Vol 23 Quarterly Bulletin of Father Muller Homoeopathic Medical College and Hospital Jan - March 2009

EDITORIAL

Dear Readers,

In our previous issue we had tried to perceive the significance of time, and now we have reached a definable and landmark moment in the history of Father Muller Homoeopathic Medical College. A total of 973 young students have walked out as homoeopathic graduates to serve humanity, since its inception in 1985.

And now the august institution stands on the eve of passing another milestone in the month of June 2009, when it will start celebrating 25 years of its establishment. To commemorate the Silver Jubilee Year of the Father Muller Homoeopathic Medical College there will be lots of academic and extracurricular events.

The year 2009 has begun well with the commencement of a Clinical Research Project in collaboration with BARC, Mumbai. This association is a big step for us in the field of research. Hopefully this opens up many opportunities for the college in taking up research activities quite seriously.

For the second consecutive year one of our students has bagged a Gold Medal from RGUHS during the Convocation 2009, for the highest marks in Final Year BHMS course, in the subject of Materia Medica. This year the awardee is Dr Sandeep Patil (2002-07 Batch). Hope in the years to come many more will be inspired by these achievements.

In this issue of ***Mullerian*** *we will be discussing an interesting case of Renal Failure. This case demonstrates the reversal of symptoms when the right remedy is prescribed. This case also demonstrates the efficacy of Homoeopathy in the so called incurable cases. Thanks to our Alumnus Dr T Semparuthi from Madurai, who has contributed this case for our learning.*

So dear friends, welcoming you once again to join us in this journey of learning.

Dr M K Kamath
Editor

CHRONIC RENAL FAILURE

Introduction

Chronic kidney disease (CKD) is a worldwide public health problem and is now recognized as a common condition that is associated with an increased risk of cardiovascular disease and chronic renal failure (CRF).

The Kidney Disease Outcomes Quality Initiative (K/DOQI) of the National Kidney Foundation (NKF) defines chronic kidney disease as either kidney damage or a decreased kidney glomerular filtration rate (GFR) of less than 60 mL/min/1.73 m^2 for 3 or more months. Whatever the underlying etiology, the destruction of renal mass with irreversible sclerosis and loss of nephrons leads to a progressive decline in GFR. The different stages of chronic kidney disease form a continuum in time; prior to February 2002, no uniform classification of the stages of chronic kidney disease existed. At that time, K/DOQI published a classification of the stages of chronic kidney disease, as follows:

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CAMPUS NEWS

A Clinical Research Project in collaboration with BARC, Mumbai was launched at Father Muller Homoeopathic Medical College Hospital on the 15th of January 2009. Rev. Fr Patrick Rodrigues, Director, Father Muller Charitable Institutions inaugurated the Research Laboratory and launched the project by first experimenting the instrument ANU-PHOTO-RHEOGRAM which is sensitive to detect the minute variations in circulation, heart rate and activity of Autonomic Nervous System.

In connection with the **'Anti Leprosy Day',** a study session was organized by the Department of Community Medicine, Father Muller Homoeopathic Medical College, Deralakatte on 31.01.2009. Dr Nanda Kishore, Professor & HOD, Dept. of Dermatology, Father Muller Medical College was the resource person and delivered a Lecture on "Recent Trends in Diagnosis & Treatment of Leprosy". The Faculty members, P.G. Students, Interns and BHMS students attended the programme.

Dr Sandeep Patil (2002-07 Batch) was awarded Dr Sundar Rao Gold Medal by RGUHS Karnataka, Bangalore during the Convocation 2009, for the highest marks in Final Year BHMS Course in the subject of Materia Medica.

BHMS EXAMINATION RESULTS - December/ January 2008-09

	Appeared	Passed
I BHMS	75	64
II BHMS	63	53
III BHMS	59	58
IV BHMS	59	58

HIGHEST MARKS

	Name of the Student	Percentage
I BHMS	Isha Ibrahim	72.7
II BHMS	Laxmi A	73.63
III BHMS	Kannan D	66.93
IV BHMS	Nicola Coutinho	72.87

The Extension Building of Ladies Hostel at Deralakatte with a capacity of 108 rooms was inaugurated and blessed by Rev. Fr Patrick Rodrigues, Director of Father Muller Charitable Institutions, on Monday, the 9th February 2009. He expressed his joy in completion of the building and thanked the persons responsible for the same. *contd... on page 7*

