HOMOEOPATHY IN THE TREATMENT OF CHRONIC DISEASE

The Richard Hughes Memorial Lecture 1978

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Mr. President, Madame Dean, Ladies and Gentlemen,

I have to thank you for the honour you have done me in asking me to deliver this Richard Hughes Memorial Lecture. I received your kind invitation with some apprehension, for I was well aware of the homoeopathic credentials of previous speakers who had delivered these lectures over past years. In the past fifteen years some of them had counselled me in the ways of Hahnemann, with varying degrees of purity, I might add.

Furthermore I was not at all conversant with the works of Richard Hughes, but on enquiry found I was not alone in my ignorance. Fortunately for me, two previous speakers, Dr. Frank Bodman[1] and Dr. Oliver Kennedy[2] had delivered excellent lectures about Hughes and his writings. All I have learned about this near forgotten homoeopath I have gleaned from these two papers.

I think I would have liked Hughes. He was controversial, he said what he thought and was not averse to stirring the establishment of his day. Although he severely criticized Hahnemann's theory of the miasms and rejected the great man's theory of chronic disease he was a dedicated homoeopath and did valuable clinical work, which is surely, at the end of the day, what medical practice is all about.

Dr. Bodman reminds us that Hughes was virtually forgotten thirty years after his death in 1902. He was 65 years old.

Accepting your invitation was one thing, finding a suitably acceptable aspect of Homoeopathy was another. During the past decade papers have been of a philosophical, historical or biographical nature. I felt a change of approach might induce discussion and at the same time allow me to express an opinion on certain aspects of present-day homoeopathic thinking.

Dr. Blackie in her Presidential Address to the British Homoeopathic Congress in 1970 opened with these words: "Two things are needed in the choice of subject for a formal lecture. The speaker must be interested in the subject or he will soon bore himself. But he must not know too much about it, lest he risk boring his audience"[3]—which I thought a very good piece of advice.

I therefore want to talk about the homoeopathic treatment of chronic

disease. My interest in this aspect of medicine spans many years, both in NHS practice and latterly in private practice. I know I shall not bore myself and I am confident I shall not bore you, for who knows too much about the treatment of chronic disease, be he homoeopath or allopath.

Ever since Hahnemann published his *Theory of Chronic Disease* controversy has raged as to the validity of his masterly approach to the subject. Hughes wrote in his *Principles and Practice of Homoeopathy*: "It is an entire mistake to call the psora hypothesis the homoeopathic doctrine of chronic disease" and goes on to say that "even if all Hahnemann's theories were proved wrong and abandoned, Homoeopathy would remain the same". He had much to say about the accepted conventional treatment of his day, especially as it touched on chronic illness. Nevertheless, as far as Hughes went, Hahnemann's approach to the whole question of *aetiology* in chronic disease was unacceptable. We must not forget that Hughes was a pathologist, as were many homoeopaths of his day. He was a 'one cell man'. By contrast let us look at the writings of Paterson. In 1954 he stated: "In the treatment of chronic disease it is well nigh impossible to get successful results without a full knowledge of Hahnemann's doctrine of the miasms. It is the chronic miasm which determines not only the symptom picture but also the type of micro-organism found in the disease."[4] Nothing could be more contrasting. And there are homoeopaths today who take the view held by Hughes and others who agree with Paterson. Both contrasting views, however, retain one basic approach to the chronic problem. They firmly believed that the successful treatment of chronic illness depends upon an assessment of the patient and his *qualities his wholesomeness*. As Stern puts it so well in *Tristram Shandy*: "Man is a body-mind-spirit relationship, one quality dependent upon the other." For my part, homoeopathic practice has led me to know that Hughes was wrong.

Having accepted that man in his completeness has composite qualities which in illness inter-react and are specifically peculiar to himself, it is logical to approach his problem in totality or completeness. One cannot discuss the treatment of chronic illness, therefore, without discussing the homoeopathic approach to this difficult problem. It is said, with increasing frequency, that homoeopathic remedies are suspect in the treatment of chronic disease because we cannot show how they work, indeed we cannot prove they work at all.

It seems to me that we ought to get this criticism into perspective. Alas, there are homoeopaths today busily asserting that we must 'scientifically' prove ourselves in order to exist as a valid group of therapists. I have so often wondered why.

