A HOMOEOPATH'S TOTALISTIC VIEWPOINT —SOME OBSERVATIONS ON DIABETES MELLITUS*

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At an academic level, full consideration of all aspects cannot justify the assertion that by merely maintaining the blood glucose at normal level, everything that is necessary (for the restoration of health), has been achieved. Rather, the present therapeutic knowledge of the modern science has been able to provide with means only to deal with this aspect of controlling blood sugar, *and nothing more.*

It is observed that diabetic patients inherit a constitution where there is a tendency for certain peculiar pathological changes in the blood vessels. The changes in the large vessels—macroangio pathology, as well as changes in the capillaries—microangio pathology are recognized. These same people tend to develop a fault mainly in the beta cells of the pancreas, resulting in insufficient production of insulin. Without insulin, carbohydrate utilisation is wanting, and gradually a total failure occurs when fat (which is burnt in the fire of the carbohydrates) also remains unutilized. This results into a toxic state, due to these unutilized substances and leads to coma, and death thereafter. This coma which was responsible for 64% of the deaths of diabetic persons (50 years ago) has been prevented by the use of insulin. Many diabetics now live longer.

However, it is doubtful whether the vascular changes have decreased as a result of the use of insulin. Not only so, on the contrary, it is feared that they may appear earlier, and faster, with the use of insulin. Some oral antidiabetic drugs have been suspected to be enhancing cardiac troubles.

Diabetic angiopathies and related neuropathy are the main features to be dealt with during the clinical treatment of diabetes. It is not certain whether the vascular factor is a primary inherited disorder and related changes (mainly in the pancreas) are the secondary effects, which breed the failure of the carbohydrate metabolism, i.e. insulin deficiency. Or whether, the carbohydrate consumption deficiency is primary, and vascular changes are secondary to it. It is also felt that, may be, both are separately carried. Lately the emphasis on hereditary factor seems to have been diluted, particularly in the cases of juvenile diabetes. A very common innocuous virus (Coxsackie B4) has been suspected to be damaging the pancreas in the youngsters.

It is also interesting to note that insulin, which in small quantities is able

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to prevent and certainly cure hyperglycaemic coma, in larger doses produces hypoglycaemic coma. The pictures of both coma are so very similar to each other that one kind of coma is likely to be mistakenly treated for the other. Many such fatal errors have, indeed, been recorded. It is necessary to explore whether our law of cure—similia similibus curentur—is in some way involved.

Under present allopathic treatment, it is this area of preventing death with insulin, that the treatment of diabetes is most effective. It is this singular success in postponing coma (and thereby death) that the use of insulin has been most spectacularly successful. However, probably a price has to be paid in terms of accelerating the disorders with macroangiopathy and microangiopathy.

People, suffering from infection fostered, and infection fostering, diabetes mellitus, have poor resistance, mainly to streptococcus infections, and ultimately to tuberculosis (our latent psora). It should be worthwhile inquiring whether it is this low resistance that is inherited, and if other complications are based on it.

It is held that some of the untoward effects of insulin may be due to the unavoidable impurities in the available preparations of insulin. Apart from impurities, carbolic acid, in small amounts, is intentionally added to prevent putrefaction. We know Carbolic acid as a drug capable of inducing painless gangrene.

The possibility that a virus can affect the pancreas was long realised by our science. Parotidinum, a virus nosode, had cured a case of diabetes. Dr. Tyler, while taking notice of the same, points out to the possibility of such other nosodes in the following manner:

"Dr. X, impressed by his results with the nosodes of previous acute diseases in difficult chronic conditions, tells of two cases of diabetes which had not been progressing favourably in spite of careful prescribing.

"No. 1 suffered from neuritis and rheumatism of thighs, of several years' duration. After 3-6 hourly doses of Parotidinum 30, the rheumatism vanished and has not returned during the last 5 months. The blood sugar has not been tested owing to war conditions.

No. 2 had a severe aggravation, and then clinical improvement. These cases are merely suggestive."

"Let us carry the matter further, on the same lines. If pancreatitis may start in infectious diseases, as enteric, pyaemia, septicaemia, and may entail diabetes, goitre, etc., we have also to consider."

In order to provide a direction for such research, I place before you some concepts which should enable us to take a totalistic view of diabetes and give proper place to the blood glucose level, alongwith some typical cases from my clinical experience, which deal with various aspects of diabetes.

