# Homoeopathic Constitutional Medicine in Benign hypertrophy of prostate

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**Introduction**

*"If I did not know for what purpose I was put here on earth -to become better myself as far as possible and to make better everything around me, that is within my power to improve- I should have to consider myself as lacking very much in worldly prudence to make known for the common good, even before my death, an art which I alone possess, and which it is within my power to make as profitable as possible by simply keeping it secret."* ***Dr. Samuel Hahnemann***

The Organon and The theory of Chronic Diseases are two books by Hahnemann which reveal new thoughts and inspiration every time one gives a reading to them.

The theory of "The Chronic Diseases" – throws a light on the burning zeal in the heart of Dr Samuel Hahnemann for the alleviation of Human suffering. Hahnemann was a great servant, inquirer and discoverer; he was as true a man, without falsity, candid and open as a child, and inspired with pure benevolence and with a holy zeal for science.

Hahnemann himself observed that homoeopathic medicines were successfully curing his patients' ailments, but that after a period of time some patients returned with similar but stronger symptoms, and he realized that the disease was actually progressing. This led him to think that the Homoeopathic physician with such a chronic (non-venereal) case has not only to combat the disease presented before his eyes, but that he has always to encounter only some separate fragment of a more deep-seated original disease. This lead to the discovery of Chronic Miasms as the cause of chronic diseases.

The true natural chronic diseases are those that arise from a chronic miasm, which when left to themselves, and unchecked by the employment of those remedies that are specific for them, always go on increasing and growing worse, notwithstanding the best mental and corporeal regimen, and torment the patient to the end of his life with ever aggravated sufferings. The most robust constitution, the best regulated mode of living and the most vigorous energy of the vital force are insufficient for their eradication.

Hahnemann says "In Europe and also on the other continents so far as it is known, according to all investigations, only three chronic miasms are found, the diseases caused by which manifest themselves through local symptoms, and from which most, if not all, the chronic diseases originate; namely, first, syphilis, which I have also called the *venereal chancre disease*; then sycosis, or the *fig-wart disease*, and finally the chronic disease which lies at the foundation of the eruption of itch; *i. e.*, the psora."

This triune of the subversive forces (chronic miasmata), are the vicarious embodiment of the internal disease, each having its own peculiar type or character by which its sole purpose and effort is to conform the organism to its nature. Each of these forces becomes a creative force, and at no time is the life force able to free itself the bond of any of them (either alone or in combination with the others), without some assistance.

The introduction of these subversive forces into the organism (which has undergone a process of adaptation capable of receiving them) is followed by an endless history of subversive changes and diseased phenomena peculiar to each type. They have its primary, secondary and tertiary stages, and world of phenomena peculiar to itself accompanying each stage or setting of the disease.

We can summarize the different stigmata, remembering that we may get all shadings of all the stigmata in their groupings in our patient, but one stigma will predominate above all the others. They all have their characteristic differences. The accentuation of psora is functional; the accentuation of the syphilitic taint is ulcerative; the accentuation of sycosis is infiltration and deposits. When suppressed, the syphilitic stigma spends itself on the meninges of the brain, and affects the larynx and throat in general, the eyes, the bones and

the periosteum. Psora spends its action very largely upon the nervous system and the nerve centres, producing functional disturbances, which are better by surface manifestations. Sycosis attacks the internal organs, especially the pelvic and sexual organs. In this stigma we find the worst forms of inflammation, infiltration of the tissues causing abscesses, hypertrophies, cystic degeneration; when thrown back into the system by suppression this stigma causes dishonesty, moral degeneracy and mania.

Benign prostatic hypertrophy (BPH) is a benign tumor that originates from periurethral prostatic tissue. So, it should be due to underlying sycotic miasm. In BPH, the normal elements of the prostate gland grow in size and number. The important symptoms of benign prostatic hypertrophy (BPH) - progressive urinary frequency, urgency, and nocturia are due to incomplete emptying and rapid refilling of the bladder.

Benign prostatic hypertrophy (BPH) is rare before the age of forty. After the age of fifty, approximately 50 percent of males manifest typical symptoms and lesions histologically, and after the age of eighty, 75 percent of males are so affected. Based on autopsy studies, the prevalence of histologically diagnosed BPH increases from 8% in men aged 31 to 40 year to 40 to 50% in men aged 51 to 60 year and > 80% in men older than 80 year. Based on clinical criteria in men aged 55 to 74 year without prostate cancer, the prevalence of BPH is 19% using the criteria of a prostate volume > 30 mL and a high International Prostate Symptom score.

Modern Medicine, through Medical textbooks, has taken pains to name various clinical conditions (syndromes) and infections in an attempt to create some order in the chaotic world of disease expression. In spite of this detailing of symptom presentation for a diagnosis of disease, these authors (all well-read and experienced MD's) would be the first to admit it is often difficult to get a grasp of a clear diagnosis when a patient presents clinically. When diagnosis becomes the only basis for treatment (as in Modern Medicine), one is lulled into a false sense of complacency that after making a diagnosis, one has the answer to treating disease! A truly sincere MD will confess that more often than not in the clinical situation, they have NO IDEA what (disease) they are dealing with, much less being able to cure it!

The scope of Homeopathy primarily relates to the dynamic pathology of diseases and not the organic pathology. Primarily Homeopathy has nothing to do with any product of disease, although secondarily it is related to all of them. The morbid processes from which the gross pathological tissue changes or organic lesions arise or to which they lead are amenable to Homeopathic medication. Homoeopathy is the best therapeutic method which can avoid many dangerous surgeries, injections and hormone therapies.
As is obvious, any patient must be treated on its individuality and not on the disease symptoms. BPH is a condition, which may mislead any physician due to dominance of disease symptoms taking priority in the hands of patient. He is so disturbed, so embarrassed that he will sometimes not give importance to his particular, uncommon peculiar and constitutional symptoms. It is prudent for a physician to take some symptoms for relief of the patient as palliative measure but if he wants to give him permanent or long lasting relief, a proper prescription on the basis of miasm, constitution, individuality, general and particular symptoms is important.

My topic of study is ”Clinical study on the predominance of sycotic background in benign prostatic hypertrophy and the efficacy of homoeopathic constitutional medicine in the management of benign prostatic hypertrophy.” In my observation I found that as a student of Homoeopathic system of medicine, Homoeopathic Medicines especially anti sycotic medicine shows a considerable control upon the growths, and therefore I presume that it can play a vital role in the successful treatment of benign prostatic hypertrophy. Hence further investigations and studies will be useful in this regard.

**Aims and Objectives: -**

1) To study the predominance of sycotic miasm in benign prostatic hypertrophy.

2) To study the efficacy of homoeopathic constitutional medicine in the management of benign prostatic hypertrophy.

**Review of literature**

Prostate
Embryology
Anatomy
Histology
Physiology
Benign Prostatic Hypertrophy
- Disease Classification
- Chronic Diseases
- Chronic miasm-Sycosis
- Constitutional Medicine
- Homoeopathic Concept of Disease
- Repertorial representation of Benign Prostatic Hypertrophy

Therapeutics of 3 mark remedies from major repertories

**PROSTATE – INTRODUCTION**

The Prostate (Prostata; Prostate Gland) is an organ linked inextricably with the endocrine system. During the development of the prostate, epithelium and mesenchyme are under the control of testicular androgens, and interact to form an organised secretory organ. Furthermore, many of the disease processes are attributed to, and therapies aimed at the manipulation of, the endocrine system. The gland resides in the true anatomical pelvis and forms the most proximal aspect of the urethra. It has been stated that the prostate gland is the male organ most commonly afflicted with either benign or malignant neoplasms.

**EMBRYOLOGY**

The development, growth and cytodifferentiation of the prostate are androgen dependent and occur via reciprocal mesenchymal-epithelial interactions, the latter referring to a cell-cell interaction initiated during embryonic periods in which mesenchyme (undifferentiated connective tissue) induces epithelial development, while the epithelium reciprocally induces mesenchymal differentiation.

In the developing prostate, urogenital sinus mesenchyme acting under the influence of testicular androgens induces ductal morphogenesis, the expression of epithelial androgen receptors, regulates epithelial proliferation and specifies the expression of prostatic-lobe specific secretory proteins. Reciprocally, the developing prostatic epithelium induces the differentiation and morphological patterning of smooth muscle in the urogenital sinus mesenchyme. In the prostate, it is traditional to consider androgens as promoters of growth, while activin and TGFbeta are regarded as potent growth inhibitors These factors do not act independently, however, and cross-talk occurs between the signalling pathways at a sub-cellular level.

The first step in development of the prostate begins with the urogenital sinus mesenchyme signalling to the epithelium, causing it to form epithelial buds. Androgens then induce bud elongation, branching and epithelial differentiation. Prenatally, the androgen receptor (AR) is expressed only in the mesenchyme, not in the epithelium. Initial epithelial development is thus controlled via paracrine interactions where activation of stromal androgen receptors stimulates growth factors and induces growth in adjacent prostatic epithelial cells.

At the 5th week, the mesonephric (Wolffian) duct opens onto the lateral surface of the urogenital sinus and gives rise to the ureteric bud (Figure 1). By the 7th week, the growth of the urogenital sinus involves the progressive incorporation of the terminal part of the mesonephric duct into the wall of the urogenital sinus. They eventually open into the Mullerian tubercle, which is the future veru montanum of the prostate. At their termination, the paramesonephric (Mullerian) ducts fuse and are surrounded by the mesonephric ducts. At 10 weeks, prostatic epithelial buds begin to arise from the circumference of the urethra, around the orifice of the paramesonephric ducts. They develop predominantly on the posterior surface of the junction of the mesonephric ducts, forming two levels, above and below them.

During the fetal period at about 6 months, multiple outgrowths arise from the prostatic portion of the urethra, particularly the posterior surface of the urethra, and grow into the surrounding mesenchyme. Glandular epithelium of the prostate differentiates from the endodermal cells of the urethra, and the associated mesenchyme into which the outgrowths grow differentiates into the dense stroma and smooth muscle fibres of the prostate. In contrast, the outgrowths situated on the anterior surface regress and are replaced by fibromuscular tissue. This region becomes the future anterior commissure of the prostate.

**ANATOMY**

The prostate is a firm, partly glandular and partly muscular body, which is placed immediately below the internal urethral orifice and around the commencement of the urethra. It is situated in the pelvic cavity, below the lower part of the symphysis pubis, above the superior fascia of the urogenital diaphragm, and in front of the rectum, through which it may be distinctly felt, especially when enlarged. It is about the size of a chestnut and somewhat conical in shape, and presents for examination a base, an apex, an anterior, a posterior and two lateral surfaces. The base (*basis prostatae*) is directed upward, and is applied to the inferior surface of the bladder, The greater part of this surface is directly continuous with the bladder wall; the urethra penetrates it nearer its anterior than its posterior border. The apex (*apex prostatae*) is directed downward, and is in contact with the superior fascia of the urogenital diaphragm.

**Surfaces** —The posterior surface (*facies posterior*) is flattened from side to side and slightly convex from above downward; it is separated from the rectum by its sheath and some loose connective tissue, and is about 4 cm distant from the anus. Near its upper border there is a depression through which the two ejaculatory ducts enter the prostate. This depression serves to divide the posterior surface into a lower larger and an upper smaller part. The upper smaller part constitutes the middle lobe of the prostate and intervenes between the ejaculatory ducts and the urethra; it varies greatly in size, and in some cases is destitute of glandular tissue. The lower larger portion sometimes presents a shallow median furrow, which imperfectly separates it into a right and a left lateral lobe: these form the main mass of the gland and are directly continuous with each other behind the urethra. In front of the urethra they are connected by a band which is named the isthmus: this consists of the same tissues as the capsule and is devoid of glandular substance. The anterior surface (*facies anterior*) measures about 2.5 cm. from above downward but is narrow and convex from side to side. It is placed about 2 cm. behind the pubic symphysis, from which it is separated by a plexus of veins and a quantity of loose fat. The urethra emerges from this surface a little above and in front of the apex of the gland. The lateral surfaces are prominent, and are covered by the anterior portions of the Levatores ani, which are, however, separated from the gland by a plexus of veins. The prostate measures about 4 cm. transversely at the base, 2 cm. in its antero-posterior diameter, and 3 cm. in its vertical diameter. Its weight is about 8 gm. It is held in its position by the puboprostatic ligaments; by the superior fascia of the urogenital diaphragm, which invests the prostate and the commencement of the membranous portion of the urethra; and by the anterior portions of the Levatores ani, which pass backward from the pubis and embrace the sides of the prostate. These portions of the Levatores ani, from the support they afford to the prostate, are named the Levatores prostatæ. The prostate is perforated by the urethra and the ejaculatory ducts. The urethra usually lies along the junction of its anterior with its middle third. The ejaculatory ducts pass obliquely downward and forward through the posterior part of the prostate, and open into the prostatic portion of the urethra.

**Structure** —The prostate is immediately enveloped by a thin but firm fibrous capsule, distinct from that derived from the fascia endopelvina, and separated from it by a plexus of veins. This capsule is firmly adherent to the prostate and is structurally continuous with the stroma of the gland, being composed of the same tissues, viz.: non-striped muscle and fibrous tissue. The substance of the prostate is of a pale reddish-gray color, of great density, and not easily torn. It consists of glandular substance and muscular tissue. The muscular tissue according to Kölliker, constitutes the proper stroma of the prostate; the connective tissue being very scanty, and simply forming between the muscular fibers, thin trabeculae, in which the vessels and nerves of the gland ramify. The muscular tissue is arranged as follows: immediately beneath the fibrous capsule is a dense layer, which forms an investing sheath for the gland; secondly, around the urethra, as it lies in the prostate, is another dense layer of circular fibers, continuous above with the internal layer of the muscular coat of the bladder, and blending below with the fibers surrounding the

membranous portion of the urethra. Between these two layers strong bands of muscular tissue, which decussate freely, form meshes in which the glandular structure of the organ is imbedded. In that part of the gland which is situated in front of the urethra the muscular tissue is especially dense, and there is here little or no gland tissue; while in that part which is behind the urethra the muscular tissue presents a wide-meshed structure, which is densest at the base of the gland—that is, near the bladder—becoming looser and more sponge-like toward the apex of the organ. The glandular substance is composed of numerous follicular pouches the lining of which frequently shows papillary elevations. The follicles open into elongated canals, which join to form twelve to twenty small excretory ducts. They are connected together by areolar tissue, supported by prolongations from the fibrous capsule and muscular stroma, and enclosed in a delicate capillary plexus. The epithelium which lines the canals and the terminal vesicles is of the columnar variety. The prostatic ducts open into the floor of the prostatic portion of the urethra, and are lined by two layers of epithelium, the inner layer consisting of columnar and the outer of small cubical cells. Small colloid masses, known as amyloid bodies are often found in the gland tubes.

**Vessels and Nerves**. —The arteries supplying the prostate are derived from the internal pudendal, inferior vesical, and middle haemorrhoidal arteries. Its veins form a plexus around the sides and base of the gland; they receive in front the dorsal vein of the penis, and end in the hypogastric veins. The nerves are derived from the pelvic plexus.

According to McNeal's model of the prostate, four different anatomical zones may be distinguished that have anatomo-clinical correlation (Figure 3):

1. The peripheral zone : is the area forming the postero-inferior aspect of the gland and represents 70% of the prostatic volume. It is the zone where the majority (60-70%) of prostate cancers form.

2. The central zone : represents 25% of the prostate volume and contains the ejaculatory ducts. It is the zone which usually gives rise to inflammatory processes (eg prostatitis).

3.The transitional zone : this represents only 5% of the total prostatic volume. This is the zone where benign prostatic hypertrophy occurs and consists of two lateral lobes together with periurethral glands. Approximately 25% of prostatic adenocarcinomas also occur it this zone.

4.The Anterior Zone : Predominantly fibromuscular with no glandular structures.

The prostate weighs approximately 20g by the age of 20 and has the shape of an inverted cone, with the base at the bladder neck and the apex at the urogenital diaphragm.The prostatic urethra does not follow a straight line as it runs through the centre of the prostate gland but it is actually bent anteriorly approximately 35 degrees at the verumontanum (where the ejaculatory ducts joins the prostate).

**HISTOLOGY**

The prostate consists of stromal and epithelial elements. Smooth muscle cells, fibroblasts and endothelial cells are in the stroma and the epithelial cells are secretory cells, basal cells and neuroendocrine cells.

The columnar secretory cells are tall with pale to clear cytoplasm. These cells stain positively with prostate specific antigen. Basal cells are less differentiated than secretory cells and so are devoid of secretory products such as Prostate Specific Antigen (PSA). Finally, neuroendocrine cells are irregularly distributed throughout ducts and acini; with a greater proportion in the ducts .The prostate has the greatest number of neuroendocrine cells of any of the genitourinary organs. Glands are structured with open and closed cell types with the open type facing the inside of the duct having a monitoring role over its contents. Most cells contain serotonin but other peptides present include somatostatin, calcitonin, gene-related peptides and katacalcin. The cells co-express PSA and prostatic acid phosphatase. Their function is unclear but it is speculated that these cells are involved with local regulation by paracrine release of peptides. Prostatic ducts and acini are distinguished by architectural pattern at low power

magnification. The prostate becomes more complex with ducts and branching glands arranged in lobules and surrounded by stroma with advancing age.

**PHYSIOLOGY**

At present, there is only limited knowledge of all of the secretory products of the prostate and how this relates to reproduction and infertility. However, the main role of the prostate as a male reproductive organ is to produce prostatic fluid, which accounts for up to 30 per cent of the semen volume. Sperm motility and nourishment are aided by the prostatic fluid constituents and the environment they create. Prostatic fluid is a thin, milky alkaline fluid containing citric acid, calcium, zinc, acid phosphatase and fibrinolysin among its many constituents (Table 1). Prostate specific antigen (PSA) is also a constituent found in prostatic secretions. During ejaculation, alpha-adrenergic stimulation results in transport of the seminal fluid containing sperm from the ampulla of the vas deferens into the posterior urethra. Interestingly, abnormal growth of the prostate is only experienced by humans and dogs and why other mammals are spared is a mystery.

| | | |
|---|---|---|
| Colour | White, opalescent | |
| Specific Gravity | 1.028 | |
| pH | 7.35-7.50 | |
| Volume | 3ml | |
| SPECIFIC COMPONENTS OF SEMEN | | |
| Gland/Site | Volume in ejaculate | Features |
| Testis/Epididymis | 0.15ml (5%) | Average approximately 80 million/ml |
| Seminal Vesicle | 1.5-2ml (50-65%) | Fructose (1.5-6.5 mg/ml)<br>Phosphorylcholine<br>Ergothioneine<br>Ascorbic acid<br>Flavins<br>Prostaglandins<br>Bicarbonate |
| Prostate | 0.6-0.9ml (20-30%) | Prostate<br>Spermine<br>Citric Acid<br>Cholesterol,phospholipids<br>Fibrinolysin, fibrinogenase<br>Zinc |

| | | |
|---|---|---|
| | | Acid phosphatease<br>Prostate-specific |
| Bulbourethral Glands | < 0.15ml (<5%) | Clear mucus |

**ENDOCRINE CONTROL OF PROSTATIC GROWTH**

It is becoming clear that intraprostatic signalling systems are important for the regulation of cell proliferation and extracellular matrix production in prostatic stroma. Central to this premise is the balance between factors such as tumour growth factor beta 1 (TGFb1), that induces extracellular matrix production, suppresses collagen breakdown and cell proliferation and factors such as fibroblast growth factor 2 and insulin-like growth factors that are mitogenic in the stromal compartment. Other endocrine pathways are being investigated and there is experimental data suggesting an abnormality in the insulin-like growth factor axis playing a role in the pathogenesis of BPH.

**Testosterone**

Prostatic epithelial cells express the androgen receptor. From the beginning of embryonic differentiation to pubertal maturation and beyond, androgens are a prerequisite for the normal development and physiological control of the prostate. Androgens also help maintain the normal metabolic and secretory functions of the prostate. They are also implicated in the development of benign prostatic hyperplasia (BPH) and prostate cancer. Androgens do not act in isolation and other hormones and growth factors are being investigated.

Androgens also interact with prostate stromal cells which release soluble paracrine factors that are important in the growth and development of the prostate epithelium. These paracrine pathways may be critical in regulation of the balance between proliferation and apoptosis of prostate epithelial cells in the adult.

The appropriate balance between testosterone and its 5 alpha reduced metabolites are key to normal prostate physiology). The metabolism of testosterone to dihydrotestosterone (DHT) and its aromatisation to estradiol are recognised as the key events in prostatic steroid response.

Testosterone, to be maximally active in the prostate, must be converted to dihydrotestosterone (DHT) by the enzyme 5alpha-reductase (Figure 5).

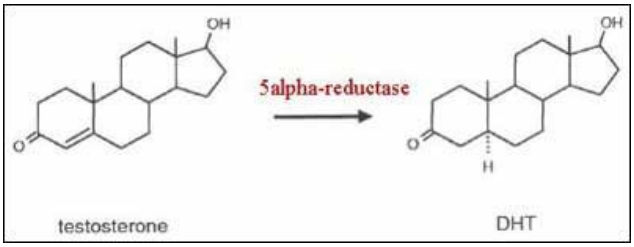



**Figure 5.** Conversion of Testosterone to Dihydrotestosterone by 5alpha-Reductase

DHT has a much greater affinity for the androgen receptor than does testosterone which allows it to accumulate in the prostate even when circulating levels of testosterone are low. DHT is about twice as potent as testosterone in studies of rats at equivalent androgen concentrations. Therefore, DHT concentrations may remain similar to those in young men in the prostate of elderly men, despite the fact that serum testosterone levels may decline with age. In the prostate, the total level of testosterone is 0.4 ng/g and the total of DHT is 4.5 ng/g. The total concentration of testosterone in the blood (18.2nnmol/L) is approximately 10 times higher than that of DHT. Circulating DHT, by virtue

of its low serum plasma concentration and tight binding to plasma proteins, is of diminished importance as a circulating androgen affecting prostate growth.

**Estrogen**

A role for estrogens in the prostate pathology of the ageing male appears likely with accumulating evidence that estrogens, alone or in combination with androgens, are involved in inducing aberrant growth and/or malignant change. Animal models have supported this hypothesis in the canine model, where estrogens “sensitize” the ageing dog prostate to the effects of androgen. The evidence is less clear in humans. Estrogens in the male are predominantly the products of peripheral aromatization of testicular and adrenal androgens. While the testicular and adrenal production of androgens declines with ageing, levels of total plasma oestradiol do not decline. This has been ascribed to the increase in fat mass with ageing (the primary site of peripheral aromatization) and to an increased aromatase activity with ageing. However, free or bioavailable estrogens may decline due to an increase in sex hormone binding globulin, which could translate to lower intraprostatic levels of the hormone. The potentially adverse effects of oestrogens on the prostate may be due to a shift in the intra-prostatic estrogen:androgen ratio with ageing.

Estrogen, which acts through estrogen receptors (ER) alpha and beta, has been implicated in the pathogenesis of benign and malignant human prostatic tumors. As stated above benign prostatic hyperplasia is thought to originate in the transitional zone (TZ) and prostate cancer the peripheral zone (PZ) of the prostate. Receptor studies have found ER-alpha and ER-beta types distributed in human normal and hyperplastic prostate tissues, using in situ hybridization and immunohistochemistry. ER-alpha expression was restricted to stromal cells of the PZ. In contrast, ER-beta was expressed in the stromal and epithelial cells of PZ as well as TZ. These findings suggest that estrogen may play a crucial role in the pathogenesis of benign prostatic hyperplasia through ER-beta. Investigations are ongoing and could result in a new range of therapies directed against BPH and prostate cancer. Dietary phytoestrogens (in soy and other vegetables) or selective estrogen receptor modulators are currently being investigated with regard to their role in the development of BPH and prostate cancer. Such ER modifiers may oppose some of the effects of natural oestrogen by modulating ER receptors, thus reducing the local impact of androgens that need active ER receptors, effectively making them anti-androgenic compounds however this requires more investigation.

## BENIGN PROSTATIC HYPERPLASIA (BPH)

Benign Prostatic Hyperplasia (BPH) is an age-related and progressive neoplastic condition of the prostate gland. BPH may only be defined histologically. BPH in the clinical setting is characterised by lower urinary tract symptoms (LUTS, see Table 2). There is no causal relationship between benign and malignant prostatic hypertrophy. Clinically apparent BPH represents a considerable health problem for older men, due to the negative effects it has on quality of life (QOL)

**Incidence and Prevalence** : A recent study has demonstrated an overall prevalence of 10.3%, with an overall incidence rate of 15 per 1000 man-years, increasing with age (3 per 1000 at age 45-49 years, to 38 per 1000 at 75-79 years). For a symptom free man at age 46, the risk of clinical BPH over the coming 30 years, if he survives, is 45%. The true prevalence and incidence of clinical BPH will vary according to the criteria used to describe the condition. It is crucial to acknowledge that LUTS can exist without signs of BPH – as the symptoms can be caused by variations in the sympathetic nervous stimulation of prostatic smooth muscle, variability of prostatic anatomy (viz., enlarged median lobe of the prostate), and the variable effects of bladder physiology from the obstruction and aging.

There have been several studies demonstrating the fact that clinical BPH is a progressive disease. The Olmsted county study showed that with each year there were deteriorations in symptom scores, peak flow rates, and increases in prostate volumes based on transrectal ultrasound scanning (TRUS). The risk of acute urinary retention (AUR) increased with flow rates below 12 ml/sec and with glands greater than 30ml. Studies have also demonstrated that those with larger prostates (>40 ml) and with serum PSA greater than 1.4 ng/ml were more likely to develop acute urinary retention. Treatment however has changed with the advent of effective non-surgical therapies. Between 1992-1998 there has been a significant lengthening of the period between first diagnosis of LUTS secondary to

clinical BPH and surgery, associated with the earlier and increased use of specific medical treatments. From the patients perspective the goals of therapy are to improve quality of life, reduce symptoms, and avoid surgery while ensuring safety from the complications of BPH.

**Risk Factors for BPH** T he only clearly defined risk factors for BPH are age and the presence of circulating androgens. BPH does not develop in men castrated before the age of forty. But other factors may influence the prevalence of clinical disease. These include:

1. **Genetics**

Clinical BPH appears to run in families. If one or more first degree relatives are affected, an individual is at greater risk of being afflicted by the disorder. In a study by Sanda et al the hazard-function ratio for surgically treated BPH amongst first degree relatives of the BPH patients as compared to controls was 4.2 (95% CI, 1.7 to 10.2). The incidence of BPH is highest and starts earliest in blacks than Caucasians and is lowest in Asians. Interestingly, despite having larger prostate glands, the age-adjusted risk of BPH was the same for blacks as for whites (RR = 1.0, 95% CI 0.8-1.2). Furthermore, in an Asian population, men presenting with BPH are likely to have higher symptom scores than blacks or Caucasians.

2. **Diet**

Diet has been reported as a risk factor for the development of BPH. Large amounts of vegetables and soy products in the diet may explain the lower rate of BPH in the orient when compared to westernized countries. In particular, certain vegetables and soy are said to be high in phyto-oestrogens, such as genestin, that have ant-androgenic effects by an as yet determined mechanism on the prostate in vitro.

By studying migrant populations with their heterogeneous exposures to the environment, it increases the probabilities of identifying potential risk factors for BPH. Therefore, the association of alcohol, diet, and other lifestyle factors with obstructive uropathy was investigated in a cohort of 6581 Japanese-American men, examined and interviewed from 1971 to 1975 in Hawaii. After 17 years of follow-up, 846 incident cases of surgically treated obstructive uropathy were diagnosed with BPH. Total alcohol intake was inversely associated with obstructive uropathy ($P < 0.0001$). The relative risk was 0.64 (95% confidence interval: 0.52-0.78) for men drinking at least 25 grams of alcohol per month compared with nondrinkers. Among the 4 sources of alcohol, a significant inverse association was present for beer, wine, and sake, but not for spirits. No association was found with education, number of marriages, or cigarette smoking. Increased beef intake was weakly related to an increased risk ($p = 0.047$), while no association was found with the consumption of 32 other food items in the study.

3. **Other Risk Factors**

It has not been possible to delineate any other risk factors for BPH such as coronary artery disease, liver cirrhosis or diabetes mellitus. There is also no causal relationship between malignant and benign prostatic hypertrophy.

**PATHOPHYSIOLOGY OF BPH**

**Natural History :** BPH is a histological diagnosis but its clinical manifestations occur after growth has occurred to such a degree and in such a strategic location within the gland, namely the transitional zone, that it impairs bladder emptying and results in LUTS. One can therefore consider the natural history of BPH as involving two phases:

1. The pathological or first phase of BPH is asymptomatic and involves a progression from microscopic to macroscopic BPH. Microscopic BPH will develop in almost all men if they live long enough but in only about half will progress to macroscopic BPH. This would suggest that additional factors are necessary to cause microscopic to progress to macroscopic BPH. The pathological phase involves development of hyperplastic changes in the transitional zone of the prostate. While there is wide variability in prostate growth rates on an individual level, prostate volume appears to increase steadily at about 1.6% per year in randomly selected community men.

2. The clinical or second phase of BPH involves the progression from pathological to 'clinical BPH' which is synonymous with the development of LUTS. Only about one half of patients with macroscopic BPH progress to develop clinical BPH. BPH consists of mechanical and dynamic components and it is these components that are responsible for the progression from pathological to clinical BPH. In clinical BPH, the ratio of stroma to epithelium is 5: 1 whereas in the case of asymptomatic hyperplasia the ratio is 2.7:1. A significant contribution is therefore made by stroma to the infravesical obstruction of BPH.

**DISEASE MANIFESTATIONS OF BPH**

**Lower Urinary Tract Symptoms (LUTS)**

Lower urinary tract symptoms (LUTS) suggestive of BPH are highly prevalent and the majority of LUTS in men is produced by BPH, but may be contributed to by a variety of conditions. LUTS are traditionally divided into voiding or obstructive and storage or irritative symptoms (Table 2).

| | |
|---|---|
| Voiding or Obstructive Symptoms | Storage or Irritative Symptoms |
| Hesitancy<br>Poor stream<br>Intermittent stream<br>Straining to pass urine<br>Prolonged micturition<br>Sense of incomplete bladder emptying<br>Terminal dribbling | Urinary frequency<br>Urgency<br>Urge incontinence<br>Nocturia |

Voiding symptoms are more common, however it is storage symptoms that are most bothersome and have a greater impact on a patient's life. The prevalence of clinical BPH rises with age and approximately 25% of men age 40 or over will suffer from LUTS.

In the past, LUTS suggestive of bladder outflow obstruction (BOO) secondary to BPH were referred to as 'prostatism', once other causes such as a urinary tract infection or prostate cancer were excluded. The pathology behind the symptoms was thought to be obstruction due to prostatic gland enlargement alone. However, today it is recognised that voiding/obstructive symptoms result from direct urinary flow obstruction whilst storage/irritative symptoms appear to be due to secondary bladder dysfunction.

This concept has been further refined in that obstructive symptoms are thought to result not only from mechanical obstruction due to glandular enlargement, but also dynamic obstruction secondary to contraction of the smooth muscle of the prostate, urethra and bladder neck. This dynamic obstruction is a result of sympathetic nervous system mediated stimulation of alpha-1adrenoceptors. Storage symptoms appear to be caused by detrusor instability related to detrusor muscle changes in response to obstruction, such as bladder wall hypertrophy and collagen deposition in the bladder. The role of adrenoceptor subtypes in the bladder in this process is currently being investigated. Adrenoceptors may be further sub-divided into alpha1A and alpha1D subtypes, with alpha1A predominant in the prostate and alpha 1D in the bladder. Thus blockade of alpha1A may be necessary for reduction of obstruction whereas the blockade of alpha1D may be required to relieve storage symptoms.

New research has also suggested that the aetiology of LUTS related to BPH is even more complex than outlined above with extra-prostatic mechanisms such as bladder wall ischaemia and changes in the central nervous system being implicated. Normal lower urinary tract function is complex, and theoretically any disruption of the pathway for micturition may lead to LUTS.

It is also worth noting the relationship between LUTS and sexual dysfunction, with sexual dysfunction being highly prevalent in men with LUTS. By sexual dysfunction, we refer to decreased libido, erectile dysfunction, decreased ejaculation and other ejaculation disorders. Kassabian expands on the relationship and agrees with Leilefeld et al in suggesting that the relationship is coincidental and both are common in the ageing male.

**COMPLICATIONS**

- Urinary retention
- Recurrent Urinary Tract Infections
- Bladder Calculi
- Haematuria
- Secondary bladder instability
- Renal Impairment

**Urinary Retention (Acute and Chronic)**

As prostate volume increase with age, the likelihood of acute urinary retention (AUR) and symptom severity both increase while urinary flow rates fall. In one study of more than 2000 men, those with a maximum urinary flow rate (Qmax) <12 ml/s had a 4 times greater risk for AUR than did men with a Qmax >12ml/s. AUR is usually painful and necessitates the insertion of a per urethral indwelling or suprapubic urinary catheter.

If the urinary retention is not dealt with in a timely fashion, the detrusor muscle becomes distended and damaged, contributing to poor detrusor function and an inability to adequately empty the bladder. The retention of urine becomes painless over time, and the sequelae of retained urine such as recurrent UTI, calculi and renal impairment may develop.

Furthermore, a situation of overflow incontinence may develop whereby the bladder automatically empties once the volume reached exceeds its new, larger capacity. The passage of urine is typically uncontrolled, and this may often be the first presentation for someone with advanced BPH. The bladder remains full despite the emptying, which is only partial.

In situations of chronic retention, there is no guarantee that by relieving the bladder outflow obstruction, the detrusor will return to normal functioning. These patients often need to use intermittent self catheterisation or have permanent drainage to keep their bladder empty and to reduce damage to the upper urinary tract, even after definitive treatment for BPH.

**Recurrent Lower Urinary Tract Infection (UTI)**

Perhaps the best host defence against infection in the lower urinary tract is the normal flow of urine and bladder emptying that accompanies normal urinary tract functioning. In BPH, bladder outflow obstruction results in disruption of this mechanism with retention and pooling of urine in the bladder, giving organisms the opportunity to multiply rather than be flushed out. Despite this logical assumption, there is little evidence in the literature to support this

theory. Nevertheless, men with significant clinical BPH are probably at risk of UTI, and men with UTI should be assessed for signs of BPH.

