Study on Miasmatic Approach in Management of Urolithiasis

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Abstract: ***Urolithiasis is also known as Nephrolithiasis or Renal Calculus. The term urolithiasis means the presence of calculi, single or multiple, in the kidney or the urinary tract. Most cases of urolithiasis present with the predominant miasm of "sycosis", representing Calculi, complications of the Genito-urinary tract and various pains of the urinary tract & if treated according to the underlying miasm, the disease can be cured easily and rapidly without causing any other disharmony, and the recurrences may also be stopped.***

Keywords: Urolithiasis, Stones, Miasm, Homoeopathy

1. Introduction

Urolithiasis is also known as Nephrolithiasis or Renal Calculus. The term nephrolithiasis means the presence of calculi, single or multiple, in the kidney or the urinary tract. A calculus may form in the renal pelvis or in the bladder. It consists of a nucleus of organic matter. The salts, although crystalline in the urine, are in the form of amorphous granules in the calculus.

Predisposing factor for Kidney Stone:

1) Environmental and dietary -
    - Low urinary volumes: high ambient temp., low fluid intake.
    - Diet: high protein, high sodium, low calcium.
    - High urate excretion, High oxalate excretion.
    - Low citrate excretion.
2) Acquired causes-
    - Hypercalcemia of any cause.
    - Renal tubular acidosis type 1
3) Congenital and inherited causes -
    - Medullar sponge kidney
    - Renal tubular acidosis type 1

Types of Stones:

Calcium salts, uric acid, cystine, staghorn, xanthine and struvite (MgNh4PO4) are most common form of kidney stones, calcium oxalate and calcium phosphate stones make up 75 to 85 percent of total kidney stones.

Clinical Features:

1) Renal colic
2) Haematuria
3) Nephrocalcinosis
4) Recurrent UTI
5) Frequency and urgency

Physical Signs:

In majority of cases characteristic physical sign are not present. The sign which may be present and should be looked for are -

- Tenderness
- Muscle Rigidity
- Swelling

Complications:

- Calculus hydronephrosis
- Calculus pyonephrosis
- Renal failure
- Infections

Investigations:

1) **Urinalysis:-**
    a) Physical examination of urine:-This may show smoky urine due to slight haematuria.
    b) Chemical examination:-It may show presence of protein due to haematuria. If pH of urine is higher than 7.6, presence of urea splitting organism is assured. Low pH is a common cause of formation of uric acid calculi.
    c) Microscopic examination:-It may show RBC, pus cells and casts.

2) **Blood Examination:**

This hardly reveals any specific abnormality, but an increased WBC count may be seen when associated with infection. Renal function must be assessed by estimating blood urea, N. P. N, creatinine.

3) **Plain X-Ray KUB:**
    - At least 90% of renal stones are radio opaque.
    - Enlarge renal shadow can be seen.
    - Staghorn calculus can be easily diagnosed and there is no confusion with other radiopaque shadows.
4) **ULTRASOUND (USG):**
    Ultrasound scanning is of most value in locating stones or treatment by Extracorporeal Shock Wave Lithotripsy (ESWL). USG provide good images of the renal parenchyma and collecting system, and in nearly all patients gives a reliable estimate of renal size as well as identified discrete lesions within the parenchyma, hydronephrosis and stones.

    - Helpful to distinguish between opaque and non-opaque stones.

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- Exact size and location of stone can be evaluated.

5) **CT SCAN:**
The "Gold Standard" diagnostic test is helical CT without contrast. CT should be considered to definitively establish the base line stone burden.
6) **IVP (Intra Venous Pyelogram):**
To locate the stone exactly in relation to kidney and ureter and to assess renal function. A non-radio opaque stone can be seen as a filling defect. Intra venous urography involves the injection of organic iodine compounds that are excreted and concentrated radiographically. It is an extremely good technique for examining the renal collecting system, the ureter and the bladder, but gives less information than ultrasound about the renal parenchyma.

General Management:

- The required total fluid intake will vary from person to person. Rather than specific how much to drink, it is more helpful to educate the patient about how much more they need to drink. For example:-If the daily urine volume is 1.5ltr then patient should be advised to drink at least 0.5ltr more per day in order to increase the urine volume to 2ltr per day.
- Avoidance of milk, cheese and great deal of calcium should be advised.
- Urine should be kept acidic all time. Alkalis should be prohibited or used in less quantity in patients who are suffering from peptic ulcer.
- Vitamin D should be stopped or used in very low quantity.

