8

SYMPTOMS

The individuality of symptoms

The idiosyncratic use of the term 'symptom' in homeopathy to include physical signs and even pathological states has been mentioned already. To most clinicians symptoms are patients' subjective experiences of their illnesses. In some disciplines the term is usually restricted to those experiences that are recognised characteristics of a specific disorder leading to a diagnosis (pathognomonic). In homeopathy, by contrast, symptoms are not only used to establish a conventional clinical diagnosis, but also the 'diagnosis', or correct choice of medicine. Symptoms are taken seriously in homeopathy *whether or not* they are recognised features of a previously known condition or of the known materia medica of any homeopathic medicines.

In fact the greatest contrast between the conventional and homeopathic use of symptoms is that in homeopathy the most valuable symptoms are those that are *not* typical of underlying pathology. In conventional medicine the reverse is true. The most useful clinical findings (symptoms, signs, test results) are those that are characteristic of the disorder (pathognomonic), and hence most commonplace among patients who present with that disorder. In homeopathy the pathognomonic symptoms and signs are the least useful in determining the prescription. The first rule of symptomatology in homeopathy is that the value of symptoms, meaning all clinical findings, is directly proportional to their individuality. This is one of the essential principles described in Chapter 4. It cannot be emphasised too strongly. The most important symptoms are those that are characteristic of the patient and of the behaviour of the illness in that patient. These will most clearly define the similarity between the clinical picture in the patient and the characteristics of the medicine. The effective medicine will be the one in which this similarity is most complete.

The analogy between the process of the conventional differential diagnosis of the illness and the homeopathic differential diagnosis of the

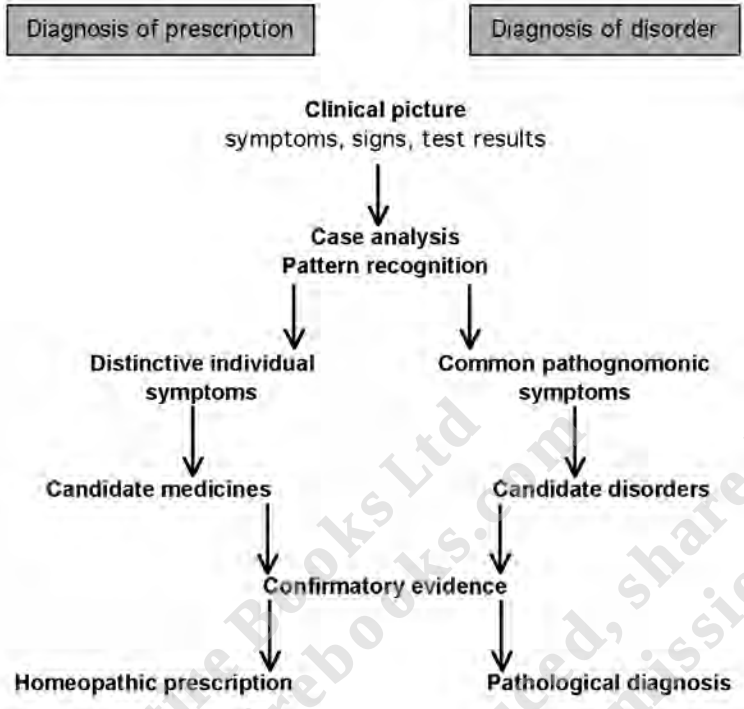

Figure 8.1 *'Differential diagnosis' in homeopathy uses the most distinctively individual symptoms rather than those most commonly associated with the disorder*

prescription breaks down at this point. The first depends on identifying the common manifestations of the illness in the patient, the second on identifying those that are not common to most patients but most individual to this particular patient (Figure 8.1).

