Homeopathic Principles and Practice of Medicine

A Textbook for Medical Students and Homeopathic Practitioners with New Chapters Immune System and Environment Related Diseases

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HOMEOPATHIC
PRINCIPLES
and
PRACTICE of MEDICINE
A Textbook for Medical Students and Homeopathic Practitioners

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PREAMBLE

The physician’s high and only mission is to restore the sick to health. The highest ideal of cure is rapid, gentle and permanent restoration of health, in the shortest, most reliable, and harmless way. If the physician clearly perceives what is to be cured, in every individual case of disease, what is curative in each individual medicine, and if he knows how to adapt, [Note that ‘remedy should not be worse than the disease itself] according to clearly defined principles, as also in respect to the exact mode of preparation and quantity of it required and the proper period for repeating the dose – if, finally, he knows the obstacles to recovery in each case and is aware how to remove them, so that the restoration may be permanent: then he understands how to treat judiciously and rationally, and he is a true practitioner of the healing art. He is likewise a preserver of health if he knows the things that derange health and cause disease, and how to remove them from persons in health.

[Organon of Medicine]
Prime aim in writing this handbook is to meet the requirements of homeopathic medical students and practitioners. Idea is to provide a basic and comprehensive approach to the treatment planning, which one must adapt in the very beginning of a given clinical situation, and follow judiciously in a realistic manner keeping in touch with the current medical practice. Our endeavour is to follow standard medical therapy in a rational and clear pattern. Selective stress has been given to those diseases which are common to this country and are incorporated in the present text. The choice of drugs is an open one. We have included those drugs which by and large are standard drugs and are being traditionally used by masters of the prescribing art. Alternative methods of treatment have been mentioned only when they are needed. The therapeutic part has drugs which is based on the clinical situation and their particular therapeutic necessity. The idea of giving allopathic medicines is that: If at all a patient who is undergoing medication, consults a homeopath, he should be aware of the drugs and he should not stop these drugs. It is to be understood that being a homeopath you are not entitled to prescribe the allopathic drugs. In such situations the patient must be referred to the concerned specialist. The reference range of serological investigations may vary according to the laboratory method adopted. As such these need to be referred from current methods adopted by the respective laboratory.

The section on emergency has been reviewed by Dr. K.K. Shrivastava, Cardiologist, specifically in reference to indications of allopathic drugs. If the patient is being concurrently seen by a homeopath, the drugs as prescribed by the allopath should not be withdrawn without mutual discussion.

This book is being framed according to the syllabus laid down by “The Central Council of Homeopathy” for the undergraduate and postgraduate level of curriculum at the national level.

The topics are divided into three broad sections. The first section deals with the Principles of Homeopathic Practice, second one with the Current Biomedical Concepts of Medicine and Their diagnosis and Homeopathic Therapeutics, the third and last one incorporates brief outline of commonly used Homeopathic Medicines.

We are fully conscious of our shortcomings and hence welcome criticism. We will highly appreciate the suggestions from our readers for the improvement of the book.

Dr. V.K. Chauhan

Dr. Meeta Gupta
ACKNOWLEDGEMENT

Many individuals have contributed to the development of this book. It is not possible to give names of each one of them, yet we would like to thank all of them for their helpful advice.

We express our sincere gratitude to Dr. K.K. Shrivastava who inspired us to study medicine and helped in understanding the finer perspectives of each subject. We also thank him for his consistent inspiration, encouragement, and motivation. We are grateful to him for the information, help and ideas to make the book informative.

We are indebted to our family members for their unconditional support and cooperation throughout the work.

Special mention is due to Dr. Sarabjeet Kaur, who is BHMS, MD in Psychiatry for the most difficult task of editing this comprehensive book.

Also special thanks to B. Jain Publishers for their support in bringing out this dream project into reality.

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**Dr. V. K. Chauhan** is working as Professor in Medicine and Pediatrics at Nehru Homeopathic Medical College, Delhi. He joined this prestigious institution as Demonstrator in 1977 and subsequently rose to become Professor. He has undergone continuous training at various prestigious institutions in India, U.K., and U.S.A. He is M.D. in Repertory. He is currently involved at institutional level in teaching undergraduate and postgraduate students at different institutions. He conducts Weekly Clinical Meet with interns, H.P. & Registrars. He is also working as indoor incharge and also as unit incharge and is involved in indoor patient care. In outdoor patient department, he conducts OPD on Arthritis. He also helps the Head of Institution in administrative activities. He is also Superintendent, Examinations for BHMS Examination of Delhi University. He frequently participates & contributes in CME of various organizations. He is External Examiner & Paper Setter in the subject of Medicine and Anatomy, Punjab University. He is member of Delhi Homeopathic Anusandhan Parishad and has co-authored many books on homeopathy alone and with Dr. Meeta Gupta. He has been awarded State Award 2006, Delhi Govt., for his untiring work in the field of homeopathy.

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INTRODUCTION TO
CHAPTER ON LOCOMOTOR
SYSTEM
ANATOMY AND PHYSIOLOGY

Joint is an articulation between two or more bones or cartilages. These are functionally classified as:

1. Immovable Joints (Skull Type): These are mostly found in the vault of the skull. These gradually ossify with the advancing age, therefore, do not present whatsoever joint complaint.

2. Slightly Movable Joints (Vertebral Type): These are mostly found in the midline of the body, i.e. between the bodies of the vertebrae, manubrium sterni and sternum, and between the pubic bones.

   The articular surfaces are coated with hyaline cartilage, and are united by an intervening disc of fibrocartilage surrounded by a ring of strong fibrous tissue, which is continuous with the periosteum of the two bones. Twisting of the disc and yielding at different points under pressure allow limited movements.

   These joints persist throughout the life. Vertebral joints, which are situated in the mobile part of the vertebral column, i.e. cervical and lumbar regions, are prone to be affected by the wear and tear, as commonly seen in chronic degenerative arthritis. Inflammatory arthritis affects all the vertebral joints, as seen in ankylosing spondylitis.

