

FUNGOID ANTIBIOTICS AND SYCOSIS*

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We are going to study to-day the effects of fungoid antibiotics on the human body and will endeavour to see whether these substances may lead to such changes as to justify the notion of sycosis as described by Hahnemann.

We will then proceed to examine the various repercussions of the fungoid-antibiotic treatment on the behaviour of the organism and its pathologic results.

We ought, therefore, to divide the problem into two parts :

(1) We will see if an antibiotic may itself be the direct cause of sycosis

(2) We will examine as well whether the changes due to antibiotics are, on the other hand, capable of creating sycosis and if such reactions are necessary and sufficient to lead us to this syndrome.

Let us first see whether an antibiotic may itself be the direct cause of sycosis.

I am afraid it is rather difficult to reply in the affirmative.

As a matter of fact sycosis is not, by definition, a morbid syndrome, which establishes itself rapidly, in a few days.

Now, such profound changes of the organism as follow the antibiotics at once are thought of by the Allopaths as occurrences due to that treatment. As far as we are concerned and because the speed at which these cases develop, we cannot consider them *a priori*, as the first steps on the way to a sycotic development.

We have to make a clear distinction between the two types of these cases :

(1) Those that are due to the toxic effect of the antibiotic substance and differ according to the antibiotic in question; cases of disturbance of the nerves and of the cochleo-vestibulair system

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as with cases of disordered blood formation as that of Tiphomycine, hepatic as with Aureomycine, etc.... All these occurrences only show the specific toxicity of each substance and the threshold where the allergic sensibility of the individual to certain antibiotic occurs.

(2) Cases demonstrating the repercussions of any antibiotic on the skin and mucous membranes.

I have to call your attention to a strange fact here; cutaneous or mucosal affections recorded at the beginning of fungic treatment are similar to those recorded much later, after the end of the treatment.

The antibiotic had simply intensified or brutally revealed the syndrome that had so far been latent and did not manifest itself.

We will see later how this comes about.

We may now say that the antibiotic itself is not responsible for the sycosis, it rather makes its appearance possible.

Therefore I do not think that the administration of dynamic dilutions of Penicillin, Streptomycine or others of the kind can produce any change whatever on a sycotic field revealed by the administration of antibiotics. These diluted and dynamised substances are of no use except in liberating the patient from the specific virulent hold of an antibiotic given in massive doses. Their only purpose is to neutralize the toxins and not a toxic-sycotic neutralization.

This is why I do not intend to classify the dilutions of dynamised antibiotics among antisycotic remedies, these may only help as adjuvants. We will see further on that, they could be extremely useful in that role.

I said adjuvants only, for the sycosis that develops by the absorption of an antibiotic needs a "relay" in order to manifest itself. What is then this relay by which this pre-existing substance is capable of revealing a latent sycosis in reaction to a fungic treatment? In my opinion it is the *Candida Albicans* or *Monilia Albicans*.

This is a mushroom from the family of Levures, a normal saprophyte of the human organism, its regular seat is the ileo-caecal region and its spores may be found in stools. The *Candida Albicans* had already been known before the age of antibiotics

but was somewhat neglected, it had suddenly come to light with the advance of antibiotics.

Our Allopath colleagues have been meditating on this problem for a long time and now attribute to *Monilia* a considerable part of the remote complications involved in fungic treatment. It had been noted that as a result of antibiotics this mushroom is in the process of multiplication. There were a number of explanations of this phenomena. According to one of them a sort of *modus vivendi* would be established between the *Monilia* and the intestinal microbic flora, preventing the further spread of this mushroom. The antibiotic in use would only affect the microbic flora and would respect the *Monilia*—the latter meets no restraining barrier and although it retains its proper position it also becomes capable of individual existence and manifests its presence thereby. Others thought that apart from the microbic antagonism, antibiotics themselves are capable of furthering the *Monilia's* virulence.

Let us nevertheless remember, that such biologists as Vand-breuseghen for instance, advise us to add some Penicillin to Sabouraud's meduim in order to gain a pure *Monilia* culture. It is hard to say whether this is to be done in order to eliminate the intrusion of microbes or for directly influencing the growth of *Monilia*.

Whatever the case may be, we see now that the first effect of the intervention of an antibiotic on the intestinal contents is the dispersion of the microbial flora of the intestine, and always in the same order; first the Coli Bacillae, then the Staphylococci Albi and finally the Clostridia and Enterococci.

