TEXTBOOK

of

PRACTICE OF MEDICINE

with homoeopathic therapeutics

Third Revised and Enlarged Edition

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PUBLISHER'S NOTE TO THE THIRD EDITION

The present edition of '*Textbook of Practice of medicine with Homoeopathic Therapeutics'* has been revised to keep our readers in step with the latest advancements made in the field of medicine and homoeopathic therapeutics. It has been made an easy reference by the addition of flow charts, images and updated list of homoeopathic therapeutics but keeping in view the need of the students the irrelevant matter has been avoided in the book making it a handy reference.

The third revised edition includes:

- Therapeutic index at the end of each chapter for quick and easy reference
- A separate chapter on the 'Diseases of Liver and Biliary system'
- New chapters have been added such as 'Lifestyle disorders'; 'Geriatric diseases'; Diseases of water and electrolytes imbalance'
- Investigations have been revised in accordance with the recent advancements
- The best pattern of teaching medicine which includes definition, etiology, signs and symptoms, lab investigations, differential diagnosis, complications, treatment with complete Homoeopathic therapeutics which has been greatly enlarged.

The book will definitely prove to be a constructive part in the studies of a serious learner.

I will be glad to receive constructive suggestions and healthy criticism from diligent and serious readers of the profession to augment the literature.

Finally, I would like to thank all the contributors for this great work especially Dr Yogesh D. Niturkar who has put diligent efforts in giving this edition the current form.

Kuldeep Jain
CEO, B. Jain Publishers (P) Ltd.

PREFACE TO THE FIRST EDITION

In the later years of my course in homoeopathic college, studying practice of medicine and homoeopathic therapeutics, created a confusion. I felt some kind of integration was required. I passed out with this desire to make a complete textbook of medicine comprising the study of diseases, their management and homoeopathic treatment.

When I started working on this project in 1988, I had a naive idea whether this work will ever be completed, as practice of medicine is a continuously growing subject; new inventions, discoveries and approach to the patient are being added every year. Another aspect which forced me for this attempt was a question which is still being put often to a homoeopathic student regarding the value of "Diagnosis." I hope this work of mine would explain this subject at length.

It is expected in homoeopathic fraternity to have controversial comments over the "generalized" therapeutic approach to the nosological diseases (disease complexes bearing names). Working over a decade and a half, I have come across the situations when scanty information from the patient, on account of emergency situation, lack of information on the part of patient, his intelligence and in the treatment of all those diseases which exhibit at very late and terminal stages (it is true, we expect lot of relevant information from patient, but patients quite often or at least initially do not think in homoeopathic way), it becomes necessary to base your prescription on visible signs and supportive laboratory procedures. The medicines mentioned in the treatment part are those which have a pathophysiological affinity and action on that particular organ or system.

Here I quote the high authority of that mast of homoeopathy, Dr. Constatine Hering for the legitimacy of this method, which he also followed in the great work. "The Guiding Symptoms". He said that he used the disease designation, and, the remedies mentioned against it are not for the purpose of recommending

the particular remedy for that disease as a patent but to show the great variety of remedies (bearing similar pathophysiological field of action) that may be used for any form of disease when otherwise indicated.

For the same reason, I would repeat that I made an attempt to prepare this book as this would be a practical handbook to a student as well as a practitioner and any aid for finding the curative remedy ought to be utilized. As Dr J. Compton Burnett expresses it, "The fact is we need any and every way of finding the right remedy; the simple simile, the simple symptomatic similimum and farthest reach of all-the pathological similimum, and I maintain that we are still well within the lines of homoeopathy that is expansive, progressive, science fostered and science fostering."

I cite a few examples here to strengthen the above quoted masters' principles. In the case of pneumonia, there are two things, *Aconite* and *Bryonia* are indicated in stage of congestion; *Ant. ars.* in the stage of red and grey hepatization and medicines like *Nat sulph., Merc. cor., Silicea* in the stage of resolution. And secondly, all these can only be prescribed when they match with their symptoms in patient - pain in chest, high feverish stage, anxiety, thirst are all must for *Aconite* to be thought for and, dry cough, rust coloured sputa, chest pain worse by coughing and deep inspiration, better by holding or pressing over the chest and rt. sided involvement cannot miss *Bryonia* and so on.

Thirdly, the oft-used expression that these are liver remedies and that group is of heart remedies, what is that? It is the same; their affinity to the diseases originating from that particular system or organ.

Now question comes of "Individualization", I recommended, do not miss any opportunity where individualistic, uncommon, peculiar, rare reaction is exhibited by a patient in a particular disease situation. For example, no matter what the disease is, if anxiety about health, fear of death, despair of recovery or hopefulness with the grievous pathology are the symptoms overlapping the symptoms of disease, they often make the basis to prescribe the indicated similimum curing the disease. But as I have quoted earlier, try to see as far as possible that similimum should also bear pathological similarity.

The dosage needs some apology. I have followed the lines led by Dr. Hahnemann and suggest the principle of deeper and extensive the pathology, lower should be the potency and in higher functional and psychiatric illnesses higher potency is advisable. But, I would suggest in most of the diseases described here 30th potency would be appropriate.

Now about the contents of the book. The book contains individual chapters pertaining to individual systems from diseases of cardiovascular system to diseases of muscles. Owing to the efficacy of homoeopathy in the book, special emphasis on relation of mind and diseases is the main feature of chapters on psychological diseases.

Imaging techniques have revolutionized the diagnostic procedures; from radiography to MRI scanning and introduction to all these are specially contributed.

At last appendix contains glossary, clinical procedures, normal values and therapeutic diets which are indispensable in managing cases and making a perfect prescription.

I wish to express appreciation to my many associates and colleagues who, as experts in their fields, have helped me with constructive and valuable criticisms of the chapters. I wish to thank the following for many helpful suggestions: Drs. Balvinder Singh, Kusum Sajwan, Vandana Sood, Anil Goyal, Mala sharma, Renu Aggarwal, Deepak Sharma, Ajay Gupta, Rajani Sharma, Sunil Batra, Babita Gupta, A.K. Gupta, V.P. Gupta, Peter Kubis, Tilman Brockhardit, Amrish Tayal, Susanne Wolf, Sonika Soni, Rakesh Saxena and Mridula Pandey.

This book could not have been edited without the dedicated help of my co-worker Dr. Rakesh Kaushal. We both are especially indebted to Dr. Bindu Kohli, Dr. Sangeeta Dhingra, Santosh Gupta, Jagdish Kumar, Mrs. Sita and Bachan Singh.

Finally, I need to say a word of thanks to our colleagues at B. Jain Publishers and Mr. Kuldeep Jain, Director. They formed a most effective team who gave constant encouragement, and were of enormous help in the countless efforts involved in brining this complex effort to fruition.

2nd March, 1995, New Delhi. **Dr. Kamal Kansal**

PREFACE TO THIRD REVISED AND ENLARGED EDITION

The present third revised and enlarged edition of "Textbook of Practice of Medicine with Homoeopathic Therapeutics" is having concise and updated knowledge on medicine and homoeopathic therapeutics. The chapters have been revised with addition of flow charts, new images; upgraded list of homoeopathic therapeutics with addition of remedies and its therapeutics part. All chapters are renamed with current terminologies except infectious and veneral diseases, tropical diseases, paediatrics, and behavioral disorders in children and poisoning. At the end of each chapter therapeutic index of diseases is given for quick and easy reference. Gastrointestinal diseases that are related to liver and biliary system have been separated and incorporated as a separate chapter titled as 'Diseases of Liver and Biliary System'. For effective understanding, the chapters on 'Diseases of muscles and joints and connective tissues' have been combined under chapter titled as 'Diseases of Locomotor System'.