3. Freely Movable Joints (Limb type): The bony ends of such a joint are covered by an articular cartilage and are connected by a fibrous capsule which is continuous with the periosteum of the bone. The inner surface of the capsule and all the intra-articular structures, which are not covered with the articular cartilage, are covered by a synovial membrane, which secretes an oily fluid called the synovial fluid. These are known as ‘Synovial Joints’.

   The structural complexity of these joints make them more vulnerable to multiple joint affections.

SYNOVIAL JOINT

These joints have the following components:

1. **Bony Articulation**: Articular bony ends are covered by hyaline cartilage. Articular cartilage is devoid of vascular, nerve, and lymphatic supply. It receives nutrition from the synovial fluid. It is not covered with the synovial membrane.

   Articular cartilage has a wear resistant, low frictional, compressible, elastic, lubricated surface ideally suited for easy movement over a similar surface and absorption of large forces of compression and shear generated by gravity and muscular power.

   Ageing results in thinner, less cellular, firmer and more brittle cartilage, as commonly seen in degenerative arthrosis.

2. **Fibrous Capsule**: It is attached to the articular ends of the bones. It is made-up of white connective tissue. It is pierced by the blood vessels and nerves. It may form localised thickening, forming ligaments and separate accessory ligaments.

   It is tough but flexible. It checks excessive or abnormal movements. It is protected from excessive tension by the reflex contraction of the appropriate muscles. Continued and excessive strain results in the loss of resilience of the capsule.

3. **Synovial Membrane**: It lines the inner surface of the fibrous capsule. It secretes a fluid ‘synovia’ which lubricates and provides nourishment to the articular cartilage.
4. **Blood Supply:** Periarticular plexus: Arteries near the joint give articular and epiphyseal branches, and supplies the capsule, synovial membrane and epiphyseal union.

5. **Nerve Supply:** Capsule and ligaments have rich nerve supply, and are sensitive to pain. Synovial membrane has least nerve supply, and is mildly sensitive to pain. Articular cartilage has no nerve endings, and is insensitive to pain. Nerve which supplies the joint also supplies the group of muscles acting on the joint and the skin covering the joint. Therefore, in joint diseases, muscles reflexly contract and fix the joint in a comfortable position, and also there may be referred pain in the skin overlying the joint.

**VERTEBRAL JOINT**

The two vertebrae are joined by the intervertebral discs. These discs are semi-elastic in nature and act as shock absorbers when the load on the vertebral column is increased.

Intervertebral disc consists of two parts:

1. **Annulus Fibrosus** (*Peripheral Part*): It is a concentric band of fibrocartilage attached to the anterior and posterior longitudinal ligaments of the vertebral column. The posterior ligament is weaker and narrower than the anterior ligament.

2. **Nucleus Pulposus** (*Central Part*): It is a gelatinous mass of water and collagen fibres situated nearer to the posterior margin of the disc. Its semi-fluid nature allows it to change its shape and permits one vertebra to move forwards or backwards on the other.

**PATHOLOGY AND SYMPTOMATOLOGY**

**SYNOVIAL JOINT**

The synovial joint pathology can be grouped in reference to the involvement of the joint structure (along with the most suitable organopathic clue to few drugs) which may be grouped as under:

1. **Articular Component:** It comprises of the bony ends along with the articular cartilage, synovial membrane and joint capsule. Disorders affecting the articular joint components are of two main varieties:
   a. **Degenerative Arthrosis:** It is characterised by focal cartilage loss, subchondral bone retraction, with simultaneous proliferation of new bone and cartilage, remodelling of joint contour and mild synovitis.

   **SYMPTOMATOLOGY**
   - Pain in joint.
   - Loss of joint function.
   - Bony swelling, with local tender spots.
   - Morning stiffness of less than 30 minutes duration.
   - Stiffness after rest of less than 5 minutes duration.
   - Crepitus present but the signs of inflammation are lacking.
   - ESR is normal.

   b. **Inflammatory Arthritis:** It is dominated with the inflammation of the synovial membrane, followed by loss of articular cartilage and subchondral bone damage.

   **SYMPTOMATOLOGY**
   - Pain in joint.
   - Loss of joint function.
   - Soft tissue swelling, with marked tenderness.
   - Morning stiffness of more than 30 minutes duration.
   - Stiffness after rest of more than 5 minutes.
   - The signs of inflammation, warmth, effusion and joint crepitations are present.
   - ESR is raised.
2. **Periarticular Components:** These constitute as:

   a. **Synovial:** Synovial lining of the bursae and the tendon sheaths are involved. The common pathology involving these structures is inflammatory synovial disease (e.g. rheumatoid arthritis) and repetitive trauma.

**SYMPTOMATOLOGY**

- Tenderness over the bursa which can be pointed by a finger tip.
- If the bursa is superficial it may appear as superficial and local swelling.
- Pain is aggravated on moving the ligament or soft tissue covering the bursa. Usually the pain is absent if the nearby joint is moved passively.
- Common examples are: Subacromial bursitis, olecranon bursitis, trochanteric bursitis, pre-patellar bursitis (housemaid’s knee), retrocalcaneal bursitis, infra-patellar bursitis (clergyman’s bursitis).

   b. **Insertional:** It includes affection at the point of insertion of the ligaments and tendons into the bone. The common pathology involving these is tendinitis which occurs at the site of tendon insertion, or within the tendon sheath along the tendon’s course. Common causes are severe trauma or inflammatory joint disorder (e.g. ankylosing spondylitis).

**SYMPTOMATOLOGY**

- The affected tendon is tender to pressure.
- Pain aggravates when the affected part is actively used against resistance. Pain is comparatively less on the passive movement.
- Joint movements are not restricted.
- Commonly involved sites are: supraspinatus, biceps, triceps, tendo-achilles

3. **Neurogenic Component:** These constitute as:

   a. **Nerve Root Affection:** Compression is the common cause of irritation to the nerve roots at the intervertebral foramen or subsequent in their course. Common causes are prolapse intervertebral disc, cervical and lumbar spondylloses.

