

Systems & Symbiosis - The Bowel Nosodes Reappraised

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A Seminar in Integrative Medicine

Core Text

Part 4

Prescribing methodologies



Course Text & Study Resources

by

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Therapeutic Guidelines

The dysbiotic case is a blocked case. Patient's whose intestinal ecosystem is significantly disordered have an on-board source of immunological and physiological chaos. If the symbiotic homeostasis is not corrected, the patient will be incapable of responding to a classical similimum. Or the response will be weak and short-lived.

One of the most important considerations for the physician is whether there are clinical features of dysbiosis. For the very experienced medical homeopath it may run against the grain to reduce the dynamics of a complex case down to a diagnostic label. If the diagnosis of intestinal dysbiosis is missed, however, the reactive features will not be enough to identify a cure for the case.

There are a number of features in the case history to look out for.

Key indications for the bowel nosodes

1. Aetiology: **infection, antibiotics or both**
2. Never well since... (**Acquired intrinsic blocks to cure**)
3. **Physiological / metabolic / immune corollaries**
(signs of fatigue, debility, toxicity and vulnerability to infection). Prominent '**generals**'.
4. Self-perpetuating illness state (see dysbiosis - **systemic cycle** below) **Systems-disturbances**.
5. Evidence of **altered surface immunity** (inflammatory conditions skin, mucus membranes, or internal integuments eg. synovium)
6. Symptoms referable to GI, GU, respiratory **tracts and body orifices** (although there are often persistent bowel symptoms, these can be surprisingly minor in comparison with the systemic corollaries)
7. **Insidious block to cure** (cases which are **failing to respond** to well chosen remedies, or where the patient consistently fails to build on an early response)
8. **Bacteriological evidence** of reduced lactose fermenting anaerobes, or evidence on stool culture of significantly increased populations of delayed/non lactose fermentors or pathogenic *enterobacteraceae*.



Drugs can give rise to dysbiosis quickly, or very insidiously.

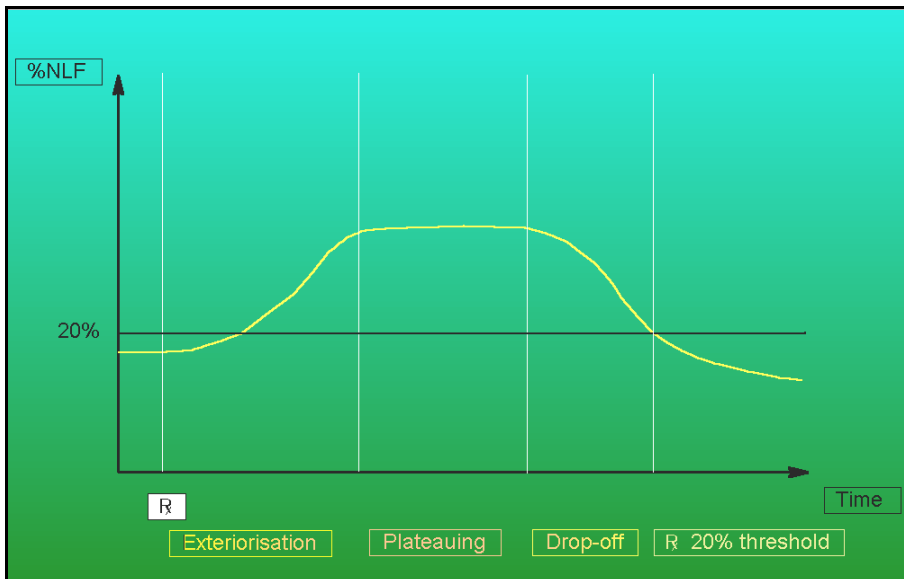


Paterson's Clinical Guidance

“...with regard to the change in the bowel flora [after a remedy]. The appearance of non-lactose fermenting organisms, I regard as evidence of the action of the defensive body mechanism. Their percentage in relation to B. coli and their persistency in point of time may be used as an indication upon which to base treatment at any period of the disease”.

“If the percentage is high (80-100%) clinical experience has shown that the potentised vaccine (nosode) does definite harm”. [May ‘block’ an acting remedy.]

