THE EFFECT OF THE HOMOEOPATHIC SIMILIMUM IN THE TREATMENT OF CLIMACTERIC SYMPTOMS

A dissertation submitted to the Faculty of Health Sciences, Technikon Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Technology: Homoeopathy

by

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DECLARATION

I, Allana Artemi declare that this dissertation is my own, unaided work. It is being submitted for the Degree of Master of Technology at the Technikon Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other Technikon or University.

Signature of Candidate

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ABSTRACT

The climacteric is defined as the phase when menstruation becomes irregular and climacteric symptoms develop, usually affecting females between the ages of 44 and 57 years old. During the climacteric many women experience adverse symptoms, ranging from headaches, hot flushes, increased perspiration, irritability, sleeping problems, and joint pains, as well as more severe diseases such as osteoporosis and an increased risk of myocardial infarctions and cerebral vascular accidents (Berkow et al, 1999:1942; Seidl and Stewart, 1998:1300).

The aim of this study was to determine the efficacy of the homoeopathic *similimum* in the treatment of climacteric symptoms and its effect on the serum oestrogen levels.

Advertisements were placed at various medical practices and health shops in Gauteng and at the Technikon Witwatersrand campus to recruit volunteers for the study. Volunteers were required to complete a Suitability Criteria Questionnaire. Ten volunteers were selected according to the inclusion criteria. Each participant participated in four homoeopathic consultations, over a period of three months. Each participant signed a consent form before participating in the study. Using each participant’s unique physical, emotional, and mental symptoms, the researcher determined their appropriate homoeopathic remedy, known as the *similimum*. Participants completed the modified Kupperman Menopause Index at each consultation. The results where then transferred to the participant’s main Kupperman Menopause Index and compared. These results, together with the participant’s case history at each consultation, were used to determine the effect of homoeopathy in treating climacteric symptoms.

In accordance with the homoeopathic laws and principles of the classical homoeopathic approach, each participant was evaluated and treated as a totality. It was anticipated that the study would provide an alternative, safe form of treatment for each individual’s climacteric symptoms.

The homoeopathic *similimum* treatment was significantly effective in alleviating climacteric symptoms in each participant. The effect of the *similimum* on the serum oestrogen levels was unclear and did not determine whether cure was achieved.
DEDICATION

This study is dedicated to my parents. To my father who lives on in my memories everyday, and to mother who continues to make such wonderful memories.
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CHAPTER ONE

INTRODUCTION

1.1 PROBLEM STATEMENT

Climacteric is defined as the phase when menstruation becomes irregular and climacteric symptoms develop. The average age that women reach menopause is fifty-one (Berkow et al., 1999:1942).

As every adult woman all over the world knows ‘the change’ refers to the changes that occur with the climacteric. Many women fear these changes (Lee, 1996: xix). Menopause should not be regarded as ‘the change’, but rather ‘a change’ in a woman’s life (Love, 1997:11-12).

There is a misconception surrounding menopause that it is a disease. Menopause is not a disease (Glenville, 2001:400), and must only be viewed as the cessation of menstruation and a natural stage of a woman’s life. Many women are faced with the fear of these changes, which brings them to asking questions such as, should I take hormones, or shouldn’t I take hormones? And if I take hormones am I going to get breast cancer? And if I don’t am I going to develop osteoporosis or die of a heart attack (Lee, 1996:5; Love, 1997:11-12)?

During this time there may be fear of growing old, not being able to create life, the loss of periods and hormones, and the ‘empty-nest’ syndrome. All these issues need to be addressed and the female made aware that the emphasis should not be placed on the losses, but rather the gain of adult maturity, wisdom and independence (Glenville, 2001:401).

Many of these changes and symptoms may or may not need treatment, and women must be informed of the many forms of prevention and treatment such as homoeopathy, naturopathy, acupuncture, reflexology, Chinese herbalism and exercise (Love, 1997:11-12), in addition to conventional medical options.
It is important for women to consider different forms of prevention and treatment in the climacteric and the menopause, and to evaluate the best possible form of treatment suited to the individual.

Homoeopathic remedies were used in this study. They were prescribed according to the principle of ‘likes cure likes’ and were specifically prescribed for each participant. The remedies are inexpensive and have little or no side effects.

1.2 HYPOTHESIS

It is hypothesised that the homoeopathic similimum remedy will reduce the symptoms of the climacteric.

1.3 PURPOSE OF THE STUDY

The research aimed at evaluating the efficacy of the homoeopathic similimum in treating climacteric symptoms, and its effect on the serum oestrogen levels.

1.4 IMPORTANCE OF THE PROBLEM

Males tend to die at an earlier age than females, thus resulting in a large number of females who will spend on average 10 latter years without a partner. Because females live longer, they suffer a greater incidence of debilitating illness, such as osteoporosis, cardiovascular disease, strokes, cancer, and depression. Some of these problems are aggravated by oestrogen deficiency (Nachtgall and Wren, 1996:1-2).

The treatment of the climacteric is very important. There are many unwanted risks associated with the climacteric, such as the risk of developing osteoporosis, depression, and cardiovascular disease. Osteoporosis has been known as ‘the silent epidemic’. Many women feel well and have no pain until a fracture results. Mortality associated with osteoporosis is very significant (Hirschowitz, 1991:38, 75).
There are divergent opinions about whether or not hormone replacement therapy should be used as a treatment for the prevention of these diseases (Naghtigall and Wren, 1996:3).

1.5 ASSUMPTIONS

It is assumed that:

- The homoeopathic remedies were prepared according to a recognized pharmacopoeia and by reliable pharmacists
- The participants in this study have taken the homoeopathic remedy in the manner prescribed
- The participants did not take any other form of medication for the treatment of the climacteric during the study
- The participants’ subjective perception during the treatment was honest, correct, and unbiased
- The participants did not change their normal lifestyle, exercise, or dietary habits immediately prior to or during the study

1.6 LIMITATIONS OF METHOD

The following variables were considered:

- The participants’ ability to take the prescribed remedy in the correct manner, their honest, truthful and accurate revealing of any changes of their symptoms
- The researcher’s knowledge of the materia medica and the principles of homoeopathy, as the remedies prescribed were dependent on the researcher’s case taking abilities, understanding, interpretation, and evaluation of the cases and the selection of the *similimum* remedies
CHAPTER TWO

REVIEW OF THE RELATED LITERATURE

2.1 INTRODUCTION

Menopause comes from the Greek words men meaning month and pausis meaning stopping (Agrawal, 1997:45). Climacteric is defined as the phase when menstruation becomes irregular and climacteric symptoms develop. The climacteric, also known as perimenopause, can last as long as fifteen to twenty years. During this phase, ovarian function is gradually compromised. Postmenopause is the period after menopause where a female has been menses free for twelve consecutive months (Hillard, 1998:49; Sonnendecker, 1995:354).

In Western society, the life expectancy of females at birth is currently calculated at approximately eighty years. According to actuarial figures in 1996, it is expected that on average females can expect to live for about 33 years after menopause (Nachtigall and Wren, 1996:1).

During the climacteric many women experience adverse symptoms, ranging from headaches, hot flushes, increased sweating, and irritability, to more severe diseases such as osteoporosis, an increased risk of myocardial infarctions and cerebral vascular accidents.

Thus, even though the climacteric is a normal bodily process, many women seek medical assistance to palliate these symptoms. Allopathic medication such as hormone replacement therapy is readily used for climacteric symptoms, but alternative treatments are often sought, as there are adverse side effects associated with hormone replacement therapy (Seidl and Stewart, 1998:1300).
2.2 THE FEMALE REPRODUCTIVE SYSTEM

The function of the female reproductive system is dependent upon complex hormonal communication between the reproductive organs and the endocrine system (Berkow et al, 1999:1925).

2.2.1 The Menstrual and Ovarian Cycles

In reproductive females a cyclic, approximately monthly, bloody, vaginal discharge occurs, commencing at puberty and usually continuing throughout their reproductive years. This is referred to as menstruation or menses (Berkow et al, 1999:1927; Moore and Persaud, 1993:20).

The hypothalamus that forms part of the brain synthesizes and secretes gonadotropin-releasing hormone. This hormone in turn regulates the secretion of follicle-stimulating hormone and luteinizing hormone from the anterior pituitary gland. Follicle-stimulating hormone and luteinizing hormone both act on the ovaries, causing the secretion of the hormones oestrogen and progesterone (Rogers, 1995:16).

The lining of the endometrium is shed, and results in a bloody discharge called menses or menstrual flow. The first day of the menses marks the first day of the menstrual cycle. The average menstrual flow occurs for five (± 2 days) days. The average menstrual cycle is 28 days long and the normal range of an ovulatory cycle is about 25 to 36 days. After menarche and before menopause the intermenstrual intervals are the longest. The average blood loss per cycle is 130 ml and is the greatest on the second day of menstruation.

The menstrual cycle is divided into three phases: the follicular (preovulatory) phase, the ovulatory phase, and the luteal (postovulatory) phase.
• The Follicular Phase

The follicular phase occurs from the first day of menses to the day before the surge of luteinizing hormone prior to ovulation. During this phase, the secretion of follicle stimulating hormone is increased slightly, stimulating the growth of 3 - 30 follicles. As follicle stimulating hormone levels decrease a follicle is selected for ovulation. The other follicles undergo atresia. Luteinizing hormone levels slowly start to rise after the increase in follicle stimulating hormone. Ovarian secretion of oestrogen by the selected follicle starts to rise 7 to 8 days before the luteinizing hormone surge and peaks the day before the luteinizing hormone surge. The secretion of oestrogen is accompanied by an increase in luteinizing hormone secretion and a decrease in follicle stimulating hormone levels. This is due to the increase in oestrogen, which inhibits the secretion of follicle stimulating hormone. Progesterone secretion also starts to rise just before the luteinizing hormone surge.

• The Ovulatory Phase

As luteinizing hormone and progesterone levels increase, oestrogen levels decrease. The luteinizing hormone surge consists of multiple increases in luteinizing hormone that is released in pulses, and lasts for 36 to 48 hours. The follicle swells during the release of luteinizing hormone and protrudes above the ovarian epithelium. Maturation of the follicle is completed 16 to 32 hours after the onset of the surge.

• The Luteal Phase

During the luteal phase the follicle undergoes change to form the corpus luteum (yellow body). The corpus luteum secretes progesterone and oestrogen for about 14 days. If pregnancy does not occur, the corpus luteum degenerates, thus the average length of this phase is 14 days in nonpregnant women. The luteal phase ends with day one of each menses. If fertilization and implantation occur, the function of the corpus luteum is the maintenance of the implanted ovum by the secretion of progesterone. Human chorionic gonadotropin is secreted from the ovum, which in turn supports the corpus luteum until the fetoplacental unit can support itself. The levels
of luteinizing hormone and follicle stimulating hormone are low and start to rise with menstruation (Berkow et al, 1999:1927-1928).

2.2.2 The Functions of the Female Hormones

Oestrogen and progesterone are polycyclic compounds manufactured from cholesterol. They circulate in the bloodstream mainly bound to plasma proteins. A small amount can be found unbound and it is this unbound portion of the hormones that are biologically active (Berkow et al, 1999:1925).

2.2.2.1 Oestrogen

Oestrogen is produced mainly by the ovaries and in small quantities by the adrenal glands and corpus luteum (Guyton and Hall, 1997:662).

Oestrogen is responsible for the functioning and development of the female. Its main function is the cause of cellular proliferation and growth of the sexual organs. It is responsible for the development of the secondary sex characteristics, and the regulation of menstruation and ovulation during puberty (Dorland and Newman, 1994:583; Guyton and Hall, 1997:662).

The physical differences between a male and a female are determined by oestrogen's effective production. Oestrogen affects the ovaries, fallopian tubes, uterus, and vagina causing them to increase in size. It causes the deposition of fat in the mons pubis and labia majora increasing them in size and causes proliferation of the endometrium and development of the glands of the endometrium, which provides nutrition of the implanted ovum (Guyton and Hall, 1997:662). Oestrogen softens the cervix of the vagina and produces the right quality of vaginal secretions to lubricate the vagina during intercourse (Glenville, 1997:9).

Oestrogen causes fat deposition in the breasts and initiates growth of the breasts and the breasts milk producing apparatus.
Oestrogen affects bone production, the growth rate of the body and the metabolic rate of the body (Guyton and Hall, 1997:662). It causes the growth spurt in females during the ages of 12 and 13, and it causes the early closure of the epiphyses of the long bones in females who thus reach their full height between 15 and 17 years of age. It facilitates calcium uptake, which sustains the density of bones. It causes the widening and lightening of the pelvis, adapting it for birth. (Marieb, 2001:1101).

Oestrogen promotes hydration of the skin, enhances high-density lipoprotein blood levels, and "feminises" the brain (Marieb, 2001:1102). The heart, arteries, liver, and bladder are also affected by oestrogen (Balch and Balch, 1997:383).

### 2.2.2.2 Progesterone

Progesterone is secreted by the corpus luteum during the second half of the ovarian cycle and prevents further ovulation.

It causes the production of a thick mucous that clogs the cervix, discouraging sperm from entering the uterus (Campion, 1998:12-13). Progesterone promotes secretary changes in the endometrium preparing the uterus for implantation of the fertilized ovum (Guyton and Hall, 1997:663), maintains pregnancy, and is necessary for the survival of the embryo and foetus. Progesterone protects against the negative effects of oestrogen such as cancer, fibrocystic breast disease, thrombosis, lowered libido, and depression (Campion, 1998:12-13).

The development of breast lobules and alveoli are caused by progesterone as well as breast swelling (Guyton and Hall, 1997:663).
2.3 THE CLIMACTERIC

The climacteric is the phase when menstruation becomes irregular and climacteric symptoms develop. The climacteric can last as long as fifteen to twenty years. During this phase, ovarian function is gradually reduced. Postmenopause is the time after menopause where a woman has not menstruated for twelve months consecutively (Hillard, 1998:49; Sonnendecker, 1995:354).

At birth, the ovaries contain approximately two million immature primordial follicles. As a female ages, the primordial follicles are destroyed naturally. Approximately at the age of fifty-one, the ova are depleted and ovulation can no longer occur. At this time menstruation ceases and the ovaries stop producing oestrogen and progesterone (Berkow et al, 1999:1942; Moore and Persaud, 1993:19). It is during the climacteric that the production of oestrogen by the ovaries gradually decreases (Hillard, 1998:49; Sonnendecker, 1995:354).

The menses may stop immediately or they may become irregular, some months, or even years before menopause. The menses may be heavy or scanty and menstruation may occur one month and not the next (Sonnendecker, 1995:354).

Once ovulation has ceased to occur, the corpus luteum no longer forms thus resulting in the decreased formation of oestrogen and progesterone. As a result the pituitary gland increases its production of follicle stimulating hormone and luteinizing hormone in an attempt to stimulate the non-responsive ovaries. The ovaries now no longer respond to the increased levels of follicle stimulating hormone and luteinizing hormone, and the levels of oestrogen and progesterone drop. This drop in oestrogen is no longer substantial enough to cause a growth in the endometrium, and menstruation ceases completely, thus resulting in menopause (Ojeda, 1998:39-41). Menopause is only diagnosed once menstruation has not occurred for one year (Sonnendecker, 1995:354).

Premature menopause may result due to ovarian failure of an unknown cause, which occurs before the age of forty. Smoking, poor nutritional status and living at high altitudes can cause premature menopause. Chemotherapy, radiation of the pelvis, an oophorectomy, or any process
that impairs blood supply to the ovaries may result in an artificial menopause (Berkow et al, 1999:1942).

2.3.1 Symptoms of the Climacteric

Sixty percent of women at the menopause are asymptomatic, twenty-five percent have mild symptoms, and fifteen percent have moderate to severe symptoms (Chamberlain and Malvern, 1996:136).

The symptoms of the climacteric vary from vasomotor symptoms to gynaecological, urinary, psychological, and general symptoms (Hoffmann, 1992:132). Vasomotor symptoms include hot flushes, night sweats, palpitations, headaches, and vertigo (Hoffmann, 1992:132; Rogers, 1995:87). Gynaecological and urinary symptoms include breast swelling and tenderness, menstrual irregularity, vaginal dryness and eventual atrophy, decrease in libido, decreased sexual enjoyment, urinary frequency, urinary urgency with dysuria and prolapse of pelvic organs. Psychological symptoms include anxiety, forgetfulness, irritability, loss of concentration and changes in mood. General symptoms include weight gain, fatigue, insomnia, arthralgia, and myalgia. As a female ages and enters into the menopause, the risk of morbidity due to myocardial infarction, cerebral vascular accident, and osteoporosis increases (Berkow et al, 1999:1943; Bisson, 1997:11; Hillard, 1998:49-50; Rogers, 1995:87/88; Sonnendecker, 1995:356-357). The most common symptoms experienced are hot flushes and dryness of the vagina (Chamberlain and Malvern, 1996:136).

2.3.1.1 Vasomotor Symptoms

Hot flushes or flashes are feelings of heat felt over the face and the upper body usually lasting for 30 seconds to 5 minutes. They are caused by vasomotor changes in the small capillaries. Perspiration of the face and upper body usually follows the hot flush and may be followed by a chill as the heat fades. Hot flushes occur suddenly and more frequently at night and can cause nocturnal waking. They may be associated with palpitations, dizziness, and faintness. The hot flushes usually last for a year or so, but have been found to last for up to four years in a quarter of

Hot flushes vary in frequency and intensity. For some women they may have a hot flush daily for two weeks, and then may not have any for a month or two (Love, 1997:164). Hot and spicy foods, alcohol intake, cigarette smoking, caffeine intake, and hot weather may all worsen hot flushes. Palpitations may be associated with hot flushes. This in turn may cause anxiety about the possibility of heart disease (Abernethy, 1997:13).

Symptoms of a hot flush coincide with a pulse in luteinizing hormone, but not every increase in luteinizing hormone coincides with a hot flush (Berkow et al, 1999:1943). Hormone replacement therapy has been shown to completely and rapidly alleviate hot flushes whilst therapy is still in progress. Upon cessation of hormone replacement therapy, they may reoccur, but in a milder form. In the absence of hormone replacement therapy, hot flushes cease spontaneously, but this may take months to years (Hirschowitz, 1991:26).

2.3.1.2 Gynaecological and Urinary Symptoms

Irregularities in the menstrual cycle are one of the most common and earliest symptom occurring during the climacteric. Usually the frequency of menstrual bleeding will decrease (which is known as oligomenorrhoea), followed by absence of menstruation (which is known as amenorrhoea). However for many women menses may become heavier, more frequent, or prolonged before the onset of oligomenorrhoea. When menstruation has not occurred for one year, menopause is established (Berkow et al, 1999:1942).

Rapid changes occur in the genitourinary systems in the absence of oestrogen. There is progressive ischaemia of the vaginal mucosa resulting in its thinning. The ischaemia together with a decrease in secretion from the Bartholin’s and cervical glands results in dryness of the vagina and dyspareunia. The tissues of the vagina, uterus, ovaries, and urethra shrink in size, resulting in the atrophy of the uterine endometrium. Fibroids may also shrink in size (Hirschowitz, 1991:27-28; Nachtigall and Wren, 1996:12).
The vaginal pH becomes alkaline due to the absence of hormones; this renders the vagina prone to bacterial infection (Hirschowitz, 1991:27). Atrophic attenuation of the endopelvic fascia, which support and strengthen the pelvic organs may occur, resulting in pelvic prolapse (Hirschowitz, 1991:28).