**SYMPTOMATOLOGY**

- **Location and character:** Local pain and stiffness in the spine. Asymmetrical paraspinal muscle spasm causes compensatory scoliosis.
- **Radiation:** Characteristic dermatomal distribution.
- **Sensory-motor changes:** Sharp pain, hyperaesthesia, anaesthesia, paraesthesia. Motor weakness in the innervated muscles.
- **Deep tendon reflexes:** Diminished or lost.
- **Aggravation:** On turning the neck or lumbar spine. Straight leg raising test increases the symptoms in the nerve root distribution.

   b. **Peripheral Nerve Entrapment:** The common pathology involved is the compression to nerves subsequent in their course. Common causes are carpal tunnel syndrome (median nerve compression at the wrist), ulnar nerve entrapment at the elbow.

**SYMPTOMATOLOGY**

- **Location and sensation:** Shooting pain or paraesthesia distal to the nerve entrapment.
- **Radiation:** Distally.
- **Aggravation:** At night.
- **On examination:** Sensory loss usual, occasionally hyperaesthesia; does not correspond to the nerve root distribution.

**VERTEBRAL JOINT**

The vertebral joints or the intervertebral discs most commonly affected are those where a mobile part of the vertebral column joins a relatively immobile part, i.e. cervico-thoracic junction and lumbo-sacral junction.
Ageing: With advancing age the water content of nucleus pulposus diminishes and is replaced by fibrocartilage. As a result the discs become thin and inelastic, and the intervertebral spaces diminish. These result in structural instability and subsequent development of degenerative arthrosis.

Prolapse Intervertebral Disc: Increased compression load on the vertebral column causes the semi-fluid nucleus pulposus to become flattened. The outward thrust is accommodated by the resilience of the surrounding annulus fibrosus. When the thrust is too great, the annulus fibrosus ruptures, allowing the nucleus pulposus to herniate. This results in:

- Narrowing of the intervertebral space.
- Slackening of the posterior longitudinal ligaments resulting in abnormal mobility of the vertebral bodies producing local pain.
- Lateral herniation causes pressure on the spinal nerve roots. This causes muscle spasm especially on the side of herniation. As a consequence, the vertebral column shows a compensatory scoliosis with its concavity on the side of the lesion. Pain is distributed along the distribution of the compressed nerve root.
- Large herniation directly backwards in the lumbar region causes compression the whole cauda equina, resulting in paraplegia.
- Central protrusion in the cervical region causes compression of the spinal cord and anterior spinal artery, with the involvement of the pyramidal tracts.

**RHEUMATOLOGICAL SIGNS**

Signs which are frequently encountered in the joint diseases are as:

**SWELLING**

1. *Bony Swelling:* It is due to the osteophytes (commonly seen as heberden’s and bouchard’s nodes in osteoarthrosis which are non tender) and other manifestations of new bone formation.

2. *Synovitis:* The inflamed, oedematous synovium produces a ‘boggy swelling’ which is often tender. Common causes of this type of swelling are rheumatoid arthritis, psoriatic arthropathy, reiter’s syndrome and infective arthritis.

3. *Effusion:* An excessive fluid in the synovial cavity may occur in arthropathies. It can be demonstrated by cross fluctuation.

4. *Localised Swellings:* As in cases of bursitis, e.g. olecranon bursitis, infrapatellar bursitis.

**LOCALISED SWELLINGS**

The important ones are:

1. *Heberden’s Nodes:* At the distal interphalangeal joints of the fingers.

2. *Bouchard’s Nodes:* At the proximal interphalangeal joints of the fingers.

3. *Rheumatoid Nodules:* These are fleshy and varying in character, more in size than the bony lumps of the osteoarthrosis. These tend to occur over the joints and the extensor surfaces of the extremities. These are seen in rheumatoid arthritis and rheumatic fever.

4. *Bony Growths:* Commonly seen in osteoarthrosis. These tend to occur in lumps over pressure points.

5. *Gouty Tophi:* Commonly seen on the ear lobe.

**MUSCLE WASTING**

Painful joint affection is associated with the atrophy of the adjacent muscles, and occur as a result of disease or reflex phenomenon.

**DEFORMITY**

It is applicable to central as well as appendicular skeleton:

1. *Flexion Deformity:* Of the knee or elbow, with inability to extend the limb.

2. *Instability of Joint:* It is due to the mal-alignment of the articulating bones without any
change in the relationship between the articulating surfaces, e.g. ulnar deviation of wrist, fingers; valgus or varus deformity.

3. Subluxation Deformity: It occurs due to the mal-alignment of the articulating bones associated with an altered relationship between their articulating surfaces. However, some contact between the joint surfaces is preserved.

4. Dislocation Deformity: It occurs due to the complete loss of contact between the articulating surfaces of the joint.

**CREPITUS**

It is an important sign and points to the nature of the underlying joint disease:

1. Soft Fine Crepitus: It is often a feature of rheumatoid arthritis, indicating that the articulation is no longer a smooth cartilage.

2. Coarse Crepitus: It is usually encountered in degenerative arthrosis.


**STABILITY**

Diseased joints can be moved into abnormal positions, due either to the joint surface damage or laxity of the periarticular ligaments.

**MOVEMENTS**

Measurement of the range of movement is essential, keeping in view two possibilities:

- Assessment of the progress of the disease.
- Assessment of the response to the treatment.

**TENDERNESS**

Discomfort may be produced by pressing on a joint in addition to the background discomfort. Following are the four grades of tenderness:

- Grade I: Pain only.
- Grade II: Pain and winching.
- Grade III: Winching and withdrawing.
- Grade IV: Palpation not tolerated.

**REDNESS**

Redness, which occurs as a diffuse erythema overlying the joint, is a feature of acute synovitis, associated with the crystal deposit synovitis, e.g. gout, pseudogout.

**LOCAL HEAT**

Increased warmth at the joint is a sensitive index of inflammatory joint disease.

**RASH**

- Psoriatic plaques may be seen over the joint or some other areas, especially along with the psoriatic arthropathy.
- Butterfly rash on the face is characteristic of S.L.E.
- Erythema marginatum, mainly on the trunk, is seen in rheumatic fever.