“Now with a positive stool yielding 20% or less, I should not hesitate to use the corresponding nosode or autogenous vaccine, provided the patient does not show other evidence of improvement”.



After a remedy there is an increased presence of non-lactose fermenters in the stool.



Therapeutic Guidelines continued

The general consensus in the literature is that the Bowel Nosodes do not stand repetition. They are given as stat doses, or split stat doses, over one or two days. The author prefers three stat doses, in rising potencies, over twelve hours.

The traditional advice is then to wait, and to avoid repetition of the nosode within 3 months.

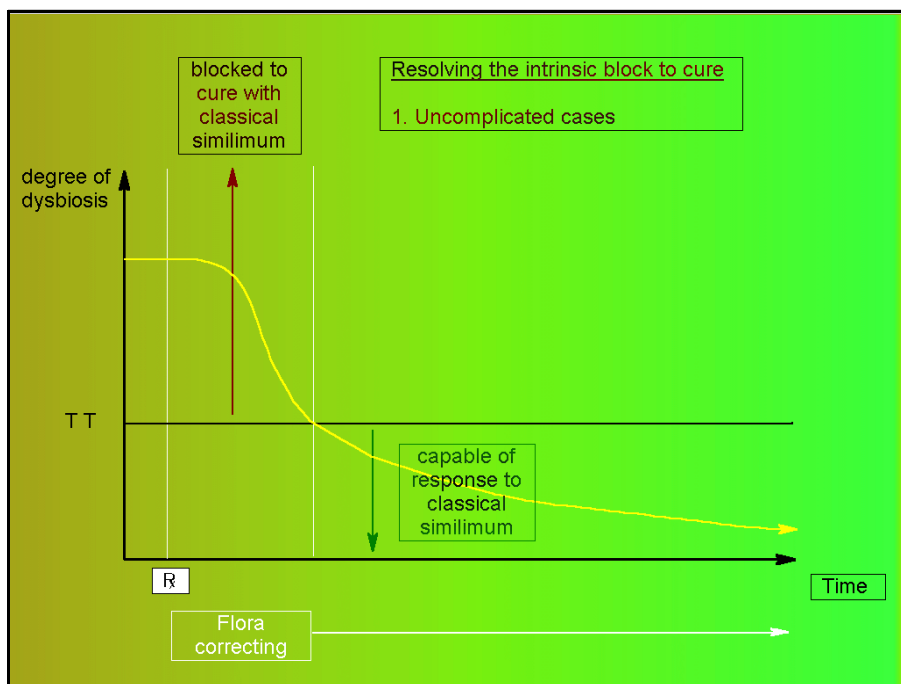
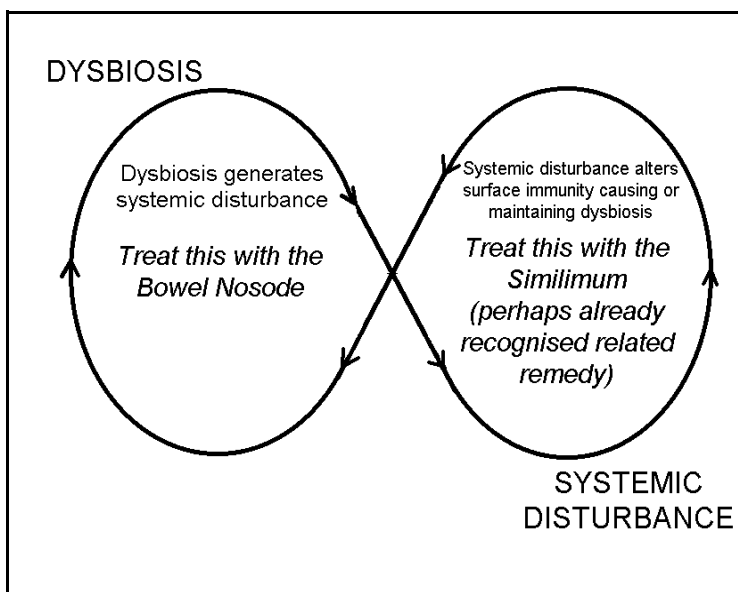
In my experience the patient usually some shows some evidence of a response within 10-14 days after a good prescription. (Sometimes earlier)

Where the bowel nosode is used on its own account, as the main therapeutic input, I would leave the resolution to unfold in an open-ended way (weeks), if they are showing ongoing improvement.