For this reason the pathological findings and in some instances the physical signs are likely to be least useful in individualising the prescription. The pathology of any disease or syndrome varies little from patient to patient. It may differ in location or extent, involve different organisms, show different levels of abnormality in the blood and so on. These will certainly be of relevance to the homeopathic prescription and may have to be a feature of the prescription. But because they will be found in the materia medica of many homeopathic medicines that include that pathology they will not by themselves identify the one prescription that the patient needs. Physical signs may vary more than pathological findings between patients with the same illness. The location and character of abnormal breath sounds may differ to a certain extent in different patients with bronchitis. The sounds may be differently affected by deep breathing, coughing or posture. But these differences will not go far in discriminating

between the number of possible medicines, only one of which will meet the need of the individual patient.

The features of an illness that most clearly define its character in the individual are the subjective symptoms – their precise detail, the pattern that they form collectively (their picture or totality) and, most importantly, their behaviour.

Modalities

The ways in which symptoms are influenced by commonplace events or activities of everyday life comprise their most individual features. Factors that may influence their behaviour range from the time of day and the weather, through physical activities and body functions to emotional states and social circumstances. These modifying factors are known as 'modalities'.

Any one symptom may have a number of modalities. The more modalities a symptom possesses the more precisely it is defined, and the more precisely it is defined the more precisely it is likely to be matched to the drug picture of a particular medicine. In one reference book (repertory) there are 10 medicines listed for left-sided sore throat, 17 for sore throat that is worse in the morning (4 on waking), 8 that are aggravated by warm drinks and 19 that have pain extending to the ear on swallowing. 43 medicines share one or more of these characteristics, but only one, Lachesis, has a left-sided sore throat worse on waking in the morning that is aggravated by warm drinks and spreads to the ear on swallowing. It may seem extravagantly hard work to select the prescription in this case if an aspirin gargle would do, and indeed it might be so, but it is a familiar scenario and makes the point. And if the problem were recurrent then aspirin gargles would not be the answer.

Of course, modalities are a familiar part of conventional diagnosis – breathlessness when lying down, heartburn when stooping, morning stiffness and so on. The difference between the conventional and homeopathic approach is one of degree, not of kind. What is of surpassing interest is the significance of these individual differences. Why do two patients with the same sore throat, in the sense that they may share the same epidemic cause and onset, have different pain reactions to hot and cold drinks? What does it mean in terms of neuropeptide response, in terms of their constitutional disposition and susceptibility to other illness, in terms of the stimulus the body may need to reinforce its self-regulating response? That these differences do define the specific need, the particular dynamics of the healing process in the individual, is evident in the effects of the medicines specifically indicated by them. If, that is, we are to accept their efficacy. Even if

condition and their level of well-being. A third reason for distinguishing the three types of symptom is the principle that a combination of at least one of each in the clinical picture is necessary to define the simillimum – the best-matched prescription. This is a useful rule of thumb, but need not be followed slavishly. It is the minimalist approach to the concept of the totality of symptoms.

The totality of symptoms

It is the totality of symptoms that ensures the uniquely individual character of the clinical picture. It encompasses everything that is going on in the patient in the course of the current illness, whether it is part of the presenting complaint or a feature of some co-morbidity – pathological states, physical signs, subjective symptoms; local, general and mental features; and all modalities.

Multiple symptoms

The totality may consist only of the features of the presenting complaint. In an acute illness or injury this will probably be the case. In chronic illness it is rarely so, and where one disorder is compounded by another the possible permutations of individual symptomatology increase enormously. Many patients who seek homeopathy do have multiple symptomatology and more than one pathological diagnosis. And it is the possibility of modifying this situation, which accounts for such a large proportion of health-care demand, that is one of the great potential benefits of the wider use of homeopathy. This multiplicity can of course provide plenty of material from which to identify the relevant medicine. But when there are symptoms in profusion it becomes increasingly difficult to see the wood for the trees. Any general practitioner will be familiar with this problem. It can create as much despair for the homeopath if the key symptoms are not carefully identified. The selection of key symptoms as indications for the prescription is dealt with in the following sections.

