

WHEEZING SYNDROME - A SYNOPSIS

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Introduction

With the emergence of increased popularity of Homoeopathy among the masses as an alternative system of medicine, Central Council for Research in Homoeopathy (CCRH, a premier research organisation in Homoeopathy in the country contributing significantly to the development of Homoeopathy) has to shoulder a greater responsibility and put efforts to make Homoeopathy a more uniform, simplified and easier system of practice of medicine. CCRH has already established a network of 51 institutes and units spread over various parts of the country. These institutes/units are engaged in various research programmes like *clinical research, drug proving, clinical verification, drug standardisation, survey, collection and cultivation of medicinal plants, literary research and documentation etc.* One such clinical research programme is being undertaken at Clinical Research Unit (CRU), Shimla, where work on various clinical projects is going on viz. bronchial asthma, tonsillitis, sinusitis, cervicitis & cervical erosion and double blind clinical trial of homoeopathic medicines in warts. This paper attempts to project a synoptic overview of the up-to-date research work being conducted on BRONCHIAL ASTHMA at C.R.U.(H), Shimla.

Bronchial asthma is perhaps one of the oldest known diseases afflicting mankind. Everything has been tried for its treatment from herbal homemade potions to swallowing live

fish. Sometimes these measures do afford relief but as such there is no established scientific basis of these practices. However, with the advent of nebulization/inhalation therapy, no doubt there is a sigh of great relief but a total cure still remains elusive. Most of the asthmatics coming to us for homoeopathic treatment are already using this therapy to keep their attacks in check and thus are drug dependent ones. To treat drug dependent asthmatics with Homoeopathy, we cannot withdraw their drugs abruptly and hence have to allow simultaneous use of bronchodilators. While treating asthma patients, this point assumes special significance and the same has been dealt with appropriately in this paper. Other topics of research interest such as asthma triggers, house-dust mite, asthma and miasms and how to control asthma along with certain relevant observations made exclusively at C.R.U.(H), Shimla, during our research work, too, have been elucidated. Tables showing figures and case reports have also been incorporated.

1. Objectives

- i. To find out a group of homoeopathic medicines in removing the dependence on allopathic drugs.
- ii. To find out miasmatic background of asthmatic cases.
- iii. To clinically evaluate the efficacy of certain homoeopathic drugs in relieving bronchial spasm, viz. *Viburnum opulus*, *Cassia sophera* etc.

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- iv. Concurrently a study of clinical characteristics especially common clinical characteristic variants of asthma is also being undertaken.
- v. A study on other relations like 'cold and asthma' 'sinusitis and asthma'; 'outside settlers in hills and asthma', etc. is also being conducted.

Setting

The study on asthma is being undertaken at Clinical Research Unit, Shimla, Himachal Pradesh (HP) a hilly terrain, is situated at an average height of 7000 ft. from sea level and climatically cold to very cold, where minimum temperature drops to -5°C or even below. Maximum temperature in summers rarely crosses the mark of 28°C . A vast variety of flora and fauna (fungal spores, pollens & mites etc.) coupled with moist cold weather makes it all the more a place where prevalence of respiratory infections, allergy and asthma is quite high. Weather in Shimla can be broadly divided into two contrasting periods.

- i. Rainy season end autumn from June and to October end when high humidity upto mid September is accompanied with a variety of biological air pollutants such as spores of aspergilli, penicillia, rhizopus etc. and microbes especially mites. During this period weather conditions are most conducive for these spores and microbes. From mid September to October end a low humidity is accompanied with a very high level of biological air pollution with 'deodar' pollens. This period (June end to October end) is the peak period for patients of asthma to get acute attacks (*an observation*).

- ii. Dry cold weather to moist cold weather from November to April end. From December to March end weather is very cold, dry and free from biological air pollutants. This is the period when asthmatic attacks are at the lowest (*again an observation*).

Again from March end humidity starts rising, temperature too starts rising, consequently, flora once again becomes alive. From April to June maximum flowerings is seen and this is the period when we find asthma attacks in moderation (*an observation*).

Design

Patients for study on bronchial asthma are taken from the case registered in the general OPD of the Unit and history recorded on the set proforma designed as per protocol provided by CCRH. And these research patients are followed up subsequently. Periodical reports (monthly, quarterly, half yearly, yearly) are submitted to CCRH Hqs. A constant supervision is also maintained by CCRH, New Delhi. Criteria adopted to assess the patient after medications is based on (i) dependence on bronchodilator drugs, (ii) frequency of asthma attacks, (iii) duration of paroxysm of attack and (iv) overall clinical presentation of the patient, subjective as well as objective. During the study one thing being applied normally as a part of general management is to avoid the use of things, as far as possible and if practicable, which have been known to trigger attacks in a given patient.

Patients

Till November, 1998, 331 patients have been registered for the study which are from all walks of religion & society. Males, females, children, young, middle aged, elderly and old ones all have been included in the study. Natives of the hills as well as outside settlers, patients from nearby places as well as from far off interior places are being studied.

Table 1
Total number of patients studied

Total	Male	Female
331	163	168

Note : Above figures show that both males and females

are more or less equally susceptible to asthma. No gender dominance has been noticed.

Table 1.1
Age-wise grouping of patients

	Total	Male	Female
Below 20 yrs. of age	86	50	36
20 yrs. to below 40 yrs.	133	48	85
40 yrs to below 60 yrs.	91	49	42
60 yrs. and above	21	16	05

Note : Above figures suggest that females in their child-bearing age are decidedly more prone to asthma.

Main outcome

(i) Study on asthmatics who are dependent on 'bronchodilator drugs' and 'inhalers' has shown that simultaneous use of homoeopathic medicines is not only effective but perhaps the only method to treat drug dependent patients with homoeopathic medicines. And gradually the allopathic drugs are withdrawn in a tapering off manner.

(ii) Regarding miasmatic background of asthmatic patients it has been observed that psorics and sycotics are more or less equally prone to asthma, whereas, patients of syphilitic and tubercular miasms are significantly less prone to asthma.

(iii) Study on 331 patients of asthma has shown that different common characteristic variant symptoms although appeared quite unusual and peculiar to make homoeopathic prescription on, in reality were not so. These were simply common clinical variants and hence as such carried not much value for making a prescription on, unless (very rarely) manifested in a very conspicuous way.

(iv) By the time project on asthma is concluded it is very likely that a definite relationship would emerge out between 'cold and asthma', 'sinusitis and asthma' and 'outside settlers in hills and asthma'. Analysis of up-to-date available data is highly suggestive of above links.

2. What is Bronchial Asthma

Bronchial asthma is characterised by hyper-responsiveness of tracheo-bronchial smooth muscles to a variety of stimuli, physical to psychogenic, resulting in narrowing of air tubes, often accompanied by increased secretion, mucosal edema and manifested by episodes of dyspnoea or cough or both with intensities that vary from a mild, persistent cough to that of severe breathlessness. And there is invariably a preceding history of exposure to triggering agents especially in extrinsic asthma.

