

BRONCHIAL ASTHMA
(An Integrated Approach)

By
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PREFACE

It was the last Sunday of June, 1987. *With my* students and colleagues I was enjoying my usual participation in the monthly symposium of our Association of Hahnemannian Homoeopathy. At that time my sincere student Dr Dilip Bhattacharya posed a proposition very emotionally. He referred to page 34 of *Homoeo Sathi*, 1st edition (my Bengali book on homoeopathic philosophy) where I expressed the necessity of writing a homoeopathy-oriented Practice of Medicine. He requested me earnestly to guide them in this respect and the gathering echoed in the same breath. So a sample topic was chosen and that was Bronchial Asthma. The present booklet is the outcome of that lecture which I delivered to them on that occasion.

Relevantly enough, I like to emphasize here the importance of integrated approach correlating the pre-clinical and para-clinical aspects of medicine with our homoeopathic subject. All the recent medical advances and also the fundamental homoeopathic principles need to be harmoniously blended. If this is not done, glaring deficiencies and broad gaps of Knowledge would exist and our approach in treating different diseases would be half-hearted and confusing. We may fail to understand the miasmatic background of a case as also its curability. As a result a proper plan of treatment cannot be made and the whole course of treatment would turn to be irregular, whimsical, chaotic and fruitless leading in some

cases to even pseudo and unhomoeopathic practice. If a proper integration be possible, our approach in treating various diseases may be standardised, though prescriptions may vary in some cases due to variations in interpretation, observation, evolution and synthesis of the case. With this aim in view I am presenting herewith the model of bronchial asthma as an example. I think we should try to integrate our knowledge in this way in all medical, medico-surgical and surgical diseases.

Intentionally I have not named here any homoeopathic medicine whatsoever because a true totalistic and integrated approach and not the superficial approach of therapeutics was my concern. A few illustrative cases are also presented herewith

Before I conclude, I earnestly request my learned readers to take a fruitful attempt, jointly or individually. To write a new textbook of medicine incorporating all modern concepts and recent developments in medicine along with the basic principles and concepts of homoeopathy.

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BRONCHIAL ASTHMA

(An integrated approach)

Definition

It is a nosological manifestation of chronic miasmatic state characterized clinically by paroxysmal attacks of *expiratory dyspnoea*, cough, wheezing etc. and pathologically by *increased responsiveness* of the *tracheo-bronchial tree* to multiple stimuli resulting in widespread narrowing of the air passages. It is an episodic disease with spontaneous remissions and relapses.

Aetiology:

1. Fundamental causes:

(a) *Sycosis*: History of bronchial asthma in the family (paternal or maternal side) without any history or manifestation of allergy is suggestive of hereditary sycosis as the basic cause the bronchial tree is set into spasm or narrowing from slightest cold without any apparent cause. It appears as if there is a lack of co-ordination in the system as manifested in the action of tracheobronchial tree,

(b) *Syco-syphiLis*: History of syphilitic miasmatic state in the family with symptoms of latent syphilis

and developed sycosis in the patient is suggestive of syco- syphilis.

(c) *Psora*: Hypersensitivity of the tracheobronchial tree to any allergen indicates psora as the basic cause. This is often associated with a family or personal history of allergic diseases. e.g. urticariarhinitis, allergic eczema etc. This may further be confirmed by positive skin test and increased level of IgE in the serum Chronic bronchitis resulting from simple hypersensitivity to cold also belongs to this group.

(d) *Mixed miasmatic state* : In some cases (though rare), a combination of all the above mentioned factors may be present making the state much more complicated and difficult to diagnose as also to treat.

2. *Predisposing factors* :

Age: The disease may occur at any age but commonly it starts in early life. First attack of bronchial asthma after 40 years of age is very rare.

Sex: Both sexes are equally affected.

Season: Psoric asthma generally aggravates in winter; Sycosis in rainy season and syphilis in summer.-But it should clearly be understood that exceptions and individual variations are always there.

Repeated vaccination: This may induce a state of vaccinosis which is similar to Hahnemann's sycosis (Burnett) This state predisposes to bronchial asthma and requires antisycotic medicines for its cure

Exciting factors : Various antigens: Antigens may provoke bronchial asthma in susceptible individuals. This is dependent upon an IgE response controlled by T and 'B' lymphocytes. Some of the antigens are:

Pollen grains (ii) Charcoal dust (ii) Plant debris, (iv) Chemicals, e.g. arsenic, coal tar etc. (v) Drugs, e.g. aspirin, fenopufen, acetyl salisylic acid etc. (vi) Food allergens, e.g. crabs, prawn, eggs etc.

(b) Environmental factors : Atmospheric conditions associated with stagnant air masses may induce an attack of bronchial asthma.

(c) Occupational factors : Some of the occupations give rise to bronchial asthma, e.g. meat wrapper's asthma, wood worker's asthma, baker's asthma etc.

Respiratory tract infection may precipitate an attack of bronchial asthma.

Physical exercise may provoke or aggravate.

Emotional stress may precipitate.

