Homoeopathy, Pathology and Outcomes Based Methodology, ensuring Clinical Excellence & improved Communication

Dr Myron Schultz : HSA Congress 2007

INTRODUCTION

Who am I?

Roses are red, violets are blue.

I am schizophrenic, and so am I.
INTRODUCTION

What this presentation is about?
- Survival → mediocrity → excellence.
- Forward based thinking vs. outcome based thinking (a decision).
- OBM & EBM.
- Merging traditional & newer concepts in patient management.
- Sensitization.
- True Holism.

Why is the presentation Necessary?
- Improving communication and clinical skill.
- Helping homoeopathy achieving its rightful place.

How am I going to go about this?
- Discussion on basic concepts, philosophically initially and then practical application.
- Literal examples used to demonstrate the merging of old & new thinking.
I USED EVERY SPARE MOMENT

Our three states of existence.

- Physiology
- Physiopathology
- Anatomical pathology

- Our three hierarchical goals.
- The ‘Hidden’ diseases.
  - Lets consider a common example, Hypertension.

IS THE VITAL FORCE MAINTAINING PHYSIOLOGY?
Damage to afferent arterioles in the kidney

Long-standing High blood pressure

Hyaline or hyperplastic arteriolosclerosis

Decreased blood supplied to the juxtaglomerular apparatus

Peripheral vasoconstriction sodium retention

Triggering off the Renin-angiotensin-aldosterone system

High blood pressure aggravated

Normal kidney, juxtalgomerular apparatus, high power microscopic
Normal kidney, high power microscopic

Nodular glomerulosclerosis and hyaline arteriolosclerosis, microscopic, PAS stain
Hyperplastic arteriolitis with hypertension, microscopic

- So to summate this phenomenon…
  - Physiopathology
  - Physiology
  - Organic change / anatomical pathology
  - Disease process becomes permanent
  - Further perpetuates and aggravates original pathology
  - Contributing to the degenerative process
PHYSIOLOGY-PHYSIOPATHOLOGY-
ANATOMICAL PATHOLOGY

• Ageing & disease;
  • The fine line rate and degree.
  • ‘Sensitization’ allowing us to prevent future morbidity.
  • E.g. Atherosclerosis.

THE HIDDEN DISEASES

• Ageing...lipid deposition...atherosclerosis
BEFORE WE GO ANY FURTHER

HAIR

I don't want to be a HAIR
I want to be a DRAGON!
SHUT UP!!!
Ok I'll be a hair

BEFORE WE GO ANY FURTHER

EACH DISEASE HAS AN EVOLUTION

The disease-patient relationship.

THE EVOLUTION OF A DISEASE

The pathogenesis: The evolution of the disease through space and time

Onset of disease:

Risk factors
Past medical Hx
Concomitant pathology
Ethnicity & Religion
Past Lifestyle
Current Lifestyle

Family Hx / Genetics

Specific etiology
Susceptible patients

Complications

End

Sx / Sg
Sx / Sg
Sx / Sg
Sx / Sg
Sx / Sg
Sx / Sg
WHERE DOES THE THEORY FIT IN?

1. Case History
   - Vital force functioning normally

2. Analysis of information
   - Achieved desired outcome

3. Physical Examination
   - Work-up patient
   - Understanding the patient in space and time

4. Analysis of information
   - Work-up patient
   - Identifying obstacles to healing that require removing
   - Analyzing how to re-establish equilibrium in the Vital Force

5. Work-up patient
   - Deciding on the appropriate outcome/s for the patient

6. Analysis of information
   - Work-up patient
   - Identifying obstacles to healing that require removing
   - Analyzing how to re-establish equilibrium in the Vital Force

7. Management plan
   - Deciding on the appropriate outcome/s for the patient

8. No
   - Re-evaluation to assess whether our methodology is moving the patient in the right direction

9. Yes
   - Achieved desired outcome

10. No
   - Patient health returned

CONTEXTUALIZING THE PATIENT

- Visualizing your patient in time and space.