(i) *Extrinsic asthma* : It is mostly episodic, has a childhood onset, and less prone to status asthmatics. IgE is raised and prognosis is generally good. A variety of trigger factors seem to be involved. Modalities in respect of time, place, season and triggering factors though appear to be individual's characteristics (unusual & peculiar) but are a common phenomenon of the disease and hence carry a lesser value in making a prescription on unless peculiarly outstanding. Clinically a very characteristic pattern was observed regarding the development of extrinsic asthma as illustrated below in figure 2(1).

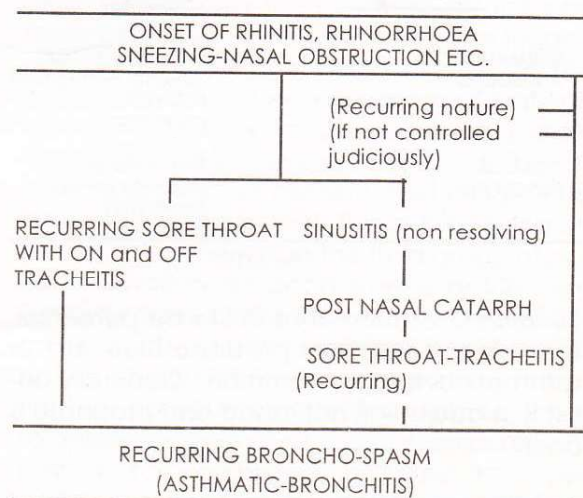
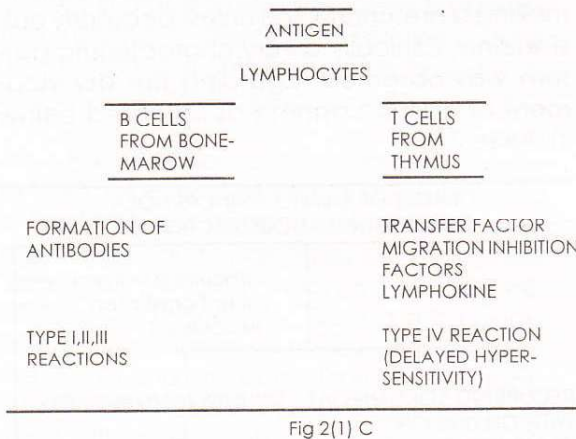
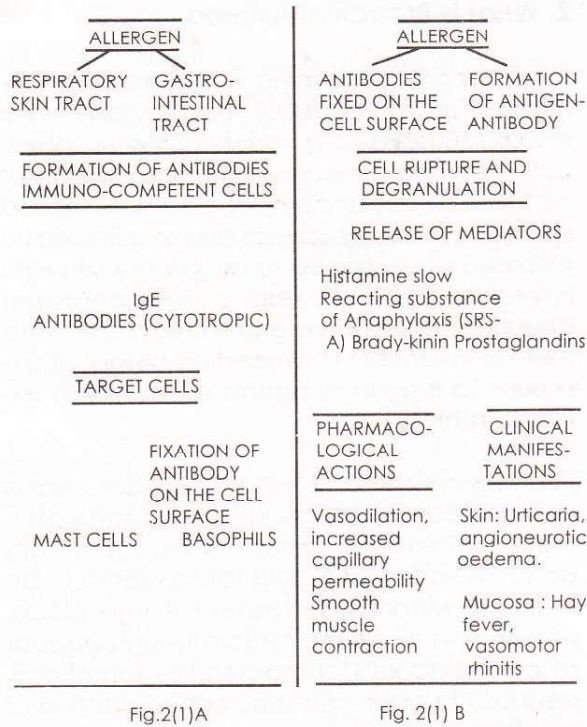


Fig.2(1) Sequence of development of asthma esp. extrinsic type and also seen in 'outside settlers' in the hills of H.P. (an observation exclusively made at CRU, Shimla)



(ii) Intrinsic asthma; It tends to be perennial. There is a hereditary predisposition, status asthmaticus is more common. Generally onset is in adults. IgE not raised and prognosis is poor.

2.1. Who can get asthma?

Anyone. Of either sex. And at any age.

Depending upon one's sensitivity (allergy) & idiosyncrasy* of genetic link and miasmatic background. One gets asthma with intensities that may vary from a mild, persistent cough to that of severe breathlessness. From homoeopathic miasmatic point of view certainly sycotics and psorics potentially are more prone to asthma. Other miasms, syphilitic and tubercular though not immune to the condition but are significantly lesser prone. (See Table No. 8)

* "If there were no idiosyncrasy there would be no homoeopathy. Every individual is susceptible to certain things, is susceptible to sickness and equally susceptible to cure" - Kent.

2.2. How can one get asthma : an update on allergies.

(i) Primarily

Asthma's genetic link : Researchers in the USA claim to have identified a gene which may be responsible for asthma says Dr. Nicholas Nichlaides, head of the team of scientists from the Institute for Molecular Medicine in Plymouth, Pennsylvania, which conducted the study. In experiments using mice, scientists were able to isolate a gene, dubbed interleukine-9(il-9) which they believe is responsible for the lung's sensitivity to many allergens. Both mice and humans are equipped with the il-9 gene. Allergies are a genetic problem as well. Researches have shown that chromosome 5 and 11 are basically responsible for the transfer of allergy to offsprings.

(ii) Secondarily

Although there is a hereditary predisposition (genetic link il-9 gene) to the condition, yet environmental factors in form of time/place/weather/variety of substances or situations, triggering agents, in most cases play the major role in bringing an asthma attack. As many as 25 per cent of the Indians are suffering from different types of allergies, including asthma, skin irritations and respiratory disorders,

according to Dr. Wiqar Shaikh, an allergist and immunologist of international repute.

Modern housing, changed food habits, consumption of more and more of junk foods, pets, plants, carpets, lack of ventilation and use of air-conditioners are further aggravating the problem and very soon it may reach epidemic levels.

In the western countries, allergies have already reached epidemic levels and 45 to 50 per cent of the population are hypersensitive to something or the other. In India, it is slightly less and around 240 to 250 million people are allergy-prone among the 970-odd million population.

Various causes for allergies, the advent of 'junk' foods like pizzas, hamburgers, noodles and pastries have added to the problem. Alcoholism, smoking and drug-addiction also lead to allergic disorders especially for those with respiratory problems.

Modern homes with its lack of ventilation, air-conditioners, carpets and mini waterfalls inside the premises promote fungus growth and dust mites responsible for allergies. The widespread use of cosmetics like lipsticks, powders and nailpolishes also have various ill effects on our skins.

The hair of pets like dogs and cats are known to be another causative factor. Even skin-flakes of these animals are very dangerous. Droppings of birds like parrots, pigeons and bulbuls are also known to be allergy causing.

Dr. Shaikh says asthma is the second commonest allergy after sneezing. Also known as rhinitis, sneezing is quite common among Indians mainly because of dust, pollen grains, pollutants and the most dangerous parthenium plant. Rhinitis coupled with cough and cold aggravates the patients and in long

run it may result in asthma too. Our study at CRU, Shimla, strongly corroborates Dr. Shaikh's contention. (See Table No. 2.2)

In England, researchers have found peanuts to be a cause of allergy among kids. Some people are also allergic to pulses (dals).