Maintaining causes

Continued living in damp or marshy areas. Persistent exposure to allergens before the patient is fully cured.

Occupation responsible for exciting the condition being maintained before the miasmatic dyscrasia is cured. Persistent mental worries, anxieties and tension.

Pathology

1. Mucosal oedema

2. Hypertrophy of the bronchial smooth muscles.
3. Marked thickening of the basement membrane.
4. Loss of the surface epithelium.
5. Eosinophilic infiltrates in the bronchial wall.

Patho-physiology

The basic factor of bronchial asthma is a reduction in diameter of airway brought about by the following:

Oedema of the bronchial wall.

Thick *tenacious secretion*.

Hypertrophy of the bronchial muscles.

Contraction of the smooth muscles of bronchial tubes secondary to hereditary inco-ordination (sycosis) or malformations and inco-ordination both at the same time (sycosyphilis) or allergic reaction between allergens and mast cells resulting in increased IgE in serum (psora). In allergic cases, due to interaction of allergen and mast cells, a substance like histamine or prostaglandin D₂ or leucotrine C, D or E, is liberated which reflexly stimulates the vasoconstrictor fibres of vagus resulting in bronchial spasm.

Result of the pathological process and changes

Decreased expiratory volumes.

Laboured breathing.

1. Hyperinflation of lungs and thorax.
2. Changes in elastic recoil of the chest wall.

Use of accessory muscles of respiration.

6. Pulmonary hypertension.
7. Right ventricular hypertrophy.
8. Gradual ballooning of alveoli and finally emphysema.

Diagnosis (See any textbook of medicine).

- Expiratory dyspnoea, cough and wheezing are the diagnostic triad. Remissions' and relapses are the basic characteristics of the disease unless complicated with emphysema when the dyspnoea may be continuous. Positive skin test, X-ray of the chest and increased eosinophil count may help in establishing the diagnosis.

Symptomatic diagnosis of the probable miasmatic state

- (i) Typical midnight aggravation is suggestive of syphilitic or syco-syphilitic miasmatic state.
- {ii} Early morning aggravation is suggestive of sycosis.
- (iii) Evening aggravation is suggestive of psora.
- (iv) First dyspnoea, then cough followed by expectoration is suggestive of sycosis.
- (v) First cough, then dyspnoea followed by expectoration is suggestive of psora.

- (vi) Dyspnoea and cough at the same time is suggestive of syco-psora.
- (vii) Sneezing, coryza and cough lasting for 1-2 days followed by dyspnoea is suggestive of allergic origin (psora).
- (viii) Dyspnoea associated with sweating which ameliorates but avoids open air suggests psora.
- (ix) Sweating aggravates and desires cold both externally and internally suggest syphilis.
- (x) Aggravation in damp, rainy weather suggests sycosis.
- (xi) Amelioration by moving slowly is suggestive of sycosis.
- (xii) Amelioration by yellowish or greenish yellow expectoration is suggestive of sycosis.
- (xiii) Profuse, frothy expectoration which may or may not ameliorate suggests psora.
- (xiv) Dyspnoea ameliorates lying on back suggests psora.
- (xv) Dyspnoea ameliorates lying on chest or abdomen suggests sycosis.

Complications (see any textbook of medicine)

Some of the complications with prognostic significance are:

- (a) Emphysema (b) Pneumothorax (c) Chronic cor-pulmonale (d) Congestive right heart failure (e) Intercurrent infection (f) Status asthmaticus.

Status asthmaticus: Successive paroxysms of dyspnoea overlap one another without any free interval. This is a grave condition and may end fatally if not controlled in time. The patient should immediately be admitted to a hospital or nursing home for facing all sorts of emergencies including artificial respiration.

Course and prognosis

The disease is slowly progressive unless checked and treated with anti-miasmatic medicines. Palliation of dyspnoea from time to time does not necessarily mean cure. Once complicated with advanced emphysema, the case may not probably be cured by any means. Constitutional ant miasmatic treatment may probably cure all cases in early childhood. In young adults, 80% cases may be completely cured. In advanced ages with well developed emphysema, life may be prolonged with suitable palliation from time to time, but no cure is probably possible. So, before deciding the prognosis of a case of bronchial asthma, we must take into consideration the following factors carefully:

- (a) Age of the patient.
- (b) Duration of suffering.

- (c) Miasmatic background.
- (d) Presence of complications if any.
- (e) Occupation and mode of living of the patient.
- (f) Treatment already adopted and continuing at present.
- (g) Effects of the constitutional and palliative medicines on the patient.

Treatment

1. Diet and regimen:

- (i) Allergic substances in food are to be avoided during the course of treatment, e.g. eggs, prawn, crab etc.; light meals are to be taken at night as early as possible so that no heavy load may cause any distress at bedtime; low residual diet is to be taken to avoid flatulence; raw onion, camphor and asafetida should better be avoided.
- (ii) Related exciting and maintaining causes are to be eliminated as far as possible;
- (iii) Morning walk in fresh open air in dry, fine, clear weather.
- (iv) Breathing exercise may be advocated as and when seems justified.
- (v) Over-exertion is to be avoided.
- (vi) Alcohol and smoking are to be strictly avoided.
- (vii) Mental tension, worries and anxieties are to

be avoided as far as possible.

