

## Section 2.2a

In the following section of this month's course you will carry out an exercise in homeopathic case taking.

### **Activity:** Homeopathic Case Taking

In the first section of this unit, we have talked extensively about case taking in homeopathic practice. Now it is time for you to apply what you have learned to a simulated case-taking exercise.

You will view a case on video. Unlike many of the case examples up to this point in the course, this case has not been extensively edited. It is therefore a closer approximation to a real-life interview situation.

As you view the case, you may wish to note down the relevant details on a blank sheet as you normally would, or you may wish to organise the information as the case is running, by entering each symptom into one of the columns on the recording sheet provided on page x. Alternatively, you may prefer to underline or highlight parts of the transcript which you feel are important and transfer the information to the recording sheet afterwards.

The reason for grouping symptoms may not be immediately apparent at this stage of your studies. It will become much clearer when you are introduced to methods of case analysis in Unit 3.

After you have viewed the case, you should consider the relative emphasis given by the patient to the various details, and their relative homeopathic significance.

If you are familiar with the use of the repertory from previous study of homeopathy, you may wish to analyse the case using a repertory.

If you have no previous experience of case analysis (which will be covered in Unit 3), you should go straight to the Case Discussion section after completing the assignments on pages x and x

Although you have been introduced to only a few homeopathic remedies so far, we hope that you will be able to make some informed 'guesses' as to the prescription.

This patient (Miss Doris S) has been treated homeopathically with a material whose of a therapeutic substance whose toxicology and pathological affinities are already part of your general medical knowledge.

## Videocase Recording Sheet

Miss Doris S

<b>MIND</b>	<b>GENERAL</b>	<b>LOCAL</b>

Videocase Transcript - Case Taking **Miss Doris S** [picture]

**Doctor:** What is the main trouble?

**Patient:** My eyes and I don't expect anything...but if they could stop from getting a bit worse. It's a question of the car and driving.

**Doctor:** Is it cataract?

**Patient:** Well this is what I know: I've got cataracts in both eyes, and a melanoma in my left eye...but I gather from Dr Jay [ophthalmologist] who says it's ageing round the retina.

**Doctor:** Is the retina actually detaching?

**Patient:** He's never said that, but I saw him about six weeks ago and he always says to me 'if you can read car number plates at 25 yards - then that's your business'. And I can do that....but he said he thought it was about time I thought of 'changing my life style'...I said to him: 'You know where I live. It is important to me to have a car and to be able to drive.'

**Doctor:** Is one eye worse than other?

**Patient:** Yes, my left eye is worse.

**Doctor:** What is the main problem with the vision?

**Patient:** I can see everything close-to quite well, but it's things coming at me from a distance: I have a bit of difficulty judging distance... but I know that and I have stopped driving at night now.

At one point I thought that there was a bit of flickering going on, but it's nothing. I do find that read....I read in bed...When I go to bed I can read perfectly well with my specs on, but if I wake in the night and try to read, then I have difficulty getting the focus right.

**Doctor:** What was your job?

**Patient:** I was head of the Occupational Therapy School in Glasgow, but I retired in 1975, so I've been retired for a long time.

**Doctor:** What about other problems... other than the eyes?

**Patient:** I don't sleep well, but I manage that. I do have hypnotics... but I only take them when I am away... otherwise I use the radio at night... I have always known I could stop [the sleeping pills] right away.

**Doctor:** Do you suffer from headaches?

**Patient:** No.

**Doctor:** Are you catarrhal?

**Patient:** If I have a cold, it usually goes to my chest. I should perhaps tell you that when I was in Russia last year... very dramatic it was... the pollution was awful, and it went for my chest... I didn't realise that our trip was a small bit up a road and I thought to myself 'I can't get up that!' Whereon someone who was passing gave me a hand and I passed out....it was not for long. But it was very splendid because a doctor came from the ship with a nurse and two sailors to carry the body ! They treated me on board. If I'm not feeling well, I always go to sleep. So I slept for three days then I got up and went on.