Table 2.2
Asthma patients suffering from upper respiratory tract allergy simultaneously.

Total	Male	Female
210	100	110

Note : Upper respiratory tract allergy like rhinitis, sneezing etc. found culminating in or associated with asthma in 63.44% patients of asthma (an exclusive observation made at CRU, Shimla).

3. What are asthma triggers?

As asthma attack can be set off by a variety of stimuli physical as well as psychogenic, one may not have to be necessarily allergic to these triggering agents but once there is hyper-responsiveness of tracheo-bronchial system only then asthma attack can easily be triggered off by one or more triggers without actually one being allergic to the same. For example in one group of patients we may find, drinking juice or eating pickles or a particular fruit triggers asthmatic attack; in second group of patients cold things or refrigerated things or fried things may bring on the attack; whereas in the third group of patients inhaling tobacco smoke or kitchen-fumes or smell of paints etc. may precipitate an acute attack and so on. These stimuli which act as triggers may vary from patient to patient i.e. individual to individual. Hence, these so appearing individual characteristics are actually not individualistic because these are simply common characteristic variants of the disease and thus constitute negative symptoms.

3.1 Most common triggering factors.

A. Biological triggers

Grass, hay, pollens, mould spores, insect parts, house dust mites, pets, pet hair, feather, pigeon droppings, cold (cold virus) and infection (chronic sinusitis) etc. (See Table No.5)

B. Chemical triggers

Tobacco-smoke, polluted air, LPG (cooking gas), kitchen fumes, perfumes, spray, deodorant, talcum powder, furniture polish, thinners, paint fumes, nail polish, nail polish remover, liquid chlorine bleach, medicines especially aspirin (See Case No.6.1) etc.

C. Physical triggers

Dust, exposure to cold, sudden chilling (see case No. 13.1(iii)1), high humidity, damp cold weather, change of season, cold drinks, juices, curd, butter milk, breathing too hard, laughing, crying, overexertion, etc.

D. Psychological triggers

Anger, fear, stress (rather distress), anxiety, tension and other psychogenic stimuli etc.

4. Asthma and cold virus

Asthma and cold virus go "hand in hand": Researchers have found a link between asthma attacks and infection by the common cold viruses. Findings at Clinical Research Unit, Shimla too are highly corroborative of the fact.

According to Dr. Sebastian Johnston, a team leader at the Southampton University's School of Medicine in Southern England, "the strength of the link was an unexpected and exciting finding".

The discovery was made during a study of the severity and incidence of asthma attacks by these doctors. In their investigations, involving a group of local school children, the researchers spent several years looking for the presence or absence of the cold viruses each

time a child had an asthma attack. They found that in over 80 percent of the cases, asthma and the cold viruses went "hand in hand". One particular type the rhino-viruses, were found in 50 percent of the cases.

5. Asthma and chronic sinusitis

As is quite established now that there is a definite relation between 'cold viruses' and asthma. Same way there appears to be some relationship existing between clinical condition of chronic non-resolving sinusitis and asthma. In our study which is still going on, it is found that in certain patients asthma started as a culmination of chronic non-resolving sinusitis. Thus, sinusitis seems, in one way or the other, to be precursor to asthma, like cold.

Table 5
Incidence of sinusitis in asthma

Total	Male	Female
81	41	40

Note : Some sort of relationship seems to exist between sinusitis and asthma as its incidence was noticed in 24.47% of asthmatics.

6. Asthma and aspirin

Use of certain medicines especially aspirin can set off asthma attack in sensitive patients. Some asthma sufferers have an acute sensitivity to aspirin, in which the drug may precipitate a life threatening asthma attack. The precise etiology of salicylate induced asthma is unclear.

6.1 Case Report

How aspirin can induce asthmatic condition can be seen from this case. There was a middle aged lady who came to take treatment for her more or less continuous asthmatic condition of mild to moderate severity. She was already taking bronchodilators orally. She

came to us to seek advice if we could do something for her. She was given some medicine on her first and second visit, and at the same time she was also advised to continue bronchodilators but no satisfactory response was noticed. Again she was interrogated in order to bring out anything relevant which could help us in finding out an appropriate medicine. And surprisingly, a very interesting fact surfaced that she was using 'disprin' tablet mixed with a little water for rinsing her mouth and massaging her gums, on the advice of some quack for her chronic gum problem. She was practising this for quite some time. Now this story of her unfolded the entire case, as on further questioning, it was established that she started getting asthmatic problem only after she had started using 'disprin'. Now without giving any medicine, she was advised to stop this practice of using disprin. She quite sincerely adhered to our advice. On her next visit, perhaps 3-4 weeks later, she smilingly expressed her gratitude that after discontinuing the use of disprin, she had stopped getting breathlessness any more. Now she had altogether left all those bronchodilators too.

7. Asthma and outside settlers in hills

An analysis of observation made while working on asthma shows that outsiders coming from plains and settling in hills get asthma surfaced easily as compared to the natives of hills. Perhaps explanation lies in sudden exposure to a vast variety of vegetation pollens/allergens, fungal spores and mites coupled with high humid (cold moist) climate as illustrated in the table. High humid climate is an established asthma precipitant.

Table 7
Outside settlers in hills afflicted with asthma

	Total	Male	Female
Natives of hills	200	104	96
Outside settlers	63	23	40
Others	68	36	32

8. Asthma and Miasms

Our ongoing study of 331 patients on asthma has revealed that psorics and sycotics are more or less equally prone to asthma, whereas patients of syphilitic and tubercular miasms are significantly less prone to asthma. However, one fact remains to be seen and needs to be researched is the miasm-wise prognosis of asthma. Perhaps syphilitics land in the worse complications like Emphysema with CCF (Cor pulmonale) and on the other hand 'psorics' can suffer even throughout their life from asthma without getting much of complications i.e. to say organic changes. This is purely a view based on some trends seen, not any conclusive statement.

Table 8
Miasm-wise breakup of asthmatic patients enrolled for study

Miasm	Total	Male	Female
Psora	156	69	87
Sycosis	155	85	70
Syphilis	9	3	6
Tubercular	9	4	5
Others	2	2	-

9. Asthma and drug dependence

The conventional treatment most patients are taking is bronchodilators (oral, injectable or in form of aerosol spray) coupled with time to time use of anti-allergic medicines, antibiotics and sometimes in certain patients steroids and other symptomatic medicines. The method most practised to keep asthma attacks in check, around the world, is the use of modern, pocket-sized inhalers. A fairly large percentage of asthma sufferers has started using this inhalation therapy for immediate benefit during acute attack. This leads to drug dependence. Continuous or SOS use of bronchodilators in any form have been known to cause 'drug dependence'. Most of the patients coming to us are those who are tak-

ing these bronchodilators but without much long term and lasting benefit.