2. Medicinal treatment:

- (i) *Palliative* treatment during acute episode covering the symptoms of dyspnoea, cough etc. with their exact sensation, modalities and concomitants, if any, as also the exciting cause.
- (ii) *Curative*: Constitutional and miasmatic medicines are to be administered with change in the plan of treatment as and when necessary.
- (iii) Antidote to previously administered medicines as also other causative factors like vaccination as and when necessary.

3. Auxiliary treatment:

- (a) O₂ as and when necessary.
- (b) Hospitalisation in cases of status asthmaticus.

Plan of treatment

A. *Cases coming to homoeopaths from the very beginning without being treated previously by other systems of medicine:*

1. To take up the case history thoroughly including the details of symptoms during acute episodes.
2. Interpretation of symptoms obtained a careful analysis of the history and a synthesis of the whole case is absolutely necessary before deciding the plan of treatment.
3. To select a constitutional ant miasmatic medicine which also covers the acute attacks if possible; the medicine should better be administered in 50-millesimal potency.
4. To change the medicine or plan of treatment as and when necessary.
5. If the constitutional medicine does not cover the symptoms of the acute attack, then it is to be administered first during symptom-free interval. After that if acute attack supervenes, the acute symptoms, modalities and concomitants are to be observed minutely and then only the indicated medicine is to be administered at suitable intervals preferably in 50-millesimal potency. After the acute attack subsides, we are to wait and observe the patient to see if the constitutional medicine has exhausted its action. If so, the same constitutional medicine is to be administered again in relatively higher potency.

Several changes in the selection of acute medicine, the constitutional medicine as also in the plan of treatment may be necessary before the patient is cured.

- B. *Cases coming from the hands of physicians belonging to other systems of medicine:*

- (i) It is better not to stop the medicine the patient had been continuing till then on the very first day. The medicine is to be withdrawn gradually depending on the response of the patient as also his/her ability to stand the acute episodes without the aid of previous medicine.
- (ii) Attempts are to be made to substitute the non-homoeopathic medicines by Homoeopathic medicines for acute attacks.
- (iii) Constitutional medicine is to be administered during the symptom-free intervals and then to follow the procedure as stated before.
- (iv) Utmost care is to be taken not to prescribe for the changed or modified symptoms after drugging but to enquire for the original symptoms which should be our main guide in the selection of constitutional medicine.
- (v) Follow-up of the cases in different seasons, weathers and climates as also in variable

circumstances and environments is absolutely necessary before declaring the patient as cured.

- (vi) In incurable cases, only palliative medicines based on the presenting totality of symptoms, are to be selected instead of

constitutional curative medicines

ILLUSTRATIVE CASES

Case No. 1

A young boy of 13 years came on 28.11.84 for his 10 year old respiratory distress. Violent cough followed by dyspnoea and wheezing in chest used to disturb him nearly every night, especially in winter and rainy season. During attack, frothy expectoration and slow walking would relieve him a little. The trouble started after an attack of measles. In the family there was history of pulmonary tuberculosis, piles, rheumatism and insanity. The boy was very much susceptible to cold and craved sweet, sour and cold drinks. He had a tendency to lie on sides and back with profuse salivation during sleep and somnambulism. Mentally quiet, hasty and intelligent, he was fond of sports and frightened of ghosts and cockroaches. On examination there were evidences of follicular pharyngitis, septic tonsils and hypertrophy of nasal turbinates. He had pigeon chest with a body weight of 33.5 kg. Blood examination revealed eosinophil 9%. Miasmatically asthmatic dyspnoea at such an early age leaves no doubt for the involvement of sycosis.

The family history, generalities and presenting symptoms confirm this, with syphilis and psora lurking. The aforesaid miasmatic states and the presenting totality of symptoms are found in the

symptomatology of Silicea. Hence it was given in 2c. 1M and 10M potencies. As anticipated, the boy had no attack of dyspnoea after the first dose. Nevertheless, he was subsequently given Morbillinum, Bacillinum, Psorinum and Hepar sulph (all in centesimal potency), basing on miasmatic background and the rest of the symptoms to remove the blocks and establish cure in the truest sense of the term.

Case No. 2

This is the case of a young, unmarried girl of 18 years of age who had been suffering from bronchial asthma and presented the following symptoms on 27.2.86.

History of recurrent attacks of tonsillitis in winter season only for last 5 years. In June 1985, she was suddenly attacked with a severe expiratory dyspnoea. The attack was so violent that she had to be admitted in a hospital that very night. Since then she has regularly been suffering from recurrent attacks of bronchial asthma especially in winter. Her dyspnoea aggravates after 10 P.M. and ameliorates by sitting up bent forward and fan air. Violent cough precedes the attack of dyspnoea. Thereafter her cough becomes productive with expectoration of profuse, yellowish jelly-like and salty matter which gives her temporary relief. She also complains of falling hair, dysmenorrhoea and leucorrhoea. Her menstrual cycle is always early and associated with pain in abdomen

For 5-6 days preceding the onset of flow: flow lasts for 3 days and contains blackish red , clotted blood. Leucorrhoea aggravates before menses.

