency sinus rhythm.

Holter ECG (day 5): normal.

Extended blood pressure monitoring (day 5): normal blood pressure, mean 131/80 mmHg. 29% of the systolic blood pressure values are too high on this day.

Imaging procedures

Echocardiography (day 3): normal.

CT of native cranium with soft tissue and high-resolution bone settings (day 2): moderate, bilateral, microangiopathic signs with smaller, lacunar defects in the outer basal ganglia on both sides, especially on the left. Also a discrete lesion with a diameter of more than 10 mm in the area of the left genuate capsule and bordering on the ventrolateral parts of the left thalamus, which could be a new circulatory problem.

EEG (day 4): pathological EEG with intermittent, moderately severe focus, frontotemporal (1) on the left and (2) on the right.

CSF testing (day 3): no pathological findings.

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Sonography of the extracranial brain nerves (day 2): normal.

Conventional treatment

Admitted to a neurological clinic on day 2. Since then, acetylsalicylic acid (e.g. ASS* 100 mg), atorv- astatin (eg. Lipitor* 20 mg) and ramipril (eg Delix* 2.5 mg).

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY

Generalities - right - left, then

Generalities - apoplexy

KENT'S REPERTORY

Mind - speech - slow

Extremities - paralysis - ataxia*

Extremities - paralysis - incoordination*

Tongue - heavy

Teeth - loose

*Rubrics condensed

Differentiation between remedies

None of the possible remedies are present in all the rubrics. However, the first choices are *Arsenicum album* and *Belladonna*. If it were not for the unusual feeling of having a tooth loose, the choice would be more likely to fall on *Belladonna*, as it is well known as a stroke remedy and matches the symptoms much better than *Arsenicum album*. However, the tooth symptom clearly indicates *Arsenicum album*, as a result of which this remedy is chosen.

Prescription

1 dose of 3 globules *Arsenicum album* 30C.

Progress

The previously scheduled check-up is performed about six hours after the patient took the remedy. The chilliness has subsided and she now feels warm. She has no palpitations which get worse when she lies down and tires

overnight; moreover, she is no longer able to stand because of a weakness in her right leg and collapses immediately when she attempts to do so. As she lives alone, she is urged to go to hospital. She is now given *Arsenicum album* Q3 to smell, with the instruction to take the remedy three to five times a day in this way. On day 3, her condition has improved and she is feeling stronger. The patient continues to take the same dose of *Arsenicum album* (Q6 from day 7 and Q9 from day 13), and her condition improves rapidly and steadily.

She is discharged from the neurological clinic on day 13 and admitted to a rehabilitation clinic on day 17, where she stays for four weeks. The discharge report describes the patient's condition: "[...] at the time of discharge, the patient not only subjectively felt very much better and had recovered her usual stamina, the function of her right hand was also completely re-established, also in terms of fine motor skills. Her gait and stamina while walking have also returned to normal [...]."

Evaluation

The initial progression of the stroke symptoms indicates that *Arsenicum album* may have stopped the condition from worsening. The patient's condition may have deteriorated on day 2 for two reasons: firstly, she may have suffered another attack of apoplexy; secondly (e.g. due to the progressive nature of the stroke), the effect of the remedy may have been exhausted, in which case it should have been repeated. Due to her remarkable progress, the rehabilitation measures were extended for one week at the patient's request in order to stabilise the outcome.

Critical commentary

The seemingly insignificant accompanying symptom of a tooth feeling loose was the decisive criterion for the choice of remedy.

Once the patient was discharged from the rehabilitation clinic, she received homeopathic treatment for the chronic complaints still existing. She did not take the prescribed chemical medication.

Case 14.1-3: Unconsciousness of unclear origin

Martin Bündner

Anamnesis

Seven weeks previously, the 63-year-old patient suffered massive temporal intracerebral bleeding on the right side as the result of a hypertensive crisis; the blood was drained by craniotomy the next day. The patient was left with hemiparesis on the left side and peripheral paralysis of the facial nerve on the right. The patient suffers recurrent bouts of pneumonia during the follow-up treatment. Five weeks before, a PEG (percutaneous endoscopically controlled gastrostomy) tube was inserted as the patient was having difficulty swallowing.

The patient has been undergoing rehabilitative measures in a neurological clinic for three weeks. The patient suddenly loses consciousness again (day 1); a computed tomography of his head rules out the occurrence of fresh intracerebral bleeding. The EEG shows no signs of increased susceptibility to epilepsy. Moreover, during the diagnostic procedures it is noted that the patient's Hb has dropped to 8.5 g/dl, although his circulation is generally stable; this gives rise to the suspicion that he is suffering from subacute gastrointestinal bleeding. The patient is taken to ICU by ambulance on day 1 with no change in his unconscious state.

He is admitted to ICU at about 2 pm. The patient's circulation remains stable throughout. However, he can still only be roused with difficulty; he wakes briefly on being vigorously shaken and is then fully responsive, but immediately sinks back into unconsciousness.

Both pupils are contracted while he is unconscious. The more he returns to consciousness, the more his pupils dilate; however, they contract when he sinks back into unconsciousness. His breathing is irregular and slow with pauses. On enquiring at the neurological clinic, it is found that no respiratory pauses had previously been observed in this patient; his breathing to date had been regular and normal.

Diagnoses

Unconsciousness of unclear origin. Previous diagnoses: organic brain syndrome. Renal insufficiency at the compensated retention stage. Arterial hypertension.

Diagnostic procedures

Findings on admission

63-year-old, multi-morbid, drowsy to stupefied patient, almost impossible to wake when spoken to. Total hemiparesis on the left side, peripheral facial nerve palsy on the right; an eyepatch has therefore been affixed to the right eye. Bronchitic crackles heard in the basal lobes of both lungs on auscultation. Few intestinal noises. 10 on the Glasgow Coma Scale.

Laboratory findings

Hb 8.6 g/dl. Urea 55.6 mg/dl. Creatinine 1.60 mg/dl. Basal TSH < 0.05 pU/ml, serum iron 40 ng/dl.

Imaging procedures

Resting ECG

Heart rate 76/min., sinus rhythm, left axis deviation. Discrete repolarisation disturbances throughout the precordium, presumably caused by medication. Incomplete right bundle branch block.

Echocardiography (day 5): early stages of concentric left ventricular hypertrophy, EF 60% **Chest x-ray in supine position:** normal.

Abdominal sonography (day 5): some sludge evident in the gallbladder.

Duplex sonography of the deep leg veins (day 6): deep leg vein thrombosis ruled out.

Conventional treatment

Monitoring in the intensive care unit.

Homeopathic treatment

With regard to the patient's sudden loss of consciousness, this case has very few symptoms. However, those symptoms he does have are very unusual and prove sufficient for the choice of remedy. The first elimination rubric is a symptom which appears in the provings of only a very few remedies: the form of unconsciousness

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he is awake. This is a characteristic symptom which is compulsory for the choice of remedy. The change in pupil diameter in constant lighting conditions depending on the patients state of consciousness is also unusual. Finally, the other symptoms used for repertorisation comprise the respiratory symptoms, which are also new and therefore directly connected with the patients unconscious state.

Repertorisation

KENT'S REPERTORY

Mind - unconsciousness - answers correctly when spoken to but delirium and unconsciousness return at once

Eye - pupils - dilate and contract alternately in the same light

Respiration - slow

Differentiation between remedies

The repertorisation process leads to *Arnica* as the main remedy. However, materia medica comparisons of the remedy in Hering's "Guiding Symptoms of our Materia Medica" and Hahnemann's "Materia Medica Pura" do not clearly confirm this choice: "Unconscious; when spoken to answers correctly, but unconsciousness and delirium at once return. [...] Could be aroused and answer intelligently, but relapsed immediately into stupor. [...] Pupils first contracted, twenty-four hours later dilated. [...] Contraction of pupils with cloudiness of head." (Hering 1995)

"Frequent, slow, deep breathing [...]." (Hahnemann 1830)

The results of the search for the pupil and respiratory symptoms in Hering and Hahnemann are unsatisfactory. The comparative symptoms in the materia medica do not describe this patient's symptoms precisely. The remedy is therefore chosen in reliance on the correctness of the entries in the repertory.

Prescription

1 dose of 2 globules *Arnica* 30C.

Progress

The patient is given the remedy at about 8 pm. At the next check-up 2-3 hours later, he is awake and fully responsive, although he had not previously been roused. At 1 am, he wants to go to the toilet. The stupor does not return at any stage during his further stay in hospital.

On day 2, he is transferred to a general ward and receives two transfusions of erythrocyte concentrate. His antihypertensive treatment is optimised during his stay in hospital. Because of the strong suspicion of gastrointestinal bleeding, an attempt to perform a gastroscopy under a full anaesthetic with complete muscle relaxation is performed on day 1 but has to be broken off because of extreme locking of the jaws. This condition can therefore not be assessed.

No reason can be found for the patient's unconscious state. He is transferred back to the neurological clinic in what for him is good condition. His haemoglobin parameter (11.0 g/dl) remains stable in following check-ups.

Evaluation

The correct homeopathic remedy can also be successful in treating unconscious patients, regardless of the cause of the unconsciousness, which even in retrospect remained completely unclear in this case.

Critical commentary

One advantage of homeopathy is the diagnosis of the remedy - not necessarily of the disease, which in any case expresses itself via its symptoms, thus leading to the choice of the correct remedy. In conventional medicine, the disease has to be diagnosed before the "cause" can be treated.

14.1 Apoplexy and intracranial bleeding

Case 14.1-4: Subarachnoid bleeding

Martin Bündner

Anamnesis

The 46-year-old patient has severe subarachnoid bleeding caused by an aneurysm and is admitted to the neurosurgical intensive care unit (day 1). The aneurysm is treated surgically on day 2. The patient is given hydrocortisone, L-thyroxine and desmopressin to correct a functional disorder of the hypothalamus and pituitary gland. The patient suffers several cerebral convulsions, as a result of which anticonvulsant treatment is administered from day 4. On day 14, the patient's wife requests adjuvant homeopathic treatment as his overall condition is so poor.

The following symptoms are observed:

- Cerebral oedema with cerebral convulsions
- The patient's head wobbles when he is falling asleep
- His forehead and body are sweating profusely. His hands and arms are cold
- His short-term memory is impaired: he cannot remember who visited him the previous day. Neither is he able to remember the date
- He has no awareness of the time of day. He believes he is having breakfast in the evening and vice versa
- The food he eats does not conform with his usual habits: he now eats stewed pears for breakfast, for example
- He thanks the staff for being fixed and makes jokes with grimaces
- Since the previous day, he seems sad and withdrawn. Although he would obviously like to speak, he can no longer find the words. He is not always aware that he is in hospital

Diagnoses

Subarachnoid bleeding H&H I°, Fischer IV. Giant aneurysm of the anterior communicating artery. Marked cerebral vasospasms. Disturbed orientation. Disturbance

Diagnostic procedures

Findings on admission

Alert, responsive patient. Short-term memory clearly impaired. Mild meningism. Rolls his eyes upwards.

Imaging procedures

Cerebral computed tomography

Day 1: severe subarachnoid bleeding with blood in the central sulcus and a large frontobasal blood clot. From day 16: marked generalised cerebral oedema with small anterior insult on the right.

Day 33: discretely enlarged ventricle system with no certain signs of impaired CSF circulation.

Cerebral panangiography

Day 1: large, lobulated aneurysm of the anterior communicating artery with a wide base. Day 16: vasospasms particularly in both anterior arteries and the left middle communicating artery. Day 18: vasospasms in the area supplied by the left media and now also in the vertebrobasilar region.

Conventional treatment

Aneurysm clipping and insertion of an external ventricle drain on day 2. Spasmolysis with local papaverine treatment (days 16 and 18). Triple H including catecholamine treatment. Anticonvulsants and antibiotics. Haemodynamic monitoring. Physiotherapy and occupational therapy. Intensive medical treatment.

Homeopathic treatment

Repertorisation I

CARD INDEX REPERTORY Cheerfulness, merriment, high spirits,

Cramp-like effects, convulsions, twitches, jerks Poor memory, memory loss, forgetful

Sweat in general, slight sweating

Differentiation between remedies

The remaining remedies are *Belladonna*, *Lachesis* and *Phosphorus*. The grimaces and head movements indicate *Belladonna*-, the jokes and loss of speech eliminate

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Progress

On day 15, the patient is already showing clear changes in his behaviour. His laughter is no longer silly and childish as it was before; he is open and asks questions. These reactions occurred immediately after administering the remedy. On day 16, extremely severe cerebral vasospasms cause his neurological condition to worsen suddenly with reduced energy and alertness. Spasmolytic treatment with papaverine administered locally only has a slight effect; however, the situation eases when *Belladonna* is given (the treatment with *Belladonna* continues as there is no other indication). On day 17, the patient develops marked aphasic disturbances and neglect (inability to recognise functional deficits on one side of his own body) on the right. On day 18, the situation from day 16 recurs; once again, the patient's condition only improves immediately after administering *Belladonna*. The severe vasospasms are no longer clinically relevant. The following functional disturbances are now reported: the patient's right foot twitches, his head is turned to the left and he perceives nothing when spoken to from his right side, which seems to be "lifeless".

As all of these symptoms are still covered by *Belladonna*, the patient is given the same dose of *Belladonna* Q9 starting on day 22. Over the next ten days, the neglect subsides significantly. It is becoming easier to establish contact with the patient; however, the improvement only becomes evident immediately after the homeopathic remedy has been administered. *Belladonna* Q12 is administered from day 29 and *Belladonna* Q15 from day 36. On day 42, the patient has been in rehabilitation for seven days; he is apathetic (he would sit in front of his food and starve) and needs an environment with few stimuli to eat, otherwise he would not be able to concentrate. When eating, he pays attention to the smallest crumb and the way in which the food is arranged, and consequently does not actually eat. He is generally slower. The EEG shows a focus with no convulsive activity. He does not understand everything which is said to him. He cannot produce speech when asked; he can only

speak spontaneously. His bladder does not empty completely. The soles of his feet are extremely calloused. His right foot is still sensitive to touch; he has not yet recovered full mobility in his right side.

Repertorisation II

KENT'S REPERTORY*

Generalities - paralysis - one-sides, hemiplegia - apoplexy, after**

Mind - slowness**

Mind - conscientious about trifles**

Mind - concentration, difficult**

Extremities - callosities - horny - soles, on*

Differentiation between remedies

The remedies remaining are *Arsenicum album*, *Baryta carbonica* and *Sulphur*. The nystagmus-like eye movements indicate *Arsenicum album* and *Sulphur*; the difficulties responding to a question are a *Sulphur* symptom; this remedy is therefore chosen.

Prescription

10 drops *Sulphur* Q6 twice a day from day 42.

Progress

One day after taking *Sulphur*, the patient's eye movements have returned to normal; he looks more alert and takes in more of what is happening. However, the patient then develops symptoms of intracranial pressure with hydrocephalus. Although he has responded well to the homeopathic remedies so far, his exhausted wife stops the treatment, as the people around her have advised her to distance herself mentally as far as possible from her seriously ill husband to prevent a total breakdown.

Evaluation

In spite of the many factors influencing the patient, it seems that only the homeopathic remedies bring about decisive progress in his condition.

Critical commentary

The complications (e.g. the vasospasms) do not speak

14.1 Apoplexy and intracranial bleeding

Case 14.1-5: Temporary cerebral hypoxia

Michael Frass

Anamnesis

One day, the husband returns home and finds his wife, who suffers from depression, lying on the floor unconscious. The 57-year-old woman is immediately taken to the local hospital with a suspected overdose. During her stay in hospital, she suffers a cardiovascular arrest of unclear origin. The patient undergoes extensive resuscitation. Problems clearing the airways and administering artificial respiration lead to hypoxia of the brain (day 1); the patient is transferred to intensive care.

Diagnoses

Temporary cerebral hypoxia after cardiovascular arrest.
Possible suicide attempt.

Diagnostic procedures

Imaging procedures

Cerebral computed tomography: no signs of apoplexy or haemorrhage. Signs of hypoxic damage.

Neurological consultation

Day 1: cerebral hypoxia. The diagnosis of apallic (persisting vegetative syndrome) syndrome cannot be ruled out.

Conventional treatment

Intensive monitoring and treatment with volume-controlled respiration and parenteral nutrition.

Homeopathic treatment

Repertorisation

COMPLETE MILLENNIUM

Generalities - cyanosis

Generalities - death - apparent, asphyxia

Respiration - arrest, arrested

Differentiation between remedies

Camphora, *Carbo vegetabilis*, *Cuprum metallicum*, *Lachesis*, *Lauzengarcus* and *Onium* are mentioned in all

meconium and he was born with asphyxia and resultant brain damage.” Friedrich Graf describes *Cuprum metallicum* in treating asphyxia in newborns. Of the remedies mentioned, only *Cuprum metallicum* and *Lachesis* appear under the keyword “Brain damage” in the “Reference Works”. The latter is only given single weighting in the second repertorisation rubric. *Cuprum metallicum* is therefore chosen.

Prescription

1 dose of 5 globules *Cuprum metallicum* 200C on day 3.

Progress

The homeopath was consulted by one of the patient's relatives. He had not known the patient before that time. In view of the diagnosis, the relative is told that the outlook is hopeless. Nevertheless, she still wants the patient to have homeopathic treatment.

Next day, to the astonishment of all the doctors and nurses, the patient is again completely responsive. However, her general condition is still poor. From this time, the medical personnel strictly forbid further homeopathic treatment without giving any reason. The patient's condition continued to improve, as a result of which she is transferred back to the general ward on day 5.

At a follow-up appointment six months later, the patient is in good condition. She has started dancing again and can do most of her housework. However, she mentions that she is lacking in energy and her memory is impaired.

Evaluation

The author does not want to use this case history to prove that homeopathy can cure apallic syndrome. However, one point open to discussion is that homeopathic treatment may have caused a patient known to be suffering from temporary cerebral hypoxia to return to normal more quickly and easily. In any case, this case should provide inspiration for further observation. The sudden improvement was completely unexpected; it can therefore be assumed that *Cuprum metallicum* had an effect.

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Critical commentary

The homeopathic physician only got to know the initially unconscious patient six months after treatment. The suggestive effect generally vaunted by opponents of homeopathy can therefore be

excluded. Everyone involved was astonished by the reaction of the intensive care team, which had itself observed and commented on the patient's rapid recovery.

Case 14.1-6: Apallic syndrome

Martin Bündner

Anamnesis

On day 1, the 67-year-old patient is taken by ambulance to the intensive care unit of a general hospital. He is unconscious, his circulation is stable, he has been intubated and is receiving artificial respiration. He was resuscitated after a 15-minute latency period between suffering a cardiovascular arrest and the arrival of the emergency services. On admission, the patient is trembling and does not react to speech or pain stimuli.

1st treatment phase: on the following day, the patient is still not responding when spoken to or when pain stimuli are administered; however, he starts breathing spontaneously in the afternoon. He also develops bronchospasms, which are treated with corticoids.

On days 2 and 4, the patient's condition remains unchanged. It is still impossible to trigger his monosynaptic reflexes. As he is constipated, he is also given laxatives on this day. As the patient is running a temperature, he is given the antibiotic gentamycin. He develops small red spots on his chest, abdomen and back, which later subside. The patient with multiple morbidities survives the critical treatment phases; however, his general condition indicates that he suffered severe hypoxic brain damage after being given cardiopulmonary resuscitation, which caused him to develop apallic (persistent vegetative) syndrome.

Symptoms established on day 5:

- No reaction to painful stimuli
- Unconsciousness
- Constipation
- Monosynaptic reflexes cannot be triggered
- Temperature

- Small red spots on chest, abdomen and back
- Eyes open, right pupil dilated with no reaction to light; dry, glassy eye on the left
- Mouth open
- Breathes deeply, lots of mucus
- Spastic breathing
- Bronchial spasms suppressed by cortisone

Diagnoses

Apallic syndrome. Multiple pathology, including coronary bypass operation, bladder carcinoma resected on two occasions, chronic obstructive pulmonary disease.

Conventional treatment

The medical progress reports and nursing reports show that the patient was given antibiotics, various combinations of morphine for sedation, anticoagulants and the usual cardioactive medication and medication for regulating his circulation, also in different combinations, throughout his time in ICU.

Day 12: PEG (percutaneous endoscopically controlled gastrostomy) tube inserted without complication. Marked stomach and intestinal atony also found.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Generalities - analgesia

Mind - unconsciousness - mental insensibility

Eye - pupils - insensitive to light

Eye - open - unconsciousness, during

Differentiation between remedies

14.1 Apoplexy and intracranial bleeding

of open eyes in a state of unconsciousness is decisive. Only one other remedy is listed with *Opium* in this rubric, which is why Hahnemanns “Materia Medica Пира” is consulted to confirm the choice of *Opium*:

“Dull stupefaction, with dull eyes and excessive powerlessness. He does not know his nearest relatives, nor the most familiar objects. Stupefaction of the senses and loss of reason. [...], open eyes. Glassy, projecting, immovable eyes that see nothing, like those of a dying person. Immobility of the pupils to light. Dilated pupils. Contracted pupils dilated, their contractility gone. Almost always binds the bowels. Checks the activity of the voluntary muscles, diminishes sensibility and hence induces sleep” (Hahnemann 1830).

Only then is the decision to administer *Opium* made.

Prescription

1 dose of 3 globules *Opium* 200C dissolved in water and administered on three consecutive days (days 5,6 and 7).

Progress

2nd treatment phase: at about 8.15 am on day 5, one dose of 3 globules *Opium* 200C is dissolved in a 2 ml syringe and administered orally. The patient was previously breathing peacefully, but starts to snore loudly after the remedy is given. During the day, the patient bites down whenever any attempt is made to perform oral hygiene; this therefore becomes extremely difficult. The red spots reappear after giving gentamycin.

Repeat prescription: as there is still no reaction to pain stimuli and the patient’s pupils are still not responding to light, another dose of *Opium* 200C is given on the morning of day 6.

Shortly after taking the remedy, the patient’s face becomes flushed. During the day, the patient shows a clear response to reflex tests for the first time, breathes deeply and changes his facial expression; his right pupil is now also responsive to light.

The patient’s facial expression also shows that he now recognises his relatives. In the afternoon, he

begins to respond clearly to instructions. He spontaneously passes liquid stool.

The neurological consultation takes place that same day and reports the following findings: “The patient sometimes has his eyes closed, other times he is awake; tries to focus with the right eye; glazed left eye. Light reaction and corneal reflex present on the right. Groans in response to painful stimuli. Tetraplegia with reduced muscle tone on all sides, no spontaneous movements; spontaneous respiration. No meningism. Oculocephalic reflex positive, Babinski negative, monosynaptic reflexes identical on both sides.”

Diagnosis: hypoxic brain damage; further neurological rehabilitation is required.

During the night, the patient turns his head to the side from which he is being addressed and makes undifferentiated defensive movements. He is still passing light brown diarrhoea. **Repeat prescription:** by the following day, he is no longer responding clearly to corresponding instructions, and so another dose of *Opium* 200C is administered in the same way. The patient again begins to snore immediately after the remedy is given. During the day, he begins to move his body in bed using his arms. Expressive movements of the facial muscles are observed. The right eye is now closed and the pupil contracted. The patient moves his head and arms and spends some time asleep. During the night, he is much more restless than before. He moves his left arm almost continuously and reacts when spoken to.

3rd treatment phase: over the next few days, the patient is physically very restless, particularly in the morning and at night. He opens his eyes when spoken to and is able to focus. He also groans surprisingly often.

Nearly one week later, he shows a marked tendency to turn onto his left side; it is now almost impossible to turn him onto his right side or even to turn his head to the right.

He has now recovered his ability to react to pain. A new symptom is observed: he moves both arms and legs in an uncoordinated, worm-like fashion.

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On day 17, he is transferred to a neurological rehabilitation clinic.

Evaluation

Before any possible effect of the remedy can be discussed, it must first be evaluated whether the patient's condition really changed during this period, and whether it improved or perhaps even deteriorated.

There is no doubt that his condition changed; this was clear and visible to everyone, even inexperienced observers. While the patient initially only lay in bed rigid, he is now able to move. He is also able to take part in what is going on around him to some degree.

The family noticed that he reacted particularly strongly to his wife. The reaction to pain, light reaction and monosynaptic reflexes also return. In all, his general condition has improved. In order to distinguish between spontaneous remission and the effects of homeopathic treatment, the treatment given to the patient during the first 17 days of his hospital stay has to be divided into three phases:

- The first phase before administering the homeopathic remedy (with defined symptoms)

- The second phase while the remedy (*Opium*) was working, with symptom changes
- The third phase after *Opium* stopped working (with a new set of defined symptoms). Despite the change in symptoms, the administration of a homeopathic remedy was dispensed with to avoid making developments, which were already difficult to assess, even more unclear
- The fourth and fifth phases came later during other hospital stays

Differentiation is made even more difficult by the fact that a large quantity of chemical medication was given, which had to be adjusted to treat the frequently changing symptoms (e.g. cardiovascular instability, fever). This wiped out some of his symptoms, making it more difficult to find the correct homeopathic remedy and evaluate the progress of this case.

Critical commentary

The following points speak against the influence of the homeopathic remedy:

- (Spontaneous) remission is possible. This is the most weighty argument, which can only be countered with difficulty. Remission can progress as far as complete freedom from symptoms. It can also occur in phases
- The early remission observed in this case makes spontaneous developments more likely than if the remission had occurred at a later stage
- The patient was influenced by more factors than just homeopathic treatment (medication, physical therapy etc.)

The following points favour the influence of the homeopathic remedy:

- As (spontaneous) remission is possible apallic syndrome must be viewed as a disorder which can in principle be cured by homeopathy
- The remission clearly began after the homeopathic remedy was administered
- The symptoms changed significantly; the remission stopped when no further dose of the remedy was given. Another remedy should in fact have been administered
- The pharmacological, physical and physiotherapeutic influences affecting the patient did not change so fundamentally that the division of the patients' progress into three phases could be explained

Further progress

On day 17, the patient is moved to another clinic for neurological rehabilitation. The discharge report from the neurological clinic states: "On admission, the patient was tetraplegic with increased muscle tone in the upper extremities and severe organic brain syndrome. We are giving the patient specialised nursing care according to the activating principle, daily individual physiotherapy on a neurophysiological basis, occupational therapy and deglutition training. The patient has made some functional progress with this treatment. In time, it was possible to mobilise him in a wheelchair for hours at a time; during this time he was

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spoke in his native language and followed simple instructions. At a later stage, the patient was mobilised so far that he was able to walk about 50 m with the help of a walker and managed the transfer almost alone.”

Attempts to swallow failed, which meant that he had to be fed via a PEG tube throughout. His frequent restlessness was a problem, e.g. because he kept manipulating the PEG tube. Ultimately, he was able to follow simple instructions and speak short, intelligible sentences. He was heavily dependent on help with daily activities. Statutory nursing care was arranged.

On day 87, the patient is again taken to hospital by ambulance accompanied by his relatives after complaining for about two hours of (“external”) chest pain. Any cardiac incident is ruled out and the pain traced to a palpable wire dislocation following a sternotomy performed as part of a prior coronary bypass operation.

4th treatment phase: the relatives caring for the patient describe the following symptoms which have become established since the period spent in neurological rehabilitation:

“The patient is generally very forgetful. At times, he talks only in the past tense; this gets worse at night. He also sees people who are not there. He does not always recognise his relatives. He is aggressive, hits out and around him. On one occasion he removed the PEG tube, which meant that he had to be fixed to the bed. He reaches for imaginary objects and frequently undresses himself. Excitement makes him vomit, as does physical exertion. Cold sweat is observed on his hands, forehead and body. When asleep, his breathing is deep and sometimes stops altogether. His speech is unclear. He can swallow neither liquids nor solids. He needs a wheelchair or the support of two people to get about, as he cannot keep his balance or walk alone.”

During the physical examination, a white coating is observed on his tongue, his heart rate is 100/min. and he is physically restless.

Homeopathic treatment

Repertorisation II

KENT'S REPERTORY

Mind - naked, wants to be

Mind - striking

Mind - gestures - hands - grasping or reaching at something

Mind - delusions - people, sees

Mind - recognise - does not, his relatives

Mind - memory - weakness of

Perspiration - cold

Throat - swallowing - impeded

Differentiation between remedies

The remaining remedy is *Belladonna*. However, *Hyoscyamus* and *Stramonium* are also mentioned in many of these rubrics; these remedies must therefore be included in further considerations. The way in which the patient breathes is typical of *Belladonna* but not of the other two remedies. *Belladonna* is also a good follow-up to *Opium*, as mentioned in Miller and Klunker's "Relationship of Remedies". *Belladonna* is therefore chosen.

As the three remedies are so similar, the choice of remedy is confirmed by consulting G. H. G. Jahr's "Ausführliche Arzneimittellehre" ("Detailed Materia Medica"):

“Fever symptoms. [...] Perspiration: [...] - on the slightest exertion, on the whole body, especially the face and nose; cold, on the forehead; [...] sudden profuse [...]. Mind - mental disturbances: after [...] apoplexy; [...]. Anger, [...] with inability to recognise his own; with raving, rage and violence, [...] striking [...]. Throat. [...] Swallowing painful, difficult or completely impeded, even of liquids, which frequently re-emerge from the nose; inability to swallow with aversion to all liquids, even anger; [...].” (Jahr 1843)

Prescription

1 dose of 2 globules *Belladonna* 30C on day 87.

Progress

The patient is given *Belladonna* during the night between

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night, he pulls out the PEG tube and peripheral IV catheter and undresses himself again. On day 89, his relatives say that he has again become more aggressive over the last two days. Another PEG tube is inserted.

On day 90, the patient insists on being moved. He is discharged from hospital the next day. Over the next four weeks, the relatives caring for him describe the following changes: he is clearly less forgetful. However, they are unable to provide a certain assessment of his habit of talking in the past tense and to people who are not there. The patient recognises his relatives more frequently. He is no longer aggressive and has stopped hitting out. He no longer has to be fixed. He has stopped reaching for imaginary objects and undressing himself. After his stay in hospital, he vomited twice more when extremely excited; however, this has now stopped, even in such situations. He is still very thirsty; the cold sweat can no longer be adequately assessed. The Cheyne-Stokes breathing has disappeared. He is now coughing a lot, which also stops him from sleeping. His speech is now clearer. He now eats yoghurt. He wishes to stop the tube feeding and resume normal eating.

5th treatment phase: in the night preceding day 134, the patient is again intubated, given artificial respiration and rushed to intensive care by ambulance after suffering from ventricular fibrillation and being defibrillated by the physician on call.

On taking his case history, it is found that he had had pneumonia about two weeks previously, which was treated at home with antibiotics. Since then, the patient has been declining rapidly: he is growing weaker and no longer wishes to sit up, as even this is too tiring. He is so tired that he can no longer be motivated to perform any physical activity. He has lost a lot of weight. The Cheyne-Stokes breathing has also returned.

The patient's family is worn out and no longer able to give detailed descriptions of his symptoms. For this reason, the family agrees not to give any further homeopathic treatment.

The patient died of heart failure at 10.38 pm on day 134 as his circulation could not be adequately restored.

Evaluation

When considering the case as a whole, the question arises of whether the patient's highly satisfactory recovery was due solely to the rehabilitative measures in hospital or whether it was promoted by the homeopathic remedy *Opium*. Would this improvement have been brought about by the correct homeopathic remedy alone? Was the ongoing improvement of the apallic syndrome after the conclusion of the neurological rehabilitation due to the administration of *Belladonna*⁷.

The following points speak against the influence of the homeopathic remedies:

- A certain self-healing tendency was stimulated by the neurological rehabilitation
- Spontaneous remission could have occurred in phases

The following points favour the influence of the homeopathic remedies:

- The success of the neurological rehabilitation could have been triggered by *Opium*. However, it must be considered that a new situation developed during the third phase and required treatment with another remedy
- After the neurological rehabilitation, the patient's condition stabilised and could not be improved any further with these measures; he was therefore discharged from the rehabilitation facility. However, the administration of *Belladonna* was followed by another marked improvement
- He responded to the dose of *Belladonna* with a drug reaction which was noticed by nursing staff and relatives alike: this started with a typical aggravation reaction and was followed by a tangible improvement
- The general prognosis for apallic syndrome worsens the longer it lasts. Nevertheless, the patient's condition continued to go into remission after the administration of *Belladonna*

which, to the best of his knowledge, there is currently no experience with homeopathic treatment in the relevant literature.

However, in view of the limited therapeutic possibilities of conventional medicine and the financial consequences for families affected, patients suffering from apallic syndrome are a group which could profit considerably from homeopathic treatment.

14.2 Epilepsy

Definition

The term “epilepsy” is used to describe aetiological and clinically heterogeneous cerebral functional disorders which cause cerebral seizures. These seizures manifest as paroxysmal disturbances of the senses, motor functions, subjective sensations and objective behaviour caused by a sudden, abnormal increase in activity in the CNS. Both exogenous factors (brain diseases such as trauma, bleeding, tumours and inflammation or diseases of the entire organism which trigger cerebral dysfunction such as uraemia, hypoglycaemia, intoxication, toxic delirium during withdrawal) and endogenous factors (different forms of hereditary disposition) play a role in the development of epilepsy to varying degrees.

Clinical information

Incidence

About 50% of all people suffer a cerebral seizure at some point in their lives.

Symptoms

The wide variety of epileptic seizures is classified nosologically for purposes of clarity:

Epilepsy with primarily generalised seizures

- Grand mal
- Petit mal
 - Myoclonic astatic seizures in early childhood -

Critical commentary

Any discussion of the patient's possible spontaneous remission is purely academic. In this particular case, the possibility of true spontaneous remission has to be ruled out as the patient not only received homeopathic medication but was also treated with chemical medication and physiotherapy.

Epilepsy with seizures which are focal in origin

- Focal seizures with elementary symptoms
 - Focal motor seizures
 - Masticatory, pharyngeal and laryngeal seizures
 - Hemiconvulsions
 - Adversive seizures
 - Somatosensory seizures
 - Rolandic epilepsy - a specific form
- Focal seizures with complex symptoms
- Focal seizures with secondarily generalised seizures
 - Grand mal
 - Petit mal: West syndrome, Gastaut-Lennox syndrome

As a rule, only acute focal or grand mal seizures are relevant to the field of emergency medicine, which is why only the symptoms of these are described here.

Grand mal seizures

Grand mal attacks can occur at any time of life.

They are not preceded by an aura and normally begin suddenly. Grand mal attacks involve tonic-clonic seizures.

Tonic phase: the long muscles of the back and extremities are usually extended tonically with no difference between sides; concomitant vegetative symptoms such as wide-open eyes with dilated pupils

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emerge from his mouth and he may involuntarily pass urine/stool.

Grand mal seizures usually last 2-4 min.; afterwards the patient may fall into a sleep from which he can be woken. Grand mal seizures often occur in conjunction with absences and myoclonic- impulsive seizures.

Acute focal seizure

Symptoms vary depending on the part of the brain affected:

- **Focal motor seizures:** tonic or clonic attacks beginning at the distal end of one extremity or at one corner of the mouth, spreading homolaterally in a proximal direction (Jackson seizure), frequently accompanied by sensory irritation in the same location
- **Masticatory, pharyngeal and laryngeal seizures**
- **Hemiconvulsions:** The patient is usually semi-conscious or unconscious, mostly clonic seizures with a tendency towards postictal, largely reversible hemiplegia
- **Adversive seizures:** patient stays conscious, tonic movements of eyes and head and movement of the torso to the side away from the focus, simultaneously tonic, later clonic seizures in the homolateral upper extremity
- **Somatosensory focal seizures:** paroxysmal abnormal sensory perceptions which take the form of visual focal seizures (distorted sight, abnormal perception of sizes, amaurosis, scotoma, colour hallucinations), acoustic focal seizures, gustatory focal seizures and olfactory focal seizures (uncinate seizures: smells and tastes which are usually very unpleasant and which the patient finds difficult to describe)

All focal seizures can progress into generalised seizures of focal origin, thus constituting the aura of these secondarily generalised grand mal attacks, which usually cause the patient to lose consciousness. Acute cerebral seizures are differentiated as follows depending on their frequency:

- **Single seizure:** not more than one seizure in 24 hours. The patients condition usually stabilises quickly and

- **Serial seizures:** more than one seizure in 24 hours. The patient regains consciousness between seizures. Serial epilepsy is not usually a vital threat but may progress to status epilepticus. Serial seizures may be triggered by external factors such as feverish infections, alcohol consumption etc
- **Status epilepticus:** numerous cerebral seizures in rapid succession. The patient does not regain consciousness between seizures. Status epilepticus is acutely life-threatening due to the risk of cerebral oedema

Diagnosis

The various forms of epilepsy can be diagnosed by taking a detailed case history and performing an electroencephalograph (EEG). Pathological EEG findings are found to varying degrees in each form of epilepsy, even while the patient is not suffering a seizure.

The differential diagnosis of cerebral seizures (dilated pupils unresponsive to light, typical tonic- clonic movements, enuresis, biting the tongue, marked cyanosis, postictal reorientation phase) as opposed to non-epileptic seizures is difficult but essential for further treatment.

Grand mal seizures must be differentiated from the following:

- Syncope (pale skin colour, accompanying vegetative reactions, abortive movements, short duration, possibly dilated pupils which are usually still responsive to light)
- Hypoglycaemia
- Psychogenic seizures (exaggerated movements frequently of complex, demonstrative character, placing weight on the back of the head and the heels while lifting the middle of the body ("arc de cercle": "wrestlers bridge position"), patient frequently reacts to external stimuli, pupil reflexes retained, eyelids deliberately pressed together, defensive movements when being examined)

Focal seizures (seizure spreads from distal to proximal = "march of convulsion") must above all be differentiated from TIAs (longer duration, no physical

14.2 Epilepsy

necessary to perform further instrumental diagnostic measures on an emergency basis.

However, if the cause of the seizure is unknown, imaging procedures (cCT or MRI) should be performed as quickly as possible. If the findings are negative, CSF tests and drug screening may also be performed.

Therapeutic crisis

Certain forms of epilepsy leading to psychopathological syndromes cannot be sufficiently controlled by modern drug treatment; the mental changes which may occur as the result of frequent seizures cannot be adequately prevented, nor can heterogeneous seizure-related brain damage.

The treatment for grand mal seizures can be just as life-threatening as the seizure itself. Complications such as cerebral oedema and side-effects of the drug treatment may also influence the patient's progress. Treatment with chemical medication only stops seizures in about 60% of patients. However, concomitant homeopathic treatment can help limit acute seizures and, if administered in the long term, may cure the epilepsy completely.

Homeopathic treatment

Symptom selection

A detailed anamnesis recording the cause and precise development of the seizures with all symptoms is critical for the choice of remedy.

Repertorisation

KENT'S REPERTORY

Generalities - convulsions (tonic-clonic seizures)

Absin., Acet-ac., Aeon., Aesc., Aeth., Agar., Alum., Ambr., Am-c., Ant-c., Ant-t., Apis, Aran., Arg-n., Arn., Ars., Art-v., Asaf., Aster., Atro., Aur., Bar-c., Bar-m., Bell., Bry., Bufo, Cact., Calc., Camph., Cann-i., Cann-s., Canth., Carb-ac., Carbn-s., Caust., Cham., Chen-a., Chin., Cic., Cina, Clem., Coca, Coa., Coc-c., Coff, Colch., Coloc., Con., Cop., Croc., Crot-c., Crot-h., Cub., Cupr., Cupr-ar., Cur., Dig., Dulc., Eupi, Ferr., Ferr-ar., Form., Gels., Glon., Graph., Hell., Hydr-ac., Hyos., Ign., Ip., Iod., Kali-br, Kali-c., Kali-chl., Kali-i., Kalm., Lach., Laur., Lob., Lyc., Lyss., Mag-c., Mag-m., Mag-p., Mane., Meh., Meph., Merc., Merc-c., Mosch., Mur-ac., Nat-m., Nat-s., Nit-ac., Nux-m., Nux-v., Oena., Olnd., Op., Ox-ac., Petr., Phos., Phyt., Plat, Plb., Psor., Pub., Ran-s., Rhus-t., Rob., Ruta, Sabad., Samb., SiL, Sec., Sep., Sil., Sin-n., Sol-n., Spig., Stann., Staph., Stram.,

KENT'S REPERTORY -

children

Aeon., Aeth., Agar., Ambr., Apis, Art-v., Bell., Bry., Calc., Camph., Caust., Cham., Cic., Cina, Cocc., Coff., Crot-c., Cupr., Dol., Geb., Hell., Hep., Hydr-ac., Hyos., Ign., Ip., Kali-c., Lach., Laur., Lyc., Mag-p., Nux-v., Op., Plat., Sec., Sil., Stram., Sulph., Verat., Zinc.

- clonic

Aeon., Agar., Alum., Ambr., Am-c., Am-m., Anac., Ant-c., Ant-t, Arg-m., Arn., Ars., Art-v., Asaf., Aster., Aur., Bar-c., Bar-m., Bell., Bor., Bry., Bufo, Calc., Calc-p., Camph., Cann-s., Canth., Carb-v., Carb-o., Carbn-s., Caust., Cham., Chin., Chin-s., Cic., Cimic., Cina, Clem., Cocc., Coff, Coloc., Con., Croc., Cupr., Dig., Dulc., Graph., Guai., Hell., Hep., Hyos., Ign., Ip., Iod., Kali-ar., Kalm., Kreos., Lach., Laur., Lyc., Lyss., Mag-c., Mag-m., Mag-p., Mang., Meny., Merc., Mez., Mosch., Mur-ac., Mygal., Nat-c., Nat-m., Nit-ac., Nux-m., Nux-v., Oena., Olnd., Op., Petr., Phos., Ph-ac., Phys., Plat., Plb., Puls., Ran-b., Ran-s., Rheum, Rhod., Rhus-t., Ruta, Sabad., Samb., Sars., Squil., Sec., SeL, Seneg., Sep., Sil., Spig., Spong., Stann., Staph., Stram., Stront., Sulph., Sulph-ac., Tarent., Tarax., Teucr., Thuj., Verat., Verat-v., Vise., Zinc.

- consciousness, with

Ars., Bell., Calc., Camph., Canth., Caust., Cina, Grat, Hell., Hyos., Ip., Kali-ar., Kali-c., Lyc., Mag-c., Merc., Mur-ac., Nat-m., Nit-ac., Nux-m., Nux-v., Phos., Plat., Plb., Sec., Sep., Sil., Stram., Stry., Sulph.

- consciousness, without

Absin., Acet-ac., Aeon., Aeth., Ant-t, Arg-n., Ars., Aster., Aur., Bell., Bufo, Calc-ar., Calc., Calc-s., Camph., Canth., Carb-ac., Caust., Cham., Chin., Cic, Cina, Cocc., Crot-h., Cupr., Dig., Ferr., Glon., Hydr-ac., Hyos., Ip., Kali-c., Lach., Laur., Led., Lyc, Merc., Mosch., Nat-m., Nit-ac, Nux-v., Oena., Op., Phos., Plat., Plb., Sec., Sep., SiL, Staph., Stram., Sulph., Tanac., Tarent., Verat., Vise.

- epileptic

Absin., Acet-ac., Aeth., Agar., Alum., Am-c., Anac., Arg-m., Arg-n., Ars., Art-v., Aster., Bar-c., Bar-m., Bell., Bufo, Calcar., Calc., Calc-p., Calc-s., Camph., Cann-L, Canth., Carb-an., Carb-v., Carbn-s., Caust., Cedr., Chin., Chin-s., Cic., Cina, Cocc., Con., Crot-c., Crot-h., Cupr., Cupr-ar., Cur., Dig., Form., Geb., Glon., Hell., Hydr-ac., Hyos., Ign., Indg., Iod., Kali-br., Kali-c., Kali-chl., Kali-s., Lach., Laur., Lyc., Lyss., Mag-c., Mag-p., Med., Merc., Mosch., Naja, Nat-m., Nat-s., Nit-ac., Nux-m., Nux-v., Oena., Op., Phos, Phos-ac, Plat, Plb, Psor, Puls, Ran-b, Sec, Sep, Sil

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KENT'S REPERTORY -

epileptiform

Aeon., Aeth., Agar., Alum., Am-c., *Anac.*, Ant-c., Ant-t., *Arg-m.*, Arg-n., Am., Ars., Asaf., Aur., Bell., Bry., *Bufo*, Calc., Calc-s., *Camph.*, Canth., Carbn-s., Caust., *Cedr.*, *Cham.*, Chin., Cic., Cina, Cocc., Coloc., Con., Cupr., *Cur.*, Dig., Dros., Dulc., Ferr., Ferr-ar., *Gels.*, Glon., Hei., Hyos., *Hyper.*, Ign., *Ip.*, Iod., Kali-br., *Kali-c.*, Kali-s., *Lach.*, Laur., Led., *Lyc.*, Mag-c., *Med.*, Merc., Mosch., Mur-ac., *Nat-m.*, Nit-ac., *Nux-m.*, *Nux-v.*, Oena., Op., Petr., Phos., Ph-ac., *Plat.*, *Plb.*, *Psor.*, *Puls.*, *Ran-b.*, Ran-s., Rhus-t., Ruta, *Sec.*, Sep., Sil., Stann., Staph., Stram., *Stry.*, Sulph., *Tarent.*, Tarax., Teucr., Thuj., Valer., Verat., Verat-v., Vise., Zinc.

- falling, with

Agar., Alum., Am-c., *Ars.*, *Aster.*, Bell., *Calc.*, *Calc-p.*, Canth., *Caust.*, *Cedr.*, Cham., Cic., Cina, Cocc., *Con.*, Cupr., Dig., Dulc., Hyos., Ign., *Ip.*, Iod., Laur., *Lyc.*, Merc., Nit-ac., Oena., Op., Petr., Phos., Ph-ac., Plb., Sec., Sep., Sil., *Stann.*, Staph., *Stram.*, Sulph., Verat., Zinc.

- falling, with - backwards

Bell., Canth., Chin., Cic., *Ign.*, *Ip.*, *Nux-v.*, *Oena.*, Op., Rhus-t., Spig., *Stram.*

- falling, with - forwards

Am., *Aster.*, Calc-p., Canth., Cic., Cupr., Ferr., Rhus-t., Sil., Sulph., Sumb.

- falling, with - to the left

Bell., Caust., Lach., Sabad.

- hysterical

Absin., *Alum.*, *Apis.*, Ars., Asaf., *Aur.*, Bell., Bry., *Calc.*, Calc-s., Cann-s., *Caust.*, *Cedr.*, Cham., Cic., *Cimic.*, Cocc., Coff., Coll., Con., Croc., *Gels.*, Hyos., Ign., *Ip.*, Iod., Lach., *Lyc.*, *Mag-m.*, Merc., Mosch., *Nat-m.*, Nit-ac., *Nux-m.*, *Nux-v.*, Op., Petr., Phos., *Plat.*, Plb., Puls., Sec., Sep., Staph., *Stram.*, Sulph., Sumb., Tarent., Valer., *Verat.*, Verat-v., Zinc.

- internal

Aeon., Agar., Ambr., Am-c., *Anac.*, Arg-m., Arn., Ars., *Asaf.*, Bell., Bism., Bov., *Bry.*, Calad., *Calc.*, *Camph.*, Canth., Caps., *Carb-v.*, Caust., *Cham.*, Cina, Cocc., Coff., Colch., Coloc., Con., Cupr., Dig., Ferr., Graph., Hyos., Ign., *Ip.*, Iod., *Kali-c.*, Kreos., Lach., Laur., Led., *Lyc.*, Mag-c., *Mag-m.*, *Mosch.*, Mur-ac., Nat-c., Nat-m., Nit-ac., *Nux-m.*, *Nux-v.*, Op., Petr., *Phos.*, Ph-ac., *Plat.*, Plb., Puls., Rhod., Sabad., Sec., Seneg., *Sep.*, Sil., Spong., Stann., *Staph.*, Stram., Stront., Sulph., Sulph-ac., Teucr., Thuj., Valer., Verat., Zinc.

- tetanic rigidity

Absin., Aeon., Aesc., Alum., Am-c., *Anac.*, Arn., Ars., Asaf., Bell., *Camph.*, Cann-i., Cann-s., *Canth.*, Carb-o., Caust., *Cham.*, *Chin-s.*, *Chlol.*, Cic., Cocc., *Con.*, Cupr., Cupr-ac., *Cur.*, Dros., *Gels.*, Hell., Hep., *Hydr-ac.*, Hyos., Hyper., *Ign.*, *Ip.*, Kreos., *Lach.*, Laur., Led., Lob., *Lyc.*, Lyss., *Mag-p.*, Merc., Mosch., Mur-ac., *Nux-v.*, *Oena.*,

KENT'S REPERTORY -

tonic

Absin., Aeon., Aesc., Alum., Am-c., *Anac.*, Arn., Ars., Asaf., i Bell., *Camph.*, Cann-t., Cann-s., *Canth.*, Carb-o., Caust., | *Cham.*, *Chin-s.*, *Chlol.*, Cic., Cocc., *Con.*, Cupr., Cupr-ac., *Cur.*, | Dros., *Gels.*, Hell., Hep., *Hydr-ac.*, Hyos., Hyper., *Ign.*, *Ip.*, I Kreos., *Lach.*, Laur., Led., Lob., *Lyc.*, Lyss., *Mag-p.*, Merc.,: Mosch., Mur-ac., *Nux-v.*, *Oena.*, Op., Petr., Phos., Phys., *Phyt.*,: Plat., Plb., Puls., Rhod., Rhus-t., Sec., Seneg., Sep., Sol-n., *Stram.*, *Stry.*, Sulph., Teucr., Ther., Verat., Verat-v., Zinc.

Bladder - urination - involuntary - convulsions, during

Art-v., Bufo, *Caust.*, Cocc., Cupr., Hyos., *Nux-v.*, *Oena.*, *Plb.*, *Stry.*, Zinc.

Mouth - biting - tongue - spasms, in

Art-v., Bufo, Camph., *Caust.*, Cocc., Cupr., *Oena.*, Op., Sec., Tarent., Valer.

Mouth - froth - convulsions, during

Agar., Ars., Art-v., Bell., Bufo, Camph., Canth., *Caust.*, *Cham.*, j Cina. Cocc.. Colch.. Cupr.. Gels.. Glon.. Hyos.. Lyss.. Oena. •

Differentiation between important homeopathic remedies

Important remedies: *Arsenicum album*,

Artemisia vulgaris, *Belladonna*, *Bufo*, *Calcarea carbonica*, *Causticum*, *Cicuta virosa*, *Cuprum metallicum*, *Hyoscyamus*, *Nux vomica*, *Opium*, *Plumbum*, *Stramonium*.

Arsenicum album: dizziness before an epileptic seizure. Pressure pain at the back of the head between epileptic seizures. Seizures followed by stupor, interrupted by restlessness. A feeling of burning heat throughout the body before seizures. Sensation of warm air before seizures; this travels along the spine up to the head. Vertigo, loss of consciousness, falling.

Artemisia vulgaris: Very surly, irritable, despondent during the day preceding a seizure at night. Epilepsy follows shock and other violent emotions. Several convulsions in quick succession followed by a longer period of calm. Loss of sensitivity after the seizure. The left pupil is more dilated than the right. The mouth is pulled to the left. Patient bites his tongue during the seizures. Petit mal:

14.2 Epilepsy

the patient is only unconscious for a few seconds or minutes and afterwards continues what he was doing as if nothing unusual had happened.

Belladonna: new cases of epilepsy with marked cerebral symptoms. Feeling of formication in the muscles before seizures, as if a mouse is running over one extremity; or a feeling of heat rising from the stomach; or visual/auditory misperceptions. The convulsions begin in the upper extremities and spread to the mouth, face and eyes. Cramps in the larynx and throat with typical closure of the throat during the seizure. Epilepsy: the patient grasps wildly at this throat; his eyes roll back in his head, he froths at the mouth; seizure triggered by shock. Convulsions recur at the slightest touch.

Bufo: the aura begins in the sexual organs or the solar plexus. Epilepsy historically believed to be from masturbation. Patient ejaculates early, without sensation of pleasure, sometimes with cramps or painful heaviness in the limbs. Epileptic aura from the uterus to the stomach. The seizures begin while the patient is asleep, followed by severe pain and upwards pressure in the head. During the seizure, the patients face is drenched in sweat. First the head is drawn to one side, either right or left, later backwards, before a seizure. Seizures prefaced by a feeling of numbness in the brain. Falls to the ground unconscious with a wild, blood-curdling scream, followed by convulsions of the limbs; distorted facial muscles, teeth grinding and foam around the mouth; ends in a loud, snoring sleep. Compression in the back of the head and neck stiffness before the seizure.

Calcarea carbonica: the aura may begin in the solar plexus and spread upwards or downwards into the uterus and legs. In some cases an aura as if a mouse were running up the patients arm. Sudden attacks of dizziness, loss of consciousness without convulsions; pharyngeal cramps followed by need to swallow; petit mal. Causation: annoyance; shock; masturbation; long periods of undulating fever; suppression of chronic skin rash. Fears for his recovery during the pauses between seizures; thinking becomes difficult or the patient seems to sink into complete idiocy.

Causticum: hysterical epilepsy during puberty, in connection with irregular menstruation. Convulsions with cries, teeth grinding and violent movements of the limbs, with feverish heat and cold hands and feet. Epileptic seizure: after shock; during puberty; at new moon; with involuntary urination, scanty menstruation and leucorrhoea in scrofulous patients; after suppressing rashes; with softening of the brain; from drinking cold water; as soon as a sensation of pressure is felt in the stomach. Petit mal, sudden loss of consciousness in the fresh air; however, the patient recovers quickly. Nocturnal epilepsy with involuntary urination. Convulsions, particularly on the right side, with head pulled to the right.

Cicuta virosa: concussion and its long-term consequences, particularly seizures. Congestion of the base of the brain and medulla oblongata. The patient first becomes rigid, opisthotonus or emprosthotonus with vacant, staring eyes, bluish face and foam around the mouth. Epileptic twitches and convulsions in children: with contortion of the upper extremities and head, bluish face, interrupted breathing, foam around the mouth; afterwards lies there uncomprehending, as if dead and devoid of feeling. Exceptionally violent convulsions, tonic and clonic and sustained distortion of the extremities; seizure followed by extreme exhaustion. Convulsions caused by worms; some cases of puerperal convulsions with unconsciousness, particularly after emotional swings.