Newly written chapters are lifestyle disorders, disorders of water and electrolytes imbalance and geriatric disorders. Investigations part has been revised as per the advancement in the medical field for accurate disease diagnosis. For easy reference reading, more words have been added to the glossary. Long forms and list of remedy abbreviations have been newly added. The chapter on 'New Born Infants' has been removed from the book considering its vastness and its scope in this current edition. All chapters have been added with details on therapeutic aspect of each remedy from source books of Homoeopathic Materia Medica.

I thank Mr. Kuldeep Jain, Director B Jain Publishers, Mr. Manish Jain, Dr. Geeta Arora and Dr. Isha Gupta for providing me this opportunity and for their expert guidance. Last but not the least I would like to thank my family members, teachers at Dr. M. L. Dhawale Memorial Homoeopathic Institute, Mumbai, friends and students for their extraordinary support and constructive

criticism which has brought this work into daylight. I would also like to thank all authors of this book for their herculean efforts in the construction of this work on Medicine.

Medicine and Homoeopathic therapeutics is as vast as an ocean and all authors of this book have tried to make it concise for better perceiving of this subject. We will be glad if the homoeopathic fraternity gives us constructive feedback for the betterment of Homoeopathic literature. I am glad that I have completed this book on the auspicious day of Guru Pournima and I dedicate this work to all my teachers for Homoeopathic enlightenment.

At last I hope and assure that this book will be a significant and most valuable tool for every learner, teacher and the practitioner in their service to humanity through Homoeopathy.

19th July 2016 **Dr. Yogesh D. Niturkar**

Guru Pournima

Latur

Maharashtra

CONTENTS

CASE TAKING: BOTH PERSPECTIVES AND NEED FOR KNOWLEDGE OF MEDICINE

Perhaps, one of the most oft-used expression in the homoeopathic circles is that case-taking is both a science and an art. The information acquired is as verifiable as any scientific data, but its acquisition and gathering is a real art. However, at the end of an arduous time spent with the patient, what and how much is 'relevant' homoeopathic information, can only be decided if the physician has a clear and concise idea about the 'disease' the patient is suffering from. This is where a sound knowledge of medicine and diseases comes in. Gathering information is easy; the difficulty and danger is in the 'interpretation'. How much of his presenting illness is a known part of a disease syndrome and how much is 'peculiar' to him as individual cannot be gauged without a thorough knowledge of medicine.

Therefore, an amalgamation and osmosis is required between homoeopathy and the so-called modern medicine. A patient presenting with a disease state expects more than just a prescription. He desires and expects to be made aware of what ails him, its prognosis and curability in any system of medicine. To be able to prescribe, prognosticate and advise him regarding the diet and regimen, knowledge of evolution and progress of disease is a must.

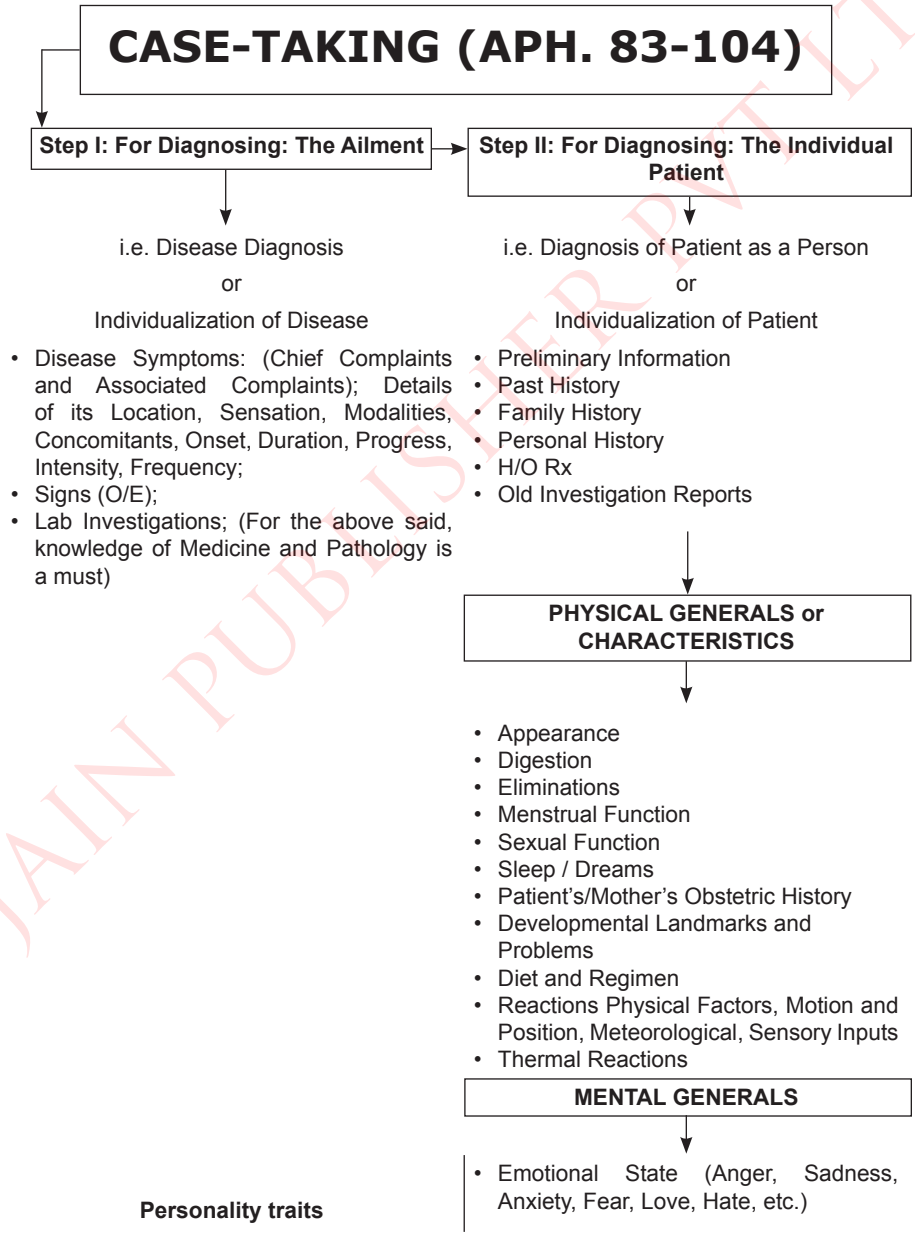
Curing an illness is one thing, but to prove it to the sceptics in our own circles, as well as, in the whole medical fraternity, well supported documentation by laboratory tests is a must. The claim of a cure must be evidently consistent with the accepted vehicles of the modern scientific mind.

Dr. Hahnemann never failed to over-emphasize the need for anamnesis of diseases and the need for employing every possible means to diagnose what ails the sick. Today, medicine has come to age and we have every possible means at our disposal to do the same and more, in the most precise manner.