Table 9

Number of asthmatic patients using bronchodilators

Total	Male	Female
250	116	134

Note : Out of 331 patients enrolled for study 250 patients i.e. 75.52% were using bronchodilators in one form or the other. To treat such patients (which constituted a major part of research cases) homoeopathically, there is no way out but to allow simultaneous use of these drugs.

When a patient comes to us at this stage can we afford to advise him to stop bronchodilators at once and are we equipped enough to combat the situation arising out of abrupt withdrawal? If yes, are we not taking the risk of triggering attack which may even lead to status asthmaticus, grievous at times, a life threatening situation?

The keyword is - *never abruptly withdraw bronchodilators used by the patient*. It is only when we have been able to manage successfully, patient himself starts reducing or missing his regular doses because he does not require them as frequently now as had been earlier. This indication of gradually reducing the doses comes first from patient's side. However, at this stage we advise gradual reduction in a more systemic way i.e. in a tapering off manner.

10. Asthma and housedust mite

Dust mites, one of the most dangerous aeroallergens have been known to induce allergies and cause rhinitis and asthma. Study on dust mites, dermatophagoides pteronyssinus and D. farinae conducted by the scientists of concerned discipline has suggested a significant number of patients presenting with rhinitis and asthma with positive skin test

to mite allergen where exposure level in their houses was found high enough to trigger symptoms of rhinitis and asthma. A quantitative study on dust mite has also revealed that about 100 mites per gram of dust are enough to set off allergies and some 500 mites per gram of dust are sufficient to cause wheezing. Their concentration declines significantly in winters whereas in summers it starts increasing. Humid weather is an established climate for the mites to reach their peak concentration.

If we co-relate above findings with clinical findings at CRU, Shimla, regarding frequency of asthma attacks, certainly frequency of attacks is seen running parallel to the concentration of mites i.e. the concentration of mites is maximum during summer and humid rainy weather, April to October, so is the frequency of asthma attacks. Whereas concentration of mites is lowest in winters, November to March, the frequency of attacks, too, is at lowest. About 10% of world's population suffers from dust mite allergy. A Mumbai study sourced about 34% of child asthma to the pesky mite. When children are exposed to dust mite allergies at an early age, life long asthma can be triggered. At least half of the asthma attacks are being attributed to the dust-mite. Even if the statement is not absolutely applicable universally one thing is certain that housedust mites have afflicted respiratory allergies to a significant populace and the topic has become a matter of greater curiosity and concern for the researchers world over.

Table 10

Showing seasonal prevalence of asthma attacks

Prevalence	Total	Male	Female
April to October	84	39	45
November to March	26	14	12
Others (continuous throughout or strictly in autumn or spring etc)	221	110	111

Note : Frequency of asthma attacks during summer and rains (here in Shimla) is found to be more than three times

higher than in winters when dust-mite are decidedly dormant and lowest in concentration. These figures show that frequency of asthma attacks appears to be running parallel to concentration of dust mites.

11. Asthma : *Viburnum opulus* and *Cassia sophera*

Viburnum opulus needs no introduction so far as spasmodic dysmenorrhoea is concerned. Dr. Hale once commented that if it was found useful in heart cramp, which was the real condition, in angina pectoris, also perhaps in spasmodic laryngitis, then why not, in asthma also? A good original thought? To explore this antispasmodic effect on bronchi clinically a trial study of *Viburnum opulus* as a research project was taken up and results thus found, were quite satisfactory. *Viburnum opulus* certainly deserves its place in the list of asthma therapeutics. Below cited case highlights how effective *Viburnum opulus* is in controlling respiratory tract spasm.

11.1 A case of Breath Holding Attacks (BHA) :
A full time normal developed child aged 16 months was brought to us with a history of BHA since the age of nine months. When child was nine months old, he was given measles vaccine and the moment needle was pricked, he went into BHA, child turned blue with clenched fist and jaws (tonic spasm). This was the first attack and ever since he started getting such attacks 2-3 times a day. Each attack would last more than a minute. The moment child came out of the attack, he was perfectly alright as if nothing had happened to him; no leftover drowsiness or any other symptom. *Viburnum opulus* 1M once a day for 8 days was given. Child's mother reported that from second day onwards, child did not get attacks for five days. On sixth day, child had once again two three attacks but each attack lasted 5-10 seconds only. Again medicine was repeated. There was no feed back from the patient for 4 1/2 months, whereafter child's mother reported that after 2 weeks of treatment child stopped getting attacks altogether. It was only when child developed acute diarrhoea and was given Gramogyl,

child became irritable and started getting attacks occasionally but with less intensity and lasting hardly 10 seconds. Few doses of *Viburnum opulus* 1M were repeated again. It was only after 8 months when child's mother came to take treatment for her ailment, while narrating her symptoms, she herself told, as we did not recognize her, that her child who was treated for BHA had been keeping well and there had been no recurrence ever since.

This case shows how effective *Viburnum opulus* is in controlling spasm and subsequently checking the recurrence. It not only cures uterine spasms but can also effectively cure respiratory tract spasm.

Cassia sophera : Evolution of it's symptoms as seen in Monograph-3 published by CCRH and the origin of extrinsic asthma in hills seems to be running quite parallel and thus makes *Cassia sophera* quite similar in its pathogenicity. Clinical results of *Cassia sophera* in extrinsic asthma are too found to be quite encouraging.

Cassia sophera and *Viburnum opulus* were mainly prescribed on their pathogenicity simulating extrinsic asthma in former and bronchospasm in latter. These two medicines singly or combined, have proved a good supporting help in cases where we have not been able to make a snap shot prescription in acute conditions or even during asymptomatic phase where we have been unable to strike a most appropriate medicine.

Table 11
Figures showing efficacy of *Viburnum opulus* and *Cassia sophera* in asthma

Medicine	Number of cases					
	Prescribed in			Found Effective in		
	Total	Male	Female	Total	Male	Female
Vib. op. Q	81	41	40	50	26	24
Cassia soph. Q	27	12	15	20	06	14
Vib. op.Q + Cassia soph. Q	09	03	06	06	02	04

12. Asthma : how to control it?

Treatment of uncomplicated asthma essentially comprises of three components - viz.

- i) Management of acute paroxysm,
- ii) Management during asymptomatic phase to prevent subsequent recurrence, and
- iii) General management.

Once the acute attack is successfully managed, the chances of curing the patient subsequently increase manifold. First and foremost, patient develops faith in his attending physician, finds himself in safe hands and is prepared to give any length of time to get his malady remedied. If a physician is unable to control acute attack, more than 90% of patients would certainly not report back. Every physician at his level best has devised his own individual techniques to tackle such attacks. Why can't we evolve, after researching on the issue, certain generalised techniques of prescribing rather than depending on individual physician's own discovered techniques? Now, after successfully managing the acute attack, it is not only the patient who feels reassured, but physician too is reassured about his patient getting cured. This strong 'sense of positive belief' also helps the physician in treating his patient. Thus, the physician has got plenty of time, after successfully controlling acute attack, and has a patient who has strong faith in his attending physician. These two factors together would certainly help in working out an appropriate medicine.