In uncomplicated cases the patient's intrinsic block to cure will resolve and they will become responsive to a classical remedy.

The indicated similimum should be given if they plateau in their clinical response.

The diagram opposite is a representation of resolving dysbiosis after a bowel nosode, showing the threshold beyond which a remedy response can occur.



When the bowel nosode is being used to resolve a block to cure, or augment the response to a partially effective remedy, I would leave 14 days or more between the nosode and the related remedy.

My rationale for this is that many chronic cases show two or more main cycles of causation, and these may need to be resolved sequentially to achieve progress.

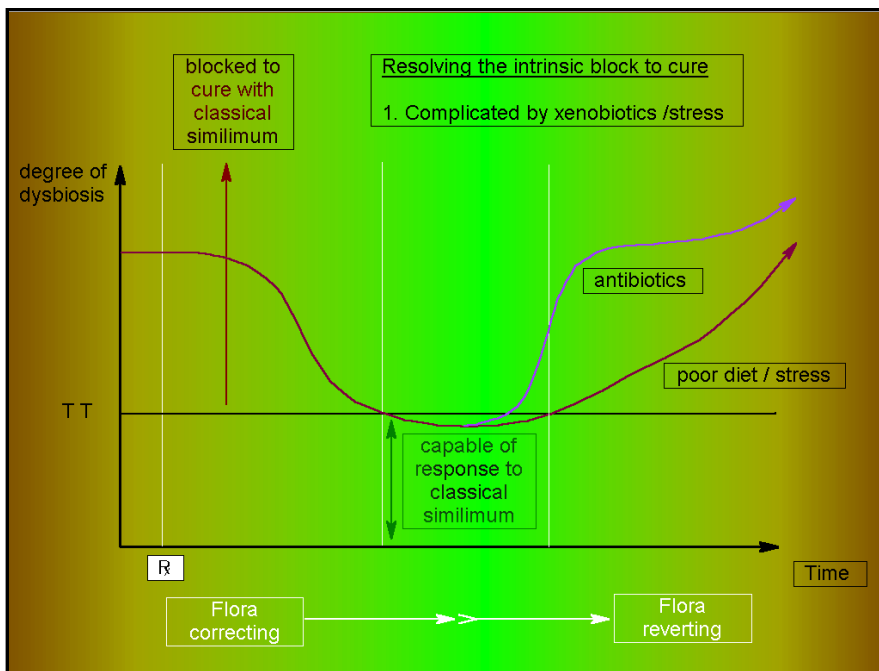


Therapeutic Guidelines continued

In some cases if you wait too long after the nosode to introduce the similimum, the systemic disturbances will re-evoked the intestinal dysbiosis. If you do not wait long enough between nosode and similimum the dysbiosis will continue to block the remedy response. In children the time lapse is shorter than in adults. Adults with longstanding active bowel symptoms and debility should be left longer to respond.

A well chosen bowel nosode does not appear to be blocked in its response by a well chosen similimum. However, a well chosen similimum which is slowly resolving a long-standing illness, may be blocked by early repetition of itself, or of its related nosode.

In cases which you have successfully 'unblocked' and which are resolving with the similimum, it is best to follow the traditional advice and avoid repetition of the nosode, unless there are clear indications that the bowel symptoms are re-emerging and the patient is deteriorating clinically.



NB Discharges, catarrhs and eruptions in the post-similimum phase of treatment are not indicators of worsening surface immunity. These features are all too frequently treated by orthodox prescribers with antibiotics - often rendering the patient dysbiotic once again and returning them to their state of fatigue or debility.

In infective acutes the early use of the correct similimum will prevent dysbiosis emerging sub-acutely. In sub-acute infective cases, the indicated nosode can be used alternately within a series of similia, in high potency, which reflect the dynamic changes in the current state of the patient.

Many patients showing signs of dysbiosis have had two sequential courses of antibiotics within a short time frame. (usually with different spectra of antibacterial activity). If they have also had treatment with antipyretics they may show signs of thermostatic instability and fatigue. In this event use a physiological similimum at an early stage of treatment. (See rubrics for fever suppressed / remittent; or rubrics relating to the abuse of quinine.)

