BRONCHIAL ASTHMA

(An Integrated Approach)

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PREFACE

It was the last Sunday of June, 1987, with my students and colleagues I was enjoying my usual participation in the monthly symposium of our Association of Hahnemannian Homoeopathy. At that time my sincere student Dr. Dilip Bhattacharya posed a proposition very emotionally. He referred to page no 34 of Homoeo Sathi 1st edition (my Bengali book on Homoeopathic Philosophy) where I expressed the necessity of writing a homoeopathically oriented Practice of Medicine. He requested me earnestly to guide them in this respect and the gathering echoed in the same breath. So a sample topic was chosen and that was Bronchial Asthma. The present booklet is the outline of that lecture which I delivered to them on that occasion.

Relevently enough I like to emphasise here the importance of integrated approach correlating the pre-clinical and para clinical aspects of medicine with our homoeopathic subject. All the recent medical advances and also the fundamental homoeopathic principles need to be harmoniously blended. If this is not done, glaring deficiencies and broad gaps of knowledge would exist and our approach in treating different diseases would be half-hearted and confusing. We may fail to understand the miasmatic background of a case as also its curability. As a result a proper plan of treatment cannot be made and the whole course of treatment would turn to be irregular, whimsical, chaotic and fruitless leading in some cases to

even pseudo and unhomoeopathic practice. If a proper integration be possible, our approach in treating various diseases may be standardised, though prescriptions may vary in some cases due to variations in interpretation, observation, evaluation and synthesis of the case. With this aim in view I am presenting herewith the model of Bronchial asthma as an example. I think we should try to integrate our knowledge in this way in all medical, medico-surgical and surgical diseases.

Intentionally I have not named here any homoeopathic medicine whatsoever because a true totalistic and integrated approach and not the superficial approach of therapeutics was my concern. A few illustrative cases are also presented herewith.

Before I conclude, I earnestly request my learned readers to take a fruitful attempt, jointly or individually, to write a new text book of Medicine incorporating all modern concepts and recent developments in medicine along with the basic principles and concepts of Homoeopathy.

S. P. Dey.

BRONCHIAL ASTHMA

(An Integrated Approach)

Definition :

It is a nosological manifestation of chronic miasmatic state characterised clinically by paroxysmal attacks of *expiratory dyspnoea*, cough, wheezing etc. and pathologically by *increased responsiveness of the tracheo-bronchial tree* to multiple stimuli resulting in widespread narrowing of the air passages. It is an episodic disease with spontaneous remissions and relapses.

Etiology :

1. *Fundamental Causes* :

(*a*) *Sycosis* : History of bronchial asthma in the family (paternal or maternal side) without any history or manifestation of allergy is suggestive of hereditary Sycosis as the basic cause. The bronchial tree is set into spasm or narrowing from slightest cold without any apparent cause. It appears as if there is a lack of co-ordination in the system as manifested in the action of tracheobronchial tree.

(*b*) *Syco-Syphilis* : History of syphilitic miasmatic state in the family with symptoms of latent syphilis and developed sycosis in the patient is suggestive of Syco-Syphilis.

(*c*) *Psora* : Hypersensitivity of the tracheo-bronchial tree to any allergen indicates Psora as the basic cause. This is often associated with a family or

personal history of allergic diseases e.g. Urticaria, Rhinitis, allergic eczema etc. This may further be confirmed by positive skin test and increased level of IgE in the serum. Chronic bronchitis resulting from simple hypersensitivity to cold also belongs to this group.

(*d*) *Mixed miasmatic* : In some cases (though rare), a combination of all the above mentioned factors may be present making the state much more complicated and difficult to diagnose as also to treat.

2. *Predisposing factors* :

(*a*) *Age* : The disease may occur at any age but commonly it starts in early life. First attack of bronchial asthma after 40 years of age is very rare.

(*b*) *Sex* : Both sexes are equally affected.