Cuprum metallicum: nocturnal epilepsy, or when seizures occur at regular intervals (menstruation) and begin with a sudden cry; unconsciousness; loss of feeling, the body is thrown forwards and upwards; cold hands and feet; livid complexion; thumbs tucked inside the hands; attacks of asphyxia; frequent urination; cloudy urine; loud, penetrating cries; comprehension difficulties or stupor; convulsions in children during teething or from suppressing rashes. Convulsive seizures while asleep; fingers, hands and arms jerk backwards and inwards towards the body, feet also jerk backwards; patient opens her eyes and rolls them but soon closes them, mouth distorted. Spasms, particularly

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when they begin in the fingers and toes and spread throughout the body. Exceptionally violent convulsions, with pale or livid face, slow pulse (often a sign of weak heart muscle activity), cold hands and feet. The patient predicts the seizure.

Hyoscyamus niger: epilepsy; seizure preceded by vertigo, flashes in front of the eyes, ringing in the ears, feeling of hunger and gnawing in the heart cavity. During the seizure: purple face, staring eyes, cries, teeth grinding, involuntary urination, foam around the mouth. After the seizure: drowsiness, snoring; patient seems bloated and his skin seems dark. Epilepsy from worry, after mood swings; consequence of alcoholism.

Nux vomica: convulsions caused by digestive upset; begins with an aura in the epigastrium which spreads upwards. Spinal epilepsy with opisthotonus. Trembling or convulsive movements of the limbs. Pressure on the solar plexus triggers renewed seizures; in the fresh air.

Opium: seizures caused by shock. Nocturnal epilepsy, lengthy phase of stertorous breathing; deep, irregular breathing; cyanotic or red, bloated, distorted face. Torpid, comatose sleep, also snoring with mouth open, eyes open and rolled back, red, bloated face, hanging jaw; slow, heavy breathing which occasionally stops, pulse slow or suppressed,

twitching in the limbs, face and corners of the mouth. Attacks of asphyxia during convulsions.

Plumbum: heaviness in the legs (feels almost like paralysis) before the seizure: paralysis and lengthy period of sleep with snoring afterwards. Epilepsy: vertigo before the seizure; numb, heavy, swollen legs; after the seizure a lengthy feeling of idiocy in the head and a long period of sleep with snoring; no aura, but seizure may be preceded by sighing. After the seizure, the patient only regains consciousness slowly and is left with feelings of paralysis. Restless, hopeless and fearful during the seizures; depression during phases of remission.

Stramonium: epileptiform convulsions with retained consciousness; head movements, patient tosses head in all directions; during convulsions usually in rapid succession to the right; sustained rotating movement of the left arm; pain in the pit of the stomach; stubborn constipation; deep sleep with snoring; depressed, fear of death; need to be alone. Risus sardonicus. Patient tosses arms and legs, particularly arms; opens and closes the hands, frequent finger movements. Petit mal. Fixed stare for one or two minutes; appears to take no notice of things around him. Vertigo with sudden loss of consciousness, when reading or out walking in the fresh air. Throat constriction; pupils dilated during the seizure.

Case 14.2-1: Grand mal attack

Martin Bündner

Anamnesis

The 4-year-old child suffers from epilepsy with absences and frequent tonic-clonic grand mal seizures. The grand mal attacks begin with a cry; the boy then stretches his arms upwards or pulls them to his chest and falls to the ground. His eyes are staring and look to the right, left, upwards or straight ahead. He smacks his lips and dribbles. He foams at the mouth, turns pale, his lips turn blue and he stops breathing for about one to two minutes. Shortly before the end of the seizure, the child takes a deep breath. During the attack, small red spots appear on his upper body and abdomen. He

pulls up his legs or stretches one leg and pulls up the other. The muscles jerk during the clonic phase and his fists are closed. The child usually urinates involuntarily. After one seizure, he frequently falls asleep and goes straight into the next. The seizures are triggered by punishment, excitement and stress. They occur particularly often when he is falling asleep or waking up. Until now, the parents had sedated the child with diazepam (e.g. Valium*) during the grand mal seizures, but were dissatisfied with this treatment because it took so long to work and because of the frequent recurrences during the postictal phase.

Diagnosis

Epilepsy.

14.2 Epilepsy

Conventional treatment

Phenytoin (e.g. Dilantin*), valproic acid (e.g. Orfiril).

Homeopathic treatment

Repertorisation

SYNTHETIC REPERTORY

Generalities - convulsions, spasms - punishment, after

Generalities - convulsions, spasms - excitement, emotional, aggravated

Generalities - convulsions, spasms - cries, with

Generalities - convulsions, spasms - cyanosis, with

Differentiation between remedies

The only remaining remedy is *Cuprum metallicum*. The emotional symptoms are also reminiscent of *Ignatia*-, however, unlike *Cuprum metallicum* it does not cover all the symptoms and is therefore ruled out.

Prescription

1 drop *Cuprum metallicum* Q6, repeated several times if

Progress

The next time the child suffers a grand mal seizure, the parents give him *Cuprum metallicum*. The seizure subsides quickly after just one drop; no more has to be given. He does not have another seizure during the postictal phase. The few grand mal attacks which follow also progress in the same way. Diazepam no longer has to be given.

Evaluation

The homeopathic remedy worked better and more quickly than the conventionally prescribed chemical drug.

Critical commentary

The incident described recurred four times more; in each case, the child's condition improved quickly after being given *Cuprum metallicum*. With the long-term treatment (in this case with *Phosphorus* as the symptoms correspond), the child has recently had no more absences or grand mal seizures; anticonvulsants are no longer needed. At the time of going to print, the follow-up observation period was just under two and a half years

Case 14.2-2: Status epilepticus

Edacheril Scaria Rajendran

Anamnesis

A 9-year-old boy is admitted to the homeopathic hospital with frequent generalised epileptic seizures (day 1). Two days previously, his parents stopped all the conventional medication he had been receiving. He has suffered from generalised seizures since he was one month old, despite long-term allopathic treatment with the antiepileptic drug carbamazepine (e.g. Tegretol*); however, the seizures occurred more frequently while he was teething. Before receiving anticonvulsant treatment, he had seizures lasting two to five minutes almost every day; the medication was unable to suppress these completely. The child has had a hyperactive behavioural disorder since he was five and was diagnosed with autism when he was eight. The boy suddenly stops speaking, shows stereotypical behaviour

plays with lifeless objects. He also has severe caries and his urine stinks abominably.

Diagnoses

Status epilepticus with preceding diagnosis of epilepsy, ADHD, autism.

Diagnostic procedures

Laboratory

Routine blood and urine tests show no abnormalities.

Imaging procedures

Magnet resonance tomography of the brain: normal.

Conventional treatment

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Homeopathic treatment

The patient is also autistic and has ADHD. The current status epilepticus is seen as an acute expression of a deeply rooted disease, which is why the choice of remedy is based on the following repertorised constitutional symptoms:

Repertorisation

KENT'S REPERTORY*

Generalities - convulsions - dentition, during*

Teeth - caries, decayed, hollow - premature in children*

Urine - odour - offensive*

Nerves - convulsions - general - children, in**

Differentiation between remedies

The choice of *Kreosotum* is confirmed by the materia medica:

“Offensive urine. [...] Enuresis in the first part of the night. [...] Must hurry when desire comes to urinate.”

Prescription

Kreosotum 200C every two hours on day 1; from day 2 onwards, the remedy is given once a day.

Progress

On day 2, the patient's condition improves visibly; he has no more seizures during the day but still about 20 during

From day 3, he is given *Kreosotum* 200C 4 times a day. On day 4, the patient is recovering well; he is still having seizures in his sleep but they are shorter and milder. On day 5, the patient has about five seizures while he is asleep. *Kreosotum* is still being given 4 times a day. The patient continues to improve over time: he regains control of his bladder and the restlessness is not so marked. He starts playing again, says a few words, begins to obey his mother and react to his surroundings.

From day 19, he is given *Kreosotum* Q6, ten drops diluted in water three times a day. This dose leads to complete recovery.

Evaluation

The crisis triggered by the parents facilitated a rapid cure, also of the patient's chronic disorders.

Critical commentary

The author regards this acute problem as an exacerbation of a chronic condition and accordingly uses the patient's chronic symptoms to select the correct remedy. Under normal circumstances, the homeopathic treatment should begin while the patient is still being treated with anticonvulsants; these should be phased

14.3 Meningitis and encephalitis

Definition

- **Meningitis:** inflammation of the meninges, which can affect both the dura mater, the pia mater and the spinal meninges. Usually a combination of these is involved. There are various forms: bacterial (purulent and non-purulent) and non-bacterial (e.g. caused by protozoa, fungi or physical impact). The colonisation of the CSF space with bacteria frequently causes fulminant inflammatory reactions in the meninges and

brain tissue, leading to cerebral oedema. Other early complications may involve the blood vessels, with vascular reactions and thromboses

- **Encephalitis:** inflammation of the brain, which may affect the grey matter (polioencephalitis), white matter (leucoencephalitis) or the entire brain (panencephalitis). The meninges may also be involved (meningoencephalitis). Encephalitis can be caused by viruses, bacteria or fungi or occur as a reaction after vaccination; the aetiology is sometimes unclear. Herpes simplex encephalitis is a particularly serious form

Clinical information

Symptoms

Meningitis

- Main symptoms: severe acute or subacute headache with neck pain, photophobia and high fever
- General symptoms: meningeal syndrome (combination of symptoms caused by meningeal diseases, e.g. headaches, photosensitivity, opisthotonus, foetal position, positive Lasegue test, neck symptoms, Kernig's sign, vegetative disorders (e.g. bradycardia, vomiting), hyperpathia and possibly mental changes), fever, in some cases impaired consciousness, even coma, convulsions, papilloedema; in newborns, the symptoms are often unspecific, possibly bulging fontanelles and convulsions. The main complications are cerebral oedema, cerebral abscesses and sepsis; hydrocephalus is a late complication. If vascular complications occur, the patient may suffer focal neurological deficits such as impaired cranial nerve function, aphasia and hemiplegia. The patient may also develop severe septic symptoms with unstable circulation, ARDS (adult respiratory distress syndrome) and disseminated intravascular coagulation

Encephalitis

The main symptoms are sudden high fever, severe headache, neck pain, possibly meningeal syndrome, impaired consciousness progressing to coma in some cases, mental disorders (psychosis), sometimes cerebral focal deficits with monoplegia or hemiplegia, focal or generalised epileptic seizures and cranial nerve dysfunction; at a later stage possibly signs of increasing intracranial pressure, ultimately leading to death. After recovery, the patient may suffer from postencephalitic syndrome.

Diagnostic procedures

Meningitis

- **Lumbar puncture** for CSF testing and to provide evidence of pathogens in the CSF using Gram staining. Marked pleocytosis often present in cases of bacterial meningitis; glucose levels usually low in

- **cCT** to rule out purulent sinusitis or otitis as foci
- Checks and monitoring of all vital parameters and blood counts

Encephalitis

- **Lumbar puncture for CSF testing:** besides the usual clinical tests, lumbar puncture for testing cerebrospinal fluid (often marked pleocytosis and increase in protein levels; may be possible to find evidence of pathogens). Neutrophilia and leucocytosis in the blood
- **Electroencephalography:** for investigating general changes
- **Magnetic resonance imaging:** may provide early evidence of cerebral oedema
- Checks and monitoring of all vital parameters and blood counts
- In cases of herpes simplex encephalitis, the EEG will show temporal foci and the cerebral CT areas of cerebral hypodensity. The changes shown in the cCT and cMRT progress in a characteristic manner over time. The cerebrospinal fluid shows moderate pleocytosis, initially with marked levels of granulocyte cell components, and low to moderate increases in lactate concentration

Therapeutic crisis

Meningitis and encephalitis: both diseases are severe, and equally severe complications are common. Mortality rates are high even with specialised treatment; spontaneous mortality rates are also high depending on the pathogen. Recovery is quite often incomplete. Despite high doses of chemical medication, these diseases frequently have serious consequences, which means that adjuvant homeopathic treatment is necessary to optimise the success of the treatment.

Homeopathic treatment

Symptom selection

The choice of symptoms is the same for both diseases and encompasses all symptoms of the case concerned

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Repertorisation

KENT'S REPERTORY

Head - inflammation of brain

Aeon., Apis, Bell., Bry., Cadm., Camph., Canth., Cham., Cina, Con., Crot-h., Cupr., Glon., Hell., Hyos., Lach., Merc., Nux-v., Op., Par., Phos., Phys., Plb., Puls., Rhus-t., Stram., Sulph., Verat-v.

- of meninges

Aeon., Apis, Arg-n., Arn., Bell., Bry., Calc., Calc-p., Canth., Cina, Cocc., Cupr., Gels., Glon., Hell., Hippoz., Hyos., Kali-br., Lach., Merc., Nat-m., Op., Phos., Plb., Rhus-t., Sil., Stram., Sulph., Zinc.

- periosteum

Aur., Aur-m., Fl-ac., Kali-i., Led., Mang., Merc., Merc-c., Mez., Nit-ac., Phos., Ph-ac., Puls., Rhod., Rhus-t., Ruta, Sil., Staph.

- tuberculous

Aur., Aur-m., Fl-ac., Kali-i., Led., Mang., Merc., Merc-c., Mez., Nit-ac., Phos., Ph-ac., Puls., Rhod., Rhus-t., Ruta, Sil., Staph.

Back - opisthotonus

Absin., Aeon., Agar., Amyg., Apis, Ars., Bell., Berb., Both., Brach., Bry., Calc-p., Camph., Canth., Carb-an., Cham., Chen-a., Cic., Cina, Cor-r., Cupr., Cupr-ar., Dig., Hyos., Hyper., Ign., Ip., Lach., Led., Med., Morph., Nat-s., Nux-v., Oena., Op., Petr., Phos., Phyt., Plat., Plb., Rhus-t., Sec., Stann., Stram., Stry., Tab., Ter., Verat-v., Zinc.

Mind - shrieking - brain cry

Apis, Am., Ars., Bell., Carb-ac., Cic., Cupr., Dig., Dulc., Glon., Hell., Hyos., Kali-i., Lyc., Merc-c., Phos., Rhus-t., Sol-n., Stram., Verat-v.

Differentiation between important

homeopathic remedies t Important remedies:

Apis, Belladonna, Cicuta virosa, Helleborus, Hyoscyamus,

Stramonium

Apis: meningitis from suppression or spread of erysipelas or any other skin rash; meningitis infantum, loss of consciousness and delirium, isolated sharp, shrill cries while asleep or when waking up, dilated pupils, puts hands behind ears when crying out; cri encephalique; sleeps with eyes wide open; initial stages of the disease: the patient bores his head backwards into the pillow and rolls it from side to side; trembling limbs; one side of the body trembles, the other is paralysed; no evidence of sight when light is brought close to the eyes; no evidence

of hearing; makes no effort to swallow if water is placed in his mouth; apathy, unconsciousness, stupor, delirious murmuring, hardness of hearing and inability to stretch out the tongue (in cases of typhus), exhaustion.

Belladonna: meningitis and encephalitis, first stage; patient starts, tosses and turns, bores his head into the pillow and tries to stretch his body backwards; violent burning and stabbing in the head; red, protruding, staring, shiny eyes; wild, threatening stare; drowsiness with rolling, half-open eyes; rush of blood to the head; pulsation of the cerebral arteries and throbbing inside the head; violent throbbing of the blood vessels in the neck; patient lies there insensible, unconscious; mute, murmuring; painful jerking, cramps and convulsions of the arms and hands; cramp-like constriction and painful narrowing of the throat; also impossible to swallow even the smallest amount; involuntary defecation resulting from paralysis of the anal sphincter; involuntary urination from paralysis of the bladder neck; urination while in deep sleep; temporary blindness with headache; while teething; after exposure to cold, dry wind; tendency to bend the head backwards even before cramp-like retraction sets in because it eases the pain; wobbling the head or bending it backwards; convulsive movements of the face and mouth (which is pulled towards the ear).

Cicuta virosa: diseases of the brain following the suppression of skin rashes; concussion and its chronic consequences, particularly convulsions; convulsions are triggered when the patient moves his head towards his shoulder; heavy head, the back of the head is bored into the pillow, patient throws his limbs about convulsively; closed eyes; the eyes stare upwards when opened; head pulled back and bored into the pillow; opisthotonus; violent twitching and jerking throughout the head, arms, legs; convulsive twisting of the limbs; patient rolls his head from side to side, rolls his eyes, terrible facial expression, penetrating cries; pupils dilated and unresponsive; cramps in the neck muscles with inability to move the head after it has been turned in any direction; tonic contractions of the

throat muscles; jerks and convulsion with shrieks; convulsive twisting and jerking of the limbs; head starts and trembles, < from movement of the head, also isolated jerks like electric shocks, < from cold, > from rest and warmth.

Helleborus niger: acute meningitis, after exudation phase; almost no reaction; more or less complete paralysis; furrowed brow, the muscles contract into folds; automatic movements of head, arms and legs at regular intervals; eyes rolled upwards; the patient often puts a trembling hand to his head; rolls his head day and night, groans. Later stage: unconsciousness, the eyes no longer react to light; inflammation of the brain, with numbness; heat and heaviness in the head; patient bores his head into the pillow, the whole body trembles; cold fingers; < from thinking about the pain; the patient is too dazed to be roused; stiff neck, holds the head far back; pupils dilated and insensitive to light.

Hyosciamus: drowsiness, loss of consciousness, delirium, the patient talks about his household affairs; sings, murmurs, smiles, grasps at fluff and suddenly jerks backwards and forwards; red face with evasive gaze moving backwards and forwards; > from shaking the head or bending over; hydrocephalus with stupor; the head is shaken backwards and forwards, sloshing feeling in the head; cramps and convulsions of individual limbs and the

whole body with watery diarrhoea; unable to speak clearly; picks at the bedclothes and murmurs; sensation of surging in the brain as if from powerful throbbing of the arteries, with pressure in the forehead, worse after bending over; pressure at the top of the head and pulling sensation in the neck when turning the head; terrible teeth grinding; locked jaw; paralysis of the tongue; stiff neck muscles with tension, as if they were too short, when bending the head backwards; stiff arms and legs; epileptiform convulsions; hyperaesthesia of the skin, large pustules, brown spots on the skin.

Stramonium: almost natural sleep with twitching of the limbs, yawning, tossing and turning, absentminded or staring gaze on waking up; slow and shy, withdrawn or needs to escape, with cries; the patient bites the people holding him; occasionally articulates words with no context; the head is bent forward rather than backward (or vice versa); loud cries, frequent and deafening; patient occasionally raises his hands to his head and hits it; trismus with great difficulty in swallowing even fluids; frequently twists the torso; requires light, or bright light and shiny objects cause convulsions; vomiting, the patient merely raises his head from the pillow; urine suppressed; ultimately stupor in which the patient perceives nothing more.

Case 14.3-1: Herpes encephalitis and herpes pneumonia with subsequent multiple thromboses.

Martin Bündner

Anamnesis

A 28-year-old patient diagnosed with Hodgkins disease is admitted to hospital for high-dose chemotherapy followed by autologous stem cell transplantation as part of a study. Five days after the transplant, the patient, who has neutrophilic granulocytopenia, develops marked mucositis with sub- febrile temperatures; he is given high-dose antimicrobial and antiviral treatment with aciclovir (e.g. Zovirax®). After a brief period of

patient becomes increasingly confused and delirious with recurrent convulsions, during which he loses consciousness. As he is suspected to have viral encephalitis and pneumonia, treatment with fos- carnit (e.g. Foscavir*) and immunoglobulin G + whole plasma protein (e.g. Octagam®) begins on day 1. Despite maximum conventional treatment, his condition worsens and ultimately becomes lifethreatening. It is difficult to establish the symptoms required for the adjuvant homeopathic treatment, as the intensive medical treatment causes changes in how the symptoms (e.g. fever, convulsions) manifest. After about one hour of observation, the following symptoms are recorded together with those in the hospital case notes: the pupils are relatively

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dilated. The patient seems to have difficulty concentrating; he also seems dull. He replies to questions, but not always with the right answer. Before the stem cell transplant, the patients girlfriend ended their relationship; this upset him badly.

Diagnoses

HHV-6 encephalitis. HHV-6 pneumonia. Thromboses of both internal jugular veins, subclavian vein (left), both brachiocephalic veins and superior vena cava with suspected heparin-induced thrombocytopenia (HIT). Prior diagnosis of Hodgkins disease.

Diagnostic procedures

Findings on admission (before stem cell transplant)

Cervical and axillary lymph nodes.

Laboratory

CSF virology (day 1): HHV-6 clearly positive, variation B.

Day 3: CSF tests for HHV-6 negative, no genomes now found in the PCR in patients blood.

HIT test negative.

Imaging procedures

Chest x-ray in supine position (day 2): discrete infrahilar linear markings on both sides. Early stages of infiltration cannot be ruled out.

MRT of cranium, native and CA, MR angiogram of cranium (day 2): extensive disruptions to diffusion on both sides in the caudate nucleus, putamen internal capsule, from the basal area to the temporal lobes and parasagittal in the frontal lobes. Otherwise normal. Findings consistent with herpes encephalitis. Day 6: discrete progress of the findings consistent with herpes encephalitis.

MRI of cranium and head (day 21): thrombotic occlusion of the left vena jugularis on the caudal side of the jugular foramen. Narrow, thinned transverse sinus on the left (medial region), most likely as part of flow phenomenon in normally perfused blood vessels in the distal regions. However, the possibility of partial parietal thrombosis in the medial sections of the left transverse

Findings of morphological imaging consistent with herpes encephalitis with evidence of remitting oedema in the limbic system with contrast enhancement (now moderate) in the area of the basal ganglia.

Angio CT of the throat, V. cava and pelvis (day 16): bilateral thromboses in the internal jugular vein, covering a lengthier area on the left side beginning on the distal side of the jugular foramen. Intraluminal thromboses in the left subclavian vein. Thromboses in the brachiocephalic veins and the superior vena cava. Collateral circulation in the left flank. New pleural effusions on both sides. Reactively enlarged lymph nodes in the mediastinum. Marginally enlarged periaortic lymph nodes. Extensive inflammatory swelling of the subcutaneous fatty tissue in the right flank and the posterior serratus muscles with evidence of large proportions of fluid.

Conventional treatment

Chemotherapy. Treatment with Foscavir[®] and Octagam[®]. Refludan^{*} (afterwards Arixtra[®]) after full-dose heparinisation.

Homeopathic treatment

Repertorisation

	KENT'S REPERTORY
Head - inflammation of brain	
Generalities - convulsions - consciousness, without	
Chest - inflammation - lungs - loss of consciousness, with	
Mind - answers - irrelevantly	
Mind - dullness, sluggishness - difficulty of thinking and comprehending	
Eyes - pupils - dilated	

Differentiation between remedies

The remedies which come under close consideration are *Hyoscyamus*, *Phosphorus* and *Sulphur*. Taking the possible reason for the patients weakness into account (the broken relationship) eliminates *Sulphur* ("Mind - love - ailments, from disappointed"). *Hyoscyamus* is a characteristic remedy for this situation and is therefore

14.4 Disc prolapse

Prescription

1 dose of 3 globules *Hyoscyamus* 30C (at night, on day 8).

Progress

The administration of *Hyoscyamus* constitutes a turning point in the patients treatment; his condition improves remarkably from this time on. He has no more convulsions; his mental state gradually returns to normal. He is given *Hyoscyamus* Q3 on day 9 and continues treatment with this remedy, increasing the potency gradually to Q33.

However, after carelessness on the part of his relatives leaves him without *Hyoscyamus* for two days, he suffers multiple thromboses with swelling of the face, right upper arm and right side of the chest on day 16. He still has a pleural effusion. The patient is restless; he wants to get up and go home. He falls out of the chair in which he is sitting. He speaks slowly, with consideration. The symptoms are still characteristic of *Hyoscyamus*, which is now administered in the next highest potency. At the same time, the heparin treatment is stopped and substituted with lepirudin (e.g. Refludan*); this is subsequently changed for fondaparinux (e.g. Arixtra*) and the patient is mobilised.

He is transferred to a general ward on day 19 and finally discharged on day 36.

Evaluation

The homeopathic remedy was instrumental in bringing about a turning point in the recovery of this patient, whose prognosis had previously been unfavourable.

Despite full-dose heparinisation, the patient develops multiple thromboses after nearly one month in hospital (after the stem cell transplant) being treated for the herpes infection. The doctors assume he has HIT, even though the HIT test was negative. It is open to debate how far the suspension of the homeopathic remedy over two days affected the patients recovery. Unfortunately, precise evaluation is impossible, since the conventional treatment was also changed.

Critical commentary

The value of a test is called into doubt when it is deemed positive even though the results were negative. Or a role was played by other factors, which had previously not been accorded sufficient weight (see Evaluation).

14.4 Disc prolapse

Definition

A disc prolapse (slipped disc, spinal disc herniation) involves the protrusion of tissue from the disc's nucleus pulposus through tears in the annulus fibrosus.

There are various degrees of severity:

- **Protrusion** with bulging of the annulus fibrosus
- **Prolapse** (herniation) into the intervertebral foramen or (more rarely) into the spinal canal following perforation of the posterior longitudinal ligament
- **Sequestration**: the prolapsed parts (sequesters) are no longer connected to the disc

Disc prolapses most often occur between L₄—L₅, L₅—S₁ and C₆—C₇.

Clinical information

Symptoms

The main clinical symptoms largely depend on the trauma-induced lesion. The acute symptoms are often caused by mechanical stress, due in particular to compression of the spinal nerve roots (radicular compression syndrome). The lesion manifests in different ways depending on the location of the damage:

- **Sciatica**: pain radiates from the groin into the affected leg as far as the foot; the patient adopts a typical protective posture, bending the leg slightly and rotating it outwards; the spine is painful when tapped or pressed in the area affected, the muscles are tense, the Valleix points are painful when pressed, the patients sensitivity is impaired in the affected leg; the toe muscles may be paralysed; the Achilles tendon

14 Neurological emergencies

Lasegue and Moutard-Martin signs, frequently minor signs, reflective scoliosis, pain on dorsal flexion of the foot, on bending and flexing the big toe when the leg is extended or on turning the leg inwards

- **Conus medullaris syndrome:** paralysis of the bladder, the external anal sphincter, erectile dysfunction, gluteal muscle paralysis (no gluteal reflex) and possibly (dissociated) impaired sensitivity in S1-S5 (so-called saddle anaesthesia)
- **Cauda equina syndrome:** flaccid paralysis occurring after a lesion of the cauda equina. Involves pain and impaired sensitivity in the lower extremities and frequently also problems with the bladder and rectum. The clinical symptoms depend on the segment in which the damage occurred
- **Cervicobrachial syndrome** (shoulder-arm syndrome, cervical syndrome): this is a collective term for sensory, motor, vegetative and trophic disorders involving the neck, shoulders and upper extremities

General symptoms include paraesthesia, pain and sensory problems in the dermatome affected, weakening of the reference muscle reflexes, possibly paralysis and muscle atrophy, restricted spinal movement and the adoption of a protective posture to avoid pain. The symptoms may progress as far as paraplegia depending on the degree to which the spinal medulla is compressed.

Diagnostic procedures

Imaging procedures with:

- Native x-ray diagnosis
- Spinal CT
- Myelography
- Spinal MRT if the location of the lesion is unclear

Therapeutic crisis

Therapeutic problems include irreversible pressure damage to the nerve roots (so-called nerve death) and paraplegia, the prognosis of which is unfavourable if it lasts for > 24 hours. Homeopathic treatment can help prevent these complications and bring about a marked improvement in even the severest pain and immobility.

Homeopathic treatment

Symptom selection

Along with the cause, the other pain modalities will lead to the correct homeopathic remedy.

Repertorisation _____ KENT'S REPERTORY

Extremities - numbness

Aeon., Agar., Alum., Arg-n., Ars., Ars-h., Bar-c., Cact., Camph., Caps., Carb-ac., Carb-s., Carl., Caust., Crot-c., Hep., Hipp., Hydr-ac., Ign., Kali-ar., Kali-c., Lach., Laur., Lyc., Mez., Nux-v., Phos., Ph-ac., Plb., Psor., Puls., Rhod., Rhus-t., Sabad., Sec., Stram., Stry., Tarent., Teucr., Verat., Zinc.

Extremitäten - numbness - tingling

Abrot., Aeon., Agar., Ail., Alum., Ambr., Ant-t., Apis, Arg-m, Arg-n., Arn., Ars., Ars-h, Aster., Atro., Aur., Bar-m., Bell., Bry, Bufo, Calc., Calc-p., Calc-s., Camph., Cann-i., Cann-s., Canth., Carb-an., Carb-v., Carb-ac., Carb-o, Carbn-s., Carl., Caust., Cedr., Cham., Chel., Chin., Chin-ar., Chin-s., Cic., Cocc., Con., Crot-c., Crot-h., Cupr., Cupr-ar., Dulc., Eup-pur., Fago., Fl-ac., Gels., Graph., Guai., Ham., Hyos., Hyper., Ign., Iod., Kali-ar., Kali-c., Kali-p., Kali-s., Kalm., Kreos., Lact., Laur., Led., Lyc., Merc., Mez., Naja, Nat-m., Nat-p., Nat-s., Nit-ac., Nux-m., Nux-v., Oena., Onos., Op., Ox-ac., Paeon., Petr., Phos., Phys., Plat., Plb., Psor., Puls., Rhod., Rhus-t., Sarr., Sec, Sep., Sil., Stram., Sulph., Tab, Tarent., Tax, Ter, Thea, Thuj, Valer, Verat, Vip, Xan, Zinc.

Extremities - tingling, prickling, asleep

Aeon, Alumn., Alum., Ambr., Anac., Arg-n, Arn., Ars, Atro, Bell, Camph, Carb-an., Carb-v., Carb-o, Carbn-s., Con, Cupr., Gels, Graph, Ign., Kali-bi, Kali-c., Kreos, Lach, Led., Lyc, Merc., Morph, Nat-m., Op, Ox-ac, Petr, Phos, Ph-ac., Plb, Psor, Puls, Rhod., Rhus-t, Sec., Sep., Sil, Stram., Stry, Sulph., Sumb, Tanac, Tep, Teucr, Thuj, Verat., Verat-v, Zinc.

Differentiation between important homeopathic remedies

Important remedies: *Arnica, Bryonia,*

Lachesis, Ledum palustre, Pulsatilla, Rhus toxicodendron.

Arnica: from overexertion; burning, stabbing, tearing pain; feeling of numbness and exhaustion in the affected limb; tingling; patient feels paralysed, has to change position often, the bed or chair feel too hard.

Bryonia: sciatica: pain < in the afternoon, when sitting up, moving and late in the evening; patient

14.4 Disc prolapse

prefers to lie on the painful side; frequently < in cold water.

Lachesis: the pain wanders continually from one place to another, sometimes in the head, sometimes in the teeth, sometimes in the sciatic nerve, together with nervousness, palpitations; fiery burning in the hypogastrium, loins and behind the sternum; ischialgia (right) with unbearable shooting pains extending from the left hip down to the foot, followed by a feeling of intense heat as if from a hot iron in the parts affected, subsequently outbreaks of sweating and general weakness, the pain forces the patient to cry out, < with increasing movement. **Ledum palustre:** the pain runs from the foot upwards; pinching, pulling pain in one or the other hip joint extending downwards via the back of the thigh, together with a feeling of muscle contraction; the limb affected is colder than the rest of the body; pain < on getting warm in bed and on touch; the left side is worse affected with weakness and heaviness; the pain is followed by swelling of the feet and limbs; extreme sensitivity of the soles of the feet.

Pulsatilla: dragging pain, < in the evening and at night. Ischialgia: pain < in the evening and at night with tendency to keep changing position; < in warm room; > in the open air; ischialgia on the left side, cannot keep still although movement <; the < the pain, the < the chills.

Rhus toxicodendron: particularly when the disorder was caused by overstrain or exposure to damp; stabbing, burning, tearing pain with a sensation of coldness and numbness, tingling and paralytic stiffness in the leg, < at rest and when starting to move, movement > for just a short time, < in the fresh air, > in dry heat; severe tearing, burning pain starting in the right buttock, following the route taken by the sciatic nerve and extending to the thigh, knee and whole leg; this pain generally occurs at night, getting worse from minute to minute until the patient is forced to get up and walk around, which > the pain.

Case 14.4-1: Cervical disc prolapse

Martin Bündner

Anamnesis

The 38-year-old patient comes for treatment of an acute cervical disc prolapse, which is soon to be operated on. She would like to avoid the operation. Because of the pain, the patient is terrified of having a stroke. She has pain in her neck radiating into both shoulders and at times into both arms, the left side being worse. The pain is almost unbearable and increases when she is speaking or lying on her back. Recurrent nausea and vomiting. Vertigo with tendency to stagger to the left; tinnitus on both sides, worse on the left.

Diagnosis

Acute disc prolapse in the cervical spine

Diagnostic procedures

Imaging procedures

MRI of the cervical spine: osteochondrosis C5/6 with small paramedical subligamentous disc prolapse to the right with impression of the dural sac but not of the cord.

Neurological consultation

Painful tension in the shoulder and neck muscles on both sides; Lasegue sign slightly positive on the left. Pallanaesthesia (impaired sensitivity to vibration) in the region of the lateral malleolus on both sides 7/8. Cranial nerves: subjective hyperacusis on the left.

Conventional treatment

Surgical treatment scheduled.

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Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - fear - apoplexy, of

Hearing - acute

Generalities - side - left

Back - pain - cervical region - extending to shoulders

Generalities - speech aggravated

Generalities - lying - back, on, aggravated

Differentiation between remedies

The repertorisation process leads to *Phosphorus*. *Lachesis* and *Thuja* are also possible; however, the local modalities eliminate both remedies.

Progress

The pain subsides a little right after taking the first dose of *Phosphorus*-, over the next few days, it subsides so much that the patient cancels the operation after consulting her orthopaedic specialist. The fear, nausea, dizziness and tinnitus also disappear rapidly.

Evaluation

The homeopathic treatment rapidly cured the symptoms of the cervical disc prolapse.

Critical commentary

Six years later, the disc prolapse recurs; this time the patient is operated on immediately rather than undergoing homeopathic treatment.

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15 Psychiatric emergencies

Martin Bundner (conventional medicine, homeopathy)

15.1 Delirium

15.2 Agitation

General

Every psychiatric emergency must follow a basic procedure which, like somatic emergencies, should involve a case history, a third-party anamnesis and a physical examination (vital parameters, internal and neurological tests). Emergency psychiatric testing should include psychopathological findings encompassing the following elements:

- External appearance, behaviour and expression
- State of consciousness and orientation including attention and concentration
- Energy levels and psychomotor skills
- Cognitive functions (e.g. comprehension, memory)
- Formal thinking
- Psychotic symptoms (delusions, hallucinations, misinterpretations etc.)
- Mood
- Suicidality

I General legal aspects of psychiatric emergencies

In cases of psychiatric emergency, the patient is frequently in a condition which does not allow him to act according to his own free will. In such cases, the patient can be admitted to a psychiatric clinic against his will on the grounds of exculpatory emergency without the need for a warrant or legal decree. Admission as an in-patient as per the German Hospitalisation Act (UBG) is possible anywhere in Germany subject to the following conditions:

- Presence of a psychiatric disease.
- The disease means that the patient poses a considerable risk to himself or others.
- This risk cannot be averted in any other way.
- (The hospital must be authorised to admit patients as per the Hospitalisation Act. These are usually psychiatric hospitals with a duty of mandatory care for the region.)

If the patient resists compulsory hospitalisation, the police must be called to support the implementation of this measure.

15.1 Delirium

Definition

Delirium is a collective term for organic psychoses which manifest with an acute impairment of cognitive functioning. It therefore also includes the conditions known as “confusion” and “twilight state”.

Clinical information

Symptoms

- Impaired comprehension, attention and consciousness
- Impaired memory and orientation; incoherent thinking
- Perception disorders (illusions, visual and auditory hallucinations, temporary delusions) and affective disorders
- Psychomotor disorders (e.g. hypoactivity, physical restlessness, extended reaction times)
- Evidence of an organic cause
- Disturbed sleep patterns
- Sudden onset and fluctuating development through to coma and death
- Withdrawal delirium: tremor, impaired blood pressure regulation, hyperhidrosis, tachycardia, convulsions

Diagnosis

The organic cause of the acutely impaired cerebral function must be found. Possible organic diseases: • Withdrawal syndromes: alcohol, sedatives, hypnotic drugs

- Brain diseases: craniocerebral trauma, epilepsy, vascular or inflammatory processes
- Intoxication with cocaine, hallucinogenic drugs and other drugs
- Extracerebral causes: infectious diseases, dehydration, metabolic disorders, surgery etc
- Exogenous toxic causes: medical drugs (e.g. anticholinergic substances such as anti-Parkinson drugs or antidepressants)

The common, often severe alcohol withdrawal delirium

*** Note:** delirium may have more than just one cause (e.g. alcohol withdrawal delirium: alcohol withdrawal and subdural haematoma).

Therapeutic crisis

The patient is at risk in various ways:

- Physical risk through to coma and death from cardiovascular failure
- Problems which may arise from the underlying disease
- Problems caused by the psychopathological symptoms (e.g. disorientation with a tendency to wander off)
- Concomitant vegetative or metabolic disorders

These complications can be minimised or even prevented with adjuvant homeopathic treatment.

Homeopathic treatment

Symptom selection

It is important to establish the current mental, psychological and vegetative symptoms. The disease underlying the delirium and its symptoms must be recorded either while it is being treated (e.g. infectious

Repertorisation

KENT'S REPERTORY

Mind - delirium

Absin., Acet-ac., Aeon., Act-sp., Aesc., Aeth., Agar., Ail, Am- c., Anac., Anat., Anthr., Ant-c., Ant-t., Apis, Arg-m., Arg-n., Arn., Ars., Arum-t., Aur., Bapt., Bar-c., Bell., Bism., Bry, Bufo, Cact., Calad., Calc., Camph., Cann-i., Cann-s., Canth., Caps., Carb-v., Carb-ac., Carbn-s., Cham., Chel, Chin, Chin- ar, Chin-s, Chlol, Cic., Cimic, Cina, Clem, Coff, Colch., Coloc, Con., Cop, Cor-r, Crot-c., Crot-h., Cupr., Dig., Dor, Dulc., Gels., Glon, Graph, Hell, Hep, Hipp, Hyos, Hyper, Ign, Ip., Jatr, Iod, Kali-ar, Kali-br, Kali-c, Kali-n, Kali-p, Lach, Lachn, Lact, Lil-t, Lob, Lyc, Lyss, Meli., Meny, Meri, Merc., Merc-cy., Mez, Mur-ac, Mygal, Naja, Nat-m, Nit-ac, Nux-m., Nux-v., Oena., Op, Ox-ac, Par, Petr., Phos., Ph-ac, Phyt, Plat, Plb, Podo, Psor, Puls., Ran-b, Ran-s, Rheum, Rhod, Rhus-t, Sabad, Sabin, Sal-ac, Samb, San, Sec, Sil, Sol-n, Stram, Stry, Sulph., Sulph-ac, Tab, Tarent, Tarax, Tax, Ter., Thea, Valer, Verat, Verat-v, Vesp, Vip, Zinc.

Differentiation between important homeopathic remedies

i Important remedies: *Arsenicum album*, *Belladonna*, *Hyoscyamus*, *Lachesis*, *Lycopodium*, *Opium*, *Stramonium*, *Veratrum album*.

Arsenicum album: slow-developing cases of mild delirium; great restlessness and anxiety. In her delirium, the patient thinks she is well. With deep depression. During fever, with unconsciousness; with mania, with a desire to be held; with raging headache.

Belladonna: severe delirium with fear of imaginary things; attempts to flee from them. Patient destroys everything around him, bites and spits. Delirium, particularly at night; with vacant stare; talks nonsense about dogs, wolves, bulls, war and soldiers. Sees fire and similar. Intense delirium; bursts into laughter, grinds teeth and tries to bite the people standing around him.

Hyoscyamus: physical restlessness. Does not stay in bed; moves from one place to another. Extreme liveliness, restlessness, hurry. Patient responds correctly when spoken to but immediately falls back into delirium and loses consciousness. Delirium lasts for as long as the patient is awake; he talks about business and complains about imaginary things. Indistinct, murmuring chatter; excessive bustle. Patient gets undressed, lies naked in bed and chatters. Afraid of being sold or poisoned. Fear of being left alone, betrayed or injured; wants to run away. Patient complains and twitches nervously but can be calmed quickly. Delirium tremens with clonic

cramps, unconsciousness and aversion to light and society.

Lachesis: delirium; patient believes he is damned for all eternity because God in his mercy decided this way. Delirium, at night; chatters a lot when feverish, in the evening. Delirium during the night; murmuring; red, sleepy face; with hanging jaw. Highly talkative, jumps from one topic to another. Delirium after being awake too long, overtiredness, loss of bodily fluids. Afraid of death; afraid to lie down because he believes he could have a seizure and die. Believes he is dead. Stupor with murmuring.

Lycopodium: drowsiness, delirium. Patient can talk lucidly about higher, even abstract things but becomes confused when talking about everyday matters.

Opium: mild or raging delirium with loud talking, laughter. Patient tries to run away. Angry muttering, with red shiny eyes and considerable physical activity. Thinks parts of his body are very large. Believes he is not at home.

Stramonium: delirium with chatter. Singing, whistling and laughter. Constant, involuntary, clumsy movements of body and limbs. All objects appear to be crooked. Delirium with very graceful movements. The patient is aware of his mentally abnormal condition. Melancholy, also with desire for company, light and sunshine; darkness and being alone make his condition worse.

Veratrum album: religious or uplifted delirium; heavy, stupefied sleep; restless, thirsty, cramps in the legs, cold sweat, tingling, irregular pulse. Lecherous, lewd words and deeds. Anxious and fearful of imaginary things.

15 Psychiatric emergencies

Case 15.1-1: Delirium of unclear origin

Martin Bundner

Anamnesis

In the evening, the 35-year-old patient calls various friends, acquaintances and the police, begging for help and talking nonsense. When her brother arrives, she is running around the apartment naked and tries to run away. Later, she lies down naked on the bed but cannot fall asleep. She does not react to the doctors questions; she answers her brother briefly and incomprehensibly then closes her eyes again. Her pupils are dilated. No indication of the possible cause of the delirium can be found. Her relatives refuse to have her admitted to hospital and request the homeopathic treatment proposed as an alternative.

Diagnosis

Delirium of unclear origin

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - naked, wants to be

Mind - escape, attempts to

Differentiation between remedies

The remaining remedies are *Hyoscyamus* and *Stramonium*. However, the totality of symptoms (e.g. the delirium, which comes and goes in the early stages) seems to indicate *Stramonium*, which is why this remedy is chosen.

Prescription

5 drops *Stramonium* Q6 as needed.

Progress

The patient falls asleep just 5 minutes after taking the first dose of *Stramonium*. Her relatives are instructed to give her another dose of the remedy when she wakes up and to keep all doors and windows closed. *Stramonium* is given once more. The next morning, the patient is again herself. She can no longer remember the events of the previous evening.

Evaluation

The homeopathic treatment causes the delirium to subside rapidly.

Critical commentary

6 5.2 Agitation

Definition

Agitation manifests as abnormal levels of energy and impaired psychomotor function.

Clinical information

Symptoms

A significant degree of tension is visible from the patients gestures and facial expressions. Some patients are physically restless or talk loudly, sometimes also incomprehensibly. Subjectively, the patient may experience restlessness, fear, rage, irritability or delusional symptoms, or fall into a state of ecstasy or euphoria. The patient may become uninhibited, lose

violent and destructive. Depending on the aetiology, this state may last for varying periods - up to several days. The patient must be monitored at all times.

He may become a danger to himself or others:

- to himself with suicidal behaviour, disorientation, wandering about aimlessly
- to others with outbreaks of aggression

Diagnosis

Agitation is mainly diagnosed on the basis of the clinical picture. For purposes of differential diagnosis, the following causes must be considered:

- Organic causes
- Intoxication with alcohol or side-effects of drugs and

15.2 Agitation

- Physical diseases such as cerebral degeneration, seizure disorders, hypoglycaemia
- Schizophrenic or bipolar psychoses
- Personality disorders
- Acute stress reactions
- Panic attacks
- Mentally retarded patients in situations where they are offended or put under excess strain

Therapeutic crisis

Cases of acute agitation often present problems with compliance; it is easier to administer a homeopathic remedy than a chemical preparation in such situations.

Moreover, the symptoms are sometimes so severe that the normal dose of medication has to be exceeded. This may necessitate the hospitalisation and monitoring of patients who could otherwise be treated as outpatients. Malignant neuroleptic syndrome is rare, but feared. The correct homeopathic remedy also helps reduce these problems.

Homeopathic treatment

Symptom selection

The trigger must always be taken into consideration when choosing the most appropriate homeopathic remedy. The other mental or physical symptoms point the way to the remedy; if the cause is organic, the relevant symptoms should also be covered.

Repertorisation

Mind - rage, fury

Aeon., Aeth., Agar., Alumn., Anac., Ant-t, Arg-n., Arn., Ars., Bar-c., Bell., Bry., Bufo, Calc., Camph., Cann-i., Cann-s., Canth., Carbn-s., Cham., Chef, Chin., Chin-s., Cic., Cimic., Cina, Colch., Coloc., Cori-r., Croc., Crot-h., Cupr., Dig., Dros., Dulc., Fl-ac., Glon., Graph., Hell., Hep., Hyos., Hyper., Jatr., Kali-c., Lac-c., Lach., Lob., Lyc., Merc., Mosch., Nat-m., Nit- ac., Nux-m., Oena.,

SYNTHETIC...^

Mind - anger

Aeon., Act-sp., Aesc., Agar., Agn., AU-c., Aloe, Ambr., Am-c., Anac., Apis, Arg-m., Arg-n., Arn., Ars., Ars-i., Asar., Aster., Atro., Aur., Bar-c., Bar-m., Bell., Bry., Bufo, Cact, Calad., Calc., Calc-p., Calc-s., Cann-s., Canth., Caps., Carb-an., Carb-v., Carbn-s., Carl., Caust., Cham., Chel., Chin., Chin-ar., Chlor., Cimic., Cinnb., Clem., Cocc., Coff., Coloc., Con., Cop., Croc., Crot-t, Cur., Cycl., Cypr., Dig., Dros., Dulc., Elaps, Eupi., Ferr., Ferr-ar., Ferr-i., Ferr-p., Fl-ac., Gels., Gran., Graph., Ham., Hell., Hep., Hydr., Hyos., Ign., Ip., Iod., Kali-ar., Kali-c., Kali-n., Kali-p., Kali-s., Lach., Led., Lyc., Mag-s., Mang., Meph., Meri., Merc., Mez., Mosch., Mur-ac., Myric., Nat-ar., Nat-c., Nat-m., Nat-p., Nat-s., Nice., Nit-ac., Nux-m., Nux-v., Olnd., Op., Osm., Pall., Petr., Phos., Ph-ac., Plat., Psor., Puls., Ran-b., Rat., Rhus-t., Ruta, Sabad., Sang., Squil., Seneg., Sep., Sil., Spig., Stann., Staph., Stram., Stront., Sulph., Sulph-ac., Tarent., Tell., Thuj., Tril., Valer., Verat., Zinc.

Ailments following anger etc.

Aeon., Agar., Alum., Am-c., Ant-t, Apis, Arg-n., Arn., Ars., Aur., Aur-m., Bell., Bry., Cadm., Calc., Calc-p., Calc-s., Caust, Cham., Chin., Cimic., Cist, Cocc., Coff., Coloc., Croc., Cupr., Ferr., Ferr-p., Gels., Hyos., Ign., Ip., Kali-p., Lach., Lyc., Mag-c., Mag-m., Mane., Mez., Nat-c., Nat-m., Nat-p., Nat-s., Nux-m., Nux-v., Op., Petr., Phos., Ph-ac., Plat., Puls., Ran-b., Rhus-t., Samb., Sec., SeL, Sep., Sil., Stann., Staph., Stram., Sulph., Tarent., Verat., Zinc.

Differentiation between important homeopathic remedies

* **Important remedies:** *Aconitum, Chamomilla, Ignatia, Nux vomica, Staphisagria.*

Aconitum: great fear which cannot be assuaged. Agoraphobia, fear of leaving the house, crossing the street (particularly narrow streets) or being in a crowd of people. Fear and worry about recovery. Patient talks about his fear of death and predicts the date of his death. Fear of the dark. Delayed consequences of shock and fear. Attacks of asphyxia with anxiety. Stitching and stabbing pain in the chest and sides of the chest, especially when breathing and coughing, often accompanied by a mood of tearful complaint, fear and fretfulness or constricted

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breathing. Miscarriage impending as the result of shock, with anxiety; circulation accelerated, fast breathing.

Chamomilla: patient feels as if his heart is being squeezed; he is beside himself with fear, whimpers and sweats profusely. Great excitement and excessive sensitivity of the nervous system. Sullen, irritable. Deep feeling of humiliation with stubborn, intolerable, extreme moods. Cantankerousness; patient focuses on all annoyances. Weeping at the slightest, possibly also imaginary insults, which may date from the distant past. Patient suspects that people have offended him.

Ignatia: afraid of trifles, particularly of objects coming closer to him. On waking up, after midnight, fear of thieves. Appears to sit in deep thought and stares ahead of him; however, he is not actually

thinking about anything at all. Prefers to be alone. Broods about imaginary problems. Restless sleep and great restlessness during the night.

Nux vomica: excessively sensitive to all external influences. Mental breakdown after insult. Patient dawdles and is undecided; he wants to do many things but believes they will all go wrong; constant indecision; clumsy, awkward behaviour, bumps himself easily or knocks things over.

Staphisagria: ailments following indignation and annoyance or from repressed anger. Great indignation about things which he or other people have done; worries about the consequences. Sullen and irritable all day; cannot let sources of annoyance go and is profoundly depressed. Great anxiety and fear of the

Case 15.2-1: Agitation

Martin Bundner

Anamnesis

A young married couple has an argument: the children dirtied the bathtub which the patient had cleaned thoroughly the night before; the husband, who was looking after the children at that time, did not see what they had done. The wife is furious about the dirt in the bathtub. She feels that her work is not recognised, and says so loudly. No explanation is accepted. She screams, abuses and insults her husband in front of the children. Finally she runs out of the house and only comes back some time later, when her husband should already be at work. She shuts herself away in the apartment, leaving her husband to look after the children. The patient starts the argument all over again and says that she is jealous of her husband's work. She says it is more important to him than she is. Another attempt to explain the situation ends with the patient telling the older child to destroy her husband's personal documents.

The conversation that night is brief and still filled with insults and abuse from the wife. She sleeps outside the

Rubric condensed

Next day, as her mood is unchanged, the husband

contacts the homeopathic doctor and asks for a

Differentiation between remedies

remedy to help her find her balance again.

Nux vomica and *Veratrum album* are present in all

Diagnosis (except for "Mind - jealousy - ailments from").

The patient's

Agitation

The patient's stormy, argumentative mood

Agitation

The patient's stormy, argumentative mood

_____ SYNTHETIC REPERTORY

Mind - disregard, contempt from others - ailments from

Mind - offence, insult, abuse - husband insults his wife in front of the children and vice versa

Mind - escape, desire to

Mind - malicious, vindictive

Mind - rage, fury

corresponds overall to *Nux vomica*; this remedy is consequently chosen.

Prescription

2 doses of 2 globules *Nux vomica* 30C.

Progress

The patient calms down after taking the homeopathic remedy. Her mood worsens towards the evening; she again becomes insulting and reproachful. She plans to sleep outside the marital bed again tonight. As her mood does not improve during the evening, she is again given

she relaxes once more. Next morning, the patient is calm and her mood remains stable throughout the day.

Evaluation

The patient could only be calmed by taking the homeopathic remedy.

Critical commentary

The fact that the patient responded quickly to the remedy on two occasions speaks against a spontaneous improvement.

The couple is still married.

Case 15.2-2: Acute exacerbated bipolar disorder

Martin Bundner

Anamnesis

The 44-year-old patient has bipolar disorder. At the time of the consultation, he is depressed. He feels unhappy, bleak and generally weak. He is afraid that something could happen to him, e.g. when travelling in a chairlift or driving through a tunnel, and is consequently barely able to do these things. He reports that he would like to stay lying down with his eyes closed, especially in the morning.

During the manic phase, a lot of ideas go through his brain simultaneously and he is unable to stop his thoughts. He feels as if he is being watched and is afraid that something could happen to his family. He describes himself as a good person and better than others. He interprets coincidences as signs from God, who uses them to guide him. His tongue is white and he has bad breath.

Diagnosis

Acute exacerbation of known bipolar disorder.

* ** Rubrics condensed

Differentiation between remedies

The repertorisation process leads to *Arsenicum album* and *Calcarea carbonica*. The fact that the patients depression is worse in the morning and the abundance of thoughts indicate *Calcarea carbonica*; this remedy is consequently chosen.

Prescription

1 dose of 2 drops *Calcarea carbonica* Q6, potencies increased over time.

Progress

Just two days after taking the *Calcarea carbonica*, the patient feels much stronger and less depressed; his tongue is no longer as white. On day 9, he no longer has any weakness or symptoms of depression; his tongue is becoming cleaner. Two and a half months later, his mood is still positive; he has recovered well from the bipolar depressive episode, his tongue is clean and the halitosis has disappeared.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - fear - happen, something, will

Mind - delusions - imagines that others will observe her*

Mind - delusions - watched, that she is being*

Mind - arrogant

Mind - mood - changeable, variable

Mind - fear - disease, of impending**

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Evaluation

The patient's condition subsided rapidly with no change in his medication.

Critical commentary

If only the patient's current mood of depression had

of a chronic disease with various mental components, the treatment would probably not have been successful.

Case 15.2-3: Psychological decompensation

Martin Bündner

Anamnesis

The 53-year-old patient comes to the clinic in tears and asks to speak to the doctor. She feels an internal trembling and vibration with nausea. She is appalled by an incident which took place before, and is also offended by a statement made by the person she was talking to previously.

Diagnosis

Psychological decompensation.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - indignation - bad effects following

Mind - mortification - ailments after

Differentiation between remedies

The repertorisation process finishes with *Nux vomica*, *Platinum metallicum* and *Staphisagria*. The patient's indignation is the key to the correct remedy in this case.

Prescription

1 dose of 2 globules *Staphisagria* 200C.

Progress

Immediately after taking the remedy, the patient stops crying and the internal trembling ceases. She calms down completely within the next five minutes.

Evaluation

Rapid improvement in response to the correct remedy.

