A CASE OF DIABETIC PERIPHERAL NEUROPATHY TREATED WITH ZINCUM MET. IN LOW POTENCY*

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Mrs. M. G., age 44, first consulted me on 20.8.82 and gave the following history. She had suffered from diabetes since 6 years old and had had insulin twice daily for the last 37 years, including 32 years on protamine zinc insulin. All this time she had been under regular hospital surveillance, and was currently maintained on insulatard (pork isophane insulin)) 40 strength, 9 units b.d. Her diabetes was still unstable, she could not control her glycosuria satisfactorily, and still had severe attacks of hypoglycaemia. (She failed to keep one of her subsequent follow-up appointments, because on that morning her husband found her nearly unconscious, and just managed to get sugar into her before the ambulance arrived in response to his 999 call.) Ten years ago she had developed severe diabetic peripheral neuropathy, and in recent years had had a frozen shoulder (left), a transposition of her left ulnar nerve (1981), and an operation for a left median carpal tunnel syndrome (1981). To add to her problems she suffered from angina pectoris and fluid retention.

For the previous year her medication had been:

Dolobid (diflunisal) q.i.d.
Feldene (piroxicam 10 mg) t.i.d.
Distalgesic (dextropropoxyphene) 8 tabs daily.
Sectral (acebutolol) 100 mg daily.
Frusemide 40 mg on alternate mornings, alternating with Moduretic (amiloride and hydrochlorothiazide).

Despite this heavy dosage with analgesics she was still in considerable pain.

She complained of:

1. Severe pain "like someone permanently sticking needles in the soles of my feet" and "like electric shocks in my legs and bottom", especially severe at night, and on waking. The pain was > cold, so that she spent most evenings sitting on a rubber ring with her legs exposed.

2. Severe cramping pains on sitting, necessitating constant changing of position; she had to stop the car three times during the 20 miles journey to her consultation, and be helped out, to stretch her legs, to ease her pain. These pains began about 10 years ago, but had been very much worse for the last year.

3. Loss of sensation in her legs, and loss of balance after sitting so that

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she had "to be helped to get balanced on attempting to stand up and walk". She was only able to walk about 20 yards.

4. Total bilateral anaesthesia of lower limbs, up to her thighs. (She demonstrated how she could insert a hypodermic needle full length into different parts of her thigh without any feeling of pain).

5. Inability to dorsiflex her ankles, so that in the days when she was still able to drive, she had to lift the whole of her foot off the pedal.

6. Inability to stand unless wearing shoes with adequate high heels.

7. Paraesthesia of upper limbs. "My arms go numb, so I don't know where they are." "It makes me drop my knitting." Wrists and fingers stiff and numb on waking, with "jumping pains" > movement.

8. Dependency on others, needing help to get up in the morning and dress. "I have to come down stairs on my bottom." "All joints from the waist down are painful and stiff on waking", necessitating movement to ease.

9. Profound lassitude.

10. Ulcers of her ankles and feet, and recurrent sepsis around her toe nails. The ulcers started about 5 years ago, invariably following minor trauma, lasted 6-8 weeks, and there was usually at least one present at a time.

11. Fluid retention. "If I don't take my diuretics I rapidly gain 2 stone (12.7 kg) in weight."

TREATMENT

As her most pressing need was for relief of pain, I prescribed mainly on her particular symptoms:

1. Phytolacca 3rd q.i.d. until improvement.
2. If no response after 10 days change to Agaricus 3rd q.i.d.

I instructed her to continue taking all her conventional medication, explaining that in her case homoeopathic medication was an additional therapy, but that she could reduce the analgesics if she found the pain diminishing.

Phytolacca in its provings produces:

Shooting pains like electric shocks, that radiate, especially in the distribution of the brachial plexus, and sciatic distribution.

Rheumatic type of pains—very like those produced by Rhus tox., i.e.
<am <wet <cold <night
>warmth >dry but are <motion (like Bryonia)

In the United States of America the fruit and root of the plant have been used to allay pain, and as an antirheumatic.[1]

Agaricus (which contains muscarin) in contrast produces:

Jerkings, twitchings, tremblings, chorea-like movements, and itching.
Neuralgia—painful spasms, tearing pains, with numbness, coldness, and tingling <cold >movement
Paralysis of lower limbs
Pains as if pierced by needles of ice
Itching of toes, and feet, as if frozen—burning, itching, redness

Swelling as if from frost bite (hence its use homoeopathically in the treatment of chilblains)
Ataxia

At her second visit 2 months later (22.10.82) she reported:
Sleeping better
Discontinued all dolobid and feldene, and reduced distalgesic from 8 to 2 daily.
"I have only taken 4 in last 4 days."
She considered Agaricus helped more than Phytolacca, and after 3 weeks had reduced the dose to Agaricus 3rd one nocte only. "It stops me waking up."
She could now sit for short spells without her cushion.

℞ Zinc. met. 200×1, repeating every 14 days if required. Try withholding Agaricus.

22.12.82—"Zinc. helped for 3-4 days, but best improvement came after reverting to Agaricus."

"Occasionally wakened by restless legs, then I have to walk the room."

℞ Zinc. met. 10M×1 and try Zinc. met. 6 t.i.d. in place of Agaricus.

