

**“A CLINICAL STUDY ON MIASMATIC APPROACH IN MANAGEMENT OF  
PATIENTS WITH CHRONIC SUPPURATIVE OTITIS MEDIA”**

A DISSERTATION TO BE SUBMITTED IN PARTIAL FULFILLMENT OF THE  
REQUIREMENT FOR THE AWARD OF THE DEGREE OF

**DOCTOR OF MEDICINE (HOMOEOPATHY): M.D. (Hom.)**

**IN**

**ORGANON OF MEDICINE AND  
HOMOEOPATHIC PHILOSOPHY**

**By**

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**SARADA KRISHNA HOMOEOPATHIC MEDICAL COLLEGE,  
KULASEKHARAM, TAMIL NADU**



SUBMITTED TO

**THE TAMILNADU Dr. M.G.R. MEDICAL UNIVERSITY, CHENNAI**

2019

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THE HEAD OF THE DEPARTMENT AND THE INSTITUTION**

This is to certify that the Dissertation entitled “**A CLINICAL STUDY ON MIASMATIC APPROACH IN MANAGEMENT OF PATIENTS WITH CHRONIC SUPPURATIVE OTITIS MEDIA**” is a bonafide work carried out by **Dr. PANCHAJANI. R**, a student of M.D. (Hom.) in **DEPARTMENT OF ORGANON OF MEDICINE AND HOMOEOPATHIC PHILOSOPHY** in **SARADA KRISHNA HOMOEOPATHIC MEDICAL COLLEGE, KULASEKHARAM, KANNIYAKUMARI** under the supervision and guidance of **Dr M MURUGAN, M.D. (Hom.), PROFESSOR and HEAD, DEPARTMENT OF ORGANON OF MEDICINE AND HOMOEOPATHIC PHILOSOPHY** in partial fulfilment of the Regulations for the award of the Degree of **DOCTOR OF MEDICINE (HOMOEOPATHY)** in **ORGANON OF MEDICINE AND HOMOEOPATHIC PHILOSOPHY**. This work conforms to the standards prescribed by **THE TAMILNADU DR. M.G.R. MEDICAL UNIVERSITY, CHENNAI**.

This has not been submitted in full or part for the award of any degree or diploma from any University.

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## **CERTIFICATE BY THE GUIDE**

This is to certify that the Dissertation entitled “**A CLINICAL STUDY ON MIASMATIC APPROACH IN MANAGEMENT OF PATIENTS WITH CHRONIC SUPPURATIVE OTITIS MEDIA**” is a bonafide work of **Dr. PANCHAJANI. R.** All her work has been carried out under my direct supervision and guidance. Her approach to the subject has been sincere, scientific and analytic. This work is recommended for the award of degree of **DOCTOR OF MEDICINE (HOMOEOPATHY)** in **ORGANON OF MEDICINE AND HOMOEOPATHIC PHILOSOPHY** of **THE TAMILNADU DR. M. G. R MEDICAL UNIVERSITY, CHENNAI.**

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## DECLARATION

I, **Dr. PANCHAJANI. R**, hereby declare that this Dissertation entitled “**A CLINICAL STUDY ON MIASMATIC APPROACH IN MANAGEMENT OF PATIENTS WITH CHRONIC SUPPURATIVE OTITIS MEDIA**” is a bonafide work carried out by me under the direct supervision and guidance of **Dr. M MURUGAN,M.D (Hom.)**, Professor and Head, Dept. of Organon of Medicine and Homoeopathic Philosophy, in partial fulfilment of the Regulations for the award of degree of **Doctor of Medicine (Homoeopathy)** in **ORGANON OF MEDICINE AND HOMOEOPATHIC PHILOSOPHY** of The Tamil Nadu Dr. M.G.R Medical University, Chennai. This has not been submitted in full or part for the award of any degree or diploma from any University.

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## **ACKNOWLEDGEMENT**

First and foremost I thank Almighty God who always guided me in my work and help me to choose the right path of life.

I express my sincere thanks to my guide **Dr. M. MURUGAN, M.D (Hom.)**, Professor and Head, Dept. of Organon of Medicine and Homoeopathic Philosophy for his valuable guidance, advice, supervision, motivation and constant support throughout my course of study and dissertation work. It's my privilege to be his student and to do this work under his guidance.

I convey my respectful regards to **Dr. C. K. MOHAN, B.Sc., M.D. (Hom.)**, Chairman, for providing the opportunity to undertake this work and extending all necessary facilities to carry out the work to my satisfaction in this institution.

I am thankful to **Dr. N. V. SUGATHAN, M.D. (Hom.)**, Principal and Medical Superintendent for his guidance and support.

My profound gratitude and deep regards to my colleague & PG coordinator **Dr. WINSTON VARGHEESE, M.D. (Hom.)**, Professor who has always been a source of support and inspiration.

I owe my sincere thanks to **Dr. MANOJ NARAYANAN, M.D. (Hom.)**, Professor, Department of Organon of Medicine and Homoeopathic Philosophy for the valuable inspiration all along for the completion of my work.

I am grateful to my colleagues in the various departments and all hospital staff who whole heartedly encouraged and supported me at all times. I take this opportunity for conveying sincere gratitude to my patients who gave consent and participated in this study.

I acknowledge with deep sense of reverence and gratitude to my mother **Mrs. RADHAMMA. L, my SISTERS & my CHILDREN** for their love, care and prayers I remain indebted to them for everything I have and whatever I have achieved.

I am very thankful for my dearest friends **Dr. M. P. LAL, Dr. L. GIRIJA, Dr. V. SIJU, Dr. SANJU** for their inspiration and care throughout my course. I would have never accomplished my goal without them.

My sincere thanks to **Dr. Chandraja Ratheesh**, for her valuable help during my work.

I also take this opportunity to thank **Mrs. Subha** for her help provided to me during my dissertation period.

I am grateful to all my Students for being helpful, supportive and loving. Special thanks to former PG student **Dr. Kousalya** for her valuable support. I extend my sincere gratitude to librarians, all my batch mates whose co-operation and timely help to end my task.

**Dr. PANCHAJANL.R**

## **ABSTRACT**

Chronic suppurative otitis media (CSOM) is a long standing infection of a part or whole of the middle ear cleft with ear discharge and perforation of tympanic membrane. It is predominantly a disease of developing world. Because of the nature and stage of disease, an anti-miasmatic treatment is more effective for reducing the recurrence and preventing complications.

Random selection of 30 cases of patient with chronic suppurative otitis media and the case been analyzed and the totality been erected. Then the remedy prescribed based on totality and miasmatic background of each case. For effective assessment and evaluation diseases intensity score were given for each cases. Statistical analysis is done by assessing the symptom score of before and after treatment using paired “t” test.

The result of this study obtained that the improvement was 100% and showed that anti-miasmatic remedies were effective in managing such cases. Syphilis was the most predominant miasm in most of the cases and Mercurius Solubilis was the indicated remedy (73%). 200<sup>th</sup> potency was more effective. Cold exposure was the prominent predisposing factor.

### **KEYWORDS:**

Chronic Suppurative Otitis Media, Mercurius Solubilis, 200 Potency

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## LIST OF ABBREVIATIONS

SL. NO.	ABBREVIATIONS	EXPLANATION
1.	Rt.	Right
2.	%	Percentage.
3.	+	Positive.
4.	<	Aggravation,more than.
5.	>	Amelioration,less than.
6.	A/F	Ailment from.
7.	Agg.	Aggravation.
8.	Aph	Aphorism
9.	F	Female.
10.	M	Male
11.	Fc	Female Child
12.	Mc	Male child
13.	F/H	Family history.
14.	H/O	History of.
15.	FMP	First Menstrual Period
16.	LMP	Last Menstrual Period
17.	Lab. Investigation	Laboratory investigation.
18.	NAD	No abnormality detected.
19.	O/E	On examination.
20.	PL	Placebo.
21.	SD	StandardDeviation
23.	SL	SaccharumLactis
24.	TEMP	Temperature
25.	N.R	Nothing relevant

## **LIST OF APPENDICES**

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# *Introduction*

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## 1.1. INTRODUCTION

Chronic suppurative otitis media (CSOM) is a long standing infection of a part or whole of the middle ear cleft characterized by ear discharge and a permanent perforation of tympanic membrane.<sup>[9]</sup> The infection in the middle ear cleft are always threatening by way of the possibility of their extension to the adjacent intracranial tissues. The attack usually follows a common cold or influenza. Eustachian tube is the most common route of infection and the other path is through the traumatic perforation of the tympanic membrane.<sup>[16]</sup> It is predominantly a disease of developing world. It is also the single most important cause of hearing impairment in rural population.<sup>[9]</sup>

A history of at least 2 weeks of persistent ear discharge should alert the problem. If the ear could be dry mopped well enough to see the ear drum, then the diagnosis of CSOM can be confirmed by visualization of the perforated tympanic membrane. The disease usually begins in childhood as a spontaneous tympanic perforation due to an acute infection of the middle ear , known as acute otitis media or as a sequel of less severe form of other types of otitis media. The infection may occur during the first 6 years of a child's life with a peak around 2 years. The point of time when ASOM becomes CSOM still controversial. Generally, patients with tympanic perforation which continue to discharge mucoid material for 6weeks to 3 months, despite medical treatment, are regarded as CSOM. The WHO definition requires only 2 weeks of otorrhoea , but otolaryngologists tend to adopt a longer duration , more than 3 months of active disease.<sup>(20)</sup>

Dr. Hahnemann describes in aphorism 204-206 that all chronic affections and diseases properly so called must be cured only from within, by the

Homoeopathic medicines appropriate for the miasm that lies at their root. Preliminary investigation of the miasm that lies at their root, of the simple miasm or its complications with a second or even with a third.<sup>(10)</sup>

The morbific agents that are causally connected with production of diseases, were designated by a general term” Miasm or Miasma”, during the time of Hahnemann.

Although the acute diseases were rapidly and completely cured by application of well selected medicines but it was observed that chronic diseases always had a tendency to relapse in a more or less varied form with new symptoms. It was also seen that in some cases they had reappeared annually with an increase of complaints. This apparent failure after discovering and practising Homoeopathy for about 30 yrs. (1790- 1820 A.D). Hahnemann had to ponder over this matter seriously which led him to discover the theory of Psora as well as of chronic miasms.<sup>[6]</sup>

Antimiasmatic medicines help to clear up the suppressions ( in relation to the past); clear up the presenting symptoms from their root or origin (in relation to the present); and clear up the susceptibility to get infection and there by strengthening the constitution (in relation to the prophylactic aspect or future)<sup>[2]</sup>.

## **1.2. NEED FOR THE STUDY**

Global prevalence of otitis media suggesting highest risk in India with other associated developing countries – as reported by W.H.O. The main cause behind otitis media is the blockage of eustachian tube with viral upper respiratory infection or by allergies. The future impact of this disease can lead to hearing loss at the early age.<sup>[11]</sup>

Incidence of chronic suppurative otitis media is higher in developing countries because of poor socioeconomic standards, poor nutrition and lack of health education. It affects both sexes and all age groups.<sup>[9]</sup> India was reported to be associated with the highest prevalence of otitis media with more than 6% experiencing the disorder.

The WHO had reported and categorised otitis media as one of the neglected tropical diseases. Most of the school children in India have been reported to associate with at least one episode of otitis media varying from 10% to 20% of the children. Among them there is more impact of the disease in slums rather than in well sanitized urban cities.<sup>[11]</sup>

In modern medicine the line of management is antibiotics, antibiotic ear drops, analgesics, nasal decongestants and Myringoplasty for perforation. Prolonged use of these medicines leads to suppression of the symptoms and the disease goes to deeper level results in serious complications.

In Homoeopathy, according to Dr. Hahnemann diseases are dynamic in origin and these dynamic diseases are classified into acute and chronic. Chronic diseases are due to chronic miasms. These miasms are inherited in our body, when these chronic diseases are treated with anti-miasmatic remedies it acts on the vital force and improves the immunity of the patient, lessens the chance of disease going into the deeper level and reduces the complications.

This study helps to know more about the effectiveness of anti-miasmatic treatment in patients suffering from chronic suppurative otitis media.



### **1.3. SCOPE OF THE STUDY**

Otitis media is a group of inflammatory disease of middle ear. Typically the disease follows viral infection of upper respiratory tract but soon the pathogenic organism invade the middle ear.<sup>[9]</sup> Few attacks of acute otitis media which have fails to resolve completely leads to chronic suppurative otitis media.<sup>[8]</sup>

Recurrent attack of otorrhoea, conductive type of deafness, otalgia due to secondary infection and otoscopy shows perforation of tympanic membrane are the features.<sup>[8]</sup> Continued infection in the absence of proper therapy produces irreversible pathological changes. The most important factor is that the outcome of otitis media is total hearing loss if it remain untreated. Treatment based on history, physical examination findings and investigation if needed. Homoeopathy differs with regular medicine in its interpretation and application of several fundamental principles of science. It is these differences of interpretation and the practice growing out of them which give Homoeopathy its individuality and continue its existence as a distinct school of medicine.<sup>[7]</sup> A healthy life style and antimiasmatic treatment with Homoeopathy will lower the prevalence and complications of CSOM.

### **1.4. STATEMENT OF THE PROBLEM**

Because of the chronic nature of disease and because the point at which ASOM changes to CSOM is unclear, prevalence seems a more appropriate indicator for measuring the disease burden. A Medline search was conducted using the following terms “chronic otitis media”, “mastoiditis”, “epidemiology” and “prevalence”. The abstracts were screened and studies that reported prevalence rates, obtained from community surveys of general population or surveys of special groups of subjects at risk(eg. School children), were included. This study shows the

prevalences of CSOM among the South – East Asian countries, prevalence rates in Thailand ranged from 0.9 to 4.7% while the Indian prevalence of 7.8% is high. This is a recent estimate from a school survey in Tamil Nadu and is lower than previous estimates that range from 16 to 34%. The hearing impairment produced by otitis media affects intellectual performance, which has been demonstrated by several studies. Long term effects on overall intellectual, linguistic and psychological development have not been consistently observed. <sup>(20)</sup>

Homoeopathy treats an individual wholistically rather than just treating the disease. Miasm has a great influence on the course of the disease and the Homoeopath can identify that course and thus act accordingly aiming for a permanent cure.