Her family history revealed rheumatism and piles (paternal side) and rheumatism and hypertension (maternal side).....

She is rather a hot patient with profuse sweat especially on palms, soles and axilla. She desires green chilies, meat, cold food and drinks and fruits: has aversion to milk and sour food. She cannot digest rich and fried food which causes loose motion. She has profuse thirst for large quantities of water at a time. She fears cockroaches and snakes. She is irritable and hasty: does not like company: fond of music, recitation and natural phenomena like thunderstorm, lightning etc.....

On examination her tonsils were found to be grossly enlarged and unhealthy; no abnormal findings were detected in her chest : blood examination revealed 16% eosinophil.

Her miasmatic state represents psora and syphilis. Her past history revealed tonsillitis. Based on

these and the generalities, her first medicine was Guaiacum 200 two doses (morning & evening the same day) on 27.2.86. She had no trouble excepting occasional headache till 28.4.86 when she complained of aggravation of leucorrhoea. A dose of Medorrhinum 200 was given and another dose of 1M potency was repeated on 20.8.86. She had no dyspnoea till 20.10.86 when she complained of mild dyspnoea for a day or two. Now a dose to Tuberculinum 200 was given. After that she had no more dyspnoea but her eosinophil count rose up to 20% on 2.12..86. Bromium was given in 200th and 1M potency thereafter her eosinophil count dropped to 6% on 2.4.87. Bromium 10M one dose was given for occasional attacks of cough and cold. Thereafter till now she is free from all troubles. Her last medicine was Syphilinum 1M one dose was given on 19.1.88 when she complained of aggravation of her falling of hair. She is still under treatment and observation.

Case No. 3

A tall, stout youngman of 28 years came on 18 11.86 He was suffering from violent cough and dyspnoea aggravating from evening onwards. Early months of winter would aggravate his troubles. During attacks, sitting up slightly bent forward and rubbing on back would relieve him a little. Expectoration was sticky at night and frothy in the morning. There was history of prolonged exposure to jute dust, rain and logged water in his

service place. He had history of measles and malaria in the past and allergic sneezing in the childhood days. There was evidence of piles, cancer of liver and mental disorder in the family. He was a chilly patient and had craving for sweets, fish, meat, milk, raw onion and, cold dishes. He had much thirst and aversion to chillies and sour food. He also had a tendency to profuse sweating especially on palms and soles, even in winter. He preferred to lie on right side in a huddled up position, pressing the chest. Though irritable he would cool down easily. He was fond of company and music. On examination the breath sound was found diminished, nasal septum deviated to the right side, multiple moles on chest and small wart-like growths on the palms. There were premature gray hair and slight tenderness in the gall bladder area. Eosinophil was found 10%. Considering the family history, past history, presenting symptoms and physical appearance of the patient the case appeared to be mixed miasmatic with predominance of psora and syphilis. This miasmatic anamnesis, added to the presenting complaints, physical and mental generals point to Bacillinum as his indicated medicine. Bacillinum 2c and 1M ameliorated his cough and dyspnoea to a greater extent. Then he required Carcinosisin 2c and 1M as a remedy complementary to Bacillinum, covering the miasmatic background and the remaining symptoms. He is having no trouble at present.

Case No. 4

It is in case of a slim, tall young boy of 7 years. He came on 20.1.84 for repeated (almost daily) attacks of spasmodic cough and with dyspnoea. Usually dry but occasionally white mucus he would expectorate. No definite modalities were found. Each spell of attack would remain for 15 to 30 minutes, after which the child was normal. The origin of his trouble dated back to 2/3 months of his age, when he was attacked with whooping cough followed by bronchitis. For last one year he was also suffering frequently from nightly pain in legs and arms tip of nose and ears. Apart from the upper respiratory tract infection he also had a history of eczema on legs 1-1/2 years ago suppressed by local applications. He had history of regular vaccination also. Family history revealed instance of eczema, bronchial asthma and chronic bronchitis. A hot patient, he would sweat profusely especially on head and chest. He was thirsty with craving for sweet, sour and cold dishes and aversion to milk. Stool was regular at that time but prior to that it was at an interval of 8 to 10 days. There was tendency to lie on abdomen with occasional salivation during sleep. He also had tendency to delayed healing of ulcers. Mentally he was restless and very fearful, especially of ghosts. He had blackish discoloration of gums and swollen turbinates of nose. Blood picture revealed eosinophil 21%.

The role of mixed miasmatic stigma could not be over-ruled here. The boy was never well since the attack of whooping cough. So our first target was the causational factor. Hence Pertussin and subsequently Drosera (firstly in 200th, then in 1M potency)

was given and the patient got symptomatic relief but recurrence of attack could not be prevented. Then the role of fundamental cause was to be thought of. The past history and family history presented evidences of psora and sycosis. The generalities pointed to both sycosis and syphilis. Hence medicines covering the miasmatic states, as also the symptom totality were administered as and when necessary. Thus Bacillinum, Hepar sulph, Causticum, Thuja and Sulphur he received, all in centesimal potencies, throughout the treatment. For last 2 years he is free from his troubles.

