Collecting clinical experience of homeopathic treatment of COVID-19

Seventh issue

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Counting, variation and semantics

Research often raises more question than it answers. This is not because the questions were not there before, but because they were hidden and research unhides them. We are now counting symptoms to find prevalence. This way we can compare medicines that are frequently used with infrequently used medicines. We also hope that this renders a better repertory, but we only know this for sure after collecting much more data and applying the outcome in daily practice.

Meanwhile, we have to handle many questions we avoided so far. The answer to many questions is difficult, some require a book to answer properly and some cannot yet be answered. We hope that by sending feedback to collected cases some questions can be partly answered, resulting in higher quality of the next batch of cases.

Variation

One of the questions that come up when we start counting is: how is it possible that the homeopathic repertory is used all over the world? When we start counting we desire definitions of symptoms to count the right thing. How can we count 'desire for sugar/sweets' without defining grams of daily intake? The average intake of sugar in Kolkata (the city of sweets) would be called 'desire for sugar/sweets' in Delhi. When we over-define symptoms we need separate repertories for Kolkata and Delhi, etcetera, but also for different cultures, religions, professions, and so on.

The answer is: **context**. Context is a container for all kinds of variables like gender, culture, climate, profession, etcetera. Now we can count things that are more frequent than average in the same context and the practitioner decides about context, with his practice experience and intuition.

Nevertheless, variation cannot be avoided. A group of 10 experienced homeopathic doctors investigated prospectively the prevalence of six homeopathic symptoms in 4094 patients. Despite more than 10 consensus meetings about methodology and definition of symptoms considerable variation remained, see Figure 1. The prevalence of the symptom 'sensitivity to injustice' was between 3% and 20%. The variation of other symptoms like 'diarrhoea from anticipation', 'recurrent herpes of the lips', 'grinding teeth during sleep' and 'loquacity' was less, but still considerable. It seems that variation cannot be avoided, but this is not a problem as long as each observer has the same cut-off value for all patients. More about this in a future newsletter.

Variation can partly be explained by context, but not all variation. Every observer has his own interpretation of things, based on his own training and experience. It is only human to think that your interpretation is the right one and to feel the need to convince others. An example. Some homeopathic practitioners do not prescribe *Stramonium* if the patient has no fear of the dark. However, when a group of Dutch doctors examined each other's best *Stramonium* cases, with more than one year follow-up, it appeared that only five out of 12 patients had fear of the dark. Consensus meetings appeared to be a valuable tool in resolving fierce discussion about personal opinions.

Counting can help in this discussion, but for this counting we have to accept a subjective choice of wording/definition of the symptom.