### **1. 5. CLINICAL STUDY**

It is an observational clinical study conducted in the OPD, IPD and rural health centres of Sarada Krishna Homoeopathic Medical College. Study is based on the observational data's collected from the patients with Chronic suppurative otitis media.

# *Aims And Objectives*

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## **2. AIMS AND OBJECTIVES**

- To find Anti-miasmatic medicines.
- To find common medicines for acute affections.
- To find out the predisposing factors for CSOM.
- To find the common potency effective for CSOM.

# *Review of Literature*

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## **3. REVIEW OF LITERATURE**

### **3.1 OTITIS MEDIA**

#### **3.1.1 Definition**

Otitis media is an inflammation of a part or all of the mucoperiosteal lining of the middle ear cleft. Otitis media is essentially a clinically based disease, while during the course of disease exudation, suppuration and proliferation or necrosis of the tissue occur.<sup>[14]</sup>

Two major forms of otitis media are Acute suppurative otitis media(ASOM) and Chronic suppurative otitis media( CSOM).

#### **3.1.2 Acute suppurative otitis media**

It is a pyogenic bacterial infection of the middle ear. It occurring at all ages and particularly in children.<sup>[16]</sup> It consists of middle ear effusion and features of acute infection such as fever , ear pain and bulging of ear drum.<sup>(3)</sup>

##### Routes of infection

- Via Eustachian tube – common route in infants and children
- Via external ear – traumatic perforation of tympanic membrane due to any cause
- Blood borne.<sup>[9]</sup>

##### Predisposing factors

- Recurrent attack of upper respiratory tract infections.
- Nasopharyngeal or nasal packs

- Infections of tonsils and adenoids
- High deviated nasal septum
- Nasal polyps
- Rhinitis and sinusitis
- Tumours of nose and nasopharynx
- Short, straight , wide eustachian tube.<sup>[16]</sup>
- Reduced immunity
- Barotrauma
- Exanthematous fevers<sup>(3)</sup>

#### Causative Micro organisms

Viral nasal infection precedes the bacterial ear infection. Common bacterias are Haemophilus influenza, Pneumococcus, Betahaemolytic streptococci, Moraxella catarrhalis, Staphylococcus aureus etc.<sup>[16]</sup>

Virus involved are respiratory syncytial virus, Human rhinovirus, Human coronavirus, Influenza virus type A, Adenovirus. About 30% is viral alone but associated bacterial infection is common.<sup>(3)</sup>

#### Pathology, Stages and Clinical presentations

Most of the patients have a history of upper respiratory tract infection .Course of the disease is divided in to five stages,

- Stage of tympanic congestion or tubal occlusion - It is the reaction of the middle ear towards the invading organism causes oedema and hyperaemia of the nasopharyngeal end of Eustachian tube. Tympanic membrane looks

congested.<sup>(16)</sup> Patient complaints of pain and fullness in ear, no fever, mild deafness.<sup>(3)</sup>

- Stage of exudation - Inflammatory process progresses and the inflammatory exudates collect in the tympanic cavity. The patient complains of throbbing pain in ear with deafness, high degree of fever, bubbling sound in the ear. Tympanic membrane shows more congested and bulging.<sup>(16)</sup> Tuning fork test shows conductive deafness.<sup>(3)</sup>
- Stage of suppuration-The collected inflammatory exudates cause pressure necrosis and perforation of the tympanic membrane. Perforation is central. The Mucosa of the middle ear is seen through the perforation as thickened and congested. Pain diminishes but hearing loss persists. Discharge is serosanguinous at the onset and later mucopurulent. Tenderness over the mastoid antrum. X-ray of mastoid shows clouding of the air cells.<sup>(16)</sup>
- Stage of convalescence - Disease starts subsiding. Recovery depends on the severity of infection, individual resistance and proper treatment. In case where proper treatment is not instituted the disease involves the mastoid air cells.<sup>(16)</sup>
- Stage of acute mastoiditis - Continued infection causes hyperaemia and thickening of the mucoperiosteum leads to bony erosion.<sup>(16)</sup> Clinical signs include profuse, purulent, pulsatile ear discharge for more than two weeks duration following an attack of acute suppurative otitis media indicates mastoiditis. Mastoid tenderness is another sign of inflammation.<sup>(16)</sup>

## Diagnosis

Diagnosed clinically. Test for hearing shows conductive deafness.

CT temporal bone shows clouding of air cells in mastoiditis.



Bacteriological examination of ear discharge for identifying the causative organism.<sup>(3)</sup>

### **3.1.3 Chronic suppurative otitis media**

CSOM is a chronic inflammatory process involving the middle ear cleft producing irreversible pathological changes.<sup>(16)</sup> It is characterized by perforation of tympanic membrane and persistent drainage from the middle ear, lasting more than 6-12 weeks. The perforation becomes permanent when its edges are covered by squamous epithelium and it does not heal spontaneously and becomes an epithelium lined fistulous tract.<sup>(9)</sup>

#### **Epidemiology**

Incidence is higher in poor socioeconomic classes. Poor nutrition and lack of health education are the contributing factors. Affects all ages and both sexes. In India the prevalence rate is higher in rural area ( 46/ 1,000 persons) than urban area ( 16/ 1,000 persons).<sup>(3)</sup>

Prevalence surveys, which vary widely in disease definition , sampling methods and methodologic quality, show that the global burden of illness from CSOM involves 65- 330million individuals with draining ears, 60% of whom suffer from significant hearing impairment. CSOM accounts for 28,000 deaths and a disease burden of over 2 million DALYs. Over 90% of the burden is borne by countries in the South-East Asia and Western Pacific regions, Africa, and several ethnic minorities in the Pacific Rim. CSOM is uncommon in the Americas, Europe, the Middle East and Australia.<sup>(20)</sup>

## Aetiology

- Few attacks of acute middle ear infection which failed to resolve completely.
- Acute infectious diseases in childhood.
- Disorder of ventilation and retraction pocket formation.
- Long standing secretory otitis media.
- Insidious chronic keratinizing process seen in attic and postero- superior part of tympanic membrane.<sup>(8)</sup>

## Bacteriology

Among aerobes *Pseudomonas aeruginosa*, *B. Proteus*, *E.Coli*, *Staphylococcus aureus* etc. Anaerobes include *Bacteroids*, *B.fragilis* etc. Anaerobes multiply as the absorption of air occurs from middle ear cleft due to granulation, thickened mucoperiosteum and cholesteatoma.<sup>(8)</sup>

## Factors responsible for the chronicity of CSOM

- Poor drainage of inflammatory exudates.
- Eustachian tube dysfunction, patulous tube etc.
- Aerobic and anaerobic flora.
- Middle ear infection from nasopharynx and respiratory tract in chronic respiratory diseases.
- Osteitis and granulation tissue blocking drainage.
- Presence of keratinizing squamous epithelium and debris help growth of organism and also cholesteatoma formation.
- Diffuse mucosal changes with scarring and devascularisation.
- Immune deficiency and recurrent upper respiratory tract infection.<sup>(8)</sup>

## Types of CSOM

### Tubotympanic type

Safe or benign type. Usually starts in child hood and as a complication of acute otitis media where there is persisting perforation of tympanic membrane .<sup>(8)</sup>The perforation does not heal after the initial acute attack because of persistent infection, if it continues the edges of perforation is covered by squamous epithelium from outer surface. A patient with such type of perforation is liable to persisting or recurring discharge secondary to upper respiratory tract infection.<sup>(15)</sup>This type involves antero inferior part of middle ear cleft and is associated with central perforationie, margin of the perforation is formed by pars tensa. No risk of serious complications.<sup>(9)</sup>It is again divided in to two,<sup>[16]</sup>

### Tubal type

Infection ascends through the Eustachian tube and the underlying cause lies either in the nose, sinuses or nasopharynx. Usually seen in children of low socioeconomic strata and involves both ear.<sup>(16)</sup>

### Tympanic type

Infection reaches the middle ear through a defect in the tympanic membrane usually a large central perforation. Seen in adults and involves one ear only.<sup>(16)</sup>

### Aetiology of Tubo tympanic type

- Sequel of acute otitis media – Tympanic membrane perforation becomes permanent and permits repeated infection from the external ear. Middle ear

mucosa is exposed to dust, pollen and other aeroallergens causing persistent otorrhoea.

- Ascending infection via eustachian tube.
- Result of allergy to ingestants such as milk, egg, fish etc.<sup>[9]</sup>

#### Predisposing factors

- Recurrent upper respiratory tract infection, nasal allergy, chronic rhinosinusitis
- Enlarged adenoids, chronic tonsillitis etc..
- Bathing and swimming in pools, picking of ear with infected material etc. .
- Malnutrition and hypoglobinaemia.<sup>(8)</sup>

#### Pathology

Remain localised to the mucosa mostly to anteroinferior part of the middle ear. The pathological changes are,

- Perforation of pars tensa – Central.
- Middle ear mucosa - Normal in inactive stage, oedematous and velvety in active stage.
- Polyp – Oedematous and inflamed mucosa protruded through the perforation and seen externally.
- Ossicular chain shows necrosis.
- Tympanosclerosis- Hyalinisation and calcification of subepithelial connective tissue. Seen in the remnants of tympanic membrane or under the mucosa of middle ear it interferes the mobility of the structures causing conductive deafness.

- Fibrosis and adhesions- Result of healing process and it further impair the mobility of ossicular chain or block the eustachian tube .<sup>[9]</sup>

#### Clinical features

- Recurrent otorrhoea- Discharge is watery or mucoid or mucopurulent. Profuse but nonfoetid. Ear is dry in between the infection. In permanent perforation ear is often dry for long periods.
- Deafness – Progressive deafness. Conductive type , mild or moderate depending on the site and size of perforation.
- Pain – Usually absent, may be present due to secondary infection.<sup>(8)</sup>

#### Diagnosis

- Otoscopy - Central perforation of tympanic membrane. It is dry in between the infection. Some times Eustachian tube can be seen through a big perforation. Middle ear mucosa is found to be pink or velvety. Occasionally pale oedematous mucosa may protrude through the perforation as a polyp.
- Source of infection is seen in the nose or nasopharynx which is the cause of persistence of the disease.
- Tuning fork test - Rinnie 's test is negative and Weber's test is lateralized to the diseased side. It indicates conductive deafness. In bilateral lesion Weber is lateralized to the more deaf ear or in the centre if equally deaf.
- Audiogram – Confirms conductive deafness with A-B gap.
- X-ray mastoid / CT temporal bone - Mastoid is usually sclerotic but may be pneumatised with clouding of air cells. No evidence of bone erosion.
- Culture of the discharge – to identify the organism.<sup>(8)</sup>

## Course of the disease

Divided in to 4 stages

- Active stage - Ear is actively discharging.
- Quiescent stage – Ear is not discharging for some times but history of otorrhoea in the past.
- Inactive stage – History of otorrhoea but the ear is dry for a period up to 3-6 months.
- Healed stage – Perforation has healed up with or without adhesive changes and ear is permanently dry. Associated with tympanosclerosis or conductive deafness.<sup>(8)</sup>

## Treatment

- Active stage – Aural toilet is repeated at regular intervals till the ear is dry. This can be done by dry mopping and suction clearance. In persistence of otorrhoea, source of infection is looked for in the nasopharynx, sinuses, adenoids, tonsils etc. As infection reaches the middle ear from these areas via eustachian tube and appropriate measures are taken.

## Instructions to patients

- Avoid entry of water in ear. Ear is plugged with cotton.
- Avoid swimming and diving.
- Maintain aural hygiene and avoid cleaning on ear with unclean or dirty cotton wool.
- General nutrition is to be improved with good food in cases of undernourished children.<sup>(8)</sup>

- Quiescent stage - The ear is dry with treatment and remains dry for several months. Patient is asked to follow the above precautions and is followed up at regular interval in the clinic. Cold and allergy are to be controlled.
- Inactive stage – If the ear remain dry for 2-3 months and patient is eager , then closure of the perforation , Myringoplasty is to be performed.<sup>(8)</sup>

#### Atticoantral type

Dangerous or unsafe. It involves attic, antrum and posterior tympanum and air cells. It is a bone eroding disease and involve adjacent structures and cause complications.<sup>[16]</sup> It involves postero superior part of the middle ear cleft and is associated with marginal perforation. Risk of complication is high.<sup>[9]</sup>

#### Aetiology

This type occurs in a middle ear cleft which has failed to become pneumatised in early childhood due to enlarged adenoids or upper respiratory infection.<sup>(8)</sup>

#### Pathology

The basic pathological findings are,

- Cholesteatoma formation- Main pathology .It is a sac of keratinized desquamated epithelium in the middle ear cleft, resting on a fibrous tissue layer called the matrix. <sup>(16)</sup>This has bone eroding property. They are formed in following ways,
- By retraction pocket formation – Due to insufficient aeration of middle ear cleft and epitympanum by tubal disfunction or obstruction, a retraction pocket develops in the pars flaccida or postero-superior region of pars tensa and there is excessive desquamation of keratin or keratinized epithelium. Initially the

retraction pocket is self cleaning later it turned in to sac , the keratin and keratinized epithelium is collected in the sac with formation of a tumor like mass called cholesteatoma.

