THE HAHNEMANNIAN GLEANINGS

Vol. XXVII JULY 1960 No. 7

WHEN THE WELL-SELECTED REMEDY FAILS TO ACT

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A most disturbing situation is encountered when a case seems to present clear-cut symptoms, definitely suggestive of a certain remedy, yet the patient fails to show a satisfactory therapeutic response when that medicine is given. To the extent that incomplete casetaking might have been at the root of the trouble, we may expect to find new leads by retaking the case. Not infrequently, however, our difficulty is accounted for by the extensive overlapping of symptoms (not only of particulars, but of mentals and generals as well), which is so typical for our materia medica. The art of selecting the simillimum from among several medicines, which share the main symptoms of a case, depends upon finding features which are characteristic of only one of those drugs. This detailed differentiation is difficult or impossible when our case has but few prescribing symptoms or when the remedies in question are but poorly proven. Thus, really precise symptomatological differentiation is limited, among remedies, to the polychrests and, among patients, to those cases which furnish a certain minimum of modalities. Unfortunately, it seems that, on the average, one out of every 4-5 patients, if we desire optimal improvement, requires a medicine which is not one of our well proven polychrests. In dealing with these cases, we have to fill in the gaps of our exact knowledge with hunches, intuition, guesswork or good luck. It may be added that in such an impasse the various

objective methods of remedy selection may be quite helpful. They can greatly enhance the accuracy of prescribing, provided they are considered as auxiliary approaches, complementary and subordinated to the symptomatic method, and not as attempts to replace it.

When our first remedy failed and the most careful restudying of the case fails to produce a better alternative, two possible courses are open to us. We may admit defeat and try intuition or a good guess. This course of action may lead us to a brilliant hit but also to a hopelessly confused, mixed up case. The second possible approach, when we are sure that our first prescription was really the correct one on the basis of the available evidence, is to classify our case as an instance of failure to respond to the properly chosen drug. Our subsequent task will now be to search for possible obstacles to recovery, such as living habits, drugs, irreversible or mechanical pathology, psychological factors and the miasmatic background. An identification of the miasmatic factor introduces new evidence which often may break the deadlock in our prescribing.

However, it would appear that, particularly in respect to psora, our understanding of the underlying constitutional factors and remedies is still rather fragmentary. The following antipsoric prescriptions have been selected for presentation because they demonstrate the vastness of the still unexplored territory :

CASE 1—Mrs. A.S., aged 28. Rectal fistula of several years standing. In cycles of 1-3 weeks there occurs engorgement with painful swelling which is followed by drainage of purulent matter. Frequent headaches, general tendency to acne and boils. Itching eruption around the arms and the genitals. Tendency to diarrhœa, offensive discharge from the navel. The patient is of heavy build, obese, sensitive to heat, worse warm wraps, uncovers her feet, has a tendency to catch colds, is irritable, desires sweets and meat, perspires freely and has a very marked, offensive body odor. *Sulphur* gave a good response but stopped acting after a few months. The general symptoms do not present a rational basis for any other remedy. Therefore, still considering *Sulphur* the legitimate medicine and classifying the case as one of failure to respond to the obviously

indicated remedy, an anti-psoric nosode seemed required. *Psorinum* helped for a while. After it failed to hold longer, *Sulphur* was again tried and worked longer and better, but still, even in the CM, failed to bring about a permanent constitutional change. At that time experience with other cases had taught me that the antipsoric nosode par excellence which has the broadest field of action seems to be not *Psorinum* but a *Tuberculin.*

Bacillinum 200. in infrequent doses is now accomplishing a cure. During the course of a year there has been no need to change the potency which still remains 200. This detail is in conformity with a gradually growing impression that whenever a frequent change of potency is necessary the medicine is likely to be the simile, rather than the simillimum.