**INVESTIGATIONS FOR ARTHRITIS**

Modern investigations provide information in regard to-

- Establish the diagnosis.
- Monitor the progress of the chronic arthritis.
- Detect the complications.
- Assess the response to the treatment.

**DISEASE ACTIVITY MARKERS**

These help in the assessment of the acute phase of the disease and, to determine the response to the treatment. These include:

1. Erythrocyte Sedimentation Rate (ESR):

   It is usually estimated by the westergren method.

   **Normal values:**
   - **Males**: Less than 15 mm / first hour.
   - **Females**: Less than 20 mm / first hour.

   **Value of the test**: It monitors the activity of the inflammatory and connective tissue diseases.

2. C-Reactive Protein (CRP): This protein is so named because of its ability to bind to the C-
Polysaccharide of the cell wall of Streptococcus pneumoniae.

CRP is the most responsive of the acute phase proteins, with increased levels usually appearing 6-10 hours after injury or infection. CRP can be much greater than the other proteins (levels over 100 mg / l are frequently being found).

**Value of the test:**
- CRP is a sensitive marker of the inflammation.
- It is an useful indicator of the extent and activity in such disorders as S.L.E. and rheumatoid arthritis.
- It is also useful in differentiating bacterial from viral infections, being raised only in the former.

**AUTOANTIBODIES**

1. **Rheumatoid Factor** *(for rheumaotid arthriti)*:

   **Value of the test:**
   - Persistent high antibodies titres are associated with more severe disease.
   - Antibodies are often absent in the early disease and it is common to have low titres of a variety of autoantibodies which includes Rheumatoid Factor. Therefore only higher titres are significant. *(Titre is significant when it is more than 60 IU/ml.)*

   **Limitation of the test:**
   - A simple positive test is of little value. At times a false positive is common, therefore, it is wise not to rest the diagnosis entirely on the antibody test.
   - A false positive test occurs in S.L.E., infective hepatitis, leprosy, leukaemia, multiple myeloma.

2. **Lupus Erythematosus (LE) Cell Preparation:**

   **Value of the test:**
   - It aids in the diagnosis of S.L.E. The presence of L.E. cell is strongly suggestive of S.L.E.
   - It monitors the progress and treatment of S.L.E.

   **Limitation of the test:**
   - Many drugs cause a false positive test. Some diseases such as active hepatitis or cirrhosis may show positive LE cell preparation.

3. **Anti-Nuclear Antibodies** *(for S.L.E.):* The anti-nuclear antibodies are immunoglobulins that are produced in response to the nuclear DNA component of the leucocytes.

   **Value of the test:**
   - It monitors the effectiveness of the treatment of S.L.E.

   **Limitation of the test:**
   - False negative tests have been reported in tissue damage such as is observed in S.L.E.

4. **Anti-Deoxyribo Nucleic Acid Antibodies:**

   The anti-DNA antibodies assay detects the antibodies against the native double stranded DNA.

   **Value of the test:**
   - It strongly supports the diagnosis of S.L.E.
   - It monitors the patient’s response to the treatment.

5. **Anti-Streptolysin O Test** *(for rheumatic fever):*

   This is a serological test that measures the relative serum concentration of the antibody to Streptolysin O.

   **Value of the test:**
   - It confirms a recent or ongoing infection with beta- haemolytic streptococci.
   - It also aids in the diagnosis of rheumatic fever and post-streptococcal glomerulonephritis in the presence of clinical symptoms.

6. **HLA–B–27 Antigen Test** *(for ankylosing spondylitis):* It refers to a certain antigen group. A number of disease processes are positively associated with HLA-B–27 antigen. It is positive in ankylosing spondylitis (90%), reiter’s syndrome (85%), psoriatic arthropathy (35%).
Therefore, it aids in the diagnosis of ankylosing spondylitis, reiter’s syndrome and some cases of psoriatic arthropathy.

**SERUM URIC ACID**

Uric acid is the end product of the purine metabolism. The serum uric acid is high in cases of gout. Whenever it is more than 7 mg % the treatment is to be continued to bring the level below 4 mg %. However 5% of the population has raised serum uric acid levels, and very few of them suffer from gout, therefore, every subject suffering from joint pain with high uric acid levels may not be actually suffering from gout. One very rarely encounters a uric acid level significantly below the normal ranges.

Interfering factors include drugs causing increased levels, e.g. thiazide diuretics, which impair uric acid clearance by the kidneys. Excessive stress and fasting cause elevation in the uric acid levels.

**PLAIN RADIOGRAPHY**

It is one of the essential and useful investigations in arthritis. It provides historical record of anatomical changes, which are often disease specific.

**SYNOVIAL FLUID ANALYSIS**

Value of the test:
- It aids in the differential diagnosis of arthritis.
- It is essential in the diagnosis of gout and in the differential diagnosis of pseudogout.
- It identifies the cause of the joint effusion.
- Aspiration of the fluid relieves pain and distension.
- Previous antibiotic therapy decreases the possibility of diagnosis by the culture.

**SYNOVIAL BIOPSY**

The synovial biopsy is useful in differentiating different inflammatory arthritis.

**MAGNETIC RESONANCE IMAGING (MRI)**

*MRI is now being increasingly used in the:*
- Detection of the extent of injury to the joint cartilages, ligaments, muscles and other soft tissues.
- Evaluation of the extent of the disc herniation and spinal cord compression.
- Patients who continue to have symptoms following surgery for back pain. Post-operative scarring can be accurately distinguished from the disc herniation by obtaining the contrast enhanced images following intravenous administration of gadolinium.

**ARTHROSCOPY:**
- It is of great value in the examination of the interior of a joint, performed by inserting a specially designed endoscope through a small incision.
- It also aids in the investigation of monoarthritis of uncertain aetiology.
- This technique also permits biopsy of the cartilage or synovium; or removal of loose bodies in the joint space.

**RHEUMATOID ARTHRITIS**

Chronic inflammatory arthritis primarily affecting synovium, characterised by bilaterally symmetrical polyarthritis, various extra-articular manifestations and positive test for ‘Rheumatoid Factor’.

