THE
HAHNEMANNIAN GLEANINGS
with which is incorporated the
INDIAN HOMŒOPATHIC REPORTER.

Vol. XIV SEPTEMBER, 1947. No. 9

THE CHRONIC MIASMS

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One of the greatest discoveries of Samuel Hahnemann which met with the most persistent opposition among allopaths as well as some homœopaths is the theory of the chronic miasms as expressed in his *Chronic Diseases*. It seeks the origin of all chronic disorders in the three miasms of psora, syphilis and sycosis. What is a miasm? We do not really know. The dictionary defines it as "a noxious emanation of imponderable nature."

To a mind trained in modern scientific methods, such a theory at first must appear utterly vague and unscientific. He may argue that a hundred years ago "nebulous miasms" were considered the cause of disease; in our time bacteria have supplanted the role. Syphilis and gonorrhœa as well as the various "psoric" skin conditions are not now considered miasmatic influences affecting the whole functioning of man's body, but rather the result of a local invasion of germs due to incidental infection. Since in most

chronic diseases the presence of these microrganisms cannot be demonstrated, it seems proven beyond doubt that the diseases could not have been caused by syphilis, gonorrhœa or psora. Thus we are taught that the belief that miasms cause chronic diseases is not much better than the belief in witchcraft or the evil eye.

Even many a homœopathic practitioner may wonder whether it is justified to deduce the psoric, sycotic or syphilitic origin of a chronic state merely from the fact that it satisfactorily responds to one of the antipsoric, antisycotic or antisyphilitic remedies, when no history of skin infection, syphilis or gonorrhœa can be obtained in the patient or his family. Such instances are quite numerous. It is in view of such cases and the apparently convincing evidence of bacteriology that an attempt is made to scrutinize and restate from the viewpoint of homœopathic experience the evidence in favour of the chronic miasms.

A condition cured by *Thuja* need not necessarily be gonorrhœic, nor does a response to *Mercury* prove a syphilitic origin. However, if a chronic condition responds to a nosode like *Medorrhinum* or *Syphilinum*, there must be some connection between sycosis or syphilis and the patient's condition. Therefore it may prove helpful to approach our problem from the experimental evidence furnished by the action of these nosodes. We arbitrarily choose *Syphilinum* as an example.

In its provings on the healthy individual, *Syphilinum* produces symptoms which can be classified

into two groups. The first group (A) bears a definite resemblance to the symptoms of clinical syphilis in its various stages (chancroid ulcers, copper-coloured eruptions, nightly bone pains, cephalalgia, etc.). In the second group (B) of typical *Syphilinum* symptoms (fear of night, loss of memory, craving for alcohol, ozæna, ulcers of tonsils, etc.) we can not yet see a convincing evidence of clinical syphilis.

Both of these groups of symptoms are produced by material which, because of its high attenuation in potency, does not contain any spirochetes. By no stretch of imagination can one classify the disturbance of health produced by the proving of the nosode as an "infection." A syphilis-like picture can be produced in Group A by a high potency which represents not the action of spirochetes but only of a dynamic energy—truly an "emanation of imponderable nature." Thus experimental evidence is furnished that the existence of "emanations of imponderable nature" which may cause disturbance of health is not merely the outgrowth of an unscientific phantasy.

What is the nature of the pathological conditions thus produced? Having been produced by the potentized syphilitic material which in this form meets the definition of the miasm, it is nothing but a simple statement of facts to say that both Group A as well as Group B are the expression, on the healthy prover, of the syphilitic miasm. Furthermore, it is demonstrated that the sphere of action of this miasm includes (Group A of symptoms) but also surpasses (Group B) what we consider clinical syphilis.

When we encounter a patient who exhibits symptoms which in their totality resemble Group A or B (or a combination), *Syphilinum* will be the curative remedy. The same would be true if he showed a close resemblance to a totality of Group B symptoms. Does that mean that in this latter case also we are right in classifying his disorder as syphilitic? Let us suppose that there is no personal or familial history whatsoever of a clinical syphilitic infection. If *Syphilinum* cures, does one deal, as has been suggested, with an entirely different nonsyphilitic condition for which it just "happens" to be the remedy? To find a satisfactory solution an attempt must be made to determine what the relation is between the symptoms of the prover and the condition of the patient. Obviously this relation must be more than what is suggested by the term similarity. It seems logically not entirely satisfactory to say that a remedy cures only because it is capable of producing symptoms which are similar to the patient's. The production of the similar picture is not necessarily an explanation for the ability to cure, as it only explains *when* a remedy will cure but not *why* it cures. However, physics furnishes us with a phenomenon which may overbridge our gap. This phenomenon is the interference of light or, generally, of electrical waves. There we have a demonstration of the fact that two vibratory energies of *identical* nature, vibratory rate and frequency but of different origin, direction or phase, completely abolish each other. Basically we seem to encounter the same phenomenon when the vibratory energy of the

potentized drug neutralizes the vibratory energy of the disease. In accordance with the physical experiment we have to postulate that the drug energy must be of identical nature *i.e.*, vibratory rate and frequency with the disease energy. They differ only in the phase, namely origin and direction: the energy of the remedy of exogenous origin a part of surrounding nature, the disease from within the patient. We truly should speak of a mercury or gold disease, for example, the metals representing the same energy in outer nature that the similar disease represents within the patient. Thus, we are led to admit that any disorder exhibiting the *Syphilinum* symptoms and curable by this nosode must be the *Syphilinum* disease, i.e., the expression of the syphilitic miasm in the patient; even if there is no resemblance nor history of what we commonly call clinical syphilis.

