Homeopathy (2008) 97, 206–213
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doi:10.1016/j.homp.2008.08.002, available online at http://www.sciencedirect.com

CLINICAL

Homeopathic practice in Intensive Care Units: objective semiology, symptom selection and a series of sepsis cases

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Abstract: **Homeopathy has been used for more than two hundred years to treat chronic disease using various approaches in a wide range of diseases. However, for acute disease and critical illness, application has been limited by inadequate training of homeopathic physicians and the small number of pertinent clinical studies. In view of the difficulty of practising homeopathy in Intensive Care Units (ICU), a protocol was developed to facilitate description of objective homeopathic symptoms with a ranking of symptoms appropriate for these situations *(Protocol for Objective Homeopathic Semiology)*. Examples of favorable results with individualized homeopathic treatments for a series of cases of Systemic Inflammatory Response Syndrome (sepsis) are described.** *Homeopathy* (2008) **97**, 206–213.

Keywords: Homeopathy; Acute disease; Critical illness; Homeopathic semiology; Intensive care units; Sepsis

> ''Why not offer this as the test of our ability and skill, and consciously admit that we must abort all acute diseases or cease to call ourselves homeopathicians?''
>
> (James Tyler Kent, *Lesser Writings,* Higher use of primary branches in medical education)

Introduction

In its 200 year history of homeopathy, treatment of chronic disease has become increasingly import, enabling a holistic approach and improving the patient-physician relationship with a therapy free of collateral effects. But little is known about the use of homeopathy in critical cases. Modern science has greatly improved life support for these patients (mechanical ventilation, cardio-circulatory support, hemodialysis and, hemofiltration, enteral and parenteral feeding, metabolic monitoring and control etc.), prolonging survival for periods and in conditions unknown to Hahnemann's time. Education of homeopathic physicians in the treatment of acute diseases and critical cases is deficient because of the lack of experience; a knowledge gap is responsible for the inability and fear of treating acute episodes or acute flare ups of chronic processes.

Because of the altered state of consciousness or impossibility of communications with critically ill patients, classic homeopathic anamnesis cannot identify the symptoms peculiar to the sick individual. This requires a different semiotic technique. In acute clinical manifestations, the various types of homeopathic symptoms demand a specific weighting to find the correctly individualized medicine.

Homeopathic practice in Intensive Care Units (ICU) faces patients on the verge of life and death, with little time to act, few characteristic homeopathic symptoms and many variables that complicate the initial approach and the evaluation of the homeopathic therapeutics.

With increasing dissemination worldwide of various types of complementary and alternative medicine (CAM),[1–3] homeopathy should be used as a complementary treatment[4] in all fields of medicine.

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Received 4 December 2007; revised 15 June 2008; accepted 6 August 2008

Specific questions concerning homeopathy and acute illness

Some questions are frequently raised:

(i) Is it possible to reconcile individualized homeopathic therapy with conventional therapy and invasive procedures of intensivist practice?
(ii) Can homeopathy contribute in critical extreme states or is it too late to recover health and equilibrium of vital organs?
(iii) How can information be obtained from a patient who is unconscious or in an altered state of consciousness?
(iv) Which symptoms should be emphasized and used in the assessment of the critically ill patient?
(v) What parameters should be used to evaluate response to therapeutic homeopathy in these cases?
(vi) How does one work with homeopathic doses and dilutions?

Objectives

To elaborate a semiotic technique, the Protocol for Objective Homeopathic Semiology for patients with an altered state of conscience.

To propose a system of evaluation and selection of homeopathic symptoms, in critically ill patients.

To enhance responses to homeopathic treatment with a series of cases of ICU patients with Systemic Inflammatory Response Syndrome (SIRS).

Objective Homeopathic Semiology

For patients who have difficulty in reporting their symptoms (unable to talk, low level of consciousness), use of objective symptoms is of fundamental importance. In intensivist homeopathy, a normal search for objective symptoms, without a protocol or system to follow is difficult. Several bedside visits to the patient often do not identify any peculiar manifestation. Lack of knowledge of signs and objective symptoms described in homeopathic Materia Medica and repertory is one of the main obstacles for identification of important symptoms in these patients.

