OBJECTIVE:

1. To feel and understand struggle, strength and weakness, adaptation and functioning of an individual.
2. To feel & vibrate with the **pain of elderly woman** & how it become asset & liabilities in perceiving of the patient.
3. To understand relationship of SON & MO. How it evolves & leads to suffering of an individual.
4. Understanding importance of diagnosis and stage of disease from homoeopathic perspective in treatment of prolonged fever
5. To understand the role of right forces in treatment of fever of long duration in complex clinical condition.
6. Learning Importance of suitable approach in selection of remedy.
7. To develop art of reasoning & retrospection for developing faculty of evaluation

DIRECTIVE:

EXHIBIT: 1 SCREENING

1. Please go through the data give your appropriate clinical diagnosis.
2. Would you like to accept this case? Give your reasons?
3. How you would like to proceed further? Give your detailed plan.

EXHIBIT: 2 SCR

1. Please give your understanding regarding final clinical diagnosis with reasons.
2. Go through the life space. Share your feelings. Give your comment on location of PP & OBS.
3. Give your understanding regarding patient as a person.
4. Take a location of consultant & give your action.
5. Form totality and come to appropriate remedy
6. Kindly give your understanding of planning and programming.

EXHIBIT: 3 FOLLOW UPS

1. Go through each follow up. Give your understanding reasons for action.

KINDLY SEND YOU'RE WORKING

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EXHIBIT: 1

NAME: PMN	AGE: 55yrs	SEX: FEMALE	DATE: 6/10/07
CAST: HINDU	ADD: M		

Chief Complain:

C/O fever since 6 month, F-daily, D – 8 - 12 hrs? I - same. In fever she had c/o Body ache++, joint pains++ (Rt hand middle finger MCP joint swelling and painful, Rt hip and shoulder joint is painful on motion and having swelling +, both knee joint having pain), Heaviness on eyes, mild lachrymation with laziness. She also felt gradually loss of wt. During fever her thirst increases, app decreases, sleep increases, aversion to noise, taste-insipid, weakness+, and no chilliness, no rigor, no perspiration, fever < night and evening. Stool - normal, but urine – yellow in color, no odor, and no difficulty.

When fever started she went for Rx and accidentally was found to have high blood sugar and she started OHA, which was stopped since 3 months on medical advise because last Ix report was normal.

She is K/C/O Hypertension since 3 yrs and she is on Anti Hypertensive medicines. But since 3 days she had not taken medicine. When B.P. is high then she feels headache and giddiness.

PAST HISTORY:→ Renal calculi

O/E:

T: 101.0F′ (O)	Pulse: 112/min	BP: 116/96	Wt. 66.5kg
No Pallor	Tg: Dry+	RS: clear	CVS: NAD

P/A: L 1½ finger palpable, non tender

MSS:

Rt hand middle finger MCP joint: tenderness+, swelling+, ROM - painful, mild redness+ / warmth+
Rt hip and shoulder joint – ROM: painful+, no swelling, no tenderness, no redness/warmth
Both Knee joint – crepitation+ Lt > Rt., no swelling, no tenderness, no redness/warmth

TREATMENT: Rx received within 6 months: Course of antibiotics, Steroids, Painkillers, IV fluids, Three times hospitalized for c/o fever. Clinical diagnosis? PUO
Tab. Amlodipin-AT OD. H/O pioglet MF now discontinue

INVESTIGATION:

USG:

30/5/07: ABDOMEN: Fatty infiltration of liver and pancreas. Angiomyolipoma both kidney. No urinary calculi / obstructive changes. No bowel mass/ ascites / lymphadenopathy

4/07/07: ABDOMEN / PELVIS: A right lobe liver hypo echoic area appears to be an area of focal fatty sparing. Bilateral renal echogenic cortical lesions appear to be Angiomyolipoma.

12/07/07: KUB: Calculus in Rt proximal ureter with Backpressure. Small calculus in the left lower calyx Changes.

X-RAY: *4/07/07: CHEST (PA):*→ Moderate cardiomegaly.

CT SCAN: *9/7/07: CHEST/ ABDOMEN/ PELVIS:* A few enlarged abdominal lymph nodes in the left Para-aortic and aorto-caval regions? Significance. Small hypo dense lesion in bilateral renal parenchyma, some of which fat density? Angiomyolipoma.

