Ulcerative colitis and diverticulitis

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Recently I reviewed the last ten years of the British Homeopathic Journal and I was surprised to find that no articles or papers on disorders of the colon had been published in that time. About a dozen individual cases had been scattered here and there.

Why was this? True that in general practice ulcerative colitis (or idiopathic proctocolitis to be up to date) is rare, so that a new patient is seen in the average general practice once in five years (Evans and Acheson, 1965).

But diverticulosis may be present in up to half the subjects aged 60 years or more (Misiewicz, 1974), though the great majority of diverticula give rise to no symptoms.

Perhaps another reason why few homeopathic physicians treat these patients is that both in colitis and diverticulosis, it is important in each case to exclude neoplasm and this generally involves referring the patient to an orthodox consultant for a barium enema or sigmoidoscopy, and so often this results in loss of contact with the patient, the radiologist reporting to the consultant only.

That these investigations are necessary and indeed should be repeated at regular intervals was brought home to me many years ago, when a city father from the South West was referred to me with diverticulitis; he responded well to homoeopathic treatment and after a few visits he was so much better, that, a very busy man with many committees and responsibilities, he contented himself with contact by occasional correspondence; so I was shocked to learn from his widow five years later that he had died from an operation for intestinal obstruction due to a carcinoma of the sigmoid colon.

First, let me discuss colitis. Lennard-Jones and Ritchie (1974) sum up that colitis is "a potentially dangerous illness that affects all age groups and diagnosis may be difficult." So the first differentiation to be made is to exclude amoebiasis. Avery Jones (1967) comments it is all too easy to accept a diagnosis of idiopathic proctocolitis in this country but if the patient has been overseas, even 20 years earlier, the stools should be completely examined for parasites. Our Indian colleague Krishnamurty (1966) adds amoebiasis as another chronic miasm to Hahnemann’s three miasms. He found that Mercurius was the remedy and reported five cases.

I choose this as the first illness to be distinguished from ulcerative colitis as the more likely in view of the rapid increase in the last decade of immigrants from India and Pakistan. But 24 years ago Dr. Beaumont (1950) in a clinical ward round on what proved to be a case of ulcerative colitis, elicited from his students no fewer than 19 diagnoses. One that his group did not list was ischaemia of the colon, a diagnosis only considered in the last 15 years, well written up and illustrated by the Norwich surgeon Marcuson (1974). It is most likely to occur in the same age group and from the same causes as coronary thrombosis. Passage of bright red blood and clots per rectum were a prominent feature in all but two patients (Marston et al., 1966). If this is a new diagnosis, in contrast I have to refer to an older unfashionable label.
A dozen years ago, I was asked to see an old woman of 68, who had been moved down from the London area to live as a semi-invalid with relatives in an out-of-the-way village in Somerset. She complained of exhaustion, unable to walk more than a few steps, restless limbs, gross flatulence, and constipation. Her previous prescriptions had been of Nux, Anacardium, Lachesis and Hyoscyamus. She was certainly irritable, volatile, and given to bad language. The picture was confused and I ordered a dose of Sulphur 30, hoping that this would clarify the indications. The result was startling as I had an indignant letter from the patient, claiming that she was now passing quantities of sand per rectum. And indeed this symptom was confirmed by the visiting district nurse who was also puzzled. So was I, but I looked up this symptom first in French’s (1912) Index of Differential Diagnosis of Main Symptoms: passage of sand per rectum had been observed in membranous colitis; it may be passed daily for weeks and then none is passed for several weeks. The sand is nearly all calcium phosphate and is not to be confused with the false sand to be found in the stools of those who have eaten largely of pears.

About this mucenembranous colitis, Lethby Tidy (1920) in his Synopsis of Medicine states that this illness occurs in neurotastic subjects, five female to every male; the women are thin and anaemic, with poor appetite, viscerotises, and muddy Complexions: passage of mucous casts and intestinal sand is common: treatment—irrigation of the colon each morning and instillation of olive oil at night, best carried out at a spa such as Ploombières or Harrogate. The NHS no longer supports the Spa at Harrogate.