In view of this, a Protocol for Objective Homeopathic Semiology was developed for all systems and regions of the body, to help detect characteristic signs and symptoms in critical ill patients who are unable to report their suffering because of intubation, unconsciousness, extreme weakness, etc.[5]

By classifying these objective characteristics according to regions of the body or chapters of the repertory, it becomes possible to distinguish signs and peculiar symptoms rarely spontaneously mentioned by patients because they express aspects that the person finds difficult to observe and note in himself, ''partly because the patients become so used to their long sufferings that they pay little or no heed to the lesser accessory symptoms, which are often very pregnant with meaning (characteristic) - often very useful in determining the choice of the remedy'' (*Organon,* paragraph 95).[6]

To measure the importance of these objective aspects in the homeopathic semiology of critically ill ICU patients, we identified many signs and symptoms that may be derived from a conventional clinical history, physical exam, diagnostic exams and direct observation of the patient and his attitudes, described in the homeopathic repertory.[7] These are distributed as follows: Mind (213 rubrics), Head (62), Eye (105), Ear (44), Nose and Smell (83), Face (93), Mouth (112), Teeth (42), Throat (74), External Throat (41), Stomach (53), Abdomen (80), Rectum (56), Stool (83), Bladder (35), Kidneys (10), Prostate gland (12), Urethra (35), Urine (33), Male genitalia (80), Female genitalia (77), Larynx and Trachea (40), Respiration (43), Couch (182), Expectoration (75), Chest (108), Back (57), Extremities (147), Nails (40), Sleep (36), Chill (90), Fever (91), Perspiration (89), Skin (72), and Generalities (258). The Protocol for Objective Homeopathic Semiology is available online.[8]

In addition to critically ill patients, application of this technique to chronic patients stimulates recognition of characteristics not detected by classicical homeopathic anamnesis. This increases the likelihood of detecting indicators for minor medicines which present rare peculiar and characteristic symptoms, which could be diagnosed with this protocol.

Literature review

We found few references in homeopathic literature to treatment of critically ill patients. However, based upon that which already existed for acute cases, we highlighted basic steps in the semiotic approach to acute, critical patients.

Hahnemann

In paragraph 73 of *The Organon,*[6] Samuel Hahnemann classified acute diseases by categories, emphasizing the significance of *biopathographical causalities* (nutrition, physical, climate, intellectual, psychic or emotional ailments etc.) with the ability to trigger an acute process such a ''transient explosion of latent psora''. He also referred to acute diseases caused by contagion, which can affect a large number of susceptible individuals in a similar way (epidemic), and acute miasms, that always return in the same form.

In paragraphs 18 and 154 of *The Organon,*[6] the importance of the characteristic symptomatic totality correct choice of homeopathic medicine for chronic as well as acute diseases was emphasised. In paragraphs 82, 99 and 152–154, the semiotic approach to acute cases is covered to mentioning the ''more striking, singular, uncommon and peculiar (characteristics) signs and symptoms'', stressing that anamnesis is ''only partially applicable to acute diseases''.

Kent

In chapters III and XXXIII of *Lectures on Homeopathic Philosophy,*[9] James Tyler Kent, refers to acute miasms (eg. diphtheria, typhoid fever, scarlet fever), orients choice towards medicines specific to the common clinical condition (medicines that reflect the pathognomic symptoms of disease, grouped under a repertory rubic with the name of

the disease) and applying differential diagnosis with specific symptoms at a given moment.

In chapter XXVI,[9] like Hahnemann, Kent distinguishes the semiotic approach to chronic and acute diseases, stressing that chronic symptoms and acute symptoms should not be mixed, orienting the prescription for a group of specific symptoms that comprise the image of the acute illness: ''the symptoms of acute attack are separate and autonomous''.

In his *Lesser Writings,* Kent emphasized that selection of medicines in acute cases, such as typhoid fever[10] and diphtheria[11] should take the following sequence: (1) grouping of medicines related to the pathognomic symptoms of the acute disease (common symptomatic totality); (2) individualization of the medicine by seeking symptoms for each specific case (characteristic symptomatic totality).

''How to treat the patient suffering acute and serious disease'', Araújo[12] summarized the main points of the Kentian approach for acute conditions:

(1) begin with pathognomic symptoms of that individual acute disease (or of a group of patients, in the case of an epidemic);
(2) from the repertory identify the homeopathic medicines able to produce this clinical condition;
(3) add the general symptoms of the patient (or of each patient in the case of an epidemic);
(4) add the specific symptoms and modalities;
(5) finally, include mental symptoms, but only those appearing during the acute stage, Kent suggested, for acute cases 1 M and 10 M at 4 to 6 h interval, until improvement.

Eizayaga

In his work *Treatise on Homeopathic Medicine,*[13] Francisco Xavier Eizayaga proposes an approach similar to Kent, in which the choice and weighting of symptoms of acute illness differ from those of chronic conditions.

