

EDITORIAL FOR THE MONTHS OF DECEMBER 2006 AND JANUARY 2007

HOMOEOPATHIC APPROACH TO MYOCARDIAL INFARCTION

Usually patients suffering from myocardial infarction do not consult a homoeopathic physician. They prefer going to a cardiologist or they get themselves admitted to any hospital where they are shifted to intensive care coronary unit and they get treated there. This has been my observation when I started my practice in the year 1979. But then over a period of years, I was called very frequently to see such cases. The reason was the 'complications'. Complications of coronary infarction are too many and at times do not respond to modern medicine. I will just narrate a small case to begin with. Last week, I was called upon to see a patient who was sinking. Reason? He had a massive infarction and there were two such episodes within the last 10 days. He was unable to maintain his blood pressure, which was in the range of 70/40. Medications like Dopavin were given to him to increase the blood pressure but he did not respond to it. There was a renal shutdown due to low blood pressure, so he was on dialysis. The cardiac pumping, though was strong and good, which was in the range of 30-40, i.e. the ejection fraction. But he had all the signs of cardiac failure. He was given many antibiotics and medicines for better pumping and all the necessary precautions were taken, but yet he did not respond. I was asked to see him and after examining him and taking his homoeopathic history, I could arrive at a drug, which helped him to maintain his blood pressure, thereby improving his renal function which in turn put him off dialysis and the patient was out of danger. So these are the situations where a homoeopathic physician is called. Now, before tackling such difficult diseases, one must have a basic understanding of such illness, and that is - acute myocardial infarction, more often, gets triggered off during physical effort than at rest, or, any unaccustomed effort may precipitate an attack, emotional state – whether acute or prolonged can also induce an attack, the attack can also come after a heavy meal and I have many times seen, that when there is a sudden fall in blood pressure as in the case of a shock or in the case of anesthesia, the attack is precipitated. The pain is usually abrupt and the intensity varies from agony to dull ache and the pain may vex and wane. The location is usually behind mid-sternum, but it may be higher or lower, radiating to the right or left arm and the discomfort in the arm is often described as 'heaviness of the arm' and is frequently accompanied by sensation of numbness or tingling in the hands and fingers. The pain may also radiate to the neck, jaw, back, in-between shoulders or abdomen. At times the pain can only be

felt in the epigastrium, left elbow, or either side of the left or right arm or left or right shoulder. The duration of the pain may last from a few minutes to several

hours. However, the residual soreness in the area of pain may remain for several days. The patient can get a little breathless and the most common symptom that I have seen is nausea, vomiting and varying degree of shock. The patient is cold, pale and looks ash-gray or cyanic. There is profuse sweating, which may drench the pyjamas, shirt or bed sheets. The patient is usually restless, confused or excited and sometimes he even becomes unconscious. This restlessness may be due to anxiety or due to pain. There is abdominal distension, a sense of epigastric fullness and hiccups, which are very common due to irritation of the diaphragm. When one examines such patients with a stethoscope, one will find that the heart sounds are muffled and distant. Usually there will be tachycardia with a tick-tack or a gallop rhythm. This definitely suggests left ventricular failure or a cardiogenic shock. A fourth sound can be heard frequently and in absence of hypertension it is almost diagnostic of myocardial infarction. Systolic murmurs are not unknown because this can be due to relative mitral regurgitation from cardiac enlargement or it could be due to malfunction of papillary muscles. The blood pressure may show transient rise due to the attack but is often quickly reversed. A slow, progressive fall of blood pressure occurs over a period of days and eventually there will be a severe fall of blood pressure if there is a cardiogenic shock. The pulse is usually rapid unless there is atrio-ventricular block but the volume will always be poor and if there is an irregularity in pulse, it is almost always due to cardiac arrhythmia. On the second or the third day of the infarction one usually has very low-grade fever. This is usually due to cardiac failure, pulmonary infarction or edema. The electrocardiogram may show tall T-waves or inverted T-waves which indicates Ischemia, an ST segment elevation, especially those leads which overlies the infarction. But the typical is ST segment elevation with T-wave inversion. Whenever one sees a Q-wave, then this indicates cell death or death of cell. Cardiac enzymes are very important to study and one must have a basic knowledge of them. Myocardial necrosis results in release of certain intra-cellular enzymes into the blood. There are certain enzymes, which are present in a very high concentration in the myocardium, and they are not present at all in a non-cardiac tissue. If one wants to know the prognosis, especially in the first two hours, then it is extremely important to take help of certain cardiac exams which are being done through-----
---nowadays in any hospital of Mumbai. The first will be CKMB – Creatinine Phosphokinase MB fraction or MB fraction of Creatinine Kinase which is the name of the enzyme. The peak of this enzyme is in 24 hours and within 48-72 hours it comes to normal, so this enzyme must be advised very fast. The highest will be between 3-12 hours. The second that comes is the LDH enzyme whose peak is between 24-48 hours but it remains so for at least 15 days. Recently induced new enzymes were cardiac-troponines. The troponine-T especially can