If we accept man in completeness, in sickness or in health, may we homoeopaths ask of our scientifically orientated critics how their treatment works and why it so often fails? Surely the rising incidence of iatrogenic disease is a glaring example of their inability to recognize complete man.

At least the homoeopath does not have this problem. In all our erudite comings and goings our feet are tending to leave the ground of reason, clinical reason I mean. Scientific medicine is dehumanizing the patient; were it not so, homoeopaths would cease to exist. To those homoeopaths who fear we shall cease to exist as a valid group, I say "Fear Not. Modern medicine will keep us busy for years to come." Charles Wheeler in his presidential address to the International Homoeopathic Congress in Glasgow in 1936 stated: "I am well aware that presentation and analysis of clinical cases can never *prove* in themselves the truth of Homoeopathy. Such presentation may however suggest even to the doubter the extraordinary value of Homoeopathy in the treatment of chronic disease."[5] He was fully aware of the lack of scientific proof for our remedies, but felt enough had not been done to present a clinical argument to a profession which then acknowledged medicine to be an art and a science. You see, even this great homoeopath was concerned about lack of scientific proof. He suggested, rather mildly I think, that clinical case presentation MAY appeal to the doubter. I feel he ought to have said SHOULD appeal to the doubter. For years I have wondered what one means by clinical proof and how much further proof is required beyond amelioration of symptoms or, in many cases, cure. Wheeler suggested in this same paper that some homoeopath should review fifty consecutive cases treated by himself, unselected therefore, with all the results put down, good, bad or indifferent. The cases should be properly diagnosed, adequately followed up and the results set down without fear or favour.

I thought this might prove to be an interesting exercise. I hope at the end of my lecture that you agree.

I took the first fifty consecutive cases seen by me from 1 July 1976. This gave me a two-year follow up.

Rhinitis (non-allergic)
Chronic parotitis
Chronic sinusitis
Schizophrenia
Chronic supra-pubic pain
Bronchial asthma
Chronic "backache"
Pericapsulitis of rt. shoulder
"Hay fever"
Reactive depression

Dermatographia
Migraine
Chronic cystitis
Post herpetic pain (scalp)

Whiplash injury of neck
Paroxysmal tachycardia
Chronic sinusitis
Ankylosing spondylitis
Recurring dislocations of rt. hip joint
Angina pectoris

Endogenous depression
Hypochondriasis
Rheumatoid arthritis
Rheumatoid arthritis
"Hay fever"
Endogenous depression
Chronic rhinitis
Cyclothymic personality
Chronic "backache"
Recurrent tonsillitis

Endogenous depression
Chronic backache
'Chest pains'
Rheumatoid arthritis
Chronic constipation
Acne vulgaris
Anorexia nervosa
Bronchial asthma
'Hay fever'
Scalp 'neuritis' postencephalitic

Rheumatoid arthritis
Chronic constipation
Ocular pain (rt. eye, ? migraine)
Chronic sinusitis
Acne vulgaris
Loss of singing voice
Dumping syndrome/diarrhoea
Melancholia
Lupus erythematosus
Heberden's nodes

Here are the fifty patients divided into five diagnostic groups and a sixth miscellaneous group.

RHEUMATOID (12)

Diagnosis	*Sex*	*Age (years)*	*Duration (years)*
Chronic backache	M	39	21
Pericapsulitis	F	59	7
Whiplash injury of neck	F	25	4
Ankylosing spondilitis	F	42	16
Rec. disloc. rt. hip	F	41	27
Chronic backache	F	33	11
Rheumatoid arthritis	F	54	12
Rheumatoid arthritis	F	45	7
Chronic backache	M	60	7
Rheumatoid arthritis	M	67	12
Rheumatoid arthritis	F	66	6
Heberden's nodes	F	56	5

PSYCHIATRIC (9)

Diagnosis	*Sex*	*Age (years)*	*Duration (years)*
Schizophrenia	F	54	44?
Endogenous depression	F	54	10
Endogenous depression	F	49	9
Reactive depression	F	68	7
Cyclothymic personality	F	40	15
Endogenous depression	M	57	30
Anorexia nervosa	F	21	4
Melancholia	M	39	17
Hypochondriasis	M	33	12

I am aware that endogenous depression can be a misleading term. I have used it in the sense of a synonym for psychotic or manic depression.