Emphasizing that homeopathic semiology in acute cases must be faithful to the ''actual similitude'', he cites the following as necessary for success acute cases:

(1) clinical and etiological diagnosis;
(2) pathognomic and common symptoms of the acute disease with its characteristic modalities, restricted to the medicines identified in the 1st stage;
(3) mental, general and local symptoms that appeared or were modified in the acute process;
(4) symptoms or effects that may have favored emergence of the acute process (meteorological, microbial, nutritional, physical, chemical etc.).

Summary of the authors

In summary, in critically ill patients, these authors advocate seeking the actual characteristic symptomatic totality, with the hierarchization of homeopathic symptoms (Table 1).

Table 1 Hierarchization of homeopathic symptoms in serious acute cases

(1) Etiological, clinical and anathomo-pathological diagnosis.
(2) Usual and pathognomic symptoms of the acute disease with typical modalities.
(3) Local, mental and general symptoms which emerged or suffered modification with acute disease.
(4) Symptoms or causalities that triggered the acute disease (biopathographical symptoms).

Case series: Systemic Inflammatory Response Syndrome (SIRS)

Examples of the homeopathic approach to the critically acute patient follow, according to the premises cited, with a series of cases of patients with Systemic Inflammatory Response Syndrome (SIRS) in ICU, who received combined conventional and individualized homeopathic treatment.[14]

All were admitted to the ICU of Hospital Amico, Unidade Vila Mariana (São Paulo, Brazil), between May and September, 1999. According to the guidelines of the Ethics Committee of the Hospital, the next of kin and those responsible for the patients consented to the homeopathic approach. Choice of patients for homeopathic intervention was based upon recognition that they were not responding satisfactorily to conventional treatment as judged by the attending ICU medical team. Homeopathic treatment was begun after the normal corrective and supportive measures (maintenance of the affected vital organs) and treatment of the primary focus (antibiotic therapy, surgical removal etc.). Conventional therapy was not modified or substituted by homeopathy. Homeopathic evaluation included medical chart data (causal disease, triggering factors, concurrent aspects etc.), information from the patient (when conscious and willing to speak) and the definition of objective signs and symptoms at bedside. The symptoms were selected for the repertory according to the hierarchization model for acute cases described above. The Clinical Homeopathic Materia Medica was use to confirm individualized homeopathic medicine for each case.

Medicines were given in Hahnemann centesimal (cH) dilutions with an initial sequence of 6, 30 and 200 cH, to reduce the number of variables that could influence assessment of results had we used a wider range of potencies. In most cases, treatment was begun with a 30 cH, considered by James Tyler Kent as a ''low enough to begin business in any acute or chronic cases''.[9] Continuation or change of medicine and the interval between doses was determined by individual evaluation of each case according to Objective parameters of therapeutic homeopathic evaluation (Table 2).

Case 1: Sepsis – Gastro–Intestinal Tract Focus

HF female, 74 years, weight 70 kg.

Summary of clinical medical history: attended at Hospital Amico – Accident and Emergency Department (Vila Mariana Unit), on 06/05/99 at 03h20 with history of abdominal pain of colicky character, in epigastrium, followed by eructation. She denied any alteration of intestinal rhythm.

Table 2 Objective parameters of therapeutic homeopathic evaluation

(1) Central Nervous function: level of consciousness and orientation in time and space.
(2) Respiratory function: breathing mechanics and arterial gasometry.
(3) Cardio-circulatory function: cardiac frequency and rhythm, arterial pressure and indirect tissue perfusion (acid-base equilibrium).
(4) Renal function: hourly urinary output by weight and follow-up of serum levels of scoria (urea and creatinine).
(5) General evolution: intensity of habitual and necessary alo-enantiopathic therapy.
(6) Others: complementary exams.

Physical examination:

Central Nervous System: conscious, oriented, with no neurological alterations.

Respiratory System: eupneic, non-cyanotic, normal pulmonary auscultation.

Cardio-circulatory System: rhythmic pulse; normal heart frequency; BP = 150/80 mmHg.

Abdomen: flaccid, painful to palpation in the epigastrium, hydro-aerial bowel sounds.

Initial treatment: antispasmodic agent in continuous solution and observation.

Re-examined at 04h40 (06/05/99): unchanged.

Management: opiate analgesic (Tramadol chloride) and histamine H2-receptor antagonist (Cimetidine).

Admitted to hospital at 05h30, she received analgesic all day, with no improvement; an abdominal ultrasonography was requested but not done.