be picked up in the first few hours, i.e. between 3-5 hours and its peak would be within 12-48 hours. Troponine-T can also remain high for a fortnight. Another troponine will be Troponine-I which has a peak of 24 hours and which can also remain for 10 days. Then comes the myoglobi---. Myoglobi--- remains high in the first 1 or 2 hours maximum, and within 24 hours it comes back to normal, so this is a very specific investigation. The last investigation will be the fatty acid binding protein, which is also high in the first few hours, i.e. between 1-3 hours, and within 24 hours it comes back to normal. These are some of the common observations that I have made in patients having infarction.

Now, as I have mentioned earlier, these patients do not come to us, and as homoeopathic physicians, we can only see them when there are severe complications, and I got most experience during these complications. I will go from the most commonest to the least commonest of the complications that I have seen and experienced. The commonest ones that I have seen are the arrhythmias and conduction blocks. Arrhythmias are directly proportional to the size and site of infarction, especially with the first 2 days after the infarction, the ventricular tachycardia ventricular fibrillation??-----are very common, or, sometimes supra-ventricular arrhythmia such as sinus tachycardia or atrial flutter or fibrillation suggest infarction of a large portion of ventricular muscle. Thus, many times this is called 'pump failure arrhythmias'. Another very common condition where I have been called many times is the 'cardiogenic shock'. When we say that a person is suffering from a cardiogenic shock, his systolic blood pressure has to be below 90 mm of HG, his skin should be cold and clammy, he should have oliguria or N-urea, he should have cerebral symptoms such as anxiety, confusion, apathy, somnolence(somnambulation??) and fatigue, he should have symptoms suggestive of metabolic acidosis. Sometimes the patient may also have pump failure as one of the complications, especially the left ventricular failure with typical pulmonary congestion, tachycardia and hypotension. Sometimes the patient may also have a right ventricular failure or dysfunction especially when the infarction is in the right ventricle and it is characterized by jugular venous distension and hypotension, but without pulmonary congestion, which is very important. Very rarely, the patient can have papillary muscle dysfunction with a rupture. This is characterized by a very loud systolic murmur, especially at the apex. But when there is a rupture, we will see a sudden onset of breathlessness, which will dominate the clinical picture. These are only some of the complications that I have seen. I do not know whether a homoeopathic physician will have the facility in a homoeopathic hospital to admit such patients. But in case if there is a homoeopathic hospital set-up to admit such cases, then it is very important that one should at least know some auxiliary mode of treatment to save the patient's life. The best thing to do is to

give oxygen to the patient, which is very essential since most of these patients are cyanotics??? Or cyanic??. Thereafter, blood samples should be taken immediately for baseline electrolytes, renal function, cardiac enzymes, etc. The patient should be immediately put on bed-rest and a drip of IV infusion should also be started using 5% dextrose. This is the minimum that a homoeopathic physician can and must do. Of course, we will not give allopathic treatment by injecting thrombolytic therapy and other such measures because we are not qualified to do that. So now I will quickly try and recognize homoeopathic remedies in such complications. My focus during the discussion will be on various types of cardiac complications that I have seen in my practice and I will discuss the remedy accordingly. My knowledge of cardiac therapeutic or therapy?? is based on reading certain cardiac therapeutics. My first book was

