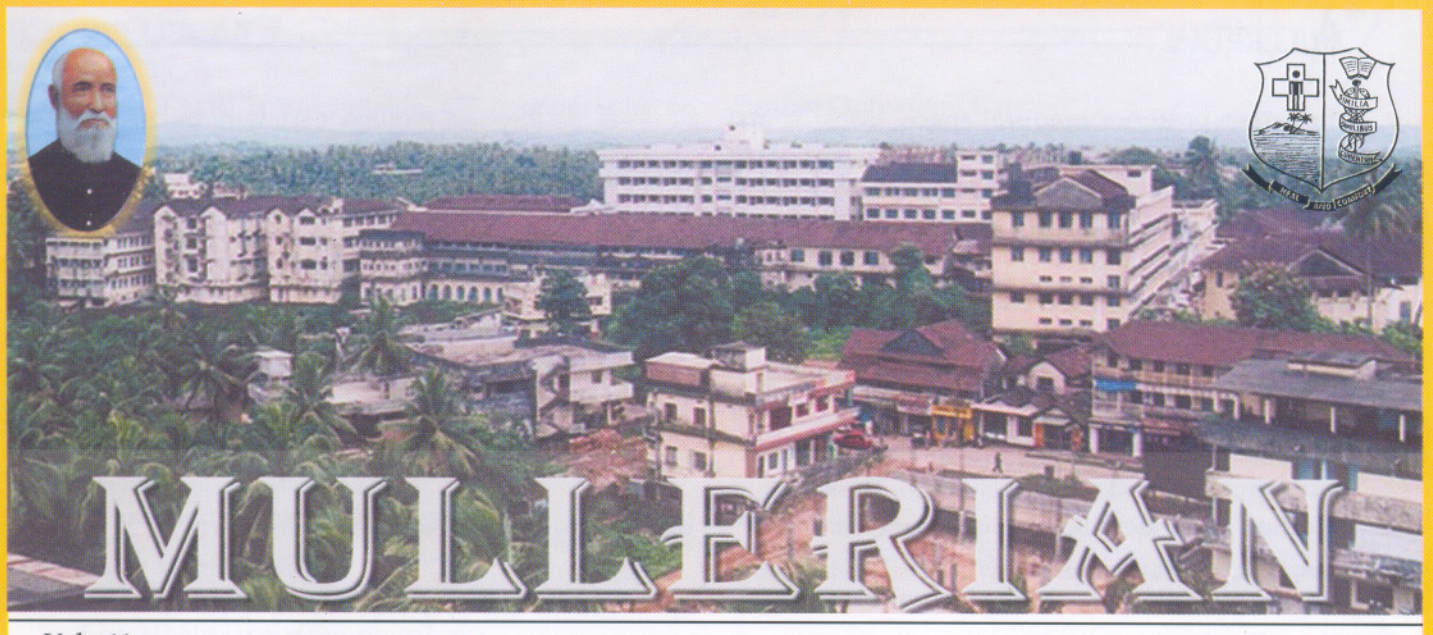

MULLERIAN

Vol - 11 April - June - 2003

EDITORIAL

Dear Reader,

The past three months of the year 2003 have been very important and eventful, beginning with the birthday celebrations of our master Samuel Hahnemann and followed by preparation as well as conducting of the University Examinations. Though the second quarter of the year began with the joyous notes of celebration of Hahnemann's birthday on 10th April, but the mood was somber with examinations in May and anticipation of the results in June.

In this issue we will bring you a case of Spinal Epidural Abscess, which is fraught with complications. The usual management is to go in for the operation, but the site of the lesion and the fear of consequences made the patient party to seek the Homoeopathic treatment. The dramatic and proper recovery of the patient over the period of stay in the hospital is in itself fascinating.

This proves the efficacy of Homoeopathic Medicines even in so-called serious illnesses. This is contrary to the general belief and fixed notion about this system of medicine. It is my appeal to all my colleagues to treat such cases with confidence and document them properly to infuse confidence in our learners. Homoeopathy cures successfully if the selection of remedy is based on totality.