Critical commentary

The patient showed no signs of calming down during the consultation, only after she had taken *Staphisagria*.

anxiety and rapid, often abrupt changes of mood. Paranoia and hallucinations with various forms of delusion (e.g. delusional jealousy, paranoia, delusions of reference), sensory delusions (e.g. voices which give commands or make comments) and depersonalisation (e.g. thought interference, thought withdrawal or thought insertion) occur frequently.

Catatonic syndromes are associated with impaired psychomotor skills. The patient's ability to establish contact and to communicate is significantly limited. In severe cases, the patient may be in a stupor, a state of motor torpidity with the inability to eat, drink or communicate verbally but which does not involve any impairment of consciousness.

15.3 Acute psychosis

Definition

Psychoses are mental disorders with structural changes in the patient's experience.

Clinical information

Symptoms

Patients with acute psychoses are no longer able to control reality. These conditions are associated with delusions, hallucinations, formal thought disorders (e.g. absentmindedness, blocking, derailment, pressure of speech), and problems with energy levels and psychomotor skills. Patients may also suffer from mood

15.3 Acute psychosis

Threatening situations may occur in states of acute psychosis:

- Acute suicidality
- Risk of endangering others, e.g. in the context of delusional misidentification
- Risk of endangering oneself arising directly from the psychosis (e.g. from imperative voices, misinterpretation of situations)
- In catatonic syndromes: sudden catatonic agitation, physical secondary complications caused by immobility and insufficient intake of food and drink, life-threatening febrile catatonia

Diagnosis

In preclinical terms, it is necessary to distinguish between organic and endogenous psychoses. The possibility of organic psychosis must be ruled out by means of differential diagnosis (e.g. anamnesis, CT, drug screening etc.).

Signs of organic psychosis

- Impaired consciousness, memory, attention and orientation
- Chronological connection with exposure to certain medication (e.g. corticosteroids, anti-Parkinson drugs, antiasthmatic drugs) or recreational drugs
- Optical hallucinations dominate
- Somatic findings correlating to severe cerebral or extracerebral diseases (e.g. metabolic or endocrine disorders, inflammatory, degenerative or traumatic brain diseases)

Endogenous psychosis is indicated in cases when the criteria for organic psychosis are not fulfilled.

Forms of endogenous psychosis

- Bipolar psychosis
- Schizophrenic psychosis
- Other psychotic states which are often only transient in nature (e.g. so-called psychotic episodes)

Therapeutic crisis

Along with the lengthy period of hospitalisation which

Homeopathic treatment helps the patient to find his way out of the psychosis more quickly and shortens the period he has to spend in hospital.

Moreover, the symptoms are sometimes so severe that the normal dose of medication has to be exceeded. This may necessitate the hospitalisation and monitoring of patients who could otherwise be treated as outpatients. Malignant neuroleptic syndrome is rare, but feared. The correct homeopathic remedy helps reduce these problems.

Homeopathic treatment

Symptom selection

The correct homeopathic remedy is determined in accordance with the symptoms of the acute psychosis; in cases of organic psychosis, somatic symptoms also occur and must also be considered.

Repertorisation

KENT'S REPERTORY.

Mind - delusions, imaginations, hallucinations, illusions Absin., Aeon., Aeth., Agar., Ambr., Anac., Anat., Ant-c., Apis, Arg-m., Arg-n., Ars., Ars-i., Aur., Aur-m., Bapt., Bar-c., Bell., Bry., Calc., Calc-s., Camph., Cann-i., Cann-s., Canth., Carban., Carb-v., Caust., Cench., Chin., Chin-ar., Cic., Cimic., Cina, Cocc., Coff., Colch., Con., Croc., Crot-h., Dulc., Elaps, Eup- pur., Fl-ac., Glon., Gran., Hell., Hura, Hyos., Ign., Iod., Kali- br., Kali-p., Lac-c., Lach., Led., Lyc., Lyss., Mag-m., Med., Merc., Mur-ac., Nat-p., Nit-ac., Nux-v., Op., Petr., Phos., Ph- ac., Plat., Plb., Psor., Puls., Rhus-t., Sabad., Samb., Sec., Sep., Sil., Spong., Stann., Staph., Stram., Sulph.,

Differentiation between important homeopathic remedies

Important remedies: *Argentum nitricum*.

Belladonna, Cannabis indica, Cocculus, Hyoscyamus, Ignatia, Lachesis, Petroleum, Sabadilla, Stramonium, Sulphur.

Argentum nitricum: unable to exert himself mentally or physically, patient feels like he has been robbed of all willpower; believes his family holds him in contempt and that everything he does is doomed to failure. Hypochondria with compulsive delusions; patient predicts the date of his death; fears that he cannot walk past a certain point in

15 Psychiatric emergencies

the street without suffering a seizure. Agoraphobia. Wakes his spouse so that he can talk to someone. Constantly in a hurry to meet his obligations; afraid of arriving late even if there is plenty of time. Thinks about suicide but does not have the courage to attempt it. Once ready, he worries about going to church or to the opera and develops diarrhoea. **Belladonna:** patient asks the people around him to kill him. Sometimes sits around half the day and breaks needles into pieces. Not in the mood to talk, or talks very quickly. Frenzy, in which the patient is often very cunning, shouts and sings, spits and bites. Believes he is seeing ghosts and various insects. Fearful madness; afraid of imaginary black dogs, the gallows, animals and terrible grimaces; tries to hide. Remembers things which were long forgotten. Performs foolish, ridiculous antics, with wild, vacant stare, sudden movements and jerks. Extremely irritable. Tears his clothing. Hits himself in the face with his fists.

Cannabis indica: countless hallucinations and fantasies. Mental agitation with constant chatter. Full of jokes and spite, patient laughs immoderately. Laughs about the smallest trifle; laughs indiscriminately at any word addressed to him. Disjointed speech, great absentmindedness. Unable to remember a thought or event because his memory is teeming with thoughts. Dimensions of time and space seem strongly magnified; seconds feel like an eternity, a few metres like an immense distance. Terrified of the dark. Agonising fear with severe anxiety; > outdoors. Cries and moans. Terrible fear of impending death. Constant fear of going mad. Voices, even one's own, seem to come from a great distance. Starts a sentence but cannot finish it because he forgets what he wanted to say or write. The patient sometimes feels as if he is someone else, as if he is in a dream and everything is unreal. Puerperal psychosis with visions and fantasies which do not frighten the patient.

Cocculus: despondency. Patient sits lost in sad thought and insults cut him deeply. Fear of heart problems and death. Fear as if the patient had committed a major crime and wants to run away from the consequences. The smallest trifle annoys him

to tears, during which his pupils are contracted; no appetite after crying. Mood swings. Cheerful, content, amusing; makes funny jokes (partly effect of healing). Time passes too quickly, and several hours seem like just one hour.

Hyoscyamus: acute mania, frenzy with remarkable excitement of the senses and highly unusual impulses. Impatience and extreme liveliness, restlessness, hurry. Reveals things that other people would have kept quiet about their whole lives. Tendency to laugh about everything. Lascivious shamelessness. Aimlessly roams long distances, wrapped in furs despite the summer heat. Rage, tries to insult and injure others. Mania; barely controllable. Insults, brawls, noisy. Has uncontrollable strength when he is angry. Everything seems larger, a straw looks like a tree trunk etc. Dullness, insensible apathy; patient lies there inert and uncomprehending; complete numbness and incomprehension. Feels no urges except for thirst; refuses to eat. Silent. Morose, sad, despairing. Afraid of being sold or poisoned. Fear of being left alone, betrayed or injured; wants to run away. Strange fear of being bitten by animals. Jealousy and strong increase in libido.

Ignatia: extreme mood swings; patient jokes and teases but then becomes tearful again. Sadness and silent grief, sighing, after disappointed love or humiliation. Prefers to be alone. Appears to sit in deep thought and stares ahead of him; however, he is not actually thinking about anything at all. Noise is intolerable; makes the pupils dilate more easily. Fear, as if patient had done something evil. Weeping, screaming, patient is beside himself about trifles. Fixed ideas, e.g. of music and melodies, in the evening, before and after lying down. Hides his worry and fantasies from others.

Lachesis: elevated mood; prone to strong emotional reactions. The patient believes he is someone else; in the hands of a higher power; he is dead and the preparations for his funeral have been made; believes he is being pursued by enemies or fears that the medication is poisonous; believes there are burglars in the house and wants to jump out of the window; feels like he is being controlled by superhuman powers; believes his visions are real; believes

he is going to die. Thoughtlessness with poor memory and a kind of anxiety when he has to speak in public; attacks every half an hour with unconnected speech, complete forgetfulness of everything which was around him and difficulty moving after he has been sitting or lying down (after annoyance). Inability to think clearly; no stamina. Mental laziness. Dementia. Foolish, almost insane jealousy; around evening. Highly talkative with remarkably lively mind. Horrific ideas, likes making fun of others. Talks, sings, whispers and makes strange movements; jumps from one topic to another. Madness with screaming. Spite and malice, hurts others in sudden attacks, all thoughts focused on mischief. Morose and tired of life; the future seems dark, patient doubts everything; hopeless and despairing, with rheumatic pain. Extremely susceptible to grief, which makes him sees the dark side of everything and to which he gives himself up completely after negative events. Distrust and suspicion, believes everyone around him means to injure him and interprets even the most harmless situations with spiteful connotations. Fear of death; afraid to go to bed; fear of being poisoned. Tired of life with fear of death. Sluggish, averse to and incapable of any kind of work, whether physical or mental.

Petroleum: Patient believes another person is lying next to him, or that one of his body parts is double. Sadness and despondency with feeling of malaise and heart weakness. Poor memory, very forgetful and disinclined to think. Becomes annoyed about everything, even the smallest trifles, and refuses to respond.

Sabadilla: Despondency caused by deep-seated abdominal complaints. Strange delusions, as if his body has shrunk like a corpse, his stomach is being eaten away, his scrotum swollen. Suffers from imaginary diseases; believes she is pregnant but the bloating is only wind. Mania; rage which can only be calmed when the head is held under cold water.

Stramonium: patient feels that his surroundings have changed completely; knows that his friends are around him one minute but forgets it the next, believes he has been abandoned in the wilderness and is afraid; animal figures suddenly jump out of the earth to push him to the side, where similar figures are chasing him, forcing him to run straight ahead. Raises head from pillow while sleeping peacefully, or the sleeper raises himself on his elbows and gazes fearfully around the room; if asked what he wants, he gives an evasive answer and lies down again. Has phases of talking uninterruptedly, or rages and bursts into loud laughter, or acts as if he is crazy. Delusions: as if his body had been cut through the middle, everything around him seems very small while he himself seems very large and lofty; believes he can see a crowd of people and reaches for them. Insanity, talks to spirits; religious madness with pious, devout actions (praying and singing). Very talkative insanity, gives lewd, salacious speeches. Talks constantly and nonsensically, laughs, claps, great sexual excitement. Melancholy, also with desire for company, light and sunshine; darkness and being alone make his condition worse. In the evening, after lying down, in bed, very sad with thoughts of death and violent weeping. Alternates between lucidity and rage.

Sulphur: great tendency to indulge in philosophical and religious raptures. Concerned about his salvation; indifferent to the fate of others. Imagines he has beautiful clothes, thinks old rags are lovely clothes, confuses a coat with a jacket, a cap with a hat. Madness: spoils her possessions, throws them away, claims she has a surplus of everything but becomes emaciated. Talks loudly and nonsensically all day and night. Patient is so stubborn and morose that he answers no-one, wants no-one around him and cannot get what he wants quickly enough.

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Case 15.3-1: Psychotic disorder and peripheral circulatory disorder

Martin Bundner

Anamnesis

The 65-year-old patient is a staunch adherent of homeopathy. She has been taking only homeopathic remedies for many years and is also active in a homeopathic organisation.

She comes for treatment with swollen feet and bluish toes, which hurt when she steps on them. Her feet are hot yet she needs to bathe them in hot water. Unlike her feet, her toes are cool. A foot massage does her good.

The patient's behaviour gives cause for concern. She seems more nervous than usual. She emphasises that she only came for treatment because her feet are not getting better. Surprisingly, she does not want to take a homeopathic remedy! On being asked why she refuses homeopathic treatment, she answers that she cannot say at the moment (the relationship between patient and doctor was previously one of trust). On further enquiry, she responds that she is still convinced of the effectiveness of homeopathy. However, her face contorts as she admits this. Questions about her refusal to take a remedy and the reasons for this are obviously unpleasant to her. She is also reluctant to talk further, which is unlike her. The therapist explains that the condition of her feet cannot be expected to improve at this time unless she undergoes homeopathic treatment. She finally promises reluctantly to take the remedy.

Diagnoses

Psychotic disorder, peripheral circulatory disorder

Homeopathic treatment

The patient's behaviour is very unusual, but there is no explanation for this; fortunately, she agrees to homeopathic treatment despite her obvious reluctance.

Repertorisation

SYNTHETIC REPERTORY

Mind - refuses - medicine, to take

Generalities - bathing - washing - aggravated - cold

KENT'S REPERTORY

Extremities - discolouration - blue*

Extremities - discolouration - foot - blueness*

Extremities - heat - foot

*Rubrics condensed

Differentiation between remedies

The best result of the repertorisation process is clearly *Lachesis*. The pain on putting the feet down and the contorted facial expression are *Lachesis* symptoms. If the leg symptoms were repertorised separately without the unusual psychological symptoms, other remedies such as *Carbo vegetabilis*, *Crotalus cascavella*, *Digitalis*, *Kalium carbonicum*, *Mercurius solubilis*, *Muriaticum acidum* and *Opium* might be considered. However, they are eliminated because they do not cover the totality of symptoms.

Prescription

3 drops *Lachesis* Q6 once a day.

Progress

During the check-up on day 7, the patient's feet appear less swollen, the toes less blue, and she has no more pain when putting weight on her feet. Her feet are no longer hot, but the patient still bathes them in hot water. She temporarily develops a suppurating pimple under the left nostril.

As she has been taking the remedy regularly, her mental condition is no longer addressed in order to avoid triggering inner resistance. No reluctance is observed in the patient when she describes her symptoms and the progress of the homeopathic treatment. In general, her behaviour appears to be normal.

On day 21, her feet appear normal except for a swelling on the outside of the ankle which developed after a walk

15.3 Acute psychosis

Prescription

From day 21:3 drops *Lachesis* Q9 once a day.

Progress

The foot remains normal. The patient is again open to further treatment with homeopathic remedies. However, she still does not wish to talk about her previous mental state.

Evaluation

The patient behaves completely unexpectedly and quite

behaviour into account, it must be assumed that she was suffering from a psychosis. It is essential to record the mental symptoms in order to find the right homeopathic remedy.

Critical commentary

The repertory must always be adapted to the case to obtain the best possible results. It is not always possible to solve a case with just one repertory. The purulent pimple under the left nostril can be interpreted as a reaction to *Lachesis*.

Case 15.3-2: Acute jealousy

Martin Bündner

Anamnesis

The patient is becoming increasingly jealous of her boyfriend's former girlfriends, although she knows that her jealousy has no grounds. As the situation is currently escalating, she would like to receive homeopathic treatment.

The following symptoms are recorded:

- The patient is restless, dissatisfied and has a feeling of inner turmoil. She is no longer as cheerful and carefree as usual
- She thinks constantly of her boyfriend and is invariably jealous
- She does not want to have sex, as she thinks of her boyfriend's earlier partners
- Because of the jealousy, which is always with her, she has had great difficulty falling asleep over the last few days
- Life is boring without her boyfriend
- Her thirst has subsided over the last few weeks; consequently she no longer drinks as much
- She used to take drugs and now substitutes them with buprenorphine (e.g. Subutex®). Without this preparation, she is fidgety, has abdominal cramps, sweats and feels cold simultaneously all over her body

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - jealousy

Mind - suspicious

Mind - discontented, displeased, dissatisfied etc.

Mind - wearisome

Mind - thoughts - persistent

Differentiation between remedies

The possible remedies are *Ignatia* and *Lachesis*. Unlike *Ignatia*, *Lachesis* covers symptoms of jealousy quite extensively; preference is therefore given to this remedy.

Prescription

5 drops *Lachesis* Q6 once a day.

Progress

The jealousy subsides tangibly just a short time after taking the first dose of the remedy: the patient succeeds in putting her thoughts into order and detaching herself from her boyfriend. Over the next few days, her mood improves and the symptoms subside. In order to stabilise the result, the patient is given *Lachesis* Q9 once a day (also 5 drops) until the jealousy disappears completely.

Evaluation

An interesting remedy indication which could simplify many relationships and help prevent conflict.

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Critical commentary

Lachesis was prescribed just once a day: although the patient's condition was acute, it took some time to reach a peak. The patients self-healing capacities should therefore not be overstrained

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16 Gynaecology and obstetrics

Martin Bündner (Conventional Medicine, Homeopathy)

- 16.1 Genital bleeding outside pregnancy
- 16.2 Emergencies during pregnancy
- 16.3 Birth and birth complications
- 16.3.1 Normal birth

16.1 Genital bleeding outside pregnancy

Definition

Genital bleeding outside pregnancy refers to the discharge of blood from blood vessels in the uterus or vagina, which may have several causes.

Genital bleeding can be caused by the following diseases:

- Postoperative bleeding caused by the excretion of necrotic tissue, insufficient suturing or the revascularisation of thrombotic blood vessels
- Bleeding after coitus and rape
- Menorrhagia with dysmenorrhoea
- Bleeding from carcinomas
- Bleeding from varicose veins or ulcerated bed sores
- Ruptured follicles or cysts
- Foreign bodies in the vagina, impalement lesions, bleeding from uterine and vaginal contusions

Clinical information

Symptoms

Possible general symptoms:

- Shock symptoms
- Muscular defence reflex in the lower abdomen
- Nausea and vomiting
- Progressive anaemia
- Increasing acute pain in the lower abdomen

Special symptoms:

- Postoperative bleeding caused by the excretion of necrotic tissue, insufficient suturing or the revascularisation of thrombotic blood vessels: frequently painful bleeding following gynaecological surgery
- Bleeding after coitus and rape: mostly painful bleeding after consensual or non-consensual intercourse
- Hypermenorrhoea with dysmenorrhoea: extremely severe, painful bleeding during the normal menstrual period
- Bleeding from carcinomas: recurrent bleeding, usually painless, increasing over months and becoming life-threatening in certain circumstances; may increase after coitus
- Bleeding from varicose veins or ulcerated bed sores: usually painful bleeding in wearers of vaginal pessaries (treatment for uterine prolapse)
- Ruptured follicles or cysts: pain increases in intensity then suddenly disappears; with or without vaginal bleeding
- Foreign bodies in the vagina, impalement lesions, bleeding from uterine and vaginal contusions: trauma in the case history, usually very painful bleeding accompanied by injuries

Diagnosis

It is often only possible to make an interim diagnosis in order to decide what emergency treatment is to be given:

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- Anamnesis (e.g. trauma)
- Basic examination
- Inspection and palpation of the abdominal wall
- Inspection of the external genitals
- If tissue has been passed, it must be saved for histological examination

Therapeutic crisis

The patient's mental state after rape or a possibly massive loss of blood can pose particular problems, as these issues may cause lasting problems and complaints.

Homeopathic treatment

Symptom selection

Particular attention must be paid to the patient's mental state when treating rape cases. The nature of the bleeding or injury must be established in all cases of genital bleeding.

The homeopathic treatment must be classified as acute or chronic (after the bleeding has stopped) depending on the cause of the bleeding. Traumatic bleeding, for example, is treated as an acute condition, while bleeding from a carcinoma which has since stopped must be treated in the long term. Note: as a mechanical problem, inadequate suturing often requires surgical intervention. Hypermenorrhoea with dysmenorrhoea is not usually acute and therefore requires long-term treatment.

Repertorisation

- Postoperative bleeding caused by the excretion of necrotic tissue, insufficient suturing or the revascularisation of thrombotic blood vessels: » 16.2
- Bleeding after coitus and rape: «s' 16.2.

Other parts of the body can of course be repertorised together with the menses.

- Bleeding from carcinomas: » 16.2
- Bleeding from varicose veins or ulcerated bed sores: >® 16.2
- Ruptured follicles or cysts: «^ 16.2

GUERNSEY: HOMEOPATHY IN OBSTETRICS Bleeding
- metrorrhagia

Abrot., *acet-ac.*, *aeon.*, Agar., *agn.*, Alet., Alumn., Am-br., Am-m., Ambr., Ant-c., *apis*, *apoc.*, Aran., Arg-m., *arg-n.*, *am.*, *ars.*, *ars-i.*, Asar., Asc-t., Aur., Bapt., BELL., Bell-p., Bor., BOTH., *bov.*, *bry.*, Bufo., *cact.*, CALC., Calc-ar., Calc-f., Calc-s., Cann-i., *canth.*. Caps., *carb-an.*, *carbn-s.*, *carb-v.*, *card-m.*, *caul.*, *cean.*, *cham.*, CHIN., Chin-ar., *chin-s.*, *cimic.*. Cina, *cinnb.*, Cit-a, *coc-c.*, *cocc.*, *coff.*, *Coff-t.*, *colch.*, Coll., *coloc.*, Cop., CROC., Crot-c., CROT-H., Cupr., Cycl., Dig., *elaps.*, Erech., *erig.*, Eupi., FERR., Ferr-ac, Ferr-ar., *ferr-i.*, *ferr-m.*, *ferr-p.*, *ferr-s.*, Fl-ac., Gall-ac., Gels., HAM., *helon.*, *hep.*, Hydr., *hyos.*, *ign.*, *iod.*, IP., Iris, Juni., Kali-ar., *kali-br.*, *kali-c.*, *kali-chl.*, KALI-F-CY., *kali-m.*, *kali-n.*, Kali-p., Kali-s., *kreos.*, *lac-c.*, LACH., Laur., *led.*, Lil-t., *lyc.*, Lycps., M-aust, Mag-c., Mag-m., Mag-s., *med.*, *meli.*, *mere.*, MILL, Mit., MURX, Nat-ar., *nat-c.*, Nat-m., NIT-AC., *nux-m.*, NUX-V., Op., Petr., PHOS., *phyt.*, PLAT., Plb., Podo., PSOR, Prun., PULS., Pyrog., RAT., *rhus-a.*, *rhus-t.*, Rob, Rosm, Ruta, SABIN, Samb, *sang.*, Squil, SEC, *senec.*, *sep.*, *sil.*, Staph, stram, *sulph.*, Sulph-ac, *tarent.*, Ter, *thlaspi.*, TRIL, *tub.*, Urt-u, UST, Verat, VIB, *vine*, *vise.*, *xan.*, Yohim, Zinc, Zinc-s.

- bright red

Aeon, Aran, *arn.*, BELL., Bov, *calc.*, Cham, Chin, *cinnb.*, ERIG, Ferr-p, *ham.*, Hyos, IP, Lac-c, *led.*, Lyc, Med, *mill.*, Mit, PHOS, Psor, Rhus-t, SABIN, *sang.*. Sec, *tril.*, Ust, Vib, Vise, Xan.

- clotted

alet., *alum.*, *apoc.*, Arg-m, *am.*, BELL, *cact.*, CHAM, Chin, Cocc, Coc-c, *coff.*, *croc.*, Cycl, Elaps, Erig, *ferr.*, Ham, Helon, Ip, Kali-c, Kreos, Lach, Laur, Lyc, *mere.*, *murx.*, Nux-v, Phos, plat, Plb, puls, *rhus-t.*, *sabin.*, *sang.* Sec, Stram, *thlaspi.*, Tril, UST, Vise.

- discharged in gushes *ferr.*, *pub.*, *ust.*

- myomas, from

Calc, Calc-f, Calc-p, *ham.*, *hydr.*, *kali-i.*, Lap-a, Led, Lyc, Merc, Nit-ac, PHOS, *plat.*, *sabin.*, Sec, Sil, Sulph, Sulph- ac, *thlaspi.*, *tril.*, UST, *vine.*

Differentiation between important homeopathic remedies

» **Important remedies** *Arnica*, *China*, *Kreosotum*, *Lycopodium*, *Pulsatilla*, *Secale cornutum*, *Sepia*, *Trillium pendulum*, *Ustilago maydis*.

Arnica: uterine prolapse; metrorrhagia after coitus.
Metrorrhagia after coitus during pregnancy.

16.1 Genital bleeding outside pregnancy

Bleeding after convulsions; particularly after injury, jarring, blows, falls or from driving on bumpy roads. Bright red blood mixed with clots. Menorrhagia with pain in the lumbar region extended to the loins, the insides of the thighs and the toes. When bleeding is caused by coitus.

China: bleeding caused by uterine atony; phases of passing black blood clots; uterine cramps, colic. Suitable for people who have lost a lot of blood, even in hopeless cases or cases with a poor prognosis with heavy head, ringing in the ears, dizziness, loss of sensory impressions, drowsiness, fainting, cold extremities, pallor and blue discolouration of the face and hands, with convulsive twitching over the abdomen. Weakness after blood loss or after severe, exhausting illness. Ringing in the ears and fainting; frail women who have already lost a lot of blood. Uterine bleeding after chamomile abuse; patient passes black blood clots, cutting pain in the body and urge to urinate.

Kreosotum: metrorrhagia which tends to come and go; patient thinks she has stopped bleeding but then the bleeding comes back. Metrorrhagia: lasts four weeks; dark, foul-smelling blood passed in large clots; unconsciousness; no pulse. Large stinking lumps of blood are discharged. Prolapse and feeling of a weight in the pelvis; as if something is about to come out of the vagina; < with movement. The subinvolution of the uterus causes some of the blood to remain trapped in the abdominal cavity; this causes the uterus to expand gradually. Metrorrhagia, < lying down, > standing up and walking around. Scirrhous on the cervix and vagina with bloody, feculent discharge, < from coitus. Ulcerlike pain of the cervix during coitus (hard lump can also be felt); more pain the morning after. Induration of the vagina, lightest touch is painful. Bleeding seems to change into a feculent discharge which corrodes the wound; bleeding then recurs; bleeding and discharge alternate. Corrosive itching and burning of the tumour. Corrosive itching between the labia and in the vulva, forces patient to rub the area, which makes the labia swell and burn. Cramplike pain extending downwards.

Lycopodium: bleeding during the menopause. Catarrh of the abdominal organs with stubborn vaginal discharge and symptoms of venous congestion in the abdomen and extremities. Patient feels as if she is full up to the throat. Haemorrhage with cutting pain across the hypogastrium, from right to left; with rumbling and gurgling in the upper abdomen descending into the lower abdomen; patient passes a lot of wind and > from passing blood. Rumbling begins in the upper abdomen and moves downwards, followed by passage of blood; this sequence occurs repeatedly. Increased discharge of blood from the genitals every time the patient passes hard or soft stool. Tearing, stabbing pain in the birth canal. Sustained dryness in the vagina.

Pulsatilla: bleeding stops for a short time then returns with doubled intensity, black blood mixed with clots, worse in women who tend to daydream; during the menopause; from fresh air. Metrorrhagia: dark, congealed blood discharged in gushes, < in the evening with contraction-like pains; usually scanty menstruation; stool normally soft; particularly during the menopause; changeable bleeding, stops and starts; sometimes profuse, sometimes scanty, mixed with clots; with anaemia; after abuse of iron and quinine. Appearance of blood varies considerably; bleeding also stops and starts. Bleeding often stronger during the day, when walking.

Secale cornutum: painless flow of blood in weak, cachectic women or in women who have spent a long time in tropical climates. Uterine bleeding, patient does not want to be covered and insists on the windows being opened wide although the room is very cold and her skin feels as cold as a corpse. Passive bleeding, dark and sustained, rarely lumpy, sometimes offensive-smelling; the slightest movement < the discharge of blood, particularly when the weakness is not caused by a preceding loss of fluids. Uterine bleeding, passive, dark, may smell offensive; tingling or formication all over the body, patient keeps her fingers spread; wants to have her limbs rubbed; finally lies there cold and unconscious.

Bleeding with severe, cramp-like contraction of the uterus; every discharge of blood is preceded by intense pain with a sensation of pressing downwards. Constant metrorrhagia. Uterine bleeding; pain in the sacrum extending into the thighs with pressure in the lower abdomen; profuse, sustained blood flow; cutting and tearing pain in the abdomen, colicky pain; cold extremities and cold sweat; weakness; bleeding < from the slightest movement; blood thin and black, with black clots or brown and liquid, vile smell; black, liquid blood; limp body; feeling of anxiety and oppression; unusual sleepiness during the day; gush of thin, black blood with even the slightest movement; general feeling of exhaustion; low body temperature; feeling of numbness and stiffness in the lower extremities. **Sepia:** congestion of the uterus with a feeling of weight, as if everything is dropping out of the vagina. Patient feels as if she must cross her legs to prevent “everything” falling out of the vagina. Metrorrhagia during the menopause or during pregnancy, particularly in the fifth and seventh months. Burning, itching, throbbing or jerking in the tumour. Cloudy, gravelled urine with red tinge in the collector; this sticks fast to the collector.

Trillium pendulum: active uterine bleeding with dark, thick, lumpy blood, lasting for several days,

followed by bleeding and great weakness, particularly in women who bleed directly after giving birth or suffering a miscarriage; also discharge of thick, dark, lumpy blood during the menopause. Profuse bleeding during the menopause, with exhaustion, dizziness, clouded vision, palpitations and painful sinking feeling around the heart (pit of the stomach). Gushes of bright red blood from the uterus on the slightest movement; blood later becomes pale due to anaemia; sometimes dark clots; frequent need to urinate. Excessive haemorrhage with fainting; face pale and anxious; cold extremities; no pain; limp body. Rapid, weak pulse. Back pain with uterine bleeding; cold legs. Passive inner uterine bleeding with occasional clots and strong odour.

Ustilago maydis: constant flow of blood; large clot of bright red blood discharged every couple of minutes with painful downwards pressure. Metrorrhagia caused by or in connection with irritation of the ovaries. Discharge of blood during the menopause; bright red blood, partly liquid, partly clotted. Gentle manual examination of these parts triggers trickle of blood with black clots, as if the composition of the blood were particularly incorrect. Trickle of dark blood, highly congealed; occasionally forming long, back, ropy clots.

Case 16.1-1: Severe genital bleeding

Martin Bundner

Anamnesis

The 51-year-old patient is on holiday at a spa resort and contacts the therapist early in the morning in despair: she has massive, sustained genital bleeding and is therefore afraid that she will bleed to death and never wake up!

The patient is already familiar as she has been receiving long-term homeopathic treatment. The last contact was three days previously. At this time, she complained of extended black menstrual bleeding. She had previously taken one dose of high- potency *Phosphorus* without consulting her homeopathic doctor.

The nature of the bleeding has changed since the previous day. The bleeding is very bright and intense, the blood comes in gushes. Dark clots are mixed in with the blood. A large tampon becomes soaked with blood every half an hour. The patient is known to have a myoma in the left side of the uterus; she also feels a “pulling” in this area. She cites the Kneipp treatment she has been undergoing as a possible cause of the bleeding, as it “might have got things moving”. The patient's circulation is already affected: she is sweating, particularly on her forehead. Her skin turgor is markedly reduced and skin folds remain standing. She is dizzy; the dizziness increases with physical exertion, particularly when climbing the stairs. The pulse is weak but hard, she feels it in her head; however, it is still

16.1 Genital bleeding outside pregnancy

78/min. She also wants to have the window open. She is trembling and anxious, unusually hungry; her neck is tense.

Diagnosis

Severe genital bleeding, myoma on the left side of the uterus.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Female genitalia - metrorrhagia - bright red - clots, with

Female genitalia - metrorrhagia - gushing

Female genitalia - metrorrhagia - profuse

Female genitalia - metrorrhagia - continuous

Female genitalia - metrorrhagia - active

Differentiation between remedies

Ipecacuanha is mentioned in all these rubrics. *Ipecacuanha* is also indicated for massive, arterial, gushing genital bleeding, but the character of the disease does not speak for this remedy. With *Ipecacuanha*, one would expect to see constant, intractable nausea with the bleeding, possibly also vomiting. *Belladonna*, *Sabina* and *Ustilago* are second-choice remedies, but are each absent from one of the repertorisation rubrics. *Sabina* catches the eye. This remedy covers all the symptoms; if it is assumed that the bleeding is caused by a myoma, it is the only remedy of those considered which is known for such complaints. The decision is therefore made to administer *Sabina*.

Prescription

1 dose of 3 globules *Sabina* 200C.

Progress

The patient refuses to undergo an urgently recommended gynaecological examination. She is therefore advised to avoid physical exertion, stay in bed, drink plenty and have herself monitored as far as possible. At 12.20 pm, the patient reports that she feels somewhat better. The circulatory symptoms have subsided. Further

only has to change the tampon every 1 1/4 hours; she is less dehydrated.

The symptoms have now changed: the patient reports pain in the sacral area, as if it were breaking off. Headaches come and go. Her pelvis feels sore when she is lying down. The pain in the lower abdomen extends into the thighs, a feeling familiar to the patient from former period pains. As the pain is related to earlier sensations and the patient's condition is still improving, no further treatment is given at this point. The next check-up is made at 8 pm. The patient is no longer as weak. The bleeding is visibly lighter, but still continuous and occasionally becomes jelly-like and lumpy. The patient's heart rate is 72/min. The lengthy period spent lying down is making the lumbar pain worse; her abdomen is bloated and she now also has wind. It is now clear that a follow-up remedy will have to be administered soon; however, the patient still feels well with *Sabina*, so no further action is taken as yet. At around 9 pm, the patient contacts the therapist again. She actually left her room briefly and had to climb a few steps; this exertion triggered a headache with a feeling of soreness which subsides when she sits or lies down. In general, she now feels that she is making no further progress with *Sabina*.

Repertorisation II

KENT'S REPERTORY

Generalities - pain - appears gradually and disappears gradually

Head - pain - ascending steps, on*

Head - pain - exertion of body etc., aggravated*

Genitalia female - metrorrhagia - bright red - clots, with
*Rubrics condensed

Differentiation between remedies

Arnica is the only remedy which appears in all these rubrics. This remedy also seems to match the new symptoms well, so the decision is made to administer this new remedy.

Prescription

Progress

The patient again refuses an urgently recommended gynaecological examination. At 11.20 pm, the patient's anxiety again increases. She cannot see any change with regard to the blood loss. Her heart rate is 68/min. She has an uncomfortable sensation on the left side of her lower abdomen.

Repeat dose: 1 dose of 2 globules *Arnica* 1M. Nothing is heard from the patient during the night. Next day, she reports that after taking the second dose of *Arnica*, she was finally able to sleep for four consecutive hours, after previously struggling in vain to fall asleep.

The symptoms have now changed again: the blood is now wine red and no more clots are being passed. The bleeding is still continuous but has subsided further. The patient has more colour than yesterday and the skin folds are no longer as raised. Despite the severe blood loss, the patient feels better than expected. The symptoms are now more focused on the left side. The soreness in the head and abdomen are now only present on the left; the pain in the lower abdomen extends to the left iliosacral joint and increases when the patient crosses her legs, i.e. when her weight is shifted more to the left. She again left her room and climbed some steps, but the headache did not increase as severely as on the previous day. However, it now worsens when she bends her head forwards. The oral mucous membranes are dry.

Repertorisation III

KENT'S REPERTORY

Abdomen - pain - extending - back, small of

Head - pain - stooping, from, aggravated

Female genitalia - metrorrhagia - continuous

Differentiation between remedies

Carbo vegetabilis is mentioned in all the rubrics; there is no reasonable alternative in this case. *Carbo vegetabilis* is therefore chosen.

Prescription

1 dose of 1 drop *Carbo vegetabilis* Q6.

Progress

As her progress is so slow, the patient is finally convinced that a gynaecological examination is necessary. The gynaecologist confirms the myoma, but is generally satisfied that she can find no other source of the bleeding and that it will soon stop, as it does shortly afterwards.

Evaluation

The patient may possibly have put herself at risk by taking high-potency *Phosphorus* inappropriately. It is assumed that the Kneipp treatment also stimulated the bleeding. An emergency situation cannot always be solved with one single remedy. In this case, the genital bleeding only subsided after three different remedies had been administered.

Critical commentary

The fact that the headache worsened when the patient bent her head forwards is covered by the rubric "Head - pain - stooping, from, aggravated". Kent's Repertory does not mention a special emphasis on either side for

1 6.2 Emergencies during pregnancy

Definition

- Ectopic pregnancy: in cases of ectopic pregnancy, the fertilised egg implants in the wrong place when

delays in transporting it. The egg may implant and the embryo develop in the ovary or abdominal cavity. A ruptured ectopic pregnancy is a life-threatening condition

- Miscarriage: refers to the premature termination of a pregnancy, when the body expels a foetus with a weight of less than 1000 g and lacking any

16.2 Emergencies during pregnancy

signs of life. Miscarriages can take place until the 16th week of pregnancy, after which a foetus born dead is referred to as a stillbirth; normally all of the embryonic tissue is expelled

- Pre-eclampsia: Pre-eclampsia (gestosis) was formerly a general term for all pregnancy-related disorders. These days, the term refers to pregnancy-induced hypertension. The term EPH gestosis (oedema, proteinuria, hypertension) is controversial, as oedema also occurs relatively often in healthy pregnant women
- Eclampsia: describes the occurrence of characteristic tonic-clonic seizures with or without loss of consciousness as a result of severe pre-eclampsia
- Vaginal bleeding: there are numerous causes of vaginal bleeding in pregnancy; in late pregnancy, this bleeding may come from the placenta
- Placenta praevia (atypical location of the placenta in the lower part of the uterus) and placental abruption (prepartal or sub partu, part or all of the placenta comes away from the uterine wall, frequently the result of gestosis (pre-eclampsia), severe external trauma, or particularly by internal trauma when the baby pulls on the umbilical cord because it is unusually short or wrapped around it several times)
- Pre-eclampsia: the symptoms of EPH gestosis are oedema, proteinuria ($> 0.5\%$ in 24 h urine) and arterial hypertension ($> 135/85$ mmHg). In cases of pre-eclampsia, the patient also suffers from psychomotor agitation, hyperreflexia, fibrillary twitches and/or subjective sensations such as headaches, disturbed vision (eye flickering through to amaurosis) and upper abdominal complaints. These symptoms can also be forerunners of eclampsia
- Eclampsia: along with the symptoms of preeclampsia, the patient also develops tonic-clonic seizures, possibly with loss of consciousness and coma of varying length. The patient will have forgotten the seizures on coming round
- Eclampsia can also lead to acute renal failure, cerebral oedema, thrombosis and bleeding [**Note:** placental insufficiency may occur and put the child's life at risk.

Vaginal bleeding:

- Placenta praevia: the symptoms of placenta praevia are painless, episodic or continuous bleeding during the last trimester
- Premature placental abruption: the more the placenta is separated from the uterine wall, the more severe the symptoms. The patient may feel sudden, frequent, stabbing pains in the lower abdomen which often persist; she may no longer feel the child moving, she will feel generally unwell and the uterus may be sensitive to pressure
- Vaginal bleeding is noticed in 70-80% of cases but is not proportional to the degree of abruption. The uterus is painfully contracted ("wooden uterus"); the increase in volume causes the fundus to rise
- Internal bleeding (also between the placenta and the internal wall of the uterus) may lead to ret- roplacental haematoma. Signs of haemorrhagic shock. Placental abruption means that the foetus will not receive enough oxygen (pathological CTG), intrauterine death, symptoms of late gestosis (hypertension, proteinuria)

Clinical information

- Ectopic pregnancy
- Ruptured ectopic pregnancy
- Miscarriage
- Pre-eclampsia, eclampsia
- Vaginal bleeding (placenta praevia and premature placental abruption)

Symptoms

- Ruptured ectopic pregnancy, miscarriage: irregular bleeding may occur after 6-8 weeks of amenorrhoea; the possibility of a pregnancy cannot be excluded. In cases of tubal pregnancy, the patient suffers contraction-like pains on one side of the lower abdomen; if the tube ruptures, severe, acute, one-sided abdominal pain with or without abdominal bleeding

16 Gynaecology and Obstetrics

*** Note:** the shock symptoms (drop in blood pressure, rise in pulse rate, dizziness and confusion) increase in proportion to the size of the separated area and the severity of the bleeding.

Diagnosis

The basic diagnostic procedure is abdominal palpation.

- (Ruptured) ectopic pregnancy: ultrasound, punctures or internal scans of the Douglas cavity and laparoscopy are the procedures of choice
- Miscarriage: a pregnancy test will reveal the existence of a pregnancy
- Pre-eclampsia: diagnosed in accordance with the findings of blood pressure measurements, urine tests for protein and checks on oedema formation («■ table 16.2-1)
- Eclampsia: it is essential to distinguish between eclamptic seizures and epileptic seizures. As they manifest in the same way, the only factors available for differential diagnosis are the lack of eclamptic symptoms (with epileptic seizures) and the existing history of epilepsy
- Vaginal bleeding: any bleeding in late pregnancy is pathological and must be investigated. There are numerous different causes which must be considered:
 - Placenta praevia
 - Premature placental abruption
 - Sinus bleeding at the edge of the placenta
 - Uterine rupture
 - Insertio velamentosa (tears in umbilical blood vessels misplaced on the caul, putting the child at risk of bleeding to death when the mothers waters

- Non-pregnancy-related causes such as cervix carcinoma, cervical polyps, portio erosion and varicose bleeding

— Unknown causes

- Placenta praevia: the location of the placenta is mentioned in the maternity card or can be found by ultrasound. The patient's general condition reflects the amount of blood lost. When palpated, the uterus is soft, not tense and not sensitive to pressure. There are few contractions. Examination with a speculum reveals bleeding from the cervix; portio or varicose bleeding must be ruled out. It may be difficult to distinguish between placenta praevia and premature placental abruption

Note: vaginal or rectal examinations are contraindicated, as they can trigger severe bleeding.

Premature placental abruption: diagnosed on the basis of the clinical symptoms, case history and ultrasound examination. CTG rounds off the range of possible instrumental diagnostic procedures. Severe bleeding from the abrupted area, usually disproportionate to the bleeding visible on the outside, signs of shock, hypofibrinogenaemia or afibrinogenaemia, sonography.

Therapeutic crisis

Vaginal bleeding during pregnancy can cause a variety of problems in addition to the general risk of foetal death; in conventional medicine, these can often only be treated with difficulty.

Ruptured ectopic pregnancies often lead to severe, potentially even life-threatening blood loss. Miscarriage leads to the death of the foetus.

Tab. 16.2-1: EPH gestosis index for evaluating the severity of advanced gestosis

Evaluation	0 points	1 point	2 points	3 points
Oedema	-	Tibial	Generalised	-
Proteinuria	< 0.5	>0.5-2	>2-5	> 5
Systolic blood pressure	< 140	> 140 - 160	> 160-180	> 180
Diastolic blood pressure	< 90	> 90 - 100	> 100-110	> 110
The maximum score (total points awarded) is 11 points.				

16.2 Emergencies during pregnancy

Pre-eclampsia can cause premature birth, retard the growth of the child and lead to premature placental abruption, coagulation disorders and cerebral bleeding (in the mother).

Eclampsia: acute renal failure, cerebral oedema, thrombosis, bleeding.

Placenta praevia puts the mother at risk of severe bleeding, even bleeding to death, infection with the risk of sepsis and air embolism. Atonic bleeding may occur during the period following the birth; the mother is also at increased risk of puerperal infection. The child is endangered by foetal bleeding with hypoxia, post-haemorrhagic shock and bleeding to death. It is often immature with respiratory distress syndrome and is more likely to present in a transverse or breech position.

Premature placental abruption can also trigger severe bleeding, which can develop into disseminated intravascular coagulation in the context of a haemorrhagic diathesis within the first 4-8 hours. As placental abruption leads to acute placental insufficiency, the child may suffer from hypoxia; the mortality rate in children is approximately 30%. The loss of blood from the open blood vessels of the villi can also be life-threatening for the mother. Concomitant homeopathic treatment is indicated. It can help minimise existing complications and increase the chances of survival for the mother and child.

Carefully targeted homeopathic treatment is also able to prevent many of these problems from the start.

Homeopathic treatment

Symptom selection

The nature of the bleeding, any shock symptoms and the severity of the abdominal pain must be taken into consideration when treating any pregnancy-related emergency.

Changes in the patient's mental state are relatively common.

When treating (pre-) eclampsia, attention must also be paid to the presence of oedema. neurological

symptoms and the nature of the headache and visual disturbances when choosing the remedy. The chosen remedy must also cover any complications.

Repertorisation

In his work *Homeopathy in Obstetrics and Paediatrics*, Guernsey lists numerous rubrics with subrubrics which can be helpful. They are not listed individually here.

- Ectopic pregnancy and ruptured ectopic pregnancy: 12
- Vaginal bleeding: 16.1
- "Convulsions": 16.3

_____ GUERNSEY: HOMEOPATHY IN OBSTETRICS
Miscarriage - miscarriage

Abrot., Absin., Aeon., *alet.*, Aloe, Ambr., Ant-c., APIS, Arg-n., *arn.*, Ars., Art-v., Asaf., *asar.*, Asc-c., Aur-m., BELL., Bor., *bry.*, *calc.*, Calc-f., Calc-s., Camph., Cann-s., *canth.*, Caps., Carb-an., Carbn-s., Carb-v., CAUL., Cause, Cedr., CHAM., *chin.*, Chin-s., *cimic.*, Cina, *cinnb.*, *cocc.*, Coff, *Coloc.*, Con., CROC., Crot-h., Cupr., Cycl., Dig., Dulc., ERIG., *eup-per.*, *eup-pur.*, *ferr.*, *ferr-i.*, Ferr-p., Fil., GELS., GOSS., Ham., *helon.*, *hep.*, Hippoz., *hyos.*, *ign.*, Iod., IP., *Iris*, *kali-c.*, Kali-m., Kali-p., Kali-s., Kou., Kreos., Lach., Lip., Lyc., *mere.*, *mill.*, Morph., Murx., Nat-c., Nit-ac., NUX-M., Nux-v., *op.*, *phos.*, *pin-l.*, *plat.*, *plb.*, Podo., PULS., Pyrog., *rat.*, *rhus-t.*, Rosm., *ruta*, SABIN., SEC., SEP., *sil.*, *stram.*, Sulph-ac., *sulph.*, *syph.*, Tanac., Tarent., *ter.*, Thlaspi., Thuj., *tril.*, *ust.*, Verat., VIB., VIB-P., Wies., Zinc.

Miscarriage - bleeding from impending miscarriage or during miscarriage

Anac., *apis*, Arn., *bell.*, Bry., *calc.*, Caul., Cham., *chin.*, Cimic., CROC., *erig.*, Goss., *ham.*, Hyos., IP., KALI-C., KREOS., *lyc.*, *mill.*, *nit-ac.*, *phos.*, PLAT., *puls.*, Ruta, SABIN., *sec.*, *sil.*, *thlaspi.*, Tril., *ust.*, VIB., *vib-p.*

Pregnancy - urine contains protein

APIS, Apoc., *ars.*, *ars-i.*, *aur-m.*, Bell., Benz-ac., Berb., Bry., Cact., *calc-ac.*, Calc-ar., *canth.*, *chin.*, Cinnb., *colch.*, *crot-h.*, *cupr-ar.*, Dig., Dulc., Ferr., *gels.*, Glon., Hell., *helon.*, Ind., *kali-ar.*, Kali-br., *kali-c.*, *kali-chl.*, *kali-m.*, Kalm., *lach.*, Led., *lyc.*, *mere.*, MERC-C., *nat-m.*, Oena., *ph-ac.*, Phos., Phyt., Rhus-t., Sabin., Senec., Sep., Sulph., Ter., Thlaspi., Thyr., Uran-n., *verat-v.*

Metrorrhagia - placenta praevia *erig.*, *ip.*, *nux-v.*, *sabin.*, *sep.*, *verat.*

Differentiation between important homeopathic remedies

| **Important remedies** *Aconitum*, *Crocus sativus*, *Nux vomica*, *Pulsatilla*, *Sabina*, *Sepia*.

Aconitum: impending miscarriage caused by shock, with agitation; rapid blood circulation and breathing.

Crocus sativus: bleeding from the uterus on the slightest movement; blood is tough, black, ropy and offensive-smelling; miscarriage in the third month. Patient expels black threads; as soon as the blood flows from the vulva, it takes on the form of black, ropy masses. Foul-smelling uterine bleeding, or when the patient is in a state of nervous erethism as the result of sustained bleeding.

Nux vomica: every contraction triggers an urge to urinate or defecate. Loses consciousness with every contraction; during labour, patient feels that she has to pass stool with every contraction; impending miscarriage or retained placenta, after miscarriage, with a continuous feeling of discomfort in the rectum, as if it has to be emptied; bleeding from the uterus with the same symptom. Irritability; afraid of being moved, pain in the uterus. Impending miscarriage caused by varicosity in the uterus, the result of frequent congestion; uterus in slackened condition. Impending miscarriage or placenta retention after miscarriage or birth, with ongoing discomfort in the rectum as if the bowel wants to be emptied. Profuse bleeding after miscarriage in the third month; bleeding < at 3 am.

Pulsatilla: impending miscarriage: the bleeding stops for a while then returns with doubled intensity; this happens several times. Black blood discharged during contractions. After shock, in the fourth month of pregnancy: contractions start a few hours later; violent contractions two days later, limited almost completely to the left side, causing the patient to scream and cry; occur every 15 minutes; dark blood with large clots expelled between contractions; violent shivering between contractions, patient shakes so violently that the

bed shakes as well; wants to be covered more warmly; shivering during labour pains; no thirst; mouth tastes slimy; cervix clearly open; impending miscarriage. Bleeding with contraction-like pains; blood discharged is blackish, sometimes liquid, sometimes lumpy; vaginal entrance very narrow, dry; examination is painful (impending miscarriage).

Sabina: untimely birth, with gush of blood from the uterus, particularly in the third month; discharge of bright red, partly clotted blood, < with every movement; pain from the sacrum to the vulva. Dragging, pressing pain from the sacrum to the vulva. Extreme anxiety and fear; constant fear of miscarriage; blood discharged on the slightest movement, alternating between bright red, liquid and dark or clotted; contraction-like pain from back to pubic bone; external genitals feel hot; os uteri half an inch dilated; impending miscarriage. In the fifth month of pregnancy: contractions at regular intervals of about 15 minutes; with light but steady flow of bright red blood. Profuse discharge of blood from the vagina; cervix considerably dilated; vagina full of dark, clotted blood; chills, nausea, great thirst; great exhaustion; in third month. Haemorrhaging dark red blood, liquid then clotted; not the slightest pain in the back or hypogastrium; great loss of strength; impending miscarriage. Severe bleeding after a miscarriage; lasts eight to ten days; profuse discharge of bright red, liquid blood during the first five days, no pain. Uterine bleeding lasting four weeks after a miscarriage.

Sepia: prone to miscarriage between the fifth and seventh months of pregnancy. Terrible itching of the vulva, causes miscarriage. Placenta retention after miscarriage; discharge smells offensive, corrosive, repeated bleeding. Sore abdomen: the baby's movements are felt too intensely. Painful feeling of emptiness in the stomach and abdomen. Hardening of the os uteri and cervix (*Aurum metallicum*, *Conium maculatum*). Neck of the uterus is hardened with stabbing pain extending upwards.

Case 16.2-1: Impending premature birth

Martin Bündner

Anamnesis

A 29-year-old pregnant woman (second child, third pregnancy) develops contractions in the 31st week of pregnancy for no clear reason. The contractions have already lasted all day, and become markedly more intense in the evening. By the time the doctor arrives, the contractions are four minutes apart and the patient's abdomen is hard. The patient is restless and anxious. She seems annoyed. She has a numb tingling in the vulva and feels as if the cervix is dilating. There is a dragging pain in the uterus. The labour pains extend downwards from here. The abdominal pain is so severe that the patient is unable to sleep despite being tired. The child moves less when she holds her belly. The abdominal pain extends around the abdomen in a semi-circle and radiates into the pubic area.

The following secondary symptoms are also recorded: • Queasy feeling in the stomach, patient feels hungry

- Patient feels full, with eructation, as if she had just eaten a huge meal
- Frequently passes wind
- Cold hands and feet
- Cold nose

Diagnosis

Impending premature birth.

Homeopathic treatment

The most threatening symptoms (the pain extending into the pubic area, the abdominal pain in the evening, the hard abdomen) are characteristic and are therefore used to select the remedy. One interesting point is the contradiction between the simultaneous feelings of hunger and fullness. However, the Kent Repertory does

Repertorisation

KENT'S REPERTORY

Abdomen - pain - extending - pubic region

Abdomen - pain - evening

Abdomen - hard

Differentiation between remedies

The remaining remedy is *Sepia*. *Colocynthis* is also interesting, but does not have the contradictory nature of *Sepia* and is therefore eliminated. A retrospective glance at the materia medica confirms the choice of *Sepia*: "Fearful, in the evening. [...] Worried and anxious, with fretfulness. [...] Restless and cheerless, many days. [...] Great hunger, in the evening. [...] Very frequent eructation. [...] Abdominal pain from navel to pubic region [...]. Stitches from navel to pubic region [...]. Feeling as if the birth canal is dilated." (Trinks and Muller 1847)

Prescription

1 dose of 1 drop *Sepia* Q3.

Progress

After taking *Sepia*, the pain and contractions quickly subside, the patient becomes noticeably calmer and falls asleep. Next day, all the symptoms mentioned have vanished; the remainder of the pregnancy is normal. A gynaecological examination two days later shows nothing abnormal.

Evaluation

The influence of the homeopathic remedy rendered a hospital stay unnecessary.

Critical commentary

After her rapid improvement, the patient could no longer be persuaded to go to the gynaecological outpatient clinic right away. There were no complications during

Martin Bundner

Anamnesis

The 33-year-old patient is in the 8th week of her fourth pregnancy when a close friend loses her child during pregnancy. This upsets her badly, particularly because she herself has had three miscarriages to date. She then begins to pass brownish blood, her abdomen is hard and cramped. She fears that she too will lose her child, and is crying.

Diagnosis

Impending miscarriage.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Mind - grief - ailments from

Female genitalia - abortion

Female genitalia - menses - brown

Female genitalia - pain - cramping - uterus

Abdomen - hard

Differentiation between remedies

The remaining remedies are *Conium maculatum* and *Pulsatilla*. *Pulsatilla* seems more suitable than

Conium because of the characteristic mood and cause; *Pulsatilla* is therefore chosen.

Prescription

1 drop *Pulsatilla* Q12 diluted in water, to be repeated as needed. The patient is also instructed to stay in bed.