Secondly, with an element of so much of reassurance on the part of patient as well as physician, and if it happens so that the physician had been able to control his acute attacks more than once, certainly a 'placebo-effect-psychology' (a very constructive effect on patient's psyche) comes into play. Under this psychological bond between patient and physician, during asymptomatic phase, the very same medicine, which has remedied acute attack might suffice to cure the patient

altogether or some other medicine prescribed by the physician after taking into account other symptoms of asymptomatic phase, could do the job. Here, further research study is required to explore the placebo effect exclusively during asymptomatic phase in such type of cases.

Concurrently, as a part of general management, patient is advised to avoid the use of asthma triggers, as far as possible and practicable, which have been known from the history of the patient to trigger off a mean asthma attack. Thus, attacks can be minimized. Another preventive measure advised is to take plenty of fluids as it is an established fact that water hydrates the respiratory passages and helps loosen sputum. Drinking plenty of luke warm water especially during an acute attack keeps mucus thin so it is easier to cough up. Certain high coloured fruits and vegetables like carrots contain flavinoids that are known to have some preventive effect. Preventive measures reduce bronchial hyperactivity, in turn hyper-responsiveness, gradually. Some case reports highlighting management of acute attack as well as asymptomatic phase of asthma are cited hereunder.

12.1 Case report

A school teacher, 35 years old female came to Shimla from plains on her transfer 8 years ago. When she was in plains, she used to suffer occasionally from coryza, sneezing with lachrymation etc. Ever since she shifted to Shimla, she not only started getting the same more frequently but with more intensity too. Within two years of coming to Shimla, she developed asthma. Every spell of cold, coryza and cough would ultimately culminate into bronchospasm. At this stage, she came to the unit with more or less continuous dyspnoeic state, taking oral bronchodilators and also inhaler. Dyspnoea worse during night, some relief afforded by bending forward. She was also getting urticarial rashes all over the body simultaneously. Her fingertips were chapped

and cracked with itching. Cough and coryza were invariably associated with menses i.e. she would get cough and coryza invariably during menses. No other well marked general or particular thermal modality was noticed. Perhaps above history was more than sufficient to individualize and prescribe accordingly. In Boenninghausen's Repertory, for coryza during menses as well as cough during menses, *Graphites* stands in highest grade and in Kent's Repertory too, *Graphites* is in highest grade for cracked finger tips. Patient was thus prescribed *GRAPHITES* first in 1M potency and later on in 10M potency. With few doses only her dyspnoea and urticaria disappeared. She left all oral bronchodilators and inhaler, and her cracked finger tips too got healed. Thereafter, patient stopped taking treatment and reported only after one year that there had been no recurrence whatsoever but for some chapping of her finger tips and that was what she had come to take treatment for. On enquiring further, she told that she had only one mild attack of cold with slight distress in respiration in the past one year which she managed on her own by drinking some hot ginger potion, made at home. It was such a mild attack that she did not bother to come to us for medicine.

12.2. Case report

An old lady, 65 years of age, suffering from contact dermatitis for more than 20 years came to the unit 2 yrs. ago. She had taken every possible treatment to get rid of this but all in vain. She had even taken treatment from Bhartiya Hospital in Delhi where she was given cortisone infections locally in the skin and had even taken homoeopathic treatment at Delhi. She came to CRU, Shimla with her skin full of lesions more so on face, hands, neck, legs etc. There was a strong family history of allergy in form of contact dermatitis and asthma. She was also suffering from asthma which she did not disclose. It was only found out from her past treatment record where at one stage inhaler had been prescribed. On enquiring

about this, quite reluctantly she disclosed some details about her asthmatic problem with the impression that it was nothing to do with her skin condition and right at that moment she was not suffering from asthma. On further interrogation one thing surfaced that she never had both complaints i.e. skin lesion and asthma simultaneously. On probing in this regard further, it was clearly established that she would suffer from only one condition at a time, while one was there, the other was not there and vice-versa. Now, in this expression alone the patient's entire individualistic totality was summed up. And only medicine given for this symptom is *Caladium*. Accordingly, medicine was given and all the skin lesions got cleared within two months and the achievement in the past 2 years has been that patient had mild recurrence of asthma once and mild recurrence of dermatitis only once.

In a 20 years old standing case of contact dermatitis and asthma with a strong family history of allergies, is this achievement not more than satisfactory?

12.3 Case report

A bank employee, 35 years of age, lean, thin, tall came to CRU Shimla, in the month of August, '96 with a history of recurring upper respiratory allergic symptoms since 1993. He narrated that he would get allergic symptoms in a particular sequence i.e. first itching, redness of eyes and lachrymation then rhinitis, rhinorrhoea, nasal obstruction and finally sneezing. Once sneezing commenced, eye symptoms would disappear. He further reported that in 1995, he got the recurrence of same problem in July/August also, apart from autumn and also developed bronchospasm and wheezing. He was given some antiallergic medicines and bronchodilators for SOS use only.

When the patient visited us in the month of August '96, he was suffering from upper respiratory allergic symptoms along with

bronchospasm. Other symptoms, worth prescribing noticed were :

- Patient was extremely chilly, icy coldness of hands and feet even during summers (*an individualistic symptom*).
- Preferring warm things even during summers (*an individualistic symptom*).
- Irritability and got offended easily during attack (*a common characteristic variant symptom of the disease*)
- Nasal obstruction and sneezing better in open air (*a common variant symptom of upper respiratory allergy*).
- Asthmatic attacks usually during first part of the night and some sweating was also associated with it (*common symptom of the disease*).
- Upper respiratory allergy worse from dust, perfumes, agarbatti smoke, kitchen fumes, cold food, cold drink and wet cold (*common characteristic variant symptom of the disease*).
- Worse working in cold water even washing hands with cold water sets off bout of sneezing consequently patient was compelled to use warm water even during summers (*highly individualistic symptom and an expression of patient's idiosyncrasy*).

On 12.8.96, patient was given *Phosphorus 30* three times a day for seven days. Patient reported on 19.8.96 that his sneezing had more or less disappeared but there was no change in bronchospasm/dyspnoea. But right at that time patient was more worried about his headache (all over the head) which he had developed following the disappearance of sneezing (this was perhaps suppression due to our inappropriate prescription). The case was reviewed and *Hepar sulphuris 30* three times a day was given on 19.8.96. Thereafter,

patient reported on 24.8.96 that ever since he had started taking *Hepar sulphuris 30* his headache had disappeared and he was much better in every respect i.e. upper respiratory allergic symptoms as well as bronchospasm, only this morning he had few sneezings that too after washing hands with cold water. Medicine was again repeated in same potency. Patient reported on 31.8.96, 7.9.96 and finally on 4.12.96. He was given *Hepar sulphuris 30* only during this period. He consumed approximately 2 drachm pills of the medicine during this period which sufficed in bringing about a total cure. How surprising! but it happened. Patient who happened to be working in a nearby bank often meets us and till date i.e. even after three years, doing well and has had no recurrence.

