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Bringing Classical and Contemporary Homoeopathy Together

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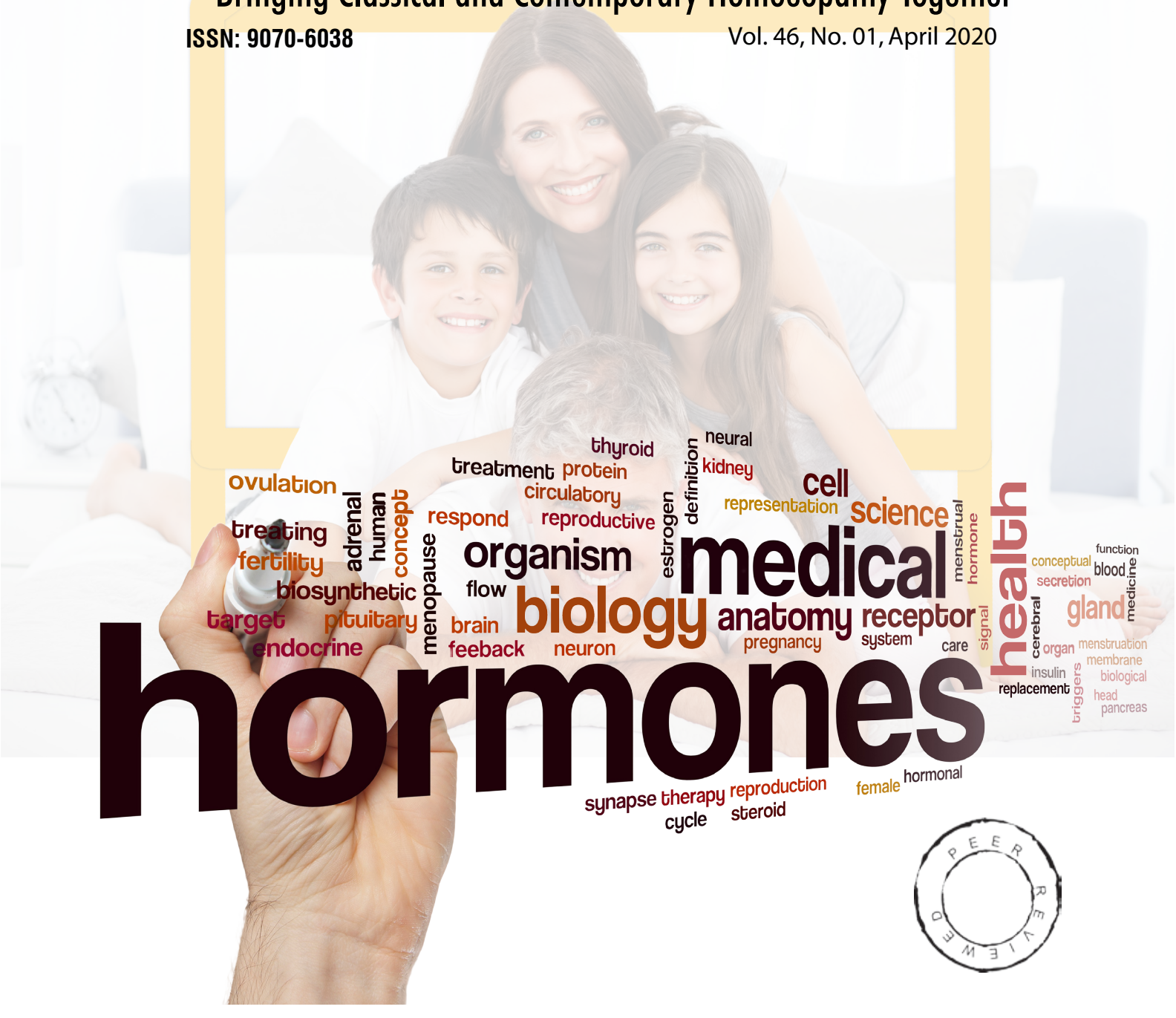

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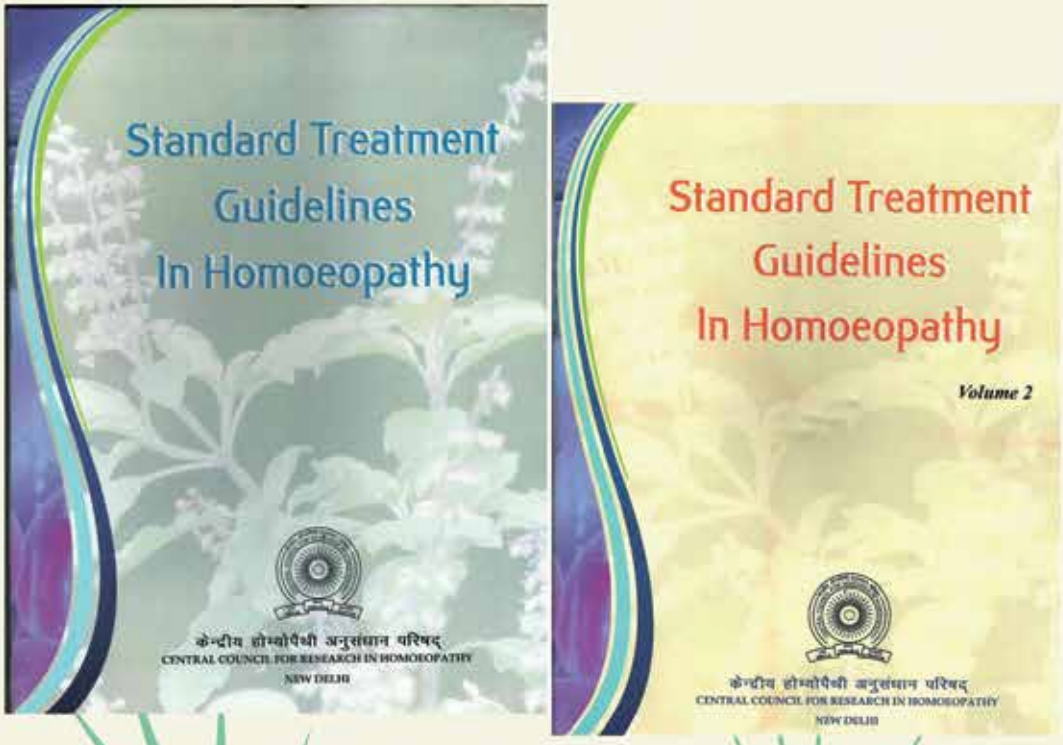

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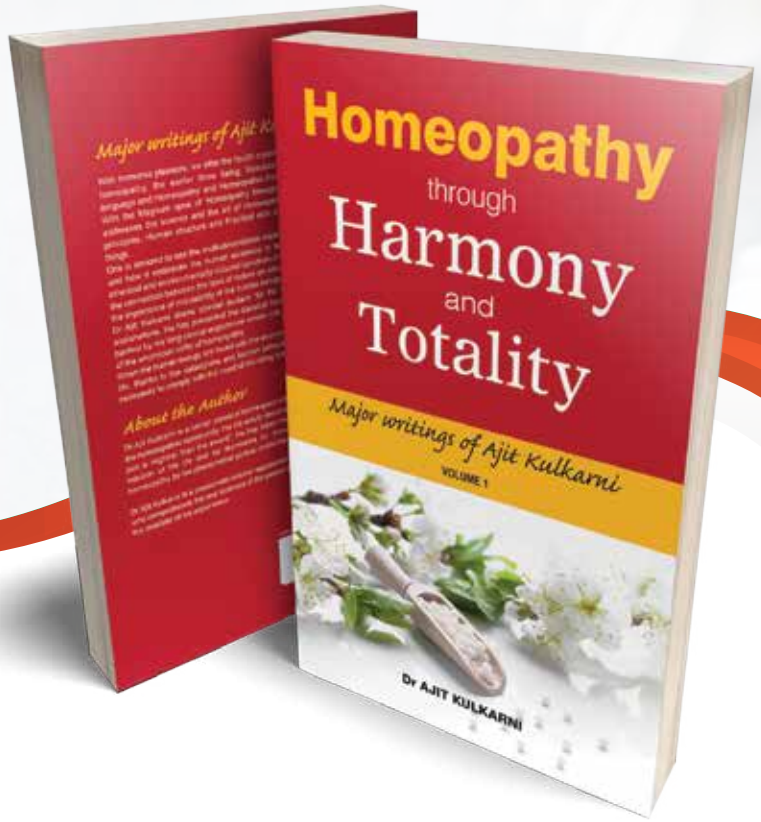

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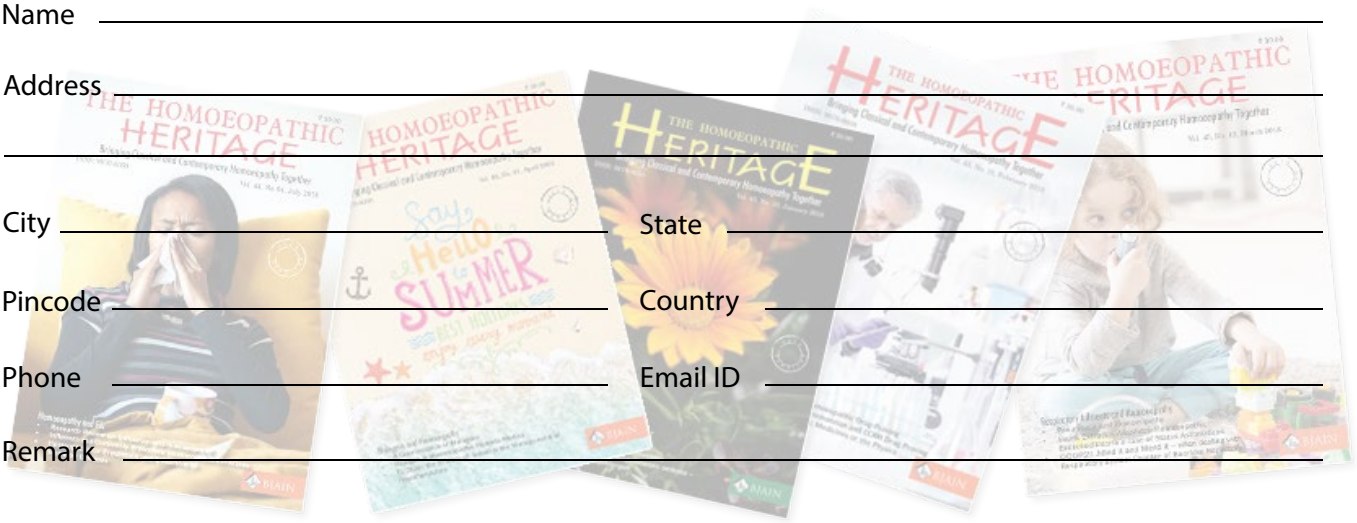

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Cover: Collage on endocrine system and hormones

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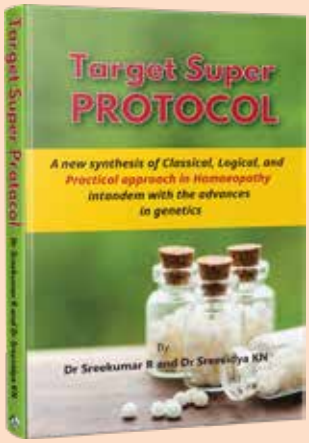

- A reference book describing a protocol, i.e. a set of guidelines to be followed by homoeopathic practitioners while dealing with any of the case to target 100% successful results in their practise.
- The book is a synthesis of classical, logical, and practical approach in homoeopathy in tandem with the advances in genetic field and the modern medicine.
- Being a homoeopath, one has to face so many hurdles while resolving cases in hand, this book is a solution for the same as it constitutes a blend of information compiled from different schools of homoeopathy and one can easily find the way to reach the simillimum remedy by using the methodology of any school of homoeopathy.
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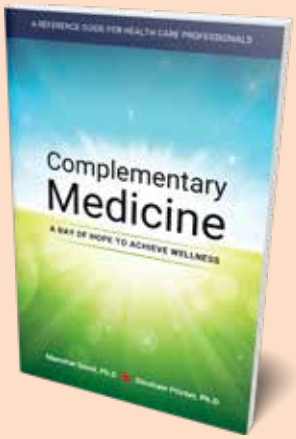

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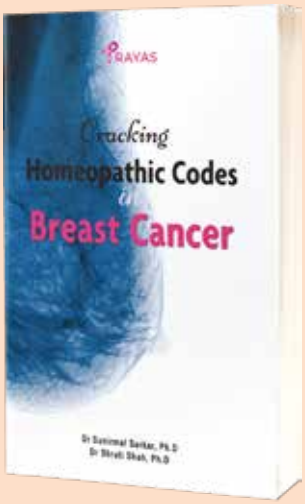

- Around 80 remedies well-explained from all kingdoms such as plant, animal and mineral, as well as from nosodes, sarcodes, radioactive substances, synthetic sources, and new plant remedies.
- Segregation of remedies according to their kingdom with their accurate symptoms described aptly.
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- All the scattered information on breast cancer remedies altogether at one place.

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Dear Readers,

Endocrine system impacts almost every cell and organ in the human body, and acts as an interface between the physical and the emotional self of an individual.

The profound effects on the physical as well as the mental level of the remedies such as *Thyroidinum, Folliculinum,* etc., struck the very core of individuals dictated by the hormones released by endocrine system. Infact, the other remedies, either made from the glands themselves (like *Pituitrin*) or made from their secretions (like *Adrenalinum*), have proven to be of paramount importance while dealing with disorders of endocrine system.

In the modern scenario, the main endocrine disorders which a physician may come across during clinical practise include diabetes mellitus, hyper- or hypo- thyroid problems, pre-menstrual tension, polycystic ovary syndrome, etc. or many symptoms of endocrine disturbances like thrush, rhinitis, auto-immune disorders like rheumatoid arthritis, and allergies. Sometimes a homoeopath may also come across patients suffering the side effects of synthetic hormones prescribed to regulate under or over functioning endocrine glands or who are being accidentally poisoned by such hormones.

According to homoeopathic perspective, 'mind and body' are inseparable to each other, therefore to heal the patient, a homoeopath needs to be proficient enough to understand underlying causes of disease at different levels, and unravel the impact of these imbalances on the rest of the body. If the cause is mental or emotional and there are no obstacles to cure, one may cure the patient prescribing on the basis of totality of symptoms, i.e. classical prescribing. Some cases you may come across could have a long history of suppression of endocrine disorders and there will be obstacles to cure such as drug toxicity, dietary and nutritional deficiencies, which may require an organ-specific remedies or based on therapeutics, allied with nutritional guidelines.

A Quick Word On Issue Content:

I would like to take this opportunity to draw the attention of the readers towards the contribution made by the authors of the present issue who are the future of homoeopathy and have come forth to get their work published in our esteemed peer-reviewed journal, *"The Homoeopathic Heritage"*. This issue is devoted to endocrine disorders and their homoeopathic management. All the articles published include high quality research papers from Dr Nirmal and Prof. Dr M.K. Kamath on subclinical hypothyroidism, and on efficacy of *Nyctanthes arbor-tristis* in tinea corporis by Dr Sudhir and Dr Dinesh. Case studies on hashimoto's thyroiditis by Dr Nishant Daryani, on hypothyroidism by Dr Yashveer, Dr Mukesh and Dr Chitralekha, on efficacy of *Stramonium* in endocrine disorder by Dr S.K. Mishra, wonderfully highlight the role of homoeopathy in different endocrine disorders. A special subjective article on autoimmune haemolytic anaemia by Dr Subhash, Dr Chandni and Dr D. Basu has been taken up in this issue to enlighten the readers about the scope of homoeopathy in an autoimmune disorder.

Thus, as a homoeopathic physician, one must possess an appropriate understanding of the endocrine system, psychoneuroendocrinoimmunology, hypothalamic-pituitary-adrenal axis, hormonal imbalance and its effect on the body, so as to therapeutically manage the endocrine disorders from allergies to thyroid dysfunction with homoeopathy.

Thank you for the patronage always!

We promise to promote the noble profession of homoeopathy as well as look forward to your valued contributions to the journal in 2020 and beyond.

Dr Yashika Arora
hheditor@bjain.com

■■

Note: *The Homoeopathic Heritage* is now a peer reviewed journal since January 2013. All the articles are peer reviewed by the in-house editorial team and selected articles from each issue are sent for peer review by an external board of reviewers and those articles are distinctly marked with a stamp of 'peer reviewed'. For inclusion of articles in peer review section, kindly send your articles 3-4 months in advance of the said month. Send your articles at **hheditor@bjain.com.**

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August 2020	Utility of Homoeopathic Remedies in cases of Kidney failure	June 15, 2020
September 2020	Skin diseases and Homoeopathy	July 15, 2020
October 2020	Homoeopathic Aggravation	August 15, 2020
November 2020	Role of Homoeopathy in Lifestyle Disorders	September 15, 2020

Homoeopathy in endocrine disorders

The endocrine system is a network of glands responsible for producing and releasing hormones which help to control many important functions of the body. Some common endocrine diseases which can be treated with homoeopathy include:

1. Type 1 diabetes.
2. Type 2 diabetes.
3. Osteoporosis.
4. Thyroid cancer.
5. Addison's disease.
6. Cushing's syndrome.
7. Graves' disease.
8. Hashimoto's thyroiditis.

Case study

A 26 years old girl came for the treatment of thyroid nodule. She was very anxious and nervous because she was advised partial thyroidectomy, after which she became confused as what to do next. Thoughts which came immediately in her mind were about her future, questions regarding her marriage and the scar left after operation, which made her consult more doctors in her area.

Past history

She had a past history of asthma as a child.

Habits and addictions

She used to smoke 2-3 cigarettes in a day, and whenever she smoked more than 4 cigarettes in a day, she suffered from headache.

Gynaecological history

Her menses were painful on first and second day, and she also suffered from white, copious leucorrhoea for which she had to use sanitary pads.

Physical generals

She had a craving for tandoori chicken and fish. She used to sleep on sides and frequently had nightmares during her sleep. She couldn't bear temperatures above 30 degrees, and immediately started sweating at such a temperature. On exposure to sun, she got perspiration on forehead.

Mental generals

She was a very hard-working, independent girl, studying in Delhi University, who always wanted freedom of movements and her views. Hence, at a very early age, she involved herself in smoking and sexual activities which was very common in her friend circle. She had multiple relationships over past five years. She often suffered from mood changes and laziness, especially after the college hours, when she used to return home.

General physical examination

On examination, pulse was found to be 120 beats per minute even though she suffered from myxoedema. She also had very fine, nervous tremors of the hand. Her hands and feet were usually cold. In last few years, she suffered from good amount of hair loss.

Totality of symptoms

Mind - anxiety - future, about

Mind - confusion of mind

Mind - laziness - evening

Mind - libertinism

Mind - mood - changeable

Mind - moral feeling; want of

Head - pain - smoking - agg.

Head - perspiration of scalp - forehead

External throat - goitre

External throat - inflammation - thyroid gland

External throat - swelling - thyroid gland

Female genitalia/sex - leucorrhea - albuminous

Female genitalia/sex - leucorrhea - copious

Female genitalia/sex - leucorrhea - hot

Female genitalia/sex - menses - painful

Extremities - coldness - feet

Extremities - coldness - hands

Extremities - trembling - hands

Sleep - position - side; on

Dreams - nightmares

Generals - cold; taking a - tendency

Generals - food and drinks - chicken - desire

Generals - food and drinks - fish - desire

Generals - heat - sensation of

Generals - hypothyroidism

Generals - myxedema

Generals - pulse - frequent

Generals - tobacco - desire for tobacco - smoking; desire for

Head - hair - falling

Repertorial analysis

nat-m.	sep.	ferr-i.	phos.	calc.	sulph.	puls.	lach.	nux-v.	merc.	lyc.	ars.	caust.	tub.	mag-c.	iod.	con.	alum.	am-c.	be
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
26	22	22	21	21	21	21	21	21	20	20	20	20	20	20	19	19	19	19	18
52	42	29	44	42	42	38	37	37	39	36	35	30	30	24	33	32	28	25	33
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Management

Based on the above analysis, she was prescribed *Natrum muriaticum* LM2, LM4, LM6 without much benefit according to the following symptoms:

1. MIND - ANXIETY - future, about
2. MIND - CONFUSION of mind
3. MIND - LAZINESS - evening
4. MIND - LIBERTINISM
5. MIND - MOOD - changeable
6. MIND - MORAL FEELING; want of
7. HEAD - PAIN - smoking - agg.
8. HEAD - PERSPIRATION of scalp - Forehead
9. EXTERNAL THROAT - GOITRE
10. EXTERNAL THROAT - INFLAMMATION - Thyroid gland
11. EXTERNAL THROAT - SWELLING - Thyroid gland
12. FEMALE GENITALIA/SEX - LEUKORRHEA - albuminous
13. FEMALE GENITALIA/SEX - LEUKORRHEA - copious
14. FEMALE GENITALIA/SEX - MENSES - painful
15. EXTREMITIES - COLDNESS - Feet
16. EXTREMITIES - COLDNESS - Hands
17. EXTREMITIES - TREMBLING - Hands
18. SLEEP - POSITION - side; on
19. DREAMS - NIGHTMARES
20. GENERALS - COLD; TAKING A - tendency
21. GENERALS - FOOD and DRINKS - chicken - desire
22. GENERALS - FOOD and DRINKS - fish - desire
23. GENERALS - HEAT - sensation of
24. GENERALS - HYPOTHYROIDISM
25. GENERALS - PULSE - frequent
26. HEAD - HAIR - falling

Follow up

Since the case was not progressing, a new totality was formed as follows, where the remedy covered the special affinity for thyroid gland myxoedema, frequent pulse with desire for chicken was being considered.