Typical bladder symptoms experienced during the menopause are stress incontinence, frequency of micturition, urgency of micturition and nocturia (Abernethy, 1997:14). The tissues of the bladder, which are dependent on oestrogen secretion, become atrophic, resulting in frequency, urgency, stress incontinence, nocturia, and recurrent bladder infections. Coughing, sneezing, running, jumping and laughing may result in a loss of a small amount of urine. This may lead to women being fearful of any activity and a diminishment in exercise may occur, thus leading to a general deterioration in health (Hirschowitz, 1991:28).

Decreased libido is another common complaint (Berkow et al., 1999:1943). There are many contributing factors such as the failure of erotic stimulation to produce vaginal lubrication, an increased time to achieve orgasm, difficulty in achieving orgasm and the vaginal mucosa becomes drier and thinner making sexual intercourse painful. These factors are all due to the diminished secretion of oestrogen (Gillespie, 1989:42). However some women have found that their libido increases, rather than decreases. With the cessation of menstruation and the reproductive stage of life ending so that the need for contraception is no longer required, many women find this relieving, and enjoy sexual intercourse more freely (Abernethy, 1997:15-16).

2.3.1.3 Psychological and Emotional Symptoms

Fatigue, insomnia, irritability, depression, memory loss, headache, anxiety, nervousness, and inability to concentrate may be related to the decrease of oestrogen. The stress of aging and life changes may also contribute to these symptoms. Fatigue and irritability may occur due to sleep disruption caused by recurrent hot flushes (Berkow et al., 1999:1942). Research indicates that women who suffered with severe premenstrual tension or postnatal depression are more likely to suffer from depression during the menopause (Hirschowitz, 1991:23). Studies show that women who have had hysterectomies are more likely to suffer from depression during the menopause.
due to the loss of a body part or due to the sudden loss of hormones. Women who have been on oestrogen therapy and stop abruptly, may also experience mood swings (Love, 1997:60-61).

The menopause often coincides with stressful life changes. Children grow up and leave home, parents' age, become more feeble and die, and spouses may become ill or leave. The loss of fertility may also be distressing and may cause depression (Love, 1997:60-61).

2.4 LONG TERM EFFECTS OF THE CLIMACTERIC AND THE MENOPAUSE

2.4.1 Cardiovascular Disease

The risk of heart disease and stroke is increased in postmenopausal women (Berkow et al, 1999:1943). In the United Kingdom heart disease is the major cause of death in women over the age of 50 years (Abernethy, 1997:40). There are conflicting views about whether or not hormone replacement therapy reduces the risk of heart disease and stroke after menopause.

Based on recent studies, the British National Formulary states that hormone replacement therapy should not be prescribed as a prevention of heart disease, and may cause an increase in the risk of heart disease in the first year of use (Mehta et al, 2004:351).

However other authors argue the opposite. According to Berkow et al and Love the use of oestrogen therapy may reduce the risk of heart disease and stroke after menopause by 50 % (Berkow et al, 1999:1943; Love, 1997:115), and according Abernethy, research shows that oestrogen therapy may reduce the risk of cardiovascular disease in the following ways by:

- Direct effect on the blood vessel walls
- Effects on the clotting factors
- Changes in the insulin metabolism
- Changes in lipid subfractions. The oestrogen therapy reduces the total cholesterol and concentrations of low-density lipoproteins, while increasing the high-density lipoproteins
- The redistribution of body fat (Abernethy, 1997:43).
2.4.2 Osteoporosis

Osteoporosis is a condition predominantly seen in women (Selby, 2000:28), characterised by a reduction in the quantity of mineralised bone (Hirschowitz, 1991:38) resulting in the structure of the bone weakening to an extent that a fracture may occur (Abernethy, 1997:25). Osteoporosis is able to cause a great deal of morbidity and even mortality if fracture results (Selby, 2000:28). These fractures may be caused by everyday activities, and are not necessarily caused by major trauma (Abernethy, 1997:25).

The main causes of osteoporosis are oestrogen deficiency and lack of exercise. The effects of the oestrogen deficiency may only be noted many years after menopause. If the disease is to be prevented, measures need to be taken at an earlier stage in life, before the menopause, (Abernethy, 1997:24; Love, 1997:86). According to the *British National Formulary* hormone replacement therapy should not be used as a prophylaxis against osteoporosis, as it needs to be administered over a long period of time to make a difference and this has other negative risk factors (Mehta *et al*, 2004:350).

White, small boned slender women; heavy alcohol drinkers; smokers; women taking corticosteroids and those who are sedentary are at the highest risk of developing osteoporosis (Berkow *et al*, 1999:1943). Smoking can reduce bone mass by up to 25 percent. Frequent use of corticosteroids, laxatives, diuretics, thyroxine, and heparin can increase the risk of osteoporosis (Glenville, 2001:425).

2.5 MANAGEMENT OF THE CLIMACTERIC

2.5.1 Hormone Replacement Therapy

Hormone replacement therapy has become the conventional treatment of climacteric symptoms. This therapy is based on the idea that the climacteric is due to a deficiency of oestrogen, therefore in order to correct this deficiency, one would need to introduce oestrogen back into the body.
Hormone replacement therapy may consist of oestrogen and or progesterone. Synthetic oestrogen used in hormone replacement therapy mimics the effects of naturally produced oestrogen produced by the ovaries. Females who have had a hysterectomy only need to take oestrogen. However, females with a uterus need to take both oestrogen and progesterone. Progesterone stimulates the release of the endometrial tissue and these women will therefore still menstruate (Hillard, 1998:52; Renfro and Julie, 1998:186).

Hormone replacement therapy may be administered in many ways: orally, transdermally, vaginally and via implants. Oral administration is the most common and convenient. Transdermal patches make oestrogen and progesterone readily available and the advantage of this route is that the oestrogen does not have to pass through the portal system, where much would be destroyed by the liver, however skin reactions may occur in 20 % of participants. Adherence is higher as the patch need only be changed every third day. Vaginal preparations are very useful in treating vaginal dryness; however large doses are needed for palliation of symptoms to occur within the body. Oestrogen may be implanted into the abdominal wall or in the thigh. The implants last for four to eight months therefore patient adherence is not significant factor. Progesterones are given orally during the second half of each cycle in order to prevent build up of the endometrium, resulting in a withdrawal bleed (Chamberlain and Malvern, 1996:139).

2.5.1.1 Risks of Hormone Replacement Therapy

There is much controversy surrounding the use of hormone replacement therapy and the related risks. The risks associated with hormone replacement therapy are breast cancer, vaginal cancer, uterine cancer, cervical cancer, venous thromboembolism, cardiac disease, pulmonary embolism, and stroke (Snyman, 2002:364).

Recent results from the Women's Health Initiative study, from the United States National Institutes of Health, whereby 16 608 postmenopausal women aged between 50 to 79 years with an intact uterus took part in a trial. The study made use of continuous-combined conjugated equine oestrogens 0.625 mg and medroxyprogesterone acetate 2.5 mg. It was a placebo-controlled, primary-prevention, randomised, controlled trial.
The trial was discontinued after a mean of 5.2 years as the health risks were considered to exceed the benefits. The results have shown that the use of combination hormonal replacement therapy:

- Is of no value in reversing established coronary heart disease or preventing coronary heart disease in otherwise healthy females
- Increases the risk of myocardial infarction, deep venous thrombosis and thromboembolism, especially in the first year to year and a half of treatment
- Decreases hip fractures and colorectal cancer, and that hormone replacement therapy remains a suitable treatment for severe osteoporosis
- Slightly increases invasive breast cancers in those participants using hormone replacement therapy. This was marked at year four and the trend declined in later years. It appears that hormone replacement therapy provides a growth-promoting role in breast cancer, rather than a causative role. However due to the study’s early termination, this question cannot be answered definitively (Yap and Farrell, 2003)

In women who have a uterus, the risk of uterine cancer increases by seven times when oestrogen therapy is used (Berkow et al, 1999:1943; Glenville, 2001:404). With oestrogen therapy, the lining of the uterus continues to thicken. Without progesterone to cause a bleed, the cells of the endometrium mutate, causing uterine cancer (Glenville, 2001:404). The combination of oestrogen and progesterone therapy decreases this risk. However even with the combination of the hormones, there is still twice the risk of developing uterine cancer when compared to women who do not take hormone replacement therapy at all (Glenville, 2001:405). Women who have had a hysterectomy need only take oestrogen, as they have no risk of developing uterine cancer (Berkow et al, 1999:1943).

The risk of breast cancer starts to rise after five years of hormone replacement therapy (Hillard, 1998:52). About one in ten women are at risk of developing breast cancer (Hirschowitz, 1991:89). The increased risk is related to the duration of hormone replacement therapy use and subsides within 5 years of stopping hormone replacement therapy (Mehta et al, 2004:350).
The risks of deep venous thromboembolism and pulmonary embolism may be increased by the use of hormone replacement therapy. It has been estimated that 3 in every 1000 women aged between 50-65 years not using hormone replacement therapy develop venous thromboembolism over 5 years, this rises to 7 in every 1000 women in those using hormone replacement therapy for 5 years (Mehta et al, 2004:350).

The risk of ovarian cancer is seventy-two percent higher in women given oestrogen (Holford, 1997:2-3).

The risk of gallbladder disease increases with the use of progesterone and oestrogen (Renfro and Julie, 1998:186).

Although there are risks, there are some benefits such as the protection against osteoporosis. Increase in libido (Love, 1997:186), improved sleep, less severe hot flushes and less vaginal dryness have been noted with the use of hormone replacement therapy (Holt and Kahn, 1994:32).

2.5.1.2 Contraindications for Hormone Replacement Therapy

The contraindications for hormone replacement therapy are:

- Breast feeding
- History of breast cancer
- Oestrogen-dependent tumours e.g. breast and endometrial cancers/tumours
- Otosclerosis
- Pregnancy
- Severe acute liver disease
- Undiagnosed vaginal bleeding
The following conditions need to be investigated prior to prescribing hormone replacement therapy:

- Gall bladder stones
- History of thrombosis
- Previous heart attack
- Untreated hypertension
- Uterine fibroids


2.5.1.3 Side Effects of Hormone Replacement Therapy

In the first few weeks of commencement of hormone replacement therapy side effects are common (Abernethy, 1997:86). Studies have shown that side effects are the main reasons for women to discontinue Hormone replacement therapy than are complications (Nachtigall and Wren, 1996:64).

Side effects related to oestrogen therapy include:

- Abdominal cramps
- Abdominal bloating
- Alopecia
- Breast tenderness and enlargement
- Depression
- Endometrial cancer
- Hypertension
- Jaundice
- Leg cramps
- Migraine
- Nausea
- Thrombophlebitis
- Vaginal thrush
- Vomiting
- Weight gain/ loss

These side effects usually subside after 6-8 weeks on therapy. If they continue, a change in dose, therapy or type of oestrogen may be necessary.

Side effects related to progesterone therapy include:

- Anxiety
- Acne
- Alopecia
- Amenorrhoea
- Abdominal bloating
- Breast pain and tenderness
- Breakthrough bleeding or spotting
- Cholestatic jaundice
- Changes in cervical erosions and cervical secretions
- Depression
- Galactorrhoea
- Hirsutism
- Irritability
- Irregular vaginal bleeding
- Increase or decrease in body weight
- Insomnia
- Nausea
- Pyrexia
- Pulmonary embolism
- Sensitivity reactions such as urticaria, pruritis, or oedema
- Severe acute allergic reactions
- Somnolence
- Thrombophlebitis

These side effects occur mainly in cyclical regimens, and are often similar to premenstrual symptoms. (Abernethy, 1997:86; Glenville, 2001:404; Lee, 1996:87-88).

2.5.2 Alternative Treatments

Due to the fact that hormone replacement therapy has many side effects, many women discontinue treatment within a year of starting, and seek alternative treatments (Holford, 1997:218). There are vast ranges of alternative therapies and lifestyle changes that improve menopausal symptoms including diet modification, exercise, pelvic floor exercises, weight control, and reducing smoking and alcohol intake (Bisson, 1997:12; Hillard, 1998:51). Complementary therapies such as reflexology, Chinese herbalism, homoeopathy, naturopathy, acupuncture, and aromatherapy are very beneficial (Hillard, 1998:51).

2.5.2.1 Diet and Exercise

Stress levels, nutrition, and environmental factors affect hormone balance in the body. In order to maintain this balance, diet and exercise play a very important role.

A low fat diet is important in decreasing the risk of cardiac disease often associated with hormone replacement therapy. Supplementation with vitamins C, E, D and B complex and the minerals calcium, magnesium and zinc have been shown to improve menopausal symptoms (Glenville, 2001:415; Holford, 1997:218). Stabilisation of blood sugar levels promotes the adrenal glands production of oestrogen, which in turn balances the decline of oestrogen produced by the ovaries. The avoidance of tea and coffee are recommended as they deprive the body of essential nutrients and trace elements. High protein diets can increase the amount of calcium excreted, these diets should be avoided in order to prevent osteoporosis and help maintain bone mass. Essential fatty acids found in fish, nuts and seeds should be consumed as they help to
lubricate the joints, skin and vagina, and are essential in maintaining a healthy metabolism (Glenville, 2001:411).

Phytoestrogens are a group of plant hormones that can be found naturally in certain foods such as soya, linseeds, wholegrains (brown rice, oats, legumes, lentils, and chickpeas), garlic, fennel, celery, rhubarb, and parsley. Phytoestrogens are believed to have a protective effect on the body, in that they stop more powerful synthetic oestrogen from binding onto oestrogen receptors found in various parts of the body, especially the breast, thus preventing breast cancer. Phytoestrogens are also believed to have a balancing effect on hormones, and are known for their cholesterol lowering effect (Wilcox et al, 1990:905-906). Research shows that postmenopausal women supplemented with phytoestrogens demonstrated a 22 percent increase in their high-density lipoprotein cholesterol. It is believed that phytoestrogens have a direct effect on lipids, inhibit protein aggregation, and have antioxidant effects (Murkies et al, 1998:297-303).

A lack of regular exercise leads to a higher risk of most diseases including heart disease and breast cancer (Hanley et al, 1999:305). Regular moderate exercise leads to a prolonged life span. Exercise reduces stress levels and strengthens the body. Cardiovascular, weight bearing and stretching exercises should be included in the exercise program in order to maintain bone density and an all round level of fitness. Exercise decreases stress and in doing so reduce anxiety and depression. It enhances mental clarity, increases energy levels, and encourages sleep and relaxation (Kenton, 1995:157-159). Exercise and diet play a very important role in reducing the risk of heart disease and stroke associated with hormone replacement therapy.

2.5.2.2 Herbs

Herbs can be used to enhance the body’s own ability to balance its hormones. Using plants or herbs in their whole form minimises side effects. The best herbs to use according to Glenville (1997:74) are adaptogenic herbs. These herbs support all major systems in the body, especially the nervous system, hormonal system and immune system; they have a balancing effect on the endocrine system without supplying hormones to the body and stimulate the immune system indirectly, by increasing the body’s resistance to stresses. Adaptogenic herbs place no stress on the body and allow the body to restore itself. Examples of adaptogenic herbs are Ashwaganda
(Withania somnifera), Milk thistle (Silymarin marianum), Black cohosh (Cimicifuga racemosa), and Dong Quai (Angelica sinensis) (Glenville, 2001:417).

2.5.2.3 Relaxation

Some studies have shown that relaxation methods, such as meditation and slow deep breathing can reduce hot flushes (Abernethy, 1997:127).

2.6 HOMOEOPATHY

2.6.1 What is Homoeopathy?

The word ‘Homoeopathy’ comes from two Greek words, omio meaning ‘same’ and pathos meaning ‘suffering’, meaning ‘similar suffering’, or ‘like cures like’ (Hayfield, 2000:6; Lockie, 1990:9). Homoeopathy is a system of treatment based on the ‘law of similars’. This law states that those symptoms, which a substance causes when administered to a healthy individual are the same symptoms that the substance can cure when administered to a sick individual (Lilley, 1998:8). It is a holistic approach to health, based on the concept that man is a whole person comprising of mind, body, and spirit (Garion-Hutchings et al, 1993:18).

Hahnemann, the founder of homoeopathy stated this therapeutic principle as ‘similia similibus curentur’, meaning let likes be cured by likes (Eizayaga, 1991:19). All homoeopathic remedies have a great dilution and low concentration, and therefore are safe to use as they have very little or no side effects (Jouanny, 1984:10). Homoeopathic remedies are believed to stimulate the body’s own natural healing abilities allowing it to heal itself (Geddes and Lockie, 1995:19).
2.6.2 The Principles of Homoeopathy

- **The Law of Similars**

The law of similars states that what a remedy can cause in the way of symptoms and signs it can also cure. The remedy, which mimics the symptoms and signs of an illness, is given to treat the illness. In order for cure to take place, the remedy must match the totality of symptoms and signs of the participant as closely as possible. The closer the match, the better the cure (Gibson and Gibson, 1987:68, 72). Hippocrates ‘the father of medicine’, stated this therapeutic principle in the fifth century BC and it was only in the 18th century that Hahnemann further developed the principle to form modern day homoeopathy (Castro, 1990).

- **Minimum Dose**

The amount of remedy needed to effect a change, is the smallest amount possible (Lockie, 1990:13). Hahnemann stated that the minimum dose is the smallest dose that is curative and that would not produce unwanted side effects (Gibson and Gibson, 1987:73).

- **Single Remedy**

Only, one, single remedy need be administered to a participant at a time (Osawa, 2001:24). This principle stems from the fact that there is only one vital force in one body and that the core problem at any one time needs to be treated and therefore only one remedy is needed to initiate cure (Chappell, 1994:88).

- **Direction of Cure (Hering’s Law of Cure)**

This principle was developed by Constantine Hering, it states that the correctly chosen homoeopathic remedy will elicit cure from within the participant, outwards. The mental and emotional spheres will be affected first, then the energy levels and lastly the physical state. Cure takes place from top to bottom, therefore from the head to the feet, and from more important
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organs to less important organs. The last symptoms to appear will be the first to disappear. Often the participant will relive in a milder form all their past illness history (Chappell, 1994:90). The use of Hering’s law of cure as a guideline to the participant’s progress or regress in a case is what differentiates classical or holistic prescribing from clinical or symptomatic prescribing (Peck, 2004).

- Holism

Vithoulkas states that the human being consists of three interactive spheres, these being the mental, physical, and emotional spheres. In homoeopathy, the chosen remedy is selected to encompass ali the spheres of the person. Every aspect of the person is taken into consideration and the participant is treated as a whole in order to produce cure in terms of Hering’s law of cure and to achieve long lasting results (Chappell, 1994:88; Vithoulkas, 1998:56).

