MANAGEMENT OF LEUKAEMIA AND ALLIED HAEMATOLOGICAL DISORDERS IN HOMOEOPATHY*

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The Hahnemannian miasmatic theory and the theory of chronic diseases are the studies of a lifetime, the study which one can never afford to neglect in present day medical structure.

Instead of talking just about the principles of chronic diseases and the miasms, today, I would prefer to take up a named group of disease condition in hand and then approach it with Hahnemannian genius philosophy. I have already talked over the coronary artery diseases, chronic respiratory disorders and disorders of liver and gall bladder. In this series we move further to the management of leukaemia and other allied malignant haematological disorders, which is the talk today.

Leukaemia and other allied malignant haematological disorders are now known for quite sometime and are also recognised as diseases of modern times.

The one basic question being asked again and again both by the layman and the practitioners of the other school is: "What has Homoeopathy to offer in conditions like leukaemia? Is Homoeopathy capable of handling such cases?"

Well the answer is not that easy to be given in a simple manner and would come gradually during the course of this paper.

Getting right into the work we first peep very briefly into the history, classification, pathology and clinical features of the disease group.

THE HISTORY OF LEUKAEMIA

Cases of splenic eulargement accompanied by purpura and lymphatic glandular swelling has been described since the earliest medical records.

The ancient Indian medicine, Ayurveda, presents records dating 2000 years back.

The history of medicine, however, does not present much till the middle of the 19th century which is regarded as the time of recognition of present day leukaemia.

A paper entitled 'Observation on Abdominal Tumors and Intumescence' illustrated by cases of diseases of the spleen by Richard Bright of Guy's Hospital, physician extraordinary to the queen makes clear the position of advanced medical opinion on this subject in 1838.

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It is interesting to note that by this time clinicians were so close to the idea of a disorder of 'sanguification' involving the spleen, pathologists and microscopists had been surprisingly slow to exploit and extend the microscopic studies of blood and recognition of white globules initiated by William Hewson in 1774.

The clear recognition of leukaemia awaited the marriage of clinical and microscopic evidence which was brought about independently in several centres between 1839 and 1845.

The introduction of differential staining methods, developed and expanded by Paul Ehrlich from 1877 onwards greatly facilitated advancement of leukaemic knowledge.

Later cases of leukaemia with clinical, post mortem and microscopic findings were independently published in Paris, Edinburgh and Berlin.

It was Virchow in his description of further similar cases published in November 1945 who identified the abnormal corpuscles in the blood as W.B.C. and later in 1847 proposed a new name leukaemia for the disease.

CLASSIFICATION

Various forms of leukaemia are classified according to the (a) anticipated acute or chronic course of the disease, and (b) the predominant type of cell involved.

A detailed clinical classification does not come under the domain of this short paper.

PATHOLOGY

The basic pathological changes in leukaemia are related to the primary proliferation of leukopoietic tissue and to secondary changes consequent upon disturbed functions of involved organs.

THE CLINICAL MANIFESTATIONS

The clinical manifestations are varied but some of the important and common manifestations are principally due to:

(a) Hypermetabolism associated with rapid growth and destruction of leukaemic tissue.

(b) Bone marrow dysfunction.

(c) Disturbances of organs involved in leukaemic proliferation.

The increase in metabolism is manifested by fever, weight loss & fatigue.

Bleeding and easy bruising are associated with thrombocytopenia.

Deficiency in normal granulocytes are associated with extensive infections.

Leukaemic infiltration may lead to enlargement of liver, kidneys and testes.

Homocopathy as such does not advocate of a case presenting for the first time as leukaemia with its classical clinical and laboratory presentations

for we must grab it symptomatically much before the pathological evidence of the disease.

THE MIASMATIC BASES OF LEUKAEMIA

It is true that Hahnemann never made or gave classification of any particular disease condition like leukaemia. He was at no time interested in doing so. He was a thinker much ahead of his time. His work on chronic diseases with special reference to miasms includes every aspect of disease not only past and present but also all the disease conditions to come in future. No matter what sophisticated aristocratic medical name they get.

The study of miasms has been a very rational and interesting study but has been from time to time confused.

We should be very clear with one basic idea that no specific pathological condition results from a specific miasm. However, all the three miasms can result in any pathological condition.

Thus leukaemia can arise from any combination of miasms.