01h00 (07/05/99): aggravation of pain in spite of analgesics. Dyspneic, hypotensive (100/60) and tachycardic (120 bpm); abdomen with abrupt decompression + and distension. Abdominal x-ray shows pneumoperitoneum.

Examined by General Surgeon and submitted to exploratory laparotomy.

Surgical finding: perforated duodenal ulcer, with intense peritonitis, purulent secretion in cavity.

Hypotensive (60/40), tachycardic, metabolic acidosis, even with precautive correction.

Resection and suture of duodenal borders carried out.

11h15m (07/05/99) – Admitted to ICU

Somnolent, still under anesthetic effect, opened eyes when stimulated.

Physical examination: hypothermic (T axillary = 35.0 °C), pale, dehydrated, feeble and accelerated pulses, oliguresis; ''although in shock state, her tongue was more moist than normal''.

Intubated, mechanical ventilation with FiO2 = 0.7 (70%) and saturation of O2 = 96%.

Heart rate 130 bpm; mean arterial pressure (MAP) = 45~50 mmHg with Dopamine 10 mcg/Kg/min.

Investigation

Metabolic acidosis equalized; Urea = 82 mg/dl, Creatinin = 1.2 mg/dl; 4.700 leukocytes with a shift to metamyelocytes; Coagulation: APTT = 40% (16 sec./ INR = 1,8). Hepatic enzymes (GOT, GPT) normal.

Clinical diagnosis: Septic shock (abdominal focus).

17h00 (07/05/99) – Acute atrial fibrillation with fast ventricular rate (200 bpm) after visit of relatives whom she recognized and contacted by signs. Received antiarrhythmic agent (Amiodarone), with reversion to sinus rhythm. Antibiotics: Imipenem-cilastatin and Vancomycin chloride. Nasogastric tube drained 900 ml.

Homeopathic evaluation 18h30 (07/05/99):

(1) Etiological, clinical and anatomo-pathological diagnosis: GENERALITIES – Septicemia, blood poisoning.
(2) Usual and pathognomic symptoms of disease with typical modalities: GENERALITIES – Pulse **-** discordant with temperature.
(3) Local, mental and general symptoms, which emerged or suffered modification with the acute disease: MOUTH – Smooth, shining, glazed, glistening, glossy tongue. MOUTH – Discoloration **-** tongue, red.
(4) Symptoms or causalities which triggered the acute disease (biopathographical symptons): ABDOMEN – Inflammation. GENERALITIES – Wounds - dissecting. GENERALITIES – Wounds **–** dissecting - ailments from.

Repertorization[7]:

1. GENERALITIES – Septicemia, blood poisoning.
2. GENERALITIES – Pulse **-** discordant with temperature.
3. MOUTH – Smooth, shining, glazed, glistening, glossy tongue.
4. MOUTH – Discoloration **-** tongue, red.
5. ABDOMEN – Inflammation.
6. GENERALITIES – Wounds - dissecting.
7. GENERALITIES – Wounds **–** dissecting - ailments from.

Homeopathic Medicines	Symptoms covered	Total weight	*Symptoms*						
			1	2	3	4	5	6	7
Pyrog	7/7	16	3	3	2	2	3	2	1
Ars	5/7	13	3		2	3	3	2	
Lach	5/7	13	3		3	2	3	2	
Apis	5/7	12	2		2	3	3	2	
Crot-h	5/7	10	3		2	2	2	1	
Ter	5/7	10	1		2	2	3	2	
Phos	4/7	10	2		2	3	3		
Rhus-t	4/7	9	2		1	3	3		
Arg-n	4/7	5	1		2	1	1		
Acon	3/7	7	2			2	3		

Homeopathic prescription: *Pyrogenium* 30 cH, single dose of 5 drops.

Continued conventional therapy, Noradrenaline (0.6 mg/h) introduced.

After 06 hour (07/05/99 at 24.00):

Temp. = 37.5°C; Heart rate (HR) 120 bpm, MAP = 68 mmHg; Diuresis = 2 ml/kg/min (880 ml/6 h).

No change in physical examination, except pulses, which were ample and with increased perfusion.

After 12 hour (07/05/99 at 06.00):

Temp. = 37°C; HR 82 bpm, MAP = 89 mmHg (Dopamine 8 mcg/kg/min and Noradrenaline 1 mg/h);

Diuresis = 2.3 ml/kg/min (980 ml/6 h); Nasogastric probe (NGP) = drained 100 ml in 12 h.

