RECURRENT TONSILLITIS :

The Problem : Its Philosophical Definition and Resolution

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INTRODUCTION

Recurrent tonsillitis is a fairly common problem in children, adolescents and young adults. Its incidence, intensity and frequency tends to decrease as age advances.

Tonsils are an asset, normally. They are a liability, under certain specified conditions. Wise people conserve assets and get rid of liabilities. A wise homoeopathic clinician can be of immeasurable assistance in determining the course of aetion in a given case of recurrent tonsillitis.

Conversely, a poorly educated homoeopathic clinician can prove a serious liability to the patient as well as to the family.

Philosophy confers wisdom on the physician.

Problem: few homoeopathic physieians are reasonably conversant with homoeopathie philosophy; fewer still are ready and willing to apply it to the *bed-side: they don't* have the necessary time to spend with the patient, undertaking a comprehensive recording of the case as Hahnemann would have it.

Result: Operation curing eternal!

The Law: Faculties not employed, *atrophy*!

A simple basic: to effect a *Hahnemannian cure,* follow the master.

Let us re-discover what Hahnemann has to offer us.

HAHNEMANNIAN VIEW

1. Diseases are *not* local, although they may have clinical expressions predominantly local.

2. Diseases may be caused by external agencies; but, these are, by and large, powerless to cause trouble, especially of a continued and progressive or recurrent type unless there is a basic defect in the constitution of the person concerned.

3. Such defects can result from modes of living not consistent with what is *yukta* (right and proper in relation to time and circumstance with reference to food, recreation, activity during waking as well as non-waking hours and *dharma*).

4. More often, such defects are a resultant of dispositions transmitted from the earlier generations whieh guide the activities of the individual so that he comes in contact with what is *ayukta* for him, thereby producing trouble, mental as well as physical, local as well as general, in ample measure, through the dysfunctioning of the vital force.

5. Such dysfunctioning affects adversely the delicate balance we term health in which efficient output is maintained. Loss of efficiency in functioning, therefore, would be the earliest evidence of illness.

6. This, when continued long enough, would lead to structural alterations leading to further functional deficits.

7. A progressive disease thus results through the operations that involve the (i) fundamental cause, (ii) The precipitating cause(s) and (iii) The maintaining cause(s).

8. Symptoms and signs, local, systemic and general—all depict to the observer this loss of balance.

9. The patient is revealed to the observer through the *characteristics* of his complaints (item 8) as well of his *attributes*, mental as well as physieal. These will include the reactions to the environmental circumstance as well as the cravings and aversions. The physiologic functions are also included in this analysis.

10. The vital force expresses itself continuously through:

(i) *The development and evolution of the individual* so that he is able to function effectively as well as efficiently as a complex open system interacting with the environmental systems to effect an organizational structure, capable of taking various forms to deliver function which is appropriate.

(ii) *The Events*: These are nothing but the forms thrown up from time to time and are drawn out by the environmental circumstances in response to the felt wants and needs of the individual that promote the various interaetions and the formation of patterns.

11. The Individuality is revealed to us through the *characteristics* we are able to identify with reference to 10 (i) & (ii). The *identification* of the individuality, however, does not rest with the *mere enumeration* of the *characteristics*. We require to integrate them into an *evolutionary structure* that permits us a full, scientific explanation of the entire route followed by the individual in his travels, right to the time of his arrival before us.

12. This *evolutionary structure* is the *Hahnemannian totality* and when we are able to discover it accurately, we are able to discern in it the phenomenon of simple harmonic motion (S.H.M.). These are the phase effects:

Positive	Psora	Tubercle	Syphilis: Destructive
Negative	Sycosis		Syphilis: Degenerative

These phase effects are basically long-lasting, chronic. Each has a capacity to throw out acute forms, appropriate to the demands made by the environmental circumstance. These appear to the casual observer as 'acute diseases' or acute exacerbations of chronic diseases. That these acute forms are related to the chronic base, is accepted *only* by the Hahnemannian observer.

13. The Hahnemannian observer, therefore, would deny an independent existence to the acute totality as denoting an acute disease in the nosological classification of 'modern medicine'. He has, necessarily, to relate it to the chronic base, if he is to effect a successful cure.

14. In order to do that, he is compelled by the philosophy he holds dear and by the principle of integrity to *investigate* the case fully to define the *totality* as defined earlier.

PERIODICITY, CHRONICITY AND REMOTE EFFECTS

Before we proceed further with the investigation of the case, it is essential that we define for ourselves the real problem we face when taking on a case of recurrent tonsillitis.

The tonsils are strategically located to ward off all germs that enter the upper respiratory tract so that serious troubles do not follow lower down. By and large they serve us well at a price we cannot consider as excessive. Their *indiscriminate removal weakens the defences* of the body and this should be avoided.