Progress

The bleeding stops right after the first dose of *Pulsatilla* is taken. A certain amount of mucus is passed the following day (day 2); the patient still feels mild cramps in the uterus. On day 3, no more mucus is passed and there are no more cramps (except for a brief cramp after a telephone call with the friend mentioned). The pregnancy progresses normally and the child is born healthy.

Evaluation

The homeopathic remedy has an astonishing effect

Critical commentary

The patient should have been advised not to call her

Case 16.2-3: Intrauterine foetal death - early pregnancy

Anamnesis

The 36-year-old patient is in the 12th week of pregnancy when she goes to the gynaecologist with severe lower abdominal pain which has been persisting for three days. He diagnoses intrauterine foetal death on the basis of the sharp drop in pregnancy hormone and a corresponding ultrasound. A curettage is now to be performed. The patient comes for homeopathic treatment of the abdominal pain.

The dragging lower abdominal pain gets worse when she is lying on her back. The pain makes her feel chilly, she needs warmth; however, if warmth is provided, she rapidly becomes too hot. She also has palpitations which get worse

and sitting. She becomes nauseous in the evening, but the nausea stops when she eats. Hunger in the evening causes eructation.

Diagnosis

Diagnostic procedures

Gynaecological laboratory and ultrasound diagnostics.

Homeopathic treatment

Repertorisation

CARD INDEX REPERTORY

Speaking, conversation aggravated

Sitting aggravated Lying, on back aggravated

Evening aggravated

16.2 Emergencies during pregnancy

Differentiation between remedies

The main remedies for consideration are *Argentum metallicum*, *Arsenicum album*, *Phosphorus*, *Rhus toxicodendron*, *Sepia* and *Sulphur*. The fact that the nausea improves when eating is unusual; of the remedies mentioned, this indicates *Phosphorus* and *Sepia*. The inexplicable chills associated with the pain are also remarkable. *Arsenicum album*, *Rhus toxicodendron* and *Sepia* all mention this symptom. The decision is made to administer *Sepia*, which covers both conditions.

Prescription

2 drops *Sepia* Q6 three times a day.

Progress

The abdominal pain subsides rapidly after taking *Sepia*. The gynaecological surgery is planned for

Case 16.2-4: Intrauterine foetal death at the end of the 2nd trimester

Martin Bundner

Anamnesis

The 30-year-old patient is in the 23rd week of pregnancy. She has not felt the child move for two weeks. The gynaecologist finds that the child has died; a curettage is scheduled.

The patient occasionally has pains which extend from the abdomen upwards; these have stopped for the time being. Since the previous day, the patient has noticed a light pulling in the lower abdomen and sacral area. She is anxious and nervous, as she has no idea what to expect. She is suffering to some degree from shock, and feels an emptiness throughout her body. The chest between the mammae feels hot and constricted.

She can no longer see as clearly; her breathing is fast and shallow; her whole body feels empty; she clenches her teeth and jaw, she is dizzy.

Diagnosis

Intrauterine foetal death.

the following day; the patient is unable to oppose it; the curettage is performed without complication.

Evaluation

Unfortunately, the patient could not wait until the foetus was expelled naturally. Once the abdominal pain subsided, the patient would have started to bleed and the surgery would have become unnecessary.

Critical commentary

The conventional treatment meant that the homeopathic therapy merely served the function of easing the pain.

Conventional treatment

Elective curettage.

Homeopathic treatment

Repertorisation

	KENT'S	REPERTORY*
	SYNTHETIC REPERTORY ** Mind	
- anticipation - ailments from, aggravated**	Mind	- news - ailments from, aggravated - bad**
	Chest	- heat*

Female genitalia - abortion*

Female genitalia - pain - labour pains - suppressed and wanting*

Female genitalia - pain - labour pains - ceasing*

Differentiation between remedies

The remaining remedies are *China* and *Pulsatilla*. In view of the patients mood, *Pulsatilla* seems more suitable than *China* and is therefore chosen.

Prescription

5 drops *Pulsatilla* Q6 as needed.

Progress

Under the influence of *Pulsatilla*, the patient develops

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completely. She is no longer in shock and can grieve for her child. The subsequent curettage proceeds without complications.

Evaluation

Taking *Pulsatilla* enables the patient to give birth to the dead child normally, an important process for helping

Critical commentary

It is open to discussion whether the curettage following the normal birth would really have been necessary.

Case 16.2-5: Allergic reaction during pregnancy

Martin Bundner

Anamnesis

Since the previous day, the 38-year-old patient has been aware of a rash similar to urticaria on her chest and abdomen, which has spread to cover her back, face, throat, arms and legs. She is in the first trimester of pregnancy.

The rash consists of small red spots which swell and grow in size. Her skin feels subjectively hot, whereas objectively it is not. Her back feels as if it is burning; otherwise she suffers from generalised itching which gets worse at night, from scratching, from pressure and from lying on the affected area.

Diagnosis

Allergic reaction in early pregnancy.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - pregnancy - ailments during

Skin - heat - without fever

Skin - itching - scratching, aggravated

Differentiation between remedies

The remaining remedies are *Arsenicum album* and *Rhus toxicodendron*. The burning pain and rash are more typical of *Arsenicum album*; *Rhus toxicodendron* is more appropriate for burning blisters.

Prescription

1 dose of 2 globules *Arsenicum album* 30C, followed by *Arsenicum album* Q3, 4 drops several times a day as needed.

Progress

The patient temporarily develops shivering and dyspnoea. During the first night, the rash moves down the body and subsides by 4 am. The patient continues to take the Q potency and has no more complaints.

Evaluation

Arsenicum album stopped and cured the progressive allergic reaction. Treatment with chemical preparations would have put the child at risk

Critical commentary

Because of the urgency of the situation, the 30C potency was prescribed first because it was more readily available. However, treatment with Q

16.3 Birth and birth complications

16.3.1 Normal birth

If a baby is expected, the following examinations are essential:

- Maternity card
 - Progress of pregnancy
 - Current status of pregnancy
 - Complications during early pregnancies/ births.
- External examination
 - Four Leopolds manoeuvres
 - Sterile vaginal examination (by experienced practitioner) to check the child's position and where it is placed in the pelvic entrance.

Normal findings: birth date $\pm$ 10 days, cephalic presentation, clear amniotic fluid, mother in good health (including pulse, blood pressure and temperature).

The birth process consists of three phases, each flowing into the next.

The first stage is the **dilation phase**, which begins with the first contraction and ends when the cervix is completely dilated to about 10 cm. The dilation of the cervix is assessed by vaginal palpation; however, this should only be performed by people with experience. The duration of the dilation phase varies from individual to individual: in firsttime mothers it usually lasts 5 to 10 hours, in mothers who have already had at least one child, it may only take 2 to 4 hours. During this phase, the contractions occur every 5-10 minutes and last 30-60 seconds.

The end of the dilation phase is signalled by the rupture of the amniotic sac. The waters may break prematurely before the contractions start. The colour of the amniotic fluid is important; it should normally be clear. Green discolouration means that the child has already been deprived of oxygen.

Once the waters have broken, the mother-to-be should stop walking around and be transported in a supine position because of the risk of cord prolapse.

The **expulsion phase** begins when the cervix is fully dilated and ends when the child is born. During this phase, the contractions become stronger, occurring at 2-minute intervals and lasting 60-90 seconds (pushing contractions). By this time, the child has almost always begun to turn into the birth position. The child's head moves downwards until the small fontanelle is under the symphysis and in direct line with the sagittal suture. The urge to push becomes stronger. The mother-to-be presses down while the contractions are occurring.

The vulva gapes and the child's head becomes visible in the vagina. The perineum must now be supported to prevent tears as the widest part of the head passes through. During this phase, the mother-to-be should pant to weaken the intensity of the contractions, so that the child's head can emerge gently and in a controlled manner. The pressure exerted on the child's head should be released slowly. Once the head is born, the front shoulder is freed by pushing the head down and the rear shoulder by exerting pressure in the direction of the pubic bone. The birth of the child signals the beginning of the **afterbirth period**, which ends with the expulsion of the placenta. The newborn's umbilical cord is usually cut at a later stage, while it is lying in bed; if it is asphyxiated, the umbilical cord is cut immediately. It is cut between two sterile clamps placed two palmwidths away from the navel using sterile scissors. The newborn is then examined and taken care of.

The contractions following the birth cause the placenta to pull away from the uterine wall; it is expelled by uterine contractions and by pressing. The volume of blood lost from the expulsion of the placenta is usually about 300 ml.

* **Note:** most births (95%) proceed without complication.

16.3.2 Birth complications

Definition

Birth complications occur when the birth takes place more than 10 days preceding or following the due date,

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child is wrongly positioned or when the labour goes on for longer than usual.

The following complications can be serious in individual cases:

- Placenta praevia «*16.2
- Prolapsed umbilical cord: a dangerous complication occurring after the rupture of the amniotic sac in which one or more loops of the umbilical cord are caught in front of the child due to insufficient closure of the lower segment of the uterus by the presenting part (narrow pelvis, feet-first position, transverse position etc.)
- Malpresentations: breech position is one atypical presentation; the head is located in the fundus and the pelvis in the lower part of the uterus. The aetiology of this position is unclear in 85% of cases when the child is born at term
- Disruptions of the birth mechanism in cephalic presentations: in transverse or oblique presentations, the longitudinal axis of the child forms a right or acute angle to the longitudinal axis of the birth canal. Oblique presentations are also known as unstable presentations, as they invariably turn into longitudinal presentations (most common) or transverse presentations (rare) when the birth gets under way. Transverse presentations are clinically significant as the child cannot be born naturally in this position. This is caused either by abnormal movement on the child's part (multiple preceding births, small children, ...)

and hydramnios) or by restriction of the child's movements (more than one child in the uterus, malformed uterus, uterine tumours, placenta praevia, narrow or deformed pelvis)

Other birth complications include:

- Abnormal contractions sub partu (intense labour pains in quick succession, secondary weakness of contractions)
- Diabetes mellitus
- Malformation of the uterus, uterine surgery
- Premature births and prolonged births
- Multiple births
- Stillbirth

Clinical information

Incidence and mortality

- Prolapsed umbilical cord: 0.3-0.7% of births, i.e. one in every 150 to 350 births
- Malpresentations: 3-5% of all births are breech presentations
- Disruptions of the birth mechanism in cephalic presentations: transverse presentations occur in 0.5% of all births

Symptoms

- Placenta praevia «■ 16.2
- Prolapsed umbilical cord: the umbilical cord is located in front of the presenting part in the vagina

Tab. 16.3-1: APGAR (asphyxia index), points system for evaluating the condition of newborns immediately after birth			
Criterion	0 points	1 point	2 points
Respiration	Absent	Weak, irregular, gasping	Strong, lusty cry
Pulse	Absent	Slow (less than 100/min.)	Over 100/min.
Activity (muscular)	Limp	Some sluggish flexion of the extremities	Active movements
Appearance (complexion)	Blue or pale all over	Body pink, blue at extremities	Completely pink
Reflex irritability on aspiration	No reaction	Grimace, feeble cry	Lusty cry, coughing, sneezing
Evaluation: the APGAR score is established 1.5 and 10 minutes after the birth. 9-10 points per test are ideal; less than 7 points show that the newborn's condition is compromised.			

16.3 Birth and birth complications

- Disruptions of the birth mechanism in cephalic presentations: a wide, prominent pelvis is noticed on examination. The fundus is low, the head can be felt as a floating part at the side

Diagnosis

- Placenta praevia «s'16.2
- Prolapsed umbilical cord: the diagnosis is clear when a loop of the umbilical cord is hanging outside the vulva
- Malpresentations: diagnosed by external examination using the Leopold manoeuvres
- Disruptions of the birth mechanism in cephalic presentations: diagnosed by inspecting the pelvis and external examination using the Leopold manoeuvres

Therapeutic crisis

- Placenta praevia ^ 16.2
- Prolapsed umbilical cord: the difficulty with this emergency is in recognising it in cases where the umbilical cord is still in the vagina and cannot be seen from the outside. The child is at risk of oxygen deprivation
- Disruptions of the birth mechanism in cephalic presentations: the incorrect presentation of the child can make birth impossible; alternatively, peripartal complications are much more common than in normal births

Homeopathic treatment

Symptom selection

- Placenta praevia «s'16.2
- Prolapsed umbilical cord: this is a mechanical problem which cannot be treated homeopathically. However, symptoms experienced by the mother in this context are amenable to homeopathic treatment
- Disruptions of the birth mechanism in cephalic presentations: the abnormal presentation is the guiding symptom for homeopathic treatment. The remedies are differentiated according to the concomitant symptoms

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Bleeding during and after the birth (also see chapter on bleeding)

acet-ac., Aeon., Adre., Alet., Alum., Am-m., Aml-n., Apis, *arn.*, Ars., *bell.*, Bry., *cann-i.*, Cann-s., Carb-v., Caul., *cham.*, *chin.*, *cinnb.*, *Cocc.*, Coff., *croc.*, Crot-h., Cycl., ERIG., *ferr.*, *gels.*, Ger., HAM., *hydr.*, *hyos.*, *ign.*, IP., Kali-c., Kalm., Kreos., Lach., Lyc., Merc., *mill.*, Nit-ac., Nux-m., Nux-v., Op., *Ph-ac.*, *phos.*, *plat.*, Plb., Puls., *rhus -t.*, SABIN., SEC., Senec., Sep., *thlaspi.*, *tril.*, *ust.*

Birth - before, during or after

aeon., Aeth., Ambr., Aml-n., *ant-c.*, Ant-t., Apis, *arg-n.*, Arn., Ars., Art-v., *atro.*, BELL., Benz-ac., CALC., *cham.*, Canth., *cupr-ar.*, *carb-v.*, Caul., Caust., *chin.*, *chin-s.*, Chlf., *chlol.*, CIC., Cmic., Cinnb., *cocc.*, *coff.*, Crot-c., *crot-h.*, *cupr.*, *gels.*, *glon.*, *hell.*, *helon.*, *hydr-ac.*, HYOS., *ign.*, *ip.*, KALI-BR., KALI-C., Kali-p., *lach.*, *laur.*, *lyc.*, Lyss., Mag-p., Merc., *merc-c.*, Merc-d., *mill.*, Mosch., *nat-m.*, *nux-m.*, *nux-v.*, *oena.*, *op.*, Ph-ac., Phos., *piloc.*, *plat.*, Puls., *sec.*, Sol-n., STRAM., *sulph.*, *ter.*, Thyr., *verat.*, *verat-v.*, *zinc.*, Ziz.

Slow birth

Arn., *bell.*, CAUL., Chlf., Choi., Gels., *ign.*, Mit., NAT-M., PULS., *sec.*, *sep.*, Vise.

Afterpains

aeon., Aml-n., ARN., Asaf., Atro., Aur., BELL., Bor., *bry.*, *calc.*, Carb-an., Carb-v., *caul.*, CHAM., Chin., Cic., Cmic., Cina, Cinnb., Cinnb., *Cocc.*, *coff.*, Coloc., *con.*, *Croc.*, CUPR., Cupr-ar., Cycl., DIOS., *ferr.*, *gels.*, *graph.*, Hyos., HYPER., *ign.*, Iod., Ip., KALI-C., Kreos., *lac-c.*, Lach., Lil-t., Lyc., *mill.*, Nat-c., Nat-m., Nux-m., Nux-v., *op.*, PAR., *phos.*, *Plat.*, *podo.*, PULS., Pyrog., RHUS-T., *ruta*, SABIN., SEC., *sep.*, Sulph-ac., *sulph.*, Ter., Ust, *vib.*, *vib-p.*, Vine., *xan.*, Zinc.

False contractions

Arn., BELL., Bor., CALC., CAUL., *cham.*, *cimic.*, *cinnb.*, Cinnb., Coff., *con.*, *dios.*, *gels.*, *kali-c.*, Kali-p., Mit., *nux-m.*, *nux-v.*, *op.*, PULS., Sec., SEP., Vib.

Contractions cease

Aeon., Arn., Asaf, BELL., *bor.*, Bry., Cact., Calc., *camph.*, Carb-an., Carb-v., *caul.*, *caust.*, *cham.*, Chin., CIMIC., Cinnb., *Cocc.*, *coff.*, *Gels.*, *graph.*, Guar., Hyos., Ign., KALI-C., Kreos., Lach., Lyc., Mag-c., Mag-m., Merc., Mosch., Nat-c., Nat-m., Nux-m., *nux-v.*, OP., Plat., Phos., PULS., Rhus-t., Ruta, SEC., *sep.*, Stann., Sulph., Sulph-ac., *thuj.*, Zinc.

Agonising contractions

Aeon., Ambr., Arn., ARS., Aur., Bell., *caul.*, Caust., Cham., Chin., Cmic., *coff.*, *coff-t.*, Con., GELS., *hyos.*, *ign.*, KALI-C., Lyc., Nux-v, Phos., Plat., Puls., Sec., SEP.

Weak contractions

Aeth., Arn., *bell.*, Bor., *camph.*, Cinnb., Cann-i., *carb-v.*, *carbn-s.*, CAUL., *caust.*, *cham.*, Chin., CIMIC., *Cocc.*, GELS., *graph.*, Guare., KALI-C., KALI-P., Lyc., Nat-c., NAT-M., Nux-m., Nux-v., OP., Plat., PULS., *ruta*, SEC., Sep., Sulph., *thui.*, Ust., Zinc.

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Excessively strong contractions

aeon., *Ambr.*, *Arn.*, *Art-v.*, *bell.*, *CHAM.*, *Chlcl.*, *cimic.*, *coff.*, *coff-t.*, *Con.*, *Cupr.*, *Lyc.*, *nux-v.*, *Puls.*, *Rhus-t.*, *Sec.*, *SEP.*, *Ust.*

Ineffective contractions

Aeon., *Arn.*, *Bell.*, *CAUL.*, *caust.*, *Cimic.*, *Cinnb.*, *coff.*, *Eup- pur.*, *Gels*, *Goss*, *Kali-c*, *Nux-v*, *On*, *Phos*, *plat*, *PIILS*, *Sec*, *Sen*, *ust*

Differentiation between important homeopathic remedies

| **Important remedies** *Aconitum*, *Arnica*, *Belladonna*, *Caulophyllum thalictroides*, *Chamomilla*, *Gelsemium*, *Pulsatilla*, *Sepia*.

Aconitum: vulva, vagina and cervix are dry, sensitive and do not dilate. Fear of not surviving the labour pains. Abnormally severe, frequent contractions; patient complains that she cannot breathe or endure the contractions; drenched in hot sweat. Contractions: agonising; vagina is hot, dry, sensitive and rigid; violent contractions in quick succession, especially when the child is large (the head seems to be stuck); inadequate contractions, the patient is overwhelmed by pain. Malpresentation of the child means that the contractions are ineffective. Convulsions during the postnatal period with brain congestion, hot, dry skin, thirst, restlessness and fear of death. Numbness and tingling of the limbs.

Arnica: tired uterus, face turns red and head becomes hot with every contraction while the rest of the body remains cool. The contractions are so strong that they almost drive the patient mad, but the birth barely seems to progress; contractions are weak or stop altogether, patients wants to change position often. Back is extremely sore during contractions, patient is excessively sensitive to pain. Feeling as if the child is lying in a transverse position, making the mother feel sore and restless, with general fatigue. Parts sore after birth. *Arnica* prevents bleeding and other complaints such as constant dripping of urine. When the pulse is full and strong; rush of blood to the head and face with

every contraction; signs of paralysis on the left side; unconsciousness; patient passes urine and stool involuntarily. Indicated during the last stage of birth and after the placenta has been expelled, due to the bruising and soreness of the genitals and the overexertion and compression of the entire muscular system. Strong afterpains; occur when nursing. Genitals sore after birth, prevents bleeding. Bleeding normally bright red or mixed with clots; head hot, body cold.

Belladonna: the contractions come suddenly, need to bear down occurs too fast, as if the entire contents of the pelvis are to be pushed out; after a while, they disappear just as quickly as they came. Spasmodic contractions of the cervix, which is hot, sensitive, red, and tends to be moist (*Aconitum*: dry). Thin, rigid cervix. (*Gelsemium*: cervix is rigid and thick). Slow, tiring birth. The mother-to-be distorts her face because of periodic pressure in the sacrum. Dragging pain extending from the sacrum into the upper thighs. Rigid muscles in older women giving birth for the first time. Agonising, cramp-like contractions; too weak or cease altogether. False, cramp-like contractions. When the cervix does not open or is constricted despite good, strong contractions. Amniotic fluid is passed but the cervix is still firmly closed. The woman lies there quietly with no contractions, merely occasional pain in the back of the head. Bleeding after birth or miscarriage. *Belladonna* is frequently indicated for uterine bleeding after the birth. Patient appears bewildered, is only semi-conscious and cannot talk; convulsive movements of the limbs and facial muscles; right half of the tongue is paralysed; foam around the mouth; convulsions recur with every contraction. Patient tosses and turns between convulsions, or sleeps deeply with grimaces, or starts up and screams with terrible visions. Muscles twitch and jerk between convulsions. Deep sleep or unconsciousness after convulsions. When the afterpains start suddenly and stop just as suddenly after a certain time. Feeling of heaviness, fullness and downward pressure in the genitals. Strong pressure in the genitals, as if everything were falling out. The lochia feel hot, the vaginal discharge increases with every afterpain.

16.3 Birth and birth complications

Violent afterpains. Sensitive female genitals; touch and jarring are unbearable. Stabbing pain in the vagina, which feels hot and dry. Placenta retention with profuse discharge of hot blood that coagulates quickly; the placenta retention may be caused by spasms. Hourglass contractions.

Caulophyllum thalictroides: spasmodic rigidity of the cervix which delays the birth; contractions like pinpricks in the cervix. Short, irregular, spasmodic contractions, patient very weak and irritable, contractions have no effect; fundus and cervix do not function synchronously. Pulling pain in the uterine ligaments. Cramp-like contractions, move from one place to another, just not in the usual, effective direction. Stomach cramps associated with uterus stimulation. Violent, spasmodic pain which does not cause the birth to progress; the contractions become weak and inadequate because the birth is protracted and the mother correspondingly exhausted. Profuse discharge of mucus from the vagina. Agonising false contractions at the beginning of the birth. Cramp-like contractions in various parts of the abdomen. Weak contractions pass with a shudder and cause great torment. Passive bleeding after birth or miscarriage. Haemorrhage, particularly after very fast birth. Seizures with very weak, irregular contractions. Afterpains throughout the lower abdomen extending into the groin; after exhausting, protracted birth with reflex pain in the back and chest. Placenta retention, particularly after protracted, tiring birth; spasmodic. No contractions; blood gushes out.

Chamomilla: cramp-like, agonising contractions; tearing pain; patient is irritable, prone to lose her temper; desires fresh air; says she has to stand up and also wants to do it. Oversensitive to pain, which seems to be unbearable and drives patient to despair. Cramp-like contractions; may push the child upwards instead of downwards. Can barely endure the pain; rigid os uteri. Contractions with frequent urination and more or less profuse discharge of dark blood; urine light and copious. Hourglass contractions; irritable; thirsty; desires fresh air; restlessness. Violent contractions and tearing in the leg veins with discharge

of dark, clotted blood. The contractions push the child upwards; mother is hot and thirsty, irritated and tends to nag and scold. Inadequate contractions which cause great restlessness and anxiety. When the cramps are triggered by rage, or when one cheek is red and the other pale. Rigid cervix; patient can barely endure the contractions; extraordinarily sensitive cervix. The afterpains are violent and agonising. Violent afterpains continuing on the second day following the birth of the fourth child; these become unbearable when the child nurses, causing the mother to cry out. Dark lochia. Bloody, copious lochia, clotted.

Gelsemium: cutting pain in the abdomen from the front to the back and upwards, occurs with every contraction and makes them unsuccessful; agonising and can be felt throughout the body. Violent abdominal pain; false contractions so strong that they interrupt the true contractions, which seem completely ineffective; sometimes cramp-like pain in various parts of the abdomen; cervix rounded and hard; feels as if it is not dilating (*Belladonna*: thin, rigid cervix). Pain in the uterus which radiates into the back and extends up the spine. Wavelike feeling from the uterus to the throat, ending with a feeling of suffocation; this seems to hinder the birth; contractions threaten to stop. Each contraction seems to push the child upwards rather than downwards. Nervous trembling, “chattering teeth” during the first stage of contractions. Uterine atony, unable to contract; passive bleeding. Contractions stop, the cervix is widely dilated; complete atony; face red and bloated; dazed facial expression; patient is sleepy, dull. Everything seems to be slack, the cervix is open, no contractions, the patient becomes sleepy, hoarse voice: risk of seizure. Patient fears the onset of the birth beforehand; nervous trembling before or immediately after the birth; talkative during the first stage. False contractions before the birth. Nervous women with rigid, unyielding cervix during contractions, accompanied by great nervous excitement. The contractions leave the uterus and pass through the whole body. Convulsions preceded by warning symptoms. Head feels very large; cramps occur at an early stage

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because the cervix stays hard and thick. Violent abdominal pain extending directly upwards or to the back then upwards; feeling of muscle weakness, the result of a lack of willpower; muscles are weak and do not obey the will; false contractions. Albuminuria during pregnancy; when the contractions begin, the patient sinks into a semi-stupefied state from which she can be roused by shaking, only to fall back into a stupor. Convulsions with loss of consciousness; dull feeling in the forehead; feeling of fullness in the area of the medulla oblongata. Albuminuria with sleepiness and twitching of various body parts, cloudy vision. Afterpains are too violent and last too long; sensitive women who cannot calm down and therefore cannot fall asleep; half awake and murmuring during sleep. Afterpains, uterine cramps; cutting pain from the front to the back and upwards. Placenta retention; cutting pain in the abdomen from the front to the back and upwards.

Pulsatilla: inactive uterus; insufficient expulsive strength, tired uterus. Contractions: extend from the sacrum up to the stomach area, causing violent stomach pain and vomiting; alternate with bleeding and restlessness; < in the evening; irregular; cause palpitations, feeling of suffocation and fainting; wants to have doors and windows wide open; needs a lot of fresh air; cramp-like and unproductive; inactive uterus; constant sensation of strong pressure in the sacrum, causes tension and pain in the thighs; unsuccessful; sluggish; too weak or ceasing altogether, with sleepiness. Sore uterus and abdominal wall (*Hamamelis*). *Pulsatilla* corrects foetal malpresentations by stimulating the uterine muscles. The child's head is located at the opening

of the pelvis minor; uterus unable to push the child out further. Mother cries because she believes people do not want her to give birth. False contractions; cannot sit for long, has to walk around to ease the pain. Convulsions following irregular, sluggish contractions; unconsciousness; skin cold and clammy, face pale; stertorous breathing and full pulse. Convulsions following sluggish or irregular contractions; unconscious; cold, clammy, pale face. Loss of consciousness and ability to move. Patient demands fresh air when she is conscious. Gentle, tearful women; afterpains too long and intense; < in the evening. Placenta retention; lack of uterine activity or spasmodic contractions. Intermittent bleeding, restless. Post partum haemorrhage caused by placenta failure to pull away from the uterine wall.

Sepia: cervix half open, contractions ineffective, front lip of the cervix is sensitive; feeling as if everything wants to come out through the vulva; shivering during contractions, more tolerable when warmly covered; shooting pains in the cervix; hard area in the cervix; dyspnoea; spasmodic cervical contractions; countless tiny, sharp stitches in the cervix; shooting pain, sometimes with burning, extending upwards from the cervix; rushes of heat; cold feet; hourglass contractions; continuous feeling of a weight in the anus; sharp, shooting pains in the vagina; contractions mainly felt in the back; intense downward pressure in the back, appears at regular intervals. Feeling of a weight or post in the anus. Intense stabbing pains in the pubic area, almost as far as the navel. Pain mostly felt in the back; intense downward pressure in the back appearing at regular intervals.

Case 16.3-1: Dystocia

Martin Bundner

Anamnesis

The 30-year-old mother's first pregnancy was accompanied by nausea and other pregnancy-related ailments which were cured with homeopathic treatment.

past her due date when she finally feels the first contractions.

The midwife's examination shows that her cervix is only 1 cm dilated.

The contractions are extremely strong and painful; they exhaust the patient completely. She vomits during the contractions. Unfortunately they are not effective, the

16.3 Birth and birth complications

around the anus up into the back and into the uterus.

The patient refuses the medication offered by the clinic. She wishes to be treated homeopathically.

Diagnosis

Dystocia.

Diagnostic procedures

Findings on admission

Gynaecological examination.

Homeopathic treatment

Repertorisation

_____ GUERNSEY: HOMEOPATHY IN OBSTETRICS

Childbirth and contractions - vomiting during contractions

Childbirth and contractions - agonising contractions

Childbirth and contractions - ineffective contractions

Childbirth and contractions - excessively strong contractions

Childbirth and contractions - exhausted by contractions

Differentiation between remedies

The two most important remedies are *Pulsatilla* and *Sepia*. The contractions radiating from the anus into the back are understood as back pains. *Pulsatilla* is a very good remedy for this condition.

Prescription

1 drop *Pulsatilla* Q15 as needed.

Progress

The intensity of the contractions decreases after taking the *Pulsatilla* just twice; the patient stops vomiting during the contractions and feels stronger. The contractions also become stronger. The patient takes *Pulsatilla* several times more until the birth.

Evaluation

Dystocia can be effectively controlled with homeopathic remedies.

Critical commentary

Case 16.3-2: Home birth

Martin Bundner

Anamnesis

27-year-old patient in her first pregnancy. Her due date is in two days. The patient is already receiving long-term treatment, and *Pulsatilla* was indicated towards the end of the pregnancy for false contractions and other symptoms; each dose currently comprises 10 drops of Q15 potency. The false contractions started one week before the birth and were felt to be very strong, but stopped completely within a few hours of taking *Pulsatilla*.

Two days previously, the patient heard an explosive noise in the upper right abdomen with no sensation of pain. This subsequently turned out to be a rupture in the upper part of the amniotic sac which did not allow amniotic fluid to escape. On examining the placenta after the birth, it was found that the membranes were not

On the previous day, the heavily pregnant woman was exposed to a temporally stressful situation at short notice. This caused her to feel exhausted and triggered a strange feeling of nausea for a few minutes; this was accompanied by dizziness which was not described more precisely. Moreover, a small amount of amniotic fluid was expelled during the afternoon; however, the patient assumed this was a profuse discharge, as there were no other signs that the birth was starting.

At about 1.30 am, the patient starts to feel light, irregular, contraction-like pains which continue. The pains are felt as a light pulling in the lower abdomen, as if a menstrual period were about to start. About an hour after the pains start, a quantity of light, clear fluid (amniotic fluid) and flesh-coloured mucus begins to drip from the vagina. This indicates that the pains signalled the beginning of the birth. The contractions continue rhythmically at intervals of about 15 minutes, but are still very weak.

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As *Pulsatilla* is a long-term remedy and is not contraindicated in this case, and because no symptoms indicative of another remedy develop, *Pulsatilla* Q15 is again given. Several doses of Q15 are administered over the next few hours. After every dose of *Pulsatilla*, the contractions become clearly stronger and the interval between them shorter. At times, the contractions become irregular, but this is also offset by taking *Pulsatilla*, which caused the contractions to become more frequent and regular. By around 6.30 am, the contractions are coming every 3-5 minutes. The midwife is notified. In order to stop the birth progressing too quickly, the treatment with *Pulsatilla* is stopped for the time being. The midwife arrives about an hour later.

The cervix is about 4 cm dilated. After giving another dose of *Pulsatilla*, the contractions increasingly take on the character of a ring in the sacral region. Small quantities of amniotic fluid are still being discharged. After another dose of *Pulsatilla* Q15, the patient feels a strong sensation of downward pressure, initially concentrated on the rectum but then moving to the middle of the lower abdomen as the contractions become stronger. The mother-to-be now gets into the bathtub to relax. The birth process comes to a halt. The mother-to-be feels a "resistance in the pelvis" which she and the child are "unable to overcome".

The contractions are now coming at very short intervals; they are causing the cervix to dilate and efface and are very painful. The nature of the contractions has changed: the pain quickly rises to a climax before subsiding slowly. There is still a sensation of downward pressure and pushing. Over time, the patient also starts to feel sore. The vaginal examination performed by the midwife during the contractions makes the pain even worse. This makes the patient very irritable.

By 9.45 am, the cervix is 5 cm dilated, thick and tough. The midwife reports that the lip of the cervix is tilted backwards and was brought forward and held with her finger.

Every examination during the contractions makes the pain even stronger and more difficult to bear. The mother-to-be reports: "The pains are just

as strong as the pushing pains which come later, but feel different. I was no longer able to breathe towards the child because the pain was so severe and because it felt like I couldn't get enough air to use my abdominal muscles. It felt like everything was going to explode in the pelvis. I was no longer able to speak because the contractions were coming thick and fast."

Meanwhile, the patient's cheeks are turning an intense dark red over the cheekbones. After another examination, the midwife reports that the cervix is at risk of tearing unless the situation changes; it is rigid and bulging at the side and is not seen to be stretching. An intramuscular dose of the spasmolytic drug butylscopolamine (e.g. Buscopan®) is now indicated but not administered. Kneeling on all fours, the mother-to-be no longer has the strength to bear down; her abdominal muscles are no longer under control. A change of position in the bathtub is attempted but does not bring the desired success. The pain is worst when sitting. The child's heartbeat can be heard regularly and strongly through the phonocardiograph. The patient is crying.

Afterwards, the patient reports: "I thought I was not going to be able to give birth. I lost any willpower to carry on. I gave up because I felt that nothing was moving and the birth had stopped. The pain made me angry and I felt more and more helpless."

Diagnosis

Impending cervical rupture and dystocia during home birth.

Diagnostic procedures

Phonocardiography.

Homeopathic treatment

Repertorisation I

GUERNSEY: HOMEOPATHY IN OBSTETRICS

Os uteri - rigid

Os uteri - rounded and hard, feels as if it is not dilating

Face - flushed, evenly

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Differentiation between remedies

The repertorisation process finishes with *Gelsemium*. *Belladonna*, *Caulophyllum*, *Chamomilla*, *Cimicifuga*, *Conium*, *Ignatia*, *Lycopodium*, *Nux vomica* and *Secale cornutum* are also worth consideration. However, only *Gelsemium* covers both the symptoms and the inexplicable facial colour, and this remedy is selected accordingly.

Lilienthal (1993) describes the symptoms of *Gelsemium* as follows:

- Agonising, can be felt throughout the body
- Feeling of muscle weakness, the result of a “lack of willpower”
- False contractions
- The muscles are weak and do not obey the will
- False contractions, so violent that they interrupt the true contractions, which seem completely ineffective
- Os uteri rounded and hard, feels as if it is not dilating
- Uterine atony, unable to contract
- Face red and bloated
- Pink facial colour, like an even flush
- Nervous women with rigid, unyielding cervix during contractions, accompanied by great nervous agitation
- Sluggish and fatigued; quickly becomes tired and exhausted

Prescription

1 dose of 3 globules *Gelsemium* 30C. 5 doses given in all.

Progress

The flush seems to subside a little during the five minutes following the first dose of *Gelsemium*; no other change is recognisable. However, the midwife's next examination reveals that the cervix is somewhat softer. Encouraged by this success, another three globules of *Gelsemium* are administered right away. A higher potency of *Gelsemium* is not available. The redness now subsides more obviously but quickly returns.

The cervix is still becoming softer but is not yet soft enough.

Another two doses each comprising 3 globules of *Gelsemium* 30C are administered, until the redness disappears completely and the midwife's examination now reveals that the cervix is soft enough. At 10.15 the cervix is 8 cm dilated, and at 10.30 am it is completely dilated. It is now flat, clear and soft enough. A bulge in the amniotic sac pushes forward at about 10.20 am.

“Right after the first dose of *Gelsemium*, I distinctly felt the heat leaving my head; I'd originally thought it came from the steam. I actually felt my cheeks turning pale. I felt dizzy for a minute after the second dose, as if I were going to collapse.”

The patient now develops pushing pains in the bathtub. As the birth is now imminent, she is given two doses of *Arnica* 200C comprising 3 globules each. *Arnica* was chosen because it is known for its general healing effect on wounds and bruises.

The cervix is still soft, but the contractions are too short and weak; the mother-to-be obviously has no strength left. Her waters broke at the last vaginal examination (amniotomy); since then, the contractions have become weaker. The child's heartbeat is still strong and regular. The patient's symptoms have again changed and *Gelsemium* is no longer indicated. The midwife believes that oxytocin, a drug used for example to strengthen weak contractions, should now be administered as a nasal spray (e.g. Syntocinon®); however, the drug is not given. The patient wants to drink some water.

Repertorisation II

_____ GUERNSEY: HOMEOPATHY IN OBSTETRICS
Contractions and symptoms during contractions

- Short contractions
- Weak contractions
- Patient exhausted by contractions
- Difficult birth

Differentiation between remedies

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contractions; a glance at the materia medica (Lilienthal 1993) is indicated:

Pulsatilla: Want of expulsive power. Inertia of uterus. Contractions unsuccessful, sluggish, too weak or cease altogether, with drowsiness. The child's head is located in the opening of the pelvis (minor), uterus unable to push the child out further.

Caulophyllum thalictroides: Short, irregular, spasmodic contractions, patient very weak and irritable. Ineffective contractions. Violent, spasmodic pains which do not cause the birth to progress. The contractions become weak and inadequate because the birth is protracted and the mother is correspondingly exhausted. The contractions become weak and exhausting because of the lengthy continuation of the birth. Thirsty, feverish.

Based on the result of the repertorisation process and the subsequent comparison with the materia medica, it is decided that *Caulophyllum thalictroides* should be administered, particularly as the exhaustion caused by the protracted birth is impressively described and emphasised. Moreover, when the individual weightings are added up after the repertorisation process, it turns out that *Caulophyllum thalictroides* is rather more heavily weighted than *Pulsatilla*.

Prescription

2 doses of 3 globules *Caulophyllum thalictroides* 30C administered within a quarter of an hour.

Progress

Caulophyllum causes the contractions to become somewhat stronger; otherwise the remedy has no effect. The child's head is only descending slowly. A large caput succedaneum is already clearly visible; the head is pushing through. It must be assumed that *Caulophyllum* is not the right remedy and is therefore not working. The child's heartbeat is still strong and regular. However, a new symptom is now observed: haemorrhoidal lumps are now appearing at the anus, which was not the case before. This symptom is taken into account when the repertorisation process is repeated.

Repertorisation III

GUERNSEY: HOMEOPATHY IN OBSTETRICS

Haemorrhoids - worse after childbirth

Differentiation between remedies

The result of this repertorisation clearly confirms the choice of *Pulsatilla*. In view of the previous considerations, *Caulophyllum* is eliminated and *Pulsatilla* is chosen.

Prescription

2 doses of 10 drops *Pulsatilla* Q15.

Progress

Right after the first dose of *Pulsatilla*, the mother- to-be appears calmer and more relaxed; this impression increases after the second dose.

After the first dose, there is also a pause in the contractions, during which she can relax and gather her strength. She now wishes to continue giving birth on the bed in a half-sitting position. The pushing contractions start again and are now stronger and sufficiently long. They now come at distinctly wider intervals than before. After the onset of the third phase of pushing contractions, a mature, slightly overdue, vital female baby is born in a left cephalic presentation at 11.22 am, about 5 minutes after administering the remedy (*Pulsatilla*).

Birth weight 3060 g, head circumference 33 cm, body length 50cm; Apgar score: 9/10/10. The newborn is aspirated. The caput succedaneum is about the size of the palm of a hand.

The mother reports: "After pushing twice and before taking the *Pulsatilla*, I had no strength left, even though the contractions were still coming. Because I didn't have the strength to push for a third time and had to breathe through the contraction instead, it was incredibly painful. The feeling of a belt around my pelvis was really strong, as if it was going to shatter my pelvis. I just didn't have the energy to push effectively. The midwife said the contractions were not working and weren't lasting long enough. I couldn't believe they weren't enough. The pain was so bad, I thought

16.3 Birth and birth complications

had been able to push. During the pushing contractions, I felt such a pressure and shifting that I had to go with it, but somehow I'd lost my concentration and was already too exhausted. I gave up and would have preferred to have an elective Caesarean. I thought I was going to die. I was dizzy, as if I was about to faint. I couldn't speak any more. The weakness was so bad that I wouldn't even have been able to get out of the bath."

She adds: "After the first dose of *Pulsatilla*, I started feeling happy again that my baby was going to be born sooner or later. With the *Pulsatilla*, I suddenly got my strength back and was able to get out of the bath. I felt relaxed and no longer needed to cry. Things more or less returned to normal in my head. I now felt that it wasn't going to take much longer, that the end was in sight. Mentally I felt much better after the second dose of *Pulsatilla*. I felt that I was able to use my abdominal muscles to help things along, because they no longer felt as weak. When the child came, I cried because I was so emotional."

Afterbirth: an examination of the genital region showed that the perineum was not torn; however, the labia were grazed at 5 am and the anterior commissures of both labia were also grazed.

The patient reports: "The grazes felt like they were burning. The burning was the worst, as it was a new pain, a new impression. But more important was the joy that my baby had finally been born."

The crying that continued after the birth was the only symptom which needed to be examined. This actually confirmed *Pulsatilla*; however, it was not deemed necessary to give the patient this remedy again. The placenta was expelled at 11.33 am with very little bleeding; the blood loss throughout the birth amounted to about 200 ml. The placenta pulled away from the uterine wall without difficulty and was complete.

The mothers comments: "The placenta came away, that wasn't bad. I felt a brief pulling, like at the beginning of a period. The slight pain felt as if the contractions had just begun. I felt some fluid (blood) coming out."

Afterpains: the afterpains begin about half an hour later. The patient remarks that they are painful, as if the contractions had just begun. As there were no symptoms indicative of another remedy, another 10 drops of *Pulsatilla* Q15 were given; the afterpains stopped after no more than 1-2 minutes. The new mother is happy and feels well.

When walking and sitting, most of all when sitting up in bed, getting up from a chair, lifting the child and tensing one buttock, the patient feels pain and soreness in the rectum and anal region reflecting the immense mechanical force to which the area was subjected.

Moreover, when urinating for the first time after the birth, she was unable to finish as the area was so sore and painful.

Because of its well-known effect on wounds and bruising, *Arnica* 200C is administered at 6 pm and again at 11.20 pm.

The next attempt to urinate is already considerably less painful; six hours after the birth, the caput succedaneum on the baby's head has already shrunk by half.

At 6 pm, the uterus is one finger-width above the navel and is shrinking back with no complications. By 3 am, the caput succedaneum has again clearly subsided. *Arnica* is again administered next day, three doses of 200C potency in all. Right after the first dose on this day, the patient can urinate with very little pain, and the other pains are also subsiding at intervals. She still feels a pain as if her menstrual period were about to begin. The uterus is now one fingerwidth below the navel. The patient can feel how the uterus is "working" and contracting. The baby's caput succedaneum is now only 3 cm in diameter. On the second day following the birth, the patient is again given one dose of 3 globules *Arnica* 200C; afterwards, she has no more pain. Another dose of 10 drops *Pulsatilla* Q15 is given during the evening, as the haemorrhoids which emerged during the birth are not yet fully back in place. Afterwards, the haemorrhoids gradually subside and the patient has no complaints during lactation; she also has no problems with breastfeeding.

Evaluation

This patient suffered from an impending cervical rupture and afterwards from dystocia during the birth. The doctors observation of the patient with her few but all the more obvious objective symptoms was enough to facilitate the homeopathic treatment of these serious complications. The primarily indicated chemical medication did not have to be used.

Critical commentary

Acute situations such as childbirth may necessitate the more frequent administration of the remedy, as its effect will wear off more quickly.

The midwives arrival had to be awaited in compliance with legal regulations; this is why *Pulsatilla* was not

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17 Urological emergencies

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17.1 Acute urinary retention

17.2 Renal and ureter colic

17.3 Urosepsis (UTI)

17.4 Injuries of the urogenital tract

17.1 Acute urinary retention

Definition

In cases of acute urinary retention, the bladder cannot be emptied spontaneously even if it is full and the patient feels the urge to urinate. Ultimately, maximum stretching of the bladder causes the sphincter to fail and the patient passes urine involuntarily.

The most common causes are prostate adenomas, other prostate diseases (e.g. carcinomas, prostatitis) and diseases of the urethra (carcinomas, strictures, folds, stones).

Clinical information

Symptoms

Painful, agonising urge to urinate and dysuria, possibly loss of urine as the bladder is overfull. Palpation and ultrasound tests will show that the bladder is high and the lower abdomen is bulging. A muffled sound is heard on percussion. The patient may have extremely severe abdominal pain.

» **Note:** the symptoms of acute urinary retention may mimic those of acute abdomen.

Diagnosis

The diagnosis can often be made just from the patient's case history; the manual findings and abdominal ultrasound will confirm it.

Therapeutic crisis

Transurethral bladder catheterisation can cause infections of the urinary tract; the area may also be traumatised and injured; perforation of the urethra is also possible. Urethral strictures are a possible late complication. The risk of infection is lower with suprapubic bladder puncture; however, there is a considerable risk of injury to the abdominal blood vessels and organs with severe blood loss and associated infection. Homeopathic treatment can cure acute urinary retention swiftly and without complications.

Homeopathic treatment

Symptom selection

Along with the local symptoms, the cause of the acute urinary retention is decisive for the correct choice of homeopathic remedy.

Repertorisation

KENT'S REPERTORY

Bladder - paralysis, retention of urine

Aeon., Aesc., Agar., All-c., Alum., Am-c., Ant-t., Apis, Ap-g., Apoc., Arg-m., Arn., Ars., Ars-i., Aspar., Atro., Aur., Bar-c., Bar-m., Bell., Bism., Bor., Bufo, Cact., Calc., Calc-s., Camph., Cann-i., Cann-s., Canth., Caps., Carbn-s., Card-m., Caust., Chel., Chim., Chin., Chin-ar., Cic., Cmic., Cinnb., Clem., Coc-c., Coch., Colch., Coloc., Con., Cop., Crot-h., Cupr., Dig., Dios., Dulc., Elaps, Euph., Gels., Graph., Hell., Helen., Hep., Hyos., Hyper., Ign., Ip., Iris, Iod., Kali-ar., Kali-chl., Kali-i., Kreos., Laur., Led., Lyc., Mag-p., Mag-s., Merc., Merc-c., Merc-cy., Mez., Morph., Mur-ac., Nit-ac., Nux-m., Nux-v., Op., Ox-ac., Pareir., Petr., Phos., Ph-ac., Phyt., Plb., Polyg., Prun., Puls., Ram-s., Rhus-t., Ruta, Sabin., Sars., Sec., Sep., Sil., Stann., Staph., Stram., Sulph., Sulph-ac., Tarent., Ter., Thuj., Tub., Urt-u., Verat., Zinc

Differentiation between important homeopathic remedies

Important homeopathic remedies *Aconitum*, *Apis*, *Cantharis*, *Causticum*, *Lycopodium*, *Nux vomica*, *Opium*, *Pulsatilla*

Aconitum: main remedy for newborns unable to pass urine during the first few days of life. Urge to urinate with great distress, anxiety and fear. Great, inconsolable anxiety. Urine retention or suppression with pressure in the bladder or stabbing pain in the kidney region.

Apis mellifica: the child cries continually and passes little or no urine. Urine retention in breastfed children.

Cantharis: constant, strong urge to urinate with inability to let the urine flow; incessant urge to urinate, urine passes in drops with the most agonising pain. Urine retention with cramp-like bladder pain. Cutting, burning pain. Urine sediment in children; the irritation extends to the penis with almost incessant pulling at this organ; only a few drops of urine are passed, with a lot of crying.

Causticum: urine retention with frequent, urgent need to urinate; a few drops or a small quantity of urine may occasionally be passed. Urge to urinate but absolutely no urine is passed; patient was forced to wait for a long time and is then only able to pass a small quantity of urine; the urge quickly returned without pain.

Lycopodium: urine retention, violent back pain, urine passed intermittently in gushes, back pain worse in the pauses during urination. Severe back pain felt before the patient urinates, makes the patient cry out; urine retention; the patient adopts the position for urinating but has to wait a long time before the urine flows, accompanied by a characteristic pain in the back which stops when the urine is expelled; children often cry out with pain before urinating. Clear, transparent urine with heavy, red, crystallised sediment at the bottom of the container; for typhus, when the patient is weak and unable to control his bladder, this sediment is then seen on the sheet; also for colic in babies when the nappies contain a lot of this sediment. Rumbling in the left side of the abdomen or gurgling; severe rumbling in the abdomen. Large quantities of loud flatulence in the abdomen or particularly in the right hypochondrium; the abdominal contents seem to be constantly fermenting, causing a loud squeaking noise. The child wakes up kicking and screaming.

Nux vomica: vain attempts to pass urine, only small quantities passed with burning and tearing sensations. Unable to give way to urge to urinate, also painful; distressing need to urinate but only drops are passed with burning, tearing pain. Urine retention with frequent defecation. Constipation as if from binding and constricting the bowels or from bowel inactivity.

Opium: urine retention with completely dry mouth and more thirst than usual. Urine retention, as if the bladder is sealed. Stool constantly kept back, constipation. No urge to urinate or defecate. The child is very sleepy and tired. Red, bloated face and thick, swollen blood vessels in the head. Full bladder; retained urine. Urine retention in breastfed children after outburst of passion from the wet nurse (or nursing mother).

Pulsatilla: when *Aconitum* or *Nux vomica* fail. Urine retention with external redness and heat in the bladder region. The bladder area hurts when touched from the outside. Frequent urge to urinate, almost always in vain, with cutting pain.

Case 17.1-1: Acute urine retention with urinary tract infection

Martin Bündner

Anamnesis

The 63-year-old patient has been an in-patient in a psychiatric facility since January, where he is being treated for a severe psychosis. His cataleptic state means that a transurethral catheter had to be fitted. At this time, he is being given olanzapine (e.g. Zyprexa®). As his clinical condition improves, the transurethral catheter is removed. He subsequently develops the following symptoms:

- Frequent passing of drops of urine by day and night
- Can only urinate by pressing
- Burning, dragging pain in the urethra and front part of the bladder when urinating
- Most recently mild abdominal pain

The diagnosis of a urinary tract infection is confirmed; the symptoms are ascribed to it. The patient is given a series of antibiotics, none of which have any effect on his condition.

He has already been taking *Nux vomica* Q6 for several days to treat his mental condition. Today, the situation becomes distinctly more acute. It is almost impossible for the patient to empty his bladder, which an ultrasound examination shows to be full and swollen. The patient asks for a homeopathic remedy to rectify the situation.

Diagnosis

Acute urine retention with urinary tract infection.

Diagnostic procedures

Abdominal sonography.

Conventional treatment

Olanzapine (e.g. Zyprexa®).

Homeopathic treatment

Repertorisation

Differentiation between remedies

The remaining remedies are *Arsenicum album*, *Cantharis*, *Nux vomica* and *Rhus toxicodendron*.

Nux vomica is eliminated as the patient is already taking it alongside his conventional medication to improve his mental condition. This remedy was unable to ease the acute urine retention.

Differentiation using the symptoms available is difficult, so the therapist consults the materia medica (Jahr 1848) with the following results:

“*Arsenicum album*: Bladder paralysis; - retention of urine, as if paralysed, despite strong urge to pass water; [...]. Frequent urge, also with burning; with frequent need to urinate, also at night, [...]; [...] passes small amounts, also with burning; [...]. Painful, difficult urination; stranguria. When urinating: burning, also only at the beginning. Cramping pain in left groin. [...]

Cantharis: [...] Burning in the bladder; bladder inflammation; [...] distension of the bladder; paralysis of the bladder neck. In the urethra: [...] burning; [...]. Urine retention: [...]; from overfull bladder; [...]. [...] Bladder urge, strong urine, stranguria, also with burning, [...]. Frequent urination: may be up to 60 times an hour; small quantities of pale urine; [...]. When urinating: considerable pain (dysuria); burning; [...].

Rhus toxicodendron: Urine retention; strong urine, can only pass drops of blood-red urine while pressing. Frequent urge, with copious urination; strong flow of urine; has to urinate every few minutes, during the day; has to get up three times at night to urinate. When urinating: [...]; burning at the base of the urethra.”

This glance at the remedy provings reveals no major differences. However, *Arsenicum album* is the only one of these three remedies which mentions the dragging pain.

The most interesting symptom fragment - the continuous dribbling of urine - is mentioned in the repertory as a sub-rubric (Bladder - urination - dribbling - involuntary - day and night) but only lists seven remedies while giving single weighting to *Arsenicum album*: the other two remedies are not listed.

KENT'S REPERTORY

Bladder, paralysis, over distension, after

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Nevertheless, the decision is made to administer *Arsenicum album*-, of the remedies available, this remedy also has the greatest similarity with the patients psychotic symptoms (left out of this case history for purposes of clarity).

Prescription

10 drops *Arsenicum album* Q6 once a day.

Progress

The remedy is administered the same day. On this and the following day, a weak flow of urine gradually develops and the symptoms slowly subside. After three days, the patient has no more urological symptoms; no indication of a urinary tract infection can now be found.

Case 17.1-2 Acute urinary retention

Martin Bündner

Anamnesis

The 62-year-old patient is in hospital, where a permanent transurethral catheter has been inserted to treat urine retention caused by the anticholinergic (side) effects of haloperidol (e.g. Haldol®). When the permanent catheter is removed, the urine retention persists, necessitating the insertion of another transurethral catheter on the same day. Later, another attempt is made to remove the catheter, but the patient again suffers from urine retention. The patient has a consultation with a urologist the same day; he again inserts a transurethral catheter.

During his stay in hospital, the patient consults a homeopathic doctor and requests treatment to make weaning off the permanent catheter easier.

The anamnesis from day 1 (period without catheter) mentions the following symptoms:

- The patient feels no urge to urinate
- The only way he can pass water at all is by pressing out single drops. For this, he has to concentrate on passing water and can only urinate standing by pressing his knees against the wall
- If he does not go to the toilet for a lengthy period, he

Evaluation

In this case, it cannot be ruled out that *Cantharis* and *Rhus toxicodendron* might have worked just as well, in view of the fact that the discrepancies were only minor.

Critical commentary

In acute cases, if the choice of remedy is difficult, the existing subacute symptoms can be included in the repertorisation process to bring about improvement across a wider spectrum.

Arsenicum album was not only able to cure the acute urine retention, it also influenced the patients psychotic condition

urine out of the bladder. His bladder is full to bursting

- The patient has severe abdominal pain
- A slightly burning, pressing pain is developing in the front of the bladder neck and in the upper part of the bladder

Diagnosis

Acute urinary retention.