After 18 hour (08/05/99 at 12.00):

36°C; HR 85 bpm, MAP = 96 mmHg (continued Dopamine and Noradrenaline); diuresis = 1.6 ml/kg/min (700 ml in 6 h); NGP = 20 ml; ventilation: decreased FiO_2 to 0,3 (30%).

After 24 h (08/05/99 at 18.00):

36.9°C; HR 80 bpm, MAP = 99 mmHg (same vasoactive drugs); diuresis = 3.3 ml/kg/min (1,400 ml in 6 h); NGP = 0.

New episode of arrhythmia: (acute atrial fibrillation) during visit of relatives, sedated.

After 48 h (09/05/99 at 18.00):

36.8°C; HR 77 bpm, MAP = 97 mmHg (drugs maintained); diuresis = 2.6 ml/kg/min (4,450 ml in the last 24 h); NGP = 0.

After 96 h (11/05/99 at 18.00):

Normal temperature, HR, MAP; extubated for 10 h; with no vasoactive drugs for 10 h; diuresis = 3.3 ml/kg/min (5,680 ml in 24 h), with only maintenance hydration (3,000 ml/ 24 h). Liquid diet was introduced.

Discharge from ICU on 14/05/99, light oral diet. Antibiotics stopped on 17/05/99.

Discharge from hospital on 19/05/99.

Evaluation by ICU team:

Recovery of functional alterations of committed organs occurred in 48 h, a fact not usually observed in cases of acute abdomen with Peritonitis, especially in older patients. Digestive system had recovery similar to elective surgeries without complications in vital organs. Of interest was the occurrence of full and prolonged polyuria (diuresis more than 2 ml/kg/hour) without excess hydration, and even after return of serum creatinine to the normal level.

Case 2: Sepsis – Pulmonary Focus

WG male, 53 years, weight = 110 kg.

Summary of clinical medical history: Attended Hospital Amico – Accident and Emergency Department (Vila Mariana Unit), on 05/05/99 complaining of colicky lumbar type pain, with radiation to right flank and associated nausea that did not improve with antispasmodics (Scopolamine butylbromide).

Physical examination: physical examination was normal, except: BP 230 × 130 mmHg and positive Giordano's signal in the right lumbar region.

Kept in observation and examined by Urology with tentative diagnosis of acute pyelonephritis. Pain ceased (analgesia) and patient was discharged next day 06/05/99.

Return to Accident and Emergency 08/05/99:

Patient was transferred to ICU 09/05/99 with Acute Respiratory Failure.

10/05/99: clinical history was taken again and patient reported that his illness began 8 days before with generalized malaise during a flu epidemic, but without typical symptoms of influenza. He became symptomatic and after 3 days without improvement felt chest pains worse on breathing and dyspnea. No symptoms of cardiopathy or digestive pathology. *Physical examination:* Hypoxia with intense dyspnea, despite use of Venturi mask with FiO_2 50%; tendency to hypotension; crepitations in lower 2/3 of both lungs: increased peripheral perfusion; tendency to hypothermia; oliguresis.

Agitated, wanted to leave ICU to go home, conscious and oriented, easy to communicate, refuses to be alone in room and afraid of dying.

Investigations: Chest x-ray, consolidation in lower 1/3 of right lung and diffuse interstitial infiltrate of remaining fields, bilaterally; Leucocytosis and severe left shift; oliguresis and raised serum urea (129 mg/dl) and creatinine (2.1 mg/dl).

Clinical diagnosis: Bilateral interstitial pneumonia; Acute Respiratory Failure and Acute Renal Failure; Systemic Inflammatory Response Syndrome [Defined as two or more of the following criteria: (1) Temperature > 38°C or <36°C; (2) Heart rate (HR) > 90 bpm; (3) Respiratory rate (RR) > 20 ipm or PaCO2 < 32 mmHg; (4) Leukocyte count > 12,000/mm^3, < 4,000/mm^3 or > 10% immature cells]

Previous history: Beta-blocker since 1995 (Atenolol) and ACE inhibitor (Captopril); Diabetes controlled with diet; obese (113 kg for 1.53 m).

11/05/99: brief improvement, requiring only non-invasive mechanic ventilation (CPAP mask) with high FiO_2 (80%).

Homeopathic evaluation 10h00 (11/05/99):

(1) Etiological, clinical and anatomo-pathological diagnosis:
GENERALITIES – Septicemia, blood poisoning.
(2) Usual and pathognomic symptoms of disease with typical modalities:
None
(3) Local, mental and general symptoms, which emerged or suffered modification with the acute disease:
MIND – Anxiety - bed, in – tossing about, with.
MIND – Anxiety – bed, in – driving out of.
MIND – Fear, apprehension, dread – death, of.
MIND – Company – desire for, aversion to solitude.
GENERALITIES – Weakness – restlessness, with.
(4) Symptoms or causalities that triggered the acute disease (biopathographical symptons):
CHEST – Inflammation – Lungs.