1. MIND - ANXIETY - future, about
2. MIND - CONFUSION of mind
3. MIND - LAZINESS - evening
4. MIND - LIBERTINISM
5. MIND - MOOD - changeable
6. HEAD - PAIN - smoking - agg.
7. HEAD - PERSPIRATION of scalp - Forehead
8. EXTERNAL THROAT - GOITRE
9. EXTERNAL THROAT - SWELLING - Thyroid gland
10. FEMALE GENITALIA/SEX - LEUKORRHEA - albuminous
11. FEMALE GENITALIA/SEX - LEUKORRHEA - copious
12. FEMALE GENITALIA/SEX - LEUKORRHEA - hot
13. FEMALE GENITALIA/SEX - MENSES - painful
14. EXTREMITIES - COLDNESS - Feet
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19. GENERALS - FOOD and DRINKS - fish - desire
20. GENERALS - HEAT - sensation of
21. GENERALS - HYPOTHYROIDISM
22. GENERALS - PULSE - frequent

Second prescription

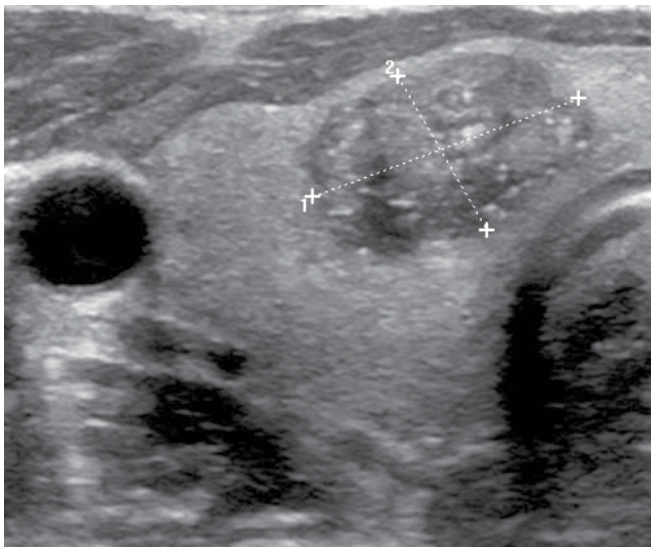

Figure 1: Adenomatous nodule thyroid before homoeopathy

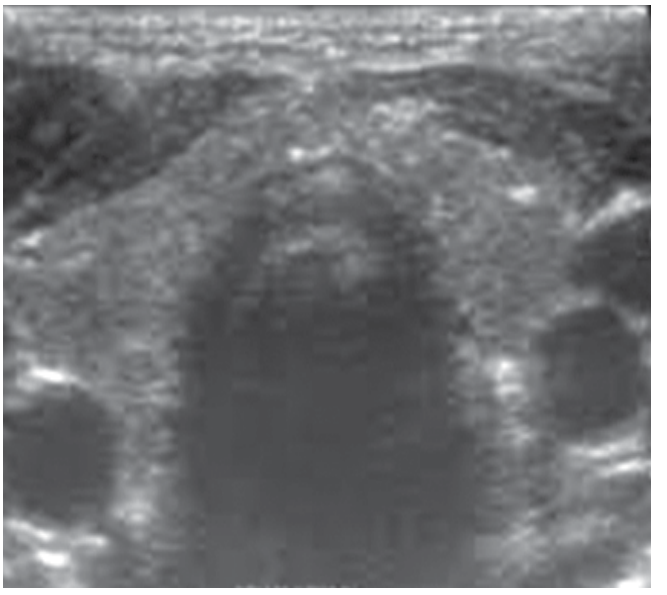

Figure 2: After 9 months of homoeopathic treatment

Ferrum iodide 30 was prescribed first, and then Ferrum iodide 10M was given.

After 3 to 4 months, she felt much better symptomatically, a ultrasonography was done again as shown by the pictures given below. (Figure 1 and 2). Figure 2 shows the disappearance of nodule in the ultrasonography.

■■

PEER REVIEWED ARTICLE

RESEARCH PAPER

A study on efficacy of constitutional homoeopathic treatment on elevated serum TSH values in cases of subclinical hypothyroidism

Dr Nirmal V. Kini and Prof Dr M. K. Kamath

Abstract:

Background: Thyroid disorders are the most common endocrine disorders which may occur at any stage of life. Subclinical hypothyroidism refers to biochemical evidence of thyroid hormone deficiency in patients who have no or a few apparent clinical features of hypothyroidism. The following study proves the efficacy of constitutional homoeopathic treatment on elevated serum TSH values in cases of subclinical hypothyroidism.

Objective: To study the efficacy of constitutional homoeopathic treatment on elevated serum TSH values in cases of subclinical hypothyroidism.

Methods: This study was being conducted on the study group of 33 individuals, which were selected based on purposive sampling method (non probability sampling method) as per the inclusion and exclusion criteria. This was a 6 months study (without control type of experimental study) in which the patients suffering from subclinical hypothyroidism (diagnosed with increased TSH level, with normal T3, T4) were being assessed by serum TSH, T3, T4. Evaluation was done before starting the treatment, and after three months and at the end of the study, by laboratory assessment of serum TSH, T3 and T4 levels to understand the improvement.

The data was presented in a standardised case record, the cases were analysed, totality were erected and suitable remedies with suitable potencies and doses were administered. The fore scores and after 3 month, 6 month scores were then compared and the effectiveness of homoeopathic treatment on improving the serum values was determined.

Results: The study parameters of pre- and post- 3 and 6 months treatment showed significant 'p' values of 0.000. Thus, it was concluded that significant changes in serum TSH values in cases of subclinical hypothyroidism were being observed with constitutional homoeopathic treatment.

Interpretation and conclusion: This study provided an evidence to confirm that constitutional homoeopathic treatment plays a beneficial role in reducing serum TSH values in subclinical hypothyroid patients.

Keywords: homoeopathy; subclinical hypothyroidism; TSH; T3; T4; constitutional treatment.

Abbreviations: ANOVA - analysis of variance, C - centesimal potency/scale, mL - millilitre, mU – milli-units, SCR - standardised case record, SPSS - statistical package for the social sciences, T3 - tri-iodo thyronine, T4 - thyroxine, TSH - thyroid stimulating hormone, OPD - outpatient department, Std - standard, Std.dev. - standard deviation.

Introduction

Hypothyroidism is a common problem resulting in symptoms that reduce the functional status and quality of life. The term "subclinical" denotes that a disease is present without overt clinical features indicating that the disease is in its initial stage only. It is more commonly encountered in middle age and adulthood. Thyroid hormones influence nearly all the major metabolic pathways.[1]

Subclinical hypothyroidism is a common biochemical finding in the general population, although prevalence figures vary with the characteristics of the populations studied, as well as the upper limit set for TSH measurements.[2]

Subclinical hypothyroidism can be best defined as a high serum TSH concentration and normal serum total/ free thyroxine (T4), tri-iodo thyronine (T3) concentrations associated with few or no symptoms/ signs of hypothyroidism.[3]

The overall prevalence has been reported to range from 4–10% in large general population screening

surveys and from 7–26% in studies of the elderly. Due to the frequency with which this condition is encountered, important questions have been raised regarding its clinical relevance and appropriate management.[4]

Thus, an elevated TSH in an individual patient, indicates that the circulating thyroid hormone concentrations are insufficient, with a few rare exceptions (TSH-secreting tumours, thyroid hormone resistance syndromes). Michael T. Mc Dermott and E. Chester Ridgway in the article, "subclinical hypothyroidism is mild thyroid failure and should be treated", published in the journal of clinical endocrinology and metabolism (2001) 86 (10): 4585-4590, observed that subclinical hypothyroidism represents mild thyroid failure and is a clinically important disorder having adverse clinical consequences which should be treated in most, if not all, cases.[4]

In general, most clinicians agree that patients having serum TSH levels >10 mU/l should be treated since they have an increased risk of progression to overt hypothyroidism. Around 2-5% of subclinical hypothyroidism patients are likely to progress to overt hypothyroidism every year. At present, there are no standard recommended criteria for screening, management, and follow up for subclinical hypothyroidism.[5]

Early treatment may even be justified in asymptomatic individuals to prevent the symptoms of more severe thyroid hormone deficiency that eventually develop as the thyroid gland progressively fails.[4] Hence, early diagnosis and treatment may prevent the onset of overt hypothyroidism and its adverse effects. Thus, this study of constitutional treatment of subclinical hypothyroidism was taken up to explore the efficacy of homoeopathic treatment in such disorders and also to explore a better alternative treatment for the patients of subclinical hypothyroidism which are on the rise in the general population.

Objective

To study the efficacy of constitutional homoeopathic treatment on elevated serum TSH values in cases of subclinical hypothyroidism.

Methodology

Research design: This was a quasi-experimental 6 month prospective study with evaluation done before treatment, a follow-up after 3 months, and then at the end of the study with non-controlled experimental study design.

Sample size: The sample consisted of 33 cases of subclinical hypothyroidism taken by purposive sampling method. All cases were selected according to the inclusion and exclusion criteria.

Source of data: The subjects were selected from OPD, in-patient department, and peripheral centres of Father Muller Homoeopathic Medical College and Hospital, Mangalore.

Period of study: The study was conducted on the cases available from may 2017 to january 2019.

Inclusion criteria:

- Diagnosed cases of subclinical hypothyroidism.
- The samples of both sexes aged between 15-60 years.

Exclusion criteria:

- Cases of central hypothyroidism.
- Previous radioactive therapy, surgery, external radiation therapy resulting in thyroid failure.
- Cases of recovery from non thyroid illness.

Methods

A study group of 33 was selected based on purposive sampling method as per the inclusion criteria. Data was collected from subjects by interviewing and clinical examination. The patients who were suffering from subclinical hypothyroidism were assessed by serum TSH, T3, T4 values before treatment, after 3 months, and at the end of the study period with constitutional homoeopathic treatment.

A therapeutic plan was evolved individually for each case. The data was recorded in standardised case record (SCR), analysed, totality was erected, and suitable remedy with suitable potency and dose was administered. The inferences were drawn by analysis of the outcome, recorded during each follow-up.

There were no control groups used in the study and all the subjects were treated on an outpatient basis. No concomitant therapy such as allopathic treatment or any other alternative medicine was being used. Subjects, who were already on other therapy, were asked to discontinue the same under medical supervision.

Selection of remedy, potencies, and repetition were as per the requisites of the case such as susceptibility, vitality and suppression (if any), changes in structural and functional level, and

the degree of correspondence to the remedies. Potencies ranging from 6C to fifty millesimal were used. Placebo administration was done in between to give psychological effect.

Follow-up

Follow up in each case was planned for a period of 3 months, and then 6 months from the commencement of treatment. Subjects were mostly reviewed to assess subjective and objective changes. During follow up, each case was evaluated for the changes in TSH values. (See Table)

Assessment of effectiveness

The effectiveness of the treatment was assessed on the following basis:

- During follow-ups, each patient was evaluated after three months through serum TSH values to understand the improvement.
- At the end of study, i.e. after 6 months, serum TSH, T3, T4 levels will be checked and changes will be analysed.

Statistical analysis: Assessment of the clinical status analysed using ANOVA of repeated measures, with the help of SPSS 16.0.

Research hypothesis [H1]: Significant reduction in serum TSH levels of subclinical hypothyroidism after constitutional homoeopathic treatment.

Null hypothesis [H0]: No significant reduction in serum TSH levels of subclinical hypothyroidism after constitutional homoeopathic treatment.

Statistical analysis

Pre-test measurement of TSH before the treatment: Mean value showed 13.989 mU/mL with a standard deviation of 11.65209 mU/mL at a 95% confidence interval of 9.857-18.121 mU/mL.

Post 1 measurement of TSH (3 months after the treatment): Mean value showed 7.984 mU/mL with a standard deviation of 5.75665 mU/mL at 95% confidence interval of 5.943—10.025 mU/mL.

Post 2 measurement of TSH (6 months after the treatment): Mean value showed 5.004mU/mL with a standard deviation of 4.62298 mU/mL at 95% confidence interval of 3.364-6.643 mU/mL.

Statistical analysis of pretest, post test 1, and post test 2 were done using ANOVA of repeated measures. The result showed 'F'* value as 17.638 and the 'p'** value as .000 indicating a highly significant reduction in serum TSH values after six months of constitutional homoeopathic treatment.

Results

- The most common age group for the occurrence of subclinical hypothyroidism was 31-45 years, i.e. 15 cases (45%).
- Subclinical hypothyroidism is more common in females (91%) than males (9%).
- Most frequently used remedy was *Natrum muriaticum* and 200C proved to be the commonly administered potency.
- After an analysis of before, during, and after 6 months of treatment, statistical analysis showed the 'p' value 0.000, which is highly significant.
- The above statistical evidence points that homoeopathic medicines play a pivotal role in improving the values of TSH in cases of subclinical hypothyroidism.

Discussion

The highest prevalence of subclinical hypothyroidism in this study was found to be in the age group of 31-45 years, had15 cases (45%), 46-60 age groups had 13 cases (40%), and 15-30 year group had 5 cases (15%). Mean age of most affected is 38 years, which correlates with the study by Hollowell JG et al; [6]also pointing out that screening of subclinical hypothyroidism should be started by age of 35 years as recommended by american thyroid association.[7]

This study of 33 patients showed a higher female prevalence, i.e. 30 were females (91.00%) and 3 males (9.00%). These observations

Table

TSH	No	Mean	Std Dev	Std. Error	95% Confidence Interval		F Value	P Value
					Lower Bound	Upper Bound		
1	33	13.989	11.65209	2.028	9.857	18.121		
2	33	7.984	5.75665	1.002	5.943	10.025	17.638	.000
3	33	5.004	4.62298	.805	3.364	6.643		HS

* F value - variation between sample means/variation within samples.
** P value - Probability of obtaining results as extreme as the observed results of a statisfied hypothesis test.

were similar to the previous studies like the Whickham survey by W.M.G.Tunbridge et al.,[8] that the prevalence of subclinical hypothyroidism is more in females.

The most prescribed medicine was *Natrum Muriaticum* for 12 cases (37%), *Sulphur* was prescribed for 5 cases (15%), *Thyroidinum* for 4 cases (12%), *Pulsatilla nigricans*, *Calcarea sulphurica*, *Nux vomica*. *Lycopodium clavatum*, *Spongia tosta*, *Iodum*, *Rhus toxicodendron*, *Sepia officinalis*, *Kalium iodatum*, *Phosphorus*, *Lachesis mutus*, *Arsenicum sulphuricum,* each prescribed in one case (3%). The prescription was done on the basis of constitutional make-up of the patients.

This study aimed at the treatment of subclinical hypothyroidism and its improvement in patients before and after the homoeopathic medical intervention, evaluating the serum TSH, T3, T4 before the commencement of treatment, follow-up after 3 months, and at the end of study period, i.e. 6 months.

In the present study, it was found that the mean serum TSH at pre-test, post 1 test and post 2 test were 13.989 mU/mL, 7.984 mU/mL and 5.004mU/mL respectively. ANOVA for repeated measures showed 'p' value of 0.000, denoting a highly significant reduction in mean TSH values before, during, and after homoeopathic treatment in subclinical hypothyroidism.

The statistically significant results with constitutional homoeopathic treatment supported the observation of Dr Chauhan et.al.[9], where they concluded that a statistically significant decline in serum TSH values indicates that the homoeopathic intervention has not only the potential to treat subclinical hypothyroidism but may also prevent progression of the disease.

Inference

There occurred a significant reduction in serum TSH values (p=.000) after homoeopathic treatment. Hence, the null hypothesis was rejected and the alternative hypothesis was accepted.

This study evidently showed that homoeopathic medicines prove to be very effective in the treatment of subclinical hypothyroidism, thereby improving the quality of life of affected individuals.

Conclusion

Thus, the study convincingly proved that homoeopathic treatment is effective in reducing serum TSH values in subclinical hypothyroidism patients and constitutional homoeopathic treatment are effective in reducing the TSH values in the patients suffering from subclinical hypothyroidism.

Ethical issues: Patients' consent for the reporting of the data has been obtained and the patients' privacy and integrity has been maintained while reporting and publishing the data.

Conflict of interest: None.

Financial support and sponsorship: Nil.

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A single blind, comparative study to evaluate the efficacy of *Nyctanthes arbor-tristis 30C* prepared from leaves to *Nyctanthes arbor-tristis 30C* prepared from seeds in cases of tinea corporis

Dr Chauhan Sudhir Shyamvachan, Dr Dinesh Kumar Goyal

Abstract:

Background: Ringworm is a highly infectious skin infection which causes a ring-like red rash on the skin. It is more prevalent in India as most of the states possess a humid environment where dermatophytes find easy to thrive and multiply. Antifungal properties are found in leaves and seeds of *Nyctanthes arbortristis*.

Materials and methods: 50 diagnosed patients of either sex with tinea corporis infection were allotted in 2 arms, group A (leaf based formulation) and group B (seed based formulation). Change in mean grading score (MGS) from the baseline to the end of study (after 3 months) for each group was the primary endpoint.

Results: At the end of study, the mean value of MGS in group A was improved from 6.7 ± 1.2 to 3.9 ± 1.5 ($p<0.0001$), whereas, in group B, the mean MGS was improved from 6.4 ± 0.8 to 3.8 ± 1.4 ($p<0.0001$). In group A, 32% of patients were found to be recovered and 41 % of the patients showed improvement. In group B, 21% of patients were found to be recovered and 58% of patients improved compared to the baseline.

Conclusion: There was significant improvement in tinea corporis infections in the patients receiving medicine prepared from leaves or seeds of *Nyctanthes arbortristis.*

Keywords: mean grading score, tinea corporis, *Nyctanthes arbor-tristis*.

Abbreviations: MGS - mean grading score, SD - standard deviation, EOS - end of study.

Introduction

The incidence of ringworm is estimated to be approximately 20% of indian population.[1] Very contagious, ringworm presents as ring-like red rash on the skin. Its recurrence rate is very high. The drug, *Nyctanthes arbor-tristis,* possesses many chemical constituents having anti-fungal properties. The medicine prepared from the leaves of *Nyctanthes arbor-tristis* provided symptomatic relief to the patient of ringworm recorded in few studies.[2] A new formulation prepared from the seed of the same plant also possesses antifungal properties. Due to recurrence and prevalence of disease, it has been always necessary to find a solution for ringworm.

Objective

To study the efficacy of *Nyctanthes arbor-tristis* 30C, either prepared from leaves or from seeds, to provide symptomatic relief and reduction in lesion score in the patients of tinea corporis.

Materials and methods

A single centre, open labelled study was conducted at Shri B.A. Dangar Homoeopathic Medical College and Hospital, Rajkot, Gujarat from july 2018 to may 2019. 50 participants with tinea corporis of either sexes were being selected. The informed consent was obtained from all the patients and follow up of each participant was taken every 15 days upto 3 months, or when required. Patients of either sex, in the age group of 21 to 45 years suffering from tinea corporis were included. Patients with other disorders like diabetes mellitus, hypertension, ischaemic heart disease, thyroid disorder, asthmatics only on inhalers were also included in the study. Patient whose total lesion score of minimum 5 grades or more were included in study. The lesion score was calculated by adding the grades of total symptoms present in a participant. Each symptom (itching, erythema, vesicles, scaling and discolouration) were graded in 4 grades

from 0 to 3. The patients under homoeopathic treatment for last 2 months or patients with active acute diseases like malaria, typhoid, dengue, hepatitis were excluded from study.

24 participants with tinea corporis were given medicine A and 26 participants with tinea corporis has been given B. *Nyctanthes arbor-tristis* 30C from leaves (MED A) and *Nyctanthes arbor-tristis* 30C from seeds (MED B) was being administered orally, empty stomach. Each case was prescribed a single dose of selected medicine, either medicine A or medicine B in powder form as stat dose on first visit, and same medicine in powder form in the follow up, as per the directions of the physician. *Rubrum* 30C was also given in powder form and each dose packed in powder form labelled as morning, evening, and night given for 15 days on the first visit. In subsequent visit, *Rubrum* 30C as per the physician discretions. At each follow up, the patients were evaluated in detail for tinea including general well-being as well as any new complaint. The subject participating in the study were asked to report on the scheduled date, i.e. after every 15 days from the date of first consultation. Whenever necessary, MED A or MED B was repeated as per the participants' complaints.

Outcome assessment criteria:

1. The primary outcome was change in mean grading score at the end of 3 months compared to baseline. Mean grading score was calculated using the grades of itching, erythema, vesicles, scaling, and discolouration**.** Each of these parameters were graded on a 4-point scale (0-3).
2. Proportion of patients who recovered, improved, and not improved at the end of 3 months' observation period. Participants were considered to be recovered if there was a reduction of 4 or more points in the MGS. They were considered as improved if the reduction in MGS was by 2 or 3 points but not 4. The patients who showed a reduction of less than 2 points were considered to be not improved.

Results

Baseline demographics:

The study included 26 females divided equally in group A (13 patients) and group B (13 patients) respectively. 24 males were part of the study. The total number of dropouts were 4 patients.

	Group A (n = 24)	Group B (n = 26)
Age (mean + SD)	32.88 + 6.9	30.42 + 6.7
Male (N)	11	13
Female (N)	13	13

Mean grading score (MGS):

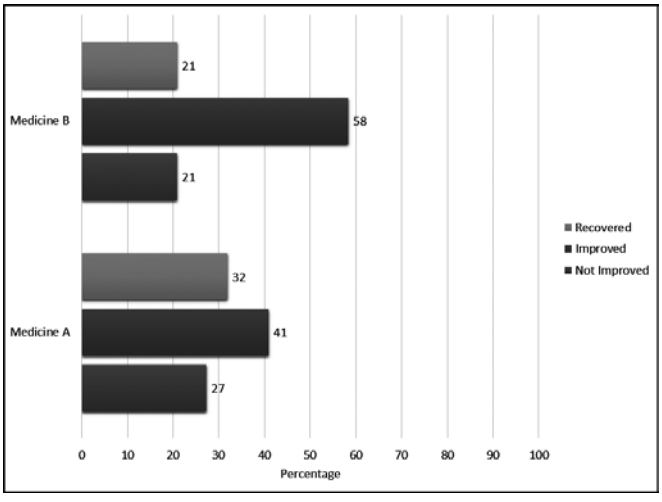
Comparison of mean grading score at baseline and end of study (EOS) (N = 46)

	Group A (n = 22)	Group B (n = 24)	P Value
Baseline	6.7 ± 1.2	6.4 ± 0.8	0.39
EOS	3.9 ± 1.5	3.8 1.4	0.72
P Value	<0.0001 < 0.0001	<0.0001	

The MGS for group A was 6.7 (±1.2) compared 6.4 (±0.8) at the baseline. At the end of study (after 3 months), the mean value of MGS in group A was 3.9 (± 1.5) (P < 0.0001). In group B, the mean value of MGS was 3.8 (± 1.4) (p<0.0001).

Percentage of cases improved versus not improved versus recovered in both groups

In group A, 32% of patients were found to be recovered. 41% of the patients showed improvement whereas, 27% of patients didn't show any improvement at all. In group B, 21% of patients were found to be recovered compared to baseline. 58% of patients improved whereas 21 % of patients did not show any improvement at all.



Percentage of cases improved versus not improved versus recovered in both groups

Discussion

Clinical symptom with change in the baseline score of ringworm values for pre- and post-treatment analysis was used as an assessment tool to evaluate whether the primary aim was achieved or not, then the observed results were corroborated by applying the required statistical test, viz. standard deviation, standard error of the mean, calculation of the mean, paired t test. Significant symptomatic relief was being observed in patients with tinea corporis, taking both the medicines at the end of study. However, the efficacy of both the medicines were comparable, resulting in no difference in the two groups.