Thus carrying forward our learning with ***Mullerian,*** *I invite the readers to share their feelings and learning, which we may be able to publish in the coming issues.*

Dr M.K. Kamath
Editor

SPINAL EPIDURAL ABSCESS

Introduction - Background: A spinal epidural abscess threatens the spinal cord by compression and also by vascular compromise. If untreated, an expanding suppurative infection in the spinal epidural space may impinge upon the spinal cord, producing sensory symptoms and signs, motor dysfunction, and ultimately paralysis and death. Intervention early in the course of the disease undoubtedly improves the outcome. Frequently the diagnosis is delayed because the initial presentation may be back pain alone.

Pathophysiology: Abscesses occur more frequently in

the larger posterior epidural space. Most spinal epidural abscesses occur in the thoracic area, which is anatomically the longest of the spinal regions. Hematogenous spread with seeding of the epidural space is the suspected source of infection in most. Reported sources of infection are numerous and include bacterial endocarditis, infected indwelling catheter, urinary tract infection, peritoneal and retroperitoneal infections, and others. Direct extension of infection from vertebral osteomyelitis occurs in adults and rarely in children. The source of infection is not identified in many patients.

Frequency: Because these abscesses occur rarely, the frequency is unknown.

Mortality/Morbidity: If untreated, spinal epidural abscess causes progressive weakness and death.

Sex: Recent data indicate a male predominance, likely reflecting the pattern of IV drug use.

Age: The average age is older than 50 years, but spinal epidural abscess can occur at any age.

Symptomatology : Clinical presentation may be quite variable. Early presentations may be subtle, and atypical presentations are not unusual. A 4-phase sequential evolution has been described, with (1) localized spinal pain, (2) radicular pain and paresthesias, (3) muscular weakness, sensory loss, and sphincter dysfunction, and finally (4) paralysis.

- Symptoms include the following:
  - o Fever, present in one third in one study
  - o Localized back pain in the majority, usually the first symptom
  - o Radiculopathy with radiating or lancinating pain, including truncal girdle pain
  - o Spinal cord syndrome, typically involving paraparesis with prospective progression to paraplegia: Epidural abscesses at the level of the cauda equina cause symptoms consistent with cauda equina syndrome rather than a spinal cord syndrome.
  - o Sphincter dysfunction
  - o Headache and neck pain: These may be present, especially with cervical epidural abscesses. (Of course these symptoms also suggest meningitis.)
  - o Physical findings vary with the degree of spinal cord compression or dysfunction.
  - o In the most advanced cases, a transverse cord syndrome is seen with motor, reflex, and sensory levels found upon neurologic examination.
  - o Localized tenderness to percussion or palpation at the site of the abscess may be noted.
  - o Signs of spinal cord dysfunction may be observed.
    - o Complete transverse spinal cord syndrome with paraplegia and sphincter dysfunction
    - o Incomplete spinal cord syndromes
  - o Reflexes may vary from absent to hyperreflexia, with clonus and extensor plantar (Babinski) responses. Areflexia may indicate spinal shock with transient inhibition of spinal reflexes.
  - o Nuchal rigidity may be present, particularly with cervical epidural abscesses.

Differential Diagnosis : Alcohol (Ethanol) Related Neuropathy, Cervical Spondylosis, Epidural Hematoma, HIV-1 Associated Vacuolar Myelopathy, Leptomeningeal Carcinomatosis, Metastatic Disease to the Spine and Related Structures, Multiple Sclerosis, Spinal Cord Hemorrhage, Spinal Cord Infarction, Subdural Empyema, Subdural Hematoma, Tropical Myeloneuropathies, Vitamin B-12 Associated Neurological Diseases.

Lab Studies:

- Complete blood count (CBC), serum electrolytes, blood cultures, and preoperative lab studies
- Elevated erythrocyte sedimentation rate (ESR) of course is a nonspecific laboratory finding and is not invariably present.