MATURITY ONSET DIABETES—AN ADAPTATION SYNDROME

When a person who is physically active and has good digestion, joins

business as an executive, in contrast to his decreasing physical activity, his intake of food continues to remain the same, or even increases. This leads to obesity resulting from deposits of the extra calories. However, a stage of saturation comes for the holding powers of the entire organism and an opening for throwing off the excess becomes a necessity. It has to be done in one or the other way. One of the several ways, by which the organism manages this physiological situation, is diabetes. During the initial state of rising level of blood glucose which is recognised as a chemical diabetic state, increasing obesity is observed. The same excess on reaching another limit then finds a vent and sugar starts passing in urine, an overt stage of diabetes. So the maturity onset diabetes is in a way 'an adaptation syndrome' to the excess of calorie absorption over the years. Naturally the 'whole situation' takes a particular shape depending upon the hereditary characteristics, the beta cells of the pancreas being in some way vulnerable contribute to the outline of the emerging picture.

PHYSICAL ACTIVITY AND INSULIN REQUIREMENT

A certain level of blood glucose is a single aspect of a total 'homoeostasis'. Homoeostasis involves a multiple of factors each of them involves autonomous counter balancing processes. It is well-known that glucose level is affected over and above that of pancreas by the secretions from pituitary, thyroid, adrenal glands and the functioning of liver; not only that, it is also affected by the functions of muscles. Increased physical activity needs increased utilisation of glucose; however, increased physical activity reduces the need of insulin. The questions of biological processes are not mathematical like that of physics and chemistry.

Restricted diet and increase in physical activity is the key to the true control of diabetes. Use of any drug for control of blood sugar should not mislead and divert the attention of the patient from this fundamental issue.

JUVENILE DIABETES: DEPRESSION OF BETA CELL FUNCTION

With this vulnerability of the beta cells of the pancreas, inherited from both the parents, one becomes a candidate for juvenile diabetes. Juvenile diabetes seems to be truly based on depressed function of the beta cells of the pancreas. This may be due to any of the acute miasmatic influences taking root on the susceptibilities nourished by the chronic miasm or certain deep acting drugs.

KETONE IN URINE AND FASTING

Ketosis may not simply be an extension of carbohydrate failure. During fasting, some persons pass ketone sooner than others without raised glucose levels in blood or glucose in the urine. Ketosis proneness is the major distinguishing criteria of juvenile and maturity onset diabetes. The key factor in the production of both the states may be partly different. The presence of both

the tendencies should be responsible for a very complicated situation of ketosis.

CLINICAL EXPERIENCES

It is generally held, very strongly, that suppurations in a diabetic person will not show a tendency to heal as long as abnormality in the carbohydrate metabolism continues. Therefore, use of insulin, or any anti-diabetic drug, is considered of paramount importance even by some homoeopaths. My experiences over the past many years lead me to the conclusion that this is not so.

I have seen suppurative conditions cured, although the urine examinations showed persistent presence of glucose. I had not been, therefore, quite rigid in insisting upon the administration of insulin. If the patient has not been on insulin, I do not put him on it, regardless of the level of glucose in blood or urine. If he was already on insulin, reducing the dose of insulin, so as to produce a slight state of deficiency (which should prove stimulating to the system) was employed by me in some cases.

My latest experiences show that insulin, probably, stands in the way of proper healing, and therefore, I am inclined to discontinue its use totally. This discontinuation should be effected in a gradual manner. For diabetic ketosis, result of extreme overt diabetes, insulin injected to control the blood sugar and rectify the failing metabolism, is the only way so far known. Thus, it is neeessary to remain on watch and ensure absence of ketone in the urine, during such treatment. I have known sueh cases becoming very serious in the hands of homoeopathic physicians. Resorting to this palliative restoration of extremely overt diabetes with ketosis should be done without hesitation, due to absence of better knowledge at present.

Case No. 1: A diabetic patient suffered from perianal abscess, with extreme sensitivity to pain. Pain was temporarily ameliorated by application of local heat. Guided by this modality the selection of Hepar sulphur was made. This promptly cured the condition.

