A TALE OF CAUTION

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This case history concerns a two-year-old child who was presented in my surgery in August 1982 with recurrent complaint of wheezing, which was brought on by exercise, eczema and a rash over his body which, by the time I saw it, was faded and papular. He had not been immunized against whooping cough or measles. He was born 3 months premature, forceps delivery, weighing 6 lbs. He was bottle fed and was then adopted by his current parents. Apart from some diarrhoea in infancy and a roseola infection, his development to date had been normal. He was a high-spirited child and was very sensitive and cried if another child cried. On examination at the time, apart from the rash his chest was clear, although I did not auscultate his heart—an omission which I later regretted. I prescribed Tub. bov. 200, three powders to be taken 12-hourly, followed by Phosphorus 6 t.d.s., and instructed his parents to try reducing the amount of dairy products that he was taking.

I will now relate the events as I have pieced them together, though it has taken many months to work it out. Due to some breakdown in communication between myself and the parents, the child was given Phosphorus before the Tub. bov. and two hours after taking the first dose, on the way home from the surgery, he became tired and pale and on reaching home passed a very dark stool. He improved slightly over the next two days then became more tired, pale and anorectic. He was given two Disprins and collapsed with gastrointestinal bleeding. He was taken into Kingston Hospital and a laparotomy performed which showed a hugely dilated stomach containing huge quantities of blood. There was no evidence of ulcer, Meckel's diverticulum or venous engorgement. The mucosa was generally oozing. A gastrostomy was inserted for post-operative irrigation, but he then developed bronchospasm and collapse—consolidation of the left lung. It was noticed just before operation that he had a systolic murmur with a 2nd split sound and immediately post-operatively he developed a persistently low arterial PO_2, demonstrating a shunt. He was transferred to Great Ormond Street where he was found to have pulmonary atresia and a VSD. He was operated on and given a Blaycock-Taussit shunt.

I am glad to say that this tale has a happy ending and he is now generally a well little boy, although he still faces the possibility of two further operations on the heart. The point of this tale is two-fold. Firstly, a reminder, mainly to myself, to always examine thoroughly the cardiovascular system in cases of difficulty with breathing. Secondly, the gastric bleeding was blamed on a mixture of Disprin and Phosphorus although the Phosphorus was in the 6th centesimal potency. Although I very much doubt whether the Phosphorus 6 could cause gastric bleeding, I felt it beneficial to publish this case

as a reminder that we do not know all the answers as to the possible interactions between Homoeopathy and orthodox medicine, and to see if further cases of bleeding have occurred after administration of *Phosphorus*.

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