Case No. 5

This is the case of a young man of 22. He came on 28.10.82 for dyspnoea since childhood days. He had aggravation from exertion, cold weather and at midnight, with profuse sweating. Open air and sitting in erect posture would relieve him a little.

Occasion-

ally it was accompanied by cough with thick, salty expectoration. He had developed blackish discolouration of face for last 4/5 years and an aching pain in upper abdomen for last 2 years. aggravating after eating and in winter. In the past he had suffered from typhoid, jaundice and suppressed ringworm scattered throughout the body. He could not furnish his family history. He was a chilly patient with tendency to catch cold easily. He used to perspire much, feeling uneasiness after sweating, which emitted foul smell and stained the clothing's yellow. Thirsty with poor appetite. He had craving for eggs, raw onions, milk, sour and cold dishes and

aversion to fish. With a tendency to salivation during sleep he had catnaps and preferred to lie on right side. The urine was usually yellowish and foul. Irritable but easily cooled down. He was hasty, forgetful and fearful especially to dark nights, ghosts and dogs. On examination the breath sound was found diminished with coated tongue, dry dandruff on vertex and plenty of acne on the face. Blood report revealed eosinophil 21%.

In spite of no family history a case of bronchial dyspnoea from the very childhood points to sycosis. Here the generalities and clinical findings confirm it. Basing on this miasmatic state and presenting symptoms, history of jaundice and suppressed skin disease, the generalities as also the clinical findings, Nat. sulph was given, firstly in fifty-millesimal and then in centesimal raising up to 10M potency. Apart from this he was given Silicea, Ars. alb, Tuberculinum and Kali carb, all in centesimal potencies, as and when necessary by the then presenting symptoms for more than one year he is having no attack of dyspnoea.

Case No. 6.

A boy aged 14 years came for treatment of his bronchial asthma lasting for 4 years. On the first day he had the following symptoms and findings. With a susceptibility to catch cold easily since childhood he had frequent attacks of sneezing and dry cough with fever (100-101" F) followed by dyspnoea aggravating in summer and rainy season. Lying on chest would relieve him somehow. Occasional epistaxis at an interval of 1 or 2 months he had from his childhood

days.

There was history of measles at the age of 4 years followed by otorrhoea at the age of 4-1/2 years. This was followed by the attack of cough and cold and finally dyspnoea. There was history of regular vaccination too. The family history revealed piles, otorrhoea and rheumatism.

The patient was hot with much sweat on head during sleep. Thirst was scanty. He desired eggs, sweets, cold foods and drinks. He had hasty, forgetful and nervous. He had dream of snakes. The blood picture revealed eosinophil 13%.

To antidote suppressed measles, Morbillinum 2c and 1M was given for his first prescription. The dyspnoea ameliorated in severity and frequency of attacks also diminished. The second prescription was Medorrhinum 1M which covers the sycotic miasmatic background as also most of the generalities. Dyspnoea stopped completely for few months but epistaxis was recurring frequently. Hence Sulphur was given to remove his psoric block. After nine months his dyspnoea relapsed but epistaxis was completely checked in the meantime. Now Psorinum was given as a complementary 'to Sulphur. He had no further attack of dyspnoea since then but epistaxis reappeared, though at long intervals. Now, to eradicate his tubercular diathesis, Bacillinum was given, basing on some of his generalities. After six months, crusty eruption appeared on scalp. He had no attack of dyspnoea in the meantime though epistaxis did not

stop completely. After waiting for 3 months more Silicea was given, as he developed one minor attack of dyspnoea inspite of disappearance of eruptions. After this the dyspnoea, epistaxis and otorrhoea disappeared completely but susceptibility to catch cold persisted for some time more, for which he was given lastly Hepar sulph. After this the patient was completely cured and the treatment was closed.

Case No. 7

A slim, tall youngman of 30 years came on 19.8.86. For long nine years he was suffering from dyspnoea aggravating especially in rainy season and autumn. Dyspnoea used to start from sunset with tickling cough and aggravated after falling asleep, turning violent after midnight. Open air, stooping posture and warm drinks used to ameliorate. There was white, tasteless and scanty expectoration giving some relief. He felt better lying on right side or in knee-chest position and feared darkness during attack of dyspnoea. As to history, he had recurrent nasal catarrh in summer and rainy seasons for 1970 to 1975 and itching eruptions in groin area since 1973. Many ointments were applied for this and in the meantime he developed autumnal dyspnoea which got relieved by allopathic medicines. In 1980 the itching eruptions disappeared completely but dyspnoea became violent since then. From 1984 he started taking homoeopathic medicines from a local physician. As to the family history there was suspected abdominal lump in the paternal side and bronchial asthma in the maternal side. He also had a haemorrhagic diathesis. A hot patient, he liked warm

