PERCEIVING LEPROSY

DR. DILIP DIKSHIT, L.C.E.H., Bombay

INTRODUCTION

Some years back, a patient was referred for intractable intense generalized burning pains with marked intolerance to heat developing after allopathic treatment for tuberculoid leprosy. She was obese; perspiration on her head was marked. Other features of the patient suggested Calcarea iodatum, which was given in the 6th potency every four hours. The patient had shown little improvement during the previous one and a half years under allopathic treatment. However, on Calc. iod. in four months not only were the burning pains and heat intolerance relieved but also her leprosy lesions sowed remarkable improvement.

Hoping for further guidance, we researched the homoeopathic literature for references on the treatment of leprosy. Aside from a few rubrics and scattered recommendations in books on therapeutics, we found no case studies which gave detailed information on the homoeopathic management of leprosy.

The dermatologist who had referred the calc. iod. patient was impressed by the result. As he was dissatisfied with the usual allopathic approach to leprosy, he agreed to cooperate in a research project. He gave us help in pathological diagnosis. A surgeon also cooperated and guided us in the management of deformities. The project was formally taken on by the Institute of Clinical Research of Bombay, an organization devoted to teaching the principles and practiee of classical Homoeopathy.

ALLOPATHIC TREATMENT OF LEPROSY

Introduction of the sulfones was a landmark in the fight against leprosy. Prior to the sulfones, no medication had shown consistent beneficial effects. Dapsone (diamindiphenylsulfone) has been in sufficient vogue through the free distribution agencies, government as well as private charitable ones, for us to realize sufficiently well the advantages as well as the limitations of the drug.

Bacterial resistance with consequent clinical inefficacy, clinical improvement with no corresponding bacterial improvement, precipitation of lepra reactions of a severe type, drug toxicity and sensitization reaetions of varying severity are the problems with dapsone.

Newer, more potent medications pose the problem of cost, some of them costing ninety times more than dapsone.

Lepra reactions pose a serious problem. Some of the patients need hospitalization for effective management. Recurrences are fairly frequent, making patient acceptance low. Failure of allopathic medication, after consi-

derable promise, makes the patient desperate. Of course, allopathic medication in no way improves the ability of the patient to fight *Mycobacterium leprae*. That is a general drawback of all antibiotic therapy.

HAHNEMANNIAN MIASMATIC APPROACH

We attempted homocopathic treatment on classical lines, basing the remedy selection on the presenting totality of symptoms. We were surprised to note a consistent lack of response to the remedy administered.

We critically reviewed these patients' records and then brought each patient back to question him more carefully. We discovered that with the onset of the disease and its subsequent progress, all evidence of earlier poor health showed a progressive tendency to disappear. In addition, with the onset of leprosy, there were *no clear localizing symptoms* (i.e. concerning the skin lesion) on which to prescribe. Even the constitutional generals were not clearly evident in a characteristic manner.

Under the circumstances we concluded that leprosy patients came under the category of one-sided disease as described by Hahnemann in the *Organon*, paragraph 185. This presenting state we attributed to suppressive therapies and decided to adopt the miasmatic approach for problem definition and problem resolution.

PROBLEM DEFINITION

Leprosy patients demonstrate:

1. Scanty data.
2. Absence of characteristic symptoms.
3. Disappearance of earlier chronic disorders (i.e. asthma) *with the onset of leprosy.*
4. Failure to respond to the constitutional medicine.
5. Symptoms suggesting the syphilitic miasm on the surface in most patients or symptoms suggesting the tubercular miasm on the surface in a few (especially neural cases).
6. A common tubercular miasmatic base whether the syphilitic miasm is uppermost or whether the tubercular is uppermost.
7. The submersion of the constitutional symptoms with their displacement by either syphilitic or tubercular symptomatology.
8. This submerged expression does not and cannot make itself accessible for constitutional therapy until the top layer (usually the syphilitic miasm) has been effectively eliminated through the repeated administration of the indicated antisyphilitic remedy adequately supported by the nosode Tuberculinum*f*Bacillinum. When the topmost layer has been removed, we must be on the lookout for the specific expressions of the constitutional remedy. We need, therefore, to study our cases in fair detail, right from the beginning.
9. Lepra reaction. This is a hypersensitivity response to the proteins liberated by the lepra bacilli. We interpret this miasmatically as an acute

exacerbation of the syphilitic miasm and prescribe accordingly in the 200th potency every four hours until improvement sets in. Assistance from Tuberculinum or Bacillinum can prove necessary in difficult cases. At times a patient might present for the first time with a lepra reaction. Such patients present a clear picture of the syphilitic exacerbation and respond well to medication. Lepra reactions also occur at the fag end of treatment when all superficial evidence of local lesions has receded and we are often thinking of ending treatment. These reactions are generally non-febrile. Urticaria is often present. They cease on stopping the remedy only to recommence on resuming it. The reactions decline in intensity even though the remedy is continued. Concomitantly, the patient usually shows accelerated clinical improvement, local as well as general. Lepra reactions, occurring late in the course of treatment, indicate that normal susceptibility is being restored. We continue treatment well after apparent cure until no further lepra reactions occur.