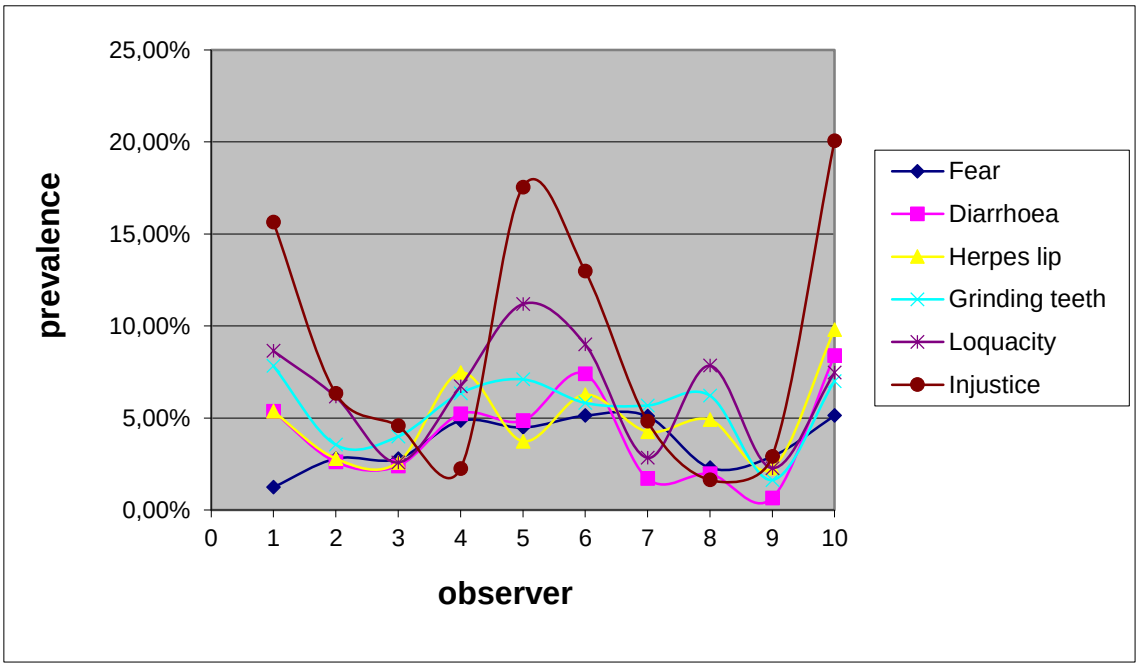

Figure 1: variation between 10 observers regarding prospective evaluation of the symptoms 'fear of death', 'diarrhoea from anticipation', 'recurrent herpes of the lips', 'loquacity' and 'sensitivity to injustice'.

Semantics

One of the first symptoms that came up in this COVID-19 epidemic was an immensely tired feeling, most than just tired, or weak or …. This is one of the occasions here doctors use different wordings for the same phenomenon, like:

- just very tired
- low energy
- Extreme fatigue
- intense weakness
- fatigue in his body but not in his mind
- désire à rester couché
- lethargy
- extreme weakness - feels like she is breaking apart
- weakness heaviness in body
- Intense prostration, walking was so difficult; desired to lie down
- General malaise and prostration
- Extreme weakness and prostration

If we want to know the prevalence of this symptom we must ignore the nuances and choose one word. In this case we chose 'prostration/exhaustion', a subjective choice and the repertory-rubric 'MIND – PROSTRATION' does fully cover the idea, nor does the rubric 'GENERALS – WEAKNESS'.

After counting the occurrence of 'prostration' in more than hundred cases we see that its' prevalence is different in populations responding well to *Arsenicum, Bryonia*, or *Phosphorus*, compared with

Camphora or *Gelsemium*. Possibly, after consensus meetings discussing various medicines, we will eventually discover that 'prostration' has different meanings in different medicine populations, but we cannot have such discussions unless we collect cases under the 'container' 'prostration'.

Lies, damn lies and statistics

While counting cases we must beware of the principle 'garbage in, garbage out'. The problem with counting and statistics is that misconceptions in the underlying data are obscured. Let's look at the first edition (21st April 2020) of our mini-repertory with LR values for COVID-19:

Table 1: LR values for frequently occurring COVID-19 symptoms, based on 97 cases, 15 responding well to Ars, 25 to Bry, 11 to Camph, 11 to Gels and 6 to Phos. Column 2 indicates frequency of the symptom in the whole population. Most important symptoms indicated in Bold type.

	total	ars	bry	camph	gels	phos
n=	97	15	25	11	11	6
prostration/exhaustion	**61**	0.95	0.78	1.18	1.53	0.78
dry cough	**47**	0.80	**1.63**	1.14	0.73	0.67
dyspnea	**34**	0.53	1.57	0.76	0.24	**2.02**
slow onset of disease	**27**	0.95	**2.30**	0.63	0.30	1.21
headache	**24**	0.78	**1.73**	1.12	0.34	1.38

On the one hand we are glad that we have a repertory based on actual cases, on the other hand we must keep guard of the quality of our cases. This is a kind of Catch-22 situation: only after collecting sufficient cases we can discuss the quality of cases. Our newsletter will deal with this step-by-step.

In next newsletters we will focus on quality of cases and we will start with bias. This is a heavy subject filling bookshelves. There is, however, one book that every medical student should read: Kahneman D. *Thinking, Fast and Slow*. London: Penguin books; 2011. A summary can be found at https://en.wikipedia.org/wiki/Daniel_Kahneman.

Resuming requisites for case descriptions

We resume the minimal necessary data for this project. We already had:

- Severity of COVID-19 illness: Mild – Moderate – Severe – critical
- Is COVID-19 confirmed?
- Medicine, with date of first intake
- Number of hours until onset of improvement and/or until absence of fever
- If possible at least 3-5 symptoms that were characteristic for the case
- Pneumonia on X-ray or CAT

Also check:

- Slow or fast onset of complaints
- Prostration/exhaustion; where is the weakness seated
- Fear/anxiety
- Restlessness
- Fever, chill, or chill alternating with fever
- Thirst
- Pain; where
- Cough dry or moist
- Dyspnea
- Throat pain
- Loss of taste and/or smell
- diarrhoea

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