ASTHMA: CLINICAL RESEARCH FROM HOMOEOPATHIC STANDPOINT*

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INTRODUCTION

Asthma is one of the most obstinate diseases, which has tormented both patients and physicians for a long time with apparently no lasting solution in sight.

Homoeopathy is one system of therapeutics which has considerable, yet for the most part untapped potential for this affliction. Asthma is definitely *curable* with the help of Homoeopathy.

But the path of treatment and cure faces several difficulties and seemingly many obstacles. Many homoeopaths have individually tried to find the way to cure without properly and scientifically 'charting' out the way. This effort, it would appear, is like undertaking to conquer Mount Everest without a proper charted path or plan. Each expedition takes on a new unknown path, while some may somehow manage to reach the peak, many others are likely to be stranded on the way, compelling a retreat and return to the 'base camp'.

If this expedition to 'the peak' of cure is properly 'charted' and planned, progress would be much easier and faster and would save the 'subsequent expeditions' (of physicians) much energy and 'heartaches'. Moreover it will bring them nearer to the goal of success. I too had to pass through the stage of agonising noviceship and had experienced frustrating 'heartaches' (though not discouraged and I am happy to say it did not result in a heartbreak). Though my journey is not over, and for most scientists it is never over as new horizons open, the end of the journey is in sight, the bright horizon is clearly seen.

BACKGROUND

It was five years ago that I launched my experiment and to say frankly started from scratch not being familiar with the 'terrain', so to say. I was ill-equipped except that I firmly believed that where there was a will there was a way. I had to improvise. Information with regard to a disease like asthma was scattered and data about drugs which can be used in asthmatic cases were scarce and also scattered. Locating and collecting the data had been a very laborious and time consuming process. Naturally the path I had to traverse on my 'maiden expedition' was a zigzag one. It has taken me five precious years of my initial practice. Over these years, more than 500 cases have helped me to reach my present level of proficiency. To think of

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it retrospectively, I should have taken no more than two to three years to achieve the same results, if only even a workable 'plan' was available.

Quite a bit of researeh has been done in Homoeopathy but much more research along scientific and appropriate lines is called for. The conventional 'control' and 'Double blind' method of research is most inappropriate and unsuited to Homoeopathy because it violates the basic principles of Homoeopathy.

THE APPROACH

May I suggest that homoeopathic research along the following lines will be several times more fruitful and rewarding if taken up in right spirit:

(1) Collection of data.

(2) Designing of separate repertory for each disease—as a supplementary to the main repertories of Kent, Boger-Boenninghausen and Boericke.

(3) Designing of a separate history form to cover detailed symptomatology of asthma.

(4) Designing *of special case record for asthma to cover totality.*

(5) Elicitation and proper interpretation of mental symptoms of patient.

(6) Diagnosis and prognosis in relation to homoeopathic miasmatic classification.

(7) Planning and programming of treatment.

(8) Thorough study and implementation of auxiliary line of treatment.

(9) Maintenance of daily record sheet.

(10) Selecting criteria for evaluation of results.

(11) Recording progress of patient with modern techniques of investigations.

(12) Retrospective study.

(13) Maintenance of a follow up sheet.

(14) Conducting the provings of drugs used by other systems of medicines.

(15) Dissemination of kuowledge through regular mectings and publication of results.

The above suggestions are made with particular reference to asthma but research on these lines hold good for all other branches of study too. We consider below specific details.

(1) Collection of data: Information pertaining to asthma needs to be gathered from different books on chest diseases. Details about anatomy of lungs, physiology of respiration, diseases of lungs, investigations, differential diagnosis, management and prognosis of asthma is collected.

Data regarding drugs are scattered. No repertory is complete. As a result of this we make use of a few widely known drugs. We are unable to take advantage of the vast array of drugs which are available to us but are unaware of their use for asthma. We have for instance, more than three hundred drugs for asthma, but we use about a seore or two, the rest are rarely tried.

If a large number of drugs are tried a wealth of data can be collected, e.g. Ars. alb. (See Appendix A).

As we continue to administer the drugs to the patients and start obtaining results we observe how the disease behaves in an individual case. A careful observation of the behaviour of the drug in a given case, enables us to understand better the evolutionary pattern of the drug. We will also be able to observe that different drugs have different evolutionary patterns and hence we will be able to differentiate drugs with greater ease. Ability to differentiate drugs will subsequently help to bring about rapid, gentle and permanent cure to different patients.

(2) *Repertory*: With the help of materia medicas and repertories already in existence, a special repertory can be compiled for asthma.

(3) *History form*: A special history form must be designed for asthma. The history form should bring out all the points relevant to asthma with the help of in-depth study of the disease, materia medica and repertories.

(4) *Case record*: We must maintain a case record—The case record is a connecting link between history form and repertory. Hence the case record must be designed to cover totality of symptoms. For example, the respiration type will have all details in the history form, case record and repertory, so if a patient mentions about respiration type one is able to trace to repertory and place the group of drugs. This type of arrangement will hold good for all symptoms. (See Appendix B).