Imaging Studies:

- If available, spinal MRI is the procedure of choice.

- If MRI is unavailable, CT myelography or conventional myelography can reveal an intraspinal extramedullary mass-a "surgical" lesion.

Other Tests: Lumbar puncture (LP) is relatively contraindicated if spinal epidural abscess is suspected. However, LP may be essential to exclude meningitis from the differential diagnosis. Lumbar puncture runs the risk of introducing purulent material into the subarachnoid space.

Treatment - Medical Care:

- Treatment consists of both medical and surgical therapy.
- Because of the rarity of the disorder, no randomized trial results are available to guide the clinician.

Surgical Care:

- Emergency surgical decompression of the spinal cord and drainage of the abscess is the usual surgical treatment.
- Increasing neurologic deficit, persistent severe pain, or persistent fever and leukocytosis are all indications for surgery.

Follow-up - Further Inpatient Care:

- Frequent neurologic assessment to detect any progression of neurologic deficit, particularly weakness, is required.
- Postsurgical patients require monitoring of neurologic status as well.
- If the patient has a deficit from spinal cord damage, nursing attention for skin care, catheter care, and Physiotherapy may be necessary.

Further Outpatient Care:

- Rehabilitation for any residual neurologic deficit may be necessary. This would include restrengthening programs and ambulation retraining.

Complications:

- The many complications of spinal cord injury include bladder dysfunction, decubiti, supine hypertension, recurrent sepsis, and other problems.

Prognosis:

- No studies have been done to assist in predicting prognosis.
- Generally, prognosis may be related to the duration of spinal cord dysfunction and the degree of cord impairment at the time of diagnosis.

Medical/Legal Pitfalls:

- Failure to diagnose spinal epidural abscess promptly is the greatest pitfall.
- Given the multitudes of patients presenting to emergency departments for treatment of back pain, recognizing this relatively rare, emergent, and potentially treatable condition is a challenge.
- Neurologic findings or complaints such as weakness in the extremities, root pain, a sensory level, or increased reflexes (often with clonus, spasms, and spasticity) may prompt further evaluation.
- High-risk behavior, and especially I.V. drug abuse, should heighten suspicion.

CASE - SPINAL EPIDURAL ABSCESS

A female patient aged 28 years was undergoing treatment in a renowned hospital at Mangalore for the complaints of acute exacerbation of *Ulcerative Colitis*. There she developed severe pain[3] and stiffness[3] of neck along with weakness and emaciation of extremities. With the help of MRI scan it was diagnosed as a case of *Epidural Abscess*. Immediate surgery was advised and the patient party was also told that the surgery might end up with serious complications.

In order to avoid surgery and its complications the patient was brought to Fr Muller Homoeopathic Hospital and was admitted on 21-12-02 with the following presentation.

LOCATIONS	SENSATIONS	MODALITIES	CONCOMITANTS
Neck (Nape of the Neck) Since one week Sudden onset with Radiation upwards to the occiput	Pain[3] Stiffness[3] Unable to turn the head No swelling	<Slightest motion <Jerk <Tension <Anticipatory Anxiety	Weakness of Limbs[3] Emaciation[2] No fever Drowsiness[3] Appetite - decreased[3] Sleep - decreased[2] No vomiting
GIT - Rectum Since 4 years	Involuntary, loose, bloody stools with mucus, 15-16 times a day Pricking pain Increased urge for stool	<After food >After stool >Warm water <Tension	Loss of weight

Past History - Nothing significant

Family History - Mother died of Krukenberg's Tumor

On Examination -

Patient semiconscious, poorly built, mal nourished. Was unable to respond to the commands.

Temp - 98.6°F. pulse - 84/min. B.P. - 130/90mmHg

Pallor ++, C-0, J-0, E-0, Wt - 32Kg.

CNS Examination :

Neck - Tenderness[3]

Unable to move[3]

Stiffness[3]

All cranial nerves - clinically normal

Motor system - normal

Kernig's sign - negative

Sensory system - clinically normal

Investigation - MRI Scan of cervical spine on 20-12-02

Right Epidural lesion C3-C6 level, displacing cord to left with focal enlargement of cord C3 - C5 level. Possibility of an Epidural Abscess.