Where there are multiple symptoms the totality is more than the sum of its parts. The symptom cluster for each separate complaint presented by the patient may consist of its own local, general and mental features and their modalities. Each of these clusters may suggest the same similimum, the one specific medicine. But it is possible that analysed separately each could suggest a different hierarchy of medicines, the hierarchy being the order of similarity of the possible medicines indicated by that particular

symptom cluster. Thus a patient with headache, irritable bowel and a skin eruption may present a cluster of symptoms for each, each of which matches a different group of possible medicines. Or the groups appropriate to each symptom cluster may include some of the same medicines but in different orders of similarity. The solution to this confusing or contradictory state of affairs is to identify the common features of each cluster of symptoms that represent a consistent view of the whole. These common features will usually be found to transcend the differences between the parts, the separate symptom clusters. They may also fit in with one of the wider perspectives of the patient that have been discussed. This might be the constitutional picture, based on the characteristics of the person rather than the illness alone (see Chapter 6), or the historical view, which describes the evolution of the illness and its contributory factors.

(See the Case study 8.2 and the Tables 8.1–8.4 in the section entitled 'Grading of symptoms' starting on page 151 as an example of this approach.)

Selecting and evaluating symptoms

Recording the symptoms

Because it is so obvious a fact it seems almost impertinent to point out that nothing in the case history will be of value unless it is carefully and accurately elicited in the first place. This is equally true and equally obvious whatever medical discipline we work in. Nevertheless we are probably more likely to mistake the correct diagnosis or prescription because we have not elicited, recognised or understood some key piece of information when taking the case history than for any other reason. This is not always our fault. It may indeed result from lack of attention but it may be that the patient has not divulged the information, by chance, through forgetfulness or even deliberately. This is why, however much we allow and encourage a spontaneous account of things from the patient, we must also be systematic. Unless the key information is clearly and readily available we must leave no stone unturned to find it.

There are two provisos to this statement. First, we have to remember the temptation to find the 'pattern with which we are familiar' or that particularly interests us at the time. We have all experienced the surprisingly high incidence of conditions or symptom pictures that we have just learned about in the days following the lecture or after reading the book. The second proviso is that we must maintain a high level of courtesy towards

introduced into homeopathy by an English physician James Compton Burnett in 1879.[2,3] Boericke's materia medica says of it: 'This (medicine) seems to possess a specific relation to the spleen – enormous enlargement of the spleen – Splenitis – Leukaemia'.[4] The author writes, "As far as the pathology goes, this (medicine) fits the bill perfectly". He later quotes Burnett as stating that 'organopathy' is correctly used only when a similimum that covers the totality and the pathology cannot be found.

Treatment was with Ceonothus 12C (centesimal dilution) daily until there was evidence of a proving (increase in Ceanothus features following continuous repetition of the dose), then Ceanothus 30C every 2 weeks. This produced a striking improvement in the clinical features of the lymphoma, which was maintained at the last reported follow-up a year later. Meanwhile, however, the clinical picture had changed. Six months after improvement in his lymphoma had been achieved he expressed a desire to see a psychiatrist because of his anxiety. He now revealed intense symptoms of Arg. nit., including a craving for sweets and salt and persistent conjunctivitis. He was given Arg. nit. and improved greatly within 2 weeks. A further 6 months later (last reported follow-up) he announced himself as feeling 95% better. The whole case study covers a 19-month period.

This case demonstrates the following features:

- The close-up and the wide-angle views of the patient – that is, the pathology and the totality.
- Their coexistence as two layers of the illness.
- The importance of the pathology in this case, and its dominance of the clinical picture.
- The choice of the pathological prescription at the expense of the totality because of the essential importance of the pathology and the absence of an appropriate totality.
- The emergence of the more fundamental psychological layer after the resolution of the pathology, and its subsequent response to the appropriate similimum.