<u>Miasmatic Relationship to Pathophysiology</u>:

PsoricSymptoms:

1) Psoric patients, especially those advancing age, experience a sensation of fullness in bladder.
2) Smarting and burning in the urinary meatus or in the lumbar area unrelated to any pathological causes might be present.
3) Modalities: Psora experiences agg from cold and amel from natural discharges such as urination.
4) Concomitants: Psoric urinary problems may be associated with anxiety, apprehension, and fear of incurable disease.
5) Flow: Psoric patients suffer from stress incontinence. The urine passes involuntarily and frequently, when sneezing, coughing, or laughing.
6) There may be burning and smarting resulting from acidic urine.
7) Kidneys: Fibrous changes in the kidney are Psoric in origin.
8) Enuresis: In psora, enuresis occurs especially in children as a result of anxiety and fear, or from other functional causes.
9) Urine: Psoric urine is generally dark but can also be yellowish or brownish.

Sycotic Symptoms:

1) Sycotic also has renal dropsy, renal calculi, and calculus deposits in other parts of the Genito-urinary tract.
2) Calculi, complications of the Genito-urinary tract and various pains of the urinary tract are generally Sycotic in manifestation.
3) Stitching and pulsating sensations with wandering pains are Sycotic.
4) Modalities: Sycotic urinary symptoms ate agg in damp, rainy weather and from the changes of the season.
5) Flow: In sycosis, micturition is painful. There may be contraction of the urethra, and children will scream while urinating.
6) Scanty urination (psora is mainly responsible for scanty discharges/excretions), but during the rainy season polyuria is a characteristic of this miasm.
7) Urinary cramps and painful spasms affecting the urethra and bladder may be present in sycosis.
8) Sycotic pts suffer from renal calculi with pains, which are stitching and wandering in character.
9) Urine: A yellow color represents sycosis.
10) Sycosis urine may have fish brine odor.

Syphilitic Symptoms:

1) All advanced conditions of the kidney and Genito-urinary tract, with pyogenic inflammations can be associated with structural and pathological changes and are therefore syphilitic in origin.
2) Burning and bursting sensation in the bladder or loin area are syphilitic.
3) Modalities: All syphilitic symptoms are agg at night, in summer, and from Warmth.
4) Most urinary complications are of Sycotic origin, but when in combination with Syphilis the result is diminished flow, and frequent desire for micturition with Burning and irritation during flow.
5) Irritation and burning of the parts, wherever the urine touches, indicates the Acridity of this miasm.
6) Fibrous changes with destructive manifestations in kidneys.
7) Urine: Red, the color of destruction, represents syphilis. Red colored urine with Streaks of pus is characteristic.

Tubercular Symptoms:

1) Haematuria: The tubercular miasm is responsible for the production of Haematuria resulting from different types of pathological manifestations of KUB.
2) A tickling sensation in the urethra is characteristic of the tubercular.
3) Modalities: Tubercular urinary manifestations agg at night and amel in the openair.
4) Concomitants: Restlessness, anxiety and weakness after micturition occur in the tubercular miasm.
5) The tubercular miasm is responsible for involuntary urination in children. Nocturnal enuresis in children should therefore undergo anti-tubercular treatment.
6) In the tubercular miasm there may be recurrent, intermittent, and periodic renal Spasm with bleeding (Haematuria), often noticed particularly during the new and full moon.
7) Albuminuria, and urine loaded with phosphate, sugar or protein are tubercular.
8) Urine: Tubercular urine is pale, colorless, and copious. An offensive, musty and putrid, even carrion like odor may be present. Haematuria occurs during sleep.

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2. Conclusion

The proper & effective Homoeopathic prescription must include miasmatic totality, manifested by the person. This helps to remove the constitutional stigma from the person. If the prescription fails in it, the dyscrasia, the susceptibility to get sick, remains untreated and leads to future recurrences of the disease & if treated according to the underlying miasm, the disease can be cured easily and rapidly without causing any other disharmony, and the recurrences may also be stopped.

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