**Bladder Calculi (Stones)**

In developed countries, the most prevalent cause of bladder calculi is bladder outlet obstruction owing to BPH.Of those who undergo prostate surgery for BPH, approximately 2% of all patients are found to have bladder stones. Stones occur in this situation due to urinary stasis combined with high urinary solute concentrations, which leads to crystal precipitation. Chronic infection with urease-producing organisms may predispose to the development of stones and rarely stones pass from the upper tract to act as a nidus in the bladder. Bladder calculi associated with BPH remain an absolute indication for transurethral resection of the prostate (TURP) because of the risk or recurrence of stone formation. However, the necessity of surgery is being challenged by the expanding use of medical management in treating BPH.

**Haematuria**

The incidence of haematuria with BPH is uncertain. However, in a retrospective review of almost 4000 patients undergoing TURP, Mebust et al noted that haematuria was an indication for surgery in 12% of patients. It is hypothesised that BPH, with its increased acinar and stromal cell proliferation, stimulates increased vascularity via angiogenesis. These new and prolific vessels may be easily disrupted leading to recurrent bleeding[71].This is supported by Foley et al who found the microvessel density to be higher in those patients with BPH having haematuria after histological studies.

**Detrusor (Bladder) Instability**

The definition of detrusor instability is the development of a detrusor contraction which exceeds 15cm $H_20$ at a bladder volume of less than 300ml. Detrusor instability is not a specific term related to BPH, but implies LUTS secondary to a detrusor problem. These symptoms are normally storage related and consist of urgency, frequency, urge incontinence and nocturia. In BPH, the normal dynamics of the bladder are altered due to detrusor muscle stretching due to retention of urine and contraction against an obstructed outlet. Although not completely understood, some of the detrusor instability may be related to changes at the adrenoceptors level, rather than just from obstruction and its consequences alone.

**Renal Insufficiency**

Renal insufficiency results from obstructive uropathy secondary to the bladder outlet obstruction of BPH. In an analysis of patients receiving treatment for BPH, 13.6% (range 0.3-30%) had renal insufficiency. Certainly, an abnormal creatinine is an indication to further investigate the upper urinary tract with imaging. Obviously, other concurrent causes of renal insufficiency need to be excluded. Those patients with renal insufficiency undergoing surgery are at increased risk (25%) of postoperative complications such as acute renal failure and urosepsis compared to patients without (17%) insufficiency.

**HISTORY**

A comprehensive medical history must be evaluated and should include the use of a voiding diary, the International Prostate Symptom Score and a discussion of the role of prostate specific antigen (PSA) testing. An outline of the evaluation and treatment options for LUTS is shown in Table 4 and is discussed in greater depth below. Previous urological disease should be documented including previous urological surgery, UTI, bladder or renal calculi, renal disease and penoscrotal pathology. Any risk factors for surgery such as diabetes mellitus, immunosuppression, ischaemic heart disease, respiratory problems, smoking as well as a comprehensive list of medications should be noted. In particular, the use of antihypertensives must be noted as any alpha-blocker treatment initiated could potentially cause severe hypotension. Consideration needs to be given to neurologic causes of voiding dysfunction such as stroke or Parkinson’s disease.

| |
|---|
| EVALUATION of LUTS |
| ESSENTIAL<br>• History<br>• Digital Rectal Examination (DRE)<br>• Urinalysis<br>• Serum creatinine<br>• PSA, if > 10 year life expectancy<br>• International Prostate Symptom Score (IPSS) or AUA symptom index<br><br>SELECTED<br>• Uroflowmetry<br>• Imaging – especially if haematuria , UTI , urolithiasis<br>• Post Void Residual (PVR) estimation<br>• +/-Pressure flow studies<br>• +/-Cystoscopy |
| TREATMENT OPTIONS |
| MEDICAL THERAPY<br>• Phytotherapy<br>SURGERY<br>• Transurethral resection of the Prostate (TURP)<br>• Transurethral Incision of the Prostate (TUIP)<br>• Open prostatectomy<br>• Laser prostatectomy/treatment<br>• Others viz., TUMT, HIFU, TUNA |

**International Prostate Symptom Score (IPSS)**

The American Urologic Association (AUA) Symptom Index was developed as a standardised instrument to assess the degree of bladder outlet obstruction in men. It is widely used and consists of seven questions that assess emptying, frequency, intermittency, urgency, weak stream and straining with each graded with a score of 0-5. Total score ranges 0-35. The index categorises patients as:

1. Mild (Score 0-7)

2. Moderate (Score 8-19)

3. Severe (20-35).

The International Prostate Symptom Score (I-PSS) is a modification of the AUA Symptom Index adding a single question assessing the quality of life or bother score based on the patient's perception of the problem (Figure 8). Both the AUA and I-PSS questionnaires, although not specific for BPH, prostate volume, urinary flow rate, post-void residual volume or bladder outlet obstruction, have been validated and are sensitive enough to be to be used in the evaluation of symptoms and selection of treatment. Many would argue that the bother score is the primary determinant of whether or not a patient proceeds to further treatment.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name: Date: | | | | | | | |
| | Not at all | Less than 1 time in 5 | Less than half the time | About half the time | More than half the time | Almost always | Your score |
| Incomplete emptying | 0 | 1 | 2 | 3 | 4 | 5 | |
| Frequency | 0 | 1 | 2 | 3 | 4 | 5 | |
| Intermittency | 0 | 1 | 2 | 3 | 4 | 5 | |
| Urgency | 0 | 1 | 2 | 3 | 4 | 5 | |
| Weak stream | 0 | 1 | 2 | 3 | 4 | 5 | |
| Straining | 0 | 1 | 2 | 3 | 4 | 5 | |
| | None | 1 time | 2 times | 3 times | 4 times | 5 times or more | Your score |
| Nocturia | 0 | 1 | 2 | 3 | 4 | 5 | |

| Total IPSS score | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality of life due to urinary symptoms | Delighted | Pleased | Mostly satisfied | Mixed – about<br><br>equally satisfied<br><br>and dissatisfied | Mostly dissatisfied | Unhappy | Terrible |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**EXAMINATION**

General appearance is of importance, especially in identifying those with neurological disease (eg. past stroke, Parkinson's disease) or other major co-morbidities (obesity, severe osteoarthritis, diabetes) that may impact on treatment or further investigation. An abdominal examination should identify those in marked urinary retention, any abnormal masses and previous surgical scars. A careful assessment of the scrotum and its contents as well as the penis is also warranted to exclude any other pathology. The digital rectal examination (DRE) is important in identifying prostatic abnormalities, including clinically apparent prostate carcinoma. Prostate size, texture and tenderness should all be assessed, as should anal tone. Any nodules should be carefully noted. Constipation may also be a contributing factor to urinary retention and anal tone should also be recorded.

**DIFFERENTIAL DIAGNOSIS OF BPH**

It is important to acknowledge that the diagnosis of BPH often relies on surrogate measures until a histological diagnosis is confirmed. These range from clinical (symptom scores), physiological (uroflowmetry), anatomical (prostatic volume on DRE or TRUS) and biochemical (PSA values) measurement. Although all of these measurements capture some component of BPH, none of them is specific for BPH which is itself a histological diagnosis. Surrogate measures are likely to represent a continuum of disease severity without the existence of a threshold. Thus, differential diagnoses need to always be considered and where appropriate, excluded. In table 5 below, some of the more obvious differential diagnoses are listed, but will not be examined in detail.

**PROSTATITIS**

Prostatitis is a common condition that must be excluded from other causes of LUTS and is a common cause of visits to primary care physicians and urologists. It may present as an acute bacterial infection or may be chronic, occasionally progressing to a debilitating illness. In practice, the clinical diagnosis of prostatitis depends on the history and physical examination, but there is no characteristic physical finding or diagnostic laboratory test. Patients with prostatitis experience considerable morbidity and may remain symptomatic for many years. Unfortunately, there is limited understanding of the pathophysiology and optimal treatment for most patients. Prostatitis has been sub-classified and an abbreviated version is in table 6.

1. Acute bacterial prostatitis
2. Chronic bacterial prostatitis
3. Chronic prostatitis/chronic pelvic pain syndrome
    1. Inflammatory
    2. Non-inflammatory
4. Asymptomatic inflammatory prostatitis

**Acute Prostatitis.**

Clinical features suggestive of acute prostatitis (Type 1, in Table 6 above) include dysuria and urinary frequency as well as perineal pain (Table 7). Systemic symptoms such as fever, rigors, myalgia and sweats are often a feature. On examination, the patient is normally febrile, and may be overtly septic depending on the infection severity. A digital rectal exam finds an extremely tender prostate which is often intolerable to the patient. An abscess is occasionally palpated.

| |
|---|
| Genital symptoms |
| • Dribbling<br>• Inguinal pain<br>• Testicular pain<br>• Retropubic pain<br>• Perineal pain<br>• Urethral Burning |
| General Symptoms |
| • Backache<br>• Sweating<br>• Tiredness<br>• Cold feet |

Investigations should include a mid-stream urine sample for microscopy, culture for bacteria, and antibiotic sensitivity. The most common organisms are typical uropathogenic bacteria such as Escherichia coli. Blood cultures for bacteria and antibiotic sensitivity should also be considered. Prostatic massage is usually contraindicated in patients with acute prostatitis due to pain and the risk of precipitating sepsis. A treatment regime is highlighted in Table 8. If there is failure to respond to therapy, evaluation for a prostatic abscess using a tran-srectal ultrasound scan or computed tomography scan may be required. If necessary, perineal or transurethral drainage of an abscess may be undertaken.

| |
|---|
| • Hydration<br>• Rest and hospitalisation if severe<br>• Empirical therapy with antibiotic until urine culture and sensitivities available |

**Chronic Prostatitis**

As the presentation may be localised to the genital region or non-specific (Table 7) a careful history and examination along with specialised diagnostic tests are needed to identify this condition. Investigations may involve prostatic massage to express organisms and/or white blood cells for analysis. Urine sample collection is often done in phases to aid in the localisation process: first void urethral urine; mid-stream bladder urine; post-prostatic massage sample. Urine microscopy and quantitative culture is then undertaken. Semen analysis for excessive white blood cell numbers may also be indicative of chronic prostatitis. A serum prostate specific antigen measurement may be undertaken and is often raised, especially in acute prostatitis or in an active phase of chronic prostatitis. Trans-rectal ultrasound is considered but not recommended to differentiate the different forms of chronic prostatitis. Urinary tract localisation procedures (culture of first void urethral urine; mid-stream bladder urine; post-prostatic massage samples of urine correlating to urethra, bladder and prostate) although theoretically correct, are often not used in clinical practice.

The various classifications of chronic prostatitis are listed in Table 6. Patients with chronic bacterial prostatitis (type II prostatitis) experience recurrent episodes of bacterial urinary tract infection caused by the same organism, usually E. coli, another Gram-negative organism, or enterococcus. Between symptomatic episodes of bacteriuria, lower urinary tract cultures can be used to document an infected prostate gland as the focus of these recurrent infections. Acute and chronic bacterial prostatitis represent the best understood, but least common, prostatitis syndromes.

Unfortunately, more than 90% of symptomatic patients have chronic prostatitis/chronic pelvic pain syndrome (type III). This term recognizes the limited understanding of the causes of this syndrome for most patients and the possibility that organs other than the prostate gland may contribute to this syndrome. Urological pain (normally in the perineum or associated with voiding or intercourse) is now recognised as a primary component of this syndrome. Active urethritis, urogenital cancer, urinary tract disease, functionally significant urethral stricture, or neurological disease affecting the bladder must be excluded. Patients with the inflammatory subtype (type IIIA) of chronic prostatitis/chronic pelvic pain syndrome have leukocytes in their expressed prostatic secretions post prostate massage urine or in semen.

In contrast, patients with the non-inflammatory subtype of chronic prostatitis (type III B) have no evidence of inflammation. In essence, they have no evidence of active infection nor of inflammation on available investigative techniques taken at a particular point in time. Repeat investigations are therefore done to make sure adequate sampling has been undertaken. This condition may be difficult to treat and requires intensive counselling, information and reassurance to the patient to be successfully managed.

Finally, asymptomatic inflammatory prostatitis (type IV) is diagnosed in patients who have no history of genitourinary tract pain complaints. It is often an incidental finding on prostatic biopsy done for other reasons (eg a raised PSA). Treatment is usually not required.

**Treatment of Chronic Prostatitis**

All patients should have investigations as outlined above. A summary of treatment options is included (Table 9). Some urologists argue that these patients should have investigation of their urinary tract by way of cystoscopy and at minimum, an ultrasound to ensure no anatomical abnormality that may be responsible.

Patients with asymptomatic prostatitis (IV) require no treatment but those with the inflammatory (IIIA) and non-inflammatory (IIIB) are more difficult.

Patients with type IIIA disease have excessive leucocytosis in their specimens but no bacteria.

- Oral and written patient education
- Stress management. Referral for psychological assessment as appropriate.
- Adequate follow-up and counselling, often with professional support
- Transurethral microwave thermotherapy

**INVESTIGATIONS OF LUTS**

As outlined by Tubarro et al, the aim of investigations for LUTS should be threefold: (1) to evaluate the possible relationship between prostatic enlargement, lower urinary tract symptoms and signs of bladder outlet obstruction; (2) to quantify the severity of benign prostatic enlargement-related symptoms and signs and (3) to rule out the presence of a prostate cancer.

**Urinalysis**

Urinalysis is used to screen for urinary tract infection as a cause of LUTS in order to identify those with microscopic or macroscopic haematuria. A formal urine culture may be undertaken if the analysis was suspicious for infection.

**Post-Void Residual Urine Volume (PVRU)**

Although there is a high degree of intra-individual variation in the PVRU it may still provide valuable information with regard to bladder emptying. It may not distinguish adequately between bladder outlet obstruction or poor detrusor function and the United States guidelines on BPH suggest it is an optional investigation because of this variability. Greater than 300ml is considered a potential risk factor for upper urinary tract dilatation and renal impairment. The PVRU does have the advantage of being used as a monitoring investigation in those opting for non-surgical therapy for BPH. It is readily and quickly performed in the office or hospital setting using portable ultrasound equipment.

**Serum Creatinine**

Most guidelines on investigation of BPH recommend this investigation and an elevated serum creatinine would be an indication to evaluate the upper urinary tract.

**Upper Urinary Tract Imaging**

Urinary tract ultrasound or computerised tomography are appropriate modalities. Most would consider upper tract imaging as mandatory if haematuria was present and recommend it if there was a history of urolithiasis, urinary tract infection or renal insufficiency. Intravenous pyelography still has a role in certain cases, as other modalities do not outline the anatomy of the collecting system with such definition.

**Urodynamics**

Urodynamics is a general term for a collection of investigations useful in quantifying the activity of the lower urinary tract during micturition. Complete pressure-flow urodynamics are complex and usually involves fluoroscopy, video recording, bladder and rectal pressure measurement, as well as an assessment of urine flow. The simplest urodynamics are pressure-flow studies, requiring only voiding into a measuring device to obtain flow rates, and may easily be done in the office setting. With regard to the investigation and diagnosis of conditions underlying LUTS, when considering inexpensive, safe and completely reversible treatments, one may opt to avoid urodynamics studies initially. However, when considering irreversible, expensive or potentially morbid therapy, such studies are considered mandatory. Many patients will not have urodynamics studies based on the first premise above. However, in reality, many surgeons and physicians will have simple pressure-flow studies easily available and will perform these as part

of an initial consultation. More complex studies require time and are costly, and so should be reserved for particular situations as discussed below.

**Urinary Flow Rate (Uroflowmetry)**

Uroflowmetry is considered by some as the single most useful urodynamic technique for the assessment of obstructive uropathy. The purpose of the uroflow examination is to record one or more micturitions that are representative of the patient's usual voiding pattern. Therefore, more than one micturition is often required and it is necessary to confirm with the patient if the flow was better, worse or about the same as their normal pattern, otherwise intra-individual variability may lead to false assumptions. The study may be performed in the office or as part of other urodynamic studies in the laboratory or operating suite.

Figure 9 indicates the most common urinary flow parameters measured. Of these, the peak flow rate is the most closely correlated with the extent of outflow obstruction (Table 10). Total voiding time is prolonged in obstruction and has a reduced Qmax. Poor detrusor contractility is impossible to distinguish from bladder outflow obstruction on uroflowmetry so other urodynamics investigations such as a cystometry are indicated.

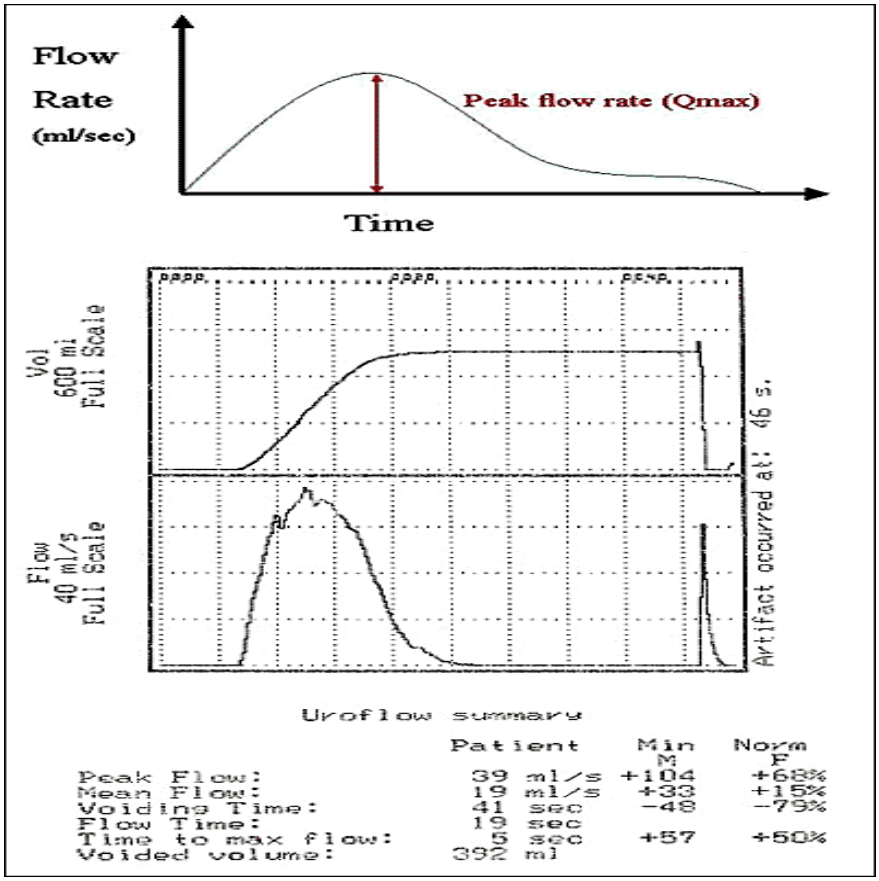



**Figure 6.** Uroflowmetry in a Normal Individual- Diagram Above and Actual Reading Below.

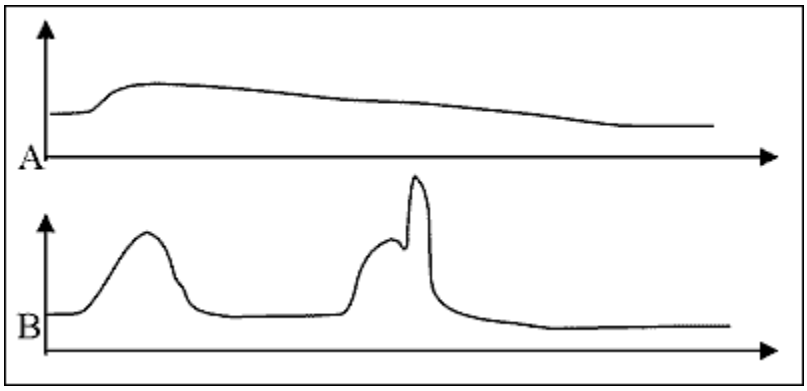



**Figure 7:** Abnormal Patterns of Uroflowmetry:

**(A)** This is likely to represent the flowmetry pattern of a patient with bladder outlet obstruction. The maximum flow reached is around 10ml/sec and the flow rate is prolonged. A diagnosis cannot be made from this reading alone but is certainly characteristic of someone with obstructed voiding and having normal detrusor muscle function.

**(B)** This pattern of intermittent flow usually represents abdominal straining in an attempt to overcome outflow obstruction. The peak flow rate may be normal or high, especially if outlet resistance is reduced.

| | |
|---|---|
| Flow rate- Qmax | Interpretation |
| >15ml/sec | Unlikely to be significant obstruction |
| <10ml/sec | Likely to be significant obstruction or weak detrusor activity |
| 10-15ml/sec | Equivocal |

**Urodynamics- Presssure-Flow Studies**

Various measurements may be used to define detrusor pressures and urethral sphincter pressures as an aid to diagnosis in specific circumstances. This is relevant in patients with LUTS who have had a stroke (or other neurologic disease) where bladder function may have sensory deficits or unstable detrusor contractions, that may need alternate management. Nevertheless, detrusor instability is not considered a negative factor with respect to the outcome of BPH surgery, provided it is adequately managed. Some have even suggested that the detection of detrusor instability in patients with LUTS is only of minor diagnostic importance.

**Urethrocystoscopy**

The performance of this investigation depends on patient history and proposed surgical intervention. It is necessary where there is a history of microscopic or macroscopic haematuria to exclude bladder tumours or stones. A history of urethral strictures, bladder tumours or prior lower urinary tract surgery should also prompt this investigation. Surgeons may also use urethroscystoscopy when planning different surgical treatments or invasive therapies.

**Transrectal Ultrasound Scanning (TRUS)**

Compared to TRUS, methods of determining prostate size such as DRE, urethrocystoscopy and retrograde urethrography are poor. It is often conducted in unison with biopsies of the prostate for suspected carcinoma, but is also a useful tool for assessing the size of an enlarged prostate so that the best mode of management may be undertaken, such as open versus endoscopic surgery.

**TREATMENT OF BPH - OVERVIEW**

The primary aim of any treatment for BPH in the vast majority of men is to relieve bothersome obstructive and irritative symptoms (Table 2). Treatment is often undertaken on an elective basis for such patients. Those in whom complications of BPH occur have treatment done urgently as a matter of course. A range of treatment options are available and may be tailored to the needs of every individual, taking into account their disease manifestations, success rates of treatment, possible complications and patient psup.

**WATCH AND WAIT/LIFESTYLE CHANGE**

Many men presenting with LUTS are often seeking a full assessment of their prostatic health rather than immediate treatment of symptoms that may not be exceptionally bothersome. People with mild symptoms may wish to pursue lifestyle changes as a way of improving their quality of life but with the option of review if such measures fail or symptoms worsen. Furthermore, when an adequate history is taken, hidden agendas such as fear of prostate cancer may even be revealed and fears allayed.

Often drinking habits may be responsible for symptoms such as nocturia, where considerable fluid volumes are consumed in the evening. Reducing fluid intake may diminish nocturia and evening urgency. Furthermore, caffeine and alcohol acting as diuretics, can further exacerbate LUTS. Simple shifts in daily fluid intake may fulfil patient expectations and result in satisfactory outcomes. Voiding diaries are useful for making patients aware of drinking habits and may be the catalyst for initiating and monitoring changes. Bladder retraining (by using timed voiding, strengthening pelvic floor exercises and monitoring oral intake) is also an option in some individuals, once a voiding diary has been examined.

It is important to discuss options with the patient and that they be made aware that the possibility of damage to their upper urinary tract or to the detrusor muscle may result if their symptoms deteriorate and they do not seek medical attention.

**PHYTOTHERAPY FOR BPH**

Phytotherapy, or the use of plant extracts, is becoming widely used in the management of many medical conditions including BPH (Table 11). Often these agents are promoted to aid “prostatic health” and a significant proportion of men try them. Factors also contributing to their widespread use include the perception that they are supposedly ‘‘natural’’ products; the presumption of their safety (although this is not adequately proven); their alleged potential to assist in avoiding surgery, and even the unproven claim that they may prevent prostate cancer. The widespread availability of these products (without prescription) in vitamin shops, supermarkets, pharmacies and over the internet has contributed to their usage and reflects the demand for these phytotherapeutic agents. The mechanisms of action are poorly understood but have been proposed to be (1) anti-inflammatory, (2) inhibitors of 5alpha-reductase, and more recently (3) through alteration in growth factors.

Phytotherapy although promising, lacks long-term, good quality clinical data. Nevertheless, because there is a large placebo effect associated with treatment of voiding symptoms, the use of herbal products that have few or no side effects may be a reasonable first-line approach for many patients. However, patients should be counselled that the efficacy, mechanisms of action and long term effects of these agents are not known and they must be aware of the limitations before proceeding.

The most popular phytotherapeutic agents are extracted from the seeds, barks and fruits of plants. Products may contain extracts from one or more plants and different extraction procedures are often used by manufacturers. Thus the composition and purity of any one product may differ even if they both originated from the same plant. Basic research on one product may not be easily transferred to another making the gathering of data and giving of advice difficult.

**Saw Palmetto Berry (Serenoa Repens)**

Extracts from the berries of the American dwarf palm (saw palmetto) are the most popular and widely available plant extracts used to treat symptomatic BPH today. At least eight possible mechanisms of action for saw palmetto have been advocated including anti-androgenic properties, anti-inflammatory properties, induction of apoptosis to name a few. It is most commonly believed that saw palmetto works as a naturally occurring 5 alpha reductase inhibitor, blocking the conversion of testosterone to dihydrotestosterone (see below in medical therapies section), as demonstrated in several in vitro studies.

Thus, saw palmetto may be expected to reduce prostate size. However, this is not the case in several trials using saw palmetto in men with BPH. The only trial to show in vivo effects of saw palmetto involved needle biopsies of the prostate gland, before and after treatment with saw palmetto or placebo. Although the mechanism is unclear, there was a significant increase in prostatic epithelial contraction in the saw palmetto group.

In a meta-analysis of 18 randomised studies relating to saw palmettto extracts, almost 3000 men with BPH were studied and the authors concluded that “the evidence suggests that saw palmetto improves urologic symptoms and flow rates but that further research is needing using standardised preparations to determine long term effectiveness”. When analysing flow rate and symptom score alone from this meta-analysis, the effect of seronoarepens was to increase the flow rate by a further 2.28 ml/sec (standard error SE 0.29) over placebo which gave an increase of 1.09 ml/sec (SE 0.45). Serenoarepens also reduced the IPSS by 4.7 (SE 0.41), which is comparable to that found with finasteride and tamsulosin. Many studies are currently underway to try and further delineate the role of saw palmetto extracts. One such study by Hruby et al. monitored progression rates in men with mild symptoms of bladder outflow obstruction (IPSS<8) receiving serenoa repens and found that they were significantly reduced as compared to patients on watchful waiting and a matched group of patients on placebo. One third of patients on watchful waiting and placebo progressed over the study period suggesting that phytotherapy may be an option in patients at risk for progression, defined as having a PSA > 1.5 ng/mL and an enlarged transitional zone volume (>25ml) on TRUS.

In summary, saw palmetto studies have shown improved symptom scores compared to placebo but generally no change in flow rates. Overall there is a real paucity of well performed, adequately powered, and placebo controlled trials in the use of phytotherapy in clinical BPH.

**African Plum Tree (Pygeum Africanum)**

Extracts come from the bark of the African plum tree. It is hypothesised, based on in vitro observation, that it acts on the prostate through inhibition of fibroblast growth factors, has anti-estrogenic effects and inhibits chemotactic leukotrienes. No strong clinical data exists of its efficacy although trials are in progress.

**Pumpkin Seed (Cucurbita Pepo)**

Dried or fresh seeds have been taken to relieve symptoms. Phytosterols are thought to be amongst the active compounds. Side effects have not been reported but evidence is lacking with no current clinical trials.

**Rye Pollen (Secale Cereale)**

This is prepared from rye grass pollen extract. In a systematic review summarizing evidence from randomised and clinically controlled trials, rye pollen was found to be well tolerated but only achieved modest improvement in symptom outcomes and did not significantly improve objective measures such as peak and mean urinary flow rates. Again, several mechanisms of action have been proposed including an improvement in detrusor activity, a reduction in prostatic urethral resistance, inhibition of 5 alpha-reductase activity and an influence on androgen metabolism in the prostate.

**Other Extracts**

South African Star Grass (Hypoxis rooperi), Opuntia (Cactus flower), stinging nettle and Pinus (Pine flower) have also been studied and used, however the data numbers are small and the types of trials do not allow conclusions to be drawn at this stage.

**MEDICAL THERAPY FOR BPH**

In 1986 Caine proposed that infravesical obstruction in men with symptomatic BPH comprised both static and dynamic components. The static component of obstruction is related primarily to the mechanical obstruction caused by the enlarging prostatic adenoma whereas the dynamic component is principally determined by the tone of the prostatic smooth muscle. Two avenues for pharmacotherapy have therefore evolved, namely shrinking the prostate tissue or relaxing the smooth muscle of the prostate. Medical therapy is now first-line treatment for most men with symptomatic benign prostatic hyperplasia. They are non-invasive, reversible, cause minimal side effects, and significantly improve symptoms.

**SURGICAL TREATMENT OF BPH**

The indications for prostatectomy, by open approach or TURP are listed in Table 11. At present approximately 90% of prostatectomies are done by TURP. Open prostatectomy should be considered when a gland is estimated to weigh more that 75g, where large bladder calculi exist that may not be dealt with endoscopically, where large bladder diverticulae requiring repair exist, if complex urethral conditions or when orthopaedic abnormalities prevent positioning in lithotomy for TURP. Contraindications to open prostatectomy include a small fibrous gland, prostate adenocarcinoma, previous prostatectomy or other surgery of the pelvis preventing access.

| |
|---|
| • Acute Urinary Retention<br>• Recurrent or persistent urinary tract infections<br>• Significant bother from LUTS secondary to bladder outflow obstruction not responding to medical therapy<br>• Recurrent haematuria known to be of prostatic origin<br>• Bladder Calculi |

**Transurethral Resection of the Prostate (TURP)**

TURP remains the most common surgical treatment for BPH. TURP involves either regional or general anaesthesia, with most patients spending a minimum of one night in hospital. TURP involves surgically debulking the periurethral and transitional zones of the prostate to relieve obstruction. Debulking is done by electrocautery in the standard TURP through endoscopic instruments introduced into the urethra and bladder. Tissue is resected in small pieces until the adenoma is removed and a new channel for passage in the prostatic urethra created, much like fashioning a pumpkin for Halloween with the capsule left behind. Despite using electrocautery, there are mild to severe degrees of haemorrhage, depending on the gland size. However transfusions are rarely needed and the procedure is relatively free of life-threatening complications and most patients experience satisfactory resolution of their micturition symptoms. Studies on urinary peak flow rates and invasive pressure flow have demonstrated the superiority of TURP over minimally invasive therapies. Complications of TURP include failure to void (6%), haemorrhage requiring transfusion (1-4%), clot retention (3%), infection (2%), bladder neck contracture or urethral stricture (6%), transurethral resection syndrome (2%), and rarely incontinence. Transurethral resection syndrome is secondary to dilutional hyponatraemia caused by absorption of the intravesical fluid uses in the TURP. It is manifest by nausea, vomiting, hypertension, bradycardia and confusion. The risk increases with larger glands and longer resection times (greater than 1 hour). The TURP must be abandoned safely with diuretics administered quickly and further treatment initiated if there is no resolution.

Retrograde ejaculation is reported to occur in almost all patients undergoing TURP as the normal bladder neck mechanism which contracts to allow antegrade ejaculation is surgically resected. Other studies have reported only 50% men with such symptoms.

Erectile dysfunction (ED) may be associated with TURP either via thermal nerve injury or emotional stress and was reported in early studies at a rate of 4-40%. This has now been shown to be an overestimation. The rate of ED in the AUA Cooperative study was found to be 13% in 1000 men. The study also demonstrated an increase of around 20% of ED in the untreated group with BPH. Although ED is often quoted as a side effect of TURP, Kassabian concluded that TURP (or even any other surgical therapy) did not appear to have a long term effect on erectile function or libido.

TURP remains the ‘gold standard’ by which other surgical (and even medical) treatments are measured.

**Open Prostatectomy**

This is the oldest, most invasive therapy for BPH. It is commonly done through a transvesical approach, but may be done retropubically. Early complications of this operation include haemorrhage, blood transfusion, sepsis and urinary retention with the most common late complication being bladder neck stricture (2-3%). TURP has lower perioperative morbidity but open prostatectomy produces equivalent, if not superior improvement with a similar or lower re-operation rate. Sexual dysfunction is not likely to be altered by the surgery however ED is still quoted at 3-5% risk. Retrograde ejaculation occurs in 90% patients. Other complications of surgery such as deep vein thrombosis, myocardial infarction and stroke are less than 1%.

**Minimally Invasive Surgical Therapies**

Minimally invasive therapies for BPH have evolved in the past decade with the goal being to achieve symptomatic improvement that is durable, without the morbidity associated with surgery or the long-term side effects or compliance issues associated with medical therapies. The aim of such treatments is to achieve results similar to TURP but with minimal anaesthesia and hospitalisation. An overview of randomised controlled trials in 2000 by Tubaro et al comparing minimally invasive and invasive modalities of treatment found re-treatment rates to be higher in the minimally invasive group .They concluded that none of the minimally invasive treatments were superior to TURP from a cost and benefit standpoint and that TURP remains the gold standard of treatment. Some view such treatments as in-between medical and TURP, so their role is not completely defined, and we await long term data on all proposed therapies.

1. **Transurethral Incision of the Prostate**

A similar approach to a TURP is used except that no surgical debulking is undertaken. Between one and three incisions are made into the prostate at the level of the bladder neck back almost to the insertion of the ejaculatory ducts. This releases the “ring” of BPH tissue at the bladder neck, creating a larger opening. There is a reduced risk of morbidity such as haemorrhage. In some instances, ejaculation may be preserved in younger men, especially if one incision is made. The procedure only works if the tissue in the periurethral area is not too bulky, otherwise a “ball-valve” mechanism of adenoma may develop. Laser may be used for incisions of the prostate, as well as standard electrocautery.

2. **Laser Therapy for Benign Prostatic Hyperplasia**

There are several evolving therapies for BPH involving lasers including Holmium laser resection of the prostate (HoLRP) and Holmium laser enucleation of the prostate (HoLEP) as well as more minimally invasive laser therapies. Laser as an energy source has an advantage of standard electrocautery by being relatively bloodless and does not carry the risk of hyponatraemia, which may rarely occur via absorption of irrigation fluid in a standard TURP. HoLRP is an operation involving laser resection of the prostate tissue via an endoscope, similar to a standard TURP using electrocautery as outlined above. The fragments of prostate tissue are made small enough to irrigate out prior to detachment from the prostate. HoLEP again uses a holmium laser but the laser acts like a finger would at an open prostatectomy, shelling out tissue until it floats in the bladder. The tissue is then morcellated and extracted. This technique may be safely used in large prostate glands (those weighing >100g) as an alternative to open prostatectomy as discussed below. Studies have demonstrated that HoLEP improved flow rates by 56-119% and by TURP 96-127%, and symptom scores reduced in both groups by 60%. Laser treatment reduced the length of hospital stay, clot retention rates, the occurrence of hyponatremia, strictures, transfusion requirements , but had a slightly higher risk of reoperation.