One other point is worth mentioning. In the course of treatment a number of observations were made of the action of Ceanothus on the patient, some from its therapeutic effects, some from the provings (incidental effects not part of the presenting clinical picture). Some of these observations of

This led to the choice of a pathological prescription that captured it precisely rather than one based on the totality.

A problem here is the fact that the materia medica of some, perhaps many, medicines is not necessarily complete. Nevertheless, the use of eliminating symptoms is a valuable technique if applied with judgement and discretion.

Criteria of a 'good symptom'

The word that best sums up for me the characteristics of a symptom that we may use with confidence to select the correct homeopathic medicine is 'vivid'. The symptoms that most vividly express the patient's experience of the illness are most likely to lead to the right prescription. The characteristics that make a symptom most vivid are *spontaneity*, *clarity*, *intensity* and *individuality*.

The value of information volunteered spontaneously by the patient has been mentioned already. There can also be a quality of spontaneity about the way a patient responds to a prompt or an enquiry. This can sometimes lead to such a lively response that it has much of the quality of a wholly spontaneous remark. Where a symptom is presented with this kind of energy I am inclined to regard as spontaneous even if it is not wholly volunteered. The quality of clarity is self-explanatory. Many symptoms are described quite vaguely, and cannot be better defined, even with help (paraphrase, etc.). A symptom that is clearly presented is likely to have had considerable impact on the patient: to have been experienced vividly and so vividly expressed. The strength or intensity of the symptom may include its severity or magnitude (the enormous spleen), or some similar aspect of its impact upon the patient (disgust, terror, etc.). This is likely to be reflected in the emphasis or intensity with which it is described.

The importance of the individuality of the symptoms has been continually stressed. Instead of being dismayed, as one may be in conventional medicine, by the description of a symptom that we have never before heard of, and that fits absolutely no pattern with which we are familiar, the homeopath should be delighted. It is likely to be vividly expressive of the individual illness and a key indication for the prescription. Despite its unfamiliarity it is surprisingly likely to be recorded in the literature of some homeopathic medicine. And now that computers give us the ability to search the whole literature for particular groups of words in seconds, there is a real possibility of finding it. If there really is no previous record of a symptom in the literature, or very few records of it, then this imposes a responsibility on us to note its apparent association with the medicine that

effectively remedies it (if that is achieved) as a possible addition to its materia medica.

Strange, rare and peculiar symptoms

The symptoms traditionally accorded the highest esteem for their individuality are described as 'strange, rare and peculiar'. A strange symptom would be the sensation that a ball bearing is rolling around inside the eyeball. It would also be rare. It would be peculiar if the eyeball had been removed surgically. A rare symptom would be an aversion to chocolate before menstruation. It is not strange, because such changes in tastes for food are commonplace, nor is such a change peculiar in association with hormone changes. But it is extremely rare because if a woman experiences a change of taste for chocolate in midcycle or before her period it is virtually always a craving. The latter is so common a feature of the premenstrual syndrome (PMS) that it is no use as an individualising symptom. After many years of special interest in PMS I can recall only one patient who actually went off chocolate. Unfortunately no homeopathic medicine is yet associated with this change, as far as I know.

Peculiar symptoms are not necessarily strange in nature but are an anomaly in the context of the patient's other attributes or symptoms. For a patient who is placid in all respects, but quickly enraged in one particular circumstance, that reaction and its modality, the factor responsible, would be valuably peculiar. Such symptoms are often paradoxical; breathlessness relieved by motion is an example. The medicine Ferrum, derived from metallic iron, is uniquely associated with breathlessness *relieved* by motion and talking.

This section is a personal interpretation of these concepts, which are not explicitly defined with clear authority in any source I know of. Hahnemann refers to them quite generally in paragraph 153 of his original treatise, the *Organon*:

> In this search for a homeopathic specific remedy . . . the more striking, singular, uncommon and peculiar (characteristic) signs and symptoms . . . are chiefly and most solely to be kept in view; for it is more particularly these that very similar ones in the list of symptoms of the selected medicine must correspond to, in order to constitute it the most suitable for effecting the cure.[5]

These facets of 'strange, rare and peculiar' are teased out in this way to demonstrate the specially individualising properties of such symptoms. In effect, though, the concept can be taken as a collective phrase for any features that are most vividly and idiosyncratically distinctive of patients' unique experience of their illnesses.