Repertorization[7]:

1. GENERALITIES – Septicemia, blood poisoning.
2. MIND – Anxiety - bed, in – tossing about, with.
3. MIND – Anxiety – bed, in – driving out of.
4. MIND – Fear, apprehension, dread – death, of.
5. MIND – Company – desire for, aversion to solitude.
6. GENERALITIES – Weakness – restlessness, with.
7. CHEST – Inflammation – Lungs.

Homeopathic Medicines	Symptoms covered	Total weight	*Symptoms*						
			1	2	3	4	5	6	7
Ars	7/7	19	3	1	3	3	3	3	3
Rhus-t	5/7	12	3		2		2	3	2
Puls	5/7	11	3		2	2	2		2
Nit-ac	5/7	9	2		1	1	3		2
Bry	5/7	9	3		1	1	2		2
Carb-v	5/7	9	3		1	1	1		3
Ph-ac	5/7	8	2			1	2	2	1
Phos	4/7	11	3			3	3		2
Lyc	4/7	10	3			3	2		2
Acon	4/7	9	3			1	3		2

Homeopathic prescription: *Arsenicum album* 30 cH, single dose of 5 drops.

Conventional treatment continued.

After 24 h (12/05/99):

Normal temperature; HR 85 bpm (used beta-blocker at home); BP = 170 × 100 mmHg (without anti-hypertensive); RR 30 breaths/min, with Venturi mask at 50% and peripheral saturation = 94%; diuresis 900 ml every 6 h, with the same alteration of the renal function. Calm, showing significant amelioration.

Homeopathic prescription: repeat a single dose of Arsenicum album 30 cH.

After 48 h (13/05/99):

Normal temperature; HF = 80 bpm; BP = 190 × 100 mmHg; RR 23 breaths/min (idem) and saturation 95%; Polyuric (2,000 ml every 6 h), recovering renal function.

After 72 h (14/05/99):

Normal temperature; HR 80 bpm; BP = 140 × 100 mmHg (without anti-hypertensives); RR 16 breaths/min, saturation 97%, with nasal catheter of O_2 at 2 l/min; Polyuric (more than 2,000 ml every 6 h), renal function normalized.

Discharged from ICU.

After 6 days discharged from hospital:

After completing antimicrobial treatment and with normal investigations (Echocardiogram, chest x-ray to follow-up evolution, hemograms, renal function, hepatic function).

Return to outpatient clinic 07/06/99:

No complaints, clinically well, BP = 160 × 100 mmHg [Atenolol 100 mg/day]. Normal chest x-ray. Advised in controlling obesity.

Evaluation by ICU team: During the first two days of ICU, before homeopathic treatment, patient showed a slow improvement which was not maintained. Hypoxemia reversion occurred after 48 h of homeopathic treatment with normalization of the respiratory and cardio-circulatory parameters, permitting ICU discharge. Arterial pressure was controlled in ICU without use of anti-hypertensives.

Case 3: Sepsis – Neurological Focus

T.M.D.M female; 6 years, weight 20 kg.

Summary of clinical medical history: Referred from another service to the Hospital Amico – Accident and Emergency Department (Vila Mariana Unit), with frontal headache, fever (39°C) and many episodes of vomiting in the first day; diarrhea denied. Admitted on 02/06/99 at 15h00.

Physical examination: active, hydrated, no fever; otoscopy showed hyperemia to the right, bright tympanic membranes; oropharynx had intense hyperemia with no purulent points.

Central Nervous System: conscious, oriented, without meningeal signs.

Respiratory System: eupneic, non-cyanotic, normal pulmonary auscultation.

Cardio-circulatory System: rhythmic pulse; normal heart frequency.

Abdomen: normal.

Skin: petechiae over entire body.

Investigations: cerebrospinal fluid; one cell, zero erythrocytes, negative reactions (proteins), negative bacterioscopy; normal sinus x-ray; normal chest x-ray.

Management: Admitted, received only symptomatic drugs, and remained under observation.

3 h after admission: numerous episodes of diarrhea, dehydration, somnolence; peripheral perfusion worsened; petechiae and hemorrhagic suffusion over the entire body (livedo reticularis).

