CURRENT THINKING ON THE MIASMS*

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GK: There still seems to be no consensus on the number or nature of the miasms. Dr. Ortega has recently written, "Only three forms of alteration of cellular function can be imagined: deficiency, excess, and perversion."[1] He also wrote that "Allen unfortunately got lost in speculation about pseudopsora."[2] But in your paper,[3] Tubercle occupies a place of importance equal to the original three.

KNK: The Calcutta school also accepts only three miasms. Tubercle was introduced by H. C. Allen, and our understanding of it was refined by Kent and Boger. Clinically the concept can be applied with success, especially here in India where the tubercular miasm is predominant. In your country I presume the dominant miasm is syphilis. In the West there is a lot of degeneration, especially neurological. Here we have more chronic fevers.

GK: Why didn't Hahnemann mention tubercle?

KNK: If you carefully read *Chronic Diseases*, vol. 1, you will see that Hahnemann included even cancer under psora. He did not clearly demarcate the miasms. He wrote very little at all about sycosis and syphilis. It was H. A. Roberts who first worked out the precise dimensions of psora. Kent wrote on latent psora and sycosis. Hahnemann didn't think of everything. Hering gave us the law of direction of cure, and we are indebted to Kent for the Twelve Observations.

GK: If one miasm can be added, then why not more?

KNK: Tubercle is not an addition, but rather a synthesis of properties first attributed to either psora or syphilis, hence the name proposed by Allen, pseudopsora.

GK: Then is it a mixed miasm?

KNK: Not in the sense of a combination of miasms, like cancer or psoriasis. It is distinct. Miasms are not static entities but a dynamic flow, wave phenomena. Interpretation derives from the time at which a patient requests a consultation.

Take for example acne vulgaris. It starts as a macule or rash, then successively forms a papule, a vesicle, and a pustule, which finally ulcerates and heals, leaving a deep scar. All the miasms have been expressed in the evolution of the ailment. If a child is born with a cleft palate, that is syphilitic miasm. We presume that the other miasms were experienced in the womb, because syphilis is always the endpoint. We say that Sulphur is an antipsoric, but it has warts in its pathogenesis, doesn't it? All the miasms are represented in every medicine.

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* An interview with K. N. Kasad, M.B.B.S., M.F. HOM., Bombay on 19th July 1982.

GK: That brings us to Dr. Ortega's central thesis, that every patient expresses in his symptomatology all three miasms in varying proportions. Doesn't this conflict with the phased and evolutionary expression of the miasms which you stressed in your paper?

KNK: Dr. Ortega is quite right. Every man is a mixed man. We exhibit different aspects of temperament according to our circumstances. So it is with the miasms. But at any given time, one miasm predominates. As chronic disease advances, psora diminishes and the others increase. Understanding this can be helpful in selection of the remedy and posology. Damaged tissues exhibit decreased sensitivity, so high potencies can be given every two hours until sensitivity is restored. In functional diseases where sensitivity is intact, repetition will cause an aggravation. We have been taken to task for unorthodox dosage schedules, but we feel that we are working along the lines laid down by Borland.

GK: What about a man who contracts syphilis. Does he acquire the miasm?

KNK: Not at all. Infection with the spirochete alters susceptibility and sets in motion the miasmatic process of syphilis. Antibiotics may remove all traces of the spirochete, but this only ensures that expression of the miasm will be in some other form than clinical syphilis.

GK: So we are born with the capability to develop all the miasms.

KNK: Which are activated by appropriate environmental triggers. Miasms are not acquired. They arise from within.

Let's take mitral stenosis. First there is the rheumatic process, which is sycotic. Then by extension, destruction of the valve occurs, which is syphilitic. We can handle the rheumatic process homoeopathically. However, the acquired deformity is a surgical problem.

GK: But I have heard of cases where murmurs were removed with a remedy.

KNK: Homoeopathy can only cure a functional murmur. We can improve cardiac function, but an organic murmur will persist. Sometimes a congenital heart defect will remain asymptomatic for years. I remember a case where Laurocerasus removed the cyanosis resulting from an atrial septal defect with a right-to-left shunt, but of course the structural problem remained.

GK: Why does one person suffer from a relatively harmless condition like acne vulgaris, while another has Parkinson's disease? Both are expressions of the syphilitic miasm.

KNK: We don't know. Science answers the question: how?. Philosophy answers the question: why?. Why does one person develop cancer of the lung, and another cancer of the colon, all other factors being equal? There is a theory of end-organ inferiority inherited at birth, but further than that we cannot go. Neurosyphilis is more common in Europe, while cardio-vascular syphilis is more common in India. Why? We don't know.

REFERENCES

1. Ortega, Dr. Proceso Sanchez: *Notes on the Miasms*, 63. New Delhi: National Homoeopathic Pharmacy (1980).
2. *Ibid.*, 69.
3. Kasad, Dr. K. N.: 'Disease (Natural and Drug): A Phenomenal Approach', *Symposium Volume on the Hahnemannian Totality* (Editor: Dr. M. L. Dhawale). Bombay: Institute of Clinical Research (1978).

—*Journal of the American Institute of Homoeopathy*, March 1984