Such characteristics do not need to be presented by the patients themselves. My first encounter with such a symptom was during a series of consultations with a 13-year-old boy with psoriasis in general practice. Building up a clinical picture cumulatively from one consultation to the next, and so far unavailingly, I got round to asking whether he was tidy. "My God", said his mother, "He's so tidy he drives me mad!" Her outcry had all the quality of spontaneity, and absolute clarity. It also revealed a 'symptom' of great intensity, and in a 13-year-old boy markedly strange, rare and peculiar. The prescription of Arsenicum suddenly became obvious; and it proved effective.

Complete symptoms

A symptom will be most vivid and therefore most useful if all its potential characteristics are fully described. A symptom may have the following four facets: *general nature of the symptom* (pain; eruption), *detailed character* (pain – throbbing; eruption – moist, crusty, itching), *location* (pain – left temple, radiating to left eye; eruption – behind the ears), and *behaviour or modalities* (pain – worse on lying down, worse on coughing, better with pressure; eruption – worse when anxious, better by the seaside). A complete symptom is one that has all its available characteristics described. Some symptoms will not have all four facets. Difficulty in breathing, for instance, will not have a site. On the other hand some symptoms have facets that would not always be thought about. Anxiety, for example, can be felt in various locations. Some facets will involve several descriptors [an eruption may have three descriptive details, and pain in the temple, three modalities]. Separate descriptors of detail might have separate modalities; the itching of the eruption might be worse at night in bed.

The more complete the symptom and the fuller the description of each facet, the more precise the identity of the similar medicine is likely to be.

Concomitant symptoms

These are symptoms that occur at the same time as the primary symptoms; they are simultaneous or directly associated in time – immediately, or at a precise interval before or after. By contrast, incidental symptoms may occur concurrently or intercurrently and are part of the patient's current clinical picture, but they do not have a direct association with the primary symptom. Itching eyes, puffy lids and sneezing might be concomitant symptoms in hay fever because they are directly associated with one another and occur simultaneously. They would not be especially useful in

BOX 8.2 *Concomitant symptoms associated with headache**

Makes mistakes writing	Nux moschata
Weakness of memory	Belladonna
Trembling	Argentum nitricum
Unable to open eyes	*Tarentula*
Acute sense of smell	**Phosphorus**
Coldness of the face	*Carbo vegetabilis* Arsenicum Ipecacuanha
Burning pain in stomach	Sanguinaria
Scanty urine during, copious after	Sanguinaria Glycyrrhiza
Sexual desire increased	Sepia
Palpitations	*Spigelia* Argentum nitricum
Coldness of foot (postmenstrual headache)	*Ferrum*
Weakness of hand and/or foot	Oleum animale

** Symptoms specific to single or very few medicines.*

identifying the prescription, however, because they are very commonplace concomitants. A patient might present with a complaint of headache and report in passing that they often feel hungry, or that they sometimes pass a profuse amount of urine. These symptoms are incidental to the main complaint of headache. But if the patient always feels hungry (a general symptom) during a headache, or passes copious urine as or just after their headache resolves, these are concomitant symptoms. Concomitant symptoms that are not commonly associated with the primary symptom are of particular value in identifying the correct medicine (see Box 8.2). We might add concomitants as another possible facet of a complete symptom.

Two instances of the problem of 'repertory language' arise from these examples. Some repertories (books of cross-reference between symptoms and medicines) express hunger only as 'appetite increased'. More recent editions attach hunger as a synonym, but increased appetite is not necessarily associated with hunger. Profuse urination is shown as ameliorating the headache. What most patients actually describe is profuse urination accompanying or following the relief of the headache. A causal association between the two may be speculative. Patients have not told me that their headache goes if they can manage to pass a lot of water. On the other hand, patients do say that if they don't drink enough they get headaches.