The minimally invasive laser therapies such as visual laser thermoablation of the prostate (VLAP) rely on deep thermal coagulation of the prostate by Nd:YAG laser with later necrosis and sloughing of the prostate tissue. They require prolonged catheterisation and have a failure rate of around 10% as reported by Chacko et al in a randomised trial in 2001.Such therapies differ from debulking surgery and require a post-procedure period for resolution of symptoms with the advantages being lack of general or regional anaesthesia. Durability and tolerability remain issues for such therapies with re-treatment rates between 10% and 49%. Certainly further studies, using randomization, larger sample sizes and comprehensive measures of outcomes and adverse events, are still needed to better define the role of laser techniques for treating benign prostatic obstruction.

3. **Other Minimally Invasive Therapies**

Thermoablation is the principle underlying the remaining minimally invasive available treatments that have been introduced thus far and these include transurethral microwave thermotherapy and transurethral electrovaporization of the prostate.

4. **Intraprostatic Stents**

In keeping with the principles of minimal invasion, a stent or coil is placed into the urethra at the point of maximal obstruction under local anaesthesia, endoscopic and radiographic guidance. Stents may be temporary/biodegradable or permanent. Although effective in the short term, they do have a significant complication rate raising concerns over safety and large randomised controlled trials are needed to establish their long term efficacy and their true role in the management of BPH.

**MEASURING OUTCOMES AND EFFECTIVENESS OF TREATMENT**

When considering the effectiveness of any treatment for BPH, one must consider the efficacy and tolerability of invasive or medical therapies (ie. the effect on both subjective symptoms and urinary flow and incidence of adverse effects), the long-term effectiveness, the impact on daily life activities (quality of life) and the costs. Large scale randomised controlled trials provide information on the tolerability and efficacy of treatment options and evidence-based databases such as Cochrane reviews, may further analyse evidence-based data from multiple trials (Table 12).

| | |
|---|---|
| Treatment | Evidence |
| TURP | Reduction 4.5 points symptom score versus watchful waiting<br>Qmax improved 6 ml/sec versus 0.4 watchful waiting |
| Laser | <u>Noncontact</u><br>IPSS improved by 2.5 points<br>Qmax improved 3.18 ml/sec<br><br><u>Contact</u><br>IPSS improved 2.9 points<br>Nd-YAG Qmax improved 1.91 ml/sec<br>HoLRP Comparable to TURP |

<u>CHRONIC MIASM</u>

“It was a continually repeated fact that the non-venereal chronic diseases, after being time and again removed homoeopathically by the remedies fully proved up to the present time, always returned in a more or less varied form and with new symptoms, or reappeared annually with an increase of complaints. This fact gave me the first clew that the Homoeopathic physician with such a chronic (non-venereal) case, yea in all cases of (non-venereal) chronic disease, has not only to combat the disease presented before his eyes, and must not view and treat it as if it were a well-defined disease, to be speedily and permanently destroyed and healed by ordinary homoeopathic remedies but that he has always to encounter only some separate fragment of a more deep-seated original disease.” – Dr. Samuel Hahnemann.

Samuel Hahnemann, states in paragraph 72 of his Organon of the Medicine: “Diseases of such a character that, with small, often imperceptible beginnings, dynamically derange the living organism, each in its own peculiar manner, and cause it gradually to deviate from the healthy condition, in such a way that the automatic life energy, called vital force, whose office is to preserve the health, only opposes to them at the commencement and during their progress imperfect, unsuitable, useless resistance, but is unable of itself to extinguish them, but must helplessly suffer (them to spread and) itself to be ever more and more abnormally deranged, until at length the organism is destroyed: these are termed chronic diseases. They are caused by dynamic infection with a chronic miasm.”

The word "miasm" comes from the Greek "miasma" which means taint, stain, and pollution. According to the common definition, a miasm is defined as polluting exhalations or malarial poisons. Hahnemann states that according to all investigations only 3 chronic miasms are found. First-syphilis, also called venereal chancre disease, then-sycosis, or the fig wart disease and finally the chronic disease which lies at the foundation of the eruption of itch i.e. psora, which Hahnemann treat of first as the most important. (Psora, or the itch disease)

WORD MEANING OF MIASM
1. Heavy vaporous exhalation or effluvium formerly believed to cause disease.
2. Obnoxious influence or atmosphere.
3. An unwholesome exhalation.
4. Polluted material.
5. Putrid vegetable matter.
6. Contagion effluvia from human body.
7. Infective material.
8. Maggots-the larvae from a fly.
9. Stain, pollution, defilement.

DEFINITIONS

**Hahnemann**

Defines "miasm as morbific agent, which is inimical to life". (§ 11)

Kent

Defines "miasm as poisons on the dynamic plane".

J.H Allen

Miasm is the negative force linked to the vital force. Existence of miasm is the true concept of chronic disease.

H.A Roberts

"A miasm is defined as polluting exhalations or malarial poisons".

Shakespeare

"Miasms are the maggots that are born within the brain"

Sir John Weir

Remarks in his book 'Science and Art of Homoeopathy'-"By miasm, Hahneman means germ of diseases"

Dr. P.S.Ortega

"This source or germ of suffering and death is positive, demonstrable and perfectly recognizable"

**Gross A. J**

"When we say miasms, we mean causes, the aetiology of acute and chronic diseases"

George Vithoulkous

"Miasm is a predisposing weakness of defense mechanism caused due to three factors such as hereditary infections, strong infectious diseases, and previous treatment".

Foster

Defines "miasm as a morbific emanation, which affects individuals directly, and not through the medium of another individual".

S.P.Dey

"A miasm is an invisible polluting substance which once gains entrance into the system of a living human being and over powers the vital dynamis, pollutes the person as a whole in such a way that it leaves behind a permanent stigma or dyscrasia which if not completely eradicated with the help of suitable anti miasmatic treatment, will persist through out the life of the patient and may be transmitted through generation after generation".

The spiritualist and idealist Homoeopaths like Dr.J.T Kent, J.H Allen, J. Paterson, H.A.Robert defined miasm as "condition, state, predisposition, dyscrasia and diathesis". But Homoeopaths of more scientific bent of mind who are known as materialists like Dr.C.Herring, R.Hughes, S.Close, G Boericke, Margaret Tyler, P. Speight and B.K Sarkar could not be satisfied with the above concept. Instead of regarding miasm as dyscrasia they included several of the dyscrasia among the morbid conditions caused by miasms.

Dr.B.K Sarkar said Hahnemann use the word 'miasm' amplified by descriptive terms "infectious, contagious, excessively minute, invisible as living creatures" applied to cholera poisoning agent, he must have meant previously which we mean today when we use terms of modern bacteriology to express the same idea. In fact the idea of "contagion vivum" originated with Hahnemann and he can be hailed as the father of bacteriology.

Dr.Phyllis speight says, 'Any Homoeopathic prescriber who ignores the miasmatic theory cannot eliminate deep seated diseases."

**CLASSIFICATION OF DISEASES**

Hahnemann's views concerning disease classification were put forward in the sections 39-61 of the first edition of Organon, which were entirely changed by Sections 72-82 of the fifth edition of Organon. During his time diseases used to be classified as general and local demanding general and local treatments. He refused this classification on the ground that each disease should not be considered as a specialty by the old anatomical conception of human being. He, next, took up the question of classifying diseases into febrile and afebrile, groups, a classification, strongly advocated by a section of his contemporaries. Hahnemann comes to the conclusion that since nature herself produces diseases of individual kind, no rational medical art can exist which does not strictly individualize each case of diseases, that is, which does not regard each case of disease as distinct and unique, which in truth it is. (Sec.16). Hahnemann's approach to the study of diseases and drug actions was clinical.

**CLASSIFICATION OF DISEASES ACCORDING TO Dr. SAMUEL HAHNEMANN**

**HAHNEMANN'S VIEW REGARDING CHRONIC DISEASES**-

All chronic diseases of mankind, even those left to themselves, not aggravated by a perverted treatment, show, such a constancy and perseverance, that as soon as they have developed and have not been thoroughly healed by the medical art, they evermore increase with the years, and during the whole of man's lifetime; and they cannot be diminished by the strength belonging even to the most robust constitution. Still less can they be overcome and extinguished. Thus they never pass away of themselves, but increase and are aggravated even till death. They must therefore all have for their origin and foundation constant chronic miasms, whereby their parasitical existence in the human organism is enabled to continually rise and grow.

During Hahnemann's time the causes of disease were known to include,

1. Mechanical factors-Traumatic agencies. lesions, injuries, destruction of tissues resulting from physical force, etc.

2. Chemical factors- Destructive action of certain chemical poisons e.g., Arsenic, Opium etc.

3. Dynamic factors-

   a. Mental or physical, atmospheric, thermic, telluric and climatic;

   b. Dietetic, hygienic, contagious miasms, etc.

Hahnemann was the first to discover that biological agents in the nature of minute, invisible living being (miasms as he called and bacteria and other micro-organisms according to modern terminology) are causative factors for the origin and spread of contagious and infectious diseases.

The discovery of miasms (but not individualized) causing acute diseases was later followed by his discovery of miasms causing chronic diseases (The Chronic Diseases-Their peculiar nature and Their Homoeopathic cure. 1st Edition 1828). Hahnemann said, "I spent 12years in investigating the source of this incredibly large number of chronic affections.''

Hahnemann stated five reasons for the recurrence of symptoms.

1. Law of similars might not be law of universal application.

2. The number of drugs discovered were too few to cover all types of diseases that affect human beings.

3. There might be some defect in application of law of similars.

4. There might be some omission in ascertaing the totality of symptom on which Homoeopathic treatment is based.

5. There might be some obstacles preventing lasting recovery.

At last after prolonged observation and laborious experiment he could realize that the above 5th point is the root of all evils. He gave a general name to obstacle retarding cure as 'psora'. By it he meant the "internal itch diseases" with or without eruption on the skin. Regarding the nature of chronic diseases Hahnemann stated, "Its start was pleasing, the continuation less favorable, and the out come hopeless''.

**HAHNEMANIANN DOCTRINE OF MIASMS**

Chronic disease all have their origin and foundation constant chronic miasm, where by their parasitical existence in the human organism is enabled to continually rise and grow.

After 12 years of study Hahnemann founded that the basic cause for chronic diseases is psora i.e. the internal itch disease with or without its attendant eruption on the skin. Psora is the most ancient, most universal, most destructive and most misapprehended chronic miasmatic disease. Psora is the most hydra headed of all the chronic miasmatic disease. Psora become the universal mother of chronic diseases. Seven eighth of all chronic disease is due to psora. Remaining eight-springs from syphilis and sycosis or from a complication of 2 of these 3 chronic miasmatic disease or from a complication of all 3 of them. Three important moments in the origin of the chronic malady are time of infection, period of time for the development of disease, breaking out of the external ailment.

Theory of chronic miasm appears first in fourth edition of organon of medicine. Hahnemann mentions about chronic miasm in aphorism 5, and define miasm in aphorism11. According to aphorism 33- morbific noxious agents or infectious miasms are conditional; while medicinal agents have an absolute unconditional power, greatly superior to the former. Hahnemann mentions about the fundamental causes of disease in aphorisms 5, 72, 78, 79, 80, 204 and 206.

Aphorism 78- "The true natural chronic diseases are those that arise from a chronic miasm, which when left to themselves, and unchecked by the employment of those remedies that are specific for them, always go on increasing and growing worse, notwithstanding the best mental and corporeal regimen, and torment the patient to the end of his life with ever aggravated sufferings. These are the most numerous and greatest scourges of the human race; for the most robust constitution, the best regulated mode of living and the most vigorous energy of the vital force are insufficient for their eradication''.
Aphorism 79- Syphilis, chronic miasmatic diseases, which when uncured ceases only with the termination of life. Sycosis (the condylomatous disease) equally ineradicable by the vital force without proper medicinal treatment was not recognized as a chromic miasmatic disease at first. Since the dyscrasia persist it is also considered as a miasmatic disease.
Aphorism 80- Psora is the only real fundamental cause and producer of innumerable forms of diseases.
**Aphorism 206-** while taking the case note whether there is any history of venereal infection. In case history, if there is contraction of syphilis or gonorrhoea, then treatment should be directed first to these miasms.

**Dr. PROCESO .S. ORTEGA'S VIEW REGARDING MIASM**

Hahnemann observed in his own practice, relapse of new diseases in apparently cured patients. The apparently different illnesses presented by the same sick person were in fact linked by a back ground which constituted a predisposition to a characteristic form in respect both to dysfunctions and to the lesions themselves. This predisposition whether constitutional or merely a constant aspect of organic man which persists in the form of its expression was called Hahnemann as miasm or chronic disease. Acute illness is an extension of the constitutional one which determines its and is its ultimate cause. Even after acquiring the knowledge of the miasms the homoeopaths acted as if every case was a new illness without considering the miasm as either unknown or forgotten.

Acute disease can be cured thoroughly by means of VIS MEDICATRIX OF THE ORGANISM. The answer to the question why this VIS MEDICATRIX of the organism in sufficient to effect a cure in chronic maladies led to the discovery of nature of chronic diseases.

Many professors of Homoeopathy says that microbes constitute what he called acute diseases and the viruses the chronic miasms (M-Tyler)

Hahnemann states about sycosis “This is the miasm that engenders the smallest number of chronic sickness, its manifestations being seen only from time to time”

In the last edition of Organon there are many references to the miasms considered by Hahnemann as diathesis or constitutional diseases. [Paragraph 78, 82 and203 to 208, paragraph 5.]

The most illustrative and precise paragraph in the organon relating to the miasms is 204. In paragraph 206 the miasms are called “dyscrasias ‘in the following lines Hahnemann calls them “diathesis.” ‘The psoric diathesis, the fundamental and most common cause of chronic diseases”. Thus the concept of diathesis, dyscrasia or constitutional pathology persists in Hahnemann’s brilliant conception of the chronic diseases.

**Condition for accepting the doctrine of miasms:**

The indispensable condition for accepting is the actual and complete knowledge of Hahnemannian Homoeopathic medical philosophy.

1. The concept of health, sickness and cure are set forth in this philosophy as process occurring on the dynamic plane Health is equanimity of the human being, illness is disequilibrium of the vital force; cure is a return to harmony with oneself and the whole world.
2. Vis Medicatrix naturae or Natura Medicatrix Morborum
3. All medical men recognized this since Hippocrates. Hahnemann refers to this healing power in paragraph 10 .4. One must have a complete understanding of the true meaning of the similimum. 5. The true similarity to be found in the similimum must encompass a maximum analogy between the medicine and the sickness.

**STUART CLOSE VIEW REGARDING MIASM**

“A misunderstanding of the sense in which Hahnemann uses the word ‘miasm’ has deceived many. It was a word loosely used in his time to express the morbific emanations from putrescent organic matter, animal or vegetable, and some times the effluvia arising from the bodies of those affected by certain diseases, some of which were regarded as infectious and others not.”

What ever the dictionary meaning of the term “miasm” may be, Hahnemann has clearly specified the meaning as “parasites”, “germs”, “viruses”, and minute living bodies” etc. in different chapters in his epoch making books “Chronic diseases” and “Lesser writings” 50 years before Koch’s discovery Hahnemann discover the parasitical nature of all infectious diseases and chronic diseases in general In defining the scope of Homoeopathy it is necessary first to discriminate between disease per se, as a morbid vital process and the material results or products in which the morbid process ultimate. With the latter, Homoeopathy primarily has nothing to do. It is concerned only with disease per se, in its primary, functional or dynamical aspect. The tangible things, which the examining physician finds in the body, are not the disease, but merely its effects. Primarily Homoeopathy has nothing to do with any tangible or physical cause, effect or product of disease although secondarily it is related to all of them.

The morbid processes from which the gross pathological tissue changes or organic lesions arise or to which they lead are amenable to homoeopathic medication. Homoeopathic remedies, by virtue of their power to control vital functions and increase resistance, often exercise a favorable influence upon physical development as well as upon the tangible products of disease. Thus the growth of tumours may be retarded or arrested, of Homoeopathy.

Hahneman in formulating his “Theory of the Chronic Miasms”he did for pathology what he had already done for therapeutics; he reduced a great mass of unsystematized data to order by making a classification based upon general principle.

**J. H.ALLEN’S VIEW REGARDING MIASMS**

The question is often asked, is it necessary to know anything about the chronic miasms, in order to successfully treat those numberless chronic maladies that we meet in our every day practice?

He, who does not know what objects disturb to vital force or keep up the disease, is not a true the vital force or keep up the disease, is not a true guardian of health. In order to cure disease intelligently we must regard the fundamental cause.

You cannot follow the evolution of the curative processes; you cannot even prescribe intelligently the proper diet for a patient, unless you know the basic miasm.

To know the basic miasm in each case helps us in many ways, besides that of being a therapeutic aid it may form a basis not only of the patient diet, but also of occupation, mode of life, habits, social relations, sexual functions and numerous other things.

Three relays we should follow in investigating the three chronic miasms. First, the period when infections took place; second, the period when the whole organism began to be tainted with the miasmatic poison, the third, the manifestations of the external expression, by means if which Nature indicates the complete development of the miasmatic disease of the internal organs.

Hahnemann says, "in the chronic miasmas as in the acute, for after the internal disease is completed, the eruptions appear."

A thorough knowledge of these chronic miasms, makes plain in the backward and forward movements of disease. It assists us in the selection, too, by the true grouping process of the anti-miasmatic remedies; thus it helps us to watch the true progress of disease,and what to expect in the evolution of each miasm, until it has become completely extinguished or separated from its bond with the life. Besides, we are enabled to set aside these symptoms that are to a great degree, latent in the organism, and select a remedy based upon the active miasm, which then removed, may allow the other symptoms to come to the front so that they can be covered with a second selection.

After having discovered Psora, he says, "This showed me that the Homoeopathic practitioner ought not to treat diseases of this kind, as separate and completely developed maladies; nor ought he to expect such a permanent cure of these diseases, as would prevent them from appearing again in the system, either in their original or in a modified and often more disagreeable form.

"The needs of the patient, are seen in the signs and symptoms," but a thorough knowledge of those signs and symptoms is only possible from a knowledge of the chronic miasms”. "If disease is cured from cause to effect, then it must remain cured,"

***Why it is necessary for a true homoeopath to know about these chronic miasms?***

We cannot select the most similar remedy possible unless we understand the phenomena of the acting and basic miasms; for the true similia is always based upon the existing basic miasms.

- The curative remedy is but the pathopoesis of a certain pathogenesis of an existing miasm.
- The proving of a remedy would be very indefinite to us if the name were with held from us. Similar is with the disease producing agent.

We should know, not only the name of the underlying principle that fathers the phenomena but also a definite knowledge of these disease forces i.e. miasms. Suppose if we prescribe the similar remedy and have no knowledge of the laws of action and reaction (or primary and secondary action) how can we watch the progress of a case without a definite knowledge of these disease forces (miasms).

- In fact, if we know nothing about the traits and characteristic of our enemy, is it possible to wage an equal warfare?
- Why should the disease return in the same form or some diverse form?
- These are the things that disturbed the mind of Hahnemann, and in the end, led him to discover the Psoric theory of disease.

Knowledge of all miasmatic phenomena would be, in toto, a complete knowledge of all that is known as diseases, and beyond these symptoms there is nothing discoverable or recognizable as disease. .

***Simple reasons given by Hahnemann as proof of the existence of a chronic miasm:***

- Persistency of chronic ailments, seen when the diet, hygiene and general health of those patients were carefully considered.

- With no external aetiological reason they seen to come from within at the organism itself, developing from some peculiar dynamis within.

- Hahnemann also observed that they accompanied some physiological process, or were in some way connected with the functions of the organism.

- Again he saw, under the action of the homoeopathic remedy (curative action) disease disappear suddenly by the use of the higher potencies, often changing its expression, a sort of retro-metamorphosis, or a receding of disease in the reverse order that it came, going back through, finally disappearing at together, leaving no trace of its prior existence. These thoughts came to him, when did it begin? What was the source of its existence?

It must be some latent, inherent, internal, pre existing cause, having its habitual in the organism, yet not connected in a material way with that organism, but with that dynamic, the life force itself, becoming a part of it or co-existent with it, and having a similar dynamis, which arose and fell as it was disturbed by other causes from without, known in our nomenclature as secondary, or existing causes. Thus he noticed the skin never produced an eruption upon itself (outside of traumatic or chemical causes); never assuming a morbid state unless obliged to do so by some previous perverted change or abnormal activity in the organism itself.

Today we under stand psora to be a basic miasm, not confined to any special form of eruption upon the skin of the individual, but that it is the parent of a multitude of functional and pathological changes that take place in the human organs. The business of the miasms is to kill, to destroy, to tear down; to murder life through there multiplied process. They kill by sepsis, by devitalizing the blood, by anemic states, so reducing the red blood corpuscles that there is no means left where by the organism can be fed. If they build, they build false structure, such as tumours, nodes, enlarged glands, fibrous growths, cancers etc. These we call abnormal growths or pathological states, which simply mean another way of life. These false or abnormal growths are constructed out of false material, because all the process of life are false or perverted, so that a physiological truth becomes a physiological lie, or a death dealing element working, or attempting to work, with a life- giving principle.

The action of the miasms is to make gaps and breaches in nature that the debilitated life forces cannot repair. They destroy men's wills, hope, courage and drive the sunshine out of life, bringing all under shadow, making him down-hearted, low spirited, hypochondriacal, even to suicide. They are co-workers with sin and with death.

***Expression of the miasms:***

There are certain conditions or states of the organism due wholly to the action of the miasms and recognized in our works on pathology under special names as cachexia, dyscrasia, diathesis, scrofula, struma, idiosyncrasy, predisposition, hereditary predisposition and hereditary states, all of which are due, directly or indirectly, to the workings of, or they are expression of miasmatic action.

When we speak of cachexia we mean a depraved condition of the whole system, we mean blood changes often due to toxic causes, whether they be due to drugs such as arsenic, quinine, plumbum, mercury or to animal poisons, vaccination, or to malarial poisons; diseased states as small pox, diphtheria, syphilis, typhoid fever, etc, it is an advanced chronic, active miasmatic state, often a disintegrative process taking place usually in the fluids of the body, especially in the blood, an involvement of every cell and fibre, a dissolution of chemical constituents and biological elements, a stasis often in the elimination of waste products from the organism. Cachexias may be acute, sub acute or chronic. Some times they depend on a single miasm, and again all the chronic miasms may be present. If sycosis or syphilis is specifically combined with psora the cachexia usually assumes a semi malignant form. The character of the miasm gives us the character of the affection or the disease formula.

***The miasms and their Relations to pathology:***

Post mortem changes and pathology are not always the end of miasmatic action or the end of disease, although they may be the end, or death of the patient. Hahnemann never rejected pathology, and there was probably none more expert in making a diagnosis; but when he was through with pathology, for the sake of knowledge, he put it where it belonged, as a part of the great whole in the pyramid of symptomatology. .

It is this minute symptomatology that Allen call our attention in our investigation and study of the miasms, for a single symptom often in miasmatics may guide you to the discovery of some one of the chronic miasms that you have over looked for an indefinite time in your treatment of the case a single persistent symptom is often quite a positive sign of a suppression, and if suppressed, compels the life forces to eradicate.

The pathology of today differs from pathology of ten years ago. It differs because of the increase of sycotic diseases, which we know to be greatly on the increase, by the constant suppression of these disease processes, by the present modern powerful suppressive agents in use today, by the imperfect life, diet, hygiene etc. Hahnemann's

wisdom and foresight help in recognizing the fact that disease lies not in the pathology alone, but in the totality of the symptoms in each individual case.

The pathological symptoms are not first causes in any case. There is some thing behind pathology, something a little deeper down in each case. Pathology may be a death process, but it was first a perverted life process, first a perverted physiology, a perverted function, and functional change preceded, and do precede, all pathology. Pathology is the finished work of the perverted life action. In pathology the term pathognomonic symptoms is intended to express the keynote of a disease, just as we use keynote in drug proving. But it does not express that disease in its fullness or designate the distinctive features that characterize one disease from another so, like wise, we say of pathology that it does not represent fully the expression of the disease in a given case. The true pathognomonic symptoms of a given case are those that cover the existing active miasm. In this way our therapeutic grouping becomes a miasmatic one and not a pathological one.

Hahnemann says, “This primitive disease evidently owed its existence to some chronic miasm”. Now this wonderful revelation of disease, nor had such a flood of light thrown upon the phenomena of disease.”Hahnemann’s recognition of this primitive existence in a chronic miasm is the only true conception of disease.

***The Relationship of the miasms to abnormal growths:***

All disease was first disturbed function and later on, as the functional disturbance increased and become more intensified, it becomes pathological. Indeed it is the perverted function or physiological stress that produced the pathological state. An internal disease process, when it becomes active, must in the general course of events and through the natural evolutive process, soon becomes an external disease process. The finished or completed work of miasm is the lesion or the pathological for the real disease. No lesion or pathological condition in the first cause of any disease, for the disease process precedes them all, and the true cause always lies (outside the mechanical) in the disturbed or distressed life force itself.

A tumour is a miasmatic correlating process. The difference often between an abscess and a tumour is that one is an inward process, while the other is an outward process. The abscess throws off or out the disease; while the tumour correlates it. One is destructive, the other constructive, both of which, up to a certain degree, become, as it were, safety valves to the organism.

To us, as homoeopaths, a tumour or any abnormal growth, infact, any pathological formation, is but a landmark of miasmatic action or change. For these manifestations present on themselves the prehistoric history of such change and such action and recognition of the real, the miasma, the subversive force as distinguished through the phenomena of disease action. They are simply ripening or ripened fruit of that prolonged perverted life action. We see in abnormal growths two things; the pathological condition and the phenomena of that condition.

We must admit that no abnormal growth can be formed without the work of the life force. We will further admit that a normal or healthy life force could not and does not construct one, as it has no power, outside of its normal physiologic action. How was it formed? There are many ways by which the life force might be disturbed that would bring forth an abnormal growth, such as a suppression of a discharge, injury to a part, suppression of disease states, such as eruptive diseases, pain, ulcerations or any marked disease process. Any stasis of disease or miasmatic suppression may produce an abnormal growth.

How do you know that a miasm is behind or at the root of all abnormal growths? First, a careful study from Hahnemann himself for twelve years, and after the most earnest thought, careful analysis and experiments he saw that the miasm lay not only at the basis of abnormal growths but that they fathered all disease outside of chemical and mechanical irritation. Secondly, when the law of cure was applied, basing the prescription on the totality of the prominent and most dependant miasmatic symptoms, the abnormal growths no longer developed and immediately began to diminish and finally disappeared. By this the tumour or abnormal growth lost its power to increase in size and began to diminish, and further more that the general health of the patient began to improve immediately with the arrest of the growth, was sufficient proof of the basic principle lying at the bottom of the disease.

***Suppression of the Miasms:***

Hahnemann speaking the treatment of psora in his Chronic Diseases, Vol 1 says; “The older physicians were much more conscientious than modern doctors, they were much more enlightened observers. Their practice was based upon experience, which showed them that the removal of psoric eruption from the skin was followed by innumerable ailments and grievous maladies.” The multiple expressions of disease, known by certain specified names, are the fruits of miasmatic action and its power over function and over life.

“Life” says Hahnemann, is a vital principle, a self-moving force, vital power which, if acting in harmony, preserves our bodies a harmonious whole; a disturbance of which is disease; a lack of which is death”. The miasm is the opposing force to the life force; therefore, the forces we bring against it must be in true opposition to the miasm, and not alone against the life itself or we disturb it more.

***Some of the ways in which suppression may take place:***

Suppression of skin eruptions such as itch (scabies), tinea, eczema and other eruptive diseases. The most frequent methods used were local applications, such as itch ailments, salves, medicated lotions, mineral baths, applications of cold and heat, and also the persistent use of crude drugs internally. The removal of the local expression of the disease only gave the miasm an opportunity to become centralized upon some organ and the body and that while the local expressions were removed, the internal conditions were unchanged, and the internal disease increased in the progress of time. He recognized the local symptoms as secondary expressions, or vicarious expressions, of the internal disorder.

We have in skin diseases and all external manifestations of disease peripheral expressions through nerve transmission. It is taken up from within and transferred outwardly as a relief process. This is nature's provisional safety valve. This is as much a biological law and a physiological process as the elimination of the urine or sweat is a physiological process. When we suppress any local disease we overcome that process or we annul it, and we are then enemies of biologies or physiological law. This is the secret of all suppression. As the miasms are multiplied the disease process become more complex and multiplied the disease process become more complex and multiplied, so that the effects of a suppression is then more complex in its phenomena, therefore more dangerous to life.

The suppressed action of a chronic miasm means much to the patient, to the family and to the race in general, for it not only weakness the race, but it means hereditary transmission of either that perverted state or that deeper and more profound involvement, by these newly developed processes, coming out of such suppressions. Another point to be considered in our study of the suppressions of the miasms and that is the resistance power of the life force. One person is gifted with more power than another; different persons resist to a greater or less degree the action of drugs.

If the miasms suppressed in the acute stage we will get acute expressions; and if sub acute, sub acute expressions, and so on as the case may be. Chronic miasmatic expression of disease is known as latent miasms. As a rule the symptoms of the miasms cannot be long suppressed or forced into a perfect latent state, for sooner or later, the life force is bound to give us some expression of it, and that expression will depend of course upon the nature the suppression, the state of miasmatic action and the blending of the miasms. There are 3 miasmatic conditions, which as a rule, when suppressed, produce disastrous conditions, which as a rule, when suppressed, produce disastrous conditions; these are acute itch (scabeacris), gonorrhoea in the first or second stage, and the malarial miasm often called intermittent fever The first may give us any disease catalogued under psora and unless a secondary eruption should appear such as eczema, etc, stasis is sure to appear in some part of the organism, and which is often incurable unless the eruptive disease can again be produced.; A gonorrhoeal suppression in may experience usually results in one of three process-a gleety discharge or catarrhal condition of some mucus surface; a localized secondary inflammation of some form or other such as metritis, salpingitis, appendicitis or inflammation of the prostate, rectum or of some other organ.

Moral insanity is of such common occurrence after a suppression of gonorrhoea, that the most casual observer cannot fail to notice it. Some of the developments of suppressed malaria are asthma, chronic headaches, chronic liver and splenic difficulties, tubercular developments, and bronchial coughs.

Hahnemann says that "in the study of the chronic miasms and their suppression, three things ought to be considered, first, when the period of infection took place; second, when the whole organism is tainted; third when external symptoms make their appearances"

Foster defines a miasm " as a morbific emanation which affects individuals directly and not through the medium of another individual.

**GEORGE VITHOULKAS VIEW REGARDING MIASM**

He emphasized the term predisposition rather than miasm. There exists layers of predisposition, which underlie the waxing, and waning of temporary ailments. These must be taken into account in treatment intending to be completely curative.

**S.P.DEY'S VIEW REGARDING MIASM**

In his book, Essentials of Principles and practice of Homeopathy, he states that the miasmatic states observed and stated by our master Samuel Hahnemann, are hundred percent true, and complete cures of chronic diseases are not possible without believing in the miasmatic states.

According to Gould's medical dictionary, the term"miasm"or "miasma" means a pollute or a "noxious effluvium" or "emanation". The term miasm was not introduced by Hahnemann; this was rather a common term in

medicine during Hahnemann's time to indicate the unknown cause of a disease, which once attacks the vital principle, pollutes the whole system in such a way that a permanent and intractable disease state is produced which when uncured, ceases only with the termination of life" (This is based on aphorism 79 of Organon of medicine)

***SYCOSIS***

Sycosis comes from Greek word 'sykon' which means fig. A medical dictionary defines sycosis as Hahnemann's term for the constitutional effects of gonorrhoeal virus. To Hahnemann, sycosis was essentially a diathesis producing warts or warts like growths. He therefore, called sycosis as Fig wart disease.

Sycosis is an anomalous constitutional state resulting from arbitrary and unnatural suppression of acute illness characterized by fluxes and abundant secretions.

Sycosis is a profoundly acting miasm. It acts upon every cell of the human organism, even to the very depths of the physical being.

Sycosis is often suppressed, and then it lies dormant in the organism like a sleeping volcano to set up, later, new processes more deadly and destructive than before.

According to Hahnemann, the most important cause of Sycosis is gonorrhoea as a cosequence of which there results a temperamental change, a chronic gonorrheal condition. Towards the end of the 19$^{th}$ century (1892), Dr. J. Compton Burnett considerably widened the field of sycosis. He showed its relation to the intempestive vaccinations. Hence, the second great cause of sycosis is anti – variolic vaccination.

Sycosis, however rarely results after primary vaccination, because it is generally followed by a physiological reaction in the form of pustules. On the contrary, the repetition of anti – variolic vacinations may be dangerous especially in cases that do not take up. It may be evidently accounted for by the clinical examination of the patient. You will know that the patient is suffering from different troubles of a nervous orgin – neuralgia, neuritis after an unsuccessful vaccination. Thirdly it is said that the action of other curative vaccinations, used as preventives, leave the taint of Sycotic miasm.

***Evolution of Sycosis***

Sycosis is generally understood as a gonorrhoeal poison. Gonorrhoea is the acute infection of Gonocooci, which takes from 5 to 10 days to develop urethritis, after an exposure. Durng this incubation period, it is purely an infection, and then the local manifestations are thrown outwards by nature at the point of attack. If the gonorrhoea is thoroughly and completely cured, no sycosis will develop, sycosis is established after suppressed gonorrhoea, when the acute infection is driven in upon the vital energy by external methods of suppression and then it becomes a systemic stigma, permeating every living cell of the organism, and transmitting its destructive power in the original individual and impregnating the mother of thr child (H. A Roberts). For example, an individual suffering from gonorrhoea at the age of 20years which was more or less suppressed, has a silent period followed by, and in consequence of which, there appears warts, then chronic rheumatism (especially if he had rheumatism during the attack of gonorrhoea) or chronic enterocolitis, neuralgia, neuritis, asthma, etc.