07/07/07: ECHO:→ Normal LV Function, No regional wall motion abnormality, LVEF – 65%

DATE	15/5/07	18/6/07	3/7/2007	4/7/2007
HB	13.7	14	13.8	13
RBC	5.04			
TC	5000	5800	5300	5100
N	60	50	69	48
L	36	45	27	49
E	2	3	2	2
M	2	2	2	1
B	0	0	0	0
PCV	41.3			
MCV	81.9			
MCH	27.2			
MCHC	33.2			
PS	NC NC			
MP	-ve		-ve	
ESR	85	90	76	60
S.CREAT			1.10	
SGPT			59	
WIDAL	-ve		-ve	
FBS/URINE	116.9/-	95/-		
PPBS/URINE	228/++	160/+		
ALK.PHOS			238	
HIV	7/7/07 Negative			
URINE				
COLOR	Pale yellow	Pale yellow	Pale yellow	Pale yellow
SP.GR	1.030	1.000	1.015	1.030
ODOR				aromatic
ALBUMIN	+ (30mg/dl)	Trace		+
KETON	Trace			
URIBILINOGEN	N	N		N
PUS CELL	2-1	4-3	0-1	4-3
EPITHELIAL	10-8	2-1	3-2	15-20
RBC	0-1	occ	-	Occ
CAST	0-1 granular			1-2 granular

Exhibit: 2 SCR

Background: Considering the complexity of the case and response to the earlier medicines we decided to admit the patient for further handling

Preliminary Data:

Date: 7/10/07 OPD: S/573/07 S/IPD/47/07
Name: PMN Age: 55yrs Sex: Female Education: 6th Std
Status: W Religion / Cast: Hindu, Patel Occupation: H.W.
Spouse: died 26 yrs back Father: Exp Mother: 75yrs
Brother: Y1 Sister: Y1, Y2 Son: S1, S2 Daughter: D1 Add: M

Chief Complain:

L	S	M	C
GEN Since 6 month F-daily D-continuous Head & Leg	Feverish feeling No chill No rigor Desire to lie down Morning 2 hrs Pain2	$<^{2}$ Night $<^{2}$ Evening $>^{3}$ After passing stool	Sleep increased Backache 2 Heaviness of eye 2 Aversion to noise 2 Thirst increased 2 glasses at long interval Appetite lost
Endocrine Since 6 months Pancreas	No complaints DM Accidentally came to know No wt decrease No polyuria No polydypsia	Pt took Pioglet 15 mg for 3 months Now stopped since 3 months	

Associated complaints:

L	S	M	C
CVS Since 2 yrs F- daily D – continues	Hypertension Headache^{2} Vertigo^{2} No nausea / No vomiting	>2 Amodep – AT OD	
MSS Lt knee joint Since 2 yrs F- daily	Pain2 No swelling Crapitation2 Difficulty in walking No limping	$<^{2}$ Climbing $<^{2}$ Walking $<^{2}$ Squatting $<^{2}$ Stand up for long time $>^{2}$ Warm water application	
Joints Rt hand middle finger MCP joint Rt hip and shoulder joint Since 6 months	Pain+ Swelling+ mild redness+ Warmth+ Painful+	No any modalities	

Patient as a Person:
Appearance: Obese Coldness: Palm+, Sole+
Perspiration: Profuse, Chest++, Back++, No Odor, No Staining
Craving: Sweet^{2}
Stool: Unsatisfactory Urine: F- 3-4 Times In Day, 2 Times in Night
Menstrual Function: Menopause; H/O: Regular Cycle -30 days, D- 2days, Occ Black2, Occ Dark Red2
Offensive2, Stains: Yellow^{2}, Indelible
Sleep: Deep^{2} Sun <^{2} Headache Noise <^{2} Headache

Thermal state:
Fan: Summer - Full, Monsoon – 0-3, Winter – 0-2
Covering: Summer- Thin Chadar, Monsoon - Choraso, winter- Rajai, Cover up To Neck
Bath: Tepid In All Seasons.
Examination: Pl refer screening sheet.

Past History: Renal Stone, Pyelo (Infection), Hysterectomy Before 6 To 7 Yrs
Family History: Father: Brain Hemorrhage

LIFE SPACE

A 55yrs old lady, wearing two gold bangles in hand, one gold chain and two earrings. She is admitted for c/o fever since 6 months. She entered in consulting room with smiling face.

Pt is coming from PATEL community. Fa was farmer. He was emotional in nature. He had 40 Bigha lands. Financial condition was average. He loved all the children and more attached with pt. Mo is calm & emotional in nature. Pt has one younger brother and 3 younger sisters. She is eldest among all she is more attached with the parents. She faced lots of difficulty at that time because of financial condition. She is having cordial relation with brother and sisters. She had never fought or quarreled with them. She understood financial condition and helped father for saving, mother for house hold work and took care of brother and sister.