Conclusion

From the above study, it was concluded that in the patients of tinea corporis, *Nyctanthes arbor-tristis* 30C (either prepared from leaves or prepared from seeds of plant) proves to be effective in giving symptomatic relief, in terms of improvement in lesion score assessed using parameters like itching, erythema, vesicles, scaling, and discoloration. However, no difference was being observed in the efficacy of the two products. Further multicentric studies with larger sample size and longer duration would be needed to substantiate the results of present study.

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Dr Dinesh Kumar Goyal.

A case report of hypothyroidism cured by *Calcarea carbonicum*

Dr Yashveer Singh, Dr Mukesh Solanki and Dr Chitralekha Tiwari

Abstract: Lack of thyroxine hormones in reproductive age group affects the health of progeny and healthy future of entire society. Homoeopathy has a great role to play in the treatment of hypothyroidism. The following case report is presented in order to assess the role of homoeopathic deep acting remedy, *Calcarea carbonicum*, in a patient suffering from hypothyroidism. The case was cured by deep acting homoeopathic medicine *Calcarea carbonicum*. Thyroid function test (T3,T4,TSH) was done before, as well as after intervention. Thus, *Calcarea carbonicum* proves to have a beneficial effect resulting in complete holistic cure as evident symptomatically and by the laboratory reports.

Keywords: Hypothyroidism, homoeopathy, *Calcarea carbonicum*, obesity.

Abbreviations: TDS – ter die sumendum (thrice a day), TSH – thyroid stimulating hormone, LMP – last menstrual period, T3 – tri-iodthyronine, T4 – thyroxine, P.L. – placebo.

Introduction

Hypothyroidism is a hypometabolic state resulting from inadequate secretion of thyroid hormone for a longer period or rarely from resistance of the peripheral tissues to the effect of thyroid hormones. It is a common condition of thyroid hormone deficiency, which is readily diagnosed and managed but potentially fatal in severe cases if untreated. The definition of hypothyroidism is based on statistical reference ranges of the relevant biochemical parameters and is increasingly a matter of debate. Clinical manifestations of hypothyroidism ranges from life threatening to no signs or symptoms. The most common symptom in adult include fatigue, lethargy,cold intolerance, weight gain, constipation,change in voice and dry skin, but clinical presentation can differ with age and sex, among other factors. A substantial proportion of patients who reach biochemical treatment targets possess persistent complaints[1].

The prevalence of hypothyroidism has increased to 5:100 with high female preponderance. It accounts as a major risk factor in pregnancy and infertility. The prevalence of gestational hypothyroidism is estimated as 13.13% in India[2]. Untreated, maltreated gestational hypothyroidism results in impaired intellectual, cognitive and neural functions of newborn. Attention deficit and hyperactive syndromes are common in children who were born to hypothyroid mother[2].

Thyroid hormones have influence over oestrogen and androgen metabolism as evident from the history of delayed puberty, menstrual irregularities, anovulatory cycles, miscarriage and infertility in hypothyroid individual[3,4].

Hypothyroidism accounts a major risk factor in 53.7% cases of infertility[5].

Although an easy-to-detect and inexpensive to treat disease, patients with hypothyroidism in India often remain undetected and untreated, thus the disease impairs the work performance and economic productivity of Indian people.

Environmental factors other than iodine deficiency might play a part in hypothyroidism in India. Goitrogens and exposure to cyanogenic compounds have an adverse impact on iodine metabolism. The unregulated use of pesticide, exposure to endocrine disruptors, unclean drinking water, and exposure to industrial pollutants like resorcinol and pthalic acid have been suggested as causes.

Hypothyroidism in pregnant women, if untreated or inadequately treated, can compromise fetal neurocognitive development. Early treatment will prevent irreversible mental retardation in a large number of newborns[6].

Calcarea carbonicum

Symptoms: disposed to grow fat, corpulent, unwieldy. Menstruation too early, too profuse, too long lasting; with subsequent amenorrhoea and chlorosis with menses scanty or suppressed. Women: menses too early, too profuse; feet habitually cold and damp, as if they had on cold damp stockings; continually cold in bed[8].

Its chief action is centred in the vegetative sphere, impaired nutrition being the keynote of its action, the glands, skin, and bones, being instrumental in the changes wrought. Increased local and general perspiration, swelling of glands, scrofulous and rachitic conditions generally offer numerous opportunities for the exhibition of *Calcarea carbonicum*. Gets out of breath easily. *Calcarea carbonicum* patient is fat, fair, flabby, perspiring and cold, damp and sour[9].

Fat, flabby anaemic subjects; sometimes they look plump, often flushed in the face, but they have no endurance, and if such a patient undertakes a little exertion he is down sick with a fever, or a headache. Weak, tired, anxious. Difficulty in breathing[10].

Most cases of *Calcarea carbonicum,* of course, are the fair, fat, flabby types which is so well described in literature. These people gain weight easily and have difficulty losing it, even when consuming very few calories[11].

Case report

A 35 years old female, diagnosed woth hypothyroidism, presented with the complaints of recent weight gain, puffiness of face (especially in the morning), scanty menses, weakness, and lethargy.

Patient as a whole

The patient was an obese housewife belonging to middle class socioeconomic group. Mentally, she was timid, fear of misfortune, averse to work. She had strong desire for sweets^{+++}, tea^{+}. Her thirst was increased, drank large quantities of water frequently. Her sleep was disturbed and unrefreshing. She had scanty menses for 2 days only in every 32 to 35 days. She suffered from chikungunya 1 year before.

Examination of thyroid gland: Movements were observed on deglutition, mild tenderness was present, with no bruit, both the thyroid gland was palpable and equal in size.

Analysis of case

The case was analysed as per the characteristic mental generals, physical generals, particular and pathological symptoms for framing the totality (the analysis and evaluation of symptoms are listed in the table 1). Considering the presenting symptomatology, *Synthesis Repertory* was preferred and using RADAR 10.0 software, systemic repertorisation was done (repertorial chart is given in table 2). Miasmatic evaluation showed the predominant miasm as psora-sycotic (miasmatic predominance chart is given in table 3)

Table 1: Analysis and evaluation of symptoms

Category	Symptoms	Intensity
Mental generals	Fear of misfortune	+++
	Laziness	++
	Timid	++
Physical generals	Hypothyroidism	+++
	Desire sweets	+++
	Weakness	++
Particulars	Swelling on face	+

Table 2 : Repertorial sheet [12]

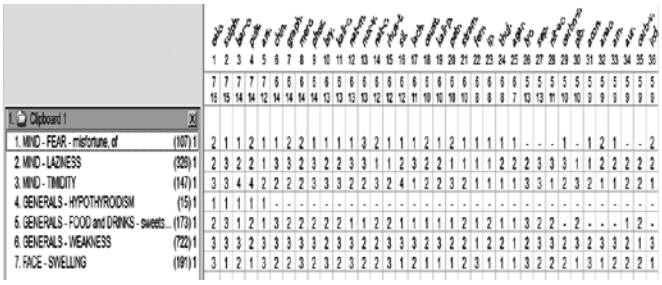

Table 3: Classification of symptoms & their miasmatic predominance [13i]

S. No.	Presenting symptoms	Classification of symptoms	Psora	Sycosis	Syphilis	Latent psora	Predominant miasm
1.	Fear of misfortune	Uncommon	√	-	-	√	Psora-sycotic
2.	Laziness	Common	√	-	-	-	
3.	Timid	Uncommon	√	-	-	-	
4.	Hypothyroidism	Common	√	√		-	
5.	Desire sweets	Uncommon	√	-	-	-	
6.	Weakness	Common	√	-	-	-	
7.	Swelling on face	Common	-	√	-	-	

Selection of remedy and its potency with justification

The reportorial result of the case showed that most of the symptoms of this case are covered by *Calcarea carbonicum*. After considering materia medica, *Calcarea carbonicum* was found to be a useful remedy for hypothyroidism. General constitutional and mental picture of the patient was also similar to *Calcarea carbonicum* as described in materia medica. In miasmatic prescribing, *Calcarea carbonicum* covered psora-sycotic miasm[9].

So, according to the totality and miasmatic basis, *Calcarea carbonicum* was selected and prescribed in 30C potency due to progressed pathology of case. Later on, the potency was increased to 200C, as justified below.

Prescription with general management

Calcarea carbonicum 30/2 doses, along with P.L.30 TDS was prescribed for 14 days. General dietary advise was also explained to her to prevent obesity.

Table 4: Follow-up of the case

Date	Symptomatology	Prescription
15.06.2018	Weakness and lethargy – better.	P.L.30 TDS prescribed for 30 days.
15.7.2018	Puffiness reduced, weakness and lethargy – better.	P.L.30 TDS prescribed for 60 days.
15 .9.2018	Heavy menstrual bleeding since 2 days, LMP -13/9/2018	*Calcarea carbonicum* 200/1 dose* , P.L.30 TDS Prescribed for 30 days.
15.10.2018.	All her complaints became better, patient's mental condition much improved. LMP -13/10/2018	P.L.30 TDS prescribed for 30 days.
15.11.2018	Patient showed great improvement in all her mental and physical complaints.	P.L.30/3 prescribed for 30 days
15.12.2018	Patient became much better.	P.L.30/3 prescribed for 60 days.
23.2.2019	Patient became much better, T3,T4,TSH became normal.	P.L.30/3 prescribed for 60 days.

*** Justification of repetition of medicine and increasing potency on 4th visit:**

Repetition of the medicine was done since when the action of medicine stops showing some improvement, and the case comes to standstill position, even after waiting for considerable period.

Change in potency:

Robert's concept:

1. Either inadequate relief or early cessation of the good effect of the potency.
2. When the potency has exhausted its action and is incapable of achieving further improvement.

Kentian concept: same potency may not be repeated on more than two occasions.

Hahnemannian concept: same potency not being repeated again, has recorded favourable effect[13ii].

At one stage of the disease when the vital reaction is low, the patient may need a low potency and frequent repetition and at another a high potency[13iii].

In section 246 of 5th edition of *Organon of Medicine*, Master Hahnemann has asserted that the minutest yet powerful dose of the best selected medicine should be repeated at suitable intervals. Kent has warned that a case can be completely spoiled by improper repetition of dose. Higher and higher potencies of the medicine may be continued so long as the patient experiences continues improvement without encountering one or another complaint that he never had before in his life[14].

Laboratory reports

Before treatment: *(see figure 1)*

After treatment: *(see figure 2)*

Discussion and conclusion

As evident from the above reportorial sheets, follow up sheets and laboratory investigations, it can be said that *Calcarea carbonicum* has the potential to cure hypothyroidism, only *Calcarea carbonicum* 30/ 2 doses and *Calcarea carbonicum* 200 one dose cured the patient completely. Thus, this case signifies the importance of individualisation in homoeopathic prescribing.

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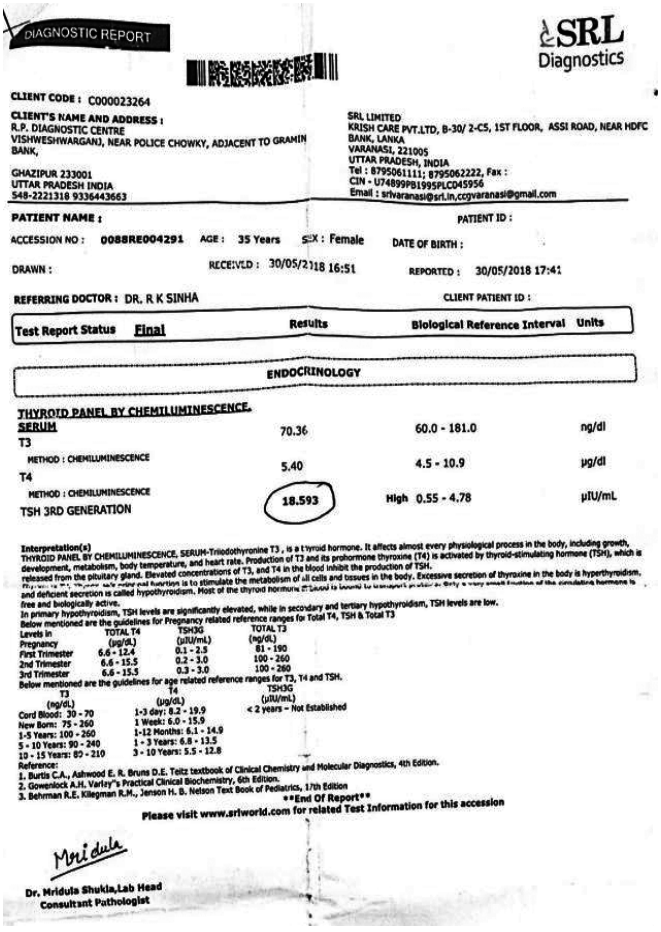

DIAGNOSTIC REPORT

SRL Diagnostics

CLIENT CODE : C000023264

CLIENT'S NAME AND ADDRESS :
R.P. DIAGNOSTIC CENTRE
VISHWESHWARGANJ, NEAR POLICE CHOWKY, ADJACENT TO GRAMIN BANK,
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Tel : 8795061111; 8795062222, Fax :
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Email : srivaranasi@srl.in,ccgvaranasi@gmail.com

PATIENT NAME :
PATIENT ID :
ACCESSION NO : 0088RE004291 AGE : 35 Years SEX : Female DATE OF BIRTH :
DRAWN : RECEIVED : 30/05/2018 16:51 REPORTED : 30/05/2018 17:41
REFERRING DOCTOR : DR. R K SINHA CLIENT PATIENT ID :

Test Report Status Final	Results	Biological Reference Interval	Units
ENDOCRINOLOGY			
THYROID PANEL BY CHEMILUMINESCENCE, SERUM			
T3	70.36	60.0 - 181.0	ng/dl
METHOD : CHEMILUMINESCENCE			
T4	5.40	4.5 - 10.9	µg/dl
METHOD : CHEMILUMINESCENCE			
TSH 3RD GENERATION	18.593	High 0.55 - 4.78	µIU/mL

Interpretation(s)
THYROID PANEL BY CHEMILUMINESCENCE, SERUM-Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
[illegible] and function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone [illegible] is bound to transport protein, only a very small fraction of the circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy			
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3, T4 and TSH.

T3 (ng/dL)	T4 (µg/dL)	TSH3G (µIU/mL)
Cord Blood: 30 - 70	1-3 day: 8.2 - 19.9	< 2 years - Not Established
New Born: 75 - 260	1 Week: 6.0 - 15.9	
1-5 Years: 100 - 260	1-12 Months: 6.1 - 14.9	
5 - 10 Years: 90 - 240	1 - 3 Years: 6.8 - 13.5	
10 - 15 Years: 80 - 210	3 - 10 Years: 5.5 - 12.8	

Reference:
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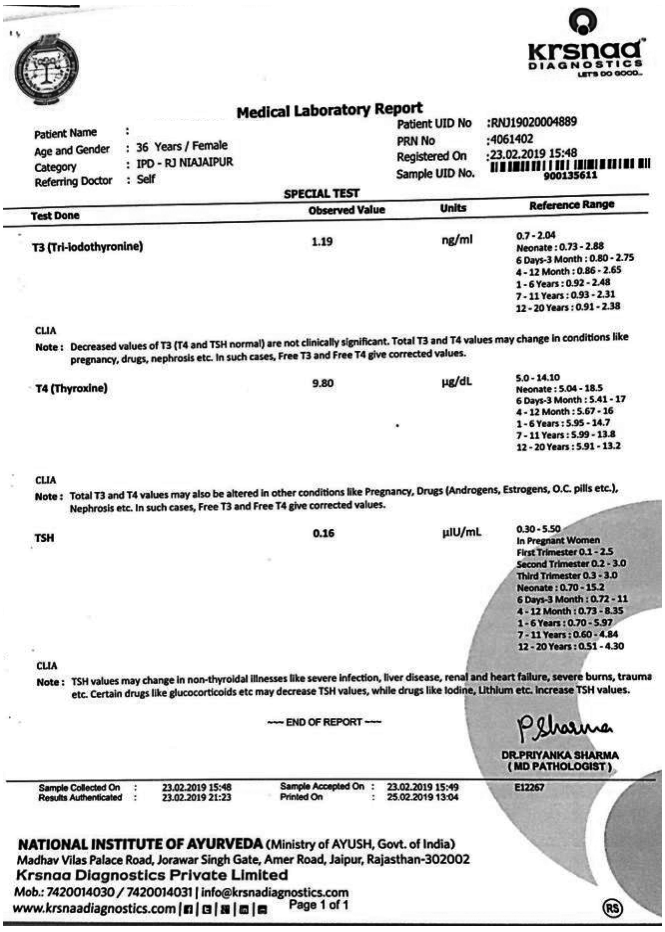
End Of Report

Please visit www.srlworld.com for related Test Information for this accession

Dr. Hridula Shukla,Lab Head
Consultant Pathologist

Figure 1



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Medical Laboratory Report

Patient Name :
Age and Gender : 36 Years / Female
Category : IPD - RJ NIAJAIPUR
Referring Doctor : Self

Patient UID No :RNJ19020004889
PRN No :4061402
Registered On :23.02.2019 15:48
Sample UID No. 900135611

Test Done	Observed Value	Units	Reference Range
SPECIAL TEST			
T3 (Tri-Iodothyronine)	1.19	ng/ml	0.7 - 2.04 Neonate : 0.73 - 2.88 6 Days-3 Month : 0.80 - 2.75 4 - 12 Month : 0.86 - 2.65 1 - 6 Years : 0.92 - 2.48 7 - 11 Years : 0.93 - 2.31 12 - 20 Years : 0.91 - 2.38
CLIA			
Note : Decreased values of T3 (T4 and TSH normal) are not clinically significant. Total T3 and T4 values may change in conditions like pregnancy, drugs, nephrosis etc. In such cases, Free T3 and Free T4 give corrected values.			
T4 (Thyroxine)	9.80	µg/dL	5.0 - 14.10 Neonate : 5.04 - 18.5 6 Days-3 Month : 5.41 - 17 4 - 12 Month : 5.67 - 16 1 - 6 Years : 5.95 - 14.7 7 - 11 Years : 5.99 - 13.8 12 - 20 Years : 5.91 - 13.2
CLIA			
Note : Total T3 and T4 values may also be altered in other conditions like Pregnancy, Drugs (Androgens, Estrogens, O.C. pills etc.), Nephrosis etc. In such cases, Free T3 and Free T4 give corrected values.			
TSH	0.16	µIU/mL	0.30 - 5.50 In Pregnant Women First Trimester 0.1 - 2.5 Second Trimester 0.2 - 3.0 Third Trimester 0.3 - 3.0 Neonate : 0.70 - 15.2 6 Days-3 Month : 0.72 - 11 4 - 12 Month : 0.73 - 8.35 1 - 6 Years : 0.70 - 5.97 7 - 11 Years : 0.60 - 4.84 12 - 20 Years : 0.51 - 4.30
CLIA			
Note : TSH values may change in non-thyroidal illnesses like severe infection, liver disease, renal and heart failure, severe burns, trauma etc. Certain drugs like glucocorticoids etc may decrease TSH values, while drugs like Iodine, Lithium etc. Increase TSH values.			

---- END OF REPORT ----

DR.PRIYANKA SHARMA
(MD PATHOLOGIST)

Sample Collected On : 23.02.2019 15:48
Results Authenticated : 23.02.2019 21:23
Sample Accepted On : 23.02.2019 15:49
Printed On : 25.02.2019 13:04
E12267

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Figure 2

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Efficacy of *Stramonium* in endocrine disorder: a case report

Dr S. K. Mishra

Abstract: Hypothyroidism is a metabolic disorder defined as failure of the thyroid gland to produce sufficient thyroid hormone to meet the metabolic demands of the body. Its management requires life-long intake of physiological doses, but total recovery from hypothyroidism has not been reported yet in the modern system of medicine. In the following article, a 20 years old female suffering from hypothyroidism since 1 year, was successfully relieved by individualised homoeopathic medicine selected on holistic approach. After 16 months of homoeopathic treatment, her thyroid stimulating hormone (TSH) levels reached towards the normal range, however her presenting complaints of hypothyroidism improved within 12 months of this duration.Thus, this case report suggested that TSH levels in blood or thyroid profile can be improved after homoeopathic intervention with marked relief in the presenting complaints. The present case is an illustration of how an individualised homoeopathic medicine selected on holistic approach works.

Keywords: Hypothyroidism, underactive thyroid disease.

Abbreviations: TSH – thyroid stimulating hormone, T3 -tri-iodothyronine, T4 – thyroxine, TPO - thyroid peroxidase antibodies, FT4 - free thyroxine.

Introduction

Hypothyroidism is a clinical disorder caused due to deficient secretion of thyroid hormone in the body, which may occur due to thyroid failure (*primary hypothyroidism*), or less commonly, pituitary or hypothalamic disease (*secondary hypothyroidism*). *Subclinical* (or *mild*) *hypothyroidism* is a state of normal free thyroid hormone levels and mild elevation of TSH; despite the name, some patients may have minor symptoms. With higher TSH levels and low free T4 levels, symptoms become more readily apparent in *clinical* (or *overt*) *hypothyroidism*.[1] Untreated hypothyroidism may contribute to hypertension, dyslipidaemia, infertility, cognitive impairment, and neuromuscular dysfunction.

Symptoms of hypothyroidism include lethargy, dry hair and skin, coldintolerance, hair loss, difficulty in concentration, poor memory, constipation, mild weight gain with poor appetite, dyspnoea, hoarse voice, muscle cramping, and menorrhagia. Cardinal features on examination include bradycardia, mild diastolic hypertension, prolongation of the relaxation phase of deep tendon reflexes, and cold peripheral extremities. Goitre may be palpated, or the thyroid may be atrophic and non-palpable. Carpal tunnel syndrome may be present. Cardiomegaly may also be present due to pericardial effusion. The most extreme presentation is a dull, expressionless face, sparse hair, peri-orbital puffiness, large tongue, and pale, doughy, cold skin. The condition may progress into a hypothermic, stuporous state (*myxoedema coma*) with respiratory depression.[1]

Epidemiology

The prevalence of hypothyroidism in India is around **11%**.[2] The peak age of occurrence is around 60 years, and prevalence increases with age. Congenital hypothyroidism is found in 1 of 4000 newborns; the importance of its recognition and prompt treatment for child development has led to the adoption of neonatal screening programmes.[1]

Among adult population in India, the prevalence of hypothyroidism has been recently studied. In this population-based study using cluster sampling strategy, done in Cochin on 971 adult subjects, the prevalence of **hypothyroidism** was **3.9%.** The prevalence of **subclinical hypothyroidism** was also high in this study, the value being **9.4%**. In **women**, the prevalence was higher, i.e. **11.4%,** when compared with **men**, where the prevalence was **6.2%**. The prevalence of subclinical hypothyroidism increases with age. About **53%** of subjects with subclinical hypothyroidism were **positive** for **anti-TPO antibodies**. In this study, urinary iodine status was studied in 954 subjects from the same sample of population, and the median value was 211µg/l; suggesting that this **population was iodine sufficient**.[3]

Diagnostic criteria for hypothyroidism

The diagnosis of primary hypothyroidism is based on a low level of thyroid hormones in association with a high TSH level. The actions of thyroid hormone are very important and crucial, and even the correction of mild thyroid dysfunction may have a positive impact on health.