(*c*) *Season* : Psoric asthma generally aggravates in winter ; Sycosis in rainy season and Syphilis in summer. But it should clearly be understood that exceptions and individual variations are always there.

(*d*) *Repeated vaccination* : This may induce a state of Vaccinosis which is similar to Hahnemann's Sycosis (Burnett). This state predisposes to bronchial asthma and requires antisycotic medicines for its cure.

3. *Exciting factors* :

(*a*) *Various antigens* : Antigens may provoke bronchial asthma in susceptible individuals. This is dependent upon an IgE response controlled by 'T' and 'B' lymphocytes. Some of the antigens are :

(i) Pollen grains. (ii) Charcol dust. (ii) Plant debris. (iv) Chemicals e.g. Arsenic, coal tar etc. (v) Drugs e.g. aspirin, fenoprofen, acetyl salisylic acid etc. (vi) Food allergens e.g. crabs, prawn, eggs etc.

(*b*) *Environmental factors* : Atmospheric conditions associated with stagnant air masses may induce an attack of bronchial asthma.

(*c*) *Occupational factors* : Some of the occupations are closely related to Bronchial asthma e.g. meat wrapper's asthma, wood worker's asthma. baker's asthma etc.

(*d*) Respiratory tract infection may precipitate an attack of bronchial asthma.

(*e*) Physical exercise may provoke or aggravate.

(*f*) Emotional stress may precipitate.

4. *Maintaining causes* :

(*a*) Continued living on damp ground or marshy areas.

(*b*) Persistent exposure to allergens before the patient is fully cured.

(*c*) Occupation responsible for exciting the condition being maintained before the miasmatic dyscrasia is cured.

(*d*) Persistent mental worries, anxieties and tension.

Pathology :

1. Mucosal oedema. 2. Hypertrophy of the bronchial smooth muscles. 3. Marked thickening of the basement membrane. 4. Loss of the surface epithelium. 5. Eosinophilic infiltrates in the bronchial wall.

Patho-physiology :

The basic factor of bronchial asthma is a reduction in diameter of airway brought about by the following :

(*a*) *Oedema* of the bronchial wall.

(*b*) Thick *tenacious secretion.*

(*c*) *Hypertrophy* of the bronchial muscles.

(*d*) *Contraction of the smooth muscles* of bronchial tubes secondary to hereditary inco-ordination (sycosis) or malformations and inco-ordination both at the same time (syco-syphilis) or allergic reaction between allergens and mast cells resulting in increased IgE in serum (Psora). In allergic cases, due to interaction of allergen and mast cells, a substance like histamine or Prostaglandin D_2 or Leucotrine C, D or E, is liberated which reflexly stimulates the vaso-constrictor fibres of Vagus resulting in bronchial spasm.

Result of the pathological process and changes :

1. Decreased expiratory volumes. 2. Increased work of breathing. 3. Hyperinflation of lungs and thorax. 4. Changes in elastic recoil of the chest wall. 5. Use of accessory muscles of respiration. 6. Pulmonary hypertension. 7. Right ventricular hypertrophy. 8. Gradual balooning of alveoli and finally emphysema.

Diagnosis : (See any text book of Medicine).

Expiratory dyspnoea, cough and wheezing are the diagnostic triad. Remissions and relapses are the basic characteristics of the disease unless complicated with emphysema when the dyspnoea may be continuous. Positive skin test, X-ray of the chest and

increased Eosinophil count may help in establishing the diagnosis.

Symptomatic diagnosis of the probable miasmatic state :

(i) Typical midnight aggravation is suggestive of syphilitic or syco-syphilitic miasmatic state.

(ii) Early morning aggravation is suggestive of sycosis.

(iii) Evening aggravation is suggestive of Psora.

(iv) First dyspnoea, then cough followed by expectoration is suggestive of sycosis.

(v) First cough. then dyspnoea followed by expectoration, is suggestive of Psora.