A few noteworthy features are brought out by this case. Obesity does not contradict *Tuberculin.* Rather, from repeated experience, obesity as well as a fair, flabby complexion, similar to *Calc. carb.,* should be listed as symptoms *positively suggestive* of *Tuberculin. Tuberculin* is the closest complementary remedy to *Sulphur, Calcarea* and *Phosphorus,* being a synthesis of their symptom pictures with *Sulphur* having the lion's share. It's similarity to *Sulphur* is so great that any *Sulphur* case which fails to respond to *Sulphur* may be tentatively considered a *Tuberculin* case on the strength of its *Sulphur* symptoms.

CASE 2—Mrs. M.R., aged 42. Recurring paronychia affecting the bases of all of her fingernails with tenderness, swelling and seropurulent discharge, always aggravated by hard use of her hands (housework, dishwashing, etc.). Chronic constipation with enema habit for years in spite of correct eating. Tendency to what she calls "bilious spells" consisting of nausea, vomiting, griping pains in the abdomen and violent headaches. Several times she found pinworms in her rectum. Recurrent violent attacks of trifacial neuralgia. She gives a history of having been a sickly child of thin build with swollen lymph glands, had several attacks of pleurisy, recurring cystitis and an outbreak of boils and carbuncles over the face and upper arm. She is of small spare stature, easily exhausted, very sensitive and emotional, impatient and irritable, easily worried, feels

worse in wet, cold weather and suffers from lack of vital heat; her menses are scanty and she feels worse before them. Easy perspiration and damp feet. The skin is dry, chafes and cracks easily. She craves sweets, starches and fruit. The neuralgia is worse on the right side and worse at night. The first prescription, *Silica,* did not touch her at all, nor did *Tuberculin. Phosphorus* initiated good progress for 5 months, then ceased to act. The next two years saw attempts with *Psorinum, Arsenicum, Sulphur, Lycopodium, Nitric ac., Hydrastis, etc.*, with absolutely no success. A reconsideration of the case started from the premise that, *Phosphorus* having been the nearest medicine which failed to hold, a fitting antipsoric nosode must be found. The tendency to pus formation led to the consideration of *Streptococcus viridans cardiacus* (Stearns) 200. The ensuing response was a true homœopathic aggravation which, prior to the improvement, singled out each group of symptoms, rather than the purulent state alone, thus marking them as belonging apparently to the pathogenesis of this drug. The first response came from the gastrointestinal tract, then came the trifacial neuralgia and lastly the inflammation of nails and skin.

From the limited experience of prescribing this nosode in other cases it would appear that the viridans strain from the cardiac lesion is the most active and therapeutically most frequently indicated one among the streptococcic strains, at least in general constitutional states. In none of the limited number of cases in which its prescription proved therapeutically effective was there any clinical evidence of rheumatic or cardiac pathology. The symptoms common to those *Strept. vir. card.* cases, which tentatively may be considered prescribing indications for the medicine, are the following : the patients are of fair complexion, rather slender build, oversensitive, emotional, active types, have a low resistance to colds and infections, a tendency to swelling of the lymphoid tissues, an unhealthy skin with a dry type of eruption. The drug is a constitutionally deep acting antipsoric, apparently, holding a midway position between *Phosphorus* and *Psorinum.* It may have to be considered when either *Phosphorus* or *Psorinum* seems indicated yet fails to work.