Immunoreactive TSH may be detected at normal or even modestly elevated levels in patients with pituitary failure; unless T_4 is only marginally low, then TSH should be >20 Mu/I to confirm the diagnosis of primary hypothyroidism.[4]

The standard range considered for thyroid profile was done by fully automated immunoassay analyser (AIA - 360)).

TT_3 = 0.79 – 1.58 ng/ml

TT_4 = 4.9 – 11.0 μg/dl

TSH = 0.38 – 4.31 μIU/ml[5]

TSH	T3/FT3	T4/FT4	INTERPRETATION
High	Normal	Normal	Subclinical hypothyroidism
Low	Normal	Normal	Subclinical hyperthyroidism
High	High	High	Secondary hyperthyroidism
Low	High/ normal	High/ normal	Hyperthyroidism
Low	Low	Low	Non-thyroidal illness/ secondary hypothyroidism

Case study

A case of hypothyroidism is presented in the following article:

Patient information

On 3rd September 2018, a 20-year-old female presented to the outpatient department [OPD-4] of Nehru Homoeopathic Medical College and Hospital , Delhi, with the complaint of trembling of hands, general weakness, and hair fall for past one year.

History of presenting complaints

The patient had been suffering from trembling of hands, general weakness and hair fall for past one year. She also had trembling of tongue, aggravated on carrying heavy things. Following her visit to the OPD, her thyroid profile was done and she was diagnosed with subclinical hypothyroidism. Her TSH levels were 7.35 μIU/ml and FT_4 was 1.22 ng/dl.

Family history

No significant family history of similar complaints.

Personal history

The patient was an arts student, in second year of college. She had an accident 7-8 years back following which she developed epileptic attacks. She also lost her grandmother 2014 which had a great impact on her, and since then she started having dreams as if someone is going to kill her.

Mental generals

The patient was very nervous and had anxiety when appearing in front of public which resulted in trembling. Patient had fear of being alone and used to feel that someone can kill her at night because of which she couldn't go to washroom alone. She had a history of suppressed emotions and used to overthink. She used to feel sad because of her disease, she was unable to do things in life which she wanted to do. She was secretive, desired company, and had the feeling of jealousy for everyone.

Physical generals

Patient had adequate appetite and thirst with desire for sour things. There was generalised scanty perspiration with intolerance to cold. Her bowel habits and urine were satisfactory with no associated complaints, and had sound but non-refreshing sleep, yet sleepy all the time even when at work.

Case analysis and repertorisation

Proper case taking was done as per the directions stated in the *Organon of Medicine* and other homoeopathic literatures. After analysis and evaluation of the symptoms of this case, the totality of symptoms was constructed and the case was repertorised.[5] The following symptoms were considered for repertorisation[5]:

- Desire for company
- Jealousy
- Loss of ambition
- Sadness

- Fear of being alone
- Anxiety in public gatherings
- Delusion that someone will kill her
- Scanty perspiration
- Trembling of hands

Table 1[6]

Symptoms	Common/ uncommon	Intensity	Miasm
Desire for company	Uncommon	2+	Psora
Jealousy	Common	1+	Sycosis
Loss of ambition	Common	2+	Psora
Sadness	Common	1+	Psora
Fear of being alone	Uncommon	3+	Psora
Anxiety in public gatherings	Uncommon	2+	Psora
Delusion that someone will kill her	Uncommon	2+	Psora
Scanty perspiration	Common	1+	-
Trembling of hands	Uncommon	1+	Psora

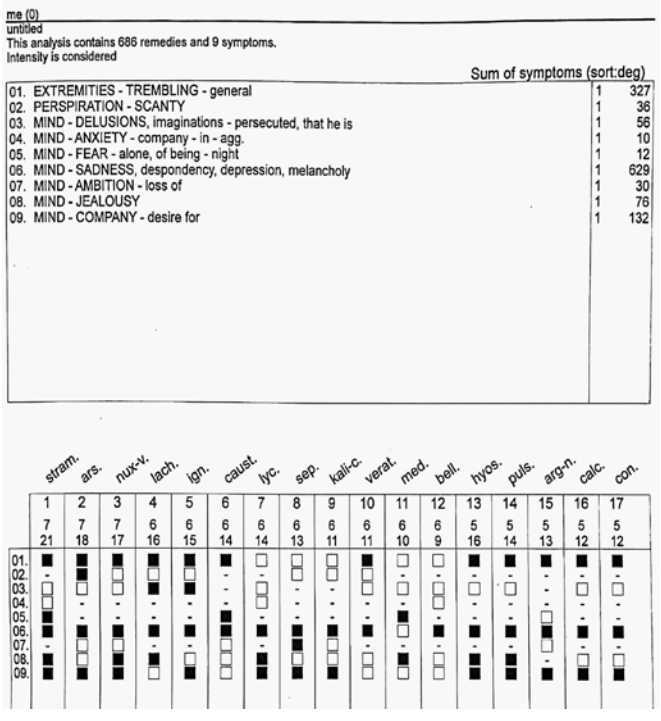
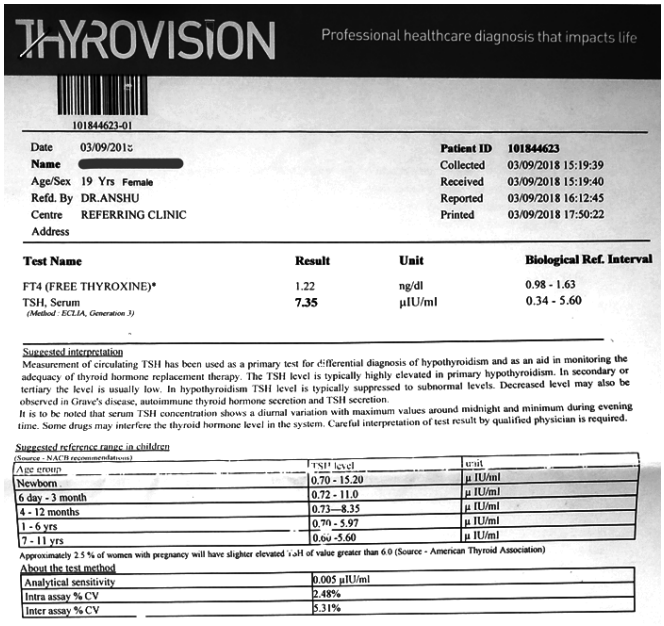


Figure 1

Diagnostic assessment

The case was diagnosed clinically by the presenting symptoms such as general weakness, lethargy, pain, hair fall and also confirmed by thyroid profile test. The free thyroxine (FT_4) came out to be ***1.22 ng/dl*** and TSH level was ***7.35 µIU/ml.*** *(see figure 2)*


THYROVISION

Professional healthcare diagnosis that impacts life

101844623-01

Date 03/09/2018
Name [redacted]
Age/Sex 19 Yrs Female
Refd. By DR.ANSHU
Centre REFERRING CLINIC
Address

Patient ID 101844623
Collected 03/09/2018 15:19:39
Received 03/09/2018 15:19:40
Reported 03/09/2018 16:12:45
Printed 03/09/2018 17:50:22

Test Name	Result	Unit	Biological Ref. Interval
FT4 (FREE THYROXINE)*	1.22	ng/dl	0.98 - 1.63
TSH, Serum (Method : ECLIA, Generation 3)	7.35	µIU/ml	0.34 - 5.60

Suggested interpretation
Measurement of circulating TSH has been used as a primary test for differential diagnosis of hypothyroidism and as an aid in monitoring the adequacy of thyroid hormone replacement therapy. The TSH level is typically highly elevated in primary hypothyroidism. In secondary or tertiary the level is usually low. In hypothyroidism TSH level is typically suppressed to subnormal levels. Decreased level may also be observed in Grave's disease, autoimmune thyroid hormone secretion and TSH secretion.
It is to be noted that serum TSH concentration shows a diurnal variation with maximum values around midnight and minimum during evening time. Some drugs may interfere the thyroid hormone level in the system. Careful interpretation of test result by qualified physician is required.

Suggested reference range in children
(Source - NACB recommendations)

Age group	TSH level	Unit
Newborn	0.70 - 15.20	µ IU/ml
6 day - 3 month	0.72 - 11.0	µ IU/ml
4 - 12 months	0.73—8.35	µ IU/ml
1 - 6 yrs	0.70 - 5.97	µ IU/ml
7 - 11 yrs	0.60 -5.60	µ IU/ml

Approximately 2.5 % of women with pregnancy will have slighter elevated TSH of value greater than 6.0 (Source - American Thyroid Association)

About the test method	
Analytical sensitivity	0.005 µIU/ml
Intra assay % CV	2.48%
Inter assay % CV	5.31%

Figure 2

Therapeutic intervention with follow-up and outcome

Stramonium was selected as the simillimum remedy on the basis of totality of symptoms, individualisation, repertorial analysis where it secured top position with maximum grades (*see figure 1*) and consultation with materia medica. Since most of the symptoms were mental generals and constituted the mental make-up of the patient, therefore it was prescribed in 200th potency.

On the first visit (3rd september 2018), *Stramonium 200*/1 dose was prescribed and clinical follow-up of the patient was assessed fortnightly or as per requirement, for 12 months. Following this, the complaints started to reappear and it became necessary to repeat the doses and change the potency as per the guidelines of the homoeopathic philosophy.

According to **Kent's** ***eleventh observation, "when old symptoms are observed to come back to stay, then a repetition of dose is often necessary".***[7]

Kent has also quoted in his book '*Lectures on Homoeopathic Philosophy*', ***" In such a case when the symptoms return, when the patient has the same general***

and particulars as formerly, it means that the first prescription was a good one, that the case is curable, and that the second prescription must be a repetition of the former".[7] Dr Kent was of the opinion that the same potency could not be repeated on more than two occasions.

Hence, *Stramonium* in ascending potencies [200C, 1M] were prescribed which improved the presenting complaints of hypothyroidism. Within 16 months of successful homoeopathic treatment, her TSH level reached up to the normal range.

Date of visit	Symptoms/indications	Prescribed remedy with potency and doses
3rd September 2018	Trembling of hands, general weakness and hair fall. FT_4 =1.22 ng/dl TSH = 7.35 μIU/ml	*Stramonium* 200/ 1 dose. Placebo till 16th december 2018
17th December 2018	Amenorrhoea since 2 months but patient felt generally better. TSH = 5.65 μIU/ml Weight = 54 kgs	*Stramonium* 200/ 1 dose. Placebo till 13th march 2019
14th March 2019	Patient felt better. LMP = 10th March 2019 Weight = 52 kgs	Placebo till 26th june 2019
27th June 2019	General complaints were relieved, patient felt better but TSH level increased. T_3= 149 ng/dl T_4 = 7.25 μg/dl TSH = 6.680 μIU/ml	*Stramonium* 200/ 1 dose Placebo for 2 months
5th September 2019	Amenorrhoea since 2 months. TSH = 4.92 μIU/ml	Placebo for 3 weeks
14th October 2019	Reappearance of complaints. T_3 = 1.03 ng/dl T_4 =4.65 μg/dl TSH = 7.19 μIU/ml	*Stramonium* 1M*/ 1 dose Placebo till 29th december 2019
30th December 2019	Patient felt much better. $T_{3=}$ 1.07 ng/ml $T_{4=}$ 5.13 μg/dl TSH = 4.79 μIU/ml**	Placebo for 2 months.
*Increase of potency as per *Homoeopathic Philosophy* by Dr Kent.[7] **TSH level is about to reach within the standard normal range. *(see figure 3)* Patient's next follow up was due on 2nd March 2020 and she was on placebo till date.		

Discussion and conclusion

Thus, in early diagnosed cases of hypothyroidism, homoeopathy plays a positive and effective role in the disease prognosis through constitutional prescribing.

Hahnemannian classical approach aims at understanding the profile of the patient through a detailed case taking, and then using the individualising features of the patient in selecting a constitutional remedy.[8]

In the above case report, the patient was prescribed a constitutional medicine, *Stramonium*, selected on the basis of totality of symptoms covering maximum symptoms remarked by the patient. It was prescribed at regular intervals, in ascending potencies, and the case stands on placebo till date.

J.H. Clarke has remarked in his book '*A Dictionary of Practical Materia Medica, Vol-2*', '*Stramonium* is supposed to produce **"a marked and persistent disorder of the mental faculties**". Hahnemann has also attached a good deal of importance to this and quoted**, "allays some spasmodic movements and restores suppressed excretions in several cases in which absence of pain is a prominent symptom."** In addition to the absence of

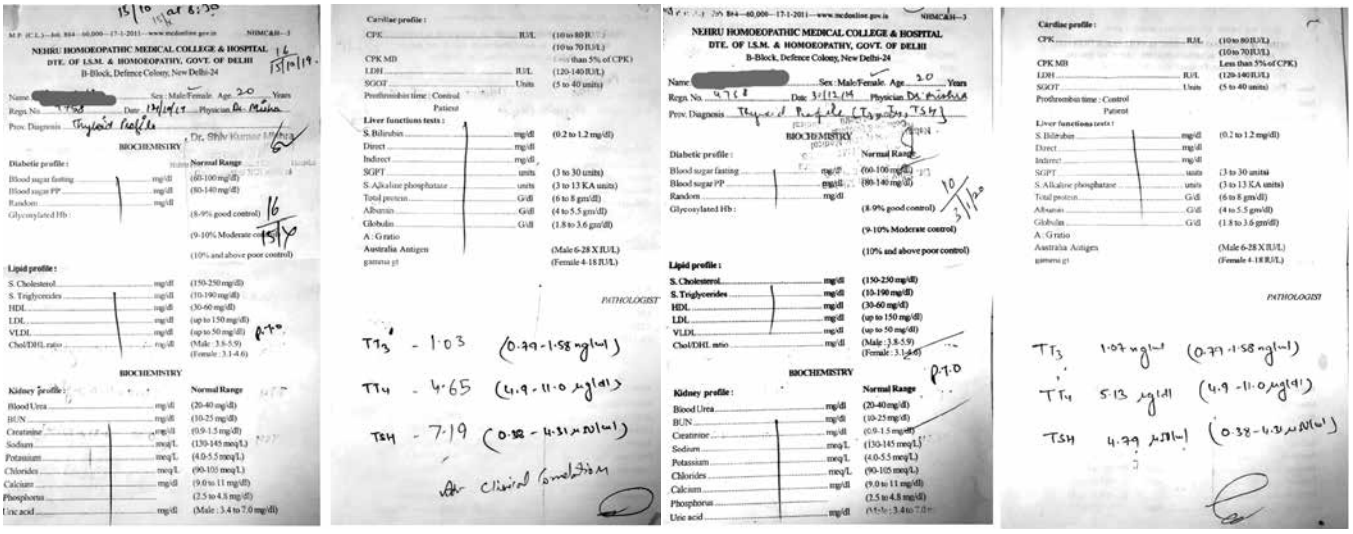


Figure 3

pain, there is an extreme muscular mobility (that affects muscles of expression and muscles of locomotion). The movements of *Stramonium* are generally gyratory and graceful when they occur in the arms. It is an excellent remedy in many cases due to suppressed secretions – menses, lochia, sweat, eruptions. The *Stramonium* patient is dependent on light and company; cannot walk in the dark. It is suited to ailments of young, plethoric persons, usually worse in evening, night, and dark while better in light and company'.[9]

This case illustrated the action of homoeopathic medicines in early diagnosed cases, especially in young patients, sufferinf from disorders like hypothyroidism including general weakness and pain in body. A comparative study can be carried out to assess whether treatment results vary with individualised medicines or with specific medicines for a clinical condition.

Acknowledgement

The author is expressing his gratitude towards '**Dr Anu Kapoor, Principal In-Charge, NHMC Delhi'**, for extending support regarding service to the patients and also acknowledge the participation and hard work of **Ms. Poorva Malakar,** Intern, at "lifestyle disorders" project, NHMC and H, in the session 2019-20, for her association in this case. The author is also thankful to the patient for her compliance and patience in regular follow-ups.

Declaration of patient consent

The author declares that they have obtained all appropriate patient consent forms. In the form, the patient has given written consent for her clinical information to be reported in the journal. The patient understands that her name will not be published and due efforts will be made to conceal her identity.

Financial support and sponsorship

Nil.

Conflicts of interest

The author has nothing to disclose and there are no conflicts of interest.

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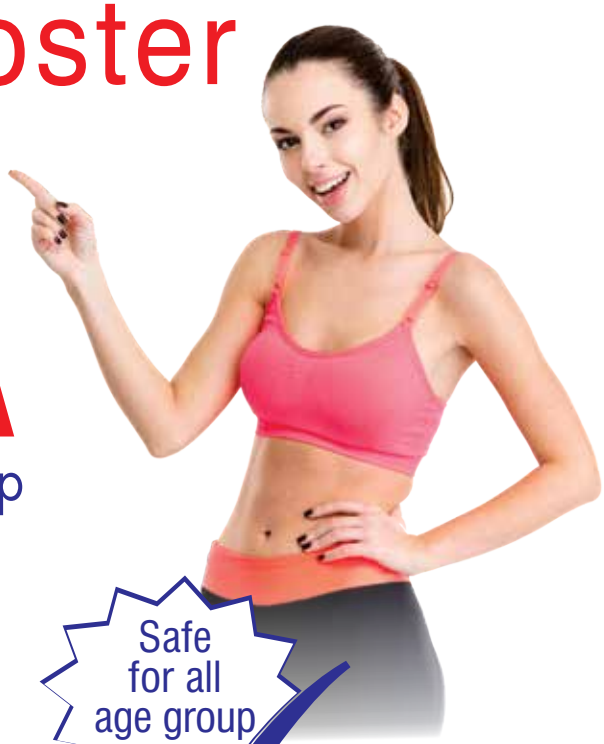

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Ammonium aceticum	1X	0.025 gm
Natrum phosphoricum	1X	0.01 gm
Kali phosphoricum	1X	0.0025 gm
Acidum citricum	1X	0.01 ml
Acidum phosphoricum	1X	0.01 ml
Glycerinum	Ø	0.25 gm
Syrup		0.50 ml
Alcohol content		5.4% v/v

Dosage : Adults & > 12 years old - 2 teaspoons (10ml), 3 times a day
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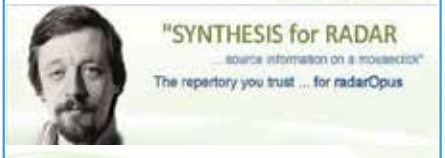

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Hashimoto's thyroiditis with migraine without aura: an evidence-based case report

Dr Nishant Daryani

Abstract: The present case report is an attempt to show the efficacy of homoeopathy in difficult cases. In the following case, patient approached to homoeopathy for treatment of hashimoto`s thyroiditis and migraine without aura after getting disappointed with modern medicine. At the time of consultation, TSH level was 12.27 μIU/ mL and anti TPO level was > 1300 IU/mL (levels >60 considered positive for hashimoto's thyroiditis), even after 3 years of modern medicine treatment. Midas scale was used to assess impact of migraine on patient's life. At baseline, midas score was 10 reflecting mild or grade II disability, with 15 days headache in past 3 months, and pain intensity remained between 3- 8 (pain scale was used to interpret pain intensity). The scale was repeated at 3 months interval to assess the treatment response.

The case was of one sided variety or in different layers, in which at the beginning, common symptoms of the disease were masking the constitutional symptoms of the patient. Initially, *Thyroidinum,* and later *Pulsatilla nigricans* were prescribed which brought complete restoration of health. From nearly, 1 year of homoeopathic treatment, the patient became completely asymptomatic, TSH level came down to normal limit,i.e. 3.25 μIU/ mL and anti TPO also came down to 58.6 IU/mL considered as negative for hashimoto's thyroiditis. The response of the homoeopathic treatment was encouraging and showed great scope in the area where our counterparts have limited answer.

Keywords: Hashimoto`s thyroiditis, individualisation, migraine without aura, *Pulsatilla nigricans, Thyroidinum.*

Abbreviations: Allo. (allopathy), anti TPO (anti-thyroid peroxidase), dL (decilitres), EMES (early morning empty stomach), IU (international units), mcg/µg (micrograms), kg (kilograms), µIU (micro international units), midas scale (migraine disability assessment scale), mL (milliliters), ng (nanograms), NCCT Head (non-contrast CT scan of head), NAD (nothing abnormal detected), TSH (thyroid stimulating hormone), Tt. (treatment), WHO (world health organization), < (aggravated by), > (ameliorated by), CT (computed tomography), wt. (weight).

Introduction

Hashimoto's thyroiditis or hashimoto's disease is an autoimmune disease of the thyroid gland, progressive in nature[1], whereas migraine is one of the most prevalent neurological disorders in the world. Globally, about 5-8% males and 11-14% females suffer from migraine and the number is increasing gradually[2].

Though both the conditions are non-life threatening, but they affect the quality of life of the patient, hampering routine activities and make them disabled[1, 2]. WHO ranks migraine among the world's most disabling illness[1].

The only answer modern medicine has for both the conditions is symptomatic relief by taking lifelong medication. There are lots of side effects of these medications as well[1, 2].

The *MIDAS* or *migraine disability assessment scale,* a test designed to assess the impact of migraine on patient's daily life, is being used, as approved by the International Headache Society and WHO.

Midas is a 7 questionnaire scale divided into 2 parts. The first 5 questions help to assess impact of migraine on patient's life in terms of limiting his/her activities at workplace, household, and social activities in last 3 months. The total of these 5 questions gives the midas score or disability score or impact of migraine on patient's life. Whereas 2nd part contains 2 questions that help to assess total number of days patient was suffering with headache in last 3 months as well as intensity of the pain[3]. The intensity of pain was assessed with the help of wong-baker faces rating scale, where 0 means no pain and 10 means worst pain[4].

Initially, information was collected from the patient about the migraine attacks in last 3 months, gives the baseline scoring, and then it was repeated every 3 month interval to assess the treatment response.

Case study

Mrs. MD, aged 37 years, housewife, suffering with hashimoto's thyroiditis from last 3 years and Migraine without aura from 1 ½ years.

Patient was apparently well 3 years back. She was a cheerful person, active doing her household activities very well. Gradually, her energy level went down, she used to get exhausted easily, and also developed aching pain in extremities. Condition got worse with the time which hampered her daily activities. She also developed sensitivity to cold, hairfall, body weight started fluctuating, difficulty in falling asleep, dryness of skin, coldness of palms and soles, heat sensation in soles at night. She consulted a modern physician where she was diagnosed as hashimoto's thyroiditis and started treatment accordingly. (thyronorm 25 mcg).