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- Stage 1: Kidney damage with normal or increased GFR (>90 mL/min/1.73 m^2)
- Stage 2: Mild reduction in GFR (60-89 mL/min/1.73 m^2)
- Stage 3: Moderate reduction in GFR (30-59 mL/min/1.73 m^2)
- Stage 4: Severe reduction in GFR (15-29 mL/min/1.73 m^2)
- Stage 5: Kidney failure (GFR <15 mL/min/1.73 m^2 or dialysis)

In stage 1 and stage 2 chronic kidney disease, GFR alone does not clinch the diagnosis. Other markers of kidney damage, including abnormalities in the composition of blood or urine or abnormalities in imaging tests, should also be present in establishing a diagnosis of stage 1 and stage 2 chronic kidney disease.

The K/DOQI definition and the classification of chronic kidney disease allow better communication and intervention at the different stages.

Causes

- Vascular disease - Renal artery stenosis, vasculitides, atheroemboli, hypertensive nephrosclerosis, renal vein thrombosis
- Primary glomerular diseases
- Secondary glomerular diseases - Diabetes mellitus, systemic lupus erythematosus, rheumatoid arthritis, postinfectious glomerulonephritis, endocarditis, hepatitis B and C, syphilis, human immunodeficiency virus (HIV), parasitic infection, heroin use, gold, penicillamine, amyloidosis, etc
- Tubulointerstitial disease - Drugs, infection, Sjögren syndrome, chronic hypokalemia, chronic hypercalcemia, sarcoidosis, heavy metals, radiation nephritis, polycystic kidneys
- Urinary tract obstruction

Pathophysiology

Approximately 1 million nephrons are present in each kidney, each contributing to the total GFR. Regardless of the etiology of renal injury, with progressive destruction of nephrons, the kidney has an innate ability to maintain GFR by hyperfiltration and compensatory hypertrophy of the remaining healthy nephrons. This nephron adaptability allows for continued normal clearance of plasma solutes so that substances such as urea and creatinine start to show significant increases in plasma levels only after total GFR has decreased to 50%, when the renal reserve has been exhausted. The plasma creatinine value will approximately double with a 50% reduction in GFR. A rise in plasma creatinine from a baseline value of 0.6 mg/dL to 1.2 mg/dL in a patient, although still within the reference range, actually represents a loss of 50% of functioning nephron mass.

Factors other than the underlying disease process and glomerular hypertension that may cause progressive renal injury include the following:

- Systemic hypertension
- Acute insults from nephrotoxins or decreased perfusion
- Proteinuria
- Increased renal ammoniagenesis with interstitial injury
- Hyperlipidemia
- Hyperphosphatemia with calcium phosphate deposition
- Decreased levels of nitrous oxide
- Smoking

Clinical Features

Initially it is without specific symptoms and can only be detected as an increase in serum creatinine or protein in the urine. As the kidney function worsens:

- Blood pressure is increased due to fluid overload and production of vasoactive hormones, increasing one's risk of developing hypertension and/or suffering from congestive heart failure.
- Urea accumulates, leading to azotemia and ultimately uremia (symptoms ranging from lethargy to pericarditis and encephalopathy). Urea is excreted by sweating and crystallizes on skin ("uremic frost").
- Hyperkalemia - with a range of symptoms including malaise and potentially fatal cardiac arrhythmias

- Erythropoietin synthesis is decreased (potentially leading to anemia, which causes fatigue)
- Fluid volume overload - symptoms may range from mild edema to life-threatening pulmonary edema
- Hyperphosphatemia - due to reduced phosphate excretion, associated with hypocalcemia (due to vitamin D3 deficiency). The major sign of hypocalcemia being tetany.
    - ✦ Later this progresses to tertiary hyperparathyroidism, with hypercalcaemia, renal osteodystrophy and vascular calcification that further impairs cardiac function.
- Metabolic acidosis, due to accumulation of sulfates, phosphates, uric acid etc. This may cause altered enzyme activity by excess acid acting on enzymes and also increased excitability of cardiac and neuronal membranes by the promotion of hyperkalemia due to excess acid (acidemia)

People with chronic kidney disease suffer from accelerated atherosclerosis and are more likely to develop cardiovascular disease than the general population. Patients afflicted with chronic kidney disease and cardiovascular disease tend to have significantly worse prognoses than those suffering only from the latter.

Imaging Studies

- Plain abdominal x-ray, Intravenous pyelogram, Renal ultrasound, Renal radionuclide scan, CT scan, MRI, Voiding cystourethrogram (VCUG) are done depending on the requirement to assess the causes of CKD.