2.6.3 The Vital Force

Hahnemann described the vital force as a “spirit-like force which rules in supreme sovereignty” and is found in all living organisms (Hayfield, 2000:12). It is the natural defence mechanism of the body (Gunavante, 1994:7). The vital force or life force maintains equilibrium within the organism, leading to health and the feeling of well-being. When it is disturbed and unable to maintain harmony within the organism, symptoms are produced and illness sets in (Garion-Hutchings et al, 1993:18). The vital force aids the curative process whether it is an acute or chronic disease (Hayfield, 2000:12). The treatment of symptoms and organs alone will only produce temporary cure, but the treatment of the body’s own healing ability, as a whole, will produce total cure (Sankaran, 1995:44). Aphorism 9 states that without a vital force the organism is dead (Hahnemann, 1997:97).
2.6.4 Miasms

Miasm is a concept developed by Hahnemann. The word ‘miasm’, meaning ‘taint’ was used to describe the deep-seated, predisposition to a chronic diseased state. Hahnemann observed that several of his acute cases kept relapsing and that the symptoms were only temporarily alleviated. The symptoms of these participants usually returned after a stressful event. Despite periods of well-being, these participants where actually on a descending spiral of health. Hahnemann concluded that there was an underlying problem or ‘miasm’ that needed to be treated in order to achieve permanent cure of the chronic diseased state (Lockie, 1990:10-11). The remedy chosen must incorporate the chronic state as well as the presenting complaint (Gunavante, 1994:15).

2.6.5 Homoeopathic Medicines

2.6.5.1 Provings

In order to know the curative properties of a remedy, we first need to know which symptoms are produced by that remedy. This is done by administering a remedy to a group of healthy volunteers (the provers), in different strengths or potencies over a period of time. The provers then note their daily signs and symptoms in their diaries. Any changes whether they are physical, mental or emotional are noted and accurate records are kept. At the end of the proving all the diaries are collected, analysed and collated. Symptoms recorded before taking the remedy are excluded. A placebo group is used as a control. All the symptoms of each remedy are recorded to form the homoeopathic materia medica (Gibson and Gibson, 1987:73; Sankaran, 1995:1).

2.6.5.2 Potency

Hahnemann discovered that some of his patients’ symptoms worsened before they improved. He called this event an ‘aggravation’. In order to reduce aggravations, Hahnemann started progressively diluting his medicines. He started making a tincture of the substance concerned, by leaving the substance in a solvent, usually pure alcohol for one month. He then strained off the liquid, which is termed the ‘mother tincture’. One drop of the mother tincture is added to 99
drops of pure alcohol and is ‘succussed’. Succession is the process whereby the liquid is thoroughly mixed by repeatedly banging it on a hard surface for a specific length of time. This process of dilution is repeated again and again, with each successive dilution having a greater strength by one hundredth of the previous dilution. This process of successive dilution and succession is known as the potentization of a substance. Hahnemann found that the diluted remedies acted faster, were more effective, and did not cause ‘aggravations’ (Lockie, 1990:10). He explained this by saying that during potentization, the vital energy of the substance was increased and roused into activity (Garion-Hutchings et al, 1993:11). Insoluble substances are triturated or ground up and dissolved before being potentized (Lockie, 1990:10).

Homoeopathic dilutions are made up into either the centesimal scale (1/100) and are denoted by ‘C’, or the decimal scale (1/10) and are denoted by ‘X’. Thus the first dilution of 1/100 is termed a 1C and the thirtieth dilution a 30C, and the first 1/10 dilution is called a 1X and the thirtieth dilution a 30X (Vithoulkas, 1998:102).

2.6.5.3 Sources of Remedies

Homoeopathic remedies are derived from the plant, animal, and mineral kingdoms. Diseased products from parts of the body called nosodes are used, as well as sarcoodes that are secretions from the body and imponderable substances such as x-rays and moonbeams (Chatterjee, 1993:3; Sankaran, 1995:4). All remedies must be produced in accordance with the guidelines of various homoeopathic pharmacopoeias and prescribed by a qualified homoeopathic practitioner (Köhler, 1989:33).

2.6.5.4 Homoeopathic Side Effects or Aggravations

According to homoeopathic philosophy, the homoeopathic remedy given stimulates the vital force into healing the body. Sometimes the healing response of the vital force to the remedy is preceded by an ‘aggravation’ or worsening of the symptoms, before an improvement of the symptoms. The homoeopathic aggravation should not be considered harmful, and should be seen
as a sign that the remedy is correct and acting on the \textit{vital force} of the body (Vithoulkas, 1998:227-228).

\textbf{2.6.6 Case Taking}

\textbf{2.6.6.1 The Initial Consultation}

Case taking is explained in Aphorisms 83 to 104 of the Organon of Medicine. In these Aphorisms it is explained how to take and record the case of a participant, when he or she is ill (Chatterjee, 1993:9).

Diagnosing in allopathic case taking will essentially determine what medicine the participant will receive, whereas in homoeopathy it is the symptoms that will determine what remedy or \textit{similimum} the participant will receive. More importantly, it is those symptoms, which ‘stand out’ and are said to be characteristic and peculiar to the participant. Thus, it is those symptoms, which are unusual and do not fit in or conform to the disease, but are characteristic to the individual participant (Chatterjee, 1993:7). This is characteristic to \textit{similimum} prescribing which this study aimed to explore.

During the initial consultation, the homoeopath will inquire about:

- The main complaint and the modalities related to this complaint
- The general symptoms such as food aversions and desires, appetite, thirst, bowel movements, urination, energy levels, sleep patterns, dreams and weather modalities
- The mental and emotional state of the participant
- The symptoms pertaining to a particular body part
- The participant’s past medical history
- The participant’s family history
The homoeopath must explore all symptoms revealed by the participant. The exact location, sensations, aggravations, and ameliorations of each symptom must be revealed. Concomitant symptoms (a symptom that accompanies the main complaint) and alternating symptoms (a symptom that alternates with the main complaint) must also be explored. Mental symptoms where striking are the most important symptoms and must take preference over all symptoms (Chatterjee, 1993:9).

2.6.6.2 Follow Up Consultation

Follow up consultations are generally much shorter than initial consultations. During the follow up consultation, the homoeopath must determine whether the participant responded to the remedy, and if so what response was it. The homoeopath must determine the next appropriate course of action.

During the follow up consultation, the homoeopath will determine:

- The response of the participant to the initial remedy
- Whether the response was curative, partially curative or suppressive
- How the participant feels in general
- Whether there has been any change in the main complaint, mental and emotional symptoms. The participant should also be asked to elaborate on previously described symptoms
- Whether new symptoms have appeared
- Whether the prescription was correct
- If another prescription is required, and what dose and potency is needed
- Whether to wait and watch (Vithoulkas, 1998:225-227)

2.6.7 Repertorization

Repertorization is the process whereby the symptoms elicited by a participant are used to determine the *similimum* remedy. This process involves the cross referencing of lists of remedies with symptoms which are characteristic and peculiar to the case. The homoeopath then studies
the remedies obtained from repertorizing in several materia medicas. The remedy chosen will best encompass most of the symptoms pertaining to the case (Vithoulkas, 1998:195-196, 208-209).

2.6.8 Case Management

Once the initial remedy has been established, administered and been granted sufficient time to complete its action, the homoeopath must determine whether a second prescription is needed. In acute cases the time period granted for a remedy to work, may be a few hours, and is much less than for a chronic case, which may need weeks or even months to work.

Cases that respond positively to a remedy may only need a change of potency to bring the participant to total cure. The homoeopath might find it beneficial not to interfere with action of the remedy and should observe any signs of improvement. This approach is called waiting and watching. If another remedy is prescribed, it may disrupt the action of the initial remedy and in turn may hamper cure. An entirely new remedy may be needed when there is no response to the initial remedy or the participant presents with a new symptom picture. It is important to remember that it is not necessary to give a remedy at every consultation (Vithoulkas, 1998:188, 223-224).

2.7 HOMOEOPATHY AND THE CLIMACTERIC

Homoeopaths have been treating climacteric and menopausal symptoms for centuries, but very little research has been done on these subjects. Homoeopathic simillimum treatment of the climacteric is based on the law of similars. Each person is treated holistically and the simillimum chosen using the persons symptoms and entire life history. When the simillimum remedy is given, the aim of treatment is curative and not merely palliative (Pellow, 2002:26).
The following studies have been conducted at the Technikon Witwatersrand:

- *A Comparative Study between Femolene Ultra* (a phytotherapeutic product) and Klimakt-Heel® (a homoeopathic product) in the Management of Typical Climacteric Symptoms (Penny, 2004:18, 24). The results of the study showed that Femolene Ultra® reduced the Kupperman Menopause index scores of the participants more significantly (63 %) when compared to the participants using Klimakt-Heel® (54 %), (Penny, 2004:45)

- *Homoeopathic Similimum Treatment of Secondary Insomnia in Peri- and Postmenopausal Women.* The results of the study showed that the homoeopathic *similimum* was found to ameliorate secondary insomnia in peri- and postmenopausal women (Pellow, 2002:129)

- *The Efficacy of Sepia® (a homoeopathic complex remedy) in the Management of Climacteric Symptoms.* The results of this study showed that Sepia® was ineffective in alleviating hot flushes, but was found to ameliorate menstrual irregularity, recurrent cystitis, body pains, mood swings, irritability, depression and weight increase, when compared with a placebo group (Compere, 2002:64)

- *The Effect of Agnus Castus D3 on Menopausal Symptoms.* The study showed that *Agnus castus* D3 was ineffective in alleviating the symptoms of menopause when used in the short term, when compared with a placebo group (Lazarus, 2001:58)
CHAPTER THREE

MATERIALS AND METHODS

3.1 STUDY DESIGN

The researcher recruited ten females with climacteric symptoms. Each participant was interviewed during a homoeopathic consultation and a homoeopathic *similimum* remedy was given. The participants were monitored at monthly intervals, at follow up consultations for three months. All the participants completed the study.

This study was submitted as a minor dissertation, it is considered to be a qualitative and multifactorial study and in keeping with the Technikon Witwatersrand research protocol, ten participants were considered sufficient for this *similimum* study.

3.2 RECRUITMENT OF PARTICIPANTS

Advertisements were placed in medical practices in Gauteng and at the Technikon Witwatersrand campus to recruit volunteers for the study. The volunteers were then informed of the three-month duration of the study and were required to complete a Suitability Criteria Questionnaire (Appendix A) with the assistance of the researcher. Ten volunteers were selected to take part in the study. These volunteers were screened (Appendix A) and met the criteria below.

Inclusion Criteria:

- Participants were female and between the ages of forty-two and fifty-eight years
- Participants were either perimenopausal or menopausal, and were experiencing climacteric symptoms
- The perimenopause or menopause had to be natural
- Participants who had discontinued hormone replacement therapy at least three months prior to enrolment, were included into the study
Exclusion Criteria:

- Volunteers were excluded from the study if the perimenopause or menopause was surgically or artificially induced
- Volunteers were excluded from the study if they were on hormone replacement therapy
- Volunteers were excluded from the study if they had experienced any of the following:
  - A bilateral ovariectomy or total hysterectomy
  - Any irradiation, chemotherapy, drug treatment, or other process that has resulted in climacteric symptoms
  - Premature failure of ovulation due to autoimmune, primary germ cell deficiency, a resistance to pituitary gonadotropin, or other reasons
  - Any process that has impaired the blood supply to the ovaries

3.3 RESEARCH PROCEDURES

An initial consultation was undertaken once suitable volunteers were chosen using the inclusion and exclusion criteria. At the first consultation, each participant was informed of the requirements of the study, and was required to complete the participant information and consent form (Appendix B). At that time, the participant’s serum oestrogen levels were measured and the Modified Kupperman Menopause Index (Appendix C) was completed with the aid of the researcher. The participant’s full case history was taken and a physical examination conducted by the researcher. The researcher selected a suitable *similimum* remedy and potency under supervision of the research supervisor. The participant received the remedy at the first consultation, and was advised on the dosage and frequency of administration of the remedy.

The second and third consultations took place at four and eight weeks after the initial consultation respectively. The participant completed another Modified Kupperman Index, and a follow-up history and physical examination was conducted by the researcher. A suitable *similimum* remedy was prescribed where needed in consultation with the supervisor, and the dosage and frequency of administration was advised.
The fourth and last consultation took place twelve weeks after the initial consultation. The participant’s serum oestrogen levels were measured and another modified Kupperman Index was completed. A follow-up history was done and a physical examination conducted by the researcher.

3.4 REMEDY ADMINISTRATION

Each participant received a homoeopathic *similimum* remedy at the first consultation. The number of doses, potency, and frequency of administration depended on each participant, and was decided upon under supervision of the research supervisor. Powders and granules were used as the dispensing method. Each participant was provided with the number of powders and granules needed for one-month of treatment. At the second, third and final consultations the selected remedy was re-evaluated. If found to be unsuitable, the researcher prescribed a new *similimum* remedy, and the dose, potency and frequency of administration was decided upon under supervision of the research supervisor.

3.5 TOOLS UTILISED

3.5.1 Serum Oestrogen Screen

Two sets of blood samples were taken from each participant, one at the initial consultation, and the other sample at the end of the study, at week twelve. This constituted the objective component of the study, as the results of the blood tests were unprejudiced and independent to any subjective feelings experienced by the participant.

The haematology department of Du Buisson, Bruinette and Kramer Inc. Laboratory uses the Centaur instrument and makes use of the Chemiluminescence method for measuring blood oestrogen levels. The oestrogen, which is detected in these blood tests, is 17β Oestradiol. The amount of oestrogen that is detected in the blood test depends on the instrument and method used. Thus when comparing blood oestrogen levels, it is vitally important to ensure that the same instrument and method is used.
At the time of the study, the normal range of values for $17\beta$ Oestradiol when the Centaur instrument and the Chemiluminescence method was used, were as follows:

1. Prepubertal levels  
   $< 139$ pmol/l
2. Follicular phase  
   40-606 pmol/l
3. Mid-cycle  
   536-1930 pmol/l
4. Luteal phase  
   121-719 pmol/l
5. Contraception levels  
   $< 140$ pmol/l
6. Pregnancy levels (1st trimester)  
   140-13956 pmol/l
7. Post menopausal levels  
   $< 136$ pmol/l

3.5.2 Kufferman Menopause Index

The Kupperman Menopause Index (Appendix D) was used as a subjective tool in the study. The Kupperman Menopause Index allowed for the participant to give an objective score to the subjective climacteric symptom she was experiencing. The participant was requested to grade the severity of her symptoms as follows:

1. Severe..................3
2. Moderate...............2
3. Mild.....................1
4. Not present............0

This number was recorded and then multiplied by the constant; the resultant value was also recorded.

The Kupperman Menopause Index (Appendix D) assigns a greater significance to the “more typical” climacteric symptoms by way of this higher constant value. The resulting values for each symptom were added and a total value for the Kupperman Menopause Index was determined. The Kupperman Menopause Index thus gave an indication of the severity of the menopausal
At the time of the study, the normal range of values for 17β Oestradiol when the Centaur instrument and the Chemiluminescence method was used, were as follows:

1. Prepubertal levels  \(< 139 \text{ pmol/l}\)
2. Follicular phase  \(40-606 \text{ pmol/l}\)
3. Mid-cycle  \(536-1930 \text{ pmol/l}\)
4. Luteal phase  \(121-719 \text{ pmol/l}\)
5. Contraception levels  \(<140 \text{ pmol/l}\)
6. Pregnancy levels (1st trimester)  \(140-13956 \text{ pmol/l}\)
7. Post menopausal levels  \(<136 \text{ pmol/l}\)

3.5.2 Kupperman Menopause Index

The Kupperman Menopause Index (Appendix D) was used as a subjective tool in the study. The Kupperman Menopause Index allowed for the participant to give an objective score to the subjective climacteric symptom she was experiencing. The participant was requested to grade the severity of her symptoms as follows:

1. Severe..................3
2. Moderate..................2
3. Mild......................1
4. Not present................0

This number was recorded and then multiplied by the constant; the resultant value was also recorded.

The Kupperman Menopause Index (Appendix D) assigns a greater significance to the “more typical” climacteric symptoms by way of this higher constant value. The resulting values for each symptom were added and a total value for the Kupperman Menopause Index was determined. The Kupperman Menopause Index thus gave an indication of the severity of the menopausal
syndrome, as experienced by each individual patient. The severity of the index was categorised as follows:

1. >35.......................severe
2. 20-35.......................moderate
3. 15-20.......................mild
4. <15.......................favourable therapeutic result

This index therefore allowed the participant to quantitatively record the way she was experiencing the typical symptoms of climacteric.

The modified Kupperman Menopause Index (Appendix C) was completed at week one, four, eight, and twelve throughout the study. Once, before the treatment, and then at monthly intervals until the twelve-week trial was completed. To eliminate any potential bias, the participant answered the modified Kupperman Menopause Index (Appendix C), which only had a section for one month. The modified Kupperman Menopause Index (Appendix C) had been included so that the researcher and the participant could not refer back to the previous months and be biased in answering that month’s index. After the consultation, the research supervisor then transferred the information from the modified index to the participant’s main Kupperman Menopause Index, (Appendix D) for the results to be compared (Schaper and Brümmer, 1997:12; Remifemin, 2003).

3.6 DATA COLLECTION AND ANALYSIS

Initial case histories were used to determine the similimum remedy. A placebo group was not included in this research. The methodological justification for this was that:

- The participant was effectively functioning as her own control
- The literature and the natural progression of the climacteric symptoms were well documented in the literature, and reviewed in this study’s literature review section
Scores of each Modified Kupperman Menopause Index were totalled and the serum oestrogen levels were determined. This information together with the case histories from each consultation were used to determine each participant’s progress during the three-month study. The results were analysed using case history analysis, One Way Anova, and t-test. Statistical analysis was conducted at the Technikon Witwatersrand with assistance of de Villiers (2004).
CHAPTER FOUR

CASE STUDIES

4.1 CASE ONE

4.1.1 First Consultation- February 2004

Summary of Presenting Case

- Date of birth: 6/08/1956
- White female
- Married
- Housewife
- Three pregnancies → three children
- Resides in Johannesburg

An overweight female, 47 years of age, presented with climacteric symptoms. The participant experienced hot flushes, mainly in the afternoons. She experienced the heat on her face and upper body. Perspiration accompanied the hot flushes, which was then followed by vertigo, with the sensation of her head spinning around and her “unable to think”. The hot flushes were aggravated by heat and physical activity, and were better for lying down or relaxing.

The participant had experienced a small flow of menses since her thermogenesis sterilization in 2002. After the sterilization the participant experienced ‘spotting’ of blood, and thereafter bled for two months, which was thick, black blood. Her menses now occur for 3-4 days. The blood was initially bright red, becoming thick, black, and slimy. The blood burns the vagina. During her menses she experienced lower back pain which radiated forward over the right side of the right flank and was worse during her menses and when constipated, and was relieved by painkillers. The participant reported that before her menses her breasts become lumpy and tender. The breast
tenderness was better for warmth. The participant had a clear vaginal discharge that had a faint sour odour, which accompanied her menses.