(vi) Dyspnoea and cough at the same time, is suggestive of Syco-Psora.

(vii) Sneezing, coryza and cough lasting for 1-2 days followed by dyspnoea is suggestive of allergic origin (Psora).

(viii) Dyspnoea associated with sweating which ameliorates but avoids open air—suggest Psora.

(ix) Sweating aggravates and desires cold both externally and internally suggest syphilis.

(x) Aggravation in damp, rainy weather suggests Sycosis.

(xi) Amelioration by moving slowly is suggestive of Sycosis.

(xii) Amelioration by yellowish or greenish-yellow expectoration is suggestive of sycosis.

(xiii) Profuse, frothy expectoration which may or may not ameliorate, suggests Psora.

(xiv) Dyspnoea ameliorates lying on back, suggests Psora.

(xv) Dyspnoea ameliorates lying on chest or abdomen suggests sycosis.

Complications : (See any text book of Medicine)

Some of the complications of prognostic significance are :

(a) Emphysema. (b) Pneumothorax. (c) Chronic cor-pulmonale. (d) Congestive right heart failure (e) Intercurrent infection. (f) Status asthmaticus.

Status asthmaticus : Successive paroxysms of dyspnoea overlap one another without any free interval. This is a grave condition and may end fatally if not controlled in time. The patient should immediately be admitted in a Hospital or Nursing home for facing all sorts of emergencies including artificial respiration.

Differential diagnosis : (See any text book of Medicine).

Course and prognosis :

The disease is slowly progressive unless checked and treated with anti-miasmatic medicines. Palliation of dyspnoea from time to time does not necessarily mean cure. Once complicated with advanced emphysema, the case may not probably be cured by any means. Constitutional antimiasmatic treatment may probably cure all cases in early childhood. In young adults, 80% cases may be completely cured. In advanced ages with well developed emphysema, life may be prolonged with suitable palliation from

time to time, but no cure is probably possible. So, before deciding the prognosis of a case of bronchial asthma, we must take into consideration the following factors carefully :

(a) Age of the patient. (b) Duration of sufferings. (c) Miasmatic background. (d) Presence of complications if any. (e) Occupation and mode of living of the patient. (f) Treatment already adopted and continuing at present. (g) Effects of the constitutional and palliative medicines on the patient.

Treatment :

1. *Diet and Regimen* :

(i) *Diet* : allergic substances in food are to be avoided during the course of treatment e.g. eggs, prawn, crab etc. ; light meals are to be taken at night as early as possible so that no heavy load may cause any distress at bed time ; low residual diet is to be taken to avoid flatulence ; raw onion, camphor and asafoetida should better be avoided.

(ii) Related exciting and maintaining causes are to be eliminated as far as possible.

(iii) Morning walk in fresh open air in dry. fine. clear weather.

(iv) Breathing exercise may be advocated as and when seems justified.

(v) Over exertion is to be avoided.

(vi) Alcohal and smoking are to be strictly avoided.

(vii) Mental tension, worries and anxieties are to be avoided as far as possible.

2. *Medicinal treatment* :

(i) *Palliative* treatment during acute episode covering the symptoms of dyspnoea, cough etc. with their exact sensation, modalities and concomitants if any as also the exciting cause.

(ii) *Curative* : Constitutional antimiasmatic medicines are to be administered with change in the plan of treatment as and when necessary.

(iii) Antidote to previously administered medicines as also other causative factors like Vaccination as and when necessary.

3. *Auxilliary treatment* :

(a) O_2^{γ} as and when necessary.

(b) Hospitalisation in cases of Status Asthmaticus.

Plan of treatment :

A. *Cases coming to Homœopaths from the very beginning without being treated previously by other systems of Medicine* :

1. To take up the case history thoroughly including the details of symptoms during acute episodes
2. Interpretation of symptoms obtained, a careful analysis of the history and a synthesis of the whole case is absolutely necessary before deciding the plan of treatment.
3. To select a constitutional antimiasmatic medicine which also covers the acute attacks if possible ; the medicine should better be administered in 50 millesimal potency.