Management : Considering her general condition and her inability to take anything orally, I.V. 5% Dextrose was started.

Homoeopathic medicine was prescribed based on the following totality-

1. Pain in the nape of the neck extending upwards to occiput
2. Pain and stiffness of neck <slight jerk, <tension
3. Anticipatory anxiety
4. Drowsiness, Dullness and Dizziness
5. Muscular weakness
6. Lack of Muscular coordination.

Gelsemium 30, one dose was given to the patient on first day of admission, on 21-12-02.

Follow-ups:

Criteria -

1. Neck pain
2. Neck stiffness
3. Dullness/Drowsiness
4. Weakness
5. Muscular coordination
6. Sleep
7. Bowels

DATE	OBSERVATIONS	REMEDY	REASONS
22-12-02	>+ | +++ | ++ | ++ | S | G | S Sleep -good for the first time. Motion - loose, bloody with mucus, every one hour	1. Gels 30 1p 2. I.V. continued	
23-12-02	>+ | >+ | >+ | ++ | >+ | G | > Motion - Frequency >, otherwise unchanged, but c/o pain abdomen - pricking and burning. Bloody stools with mucus, and with chills.	1. Canth 200 1P 2. I.V. stopped. Adv Oral intake of liquids	The second sector presenting symptoms with more intensity and characterestics.

DATE	OBSERVATIONS	REMEDY	REASONS
24-12-02	>+ | >+ | >+ | >+ | >+ | G | >++ Generally feels better. Motion frequency >+++, no blood & mucus, Chills - 0. Number of stools 4/D, Pain abdn >+	1. Gels 30 1p	
26-12-02	>++ | >++ | >++ | >++ | >+ | G | < Now able to getup with support. Motion - 11/day, with bloody stools.	1. Canth 1M 1p	Patient initially responded well to Canth 200 1p , but as there was a relapse the potency of Canth was raised.
28-12-02	>++ | >++ | >++ | >++ | >++ | G | > Pain in the neck only while getting up. Can move her head with mild stiffness. Motion unchanged but frequency >++	1. Gels 30 1p 2. Light solid food advised	
30-12-02	0 | >++ | >++ | >++ | >++ | G | S Sits properly without support. Weight 35kg. Stools are bloody with mucus, and chills. Frequency increased with <Night++. Stools are changeable.	1. Puls 30 1p	New totality in the G.I. sector
02-01-03	0 | >++/+ | >++ | >++ | >++ | G | >++ Blood and mucus in stool >++ Patient feels generally better, but neck stiffness still +.	1. Gels 200 1p	Though the patent is generally better, the neck stiffness was still present. So the Gels was raised to 200.
05-01-03	0 | >3+ | >++ | >++ | >++ | G | >++ Motion only 3/d. Weight 36kg	1. Gels 200 1p	
10-01-02	0 | >3+ | >3+ | >3+ | N | G | >++	1. Gels 200 1p 2. Repeat MRI	
11-01-02	MRI Report - Normal study of cervical spine. Epidural lesion seen in the previous scan is resolved. Hb- 10.2g%. Weight 40kg. Patient was Discharged	1. Placebo daily 2. Puls 200 SOS	

> is better. < is worse.S - indicates no changes. G - is good.

Later on constitutional totality was collected and patient was given Nat mur 200. Patient still reports to the OPD once a month for regular follow-ups. Last reportd on 14-06-03 - Had no complaints. Weight is 47 kg.

Discussion - This case confirms that critical and complicated cases can also be managed successfully with homoeopathic medication. This case also suggests the importance of supportive treatment in the general management of such cases.

NEWS IN CAMPUS

1. Hahnemann Day Celebrations : The Faculty and Students of Fr Muller Homoeopathic Medical College celebrated birthday of Dr Samuel Hahnemann on 10th April 2003 with great reverence and enthusiasm.