10. We have observed that patients demonstrate progress as per Hering's law.

11. Social stigmas, disfiguring lesions, functional incompetence, denial of job opportunities—all these combine to produce a degree of depression in most patients. The clinical diagnosis of leprosy and failure of the promised cure elicits an understandable anxiety response in most patients that call on us for homoeopathic treatment.

PROBLEM RESOLUTION

The resolution of the problem has to be related to the problem definition. An understanding of Hahnemann's miasmatic theory is required. The problems were resolved by adhering to the following:

1. We treat first the dominant miasm with the appropriate anti-miasmatic remedy which has been discovered by paying attention to the presenting totality.

2. We try to be alert to changes in symptoms and miasmatic phases in order to effect appropriate changes in medication.

3. We use the indicated anti-syphilitic remedy in low potency for a prolonged period, sometimes months on end.

4. We use Tuberculinum or Bacillinum as intercurrent remedies. These are given weekly in neural cases and sometimes as often as daily in tuberculoid types.

5. We pay attention to Hering's law and its manifestation as evidence that the patient is indeed progressing towards cure.

These patients all exhibit low susceptibility. Consequently, they demand repeated doses of the anti-miasmatic remedy. This remedy is often selected on very scanty data; sometimes it is selected purely on the basis of relationship to the probable constitutional remedy. Many times we have found a poor initial response when the anti-miasmatic remedy was not supported

by periodic, frequent administration of the indicated intercurrent (i.e. Tuberculinum or Bacillinum) remedy.

Lepra reactions caused by allopathic chemotherapy often demand a different initial remedy from lepra reactions occurring later under homoeopathic prescribing. The latter are usually controlled merely by suspending the homocopathic medicine and beginning it again after the reaction has subsided. Gradually, with this plan, the trouble recedes.

We administer the patient's constitutional remedy only much later in the course of treatment. Case-taking, however, has to be thorough right from the beginning to determine the probable sequential plan of homoeopathic management. We must become super sensitive to slight changes in symptomatology, considering how reaction-poor these patients usually are.

If, in the course of treatment, a periodic disease like asthma erupts, it often demands a change in the prescription based on the newly presenting symptoms. It is important to remember, however, that the intercurrent remedy does not change.

METHODOLOGY

The entire project was handled in private practice with little access to clinical investigations except for skin biopsies. This proved a serious limitation, especially from the standpoint of clinical research with its more exacting demands.

Because of our limitations, it was not possible for us to adopt the current classification with its accent on histology and bacteriological investigations. We have employed the earlier classifications: tuberculoid, lepromatous, neural, and indeterminate.

ANALYSIS

The results obtained in the current series of patients are presented in Tables 2 to 7. These are self-explanatory. A few points need special emphasis.

1. Low susceptibility explains the tolerance of certain patients to the frequent repetition of the homocopathic remedy over a prolonged period.

2. Clinical improvement usually comes about with a restoration of susceptibility after the correct anti-miasmatic remedy has been given in combination with the correct intercurrent remedy.

3. Remedies need to be continued till evidence of overflow symptoms (i.e. a drug reaction or proving) has manifested. This is considered proof of restoration of susceptibility.

4. Indications for constitutional prescribing are usually not seen until the patient has been under this combined treatment (No. 2 above) for some time.

We are presenting below examples of cases that illustrate certain peculiarities of patients with leprosy who are improving under homoeopathic treatment.

ILLUSTRATIVE CASE REPORTS

Case No. 1: Male, 25 years old. Tuberculoid leprosy with contractures.

This case was referred to by a surgeon who had earlier witnessed cures with Homoeopathy. The patient was already under allopathic treatment for four years. The surgeon thought he would operate on the patient after the nerve function improved under homoeopathic treatment. Merc. iod. flavus 30 was given every four hours. In three weeks his contractures became less; he was able to keep his fingers straight. There was less wasting. Sensation of touch and pain returned within two weeks. The combined treatment of Tub. 10M weekly and Merc. iod. fl. 30 every four hours was continued for 2½ years in order to secure improvement in motor function and prevent further wasting. By then, an 85% improvement had been achieved. The remedies were discontinued when symptoms of throat trouble, indicative of too much Merc. iod. fl., appeared. On stopping the medicines, these symptoms disappeared within a week. The patient went to Dubai afterwards and we lost track of him.

Case No. 2: Male, 31 years old. Borderline lepromatous.