dishes, eggs, chillies, raw onion and milk. Sweet and sour were disliked. She had scanty thirst and profuse sweat which would ameliorate. She had offensive foot sweat till three years back. The urine had offensive and the stool had nothing abnormal. He preferred to lie on right side and dreamt frequently of flying or walking at the sea shore. Nervous and forgetful, he would fear bloodshed and was fond of rainfall, solitude and music. He had suppressed irritability and tidy habits. On examination the tongue was found flabby, moist and white coated with congested throat moist and polypoidal growth in the nostrils. The breath sound was diminished and the expiration prolonged. His bodyweight was 50.5 kg. and there was eosinophil 21%. The history of the case indicates psora and syphilis as the predominating miasmatic states. The present complaints and generalities corroborate it. Basing on this miasmatic state and covering the present complaints as well as the generalities, especially the strong mental symptoms, Bacillinum was given first in 1M and then in 10M potency with remarkable improvement in all spheres. His bodyweight increased to 53.5 kg. Afterwards he started losing it in spite of having no dyspnoea. This time he was given Syphilinum 1M as a medicine complementary to Bacillinum, covering the rest of the symptomatology with stress on the syphilitic miasmatic state. Curiously enough, it brought back the old eczematous eruptions with marked general. Curiously enough, it brought back the old eczematous eruptions with marked general improvement. For more than one year he has no dyspnoea.

Case No. 8

A lady (widow) aged 45 years came for consultation on 27.5.88 for treatment of her bronchial asthma lasting for about nine years. Her symptoms were as follows :

She used to suffer from respiratory allergy since long time back with paroxysmal sneezing and fluent coryza. She suddenly developed dyspnoea in 1979 without any incidental cause.

Dyspnoea aggravated in winter and at midnight; had to sit up on bed bending forward; frequently associated with vomiting of frothy mucus which ameliorated; the expectoration was generally salty; sneezing and coryza preceded dyspnoea for 2-3 hours.

The other associated complaints were shifting arthritis for last 2/3 years; first started in left great toe, gradually other joints were involved; now almost all the joints were affected; restless feet at night disturbing sleep.

On enquiry the following symptoms were obtained:

Appetite becoming progressively less day by day; easy satiety from small quantity of food: urine scanty with occasional burning: thirst poor; craving for sour and extra salt in diet: aversion and intolerance of milk and milk products; sleep late and disturbed due to pain in legs; occasional salivation during sleep; extraordinarily tidy—felt everything was dirty and persistently thought about it; easily irritable but quieted down soon; hasty in habit; fear of thunderstorm,

lightning; mental depression and aversion to do any work-even did not like to go out of her home.

Menstrual history: Early, scanty, lasted for 3 days; no pain; occasional leucorrhoea before menses.

Obstetrical history: Three issues: last one 16 years back; all normal delivery, severe post-partum haemorrhage after first issue - was hospitalised; grossly anaemic since then.

Past history: Nasal polyp both sides with epistaxis; operated in 1967; ligation 16 years back.

Family history: Bronchial asthma (father-in-law); diabetes mellitus with jaundice (husband) – died of the same; tumour and thyroid disorder (mother).

Findings on examination

Becoming obese day by day; anaemic look; multiple moles and warts on face and neck; tongue moist, coated with imprint of teeth; inflamed left great toe; B.P. 104/80 mm Hg.

Blood report of 23.4.88.....
Hb 9.91 gm%; W.B.C. 5800; P-59, L-37, E 4%;
E.S.R. 37.5 mm; serum uric acid 4.5 mgm%.

First prescription on 27.5.88:.....
Rx *Carcinosin 200*/ one dose only. History of diabetes mellitus in husband; extraordinary fastidiousness; multiple moles and warts; mixed miasmatic state with predominance of syco-psora: craving for extra salt and

aversion to milk and milk-products; disturbed sleep; mental depression with irritability; all these led me to select Carcinisin as her first medicine.

Follow up:

6.7.88: Occasional sneezing, no dyspnoea; was feeling much better till one week back;

Rx: *Carcinosin IM/one dose only.*

23.9.88: No dyspnoea; arthritic pain in finger joints and ankles aggravated very much for last 4/5 days; Hb. 8.7 gm%.

Rx: *Medorrhinum 200/one dose only.*

2.12.88: Arthritis ameliorated, but dyspnoea reappeared, " though mild; inability to lie on right side.

Rx: *Kali carb 0/3, 8 doses.*

One dose to be taken every 4th day in the morning.

22.2.89: Much better in all respects; occasional Pain in knees.

Rx: *Kali Carb 0/6, 8 doses, direction same.*

1.5.89: Urticaria appeared and backache aggravated for about 5 days; no dyspnoea.

Rx: *Kali Carb 2001 one dose.*

16 8 89: Pain with restlessness of feet aggravates at night disturbing sleep; warts

aggravating; no dyspnoea.

Rx: *Causticum* 0/5, 12 doses.

One doses to be taken every alternate day.

3.11.89: Warts disappearing; no dyspnoea;

Rx: *Causticum* 0/8, 8 doses

One dose to be taken every 4th day.