There is plenty of room for error in the selection process for a bowel nosode on purely clinical features. Even careful symptom-analysis using a bowel nosode repertory like the one given in this book can lead to the wrong choice of nosode. If the patient fails to respond, but conforms to any the criteria on page 5.1, it would be wise to try another bowel nosode before moving into an entirely new field of prescribing.



Clinical Remedy Relationships

Notes on the Bowel Nosode Relationships

The materia medica of the bowel nosodes has been worked out in the clinic over the course of several working lives. A major element in the treatment of chronic cases is in the process:

- C clinical exploration
- C development of models for the illness
- C engagement with the available treatment data
- C selection and timing of treatment
- C re-evaluation and adjustment of models, analyses and treatment
- C feedback into the fund of clinical data and teaching of others

These cycles of clinical feedback generate information of potential value to other prescribers. In studying and using the bowel nosodes, there are several ways in which historical clinical information can be helpful:

- C providing additional information governing choice of nosode
- C understanding the relationship of the nosode to other treatments
- C informing their timing and placement within the treatment programme

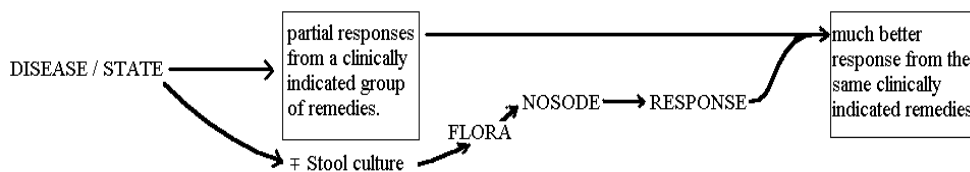
In the early days, the bacterial composition of the stool was an important factor in guiding treatment choices. Stool composition changes under the influences of:

- C illness
- C diet
- C drug treatment
- C the clinical homeopathic similimum
- C the indicated nosode

In the ill patient with bowel dysbiosis, use of the clinical similimum or constitutionally based remedy appears to evoke host responses and a shift in the surface immunity in the bowel.

In the clinical experiments of Bach and Paterson, the number of non-lactose fermenting organisms was frequently observed to increase in the stool, for a time after homeopathic treatment (perhaps as bacterial surface adherency diminished). This shift in flora was associated with clinical improvement.

The observed shift in the bacterial composition of the stool appeared to bear some relationship to the remedy used. As time went on, this quasi-objective information was collated and became the first major influence on remedy-nosode relationships.





It is clear that much of the existing data suffers from some obvious limitations in mid twentieth century microbiological knowledge, and all these basic hypotheses really need to be reinvestigated. It is also clear that many other variables may be operating in these complex clinical situations, and control group comparisons are not available, so we have to be careful not to rely entirely on these observed associations.

As the body of knowledge and experience increased, clinical outcomes became the main method of establishing remedy-nosode relationships. 'Blocked' cases or cases which had plateaued in their response would be found to improve after the use of an appropriate nosode. Their response to the similimum or constitutionally based treatment would then improve, and the empirical relationship between nosode and remedy would be documented. Clinicians like Wheeler, Dishington, Griggs and Elizabeth Paterson³⁸ have been very influential in reporting cases and gradually extending these clinical relationships. (see table 18). I have found this information very useful in the clinic and there appears to be more than a little truth in these observed relationships, although proving them statistically is an entirely different matter!

Looking at the remedy list (in table 18) it is obvious that there are hundreds of remedies in general use among experienced homeopaths, for which a nosode relationship is not established. Today we have access to remedy data that was much more difficult to access in years past. So it is possible to synthetically repertorise on the key clinical information available for each nosode and explore possible relationships further. It is also interesting to see whether 'known' relationships are borne out by the repertory.

On the pages that follow there are a series of experimental repertorisations. Symptom information from '*A survey of the bowel nosodes*' by Elizabeth Paterson³⁸ has been entered in various combinations and the rubrics analysed.