**Doctor:** Have you got any other areas of low resistance in terms of your health, would you say?

**Patient:** No, I don't think so. I very seldom get a cold, but if I do it goes to my chest and I have a cough like a graveyard.

**Doctor:** I'm looking for all the remedies relating to retinal degeneration... etc. In general, do you have a good time or bad time of the day, in terms of your energy?

**Patient:** Yes, I'm better in the morning.

**Doctor:** Are you warm or chilly in reaction to temperature?

**Patient:** Chillier than I used to be.

**Doctor:** Are you tolerant of the sun?

**Patient:** I don't like sitting in the sun any more.

**Doctor:** What about food likes and dislikes.. any strong preferences?

**Patient:** No, I haven't really.

**Doctor:** Are you a non-smoker?

**Patient:** I smoke two cheroots a day.

**Doctor:** Did you smoke more in the past?

**Patient:**(laughing)Oh yes, but that again is a long time ago. I suppose I smoked quite heavily, but that would be thirty years ago.

**Doctor:** Do you like salt?

**Patient:** Not particularly, no. Well I don't use a lot, because I steam vegetables without salt.

**Doctor:** How would you describe yourself in terms of personality?

**Patient:** I do get depressed in the winter time... after Christmas. I enjoy being with people and I think I get on with people well. I had to in my job and I still do it.

**Doctor:** Are you a diplomatic person, or are you fairly blunt do you think?

**Patient:** I think I could control my bluntness and again that's been a question of doing it... as far as jobs are concerned. I can dislike people, but there again I think I can control it.

**Doctor:** Is there any food that disagrees with you?

**Patient:** If I eat shellfish... that's disastrous.

**Doctor:** What do shellfish do to you?

**Patient:** I get very sick indeed.

### Activity

Select the symptoms that you feel are important.

Organise them into mind symptoms, general symptoms, and local symptoms.

Consider your impression of Mrs Doris S in terms of her demeanour and life-style.

Consider the evolution of her problems, starting with any precipitating factors.

Consider the materials that you know which are capable of generating this kind of illness. Make any notes relevant to this activity in the box on the following page.

Mrs Doris S

Mind symptoms	
General symptoms	
Local symptoms	
Your impression of the patient	
Evolution of problems	
Materials capable of generating this illness	

Now move on to the next part of this discussion below.

This chart [picture] shows a computer analysis of Miss S's symptoms. The symptoms as they appear in the computer's index appear down the left hand column, and the remedies which are related to each symptom are tabled in the grid horizontally. The strength of the relationship between symptom and remedy is indicated by the numbers in the boxes. A remedy association which is marked with a three is strong, and a grade one listing is weak.

Can you see why each of these chosen symptoms may be relevant to Miss S?

Discussion:

Q1. Although there are focal pathologies which are impairing this lady's vision, which aspect do you think is progressive?

Q2. What factors (present and past) may be contributing to the degenerative process? What other information does the patient give us to support this presumption?

Q3. Can you think of a derivative compound which may have homeopathic indications?

Q4. This lady required a homeopathic potency of a material which is in common use. Can you think of other materials which are in common use and have a toxic picture, and which may have a therapeutic value when used homeopathically?

Material	Main Toxic Effects	Possible homeopathic indication
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Argument

1. The melanoma is static in size and the ophthalmologist does not find any evidence of progression. Her cataracts are slowly progressive but would not account for the relatively rapid deterioration that Miss S. is encountering. The "ageing" of the retina is the main degenerative process. Because it is diffuse feature it accounts for her general loss of acuity, and her increasing difficulty with night vision.

2. This lady has smoked very heavily for a large part of her adult life and recognises this as having undermined her health. (Listen to the irony in her voice as the subject arises in the interview.)

Tobacco blindness is a well-known phenomenon, arising directly due to retinal toxicity, and indirectly as a result of small vessel disease.

*Tabaccum* (Tobacco) is the top-scoring remedy in the computer analysis. On the analysis performed at the clinic *Tabaccum* featured seventh. Some additional symptom selection has been undertaken to show that the relationship is deep-seated and not merely restricted to local phenomena.

Tobacco is essentially a social drug. Did you note her social ease.

