CASE REPORT

AN EXAMPLANARY FALLACY IN THE DIAGNOSIS AND TREATMENT OF A DYSPHAGIA CASE

Way back on 9th of August, 1973 a female patient was brought in a prostrated condition having declared by specialists in the leading Hospitals of the Capital as a hopeless case of Rabies. Although she was brought in a chair but it was apparent that she enjoyed it the least. She was not able to speak for herself. On inquiry it was told that she had not taken anything solid or liquid for the preceeding 2-3 days, as she was unable to swallow anything.

Further enquiry revealed the following *signs* and *symptoms* :

Acute dysphagia with inability to drink even a spoonful of water; when forced to drink she felt constriction and intolerance pain in the throat accompanied by intense agony and prostration.

She had not eaten or drank anything for the preceeding 48 hours,

— Distensive flatulence,

— Belching, agony and Dysphagia being steadily aggravated,

— Discomfort, feeling of, in the throat, chest and abdomen,

— Vertigo.

— Extreme debility, and

— Appetite, diminished

On examination :

Oral temperature was 101.5°F., radial pulse rate 110 p.m. and Blood pressure 100/60 mm hg.

Throat examination revealed nothing in particular.

Hand grip — week,

Sensation — Blunt in Y Cv/7,

Jerk — Brisk,

X-ray neck — Cervical spondilosis

Anaemia+++

Tenderness over left shoulder and sternocleidomastoid region.

Menstrual History : Dysmenorrhoea since long; anorexia and vertigo during menstruation.

Mind : Changable disposition; pleasant and yielding-alternating with extreme irritability and quarrelsomeness. Mood-contradictory.

Past History : She used to have abdominal colic and Laparotomy was done in 1972 but without much success. The only benefit she derived was that the paints were less in intensity afterwards. But simultaneously she developed distensive flatulence, continuous in character. It was also gathered that she was now and then having hysteric fits for the last 7-8 years, marriage and child birth etc. also made no difference whatsoever in this condition.

Family History : Nothing significant except that her brother was suffering from traumatic paraplegia.

DIAGNOSIS :

On the basis of available symptomatic data it was diagnosed as a case of "Hysteria".

TREATMENT :

9.8.73 1. Ignatia Amara 200/4 doses, a dose every two hours.

2. Kali Phos. 6X, Nat. Phos. 6X, Mag. Phos. 6X 2 tabs each/QID X 2 days

She was advised to resume her normal habits of food and drinks and take sufficient rest.

10.8.73

It was reported that the patient sipped a few mouthfuls of water, drank tea and slept well.

1. Ignatia Amara 200/BD X 1 day
2. Repeated as above.

11.8.73

Patient drank tea and milk both and seemed cheerful.

1. Ignatia Amara 200/1 dose
2. Repeated as above.

13.8.73

She had semisolid food such as Khichri and drank tea and milk and also slept well.

1 & 2 Repeated as on 11.8.73.

14.8.73

Patient looked considerably improved and cheerful. She took normal food and other drinks like tea, milk etc. but she complained of the following : mild headache, constipation, excessive thirst with coated tongue and impaired appetite.

1. Bryonia Alba 200/BD X 1 day
2. Kali Mur. 6X/4 tabs/QID X 2 days

16.8.73

The patient reported that she was feeling better in respect of anorexia, headache, constipation etc.

1. Natrum Mur. 200/BD
2. Kali Mur. 6X/4 tabs/TDS X 3 days

Later on she was prescribed Graphites, China, Sepia. Natrum Mur. etc. for complaints other than those for which she had been visiting the Institute with beneficial results.

DISCUSSION :

The patient had visited leading Hospitals of the Capital prior to the visit to the Institute and was diagnosed by the specialists there as a case of Rabies presumably on the basis of the past history of Dog-bite. Her relatives were told that she was in a hopeless state and may not be able to survive for more than three days. As such she was denied the treatment.

Here at the Institute, detailed history and follow up of the case revealed that this was purely a case of Hysteria; and the fallacy of "Rabies" infection. was made over.

What does then this case signifies ?

It brings home the value of the case taking, It also proves that the pathological, radiological and biochemical findings are secondary to objective signs and subjective symptoms in importance. And that in Homoeopathy, the prescription be better made on the basis of the latter. As is evident, it also proves that a correct similimum can only be found if the history of the case is taken meticulously and a correct diagnosis is arrived at.

Here it may also be borne in the mind that in every case taking, whether past or present, family or personal, there may occur many FALLACIES; and many BAFFLING SITUATIONS may be faced. Therefore, every part of the casetaking becomes equally important and the same is to be understood in true perspective; and to achieve this accurate PERMUTATION and COMBINATION of FACTS is strictly essential. OTHERWISE-FALLACIES will remain unsolved and INCORRECT DIAGNOSIS and REPETITION of MISTAKES committed.

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