This will result in a microbic destruction that might in turn let loose a toxic invasion, which itself is a cause of sycosis. On the other hand, some persisting germs such as the *Proteus*, *Prodigiosus*, *Staphylococcus*, *Pseudomonas* and *Mycose* may appear and they could also lead to sycosis. Another important result of the antibiotic treatment is the disappearance of the Vitamins in the organism, especially the vitamins of group B.

There are two principal explanations of this fact;

On one hand it is attributed to the disappearance of microbes responsible for the entero-synthesis of vitamin B.

On the other hand, it has been suggested that the *Candida Albicans* could itself be a great consumer of vitamin B.

Cases of deficiency of vitamin B during antibiotic treatment are so common that some tried to reinfect the intestine with Lactic bacilli but this proved to be of no avail. Patients have been given vitamin B or its relatives of the B group such as Thiamine hydrochloride, Riboflavine, Nicotinic Amide, Calcium Pantothenate, Pyridoxine hydrochloride. These synthetic vitamins seem to give the best results but are as yet inconsistent. As for our own position, we believe in prescribing more of those synthetic vitamins in the form of dry yeasts which contain vitamins of the B group.

What are the clinical manifestations of vitamin B deficiency?

It is astonishing to note that we encounter once again the affections of the skin and mucosae attributed to *Candida Albicans*. There is an alarming similarity. Is one the cause of the other or vice versa?

Or are they in fact common syndromes? At present it is impossible to answer the problem with any certainty.

To resume, we may think that antibiotics (even if they are not direct causes of sycosis) are capable of producing many of them by the following mechanisms.

1. By producing microbic lysis and thus liberating toxins—
2. The appearance of a new microbic flora producing toxins—
3. Deficiency of the B vitamins—
4. The proliferation of *Monilia Albicans* which becomes pathogenic.

Everything I have said so far is already known. As for the *Monilia Albicans*, the relationship between sycosis and this abnormally flourishing mushroom has not been established. Until now the sycosis as described by Hahnemann contained microbic elements only. Now it becomes possible to specify a new form of sycosis based on an element of Mycology. We are already calling it "Mycosycosis".

We did not want to call it "Fungosycosis" for this would have implied that the fungoid antibiotic element was the *primum movens* of this sycosis—while in fact the mycologic element in question certainly seems to be the *Monilia Albicans*. There are

many pathogenetic signs of the *Monilia Albicans*, nevertheless I am going to demonstrate to you only those that have been regularly observed in a fair number of cases. I have deliberately disregarded all inconstant symptoms, whatever their value otherwise may be. This is why my list is quite short, my main pre-occupation being scientific accuracy. I have to add, on the other hand that the following pathologic symptoms are not in the least a transposition of facts that could be called in evidence by the Allopaths. These are symptoms that we ourselves observed either disappearing by the first administration of *Monilia* or appearing at once, in a few hours after *Monilia* had been taken and had provoked a medicamental aggravation.

One final remark: having examined the beginning of pathogenesis we were struck by its close relationship with some already known sycotic remedies, such *Arum Triphyllum*, *Antimonium Crudum*, *Petroleum*, *Nitric Acidum*, *Argentum Nitricum*, *Graphites*, *Dulcamara*, *Rhus Tox.*, *Natrum Sulfuricum*, *Thuja*, *Mercurius*, *Alumina* etc. . . .

All these are hydrogenoid medicines, their sphere of action is cutaneo-mucous and their origin gravitates around the digestive tube; this may clearly demonstrate the gastro-intestinal origin of this kind of sycosis.

Here is, in brief, the pathogenesis of the *Monilia Albicans*:

Mouth—Difficulties of speech, dry, cracking, red, either white in the posterior half or the papillae extend and the tongue seems to be hairy, if pushed with a tongue depressor it would leave a trace of depression resembling trampled grass and the tongue depressor is covered with a kind of exudate. The stomatitis is aphthous with whitish vesicles and sediment and a fetid breath.

Considerable sanguineous gingivitis. Mouth and tongue are extremely dry. Dry cracked lips, reddish and itching of the type of *Arum Triphyllum*, *Rhagades*.

Skin—Eczemas, mainly characterised by linear fissure, localised in cutaneous or mucous creases. The legs are to be examined above all:

Legs—The most important eczema is located in the fourth interdigital zone, representing a macaretion of the skin with a red linear, more or less deep and painful fissure underneath. Small

vesicles on the toes, on their external and internal sides and the planter side. These vesicles are usually of the size of a pin's point but may acquire much larger dimensions, become confluent and surrounded by an inflamed red zone, accompanied by itching. They contain a viscous white liquid which may also be blackish and haemorrhagic, specially in more severe cases. They desquamate when dry. These lesions remind one exactly of what is described as athletes foot, caused by the fungi related to *Monilia* such as the *Trichophytum* and *Ctenomyces interdigitalis*.