Is this an extinct disease? There were still cases in Kent’s era. In his Repertory (Kent, 1924) “Sand-like stool” is a symptom of Argentum mettallicum, and in his lecture (Kent, 1923) on Argentum metallicum he refers to the exhaustion, fatigue, the restlessness, cannot keep still, cannot walk, the passage of dry stool like sand.

I sent this lady a dose of Argentum metallicum, but she indignantly refused to take it, and complained I had done her enough harm already. But it is interesting that the Sulphur had succeeded in restoring a previous feature of her long-standing chronic illness, for she admitted the sandy stool had previously occurred.

But even ulcerative colitis was a new diagnostic label 100 years ago (Wilks and Moxon, 1875) when it was distinguished from bacillary dysentery: one might have expected that Paterson’s node of Dysenteric Co. would have been tried more often but I can find only one case in the literature (Gibbs, 1970).

“A senior physiotherapist had complained of recurrent diarrhoea every 3 months. He had had this for 20 years. I was in his car and had reason to compliment him on his driving. ‘I have never had any driving lessons as I was a driver at Dunkirk.’ ‘Did you have dysentery?’ ‘Oh yes, we all did.’ I gave him Dys. Co. and his symptoms were considerably improved. Another dose 3 months later and he was completely cured.”

Dr. Gibbs considered at first that there was a psychosomatic element in this case.

In the thirties I read a paper on the psychological background of colitis to the Medical Society of Individual Psychology (Bodman, 1934) illustrated by 12 patients of my own. On this short series I commented that it was remarkable how so often the dominant mother was a feature—particularly, the widow who in the absence of the father has a reinforced authority. On the part of the patient, there seemed to be a remarkably childish outlook, a submission to the wishes
of her parents, and a lack of initiative in tackling the problem of earning a living. I claimed that colitis is “often the somatic expression of the emotional conflict between the reality ‘You must grow up’ and the phantasy ‘I want to retain my childish dependence on my mother’”.

But recent papers by Willoughby (1974) lay stress on a predisposition which is genetic. As long ago as 1962, two New Zealand doctors (Wriglay and McLaurin, 1962) published family trees showing five families affected with colitis, and commenting at the same time on the highly significant difference between the incidence of colitis in European and Maori families. Willoughby (1974, ii) published a table showing the incidence of ulcerative colitis, Crohn’s disease and ankylosing spondylitis in one family (Sherlock et al., 1963). Another sidelight on possible genetic factors is the discovery of a group of five unrelated Lithuanian emigrants, all suffering from Crohn’s disease, and all found to be suffering from a deficiency of the enzyme G-6-PD (glucose-6-phosphate dehydrogenase).

Predisposition may be genetic, but there may be a variety of precipitating causes, such as trauma, a virus, emotional stress. Our learned colleague, Pierre Schmidt (1966) in his address to the International Homoeopathic League in London on Homoeopathy and Psychosomatic Disorders listed homoeopathic remedies indicated in emotional diarrhoea and diarrhoeas from excitement, that is to say, the precipitating causes.

Diarrhoea after anger: ALOE, CALC. PHOS., CHAMOMILLA, COLOCYNTH, NUX VOMICA, STAPHISAGRIA
from anticipation: ARGENTUM NIT., GELSEMIUM, PHOSPHORIC ACID
from anxiety: ARSENICUM
from bad news: GELSEMIUM
after chagrin: Staphisagria
from domestic cases: COFFEA
from fright: ARGENTUM NIT., GELSEMIUM, KALI PHOS., PULSATILLA
from grief: COLOCYNTH, GELSEMIUM, IGNATIA, PHOSPHORIC ACID
after sudden joy: COFFEA, OPIUM
after vexation: CALCAREA PHOS., COLOCYNTH, PETROLEUM, STAPHISAGRIA

These remedies will deal with the effects of the precipitating cause, whatever it is, but in my view other remedies will be needed to deal with the constitutional predisposition, whatever it may be, missing enzyme, chronic virus infection, or whatever. This may be another reason at the scarcity of reports of ulcerative colitis in our literature because there will be few established cases cured by a single remedy. And the cure, rather than relief, of such a constitutional illness will be measured in months rather than days, and because of the natural tendency to relapse, cases need to be followed up for years if cure is to be substantiated.