(5) *Mental study*: We should probe into mental symptoms and mental make-up of the patient, it is an essential part of case totality. Mental study enables us to understand the patient better and gives us the totality on which to base the selection of the constitutional remedy. Besides oral questioning, the patient must be pursuaded to write a detailed account about himself. Some selected psychological tests can also be administered.

(6) *Miasm*: The physician must have a clear idea of miasms and how they play an important role in the management of patients. All details pertaining to past illness, illnesses in the family and present history are to be considered in detail. Study of miasm will enable us to decide about anti-miasmatic remedy, curability of the disease and prognosis of the patient. Miasmatically asthma can be classified into the following types along with its detailed characteristics.

A. Psoric Asthma

(i) Psoric personality with ready swings and functional disturbances.

(ii) Active skin complaints or h/o skin complaints.

(iii) Purely psychogenic asthma as represented in the predominantly hysterical group of remedies in homoeopathic materia medica.

(iv) Sudden appearance and disappearance of spasm with minimal secretory phase, e.g. classical case—Charcot's patient with asthma precipitated by a paper rose.

(v) Re-establishing skin symptoms and asthma is better.

B. Sycotic Asthma

(i) Sycotic personality.

(ii) Asthma is aggravated by the damp and rainy season and by getting wet. The patient feels better in the dry climate.

(iii) Cough with little expectoration, which comes out with great efforts.

(iv) H/O suppression of discharges from mucous membranes.

(v) Charaeteristic sycotic inflammatory discharges.

(vi) Re-establishing of discharge from mucous membrane will ameliorate asthma.

(vii) Concomitant musculo-skeletal manifestations.

C. Tubercular Asthma

(i) History of viral infections leading to asthma.

(ii) Attacks are erratic and the severity may increase or decrease rapidly.

(iii) Tubercular base and expressions may be present.

(iv) Congh with excessive expectoration, purulent or mucopurulent.

(v) Anxiety[3] with imaginations[2]. Building castles in the air.

(vi) Chest narrow, weak persons—easily exhausted.

(vii) Aggravated at night.

(viii) Easy suppuration, with tendency to super added infection and fever.

D. Syphilitic Asthma

Where structural changes have been produced—emphysema ultimately leading to cor-pulmonale.

(7) *Special Repertory*: After taking up the case in detail, the case is worked out with the help of generals (Kent's, Boger-Boeninghausen's or Boericke's repertory), Boeninghausen's *Therapeutic Pocket Book*, and special repertory (which should be worked out beforehand).

We determine the acute, constitutional and intercurrent medicines. We plan and programme the treatment and note down the expected responses which are to be checked in actuality during treatment.

(8) *Auxiliary*: Detailed study of auxiliary measures is necessary in order to have a permanent cure. It has been observed that auxiliary measures have proved a great help to the patients in asthma.

(a) Avoid food or other items to which one is allergic.

(b) Take dinner before 7 p.m.

(c) Avoid raw onion, raw garlic, tobacco, alcohol and coffee.

(d) Avoid rice or rice preparations, especially at night.

(e) Avoid sour and oily food, aerated drinks and outside food.

(f) Gargle with warm salt water at least 3 times a day.

(g) Avoid use of balm or vicks or any other local application.

(h) Application of oinment on skin eruptions is strictly forbidden. Infringement of this rule aggravates asthma.

(i) If any discharge from the nose starts or if there is any skin eruption,

it is to be considered as a good sign. It suggests improvement in the patient's condition. Do not try to stop it.

(j) Avoid use of any pesticide, insecticides, mosquito coil or perfumed stick, as it is known to cause asthma.

(k) Clean curtains and bedsheets at regular intervals and expose mattresses to sunlight.

(l) Regular deep breathing exercises, including *yoga* should be done.

(9) *Daily record*: Maintenance of *everyday* sheet or event chart. This is a progress report of the patient. He has to fill in details everyday so that we are able to judge the patient's response to the medicine. It will permit us to decide about the medicine, its repetition, anticipated changes and actuality as observed.

For example in the case of asthma, one must note details about cough (c), cold (co), breathlessness (b), time of attacks, medicines taken and the periodicity (↑) increase, and (†) decrease should be noted. (See Appendix C).

(10) *Criteria for evaluation of results*: We must lay down in advance criterias for evaluation of patients as follows:

(a) Application of Hering's law of cure.

(b) Reduction in frequency of attacks.

(c) Reduction in severity of attacks.

(d) Break or change in periodicity of attacks.

(e) Feeling of well-being in patients.

(f) Investigation findings such as pulmonary function Testing, changes in IgE and IgM in cases of asthma.

(g) Drop in level of eosinophilia in cases of asthma.

(h) Increased resistance to known precipitating factors.

These criteria do not permit any exception. The patient's improved condition must be correlated with clinical findings and there has to be reversal of symptoms.

(11) *Progress Record*: Recording the progress of patients with modern methods of investigations as stated in para (10) above.