At the age of 16-17 yrs she got married with Mr.N. In her in-laws family she had FIL, MIL, Y BIL, and Y SIL. Husband was irritable & very suspicious in nature. Financial condition was better because they had one shop and 100 bigha land. Husband had a habit of drinking... he used to beat patient on small matters. She was afraid of him and never said anything. But internally she is having anger for that which she has never shown. Whenever they went out side always took extra care of her because of suspiciousness. If any body stands up or sits near to her then he doubted and beat her. She had fear3 of him and because of that she was not able to tell any thing to him. Because of that type of nature he didn't listen to Fa & Mo. She thought of suicide but she didn't do it because of children. When pt was 26 yrs old, husband expired because of cirrosis of liver. Untimely demise of husband lead to sadness2. There was no moral support & she had to look after small children. Pt's father got paralyzed after hearing the news of death of Son-I-L. Within 6 yrs he expired. Those moments were painful for her because she was more attached with them. Pt's mother used to weep in memory of husband. When ever pt saw tears in mother's eyes, she could not control her tears.

Environment remained same after demise of Husband. MIL was strict & same way her suspiciousness continues as patient was young widow. MIL didn't allow her to go out side and talk with others. She was also following strict rules of socio-cultural norms. When MIL doubted her, she felt very bad, irritable and became sad because she hadn't done anything wrong. She felt irritation 3 but she never responded to her. She felt after all one has to give respect to elders. She would become angry 3 when things became intolerable & develop headache and trembling of body... FIL's nature was opposite to MIL. He has taken good care of her. He always took side of her like a daughter. He would sit with her for lunch and dinner.

He expired after the 1 ½ yrs of her H's death. This was again a very painful incident in her life. She took all responsibility of family after the death of FIL. After that she became anxious about family and children's future. She would think that what will happen to my children. Who will take care of them? She had 5 buffalos, and some land. So 'munim' was taking care of farm and she was doing all her house hold work and also looked after milk business. Her BIL was helping her. He is staying separate at Baroda, and he is a lawyer. She brought up children/family by doing "KARKASAR". She took care of children and their study with struggle. She never thought for second marriage for children's future &. It was not acceptable socially too.

Daughter got married at the age of 22 yrs and happily settled. Elder son completed his college and doing business in karjan. Y. son is having fertilizer shop in karjan. Both the sons have settled hence financial condition improved. Both the DILs are real sisters. There are a no major conflicts between DIL & MIL. She described their nature as a good. If patient can not express her anger on DIL it leads to headache & trembling of the body. Now a day's pt willingly stops the quarrel.

Both sons separated before 5 yrs, first elder son separated because of education of children. He has settled in Karjan. Younger son settled in karjan for the business purpose. No one was ready to stay with MO & grand Mo in village & shoulder responsibilities of old women. One has to spend 2000-3000 rupees for treatment of MIL. Sons were not ready to help mother on above issue. BIL was not happy the way they refused to take responsibility of both women. He came forward & shouldered responsibilities of both women in all respects. (Money / servants etc.). He clearly passed message to both nephews that if no one is ready to take responsibilities of both "MO" then he will look after them for life time. Later on younger son came for few months & again went back to Karjan. Pt & Mil is staying at village. She felt deep hurt & sadness3 about entire episode. She said, "I have brought up both children with struggle & they have settled according to their preference" it was quite painful & evident during interview. She is more attached with her brother but since 8 months he has not visited her so she feels bad about that and occ wept also. Now a days financial condition is poor in her maternal family. She is having cordial relationship with all the sisters and having emotional bond with them.

By nature she described herself as 'bholo', and 'dildar'. She takes care of DIL's like own daughters and ready to help others. Whenever she sees other's problem, she feels sad for that and tries to help them out... She was working hard and struggled lots for the family but she didn't get 'jash (success)' from any side. Now at this age she takes care of MIL/ DIL. she felt she never got appreciation. She is fast in work and wants every thing perfect. DIL is slow in work she often helps them for completing work. She has fear2 of water and height. She doesn't like to stay alone. She had dreams of her husband like she is talking with him. She had also some bad dreams but she can't recollect those dreams.

At the end of interview she summarized that she never gets 'jash' from any where and 'main maru jivan kadhi nakhhu ane baki nu pan nikali jashe'. And lastly says to pp that 'bhul chuk hoy to maf karajo'. PP & OBS both felt there was no major reaction to all stress of life.