The participant reported a decrease in her libido over the last six months. She also reported vaginal dryness which was worse after intercourse and which caused pain during intercourse.

The participant experienced two types of headaches. The one headache was due to a pinched nerve in her neck caused by a car accident, and the second headache started in the vertex and radiated to the eyes. The eyes felt dry and the participant found it difficult to concentrate. The headache was worse for light.

Over the last six months, the participant reported a decrease in her concentration levels. She says she was forgetting everything. She says she had had a fantastic memory if she wants to remember but that she has been forgetful since her hiatus hernia operation.

The participant reported joint pain of her legs, hips and arms, “as if my bones are breaking”. The pain was felt as if it was in the bone. It was a sharp pain that radiated out from the bone, which was better for warmth and worse for cold (all pains aggravated for cold). The participant’s toes cramped and contracted together or stuck together and there was scoliosis of the spine in the lumbar region to the left.

There was a tendency to throat infections. The participant reported a sensation of drowning or choking accompanying throat infections.

The participant became aggravated by wearing polo necks or collared shirts and did not wear bras or shoes, as she feels restricted by them.

The participant reported a sound inside her ears that could not be explained medically.

The participant felt depressed and tearful for no reason. She was a sensitive person, who did not cry in public and did not like to be consoled or touched when she was crying. When she became
angry, she also cried. The participant felt better after she had cried and had a hot bath or hot milk. The participant did cry easily in movies. The participant described herself as a lovable person.

The participant would fall asleep between 9 and 10 pm, and would wake-up between 1 and 2 am, unable to fall back to sleep until 3-4 am. During summer, she slept with her feet uncovered and during winter with them covered.

The participant feared medication, germs, and diseases. She would take half the dose first, before taking the full dose, would not touch toilet seats and would wash the tap before washing her hands in a public toilet. She did not like slimy textures, such as mussels and snails.

The participant was very sensitive to odours. She would smell everything. The participant’s circulation was impaired and she often experienced numbness of her hands, feet, and legs.

**Generals**

- Food aversion- Slimy foods (mussels, oysters, snails), sweet foods and bread
- Food desires- Creamy sauces, potatoes, crispy foods, crisps and milk
- Food aggravations- Fizzy drinks, wheat and peppers
- Appetite- The participant said she was either very hungry or not hungry at all
- Thirst- Very thirsty
- Bowels- Constipation since thermogenesis sterilization. The participant reported a pressure like sensation in the rectum which urged her to go to the toilet
- Urine- When urine was acidic it smelt like cats urine. Past history of kidney stones and stress incontinence (repaired surgically in 1978)
- Weather modalities- Participant was aggravated by the extremes of temperature and better for moderate temperatures
- Energy levels- “terrible”, decreased energy levels for the last five months
Medical History

- Date of birth: 6/08/1956
- At the age of 2 years the participant had Scarlet fever
- 1973- Pregnancy → Natural delivery
- 1973- Pregnancy → Natural delivery
- 1978- Participant had a surgery for correction of a retroverted womb and a prolapsed bladder
- 1979- Pregnancy → Emergency caesarean at 35 weeks
- 1979- Removal of an left ovarian cyst
- 1980- Tonsillectomy
- 1991- Amalgam fillings removed
- Removal of right meiobian cysts
- 2002- Thermogenesis sterilization (due to menorrhagia)
- 2003- Hiatus hernia operation (fixed valve) and removal of gall bladder which was diseased

Allergies

- Bee stings, house dust and cigarettes

Observations and Vital Signs

The participant was observed to be very cheerful and chatty. She was very conscious of what the researcher was writing during the case and was very loquacious.

The following vital signs were recorded:
- Blood pressure: 130/85 right arm, lying down
- Pulse rate: 60 beats per minute, regular
- Respiratory rate: 20 breaths per minute, regular
- Temperature: 37.5 degrees Celsius
- Slight dehydration of skin
**Medical History**

- Date of birth: 6/08/1956
- At the age of 2 years the participant had Scarlet fever
- 1973- Pregnancy → Natural delivery
- 1973- Pregnancy → Natural delivery
- 1978- Participant had a surgery for correction of a retroverted womb and a prolapsed bladder
- 1979- Pregnancy → Emergency caesarean at 35 weeks
- 1979- Removal of an left ovarian cyst
- 1980- Tonsillectomy
- 1991- Amalgam fillings removed
- Removal of right meiobian cysts
- 2002- Thermogenesis sterilization (due to menorrhagia)
- 2003- Hiatus hernia operation (fixed valve) and removal of gall bladder which was diseased

**Allergies**

- Bee stings, house dust and cigarettes

**Observations and Vital Signs**

The participant was observed to be very cheerful and chatty. She was very conscious of what the researcher was writing during the case and was very loquacious.

The following vital signs were recorded:

- Blood pressure: 130/85 right arm, lying down
- Pulse rate: 60 beats per minute, regular
- Respiratory rate: 20 breaths per minute, regular
- Temperature: 37.5 degrees Celsius
- Slight dehydration of skin
• Sensitivity of the abdominal and uterine regions on palpation
• The participant scored 26 on the Kupperman Menopause Index = moderate menopausal symptoms
• $17\beta$ Oestradiol = 135.6 pmol/l

Prescription

• *Lachesis mutas* (Surucucu snake) 1M, one dose, daily for 28 days
• The researcher prescribed the 1M potency as the participant was partaking in another *similimum* study whereby the potency had to be 1M. Together the two researchers concluded what remedy was to be given, under supervision of the supervisors

Motivation for Remedy Selection

The participant requiring *Lachesis mutas* is typically loquacious (Sankaran, 1996:69). ‘One word often leads into midst of another story’ (Vermeulen, 1997:991), this was typical of this participant as she told the researcher about one symptom it lead to a story about her life. The sensation of anything tight aggravates. This could be seen in that the participant felt restricted by wearing polo necks or collared shirts, bras and shoes, this is typical of a *Lachesis mutas* (Boericke, 1998:387; Sankaran, 1996:70). On palpation of the participants abdomen and uterus there was sensitivity to pressure, which is another characteristic of *Lachesis mutas* (Agrawal, 1997:47). The depression experienced by the participant during the climacteric is also characteristic of *Lachesis mutas* (Boericke, 1998:387). This depression was alleviated by eating and drinking hot milk, which is another characteristic of *Lachesis mutas* in that eating, ameliorates (Sankaran, 1996:70).

Some of the more general symptoms of *Lachesis mutas* that were distinct in the case included:

• Sleepiness yet cannot sleep, awakens at night and is unable to sleep again (Vermeulen, 1997:1001)
• Pain on the vertex of the head (Boericke, 1998:387)
• Flashes of heat (Boericke, 1998:389)
• Great inclination to sweat especially about the head and neck (Vermeulen, 1997:1001)
• Constipation (Vermeulen, 1997:997)
• Hungry or loss of appetite (Vermeulen, 1997:995)
• Aggravated by suppressed discharges and especially loss of menses and menopause (Vermeulen, 1997:998)

4.1.2 Second Consultation- March 2004

The second consultation took place four weeks after the first consultation. After taking the remedy for one week, the participant’s hot flushes and perspiration associated with the hot flushes, disappeared.

The participant reported having a dull headache, and a feeling of cloudiness in her head.

The participant was able to pass a stool everyday even though the constipation persisted.

The participant’s general feeling of well-being had improved; she felt more energized and was sleeping better.

The participant was not as depressed and stressed, had not cried and was not going to let small trifles get her down.

The participant’s appetite had returned to three meals per day. She said she was not too hungry or too full and that she still was very thirsty.

The participant’s menses occurred two weeks after taking the remedy. She said there was a slight show of blood, which lasted for a day. There was no change in her libido, and the vaginal dryness persisted.
Observations and Vital Signs

The participant looked happier, more relaxed, and less stressed.

The following vital signs were recorded:
- Blood pressure: 130/80 right arm, lying down
- Pulse rate: 62 beats per minute, regular
- Respiratory rate: 20 breaths per minute, regular
- Temperature: 37.0 degrees Celsius
- Sensitivity of the abdominal and uterine regions on palpation
- The participant scored 11 on the Kupperman Menopause Index, and previously scored 26 = a favourable therapeutic result

Discussion

Based on the positive reaction of the participant to the remedy and the overall feeling of improvement, the researcher decided not to change or interfere with the remedy’s action.

Prescription

- One dose of *Lochesis mutus* 1M, three times a week
- The researcher reduced the dose to three times per week, as she felt the participant might prove the remedy if she continue to take it daily

4.1.3 Third Consultation- April 2004

The third consultation took place four weeks after second consultation. The participant had maintained her energy levels despite not sleeping through the night. The participant was still waking during the night but found it easier to fall back to sleep. She was waking up feeling refreshed.
The participant’s concentration levels had improved and her mood swings were “a lot better”.

The participant did not have a normal menses. There was a slight show of blood the day before the third consultation.

She had noticed that she was hungrier, and that she craved crunchy foods like chips and digestive bran biscuits.

Observations and Vital Signs

The participant was very loquacious.

The following vital signs were recorded:

- Blood pressure: 125/80 right arm, lying down
- Pulse rate: 60 beats per minute, regular
- Respiratory rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant still scored 11 on the Kupperman menopause index = a favourable therapeutic result

Discussion

The participant had maintained her feeling of well being and energy levels. The researcher felt that the *similimum* remedy had helped the participant and that another prescription was not necessary. The participant was instructed to stop taking the *Lachesis mutus*.

Prescription

- Nil
4.1.4 Final Consultation- May 2004

The final consultation took place four weeks after the third consultation. The participant was pleased to report that the hot flushes had not appeared again. Her sleeping patterns had improved and she was not waking at night. The participant found that she was more stressed due to her moving house.

She complained of worsening of her joint pains, due to her packing boxes and moving, and that the cold weather had aggravated the pains.

The participant reported a headache that she was having difficulty getting rid of. The headache was around her temples and it felt as if there was something in the middle of her forehead. The participant recalled having a similar headache before when she had a sinus infection.

Since starting the remedy, the constipation had improved, the stools were not as hard, and she was able to pass a stool most days.

The participant’s libido had not improved despite the improvement of her vaginal dryness. The participant had not had a period.

Observation Signs and Vital Signs

The following vital signs were recorded:
- Blood pressure: 130/80 right arm, lying down
- Pulse rate: 60 beats per minute, regular
- Respiratory rate: 20 breaths per minute, regular
- Temperature: 37.0 degrees Celsius
- The participant scored 10.5 on the Kupperman menopause index = favourable therapeutic result
- $17\beta\text{Oestradiol} = 488.2$ pmol/l
Discussion

The researcher was pleased with the overall feeling of improvement in the participant. The development of temporal headaches was not regarded as negative as they did not affect the participant’s general feeling of well being. The researcher did not prescribe another remedy and decided to wait and watch what course the *vital force* took.

Prescription

- Nil

4.1.5 Overview of Case One

The participant improved after the first consultation. The *Lachesis mutus* was seen to continue its action on the *vital force*. By the final consultation, the improvement was maintained. The researcher did not represcribe, preferring to wait for suggestions of a relapse.

On the initial Kupperman Menopause Index the participant scored 26, and scored 10.5 at the last consultation. This indicated a lessening in the severity of the participant’s climacteric symptoms.

The initial serum level of oestrogen was 135.6 pmol/l and the final serum oestrogen level had increased to 488.2 pmol/l.
4.2 CASE TWO

4.2.1 First Consultation- February 2004

Summary of Presenting Case

- Date of birth: 26/07/1955
- White female
- Married
- Housewife
- Three pregnancies → three children
- Resides in Johannesburg

A plump woman, 48 years of age with Type II Diabetes mellitus presented with climacteric symptoms.

She complained of hot flushes, which had started eight months ago. The hot flushes stopped after six months and reoccurred a month ago. She said the flushes were ‘driving her insane’ and that she wanted to undress due to the heat. They started in the region of the forehead and radiated down to the arms. Her skin would become clammy and saturated and she would have at least six hot flushes per day. The hot flushes increased in frequency in the afternoons and did not occur at night in bed. The hot flushes caused her sugar levels to increase to 10 mmol/L (the participant became aware of this one day when she was monitoring her blood sugar levels).

The participant also complained of sleeplessness. She would wake between 3 and 4 am for no cause and would only be able to fall back to sleep ± half an hour later.

The participant reported sharp joint pains in her knees, which were aggravated by climbing down stairs. She also complained of cramps in her legs, feet, and shoulders. The cramps in her legs and feet felt better when the participant walked and were worse in bed at night. Her feet and legs felt restless at night in bed.
The participant complained of being ‘stranded’ at home due to sharing a car with her husband. She said this caused her stress, as she could not go out. She had a large number of friends, enjoyed being out the house, going to gym and socializing. She found it difficult to relax.

She cried easily and did not take criticism very well, she became angry. She was bossy, enjoyed being the centre of attraction, and loved leading others. She loved organizing and having power.

The participant’s daughter had recently joined the airlines as an airhostess and the participant was missing her daughter very much.

**Generals**

- Food aversions- Liver, heart, game
- Food desires- Chicken, spicy foods, vegetables, salads
- Food aggravations- None
- Appetite- Good appetite eats three meals a day
- Thirst- Not thirsty
- Bowels- Passes stool everyday/ every second day
- Weather modalities- Cannot bear the sun and cold. Likes moderate weather
- Energy levels- Decreased during the day and better at night

**Medical History**

- Date of birth: 26/07/1955
- Breast lumps removed at 17 years old
- Three pregnancies → three caesarean deliveries
- 1992- Hysterectomy due to uterine fibroids
- 2000- Diagnosed with Type-2 Diabetes
Allergies

- Dust

Medication

- Candesaten cilexetil® for high blood pressure
- Iron tablets
- Calcium and magnesium, vitamin C, garlic and parsley supplements (Dose: Recommended daily allowance)

Observations and Vital Signs

The participant spoke with great articulation and calmness. She answered questions well and to the point. She looked very relaxed and happy.

The following vital signs were recorded:

- Blood Pressure: 112/75 right arm, lying down
- Pulse Rate: 64 beats per minute, regular
- Respiratory Rate: 18 breaths per minute
- Temperature: 37.1 degrees Celsius
- Thin, greasy hair
- The participant scored 28 on the Kupperman Menopause Index = moderate menopausal symptoms
- $17\beta$ Oestradiol = 63.8 pmol/l
**Prescription**

- *Calcarea carbonica* (prepared from carbonate of lime) 200CH, three powders, one taken daily for the first three days of treatment. The reason for prescribing three powders of 200CH was that the researcher felt the selected remedy was well chosen and that the participant's *vital force* was strong enough for a high potency.

- *Calcarea carbonica* 3CH, granules, a quarter capful taken daily. The reason for prescribing the 3CH granules was to continually stimulate the *vital force*.

**Motivation for Remedy Selection**

People requiring this remedy are typically plump. They may report that they have an anxiety that they will go insane or are going insane. The participant’s need to be the centre of attraction and a leader can be seen in the symptom picture of *Calcarea carbonica* in that they desire to be magnetized. Wakes too early, cannot sleep after 3 am, this was seen in the participant’s sleeping patterns. The participant’s joint pain was also seen in the *Calcarea carbonica* picture, in that most pains are felt while lying in bed and there are cramps in the calves at night (Vermeulen, 1997:355).

**4.2.2 Second Consultation - March 2004**

The second consultation took place four weeks after the first consultation. The participant was very happy with the outcome of the remedy. Her general well-being had improved and she reported that she was sleeping better and waking less often during the night. She was extremely happy that her energy levels had increased and was glad that she had lost 2 kilograms.

The number of flushes per day had decreased, and when she did have a hot flush, they occurred late afternoon and were less intense. There was just a feeling of warmth, without the urge to undress.
The participant complained of a dull, ‘horrible’, temple headache that occurred on waking in the morning. As the morning went by the headache would disappear. The participant recalls having similar headaches in the past.

The participant still did not have access to a car and was still feeling stressed about it. She was trying to cope better by baking and cleaning.

The participant also reported that she was still missing her daughter terribly.

**Observations and Vital Signs**

The following vital signs were recorded:
- Blood Pressure: 118/70 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 14 on the Kupperman Menopause Index = favourable therapeutic action

**Discussion**

Overall, the participant appeared much better. The occurrence of the headaches was accepted as a return of old symptoms (in accordance with Hering’s Law of Cure). The participant’s general feeling of well-being was satisfying and the researcher reduced the dosage of the remedy. The participant was required to take the remedy when she felt it necessary.

**Prescription**

- *Calcarea carbonica* 3CH, granules, a quarter capful to be taken when the participant felt necessary
- The researcher reduced the dose as she did not want the participant to prove the remedy
4.2.3 Third Consultation- April 2004

The third consultation took place four weeks after the second consultation. The participant reported the occasional hot flush. She said that there was marked improvement since the last consultation.

Her joint pain had improved remarkably, and that she had experienced only a small amount of pain in her right foot.

The participant had developed a bladder infection the week before the consultation. She said she was feeling very tired and that she had not slept well due to the infection. She said it felt as if she was on a cloud.

The participant reported that her headaches had stopped about a week after the last consultation.

**Observations and Vital Signs**

The participant looked very tired.

The following vital signs were recorded:
- Blood Pressure: 120/ 73 right arm, lying down
- Pulse Rate: 64 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37.1 degrees Celsius
- The participant scored 2 on the Kupperman Menopause Index = favourable therapeutic action

**Discussion**

The participant had maintained better physical, mental, and emotional health. Her hot flushes had decreased further in intensity and frequency, and her joint pains were alleviated. The researcher interpreted the bladder infection as an opportunistic disease associated with Diabetes.
The researcher believed the remedy was still working and she did not feel it necessary to change the remedy.

**Prescription**

- *Calcarea carbonica* 3CH, granules, a quarter capful to be taken when the participant felt necessary

**4.2.4 Final Consultation- May 2004**

The final consultation took place four weeks after the third consultation. The participant reported that all the hot flushes had disappeared, as well as the perspiration that accompanied the hot flushes.

She felt placid and relaxed.

The participant had started exercising again and felt more energized.

**Observations and Vital Signs**

The participant was calm, relaxed, and very cheerful.

The following vital signs were recorded:

- Blood Pressure: 120/75 right arm, lying down
- Pulse Rate: 64 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37.1 degrees Celsius
- The participant scored 5 on the Kupperman Menopause Index = favourable therapeutic result
- $17\beta$ Oestradiol = 179.5 pmol/l
Discussion

The researcher viewed a definite improvement in the participant. Her observable progress and happy state of mind was convincing enough for the researcher and the participant was instructed to stop taking the remedy.

Prescription

- Nil

4.2.5 Overview of Case Two

There was a remarkable lessening of the participants symptoms. The remedy continued its positive action within the participant and by the final consultation the researcher felt that the participant did not need another remedy.

On the initial Kupperman Menopause Index the participant scored 28, and scored 5 at the last consultation. This indicated a lessening in the severity of the participant’s climacteric symptoms.