(12) *Retrospective study*: A retrospective study about the patient's case, treatment given and response received is to be done.

Retrospective study will provide information with regard to

(a) Clinical symptoms,

(b) Evolution of drugs,

(c) Response to medicine,

(d) Disease Prevalence,

(e) Frequency of disease in family,

(f) Type of allergens causing trouble,

(g) Mistakes committed which can be rectified.

(13) *Progress review chart*: Regular record of changes in patients response is recorded in this chart. (See Appendix D).

(14) *Drug proving*: Many new drugs from modern medicine, *Ayurveda*

and other systems of medicine can be incorporated by conducting drug proving. Data from toxicology and different pharmacopoeias can be collected.

(15) *Dissemination*: Regular meetings should be held to discuss the problems of research and new findings. We have to publish the results of our research in the form of a book or publish them in various journals.

We have discussed various aspects of an organised research. This type of work will enable us to evolve a well defined cure with greater effectiveness. It will also serve as a guideline for conducting research in different fields. It will be easily understood by a new entrant who follows an experienced physician and thus there will be continuity of work. The right approach will prove to be of help to the medical world and those who are associated with it such as government, institutions, medical scholars and para medical personnel, the efficacy of homoeopathic therapy.

(*See Appendix A on next page*)

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APPENDIX A

ARSENICUM ALBUM

Location	Sensation and complaints	A/F & <	>	Concomitants
Respiration	Respiration impeded, obstructed, imperceptible, irregular, impossible, gasping, short, loud, quick, anxious, rapid, stertorous, noiseless, hardly audible, oppressed, labored, snoring, hurried, gasping, deep, difficult, interrupted, whistling expiration, wheezing, choking; dyspnoed respiration loud, groaning, moaning. Respiration sighing, stertorous. Suffocative attacks want of breath, cardiac dyspnoea due to fatty granulation and degeneration of heart. Attacks of suffocation. Frequent inclination to sigh. Air passage seem constricted, cannot breathe fully. Sensation as if dust in air passages. Cramp in chest as if too narrow. Expiration whistling; throat and chest as if bound together. Respiration jerking during expiration. Dyspnoea felt in nose. Hay asthma. Humid asthma. Periodical. Gradually breathing became difficult esp. expiration, fine in tone like highest falsetto. Feels as if she would die of strangulation. Asthmatic attacks accompanying emphysema. Has to spriug out of bed.	A/F suppressed eruptions suppressed coryza suppressed itch < open cold air < vexation, anger < movement < nervous causes < laughing < every little excitement < lying down as soon as < dust < feathers < evening < walking < turning in bed < motion < cold drink < cold air < at p.m. < damp weather < windy	> Sitting up bend forward > from expectoration > drinking coffee or sugar with water > warm water or warm drink > warmth > rocking > sitting erect > retraction of shoulders	Restlessness Praecordial anxiety Fear of death Cyanosis Cannot bear sight or smell of food Feeling of great dryness Violent thirst; drinks little at a time Offensive smell from mouth Asthma with cough. Asthma with perspiration Abdominal distress Nausea, vomiting Exhaustion Cold clammy sweat Taste metallic, bitter and putrid Pain & palpitation

(continued)

APPENDIX A (*contd.*)

Location	Sensation and complaints	AF & <	>	Concomitants
Respiration	Asthma in old people. Asthma alternating with skin complaints.	< stormy < lying on back, side < midnight < after midnight < 12 midnight to 2 a.m. or 12 noon to 2 p.m. < going upstairs < wet weather < eating after < after exertion < expiration < inspiration < after emotions < offensive, fetid odours < walking in open air < from mucus in trachea < lying on back or sides < seashore < coughing < heavy air < warm & tight clothings		

APPENDIX B

Abdominal	Accelerated	Anxious	Arrested
Asthmatic	Catarrhal	Catching	Cheyne-Stokes
Convulsive	Deep	Difficult	Feeble
Forcible	Gasping	Groaning	Hard
Heavy	Hiccoughing	Hoarse	Hurried
Hysterical	Impeded	Imperceptible	Intermittent
Interrupted	Irregular	Jerking	Laboured
Loud	Long	Moaning	Nervous
Noisy	Obstructed	Painful	Panting
Paroxysmal	Periodic	Rattling	Shallow
Sighing	Short	Slow	Snoring
Snuffling	Sobbing	Spasmodic	Sponge, as if through
Superficial	Suppressed	Stertorous	Stridulous
Tremulous	Violent	Wheezing	Whistling

APPENDIX C

Week	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	Remarks
1st week	—	b.2 a.m. ↓ c̄ ℞	—	c. 4 p.m. ↓ c̄ ℞	—	—	—	Medicine was repeated every 2 hours.
2nd week	—	—	—	—	—	co 8-30 a.m. ↓ c̄ ℞	—	
52nd week								

APPENDIX D

Item					
Date/Month/Year					
Duration } average between 2 attacks					
Frequency per month					
Intensity					
Complications					
P.F.R. findings					
P.F.R. readings					
Reversal of signs/symptoms					