- By migration of squamous epithelium from deeper part of the canal through a marginal tympanic membrane perforation cholesteatoma mass forms.<sup>(8)</sup>

#### Types of cholesteatoma

- Congenital – Arises from the embryonic epidermal cell rests in the middle ear cleft or temporal bone. Sites involved are middle ear, petrous apex, and the cerebellopontine angle.
- Primary Acquired - No history of previous otitis media or a pre-existing perforation.
- Secondary Acquired - There is already a pre- existing perforation in pars tensa and often associated with posterosuperior marginal perforation or a large central perforation.<sup>(9)</sup>

#### Spread of cholesteatoma

Once cholesteatoma is formed it continues to grow the expense of neighbouring structures particularly bone and involves vital organs.<sup>(8)</sup> In the middle ear cleft, cholesteatoma follows the path of least resistance and causes enzymatic bone destruction. The growth of attic cholesteatoma is limited by the mucosal folds and suspensory ligaments of the ossicles.<sup>(3)</sup>

Cholesteatoma destroys the bone , which come in its way such as ear ossicles, bony labyrinth, canal of facial nerve, sinus plate and tegmen tympani. Formerly , bone destruction was believed to be due to pressure necrosis , currently, bone destruction



has been attributed to enzymes liberated by osteoclasts and mononuclear inflammatory cells and include collagenase, acid phosphatase and proteolytic enzymes.<sup>(3)</sup>

Osteitis and granulation tissue - Osteitis involves outer attic wall and posterosuperior margin of tympanic ring and granulation tissue surrounds the area of osteitis and may fill the attic, antrum, posterior tympanum and mastoid.<sup>(9)</sup>

Ossicular necrosis - Destruction may be limited to the incus or may involve stapes, handle of malleus or the entire ossicular chain. So hearing loss is greater than tubotympanic type.

Cholesterol granuloma - Mass of granulation tissue with foreign body giant cells surrounding the cholesterol crystals. It is a reaction to long standing retention of secretions or haemorrhage.<sup>(3)</sup>

#### Clinical features

- No symptoms – Remain asymptomatic in initial stage of disease.
- Ear discharge – The discharge is purulent, foul smelling and scanty in amount occasionally blood stained. The discharge is so scanty that the patient is unaware of it. The cessation of discharge in a continuously discharging ear is a threatening sign. The perforation might be sealed by crusted discharge, mucosa or polyp leads to obstruction to the free flow of purulent discharge result in complications.<sup>(3)</sup>
- Hearing loss- Conductive deafness. Deafness is of slow onset, progressive due to ossicular destruction and may be associated with tinnitus.<sup>(16)</sup> Hearing is

normal when ossicular chain is intact.<sup>(3)</sup>In some cases where cholesteatomabridges the ossicular gap hearing may be good.<sup>(8)</sup>

- Bleeding can occur from granulations and red fleshy polyp while cleaning the ear.<sup>(3)</sup>
- Ear ache, vertigo, facial palsy, headache, vomiting, ataxia and fever signify the onset of complications such as extradural abscess, labyrinthitis, meningitis, facial paralysis, jugular venous thrombosis etc..
- Otoscopy/ Endoscopy
  - Perforation is either in the pars flaccida( attic variety)or postero superior margin ( marginal). Discharge is foetid and scanty.
  - Granulation in the attic or posterosuperior segment of the tympanic membrane.
  - Polyp- usually red and granular, sometimes covered by mucosa with the pedicle towards roof or posterosuperior wall.
  - Cholesteatoma – seen as pearly sheets or grayish white mass in the attic or posterosuperior quadrant.<sup>(8)</sup>
  - Ossicular necrosis- bony destruction may involve the long process of incus, stapes and handle of malleus or the entire ossicular chain.<sup>(3)</sup>
  - Cholesterol granuloma - mass of granulation tissue , gives the ear drum a dark blue or black appearance.<sup>(8)</sup>
  - Fistula test- positive when there is erosion of the lateral semicircular canal.

## Investigations

- Hearing assessment – Tuning fork test- reveals conductive deafness.
- Radiology – X-ray mastoid, Towne's, Schuler's and Law's lateral views and CT scan of the temporal bone are taken to detect the extension of the disease. The mastoids are usually sclerotic, hypocellular or acellular. CT and MRI are needed if the patient is having any complications of CSOM.
- Culture of the discharges for identifying the organism.<sup>(3)</sup>

## Diagnosis

- Recurrent otorrhoea.
- Conductive deafness.
- Pain due to secondary infection.
- Otoscopy shows perforation of tympanic membrane.
- Tuning fork test- Rinne's negative, Weber's is lateralized to the diseased ear. In bilateral lesion Webers lateralized to deaf ear or in the centre.
- Audiogram – A-B gap.
- X-ray mastoid/CT Temporal bone- usually cellular but may be hypocellular.
- Culture and sensitivity of discharge to identify the organism.<sup>[8]</sup>

## Treatment

The aim of treatment is to make the ear safe by eradicating the disease and to prevent its recurrence.<sup>(16)</sup>

Conservative treatment- Dry mopping, suction clearance.

Depending up on the extent, location of disease, and degree of deafness , various surgical procedures are undertaken like atticotomy, mastoidectomy, tympanoplasty.<sup>(16)</sup>

## Complications of CSOM

- Extradural abscess and Perisinus abscess
- Labyrinthitis and cerebellar abscess
- Facial palsy due to erosion of facial canal.
- Meningitis .
- Brain abscess.
- Mastoiditis.
- Temporal lobe abscess.<sup>(3)</sup>

## 3.2 Homoeopathic concept

### 3.2.1 Miasm:

The term miasm is from a Greek word Miasma, pollution to stain or pollute a morbidic emanation which affects individuals directly. In homoeopathy it means dynamic influence upon Vital Force of a morbidic agent inimical to life, and deranges the Vital Force of a man and is present in the surrounding of all human being. Miasms denotes not an influence from without, but a change from with in.<sup>[17]</sup>

According to the common definition, a miasm is defined as polluting exhalations or malarial poisons<sup>[19]</sup>. Miasm is the abnormal inherent ethereal force which manifests itself by abnormal function and sensation-disease. Miasm is the basis of all true natural chronic diseases.<sup>[17]</sup>

In general Miasm means (1) a heavy vaporous exhalation or effluvium formerly believed to cause disease. (2) Obnoxious influence or atmosphere. (3) An unwholesome exhalation. (4) Polluted material. (5) Putrid vegetable matter. (6) Contagion effluvia from human body. (7) Infective material. (8) The maggots- the larvae from a fly.<sup>[6]</sup>

The morbific agents which are casually connected with production of diseases, were designated by a general term 'miasm or miasma' during the time of Hahnemann.

"Miasms are excessively minute, invisible, living creatures, so inimical to human life..." "... Millions of these miasmatic animated beings."- Hahnemann, 'The Lesser Writings'<sup>[6]</sup>. "Hahnemann was the first to perceive and teach the parasitical nature of infection or contagious diseases, including syphilis, gonorrhoea, leprosy, tuberculosis, cholera, typhus and typhoid fevers; and the Chronic Diseases in general, other than occupational diseases and those produced by drugs and unhygienic living, the so-called drug diseases"<sup>[7]</sup>.

In aphorism 204 Hahnemann says the development of these three chronic miasms, internal syphilis, internal sycosis, but chiefly and in infinitely greater proportion, internal psora, each of which was already in possession of the whole organism, and had penetrated it in all directions before the appearance of the primary, vicarious local symptom of each of them (in the case of psora the scabious eruption, in syphilis the chancre or the bubo, and in sycosis the condylomata) that

prevented their outburst; and these chronic miasmatic diseases, if deprived of their local symptom, are inevitably destined by mighty Nature sooner or later to become developed and to burst forth, and thereby propagate all the nameless misery, the incredible number of chronic diseases which have plagued mankind for hundreds and thousands of years, none of which would so frequently have come into existence had physicians striven in a rational manner to cure radically and to extinguish in the organism these three miasms by the internal homoeopathic medicines suited for each of them, without employing topical remedies for their external symptoms<sup>[10]</sup>.

In all chronic miasmatic diseases, these miasmatic suppressions resulted into deep seated interferences and obstacles in the natural process of recovery and cure<sup>[17]</sup>.

Our remedies only deal with miasms, not names of diseases. The law of similia is only co-operative with that which disturbs life, not the organism as a part, and we have learned that the miasms are the persistent disturbances of life. “The miasms are the maggots that are born within the brain”, as Shakespeare says, and those maggots never die until overthrown by similia<sup>[1]</sup>.

In foot note of Apho.80 Dr. Hahnemann explains that “I spent twelve years in investigating the source of this incredibly large number of chronic affections, in ascertaining and collecting certain proofs of this great truth, which had remained unknown to all former or contemporary observers, and in discovering at the same time the principal (antipsoric) remedies, which collectively are nearly a match for this thousand-headed monster of disease in all its different developments and forms. I have published my observations on this subject in the book entitled *The Chronic Diseases* (4 vols. Dresden, Arnold. [2nd edit., Dusseldorf, Schaub.]) before I had obtained this knowledge I could only treat the whole number of chronic diseases as

isolated, individual maladies, with those medicinal substances whose pure effects had been tested on healthy persons up to that period, so that every case of chronic disease was treated by my disciples according to the group of symptoms it presented, just like an idiopathic disease, and it was often so for cured that sick mankind rejoiced at the extensive remedial treasures already amassed by the new healing art. How much greater cause is there now for rejoicing that the desired goal has been so much more nearly attained, inasmuch as the recently discovered and far more specific homoeopathic remedies for chronic affections arising from psora (properly termed antipsoric remedies) and the special instructions for their preparation and employment have been published; and from among them the true physician can now select for his curative agents those whose medicinal symptoms correspond in the most similar (homoeopathic) manner to the chronic disease he has to cure; and thus, by the employment of (antipsoric) medicines more suitable for this miasm, he is enabled to render more essential service and almost invariably to effect a perfect cure”.

### **3.2.2 Miasmatic characteristics of ear symptoms.**

Psoric otitis

Otitis occurs with dryness of the meatus. Meatus and canal appear dry and lustreless. Dry scales. Functional disturbance of the ear. Constant itching, sensation of crawling, dryness and pulsation in the ears. Very sensitive hearing. Sound causes pain in the ears. Nervous restlessness and anxieties may accompany.

Sycotic symptoms:

Profuse exudation. Ear appears swollen and thick about the pinna and can be oedematous. Stitching, pulsating, wandering pains. Incoordination in the sense

of hearing causes the Patients hears better in noisy places. Ear pain < during day and by change in the weather. Pain in the ear make the patient physically restless.

Syphilitic symptoms:

Ulceration. All structural and organic ear problems .Mastoiditis occurs with degenerative changes in the bones. Degenerative inflammation and destruction of the ossicles of the ear. Burning , bursting and tearing ear pains.Impairment and total loss hearing may occur. Otitis media with offensive discharge of pus < at night and from warmth. Otitis media is a concomitant with common cold, eruptions, measles, chicken pox etc.<sup>[2]</sup>

### **3.2.3 Leading Anti–Miasmatic remedies**

Psora - Calc. Carb.,Capsicum, Graphitis,Hepar. Sulph.,Lyco., Phosphorus, Psorinum, Sulphur, Tuberculinum, Zincum. Met..

Sycosis - Causticum, Medorrhinum, Merc. Dulcis, Merc. Cor, Natrum. Sulph ,Nitric acid, Pulsatilla,Pyrogen, Sepia, Staphysagria, Thuja, Tuberculinum.

Syphilis - Aurum. Met. ,Fluoric acid, Merc. Sol., Mezerium,Nitric Acid, Phosphorus, Phytolocca, Tarendula, Syphillinum, Silicia,<sup>(2)</sup>

### **3.3 Related Researches:**

Homoeopathic Cure of a Boy with Atticoantral CSOM

Chronic suppurative otitis media is a commonly encountered childhood illness, especially in developing countries like India. A diagnosed case of atticoantral unsafe variety was treated with homoeopathic remedy fluoric acid. The boy recovered in a span of 3 months with complete restoration of hearing. He was



further followed up for nearly 4 years without any relapse of complaints. Besides removing the local pathology, the similimum also remedied his personality.

# *Materials And Methods*

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## **4. MATERIALS AND METHODS**

It includes Collection of data, Methodology, Assessment and Interpretation of data.

### **4.1 METHOD OF COLLECTION OF DATA**

Sample Size - Minimum 30 cases

Sampling Technique- Purposive sampling

Patients will be selected on the basis of inclusion and exclusion criteria, history and findings. The cases are recorded in the Sarada Krishna Homoeopathic Medical College and Hospital Standard Case Record Format to gather socio-demographic and relevant information such as history of current symptoms and previous history. After which the study physician conducted general physical examination and ENT examination.

### **4.2 DATA MANAGEMENT AND ANALYSIS**

The case is analyzed accordingly and totality is evolved. Repertorization is done if necessary. Prescription is done with reference to text books of MateriaMedica. Potency selection and repetition are done according to the principles laid down in the Organon of medicine.

Follow ups of cases done minimum three months. Observations will be noted in tables and charts. Statistical analysis will be done and results will be presented.

### **4.3 INCLUSION CRITERIA.**

- Both Sexes.
- Age group between 5 to 60 years.

- Patients with otalgia and otorrhoea.

#### **4.4 EXCLUSION CRITERIA.**

- Patient with complications.
- Patient taking other system of medicine for pain.
- Patients with neurological disorders.

#### **4.5 OUTCOME ASSESSMENT**

Assessment was done based on general and symptomatic improvement of the patient. Assessment was done every week and the changes are recorded for OPD and Rural patients. Daily assessment is done for IPD patients. For effective assessment and evaluation, disease intensity score were given for each case. Before and after treatment scores were analysed by using paired 't' test.

#### **4.6 INTERPRETATION OF DATA**

Change in clinical findings like the presenting symptoms and signs are the parameters for assessing recovered, improved and not improved criteria.

Recovered- No recurrency, Total control of the symptoms.

Improved - Symptomatic relief.

Not improved- Recurrence, No improvement in signs and symptoms.