Knowledge of medicine makes the physician aware of the limitations of his therapeutic system. When to continue the management of a case and when to 'refer' the 'emergency' to the care of institutionalized management – the

decision comes naturally when the physician is sure in his knowledge of the disease.

If we care to study our Materia Medica through the eyes of diagnostic orientation, we would be surprised how clear the representation is! Remedies from various kingdoms have the most vivid similarities between diseases at their various stages and the remedy picture. For e.g. Chelidonium and Hepatitis, Belladonna and Tonsillitis, China and Malaria: the list is endless.



- Intellectual State (Perception, Memory, Thinking, Consciousness, Confidence, Orientation, Judgement, Motivation, Will, Drive etc)
- Temperament
- Reactions: <,> Ailments from
- Action: Speech, Behaviour, Functioning

Step- I + Step- II =

↓

- **Totality of Symptoms (Individualization of Disease and Patient as a Person) =**

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Similimum

POTENCY SELECTION

Depends on **STAGE OF DISEASE**

1. Purely functional (High potency, Infrequent repetition).
2. Acute / Reversible Pathology (Medium potency, bears repetition)
3. Deep / Chronic Pathology (Medium / low potencies)
4. Irreversible Pathology (lowest potency or 50 Millesimal scale)

The above said recommendations have been clinically verified over two decades of author's practice.

What is peculiar to the patient suffering from a disease can only be known after sieving out the common disease symptoms - a futile exercise if the physician does not knows what? We, as homoeopaths cannot rest in the complacence of a few isolated, undocumented 'cures', for these are unacceptable in the medical circles of today.

Homoeopathy is scientific, that we cannot escape. It copes with the same facts as the rest of the scientific world, but interprets them in so different manner as to be startling. We must evaluate, as we evaluate our symptoms in case-taking, and be precise and profound, both objective and subjective. We should use every known scientific method of diagnosis and laboratory research to make our findings judgeable by other scientists. This needs both a clear and concise grasp of Homoeopathic principles and therapeutics, as well as, a deep understanding of medicine: to look behind the symptoms of the patient. "The future of highest homoeopathy" said Compton Burnett "lies in behind the symptoms."

CLINICAL EXAMINATION

Sir Robert Hutchison in his book *Clinical Methods* mentioned that "diagnosis should precede treatment whenever possible but the wise doctor should always strive not simply to be a diagnostician but rather someone who elucidates human problems so as to help the patient and family, manage the problems caused by a disease and where possible, offer treatment, cure or prevention." This thinking process of Sir Hutchison is parallel to Homoeopathic concept of Holistic approach towards Man in Disease.

Clinical examination is the term used to describe a properly organized approach to the patient and to his/her disease. In order to prove scientificity of Homoeopathic cure, every physician should possess the skill of clinical examination i.e. sign/objective findings (symptoms) in order to evaluate the subjective symptoms. The topic on Clinical Examination is vast but we felt to incorporate it in brief schematic manner.

General Examination (G/E)	Systemic Examination (S/E)	Local Examination (L/E)
• Built • Nutrition • Temperature • Pulse • Respiration Rate • Blood Pressure • Weight • Height • Gait • Tongue • Throat • Nose • Ears • Decubitus • Clubbing • Cyanosis • Jaundice • Pallor • Lymphadenopathy • Edema • Skin, Hair and Nails	• Central Nervous System (CNS) • Cardiovascular System (CVS) • Respiratory System (RS) • Gastrointestinal System (GIT) • Genitourinary System • Locomotor System	The physician may examine from scalp to foot, to observe any finding that patient had forgotten to inform

General Examination (G/E)	Systemic Examination (S/E)	Local Examination (L/E)
Step I: Case Taking (Symptoms: Chief and Associated Complaints) Step II: Clinical Examination (Signs) Step III: Laboratory Investigations (As per the demand of the case)		Disease Diagnosis i.e. Individualization of Disease

Physician should plan what to examine in detail and emphasize the areas that the history suggests abnormal.

NEED OF DIAGNOSIS – AN EXPLANATION

The science and art of medicine has advanced in leaps and bounds since the times of Hahnemann. Many theories conceived by Hahnemann in his Organon are becoming true, and books on pathology, practice of medicine, dermatology, psychiatry have admitted Hahnemann's views on individualization and causes of diseases. Many new branches of science such as immunology, virology, bacteriology, pathology etc. have helped in finding out the pathogenesis of diseases. These sciences were either not in existence during the time when homoeopathy was discovered or were in the state of infancy at that time. Books on these specialised sciences have also realised that diseases cannot be treated simply by their names though they have called them by different nouns and adjectives. But nowhere the importance of adding nomenclature to disease have been sidetracked. It has its own importance and we, as Homoeopaths, cannot ignore this fact from Hahnemannian point of view.

Our materia medicas have also mentioned names of diseases under each medicine. The science and art of medicine has advanced leaps and bounds since the times and symptoms of the drugs we will find that they always tally with the clinical picture of one, or the other disease... but a few of the symptoms are peculiar for individualising persons suffering from the same disease. Even Hahnemann in different aphorisms of Organon has used the word disease repeatedly. In aphorism 18 he has used the words "Individual case of disease." Stress has been put by him on the sum total of objective and subjective symptoms forming the totality of disease which has to be kept in view while treating an individual diseased person. What he meant by the words objective and subjective? Does it not corroborate with the signs and symptoms of any disease described in the textbooks of medicine of individual diseases?

How can we therefore minimise the importance of the objective and subjective symptoms as homoeopaths on the plea that Homoeopathy needs no help of anamnesis for helping them in the treatment of an individual.

Anamnesis ascertains all characteristic signs of a healthy person and all characteristic symptoms of the sick persons. This used to be done in old times by comprehending patient's own account of trouble, account

narrated by his relatives, the observations made by the physician himself. Formerly the examination of the patient by the physician was only taken as a supplement for anamnesis. In modern days such examination along with the help of pathological and other findings found with the help of the modern diagnostic technique are of primary importance not only for planning treatment but also management of the case and its prognosis. It helps us in knowing our limitations and in taking up the line of palliative treatment in far advanced cases where gross, major irreversible pathological changes have taken place in different organs of the body thereby affecting the individual. Such frank advice to the patients regarding the future of the case, instead of keeping the patient under the impression that he would be cured wins the confidence of the patient in the physician, thereby establishing a cordial patient-doctor relationship.

Organon has also not minimised the importance of diagnosing a disease. Kent also has in his *Lesser Writings* stressed upon the need of diagnosing diseases. Had this not been a fact our original literature would have boycotted the nomenclature given to different diseases. They are full of medical terminologies as used in the other medical books. If we delve deep in this matter we can see that we are a step forward from other therapeutic sciences by adopting this technique of invalidation and thereby establishing a new approach to treat diseases. On going through the latest medical literature we can conclude that the modern medical science has now realised the importance of treating the individual while treating diseases. A few lines from the chapter on *Diseases and its Causes in a Textbook of Pathology* by William Boyd goes to sanctify the doctrine enunciated by Hanhneman — *"Man is more than a sum of his parts and the future doctor must remember that his vocation is not only to treat diseases but care of the patient."* There is an old french proverb "There are no diseases but only sick persons"

Virology has been able to find out the relationship between many signs and symptoms mentioned by Hahnemann under psora. Most of our antipsoric medicines are capable of treating viral diseases, immune deficiency diseases and many other known syndromes which modern medicine has not so far been able to treat. What more proof is required about this than to observe the action of our remedies in eliminating different types of warts without the help of surgery. The clinical description of syndromes can be compared with the drug picture of many of the medicines described in our materia medica. A physician having a perfect knowledge of these disease conditions obtained from books on medicine, surgery, gynecology, and other allied sciences would be able to find out a similimum after individualization more quickly by setting aside or eliminating the irrelevant signs and symptoms. Thus, the knowledge of diagnosing a case would help him in individualisation in a more perfect way and he can prove to be a better physician with his all round knowledge.