**HAHNEMANN'S VIEW REGARDING SYCOSIS**

Hahnemann describes sycosis as a condylomatous disease, which undoubtedly can be transmitted hereditarily. The primary manifestation of gonorrhea is pus like discharge from the urethra whereas the primary manifestation of sycosis according to Hahnemann is the appearance of fig warts or condylomatous growths and around the genitals with or without an attending greenish discharge from the urethra.

The transmission of sycosis is not dependent on the existence of gonococcus in the system i.e. why, from homoeopathic viewpoint, sycosis is a hereditary disease, which may be transmitted to the other partner, or offspring

in the stage the patient had been suffering. No doubt sycosis results from impure sexual intercourse, but the diseases may occur even in the absence of a single gonococcus in the vaginal or prostatic fluid smear of the person transmitting the disease. Moreover, the primary fig wart or the condylomatous growth and the latent symptom of sycosis suggest that gonorrhea from nosological point of view and sycosis from homeopathic viewpoint are not the same.

**HAHNEMANNIAN VIEW OF DEVELOPMENT OF SYCOSIS**

*Primary manifestation of sycosis*

The veneral miasm of sycosis pervades the human organism internally and on complete development inside, manifests itself locally by excrescences. They, appear, usually but not always, attended with a sort of gonorrhoea from the urethra, several days or several weeks, even many weeks after infection through coition. More rarely, they appear dry and like warts, more frequently soft, spongy, emitting a specifically fetid fluid (sweetish and almost like herring-brine), bleeding easily and in form of a coxcomb or a cauliflower. These in males, sprout forth on glans and on or below the prepuce, but in women on the parts surrounding the pudenda themselves, which are swollen are covered often by a great number of them.

*Development of secondary manifestation of sycosis*

These excrescences were always treated by allopathic physicians in the most violent external way by cauterizing, burning, cutting or by ligatures. When these excrescences are violently removed the natural effect is, that they will usually recur and usually they are then subjected again in vain to a similar painful cruel treatment. But even if they could be rooted out in this it would merely have the consequence that the figwart disease after having being deprived of the local symptoms, continues to develop internally and appear in other and much worse ways in secondary ailments.

***Cure of the chronic disease***

**Sycosis**- This is the miasma, which had produced finest chronic disease. Fig wart disease in later times (in the years 1809-1814) was so widely spread and it was treated, almost always in an in efficient and injurious manner, internally with mercury, because it was considered homogeneous with venereal chancrous diseases; but the excrescences on the genitals were treated by Allopathic physicians always in the most violent external way by cauterizing, burning and cutting, or by ligatures.

The gonorrhoea dependent on the fig wart miasms as well as the excrescences (i.e. whole sycosis) are meet most surely and most thoroughly through the internal dose of Thuja (M. medica Pura Part VI) which is in this case is homoeopathic is a dose of a few pellets as large as poppy seeds, moistened with the dilution potentised to decillionth degree. If further dose of Thuja is required, they are used most efficiently from other potencies. When these have exhausted their action after 15, 20 30, 40 days, alternating with just a small dose of nitric acid diluted to decillionth degree, which must be allowed to act as long a time in order to remove the gonorrhoea and excrescences i.e. the whole sycosis. It is not necessary to use any external application except in the most inveterate and difficult cases, when the larger fig-warts may be moistened everyday with the mild, pure juice pressed from the green leaves of Thuja mixed with an equal quantity of alcohol.

When psora latent in this and both of this miasmatic are conjoined in a three-fold complication with syphilis. Then it is necessary first to come to the assistance of the most afflicted part, the psora with specific anti-psoric remedies and then to make use of remedies for sycosis before the proper dose of the best preparation of mercury is given against syphilis. The same alternating treatment continued until a complete cure is affected. Externally, no remedy is needed, only clean, dry lint. In inveterate cases-juice of thuja externally.

**STUART CLOSE VIEW REGARDING SYCOSIS**

Gonorrhea, as a constitutional disease was but little known but Hahnemann's keen mind had detected its relation to many evil consequences following the suppression of the primary discharge by local treatment. He had

also observed the evils arising from the topical and mechanical treatment of the anomalous venereal condition variously known as sycosis, or the" fig wart disease", condylomata Fins marisca, atrices and warts, (London Medical Dictionary, 1819)

Some authorities regarded certain forms of condylomata as due to syphilis. Although it was known that the tumours were sometimes of venereal origin and accompanied by a kind of gonorrhoea discharge from the genital passages or the rectum, they were not recognized as the manifestations of a distinct disease, differing in many important respects from syphilis, nor were they necessarily connected with gonorrhoea.

Condylomata were not regarded as having any connection with the larger number of peculiar constitutional symptoms, which are present in many cases. Hahnemann made extensive researches in the phenomena presenting in such cases and came to the conclusion, first, that they constituted a definite and distinct infections, constitutional venereal disease, clearly distinguishable from syphilis on the one hand, and the simple, non specific urethritis on the other; and second, that it was due to the presence of specific, living micro organisms.

To this newly recognized pathological form he applied the generic name sycosis, using the Greek term commonly employed in his day to designate the typical physical manifestation, the fig wart". His researches in the general subject of syphilis and gonorrhoea, conducted by the inductive method in science, resulted in throwing a flood of light upon a previously obscure subject, more clearly defining and greatly broadening not only the sphere of the venereal diseases, but the scope of all subsequent research. He was thus the precursor by more than fifty years of Noeggerath, who called attention anew to the importance of gonorrhoea as constitutional disease and demonstrated the gonococcus as its specific proximate cause.

**KENT'S VIEW REGARDING SYCOSIS** -

It is not generally known that there are 2 kinds of gonorrhoea, one that is essentially chronic, having no disposition to recovery, but continuing on indefinitely and involving the whole constitution in varying forms of symptoms, and one that is acute, having a tendency to recover after a few weeks or months. They are both contagious. The majority of the cases of gonorrhoea are acute and rarely and truly be called as gonorrhoea, because about all there is of it is this discharge. If the suppressive treatment be resorted to in the acute, the system is sufficiently vigorous in most cases to throw off the constitutional symptom called sycosis. Fig warts, nor constitutional states, such as amnesia, cannot follow it. But while constitutional symptoms cannot follow the suppression of the acute miasm, they will follow suppression of the chronic miasm, and become very serious

In both the acute and chronic, the prodromal period is about the same, from 8 to 12 days, and there is no essential difference between the discharge of the acute and chronic. It is a micro purulent discharge, and may have all the appearances that any acute discharge of the urethra might take one.

Anti sycotic remedies are needed to turn the constitutional sycotic gonorrhoea into health. Remedies are picked out for sycosis in the same way that the remedies are picked out in any miasmatic disease, it by making an anamnesis. An anamnesis of all the sycotic cases which we have had enables us to look at the constitutional state of sycosis just in the same way as Hahneman, by an anamnesis of psora, ascertained its nature and worked out the remedies that are similar in nature and action to psora. All medicines that are capable of producing the image of sycosis may be called anti-sycotic, but we can put it in this way also and say all those remedies are anti-sycotic which when given to a sycotic case in its advanced state are able to turn the disease backward, to reproduce the earlier forms and bring back the discharge. That is the practical way of demonstrating that a medicine is an anti sycotic.

Cases of gonorrhoea that have been suppressed by injections in the hands of the old school are considered ended, and soon after the discharge has stopped, the sycotic patient may be told by his physician that he is a fit subject to marry as he has been cured. But in a year or 18 months after marriage wife was brought with uterine trouble, with ovarian disease, with abdominal troubles, with all sorts of complaints peculiar to the woman.

Sycosis affects the soft tissues; syphilis affects the soft tissues and bones. Psora affects the whole economy, nothing escapes; it causes a general break down. This disease, sycosis, does not manifest itself by many eruptions, except those of a warty character, it does not manifest itself by eruptions like syphilis and psora, but operates by bringing about a rheumatic state and an anemic condition of the blood. It takes hold of the blood first and confors to the subjects who are advanced in deep-seated troubles, subjects disease and to acute phthisis. If they have phenomena, it is likely to end in a break down of some sort in the lungs. It they have any acute disease of a prolonged character, like typhoid, the recovery is always slow. The susceptibility to sycosis is laid by inheritance, just as our parents lay the susceptibility to psora. Man can only have one attack in his natural lifetime of one of the three chronic miasms; a man cannot take syphilis twice, he cannot take sycosis twice, he cannot take psora twice.

**KENTIAN VIEW OF THE DEVELOPMENT OF SYCOSIS**

It is generally known there are two types of gonorrhoea.

a) Chronic gonorrhoea
b) Acute gonorrhoea

The chronic gonorrhoea has no disposition to recovery but continues indefinitley, involving the whole constitution in varying forms of symptoms. But the acute gonorrhoea has a tendency to recover after a few weeks or months. They are both contagious.

Inflammation of the urethra is of two types.

a) Simple inflammation
b) Specific inflammation

**J.H.ALLEN'S VIEW REGARDING SYCOSIS**

Sycosis is not a new name for gonorrhoea neither is it gonorrhoea in any sense of the word. The well known specific urethritis, presents only in its initial stage, similar phenomena to that of sycosis, and the history of the two diseases differs widely in their constitutional developments and progress. Gonorrhoea simplex is not a basic miasm, while sycosis comprises one of the chronic miasms of Hahnemann, and next to psora it is the most persistent of the great triune of the subversive forces, syphilis, sycosis and psora.

Sycosis implanted on a rich pseudopsoric soil, develops into one of the most formidable enemies of the race, whose destructive power and depth of action upon the organism cannot be expressed by any combination of words. What the pathologist of today call gonorrhoeal infection, is what we term sycosis. But it is not an infection from supposed gonorrheal catarrh, for gonorrhoea simplex does not affect the organism, as does gonorrhoeal sycosis

The early history of gonorrhoea simplex is a history of painful and spasmodic symptoms and of decided vesical irritation of chordee, and marked specific urethritis, while the history of a typical case of sycosis in its initiatory stage is lacking in many of the above symptoms, and should the symptoms to present, they are so modified that a casual observer can readily distinguish between the two. As a rule in sycosis very little pain is present sometimes but not always there is a decided soreness and some tenderness is felt along the anterior surface of the first third of the organ. The patient experiences' more or less burning at the meatus, but it never assumes that degree of severity experienced in the spasmodic or simple form of the disease. The catarrhal discharge in the sycotic form is scanty, and as a rule muco purulent at a very early date. The colour varies in the different cases, but it is generally dirty coloured pus, yellowish green, or a mixture of brown, yellow and green. Quite often it is offensive, and in many cases has a stale fish, musty or fish brine odor, and it maintains this peculiar offensiveness more or less through out the various stages of the disease. Its incubative period is from 5 to 10 days, and these patients early show more or less mental anxiety, with a desire to frequently examine the organ. These are the first symptoms to present themselves, and they frequently follow the diseases through out in its various phases, usually developing into an over anxiousness as their condition. The patients anxiety some time forces the physician to resort to means unprofessional and against his better judgment in his haste to dry up or suppress the discharge, which the patient thinks is the embodiment of the disease.

In truth it is but the eliminative process, for when the discharge is suppressed, a secondary stage of the disease develops, characterized by stasis to internal organs, more manifest in the pelvic inflammation of women. –a field so fruitful of late, to the work of the modern surgeon. Should the disease not be cured by constitutional treatment, it will by no means end with the secondary stage, but usually within a period of from one to three years, it passes into a tertiary form (or true sycosis), which if not cured, may last the entire life of the patient. Quite frequently, however, the disease runs into some malignancy, such as scirrhus of the different organs of the body or cystic degeneration, fibrous growths, stasis in internal organs, chronic rheumatism, and gouty conditions. This last may be shown by gouty concretions of the joints, gout of the heart stomach or any of the internal organs.

Sycosis may be said to be the most venereal of all venereal diseases, as it is seldom contracted (outside of gonorrhoeal opthalmia) in any other way than through sexual congress. It is a disease of lust in the broadest sense of the word, hence the appearance of the mental phenomena in its early history. That monarch of the mind, the will, is over thrown. He thinks, he wills, hearts and out of that false triune develops the lust disease.

The majority of married women suffer in someway from sycosis, either from the suppressed or imperfectly cured forms. Children born of such parents invariably show some form or manifestation of the disease and not in frequently opthalmia neonatorum. If they escape this dread disease, they suffer with colic almost from the moment of their birth; not the ordinary flatulent colic, but one of a severe and specific nature, continuing often from one to three months after birth. Children writhe and twist and squirm with pain, drawing up their limbs and screaming often for hours, at a time.

The male is capable of infecting the female at any remote period in the history of the case, even years after the disappearance of the discharge, and their off spring will show symptoms of infection at birth, and all though their natural life, unless anti-sycotic constitutional treatment is given to the mother before and during gestation.

A history of good health in the wife before marriage, and then a sudden decline (in non-tubercular patients) is a pretty positive sign of sycotic infection, especially where pelvic symptoms are present. When sycosis is suppressed in a pseudopsoric or tubercular patient, the miasmatic union becomes one very difficult to separate.

The pus, the local inflammatory process is similar to sycotic inflammations in other organs, and especially pelvic inflammations of woman. The dirty, brownish or yellowish green color, the odor so characteristic, the spasmodic pains assuming that of a colicky nature, and the characteristic adhesions besides the specific and septic character of process in general all show that sycosis are present.

***Complications of sycosis in the first stage***

Complications in the primary stage are few and seldom dangerous; cystitis of a mild form is often present, severe forms develop only in cases where local treatment is employed; these may go on even to abscesses about the neck of the bladder or in the urethra. The first great change which sycosis produces when suppressed is to attack the blood and to produce anemic states and conditions. Inflammations follow in organs and in soft tissues; fibrous changes in any organ are to be met with, until the whole organism is overcome by this death dealing process due to the suppression.

**H.A.ROBERT'S VIEW REGARDING SYCOSIS**

One of the accepted definitions of the word sycosis is that which Hahnemann had in mind, and which he called alternatively the fig wart disease. Sycosis is established after a suppressed gonorrhoea, when the acute infection is driven in upon the vital energy by external methods of suppression, and it then becomes a systematic stigma, permeating every living cell of the organism, and transmitting its deadly destructive forces to the offspring as well as retaining the full destructiveness of its power in the original individual, and impregnating the mother of the child. The suppressed gonorrhoeal infection is very apt to first show itself in attacking the blood and producing an anemic condition, and is set up. Often times inflammatory rheumatism develops; inflammation follows in the soft tissues, and changes in the fibre of the muscles. In fact, the whole organism becomes involved. Sometimes a stasis develops in the lymphatic; there is a swelling in the groin following the suppression, and inflammation in the prostatic gland. These are the symptoms that are first produced after suppression, showing that the whole organism is involved and in the grip of this destructive force.

Sycosis attacks the internal organs, especially the pelvic and sexual organs. In this stigma we find the worst forms of inflammation, infiltration of the tissues causing abscesses, hypertrophies, cystic degeneration; when thrown back into the system by suppression this stigma causes dishonesty, moral degeneracy and mania.

**P. N BANERJEE'S VIEW REGARDING SYCOSIS**

Sycosis, therefore, is not Gonorrhoea, but it is that condition of the system, which is bonded to it by Gonorrhoea, when it is not cured, but only made to disappear, either by a course of unhomoeopathic treatment, or of itself. Sycosis is also a condition of the life force, and that it is acquired by suppression of Gonorrhoea, and there should, therefore, be no ground for confounding or identifying it with gonorrhoea. Evil thinking, and sycosis acquire Psora by evil action. The course of psora is from the center to the circumference, from the mind to the body, from mental itching to physical itching, but the course of sycosis is naturally from the circumference to the center, from the body to the mind, from the gonorrhoeal discharge to colic, rheumatism and insanity.

**GENERAL FEATURES OF SYCOTIC MIASM**

- Inco-ordinating miasm
- Mischievous miasm
- Over production of growth.
- Excess, escape, hyperplasia.
- Deposition and infiltration of tissues.
- Organs and tissues mainly it acts is on pelvic and sexual organs, internal organs, soft-tissues (blood) and endoderm.
- All hyperplasic conditions.
- Primary manifestation is condylomatous growth on the body some times associated with gonorrhoeal discharge.
- Slowness of recovery.

Human barometer-when it rains he has pain. When the atmosphere is filled with moisture he suffers. The rain, the snow, the cold are his enemies.

MENTAL GENERAL

1. Excess, escape, hyperplasia
2. Selfishness or covetousness- Taking of advantage of others through lack of consideration.
3. Mischievous, destruct full- Sycosis makes the victim devoid of all sense of righteousness. Thief's, robberers, murderers are the product of sycosis. Worst form of cruelty.
4. Suspiciousness that leads to jealousy.
5. Extreme irritability. Approach of storm or rain leads sycotic patient to burst.
6. Brooding over things.
7. Forgetfullness- forgets recent happenings in respect of name and date. There is poverty of language and thought. Recollection of recent things difficult while they can recall things of past.
8. Quarrelsome.They harm others, harm animals.
9. Cross-, cruel, cunning.
10. Making a secret of every thing.
11. No love or affection for others.

Sycosis coupled with psora is the basis of criminal insanity and of most suicides. Men and women who commit suicide today are mainly sycotic. All the vicious individuals on earth-thieves, robbers and murderers are the product of sycosis. It makes a beast out of man. Mental conditions of sycosis are ameliorated when warts or fibrous growth appear. Mentally sycotic patients are malactive, bad, absent minded, mischievous, suicidal tendency but will not perform the act and have a superiority complex.

PHYSICAL GENERAL

1. Over construction, over growth, hyperplasia.
2. Anaemia-destructionof R.B.C.'s due to imperfect oxidation.
3. Condylomatous growth.
4. Pain and colic- changing, erratic, stabbing, unbearable and ameliorated by hard pressure.
5. Living barometer-sensitive to atmospheric changes.
6. Fish brine odour.
7. Yellowish discharge.
8. Modalities-<-Damp wet, getting wet, change of weather, meat. >-Slow motion, lying on abdomen, dry weather, return of suppressed normal discharge.

VERTIGO

Vertigoes beginning in the base of brain are more apt to be of a sycotic or syphilitic nature or may be of tubercular origin

HEAD

Night headache, Frontal or vertex head ache.

Headache with feverishness, restlessness, crying, worrying

Head symptom resemble syphilitic in < at night and lying down. Same type vertigo at base of brain.

< At or after mid night, mental and physical exertion, lying down, night.

> Gentle motion, warm application.

HAIR

Dead broken hair in beard, prematurely gray hair

Hair falls out in little circular patches, scalp perspires ( But there are not the moist matting eruptions of syphilis), fishy odour from hair.

EYES AND VISION

Sycosis never gives a true ulcer, chronic corneal ulcer in children

Thick, copious, pus formation (greenish or yellowish green), gout of eyes, and arthritic troubles of eyes, neuralgia -<change of weather, rainy weather, moisture. Opthalmia neonatorum (Babies born from sycotic parents).

EAR

Gouty concretion.

NOSE AND SMELL

Loss of smell, snuffles (stoppage is due to local congestion thickening of membrane, hypertrophied turbinates], snuffles in new babies born of sycotic parents, no ulceration, no crusts. If purulent-fish brine odour. Red nose with enlarged capillaries. Hay fever-nose clear one hour, the next he cannot get a particle of air through his nasal passages. Take cold easily in children from sycotic parents complicated with gout.

FACE

All warty eruptions, moles, papiloma, erysipelas of face-psoric and sycotic

CAVITY OF THE MOUTH, TEETH AND GUMS

Gouty concretion.

TASTE

Putrid, musty or fishy taste

DESIRES AND AVERSION

Craves beer, intolerance of meat, desires hot or cold food

Meats in sycotic assist in developing the uric acid gouty diathesis

STOMACH SYMPTOMS

Worse by eating any kind of food, even mothers milk, better by lying on stomach, by pressure over region of stomach, by violent motion

Pains-Crampy, colicky and paroxysmal. Gas is frequently expelled from stomach with great force is quite pathognomic of sycotic colic.

Prefers food warm Heat gives temporary relief.

CHEST, HEART, LUNGS

Cough-dry, prolonged teasing bronchial

Expectoration- Clear mucous and scanty. Ropy or cottony nature

Bronchitis often in autumn/winter

Coryza- During summer, symptoms usually free, but always taking cold on least exposure to cold. As a rule they cannot breathe through mouth.

HEART

Dangerous heart condition. Valvular disease of heart. Rheumatic heart disease. Reflex from rheumatic trouble, especially if local applications are used to relieve the pain. Pain from shoulder to heart or from heart to scapula in rheumatic cardiac troubles. Heart troubles for years without causing pain or dyspnoea. Very little mental disturbance in heart trouble even at critical period of disease Die suddenly without warning. Heart patient even anginal pain better motion as walking, riding or gentle exercise.

Pulse-Slow, soft

Patients-fleshy, puffy, obesity lies at the bottom of their dyspnoea. They are constantly gaining in flesh.

BOWELS AND INTESTINAL TRACT

Appendicitis. True colic-simplest form of food produces colic and pain in abdomen or through out the intestinal tract.

< Eating fruit, > bending double, hard pressure

Ulceration of umbilicus- Puss yellowish, green, watery, thin, excoriating, offensive-fish brine odour.

Diarrhoea -Stool-slimy mucous, sour smelling, changeable.

Diarrhoea from getting wet

Tenesmus present.

Even child smells sour-inherited sycosis. Bleeding hemorrhoids

Pruritis-Scanty, thin, watery discharge oozing from rectum has a fish brine smell. Rectal structure, sinuses, fistula and fistulous pocket are all of a tubercular origin or have pseudo psoric nature. But are greatly magnified by sycosis.

URINARY ORGANS

Screams when urinating, gout of the bladder, gouty concretions in urethra of young babies when born of sycotic parents.

If sycosis present in diabetic patients it is more malignant and more fatal.

Brights disease, fibrous change in kidneys, prostatic trouble, renal stone

Rectum-Combination of tubercular diathesis with sycosis produce cancerous affections)

SEXUAL SPHERE

Complaint < at or during menses.

Spasmodic, colicky, paroxysmal pain, acrid discharges, pruritus

Painful and often frequent urination,offensive discharge.

Menses-acrid, excoriating, biting and burning the pudendum.

Menses flow often and only with pain. Discharge-acrid, fish brine odour. Menses-dark, clotted, stringy

Leucorrhoea-This look like dirty water. Greenish yellow, some times scanty, acrid producing hitting itching and burning of the parts. Odour is-state fish or fish brine. Discharge produces little vesicles or excoriations on the pudendum. Like dirty green water, little vesicles of excoriation

Pain-spasmodic, colicky, paroxysmal. Many of the ovarian or tubular symptoms that develop during the menses, are dependent more on sycosis than to any other miasm

UPPER AND LOWER EXTREMITIES

Gouty diathesis. Rheumatic diathesis.

Pain in joints due to gouty concretion. Muscles, finger, periosteum, small joints are affected with shooting tearing pain.

< Rest, > rubbing, motion, stretching.

< Damp weather, > dry weather, > rubbing, motion, stretching

Stiffness, soreness, lameness is very characteristic of sycosis.

Nails-ridged, deformed.

In arthritis or rheumatism we have an infiltration of inflammatory deposits but it readily absorbs and is never formative as we find in syphilitic and tubercular changes, which are permanent.

SKIN

Skin lesions in tertiary stage, warty eruptions or warty growths

Condylomata (presence of syphilis and sycosis.

Scales-patches in circumscribed spots.

Acne-do not suppurates, but are sore to touch and sensitive.

All forms of ringworm, lichen planus (sycosis and pseudo psora)

Psoriasis.

**CLINICAL POINTERS TO THE SYCOTIC MIASM**

In coordination, intemperance, excess or a proliferation of tissues is the most significant indication of sycosis.

Mentally suspicious. Develops the worst forms of degeneracy, because of the basic suspicion, jealousy and privacy. Tendency of making a secret of everything, strict privacy concealment.

Sycosis is the mischievous of all the miasms. He is always focused upon mischief and misdeeds. The sycotic mind is grossly debased. Sycosis makes the victims devoid of all sense of righteousness. It makes him a liar and a vicious scoundrel, destitute of all love and affection for others and thus making him mean and selfish. All the vicious individuals of the earth – thieves, robbers and murderers are the products of sycosis. It makes a beast out of man.

Forgetful. Recollection of recent events is difficult, whilst they can recall things of the past. Absent-minded.

Fixed ideas especially about religion.

Fear. Despair of recovery, dissatisfaction, repentance. Vague sensations in the form of phobias regarding the shape and size of the body characterized by various delusions such as

- Body, body parts, brittle, his head belongs to another, legs, long, too.
- Divided, two parts, into.
- Double, he is.
- Glass, she is made of.
- Heavy, is.
- Light, incorporeal, immaterial, he is.
- Wood, made of.

To sum up, the mentality of sycosis is suspicious, mischievous, mean, selfish and forgetful.

Joints and connective tissues are affected.

Condylomatous growth.

Warts and moles

Unusual fleshy growths, all kinds of tumours and tumourous growths.

Excrescences. Malformation. For that reason it is also called the formative miasm.

Eczema, with cracks which oozes sticky fluids.

Skin is oily. Tip of the nose is red.

Haemangioma.

Acquired gonorrhoea or history of hereditary gonorrhoea.

Hair is thick and coarse. Alopecia areata on head and face. Unwanted hair.

Nails are ridged or ribbed and thick.

Slow recovery, even acute diseases recover slowly.

Bronchial asthma or gonorrhoea.

Chronic or long continued inflammation, especially of joints.

Gonorrheal inflammations or blockage of the fallopian tubes and sterility.

Oedema or anasarca in any part or of the whole organism.

Benign hypertrophy of the prostate gland and prostate malignancy.

Worse by rest, rain and rainy weather, cold, damp cold weather and places, 4 – 6 am, mid day to mid night. When it rains he has pains – is one of the great indications of sycosis, when the atmosphere is filled with moisture. Better by movement, while in active condition, better by heat.

Natural discharges like diarrhoea, free urination, even perspiration gives no amelioration.

If suppressed, sycosis attacks the internal organs, especially the pelvic and sexual organs in the worst specific form of inflammation producing hypertrophies, abscesses, cystic degenerations, mucus cysts etc. and when thrown up to the brain, it produces headaches, severe acute mania, insanity, moral degeneracy, dishonesty etc.

Sycosis disturbs the endocrinal axis thereby affecting various metabolic and hormonal functions, leading to dwarfism, emaciation of particular parts, anaemia, cretinism, myxoedema and Addison's disease.

Sycosis affects organs developed from the tissues of endodermal origin.

**Constitutional Medicine**

**The** Word Constitution comes from the Latin word, constituere, or constitute which means to set up, to establish, to form or make up, to appoint to give being to. Chambers Dictionary defines constitutions as: the natural condition of the body or mind; disposition. Constitutional means; inherent in the natural frame, or inherent nature.
Constitution is defined as the structure, composition, physical make up or nature of something, comprising inherited qualities modified by the environment.

According to S.K.Banerjee "constitution is that aggregate of hereditary characters, influenced more or less by environment, which determines the individual's reaction, successful or unsuccessful, to the stress of environment".

Constitutional medicine means the medicine which can correct the constitutional defects-inherent and acquired. Every antimiasmatic medicine is a constitutional medicine.

**History of doctrine of constitution in Homoeopathy**

In his “Organon of rational healing” (1810) Hahnemann had presented his new method of healing systematically. The main directing line was symptom similarity. But later he became doubtful about the full efficacy of such a method of drug selection in Chronic diseases. He recognized that in chronic diseases one had to deal with a separate fragment of a deep lying original evil. Then he sought for the original evil which is responsible for the diversity of chronic disease manifestations.

He was not satisfied with the recognition of only the endogenous causative conditions but he went farther to the conception of a few exogenous causative damages. According to his view they must be of a ‘chronic miasmatic nature’. These diseases show such a permanence and continuance that as soon as they have developed increase ever more and more, not lessened even by the intrinsic powers of the most robust nature nor by a healthy mode of living and diet, still less conquered and removed, never depart of themselves but grow and increase until death.

According to Hahnemann there are only three such chronic infections as causes of not all but most chronic evil namely syphilis,

Sycosis or the fig wart disease and the Psora which has the itch eruption lying at its base. In respect to syphilis Hahnemann gave a significance which is approximately that which we attribute to it at present. By Sycosis he understood the general involvement of complicated gonorrhoea in which the local symptom is expressed as the fig wart.

Hahnemann emphasized the Psora as of outstanding importance. Psora is the oldest, most universal, most pernicious and still usually mistaken chronic miasmatic disease. At least seven-eighth of all chronic illness is due to Psora. It is the beginning of all physical sickness. It is the primitive or primary disorder of human race. It is the disordered state of human race. It is considered as the mother of all chronic diseases. It is the most ancient and most destructive of all chronic miasms.

When the internal infection is completed it comes out on the skin in the form of small vesicular eruptions with a peculiar odour and terrible itching. These are the symptoms of primary Psora. When the primary manifestation of Psora is suppressed by local applications, the local cutaneous eruptions disappear but the disease is driven inwards and may remain dormant. This state is called as the latent state of Psora. Later on it produces various forms of disease conditions like mania, hysteria, cancer, jaundice, haemorrhage etc. This occurs when the person who has the Psora slumbering within has exposed to some exiting or maintaining cause. Thus it becomes Secondary Psora.

Sycosis is the venereal fig wart disease, a venereal chronic miasm primarily manifested externally by the condylomatous growths following impure coition. When these are removed by external measures some other secondary ailments worse than the primary one result.

Syphilis is a venereal chronic miasm primarily manifested outwardly by the venereal chancre developed following an impure coition. When the primary manifestation is driven out by some local treatment, the nature develops far more secondary ailments through the outbreak of whole chronic syphilis.

These chronic miasms have passed through many generations of people with different congenital corporeal constitutions and exhibit their symptoms in various diversity. The miasms influence the constitutional make up of an individual to a great degree. In fact it is one of the intimate aspect of constitution.

Thus the concept of morbid constitution is closely related to the theory of chronic disease in Homoeopathy.

In the text book of Organon of medicine Hahnemann speaks of Constitution in different Aphorisms.45

In the German text the word beschaffenheit has been translated into English as the word constitution

In the Introduction to Organon, he speaks about the constitution in many places. “The vital force, I say, produces, in accordance with the laws of the constitution of the organism to which it is subject, a disease of a different sort, intended to expel the disease by which it was attacked.”

He again refers to constitution in the discussion of vermicular diseases. “A few lumbrici may be found in some children; in many there exists ascarides. But the presence of these is always dependent on a general taint of the constitution and the former cured homoeopathically, which is most easily effected at this age”.

Then he speaks about the impossibility of vital force to cure itself and it act according to the constitution. “But the vital force, which of itself can only act according to the physical constitution of our organism, and is not guided by reason, knowledge and reflection, was not given to man to be regarded as the best possible curative agent to restore those lamentable deviations from health to the normal condition”.

In the **Aphorism no.5,** Hahnemann discusses about the fundamental cause which is based on chronic miasm and how to investigate it. “In these investigations, the ascertainable physical constitution of the patient (especially when the disease is chronic), his moral and intellectual character, his occupation, mode of living and habits, his social and domestic relations, his age, sexual function, ..etc., are to be taken into consideration.” Here he emphasis the importance of constitutional symptoms in the treatment of chronic diseases.
In Aphorism no.52 while criticizing the result of dissimilar Allopathic treatment, Dr. Hahnemann says that they ruin the constitution of the patient. “… thus at a sacrifice of the patient's strength, inducing a morbid state quite heterogeneous and dissimilar to the original one, to the ruin of his constitution, by large doses of mixtures of medicines generally of unknown qualities.”
In Aphorism no.78, he says that in case of True chronic disease the most robust constitution, the best regulated mode of living and the most vigorous energy of the vital force are insufficient for their eradication.
In Aphorism no.81, The influence of congenital corporeal constitution in the manifestations of Psora is discussed.
In order to find out the genus epidemicus (Aphorism no.102), he says that the totality of the disease cannot be learned from one single patient, but is only to be perfectly deduced (abstracted) and ascertained from the sufferings of several patients of different constitutions.
Idiosyncrasy is defined as a peculiar corporeal constitution which, although otherwise healthy, possesses a disposition to be brought into a more or less morbid state by certain things which seem to produce no impression and no change in many other individuals. (Aphorism no.117)
Aphorism no. 135 says that a proving is complete only when medicines are tested on various constitutions.
In the foot note to Aphorism no.246, Hahnemann says that in the repetition of dose many factors are taken into consideration.1.Nature of the medicinal substance 2.Corporeal constitution and 3. Magnitude of the disease.

**DR. KENT’S VIEW REGARDING CONSTITUTION:**
Dr. Kent says “physical constitution is the external disorder following disorder in the man, the vital force”. He also says that there are constitutional states in patients by virtue of which they are always affected in a certain way.
'Lectures on homoeopathic philosophy':
Lecture 29: Idiosyncrasies:
There are persons who are sensitive, not merely to one or a few things, but to all things; oversensitive to the high potencies, oversensitive in taste, oversensitive to light, and a great many other things. This is a constitutional state; the patient is born with it.
Lecture 16: Oversensitive patients.
All these patients will have alternating symptoms which will confuse the physician before he knows their constitutional state.
It is an important thing to know the constitutional state of a patient before prescribing.
You will always be able to do better for your patients when you know all of their tendencies.
Of course, in acute diseases symptoms sometimes stand out so sharply that an acute remedy can be administered without reference to any constitutional state.

Lecture 21: Chronic disease -Sycosis
The suppression cannot bring on the constitutional symptoms called Sycosis. It cannot be followed by fig warts, or constitutional states, such as anemia.
But while constitutional symptoms cannot follow the suppression of the acute miasm, they will follow suppression of the chronic miasm, and become very serious.
From Kent's 'Lesser writings':
Syphilis as a miasm
Thus syphilis, being a constitutional disease, is made, I may say, ten times more constitutional by suppression.
Homoeopathy: its fundamental principles outlined
Hahnemann describes three constitutional miasms that may exist in latency, that develop and progress in the vital "dynamis" without changing the tissues, which may spring into destructive activity and attack organs and give shape to countless lesions called disease; that these miasms should be recognized as primary wrongs out of which grow incurable maladies, and all structural changes.
In his lesser writings (page 272) he highlights the importance of individualization of constitution of each patient. “The symptoms that represent the morbid constitution or disorder of the individual are the ones that the skillful prescriber always seeks.”

**DR.STUART CLOSE:**

According to Stuart Close “constitution is that aggregate of hereditary characters, influenced more or less by environment, which determines the individual’s reaction, successful or unsuccessful, to the stress of environment”.
He also says that constitution and temperament modify susceptibility. While giving medicine sensitive persons of nervous, choleric or sanguine temperament can receive higher potencies. Lower potencies are suitable to torpid and phlegmatic individuals.