**CLINICAL FEATURES**

**Prodrome:**
- Fatigue.
- Malaise.

**Symptoms**
- Joint stiffness
  - More marked in morning.
  - Pain in joints.
  - Limitation of movement of joints.
ETIOLOGY
- Exact cause is not known.
- Evidence points to autoimmune etiology.
- Genetic predisposition common.
- Precipitating causes
  • Physical or emotional stress.
  • After childbirth (remission during pregnancy).
- Hormonal disturbance:
  • Puberty.
  • Menopause.
- Age: 20 - 45 years.
- Sex: Common in females.

- Fever.
- Malaise.
- Night sweat.
- Loss of grip strength.
- Weight loss.
- Joint deformities.

Signs
- Joints involved
  • Small joints.
  • Bilaterally symmetrical.
  • Joints swollen, hot, tender.
  • Limitation of movements.
- Subcutaneous rheumatoid nodules present on extensor surfaces.
- Bursitis.
- Tenosynovitis.
- Muscle wasting above and below affected joints.
- Ulnar deviation of wrist.
- Swan neck deformity of fingers.
- Boutonniere deformity of fingers.
- Z-thumb deformity.
- Tender prominent metatarsal heads with secondary corns.
- Lateral deviation and over-riding of toes with pressure sores.

Baker’s cyst:
- Herniation of synovial cavity into back of knee causing pain and tenderness of calf.

COMPLICATIONS
- Subluxation of atlanto-axial joint.
- Carpal tunnel syndrome.
- Fibrosing alveolitis.
- Sjogren’s syndrome.
- Septic arthritis.

DIAGNOSIS
Revised American College of Rheumatology criteria for classification of rheumatoid arthritis is as:
1. Morning stiffness in and around joint lasting at least for an hour before maximum improvement. Duration of at least six weeks.
2. Arthritis of three or more joint areas simultaneously of at least six weeks duration.
3. Arthritis of hand joints of at least six weeks duration.
4. Rheumatoid nodules.
5. Positive rheumatoid factor.
7. Radiographic changes typical of rheumatoid arthritis.
- Patient is said to have rheumatoid arthritis if he satisfies at least four of above seven criteria.

Disease activity markers
- Severity and duration of morning stiffness.
- Soft tissue swelling.
- Presence of subcutaneous nodules.
- Prominent systemic symptoms.
- Recent involvement of new joint.
- Degree of anaemia
- Radiological progression of bone erosion.

INVESTIGATIONS
Blood
• Hb%:
- Low.
- Degree of anaemia reflects severity of disease.
- Improves with control of disease.

• ESR: raised.
• Rheumatoid factor:
  - Positive and titre is raised.
• Synovial fluid analysis
  - Transparency: cloudy.
  - Colour: yellowish.
  - Viscosity: low.
  - Mucin clot: poor.
  - Cell count: raised.

**Synovial biopsy:**
- Shows thickening of synovial layer with infiltration of abnormal cells.

**X-Ray joint**

*Early*
- Soft tissue swelling.
- Narrowed joint space.
- Juxta-articular osteoporosis.
- Marginal bone erosion.

*Late:*
- Marked osteoporosis.
- Loss of joint space/subluxation.
- Secondary osteoarthrosis.
- Subchondral cysts.
- Marked bone destruction.
- Ankylosis.

**PROGNOSIS**
- Course variable.
- Patient manages self care and routine purposeful activity with proper treatment.

*Features of favourable prognosis are as*
- Acute onset.
- Male sex.
- Onset at later age.

- Asymmetrical and monoarticular involvement.
- Negative rheumatoid factor.
- Absence of subcutaneous nodules.
- Absence of vasculitis.
- Prompt response to therapy in early stages of the disease.

*Features of poor prognosis are as:*
- Insidious onset.
- Female sex.
- Persistent disease activity.
- Younger age of onset.
- Positive rheumatoid factor.
- Early erosive radiological changes.
- Marked systemic features.

**MIASMATIC CLEAVAGE**
- Predominantly syphilitic disorder.

**THERAPEUTIC AIM**
- To achieve remission.
- To control disease activity.
- To preserve joint function.
- To maintain muscle strength.

**GENERAL MANAGEMENT**

*During acute stage:*
- Bed rest.
- Local rest to joint with splints (to prevent deformity).

*As acute swelling subsides*
- Start physiotherapy (to avoid contractures).
- Local infra-red radiation or short wave diathermy (for relaxation of muscles and relief of pain).
- Occupational therapy.
- Let patient carry out various activities of daily life independently.
- Well balanced, high protein, easily digestible diet.
MEDICAL TREATMENT

Intercurrent:
- Thuja (Altered immune reaction).
- Rhododendron (Rheumatism in hot weather).
- Medorrhinum (Sunrise to sunset).
- Syphilinum (Sunset to sunrise).

Constitutional, symptomatic:
- Actaea spicata (Small joints involved).
- Bryonia (< slight movement, > rest).
- Caulophyllum (H/o habitual abortion).
- Causticum (Contractures).
- Dulcamara (< cold, dampness).
- Natrium sulphuricum (< cold, dampness).
- Pulsatilla (Complaints at puberty).
- Radium bromatum (Secondary degeneration).
- Rhus toxicodendron < fist movement).
- Sepia (Complaints at menopause).
- X-Ray (Aroused reactive vitality).

Palliative:
- Chininum sulphuricum.
- Formicum acidum.
- Formica rufa.
- Gaultheria.
- Guaicum.
- Thiosinaminum.

Preventive:
- Alfalfa:
  Helps in achieving the remission.
- Q 1 drop per 2 Kg body weight in divided doses.

Note:
Reference to CCRH annual report 2001-2002 related to the clinical research in:
- Drug related clinical research in arthritis (not specified the particular type of arthritis):
  Following medicines were evaluated for the efficacy and found effective in giving symptomatic relief in arthritis. However no particular potency has been mentioned:

- Actea spicata.
- Angustura vera.
- Radium bromatum.
- Caulophyllum.
- Formica rufa.
- Magnolia grandiflora
- Stellaria media

Intercurrent medicines found effective
- Medorrhinum.