From last one and half years, she also developed hemicranial pains in either side, of mild to moderate intensity, lasting for 1-2 days, without any known cause except occasionally around menstrual cycle. Pains were associated with nausea and usually < in morning after rising from sleep and felt temporarily better by pressure and rest.

The frequency and intensity of episodes increased with the time, later on, diagnosed as migraine without aura and treated accordingly but without much relief in the condition.

Gradually, she became irritable and indifferent because of the pains and easy exhaustion.

Tablet thyronorm was started initially with 25 mcg dose, which gradually was raised to 100 mcg without any significant relief, and then patient decided to go for homoeopathic treatment.

Patient in person

She was 5 feet 3 inches, 54 kg, average built, wheatish complexion, chilly person (earlier ambithermal). Her thirst was average and she had desire for cold water/ drinks (earlier not specific).

Past history

Leucorrhoea, tt. with allo. off and on.

Family history

Father : vitiligo

Mother : hypothyroidism, migraine, taking allo.

Sister : hypothyroidism, taking allo.

Laboratory investigations

Baseline 27.09.2018 – (reports attached)

DIAGNOSTIC REPORT

SRL Diagnostics

CLIENT CODE : C000053855

CLIENT'S NAME AND ADDRESS : SRL PSC - JAIPUR, ADVANCE SUPER SPECIALITY CLINI S-72, MAHAVEER NAGAR, JAIPUR 302018, RAJASTHAN INDIA, 0141-4042123

SRL LIMITED, C/O AAKRITI LABS PVT LTD, A-430, AGRASEN MARG, MALVIA NAGAR, JAIPUR, 302017, RAJASTHAN, INDIA, Fax :, CIN - U74899DL1995PLC070603

PATIENT NAME :

PATIENT ID :

ACCESSION NO : 0099PI004918 AGE : 37 Years SEX : Female DATE OF BIRTH :

DRAWN : 27/09/2018 09:32 RECEIVED : 27/09/2018 12:57 REPORTED : 27/09/2018 14:04

REFERRING DOCTOR : DR. P P Patidar CLIENT PATIENT ID : 1506/16

Test Report Status Final	Results	Biological Reference Interval	Units
ENDOCRINOLOGY			
THYROID PANEL, SERUM			
T3	95.32	60.00 - 200.00	ng/dl
METHOD : CHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	5.47	5.10 - 14.10	µg/dl
METHOD : CHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH 3RD GENERATION	12.27 High	0.27 - 4.20	µIU/mL
METHOD : CHEMILUMINESCENCE, TWO STEP SANDWICH IMMUNOASSAY			

Test Method(s)

THYROID PANEL, SERUM: Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Hypothyroidism's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficiency is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH(3G) (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	9.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	8.4 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3, T4 and TSH.

T3 (ng/dL)	T4 (µg/dL)	TSH (µIU/mL)
Cord Blood: 30 - 70	1-3 days: 8.2 - 19.9	< 2 years - Not Established
New Born: 75 - 260	1 Week: 8.0 - 15.9	
1-5 Years: 100 - 265	1-12 Months: 6.1 - 14.9	
5 - 10 Years: 90 - 240	1 - 5 Years: 6.8 - 13.5	
10 - 19 Years: 80 - 210	5 - 10 Years: 5.5 - 12.8	

Bertis C.A., Ashwood E. R., Bruns D. E., Tietz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Lawrence A.M. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

End Of Report

Please visit www.srlworld.com for related Test Information for this accession

(T3 95.32 ng/dL, T4 5.47µg/ dL, TSH 12.27µIU/mL)

DIAGNOSTIC REPORT

SRL Diagnostics

CLIENT CODE : C000053855

CLIENT'S NAME AND ADDRESS : SRL PSC - JAIPUR, ADVANCE SUPER SPECIALITY CLINI S-72, MAHAVEER NAGAR, JAIPUR 302018, RAJASTHAN INDIA, 0141-4042123

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PATIENT NAME :

PATIENT ID :

ACCESSION NO : 0002PF075211 AGE : 37 Years SEX : Female DATE OF BIRTH :

DRAWN : 27/09/2018 09:32 RECEIVED : 28/09/2018 06:12 REPORTED : 28/09/2018 14:16

REFERRING DOCTOR : DR. P P Patidar CLIENT PATIENT ID : 1506/16

Test Report Status Final	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
ANTI-THYROID PEROXIDASE ANTIBODIES, SERUM			
ANTI-THYROID PEROXIDASE ANTIBODIES	>1300.00 High	< or = 60 (Negative) > 60 (Positive)	U/mL
METHOD : CHEMILUMINESCENCE,COMPETITIVE IMMUNOASSAY			

Interpretation(s)

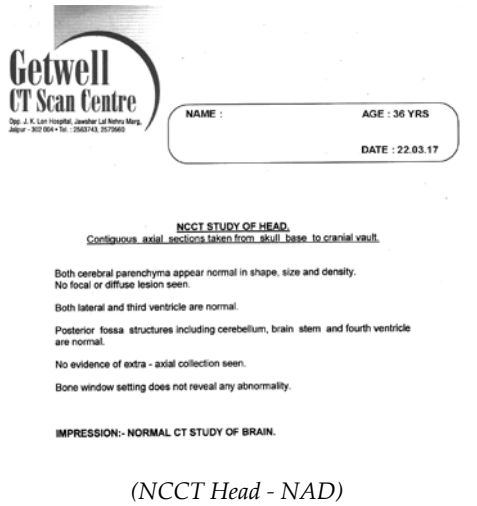
ANTI-THYROID PEROXIDASE ANTIBODIES, SERUM:

Anti-thyroid peroxidase (anti-TPO) antibodies are specific for the autoantigen TPO, a 103kDa glycoprotein that catalyses iodine oxidation and thyroglobulin tyrosyl iodination reactions in the thyroid gland. Anti-TPO antibodies are the most common anti-thyroid autoantibody, present in approximately 90% of Hashimoto's thyroiditis, 75% of Graves' disease and 10-20% of nodular goitre or thyroid carcinoma. It is considered as the gold standard for diagnosis of Chronic Autoimmune (Hashimoto) Thyroiditis. Also, 10-15% of normal individuals can have high level anti-TPO antibody titres.High serum antibodies are found in active phase chronic autoimmune thyroiditis. Thus, antibody titer can be used to assess disease activity in patients that have developed such antibodies.

End Of Report

Please visit www.srlworld.com for related Test Information for this accession

(Anti TPO > 1300 IU/mL)



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NAME : AGE : 36 YRS

DATE : 22.03.17

NCCT STUDY OF HEAD.

Contiguous axial sections taken from skull base to cranial vault.

Both cerebral parenchyma appear normal in shape, size and density.
No focal or diffuse lesion seen.

Both lateral and third ventricle are normal.

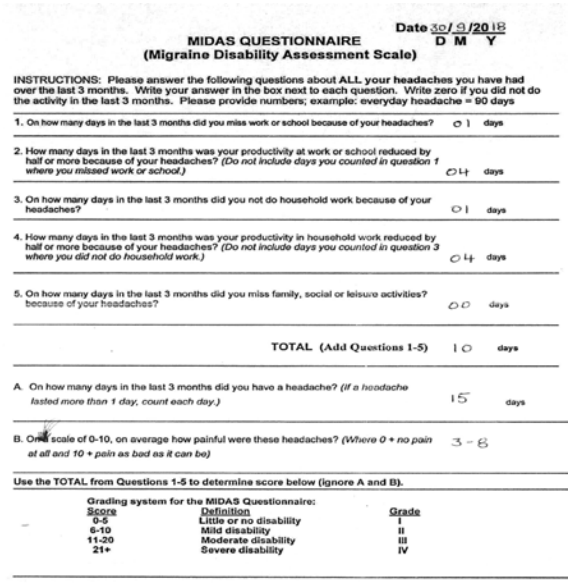
Posterior fossa structures including cerebellum, brain stem and fourth ventricle are normal.

No evidence of extra - axial collection seen.

Bone window setting does not reveal any abnormality.

IMPRESSION:- NORMAL CT STUDY OF BRAIN.

(NCCT Head - NAD)



Date 30/9/2018 (D M Y)

MIDAS QUESTIONNAIRE
(Migraine Disability Assessment Scale)

INSTRUCTIONS: Please answer the following questions about **ALL your headaches** you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months. Please provide numbers; example: everyday headache = 90 days

1. On how many days in the last 3 months did you miss work or school because of your headaches?	01	days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school.)*	04	days
3. On how many days in the last 3 months did you not do household work because of your headaches?	01	days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days you counted in question 3 where you did not do household work.)*	04	days
5. On how many days in the last 3 months did you miss family, social or leisure activities? because of your headaches?	00	days
TOTAL (Add Questions 1-5)	10	days
A. On how many days in the last 3 months did you have a headache? *(If a headache lasted more than 1 day, count each day.)*	15	days
B. On a scale of 0-10, on average how painful were these headaches? *(Where 0 = no pain at all and 10 = pain as bad as it can be)*	3-8	

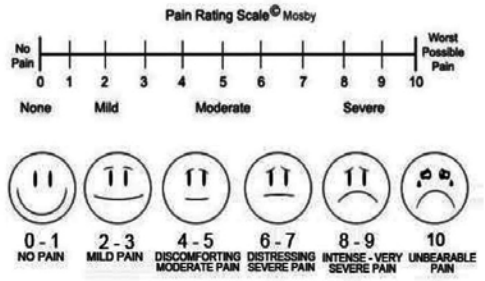
Use the TOTAL from Questions 1-5 to determine score below (ignore A and B).

Grading system for the MIDAS Questionnaire:

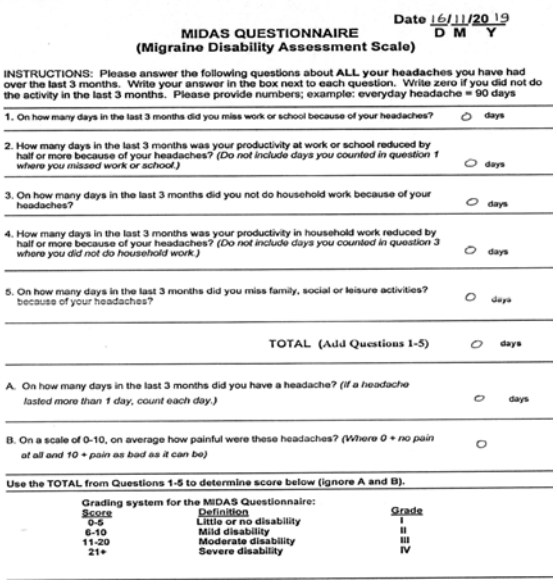
Score	Definition	Grade
0-5	Little or no disability	I
6-10	Mild disability	II
11-20	Moderate disability	III
21+	Severe disability	IV

(MIDAS scale – baseline – 30.09.18)

Migraine disability assessment score (continued)



(Pain scale)



Date 16/11/2019 (D M Y)

MIDAS QUESTIONNAIRE
(Migraine Disability Assessment Scale)

INSTRUCTIONS: Please answer the following questions about **ALL your headaches** you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months. Please provide numbers; example: everyday headache = 90 days

1. On how many days in the last 3 months did you miss work or school because of your headaches?	0	days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school.)*	0	days
3. On how many days in the last 3 months did you not do household work because of your headaches?	0	days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days you counted in question 3 where you did not do household work.)*	0	days
5. On how many days in the last 3 months did you miss family, social or leisure activities? because of your headaches?	0	days
TOTAL (Add Questions 1-5)	0	days
A. On how many days in the last 3 months did you have a headache? *(If a headache lasted more than 1 day, count each day.)*	0	days
B. On a scale of 0-10, on average how painful were these headaches? *(Where 0 = no pain at all and 10 = pain as bad as it can be)*	0	

Use the TOTAL from Questions 1-5 to determine score below (ignore A and B).

Grading system for the MIDAS Questionnaire:

Score	Definition	Grade
0-5	Little or no disability	I
6-10	Mild disability	II
11-20	Moderate disability	III
21+	Severe disability	IV

(MIDAS scale at end of tt – 16.11.19)

Totality of symptoms

- Irritability from contradiction
- Indifference to everything
- Chilly patient
- Desire cold drinks/cold water
- Weakness from exertion
- Weight: fluctuating
- Difficulty in falling asleep
- Dryness of skin
- Aching pain in extremities
- Coldness of hands
- Coldness of feet
- Heat feeling in soles at night
- Headache < morning after waking from sleep
- Hair fall
- Hashimoto's thyroiditis

Analysis and evaluation of symptoms

	Symptoms	Intensity
Mental generals	Irritability from contradiction	++
	Indifference to everything	++
Physical generals	Chilly patient	++
	Desire cold drinks/cold water	++
	Weakness from exertion	++
	Weight: fluctuating	+
	Difficulty in falling sleep	+
Particulars	Heat feeling in soles at night	++
	Aching pain in extremities	++
	Headache < morning after waking from sleep	++
	Coldness of hands	+
	Dryness of skin	+
	Coldness of feet	+
	Hair fall	+
	Hashimoto's thyroiditis	++

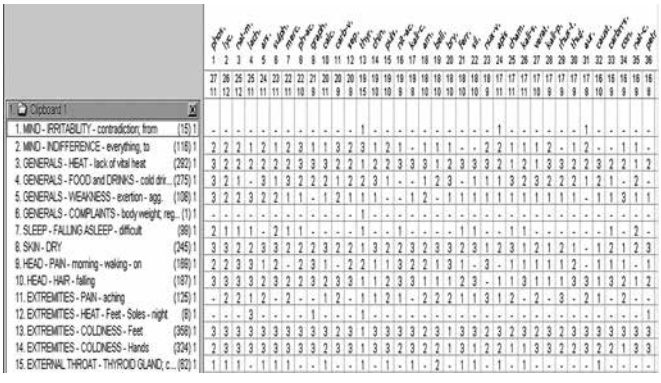
Miasmatic evaluation[5,6,7]:

S. No.	Presenting complaints	Psora	Sycosis	Syphilis
1.	Irritability from contradiction	+		
2.	Indifference to everything	+		+
3.	Chilly patient	+		
4.	Desire cold drinks/ cold water			+
5.	Weakness from exertion	+		
6.	Weight: fluctuating	+		+
7.	Difficulty in falling asleep	+		
8.	Dryness of skin	+		
9.	Aching pain in extremities			+
10.	Coldness of hands	+		
11.	Coldness of feet	+		
12.	Heat feeling in soles at night	+		+
13.	Headache < morning after waking from sleep	+		
14.	Hair fall	+		
15.	Hashimoto's thyroiditis	+	+	+
	Marks obtained by each miasm	**14**	**1**	**6**

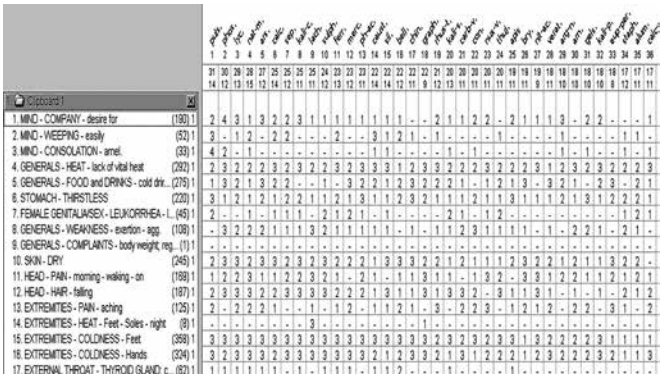
Predominate miasm: Psora-syphilis

Repertorisation – through RADAR 10.5 software using *Synthesis Repertory*

(Figure -1)[8]



(Figure - 2)[8]



Selection of medicine

1. After repertorisation, *Phosphorus* 27/11, *Lycopodium clavatum* 26/12, *Natrum muriaticum* 25/12, *Lachesis mutus* 25/11, and *Arsenicum album* 24/11 were neck to neck, but because the case or the totality was full of common symptoms of the disease and lacking individualistic or constitutional symptoms, selection of constitutional medicine was avoided, and ***Thyroidinum*** 19/15 was selected being one of the most common medicine for thyroid disorders, and moreover, it was the only medicine covering the complete repertorial totality. Because of predominantly common symptoms in the case, the prescription was made in medium potency or 30C potency and repetition was done till the case improved satisfactorily ***(figure – 1)***[8,9,10,11,12,13].

2. Even after raising the potency of *Thyroidinum* when no further positive change in the condition was observed rather symptoms took reverse direction, the case was reassessed and re-repertorised including the new symptoms in the totality like company desires, weeps easily, consolation amelioration, thirst reduced, leucorrhoea bland. And symptoms that were relived like irritability from contradiction, indifferent to everything and sleep difficult were excluded from the totality[8,9,12].

   Now, after repertorisation, with the new totality

Thyroidinum no more existed in chart, and ***Pulsatilla nigricans*** which was on 15th position previously, now covered the maximum totality and was on the top position ***(figure – 2)***[8], also company desires, weeps easily, consolation amelioration, thirst reduced, leucorrhoea bland, and changeability in symptoms are characteristic of *Pulsatilla nigricans*[5,6]. So, *Pulsatilla nigricans* was selected for the case.

Date	Symptoms	Prescription
30.09.18	At baseline - TSH 12.27 μIU/mL, anti TPO > 1300 IU/mL, CT scan head - NAD, MIDAS score 10 (grade II disability), 16 days headache in last 3 months, pain intensity between 3-8, wt. 54 kg ***(Figure - 1)*** (repertorial sheet enclosed)	*Thyroidinum* 30/ 2 x 14 days
14.10.18	Pain extremities >+, headache 1 episode – nausea >+ otherwise not much change	*Thyroidinum* 30/ 2 x 14 days
31.10.18	Pain extremities >+, weakness >+, irritability >+, sleep >+, hairfall >+, headache 1 episode, intensity >+, nausea >++	*Thyroidinum* 30/ 1 x 1 month
08.12.18	Pains extremities >+, weakness >+, irritability >++, sleep >++ (now can sleep without any problem), hairfall >+, headache - 3 episodes, intensity >+, no nausea in any episode. Some positive changes in patient`s behaviour were also observed by patient herself and family members like – she was now doing household work happily, liked to be in company, enjoyed going out, became more emotional – used to weep easily and relaxed when sympathised, wt. 53.4 kg	*Rubrum* 30/ 1 x 1 month
07.01.19	Condition: status quo, leucorrhoea – 10 days, no itching or burning. MIDAS score - 8, 12 days headache in past 3 months, pain intensity between 3 - 6.	*Thyroidinum* 200/1dose EMES Rubrum 30/ 2 x 14 days
24.01.19	Pain extremities+, leucorrhoea continued, headache - 2 episodes, intensity+, thirst – reduced now a days. Even after raising the potency when no positive change was observed in the condition rather symptoms took reverse direction, so the case was reassessed and repertorised ***(Figure-2)*** (repertorial sheet enclosed)	*Pulsatilla nigricans* 200[3,5,6]/1dose EMES *Rubrum* 30/ 2 x 14 days On the basis of following, *Pulsatilla nigricans* was given: covering maximum symptoms and getting maximum marks in repertorisation company desires, weeps easily, consolation amelioration, thirst reduced, leucorrhoea bland and changeability in symptoms ***(figure- 2)***
09.02.19	Pain extremities >+, leucorrhoea >+, hairfall >++, heat feeling in soles at night >+, headache - 1 episode, intensity >+	*Rubrum* 30/ 2 x 1 month
15.03.19	Pain extremities ↑↓ leucorrhoea ↑↓ headache – 2 episodes, intensity >+, wt. 52.3 kg	*Pulsatilla nigricans* 1M/1 dose EMES *Rubrum* 30/ 2 x 1 month
20.04.19	Heat feeling in soles >+, otherwise >++ in general, no headahce in between. MIDAS Score - 5, 7 days headache in past 3 months, pain intensity between 2 – 6. (Reports attached - TSH 5.27 μIU/mL, anti TPO 722.68 IU/mL)	*Rubrum* 30/ 2 x 1 month

19.05.19	Pain extremities+, headache - 2 episode, intensity+	*Pulsatilla nigricans* 10M/1 dose EMES *Rubrum* 30/ 2 x 1 month
26.06.19	>++ in general	*Rubrum* 30/ 2 x 1 month
31.07.19	>++ in general MIDAS score - 2, 4 days headache in past 3 months, pain intensity between 2 – 5.	*Rubrum* 30/ 2 x 1 month
05.09.19	Asymptomatic	*Rubrum* 30/ 2 x 1 month
12.10.19	Asymptomatic (Reports attached -TSH 3.25 µIU/mL, anti TPO 58.6 IU/mL)	*Rubrum* 30/ 2 x 1 month
16.11.19	Asymptomatic, wt. 50.9 kg (MIDAS scale attached – score 0, 0 days headache in past 3 months, pain intensity 0)	Advised to stop medicine and get investigations done at intervals of every 6 months and report if any problem occurs in future.

Laboratory investigations

20.04.2019


Kiran
Diagnostic & Research Centre
Opp. S.M.S. Hospital, Jaipur (Raj) • Phone : 0141-2373027, 2218446
KIRAN DIAGNOSTIC & RESEARCH CENTRE
Name :
Age : 37 Year(s) Sex : Female
Visit Date & Time : 20-04-2019 12:25PM
Reg. No. : 11634167
LIS / LAB No. : 11634167 / 12997
Ref. Doctor : Dr. Nishant Daryani
Ref. Lab/Hsp. : Kiran C.T & M.R.I Centre Jaipur
HORMONES & MARKERS
Name of the Test : Thyroid Profile
Methodology & Other Information
Method : Chemiluminescence
Type of Specimen : Serum
Instrument Used : CENTAUR XP/ UNICEL DXI 800
Reagent Kit : SIEMENS/ BECKMAN COULTER
REPORT
Investigations | Status | Result | Biological Reference Interval
T3 | 0.90 ng/ml | 0.69 - 1.81 ng/ml | Child - 1.2-2.27 ng/ml
T4 | 7.2 ug/dl | 4.59 - 10.90 ug/dl | Child - 6.9- 22.7 ug/dl
TSH (ULTRASENSITIVE) | 5.27 uIU/ml | Adult 0.38 - 5.33 | >20 Years
** End of Report **
Interpretation of TSH :
Kindly correlate with age & clinical findings.
Age | Children | Pregnancy
1 - 2 Days | 3.20 - 34.6 | 0.30 - 4.50 | 1st Trimester
3 - 4 Days | 0.70 - 15.4 | 0.50 - 4.60 | 2nd Trimester
15Days - 5 Months | 1.70 - 9.10 | 0.80 - 5.20 | 3rd Trimester
5Months - 20 Years | 0.70 - 6.40
Clinical Information :
Primary malfunction of the thyroid gland may result in excessive(hyper) or low(hypo) release of T3 or T4.In additional,as TSH directly affect thyroid function,malfunction of the pituitary or the hypothalamus influences the thyroid gland activity.Disease in any portion of the thyroid-pituitary-hypothalamus system may influence the level of T3 and T4 in the blood,in Primary hypothyroidism,TSH levels are significantly elevated,while in secondary and tertiary hypothyroidism,TSH levels may be low.IN addition,In Euthyroid sick Syndrom,multiple alterations in serum thyroid function test findings have been recognized.