The chief guest Dr Ravi.M.Nair, former Advisor of Homoeopathy to Govt. of India, inaugurated the Hahnemann's day celebrations. In the inaugural address he highlighted the various aspects of Hahnemann's life and emphasized the need of advanced study and research in Homoeopathic system of medicine. He also appreciated the work of Fr Muller Homoeopathic Medical College in the field of homoeopathic education and practice.

Rev. Fr Baptist Menezes, Director of Fr Muller Charitable Institutions, who presided over the function, emphasized the importance of value based

Homoeopathic Medical Education. He also stressed on the necessity of creating public awareness and treatment of needy and downtrodden people through Homoeopathic system of medicine.

Rev. Fr Stany Tauro, Administrator, felicitated all the participants and appealed to all the faculty and students to derive learning from the life of the founder. He also emphasised the need of research in Homoeopathy.

Dr S. K. Tiwari welcomed the gathering and introduced the chief guest. Dr Valarmathy Fernandes, Convener of the program delivered the vote of thanks.

The inauguration program was followed by various academic and cultural activities.

2. Teachers' Orientation Program : A one-day workshop on Effective Classroom Communication for the teaching Faculty of Fr Muller Homoeopathic Medical College was organized on 14th June 2003. Dr Anandi Martis, Professor of Education, St Ann's College of Education, Mangalore, was the resource person.

Inaugurating the workshop Rev. Fr Stany Tauro, the Administrator of Fr Muller Homoeopathic Medical College and Hospital, expressed his happiness and called upon the Staff to enrich themselves with various modes of Communication Skills used in the classroom.

The objectives of the workshop were -

1. Understanding the meaning, types and phases of Communication.
2. The concepts of teaching and learning.
3. Skills of effective classroom communication.

The entire teaching faculty participated actively in the session.

3. Awards : Mr Sathish Arabindo, Mr Vivek M, Mr Subhash S., Mr Sabarish, students of Final BHMS were selected for RGUHS cultural scholarship for the year 2001-2002.

4. College reopened after a short vacation on the 23rd of June '03.

5. Our college was one of the Examination Centers for RGUHS Examinations May 2003 - for the UG, from 7th May 2003 to 14th May 2003.

6. Results of MD(Hom) Examinations March 2003 conducted by RGUHS Karnataka are announced. The college has got 100% results.

7. Free Medical Camps - Medical camps were organized by Fr Muller Homoeopathic Medical College in the following places -

27-04-03	Maroli Paade	65 cases
29-05-03	Vittal	48 cases
21-06-03	Salettur	102 cases

Free Regular monthly camps were conducted in following places

	April	May	June
Pavoor	15	21	20
Bela	261	232	233

FACULTY IN LIGHT

Dr S.K. Tiwari was appointed as the external Examiner by N.T.R. Health University Andhra Pradesh to conduct MD(Hom) II examinations at J.S.P.S. Homoeopathic Medical College, Hyderabad on 16th June 2003.

Dr S. K. Tiwari was invited to deliver a talk on 'Homoeopathic Concept of Oncogenesis', at a workshop on Homoeopathic treatment of Cancer, on 18th June 2003. The program was organized by Govt. Homoeopathic Medical College, Calicut and sponsored by Department of ISM & H, Ministry of Health and Family Welfare, Govt Of India. Dr Sunny Mathew, Dr Shivaprasad,Dr Alphonse D'Souza, and Dr Roshan Pinto, Dr Girish Navada participated in the workshop.

Dr Srinath Rao and Dr Girish Navada attended a workshop on "Environmental Issues and Pollution Control" organized by RGUHS Karnataka, Bangalore on 28-5-2003.

RGUHS Karnataka, Bangalore, appointed Dr M. K. Kamath as Observer for the Examinations conducted in May 2003.