ENT AND RESP. S. (11)

Diagnosis	*Sex*	*Age (years)*	*Duration (years)*
Rhinitis (non-allergic)	F	26	10
Chronic sinusitis	M	57	35
Bronchial asthma	F	9	6
"Hay fever"	F	21	13
Chronic sinusitis	F	16	6
"Hay fever"	F	14	8
Rhinitis	F	14	10
Recurrent tonsillitis	F	18	16
Bronchial asthma	F	25	23
"Hay fever"	M	11	5
Chronic sinusitis	F	58	25

DERMATOLOGICAL (5)

Diagnosis	*Sex*	*Age (years)*	*Duration (years)*
Dermatographia	F	34	16
Post herpetic pain	M	71	5
Acne vulgaris	F	21	9
Acne vulgaris	F	29	16
Lupus erythematosus	F	38	5

GENITOURINARY AND GASTROINTESTINAL

Diagnosis	*Sex*	*Age (years)*	*Duration (years)*
Chronic cystitis	F	42	19
Chronic constipation	F	19	8
Chronic constipation	F	43	21
Dumping syndrome	F	38	3

MISCELLANEOUS GROUP

Diagnosis	*Sex*	*Age (years)*	*Duration (years)*
Chronic parotitis	F	41	4
Chronic supra-pubic pain	F	39	12
Migraine	F	45	20
Paroxysmal tachycardia	F	51	10
Angina pectoris	F	74	7
"Chest pain"	M	43	5
Scalp "neuritis"	M	11	5
Migraine	M	37	22
Loss of singing voice	F	25	5

No. of female patients 38 = 76%
No. of male patients 12 = 24%

I now wish to present the same diagnostic groupings with an analysis of Constitutional Remedies (C.R.), number of remedies given, and the end result of treatment. I have used a rough coding to denote results of treatment:

Total elimination of presenting symptoms ++
Amelioration of symptoms +
Failed cases —

RHEUMATOID

Diagnosis	*C.R.*	*No. of remedies given*	*Result*
Chronic backache	Yes	4	++
Pericapsulitis		2	+
Whiplash injury	Yes	2	+
Ankylosing spond.		6	–
Rec. disloc. rt. hip		6	–
Chronic backache		3	++
Rheumatoid arthritis		5	+
Rheumatoid arthritis	Yes	4	+
Chronic backache	Yes	2	+
Rheumatoid arthritis		4	+
Rheumatoid arthritis	Yes	3	+
Heberden's nodes		2	+

Some of this group also attend an osteopathic colleague who had referred them to me for additional therapy. The patients without exception report an improvement in general health since using homoeopathic treatment. I am satisfied that this coupled approach produces in many cases results as good as or superior to those obtained in rheumatology units, without oral steroids.

PSYCHIATRIC

Diagnosis	*C.R.*	*No. of remedies given*	*Result*
Schizophrenia		12	–
Endogenous depression		3	–
Endogenous depression		6	–
Reactive depression		2	++
Cyclothymic personality		4	Hospitalized
Endogenous depression		3	+
Anorexia nervosa		2	Hospitalized
Melancholia		4	+
Hypochondriasis (cancerophobia)		4	+

It is interesting that in this group I was unable to find a constitutional remedy. This is not always the case. All present on a variety of tranquillizers and tricyclic anti-depressants. The three single + ratings in this group are off all allopathic drugs and still under treatment by me. I read in a journal recently that about one-third of depressed patients responded inadequately to tricyclic anti-depressants. It was felt that plasma levels were too low to give maximum response and the suggestion was made that these ought to be raised, a fairly obvious suggestion if you are an allopath. Could it be that the drug

does not work in a third of patients taking it? I wonder if preoccupation with plasma levels is iatrogenic.

ENT AND RESP. S.