- PAST
  - Family history
  - Past medical and surgical history
  - Significant events
  - Past and current lifestyle
  - Family upbringing
  - Past and current drug history

- PRESENT
  - Ability to adapt
  - Weight / BMI
  - Level of stress
  - Any current disease
  - Energy
  - Spirituality
  - Current state of vital force

- FUTURE
  - Future health
CONTEXTUALIZING THE PATIENT

The ‘Present’, a wave of change...

Effect of the Past

Present

Past -- Future

Direction of Wave

The ‘Now’ defined holistically

Past -- Current state -- Future

Our ‘Current Health’ --> the ‘Now’
WORKING UP THE PATIENT

Why?: Extra effort to understanding the patient in time & space.

How?: Ask the right questions.
  – Acute / Chronic.
  – Primary / Secondary.

DEFINING THE OUTCOME/S

May be achieved after ‘contextualizing’ the patient.

Do not confuse this with the ‘natural history’.

May have multiple outcomes.

A dynamic process.
MANAGING THE PATIENT: ‘POA’

- Managing a patient does not equate to treating a patient.
- Evidence-base

Managing a Patient

- Deciding on the appropriate outcome for the patient
- Predicting the possible outcome/s of the patient's current status
- Seeing the patient in time & space
- Being sensitized enough to detect pathology before it becomes permanent
- Remove obstacles to healing
- Continually revising the patient's status until the full functioning of the vital force is achieved
- Educate and guide the patient to ensure compliance
- Apply the necessary treatment regimes

- Continual re-evaluation (dynamic)

MANY HOURS CONTEMPLATING

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OTHER FACTORS TO CONSIDER

- Simple primary diseases with favourable outcomes.
- Acute exacerbation of chronic pathology.
- The pattern of illness within a patient.
- Risk factors.
- Co-morbid pathology.
- Terrain / constitution.
- Miasma / Hereditary traits.
- Clinical intuition

CLINICAL GEMS

- Presented in themes.
Holistically, what do you regard as the NOW?

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DISEASE PATTERNS: The Common Cold

- Two-year-old Indian female
- Recurrent pathology
- Primary and secondary disease
- Normal Hb, normal Fe?

E.G. Recurrent URTI's

- Patient presents with
  - FBC with ESR.
  - Fe studies.
  - IgG, IgM, IgA.
  - IgE/Phiadiotop.
ANOTHER LOOK AT PATHOLOGY

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JUST BECAUSE A PATIENT FEELS WELL, DOES NOT MEAN THAT THEY ARE!

• Age-related diseases.
  - Fhx: Hypercholesterolemia & Hypertension
  - Afrikaans
  - Physically active
  - Conscientious about diet
  - Past Shx and Mhx: Nil
  - Drug Hx: Nil

Patient comes to see you for a general check-up

Intimal damage to the endothelium of coronary arteries

Lipo (a), (A) & B, hs-CRP and homocysteine

Lipogram: Increased total cholesterol & LDL

Generally feels & appears well

Managing this patient.

When to re-evaluate.

Predicting the future.
• Managing this patient.
• Insulin resistance & Cushing’s.
• Primary and secondary diseases.

JUST BECAUSE THERE ARE NO SYMPTOM’S AND SIGN’S DOES NOT MEAN THERE IS NO DISEASE PROCESS!

Patient visits you complaining of poor concentration
During physical exam you identify patient is over-weight
Difficulty losing weight

Consider analyzing the vertical & horizontal axis
Increased TSH
- Fast Insulin
- TSH
- Cortisol

Three pathologies I like to rule out
AI disease
Chronic inflammation
Hypothyroidism
Hashimoto thyroiditis

- Increased TSH
- Normal T4 & T3
- Raised microsomal & thyroglobulin Ab’s

TFT + autoantibodies

JUST BECAUSE LABORATORY TESTS ARE NEGATIVE DOES NOT MEAN THE PATIENT DOES NOT HAVE THE DISEASE!

Patient presents with symmetrical joint pain & morning stiffness > 1 hour
Other factors pointing towards RA are noted
- RF negative!
- Autoimmune profile negative!