But before I review some of the successes of my colleagues and discuss some of my own cases, let me deal with one more precipitating cause, this time a dietary one, sensitivity to milk: Truelove found that 6.5 per cent. of 200 colitis patients improved when milk was withdrawn from their diet (1961) and relapsed when milk was reintroduced. These patients registered higher figures for
antibodies to milk proteins than controls (Taylor and Truelove, 1961). Kent's Repertory has diarrhoea after milk.

CALCAREA, KALI-A, KALI-C, LYCOPODIUM, MAGNESIUM CARB., MAGNESIUM MURIATICUM, NATRUM ARSENIOSUM, NICCOLOM, NUX MOSCHATA, SEPIA, SILICA, SULPHUR.

(Kent, 1924).

Of the dozen cases of ulcerative colitis that I have found scattered through the last ten years of the British Homoeopathic Journal, let me refer to Dr. Ledermann's case (1967) of a 34-year-old woman with a ten years' history who had responded only temporarily to cortisone and psychotherapy. Hurry was the feature of this patient, always felt in a hurry, the food hurried along the digestive tract. Tarantula is one of the hurry remedies and helped this patient. Dr. Gibson (1967) in his Richard Hughes Memorial Lecture records a middle-aged European who had suffered from diarrhoea and dysentery for three years despite much treatment. He had had no remissions from his symptoms from the date on which the boat in which he was rowing had capsized and he, hot with perspiration, was thrown into cold water. He was ordered Dulcamara 200, one dose, and after this solitary powder the diarrhoea had ceased and freedom from symptoms was maintained during the three years follow-up.

Dr. Isabel Campbell (1968) reported on a woman of 57 with a 12-year history of diarrhoea, passing blood and mucus. Unable to go to a cinema, theatre or church, only ten minutes in a bus. Rush to stool in the morning and after any food; no meal till she was home in the evening. Sulphur 30 and Podophyllum 30 relieved but did not cure. Twelve years ago she had had a major gynaecological operation followed by deep X-ray therapy. This was when the diarrhoea began. Radium bromide 30 was prescribed and real improvement followed with a single, formed stool for the first time for twelve years. She was followed up for 12 years with no relapse.

Dr. Ross (1965) reported on a woman of 57 who had a form of colitis with a loose stool every evening for 14 months. Arsenicum album 200 began improvement but after 4 months she relapsed, this time China arsenicicum 30 was prescribed and steady improvement followed. Later she reported: "I am a new woman."

To illustrate in a little more detail the problems of treating these ulcerative colitis cases, let me report two of my cases. The first is a man of 28. His father suffered from ulcerative colitis. In the last war the home was damaged in an air-raid and as a 5-year-old he was evacuated with his mother. At 13 his ambition was to teach music and he later proceeded to university, but his thesis for a higher degree in music was rejected and the first attack of diarrhoea began which continued during his first year as a music teacher at a public school. He was referred to a consultant who considered him depressed and prescribed him Tofranil which he only took for a month. His general practitioner referred him to me with nausea, abdominal pain and diarrhoea. I arranged for sigmoidoscopy which revealed an irritable colon. He did not improve on Argentum nit., but developed a labyrinthine type of vertigo which Cocculus indica improved. His general practitioner, a homoeopathic physician, prescribed Aloes and Mercurius corrosivus with little effect; depressed at so little improvement, he was then ordered Aurum met. 6, this aggravated the diarrhoea. At the beginning of the next year he contracted tonsillitis, was ordered Phytolacca, which aggravated the diarrhoea, but Mercurius solubilis improved the loose stool.
Next month he asked his GP for Tofranil, but stopped taking it, and was ordered prednisone. He came home from school for leave at Easter, was ordered Colocynthe, but claimed that a new prescription always aggravated his symptoms. He asked for another opinion and was seen by a consultant physician who considered him depressed and ordered another anti-depressive. Back at school he consulted another psychiatrist, who elicited, what I had failed to do, well masked homosexual tendencies. In the summer holidays, he asked me for an appointment, and at the last moment, cancelled it. Of course, with such proclivities, the stress of teaching in a boys' public school must have been a continuous precipitating factor. Predisposing factors were the familial organ inferiority and the latent homosexuality. As far as treatment was concerned, it did not help that during term and vacation he shuttled between two general practitioners and two consultants.