23.2.90: No dyspnoea; pain in left heel aggravates by initial movement; pain in knees aggravates at night.

Rx: *Medorrhinum LM* / one dose only.

Comment and conclusion

The patient is still under my observation (January 1994) but there has been no relapse of dyspnoea so far. She inherited sycosis and her first major illness was also sycotic (nasal polyp). *Carcinosin* paved the way but *Medorrhinum* completed the cure in this case.

Case No. 9

A male, unmarried patient, aged 26 years, consulted on 1.8.89 for following:

Difficulty in breathing for last 12/13 years; dyspnoea used to aggravate in rainy season and winter previously now may occur any time; ameliorates by pressing on chest with hand, lying on chest

and open air; frequent loose motion and profuse sweating on head and forehead during dyspnoea, having daily attacks of dyspnoea for last two months; expectoration salty and thready.

History of present illness

The patient used to suffer from pustular eruptions all over his body since childhood and was relieved from time to time by allopathic medicines (antibiotics) and ointments. Thereafter developed susceptibility to cold, headache and epistaxis: was treated a sinusitis with surgical interference twice- thereafter dyspnoea started; now alternates with skin eruptions. Dyspnoea was relieved for last two years when skin eruptions aggravated very much. They were relieved by ointment resulting in persistent dyspnoea for last two months.

Past history:

History of regular vaccination; pustular eruptions with occasional fever etc recurring since childhood - used plenty of allopathic medicines, injections, ointments etc. Peptic ulcer in 1980 - was treated with allopathic medicines; sinusitis - treated surgically twice - last one 3 years ago.

Family history: Pulmonary tuberculosis (father and maternal uncle).

Generalities: Ambithermal patient with burning of dorsum of hands; craving sour, sweets and milk aversion and intolerance - fried and rich food- thirst scanty; sweat profuse on scalp and forehead which gives relief, emitting sour smell; dreams as if pursued by snakes, of flying away and falling down-

very irritable but no outburst; fond of traveling, music and drawing; fear of dogs; impatient and restless.

Findings on examination: Pulse 100 pm breath sound diminished both sides; rhonchi ++ both lungs all through; granular pharyngitis; tongue moist and white coated.

First prescription:.....
Rx *Mezereum 0/2, 12 doses.* One dose to be taken every alternate day.

Follow up.....
26.8.89: Dyspnoea much relieved:
Rx: *Mezereum 0/3 12 doses.* One dose to be taken every alternate day.....

17.10.89.-Improvinng steadily; feeling greatly relieved.
Rx *Mezereum 0/5/8 doses.* One dose to be taken every 4th day.....

15.3.90: Eczematous eruptions appeared on right leg with profuse discharge and burning; dyspnoea occasional.
Rx: *Mezereum 200 one dose only.*

26.5.90: Eruptions drying; no dyspnoea.
Rx *Mezereum 1M/one dose only*.....

30.7.90: Pustular eruptions on both legs reappeared; tongue moist with profuse thirst.
Rx Merc sol 0/2/8 doses - one dose to be taken every 4th day.....

21.11.90: No skin eruptions; no dyspnoea.
Rx Merc sol 0/4/8 doses - one dose to be taken every 4th day.

8.2.91: Two ringworm like lesion appeared in groin with mild dyspnoea.....
Rx Bacillinum 1M/one dose only.....

8.1.92: He had no dyspnoea or skin eruptions during this period. Papular eruptions appeared in both hands for last few days.
Rx Bacillinum 1M/one dose with 10 succussions.

26.2.92: Eruptions further aggravated; dyspnoea also aggravated for last two days.
Rx Graphites 0/2/8 doses – one dose to be taken every 4th day.

After this, the patient was on Graphites in successive higher potencies of 50-millesimal scale followed by Graphites in centesimal (200, 1M and 10M) till 14.5.93. After 26.2.92 till this date (January 1994) the patient had no further attack of dyspnoea or skin eruptions. He is perfectly all right now.

Conclusion and comment

Suppression of skin eruptions was the main

cause of bronchial asthma in this case. There was no family history of bronchial asthma but history of pulmonary tuberculosis in both paternal and maternal sides. The patient had also history of peptic ulcer in the past. These were suggestive of mixed miasmatic state (psora + syphilis). The character of original skin eruptions was suggestive of Mezereum. Mental makeup and other generalities were also in favour of Mezereum. Hence Mezereum was given. Mezereum resulted in great improvement which was followed by Merc sol and Bacillinum according to the altered symptoms then present, but both the drugs cover the basic miasmatic state. The treatment had to be concluded with an antipsoric (Graphites) as advised by Hahnemann in his "Chronic diseases". It is to be specially noted in this case that no palliative medicine had to be given for temporary relief. This is probably the difference between palliation and cure.

Case No. 10

Boy aged 17 years. Date of first visit 24.1.90.

Present complaints.....