The initial serum level of oestrogen was 63.8 pmol/l and the final serum oestrogen level had increased to 179.5 pmol/l.
4.3 CASE THREE

4.3.1 First Consultation- February 2004

Summary of Presenting Case

- Date of birth: 22/12/1951
- White female
- Married
- Housewife
- One child
- Resides in Johannesburg

A 52-year-old female presented with climacteric symptoms.

The participant reported severe hot flushes, which occurred every day, at least every hour. The hot flushes occurred from the breasts, upwards towards the chest and face and were accompanied by perspiration of the arm pit, forehead and above the top lip, which stained yellow. The hot flushes were aggravated by exertion and shock.

The participant suffered from occasional vertigo upon rising from the lying position, or when she swung her body quickly.

She tended to get nervous while driving, especially if a large truck passed her. She would clench the steering wheel. Peoples opinions about her also made her nervous, which resulted in her becoming suspicious and withdrawn from people. When she became depressed she could laugh and cry at the same time. When she did not have anything to do she became unmotivated.

She described herself as a loner but enjoyed her spouse’s company. The participant had a fear of dogs and cats and enjoyed gardening.
The participant had difficulty in remembering how to spell words, taking her medication and what groceries she had to buy.

The participant’s libido had decreased and she found herself faking orgasms during sexual intercourse. She complained of vaginal dryness, which affected her sex drive negatively. The participant stopped menstruating 5 years ago.

The participant complained of her muscles contracting into “knobs”, which were better if she stretched. She complained of sore neck muscles, as if there was tiredness over the top of her shoulders.

The participant slept well. She would often wake up feeling aggressive and angry for no reason.

**Generals**

- Food aversions- Cabbage, orange juice, peanuts (cannot chew them)
- Food desires- Starches, sandwiches, cookies/ biscuits, cheesecake, potatoes
- Food aggravations- Green peppers, garlic
- Thirst- Not thirsty. Likes coffee with creamer and 2 sugars. Drinks six cups of coffee a day
- Bowels- The participant has been constipated since a child. She was bloated. The stools are passed with much strain, but the participant is relieved after passing her stools. Sweet corn passes undigested. Haemorrhoids
- Urine- Yellow. Smells like coffee
- Weather modalities- Prefers cold temperatures
- Energy levels- Low

**Medical History**

- Date of birth: 22/12/1951
- Tonsillectomy
- Natural pregnancy
• 1992- Removal of appendix
• 2000- Removal of right ovary due to cyst

Medication

• Kelp, Folic acid and multi-vitamins (Dose: Recommended daily allowance)

Observations and Vital Signs

The participant expresses herself by using her hands during conversation. The participant thought about what she was going to say before she answered any questions.

The following vital signs were recorded:
• Blood Pressure: 130/90 right arm, lying down
• Pulse Rate: 62 beats per minute, regular
• Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 36 on the Kupperman Menopause Index = severe menopausal symptoms
• $17\beta$ Oestradiol = 49.3 pmol/l

Prescription

• Sepia officinalis (Cuttle fish) 1M, one dose, daily, for 28 days
• The researcher prescribed the 1M potency as the participant was partaking in another similimum study whereby the potency had to be 1M. Together the two researchers concluded what remedy was to be given, under supervision of the supervisors.
• 1992- Removal of appendix
• 2000- Removal of right ovary due to cyst

Medication

• Kelp, Folic acid and multi-vitamins (Dose: Recommended daily allowance)

Observations and Vital Signs

The participant expresses herself by using her hands during conversation. The participant thought about what she was going to say before she answered any questions.

The following vital signs were recorded:
• Blood Pressure: 130/90 right arm, lying down
• Pulse Rate: 62 beats per minute, regular
• Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 36 on the Kupperman Menopause Index = severe menopausal symptoms
• $17\beta$ Oestradiol = 49.3 pmol/l

Prescription

• *Sepia officinalis* (Cuttle fish) 1M, one dose, daily, for 28 days
• The researcher prescribed the 1M potency as the participant was partaking in another *similimum* study whereby the potency had to be 1M. Together the two researchers concluded what remedy was to be given, under supervision of the supervisors.
Motivation for Remedy Selection

Some of the more general symptoms of *Sepia officinalis* that were distinct in the case included:

- Hot flushes at menopause accompanied by perspiration and weakness
- Upward tendency of symptoms. This was seen in the participant’s hot flushes, which occurred from the breasts upwards to the face
- There is excessive prostration and faintness, especially on rising. This was observed in that the participant often suffered from vertigo upon rising
- Loss of thirst
- Constipation
- Piles

(Vermeulen, 1997:1459-1460, 1464)

4.3.2 Second Consultation- March 2004

The second consultation took place four weeks after the first consultation. The participant noted a decrease in the frequency and severity of her hot flushes. She said they were precipitated by anxiety or when she had to move about quickly. The perspiration accompanying the hot flushes had also decreased.

The participant complained of a headache over her left eye, which radiated to the vertex of her head. She said bright stage lights precipitated the headache. She felt better after she had eaten and received a back massage.

The participant’s libido had increased and her vaginal dryness had improved slightly.

When questioned about her emotions, she said sometimes she felt tearful for no reason, and that the tears would just come and she would get a lump in her throat. The participant felt better by relaxing. She also felt fearful and anxious about not completing her tasks, even before she had started them.
Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 125/90 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37.1 degrees Celsius
- The participant scored 24 on the Kupperman Menopause Index = moderate menopausal symptoms

Discussion

The participant felt much better generally since starting the Sepia officinalis. Her hot flushes had decreased in severity, she was not perspiring as much, and her vaginal dryness was less.

The development of the headache was not seen negatively, as it was caused by staring at bright stage lights and there was no reoccurrence of headaches.

The researcher instructed the participant to continue taking the Sepia officinalis.

Prescription

- Sepia officinalis 1M, one dose, taken daily, for 28 days

4.3.3 Third Consultation- April 2004

The third consultation took place four weeks after the second consultation. The participant was very pleased with the marked improvement of her hot flushes. She was also pleased in that her vaginal dryness had improved since the last consultation.
The participant reported that she was feeling great mentally, emotionally and physically. She was not tearful and felt more relaxed.

She had not had any headaches.

**Observations and Vital Signs**

The following vital signs were recorded:

- Blood Pressure: 125/85 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 15 on the Kupperman menopausal index = mild menopausal symptoms

**Discussion**

The researcher was pleased with the participants overall improvement. The participant was instructed to take the *Sepia officinalis* only three times a week.

**Prescription**

- *Sepia officinalis* 1M, one dose taken three times a week

**4.3.4 Final Consultation- May 2004**

The final consultation took place four weeks after the third consultation. The participant only suffered hot flushes if she drank alcohol. She said that the perspiration had ceased.

She felt less nervous and depressed. She said she was coping with her daily tasks and that she had started meditating.
She had a desire to learn new languages.

Generally she felt better and was sleeping well. The participant was trying to lose weight.

**Observations and Vital Signs**

The following vital signs were recorded:

- Blood Pressure: 125/85 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 16 on the Kupperman Menopause Index = mild menopausal symptoms
- $17\beta$ Oestradiol = 2.8 pmol/l

**Discussion**

The participant also experienced a general improvement of well-being. She felt less nervous and depressed, and more relaxed and calm. The researcher instructed the participant to stop taking the *Sepia officinalis*.

**Prescription**

- Nil

**4.3.5 Overview of Case Three**

The participant did show a favourable response the *Sepia officinalis*. The remedy acted on the participant’s *vital force* sufficiently to maintain general well-being.

On the initial Kupperman Menopause Index the participant scored 36, and scored 16 at the last consultation. This indicates a lessening in the severity of the participant’s climacteric symptoms.
The initial serum level of oestrogen was 49.3 pmol/l and the final serum oestrogen level had decreased to 2.8 pmol/l. Despite the decrease in the participants serum oestrogen levels, she still felt much better and was satisfied with the results achieved at the end of the study.
4.4 CASE FOUR

4.4.1 First Consultation - March 2004

Summary of Presenting Case

- Date of birth: 10/10/1953
- White female
- Married
- Business woman
- Two pregnancies \(\rightarrow\) two children
- Resides in Johannesburg

A fair, red haired, 51-year old female presented with climacteric symptoms. The participant had been experiencing the symptoms for the last year.

The participant had stopped menstruating two and a half years ago.

The participant was experiencing hot flushes 2-4 times a day. She said it felt as if a blowtorch was being held to her head. The hot flushes occurred from her chest and radiated upwards to her head, and were accompanied by perspiration of her forehead. The participant also experienced hot flushes during the night, which woke her from her sleep, and she would often find herself drenched from perspiration. She found the flushes at night more severe than the hot flushes, which occurred during the day. The hot flushes were aggravated when the participant became agitated or had to do a task quickly and were alleviated when the participant remained calm.

The participant complained of vaginal dryness, which caused burning during intercourse.
The participant reported pain of her two big toes, which felt as if the joint was bruised. The participant had the pain for the last 16 years and could not tell the researcher what the cause of the pain was. The pain was aggravated by rising onto the toes, cold weather or if she moved the toes in circular motions.

The participant described herself as a hard working, businessperson who enjoyed her work. She said she cannot relax and that she was always doing something. She did not like diving and flying as she did not feel in control, and did not enjoy surprises. The participant liked to be in control of her emotions.

Generals

Food aversions- Asparagus, artichokes
Food desires- None
Food aggravations- Game fish (tuna, marlin) causes diarrhoea
Appetite- Very good. The participant eats three healthy meals
Thirst- Thirsty, drinks 1-2 litres of water per day. Drinks 2 glasses of wine with supper
Bowels- Good
Urine- Good
Weather- Enjoys hot, humid weather
Energy levels- Good

Medical History

- Date of birth: 10/10/1953
- Two pregnancies delivered by natural birth
Medication

- Calcium, magnesium and zinc complex (Dose: Recommended daily allowance)
- Imodeen® (skin supplement consisting of seaweed)
- Absolute oxygen® (Dose: Recommended daily allowance)

Observations and Vital Signs

The participant was very cheerful and happy. She answered with ease and was very easy to talk communicate with.

The following vital signs were recorded:
- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 16 on the Kupperman Menopause Index = mild menopausal symptoms
- $17\beta$ Oestradiol = 41.6 pmol/l

Prescription

- *Phosphorus* 200CH, three powders, one powder taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated and that the participant’s *vital force* was strong
- *Phosphorus* 6CH, quarter capful of granules, taken daily. The reason for prescribing the 6CH granules was to continually stimulate the participant’s *vital force*
Motivation for Remedy Selection

Symptoms of the participant, which match Phosphorus, include:

- Fair skin and fine, red hair (Vermeulen, 1997:1293)
- There was the desire to be magnetised (Vermeulen, 1997:1282)
- A flame of fire seemed to be passing through her (Vermeulen, 1997:1282); this was experienced by the participant as it felt as if someone was holding a blowtorch to her head during a hot flush
- There was perspiration at night (Schroyens, 2001:1512)

Other characteristic symptoms of Phosphorus include the strong desire for wine (Vermeulen, 1997:1286) and the fear of flying (Schroyens, 2001:111).

4.4.2 Second Consultation- April 2004

The second consultation took place four weeks after the first consultation. The participant’s hot flushes had not decreased in severity or frequency. The participant said it felt as if she was standing on a hot plate, and that the heat started from the knees and radiated upwards, towards the head. The participant was still experiencing hot flushes accompanied by perspiration at night. She complained that the hot flushes were waking her up at night and that she would become anxious and develops heart palpitations, about whether or not she would get enough sleep to cope with her busy day.

There was no change in the participant’s vaginal dryness.

Observations and Vital Signs

- Blood Pressure: 120/68 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
• The participant scored 24 on the Kupperman Menopause Index = moderate menopausal symptoms

Discussion

Due to the participant not responding to the Phosphorus, the researcher retook the case and found that the remedy indicated was still Phosphorus. The researcher decided to continue prescribing Phosphorus.

Prescription

• Phosphorus 6CH, quarter capful of granules taken every morning

4.4.3 Third Consultation - May 2004

The third consultation took place four weeks after the second consultation.

The participant was feeling well mentally.

The participant was still experiencing hot flushes, but they had decreased in severity. The hot flushes continued to wake the participant at night, but she did not become anxious about whether or not she was going to fall back to sleep. Despite the lack of sleep the participant was waking refreshed.

The participant's vaginal dryness had lessened, and her libido had increased.
Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 125/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 8 on the Kupperman Menopause Index = favourable therapeutic action

Discussion

The researcher was pleased with participant’s progress and the participant was instructed to stop taking the Phosphorus. Another remedy was not prescribed, as the researcher wanted to wait and watch the response of the vital force.

Prescription

- Nil

4.4.4 Final Consultation- June 2004

The final consultation took place four weeks after the third consultation.

The hot flushes had decreased in severity and frequency, and the participant was feeling well.

Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 125/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 8 on the Kupperman Menopause Index = favourable therapeutic action

Discussion

The researcher was pleased with participant’s progress and the participant was instructed to stop taking the Phosphorus. Another remedy was not prescribed, as the researcher wanted to wait and watch the response of the vital force.

Prescription

- Nil

4.4.4 Final Consultation- June 2004

The final consultation took place four weeks after the third consultation.

The hot flushes had decreased in severity and frequency, and the participant was feeling well.

Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37.1 degrees Celsius
- The participant scored 6 on the Kupperman Menopause Index = favourable therapeutic action
- $17\beta\text{Oestradiol} = 167.1\ \text{pmol/l}$

**Discussion**

The researcher was pleased with the participant's progress. However the participant felt that the persistence of the hot flushes, despite the decrease in frequency and intensity, was unsatisfactory.

**4.4.5 Overview of Case Four**

The participant's response to the remedy was satisfactory. The participant scored 16 on the Kupperman Menopause Index at the first consultation and scored 6 at the last consultation, which indicated a favourable therapeutic results. The participant's serum oestrogen levels increased from 41.6 pmol/l to 167.1 pmol/l.
4.5 CASE FIVE

4.5.1 First Consultation- March 2004

Summary of Presenting Case

- Date of birth: 5/07/1958
- Creole female
- Married
- Waitress
- Four pregnancies → four children
- Resides in Johannesburg

A 46-year-old female presented with the following symptoms: nervousness, irritability, headaches, inability to concentrate and heart palpitations. The participant had been experiencing the symptoms for eight months.

The participant was sent by her husband, to investigate as to why she was feeling very tearful. The participant complained of her crying almost everyday. She felt tearful and was very sensitive. She said she could not stop herself from crying and that the tears would just come uncontrollably. The participant would cry at work. The participant said her husband was a nice and understanding man, and that she felt better when she was consoled. She had experienced heart palpitations, which occurred suddenly, often accompanying the crying. The participant’s biggest fear was to lose her family.

The participant complained of frontal headaches, which occurred often. The headache would start in the morning, increasing in intensity as the day progressed, and disappearing 2-3 hours after the onset. The headache was accompanied by nausea without vomiting and the participant felt better if she lay down with her eyes closed in a quiet room.
The participant had a bad taste and smell in her mouth. She would brush her teeth 2-3 times a day to hide the smell.

The participant reported that her libido had increased in the last few months.

The participant experienced irregular menses and the discharge was a black blood. The participant reported a light brown leucorrhoea. This occurred when the participant ran or moved about quickly.

Generals

Food aversions- Raw fish
Food desires- Sweet foods (ice cream, cake, dessert)
Food aggravations- Spinach and milk cause diarrhoea
Appetite- Enjoys eating. She eats all the time
Thirst- Forces herself to drink water
Bowels- Good
Urine- Good
Weather- Prefers colder weather
Energy levels- She said it feels as if her energy levels are going down. She says it is an effort to do tasks, as she has no energy
Sleep- The participant sleeps well and wakes feeling refreshed

Medical History

- Date of birth: 5/07/1958
- Four Pregnancies→ four natural births. The participant described her pregnancies as difficult pregnancies. She said she could not eat, as she was constantly nauseous and would vomit. She also was very tired during her pregnancies
- 2002- Gallbladder stone removed
Observations and Vital Signs

The participant was happy to talk about her emotions. The participant was from Mauritius and she did not understand English very well.

The following vital signs were recorded:

- Blood Pressure: 140/100 right arm, lying down
- Pulse Rate: 64 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 13 on the Kupperman Menopause Index
- $17\beta$ Oesradiol = 147.2 pmol/l

Prescription

- *Pulsatilla nigricans* (prepared from the Windflower) 200CH, three powders, one taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated and that the participant’s *vital force* was strong
- *Pulsatilla nigricans* 6CH, quarter capful of granules taken when needed. The reason for prescribing the 6CH granules was to continually stimulate the participant’s *vital force* into healing the body

Motivation for Remedy Selection

The keynote of this remedy was the disposition and mental state of the participant. It was pre-eminently a female remedy, especially females with a mild, gentle, and yielding disposition. The *Pulsatilla nigricans* participant is typically sensitive, sad, and tearful. She readily weeps at everything, whether it is joyful or sorrowful, and is better for being consoled (Vermeulen, 1997: 1346-1347). This theme was evident in the participant’s constant sadness accompanied by crying.
She had a mild and timid disposition, and a gentle, nurturing nature. She felt better when she was consoled.

Another keynote of *Pulsatilla nigricans* participants is the amelioration from cold, fresh, open air. This was also expressed by the participant in that she felt better in cold weather.

The *Pulsatilla nigricans* participant is typically not thirsty and has an offensive odour from her mouth (Vermeulen, 1997:1350). This could be seen in the participant as she brushed her teeth 2-3 times a day in order to hide the offensive odour. She was thirstless and did not enjoy drinking water.

The participant craved sweet foods and ice-cream which was another symptom expressed by *Pulsatilla nigricans* participants (Vermeulen, 1997:1351). The *Pulsatilla nigricans* participant may have profuse menses of a dark colour and sexual excitement (Vermeulen, 1997:1354); this was seen in the participant as she too had dark menses and an increased libido.

**4.5.2 Second Consultation- April 2004**

The second consultation took place four weeks after the first consultation. The participant reported feeling better about her emotional state. She was not as miserable and was crying much less.

The headaches reported by the participant in the first consultation had decreased in frequency and severity, and the participant only had experienced two headaches since starting the remedy.

The participant was feeling very tired. Her libido had also decreased and she said it was due to her feeling so tired.

The participant did have a normal menstrual period, which lasted for 5 days.
Observations and Vital Signs

The participant was cheerful and talkative, despite her looking very tired.

The following vital signs were recorded:
- Blood Pressure: 140/90 right arm, lying down
- Pulse Rate: 68 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 14 on the Kupperman Menopause Index = a favourable therapeutic result

Discussion

The remedy had helped improve the participant's emotional state, as she was feeling better about herself. The participant’s blood pressure had also decreased. The researcher saw these as positive signs and in accordance with Hering’s Law of Cure. The researcher instructed the participant to continue taking the *Pulsatilla nigricans*.

Prescription

- *Pulsatilla nigricans* 6CH, quarter capful of granules taken when needed

4.5.3 Third Consultation- May 2004

The third consultation took place four weeks after the second consultation. The participant was very pleased about her emotional state. She was happy and cheerful, and had cried only once since the last consultation.