**DR.H.A ROBERT**:
In his work ‘The principles and art of cure by Homoeopathy’, he gives a chapter on temperaments. There are 4 classical temperaments. Nervous, bilious, sanguinous, phlegmatic. There are many combinations of these temperaments.
These temperaments are to a very large extend physiological. But besides the stature of the patient it includes colouring, functional tendencies of the circulation, elimination, respiration, mental and emotional tendencies in reaction to environment. The matter of temperaments is closely allied with the basic dyscracias.
It has been said that the temperaments are cast in the very beginning of the new individual and it can not be influenced or changed by the action of our remedies. But a Homoeopathically indicated remedy, prescribed accurately in children can modify the physiological tendencies as to prevent their unfavorable ultimates.
The Homoeopathic prescription is often biased by the temperament to the extend that certain temperaments bring out certain symptom picture more readily. Various remedies have brought out different proving in different temperaments, but the recorded symptoms are useful in any temperament.
He also says that prescribing on types or temperaments is at best a slack method of using the blessings of Homoeopathy.

**DR. RICHARD HUGHES**:
In his book “The principles and practice of Homoeopathy” in the chapter Administration and selection of similar remedy, he says that the similar remedy should be given singly, rarely and constitutionally. It is chosen from the correspondence of the totality of the symptoms with those of the patient, that it may embrace the whole malady.

**DR.DUNHAM**:
In his book ‘Homoeopathy the science of therapeutics’, while discussing on alternation of remedies, he says “the constitutional disturbances are even more important indications for treatment than the more obvious and objective symptoms. But how can we analyze these more obvious symptoms, and ascertain those “constitutional disturbances” in which they have their origin? In no other way than by a study of the functions of the entire organism. But this brings us at once to that rule on which Hahnemann so strongly insisted, that the entire organism of the patient should be examined in every possible way, and that the “totality of the symptoms” should be made the basis of the prescription; nay, that the constitutional, general symptoms are often more conclusive as to the proper treatment than the more obvious local symptom.”
In his work on Collection of papers- Cholera, Dunham explains about Constitutional prescribing. “Hereditary patterns reflect our constitution – the environment in which we live and our lifestyle, including diet. In constitutional prescribing both the physical and psychological symptoms are expressed by the patient and these symptoms are used by the physician to prescribe a remedy”.

DR.HERING’S CONTRIBUTION:
Hering created a separate section for constitution and temperament in his materia medica called Stages of Life and Constitution.
Hering's provings and clinical confirmations are the source of constitutional characteristics such as: Nux Vomica is well adapted to angry, irritable, dark, thin, dry, bilious, choleric; Pulsatilla is well adapted to gentle, blond haired, blue eyed phlegmatic temperaments … Such characteristics do not lead to remedies by themselves as they are only part of the over all totality of the symptoms as they represent constitutional general symptoms.

DR. J H ALLEN
The constitution of each patient should be carefully studied, for his disease will be found to be dependent upon some miasmatic basis, and the physician who cannot detect the presence of Sycosis in his patient, without a history of gonorrhoea, has very little knowledge of miasmatics. Phthisis may be headed off before an abscess forms in the lung tissue, if we are familiar with the phenomena of its incipiency. The bond between two miasms can only be broken by a prescription that will meet the totality of the more active one. Each has its own phenomena of expression, its times, modalities and order of arrangement. The appearance of sequelae is an appearance of a chronic disease or rather an expression of one, dependent upon the miasmatic government within. Whatever has been sown in life, will blossom

and bring forth fruit in the family tree. If you cannot find the insignia upon the surface of the body, voices from within will continue to cry out until it is removed.

**DR.R.K. MUKHERJI:**
In the introduction to his book 'Constitution and temperament' he gives an account of the term constitution. According to Pro. Minkowski constitution is defined as the ensemble of characters of the individual performed from the very beginning of the biological existence.
According to Mukherji the homoeostatic state of the individual's interior vitality which is subject to only minor modifications is called his constitution. Constitution is 'what is.' Temperament is 'what becomes'. Constitution is the backbone of the individual upon which he builds himself. It will not change. It is static.
Temperament is 'dynamic.' It is the ensemble of all the possibilities in the physical, psychological, biological and the dynamic sphere of the individual. Temperament change temporarily on the constitutional ground.

DR. K.N. MATHUR:
In his foreword to 'Organon of medicine', Dr.Mathur gives division of constitution. The dynamic and adynamic constitution. Patients with good resistance and well developed immunity mechanism are included in dynamic variety. They are the curable patients. The adynamic constitution includes patients with poor reaction and immune system. They fail to respond to dynamic medicines.

**Factors related to constitution**
1. Physical make-up of the body
2. Temperament
3. Heat and cold relation
4. Desire, aversion and intolerance to food
5. Miasm
6. Diathesis
7. Susceptibility and responses
8. Addiction, habit, etc.

**HOMOEOPATHIC CONCEPT OF DISEASE**
Homoeopathy means a method of scientific study, which implies a particular way of applying drugs to diseases according to a specific principle, known as 'Similia Similibus Curentur'and implies theories of vital force, of chronic miasms, and of dynamisation of drugs. Homoeopathy is a scientific system of medicine, following the definition of science; express the relation between 2 series of phenomenon, i.e. disease and drug phenomenon, it is based on law of cure, which possesses the requisite characteristic of a scientific law. This law is justified by induction, deduction and verification. It follows the scientific principle of observation, generalizations, and formation of hypothesis. It can predict the effect of its application and result is reproducible. Diseases are alterations in the state of health of the
When a person falls ill, the first noticeable change consists of altered sensations and functions indicating affection of the qualitative vital force of the life principle. If this morbid process is not checked by any means, it leads eventually to changes in the system of bodily and organs and secretions and excretion there of both qualitatively and quantitatively. Hence, according to Hahnemann, the perceptive pathological changes in the body are not the causes of diseases but they are the end results of the morbid vital process, which is disease "per se."
Homoeopathy regards disease "per se" as a morbid vital process caused by dynamic influence of noxious agents of the vital principle as manifested through perceptible signs and symptoms, the totality of which constitutes for all practical purposes what goes by the name of disease.
Homoeopathy regards that the source of life and energy is not material but spiritual. The basis, the foundation on which the life and energy stand and work, is physical. The scope of Homoeopathy lies in treating the actual morbid vital process and neither its causative agents nor its ultimates.
Hahnemann's first postulate is that a physician should "clearly perceive what is to be cured in diseases, that is to say in every individual case of disease". Such an individualistic approach to the study of disease is what Hahnemann advocates. This new approach gives a new turn to the study of medicine whose scope and subject matter is the study of man.
Disease" per se"is the morbid process of functioning of the life-principle; if this process is unchecked, it eventually leads to structural changes. These structural changes might be of two types viz., reversible and irreversible; they are the end results of morbid vital process and act as obstacles to restoration of the abnormal vital process to its previously healthy condition. The more the pathological changes are of severe degree and of irreversible type, the less the chances are for recovery.

AETIOLOGICAL CONCEPT OF DISEASE
Causation is a stimulus, which is able to change the inertia of a living substance. There are mainly three types of causes of diseases. They are exciting cause, maintaining cause and fundamental cause. Exciting cause are cause which excites a disease condition either acute disease or acute exacerbation in a chronic disease. Maintaining cause means any avoidable noxious influence, which is responsible for the prolongation or maintenance of the chronic disease process or development of the false or pseudochronic disease. The fundamental cause is generally due to a chronic miasm, which is responsible for the development of true natural chronic diseases. There are three chronic miasms-psora, syphilis and sycosis.

RELAVENCE OF CLINICAL FEATURES
Clinical features helps in individualization of the patient and diagnosis of the disease.

SIGNIFICANCE OF DIAGNOSIS AND INVESTIGATION
1. To fore cast the prognosis of the case.
2. For management of the case i.e. dietary, mode of life and auxillary management
3. For therapeutic purpose i.e. to know the curability of the case, to select the line of treatment, to know whether the disease is natural or artificial, to select the homoeopathic medicine.
4. To follow up the case i.e. to evaluate new symptoms and to ascertain the effect of treatment.
5. Isolation of patient in order to prevent the disease in community.
6. To convince the patient and relatives about the disease.
7. To issue sick certificates, death certificates etc.
8. For medico legal purposes.
9. For record keeping, statistical analysis, research works, seminars etc.

**HOMOEOPATHIC MANAGEMENT**
A medicine is selected which bears the greatest similarity to the totality of symptoms observed in a given case of natural disease. Totality of symptom means sum of the symptoms reflecting the individuality of the patient. Hahnemann has clearly pointed out that the fundamental causes are responsible for each and every type of chronic disease. Until and unless these fundamental causes are uprooted, the chronic diseases cannot be cured permanently. When we select a remedy based on basic miasmatic symptoms, not only the secondary or tertiary manifestations of the miasm, but also the effects of the miasm as a whole, or the sum total of all that is known as disease are removed. Homoeopathy regards all the structural changes in the body as end-results of morbid vital process. Hence fibroid uterus is considered as the end result of the basic and predominating miasm.

DIETARY MANAGEMENT
In all chronic patients, besides the actual medicines of all kinds, the diet and regimen that is to be avoided are explained in detail in aphorisms 259,260 and 261.

MEDICINAL MANAGEMENT
Medicines- discussed in the section, Therapeutics.
Dose-The dose of a medicine whose selection has been accurately homoeopathic must be reduced to the degree of minuteness appropriate for a gentle remedial effect. According to Hahnemann, pure experiment, careful observation and accurate experience can alone determine the degree of minuteness necessary to affect the best cure in a given case.
Repetition of doses- The only axiom for repetition is to repeat when the original symptoms reappear or when improvement ceases.
Potency- In general it may be stated that any curable diseases may be cured by any potency, when the indicated remedy is administered, but that the cure may be much accelerated by selecting the potency appropriate to the individual

**REPERTORIAL REPRESENTATION OF BENIGN PROSTATIC HYPERTROPHY**

SYNTHESIS REPERTORY 8.1

**MIND –**

LASCIVIOUS - prostate; with enlarged –

1 Mark - dig.

PROSTRATION of mind - prostatic complaints; in –

1 Mark - thuj.

**EYE –**

INFLAMMATION - Iris - accompanied by - Prostate; complaints of

1 Mark - sabal

**PROSTATE GLAND –**

SWELLING - accompanied by - Eyes; red discoloration-

1 Mark - Sabal, solid.

INDURATION - accompanied by - Tongue - brown discoloration-

2 Mark- *Iod.*

SWELLING - accompanied by – constipation –

1 Mark - arn. sil.

**RECTUM –**

HEMORRHOIDS - accompanied by - Prostate gland; enlarged –

1 Mark - staph.

**BLADDER –**

INFLAMMATION - accompanied by - Prostate gland; swelling of

1 Mark -sabal

RETENTION of urine - enlarged prostate, from –

1 Mark - bell, benz-ac, canth con, ferr, hyos, kali-I, merc-d. morph, pareir. sep., stram., Zinc.

2 Mark- *Apis Cact . Chim. Chin. Puls. Sabal Tritic.*

3 Mark - **DIG. STAPH.**

**URINATION –**

dribbling - enlarged prostate, with

1 Mark - arn. bar-c. bell. cop. mur-ac. pareir. petr. sabal sel. sep.

2 Mark - *Aloe Dig Nux-v. Puls. Staph*

dysuria - accompanied by - Prostate gland; swelling of-

1 Mark – apis, med. petros.

interrupted - spurts and with each spurt cutting pain in swollen prostate; in

3 mark - **PULS.**

involuntary - accompanied by - Prostate gland; swelling of

1 Mark - Iod. pareir.

involuntary - old people; in - men with enlarged prostate

1 mark - apoc. dig.. kali-p. nux-v.

2 mark *All-s. Aloe Cic. Iod Pareir. Sec. Thuj.*

**PROSTATE GLAND –**

COMPLAINTS of prostate

1 Mark - aesc. aloe am-m. apis aur. bar-c. baros. bell. benz-ac. calc. caps. carb-v. caust. chel. chim. clem. con. crot-h. dam. dig. fab. ferr-pic. gnaph. hep. iod. kali-i. lyc. mag-m. med. merc. nat-s. nit-ac. nux-v. pareir. petr. phos. phyt. pic-ac. polyg-h. pop. puls. sabad. sabal sel. senec. sep. solid. spirae. staph. sul-i. sulph. thuj. zinc-pic.

2 Mark - *Hydrang. Mela.*

INFLAMMATION

1 Mark - acon. aesc. agn. aloe alum. alum-sil. anac. apis arg-met. arist-cl. arn. bar-c. bell. bov. bry. cact. cann-i. cann-s cann-xyz. canth. caust. chim. cic. clem. coli. cop. cub. cycl. ferr-p. ferr-pic. gonotox. hipp. iod. kali-br. kali-c. kali-i. kali-n. lach. lil-t. lith-c. med. merc-c. merc-d. naphthoq. ol-sant. Pareir petr.. pic-ac. pitu-gl. podo. polyg-h. polyg-s. psor. pyrog. sabad. sabal sal-n. sars. sec. *Sel.* senec. *Sep Sil.* solid. spong. *Staph.* staphycoc. sul-ac. *Sulph. Thuj. Trib.* tritic. *Verat-v.* vesi. zinc.

2 Mark - *Aur. Caps. Colch. Con. Dig. Dulc. Fab. Gels Hep. Kali-bi Lyc. Merc. Nit-ac. Nux-v. Ph-ac*

3 Mark**- PULS.**

BALL; sensation of sitting on a

1 Mark- cann-i. sil.

2 Mark - *Chim.*

3 Mark - **SEP.**

FULLNESS

1 Mark- alum. berb. bry. nux-v.

2 Mark - *Chim. Cycl.*

HARDNESS

1 Mark- iod. med. . plb. senec.

2 Mark - *Cadm-p, Cop., Phos. Sil. Thuj.*

HEAVINESS

1 Mark - cact. caust. *Con.* cop. graph. hydrc. *Med.* puls. sulph.

INDURATION

1 Mark - am-m. Bar-c. crot-h. . plb. senec. .

2 Mark - *Cadm-p. Con. Cop. Iod. Phos Psor. Sel. Sil Sulph*

*3 Mark*- THUJ.

PAIN

1 Mark - acon. alum-sil. apis asaf. . berb. bov. brom. cact. calc-p. . clem. . cop. . cupr-ar. dig. gnaph. graph. laur. . lyss. med. merc. ol-an. pareir. podo. polyg-h. sel. sul-i. sulph. symph. tarent. thuj.

2 Mark - *All-c. Alum, Bell , Caps. Caust. Chim , Con Cub, Cycl, Lyc. Phos, Puls. Rhus, Sil. Staph*

SWELLING

1 Mark - alf. aloe alum. alum-p. alum-sil. apoc asar. aspar. bar-i.. cact. calc-f. calc-i. calc-sil. cann-s. cann-xyz. canth. chel. chlam-tr. chr-s. cic. clem cop. cub. cuc-p. dam. eup-pur. ferr-pic. fl-ac. graph. hed. hep. hipp. hydrang. kali-bi. kali-br. kali-c. kali-p. kreos. lith-c. mag-s. merc-d. nat-p. nux-v. ol-an. ol-sant. oxyd. petr. pic-ac. pip-m. polytr-c. rhus-a. sabal sars. senec. sep. solid. stigm. sul-ac. sul-i. symph. ther. thymol. thyr. trib. tritic. tub. uncar-tom. uva x-ray .

2 Mark - *Am-m. Apis . Arg-n. Aur-m Benz-ac Berb. Cimic. Dulc. Fab. Ferr-m. Gels. .Hyos. Iod Kali-i. Lyc Med. Merc. Nat-c. Nat-s. Nit-ac. Pareir. Phos. .Pop. Psor. Sec. Sel. Sil. Spong. Staph. Sulph. Thiosin. Thuj. Zinc*

*3 Mark*- BAR-C,. CALC,. CHIM,.CON,. DIG, PULS

TENSION

1 Mark- clem. kali-p. lyc. thuj.

SWELLING - sensation of

1 Mark - alum. berb. bry. chim. cycl. nux-v. senec. *Ther.*

**URETHRA –**

COMPLAINTS of urethra - Prostate; near

1 Mark - sabal

**MALE GENITALIA/SEX –**

POLLUTIONS - prostatic disease, in

*2 Mark - Aesc.*

**DREAMS –**

CONFUSED - prostatitis; in

*2 Mark - Sel.*

**COMPLETE REPERTORY**

**Mind:** Lasciviousness, lustfulness: Old men with enlarged prostate: - Dig

**Eye**

Inflammation: Iris, iritis:

Prostate gland inflammation, with:-: Sabal

**Rectum**

Constipation: Prostate enlarged, with:-: Arn, Sabal, Sil

**Stool:**

Flat, like a ribbon: Prostate, from enlarged, or from uterus retroversus: - **Arn**

**Bladder:**

Inflammation: Chronic: Enlarged prostate, with: - Fab

Prostatism (see prostate, complaints in general):

Retention of urine: Enlarged prostate, from: - **Dig, Staph**, Apis, Cact , Chim, Puls ,Bell; Benz-ac; Canth; Con; Ferr; Hyos; Kali-i; Merc-d; Morph; Pareir; Sep; Stram; Zinc.

**Urination:**

Dribbling by drops: Enlarged prostate, with: - Aloe, Dig, Nux-v, Puls, Staph, Arn, Bar-c, Bell, Benz-ac, Cop, Ferr-pic, Mur-ac, Pareir, Petr, Sabal, Sel, Sep.

Urination: Dysuria: Prostate enlargement, with: - Apis, Med, Petros.

Urination: Frequent: Old people: Enlarged prostate, with: - Con, Ferr-p

Urination: Frequent: Prostate complaints, with: - Apis, Ferr-pic, Sabal, Staph Thuj.

Urination: Interrupted, intermittent: Spurts, in swollen prostate, with each spurt cutting pain: - Puls

Urination: Involuntary: Old people, in: Men with enlarged prostate: - All-s, Aloe, Cic, Iod, Pareir, Sec, Thuj, Apoc, Dig, Kali-p, Nux-v.

Urination: Involuntary: Prostate enlargement, with:-

Urination: Retarded, must wait for urine to start: Press, must: Prostate complaints, in:-**Prostate Gland**

Enlargement:

3 mark Bar-c, Calc, Con, Dig, Puls

2 mark Aloe, Am-m, Apis, Arg-n, Aur-m, Benz-ac, Berb, Chim, Cimic, Actaea rac, Dulc, Ferr-m, Gels, Hyos, Iod, Kali-I, Lyc, Med, Merc, Nat-c, Nat-s, Nit-ac, Ol-sant, Pareir, Phos, Pop, Psor, Sec, Sel, Senec, Sil, Solid, Spong, Staph, Sulph, Thiosin, Rhodallin, Thuj,

1 mark Acon, Alf, All-s, Alum,-p, Alum-sil, Apoc, Arn, Asaf, Asar, Aspar, Aur, Bar-I, Bell, Bry, Cact, Calc-f, Calc-i, Calc-sil, Cann-s, Canth, Caps, Carb-v, Cedr Chr-s, Cic, Cicuta virosa, Clem, Cop, Cub, Cycl, Epig, Eup-pur, Euphr, Ferr-p, Ferr-pic, Graph, Hep, Hydrang, Kali-bi, Kali-br, Kali-p, Lith-c, Mag-c, Mag-I, Mag-s Merc-d, Mur-ac, Nat-p, Nat-sil, Nux-v, Ol-an, Oxyd, Pic-ac, Pip-m, Plat, Rhus-a Sabal, Sars, Sul-I, Terebe, Ther, Thymol, Thyr, Trib, Tritic, Uva , X-ray

**KENTS REPERTORY**

**PROSTATE GLAND**

**BALL**, sensation of sitting on a:

3 Mark - **Sep.**

2 Mark - *chim.*

1 Mark- Cann-i., sil.

**EMISSION prostatic fluid** :

3 Mark - **Ph-ac.**, **Sel.**, **Sep.**, **Staph.**,

2 Mark - Agn., anac., apis., aur., calc., elaps., ery-a., eupho., hep., lyc., lyss., mag-c., nat-c., nat-m., nit-ac., petr., phos., psor., puls., sil., spig., sulph., thu., zinc.

1 Mark- Agar., alum., am-c., bell., cann-s., canth., casc., chim., con., daph., dig., gels., mang., nux-m., pic-ac., plb., sabal., tab., tarent.

dribbling :

3 Mark - **Sel.**
2 Mark - *Phos.,*

easily discharged, so that even an emission of flatus causes :
1 Mark - Mag-c.

emotion, with every :
3 Mark - **Con.**,
1 Mark - hep., puls., sel., zinc.

erections, during :
3 Mark- **Ph-ac.**,
2 Mark - *puls.*
1 Mark - Nit-ac.,

without :
3 Mark – **Sel.**,
2 Mark - *lyc., nat-m., phos.,*
1 Mark - Aur., bell., cann-s., con., eupho., lyss., thu.

flatus, while passing :
2 mark- *mag-c.*
1 Mark - Con.,

fondling women, while :
3 mark- **Con.**
1 Mark - Agn.,

lascivious thoughts, during :
3 Mark – **Con.**, **Nit-ac.**,

2 Mark - *lyc., nat-m., ph-ac., phos.,*
1 Mark - pic-ac.

sitting, while : 2 Mark- *Sel.*

stool, with :
3 Mark – Con., Nux-v., Ph-ac., Sel., Sep.
2 Mark - agn., calc., caust., hep., ign., iod., kali-bi., nat-c., nat-m., nit-ac., petr., phos., sil., zinc.

1 Mark - Agar., alum., am-c., anac., ars., aur-m., carb-v., carl., cor-r., elaps., nat-p., staph., sulph.,

difficult, with :
3 mark – **Nit-ac., Ph-ac., Sil., Sulph.,**

2 mark – *Agn., carb-v., hep., nat-c., phos., sep,. staph.,*

1 mark - alum., am-c., anac., arn., cann-i., con., gels., psor., zinc.

soft, with :
2 Mark - *sel.*
1 Mark - Anac.,

after :
3 Mark - **Sulph.**
2 Mark - *calc., caust., hep., iod., kali-c., nat-c., nit-ac., sel., sep., sil.*
1 Mark - Am-c., anac., cur.,lyss., phos., zinc.

talking to a young lady, while :
2 Mark - *Nat-m., phos.*

thinking of it : 1 Mark - Nat-m.

urination, before : 1 Mark - Psor.

during : 1 Mark - Anac., hep., nat-c., nit-ac., sep., sulph.

after :

3 Mark – **Sulph.**
2 Mark- *daph., hep., kali-c., nat-c., sep., sil.,*

1 Mark - Anac., calc., cur., hipp., lyc., lyss., nat-m., sel.,

walking, while :

3 mark – **Sel.**
1 Mark - Agn., sil.

**ENLARGEMENT** :

3 Mark – **Bar-c., Calc., Con., Dig., Puls.,**

2 Marks - *am-m., apis., aur-m., benz-ac., berb.,chim., ferr-m., hyos., iod., kali-i., lyc., med., merc., nat-c., nat-s., nit-ac., pareir., phos., psor., sec., sel.,sil., spong., staph., sulph., thu.,*

1 Marks - Aloe., alum., asar., aspar., cact., cann-s., canth., cic., clem., cop., kali-p., lith., nat-p., nux-v., senec., uva.

dribbling urine after stool and urine : 3 Mark - **Sel.**

senile :

3 Mark – **Bar-c.**, **Dig.**, **Sel.**,

2 Mark – *benz-ac., con., iod.,staph.,*

1 Mark- Aloe., nux-v., sabal., sulph.

sensation of :

2 Mark - *ther.*
1 Mark - Alum., berb., bry., chim., cycl., nux-v.,

**FESTERING sensation** : 1 Mark - Cycl.

**FULLNESS**:

2 Mark - *chim., cycl.,*

1 Mark - Alum., berb., bry., nux-v.

**GURGLING sensation**: 1 Mark - Phyt.

**HARDNESS**:

3 Mark – Con**.**
2 Mark- Cop., sil., thu.

1 Mark - Iod., med., plb., senec.,

without enlargement : 1 Mark - Cop.

**HEAT** : 2 Mark - *puls.*
1 Mark - Ptel.,

**HEAVINESS** :

2 Mark- *con., cop.*
1 Mark - Cact., caust., graph., hydrc., puls., sulph.

lascivious thoughts, during : 1 Mark - *Graph.*

**INDURATION** :

3 Mark – **Thu.**
2 Mark – Con., cop., iod., psor., sel., sil., sulph.,

1 Mark - Plb., senec.,

**PROSTATE GLAND**
**INFLAMMATION** :

3 Mark – **Apis.**, **Chim.**, **Puls.**,

2 mark – *caps., caust., con., cop., cub., dig., hep., kali-bi., lyc., merc., nux-v., petr., ph-ac., sel., sep., sil., staph., sulph., thu.,*

1 Mark - Acon., æsc., agn., alum., arn., bell., bov., cact., cann-i., canth., cycl., hipp., lach., lil-t., lith., med., merc-d., pareir., sabal., sec., senec., sul-ac., zinc.

suppressed gonorrhœa, from :
3 Mark- **Nit-ac., Thu.**

2 Mark – *cop., dig., med., merc., nux-v., petr., puls., sep., sulph.,*

1 Mark - Bell., cupr., staph.,
**IRRITATION in**: 2 Mark – *dig.,*
1 Mark - Cact., gnaph.
**JERKING in region of**: 1 Mark- Form.
**ONANISM**, complaints after: 1 Mark- Tarent.
**PAIN**:

2 Mark – *All-c., alum., bell., caps., caust., chim., con., cub., cycl., lyc., phos., puls., rhus-t., staph.,*
1 Mark - Acon., apis., asaf., berb., bov., brom., cact., calc-p., cop., cupr-ar., dig., gnaph., graph., laur., lyss., merc., ol-an., pareir., podo., polyg-h., sel., sul-i., sulph., tarent., thu.

blowing nose, on : 1 Mark - Alum.
cancer, in : 1 Mark - Crot-h.
coition, after : 2 Mark - *All-c., psor.,*

1 Mark- alum., caps., sel.

erection, during : 1 Mark - Alum.
gonorrhœa, during : 2 Mark- *Caps.,*
1 Mark - cub.
jarring agg. : 3 Mark - **Bell.**
riding agg. : 1 Mark - Staph.
sitting, while : 2 Mark - *Chim., cycl.,*
1 Mark - dig., rhus-t.
standing : 1 Mark - Cycl.
stool, urging to : 2 Mark - *Cycl.,*
1 Mark - rhus-t.
after : 1 Mark - Phos.
urination, during : 2 Mark - *Apis.,*
1 Mark - cop., lyc., pareir.
at close of : 1 Mark - Coca.
after : 3 Mark - **Puls.**
1 Mark - Lyc.,
urinate, urging to : 2 Mark - *Cycl., rhus-t.*
walking agg. : 2 Mark - *cycl.,*

1 Mark - All-c., brom., staph.

amel. : 2 Mark - *Rhus-t.*

aching : 1 Mark- Thu.
bladder, and, deep in pelvis, morning and forenoon after coition : 1Mark - All-c.
sitting and walking, while : 1 Mark- Cycl.
biting: 1 Mark - Carb-an., con.
burning: 1 Mark - All-c., ambr., cop., lyss., ph-ac.
constrictive: 2 Mark- *Caust.,* .
1 Mark- Canth., puls., sulph

dragging : 1 Mark - Nat-a., sil.
drawing : 2 Mark - *cycl.,*
1 Mark - Clem., kali-bi., mez.

sitting or walking : 2 Mark - *Cycl.*
pressing : 2 Mark- *alum., caust., con., cycl., lyc., phos., puls., sel.,*

1 Mark -All-c., apis., asaf., berb., brom., cact., chim., laur., merc., ol-an., sulph., thu.

coition, during : 2 Mark - *Alum.*
erection, at beginning of : 2 Mark - *Alum.*
nose, on blowing : 1 Mark - Alum.
standing : 1 Mark - Cycl.
urination, during : 2 Mark - *Lyc.*
after : 3 Mark - **Puls.**
1 Mark - Lyc.,
walking, while : 1 Mark - All-c., brom., *cycl.*
pulsating : 1 Mark - Caust., polyg-h.
region of : 1 Mark - Bov.
straining to urinate, while : 1 Mark - Dig.
--- shooting (See Stitching)
soreness : 3 Mark - **Chim.**,
2 Mark - *cycl., rhus-t.,*
1 Mark - Alum., sul-ac.
sticking : 1 Mark - Nit-ac.
stitching : 2 Mark - *con., cycl., puls.*
1 Mark - Bov., calc-p., kali-bi., kali-c., kali-n., lyc.,

afternoon : 1 Mark - Aur., kali-bi.
urination, during : 1 Mark - Cact., caust., cop., cycl., kali-n., merc-d., pareir., sel.
walking agg. : 2 Mark - *Kali-bi.*
extending to genitals : 1 Mark - Bov.

**QUIVERING**, nervous : 1 Mark - Form.
**SUPPURATION** : 3 Mark - **Sil.**
1 Mark - Hep.,
**SWELLING** : 3 Mark - **Chim.**,
2 Mark – *con., dig., iod., puls.,*
1 Mark -Cann-s., chel., cop., cub., dulc., hipp., med., merc-d., sel., senec., sep., staph., sul-ac., thu.

**TENSION** : 1 Mark - Clem., lyc., thu.
**TWITCHING** : 1 Mark - Form.
**UNEASINESS** : 1 Mark - Ptel.

**BOERICKE REPERTORY**

Male Sexual System Prostate gland: Hypertrophy:

3 Marks – **Aloe, Arg-n, Bar-c, Chim, Cimic, Ferr-pic, Gels, Hydrang, Pop, Sabal, Senec, Sulph, Thiosin, Thuj**.

2 Marks - Alf, Am-m, Benz-ac, Calc-f, Calc-I, Chr-s, Con, Eup-pur, Graph, Hep, Iod, Kali-bi, Kali-br, Lyc, Med, Ol-sant, Oxyd, Pareir, Pic-ac, Pip-m, Puls, Rhus-a, Sars, Staph, Thyr, Trib, Tritic.

Male Sexual System Prostate gland: Inflammation (prostatitis):

3 Marks – Bell, Chim, Cop, Fab, Gels, Hep, Iod, Merc-d, Nit-ac, Puls, Sabal, Sil, Solid, Staph, Thuj, Verat-v

2 Marks - Acon, Aesc, Aloe, Apis, Bry, Canth, Colch, Cub, Dig, Ferr-p, Kali-br, Kali-I, Kali-n, Merc-c, Ol-sant, Pic-ac, Sabad, Salx-n, Sel, Tritic, Vesi

**THERAPEUTICS OF 3 MARK REMEDIES FROM MAJOR REPERTORIES**

As is obvious, any patient must be treated on its individuality and not on the disease symptoms. BPH is a condition, which may mislead any physician due to dominance of disease symptoms taking priority in the hands of patient. He is so disturbed, so embarrassed that he will sometimes not give importance to his particular, uncommon peculiar and constitutional symptoms. It is prudent for a physician to take some symptoms for relief of the patient as palliative measure but if he wants to give him permanent or long lasting relief, a proper prescription on the basis of miasm, constitution, individuality, general and particular symptoms is important. Sycosis plays an important part in this disease whereas overall mixed miasm may be found in patients.

**ALOE SOCOTRINA -** Sensation as if a plug were wedged between symphysis and coccyx, pressing downward; incontinence of urine from enlarged prostata; intense pain and soreness in rectum after stool with protrusion of piles, aggravation from touch and temporarily amelioration by cold water.

**BARYTA CARBONICUM:** It has a marked influence on the growth esp. of old people. There is a tendency to enlargement of the glands, with indurations especially prostate, tonsils and cervical. It is a remedy for early senility and when degenerative changes in old men begin in heart, brain and vascular system. Enlarged prostate gland. Urging to urinate; cannot retain the urine. Burning in urethra, while urinating. Frequent urination. Irritation of bladder, worse at night. Constant urging and frequent emission of urine. Every individual medicine is selected on the basis of constitutional approach. Hypertrophy of prostata; after urinating renewed straining with dribbling of urine; numbness in genitals for several minutes; frequent micturition, no stool, in old men.

- Enlarged prostate in old men with dribbling long after urination.
- Prostatic hypertrophy prematurely - men in their 40's.
- Prostatic hypertrophy from diminished sexual capacity.
-

**CALCAREA CARBONICA** - Chronic cystitis, foetid or pungent urine, which is clear and pale; frequent micturition, it seems as if he could not hold his urine and sensation as if he could not finish urinating, as if some urine remained in the bladder.

- Prostatic hypertrophy, firm and very large.
- Ejaculation difficult, long delayed.
-

**CHIMAPHILA UMBELLATA -** Sensation of swelling in perinaeum, as if on sitting down a ball were pressing against it; inability to urinate without standing with the feet wide apart and the body inclined forward. Acute prostatitis from sitting on a cold damp stone, excessive itching and painful irritation of urethra from the end of penis to neck of

bladder, which dysuria may increase to complete retention from swelling of prostata; great quantities of thick, ropy, bloody mucus in urine; prostatic disease with waste of prostatic fluid.

- Acute prostatic inflammation, swelling and retention.
- Burning pain in prostate with constant urging for urine.
- Worse: Cold, damp. Sitting on cold bench or stone. Sitting.
- Itching in urethra or prostate.
- Ball sensation in perineum.
- Sensation as if perched on a ball while sitting (Cann-S).
- Better: Walking slowly.
- Bladder does not empty; can only pass urine when standing with leg spread and bending forward.
-

**CONIUM MACULATUM:** This drug is prepared from the plant commonly known as poison hemlock. Acts on the glandular system, engorging and indurating it, altering its structure like scrofulous and cancerous conditions. Enlarged glands. Much difficulty in voiding. Urine flows and stops again. Interrupted discharge. Dribbling of urine in old men. Enlargement and induration of prostata cause intermittent urination in old people, urine flows and stops; discharge of prostatic fluid on every change of emotion, without voluptuous thoughts or while expelling faeces, with itching prepuce; pressure in neck of bladder, with stitches, aggravation when walking, amelioration when sitting; weight like a stone in perinaeum.