My second patient has a more satisfactory outcome. This was a woman of 31, whose mother died of cancer when my patient was 10. She won a place at a grammar school, proceeded to a teacher's training college. While she was still in training, her father too had died of cancer, but the next year at 21 she started teaching in an elementary school. Eight years later she had a series of attacks of diarrhoea, admitted "fear of cancer", had an appendectomy the next year, took an examination in music, and the diarrhoea relapsed. She was referred to me, and her main symptoms were profuse watery stools, much worse at the menses, accompanied by offensive mucus. She was upset by hot weather. I ordered her Veratum alb. 200 and she reported much better in herself but diarrhoea still persisted. I then prescribed Natrum sulph. 30 and she reported herself quite fit the following month, and remained well for five months. Then at that monthly period she had one bad attack of diarrhoea, and another dose of Veratum alb. Two months later another attack and another dose of Veratum. Then she was clear for five months. Another dose of Veratum and she was clear for six months, one slight attack until the following summer, when she had a final attack and was given Veratum alb., and a final dose of Natrum sulph. 200 a month later. She continued to report for several months without further recurrence, and to the best of my knowledge, has been well for the last ten years. But active treatment was prescribed over a period of two years and three months.

My experience of Crohn's disease was limited to watching a colleague's progressive deterioration in health until resignation was inevitable. I was not her adviser, but I was relieved to learn that some years later she recovered, married and bore a child.

In Crohn's disease the main pathology is in the terminal ileus, and all layers of the bowel wall are involved, both mucous membrane and muscular coats. Under the microscope the lesions have a close relationship to sarcoidosis (Hunt, 1974). It would appear that there is a genetic factor here, as Sherlock (1963) and her team published a family tree of three generations with five cases of Crohn's disease, two of ulcerative colitis and one of ankylosing spondylitis.

Dr. Gordon Ross (1969) published a case of Crohn's disease confirmed by laparotomy, occurring in a widow of 61 working as a home help. In hospital she was prescribed Lycopodium, Arnica, Colocynthe and S.S.C. He demonstrated this patient three years later at a clinical meeting in Glasgow and she was well and working hard.

It is clear that the homeopathic treatment of ulcerative colitis is difficult and likely to be prolonged but what are the modern alternatives?
Early surgical treatment has been recommended even for elderly patients (Goligher, 1967). But even after operation some 40 per cent. of patients still had between five and nine motions in 24 hours (Jagelman, 1969). In the more radical complete proctocolectomy, there is a danger of damaging the pelvic plexus and interfering with subsequent sexual function (Hughes, 1969).

It is claimed that the widespread use of steroids in the last ten years has reduced the mortality (de Dombal, 1966), but in children the risks of steroid treatment are suppression of growth, osteoporosis, and high blood pressure. But colitis in these children carries a definite risk of cancer—after 20 years of colitis symptoms, the risk of malignant change is 5-8 per cent. and this would rise to a staggering 42 per cent. after 25 years (de Dombal, 1966).

The current interest in medical treatment of colitis is the use of antimetabolites such as azathioprine, but this involves regular blood counts because of the risk of severe leucopenia, and a minor disadvantage is alopecia, the loss of hair (Lennard-Jones, 1974).

What do you think? Would you not give homeopathic treatment a fair trial if you were faced with a case of ulcerative colitis in a near relative?