On another occasion in the same patient, a painful palatal cyst was caused by a septic tooth. The pain was ameliorated by local application of cold as well as heat. Mereurius iodatus flavus CM relieved the pain in a short time, and started a fever with rigor. However, the patient became well the next morning.

The same remedy cured a whitlow of the right middle finger that had destroyed a part of the nail. Within a period of 3 months, the nail was restored so well that no defect could be detected even during the most careful examination. The local modalities, and the right side, guided me to this prescription.

It is interesting to note that during all these episodes, the patient continued to pass glucose in his urine (yellow precipitate with Benedict's solution). No insulin, or any other medicine, was given.

Case No. 2: A 72-year-old man was having a carbuncle on the hip. The indurated area was about 3″ in extent, all around. He was previously treated

with antibiotics, which had adverse effects on the renal function. He refused to take injections. The urine showed presence of glucose. He was grossly overweight, with a dry and rough skin, which was itching badly. He was put on Graphites 1M, 4 to 6 times a day. About 2 ozs. of pus could be expressed every day on pressing the surronnding area. Later on, he developed the following symptoms: (i) waking up frequently at night from sleep, (ii) scratching followed by burning.

Sulphur 1M was administered in repeated doses on the basis of these indications, considering the previous treatment with antibiotics. He made a good recovery and the subsequent three years' follow-up did not show any recurrence of suppuration.

Case No. 3: A woman, aged 32 years, sustained burns on both legs. This was a result of application of hot water bottle during the state of collapse, following a delivery of twins. The denuded surface on each leg was approximately 6 inches long and about 1½" wide. The area dried up within a week, under Ars. alb. 1M, given in repeated doses. The condition, however, flared up with a rise of temperature after the patient had a hearty meal of *puranpoli* (an extremely high sugar content delicacy of Gujarati people). Phos. ac. and Calc. gave no relief. Silicea was finally selected on the basis of (i) fever with chill followed by perspiration (temp. rising upto 102°F-104°F), (ii) dirty white pus, resembling muddy milk, (iii) pain, Amel. by application of local heat, and (iv) offensive perspiration, which cured the condition.

All through the sickness, the urine showed the presence of glucose. Six months later, urine examination did not show any glucose. A follow up, ten years after, had indicated absence of diabetes.

Case No. 4: Mr. B. V. P., aged 50, an uncontrolled diabetic for several years, came down with an attack of postero-lateral myocardial infaretion. He was in a state of collapse, and had a slow pulse. He recovered well on Ant. tart. 1M in every four hours' given for two months. He was passing 2% to 4% sugar in the morning urine. At the end of two months, he came out with a small white pustule on his calf with a large dark pink areola. Ant. tart. was continued because his heart condition was improving. The pustule with pink areola enlarged considerably and evolved into a carbuncle. Ant. tart. was continued (interpretation: calf muscle in the place of the heart muscle). After three days, when this opened, there was an initial discharge of considerable quantity of pus following 'brick red pus' and ultimately copious discharge of bright red blood occurred. The allopathic consultants opined that unless immediate antibiotic and insulin treatment was applied, a gangrenous condition would be the definite outcome.

As the patient had full faith in Homoeopathy he continued my treatment. At this stage he was put on Phos. 1M, every four hours. The discharge of blood gradually reduced and the wound healed in about 3 weeks. He was kept on Phos. 1M B.D. and thereafter it was continued in 10M, 50M & CM

potencies for about two years. His diabetes, however, continued in almost the same severity.

Case No. 5: This male diabetic patient, 58 years age, had the suppuration on legs. He was an addicted smoker from his very young days. The surgeons had advised an amputation, the actual site of amputation to be determined at the time of the operation. The choice of site was between above knee, or below knee. The patient, obviously wasn't keen about either! The treatment was commenced with Arsenic alb. 1000, in repeated doses. After two weeks, Acid nitric 200 in repeated doses was given on account of the strong smell of urine. A few days later, the patient developed the symptom, perspiration on the side not lain on, and Thuja 1M was given for 2 days, in repeated doses. At this stage, the ulcer started bleeding copious, non-coagulable red blood. This occurred after the patient ate several green chillies (he had a great craving for it). The purulent discharge thoroughly mixed with red blood gave a brick red appearance. Taking into account these symptoms, Phosphorus 1M was started and continued for 2½ months, till the healing was complete.