SJÖGREN’S SYNDROME
(Keratoconjunctivitis Sicca)

This condition is characterised by lymphocytic infiltration of salivary and lachrymal glands resulting in salivary gland enlargement, dry mouth and dry eyes.

CLINICAL FEATURES

Symptoms
- Onset insidious.
- Gradual dryness of mouth, eyes, nose, throat.

ETIOLOGY
- Exact cause is not known.
- Evidence points towards autoimmune etiology.
- Strong association with HLA-B8 DR3.
  - Primary (sicca syndrome)
    - Idiopathic.
  - Secondary
    Associated with:
    - Rheumatoid arthritis.
    - S.L.E.
    - Scleroderma.
    - Dermatomyositis.
    - Myasthenia gravis.
    - Thyroiditis.
  - Age: Onset between 40-60 years.
  - Sex: Common in females.
**Signs**
- Dryness of mucous membrane of mouth (xerostomia).
- Dryness of conjunctiva (keratoconjunctivitis sicca).
- Gradual enlargement of salivary glands.
- Anaemia.
- Spleen may be enlarged.
- Lymph nodes may be enlarged.

**INVESTIGATIONS**

*Blood*
- ESR: raised.
- Rheumatoid factor: May be positive.

*ANA*
- May be positive.

*Antibody against SS-A and SS-B*
- Raised.

**PROGNOSIS**
- Variable.

**MIASOMATIC CLEAVAGE**
- Predominant sycotic disorder.

**THERAPEUTIC AIM**
- To treat symptomatically.

**GENERAL MANAGEMENT**
- No specific treatment.
- Artificial tear drops may be used.

**MEDICAL TREATMENT**

General dryness of mucous membranes:
- Alumina.
- Bryonia.

**JUVENILE RHEUMATOID ARTHRITIS (Still’s Disease)**

Inflammatory arthritis, characterised by fever, rash, hepato-splenomegaly and arthritis in children.

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**ETIOLOGY**
- Exact cause is not known.
- Evidence points to autoimmune etiology.
- Associated with physical or emotional stress.
- Age: Under 6 years of age.
- Sex: Common in girls.

**CLINICAL FEATURES**

**Symptoms**
- Onset: acute or insidious.
- Fever.
- Swelling, pain in joints.
- Stiffness of joints.
- Child refuses to walk without being able to explain why.
- Poor appetite.
- Loss of weight.
- Irritability.
- Listlessness.

**Signs**
- Fever: remittent (39°C).
- Rash on trunk, limbs as patches of erythema.
- Generalised lymph node enlargement.
- Hepatomegaly.
- Splenomegaly.
- Affected joints swollen, hot, tender.
- Effusion of joint.
- Limitation of joint movement.

**Rarely**
- Iritis.
- Pericarditis.

**INVESTIGATIONS**

*Blood*
- Hb%: low.
- TLC: 20,000-50,000 / cu. mm.
- DLC: increased polymorphs.
- ESR: raised.
- Rheumatoid factor: positive (15%).
- ANA: Positive (25%).
Principles and Practice of Medicine

X-Ray joint:
- Soft tissue swelling.
- Loss of joint space.
- Irregularity of joint surfaces.
- Periosteal new bone formation.
- Growth disturbance.

PROGNOSIS
- Attacks last a few weeks.
- Occur off and on throughout childhood.
- Disease is in complete remission by puberty.

ETIOLOGY
- Exact cause is not known.
- Evidence points to autoimmune etiology.
- Family history positive in many.
- Age: 15 - 30 years.
- Sex: Common in males.

X-Ray joint:
- Soft tissue swelling.
- Loss of joint space.
- Irregularity of joint surfaces.
- Periosteal new bone formation.
- Growth disturbance.

PROGNOSIS
- Attacks last a few weeks.
- Occur off and on throughout childhood.
- Disease is in complete remission by puberty.

MIASMATIC CLEAVAGE
- Predominant sycotic disorder.

THERAPEUTIC AIM
- Treat symptomatically.
- To prevent complications.
- To achieve remission.
- Consolidate remission.
- Maintain remission state.

GENERAL MANAGEMENT
- Reassurance.
- Emotional support.
- Encourage child and family to maintain positive outlook.
- Rest during acute stage.
- Controlled activity to maintain general mobility.
- Confine child to bed with systemic manifestations.
- Bed should be firm.
- Provide a low pillow.
- Splinting of joint.
- Gentle passive joint movements many times during day.
- Corrective support to deformity.

MEDICAL TREATMENT

Intercurrent
- Thuja.

Symptomatic
- Medorrhinum.
- Tuberculinum.
- Calcarea carbonica.

Palliative
- Chininum sulphuricum.
- Formic acid.
- Formica rufa.
- Gaultheria.
- Guaiacum.

Preventive
- Alfalfa.

ANKYLOSING SPONDYLITIS
Chronic inflammatory arthritis affecting axial skeleton, characterised by ankylosis of sacro-iliac and intervertebral joints, and ossification of spinal and paraspinal ligaments.

CLINICAL FEATURES

Prodrome:
- Malaise.

ETIOLOGY
- Cause
  - Exact cause is not known.
  - Evidence points to autoimmune etiology.
- Family history positive in many.
- Age: 15 - 30 years.
- Sex: Common in males.
- Tiredness.
- Anorexia.

**Symptoms**
- Onset: Insidious.
- Pain in back, buttocks.
- Morning stiffness, better with activity.
- Gradual involvement of
  - Whole vertebral column.
  - Hips.
  - Costo-chondral joints.
  - Rarely shoulder joints.
- Weight loss.
- Fatigue.
- No movement possible (late).

**Signs**
- Tenderness at sacro-iliac joint.
- Cervical, thoracic spine become tender.
- Restricted movements.
- Patient cannot erect spine.
- Sits, walks with flexed spine.
- Lumbar lordosis disappears.
- Chest expansion diminished.
- Complete rigidity of spine and involved joints.
- Kyphosis.
- Lately sacro-iliac tenderness is absent (bony ankylosis).

**COMPLICATIONS**
- Atlanto-axial subluxation.
- Aortic incompetence (calcification of valve).
- Recurrent chest infection.