‘Homoeopathic treatment of the disease of the heart’ by Dr Jean Poirier. My second book will be ‘Disease of the heart ‘ by A L Black Wood, the third will be ‘Diseases of the heart’ by Edwin Hale, the fourth book will be ‘Remedies of the circulatory and the respiratory system’ by Fortier Bernoville, the fifth will be ‘Treatment of heart condition’ by Douglas -----. There is also an Indian author who has compiled in a very nice manner all the information from various source books in his book called ‘Cardio-vascular disease and homoeopathic treatment’ by Dr E Balakrishnan. So these are some of the useful therapeutic books which I have gone through and my experience is chiefly from these books. Of course, books on Materia Medica and reference books, the Encyclopedia Homoeopathica Programme, the Synthesis repertory and the Radar software has been of great help to me in solving the most difficult cases and understanding a remedy in a much better manner. My first remedy will definitely be Arsenic Album. Now with this remedy, one can typically see a mentally distressed person with extreme fear, extreme anxiety with mental and physical restlessness and constant thirst with desire for sips of ice-cold water. So, as far as the actual local symptoms are concerned the main complaints are - a feeling of extreme cardiac pressure, a feeling of heavy weight on the chest or constriction in the chest that is associated with a feeling of not getting enough air in the lungs and the patient feels that he will die. The patient has a rolacold??. he complains that he is feeling cold though he may also complain that there is burning in the chest. In appearance, the patient looks extremely anxious. The expression looks confused, distressed, haggard and tired. The face appears slightly greasy. The patient appears grey and the lips are pale and cyanotic or cyanic?? giving one the impression of being dangerously ill. The patient often has a peculiar pinch, wrinkled and grey appearance but as a rule, in these cases one gets the history that the attack was developed quite suddenly and the respond through Arsenic should be -----?? Now, with this particular symptomatology, if one gives

Arsenic and the response is not good within 30-60 minutes, i.e. by giving Arsenic if the mental anxiety, fear and restlessness of the patient does not subside or if the patient does not become warmer than before, then one must change the remedy because Arsenic, when indicated very nicely and properly, will show results with a few hours after its administration. In such a case where one sees a perfect picture and similarity to Arsenic Album, please do not start with a low potency, start directly with a 10M, 50M or a CM potency on a centesimal scale. Now here, the question arises – ‘what should be the frequency of repetition?’ The repetition that I usually use is any time between 15-45 minutes. One must put a drop of medicine in a glass of water and stir it and with every repetition, one must stir at least 10-15 times with a spoon. Now here, if one gives Arsenic and the patient feels better, do not prolong this remedy for many days. Arsenic may not hold the patient for long in this particular situation. I have seen that after initial major improvement for one or two days, the patient will suddenly die and one will be disappointed and ask that why this happened. This is because, Arsenic is a remedy that, by itself, will never help the patient to pull through from this particular situation. One has to immediately support this with another remedy and the remedy that I have found to be very useful in supporting Arsenic is Phosphorus or Sulphur. Though this helps in majority of the cases, it does not always prove to be successful. I have used other remedies like Lycopodium also. Now, what is the difference?? between----- ?? We discussed earlier that the patient was grayish looking, pinched??, anxious and he was getting better and warmer, he was appearing less grey, less pinched??, face was a little less drawn, anxiety was less and the reddish color was appearing back on the face. This is the transition phase that the patient is going through, i.e. from Arsenic to Phosphorus. But at times, while Arsenic is helping the patient, the patient becomes too hot with irregular waves of heat and cold, tending to push the blankets off still with air-hunger – then this is the Sulphur stage. So one needs to be careful when one understanding the remedies. Now, let us discuss certain clinical observations that I have seen in Arsenic. The head will be extremely sensitive to cold air, the head may be drawn sideways, there may be slight jerking of the head, the head may be restless, the eyes may be slightly agglutinated, there may be injection of the conjunctival blood vessels, there may be a certain degree of photophobia, the pupils would usually be insensitive to light and they may be dilated or contracted, the face appears bloated especially around the eyes, above the eyes or under the eyes, there may be dropping of the jaw, the face may appear greasy and sunken, the tongue may be bluish, dark or pale or it may have red stripes down the center, the mouth may be dry with thirst, Arsenic may sometimes have a mapped tongue with offensive odour from the mouth, the speech may be difficult and at times it may be lisping, the respiration is especially accelerated with a typical air-hunger

and it can get arrested when the patient makes an attempt to cough, there may be gasping respiration, and it must be noted that in Arsenic, the respiration is always affected by anxiety, cough is usually accompanied by salivation and slightest cold air will excite the cough, the arrhythmias that I have usually seen in Arsenic are either atrioventricular nodal rhythm with extra systole or intraventricular block, especially the right bundle branch block or simple tachycardia due to anemia or due to anxiety, I have sometimes seen in Arsenic that when one gives a lot of salbutamol??, there is tachycardia, there is tachycardia after a history of chronic smoking of tobacco, the heart failure is usually accompanied by severe weakness and prostration, the murmurs will definitely be present especially the murmur of aortic regurgitation which is highly characteristic of Arsenic Album, the pulse can be bounding and this occurs especially when the patient is anxious, but otherwise the pulse will be imperceptible, irregular and slow in Arsenic Album.