(T3 0.90 ng/mL, T4 7.27 µg/dL, TSH 5.27 µIU/mL)

12.10.2019


Kiran
Diagnostic & Research Centre
Opp. S.M.S. Hospital, Jaipur (Raj) • Phone : 0141-2373027, 2218446
KIRAN DIAGNOSTIC & RESEARCH CENTRE
Name :
Age : 37 Year(s) Sex : Female
Visit Date & Time : 12-10-2019 12:09PM
Reg. No. : 11658697
LIS / LAB No. : 11658697 / 829
Ref. Doctor : Dr. Nishant Daryani
Ref. Lab/Hsp. : Kiran C.T & M.R.I Centre Jaipur
HORMONES & MARKERS
Name of the Test : Thyroid Profile
Methodology & Other Information
Method : Chemiluminescence
Type of Specimen : Serum
Instrument Used : CENTAUR XP/ UNICEL DXI 800
Reagent Kit : SIEMENS/ BECKMAN COULTER
REPORT
Investigations | Status | Result | Biological Reference Interval
T3 | 0.94 ng/ml | 0.69 - 1.81 ng/ml | Child - 1.2-2.27 ng/ml
T4 | 7.7 ug/dl | 4.59 - 10.90 ug/dl | Child - 6.9- 22.7 ug/dl
TSH (ULTRASENSITIVE) | 3.25 uIU/ml | Adult 0.38 - 5.33 | >20 Years
** End of Report **
Interpretation of TSH :
Kindly correlate with age & clinical findings.
Age | Children | Pregnancy
1 - 2 Days | 3.20 - 34.6 | 0.30 - 4.50 | 1st Trimester
3 - 4 Days | 0.70 - 15.4 | 0.50 - 4.60 | 2nd Trimester
15Days - 5 Months | 1.70 - 9.10 | 0.80 - 5.20 | 3rd Trimester
5Months - 20 Years | 0.70 - 6.40
Clinical Information :
Primary malfunction of the thyroid gland may result in excessive(hyper) or low(hypo) release of T3 or T4.In additional,as TSH directly affect thyroid function,malfunction of the pituitary or the hypothalamus influences the thyroid gland activity.Disease in any portion of the thyroid-pituitary-hypothalamus system may influence the level of T3 and T4 in the blood,in Primary hypothyroidism,TSH levels are significantly elevated,while in secondary and tertiary hypothyroidism,TSH levels may be low.IN addition,In Euthyroid sick Syndrom,multiple alterations in serum thyroid function test findings have been recognized.

(T3 0.94 ng/mL, T4 7.7 µg/dL, TSH 3.25 µIU/mL)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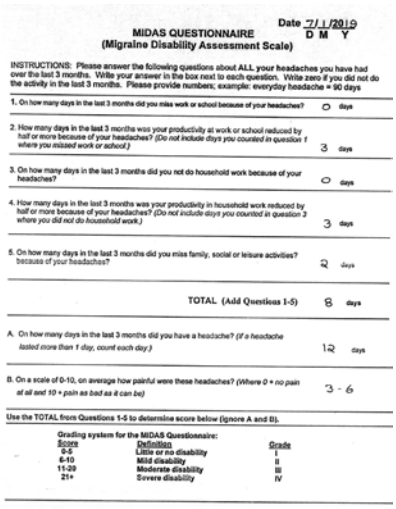
Diagnostic & Research Centre
Opp. S.M.S. Hospital, Jaipur (Raj) • Phone : 0141-2373027, 2218446
KIRAN DIAGNOSTIC & RESEARCH CENTRE
Name :
Age : 37 Year(s) Sex : Female
Visit Date & Time : 20-04-2019 12:25PM
Reg. No. : 11634167
LIS / LAB No. : 11634167 / 12997
Ref. Doctor : Dr. Nishant Daryani
Ref. Lab/Hsp. : Kiran C.T & M.R.I Centre Jaipur
HORMONES & MARKERS
Name of the Test : THYROID PEROXIDASE ANTIBODIES (TPO)
Methodology & Other Information
Method : Chemiluminescence
Primary Sample : Serum
Instrument Used : CENTAUR XP/ UNICEL DXI 800
Reagent Kit : SIEMENS/ BECKMAN COULTER
REPORT
Investigations | Status | Result | Biological Reference Interval
Thyroid Peroxidase Antibodies (Anti - TPO) | H | 722.68 IU/ml
** End of Report **
Clinical Information :
Thyroid peroxidase (TPO) is an intergal membrane homoprotein which catalyzes the iodination of thyroglobulin (Tg), as well as the coupling of two di-iodotyrosine residues in the Thyroglobulins (Tg) molecule to form thyroxine. Antibodies to thyroid peroxidase have been shown to be characteristically present from patient with Hashimoto's thyroiditis (95%), Idiopathic Myxedema (90%) and Graves Disease (80%). The titres do not correlate with thyroid functional states. However, there is good correlation between the degree of lymphocytic-infiltaration of the thyroid gland and the presence of TPO antibodies. The Anti-TPO is a diagnostic aid. A definite clinical diagnosis should not be based on the results of a single test, but be made by the Physician after all clinical and lab. Finding have been evaluated.

(Anti TPO - 722.68 IU/mL)


Kiran
Diagnostic & Research Centre
Opp. S.M.S. Hospital, Jaipur (Raj) • Phone : 0141-2373027, 2218446
KIRAN DIAGNOSTIC & RESEARCH CENTRE
Name :
Age : 37 Year(s) Sex : Female
Visit Date & Time : 12-10-2019 12:09PM
Reg. No. : 11658697
LIS / LAB No. : 11658697 / 829
Ref. Doctor : Dr. Nishant Daryani
Ref. Lab/Hsp. : Kiran C.T & M.R.I Centre Jaipur
HORMONES & MARKERS
Name of the Test : THYROID PEROXIDASE ANTIBODIES (TPO)
Methodology & Other Information
Method : Chemiluminescence
Primary Sample : Serum
Instrument Used : CENTAUR XP/ UNICEL DXI 800
Reagent Kit : SIEMENS/ BECKMAN COULTER
REPORT
Investigations | Status | Result | Biological Reference Interval
Thyroid Peroxidase Antibodies (Anti - TPO) | 58.6 IU/ml
** End of Report **
Clinical Information :
Thyroid peroxidase (TPO) is an intergal membrane homoprotein which catalyzes the iodination of thyroglobulin (Tg), as well as the coupling of two di-iodotyrosine residues in the Thyroglobulins (Tg) molecule to form thyroxine. Antibodies to thyroid peroxidase have been shown to be characteristically present from patient with Hashimoto's thyroiditis (95%), Idiopathic Myxedema (90%) and Graves Disease (80%). The titres do not correlate with thyroid functional states. However, there is good correlation between the degree of lymphocytic-infiltaration of the thyroid gland and the presence of TPO antibodies. The Anti-TPO is a diagnostic aid. A definite clinical diagnosis should not be based on the results of a single test, but be made by the Physician after all clinical and lab. Finding have been evaluated.

(Anti TPO - 58.6 IU/mL)

MIDAS scale[3]



MIDAS QUESTIONNAIRE
(Migraine Disability Assessment Scale)

Date 7/1/2019 D M Y

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months. Please provide numbers; example: everyday headache = 90 days

1. On how many days in the last 3 months did you miss work or school because of your headaches? 0 days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.) 3 days
3. On how many days in the last 3 months did you not do household work because of your headaches? 0 days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.) 3 days
5. On how many days in the last 3 months did you miss family, social or leisure activities? because of your headaches? 2 days

TOTAL (Add Questions 1-5) 8 days

A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.) 12 days

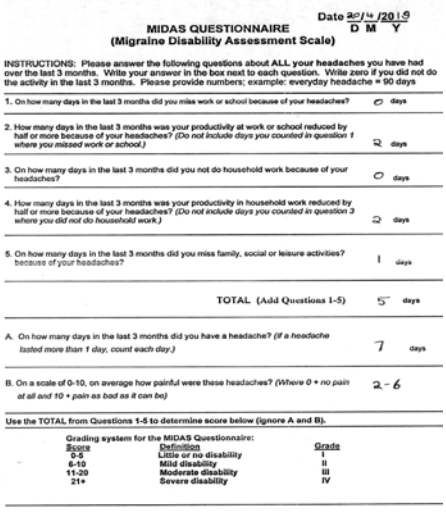
B. On a scale of 0-10, on average how painful were these headaches? (Where 0 = no pain at all and 10 = pain as bad as it can be) 3-6

Use the TOTAL from Questions 1-5 to determine score below (ignore A and B).

Grading system for the MIDAS Questionnaire:

Score	Definition	Grade
0-5	Little or no disability	I
6-10	Mild disability	II
11-20	Moderate disability	III
21+	Severe disability	IV

(07.01.2019)



MIDAS QUESTIONNAIRE
(Migraine Disability Assessment Scale)

Date 20/4/2019 D M Y

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months. Please provide numbers; example: everyday headache = 90 days

1. On how many days in the last 3 months did you miss work or school because of your headaches? 0 days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.) 2 days
3. On how many days in the last 3 months did you not do household work because of your headaches? 0 days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.) 2 days
5. On how many days in the last 3 months did you miss family, social or leisure activities? because of your headaches? 1 days

TOTAL (Add Questions 1-5) 5 days

A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.) 7 days

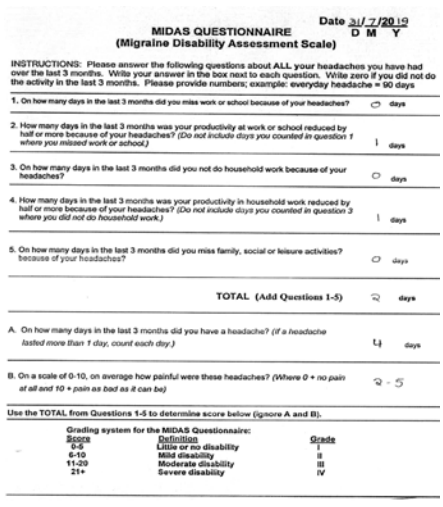
B. On a scale of 0-10, on average how painful were these headaches? (Where 0 = no pain at all and 10 = pain as bad as it can be) 2-6

Use the TOTAL from Questions 1-5 to determine score below (ignore A and B).

Grading system for the MIDAS Questionnaire:

Score	Definition	Grade
0-5	Little or no disability	I
6-10	Mild disability	II
11-20	Moderate disability	III
21+	Severe disability	IV

(20.04.2019)



MIDAS QUESTIONNAIRE
(Migraine Disability Assessment Scale)

Date 31/7/2019 D M Y

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months. Please provide numbers; example: everyday headache = 90 days

1. On how many days in the last 3 months did you miss work or school because of your headaches? 0 days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.) 1 days
3. On how many days in the last 3 months did you not do household work because of your headaches? 0 days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.) 1 days
5. On how many days in the last 3 months did you miss family, social or leisure activities? because of your headaches? 0 days

TOTAL (Add Questions 1-5) 2 days

A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.) 4 days

B. On a scale of 0-10, on average how painful were these headaches? (Where 0 = no pain at all and 10 = pain as bad as it can be) 2-5

Use the TOTAL from Questions 1-5 to determine score below (ignore A and B).

Grading system for the MIDAS Questionnaire:

Score	Definition	Grade
0-5	Little or no disability	I
6-10	Mild disability	II
11-20	Moderate disability	III
21+	Severe disability	IV

(31.07.2019)

Discussion and conclusion

Like other auto-immune diseases, hashimoto's thyroiditis too is a challenging disease to be treated by any system of medicine. The case becomes more challenging when associated with migraine (another difficult condition to treat). The outcome of the present evidence based case report is highly encouraging, showing the efficacy of individualised homoeopathic medicine in enhancing/ stimulating body's immune system, i.e. self-regulatory mechanisms over the particular or pathological/ diagnosis basis.

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Role of homoeopathy in autoimmune haemolytic anaemia

Dr Subhash Chaudhary, Dr Chandni Singh and Dr D. Basu

Abstract: This article deals with autoimmune haemolytic anaemia which is one of the lesser known yet important autoimmune diseases in clinical practise. The article outlines the approach towards understanding and treatment of autoimmune haemolytic anemia with homoeopathic system of medicine. It integrates the knowledge of *Organon of Medicine*, homoeopathic materia medica and homoeopathic repertory for better management of such cases of anaemia; and also provides some basic information on pathology, manifestations, and diagnosis of this type of anaemia.

Keywords: Anaemia, autoimmune haemolysis, splenomegaly, jaundice, coomb's test.

Abbreviations: autoimmune haemolytic anaemia (AIHA), fragment crystallizable (Fc), systemic lupus erythematosus (SLE), red blood cells (RBC), *Trinitrotoluene (TNT).*

Introduction

Autoimmune diseases are characterised by sustained and persistent immune response against self-constituents of the body and the breakdown of tolerance.[1] The response of such diseases to homoeopathic treatment is known to be encouraging.

There are various autoimmune diseases which one comes across on daily basis in clinical practise which include various multisystem diseases like rheumatoid arthritis, systemic lupus erythematosus, as well as organ specific diseases like autoimmune thyroiditis. In the field of haematological diseases, the most important autoimmune disease is autoimmune haemolytic anaemia. Though this mechanism is an important reason for anaemia in patients, it is often overlooked. Apart from nutritional deficiency, bone marrow failure, congenital haemolytic disorders, there are several reasons which can be considered for diagnosis of the mechanism for anaemia in a patient. AIHA is one of them.

Pathology

Autoimmune haemolytic anaemia is caused by autoantibody directed against the red cell antigen that is molecules present over the red cell membrane. Once the auto-antibody binds to the red cell, the fragment crystallizable region (Fc) portion of the antibody is recognised by the Fc receptors of the macrophages leading to erythrophagocytosis.[2]

AIHA is often idiopathic but several diseases like SLE and lymphoproliferative (lymphoma/ lymphocytic leukaemias) diseases are to be considered as underlying mechanism. Several modern medical agents may also be responsible.

AIHA can be isolated or can be a part of other autoimmune diseases such as SLE. One of the associated haematological autoimmune diseases is autoimmune thrombocytopenia. This combination is called Evan's syndrome.[2]

Clinical aspects

Clinical presentation of AIHA is a combination of anaemia, splenomegaly and jaundice. Anaemia depends on the extent of haemolysis. When anaemia becomes prominent, pallor appears. When haemolysis becomes prominent, jaundice may appear but may not be present in all cases. Since the haemolysis occurs in the spleen, the patient often suffers from splenomegaly.

From immunological point of view, there are two sub-types of AIHA depending upon the temperature in which the auto-antibodies are most active, known as warm and cold varieties of AIHA.[3] The clinical importance of this distinction is limited as both varieties may result in disease manifestation of AIHA.

Laboratory diagnosis

Diagnosis can be confirmed by the direct coomb's Test. The physician advising for the coomb's test must remember to specify that the direct Test is required, otherwise the laboratory is likely to perform the indirect test, to investigate maternal blood for Rh incompatibility during pregnancy.[2]

Homoeopathic approach

Homoeopathic treatment is based on a fundamental principle of individualisation, which is to be followed in every case. It is essential for homoeopathic physicians to approach on the principle of individualisation in cases of autoimmune haemolytic anaemia, since each case has its own fundamental miasm and peculiar totality.

To understand the miasmatic background of this disease condition, it is important to study the disease process which is destructive in nature. In this disease, the **destruction** of red blood cells (RBC) leads to the anaemia, so the dominant miasm is **syphilitic**.[4]

AIHA being an autoimmune, chronic disease, it is essential for physicians to find the fundamental miasm of each individual case. This AIHA cases may have predominance of either psora, sycosis or syphilis, and can even be mixed miasmatic, depending upon the case.

Since in this disease, the destruction of RBC is taking place in spleen, therefore those remedies having affinity for spleen and blood dyscrasias can be best utilised in these cases.

The remedy which would cover the generalities of the individual case along with the underlying miasm, and has its sphere of action on blood dyscrasia would be the most appropriate remedy.

Some homoeopathic medicines which have their affinity to control the RBC dyscrasias and which help to improve anaemia are as follows:

1. *Trinitrotoluene (TNT):* has destructive action of TNT on RBC, and is responsible for anaemia and jaundice with their secondary symptoms.[5]
2. *Crotalus horridus:* for general disorganisation of the blood, haemorrhages and jaundice. Blood decomposition, haemorrhagic diathesis. Distended, pain in region of liver.[5]
3. Lachesis *mutus*: decomposition of red blood cells rendering it more fluid, leading to haemorrhage, haemorrhagic tendency, liver region sensitive and painful. [5]
4. *Ceanothus americanus:* it is splenic remedy of par excellence, painful inflammation, or enlarged spleen, either alone or with other affections, indicate its use; chilliness, principally down back; shivering; rigors,< in cold weather. Low spirits with splenic affection. [6]
5. *Cinchona officinalis: China officinalis,* placed by Teste in the *Ferrum* group along with *Plumbum metallicum, Phosphorus, Carbo animalis, Zincum metallicum,* and others, which not only "have the property of remaking the altered blood, or increasing for the time being in a healthy person, the relative amount of haematin, globulin, fibrin, etc.", but also, "after certain lapse of time, they produce opposite results such as impoverishment, discolouration and liquification of the blood." Spleen is aching and sore, liver is swollen and sensitive.[6]

In various repertories also, which are in use today, there are so many medicines mentioned for anaemia, any of which may be used. The following search was made to identify rubrics and sub-rubrics that are more explicit and mention about autoimmunity in repertories:

In *Complete Repertory*, in chapter "SKIN: discoloration, yellow, jaundice, icterus, etc. haemolytic" and in chapter, "GENERALITIES: anaemia, hemolytic" is being mentioned.[7]

In *Synthesis Repertory*, in the chapter "ABDOMEN", rubric "spleen-accompanied-anemia", in chapter, "GENERALS, rubric "anemia-progressive" etc. may be considered for auto-immune haemolytic anemia. The chapter "ACUTE DISEASES" also constitute a rubric "hematological disorder-anemia-hemolytic anemia".[8]

In *BBCR Repertory*, in chapter "ABDOMEN- LIVER and region of liver, complaints of- accompanied by-anemia", "ABDOMEN-SPLEEN; complaints of-accompanied by- anemia", "GENERALS-ANEMIA".[9]

Conclusion

It is quite clear that just as in so many other autoimmune diseases, homoeopathic medicines have a significant role to play in the management of autoimmune haemolytic anaemia. For proper documentation of the improvement achieved, it is essential that the disease is confirmed through direct coomb's test. In severe conditions, the patients need to be advised for blood transfusion, along with the help of homeopathic treatment, aiming that the frequency of such blood transfusions may get reduced. But the physician needs to be aware about the nature of the disease and its clinical manifestations to be able to select the homoeopathic medicine.

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Dr D. Basu *(Prof. & HOD), MBBS, PhD, Department of Practice of Medicine, National Institute of Homoeopathy, Kolkata. An autonomous institution under Ministry of AYUSH, (Govt. of India)*

A homoeopath's totalistic viewpoint-some observations on diabetes mellitus**

Dr Sarabiiai Kapadia, B.SC., D.M.S., Bombay

At an academic level, full consideration of all aspects cannot justify the assertion that by merely maintaining the blood glucose at normal level, everything that is necessary (for the restoration of health), has been achieved. Rather, the present therapeutic knowledge of the modern science has been able to provide with means only to deal with this aspect of controlling blood sugar, *and nothing more.*

It is observed that diabetic patients inherit a constitution where there is a tendency for certain peculiar pathological changes in the blood vessels. The changes in the large vessels—macroangio pathology, as well as changes in the capillaries—microangio pathology are recognized. These same people tend to develop a fault mainly in the beta cells of the pancreas, resulting in insufficient production of insulin. Without insulin, carbohydrate utilisation is wanting, and gradually a total failure occurs when fat (which is burnt in the fire of the carbohydrates) also remains unutilized. This results into a toxic state, due to these unutilizcd substances and leads to coma, and death thereafter. This coma which was responsible for 64% of the deaths of diabetic persons (50 years ago) has been prevented by the use of insulin. Many diabetics now live longer.

However, it is doubtful whether the vascular changes have decreased as a result of the use of insulin. Not only so, on the contrary, it is feared that they may appear earlier, and faster, with the use of insulin. Some oral anti-diabetic drugs have been suspected to be enhancing cardiac troubles.

Diabetic angiopathies and related neuropathy are the main features to be dealt with during the clinical treatment of diabetes. It is not certain whether the vascular factor is a primary inherited disorder and related changes (mainly in the pancreas) are the secondary effects, 'which breed the failure of the carbohydrate metabolism, i.e. insulin deficiency. Or whether, the carbohydrate consumption deficiency is primary, and vascular changes are secondary to it. It is also felt that, may be, both are separately carried. Lately the emphasis on hereditary factor seems to have been diluted, particularly in the cases of juvenile diabetes. A very common innocuous virus (Coxsackie B4) has been suspected to be damaging the pancreas in the youngsters.

It is also interesting to note that insulin, which in small quantities is able to prevent and certainly cure hyperglycaemic coma, in larger doses produces hypoglycaemic coma. The pictures of both coma are so very similar to each other that one kind of coma is likely to be mistakenly treated for the other. Many such fatal errors have, indeed, been recorded. It **is** necessary to explore whether our law of cure—similia similibus curentur—is in some way involved.

Under present allopathic treatment, it is this area of preventing death with insulin, that the treatment of diabetes is most effective. It is this singular success in postponing coma and thereby death) that the use of insulin has been most spectacularly succesful. However, probably a price has to be paid in terms of accelerating the disorders with macroangiopathy and microangiopathy.

People, suffering from infection fostered, and infection fostering, diabetes mellitus, have poor resistance, mainly to streptococcus infections, and ultimately to tuberculosis (our latent psora). It should be worthwhile inquiring whether it is this low resistance that is inherited, and if other complications are based on it.

It is held that some of the untoward effects of insulin may be due to the unavoidable impurities in the available preparations of insulin. Apart from impurities, carbolic acid, in small amounts, is intentionally added to prevent putrefaction. We know Carbolic acid as a drug capable of inducing painless gangrene.

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* The section of Old Archives is presented to the readers in the original form to maintain the originality of the articles with no editorial changes in respect to grammar, language and spellings.

** Presented at the monthly meeting of HMAI, Bombay (North Bombay and Midtown Units), and also at the meeting of Indian Institute of Homoeopathic Physicians, Bombay.