## 5.1 OBSERVATIONS AND RESULT

### 5.1.1 DISTRIBUTION OF CASES ACCORDING TO AGE

Table No – 1

SL.NO	AGE	NO. OF CASES	PERCENTAGE
1	1-10	1	3.33%
2	11-20	9	30%
3	21-30	3	10%
4	31-40	8	26.67%
5	41-50	5	16.67%
6	51-60	4	13.33%

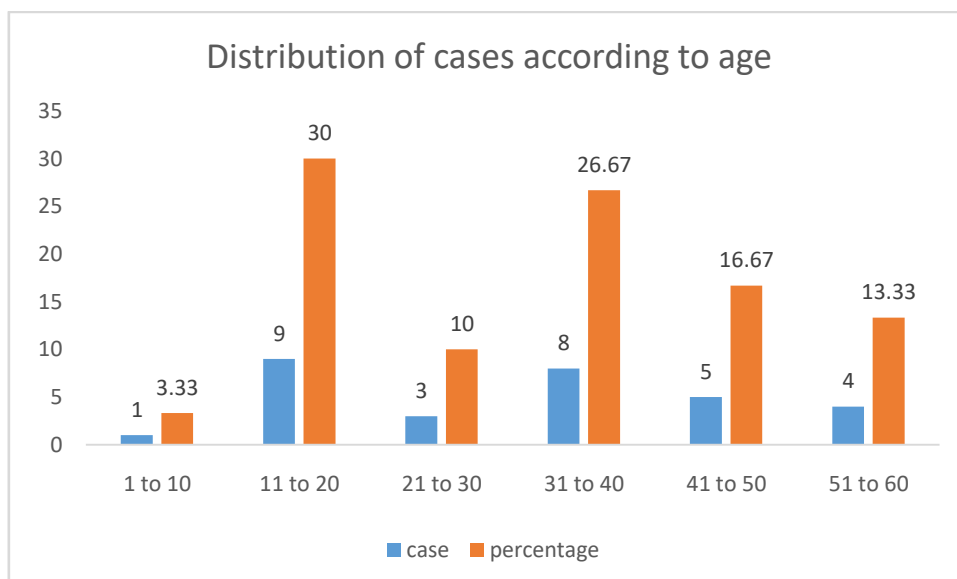


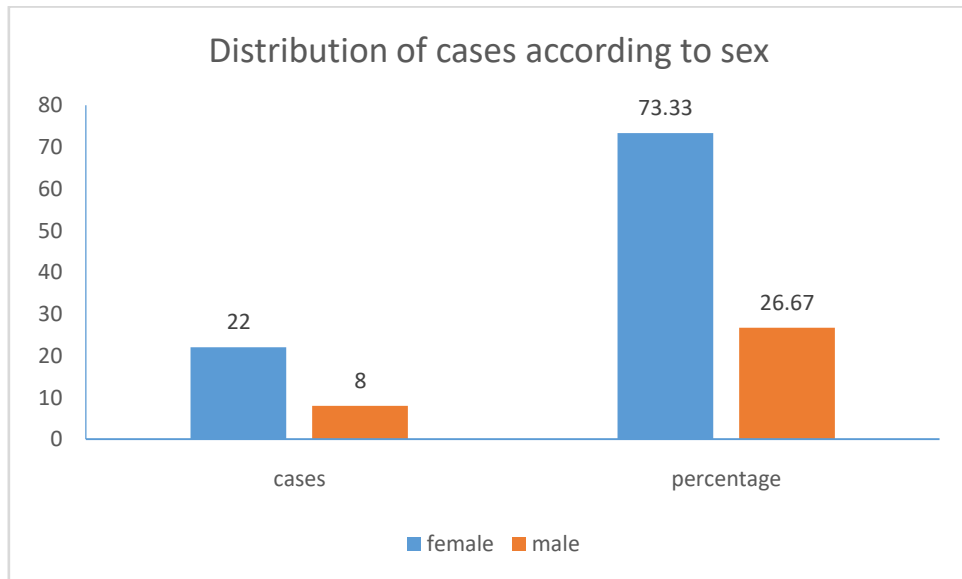
Chart No – 1

In the sample of 30 cases, maximum of 9 patients (%) were between the age group of 11-20 years, 8 patients (%) were between the age group of 31-40years, 5 patients (17%) were between the age group of 41-50 years, 4 patients (%) were between age group of 51-60 years, 1 patient (%) were between the age group of 1-10 years.

### 5.1.2 DISTRIBUTION OF CASES ACCORDING TO SEX

**Table No – 2**

SL.NO	SEX	NO. OF CASES	PERCENTAGE
1	Female	22	73.33%
2	Male	8	26.67%



**Chart No – 2**

Out of 30 cases in the study, 22 cases (%) were females and 8 cases (%) were males.

### 5.1.3 DISTRIBUTION OF CASES ACCORDING TO PAST HISTORY

Table No – 3

SL.NO	PAST HISTORY	NO. OF CASES	PERCENTAGE
1	Chickenpox	10	33.33%
2	Fever	4	13.33%
3	Measles	4	13.33%
4	CSOM	2	6.67%
5	Pneumonia	2	6.67%
6	Hepatitis	2	6.67%
7	Chikungunya	1	3.33%
8	Head injury	1	3.33%
9	Thyroiditis	1	3.33%
10	Otorrhoea	1	3.33%
11	Dyslipidaemia	1	3.33%
12	Uterine fibroid	1	3.33%
13	Mumps	1	3.33%
14	Diabetes mellitus	1	3.33%

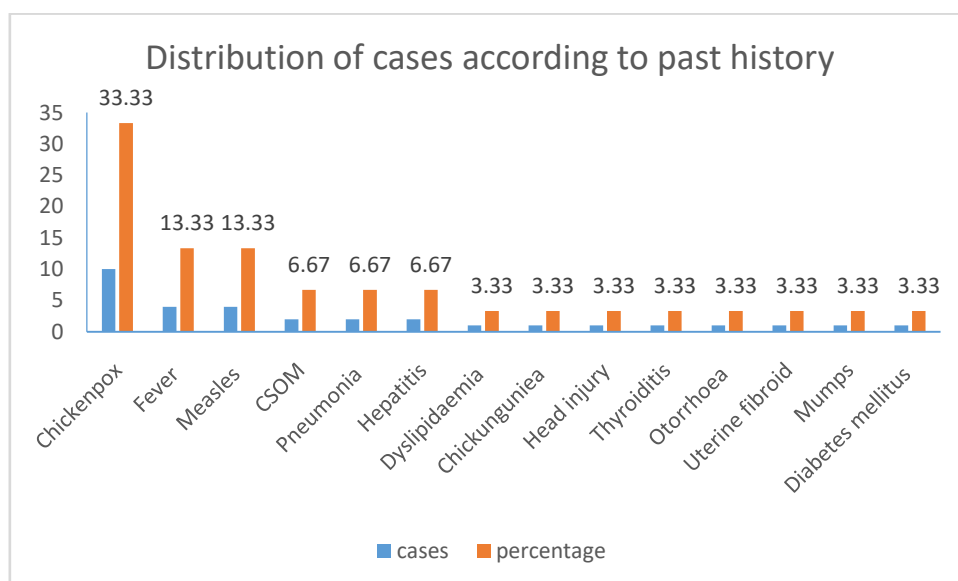


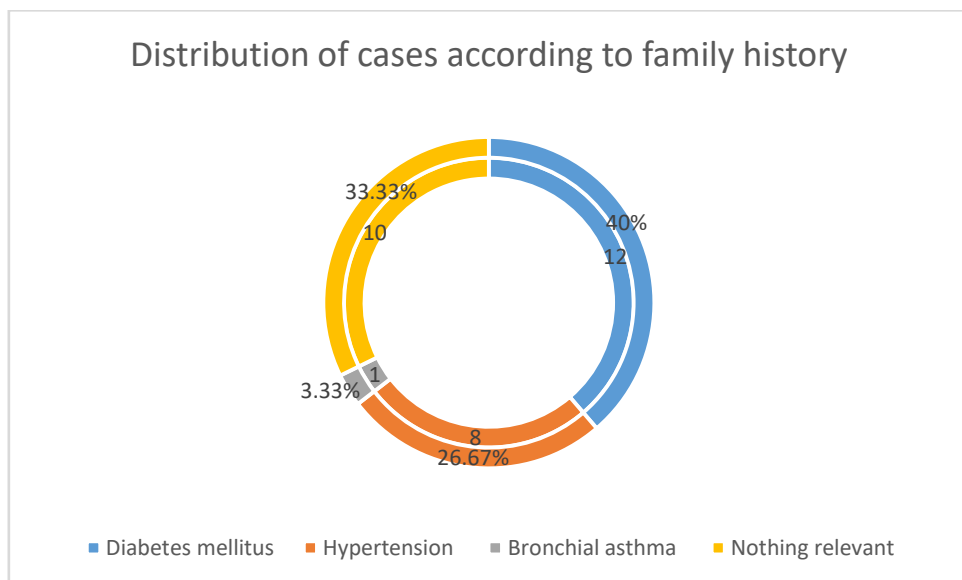
Chart No – 3

Out of 30 cases, 10 cases (33%) had past history of Chickenpox, 4 cases (%) each had fever and Measles, 2 cases (%) each had CSOM, Pneumonia and Hepatitis, 1 case (%) each had Dyslipidaemia, Chickenguinea, Head injury, Thyroiditis, Otorrhoea, Uterine fibroid, Mumps and Diabetes mellitus.

#### 5.1.4 DISTRIBUTION OF CASES ACCORDING TO FAMILY HISTORY

**Table No – 4**

SL.NO	FAMILY HISTORY	NO. OF CASES	PERCENTAGE
1	Diabetes mellitus	12	40%
2	Hypertension	8	26.67%
3	Bronchial asthma	1	3.33%
4	Nothing relevant	10	33.33%



**Chart No – 4**

Out of the 30 cases with respect to the family history 12 cases (%) patients had family history of Diabetes mellitus, 10 cases (%) patients had no family

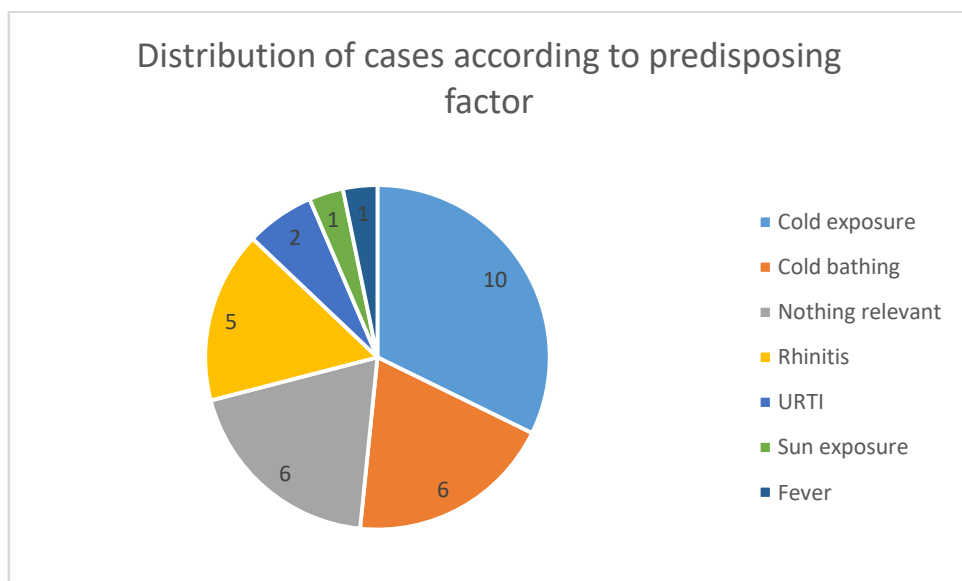


history, 8 cases (%) patients had Hypertension, 1 case (3%) patient has family history of Bronchial asthma.

**5.1.5 DISTRIBUTION OF CASES ACCORDING TO PREDISPOSING FACTOR**

**Table No – 5**

SL.NO	PREDISPOSING FACTOR	NO. OF CASES	PERCENTAGE
1	Cold exposure	10	33.33%
2	Cold bathing	6	20%
3	Rhinitis	5	16.67%
4	URTI	2	6.67%
5	Sun exposure	1	3.33%
6	Fever	1	3.33%
7	Nothing relevant	6	20%



**Chart No – 5**

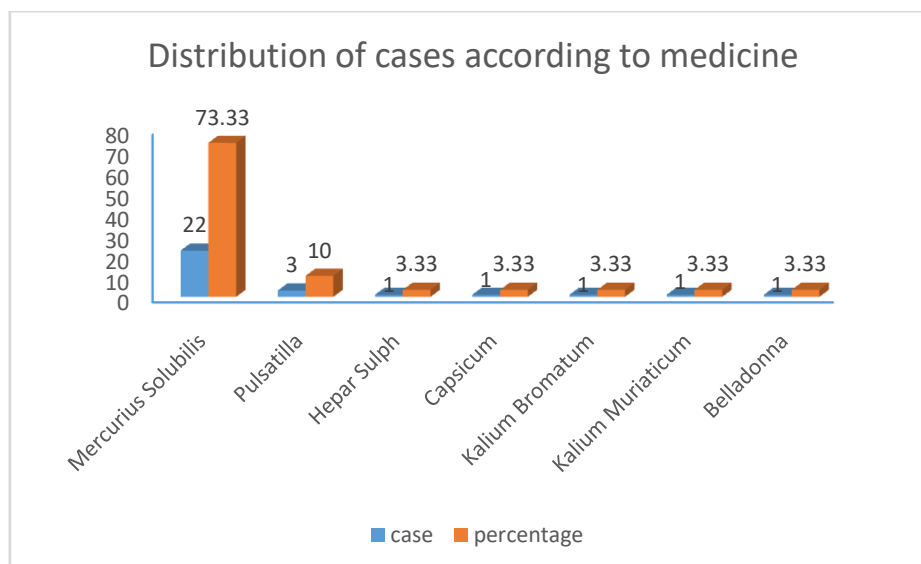
Out of 30 cases with respect to the predisposing factors 10 cases (%) patients are predisposed to cold exposure, 6 cases (%) patients each are predisposed to cold bathing and nothing relevant, 5 cases (%) patients are predisposed to Rhinitis, 2 cases (%) patients are predisposed to URTI, 1 case (%) patients each predisposed to sun exposure and fever.