The primary lesion in ulcerative colitis is in the mucous membrane; in contrast to this, the primary lesion in diverticulosis is in the smooth muscle. Just as ulcerative colitis was first distinguished from bacillary dysentery 100 years ago (Wilks and Moxon, 1875), so diverticulosis was discovered in the same year. But in contrast to the comparative rarity of ulcerative colitis in general practice, diverticulosis is quite common; half the subjects over 60 develop diverticula, so that in the average general practice of 2,500, 225 subjects can be expected, but many of them will be symptomless and the diverticula will only be demonstrated by recurrent X-rays or subsequent post-mortem studies.

But if diverticulosis is to be expected in old age pensioners, what were the early stages? It has been suggested that the first stage would be of colon spasm before any diverticula have developed; but one physician has pointed out that the differential diagnosis between colon spasm and psychoneurosis is very difficult (Goligher, 1965).

The syndrome of colon spasm is defined as an association of abdominal pain with colonic hypermotility after meals, discomfort, flatulence, and sometimes quite severe pain; these patients develop exceptionally high pressures in the sigmoid colon: the effect of gastro-colic reflex in these patients is to hold up the passage of faeces through the sigmoid (Connell, 1965). Indeed these exaggerated contractions result in a functional obstruction which my Bristol colleague Dr. Naish (1974) has described as a pseudo-obstruction and indeed patients have been operated on for this suspected intestinal obstruction. It is important to remember that morphia will increase the pressure in the colon and must not be given for this pain (Musiewicz, 1974).

This raised pressure in the colon results in the prolapse of the mucosa and these prolapses constitute the diverticula, which are then liable to infection, perforation, peritonitis, and fistulae into the bladder or vagina.

It has been argued that as diverticulosis is rare in African tribes subsisting on high residue diets, that adding fibre to the diet in the form of bran would prevent attacks. But in my experience, this is an example of shutting the stable door after the horse has escaped. In established diverticulitis I find that additional fibre in the diet exaggerates the discomfort and the pain. One must always remember that diarrhoea and constipation mean different things to different people, and this is specially important to homœopaths, who must
closely question the patient for details; most diverticulitis patients complain of constipation and indeed one physician has suggested that the hiatus hernia so often observed in these patients is due to straining at stool.

It was a Plymouth surgeon who proposed a new operation for the treatment of diverticulitis on the lines of Ramstedt’s operation for congenital pyloric stenosis (Reilly, 1964). This was a division of the thickened muscle coat of the colon. Before this, the surgical approach was resection of the affected part of the colon. A follow-up of 100 consecutive patients operated on in a London hospital showed recurrences of 33.6 per cent. (Bolt and Hughes, 1966). A follow-up of 521 diverticulitis patients in Belfast showed recurrences of 22 per cent. after operation and 30 per cent. after medical treatment (Parks, 1969).

I have no comparable statistics to offer for homoeopathic treatment, but I have retrieved some individual cases from the homoeopathic literature.

Dr. Blaquiere found some of these patients responded to Nux vomica 30 at bedtime or Sepia 200. He deprecates using both remedies together as Nux intensifies the action of Sepia and could lead to an aggravation (Blaquiere, 1971). Fergus Stewart (1968), discussing laxatives in diverticulitis, warned against the use of preparations containing phenolphthalein.

Up to date I have not been able to gain access to my old outpatient records though I can recall several cases of diverticulitis greatly relieved by homoeopathic remedies. I quote here one private case of a married woman of 45 referred to me by a homoeopathic general practitioner. He had had occasion in the past to treat her successfully for an intercurrent angioneurotic oedema with Apis. But her recurrent attacks of colic and diarrhoea had not responded to Phosphorus and a barium enema had demonstrated a spastic colon and diverticulitis. She was an anxious patient, who was fearful in a closed space; after a shock she wept and felt cold internally. Using the repertory it is true that Phosphorus came through strongly, but even stronger was Veratrum alb. which I recommended in the 200 and I understood from her doctor that she was free from subsequent attacks of pain and diarrhoea for several years.