The age at which disease occurs is a measure of the number of miasms

Let us consider two patients with Leukaemia:

(A) Patient A at an age of 70 after a life time of good health. In this case may be only psoric miasm is involved.

(B) Patient B in childhood. In this there may be a likelihood of dominance of more than one miasm.

This can be easily determined by patient presentation.

It would be interesting to glance at the view of Grauvogl here: "The glandular enlargement and accompanying cachexia described by Virchow were familiar to the older physician under the name of sycosis."

Grauvogl admits an infection of the system by gonorrhoeal poison and its accompanying condyloma as only one of its exciting causes and believes the essential condition to be one in which the blood contains too much water. The patient feels worse from cold, damp weather and rain.

The complaints are aggravated by bathing, drinking much fluid etc.

And these I have personally observed time and again in leukaemic cases, suggesting the dominance of the sycotic miasm.

MANAGEMENT

And now we finally come to the most important part of our talk that is the management.

Before we enter into the world of management we must be very clear with one basic idea that we are managing not only leukaemia but the patient as an individual with leukaemia. *It is not enough for us to know that it is* a case of leukaemia or further that it is a case of acute lymphocytic leukaemia. But, how does this individual case differ from every other case.

This is our basic philosophy and at no time can we afford to neglect. This is the first important hurdle for us to cross. There can be no compromise at this basic primary stage.

Now we move further with an open unprejudiced mind.

Despite the advances in radiotherapy and selective chemotherapy, leukaemia still remains an ultimately fatal disease, the course of which, however, palliated, is beset from time to time.

The clinical presentation can be divided into three categories:

(A) Patients who present features suggestive of leukaemic disorder but without any pathological evidence of the disease.

This is the most ripe field for us to work. Such patients as a rule present derangement more marked in the mental sphere.

Green (1949) reported studies on twenty males and thirty-two females with leukaemia and concluded that the majority of patients suffered from various types of personal loss or separation from a key object or goal with resulting sadness, depression, hopelessness, weakness and anorexia for months before the onset of the somatic disease.

Here we have to individualise the patient considering both the mental and physical sphere. We have to determine the dominant miasm and go immediately for the appropriate similimum.

(B) Patients who present a definite leukaemic pattern supported by pathological evidence of the disease type.

Such patients as a general trend do not usually come in directly at the homoeopathic outdoor and indoor sections but prefer to go in for the more popular chemotherapy and radiations.

Although at this stage the right homoeopathic symptomatic treatment has time and again relieved suffering.

(C) Patient as an established case who has had adequate radiation and chemotherapy.

These are some of the common cases coming to the homoeopathic wards with shattered last rays of hope.

Homoeopathy has still to offer at this stage. In such terminal cases palliation is the most challenging task confronting the homoeopathic physician. Such cases as a rule respond temporarily well to the acute remedies which are to be changed constantly to the ever changing totality in order to obtain right palliation. In patients who have already had adequate steroids and chemotherapy it is a great problem to administer chronic deep acting remedies. They time and again generate a sort of reaction in the body from which it is difficult to arouse the patient.

In these terminal cases with malignant haematological disorders my experience has been to see the patient daily changing the acute remedies constantly and timing the dose according to ever changing totality and severity.

(D) At the end in a dying patient

Our role as a homoeopath still continues to minimise the suffering at the time of death.

As the time of death approaches Homoeopathy's role changes from the

process of cure to the goal of offering the patient the maximum degree of awareness with minimum amount of suffering.

And now some of the important remedies.

Grauvogl recommends: Natrum sulph. and Thuja occidentalis as the main remedies.

Lilienthal in a study of leukaemia recommends the study of Natrum muriaticum.

Richard Hughes in his *Principles and Practice of Homoeopathy* recommends a promising remedy in Picric acid.

William Boericke in his *Materia Medica with Repertory* refers to Arsenicum, Picric acid and Thuja occ.

Kent's *Repertory* under the rubric Leukaemia presents the following as first and second grade medicines: *Calc., Calc. phos., China,* Nat. ars., *Nat. mur., Nat. phos., Nat. sulph., Picric acid.*

Julian in his *Materia Medica of New Homoeopathic Remedies* refers to X-ray and Sulfanilamide.

We these are some of the important remedies recommended by elderly homoeopaths. But they in no way limit the number of remedies to be used, for the similimum is the final goal.