The possibility that a virus can affect the pancreas was long realised by our science. Parotidinum, a virus nosode, had cured/a case of diabetes. Dr. Tyler, while taking notice of the same, points out to the possibility of such other nosodes in the following manner:

"Dr. X, impressed by his results with the nosodes of previous acute diseases in difficult chronic conditions, tells of two cases of diabetes which had not been progressing favourably in spite of careful prescribing.

"No. 1 suffered from neuritis and rheumatism of thighs, of several years' duration. After 3-6 hourly doses of Parotidinum 30, the rheumatism vanished and has not returned during the last 5 months. The blood sugar has not been tested owing to war conditions.

No. 2 had a severe aggravation, and then clinical improvement. These cases are merely suggestive."

"Let us carry the matter further, on the same lines. If pancreatitis may start in infectiouS diseases, as enteric, pyaemia, septicaemia, and may entail diabetes, goitre, etc., we have also to consider."

In order to provide a direction for such research, I place before you some concepts which should enable us to take a totalistic view of diabetes and give proper place to the blood glucose level, alongwith some typical cases from my clinical experience, which deal with various aspects of diabetes.

Maturity onset diabetes—an adaptation syndrome

When a person who is physically active and has good digestion, joins business as an executive, in contrast to his decreasing physical activity, his intake of food continues to remain the same, or even increases. This leads to obesity resulting from deposits of the extra calories. However, a stage of saturation comes for the holding powers of the entire organism and an opening for throwing off the excess becomes a necessity. It has to be done in one or the other way. One of the several ways, by which the organism manages this physiological situation, is diabetes. During the initial state of rising level of blood glucose which is recognised as a chemical diabetic state, increasing obesity is observed. The same excess on reaching another limit then finds a vent and sugar starts passing in urine, an overt stage of diabetes. So the maturity onset diabetes is in a way 'an adaptation syndrome' to the excess of calorie absorption over the years. Naturally the 'whole situation' takes a particular shape depending upon the hereditary characteristics, the beta cells of the pancreas being in some way vulnerable contribute to the outline of the emerging picture.

Physical activity and insulin requirement

A certain level of blood glucose is a single aspect of a total `homoeostasis'. Homoeostasis involves a multiple of factors each of them involves autonomous counter balancing processes. It is well-known that glucose level is affected over and above that of pancreas by the secretions from pituitary, thyroid, adrenal glands and the functioning of liver; not only. that, it is also affected by the functions of muscles. Increased physical activity needs increased utilisation of glucose; however, increased physical activity reduces the need of insulin. The questions of biological processes are not mathematical like that of physics and chemistry.

Restricted diet and increase in physical activity is the key to the true control of diabetes. Use of any drug for control of blood sugar should not mislead and divert the attention of the patient from this fundamental issue.

Juvenile diabetes : depression of beta cell function

With this vulnerability of the beta cells of the pancreas, inherited from both the parents, one becomes a candidate for juvenile diabetes. Juvenile diabetes seems to be truly based on depressed function of the beta cells of the pancreas. This may be due to any of the acute miasmatic influences taking toot on the susceptibilities nourished by the chronic miasm or certain deep acting drugs.

Ketone in urine and fasting

Ketosis may not simply be an extension of carbohydrate failure. During fasting, some persons pass ketone sooner than others without raised glucose levels in blood or glucose in the urine. Ketosis proneness is the major distinguishing criteria of juvenile and maturity onset diabetes. The key factor in the production of both the states may be partly different. The presence of both the tendencies should be responsible for a very complicated situation of ketosis.

Clinical experiences

It is generally held, very strongly, that suppurations in a diabetic person will not show a tendency to heal as long as abnormality at the carbohydrate metabolism continues. Therefore, use of insulin, or any anti-diabetic drug, is considered of paramount importance even by some homoeopaths. My experiences over the past many years lead me to the conclusion that this is not so.

I have seen suppurative conditions cured, although the urine examinations showed persistent presence of glucose. I had not been, therefore, quite rigid in insisting upon the administration of insulin. If the patient has not been on insulin, I do not put him on it, regardless of the level of glucose in blood or urine. If he was already on insulin, reducing the dose of insulin, so as to produce a slight state of deficiency (which should prove stimulating to the system) was employed by me in some cases.

My latest experiences show that insulin, probably, stands in the way of proper healing, and therefore, I am inclined to discontinue its use totally. This discontinuation should be effected in a gradual manner. For diabetic ketosis, result of extreme overt diabetes, insulin injected to control the blood sugar and rectify the failing metabolism, is the only way so far known. Thus, it is necessary to remain on watch and ensure absence of ketone in the urine, during such treatment. I have known such cases becoming very serious in the hands of homoeopathic physicians. Resorting to this palliative restoration of extremely overt diabetes with ketosis should be done without hesitation, due to absence of better knowledge at present.

Case No. 1: A diabetic patient suffered from perianal abscess, with extreme sensitivity to pain. Pain was temporarily ameliorated by application of local heat. Guided by this modality the selection of Hepar sulphur was made. This promptly cured the condition.

On another occasion in the same patient, a painful palatal cyst was caused by a septic tooth. The pain was ameliorated by local application of cold as well as heat. Mercurius iodatus fiavds CM relieved the pain in a short time, and started a fever with rigor. However, the patient became well the next morning.

The same remedy cured a whitlow of the right middle finger that had destroyed a part of the nail. Within a period of 3 months, the nail was restored so well that no defect could be detected even during the most careful examination. The local modalities, and the right side, guided me to this prescription.

It is interesting to note that during all these episodes, the patient continued to pass glucose in his urine (yellow precipitate with Benedict's solution). No insulin, or any other medicine, was given.

Case No. 2: A 71-year-old man was having a carbuncle on the hip. The indurated area was about 3" in extent, all around. lie was previously treated with antibiotics, which had adverse effects on the renal function. He refused to take injections. The urine showed presence of glucose. He was grossly overweight, with a dry and rough skin, which was itching badly. He was put on Graphites 1M, 4 to 6 times a day. About 2 ozs. of pus could be expressed every day on pressing the surrounding area. Later on, he developed the following symptoms : (i) waking up frequently at night from sleep, (ii) scratching followed by burning.

Sulphur 1M was administered in repeated doses on the basis of these indications, considering the previous treatment with antibiotics. He made a good recovery and the subsequent three years' follow-up did not show any recurrence of suppuration.

Case No. 3: A woman, aged 32 years, sustained burns on both legs. This was a result of application of hot water bottle during the state of collapse, following a delivery of twins. The denuded surface on each leg was approximately 6 inches long and about $1^1/_2$" wide. The area dried up within a week, under Ars. alb. 1M, given in repeated doses. The condition, however, flared up with a rise of temperature after the patient had a hearty meal of *puranpoli* (an extremely high sugar content delicacy of Gujarati people). Phos. ac. and Calc. gave no relief. Silicea was finally selected on the basis of (i) fever with chill followed by perspiration (temp. rising upto 102°F-104°F), (ii) dirty white pus, resembling muddy milk, (iii) pain, Amel. by application of local heat, and (iv) offensive perspiration, which cured the condition.

All through the sickness, the urine showed the presence of glucose. Six months later, urine examination did not show any glucose. A follow up, ten years

after, had indicated absence of diabetes.

Case No. 4: Mr. B. V. P., aged 50, an uncontrolled diabetic for several years, came down with an attack of postero-lateral myocardial infarction. He was in a state of collapse, and had a slow pulse. He recovered well on Ant. tart. 1M in every four hours' given for two months. He was passing 2% to 4% sugar in the morning urine. At the end of two months, he came out with a small white pustule on his calf with a large dark pink areola. Ant. tart, was continued because his heart condition was improving. The pustule with pink areola enlarged considerably and evolved into a carbuncle. Ant. tart. was continued (interpretation: calf muscle in the place of the heart muscle). After three days, when this opened, there was an initial discharge of considerable quantity of pus following 'brick red pus' and ultimately copious discharge of bright red blood occurred. The allopathic consultants opined that unless Immediate antibiotic and insulin treatment was applied, a gangrenous condition would be the definite outcome.

As the patient had full faith in Homoeopathy he continued my treatment. At this stage he was put on Phos. 1M, every four hours. The discharge of blood gradually reduced and the ?wound healed in about 3 weeks. He was kept on Phos. 1M B.D. and thereafter it was continued in 10M, 50M & CM potencies for about two years. His diabetes, however, continued in almost the same severity.

Case No. 5: This male diabetic patient, 58 years age, had the suppuration on legs. He was an addicted smoker from his very young days. The surgeons had advised an amputation, the actual site of amputation to be determined at the time of the operation. The choice of site was between above knee, or below knee. The patient, obviously wasn't keen about either! The treatment was commenced with Arsenic alb. 1000, in repeated doses. After two weeks, Acid nitric 200 in repeated doses was given on account of the strong smell of urine. A few days later, the patient developed the symptom, perspiration on the side not lain on, and Thuja 1M was given for 2 days, in repeated doses. At this stage, the ulcer started bleeding copious, non-coagulable red blood. This occurred after the patient ate,several green chillies (he had a great craving for it). The purulent discharge thoroughly mixed with red blood gave a brick red appearance. Taking into account these symptoms, Phosphorus 1M was started and continued for 24 months, till the healing was complete.

During this period the patient was showing febrile reaction on and off, and with every such episode of fever, he showed further improvement. A sterile gauze was used as a dressing, throughout. No other local application was used. The opening continued to discharge masses of necrotic muscles throughout this period till the process of healing was completed. These ulcers and lesions were totally painless.

Case No. 6: A case of gangrene failed to respond to proper homoeopathic prescribing (in contrast to case No. 5). One fails to appreciate this failure and is inclined to take two probable causes which prevented the cure: (1) sympathectomy operation was performed on her earlier. (2) insulin was permitted to maintain control of the blood sugar.

Case No. 7: A chronically ulcerated bunion near the great toe was treated over a period of six months by me, where properly indicated remedies failed to bring about a permanent healing of the ulcer. Each time there was a recurrence of the ulceration after some signs of healing in response to the remedy given. The same person had earlier taken treatment from other homoeopathic physicians with similar experiences. During homoeopathic treatment, he was permitted to take anti-diabetic treatment as well.

Case No. 8: I have been suffering from diabetes since 1965 which was detected during a life insurance medical check-up—urine sugar giving a yellow precipitate with Benedict's solution. I had to resort to insulin in 1978, when I had started passing Ketone + + + over and above glucose + + + This crisis had occurred when there were long hours of fasting each day.

I suffered from ulceration of a bunion in May 1980 which was caused after a shoe bite. The ulcer developed into a deep crack and was oozing black offensive, sero-pus. This happened during the period when I was controlling my blood sugar with a diet, accompanied by regular injections of insulin. The ulcer became increasingly ugly, black, and was threatening to become a gangrene.

Several good prescriptions, after eliciting a healing response, failed to produce a total healing.

On the contrary, the ulcer kept on recurring and enlarging. For a period of eight months, this deterioration continued.

At this stage, I decided to discontinue insulin and resort to a stricter diet control. In approximately eight weeks' time, the ulcer healed completely. Though the skin in this area had remained slightly thickened, there was no recurrence of the ulcer for last one year. Sugar in the urine had gradually gone up to a dark brown colour on diastic showing over 2%. My fasting blood sugar estimate: 311 mg/c.c. Such cases have led me to conclude that insulin intake may be a serious impediment to the action of proper homoeopathic medicine at least in some cases. This is more so when suppurative and gangrenous condtions are threatening.

Case No. 9: in this note Shri Rawal, B.Sc. (Hons.), B.S.Ch.E., M.S.Ch.E., Michigan, U.S.A., aged 60 years (birth date: 3.4.1922); a consultant in pharmaceutical chemicals tells his own story.

The first detection of diabetes in my case was in August 1955. During the onset period one tablet of 500 mg of tolbutamide per day was prescribed. The dose was gradually increased and by the year 1965 I was taking three tablets of tolbutamide. Blood sugar after one hour of intake of glucose used to go as high as 200-250 mg. By 1970 the drug dose was four tablets of 500 mg tolbutamide and three tablets of phenformin; with this blood sugar after one hour of glucose intake used to be at the level of 150-170 mg. This dosage was continued till August 1972.

During 1962-72, off and on high blood pressure and ischemic pain along with high cholesterol were observed. Highest cholesterol at one time was 375 mg. For this and high blood pressure treatment from late Dr. Jal Vakil was taken. Blood pressure would sometime shoot up to 180-190/115.

Along with these troubles I used to have lumbago like pain in the back. This pain used to come at least twice a year. At one time it was so severe that hydrocortisone was injected in the lower rcgioh of spine. With this there developed a cervical spondylosis for which traction and use of belts on the neck were needed.

From August 1972 homoeopathic treatment was started; during the treatment every alternate month post lunch blood sugar was done. After one year, i.e. by August 1973 the antidiabetic drugs were gradually reduced to two tablets of 500 mg tolbutamide per day. By April 1974 the allopathic drug was completely stopped.

During this period of the treatment in the initial stage itself there was marked improvement in spondylosis and the use of the belt was abandoned. When the allopathic treatment was completely stopped the blood sugar level used to be fasting 95-110 mg, post lunch 120-140 mg; this level was maintained with normal diet with occasional intake of little bit of sweets. For five years the sugar level was maintained at the above mentioned level. During this period once in a year lumbago like pain used to occur but for this, one or two days of homoeopathic treatment sufficed to cure the same. This pain did not appear at all during the last two years.

Yearly cardiograms showed continuous improvement over the previous ones. Ischemic pain was gone and cholesterol level remained under 250 mg/c.c. Late 1979, the post lunch sugar was found to be at the level of 180 mg. This level again came down to normal at 130-140 mg within six months. During this period also no other drug was taken.

Before starting the homoeopathic treatment I used to get tired easily and stamina to work used to be at very low level. Because,of this treatment my tiredness is not there. I am now 10 years older but I am able to work 8-12 hrs. a day and even when my work includes occasional travelling, I work with greater ease and comfort in spite of suffering from asthma.

During this treatment, asthma appeared. I did not feel it at that time. From the beginning it was observed that my breathing was not normal. Treatment for asthma is being continued for the last three years. The heavy attacks are not there but morning and evening breathlessness comes occasionally. The treatment is continued for the same.

Therapeutic hints about the treatment of suppuration

There are several drugs recorded in repertory under abscesses, unhealthy skin and other places. However, we have quite a few drugs with well defined indications that enable us to control the suppurative processes and promote healing. Diabetes or no diabetes, the choice of the remedy should, as usual, be dictated by the general symptoms, especially the mental

state, if prominent., the site of suppuration (side), direction of spread, the character of the pus, and the local sensations along with concomitant symptoms and their modalities.

The modalities of heat and cold are of prime importance in determining the remedy. Effects of heat and cold stated by the patient, based on his offhand impressions. may be erroneous. Therefore, it is important to determine them by actual testing with the application of heat as well as cold to the painful part and be absolutely certain about them. I shall narrate a case to indicate the significance of this.

Mr. Das, a middle aged man, suffered from right sided hydrothorax of undetermined aetiology. He was operated upon his thorax, with removal of three ribs. Subsequently, chest fluid was tapped, three times, before he came under my treatment. I do not recollect the remedies administered in the beginning to which he responded partially. There was some slowing down in the collection of fluid; however, the same continued to increase causing a greater sense of heavifiess on that side. On screening his chest, it became known that the entire right side was completely filled up with fluid. This called for an urgent tapping. which I was supposed to avoid. On returning from the radiologist, I once again sat down with the patient to elicit if at all there were any other new symptoms which were annoying him, apart from the heaviness of the chest. He told me that for last few days he had been very much troubled by pain in one tooth, and that he did not mention about it because he did not want to burden me with many problems. He was given two glasses of water, one considerably warm and the other ice cold, to test the effect on the paining tooth, by holding mouthfuls of each in turn. He found that both aggravated his pain. On this I prescribed Merc. i.f. 1M, every two hours, while awake. He felt slight relief in the sense of heaviness during the first 24 hours. When he was x-rayed after five days the fluid had disappeared.

The second important point I would like to stress is that thC suppurative drugs may not often act well unless we first treat the immediate causative factor. e.g. injury with appropriate drugs like Arnica (soft tissue injury), Hypericum (nerve injury), Symphytum, (bone injury) and Ruta (sprains of ligaments, periosteal and scalp injury). At times any one of these remedies, alone, may prove sufficient to check suppuration and complete the healing process.

The third significant point is that the prescriber should take into account the miasmatic background, if any and prescribe the appropriate remedy or nosode, and not rely merely on the anti-suppurative remedy. These, however, may be indicated later on during the treatment in order to complete the cure. They do not act well if prescribed right at the beginning, without prior preparation.

I have seen that Arsenic alb. although indicated is often quite insufficient to cure on its own. Its action often ceases and even the higher potencies show no better response. Finally, one is required to turn to some other more deep acting remedy. Valuable time may be saved by a timely change. I have since stopped relying on it except as an initial remedy to be followed socn by one of the more appropriate deep acting remedies.

Range of Acid fluor. in suppuration is very deep. With amelioration from cold accompanied by amelioration from short sleep, it manages to cover the case fully. It appears to take over the work of final healing process as a complementary after most remedies. It rarely needs another remedy to complete its work after it has come in in the right manner. Even the work left over by Secale cor. in gangrene is completed by its action and it is one of the finest remedies of gangrenous states on its own.

Leaders in the treatment of suppuration

Amelioration from warmth with aggravation from cold, brings in mainly Hepar sulph., Silicea and Ars. alb. for consideration. Hepar sulph. has splinter-like pains, extreme hypersensitiveness to touch and draft, the immediate relief from local heat is so ‘flitch that it becomes possible to touch and even press the painful part after application of heat; the pus is sanguineous, the desire for pungent food and sour articles, which aggravates, are its additional features. Ars. alb. has burning pain ameliorated by heat; prostration, thirst, and anxiety with its extreme restlessness; Ars. alb. shares its restlessness with Tarentula. (In Tarentula there is amelioration from music.) Silicea has amelioration from local heat,

and has the offensive sweats in cold palms and soles. The pus has a peculiar dirty-muddy, white, appearance.

Amelioration from local cold should draw attention mainly, to the remedies; Fluoric acid, Lachesis, Secale cor., Calc. sulph.. Picric acid and Kali iodide. Fluoric acid is ameliorated by short sleep; whereas Lachesis and Picric acid are aggravated by sleep. Picric acid has considerable thirst for cold water, the neurasthenic state, and aversion to mental work with desire to sit still and listless. We have observed that joyotis and happy-go-lucky type Fluoric acid and jealous Lachesis bear inimical relationship to each other. It requires Pulsatilla, as a bridge between the two. Lachesis, as well as Pulsatilla, are jealous patients. Kali iodide patient has strong desire for open air and motion (walking) and has a very harsh temper like Hepar sulph.

I would like to point out my observation that many of the patients requiring Phosphorus often show an inordinate craving for chillies and pungent things; as regards cold drinks, many of them have learnt through experience to avoid these because cold drinks cause trouble to: them. Hence craving for cold water of a Phosphorus patient is often not easily seen. Many phosphorus patients have been seen by me, who perspire on scalp while eating particularly pungent food or warm food. Perspiration on side not lain on has also been observed in a few of them. Brick red colour of the pus when pus appears to be thoroughly mixed with blood is characteristic of Phosphorus.

Acid fluor. often follows as a complementary medicine, especially when the characteristic amelioration from cold is present.

One sees in the chapter of Generalities in Kent's *Repertory* that there are many remedies cited for aggravation from cold as well as heat. In this list also appear Acid fluor. as well as Silicea. However, in our experience it is seen that local modality of Acid fluor. in suppurating condition is aggravated by heat and ameliorated by cold and the reverse of the same is Silicea.

The placing of various remedies in this particular rubric shows that there are considerable symptoms which have shown aggravation from. cold whereas more or less symptoms have also shown aggravation from heat. Fluoric acid is a remedy of overheated states, even ravages made by long hectic fevers of tuberculosis. Silicea is positively a leader for complaints on being chilled when overheated.

For amelioration from cold as well as from warmth, and aggravation from extremes of cold as well warmth, Mercury is most important. In Mercury, the affected part burns on touch, like Cantharis. Mercury also has a shivering sensation in an abscess. I have commonly used the iodides: Merc. i.f. for the right sided or for right to left, whereas Merc. i.f. for left sided or for left to right aggravation.

These comments on leading suppurative remedies are based on my partial notes made more than twelve years ago. These partial notes were compiled at that time, when I first thought of writing about diabetes and suppurations. Not only it is very far from an exhaustive therapeutics of the topic, even the indications of the remedies that have been described are very incomplete and cursory.

However, I feel I should share this information with my colleagues because:

(a) A full appreciation of a drug as a remedy as to its sphere of action and clinical utility cannot be derived without repeated clinical trials based on certain easily ascertainable indications. The experiences of old masters have repeatedly shown that wide efficacy and utility of approximately one hundred polychrest drugs. These same drugs are widely applied in the practice of Homoeopathy very successfully.

(b) At the same time, during scientific practice, one cannot overlook the immense value of a rare medicine which might be needed in a case before us. There are more than 50 remedies listed under the rubric Abscess, as well as Unhealthy skin, in Kent's *Repertory.* At various localities, again there may be different remedies mentioned. At the same time, one should be well aware that any of the approximately 650 remedies (or 1540, if we consider latest additions) may be called for in any given case. However, a kind of therapeutics of well defined, properly evaluated remedies has to evolve gradually. Such notes will contribute to the development of such therapeutics.

Source:
The Hahnemannian Gleanings
Vol. XLIX, No. 7, July 1982

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Open Discussion Forum

Winner for April 2020
Dr Bhavana
Prize:
Defeat Diabetes by Dr Ritu Jain

Question for May 2020 is

What is the role of homoeopathy in the management of hypertensive cases?

Send your reply at hheditor@bjain.com. (Last date 7th April 2020)
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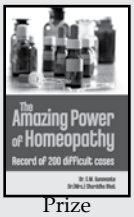

Prize

Question for April 2020 was

Can homoeopathy be an alternative to conventional treatment available for diabetes mellitus?

Yes absolutely, homoeopathy can be used as an alternative for diabetes mellitus as well as a first line therapy in developing cases of diabetes mellitus, along with lifestyle and diet modifications. While in full blown cases of diabetes, one needs to taper off the conventional medicine gradually along with inclusion of homoeopathic remedy. As homoeopathy tends to root out the deeper state of patient, therefore in order to get the causation clearly, the attending physician needs to be very thorough with the patient as a person. In very advanced cases of diabetes mellitus, homoeopathy prove to be helpful in preventing the grave changes. Hence, in all stages, homoeopathy benefits, proving it's efficacy.