The editors of the first edition of *Harrison's Principles of Internal Medicine* have mentioned something very scientific regarding fundamental commitment of physician towards the patient which I take the liberty of quoting here. *"Tact, sympathy and understanding are expected of the physician for the patient is no more collection of symptoms, signs, disordered functions, damaged organs and disturbed emotions. He is human, fearful and hopeful, seeking relief, help and reassurance. To the physician, as to the anthropologist, nothing human is strange or repulsive. The misanthropic may become a smart diagnostician of organic disease, but he scarcely hope to succeed as a physician."* This same book on patient physician relationship has mentioned: It may be true to emphasize that physicians need to approach patients not as cases or disease but as individuals whose problems "too often transcend the components which bring them to the doctor." On going through the introductory chapter of this widely used *Textbook of Medicine* it is observed how the writers have emphasized on the clinical skill of history taking and its importance. None of the parts mentioned in Organon in the aphorisms on case taking have been missed in these instructions. Organon has also put stress on physical examination of the patients and instructed us to add these findings in finding out a suitable remedy for treating these cases. Laboratory methods were not in such an advanced state during Hahnemenn's time. *Had he lived to see these advances he would also have instructed to utilise these findings in finding out a similimum.*

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CARDIOLOGY (DISEASES OF CARDIOVASCULAR SYSTEM)

MOST COMMON SYMPTOMS OF THE DISEASES OF HEART

Angina (ischemic cardiac pain)

Squeezing, crushing, strangling, constricting pain in centre of chest. Pain may radiate to left shoulder, left arm, right shoulder, jaw.

- **Stable (typical) angina**: Angina upon effort, or an angina induced by increased blood pressure or increased heart-rate. Angina is relieved by nitroglycerin, although it is not specific for this type of angina.
  Levine's sign: Patient makes fist and holds it up to his chest, to describe the pain.
  Second-wind phenomenon: If patient repeats same activity after the attack, he may not feel the attack again the second time.
  Walk-through angina: The pain subsides as patient continues the activity.
- **Atypical angina**: Atypical presentation of typical angina.
  Atypical symptoms: Sharp or stabbing pain, rather than crushing pain.
  Atypical causes: Angina with change in position, for example, rather than angina strictly upon effort.
- **Angina equivalents**: Other symptoms that are caused by Myocardial ischemia: Exertional dyspnea, nausea, indigestion, dizziness, sweating.
- **Unstable angina**: Angina even at rest, or angina that has recently gotten worse. It is associated with sharply increased risk for myocardial infarct within 4 months.
  Angina decubitus is a specific term for angina occurring at rest.

- **Variant angina (prinzment angina):** Paradoxic angina occurring during rest but usually not during exercise. It is caused by coronary artery spasm. It can be hard to spot because it can coexist with typical angina.
  Characteristic ECG findings can help distinguished variant angina from typical angina.
  Nitroglycerin will probably still relieve pain, as it relaxes coronary arteries.
- **Myocardial infarct**: Typical presentation is unstable angina lasting longer than 15 minutes that is not relieved by Nitroglycerin.
  Silent MIs and MIs with atypical presentation do occur.

Non-ischemic cardiac pain

- **Mitral valve prolapse**: Usually asymptomatic, but many present with an intermittent, sharp, sticking pain over left precordium.
- **Pericarditis**: The patient feels relief by shallow breathing and by sitting up and leaning forward.
- **Dissecting aneurysm**: Sudden, severe tearing pain, radiating to the abdomen, neck, or brick, depending on where the aneurysm is going.

Pleuritic (pulmonary) chest pain

- **Pulmonary embolism**: May be asymptomatic, or the patient may feel a dull tightness if the embolus is large enough. Paroxysmal dyspnea is the most common symptom of pulmonary embolism.
- **Pleurisy**: Pain upon breathing. May be caused by pulmonary embolism, pneumonia, bronchitis, or pleural effusion.
- **Pulmonary hypertension**: Dyspnea is a more common symptom than pleuritic pain.
- **Pneumothorax**: Pain may be confused with pain of an MI.
- **Mediastinal emphysema**: Free air in the mediastinum produces chest tightness and dyspnea.
  Hamman's sign: Crunching, rasping sound heart synchronous with the heartbeat indicative of mediastinal emphysema.

Gastrointestinal chest pain

- **Esophageal spasm**: Substernal chest pain and dysphagia.
- **Esophageal reflux (GERD)**: Chest pain relieved by antacids.
- **Gallstone colic**: Colicky RUQ (Right Upper Quadrant) pain radiating to back and to right shoulder. Occasionally, it may be confused with angina.

Chest wall pain

- **Tietze's syndrome (costochondritis)**: Inflammation of costochondral joints. Pain is often localized and can be elicited by palpating the sternum over the involved ribs.
- **Herpes zoster**: Pain may precede the appearance of the rash. Both pain and rash follow dermatomal distribution.
- **Dacosta's syndrome**: Psychogenic pain usually localized to the cardiac apex. May be associated with anxiety.
  Also seen are palpitations, hyperventilation, dyspnea, weakness, depression, or other signs of anxiety.
- **Vertebral column disease**: It may occasionally lead to anterior chest pain.

Dyspnea

Air hunger or difficulty in breathing may be associated with cardiac disease.

- **Exertional dyspnea**: Dyspnea on exertion is a common symptom of mild or severe congestive heart failure.
- **Dyspnea at rest**: Pulmonary causes of dyspnea [PE (Pulmonary embolism), COPD (Chronic obstructive pulmonary disease), Pneumothorax] often occur at rest. With cardiac problems, dyspnea usually does not occur at rest, or it is overshadowed by angina.
- **Anxiety dyspnea**: Difficulty in breathing due to anxiety occurs only at rest.
- **Orthopnea**: Dyspnea occurring with patient in the supine position. Orthopnea is a sign of congestive heart failure that is more severe than that associated with exertional dyspnea.
  Cause: Supine position increases pulmonary blood flow — exacerbate pulmonary congestion and pulmonary edema. The problem is relived by resuming a more upright position.
  Two-pillow, three pillow orthopnea: Terms to describe the severity of the orthopnea. Three pillow is worse than two pillow.
- **Paroxysmal nocturnal dyspnea (PND)**: Similar to orthopnea, except it has sudden onset and occurs only after the patient has been lying down at rest for at least an hour.
  Unlike orthopnea, it is not relieved immediately by sitting up. Patient is usually able to return to sleep, eventually.

Pulmonary edema

Pulmonary edema is usually a manifestation of left ventricular failure (LVF). Peripheral edema associated with congestive heart failure (CHF) is a manifestation of right sided heart failure (Cor Pulmonale).