The participant reported having had a headache that was not severe and only lasted for about an hour.
Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 135/90 right arm, lying down
- Pulse Rate: 64 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 12 on the Kupperman Menopause Index = a favourable therapeutic result

Discussion

The researcher was pleased with the participant’s progress and instructed her to take one dose of the remedy, once a week.

Prescription

- Pulsatilla nigricans 6CH, quarter capful of granules taken once a week

4.5.4 Final Consultation - June 2004

The participant was pleased with the improvement of her mental state. She had not cried and was feeling happy.

Her energy levels had increased, she was feeling a lot less tired and had not experienced any headaches since the last consultation.
Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 130/75 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 9 on the Kupperman Menopause Index = a favourable therapeutic response
- $17\beta$ Oestradiol = 155.1 pmol/l

Discussion

The participant’s blood pressure had come down overall from 140/100 to 130/75. The researcher was happy with the participant’s overall improvement, and instructed the participant to stop taking the Pulsatilla nigricans.

Prescription

- Nil

4.5.5 Overview of Case Five

The participant improved considerably after the first consultation. The remedy had elicited improvement on the mental, emotional, and physical levels, and continued its positive action on the vital force until the end of the study.

On the initial Kupperman Menopause Index the participant scored 13, and at the last consultation she scored 9. This indicated a lessening in the severity of the participant’s climacteric symptoms.
The initial serum level of oestrogen was 147.2 pmol/l and the final serum oestrogen level had increased to 155.1 pmol/l.
4.6 CASE SIX

4.6.1 First Consultation- March 2004

Summary of Presenting Case

- Date of birth: 30/10/1958
- Black female
- Married
- Printing machine operator
- Four children
- Resides in Johannesburg

A 45-year old female presented with climacteric symptoms. The participant had been experiencing the symptoms for the last two years.

The participant reported she was experiencing hot flushes 5-6 times per day. She said it felt as if there was a heater in front of her face. Perspiration of her face, chest, and back accompanied the hot flushes, as well as heart palpitations and slight frontal headaches. The participant felt better when she drank tap water, relaxed and cooled down in fresh air.

The participant complained that small trifles made her irritable and cross. She said she often spoke ‘cheekily’ to people and only after, had she realized what she had said or done. She felt sorry after getting cross and said she did not like to make ‘unnecessary noise’. The participant expressed her concerns about her family problems. The participant had recently had an argument with her niece and was not talking to her. Despite them not talking, the participant still went to visit her niece in hospital when she was ill.
The participant's libido had decreased. She did not feel the desire to have sexual intercourse at all and said she just 'does not want it' and that she 'wishes she could just run out'. She was experiencing vaginal dryness and she said it was painful during sexual intercourse. The participant stopped menstruating four years ago.

The participant complained of joint pains in her hips when she stood or walked a lot.

**Generals**

- Food aversions- Red meat, coffee
- Food desires- Vegetables, cooked beetroot, pap
- Food aggravations- None
- Appetite- Good
- Thirst- Not thirsty. Does not like cold water
- Bowels- Good. Bread makes her constipated
- Urine- Good
- Weather- Enjoys summer weather
- Energy levels- Good
- Sleep- Sleeps from 9 pm – 5 am. Wakes-up feeling refreshed

**Medical History**

- Date of birth: 30/10/1958
- Four pregnancies → four natural births. The participant was very active during her pregnancies and did not experience any problems
- 1991- Ectopic pregnancy. The participant's fallopian tube ruptured and the participant was sterilized
Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 120/70 right arm, lying down
- Pulse Rate: 60 beat per minute, regular
- Respiratory Rate: 20 breaths per minute regular
- Temperature: 37 degrees Celsius
- The participant scored 28 on the Kupperman Menopause Index = moderate menopausal symptoms
- $17\beta$ Oestradiol = 43.1 pmol/l

Prescription

- *Natrum muriaticum* (prepared from common salt) 200CH, three powders to be taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated and that the participant had a strong *vital force*
- *Natrum muriaticum* 6CH, a quarter capful of granules taken when needed. The reason for prescribing the 6CH granules was to continually stimulate the participant’s *vital force*

Motivation for Remedy Selection

A keynoted symptom of *Natrum muriaticum* was the dryness found throughout the systems of the body (Vermeulen, 1997:1172, 1179). This was noted in the participant’s vaginal dryness and her aversion to coition.

The participant’s preference of hot weather was noted in the *Natrum muriaticum* symptom picture. There was great inability to take cold (Vermeulen, 1997:1172).

The *Natrum muriaticum* patient becomes irritable and passionate about trifles (Vermeulen, 1997:1172), this applied to the participant in that minor trifles made her cross. Vermeulen (1997:1173) says there are *'mistakes in speaking, what he doesn’t intend to'* this was clearly seen
in the participant in that she spoke hastily to people, and only realized after she said or did something, that she did not intend to do what she said or did.

Aversion to bread, coffee and meat are noted in the materia medica picture of *Natrum muriaticum* (Vermeulen, 1997:1176), these elements were noted during the consultation.

Flushes of heat and headache (Vermeulen, 1997:1182) are also noted in the materia medica and this was seen in the participant’s hot flushes accompanied by headaches.

**4.6.2 Second Consultation- April 2004**

The second consultation took place four weeks after the first consultation. The participant reported an improvement of her hot flushes. She had only experienced 1-2 hot flushes per day and they were not as hot as before. The participant did not experience palpitations with her hot flushes.

The participant was pleased to tell the researcher that her libido had increased, her vaginal dryness had improved, and that the joint pain in her hips had disappeared.

She said she felt excellent and that her energy levels were very good.

**Observations and Vital Signs**

The following vital signs were recorded:

- Blood Pressure: 120/75 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 13 on the Kupperman Menopause index = a favourable therapeutic result
Discussion

The participant had improved physically, mentally and emotionally. *Natrum muriaticum* appeared to have been her *similimum* remedy. The researcher concluded that it was not necessary to prescribe another remedy and decided to wait and watch the participant's *vital force*.

Prescription

- Nil

4.6.3 Third Consultation- May 2004

The third consultation took place four weeks after the second consultation. The participant reported that she was still feeling good, that she was sleeping well and had maintained her energy levels.

Her hot flushes had improved and were only occurring once a day.

Observations and Vital Signs

The participant was cheerful.

The following vital signs were recorded:
- Blood Pressure: 125/75 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 10 on the Kupperman Menopause Index = a favourable therapeutic result
Discussion

The Natrum muriaticum had continued to show its effectiveness on the participant's overall energy. The researcher did not feel the need to prescribe another remedy.

Prescription

- Nil

4.6.4 Final Consultation - June 2004

The final consultation took place four weeks after the third consultation. The participant was pleased to report that her hot flushes had disappeared. She was sleeping well and had maintained her energy levels. She felt better about her family problems and was less stressed.

Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 120/70 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 10 on the Kupperman Menopause Index = a favourable therapeutic response
- $17\beta$ Oestradiol = 55.5 pmol/l
Discussion

The Natrum muriaticum had sufficiently stimulated the participant’s vital force to maintain, physical, mental and emotional well-being.

Prescription

• Nil

4.6.5 Overview of Case Six

The participants improved physical symptoms, mental symptoms and happier mood were a clear indication that the participants simillimum, Natrum muriaticum, had had a positive effect on all levels of the participants health.

On the initial Kupperman Menopause Index the participant scored 28, and at the last consultation scored 10. This indicated a lessening in the severity of the participant’s climacteric symptoms.

The initial serum level of oestrogen was 43.1 pmol/l and the final serum oestrogen level had increased to 55.5 pmol/l.
4.7 CASE SEVEN

4.7.1 First Consultation - May 2004

Summary of Presenting Case

- Date of birth: 31/12/1949
- White female
- Married
- Ex-dancing teacher → housewife
- One pregnancy → twins
- Resides in Johannesburg

A 54-year old female presented with climacteric symptoms. The participant had been experiencing the symptoms for the last two years.

The participant complained of her sleeping problems. She would go to bed exhausted at about 9:30 pm and would wake-up, feeling agitated between 1-3 am. The participant said she sometimes experienced palpitations on waking. The participant would get up, take a Stopayne® and make herself tea and a snack. She said the Stopayne® would help her fall back to sleep and that it made her feel relaxed and calm. The participant often had dreams about struggling. She felt tired during the day.

The participant described herself as an irritable and serious person. She liked to be in control and felt out of control if she became drunk or when having had a local anaesthetic at the dentist. She constantly felt nervous and would become stressed if she had a lot to do for the day. She was irritable with her children and her husband, and her children often told her to ‘get off their backs’. She said ‘what’s it all about’ and that she would like to pack her backpack and travel into the sunset. She had a fear of drowning and snakes.
The participant was still menstruating. The day before starting her menses the participant would become irritable and angry. She complained of very heavy periods that would last for 6-7 days, accompanied with dysmenorrhea of her lower abdomen and breast tenderness. The participant’s menses were red and contained ‘liver clots’. When the participant sat or stood, she felt a gush of blood.

The participant complained of a stabbing pain in her left thumb joint. The pain was only noticeable if the participant grasped an object or opened a bottle. The participant also had the same pain in her knee joints, which was aggravated by cold weather. Her family doctor had diagnosed the pain as mild rheumatism. The participant had been experiencing these pains for a few years.

The participant had suffered from classical migraines since the age of 13 years. The migraines were precipitated by stress, chocolate, caffeine, and yoghurt. The participant had not experienced a migraine for many years, but instead experienced frequent headaches. The headaches would occur every day or every second day in the frontal region of the head, and would settle over the eyes. The participant would take 2 Stopayne® to alleviate the headaches.

The participant was finding it difficult to concentrate and to remember. She would forget to do things. She found it too much effort to focus on what she was reading and would skim the page.

**Generals**

Food aversions- None
Food desires- Biscuits, cake, chocolates and ice-cream
Food aggravations- None
Appetite- Very hungry and eats all day
Thirst- Not thirsty. She enjoys drinking tea
Bowels- Constipated. The participant may pass a stool once every two days or nothing for about four days
Urine- Good
Weather: The participant was a very cold sensitive person. She hates winter and prefers summer.

Energy levels: The participant’s energy levels were very low. She would wake-up feeling tired.

Medical History

- Date of birth: 31/12/1949
- Wisdom teeth extraction
- Inguinal hernia operation
- 1983 \( \rightarrow \) Pregnant with twins. Threatened miscarriage in the seventh or eighth month of pregnancy. She was very heavy and was put to bed for the rest of her pregnancy. The twins were delivered naturally with an epidural.

Medication

- Arthroguard\textsuperscript{®} (Dose: Recommended daily allowance)
- Pharmaton\textsuperscript{®} (Dose: Recommended daily allowance)
- Synflex\textsuperscript{®} (the participant takes two every four hours for the first two days of her menses)
- Buscopan\textsuperscript{®} (the participant may take one during her menses for dysmenorrhoea)
- Stopayne\textsuperscript{®} (the participant may take one – two for headaches and to make her fall asleep)

Observations and Vital Signs

The participant was observably tired yet cheerful.

The following vital signs were recorded:

- Blood Pressure: 120/70 right arm, lying down
- Pulse Rate: 48 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 20 on the Kupperman Menopause Index = moderate menopausal symptoms
• $17\beta$ Oestradiol = 947.3 pmol/l

Prescription

• *Aurum muriaticum natronatum* (prepared from double chloride of sodium and gold) 200CH, three powders, one powder taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated and that the participant had strong *vital force*

• *Aurum muriaticum natronatum* 30CH, a quarter capful of granules taken daily. The reason for prescribing the 30CH granules was to continually stimulate the participant's *vital force*

Motivation for Remedy Selection

Patients requiring *Aurum muriaticum natronatum* are typically female, as it has profound effect on the female organs (Vermeulen, 1997:250).

The irritable disposition of the participant was another symptom of *Aurum muriaticum natronatum* (Vermeulen, 1997:250). The time the participant wakes during the night, the irritability and the participant's attitude and coping mechanisms towards her feeling about her family (her feeling of packing her backpack and travelling into the sunset), are all indications of depression.

Rheumatism aggravated by cold was also a feature of *Aurum muriaticum natronatum* (Vermeulen, 1997:250).

4.7.2 Second Consultation - June 2004

The second consultation took place four weeks after the first consultation. The participant reported that not much change had occurred in her symptoms. She was still waking during the night, her mood had not changed, and she was still feeling irritable with her family.
The participant’s energy levels had increased, she was feeling good, and her knee and thumb joint pains had improved.

She had not had any headaches since the last consultation and had not menstruated.

Observations and Vital Signs

The participant was observably tired. She was cheerful.

The following vital signs were recorded:

- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 52 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 16 on the Kupperman Menopause Index = mild menopausal symptoms

Discussion

Despite the lack of improvement of the participant’s mental symptoms, the researcher continued prescribing *Aurum muriaticum natronatum*.

Prescription

- *Aurum muriaticum natronatum* 30CH, a quarter capful of granules taken daily

4.7.3 Third Consultation- July 2004

The third consultation took place four weeks after the first consultation. The participant was still waking up at about 3 am.
The participant’s energy levels had improved, and it was towards the end of the day that her energy levels became low.

The participant was still irritable with her family and felt as if she could run away to a deserted island. She felt less depressed and was coping better with stress.

She found an improvement in her ability to concentrate, and was found it easier to read.

The participant’s joint pain had disappeared, and she only had two headaches since the last consultation, and had taken Stopayne® on one occasion.

The participant had menstruated for a week since the last consultation. The flow was heavy and accompanied by dysmenorrhoea and breast tenderness. The breast tenderness persisted for about a week after the end of her menses.

Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 120/70 right arm, lying down
- Pulse Rate: 52 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 9 on the Kupperman Menopause Index = a favourable therapeutic result

Discussion

The researcher viewed a definite improvement in the participant. The alleviation of the participant’s joint pains and headaches, and the improvement of her energy levels and concentration levels were encouraging. The participant was feeling less depressed. The participant was instructed to stop taking the Aurum muriaticum natronatum.
Prescription

• Nil

4.7.4 Final Consultation- August 2004

The final consultation took place four weeks after the third consultation. The participant’s energy levels had increased and she was feeling better than when she started the study. She was sleeping well and waking up less frequently.

She had not experienced any headaches since the last consultation, her libido had increased, her concentration levels had improved, and her bowels were not constipated.

The participant had menstruated since the last consultation. Her menses lasted for 3-4 days and the flow was not as heavy. She had dysmenorrhoea, but no breast tenderness.

Observations and Vital Signs

The following vital signs were recorded:

• Blood Pressure: 120/65 right arm, lying down
• Pulse Rate: 52 beats per minute, regular
• Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 7 on the Kupperman Menopause Index = a favourable therapeutic result
• $17\beta$ Oestradiol = 181.9 pmol/l
Discussion

The participant did show a favourable response to the *Aurum muriaticum natronatum*. However the response was not satisfactory. The researcher was not convinced that *Aurum muriaticum natronatum* was the participant's *similimum*.

4.7.5 Overview of Case Seven

The participant did show a response to the remedy. However the response was insufficient, convincing the researcher that *Aurum muriaticum natronatum* only partially covered the case. The researcher retook the case and concluded that the participant would have benefited from *Sepia officinalis*.

On the initial Kupperman Menopause Index the participant scored 20, and scored 7 at the last consultation. This indicated a lessening in the severity of the participant’s climacteric symptoms.

The initial serum level of oestrogen was 947.3 pmol/l and the final serum oestrogen level had decreased to 181.9 pmol/l. Despite the drastic decrease, there was some palliation of the participant’s climacteric symptoms.
4.8 CASE EIGHT

4.8.1 First Consultation- April 2004

Summary of Presenting Case

- Date of birth: 15/10/1957
- White female
- Widow
- Receptionist
- Two children
- Resides in Johannesburg

A 46-year-old female presented with climacteric symptoms. The participant had been experiencing the symptoms for the last year.

The participant complained of hot flushes, which were getting progressively worse over time. The hot flushes started from the chest and radiated upwards to the head. The hot flushes occurred more frequently during the day and more severely at night, and would wake the participant from her sleep.

The participant also had trouble sleeping through the night. She would wake-up between 1-2 am, unable to fall back to sleep easily, and would then have to wake-up at 5 am in order to get ready for work. The participant would be exhausted the next day if she did not have a good nights rest. The participant became very irritable and 'down' when she was sleep deprived.

The participant was still menstruating. Her menstrual cycle had become irregular. One month her menstrual flow would be light and would last 2-3 days, and the next month would be heavy, clotted, last for 5-6 days and was accompanied by dysmenorrhoea and breast tenderness. The participant described the dysmenorrhoea as if her insides were being torn out.
The participant complained of joint pain in her knees that would come and go spontaneously. She described the pain as 'it's just there and not very painful', which was aggravated by walking, rising from a seated position and standing.

The participant reported having headaches, which would wake her at about 1-3 am. The headaches were described as frontal headaches, which started over the left side of the forehead, radiated to the right side, and settled over the entire forehead. The participant said it felt 'as if holes were being drilled in her head'. The headaches were accompanied by nausea and were better for lying down.

She complained about her son. She said he was getting on her nerves even if he had not done anything wrong, and that she wanted him to 'get out of her hair and leave her alone'. She had spoilt her son since the death of his father in 1996.

She described herself as helpful and friendly. She had a fear of heights, flying and big dogs (a dog bit the participant when she was a child). The participant was also claustrophobic.

The participant’s memory had progressively worsened over the last year. She had to write lists of to do’s in order not to forget. She was very good at remembering faces, but not names.

**Generals**

Food aversions- Brussels sprouts, eggplant, and red meat (caused abdominal bloating, and the smell made her nauseous)  
Food desires- Milk, fruit and vegetables  
Food aggravations- Red meat  
Appetite- Good appetite, she enjoys eating  
Thirst- Thirsty, drinks 1-2 litres of ice-cold water a day  
Bowels- Tendency towards constipation, the participant may pass a stool every 2-3 days. The participant did not have the urge to go to the toilet  
Urine- Normal
Weather - Enjoyed hot weather and she hated being cold
Energy levels - Terrible

Medical History

- Date of birth: 15/10/1957
- Two pregnancies. Her daughter was delivered by natural birth and her son by caesarean

Medication

- Multi-vitamin (Dose: Recommended daily allowance)

Observations and Vital Signs

The participant was cheerful and very open to answering questions.

The following vital signs were recorded:
- Blood Pressure: 110/60 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 18 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 28 on the Kupperman Menopause Index = moderate menopausal symptoms
- \(17\beta\text{Oestradiol} = 84.9 \text{ pmol/l}\)
Prescription

- *Sepia officinalis* (prepared from Cuttle fish) 200CH, three powders, one powder taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated that the participant had a strong *vital force*

- *Sepia officinalis* 6CH, a quarter capful of granules taken every morning. The reason for prescribing the 6CH granules was to continually stimulate the participant’s *vital force*

Motivation for Remedy Selection

The *Sepia officinalis* patient is irritable, easily offended, and sad. This was expressed by this participant in that small trifles like driving and traffic made her irritable. The participant was averse to her son and would have liked him to move out of home. This was characteristic of *Sepia officinalis*, in that they are indifferent to their families (Vermeulen, 1997:1460).