- Enlarged and hard prostate - frighteningly hard gland.
- Rapid growth of gland from sexual suppression.
- Heavy feeling in the prostate.
- Seminal emissions from stool; from every emotion.
- Ejaculation too easy; during foreplay.
- Urination too frequent or dribbling from enlarged prostate.
- Urination interrupted - stops while straining then flows when relaxed.
-

**DIGITALIS PURPUREA -** The urinary symptoms of Digitalis consist of a dragging and pressure in the bladder which micturition does not relieve. It has been found useful in inflammation in the neck of the bladder with intense desire to urinate, which is increased even by the passage of a few drops. The patient walks about in great distress; at the same time there is tenesmus of the rectum. The patient is relieved somewhat of these symptoms by lying on the back. The pain at the neck of the bladder is throbbing. The urine is scanty, thick and turbid, and contains sediment of brick-dust, like Lycopodium. The urging to urinate in cases calling for Digitalis is often due to the enlargement of the prostate gland, for which it is a remedy. Senile hypertrophy of prostate, cardiac symptoms marked; dribbling discharge of urine and continued fulness after micturition or fruitless effort to urinate; throbbing pain in region of neck of bladder during the straining efforts to pass water; increased desire to urinate after a few drops have passed, causing the old man to walk about in distress, though motion increases desire to urinate; frequent desire to defaecate at the same time; very small, soft stool passed without relief; urine pale, slightly cloudy, looking smoky.

- Urinary retention or dribbling with enlarged prostate in the elderly.
- Fullness in bladder after urinating; fruitless urging; painful dribbling.
- Constant urge for urination at night.
- Pain in prostate: Worse: Urination. Sitting.
- History of gonorrhea.
-

**FERRUM PICRICUM (PICRATE OF IRON) -** This remedy is prepared from potentized picrate of Iron and is another very good remedy for prostate disorders. Senile hypertrophy of the prostate. Pain along entire urethra. Frequent micturition at night, with full feeling and pressure in rectum. Smarting at neck of bladder and penis. Retention of urine. One of the best medicine for senile prostatic hypertrophy.

- Good medicine to complete the action of other medicines (Boericke)
- Frequent micturition at night
- Full feeling and pressure in rectum

- Retention of Urine
- Smarting at neck of bladder

HYDRANGEA (SEVEN BARKS) Hydrangea has been used for hundreds of years as a treatment for enlarged or inflamed prostate glands, and is often combined with Horsetail for this purpose. It is one of the best herbal remedies for treatment of pain related to kidney problems, especially kidney stones, by reducing the size of the stones and allowing them to pass painlessly. In Greek mythology, Hydra was a water monster with nine heads, and if one was cut off, the monster grew back two. A water "hydrant" also helps remind us that hydrangea has to do with the body's water. Hydrangea is very high in silicon, needed to maintain flexible arteries, especially important for good blood circulation through the filtering tubules of each kidney. Manganese has only been appreciated the last few years in its ability to strengthen nerves, the immune system, digestion of fats, blood sugar regulation, growth and reproduction. These factors also impact demands on the urinary system. Also found naturally in relatively large amounts is chromium, essential for proper blood sugar levels and circulatory health.

- Enlargement of prostate
- Remedy for stones, profuse deposits of white amorphous salts in urine
- Burning in urethra and frequent desire
- Urine hard to start
- Sharp pains in loins
- Enlarged prostate with great thirst
-

**POPULUS TREMULOIDES -** Enlarged prostata; catarrh of bladder, painful urination, irritation of bladder and urethra.

**PULSATILLA PRATENSIS** - Continued dull stitches in neck of bladder, with a pressure of urine, while lying upon his back; after micturition spasmodic pains in neck of bladder, extending to pelvis and thighs; prostatic troubles of elderly people, faeces flat, small in size.

- Acute and chronic prostatitis with painful, spurting stream.
- Severe prostate pains.
- Worse: After urination. Suppressed gonorrhea.
- Retention of urine in the elderly; retention with enlarged prostate.
- Prostatitis after suppressed gonorrhea.
- Prostatic emissions from erections, from stool or urination.
-

**SABAL SERRULATA ( SAW PALMETTO)** This medicine has been recommended for various prostatic troubles, but its homeopathic use seems confined to acute cases of enlarged and inflamed prostate. The gland is hot, swollen and painful. Sabal is also a useful drug in senile hypertrophy. There has been a marked palliative action in several cases and avoidance of surgical interference after the use of this drug. Recently, medical literature has provided increased support for the use of naturally occurring nutrients that prevent the progressive enlargement of the prostate gland (BPH). Some of these nutrients have even been demonstrated to reduce the incidence of prostate cancer! These nutrients that combat the detrimental effects of DHT in the prostate can be utilized to combat the effects of DHT in hair loss.

This is by far the most commonly recognized and discussed herb concerning the prostate. Saw palmetto is a plant (dwarf palm tree) native to the United States. It has been used medicinally for over a century with its first use being described in the medical literature in the 1800s. Early literature concerning saw palmetto described it as relieving symptoms ranging from prostate enlargement in men to gynecological problems in women such as menstrual discomfort. Most of the substances found to be effective in treating benign prostatic enlargement are found in the extract form. The extract form has been demonstrated to be more potent than the dried berry form. The active constituents are volatile oil, steroidal saponin, tannins, and polysaccharides. Saw Palmetto is one of the few herbal products that is considered to be anabolic - it strengthens and builds body tissues. For men it treats an enlarged and weakened prostate gland. It has shown significant action in treatment of conditions associated with benign prostatic hypertrophy (BPH). Saw palmetto extract works to prevent testosterone from converting into dihydrotestosterone, the hormone thought to cause prostrate cells to multiply leading to an enlarged prostate, and to increase male & female pattern baldness. It is chiefly used as a diuretic and to tone the bladder by improving urinary flow, and relieving strain.

Regular use of saw palmetto may decrease urinary frequency, especially during the night, by allowing complete bladder expulsion and reducing inflammation of the bladder and enlarged prostrate. Saw palmetto inhibits androgen and estrogen receptor activity and may be beneficial for both sexes in balancing the hormones and stimulating healthy hair growth. Constant desire to urinate < night

- Enuresis
- Paresis of sphincter vesicae
- Cystitis
- Acts on membrano-prostatic part of urethra
-

**SULPHUR -** Offensive sweat around genitals; stools hard, knotty, insufficient; urine foetid, with greasy-looking pellicle on it; painful desire, with discharge of bloody urine, requiring great effort; mucous discharge from urethra.

- Prostatitis with marked burning in urethra or prostate.
- Inflamed and hard prostate with painful, burning ejaculation.
- Prostate and low back pain.
- Worse: After coition. While standing.
- Emissions after urination or stool, especially straining at stool.

**THUJA OCCIDENTALIS ( ARBOR VITAE )** One of the very good remedies for various prostate complaints especially for prostate enlargement. The patient complains of frequency, urgency. Pain and burning during urination. Pain in the penis. Urinary stream split and small. Sensation of trickling after urinating. Severe cutting after urination. Frequent micturition. Desire sudden and urgent, but cannot be controlled. The remedy acts on skin, blood, gastrointestinal tract, kidneys, brain. It has tendency to produce benign growths, spongy tumors, warts, condylomata. Has specific antibacterial action in gonorrhea. Patient in general feels better in dry weather and worse in damp, humid atmosphere. Patient has many fixed ideas; music causes weeping and trembling.

- Emotional sensitiveness.
- Acts on genito urinary tract producing sycotic dyscrasia.
- Sycotic pains: pain muscles and joints
- Hydrogenoid constitution
- Rapid emaciation and exhaustion
- Fixed ideas: as if a strange person is at his side, as if soul and body were separated, as if something alive were in abdomen
- BPH
- History of gonorrhoea
- Inflammation of glans and prepuce
- Gonorrheal rheumatism
- Swelling of urethra with split stream
- Sensation of tickling in urethra after urinating
- Desire sudden and urgent, can not be controlled
- Frequent desire to urinate
- Pain lower abdomen

Syphilis and sycosis, especially suppressed or badly treated gonorrhoea; stitches in urethra from behind, also from rectum into bladder; rectal tenesmus, deep perineal pains; dysuria, retained urine; cutting at beginning of passing water, the pain descending the urethra to a point just above the external meatus; urine squirts out or slowly drops; scalding and cutting at the close of urination; stream interrupted several times before bladder is entirely emptied; frequent desire to urinate in the evening, amel. by lying down.

***Medicines that showed efficacy other than the above mentioned drugs when selected constitutionaly during the study .***

**CAUSTICUM -** Pulsations in perinaeum; after passing a few drops pain in urethra, bladder and spasms in rectum, with renewed desire; must pass water every few minutes at night with extremely painful pressing and urging; chronic prostatitis; contraction of sphincter, with excoriating serous discharge from anus.

**LYCOPODIUM CLAVATUM -** Pressing on perinaeum near anus, during and after micturition; stitches in neck of bladder and anus at the same time; urging to urinate, must wait a long time before it passes; incontinence of urine.

- Prostate enlargement accompanying sexual dysfunction.
- Pain in prostate during or lasting long after urination.
- Ejaculations from mere sexual thoughts; ejaculations despite impotence.

MEDORRHINUM

- Prostatitis after suppressed gonorrhea.
- Prostatitis and urinary infections after beginning a new relationship.
- Frequent, painful urination with enlarged prostate.
- Heaviness in the prostate or perineum.
-

**NATRUM SULPHURICUM**

- Enlarged prostata, pus and mucus in urine; sycosis.

**NITRICUM ACIDUM**

- Chronic prostatitis often associated with chronic or recurring herpes.
- Prostatitis after suppressed gonorrhea.
- Easy emissions of prostatic fluids from stool or least excitement.

**SELENIUM -** Selenium has neuraesthenia from sexual excesses, dribbling of prostatic fluid. This medicine has been recommended for various prostatic troubles, but its homoeopathic use seems confined to acute cases of enlarged and inflamed prostate. The gland is hot, swollen and painful. Here also come in our regular inflammation polychrests such as Aconite and Belladonna and it will not be necessary to go outside of them. Selenium has the symptom that the prostatic fluid oozes while sitting, during sleep, when walking and during stool. It is useful in advanced cases where the organs are in a state of irritability.

- Prostate enlarged and boggy in elderly men.
- Involuntary dribbling of urine:
- Worse: Walking. After urine or stool. Long after urination.
- Dribbling of prostatic fluid:
- Worse: Any stool. Walking. Sitting.
- Weakness of prostate and whole genital system. Impotence.
-

**STAPHISAGRIA -** Staphisagria is the remedy for the bad effects of masturbation where there is great emaciation with dark rings under the eyes, sallow face, peevishness and shyness. The patient is hypochondriacal and permits the mind to dwell too long on sexual subjects; the boy becomes apathetic and gloomy, he has the sunken face and he becomes uneasy about the state of his health. There may also be irritability of the prostatic portion of the urethra. In the female, Staphisagria is the remedy when the organs are in a state of irritability. It is the remedy for the advanced stages and in cases of long standing. It is the best remedy in anxious and imaginary persons who are uneasy about the state of the health.

- Retention or dribbling of urine with enlarged or indurated prostate.
- Frequent, scant urine or comes drop by drop.
- Chronic dribbling of semen.
- Prostatic pains and burning.
- Worse: From urination. From riding in car. After anger.

Prostate enlargement from marked and frequent masturbation

## MATERIALS AND METHODS

The study was conducted in male patients attending the outpatient unit of the department of Homoeopathic Philosophy, Government Homoeopathic Medical College, Thiruvananthapuram, between the age group of 50- 75 years of during the period 2005 to 2007.

**Samples:**

Samples of 30 cases diagnosed, as benign prostatic hypertrophy based on ultra sonography report were selected. All the patients selected were already diagnosed as benign prostatic hypertrophy before conducting the study. Aim of the study was to assess the sycotic predominance in benign prostatic hypertrophy cases and to find out the action of anti sycotic drugs and also to access the efficiency of constitutional Medicines in the Management of benign prostatic hypertrophy.

**Diagnostic Point**

1.Symptoms of incomplete emptying, frequency, intermittency, urgency, weak stream and straining.
2. Positive ultrasonogram finding.
3. Digital rectal examination.

Inclusion criteria

1. 30 well-diagnosed Benign prostatic hypertrophy cases, confirmed on the basis of clinical feature along with the positive ultra sound sonography were randomly selected.
2. Age group 50-75 yrs
3. Purely benign cases

Exclusion Criteria

1. Cases with high serum PSA levels
2. Cases with DRE findings suggestive of C.A Prostate
3. Case that do not fulfill the diagnostic criteria

**Methods**

History of illness was elicited in an elaborate manner as per the directions given by Dr. Samuel Hahnemann the aphorisms 83-104 of the 5$^{th}$ edition of Organon of medicine. Case history was recorded in detail. All the symptoms including subjective and objective were considered. After taking the totality of symptoms evaluation of the cases according to Kent's Method was done to find out the similimum. Individualizing symptoms were given more importance. Remedies were selected based on individual constitutional peculiarities. Based on the susceptibility of the patient, 30$^{th}$, 200$^{th}$ and 1000M potency were given. For assessing the miasmatic nature of symptoms, J.H Allen's work on "Chronic Miasms Psora and Pseudo Psora" and miasmatic diagnosis-Practical tips with clinical comparisons by Dr. Subrata Kumar Banerjee" were used. When the totality of symptoms under went considerable changes, case was retaken and the second medicine was given based on the symptom similarity. In between two doses of medication, placebo was administered liberally.

Homoeopathic principles and single medicine, similar remedy and minimum dose were strictly adhered.Repetition was done by same potency or ascending potencies

Diet and Regimen

All the patients were advised not to take other medications, internally or externally, strong and spicy foods, coffee, tea, condiments and other food items supposed to be of possessing medicinal value during the study period. However, 100 percent diet restriction cannot be guaranteed.

## OBSERVATION & RESULTS

Demographic Data

Distribution of cases according to the age.

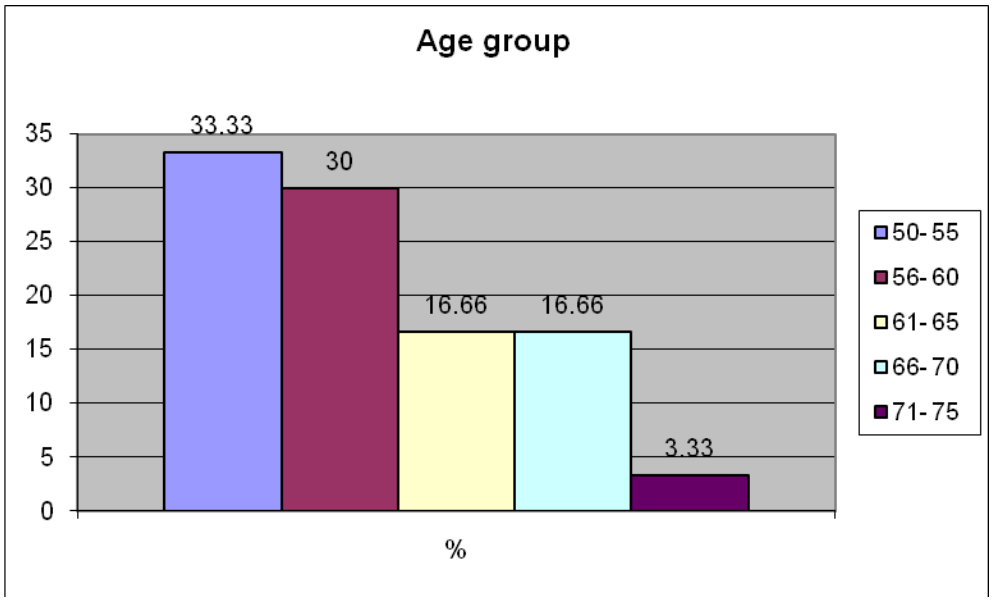



Diagram No. 1

| Age group | Number of people | % |
|---|---|---|
| 50- 55 | 10 | 33.33 |
| 56- 60 | 9 | 30 |
| 61- 65 | 5 | 16.66 |
| 66- 70 | 5 | 16.66 |
| 71- 75 | 1 | 3.33 |

Patients coming in the age group 50- 75 were included in the study. From the above diagram it is clear that the occurance of benign prostatic hypertrophy were more among age group 50- 55. Next significant age group was 56- 60.

Representation of patients according to the Domicile

| Domicile | No. of people | % |
|---|---|---|
| Urban | 22 | 73.33 |
| Rural | 8 | 26.67 |

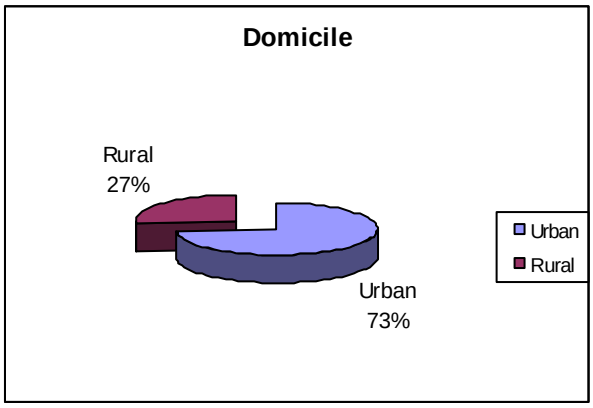



Diagram No. 2

27% are from rural area and 73% patients are from urban area

**Representation of patients according to the Socio - Economic Status**

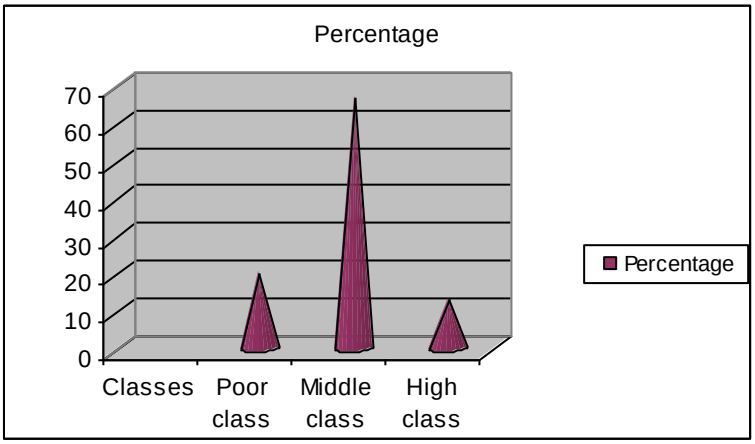



Diagram No.3

| Socio Economic Class | No. of cases | Percentage |
|---|---|---|
| Poor class | 6 | 20.0 |
| Middle class | 20 | 66.7 |
| High class | 4 | 13.3 |

Out of 30 patients treated majority from middle socio economic group and next is poor class.

Representation of patients according to the Associate Complaints

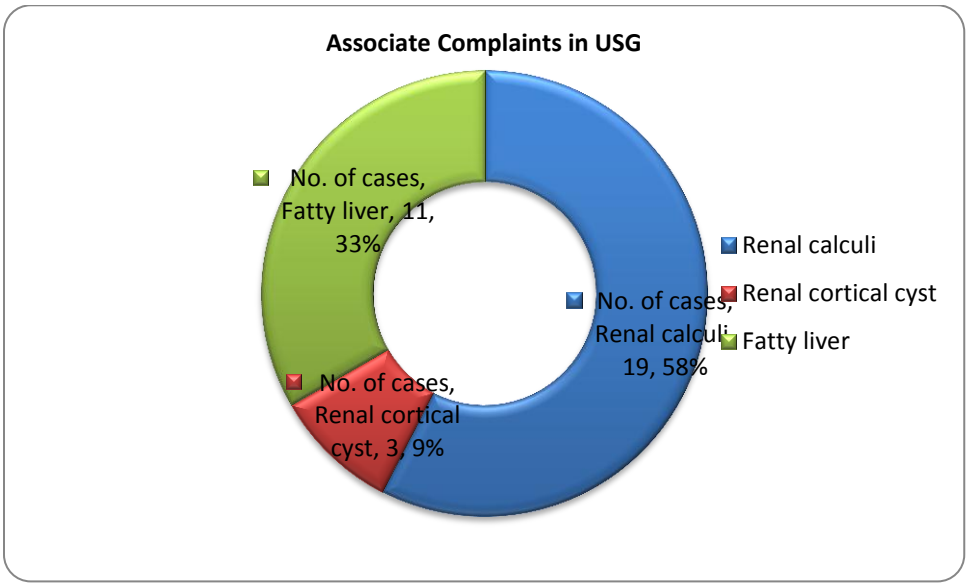



Diagram No. 4

| Associate complaint | No. of cases | % |
|---|---|---|
| Renal calculi | 19 | 63.33 |
| Renal cortical cyst | 2 | 6.67 |
| Fatty liver | 9 | 30 |

Among 30 cases, 19 cases (63.33%) shows renal calculi, 9 cases (30%) shows fatty liver and 2 cases (6.67%) shows renal cortical cyst.

Representation of patients according to the the Miasmatic cleavage

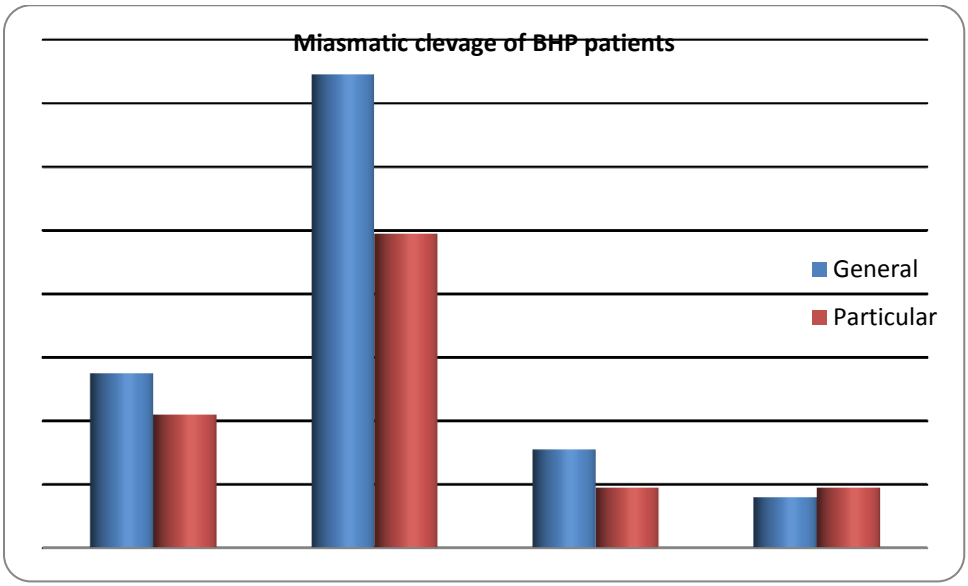
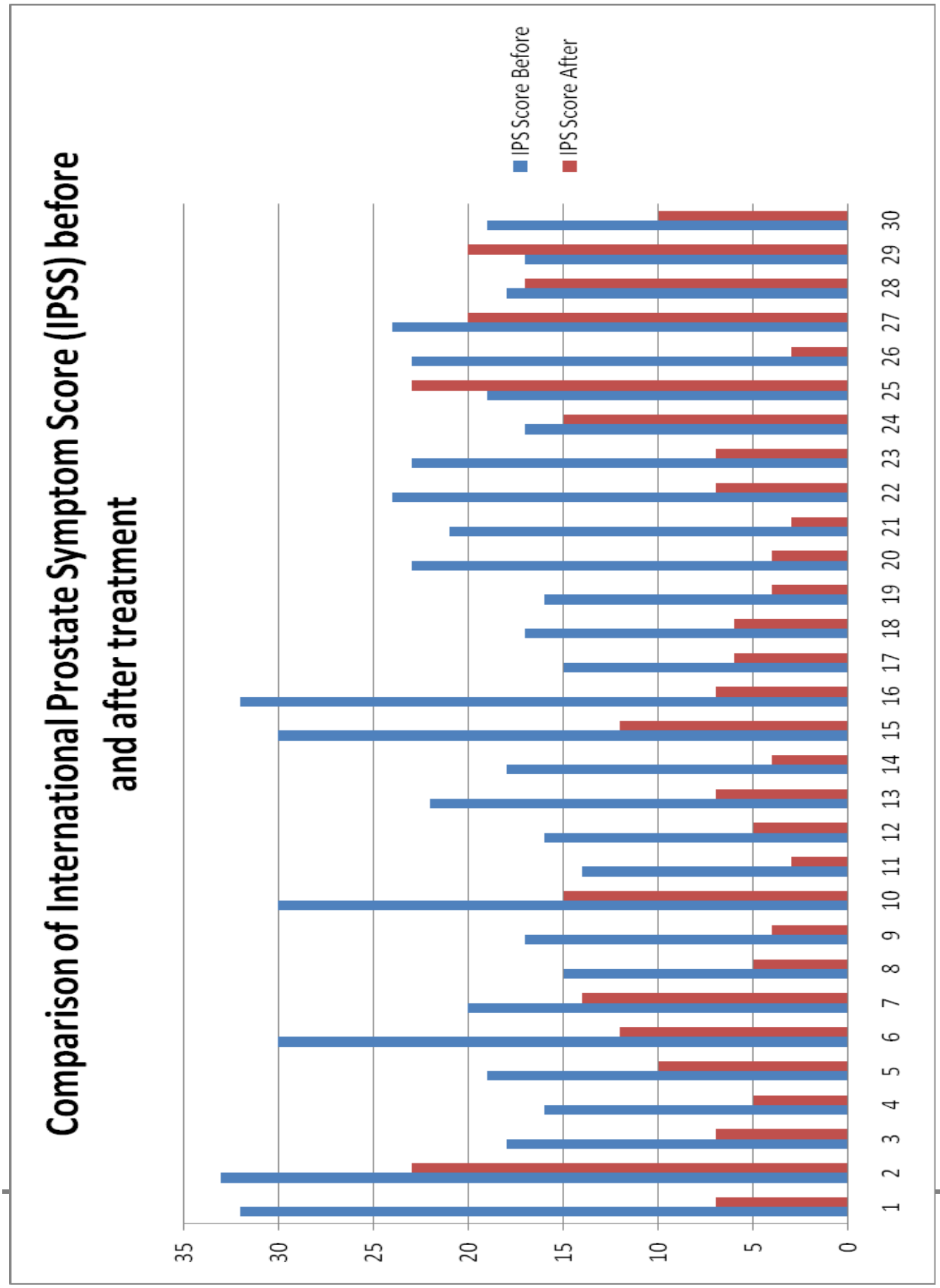
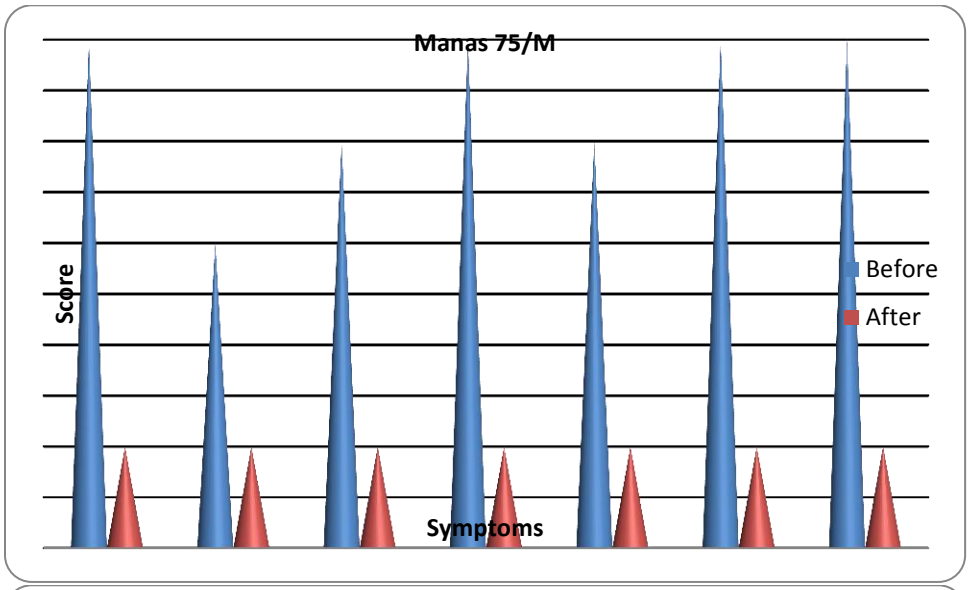


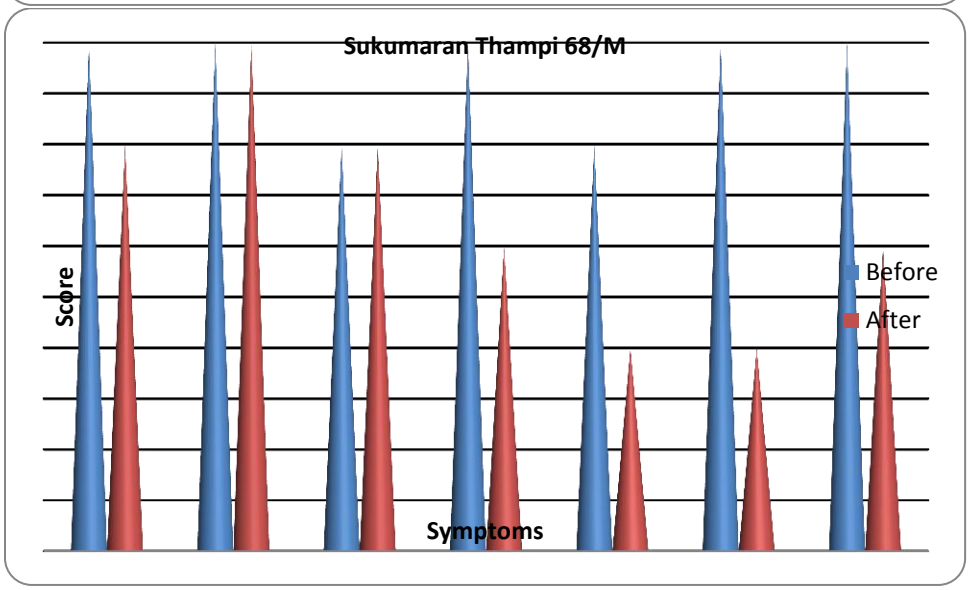

Diagram 5

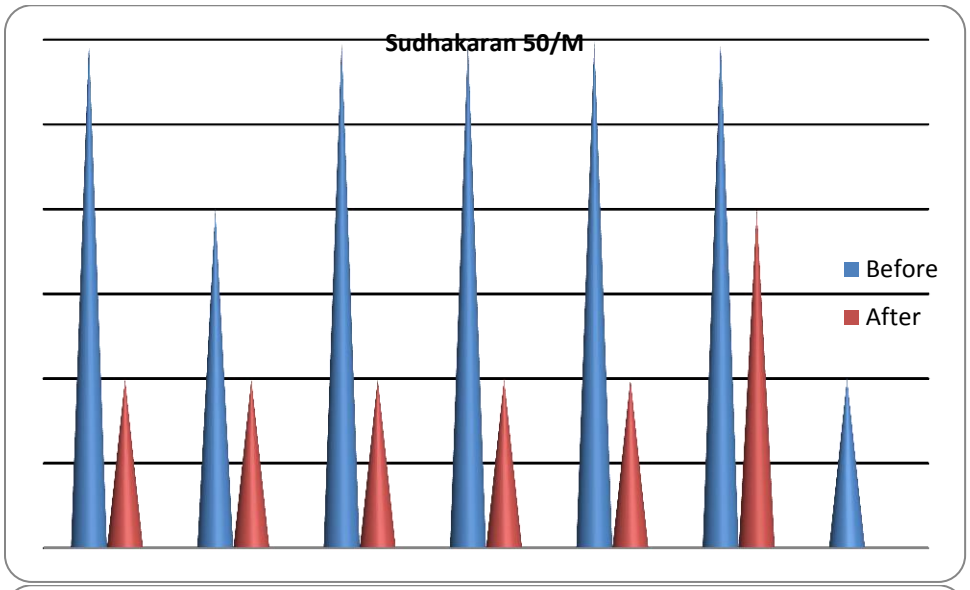
| Miasm | General | Particular | % |
|---|---|---|---|
| Psora | 55 | 42 | 22.56 |
| Sycosis | 149 | 99 | 57.67 |
| Syphilis | 31 | 19 | 11.63 |
| Pseudopsora | 16 | 19 | 8.14 |

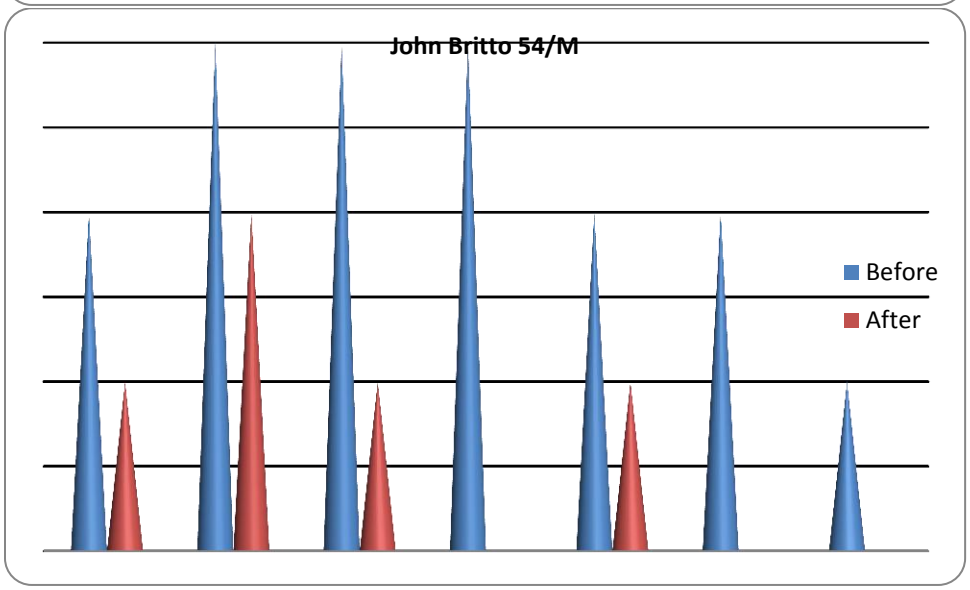
From the analysis of the general and particular symptoms (total 430 symptoms) of the 30 cases, it has been noted that sycosis shows maximum predominance, 57.67 % of symptoms. Psora shows a predominance of 22.56%, syhilis 11.63% and pseudopsora 8.14 % of symptoms