Tobacco smokers are often pragmatic and, particularly nowadays, they embrace a fatalistic view of life. Consider this lady's attitude to her collapse on holiday. Did it stop her going on after a rest? Did she insist on extensive cardiovascular investigations? Consider what the response of an *Arsenicum* patient would have been? The inherent fatalism of tobacco smokers is listed in the index as Courageousness.

Tobacco contains nicotine which has a profound effect on the autonomic nervous system. Its relaxant and vaso-active properties can cause an acute reduction in blood pressure and various vaso-vagal phenomena. Think of the nausea and faintness, that occurs in a novice smoker. Chronic tobacco use, however, can cause "nicotinism" which is characterised by a state of

lowered reactivity in the blood pressure and venous return, leading to a tendency to faint with exertion or excitement. Drop attacks, and vertebro-basillar insufficiency are common in chronic smokers. This lady experienced her most dramatic episode while on holiday and undertaking unaccustomed exercise. Note the association in the analysis between ascending a hill and sudden weakness.

Rigidity of cardiovascular compliance is also due to arteriosclerosis, which is associated in the homeopathic and allopathic literature with tobacco. The hippocratic face, with its deep lines and greyish complexion has long been associated with chronic tobacco use, and is well represented in the homeopathic database. This patient typifies the hippocratic appearance (apologies for the quality of the recording.)

3. Nicotine is among the most active constituents in tobacco and it can be used homeopathically in its pure form (*Nicotinum*). Many plant materials contain alkaloids which can be useful in extracted form, eg *Atropine* from *Belladonna*, *Strychnine* from *Nux vomica*, *Veratrinum* from *Sabadilla*, *Digitoxin* from *Digitalis*. The alkaloids tend to produce more focussed organ-specific physiological effects. In a homeopathic form they are not associated with as many “constitutional” features as preparations of the parent plant.

4. Consider the symptom pictures of Coffee (*Coffea*), Tea (*Thea*), Cayenne Pepper (*Capsicum*), Onion (*Alium cepa*), Common salt (*Natrum muriaticum*) Fluoride, (*Calcarea fluorica*) Milk of magnesia (*Magnesia carbonica*), Nutmeg (*Nux moschata*). The following database searches show some of the features which are associated with tobacco. How many of them would you have thought of?

Can you spot any more symptoms which are in keeping with Miss S’s descriptions?

The challenge in Homeopathy is to recognise what constitutes important information. Very often it is not what is said, but the way in which it is said that gives us our most important clues.

Similarly, the patient’s stories, anecdotes and metaphors often contain gems of information which are far more “telling” than facts which are given in response to direct questioning.

Miss S. spoke about her visual difficulty with distances (accommodation diminished), and her problems reading at night (looking at white objects)...the page of a book is mostly white!

A patient never displays the full symptom-picture of a remedy. The absence of a characteristic symptom does not, in itself, diminish the argument for that remedy. However, the lack of an important **group** of symptoms, eg lack of **any** cramps in a patient being considered for treatment with *Cuprum met*, is a strong counter-argument to the use of that remedy.

Mrs Doris S.

Prescription: *Tabacum 6c*, four times daily

What are the arguments for using frequent doses of a low potency compared with high potencies in this case?

Follow up  
Letter 5 weeks later:

Dear Dr. M

Thank you for sending me a new remedy. I took it as directed on 23rd. There has been a reaction, though I find it difficult to be specific. The slow deterioration of sight seemed at first slightly worse. ie the daily newspaper required closer reading. This has now returned to the usual and is perhaps better. I haven't had a bothersome shadow usual on my left eye. Anyway I feel better ! and hope the degeneration is halted. I will keep in touch and thank you for your help.

Yours sincerely,

Doris S.

Letter 6 weeks later:

Thank you for the repeat prescription. I can now definitely say that there has been a clearing of my vision compared to the way it was before treatment. Somehow I also feel mentally brighter. There has been no return of the shadow that used to plague the vision in my left eye. Can you let me know if you need to see me at the clinic at some point...

Yours sincerely,

Doris S.