These are semantic problems for the homeopathic literature, but they are also fascinating examples of the opportunities for natural history and the possible physiological insights that homeopathy offers.

Summary

The most valuable symptoms for the differential diagnosis of the homeopathic medicine are those that are most complete in their description and that most vividly express the individual character of the illness. These symptoms combine to form a totality of symptoms, which may comprise a number of separate complaints. The complete clinical picture that they represent is usually the best basis for selecting the prescription. A more circumscribed view of the case, even a single pathological feature, may, however, sometimes be used. This is justified by the overwhelming significance of the particular feature, especially if the totality does not adequately encompass it.

Grading of symptoms

The purpose of grading symptoms is to assist in the selection of those that will provide the key indications for the chosen medicine. The selection of symptoms will be successful only if they are elicited and recorded thoroughly, carefully and perceptively in the first place. Similarly, their grading will have meaning and value only if their significance has been properly assessed. The value of this assessment will in turn be lost if it is not recorded in the notes and readily available when the case comes to be analysed.

Grading of symptoms is a common feature of the repertories. The grades are represented by the type in which the names of the medicines are printed. Nowadays four grades are often used: bold capitals for the highest, bold lower case for the next, italic for the next and plain type for the lowest grade. This formalism denotes the range from a highest grade medicine, in which the symptom or characteristic is vividly and indisputably represented, down to those in which it has been observed but with no great intensity or high degree of corroboration. The repertory grades are supposed to represent the frequency with which the symptom has been caused by the medicine in provings (experimental pathogenesis) and cured by it in clinical practice. The strictness and consistency with which these criteria are applied is open to question. The so-called 'small remedies', those that have few known symptoms in their materia medica, and the 'plain

symptoms most vividly and faithfully expresses the disturbed equilibrium of the patient.

Several of the points discussed in this and adjacent chapters are illustrated in the case study (see Case 8.2).

CASE 8.2 Reflux oesophagitis

Mr H. A. (aged 64) was referred for treatment of reflux oesophagitis of 5 years' duration, preceded by many years of indigestion. In addition he suffered from irritable bowel symptoms and a barium enema had revealed mild diverticulitis. Two distinctive patterns of symptoms were described and are depicted in Tables 8.1 and 8.2 The tables are derived from the printout of a computer analysis (repertorisation) of the key features.[i] Each table shows a number of medicines whose materia medica includes the selected symptoms. The grade with which the symptom is represented by each medicine is shown in the squares of the grid. The importance of each symptom in the patient's clinical picture is shown to the far left of the symptom rubric. Each symptom rubric shows the source of the data (the name of the repertory), then the site or type of the symptom, then the symptom detail. The symbol '<' means 'made worse by'.

No single medicine is identified with every key symptom and groups of medicines that correspond best to each set of symptoms differ. Two medicines occur in each group: Causticum and Phosphorus. Table 8.3 shows a 'strange, rare and peculiar' symptom – frequent waking at midnight with such a start that the patient is jerked out of bed – and a number of 'constitutional' characteristics. Overall, Causticum is best represented, and when the analysis is applied to the most distinctly individual symptoms (see Table 8.4) the choice of Causticum is even more strongly emphasised. The 'total weighted score' shows the additional emphasis provided by the relative rarity with which the particular symptom is found in the materia medica. The fewer medicines that include it, the greater is the emphasis.

Causticum is the medicine whose materia medica or 'drug picture' is most like the 'clinical picture'. This is the 'similimum', the medicine whose characteristics are most similar to the individual presentation of the totality of symptoms, the whole pattern of disorder in this patient.