During this period the patient was showing febrile reaction on and off, and with every such episode of fever, he showed further improvement. A sterile gauze was used as a dressing, throughout. No other local application was used. The opening continued to discharge masses of necrotic muscles throughout this period till the process of healing was completed. These ulcers and lesions were totally painless.

Case No. 6: A case of gangrene failed to respond to proper homoeopathic prescribing (in contrast to case No. 5). One fails to appreciate this failure and is inclined to take two probable causes which prevented the cure: (1) sympathectomy operation was performed on her earlier, (2) insulin was permitted to maintain control of the blood sugar.

Case No. 7: A chronically ulcerated bunion near the great toe was treated over a period of six months by me, where properly indicated remedies failed to bring about a permanent healing of the ulcer. Each time there was a recurrence of the ulceration after some signs of healing in response to the remedy given. The same person had earlier taken treatment from other homoeopathic physicians with similar experiences. During homoeopathic treatment, he was permitted to take anti-diabetic treatment as well.

Case No. 8: I have been suffering from diabetes since 1965 which was detected during a life insurance medical check-up—urine sugar giving a yellow precipitate with Benedict's solution. I had to resort to insulin in 1978, when I had started passing Ketone + + + over and above glucose + + + This crisis had occurred when there were long hours of fasting each day.

I suffered from ulceration of a bunion in May 1980 which was caused after a shoe bite. The ulcer developed into a deep crack and was oozing black offensive, sero-pus. This happened during the period when I was controlling my blood sugar with a diet, accompanied by regular injections of insulin. The

ulcer became increasingly ugly, black, and was threatening to become a gangrene.

Several good prescriptions, after eliciting a healing response, failed to produce a total healing. On the contrary, the ulcer kept on recurring and enlarging. For a period of eight months, this deterioration continued.

At this stage, I decided to discontinue insulin and resort to a stricter diet control. In approximately eight weeks' time, the ulcer healed completely. Though the skin in this area had remained slightly thickened, there was no recurrence of the ulcer for last one year. Sugar in the urine had gradually gone up to a dark brown colour on diastic showing over 2%. My fasting blood sugar estimate: 311 mg/c.c. Such cases have led me to conclude that insulin intake may be a serious impediment to the action of proper homoeopathic medicine at least in some cases. This is more so when suppurative and gangrenous conditions are threatening.

Case No. 9: In this note Shri Rawal, B.Sc. (Hons.), B.S.Ch.E., M.S.Ch.E., Michigan, U.S.A., aged 60 years (birth date: 3.4.1922); a consultant in pharmaceutical chemicals tells his own story.

The first detection of diabetes in my case was in August 1955. During the onset period one tablet of 500 mg of tolbutamide per day was prescribed. The dose was gradually increased and by the year 1965 I was taking three tablets of tolbutamide. Blood sugar after one hour of intake of glucose used to go as high as 200-250 mg. By 1970 the drug dose was four tablets of 500 mg tolbutamide and three tablets of phenformin; with this blood sugar after one hour of glucose intake used to be at the level of 150-170 mg. This dosage was continued till August 1972.

During 1962-72, off and on high blood pressure and ischemic pain along with high cholesterol were observed. Highest cholesterol at one time was 375 mg. For this and high blood pressure treatment from late Dr. Jal Vakil was taken. Blood pressure would sometime shoot up to 180-190/115.

Along with these troubles I used to have lumbago like pain in the back. This pain used to come at least twice a year. At one time it was so severe that hydrocortisone was injected in the lower region of spine. With this there developed a cervical spondylosis for which traction and use of belts on the neck were needed.

From August 1972 homoeopathic treatment was started; during the treatment every alternate month post lunch blood sugar was done. After one year, i.e. by August 1973 the antidiabetic drugs were gradually reduced to two tablets of 500 mg tolbutamide per day. By April 1974 the allopathic drug was completely stopped.

During this period of the treatment in the initial stage itself there was marked improvement in spondylosis and the use of the belt was abandoned. When the allopathic treatment was completely stopped the blood sugar level used to be fasting 95-110 mg, post lunch 120-140 mg; this level was maintained with normal diet with occasional intake of little bit of sweets. For

five years the sugar level was maintained at the above mentioned level. During this period once in a year lumbago like pain used to occur but for this, one or two days of homoeopathic treatment sufficed to cure the same. This pain did not appear at all during the last two years.