Symptom groupings have been analysed on various rationale:

- C 'totality' (selection of the most consistent contextual information)
- C 'essence' (key mind rubric and consistent contextual and local information)
- C 'pathological' (key rubrics for surface-immunity, system or locality)

The resulting analysis for each nosode usually contains 'established' clinical relationships and also lists a variety of possible relations that have not yet been confirmed clinically. Some nosodes (most notably Proteus) do not align very convincingly with established relationships and a short impression for each analysis is given on the pages that follow.** This section is now available on CD.**

The rest of this section is made up of a series of tables which bring together 'established' and 'notional' relationships. I have annotated the entries to show those that have been 'confirmed' in my experience, together with some theoretical relationships borne out of the repertory search. A few of which are annotated to show which of these 'unknown' relationships appear to have worked for my patients. **This section is now available on CD.**



Bowel Nosodes and the Mind

There is little doubt that homeopathy has tended to place the mind at the centre of the case since the time of Kent. The prescribing data should be placed in the context of the prevailing Kentian methodologies of those who did most of the seminal work on them. This raises several questions on the nature of the mind symptoms attributed to the bowel nosodes:

Do the mind features represent attributes that drive the case towards a particular kind of dysbiosis?

Does overgrowth of a particular organism accentuate certain mental/emotional symptoms?

Are there any psycho-immunological models that help to explain mind phenomena associated with these nosodes?

Have the mind symptoms in the literature been projected onto the bowel nosodes from those of their apparently related remedies?

Most of these questions are difficult to answer in a concrete way. We will briefly examine some possible immunological models for some of the central effects that occur in infective and dysbiotic states. It is thought that a number of cytokines have neuro-endocrine effects which may alter mood and the pituitary adrenal function.

Some gram negative organisms (including several implicated in dysbiosis) release lipopolysaccharides which induce TNF, interleukin-1. (Fig. 47)

The presence of these compounds is associated with bacteriologically mediated inflammatory responses and if their levels are chronically raised, as a result of dysbiosis, they may reduce immunological efficiency and predispose to secondary infection. (Fig. 48)

IL-1 stimulates pituitary function and evokes a biochemical stress response. In the acute infection a short term positive increase in adrenal function is probably immuno-stimulatory. However, protracted increases in adrenal activity ultimately inhibits cellular immunity. We observe the same phenomenon in people who are chronically stressed. (Fig. 49)

The question of whether emotional disturbance predisposes to dysbiosis appears to tenable in terms of mind-body relationships and the foregoing observations. Whether certain mental/emotional themes predispose to specific kinds of dysbiosis is a tantalising but purely speculative idea at the present time. Here are some thoughts:

- Bacillus 7** - driven by material ambition or fear of insolvency - work
- Bacillus 10** - driven by fear of aging or losing sexual allure - sex
- Dysentaria co.** - driven by anxiety of conscience - self worth
- Gaertner** - driven by awareness of frailty and the need to make a mark - creativity
- Proteus** - driven by unremitting environmental stress - chronic autonomic overdrive
- Sycotic co.** - driven by shame (try to compensate for their dirtiness) - infected
- Morganiae** - driven by greed for the good life
- Faecalis** - driven by the desire for understanding