Diagnosis	*C.R.*	*No. of remedies given*	*Result*
Rhinitis	Yes	2	++
Chronic sinusitis		3	+
Bronchial asthma		2	+
"Hay fever"		2	+
Chronic sinusitis	Yes	2	+
"Hay fever"	Yes	2	+
Rhinitis	Yes	2	+
Recurrent tonsillitis	Yes	2	++
Bronchial asthma	Yes	2	+
"Hay fever"		4	++
Chronic sinusitis		3	+

This group of diseases is very responsive, providing sensitivity tests are carried out and the positive moieties given the appropriate homoeopathic remedy. Four of the six C.R.s were Pulsatilla. In my total series seven patients gave a history of parental tuberculosis. A family history of tuberculosis was found in four, giving a total of 22 per cent. This 22 per cent. were at some stage of treatment given Bacillinum with splendid results. Hahnemann was not as much in error as Hughes believed. I mention this here because I am sure homoeopaths not only find tubercular histories but act upon them, and this is but one aspect of homoeopathic treatment which makes for cure of often long-standing cases treated allopathically.

DERMATOLOGY

Diagnosis	*C.R.*	*No. of remedies given*	*Result*
Dermatographia	Yes	2	++
Post herpetic pain (scalp)		3	++
Acne vulgaris		3	++
Acne vulgaris		2	++
Lupus erythematosus		2	+

GENITOURINARY AND GASTROINTESTINAL

Diagnosis	*C.R.*	*No. of remedies given*	*Result*
Chronic cystitis		2	±
Chronic constipation		2	+
Chronic constipation		2	+
Dumping syndrome		4	+

MISCELLANEOUS GROUP

Diagnosis	*C.R.*	*No. of remedies given*	*Result*
Chronic parotitis		2	++
Chronic supra-pubic pain	Yes	2	++
Migraine		2	±
Paroxysmal tachycardia	Yes	2	+
Angina pectoris	Yes	2	+
"Chest pains"		3	++
Scalp neuritis (post en.)		1	±+
Migraine	S.P.S.	1	++
Loss of voice		2	++

This is an interesting group, quite by chance. The chronic parotitis case was a young lady of twenty-six. At the age of twenty-two she had upper and lower molars and premolars (left side) extracted following a six-year history of intermittent but severe left-sided facial pain. The pain still persisted and following sialograms she underwent surgery to her parotid gland and duct. She developed a duct sinus and for four years she had a foul discharge, with halitosis. Pain was intermittently present. She was given Silica which produced a gritty discharge within days. She had less pain in her face although she experienced tingling sensations in her buccal mucous membrane for the first time. After two months the discharge became clear and inoffensive. She was depressed and had been for two or three years. She was given Bacillinum because of her maternal grandfather's tuberculosis. Her depression resolved. Her weight increased. This may have been due to improved appetite because of oral reaction. Discharged well after one year.

The case of chronic supra-pubic pain was interesting. She was aged thirty-nine and had a twelve-year history. In this time she had two barium meals, two barium enemas, one sigmoidoscopy, and six D & Cs, which were all negative. A laparotomy was carried out, with an appendicectomy as an encore. She had explosive diarrhoea at three o'clock every morning. Her C.R. was Calcarea carb. and this she was given with aggravation of pain during the first week. Pain became discomfort after one month. By the third month her only

nightly discomfort was the passing of flatus which cleared up on Carbo veg. She was pain free and well after six months.

The migraine case was a widow aged forty-five. She had been worse since the death of her husband five years previously, although her migraine had been present for twenty years. She had had 'pneumonia' several times as a child. Her grandfather died when he was middle aged, from chronic chest trouble. She was given Natrum mur. and within one month she had ceased to vomit during the attacks. Attacks lessened in frequency and severity over four months. At five months she was given Bacillinum with good improvement. At the ten-month follow-up, she reported transient tension heads; but no further migraine.

Paroxysmal tachycardia was seen in a female patient aged fifty-one. She had a ten-year history. She was digitalized. She reported recent attacks of increasing severity. Her C.R. was Sepia. Attacks were daily. After two months she reported no attacks for three weeks. She still sees me after two years and she has one attack approximately every five weeks. The Digoxin has been reduced from 0.25 mg to 0.125 mg daily.

Angina pectoris. Lady of seventy-four with a seven year history. Her C.R. was Natrum mur. After one month she felt more relaxed and her family had remarked upon the improvement in her temper. After two months she was using less trinitrate and reported much less frequent attacks. She moved south and I lost follow-up contact, so I have given her one +.