Yearly cardiograms showed continuous improvement over the previous ones. Ischemic pain was gone and cholesterol level remained under 250 mg/c.c. Late 1979, the post lunch sugar was found to be at the level of 180 mg. This level again came down to normal at 130-140 mg within six months. During this period also no other drug was taken.

Before starting the homoeopathic treatment I used to get tired easily and stamina to work used to be at very low level. Because of this treatment my tiredness is not there. I am now 10 years older but I am able to work 8-12 hrs. a day and even when my work includes occasional travelling, I work with greater ease and comfort in spite of suffering from asthma.

During this treatment, asthma appeared. I did not feel it at that time. From the beginning it was observed that my breathing was not normal. Treatment for asthma is being continued for the last three years. The heavy attacks are not there but morning and evening breathlessness comes occasionally. The treatment is continued for the same.

THERAPEUTIC HINTS ABOUT THE TREATMENT OF SUPPURATION

There are several drugs recorded in repertory under abscesses, unhealthy skin and other places. However, we have quite a few drugs with well defined indications that enable us to control the suppurative processes and promote healing. Diabetes or no diabetes, the choice of the remedy should, as usual, be dictated by the general symptoms, especially the mental state, if prominent; the site of suppuration (side), direction of spread, the character of the pus, and the local sensations along with concomitant symptoms and their modalities.

The modalities of heat and cold are of prime importance in determining the remedy. Effects of heat and cold stated by the patient, based on his off-hand impressions, may be erroneous. Therefore, it is important to determine them by actual testing with the application of heat as well as cold to the painful part and be absolutely certain about them. I shall narrate a case to indicate the significance of this.

Mr. Das, a middle aged man, suffered from right sided hydrothorax of undetermined aetiology. He was operated upon his thorax, with removal of three ribs. Subseqnently, chest fluid was tapped, three times, before he came under my treatment. I do not recollect the remedies administered in the beginning to which he responded partially. There was some slowing down in the collection of fluid; however, the same continued to increase causing a greater sense of heaviness on that side. On screening his chest, it became known that the entire right side was completely filled up with fluid. This called for an urgent tapping, which I was supposed to avoid. On returning

from the radiologist, I once again sat down with the patient to elicit if at all there were any other new symptoms which were annoying him, apart from the heaviness of the chest. He told me that for last few days he had been very much troubled by pain in one tooth, and that he did not mention about it because he did not want to burden me with many problems. He was given two glasses of water, one considerably warm and the other ice cold, to test the effect on the paining tooth, by holding mouthfuls of each in turn. He found that both aggravated his pain. On this I prescribed Merc. i.f. 1M, every two hours, while awake. He felt slight relief in the sense of heaviness during the first 24 hours. When he was x-rayed after five days the fluid had disappeared.

The second important point I would like to stress is that the suppurative drugs may not often act well unless we first treat the immediate causative factor, e.g. injury with appropriate drugs like Arnica (soft tissue injury), Hypericum (nerve injury). Symphytum (bone injury) and Ruta (sprains of ligaments, periosteal and scalp injury). At times any one of these remedies, alone, may prove sufficient to check suppuration and complete the healing process.

The third significant point is that the prescriber should take into account the miasmatic background, if any and prescribe the appropriate remedy or nosode, and not rely merely on the anti-suppurative remedy. These, however, may be indicated later on during the treatment in order to complete the cure. They do not act well if prescribed right at the beginning, without prior preparation.

I have seen that Arsenic alb. although indicated is often quite insufficient to cure on its own. Its action often ceases and even the higher potencies show no better response. Finally, one is required to turn to some other more deep acting remedy. Valuable time may be saved by a timely change. I have since stopped relying on it except as an initial remedy to be followed soon by one of the more appropriate deep acting remedies.

Range of Acid fluor. in suppuration is very deep. With amelioration from cold accompanied by amelioration from short sleep, it manages to cover the case fully. It appears to take over the work of final healing process as a complementary after most remedies. It rarely needs another remedy to complete its work after it has come in in the right manner. Even the work left over by Secale cor. in gangrene is completed by its action and it is one of the finest remedies of gangrenous states on its own.