Repertory Reference : (Synthesis)

- (i) Nasal obstruction air-open, in, amel: *Phosphorus* appears as one of the medicine
- (ii) Sneezing- Cold, becoming cold from : only *Hepar sulphuris* is mentioned.

Note : This symptom, sneezing from putting hands in cold water or washing hands with cold water, when present in a patient in its true sense is highly individualistic of the patient and we find corresponding medicine for the same in Hepar sulphuris This symptom has been verified repeatedly.

12.4 Case report

A middle aged man was suffering from recurrent rhinitis, rhinorrhoea and sneezing in bouts for the last 7-8 years. This culminated into bronchial asthma one year ago and was given bronchodilators (oral/inhaler), anti-allergic medicines and other medicines. At this stage patient came to us in 1995. Even after thorough interrogation not much symptoms could be gathered because of regular use of bronchodilators and anti-allergic medicines. The moment he felt least discomfort he would take one medicine or the other. Thus, keeping his disease under check or in other words he had developed this drug dependence. To get a clearer picture we could not afford and

ask the patient to stop the medicines. Therefore, in order to mitigate his problem to some extent and to reduce his dependence on drugs, *Viburnum opulus* Q and *Cassia sophera* Q afforded him some relief and helped in reducing his drug dependence to a certain extent.

At this stage patient was advised, as far as possible, to avoid the use of bronchodilators at least for a few days. Once it happened so and patient developed an acute asthmatic attack. It was found that cough was quite a dominant feature during attack along with dyspnoea. Cough and dyspnoea would subside only after he could vomit out glairy, tenacious mucus. Thus vomiting with this typical vomitus would give him instant relief. *Coccus cacti* in 30th potency was given. Following this, relief was instant, tremendous and, beyond our belief and expectation just within 5 days. Thereafter, within 20 days patient became almost asymptomatic and stopped all bronchodilators/anti-allergic medicines. On examination occasional wheeze was found on deep expiration. The same medicine was repeated from time to time and increasing the potency to 200th which brought about a remarkable change in the patient. Patient is still under observation, although total cure is yet to be established but he is managing well without bronchodilators and anti-allergic medicines.

13. Views and Discussion

Quote

A thousand drugs have a hundred thousand symptoms in common : how are we to choose among them? They are useless for prescribing, UNLESS WE GET A LEAD, then they fall into line.

Unquote

Beautifully quoted by John Weir, C.V.O., M.B. in his article 'Problems of

Homoeopathic Education' appeared in The Homoeopathic Heritage Summer'98 issue. And perhaps the essence of successful homoeopathic prescribing -

There is no dearth of cases where every practising homoeopath might have treated the asthma patients successfully, what to say of masters, making their prescriptions on prescribed and well established methods of homoeopathic prescription, after sessions of sittings. If we work out these sessions in terms of time, and if I am not exaggerating, it would not be less than hours and hours in a given patient. And even after devoting so much of time and taking so much of pain, what is the percentage of patients relieved or percentage of cure effected is anybody's guess. Now question arises.

- Can every physician at all times and for all patients afford to devote so much of time? *Perhaps not.*
- Can every patient each time he falls sick and requires homoeopathic medication afford to spend so much of time? *Perhaps not.*
- Can every physician be expected to be of that clinical acumen as our masters have been to effect a cure? *Certainly not.*
- Can we expect every patient to be that diligent who can express himself as required by a homoeopath and that too every time he falls sick and requires homoeopathic treatment? *Perhaps not.*

CCRH, in its objectives of the clinical research programmes has very correctly made it a point to evolve easier, simplified and generalised practicable techniques of prescribing and also to aid clinical practice by reducing the size of therapeutics for a given condition. Following KEYWORDS need to be explained and understood thoroughly and clearly to achieve these objectives.

- COMMON CHARACTERISTIC VARIANT SYMPTOMS (CCVS)
- NEGATIVE SYMPTOMS
- PIVOTAL EXPRESSION
- PLACEBO-EFFECT PSYCHOLOGY

(i) Common Characteristic Variant Symptoms (CCVS)

These are individual expressions of a given disease which are inappropriately labelled as individualizing symptoms of the patient can be termed as CCVS. These are usually negative symptoms unless manifested in quite a conspicuous way.

A typical picture of a disease is usually constructed by observing so many patients by so many observers and over a period of time. The text book picture of a disease thus described in the books in fact has not included all the symptoms of all the patients unlike our data collection during drug proving. A typical disease picture comprises of only those symptoms which were found to be present in all the patients and were taken in general and concise sense to restrict their significance to the extent of making a clinical diagnosis of the condition alone. These common symptoms were not split further to bring out their variants because those were not considered of any additional value in making a clinical diagnosis and thus were ignored and not included in the text book picture of the disease. Yet, they existed in the patients as various variants of the common symptoms of the disease. For example, going by the text book symptomatology, an asthmatic patient experiences a great deal of difficulty in breathing by lying down and finds some relief when he sits up. In text books, this symptom has been restricted to this extent only.

This symptom was not split further which could have varied from person to person or a group of patients to another group of patients in form of variants in their sitting postures like few patients may have sat erect, some may

have sat propped up with pillows while others may have bent forward to obtain relief etc. These various variants of sitting postures were not taken into account as the same were not considered of any additional help in making a clinical diagnosis. And thus were not included in the text book picture. But these certainly existed in the patients. These different sitting postures in different patients are the split symptoms of the common symptoms of difficulty in breathing by lying down and finding relief by sitting up. Had these symptoms been included in the disease picture, (which could easily have been, had they desired so) we would have become familiar with them and could have taken them as common symptoms of the disease. Sometimes due to this lack of knowledge, when we take history of the patient exhaustively, we gather these split symptoms (CCVS) also and pile up in our case record considering them as individualizing symptoms which actually are not.

These are simply common characteristic variants of the disease and often inappropriately classified as individualizing symptoms. However, sometimes when a CCVS in certain patient is manifested in a conspicuous manner, then of course it becomes individualizing otherwise not for e.g. in some patients of asthmatic bronchitis where cough is an important common symptom, may experience nauseous feeling on coughing. This is a CCVS and not an individualizing symptom (which we inappropriately label as individualizing). But in certain patients this very symptom of nausea with cough becomes exaggerated to such a degree that patient feels nauseous on least coughing or even without coughing, then it becomes conspicuous and thereby an individualizing symptom, not otherwise.

(ii) Negative Symptoms

Common and common characteristic variant symptoms of the disease are negative symptoms. Margaret Tyler and J.H. Clarke called the symptoms "*which are not appli-*

cable to the case" as negative symptoms and advised that it is the positive symptoms only in a case which should guide us. Leading and characteristic symptoms on which the whole symptomatology revolves are positive symptoms and reflect pivotal expression of the disease in a given patient at a given stage of the disease.

(iii) Pivotal Expression

In Recorder, Sept., 1931, Kent says, "If there were no idiosyncrasy there would be no Homoeopathy. Every individual is susceptible to certain things, is susceptible to sickness and equally susceptible to cure".