4. To change the medicine or plan of treatment as and when necessary.
5. If the constitutional medicine does not cover the symptoms of acute attack, then the constitutional medicine is to be administered first during free intervals. After that if acute attack supervenes, the acute symptoms, modalities and concomitants are to be observed minutely and then only the indicated medicine is to be administered at suitable intervals preferably in 50 millesimal potency. After the acute attack subsides, we are to wait and observe the patient to see if the constitutional medicine has exhausted its action. If so, the same constitutional medicine is to be administered again in relatively higher potencies.
   Several changes in the selection of acute medicines, the constitutional medicine as also in the plan of treatment may be necessary before the patient is cured.

B. *Cases coming from the hands of physicians belonging to other systems of medicine* :

(i) It is better not to stop the medicine the patient had been continuing till then on the very first day. The medicine is to be withdrawn gradually depending on the response of the patient as also his / her ability to tolerate the acute episodes without the aid of previous medicine.

(ii) Attempts are to be made to substitute Homoeopathic medicines for acute attacks in place of the non-homoeopathic medicines.

(iii) Constitutional medicine is to be administered during the free intervals and then to follow the procedure as stated before.

(iv) Utmost care is to be taken not to prescribe for the changed or modified symptoms after drugging but to enquire for the original symptoms to start with which should be our main guide in the selection of constitutional medicine.

(v) Follow up of the cases in different seasons, weather and climates as also variable circumstances and environments, is absolutely necessary before declaring the patient as cured.

(vi) In incurable cases, only palliative medicines based on the presenting totality of symptoms, are to be selected instead of constitutional curative medicines.

ILLUSTRATIVE CASES

Case No. 1.

A young boy of 13 years came on 28.11.84 for his 10 years' old respiratory distress. Violent cough followed by dyspnoea and wheezing in chest used to disturb him nearly every night, especially in winter and rainy season. During attack, frothy expectoration and slow walking would relieve him a little. The trouble started after an attack of measles. In the family there were episodes of Pulmonary Tuberculosis, Piles, Rheumatism and Insanity. The boy was very much susceptible to cold and craved sweet, sour and cold drinks. He had a tendency to lie on sides and

back with profuse salivation during sleep and somnumbulism. Mentally quiet, hasty and intelligent, he was fond of sports and frightened of ghosts and cockroaches. On examination there were evidences of follicular pharyngitis, septic tonsils and hypertrophy of nasal turbinates. He had pigeon chest with a body weight of 33·5 kg. Blood examination revealed Eosinophil 9%.

Miasmatically asthmatic dyspnoea at such an early age leaves no doubt for sycosis. The family history, generalities and presenting symptoms confirm this, with syphilis and psora lurking behind. Now, a drug covering the aforesaid miasmatic states and the presenting totality of symptoms is found in the symptomatology of silicea. Hence it was given in 2c, 1M and 10M potencies. As anticipated, the boy had no attack of dyspnoea after the first dose. Nevertheless, he was subsequently given Morbillinum, Bacillinum, Psorinum and Hepar sulph (all in centesimal potency), basing on miasmatic background and the rest of symptoms to remove the blocks and establish cure in the truest sense of the term.

Case No. 2.

This is the case of a young, unmarried girl of 18 years of age who had been suffering from bronchial asthma and presented the following on 27.2.86.

History of recurrent attacks of tonsillitis in winter season only for last 5 years. In June 1985, she was suddenly attacked with a severe attack of expiratory dyspnoea. The attack was so violent that she had to be admitted in a hospital that very night. Since then she has regularly been suffering from recurrent attacks

of bronchial asthma especially in winter. Her dyspnoea aggravates after 10 P.M. and ameliorates by sitting up bending forward and fan air. Violent cough precedes the attack of dyspnoea. Thereafter her cough becomes productive with expectoration of profuse, yellowish jelly like and salty expectoration which gives her temporary relief. She also complains of falling of hair, dysmenorrhoea and leucorrhoea Her menstrual cycle is always early and associated with pain in abdomen 5-6 days preceding the onset of flow ; flow lasts for 3 days and contains blackish red, clotted blood. Leucorrhoea aggravates before mense.