Diagnostic procedures

Urological diagnosis.

Conventional treatment

Insertion of a permanent transurethral catheter.

Homeopathic treatment

Repertorisation

_____ **KENT'S REPERTORY**
Bladder - urging - absent - distended bladder, with

Bladder - paralysis - over-distension, after

Bladder - pain - neck

Bladder - urination - dribbling (by drops)

Differentiation between remedies

Hyoscyamus is the only remedy present in all rubrics.

17.2 Renal and ureteral colic

Hyoscyamus (weighted doubly), which means the administration of this remedy appears justified.

Prescription

10 drops *Hyoscyamus* Q6 once a day.

Progress

On day 5, the doctors at the hospital decide to discharge the patient while leaving the permanent urethral catheter inserted.

On day 9, the permanent transurethral catheter is removed by a local urologist; after removal, the patients bladder still contains about 70 ml urine which he is unable to pass. The patient refuses to have a permanent suprapubic catheter inserted. However, he is told that a permanent suprapubic catheter will be inserted that evening if the urine retention recurs.

During the day, the symptoms described reappear: the patient has increasing abdominal pain but no urge to urinate; he is again unable to pass water. He takes another dose of *Hyoscyamus*, which improves his condition. Another dose eases his condition so much that he can now pass water relatively easily; a slight urge to urinate is felt and the abdominal pain subsides. Further treatment with this remedy is suspended for the time being.

At night, the patient has to get up two or three times to urinate. Afterwards, he is unable to get back to sleep because his thoughts keep churning. He takes *Hyoscyamus* twice a day until day 11; from day 12, he has no more urological problems.

Nevertheless, he continues taking *Hyoscyamus* once a day for the sleep problems and to stabilise his urological condition.

The urine retention does not recur.

Evaluation

The patients progress shows that he needed to take more of the remedy than prescribed. The initial dose of *Hyoscyamus* was too weak to take full effect on the morning of day 9. Only when the patient took more than one dose a day did his condition return to normal. However, as he was still wearing his permanent catheter, it was not possible to establish the optimum dose at first.

Critical commentary

It must be assumed that the early administration of *Hyoscyamus* smoothed the way; as it was only prescribed on the day the permanent transurethral catheter was removed, it should have been taken much more

17.2 Renal and ureteral colic

Definition

Colic is an extremely painful, cramp-like, wave-like contraction of the ureter. It can be accompanied by nausea, vomiting and even intestinal atony.

Blockages of the ureter lumen may be caused not only by kidney and ureter stones, but also by blood clots or tissue particles from tumours in the kidney or renal pelvis. As a result, the intraurethral pressure rises and the peristaltic waves become more frequent. The pain is caused by this hyperperistalsis in combination with the overstretching of the ureter and renal pelvis.

75% of kidney and ureter stones consist of calcium salts, only 15% are made of uric acid; the others are infection-related, cystine and xanthine stones.

Kidney and ureter stones occur when the composition of the patients urine is pathological (e.g. acidosis) or when the urodynamics are disrupted, e.g. in cases of ureter stenosis and pathological kidney morphology (nephrocalcinosis, renal cysts).

Clinical information

Incidence and mortality

The incidence is 5/1000 per annum.

Symptoms

The wave-like pain is typical; depending on the location of the sediment, it may occur in the flank: if the stone is located lower in the central and lower abdomen, the pain may extend to the external inguinal ring. In men, the pain can extend to the penis, perineum and scrotum, in women to the pelvis minor, labia and thighs.

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If the ureter stenosis has been present for a long time, the recurrent, wave-like pain will change into a dull, constant pain.

Diagnostic procedures

If the patient has colicky pain and a corresponding medical history, a urine analysis with test strips to establish the presence of microhaematuria or macrohaematuria can be performed at the emergency site (provided they are available in the emergency vehicle). An acute abdomen should be excluded during a pain-free interval.

The clinic will perform imaging procedures such as sonography and i.v. urograms.

Therapeutic crisis

Even with successful conservative treatment, tears in the mucous membrane, pressure necrosis, perforation and kidney congestion with infections and pyelonephrosis may occur. Homeopathic treatment may help prevent these, enhance the success of conservative conventional treatment and prevent problems which may occur at advanced stages (stenosis, hydronephrosis and renal insufficiency). Anuria is a rare complication in patients suffering from renal colic on both sides. If the patient is feverish, the possibility of kidney congestion and urosepsis should be considered. Homeopathic treatment may also be helpful in such cases.

Homeopathic treatment

Symptom selection

Renal or ureter colic can be treated successfully if the modalities of the symptoms are used to establish the choice of remedy along with the patients sensations and the location of the symptoms.

Repertorisation

KIMESREPERTORY

Kidneys - pain - extending, abdomen

Berb., Canth., Kali-bi., *Nux-v.*

- extending, bladder

Arg-n., Ars., Bell., Berb., Canth., Chef, Coc-c., Kali-i., Lyc., Nit-ac., Oci., Petr., Phyt., *Sars.*, Tab.

KENT'S REPERTORY

- extending, hip

Arn., Berb., Lyc., *Nux-m.*, *Nux-v.*, Ox-ac., Ter.

Kidneys - pain - region of

Abrot., AH-s., Ars-h., Bov., Cadm., Cain., *Calc.*, *Calc-p.*, Chel., *Chin-ar.*, Cop., Erig., Fl-ac., Hydr., Kreos., Myric., Ox-ac., Phys., Rhus-t.

- region of - extending, downward

Berb., *Sars.*

- region of - extending, groin

Kali-bi., Pareir., Petr.

- region of - extending, prostate

Graph., Sei.

- region of - extending, thighs

Agar., Berb., Hep., Ip., Kali-bi., *Nux-v.*

- region of - extending, ureters

Canth., Chel., Oci., Phyt.

Kidneys - pain - ureters - left side

Aesc., Agar., Aloe, Benz-ac., *Berb.*, Calad., Cann-s., Canth., Epig., *Ipom.*, Kali-c., *Lyc.*, *Pareir.*

Kidneys - pain - ureters - right side

Apis, Berb., Cann-s., Canth., *Dios.*, Indg., *Lyc.*, *Nux-v.*, *Oci.*, *Sars.*, Tab., Tarent.

Kidneys - pain - ureters - radiating from renal region

Berb., Pareir.

Kidneys - pain - ureters - extending, urethra, into

Berb., Canth., Coc-c.

- aching

Apoc., Benz-ac., *Calc.*, *Cann-i.*, *Canth.*, Chel., Cinnb., Coc-c., *Crot-h.*, Equis., *Eup-pur.*, *Helon.*, Kali-bi., *Lyc.*, *Nat-ar.*, Scut., Tarent, *Ter.*, Zing.

- aching, region of

Aeon., Agar., All-c., Ambr., Ant-c., Apoc., Berb., Brach., Calc., Carl., Caust., Coc-c., Elat., Equis., Ham., *Hydr.*, *Kali-bi.*, *Lyc.*, Merc-c., Mit, Nat-ar., Pall., Phos., Phys., Sabad., Sep., Still., Tab.

- cramping

Cadm., Caust., *Chel.*, Cycl., Kali-i., *Nit-ac.*, Oci.

- pain, burning

Apis, *Ars-h.*, Arund., *Bell.*, *Benz-ac.*, *Berb.*, Bufo, Cann-i., *Canth.*, *Helon.*, Hep., *Ip.*, *Kali-bi.*, *Kali-c.*, *Kali-i.*, Kali-n., Nat-m., *Nux-v.*, Pin-s., *Pub.*, Rheum, Ter., Zinc.

17.2 Renal and ureteral colic

KENT'S REPERTORY -

pain, cutting - ureters

Aesc., *Apis*, *Arg-n.*, *Arn.*, *Ars.*, *Aspar.*, *Bell.*, *Benz-ac.*, *Berb.*, *Cann-s.*, *Canth.*, *Carb-an.*, *Chlol.*, *Coc-c.*, *Colch.*, *Con.*, *Dios.*, *Equis.*, *Erig.*, *Eup-pur.*, *Indg.*, *Kali-ar.*, *Kali-c.*, *Lach.*, *Lyc.*, *Med.*, *Nat-s.*, *Nux-m.*, *Nux-v.*, *Oci.*, *Op.*, *Pareir.*, *Phos.*, *Psor.*, *Sars.*, *Senec.*, *Sep.*, *Sil.*, *Tab.*, *Verat.*, *Zinc.*

- pain, drawing

Clem., *Coc-c.*, *Nux-m.*, *Ter.*, *Zinc.*

- pain, drawing - region of

Aloe, *Alum.*, *Benz-ac.*, *Berb.*, *Cann-s.*, *Carl.*, *Cinnb.*, *Iod.*, *Kali-n.*, *Lach.*, *Meny.*, *Ruta*, *Ter.*, *Zinc.*

- pain, drawing - ureters

Berb., *Cham.*, *Nat-m.*, *Sulph.*, *Thuj.*

- ureters - extending to penis and testes

Cann-i., *Canth.*, *Con.*, *Dios.*, *Nux-v.*

- ureters - extending, urethra and seminal cords

Clem., *Dios.*

- pain, gnawing

Berb., *Tarent.*

- pain, pressing

Am-br., *Aphis*, *Calc.*, *Canth.*, *Carl.*, *Cimic.*, *Clem.*, *Coc-c.*, *Hyper.*, *Kali-c.*, *Nit-ac.*, *Nux-v.*, *Ran-s.*, *Ter.*, *Thuj.*, *Zinc.*

- pain, pulsating

Berb., *Bufo.*

Kidneys - pain - sore, bruised

Aeon., *Agar.*, *Alum.*, *Apis*, *Arg-n.*, *Ars.*, *Asaf.*, *Asar.*, *Benz-ac.*, *Berb.*, *Brach.*, *Cact.*, *Calc-ar.*, *Calc.*, *Cann-s.*, *Canth.*, *Chel.*, *Cinnb.*, *Clem.*, *Coc-c.*, *Colch.*, *Ferr-i.*, *Graph.*, *Hell.*, *Helon.*, *Hep.*, *Kali-i.*, *Mane.*, *Meny.*, *Merc.*, *Merc-c.*, *Nat-s.*, *Nux-v.*, *Pareir.*, *Phys.*, *Phyt.*, *Plb.*, *Puls.*, *Rat.*, *Rhus-t.*, *Sei.*, *Solid.*, *Tab.*, *Tarent.*, *Tell.*, *Ter.*, *Vesp.*, *Zinc.*

- pain, stabbing, in the region

Am., *Erig.*

- pain, stitching, radiating

Berb.

- extending, bladder

Arg-n., *Bell.*, *Berb.*, *Coc-c.*, *Cupr-ac.*, *Kali-bi.*, *Lach.*, *Oci.*

- extending to knees

Berb., *Ip.*, *Kali-bi.*

- extending, ureters, into

KENT'S REPERTORY -

pain, stitching, stinging, sticking

Aeon., *Aesc.*, *Aeth.*, *Agar.*, *Anat.*, *Ant-t.*, *Arn.*, *Ars.*, *Astac.*, *Bapt.*, *Bell.*, *Berb.*, *Bov.*, *Calc-f.*, *Cann-i.*, *Canth.*, *Carb-an.*, *Chel.*, *Chin.*, *Coc-c.*, *Coloc.*, *Crot-t.*, *Cycl.*, *Dig.*, *Erig.*, *Gamb.*, *Grat.*, *Hep.*, *Ip.*, *Kali-ar.*, *Kali-bi.*, *Kali-c.*, *Kali-i.*, *Kali-n.*, *Kali-p.*, *Kali-s.*, *Lach.*, *Lob.*, *Lyc.*, *Mag-m.*, *Mang.*, *Mez.*, *Nat-m.*, *Nat-p.*, *Nux-v.*, *Phos.*, *Ph-ac.*, *Plb.*, *Ran-s.*, *Sep.*, *Staph.*, *Sulph.*, *Tarent.*, *Ter.*, *Upa.*, *Valer.*, *Vip.*, *Zinc.*

- pain, tearing

Aesc., *Berb.*, *Canth.*, *Kali-c.*, *Lyc.*, *Mez.*, *Raph.*, *Rhus-t.*, *Zinc.*

Urine - bloody

Aeon., *Aloe*, *Alumn.*, *Ambr.*, *Ant-c.*, *Ant-t.*, *Apis*, *Arg-n.*, *Arn.*, *Ars.*, *Aspar.*, *Aur.*, *Bell.*, *Benz-ac.*, *Berb.*, *Both.*, *Cact.*, *Calc.*, *Camph.*, *Cann-s.*, *Canth.*, *Caps.*, *Carb-v.*, *Carbn-s.*, *Caust.*, *Chim.*, *Chin.*, *Chin-am.*, *Chin-s.*, *Cimic.*, *Coc-c.*, *Colch.*, *Coloc.*, *Con.*, *Cop.*, *Crot-c.*, *Crot-h.*, *Cub.*, *Cupr.*, *Cupr-s.*, *Dulc.*, *Equis.*, *Erig.*, *Ferr.*, *Ferr-ar.*, *Ferr-m.*, *Ferr-p.*, *Ham.*, *Hell.*, *Hep.*, *Hyper.*, *Ip.*, *Jatr.*, *Kali-ar.*, *Kali-chl.*, *Kali-i.*, *Kali-n.*, *Kalm.*, *Kreos.*, *Lach.*, *Lyc.*, *Merc.*, *Merc-c.*, *Mez.*, *Mill.*, *Murx.*, *Nat-m.*, *Nit-ac.*, *Nux-v.*, *Op.*, *Ox-ac.*, *Pall.*, *Pareir.*, *Petr.*, *Phos.*, *Ph-ac.*, *Plb.*, *Psor.*, *Puls.*, *Rhod.*, *Rhus-a.*, *Rhus-t.*, *Sabad.*, *Sabin.*, *Sars.*, *Squil.*, *Sec.*, *Senec.*, *Sep.*, *Sulph.*, *Sulph-ac.*, *Tab.*, *Tarent.*, *Ter.*, *Thuj.*, *Uva.*, *Vesp.*, *Zinc.*

Differentiation between important homeopathic remedies

| **Important homeopathic remedies** *Berberis vulgaris*, *Cantharis*, *Kalium bichromicum*.

Berberis vulgaris: stabbing, digging, tearing or throbbing pain in the region of one or both kidneys. A stabbing, digging or tearing pain in the region of one of the kidneys, as if pus were forming there; from deep pressure. Tearing, throbbing pain in the right kidney. Cutting pain from the left kidney into the bladder, urethra and penis. Stitching pain from the kidneys into the bladder and urethra. Red sediment in the urine. Unusual facial pallor with dirty grey tinge, sunken cheeks and sunken eyes surrounded by bluish or blackish rings. Dyspepsia.

Cantharis: Dull, pressing pain in both kidneys, urge to urinate which constantly increases in intensity. Attacks of cutting, burning pain in both kidneys, the area is very sensitive to touch, alternating with pain at the tip of the penis; urge to urinate; painful passing of drops of bloody urine and

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sometimes of pure blood. Dull, heavy pain in the kidney region, on one side, no relief in any position; patient twists and turns constantly with groans and cries ending in nausea, retching and vomiting, unless the stomach is empty; no significant urge to

urinate but a tickling shiver runs down the back of the penis to the glands.

Kalium bichromicum: thread-like mucus in the urine. Kidney congestion. Pyelitis. Urine mixed with epithelial tissue, mucus, pus or blood.

Case 17.2-1: Renal colic

Edacheril Scaria Rajendran

Anamnesis

33-year-old patient with severe pain in the right lumbar region extending to the testes, penis and right thigh. Severe nausea and vomiting of acidic fluid during the pains. The abdomen in particular is sensitive to clothing. Kidney stones surgically removed from the left kidney two years previously.

Diagnosis

Renal colic on the right with nephrolithiasis.

Diagnostic procedures

Findings on admission

Sensitivity in the right side of the lumbar region.

Imaging techniques

Abdominal sonography

5 mm stone in the upper calyx of the right kidney.

Homeopathic treatment

The kidney stone and the side affected are guiding symptoms and are supplemented by the patient's hypersensitivity and the characteristic pain extending to the testes and thighs.

Repertorisation

KENT'S REPERTORY

Kidneys - pain

Differentiation between remedies

The remedy diagnosed, *Nux vomica*, is confirmed by the materia medica:

“Colic. Kidney stones.” (Clarke 1995)

“Renal colic extending to genitals [...]”. (Boericke 1996)

“A pulling under the left breast with anxiety, a kind of constriction around the heart which makes breathing difficult. [...] First pressure in the scro- bicus cordis, then cutting in the lower abdomen with constant nausea. [...] Pulling, gripping pain in the lower body. [...] Pain in the abdominal muscles as if beaten, particularly painful on movement. [...] The lower body is painful to the touch. (Hahnemann 1992)

Prescription

10 drops *Nux vomica* 10M in water once an hour.

Progress

After administering the remedy three times, the patient has no more pain. He continues to take 10 drops twice a day for a month. The ultrasound then performed shows no stones in the kidney. The renal colic has not recurred since then (seven years ago).

Evaluation

The colic subsided very quickly when treated with very high potencies.

17.3 Urosepsis (UTI)

17.3 Urosepsis (UTI)

Definition

UTI is defined as septicaemia or septic shock originating in the urogenital tract. Urosepsis is a life-threatening disease.

It is usually caused by disruptions in urine flow (congestion) together with an infection, e.g. in cases of pyelonephritis, renal abscesses, prostatitis, epididymitis and pyonephrosis. Urosepsis may also occur after urological surgery, particularly of the lower urogenital tract.

The pathogens most frequently involved in urosepsis are *Escherichia coli* (60-70%), *Proteus mirabilis* (10%), *Streptococcus faecalis* (10%), *Klebsiella* (5%) and *Pseudomonas* (5%).

Note: Urosepsis is particularly dangerous in older people in poor condition and patients with diabetes mellitus or consuming diseases.

Clinical information

Incidence and mortality

Despite intensive medical treatment, the mortality rate is approx. 15-25%.

Symptoms

The patient becomes feverish with septic temperatures,

condition deteriorates quickly, his blood pressure drops, his heart rate rises, he develops oliguria or anuria and becomes confused; the condition ultimately leads to shock and coma.

Diagnostic procedures

The **anamnesis** provides critical information: a history of urological diseases or surgery, kidney stones, renal colic, prostate hypertrophy, tumours, dysuria, permanent catheter wearing and macrohaematuria. The **physical examination** reveals a high body temperature and excessively warm extremities although the blood pressure is low. Classic shock symptoms develop later.

The **manual urological examination** and urine test with strips may indicate an infection of the urogenital system (orchitis, epididymitis, urinary tract infection); pain on tapping the kidney region may indicate pyelonephritis.

Therapeutic crisis

Complications include shock kidney, uraemia and thrombophlebitis in the pelvic veins.

By treating the urosepsis, homeopathy may help prevent complications and reduce mortality rates.

Homeopathic treatment

Case 17.3-1: Pyelonephritis on both sides

Martin Bundner

Anamnesis

The 61-year-old patient with pyelonephritis on both sides and a temperature of 39.6 °C visits the homeopath (day 1); he refuses antimicrobial treatment. The infection began after he was exposed to a draught while in a sweaty condition. The fever progresses in three stages: first he shivers, then he sweats, then he is hot. He does not find it easy to talk while he is shivering; speaking is very hard work. His sweat stinks. He suffers from nausea and vomiting. He also has severe pain in both kidneys and flanks; this subsides when he lies on

and increases when lying on his back or side and when touched. In the early stages, he was unable to pass water even though his bladder was full, then he suddenly began to urinate frequently and blood was visible in his urine. He feels a burning sensation in the urethra when urinating and a pressure in the penis and urethra. He is only passing a small amount of urine.

The buzzing headache extends from his neck to his eyes and is affecting his vision. The headache worsens when walking, reading and watching TV.

Diagnosis

Pyelonephritis on both sides

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Diagnostic procedures

Findings on admission

Both kidney regions are painful on pressure and when tapped. The patient refuses any other conventional examinations.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Generalities - air - draught aggravated

Generalities - lying - back, on - aggravated Generalities - lying - side, on - aggravated Generalities - touch - aggravated

Fever - succession of stages - chill followed by sweat, then heat

Differentiation between remedies

The most striking symptom in the case is without a doubt the progress of the fever. However, this rubric contains only one remedy (*Belladonna*) and is therefore placed at the end of the repertorisation list. The remedies remaining when this rubric is left out (*Aconitum*, *Bryonia*, *Calcarea carbonica*, *Causticum*, *Kalium carbonicum*, *Lachesis*, *Mercurius solubilis*, *Natrium muriaticum*, *Nux vomica*, *Phosphorus*, *Ranunculus bulbosus*, *Rhus toxicodendron*, *Sepia*, *Silicea* and *Sulphur*) are eliminated in view of the fact that the life-threatening disease began very suddenly, a characteristic which indicates *Belladonna*. The headache with visual disturbances is also a *Belladonna* symptom, and this remedy is consequently chosen taking the totality of symptoms into account.

Prescription

2 globules *Belladonna* 30C as needed from day 1.

Progress

After taking the remedy, the patient rapidly falls into a deep sleep. He takes *Belladonna* again on waking up. On day 2, his temperature has dropped to 37-38 °C, the pain has subsided and he is sweating more profusely. He takes *Belladonna* for the third time. At around 10 pm, his temperature rises again; this time, the sweat follows the

cold. He can only urinate when drinking. Initially, he can only pass a few drops of urine; when the urine finally begins to flow, he feels a sensation of burning in the urethra. His urine is now completely clear. He has stabbing pains in the regions of both kidneys which worsen on pressure and when he lies on his side or back. His forehead is hot. He has a bursting headache over his eyes which worsens on pressure and when turning over in bed.

Repertorisation II

KENT'S REPERTORY

Fever - uncovering - chilliness, from

Fever - succession of stages - heat followed by sweat
Bladder - urination - retarded - must wait for urine to start

Bladder - urination - dysuria - fever, during

Urine - watery, clear as water

Differentiation between remedies

The remaining remedy is *Nux vomica*. The rubric "Bladder - urination - dysuria - fever, during" is only small and excludes *Belladonna* and *Rhus toxicodendron*. *Belladonna* is also eliminated by the fact that the patient's symptoms worsen when he turns over in bed. The character of *Rhus toxicodendron* seems less appropriate than that of *Nux vomica*, and the last-named remedy is therefore chosen.

Prescription

5 drops *Nux vomica* Q3 three times a day from day 2.

Progress

Next day, the fever and the pain in the limbs and muscles have gone. The patient still has a headache when moving, his urine is yellowish-red and his tongue is coated white. *Nux vomica* is administered further without changing the dose.

On day 4, the symptoms change again: the patient breaks into a sweat on the slightest exertion. He feels pain in the prostate when sitting down. He is only able to pass drops when beginning to urinate; he also has a burning sensation when doing so. He needs to exert sufficient pressure to urinate; he is unable to urinate when sitting down. His tongue is coated white.

17.3 Urosepsis (UTI)

*The rubric "Rectum pain" also covers prostate symptoms.

Repertorisation III

KENT'S REPERTORY

Bladder - urination - retarded - must wait for urine to start - standing, can only urinate when standing
Bladder - urination - dribbling (by drops)

Differentiation between remedies

The repertorisation process concludes with *Pulsatilla* and *Sarsaparilla*. Prostate pain is best covered by *Pulsatilla*.

Prescription

10 drops *Pulsatilla* Q3 four times a day from day 4.

Progress

The patients condition again improves after taking *Pulsatilla*. He now has stabbing pains before passing water and develops herpes labialis on both lips. The patient no longer feels pain if he wears an angora corset over the kidney area (day 6). On day 8, the patient reports hot flushes which developed during a very strenuous walk on day 7. Once again, he can only pass water if he has enough pressure on the bladder. The urine initially flows in drops, then in a stream. He again feels pain in the prostate when sitting down, and now also before urinating.

Repertorisation IV

KENT'S REPERTORY

Rectum - pain* - sitting, while (aggravated)

Differentiation between remedies

The remaining remedies are *Causticum*, *Muriaticum acidum*, *Sarsaparilla* and *Thuja*. Only *Muriaticum acidum* is weighted doubly or triply in both rubrics, and is therefore chosen.

Prescription

3 drops *Muriaticum acidum* Q3 three times a day from day 11.

Progress

After taking *Muriaticum acidum*, the remaining symptoms subside rapidly and the patient no longer feels as weak. On day 21, the patient is completely symptom-free and is prescribed 1 drop of *Muriaticum acidum* Q6 once a day until the bottle is empty in order to stabilise his condition.

Evaluation

This case study describes the complicated progress of a life-threatening disease, which in general responded well to homeopathic treatment.

Critical comments

Case 17.3-2: Recurrent urosepsis and pneumonia following early stages of multiple organ failure

Martin Bundner

Anamnesis

The 80-year-old patient feels well during the day; however, in the evening he suddenly becomes unresponsive and almost stops breathing. His relatives call an ambulance. The patients skin is marbled, he is short of breath, his blood pressure cannot be measured, his

pulse is tachycardic. He is immediately intubated, respiration and volume-loaded at the emergency site. He is admitted to the hospital intensive care unit at around 10.30 pm with septic shock.

The patients condition improves while being respiration and on beginning antibiotic treatment with ampicillin (e.g. Binotal*), as a result of which he is extubated the day after admission (day 2). On day 5, the patient is transferred to a general ward while still receiving antibiotic treatment. An agreement is reached with his relatives that he is no longer to receive intensive treatment if his condition again

17 Urological emergencies

worsens; this is due to his multimorbidity and his generally very poor prognosis with early multiple organ failure and respiratory insufficiency, depressed circulation and early disseminated intravascular coagulopathy.

On the general ward, it is noticed that the patient is unable to speak clearly. He is dehydrated, but his skin is no longer marbled and subjectively he feels well. Although the antibiotic treatment has been continued unchanged, his temperature rapidly rises from 36.6 °C to 39.8 °C. A blood sample is taken for culture, but no evidence of pathogens is found (patient on antibiotics).

The physical examination reveals a very dry, coated tongue with a red tip. The right arm and the fingers of the right hand feel cold. The distal end of the right thigh is colder than the left thigh. The patient is not thirsty. Foamy, bloody, flaky blood is visible in the permanent catheter. The skin is marbled, the patient is hyperventilating. Astonishingly, the patient still feels well, although he seems somewhat confused.

Diagnosis

Recurrent urosepsis after early multiple organ failure. Coronary three-vessel disease. Primary chronic polyarthritis. Osteoporosis.

Diagnostic procedures

Findings on admission

80-year-old cachectic patient, poor general and dietary condition, seriously ill. Intubated and respirated. Skin cool and pale. Heart rate 100/min., blood pressure 95/55 mmHg. Abdomen somewhat marbled. Poor peristalsis.

Laboratory

Day 1: urea 63 mg%. Creatinine 2.82 mg%. Uric acid 11.1 mg%. Calcium 2.20 mmol/l. CRP 68 mg/l. Leucocytes 22 900/pl. Quick 43%. Ferritin 437 ng/ ml (normal 3 - 378).

Imaging techniques

Resting ECG (day 1): heart rate 102/min., SR, LT. Persistent ST elevation in VI - V3. Negative T wave in V5 and V6.

Chest x-ray in supine position (day 2): standard CVC from right. No congestion, no infiltration.

Abdominal sonography (day 1): aortic aneurysm, 2.7 cm diameter. Otherwise normal.

Conventional treatment

Intubation and respiration, monitoring in intensive care unit, treatment with ampicillin.

Homeopathic treatment

Repertorisation I

KENT'S REPERTORY

Stomach - thirst - thirstless - heat, during

Chill - on one side

Urine - frothy

Skin - discolouration - marbled

Mouth - dryness - thirstless

Tongue - red - tip

Differentiation between remedies

Apis and *Lycopodium* are both mentioned in all these rubrics. The criterion of marbled skin cannot be used for differentiation as this rubric is only small and incomplete. Both remedies mention a dry tongue. It is assumed that the patients septic condition requiring respiration and intensive care should have been treated with the same homeopathic remedy. Unlike *Lycopodium*, *Apis* mentions fever with dyspnoea in both the heat and chill stages.

Prescription

1 dose of 2 globules *Apis* 30C on day 5 and day 8.

Progress

The patient has developed UTI. As agreed with his relatives, he is not readmitted to intensive care. On day 6, the patient has a temperature of 37.8 °C in the morning which drops to 37.0°C at midday. The antibiotic has not been changed. On day 7, the patient is confused and talking nonsense. This symptom was not present before he was admitted to intensive care; it is therefore assumed that he has developed organic brain

17.3 Urosepsis (UTI)

He is discharged from hospital on day 9 with no fever. He has to continue taking ofloxacin (e.g. Floxin*). Despite continuing the antibiotic treatment with ofloxacin, the patient develops severe cyanosis on the evening of day 11 while being given oxygen at home, and his systolic blood pressure drops to 70 mmHg. An ambulance is called. His heart rate is 148/min., his oxygen saturation 49% and his body temperature 39.2 °C. The patient is admitted to hospital and taken to a general ward with suspected septic shock. The patient feels well, even though his condition is life-threatening.

He is given one dose of 3 globules *Apis* 30C, as this remedy has already proven effective. After taking the remedy, the patient's temperature does not fall as hoped; instead, it continues to rise to over 40 °C. The left foot and thigh and the right hand and arm are cold.

Diagnosis

Recurrence of UTI with septic shock and pneumonia in the left basal lobe after early stages of multiple organ failure.

Diagnostic procedures

Findings on admission

Day 11: poor general and dietary condition. Left hand warm, right hand cool. Body warm. Left foot cold. Lower lip trembles, chin twitches. Tongue dry with a dirty coating. Shallow breathing. Heart rate 148/min. Abdomen painful on pressure. Slight marbling on both thighs. Patient is shivering a little.

Laboratory

Day 11: Leucocytes 20 200/pl, Quick 65%. Creatinine 1.19 mg%. Uric acid 7.5 mg%. CRP > 120 mg/l.

Imaging techniques

Chest x-ray in supine position (day 11): partly extensive, partly striped thickening in the left basal lobe. Pneumonic infiltration with partial atelectasis and reactive effusion.

Conventional treatment

Monitoring on general ward, treatment with amoxicillin + clavulanic acid once the fever subsides after taking the

Homeopathic treatment

Repertorisation II

CARD INDEX REPERTORY

Blotchy, mottled, marbled

Heat - fever

Coldness of individual body parts

Direction diagonal

Face bluish

Differentiation between remedies

The repertorisation process finishes with *Lachesis*. The twitching in the lower jaw was not observed during the patient's previous stay in hospital, and must therefore be viewed as a new symptom. This also confirms *Lachesis*. The fact that the pneumonia is in the left lung can also be seen as an indication for this remedy. Moreover, *Lachesis* has repeatedly proven its reliability when treating sepsis, insofar as the patient has *Lachesis* symptoms.

Prescription

1 dose of 2 globules *Lachesis* 30C at 8.30 pm on day 11.

Progress

By 10 pm, the patient is sweating profusely but has regained a degree of mental clarity. At midnight, he is sleeping deeply and still sweating. The fever disappears completely during the night. He sweats so profusely that the bed has to be changed several times. Another blood culture is made after the fever disappears; again, there is no evidence of bacteria. Next morning (day 12), the patient commences antibiotic treatment with amoxicillin and clavulanic acid (e.g. Augmentin'). His general condition then worsens; both pupils contract to a minimum, he stops talking and only reacts slowly and very little when spoken to. His relatives are informed that he is close to death. However, he recovers during the day: he can eat, drink and becomes increasingly oriented and responsive. Because of his poor kidney parameters, infusion treatment is initiated on day 14; his kidney

Tab. 17.3-1: Progress of parameters following initial administration of Lachesis											
Date	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
Medication	Lachesis (homeo- pathic remedy)	Antibiotics	Antibiotics	Antibiotics	Antibiotics	Antibiotics	Antibiotics	Antibiotics	Antibiotics	Antibiotics	Antibiotics
Temperature	40.0 °C (8.30 pm) 39.0 °C (9.30 pm) 37.8 °C (11 Pm) 36.6 °C (4.30 am)	37.4 °C (morning) 37.4 °C (afternoon)	37.6 °C (morning) 37.6 °C (afternoon)	37.7 °C (morning) 38.7 °C (afternoon)	37.8 °C (morning) 38.2 °C (afternoon)	36.2 °C (morning) 36.2 °C (afternoon)	36.2 °C (morning)	36.6 °C (morning) 38.3 °C (afternoon)	37.4 C (morning) 39.2 °C (afternoon) 38.2 °C (evening)	36.9 °C (morning) 38.4 °C (afternoon)	37.2 °C (morning)
CRP (mg/l)	> 120	> 120	-	-	228	-	159	-	154	-	166
Leucocytes	20 200	13 100	-	-	17 400	-	17 800	-	-	-	16 100
Creatinine (mg%)	1.19	2.20 mg%	-	2.48	0.94	-	-	-	0.67	-	0.71
Urea (mg%)	-	-	-	-	44.3	-	-	-	27.2	-	26.0
Astrup		Partial respiratory insufficiency	—			Partial respiratory insufficiency				—	Partial respiratory insufficiency

17.4 Injuries to the urogenital tract

His condition is not stable, either radiologically or in terms of laboratory findings and body temperature. Nevertheless, he is discharged with instructions to take ampicillin and sulbactam (e.g. Unacid®) in addition to his other medication until day 31. Nothing is known about what happened afterwards.

Evaluation

Treatment with *Apis* succeeds in arresting another attack of sepsis. However, the patient is discharged from hospital before his infection is completely cured, as a result of which he has to be readmitted shortly afterwards in life-threatening condition despite the treatment with antibiotics. As the symptoms have changed, the remedy which initially matched his symptoms no longer works.

Before changing the antibiotics, *Lachesis* reduced the fever and clearly improved his general condition. He also recovered from the organic brain syndrome from which he had been suffering since being respirationally supported. After changing the antibiotics and repeating the dose of *Lachesis* (although this was not strictly necessary), the laboratory findings improved slowly but the patient's body temperature was still variable and the infection was not yet cured. Further doses of *Lachesis* could have improved his condition.

Critical commentary

The progress of this case shows the weakness of the current health system. The actions taken are not determined by the individual's state of health, but by economic considerations which limited the patient's stay in hospital.

17.4 Injuries to the urogenital tract

Definition

Kidney trauma

Injuries to the urogenital area are the result of dull and/or sharp impact to the abdomen and perineum. 95% of kidney injuries are closed, the rest are open. The latter are most commonly caused by gunshot wounds. Closed kidney trauma usually occurs as part of a polytrauma suffered during road accidents. The injuries may range from kidney contusions (65- 85%) to kidney rupture and tears in the renal pedicle.

Bladder rupture

Closed bladder rupture is also the result of direct abdominal trauma when the bladder is full, and also frequently occurs during road accidents. The result may be intraperitoneal or extraperitoneal bladder perforation. Open bladder injuries occur as the result of stabbing, gunshot wounds or impalement.

Urethra rupture

Urethra rupture is usually also one of many injuries suffered in a polytrauma. However, it may also occur

(impalement, knife wounds, incorrect catheterisation etc.). The pars membranacea urethrae, the part of the urethra attached to the pubic bone, is the part most commonly affected when the urethra ruptures.

Clinical information

Symptoms

Kidney trauma

As kidney injuries frequently occur as part of a polytrauma, the patient may often be suffering from shock. There may also be indirect indications of injury such as grazes, contusions or haematomas in the flank area. Microhaematuria or macrohaematuria also indicate that the kidneys may be involved.

Bladder rupture

Open bladder wounds lead to the discharge of urine tinged with blood from the urethra or the open wound. However, macrohaematuria is not the rule; anuria may also be present.

The bulge in the abdomen is caused by haematoma and the leakage of urine; the patient may develop a defensive muscle reflex and peritonitis.

Urethra rupture

Perineal haematoma and spontaneous bleeding from the

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Diagnostic procedures

Kidney trauma

In cases of polytrauma, other injuries may be more obvious and urological injuries are frequently

*** Note:** look for signs of kidney trauma when dealing with cases of polytrauma!

The suspected diagnosis of kidney trauma is derived from the case history including an evaluation of the accident or the possible trauma and from the clinical symptoms, with pain as the leading symptom.

Urine diagnostics, sonography, spiral CT with contrast agent and selective renal angiography round off the diagnostic procedures.

Bladder and urethra rupture

The suspected diagnosis can be made on the basis of the symptoms and the typical anamnesis. Instrumental examination techniques such as catheterisation should not be employed in such cases.

Therapeutic crisis

Injuries in the urogenital tract are subject to a high risk of complications (primary, e.g. infections; secondary, e.g. stenosis). Homeopathic treatment supports the healing process.

Homeopathic treatment

Symptom selection

The type of injury and the subjective and objective injuries should all be incorporated into the choice of

Repertorisation

KENT'S REPERTORY

Bladder - calculi - after operation for

Arn., *Calen.*, *Cham.*, *Chin.*, *Cupr.*, *Nux-v.*, *Staph.*, *Verat.*

Bladder - haemorrhage

Crot-h., *Erig.*, *Ferr-p.*, *Ham.*, *Lyc.*, *Phos.*, *Sec.*

Bladder - paralysis - parturition, after - no desire

Ars., *Canth.*, *Caust.*, *Ferr.*, *Hyos.*, *Kreos.*, *Nux-v.*, *Phos.*, *Zinc.*

Bladder - retention of urine - confinement, after

KENT'S REPERTORY

Bladder - urination - dysuria - married women, newly

Cann-s., *Ery-a.*, *Staph.*

Urethra - haemorrhage

Aloe, *Ambr.*, *Am-c.*, *Ant-c.*, *Ant-t.*, *Arg-n.*, *Am.*, *Ars.*, *Arum-m.*, *Bell.*, *Bry.*, *Cact.*, *Calc.*, *Camph.*, *Cann-s.*, *Canth.*, *Caps.*, *Carbn-s.*, *Caust.*, *Chel.*, *Chin.*, *Chin-s.*, *Con.*, *Croth-h.*, *Cur.*, *Erig.*, *Euph.*, *Ferr-m.*, *Ferr-p.*, *Graph.*, *Ham.*, *Hell.*, *Hep.*, *Ip.*, *Kali-ar.*, *Kali-c.*, *Kali-i.*, *Kali-s.*, *Lyc.*, *Merc.*, *Merc-c.*, *Mez.*, *Mill.*, *Murx.*, *Mur-ac.*, *Nat-m.*, *Nit-ac.*, *Nux-v.*, *Phos.*, *Plb.*, *Puls.*, *Sars.*, *Squil.*, *Sec.*, *Senec.*, *Seneg.*, *Sep.*, *Sulph.*, *Ter.*, *Thuj.*, *Zinc.*

- pure blood

Bry., *Canth.*, *Caps.*, *Ham.*, *Hell.*, *Mez.*

- coagulated blood

Cact., *Caust.*, *Chin.*, *Coc-c.*, *Nux-v.*

- pain in kidneys and bladder, with

Ip., *Puls.*

- painful

Merc., *Zinc.*

- painless

Ars-h., *Lyc.*, *Merc.*, *Psor.*, *Sec.*

- urinating, after

Dulc., *Hep.*, *Mez.*, *Puls.*, *Sars.*, *Sulph.*, *Thuj.*, *Zinc.*

Differentiation between important homeopathic remedies - 9.

Important homeopathic remedies *Arnica*,

Arsenicum album, *Staphisagria*.

Arnica: dark, brick-red sediment. Bladder tenesmus with very painful micturition.

Arsenicum album: the bladder seems paralysed. Cylindrical fibrin lumps and clumps of pus and blood in the urine.

Staphisagria: pain following kidney stone operation. Unproductive urge to urinate in newly married women. Pressure on the bladder. Feeling as if a drop of urine is constantly running down the urethra.

17.4 Injuries to the urogenital tract

Case 17.4-1: Sterilisation

Martin Bündner

Anamnesis

The 44-year-old patient wishes to be sterilised in an elective operation.

Diagnosis

Planned sterilisation.

Conventional treatment

Vasectomy.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - wounds - penetrating

Generalities - wounds - cuts

Differentiation between remedies

Repertorisation with these two rubrics leaves *Ledum*, *Silicea* and *Sulphur*. Of these, *Ledum* is the most important remedy for treating the deep injuries which will occur during this surgery. Tyler, Allen and

Case 17.4-2: Imminent prerenal kidney failure caused by stomatitis

Martin Bündner

Anamnesis

The one-and-a-half year old girl has had a severe cold with fever for more than a week, which has been treated with the "usual" home remedies. After the fever subsides, greyish and extremely painful ulcers develop everywhere in her mouth; this is diagnosed as stomatitis. Despite painting with antiseptic and giving the child an antibiotic (penicillin) to avert the risk of superinfection, the disease gets visibly worse. Within a very short time, the whole mouth is affected. from the lips to the tip of

Phatak confirm this: "Puncture wounds from sharp tools such as awls, nails [...]"

Prescription

2 doses of 2 globules *Ledum* 30C in the evening before the surgery at an interval of three hours; in the morning 2 globules before and after the surgery.

Progress

The surgery proceeds without complications. After the operation, the patient merely reports an occasional tugging sensation. Otherwise he has no difficulties.

Evaluation

We can only wish that everyone undergoing this surgery had this remarkably uncomplicated experience, as it is usually followed by severe pain and restricted movement for about three days.

Critical commentary

This remedy should not necessarily be administered for

Two weeks after the stomatitis aphthosa began, the now completely exhausted and worried mother (a nurse) decides to take the child for homeopathic treatment. For days, her daughter has been refusing the water she normally likes to drink. The mother was usually able to get at least 200 ml water into her mouth with a syringe, but today she only managed 100 ml. She refuses infusion treatment, as this would mean a hospital stay, which she wants to avoid on personal grounds. The fever has gone. The mother describes the child's sweat as foul smelling. The girl sleeps poorly and wakes several times a night with pain in her mouth.

Diagnoses

Impending prerenal kidney failure. Stomatitis.

Diagnostic procedures

Findings on admission

Apathetic, very ill toddler with pallor around her mouth. She clearly has severe pain in her mouth.

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Grey ulcers can already be seen on the lips. She only opens her mouth a little, as a result of which only the tip of the tongue can be inspected. Here an ulcer measuring approx. 1.5 x 1 cm is seen; the ulcer looks apthous. No body odour is perceptible during the examination.

Conventional treatment

Antiseptic. Previously penicillin (treatment concluded).

Homeopathic treatment

In view of the very distinctive finding, none of the symptoms except for the stinking sweat are unusual. The condition may have been caused by the preceding cold, which must be viewed as having been suppressed. The stomatitis itself is a local symptom; however, the remedy must be listed in the relevant rubric for lack of any other characteristic symptoms. This is a one-sided disease. The pain of the apthous ulcers is a pathognomonic symptom in view of the extremely advanced stage of the disease; however, as the disease is one-sided, the pathognomic symptoms are also repertorised for lack of any others. The matching rubric "Mouth - ulcers - painful" lists only eight remedies; however, the rubric "Mouth - ulcers" has 69. As ulcers in the mouth are usually painful and this symptom is therefore very common, it must be assumed that the small number of remedies given in this rubric is incomplete. These two rubrics are therefore condensed during repertorisation.

Repertorisation I

_____ **KENT'S REPERTORY**

Perspiration - odour - offensive, foetid

Mouth - stomacae

Mouth - ulcers - painful

Mouth - stomacae - cold, after a

Differentiation between remedies

The remaining remedy is *Dulcamara*, which is well-known for treating the severe consequences of suppressed diseases. In "The Encyclopedia of Pure Materia Medica", T.E Allen says the following about *Dulcamara* under "Mouth - general mouth":

"Pimples and ulcers in the mouth, on the inside of the lower lip, on the anterior portion of the palate, with tearing pain on moving the parts".

According to the results of the repertorisation, other possible remedies could include *Mercurius solubilis*, to a limited degree also *Ferrum metallicum* and *Hepar sulphur* or *Carbolicum acidum*. However, *Dulcamara* seems ideally suited in view of the cause of the disease. Although it is not completely definite, *Dulcamara* seems appropriate in homeopathic terms and is therefore chosen.

Prescription

1 dose of 3 globules *Dulcamara* 30C.

Progress

An improvement is seen immediately after taking the remedy; however, this only lasts for two hours. The child then appears to return to her previous state; in fact, her condition seems to worsen! She is even more apathetic than before, and nothing seems to have changed on external impression. When asked what the sweat smells of, the mother replies that it smells sweetish, as is sometimes found in very old, sick women. It is also clammy. The case is progressing extremely unfavourably and is causing great doubt about the choice of remedy. If *Dulcamara* had been the correct remedy, the disease would have at least stagnated, making it clear that the remedy had been used up and another dose was necessary.

The sticky, sweet-smelling sweat is a characteristic symptom with which the repertorisation process is repeated:

Repertorisation II

_____ **KENT'S REPERTORY**

Perspiration - odour - sweetish

Perspiration - clammy and cold

Mouth - ulcers - stomacae

Differentiation between remedies

Mercurius solubilis is now the only remedy mentioned

17.4 Injuries to the urogenital tract

In order to confirm the choice of *Mercurius solubilis*, which had already been considered the last time round, the rubrics “Mouth - apthae - children, in” and “Mouth - ulcers - painful” (already mentioned) are checked: *Mercurius solubilis* is triply weighted in the former (which incidentally does not list *Dulcamara*) and doubly weighted in the latter.

The rubrics “Sleep - disturbed” and “Sleep - interrupted” do not eliminate *Mercurius solubilis* either. This remedy is therefore chosen.

Prescription

1 dose of 3 globules *Mercurius solubilis Hahnemanni* 200C, about four hours after taking *Dulcamara*.

Progress

The mother is told to contact the homeopath again if there is no improvement, even in the night. However, this does not happen. Next morning, the mother reports that her daughter slept relatively well and hardly woke up in the night. About half of the ulcers on her lips have healed; the ulcer on the tip of her tongue is only about 20% its previous size.

Moreover, during the evening and every time she woke up in the night, she drank larger quantities of water for the first time since the disease began; she has clearly started passing water again. Within two days, her mouth is completely healed; no other problems occur. In just under a month, the girl has regained all her weight and is lively and healthy.

Evaluation

In the authors view, this case history describes the rare occurrence of a one-sided disease presenting as an acute case. The progress of this case proves that both allopathic medicine and homeopathy (here with *Dulcamara*) can provide effective palliative treatment.

Critical commentary

In such an acute case, it is essential to see the patient at short intervals or at least to have a reliable person report on his progress so that any unfavourable developments or stagnation can be recognised in good time. The therapist must also be called at once in the event of the patients condition worsening.

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18 Thermal emergencies

Martin Bundner (Conventional Medicine, Homeopathy)

18.1 Hypothermia and frostbite

18.2 Burns and scalds

18.1 Hypothermia and frostbite

Definition

Hypothermia

Hypothermia is understood as the reduction of body temperature below normal. It occurs when the warmth emitted by the body exceeds the energy it produces over a long period. There are three different forms of hypothermia:

- **Subnormal body temperature** e.g. in cases of collapse, hypothyroidism, cachexia
- **Accidental hypothermia** from exposure to cold; people involved in accidents in water and in the mountains are at particular risk
- **Artificial (iatrogenic) hypothermia** from reducing the body temperature, e.g. with the aid of a heat exchanger when using the heart-lung machine

Frostbite (congelatio)

Frostbite is the most severe form of (local) cold damage. It is made more likely by the patient's disposition (abnormal reactivity of the vascular system), nicotine abuse, the effects of dampness and wind and tight, wet clothing.

The acral body parts (nose, ears, fingers, toes) are most prone to frostbite as the result of accidental exposure. Frostbite occurs at temperatures < 6 °C.

Clinical information

Symptoms

Hypothermia (» table 18.1-1)

Tab. 18.1-1: Clinical signs of a tolerated cardiovascular arrest		
Body temperature	Clinical symptoms	Tolerated cardiovascular arrest (in min.)
36 °C	Shivering, cold feeling	4-10 min. (mild h.)
35-34 °C	Mental changes	-
33 °C	Rigor instead of shivering	-
30 °C	Loss of consciousness, dilated pupils	10 - 16 min. (moderate h.)
28 °C	Ventricular fibrillation, asystole or other cardiac arrhythmia	-
27 °C	Muscle relaxation	16 - 60 min. (deep h.)
18 °C	Isoelectric EEG	60 - 90 min. (severe h.)

Stages of hypothermia

- **Defence stage** (excitation stage, core body temperature 37-34 °C):
 - Cold, pale skin
 - Mental agitation
 - Shivering.
 - Rapid, deep breathing
 - Pain, particularly in the hands, feet and knees
 - Tachycardia

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— **Exhaustion stage** (core body temperature 34-28 °C):

- Cold, pale skin
- Drowsiness
- Increasing muscle rigidity
- Irregular, superficial breathing
- Feelings of pain subside
- Slow, irregular pulse which gradually grows weaker

— **Paralysis stage** (core body temperature 30-27 °C):

- Cold, pale skin
- Unconsciousness
- Muscle rigidity
- Barely perceptible pulse
- Barely perceptible respiratory movements

Frostbite

The clinically most striking signs of frostbite are hard, white, numb acrae; the transitional area is painful. This

Tab. 18.1-2: Classification of frostbite according to severity	
I	Pallor, cooling, numbness. After warming: hyperaemia, mild pain, itching.
II	Blisters appearing immediately or a few hours later which are able to heal without leaving scars.
III	Dry necrosis (mummification) or bluish-red blood blisters; wet necrosis becomes visible at various depths when these burst. Scars left behind after healing.

Diagnosis

Both hypothermia and frostbite are largely diagnosed from the anamnesis and clinical signs.

Special diagnostic procedures (e.g. ECG, EEG) are only used to find or rule out complications.

Therapeutic crisis

Hypothermia is a potentially life-threatening condition, as even if the case progresses favourable, the warming process may be accompanied by severe pain.

Frostbite patients are frequently left with chronic pain in the acrae; in severe cases, the body part affected may have to be amputated. Prompt homeopathic treatment can limit the damage.

Homeopathic treatment

Symptom selection

Hypothermia

All symptoms present at the respective stage must be ascertained and used to find the correct remedy.

Frostbite

Special consideration must be paid to the local symptoms in acute cases; the chronic consequences of frostbite must be treated professionally over a lengthy period.

Repertorisation

KENT'S REPERTORY

Chill - coldness in general

Aeon., Aesc., Aeth., Agar., Agn., Ail., Alst., Alum., Ambr., Am- c., Am-m., Anac., Anthr., Ant-c., Ant-t., Apis, Aran., Arg-m., Arn., Ars., Ars-i., Arum-t., Asaf., Asar., Aur., Aur-m, Bapt., Bar-c., Bell., Berb., Bol., Bor., Bov., Brom., Bry., Bufo, Cact., Cadm., Calad., Calc-ar., Calc., Calc-p., Camph., Cann-i., Canth., Caps., Carb-an., Carb-v., Carbn-s., Cast., Caust., Cedr., Cham., Chel., Chin., Chins., Cic., Cimx., Cimic., Cina, Coca, Cocc., Coff., Colch., Coloc., Con., Cop., Com., Croc, Crot-h., Crot-t., Cupr, Cupr-ar, Cycl., Daph, Dig., Dios, Dros, Dulc, Elaps, Elat, Euon, Eup-per, Eup-pur., Eupi, Ferr., Gamb, Gels, Graph., Grat, Guai, Hell, Helo, Hep., Hyos., Ign, Ip, lod., Kali-bi, Kali-c., Kali-i., Kreos, Lac-c, Lach., Lachn., Laur, Led, Lil-t., Lith, Lob, Lyc, Lyss, Mag-c, Mag-m, Mag-s, Mang, Meny, Merc, Merc-c, Mez, Mosch, Mur-ac., Naja, Nat-ar., Nat-c, Nat-m, Nat-p, Nice, Nit-ac, Nux-m, Nux-v, Op., Par, Petr., Phel, Phos., Ph-ac., Phyt, Plan, Plat, Plb, Podo., Psor., Puls, Ran-b, Rhus-t, Rob., Ruta, Sabad, Sabin, Samb., Sang, Sarr, Sars, Sec, Sei, Senec, Seneg, Sep, Sil., Spig, Spong, Stann, Staph, Stram., Sulph, Sulph-ac., Sumb., Tarent., Tazax, Teucr, Ther, Thuj, Valer, Verat, Verat-v, Vip.

Chill - creeping

Aeon, All-c, Aloe, Am-m, Aml-n, Anac, Ang., Ant-t, Apis, Ars, Ars-h, Asaf, Berb, Bol, Bry., Calad, Calc, Calc-p, Camph, Cham, Chlor, Cimx, Clem, Crot-h, Crot-t, Dig., Dros, Grat, Kali-i, Lyc, Meny, Merc, Merc-s, Mez, Nat-m., Ph-ac, Psor., Rhus-t, Ruta, Samb, Sec, Spig., Stram, Sulph., Sulph-ac, Thuj., Til, Tub., Valer, Verat, Zing.

Chill - pain, with

Ang, Aran., Ars., Asaf, Aur, Bar-c, Bov, Bry, Caps, Cocc, Coloc,

WLES_KfēēfñēY

WdfoLEWdfrRI

Chill - shaking

Abrot., Aeon., *Aesc.*, Aeth., *Agar.*, *Alum.*, Am-c., Am-m., Anac., Ang., Ant-c., Ant-t., *Apis.*, *Aran.*, *Arg-n.*, Arn., *Ars.*, *Asaf.*, Asar., Asc-t., Aur., Aur-m., *Bapt.*, Bar-c., *Bar-m.*, Bell., Bism., Bol., Bov., Brom., Bry., *Cact.*, Calad., Calc., Camph., Caps., *Carb-an.*, Carb-v., Carbn-s., Caust., Cedr., *Cham.*, Chel., *Chin.*, *Chin-s.*, *Cic.*, Cimx., Cist, *Clem.*, Cocc., Coff., Colch., Con., Corn., Croc., Crot-t., Cupr., Dig., *Dros.*, Dulc., Euphr., Ferr., Ferr-p., Gamb., *Gel.*, Graph., Hep., Hydr., *Ign.*, *Ip.*, Kali-bi., Kali-c., Kali-p., *Kali-s.*, Kreos., Lach., Lachn., Lac- ac., Lact., *Laur.*, *Led.*, Lept, Lyc., Meny., *Merc.*, *Merc-c.*, Mez., Mill., Mosch., Mur-ac., Nat-ar., Nat-c., *Nat-m.*, Nat-p., *Nat-s.*, Nit-ac., Nux-m., Nux-v., *Olnd.*, Op., Ox-ac., Par., *Petr.*, *Phos.*, Ph-ac., *Plat.*, Plb., Podo., Puls., Ran-b., *Rhus-t.*, *Sabad.*, Sabin., Squil., Sep., *Sil.*, Spig., Stram., Stront., Sulph., Sumb., *Tarent.*, Tarax., Ter., Teucr., Valer., Viol-t, Zinc.