Thus, idiosyncrasy matters in causing a disease so is true that it matters in curing the disease, as well. It is on this account that we are able to differentiate the patients suffering from the same disease and thus individualize and prescribe accordingly. Expression of this idiosyncratic locus is invariably found in all the patients, all the time irrespective of the stage and nature of the disease (whether curable or not) in form of an individualistic symptom or a manifestation or another expression of the disease in a given patient at a given stage of the disease and that is PIVOTAL EXPRESSION.

Pivotal expression can easily be identified if we have the sound knowledge of common and CCVS which makes the work easier. Pivotal expression which expresses patient's idiosyncrasy can be located, palpated or could be seen in a cause, in a modality, in a concomitant, in a pathology, in a generality or even in a common symptom etc. In following case reports, pivotal expression was identified and an appropriate medicine was prescribed accordingly and total cure followed.

1. *Pivotal expression identified in cause :*
A patient of bronchial asthma with as usual presentation i.e. dyspnoea and slight cough worse on lying down, wheezing and worse from cold in general as well as in particular.

On interrogation it was revealed that in the month of January he was staying in a guest house and there was snow all around. He took heavy drinks along with chicken and went to sleep. At night he woke up with irresistible thirst. He did not find water around in the room. He came out in the balcony and picked up handfuls of snow and literally ate it to quench his thirst and again went back to sleep. In the morning he got up with his chest all congested and there was cough, dyspnoea and wheezing. This was his first attack and that was how it all started. Now here in this case expression of asthma after eating snow depicts his idiosyncrasy, a very individualistic state, and that becomes pivotal expression. Medicine thus prescribed on this pivotal expression which was identified in the cause, here, not only effectively controlled acute attacks but also brought about a total cure.

2. *Pivotal expression found in a concomitant symptom :* A three year old female child was suffering from recurrent attacks of asthmatic bronchitis. She hardly recovered from one attack that the other ensued. This was going on for the last more than a year and child was being given anti-allergic medicines, bronchodilators, antitussive and antibiotics on & off. At this stage child was brought to us. We recorded her complete history-- cough, dyspnoea, fever, rattling chest, rhonchi and abdomino-thoracic respiration well marked. There was one expression which one could not have afforded to overlook and that the child was continuously picking at her nose, lips, even at anus and sometimes boring finger in the nose. On inquiring it was further told that despite scolding her or even smacking her she would not stop this. One more interesting fact in this connection was told that during the attack of bronchitis she would do it more and non-stop. This concomitant expression certainly revealed pivotal expression and medicine was prescribed accordingly. To everyone's surprise not only her acute attack resolved quickly but she stopped getting recurrence of attacks too. Worth noticing was that

she also stopped picking at nose and lips altogether. This shows how integral was this concomitant symptom. Certainly this was idiosyncratic expression of the patient and there could have been no other better individualising expression than this pivotal expression which was found in a concomitant symptom; child improved and medicine was discontinued. After 2 months there was a mild recurrence of bronchitis along with concomitant symptom. Medicine was again repeated and child has been completely free from any recurrence for the past 6 months.

3. *Pivotal expression seen in a mental general* : A six year old male child suffering from acute colicky pain in abdomen (? could be due to worms). Some element of physical restlessness was there. Sometimes child would lie on abdomen then folding his thighs and bending sometimes. He would lie down the moment severe colic came. Child was suffering for the last 2 hours or so in this way. There were plenty of such common and common variant symptoms to fill two pages. Strikingly with each attack child would start crying in such a piteous way that anyone would have loved to pat and console him. This quality of his weeping was such an individualising symptom that moment that is to say this pivotal expression lay in this mental general. After administration of a single dose on this pivotal expression relief was so instant that child ran out and started dancing as if nothing had happened to him. However, a few more doses of the same medicine were repeated at a short interval.

4. *Pivotal expression found in a physical general* : An old man 62 years of age, whose son and daughter-in-law both were doctors, was suffering from recurring ulcers (stomatitis) on tongue. He had already been given lots of vitamins and occasionally antibiotics too. But recurrence of ulcers did not stop. He consulted us at this stage. As usual so many symptoms could have been gathered but we did not. While conversation was going on, one thing surfaced that ulcers would appear on alter-

nate sides of the tongue. On further questioning in this regard it was established beyond any doubt that he was getting ulcers on alternate sides of the tongue. But for this (pivotal expression) symptom even after repertorising his case on totality basis in toto, we would not have reached the medicine which cured him. In Kent's Repertory this medicine did not even find a mention under stomatitis & ulcers on tongue. How could we have reached to this medicine? Alternation of sides here represented patient's idiosyncratic locus which strictly individualised him. And clinically his idiosyncrasy i.e. pivotal expression was located in physical general in form of alternation of sides. Medicine prescribed on this symptom in 30th potency for 10 days not only relieved the ulcers but also sufficed to check recurrences altogether. It was only after six months slight recurrence was complained of and a few doses of the same medicine in 200th potency established a total cure as there has been no recurrence for the past more than one and a half year.

5. *Pivotal expression identified in a modality* : An old case of asthmatic bronchitis was getting attacks with rhinitis & sneezing, dyspnoea associated with incessant cough (cough was a dominant feature worse late in the evening & at night). So many other common symptoms and common variant symptoms were present as usual. Drinking hot tea, hot water would give some relief. But eating hot food certainly would relieve his cough & dyspnoea substantially, therefore, patient had developed a habit of eating very hot food especially in the dinner to ward off his attack and to have a comfortable sleep at night. Medicine prescribed on this expression of the patient controlled his acute attacks very well, relieving his cough same way as hot food had been. This patient being a VIP could not be followed up for a longer period.

6. *Pivotal expression located in common exaggerated common symptom* : Here I am citing a case seen long ago and was treated

by our veteran physician, Dr. D.P. Rastogi at Nehru Homoeopathic Medical College & Hospital, New Delhi. A young child crying of pain in his lumbar region, who happened to be a case of renolith and was having ureteric colic at that point of time.

Pain was so terrible and perhaps excruciating as was evident from the patient's cry and expression. Terrible pain due to passage of a stone through ureter was such a highly exaggerated common symptom and the medicine was prescribed on this common exaggerated symptom. To everyone's utter surprise pain subsided in few seconds and the sleep prevailing upon the patient was so instant that it was beyond our expectation and explanation.

7. *Pivotal expression seen in a pathology* : A young girl aged 15 years was advised surgery as the only treatment for an almond sized hard tumour under her left nipple and areola and bloody discharge was coming out from the nipple. As usual, dread of surgery brought her to CRU, Shimla. There was paucity of symptoms and whatever symptoms available were hardly of any substance to make a prescription on. A pivotal expression depicting her idiosyncratic locus could not be established from the available meager symptoms. Unable to locate it, one thing is certain (it is my belief), whether disease (more appropriately the patient) is curable or not whether there is a corresponding medicine in our materia medica or not, but there has to be some expression may be in subjective or objective form, in each and every patient, which reflects his or her idiosyncrasy in the form of a pivotal expression. Medicines like *Lachesis*, and *Conium* were tried which did not afford any relief. One day while examining the tumour it was noticed that the character of bloody discharge oozing out of the left nipple was quite striking that is to say dark brownish, thin and would remain fluid. Here was the objective expression in pathology which reflected her idiosyncratic locus, a pivotal ex-

pression. And the medicine prescribed on this pivotal expression seen in a pathology brought about total cure within a span of six months. There has been no recurrence even after ten years and now the lady is a mother of two children.