The nails are also affected. The skin of the nail-bed is swollen and depressed, red and inflamed. The nail itself shows traces of transformation caused by perionychia. These changes are always due to the perionychia, for the *Monilia* does never affect healthy keratine initially but only when the keratine has been altered. The nail then shows transverse furrows, becomes black and very depressed, its distant inferior side is proliferated to form a comb or a brush, forms a sort of raising hair, hardens and its growth is arrested. This is first visible on the big toe, it is the nail of Graphites.

Hands—The same vesicular eruption is found on both the internal and external sides of the fingers. Small pruriginous eruptions go on to desquamation. The same kind of changes are seen in the nails as observed on the toes.

Other sites of the *Monilia* eczema, which, let us remember again, are always characterised by linear crevices of the cutaneous or mucous creases are:

Popliteal abscesses, inguino-perineal intertrigo, perineal eczema, eczema of the creases of the buttock, greasy and fissured eczema of the umbilicus, moist and fissured eczema of the submammary creases, axillary eczema, squamous and crevaceous eczema of the creases of the elbow.

Another very important symptom is the lichenoid vulvovaginitis with vesicles and pustules of intense itching and greasiness. These lesions might result in a veritable vulvo-perineal keratinisation, showing a picture of Kraurosis vulvae.

As we have just seen these localisations, excepting the creases of the elbow and the popliteal hollow, are usually at the moist

cutaneous and mucous creases. As in nature, the fungi prefer the shelter of humidity and creases to light.

Apart from these typically eczematous lesions, symmetric eczemas of the thorax, the arms and forearms are often observed. They might either be dry or vesicular; it has been impossible to isolate the spores of these vesicles up to now. These supposedly allergic lesions easily disappear when treated with dynamised dilutions of the *Monilia*.

This idea of cutaneous allergy had led us to observe the veritable and often spectacular action of *Monilia* in the case of allergic asthma that may be clinically observed provided that the asthmatic patient show symptoms of *Monilia* beforehand.

As for the intestines the main complaint is constipation often accompanied by entero-colitic pains, especially felt in the region of the caecum which is the preferred site of the *Monilia Albicans*. The use of this remedy not only eases or disperses caecal sensibility, but also has a considerable influence on the constipation.

We have also noticed that the *Monilia* is capable of dispersing mucous and cutaneous lesions and may cause complaints of a polyarticular arthritic nature. Again the administration of *Monilia* allays the arthritic lesions if they were already present.

So far we have been unable to describe with the same certainty other characteristic symptoms of *Monilia*. Nevertheless, we may say that the *Monilia* seems to have a considerable influence on the endocrine glands, especially on the ovaries and the thyroid. It seems as if the administration of *Monilia* raises a veil that covers the ovaries and the thyroid and interferes with their normal work. We have seen, among others a benevolent influence of *Monilia* on utero-ovarian congestion associated with ovulation.

How should we, in fact, approach the treatment of this sort of sycosis?

Let me at once say that we had started by prescribing decimal dilutions and very soon we got as far as the fifteenth Hahnemannian centesimal. This is the dilution of which we have the greatest experience. We approached Mr. Henri Boiron and asked him to prepare it for us. The culture of *Monilia Albicans* was supplied by the Pasteur Institute and the dilutions were prepared according to the usual method.

I ought to stress that there is no question of letting the *Monilia* replace the usual sycotic remedies that I had mentioned, but when the activity of *Thuja* for instance seems to be arrested and ineffective the administration of *Monilia* does away with the sycotic barrier and lets the *Thuja* work with all its force.

I have to call your attention to an extremely important point in this regard; in spite of the tradition which demands the administration of Nosodes such as *Medorrhinum*, *Psorinum* etc. . . . at the end of the treatment, it is exactly the opposite which should be done—*Monilia* should be given the first day before anything else. Thus the Mycosycotic barrier will be overcome, and thereby all further drugs that follow will be able to regain their real nature and intensified potential. This is why we are in the habit of giving two grains of *Monilia* 15th at the beginning of the treatment and this does not at all prevent us from repeating it in the following weeks.

Secondly, as we have just observed, the pathogenic action of the *Monilia Albicans* goes hand in hand with a disturbance of the intestinal microbic harmony and with a deficiency of vitamin B, it seems normal that we add these two notions into our therapy.