This patient was referred to by his employer for swelling of his feet and foot drop. He was under dapsone treatment but had shown little improvement. He had a loss of sensation below the knees in both legs. When the limbs hung down the edema increased. He was prescribed a sling for his foot drop.

He had pain and swelling in all joints, worse first motion and better continued motion.

He was given Calc. fl. 6x every four hours along with Tub. 1M weekly. His edema disappeared shortly and the foot drop was gone in one and half months.

Six months later, the patient developed a pleural effusion after getting wet and was treated by Allopathy. The edema and leg pains returned.

This time he received only Calc. fl. 6x every four hours. Tub. was not given in view of a history of tuberculosis. He recovered quickly and has been well now for one and half years.

Case No. 3: Male, 13 years old. Tuberculoid leprosy.

This child had a light colored patch on his right knee for five years. The family physician had diagnosed it as a vitamin deficiency. One day at school he attended a lecture on leprosy and learned that absence of sensation is sometimes diagnostic of leprosy. He went for further tests and was diagnosed with tuberculoid leprosy.

He was given Merc. iod. fl. 6x every four hours. In one week everything became normal. After two weeks, he developed a cough and cold. The potency was raised to 30 and Tub. 10M was given weekly for support. This

treatment was continued for six months. The patient has been under observation now for five and half years and is doing well.

Case No. 4: Female, 56 years old. Macular anesthetic patches. Tuberculoid leprosy. Bronchial asthma.

The patient presented herself with anesthetic patches on her right arm, wrist and face in December 1977, which had increased after treatment with dapsone. Her asthma of the previous 25 years had declined in terms of intensity as well as frequency with the onset of leprosy. At present, she had infrequent asthmatic episodes.

Questioning elicited the following symptoms:

1. Asthma attacks occurred around 3-4 a.m.
2. Hot patient.
3. Moon phases aggravate.
4. Depression in the past.

Her constitutional remedy was fixed as Kali bich. on the strength of past symptoms. This was given in the 6th potency in frequent doses. As the months passed, the potency was progressively raised to 30, 200, 1M, 10M and 50M. Tub. 10M was given weekly.

Improvement in her leprosy brought a recrudescence of her asthma. These attacks necessitated finding acute remedies to counter the asthma. The following remedies were used: Merc. iod. fl., Hepar, Ars. iod., Ars. alb. and Ant. tart., all in 30 and 200.

Under this regimen, both illnesses showed further improvement. The patient has continued under observation.

Case No. 5: Male, 8 years old. Tuberculoid leprosy.

This boy was referred to by a skin specialist, as he was not responding to regular treatment. He had one small anesthetic patch which was discoloured on his right wrist. Ulnar nerve thickening was quite marked. He was hot and lean. Apart from grinding of the teeth, no other characteristic symptoms were available.

He was given Merc. iod. fl. 30 every four hours and Tub. 1M weekly. In eight months sensation was restored. However, the nerve thickening remained. He was then given Tub. 10M every night and at times three times a day. Under this regimen, the nerve became less thickened and the patch disappeared. The nerve is still palpable, however.

Note: The Leprosy Project was undertaken under the direction of Dilip Dikshit in the Thane, Dombivli, Kalyan region near Bombay. Clinical expert: Dr. A. D. Kharkar, M.B.B.S., D.V.D. Surgeon: Dr. A. T. Thakkar, M.B., F.R.C.S., D.G.O. Project director and consulting homoeopathic physician: Dr. M. L. Dhawale, M.D., Director of the Institute of Clinical Research, Bombay.

REFERENCES

Two excellent sources on miasms are:

The Principles & Art of Cure by Homoeopathy by Dr. H. A. Roberts.

The following papers by Dr. K. N. Kasad in the *Symposium Volume on Hahnemannian Totality*: Paper C.1 Disease (Natural and Drug), A Phenomenological Approach. Paper D.2 Repertorial Concept and Technique: The Bridge that Gulfs the Gap Between the Natural Disease and the Drug Disease. Paper G.2 Homoeopathic Prescribing: Acute—Chronic; The Unbalanced Image: Standardized Prescribing.

(Tables on pages 316-320)

TABLE 1
CLINICAL CLASSIFICATION

Item	Tuberculoid (T)	Lepromatous (L)	Neural (N)	Indeterminate (I)
Criteria	Macular, anaesthetic patches Pigmentation ± Local Nerve ± Local Lymph Nodes ± Peripheral Nerves Thickening Sensory loss Heat & Cold ↓ Burnings Lepromin Test ±	Skin—diffuse infiltration; flat or thick patches Nodules—Ulcers Extension—Skin, Nerves, Lymph Nodes A.F.B. + *or* Skin Biopsy: Foam Cells +	Nerve involvement + Neuritis Motor loss Nerve thickening Skin lesions o	Lesions: Ill-defined Pigmentation ↓ in Patches Macules—Erythematous without definite sensory loss Mixed variety
Progress	Slow	Fast	Slowest	Slow
Improvement	Patch: Thickness Sensations Colour Nerve: thickening	Nodules: Colour, size Reactions Hypopigmentation Anaesthetic patches	Pain, numbness Paraesthesias Nerve thickness	Same as (T)
Therapeutic Presentation Sensitivity	Syphilitic (S) Low	Sector Totality + Constitutional + High	Tubercular (T) Least	(S) or (T) Low