Consider anti-CCP

- ?Seronegative RA or another pathogenesis
Autoimmunity confirmed

• Managing this patient.
• Why is it important to identify if the pathogenesis is autoimmune?
87-year-old patient complains of insomnia

Case hx & physical exam: NAD

Presenting complaint appears to be a primary pathology

Considering the patient's age, there are certain age-related questions

Request all previous lab tests

In conjunction with the LFT, the protein electrophoresis demonstrates: immune paresis & monoclonal gammopathy

Request Ig profile & urine study for Bence Jones proteins

- U-protein = incr i.e. urine contains monoclonal free kappa band: Bence Jones proteins

Urine protein profile displays

- Lipogram
- PSA
- Fbc

- Decr IgG
- Incr IgM
- Decr IgA

Multiple myeloma

• Viewing results serially.
• How do we manage this patient?
• What do we monitor?
• Geriatrics often do not ‘react’.
More of how I think

• Managing this patient.
• Serial analysis of lab results. E.G. LFT, U&E etc.

EVEN THOUGH LAB RESULTS FALL WITHIN NORMAL PARAMETERS, THEY MAY STILL HAVE PREDICTIVE VALUE!

55-year-old male presents with hesitancy, intermittent interruption of urinary flow & incr urinary freq

No previous results indicate any of the values above the upper border (4.0ug/ml)

But when viewing these results serially

There is an upward trend

Draw all previous lab tests to review prostatic antigen

May be indicative of an abnormality

? Prostatism
A CASE OF WEAKNESS: DON’T FALL FOR THE TRAP!

Patient complains of weakness

Recent decr Hb

Call lab and 'add-on' FE studies

Draw all previous lab's

- Decr S-FE
- Ferritin close to lower border

Anaemia + FE deficiency ???

Anaemia + FE deficiency ???

Consider what may cause anaemia

Workup the patient

Initial studies to consider

Initial studies to consider

Workup the patient

Acute/Chronic Primary/Secondary

? Cannot answer these questions

- FBC with ESR.
- Glucose fasting.
- LFT and U&E.
- Calcium & phosphate.

Initial studies to consider

Initial studies to consider

Workup the patient

Patient complains of weakness

Recent decr Hb

Call lab and 'add-on' FE studies

Draw all previous lab's

- Decr S-FE
- Ferritin close to lower border

Anaemia + FE deficiency ???

Consider what may cause anaemia

Blood loss

Not making enough blood

Breaking RBC's

Options for Treatment considered

Gastroscopy & endoscopy

Gastroscopy & endoscopy

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Gastric ca

Chronic blood loss has caused the initial anaemia

Consider common causes of decreased FE?

Is this anaemia of iron deficiency?

Chronic blood loss also caused FE deficiency

FE deficiency will have an impact on the manufacture of RBC's

Now chronic blood loss & FE deficiency both contribute to the anaemia

• Managing this patient.
• Treating the entire patient.
• Watching out for future health.
THE GOLDEN RULES : GENERAL PATHOLOGY PRINCIPLES

• The body will always strive to survive, but in the process may eventually contribute to the pathogenesis.

• Chronic inflammation results in fibrosis.

• A fluid that does not move → infection / fibrosis.

• Anaemia is not a diagnosis, and thus not cured by FE supplementation.

• All diseases are secondary until otherwise proven.

• The ‘text book’ is something we must not expect to see.

THE GOLDEN RULES : GENERAL PATHOLOGY PRINCIPLES

• High cell turnover leads to mistakes → dysplasia.

• When the liver suffers, so does the kidney (hepatorenal syndrome).

• What concerns a patient most, might not be the biggest concern.

• Don’t see what you want to see, babble babble, are there results?
THE GOLDEN RULES: GENERAL PATHOLOGY PRINCIPLES

• Paediatrics and geriatrics say nothing.
• Obesity is not ok.
• Look to identify ‘normal’.
• When in doubt, remember the patient is your priority, and ask for help.

STRESS: HAVE I ACHIEVED MY GOAL?
CONCLUSION

- Improving communication by comparing apples with apples.
- Standard methods of assessment and understanding of the pathogenesis.
- Conducting credible research.
- Pushing the boundaries of homoeopathy.

OUR VISION

Homoeopathy leading in Health & Wellness
Thank you for your time

REFERENCES

- Iron Deficiency & decreased immunity.
  - Iron and infection.