[i] CARA (2.6 for Windows). West Bridnorth: Micant; 1996.

response to treatment she experienced the recurrence of a quite specific and very distressing symptom from her early teenage years. At that time she had suffered a psychotic breakdown following the discovery that she was an adopted child. The episode had been managed chiefly with psychotropic drugs, and no particular attention was paid to the psychodynamics. One of the symptoms had been that when she looked in the mirror she was unable to recognise the face that she saw. It was this symptom that recurred during treatment. Not surprisingly it caused considerable distress. It was also completely unforeseen, because although the past events and illness had been mentioned during the case history the symptomatology of that episode had not been discussed. Also, at that time in my homeopathic career I was not experienced enough to be alert to the possibilities of this unwinding of the evolutionary process.

This phenomenon is possibly the most remarkable and thought provoking that may be encountered in the practice of homeopathy. It is also alleged, though I cannot yet confidently confirm it from my own experience, that the phenomenon can include symptoms of disorders in the past history of the family. These are disorders that are not manifest clinically in the patient, or indeed detectable on investigation. An example would be the transient occurrence of thirst and polyuria in a patient with a family history of diabetes, in the absence of any other stigmata of the condition in themselves. Of course in this case there is the possibility that diabetes might become manifest in the patient at some stage. The possibility of a predisposition to a familial illness is also present even when no hereditary mechanism has yet been demonstrated. The interesting feature of this phenomenon is that it is transient, and the patient does not go on to develop the condition. The implication is that the underlying trait is exhibited during the healing process and resolved. We cannot know whether it would have become manifest later in the course of events if the homeopathic intervention had not been made.

Symptoms that do not fit

Problems can be caused in case analysis by symptoms that do not fit the picture. The pattern of symptoms may clearly represent a recognisable drug picture with the exception of one or two possibly quite glaring exceptions. This should not necessarily undermine our confidence in the prevailing clinical picture provided its other features are valid, though we should take particular care to justify it. If we see a reproduction of the Mona Lisa wearing a modern earring, it remains in essence the Mona Lisa.

Two reasons have already been given why odd features may crop up in an otherwise consistent clinical picture. One is the appearance of symptoms that actually belong to another layer of the illness. The other is the possibility that the materia medica on which we are basing our similimum is incomplete, or even incorrect. A third reason may be our own ignorance of the possible variety of forms that a particular symptom may take in the relevant materia medica, or our too-rigid interpretation of the references to it. If we do not know that Pulsatilla patients can be obstinate as well as yielding we may stumble when we encounter this apparent anomaly. Similarly if we do not know that generally warm-blooded Pulsatilla can be chilly in an acute state, we may be puzzled. If we believe that Phosphorus patients are frightened of thunderstorms (a bold capitals repertory entry), we may be disconcerted by an apparent Phosphorus patient who enjoys them. The truth may be that Phosphorus patients are intensely stimulated by thunderstorms and react either with fear or excitement, or even both.

We have to remember, however, that we are dealing with patterns in patients that are actually unique. We treat many patients with the same major medicines. Each patient will present a unique permutation of the known features of that medicine together with some that are entirely individual. There can be no pattern that embraces every possible unique permutation of individual detail. Somewhere there is a Mona Lisa with an earring or a ptosis, or whatever. The *Mona Lisa* remains the similimum.

There is one further consideration. Contemporary homeopaths are devoting a great deal of effort and energy to exploring the 'small remedies' in greater depth and investigating the properties of substances that are new to the homeopathic repertoire. The scope for this process of extension and refinement of the materia medica is almost infinite. Any substance has the theoretical possibility of showing therapeutic potential when its homeopathic properties are investigated. The implication is that more precise similarity between clinical pictures whose similimum we think we can identify and newly or better defined medicines may become possible. This should in turn make more profound and complete therapeutic action by the medicines possible. This is something of a nightmare scenario because the therapeutic possibility would be accompanied by the added difficulty of finding this more precise similimum from an increasing multitude of possible medicines. This is a practical and philosophical problem for the future, but perhaps not the distant future.[6]

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