Chest pains in a man aged forty-three with a five-year history. All investigations were negative as to causation. He was a printer to trade and it was thought his pain might have an occupational cause. The pain was worse for stress and worry. He was given Sulphur in two increasing potencies, and eventually Bryonia cleared him up. One year follow-up, no pain.

Scalp neuritis in a lad of eleven. Presented with a five-year history of morning headaches present since attack of mumps encephalitis at age of six. Parotidinum cleared headaches after ten days. No recurrence.

The second case of migraine is of interest. A male with a twenty-two-year history of pain in his right eye with peri-orbital involvement. He was aged thirty-seven. Pain dated from injury to eye when he was thirteen years old. He had been shot in the eye with pearl barley from a pea shooter. Investigations by an ophthalmologist were negative. For some years the pain had been controlled with mild analgesics. Some six years before I saw him his attacks became quite incapacitating and had a marked periodicity—three months of constant attack and three months free from attack. He remarked upon a strange peculiar symptom. He had two patches of coldness in both flanks which radiated to his abdomen. His wife had remarked upon this, as also had his masseur. On repertorizing BACK coldness extending to abdomen—Croton tiglium in ordinary type. A remedy I had never heard of. Three further remedies all in italics—Phosphorus, Secale and Spigelia. He was given Spigelia. After one month attacks were reduced from one hour or more daily to

twenty minutes on alternate days. Second month no attaek for three weeks. Cold patches improved. Eighteen month follow up, no attacks for ten months.

Loss of singing voice is my last case. A female part-time professional singer aged twenty-five. Three-year history of hoarseness on top notes. Mysteclin for two years daily. Natrum mur. produced voice improvement in one month. In three months no recurrence. Takes occasional Natrum in reduced poteney.

SUMMARY

Constitutional remedy	15	30%
History of T.B. in parent	7	14%
Family history of T.B.	14	8%
Total elimination of presenting symptoms	16	32%
Amelioration of symptoms	27	54%
Unsuccessfully treated	7	14%

I trust that I shall not be accused of anecdotal presentation as far as my short case histories go. This is a word some practising homoeopaths are getting a little neurotic about. How otherwise can we present our cases, especially when we are submitting a group of cases! I feel, however, I cannot conclude without giving you a case history. Call it anecdotal if you wish, but it has a moral somewhere.

In June I saw a married lass aged thirty-one. Christmas 1976 she commenced with pain in her lower abdomen. The area involved was roughly triangular formed by both iliac fossae and pubis. She was examined by her doctor who referred her to a gynaecologist. E.U.A. was negative. Pain increased in frequeney. Only relieved by strong analgesics. Referred back to gynaecologist and given antibiotics for four months for considered pelvic infection. No improvement. Referred back to gynaecologist. Laparoscopy carried out. Told she might have hormone deficiency when laparoscopy was negative. Treated with a series of injections of she knew not what. Pain persisted. Christmas 1977 referred to general surgeons. Investigations negative. Referred to psychiatrist and given Valium.

She saw me whilst on holiday. She was 14/16 weeks pregnant. Taking a history of pain modalities and finding on examination that if she lay prone on my couch she was unable to extend her spine because of marked increase in pain, I gave her Arnica 6 c t.d.s. with a letter to her doctor. Two days after taking Arnica the pain disappeared. She saw an orthopaedician who agreed her pain was primarily spinal. The patient informed me by letter that the consultant had been more interested in her homoeopathic tablets which her GP had told her to take with her. She did not know what the remedy was.

Some weeks after her letter to me, my pharmacist showed me a letter he had received from the consultant asking that he be informed of the name of

the remedy which my patient had been prescribed. Not, mark you, a letter to me. Neither did the GP reply. Follow-up on 4 October: the patient was painfree.

It has recently been stated in academic circles that Homoeopathy bears no relevance to modern medical practice. I think forty-three of my randomly selected cases would disagree.

Richard Hughes claimed that Homoeopathy worked irrespective of the theories of drug action prevalent in his day. I see no reason to alter this statement when applied to the theories of drug action prevalent in my day. He was quite unable to reason why homoeopathic potencies worked, but they did and that was good enough for him.

Ladies and Gentlemen, it is also good enough for me.

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