Apart from doses of *Monilia* and other sycotic remedies as indicated by the Medical Material we should then consider about various nosodes corresponding to the toxins liberated by microbic lysis or by the appearance of a new microbic flora, that is to say the Staphylococci, Colibacilli, Enterocci, Proteus, Prodigiosus etc. We supplement the deficient vitamins by vitamin B or, even better by dry yeasts etc. Lastly, let us not forget from the list the antibiotic that started the sycotic manifestation in dynamised dilutions.

I have just mentioned the appearance of a new microbic flora. May I describe the results of some personal observations, concerning the role of Prodigiosus, that have been lately confirmed, by the trials of our Allopathic colleagues. Before the Nosodes were suppressed, we used to associate the *Monilia Albicans* with the Prodigiosus.

As a matter of fact, a long time before the action of *Monilia Albicans* had been observed, we remarked the intestinal of Bacillus Prodigiosus in collodial suspension that Dr. Chauchard adminis-

tered to patients with certain forms of cancerosis. These preparations frequently provoked intestinal crisis or at least had a favourable influence on constipation. Thanks to the kindness of Dr. Chauchard we could make homœopathic dilutions of this *Bacillus Prodigiosus* from these preparations.

We were then able to make clinical observations and realised that these dynamised dilutions had also an important intestinal action. But at this stage we could not say why and exactly on what subjects these dynamised dilutions of the *Prodigiosus* reacted in a characteristic manner. We thought that perhaps the Laboratory might be of help. Mr. Henri Boiron was kind enough to put his biological laboratory at our disposal, where we made the following experiment; we filled the left hand part of a Petri dish up to its middle with *Monilia Albicans* and the right half was inoculated with *Bacillus Prodigiosus*. In a few days we could observe that these two originally juxtaposed cultures were divided by a sort of no man's land, free of any traces of colony or culture conquering and driving back the zone of *Monilia* as if the *Prodigiosus* had hidden some substance that destroys the *Monilia*. We then proceeded to make the same experiment with other bacteria but the *Monilia* stayed absolutely indifferent to their proximity.

Our financial problems have unfortunately prevented us from recommencing and continuing these experiments, I simply indicated these results hoping to repeat and control the above mentioned experiments as soon as possible. Up to now and as I have just said with the reservation of further controlled experiments it is only the *Prodigiosus* that seems to have a decisive action on the *Monilia* in forcing it to withdraw.

Only the future will tell us whether we may be able to find an explanation of the clinical results that we observed while associating *Monilia* to the *Prodigiosus*. We shared our conclusions with Dr. Chauchard and they confirmed, according to him, his bacterologic research. Dr. Chauchard and Dr. Despujols have in fact succeeded in isolating from the *prodigiosus* an antibiotic found only in the pigment of this bacilli, but this new antibiotic proved to be too virulent to make use of it without danger. Let us say on this subject that the Americans have focused attention on a new substance coming from the *Streptomic Noursei*, that they

are calling Nystamine. Contrary to antibiotics, it has an elective action on *Monilia* and is ineffective against normal microbes. In allopathic medicine the tendency is to associate it with the usual fungic substances.

And one last question; could this form of sycosis be hereditary?

We are short of information and unable to express an opinion. This notion of heredity would in any case be quite difficult to establish. We might remark that the Moniliases are such more frequent in case of babies and children in the present age than before the age of antibiotics. But this would not however permit to affirm the notion of heredity. In fact, the Vaginal Moniliasis have become frequent since the often thoughtless use of various antibiotics and the new-born is infected at birth.

It would be possible to make observations in case of children born by caesarian section eliminating thereby all risks of contamination. The examination of salts of this new-born could also be systematically followed in order to prevent cuticular and intra-dermal reactions to *Monilia*, as already practiced in Allopathy.

Let us note however that it has been proved that Penicillin acquires allergic properties owing to its combination with the protein of serum. Sensibilisation might come into effect in utero, by the fact that the Penicillin goes through the placental barrier and circulates in foetal blood in a concentration representing two thirds of the original dose. This was communicated by Dr. Bickel of Geneva at the thirtieth Congress of Medicine in 1955 in Algiers.

To conclude this lecture; we have seen that if the use of antibiotics may result in a case of sycosis this may only happen by the means of relays that I have just mentioned and they are the real causes of this sycosis. As for the Mycosis it is only one of the forms revealed by the spread of *Monilia*, thanks to the intervention of antibiotics.

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