OBSERVATION:
Speech slow with smile on face in whole interview. On painful issues she became sad but again smiling. And in IPD ward also she freely talks with others and most of the time giving smile to all and co-operative.

INVESTIGATIONS:

6/10/07 HB: 11.9, RBC: 4.47, TC-5600, N-54, L-41, E-3, M-2, B-0,
PCV-36.5, MCV-81.7, MCH-26.6, MCHC-32.6, PLT-189000
ESR-82, RBS-128/NILL,

10/10/07 ANTI ds DNA- 7.0 (0-20 iu/ml)
ANA – 0.43 (>1)
CRP – 63.8 (0-6)
URINE: Albumin-(+), Sugar (+), Pus cell (3-4), epithelial cell (8-10)
Amorphous urates (+)

11/10/07 RA – 22 (1-25)

16/10/07 LFT: S.Billirubin-Total—0.68, Direct—0.28, Indirect—0.4
SGPT-36, SGOT-53, Alk phosphate- 138,
Total protein- 8.3, S.Albumin-3.7, S. Globulin-4.6

Exhibit: 3 **FOLLOW UP CRITERIA:**

1. Feverish feeling/ Temp
2. Headache
3. Backache
4. Heaviness on eyes
5. Thirst/ app
6. Sleep/ taste
7. Laziness/weakness
8. Extremities pain
9. Rt middle finger mcp joint pain / swelling/ warmth
10. Rt shoulder joint pain
11. Urine- yellow
12. Knee joint pain Rt/Lt
13. BP
14. Pulse
15. P/A

DATE/ TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	action
13/10/07 11:00am					CONSULTANT : over all better											CR 30 1P STAT
13/10/07 7:15pm 6/10/07 8:20 pm	A 99.0 A 101.6	A mild	A +	A A	N/N N/N	- -	> +	A +	> +	A > +	S ↓	> S	110 90 130 96	100 112	S L1 1/2F	SL SL
13/10/07 9:00pm 7/10/07 8:30am	A/ 98.8	>+	>+	T-101.4F', P-112, INFORMED TO CONSULTANT A	N/N	G/ -	>+	>+	S	> +	S	S	120 94	104	S	CR 30 1P STAT SL
14/10/07 9:30am 8/10/07 8:00am	A 98.4 98.8	A mild	A +	A	N/N	G/ -	A >+	A >	>+ +	A	S ↓	>+	120 80 86	88 84	S	CR 30 1P STAT SL
14/10/07 10:00pm 9/10/07 7:00pm	A 100.8 100.3	Mild + mild	Mild + A	Mi ld A	N/N	-	Mil d >	A >	>	A	↓	>+	120 80	100 104	S	CR 200 1P ST SL
15/10/07 9:40am 9/10/07 11:20pm	A 98.6 ALL C/O SAME AS EVENING	A	Mild at night	A	N/N	DI ST	>++	A	A	A	A ↓	>++	120 86 CR30 1P STATE	92	S	SL
10/10/07 8:30pm	A	>	>	A	N/N	-	>+	A	>	A		>	120 78	100	S	SL
15/10/07 7:30pm	A 102 101.2	A	A	A	N/N	-	A	A	A	A	A	>	130 86	108	S	SL
11/10/07 10:30am	A	A	A	A	N/N	-	>	A	>	A	↓	>+	124	92	S	IR 1M STATE
16/10/07 7:30am	A 99.0 98.8	A	A	A	N/N	G/ -	A	A	A	A	A	>	120 86 86	92	S	SL
11/10/07 7:15pm	A	A	A	A	N/N	-	S	A	>	A	↓	>++	114 80	96	S	SL
16/10/07 7:35pm	A 101.6 99.6	A	A	A	N/N	-	A	A	A	A	A	>	106 80 90	88	S	SL
12/10/07 8:45am	A 99.0	A	A	A	N/N	G/	S	A	>+	A	↓	>	118 90	96	S	SL
17/10/07 8:00am	A	A	A	A	N/N	G/ -	A	A	A	A	A	>	124 90	92	S	SL
12/10/07 11:00pm	97.0	CONSULTANT : temp relatively better according to pt, app increase, slept well														CR 30 1P STAT
17/10/07	CONSULTANT : much better															SL
12/10/07 11:00pm 7:30pm	A 101.4	A	A	A	N/N	-	>	A	>	A		>	130 80	88	S	SL
17/10/07	A	mild	A	A	N/N	-	A	A	A	A	A	>	116	96	S	SL
13/10/07 7:00pm 7:30am	A 100.6 98	A	A	A	N/N	G/ -	>	A	>	A	↓	>	124 88 80	96	S	SL