#### 5.1.6 DISTRIBUTION OF CASES ACCORDING TO MEDICINE

##### PRESCRIBED

Table No – 6

SL.NO	MEDICINE	NO. OF CASES	PERCENTAGE
1	MercuriusSolubilis	22	73.33%
2	Pulsatilla	3	10%
3	HeparSulph	1	3.33%
4	Capsicum	1	3.33%
5	KaliumBromatum	1	3.33%
6	KaliumMuriaticum	1	3.33%
7	Belladonna	1	3.33%



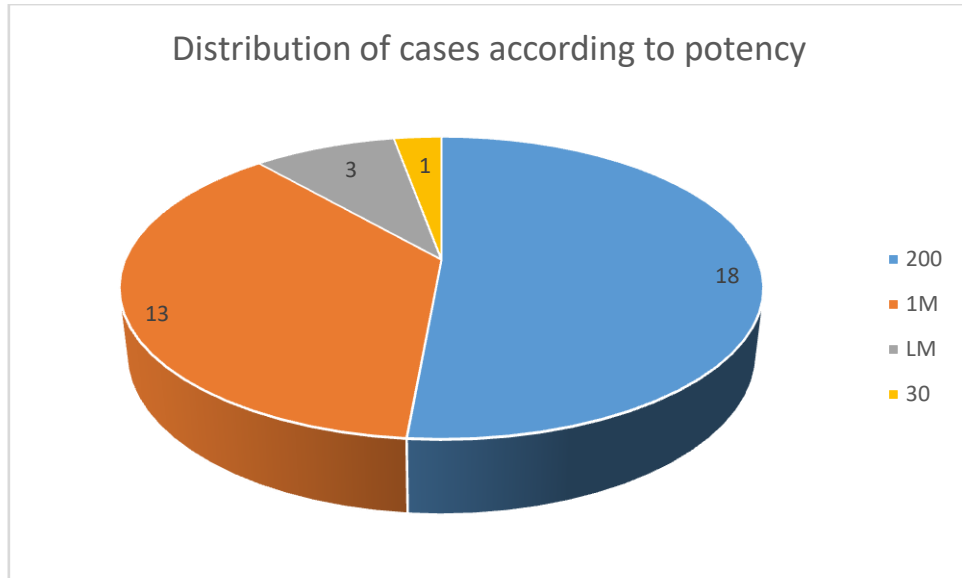
**Chart No – 6**

For the sample of 30 cases the medicine was prescribed based on the totality and out of the 30 cases 22 cases (%) was prescribed with MercuriusSolubilis,3 cases (10%) was prescribed with Pulsatilla, 1 case (3%) was prescribed with HeparSulph, Capsicum, KaliumBromatum, KaliumMuriaticum, Belladonna for each case.

### **5.1.7 DISTRIBUTION OF CASES ACCORDING TO POTENCY SELECTED**

**Table No – 7**

<b>SL.NO</b>	<b>POTENCY</b>	<b>NO. OF CASES</b>	<b>PERCENTAGE</b>
1	200	18	60%
2	1M	13	43.33%
3	LM	3	10%
4	30	1	3.33%



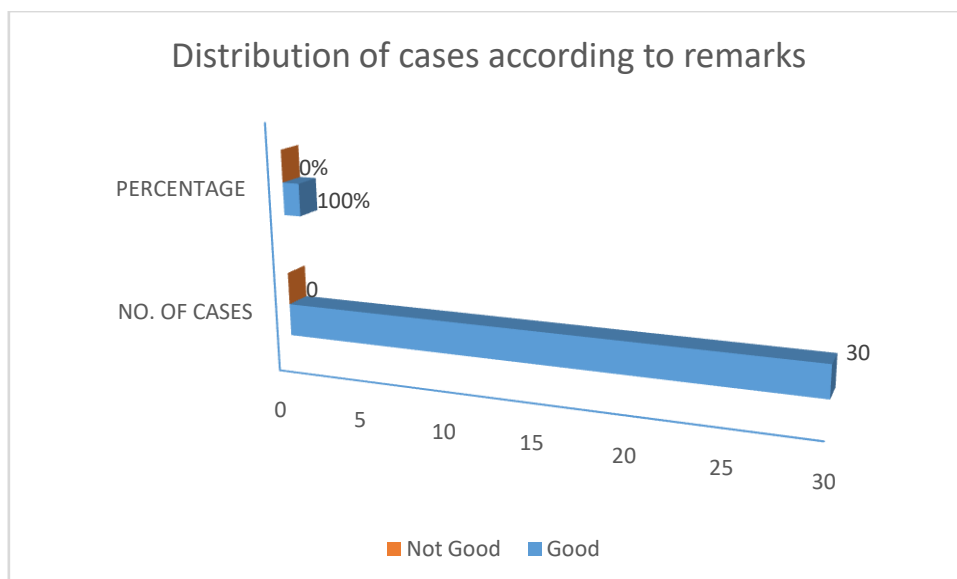
**Chart No – 7**

For the sample of 30 cases 18 cases (%) was given with 200<sup>th</sup> potency, 13 cases (%) was given with 1M potency, 3 cases (%) was given with LM potency, 1 case was given with 30<sup>th</sup> potency.

#### 5.1.8 DISTRIBUTION OF CASES ACCORDING TO REMARKS OF IMPROVEMENT

**Table No – 8**

SL.NO	REMARKS	NO. OF CASES	PERCENTAGE
1	Good	30	100%
2	Not Good	0	0%



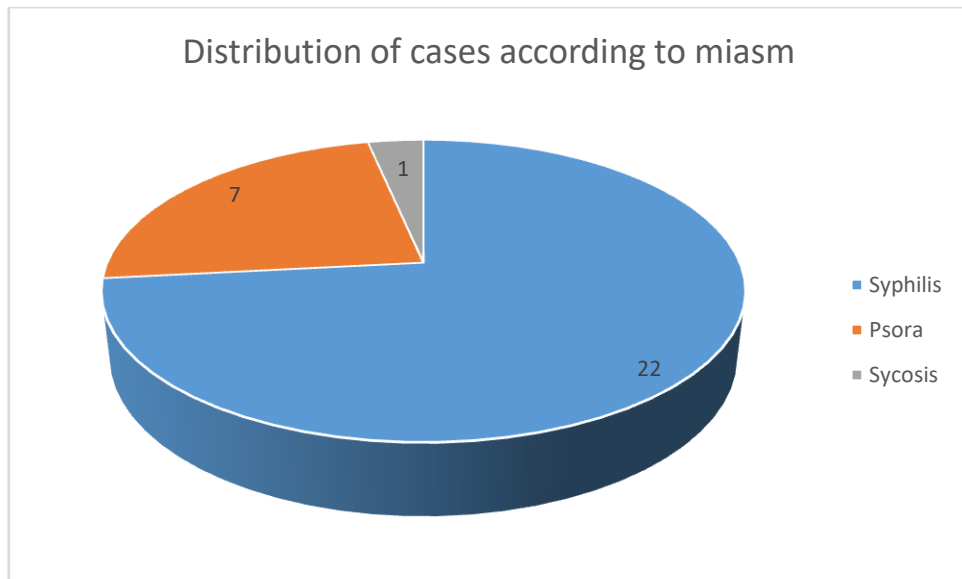
**Chart No – 8**

Out of the 30 cases all the 30 cases (100%) patient shows good improvement.

### **5.1.9 DISTRIBUTION OF CASES ACCORDING TO PREDOMINANT MIASM**

**Table No – 9**

<b>SL.NO</b>	<b>MIASM</b>	<b>NO. OF CASES</b>	<b>PERCENTAGE</b>
1	Psora	7	23.33%
2	Sycosis	1	3.33%
3	Syphilis	22	73.33%



**Chart No – 9**

According to the study 22 cases (73.33%) had Syphilis as their predominant miasm, 7 cases (23.33%) had Psora as their miasm, and 1 cases (3.33%) was Sycosis.

## 5.2 SUMMARY OF FINDINGS

The result is based on the observation and outcome of 30 cases under study and interpretation was done based on statistics. The following findings been drawn from the study.

- Maximum prevalence of CSOM was noted in the age group of 11-20years (30%).
- Females are highly affected by CSOM (73.33%).
- Chickenpox (33.33%) in the past history persons are highly affected by CSOM.
- According to family history the person having Diabetes Mellitus (40%) are highly affected by CSOM.
- The predisposing factor of CSOM is Cold exposure (33.33%).
- Mercurius Solubilis was the most indicated remedy prescribed (73.33%).
- 200<sup>th</sup> potency was more effective in most of the cases.
- Syphilis was the most predominant miasm (73.33%) followed by Psora (23.33%)
- In all the thirty cases studied there was a marked improvement in the scores before and after treatment. In all the cases the intensity of the symptoms has markedly reduced (100%).

### 5.3 STATISTICAL ANALYSIS

<b>X</b>	<b>y</b>	<b>d=x-y</b>	<b>d-<math>\bar{d}</math></b>	<b>(d-<math>\bar{d}</math>)<sup>2</sup></b>
9	2	7	1	1
8	3	5	-1	1
9	3	6	0	0
5	0	5	-1	1
8	2	6	0	0
6	0	6	0	0
8	2	6	0	0
9	0	9	3	9
7	1	6	0	0
10	2	8	2	4
7	1	6	0	0
6	1	5	-1	1
6	1	5	-1	1
6	2	4	-2	4
9	3	6	0	0
6	0	6	0	0
7	1	6	0	0
8	2	6	0	0
8	2	6	0	0
8	1	7	1	1
5	1	4	-2	4
9	1	8	2	4



7	1	6	0	0
6	2	4	-2	4
8	2	6	0	0
6	2	4	-2	4
5	1	4	-2	4
8	1	7	1	1
6	0	6	0	0
12	2	10	4	16
		$\Sigma d_1=6$		$\Sigma(d_1-\bar{d}_1)^2 = 60$

**X**= Score before treatment

**Y**= Score after treatment

**d<sub>1</sub>**= Difference between before and after score

**A. Question to be answered:**

Is there any difference between the scores taken before and after the Homoeopathic treatment?

**B. Null Hypothesis:**

There is no difference between the scores taken before and after the Homoeopathic treatment.

**C. Standard error of the mean differences:**

The mean of the differences,  $\bar{d}_1 = \Sigma d_1/n = 180/30 = 6$

The estimate of population standard deviation is given by,

$$\Sigma(d_1-\bar{d}_1)^2 = 60$$

$$\begin{aligned}
SD &= \sqrt{\Sigma(d1 - \bar{d}1)^2 / n - 1} \\
&= \sqrt{(60/29)} \\
&= \sqrt{2.068} \\
&= 1.43805 \\
&= \text{Standard error (S.E)} = S.D/\sqrt{n} = 1.43805/\sqrt{30} = 0.26255
\end{aligned}$$

**D. The test statistics is Paired t:**

$$\begin{aligned}
\text{Critical ratio, } t &= \frac{\bar{d}}{S.D/\sqrt{n}} \\
&= 22.8527899
\end{aligned}$$

**E. Comparison with tabled value:**

This critical ratio, t follows a distribution with n-1 degrees of freedom. The 5% level is 2.045 and 1% level is 2.756 for 29 degrees of freedom. Since the calculated value 22.85 is greater than tabled value at 5% and 1% level, the test is statistically significant and hence the null hypothesis is rejected.

**F. Inference:**

This study provides an evidence to show that there is significant reduction in the disease intensity scores after administering the homoeopathic remedies. Hence, we can conclude that the Antimiasmatic management of CSOM is very effective.

# *Discussion*

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## 6. DISCUSSION

In this study age group of 1-10 are the least prone group and 11 to 20 are more prone group than the other age groups. Overall study showed that the otitis media is increased in children than adults. This is because the eustachian tube shifts its anatomical orientation and gradually changes its angle from horizontal to vertical with age and as the child grows the immune system gets stronger by having met many types of allergens. The WHO had reported and categorised otitis media as one of the neglected tropical diseases. Most of the school children in India have been reported to associate with at least one episode of otitis media varying from 10% to 20% of the children. Among them there is more impact of the disease in slums rather than in well sanitized urban cities<sup>11</sup>.

Among 30 cases, 22 cases were females and 08 were males. In this study females are more affected with CSOM. But it is equally affected in both sexes<sup>3</sup>.

Out of 30 cases, 10 cases had Chicken pox as past history, 4 cases each have febrile illness and Measles as their past history, 2 cases each has CSOM, Pneumonia and Hepatitis, 1 cases each have Head injury, Dyslipidemia, Chickenguinea, Thyroiditis, Otorrhoea, Uterine fibroids, Mumps, Diabetes mellitus. This study shows that there is some relation between Infectious disease and Otitis media. In this study Chickenpox is the most common past history. Infectious disease history is one of the predisposing factor for CSOM<sup>3</sup>.

Out of 30 cases 12 cases have Diabetes Mellitus as a family history, 8 cases having Hypertension. One case having Bronchial asthma.

Out of 30 cases 22 cases had Syphilis as their predominant miasm, 7 had Psora as their predominant miasm and 1 case as Sycosis miasm.

In this study 10 cases has cold exposure as a predisposing factor , 6 cases has cold bathing, 5 cases has Rhinitis, 2 cases having URTI and each cases having sun exposure and fever as a predisposing factor. Other studies revealed that cold exposure is the predominant predisposing factor for otitis media and also seasonal variation i.e., cold and flu are more common during the winter and rainy seasons.

For these 30 cases medicines were prescribed according to individualization and miasmatic analysis. Most of the cases (22) Mercurius Solubilis is the indicted medicine . Pulsatilla Hepar Sulph, Capsicum, Kalium Bromatum, Kalium Muriaticum, Belladonna were the other indicated medicines for CSOM in this study.

Out of 30 cases, 50millisimal is given for 3 cases, 1M is given for 13 cases, 200 potency is given for 18 cases and 30 is given for 1 case. So the most indicated potency is 200 potency. All the 30 cases are improved with better results.

## **6.1 LIMITATIONS**

1. Number of samples used in this study is very small. Therefore, generalisation of the result and inferences of the study need to be done cautiously.
2. Some good cases couldn't be considered in this study because of discontinued treatment in between the study period.
3. Selection of cases was difficult since many of the cases were irregular for reporting.
4. This is a time bound study.
5. There was no control group since the sample size was small.