TABLE 2

Total number	137†
No. presented for leprosy (Primary Complaint)	97
Drop outs	46
No. Under observation	91

Period of observation	5 yrs.	4 yrs.	3 yrs.	2 yrs.	1 yr.	6 months to 1 yr.	Less than 6 months	Total
Number of cases	26	12	10	26	20	16	27	137
Result clinical cure:								
Good*	22	10	7	18	16	10	20	103
Fair**	4	2	3	4	2	4	1	20
Nil	—	—	—	4	2	2	6	14
Relapses	—	—	—	—	—	—	—	0

*Sensations, discoloration, lesions—disappeared or disappearing—good result on all counts.
**Partial—sensations improving but discoloration or lesions same or slightly less.
†This does not include 83 patients who called in the past 2½ months. Many show good improvement.
Total Number = 220.

TABLE 3
PERIOD OF OBSERVATION

Categories	5 yrs.	4 yrs.	3 yrs.	2 yrs.	1 yr.	6 months to 1 yr.	Less than 6 months	% Improved
Tuberculoid	20 (20)	10 (10)	8 (8)	18 (15)	10 (9)	10 (9)	14 (12)	92.2 %
Indeterminate	4 (4)	1 (1)	2 (2)	4 (3)	6 (5)	4 (3)	6 (4)	81.4 %
Neural	2 (2)	1 (1)	– (–)	1 (1)	2 (1)	1 (1)	3 (2)	80 %
Lepromatous	– (–)	– (–)	– (–)	1 (1)	2 (1)	1 (1)	4 (3)	75 %

NOTE: 1. Basic types: Tuberculoid and typical lepromatous. All other forms will be considered as indeterminate or Dimorphous.
2. Figures in brackets indicate cases which improved.

TABLE 4
DROP OUTS
PERIOD OF OBSERVATION

Improvement	5 yrs.	4 yrs.	3 yrs.	2 yrs.	1 yr.	6 months	Less than 6 months	Total
Good				8	5	3	1	17
Fair				5	4	4	7	20
Nil				3	2	2	2	9
							TOTAL	46

TABLE 5
PRESCRIBING INDICATIONS AS OBSERVED IN THE SERIES

Merc. iod. flav.	Hepar sulph.	Arsenic alb.	Hura bras.	Calotropis gig.	Merc. iod. ruber	Calc. fluor.
Dominant syphilitic miasm Hot patient Throat complaints Post ½ tongue coated. Or, no contraindications, i.e. not a silica patient	Chilly patient Syphilitic base Suppurative tendency	Chilly patient Pain burning, local heat	Leprosy Burning lt. foot, rt. foot cold Throat	Resistance to Hep. sulph. & Merc. iod. flav.	Glands Throat: lt.—rt.	Sycotic dominant Joint pains Backache Varicosity
Constitutional Remedy	This is selected on classical lines, adhering to the totality that forms the portrait of disease					
	Tuberculinum			Bacillinum		
	Tubercular base Hot patient *Nerves*			Tubercular base Chilly patient Respiratory Concomitant		

TABLE 6

Acute	Merc. iod. flav.	Hepar sulph.	Arsenic alb. iod.	Hura. bras.	Calo-tropis gig.	Merc. iod. ruber.	Calc. fluor.	
	45	37	8	14	4	3	40	
Constitutional	Calc. iod.	Nat. mur.	Calc. fluor.	Silicea	Antim. crud.	Kali bich.	Mag. sulph.	Ferrum sulph.
	8	18	7	12	2	14	5	1
Intercurrent	Tuberculinum Bacillinum							
	137							

Note: A single case at times demands more than one acute remedy at different times. The total number thus exceeds the total number under observation.

TABLE 7

Clinical improvement	Period of observation						
	5 yrs.	4 yrs.	3 yrs.	2 yrs.	1 yr.	6 months to 1 yr.	less than 6 months
Lesions:							
Colour							
Size							
Induration	22	10	7	16	14	2	5
Sensations	20	8	9	20	16	12	17
Nerve thickening	2	1	—	1	1	1	—
General health	18	7	6	8	9	—	—
Associated diseases							
Asthma							
Warts/corn							
Colitis	10	2	2	2	3	2	

NOTE: Overlap of criteria explains the discrepancy in the totals. —*Journal of the American Institute of Homoeopathy*, June 1984