The tonsils serve as a major portal of entry for practically all germs: Streptococci, c. diphtheriae, m. tuberculosis, viruses—to cite a few.

Sycotic miasmatic disposition promotes hypertrophic response on the part of the tonsils. The suppurative, by contrast, is the privilege of the tubercular miasmatic disposition. The shrivelled tonsil exuding pus on pressure is the end-point liability of a long-drawn out *battle that has gone against the* host. If a patient reports at this end-point, it is best to get rid of the liability through *operative removal after* constitutional homoeopathic treatment.

In the sycotic process we get remote involvement of the fibro-muscular structures as well as the serosal surfaces. Extensions can occur to involve the cartilage and the joints. We thus get the rheumatic processes initiated by, maintained by and aggravated by the primary process going on in the tonsils. Control of the primary process affords reasonable control over the remote processes has been demonstrated adequately through the administration of *long-acting depot antibiotic* to children with rheumatic fever. This has helped to clarify the mechanisms. The dramatic successes of the septic focus theory in some instances affords us evidence of the remote effects brought about by continued infections which the R.E.S. has failed to bring under its effective control.

In the tubercular process we find evidence of *superadded extension into* the tubercular miasm which accelerates the remote effects and adds to them *the dimensions* of suppuration and emaciation; frequent changeability as well as haemorrhagic tendencies and acute extensions into the lower respiratory tract are also seen. We also get evidences of generalized lymph node involvement as well as that of the spleen. Often, we get a clinical history of some

virus infection that triggered off the whole process. Poor nutrition and capricious appetite are the presenting features.

In the syphilitic dimension we get the rheumatoid arthritis with node involvement that follows the syphilitic pattern coupled to the proverbial nocturnal aggravations.

It is important to recognize these essentially different processes (although similar from the clinico-pathologic angle), as the homoeopathic management, especially the selection of the acute remedy and its administration, will vary widely.

Remote effects also take on the character of vascular damage as is evidenced in the pathology of glomerule-nephritis. The link between the two, as well as the demonstration of the mutual exclusiveness of these two remote effects, is demonstrated well in scarlet fever.

We thus find that the stakes are quite high: failure to control the primary process in recurrent tonsillitis poses a grave risk of damage to vital organs like the heart and the kidney or an incapacitating, releutless chronic disorder like rheumatoid arthritis.

And, this is most important for the homoeopathic physician to realize, these processes can never be brought under control through homoeopathic treatment unless the treatment is carefully planned and programmed in a most meticulous manner and pursued till *all the evidences of alterations* are removed.

ALTERATIONS

We get evidence of contact with the germ: (i) Local Examination of the tonsils, (ii) Serologic titres of antibodies and constitutional evidences of altered susceptibility like the R.A. test.

We can study the R.E.S. response through globulin electrophoresis which demonstrate aberrant patterns when the remote effects have set in. Incidentally, these are the last to return to normality under a homoeopathic cure, the local remote effects being set right much earlier.

Depending on the site of remote effects and the pathology produced, we can order a number of tests appropriate to reveal the damage. We need not go into the details of that. Suffice it to say, that cure cannot be pronounced till *all alterations* have been reverted.

From this it should be clear that modern clinical investigations have a lot to offer to the wise homoeopathie clinician ready and willing to utilize these in his practice.

INVESTIGATION OF THE CASE

No homoeopathic physician worth his salt will ever shirk from the responsibility of *fully recording* the history so that all the data necessary for erecting the *totality* as defined earlier is obtained.

Implication: No short cuts! Sufficient time will have to be spent with the patient, apart from his tonsils! Falling in love with the tonsils, proves fatal to the *homoeopathic physician!*

The *record* must bring out the *characteristics* in respect of the (i) tonsils, (ii) other complaints and (iii) the patient as a person: attributes. The past, personal as well family, will contribute to our understanding of the pre-dispositions.

The I.C.R. Standardized Case Record System permits the physician the luxury of an 'automatic' system that would guide him surely through the intricacies of homoeopathic prescribing since it also incorporates data processing that permits the erection of the evolutionary Hahnemannian totality.

If we are especially interested in having a full, detailed record in respect of the sector totality of tonsils it is advisable to have it again in a standardized fashion to enable comparisons. We suggest the use of SCR Special Record which reflects the essential repertorial study of the sector. This is reproduced in the Appendix. This Special Record, it should be remembered, forms an attachment to the SCR and should be read along with it. Since the sector totality often is associated with fever, we will have to compare the section of fever totality in the SCR.

Miasmatic basis of the case should be clear from the study of the full SCR. This implies knowledge of both cause as well as the effects.