— Dr Bhavana

Yes, homoeopathy can absolutely be an alternative to conventional treatment for diabetes mellitus because homoeopathic medicines stimulate beta cells of pancreas, thus help in restoring their normal function. The medicines, on administration, may lead to decrease in blood sugar level or may cause diminution in urine as well. Homoeopathic medicines also work on preventing the complications of diabetes such as diabetic retinopathy, nephropathy, neuropathy etc. when taken in earlier stage of diabetes. Also, they facilitate the immune system of the body so that the influx of vital energy in the body is maintained in harmony and all the functioning becomes normal.

—Urooj Fatima

The answer is obviously yes, homoeopathy can do wonders in managing diabetes mellitus. The distrubance in metabolism may lead to diabetes. There are two type of diabetes, i.e. type 1 diabetes (also known as juvenile diabetes), which is insulin dependent, and the body fails to produce insulin, and type 2 diabetes, i.e. the most common type of diabetes.In homoeopathy, there are abundant medicines available for diabetes mellitus, for example *Syzygium jambolanum* plays a major role in treating diabetes. As homoeopathy treats the patient as a whole, not only the organs, therefore, when diabetes is being initially identified, one can treat the patient by keeping the blood sugar level in control, even if it is identified in a later stage, use of similar medicines may help to increase the quality of life of the patient. Being a lifestyle disorder, due to life style modifications such as improper food habits, eating junk foods, obesity, lack of physical excersie, chronic stress, etc., many people get affected with diabetes. Master Hahnemann has also pointed out this in aphorism 5 of *Organon of Medicine*, stating that the ascertainable physical constitution of the patient (especially when the disease is chronic), his moral and intellectual character, his occcupation, mode of living and habits, his social and domestic relations, his age, sexual function, etc. are to be taken into consideration. Accordingly, the patient's entire history has to be taken to give a proper similar remedy, along with proper diet and regimen which will help to increase the quality of life of the patient. Thus, homoeopathy can be an alternative to conventional medicine in treating diabetes mellitus.

—Dr Harsha Varthini. M

National News

Supreme Court Allowed AYUSH Students To Continue Their Course In Punjab And Haryana

Supreme Court has granted permission to the students of ayurvedic, homoeopathic, and unani medicine to continue the course. Hundreds of students whose admissions were cancelled after the December 2019 Punjab and Haryana High Court judgment that made National Eligibility and Entrance Test (NEET) mandatory for admission to bachelor's degrees in ayurvedic medicine, homoeopathic medicine and unani medicine in both Punjab and Haryana, are being permitted to continue their sessions by the SC.

International News

WHO Declared Novel Coronavirus Outbreak A Pandemic Disease

On 10th March 2020, World Health Organization declared the novel coronavirus outbreak as a PANDEMIC. WHO stated that there has been 118,000 cases, more than 4000 deaths, and it is being found that it will have a foothold on every continent except for Antarctica. Therefore, it is being declared as a "Public Health Emergency of International Concern".

Elliott Dean Schmerler Elected As President Of Arizona Homeopathic And Integrative Medical Association

Dr Elliott Dean Schmerler, known by his patients and colleagues as Dr Dean, has been elected for a second term as the President of the Arizona Homeopathic and Integrative Medicine Association, an association formed by Arizona licensed homeopathic and integrative medicine physicians.

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Upcoming Events Calendar

MAY 2020

NJH's International Foray with Unique Evening Seminar, Azerbaijan And Georgia
May 4-10, 2020

15th Annual Joint American Homeopathic Conference, Orlando.
Date: May 15-17, 2020

JUNE 2020

6th World Congress on **Polycystic Ovarian Syndrome (PCOS 2020), Frankfurt, Germany.**
June 08-09, 2020.

One Week Summer School 2020, Allen College of Homoeopathy, Chelmsford
Speaker: Dr Subrata K. Banerjea
June 20-27, 2020

75th LMHI World Congress of Homoeopathy At IZMIR/Turkey
June 24 – 27, 2020

JULY 2020

LCH UK's HomeoCon 2020, London College Of Homeopathy, UK.
July 4-5, 2020.

Classical Homoeopathy Workshop 2020, Pune
July 25-26, 2020

SEPTEMBER 2020

International Homoeopathic Congress "Homoeo-World-Vision 2020", IIHP-Haryana
September 5-6, 2020

FEBRUARY 2021

"Homoeo Youth 2021" 8th Dr D. P. Rastogi Memorial National Homoeopathic Seminar, Lucknow
Dr Farokh J. Master
Dr Sunirmal Sarkar
February 13-14, 2021

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Get your events listed here. Send the details to hheditor@bjain.com.

Cracking Homoeopathic Codes In Breast Cancer

By Dr Sunirmal Sarkar, PhD and Dr Shruti Shah, PhD

Reviewed by Dr M.K. Sahani, PhD

Personal tragedy often opens understanding to undertake new assignments and provoke one to have deeper understanding leading to experiences . Finding limitations in the presenting situation makes one to think differently and explore into the relate d, but alternative direction. Authors being homoeopathic practitioners with deep insight and academi c background, observed the limited scope of cancer in the mainstream system of medicine and decided to explore in their own field. The spirit of team work made them to establish "Prayas Homoeopathy and Cancer Foundation" with the most experienced homoeopath, Dr Sunirmal Sarkar. The research and academic studies as well as clinical experiences were blended together to bring out this work. After making massive literary search, right from the fundamental literature to the available clinical presentation, they developed a deeper understanding on the subject related to cancer. Encouraging clinical results made them more confident to work on specialisation on the different aspects of cancer.

Clinical evidences strengthened them more with the learning from the homoeopathic masters. Specific therapeutical understanding of the explanation of cancer by Dr Grimmer and other sources of inspiration made them collect the data available in the treasure house of stalwarts in homoeopathy. Studies on the current development on cancer have been incorporated as well.

The efforts of the author resulted into the materia medica of breast cancer (oncology materia medica) of medicines, compiled from 51 remedies from the *Kent's Repertory* and more than 200 remedies from the *Complete Repertory*. This book made presentation of 80 breast cancer related remedies. One of the most interesting aspects of homoeopathy is its reproducibility. Choosing the right homeopathic medicine for the individual patient is about estimating chances is the statistical aspects of understanding.

The objective of this book includes awareness about homoeopathy and its potential role in the management of cancer. This book is an effort to combine contemporary medicines and classical homoeopathic medicines for clinical use in breast cancer. The book is based on the authentic sources as well as clinical experience of well reputed scholar in homoeopathy, Dr Sunirmal Sarkar.

This book is divided into 11 chapters presenting different aspects of the breast cancer and its clinical aspects. Separate group of homoeopathic remedies from plant kingdom, animal kingdom, mineral kingdom, nosodes, sarcodes, radioactive substances, and synthetic remedies are being listed and explained separately. Each medicine included have a strong base from authentic source books. Description of the remedies include their basic information and authentic symptoms as presented in the source book. The book was being made more presentable by the editor.

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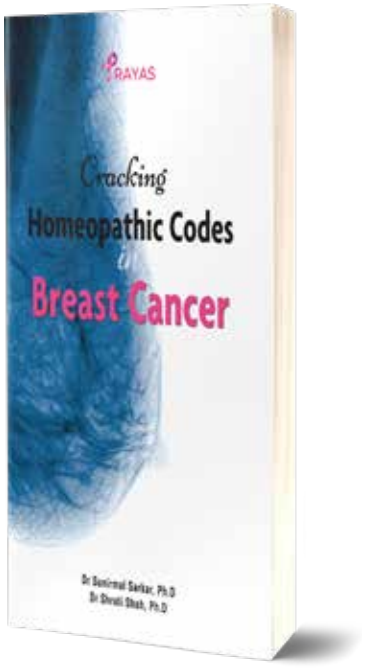


Overall, the book is a good attempt by the authors to make oncology of breast cancer and explain the applied aspects of homoeopathy in a more comprehensible and easier way in order to study and make it useful duirng clinical practise. It will prove to be very useful for all serious homoeopathic students and practitioners, and inspire them to get well versed with the applied aspect of homoeopathy in oncology. It can also be used as a reference book for treating cancer cases.

(Dr M.K. Sahani)

Target Super Protocol In Homoeopathy

By Dr Sreekumar R, Dr Sreevidya KN

Reviewed by Dr Mansoor Ali

This book consitutes a set of guidelines for homoeopathy practitioners to get high-end results not only in common acute and chronic diseases, but also in autism, attention deficit hyperactivity disorder, visual and auditory challenges and many hereditary diseases. A new synthesis of classical, logical and practical approach in homoeopathy in tandem with the advances in genetics. This book will help the new and existing generation of homoeopaths to build confidence in classical homoeopathy.

Clinical protocols are there in allopathy but not suitable for the concept of homoeopathy – since we are treating on individualisation. Therefore, a protocol in homoeopathy must meet the concept of individualisation. *Target Super Protocol* developed by the authors is envisaged to enhance therapeutic success in homoeopathic practises by addressing various challenges in the therapeutic field.

When this protocol was applied to the school health programme Jyothirgamaya of Kottayam district, out of 32 cases, 320 cases showed promising and positive results. This book acts as a reference book describing a protocol, i.e. a set of guidelines to be followed by homoeopathic practitioners while dealing with any of the cases to target 100% successful results in their practise. To overcome the limitation of repertorisation – a concept of effective rubric selection also mentioned. Along with the current rubrics, one must include old disturbing or dormant symptoms form the past history as target rubrics.

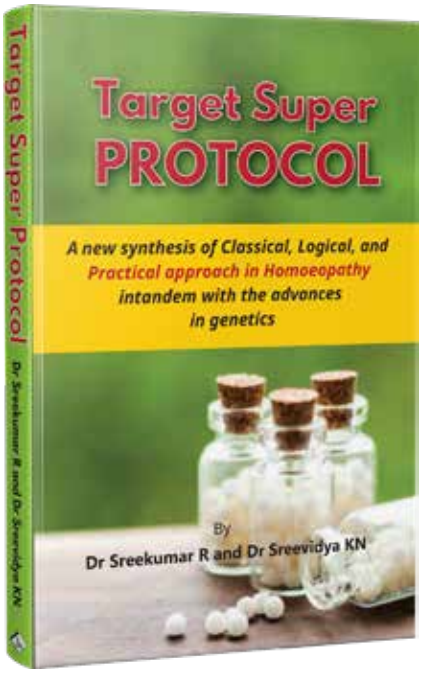
A chapter, "**Sree Doctrine of Inheritance",** explains how to tackle inherited disorders and prevent unhealthy inheritance.

Illustrative cases: Being a homoeopath, one has to face so many hurdles while resolving cases in hand, this book explains many cases that seem to be incurable by other systems of medicine – the process of case taking, point of entry and rubric selection in a methodical way. This book acts as a guide to enhance therapeutic success in homoeopathic practise by addressing various challenges in case taking, therapeutic field as well as provides a clinician with the direction to crack difficult and incurable cases.

Chapters: Correcting intra-uterine petal abnormalities, a protocol for congenital anomalies, ADHD, learning disability are interesting and replicable.

Tricky target rubrics: One of the main problems one may encounter in clinical practise is the conversion of patients' symptoms into the language of the repertory. This chapter helps the practitioners to find out

ISBN: 978-81-319-6402-6
Pages: 244
Publisher: B Jain Publishers



appropriate rubrics for various conditions encountered in day to day practise.

Authors:

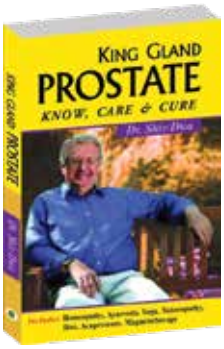
Late **Dr Sreekumar R** – a leading practitioner from Kerala, was a Medical Officer in the department of homoeopathy – Govt of Kerala, who played a memorable role as the project officer "Janivijaya" – a programme to vijayapuram panchayat – a disability-free panchayats through homoeopathy.

Dr Sreevidya, w/o Dr Sreekumar – greatly contributed in designing genetic profile in *Target Super Protocol* to overcome the challenges ahead in therapeutics.

■■

King Gland Prostate Know, Care & Cure

Dr Shiv Dua



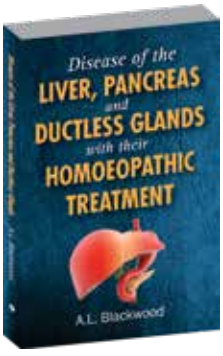
Distinguishing Features:

- The utility of the book is for "old gold aged" patients suffering from prostate disease and its homeopathic management.
- The book deals with the causes, signs and symptoms of prostate enlargement, and care and cure of prostate cancer.
- Also includes how to deal prostate affections with yoga, acupressure, magnetotherapy, homoeopathy, ayurveda, naturopathy and diet

ISBN: 978-81-319-0345-2 | ₹ 199 | 224pp

Diseases of the Liver, Pancreas and Ductless Glands with their Homoeopathic Treatment

A.L. Blackwood



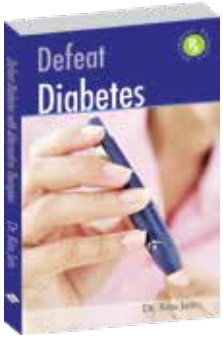
Distinguishing Features:

- A small work covering the treatment of diseases of liver, pancreas and ductless glands explained proving the importance of organopathy.
- A concise discussion of the disease of these important organs which students and practitioners will find useful.
- The treatment part has been given in a elaborate way.
- Contains the primary facts common to all medical schools which every student and physician must master, together with the homoeopathic treatment.

ISBN: 978-81-319-1034-4 | 176pp

Defeat Diabetes

Dr Ritu Jain



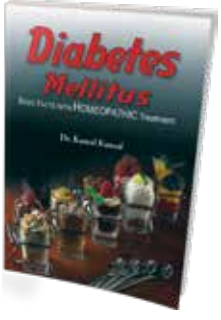
Distinguishing Features:

- Every aspect related to diabetes has been explained in easy-to-understand language including causes, signs and symptoms, when to consult your doctor, laboratory-investigations, treatments, complications and prevention.
- Many figures, diagrams and illustrations have been included.
- Complication of diabetes has been individually explained in different chapters.
- Conventional treatment alongwith alternative therapies given.

ISBN: 978-81-319-0384-1 | 244pp

Diabetes Mellitus

Dr Kamal Kansal

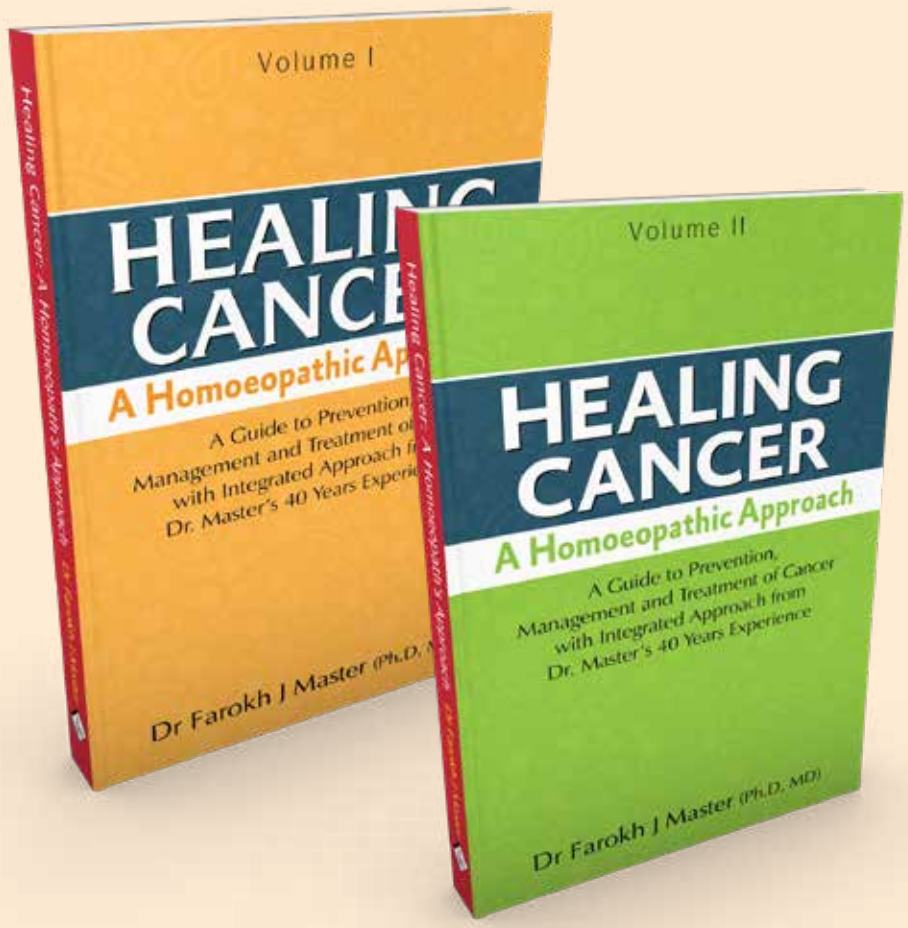


Distinguishing Features:

- This book discusses about diabetes mellitus and effective homoeopathic treatment.
- Other features are diet charts, food exchanges, homoeopathic and biochemic treatment, interesting illustrations.

ISBN : 978-81-319-0326-1 | 96pp

Healing Cancer:
A Homoeopathic Approach
(2 Vol. Set)
Dr Farokh J Master



- The book covers the cancer related topics beginning from cancer archetype, clinical information on diagnosis, prevention, conventional treatment, homoeopathic aspects, therapeutics, polycrest remedies, rare remedies, Indian remedies, wisdom from the repertory, naturopathic and dietary suggestions, Iscador therapy, social aspects of cancer to the latest researches in the field of cancer.
- The book paves the way to a holistic homoeopath's approach, which is in line with the Master Hahnemann's teachings like indisposition, obstacles to cure, miasm, susceptibility, palliation.

ISBN: 978-81-319-6122-3 (Vol. I & II) | ₹1199 | 972 pp
(Vol I 500pp & II 472pp)

2019-nCoV
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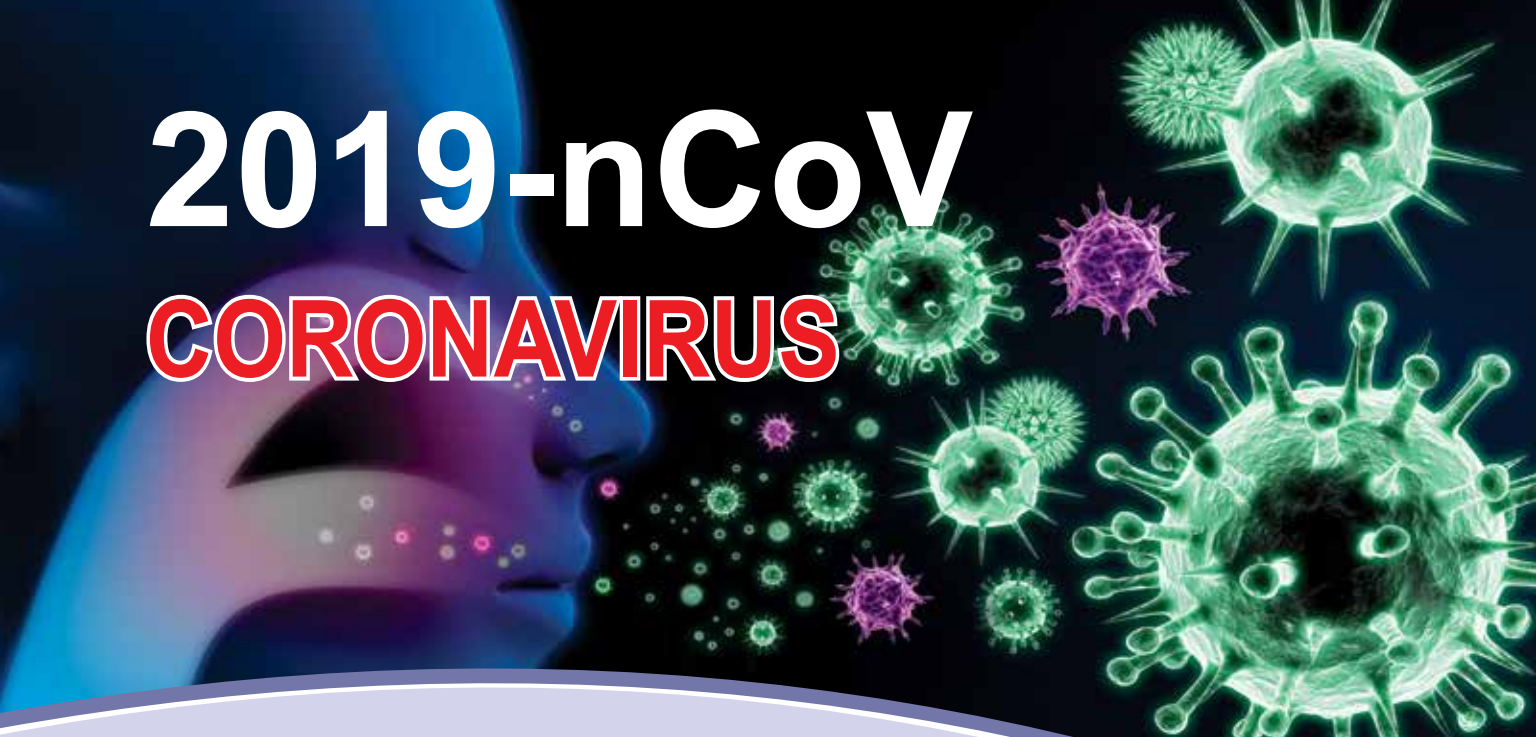
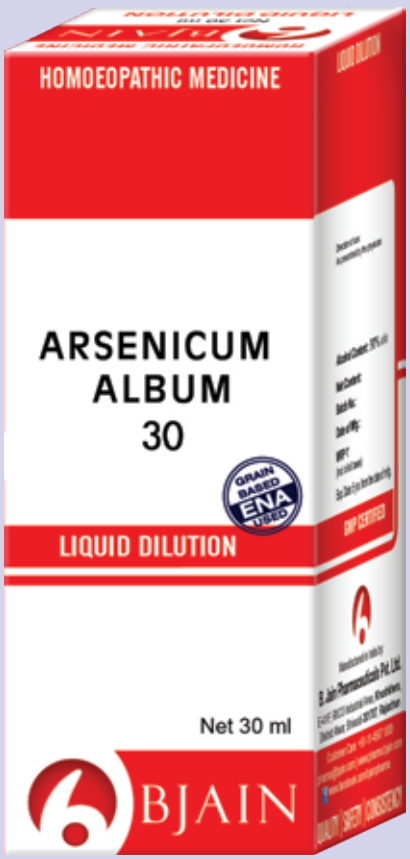


Prevention is BETTER than CURE

- AYUSH ministry has issued a health advisory recommending Homoeopathic medicine **"Arsenicum album 30"** as a preventive.



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