LEADERS IN THE TREATMENT OF SUPPURATION

Amelioration from warmth with aggravation from cold, brings in mainly Hepar sulph., Silicea and Ars. alb. for consideration. Hepar sulph. has splinter-like pains, extreme hypersensitiveness to touch and draft, the immediate relief from local heat is so much that it becomes possible to touch and even press the painful part after application of heat; the pus is sanguineous,

the desire for pungent food and sour articles, which aggravates, are its additional features. Ars. alb. has burning pain ameliorated by heat; prostration, thirst, and anxiety with its extreme restlessness; Ars. alb. shares its restlessness with Tarentula. (In Tarentula there is amelioration from music.) Silicea has amelioration from local heat, and has the offensive sweats in cold palms and soles. The pus has a peculiar dirty-muddy, white, appearance.

Amelioration from local cold should draw attention mainly, to the remedies; Fluoric acid, Lachesis, Secale cor., Calc. sulph., Picric acid and Kali iodide. Fluoric acid is ameliorated by short sleep; whereas Lachesis and Picric acid are aggravated by sleep. Picric acid has considerable thirst for cold water, the neurasthenic state, and aversion to mental work with desire to sit still and listless. We have observed that joyous and happy-go-lucky type Fluoric acid and jealous Lachesis bear inimical relationship to each other. It requires Pulsatilla, as a bridge between the two. Lachesis, as well as Pulsatilla, are jealous patients. Kali iodide patient has strong desire for open air and motion (walking) and has a very harsh temper like Hepar sulph.

I would like to point out my observation that many of the patients requiring Phosphorus often show an inordinate craving for chillies and pungent things; as regards cold drinks, many of them have learnt through experience to avoid these because cold drinks cause trouble to them. Hence craving for cold water of a Phosphorus patient is often not easily seen. Many phosphorus patients have been seen by me, who perspire on scalp while eating partieularly pungent food or warm food. Perspiration on side not lain on has also been observed in a few of them. Brick red colour of the pus when pus appears to be thoroughly mixed with blood is characteristic of Phosphorus.

Acid fluor. often follows as a complementary medicine, especially when the characteristic amelioration from cold is present.

One sees in the chapter of Generalities in Kent's *Repertory* that there are many remedies cited for aggravation from cold as well as heat. In this list also appear Acid fluor. as well as Silicca. However, in our experience it is seen that local modality of Acid fluor. in suppurating condition is aggravated by heat and ameliorated by cold and the reverse of the same is Silicea.

The placing of various remedies in this particular rubric shows that there are considerable symptoms which have shown aggravation from cold whereas more or less symptoms have also shown aggravation from heat. Fluoric acid is a remedy of overheated states, even ravages made by long hectic fevers of tuberculosis. Silicea is positively a leader for complaints on being chilled when overheated.

For amelioration from cold as well as from warmth, and aggravation from extremes of cold as well warmth, Mercury is most important. In Mercury, the affected part burns on touch, like Cantharis. Mercury also has a shivering sensation in an abscess. I have commonly used the iodides: Merc.

i.f. for the right sided or for right to left, whereas Merc. i.r. for left sided or for left to right aggravation.

These comments on leading suppurative remedies are based on my partial notes made more than twelve years ago. These partial notes were compiled at that time, when I first thought of writing about diabetes and suppurations. Not only it is very far from an exhaustive therapeutics of the topic, even the indications of the remedies that have been described are very incomplete and cursory.

However, I feel I should share this information with my colleagues because:

(a) A full appreciation of a drug as a remedy as to its sphere of action and clinical utility cannot be derived without repeated clinical trials based on certain easily ascertainable indications. The experiences of old masters have repeatedly shown that wide efficacy and utility of approximately one hundred polychrest drugs. These same drugs are widely applied in the practice of Homoeopathy very successfully.

(b) At the same time, during scientific practice, one cannot overlook the immense value of a rare medicine which might be needed in a case before us. There are more than 50 remedies listed under the rubric Abscess, as well as Unhealthy skin, in Kent's *Repertory*. At various localities, again there may be different remedies mentioned. At the same time, one should be well aware that any of the approximately 650 remedies (or 1540, if we consider latest additions) may be called for in any given case. However, a kind of therapeutics of well defined, properly evaluated remedies has to evolve gradually. Such notes will contribute to the development of such therapeutics.