Thus when we define the sphere of the syphilitic miasm by the symptoms of the nosode and related remedies, we find that what we once called syphilis in the clinical sense is only a small part of the whole miasmatic sphere. We often encounter the miasmatic symptoms in patients without clinical syphilis, but never do we find the clinical syphilis without the miasmatic symptoms. Would this not justify the conclusion that this miasmatic state is the prior condition, and the clinical syphilis only secondary, incidental to it? If a person is constitutionally affected with the syphilitic, sycotic or psoric misam, he may because of it fall prey to an infection of spirochetes, gonococci or any of the germs found in

the psoric conditions. This assumption finds its support also in the well known fact that the exposure to any source of infection results in the "taking" of the infection by some of the individuals but not necessarily by all thus exposed. The discrepancy has been juggled between a so far undefined resistance factor or a highly hypothetical local skin injury. We may feel justified in the assumption that this resistance factor depends at least partly upon the miasmatic predisposition.

It is not clinical syphilis, gonorrhœa or scabies then, that cause chronic disease. Neither are they, as our present theories would make us believe, incidental and merely external local infections. Rather are they the consequence of a preëxisting disturbance of the patient's life energy. Any influence which engrafts or increases the miasmatic influence or is otherwise capable of converting the chronic state into an acute one will produce the picture of clinical syphilis, gonorrhœa or one of the psoric manifestations, thereby creating locally a suitable environment for the growth of germs which would be repelled by a nonmiasmatic body. According to Hering's law, such an occurrence will also take place in the course of progress towards a cure of the chronic condition.

We cannot define yet the nature of the miasm any better than by stating that it resembles the energy which in outer nature is represented by the dynamic forces of *Syphilinum*, *Medorrhinum*, *Psorinum*, *Mercury*, *Thuja*, *Sulphur*, etc., and that it can be engrafted on a previously healthy organism. The old definition of

a miasm as a noxious emanation of imponderable nature seems at our present time to approach most closely the actual facts.

The fact, once established, that the symptoms of Group A or B are the true expressions of the syphilitic miasm must also be applied to any other remedy producing and curing these symptoms. The similarity between the totality of the patient's and the prover's symptoms is not a superficial coincidence but the expression of the identity of the basic energies in the remedy and the disease. We are entitled, therefore, to the conclusion that to the extent that *Syphilinum*, *Mercury*, *Aurum*, or other substances share the symptoms recognized as syphilitic, they also share and express the syphilitic miasm.

Syphilis and sycosis offer simple drug and disease pictures in comparison to psora which Hahnemann called the thousand headed hydra. The law developed for syphilis and sycosis must be equally applicable for psora. The miasms may express themselves in the acute peripheral manifestations on the skin, the genitals, etc. These cases, as we know, give the better prognosis. The more difficult cases of chronic diseases are those where the peripheral manifestations have been suppressed or where peripheral manifestations never have taken place: insidious psora, syphilis and sycosis.

The question as to the ultimate origin and cause of the miasms poses the most difficult scientific and philosophical problems. The answers will be found only by courageously building a new approach to

physiology, based on the experimental evidence furnished to us by the true Hahnemannian method.

—*The Homœopathic Recorder, December, 1946.*

DISEASES OF THE KIDNEYS

BY DR. W. KARO

I.—*Anatomy.*—The kidneys are two flattened, reddish-brown organs with rounded ends, shaped like a kidney bean. They are symmetrically placed below the diaphragm, outside of the last thoracic and the three upper lumbar vertebræ. Their outer margin is convex, their inner margin irregular, forming the so-called hilum, through which the blood and lymph vessels enter the organ. The hilum unites with the ureter, which runs downwards to the bladder, whence the urine is emptied through the urethra.

Thus a direct canal is formed—kidney, pelvis, ureter, bladder, urethra—and it is this canal, through which, under certain circumstances, dangerous infections may reach the kidneys.

The kidneys are wrapped in layers of fat and areolar tissue. They are not too firmly fixed in position, thus they are apt to move or float.

In cases of so-called *movable* or *floating* kidney, the organ may sink into the abdominal cavity or even into the pelvis, giving rise to the most serious subjective symptoms.

Each kidney has a firm fibrous capsule, which, in a healthy kidney, can easily be stripped off. The size