Her family history revealed rheumatism and piles (paternal side) and rheumatism and hypertension (maternal side).

She is rather a hot patient with profuse sweat especially on palms, soles and axillae. She desires green chillies, meat, cold food and drinks and fruits ; has aversion to milk and sour. She can not digest rich and fried food which causes loose motion. She has profuse thirst for large quantities of water at a time. She fears cockroaches and snakes. She is irritable and hasty ; does not like company ; fond of music, recitation and natural beauty like thunderstorm, lightning etc.

On examination, her tonsils were found to be grossly enlarged and unhealthy ; no abnormal findings were detected in her chest ; blood examination revealed 16% eosinophil.

Her miasmatic state represents Psora and Syphilis. Her past history revealed tonsillitis. Based on these and the generalities, her first medicine was Guaiacum

—200 two doses (Morning & Evening the same day) on 27.2.86. She had no troubles excepting occasional headache till 28.4 86 when she complained of aggravation of leucorrhoea. A dose of Medorrhinum—200 was given and another dose of 1M potency was repeated on 20.8.86. She had no dyspnoea till 20.10.86 when she complained of mild dyspnoea for a day or two. Now a dose of Tuberculinum—200 was given. After that she had no more dyspnoea but her eosinophil count rose upto 20% on 2.12.86. Now Bromium was given in 200th and 1m potency. Thereafter her eosinphil count dropped to 6% on 2.4.87. Bromium 10m one dose was given for occasional attacks of cough and cold. Thereafter till now she is free from all troubles. Her last medicine was Syphilinum 1m one dose on 19.1.88 when she complained of aggravation of her falling of hair.

She is still under treatment and observation.

Case No. 3

A tall, stout youngman of 28 years came on 18.11.86. He was suffering from violent cough and dyspnoea, aggravating from evening onwards. Early months of winter would aggravate his troubles. During attacks, sitting up slightly bending forward and rubbing on back would relieve him a little. Expectoration was sticky at night and frothy in the morning. There was history of prolonged exposure to jute dust, rain and logged water in his service place. He had history of measles and Malaria in the past and allergic sneezing in the childhood days. There was evidences of Piles, Cancer of liver, and mental disorder in the family. He was a chilly patient and

had craving for sweets, fish, meat, milk, raw onion and cold dishes. He had much thirst and aversion to chillies and sour. He also had a tendency to profuse sweating especially on palms and soles, even in winter. He preferred to lie on right side in a huddled up position, pressing the chest. Though irritable, he could cool down easily. He was fond of company and music. On examination the breath sound was found diminished, nasal septum deviated to the right side, multiple moles on chest and small wart like growths on the palms. There were premature gray hair and slight tenderness in the gall bladder area. Eosinophil was found 10%.

Considering the family history, past history, presenting symptoms and physical appearance of the patient the case appeared to be mixed miasmatic with predominance of psora and syphilis. This miasmatic anamnesis, added to the presenting complaints, physical and mental generals point to Bacillinum as his indicated medicine. Bacillinum 2c and 1M ameliorated his cough and dyspnoea to a greater extent. Then he required Carcinosin 2c and 1M as a remedy complementary to Bacillinum, covering the miasmatic background and the remaining symptoms. He is having no trouble at present.

Case No. 4.