**INVESTIGATIONS**

**Blood**
- Hb%: low.
- ESR: raised.
- HLA-B-27: positive.
- CRP: raised
- Rheumatoid factor: negative.
- ANA: negative.

**X-Ray sacro-iliac joints**

*Early*
- Sacroiliacs
  - Narrowing of joint space.
  - Haziness of joint margins.
- Marginal erosions.
- Marginal sclerosis.

*Late:*
- Ankylosis
  - New bone formation.
  - Bridging of joint cavity.

**X-Ray vertebral column**
- Ossification of spinal, paraspinal ligaments.
- Squaring of vertebrae.
- Ossification of intervertebral discs.
- Syndesmophyte formation.
- Bamboo spine (fusion of entire vertebral column).

**PROGNOSIS**
- Well managed patients lead a full, purposeful life span.

**MIASMATIC CLEAVAGE**
- Predominant sycotic disorder.

**THERAPEUTIC AIM**
- To achieve remission.
- To control disease activity.
- To preserve joint function.
- To maintain muscle strength.

**GENERAL MANAGEMENT**
- Before ankylosis takes place
  - Provide straight back chair for sitting.
  - Firm bed with one pillow at night.
- Encourage swimming.
- Extension exercises.
- Encourage lying in prone position (idea is that even if spine gets fixed it should be in straight posture).
- Stop smoking.
ETIOLOGY
- Exact cause is not known.
- Family history of
  • Psoriasis.
  • Ankylosing spondylitis.
- History of:
  • Sexually acquired non-specific urethritis by chlamydia trachomatis proceeds about 4 weeks.
  • Enteric infection by Shigella flexneri, Yersinia enterocolitica or Salmonella, occurring up to 10-30 days.
- Age: 18-35 years.
- Sex: Common in males.

- Low grade fever.
- Malaise.
- Anorexia.
- Loss of weight.

Signs
- Joints affected:
  - Knee, ankle, shoulder, elbow, wrist.
  - Joints swollen, hot, tender.
  - Achilles tenosynovitis.
  - Keratoderma blenorrhagica.
  - Hyperkeratotic lesions resembling pustular psoriasis.

Circinate balanitis
- Painless superficial coalescing ulcers around glans penis.

INVESTIGATIONS

Blood
- TLC: leucocytosis.
- ESR: raised.
- HLA-B-27: positive in 80% cases.
- Rheumatoid factor: negative.

X-Ray joint
- Juxta-articular osteoporosis.
- Narrowing of joint spaces.
- Marginal erosions; metatarso-phalangeal joints, asymmetrical.
- Calcaneal erosion at insertion of achilles tendon.

**COURSE AND PROGNOSIS**
- Most patients recover within 4 months.
- Some patients have chronic course, with remissions and relapses.
- Remission may last for years.

**MIASMATIC CLEAVAGE**
- Predominantly sycotic disorder.

**THERAPEUTIC AIM**
- Treat symptomatically.
- To achieve remission.
- To prevent complications.

**GENERAL MANAGEMENT**
- Rest in early stages, during acute exacerbations.
- Affected joints may be provided splintage.
- As acute stage is over
- Initiate physiotherapy (to prevent flexion contractures).

**MEDICAL TREATMENT**
- Apis.
- Mercurius solubilis.
- Natrium arsenicosum (Marked dermatological lesions).
- Sulphur.
- Thuja.
- X-Ray.

**PSORIATIC ARTHROPATHY**
Arthropathy associated with psoriasis.

**CLINICAL FEATURES**

**Symptoms**
- Psoriasis may precede arthritis for years.
- Psoriatic nail changes

**ETIOLOGY**
- Exact cause is not known.
- About 5% cases of psoriasis develop arthritis.
- Heredity, family history: positive in 30%.
- Age: young adults.
- Exceptionally profound in patients who develop arthritic manifestations.
- There is no correlation between activity of psoriasis and activity of arthritis.
- Joints swollen, painful.
- Morning stiffness.

**Signs**
- Joints involved:
  - Small joints of hands, feet, wrists, ankles, knees, elbows.
- Skin and nail changes typical of psoriasis:
  - Scaly lesions over extensor surface.
  - Nails show:
    - Pitting.
    - Onycholysis.
    - Subungual hyperkeratosis.
    - Horizontal ridging.
- Joints swollen, red, hot, tender.
- Restricted joint movements.
- Joint deformities.

**INVESTIGATIONS**

**Blood**
- Hb%: normal, if disease is mild and limited.
- ESR: raised.
- HLA-B-27: positive in 15%.
- Rheumatoid factor: negative.
- ANA: negative.
- Uric acid: raised.

**X-Ray joint:**
- Marginal erosions.
- Osteolytic bone destruction.
DEGENERATIVE ARTHROSIS

[Osteoarthrosis]

Non-inflammatory degenerative disorder of synovial joints, and characterised by wear and tear of articular surfaces and new bone formation at joint margins.

**ETIOLOGY**
- Primary: Idiopathic.
- Secondary:
  - Mal-alignment of joints.
  - Valgus deformities.
  - Congenital dislocation of hip joint.
  - Perthe’s disease.
  - Osteochondral fractures.
  - Torn menisci.
  - Damaged articular cartilage from
    - Pyogenic arthritis.
    - Rheumatoid arthritis.
    - Haemophilia.
    - Neuropathic arthritis.
    - Diabetes mellitus.
    - Acromegaly.
    - Hypothyroidism.
    - Gout.
  - Obesity.
  - Senility.
  - Occupation involving repetitive strain.
  - Age
- Primary:
  - After 55 years.
- Secondary:
  - Before 55 years.

**CLINICAL FEATURES**

**Osteoarthrosis knee joint**

**Symptoms**
- Onset: insidious.
- Pain in joint
• Deep, boring.
• Worse after long walk or exercise.
• Better from rest, local warmth.
- Morning stiffness
  • Lasts for 5-15 minutes.
  • Better by walking.
- Restricted joint movements.
- Swelling around affected joint.
- Marked immobility (late).
- Deformity (late).