- **Symptoms**: Severe symptoms - Extreme anxiety, dyspnea, air hunger, cold sweats, fear of impending death.

- **Signs**: Pink frothy sputum, and bubbly breath sounds.

Valvular heart disease

- Mitral stenosis is associated with dyspnea.

Congenital heart disease

- **Tetralogy of Fallot**: Exertional dyspnea is common.
- **Ventricular septal defect**: Tachypnea and sweating. Late cyanosis.

Other causes of shortness of breath

- **Kussmaul respiration**: Intense hyperventilation (respiratory alkalosis) occurring with diabetic ketoacidosis, as a compensatory mechanism to relieve the metabolic acidosis.

Palpitations

It is an unpleasant awareness of one's own heart beat.

- Paroxysmal Atrial Tachycardia.
- Premature Ventricular Contractions (PVC).

Syncope

Transient loss of consciousness.

- Vasovagal reflex
- Anxiety
- Arrhythmias
- Stokes Adams Syndrome
- Aortic stenosis
- Myxomas: benign myocardial tumors.
- Tetralogy of Fallot.
- Myocardial ischemia.
- Carotid sinus syncope.
- Orthostatic hypotension.
- Micturition, cough syncope.

Edema

- **Pitting edema**: Congestive heart failure.
- **Presacral edema**: It may be found in bed ridden patients.
- **Anasarca**: Severe generalized oedema and ascites seen in liver cirrhosis, CHF.
- **Lymphedema**: Filiarisis.

Cyanosis

It is the presence of deoxygenated hemoglobin in blood. It is only noticed when deoxygenated Hb levels fall below 5 gm%.

- **Central cyanosis**: Visible in the lips, face, conjunctivae, tongue. Causes - tetralogy of fallot, AV shunt.
- **Peripheral cyanosis**: Visible in the finger and toes, earlobes, nose. Caused due to localized hypoxia, e.g. CHF, shock, Buerger's disease, etc.

CONGENITAL HEART DISEASES

Diseases with shunt between right and left side of heart		
Disease	**Features**	**On examination**
Atrial septal defect (Blood flows from left to the right atrium) (L→R)	• More common in females. • Usually asymptomatic before 3rd or 4th decade. • Dyspnea, palpitation, rarely cardiac failure.	• Pulse low in volume. • Right ventricular hypertrophy. • Systolic murmur in pul. area. • Wide and fixed splitting of IInd heart sound. • X-ray shows prominent pul. artery and enlarged rt. ventricle. • Fluoroscopy reveals "Hilar dance". • ECG. shows incomplete rt. bundle branch block.
Ventricular septal defect (Blood from lt. ventricle goes to rt. ventricle) (LV→RV)	• Usually asymptomatic till 2nd or 3rd decade. • Breathlessness, fatigue, cardiac failure etc. • Frequent chest infection. • Ventricular enlargement. • Can become symptomatic around 6 to 10 weeks of age.	• Systolic thrill over the lt. (lower) sternal edge. • A very harsh systolic murmur over the same area. • X-ray - no finding in small defect. • Evidence of ventricular enlargement. • ECG - evidence of ventricular hypertrophy.
Patent ductus arteriosus (Blood from the aorta is shunted to the pul. artery during systole and diastole both) (L→R)	• Females commonly affected. • Usually asymptomatic for many years. • Dyspnea, fatigue, cardiac failure etc.	• Pulse-collapsing type. • Lt. ventricular enlargement. • Continuous machinery murmur, with late systolic acentuation, may be heard over lt. second intercostal space. • Pul. component of IInd heart sound accentuated. • X-Ray – enlarged pul. artery. • ECG – May show evidence of lt. ventricular hypertrophy.

Disease	Features	On examination
Fallot's tetralogy (Congenital cyanotic heart disease consisting of (1) Pul. stenosis (2) Ventricular septal defect (VSD) (3) Rt. ventricular hypertrophy (4) and dextra position of the aorta) (R→L)	• Dyspnea and fatigue. • Severe cyanotic spells when child assumes squatting position. • Central cyanosis. • Delayed development of child. • Clubbing of fingers.	• Loud systolic murmur in the lt. second intercostal space. • No parasternal lift present. • Single second heart sound. • X-ray – Oligaemic lung fields, boot shaped heart and absence of pul.conus. • ECG – Moderate rt. ventricular hypertrophy.
Eisenmenger's syndrome • Right to left shift. • Pulmonary stenosis. • Right ventricular hypertrophy. • Over-riding of big vessels like aorta.	• May be associated with • Coarctation of aorta. • Syncope, haemoptysis and anginal pain.	• Central cyanosis. • Clubbing.

Diseases without shunt between the sides of heart		
Disease	**Features**	**On examination**
Coarctation of aorta (CoA) • Congenital condition of aorta • Aorta narrows in the area where the ductus arteriosus inserts • Coarctations most common where the aorta arches towards abdomen and legs	• More common in males. • Headache, giddiness due to high B.P. • Cramps in lower limbs due to less blood flow. • Angina may occur. • Most common are syncopal attacks. • Middle aged or elderly. • Presenting complaint is breathlessness.	• B.P. in lower limbs is lower than upper limbs. • Femoral pulse delayed and weak. • Collateral arterial pulsation present around the scapulae and in the axillae. • Sometimes a murmur may be heard over in those areas. • Left ventricular enlargement. • Systolic murmur over the stenosis loudest at the back. • Carotid pulse shows a slow upstroke with plateau. • On auscultation fourth heart sound is present at cardiac apex. • ECG - shows left ventricular hypertrophy. • X-ray chest: - Cardiac hypertrophy. - Notching of ribs. - Double contour of aorta.
Pulmonary stenosis (usually congenital) • Dynamic/fixed obstruction of flow from RV of the heart to the PA	• Shortness of breath/ dyspnea esp. during exertion • Chest pain • Loss of consciousness (fainting) • Fatigue	• Rt. ventricular hypertrophy. • Systolic thrill and a harsh mid systolic ejection murmur over the pul. area. • Feeble or normal pul. component of the second heart sound. • X-ray lungs oligemic.

Disease	Features	On examination
Pulmonary Incompetence or Insufficiency or Regurgitation (usually functional from pul. hypertension as in mitral stenosis)	Usually no early symptoms are noticed by the patient	• Early diastolic murmur over pulmonary area (Grahm Steel murmur). • Rt. ventricular enlargement.
Tricuspid stenosis and incompetence (may be congenital)	• Rheumatic • Functional in origin	• Pan-systolic murmur of tricuspid incompetence. • Pre-systolic murmur of tricuspid stenosis (both heard best at the lower right sternal border). They usually increase on inspiration. • Pre-systolic liver pulsation in tricuspid incompetence, systolic liver pulsation in T. stenosis seen. • X-ray - huge right atrial dilatation. • ECGs - Rt. atrial hypertrophy.
Dextrocardia • True dextrocardia. • False dextrocardia	• May be associated with situs inversus (Rotation of abdominal organs). • Usually asymptomatic. • In some-frontal sinusitis and bronchiectasis associated (Kartagener's syndrome). • Displacement of the heart due to chest diseases.	• X-ray reveals the cause whether false or true. • ECG will show specific findings.
	• Serious cardiac abnormalities-Usually associated with signs/symptoms of fibrosis, collapse of lung, increased intra-pleural pressure, pneumothorax.	