## **6.2 RECOMMENDATIONS**

1. Bigger sample size with extended time of research would provide better results.
2. It will be always scientific if control (placebo) group would have been kept simultaneously to verify the effectiveness of treatment.

*Conclusion*

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## 7. CONCLUSION

The study consists of a sample of 30 cases of patients with CSOM from the OPD, IPD and rural health centers of Sarada Krishna Homoeopathic Medical College and Hospital.

It is concluded that CSOM is,

- Most common in the age group between 11-20.
- Females are more affected.
- Cold exposure is more prominent predisposing factor.
- Mercurius Solubilis is the remedy mostly suited for Otitis media.
- 200<sup>th</sup> potency is effective scale for treating otitis media.

The score were statically evaluated and then conclude that Antimiasmatic medicine has tremendous effect for treating otitis media.



# *Summary*

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## 9. SUMMARY

In all the 30 cases of CSOM studied, there was a marked improvement in the scores before and after treatment. In this study another important factor noted is maximum number of cases have the previous history of Chicken pox which is also considered as a predisposing factor. The most predominant miasm is syphilitic miasm (73.3%). In 30 cases studied 22 cases (73%) were treated with Mercurius Solubilis the rest of the cases were treated with Pulsatilla, Hepar Sulphuris, Belladonna, Kalium Muriaticum. It shows that in most of the cases the indicated remedy is Mercurius Solubilis. The cases were treated with different potencies. In that 200<sup>th</sup> potency is effective in 13 cases (59%) 1M in 7 cases (32%). Thus it is found that in CSOM 200 Potency is more effective. The most predominant miasm is syphilitic miasm (73.3%).

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# *Appendices*

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## **APPENDIX I**

### **GLOSSARY**

1. Aggravation: A situation in which the patient feels worse from or symptoms are increased by a remedy.
2. Amelioration: An improvement of the patient or decrease in symptoms.
3. Dose: The quantity of drug or other therapeutic agents taken at a time or in fractional amounts within a stated period.
4. Miasm: An influencing or infecting agent being a particular forms of minute, invisible, animated being or specific to particular forms of disease.
5. Potency: The degree of dilution that a homoeopathic remedy had undergone in its manufacturing process.
6. Remedy: A medicine, application or treatment that relieves or cures a disease.
7. Symptom: A physical or mental feature which is regarded as indicating a condition of disease that is apparent to the patient.



## APPENDIX II

*'Case Records Are Our Valuable Asset'*

SARADA KRISHNA

CONFIDENTIAL

HOMOEOPATHIC MEDICAL COLLEGE HOSPITAL

KULASEKHARAM, KANNIYAKUMARI DIST, TAMIL NADU- 629 161

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### CHRONIC CASE RECORD

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Date: .....

Unit.....

Regn. No.....

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#### 1. PERSONAL DATA

Name of Patient:.....

Age :..... yrs    Sex : M/F/T    Religion :.....    Nationality :.....

Name of Father / Spouse / Guardian / son / Daughter .....

Marital status : Single / Married . Widow (er) / Divorcee / Live-relation

Occupation :.....    Income per capita :.....

Family size (members living together) :.....

Diet : Veg. / Non veg. / Mixed

Address :.....

.....

Phone (Office) .....    Residence .....

Mobile .....    e-mail .....

Referred to by:.....

#### FINAL DIAGNOSIS :

Homoeopathic	
Disease	

<b>RESULT:</b>	Cured	Relieved	Referred	Otherwise	Expired
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Attending Physician .....

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**2. Initial presentation of illness**

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<b>PATIENT'S NARRATION</b> (In the very expression used by him / her)	<b>PHYSICIAN'S INTERROGATION</b> (Details regarding symptoms narrated)	<b>PHYSICIAN'S OBSERVATION</b>



**3. H/o Presenting Illness :**

(origin, duration and progression of each symptom in chronological order along with its mode of onset, probable cause (s), details of treatment and their outcome)

**4. H/o Previous Illness**

No.	Age/Year	Illness, trauma, fright, burns(s), drug allergy(ies), operation(s), exposure(s), inoculation, vaccination(s), serum, steroids, hormone therapy, antibiotics, analgesics, etc	Treatment adopted	Outcome

## **5. H/o FAMILY ILLNESS**

### **6. PERSONAL HISTORY:**

#### **A. LIFE SITUATION**

Place of birth :

Religion :

Education :

Occupation :

Socio-economic status :

Nutritional status :

Marital status :

Family status :

#### **B. HABTS & HOBBIES:**

Food :

Addictions :

Sleep :

Artistic :

Games / Sports :

#### **C. DOMESTIC RELATIONS:**

With family members :

With other relatives :

With neighbours / friends / colleagues :

#### **D. SEXUAL RELATIONS:**

Pre-marital:

Marital:

Extra Marital:

**7. LIFE SPACE INVESTIGATIONS** (as perceived by the ‘Interrogator/  
Physician)

(birth and early development (milestone), behaviour during childhood, education, adolescence & psychosexual history, occupational history, mental history, children, geriatrics history & travel history)

## **8. GYNAECOLOGICAL HISTORY**

**A. Menses**

**B. Previous History**

**C. Climacteric**

**D. Abnormal Vaginal Discharges**

**E. H/o gynaecological surgeries : Yes/No**  
(If yes state the reason)

## **9. OBSTETRICAL HISTORY**

**A. Previous Pregnancies including abortion:**

**B. Contraceptive method(s) adopted:**

**C. Present Pregnancy:**

**D. Physical Examination – Gynaecological / Obstetrical**



## **10. GENERAL SYMPTOMS**

### **A. Physicals**

#### **i. Functional**

Appetite:

Thirst:

Sleep:

#### **ii. Eliminations**

Stool:

Urine:

Sweat:

#### **iii. Reactions to**

#### **iv. Constitutional**

## **B. Mental General**

**i. Will & emotions including motivation**

**ii. Understanding and intellect**

**iii. Memory**

## **11. PHYSICAL EXAMINATION**

### **A. General Examination**

- Conscious/unconscious
- General appearance
- General built
- Ht : cm    Wt : Kg    BMI :
- Anaemia
- Jaundice
- Cyanosis
- Oedema
- Skin
- Nails
- Gait
- Lymphadenopathy
- Blood pressure            Pulse
- Temp                        Resp. rate
- Others

## **B. Systemic Examination**

i. Respiratory system

ii. Cardiovascular system

iii. Gastro Intestinal system

iv. Urogenital system

v. Skin and Glands

vi. Musculo-skeletal system

vii. Central Nervous system

viii. Endocrine

ix. Eye & ENT

x. Others

## **C. REGIONALS**

## **12. LABORATORY INVESTIGATIONS & FINDING AND SURGICAL INVESTIGATIONS**

(urine, stool, blood, sputum, imaging, ECG, and other investigations)

## **13. DIAGNOSIS**

### **A. Provisional Diagnosis**

### **B. Differential Diagnosis**

### **C. Final Diagnosis (Disease)**

## 14. DATA PROCESSING

### A. Analysis of case

Basic / Common / Pathognomonic Symptoms	Determinative / Uncommon / Non-pathognomonic Symptoms

### B. Evaluation of Symptoms

**C. Miasmatic Analysis**

PSORA	SYCOTIC	SYPHILIS

Miasmatic Diagnosis :	
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**D. Totality of Symptoms**

**E. Homoeopathic Diagnosis (Hahnemannian Classification)**



## **15. SELECTION OF MEDICINE**

### **A. Non Repertorial Approach**

### **B. Repertorial Approach**

**16. SELECTION OF POTENCY AND DOSE**

**17. PRESCRIPTION**

**18. GENERAL MANAGEMENT INCLUDING AUXILLARU MEASURES**

**A. General/Surgical/Accessory**

**B. Restrictions (diet, regimen etc)**

Disease	Medicinal

**19. PROGRESS & FOLLOW UP**

Date	Symptom(s) changes	Inference	Prescription

### APPENDIX III

#### Disease intensity Score of Chronic Suppurative Otitis media

Sl.No.	Symptoms	Score	Before	After
1.	Otalgia	Severe - 3		
		Moderate - 2		
		Mild - 1		
		Absent - 0		
2.	Otorrhoea	Profuse - 2		
		Scanty - 1		
		Absent - 0		
3.	Hearing impairment	Severe - 3		
		Moderate - 2		
		Mild - 1		
		Nil - 0		
4.	Mastoid tenderness	Present - 1		
		Absent - 0		
5.	Lymphadenopathy	Present - 1		
		Absent - 0		
6.	Vertigo	Present - 1		
		Absent - 0		
7.	Tinnitus	Present - 1		
		Absent - 0		
8.	Associated symptoms	Present - 1		
		Absent - 0		

## APPENDIX IV

CASE NO : 1

### 1.PERSONAL DATA

Unit : IV A

Date : 28 JULY 2016

Op no : 7379/16

Name of the patient: Mrs. R

Age : 57 yrs

Sex : F

Religion: Hindu

Nationality: Indian

C/o : Mr. Vinod

Occupation: Housewife

Family size: 4 Members

Diet : Mixed

Address: Vinod Bhavan, Kudappanammoodu

Attending Physician: Dr. R. Panchajani

## 2. PRESENTING COMPLAINT(s)

Complaints with duration	Location & extension	Sensation/ character & pathology	Modalities(<, >) & A/F(=)	Concomitants/ associated symptoms with duration
Pain, itching, discharge of pus on Ear( both ) Since childhood (first right; then now left)	Ear (both)_since childhood ( first right and then left)	slight pain Itching Pus discharge Offensive discharge Sound hearing on ears.	<getting wet < from cold exposure <touch < cold food < cold drinks < cold air >rubbing with buds	Impairment of hearing Vertigo

## 3. H/O PRESENT ILLNESS;

The patients complaints of itching and purulent discharge from right ear since her 15 yrs of age. She has done a surgery for this complaint. She took Allopathic and Ayurvedic medication. But she didn't get any relief.

**4. H/O PREVIOUS ILLNESS WITH TREATMENT ADOPTED:**

Since 2 yrs : Dyslipidaemia

Before 8 yrs : Surgery done on right ear for CSOM.

**5. FAMILY HISTORY:**

Mother - Diabetes Mellitus

**6. GENERAL SYMPTOMS :**

Appetite - Normal

Stool - Regular

Thirst - Normal

Urine - Normal

Sleep - Good

Sweat - Normal

Mental generals :

Co-operative

Desire company

Reaction to:

Desire covering

Aversion fanning

Desire warm food and drinks.

Thermal: Chilly

## 7. PHYSICAL EXAMINATION:

### A. General examinations

- Conscious/unconscious : Conscious
- General appearance (expression,look,decubitus,etc.):Normal
- Intelligence and education level: Intelligent
- General built up and nutrition:Normal
- Anameia: No pallor, Jaundice: Not icteric, Cyanosis: Nil, Odema: Nil
- Skin: Normal
- Nails: Normal
- Gait:Steady
- Lymphadenopathy(cervical, axillary, inguinal,post auricular etc): Nil
- Blood pressure: 106/68mm of Hg
- Pulse: 72/minute
- Temperature: 98.6F
- Resp. rate: 16b/ m
- Others: Normal

### B. Systemic examination:

O/E **Ear:** Surgical scar present on posterior part of right ear.

Greenish-yellowish discharge present in left ear.

Rinne's test: Right side-Negative.

Left side: Negative



Weber's test: Lateralised to right ear( Conductive deafness)

**8. LAB INVESTIGATIONS AND FINDINGS :**

Nil

**9. PROVISIONAL DIAGNOSIS;**

CHRONIC SUPPURATIVE OTITIS MEDIA

**10. DATA PROCESSING;**

A. Analysis of case:

Common symptoms	Uncommon symptoms
Pain in ears< cold exposure  < touch  <cold foods  <cold drinks  <getting wet  Vertigo  Offensive pus discharge from ears.  Sound hearing on ears.	Desire warm food and drinks

B. Evaluation of symptoms:

Mental general	Physical general	Particular
<p>Co-operative</p> <p>Desire company</p>	<p>D – warm food and drink</p> <p>Thermal: chilly</p>	<p>Pain in ears</p> <p>&lt; cold exposure</p> <p>&lt; touch</p> <p>&lt; cold foods</p> <p>&lt; cold drinks</p> <p>&lt; getting wet</p> <p>Offensive pus discharge from ears.</p> <p>Sound hearing on ears.</p>

C. Miasmatic Analysis

Psora	Sycosis	Syphilis
<p>Sound hearing on ears .</p> <p>Itching</p>	<p>Pain in ears &lt; cold exposure .</p> <p>Vertigo</p>	<p>Offensive pus discharge from ears.</p> <p>Loss of hearing</p>

D. Totality of symptoms:

- Co-operative
- Desire warm food and drinks
- Pain in ears < cold exposure ,
- < touch,
- < cold foods

< cold drinks

< getting wet

**11 SELECTION OF MEDICINE;** (repertorial/ non repertorial)

Non-repertorial

**12. SELECTION OF POTENCY AND DOSAGE;** (justified)

According to the susceptibility of the patient and Homoeopathic principle.