It is in case of a slim, tall young boy of 7 years. He came on 20.1.84 for repeated (almost daily) attacks of spasmodic cough with dyspnoea. Usually dry but occasionally white mucus he would expectorate. No definite modalities were found. Each spell of attack would remain for 15 to 30 minutes, after which the

child was normal. The origin of his trouble dated back to 2/3 months of age, when he was attacked with whooping cough followed by bronchitis. For last one year he was also suffering frequently from nightly pain in legs and arms, tip of nose and ears. Apart from the upper respiratory tract infection he also had a history of eczema on legs $1\frac{1}{2}$ years ago, suppressed by local applications. He had history of regular vaccination also. Family history revealed instance of Eczema, Bronchial Asthma and Chronic Bronchitis. A hot patient he would sweat profusely, especially on head and chest. He was thirsty with craving for sweet, sour and cold dishes and aversion to milk. Stool was regular at that time but prior to that it was at an interval of 8 to 10 days. There was tendency to lie on abdomen with occasional salivation during sleep. He also had tendency to delayed healing of ulcers. Mentally he was restless and very fearful, especially to ghosts. He had blackish discolouration of gums and swollen turbinates of nose. Blood picture revealed Eosinophil 21%.

The role of fixed miasmatic stigma could not be over ruled here. The boy was never well since the attack of whooping cough. So our first target was the exciting factor. Hence, Pertussin and subsequently Drosera (firstly in 200th, then in 1M potency) was given and the patient got symptomatic relief but recurrence of attack could not be prevented. Then the role of fundamental cause was to be thought of. The past history and family history presented evidences of Psora and Sycosis. The generalities pointed out to both sycosis and syphilis. Hence medicines covering the miasmatic states, as also the symptom totality were

administered as and when necessary. Thus Bacillinum, Hepar sulph, Causticum, Thuja and Sulphur he recieved, all in centesimal potencies throughout the whole of curative process. For last 2 years he is free of his troubles.

Case No. 5.

This is the case of a youngman of 22. He came on 28.10 82 for dyspnoea since childhood days. He had aggravation from exertion, cold weather and at midnight, with profuse sweating. Open air and sitting in erect posture would relieve him a little. Occasionally it was accompanied by cough with thick, salty expectoration. He had developed blackish discolouration of face for last 4/5 years and an aching pain in upper abdomen for last 2 years, aggravating after eating and in winter. In the past he had suffered from Typhoid, Jaundice, and suppressed ringworm scattered throughout the body. He could not furnish his family history. He was a chilly patient with tendency to catch cold easily. He used to perspire much feeling uneasiness after sweating, which emitted foul smell and stained the clothings yellow. Thirsty with poor appetite he had craving for eggs, raw onions, milk. sour and cold dishes and aversion to fish. With a tendency to salivation during sleep he had tendency to cat naps and preferred to lie on right side. The urine was usually yellowish and foul. Irritable but easily cooled down he was hasty, forgetful and fearful especially to dark nights, ghosts and dogs. On examination the breath sound was found diminished with coated tongue, dry dandruff on vertex and plenty

of acne on the face. Blood report revealed Eosinophil 21%.

In spite of no family history a case of bronchial dyspnoea from the very childhood points to sycosis. Here the generalities and clinical findings confirm it. Basing on this miasmatic state and presenting symptoms, history of Jaundice and suppressed skin disease, the generalities as also the clinical findings, Nat. Sulph was given, firstly in fifty millesimal and then in Centesimal raising upto 10M potency. Apart from this he was given Silicea, Ars. alb, Tuberculinum and Kali carb, all in Centesimal potencies, as and when necessary, by the then presenting symptoms. For more than one year he is having no attack of dyspnoea.

Case No. 6.

A boy aged 14 years came for treatment of his Bronchial Asthma lasting for 4 years. On the first day he had the following symptoms and findings. With a susceptibility to catch cold easily since childhood he had frequent attacks of sneezing and dry cough with fever (100-101°F) followed by dyspnoea aggravating in summer and rainy season. Lying on chest would relieve him somehow. Occasional epistaxis at an interval of 1 or 2 months he had from his childhood days.