In a recent number of the British Medical Journal there was a preliminary communication on the use of glucagon in the treatment of acute diverticulitis (Daniel et al., 1974). In 20 patients intravenous injections of glucagon relieved the pain in an average of 12 hours compared with the average 4 days by conventional treatment. Glucagon is a hormone recently discovered from the alpha cells of the pancreas. It has a wide range of action on the metabolism of sugar and fat, increases myocardial contractions and cardiac output, without producing arrhythmias, reduces gastric and pancreatic secretions and inhibits gastric, jejunal and colonic motility. It is this last activity which is probably the basis of its action in diverticulitis but the action is of short duration and it must be given parentally (Today’s Drugs, 1971). It has been noted that as it is a polypeptide of protein derivation, allergy may develop and when it was used with some success in acute pancreatitis (Knight et al., 1971) nausea and vomiting were common. Even if this hormone is used to relieve the acute attack, treatment will still be required to prevent recurrence and here the homoeopathic remedies come into their own.

In diverticulitis then I think of—Nux vomica, Aloes, and Veratrum alb.—Nux vomica was one of the two drugs to which Hahnemann drew special attention by describing the special temperamental features of the patients for whom it was best indicated (Hahnemann, 1810).

Dr. Hubbard (1969) elaborates this picture bringing it up to date. She wrote,
"Another of the builders of our modern civilization is Nux vomica, the certified
public accountant, charged with details of which he is a perfect master but
which irritate him into fault finding, vehemence, and even spite. He must have
an outlet from his sedentary and exacting occupation, he cannot bear reading or
conversation, he takes to dissipation or lets out in spells of touchiness; he will
kick the chair and rip off the button from irritable weakness; he has too many
irons in the fire and they are always hot, he is harried by a thousand details and
takes it out on the family. His mental peristalsis is reversed, he is full of perversity,
he strains not only to vomit, to stool and to urination but to forcing things
his own way. He suffers and makes all about him suffer from mental tenesmus.")
Daniel and his Iraqui colleagues claimed that glucagon will relieve the pain in
12 hours, but our Dr. Borland (1941) claimed that Nux will act in acute condi-
tions in 20 minutes to half-an-hour. But Borland also used Nux in chronic
conditions, "the patient who has been persistently overdoing it at work, too
much anxiety, too much stress; he has disturbed nights, not sleeping well, then
falling into a heavy sleep in the later part of the night and waking up feeling
perfectly awful when it is time to get up."

Dr. Jack found Aloea effective in low potency, the 3rd, but he comments
that "the initially correct and effective remedy presumably modifies the drug
picture and the problem is then to find the complementary remedy that follows"
(Jack, 1971). Here, as Dr. Elizabeth Hubbard (1933) recommends, the best
source of information is Dr. Gibson Miller’s little pamphlet, the Relationship
of Remedies (undated).

As for Veratrum album, Dr. Tyler (1935) considers it near to Arsenicum, but
Arsenicum has extreme anxiety and restlessness whereas Veratrum is quiet.
Dr. Hubbard visualizes Veratrum album as a woman’s remedy: "The Dowager—
unkindly ... loquacious, malicious, ... destruction with rapier ability in the
women’s Club of which she is president" (1969). Was she thinking of Dorothy
Parker?

To sum up, in caring for these patients with serious disorders of the colon,
it is essential that they are properly investigated, that barium enemas and
sigmoidoscopies are carried out, but that, at any rate with neoplasms excluded,
your patients should be given the option of homeopathic treatment before
steroid therapy, or major surgery, is undertaken. We must remember, too, that
we may need one drug to treat the acute exacerbation due to whatever precip-
itating cause, and another drug to deal with the predisposing constitution,
and cure, as distinct from relief, must be envisaged in terms of months, even
years, as compared with relief in hours or days.

REFERENCES
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XXXI International Homeopathic League Congress

The Congress will be held at the National Foundation of Scientific Research in Athens, from 16 to 22 May 1970. The Congress President will be Dr. Irene Bachas, President of the Hellenic Homeopathic Medical Society. Further details are available from

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