**13. PRESCRIPTION :**

R<sub>x</sub>

MERCURIUS SOLUBILIS 0/3/1D (Stat) in aqua

10gtt 4 hrly

B. Disk 1-0-1

B. Pills 3-3-3 x 4 days

**14. GENERAL MANAGEMENT AND AUXILLARY MEASURES :**

Avoid cold exposure, entry of water in to ear. Proper aural toileting

**FOLLOW UP**

Date	Symptom(s) changes	Inference	Prescription
9/1/2017	<p>Discharge of pus in left ear feels slightly better; but persists.</p> <p>Sound heard in left ear feels better than before.</p> <p>Occasionally vertigo present since 1 month</p> <p>Generals: Good</p> <p>BP: 110/70mmHg</p>		<p>R<sub>x</sub></p> <p>MERC. SOL. 0/3/1D (HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x 1 month</p>
13/2/2017	<p>Discharge of yellowish pus in left</p>		

<p>13/3/2017</p>	<p>ear feels slightly better than before.</p> <p>Itching occasionally present.</p> <p>Sound heard in left ear feels better than before.</p> <p>No offensiveness of the discharge.</p> <p>Generals: Good</p> <p>BP: 110/72 mmHg</p> <p>Discharge of pus from left ear persists as same.</p> <p>Itching feels better than before; but occasionally persists.</p> <p>Sound heard from left ear feels better</p>		<p>R<sub>x</sub></p> <p>MERC. SOL.0/3/1D (HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x 1 month</p> <p>R<sub>x</sub></p> <p>MERC. SOL 0/3/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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<p>27/3/2017</p>	<p>than before.</p> <p>Generals: Good</p> <p>BP:110/70mmHg</p> <p>Discharge of pus from the left ear with itching feels better than before.</p> <p>Sound heard from left ear feels better than before.</p>		<p>Rx</p> <p>MERC.SOL 0/3/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
<p>11/4/2017</p>	<p>Generals: Good</p> <p>BP:110/70mmHg</p> <p>Discharge of pus from left ear feels better than before.</p> <p>Itching in left ear persists as same.</p> <p>Sound heard in left ear occasionally</p>		<p>Rx</p> <p>MERC. SOL 0/3/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>

<p>24/4/2017</p>	<p>persists.</p> <p>Heaviness of head better.</p> <p>Generals: Good</p> <p>BP:110/70mmHg</p> <p>Discharge of pus from left ear feels better than before.</p> <p>Itching in left ear persists; but feels better than before.</p> <p>Tinnitus occasionally present.</p> <p>Generals:</p> <p>Appetite:Decreased</p> <p>Thirst: Decreased</p> <p>BP:110/70mmHg</p>		<p>Rx</p> <p>SAC LAC /7D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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8/5/2017	<p>Discharge from left ear feels better.</p> <p>Itching of left ear feels better.</p> <p>Tinnitus present.</p> <p>Generals:</p> <p>Sleep: Reduced</p> <p>BP:110/70mmHg</p>		<p>Rx</p> <p>SAC LAC /7D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
25/5/2017	<p>Ear pain feels better than before.</p> <p>Discharge from right ear persists.</p>		<p>Rx</p> <p>SAC LAC /7D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
15/6/2017	<p>Whitish discharge from left ear persists.</p> <p>Discharge f pus from right ear persists.</p> <p>Pain in right ear</p>		<p>Rx</p> <p>SAC LAC /7D(HS)</p> <p>SD – 1-0-1</p>



<p>19/6/2017</p>	<p>persists.</p> <p>Itching present in both ears.</p> <p>Tinnitus present on left ear.</p> <p>Generals: Good</p> <p>BP:110/70mmHg</p> <p>Yellowish discharge from left ear occasionally persists.</p> <p>Pus like discharge from right ear persists.</p> <p>Pain and oedema in both ears occasionally persists.</p> <p>Itching present on both ears.</p> <p>Generals: Good</p>		<p>SG- 3-3-3 x2 weeks</p> <p>Rx</p> <p>SAC LAC /7D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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<p>23/6/2017</p>	<p>BP:120/80mmHg</p> <p>Colourless watery discharge from the left ear.</p> <p>Pus like thick discharge from the right ear.</p> <p>Itching over both ears feels better.</p> <p>Pain in the ear&lt;cold exposure.</p> <p>Left ear feels blocked and hearing sensation impaired when the discharge comes.</p> <p>Tinnitus present in the left ear.</p> <p>O/E: Yellowish discharge present in</p>		<p>Rx</p> <p>MERC. SOL.0/3/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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<p>17/7/2017</p>	<p>the right ear.</p> <p>Generals: Good</p> <p>BP:120/90mmHg</p> <p>Discharge from right ear is more than the left.</p> <p>Discharge of colourless fluid still persists.</p> <p>Generals: Good</p> <p>BP:130/100mmHg</p>		<p>Rx</p> <p>MERC.SOL.0/3/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
<p>29/7/2017</p>	<p>Tinnitus of right ear feels better than before.</p> <p>Generals: Good</p> <p>BP:130/100mmHg</p>		<p>Rx</p> <p>MERC. SOL 0/3/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>

14/8/2017	<p>Oozing from right ear feels better; but persists.</p> <p>Blocked sensation in left ear.</p> <p>Tinnitus present in left ear.</p> <p>Generals: Good</p> <p>BP:120/80mmHg</p>		<p>Rx</p> <p>MERC. SOL. 200/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
28/8/2017	<p>Oozing of watery discharge from left ear present.</p> <p>Tinnitus present in left ear.</p> <p>Oozing of yellowish discharge from right ear occasionally present.</p> <p>Generals:Good</p>		<p>Rx</p> <p>MERC. SOL.200/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>

<p>11/9/2017</p>	<p>BP:120/70mmHg</p> <p>Oozing of watery discharge from left ear feels slightly better than before.</p> <p>Tinnitus present.</p> <p>Oozing of fluid occasionally present from right ear.</p> <p>Generals:Good</p>		<p>Rx</p> <p>MERC.SOL200/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
<p>25/9/2017</p>	<p>Oozing of watery discharge from left ear feels better than before.</p> <p>Tinnitus present.</p> <p>Oozing of pus occaionally present from right ear.</p> <p>Generals:Good</p> <p>BP:128/84mmHg</p>		<p>Rx</p> <p>MERC. SOL.200/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>

<p>9/10/2017</p>	<p>O/E:Right ear:  Presence of pus  Left ear:Discharge of  pus  Tinnitus  No mastoid  tenderness.  Weber's test:  Lateralised to the left  ear.  Rinnie's  test:Negative on both  ears.  Vertigo occasionally  present.  Oozing of watery  discharge from left  ear feels better than  before.</p>		<p>Rx  MERC. SOL.200/1D(HS)  SD – 1-0-1  SG- 3-3-3 x2 weeks</p>
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<p>23/10/2017</p>	<p>Tinnitus feels better than before.</p> <p>Pus from right ear feels better than before.</p> <p>Generals: Good</p> <p>BP:120/80mmHg</p> <p>Tinnitus present.</p> <p>Pain in ears present.</p> <p>Discharge of pus from ears present.</p> <p>Generals:Good</p> <p>BP:120/80mmHg</p>		<p>Rx</p> <p>MERC. SOL.200/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
<p>16/11/2017</p>	<p>Pain and itching on both ears feels better;but persists.</p> <p>Tinnitus present in</p>		<p>Rx</p>

28/11/2017	<p>left ear.</p> <p>Watery discharge present from left ear.</p> <p>Generals:</p> <p>Sleep:Disturbed</p> <p>Others:Good</p> <p>BP:120/80mmHg</p> <p>O/E:</p> <p>Weber's test:</p> <p>Lateralised to the right ear</p> <p>Rinnie's test: Left side:</p> <p>Negative(BC&gt;AC)</p> <p>Right side-Negative.</p> <p>Pain and itching in both ears feels better;but persists.</p>		<p>MERC. SOL.200/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p> <p>Rx</p> <p>MERC. SOL.200/1D(HS)</p> <p>SD – 1-0-1</p>
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8/12/2017	<p>Tinnitus occasionally present in left ear.</p> <p>Watery discharge from left ear occasionally present from left ear.</p> <p>Generals: Good</p> <p>BP:120/80mmHg</p> <p>Itching in both ears slightly better; but persists.</p> <p>Tinnitus occasionally present in left ear.</p> <p>Watery discharge from left ear feels better than before.</p> <p>Generals:Good</p> <p>BP:120/90mmHg</p>		<p>SG- 3-3-3 x2 weeks</p> <p>Rx</p> <p>MERC. SOL.1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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20/12/2017	<p>Yellowish discharge occasionally from right ear persists.</p> <p>Watery discharge from left ear feels better.</p> <p>Tinnitus occasionally present in left ear.</p> <p>Generals:Good</p> <p>BP:120/90mmHg</p>		<p>Rx</p> <p>MERC.SOL.1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
27/12/2017	<p>Yellowish discharge from right ear present.</p> <p>&lt;morning</p> <p>Itching on both ears present.</p> <p>Generals:Good</p> <p>BP:110/80mmHg</p> <p>Pulse:68/minute</p>		<p>Rx</p> <p>MERC .SOL. 1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>

<p>9/1/2018</p>	<p>Resp.rate:17/minute</p> <p>Yellowish discharge from right ear present.</p> <p>&lt;morning</p> <p>Itching present on both ears.</p> <p>Watery discharge and discharge of pus persists as same.</p> <p>Generals:Good</p> <p>BP:120/80mmHg</p>		<p>Rx</p> <p>MERC. SOL. 1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
<p>5/3/2018</p>	<p>Tinnitus present in right ear; with discharge of pus occasionally.</p> <p>O/E: Pus present.</p> <p>Discharge from left ear feels better than</p>		<p>Rx</p> <p>MERC .SOL. 1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>

<p>26/3/2018</p>	<p>before; but persists</p> <p>Itching in both ears present; but more on right.</p> <p>Generals:Good</p> <p>BP:110/60mmHg</p> <p>Tinnitus present in right ear with discharge of pus.</p> <p>O/E: Pus present.</p> <p>Blocked sensation and tinnitus present in left ear with discharge of pus occasionally.</p> <p>Itching in ears occasionally present.</p> <p>Generals:Good</p> <p>BP:120/66mmHg</p>		<p>Rx</p> <p>MERC. SOL. 1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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8/4/2018	<p>Tinnitus present in right feels feels slightly better than before.</p> <p>Tinnitus present in left ear; oozing of discharge from left ear feels slightly better; but persists.</p> <p>Itching in both ears persists.</p> <p>Generals:Good</p> <p>BP:130/90mmHg.</p>		<p>Rx</p> <p>MERC. SOL. 1M/1D(HS)</p> <p>SD – 1-0-1</p> <p>SG- 3-3-3 x2 weeks</p>
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**CASE NO : 2**

**1. PERSONAL DATA**

OP NO : 5105/15

DATE: 16/ 3/17

UNIT : 1V A

NAME : A.M

AGE : 15yrs

SEX : Male

ADDRESS : Makaravila, Kallamkuzhi

Occupation – Student

Phone- 9787002550

## 2.PRESENTING COMPLAINTS

LOCATION	SENSATION	MODALITIES	ACCOMPANIMENTS
EAR (Rt inner ) Since 1 month	Tinnitus		
Ear – left –since 2yrs.	Pain, Yellowish discharge from ear. Offensive.	< cold exposure	
HEAD Since 3 days	Heaviness	>lying down <stooping <walking <early morning	
RESPIRATORY SYSTEM Since 1 month	Coryza with watery discharge		

### 3. HISTORY OF PRESENTING ILLNES:

The patient complaints of having tinnitus heard in right ear since 1month. Yellowish discharge from left ear since 2yrs. He also has sensation of heaviness on head and coryza with watery discharge from nose(recurrent) .For this complaint he had taken allopathic medication but got no relief.

**4. HISTORY OF PREVIOUS ILLNESS WITH TREATMENT ADOPTED:**

At 9 yrs – Chickenpox-Allopathy – Relieved

**5. FAMILY HISTORY:**

Grandfather- Diabetes Mellitus

**6. PHYSICAL GENERALS**

Appetite : Normal

Thirst :Normal

Sleep : Good

Stool : Regular

Urine : Normal

Sweat : Normal

**REACTIONS TO**

Desire fanning

Desire covering

Desire meat

Aversion milk

Aversion vegetables



Desire sweets

## 7. PHYSICAL EXAMINATIONS:

### A. General examinations

- Conscious/unconscious :Conscious
- General appearance (expression,look,decubitus,etc.):Normal, thin
- Intelligence and education level: Std 10<sup>th</sup> , Normal
- General built up and nutrition: Normal
- Ht : 156.5cm            Wt : 51.6kg            BMI:
- Anaemia: Mild pallor, Jaundice: Not icteric, Cyanosis: Nil,
- Oedema: Nil
- Skin: Nil
- Nails:Nil
- Gait:Steady
- Lymphadenopathy(cervical, axillary, inguinal, etc): Nil.
- Blood pressure: 100/72 mm of Hg
- Pulse: 78/minute
- Temperature: 98.6 F
- Resp. rate: 16/ minute
- Others: Normal

### B. Systemic examination:

Ear examination:

O/E –yellowish discharge present on left ear, no swelling,

Mastoid tenderness present.

Rinnie’s test –Positive. Weber’s test- Centralised

## **8. LAB INVESTIGATIONS AND FINDINGS:**

Nil

## **9. PROVISIONAL DIAGNOSIS :**

CHRONIC SUPPURATIVE OTITIS MEDIA.

## **10. DATA PROCESSING:**

### A. Analysis of case:

Common symptom:

Uncommon symptom:

Heaviness of head

right ear Tinnitus

< lying down

yellowish discharge from left ear.

< stooping

Offensive.

Coryza with watery discharge

### B. Evaluation of symptoms:

Mental general:

Easily angered

< consolation

Physical general:

Desire fanning

Desire covering

Desire meat

Desire sweets

Aversion to milk, vegetables.

Particulars:

Left ear pain with discharge with slightly offensive

Tinnitus in right ear

Heaviness of head

Coryza watery.

### C. Miasmatic Analysis

Psora	Sycosis	Syphilis
Tinnitus	Ear pain	Offensive
Heaviness of head		discharge from the
Coryza		ear.

D. Totality of symptoms:

Easily angered.

Desire fanning

Desire covering

Desire meat

Desire sweets

Aversion to milk, vegetables.

Left ear pain with discharge, have slight offensiveness

Tinnitus- right ear

Heaviness of head.

Watery coryza.

**11. SELECTION OF MEDICINE** (repertorial/ non repertorial)

Non repertorial.

**12. SELECTION OF POTENCY & DOSE**(justified)

According to the susceptibility of the patient and Homoeopathic principles.

**13. PRESCRIPTION:**

Rx

MERCURIUS SOLUBILIS 0/3/1 DOSE(M)

BLANK PILLS-TDS x1wk

**14. GENERAL MANAGEMENT AND AUXILLARY MEASURES;**

Avoid entry of water in to ear, maintain proper aural hygiene.