Bronchial asthma since 2-3 months of age: starts with dry cough followed by noisy wheezing which can be heard from a distance place; this is followed by difficulty in breathing; aggravates evening onwards followed by gradual amelioration the next morning; maximum trouble occurs in the middle of night - sits up on bed bending forward which gives temporary relief; profuse sweating with dyspnoea which also

gives some relief; craves open air; frequent desire for defecation occurs during dyspnoea with scanty semisolid stool ameliorating dyspnoea to some extent; dyspnoea aggravates in winter as also in summer from suppression of sweat.

Itching in the groins for long past, for which applies various skin ointments.

Grinding of teeth during sleep; itching at the anus and passing of pinworms with stool since childhood.

Past history

Delayed milestones especially speech, was given Encephabol tabs for one month; repeated boils on scalp at 2 years of age treated with allopathy; measles at 5 years of age: suspected P.T. at 6 years of age - treated with anti-tubercular medicines and injections; jaundice at 7 years of age treated with allopathy; nephritis at 8 years of age - also treated and ameliorated by allopathy. Respiratory distress with asthmatic manifestations developed at the age of 2-3 months (earliest complaint).....

Family history

Bronchial asthma (mother); paralysis (grandfather); cancer (maternal grandmother); peptic ulcer (maternal side).

Generalities

Hot patient - keeps feet out of covering even in winter;

sweat +++ especially chest, head, axilla, palms and soles emitting foul smell and feels exhausted after sweating, though sweating ameliorates dyspnoea; profuse thirst for large quantities of water at short intervals even at night; frequent urination both during night and day; craving meat, chillies, raw onions and eggs; prefers rather cold food and drinks; aversion to milk and sour intolerance of fried food - causes indigestion; stool never in form, associated with much flatulence in abdomen and noisy flatus during stool; grinding of teeth during sleep; irritable and obstinate sympathetic to others, fond of social work, fear of dogs ++.

Findings on examination

Tongue moist, broad with imprint of teeth; lungs - breath sound diminished, no adventitious sounds at present; weight - 54 kg, pulse 72 p.m.

Treatment:

24.1.90:

Rx: *Tuberculinum* JM/one dose only (first prescription).

12.3.90: Dyspnoea aggravated and had to take allopathic medicines from 24.2.90 on wards; not taking any medicine for 3/4 days. Itching at anus aggravated; polyuria unchanged. Wt. 52 kg.

Rx *Tuberculinum* 1M/one dose only giving 6 succussions to the phial.

16.4.90.-

Dyspnoea aggravated 13.3.90, continued for one week; had to take Asthalin which ameliorated; old sneezing and coryza recently aggravated; wt. 53.5 kg; O.E. chest free.

21.5.90;

Measly rash came out and subsided spontaneously

one abscess also appeared on thigh and subsided spontaneously; acidity aggravated esp. in the afternoon; no dyspnoea.

Rx *Tuberculinum* 1M/one dose only giving 10 succussions.

20.8.90:

No complaints excepting occasional sneezing.

Rx *Tuberculinum* 1M!one dose only giving 20 succussions.

19.10.90:

No dyspnoea. Granular eruptions appeared all over the body for last 8/10 days (old complaint reappeared in severe form). Itching too much, unable to sleep or read.

Rx *Psorinum* 0/2/4 doses. One dose to be taken every 4th day.

16.11.90:

No dyspnoea. Eruptions aggravated further; wt. 53.5 kg.

Rx *Psorinum* 0/3/8 doses. One dose to be taken every 4th day.

19.12.90:

Eruptions drying but still coming out; occasional mild dyspnoea at night but requires no medication.

Rx *Psorinum* 200/one dose only.

6.2.91:

Eruptions standstill; dyspnoea relapsed on 5/2/91 did not take any allopathic medicine.

Rx *Bacillinum* 0/2/4 doses. One dose to be taken every 4th day.

11.3.91:

Skin improving, once had slight dyspnoea: wt. 54 kg. Rx *Bacillinum* 0/3/4 doses. One dose to be taken every week.

After this, the patient had never any attack of dyspnoea excepting occasional breathlessness on exertion. Skin eruptions completely disappeared within another one month. Till now the patient is in touch with me (January 1994) and having no complaints of dyspnoea or skin eruptions. His general health also has improved to a great extent.

Comment and conclusion

Delayed learning to speak is suggestive of sycotic inheritance which is further confirmed by history of bronchial asthma in mother. But the first illness of the patient was repeated boils on scalp followed by measles. This suggests flaring up of latent psora. Jaundice and nephritis also suggest secondary psora. In the meantime he also suffered from P.T. which is suggestive of psora and syphilis. Hence this is a mixed

miasmatic case with predominance of syco-psora when he came for homoeopathic treatment. Tuberculinum brought back the suppressed skin eruptions which lasted for a considerable period when antipsoric Psorinum was given to fully manifest the skin lesion on the surface. Finally Bacillinum was given to take care of the remaining skin lesions as also the respiratory syndrome. To remove the sycotic dyscrasia, the patient was given Natrum sulph later on for indigestion, acidity etc. That resulted in complete cure. Even then the treatment was rounded off with a dose of Sulphur 200 in June 1993.

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1. Harrison's Principles of Internal Medicine, tenth edition.
2. A companion to medical studies by R. Passmore & J. S. Robson, third print.

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