VALVULAR DISEASES OF HEART

Disease	Etiology	Symptoms	Signs	Investigations	Complications
Mitral stenosis	• Rheumatic fever • Rarely congenital	• Exertional dyspnea • Paroxysmal nocturnal dyspnea • Orthopnea • Repeated attacks of winter bronchitis • Pressure symptoms: dysphagia, hoarseness of voice • Palpitation • Haemoptysis from streaked sputum to frank sputum to frank haemoptysis. • Pt. may complain of angina	• Malar flush over cheeks. • Pulse small in volume • B.P. Low pulse pressure • Heart: apex-beat of tapping quality • Left parasternal heave • A diastolic thrill at apex • Pul. component. 2nd H.S. loud • Mid-diastolic murmur at the apex rumbling and best heard with bell of stethoscope. Pitch of murmur low • Pre-systolic accentuation of murmur • Opening snap precede the murmur • Lung crepitations at the bases.	• X-ray chest; left atrial and rt. ventricular enlargement • Pul. venous congestion. • Prominent pul. conus. . • Kerley B lines present. • Calcified valve may be seen. • E.C.G:. Lt. atrial hypertrophy. • Evidence of R.V.H. • P. mitral pattern. • Echocardiography will reveal the size of mitral opening.	• R.V. failure • Atrial fibrillation • S.A.B.E. • Cerebral embolism. • Haemoptysis • Recurrent bronchitis. • Pressure symptoms - Dysphagia. - Dyspnea. - Hoarseness of voice.
Mitral regurgitation	• Rheumatic heart disease • Rupture of chordae • Infective endocarditis • Spontaneous trauma	• Palpitation • Other symptoms same as that of mitral stenosis.	• Apex beat down and out • 1st H.S. soft • Pan systolic, soft mumur at apex, increased with expiration, transmitted to left axilla	• X-ray: enlarged Lt. atrium and Lt. ventricle • E.C.G.: Lt. axis deviation "P" mitrale • Lt. ventricular hypertrophy • Echocardiography – will	• S.A.B.E. • L.V.F. • R.V.F. • Angina, haemoptysis, embolic phenomena.

Disease	Etiology	Symptoms	Signs	Investigations	Complications
	• Acute myocardial infarction • Wide AV ring • Rarely congenital			• Reveal the left ventricular and left atrial size and functions. • Doppler studies may be done to confirm mitral regurgitation.	
Aortic stenosis	• Rheumatic fever. • Congenital • Atherosclerosis	• Asymptomatic in early stages. • In later stages – syncope. • Chest pain. • Easy fatigueability. • Sudden death. • Sign/ symptoms of L.V.F. • Orthopnea. • Paroxysmal nocturnal dyspnea.	• Apex beat thrusting • Pulse-low pressure. • Systolic thrill in aortic area. • Aortic component IInd sound weak. • Ejection systole murmur in aortic area (Rt. IInd intercostal space, parasternal). • Ejection click murmur. Harsh, rough, increased with expiration and transmitted to carotid artery. (Best heard with Pt. leaning forward and breath held in maximal expiration)	• X-ray chest: prominent, ascending aorta. - LVH in late stages. - Calcified valve may be seen. • ECG-LVH. • Echo and doppler studies – to confirm the diagnosis.	• LVF • Infective endocarditis • Coronary insufficiency
Aortic regurgitation	• Rheumatic • Atherosclerosis • Systemic diseases: Ankylosing spondylitis, Rheumatoid arthritis, Marfan syndrome.	• Same as of aortic stenosis	• Strong, abrupt carotid pulsations. • Pulse-collapsing or water hammer type. • Pulse pressure	• X-ray chest: L.V.H. - Prominent aortic notch. • Aortic pulsation may be seen on flouroscopy. • E.C.G. - L.V.H.	• Same as of aortic stenosis.

Disease	Etiology	Symptoms	Signs	Investigations	Complications
	• Syphilis. • Inf. endo-carditis		high with low diastolic pressure. • B.P.– Lower limbs higher than U. limbs • Heart-Lt. ventricular dilatation, forceful cardiac impulse down and outwardly, displaced, 1st H.S. - soft, early diastolic murmur loudest along Lt. sternal border in 3rd-4th intercostal space, aortic blowing, faint and best heard in pt. leaning forward and breath held in expiration. Auscultation on femoral artery pistal shot sounds.	• WR, KT, VDRL in syphilitic cases (Positive) • Echo and doppler studies to confirm the diagnosis	

HYPERTENSION

Hypertension (HTN or HT), also known as high blood pressure or arterial hypertension is a chronic medical condition in which the blood pressure in the arteries is persistently elevated. Blood pressure is expressed by two measurements, the systolic and diastolic pressures which are maximum and minimum pressures respectively in the arterial system.

Types

- Primary where etiology is obscure.
- Secondary to some recognizable disease.

Essential or primary hypertension

It is the name given to the type of hypertension with obscure cause. It is most common form and affects both sexes.

- Definite – Systolic over 160
  Diastolic over 95
- Borderline – Systolic over 140
  Diastolic over 90
- Normal – Systolic below 140
  Diastolic below 90

Etiology

- Age: between 40 to 60 yrs,
- Heredity: is an important factor,
- Obesity: is usually associated,
- Smoking,
- Hypercholesterolemia,
- Nervous factors:
  – Temperamental,
  – Emotional stress,
- Increased Na^+ intake, NSAIDs,
- Alcohol.

Secondary hypertension

Generally secondary to some disease condition such as:

- Renal disorders,
- Endocrinal disorders:
  – Cushing's syndrome,
  – Pheochromocytoma,
  – Primary hyperaldosteronism,
- Toxaemia of pregnancy,
- Neurogenic disorders,
- Connective tissue disorders,
- Coarctation of aorta,
- Miscellaneous:
  – Oral contraceptives,
  – Steroids.

Symptoms / signs

- High blood pressure is often detected on routine examination.
- Very rarely symptoms are present.
- In early stages, the hypertension is fluctuant. It rises to abnormal levels under the influence of emotional changes etc. and later on it becomes permanently elevated even at rest.