Admitted to ICU (12/06/99 18h30):

Physical examination: unconscious, in septic shock; absence of all pulses, except the carotids which were too weak (+/4+); petechiae disseminated, including conjunctival; without nape rigidity; severe cyanosis (purple lips); hypoxemic (gasometry and peripheral saturation); tachycardic (HR 170 bpm); local vasodilatation in the face, with intense hyperemia.

Management: Intubated and ventilated with FiO_2 at 100%; central venous catheter inserted and vigorous volume expansion. In 4 h received: 0.9% NaCl 1,000 ml, Ringer's lactate 1,500 ml, Gelatin solution 500 ml, and Albumin 500 ml. Even with many vigorous volume expansions, shock was maintained. Arterial puncture unsuccessful.

At 21 h: Dopamine (20 mcg/kg/min), Cefitriaxone sodium 1 g, Hydrocortisone succinate 300 mg, Fentanyl, IV initiated due to extreme agitation.

Coagulogram: APTT increased and low APT.

Clinical diagnosis: Meningococcemia, critically ill

Homeopathic Evaluation 22h00 (12/06/99):

(1) Etiological, clinical and anatomo-pathological diagnosis:
FEVER - Cerebrospinal fever.
GENERALITIES – Septicemia, blood poisoning.
(2) Usual and pathognomic symptoms of the disease with typical modalities:
HEAD - Congestion, hyperemia.
SKIN - Discoloration - Mottled.
GENERALITIES – Cyanosis.
(3) Local, mental and general symptoms, which emerged or suffered modification with the acute disease:
GENERALITIES – Pulse - weak.
FACE - Dryness - lips.
(4) Symptoms or causalities that broke out the acute disease (biopathographical symptons):
EAR - Inflammation - inside.

Repertorization[7]:

1. FEVER - Cerebrospinal fever.
2. GENERALITIES – Septicemia, blood poisoning.
3. HEAD - Congestion, hyperemia.
4. SKIN - Discoloration – Mottled.
5. GENERALITIES – Cyanosis.
6. GENERALITIES – Pulse – weak.
7. FACE - Dryness - of lipss.
8. EAR - Inflammation – inside.

Homeopathic Medicines	Symptoms covered	Total weight	*Symptoms*							
			1	2	3	4	5	6	7	8
Verat-v	8/8	17	3	2	1	2	3	2	3	1
Lach	7/8	19		3	3	3	3	3	2	2
Carb-v	7/8	16		3	3	2	3	3	1	1
Rhus-t	7/8	15	2	2	2		2	2	3	2
Bell	7/8	15	3	1	3		2	1	2	3
Ars-a	7/8	14	1	3	2	1	2	3	2	
Lyc	7/8	13	1	2	3		1	1	2	3
Phos	7/8	13	2	2	3		1	2	2	1
Bry	7/8	12	1	2	3		1	1	3	1
Acon	7/8	11	1	2	2		1	1	2	2

Homeopathic treatment: Veratrum viride 30 cH, single dose of 5 drops.

Conventional treatment continued.

After 1 h (12/06/99 at 23.00):

Temp. 37°C; skin coloration improved; HR 142 bpm; increase of diuresis.

Homeopathic treatment: repeated single dose of *Veratrum viride* 30 cH.

After 2 h (12/06/99 at 24.00):

Temp. 37.6°C; skin normal; increased perfusion; easily palpable pulses; HR 170 bpm; diuresis in 2 h = 1,000 ml, clear; Dopamine continued in the same dose.

Homeopathic treatment: none, observe.

After 4 h (13/06/99 at 02.00):

Temp. 37.8°C; skin normal; increased perfusion; full pulses; HR 130 bpm; diuresis = 200 ml/h; hypotension after attempting to decrease dopamine.

Homeopathic treatment: repeated single dose of *Veratrum viride* 30 cH.

After 6 h (13/06/99 at 04.00):

Temp. 37°C; skin normal; perfusion still improving; normal pulses; HR 125 bpm; diuresis = 300 ml/h; BP = 100 × 60 mmHg; face with normal color, rose colored lips.

Homeopathic treatment: none, observe.

After 8 h (13/06/99 at 06.00):

Temp. 37°C; skin normal, pulses and perfusion; HR 133 bpm; diuresis = 400 ml/h; BP = 100 × 55 mmHg; Dopamine and Fentanyl decreased.

After 10 h (13/06/99 at 08.00):

Temp. 37.2°C; skin normal, normal pulses and perfusion; HR 123 bpm; diuresis = 140 ml/h; BP = 94 × 47 mmHg with dopamine dose maintained; FiO_2 decreased gradually to 21% with saturation maintained at 98%.