19.1.83—"Zinc. 6 suits better than Agaricus 3rd."

She c/o burning, swollen, hot, stinging wrists, swollen feet and ½ stone (3.2 kg) weight gain each evening (despite diuretics) which disappeared each morning.

℞ Apis 3rd q.i.d. until relief.

2.3.83—Discontinued all conventional analgesics for last 3 weeks. Apis relieved both wrist pains and fluid retention dramatically.

"I can now move more easily, and walk 50 yards, the best for over a year."

I have no jumping pains, and the numbness is considerably improved."

9.5.83—No analgesics for last 3 months.

Sleeping more comfortably—less dependent, more mobile. Takes Zinc. 6 q.h.

1-2 doses on days when pain returns, on average on four days each fortnight.

She stated that one or two doses of Zinc. 6 predictably stopped her pain.

However, she complained of persistent dyspepsia for last month with hunger pains, eased by Tagamet (cimetidine) and Maxolon (metoclopramide).

She was awaiting a cholecystogram.

She was intolerant of fats, admitted to being 'wet eyed' (found her eyes watered when she saw, or heard anything moving or touching); she liked change. ("My husband is often surprised when he comes home, because I've had the furniture rearranged.")

℞ Pulsatilla 30 q.h. until reaction.

14.5.83—Five days later she attended the Midlands Branch Tutorial at Selly Oak Hospital as a case demonstration.

She stated her dyspepsia was already much improved, "better than in all the previous month".

In the discussion that followed, Dr. Mollie Hunton observed that there was a relationship between plasma zinc levels and healing of ulcers, and asked if the patient's ulcers had improved since using Zinc. 6. On learning that there had been no significant change, she suggested giving dietary zinc. Dr. Anita Davies, who made a video recording of the demonstration, commented on the balance between zinc and copper in the body, and that the body used up a lot of zinc in healing ulcers. She suggested that a plasma zinc estimation might be of value.

12.9.83—Patient is still controlling her neuralgia adequately with Zinc. met. 6. "The pain goes within one hour of taking a tablet." Her cholecystogram and gastric investigations were all unremarkable.

11.10.83—Not taken any conventional analgesics for the last 8 months.

Pulsatilla no longer eased her dyspepsia, but surprisingly she found that Zinc. met. 6 did, and was more effective than Maxolon. She needed to take it q.i.d., otherwise her gastralgia lasted for hours. Her neuritic pains *were still controlled effectively with Zinc. She could now walk* ¾ of a mile—a big improvement on her original limit of 20 yards.

DISCUSSION

McLeod states that "the most common form of peripheral neuropathy in diabetes mellitus is a symmetrical, predominantly sensory, polyneuropathy. When there is severe sensory impairment, perforating ulcers of the feet and *neuropathic joints may occur, with associated sensory ataxia* (diabetic pseudotabes). Motor and sensory conduction are impaired.

"Isolated peripheral nerve lesions are common, particularly carpal tunnel syndrome, ulnar nerve lesions at the elbow and radial, femoral and lateral popliteal nerve palsies."[2]

The same author lists the metals and industrial agents that cause peripheral neuropathy, and includes arsenic, lead, mercury, thallium and gold (but not zinc).

The reason I considered Zinc. met. might be even more effective than Agaricus was because of two previous occasions when I had prescribed it for diabetic patients with peripheral neuropathy. Both had received protamine zinc insulin (PZI) for many years, and both found that low potency Zinc. met. afforded considerable relief. This patient had had PZI for 32 years, and displayed several of the features one associates with the provings of Zincum:

Severe pain, twitching and trembling of her lower limbs with marked weakness.

Pain temporarily relieved by motion, making her constantly move her legs and change position ("restless legs", "fidgety feet").

Very sensitive soles of her feet.

Profound prostration, "feeling totally exhausted", with mental apathy. Dyspepsia.

She claims that Zinc. affords more relief than Agaricus, which certainly helped her.

SUMMARY

This woman was presented at our Tutorial, for teaching purposes only, and not in an attempt to prove that Zinc. met. in potency would predictably alleviate, or improve diabetic neuropathy. It is interesting to speculate on the possible association between her prolonged use of PZI and the apparent benefit she obtains from low potency Zinc.

It is also worth observing that it often happens, as in this case, that more than one drug in low potency may help a patient, though none may be the exact similimum; obviously the one whose side effects most nearly match the total cluster of the patient's symptoms should prove the most effective. *Finally, this patient found more benefit from low potency Zinc.* than high—confirming common experience that where there is advanced pathological change, with physical rather than mental symptoms, low potency prescribing is generally the most successful.[3-4]

BIBLIOGRAPHY

1. Jolliffe, G.: 'Phytolacca, A Study of Its Properties and Uses', *The British Homoeopathic Journal* (1982) 71: 31.
2. Mcleod, J. G.: 'Peripheral Neuropathy', *Medicine* (1980) 34: 1756.
3. Blackie, M. G.: 'Richard Hughes Memorial Lecture', *The British Homoeopathic Journal* (1960) 49: 88.
4. Boyd, H. W.: *Introduction to Homoeopathic Medicine*, 57. Beaconsfield: Beaconsfield (1981).

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