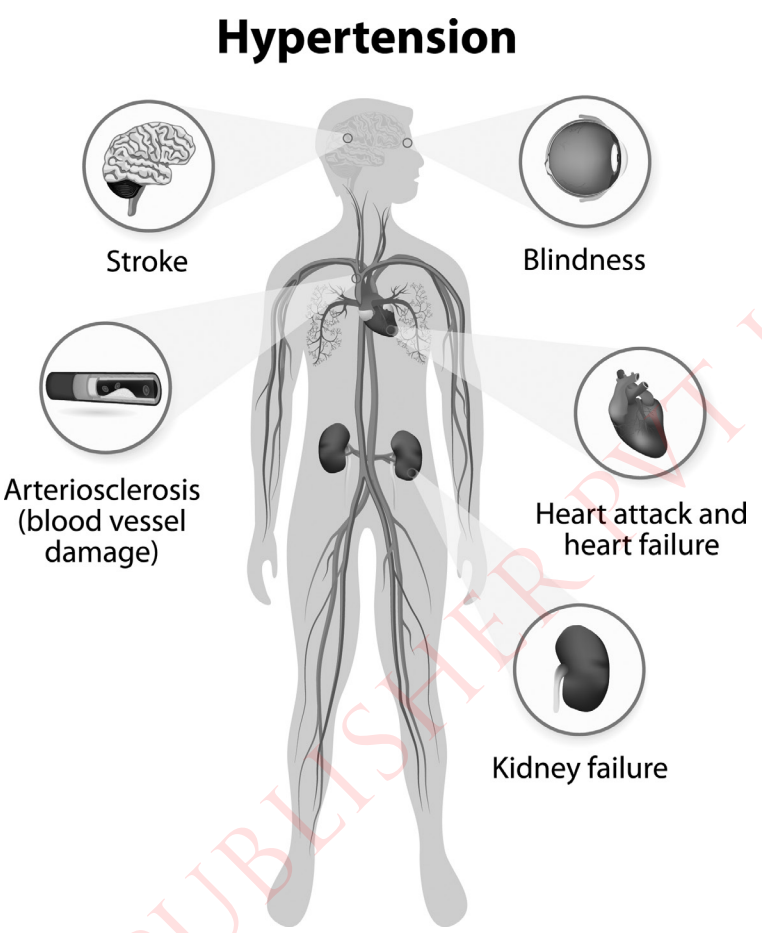
Hypertensive urgencies

Diastolic blood pressure > 120 mmHg with minimal target organ damage.

- Grade 1 and 2 fundoscopic changes.
- Post-operative /pre-operative uncontrolled hypertension.
- Diastolic blood pressure 120 mm of Hg with major organ damage i.e. CNS/kidney/cardiovascular.
- Intracranial / subarachnoid hemorrhage.
- CVA, hypertensive encephalopathy.
- Acute aortic dissection, pulmonary oedema.
- Myocardial infarction. Unstable angina.
- Eclampsia.
- Pheochromocytoma.
- Grade III or IV, K.W. fundoscopic changes.

Investigations

- History
  - Family history of hypertension,
  - History of renal disease,
  - Undue breathlessness,
  - Clinical features of other responsible diseases.
- Assessment of blood pressure.
- Examination of cardiovascular system:
  - Evidence of left ventricular hypertrophy,
  - Signs of cardiac failure,
  - Evidence of ischaemic heart disease (IHD),
  - Examination of optic fundus,
  - Femoral pulse must be palpated,
  - ECG: ST-T wave changes,
  - Echocardiography.
- Renal function tests.
- Radiology
  - Cardiomegaly
  - Hyperaemic lung, prominent hilar shadow
- **Electrocardiography:** Myocardial (Coronary) disease may be present.
- **Examination of other systems:** Abdomen for large kidney.
  - Acute aortic dissection, pulmonary oedema.
  - Myocardial infarction. Unstable angina.
  - Eclampsia.
  - Pheochromocytoma.
  - Grade III or IV, K.W. fundoscopic changes.



Pre-eclampsia syndrome

- It is of unknown Etiology, characterized by hypertension, edema, proteinuria occurring after 20 weeks of gestation.
- When only hypertension is present it is called gestational hypertension.
- If patient of Pre-eclampsia develops seizures it is called eclampsia, it can occur in ante, intra and early post partum period.
- Pre-eclampsia often develops in primiparas with diabetes.

Diagnosis

Rise in systolic blood pressure of 30 mm of Hg and/or a rise in diastolic blood pressure of 15 mm of Hg calls for medical attention.

Complications

- Fits
- Retinal hemorrhage
- Pulmonary edema

- Coma
- Severe epigastric pain
- Headache
- Intra-uterine growth retardation

Note: *Estimation of catecholamine* excretions in urine if phaeochromocytoma is suspected.

Complications of hypertension

Hypertensive heart disease

- Right ventricular failure.
- Coronary artery disease may be associated.
- Left ventricular enlargement and subsequent hypertrophy.

Cerebral complications

- Headache, dizziness, vertigo etc.
- Headache is usually occipital; starts on waking and improves with the day.
- Encephalopathy: disturbances of vision, speech, paresis, paraesthesias, disorientation and fits or loss of consciousness may occur because of acute focal cerebral ischemia.
- Cerebral hemorrhage.
- Cerebral thrombosis.
- Gradual cerebral deterioration (Cerebral hemorrhage and thrombosis commonly occurs in patients with hypertension).

Eye changes

Haziness of vision, progressive deterioration in vision, sudden loss of vision, diplopia etc. Hypertensive retinopathy changes: sclerosis, hemorrhages, exudates and papilledema can be detected by opthtalmoscopy.

Renal hypertension

Hypertension is common in all types of renal diseases — glomerular as well as interstitial. It can cause renovascular hypertension due to chronically raised blood pressure because of stenosis of a main renal artery or one of its branches. The following features make renal hypertension more likely:

- Onset before 30 years and after 50 years,
- Past history of renal disease,
- Nocturia, hematuria or puffiness of face in the morning,
- Severe hypertension,
- Raised creatinine level,
- Sudden worsening of previously controlled hypertension, and
- Poor response to medical treatment.

Etiology

- Stenosis of a renal artery,
- Atherosclerosis,
- Fibromuscular dysplasia,
- Thrombosis or embolism of a renal artery,
- Intimal flap after abdominal trauma,
- Dissection of renal artery,
- Coarctation of aorta and aneurysm.

Physical examination

- Palpable kidneys.
- Epigastric bruits.
- Nerve deafness.

Investigations

- Urine analysis: will show proteinuria, hematuria, casts etc.
- BUN and creatinine levels: may be raised.
- FBS (Fasting Blood Sugar) and PPBS (Post Prandial Blood Sugar): elevated PPBS in diabetic patients.
- Renal ultrasound for renal size and to rule out obstructive uropathy and polycystic kidney.
- Intravenous urograms: to be done only if indicated and creatinine is less than 2 mg%.
- Renal scan – Hippuran and DTPA scans: safe and tells about renal function.
- Renal angiogram - conventional of DSA - To rule out renal artery stenosis.
- Rapid sequence intravenous urography,
- Radioisotope renogram with captopril,
- Conventional angiography,
- Doppler study.

Treatment

There is no universally accepted treatment in patients with renovascular hypertension. The choice of treatment depends on age, actual and previous control of the blood pressure, underlying renal function, concomitant disease, estimated operative risk, the type, extent and site of stenosis, renal vein tests, local surgical and angiological experience and last but not the least the preference of the physician and the patient.

Invasive treatment: Two modalities are available -percutaneous transluminal renal angioplasty (PTRA) or reconstructive surgery.

Treatment of hypertension

It should be patient oriented rather than disease oriented.

Non-remedial therapy

- Weight reduction,
- Low sodium diet,
- Potassium, magnesium and calcium supplementation,
- High PUFA diet,
- Moderation of alcohol,
- Psychological factors should be treated first,
- Rest:
  - Going to bed early,
  - Rest after meals,
  - Resting at weekends,
  - Relaxation.
- Physical activity: moderate exertion within the limits of dyspnea should be encouraged and undue tiredness should be avoided,
- Strenuous exertions, sudden and prolonged stress should be restricted or stopped.

Surgical treatment

For coarctation of aorta, renal artery stenosis, phaeochromocytoma, Conn's syndrome etc.

Homoeopathic medicines

(As stated above, an individualistic approach is advisable in treating patients of hypertension).