Homeopathic treatment: repeat single dose of *Veratrum viride* 30 cH.

After 20 h (13/06/99 at 18.00):

Stable.

After 32 h (14/06/99 at 06.00):

Temp. 37°C; HR 99 bpm; BP = 130 × 80 mmHg; normal respiratory parameters; diuresis = 150 ml/h; conscious, oriented, cooperative and calm; asked for full glass of water; single episode of diarrhea.

After 36 h (14/06/99 at 10.00):

Extubated, no vasso-active drugs. Slight episode of bronchospasm; 4 episodes of diarrhea.

After 60 h (15/06/99 at 10.00):

Discharged from ICU: blood and urine culture negative.

Discharged from hospital on 21/06/99:

After completing antibiotic treatment, clinically well, discolouration of the skin at sites of haemorrhages.

Continued follow-up: with private doctor (allopathic pediatrician), in good condition, no recurrence. Parents requested referral to a homeopathic physician.

Evaluation by ICU team: Septic shock for Meningococcemia reverted after 24 h of treatment, haemodynamic, respiratory and renal parameters rapidly normalized. Once more, polyuria was observed even after normalization of creatinine, with no other causes. Many episodes of diarrhea observed but without clinical repercussions.

Discussion

Despite conventional therapy, invasive procedures and severe illness of patients SIRS in ICU, it was possible to select individualized homeopathic medicines. Conventional treatments and procedures were never interrupted according to commitments made to the Ethics Committee of the Amico Hospital. It was not possible to observe the diversity of symptomatic changes (homeopathic aggravations, discharges, new symptoms, return of previous symptoms etc.) after homeopathic medication and to evaluate the efficiency of the medicine chosen,[15] to ratify or rectify therapeutic action.

The results of homeopathic treatment was evaluated by using objective parameters of evaluation of homeopathic therapy (function of vital organs, need for therapy, pathological tests etc.) The efficacy of correctly chosen homeopathic medicines was signaled by rapid reestablishment of the normal function of vital organs.

The 30cH potency was preferred and seemed to give a satisfactory response without undesirable effects. Repetition of homeopathic medicine doses follow classic homeopathic criteria (cessation of improvement, return of guide-symptoms, or worsening of symptoms).

After administration of individualized homeopathic medicine, normalization of cardiac rate was often observed, concomitant with increase of diuresis and reestablishment of the renal function as proven by the laboratory parameters (plasma urea and creatinine) and reestablishment of normal ventilation dynamics shown by diminished need for ventilation and increased oxygen saturation with normalization of respiratory rate and of partial oxygen and carbon dioxide pressures.

Frass *et al* conducted a randomized, double-blind, placebo-controlled trial in ICU to evaluate how homeopathy influences the long-term outcome in these patients, using

objective and pathognomic symptoms for the choice of homeopathic medicines. Results showed that after 180 days, there was a statistically significant higher survival with verum homeopathy. The authors mentioned in discussion constraint to wider application of this method is the limited number of trained homeopaths.[16]

A collection of clinical evidence about homeopathic treatment of patients in critical condition in ICU has recently been published in *Additive Homöopathie in der Notfall- und Intensivmedizin,* offering to homeopathic physicians more technical and scientific support for this type of practice in several areas of emergency and medicine: including infectious diseases; hemostatic disturbances; cardiovascular, lung, kidney and gastrointestinal illnesses; intra and postoperative syndromes; toxicology; traumatology etc.[17]

Homeopathic training should include, beside the theoretical study experience of treatment of acute illness.

Conclusion

Various aspects need to be studied, clarified and improved in the proposed approach to homeopathic treatment of acutely critically ill patients. These include improvement in methods for choice of homeopathic medicine, control of variables that could facilitate prognostic evaluation of the response, improvement of the methods for substantiating results. Absence of a control group complicated quantitative evaluation of results. Evaluation was based on the opinion of the team of physicians in charge of the ICU.

Our experience of patients with SIRS receiving homeopathic treatment leads us to conclude that it can be used for critically ill patients in conditions unsuitable for classic homeopathic anamnesis, improving prognosis by triggering the vital response.

Further improve systematization of the semiotic, therapeutic and prognostic approaches to these cases will lead to increasingly good results. However, our initial results show potential support of homeopathic medicines in the recovery of patients in critical condition in ICU.

The practice of homeopathy may effectively be extended beyond treating chronic cases toward the less familiar but highly important frontiers on the verge of life and death.

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