The second remedy that I have found to be very useful in such conditions is Antimony Tart. Ant-tart patient presents a somewhat similar picture as Arsenic Album?? but there is a clear point of differentiation, i.e. in Ant-tart there is a more definite cyanosis than in Arsenic, one usually does not see a Ant-tart patient without cyanosis and this may either involve the full extremities or only a finger or toe-nail, one never sees the same type of mental anxiety in Ant-tart as in Arsenic, the patient in Ant-tart is down and out, much more hopeless and depressed, the patient is not quite so restless and pale as Arsenic, there is no thirst in Ant-tart that one sees in Arsenic, in fact, anything to drink seems to increase the patient's distress in Ant-tart and even though Ant-tart is listed as a remedy of ??? thirsty patients, in practicality, I have hardly seen Ant-tart patients being thirsty and if they do drink water, they develop a lot of distress in the heart and abdomen. Another contrasting feature is that Ant-tart patient is aggravated by heat, especially by any stuffiness in the atmosphere. There is one point worth noting that as a contrast between Ant-tart and Carbo-veg, Ant-tart patients will not like stream of air circulating around them, they want a room fresh and they like it still??? In most of the Ant-tart patients, there is a very early tendency to edema of the lower extremities. Another point that will help one in the selection of Ant-tart is that practically all these patients will have a very thickly coated tongue, a white coat with a rather strictly uncomfortable mouth. They have a feeling of fullness in the chest rather than the feeling of acute pressure as in Arsenic and one usually finds generalized and diffused Rals in the lower part of the lungs. In contrast to Arsenic, if one has a case of this type, then it is a kind of collapse one meets after a pneumonic crisis if the patient responds to Ant-tart it will carry him through.

Now, we will discuss some of my observations of Antimony-tart, which I have confirmed in my practice. The first and most important observation is the

perspiration, especially cold perspiration on the forehead. Perspiration on the head when coughing and trembling of the head when coughing are also the important characteristic features of Ant-tart that I have witnessed. The eyes will be injected, the pupils are usually contracted in Ant-tart, the face appears dark, cyanotic or cyanic?? and bluish, the lips are chapped, the face is bloated, the expression is usually of suffering and anxious, there can be cold perspiration even on the face with slight trembling of the jaw, the gums can be bleeding, the tongue is usually bluish or pale or having red stripes down the center, but the characteristic is the coated tongue and the coating is tough and white. There can also be an indented tongue or a mapped tongue like Arsenic that I described earlier. The mouth is usually open, the speech is difficult, on examining the mouth one may see that the gums are spongy, the respiratory rate will be accelerated, especially when the patient is in lying position, at times the respiration may be abdominal, and if there is severe respiratory failure, then there can be gasping and irregular breathing. One can also find moaning in Ant-tart patient. The cough is dry and constant during day and night in Ant-tart patient, and it can get aggravated by eating and can be better by eructations. There may be pulmonary edema and the common arrhythmias that I have seen is the right bundle branch block in Ant-tart. There may be palpitations with anxiety, and the palpitations may be so strong that they can be audible and visible. The pulse can be frequent, imperceptible, slow, soft, thready and weak.

The next remedy will be Carbo-veg and this presents a classical picture of patients with all forms of collapses. They have cold and sweaty skin, they are mentally dull and foggy in their outlook, they do not have a clear idea of where they are or what is going on or what is going to happen to them, they have a very intense air-hunger and in spite of their cold clammy extremities, they want air blowing on them, they cannot bear to have bed clothes around their neck and they definitely benefit from the administration of oxygen, the more oxygen given to them, the better they feel. They are paler than Ant-tart patients and the lips are pale rather than cyanotic or cyanic?? and there is none of the underlying blueness that one associates with Ant-tart. So, if one has to give marks to blueness in the remedies, then Ant-tart gets 5 marks and Carbo-veg gets 3 marks. The next point is that they (Carbo-veg patients??) always have a terrible feeling of distension. This is often not so much in the chest as in the upper abdomen and the cardiac distress is always associated with a great deal of flatulence. Like Ant-tart patients, any attempt to eat or drink tends to increase the distress a great deal and they have none of the Arsenic thirst. Another apparent contradiction that one comes across in Carbo-veg patients is that in spite of the desire to be uncovered and the intolerance of blankets around the upper part of the neck or chest, these Carbo-veg patients complain of ice-cold extremities and they feel as if their legs

are lumps of lead and they cannot get them to be warm at all. I think that in Carbo-veg one has to be careful as to how long one is to keep up the administration once the patient starts responding when the sweating is less, the surface becomes warmer and the distress is less acute???? It is wise then to hunt around for a second drug in need because some Carbo-veg patients do relapse although many of them make quite straight recovery on Carbo-veg. The remedies that usually follow Carbo-veg would either be Sulphur or Kali-carb.