**Signs**
- Early
  - Joints commonly affected:
    • Knee and hip joint.
    • Distal and proximal interphalangeal joints.
  - Variable tenderness at joint margins.
  - Palpable fine joint crepitus.
  - Slight thickening of joints
    More marked at margins (caused by marginal osteophytes)
    • Distal interphalangeal joints show heberden’s nodes.
    • Proximal interphalangeal joints show bouchard’s nodes.
  - Mild effusion, no local heat.
  - Restricted joint movements.
- Late
  - Muscle wasting of muscles.
  - Deformity.
  - Palpable coarse joint crepitus.
  - Loose bodies in joint.

**INVESTIGATIONS**

**Synovial fluid analysis**
- Transparency: turbid.
- Fibrin clot: small.
- Mucin clot: good.
- Crystals: nil.
- WBC: less than 200 / cu. mm.
- Polymorphs: less than 25.

**X-Ray joint**

*Early*
- Subchondral sclerosis.
- Narrowed joint space.
- Subchondral cysts.
- Irregularity of joint margins.
- Osteophyte formation.

*Late:*
- Marked osteophytes.
- Joint destruction.
- Deformity.

**CERVICAL SPONDYLOSIS**

Degenerative arthrosis of cervical spine affecting intervertebral discs and posterior intervertebral joints, and characterised by pain and stiffness in neck with referred sensory-motor symptoms in upper limbs.

**CLINICAL FEATURES**

**Symptoms**
- Onset insidious.
  - Pain:
  - Location:
    • In occipito-cervical region.
  - Radiation
    • To shoulder.
    • May reach fingers.
  - Character
    • Aching.

**ETIOLOGY**

Age: Elderly subject.
Predisposing causes:
- Faulty posture.
- Trauma.
- Wear and tear due to
  • Osteoarthritis.
  • Carrying weight.
• Stiffness.
  - Worse
    • In morning.
    • While coughing.
    • Sneezing.
• Restricted neck movements during acute exacerbation.
• Paraesthesia or tingling sensation in hands.
• Vertigo, giddiness”
  - Precipitated on turning head.
- Muscular weakness in hands (late).

**Signs**
- Mild tenderness in posterior neck muscles.
- Restricted neck movements (due to spasm and rigidity of cervical muscles).
- Crepitations audible on neck movement.
- Sensory-motor changes
  • Paraesthesia in involved dermatomal distribution of nerve root (in upper limb).
  • Muscle wasting in upper limbs (late).

**COMPLICATION**

*Cervical compressive myelopathy:*
- Paraplegia.
- DTR’s: exaggerated in lower limbs.
- Plantar response: extensor.

**INVESTIGATIONS**

*X-Ray features of cervical spine*

*Early:*
- Narrowed intervertebral disc space.
- Loss of normal lordosis.
- Osteophyte formation.

*Late*
- Loss of intervertebral disc space.
- Encroachment of osteophytes into intervertebral foramen.

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**LUMBAR SPONDYLOSIS**

Degenerative arthrosis of lumbar spine, characterised by pain and stiffness of back and lower limbs.

**ETIOLOGY**
- Same as cervical spondylosis.

**CLINICAL FEATURES**

**Symptoms**
- Onset: insidious.
- Pain:
  - Location
    • Lumbar region
  - Radiation
    • To lower limbs.
  - Character
    • Aching.
    • Stiffness.
  - Worse from
    • Movement.
  - Better by
    • Rest.
- Acute exacerbation of pain
  - Occurs due to lumbar strain.
  - Onset sudden.
  - Persists for some weeks.
- Pain, paraesthesia in lower limb (late feature due to nerve root compression in intervertebral foramen).
- Muscular weakness in lower limbs (late).

**Signs**

*Early:*
- Mild tenderness of lumbar region.
- Restricted lumbar movements.
- Forward bending is more painful.
- During acute exacerbation
  • Restricted all spinal movements.
  • Marked muscle spasm.
- Straight leg raising test: positive.
Late
- Sensory–motor disturbances
  • In dermatomal distribution of compressed nerve root.
- Straight leg raising test:
  • Positive on affected side.
- DTR’s: diminished in lower limbs.
- Plantar response: may be abolished.
- Muscle wasting.

COMPLICATION
- Prolapse lumbar intervertebral disc.

INVESTIGATIONS
X-Ray features of lumbar spine
- Same as cervical spondylosis.

PROGNOSIS
- Variable.

MIASMATIC CLEAVAGE
- Mixed miasmatic disorder.

THERAPEUTIC AIM
- To correct modifiable causes.
- To control disease progress.
- To preserve joint function.
- To maintain muscle strength.

GENERAL MANAGEMENT
- Active exercises.
  • Regular exercise helps to reduce pain.
  • Walking and swimming every day for 5 – 10 minutes, or which one enjoys is good.
  • Too much exercise that stresses the knee, hip or other joints – leads to osteoarthrosis.
  • Wear shoes that fit well, well cushioned soles reduce stress on weight bearing joints.
  • If there is extra pain it points to over exertion, it needs to cut down.
- Avoid strenuous activity.
- Avoid prolonged joint stress.

- Maintain correct posture at work.
- Avoid undue trauma to joint.
- Reduce weight, if obese.
- Diet: take in plenty; whole grain cereals, fresh fruit and vegetables.
- Avoid; Highly refined foods, saturated fats, salt and sugar.
- Rest to joint in acute inflammation.
- Rest in position of least discomfort:
  • Often flat on back on firm surface or on sides with knees bent up.
- Local treatment
  • Heat: to relieve pain and stiffness.
  • Cold: for acutely inflamed joint.
  • Ultrasound.
  • Short wave diathermy.
- Physiotherapy for joint mobility and muscle strength.
- Supportive aids
  • Walking stick.
  • Cervical collar.
  • Lumbar corset.
- Manipulative therapy:
  • Traction and mobilisation.
- Surgical intervention (late stages).

MEDICAL TREATMENT
Intercurrent
- O.A. Nosode.
- Thuja.
- Rhododendron.
- Medorrhinum.
- Syphilinum.

Constitutional
- Calcarea carbonica.
- Capsicum.
- Conium.
- Lycopodium.
- Nux vomica.