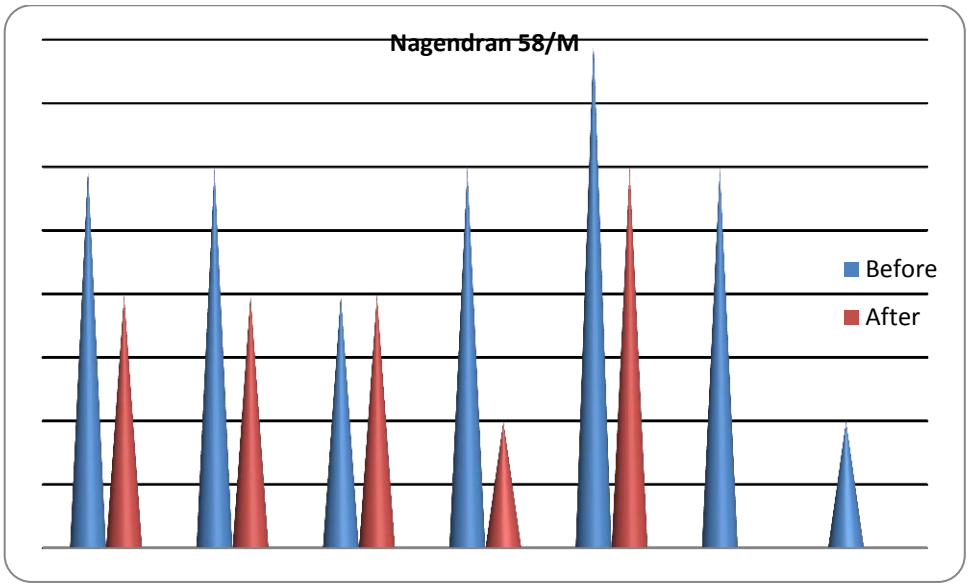

Comparison of International Prostate Symptom Score (IPSS) before and after treatment
IPS Score Before
IPS Score After
35
30
25
20
15
10
5
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