**FOLLOW UP-**

Date	Symptoms changes	Prescription
19/4/17	Tinnitus heard over right ear persists as same. Discharge of pus from left ear persists. Ulceration of tongue feels better. Sneezing with watery discharge better but persists. Cough with out expectoration Generals- good	Rx MERC. SOL. 0/3 /1D(M) BLANK. TAB- BDS x 2wks
22/5/17	Tinnitus -persists Discharge from ear persists	Rx

15/6/17	<p>Sneezing when exposure to dust.</p> <p>Coryza persists.</p> <p>Generals- good</p> <p>Tinnitus in right ear persists.</p> <p>Discharge from left ear.- watery with offensive.</p> <p>Sneezing.&lt; dust exposure.</p> <p>Generals- good.</p>	<p>MERC. SOL. 0/3 /1D(M)</p> <p>BLANK. TAB- BDS</p> <p>x 2wks</p> <p>Rx</p> <p>MERC. SOL. 0/3 /1D(M)</p> <p>BLANK. PILLS-TDS</p> <p>x 1 Month</p>
10/ 7/17	<p>Pus in the left ear persisting with offensive smell.</p> <p>Tinnitus persisting in right ear.</p> <p>Sneezing better.</p> <p>Generals- good</p>	<p>Rx</p> <p>MERC. SOL. 0/6 /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
24/7/17	<p>Pus discharge from ear persists.</p> <p>Tinnitus persists but better.</p> <p>Generals- Good</p>	<p>Rx</p> <p>MERC. SOL. 0/6 /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>

4/9/17	<p>Pus discharge from left ear.</p> <p>Tinnitus in right ear.</p> <p>Generals- good</p>	<p>Rx</p> <p>MERC. SOL. 0/6 /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
9/ 10/ 17	<p>Ear discharge purulent offensive.</p> <p>Tinnitus persists.</p>	<p>Rx</p> <p>MERC. SOL. 10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
29/11/17	<p>Ear discharge persists.</p> <p>Itching since 1 week.</p>	<p>Rx</p> <p>MERC. SOL. 10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
29/12/ 17	<p>Ear discharge slightly better but persists.</p> <p>Tinnitus persists.</p> <p>Discharge is thick and whitish from left ear.</p>	<p>Rx</p> <p>MERC. SOL.10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>

29/1/18	<p>Ear discharge persists with smell.</p> <p>Tinnitus present.</p> <p>Itching better.</p> <p>Watery coryza since 3 days.</p> <p>Cough with yellow expectoration since 3 days.</p>	<p>Rx</p> <p>MERC. SOL. 10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
9/4/18	<p>Generals – Good.</p> <p>Offensive whitish discharge from left ear feels better than before.</p> <p>Tinnitus persists.</p> <p>Watery nasal discharge feels better.</p> <p>Cough better.</p> <p>Generals – Good.</p>	<p>Rx</p> <p>MERC. SOL. 10 M</p> <p>/1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
28/ 5/18	<p>Offensive whitish discharge from left ear feels better.</p> <p>Tinnitus persists</p> <p>Generals- Good.</p>	<p>Rx</p> <p>MERC. SOL. 10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>



1/8/18	<p>Sneezing persists.</p> <p>Watery discharge from nose feels better.</p> <p>Offensive whitish discharge from left ear persists.</p> <p>Tinnitus persists.</p> <p>Generals- Good.</p>	<p>Rx</p> <p>MERC. SOL.10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
3/9/18	<p>Thick yellow offensive discharge from left ear persists.</p> <p>Tinnitus present on right ear persists.</p> <p>Generals – Good.</p>	<p>Rx</p> <p>MERC. SOL. 10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 1Month</p>
10/ 10/18	<p>Sneezing with watery coryza since 1 day.</p> <p>Thick yellow offensive discharge from left ear persists.</p> <p>Tinnitus present in right ear persists.</p> <p>Fever since 1 day.</p> <p>Headache</p> <p>Generals –Good.</p>	<p>Rx</p> <p>MERC. SOL. 10M /1D(M)</p> <p>BLANK. PILLS- TDS</p> <p>BLANK. DISC- BDS</p> <p>x 3 WKS</p>

**APPENDIX V**  
**MASTER CHART**

Sl. No	O.P No.	Age	Sex	Occupation	Predisposing factors.	Past history	Family history	Miasm	Acute medicine	Miasmatic medicine	Potency	Disease intensity score		Result
												Before	After	
1	737 9/1 6	57	F	House wife	Exposure to cold	Dyslipidaemia, CSOM	Diabetes mellitus	Syphilis	MERC.SOL	MERC.SOL	0/3, 200, 1M	9	2	Improved
2	510 5/1 5	15	M	Student	Rhinitis	Chicken pox	Diabetes	Syphilis	MERC.SOL	MERC.SOL	0/3, 0/6, 10M	8	3	Improved
3	188 5/1 5	18	F	Student	Rhinitis	Typhoid	N.R	Syphilis	MERC.SOL	MERC.SOL	1M, 0/3, 0/6	9	3	Improved
4	422 2/1 8	33	F	House wife	N.R	N.R	Hypertension	Syphilis	MERC.SOL	MERC.SOL	200	5	0	Improved
5	177 7/1 7	18	F	Student	Cold exposure	Measles, Chicken pox	N.R	Syphilis	MERC.SOL	MERC.SOL	200	8	2	Improved
6	465 4/1 8	32	F	House wife	Sun exposure	N.R	Hypertension & Diabetes	Psora	HEPAR.SULPH	HEPAR.SULPH	1M	6	0	Improved
7	237 9/1 5	25	F	Student	Cold exposure	pneumonia	Bronchial Asthm	Psora	PULSATILLA. NIGRICA	PULSATILLA. NIGRICA	200	8	2	Improved

							a		ANS	NS				
8	125 8/1 7	51	M	Coolie	Cold exposure	Chicken pox, Chikungunya	Hypertension	Psora	PULSATILLA. NIGRICANS	PULSATILLA. NIGRICANS	200	9	0	Improved
9	152 3/1 7	11	M	Student	N.R	Chicken pox, Pneumonia, Dengue fever	N.R	Syphilis	MERC.SOL	MERC.SOL	200, 1M	7	1	Improved
10	144 30/ 13	44	F	House wife	River bathing	CSOM	Diabetes Mellitus	Syphilis	MERC.SOL	MERC.SOL	1M,	10	2	Improved
11	351 9/1 8	39	F	House wife	Fever	Diabetes	Diabetes mellitus	Syphilis	MERC.SOL	MERC.SOL	1M	7	1	Improved
12	608 2/1 8	38	F	Manager	Rhinitis	N.R	Hypertension	Psora	BELLADONNA	BELLADONNA	200	6	1	Improved
13	348 4/1 7	12	F	Student	Rhinitis	Otorrhea	Diabetes	Syphilis	MERC.SOL	MERC.SOL	200	6	1	Improved
14	473 6/1 8	36	M	Maison	River bathing	Chicken pox, typhoid	Hypertension	Psora	KALIMUR	KALIMUR	30	6	2	Improved
15	154 7/1 5	30	F	House wife	Rhinitis Upper respiratory tract	Hepatitis	Diabetes	Syphilis	MERC.SOL	MERC.SOL	200	9	3	Improved

					infections									
16	895 5/1 7	8	M	Student	Cold bathing	Viral fever	N.R	Psora	PULSAT ILLA. NIGRIC ANS	PULSATI LLA. NIGRICA NS	1M	6	0	Improved
17	134 8/1 8	18	F	Sister	N.R	Chicke n pox	Diabet es mellitu s	Syphilis	MERC.S OL	MERC.S OL	200	7	1	Improved
18	490 8/1 8	42	F	House wife	Cold climate	Chicke n pox, Thyroi ditis	Hypert ension	Psora	CAPSIC UM	CAPSICU M	1M	8	2	Improved
19	106 20/ 07	35	F	House wife	Cold climate	N.R	Hypert ension	Syphilis	MERC. SOL	MERC. SOL	1M	8	2	Improved
20	857 7/1 7	43	F	House wife	Nothing relevant	Meascl es, Uterine fibroid	Diabet es mellitu s	Syphilis	MERC.S OL	MERC.S OL	200	8	1	Improved
21	269 1/1 8	36	F	House wife	Exposure to cold	Chicke n pox	N.R	Syphilis	MERC.S OL	MERC.S OL	1M	5	1	Improved
22	807 4/1 7	59	F	Rtd. Office staff	N.R	Chicke n pox	Diabet es mellitu s	Syphilis	MERC.S OL	MERC.S OL	200	9	1	Improved
23	584 1/1 8	15	M	Student	Cold bathing, cold exposure	Meascl es	Diabet es mellitu s	Syphilis	MERC.S OL	MERC.S OL	200	7	1	Improved

24	849 6/1 7	43	F	House wife	N.R.	Meascl es	N.R	Syphilis	MERC.S OL	MERC.S OL	200	6	2	Improved
25	683 9/1 8	33	F	House wife	Upper respiratory tract infection	Chicke n pox	N.R	Syphilis	MERC.S OL	MERC.S OL	200	8	2	Improved
26	433 5/1 8	43	F	House wife	Cold bathing	Chicke n pox	N.R	Syphilis	MERC.S OL	MERC.S OL	200	6	2	Improved
27	354 7/1 8	15	F	Student	Cold exposure	Mumps	N.R	Syphilis	MERC.S OL	MERC.S OL	200, 1M	5	1	Improved
28	684 5/1 8	26	M	Welding	N.R	N.R	Diabet es mellit s	Sycosis	KALI.BI CH	KALI.BIC H	1M	8	1	Improved
29	247 9/1 8	13	M	Student	Cold bathing	N.R	N.R	Syphilis	MERC. SOL	MERC. SOL	200	6	0	Improved
30	935 0/1 7	57	F	Coolie	Exposure to cold	Hepatit is Head injury	Hypert ension	Syphilis	MERC.S OL	MERC.S OL	200	12	2	Improved

## **APPENDIX VI**

### **FORM – 4: CONSENT FORM (A)**

#### **INFORMATION FOR PARTICIPANTS OF THE STUDY**

Title of my study is “A CLINICAL STUDY ON MIASMATIC APPROACH IN MANAGEMENT OF PATIENTS WITH CHRONIC SUPPURATIVE OTITIS MEDIA”. The purpose of my study is (1) to find antimiasmatic medicines (2) to find common medicines for acute affections (3) to find out predisposing factors for CSOM (4) to find common potency effective for CSOM. Duration of my study is from July 2017 – January 2019.

The procedures include selection of 30 cases of female patients with CSOM are selected from OPD, IPD and from peripheral centers of Sarada Krishna Homoeopathic Medical College. The case will be analysed and evaluated. It is repertorised and a well selected remedy will be prescribed after referring the Materia Medica. The repetition of doses will be done based on the Homoeopathic principles. Assessment will be done once in a week or two weeks and changes will be recorded. In 3 to 6 months study, cases will be assessed on one year observation.

The benefits to the subject or others, reasonably expected from research are (1) The participants are investigated to find out whether he/she is having CSOM. (2) If the participant is identified to have CSOM or is a known patient with CSOM, in both cases he/she will be given awareness about the risk factors of CSOM by which they can reduce/ control their disease. (3) Thus study is a benefit not only to the participant but also to the society as a whole. The records are maintained highly confidential. Only the investigator has the access to the subject’s medical records. Participant’s identity will never be disclosed at any time, during or after the study

period or during publication of the research. Securely store data documents in locked locations and Encrypt identifiable computerized data. All information revealed by patient will be kept as strictly confidential. Free treatment for research related injury is guaranteed. Compensation of the participants not only disability or death resulting from such injury but also for unforeseeable risks is provided, in case situation arises.

Contact for trial related queries, rights of subjects and in the event of any injury.

#### INVESTIGATOR

Dr. Panchajani R., P.G. Scholar,

Department of Organon of Medicine,

Sarada Krishna Homoeopathic Medical College,

Kulasekharam, Mobile no: 9442402947.

#### GUIDE

Dr. M. Murugan

Professor and Head,

Department of Organon of Medicine,

Sarada Krishna Homoeopathic Medical College,

Kulasekharam, Mobile no: 9443343707.

There will not be any anticipated prorated payment to the subject for participating in the trial. The responsibilities of the participants in the trial are they must disclose all about the complaints. Participants must strictly stick on to the scheduled Diet, Regimen and Medicine.

The participation is voluntary, that the subject can withdraw from the study at any time and that refusal to participate will not involve any penalty or loss of benefits to which the subject is otherwise entitled.



**FORM- 4 A**

**CONSENT FORM (B)**

Informed Consent form to participate in a clinical trial

Study Title: A CLINICAL STUDY ON MIASMATIC APPROACH IN  
MANAGEMENT OF PATIENTS WITH CHRONIC SUPPURATIVE OTITIS  
MEDIA

Study Number: Subject's Initials \_\_\_\_\_ Subject's Name \_\_\_\_\_

Date of birth/Age: \_\_\_\_\_

Please initial

Box (Subject)

- i. I confirm that I have read and understood the information sheet dated July 2017 for the above study and have had the opportunity to ask question. [ ]
- ii. I understood that my participation in the study is voluntary and that I am free to withdraw at any time without giving any reason. Without my medical care or legal rights being affected. [ ]
- iii. I understand that the sponsor of the clinical trial, others working on the sponsor's behalf the Ethics Committee and the regulatory authorities will not need my permission to look at my health records both in respect of the current study and further research that may be conducted in relation to it, even if I withdraw from the trial. I agree to this access. However, I understand that my identity will not be revealed in any information released to third parties or published. [ ]

iv. I agree not to restrict the use of any data or result that arise from this study provided such a use only for scientific purpose(s) [ ]

v. I agree to take part in the above study.

Signature (or Thumb impression of the subject/legally acceptable)

Representative: \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signatory's Name: \_\_\_\_\_

Signature of the Investigator: \_\_\_\_\_

Study Investigator's Name: Dr. Panchajani. R

Signature of the Witness \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of the Witness \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_