Applied Significance

1. A pivotal expression in form of a symptom, a manifestation or any other subjective/objective expression which reflects individual patient's idiosyncrasy, that is to say an expression of the 'patient as a whole' and entire totality is summed up in this expression; alone is sufficient to prescribe an appropriate medicine to manage the disease effectively at a given stage, more so if it happens to be an acute stage. Our entire effort and concentration gets precisely converged on finding out idiosyncratic expression of the patient as elucidated in above cases rather than the divergent approach in recording all the symptoms, analysing and evaluating, and finally repertorising in toto, which could, of course, be relatively easier during asymptomatic phase but not at all conveniently practicable during acute phase.

2. Prescribing on pivotal expression not only makes the process of arriving at a final selection of the medicine much easier but also we find that prescriptions thus made would be so general that it would not vary from physician to physician for a given patient (which we often find varying). Because here effort & approach being convergent in nature not divergent and above all strictly on individualisation basis. To make prescription simpler, easier and general, perhaps would be the ultimate aim of any research organisation anywhere in the world.

(iv) Placebo-Effect Psychology

There is a joke : "If you make a sugar-pill placebo and charge a lot for it, it works better than a placebo for which you charge

very little. And if you have certain colours on that pill, it might work even better".

For long, placebos have been used in pharma experiments to know whether or not the chemicals in particular drugs are having a beneficial effect. But new research shows that when somebody experiences a placebo effect the person's own endorphins-dopamine, serotonin and nor-epinephrine are doing something for him as a consequence of a caring and healing act and his belief that he is getting better. In his bestseller, '*Ageless Body Timeless Mind*' (Rider) by Deepak Chopra draws attention to the fact that placebos can be used to kill pain, stop excess gastric secretions in ulcer patients, lower blood pressure and achieve a host of other positive physiological changes. But on the flip side, all the side-effects of chemotherapy can be induced in cancer patients by giving them a sugar pill. Since the same inert pill can lead to such totally different responses, writes Dr. Chopra, we must conclude that the body is capable of producing any biochemical response once the mind has been given the appropriate suggestion. Or as someone remarked, mother's chicken soup works precisely because mother is giving it to you. (A clipping from the Sunday Times, The Sunday Review August, 25, 1996).

As is evident from above, once a patient's mind has been made to believe by positive suggestion, which we can do by controlling his acute asthma attack and if it happens so that we are able to control his acute attacks more than once, a constrictive psyche prevails upon the patients. Under such a strong psychological reassurance (which we have been able to generate by controlling his acute attacks) a Placebo-Effect Psychology may come to play a very constrictive role in any of the manner:

(i) Very same medicine which has helped the patient in controlling his acute attack be it *Ipecac*, *Drosera*, *Antimonium tartaricum*, *Coccus cacti.*, *Arsenic album* or

any other, might go a long way and suffice in checking recurrences of attacks too. Patient may not, at all, require any other medicine and thus cure can be accomplished by a single medicine alone.

13.1 (iv) 1. Case report : A patient suffering from some chronic disease came to CRU from Mandi, H.P. (7-8 hours driving distance from Shimla). He gave reference that he had been referred here for treatment by his uncle whose daughter suffering from asthma for quite some time got cured after taking treatment from this unit, only once, more than 2 years ago. Knowing that we had never registered a case of asthma from Mandi as a research case, we further enquired from the patient, the name, age and approximate month when the said patient of asthma visited us for treatment. He gave us the required particulars. This patient was attended to as usual and was given medicine accordingly.

Now, out of curiosity, we took out the O.P.D. register and looked for the patient with particulars as provided to us. After searching the register page by page, the said patient could be located. And it was found out that she had been given *Drosera* 30, 1/2 drachm pills, to be taken three times a day *Drosera* 30, 1/2 drachm pills which could have hardly lasted 10-15 days sufficed to bring about a cure. Perhaps in this case, *Drosera* was given on severe spasmodic nocturnal cough associated with asthma attacks. Patient had been suffering from asthma for quite sometime and had taken all the available treatment at Mandi but without any benefit. This detail was provided to us by the patient who had been referred to us.

On analysing that such a chronic desperate patient after receiving *Drosera* on clinical similarity must have found relief in her acute attacks and perhaps had generated a confidence beyond doubt with strong psychological self assurance that at last she had been to a doctor who had understood her disease.

Prevalence of such a constructive psyche upon her, might have triggered a 'placebo-effect' which had brought about total cure simply with 1/2drachmpills of *Drosera* 30.

(ii). Or any other medicine selected and given during asymptomatic phase may help the patient in accomplishing total cure but on the flip side, we may sometimes draw wrong conclusion with regard to follows well or complementary medicines etc.

This Placebo-Effect Psychology whether comes into play or not is a matter of study and needs to be researched further to evaluate the effect of placebo during asymptomatic phase in patients where acute asthmatic attacks have been managed effectively more than once.

14. Two Important Observations

1. Individual susceptibility/modality regarding time, weather, place and in respect of other triggering agents which no doubt often appear quite characteristic and individualising, may be found varying from a group of patients to another group of patients, are in fact common variant expressions of the disease. These common variants merely constitute negative symptoms. Thus, the knowledge of common characteristic variant symptoms becomes very essential in the treatment of asthma, because this can help us in eliminating them out altogether or at least not place them at a higher rank.

2. Long term continuous contact with the patient i.e. good compliance and follow-up is needed to accomplish a total cure. To achieve this, again management of acute attack becomes essentially vital. And for that the knowledge of pivotal expression (a leading symptom on which the whole symptomatology revolves, strictly an individualistic expression of patient's idiosyncrasy) becomes all the more essential.

Conclusion

Study on project of bronchial asthma is continued. Certain inferences and statements made in this paper are based on various clinical data which may not be conclusive proof but are indicators of trends. This work is a preliminary study and certain trends which seem to have emerged need to be researched further separately and in a more specified manner. These include -

1. Development of asthma in 'outside settlers in hills' and its homoeopathic treatment with particular reference to *Cassia sophera*.
2. Extrinsic asthma, with a typical onset and it's homoeopathic treatment with particular reference to *Cassia sophera*.
3. Miasmatic study of asthma patients with particular reference to course and prognosis of the disease miasm-wise.
4. 'Placebo-Effect Psychology' in the treatment of asthma. etc.

This paper relates to various data-based trends; consequent upon these observations and trends I would emphasise the significance of controlling acute asthmatic attacks effectively in accomplishing a total cure, which is our mission too.

"The physician's high and only mission is to restore the sick to health, to cure, as it is termed".

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