*Sepia officinalis* headaches are described as a sensation of ‘Fullness in the forehead, surging in the forehead, like waves of pain rolling up and beating against frontal bone’ better for lying down and aggravated by movement (Vermeulen, 1997:1461). This was seen in the participant’s headaches.

A very characteristic symptom of *Sepia officinalis* was the feeling as if everything would escape through the vagina (Vermeulen, 1997:1466); this was seen in the participant in that her dysmenorrhoea felt as if her insides were being torn out.

Some more of the general symptoms that were distinct in the case, reflecting the *Sepia officinalis* picture included:

- Feels cold even in a warm room
- Aversion to meat
- Voracious appetite
- Constipation, large, hard stools and cannot strain
• Sudden hot flushes during the climax (Vermeulen, 1997:1459-1466)

4.8.2 Second Consultation- May 2004

The second consultation took place four weeks after the first consultation. The participant reported that her hot flushes had decreased in frequency and severity, and were precipitated by hot drinks and emotions.

The participant had not menstruated since the last consultation.

The participant felt more energetic, was sleeping better, and was not waking as frequently.

The participant’s headaches were still occurring, but less frequently and were less severe.

The participant reported that her concentration levels seemed better, she was not as irritable and was feeling happier with her son.

The participant’s joint pain in her knees was much better.

Observations and Vital Signs

The following vital signs were recorded:
• Blood Pressure: 110/65 right arm, lying down
• Pulse Rate: 60 beats per minute, regular
• Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 16 on the Kupperman Menopause Index = mild menopausal symptoms
Discussion

The researcher was happy with the participant’s general feeling of well-being.

The participant’s joint pain, irritability, and concentration levels had all improved.
The hot flushes had decreased in severity and frequency and the participant was sleeping better.

The researcher instructed the participant to continue taking the *Sepia officinalis*.

Prescription

- *Sepia officinalis* 6CH, a quarter capful of granules taken every morning

4.8.3 Third Consultation- June 2004

The third consultation took place four weeks after the second consultation. The participant had very few hot flushes since the last consultation and they were very mild.

The participant’s joint pain was remarkably better and had not had any pain since the last consultation.

The participant had been experiencing more headaches. She said it felt ‘as if something or a weight was sitting on her head’. The headaches occurred mostly at night and woke the participant between 1-3 am.

The participant reported an improvement of her concentration and energy levels. Despite the headaches, she felt better physically and emotionally, and was coping better with her stress.

The participant was less constipated and was able to pass a stool easily.

The participant had menstruated. She did not have any dysmenorrhoea or breast tenderness.
Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 115/60 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 5 on the Kupperman Menopause Index = a favourable therapeutic result

Discussion

The researcher was pleased with the participant’s overall improvement and instructed the participant to take the remedy three times a week.

Prescription

- Sepia officinalis 6CH, a quarter capful taken three time a week

4.8.4 Final Consultation- July 2004

The final consultation took place four weeks after the third consultation. The participant was pleased to inform the researcher that she had only two headaches since the last consultation that she was sleeping better, was not waking up during the night and had not had any joint pains and hot flushes.

She was feeling well and was not depressed.
Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 115/60 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 9 on the Kupfferman Menopause Index = a favourable therapeutic result
- $17\beta$ Oestradiol $= 286.9 \text{ pmol/l}$

Discussion

The participant was pleased with her treatment. She felt great and was very happy about the decreased frequency of her headaches. The researcher did not feel the need for another prescription and instructed the participant to stop taking the Sepia officinalis.

Prescription

- Nil

4.8.5 Overview of Case Eight

The participant responded positively to the Sepia officinalis. The remedy affected the participant’s vital force sufficiently to maintain mental, emotional, and physical health. The researcher was convinced that Sepia officinalis was the participant’s simillimum remedy. The increase in the participant’s serum oestrogen levels from 84.9 pmol/l to 286.9 pmol/l was indicative of the improvement of the participant’s symptoms.

On the initial Kupfferman Menopause Index the participant scored 28, and at the last consultation scored 9. This indicated a lessening in the severity of the participant’s climacteric symptoms.
4.9 CASE NINE

4.9.1 First Consultation - May 2004

Summary of Presenting Case

- Date of birth: 7/07/1949
- Black female
- Widow
- Printing machine operator
- Three children
- Resides in Johannesburg

An overweight female, 55 years of age presented with climacteric symptoms. The participant had been experiencing the symptoms for the last year.

The participant complained of hot flushes accompanied by perspiration of her head and face, which occurred anytime of the day. The participant described the hot flushes as if hot air from an air conditioner was blown on her head. The hot flushes were aggravated by hot weather. The participant's pillow would become wet and she would uncover her feet at night, during sleep.

The participant was still menstruating. Her menses were irregular and lasted for 2-3 days.

The participant would go to bed at about 9 pm and would wake at about 2 am, unable to fall back to sleep. She often dreamt of flying, driving, snakes, and her deceased mother. Her mother passed away in 1998 and the participant still felt sad about it.

The participant's husband passed away in 2000 from a car accident. The participant was married for 26 years. The participant said that maybe she should have died with her husband, as she did not go with him to church that day.
The participant was very sensitive to odours, especially of bad odours. She sometimes cried if the odour was very strong and felt better after she cried.

The participant expressed her hatred of people lying and said people should admit to their wrong doings.

**Generals**

Food aversions- Red meat (it made the participant’s stomach feel heavy)
Food desires- Spinach, mielie meal, fish and vegetables
Food aggravations- None
Appetite- Good appetite
Thirst- Thirsty. Drinks 1-2 litres of water per day
Bowels- Good
Urine- Good
Weather- Preferred winter
Energy levels- Good

**Medical History**

- Date of birth: 7/07/1949
- Three pregnancies→ the first two delivered by natural birth and the third delivered by caesarean
- Arthritis of the left knee and ankle

**Observations and Vital Signs**

The following vital signs were recorded:
- Blood Pressure: 130/70 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 15 on the Kupperman Menopause Index = mild menopausal symptoms
• $17\beta$ Oestradiol = 52.0 pmol/l

Prescription

• *Lachesis muta* (prepared from the Suracucu snake) 200CH, three powders, one powder taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated and that the participant had a strong *vital force*
• *Lachesis muta* 6CH, a quarter capful of granules taken every morning. The reason for prescribing the 6CH granules was to continually stimulate the participant’s *vital force*

Motivation for Remedy Selection

The *Lachesis muta* patient has flushes of heat worse at night (Vermeulen, 1997:1001); this was seen in the participant.

The *Lachesis muta* patient may dream of snakes and of the dead (Vermeulen, 1997:1001).

*Lachesis muta* patients are typically affected on the left side of their body (Vermeulen, 1997:1000). This was expressed by the participant and was seen in the participant’s rheumatism of the left knee and ankle.

*Lachesis muta* is a leading remedy for menopausal aggravations.

4.9.2 Second Consultation- June 2004

The second consultation took place four weeks after the first consultation. There was no change in the severity or frequency of the participant’s hot flushes.

The participant felt better, more energetic, slept well, and was waking refreshed in the morning.
Observations and Vital Signs

The following vital signs were recorded:
• Blood Pressure: 125/70 right arm, lying down
• Pulse Rate: 62 beats per minute, regular
• Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 19 on the Kupperman Menopause Index = mild menopausal symptoms

Discussion

The researcher was pleased with the general feeling of improvement in the participant. The participant was instructed to continue taking the 6CH *Lachesis mutus* every day.

Prescription

• *Lachesis mutas* 6CH, a quarter capful of granules taken every morning

4.9.3 Third Consultation- July 2004

The third consultation took place four weeks after the second consultation. The participant expressed her happiness about sleeping well. She was not waking during the night, and was sleeping through to about 5 am.

The participant’s hot flushes had decreased in severity and frequency, and the participant was feeling very happy.
Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 130/70 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 15 on the Kupperman Menopause Index = mild menopausal symptoms

Discussion

The researcher was pleased with the improvement of the hot flushes and the participant’s general feeling of well being. The participant was instructed to take the remedy three times per week.

Prescription

- *Lachesis mutus* 6CH, a quarter granules taken three times a week

4.9.4 Final Consultation- August 2004

The final consultation took place four weeks after the third consultation. The participant’s hot flushes had decreased dramatically in severity and frequency.

The participant was feeling better emotionally and mentally. She was more relaxed.

Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 130/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
• Temperature: 37 degrees Celsius
• The participant scored 17 on the Kupperman Menopause Index = mild menopausal symptoms
• $17\beta$ Oestradiol = 23.5 pmol/l

Discussion

The participant felt that the *Lachesis muta* had sufficiently reduced the severity and frequency of her hot flushes, and was happy with the outcome of the study.

4.9.5 Overview of Case Nine

On the initial Kupperman Menopause Index the participant scored 15, and scored 17 at the last consultation. This indicated a slight worsening in the severity of the participant’s climacteric symptoms, despite the improvement in the participants well being and the alleviation of her hot flushes.

The initial serum level of oestrogen was 52.0 pmol/l and the final serum oestrogen level had decreased to 23.5 pmol/l.
4.10 CASE TEN

4.10.1 First Consultation- June 2004

Summary of Presenting Case

- Date of birth: 3/10/1959
- White female
- Married
- Housewife and student
- Three children
- Resides in Johannesburg

A plump female, 45 years of age presented with climacteric symptoms. The participant had been experiencing the symptoms for the last year.

The participant complained of vaginal dryness, which sometimes resulted in cracking of the mucosa of the vagina. The participant had a tendency towards thrush of the vagina, which made the participant itchy. The thrush was aggravated by soap.

The participant was still menstruating and her menstrual cycle had reduced from 24 days to 19 days. The flow of the participant’s menses had decreased, was bright red and clotted. The participant’s menses were accompanied by pelvic dysmenorrhea on the first day of the menses, which was of a constant, diffuse pain. Breast tenderness, breast swelling and temporal headaches often accompanied the menses. The headaches were aggravated by noise, caused the eyes to redden, and usually occurred the day before menstruating or on the first day of menstruating, but they did not occur with every menses. The participant usually became ‘moody’ a week before menstruating. She became tearful and irritable, and did not feel in control.

The participant had a fear of heights, insects and was claustrophobic. The participant was aggravated by wearing polo necks, as she felt claustrophobic.
The participant described herself as an introverted, serious person and short tempered.

Generals

Food aversions- Okra, slimy foods, rocket, curries, greasy food, and pasta
Food desires- Sweets, avocado pear and toasted cheese
Food aggravations- Fish and shellfish (the participant had an allergy to fish and shellfish, it caused severe eczema)
Appetite- Good
Thirst- 1-2 litres of water per day. Drank four cups of tea per day. When the participant was pregnant, she could not drink tea or coffee as it made her nauseous
Bowels- The participant had a tendency towards constipation. The constipation started during the participant’s last pregnancy. The participant had the urge to go to the toilet, but was unable to pass a stool. The participant may pass a stool every second or third day
Urine- Fine
Energy levels- Good
Sleep- The participant slept well. She seldom remembered her dreams

Medical History

- Date of birth: 3/10/1959
- The participant suffered from chronic asthma, which was precipitated by pollen, smoke, and fish and was aggravated at the coast. The participant took Ventolin® and Seretide® daily
- The participant had bronchopneumonia as a child
- Three pregnancies delivered by natural birth
- Haemochromatosis (homozygous)

Allergies

- Fish
- Seafood
Medication

- Ventolin® and Seretide®

Observations and Vital Signs

The participant was very cheerful and tried to explain all her symptoms to the researcher with great enthusiasm.

The following vital signs were recorded:
- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 11 on the Kupferman Menopause Index
- $17\beta$ Oestradiol = 314.0 pmol/l

Prescription

- Sepia officinalis (prepared from Cuttle fish) 200CH, three powders, one powder taken daily for the first three days of treatment. The researcher prescribed the 200CH potency as she felt the remedy was well indicated and that the participant had a strong vital force
- Sepia officinalis 6CH, a quarter capful of granules taken every day. The reason for prescribing the 6CH granules was to continually stimulate the participant’s vital force

Motivation for Remedy Selection

Patients requiring Sepia officinalis are usually relaxed, weak, pot-bellied mothers and more often brown-haired people.
The participant and the remedy both share the following symptoms:

- Marked dryness of the vaginal mucosa and diminished sexual desire
- Constipation during pregnancy and chronic obstinate constipation
- Asthma
- Desire for sweets
- Irritability and easily offended (Vermeulen, 1998:1464-1467)

4.10.2 Second Consultation - July 2004

The second consultation took place four weeks after the first consultation. The participant complained of gastritis due to the remedy. She said her bowels were bloated, her abdomen was painful, and she had had diarrhoea. The participant said her pelvic organs felt very congested and that she had experienced dysmenorrhoea type pains without menstruating. The pains lasted for about two days. The participant menstruated five days after the dysmenorrhoea.

Observations and Vital Signs

The following vital signs were recorded:

- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 60 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 11 on the Kupperman Menopause Index = remains unchanged

Discussion

The researcher did not think the gastritis was caused by the remedy. However, the participant was insistent that the remedy had caused the gastritis and the researcher advised the participant to stop taking the remedy for a week.
Prescription

- Nil for the first week after the second consultation
- Sepia officinalis 6CH, a quarter capful of granules taken every second day. The researcher reduced the dose as she felt the participant might have had been proving the remedy

4.10.3 Third Consultation- August 2004

The third consultation took place five weeks after the second consultation. The participant felt very irritable and shorttempered. She said small trifles were making her irritable and frustrated. She would cry after becoming irritable, and she felt better after crying.

The participant complained of heartburn and a worsening of her vaginal dryness. The participant’s libido was decreased due to the vaginal dryness.

Her menstrual cycle had shortened to 22 days and her menses was accompanied by breast engorgement.

The participant’s bowels had returned to being constipated.

The participant had been experiencing temporal headaches, which were aggravated by noise.

Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 125/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minute, regular
- Temperature: 37 degrees Celsius
- The participant scored 3.5 on the Kupferman Menopause Index = a favourable therapeutic result
Discussion

The researcher was unsatisfied with the persistence of the participant’s symptoms. The case was re-evaluated and *Natrum muriaticum* was prescribed.

Prescription

- *Natrum muriaticum* 30CH, a quarter capful of granules taken daily.

4.10.4 Final Consultation- September 2004

The final consultation took place four weeks after the third consultation. The participant was feeling much better. She was less irritable and more relaxed. She was less constipated and found it easier to pass a stool.

The participant’s energy levels had improved and she had only had two headaches since the last consultation, which were not severe.

The participant had menstruated for about four days. The menses were not heavy and was accompanied by dysmenorrhoea of the lower abdomen.

Observations and Vital Signs

The following vital signs were recorded:
- Blood Pressure: 120/65 right arm, lying down
- Pulse Rate: 62 beats per minute, regular
- Respiratory Rate: 20 breaths per minuet, regular
- Temperature: 36.9 degrees Celsius
- The participant scored 6 on the Kupperman Menopause Index = a favourable therapeutic result
- $17\beta$ Oestradiol = 319.3 pmol/l
Discussion

The researcher was happy about the alleviation of the participant's symptoms, and the general feeling of well being. The participant was instructed to continue taking the *Natrum muriaticum* for another week.

4.10.5 Overview of Case Ten

The participant's response to the *Sepia officinalis* was partial. The researcher did not think the gastritis was caused by the *Sepia officinalis*, but rather it was coincidental to the starting of the remedy. The researcher felt the *Natrum muriaticum* to be of a more appropriate remedy, and this was seen in the alleviation of the participant's symptoms.

On the initial Kupperman Menopause Index the participant scored 11, and at the last consultation scored 6. This indicated a lessening in the severity of the participant's climacteric symptoms.

The initial serum level of oestrogen was 314.0 pmol/l and the final serum oestrogen level had increased to 319.3 pmol/l.
CHAPTER FIVE

RESULTS

5.1 INTRODUCTION TO RESULTS

The Kupperman Menopause Index (Appendix D) was used to assess the participant’s subjective feelings about her symptoms. It helped the researcher assess whether or not the participant’s symptoms were worsening or improving. Lowered scores on the Kupperman Menopause Index indicated less severe symptoms and higher scores indicated more severe symptoms. The scores for each patient were plotted on a bar graph to demonstrate any change in the severity of the climacteric symptoms, in response to homoeopathic treatment, over a three-month study period.

The serum oestrogen screen was used to assess whether the homoeopathic *similimum* remedy had an effect on the levels of *17β Oestradiol*. The levels for each patient obtained before the commencement of treatment and at the end of the three-month study, were plotted on a bar graph to demonstrate any change in the serum levels of *17β Oestradiol*.

All figures used to chart the graphical representation of the results are to be found in Tables E1 and E2 (Appendix E).
5.2 RESULTS OF CASE ONE

5.2.1 Kupperman Menopause Index Scores

Figure 5.1 below shows a reduction of the Kupperman Menopause Index score. The initial score of 26, at the commencement of the study, was reduced to 10.5 by the end of the study, which is termed as a "favourable therapeutic result" (Schaper and Brümmer, 1997:12).

![Kupperman Menopause Index Scores](image)

5.2.2 Serum Oestrogen Screens

Figure 5.2 below shows an increase in the levels of 17β Oestradiol, from 135.6 pmol/l at the commencement of the study to 488.2 pmol/l by the end of the study.

![17β Oestradiol pmol/l](image)
5.3 RESULTS OF CASE TWO

5.3.1 Kupperman Menopause Index Scores

Figure 5.3 below shows a reduction in the Kupperman Menopause Index score. The initial score of 28, at the commencement of the study, reduced to 5 by the end of the study, which is termed as a “favourable therapeutic result” (Schaper and Brümmer, 1997:12).

![Bar graph showing Kupperman Menopause Index Score]

5.3.2 Serum Oestrogen Screens

Figure 5.4 below shows an increase in the levels of $17\beta$ Oestradiol, from 63.8 pmol/l at the commencement of the study to 179.5 pmol/l by the end of the study.

![Bar graph showing 17β Oestradiol pmol/l levels]
5.4 RESULTS OF CASE THREE

5.4.1 Kupperman Menopause Index Scores

Figure 5.5 shows a reduction in the Kupperman Menopause Index score. The initial score of 36, at commencement of the study, reduced to 16 by the end of the study, which is termed as “mild menopausal symptoms” (Schaper and Brümmer, 1997:12).

5.4.2 Serum Oestrogen Screens

Figure 5.6 shows a decrease in the levels of $17\beta$ Oestradiol, from 49.3 pmol/l at the commencement of the study to 2.8 pmol/l by the end of the study, contrary to Figure 5.5, which shows a decrease in the Kupperman Menopause Index score.
5.5 RESULTS OF CASE FOUR

5.5.1 Kupperman Menopause Index Scores

Figure 5.7 shows a reduction of the Kupperman Menopause Index score. The initial score of 16 at the commencement of the study, decreased to 6 by the end of the study, which is termed as a "favourable therapeutic result" (Schaper and Brümmer, 1997:12).

![Kupperman Menopause Index Scores Graph]

5.5.2 Serum Oestrogen Screens

Figure 5.8 below shows an increase in the levels of $17\beta$ Oestradiol, from 41.6 pmol/l at the commencement of the study to 167.1 pmol/l by the end of the study.