CASE 3—Mrs. J. C., aged 57. Her complaint is rapid heart action (pulse rate about 100). This state is punctuated by more acute spells of tachycardia attended by shaking of hands and feet. She also suffers from intense headaches localized on top of the head, pressing or penetrating pains. She is very apprehensive, nervous and impatient and very sensitive emotionally. There is a fine tremor of hands and fingers, globus sensation in throat, easy perspiration. Her basal metabolism rate was above + 15 when taken several times in the past. Tendency to constipation and flatulent distension from sweets and fats. Clinically, this is a definite case of hyperthyroidism (in the past she had had treatments with Lugol's solution without any effect). *Generals* : lack of vital heat, better from warmth but worse in closed rooms, worse night, after eating, in damp weather, approaching storm ; she is of fine, thinly built, narrow-chested, phthisical habitus. The obvious prescription was *Sulphur,* which over 2 years improved her condition but never succeeded in bringing about a really decisive change. In spite of giving it as high as 50M, she still was in need of monthly repetitions and, though in a milder form, retained her tachycardia, as well as the acute cardiac syndrome, and the migraine. *Arsenicum iod., Tuberculinum, Psorinum, Thyroidinum* proved of no avail. *Iodum* is evidently not indicated by the modalities. *Sycotic Co.* (Paterson), a single dose of the 200. proved the most effective prescription she had ever received. A progressive improvement of all symptoms still continues after 4 months without any repetition of the dose, thus showing that this remedy effects her more deeply and lastingly than *Sulphur,* which by her symptoms seemed indicated.

Sycotic Co. is one of the non-lactose fermenting organisms which were introduced into our homœopathic armamentarium by the work of E. Bach and J. Paterson. The most comprehensive symptomatology, so far available, of these important medicines can be found in the July 1950 issue of the *British Homœopathic Journal ;* reprints of this essay are available in pamphlet form from A. Nelson and Company, London. These intestinal nosodes have proven themselves as deep antipsorics, indispensable for chronic case work ; I, personally, would care to miss

them as little as I would wish to have to practice without *Tuberculinum* and *Psorinum.*

Paterson regards *Sycotic Co.* as a pretuberculous remedy, complementary to *Bacillinum* and *Thuja.* It fits the narrow-chested type of person with sallow complexion and an oily skin, of a sensitive, nervous, irritable disposition and a tendency to fears, anxieties and bad temper. These constitutional types, often enough, have an overactive thyroid function. Further features of these types are anemia, rheumatic and catarrhal tendencies. Apparently, we have here a blending of the psoric and sycotic miasms.

In each of the cases presented in this paper, we were confronted with a symptom picture which definitely and apparently unequivocally pointed to an antipsoric remedy, which, when prescribed, proved ineffective in the long run. The lesson to be learned from these cases is that, in a clinical deadlock with such a definite, clear cut symptomatology, the true simillimum has to be sought out from among the antipsoric nosodes. Probably their real number may exceed those known to us at the present. Statistically, on the basis of present experience, the nosode most frequently called for in a situation like those described is *Tuberculinum* or *Bacillinum* (in acute cases, *Influenzinum*). Then follow the intestinal nosodes and lastly *Psorinum* and *Streptococcinum.*

Needless to say, this order of frequency is given as a summary of one prescriber's experience with his particular case material. It is meaningless in the face of a given individual patient's problem, which must always be evaluated on its own merits, regardless of all statistical considerations, as though one never had seen or heard of a similar case.

DISCUSSION

DR. F. K. BELLOKOSSY [Denver, Colo.] : Do you give *Tuberculin bovinum* or *Human Tuberculin* ?

DR. WHITMONT : I do not know the difference. I have one marked "Tuberculin," and another marked "Tuberculin Bovinum."

DR. BELLOKOSSY : They are not the same.

DR. WHITMONT : What is the other ?

DR. BELLOKOSSY : Heath.

DR. WHITMONT : No, another preparation.

DR. SCHMIDT : Koch Tuberculin.

DR. WHITMONT : As a rule I now stick to Bacillinum.

DR. UNDERHILL : Where do you obtain that ?

DR. WHITMONT : From Nelson, in London.

DR. UNDERHILL : In the *British Homœopathic Journal* they have a reprint on nosodes.

DR. WHITMONT : I read the *British Homœopathic Journal* regularly and consider it the best homœopathic publication there is, even the equal or superior to our *Recorder,* particularly because they have much more material. It is the official organ.

DR. SUTHERLAND : The *British Homœopathic Journal* is well worth reading and has excellent material. Of course, the excellence of the *Journal* depends on the excellence of the authors contributing to it, and may be that explains why it is the best homœopathic journal extant. You can take that for what it means.