Procedures

- Percutaneous renal biopsy - It generally is indicated when renal impairment and/or proteinuria approaching the nephrotic range are present and the diagnosis is unclear. It is not indicated in the setting of small echogenic kidneys on ultrasound because these are severely scarred and represent chronic irreversible injury. The most common complication of this procedure is bleeding, which can be life threatening in a minority of occurrences.
- Surgical open renal biopsy can be considered when the risk of renal bleeding is felt to be great, occasionally with solitary kidneys, or when percutaneous biopsy is technically difficult to perform.

Treatment

Medical Care

The medical care of patients with chronic kidney disease should focus on the following:

- Delaying or halting the progression of chronic kidney disease
- Treating the pathologic manifestations of chronic kidney disease
- Timely planning for chronic renal replacement therapy

Diet

- Protein restriction early in chronic kidney disease as a means to delay a decline in the GFR is controversial; however, as the patient approaches chronic kidney disease stage 5, this is recommended to delay the onset of uremic symptoms.
- Phosphate restriction starting early in chronic kidney disease
- Potassium restriction
- Sodium and water restriction as needed to avoid volume overload

Further Care

- Patients who develop potentially life-threatening complications of chronic kidney disease should be hospitalized and closely monitored.
- A multidisciplinary approach to care, including involvement of the nephrologist, primary care physician, renal dietitian, nurse, and social

worker, should be initiated early in the course of chronic kidney disease, with close patient follow-up.

- Patients with chronic kidney disease acutely presenting with indications for dialytic therapy should be transferred to a hospital center where acute dialysis can be performed.

Prognosis

- Patients with chronic kidney disease generally progress to ESRD. The rate of progression depends on the underlying diagnosis, and on the individual patient.
- Patients on chronic dialysis have a high incidence of morbidity and mortality.
- Patients with ESRD who undergo renal transplantation survive longer than those on chronic dialysis.

Patient Education

- Patients with chronic kidney disease should be educated about the importance of compliance with secondary preventative measures, natural disease progression, prescribed medications (highlighting their potential benefits and adverse effects), avoidance of nephrotoxins, diet, chronic renal replacement modalities, including peritoneal dialysis, hemodialysis, and transplantation, and permanent vascular access options for hemodialysis.

CASE STUDY

Name: Mrs. S, Age: 34yrs, Occupation: Dentist

Lab investigation (02.11.08) Blood urea-142.7, Serum creatinine: 6.62

On initial presentation, based on the the following symptoms -

- Religios, affections
- Dryness of skin, inability to perspire
- Contented in life
- Indifference

On 2.11.08 first prescription Aur met 0/2 10ml was given

Follow-up -

5.11.08 - Blood urea: 102, Serum creatinine: 4.7

7.11.08 - Blood urea: 124, Serum creatinine: 4.9

8.11.08 - Blood urea: 107, Serum creatinine: 5.3

9.11.08 - Bld urea: 74, Ser creatinine: 5.8, Hb: 7.7

Blood Urea decreasing and Serum Creatinine increasing - Good Sign or Bad Sign ?!

CASE WAS RETAKEN

Presenting complaints

Since 20 days bitter taste in mouth with urea smell like odour, with weakness and chilliness <evening

History of presenting complaints

Complaints started with bitter taste in mouth followed by nausea, diarrhoea and then vomiting.

Past history

Up to 3 yrs of age diarrhoea

Since 2001-PCOD- Under Allopathic & Ayurvedic treatment until she developed Renal Failure

Family history

Father died because of MI, Mother has HTN

Physical generals

App; normal, Thirst: 1½L\day, Sleep: good

Stool: irregular; once in 2 days, Urine: cloudy

Perspiration: Never Sweats

Desires: sweets, egg, ice cold drinks, potatoes, butter, beans

Thermal: chilly

Menstrual history

Menarche 11yrs. Cycles: Regular. L.M.P: 17.10.08

Duration: 3-5days. Flow: Profuse for 3 days.

Clots: Occasionally. Colour: Dark red

Before Menses: pain in extremities. During menses 1st day: lower abdominal pain

Obstetric: no issues

Life space investigation

Born in Virudhunagar; 2nd child; has 2 sisters(one elder & one younger), I younger brother, married at the age of 27yrs.