![Serum Oestrogen Screens Graph]
5.6 RESULTS OF CASE FIVE

5.6.1 Kupperman Menopause Index Scores

Figure 5.9 below shows that the initial Kupperman Menopause Index score of 13, at the commencement of the study, was only slightly reduced to 9 at the end of the study, which is termed as a “favourable therapeutic result” (Schaper and Brümmer, 1997:12).

5.6.2 Serum Oestrogen Screens

Figure 5.10 below shows an increase in the levels of 17β Oestradiol, from 147.2 pmol/l at the commencement of the study to 155.1 pmol/l by the end of the study.
5.7 RESULTS OF CASE SIX

5.7.1 Kupperman Menopause Index Scores

Figure 5.11 shows a reduction of the initial Kupperman Menopause Index score of 28, at the commencement of the study, to a score of 10 at the end of the study, which is termed as a "favourable therapeutic result" (Schaper and Brümmer, 1997:12).

![Kupperman Menopause Index Scores](image)

5.7.2 Serum Oestrogen Screens

Figure 5.12 below shows an increase in the levels of $17\beta$ Oestradiol, from 43.1 pmol/l at the commencement of the study to 55.5 pmol/l by the end of the study.

![Serum Oestrogen Screens](image)
5.8 RESULTS OF CASE SEVEN

5.8.1 Kupperman Menopause Index Scores

Figure 5.13 below shows that the Kupperman Menopause Index score was reduced from an initial score of 20, at the commencement of the study, to scores of 9 and 7 at the third and final consultations respectively, which is termed as a “favourable therapeutic result” (Schaper and Brümmer, 1997:12).

![Diagram showing Kupperman Menopause Index scores over visits 1 to 4.]

5.8.2 Serum Oestrogen Screens

Figure 5.14 below shows a decrease in the levels of $17\beta$ Oestradiol, from 947.3 pmol/l at the commencement of the study to 181.9 pmol/l by the end of the study.

![Diagram showing $17\beta$ Oestradiol levels before and after treatment.]

5.9 RESULTS OF CASE EIGHT

5.9.1 Kupperman Menopause Index Scores

Figure 5.15 below shows a sharp reduction in the initial Kupperman Menopause Index score of 28, at the commencement of the study, to a score of 5 at the third consultation. The score then increased slightly to 9 at the end of the study, which is termed as a “favourable therapeutic result” (Schaper and Brümmer, 1997:12).

![Kupperman Menopause Index Scores](image)

5.9.2 Serum Oestrogen Screens

Figure 5.16 below shows an increase in the levels of \(17\beta\) Oestradiol, from 84.9 pmol/l at the commencement of the study to 286.9 pmol/l by the end of the study.

![17\beta Oestradiol pmol/l](image)
5.10 RESULTS OF CASE NINE

5.10.1 Kupperman Menopause Index Scores

Figure 5.17 below shows an increase of the initial Kupperman Menopause Index score of 15, at the commencement of the study, to 19 at the second consultation. The score then slightly decreased to 17 at the final consultation, which is termed as “mild menopausal symptoms” (Schaper and Brümmer, 1997:12).

![Kupperman Menopause Index Scores](image)

5.10.2 Serum Oestrogen Screens

Figure 5.18 below shows a decrease in the levels of $17\beta$ Oestradiol, from 52 pmol/l at the commencement of the study to 23.5 pmol/l by the end of the study.

![17\beta Oestradiol pmol/l](image)
5.11 RESULTS OF CASE TEN

5.11.1 Kupperman Menopause Index Scores

Figure 5.19 below shows a reduction of the initial Kupperman Menopause Index score of 11, at the commencement of the study, to 6 at the end of the study, which is termed as a "favourable therapeutic result" (Schaper and Brümmer, 1997:12).

![Kupperman Menopause Index Scores](image)

5.11.2 Serum Oestrogen Screens

Figure 5.20 below shows a slight increase in the levels of $17\beta$ Oestradiol, from 314 pmol/l at the commencement of the study to 319.3 pmol/l by the end of the study.

![17β Oestradiol pmol/l](image)

Before | After
5.12 COMBINED RESULTS OF THE TEN CASES

5.12.1 Average Kupperman Menopause Index Scores of the Ten Cases

Figure 5.21 below shows the reduction in the average of the Kupperman Menopause Index scores from 22.1 at the start of the study, to 9.6 on completion of the study, which is termed as a "favourable therapeutic result" (Schaper and Brümmer, 1997:12).

The differences in the mean values among the treatment groups are greater than would be expected by chance; there is a statistically significant difference (P = <0.001).
5.12.2 Average Serum Oestrogen Screens of the Ten Cases

Figure 5.22 below shows a slight reduction in the average of the serum oestrogen levels from 188 pmol/l at the commencement of the study, to 186 on completion of the study.

The difference in the mean values of the two groups is not great enough to reject the possibility that the difference is due to random sampling variability. There is not a statistically significant difference between the input groups ($P = 0.985$).
CHAPTER SIX

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

6.1 DISCUSSION AND CONCLUSION

Within the three month study period, participants demonstrated a significant improvement of their climacteric symptoms. Most of the participants' symptoms were ameliorated within the first four weeks of treatment and continued to be ameliorated but at a slower rate. The results indicated a general improvement of well being and energy of the participants.

Each participant was treated according to her symptoms and was prescribed a similimum. Each participant was evaluated individually and the treatment individualised. It must be noted that each participant's vital force acted in its own capacity, and thus determined the rate and intensity with which each participant progressed. The stronger the participants vital force, the more likely a quicker response to the similimum. The protocol for each participant was individualised and the length of therapy and number of remedies prescribed depended upon each participant's vital force.

The Kupperman Menopause Index scores indicated the subjective results of each participant. Seven participants suffered from hot flushes when commencing the study and by the end of the study the intensity and frequency of all the participants hot flushes had decreased. Seven participants suffered from sleeping problems when commencing the study and by the end of the study, six of these participants sleeping problems had lessened, and one had stayed the same. Eight participants complained of nervousness and irritability when commencing the study. By the end of the study, five of the participants were less irritable and nervous, two participants had not changed, and one participant felt more irritable and nervous. At the commencement of the study, eight participants were depressed, by the end of the study, five of these participants were not depressed anymore, and the other three had stayed the same. Seven participants complained of headaches at the commencement of the study. The severity and frequency of the headaches had decreased for all seven participants by the end of the study. Seven participants suffered with joint
pain at the commencement of the study. By the end of the study, six of these participants joint pain had been alleviated. Nine participants complained of inability to concentrate at the commencement of the study. Eight of these participants felt that their concentration levels had improved by the end of the study and one of these participants felt that her concentration levels had stayed the same. At the commencement of the study, four participants complained of vertigo. By the end of the study, only one of these participants continued to suffer from occasional vertigo. At the end of the study, eight of the participants Kupperman Menopause Index scores were less than fifteen, which is termed as a favourable therapeutic result (Schaper and Brümmer, 1997:12).

It was found that seven out of the ten participants' serum oestrogen levels increased and three decreased. The serum oestrogen levels were difficult to evaluate, as they are erratic due to natural variations and fluctuations during the climacteric. Despite the serum oestrogen levels being conducted at the same time of each month of the participants' cycles, the cycles were not perfectly regular and therefore the serum oestrogen screens were not a useful tool and had no statistical value.

In conclusion, the researcher found homoeopathy to be a very useful alternative form of treatment of climacteric symptoms and observed its mild, curative action upon all spheres of the participants. The time and cost factor over this period appears to be well justified as homoeopathic remedies are cheap, whereas hormone replacement therapy is expensive, requires specialist treatment and regular adherence. Homoeopathic studies need be done on larger scales and for longer periods of time in order to ascertain the long-term benefits and side effects (Penny, 2004:46).
6.2 RECOMMENDATIONS

6.2.1 Continued Studies

Based on the results of this study, it is recommended that further studies be carried out and documented so that:

- A larger sample of participants be exposed to homoeopathic medicines
- Participants are monitored for a longer period of time so as to observe the long term effects of homoeopathic medicines
- Two samples of participants with climacteric symptoms be studied to compare the results of participants receiving placebos versus those receiving their *similimum*
- Two samples of participants with climacteric symptoms be studied to compare the results of participants receiving a complex homoeopathic product versus those receiving their *similimum*
- A study be performed within one season, as hot flushes are influenced by environmental temperatures
- A study be performed by prescribing one homoeopathic remedy that is commonly prescribed for the climacteric and menopause
- A study be performed by prescribing single phytotherapeutic preparation for the treatment of climacteric symptoms, examples are Wild yam (*Dioscorea villosa*), Black cohosh (*Cimicifuga racemosa*), etcetera
- The serum oestrogen screen is not utilized, as there was poor statistical value in this investigation and the test is expensive
- It would be valuable to do a full menopausal blood screen as this would analyse the levels of luteinizing hormone, follicle stimulating hormone, progesterone and oestrogen
- The Kupperman Menopause Index be utilised in further studies and in menopausal management as it proved useful in this dissertation
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- A study be performed within one season, as hot flushes are influenced by environmental temperatures
- A study be performed by prescribing one homoeopathic remedy that is commonly prescribed for the climacteric and menopause
- A study be performed by prescribing single phytotherapeutic preparation for the treatment of climacteric symptoms, examples are Wild yam (*Dioscorea villosa*), Black cohosh (*Cimicifuga racemosa*), etcetera
- The serum oestrogen screen is not utilized, as there was poor statistical value in this investigation and the test is expensive
- It would be valuable to do a full menopausal blood screen as this would analyse the levels of luteinizing hormone, follicle stimulating hormone, progesterone and oestrogen
- The Kupperman Menopause Index be utilised in further studies and in menopausal management as it proved useful in this dissertation
6.2.2 Potential for Technology Transfer

The value of such a study is that people may consider homoeopathy as an alternative form of treatment for climacteric symptoms. Together with other health care workers such as nutritionists, allopathic practitioners, and psychologists, a multidisciplinary approach may be used in achieving physical, mental, and emotional well-being of participants suffering climacteric symptoms.

6.2.3 Benefits of the Study

- Homoeopathy offered a treatment that was cost effective and non-toxic for those suffering from climacteric symptoms
- The study should contribute to medical and homoeopathic knowledge and aid in the treatment of climacteric symptoms in future participants

6.2.4 Limitations of the Study

- The sample size of the study was small
- The Kupperman menopause index used was dependent on the truthfulness of each participant
- Participants commenced their treatment on different days and stopped their treatment on different days. The treatment period commenced between the months of February to September. During the treatment period, the seasons changed from being extremely hot to extremely cold and back to extremely hot. Hot flushes are usually more intense during hot weather (Rogers, 1995:87); therefore the change in weather might have affected the intensity, frequency and severity of hot flushes
- The serum oestrogen screens are expensive and did not yield any statistical viable information perhaps because the participants’ serum oestrogen levels are unpredictable during the climacteric and menopausal periods

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REFERENCES


Agrawal, YR (1997) Menstrual Disorders and Homeopathy, First edition, Vijay Publications, Delhi, India, p 45, 47


Bisson, D (1997) Menopausal Symptoms, Update, Volume 12, Number 10, pp 11-12


Marieb, EN (2001) *Human Anatomy And Physiology*, Fifth Edition, Daryl Fox (Publisher), United States of America, pp 1101, 1102


Remifemin, GlaxcoSmithKline, (10 December 2003), http://www.remifemin.com/5


Schaper and Brümmer (1997) *Remifemin®, The Herbal Preparation for Gynecology*, Schaper and Brümmer, Salzgitter, Germany, p 12


Schaper and Brümmer (1997) *Remifemin®, The Herbal Preparation for Gynecology*, Schaper and Brümmer, Salzgitter, Germany, p 12


APPENDIX A

SUITABILITY CRITERIA QUESTIONNAIRE

Name: 
Address: 
Telephone number: 
Date of birth: 
Date: 

Please note: only female participants are required for this study.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is the volunteer between 42 and 58 years of age?</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>Which climacteric symptoms is the patient experiencing?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1. Hot flushes</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.2. Profuse sweating</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.3. Sleeping problems</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.4. Nervousness/irritability</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.5. Depressive moods</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.6. Feelings of vertigo</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.7. Inability of concentration</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.8. Joint pain</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.9. Headache</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>2.10. Heart palpitations</td>
<td>☐</td>
</tr>
<tr>
<td>3.</td>
<td>3.1 Is the volunteer on any other treatment for climacteric?</td>
<td>☐</td>
</tr>
</tbody>
</table>

*If the volunteer has been on hormone replacement therapy before:*

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Been off the therapy for three months or more?</td>
<td>☐</td>
</tr>
</tbody>
</table>
4. Menstrual history:

4.1 Date of menarche: ________________________________

4.2 Dysmenorrhoea: ________________________________

4.3 Length of time that climacteric symptoms have been experienced: __________

4.4 Is the volunteer still menstruating? ________________________________

4.4.1 If NO, date of the last menstrual period: ________________________________

5. Climacteric Symptoms:

5.1 Is the cause of any of the climacteric symptoms due to a process unrelated to climacteric?

_____________________________________________________________

5.2 Is the climacteric natural? ________________________________

The volunteer will be excluded from the study if she has had a total hysterectomy, undergone any process where the ovaries blood supply has been impaired, undergone any irradiation, chemotherapy, drug treatment, or received any treatment that has caused climacteric symptoms, or if she has premature failure of the ovaries.
APPENDIX B

PATIENT INFORMATION AND CONSENT FORM

Dear Participant

Climacteric is an important period in a woman’s life. It is a period of hormonal adjustment and can be accompanied by many symptoms.

The aim of this study is to determine the efficacy of homoeopathy in treating climacteric symptoms. Homoeopathy will offer cheaper alternative to treatment of climacteric and there are no side effects.

You, the participant is experiencing climacteric symptoms and has agreed to participate in this study. The treatment will be free, and you are required to participate in the study for three consecutive months.

All participants in this research project must be female and between the ages of forty-two and fifty-eight years of age. You must be experiencing climacteric symptoms, and must not be on any other treatment for your climacteric symptoms. Your climacteric must be natural and not artificially or surgically induced.

All volunteers will first be requested to complete a questionnaire, with the help of the researcher, in order to select suitable participants for the study. You will be required to complete another questionnaire, under the supervision of the researcher, at the beginning of the research, and then at the fourth, eighth and twelfth week. The questionnaire is repeatedly completed to analyse any changes experienced by you through the trial period. Blood samples will be taken from you at the first and last consultation to assess any changes in the blood oestrogen levels. The participant will receive medication at the first, fourth, and eighth week consultations. The research supervisor will select the medication needed. You will be requested to take the medication provided for the twelve-week period.
To the best of the researcher’s knowledge, there are no risks anticipated in this study. Any complications arising during the study will immediately be brought to the clinician’s attention, and the participants will be withdrawn from the research. Contact details of the researcher and the clinician will be given to the participants.

The potential benefit for the participants is an improvement or eradication of climacteric symptoms. All participants will be contributing to medical and homoeopathic knowledge, adding to the much-needed research on the benefits and risks of alternative therapies.

Taking part in this study is voluntary and the participant is free to refuse or withdraw her consent and can, at any time, discontinue her participation. A signed copy of this consent form will be made available to the participant. The researcher has explained the procedures and their purposes, and has answered any questions from the participants to the best of her ability.

__________________________________________

RESEARCHER: _______________ DATE: _______________

Contact number: 083 324 2916

I have been fully notified about the procedures that will be followed in this research study. If, at time, I have more questions about the study, I understand that they will be answered. In signing this consent form, I agree to the method of treatment and understand that I may withdraw my consent at any time.

PARTICIPANT: ______________________ DATE: _________________
APPENDIX C

THE MODIFIED KUPPERMAN MENOPAUSE INDEX

Instructions: The participant will be assisted by the researcher at each consultation to complete the index.

The participant is requested to grade the severity of her symptoms as follows:

1. Severe....................3
2. Moderate................2
3. Mild.......................1
4. Not present.............0

Participant name:..................................................
Remedy reference number:.........................................

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Week.....</th>
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<td>Hot flushes</td>
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<tr>
<td>Profuse sweating</td>
<td></td>
</tr>
<tr>
<td>Sleeping problems</td>
<td></td>
</tr>
<tr>
<td>Nervousness/irritability</td>
<td></td>
</tr>
<tr>
<td>Depressive moods</td>
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<tr>
<td>Feelings of vertigo</td>
<td></td>
</tr>
<tr>
<td>Inability of concentration</td>
<td></td>
</tr>
<tr>
<td>Joint Pain</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td>Heart palpitations</td>
<td></td>
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</tbody>
</table>
APPENDIX D

THE KUPPERMAN MENOPAUSE INDEX

Participant Name: ....................................................
Remedy reference number: ........................................

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Constant</th>
<th>Before treatment</th>
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<th>Week Eight</th>
<th>After treatment</th>
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<tr>
<td>Joint pain</td>
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<td>Head ache</td>
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<td><strong>Total</strong></td>
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(Schaper and Brümmer, 1997:12; Remifemin, 2004)
APPENDIX E

TABLES

Table E1 illustrates the Kupperman Menopause Index scores totalled at each consultation

<table>
<thead>
<tr>
<th>CASE</th>
<th>VISIT ONE</th>
<th>VISIT TWO</th>
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<td>11</td>
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<td>TWO</td>
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<td>THREE</td>
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<td>5</td>
<td>9</td>
</tr>
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<td>17</td>
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<td>11</td>
<td>3.5</td>
<td>6</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>22.1</td>
<td>16.2</td>
<td>9.1</td>
<td>9.6</td>
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</table>
Table E2 illustrates the serum oestrogen levels at the commencement of the study and at the end of the study.

<table>
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<tr>
<th>CASE</th>
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<th>AFTER</th>
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<tr>
<td>ONE</td>
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<td>488.2</td>
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<tr>
<td>TWO</td>
<td>63.8</td>
<td>179.5</td>
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<tr>
<td>THREE</td>
<td>49.3</td>
<td>2.8</td>
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<tr>
<td>FOUR</td>
<td>41.6</td>
<td>167.1</td>
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<tr>
<td>FIVE</td>
<td>147.2</td>
<td>155.1</td>
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<tr>
<td>SIX</td>
<td>43.1</td>
<td>55.5</td>
</tr>
<tr>
<td>SEVEN</td>
<td>947.3</td>
<td>181.9</td>
</tr>
<tr>
<td>EIGHT</td>
<td>84.9</td>
<td>286.9</td>
</tr>
<tr>
<td>NINE</td>
<td>52.0</td>
<td>23.5</td>
</tr>
<tr>
<td>TEN</td>
<td>314.0</td>
<td>319.3</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>188</td>
<td>186</td>
</tr>
</tbody>
</table>
APPENDIX F

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To Whom It May Concern

If a student/staff member includes a questionnaire or graph/diagram from a book or website in their research project/theses for criticism or review purposes (Section 12(b) of the Act), then clear acknowledgement of the source would suffice.

Thapelo Mashishi

Copyright Administrator