DR. ELIZABETH WRIGHT HUBBARD [New York, N. Y.] : May I say two things ? *Tuberculinum bovinum* I find not only wonderful in all the glands of the neck where you would expect it to be wonderful, because, when you get cow tuberculosis—we don't have them so much any more, but we used to have them—that gives you the glandular condition in the neck or mesentery. There *Tuberculinum bovinum* works wonders.

The *Bacillinum* I find much better in the tubercular cases with mixed infection, as you usually get from the actual lungs of active tubercular cases. I have watched this with interest. When you have an inherited tubercular tendency, which is human, *Tuberculin bovinum,* curiously enough, does very well, amazingly well, but I am inclined to think that the *Tuberculinum* cough, which is human in origin, does even better. You don't agree ?

DR. WHITMONT : I have tested in many instances with various tuberculins for the given case and I do not know of a single instance where the *Tuberculin* came through a test.

DR. HUBBARD : I know where it comes through ; in fact, it helps. I don't know about the test.

Also I should like to say that I thank you for that phrase "miasmatic background as an obstacle to cure," because when we go through what are, in a way, the obstacles to cure, we often forget that, and I think that is a good phrase.

DR. ROGER A. SCHMIDT [San Francisco, Calif.] : Speaking of tuberculins, the French School has been doing a great deal of work with them. I think they were rather the first ones to infer from the psora through tuberculous tendencies and inheritance, and they have in their hands and have evolved and put on the market a number of preparations.

I don't know whether Dr. Whitmont has tuberculins, which have given good results in my hands, particularly with the bony structures and fibrous tissues affected as in chronic rheumatoid arthritis and things of that sort, which, as you know, are very often mixed up with tuberculous background. For those I usually use *Tuberculin Koch.* Sometimes where *Tuberculinum bovinum* has not given me any result, I use *Tuberculin Koch.* I have had results with *Tuberculinum bovinum,* but it is true that in the inherited tendencies and background *Bacillinum* is, I think, the remedy of choice and maybe one of the broadest categories. That is my experience.

DR. HUBBARD : *Tuberculinum aviare,* the bird tuberculin, is extraordinarily helpful in some of the influenza virus pneumonia epidemics. Whether or not they are carried by our ubiquitous pigeons, I don't know, but it gives one to think.

DR. SCHMIDT : I had a remarkable case where *Tuberculinum aviare* 1M cured a tuberculous tendency, just a tuberculous tendency.

DR. WHITMONT : [*closing*] : One main point I want to impress upon you is that in two-thirds of all tuberculin cases there was neither any clinical evidence, nor any historical evidence, nor systemic evidence, or any evidence of anything whatsoever reminding one of tuberculosis. We should divorce *Tuberculin* and tuberculosis from each other. It may happen that a *Tuberculin* case may also have a tuberculous background, but

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tion, as, for instance, a seven-year headache from a fall downstairs cleared by *Natrum sulph.* 10M ; annual recurrence of angio-neurotic œdema from strawberries cleared by *Fragaria* 10M, and a pruritis ani following the use of carbolated vaseline which was desensitized, antidoted and cleared by the prescription of *Carbolic acid* in 10M and CM potencies.

One understands, of course, that illness or trauma may result either in functional derangement of actual pathological tissue variance. Loss of taste and smell from fright is an example of the former. Pathological pictures may be based upon meningeal damage, abcess, scars, fibrosis and contractions. It may not be possible fully to disperse such tissue change, but it is surprisingly possible to eliminate the troublesome symptomatology by accurate remedial action and so nullify the ravages of old griefs to a high degree. To the homœopath there is truly "Gold In Them Thar Hills."

—*Journl. of the Am. Inst. of Homœopathy, June, '57*

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we should think of it as an antipsoric nosode, and, as I would say, the most frequently used remedy next to *Sulphur,* regardless of tuberculosis.

—*The Homœopathic Recorder, June, '52*

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