Clinical investigations should be ordered with care and a few select ones performed as serial investigations for the follow-up control. The details can be abstracted from any good standard book on clinical medicine and clinical investigations.

PROBLEM-DEFINITION AND PROBLEM-RESOLUTION

We define any problem as per our understanding at the general level. The specificity can never be operationally understood except by reference to general rules and procedures. These are derived from the philosophy of any discipline.

We have presented in a comprehensive and deductive manner the integrated point of view with reference to the clinical phenomenon of recurrent tonsillitis.

We have demonstrated how the view guides us in launching an appropriate programme of clinical investigation and data recording.

Homoeopathic philosopby guides us lawful physieians to effect a Hahnemannian cure *provided* we do not trade sound sense for something that glitters.

From the operational standpoint, problem-definition in bits leads to corresponding problem-resolution thus redefining progressively the problem till total resolution is achieved. We thus obtain the upward spiral.

Any compromise proves fatal to the evolution of the above spiral and the physician goes into a nose-dive with results disastrous!

We must never forget that all our definitions and attempts are mere estimates that guide the 'operation'. We must have a continuous system of feedback to alert us to detect early deviations so that immediate corrections can be applied fruitfully.

Problem: We often relax our vigil to get sucked into a vortex.

Resolution demands supreme effort to propel in a tangential manner after taking a further deep dive! Few demonstrate the versatility necessary for survival under these circumstances.

Conclusion: Adherence to philosophy assures us continued survival under all sorts of variable environmental situations. Moreover, we are able to function most efficiently *provided* we have mastered the tools and evolved professional judgment and expertise.

Negation of philosophy or equivocal adherence to it, by contrast, assures us a long-drawn out destructive process of a progressively increasing order.

Choice: is ours! *Result*: we cannot avoid!

CLINICAL RESEARCH IN HOMOEOPATHY

In private homoeopathic medical practice, even the most conscientious practitioner is severely handicapped by the absence of various facilities essential for careful investigation, recording and follow-up. He may produce a cure. But, the documentation may not be precise or the clinical investigations inadequate, the follow-through short and so on.

We need organizations for research in order to get over these difficulties. These organizations need to be funded adequately. And funds need to be expended wisely and in a manner accountable to undiluted academic standards mostly incorporated in Hahnemannian Homoeopathy (which also includes all that is valuable in the post-Hahnemannian era).

All of us were glad that the Central Council of Research in Homoeopathy (CCRH) has adopted the Standardized Case Record for Documentation of Cases.

The same Council decides with reference to the problem of tonsillitis: "In acute conditions or in acute manifestation of chronic miasms the relevant spheres will have priority and comprehensive recording will be limited to the extent feasible and practicable."

The above decision was duly recorded by the Scientific Advisory Committee (SAC) of the CCRH.

"We shall be virtuous to the extent feasible and practicable": the SAC of the CCRH assures us most solemnly!

Can *truth* survive such manhandling?

Hahnemann denied, can Homoeopathy survive?

The CCRH Annual Report (1978-79) has a small para devoted to clinical research on *tonsillitis. It is not clear in* what way the CCRH has advanced our knowledge in the homoeopathic management of tonsillitis. Probably, the space for reporting was inadequate to bring out the *truth.*

It is imperative that the CCRH publishes *the full report in respect of its* work on tonsillitis in order to justify its anti-Hahnemannian stand reflected in the above quotation.

Either it fully justifies its opinion or revokes it, to prevent further damage to research programmes as a result of such patently erroneous point of view.

The SAC members should come out in the open as the above decision has been 'unanimous' as reported by the Director, CCRH. Operating in the dark is not a useful exercise for persons engaged in the discovery of *truth.*

The over-all impression one gets after perusing the report (it does not merit any detailed study) is that of sterility in respect of *knowledge* (increment).

With more than eight lacs spent *in the year, the CCRH should have come* out with something more tangible, something more fruitful.

It has laboured to produce a mouse!

CONCLUSION

Research is possible only when we are welded to *philosophy* and seek *practice* as an effective *demonstration* of these fundamentals.

Compromise compromises, leads to bigger compromises till nothing is left.

These lessons, quite a few of us, have still left to learn at the end of a life full of successes.

Success, as defined *by Hahnemann,* eludes them always.

Is it ever too late to mend? Are we incurable?

Have we convinced ourselves through our convenient 'convictions'?

All have to answer especially those opposed to the *scientific standardization* of homoeopathic medical education, practice and research.

Constitutional aversion to work, love of wealth, power, status, disposition to compromises of all sorts: all these arch enemies of *knowledge,* buttressed by an incurable *prejudice* that forces prejudgments on us, effectively prevent us from efficient functioning as Hahnemannian physicians.