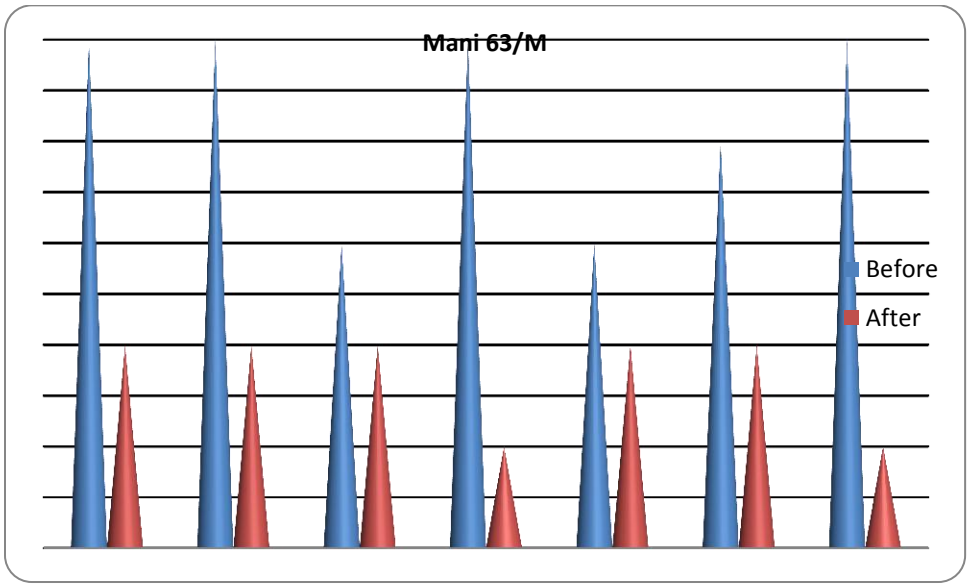

Manas 75/M
Score
Symptoms
Before
After

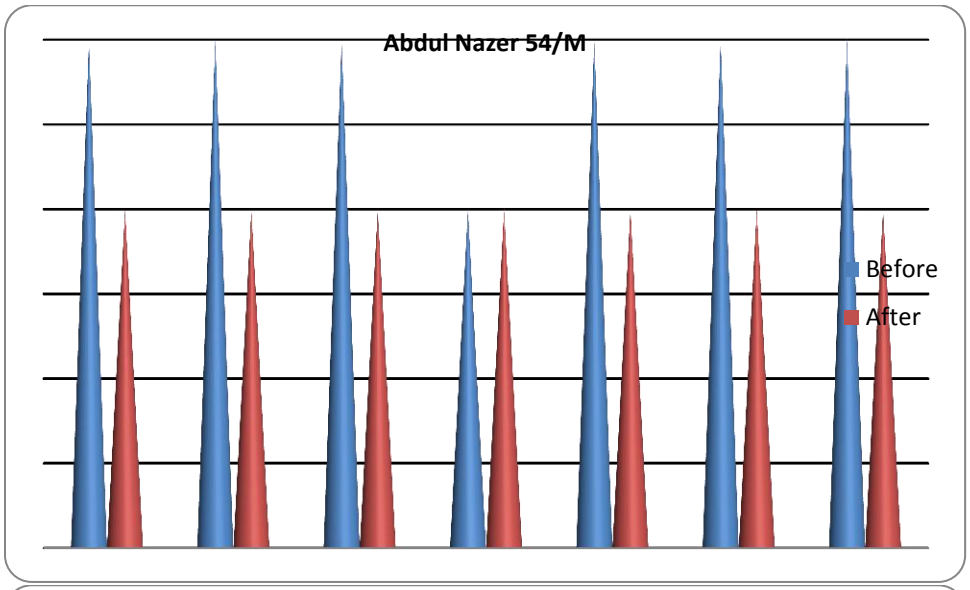

Sukumaran Thampi 68/M
Score
Symptoms
Before
After

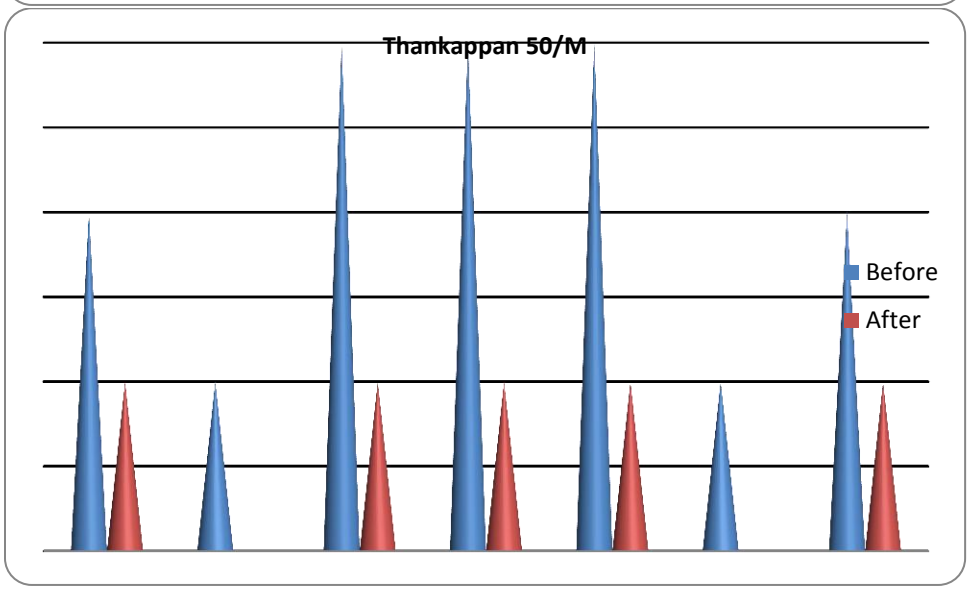

Sudhakaran 50/M
Before
After

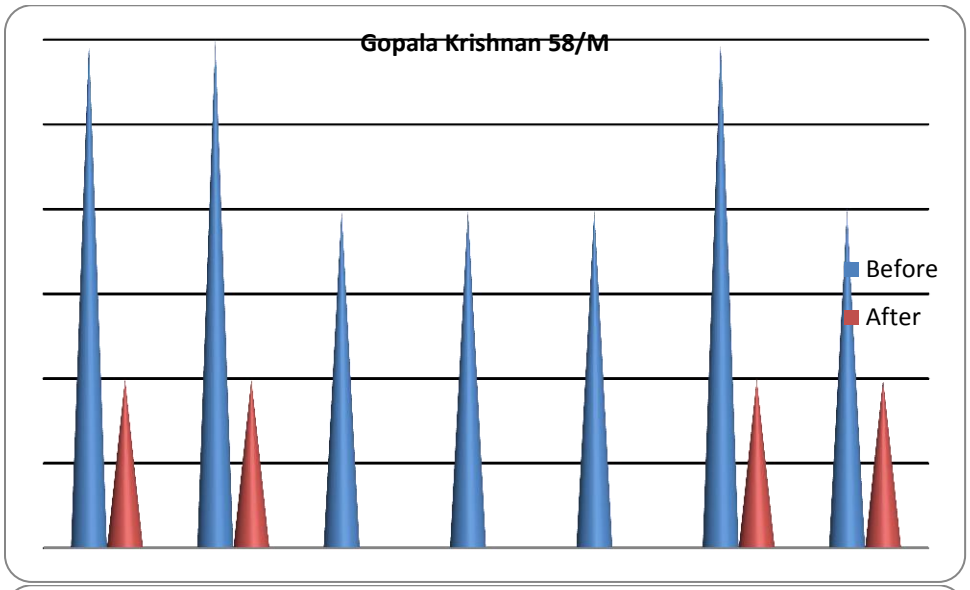

John Britto 54/M
Before
After

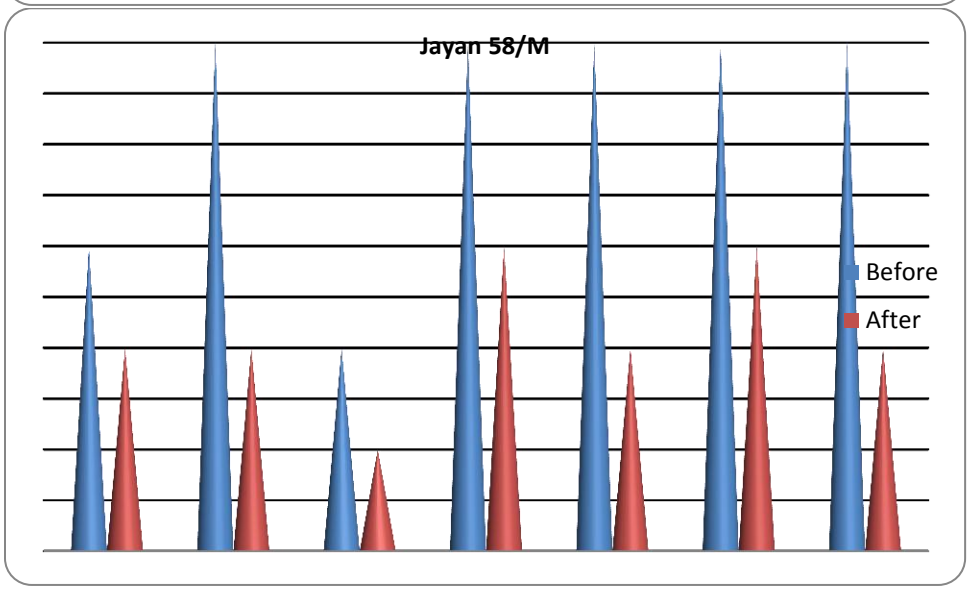

Nagendran 58/M
Before
After

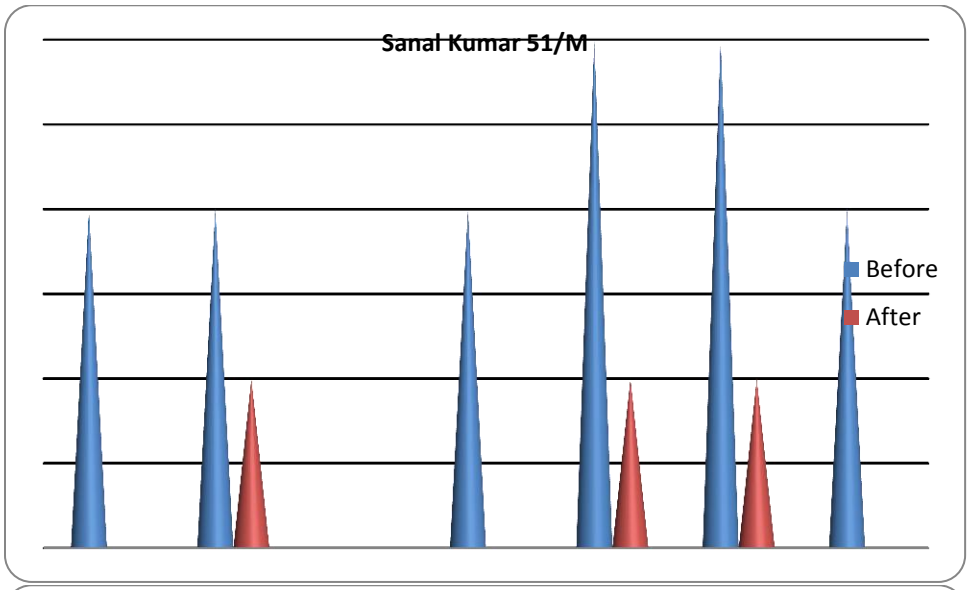

Mani 63/M
Before
After

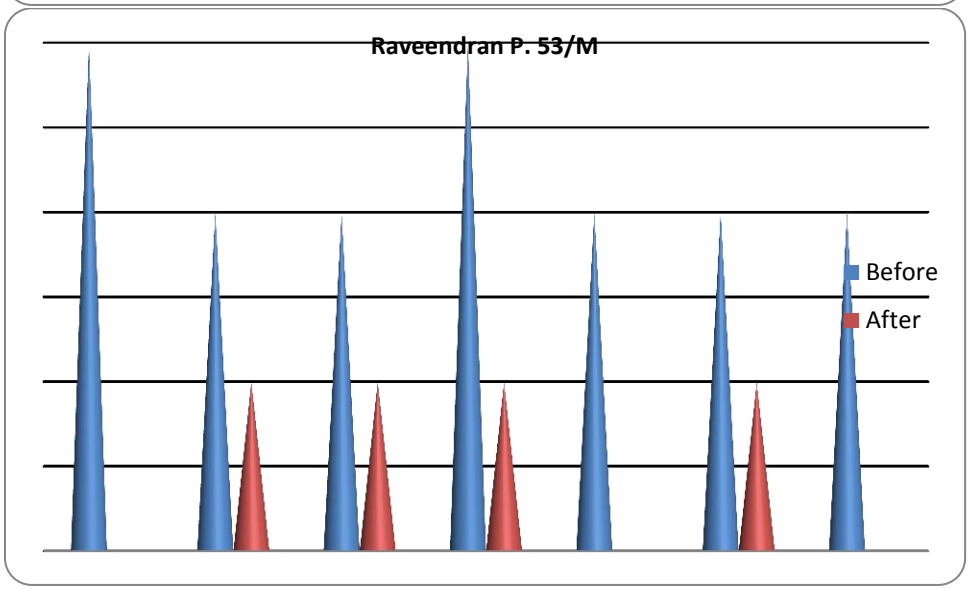

Abdul Nazer 54/M
Before
After

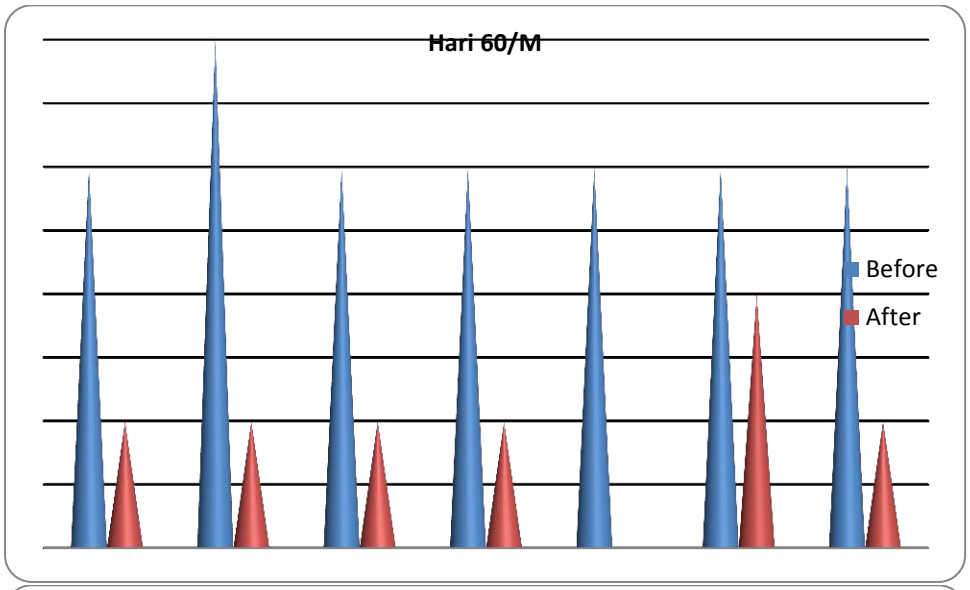

Thankappan 50/M
Before
After

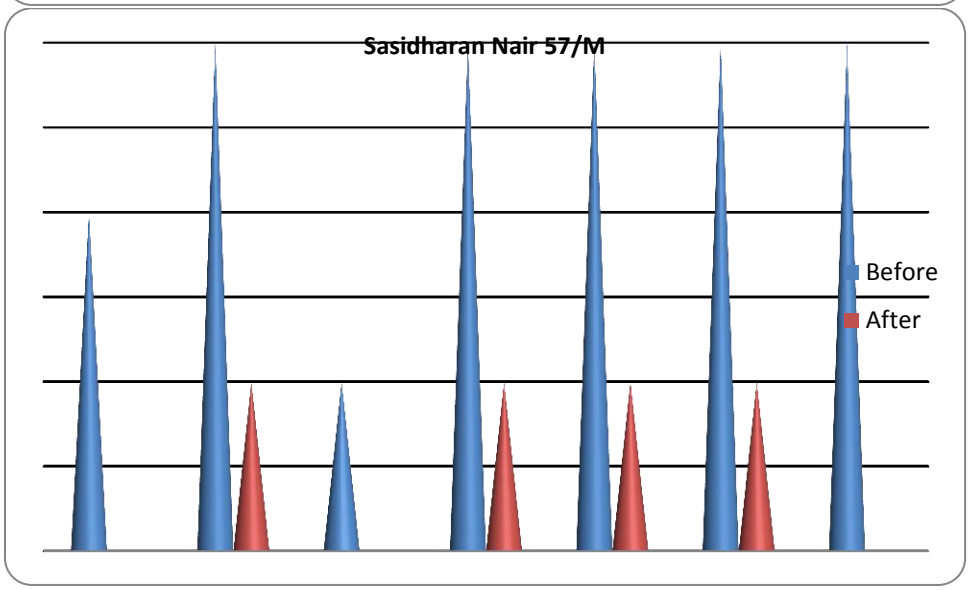

Gopala Krishnan 58/M
Before
After

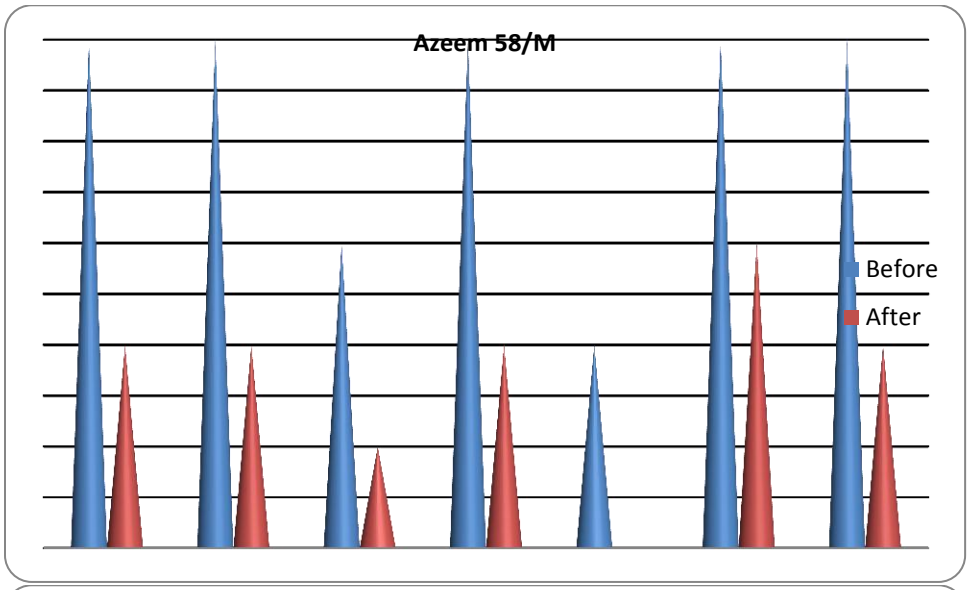

Jayan 58/M
Before
After

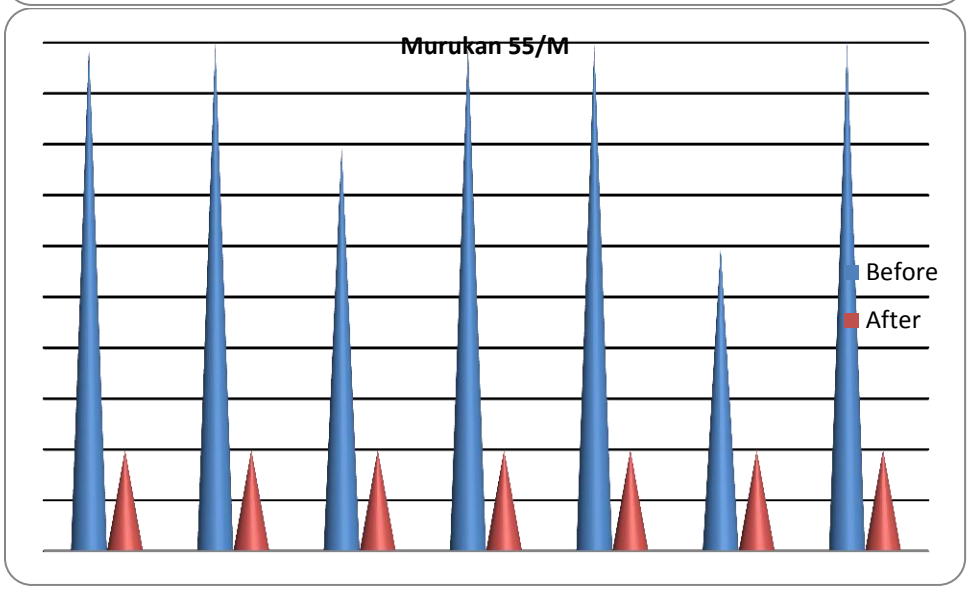

Sanal Kumar 51/M
Before
After

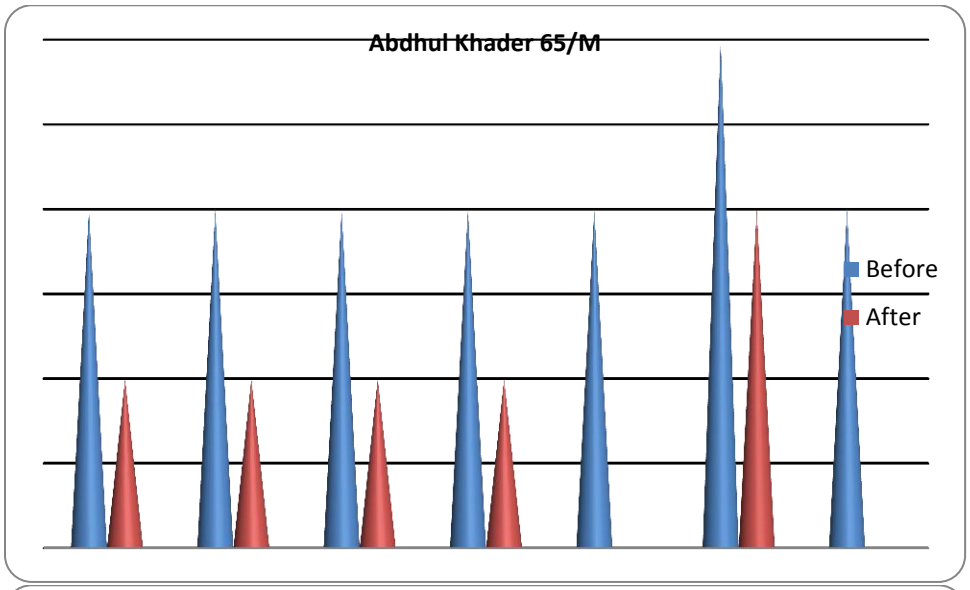

Raveendran P. 53/M
Before
After

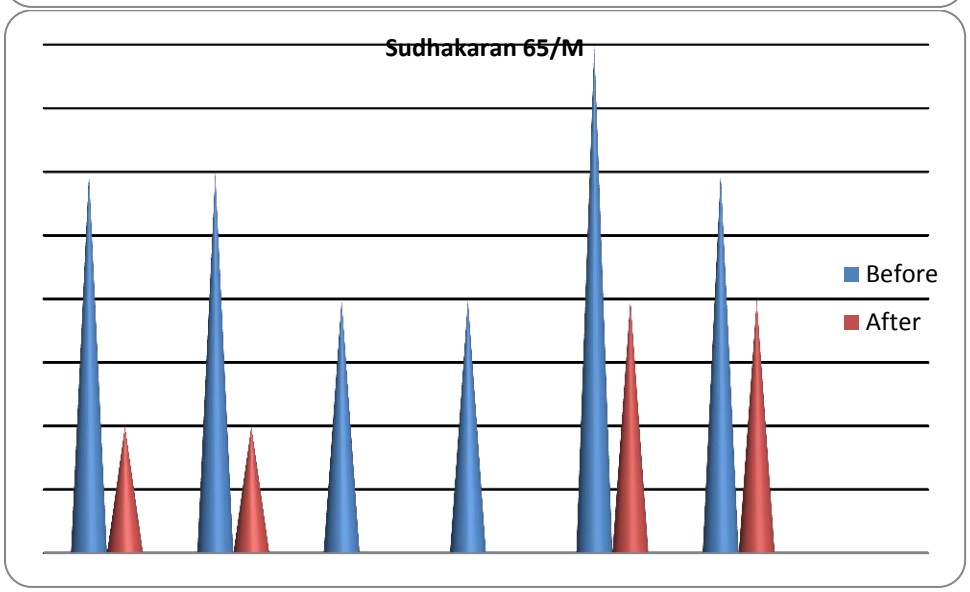

Hari 60/M
Before
After

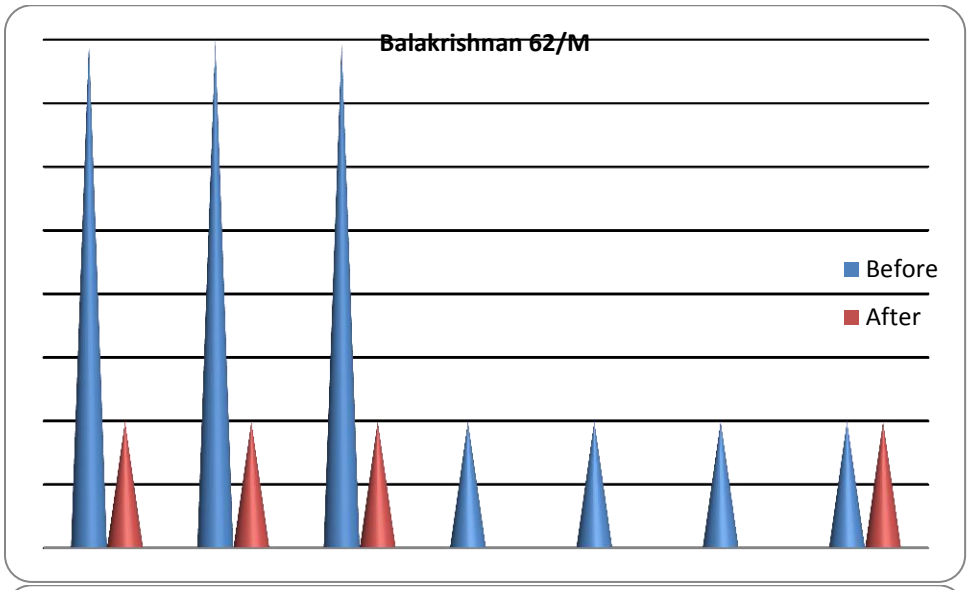

Sasidharan Nair 57/M
Before
After

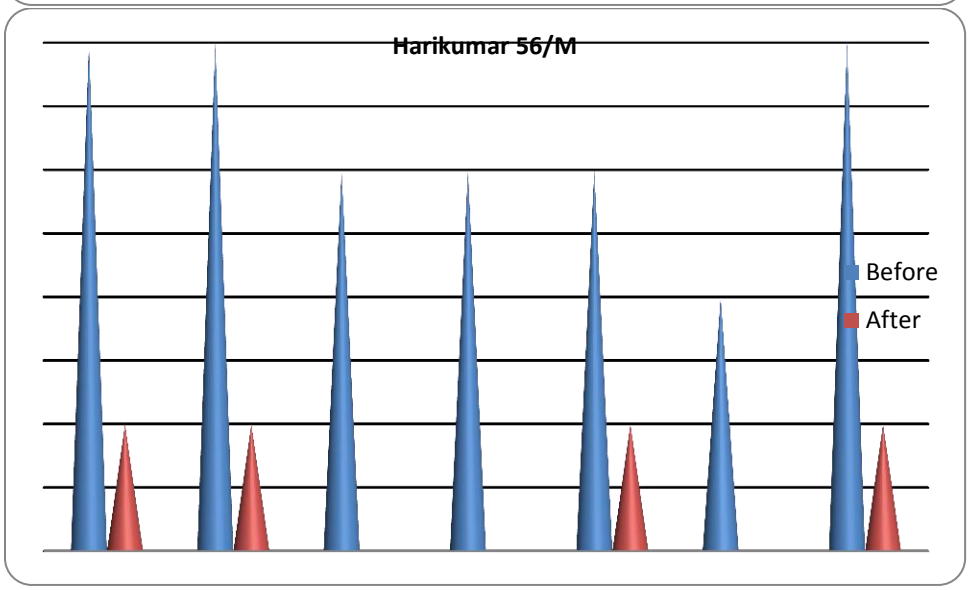

Azeem 58/M
Before
After

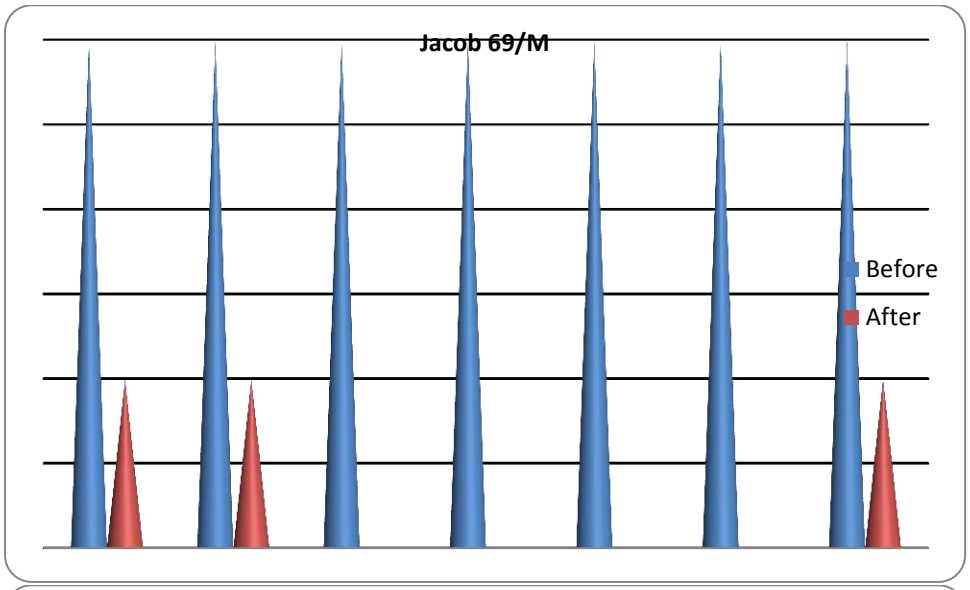

Murukan 55/M
Before
After

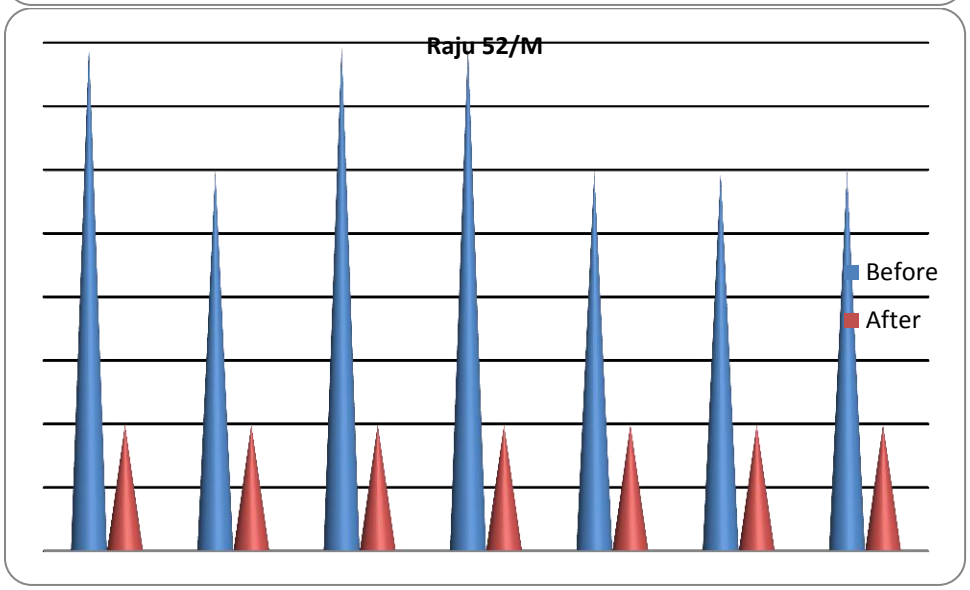

Abdhul Khader 65/M
Before
After

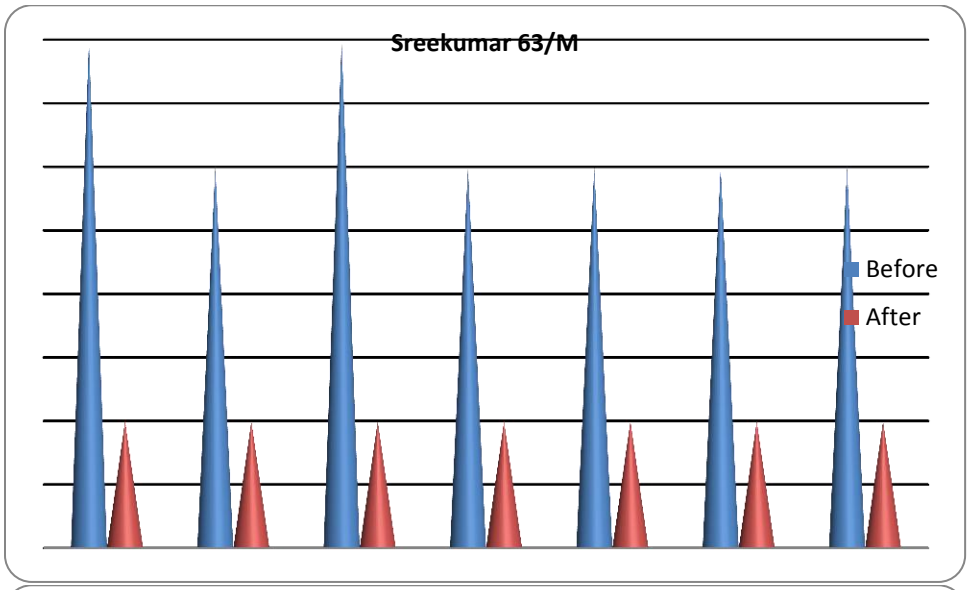

Sudhakaran 65/M
Before
After

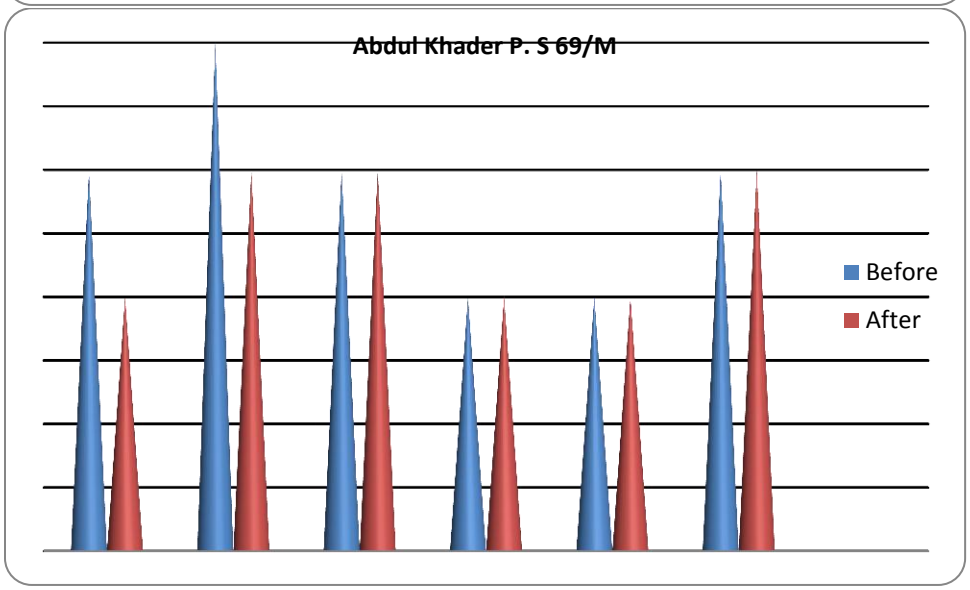

Balakrishnan 62/M
Before
After

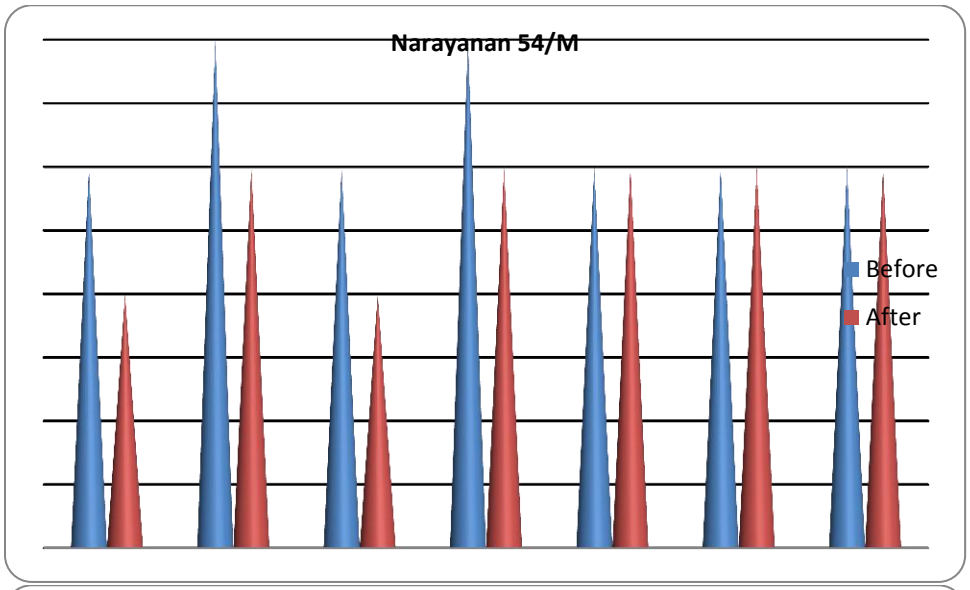

Harikumar 56/M
Before
After

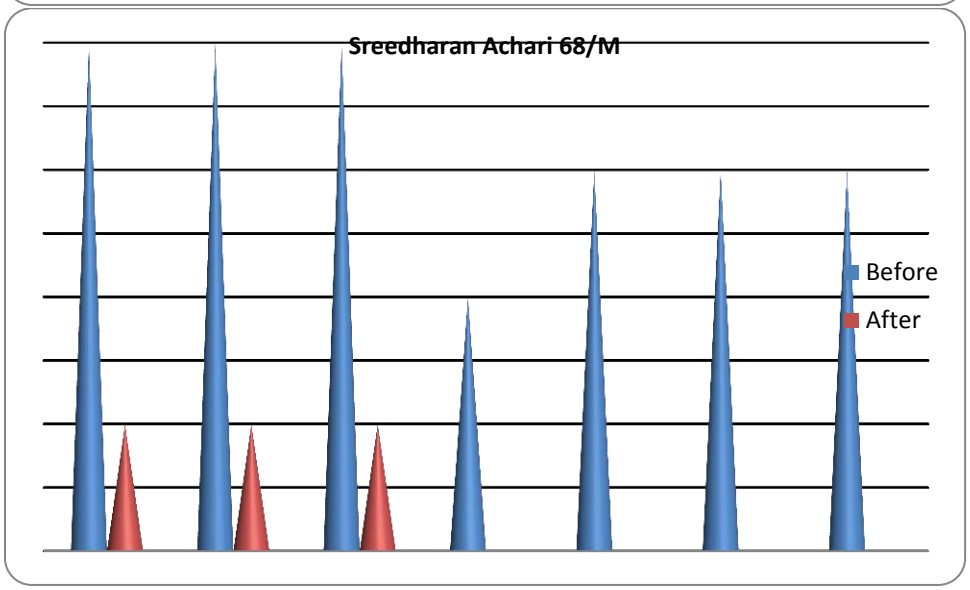

Jacob 69/M
Before
After

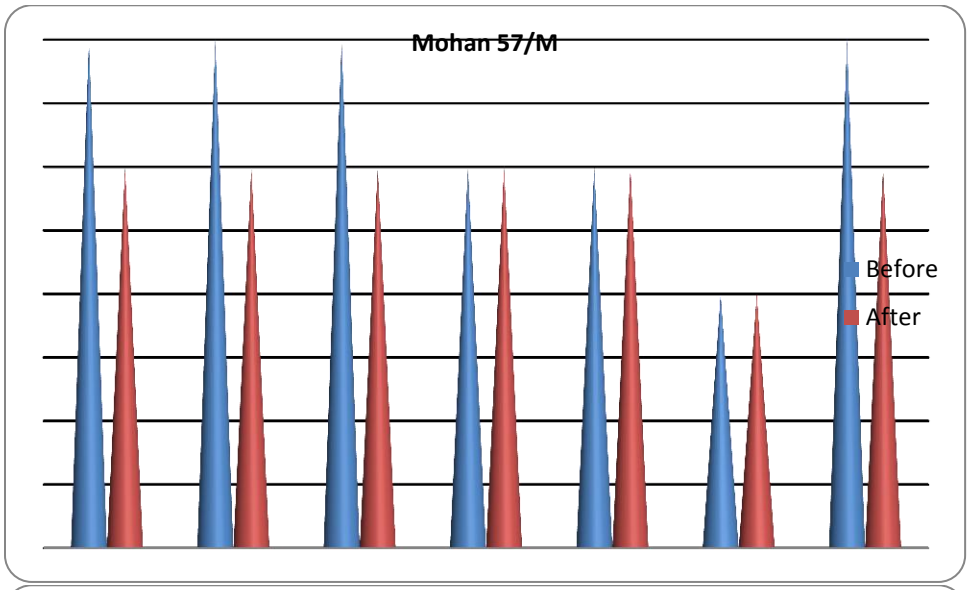

Raju 52/M
Before
After

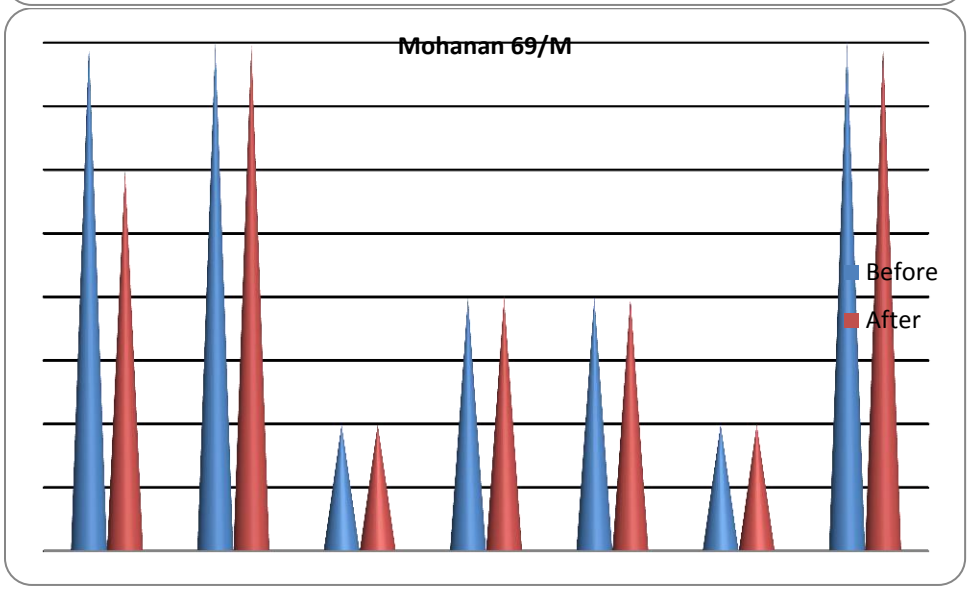

Sreekumar 63/M
Before
After

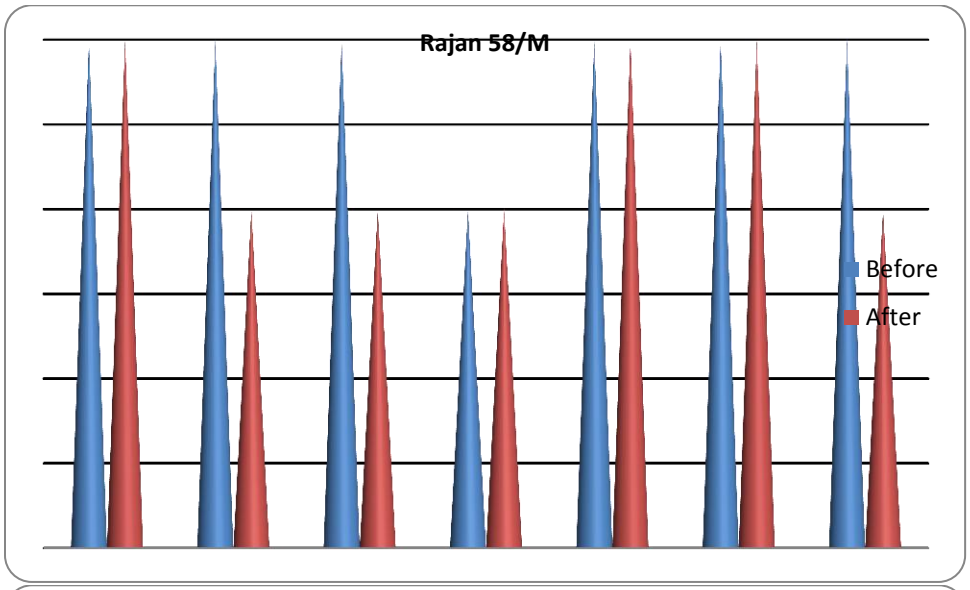

Abdul Khader P. S 69/M
Before
After

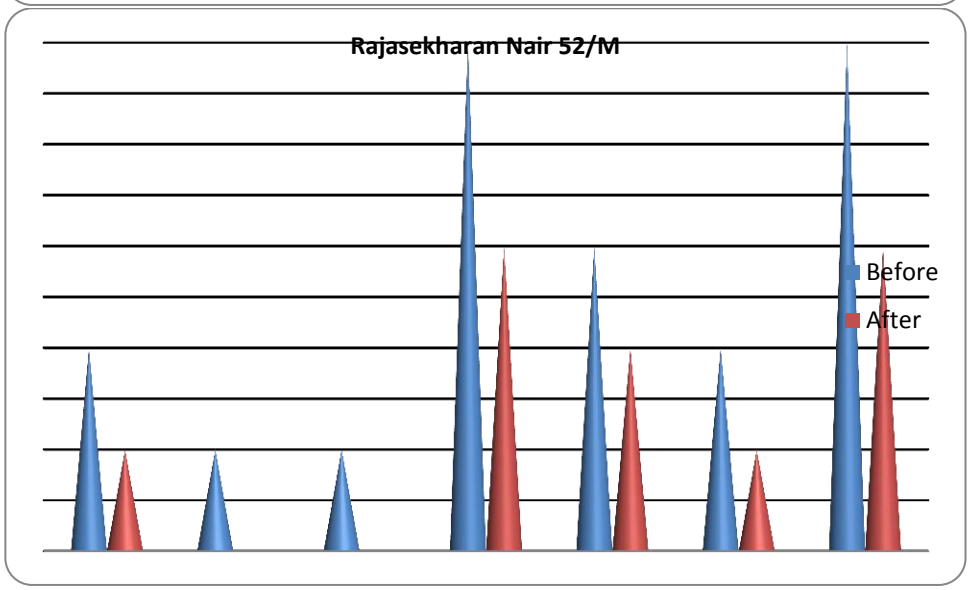

Narayanan 54/M
Before
After


Sreedharan Achari 68/M
Before
After


Mohan 57/M
Before
After


Mohanan 69/M
Before
After




**Order of effective medicine**

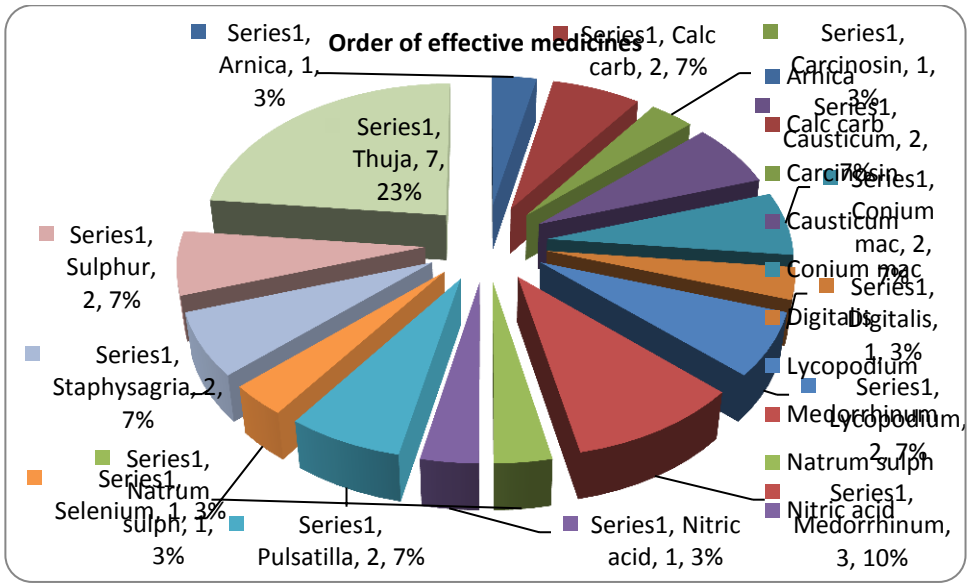
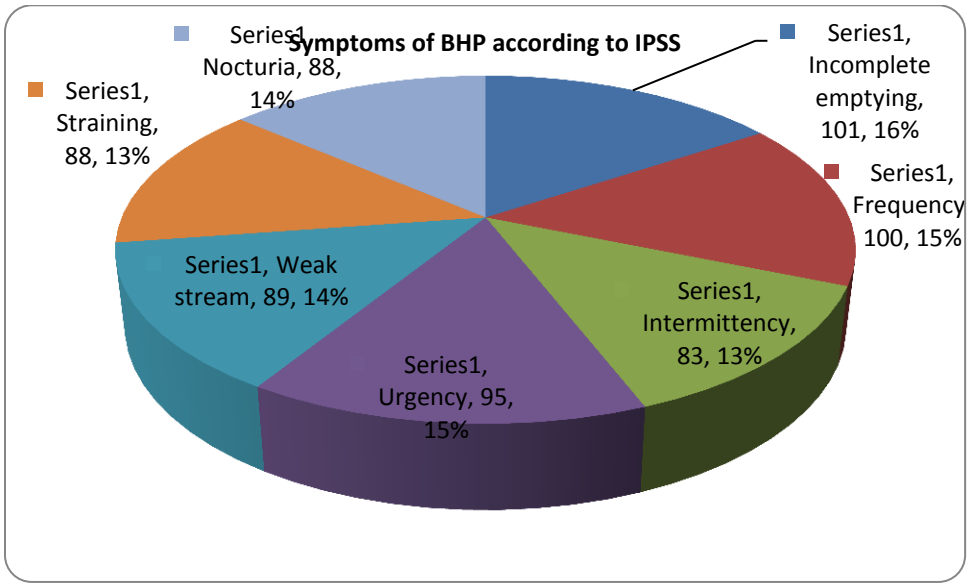



***Diagram 38***

| | |
|---|---|
| Arnica | 1 |
| Calc carb | 2 |
| Carcinosin | 1 |
| Causticum | 2 |
| Conium mac | 2 |
| Digitalis | 1 |
| Lycopodium | 2 |
| Medorrhinum | 3 |
| Natrum sulph | 1 |
| Nitric acid | 1 |
| Pulsatilla | 2 |
| Selenium | 1 |
| Staphysagria | 2 |
| Sulphur | 2 |
| Thuja | 7 |

Among 30 cases medicine indicated most of times is Thuja- 23%. Then Medorrhinum 10%, followed by Calc carb, Causticum, Conium mac, Lycopodium, Pulsatilla, Staphysagria, Sulphur 7%.

**Symptoms of BHP According to IPSS**




DiagramNo. 39

| | |
|---|---|
| Incomplete emptying | 101 |
| Frequency | 100 |
| Intermittency | 83 |
| Urgency | 95 |
| Weak stream | 89 |
| Straining | 88 |
| Nocturia | 88 |

From the analysis of the IPSS sheet of 30 cases the above pattern of symptom predominance was noted.

**STATISTICAL ANALYSIS**

Statistical analysis of change in size of prostate in Ultrasonogram.

To analyze the difference between pre-treatment and post-treatment observations paired't' test is used.

Let $X_1$ be the value before treatment and $X_2$ after the treatment

Let the hypothesis be $H_0$: no difference before and after treatment

H: $X_2 < X_1$

| Sl. No. | $X_1$ | $X_2$ | d $(X_1-X_2)$ | $d^2$ |
|---|---|---|---|---|
| 1 | 98.9 | 23.33 | 75.57 | 5710.82 |
| 2 | 151.2 | 116.75 | 34.45 | 1186.80 |
| 3 | 55.69 | 24.19 | 31.5 | 992.25 |
| 4 | 44.1 | 23.35 | 20.75 | 430.56 |
| 5 | 50.06 | 43.68 | 6.38 | 40.70 |

| | | | | |
|---|---|---|---|---|
| 6 | 105.94 | 60.762 | 45.18 | 2041.23 |
| 7 | 57.02 | 40.32 | 16.7 | 278.89 |
| 8 | 43.78 | 23.52 | 20.26 | 410.46 |
| 9 | 47.97 | 26.88 | 21.09 | 444.78 |
| 10 | 75.01 | 44.27 | 30.74 | 944.94 |
| 11 | 48.60 | 23.49 | 25.13 | 631.51 |
| 12 | 52.29 | 26.88 | 25.41 | 645.66 |
| 13 | 60.12 | 32.64 | 27.48 | 755.15 |
| 14 | 51.17 | 24.19 | 26.98 | 727.92 |
| 15 | 80.64 | 42.92 | 37.72 | 1422.79 |
| 16 | 94.96 | 33.06 | 61.9 | 3831.61 |
| 17 | 40.94 | 31 | 9.94 | 98.80 |
| 18 | 51.80 | 30.46 | 21.34 | 455.39 |
| 19 | 50.40 | 26.88 | 23.52 | 533.19 |
| 20 | 63.84 | 23.33 | 40.51 | 1641.06 |
| 21 | 62.24 | 22.31 | 39.93 | 1594.40 |
| 22 | 76.61 | 32.36 | 44.25 | 1958.06 |
| 23 | 74.59 | 31.62 | 42.97 | 1846.42 |
| 24 | 53.20 | 56.30 | - 3.1 | 9.61 |
| 25 | 39.93 | 45.50 | - 5.57 | 31.02 |
| 26 | 62.10 | 19.50 | 42.6 | 1814.76 |
| 27 | 65.43 | 59.94 | 5.53 | 30.58 |
| 28 | 54.41 | 54.65 | - 0.24 | .0576 |
| 29 | 46.62 | 49.21 | - 2.58 | 6.65 |
| 30 | 46.63 | 46.63 | 0 | 0 |
| **Σ d= 766.34** | | **Σ $d^2$ = 30516.07** | | |

Σ d= 766.34
Σ $d^2$ = 30516.07

$$\bar{d} = \frac{\sum d}{n} = \frac{766.34}{30} = 25.54$$

$$SD_{(d)} = \sqrt{\frac{åd^2 - (åd)^2}{n}}{(n-1)}$$

By substituting the values, S D = 19.4228

$$\text{Paired } t = \frac{|\bar{d}|}{SD_{(d)}/\sqrt{n}} = \frac{|\bar{d}|x\sqrt{n}}{SD_{(d)}}$$

$t_{29}$ = 7.19

From the table paired t value is $t_{29}$ 1.699 at 5% significance and $t_{29}$ 2.462 at 1% level of significance.

So here $t > t_{\alpha}$

The calculated value of t is greater than table value. So we reject the null hypothesis and accept the alternate hypothesis. That is the mode of treatment is effective in reducing size of prostate .

STATISTICAL ANALYSIS

Statistical analysis of change in IPS Score.

To analyze the difference between pre-treatment and post-treatment observations paired't' test is used.

Let $X_1$ be the value before treatment and $X_2$ after the treatment

Let the hypothesis be $H_0$: no difference before and after treatment

H: $X_2 < X_1$

| Sl. No. | $X_1$ | $X_2$ | d $(X_1 - X_2)$ | $d^2$ |
|---|---|---|---|---|
| 1 | 32 | 7 | 25 | 625 |
| 2 | 33 | 23 | 10 | 100 |
| 3 | 18 | 7 | 11 | 121 |
| 4 | 16 | 5 | 11 | 121 |
| 5 | 19 | 10 | 9 | 81 |
| 6 | 30 | 12 | 18 | 324 |
| 7 | 20 | 14 | 6 | 36 |
| 8 | 15 | 5 | 10 | 100 |
| 9 | 17 | 4 | 13 | 169 |
| 10 | 30 | 15 | 15 | 225 |
| 11 | 14 | 3 | 11 | 121 |
| 12 | 16 | 5 | 11 | 121 |
| 13 | 22 | 7 | 15 | 225 |
| 14 | 18 | 4 | 14 | 196 |
| 15 | 30 | 12 | 18 | 324 |
| 16 | 32 | 7 | 25 | 625 |
| 17 | 15 | 6 | 9 | 81 |
| 18 | 17 | 6 | 11 | 121 |
| 19 | 16 | 4 | 12 | 144 |
| 20 | 23 | 4 | 19 | 361 |
| 21 | 21 | 3 | 18 | 324 |
| 22 | 24 | 7 | 17 | 289 |
| 23 | 23 | 7 | 16 | 256 |
| 24 | 17 | 15 | 2 | 4 |
| 25 | 19 | 23 | - 4 | 16 |
| 26 | 23 | 3 | 20 | 400 |
| 27 | 24 | 20 | 4 | 16 |
| 28 | 18 | 17 | 1 | 1 |
| 29 | 17 | 20 | - 3 | 9 |
| 30 | 19 | 10 | 9 | 81 |
| **Σ d= 360** | | **Σ $d^2$ = 5617** | | |

Σ d= **360**

Σ $d^2$ = **5617**

$$\bar{d} = \frac{\Sigma d}{n} = \frac{360}{30} = 13$$

$SD_{(d)} = \sqrt{\frac{åd^2 - (åd)^2}{n}}$

$(n - 1)$

By substituting the values, S D = 6.5752

Paired t = $\frac{|\bar{d}|}{SD_{(d)} / \sqrt{n}} = \frac{|\bar{d}| x \sqrt{n}}{SD_{(d)}}$

$t_{29} = 10.83$

From the table paired t value is $t_{29}$ 1.699 at 5% significance and $t_{29}$ 2.462 at 1% level of significance.

So here $t > t_{\alpha}$

The calculated value of t is greater than table value. So we reject the null hypothesis and accept the alternate hypothesis. That is the mode of treatment is effective in reducing IPS Score .

**DISCUSSION**

To arrive at a valid conclusion, I am indebted to discuss some of the findings that have evolved out of this study. The result is exclusively based on the observation and result presented in former section.

1. Age incidence: The incidence was maximum in the age group 50 -55. The next greater prevalence was in age group 56 - 60.

2.Domicile: Rural population amount to 26.67% and urban population 73.33%. It may be due to the particular diet habits and sedentary life style of urban people which are contributors to the progress of sycotic miasm.

3.Distribution of patients according to socio economic class:-In this study conducted, benign prostatic hypertrophy is found more among middle class (66.7%)

4.Distribution of patients according to associate complaints:-In this study conducted benign prostatic hypertrophy is found to be associated with infiltration and deposition of various organs and tissues which confirms the sycotic predominance in BHP patients. In USG renal calculi, renal cortical cyst and fatty liver and in analysis of case records warts, hydrogenoid constitutions etc which are all pathologies having base on sycotic miasm are found associated with BHP.

5.Economic aspect: Only 13% of the total patients were in the poor economic class. Majority belonged to middle and higher class, showing the more prevalence of disease among the middle and higher class due to their life style.

6.Distribution of clinical features: Among the symptoms given in the IPSS sheet, the predominance of the symptoms were noted as follows, Incomplete emptying of bladder (16%), increased frequency of micturation (16%), urgency (15%), weak stream (14%), straining (13%), nocturia (13%) intermittency (13%).

7.Distribution of miasm: All patients showed predominance of sycotic miasm. From the analysis of the general and particular symptoms (total 430 symptoms) of the 30 cases, it has been noted that sycosis shows maximum predominance, 57.67 % of symptoms. Psora shows a predominance of 22.56%, syhilis 11.63% and pseudopsora 8.14 % of symptoms

8.Evaluation of change in disease criteria: The comparison of the USG measurement of prostate and the IPS Score before and after treatment showed statistically significant result.

9.Medicines used: Among 30 cases medicine indicated most of times is Thuja- 23%. Then Medorrhinum 10%, followed by Calc carb, Causticum, Conium mac, Lyco, Pulsatilla, Staphysagria, Sulphur 7%. This shows the effectiveness of antisycotic constitutional drugs in the treatment of Benign prostatic hypertrophy.

**CONCLUSION**

From the evaluation of results obtained after the statistical analysis of the benign prostatic hypertrophy cases, it is obvious that sycotic miasm shows a pre-dominance of 57.67%.
Anti-sycotic medicines like Thuja, Medorrhinum, Staphysagria, Causticum, Conium mac were found to be effective. Also trimiasmatic medicines like Calcarea carb, Lycopodium also found to be effective.
By anti-miasmatic constitutional treatment it is found that the enlargement of prostate can be retarded or prevented. Miasmatic symptoms should be given prime importance in the selection of remedy.
The other observed facts in this study are the maximum representation was from the age group 50 -55. The next greater prevalence was in age group 56 – 60
Complaints such as renal calculi, fatty infiltration of liver, renal cortical cyst, and gallstone were found to be associated with benign prostatic hypertrophy.
It is found that the comparison of the USG measurement of prostate and the IPS Score before and after treatment showed statistically significant result. It can also be claimed that Homoeopathy is safe, simple, less expensive and more effective in treating benign prostatic hypertrophy cases. Unnecessary surgery can be avoided.
Homoeopathy as a system of medical treatment has a philosophy of its own and its therapeutics is based on certain fundamental principles. Out of these fundamental principles theory of chronic disease play a vital role in treating chronic cases.

To conclude in Hahnemann's words *"He, who has had as many opportunities as I to make observations,… he, who is induced by his desire for the welfare of his fellow beings to think and act for himself, he, who like myself feels hatred for the prejudices and preferences for old or new, or, generally speaking, for any kind of recognition or great name, and he, who eagerly endeavours, as I myself have done, to act and to think independently…. he will see excellent results for his industry which is the greatest reward that an honest physician can expect".*

Limited reliability can only be guaranteed with such a study involving a chronic disease with 30 cases, for 2 year period. A long term follow-up study will be more reliable. Increasing the sample size can be considered in further studies, to furnish more statistical evidence. Comparative studies involving other systems of medicines can also be accomplished with better results.

**BIBLIOGRAPHY**

1.William Boericke- Materia medica and Repertory. New Delhi, B.Jain Publishers Pvt Ltd.sss
2.Subrata Kumar Banarjee-Miasmatic Diagnosis-Practical tips with clinical comparisons. New Delhi, B.Jain Publishers Pvt Ltd.

3. Shasi Kant Tiwari-Essentials of Repertorization , 3rd Revised and Enlarged Edition, New Delhi, B.Jain Publishers Pvt Ltd.

4. Robin Murphy-Homoeopathic medical Repertory, New Delhi, B.Jain Publishers Pvt Ltd.

5. Richard Hugers-The principles and Practice of Homoeopathy, New Delhi, B.Jain Publishers Pvt Ltd.

6. Processo.S. Ortega-Notes on the miasms, New Delhi, B.Jain Publishers Pvt Ltd.

7.Mahajan.B.K-Methods in Biostatistics, New Delhi, Jay Pee Brothers

8.James Tyler Kent-Repertory of Homoeopathic Materia medica-6th American Edition, New Delhi, B.Jain Publishers Pvt Ltd.

9. George Vithoulkas-The Science of Homoeopathy. New Delhi, B.Jain Publishers Pvt Ltd.15th edition.

10.Caroll Dunham-The science of Therapeutics, New Delhi, B.Jain Publishers Pvt Ltd.

11.Boger C. M- Boenning hausen's characteristics and Repertory. New Delhi, B.Jain Publishers Pvt Ltd.

12 Boenninghausen- Therapeutic Pocket Book New Delhi, B.Jain Publishers Pvt Ltd.

13. Boericke W.M 1999- A compend of the Principles of Homoeopathy, Reprint Edition, New Delhi, B.Jain Publishers Pvt Ltd.

14. Ashok Kumar Das-A treatise on Organon of medicine-part III New Delhi, B.Jain Publishers Pvt Ltd.

15. S. P Dey-Essential of Principles and Practice of Homoeopathy

16.Dr. Hari Mohan Choudary-Indications of miasm

17.Spirit of Organon

18..Richard Haehl, M.D-Samuel Hahnemann his life and work, New Delhi, B.Jain Publishers Pvt Ltd.

19..Herbert A. Roberts, M. D-The Principles and Art Of cure by Homoeopathy, New Delhi, B.Jain Publishers Pvt Ltd.

20.Stuart Close, M. D-The Genius of Homoeopathy Lectures and essay on Homoeopathic Philosophy, New Delhi, B.Jain Publishers Pvt Ltd.

21.P.N.Banerjee-Chronic Diseases-Its cause and Cure

22. Dr. Samuel Hahnemann-Chronic Diseases, Their peculiar nature and their Homoeopathic Cure.New Delhi, B.Jain Publishers Pvt Ltd.

23.Organon of medicine-Samuel Hahnemann- R.E.Dudgeon , M. D-William Boericke, M.D- James Krauss, M.D New Delhi, B.Jain Publishers Pvt Ltd.

24. Organon of medicine-Samuel Hahnemann-B, K.Sarkar,M. B (CAL) D. M. S (Hom) New Delhi, B.Jain Publishers Pvt Ltd.

25. V. Padubidri MD, FRCOG (Lond) & Shirish N. Daftary- Howkins and Bourne Shaw's Textbook of Gynaecology. New Delhi, B.I Churchill Livingston Pvt Ltd.

26.Rima Handley –In Search of the Later Hahnemann.

27.James Tyler Kent-Lectures on Homoeopathic Philosophy. New Delhi, B.Jain Publishers Pvt Ltd.

28. The Chronic Miasms Psora and Psuedo Psora- Volume I & II J. Hendry Allen, M.D New Delhi, B.Jain Publishers Pvt Ltd.

29.R.E Dudgeon-Lecture s on the Theory and practice of Homoeopathy,(Delivered at the Hahnemann Hospital school of Homoeopathy),New Delhi, B.Jain Publishers Pvt Ltd.

30. Samuel Hahnemann-R. E Dudgeon. M.D- The Lesser writings.

31. Samuel Hahnemann-Dr. Mahendra singh & Dr. Subhash Singh. –Organon of Medicine-Homoeopathic Publications.

32.Journals and manuals published by different institutions

33.Short practice of surgery, Bailey & Love's, Arnold, London.

34. www.fleshandbones.com

35. www.emedicine.com

36. www.similima.com

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