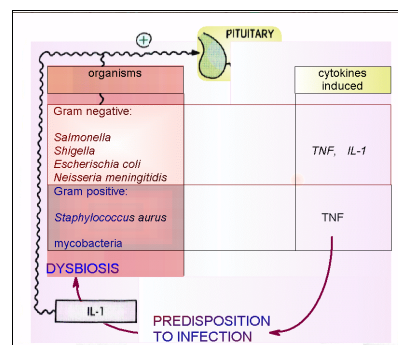


Fig 47

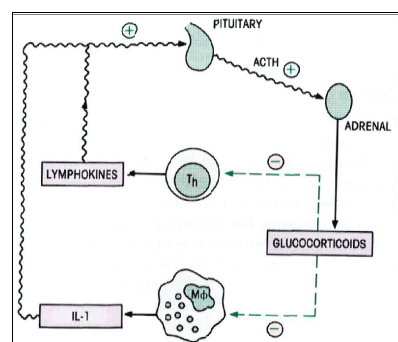


Fig 48

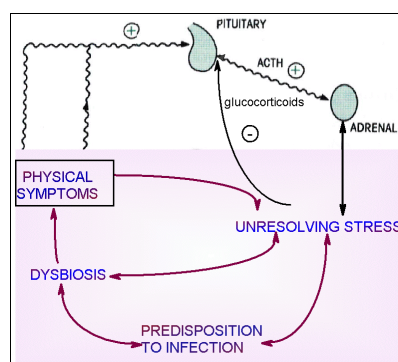
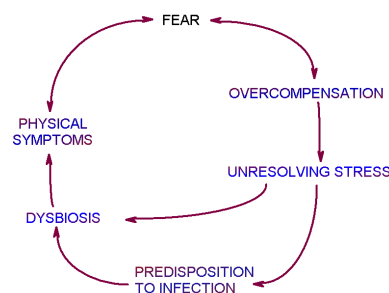


Fig 49





Bowel Nosodes and the Repertory

The data

At first glance, the remedy data for the bowel nosodes seems too vague and general to be of clinical value. The leading symptoms and keynotes can rarely be classed as 'strange', or 'peculiar'. So bowel nosodes are not usually 'jumped to' on the basis of a single strong feature in the case. A variety of inductive methods (based on the context) are required. It may also be necessary to undertake some form of analysis using the available clinical data.

Empiricism

The data for the remedies themselves is highly empirical. Most of the patients, for whom they have been prescribed in the past, have been chronically unwell, or at least sub-acute. The remedies themselves cannot be said to have undergone a standard proving, although clinical observation and stool culture data lends some objectivity to Paterson's case series.

The priorities of Bach and Paterson were, as far as possible, to establish a scientific basis for the selection of bowel nosodes. Whether it was this priority, or a general lack of keynotes, (in what was a chronic and often debilitated patient sub-population), we find that 'leading symptoms' for the bowel nosodes are in short supply. However, what information there is, is in my opinion, more reliable than much of the proving data in the materia medica as a whole.

Repertories

Modern repertories have imported the bowel-nosodes into their rubrics, but no one appears to have marked up the rubric entries as they are clinically verified, in spite of the considerable number of cases that have appeared in the journal literature over the last fifty years. As a result, the nosodes have never been elevated above 'normal type' in the standard repertories of the day.

This low-key representation, together with the small overall number of symptoms, means that these nosodes never turn up in a totality analysis. 'Broad sweep' repertorisations, which analyse only large headline rubrics, do not bring them out. Expert systems and family group searches fail to show them up, even in those patient analyses where they are clearly indicated and ultimately shown to be effective.



Given this poor representation, it is wise to do two repertorisations in those cases where the bowel nosodes are clearly indicated.

- in one repertorisation you would use traditional methodology (whether it be totality, thematic, pathological or synthetic) and establish the range of potential similia.

- in the other repertorisation you would use a nosodes repertory to assess which remedy is most likely to address the *systems disturbances* relating to the patient's dysbiosis

As you become more familiar with the nosodes, these two repertorisations will inform one another. So, for example, if your 'traditional' analysis yields *Phosphorus*, *Silica* or their salts, you will probably use the nosodes analysis to assess whether *Gaertner* is indicated.

With experience you will come to use these empirical relationships to good effect, using the remedies sequentially to 'unblock' the case or augment the response of each to the other.

We have included a recompiled bowel nosode repertory (on page #), which uses the search-word and chapter conventions of modern clinical repertories. Because the listings are short, it takes only a few minutes to do a hand repertorisation on the nosodes.

Analysis methodology

Unless you are very clear that an uncommon symptom is unique to a remedy you would be wise to keep the analysis general and favour the head rubrics. The more unusual the feature, the more likely that the data is derived from a single case study, and potentially the same symptom could arise from time to time in patients who are sensitive to a different nosode.

So beware, don't use small rubrics to exclude remedies. Use them only to lend support. Nosodes which do not appear in the listing for a common feature are easier to exclude.

Beware that 'small' nosodes like *Bacillus-10* are severely under-represented, even in a highly selective bowel nosode repertory like this. It has been used very rarely and has therefore generated much less data than its counterparts. If an analysis throws up three points of contact with *Bacillus-10*, as opposed to six for *Morgan pure*, you should consider *Bacillus-10* quite carefully and read the materia medica of the remedy.



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