CLINICAL CASES

Case 1: Mr. J a male aged 38 years first sought medical advice in March 1978 because of enlargement of lymph glands in the neck. Examination revealed gross lymphadenopathy at all palpable sites. The gland masses measuring up to 7 cm in diameter. The spleen extended 10 cm below the umbilicus. A sternal marrow aspirate and lymph gland biopsy confirmed the diagnosis of chronic lymphocytic leukaemia.

Not being bothered with the name of the disease I preferred to go in for symptomatic presentation. Mr. J was calling all the time for Bryonia alba. He was always wanting to lie down. Feeling a little better by sleeping over the enlarged spleen. A dry spasmodic cough, hard dry stool and dryness of lips added further weightage to administration of Bryonia.

Bryonia was prescribed in 30c potency thrice daily along with Ceanothus americanus 5 drops twice daily. Case responded well with marked reduetion in size of palpable lymph glands and spleen besides a general fecling of well-being.

At this time I knew that Bryonia alone would not cover up the case. I was on a look out for a deep acting chronic remedy. Case was repertorised. Phosphorus and Calcarea were the two remedies shariug equal claims. Phosphorus was decided as the patient had a tall cylindrical appearance and his mother added how her son used to get frightened during thunderstorms.

Phosphorus was prescribed in 1M potency a single dose. This was followed by several doses of placebo and other acute remedies. Patient feeling gradually all the time better.

Complete investigations done exactly after six months showed a spectacular improvement.

Haemoglobin—12.2 g per cent

Platelet count—350,000 per cu mm.

Total leucocyte count—4,000 per cu mm.

Spleen was non palpable.

Full remission was maintained for nearly 2 years before recurrent lymphadenopathy, enlarged liver and spleen in April, 1980.

This time the patient and his family members preferred to go in for the chemotherapy. This was continued for about two months, with patient's condition getting worse. It is important to note here that patient never felt mentally well. He was again brought to me but in spite of repeated efforts did not respond before his death two months later.

Remarks: One basic difference observed time and again between well selected homoeopathic remedies and much talked of chemotherapy is the all time feeling of betterment in the mental sphere with homoeopathic remedies. The patient feels mentally happy, cheerful which is very important.

Case 2: A young male aged 16 years coming from a middle class Indian family was first seen in early July 1977 with chief presenting complaint of loss of appetite and painful, hot, swollen stiff right knee joint. On examination a moderate splenomegaly and lymphadenopathy was found:

Laboratory investigation revealed: primitive cells in the peripheral blood, sternal marrow showed 90% lymphoblast.

Belladonna in the 30c potency was prescribed twice daily as it was a typical Belladonna presentation. This was supported with whole blood transfusion. Laboratory investigation on the twelth day revealed normal bone marrow and peripheral blood cytology. After a 2 month remission a severe relapse rapidly developed with gross splenomegaly and Lymphadenopathy at all palpable sites.

The acute condition called immediately for Rhus tox which was prescribed again twice daily in the 30c potency. The patient did not improve getting a little more restless rather somehow wanting to move to ameliorate his condition. Rhus tox was prescribed in the 200c potency. This helped to improve the acute conditions. This was followed by other acute remedies namely Colchicum, Bryonia and Ferrum phos. In the meantime with amelioration of acute conditions I was on a look out for a chronic remedy. The strong family history of tuberculosis, the body structure, emaciation and ever changing of symptoms found its similimum in Tuberculinum which was prescribed in 1M potency. Patient recovered very well and in two months time could resume his day to day activities.

Laboratory investigations done in middle October 1977 showed:

Haemoglobin—11.4 g per cent

Platelet count—80,000 per cu mm

Total leucocyte count—8,000 per cu mm.

The only abnormal physical sign was just detectable splenomegaly. The patient was discharged and was called first every month and later every two months for a follow up. Later we did not hear from the patient for eight months as he felt normal. Patient again reported with severe relapse in our outpatient department in early November 1979 and later died the third day with severe bronchopneumonia and cerebral haemorrhage.

Remarks: We have a number of illustrated cases doing very well. I particularly wanted to present this case to show that we could not do much in this case because of an ill follow up on the part of the patient. There are numerous cases who have responded very well, depending upon the follow up management. It is important to note that in cases who have had no chemotherapy there is a fairly good response to our well selected remedies.