The following faculty members were appointed as external Examiners for conducting BHMS examinations in various centers of RGUHS Karnataka, Bangalore - Dr S. K. Tiwari, Dr M. K. Kamath, Dr Roshan Pinto, Dr (Sr) Vida Olivera, Dr D. J. Karat, Dr Alphonse D'Souza, Dr Guruprasad, Dr Praveen Raj, Dr Joseph Thomas.

Dr S. K. Tiwari, Dr S. Rao, and Dr Shivprasad, were appointed as external examiners by Goa University to conduct BHMS Examinations.

Dr Girish Navada, and Dr N.C. Dhole were appointed as external examiners by MG University Kottayam.

PHOTO ALBUM

Chief Guest Dr Ravi M. Nair, Former Adviser of Homoeopathy to Govt. of India inaugurating the Hahnemann's Day Celebrations 2003.

Rev. Dr Baptist Menezes, Director, FMCI delivering the Presidential Address on the occasion of Hahnemann's Day Celebrations 2003.

Medi-Quiz conducted by Dr Guruprasad on the occasion of Hahnemann's Day Celebrations 2003.

Inauguration of Workshop on Effective Class Room Communication for the teaching faculty by Rev. Fr Stany Tauro, Administrator, FMHMCH.

A Medical Camp in Salettur conducted by Fr Muller Homoeopathic Medical College in Progress.

ALUMNI NEWS

It is good news all around with celebrations. The following alumni got married

Dr B Anantharaman ('91 Batch) with Vidya on 9-06-2003.

Dr F.X. Bruno Xavier ('94 Batch) with Suja on 26-05-2003.

Dr K C Annadore ('95 Batch) with Annapoorna on 26-06-2003.

Dr Karishma K ('96 Batch) with Srikanth on 21-05-2003.

Dr Dhanya ('96 Batch) with Abhilash on 24-04-2003.

Dr Saritha G ('96 Batch) with Ramesh on 4-05-2003.

We wish them all a Happy Married Life.

Admission 2003

FR MULLER HOMOEOP ATHIC MEDICAL COLLEGE

(Religious Minority Institution)

CONDUCTING FOLLOWING COURSES

M.D. (HOMOEOP ATHY)

Subject	:	1. Material Medica 2. Organon 3. Repertory
Course Duration	:	3 years
Eligibility	:	B.H.M.S. Degree
Last date of submission of filled in application forms	:	19.08.2003
Date of Entrance Test	:	30.08.2003
Date of Interview	:	31.08.2003
Last date of Admission	:	15.09.2003

Prospectus and Application fees : Rs. 500/-

Prospectus and Application forms can be obtained from:

The Admission Officer

Fr Muller Homoeopathic Medical College & Hospital

Fr Muller Road, Kankanady, Mangalore 575 002

CONGRA TULA TION

Dr B.S. Nataraj MD (Ay) is appointed as Director of Indian System of Medicine & Homoeopathy Govt of Karnataka.

Fr Muller Homoeopathy Medical College congratulates the New Director on this appointment and wish him all the success.

HOMOEOP ATHIC CONFERENCE - 2003

Organised by

Fr Muller Homoeopathic Medical College, Mangalore

On

13th and 14th December 2003

Venue - Conference Hall,

Fr Muller Institute of Health Sciences

CLINICAL THEMES

Boger's Repertory in the selection of Simillimum

Homoeopathy in Neurological Disorders

Low Back Pain

Scientific papers are invited in the above clinical themes

(Last date for the receipt of scientific papers - 31st Oct. 2003)

Registration Fees	Before 31st Oct. 2003	After 31st Oct. 2003
Delegates	Rs. 400/-	Rs. 500/-
Student / Intern	Rs. 300/-	Rs. 400/-

For further details contact -

Dr Alphonse D'Souza, Organising Secretary

Fr Muller Homoeopathic Medical College and Hospital

Ph : 0824 - 2436301 - 307 (7 lines) Mobile : 98452 91121

e-mail : souzaalphs@hotmail.com

Senders Name and Address

Fr Muller Homoeopathic Medical College & Hospital

Fr Muller Road, Kankanady,

Mangalore 575 002

BOOK POST

To