18/10/07 7:30am	A 98.2	>	A	A	N/N	G/ -	A	A	A	A	A	>	120/84	88	S	SL
18/10/07 10:30am	A 98.8	A	A	A	N/N	-	A	A	A	A	A	>	130/86	88	S	SL
18/10/07 11:00am	CONSULTANT : BETTER, Fever pattern irregular and improve with no other subjective or objective distress															IR 1M 1P STAT

OTHER FOLLO

WS UP:

	FOLLOW UP	ACTION
19/10/07	Yesterday night T-101 at 1.00am T-98.0 at 3.00am No any c/o, mild pain on thigh O/E: T-98.2, P-88/min, BP-130/86	CR 200 1P Stat
20/10/07	yesterday night T-98.0 at 7.00 O/E: T-96.6, P-86 mild leg pain and burning in eye BP-130/80	SL
22/10/07	No fever, no any c/o, App-Improve O/E: P-88, T-95.4 BP-110/80	SL
24/10/07	No fever No any c/o App-Good O/E: P-80, T-96.2 BP-130/82	SL
27/10/07	No fever, no other c/o, App-Improved, Occ burning in eye, mild pain in wrist joint On lateral side since today morning, no swelling No warmth and no redness BP- 120/90 P-84, T-98.2	SL
29/10/07	No fever and no other c/o, wrist pain-0 Adv-regular exercise O/E: P-80, T-96.2 BP-110/80	SL
02/11/07	No fever, mild Backache+ O/E: P-88, T-96.4 BP-120/82	SL
07/11/07	mild Backache-S O/E: P-80, T-97.2 BP-110/80 HB-13.0, WBC-4900, RBC-5.00, N-50, L-46, E-3, M-1 PCV-41.8, MCH-257, MCHC-31.3, RDW-SD—47.3 ESR-80	CR 200 1P
22/11/07	Over all much better, no any c/o, Diet and Exercise irregular O/E: BP-120/86 Adv-FBS/PPBS	CR 200 1p
08/12/07	No c/o, no swelling of joint Diet and Exercise irregular, O/E: Wt.-66kg, BP-130/70	CR 200 1P
14/12/07	Since 12th night sudden swelling++ at Lt.ankle, pain-pulsating++, redness+ ,swelling and pain<2 Walking, <2 Cold air, >2 Warm, Thirst-decrease, Knee pain+, Yesterday Chill with Rigor3 at 4:00pm and need Covering three gadala on Upperextrimities2 and Head Warm2 ? Acute Exacerbation of RA	AR 200 4 hrly

	? Increased Uric acid O/E: redness+ and swelling++ on the Lt.ankle joint, painful movement Adv-CBC, ESR, RA, CRP, S.Uric acid, FBS, PPBS Ortho opinion: Diagn—Acute Synovitis Adv- T.Solon 5mg TDS T.Voveran plus TDS T.Rekool TDS [ADV- Not takes any allopathic medicine and continues our Homo. Rx]	
17/12/07	Lt Ankle Pain>90%, < walking only, swelling>+, redness-A Knee pain>+, HB-12.5, TC-5800, ESR-80, N-63, L-30, E-5, M-2, RBC-4.63, PCV-36.9, MCV-79.7, MCH-27, MCHC-33.9, RDW-SD—45.8 PLT-199000, CRP-117, FBS-126, PPBS-262, RA- Quantitative – 10 (1-25), CRP- Quantitative—117 (1-10) S.Uric acid – 4.5 (2.0-7.2)	AR 200 4 hrly
21/12/07	Lt Ankle joint pain>3, swelling-A, no difficulty in walking O/E: P-92/min, T-98.4, BP- 130/80,	SL
08/01/08	No any c/o O/E: BP-130/80, Wt.-66Kg Strict adv for diet and exercise. Adv-FBS, PPBS	CR 200 1P
Summery: Homoeopathic: since march 09 she becomes irregular. Until march she received 3doses of CR 1M with infrequent doses of I.R. her B.P remained under control. All her other complaints >3.she become irregular3 in reporting. Allopathic : she is on ½ tab B. D from 4.8.08 . Later on it was made OD as blood sugar came under control with poor diet control & exercise. March 09 onwards we need to increase doses of metformin ½ bd as she was irregular in treatment. 25/8/09 : came after 2 months FBS 129 & PP2BS 306. BP>. 130/80 numbness 2 in legs. IR. 1M & CR 1M 6 p HS.		