Chill - shaking, shivering, rigors

Aeon., *Aesc.*, *Agar.*, Aloe, *Alum.*, *Am-c.*, Anac., Ang., Ant-c., *Ant-t.*, *Apis.*, *Aran.*, Arg-m., Arg-n., Arn., *Ars.*, *Ars-i.*, Asaf, Asar., Aster., Aur., *Bapt.*, Bar-c., Bar-m., *Bell.*, Berb., Bol., Bor., Bov., Brom., Bry., *Cact.*, Calad., *Calc.*, Calc-p., Calc-s., Camph., *Cann-s.*, *Canth.*, *Caps.*, *Carb-an.*, *Carb-v.*, Caust., Cedr., Cham., Chef, Chin., *Chin-ar.*, Chin-s., *Cina.*, *Clem.*, Cocc., *Coff.*, Colch., *Coloc.*, Con., Croc., Cupr., Cycl., Dig., *Dros.*, Dulc., *Elaps.*, *Eup-per.*, *Eup-pur.*, *Euph.*, Eupl., Ferr., Ferr-i., Ferr-p., *Gamb.*, *Gels.*, Graph., Guai., Hell., Hep., Hyos., *Ign.*, *Ip.*, *Iod.*, Kali-ar., *Kali-c.*, Kali-chl., *Kali-i.*, Kali-p., Kali-s., Kalm., Kreos., *Lach.*, *Laur.*, *Led.*, *Lob.*, Lyc., Lyss., *Mag-c.*, Mag-m., Mag-s., Mang., *Meny.*, *Merc.*, *Merc-c.*, *Mez.*, *Mosch.*, *Mur-ac.*, *Nat-ar.*, *Nat-c.*, Nat-m., Nat-p., *Nat-s.*, Nit- ac., Nux-m., Nux-v., *Olnd.*, Op., Par., *Petr.*, *Phos.*, *Ph-ac.*, Plan., *Plat.*, Plb., *Podo.*, Psor., Puls., Pyrog., *Rhus-t.*, Ruta, *Sabad.*, Sabin., *Samb.*, Sang., Sarr., *Sec.*, Sep., *Sil.*, Spig., Spong., Stann., *Staph.*, Stram., Sulph., *Tab.*, *Tarent.*, *Tazax.*, Ter., Thuj., Verat, Verb., Zinc.

- bed - putting hand out of bed

Hep., Phos., *Rhus-t.*

- face livid

Rhus-t.

- hair standing on end, with

Am-c., Bar-c., Calc., Caust., Cina, Dulc., Meny., Nit-ac., Puls., Sil.

- motion, during

Alum., Ant-t., *Caps.*, Cedr., Eup-per., Sang., Sil., Sulph., Thuj.

- skin, cold and blue, with

Chill - trembling and shivering

Aeon., *Agar.*, Agn., Anac., Ant-t., Apis, Arn., *Ars.*, Asaf, Bell., Berb., Bor., Bov., Brom., Bry., Calc., Cann-s., Canth., Caps., Carb-an., Cham., Chin., Chin-s., Cic., Cimic., Cina, Cocc., Con., *Croc.*, *Eup-per.*, Ferr., Ferr-ar., Kali-n., *Led.*, Merc., Merc-j-f, Mygal., Nat-c., Nat-m., Nux-v., *Olnd.*, Op., Par., Petr., Phos., Ph-ac., Plat., Psor., *Puls.*, *Rhus-t.*, *Sabad.*, Sil., Stram., Sulph., *Tarent.*, Teucr., Ther., *Valer.*, Zinc.

Extremities - stiffness

Abrot., Absin., Aeon., Aeth., *Agar.*, Am-c., Am-m., *Aran.*, Arg-m., *Ars.*, *Ars-i.*, *Ars-s-f.*, Asaf, *Bell.*, Bov., Brom., Bry., *Calc.*, Calc-p., Calc-s., Camph., Cann-i., Cann-s., Canth., *Caps.*, *Carb-an.*, Carb-v., *Carb-ac.*, Carb-o., *Carbn-s.*, Carl., Caust, *Cham.*, Chef, *Chin.*, Chin-ar., *Cic.*, Cimic., Cocc., *Colch.*, Cupr., Cycl., Dig., *Dulc.*, Eup-per., Ferr-ar., Graph., *Guai.*, *Hell.*, Hydr- ac., Hyos., Iod., Kali-ar., Kali-bi., Kali-c., Kali-p., Kalm., Lach., *Kali-c.*, *Laur.*, *Led.*, Lith., Lyc., *Med.*, Meny., *Merc.*, *Merc-c.*, Merc-i-r., Merc-s., Mosch., Naja, Nat-ar., Nat-c., *Nat-m.*, *Nat-s.*, Nit-ac., Nux-m, Ph-ac., *Phyt.*, Plan., *Plat.*, Plb., Psor., *Puls.*, *Rhus-t.*, *Sang.*, Sars., *Sec.*, SeL, Sep., Sil., *Spong.*, *Stram.*, *Stry.*, Sulph., Tab., *Thuj.*, Verat, Verat-v., Zinc.

Chill - icy coldness of the body

Acon-f, Ant-t., *Ars.*, Bism., Bry., Cadm., *Calc.*, Camph., Carb-v., Carbn-s., Cic., Con., Cupr., Hell., Lachn., *Merc-c.*, Nat-m., Nat-s., Nux-v., Sec., *Sep.*, Sil., Stram., *Tarent.*, Verat, Zinc.

- affected parts

Ars., Calad., Camph., Meny.

- as if lying on ice

Lyc.

- of skin and covered with a cold sweat - hands and feet livid

Stram., Verat.

- skin dry and blue, yet wants to be uncovered

Camph.

- the whole body - with cold breath

Carb-v., Verat.

- uncover, with desire to

Camph., Sec.

- with clammy sweat and blueness - cannot bear to be covered

Sec

Generalities - analgesia

18 Thermal Emergencies

KEHILS REPERTORY,

Generalities - irritability - lack of

Agn., *Alum.*, *Ambr.*, *Am-c.*, *Anac.*, Ant-c., Ant-t., Arn., Ars., Asaf., Bar-c., Brom., Bry., Calc., Calc-i., *Camph.*, Cann-s., Caps., *Carb-an.*, Carb-v., Caust., Cic., *Cocc.*, Colch., Coloc., Con., Croc., Cupr., *Dulc.*, Euph., Ferr., Gels., Graph., *Guai.*, Hell., Hyos., *Ip.*, *Iod.*, *Kali-bi.*, Kali-c., Lach., Laur., Led., *Lyc.*, Mag-c., Mag-m., Mez., *Mosch.*, Mur-ac., Nux-m., Olnd., Op., Petr., Phos., Ph-ac., Plb., Psor., *Rhod.*, Rhus-t., Sec., Seneg., *Sep.*, Spong., Stann., *Stram.*, Stront., *Sulph.*, Thuj., *Valer.*, Verb., Zinc.

Generalities - painlessness of complaints usually painful

Hell., Op., *Stram.*

Generalities - pulse

frequent, accelerated, elevated, exalted, fast, innumerable, rapid

Aeon., Aesc., *Aeth.*, *Agar.*, *Ail.*, AU-c., Aloe, Alum., Ambr., Am-c., Am-m., Anac., Ant-c., Ant-t., Apis, Arg-m., *Arg-n.*, Arn., Ars., Ars-i., Asaf., Asar., Aster., Aur., *Aur-m.*, Bapt., Bar-c., Bar-m., Bell., *Benz-ac.*, Berb., Bism., Bor., Bov., Brom., Bry., Calad., Calc., *Camph.*, Cann-i., *Canth.*, Carb-v., Caust., Cedr., *Cham.*, Chel., Chin., Chin-ar., *Chin-s.*, *Cina.*, Clem., Cocc. Coc-c., Coff., *Colch.*, CoU., Coloc., Con., Crot-c., Crot-t., Cupr., Cycl., Dig., *Echi-a.*, Euph., *Ferr.*, Ferr-i., Ferr-p., Fl-ac., Gels., Glon., Grat., *Guai.*, Ham., *Hell.*, Hep., Hipp., *Hyos.*, *Hyper.*, *Ign.*, Ip., Iod., Kali-bi., Kali-c., Kali-i., Kali-n., Kreos., *Lach.*, *Laur.*, Lob., Lyc., *Lycps.*, *Mane.*, Mang., Merc., Merc-c., Merc-cy., Mez., Mill., *Mosch.*, Mur-ac., *Naja*, Nat-ar., *Nat-c.*, Nat-m., *Nat-s.*, Nice., *Nit-ac.*, *Nux-m.*, Nux-v., Olnd., Onos., Op., Osm., Ox-ac., Par., Petr., Phel., Phos., Ph-ac., Phys., *Phyt.*, Pic-ac., *Plat.*, *Plb.*, Podo., *Puls.*, Pyrog., Ran-b., Ran-s., Rheum, *Rhod.*, Rhus-t., *Rhus-v.*, Sabad., Samb., *Sang.*, Sars., Sec., Seneg., *Sep.*, Sil., Spig., *Spong.*, Stann., Staph., Stram., Sulph., Sulph-ac., *Tab.*, Tell., Ter., Thuj., *Valer.*, Verat., Verat-v., Vesp., Zinc,

- imperceptible

Aeon., Am-c., Ant-t., *Apis*, Ars., Bell., Camph., Chin., Crot-h., Dig., Ferr., Gels., Glon., Ham., Hell., *Ip.*, Kali-bi., *Lach.*, *Laur.*, Mang., *Merc.*, *Naja*, Olnd., Op., Ox-ac., Phos., Ph-ac., Plb., *Podo.*, *Puls.*, *Rhus-t.*, Seneg., *Spong.*, *Stram.*, *Tab.*, Ther., Verat., Zinc.

- imperceptible

Aeon., Agn., Ant-t., Ars., Bell., Benz-ac., *Cact.*, Cann-i., Cann-s., *Canth.*, Carb-v., *Carb-ac.*, Chel., Chin., Cic., *Cocc.*, Colch., Coloc., Crot-h., Cupr., Dulc., Ferr., *Guai.*, Hell., Hyos., *Ip.*, Kalm., Kreos., Lach., Laur., *Merc.*, Merc-c., *Naja*, Nux-v., *Op.*, Ox-ac., Phos., Ph-ac., Plat., Plb., Puls., Rhus-t., Sec., Sil., Stann., Stram., Sulph., Sulph-ac., Tab., Verat., Zinc.

KENT'S REPERTORY

- irregular

Aeon., *Agar.*, Agn., Aloe, Alum., Aml-n., Ant-c., Ant-t., Apoc., Arg-m., *Arg-n.*, Am., Ars., *Ars-i.*, Asaf., *Aspar.*, Aur., Bapt., Bell., Benz-ac., Bism., Bry., *Cact.*, Calc., Camph., Cann-i., Canth., Caps., Carb-an., Carb-v., Carb-ac, Cham., Chel., Chin., *Chin-at.*, Cimx., *Cimic.*, Coff., *Colch.*, Con., Cor-r., *Crot-h.*, Cupr., Dig., Gels., Glon., Ham., Hell., *Hep.*, Hyos., Ign., Iod., *Kali-bi.*, *Kali-c.*, Kali-chl., *Kali-i.*, Kali-p., *Kalm.*, Lach., Laur., Lob., *Lycps.*, Mang., Meny., *Merc.*, *Merc-c.*, Merc-cy., Mez., *Naja*, Nat-ar., Nat-m., Nit-ac., Nux-v., *Olnd.*, Op., Ox-ac, Phos., Ph-ac., Phys., *Phyt.*, *Plan.*, *Plb.*, Pyrog., *Rhus-t.*, Sabad., Sabin., *Samb.*, *Sang.*, Sec, Seneg., *Sep.*, Sil., *Spig.*, *Still.*, Stram., *Sulph.*, Sulph-ac, *Tab.*, Thea, Thuj., Valer., *Verat.*, Verat-v., Zinc.

- irregular and slow

Aeon., Arn., Ars., Asaf., Bell., Camph., Cann-i., Chel., Chin., Cimic., Colch., Dig., Dulc., Ham., Hell., Hyos., Iod., Kalm., Laur., Lob., Merc-c., Merc-cy., Mez., *Naja*, Nit-ac., Nux-v., Olnd., Op., Ox-ac, Ph-ac, Phys., Phyt., Plb., Rhus-t., Seneg., Sulph-ac., Tab., Verat., Verat-v., Zinc.

- slow

Acet-ac., Aeon., Acon-f., Aeth., *Agar.*, Agn., Amyg., Ant e., *Ant-t.*, Apoc., Am., Ars., Asaf., *Aspar.*, Bapt., Bell., Benz-ac, Berb., Brom., *Camph.*, Cann-i., *Cann-s.*, *Canth.*, Caps., Caust., *Chel.*, Chin., *Chin-s.*, Cic., Cimic., Colch., Coloc., Con., *Crot-h.*, Cupr., Dig., Dulc, Ferr., Gels., Glon., Ham., *Hell.*, Hep., Hydr- ac, Hyos., Ign., Iris, Iod., Kali-bi., Kali-c, Kali-chl., Kali-n., Kalm., Kreos., Lach., Lachn., *Laur.*, Lob., *Lycps.*, *Mane.*, Meny., Merc., Merc-c., Merc-cy., Mez., Mosch., Mur-ac., Myric., *Naja*, Nit-ac., *Nux-m.*, Nux-v., Olnd., Op., Ox-ac., Par., Petr., Phos., Ph-ac., Phys., Phyt., Pic-ac., Plb., *Podo.*, Puls., Rhod., Rhus-t., Ruta, Samb., *Sang.*, Sars., Squil., Sec., Sep., Sil., Spig., Spong., Stram., *Tab.*, Thuj., Valer., Verat., Verat-v., Zinc.

- weak

Acet-ac., Aeon., Aesc., Aeth., Aloe, Am-m., Ant-t., Apis, Am., Ars., Asaf., *Aspar.*, Aur., Bapt., Bell., Berb., Bry., Camph., Cann-i., *Canth.*, Carb-an., Carb-v., Cedr., *Chin.*, *Chin-ar.*, Cimx., Cimic, Colch., Crot-h., Crot-t., Cupr., Cycl., Dig, Ferr-m., Gels., Glon., Ham., Hell., Hyos., *Ign.*, *Ip.*, Iris, *Iod.*, *Kali-bi.*, *Kali-br.*, *Kalm.*, Kreos., Lach., Lac-ac., Laur., Lil t., Lob., *Lycps.*, *Mane.*, Mang., *Merc.*, *Merc-c.*, Merc-cy., Mez., *Mur-ac.*, *Naja*, Nat-m., Nux-v., Olnd., Op., Ox-ac., *Phos.*, Ph- ac, Phys., Phyt., Plb., Podo., *Puls.*, Rhod., *Rhus-t.*, Rhus-v., *Sang.*, Sec., Seneg., Sep., *Spig.*, Staph., Stram., Sulph-ac., *Tab.*, Verat., Verat-v., Zinc.

Generalities - unconsciousness - chilly stage of fever, during

Ars., Asaf., Sep.

Repertorisation hypothermia

Ambr., Am-c., Am-m., Amyg., Anac., Anthr., Ant-c., Ant-t., Apis, Apoc., Arg-n., Arn., Ars., Ars-h., Arum-t., Asar., Aster., Bapt., Bar-Mind - excitement, excitable
c., Bar-m., Bell., Bism., Bov., Bry., Bufo, Cact., Cadm., Calad., Calc., Camph., Cann-i., Cann-s., Agar., Agn., Alum., Am-c., Ambr., Am Carb-an., Carb-s., Caust., Chama., Chin., Chin-ar., Chin-s., Chlor., Cica, Cimic., Cina, Coca, Coff., Colch., Coloc., Con., Cor-i., Crot-h., Crot-h., Cupr., Cycl., Dig., Dulc., Eup., Ferr., Ferr-ar., Ferr-i., Ferr-p., Fl-ac., Form., Geb., Glon., Gran., Graph., Hell., Hipp., Hura, Hyos., Hyper., Ign., Iod., Jug-r., Kali-ar., Kali-bi., Kali-br., Kali-c., Kali-i., Kali-n., Kali-p., Kreos., Lach., Lachn., Lachn., Laur., Lee., Lil t, Lith., Lyc., Lycps., Lyss., Mag-m., Mag-s., Meph., Med., Merc., Merc-c., Mill., Mosch., Mur-ac., Naja, Nat-ar., Nat-c., Nat-m., Nat-p., Nit-ac., Nux-v., Ol-j., Op., Ox-ac., Paeon., Pall., Par., Petr., Phos., Ph-ac., Plan., Plat., Podo., Psor., Puls., Raph., Rheum, Rhus-t., Sabad., Sal- ac., Samb., Sang., Sec., SeL, Seneg., Sep., Sil., Spong., Stann., Stram., Stry., Sulph., Sulph-ac., Sumb., Tab., Tarent, Tell., Teucr., Thea, Thuj., Tril., Tub., Valer., Verat., Verb., Viol-o., Vip., Ziz.

- chill, fever, during⁴

Aeon., Ars., Aur., Calc., Canth., Caps., Carb-v., Caust, Cham., Coff, Hep., Lach., Lyc., Nat-m., Nux-v., Phos., Puls., Sulph., Verat.

Mind - stupefaction

Absin., Acet-ac., Aeon., Aesc., Aeth., Agar., Alum., Amyg., Anat, Ant-t., Apis, Arg-n., Ars., Ars-i., Asaf., Asar., Bapt., Bell., Bism., Bov., Bry., Calc., Calc-s., Camph., Carb-an., Carbn-h., Carbn-s., Caust, Cham., Chel., Chin., Chin-ar., Chin-s., Chlor., Cic., Cina, Clem., Cob., Cocc., Coc-c., Coloc., Con., Cor-i., Croc., Crot-h., Cupr., Cycl., Dulc., Ferr., Ferr-ar., Ferr-i., Ferr-p., Geb., Gran., Graph., Hell., Helon, Hyos., Ip., Jatr., Iod., Kali-br., Kali-n., Kali-p., Kreos., Lach., Laur., Lyc., Mag-m., Merc-c., Nat-c., Nat-h., Nat-m., Nat-p., Nat-s., Nice., Nux-m., Nux-v., Olnd., Op., Petr., Phos., Ph-ac., Phys., Plan., Plat., Plb., Psor., Pub., Raph., Rheum, Rhod., Rhus-t., Rhus-v., Sars., Squil., Sec., SeL, Seneg., Sep., Sil., Spig., Stann., Staph., Stram., Sulph., Tab., Ter., Thuj., Valer., Verat., Verb., Vip., Vise., Zinc.

- chill, fever, during⁴

Bor., Con., Hell., Nux-m., Stram.

Mind - unconsciousness

KENT'S REPERTORY

Led., Lil-t, Lyc., Mag-c, Mag-m., Mane, Merc, Merc-c., Mez., Mosch., Mur-ac., Naja, Nat-c., Nat-m., Nat-p., Nit-ac., Nux-m., Nux-v., Oena., Olnd., Ol-an., Op., Ox-ac., Petr., Phos., Ph-ac, Plat., Plb., Puls., Ran-b., Rheum, Rhod., Rhus-t., Ruta, Sabad., Sabin., Sars., Squil., Sec., SeL, Sep., Sil., Sol-n., Spig., Stann., Staph., Stram., Sulph., Sulph-ac., Tab., Tanac, Tarax., Tax., Ter., Valer., Verat., Verat-v., Verb., Vesp., Viol-o., Vip., Vise., Zinc.

- chill, fever, during'

Ars., Bell., Camph., Caps., Cic., Con., Hep., Kali-c., Nat-m., Nux-v., Op., Puls., Stram., Valer.

Respiration - accelerated

Absin., Acet-ac., Aeon., Aesc., Agar., Ail., Alum., Am-c., Aml-n., Anthr., Ant-t., Apis, Apoc., Arg-n., Arn., Ars., Ars-i., Asaf., Aspar., Aur., Bar-c, Bar-m., Bell., Bor., Brom., Bry., Calc., Calc-p., Camph., Cann-i., Cann-s., Canth., Carb-v., Carb-ac., Carbn-s., Cast., Cedr., Cham., Chel., Chin., Chin-ar., Chin-s., Chlor., Cimic., Cina, Clem., Coca, Cocc., Coc-c., Coff., Colch., Coloc., Con., Cop., Crot-h., Cub., Cupr., Cycl., Dig., Dulc., Gels., Glon., Hell., Hep., Hydr., Hydr-ac., Hyos., Ign., Ip., Iod., Kali-ar., Kali-bi., Kali-c., Kali-i., Kali-n., Lact., Laur., Led., Lyc., Lyss., Merc., Merc-c., Merc-s., Mez., Mur-ac., Naja, Nat-ar., Nat-c., Nat-m., Nux-m., Nux-v., Op., Ox-ac., Petr., Phos., Phyt., Plan., Plb., Pub., Rhod., Rhus-t., Samb., Sang., Squil., SeL, Seneg., Sep., Sil., Spong., Stann., Stram., Sulph., Sulph-ac., Tab., Tub., Verat., Verat-v., Vesp., Vine., Zinc.

Respiration - deep

Aeon., Agar., Ail., Am-m., Ant-c., Ant-t, Arg-n., Am., Ars., Aur., Bar-c., Bar-m., Bell., Bor., Bov., Brom., Bry., Cact., Calc., Calc-p., Camph., Cann-s., Caps., Carb-v., Cast., Caust., Cham., Chel., Chin., Chin-ar., Chlor., Cic., Cimx., Colch., Croc., Cupr., Dig., Dros., Euon., Euph., Fl-ac., Gamb., Glon., Hell., Hep., Hydr-ac., Hyos., Ign., Ind., Ip., Kali-ar., Kali-c., Kreos., Lach., Lachn., Lact., Laur., Lob., Lye., Merc., Mez., Mur-ac., Nat-ar., Nat-c., Nat-m., Nat-s., Nice., Nux-v., Olnd., Op., Ox-ac., Par., Phos., Plat., Podo., Poth., Prun., Ran-b., Ran-s., Rhus-t., Sars., Squil., Sec., SeL, Sil., Spig., Spong., Stann., Stram., Stry., Sulph., Sulph-ac., Tab., Ther., Thuj., Zinc.

Respiration - irregular

Absin., Acet-ac., Ail., Ambr., Ang., Ant-t., Ars., Ars-L, Aur., Bell., Calad., Camph., Canth., Cham., Chin-s., Chlor., Cic., Cina, Clem., Coca, Cocc., Colch., Crot-h., Cupr., Dig., Dros., Gels., Hippoz., Hydr-ac., Hyos., Ign., Iod., Laur., Led., Merc., Morph., Mosch., Nice., Nux-v., Olnd., Op., Phos., Plb., Pub., Sep., Sol-t-ae., Stram., Stry., Sulph-ac., Tab., Tax., Ter., Verat-v., Zinc.

Respiration - superficial

Chin., Nux-m., Phos., Ph-ac., Puls.

- imperceptible

Aeon., Amyg., Ars., Benz-ac., Carb-ac., Chlor., Cic., Cocc., Gels., Hydr-ac., Merc., Morph., Naja, Nux-v., Op., Petr., Stram.

* The rubrics "Chill, fever, during" are applied together even when

KENT'S REPERTORY

Differentiation between important homeopathic remedies

| **Important remedies - hypothermia** *Aconitum*, *Arsenicum album*, *Camphora*, *Carbo vegetabilis*.

Aconitum: severe pain following (life-threatening) hypothermia. Stabbing pain or heat in the head.

Arsenicum album: violent, particularly fiery, burning pain after (life-threatening) hypothermia; the pain is unbearable. Weakness and restlessness. **Camphor:** the patient is icy cold but nevertheless wants to be uncovered.

Carbo vegetabilis: severe, often also burning pain following (life-threatening) hypothermia. Patient is cold but wants to have air fanned over him.

Repertorisation - frostbite

KENT'S REPERTORY

Extremities - coldness - foot

Alum., Pic-ac., Puls.

Extremities - chilblains

Abrot., Agar., All-c., Aloe, *Alumn.*, Alum., Arn., Ars., Aur., Bad., Bell., Bor., Bufo, Cadm., Carb-an., Carb-v., Cham., Chin., Cop., Croc., Cycl., Hyos., Kali-ar., Kali-c., Kali-chl., Kalm., Lyc., Mur-ac., Nit-ac., Nux-v., Petr., Phos., Ph-ac., Plan., Puls., Rhus-t., Sep., Stann., Staph., Sulph., Sulph-ac., Thuj., Zinc.

- blisters, with

Carb-an., Mag-c., Nit-ac., Phos., Rhus-t., Sep., Sulph.

- inflamed

Ars., Cham, Lyc, Nit-ac., Nux-v., Puls, Staph, Sulph.

- throbbing

Differentiation between important homeopathic remedies

* Important remedies - frostbite

Agaricus muscarius, *Arnica*, *Arsenicum album*, *Belladonna*, *Carbo vegetabilis*, *Chamomilla*, *Cyclamen*, *Lycopodium*, *Nitricum acidum*, *Nux vomica*, *Petroleum*, *Pulsatilla*, *Sulphur*, *Zincum metallicum*

Agaricus muscarius: burning and itching in both hands, as if frozen; heat, swelling and redness of parts affected. Pain and inflammation of frozen toes. Shooting pains in fingers and toes. Itching of, in and behind the ears, also with burning and redness as if after frostbite. Frostbitten nose with itching.

Arnica: the inflammation of the chilblain is caused by rubbing, squeezing etc.

Arsenicum album: the blisters appear to turn blackish, with a tendency to develop wet gangrene. Inflamed chilblains. Chilblains which are turning gangrenous. Ulcerated chilblains. Pain remaining after the limbs were completely frozen and thawed by applying snow.

Belladonna: blue-red, bluish chilblains. Chilblains which are turning gangrenous.

Carbo vegetabilis: ulcerated chilblains. Pain remaining after the limbs have been completely frozen and thawed by applying snow.

Chamomilla: Inflamed chilblains. Ulcerated chilblains.

Cyclamen: light red chilblains.

Lycopodium: light red chilblains.

Nitricum acidum: chilblains with itching, swelling and pain, particularly in very cold weather; inflammation from coldness. Cracked skin. Skin redness remaining after the limbs have been completely frozen and thawed by applying snow.

Nux vomica: superficial inflammation, with light red swelling, burning, itching or when the numb parts tear and bleed. Light red chilblains.

Petroleum: chilblains, particularly when they itch severely and ooze fluid; itching and burning like fire. Swelling and reddening of the heels, with burning and stabbing, < when walking. Stinking foot sweat and sensitivity. Bloody rhagades. Ulcerated chilblains.

Pulsatilla: chilblains; swollen, bluish, hot, with throbbing pain and intense itching, particularly in the soles, after warming up in bed. Blue-red, bluish chilblains. Inflamed chilblains. Ulcerated chilblains.

Sulphur: reddened and swollen chilblains with suppurative tendency; red chilblains with tears in

the joints; itching, < in warm bed. Blue-red, bluish chilblains. Inflamed chilblains. Ulcerated chilblains. **Zincum metallicum**: chilblains on the hands, which swell and itch terribly. Chilblains itch and swell.

Case 18.1-1: First-degree frostbite of the hands

Martin Bündner

Anamnesis

The 13-year-old boy is out sledging all day. This is followed by a snowball fight; his gloves are soaked through. Only afterwards does he notice that his hands are icy cold and he can no longer feel pain in them. His fingers are whitish. The boy goes to see the doctor.

Diagnosis

Frostbite of the hands.

Homeopathic treatment

As no homeopathic remedies are currently available, the only option is non-medical treatment following homeopathic principles (law of similars: *similia similibus curentur*).

Progress

After rubbing with snow, the boy's hands are immersed in icy water which is warmed only very slightly and very slowly. In this way, circulation is re-established in the hands with no pain.

Evaluation

First-degree frostbite of both hands is cured using a simple method following the law of similars (frozen hands - snow/icy cold water). Most readers are sure to have experienced a similar, milder situation, in which they tried to warm cold hands in warm water. They will

Critical commentary

This case study describes a relatively harmless case of mild frostbite. However, homeopathy can also offer help in such situations:

“When a person, by remaining long in the cold, has brought upon himself a torpid feeling, or an irresistible propensity to sleep, let him take, or frequently smell, a small piece of camphor.” (Hering 1864) Even patients with severe hypothermia leading to death were rescued by the early homeopathic doctors when the law of similars was applied. The homeopathic physician Constantin Hering recommended the following procedure:

“Persons frozen may be recalled to life several days after. Take them up and carry them away with great caution, to prevent individual parts being broken by imprudent pressure. Bring them under cover, but consider that even a very moderate heat may kill them; a cold room, or a barn where there is not the least draught, is the best place. Cover them entirely with snow, face and all, leaving merely the mouth and nostrils free, in such a manner that every part of the body is at least covered with several inches of it. Place them in such a manner that the melting snow may run off easily, and be renewed by fresh. Where there is no snow, put them into a cold bath, the temperature of which has been reduced by ice. When ice attaches itself to the body or to the clothes, remove it. In this manner thaw the body until every part becomes perfectly pliable, then undress them by degrees, and, if necessary, cut the clothes from the body. As the soft parts become pliable, commence to rub them with snow, and continue it until they become red, when you may leave off and finish undressing them. Place them on a dry bed, and rub them with cold woollen or flannel cloths, stockings, old pieces of felt, &c.,

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always towards the heart. If signs of returning life do not soon manifest themselves under this treatment, take a small piece of camphor or some spirits of camphor, shake it in water, and give a small injection of it. Repeat this every quarter of an hour. If they commence to revive during the friction, or after the camphor, and give symptoms of returning animation, give small injections of lukewarm coffee, without milk, and as soon as they can swallow some coffee, give a teaspoonful at a time.

As the symptoms of life augment, remove every thing that is wet, and rub the whole body until dry, but not so much as to produce any heat. The patient must recover his natural warmth in the bed, and no other external heat must be applied, except if he is a small child, when someone should lie down with him in bed when he begins to breathe.

It frequently takes hours to restore them to life, but we should not be sparing of labour. For the violent pains which are felt after they are revived, give carb. veg. [*Carbo vegetabilis*] as often as necessary; if this proves unavailing, give ars. [*Arsenicum album*]. If heat or pricking pains are felt in the head, a few doses of acon. [*Aconitum*] will be of service. If the patient craves wine or brandy, give him a few drops at a time, and only as long as the craving continues. Later use the remedies mentioned for “chilblains” [...]. A person who has recovered from being frozen, must avoid the heat of the stove and of the fire for a long time, as it might occasion diseases of the bones, which sometimes do not manifest themselves until the coming summer.” (Hering 1864)

18.2 Burns and scalds

Definition

Burns (Combustio)

Burns refer to thermal tissue damage caused by external (e.g. a naked flame) or internal (e.g. electric shock) heat.

Scalds

Scalds refer to tissue damage caused by hot liquids or

*** Note:** the time for which the patient has been exposed to the heat, the temperature, the type of heat and the extent of the heat damage all influence the prognosis and the success of the treatment.

Clinical information

Incidence and mortality

In Germany, between 5000-10,000 patients are treated

Tab. 18.2-1: Stages

1 st degree burns	Combustio erythematosa	Local redness and swelling, feeling of tautness. Heal without complications within a few days.
2nd degree	Combustio burns bullosa	Additional (subepidermal) blistering (wheals). Superficial dermal burns heal spontaneously within 10-15 days; deep dermal burns heal spontaneously but poorly within 3-4 weeks leaving severe scarring; skin grafts are usually necessary in such cases.
3rd degree	Combustio burns escharotica	Destruction of epidermis and dermis, possibly also of tissue layers under these (so-called carbonisation) with leathery necrosis (pain-free wound). Characteristic tatters of dry skin on a white demarcated, black charred or waxy yellowish, dry surface. The tissue is hard and swollen, the hair and nails can be pulled out. Painless wound area, needle pricks do not bleed. Spontaneous healing impossible or only very slowly from the edges of the wound.

1000 of these require intensive care in special burns units.

Most burns (75%) occur during leisure activities or at home, 5% are self-inflicted with suicidal intentions, 20% happen at work.

In children, most burns occur from contact with hot drinks and cooking utensils. Children aged between one and four are most frequently affected, with the peak being around the age of two.

The incidence of inhalation trauma increases with the duration of exposure to the fire; it is particularly high in cases of fires or explosions in closed spaces. 80% of patients who die in fires primarily perish from asphyxiation or suffer a lethal inhalation trauma. The most common causes of death in house and apartment fires, carbon monoxide and cyanide poisoning, should not be overlooked.

Symptoms

The degree of burns is established according to how deeply they have penetrated the epidermis and dermis (« table 18.2-1).

In 1st to 3rd degree burns, only the skin is affected to a varying extent. 4th degree burns refer to the thermal destruction of subcutaneous fatty tissue and muscle.

In general, the depth of the injury should be reassessed after 24 hours to correct any false estimates. This reassessment accounts for the phenomenon of “afterburning”, which results in the injury becoming deeper over time.

Diagnosis

Burns and scalds are diagnosed according to their extent,

Extent

In adults, the extent of the burns (scalds) can be roughly estimated using the Wallace Rule of Nines (■s table 18.2-2).

In addition, the following rule of thumb applies when estimating the percentage of burns: the palm of the patients hand (irrespective of his age) corresponds to roughly 1% of his body surface.

The Rule of Nines is invalid in children, as the proportions of the head, extremities and torso are completely different to those of adults. The calculations given in ■• table 18.2-3 are recommended in such cases.

Accompanying injuries: along with the body surface, the patients life may be put at risk by hot, dry gases (glottal oedema with increasing dyspnoea and inspiratory stridor).

The mucous membranes of the mouth and throat should therefore be examined. Perioral burns may indicate inhalation trauma, but do not constitute evidence of it.

The first pathological finding on auscultation is discrete bronchospasm which on the development of pulmonary oedema is associated with wheezing, fine crackles, orthopnoea and cyanosis.

Therapeutic crisis

Depending on its depth and extent, thermal trauma not only causes local tissue damage, but also triggers a large number of pathophysiological processes ending in burn shock and burn sickness. One risk which should not be neglected is that of infection, which can negatively influence the healing process particularly during the burn sickness stage.

Tab. 18.2-2: Wallace Rule of Nines for assessing the extent of burns and scalds

Body region affected	Extent of burns
Head and throat	9%
Front of torso	18%
Back of torso	18%
Arms, each	9%
Legs, each	18%
Perineal region	1%

Tab. 18.2-3: Calculating burns in children

Body region affected	Extent of burns 0-1 year	Extent of burns 5 years
Head and throat	20%	16%
Arm, each	10%	9%
Torso, front	15%	16%
Torso, back	15%	16%
Legs, each	15%	17%

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The occurrence and intensity of this burn disease can be eased by conventional methods; however, even today, burn sickness is still a serious disorder which is difficult to treat. Adjuvant homeopathic treatment - better still, minimisation and/or prevention by early, adequate wound care - can be very helpful. The regional tissue damage with its associated symptoms and possible wound infection are also undesirable, conventional treatment is protracted and the results are often unsatisfactory from a cosmetic viewpoint. The patient can also benefit from homeopathic treatment in this respect.

The inhalation trauma which may accompany burns and scalds may lead to toxic pulmonary oedema; if the patient survives this, he may develop pneumonia. There is a variety of pathomechanisms which may cause all cases of inhalation damage to end in acute respiratory failure. The complication of inhalation trauma consequently has a significant influence on the lethality and prognosis of the burns. Homeopathic treatment may be helpful in such cases, but should be left to a specialist.

Homeopathic treatment

The conventional method of cooling small burns and scalds leads to complications and prolongs the healing process.

Simple wounds can be treated using the homeopathic principle (law of similars: burns with heat): the wound is brought close to a source of heat (several times if required). Care should be taken not to inflict new burns; instead, the existing pain should merely be offset by the radiating heat. If this procedure is used, the pain subsides relatively quickly and the wound usually heals without complications. The burn should not be cleaned; blisters should not be opened or removed. The wound should not be coated with antiseptic substances, ointments, powders or similar. It should be covered with sterile materials which do not stick to it.

Symptom selection

In cases of burns or scalds, the local findings (or the findings before initiating conventional treatment) are frequently decisive when establishing the correct

Should accompanying symptoms occur, these are usually more important than the local findings and should therefore be given priority during repertorisation. If possible, the remedy should give equal consideration to the general, accompanying and local aspects of the condition.

The symptoms of inhalation trauma may indicate a different remedy from the local injury. As inhalation trauma is potentially life-threatening, this must primarily be treated homeopathically on the basis of the individual symptoms. The local symptoms may be treated with another remedy if necessary. In exceptional cases, the homeopathic remedy can be applied externally to the wound as well as being taken internally, as Hahnemann explained using *Arnica* as an example (Hahnemann 1830).

Repertorisation

SYNTHETIC REPERTORY

Carbon monoxide - poisoning with

Aeon., Bell., Op.

Burns

acet-ac., aeon., agar., aloe, alum., alumn., ant-c., arist-cl., am., ARS., bar-c., bell., bry., calc., calc-p., calc-s., calen., camph., CANTH., carb-ac., carb-v., carbn-s., caust., chin., cic., crot-h., cycl., des-ac., echi-a., euph., ferr., gaul., grin., ham., hep., hoit., hyos., hyper., ign., jab., kali-bi., kali-c., kali-m., kreos., lach., mag-c., mag-m., mere., nat-c., nux-v., op., par., passi., petr., phos., pic-ac., plan., plat., plb., puls., ran-b., rhus-t., ruta, sabad., sec., sep., sil., spira., stram., sul-ac., ter., thuj., urt-u., verat.

- x-rays, from

calc-f.

Intoxication - smoke, from

ars., brom., calc., caust., chin., euphr., kali-bi., lyc., naja, nat-m., nux-v., olnd., puls., sep., SPIG., sulph.

Repertorisation

KENT'S REPERTORY

Chest - dropsy

Acet-ac., Am-c., Ant-t., Apis, Apoc., Ars., Asaf., Aspar., Aur-m., Bry., Calc., Canth., Carb-v., Carbn-s., Chin., Chin-ar., Colch., Crot-h., Dig., Dulc., Ferr-m., Fl-ac., HeU., Iod., Kali- ar., Kali-c., Kali-i., Lach., Lact., Lyc., Merc., Merc-s., Mez., Mur-ac., Nat-m., Op., Psor., Ran-b., Rat., Sang., Squil., Seneg., Sil., Spig., Stann., Sulph., Ter., Uran., Zinc.

Chest - lungs - oedema

KENT'S REPERTORY

Respiration - jerking - inspiration Ox-ac.

Respiration - slow - inspiration

Cham., Chin., Ign., Stram.

Respiration - loud - inspiration

Bell., Caps., Cham., Chin., Cina, Coloc., Hyos., Ign., Mag-s., Nux-v., Puls., Rheum.

Respiration - wheezing - inspiring, while

Alum., Caps., Chin., Kali-c., Spong.

Differentiation between important homeopathic remedies

Important remedies: *Aconitum*, *Arsenicum album*, *Calendula officinalis*, *Cantharis*, *Carbo vegetabilis*, *Kreosotum*, *Rhus toxicodendron*, *Urtica urens*.

Aconitum: immediately after the burn, to counter the shock to the nerves. Reaction with the following symptoms: dry, burning, hot skin. Hot, painful head. Extremely hot head. Red face. Hard, fast, constricted pulse. Restlessness, agony, inner anxiety. Fear of impending death.

Arsenicum album: for all burns in which pain is still felt, or when the blisters turn black and show

a tendency to become gangrenous. Swelling and inflammation with burning pain. Septic changes in the blood.

Calendula officinalis: this remedy prevents or minimises the development of gangrene. Promotes granulation and prevents disfiguring scars. Promotes scar formation with the minimum suppuration necessary. Prevents exhaustion from blood loss and extreme pain with delirium.

Cantharis: vesicular, inflamed burns and scalds. Superficial ulceration caused by burns, with burning pain and lachrymation. Tetanic or epileptiform convulsions followed by coma.

Carbo vegetabilis: bleeding ulcers. Extreme pain which makes the patient fear he is about to die. Pain accompanied by great anxiety and heat. Deep, extensive burns with signs of inadequate oxygen supply to the blood (fine powdered charcoal used externally on the ulcers and taken internally as *Carbo vegetabilis*). Wet gangrene. Putrid secretions. Great fatigue.

Kreosotum: ulcers left after burns bleed easily.

Rhus toxicodendron: blisters and pustules form after burns and scalds; extensive but superficial injuries. Tendency to develop erysipelas with typhoid pain.

Urtica urens: burns, only the skin is affected. Severe burning and itching.

Case 18.2-1: Second-degree burns to the right hand

Martin Bündner

Anamnesis

A 32-year-old mechanic burns his right hand by grasping a scorching piece of metal. He has not yet consulted a surgeon. He immediately seeks homeopathic help for the fresh injury. He is instructed on the telephone not to cool the area.

Diagnosis

Diagnosis

Findings on admission

The inside of the hand is massively swollen and blistered, the tissue characteristically discoloured.

The pain is burning and very intense.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - burns

Skin - eruptions - blisters - as if from a burn

Skin - eruptions - burning

Differentiation between remedies

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differentiated repertorisation is impossible except for the help of two basic rubrics. The remedy is therefore chosen according to the clinical indications. *Cantharis* is recommended for second-degree burns (symptoms: blistering, reddening, pain), as the original substance is well known for blistering. *Arsenicum album* is also clinically indicated but does not match the injury as specifically as *Cantharis*.

Prescription

10 drops *Cantharis* Q6, dose to be repeated when the pain again seems to be increasing. The patient should refrain from cooling the wound.

Progress

Next day, the patient has no more pain. The swelling is already clearly subsiding.

Prescription

10 drops *Cantharis* Q6 five times a day from this point on.

Progress

On the second day after the burn, the only remaining sign of injury is a blister approximately 1 x 2 cm in size; the hand is otherwise completely healed.

Prescription

10 drops *Cantharis* Q9 five times a day. The potency is changed because the first bottle is empty.

Progress

On the third day of treatment, the blistering has disappeared and the burn is completely healed.

Evaluation

From a homeopathic viewpoint, conventional treatment with cold water and painkillers delays the wound healing and is therefore contraindicated - as reports from experienced homeopaths have shown. This case history shows how non-life-threatening burns can be healed quickly and without complications by applying the law of similars. Homeopathic treatment as an adjuvant to conventional therapy should be encouraged in burns

A study approved by the ethics commission of the Medical University in Vienna had to be cancelled for two reasons: firstly, no funding could be obtained for patient insurance; secondly, only patients able to sign the declaration of agreement could be included. Patients with severe burns, who would have been particularly interesting in research terms, were therefore excluded right from the start.

Critical commentary

Hahnemann wrote in his "Organon": "[Even Stahl is] convinced that diseases will yield to, and be cured by, remedies that produce a similar affection (similia similibus): burns by exposure to the fire, frostbitten limbs by the application of snow and the coldest water [...]" (Introduction to the Organon of the Healing Arts, 2003).

A severe injury like that mentioned in this case requires medical treatment and should not be left to heal with heat treatment (exposing the wound to a source of heat, several times if necessary, until the pain of the wound is overcome by the heat).

The possibility of treating a burn with heat is shown by a case reported to the author by the patient: late one evening, the 35-year-old patient accidentally leaned on a hot electric plate with his right hand. Parts of the palm and fingers D3 to D5 were affected. As the patient had no homeopathic remedy at hand, he treated the burn using the law of similars, which can also be applied without remedies.

For 90 minutes, he held his hand and fingers about 5-10 cm away from the source of heat until the heat clearly overcame the pain of the wound. Over time, the pain subsided more and more until it finally disappeared completely. No redness or blistering appeared.

Note: in this case, application of the law of similars (similia similibus curentur) was perfectly adequate. The burn caused by exposure to heat was cured by the effects of heat, as the stimulus was only slightly stronger than the pain of the burn. This corresponds to the stimulus of the remedy, which is only slightly stronger than the disease. Homeopathic treatment usually involves the administration of remedies, but this is not always compulsory.

18.2 Burns and scalds

The patient's self-treatment led to a rapid cure without complications.

As he was untrained, the severity of the burn could only be assessed to a limited degree. The extent of the burn and the patient's understanding set limits on this remedy-free homeopathic method.

* **Note:** treatment with homeopathic remedies is normally preferable to treatment without; medical treatment is essential for children and severe burns cases.

Case 18.2-2: Burn on the sole of the left foot

Martin Bündner

Anamnesis

The 28-year-old patient treads on a scorching piece of metal from an open fireplace, which he had previously placed on the floor. The skin is demarcated, no blistering, more whitish.

Diagnosis

Burn on the sole of the left foot.

Diagnosis

Local physical examination.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - burns

Skin - eruptions - burning

both rubrics. Problems with healing and scarring are anticipated because of the location of the burn. *Causticum* is well known for its curative effect on the consequences of burns.

Prescription

1 dose of 3 globules *Causticum* 30C with the instruction to repeat the dose if the pain increases.

Progress

The pain subsides rapidly. Nevertheless, the dose has to be repeated several times. By the next day, the skin and the wound have healed without complications.

Evaluation

Rapid, uncomplicated healing of a burn.

Critical commentary

The early homeopathic literature (e.g. Hering 1864) suggests other, partly supplementary (and today

Case 18.2-3: Burns from x-rays

Martin Bündner

Anamnesis

After the surgical removal of a mammary carcinoma, the 56-year-old patient's right side is irradiated daily for 30 days. By the end of the radiotherapy, she is suffering from the following symptoms:

- Extensive and very painful burns around the chest and throat

- Clothing makes the burning pain worse. The patient therefore wears a loose shirt when she is not at home. She feels better without the shirt or any other clothing
- The burning subsides considerably when the body parts affected are uncovered
- The touch of even the lightest bed covering is unpleasant; this again causes a sensation of intense burning. As a result, the patient no longer covers herself in bed, although she would like to
- The pain increases when the bed warms up

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- She cannot swallow any hard foods. This causes stabbing pain (the larynx was within the area covered by the radiotherapy)

Diagnosis

Burns from radiotherapy after the surgical removal of a carcinoma in the right breast.

Homeopathic treatment

Repertorisation

KENT'S REPERTORY

Generalities - clothing - intolerance of

Generalities - warm - wraps, aggravated

Generalities - warm - bed, aggravated

Generalities - touch, aggravated

Larynx and trachea - pain - larynx - swallowing, on Larynx and trachea - pain - stitching - larynx

Differentiation between remedies

The repertorisation process finishes with *Calcarea carbonica* and *Phosphorus*, with the exception of the last rubric also *Lycopodium*, which is almost always doubly or triply weighted in the other rubrics, which is not the case with the other two remedies mentioned. The decision is not easy. If great importance were attached to the pain around the larynx. *Lycopodium* would have to

burning pain primarily indicates this remedy, which is also well known for treating radiation damage. *Phosphorus* is therefore chosen.

Prescription

1 dose of 4 globules *Phosphorus* 200C.

Progress

The pain subsides completely within three days. After this time, the patient is again able to lie on the affected side. The skin heals without complications within about two weeks.

Evaluation

Homeopathic remedies are also effective in treating radiotherapy damage.

Critical commentary

In the Kent Repertory, the rubric "Burns" is relatively small and was therefore not used, even though it perfectly covers the clinical situation. The only one of the three possible remedies it contains is *Calcarea carbonica*. However, *G. H. G. Jahr* mentions burns in an entry appended to *Phosphorus* in the Synthetic Repertory.

It should rightly be considered whether *Lycopodium* or *Calcarea carbonica* would have had a positive effect in

1 8.3 Heat damage

Definition

Heatstroke

Heatstroke is defined as a thermal regulation disorder which occurs when the patient has been exposed to high temperatures for some time and has not given off enough heat.

This is a life-threatening condition characterised by a rise in body temperature to over 40 °C and the failure of the body's temperature regulation mechanism. As the condition progresses, the patient may suffer from multiple organ failure, frequently with fatal

Sunstroke

Sunstroke (insolation, heliosis, ictus solis) is a form of heat damage. It is caused by direct exposure to sunshine, particularly of the uncovered head and neck. Other forms of heat damage include:

- Heat exhaustion (profuse perspiration with insufficient fluid intake, e.g. after sport, which may progress as far as shock though reduction of the extracellular space; no increase in temperature)
- Heat cramps (the result of hard labour in high ambient temperatures, e.g. furnace workers) occur with salt deficiency and a deficit of 2-4l extracellular fluid, which causes muscle jerks and cramps

18.3 Heat damage

Clinical information

Incidence and mortality

Heatstroke

In the USA, the incidence is around 20 per 100,000 inhabitants; no equivalent figures could be obtained for Germany.

Mortality rates fluctuate depending on the severity of the heatstroke. In the best case, it is about 10%, in the worst more than 80%.

Symptoms

Heatstroke

One characteristic warning sign is the reduction or complete cessation of bodily sweating. Other warning symptoms of heatstroke are muscle cramps, particularly in the muscles of the abdominal wall, and sudden feelings of faintness with propensity to collapse.

Almost every organ system can be affected by heatstroke. In the CNS, it causes cerebral oedema leading to increased intracranial pressure (headache, nausea); in the circulatory system, individual fibres in the cardiac muscle may rupture, leading to myocardial pump failure; the capillary membranes in the lung tissue may also be damaged, leading to pulmonary oedema. The patient's blood pressure is initially normal but then drops; the skin is red, dry and hot. Rhabdomyolysis, renal failure and hepatic cell necrosis are also possible consequences of

Indications include the appearance of neurological symptoms (dizziness, confusion, unconsciousness, convulsions) with a core body temperature of more than 40 °C. The skin is hot and bright red.

Classic heatstroke occurs in patients who did not undergo any particular physical exertion while they were exposed to the heat. This form mainly occurs in older patients and develops over a period of hours to days. In children, it develops when the child is left in the car (supposedly for a short time). The pathophysiological correlative of classic heatstroke is dehydration (» table 18.3-1). Dry skin is therefore a guiding symptom of classic heatstroke.

Sunstroke

The following symptoms may occur: severe headache, nausea and vomiting, fever, dizziness, buzzing in the ears, rapid pulse, exhaustion, possibly collapse and death. In pathoanatomical terms, the patient is found to have serous meningitis and cerebral hyperaemia.

Diagnosis

Heatstroke

The diagnosis is made on the basis of the patient's case history and the findings of the physical examination. The patient's exposure to heat is very helpful in terms of differential diagnosis, as heat damage caused by hyperthermia can be mistaken for a few other conditions which are also associated with neurological disorders such as confusion or unconsciousness and which may also be accompanied by tachycardia, skin redness and elevated body temperature.

Tab. 18.3-1: Guiding symptoms of dehydration	
Mild dehydration	• Dry mucous membranes • Pallor • Tachycardia • Oliguria
Moderate dehydration	• Reduced skin turgor • Upright skin folds • Sunken fontanelles • ~~Sunken eyes with dark rings~~
Severe dehydration	• Marbled skin • Drop in blood pressure • Bradypnoea • Areflexia • Cramps

Tab. 18.3-2: Infusion therapy	
Mild dehydration	• 10-20 ml/kg BW/h Ringer lactate solution
Moderate dehydration	• 20-30 ml/kg BW/h Ringer lactate solution • Additionally 5-10 ml/kg BW plasma expander
Severe dehydration	• 30-40 ml/kg BW/h Ringer lactate solution • Additionally 10 ml/kg BW plasma expander

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The most important differential diagnoses are existing infection or sepsis, thyrotoxicosis, intoxication or central anticholinergic syndromes.

Sunstroke

Sunstroke can be diagnosed without instrumental procedures. The leading indication is exposure to direct, intense sunlight with inadequate head protection.

Therapeutic crisis

Heatstroke is a serious condition which is still difficult to control today, particularly when complications develop; this is reflected by the high mortality rates. Homeopathic treatment should definitely be administered concomitantly to optimise the therapy available.

Sunstroke is characterised by mild to moderate vegetative disorders with corresponding malaise; in severe cases, the outcome may be fatal. The symptomatic treatment offered by conventional medicine often seems inadequate. Homeopathic treatment is the ideal adjuvant.

Homeopathic treatment

Symptom selection

The cause must by all means be taken into consideration.

The patient must undergo close examination with regard to mood changes, neurological symptoms and pain in the head area (also neck stiffness). Sleep disorders are a frequent occurrence.

In view of the wide variety of complaints which may occur, particularly in cases of heatstroke, all acute objective and - even more important - subjective symptoms must be recorded to ensure that the correct homeopathic remedy is found.

Repertorisation - heatstroke

KENT'S REPERTORY

Generalities - faintness

- summer heat, from

Ant-c., Ip.

- warm room

Aeon., In., Kreos., Lach., Lil-t., Lyc., Nat-m., Nux-v., Puls., Sen.,

KENT'S REPERTORY

Generalities - jerking - muscles

Aeon., Aesc., Agar., Alum., Am-c., Anac., Ant-c., Ant-t., Apis, Arg-m., Arg-n., Arn., Ars., Asar., Bar-c., Bell., Bry., Cadm., Calc., Calc-p., Cann-i., Caps., Carbn-s., Cham., Chin., Chion., Cic., Cimic., Cocc., Colch., Con., Croc., Cupr., Dulc., Euph., Euphr., Ferr., Ferr-ar., Gels., Glon., Graph., Hyos., Ip., Kali-i., Kali-s., Lach., Lil-t., Mag-c., Meny., Merc., Merc-c., Mez., Mosch., Nat-c., Nat-m., Nit-ac., Nux-m., Nux-v., Olnd., Op., Petr., Phos., Ph-ac., Plat., Plb., Puls., Rhus-t., Ruta, Sabad., Sabin., Sep., Sil., Spig., Stann., Staph., Stram., Stront., Sulph., Sulph-ac., Tarent., Ter., Valer., Viol-t., Vise., Zinc.

Generalities - weakness - heat, from

Aster., Carbn-s., Coc-c., Lach., Nat-c., Nat-p., Puls., Rhod., Sei., Sulph., Tab., Vesp.