There was history of measles at the age of 4 years followed by otorrhoea at the age of 4½ years. This was followed by the attack of cough and cold and finally dyspnoea. There was history of regular vaccination too. The family history revealed Piles, Otorrhoea and Rheumatism.

The patient was hot with much sweat on head during sleep. Thirst was scanty. He desired eggs, sweets, cold foods and drinks. He had much salivation during sleep. The patient was quiet but hasty, forgetful and nervous. He had dream of snakes. The blood picture revealed Eosinophil 13%.

To antidote suppresed measles, Morbillinum 2c and 1M was given as his first prescription. The dyspnoea ameliorated in severity and frequency of attacks also diminished. The second prescription was Medorrhinum 1M which covers the sycotic miasmatic background as also most of the generalities. Dyspnoea stopped completely for few months but epistaxis was recurring frequently. Hence sulphur was given to remove his psoric block. After nine months his dyspnoea relapsed but epistaxis was completely checked in the meantime. Now Psorinum was given as a complementary to Sulphur. He had no further attack of dyspnoea since then but epistaxis reappeared, though at long intervals. Now, to eradicate his tubercular diathesis, Bacillinum was given, basing on some of his generalities. After six months crusty eruption appeared on scalp. He had no attack of dyspnoea in the meantime though epistaxis did not stop completely. After waiting for 3 months more Silicea was given, as he developed one minor attack of dyspnoea inspite of disappearance of eruptions. After this the dyspnoea, epistaxis and otorrhoea disappeared completely but susceptibility to catch cold persisted for sometime more, for which he was given lastly Hepar Sulph. After this the patient was completely cured and the treatment was closed.

Case No 7.

A slim, tall youngman of 30 years came on 19.8.86. For long nine years he was suffering from dyspnoea aggravating especially in rainy season and Autumn. Dyspnoea used to start from sunset with tickling cough and aggravated after falling asleep, turning violent after midnight. Open air, stooping posture and warm drinks used to ameliorate. There was white, tasteless and scanty expectoration giving some relief. He felt better lying on right side or knee-chest position and feared darkness during attacks of dysponea.

As to the history he had recurrent nasal catarrh in summer and rainy season from 1970 to 1975 and itching eruptions in groin area since 1973. Many ointments were applied for this and in the meantime he developed Autumnal dyspnoea which got relieved by modern medicines. In 1980 the itching eruptions disappeared completely but dyspnoea became violent since then. From 1984 he started taking homoeopathic medicines from a local physician. As to the family history there was history of suspected abdominal lump in the paternal and Bronchial asthma in the maternal side. He also had a haemorrhagic diathesis.

A hot patient he liked mild warm dishes, eggs, chillies, raw onion and milk. Sweet and sour disliked. She had scanty thirst and profuse sweat which would ameliorate. She had offensive footsweat till three years back. The urine had offensive smell and the stool had nothing abnormal. He preferred to lie on right side and dreamt frequently of flying or walking at the sea shore. Nervous and forgetful he would fear bloodshed and was fond of rainfall, solitude and

music. He had suppressed irritability and tidy habits. On examination the tongue was found flabby, moist and white coated with congested throat and polipoidal growth in the nostrils. The breath sound was diminished and the expiration prolonged. His body weight was 50·5 kg and there was Eosinophil 21%.

The history of the case indicates psora and syphilis as the predominating miasmatic state. The present complaints and generalities corroborate with it. Basing on this miasmatic state and covering the present complaints as well as the generalities, especially the strong mental symptoms, Bacillinum was given firstly in 1M and then in 10M potency with remarkable improvement in all spheres. His bodyweight increased to 53·5 kg. Afterwards he started losing body weight inspite of having no dyspnoea. This time he was given syphilinum 1M as a medicine complementary to Bacillinum, covering the rest of symptomatology and stressing on the syphilitic miasmatic state. Curiously enough, it brought back the old eczematous eruptions with marked general improvement. For more than one year he has no dyspnoea.

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