Calm, reserved. Fastidious-Neatness in work. Decisive. Stage fear +

Negative thoughts for the past 2 yrs; something fatal might happen - PESSIMIST

Forgets what she decided to do

Religious+++ - Interested in reading holy books, listening to devotional songs

Weeps From emotional scenes in TV or Film

Repertorisation

1. MIND - RELIGIOUS - affections, general
2. MIND - YIELDING disposition
3. MIND - PESSIMIST
4. MIND - INDIFFERENCE, apathy - life, to
5. SKIN - DRYNESS - inability to perspire
6. GENERALITIES - HORRIBLE things, sad stories affect her profoundly

	Lyc. 14/5	**Sep. 13/6**	**Puls. 12/5**	**Nux-v. 11/5**	**Sil. 9/4**	**Zinc. 8/3**	**Nat-m. 7/5**	**Ign. 7/3**	**Caust. 6/4**	**Ph-ac. 6/4**
1	3	4	3	1	1	4	1	3	1	1
2	4	1	4	3	1	1	1	1	1	1
3	-	1	1	3	-	-	3	-	1	-
4	1	3	-	-	-	-	-	-	-	1
5	3	1	1	1	4	-	1	-	-	3
6	3	3	3	3	3	3	1	3	3	-

As the patient was thirstless & chilly, Sepia was selected as the remedy.

First Prescription - 10.11.08 - Sepia 200

Follow-ups -

15.12.08 Serum creatinine: 5.1, Blood urea: 71

Tc-9300, P-34, L-60, E-6, ESR-56mm, Hb-7.8

23.12.09 Serum creatinine-4.6, Blood urea-64

30.12.08 Serum creatinine-4, Blood urea-57, Hb-7.8

6.1.09 Serum creatinine-3.7, Blood urea-56

USG: No Sonological Manifestations of medical Renal Disease at present GALLBLADER POLYP+ - (Inference - Sycotic manifestations reappeared)

12.03.09 Serum Creatinine: 2.7, Blood Urea: 29.0

13.04.09 Serum Creatinine: 2, Blood Urea: 28.0

Only one dose of Sepia 200 was administered in the beginning after re-evaluating the case, and during follow-ups no medicines were given. This case demonstrates the effectiveness of a well selected homoeopathic remedy and its ability to overturn the perception that the CKD is irreversible.

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The Internship programme for the year 2009-10. A total number of 62 interns (students of 2004-2005 batch) joined the programme. Inaugurating the programme Rev. Fr Patrick Rodrigues, Director, Father Muller Charitable Institutions, congratulated the students for the good results in the Final Year and advised them to develop the humane values, so that the knowledge of physician is applied to the betterment of the patient; and to make the best use of the opportunity given. Rev. Fr Wilfred Prakash, Administrator, Dr S.K. Tiwari, Principal and Dr Girish Navada, Intern's Co-ordinator were present on the occasion.

School Health Check-up 26-02-2009 - A free health check-up and medical camp was organized by NSS Unit of Father Muller Homoeopathic Medical College in Kulavaru A.U.P. School in Chelair Padavu. A total of 157 students were screened for health problems. A team of 8 Doctors was lead by Dr N. C. Dhole, the NSS Coordinator.

Staff Orientation Programme -One day staff orientation programme was organised on 7-3-2009 by the management of FMHMCH. J V Global, Bangalore was the resource organisation.

Institutions Day and Graduation ceremony - 2009 took place at Father Muller Stadium, Kankanady on 13-03-2009. The Chief Guest of the function was His Excellency General (Retd.) S.F. Rodrigues, P.V.S.M., V.S.M., Governor of Punjab and Administrator, U.T. Chandigarh. Most Rev. Dr. Aloysius Paul D'Souza, Bishop of Mangalore and the President of FMCI presided over the function. Around 74 U.G. Homoeopathy and 14 P.G. students were graduated on that day. Dr Lydia Lobo was awarded 'Best Outgoing Student'.

ROTP 23rd to 28th March 2009 - Reorientation Training Programme for the Teachers of various Homoeopathic Medical Colleges was organized in the subjects of Forensic Medicine & Toxicology and Homoeopathic Repertory in association with Department of AYUSH, Govt of India. A total number of 50 teachers participated as delegates. Dr M. P. Arya, Honorable Director, Reseach Centre, D.S.Homoeopathic Medical College Pune, inaugurated the programme.

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Medical Camp at Ranipura 27-03-2009 - A team of Doctors lead by Dr Jacintha Montheiro, participated in a Medical Camp organized by CODP, Mangalore. A total of 184 patients were given free health checkup and medicines.

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