Generalities - warm, aggravated

Aeon., Agar., Agn., All-c., Alum., Ambr., Ant-c., Ant-t., Apis, Arg-n., Arn., Ars-i., Aur., Aur-m., Bar-c., Bell., Bism., Bor., Bry., Calad., Camph., Cann-s., Canth., Carb-v., Carbn-s., Caust., Cham., Cina, Cocc., Coc-c., Colch., Coloc., Croc., Dig., Dros., Dulc., Euph., Euphr., Ferr-i., Gels., Glon., Graph., Guai., Hell., Ign., Ind., Ip., Iod., Kali-br., Kali-s., Lac-c., Lach., Laur., Led., Lyc., Merc., Mez., Mur-ac., Nat-c., Nat-m., Nat-s., Op., Phos., Ph-ac., Plat., Puls., Sabad., Sabin., Sec., SeL, Seneg., Spig., Spong., Staph., Sulph., Tab., Teucr., Thuj., Verat., Zinc.

- warm air, aggravated

Agn., Aloe, Ambr., Ant-c., Ant-t., Arg-n., Ars-i., Aur., Aur-m., Bry., Calad., Calc., Calc-s., Cann-s., Carb-v., Cham., Cina, Cocc., Colch., Croc., Dros., Euph., Fl-ac., Glon., Ign., Ind., Ip., Iod., Kali-bi., Kali-s., Lach., Led., Lyc., Merc., Mez., Nat-m., Nat-s., Nux-m., Nux-v., Op., Phos., Pic-ac., Plat., Podo., Puls., Sabin., Sars., Sec., SeL, Seneg., Sulph., Teucr., Thuj., Xan.

- warm - becoming in open air, aggravated

Aeon., Agn., Alum., Ambr., Ant-c., Aur., Aur-m., Bar-c., Bell., Bor., Bov., Bry., Calad., Calc., Cann-s., Carb-v., Caust., Cham., Chin., Cina, Cocc., Coff., Colch., Coloc., Croc., Dros., Dulc., Euph., Glon., Graph., Ign., Ip., Iod., Kali-c., Lach., Led., Lyc., Mang., Merc., Mez., Nat-c., Nat-m., Nat-s., Nit-ac., Olnd., Op., Petr., Phos., Ph-ac., Plat., Puls., Sabad., Sabin., Sec., SeL, Seneg., Sep., Sil., Spig., Spong., Staph., Sulph., Teuer., Thuj., Verat.

- warm, wet weather aggravated

Carb-v., Gels., Iod., Kali-bi., Lach., Nat-s., Sil.

- wraps, aggravated

Aeon., Apis, Arg-m., Arg-n., Ars-i., Aur., Aur-m., Bor., Bry., Calc., Calc-s., Camph., Carb-v., Carbn-s., Cham., Chin., Coc-c., Coff., Ferr., Ferr-i., Fl-ac., Glon., Ign., Iod., Kali-s., Lac-c., Lach., Led., Lyc., Merc., Mosch., Mur-ac., Nit-ac., Nux-v., Op., Phos., Plat., Puls., Rhus-t., Sec., Seneg., Sep., Spig., Staph., Sulph., Tab., Thuj.,

18.3 Heat damage

KENT'S REPERTORY

Skin - dry - inability to perspire

Aeon., *Alum.*, Ambr., Am-c., *Anac.*, Apis, Apoc., Arg-m., Arn., Ars., Ars-i., Bell., Bism., Bry., Calc., Cann-s., *Cham.*, Chin., Coff., Colch., Con., Cupr., *Dulc.*, Eup-pur., Graph., Hyos., Ip., Iod., Kali-ar., Kali-c., Kali-s., Laur., *Led.*, *Lyc.*, Mag-c., Merc., Merc-c., Nat-m., Nit-ac., Nux-m., Nux-v., Olnd., Op., Phos., *Ph-ac.*, Plat., Plb., *Psor.*, Puls., *Rhus-t.*, *Sabad.*, *Samb.*, Squil., Sec., Seneg., Sep., Sil., Spong., *Staph.*, Sulph., Teucr., Thuj., Verb., Viol-o.

For the severe stages of heatstroke, refer to the corresponding rubrics in the repertory depending on the existing symptoms.

Repertorisation - sunstroke

KENT'S REPERTORY

Back - stiffness - cervical region

Aeon., *Aesc.*, Agar., *Alum.*, Am-c., *Am-m.*, *Anac.*, Anat., *Ang.*, *Ant-t.*, *Apis*, Arg-m., Ars., Arum-t., Asar., Aur., Bad., *Bapt.*, Bar-c., Bell., Berb., Brach., *Brom.*, Bry., Calad., Calc., *Calc-p.*, Calc-s., Camph., Cann-i., *Canth.*, Caps., *Carb-v.*, Carb-ac., Carbn-s., Caul., Caust., *Cedr.*, Chel., Chin., Chin-ar., Cic., Cimic., *Cocc.*, Colch., *Coloc.*, Com., Con., Cor-r., Cupr-ac., Cupr-ar., Cycl., *Dig.*, *Dros.*, *Dulc.*, Elaps, Eup-pur., Euph., Fago., *Ferr.*, Ferr-ar., Ferr-i., Ferr-p., *Fl-ac.*, Form., *Gels.*, *Glom.*, *Graph.*, *Guai.*, Hell., *Hep.*, Hura, Hyos., Ign., Ind., *Kali-bi.*, Kali-c., *Kali-chl.*, *Kali-i.*, *Kali-n.*, Kali-p., *Kali-s.*, Kalm., *Lac-c.*, Lach., Lachn., Laur., *Led.*, *Lyc.*, *Lyss.*, Mag-c., *Mane.*, Mang, Meny., Merc., Merc-j-f., Mez., Morph., Myric., Nat-ar., *Nat-c.*, *Nat-m.*, Nat-p., *Nat-s.*, Nit-ac., Nux-v., Ol-an., Pall., *Par.*, Petr., Phos., Ph-ac., Phys., Phyt., Plat., Plb., *Podo.*, *Psor.*, Puls., *Rat.*, *Rhod.*, *Rhus-t.*, *Rhus-v.*, Sang., Squil., Sec., SeL, Sep., Sil., *Spig.*, Spong., *Staph.*, Stram., Stry., Sulph., Syph., Tab., Tarent., Thuj., Verat., Zinc., Zing.

Chill - exposure - sun, to the heat of

Bell., *Cact.*, Glon., Lach., Nat-c.

Fever - sun - in heat of

Ant-c., Bell., *Cact.*, *Glom.*, Lyss., Nat-c., Puls., Sep.

Generalities - sun - from exposure to

Agar., *Ant-c.*, *Arg-m.*, *Bar-c.*, Bell., Brom., Bry., Cadm., Calc., *Camph.*, *Carb-v.*, Cina, Clem., *Euphr.*, Gels., Glon., Graph., Ign., Ip., Iod., Kalm., Lach., Lappa., Lyss., Mag-m., Nat-c, Nat-m., *Nux-v.*, Op., *Psor.*, Puls., SeL, Stann., Sulph., *Valer.*, Zinc.

Head - pain - sun, from exposure to, aggravated

Aeon., Act-sp., Agar., Aloe, *Ant-c.*, *Arum-t.*, *Bar-c.*, Bell., Brom., Bruc, Bry., Cadm., Calc., Calc-s., *Camph.*, Cann-L, *Carb-v.*, Cast-v., Chin., Chin-s., Coa., Euphr., Gels., Genist, Glon., Hipp., Hyos., Ign., Lach., Mane., Nat-ar., Nat-c, *Nat-m.*, *Nux-v.*, Puls., SeL, *Stram.*, Sulph., Syph., Ther., Valer., Verat-v., Zinc.

Differentiation between important homeopathic remedies

Important remedies for heatstroke and sunstroke:

Aconitum, *Antimonium crudum*, *Belladonna*, *Bryonia*, *Cactus grandiflorus*, *Carbo vegetabilis*, *Glonoinum*, *Lachesis*, *Natrium muriaticum*, *Silicea*, *Ther- idion curassavicum*, *Veratrum viride*

Aconitum: important remedy when the patient has been directly exposed to heat or sun. Burning heat, particularly in the head and face, with dry, burning skin. Burning, unquenchable thirst Red eyes and cheeks. Bloodshot eyes. Red cheeks and fear of death. Restlessness, agony, inner anxiety. Fear of impending death. Nausea, dizziness and headache < with warmth. Vertigo, headache, nausea, retching, cold. The heart initially works harder but later loses strength while increasing its frequency. Particularly at the beginning of the disorder and with severe inflammatory fever; patient talks crazily and suffers from raging delirium; intense, burning pain throughout the brain and particularly in the forehead. Face red and bloated. Counters the effects of sunstroke or excess (furnace) heat, and for any incident when the patient has been sleeping either in the sun or close to a hot oven. Unconscious patient with heat of both head and body. Pupils contracted, facial colour changeable. Large, full, hard pulse. Individual movements testify to restlessness and anxiety. Starting or grasping the head, grinding the teeth, rolling the eyes.

Antimonium crudum: heat of the sun is unbearable. Exhaustion after the slightest exertion in the sun, with nocturnal sweating. < from exertion in the sun. Great sleepiness during the day, falls asleep in a sitting position in the afternoon; almost unconquerable sleepiness in the evening, followed by sleep until the early morning, then tiredness which renders the patient barely able to keep his eyes open; narcolepsy; dozing with dreams. Gastric symptoms etc. When the summer heat is unbearable, or when even a little exertion immediately exhausts the patient, with nocturnal sweating, constant desire to sleep, gastric symptoms etc., and when *Bryonia* is not enough to

18 Thermal Emergencies

treat this condition. Intolerance of summer heat or exertion in the heat, particularly with *nocturnal sweating*, *great sleepiness*, or *complaints in the stomach and lower abdomen* which are not helped by *Bryonia*. (Note: *Lycopodium* can be helpful in women.) **Belladonna:** first stage of sunstroke. Face red, head hot, likewise the whole body. Headache with feeling of fullness and a sensation as if everything is trying to push its way out of the forehead. < when stooping, moving or from the slightest change of mood. Pain when bending forwards, as if everything wants to fall out of the patient's forehead; rush of blood to the forehead, head becomes heavy and dizzy. Severe irritation of the cranial nerves or great fear. Great propensity to startle and fear nearby things. When falling asleep, the patient is startled by an inner blow directed upwards, and is unable to sleep. Children wail, scream and cry bitterly. Violent crying, whimpering and wailing with no cause, associated with fear. When the patient bores his head into the pillow, when the slightest noise and dimmest light make his condition worse, or when he has the following: violent, burning, stabbing pain in the head; red, shiny eyes with angry expression; red, bloated face; narcoleptic sleep, with eyes rolled and half open; severe heat in the head with intense throbbing of the arteries in the neck; swollen veins in the head; unconsciousness and loss of speech, or murmuring, or severe delirium; convulsive limb movements; cramp-like constriction of the throat with difficulty swallowing and other hydrophobic symptoms; vomiting, involuntary urination and defecation. When *Aconitum* is insufficient to treat the consequences of sunstroke or excessive exposure to (oven) heat, or headache, with feeling of fullness and a sensation in the forehead as if everything were trying to fall out of it, worse when stooping, on the slightest movement and with every change of mood; accompanied by great anxiety and restless, anger or at least great agitation, or great fear, nervousness and fear of things nearby; tendency to cry and scream. Vacant or half-open eyes, wide, large pupils, or very small, or differing in size. Full, hard pulse, with isolated jerks or trembling in the limbs, patient grasps his head, bends head backwards, heavy sleep.

Headache as if the head is too full, pushing it apart, worse when stooping, especially in the forehead, as if everything is trying to fall out, worse when walking, putting the feet down, with every change of mood; heat-induced fever with great thirst, often also vomiting and insomnia. Great anxiety and restless, rage or at least hastiness, or great despondency, nervousness and fear of things nearby, prone to cry, wail and scream.

Bryonia: great fullness and heaviness in the head, with scrabbling pressure on the head; when stooping, the patient feels as if everything were trying to fall out. Revulsion and disgust of food. Loses appetite with the first bite. Vomiting and diarrhoea. Very irritable nature, very prone to anxiety, fear and anger. Irritability and violent rage; outbreaks of rage possible during the period following the sunstroke. For sustained chills with red face, hot head and great thirst; with constant need to sleep, with delirium; patient startles suddenly out of sleep, cries out, cold sweat on the forehead, burning pain and pressure in the head, or stabbing pains passing through the brain. When the following occur as the result of work or exertion in the heat: painful feeling of fullness in the head; lack of appetite or revulsion against food, vomiting and diarrhoea; milk intolerance; constant movement with trembling; when the patient does not tolerate clothing over the hypochondria; angry moods and real anger; fear of the future. Headache as if the head were too full, from summer heat, from excessive exertion in the sun, from getting too warm in front of the fire, with lack of appetite, particularly in the morning, great thirst, fever, trembling, sometimes also with nausea and vomiting, sometimes with diarrhoea.

Cactus grandiflorus: dizziness caused by rush of blood to the head. Extreme pain in the head, the patient is so anxious that he cannot stay in bed; weakness, lack of energy. Severe pressing pain like a weight on the crown of the head, > with pressure but < with noise, when someone speaks, from strong light. Cloudy vision. Throbbing in the ears. Difficult breathing; sustained feeling of constriction and malaise, as if the chest is being constricted by a (hot) iron band and cannot expand to breathe normally. Breathing fresh air is very revitalising.

18.3 Heat damage

Carbo vegetabilis: cerebral irritation from overheated rooms, with cramp-like constriction, nausea and pressing pain over the eyes, feeling that the nose is blocked. When every source of heat triggers a headache, or heaviness, throbbing pain and pressure over the eyes; also for pain in the eyes as soon as the patient exerts himself to see something. Headache from every source of heat, especially heaviness, throbbing, pressure over the eyes; the eyes hurt when the patient tries to see.

Glonoinum: patient loses his senses and sinks unconscious to the ground; congestion alternating between the head and the heart. Previously dizziness, nausea, severe headache, red face and cold body. The whites of the eyes are red; the eyes protrude and look wild. Black spots in front of the eyes, dimming eyesight with fainting. Sparks, flashes in front of the eyes. Pale face with heat and rush of blood to the head and chest. Thirst. Fear of impending death. Laboured heartbeat, constriction, rapid pulse. Violent heart activity, throbbing perceptible all over the body. Trembling muscles, drowsiness. Feeling of weakness. No perspiration. Severe consequences of sunstroke; cannot bear heat on the head; cannot go out in the sun, has to stay in the shade or carry a parasol, cannot endure heat from the oven. Particularly suitable when the patient has been exposed to strong sunlight, also often after the most dangerous consequences. Head seems too full, blood seems to rise as if it wants to burst the head, severe throbbing and pain, worst when shaking the head.

Lachesis: delirium at night; patient talks a lot when feverish, in the evening. Feeling of shock. Very poor memory. Brief, frequent attacks of dizziness, particularly when closing the eyes. Headache deep inside the head; pain over the eyes into the base of the nose, almost all day; in the back of the head, the whole morning; extends into the neck and throat. Flickering in front of the eyes, particularly in the right eye, with twitching, with severe congestion of the head > when moving outdoors. Nose drips blood. Patient looks wretched, haggard, tired. Hot, red, swollen face. Difficulty putting out the tongue; the tongue trembles. Feeling of constriction in the throat. Palpitations with faintness and anxiety. Changeable pulse. Pulse small, weak

but rapid, irregular or intermittent, or alternating between full and small. Muscle cramps.

Natrium muriaticum: hot weather is tiring, makes the patient languid, dizzy and faint. Unable to do anything; patient just wants to sit with his hands in his lap or sleep, in the afternoon. Feels dull and sleepy. Dull, clouded head. Clouded vision; objects become unclear. Face yellowish, ashen. Great pallor. **Silicea:** when the heat causes nausea or other gastric problems, and neither *Antimonium crudum*, *Bryonia* or *Carbo vegetabilis* are enough to cure this condition. The heat causes nausea and other gastric problems. Great wooziness, as if drunk. Strange feeling in the head, as if it were falling backwards and forwards, with ringing in the ears. Dizziness with nausea and retching. Patients actions are uncertain and confused. Frequent deep sighs. Humming and jarring in the brain when treading heavily or striking something with the foot. Strange feeling as if everything in the head is alive and is turning and whirling inside.

Theridion curassavicum: sunstroke, first and second stages with unbearable headache. Consequences of sunstroke, with the most intolerable headache, nausea and vomiting. Headache with trembling, nausea and vomiting, as if seasick. Violent headache with nausea, patient cannot endure the slightest noise. Throbbing from the forehead into the back of the head. Nausea in the stomach, < when sitting up. Violent frontal headache with heavy, dull pressure behind the eyes.

Veratrum viride: cold sweat on the face, hands and feet. Thermal fever in connection with great heat from the sun. Head feels full, with throbbing arteries; increased sensitivity to noise; buzzing in the ears; double vision or blind spots in the field of vision; sunstroke. Dilated pupils. Tongue is red in the middle, yellow at the edges and root. Patient vomits food and bile, with fainting and cold sweat. Constant diarrhoea. Severe dyspnoea from pulmonary congestion, with rapid breathing and dull burning in the heart region. Prone to faint after returning upright from stooping, with blindness. Convulsions. Paralysis.

18 Thermal Emergencies

Case 18.3-1: Heatstroke

Martin Bundner

Anamnesis

The 51 -year-old patient spends the whole of an August day in the blazing sun. In the evening, she is extremely nauseous and complains of a pressing headache.

She is sweating and has hot flushes. Her head, face and neck are hot. She is woken by hot flushes during the night. Before the hot flushes occur, she develops a feeling of constriction in the chest. Her neck is tense and painful, turning her head makes the pain worse; it also affects the head. She also feels pain in her left elbow extending into her hand. Her face is ashen.

The next day, she feels worse after a restless night and requests homeopathic treatment.

Diagnosis

Sunstroke.

Homeopathic treatment

Repertorisation

	KENT'S SYNTHETIC	REPERTORY** REPERTORY*
Generalities - sun - from exposure to*		

Differentiation between remedies

The main remedies are *Antimonium crudum*, *Bel-ladonna*, *Carbo vegetabilis*, *Lachesis* and *Sulphur*. Taking the nausea caused by the heat of the sun into account, *Carbo vegetabilis* is the only remedy left if the rubric "Stomach - nausea - sun, heat of" is applied.

Prescription

1 drop *Carbo vegetabilis* Q6 several times a day as needed.

Progress

The headache and nausea improve significantly right after the patient takes the first dose of *Carbo vegetabilis*. The patient repeats the dose during the day whenever the improvement stagnates. She sleeps well without waking up; next day, her symptoms have gone.

Evaluation

Heat damage responds well to homeopathic treatment.

Critical commentary

Remedies do not necessarily have to be administered when treating heat damage. In 1864, Hering addressed the subject as follows: "After overheating in summer, it is good to take a few drops of rum or strong brandy on sugar, or a gulp of strong, fiery wine, and only to take cold water some time later."

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IV Materia medica

Martin Bundner, Michael Erass

Aconitum napellus	Crotalus cascavella	Nux vomica
Alumina	Cuprum metallicum	Opium
Anthracinum	Dulcamara	Phosphorus
Antimonium tartaricum	Gelsemium	Pulsatilla pratensis
Apis mellifica	Helleborus niger	Pyrogenium
Arnica montana	Hepar sulphur	Ranunculus bulbosus
Arsenicum album	Hydrocyanicum acidum	Rhus toxicodendron
Aurum metallicum	Hyoscyamus	Ruta graveolens
Baptisia tinctoria	Hypericum perforatum	Sabina
Belladonna	Ignatia	Secale cornutum
Berberis	Iris versicolor	Sepia
Bovista	Kalium bichromicum	Silicea
Bryonia alba	Kalium carbonicum	Spigelia
Calcareo carbonica	Kreosotum	Staphisagria
Camphora	Lachesis	Stramonium
Cantharis	Laurocerasus	Strophanthus hispidus
Carbo vegetabilis	Ledum palustre	Sulphur lotum
Caulophyllum thalictroides	Lycopodium clavatum	Symphytum officinale
Causticum	Mercurius solubilis	Thuja
Chelidonium	Morphinum	Tuberculinum
China	Muriaticum acidum	Vipera berus
Cocculus indicus	Myristica sebifera	Veratrum album
Colocynthis	Naja naja	Veratrum viride
Conium	Natrium chloratum (Natrium	
Crataegus	muriaticum)	

19 Materia medica

19.1 Introduction

The basis for prescribing homeopathic remedies is the homeopathic materia medica, which contains all the existing knowledge about potentised medicines.

From the awareness and conviction that no homeopathic work is complete without this basic literature, a small “materia medica for ICU and emergency cases” listing the remedies mentioned in the case studies has been specially compiled for this book. The original text of this materia medica has been stringently edited. The original wording of the symptoms is only integrated into some case studies in individual chapters to illustrate the practical proceedings. We are not concerned with describing the subtle nuances of each remedy; for this, it would be necessary to study an appropriate work. Instead, this materia medica describes a few essential characteristics and principal symptoms (making no claim to completeness) along with the extremely important modalities which aggravate and/or cause the complaints.

Even though this collection offers guidelines for using each of the remedies, it can by no means replace those sources which adhere more closely to the proving texts (first group of “secondary materiae medicae”) or present the actual results of the remedy provings (“primary materiae medicae”).

Every homeopath will quickly acquire one or more materiae medicae to help him work more efficiently. Examples of possible sources may include the literature mentioned below, which was used to compile the following overviews of each remedy.

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Aconitum napellus

19.2 Materia medica

Case studies and remedy prescriptions s. XIII 1.4, p. 5511., table 4.6-1, remedy kit II Intensive care medicine

III Emergency medicine

Aconitum napellus

Clinical indications

Agitation. Angina pectoris. Apoplexy. Asthma. Birth contractions. Bleeding. Croup. Dropsy. Encephalitis. Fear, effects of. Heart diseases. Lung diseases. Meningitis. Miscarriage. Peritonitis. Phlegmasia alba dolens. Pleuritis. Pneumonia. Purpura. Urine retention.

General information with main symptoms

Acute, violent, painful complaints. Sudden manifestation. Severe pain. Patient screams and is out of his mind with fear. Arterial blood vessels. Rush of blood to the head. Bright red bleeding. Stabbing, tearing pain. Collapse. Convulsions. Burning, numbness, tingling.

Ameliorating circumstances Outdoors. At rest. Warm sweat.

Aggravating circumstances

Fear, shock, frost, cold dry winds, heat (particularly from the sun), injuries, surgery. Dry cold. Lying on the side. Noise. Light. Teething. Sleeping in the sun. Music. Tobacco smoke. Breathing in. Pressure. Touch.

Alumina

Clinical indications

Lockjaw.

General information with main symptoms

Marked effect on the cerebrospinal nervous system with coordination problems and paralysis. Dry skin and mucous membranes. Patient prefers to lie down due to weakness; however, this makes the weakness worse.

Ameliorating circumstances

In the evening. Outdoors. Cold washes. Damp weather. Moderate bodily movement and moderate temperatures.

Aggravating circumstances

Anger, disappointment, lifting, physical exertion. Warm rooms. Warm bed. Preserved, artificial foods. Starchy foods. Salt. Smoking. Dry weather. Waking up early in the morning. Sitting. Full moon and new moon.

Anthracinum

Clinical indications

Erysipelas. Carbuncles, malignant ulcers and problems with ulceration, necrosis and unbearable burning. Black, thick, tarry, rapidly decomposing blood flowing from every orifice.

General information with main symptoms Abscesses with burning, recurring abscesses. Black pustules on the lips, brown tongue, stinking breath. Painful ulcers and rashes, gangrenous, burning, black, cloudy, brownish-black secretions.

Aggravating circumstances

Complaints from inhaling decaying odours from pus or incisions.

Antimonium tartaricum

Clinical indications

Bronchial catarrh with profuse mucus production, bronchiolitis, pleuropneumonia etc. in connection with toxic circulatory damage and heart failure.

General information with main symptoms Rattling mucus but little expectoration. Great exhaustion and rapid loss of strength, cardiovascular weakness, Hippocratic face. Sleepiness with trembling weakness and profuse sweating. Weak circulation with rattling mucus in the trachea. The mucus seems loose but the patient is too weak to expectorate it. Nausea and vomiting which exhaust the patient but then relieve his symptoms. Vomiting mucus when coughing, diarrhoea with exhaustion. Children are very fractious and don't want to be looked at or touched. Patient doesn't want to be looked at or spoken to. Loses consciousness between attacks of coughing. Talks to himself Sunken eyes, dull, sickly appearance, haggard face. The nostrils flutter when breathing. Asphyxia in newborns. Breathlessness

trachea. Atelectasis of the lungs. Sweating when breathless.

Ameliorating circumstances

Better on sitting up. Chest complaints improve when expectorating, stomach complaints when vomiting.

Aggravating circumstances

In the evening; in damp, cold weather; milk and acidic foods. Worse in warmth (antimony component). Coughing in the morning. Lying down at night (potassium component).

Apis mellifica

Clinical indications

Apoplexy. Dropsy. Gangrene. Heart diseases. Hydrocephalus. Hydrothorax. Incision wounds. Injuries. Insect bites, effects of. Jealousy, effects of. Meningitis. Peritonitis. Phlebitis. Pleuritis. Stab wounds. Surgery, effects of. Wounds.

General information with main symptoms Burning, stabbing, biting, prickling. Swelling, oedema, bloatedness. Symptoms develop rapidly. Worse on the right.

Ameliorating circumstances

Coolness (air, bathing, washing). Removing clothes. Movement. Sitting upright.

Aggravating circumstances

Worry, shock, anger, jealousy, bad news, mental shock, suppressed rashes, insect bites and stings. Heat (room, weather, fire, drinks, bath, bed). Touch. Pressure. After sleep. Lying down. 4 pm.

Arnica montana

Clinical indications

Apoplexy. Birth contractions. Brain diseases. Breast diseases. Contusions. Ecchymosis. Heart diseases. Injuries, effects of. Insect bites and stings. Meningitis. Miscarriage. Pleurodynia. Purpura. Sprains. Tetanus. Traumatic fever. Wounds.

Ameliorating circumstances

Lying horizontally or with the head low.

Aggravating circumstances

Mechanical injuries, shock, anger. Touch. Movement. After sleep. Alcohol. Lying on the left side.

Arsenicum album

Clinical indications

Agitation. Alcoholism. Asthma. Burns. Delirium tremens. Dropsy. Gangrene. Heart diseases. Hydrothorax. Lung diseases. Oedema. Peritonitis. Perityphlitis. Pleuritis. Pleurodynia. Pneumonia. Purpura. Pyaemia. Unconsciousness. Wounds.

General information with main symptoms Weakness. Sudden illness. Burning like fire. Pain drives the patient crazy. Patient breathless with pain. Great agitation. Pale, sack-like, pendulous swellings. Rotten, carrion-like odours. Periodicity.

Ameliorating circumstances

Warmth (applications, food, drink, wrapping up warmly). Movement. Walking around. Lying down with the head raised. Sitting upright. Company. Sweating. Outdoors.

Aggravating circumstances

Spending time in water, ice cream, inadequate nutrition, fruit, spoiled meat, alcohol, tobacco, quinine, iodine, sea voyages, bathing in the sea, climbing mountains, contusions, burns, passionate outbursts, worries, shock. Midnight. Cold (ice, drinks, food, air, weather). Drinking. Spoiled meat/food. Physical exertion. Tobacco.

Aurum metallicum

Clinical indications

Alcohol, effects of. Angina pectoris. Asthma. Love-sickness. Melancholy. Mercury poisoning. Suicidal tendencies.

General information with main symptoms Deep-seated mood disorders. Circulatory disorders. Irregular rushes of blood. Venous congestion. Bone caries.

Baptisia tinctoria

Aggravating circumstances

Mood swings. Oppressive feelings. Mental exertion. Cold, cold weather. At night, from sunset to sunrise. Mercury abuse. Alcohol. Potassium iodide. Cloudy weather.

Baptisia tinctoria

Clinical indications

Apoplexy. Appendicitis. Gallbladder problems. Hysteria. Methane sludge poisoning. Miscarriage, impending. Softening of the brain.

General information with main symptoms

Affects the blood. Soreness. Pain and heaviness in the muscles. Rapid exhaustion. Bed is too hard but patient too weak to move. Dark red mucous membranes. Smell of decay. Brown secretions.

Aggravating circumstances

Moist warmth. Fog. In a room. Pressure. When waking up. Walking. Outdoors. Cold wind. Autumn. Hot weather.

Belladonna

Clinical indications

Agitation. Apoplexy. Brain diseases. Colic. Convulsions. Croup. Delirium tremens. Depression. Epilepsy. Fear, effects of. Heart diseases. Hydrocephalus. Lung diseases. Mania. Meningitis. Peritonitis. Phlegmasia alba dolens. Pleuritis. Pneumonia. Pregnancy problems.

General information with main symptoms Burning heat. Bright, shiny redness. Dryness. Severe neuralgic pain. Sudden appearance and disappearance. Rushes of blood. Throbbing, sharp, shooting pain. Cramps. Twitches. Tightness. Complaints on the right side.

Ameliorating circumstances

Light covers. Bending backwards. Bed rest. Standing. Bending/arching the part affected. Leaning the head on an object.

Aggravating circumstances

Shock, fear, anger, insults, cutting the hair, getting the

bites from venomous animals, insect stings. Company. In the afternoon. Lying down. Touch. Pressure. Movement. Letting the body part affected hang down.

Berberis

Clinical indications

Liver disorders, gallstones, kidney stones.

General information with main symptoms Kidney and back pain with exhaustion and paralytic weakness. Pain in the liver area. (Stabbing, cutting) pain seems to radiate from the kidney. Pain in the ureters, bladder and urethra. Urine yellow or red, changeable consistency. Rapid changes in symptoms, for example from thirst to thirstlessness, from hunger to lack of appetite, from thick, cloudy urine to light, water-like urine. General weakness and fatigue, physical and mental.

Ameliorating circumstances Cold applications (skin).

Aggravating circumstances

Movement. Travelling by car. Any sudden, jarring movement. Standing. Letting the limbs hang.

Bovista

Clinical indications

Allergic reactions to conventional medication (antibiotics), drug eruptions, haemorrhage; marked lassitude and fatigue. Asphyxia from charcoal fumes. Bleeding from the uterus and nose.

General information with main symptoms Secretions from the nose and mucous membranes are very sticky, ropy, tough. Patient cannot bear tight clothing around the waist. Stammering children, older women with palpitations and “troublesome” patients. Menses: only flow at night. Haemorrhage, especially menorrhagia: dark, lumpy, black. Feeling of enlargement, particularly with headaches. Feeling of coldness in the stomach.

Ameliorating circumstances Sweating.

Aggravating circumstances In the morning and at night.

Camphora

Bryonia alba

Clinical indications

Alcoholism. Apoplexy. Asthma. Biliary colic. Brain diseases. Cardiac inflammation. Hydrocephalus. Meningitis. Peritonitis. Phlegmasia alba dolens. Pleuritis. Pleurodynia. Pneumonia. Pyuria.

General information with main symptoms Affects serous membranes, with inflammation and exudation. Aversion to the slightest movement. Dry mucous membranes. Bursting, stabbing pain, as if a weight is pressing on a sore area.

Ameliorating circumstances

Pressure. Lying on the painful part. Bandaging. Coolness, fresh air. Rest. Damp, cloudy days. Drawing up the knees (with abdominal pain). Warmth on the inflamed part. Downwards movement. Sitting up. Cold food and drink.

Aggravating circumstances

(Slightest) movement. Straightening up. Stooping. Coughing. Physical exertion. Breathing deeply. Dry cold or warmth. Annoyance. Touch. Becoming hot. Warmth (room, weather). Drinking when overheated. Eating. Vegetables. Acidic foods. Calomel. Suppression. Catching cold. Early in the morning.

Calcareo carbonica

Clinical indications

Swollen glands, uterine myomas.

General information with main symptoms

Fear of cancer, mental illness and dogs. Tendency to become fat, corpulent, clumsy. Children with red faces and flabby muscles who sweat easily and quickly catch cold afterwards. Big heads and bellies; the fontanelles and cranial sutures are open; the bones are soft and develop very slowly. Distortion of the bones, particularly of the spine and long bones; the extremities are misshapen; the bones unevenly developed. Sweating of the head, particularly at night; the pillow gets wet. Sweating of certain body parts (e.g. head, hands, feet.

for eggs; the patient demands indigestible things to eat; aversion to meat. Excess acidity in the digestive tract (acidic eructation, vomiting, acidic stool); whole body smells sour. General tiredness, lack of vitality and initiative; rapidly tires from physical and mental exertion. Mood of gloom, sees the worst in everything. Despondency. Swelling of the lymphatic system. White, clay-like stool. Aversion to milk. Tendency to obesity. Menstruation too early, too long and too heavy.

Ameliorating circumstances

Desire for fresh air. Constipation. Dry weather, lying on the painful side. Blowing the nose. Pain in head and neck.

Aggravating circumstances

Talking about symptoms. Shrill noises. Cold air; wet weather, cold, damp climates; cold water; from washing; in the morning; at full moon. Mental or physical exertion.

Camphora

Clinical indications Collapse, cholera.

General information with main symptoms

Whole body is icy cold; sudden feeling of weakness; pulse small and weak. This condition is typical of cholera, the disease with which *Camphora* gained its classical reputation. Great anxiety and restlessness. Great agitation. Patient is tempted to throw himself out of the window or kill someone. Tendency to scream loudly. Terrifying visions and delirium. Loss of consciousness with violent convulsions. Whole body is cold. Vertigo which makes the patient stagger. Oppressive headaches, epileptiform seizures. Early stages of colds with shivering and sneezing. Extreme restlessness. Cracking joints. Epileptiform convulsions.

Ameliorating circumstances

Warmth.

Aggravating circumstances

Thinking about symptoms, movement, at night, cold air.

Cantharis

Cantharis

Clinical indications

Priapism. Peritonitis. Retained placenta. Pleuritis. Pregnancy-related ailments. Burns.

General information with main symptoms Acute, severe inflammation. Cutting, burning, nipping pain.

Ameliorating circumstances Warmth. Rest. Rubbing.

Aggravating circumstances

Burns. Scalds. Drinking. Cold drinks. Touch. Coffee. Urinating. Sound of running water.

Carbo vegetabilis

Clinical indications

Poor circulation with outbreaks of sweating, cold sweat, respiratory insufficiency, venous stasis. Asthma which can be traced back to attack of measles or whooping cough in childhood. Gastritis.

General information with main symptoms Tendency to collapse. Great weakness and tiredness caused by sluggish blood circulation. People who never fully recovered from the exhausting effects of a past disease. Desires fresh air; sits at open window or wants to be fanned with cold air. Icy cold skin, cold hands and feet, the feet are cold right up to the knees; general coldness. Cold breath, cold mouth, cold sweat. Skin blue and cyanotic. Veins in both legs congested. Better for elevating the legs. Passive bleeding. Mucous secretions are sharp and smell offensive. Mouth ulcers. Upset stomach with great flatulence, fermentation and acid formation. Abdominal plethora. Catarrh of the respiratory tract with weak heart activity and poor circulation, particularly in elderly people. Tendency to suffer septic and gangrenous inflammation of the glands (lymph glands, parotid glands, mammary glands) and skin (boils, carbuncles, whitlows). Anxiety in bed at night, when closing the eyes. Does not like strangers or appearing in public. Dazed feeling in head as if intoxicated. Head feels constricted as if from a helmet. Tympanitic abdomen. Asthma caused by cold and flatulence.

Ameliorating circumstances Being fanned, eructation. Passing wind.

Aggravating circumstances

Warm, humid air. In the evening and at night. Butter, pork, fatty food. Loud singing or reading.

Caulophyllum thalictroides

Clinical indications

Impending miscarriage. Abnormal birth. After- pains. Pregnancy-related ailments. Uterine atony. Uterine cramps. Abnormal contractions, contractions which stop and start, false contractions.

General information with main symptoms Wandering, pulling, rheumatic pain. Internal trembling, great exhaustion. Contraction-like pain extending in all directions. Contractions too weak, short or irregular. Cramped, rigid cervix. Repeat miscarriages. Painful lumps on the finger joints, rheumatism in the small joints.

Aggravating circumstances

During pregnancy. Amenorrhoea. Outdoors. Coffee.

Causticum

Clinical indications

Laryngitis, lung failure.

General information with main symptoms Rheumatic, arthritic, neuralgic symptoms. Treatment for everything from spasms and cramps via paralytic weakness to paresis and paralytic conditions (e.g. eyelids, facial nerves, vocal cords, rectum, bladder). Dyskinesia caused by a mixture of spasms and paralysis (easier to defecate while standing, struggles to pass stool in vain). Catarrh of the airways with paralysed vocal cords and dry cough, better with cold water. Passes splashes of urine when coughing. Hoarseness worse in the morning, better from coughing up mucus and clearing the throat. Cough which occurs when the patient exhales. Dry rashes. Pain usually burning in character. A lot of complaints are accompanied by shivering. Roughness or soreness of the head, throat, airways, rectum, anus, urethra, vulva, uterus. Despondent mood; sad, hopeless.

China

worry, sorrow, suffering; with crying, “child weeps at the slightest provocation”. Intense sympathy for other peoples suffering.

Ameliorating circumstances

Cold, wet weather, warm air. Doubling up (abdomen, back).

Aggravating circumstances

Clear, pleasant weather, coming into a warm room from the fresh air; cold air, particularly cold draughts; getting cold; getting wet or bathing. In the morning between 3 am and 5 am and after getting up. Before and during menstruation. Thinking about symptoms. Excitement, shock, worry, grief, joy, anger, annoyance, lack of sleep.

Chelidonium

Clinical indications

Gallstones with pain under the right shoulder blade, terrible attacks of biliary colic, organotropic relationship with the liver. Important liver and gallbladder remedy. Angina pectoris. Pain in the limbs as a result of influenza. Hepatitis. Old, purulent, expanding ulcers when patient has a history of liver disease or a tuberculous disposition. Asthma at night.

General information with main symptoms Chelidonium patients are often blonde, thin, skinny, irritable; tendency to suffer liver, stomach and intestinal disorders; any age, sex and temperament. Aggressive, dominant personality. Complaints on the right side; liver and gallbladder pathology. Constant pain at the lower medial angle of the shoulder blade. Tongue has a thick yellow coating, red edges and tooth imprints. Desires very hot drinks. Periodic attacks of orbital neuralgia with profuse lachrymation. Alternating constipation and diarrhoea. Pneumonia particularly in the right upper lobe, convulsive coughing; small lumps of mucus fly out of the mouth when coughing. Great tiredness, exhaustion and fatigue. Usually despondent, full of gloomy thoughts; patient believes he is going to die. Restless and anxious, as if the patient had committed a major crime. Anger and irritability, outbreaks of rage over any trifle.

Needs to sleep during the day, patient falls asleep in sitting position; sleep with restless, frightening dreams. Dreams about corpses and burials. Feeling of constriction in the larynx and trachea with anxiety. Constriction in the chest, difficult breathing as if the chest is too tight and no air can pass through. Hoarseness and scratching sensation in the larynx; dry, convulsive cough. Stabbing pain under both shoulder blades. Bronchitis, bronchopneumonia, influenza, bronchial asthma when it is clear that the liver is involved. Gastritis, caused in particular by hydrochloric acid deficiency. Shivering with chattering teeth, the whole body is cold. Cold fingers and fingertips, cold toes. Feeling of heat everywhere, particularly in the face and hands; outbreaks of sweating. Swollen veins in the hands and lower arms. Palpitations, slow pulse.

Ameliorating circumstances

Warm room. Stomach problems and other symptoms improve when eating and drinking warm drinks.

Aggravating circumstances

Right side of the body, e.g. neuralgia on the right side of the head, cold right foot (however, the effect on the right side of the body was observed when treating patients and not when proving the remedy). Cold, harsh weather; touch. 4 am and 4 pm. Pain worsens on movement and touch, better with heat (except headache). Lying on the painful side.

China

Clinical indications

Consequences of loss of bodily fluids such as blood, pus, semen, milk, bleeding into the muscles, into all bodily cavities and the intestines; after catarrhal intestinal disorders and other serious diseases. Malaria.

General information with main symptoms Great weakness and frailty with nervous hypersensitivity and strong proneness to sweating. Attacks of fever with congestion of the head, hot face with cold hands and feet. Accompanied by profuse sweating, general weakness and nervous irritability. Tendency to bleed dark blood from all mucous membranes.

Cocculus indicus

Rushes of blood to the head with headache and tinnitus, outbreaks of sweating, dizziness, often periodical. Nervous system and sensory organs strongly overstimulated, great sensitivity to touch and all external impressions. Periodical complaints returning at the same time every day or after several days, e.g. attacks of fever, biliary colic. Meteorism, worse after eating, frequent eructation which does not ameliorate. Food, rest and sleep, which normally strengthen the body naturally, do not improve the patients condition. Apathetic, indifferent, silent; despairing, gloomy, no will to live but does not have the courage to commit suicide. Ailments caused by loss of bodily fluids, especially bleeding, profuse lactation, diarrhoea, purulent discharge; caused by malaria, with clear periodicity; the complaints return every other day. After menopause with profuse bleeding; acute diseases often end with dropsy. Pain: pulling or tearing, in every joint, all bones. The periosteum seems overstrained and sore everywhere; the patient has to move his limbs often as this gives him some relief; the pain returns on being touched and gradually escalates to become very severe. Headache, as if the skull is about to burst; intense throbbing of the head and carotid arteries, red face; extending from the occiput all over the head; patient has to stand or walk.

Ameliorating circumstances

Warmth, in a warm room. Firm pressure. Bending double.

Aggravating circumstances

Loss of bodily fluids. Cold, wet weather, draughts. Touch; touch often triggers an attack of pain. At night. After meals. Every second day. Excitement.

Cocculus indicus

Clinical indications

Convulsions. Colic. Meningitis. Unconsciousness.

General information with main symptoms Disorders of the sensory organs and cerebrospinal axis. Weakness (holding the head up, standing, talking). Individual body parts seem to fall asleep. Feeling of hollowness or emptiness. Trembling. Painful muscle cramps. Sensitivity to cold.

Ameliorating circumstances

Sitting down. Indoors. Lying on the side.

Aggravating circumstances

Movement, also passive. Swimming. Lack of sleep. Touch. Noise. Jarring. Mood swings. Anxiety. Kneeling. Stooping. During menstruation. Eating. Cold. Outdoors. Exertion.

Colocynthis

Clinical indications

Colic. Peritonitis.

General information with main symptoms Acute gastrointestinal disorders. Sudden, terrible, cramp-like abdominal pain. The patient screams, tosses, turns and twists his body. Neuralgia with cutting, nipping, clenching, gnawing or boring pain. Constriction.

Ameliorating circumstances

Hard pressure. Heat. Rest. Gentle movement. After passing stool or wind. Bending double.

Aggravating circumstances

Annoyance, chagrin, disgust, worry, catching cold. Lying on the pain-free side. At night, in bed. Before and after urination. Draughts.

Conium

Clinical indications

Rising paralysis, hardening of the glands (mammary, prostate), paraesthesia, carcinomas.

General information with main symptoms Vertigo, particularly when lying down or turning over in bed; triggered by slight movements of the head or even the eyes; patient has to keep his head absolutely still. Convulsive attacks of coughing caused by a dry area in the larynx; with itching in the throat and chest. Great difficulty passing water; the flow of urine stops and starts; diseases of the uterus and prostate. Aversion to light without inflammation of the eyes; worse in artificial light; frequently prescribed for students needing bright room illumination. Sensitivity to cold.

poor memory. Hypochondria with aversion to company but fear of being alone, often due to sexual disorders or age. Great exhaustion, weakness and trembling in the muscles of the limbs, especially the legs; tremor in the hands, clonic convulsions. Weakness which forces the patient to lie down. Coordination difficulties when moving the limbs, the tongue (when speaking) and the eyes (seeing double). Tendency to perspire, sweats when falling asleep, even when closing the eyes. Cold sweat on the palms and fingers. Tumour development as the result of blows, hardened glands; palliative effect for patients with cancerous tumours. Nervous disorders as the result of sexual weakness or overstimulation. Rising paralysis, trembling, sudden loss of strength while walking.

Ameliorating circumstances

Stomach complaints and general condition improved by eating.

Aggravating circumstances

At night; when lying down; turning over or raising oneself in bed. Celibacy. Sexual intercourse and ejaculation; unsatisfied lust or extreme lack of restraint. At night and in the morning after waking up. Sleep, also siesta. Small quantities of alcohol. Physical and mental exertion, from cold, when resting (pain in the limbs).

Crataegus

Clinical indications

Inflammation. Haemoptysis. Haematuria. Purpura haemorrhagica. Heart diseases in elderly people.

General information with main symptoms Affects blood pressure; a positive effect on coronary circulation has been observed during experiments. Great fatigue, tiredness. Feeling of exhaustion. Lack of appetite. Depressed, anxious, irritable mood. Dazed feeling in the head, vertigo. Sleeps remarkably well, or restless sleep with frightening dreams. Frontal headache, usually on the left. Pain in the left temple. Intense rush of blood to the head. Lack of appetite, nausea, eructation of air, loose faeces with strong urge to defecate, nipping pain in

the bowel, haemorrhoids. Palpitations, extrasystoles, irregular pulse, slow heart activity. Feeling of chest constriction on slightest physical exertion, cramp-like pain in the heart region which extends into the left arm as far as the fingertips. Feeling of pressure on the heart. Low pressure. Feeling as if the heart is too big.

Ameliorating circumstances Fresh air, rest.

Aggravating circumstances In warm rooms.

Crotalus cascavella

Clinical indications

Gangrene, sepsis, haemorrhage. Exceptionally inflamed hives which appear in certain areas.

General information with main symptoms

Sharp pain made worse and more frequent by washing in cold water. Bone pain. Vivid, unusual hallucinations. Headache after sleeping. Thoughts and dreams of death. Impaired consciousness. Agonising fear. Answers “no” to all questions. Fear of being alone at night. Thoughts of death when alone. Melancholy, patient wants to throw himself out of the window. Confused speech; imagines he hears voices. Feeling as if the brain is being compressed by an iron helmet. Difficulty speaking, the tongue seems heavy. Feeling of a foreign body in the throat, does not improve when swallowing. Aversion to tight collars and clothing.

Aggravating circumstances

At night. Patient cannot endure tight clothing. After sleep.

Cuprum metallicum

Clinical indications

Angina pectoris. Epilepsy. Croup. Laryngospasm. Meningitis. Afterpains. Pseudocroup.

General information with main symptoms Nerves in the cerebrospinal axis. Spastic symptoms: violent convulsions and cramps. Trismus. Cyanosis. Hypersensitivity.

Dulcamara

Ameliorating circumstances

Placing hands on the body part affected. Cold drinks. External pressure over the heart.

Aggravating circumstances

Suppression, shock. Rage. Emotional upheaval. Physical and mental overexertion. Lack of sleep. Movement. Touch. Hot weather. Vomiting. Raising the arms. Before menstrual period. At new moon.

Dulcamara

Clinical indications

Meningitis. Dropsy.

General with main symptoms

Excess mucus secretion. Numb, painful muscles in the back and loins. Paralysis with icy coldness of the parts affected. Gripping pain in the bowels, particularly around the navel.

Ameliorating circumstances

Walking around. Warmth. Dry weather.

Aggravating circumstances

Chills, particularly after getting overheated. Sudden cold weather. Cold, wet climates. Cold drinks. Ice cream. Damp floors, basements or beds. Cold around the feet. Absence or suppression of secretions, skin rashes, sweat etc.; hot days with cold nights. At night. Rest. Injuries. Before storms. Mercury abuse. Undressing.

Gelsemium

Clinical indications

Albuminuria during pregnancy. Epilepsy. Biliary fever. Brain diseases. Heart diseases. Heat damage. Hysteria. Convulsions. Meningitis. Sunstroke. Labour pains. Puerperal eclampsia.

General information with main symptoms Mainly affects the muscles and motor nerves. Pain, tiredness, heaviness, weakness, soreness. Functional paralysis. Tremor. Passive arterial or venous hyperaemia. Feeling of fullness and heaviness. Catarrh of the mucous

Ameliorating circumstances

Profuse urination. Sweating. Shaking the head. Alcohol. Mental occupation. Bending the head forward. Continued movement. In the afternoon. Leaning back while sitting and resting the head.

Aggravating circumstances

Emotional upheaval (fear, shock, before exams, surprises). Movement. Weather: damp weather, spring, fog, cold, damp climate. Heat (sun, summer). Storms. Periodicity. While teething. When thinking about the complaints.

Helleborus niger

Clinical indications

Stupor, coma, cerebral oedema. Inflammation of the brain, hydrocephalus. Kidney inflammation following infectious diseases (scarlet fever, measles), acute nephritis and chronic pyelonephritis.

General information with main symptoms Remedy for brain and meninges, dulled mental faculties, hypersomnia, melancholy or severe nervous agitation and delirium. Patient is dazed, cannot wake up. Unconscious, abstracted. Extremely poor memory. Everything seems new. Congestion moving towards the brain with throbbing, pressing headache. Kidney remedy for patients with tendency to develop dropsy-related swelling and kidney irritation, even haematuria. Unconscious; dull; the patient responds to questions slowly. Muscle weakness, general weakness and state of collapse. Severe inflammation of all mucous membranes, even bleeding from the bowel. Tendency to develop oedema and exudates in the bodily cavities. Patient bores his head into the pillow; rolls from side to side, hits his head with his hands. Diarrhoea: with acute hydrocephalus, teething, pregnancy; watery, clear, tough, colourless mucus; white, jelly-like mucus; like frog spawn; involuntary. Urine red, black scanty, sediment like coffee grounds with brain disorders and dropsy; albuminous. Dropsy: in brain, chest, abdomen; after scarlet fever, malaria; with fever, weakness, suppressed urine production; from suppressed rashes.

Ameliorating circumstances Diuresis.

Hepar sulphur

Clinical indications

Purulent discharges of the skin and mucous membranes with cheesy odour, otitis media, bronchitis, digestive disorders. All kinds of local purulent inflammation and suppuration. Inflammations which begin to suppurate.

General information with main symptoms

Great hypersensitivity to cold; chilly people who catch cold from every draught or exposure to cold air. Oversensitive to pain. The diseased parts are painful to the touch. Great suppurative tendencies everywhere, particularly in the skin and lymph glands. The smallest injury suppurates. Hepar can open abscesses and accelerate healing. Catarrh with thick, yellow secretions, "old" catarrh. Patient desires highly spiced, acidic foods and alcohol. Secretions smell offensive, typically of old cheese. Splinter-like pain in the inflamed parts. Profuse, sour-smelling or offensive sweats which bring no relief. First-aid remedy. Never happy, rude. Delusion: the world is burning. Violent rage. Malicious. Recurring croup. Earache better from wrapping the head warmly. Purulent nail ulcers. Great sensitivity to pain and cold. Irritated by the slightest thing; fast, hasty speech and drinking. The patient is morose, annoyed by trifles; hypochondriac; anxious for no reason. Extremely sensitive to cold air; patient imagines he can feel the draught when a door is opened in the next room; has to be covered up to his face, even in hot weather; cannot bear being naked; catches cold from the slightest exposure to fresh air. Urine: flow obstructed, urine passes slowly, without pressure, drips vertically; the patient has to wait a while before the urine starts to flow; the bladder is weak, unable to finish the process; seems as if some urine is always left behind. Patient coughs when a body part is not covered. Asthma: breathing fearful, wheezing, rattling; short, deep breaths, the patient is afraid of

suffocating; has to bend his head backwards and sit upright; after suppressed skin rashes.

Ameliorating circumstances

Warmth, warm weather. Wrapping up warmly, especially the head; in damp, wet weather.

Aggravating circumstances

Draughts, cold, getting undressed. Cold, dry weather. Several hours at night and in the morning. Lying on the painful side. Eating or drinking cold things. Touching diseased body parts.

Hydrocyanicum acidum

Clinical indications

Angina pectoris. Asthma cardiale. Severe attacks of asthma bronchiale. Spasms in all body parts, e.g. epilepsy, cramps in the bronchial muscles and diaphragm. Cyanosis of the skin.

General information with main symptoms

Icy cold skin, cold sweat, face pale to cyanotic. Rush of blood to head with cyanosis. Lack of feeling in the skin. Sudden collapse from abrupt paralysis of the respiratory tract, circulation or brain. Constriction in the throat, chest, with feeling of anxiety and intermittent breathing. Tonic and clonic cramps in all muscles. Fluid can be heard gurgling through the oesophagus (spasms). Difficulty concentrating. Afraid of going to sleep. Hysteria, gathers bedclothes and takes care that nothing is removed. Self-harm. Insanity with lack of sensitivity to pain. Blue or grey lips. Paralysed tongue. Asthma with constriction in the throat. Needs to breathe deeply. Gasping for air. Oppressive heart pain. Apoplexy. Convulsions while unconscious, with cyanosis.

Ameliorating circumstances

Eating.

Aggravating circumstances During pregnancy.

Hyoscyamus

Clinical indications

Angina pectoris. Delirium tremens. Epilepsy. Mental

Hypericum perforatum

General information with main symptoms Deep-seated disorders of the mind and emotions. Convulsions, trembling, jerking. Active delirium or cramps alternating with deep stupor. Carphology. Subsultus tendinum.

Ameliorating circumstances

Sitting up. Movement. Warmth. Stooping.

Aggravating circumstances

Mood swings. Jealousy. Shock. Being unlucky in love. Before and during menstruation. Touch. Cold. During sleep. Lying down. Suppressed lactation.

Hypericum perforatum

Clinical indications

Asthma. Bites. Commotio cerebri. Commotio spinalis. Mental disorders. Complex fractures. Ischialgia. Meningitis. Afterpains. Consequences of surgery. Bruises. Gunshot wounds. Tetanus. Consequences of labour pains. Wounds.

General information with main symptoms Lacerations. Violent, unbearable, shooting and stabbing pain. Injuries to the brain, spine and spinal medulla.

Ameliorating circumstances

Lying on the face. Bending backwards. Rubbing.

Aggravating circumstances

Shock, bites, wounds, jarring. Exertion. Touch. Changes in the weather. Fog. Cold, wet weather. Movement. After forceps birth.

Ignatia

Clinical indications

Physical and mental instability.