Aconite: Tachycardia, angina pectoris with pain in left shoulder, stitching in character. Palpitation with extreme anxiety, fear of death, fainting and tingling in fingers. Pulse full, hard, tense and bounding. He believes he will die, predicts the day. Extreme thirst. Shortness of breath.

Allium sativa: Arterial *hypotension* or a fall of blood pressure begins in 30 to 45 minutes after 20 to 40 drops of mother tincture have been given in water for one dose.

Bar m.: Hypertension on account of arteriosclerosis. High systolic pressure attended with cerebral and cardiac symptoms.

Crataegus: In threatened heart failure during tension, it will work well. Painful sensation of pressure in the left side of the chest below the clavicle is a good indication.

Glon: Palpitation with dyspnea. Little exertion brings rush of blood to heart with fainting spells. Throbbing in the whole body even to finger tips. Sun headache. Sudden and violent irregularities of pulse.

Lycopus vir.: It reduces blood pressure, reduces the heart rate and increases the systole to facilitate the circulation in cases of ventricular tachycardia. Angina in valvular disease of heart. Malignant hypertensions.

Strophanthus: Irritable heart with tense arteries and a free discharge of urine. Useful for heart failure of the aged in troubles of heart, dependent on kidney diseases.

Verat v: Intense arterial excitement and congestion, the force and frequency of pulse being abnormal which is sometimes slow and sometimes rapid.

Viscum album: In arteriosclerosis and atheromatic, gouty complaints especially when there is hypertension; pulse small and weak; dyspnea worse on left side; weight and oppression of heart, as if a hand was squeezing it.

Wyethia Q: 3 to 4 drops of mother tincture at a time, till relieved.

Other remedies: Aurum, Adrenaline, Pituitary gland extract (after meals), Gelsemium, Natrum iodide, Ergotine, Adonis, Baryta iod., Natrum mur., Nux vom., Rauwolfia.

ISCHAEMIC HEART DISEASE

It is the cardiac damage because of an inadequate coronary blood supply. Generally it is due to the narrowing of the coronary arteries from atherosclerosis. Ischaemic heart disease can manifest in various presentations clinically:

- Angina pectoris
- Acute myocardial infarction
- Sudden death
- Arrhythmias
- Cardiac failure
- Connective tissue disorders
- Conduction defects
- Shock

ANGINA PECTORIS

It is an episodic clinical syndrome, in which the pain is of shorter duration, without any permanent damage to myocardium, or in other words the ischaemia of *Angina* is reversible and transient.

Etiology

- Atherosclerosis,
- Arterial embolism,
- Spasm,
- Arteritis,
- Angina is also be seen in condition like hyperthyroidism, severe anemia, PVT etc.

Symptoms / signs

- Pain: It is felt behind the sternum or across the chest, radiating to left shoulder, to both arms, even to infrascapular area or jaw.
- It is usually described as constricting or crushing in type, heaviness, squeezing, or choking. There can be discomfort or unpleasant sensation of pressure in place of actual pain.
- Most of the attacks of angina are of short duration, and subside within 30 mins.
- It may be described as indigestion or 'gas'.
- Pain has definite relation to exercise, emotions, sexual activity, after meals.
- It is better by rest and taking glycerine trinitrate.
- There will be tachycardia, sweating and shortness of breath, rise in B.P.
- Signs of diabetes, hormonal diseases, cigarette smoking, cardiac enlargement and evidence of hypertension must be elicited.
- On examination B.P. may be found to be raised. A gallop rhythm may be seen on pulse examination. On auscultation apical systolic murmur may be heard during an attack.

Risk factors for coronary disease

- Fixed
  - Age
  - Male sex
  - Positive family history
- Potentially changeable with treatment
  - Strong association:
    - Hyperlipidemia
    - Cigarette smoking
    - Hypertension
    - Diabetes mellitus
  - Weak association:
    - Personality
    - Obesity
    - Gout
    - Soft water
    - Lack of exercise
    - Contraceptive pill
    - Heavy alcohol consumption

Indications for coronary angiography

- Angina refractory to medical therapy
- Severely abnormal exercise ECG
- Unstable angina

- Sub-endocardial myocardial infarction (non-Q-wave infarction), especially if exercise test is abnormal.
- Angina or myocardial infarction in a young patient (< 50 years) patient, especially if exercise test is abnormal.

Investigations

- History often is very characteristic.
- Urine for diabetes.
- Blood
  - Lipids
  - Glucose
  - Creatinine
  - Hematocrit
- Chest X-ray
- Coronary arteriography, Thallium stress test
- Electrocardiogram: at rest may be normal and after sufficient exercise usually abnormal and is very characteristic, it shows depressed ST segment.
- Myocardial perfusion scintigraphy.
- PET (Positron Emission Tomography).

Differential diagnosis

- Pericarditis
- Myocarditis, Cardiomyopathy
- Spontaneous pneumothorax
- Anterior chest wall syndrome
- Pulmonary embolism
- Dissecting aneurysm of aorta
- Acute gastro-intestinal disease including bile duct or pancreas
- Oesophageal pain: hiatus hernia
- Peptic ulcer
- Neuralgias
- Myalgias

Treatment

- Explain to patient that this pain arises from stressed heart.
- Reassurance of good prognosis.
- Check emotional worries and strains.
- Advise exercises (provided this does not induce pain).
- Obesity and anaemia must be corrected if present.
- Meals should be small, eaten slowly and followed by rest period.
- Cigarette smoking and consuming alcohol must be stopped.

Surgery

- PTCA (Percutaneous transluminal coronary angioplasty). Here stenosis is dilated using inflation of baloon under high pressure.
- CABG (Coronary artery bypass grafting).

Homoeopathic medicines

Aconite: A fine heart remedy, when there is numbness in the left arm and tingling in fingers. Mental anxiety; oppression, restlessness, palpitation are other permanent symptoms.

Adrenaline: 2x or 3x is one of the new remedies. It strengthens the heart beat, and prevents hemorrhages; angina with vertigo, nausea and vomiting and abdominal pains are other symptoms.

Amyl nitrate: Oppressed breathing and constriction of chest about heart; useful in angina pectoris.

Arsenic: A grand remedy in disease of heart, depending upon constitutional causes of fatty degeneration of blood vessels. Restlessness, edema, puffiness of eyes, swelling of feet, attacks of suffocation at night on lying down after 12 a.m are suggestive.

Cactus g.: It is a great remedy for angina pectoris, when there is a great irriation of cardiac nerves.

Crataegus: It is very useful, when the heart's action is very feeble and pulse is small and intermittent.

Glonoine: Pulsating headache; fullness in the region of heart; laboured breath.

Lil. tig.: It is associated with uterus troubles and there is nervous palpitation. Pain in heart, as if grasped in a vice, which awakens the patient from sleep.

Naja: In this remedy, hypotension (low blood pressure) is marked. The pulse is slow. The patient is melancholic and all the symptoms are better from walking or riding in open air. This remedy has good effect in valvular defects of the heart with dry teasing cough.

Oxalic ac: It is useful in stabbing heart pain, which radiates to the left shoulder in case of aortic insufficiency.

Spigelia: It has the most beneficial effect in angina pectoris which is a kind of neuralgic pain.

Other remedies: Arnica, Cocaine, Cuprum ac, Hydrocyanic acid, Latrodectus, Magnesium phos., Nux vom., Spongia, Tabacum, Kalmia.