We, indeed, need to follow the master to *discover* the *truth*: first, about our good selves and next of our good patients who trust us with their most precious *possession—their life.*

Are we justified in trading their lives for the various advantages we secure for ourselves when we set on the *road compromise*?

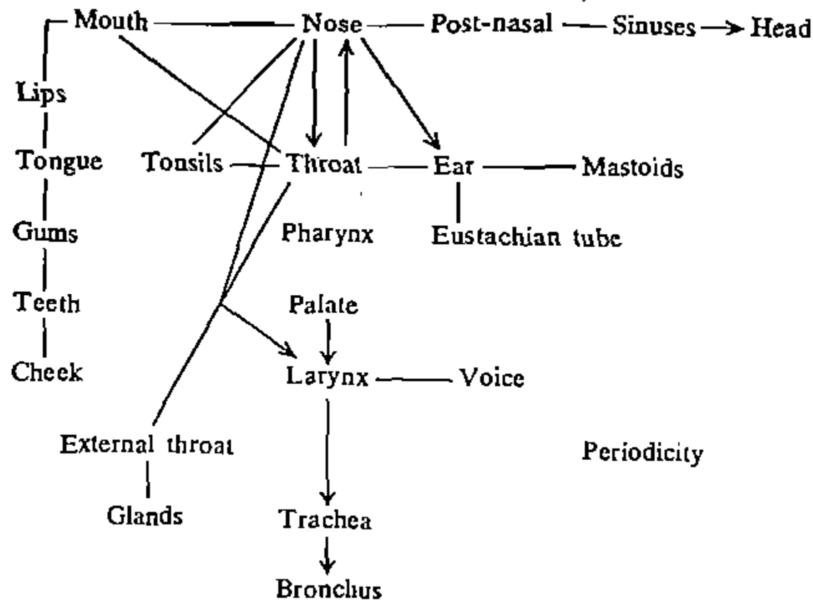
Are we *sensitive* to perceive the crosses *in the fields on both sides of* road we prefer to take?

If we are, we shall not stray from the path lit for us by the master.

We need to demonstrate our courage in *practice.*

Appendix

SCR SPECIAL DATA RECORD SHEET: TONSILLITIS



Compare: Fever Totality

1

THROAT

Dryness	Choking	Lump	
Foreign body sensation		Hawking	
Inflammation			
Pain (Types)			
Paralysis			
Discolouration			
Membrane			
Regurgitation		Swallowing difficult:	Solids
			Liquids
			Empty
Swelling		Voice: Hoarse	
		Lost	
		Cracked	

EXTERNAL THROAT:	Glands		
Pulsations	Cloth Aggr.	Swelling	Fistulae
Torticollis	Stiffness		

2

COUGH:	Dry		Wet
EXPECTORATION:	Character: Colour		Odour
	Consistency		Taste
	Quantity		Modality: Time
			Postural
Chill	Heat		Perspiration
Compare: Fever			

NOSE

Catarrh	Coryza: Ascending/Descending		Post-nasal
DISCHARGES:	Colour	Odour	Sinuses
	Taste	Quantity	Consistency
	Bland/Acrid		

3

Inflammation		Swelling
Cancer	Nodosities	
FEVER: Chill	Heat	Perspiration
Epistaxis	Cracks	
Obstruction		
Pain (Types)		
SMELL: Acute/Lack/Abnormal		Aggravates
Regurgitation	Sneezing	Irritation/Itching
Alae Nasi	Hearing: Impaired/Lost	

4

EARS			LARYNX & TRACHEA
Obstruction, As If			Dryness
Pain (Types)			
Inflammation			
Itching			Irritation
Wax			Voice: Hoarseness/Aphonia
Hearing: Impaired		Lost	Croup
Acute	Noises		Mucous
DISCHARGES:	Colour	Odour	Spasm
	Consistency		Oedema
	Quantity	Bland/Acrid	
Vertigo			

5

MOUTH		TONGUE
Dryness/Salivation		
Moist		
Inflammation		
Ulcers/Aphthae		
Odour	Taste	
Discolouration		
Speech		Swelling
		Surface
Atrophy		Motion
LIPS: Dryness	Chapped	Cracks
Discolouration	Eruptions	Swelling

6

GUMS		TEETH
Discolouration		
Inflammation		
Pain		
Pus	Bleeding	Abscess
Spongy	Ulcers	Shape
Swelling		Caries
		Deformities/Displacements
Dentition: Delayed		Difficult
Wisdom Teeth: A. F.		Grinding
		Elongated, As if

7

Periodicity of complaints
Alternations
Local expressions of general disturbances
Significance of complaints

8

Note: The Special S.C.R. has been designed by Dr. K. N. Kasad, Hon. Associate Director, I.C.R., Bombay.