General information with main symptoms Sensitive, highly excitable women; dark hair and skin, gentle nature, rapid powers of comprehension and execution. Great contradictions: buzzing in the ear better when listening to music; haemorrhoids better when walking; cough gets worse the more the patient coughs; coughs

incredibly short time, from joy to grief, laughter to tears; involuntary sighs; feeling of weakness and emptiness in the pit of the stomach. Broods alone over imaginary problems. Desires to be alone. Inconsistent, impatient, indecisive, quarrelsome. Loveable nature when well but easily unsettled by the slightest mood swings; easily offended. Children who have been rebuked suffer convulsions while asleep or become ill. Headache as if a nail is being driven through the head from the outside; improves when lying on the side affected. Tendency to become melancholic and grieve silently. Sudden, remarkable change of mood from one extreme to another: one minute laughing and cheerful, the next weeping or annoyed. Contradictions trigger outbursts of rage. Body trembles, great proneness to convulsions. Emotional excitement, worry or brooding over an insult triggers convulsions. Fits of laughter or tears caused by mental excitement - involuntary, spasmodic sighing. Feeling of weakness in the pit of the stomach.

Ameliorating circumstances

Feeling as if there is a foreign body in the throat and oesophagus, better from swallowing. The sensations felt by the patient seem very contradictory and absurd: sore throat better when swallowing, headache better when stooping, toothache better when chewing. Pain improves on pressure but worsens from gentle touch. Thirsty when chilly but not thirsty during the heat stage of fever, red face when chilly. Stomach pain (better from eating) probably caused by this contradictory behaviour. Indigestible foods are not vomited. Nausea ameliorated by eating.

Aggravating circumstances

Smoking tobacco. Coffee. Thinking about symptoms. Excitement, sorrow, worry, disappointed love and jealousy. Blame. Contradiction. Bad news. Shame. Insults. Exertion (mental and physical). In the morning. Cold air.

Iris versicolor

Clinical indications

Biliary colic. Pancreatic diseases.

Kreosotum

General information with main symptoms Particularly affects the mucous membranes in the digestive tract, salivary glands, liver and pancreas. Sharp, acidic secretions which cause burning. Feeling of a fatty coating in the nose, fatty taste in the mouth, fatty stools.

Ameliorating circumstances Moderate movement.

Aggravating circumstances

19.3 am - 3 am. After midnight. Mental exertion. Hot weather.

Kalium bichromicum

Clinical indications

Chronic sinusitis, tracheal secretions. Ulcers.

General information with main symptoms

The secretions from all mucous membranes are tough and stringy, also streaked with blood. Ulcers in the skin and mucous membranes which penetrate deeply, as if cut out with a hole punch. Great sensitivity to cold, complaints aggravated by it. Pain in all body parts which frequently changes location. Diseases of the mucous membranes - eyes, nose, mouth, throat, bronchi; gastrointestinal and urogenital tract. Ailments in hot weather. Patient tends to catch cold in the fresh air. Rheumatism alternating with gastric symptoms, one in autumn, the other in spring. Pain: in small areas which can be covered by the tip of a finger; moves quickly from one body part to another; appears and disappears suddenly. Neuralgia at the same time every day. Stomach complaints: lack of appetite; heavy weight in the pit of the stomach; flatulence; aggravated shortly after eating; vomiting sticky mucus and blood; circular stomach ulcer. Nose: pressing pain at the base of the nose, secretes lumps, tough, sticky, green, liquid mucus, clear masses; patient suffers severe pain from the occiput to the forehead when the secretions stop. Ulceration of the nasal septum with bloody secretions or large flakes of hard mucus. Pseudomembranous deposits, solid, bead-like, fibrinous, readily spread downwards to the larynx and trachea.

Ameliorating circumstances

Eating. Fresh air, warmth. When secretion begins. Rheumatic pain improves with movement.

Aggravating circumstances

Hot weather, particularly stomach complaints. In the morning and between 3 am and 5 am. Beer.

Kalium carbonicum

Clinical indications

Recurrent miscarriage. Asthma. Heart complaints. Hydrothorax. Pleuritis. Pleurodynia. Dropsy.

General information with main symptoms Weakness (muscles, heart, back, limbs, mind). Weak joints. Back feels broken. Sweating, back pain. Sensitivity to cold. Sharp, stabbing, boring pain. Throbbing pain. Numbness or cold feeling in individual body parts. Cramps (better on eructation).

Ameliorating circumstances

Warmth. Sitting while supporting the elbows on the knees. During the day. Outdoors. Movement.

Aggravating circumstances

Cold (air, draughts, water). Becoming hot. Exertion. 2 am - 3 am or 4 am. Before menstruation. Lying on the painful or on the left side. Loss of bodily fluids. After giving birth. Miscarriage. Stooping. Sudden or careless movements. Changes in the weather. After coitus. Touch. Movement.

Kreosotum

Clinical indications Bleeding. Neuralgia.

General information with main symptoms Mucous membranes of the digestive tract and female genitals affected. Disintegration of blood. Fiery burning. Secretions are profuse, sharp, burning hot, smell decomposed. Redness of the parts touched by the secretions. Bleeding. Black discolouration. Throbbing.

Ameliorating circumstances

Lachesis

Aggravating circumstances

Teething. Pregnancy. Rest. Cold. Eating. Lying down. Offensive odours. During menstruation. 6 pm to 6 am. Coitus. Touch. Sprains.

Lachesis

Clinical indications

Infectious diseases, severe septic processes, abscesses, phlebitis, pulmonary embolism, rheumatism of the joints. Sepsis and septic progress of all diseases. Sepsis development in injuries. Phlegmon, carbuncles, erysipelas and mastitis with septic tendencies, appendicitis, peritonitis, pelveoperitonitis, puerperal fever, acute rheumatism of the joints, endocarditis acuta and lenta, influenza with haemorrhage and collapse, and many other conditions. Endocrine disorders caused by the thyroid (Graves disease) and the pituitary gland (or ovary) during the menopause. Vascular system: vasomotor disorders: hot flushes, hypertension, hypotonic regulation disorders, collapse. *Lachesis* is usually mentioned for hypertension, *Naja* for hypotension. Thrombophlebitis. Embolism and embolic infarctions. Angina pectoris. Myocardial infarction. Acute endocarditis after angina and polyarthritis rheumatica, endocarditis lenta. Neuritis. Cachexia caused by malignant tumours. Agranulocytosis.

General information with main symptoms Emotionally very agitated and talkative; distrustful, jealous; sad, depressed. Great sensitivity to touch with feelings of constriction, mainly round the throat but also in the stomach and abdominal areas. Great mental and emotional agitation which is often vented in an endless stream of chatter. Symptoms tend to begin on the left side and move to the right or become more severe on the left. Patient is oversensitive to touch, the slightest movement makes him feel constricted, particularly around the stomach area and the throat, where a feeling of asphyxia may occur. Feeling of inner tension and constriction eases when secretions start to flow (sputum, menstrual blood, sweat). Hot flushes with great anxiety and annoying outbreaks of sweating, interrupted by coldness and chills. Eever without sweating, with dry skin and mouth,

or chills alternating with sweating. Prone to weak heart, sudden collapse and heart spasms. Hypotension with attacks of weakness. Endocrine disorders of the thyroid (Graves disease) and menopause; circulation strongly stimulated. Small, weak and irregular pulse; strikingly high heart rate. Weakness progressing to collapse with cold limbs and cyanosis. Ailments caused by long periods of grief; worry, shock, annoyance, jealousy or heartbreak. Women who never recovered from the menopause, "I haven't felt well since". Remedy for the left side; complaints begin on the left and move to the right. Throat, stomach, abdomen all sensitive to touch; patient cannot endure his pyjamas or bedclothes touching his throat or abdomen, not caused by soreness or delicacy. Patient wants to talk all the time; jumps from one thought to another; a single word often leads to another story. Constipation: sluggish bowel, stool lies in the rectum with no urge to defecate; all pain improves during menstruation. Haemorrhoids with stabbing pain shooting upwards (*Nitricum acidum*). The smallest object coming close to the mouth or nose disrupts the breathing; patient wants to be fanned, but slowly and from a certain distance. Lengthy chills and shivering; cold limbs and hot head; fever with hot flushes and outbreaks of sweating. Worse after sleeping. Starts out of sleep with fear and breathlessness; prone to circulatory collapse. Skin oversensitive to the touch of clothing or the bed. Warm applications are not tolerated and cause collapse. Acute joint rheumatism with septic progression; recommended right from the start if symptoms become worse after sleep or when applying hot compresses. Endocarditis with heart complaints wakening the patient from sleep. Diphtheria and scarlet fever: begins on the left side and only later moves to the right; throat hypersensitive to touch. Liquids are swallowed with more difficulty than solids (corresponding to aggravation by touch and improvement with firm pressure). Hot drinks are refused. Prone to collapse. Typhoid condition with delirium and talkative excitement. Bleeding from the mouth or nose. Major remedy for tonsillitis beginning on the left and tonsillitis with abscesses.

Ameliorating circumstances

Emergence of secretions, warm applications. Fresh air and movement.

Aggravating circumstances

After sleep; *Lachesis* sleeps until the symptoms become worse; left side, warm bath, pressure or constriction, hot drinks. Closing the eyes. Non- appearance of secretions. All kinds of warmth: summer, warm room. Wine, beer and tobacco. Rest. Touch; extremes of temperature; acids; alcohol; quinine; sunshine. Warm, damp weather.

Laurocerasus

Clinical indications

Right heart insufficiency. Latent cardiac insufficiency, cyanosis, cardiovascular weakness.

General information with main symptoms The main trio of symptoms comprises cyanosis, pulmonary dyspnoea and a tickly cough. Feels cold, low body temperature, but cannot tolerate external warmth. Cramps in the smooth and skeletal muscles. Sluggishness, idiotic expression. Icy coldness around the head. Drinks can be heard flowing through the oesophagus and intestines. Coughing with heart diseases. Rapid pulse. Proneness to collapse. Asphyxiating attacks of coughing.

Ameliorating circumstances

Lying down. Better outdoors. Sleep disorders improve if the upper body is kept high.

Aggravating circumstances Sitting down.

Ledum palustre

Clinical indications

Asthma. Black eye. Drunkenness. Bites. Insect stings. Bruises. Puncture wounds. Tetanus. Wounds.

General information with main symptoms

Skin and joint complaints. Bluish-red discolouration and swelling of the parts affected. Affected body parts are icy cold, but patient is averse to external warmth.

Ameliorating circumstances Cold (bath, air). Rest.

Aggravating circumstances

Warmth (bed, stove, air). Injuries. Movement. At night. Eggs. Wine. Spitting.

Lycopodium clavatum

Clinical indications

Miscarriage. Aneurysm. Angina pectoris. Asthma. Biliary colic. Gallbladder problems. Heart diseases. Hydropericardium. Hypochondria. Hysteria. Lung diseases. Peritonitis. Quinsy. Phlegmasia alba dolens. Pneumonia. Dropsy. Abnormal labour pains.

General information with main symptoms Right side.

Right to left. Changeable symptoms. Abdomen full of flatulence. Oversensitive to pain.

Ameliorating circumstances

Warm food and drinks. Cold applications. Movement. Eructation. Urination. After midnight.

Aggravating circumstances

Fear, anxiety, shock, annoyance, rage, anger, fever, overstraining, masturbation, travelling by car, chewing tobacco, wine. Pressure of clothing. Warmth. Waking up. Wind. 4 pm to 8 pm. Wet or stormy weather. Pressure. Milk. Cabbage. Beans. Vegetables. Bread. Pastries.

Mercurius solubilis

Clinical indications

Inflammation of the skin, mucous membranes and lymph glands with tendency to suppurate, slimy diarrhoea, profuse sweating at night.

General information with main symptoms Catarrh and inflammation of the mucous membranes everywhere in the body, particularly the beginning and end of the digestive tract, i.e. inflammation of the mouth, Waldeyer's ring and rectum with typical tenesmus. The mucous membranes appear red, livid to bluish-red, are extremely swollen and tend to become ulcerated and

Morphinum

and yellowish-green, also bloody. As the swelling of the mucous membranes is typical of mercury intoxication, mercury is not often indicated in the early stages of mucous catarrh; it mainly takes effect when the mucous membranes begin to swell. Inflammation of the lymphatic system, lymphatic vessels and lymph glands, adenoids and palatine tonsils, lymph follicles in the intestines including the appendix. Feverish angina follicularis. Inflammation of the skin, subcutaneous tissue, the entire connective tissue in all body parts and organs, with suppurative tendencies. Corresponds to the stage of inflammation immediately preceding suppuration or when purulent necrosis sets in. Wet skin eczema with purulent pustules. Inflammation of the joint capsules, periosteum, tendons, tendon sheaths, periodontal membrane and dental pulp. Many diseases are accompanied by profuse, offensive sweating which does not ameliorate the symptoms (leading symptom).

Offensive foetor ex ore and profuse salivation. Offensive-smelling, sticky, also yellowish sweat which often aggravates the condition rather than improving it. The sweat turns the patient's clothes yellow and is particularly profuse at night. All secretions are sharp and therefore often mixed with blood, later slimy, purulent and mild. The inflamed parts usually swell considerably (skin, mucous membranes, all glands). The swollen, inflamed mucous membranes give rise to a feeling of tenesmus in the throat, anus and urethra. Freezing in the cold air, general chills. The more the patient tries to warm himself at the heater, the chillier he feels. Patient is cold in bed at night. Heat and cold alternate. Constant tendency to sweat at the slightest trigger. Pain worse at night; swollen glands with or without suppuration, but particularly when the suppuration is too profuse. Cold swellings; abscesses which suppurate slowly. Great weakness and trembling at the slightest exertion. Rapid, hasty speech. Catarrh with frequent sneezing; flowing, sharp, acrid; the nostrils are sore, ulcerated; yellowish-green, stinking, like pus; the osseous part of the nose is swollen;

aggravated at night and in damp weather. Toothache: throbbing, tearing, excruciating, shoots into face or ears; aggravated in damp weather or night air, warmth of bed, cold or warm things; better when rubbing the cheek. The crowns crumble and the roots remain. Tough, soapy, stringy, profuse, foul smelling, metallic-tasting saliva. Tongue: large, limp, shows impressions of teeth. Intense thirst although the tongue appears moist and the patient salivates profusely. Stool is slimy, bloody, with colic and fainting, severe abdominal cramps during and after stool and not improved by defecation, followed by chills and a feeling of being "unable to stop". The more blood there is, the more this remedy is indicated. The quantity of urine passed is larger than the quantity drunk; frequent urge to urinate. Nocturnal emissions with bloody tinge. Vaginal secretions: sharp, burning, itching.

Tired of life, blames others, loathes life, liable to commit suicide with a knife. Drives the patient to kill the person he or she loves. Restless at night. Suppuration of the eardrum and inner ear. Salivation at night and during the day. Suppuration of the teeth. Bone pain at night.

Aggravating circumstances

At night, in the warmth of the bed. Patient can tolerate neither heat nor cold. Cold, wet weather. Lying on the right side.

Morphinum

Clinical indications

Lightning strikes. Convulsions. Trismus.

General information with main symptoms Restlessness. Hyperaesthesia. Sudden appearance of symptoms. Vertigo from (slightest) movement of the head.

Ameliorating circumstances Walking around. Coffee.

Aggravating circumstances

Electric shocks, lightning strikes, storms. Eating. Movement. (Slightest) movement of the head. After sleep. In the morning. Vinegar.

Natrium chloratum (Natrium muriaticum)

Muriaticum acidum

Clinical indications

Severe infectious diseases with gradually developing feeling and great weakness, e.g. abdominal typhus. Septic conditions, dyspepsia, gastritis, haemorrhoids.

General information with main symptoms Secretions smell rotten and offensive, are sharp and acrid. Patient tends to bleed from the mucous membranes due to the destructive character of the acid. Great general weakness and dazed feeling. The patient is so weak that he slides down in bed; falls asleep sitting up, the lower jaw drops. Involuntary urination and defecation. Pain in the head and limbs of all kinds with no specific characteristics.

Ameliorating circumstances Lying on the left side.

Aggravating circumstances

Lightest touch of the genitals (not even the underwear). Close to water. Damp weather. Before midnight.

Myristica sebifera

Clinical indications

Suppuration, abscesses, “homeopathic knife”, phlegmonous inflammation.

General information with main symptoms Affiliation with purulent inflammation. Cures suppuration, unless it is to be reabsorbed; otherwise the suppurative process is boosted and accelerated. Inflammation of the skin, cell tissue and periosteum. Traumatic infections. Parotitis. Fistulas. Carbuncles. Paronychia. Pain in the fingernails with swelling of the phalanges. Tongue white and cracked. Accelerates opening of abscess, often without surgical intervention. Otitis media.

Naja tripudians

Clinical indications

Acute coronary ischaemia, heart disease, acute and chronic myocarditis, endocarditis, hypertensive heart, conduction disorders, septic processes, heart valve defects following joint rheumatism. Nervous heart disorders, thyrotoxicosis.

General information with main symptoms

Like *Lachesis*. Heart disease. Cardiac hypertrophy. Palpitations on the slightest exertion. Angina: pain radiates into the neck. Cough caused by heart problems. Melancholy. Thinks about suicide. Feeling of heat (hot iron) in the chest. Inability to speak. Choking feeling in the throat. Difficulty swallowing - oesophageal constriction. Delusions with suicidal tendency; the patient broods constantly about imaginary worries.

Ameliorating circumstances Walking or travelling outside.

Aggravating circumstances

Lying on the left side, tight clothing, at night. Using stimulants; pain aggravated by car travel or lying on the side.

Natrium chloratum (Natrium muriaticum)

Clinical indications

Loss of bodily fluids: menstruation, seminal emission. Mood disorders: grief, worry. Exhaustion. Weight loss.

General information and main symptoms

For anaemic, cachectic people. Highly prone to catch cold. Irritability: children are annoyed when spoken to; cry at the slightest thing; get excited about trifles, especially when consoled. Marked tendency to burst into tears; sad, tearful mood for no reason; worse when consoled by others. Headache begins with blindness; blinding zigzags like lightning in the eyes which signal a throbbing headache; from eye strain. Constipation: feeling of constriction in the anus; torn, bloody and painful after passing stool; stool is dry, hard, difficult, crumbly; urine: passed involuntarily when walking, coughing, laughing; patient has to wait a long time until the urine begins to flow if others are present. Sour foods, bread, quinine, excess salt consumption.

Ameliorating circumstances

In the fresh air. Cold baths. Lack of regular meals during the day. Lying on the right side. Pressure on the back, tight clothing. In the afternoon and evening.

Nux vomica

Aggravating circumstances

Physical and mental exertion. Coldness and cold weather. Prone to catching cold. Dry mucous membranes (or increased secretions). Towards the end of the menstrual period. Periodic occurrence of complaints (headache and fever). Heat and sunshine are not tolerated; patient feels miserable and develops a headache. Spending time at the seaside; in some cases, the patient's condition may initially improve then worsen weeks later. From spring to autumn. Annoyance. Cannot let go of his worry or anger. Consolation.

Nux vomica

Clinical indications

Alcoholism. Apoplexy. Asthma. Epilepsy. Gallbladder problems. Brain diseases. Heart diseases. Hypochondria. Colic. Convulsions. Lumbago. Seasickness.

General information with main symptoms Digestive disorders. Unconsciousness. Bleeding. Feeling of rawness. Twitching and jerking.

Ameliorating circumstances

Wrapping up the head. Rest. Hot drinks. Milk. Fatty foods. Humid air. Lying on the side. Secretions. Taking a nap.

Aggravating circumstances

Anger, coffee, alcohol, dissipation, masturbation, sexual excesses, injuries. After waking up in the morning. Cold. Draughts. Undressing. Mental exertion. Yawning. Tobacco. Music.

Opium

Clinical indications

Drowsiness. Painless, accompanied by deep, drugged sleep. Sweaty skin. Euphoria, racing thoughts, happy fantasies, hypersensitive sensory organs, nervous irritation and insomnia, sad mood, somnolence, numbness, lack of reaction to external stimuli with reduced sensitivity to pain and weak reflexes. Cramps of the smooth muscles and atony of the digestive organs with diarrhoea, atonic and spastic constipation, colic. Urinary tract, dysuria, and bladder weakness. Sexual

and cessation of sexual activity. Twitching, spasms and trembling of the skeletal muscles. Bluish, livid skin and mucous membranes (in the mouth) and congestion to the head with dark red to bluish-red facial colour. Stimulated or reduced bowel activity: dry mouth, diarrhoea or dry stool, impotence in men, ova fail to ripen in women; tendency to sweat profusely.

General information with main symptoms Stupor and drowsiness, insensitivity of the nervous system. Unusually low sensitivity to pain. Face dark red and sweaty; livid lips and tongue. Cerebral paralysis with snoring. The cerebral and nerve paralysis causes bad reactions to medication. Excessive brain activity and hypersensitivity of the cerebral organs. Anxiety and nervousness. Hypersensitivity to noise, light and even faint odours. Paralysis and spasms of all skeletal and smooth muscles. Lack of response to medication; lack of vital reaction, a well-chosen remedy makes no impression. Symptoms: with insensitivity and partial or complete paralysis; caused by shock, its severe consequences or when the fear does not go away; from charcoal fumes; from inhaling gas; alcoholics. Deep sleep accompanies all symptoms; no pain, the patient does not complain, has no requests. Seizures: in children when strangers approach; from breastfeeding after the mother has had a shock; from screaming; the eyes are half open and rolled upwards. Shrieking before or during a seizure. Deep breathing, rattles on both inhalation and exhalation. Delirium: the patient talks constantly, his eyes are wide open, his face is red, swollen; alternatively he is unconscious, his eyes are glassy, half-closed, his face is pale, deep coma, preceded by drowsiness. Patient thinks he is not at home; this is constantly on his mind. Plucks at the bedclothes while asleep (when awake). Delirium tremens: in elderly, emaciated people; flushed face, apathy, the eyes are hot, dry and burning; with loud snoring. Sleep: deep, with rattling breath; skin covered with hot sweat. Patient is tired but cannot sleep.

Ameliorating circumstances

Cold things, constant walking. Cooling down.

Aggravating circumstances

Warmth as a consequence of capillary paralysis, during and after sleep. Heat. Shock. Annoyance.

Phosphorus

Clinical indications

Pneumonia, epistaxis, exhaustion, liver diseases (liver dystrophy), eye diseases, hyperactivity in children.

General information with main symptoms

Great nervous excitability and weakness of the nervous system with exhaustion and hypersensitivity to external impressions, especially to sensory impressions on the eyes, ears and nose, also to mental exertion and emotional excitement. Extremely ticklish. Fear of being alone, at dusk, in the dark. Fear of storms, which cause symptoms to worsen. Misery and rapid dissipation of bodily substance. Trembling weakness when the stomach is empty; patient therefore has to eat often (this is a leading symptom not only for stomach and liver problems and Graves disease, but also for nervous exhaustion, heart problems etc. and often indicates *Phosphorus*). Prone to sudden attacks of weakness and fainting but patient recovers quickly. Weakness after debilitating diseases, loss of bodily fluids such as bleeding, breastfeeding or birth, or the result of rapid growth. The feeling of burning predominates with all symptoms. Tendency to bleed from all organs. Small wounds bleed profusely. The slightest knock causes bruising. Haemorrhagic diathesis. Cold and fresh air are poorly tolerated, except for vertigo and headaches, which improve in the fresh air; patient prone to catching colds. Desires cold drinks which are vomited as soon as they warm up in the stomach. Constricted breathing, forcing the patient to sit up. Senses hypersensitive to all external influences: light, noise, smells, touch. Restless, edgy; the patient is constantly on the move, cannot sit or stand still for a minute. Burning between the shoulder blades; or intense heat running up the back; on the palms of the hands; in the chest

and lungs; in every organ or bodily tissue; general remedy for diseases of the nervous system. Haemorrhagic diathesis: small wounds bleed profusely, from every opening in the mucous membrane. Great weakness and exhaustion; with nervous weakness and trembling of the whole body; weakness and fatigue due to loss of bodily fluids. Pain: particularly when lying on the left side. The patient is apathetic, unwilling to speak, answers slowly, moves sluggishly. Patient is tired of life, full of gloomy premonitions.

Ameliorating circumstances

Feels particularly comfortable in cold water. Rest and sleep, even if brief. In the dark; lying on the right side; being massaged; from cold food, cold water, until it gets warm; washing in cold water.

Aggravating circumstances

Lying (left side). In the evening and at night. Physical and mental exertion. Excitement. During storms. Climbing stairs.

Pulsatilla pratensis

Clinical indications

Tapeworms. Epilepsy. Malpresentation of foetus. Moles. Phlegmasia alba dolens. Retained placenta. Priapism. Pregnancy-related ailments. Phlebitis. False contractions. Puerperal eclampsia.

General information with main symptoms Changeable, wandering symptoms. Symptoms move to the side on which the patient is lying. Lack of thirst. Contradictory symptoms. Mucous secretions are profuse, mild, thick, yellowish green. Shifting symptoms. Ailments after suppressing secretions.

Ameliorating circumstances

Cold, fresh air. Slow movement. Upright posture. Lying down with the head high. Constant movement. Rubbing. External pressure.

Aggravating circumstances

Frost, getting the feet wet, pork, fat, bakery products, ice cream, mixed diet, tea, storms. Warmth, warm air, warm rooms. Warmth of bed. In the evening. Rest. When

Pyrogenium

Pyrogenium

Clinical indications

Septiform fever with marked shivering and high temperature; septic conditions with rotten-smelling diarrhoea, restlessness, strong urge to keep moving. Soreness, bed feels too hard. Pain in the limbs. All secretions smell offensive. Pulse unusually fast for the patient's body temperature, or slow pulse with high fever. Puerperal fever. Infected wounds with general infections. Septic conditions, when carefully chosen remedies do not work. Abscesses in the peritoneum and pelvis minor; kidney inflammation developing in the course of septic diseases. Influenza and its complications, such as bronchitis, angina, pneumonia, pleuritis. Intestinal catarrh. Pneumonia with decomposed sputum, pulmonary abscess, phthisis in the hectic stage, typhus and typhoid fever. Paratyphus, typhus, acute infectious gastrointestinal catarrh with collapse, cold sweat and stools which smell like carrion. *Pyrogenium* is known as the *Aconitum* of typhus and typhoid fever. Diphtheria with foetor smelling of carrion; acute tonsillitis alternating with *Mercurius sol.* Abscesses.

General information with main symptoms All excretions smell offensive. Chills and shivering even with high temperatures and despite sweating. Typhoid fever progression with typhus, paratyphus etc. All excretions smell vile, stools or breath smell like carrion. Diarrhoea with mucus and blood. Soreness and pain all over the body, the bed feels too hard. Recommended for all cases of fever beginning with pain in the limbs. Restlessness with strong urge to keep moving. The body parts on which the patient is lying feel sore and bruised; rapidly progressing bedsores. Great restlessness, patient has to keep moving to ease the soreness of his body parts. Tongue: large, limp, clean, dry, cracked; speech is difficult. Taste: sweetish, terrible smell, purulent as if before an abscess. Vomiting: sustained, brownish, coffee grounds; stinking, faecal; in cases of intestinal constriction or obstruction. Diarrhoea: appalling smell, brown or black; painless, involuntary; uncertainty when passing wind. Constipation with complete sluggishness of

bowel. Retained foetus or placenta, decomposed, dead for days, black; secretions smell appalling; "never felt well" since the septic fever following a discharge or birth. Lochia: thin, sharp, brown, very rotten; suppressed, followed by shivering, fever and profuse offensive sweating. Patient feels tired, as if larger than usual; constant buzzing, throbbing, pounding in the ears which prevents him from sleeping; heart weakness with septic conditions. Abnormal pulse unrelated to temperature.

Ameliorating circumstances Warmth.

Aggravating circumstances

Movement.

Ranunculus bulbosus

Clinical indications

Alcoholism. Delirium tremens. Chilblains. Neuralgia. Pleurodynia.

General information with main symptoms Painful conditions of the nerves, chest, muscles, mucous membranes and skin. Shattering pain, also in small areas. Feeling of deep-seated pus. Sharp, stabbing, piercing pain in the chest.

Ameliorating circumstances Standing. Sitting bent over.

Aggravating circumstances

Rage, changes in temperature or weather, injuries, alcohol. Cold, damp air. Draughts. Moving the arms. Inhaling. Touch. Eating. Shock. Rainy weather, storms. Standing.

Rhus toxicodendron

Clinical indications

Miscarriage. Appendicitis. Bleeding. Lumbago. Pleuritis. Pleurodynia. Pneumonia. Sprains. Cyanosis.

General information with main symptoms

Skin, connective tissue, joints, ligaments. Paralysis. Tearing, shooting, stabbing pain. Impossible to rest. Hot,

Ameliorating circumstances

Constant movement. Heat (bathing, getting warm, wrapping up). Rubbing. Holding the body part affected. Stretching out the limbs. Changing position. Warm, dry weather.

Aggravating circumstances

Slightest annoyance, cold, wet head, damp sheets, bathing in fresh or salty water. Getting wet when overheated, overexertion, overstrain, stretching the arms upwards to lift something, drinking iced water, beer. Wet. Cold. Uncovering body parts. When starting to move. Rest. Before storms. After midnight.

Ruta graveolens

Clinical indications

Bleeding. Fractures. Bone contusions. Strains.

Sprains.

General information with main symptoms Special affinity with connective tissue and flexor tendons, joints (particularly in the hands and feet), cartilage, periosteum and uterus. Pain - feelings of soreness, bruising or as if beaten. Restlessness with pain. Intense, painful exhaustion. Feeling of heaviness. Feeling of a rough, blunt stake penetrating a body part. Paralytic stiffness. Gnawing, burning pain.

Ameliorating circumstances

Lying on the back. Warmth. Movement. Rubbing. Scratching.

Aggravating circumstances

Overexertion. Injuries, particularly sprains. Eyestrain. Cold (air, wind) and cold dampness (weather). Lying down. Sitting down. Pressing against an edge. Stooping. During menstruation. Raw or indigestible foods. Going up or down stairs, particularly downwards.

Sabina

Clinical indications

Miscarriage. Afterpains. Nephritis. Retained placenta.

General information with main symptoms Deen-seated

Ameliorating circumstances

Cold. Cool air and cold applications. Outdoors. Exhaling.

Aggravating circumstances

At night. Warmth (bed, room). Physical exertion. Pregnancy. Menopause. Fog. Stooping. Letting the limbs hang down. Breathing deeply. Music.

Secale cornutum

Clinical indications

Gangrene, impending miscarriage, collapse.

General information and main symptoms

Pale, gaunt face. Passive bleeding. Haemorrhagic diathesis: the smallest wound bleeds for weeks; discharge of foetid, liquid blood with strong tendency to decompose; discharge green, brown, stinking. Boils: small, painful. Face: pale, narrow, ashen, sunken, hippocratic; distorted, with sunken eyes; blue marks around the eyes. Diarrhoea: profuse, watery, purulent, brown; stool pressed out with great effort; very exhausting; painless, involuntary; the anus is wide open. Burning: of all body parts, as if sparks of fire are falling on the patient. Gangrene: dry, in geriatrics, worse from external warmth. Collapse with cholera-like diseases; the skin is cold but the patient cannot tolerate being covered. Icy cold extremities. Impending miscarriage, particularly in the third month; long-lasting, oppressive, exhausting pain.

Ameliorating circumstances

Better lying down. In cold air; cooling diseased body parts by uncovering them; rubbing.

Aggravating circumstances

Worse from movement and sitting up. Heat; warmth from covers on all diseased body parts.

Sepia

Clinical indications

Gynaecological diseases. Hot flushes. Proneness to collapse.

Silicea

patient (e.g. husband, children, duties). Annoyance and irritation. Hopeless and worried about health. Anxiety: with fear, hot flushes in face and head, of real or imaginary evils; around the evening. Deep melancholy and weeping. Fear of being alone, of people, of meeting friends; uterine complaints. Venous congestion throughout the body starting from congestion in the portal vein system and the female sexual organs. Feeling of sinking and loosening in the abdominal organs, particularly in the uterus. Prolapsing female sexual organs; patient has to sit down and cross her legs. Menstruation usually late and scanty. Yellow spots on the face, particularly over the nose and around the mouth. Constipation with the feeling of a lump in the vagina or rectum. All excretions smell offensive (sweat, stool, urine, menstrual blood). Venous congestion: cold hands and feet, frequent chills. Heat and chills, hot flushes and sweat. Cold feet and warm hands alternating with warm feet and cold hands. Pain extends from other body parts to the back; associated with shivering. Lack of vital warmth ("I get cold so easily"), particularly in cases of chronic disease. Feeling of a ball in the internal organs; during menstruation, pregnancy, nursing; constipation, diarrhoea, haemorrhoids, vaginal discharge and all uterine diseases. Patient faints easily: after getting wet, from extreme heat or cold; travelling by car; kneeling in church. Headache, crown of the head is cold.

Ameliorating circumstances

Warmth of bed. Warm or hot applications. Violent exertion. Physical exertion, particularly in the fresh air. Outdoors. Pressure. Drawing up the limbs. Cold baths. After sleep.

Aggravating circumstances

Cold air or dry east wind. Sexual excess. Rest. Damp, humid weather. Before storms. Standing. Coldness, before and during menstrual period. Sexual intercourse. After meals. In the morning or evening. Washing. Doing laundry. Left side. After sweating.

Silicea

Clinical indications

Suppuration. Prone to catching cold. Epilepsy.

General information with main symptoms Lack of vital warmth. Many complaints are associated with chills. Helps abscesses ripen as it promotes suppuration. The *Silicea* patient is cold and chilly, loves fire, likes to wear a lot of warm clothing, hates draughts; hands and feet are cold, worse in winter. Mental and physical exhaustion. Nervous exhaustion; exhaustion with flushing; from hard work and intense concentration; can be overcome by willpower. The patient is restless, nervous, starts at the slightest noise. Anxious, yielding, timid. Mental work is difficult; reading and writing are tiring; the patient is barely able to think. Indecisive. Does not tolerate alcoholic drinks. Excretions usually have an offensive smell, e.g. sweat, pus, sputum, vaginal discharge, stool. Prone to sweating, especially of the head, at night and early in the morning. Ailments from suppressed secretions, suppressed sweating. Whole body is painful, patient therefore hypersensitive to touch. Oversensitive to all sensory impressions. Difficulty passing stool, which slides back into the rectum. Bloating abdomen; weak ankles; children are slow in learning to walk. Extreme weakness and frailty; patient wants to lie down.

Ameliorating circumstances

Warmth and wrapping up warmly, particularly the head. Cold food (stomach disorders).

Aggravating circumstances

Cold. In winter. During menstruation. At new moon. Uncovering, especially the head. Lying down. Vaccinations.

Spigelia

Clinical indications

Angina pectoris. Heart diseases. Neuralgia.

General information with main symptoms Marked effect on nerves, particularly N. trigeminus, and on heart, eyes and left side of the body. Severe pain. Sensitivity to touch with chills in the part touched.

Ameliorating circumstances

Lying on the right side with the head high. Breathing in. Constant pressure. When eating.

Sulphur lotum

Aggravating circumstances

Cold, tobacco. Touch. Movement. Jarring. Coitus. Raising the arms. After meals. Thinking about symptoms. Stooping. Blowing the nose. Exhaling.

Staphisagria

Clinical indications

Ischialgia. Seasickness. Fits of rage.

General information with main symptoms

Nerve disorders with trembling. Torn tissue. Sexual disorders. Powerful effect on teeth and urinary tract. Extremely hypersensitive mood.

Ameliorating circumstances Warmth. Rest. Morning meal.

Aggravating circumstances

Anger, suppressed or unexpressed rage, injury, falls, clean wounds with smooth edges, surgery, coitus, masturbation, sexual abuse, seminal emissions, teething, tobacco, mercury. Touch. Cold drinks. Worry. Annoyance. Fretting. Indignation. Arguments. Stretching body parts. At night.

Stramonium

Clinical indications

Mental disorders. Violent agitation with wild delirium and confusion. Sleep disorders in small children.

General information with main symptoms Congestion of the head and brain, face is hot, swollen, bright red. Extreme agitation with raving, jumpiness and anxiety. Hallucinations, particularly of the face and hearing. Constant chatter, laughs, sings, shouts or prays incessantly. Convulsions triggered or worsened by looking at shiny objects, bright light, or liquids. Rhythmic or convulsive, involuntary movements. Choreatic movements and difficulty coordinating movements (sways when walking, stammers when speaking). Tremor paralysis. Needs light constantly because of fearful fantasies but worse in bright light. Pain surprisingly absent despite the intensity of the symptoms. Attempts to swallow trigger cramps in the throat; fear of swallowing liquids. Worse from sleep and

the dark; cannot enter dark rooms. Patient wakes up with a horrified expression, as if he is afraid of the first object he sees. Delusions which terrify the patient. Wants to run away when delirious. Has all kinds of delusions: being double, being at odds with people etc. Head feels as if it has been spread around the surrounding area. Eyes wide open, protruding, shiny, pupils dilated, unresponsive; rolling eyes and eyelids.

Ameliorating circumstances Bright light. Warmth.

Aggravating circumstances

Suppressed excretions (menstrual period, lochia, rashes, sweat). In dark rooms. Being alone (demands company). Sight of bright or shiny objects. Just before sleep. Swallowing.

Strophanthus hispidus

Clinical indications

Alcoholism. Heart diseases. Cardiac oedema.

General information with main symptoms

Poor contractility of heart muscle, weak systoles, excessively rapid contractions. Muscle twitching. Stabbing pain. Feeling of waves moving throughout the body. Rapidly changing symptoms.

Aggravating circumstances

Alcohol, tea, tobacco. Physical exertion.

Sulphur lotum

Clinical indications

Alcoholism. Asthma. Epilepsy. Miscarriage. Chilblains. Cerebral congestion. Hydrothorax. Hydrocephalus. Hypochondria. Ischialgia. Lumbago. Lung diseases. Mania. Meningitis. Peritonitis. Phlegmasia alba dolens. Pleuritis. Pneumonia.

General information with main symptoms

Bodily openings are very red. Symptoms move upwards. Burning pain. Unwashed, unclean. Offensive body odour despite washing.

Ameliorating circumstances

Symphytum officinale

Aggravating circumstances

Suppression, alcohol, sun, sprains, chills, overexertion, reaching upwards with the arms, falls, blows, bedsores. Bathing, washing. Warmth of bed. 11 am. Standing. Stooping. Raising the arms. Sweet foods. Looking down.

Symphytum officinale

Clinical indications

Abscesses. Eye injuries. Fractures. Sprains. Periosteum. Pseudoarthrosis. Wounds. Gunshot wounds.

General information with main symptoms Injuries to cartilaginous tissue, bones (comminuted fractures) or periosteum with extremely severe pain. Pseudoarthrosis. Insufficient callus formation. Facial injuries. Typical stabbing pain.

Aggravating circumstances

Fractures. Injuries (eyes, bones, periosteum). Falls. Blows. Blows with a blunt object. Touch. Rapid, violent movements. Excessive sexual activity.

Thuja

Clinical indications

Consequences of vaccinations, wart-like growths.

General information with main symptoms Consequences of acute and also chronic infections. Gonorrhoea - often suppressed, vaccinosis, influenza. Main sycotic remedy according to Hahnemann. Bloated, obese people with impaired ability to absorb iodine, or thin, demineralised sycotics with sickly appearance and trophic skin disorders. Cold and wet are not tolerated and trigger rheumatic and neuritic symptoms and catarrh of all mucous membranes; sudden pains which vanish just as suddenly. General chilliness, cold hands and feet. Nevertheless, these patients feel better when moving in the fresh air. Profuse sweating; sweating restricted to uncovered body parts, e.g. face, throat and upper lip. Left side more commonly affected: cold feeling, headache as if a nail is being hammered into the left side of the head, rheumatic pain etc. Right-sided complaints do not contraindicate this remedy. Warts and condylomas form on the skin, polyps and papillomas on the mucous

membranes. Diarrhoea after breakfast pouring out as if from a bung hole. Suppressed or poorly treated gonorrhoea. Fixed ideas: as if a strange person is walking next to him; as if body and soul are separate; as if there is a live animal in the patient's abdomen; as if under the influence of a higher power. Delirious women do not want to be touched or allow anyone to come close to them. Vertigo, when closing the eyes. Headache: as if a nail is being driven into the parietal bone, or as if a convex button is being pressed onto the part affected; aggravated by sexual excess; overheating; lea.

Ameliorating circumstances

Sweating and movement. Emission of secretions (e.g. sweat, runny nose with frontal sinus catarrh, urethral discharge with epididymitis. Warmth and warm applications. Dry weather. Left side, when drawing up the extremities.

Aggravating circumstances

Rest (except joint pain). 4 pm to 4 am. At night. Warmth of bed. Cold, damp air. Changes in the weather. Before and during storms. After breakfast. Fatty foods. Coffee. Vaccinations.

Tuberculinum

Clinical indications

Appendicitis. Asthma. Heart problems. Pulmonary oedema. Mania. Pleuritis. Pneumonia.

General information with main symptoms Particularly affects mind, mood and lungs. Constantly changing symptoms. Reduced vitality. Clothing feels damp. Tuberculous disposition.

Ameliorating circumstances Cool wind. Outdoors. Movement.

Aggravating circumstances

Closed spaces. Damp weather, changes in the weather, cold climates. Draughts. Exertion. Movement. Waking up. Noise. When thinking about the complaints. Excitement. Music. Pressure from belt. Standing.

Vinera herus

Veratrum viride

General information with main symptoms

Blood and blood vessels (particularly veins) affected.
Tendency to bleed. Feeling of bursting.

Aggravating circumstances

Allowing the affected limbs to hang down. Cold. Touch.
Changes in the weather.

Veratrum album

Clinical indications

Anasarca. Angina pectoris. Apoplexy. Asthma.
Epilepsy. Hydrocephalus. Hysteria. Colic. Collapse.
Pulmonary oedema. Mania. Meningitis. Unconsciousness. Peritonitis. Pneumonia.

General information with main symptoms Profound
effect on mind, mood and nerves. Profuse secretions.
Enormous loss of strength. Cold. Blue discolouration.
Collapse. Sudden, violent symptoms.

Ameliorating circumstances

Warmth and warm covers. Walking around. Hot drinks.
Lying down. Meat. Milk.

Aggravating circumstances

Shock, shock of injury. Disappointed love, injured pride
or honour, suppressed exanthema, opium, tobacco,
alcohol. Exertion. Drinking, particularly cold drinks.
Cold, wet weather. Changes in the weather. Before,
during and after passing stool. Touch. Pressure.

Veratrum viride

Clinical indications

High fever. Meningitis. Seizures. Acute rheumatism.
Tachycardia.

General information with main symptoms Inflammation
accompanied by severe pain. Full, hard, racing pulse.
Severe pain in joints and muscles. Scanty, red urine. The
child trembles, jerks, imminent seizures. Constant
twitching or nodding of the head. Nervous headache or
migraine. Rushes of blood caused by suppressed
menstruation. Apoplexy, difficult speech. Cerebrospinal

opisthotonus; cold sweat. Pulse rate increases suddenly
and decreases slowly. Yellow coated tongue with red
stripe in the middle.

Ameliorating circumstances Better lying down.

Aggravating circumstances

Worse from movement and sitting up.

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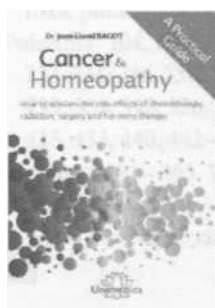
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Jean-Lionel Bagot

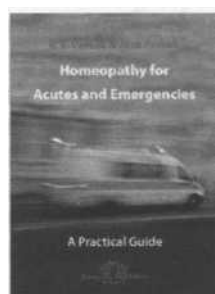
Cancer & Homeopathy

How to alleviate the side effects of chemotherapy, radiation, surgery and hormone therapy

328 pages, pb, € 24

Cancer treatment has progressed enormously in recent years. However, the therapies often expose patients to side effects which can impair their quality of life. Solving this problem is what has driven Dr. Jean-Lionel Bagot on for over ten years now. With a team of Strasbourg oncologists he can now offer homeopathy in support of surgery,

chemotherapy, radiotherapy and hormonal therapy. This approach has been amazingly successful! Homeopathy is surprisingly able to help and support patients. This book details the homeopathic remedies and their dosage by cancer and treatment type, according to the side effects encountered. He also deals with the emotional management of the disease and its therapies.



Alok Pareek / R.S. Pareek

Homeopathy for Acutes and Emergencies

A Practical Guide

160 pages, hb, € 29

A practical guide to homeopathic prescribing in acute illnesses and emergencies. Dr. Alok Pareek's extensive experience has given him a wealth of opportunity to carry out and refine homeopathic treatment in a wide range of acute and emergency situations. Based on this experience, the book offers a clear, practical guide to successful clinical prescribing, with case examples and a living materia medica for problems relating to:

the heart and circulation; neurological and psychiatric emergencies; acute trauma, injury and pain; surgery; adverse drug reactions; and selected organ specifics. Dr. Pareek demonstrates that homeopathy has much to offer in acute and emergency settings. He aims to increase the confidence of practitioners, to improve results and encourage them to offer safe and effective treatment in this important field, enabling homeopathy to take its place alongside conventional approaches within mainstream medicine.



Heidi Brand and Norbert Groeger

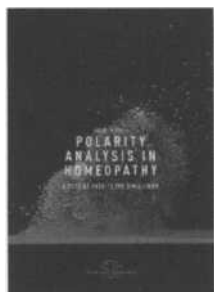
Chara intermedia

The Cleansing Power of an Ancient Alga

208 pages, € 24

Chara intermedia is one of the oldest organisms on the planet. Chara intermedia is capable of cleansing water. The homeopathic proving resulted in similar topics such as cleaning up, disposing, cleansing and reducing things to what is essential.

Chara intermedia has the potential to bring what is suppressed from the unconscious into conscious-ness and helps to clarify and release stress.



Heiner Frei

Polarity Analysis in Homeopathy

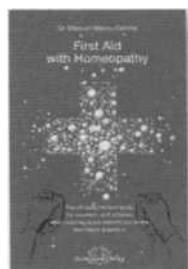
A Precise Path to the Simillimum

Completely Revised Edition, 288 pages, hb, € 49

Polarity analysis is an efficient method that helps a busy practitioner by making the homeopathic prescription faster and more precise. Heiner Frei developed this method to demonstrate the efficacy of homeopathic treatment of ADHD children in a controlled 5-year clinical study. The study demonstrated highly significant effects of homeopathy. His method is easy to learn. His success rate of 80 % speaks for itself.

New in this completely revised edition:

- Latest developments of the method, all aimed at further increasing the reliability of remedy selection.
- Working with assigned reliability levels for each symptom of Boenninghausen's Therapeutic Pocketbook (BTB)
- The previous multiple checklists for different pathologies have been replaced by just three: A Comprehensive Checklist of Reliable Symptoms, a Checklist for Perception Disorders, and a Questionnaire for Diagnoses and



Manuel Mateu i Ratera

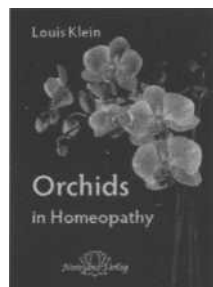
First Aid with Homeopathy

960 pages, pb, € 36

The Spanish physician Dr Mateu i Ratera has spent many years studying the use of homeopathy for emergency medicine, and he gained valuable insights on mountaineering expeditions even to Mount Everest.

This book is the fruit of his vast experience. It provides both homeopaths and lay people with well-founded advice presented in an easy-to-understand way. It is a great and truly original book that quickly became a bestseller and a standard work.

The author clearly presents treatments for a multitude of accidental injuries from wounds or shock, snake bites or animal bites, burns, frostbite and electric shock to altitude sickness, suffocation, food poisoning, dysentery, etc. There is also a materia medica section with differential diagnoses, making this book a comprehensive yet handy reference in a multitude of emergency cases - whether at home or in the tropics or the high mountains.



Louis Klein

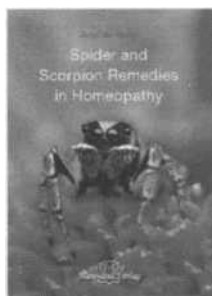
Orchids in Homeopathy

544 pages, hb, € 49

“Orchids are one of the largest and most fascinating plant families in the world. In spite of that, they have been poorly represented in our homeopathic materia medica. I came to a realization that Orchids could be very useful homeopathically for a broad spectrum of problems and so, along with close senior practitioners, I undertook to introduce more Orchids into the homeopathic profession through provings, clinical experience and natural history information.” “This book started as a collaboration.

When I first conceived that Orchids may play an important role in homeopathy and in the treatment of many neuro-behavioral disorders, many of my students and colleagues enthusiastically responded and enrolled their talents in The Orchid Project.”

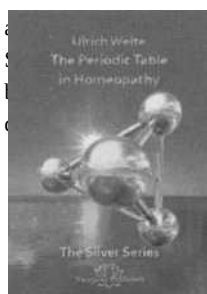
Further Titles from Narayana Verlag



Jonathan Hardy
the most clear differentiations for Spiders and Scorpions old and new.

Spider and Scorpion Remedies in Homeopathy
ed to bring you a truly complete and satisfying remedy key by completing a fine web of material and shedding valuable light on this corner of the Animal Kingdom.
208 pages, hb, € 29

Often mistrusted, sometimes loathed, these creeping, crawling creatures are among the most distinctive Animal remedies in the homeopathic materia medica. Exploiting his zoological background and extensive clinical experience, Jonathan Hardy offers a vivid and enticing portrait of the Arachnid Group and its members, for both adults and children.



Ulrich Wehr
to the Theory of Elements in 64 vivid cases of patients treated with the elements of the basis of case histories of suffering people and their symptoms we learn how to use typical
The Periodic Table in Homeopathy
ger situations, professions and other characteristics to find individual remedies that go
even **The Silver Series: A Practical Guide with Case Studies**

340 pages, hb, € 33

The Periodic Table of Elements was one of the most ingenious discoveries of all times. To translate this system of elements into homeopathic thinking and language is one of the most fascinating pioneer works of present medicine. The chemistry of human interactions is an analogy to the chemical interactions of elements and evolves through



James Tyler Kent

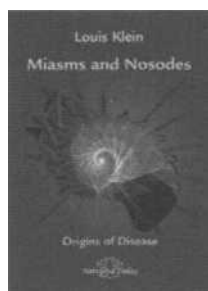
Repertory of the Homeopathic Materia Medica

High-quality edition in lightweight paper with a handy thumb index and supple, flexible binding.

1664 pages, flexible binding, € 58

This edition features corrections for a raft of errors that were identified by experts in the original edition.

Due to its clear structure, it became the model for the most popular modern repertories. Indeed, many homeopaths continue to use it due to its reliability. It was Kents life work, requiring decades of painstaking effort, and he continued refining it right up to the end of his life, continually supplementing it with remedy provings and clinical experience. Once you pick it up, you won't want to put it down again.



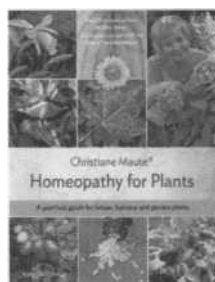
Louis Klein

Miasms and Nosodes

Origins of Disease - Volume I

528 pages, hb, € 49

On the basis of his broad clinical experience, Louis Klein attributes many known remedies to miasmatic states. A miasmatic state becomes the core idea around which similar remedies are grouped. For example the Tetanus miasm comprises not only Tetanus nosode but also remedies like Hypericum, Angustura, Helodrilus and Tellurium. It is clinically linked also with tetanic syndromes, spasms or even convulsions. This new classification of miasmatic remedies is highly practical and opens a new chapter in homeopathy, demystifying and redefining the existing miasms, while adding several important new ones. It also introduces new remedies like Johneinum and Helodrilus, which he has proved extensively. So Louis Kleins work on miasms and nosodes is a landmark in homeopathy.



Christiane Maute

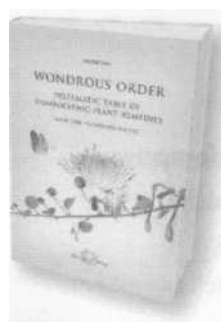
Homeopathy for Plants

A practical guide for indoor, balcony and garden plants with tips on dosage, use and choice of potency

224 pages, hb, € 28

The publication of Homeopathy for Plants heralded the start of a truly green revolution. The book has sold over 76.000 copies and been translated into many different

Its a handy guide to the most common plant diseases, pests and types of damage with information on how to treat your plants with homeopathy. Christiane Maute' is one of the pioneers who has been using homeopathy on ornamental and edible plants for many years.



Michal Yakir

Wondrous Order - The Table of Plants

The botanical system in homeopathy

866 pages, hb., € 124.-

Michal Yakir is a homeopathic pioneer who has unlocked the plant kingdom for homeopathy. She has developed her own system for the plant kingdom in the form of a simple tabular set of coordinates with columns and rows, which shows how each column of the plant table can be assigned to different types with varying psychological traits and physical pathologies.

Her monumental work contains over 800 different plant remedies, amounting to 95% of the remedies known to homeopathy, including many so far unknown plants. She clearly explains their themes and pathologies in terms of their family and placement in the table. Hundreds of short cases provide graphic sketches of the essences of the individual remedies.

This is a unique work, which documents how homeopathy can achieve predictably successful results in emergencies such as anaphylactic shock, acute abdomen, acute asthma, myocardial infarction of the inferior wall, and oedema of the glottis.

The book contains 145 well-documented case histories, similar to those written by the old American homeopathic clinicians. In each case it is clearly demonstrated how to quickly find the best remedy using straightforward Kentian repertorisation. The results are impressive. The authors show that conventional treatment and homeopathy can perfectly complement each other.

This work offers; also a lot of general information on homeopathy like potentisation, source materials used in homeopathic remedies and methods of administration. It also comprises a stringently edited materia medica of the most important 70 remedies for ICU and emergency situations.

Both editors have extensive experience in emergency medicine and homeopathy. Michael Frass is former head of the intensive internal medicine unit at the Medical University of Vienna and Martin Bunder also has long-standing service in rescue and emergency medicine.

“At first glance the idea that homeopathy can help in intensive care and emergency medicine seems far-fetched, since we normally associate an intensive care ward with high-tech equipment rather than gentle remedies. So it is all the more surprising to see how sensitively authors Michael Frass and Martin Bundner deal with this controversial field, which is often a matter of life or death. Their main focus is on integration.

What stands out here is the high-class presentation of case-related detail, including repertorisation and remedy selection as well as evaluation and criticism of each case. The treatment section remains exceptionally clear, guaranteeing the practical usefulness of the high-quality scientific information in this book. This book is to be recommended not just to homeopaths but also to doctors working in a conventional clinical setting who have so far only used orthodox medical techniques. ”

Review by the Karl and Veronica Carstens Foundation. Germany