Symposium Kent Boenninghausen **Devangini/ Devendra/NSP**
September 09

EXBHIT-I

OBJECTIVES:

1. Learning how to observe a patient in acute situation for acute prescribing in homoeopathy,
2. Learning how to interpret observations in the light of homoeopathic philosophy, repertory and materia medica.
3. Learning to understand the theme of the patient's state and homoeopathic remedy in materia medica by interpretations of various modes of communications --- verbal/non-verbal and anatomical/physiological level.

DIRECTIVES

1. Formulate LSMC of the given data.
2. Do the analysis and evaluation of the derived symptoms.
3. Select suitable approach & repertorise the case
4. Co-relate the mental state with physical examination findings.
5. Derive the theme of the clinical state and search parallel state in homoeopathic material medica.

EXHIBIT-1

PRELIMINARY INFORMATION:

Registration no: Date:29/7/2009 Name: Mrs.VSD Age: 26 yrs.

Sex: female Education: 4th STD Occupation: H.W. Marital status: Married since 2 yrs

Father: died 4-5 yrs back, chronic alcoholic Mother: living

Brothers: 2 younger Sisters: 1 elder

INTRODUCTION:

Patient came in the gynaecology OPD first time on 12/7/09 accompanied by one female relative. That time she was having? 5 month amenorrhoea and UPT done on 24/3/2009 was positive. Every thing was all right during ANC check up. On examination

FHR was regular. Patient and relative were happy because she had conceived after 2 yrs of marriage.

But when patient came for the second follow up at that time FHS was not detectable. So the relative accompanying her was explained about the situation. But the relative got scared, how did this happen? So she called patient's husband. He came after the 2-3 hrs. Then we explained the situation and advised to go for USG. {USG: SUG at 16.2 wks, no cardiac activity, and placenta anterior, cervical os closed}

Patient also got hint about what ever happened, but she did not accept that the baby has died.

As per the patient's obstetric history LMP was ?21/2/09 (by date 22.5 wks) and per abdomen examination also suggested that she is around 20-22 wks of gestation. So patient was admitted for second trimester induction.

On 29/7/2009 patient was admitted for induction of the second trimester at 4 pm. At that time per vaginal finding was cervical os closed and posterior, no uterine contractions. Gynaecologist advised Tab. misoprost 100 mcg per vaginal.

Since admission patients mood was low. She was just starring around, not communicating with any relative or doctor. She was just lying down on the bed. Sad expressions on the face, eyes were dry.

Around the 10:15 pm patient had very minimal uterine contractions at long intervals and P/V finding was cervical os closed and posterior, so gynaecologist advised to put Tab. misoprost 200 mcg per vaginally.

Through out the night patient did not progress. On 30/7/09 at 8 am the uterine contractions were very weak and per vaginal examination suggestive of cervical os closed and posterior. Situation informed to the gynaecologist. Patient had already received over dose of prostaglandins. For the last try Tab. misoprost 200 mcg inserted per vaginally.

Resident who was monitoring the patient during whole night observed that patient had not taken food since yesterday and even had not drunk water. She was very much quiet, not responding to any verbal communication, as if she was in her own world.

Around 12:30 pm patient was getting uterine contractions once in 8-10 min lasting for 25-30 sec but per vaginally cervical os tight and posterior.

EXHIBIT – II

DIRECTIVES

1. Write down your totality after the analysis and evaluation of symptoms.
2. Select suitable approach for this case and discuss your final impression of constitutional remedy.
3. Discuss your actions during the subsequent follow ups with reasoning.

CHIEF COMPLAINTS: (CASE DEFINED ON 31/7/2009)

Location	Sensation	Modality	Accompaniments
A) HEAD Frontal Vertex F : 1/8-10 days D; 2 days O: sudden	Throbbing pain2 No nausea /vomiting	A/F improper sleep (afternoon) < strong odour 3 < sun2 < noise 2 > pressure 2 > massage 2 > after sleep2	Lachrymation 2 Redness of eye 1 Wants to be alone Does not want to talk with anyone
B) GIT Since long time Epigastric region F: occ. D: 1 day	Vomiting Burning	A/f : exposure to sun	Occ. headache

PATIENT AS A PERSON:

Appearance: - lean, wheatish to fair complexion

Sweat: - partial on forehead and upper lip

Appetite/Thirst: - thirst in sips every 5-10 min

Craving: - apples+ Aversion: - milk++

Urine: - Normal Stool: - regular

Menstrual Function: - Regular, 2/ 26 days cycle, colour-dark red, moderate

Odour- fishy Consistency thick, stains-reddish, indelible

Lower abdominal pain colicky pain only 1-2 days at the beginning of Menses

Leucorrhoea – 4-5 days after the menses, milky white

Sexual function – desire decreased due to pain

Obstetric history: - G_1 P_0 A_1 L_0,

Sleep: disturbed when anyone dies Dreams: Ghost 2, snakes 2, wedding 2

Riding in bus causes headache

Sun exposure: causes headache^{2+} Thermals: - C4H

PHYSICAL EXAMINATION

General examination: T: 99.2 F Pulse: 96 /min B.P: 124/80mmhg

Systemic examination: R.S: NAD, P/A: NAD, C.V.S: NAD

P/A- uterus relax, 20-22 wks, FHS not audible

INVESTIGATIONS: 29/7/09

Hb-9.2 gm%	Blood group –"O" positive	RBS- 92.0 mg/dl
HIV- Negative	HBsAg – non-reactive	VRRL- Nonreactive

Patient was discharged on 31/7/09 at evening

3/8/09
After going home patient wanted to weep but not much. On Sunday (1/8/09) patient wept a lot, even started becoming irritable on husband.
During this follow up patient was giving answers in short
Appetite/thirst- normal Sleep- normal
But since 2-3 days patient was complaining of pain in the uterine region, it is mainly uterine soreness < sitting > lying on abdomen > warmth No P/V bleeding

O/E BP-120/80mmhg Pulse- 80/min
P/A: mild tenderness in hypogastric region, uterus well contracted
P/S: No lochia, no other discharge/bleeding, cervix healthy, os closed ACTION??

10/8/09
Husband told that now intermittently mood changes but irritability decreased
Even weepy mood decreased. Abdominal pain decreased 80%
Spotting occasionally Appetite/thirst- normal

ACTION??

17/8/09
Patient smiling, feeling comfortable. Desires to work, no swing of mood or weeping in last week. Appetite/thirst-normal Sleep-normal No abdominal pain
No spotting No headache *Minimal lactation*

ACTION??